

Safeguarding Annual Report 2016/17



The Strategic Safeguarding Committee, 12th June 2017

Safeguarding is everybody's responsibility.

Formal Opening Changing Places, 16th May 2017



Executive Summary

The Royal Berkshire NHS Foundation Trust (RBFT) is dedicated to safeguarding vulnerable people. It has an experienced safeguarding team with the skills and experience to support different groups: adults, children, and people with a learning disability, people with mental health problems and families accessing our maternity services. The team provides a cohesive approach to training and support of staff to meet the needs of vulnerable people. In line with national guidance on multi agency working the safeguarding team represent the Trust on a variety of partner agency groups. They work with individual patients and teams in ‘making safeguarding personal’ coordinating a multi-disciplinary, multiagency approach balancing the principles of empowerment and autonomy with our responsibility to protect and safeguard.

There have been significant achievements and improvements in safeguarding since the publication of the Mazars Report into Southern Health, 2015 and Verita Investigation of the Myles Bradbury Case, 2015

The essence of good safeguarding is continuous learning, quality improvement, professional curiosity and challenge. We have worked with our partners to implement the recommendations from the CQC inspection of health providers, child safeguarding and looked after children report for Wokingham CCG, May 2016 and Ofsted Inspection reports for West Berkshire and Reading Local Authorities Children's Services and LSCBs published in May 2015 and August 2016. We participated in safeguarding children, neglect and domestic abuse peer reviews commissioned by West Berkshire, July 2016 and Wokingham, February 2017. We actively participated in a Wokingham Domestic Homicide Review and partnership reviews, Serious Case Reviews and Safeguarding Adult Reviews. We brought learning from these reviews back to the RBFT to improve our safeguarding systems, processes and staff knowledge and competency.

The RBFT has obligations under the Children Act 1989 and 2004, Care Act 2014, MCA, 2005, Mental Health Act (MHA), 1983 to ensure it provides safe effective and well led services which safeguard the vulnerable. Compliance with Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework and CQC regulation 13 Safeguarding Service Users from Abuse and Improper Treatment are the standards we employ to focus on our declared aim of ‘promoting the safety and well-being of all children, young people and adults’ who have contact with our services. Training, audit and review against those standards are the foundations of our assurance reinforced by



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supervision and management overview. Our Annual Safeguarding Plan for 2016/17 was based on the findings of a Price Waterhouse Cooper audit of Safeguarding commissioned in October 2016 by our Audit and Risk Committee and the 'amber areas' of the 2015/16 annual safeguarding standards self-assessment which includes our Section 11 audit of the Children Act 2004 which is submitted to our commissioners. We actively participate in the Quality and Performance sub groups of the Local Safeguarding Children Boards and Safeguarding Adult Board for the West of Berkshire.

Challenges include training staff in all aspects of safeguarding, consistency of knowledge, competency and application in practice; transition for children to adult services including Child and Adolescent Mental Health Services (CAMHS); a year on year increase in activity for all vulnerable groups including, elderly patients living with dementia and adults with learning difficulty who are delayed in hospital; high numbers of mental health patients of all ages with complex psychosocial needs in the acute setting; an increase in the number of vulnerable patients delayed in hospital; an increase in the complexity in cases of at risk unborn babies and self-harm and suicide prevention. Monitoring the impact of health and social care budget cuts, homelessness and workforce sufficiency on services for the vulnerable, gaps in services for disabled children and children and young people with Special Educational Needs and Disability (SEND) , domestic abuse, neglect and self-neglect, safe recruitment and allegation management and the sufficiency of mental health services and the national Prevent scheme are continuing or emergent themes.

Patricia Pease, Associate Director of Safeguarding, June 2017

Introduction

This is the annual safeguarding report for the Royal Berkshire Foundation Trust (RBFT) it covers all areas of safeguarding work across the Trust and through multiagency working, and sets out our priorities for further work.

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect (CQC 2016). Safeguarding at the Royal Berkshire Hospital is fundamental to high-quality health care. Safeguarding is everybody's responsibility.

The Safeguarding Team Structure

The safeguarding team structure (nursing and administration) and lines of responsibility and accountability for the RBFT is shown on the diagram below:



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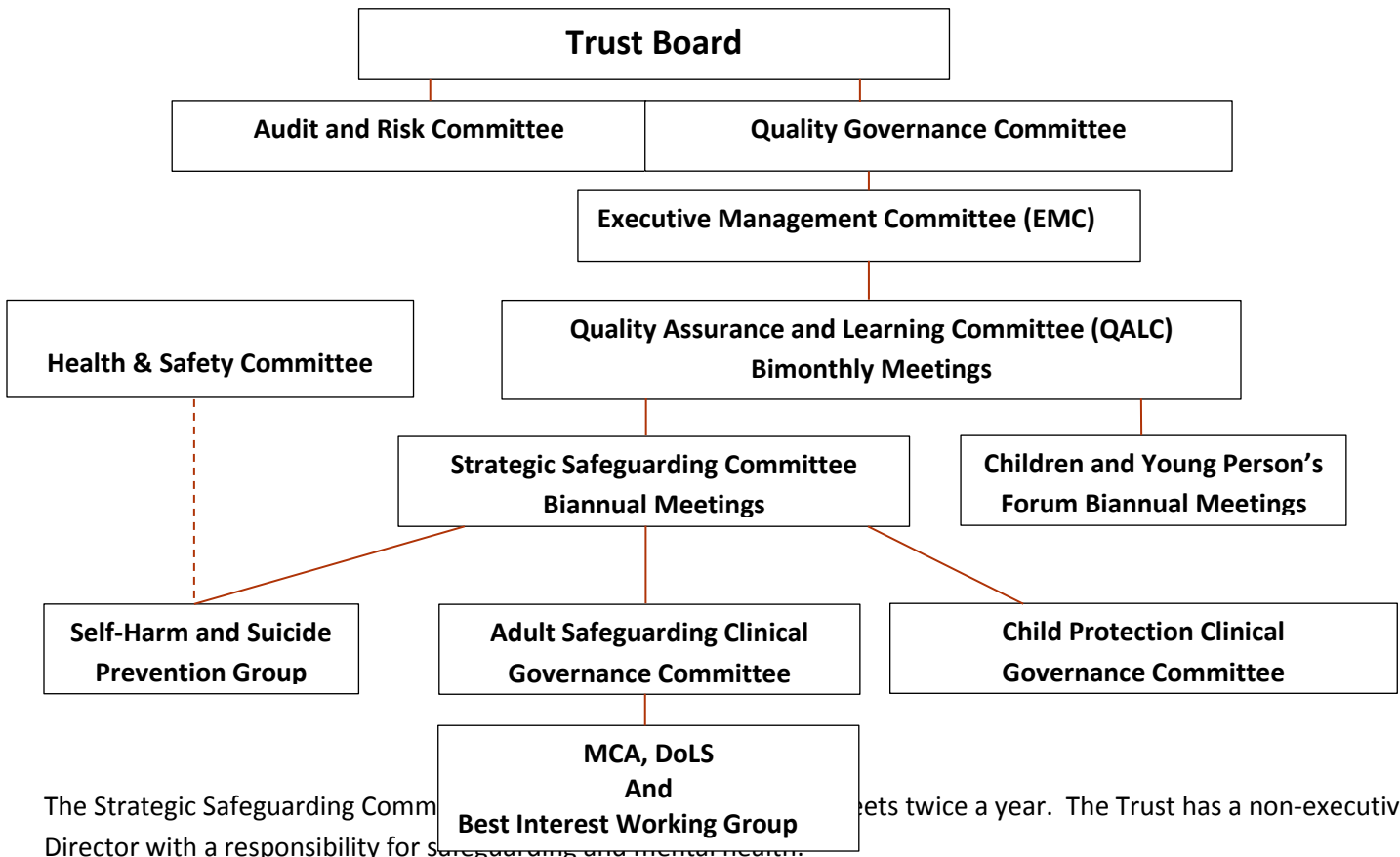


<p>Adult Safeguarding: Medical Leads</p>	<ul style="list-style-type: none"> • Dr. Chris Danbury: Urgent Care Group • Dr. Kim Soulsby: Planned Care Group • Vacant: Networked Care Group
<p>Child Protection: Medical Leads</p>	<ul style="list-style-type: none"> • Dr Andrea Lomp: Designated Doctor Child Protection, Berkshire West • Locality Paediatricians to support Designated Doctor Child Protection based at Dingley Specialist Children’s Centre. This team also provide Child Protection Examinations • Dr Ann Gordon: Named Doctor for Child Protection • Dr Niraj Vashist: Medical Advisor to Fostering and Adoption Panel
<p>Child Death</p>	<ul style="list-style-type: none"> • Patricia Pease: Designated Healthcare Professional Child Death Berkshire West
<p>Sexual Health</p>	<ul style="list-style-type: none"> • Julia Tassano-Smith: Nurse Consultant
<p>Human Resources</p>	<ul style="list-style-type: none"> • Suzanne Emerson-Dam: Assistant Director Workforce Designated HR Officer Safe Recruitment & Allegations Management

The Safeguarding service is accountable to the RBFT EMC and Board, Berkshire West CCG, Reading, West Berkshire and Wokingham Local Safeguarding Children Boards (LSCBs), Berkshire West Safeguarding Adult Board (SAB) and participates in Mental Health, Learning Disability, Strategic Disability and Transition partnership meetings.



