Agenda item: 11
Enclosure no: TB2018/098

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
26 SEPTEMBER 2018

Details of the Paper

Title	Annual antimicrobial report				
Responsible Director	Tina Kenny Medical Director and Director for Infection Prevention Control				
Purpose of the paper	To offer an overview of the activity of the antimicrobial team over the year 17/18 focusing on Antimicrobial Management within the Trust Operational delivery of antimicrobial stewardship Clinical governance and risk management for antimicrobial prescribing Education and training related to antimicrobials Interface with primary care and other clinical developments				
Action / decision required (e.g., approve, support, endorse)	For approval				
IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*
ANNUAL OBJECTIVE					
Which Strategic Objective/s does this paper link to? Objective: MRSA bacteraemia annual objective – zero cases Objective: Clostridium difficile annual objective – 31 cases					
Please summarise the potential benefit or value arising from this paper:					
RISK					
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: *Financial Risk*:				
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY					
Which CQC standard/s does this paper relate to?	CQC - Regulation 12 safe care and treatment				
Author of paper: Dr Jean O'Driscoll and Claire Brandish					
Presenter of Paper:Dr Tina Kenny					
Other committees / groups where this paper / item has been considered: **Infection Prevention Control Committee**					
Date of Paper: July 2018					

ANTIMICROBIAL STEWARDSHIP
ANNUAL REPORT APRIL 2017 – MARCH 2018

Introduction
The cornerstone of Antimicrobial Stewardship at BHT is the Antimicrobial Stewardship Committee (ASC) which reports to the Trust Infection Prevention and Control Committee (IPCC) and formerly the Drugs and Therapeutics Committee (DTC). Its purpose is to develop and oversee the delivery of the Antimicrobial Stewardship (AS) Strategy Programme for Buckinghamshire Healthcare Trust with the aim of promoting the safe, rational, effective and economical use of antimicrobial agents. Dr Jean O'Driscoll Chairs the ASC and is supported by Claire Brandish, Lead Antimicrobial Pharmacist.

The purpose of the Antimicrobial Stewardship (AS) Strategy Programme 2017/18 was to formulate an organised antimicrobial stewardship programme to promote rational antimicrobial prescribing.

The BHT Antimicrobial Stewardship Strategy Programme was divided into the following sections:

1. Antimicrobial Management within the Trust
2. Operational delivery of antimicrobial stewardship
3. Clinical governance and risk management for antimicrobial prescribing
4. Education and training related to antimicrobials
5. Interface with primary care and other clinical developments

Progress on these areas is detailed below.

1. Antimicrobial Management within the Trust

- Minutes and resulting actions from ASC were reported to IPCC. The format of DTC underwent revision during the year.
- Membership for the ASC was revised with the inclusion of junior doctor representation from May 2017.
- A business case was approved to expand the current pharmacy service to a structured infectious diseases/ antimicrobial stewardship team supports the delivery of the Trust-wide Antimicrobial Stewardship Strategy Programme. Capability of the service was increased by successful recruitment of an additional 1.0 WTE Band 8a Infectious Diseases pharmacist (HIV/ GUM/ Hepatology) and 1.0 WTE Band 7 Antimicrobial Pharmacist, both of whom started in post in April 2018. Furthermore, a 0.5 WTE Band 2 administrative post was also approved which is yet to be advertised and recruited to. A Project Initiation Document was linked to the business case.
- A Consultant Antimicrobial Pharmacist from Southampton undertook a Peer Review of antimicrobial stewardship at BHT in November 2017. This provided a useful insight into our stewardship activities and how these are perceived by staff at ward level. Recommendations to improve stewardship were included in the work programme for 2018/19.
- A review of the following National guidelines relevant to antimicrobial use took place:

  - NICE Guidance:
    - Otitis media (acute): antimicrobial prescribing, NG91, March 2018;
    - Antimicrobial Stewardship: Prescribing Antibiotics, KTT9, February 2018;
    - Sore throat (acute): antimicrobial prescribing, NG84, January 2018;
    - Antimicrobial Prescribing: Ceftazidime/avibactam, ES16, November 2017;
    - Urinary Tract Infections in children and young people, QS36, September 2017;

    - Urinary Tract Infections in under 16's: diagnosis and management, CG54, September 2017;
    - Sepsis, QS161, September 2017; Sepsis: recognition, diagnosis and early management, NG51, September 2017;
    - Fever in under 5's: assessment and initial management, CG 160, August 2017
  - English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) Report 2017

- An Antimicrobial Guardian section was included in the monthly newsletter, the Infection Control Times.

2. Operational delivery of antimicrobial stewardship

a) Trust wide guidelines

- In total, 39 Trust guidelines were written or reviewed and revised, where necessary, by the ASC over the past 12 months.
- A major review of the respiratory tract infection guidelines was undertaken aimed at diversifying antimicrobial use (and reducing broad-spectrum antibiotic use, specifically co-amoxiclav, piperacillin/tazobactam and meropenem). Stricter definitions for duration of therapy were also introduced which are supported by evidence.
- A number of guidelines required update over the past year due to severe national antibiotic shortages, most notably, piperacillin/tazobacatam from April - August 2017.
- Upload and promotion of antimicrobial guidelines accessed via RxGuidelines App. The addition of publication dates to RxGuidelines was introduced to support the governance arrangements and a database of uploads introduced.

b) Antimicrobial Formulary

- There was a review of antimicrobials on the Trust Formulary to ensure cost-effective and safe product selection.
- Co-ordination of temporary changes to Trust formulary and stock holdings was required due to critical antibiotic stock shortages throughout 2017/18.
- Patient Group Directions for the use of various antimicrobials were reviewed and updated.

c) Implementation of the new (short stay) prescription chart March 2018

Audits and clinical incidents involving the prescribing of gentamicin and vancomycin had highlighted a number of delayed or missed doses due to missing prescription charts, as well as over-doses as a result of multiple prescription charts being in use. In response to these patient safety concerns, a generic Variable Dose Antimicrobial prescription page was incorporated into the new Trust short stay drug chart. For areas using the long stay drug chart (NSIC wards and wards at Amersham Hospital), the separate gentamicin and vancomycin charts were replaced with a variable dose antimicrobial prescription with sticky edge so that these could be inserted permanently into the drug chart.
The new (short stay) prescription chart and the variable dose antimicrobial prescription chart have incorporated the Antibiotic Review Kit (ARK) definitions (see later).

d) Antimicrobial Policy for all Staff

An Antimicrobial Policy concerned with the supply, prescribing, administration and monitoring of antimicrobials was approved by the Trust-wide Policy and Strategy Group in October 2017. This outlines roles and responsibilities for the prudent use of antimicrobials and includes guidance on IV to oral switching, use of reserved and restricted antimicrobials and recommendations for antimicrobial use in frail, elderly patients.

e) Advancements in Microbiology Laboratory to support diagnostics

- Introduction of 7 day in-house molecular testing for influenza (seasonal) and Cerebrospinal Fluid (CSF) samples.
- The introduction of plastic blood culture bottles, which can be conveyed to the lab via the transport chute reducing the time to detection of positive samples.

- Evaluation of a second trial of procalcitonin testing on ITU to encourage antibiotics to be stopped in the absence of evidence of infection. A business case is being prepared to support the introduction of this test.

f) Introduction of Antimicrobial Stewardship Ward Rounds

- Continuation of daily visits to ITU by Microbiology and weekly MDT meetings with orthopaedic teams to discuss complex patients requiring specialist input.
- Additional routine MDT meetings introduced to haematology (twice weekly) and NSIC wards(fortnightly).
- Weekly Antimicrobial Stewardship ward rounds took place, with Antibiotic Care Bundle audits completed for each area visited. Interventions were logged and observations fedback directly to prescribers to optimise antimicrobial use and/or used to inform areas for improvement, e.g. identify gaps in Trust guidelines, improved sampling.

Intervention	March 2017-April 2018
Number of ward rounds	39
Patients reviewed	275
Duration of antibiotic course stated	55
Number of patients to have antibiotics stopped	65
Change/ de-escalate antibiotics	13
Request for microbiology tests	37
Addition/ prescription of antibiotics	13
Dose change/ advice	21
Allergies confirmed	15
Referral for investigation	8
Release further sensitivity results	2
Back –up antibiotic plan	5
IV to oral switch	12

3. Clinical governance and risk management for antimicrobial prescribing

a) Audits

- *Antimicrobial Care Bundle Audits (Monthly)*
  Antimicrobial Care Bundle audits have continued this year with the results being shared with the Divisions for discussion at Divisional and SDU Quality meetings. The aim is to assess whether a “Start Smart then Focus” approach is being adopted when antimicrobials are prescribed.

- *Antibiotic Review Kit (ARK) Implemented in February 2018*
  A series of education and training sessions together with an on-line learning tool supported the implementation of the Antibiotic Review Kit. The ARK tool involves stating at the initiation stage of antibiotics whether the presence of an infection is “probable” or “possible”. This strengthens the 24-72 hour review of antibiotics with a view to stopping antibiotics if there is no evidence for infection. The ARK study involved 12 weeks of data collection with feedback to the relevant teams. AMU, and Wards 4, 6, 7, 8, 9 and 10 were enrolled in the study. As a result, there has been an

improvement in the quality of the 24-72 hour review with additional activities to support good antimicrobial stewardship being demonstrated. More decisions to stop or switch from IV to oral antibiotics have been noted compared to baseline where the default was to review and continue. It has been decided to continue with a sustainability programme for the study with anticipated roll-out to other areas throughout the Trust following its success. The new drug chart facilitated the introduction of this study.

- *Regional Point Prevalence Audit February 2018*
  Purpose: to benchmark antimicrobial prescribing with other regional, Thames Valley and South Coast Trusts. Final results and write-up are pending.

- *An Audit on the Appropriateness of Antibiotic Prescribing in Patients with Escherichia coli Bacteraemia in Buckinghamshire Healthcare NHS Trust August- September 2017*
  Results: The treatment of E.coli bacteraemia at BHT (Aug-Sept 2017) was appropriate in 80% of cases, 72 hour review appropriate in 96% of cases, and duration of treatment appropriate in 83% of cases. Choice of agent usually provided additional antibiotic cover rather than insufficient cover. On the other hand, for the second part of the audit, looking at the 6-month use of antibiotics prescribed in Primary Care prior to the detection of the bacteraemia, antibiotic choice was only appropriate in 1/3 of courses, course length appropriate in approx. 50% and when these were looked at together as a care bundle, only 40% of antibiotic courses were appropriate in terms of choice and duration. . This audit was presented at a Bucks Bridges Meeting on 8th February 2018, and good discussions were had with consultants and GPs.

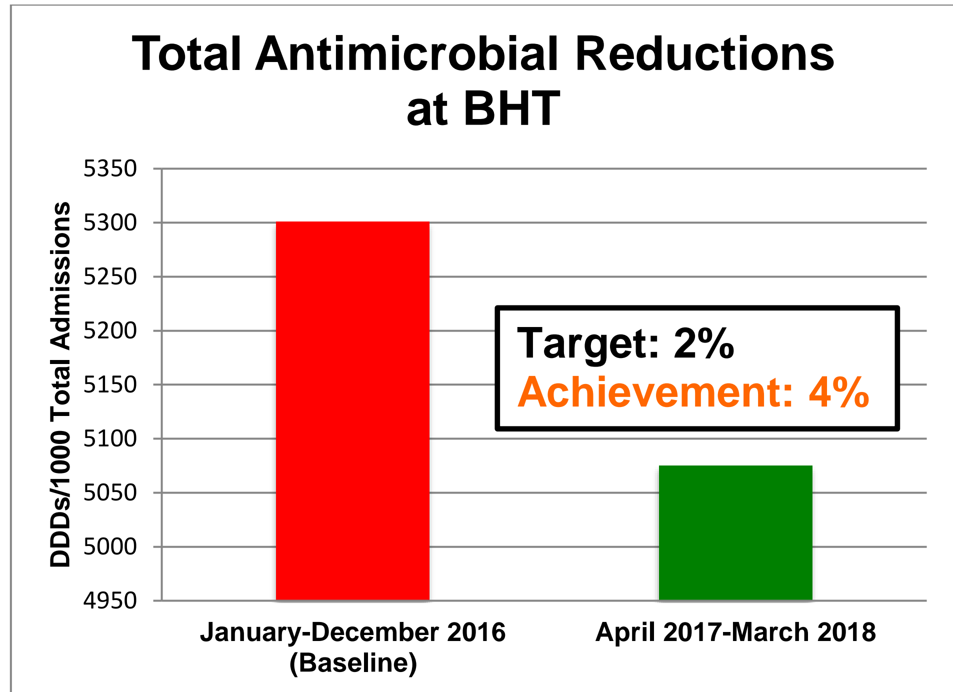
- *Human Bites; audit of compliance with Trust Guidelines , October 2017*
  This was a retrospective audit undertaken by Plastic Surgery Doctors.
  Results: all patients received co-amoxiclav as per Trust Guidelines. However, only 20% received Blood-Borne Virus exposure counselling. Tetanus risk was only considered in one-third of patients.

