

Adult Safeguarding Annual Report

2016/17

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Adult safeguarding is the term used for protecting adults from abuse or neglect

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Executive summary

The Safeguarding Adult Annual Report 2016/17 outlines the work undertaken by the Trust during the past year. Adult Safeguarding is the term used for protecting adults from abuse or neglect.

Adult Safeguarding leads within the Trust are the Director of Nursing and Patient Experience, who has executive responsibility, the Deputy Director of Nursing, the Lead Nurse Adult Safeguarding (Named Nurse) and the Lead Consultant Adult Safeguarding (Named Doctor).

Adult Safeguarding is a whole systems approach and the Trust is a partner agency of the Hertfordshire Safeguarding Adult Board (HSAB). The Trust is represented on the board by the Director of Nursing.

During 2016/17 the Trust has participated in HSAB activities which have included attendance at Board meetings, involvement in sub-group work, attending the Hertfordshire Safeguarding forum and Mental Capacity Act forum, updating the Hertfordshire policies and procedures, participating in Safeguarding Adults and Domestic Homicide Reviews, and the IMR (internal management reviews) writers training.

The Trust achieved the target of 90% compliance with Adult Safeguarding training with 91% of staff compliant with training, which includes Prevent awareness.

428 staff attended Prevent WRAP extended training in 2016/17.

The leads for adult and child safeguarding were given update training from a Prevent interventionist, which included information about extreme Right wing ideologies as well as extreme Islamist ideologies.

Mental Capacity Act and Deprivation of Liberty Safeguards Masterclasses were held during 201/17 and 259 clinical staff attended.

Reported safeguarding concerns increased by 41% from the previous year, which seems to reflect improved levels of reporting as the local authority also saw an increase in reported concerns during this period (HSAB data). 238 concerns were reported.

Deprivation of Liberty Safeguards urgent authorisations increased again during 2016/17, by 30%. In total there were 216 urgent authorisations and requests for standard DoLS completed.

Four senior nurses completed the Best Interests Assessor training at the University of Hertfordshire, providing increased capacity in the expert knowledge available to guide and advise Trust staff.

The Hertfordshire IDVA (Independent Domestic Abuse Advisor) provider service changed to 'Refuge' in October 2016. Since then turnover in the hospital based IDVA post has been high and is currently vacant. This has reduced the visibility of the IDVA in the Trust, however, staff continue to seek advice from the safeguarding teams and make referrals to Refuge for domestic abuse victims.

The Diabetic Eye Screening team was successful in being awarded the 'Purple Star' accreditation in recognition of good practice around the care of people with Learning Disabilities who attend their services. The Trust Ophthalmology team and the New QEII Hospital are also progressing work to achieve this quality mark.

The Trust has participated in setting up the Hertfordshire processes for the National Learning Disability Mortality Reviews (LeDeR) from April 2017 and two senior clinical staff have been nominated to undertake reviews in Hertfordshire.

The CCG undertook the annual assurance visit in March 2017 and were reassured overall about Adult Safeguarding processes and systems in the Trust.

1.0 Introduction

This is the Annual Report for Adult Safeguarding for East and North Hertfordshire NHS Trust for 2016/17. The report outlines the work undertaken by the Trust since April 2016 to support the frameworks for Safeguarding Adults.

The 2014 Care Act was implemented in April 2015 and established the legal framework for Safeguarding Adults. The Department of Health (DH) last updated the statutory guidance for the Care and Support Act in February 2017.

Adult Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about working with adults who have care and support needs, who may be in vulnerable circumstances and at risk of abuse or neglect, with the multi-agency teams working together, and with the individual, to prevent and stop the risks and experience of abuse or neglect.

Making Safeguarding personal means that an adult's wellbeing is promoted and that there is regard for the adult's views, wishes, feelings and beliefs in deciding on any action to be taken, wherever possible.

The Care Act definition of an adult at risk is:

- A Person aged 18 years and over, who has needs for care and support (whether or not the local authority is meeting any of those needs) and is experiencing, or is at risk of, abuse or neglect, and as a result of their care or support needs is unable to protect him or herself against abuse or neglect, or the risk of it.

2.0 Adult Safeguarding

2.1 The Trust Adult Safeguarding Structure:

Role	Name and Job Title
Executive Director Safeguarding	Angela Thompson, Director of Nursing and Patient Experience (to December 2016) Liz Lees MBE, Interim Director of Nursing and Patient Experience (from December 2016)
Deputy Director Safeguarding	Liz Lees MBE, Deputy Director of Nursing Debbie Whittaker, Interim Deputy Director of Nursing (from December 2016)
Lead Nurse Adult Safeguarding (Named Nurse)	Bernadette Herbert, Lead Nurse Adult Safeguarding
Lead Doctor Adult Safeguarding (Named Doctor)	Dr Emma Lines, Consultant Physician (on leave since September 2016) Dr Deepak Jain, Consultant Physician since September 2016
Enda Gallagher	Adult Safeguarding and Patient Falls Prevention Nurse

Within the Clinical and Non-Clinical Divisions the Divisional Director and Divisional Chairs or Senior Managers are responsible for the implementation of and compliance with Trust policies and procedures and maintaining standards of practice and quality of care provision with clinical and non-clinical teams.

The Director of Nursing is the Executive and Strategic Lead for Safeguarding and a member of the Hertfordshire Safeguarding Adults Board.

2.2 Trust policies and procedures which support the framework for Adult Safeguarding are:

- Safeguarding Adults from Abuse and Neglect and Prevent policy
- Hertfordshire procedures for Safeguarding Adults from abuse
- Mental Capacity Act policy
- Deprivation of Liberty Safeguards policy
- Care of Adults with Learning Disability policy
- Domestic Abuse policy
- Chaperoning policy
- Employee and workforce policies and procedures
- Disclosure and Barring checks and disclosure of information, Trust policy
- Raising Concerns at Work policy – ‘Whistleblowing’
- Statutory and Mandatory training policy
- Equality, Diversity and Human Rights Strategy
- Safer Staffing

2.3 Lead Nurse Adult Safeguarding

The post of Lead Nurse for Adult Safeguarding is the Named Nurse for Adult Safeguarding, providing strategic and operational leadership, guidance and advice for Trust staff.