Safeguarding Governance Committee Structure



The Strategic Safeguarding Committee meets twice a year. The Trust has a non-executive Director with a responsibility for safeguarding and mental health.

Safeguarding and mental health quality indicators are reported monthly to the Board and CCG. A bi-monthly safeguarding and mental health report including key performance indicators is submitted to the Board as part of the QALC report.

Multidisciplinary child protection clinical governance is held every 2 months; this is chaired by the Named Nurse for Child Protection. Safeguarding Adult Clinical Governance is held every 3 months chaired by Dr. Chris Danbury. A Mental Capacity, DoLS and Best Interest Working Sub Group that includes the Head of Legal Affairs meet every 6 months, reporting to Safeguarding Adult Clinical Governance. The Mental Health Coordinator chairs a quarterly Suicide and Self Harm Prevention Group, which reports by exception to the Health and Safety Committee.

Quarterly Safeguarding Concerns and Allegations Review Meetings, chaired by the Designated HR Officer Safe Recruitment & Allegations Management, were established in 2016, live cases are reviewed to ensure timely conclusion and closed cases are reviewed in order to identify patterns or theme.

The Children and Young People’s Committee monitors work streams to benchmark and improve the quality and safety of Trust services for children: the work of this group is under review.

The safeguarding nursing team meets monthly to discuss operational safeguarding issues and prepare performance reports; agendas and minutes are kept for these meetings.



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Statistics/Activity - The table below sets out indicative statistics for the RBFT for information and background.

	2013/14	2014/15	2015/16	2016/17	Comment
Population number served	1,000,000	1,000,000	1,000,000	1,000,000	↔
% of population under 18 years	20%	24%	24%	24%	↔
Number of adult attendances to ED	83,298	87,288	89,711	94,348	↑4.9%
Number of attendances by under 18s to ED	26,686	27,864	29,087	29,427	↑1%
No of over 65s attending ED	22,644	24,569	25,635	27,159	↑ 5.6%
No of mental health attendances at ED all ages	2169*	2810	2809	2778	↓19%
Number of adult admissions	80,766	84,434	90,933	92,791	↑ 2%
Number of admissions to paediatric wards	7,146	7181	7607	8589	↑ 11.4 %
Number of under 18s admitted to adult wards			550	704	↑ 21.88%
No over 65s who were admitted	32,821	35142	39515	39785	↑0.68%
No over 75s admitted for >72 hrs	5,301	5288	5451	6449	↑15.48%
No over 75s admitted for >72 hrs with cognitive issues	1602	1483	1195	1,582	↑24.46%
Number of in-patients with a learning disability	227	289	315	278	↓12%
No of patients admitted because of mental health issues		798	1596	1610	↑19%
Number of babies born	5,689	5681	5596	5391	↓ 3.8%
Number of under 18s attending out-patient clinics	65,296	62,767	62,437	72,539	↑13.93%
Number of under 18s attending clinics providing sexual health services	2,959	2016	2356	2059	↓13% - episodes 4036
Dingley child protection medicals – calendar years	54	98	120	112	
Number of employees	Approx. 5000	Approx. 5000	5360	5470	

Training

Training is reported monthly to the CCG as part of the quality schedule. A Trust annual training plan for child and adult safeguarding 2017/18 has been completed and approved by the Trust Education Committee. At the end of March 2017 safeguarding training was at or above the expected and agreed level with the exception of:

- Safeguarding Children Level 1 Training – 86% against a target of 95%
- Adult Safeguarding Training – 89% against a target of 90%

All training programmes are regularly reviewed to ensure they include learning from serious case reviews and changes to national policy and guidelines.

Safeguarding Adults training

All staff need to be trained in safeguarding adults. Staff that make clinical decisions with patients need to be trained in the mental capacity act (MCA) and its application. The focus in 2017/18 will be application in practice of the MCA.

Safeguarding Children training

All staff need to be trained in child protection to the level that their job role requires 'Intercollegiate document, Child Protection Roles and Competencies for Health Staff, 2014'. A review of level 1, 2 and 3 training was undertaken during 2016/17 this included an increase in the number of hours of update training annually for specialist midwives. In 2017/18

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the content of the programme for specialist midwives will be reviewed and there will be a wider review of how we evaluate skills, knowledge and confidence of the children's workforce to inform the need for further work.

Child Sexual Exploitation (CSE) Training

CSE is embedded into safeguarding children training at all levels. Four CSE one hour updates at level 3 are available annually. The Department of Sexual health holds a one hour CSE case study peer review bimonthly. All staff can access E.learning via the CSE intranet pages. In 2017/18 we will concentrate on embedding the use of CSE assessment tools.

Domestic Abuse

Domestic abuse is raised in adult and all levels of child safeguarding mandatory and statutory training; specific domestic abuse training is available for maternity staff. Level 3 days for the children's workforce include clear guidance for staff who are working closely with children and families on how to support and refer to other agencies where there are parental risk indicators. In the 2017/18 further work will be undertaken with the Emergency Department (ED) and their Domestic Abuse champions.

Prevent (Anti-terrorism Training)

Prevent awareness forms part of the level one training for all staff and is included in adult and child safeguarding training. 1 hour Wrap training is delivered to selected staff. The focus in 2017/18 will be Human Resources, the Emergency Department, Paediatrics and the Clinical Site Management Team. This can be delivered face to face or via e-learning. An E learning has also been promoted for use within the Trust.

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

MCA and DoLS awareness are delivered as part of the core mandatory training day and as part of Trust induction safeguarding adults training. For patient facing staff MCA enhanced training will continue to be delivered to a selected group of staff to achieve a minimum of 80% compliance. There will be a 'MCA, Consent and Best Interests Assessment' priority programme during 2017/18 using an 'engage and enable' approach which will include roll out of flow charts and documentation to support knowledge and application in practice and promote confidence.

Mental Health Training

The Mental Health Coordinator (MHC) continues to provide training to staff on the Mental Capacity Act, the Mental Health Act (MHA), mental health disorders, stigma, and the processes in place within the hospital to ensure good patient care. The MHC provides training to ED Senior House Officers, ED Middle Grades and Health care assistants at induction. A Mental Health training day was established in 2016 for ED, Acute Medical Unit and Short Stay Unit nursing staff which includes understanding of the MHA, MCA, mental health disorders and the process if a patient is detained under the MHA. In 2017/18 this one day training will include risk management in practice, a Consultant Psychiatrist will join the team and the days will be extended to medical staff. The session already included in HCA induction will be extended to nurse, midwife and allied health professional (AHP) induction. A programme of monthly training on the application of MHA delivered by two Consultant Psychiatrists started in June 2017 – this will support the RBFT 'Quick Guide to MHA'.

Allegations and Safer Recruitment training

Safeguarding concerns and allegations awareness is delivered as part of child and adult safeguarding core mandatory training. A one off training for consultants, outpatient reception and outpatient nurses on learning from Myles Bradbury was delivered in 2016. In 2017/18 a training need analysis will be carried out to inform the need for additional training for specific staff groups and a larger cohort of managers trained to investigate allegations will be identified.

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Conflict management training and training in physical restraint

Security Staff are trained in physical restraint; all are qualified in Caring Intervention level 3 Control and Restraint. Conflict management training is available and mandatory for all clinical staff and includes breakaway techniques and understanding of the application of the Mental Capacity Act. Restraint in relation to clinical treatment and best interests is discussed in Level 1 adult safeguarding training and Level 3 child protection training. In 2017/18 there will be a review of the Trust management of patient challenging behaviour, violence and aggression and restraint policies and protocols and a subsequent training needs analysis and review.

Transition training

By April 2017 transition training as part of the 'Ready Steady Go' framework for transition planning roll out was delivered to 18 adult specialties. During 2017/18 specialties' will be expected to maintain the knowledge and skills of their staff in relation to transition through ward and department training.

Learning Disability

A DVD is shown at core induction; there are raising awareness sessions for RNs and HCAs as part of nurse/HCA induction. A communication session is delivered on a training day for care crew teams. LD awareness has been included in junior doctor induction. In 2017/18 there will be work to support a consistent response to an LD flag or diagnosis 24/7.

Ongoing Challenge/Risks:

- **Training compliance of our staff in all aspects of safeguarding**
- **Consistency of knowledge and application in practice**
- **Consistency in recognition and assessment of risk and confidence of our staff to respond**

Safeguarding Audit

A comprehensive self-audit was completed for the CCG in September 2016. The audit is RAG (Red, Amber, Green) rated; there were 8 "amber" areas for improvement in 2016/17. The other 42 areas were green. Programmes of work and/or action plans were developed for each amber area. For 2017/18 the 'amber' rated areas will be reviewed by the Safeguarding Team and the CCG. A safeguarding staff survey using survey monkey will be completed in October 2017.