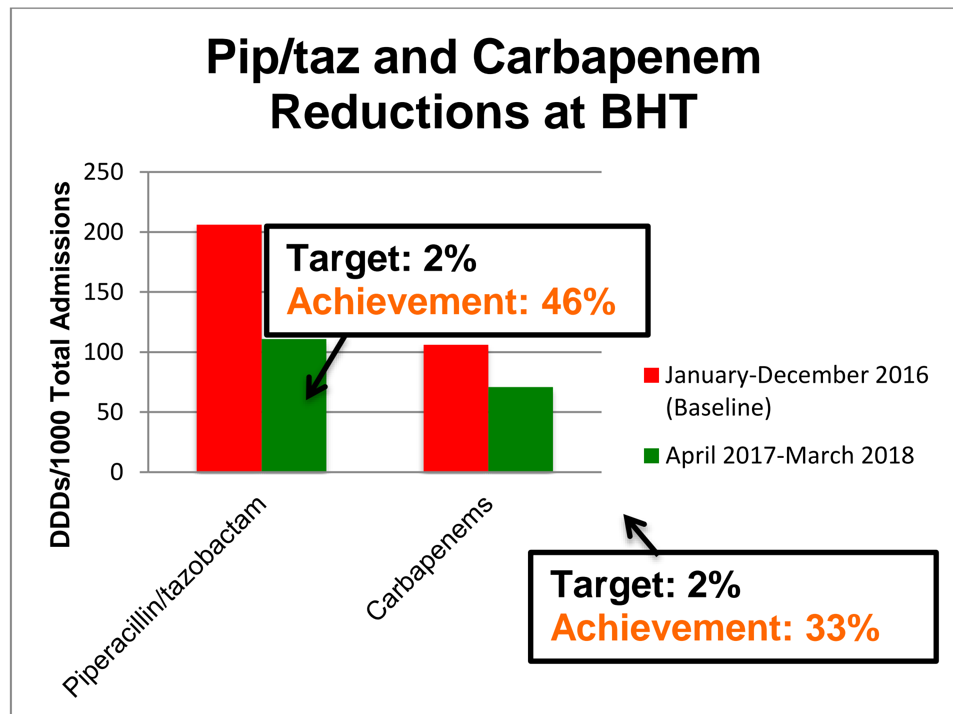
- *Implantable Cardiac Electronic Device (IECD) Infection and Antibiotic prophylaxis Surveillance, January – March 2017* – audit to look at compliance with Trust guidelines for antibiotic prophylaxis in patients undergoing an IECD procedure. A total of 122 devices between January – March 2017 were eligible for surveillance inclusion. Of these, 85 patient records were available on Evolve to assess.
  Results: Antibiotic prophylaxis was given in 83/85 cases (98%). The recommended schedule of a single dose of teicoplanin was given in 82/83 cases (99%). The correct dose of teicoplanin could only be verified in 31/85 patients (36%). The correct timing of teicoplanin administration could only be verified in 53/85 patients (62%).
  Continuation of antibiotics post-procedure: (not recommended in the BHT Guideline): One patient was given 5 days' post-procedure antibiotics (oral flucloxacillin plus amoxicillin), although the IECD site looked normal. Methods to improve documentation of patient weight and correct dosing have been discussed and agreed with the cardiology department. There was an agreement to only use prolonged prophylaxis courses if a procedure is complicated.

- *Audit on Discitis Management – SMH, March 2015-March 2016*
  This was a retrospective audit. Results: All patients had an MRI scan, but only 75% had an MRI of the whole spine. Biopsy was undertaken in only 42% and majority of patients were not discussed with Spinal team prior to initiation of antibiotics. There was a recommendation to produce some local guidelines on pathways and treatment choices, which has been done.

b) Antimicrobial Consumption

All three targets stipulated by PHE for the AMR CQUIN were exceeded this year.





c) **Response to review of clinical incidents**
- During this 12-month period, clinical incidents involving the prescribing of antimicrobial drugs were reported and reviewed by the ASC. Quarterly summaries were fed back to Divisions with a request that they be discussed at Divisional Quality meetings.
- Yellow cards were completed (MHRA informed) for serious adverse events associated with teicoplanin.
- Identification of incidents involving gentamicin prescribing for infective endocarditis has led to guideline updates with input from doctors working on the wards. The new variable dose antibiotic prescription section should also help to support the correct use of these guidelines.
- Other gentamicin incidents were shared at teaching sessions for emergency and acute medicine teams with example cases.
- The ASC has supported the review of antimicrobial use in patients diagnosed with *C.difficile* infection.

4. Education and training related to antimicrobials

- Delivery of face-to-face education and training in the prudent use of antimicrobials to pre-registration pharmacists (August 2017), junior pharmacists (September 2017), FY1 doctors (October 2017), FY2 doctors (November 2017) and Ward 2 doctors (November 2017), Trauma and Orthopaedic Junior Doctors, and IPC Link Practitioners.
- Provision of Grand Round, Medical Directorate, and ad hoc sessions to medical and other staff.
- In response to increasing numbers of *C. diff* cases, an Infection Control Summit was held in May 2017 led by the Medicine for Older People SDU, with excellent attendance. Several followup meetings were held. One outcome was the production of new guidance for prescribing in frail, older people (which is now part of the Antimicrobial Policy).
- Provision of education and training for the safe prescribing and monitoring of antibiotics that require Therapeutic Drug Monitoring to pharmacists, doctors and nurses on wards.
- Participation in World Antimicrobial Awareness Week and European Antibiotic Awareness Day in November 2017. School poster competition ran from October-December 2017 which saw more than 300 posters submissions from local schools to raise awareness of AMR, These were displayed throughout the hospital and BHT were shortlisted for the National Antibiotic Guardian Children and Family Award 2018. Two pharmacists held a session at Willows Day Nursery to educate the children of the importance of hand washing.
- Improved use of Patient Information Leaflet for patients prescribed antibiotics as part of the ARK study.
- Health Education England AMR e-module was adapted and has been for use in the Trust as part of mandatory training (incorporated in the Level 2 Infection Prevention and Control eLearning module).

5. Interface with primary care, and other clinical developments

- There is a CCG representative on the ASC, where there is a set CCG item on each Agenda.
- The OPAT service continues to be reviewed at part of the ASC.
- Aylesbury Vale and Chiltern CCG (now merged to form NHS Buckinghamshire CCG), Primary Care Antibiotic Guidelines were revised in 2017 with review of related NICE guidance which will be issued regularly focussing on common infections (sore throat, otitis media).
- Presentation at Bucks Bridges with a focus on Urinary Tract Infections and Catheter-Associated Urinary Tract Infections (CAUTIs).

- Focused educational drive on correct diagnosis of CAUTIs in the community, including the production of a joint poster on how to correctly diagnose a CAUTI which was circulated to all sites (wards, GP practices, district nurse bases all care homes, and published on QiCT & CCG website).
- AMR Quality Premium: The thresholds were met for the following aspects relating to antibiotics:
    1. a greater than 10% reduction in the Trimethoprim: Nitrofurantoin prescribing ratio based on practice baseline data (June15-May16) for 2017/18.
    2. a greater than 10% reduction in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) for 2017/18.
    3. a sustained reduction of antibiotic prescribing in the practice equal or below NHS England 2013/14 mean performance value of 1.161 items per STAR-PU.
- Monthly data analysis was provided to all GP practices on antibiotic prescribing patterns made available as a dashboard giving comparisons with other practices within their locality and CCG averages, and discussed at quarterly prescribing forums. Outlying practices weresupported by deeper dive and medicines management support
- Input into RCA of *C. diff* cases.
- Attendance at Regional Microbiologist Professional Development Group meetings held twice-yearly, including participation in audit activities.
- Attendance and engagement with South Central Antimicrobial Network regional meetings.

Agenda item: 13
Enclosure no: TB2018/100

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Buckinghamshire Healthcare NHS Trust

Trust Board in Public
26 September 2018

Details of the Paper

Title	Compliance with Regulations and Legislation
Responsible Director	Chief Nurse
Purpose of the paper	To update the Board on compliance with regulations (including Care Quality Commission) and other legislation.
Action / decision required (e.g., approve, support, endorse)	The Board is asked to consider the assurance provided in this paper and indicate support for actions to address concerns.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE
Compliance with legislation / regulation underpins the delivery of all objectives with a primary purpose of keeping staff and patients safe.
Please summarise the potential benefit or value arising from this paper: The benefit of this paper is to keep the Board informed about the compliance position of the Trust and the actions being taken to address any concerns.

RISK	
Are there any specific risks associated with this paper? If so, please summarise here	*Non-Financial Risk*: There is a risk to safety if we cannot demonstrate compliance with legislation / regulation.
	Financial Risk: There is a financial risk associated with rectifying any issues of non-compliance.
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	ALL

Author of paper: Liz Hollman, Director for Governance
Presenter of Paper: Carolyn Morrice, Chief Nurse
Other committees / groups where this paper / item has been considered: Individual executive directors have contributed to this paper.
Date of Paper: 18 September 2018

Agenda item: 13
Enclosure no: TB2018/100

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

COMPLIANCE WITH REGULATIONS (INCLUDING CARE QUALITY COMMISSION) AND OTHER LEGISLATION

1. PURPOSE

The purpose of this paper is to update the Board concerning compliance with regulation and other legislation.

2. BACKGROUND

Each year the Trust conducts a self-review of compliance, and this underpins the declaration in the Annual Governance Statement. In 17/18 this culminated in a report to the Board in March 2018 providing assurance of compliance.

Since this declaration there has been an internal audit of the process with recommendations for how this can be strengthened in 18/19.

Again, since the declaration in March the Trust has commissioned an external specialist to review compliance with HTM (Health Technical Memoranda) requirements in the retained estate. This review has identified serious issues of compliance which have been urgently addressed. In addition a Serious Incident investigation is in progress in order to understand how the Trust found itself in a position where there were compliance issues in this way. No patient or member of staff has come to harm as a result of this incident as far as it is reasonable to ascertain.

Each executive director is in the process of reviewing the areas of compliance for which they are responsible in order to confirm that there are no other significant compliance issues which had not been previously identified. The updated sign-off will be reviewed by the Executive Management Committee in October 2018.

3. KEY ISSUES

The HTM compliance issues identified in the retained estate related to assurance around water safety, air handling, up-to-date asbestos register and an overdue medical gas risk assessment. Action has been taken to confirm that the Trust is safe in relation to these matters. A serious incident investigation is in progress to ensure that there is learning from these events. The Finance and Business Performance Committee and Strategic Workforce Committee have been briefed about the situation and continue to receive updates.

The review of other areas of compliance has so far confirmed that there is no change to the declaration of compliance as made to the Board in March. If this changes as a result of the Executive Management Committee discussion in October then the Board will be briefed accordingly.

There are a couple of further updates to provide to the Board which are set out below.

With respect to the Duty of Candour requirements set out in CQC regulation the Trust is compliant. However, further assurance is being sought to confirm that incidents that occurred between April 2015 (when the regulation came in) and October 2017 followed due process with respect to Duty of Candour. The recording process for Duty of Candour was significantly strengthened in October 2017. Before that time the Duty of Candour process was being followed but not captured centrally,

hence the need to confirm centrally in a retrospective way that the process has been appropriately followed.

In the past few months there has been considerable effort to review the quality of care at service level through the use of the Perfect Ward app, and through a peer review inspection type process. This rigour of these reviews has highlighted that there is more that we can do as an organisation to strengthen compliance with privacy and dignity regulation. Action is being taken in specific service areas as required.

One of the areas of learning in the past two months is the need to review compliance at Board level in detail at least once a year and to have at least two further updates each year. There will be time allocated in a board development session to review compliance in more detail in Quarter 4.

4. CONCLUSION

This paper has provided an update to the Board on compliance with regulation / legislation.

Actions are being taken to address issues of compliance.

Board time will be allocated for ongoing reviews of compliance.

5. RECOMMENDATION

The Board is asked to note this update and support the actions in relation to the compliance process.

Liz Hollman, Director for Governance, 18 September 2018

Agenda item: 14
Enclosure no: TB2018/101

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Buckinghamshire Healthcare NHS
NHS Trust

TRUST BOARD MEETING
26 September 2018

Details of the Paper

Title	Fit and proper persons test for Directors
Responsible Director	Bridget O'Kelly
Purpose of the paper	To provide assurance to the Board that the requirements of the fit and proper persons test are in place for the Board
Action / decision required (e.g., approve, support, endorse)	The Board is asked to note the report

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	***Public Engagement /Reputation***	***Equality & Diversity***	*Partnership Working*	*Information Technology / Property Services*
ANNUAL OBJECTIVE					
Attracting and retaining high calibre and engaged people					
Please summarise the potential benefit or value arising from this paper: Information & Assurance					

RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	Non-Financial risk: • Reputational risk to the trust • There is a risk to us delivering all corporate objectives if we don't attract and retain high calibre and engaged people
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Well led *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Karon Hart
Presenter of Paper: Bridget O'Kelly
Other committees / groups where this paper / item has been considered: N/A
Date of Paper: 10 September 2018

Fit and proper persons test

Introduction

The fit and proper person regulation (FPPR) requirements came into force for all NHS trusts and foundation trusts in November 2014. The regulations require NHS trusts to seek the necessary assurance that all executive and non-executive directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role.

Background and detail

The CQC requires that the fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.

In order to meet compliance with these requirements, all NHS trusts must ensure they have robust processes in place to assess the suitability of directors at the point of recruitment and throughout their ongoing employment. They are also required to have effective arrangements in place to tackle issues should any concerns be raised about a directors' ongoing fitness and suitability to carry out any such role. The purpose of these requirements is not only to hold board members to account in relation to their conduct and performance but also to instil public and patient confidence in those who have lead responsibility for NHS organisations and the services they provide.

The Care Quality Commission (CQC) holds NHS trusts to account in relation to FPPR as part of the key lines of enquiry under their regulatory assessment framework (under their well-led domain). Its role is to assess that NHS trusts have appropriate and effective processes in place to assess a directors' suitability and to take action if they are failing to meet these requirements. While the CQC cannot investigate or prosecute for a breach of the requirements, it can take regulatory action against an individual's breach of a regulation, condition of its registration, or other relevant requirement. It can also assess the quality of any evidence presented and whether the NHS trust has appropriately taken this into account. Where the CQC has its own concerns about a director, it has the power to take enforcement action against the employing organisation.

Meeting compliance

To ensure compliance with regulatory requirements, NHS trusts must be able to demonstrate to the CQC that they have robust and effective:

- Recruitment processes in place to assess the suitability of all newly appointed director as outlined within the NHS Employment Check Standards
- Assessment processes in place to regularly monitor and review the ongoing fitness of directors in their employ. We would suggest that this may form part of pre-existing appraisal and revalidation processes, as appropriate
- Arrangements in place to handle concerns about a directors' fitness and suitability in a timely manner, ensuring these are widely communicated and understood by all staff, including processes of appeal for directors
- Arrangements in place to share relevant information to health and social care regulators and other bodies (as appropriate), if a director no longer meets the FPPR requirements

Guidance from NHS Employers, NHS Confederation and NHS Providers is that on an annual basis:

- An assessment of continued fitness be undertaken each year as part of appraisal process.
- Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process.
- Board/Council of Governors reviews checks and agrees the outcome.

