NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

ANNUAL SAFEGUARDING ADULTS UPDATE

Date of the meeting	19/03/2014
Author	V Cooper, Adult Safeguarding Nurse Specialist
Sponsoring Board Member	T Goodson, Chief Officer
Purpose of Report	Annual adult safeguarding report (Quarter 1, 2, 3 2013 /14), to highlight level of safeguarding activity across Dorset, Bournemouth and Poole. To highlight the continued developments of the role of the Adult Safeguarding Lead within the Clinical Commissioning Group
Recommendation	The Governing Body is asked to **Note** the report.
Stakeholder Engagement	• The Adult Safeguarding Nurse Specialist is a member of number of a number of the adult safeguarding board's subgroups, including Quality Assurance, Policy and Procedures, Education and workforce group. • The role has also included monthly engagement meetings with all NHS provider safeguarding leads, and the three local authority safeguarding teams. • The role has engaged and developed a working relationship with General Practice and Primary Care • The role has embraced engagement with the Wessex Local Area team safeguarding forum. • Elements of public engagement have being undertaken through the wider pan Dorset Adult Safeguarding Boards. • Engagement with communication team in the CCG.
Previous GB / Committee/s, Dates	None

Monitoring and Assurance Summary

This report links to the following Assurance Domains	• Quality • Engagement • Outcomes • Governance • Partnership-Working • Leadership

I confirm that I have considered the implications of this report on each of the matters below, as indicated:	**Yes** [e.g. ✓]	**Any action required?**	
		Yes Detail in report	**No**
All three Domains of Quality (Safety, Quality, Patient Experience)	√		√
Board Assurance Framework / Risk Register	√		√
Budgetary Impact	√		√

Legal / Regulatory	√		√
People / Staff	√	√	
Financial / Value for Money / Sustainability	√		√
Information Management &Technology	√		√
Equality Impact Assessment	√		√
Freedom of Information	√		√

Initials VC

1. INTRODUCTION

1.1 The Lead Executive for Adult Safeguarding is Suzanne Rastrick, Director of Quality, and the representative for both Dorset and Bournemouth & Poole Safeguarding Adults Boards is Sally Shead, Deputy Director of Quality.

1.2 All the NHS Acute providers and Dorset Health Care Foundation Trust, have a Safeguarding Adult lead within their organisation. They follow their own internal governance structures with regards to the reporting of safeguarding activity; there is a variation across providers in these governance arrangements. The process for raising alerts within the Acute Trusts has several steps that have been identified as potential delay in communication and timeliness of awareness of the alerts being received within the Clinical Commissioning Group.

1.3 The Adult Safeguarding Nurse Specialist has been meeting monthly with the safeguarding leads in all the NHS providers, to work together to address communications, review alerts and referrals, gain an understanding around the alerts that are proceeding to investigation, and to ensure there is appropriate reporting of serious incident requiring investigation (SIRI). All NHS providers are responsible to ensure that all SIRIs are reported to the Strategic Executive Information System (STEIS) which reports to the Department of Health managed by the NHS England. This also ensures a consistent approach to Data Collection.

1.4 All providers are requested to inform the CCG if a patient is admitted with a safeguarding issue from a care home (Nursing and Residential) via an AIRS form, this is monitored between the Adult Safeguarding Nurse Specialist and the Patient Risk Management team on a fortnightly basis.

2. ROLE OF THE CCG ADULT SAFEGUARDING LEAD

2.1 The Adult Safeguarding Nurse Specialist role provides a number of functions both within the CCG and to local stakeholders engaged within Adult Safeguarding process.

2.2 The functions include specialised assistance and support to all safeguarding alerts and referrals that have involved serious safeguarding concerns, or a multiple number of alerts and serious misconduct.

2.3 The decision for the Adult Safeguarding Nurse Specialist to attend a strategy or case conference meeting is determined by following the principles outlined in DCCG Safeguarding Adult Policy, these being:

- seriousness of allegation and harm;
- scope of the allegation; multiple alerts;
- Allegations against Primary Care Independent Contractors.

2.4 The role has led and co-ordinated reviews of health services in relation to Serious Case Reviews.

2.5 The role has provided regular quality reports from data analysis on any areas of concern, repeated issues or significant failures in care;

- It has provided support to the quality monitoring of contracts across health providers in relation to their Adult Safeguarding responsibilities;
- It has addressed the training uptake across the CCG with regard to mandatory Adult Safeguarding training;
- The role has ensured the CCG has met its obligations and responsibilities in relation to local policy. Positive engagement with the Wessex Local Area Team has been established, and all nationally driven reports, documentation and legislation have been shared circulated across the organisation.

2.6 The role ensures the outcomes of safeguarding referrals have met the requirements of the NHS Outcomes Framework with particular emphasis on domain 4 (Ensuring that people have a positive experience of care) and domain 5 (treating and caring for people in a safe environment and protecting them from avoidable harm). All safeguarding activity is also considered in line with the 6 C's for Nursing (Communication, Care, Courage, Commitment, Competency and Compassion).

2.7 The role has continued to develop and build strong and effective working relationships across all the Local Authority safeguarding teams, to ensure appropriate and timely information is shared across the agencies for the safety of adults across Dorset.

2.8 The role offers support and advice to all the Local Authorities and NHS Health Care Providers, whilst continuing to raise the profile for adult safeguarding across the CCG community.

2.9 Elements of Adult Safeguarding and Mental Capacity Act training has been offered to General Practice staff throughout the year to support General Practice to meet the needs of Quality Care Commission.

2.10 Two Adult Safeguarding lead GP's have been appointed for a session a week each to promote adult safeguarding across the county. These roles will also be involved in serious case reviews, training and education as well as being a resource for alerts and referrals received.

2.11 The role has engaged with the Wessex Local Area Team Safeguarding Forum and has established a specific adult safeguarding group as one of the work streams.The purpose of this work stream will be to ensure that Adult Safeguarding remains on the agenda of the wider safeguarding forum in collaboration with Children's safeguarding.

2.12 The role has worked in collaboration with the Local Authorities to consider the engagement of service users, to gain views of their experiences following safeguarding investigations. Fact sheets explaining the safeguarding process to individuals have been developed as part of the Policy and Procedures group.

2.13 Throughout the year the Policy and Procedures subgroup have also worked together to refresh the Multi-Agency Dorset, Bournemouth and Poole adult safeguarding policy. This has included the inclusion of the multi-agency risk sharing protocol for individuals at risk of self-neglect.

2.14 The Education and Workforce subgroup have developed and circulated standards for adult safeguarding awareness training widely across Dorset; future work will include the implementation of these standards and the evaluation of its effectiveness.

2.15 The Quality Assurance subgroup have reviewed the cross county differences in the interpretation of the policy, and are working to ensure there is consistency in the threshold of alerts. This will also ensure those that are related to health are made known to the CCG.