The Audit and Risk Committee commissioned Price Waterhouse Cooper to carry out an audit of Safeguarding in October 2016. This review covered the Trusts processes for safeguarding children and vulnerable adults, including; the training provided to staff; management of safeguarding concerns, and the Trust's involvement in and liaison with local Safeguarding Boards. Safeguarding was last reviewed by Internal Audit in 2012/13, where a high risk report was issued, largely as a result of; poor training compliance at that time; safeguarding policies and procedures requiring update and approval from the Trust Board, and limited internal reviews and assessment being undertaken. It was noted in the 2016 report that the Trust had improved in each of these areas; however at the time of the review training was not fully compliant with national targets.

The Safeguarding Team coordinates an agreed audit program that includes single and multiagency audits monitored through our internal governance systems and the quality and performance sub groups of the LSCBs and SAB.

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Safer Recruitment and Allegations Management

Key Achievements

- Review of the Managing Safeguarding Concerns and Allegations Policy (April 2016), the Recruitment and Selection Policy (January 2017) and the Disclosure and Barring Policy (January 2017).
- Commenced the 3 yearly DBS checks for staff/volunteers concentrating on priority groupings.
- Implementation of Quarterly Safeguarding Review Meetings where live cases are reviewed to ensure timely conclusion and closed cases are reviewed in order to identify patterns or themes and actions identified as a result of identified themes.
- Attendance at the West Berkshire Council Serious Case Review Event in order to identify lessons learnt.

Summary of Cases

In the financial year 2016/17 a total of 17 allegations were made; 10 relating to vulnerable adults and 7 relating to children. Over the same period a total of 7 concerns were raised; 5 relating to vulnerable adults and 2 relating to children.

Of the 24 concerns/allegations raised, 16 related to Trust employees; the others related to agency workers, volunteers or “others”. One of the allegations related to historical issues.

In comparison with the previous two years the number of allegations increased from 8 to 11 to 17 and the number of concerns rose from 4 to 5 to 7. In order to provide appropriate HR support to safeguarding concerns and allegations the number of HR staff trained to deal with safeguarding concerns and allegations is being increased from 1 to 3.

Key Areas of Work for 2017/18

Concerns/Allegations Management

- To work with the Associate Director for Safeguarding to provide support/guidance/templates to managers who have attended the Managing Safeguarding Concerns and Allegations Training Programme particularly in relation to report writing.
- To develop a larger cohort of managers trained to investigate allegations
- To carry out a multidisciplinary training needs analysis of managers in relation to managing safeguarding concerns and allegations in practice

Safer Recruitment

- To review the content of the Recruitment Training Programme and the number of staff trained.



Ongoing Challenge/Risks:

- **Capacity to release clinical managers to undertake safer recruitment and allegation training**
- **Capacity of the Safeguarding team to effectively administer the investigation process given a year on year increase in concerns and allegations raised**

Child Protection and Safeguarding**Key achievements**

- We worked with our partners to implement the recommendations from the CQC inspection of health providers, child safeguarding and looked after children report for Wokingham CCG, May 2016 and Ofsted Inspection reports for West Berkshire and Reading Local Authorities Children's Services and LSCBs published in May 2015 and August 2016.
- We participated in safeguarding children, neglect and domestic abuse peer reviews commissioned by West Berkshire, July 2016 and Wokingham, February 2017 and received very positive feedback.
- In May 2017, Wokingham Local Authority had a Joint Targeted Area Inspection which focused on children from 7 to 15 years old and neglect. RBFT worked closely with all agencies, feedback for the RBFT was very positive with some learning about multiagency communication in the perinatal pathway.
- We have actively participated in two partnership reviews with Reading LSCB; learning has been disseminated through training. We are currently participating in a serious case Review for Reading LSCB.
- Level 3 Multi-agency Child protection training has been embedded, delivered and adapted to the changing safeguarding environment. Partner agencies teach on the day and are invited to participate.
- The pilot of a CAMHS Urgent Response Service proved to be successful and is now commissioned to provide a more comprehensive assessment service for children and young people attending with mental health needs being seen in a timely manner and by an appropriate practitioner.
- The Named Nurse continues to meet regularly with partner agencies, good strong relationships have been developed and feedback on our service has been invited and valued.
- The annual audit of child protection referrals to Local Authorities identified staff referring appropriately, engaging with child protection thresholds, demonstrating more confidence in raising concerns and using more effective information sharing.
- Previous audits of children not brought for health appointments have demonstrated good processes in place but a need to explore the role and responsibilities of the GP. The Named Nurse for Child Protection and Safeguard Lead for GP's are repeating the audit to include GP practice.
- An audit of the pathway of referral to health visitors and school nurses in March 2017 showed that Emergency Department was very effective in their communication. The Paediatric ward showed good knowledge but inconsistent application in practice.
- Following the establishment of a task and finish group the monthly audit of young people attending adult ED with mental health issues being discussed with Children's Social Care has improved.
- In October 2016, Price Waterhouse Cooper (PWC) was commissioned to review Safeguarding Adults and Children. As a result the process for recording and reporting child safeguarding children is being reviewed to develop an electronic approach which will improve information sharing, the communication of safeguarding concerns and audits. PWC recognised that there was an established process for clinicians to follow when discharging children

where safeguarding concerns have been raised, including the completion of a specifically designed checklist. However, found no established mechanism for the Safeguarding Team to be assured that the process was adhered to – that has been remedied, an audit has been established.

Fig 1: referrals to local authority per month 2016/17 from RBFT:

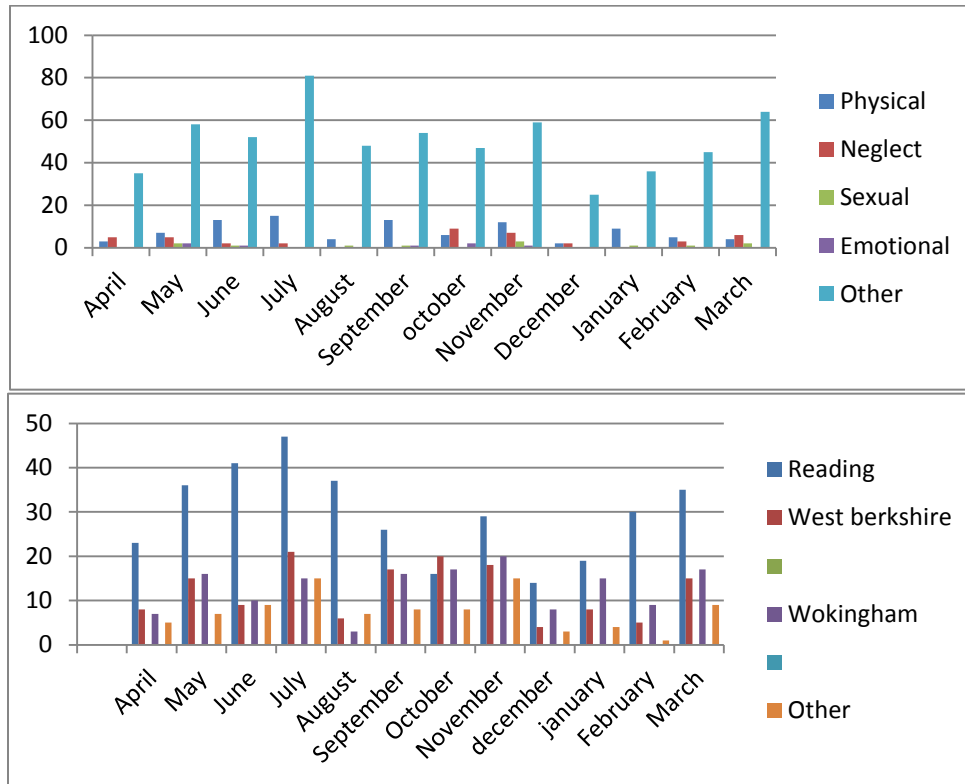


Figure 2: Referrals by category of abuse per month 2016/17 from RBFT

“Other” abuse is child protection referral for risk factors such as mental health concerns, domestic abuse, substance misuse, Female Genital Mutilation (FGM) and parenting concerns.

Key Areas of Work for 2017/18

- Continue working with Information Management and Technology (IM&T) Services, clinical teams and NHS England to ensure Child Protection Information Sharing (CP-IS) is fully integrated into unscheduled care settings by March 2018 and to develop an electronic approach to our child safeguarding referral and information sharing
- Continue working with Information Management and Technology (IM&T) to develop an electronic approach to our child safeguarding referrals and information sharing
- Continue working in partnership with BHFT, TVP, SCAS and the three local authorities in Berkshire West to pilot a high impact user multiagency risk management approach to improve care of a small group of high risk children and young people who are ‘frequent attenders’
- Work in partnership with Reading local authority on their Ofsted improvement journey through active membership and participation in Reading CSIB and LSCB.
- Named Nurse for Child Protection working closely with frontline practitioners in Paediatrics and ED, to raise safeguarding skills and confidence, champions are being identified and peer supervision for nurses set up.