Directors' compliance: 31 August 2018

Assessment/check	**Non-executive directors**	**Executive directors**
Annual appraisal	Carried out by the Trust chair in Q1-2	Carried out by the Trust CEO in Q4 (17/18)
Insolvency and bankruptcy register	On-line check carried about by a member of the recruitment team during April 2018	
Signed FPPT declaration	All have signed FPPT declarations within the last 12 months	
DBS checks	All have DBS checks in place in line with Trust requirements	

Agenda item: 12
Enclosure no: TB2018/099

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

PUBLIC BOARD MEETING
26 SEPTEMBER 2018

Details of the Paper

Title	Safeguarding Annual Report 2017 - 2018
Responsible Director	Chief Nurse, Carolyn Morrice
Purpose of the paper	To provide assurance to the Board that effective governance arrangements are in place to monitor and ensure that the Trust complies with statutory safeguarding requirements.
Action / decision required (e.g., approve, support, endorse)	To support and endorse the progress made in the past year and recognise the breadth of the safeguarding work carried out within the Trust. To support the achievements of the Safeguarding Team and the future direction of its work. The Board is also asked to support the future direction of safeguarding activity and the development of the safeguarding team so that it can continues to respond to change and to meet Trust and legislative objectives.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)

Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
Quality

Please summarise the potential benefit or value arising from this paper:

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: Risk around staff understanding MCA & DoLS – this is addressed within the report.
	Financial Risk: None

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	CQC Regulation 13 *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Nuala Waide Associate Director for Safeguarding

Presenter of Paper: Carolyn Morrice, Chief Nurse

Other committees / groups where this paper / item has been considered:

- BHT Quality and Governance Committee
- BHT Quality and Patient Safety Committee
- BHT Nursing, Midwifery and Therapists Professional Board
- BHT Safeguarding Committee

Date of Paper: 26th September 2018

Safe & compassionate care,
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Safeguarding Annual Report
2017 – 2018

Author Nuala Waide, Associate Director for Safeguarding

Presented by Carolyn Morrice, Chief Nurse

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Executive Summary

In the year form April 2017 to April 2018 the Trust safeguarding function has built on previous achievements and is continuously improving and developing both internal and external partnership working. The Safeguarding Team continues to develop in accordance with the Trust strategic objectives and in line with the required CQC safeguarding standards. The report has been structured to reflect the various standards set out in CQC Regulation 13 and to demonstrate accomplishment against these standards.

This annual report highlights the significant achievements made in respect of all aspects of safeguarding training compliance and also recognises the work still to be done in this regard. Achievements in respect of Level 3 safeguarding children and Prevent are particularly noteworthy. The focus has also been, and continues to be on ensuring the quality and relevance of all safeguarding training programmes.

Referral activity is reflective of the impact of training and shows staff understanding of their responsibilities in regard to reporting abuse of all types and safeguarding people who may lack capacity. Whilst mental capacity training figures are respectable more work needs to be done to ensure robust staff understanding of implementing the principles of the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) in practice. This work has been started and it is anticipated that evidence of improvement will be apparent as a result of the measures being taken to support Trust staff in this regard.

Incidents and complaints may be reflective of the quality of care and may on occasions be indicative of abuse; learning from incidents and complaints is important in order to prevent harm to patients through abuse or poor treatment. The Safeguarding Team receives information via Datix incident reports and complaints which enables the development of training and opportunities to learn. The top six safeguarding-related incidents reported are:

- Pressure sore / decubitus ulcer
- Implementation of care or ongoing monitoring – other
- Discharge
- Abuse - other
- Slips, trips, falls and collisions
- Possible delay or failure to monitor

A key area focus for the coming year within the Safeguarding Team will be on contributing towards discharge planning to ensure that all discharges are safe and effective.

Partnership working to address and minimise risk of abuse are effective; BHT is actively engaged in partnership work with all relevant agencies and on many different levels. BHT contributes significantly to case reviews, reports and plans aimed at identifying and minimising risk. The Safeguarding Team continues to develop in a way that reflects the needs identified through action plans, audits and learning from incidents, complaints and case reviews.

Introduction

This report sets out the work and achievements in respect safeguarding within Buckinghamshire Healthcare NHS Trust (BHT) for the period 1st April 2017 to 31st March 2018. The report also draws attention to areas of future development and planned safeguarding activity for the coming year.

Safeguarding work is directed by a number of legislative arrangements and statutory expectations. As set out in the Care Quality Commission (CQC) regulation 13, BHT service users must be protected from abuse and improper treatment and systems and processes must be established and operated effectively to prevent abuse (see Appendix 1 for regulation 13 in full).

CQC Regulation 13 also requires that safeguarding must have the right level of scrutiny and oversight, with overall responsibility held at board level or equivalent. This report provides assurance to the Board that effective governance arrangements are in place to ensure that the Trust complies with statutory safeguarding requirements (see Appendix 2 for list of associated legislation for CQC Regulation 13).

Systems and Processes

Systems and processes must be established and operated effectively to prevent abuse of service users.

Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
(CQC Regulation 13)

In addition to safeguarding-focused policies and activities, BHT espouses values and has in place wide ranging strategies, policies and training to support staff in the delivery of safe and effective care for its patients.

Safeguarding
Training and Supervision

Staff must understand their roles and associated responsibilities in relation to any of the provider's policies, procedures or guidance to prevent abuse.

As part of their induction, staff must receive safeguarding training that is relevant, and at a suitable level for their role. Training should be updated at appropriate intervals and should keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns.
(CQC Regulation 13)

In order to ensure that BHT staff are aware of their roles, safeguarding training is provided is provided as part of corporate induction and is updated at regular intervals in accordance with

specific roles and responsibilities. This training has recently undergone a significant overhaul and has been delivered as of January 2018. The revised induction training provides a greater level of assurance for the Trust that new staff are trained effectively and at the right levels in all aspects of safeguarding; it has been positively received and evaluated by staff who attend.

Safeguarding training is fundamental to promoting welfare and protecting people from harm and ensuring that the Trust can effectively discharge its statutory obligations to safeguard people. Attaining and sustaining effective levels of training compliance continues to be a high priority for the organisation and the Trust Safeguarding Team.
Training topics reflect key areas of safeguarding activity and statutory responsibility and are intended to enable staff to be competent and confident to undertake their safeguarding roles and responsibilities.

As well as providing internal training for staff BHT, works in partnership with the Buckinghamshire Safeguarding Adults and Children's Boards (BSAB and BSCB) to identify current training needs and develop training programmes to meet these needs.

The Trust provides a training programme which recognises the different levels of competency for different groups of staff. These levels are based on the levels set out within:

- - *Safeguarding children and young people: roles and competences for Health care staff. Intercollegiate Document (2014); and*
- *Bournemouth University National Competence Framework for Safeguarding Adults (2010).*

A Trust-wide training needs analysis identifies which groups of staff must be competent at the level identified for their role; the training is identified as being a statutory requirement for all staff.

Supervision is vital within the field of safeguarding; it provides staff with the opportunity to put concerns into perspective and address issues that might otherwise be overlooked. Supervision enables reflection on actions already taken and planning for actions that may be needed for future practice.

Arrangements are in place in BHT to ensure the provision of safeguarding supervision to all clinical staff who work predominantly with children. Provision for safeguarding adult supervision is generally on a more ad hoc basis but some teams have made arrangements with the Named Nurse for Safeguarding Adults to receive regular safeguarding supervision.

Training Compliance Safeguarding Children

Table 1 and figure 1 below set out safeguarding children training compliance for the reporting period. The data generally shows a steady upward trend in all levels of training compliance especially for level 3. Whilst there has been progress in respect of levels 1 and 2 compliance, more work is needed to consistently attain 90% and above; plans are underway to enable this objective. Further detail regarding future working for the delivery of safeguarding training are set out below in the section titled "Safeguarding Team".

Safeguarding Children Training Compliance

Month	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
% of staff completed Level 1	78.23	75.99	74.58	75	74.80	75.72	79.16	79.00	91.00	92.00	91.61	88.23
% of staff completed Level 2	65.56	67.13	63.36	66	68.75	68.87	70.93	71.00	82.00	83.00	83.79	79.47
% of staff completed Level 3 training	86.50	92.08	92.53	95	91.41	87.02	90.14	89.00	94.00	94.00	95%	94.05

Table 1

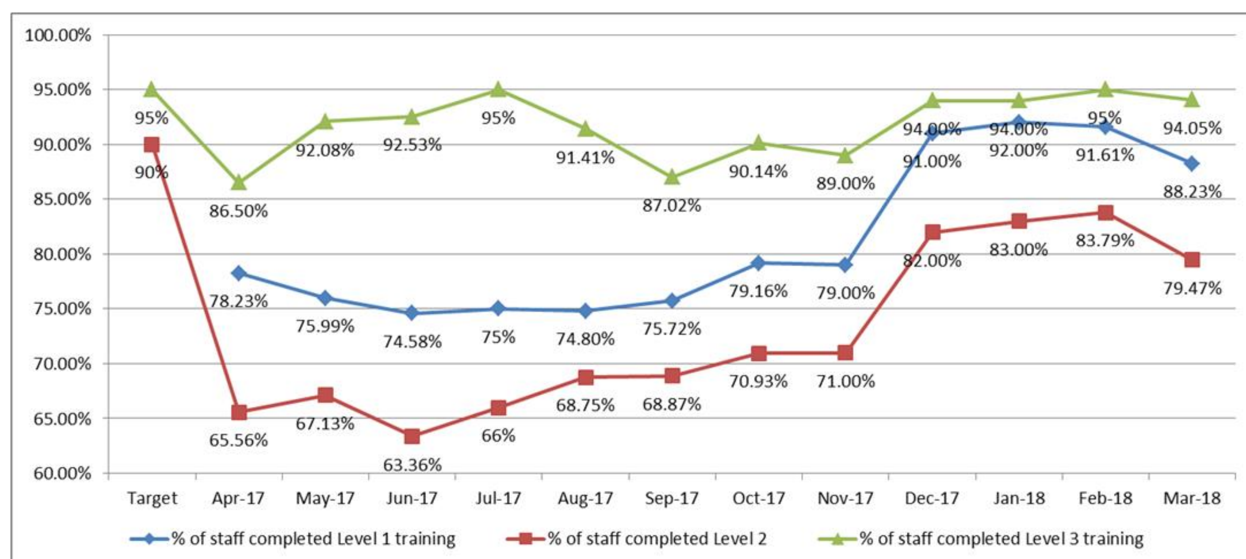

Figure 1

Training Compliance Safeguarding Adults

Safeguarding Adults training is currently delivered at awareness (level 2) and is evolving gradually to reflect the national competence framework. Whilst more work is required to further expand the levels safeguarding adult training, the Board can be assured that relevant staff groups are trained effectively in this subject. Developments within the Safeguarding Team structure as set out below in the Safeguarding Team section of this report explain how improvements are being made and which will be presented in next year's annual report.

Improvements in training compliance for safeguarding adults are set out in ***table 2 and figure 2*** below. Compliance has not yet reached 90% and above but it is anticipated that this target will be achieved and sustained in the coming year.

Training compliance in respect of MCA and DoLS is set out in ***tables 3 and 4*** and figures and ***figures 3 and 4*** below; significant increase in staff training compliance is demonstrated throughout the reporting period. It is anticipated that this will gradually translate into increasing and more appropriate DoLS applications.

Safeguarding Adult Awareness Training Compliance

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
% of staff completed	74	72.94	73.23	73	71%	70.67	74.25	74.00	89.00	88	88.77	86.26

Table 2

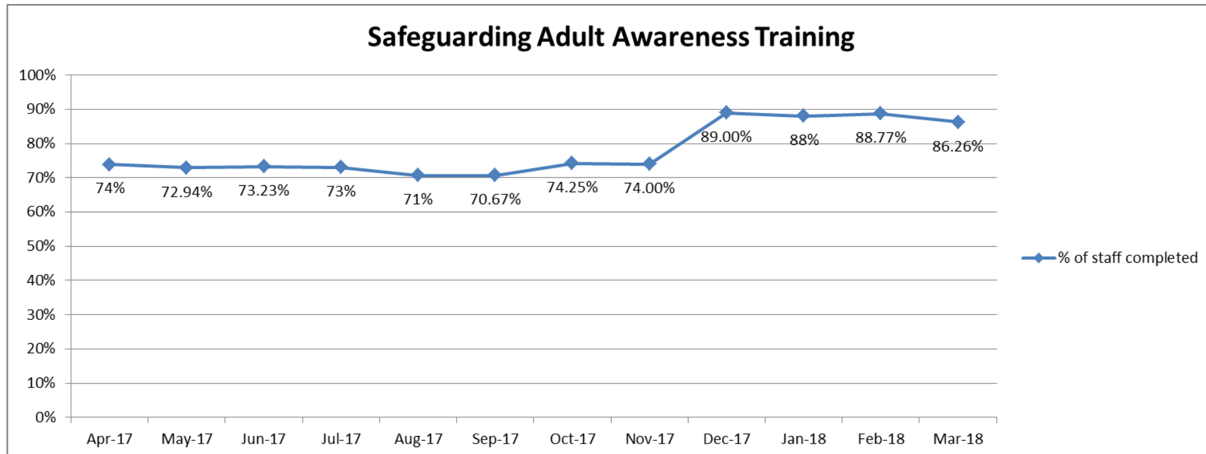

Figure 2

Training Compliance Mental Capacity Act and DoLS

Mental Capacity Act Training Compliance

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
% of staff completed MCA training	85.76	84.71	85.22	85.12	84.54	84.09	83.82	84.95	85.17	86.11	87.72	88

