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NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

SAFEGUARDING ADULTS UPDATE

Date of the meeting	19/11/2014
Author	V Cooper – Adult Safeguarding Nurse Specialist
Sponsoring Clinician	Dr P French, Locality Chair for East Bournemouth
Purpose of Report	This report highlights the level of safeguarding adult activity across Dorset, Bournemouth and Poole for the period 1January 2014 to 30 September 2014 (Quarter 4, 2013, Quarter 1 and 2, 2014)
Recommendation	The Governing Body is asked to **Note** the report.
Stakeholder Engagement	• The Adult Safeguarding Nurse Specialist is a member 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	N/A

Monitoring and Assurance Summary

This report links to the following Strategic Principles	• Services designed around people • Preventing ill health and reducing inequalities • Sustainable healthcare services • Care closer to home		
	Yes [e.g. ✓] *Copy & paste tick*	**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	✓		✓
I confirm that I have considered the implications of this report on each of the matters above, as indicated	✓		

Initials : VC

1. Report

Quality (Safety, Quality, Patient Experience)

Introduction

1.1 The Lead Executive and representative on both Dorset and Bournemouth & Poole Safeguarding Adults Boards is Sally Shead, Director of Quality.

1.2 This report provides an overview of the safeguarding activity over the period 1 January 2014 to 30 September 2014.

1.3 The lead agency for undertaking Adult Safeguarding is the Local Authority.

2. General Safeguarding Information

2.1 The Adult Safeguarding Nurse Specialist provides specialised assistance and support for all safeguarding alerts that have serious safeguarding concerns around health services or for multiple number of alerts from one provider and issues around serious misconduct.

2.2 The decision for the Adult Safeguarding Nurse Specialist to attend a strategy or case conference meeting is determined by following the principles outlined in Dorset Clinical Commissioning Group (CCG) Safeguarding Adult Policy, these being:

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

2.3 Information gathered at the strategy meetings will determine the terms of reference if safeguarding alerts proceed to investigation, to ensure all relevant elements are investigated to contribute to the outcomes of care. During the strategy process, wider risks are identified to other service users receiving care from that provider, to minimise any larger institutional risk and identify poor practice.

2.4 A monthly meeting with all the NHS provider safeguarding leads allows for all parties to address communications issues, review alerts and referrals that have been instigated by or alleged against the provider. This meeting allows for the CCG to gain greater understanding of the alerts that are proceeding to investigation, and to ensure appropriate reporting of serious incidents requiring investigation (SIRIs) is undertaken. 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 NHS England. This also ensures a consistent approach to data collection.

2.5 The Adult Safeguarding Nurse offers health support and advice to the Local Authorities' safeguarding teams, as well as Primary Care whilst continuing to raise the profile of adult safeguarding within the CCG.

2.6 Elements of adult safeguarding and Mental Capacity Act training have continued to be offered to General Practice staff throughout the year to support Practices in meeting their requirements for the Care Quality Commission.

2.7 The two Adult Safeguarding Lead GP's work in collaboration with the Adult Safeguarding Nurse to provide clinical support for any complex safeguarding referrals, they also support Serious Case Reviews, whilst also contributing to the delivery of training and education to primary care.

2.8 The Adult Safeguarding Lead Nurse has continued to engage with the Wessex Local Area Team Safeguarding Forum and has undertaken the role of Chair for the Area Team Adult Safeguarding group. The purpose of this group is to ensure that Adult Safeguarding remains on the agenda of the wider safeguarding forum alongside Children's safeguarding.

2.9 In collaboration with the Local Authorities, ongoing work continues to consider ways to engage with service users in the safeguarding process. This is to gain views of individual's experiences both during and following safeguarding investigations. Fact sheets explaining the safeguarding process for individuals have been developed as part of the Policy and Procedures group.

2.10 The three Local Authorities have undertaken the decision to engage with 'Making Safeguarding Personal' at silver level. The implications of how this will affect practice are still under discussion within the Local Authorities and consideration as to how health services will be engaged will evolve.

2.11 Throughout the year the Policy and Procedures subgroup have also worked together to review the variations in practice delivery, risk management for individuals who self-neglect and continue work on the threshold criteria.

2.12 The Education and Workforce subgroup have continued to work on their designated work plan, with emphasis on reviewing current training programmes in line with the care act.