The Lead Nurse is supported by the Adult Safeguarding and Falls Prevention Nurse. During 2016/17 the Falls Prevention Nurse has been supported to take on more of the work involved in Adult Safeguarding. This development has provided additional capacity in the Adult Safeguarding team.

The Safeguarding Nurses receive clinical supervision from the Hertfordshire CCGs Head of Adult Safeguarding.

2.4 Lead Doctor Adult Safeguarding

The Medical Director has nominated the Named Doctor for Adult Safeguarding, who is also the Medical Lead Learning Disability Champion.

The post holder works collaboratively with the Lead Nurse and provides medical advice when required for adult safeguarding cases. The post holder is the champion for adult safeguarding, and patients with a learning disability, to raise awareness and knowledge with medical colleagues and doctors in training.

During 2016/17 Dr Lines went on maternity leave and the post has been covered by Dr Jain, one of the Elderly Care Consultants.

2.5 Safeguarding Liaison and Hospital Social Work Teams

Safeguarding referrals raised within the Trust are processed by the Adult Safeguarding Nurse and Health and Community Services (Local authority). The investigation of a safeguarding referral is led by the local authority, following the Hertfordshire policy, procedures and practice guide for Safeguarding adults at risk. On occasions the investigation will be led by a different local authority dependant on the residency of the adult in need of safeguarding or the location of an alleged incident. If a crime is suspected the police will lead the investigation.

Since April 2015 the NHS Serious Incident framework has included incidents of abuse where:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
- where abuse occurred during the provision of NHS-funded care.

2.6 Hertfordshire Safeguarding Adults Board

The Trust is a member of the Hertfordshire Safeguarding Adults Board (HSAB) and is represented by the Director of Nursing.

The Trust is an active partner of the Board and participates in the working sub-groups, Safeguarding Adult's Reviews and Board activities.

Feedback from HSAB to the Trust is given via the Trust Safeguarding Committee and by the Director of Nursing to the Trust Board.

During 2016/17 the Trust staff have participated in the HSAB meetings, the review and updating of the Hertfordshire policy and procedures, the annual safeguarding conference, the review and updating of the mental capacity act policy, Safeguarding Adults Reviews, Domestic Homicide Reviews, the development of the Hertfordshire Mental Capacity App, the Hertfordshire Mental Capacity Act forum and the Safeguarding Adults forum. Three senior nurses also attended the Board's IMR (internal management reviews) writers training day.

2.7 Trust Safeguarding Committee

During 2016/17 the Safeguarding Committee has continued as the joint committee for children and adults, chaired by the Director of Nursing. Representation is provided from clinical divisions across the Trust, the Trust Child Safeguarding team, the Trust Adult Safeguarding Nurse and Doctor, Designated Nurses for Child and Adult Safeguarding, Learning Disability Liaison Nurse, Independent Domestic Violence Advisor, Trust Education team, Emergency Department consultant and Dementia team and the CCG leads for Adult and Child Safeguarding.

The Safeguarding Committee meets monthly and reports to the Risk and Quality Committee via the Director of Nursing.

During this year the Safeguarding Committee has had presentations from the Sexual Assault Referral Centre, the Stevenage Borough Council Anti-social Behaviour Unit and case presentations related to Domestic Homicide and Serious Incidents.

The Adult and Child Safeguarding Leads and teams also had an update training half day on Prevent in October 2016, led by an expert in Prevent and interventionist work for radicalised individuals. The session covered different types of radicalisation and different ideologies including risks from extreme right wing and extreme Islamic ideologies. It was thought provoking and added to existing knowledge and understanding which is being utilised in Trust staff training sessions.

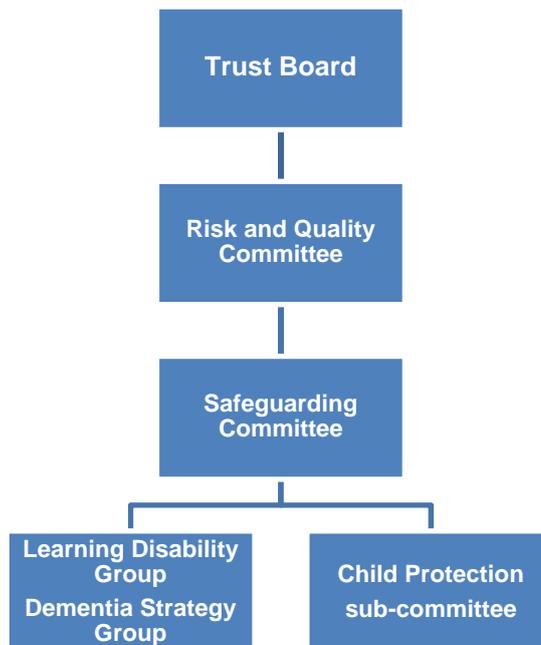
2.8 Risk and Quality Committee (RAQC)

The Risk and Quality Committee is a sub-group of the Trust Board, chaired by a Non-Executive Director. The Adult Safeguarding report is provided to RAQC quarterly in the Director of Nursing's Patient Safety Report.