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- All face to face level 3 child safeguarding updates for 2017/18 will include a 'back to basics' session on thresholds, risk assessment and escalation
- Achieving level 1 Child Protection Compliance

Ongoing Challenge/Risks

- **RN nurse vacancies on Paediatric Wards and ED, safeguarding skills and experience of practitioners managing complex cases**
- **Small group of child and young people 'frequent attenders' who are high profile in terms of self-harm, complex psychosocial issues, significant mental health concerns and increased length of stay**
- **The numbers of children and young people with mental health problems at risk from self-harm and suicidal ideation attending ED**
- **< 16s admitted to the paediatric unit and 16/17 year olds to ED Observation Bay, Acute Medical Unit or Short Stay Unit requiring admission to Tier 4 Child and Adolescent Mental Health Service bed and delayed in the Royal Berkshire Hospital**
- **The Trust does not have an adolescent or young person inpatient facility young people aged 14-18 years are either admitted to a paediatric or adult ward.**

Maternity Child Protection

Key Achievements

- Multiagency vulnerable women's meetings continue monthly, since March 2016 this has included representation from Wokingham Health Visitors. The aim is to improve communication and information sharing between the multi-disciplinary team and between agencies working with vulnerable families. In terms of early help, attendance of Perinatal Mental health services at this meeting ensures that women who suffer from poor emotional wellbeing get the support they need to allow them to care for their new born baby.
- The Child Protection Midwife continues to attend Multi Agency Risk Assessment Conferences (MARAC) in all three local Authorities. Individuals discussed at MARAC are "flagged" on EPR; this includes high risk victims' in addition to women attending Maternity Services. The Child Protection Midwife also attends Domestic Abuse Repeat Incidence meetings (DARIM), where repeat offenders of standard and medium risk domestic abuse incidences are discussed.
- The Poppy team establishment has increased; this includes a good skill mix of senior midwives. Each local authority has a named Poppy team midwife who holds a caseload and supports other midwives in the care of vulnerable women/families. The Substance Misuse midwife has been amalgamated into the Poppy team, this allows for more joined up working and greater continuity of care for women in both the hospital and community setting.
- Three Court reports were undertaken in 2016/2017.
- There has been at least a 10% increase in the number of child protection conferences in 2016-2017; midwives attended 93% compared with 80.6% in 2015-2016, there is a direct correlation between the improvements in Poppy Team establishment and improved performance in attendance at child protection conferences despite the significant increase in activity.

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- Funding was identified for Named Midwife for Child Protection who is covering maternity leave until January 2018 to attend the NSPCC Supervision Course. This has allowed high quality supervision to be continued and will provide additional support for the Named Midwife for Child Protection with safeguarding supervision in the future.

Key Areas of Work for 2017/2018

- Named Midwife and Named Nurse for Child Protection will review consistency of safeguarding knowledge and practice in maternity services through competency based retraining, supervision of safeguarding cases and audit. This work will start with specialist midwifery services and be carried out in collaboration with Practice Educators, Matrons and the Director of Midwifery.
- Working with Band 5 midwives in the community setting; to provide newly qualified midwives with on the job support concerning their safeguarding practice. Teaching on the preceptorship day has been included since April, 2017.
- Named Midwife for Child Protection will provide a safeguarding training session on the Midwifery Mandatory Professional day.
- Named Midwife for Child Protection will establish group supervision/ reflective sessions for all Midwives as part of their level 3 child protection updates.

Ongoing Challenge/Risks:

- **Increase in the complexity in cases of at risk families and unborn babies**
- **Capacity of the Named Midwife to provide 1:1 safeguarding supervision for the poppy team and support safeguarding practice in the increasing number of newly trained midwives**
- **Capacity of Poppy Team to write reports and attend increased number of child protection conferences**
- **Maintaining maternity staff compliance Level 3 Safeguarding Children Training**

Looked After Children (LAC) Initial Health Assessments and Fostering and Adoption

The RBFT was commissioned to provide the Doctors to run Initial Health Assessment (IHA) clinics in 2014. In April 2016, we took over providing the administration and chaperoning of IHA clinics from BHFT.

Key achievements

- CQC report following a review of health services for children looked after and safeguarding, in Wokingham, May 2016 described our IHAs and healthcare plans for children placed within area as 'of a good standard'.
- Following an in depth review of the RBFT administration process early in 2017 IHA performance improved.
- Smooth hand over to Berkshire Healthcare Foundation Trust as providers was achieved by 1st April 2017

Key Areas of Work for 2017/18

- Consider a multiagency review/audit of the fostering and adoption pathway with Reading Children's Services including preparation for court

Female Genital Mutilation (FGM)

FGM continued as a focus for 2016/17 and will remain so in 2017/18.

FGM data reported to NHS Digital June 2016 – May 2017

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- Maternity – cases reported 38, referrals to children’s social care 36
- Gynae/sexual health – cases reported 2, referrals to children’s social care 1
- Paediatrics – cases reported 0

Key Achievements

- The FGM pathways and tools are embedded. A Berkshire wide bespoke training package is due to be launched during the summer 2017.
- A centre for adult victims of FGM (Reading Rose Centre) is due to open in the summer. Our Maternity Services with commissioners and the Alliance for Cohesion and Racial Equality (ACRE) collaborated to develop this service and from September one of our doctors will provide clinical input.

Key Areas of Work for 2017/18

- Maternity and Information Management and Technology (IM&T) Services continue working with FGM Prevention Programme, Project Manager NHS England for them to support our implementation of FGM Risk Indication System to allow clinicians to note on a record that girls are at risk of FGM.

Child Death

46 deaths of Children and Young People < 18 years were reported to the Berkshire Child Death Overview Panel (CDOP) in 2016/17. 11 of those deaths were unexpected where ‘the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death’. In addition, the CDOP undertook a special review of the circumstances of a serious road traffic incident on the A34 which resulted in both child and adult fatalities.

21 Children and Young People < 18 years resident in Berkshire West died 01/04/16-31/03/17

- 10 neonatal deaths due to extreme prematurity, chromosomal, genetic, congenital anomalies
- 6 expected due to chronic medical conditions, chromosomal, genetic and congenital anomalies or malignancy
- 5 unexpected child deaths – 1 of which is waiting to go to inquest and CDOP

Rapid Responses were initiated for all unexpected child deaths, including the A34 case which resulted in both child and adult fatalities and a learning event was held for the case of a child who was expected to die after an unexpected collapse where there were safeguarding concerns. The 2016-17 Berkshire West Rapid Response audit will be presented to CDOP in October 2017 and subsequently shared with the RBFT Mortality Surveillance Committee, the LSCBs of the West of Berkshire and Berkshire West CCG.

During CDOP meetings panel members categorise each child’s death using 10 national categories:

Category		
1	Deliberately inflicted injury, abuse or neglect	0
2	Suicide or deliberate self-inflicted harm	0
3	Trauma and other external factors	0
4	Malignancy	1
5	Acute medical or surgical condition	0
6	Chronic medical condition	1

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7	Chromosomal, genetic and congenital anomalies	12
8	Perinatal/neonatal event	3
9	Infection	1
10	Sudden unexpected, unexplained death – pathological diagnosis either ‘SIDS’ or unascertained	0
	Deaths waiting to go to inquest	1
	Awaiting post mortem report	1
	< 23 week gestation not categorised	1

Fig 3. 2016/17 Berkshire West Deaths by category

Key achievements and learning from CDOP:

Establishment of a Neonatal Deaths Special Review Panel

- Neonatal cases (<28 days) are numerically the largest sub-group group of all deaths in 0-18 years.
- Most deaths are due to congenital anomalies and/or perinatal medical problems, particularly complications of prematurity and low birth weight.
- The group met for the first time in March 2017 and reviewed all neonatal cases between 01/01/2016 and 31/12/2016 with a focus on categories, modifiable factors, trends and further actions.
- The panel consisted of Dr. Peter de Halpert and Gill Valentine, Director of Midwifery (RBFT) and Dr. Rekha Sanghavi (FHFT), supported by the CDOP Administrator.
- 20 deaths reviewed (three deaths at 22 weeks gestation, a gestational age not usually considered by the CDOP), ten (7, plus the three deaths at 22 weeks) found to be caused by perinatal factors and 10 by chromosomal/genetic factors.
- One of the deaths caused by perinatal factors occurred at term; all the others occurred pre-30 weeks.
- One of the deaths caused by chromosomal/genetic factors occurred at or after term.

The neonatal review identified the following learning points:

- Challenges for parents receiving appropriate bereavement support when an infant’s care is transferred between two or more hospitals.
- 2 cases of preterm labour, mothers seen with signs and symptoms of a urinary tract infection a few days prior to spontaneous labour. Neither case was treated. While this may not have been causative, infection can trigger preterm labour. It is recommended to treat clinical UTIs in pregnancy
- Concern that not all cases have been notified. The CDOP coordinator has contact local trusts to review the notification process.
- The majority of the chromosomal/genetic factor cases were ante-natally diagnosed, and parents elected to continue with the pregnancy after counseling. The deaths were, in these cases, “expected”.
- 3 of the 10 chromosomal/genetic factor cases were associated with consanguinity.