2.13 The Quality Assurance subgroup continue to review the cross county differences in the interpretation of the policy, and are working to ensure there is consistency in the threshold of alerts. This continues to ensure that referrals related to health are made known to the CCG in a timely manner.

3. Safeguarding Adults Process

3.1 Once the CCG is made aware of a safeguarding alert by the Local Authorities, the information is captured on the CCG database *Ulysses.* This allows the CCG to gather intelligence around service providers, themes and lessons learnt to be gathered. The role monitors the safeguarding process and outcomes to ensure the lessons learnt are identified. This continues to be challenging following organisational changes across provider and Local

Authorities structures. To address the issues regular meetings between the CCG Adult Safeguarding Nurse specialist have been established to improve exchange of information and communication.

3.2 Information sharing from the three Local Authorities remains variable around safeguarding within care homes, with delays in the CCG being made aware if the process proceeds to a large scale investigation. Again this is being addressed through continual engagement between the CCG and the Local Authorities. Once information around safeguarding activity within care homes is received, it is shared with the quality assurance care home team.

3.3 The role has built relationships with Continuing Healthcare (CHC), to identify individuals funded by CHC who are subject to the safeguarding process. This has highlighted some individuals whose care does not actually meet the threshold for safeguarding, but the team require ongoing support with management of complex care through the multi-agency risk sharing protocol.

4. Safeguarding Adults within the CCG

4.1 Adult safeguarding training is included in the mandatory training programme across the CCG, and line managers have been tasked with ensuring all staff have completed the training. Uptake has improved with 92% of all staff undertaking level A awareness training and 64.8% undertaking level B induction training. Level B induction training is aimed at clinical staff.

4.2 The Local Authority have a training programme for adult safeguarding which includes training for Accountable Officers and CEO's of providers. It has been attended by the CCG.

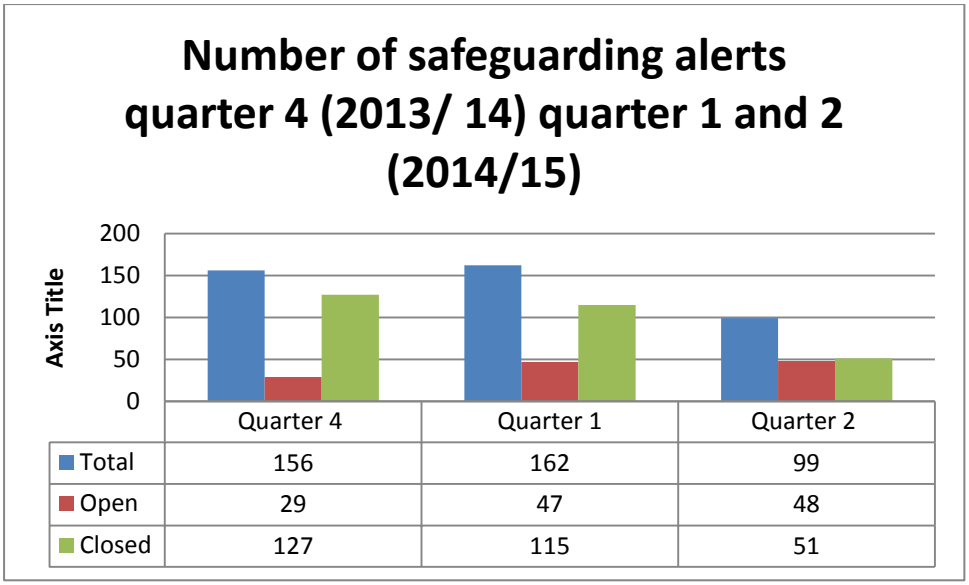
5. Safeguarding Adults within Provider Organisations