Table 3

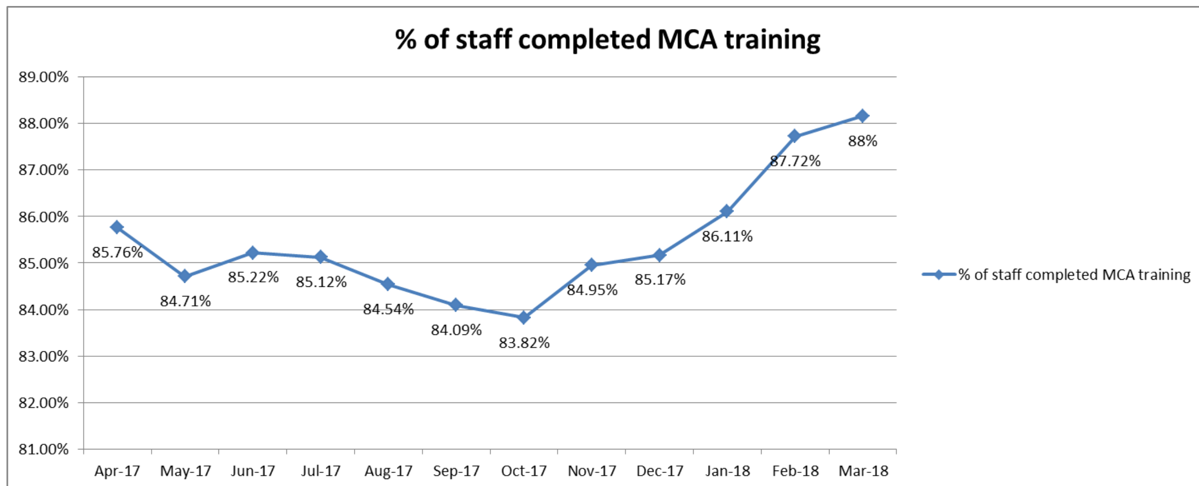

Figure 3

Deprivation of Liberty Safeguards Training Compliance

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
% of staff completed DOLs training	82.89	83.93	85.06	85	85.31	85.16	84.71	86.45	86.73	87.99	89.82	90.49

Table 4

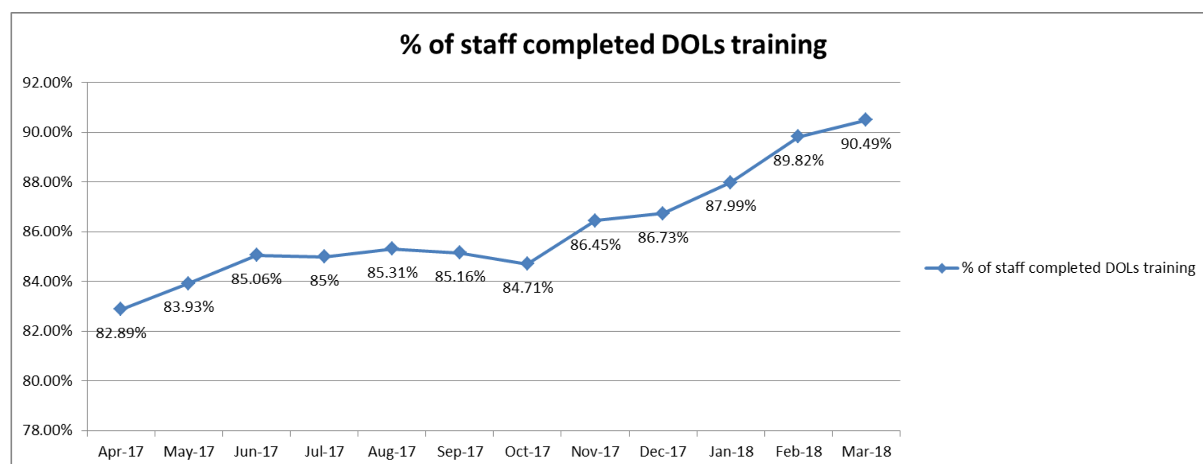

Figure 4

Training Compliance Prevent

As shown in ***table 5 and figure 5*** below, BHT compliance in respect of Prevent training has increased throughout the past year and is being sustained at significantly high levels. In common with many other agencies within Buckinghamshire, Prevent referrals in BHT are low (3 referrals in the past year). Efforts across the Prevent network are aimed at driving up referrals.

BHT is actively engaged in the Prevent network across the region and works in collaboration with the police to ensure that the Trust is an effective partner in counter terrorist arrangements in Buckinghamshire.

Prevent Training Compliance

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
% of staff completed WRAP training	69.99	68.56	70.96	72.64	75.22	75.16	77.55	79.98	81.19	83.27	84.53	86.83
% of staff completed Prevent E-Learning training	90.80	91.20	91.88	91.83	92.21	91.90	93.19	94.44	94.79	95.66	96.87	97.13

Table 5

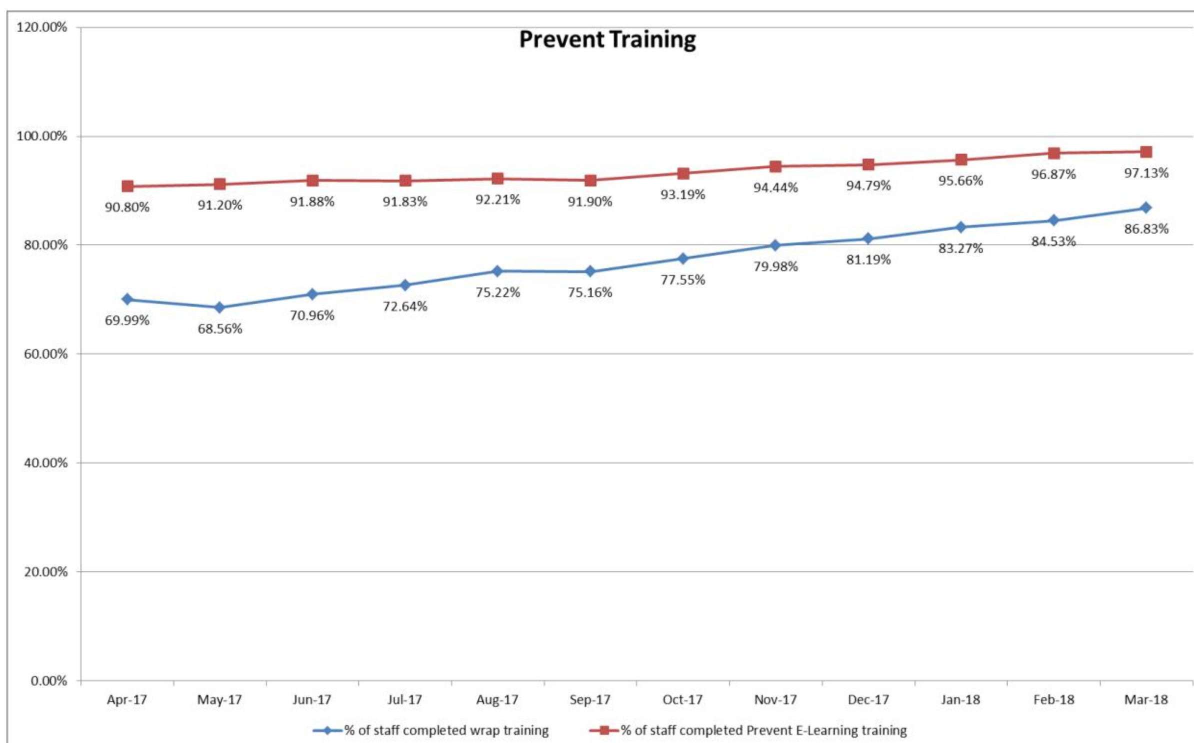

Figure 5

Referral Activity

Providers must take action as soon as they are alerted to suspected, alleged or actual abuse, or the risk of abuse. Where appropriate, this action should be in line with the procedures agreed by local Safeguarding Adults or Children Boards.

Providers and staff must know and understand the local safeguarding policy and procedures, and the actions they need to take in response to suspicions and allegations of abuse, no matter who raises the concern or who the alleged abuser may be. These include timescales for action and the local arrangements for investigation.
(CQC Regulation 13)

BHT staff receive training in how to recognise and refer abuse and this is reflected in safeguarding referral activity and staff contacting the safeguarding team for advice and support. Training reinforces the importance of being aware of the BSAB safeguarding adult multi-agency procedures and guidelines.

Safeguarding Adults

Table 6 and figure 6 below show the activity for safeguarding adult referrals. A total of 141 referrals were completed for this reporting year as compared to 205 for the previous year; this is a decrease in n = 64 which represents a 31% drop in adult referrals. The launch of the BSAB safeguarding threshold document in 2017 may be a contributory factor in this decline. The threshold document was launched to address the problem of high numbers of inappropriate

safeguarding adult referrals that were being received by the local authority Safeguarding Adult Team.

The document guides staff to be able to recognise and respond accordingly to the different levels of concern and need for adults and the appropriate response to those concerns. The use of the threshold document is actively promoted in safeguarding training and its use will ensure that referrals made are more appropriate.

It is anticipated that the revised BHT safeguarding training programme will better prepare clinical staff to recognise differing levels of abuse and when to refer. This may lead to an increase in referrals which will be quality reviewed by the Safeguarding Team via audit. Information from the in-year safeguarding dashboard shows an upward trend in referrals for 2018/19; the dashboard is monitored monthly by the Trust Safeguarding Committee.

Safeguarding Adult Referrals

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of referrals made to Adult Social Care	14	12	14	15	11	10	9	8	11	16	8	13	141
Number of those referrals investigated	14	12	14	14	11	10	9	8	11	16	8	13	141
Number of referrals substantiated or partially substantiated	5	6	8	14	3	2	0	4	0	1	2	4	49
Number of referrals inconclusive	7	6	4	3	1	4	0	1	4	0	5	1	36
Number of referrals unsubstantiated.	2	4	2	2	1	1	2	3	3	8	1	5	34
Number of investigations health are asked to undertake on behalf of the LA.	1	1	3	3	3	1	4	4	3	6	2	1	34

Table 6

Safeguarding Adult Referrals

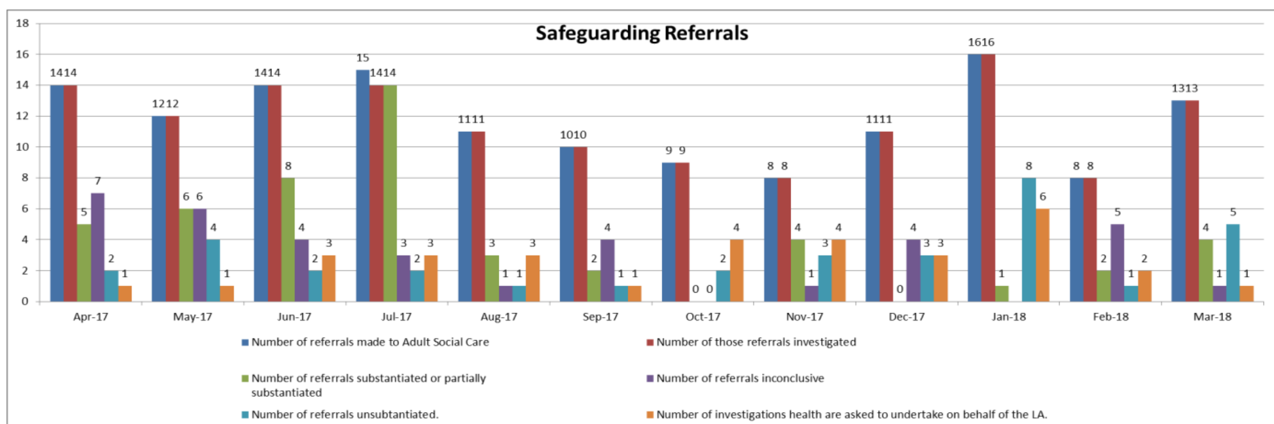

Figure 6

DoLS applications

DOLs activity 2017-2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Number of DOLs applications	9	14	17	0	19	6	11	15	15	17	24	17	328
Number of DOLs applications / authorised	1	0	0	0	1	0	0	2	1	5	2	0	12
Number of DOLs applications declined	7	8	13	0	5	6	1	0	5	12	5	8	140
Number of DOLs with a breach in timescale.	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of deaths under DOLs	0	1	1	0	0	0	0	0	0	0	0	0	2
Number of death or discharge before authorisation.	7	6	11	0	0	0	0	2	1	12	4	7	50

Table 7

DOLs activity 2017-2018

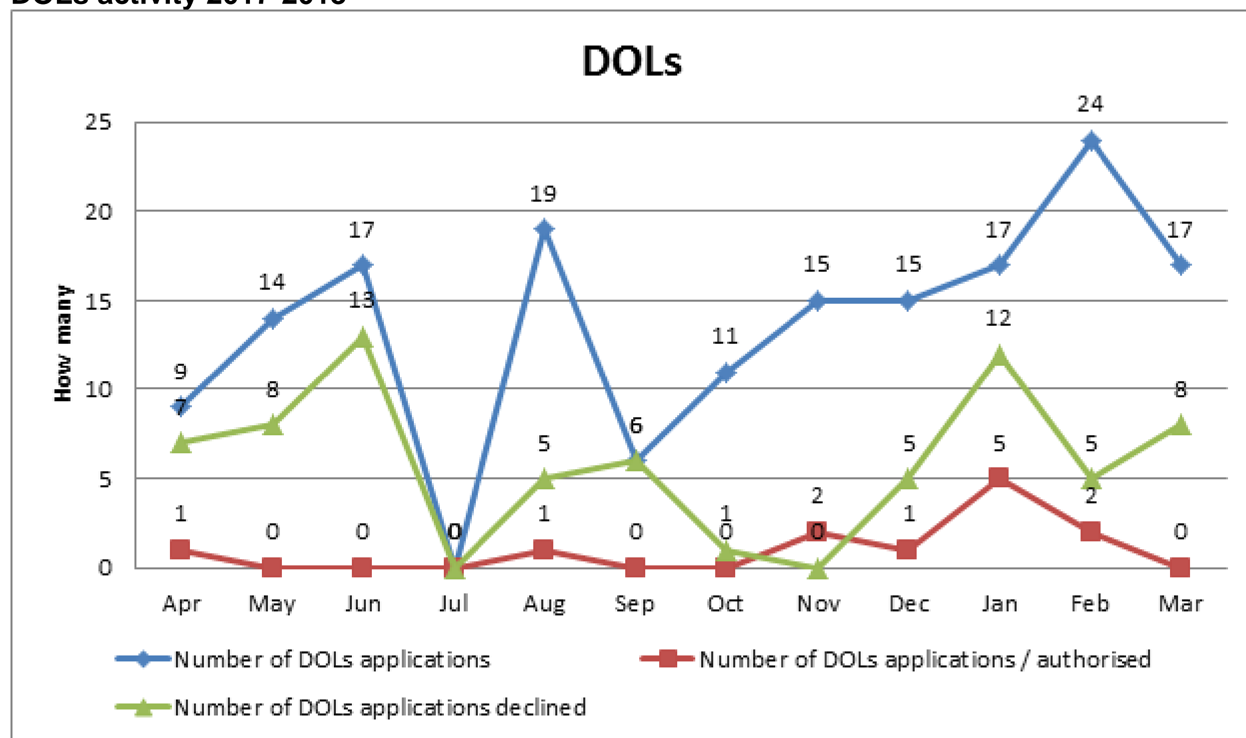

Figure 7

Table 7 and figure 7 above show activity in respect of DoLS applications to the Local Authority. for the past year; whilst the number of applications made and subsequently declined fluctuates across the year the number of authorisations remains fairly constant except for an unexplained peak in authorisations in January 2018.