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- A cluster of chromosomal/genetic factor deaths with Potters syndrome. However no association with modifiable factors could be made. It is likely that this is a statistical blip. CDOP will try to clarify this through the use of longitudinal data
- Midwifery representation from Frimley Health will be sought for the neonatal subgroup.
- The group unanimously felt that 22/40 gestation babies should not be included in the analysis as all national and network guidance states these babies should not be resuscitated (unless there are exceptional circumstances). As such they have been separated out for the purpose of this report.

Modifiable Factors and Learning – 7 Pan Berkshire reviewed deaths with modifiable factors:

- Co-sleeping with an infant
- Alcohol consumption
- Consanguinity
- Untreated UTI in mother before delivery
- Missed opportunity in healthcare

Some modifiable factors were relevant to more than one child death

Learning from some of the deaths reviewed led to procedural changes for the health services involved and the opportunity for learning for others:

- Consultant Paediatrician and Intensive Care Consultant review for sudden deterioration
- Consultant Paediatrician review for second presentation to A&E
- Accurate documentation during resuscitation
- Review of Sepsis triage tool and collaboration of practice across the county
- Training for healthcare professionals should include recognition of shockable rhythms and defibrillation

Other learning included:

- A recommendation that if a pathologist carries out a post mortem on an adolescent in circumstances of a medical death they should consider seeking the opinion of a paediatric pathologist
- Complete agreement with the police advice to never use a mobile phone while driving

Operational achievements:

- CDOP has maintained good operational performance against national standards. It is well attended by relevant partners. Discussions are of quality and improvements have been made to documentation to facilitate categorisation of deaths, identification of modifiable factors and recording of recommendations, which are circulated via a regular CDOP Newsletter and to LSCBs for their attention and action
- A CDOP induction pack has been issued and is available to all new (and existing) panel members
- A multi-agency training day entitled “Saving Children’s Lives” was held on 1 March 2017 in Bracknell Forest with 90 people attending. The day included a series of talks by Professor Peter Sidebotham, Associate Professor of Child Health from Warwick Medical School, followed by break out groups with practical sessions. This counted as a full day CPD training course and Level 3 Child Protection training.
- CDOP has developed a new website to support frontline practitioners, parents and the public

Key Areas of Work for 2017/18

For 2017/18 CDOP will be carrying out thematic reviews on the following:

- Sepsis management/effectiveness of paediatric early warning and sepsis tools
- Knife crime (because nationally this is rising)

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- Children with life limiting conditions and deteriorating neurological conditions – now the largest group we review other than neonatal
- Better community understanding of Safe Sleeping
- Home educated children, as they can become invisible

Ongoing Challenge/Risks:

- **Provision of joint home visit and immediate family support – unexpected death**
- **Appropriate bereavement support when an infant/child's care healthcare is transferred**
- **Quality of life issues for children with complex/chronic conditions**
- **Supporting schools following an unexpected death**
- **Knowledge, skills, competence and confidence of multi-agency frontline managers and practitioners who rarely encounter unexpected child death**

Sexual Health

Key Achievements – service delivery and safeguarding

- Clinical Delivery in the hub at 21a Craven Road provides open access from 7am to 7pm Monday to Friday and 9.30 am to 11.30 am Saturday mornings
- There are specific outreach clinics for young people across the three Local Authorities of Berkshire West, provided in educational and non-educational settings. Staff work with multi agency partners to deliver holistic care from these venues.
- Designated Outreach posts dealt clinically with 736 vulnerable cases that would not otherwise have accessed mainstream delivery.
- The designated sexual health outreach nurse for young people is the key front line member of staff exposed to, and dealing with, operational issues and the clinical care of young people affected by or at risk of CSE.
- Safeguarding process – all young people under the age of 18 (and anyone with vulnerabilities identified during history taking) has a full safeguarding assessment carried out at the time of consultation
- Safeguarding audit completed June 2016 led to an update of safeguarding form to allow meaningful assessment of 16 and 17 year olds, and provide mechanism for recording re assessments.
- Sexual Health Department contributes to Level 3 Child Protection Training and CSE training.
- During 2016/17 a consistent and current flagging system implemented between the safeguarding team and sexual health to ensure children and young people subject to child protection plans or Looked after Children are identifiable on both EPR and the sexual health systems to alert clinical staff to vulnerabilities.

Key Achievements - Child Sexual Exploitation (CSE) information sharing and governance

- Close working relationship with Head of Children's Safeguarding for Berkshire West Clinical Commissioning Groups (CCG) sharing good practice. The Trust Safeguarding CSE proforma has been adopted by the CCG safeguarding team and rolled out for use across GP practices. This followed a CQC inspection where gaps in GPs knowledge were identified.
- Provision of equal input across all three Berkshire West local authorities which involves:

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- Preparation for and monthly attendance at each of the CSE operational group meeting in all 3 unitary authorities.
- Attendance at CSE workshops, review meetings, audit and challenge meetings
- Attendance at locality strategic group meeting has been scaled back due to capacity issues. Regular attendance at Reading Strategic meeting, receipt of minutes and attendance if required for West Berkshire and Wokingham
- Internal CSE Information Sharing processes have been finalised and continue to guide practice.
- Pan Berkshire Information Sharing and Assessment agreement and Protocol is embedded within Berkshire Child Protection Procedures to which all LSCB statutory partner agencies, including the RBFT are signatories
- CSE is embedded into the Trust Child Protection Clinical Governance agenda as a standing item

Ongoing Challenge/Risks:

- **Management of CSE continues to be a challenge in relation to capacity within sexual health services**

Safeguarding Adults

Key achievements

- Safeguarding (adults) clinical governance has continued throughout the year and the safeguarding team medical clinical leads have formed a valued part of the safeguarding team.
- Safeguarding concerns continue to be raised via the Datix incident reporting system. This assists in giving feedback to the individual who raised the concern where available, and means that only one reporting mechanism is used for reporting concerns about adults which supports overview and quality assessment
- Learning from two Safeguarding Adult Review (SAR) and Domestic Homicide Reviews (DHR) is included in safeguarding adults training. Learning from the DHR has been discussed at clinical governance in the area where the patient was being treated.
- The Lead Nurse adult safeguarding was included in the review team for two SARs and the Internal Management Review (IMR) writer for the DHR.
- In October 2016, Price Waterhouse Cooper (PWC) was commissioned to review Safeguarding Adults and Children. As a result the process for recording and reporting adult safeguarding concerns is being reviewed to develop an electronic approach which will improve governance.
- In March 2017 a notes audit was carried out for the Berkshire West Safeguarding Adults Board of adults with dementia to test documented evidence of mental capacity act (MCA) assessment and safeguarding principles in practice – that demonstrated that MCA and safeguarding principles were being applied in practice however the Trust's the MCA assessment was not consistently being recorded on the Trust's blue MCA assessment form.
- In March 2017 the MCA, DoLS and Best Interest Working Group met for the first time and developed a Quality Improvement project plan for 2017/18
- In November 2016 we worked with NHSI to review a case – as a result we are developing an Adult Safeguarding protocol to support our policy. This will be approved by the Adult Safeguarding Clinical Governance and the Strategic Safeguarding Committees as part of the 2017/18 Safeguarding Annual Plan.

Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

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One of the key findings of the CQC inspection published in June 2014 (<http://www.cqc.org.uk/location/RHW01/reports>) highlighted that knowledge of the Mental Capacity Act was not sufficient. The CQC recommended that the RBFT must “increase staff knowledge of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) through necessary training to improve safeguarding”. The safeguarding team has worked with support of the CCG to improve staff knowledge and competence around the MCA and DoLS. Mental capacity and DoLS training forms part of induction training and the core mandatory training day.

Enhanced metal capacity training was offered monthly through 2016 and alternate months in 2017 the 80% target was reached by March 2017. The number of DoLS applications is a key performance indicator report to the CCG as part of the Quality Schedule and in the integrated Board report monthly. Numbers of applications showed further decline in 2016/17

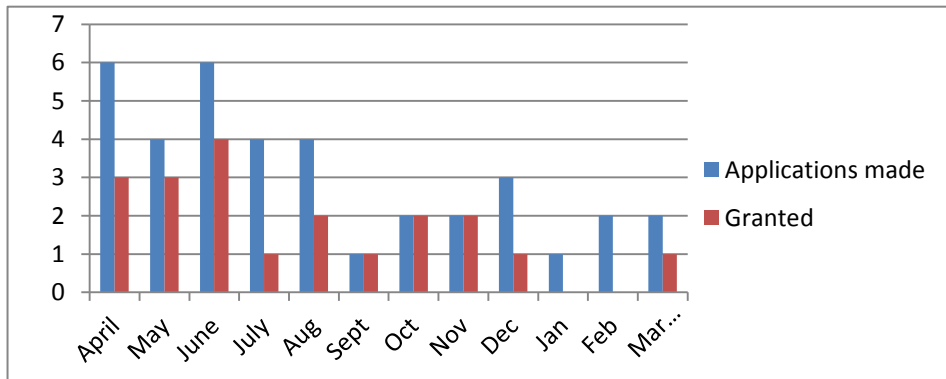


Fig 4 Deprivation of Liberty Safeguard applications for 2016/17.