3. SAFEGUARDING ADULTS PROCESS

3.1 The lead agency for Adult Safeguarding is the Local Authority.

3.2 The CCG Adult Safeguarding Nurse Specialist has requested to be informed of all alerts that have a health component that are received within the Local Authorities. This allows health to have an active role within strategy discussions to ensure that the terms of reference for investigation are relevant and contribute to the outcomes of care. During the strategy process, risks are identified for others receiving care, to minimise any larger institutional risk and identify poor practice.

3.3 Alerts of all safeguarding nature will proceed through the Dorset, Bournemouth and Poole Multi agency safeguarding process, and only those received within the CCG via the local authority are registered as safeguarding on the CCG data base Ulysses, which allows for robust information around service providers and themes to be gathered.

3.4 Throughout the year, work has continued on building and developing working relationships with all three Local Authority Safeguarding Teams, to offer support around triaging of alerts and referrals, to review current communication methods and to aim toward a consistent implementation of the Multi Agency, Dorset, Bournemouth and Poole Adult Safeguarding Policy across the County. Variations in interpretation of the policy, particularly around the process and pathways followed, is addressed through the Policy and Procedures subgroup.

3.5 There has been an opportunity to address some of the historic gap in the timeliness of reporting to CCG from all the local authorities, with some good results. There has also been an increase in the number of alerts pertaining to

Learning Disabilities, Acute Trusts and Mental Health being brought to the attention of the CCG.

3.6 Reporting alerts and referrals to the CCG remains challenged by the difference in organisational changes, within local authority structures and changes within the NHS. To continue addressing these issues the Adult Safeguarding Nurse Specialist has worked regularly with the main NHS providers, and local authorities to address the issues.

3.7 Information sharing around safeguarding within the Care Homes remains variable, and the CCG are not always made aware in a timely way when a care home alerts have proceed to a pathway 4 (large scale investigation). This therefore creates challenges in chasing up outcomes of meetings and investigations. In order to address this, discussion has been had with the chair of the Quality Assurance sub-group, and Safeguarding leads within the local authority, to develop a system of sharing information in a timely manner.

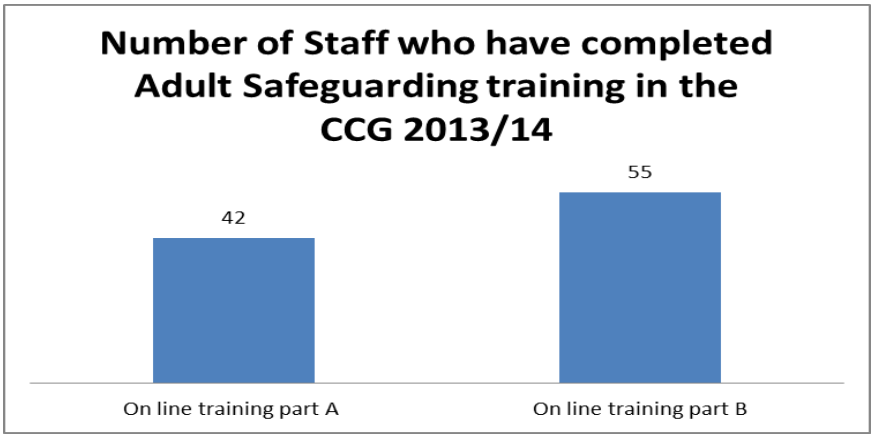
3.8 The Adult Safeguarding Nurse Specialist has worked with the Local Authorities and the safeguarding leads in each of the acute trusts and community health services to develop a regular Safeguarding Quality Assurance Group in each provider to ensure there is consistency in data reporting across the county, and allow an opportunity to continually review current safeguarding process.

3.9 The Adult Safeguarding Nurse Specialist continues to supports the wider health economy through the identification of individuals who may not directly be at risk under the Adult Safeguarding process, but meets the criteria for the multi-agency risk sharing protocol, by ensuring NHS providers are aware of the protocol and have commenced strategies for it to be implemented.

4. SAFEGUARDING ADULTS WITHIN THE CCG

4.1 Adult safeguarding training has been included within the mandatory training programme across the CCG, however, uptake remains poor.

4.2 All staff should have undertaken adult safeguarding training part A on line, and all clinical staff should either have undertaken a clinical training day or undertaken clinical training part B on line.



4.3 There are 267 staff directly employed within the CCG, there is 15.7% who have completed part A training and 20.5% who have completed part B.

4.4 Due to the limited number of staff who have undertaken the mandatory training for adult safeguarding across the CCG, the Adult Safeguarding Nurse Specialist, has engaged with Human Resources, and requested for communication to be sent across all personnel and directorates to request staff to urgently request for an review and attention.

4.5 The Local Authority have developed and delivered Adult Safeguarding training for Accountable Officers and CEO's of providers. This has been attended by the CCG.

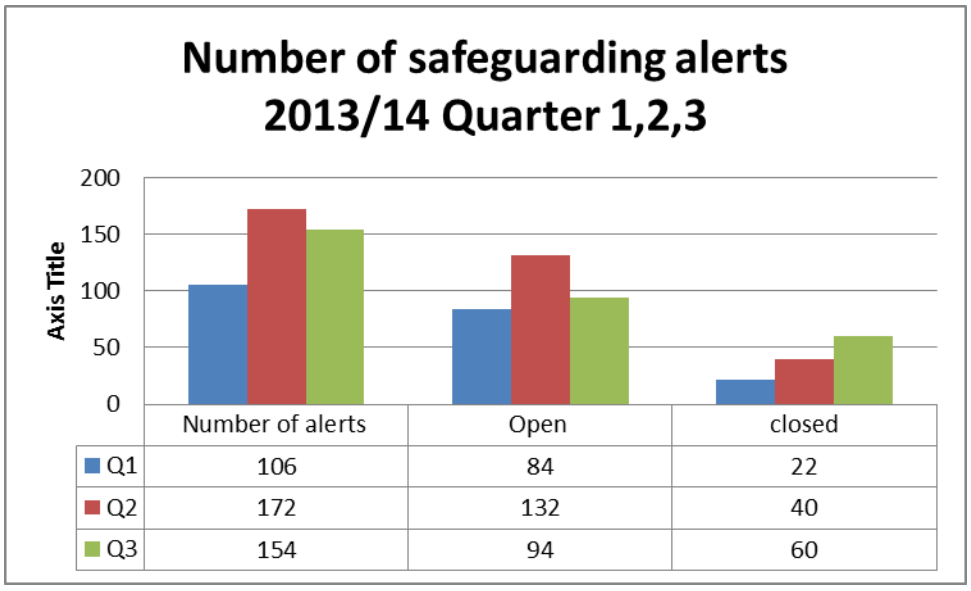
4.6 The adult safeguarding board, education and workforce group have developed standards for adult safeguarding awareness training which have been disseminated across all providers and the CCG for implementation. Further discussion around the monitoring and evaluation of the document, will continue via the sub group.

4.7 The Adult Safeguarding Nurse Specialist in collaboration with the Designated Children lead, is reviewing how awareness of PREVENT and Domestic Violence is gained across the CCG. This will continue to be developed over the next year.