Comparison with the previous year's DoLS data is interesting. Whilst the total number of DoLS applications for the current reporting year have increased by 42% as compared to the previous year (n = 129 versus *n* = 328) the number of DoLS authorised has decreased.

In the year 2016-2017 the number of DoLS authorised was n = 15 (11.5%) as opposed to n = 12 (3.6%) for the current reporting period. This could indicate an increasing level of staff awareness for the need to apply for a DoLS with a corresponding decline in the quality of these applications. The Safeguarding Team is now working on an audit programme for DoLS which will include an audit of quality standards.

In order to aid staff understanding about MCA and DoLS, the Safeguarding Team has created a poster for all in-patient areas which contains flow charts relating to effective DoLS applications; this has been distributed across the entire Trust.

Safeguarding Children

Table 8 and figure 8 below show attendance in ED by children and young people for this reporting period. Attendance has increased since the last reporting period by *n* = 1,146 (5.5%)

Children and young people ED attendances 2017 - 2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
ED Total C&YP attendees	1750	1957	2170	1819	1354	1791	1865	2093	1733	1710	1638	2008	21,888

Table 8

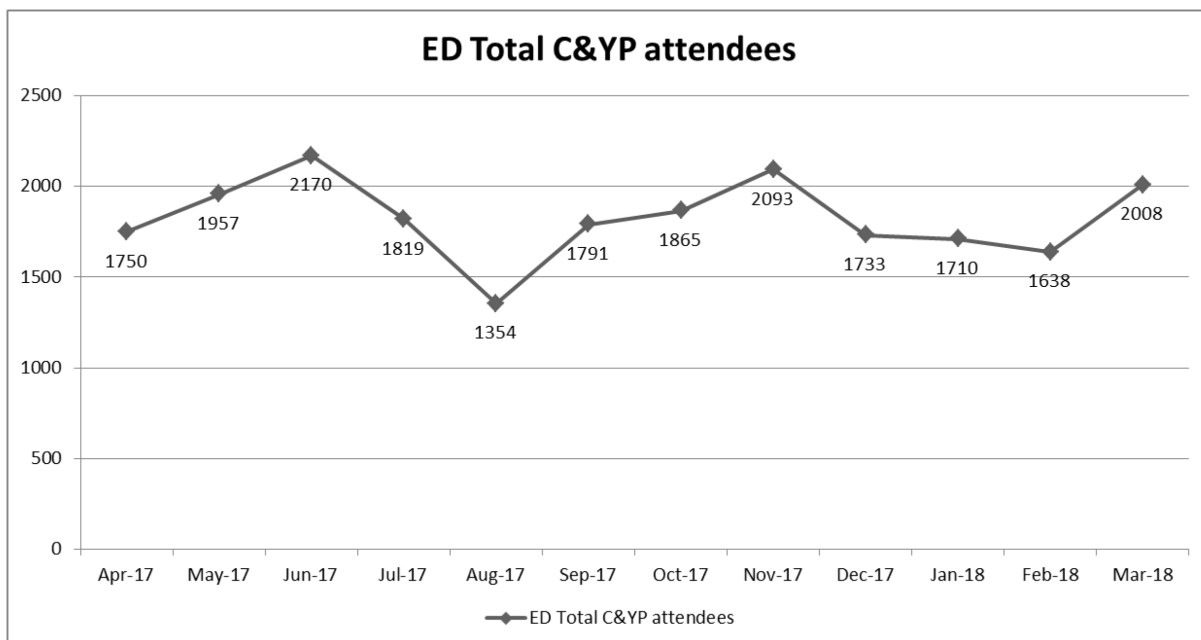

Figure 8

Safeguarding Children Referrals to Children's Social Care

Table 9 and figure 9 below show the pattern of referrals to children's social care for the reporting period. Referrals seem to peak in late spring/early summer and are at their lowest during school holidays. It is not surprising that referrals are at their lowest when children are less visible to adults outside of their families and at their highest when they are more visible (especially when lighter summer clothing may reveal non accidental injuries).

The total number of safeguarding referrals for children has increased by n= 54 since the last reporting period; this represents a year on year increase of 10.5%. This indicates that staff are responding to training and are recognising and reporting concerns about abuse or children in need of early help. ED carries out the greatest number of referrals within BHT which may be reflected in the increasing numbers of children and young people attending ED. This is followed by maternity services; community nursing services, especially school nursing are the lowest reporters of concerns about children to children's social care.

School nursing is a very small service and practitioners tend to work with individual children on a referral basis, so would not have contact with all children in the school population or know about their home circumstances. School staff who work on a daily basis with children are more likely to make referrals to children's social care.

Health visitors (HVs) have the benefit of working with families in the home environment and are able to develop better understanding of parenting styles and the effects of these may have on a child or children. HVs are also in a better position to offer early help to families and to carry out preventative work which may prevent the need for referral to children's social care. On the other hand staff working in ED who are presented with children with physical injuries, who seem to be neglected, have unmet needs, or are in mental distress need to make more rapid on the spot decisions about potential concerns relating to a child or family. This is a likely to be a contributing factor to the larger number of referrals from ED.

Midwives work with expectant and new parents for a limited period of time and see them intermittently; they also see proportionately less in relation to parenting interactions than perhaps do HVs so this may be indicative of the higher numbers of precautionary midwifery/maternity referrals.

All MARFs are quality assured by the Safeguarding Team in terms of the appropriateness of the referral and the completeness of the information provided. BHT staff are trained in respect of use of the threshold document for children and audits carried out by children's social care do not suggest that BHT staff make a high number of inappropriate referrals. There is evidence of a high number of repeat referrals by BHT practitioners for the same child/family; repeated referrals are generally indicative of inappropriate responses to earlier referrals and BHT staff should be commended for their persistence in trying to obtain the right support for children and families in their care.

Number of multi-agency referrals forms sent by BHT to Children's Social Care 2017-2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total MARFs from BHT	46	65	66	44	33	30	53	42	48	39	46	57	569
ED	29	43	56	37	17	20	31	30	34	21	25	28	371
Maternity	10	16	6	5	11	5	15	5	6	10	11	9	109
Health Visiting	3	2	2	0	3	3	3	3	6	3	5	7	40
School Nursing	1	1	1	1	0	0	1	1	1	1	1	0	9
Paediatrics	2	1	0	0	0	1	2	1	1	2	2	4	16
Other	1	2	1	1	2	1	1	2	0	2	2	9	24

Table 9

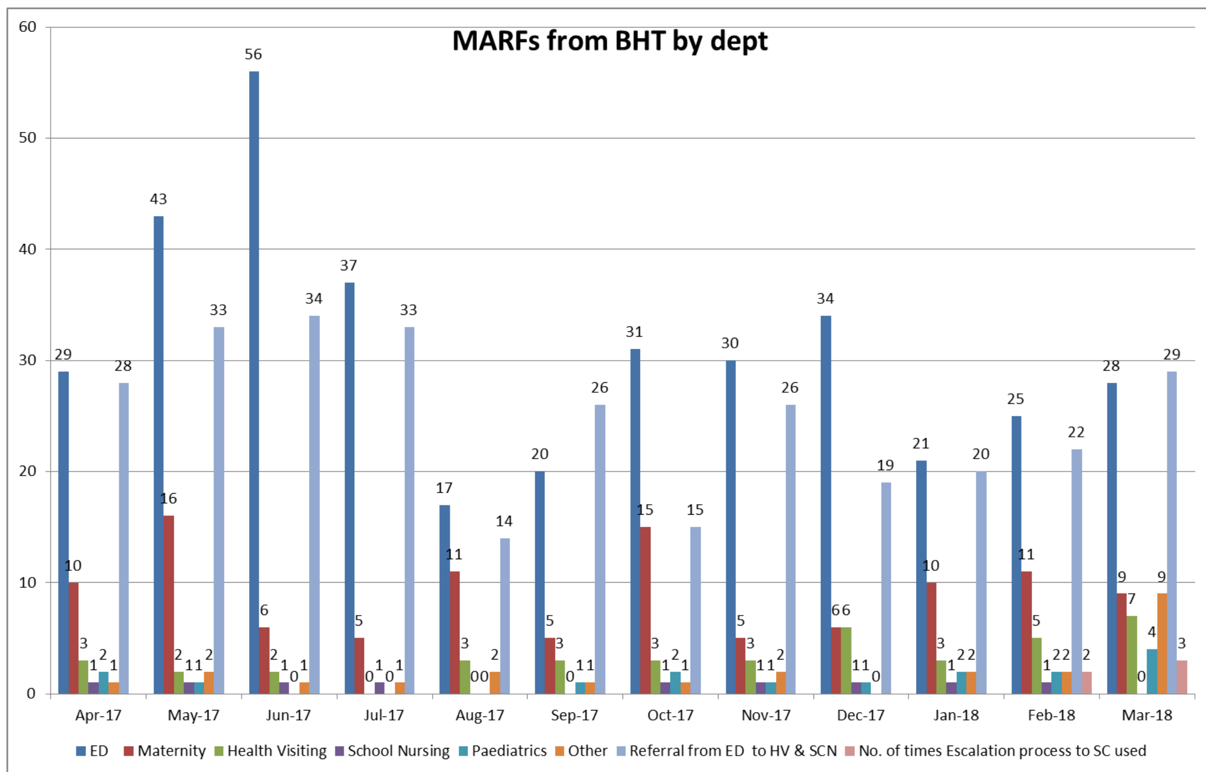

Figure 9

Children's MASH

BHT is expected to provide regular nursing and administrative staffing within the MASH for children, although this creates a strain on resources at times. On several occasions throughout the past year the BHT Safeguarding Team has not been able to provide a continuous nursing

resource for the MASH; this has been largely due to staffing pressures within the team. Nonetheless strong relationships exist between BHT safeguarding personnel and partner agencies within the MASH. Every effort is made to ensure that the MASH is staffed appropriately and this has largely been achieved on most days; where this is not possible virtual working allows for effective information sharing when required. The administrative service provided by BHT to the children's (and adult) MASH has been consistent throughout the year.

As part of the responsibilities within MASH, data about health activity is collated and reported within the safeguarding dashboard. This data is set out in ***table 10 and figure 10*** below and indicates the level of activity expected of health personnel within the MASH. It is largely expected that health personnel attend strategy discussions within MASH; again this is not always possible because of the limited resource BHT is able to provide, but again contribution to these meetings can happen virtually.

.

Children's MASH activity 2017-2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Number of MASH enquiries	41	45	58	61	47	44	26	35	17	31	51	50	517
Total Number of MASH information searches	139	150	216	227	152	160	98	114	63	126	180	188	1813
Number of MASH Strategy meetings	30	47	48	47	44	68	59	48	51	88	64	64	2492

Table 10

Children's MASH activity 2017-2018

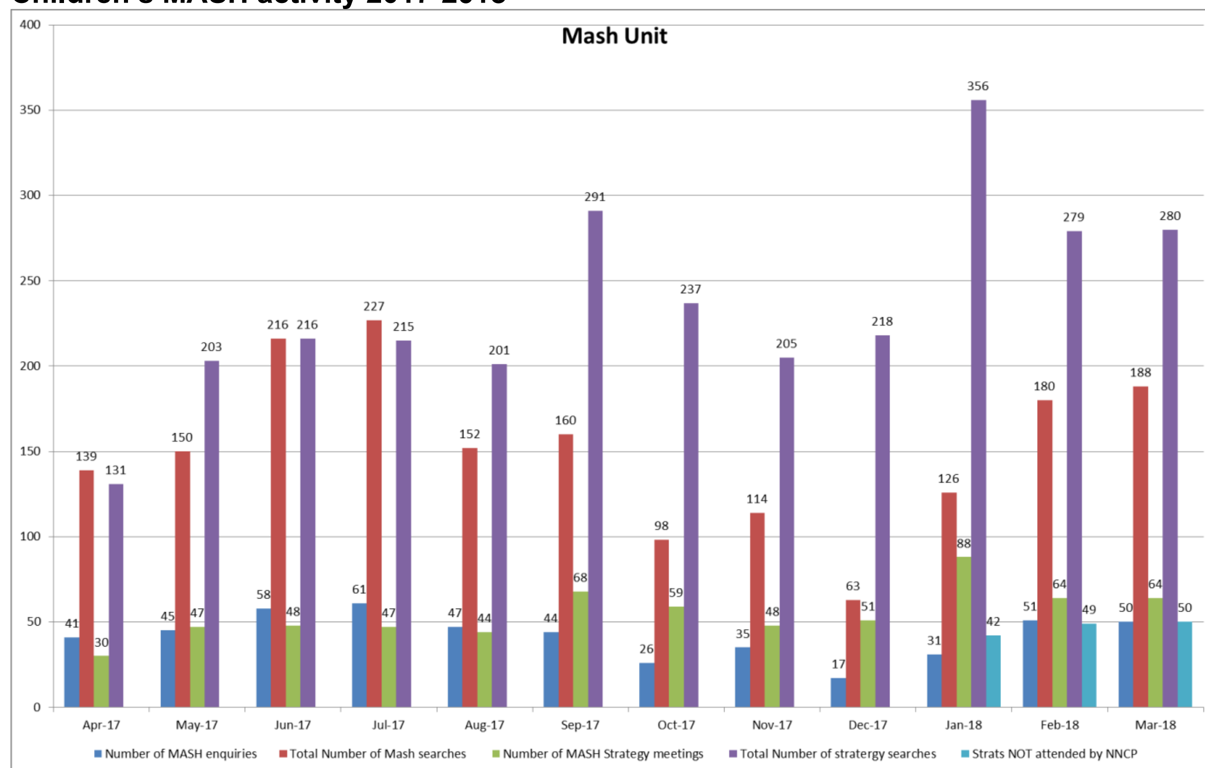

Figure 10

Child protection conference activity

This is the first complete year of collating information on the safeguarding dashboard pertaining to BHT staff activity in relation to expectations around child protection conference. Wherever possible and especially if significantly involved with a child or family, health professionals are expected to attend child protection conferences.