Adult safeguarding concerns

	Concerns raised by the Trust where harm occurred outside the Trust.	Concerns raised against RBFT
April	17	1
May	17	4
June	23	6
July	18	1
August	20	6
September	18	4
October	30	2
November	24	5
December	17	1
January	25	3
February	19	4
March	25	3

Fig 5 Adult safeguarding concerns raised during 2016/17

All concerns raised by our staff about potential harm or abuse outside of the Trust are reviewed by the local authority and if necessary investigated through the Safeguarding process.

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For externally raised safeguarding concerns a fact finding exercise is carried out by the Adult Safeguarding Nurse. This information is given to the Local Authority for them to decide on the outcome of the concern and further enquiry. The majority of safeguarding concerns raised against the Trust continues to be around pressure damage, in the majority of cases there is a lack of information/documentation provided concerning pressure damage as part of the discharge process.

Prevent (anti-terrorism)

There was 1 possible Prevent concern discussed with outside agencies related to a patient. Appropriate action was taken there was no further involvement or action for the Trust.

Key Areas of Work for 2017/18

- MCA, DoLS and Best Interest Quality Improvement project
- Continue working with Information Management and Technology (IM&T) Services to develop an electronic approach to our adult safeguarding referrals and information sharing

Ongoing Challenge/Risks:

- **Year on increase in activity for vulnerable groups with multiple co-morbidities and complex psycho-social problems**
- **Elderly patients living with dementia delayed in hospital**
- **Increasing and maintaining workforce knowledge of the Mental Capacity Act and DoLS**
- **Supporting patients and the staff caring for them where there is homelessness or other external service/resource issues beyond our control**

Mental Health Service Provisions

Poor mental health is a risk factor in the development of cardiovascular disease, diabetes, chronic lung diseases and a range of other conditions. It is a major public health issue in its own right, accounting for 23 per cent of disease in the UK. Poor mental health is associated with higher rates of smoking, alcohol and drug abuse, lower resilience, decreased social participation and weaker social relationships – all of which leave people at increased risk of developing a range of physical health problems. For most people, mental health problems begin in childhood or adolescence and can have lifelong effects. <https://www.kingsfund.org.uk/publications/physical-and-mental-health/priorities-for-integrating>

Activity

Activity data provided by the Trust Emergency Department (ED) shows that on average 230 people per month attended with a primary mental health presentation in 2016/17, 58% were subsequently admitted.

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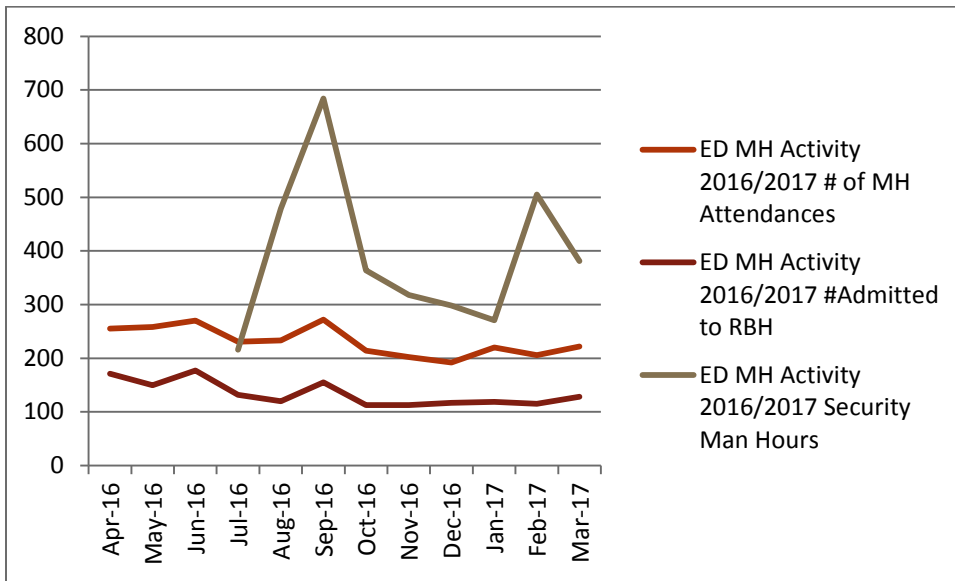
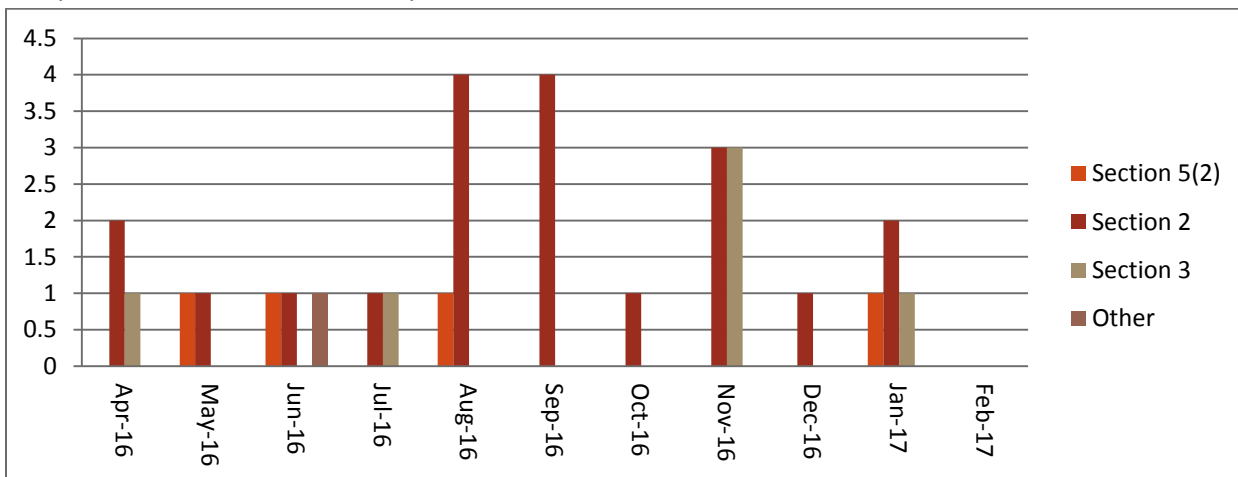


Fig 6 Mental Health presentations to ED April 2016 – March 2017 including security man hours

Mental Health Act Detentions

Fig 7 Detentions to the RBFT in 2016/17 - there were 34 detentions (plus a Community Treatment Order - CTO) compared to 12 in the same time period in 2015/16



A nearly 200% increase in MHA detentions in 2016/17 has presented a significant challenge in terms of:

- Increase in length of stay for mental health patients in the Emergency Department Observation Bay and other wards
- Increase in requirement for 1:1 nursing and security presence for patients detained under the MHA
- Increase in risk of patients being Absent Without Leave (AWOL)
- Increase in administrative and clinical work for the Mental Health Co-ordinator
- Increase in administrative and clinical work for the Clinical Site Managers who manage detentions out of hours – nights, weekends and bank holidays

Fig 8 Location of patients detained and under which section of the MHA (taken from KP90 return)

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Ward/ Dept.	Sec 5(2)	Sec 2	Sec 3	CTO
ED Observation Bay	4	11		
AMU	1	1		1
SSU			1	
Sidmouth			1	
Victoria			2	
Trueta		1		
Whitley		2	1	
Woodley		1		
SAU		1		
Castle		1	1	
Lister	1			
ICU		1		
Burghfield		1		
ASU		1		
Dorrell	1			

NB whilst a number of these patients were detained to the RBH as they required treatment for both their mental and physical disorder, there were a number of patients who had no physical disorder and were awaiting a mental health placement.

Key achievements

- Compliance with the Mental Health Act 1983 and Mental Health Act Code of Practice, 2015**
 An Annual Mental Health Act Report, April 2016 – March 2017 was submitted to QALC in June 2017 and subsequently approved by the Executive Management Team and the Quality Governance Committee. This report provided assurance about key issues, risks and themes, and Trust compliance with the Mental Health Act and Code of Practice.



- **Deaths of patients detained or likely to be detained under the MHA**

Patients who die whilst inpatients at RBFT who are detained or likely to be detained under the MHA are subject to a full mortality review within the organisation; the outcomes and any lessons learnt are reported and monitored by the Trust Mortality Surveillance Committee. If the death reaches Serious Incident Requiring Investigation (SIRI) criteria it will be reported on STEIS, to Berkshire West CCG and to the Safeguarding Adult Board case review sub - group.

- **Section 136 of the Mental Health Act Audit**

Currently the police have the power to place an individual under section 136 of the Mental Health Act (MHA), for a maximum of 72hrs and take them to a place of safety whilst awaiting a mental health act assessment. Audits in 2016/17 demonstrate we are compliant with the MHA code in relation to section 136. In January 2017 the Policing and Crime Act received royal assent. The act contains a wide range of measures, importantly it contains changes to MHA 1983 section 136 powers relating to the police and to the operation of Places of Safety. It is not clear when in 2017 these changes will be implemented or what impact they will have in ED. Through the Berkshire Mental Health Crisis Concordat the multiagency team is committed to making a local implementation plan.