5. SAFEGUARDING ADULTS WITHIN PROVIDER ORGANISATIONS

Safeguarding Alerts

5.1 Throughout the year quarter one, two and three there have been 432 alerts made known to the CCG.



5.2 122 of these alerts have been closed to the safeguarding process.

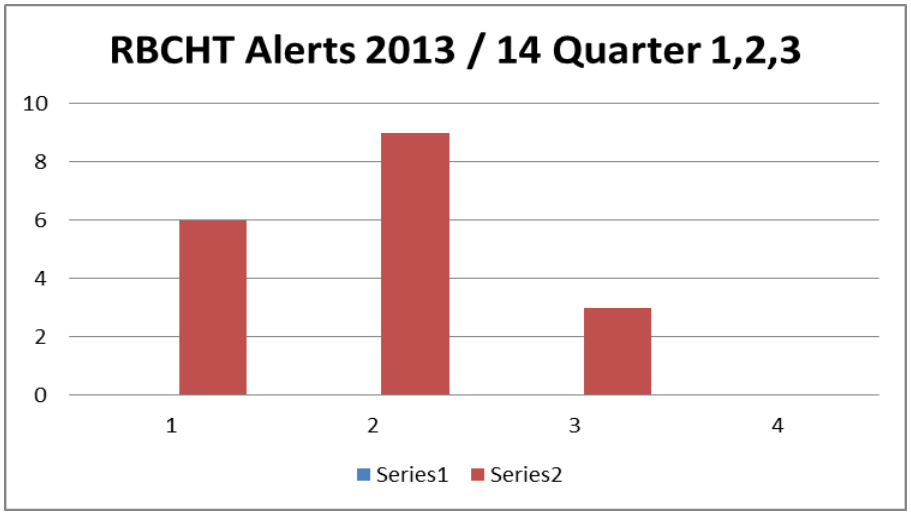
5.3 310 alerts remain open, however not all of these will have active CCG engagement, due to the severity of the threshold. Work is in place to ensure there is a robust process for information to be sent to the CCG regarding outcomes of those alerts in which the CCG have not been actively engaged.

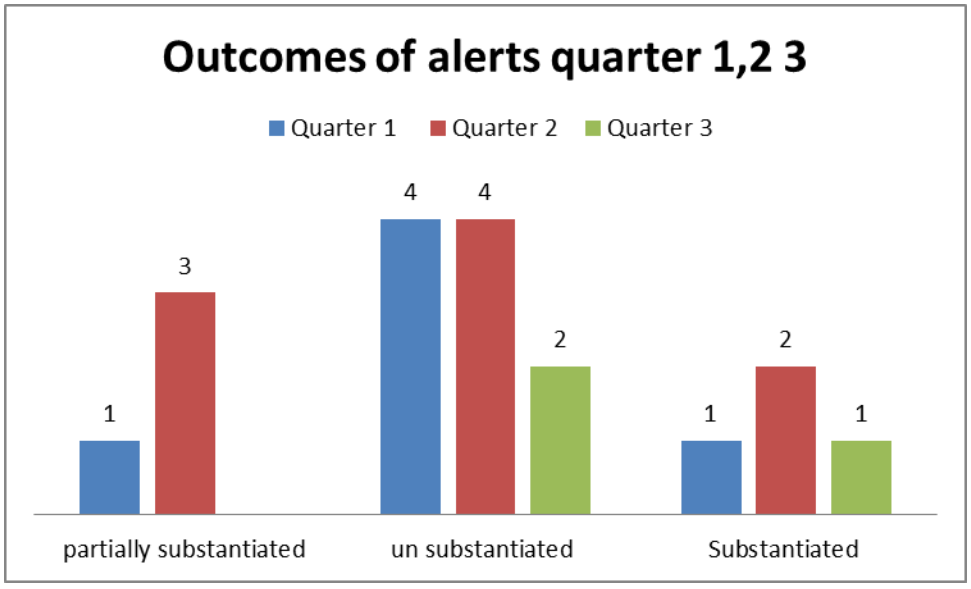
5.4 Of all the alerts that remain open for the year, the Adult Safeguarding Nurse Specialist is involved within the alerts pertaining to the main NHS providers. A number of alerts pertaining to the care homes will be overseen by the CCG through the quality care home team, unless the care home is subjected to a pathway 4 investigation.

NHS providers

Royal Bournemouth Hospital

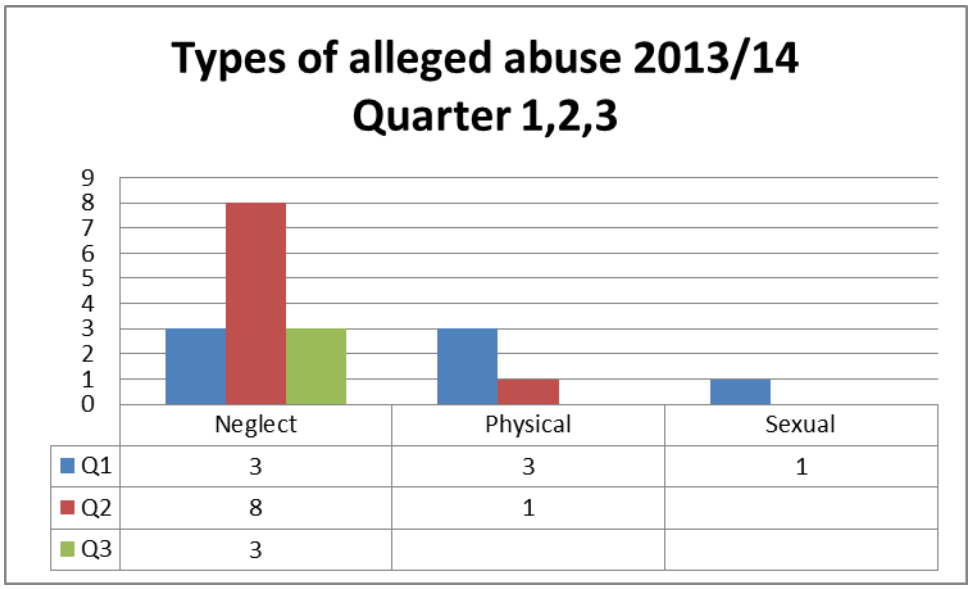
5.5 There have been 18 alerts throughout the year; all alerts that have proceeded to investigation have been completed.





5.6 Themes of non substantiated adult safegaurding alerts have been around attitude of staff, personal care , lack of dignity and privacy , lack of information, lack of best interest decisions, pressure area care, sexual allegation, conflicting diagnosis, falls, not answering call bells, discharge process, accidental injury, unexplained bruising and nutrition

5.7 Themes identified within safeguarding alerts that were substantiated were around a preventable accidental injury, nutritional needs, avoidable grade 4 pressure sore, conflicting diagnosis to a family, falls from bed and not answering call bells and lack of personal care.