Adult Safeguarding Structure



Trust Safeguarding Committee Structure



3.0 2016/17 Safeguarding Adults at Risk

3.1 Safeguarding Concern 'Alerts'

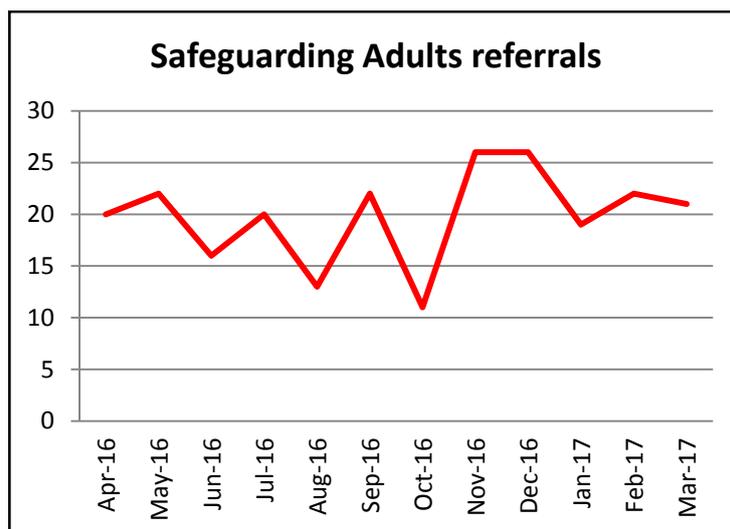
From April 2016 to March 2017 the Trust recorded 238 Safeguarding Adults at Risk concerns; these include all concerns reported by Trust staff as well as those raised about care in the Trust.

In comparison to the previous year (168 concerns) this shows an increase in reported concerns by 41%. The increase does not necessarily show an increase in incidents of abuse or neglect but better reporting of concerns. Both the Trust and Hertfordshire Health and Community Services have seen more concerns being raised by East of England ambulance teams, who will see the individual's circumstances in their home environment, and these will be reported to Trust clinical teams when the patient is brought into hospital. The increase also reflects the increase seen generally in Hertfordshire, as shown in the HSAB performance reports, which have shown improvements in reporting and recording of concerns since 2015/16.

Within the Trust there were 36 concerns were about care in the Trust. Five went to Serious Incident (SI) investigations. Of these two were for patients with Learning Disability and the detail is listed in section 6.3. One was an allegation that the Trust had discharged a lady and not informed the care agency that she was being discharged. She was not seen at home for three days. The outcome was that this was not substantiated against the Trust as the care agency had been informed of her being discharged and should have arranged carers to attend. One SI was an incident where an agency nurse was verbally aggressive and physically threatening towards a patient, and whilst there was no harm caused to the patient the behaviour was unacceptable and a referral was made to the Nursing and Midwifery Council (NMC) regarding the nurse's fitness to practice. The nurse is currently suspended from practice whilst the NMC conduct their investigation. One SI was about a patient who had a fall and head injury in hospital and the family raised concerns about their care. This SI is still in the investigation period.

Five concerns were dealt with as complaints. One Safeguarding concern about staff causing bruising was not substantiated. In 18 concerns they did not progress to formal enquiries as evidence was provided to show abuse or neglect did not occur in hospital. Five concerns were about poor discharge communication or practice and these were addressed by the relevant matrons and appropriate actions taken at ward level. Two related to hospital acquired unavoidable deep tissue injury (pressure ulcers).

The chart below shows the month by month number of concerns reported.



The categories of alleged abuse or concerns raised for safeguarding adults included: neglect, self-harm, self-neglect, financial, physical, sexual, discriminatory, psychological abuse or domestic abuse and suspected people trafficking. Staff will also make referrals for concerns related to the increased care needs of individuals and whilst this is not abuse or neglect it may mean people are 'at risk' and in need of care and support services.

The actions taken by the Trust in relation to the concerns raised against the Trust included:

- Reporting alleged abuse to the police,
- Ward managers and matrons reviewing practice in clinical areas and taking steps to improve practice
- Referral to the NMC Fitness to Practice Panel for an agency nurse
- Staff training programmes including use of Mental Capacity Act and Best Interests decisions, diabetes management and sepsis management
- Initiatives to improve patient safety, such as introduction of the Sepsis team and e-obs (electronic observations).

3.3 HSAB Safeguarding Adults Reviews

During 2016/17 the Trust participated in two Safeguarding Adults Reviews led by HSAB. The reviews were concluded and learning shared with the multi-agency membership of the Board. The key learning areas were around raising awareness about self-neglect and adult safeguarding, information sharing agreements between agencies, working with adults who have mental capacity to make unwise decisions, and improving access and recognising the specific needs of harder to reach communities or individuals. The learning from the SARs has influenced the strategic objectives and work plan for the HSAB for 2017/18.

3.4 Domestic Abuse

3.4.1 Independent Domestic Violence Advisor (IDVA)

The hospital based IDVA post was established in January 2015. Up to October 2016 the service was managed by Victim Support. Since October the Hertfordshire IDVA service has been managed by Refuge. Unfortunately, the changes have led to higher turnover of IDVA staff with two experienced IDVA leaving within a three month period, and at the end of March the on-site IDVA post was vacant. Referrals are still being made for patients to the Herts Refuge team; however, the visibility of the IDVA in the Trust has reduced. The

Refuge service has plans in place to recruit a replacement. The risk has been added to the Trust Risk Register and concerns were shared with the Clinical Commissioning Group at the Trust annual assurance visit.

As a result of the changes in IDVA personnel, the data about their work in 2016/17 is not available at the current time.

During the period that the IDVA was on-site they continued to work closely with clinical and safeguarding teams and provided advice and guidance to teams to support and safeguard victims of domestic abuse. Clients referred to the IDVA during 2016/17 ranged from all age groups, gender and ethnicity. There were some patients who had experienced abuse for many years, in some cases decades, and the IDVA was able to offer support to the individuals and gave practical assistance in the patient's decision to leave the abusive relationship.

The IDVA has also been able to offer support and advice to staff members who were victims of abuse.

The IDVA worked closely with the police, local authority safeguarding teams, victim support and Refuge.

Stevenage Borough Council Anti-social Behaviour Unit also has support services for victims of Domestic Abuse that Stevenage residents can be referred to. The team gave a presentation to the Trust Safeguarding Committee about their services earlier in the year.

3.4.2 Multi-Agency Risk Assessment Conference – MARAC

The Trust receives requests for information from three MARAC teams in Stevenage and North Hertfordshire, Welwyn and Hatfield and Broxbourne and Cheshunt. Relevant information is shared with MARAC for victims, perpetrators and children to assist in the implementation of protection plans for victims. Information is shared by the Adult Safeguarding team, the Children's Safeguarding team and the Safeguarding Midwives.