Attendance by BHT at Child Protection Case Conferences 2017 - 2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Invitation to Initial case conference	50	40	27	8	25	37	28	48	37	26	32	32	390
Attendance at both initial and review case conferences	68	85	145	30	60	136	42	113	56	47	59	81	922
Reports submitted to conference	54	46	41	28	36	51	53	107	69	75	71	90	721

Table 11

Attendance by BHT at Child Protection Case Conferences 2017 - 2018

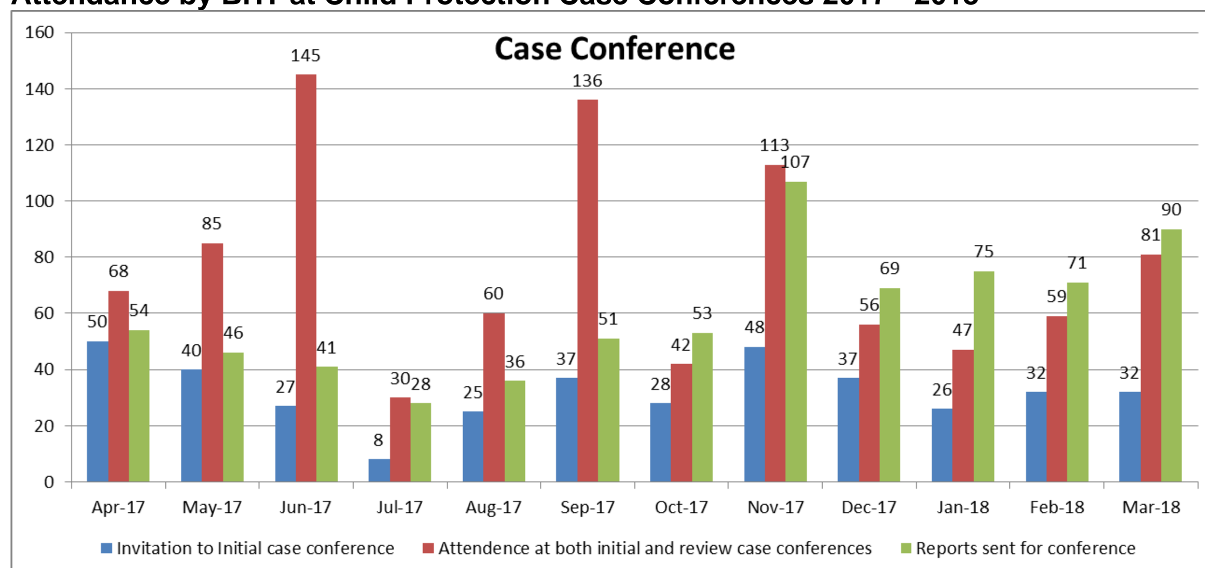

Figure 11

Table 11 and figure 11 above show activity relating to child protection conferences across this reporting period. All indications are that the number of child protection conferences being held in the county is increasing and this is indicative of wider social changes that are affecting children and their families and the changing demographics within Buckinghamshire. This in turn has consequential effects on the work of BHT staff, creating more activity and greater pressure on both staff and time resources.

The pressures on staff extend beyond attendance at conference as many BHT professionals are expected to support the delivery of child protection plans as members of the Core Group. In addition many of the Trust staff who are working with complex families may require additional support and supervision from their line managers and the Safeguarding Team.

The data reported above is reflective of the pattern of child protection referrals made by BHT staff across the year - see MARF data in ***table and figure 9*** above. BHT is working closely with local authority colleagues to address the issues of appropriate representation at child protection conferences.

SWAN unit for children and young people at risk of sexual exploitation.

Whilst the SWAN unit focuses mainly on sexual exploitation, exploitation in all its forms and across all age ranges is a growing area of concern. It is increasingly being recognised both locally and nationally that people who experience one particular type of exploitation are likely to be exploited in other ways and there is often an overlap in sexual, financial, gang related and modern slavery forms of exploitation.

In the current reporting period, 252 children have been discussed as part of multi-agency sexual exploitation (MASE) meetings in the Swan unit; this activity is reflected in ***figures 12 and 13*** below.

It is highly likely that in the coming year the SWAN unit will broaden its remit to deal with all types of exploitation and all age groups; this will inevitably place more expectations on health agencies, including BHT, to provide additional staffing resource for this service.

Cases discussed within Swan Unit MASE meetings and strategy discussions 01.04.2017-31.03.2018

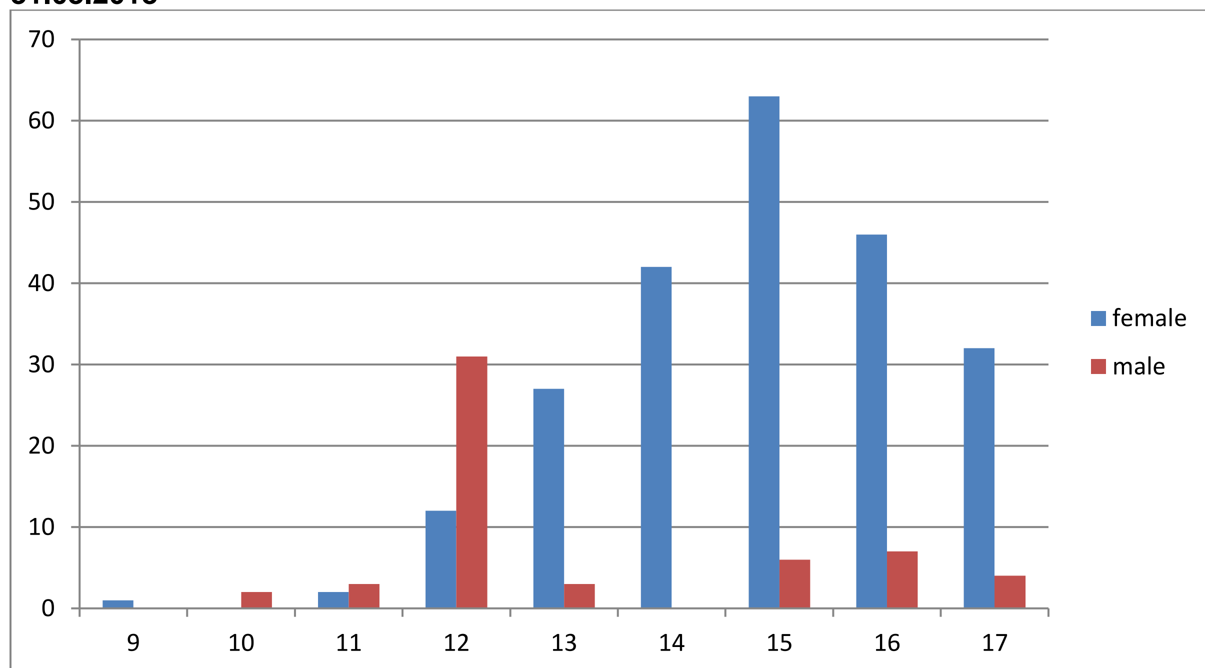

Figure 12

Health assessments offered to children discussed within Swan Unit MASE meetings and strategy discussions 01.04.2017 - 31.03.2018

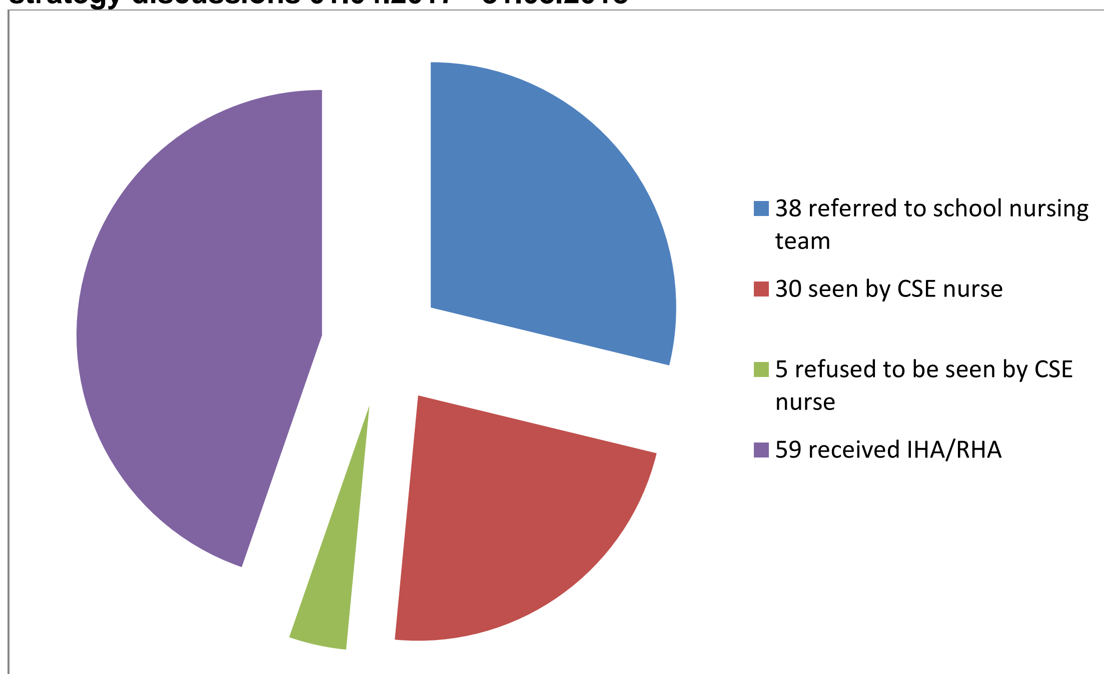

Figure 13

Learning Disability Liaison

Table 12 below shows the number of requests for assistance from the LD liaison nurses in the BHT Safeguarding Team from within BHT and from external providers.

Learning Disability- requests for advice/support 2018-2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Total Number of requests	30	26	30	33	20	31	27	28	26	24	19	18	312
From BHT	?	16	18	20	12	14	13	15	14	20	9	10	161
From external providers	?	10	12	13	8	17	14	13	12	4	10	8	121

Table 12

Information in relation to LD liaison activity has been included on the safeguarding dashboard as of May 2017. The data is indicative of increasing demand for the services; during the year 2016/17 the LDLNs received 200 referrals as opposed to 312 for the current reporting period (an increase of $n = 112$ or 56%). This increasing activity shows greater staff awareness and appreciation of the service provided by LD liaison and also demonstrates appropriate responses by staff to the needs and rights of people with LD who access health care.

Incidents and Complaints

Providers should use incidents and complaints to identify potential abuse and should take preventative actions, including escalation, where appropriate.
(CQC Regulation 13)

The interface between the SI reporting and management process and local safeguarding procedures is articulated in the NHS England Serious Incident Framework. In determining whether a safeguarding-related incident meets the definition of an SI, the following criteria will be considered:

- Pressure Ulcer incidents that result in severe harm (Grade 4 pressure tissue damage);
- Abuse/alleged abuse of an adult patient by staff;
- Abuse/alleged abuse of an adult patient by a third party (if on Trust Premises or by another patient);
- Abuse/alleged abuse of a child patient by staff;
- Abuse/alleged abuse of a child patient by a third party (if on Trust Premises or by another patient);
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
    - The Trust did not take appropriate action/intervention to safeguard against such abuse occurring; or abuse occurred during the provision of the Trust's care.
    - This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation, where delivery of NHS funded care caused/contributed towards the incident.

The Safeguarding team works closely with the patient Safety and Complaints Teams to identify whether an incident or complaint should be taken down the safeguarding route or to provide an appropriate response when safeguarding is considered to be a factor. The team also works closely with the BHT Tissue Viability Nurses to identify those pressure ulcers which meet the criteria for a safeguarding investigation.

Set out in ***table 13*** below are the top six safeguarding-related incidents reported using the Datix system. Not all incidents reported as safeguarding concerns on Datix translate into safeguarding adult referrals; nonetheless these incidents are worth further attention and exploration, especially those incidents relating to ongoing care and discharge.

Table 14 below shows safeguarding incidents by Division. Integrated Medicine and Elderly and Community Care Divisions are the top two referrers. These divisions deal with some of the most complex and vulnerable patients and it is not surprising that they recognise and report more safeguarding incidents. Higher levels of referral do not necessarily need to be viewed negatively and can be indicative of higher levels of awareness and lower tolerance of abuse by staff. Conversely, extremely low referral rates may also be worthy of attention.

Safeguarding Adult Incidents by Category 2017 – 2018

Incident detail	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Pressure sore / decubitus ulcer	4	6	7	8	9	13	9	7	11	15	11	14	114
Implementation of care or ongoing monitoring - other	5	2	9	15	3	9	7	0	0	4	1	2	57
Discharge	3	5	6	1	10	9	2	2	3	4	4	7	56
Abuse - other	1	3	0	5	1	6	3	7	2	7	1	0	36
Slips, trips, falls and collisions	2	1	2	1	4	3	1	1	1	3	0	0	19
Possible delay or failure to monitor	1	0	0	0	3	0	2	2	0	4	2	1	15
Grand total	16	17	24	30	30	40	24	19	17	37	19	24	297

Table 13

Safeguarding Adult Incidents by Division 2017 – 2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Integrated medicine	11	19	18	17	19	19	17	11	12	15	6	14	178
Elderly and community care	6	7	14	12	11	20	12	9	12	24	14	11	152
Surgery and critical care	1	4	3	6	7	5	5	2	4	1	2	1	41
Specialist Services	2	1	1	6	2	4	4	4	2	0	3	2	31
Women and children	1	0	0	1	0	2	1	0	1	0	1	4	11
Corporate/non clinical support services	0	0	0	0	0	0	0	0	0	1	1	0	
Total	21	31	36	42	39	50	39	26	31	41	27	32	415

Table 14

In the past year the Safeguarding Team has been consulted in relation to several complaints in which safeguarding was a factor; on most occasions BHT had acted appropriately in identifying and reporting a safeguarding concern. The main learning from these complaints has been to recognise that training must reinforce respectful communication by staff when pursuing a safeguarding concern.