- **Liaison Psychiatry in Emergency Department (ED) – Psychological Medicine Service (PMS)**

There continues to be a high level of support for patients presenting with mental health needs. The team works collaboratively with ED staff to ensure that those with mental health needs are adequately assessed, treated and signposted as necessary. ED and PMS have regular operational meetings in order to achieve a collaborative way of working.

- **Suicide and Self Harm Prevention**

The Suicide and Self Harm Prevention Clinical Governance Group and action plan works towards a zero tolerance of self-harm and suicide attempts within the Trust. The group has been instrumental in:-

- Contributing to the Berkshire wide Suicide Prevention Strategy and action plan
- Ensuring that a baseline ligature audit was completed in 2016 - risks identified, addressed, mitigated
- Influencing securing funds in the 2017/18 capital programme for compliance works to the multi-storey car park
- Regular audits of the Adapted Australian Triage Tool (AATT) leading to improved compliance in ED
- Working alongside the Samaritans who now provide regular support for patients within the ED, as well as training for hospital staff

- **Frequent Attenders Project**

The RBFT continues to work closely with BHFT and other agencies to develop client case management plans for the top 20 ED reattenders to reduce the number of unnecessary visits. In 2016/17 the project achieved a 46% reduction in attendances for this cohort of vulnerable people. In 2017/18 there is a national CQUIN 'Improving Service for People with Mental Health Needs who Present at A&E' the aim '*To reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable*'.

- **Berkshire Mental Health Crisis Care Concordat**

The Trust contributes to and through partnership working has delivered improvement in care to those presenting in crisis to frontline services. The key areas of focus for the RBFT in 2017/18, our contribution to the Berkshire Crisis Concordat action plan based on our suicide prevention and safeguarding strategic statements in relation to improving the quality of care for patients with mental health disorders:

- Collaborative working with the Psychological Medicine Service (PMS) or Child and Adolescent Mental Health Service (CAMHS) Urgent Response Service and patient families and carers to risk assess individuals who attend in crisis.

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- Providing a safe environment for patients and staff - reducing access to means
- Training, supervision and support to provide staff with skills and competence to recognise risk and manage it proactively in partnership
- Collaborative working with multiagency colleagues, patients, families and carers and our staff as part of a wider 'Let's Talk Mental Health' campaign.
- Staying healthy – people with mental health conditions have ordinary as well as specific health care needs and experience more ill health than the general population – parity of esteem
- Staying Safe – people with mental health conditions are significantly more vulnerable to the effects of discrimination and abuse Healthcare workers play an important role in recognising and reporting signs and concerns of abuse, making safeguarding referrals and supporting the person who has suffered or is at risk of suffering significant harm during safeguarding investigations.

There are two programmes of work planned that will roll out collaboratively during 2017/18:

- 'Let's Talk Mental Health' – patients led by the Associate Director of Safeguarding and Mental Health
- 'Let's Talk Mental Health' – staff led by the Occupational Health Manager
- The roll out of 'Let's Talk Mental Health – patients is based on risk and urgency, the first action plan was developed up in March with the clinical and operational leaders in ED and ED Observation Bay and initial meetings have been held with Castle (Endocrinology, Rheumatology and General Medicine)
- The Acute Medical Unit/Short Stay Unit and Paediatric services will be in the next phase
- BHFT colleagues will be asked to peer review our ED & ED Obs Bay – Safe Management of Mental Health Patients action plan
- A joint RBFT/BHFT mental health clinical governance committee will be established

- **Mental Health multiagency governance arrangements and the Safeguarding Adults Board**

During 2016/17 systemic safeguarding risks in relation to mental health were raised by the Royal Berkshire NHS Foundation Trust and Berkshire NHS Foundation Trust to the Berkshire West A&E Delivery Board in October 2016 and at an extraordinary Safeguarding Adults Board (SAB) meeting in January 2017. As a result Berkshire West CCG has worked with multiagency partners to review and revise the operational and commissioning governance and assurance framework, structure and escalation process.

Berkshire West Clinical Commissioning Federation and the providers they commission are accountable and/or responsible for:

- Commissioning appropriate services
- Monitoring the quality and safety of services in the services
- Setting and monitoring safeguarding standards
- Working in partnership with statutory and voluntary agencies to safeguard

Mental health is a Safeguarding Adults Board risk related priority for 2017/18.

Key points of quality assurance and improvement

There has been a significant amount of good multiagency partnership working in relation to safeguarding the health and wellbeing and improving safety and the experience of mental health patients in Berkshire West in the last year, demonstrating parity of esteem for mental health. This has been achieved by:

Meetings/committee structure:

- Establishment of weekly multiagency delayed transfer of care conference calls

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- Establishment of a monthly multiagency 'Mental Health Activity' Group where key safeguarding indicators e.g. detentions under the mental health act, availability of AMHPS are reported, analysed and escalated
- Thematic review of patient experience presenting in crisis completed by Head of Patient Experience RBFT
- Establishment of Mental Health Strategy Steering Group
- Review of the monthly Berkshire Policies in Practice Group (PIP) chaired by BHFT, including reporting and escalation to the Mental Health Crisis Concordat Steering Group
- Establishment of Berkshire Suicide Prevention Steering Group and agreement of a Berkshire Suicide Prevention Strategy – launch event 17th October 2017, Wokingham Town Hall

Ongoing Challenge/Risks:

- **The number of mental health patients of all ages presenting to ED and being admitted**
- **Increase in complexity, homelessness, social isolation**
- **Gaps in community services for patients who are in crisis, leading to individuals attending ED**
- **Delayed Transfers of Care for Prospect Park Hospital and Royal Berkshire Hospital**
- **Increase in number of patients detained to Royal Berkshire Hospital under the Mental Health Act**
- **Delay in Approved Mental Health Professional (AMHP) attending to 'section' a patient particularly out of hours – this is a Berkshire capacity issue**
- **Capacity of the security services and nursing teams to consistently provide a safe environment for high risk patients**
- **Suitability of acute health care settings when managing patients who are a risk to themselves or others**
- **Social care supporting safeguarding risk assessments – in and out of hours, the response is variable**
- **Local authority commissioned substance abuse services – models vary across Berkshire West, access for professionals and public is confusing, capacity and effectiveness – increasing substance abuse leading to increased pressure on health services no in reach services for RBH**

Learning and Complex Disabilities - adults

There were 275 in-patients with learning and complex disabilities supported during 2016/17. Very few patients require no input at all and a number of patients require significant input. Those who are having planned medical intervention will often require input from the Learning Disability Co-Ordinator (LDC) prior to admission. The LDC provides support to the hospital staff involved with the patient and who request advice with strategies to ensure LD patients receive the most effective care.

- There were 8 families who required a great deal of support, either because of the complexity of the patient's condition or social circumstances, or because of frequent admissions. These families had particularly high expectations of the LDC who worked to meet those for the benefit of the patient. In several cases there were a number of consultants involved with individual patients, the LDC provides support for those colleagues in relation to the patient's learning disability and the best interest decision making process.
- 5 patients have required on-going and intensive support with out-patient visits and associated health care advice. Some of these patients do not meet the threshold for social care support but require help when dealing with health issues, particularly understanding information.
- There is a small group of parents with a learning disability who require support with their adult children who lack capacity to make their own decisions around healthcare.

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- The LDC is contacted by families and carer about individuals who are going to be treated by the Community Dental Service at Royal Berkshire Hospital. Orientation visits are organised and information passed on to the community dental team and / or the anaesthetist as necessary.
- The LDC attends the team meetings of the community learning disability nurses for Reading to discuss care for individual patients where necessary. There has been joint working around individuals who do not use ED appropriately and those who benefit from effective partnership between acute and primary healthcare.

Key achievements

Patient experience

The Learning Disability Co-Ordinator represents the Trust on the Learning Disability Partnership Boards (LDPB) and the LDPB health sub groups for Reading, Wokingham and West Berkshire. The presence of the LDC at these meetings is valuable in terms of those people using services and their carers feeling able to discuss issues that have affected them when they have been patients. It is also useful for people to discuss concerns they may have before coming to hospital.

- During 2016 – 2017 a member of one of the LDPBs who is a family carer told the story about when her brother who has a learning disability was an inpatient to the Trust Patient Experience Facilitator, this was filmed. The film will be used as part of training to provide staff with an insight into a carer's experience of supporting a family member in hospital.
- The Enter and View team, who are part of Reading Healthwatch, continue to visit the Royal Berkshire Hospital, they made 3 visits during 2016 – 2017. They have highlighted communication consistently as being an issue, particularly for patients with a learning disability who are non-verbal.
- Free Makaton training is provided for Trust staff by Berkshire Healthcare and OTs and Practice Educators have begun to take advantage of this. Resources for wards have also been identified.
- The LDC talks to Registered Nurses, therapists and Health Care Assistants each month on induction programmes. She also talks to junior doctors at their induction about her role and some key issues affecting patients with a learning disability. A short film about the experience of patients with a learning disability is shown every month at core induction. The LDC is present at these sessions to highlight her role to all new staff
- Several times a year the LDC provides a session for HCAs involved in supporting patients on a 1:1 basis, focusing on doing that effectively with patients who have a learning disability.
- The LDC attended a sensory communication workshop to gain knowledge and ideas about how to use sensory tools and she aims to share what she learned with Trust staff who attend the 1:1 training.
- The LDC attended training around the use of Books without Words which was very useful in understanding how to communicate about sensitive issues with patients who have a learning disability. The LDC has been able to pass on this learning to others and plans to expand on that.