3.4.3 Domestic Homicide Reviews (DHRs)

DHRs are a statutory requirement under the Domestic Violence, Crime and Victims Act 2004. DHR means 'a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a) a person to whom he/she was related or with whom he/she was, or had been, in an intimate personal relationship, or
- b) a member of the same household as him/herself

held with a view to identifying lessons to be learnt from the death' (Home Office 2016).

During 2016/17 the Trust has been asked to provide information and participate in four DHRs for Hertfordshire residents as the victim, or the perpetrator, had accessed Trust services at some point before the death. The DHR cases included: a young woman murdered by her older half-sister, an elderly man killed by his son-in-law, a young mother killed by her partner who then killed himself, and another lady who was killed in the south of England.

An internal management review (IMR) has been provided for one of the reviews. The Trust learning from this review has been about staff recognising that assault between adult siblings is within the definition of Domestic Abuse and that individuals will need risk

assessment and referral to DV services. Raising awareness of this has been included in Safeguarding training and in training briefings in the ED.

All four reviews are still in progress.

4.0 Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act is an important part of everyday practice in the NHS and it is the responsibility of all Trust staff to have regard for the requirements of the act.

Staff receive training about the MCA and DoLS in their statutory and mandatory training, provided at induction and in two yearly updates.

During 2016/17 additional MCA/DoLS Masterclass workshops and 'lite bite' sessions have also been held to help staff to develop their knowledge and skills in this area. 259 staff attended the training.

Additional learning tools have been provided to staff to help them increase their knowledge and understanding of MCA and DoLS (see appendix 1, 2 and 3).

The Trust has also encouraged staff to utilise the smart phone application for Mental Capacity Act and DoLS prompts developed by the Hertfordshire Adult Safeguarding Nurses and the CCG on behalf of the HSAB (see appendix 4).

Importantly, the CCG provided funding between 2015 and 2016 for four senior nurses to undertake the Best Interests Assessor qualification at the University of Hertfordshire. This has increased the number of staff available within the Trust to provide expert guidance and advice to clinical staff.

MCA audits have been undertaken and the findings fed back to clinical teams for learning and improvement actions. Audits have demonstrated a need to improve documentation of mental capacity assessments with patients who have impairment to the functioning of the mind or brain, and of the best interest's decisions made for patients who are assessed to lack the mental capacity to make the decision themselves.

4.1 Deprivation of Liberty Safeguards (DoLS)

DoLS provide legal protection for those people aged 18 years and over who lack the mental capacity to consent to the arrangements for their care or treatment in a hospital, or care home, and in whom, within the meaning of Article 5 of the European Convention of Human Rights (ECHR), are deprived of their liberty, in their best interests, to protect them from harm.

The Supreme Court established the 'acid test' in March 2014 and stated that a deprivation of liberty should be considered where:

- The person is under continuous supervision and control **and**
- is not free to leave **and**
- lacks the mental capacity to consent to remain in hospital or a care home

The person does not have to be saying or showing that they want to leave for a deprivation of liberty to be considered.

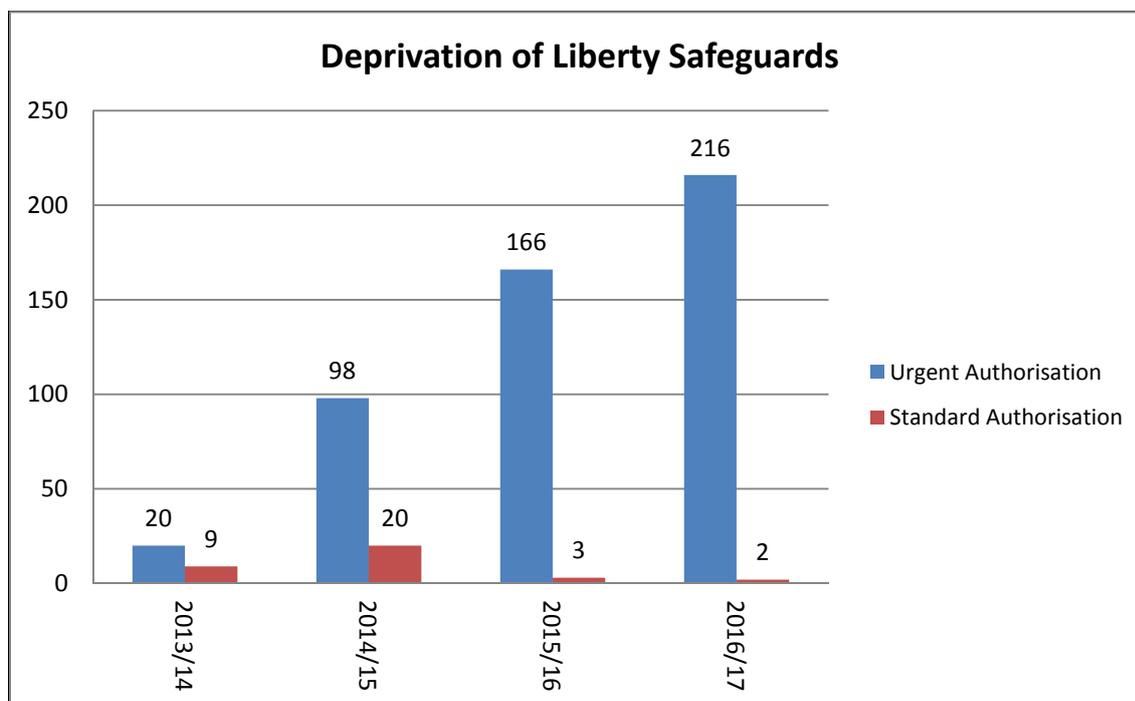
The charts below show the changes in Deprivation of Liberty Safeguards applications since 2013. The changes show that the number of urgent applications made by the Trust (managing authority) has increased year on year, and this does indicate an improvement in recognising the need to use DoLS with patients who lack capacity to consent to their admission to hospital. However, the number of standard authorisations by the Supervisory body (Local Authority DoLS teams) for patients in the Trust has decreased over the same period. This reflects the continued difficulties that the Hertfordshire Supervisory body experiences in dealing with the significant increase in the number of DoLS applications since the Supreme Court changes in 2014, and that the team are not able to send out assessors to complete the standard authorisation before patients are discharged or die.