5.8 The abuse categorised under sexual, was investigated and non-substantiated.

5.9 All safeguarding alerts that were substantiated were subject to a protection plan, which is monitored through the monthly safeguarding meeting at the trust.

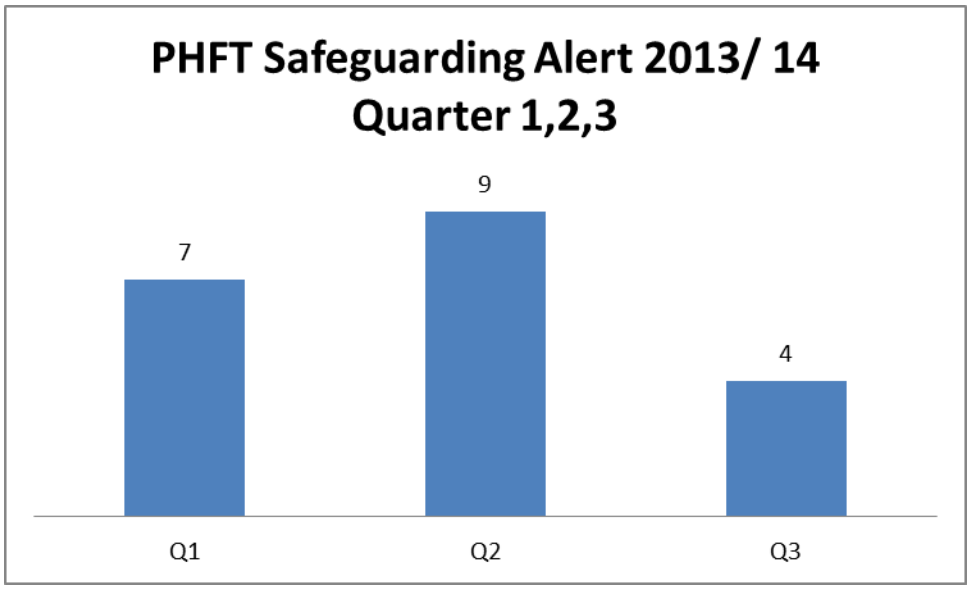
5.10 There remains a need to focus on the timeliness of the CCG being made aware of the alerts from Royal Bournemouth and Christchurch Foundation Trust however the Adult safeguarding Nurse is working with the trust and LA to improve this.

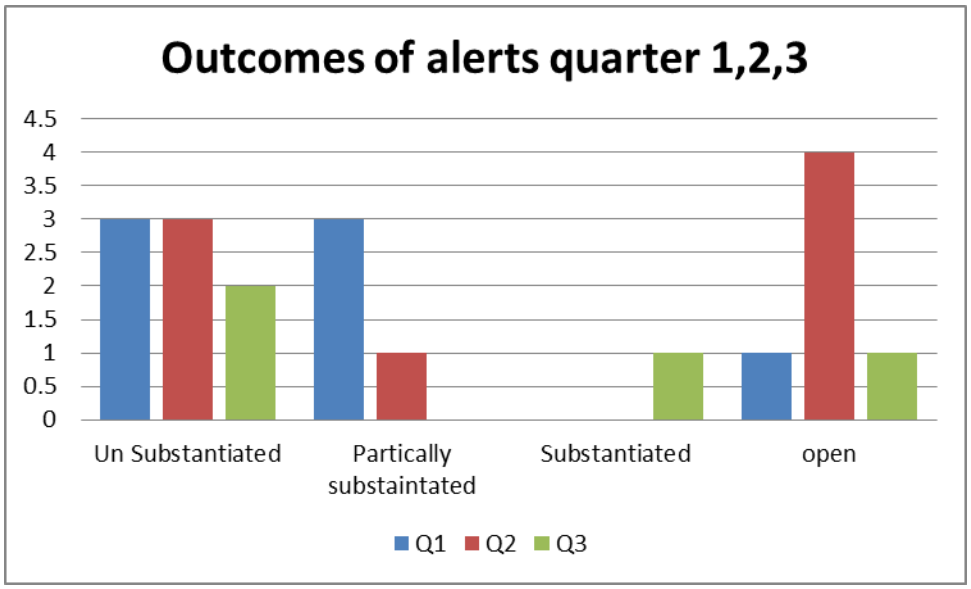
Poole Hospital Foundation Trust

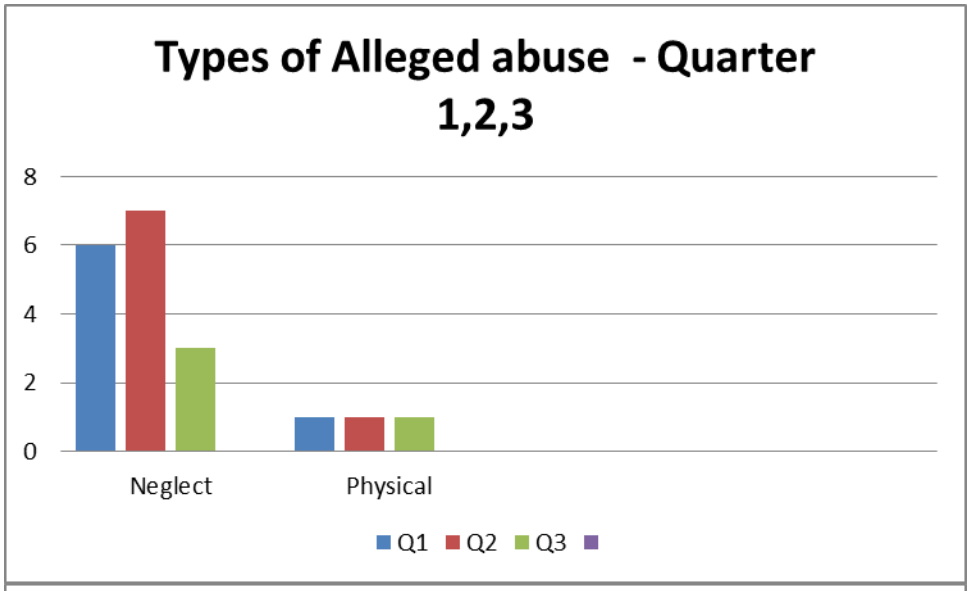
5.11 There have been 20 alerts throughout the year, 15 have been completed, and 5 remain outstanding.