When dealing with allegations of abuse against staff, the Trust follows the multi-agency procedures set out by the Buckinghamshire Safeguarding Adults Board (BSAB) and Buckinghamshire Safeguarding Children Board (BSCB).

Partnership Working

Providers should work in partnership with other relevant bodies to contribute to individual risk assessments, developing plans for safeguarding children and safeguarding adults at risk, and when implementing these plans.
(CQC Regulation 13)

BHT is engaged in partnership working on many levels from front line practice to high-level inter-agency meetings; all of this work is directed at protecting all individuals from the harm caused by abuse. Partnership working may entail practitioners working together to share information and formulate protection plans, senior level practitioners participating in safeguarding boards or professionals contributing to reviews and recommending changes or actions when things have gone wrong.

The Trust is actively engaged in and contributes financially to both safeguarding boards (BSAB and BSCB; BHT is also represented on the sub-groups of those boards. Safeguarding Team practitioners provide staffing within the multi-agency safeguarding hub (MASH) for children and contribute remotely to the adult MASH. The Trust also provides a practitioner to work in the SWAN unit which is a cross-agency team designed to identify and prevent sexual exploitation of children and young people. BHT is actively involved in the Risk Assessment Multi-agency Panel (RAMP) which supports practitioners working with high risk safeguarding adults cases. Frontline practitioners in BHT work in partnership with colleagues in social care and other agencies; this may be via sharing information in the form of referrals, contributing to investigations and attending meetings or conferences aimed at safeguarding adults or children when the risk of harm is considered to be high.

The national child protection information sharing system (CP-IS) is now fully embedded within BHT services. CP–IS connects the systems used by local authority children's social care teams with those used by NHS unscheduled care settings. It ensures that health and social care professionals are notified when a child or unborn baby with a Child Protection Plan or looked after child (LAC) status is treated at an unscheduled care setting. CP-IS supports the essential partnership work that BHT and the local authority (LA) are already doing to safeguard children.

The continuing implementation of CP-IS within BHT is being closely monitored by the Senior Named Nurse who provides ongoing support and ensures that audits of its effectiveness are conducted. Audits have shown that in the most part the system is working well and that staff working in urgent care settings are using the system effectively.

In the past year the Trust Safeguarding Team has worked in partnership with mental health colleagues in the psychiatric in-reach liaison service (PIRLS) and other colleagues in Oxford Health Foundation Trust (OHFT) to develop a mental health policy for BHT. BHT is also represented at the monthly Partnership in Practice meeting (PiP) meetings at the Whiteleaf Center in Aylesbury. These meetings are multi-agency and are aimed managing the interface between local agencies with regards to the care and treatment of people with mental health needs through:

- monitoring the use of section 136 MHA 1983 and the use of "place of safety" as defined in section 135(5) MHA 1983;
- addressing any concerns with regards to the application of the Mental Capacity Act / Mental Health Act;
- monitoring episodes of absence and absconsions from in-patient care;

- discussing concerns that have arisen between agencies in the preceding month and agreeing actions and responsibility to address those concerns.

Child Serious Case Reviews

BHT has worked in partnership in the production of several child serious case reviews that have been published in the previous year and which are set out below. Working Together 2015 states that a Serious Case Review (SCR) must be undertaken by Local Safeguarding Children Boards (LSCBs) where:

(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

In the year April 1st 2017 to March 31st 2018 BSCB published the following SCRs:

1. Child Sexual Exploitation in Buckinghamshire 1998-2016 – Published April 2017

In recent years the systematic sexual exploitation of children and young people has been a growing concern within England and has elicited much media attention; Buckinghamshire is not immune from this kind of abuse. This wide-ranging report was commissioned to learn the lessons from the past and further improve the protection of children and young people in the present. BHT was represented on the SCR panel.

Reports of child sexual exploitation across Buckinghamshire stretch back to 1998 and in 2013, a serious case review was undertaken to examine the response to one young person but until this specific review, the impact of sexual exploitation on other young people had not been examined. The report was commissioned to ensure that the appropriate processes, interventions and expertise are in place within the local area to ensure that young people are receiving the level of support they deserve.

The SCR recognises the work undertaken by BHT in terms of strategic leadership, staff training and support and dissemination of information, all of which has raised awareness and improved practice with regard to the sexual exploitation of children and young people, especially in respect of particularly vulnerable young people such as those with learning disability. In addition BHT employs a Specialist Nurse to work in the Buckinghamshire Swan (sexual exploitation) Unit; this role ensures that BHT processes to identify and support young people at risk of sexual exploitation are more robust.

The report concludes that "The challenge for the future centres around leadership, continued commitment to multiagency working and joint funding, particularly in a climate of austerity and cutbacks where agencies might be inclined to protect their own spheres of influence and revert to working in silos." BHT is committed to continuing multi-agency working and the development of the Buckinghamshire Integrated Care System is likely to strengthen a joined-up approach to this particular issue.

2. Baby E - Published June 2017

This report was commissioned in May 2012 and relates to a baby aged 14 weeks who presented to hospital with poor feeding and being unsettled, having been referred by the family health visitor. Following examination it transpired that Baby E had sustained a fractured femur; the injury was thought to be 2 weeks old. BHT was represented on the panel of this SCR.

Prior to this incident professionals had raised anxieties or been aware of concerns about Baby E and her family circumstances as follows:

- Baby E was born prematurely and spent the first nine weeks of life in hospital. She had an older sibling, Child F who did not share the same father.
- There were concerns about baby E and child F's welfare from the point of the birth due to the discovery that their mother's new partner had previously been involved in a relationship which involved many domestic violence incidents. The children in that household were subject to child protection plans, in part due to the possibility of contact with this man.
- Whilst baby E was in hospital it was noticed that her mother did not visit consistently, nor take a great deal of interest in her child's development and progress. However, following the articulation of these concerns by hospital staff, she demonstrated more interest in her baby and eventually brought her new child home.
- When baby E was aged 11 weeks and had been home for just over 2 weeks, the health visitor discovered baby E to have facial bruising, which a consultant paediatrician concluded was 'less likely to be accidental injury'.
- Baby E returned home whilst a child protection enquiry and criminal investigation were undertaken into the bruising, with an agreement with mother that her new partner would be excluded from all childcare tasks and not reside at the home. The mother and her partner provided several possible explanations for the bruising, but just before the planned meeting to consider the outcome of the investigations baby E was admitted to hospital following the health visitor being concerned that baby E was not feeding properly and cried on movement. Following admission at the hospital, baby E was diagnosed as having suffered a fractured femur. The health visitor was commended for her role in the care of Baby E.

The key findings were as follows:

- History taking and professional knowledge of the family was good but having recognised risks to the children in the household, there was a reluctance by professionals to identify these in terms of the child protection threshold, with the view that further evidence was required to be able to explicitly consider this further.
- When the child protection threshold was identified, the subsequent multi-agency investigative process (medical, police and social care) lacked rigour, consequently weakening the chances of identifying the perpetrator of the bruising on baby E and potentially the extent of baby E's injuries.
- Having identified the child protection threshold, assumptions were made about the identity of the perpetrator and there was professional optimism about the mother's ability to safeguard her children, so leaving both children at risk of significant harm in the home.
- Multi-agency processes were insufficiently collaborative; this weakened the assessments undertaken. Most strikingly the GP was totally excluded from all such processes as well as routine communications, which impacted on available information about the relationship between mother and her baby.

3. <u>Baby Q - Published June 2017</u>

This report was commissioned in July 2016 and relates to a baby aged 12 weeks who presented at a child health clinic and was noted by a community staff nurse (CSN) to be thin and lethargic and poor weight gain was recorded. The baby cried when being undressed CSN observed that the baby's right leg was very swollen; a subsequent x-ray showed a fracture of the right lower limb. It was felt at the time that the injury was non-accidental, however children's social care was informed and an initial investigation undertaken.

Later that evening whilst being undressed to be weighed it was noted that there was a subtle deformity of Baby Q's left forearm and two linear marks on this forearm. A subsequent x-ray and a skeletal survey the next day revealed fractures to all four limbs and to her ribs. The parents were unable to give any explanation for these injuries.

Baby Q was the youngest of 3 siblings, all born within three years to parents with known learning difficulties – both parents had statements of special educational as children. Following the birth of Baby Q's older brother concerns had been raised by the midwife about mother's mental health. The family health visitor who had known the family from the birth of the first child had identified that the family needed additional support.

The GP surgery also recognised that this was a vulnerable child especially in the light of her faltering growth and the frequency with which her parents failed to bring her to an appointment. (At the time the surgery did not have a system for flagging the notes of vulnerable patients and children but this is now in place.)

Despite being registered as mother's carer because of her visual impairment and learning difficulties, Baby Q's father was little in evidence when professionals had contact with the family. Mother brought Baby Q to appointments either alone or with a member of her extended family such as paternal grandmother and sometimes maternal grandmother. Mother described how her and her husband shared the care of all three children but professionals were unable to observe the interaction between the father and Baby Q and her siblings.

The findings and recommendations of this SCR recognise gaps in reviewing routine assessments, for instance around domestic abuse and also the assessment of the capacity of parents with learning difficulties.

Not fully recognising the role of the extended family was a concern in this SCR and whilst there had been no previous concerns about the care of the two older siblings, the family had lived with paternal grandparents until some point during the pregnancy with Baby Q. Having moved into their own accommodation Baby Q's parents were difficult to engage and missed a raft of health appointments.

<u>SCRs commissioned</u>

One SCR (Baby S) has been commissioned by the BSCB the past year and the report has not yet been completed. BHT is represented on the SCR panel. This case involves the death of a baby aged 5 months from suspected non-accidental injury. The case is subject to criminal proceedings and the SCR publication will be delayed until after the conclusion of the case in the courts.

<u>Learning from SCRs</u>

Each SCR highlights specific issues relating to an individual case, thematic analysis reveals that common themes emerge across different reviews. These can be summarised as follows:

1. **Voice of the Child** – It is frequently found in SCRs that practitioners do not hear or seek to understand the views and wishes of the child and focus too often on the adult's beliefs and feelings to the detriment of the child. Whilst it is important to listen to parents or carers, practitioner's must always consider what is it may be like to be a child in a particular family and seek to articulate their views or feelings regardless of age or stage of development.
2. **Confidence, competence and knowledge of practitioners** - All too often warning signs and symptoms of abuse are missed, not understood adequately or not categorised as being a high level risk. Training and supervision are key to addressing these shortfalls.
3. **Challenge and curiosity** – All too often practitioners are not sufficiently curious about a child or family's circumstances or are reluctant to challenge the picture being presented. Information that is known is often taken at face value and not analysed adequately and there is often professional over-optimism about what a family can achieve is. For children to be kept safe, they need practitioners to be curious and bold enough to challenge.
4. **Information sharing/dumping** – The matter of information sharing is a regular theme in the findings of child SCRs, with communication across agencies being challenged as often not being good enough. Whilst individual agencies may carry out their own discrete assessments, these are not always shared so that a holistic view of a family can be obtained. Information sharing protocols are available but are often misunderstood and there is frequently a presumption that information should be kept confidential. When information is shared it must not be 'dumped' – it is a common theme of SCRs that practitioners share information with children's social care or other agencies via referrals or conversations and then believe that their role has finished. It is essential that actions arise from all shared information; it is a practitioner's responsibility to ensure they receive an outcome from any dialogue or referrals and that they actively pursue this via the agreed escalation procedures when no outcome can be confirmed.
5. **Professional deference** – It is recognised in SCRs that some professional views can take precedence over those of others and individual's assessment may not be valued as highly as another person's. A "dominant view" can drive the outcome of child protection investigations and conferences and may divert the efforts of other professionals away from issues of concern. It is important that there is respect for the opinions of all parties and that each person is given an opportunity to be heard. Professionals must be supported to believe that their judgements are valued and that, whilst being able to listen to and respect others, they must be supported to challenge constructively when they have concerns.
6. **The role of fathers** - whilst men play an important part in family life they are often hidden from view or ignored by professionals. In the rearing of children services tend to focus on mothering rather than parenting to the exclusion of fathers. The failure to recognise the role of men within a household can have detrimental effects on children because either men who could pose a risk of harm were not recognised, or estranged fathers who could play a protective role in the lives were overlooked. Professionals working with families must show curiosity about who is living in a household and what is their role in respect of the children.

In the coming year BHT plans to carry out a thematic analysis of recent SCRs involving very young infants with a view to better understanding how review look Y

Safeguarding Adult Reviews

BSAB has commissioned and completed two serious adult reviews (SARS) in the year from April 1st 2017 to March 31st 2018 – Adult T and Adult Q. BHT was not involved in the care of either of these adults but has actively cooperated in the production of both SARs and identification of lessons learned.

The Care Act 2014 states that a safeguarding adults board (SAB) must:

- arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
    - there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and if:
    - the adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died); ;or
    - the adult is still alive, and the SAB knows or suspects that the adult has experienced abuse or neglect.

1. Adult T- Published August 2017

Miss T was a young woman, who was born in Buckinghamshire of Asian origin. She had mental health problems as well as a history of asthma and type 2 diabetes. She had been known to the local mental health services for several years and also had been supported by primary care. In February 2016, following a call from Miss T's friend, the police forced entry and she was found dead. There were no sign of suspicious circumstances. The Coroner concluded that the cause of Miss T's death could not be ascertained and an open verdict was recorded.

During the period of the review she was living on her own in a rented property. Over the years she had been employed in an accountancy role but her employment was usually part time. She had no contact or support from her parents since leaving home in 2013 since, apparently for cultural reasons, they did not approve of her lifestyle. Her partner had returned to his own country and therefore it would appear that she had limited network of support around her at this point in her life.

Miss T was last seen alive in October 2015 and during the period of time up until she was found dead there had been several failed contacts by various agencies including health, social care and housing. The SAR acknowledged the difficulty faced by practitioners on how best to act when the person at the centre of their concerns is not willing to accept help, or at best, to do so on his/her own terms. Various recommendations were made around:

- the way agencies work together;
- poor information-sharing;
- following policy and procedures for missing people;
- how to effectively feed back to friends or members of the public who raise concerns.