Unauthorised DoLS (after the urgent authorisation has expired) continues to be a risk for the Trust and is recorded on the Trust Risk Register. However, this position is reflected across all organisations in Hertfordshire and is being monitored by the HSAB.

There were 216 urgent DoLS and requests for Standard DoLS made in 2016/17. In the previous year it was 166 and therefore this shows a 30% increase. Since 2014 the Trust has seen an almost 10 fold increase in DoLS applications.

DoLS authorisations 2013-2017

Year	Urgent Authorisation	Standard Authorisation
2013/14	20	9
2014/15	98	20
2015/16	166	3
2016/17	216	2



The requirement to notify the Coroner about a patient who has died with DoLS in place has changed, as a consequence of the changes to the Policing and Crime Act 2017, deaths of patients with DoLS in place from 3 April 2017 no longer need to be notified to the coroner solely on the basis that DoLS was in place.

4.1.2 Proposals to replace DoLS with Liberty Protection Safeguards

Over the past three years the Law Commission has been reviewing the process used for Deprivation of Liberty in England and Wales. The final report and draft bill were published in March 2017.

The Law Commission's proposed replacement scheme is called 'Liberty Protection Safeguards' (LiPS). The LiPS replaces the 'supervisory body' with the 'responsible body'. It creates a stronger link between the commissioning of the arrangement for care and treatment and consideration of whether deprivation of liberty is justified.

The responsible bodies will be:

- the hospital manager for hospital care/treatment arrangements
- the CCG for continuing health care arrangements
- the responsible local authority, where the person is ordinarily resident, for people in their own homes

The new proposals will apply to persons aged 16 and over.

There are also proposed wider reforms to the Mental Capacity Act which are intended to protect Article 8 rights (right to a family life) and improve decision making under MCA and the best interests decisions.

Significantly, protection from liability under the MCA will only be available to professionals if a written record has been prepared confirming that a formal mental capacity assessment has been undertaken and rights to advocacy have been given effect.

The implications of the proposed changes are:

- More responsibility on frontline staff to better understand and apply MCA
- Training requirements for all staff on the changes to the Act and their responsibilities under the Act.
- The Best Interests check list (MCA s4) will give rebuttable presumption in favour of the person's wishes and feelings. Decision makers will be required to give much more weight to the person's wishes. Currently the person's wishes and feelings must only be 'considered' or 'taken into account'.
- Care or support plans will need to be much more specific in terms of recording any restrictive elements in care arrangements.
- A new role of independent reviewer is suggested to conclude that the conditions for an authorisation are met – it is not clear yet who would be the reviewer but it may be an advanced practitioner (social worker) or a senior nurse
- A new role of Approved Mental Capacity Professional (AMCP) is created, building on existing BIA roles. This person would receive referrals under LiPS where the person objects to being accommodated at or receiving care and treatment at a particular place, or that the arrangements are necessary and proportionate due to likelihood and seriousness of harm to others. The AMCP would be responsible for authorising these arrangements.
- The Responsible body would have a duty to appoint an appropriate person to represent the 'cared for person'.

Further information about the proposed changes can be found at:
<http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>

The proposed changes, if accepted, will need to be considered for the impact it will have on processes within the Trust and the impact on frontline staff and the Adult Safeguarding team, this will need to be considered in the work plan for 2017/18.

5.0 Adult Safeguarding and Prevent Training

5.1 Adult Safeguarding training

Adult Safeguarding training is provided for all Trust staff through the statutory/mandatory training programme and new staff induction programme. All staff receive mandatory updates every two years, Adult Safeguarding level 1 & 2, MCA, DoLS and Prevent awareness. Compliance with training attendance is recorded on the Electronic Staff Record and monitored through monthly reports to line managers, the Statutory-Mandatory Training Committee and the Safeguarding Committee.

Adult safeguarding training compliance at the end March 2017 was 91%, which achieved the Trust target of 90%.

5.2 Prevent training

From April 2015 Prevent awareness has been included in mandatory Safeguarding training and is provided to all staff.

All staff are also invited to undertake the Prevent WRAP workshop. During 2016/17 428 staff attended these workshops. When combined with attendances from previous years the number of staff who have now participated in a WRAP workshop is 891. Prevent workshops have been held at the Lister Hospital, Mount Vernon Cancer Centre and Luton Renal Unit.

The Trust has not made any referrals to the Channel panel in 2016/17.