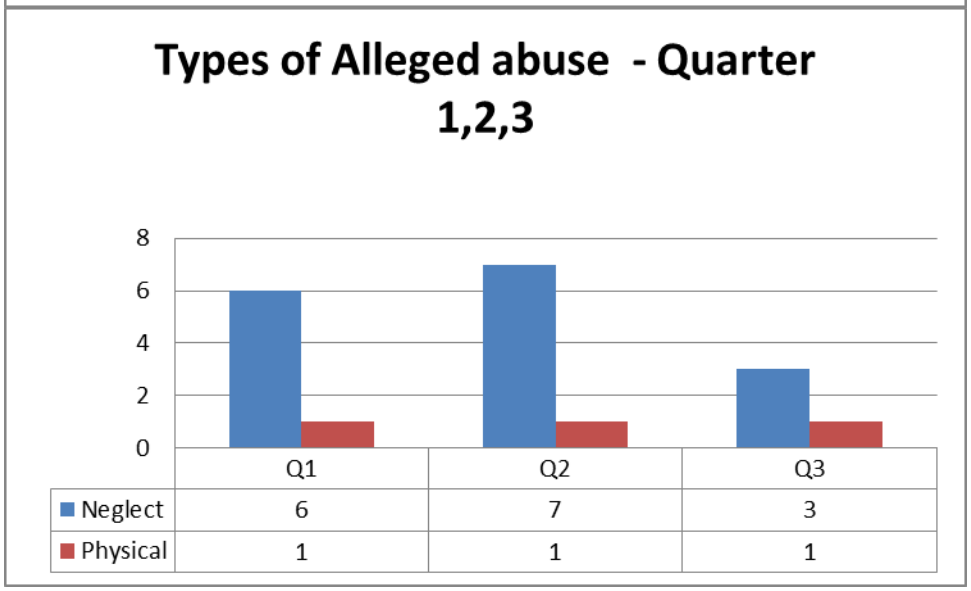
5.12 Poole Hospital has been subjected to a Pathway Four whole service review for safeguarding, which was concluded in Jan 2014, with some positive actions being taken by the trust. This has included the establishment of a 3 monthly safeguarding meeting, to monitor on-going safeguarding issues and regular reviews of any safeguarding action plans in place. This meeting will be

orchestrated in collaboration with the trust's internal governance reporting mechanims to minimise any duplication of reporting.









5.13 Themes of non substaniateed safeguarding alerts have been around poor communication between clinicans, poor documentation and reporting of safeguarding in a timely manner, pressure area care, and identification of indivudals needs. Evidence of departments working independently and not collaboratively has been apparent.

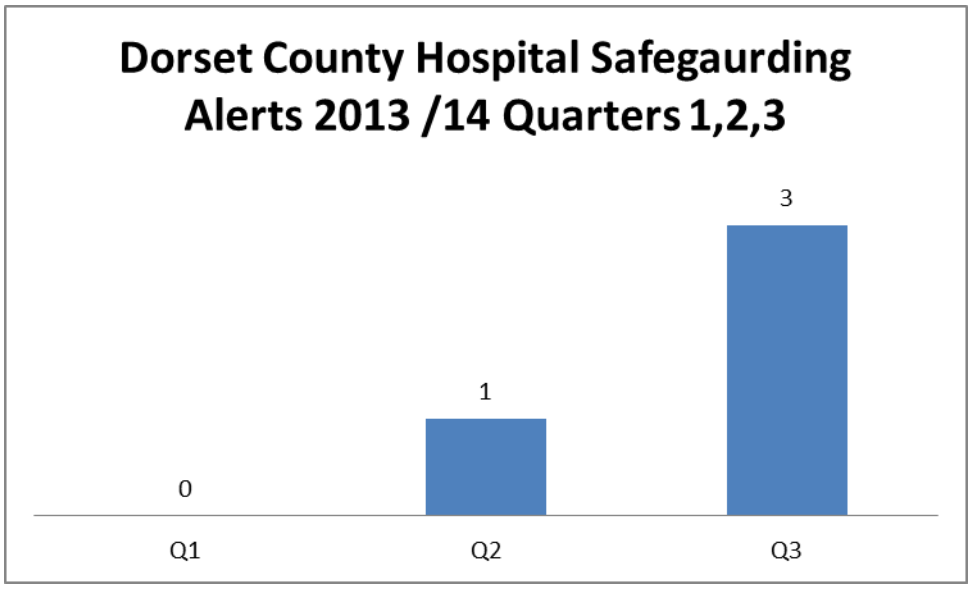
5.14 Themes identified within safeguarding alerts that were substantiated were around attitude and competency of staff.

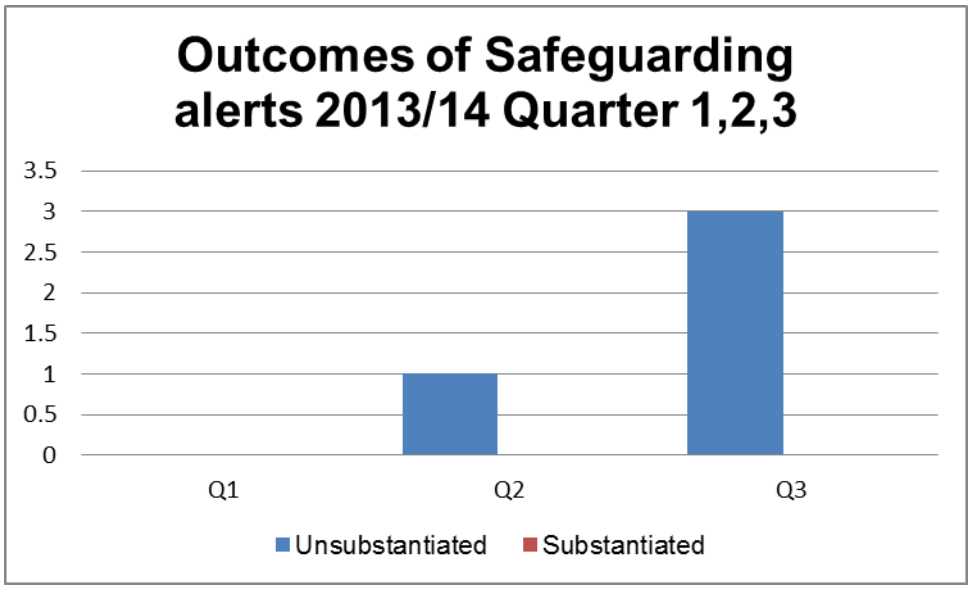
5.15 Learning from all the safeguarding alerts will be addressed via the trust and monitored through the three monthly safeguarding meetings.