Familiar carers

RBFT continues to fund 1:1 familiar carers for in-patients with a learning disability who require that level of support to make them feel less anxious and more likely to comply with medical and nursing interventions in the hospital environment. Social care will not fund this type of support when an individual is in hospital as their responsibility for funding only applies to people who have been assessed as eligible for funding at home or in the community.

Work is underway on streamlining the payment process and taking it out of the job role of the LDC to improve timeliness and governance of payments.

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Training secondment for experienced occupational therapist from June to December 2016

An occupational therapist who is training to become a learning disability consultant practitioner had requested to do a placement with the LDC to gain insight in to the role within an acute Trust. She was invaluable in supporting the LDC with a number of complex patients during the placement and as part of a quality improvement project established a small library of activities and sensory tools for patients with a learning disability. Her plan to employ the services of a volunteer to manage the library will be progressed.

Transition clinics

The LDC attends the neuro – rehabilitation transition clinics to meet young people and their parents who are about to start using adult services within the Royal Berkshire Hospital. This provides an opportunity to explain what they can expect in adult services and to reassure young people and their families that reasonable adjustments will be made for them. There are 3 -4 clinics each year. The paediatricians or nurse specialists notify the LDC of other young people with cognition difficulties who are transitioning to adult services within the Trust and she makes contact with those young people at clinic. Some young people do not need to be seen by clinicians on a regular basis but may use services at RBFT for emergencies or planned surgery. There is a great deal of anxiety around using adult services for young people who have cognition difficulties and the LDC supports those individuals and their families as much as is possible

Deaths of patients with a learning disability

LD patients who die whilst inpatients at RBFT are subject to a full mortality review within the organisation, the outcomes and any lessons learnt are reported and monitored by the Trust Mortality Surveillance Committee. If the death reaches Serious Incident Requiring Investigation (SIRI) criteria it will be reported on STEIS, to Berkshire West CCG and to the Safeguarding Adult Board case review sub - group.

In response to the Mazars Report into Southern Health, the CCG is establishing a review panel for all deaths of individuals with a learning disability as part of the Learning Disability Mortality Review (LeDeR) programme. The purpose of the review panel is to gather information which will ultimately contribute towards the aim of reducing premature death in people with a learning disability. The RBFT is a member of the Berkshire West LeDeR steering group.

Changing Places toilet

Work was completed on the conversion of an existing toilet in a public area to a Changing Places toilet by the end of 2016. A hoist and a changing plinth suitable for adults is incorporated into this toilet so that disabled people can be assisted by their carers easily in using the toilet and being changed. The facility was formally opened by the Chief Executive on 16th May 2017

Mental Capacity Act and DoLS training

The LDC talks to all new clinical staff at core induction each month about the Mental Capacity Act and DoLS. She also provided 26 sessions at mandatory training for clinical staff during 2016 / 2017. These sessions are in the form of questions to help staff consolidate their knowledge and discuss issues that they experience in practice.

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Ongoing Challenge/Risks:

- No significant decrease in activity for this vulnerable group, increase in complexity and family expectations
- Patients with LD being delayed in hospital waiting for appropriate social care placements
- Affordability of funding familiar carers
- Increasing and maintaining workforce knowledge of the Mental Capacity Act and best interest assessments
- Capacity of the Learning Disability Co-Ordinator to maintain the current level of service

Disabled Children and Young People, Special Educational Needs and Disability (SEND) reforms and Transition

Disabled Children's Services

Dingley Child Development Centre provides multi-disciplinary specialist paediatric neurology/epilepsy and community paediatric services, a child protection medical service and adoption and fostering medical service to children resident in Berkshire West. They also provide tertiary services including assessment of visual impairment and spasticity and a botulinum service. The specialist paediatric inpatient therapy services are provided by the team based in Dingley.

Respite care for children with complex health needs is provided by BHFT at Ryeish Green in July 2016 they notified the CCG that they were no longer able to sustain the provision.

Key Achievements

The Trust Board has supported the future development of Dingley Child Development Centre. The plan is to relocate to a site on Reading University site in autumn 2018. This site has better access than our current location with a large number of parking spaces including over 20 disabled parking spaces. We have been assured by Berkshire Healthcare Trust that we will not have to vacate our current building until the new premises are ready.

SEND Reforms

Trust services provided to people 0- 25 years who have Special Educational Needs and Disability are subject to compliance with these reforms, essentially these are paediatric services including Dingley Child Development Centre and adult long term conditions services, particularly neurology.

Joint inspections of local area special educational needs or disabilities (or both) provision – in May 2016 Ofsted and the Care Quality Commission (CQC) started a new type of joint inspection; the aim to hold local areas to account and champion the rights of children and young people.

Key Achievements

- Together with the Berkshire West CCG and BHFT the RBFT have completed a self-audit against the SEND standards for health.
- A strategic SEND Berkshire West 10 group has been established chaired by the Director of People Services, Wokingham Borough Council, RBFT are represented.

Transition

Key Achievements

- The Safeguarding Team hosted a transition nurse post to lead a two year 'Ready Steady Go' implementation pilot until March 2017.
- The lead paediatric and adult clinicians and steering group were and are positive about developing their transition services and rolling out the Transition Plan.
- The nurse spent 1.5-2 days per week based in Reading to embed the transition plan and roll out training to Paediatrics and 18 adult specialties.
- Comparing the 2015 and 2016 surveys from young people and families demonstrated a marked improvement in the way young people/parents / carers experienced transition services at the Royal Berkshire Hospital. In the 2016 survey 100% of respondents said that they were satisfied with the services compared to 17% in 2015.
- An audit of a random sample of notes, 13 -18 year olds with long term conditions requiring transition in April 2017 showed 55/60 (92%) had a Transition Plan. 54/60 (90%) had a named transition worker documented in their Transition Plan.
- Transition is in the commissioners' quality schedule for 17/18, paediatric consultants are responsible for generating transition plans, the Paediatric Matron for carrying out quarterly audits.
- The pilot developed a platform to extend work and learning to partners in the local authority, schools, colleges, Reading University and mental health services to support young people preparing for and settling into adult services. A costed case has been written and funding is being actively sought by the Berkshire commissioners GP Lead for Children and Young People. In a recent Chief Executive engagement meeting with parent carers they indicated that transition is one of their top issues.

Ongoing Challenge/Risks:

- **No respite service would impact on children and families and lead to increased admissions and length of stay**
- **Readiness and capacity to engage with preparation for CQC/Ofsted SEND inspection**
- **Commissioning of the Designated Medical Officer - SEND**
- **Availability of a Community Paediatrics SEND data set**
- **No dedicated resource to develop and monitor transition service**
- **No clinical nurse specialist for young people and families with neurodisability in transition**

Risk Based Priorities for 2017/18

1. Multiagency working to:
 - Understand demand and develop strategies to safely manage and safeguard the rights and well-being of people with mental health disorders learning disability and complex disability, including transition.

- Implement findings of Mazars report into mental health and learning disabilities deaths in Southern Health the LeDeR mortality review programme; align with the work of CDOP
 - Implement LSCB and SAB priorities e.g. neglect including self-neglect, domestic abuse, mental health, safer recruitment and allegation management, communication and information sharing and Prevent.
 - To implement CP-IS and FGM RIS
2. Partnership work to:
- Progress improvement plans following local authority inspection judgments of 'inadequate'.
 - To further develop action plans for safe management of mental health patients with Berkshire Healthcare Foundation Trust
 - To review our safeguarding strategy and governance structures to ensure they are robust and align with the rest of the healthcare economy as part of the Berkshire West Accountable Care System
3. Training review:
- Mental Health Act, Mental Capacity Act, DoLS, child and adult safeguarding to ensure the knowledge, competency and confidence of our staff in practice is consistent
 - Complete a frontline practitioner self-assessment concerning the effectiveness of our safeguarding arrangements in October
4. Work with IT informatics and EPR:
- To building safeguarding referral forms and risk assessments
 - Review the flagging of vulnerabilities
 - Ensure Safeguarding is a priority in the development of a digital hospital
 - To develop a SEND health data set compliant with national requirements
5. Workforce capacity:
- Review the administrative support to the Safeguarding Team to reflect increased activity and complexity
 - Work with operational teams to monitor the impact of increased safeguarding activity/complexity in sexual health and maternity services
 - Work with our commissioners in relation the medical capacity to support SEND reforms