6.0 Care of Adults with a Learning Disability

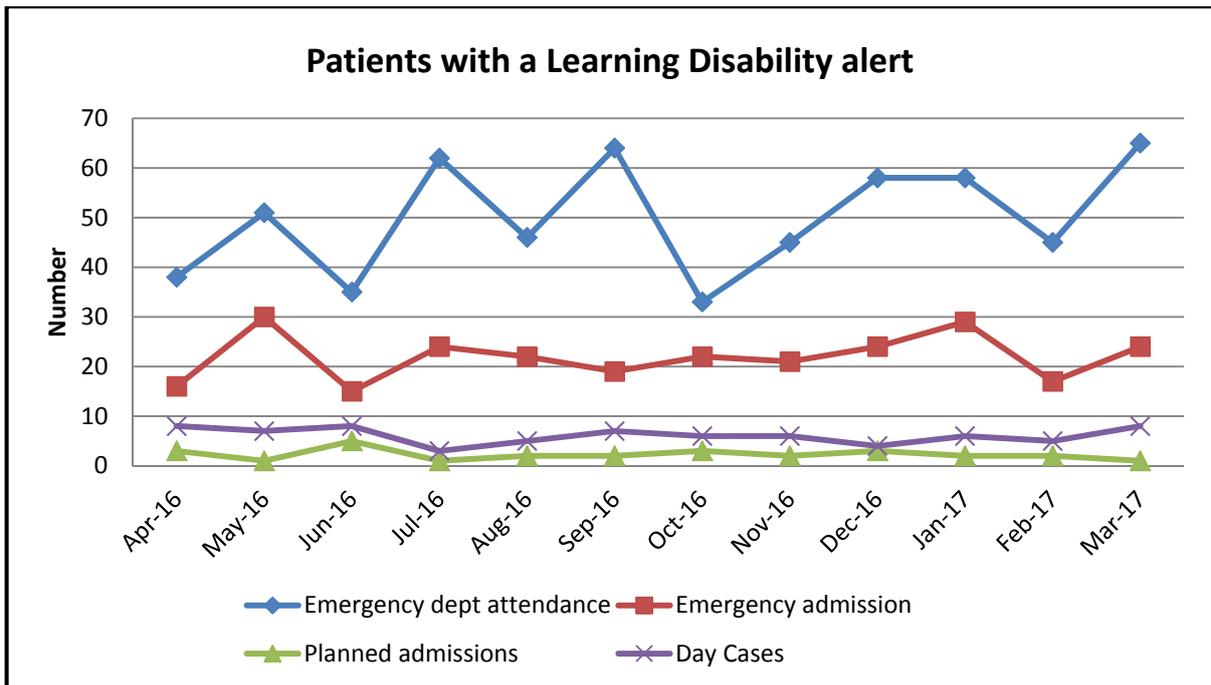
The Acute Liaison Learning Disability Nurses (Hertfordshire Health and Community Services) are involved with supporting patients with Learning Disabilities (LD) and their carers when using hospital services. They will assist Trust staff in making reasonable adjustments for patients, advising staff about what reasonable adjustments might be required, using appropriate communication tools for people with LD, enabling appropriate discharge packages of care, end of life care and will provide training for staff around the needs of patients with a learning disability.

The Trust uses PAS alerts (Patient Administration System) to attach an alert to the PAS record of a patient with a LD where that information has been shared from the local authority or when a patient is identified to have a learning disability and consents to the alert being used. The use of the alert helps to identify when a patient with LD is admitted, attends the Emergency Department or is due to attend for an outpatient clinic or for an elective admission.

The charts below show the patient activity in 2016/17. The numbers are for attendances and not the number of patients, as a patient may attend more than once.

Patient activity 2016/17 using the LD PAS alert (Source: Acumen reports)

Activity Type	Attendances
Emergency Department attendances	600
Inpatient admission (emergency)	263
Inpatient admission (planned)	27
Day case attendance	73



The Learning Disability Nurses have continued to provide training and team briefings for staff across the Trust during 2016/17. This has included awareness sessions on the additional needs of people with a Learning Disability and use of the 'Purple folder' (health passports) and reasonable adjustments. They also provide training for clinical staff on the patient safety day and preceptorship nurses induction programme.

The Adult Safeguarding Nurse gave an update on work within the Trust to the Hertfordshire LD partnership in October 2016 along with the LD nurses and West Herts Hospitals Trust.

6.1 Improving Health Outcomes

The Trust has continued to participate in the Hertfordshire 'Improving Health Outcomes' group, the multi-agency group leading on the implementation of strategies to improve health outcomes for people with LD as part of the work of the Transforming Care Board in Hertfordshire.

6.2 National Mortality Review for people with Learning Disability (LeDeR programme)

From April 2017 the Trust will be required to notify the deaths of people with LD, aged 4-75 years, to the National Mortality Review programme. The aim of the programme is to review the deaths of people with LD to identify the learning for policy makers and services, so that improvements can be made for the health outcomes of people with LD, improve mortality rates and reduce the risks of premature death.

The Trust has participated in establishing the National LD Mortality Review programme in Hertfordshire. The Adult Safeguarding Nurse and an Emergency Department consultant have been nominated to be reviewers. The Trust is a member of the Hertfordshire Steering group, which has been established as a sub-group of the Adult Safeguarding Board. The Adult Safeguarding nurse has worked with the Deputy Medical Director to establish the procedures within the Trust for notifying deaths of patients with LD to LeDeR.

6.3 Serious Incidents

During 2016/17 five Serious Incident investigations included the care of patients with LD:

Incident date	Summary of incident	Outcome and Learning
January 2016	Non-verbal patient with physical and learning disability – missed hip fracture in ED	Patient treated and fractured hip repaired. Community Adult Safeguarding investigation completed – neglect substantiated. Cause of fracture remained inconclusive. Trust implementation of ‘Sticky note’ system in ED to ensure communication about Radiography reports between Radiography and ED.
February 2016	Patient with LD and autism self-discharged when acutely unwell, patient’s mental capacity to make the decision not formally assessed prior to discharge. Patient readmitted to Intensive Care with sepsis.	Patient recovered and discharged home. Training for Trust staff for assessing mental capacity and using DoLS. Training for Trust staff about sepsis and the deteriorating patient. Need for ‘carer’ staff to immediately escalate if they have concerns about taking someone home.

Incident date	Summary of incident	Outcome and Learning
April 2016	Patient with LD discharged from hospital following drainage of an abscess, had high blood glucose levels and subsequently readmitted with Diabetic Ketoacidosis and required care in Intensive Care.	Patient recovered and discharged to enablement bed. Training for staff in Diabetes management. Actions by staff to improve communication with GP and follow up on abnormal results. Individual reflection and learning for staff involved in incident. Staff ensuring they use the Mental Capacity Act to support decision making
September 2016	Patient death due to sepsis.	Premature death of an adult with LD. Learning is the need for staff to recognise and manage sepsis.
January 2017	Patient death due to aspiration pneumonia.	This SI is still being investigated

Learning and actions from all Serious Incidents are monitored through the Clinical Governance Committee and the Risk and Quality Committee.

Managing Sepsis has been a focused work programme in the Trust with the establishment of a specialist team and extensive training programme for staff.

Work has also been undertaken across the Trust to improve knowledge and skills in the practical application of the Mental Capacity Act in clinical decision making.