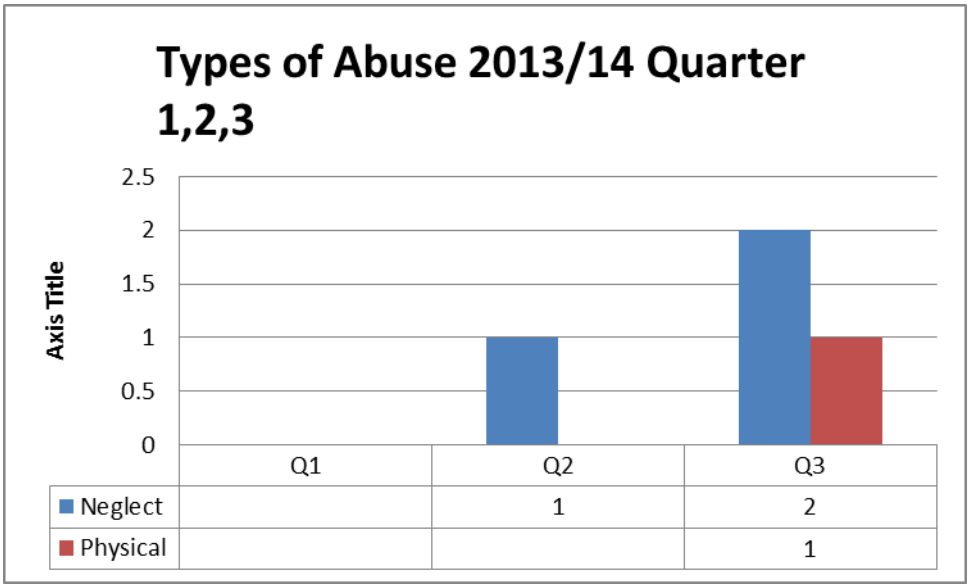
5.16 Information has now been requested to determine which wards or department have been implicated by safeguarding alerts.

Dorset County Hospital

5.17 There have been four adult safegaurding alerts for Dorset County Hospital Foundation Trust throughout the first 3 quarters of 2013/14, which did not proceed to investigation. The main theme was around alleged physcial harm, but it was not substainated.







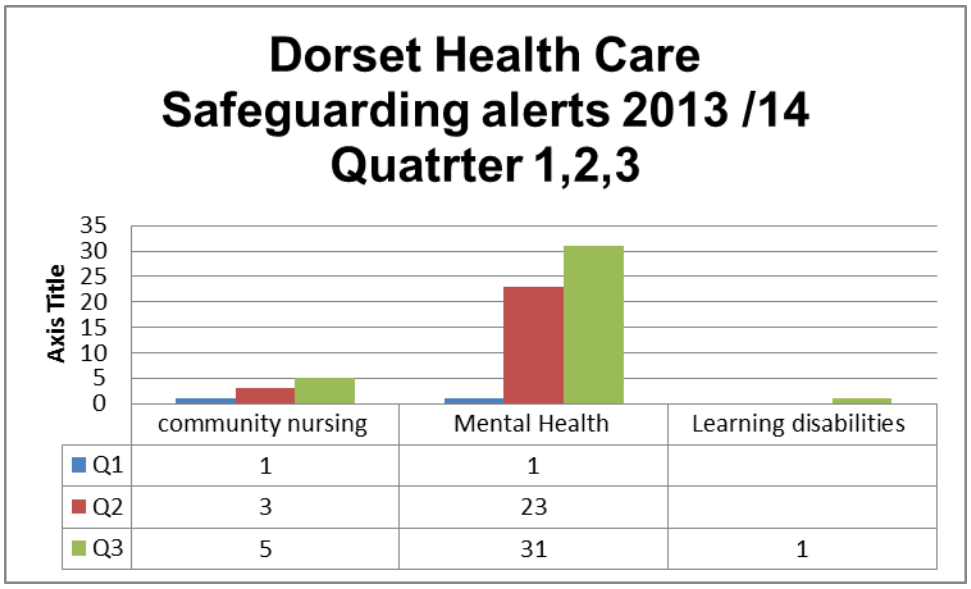
5.18 The wider themes from the safeguarding alerts within Dorset County Hospital are around pressure area care, discharge process and an unexplained bruise.

5.19 Cause for concerns are submitted to the Local Authority based within the hospital, who review each referral and gather information prior to the alert being submitted as an actual safeguarding alert.

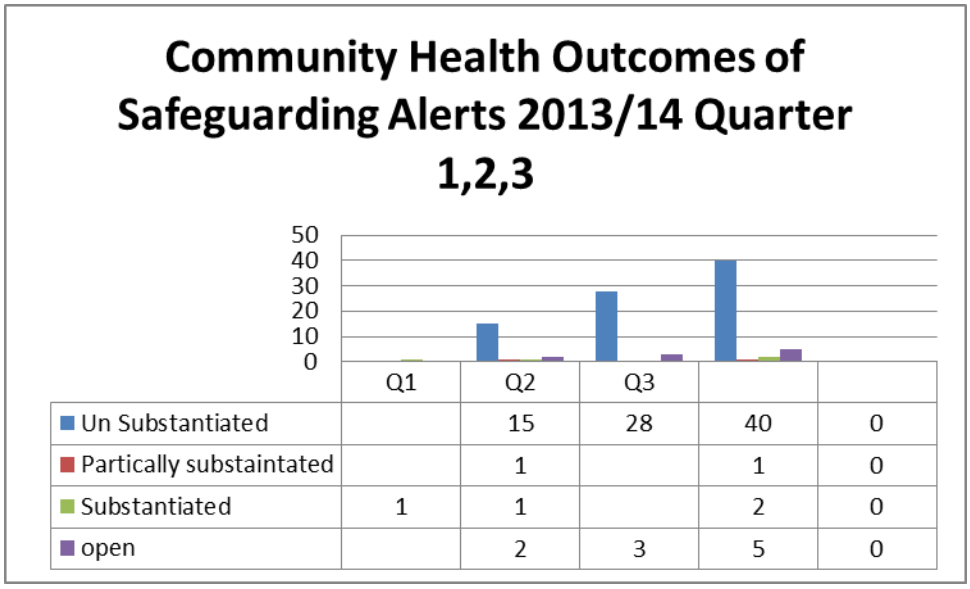
5.20 Information has now been requested to determine which wards or department have been implicated by safeguarding alerts.

Dorset University Healthcare Foundation Trust

5.21 There have been 58 alerts throughout the year from Community Health, Mental Health and Learning Disabilities teams, 55 have been completed, and 3 remain outstanding waiting further investigation and conclusion.



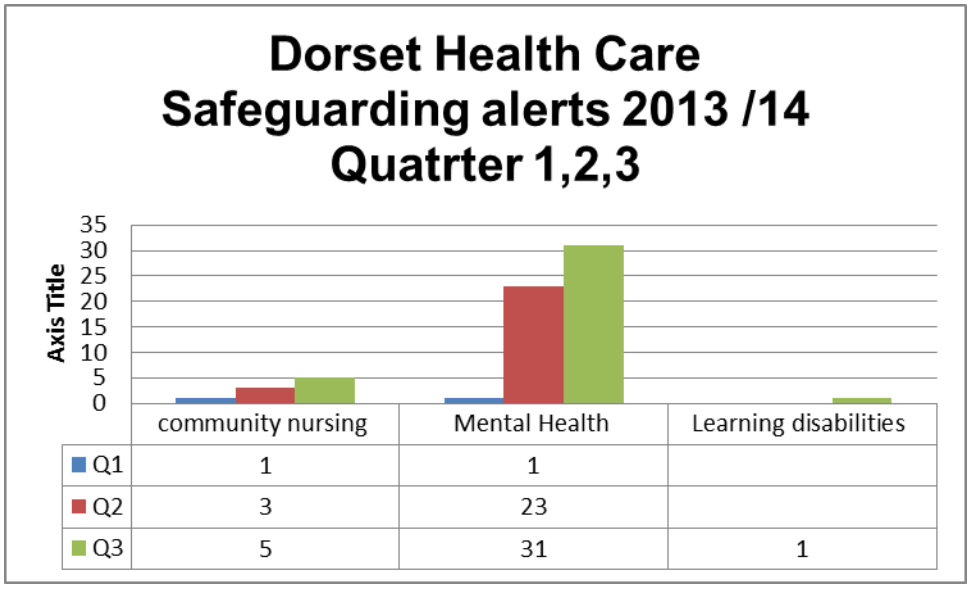
5.22 From the nine alerts received for community nursing, one has been substantiated which has been around poor coordination of care, and lack of robust communciation between services. The alert that remains open is underpinned by Community Mental Health Services and Community health, where there has been a misunderstanding of roles and identified need of the individual.