2. Adult Q – Published July 2017

Adult Q was 74-year-old man who lived alone in a private rented dwelling and who was found deceased at his home address. Adult Q had a diagnosis of bipolar affective disorder and through the last months of his life he demonstrated a number of symptoms of mania, including disinhibition and reckless spending, paranoia, pressure of speech and flight of ideas.

Towards the end of his like Adult Q was said to be living in an environment that was "very messy, with rubbish covering the floor space and the bed covered in household items"; he experienced several admissions to acute hospital services and was known to community mental services. Probably as a result of the deterioration in his mental state Adult Q began to avoid care calls and appeared to have become paranoid about his carers and members of his informal support networks, believing that they were taking money from him, moving items around in his home, and creeping around in the house in the middle of the night. He stated that he was hiding from people who were harassing him and seemed to be worried about being admitted to hospital or being placed in a residential or nursing home.

The SAR concluded that while it was not possible to say that the death of Adult Q was predictable or preventable, the circumstances of his death highlighted a number of concerns about responses to self-neglect and the deterioration in his mental health as well as the way agencies worked together. A number of recommendations were made including:

- the development of a self-neglect pathway;
- a review of the RAMP process;
- seeking assurance that the level of expertise and knowledge of staff across health and social care in relation to assessing capacity and carrying out best interests' decision-making is sufficient, and taking action to remedy skills and knowledge deficits.

SARs commissioned

One SAR (Adult V) has been commissioned by the BSAB the past year and the report is in the early stages of production. BHT was not involved in the care of Adult v but is represented on the SAR panel. The case involves the death of a man who lived alone and appeared to be resistant to services.

Learning from SARs

In many ways the learning from SARs is comparable to that of child SCRs with factors such as effective working together, information sharing and professional curiosity/challenge being dominant key themes. Other learning identified form SARs across the country is as follows:

- organisational abuse (mainly neglect) and self-neglect are the most common forms of abuse identified in the cases reviewed;
- failure to follow a "think family approach"
- **the quality of direct work with an individual including:**
    - missing or poorly performed mental capacity assessments and in some cases an absence of explicit best interests decision-making
    - absence or inadequacy of risk assessments, failure to identify persistent escalating risk and failure to act commensurate with risk;
    - making safeguarding personal – (a) lack of personalised care and focus on needs, wishes and preferences, insufficient contact and reliance on the views of others; (b) personalisation prioritised to the exclusion of the needs of other considerations such as risk to others;

  - failure to involve carers and recognise their needs and an absence of attention to complex family dynamics;
- **organisational factors that influence how practitioners work including:**
  - records and recording – key information in case documentation absent or unclear; failure to consult records; technology shortcomings that compromise recording practice or easy to access information;
  - failure to escalate cases and lack of management scrutiny of case-working;
  - staffing levels and staff working with inadequate resources including financial and time resources.

BHT Safeguarding Team ensures that the lessons learned, recommendations and action plans from SCRs and SARS are incorporated into staff training and supervision. Testing of whether learning is embedded is carried out via the safeguarding audit schedule.

The Safeguarding Team

The Trust Safeguarding Team plays a key role in promoting good professional practice throughout the organisation in order to ensure that all who come into contact with BHT services are safeguarded from harm caused by abuse. This is done through provision of training, supervision and day-to-day advice for staff and also through effective partnership working with other agencies and bodies.

The Team is continuously evolving in order to align with Trust objectives, CQC Regulation 13 requirements and the needs identified through work within the Trust Divisions. The role of the divisional safeguarding lead (DSL) within the Safeguarding Team was highlighted in last year's safeguarding annual report and the model of working is steadily developing. DSLs are adapting to the different ways of working and the requirements of each division. Whilst this is still very much "work in progress" initial evidence suggest that more effective relationships are building and the principle that safeguarding is everybody's responsibility is embedding.

Progress is being made in enabling the Safeguarding Team to be co-located on the Stoke Mandeville Hospital (SMH) site; it is anticipated that this will be accomplished by the autumn of 2018. The main objective of co-location is to create a "Safeguarding Hub" which will be easily accessible to all Trust staff, as well as ensuring that Safeguarding Team members can work more efficiently and provide each other with mutual support on a daily basis.

BHT Safeguarding Team incorporates the following functions:

- Learning Disability Liaison
- Looked After Children
- Safeguarding Adults
- Safeguarding Children
- An overarching role of Safeguarding Practitioner for Quality and Development (new appointment in the past year).

Learning Disability Liaison

People with a learning disability (LD) can often be a particularly vulnerable group of patients; they have the same right to good health as the general population but often need additional support to help them access health services.

The Trust learning disability liaison nurses (LDLNs) facilitate access to acute healthcare services for people with learning disabilities and/or autism. They receive referrals from within BHT and from external providers such as GPs and care organisations. The primary reasons for referral to LDLNs are mainly in relation to:

- patients in the Emergency Department (ED);
- support with decision-making (all Trust areas); and
- preparing LD service users for clinical procedures or operations (particularly if previous attempts have been unsuccessful).

The Trust LDNs provide an essential resource in supporting patients with LD and their carers; the aim is to ensure that BHT services make reasonable adjustments to meet their needs and thus avoid preventable harm or untimely deaths within this cohort of patients.

The LDLNs also provide support and consultation for BHT staff in respect of patients with LD, as well as facilitating inter-agency and inter-professional communication in mainstream services and in primary care. To enable this work they have flagged on the Trust Medway system almost 1,000 adults with LD who are known to BHT services. This flagging system helps staff to think about what reasonable adjustments they may need to make and whether there may be a need to contact the LDLNs; flagging has been positively received by carers.

In order to promote greater staff awareness of the needs of LD patients, a “Think TWICE” approach is being actively promoted. This mnemonic assists staff to consider the following:

Time - do you need to give the individual more time or do you need a different appointment?
Where - is the environment right for the individual or do you need to find an alternative space?
Include the individual and their family/carers; they will know the patient best.
Communication – do you need to consider different methods of communication, e.g. signing, pictures / drawing etc?
Experience – if you can make the necessary reasonable adjustments then the individual, family and staff team will all have a more positive experience and the individual’s health needs will be more effectively met.

Other key areas of LDLN work in the past year have included:

- Providing LD awareness training for all BHT staff and promoting the use of the health passport;
- Working with the Trust Dementia Nurse to provide training around understanding the Mental Capacity Act (MCA) – this has been very well evaluated;
- Working closely with the Matron in A&E and providing local training based on identified learning needs;
- Working very closely with the Nutritional Nurse Specialist to ensure that individual patients nutritional needs are met and supporting wards, patients and families in discussions and decisions regarding percutaneous endoscopic gastrostomy (PEG) feeding. This is extremely vital work as it has been identified that the number of people with LD being admitted to NHT in-patient services who have eating and swallowing

difficulties is rising. This has been ascribed to the increasing number of people with learning disabilities coupled with dementia as well as a growing number of patients being admitted with respiratory issues, some due to aspirational pneumonia;

- Linking more effectively with community learning disability health teams (CLDHTs) to enable easier inward referral processes and care smoother pathways prior to discharge from acute services;
- Participating part in a working group including with joint commissioner for LD to Improve health care for people with LD throughout Buckinghamshire;
- Proactively working with the BHT resuscitation manager to clarify protocols and recording categories of do not attempt cardio-pulmonary resuscitation (DNACPR) for people with LD; there is a need to ensure that the reasons recorded are appropriate for the individual in question;
- Supporting the national Learning Disabilities Mortality Review (LeDeR) programme which has been established to support local areas to review the deaths of people with learning disabilities. The LDLNs are working with the Buckinghamshire CCG so that learning from those deaths is being identified and taken forward into service improvement initiatives.

Looked After Children

The BHT looked after children (LAC) service has been part of the Safeguarding team for a year. The service provides statutory initial and review health assessments for children coming into care and those who remain in care.

Promoting the health and well-being of LAC is essential work and is directed by much legislation and statutory guidance. Performance in respect of LAC health assessments is heavily monitored because of the recognition of the likelihood of unmet health needs being present in this vulnerable group.

In line with national and local requirements a separate stand-alone report will be provided for the Trust Board in August 2018 in order to provide assurance that BHT is meeting statutory requirements for LAC.

Safeguarding Adults

The BHT safeguarding adult service continues to develop in response to increasing demand and expectations. The team members are all relatively new, having come into post within this reporting period; they are nonetheless very capable and self-motivated individuals who have been able to add value to the team. When they arise, staff vacancies are filled according to dynamic the nature of safeguarding adult work rather than always replacing like with like. This approach allows for greater flexibility and different approaches to working – the latest recruit to the team has a safeguarding background within the police service.

The focus of the safeguarding adult part of the team has been on developing relationships with in-patient and community services, providing team-based training and responding to individual cases and problems so that learning from these can be embedded into practice. Key areas of focus have been on MCA and DoLS activity; work with the Trust practice development nurses (PDNs) in respect of training them to provide local support for MCA and DoLS is beginning to reap benefits and should be supported by evidence in next year’s safeguarding annual report.

The new position of Safeguarding Practitioner for Quality and Development is managed within the safeguarding adult team, although this has an overarching role for the whole team – see below for more information about this post.

Safeguarding Children

The Trust children's safeguarding function has undergone several changes in staffing throughout the past year; this has refreshed the team and proved advantageous to the safeguarding service as a whole.

The Named Doctor for Safeguarding joined the service within this reporting period and works closely with the Safeguarding Children Team. There is currently no equivalent safeguarding doctor role for adult safeguarding and this should be given due consideration.

Changes within community children's services following the integration of speech and language therapists into BHT are beginning to embed and are enabling a more integrated team approach to working with children and their families. All therapists working with children receive regular safeguarding supervision and are able to act as lead professionals in child safeguarding cases.

Safeguarding Practitioner for Quality and Development

This is a newly created role within the Team and was created in response to an identified need to devote more focused time to developing training plans and audit programmes within the safeguarding team. The post holder has initially been concentrating on MCA and DoLS training and awareness-raising and also on ensuring that the software for the management of missing persons (Elpis) can be introduced into BHT.

The post holder is also working with the BHT Patient Experience Team and looked after children ambassadors to improve the uptake and experience of LAC health assessments in older aged children and young people. In addition the post-holder is ensuring that all training programmes delivered by the Safeguarding Team are supported by robust evidence-based training plans.

Future Work Plans and Developments

For the forthcoming year the Safeguarding team will be focusing on the following key areas of work:

- MCA and DoLS – to improve on direct work with patients in these fields of work so as to ensure that staff understand the how to carry out an effective mental capacity assessments and make decisions in the best interests of patients.
- Making Safeguarding Personal – promoting making safeguarding personal is one of the key objectives of BSAB for the coming year. BHT Safeguarding Team will focus on promoting personalisation and will actively promote the involvement of patients in all decisions about them and ensure that their needs, wishes and preferences are given a voice.
- Self-neglect – this is an increasing area of concern in respect of safeguarding adults. The use of the BSAB Threshold Tool will be promoted and BHT will continue to actively engage in the RAMP process.

- Supporting staff in ED recognise who work with children and young people to respond effectively and consistently to suspected child abuse. Staff must recognise that 16 – 18 year olds are children and that responses to concerns must follow expected child protection procedures.
- Care of children and young people aged over 16 years on adult wards – ensuring that staff on adult wards are aware of child protection procedures and receive child protection training at the right levels.
- Working with children's and adult services to ensure seamless transitions for children and their families into adult services.
- Exploitation in all its forms – this is an ever increasing area of activity for all agencies in Buckinghamshire and includes modern-day slavery, sexual and financial exploitation and gang related activity. BHT Safeguarding Team will explore ways of supporting Trust staff to identify and address exploitation and will also work with other organisations to further develop multi-agency working.
- Develop robust staff training for domestic abuse and ensure that learning from all case reviews in respect of domestic abuse issues can be embedded into practice. This will include a renewed emphasis on a "think family" approach.
- Missing persons - work with the Trust Head of Security to introduce the Elpis multi-agency database into BHT to better enable the management of patients who go missing. The system allows for real-time information sharing allows for dynamic decision making; taking a safeguarding approach enables early identification of risks, vulnerabilities and potential triggers.
- End of life care for people with learning disabilities - improve staff understanding of the rights of people with LD when receiving end of life care.
- People with LD who access ED – ensure that ED staff are appropriately trained and supported to deliver services to people with LD.
- Working with midwifery and gynaecology services as well as children's social care to ensure effective identification and reporting of female genital mutilation (FGM).
- Discharge planning for patients with LD - improve communication between community LD teams and BHT LD liaison team - an event to promote discharge planning and care pathways for people with LD will take place on 13th September in the Guttman centre in SMH.

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Appendix 1 CQC Regulation 13 in full

1. Service users must be protected from abuse and improper treatment in accordance with this regulation.
2. Systems and processes must be established and operated effectively to prevent abuse of service users.
3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
4. Care or treatment for service users must not be provided in a way that—
    a. includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
    b. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,
    c. is degrading for the service user, or
    d. significantly disregards the needs of the service user for care or treatment.
5. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.
6. For the purposes of this regulation—
   'abuse' means—
    a. any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(a),
    b. ill-treatment (whether of a physical or psychological nature) of a service user,
    c. theft, misuse or misappropriation of money or property belonging to a service user, or
    d. neglect of a service user.
7. For the purposes of this regulation, a person controls or restrains a service user if that person—
    a. uses, or threatens to use, force to secure the doing of an act which the service user resists, or
    b. restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means.

Appendix 2 CQC Regulation 13 - Related Legislation

Children Act 1989

Children Act 2004

Children and Young Persons Act 1933

Equality Act 2010

Equality Act 2010: Chapter 1 (protected characteristics) Chapter 2 (prohibited conduct) and Chapter 3 (services and public functions)

Human Rights Act 1998

Mental Capacity Act 2005 and associated Code of Practice

Mental Health Act 1983 (amended 2007) and associated Code of Practice

Protection of Freedoms Act 2012 – links to The Protection of Freedoms Act 2012 (Disclosure and Barring Service Transfer of Functions) Order 2012

Safeguarding Vulnerable Groups Act 2006