6.4 Purple Star Accreditation

During 2016/17 teams across the Trust have been progressing work to achieve the Hertfordshire Purple Star accreditation, which is recognised as a quality standard mark for being an 'LD friendly' service. The work programme includes assessments and feedback from service users with LD and experts by experience. The teams progressing this work are Ophthalmology, the New QEII hospital and the Diabetic Eye Screening programme. The Diabetic Eye Screening programme was awarded the Purple Star accreditation in March 2017 and became the second Trust service to receive the award.

6.5 Hospital Experiences of Adults with Learning Disability (HEALeD) research project

The joint research project with Cambridge University, Cambridge University Hospitals and East and North Hertfordshire NHS Trust to examine the hospital experiences of adults with learning disability has continued in 2016/17. The research outcomes are currently being written up by the research team and will be published in 2017.

Poster presentations were given at two conferences, in East Anglia and Scotland, and presentations were given at the East of England LD network day and at the NHS England Directors of Nursing Conference in 2016.

One of the patient stories from the research was presented to the Trust Board by one of the research assistants in November 2016.

Some emerging themes have been:

- Parents and carers expected there to be problems when the patient with LD came to hospital.
- Carers saw themselves as having a vital role in supporting people with LD to ensure that the care the patient receives is appropriate and safe.
- Carers and parents expect hospital staff to listen to them and follow the advice and guidance they provide and involve them in decision making.
- Staff fear that they will do something wrong and do not always feel confident in providing care for patients with complex needs.
- Staff also said that they would be more gentle and sympathetic with patients with LD and that they would make reasonable adjustments in providing care.

6.6 Learning Disability Champions

The Trust has a number of LD champions across the Trust who support developing good practice and care for adults with LD and to support making reasonable adjustments for patients with LD.

The LD champions have been instrumental in progressing the work for the Purple Star accreditation, as shown in the Day Surgery unit in 2015 and Diabetic Eye Screening programme in 2017 and the work being done by Ophthalmology and the New QEII Hospital teams.

The LD champions have also participated in the work to implement the Accessible Information Standards in the Trust.

6.7 Patient Alerts and Reasonable Adjustments

The Trust uses an LD alert on the Patient Administration System (PAS) to assist in identifying patients who may need additional support or reasonable adjustments. The Hertfordshire County Council LD register was last shared in 2015 and used to update the PAS system.

Reasonable adjustments may need to be made for patients with LD or autism to achieve equitable access to services. During 2016/17 examples of reasonable adjustments made included:

- Providing information in a way that patients can understand – all wards were provided with the Hospital Communication book, which had been funded by the Trust charity. The book has many pictures related to things that can happen in hospital and this can help staff to communicate with patients with LD in an easier format if it is needed.
- Learning disability nurses attending hospital appointments with patients with LD to provide support and assist with communication.
- Learning disability nurses supporting patients and carers during hospital admissions or attendance to the Emergency Department (ED).
- Using the patient's 'Purple Folder' or health passport to understand the needs of an individual.
- Using the Trust data sets to identify the future admission or clinic attendance of a patient with LD and to plan for attendance and involve the LD nurses as required.
- Discharge planning and involving patient and carers or relevant parties in organising discharges as well as for complex care requirements

- Supporting paid or family carers to stay with patients during hospital admissions, involving the Carer's Lead to provide support and information to carers
- Adjustments made to appointment times or theatre schedules to accommodate the needs of an adult with LD.
- Pre-operative arrangements made to enable patients and their carers to reduce anxiety or stress which some patients may experience when coming to hospital, for example; admission day before surgery to allow patient to settle, admission direct to ward rather than admissions unit, carers going with the patient into theatre
- Using quiet spaces in ED for patients who find busy or noisy areas distressing
- Making changes in the way things are done for blood testing with a patient who had severe needle phobia to minimise distress

7.0 Dementia Care and Enhanced Care team

Over recent years the Trust has focused on improving care for patients with dementia. There have been initiatives to improve the ward environments and make the areas more 'dementia friendly', particularly on the Elderly Care wards where a higher number of people with dementia are admitted. The wards have reminiscence rooms with décor and furniture which reminds patients of a home environment pictures and books remind people of times past. For some patients this helps with reducing agitation, distress or disorientation as the environment is more familiar to them. The ward décor has been changed to make 'way finding' easier with different bays having different colours to identify them. As dementia can affect neuro-visual pathways brightly coloured toilet seats have been used so that the toilet stands out and does not blend into the background decor. Brightly coloured crockery is also used to help patients see things better and this helps with patients eating at mealtimes.

The Trust has developed its Dementia Care team which includes a Matron, Specialist Nurse and Elderly Care Consultants who work in collaboration with the RAID team from the Mental Health Trust.

The Trust has also developed an Enhanced Care team, which is a team of Clinical Support Workers who provide additional support to wards when patients need more 1:1 care or supervision. The development of the team has reduced the reliance on temporary, or agency, staff who were being used when additional support was needed. The enhanced care team have had additional training to develop their skills in the care of patients with dementia, learning disability, confusion or agitation. They have also undertaken the MCA/DoLS master classes so can assist staff in undertaking mental capacity assessments and identifying patients who are being deprived of liberty and need the safeguards put in place. Feedback has shown improved satisfaction from relatives, more consistent support from staff who are able to get to know the patient, cover for seven days a week, reduction in the use of bank or agency staff to provide 'specialling' cover. The team have also received awards and commendations for the work that they have been doing.

During 2016/17 the Trust also adopted the national initiative 'Stay with me - Johns campaign' which is an initiative to support carers of people with dementia to stay with the patient when they are in hospital, if they want to. As part of the initiative visiting hours on wards were reviewed and open visiting was piloted on the Elderly Care wards and then rolled out to all wards. The Trust also has a number of initiatives to support carers, such as discounts on food and car parking and guest beds so that carers can stay in overnight if they want to. The Carers Lead also received a Royal College of Nursing award for the work she has done in the Trust in supporting unpaid carers.

8.0 CCG Safeguarding Adults Quality Assurance Assessment 2017

The CCG undertook their third quality assurance visit in March 2017. The self-assessment audit was completed prior to the visit, different questions were asked from those asked in the previous year. This was followed up by an on-site visit by the CCG Director of Nursing and Head of Safeguarding. The CCG feedback was that they were reassured overall regarding the standard of Adult Safeguarding within the Trust and made some recommendations to enhance continuous improvement.