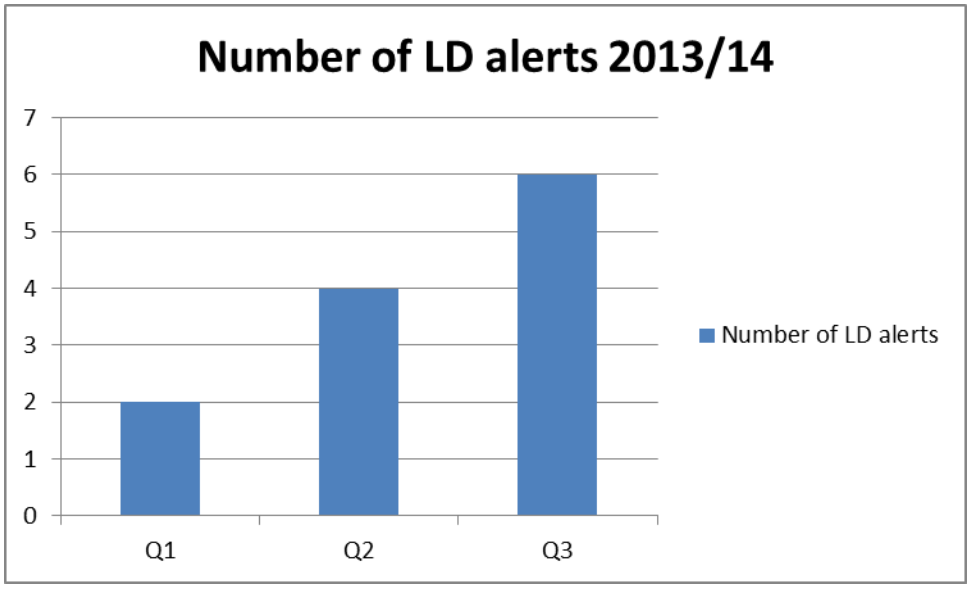
	Q1	Q2	Q3		
Un Substantiated		15	28	40	0
Partically substaintated		1		1	0
Substantiated	1	1		2	0
open		2	3	5	0

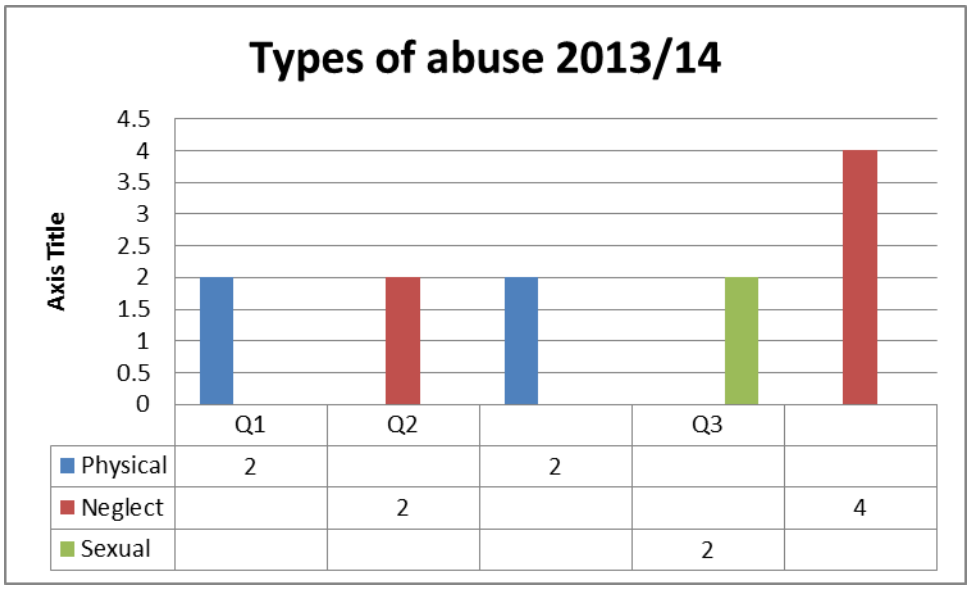
5.23 There have been a total of 48 alerts from Mental Health Servcies throughout the first three quarters of 2013. A large percentage of the alerts have been deemed to be low level patient on patient assult, or due to the complexity of the indiviuals mental health needs.

5.24 There has been one particular mental health ward, that had been subjected to a Care Quality Commission report and were implicated as not reporting sufficent safeguarding alerts, which has subsequently seen an increase in the number of alerts. This was acknowledged by the CCG, the Local Authority and the provider and a monthly service improvement meeting has been set up to look at the alerts and to ensure that appropriate risk management and care planning has been put in place.

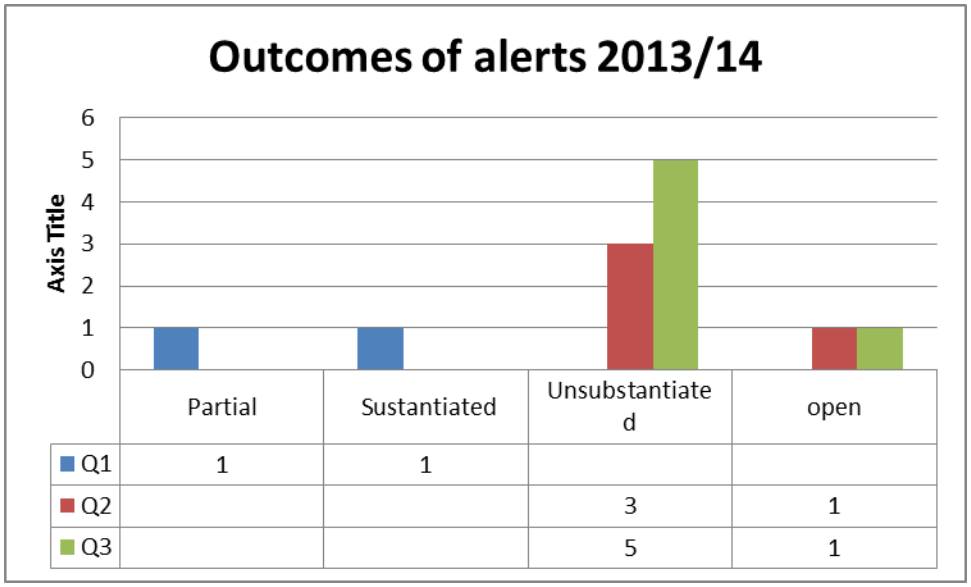


5.25 There has been one alert from Learning Disabilites that has direct involvment with Dorset Health Care Learning Disabilities Integrated care team. However there have been a number of safeguarding alerts for learning disabilites providers of domicillary care, some of which have engagement with the intergrated learning disabilites team.