Key findings from the review were:

- Increased safeguarding adult capacity with the addition of the Falls Prevention Nurse to support the Lead Nurse.
- Dip sampling of patient records has shown a mixed picture for the recording of Mental Capacity Act (MCA) assessments.
- Training compliance for levels 1 and 2 has increased to over 90%
- The Lead Nurse and ED Consultant have been identified to attend the Learning Disability Mortality Review training and then undertake reviews.
- Through the dementia care strategy and fund raising campaign the Trust has developed the environment of the Elderly Care wards to be more dementia patient friendly.
- The on-site Independent Domestic Violence Advocate has enabled early intervention with victims of domestic abuse.
- The Palliative Care team has worked with voluntary services to train volunteers to sit with patients who are at the end of their lives to ensure they are not on their own.

Good Practice identified was:

- The Trust had four Best Interests Assessors (BIA) in practice who support staff to embed their knowledge around the Mental Capacity Act.
- The Lead Nurse holds monthly MCA / DoLS training workshops across the Trust.
- MCA is discussed at Clinical Governance meeting.
- Training has been provided to the Operations on call staff.
- Introduction of a dedicated Enhanced Care Team to special patients with dementia which has reduced hospital stays.
- The Trust has been shortlisted for a Royal College of Nursing award for their 'Stay with me' John's Campaign.

Recommendations:

- The Trust to develop an MCA action plan in readiness for CQC visits.
- To improve the consistency of MCA documentation recording.
- To continue to increase the knowledge, application and recording of MCA and DoLS.
- The Trust to increase the availability of domestic abuse training for staff.
- The CCG suggest that the Lead Doctor for Adult Safeguarding contacts his equivalent within WHHT to share best practice.
- The Trust to review its membership of the HSAB sub-groups to increase representation and involve other Trust staff with the relevant skills, such as

- performance management, public engagement, learning and development.
- The Trust to implement a programme of Adult Safeguarding audits.
- The Trust to continue to roll out the Purple Star accreditation to more services.
- The Trust to develop a network of Adult Safeguarding Champions across all sites

The action plan was presented to the April 2017 safeguarding committee for approval.

9.0 Adult Safeguarding Committee

The Safeguarding committee met regularly during 2016/17. The work plan for the committee and the Adult Safeguarding team during 2016/17 has included:

- Staff training for Adult Safeguarding, MCA , DoLS and Prevent WRAP.
- Updates of policies or guidelines.
- Providing advice and guidance to clinical and managerial staff in relation to Adult Safeguarding and the Mental Capacity Act
- Working with the multi-agency team to prevent abuse and neglect and where abuse and neglect has been identified, working to reduce the risks of abuse and neglect.
- Undertaking Serious Incident, Safeguarding Adults Reviews and Domestic Homicide reviews, identifying learning and working with clinical teams to implement learning.
- Safeguarding teams update training on Prevent (Level 3).
- Participation in the Hertfordshire Adults Safeguarding Board meetings and sub-groups.
- Participation in the Hertfordshire LD Health Outcomes Group.
- Participation in setting up the National LD Mortality reviews in Hertfordshire.
- Progression of the Purple Star Accreditation with Ophthalmology, New QEII Hospital and Diabetic Eye Screening team.
- Participation in the Hertfordshire MCA forum.
- MCA/DoLS audits and dip sampling.
- Presentations of the HEALeD study research.
- Information shared with locality MARAC teams for safeguarding victims of domestic abuse.
- Participation in Safeguarding enquiries (Care Act 2014 section 42 enquiry) and providing clinical advice to social work teams.
- Two senior nurses participate in the Hertfordshire BIA rota.
- The alert symbol for identifying victims of Domestic Abuse was developed but is on hold due to the implementation of the new patient information system (Lorenzo).
- The seven day working for the LD nursing team was reviewed by HCS but requires additional financial resources and therefore has not been progressed at this stage. This will need a decision made by the joint commissioning teams.

Work plans and priorities for 2017/18 in addition to regular and continuing adult Safeguarding work:

- Continuing to develop the knowledge and skills of staff in the practical application of the Mental Capacity Act.
- Implementing the actions from the action plan following the CCG assurance visit.
- Preparing for and implementing any changes made to the Deprivation of Liberty arrangements.
- Continuing Prevent WRAP training.
- Under taking training needs analysis for Domestic Abuse and implementing training plans, with support from Refuge.
- Re-establishing the IDVA on site.

- Participate in the National LD Mortality Reviews and share learning to improve patient care and health outcomes.
- Share the learning from the HEALeD study when published.
- Share learning from SIs, SARs and DHRs.
- Support teams in preparing for the next CQC visit.

10.0 Notable achievements in Adult Safeguarding in 2016/17

- Improved reporting of safeguarding concerns.
- Improvement in the use of Deprivation of Liberty Safeguards.
- Improvement in the use of formal mental capacity assessments.
- 91% of staff are compliant with Adult Safeguarding training.
- Increased attendance at Prevent WRAP workshops.
- Diabetic Eye Screening programme achievement of Purple Star accreditation in March 2017.
- Four senior nurses completed the Best Interests Assessor course at the University of Hertfordshire increasing the number of staff who have expert knowledge of MCA and DoLS.
- The Trust Enhanced Care team established, showing improvements in quality of care provided to patients.
- Capacity within the Adult Safeguarding team has improved with the development of the falls prevention nurse and recruitment of administrative assistance.
- Trust demonstrated overall assurance in Adult Safeguarding to the CCG.

11.0 Recommendation

The RAQC is asked to note the achievements in 2016/17 and the planned progress for 2017/18 as outlined in the work plan.

References:

Home Office (2016) Multi-Agency Statutory Guidance for the conduct of a Domestic Homicide Review: www.gov.uk

Law Commission (2017) Mental Capacity and Deprivation of Liberty: www.lawcom.gov.uk