5.26 The alerts pertaining to the category of sexual abuse were investigated and have not been substaniated, and were regarding an individual who was sexually dis-inhibited and had raised allegations.



6. SAFEGUARDING ADULTS BOARD (INCLUDING DOMESTIC VIOLENCE)

6.1 The Adult Safeguarding Board has a set of subgroups that all have an action plan developed in response to work streams. The outcomes from these meetings are fed into the Board.

6.2 The Policy and Procedures subgroup completed a refresh of the multi-agency Dorset, Bournemouth and Poole policy which has included the multiagency risk protocol.

6.3 The Education and Workforce group have completed and launched the Standards for Safeguarding Adult's Awareness training document to all

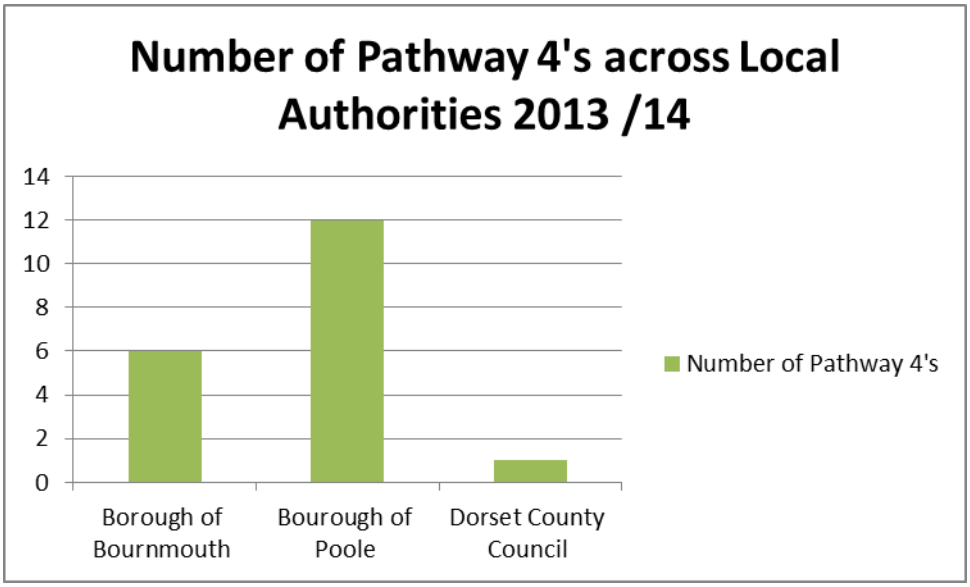
providers of health and social care across the county. There is on-going work to implement this into practice and to develop ways to evaluate its effectiveness.

6.4 The safeguarding teams within the Local Authorities have been working together throughout the year to review the thresholds for alerts to safeguarding, to achieve equity and parity across the county.

6.5 A review of how individuals can access information on how to report concerns of protection of adults and safeguarding issues through the Clinical Commissioning Group website has been undertaken. The website now allows searches on “abuse” or “potential abuse” to take the individual direct to the safeguarding page, which includes information around PREVENT and Domestic Violence.

7. SERIOUS CASE REVIEW / CASE AUDITS /PATHWAY FOURS

7.1 Throughout this year there have been a number of pathway 4 whole service reviews around care homes and one acute trust.



7.3 It has been noted there is a large variation on the management of Pathway 4’s across the county, which again has been brought to the attention of the Adult Safeguarding Board and the Quality Assurance Sub group.

7.4 There has been one Serious Case Review concluded this year which has had a robust action plan implemented and is being monitored through the Serious Case Review subgroup. This report has been release in the public domain.

7.5 Two serious case audits and a large scale serious case audit are awaiting publication, although working groups and action plans have been put in place to start addressing the issues.

7.6 There has been one further case audit undertaken around an individual who received care from two residential homes, CHC and Primary Care. Issues around hydration and early identification of deterioration were highlighted. An action plan is being developed to address the issues, which will be shared with all providers involved.

7.7 There has been one further case audit commenced in quarter 3 2013/14, which has had chronologies undertaken to date.

7.8 The Adult Safeguarding Nurse Specialist is supporting the Designated Children's Nurse, with the delivery of the recommendations from the Serious Case review into a domestic homicide, to ensure the message of Adult Safeguarding and Mental Capacity is included.

8. EXTERNAL INSPECTIONS AND REVIEWS

8.1 The Borough of Poole has been informed they will be subjected to a peer review of their safeguarding processes in quarter four of this year.

8.2 Dorset County Council has commissioned a review by Hampshire County Council of their safeguarding processes and triage, the outcomes of this are expected in the near future.

8.3 Bournemouth Borough Council underwent a peer review at the end of the financial year 2012/ 13, and an action plan has been developed and shared across the safeguarding board and will be implemented into practice via the subgroups.

9. CONCLUSION

9.1 There is positive engagement across all three Local Authorities. This has allowed for an improvement in communication and information sharing to meet the needs of patient safety and to ensure the CCG is engaged within a timely manner.

9.2 Some concerns continue around the actual timeliness of alerts / referrals with a health related component being reported to the CCG, There has been some improvement around the internal governance and reporting of safeguarding across the Acute Trusts, however, there remains a concern around the appropriateness and timeliness of some of the alerts and the feedback received by both the CCG and the individuals making the alerts.

9.3 A monthly Safeguarding Leads meeting has been established which is led by the Adult Safeguarding Nurse Specialist. This allows all the safeguarding leads from the NHS providers to meet regularly to share information around national and local policy, good practice, and to offer supervision. In addition to this the Adult Nurse Specialist attends all the safeguarding meetings within all

the NHS providers, which again strengthens the transfer of information and monitoring of protection plans.

9.4 The Adult Safeguarding Nurse Specialist has developed stronger links with the Continuing Health Care team, to ensure timely and appropriate information is shared.

9.5 The number of alerts that the CCG is made aware of has increased from Learning Disabilities and Mental Health is increasing throughout the year, this will need to continue to be monitored to ensure that the CCG receives appropriate and timely information and engagement.

9.6 Considerable work has been undertaken within the Quality Directorate, Risk Management and Safety team to ensure that there is robust cross referencing of safeguarding alerts and incidents reporting to ensure appropriate information is shared with NHS England.

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Date : **24 February 2014**
Telephone Number : **01305213515**