Safeguarding Alerts

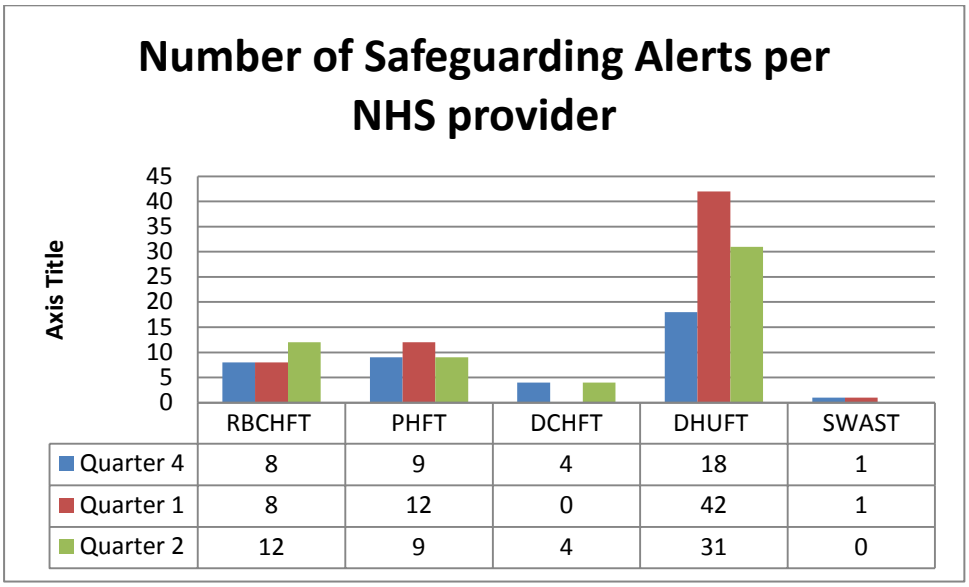
5.1 Throughout the year quarter four (2013 / 14), quarter one, and two (2014/ 15) there have been 417 alerts made known to the CCG.

5.2 Of the alerts received, 293 have been closed to the safeguarding process which equals 70.26%.

5.3 One hundred and twenty-four (124) of the alerts received during the reporting period remain open. Compared to the previous reporting period the number remaining open has reduced. This could be contributed to considerable work being undertaken to work with the Local Authorities to gain information around the outcome of cases. The alerts open will not all be overseen by the Adult Safeguarding Nurse specialist, but may be actively managed via CHC engagement, this is determined due to the severity of the threshold of the alert.



	Quarter 4	Quarter 1	Quarter 2
Total	156	162	99
Open	29	47	48
Closed	127	115	51



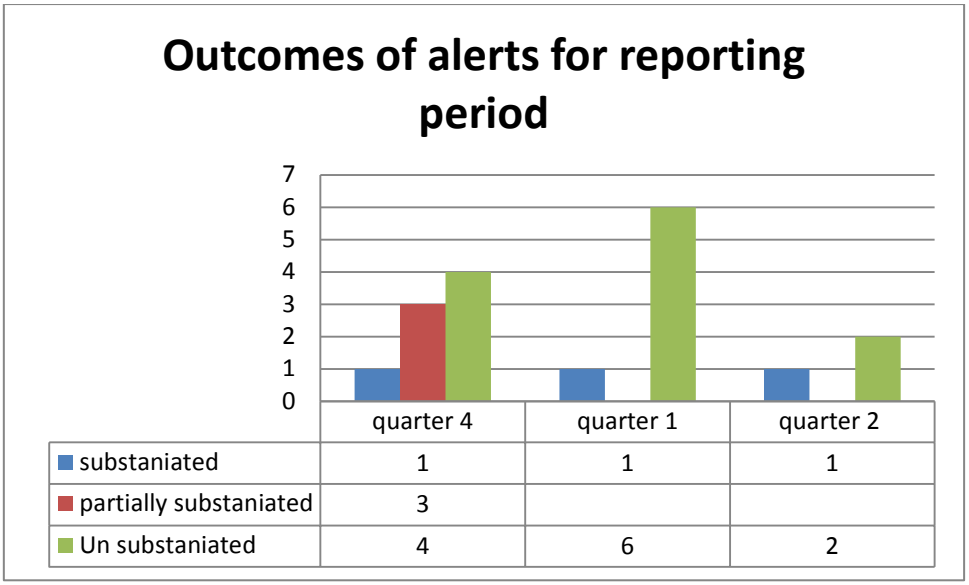
	RBCHFT	PHFT	DCHFT	DHUFT	SWAST
Quarter 4	8	9	4	18	1
Quarter 1	8	12	0	42	1
Quarter 2	12	9	4	31	0

5.4 Of all the alerts that remain open for the year, the Adult Safeguarding Nurse Specialist is involved with 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 & Christchurch Hospitals NHS Foundation Trust

5.5 In total the CCG has been made aware of 28 alerts. Not all alerts have proceeded beyond strategy, as it was felt sufficient information had been gathered to determine no further actions were required. 35% of the current alerts remain open.



5.6 Themes of the adult safegaurding alerts that have been completed remain around discharge planning, communication and restraint of patients.

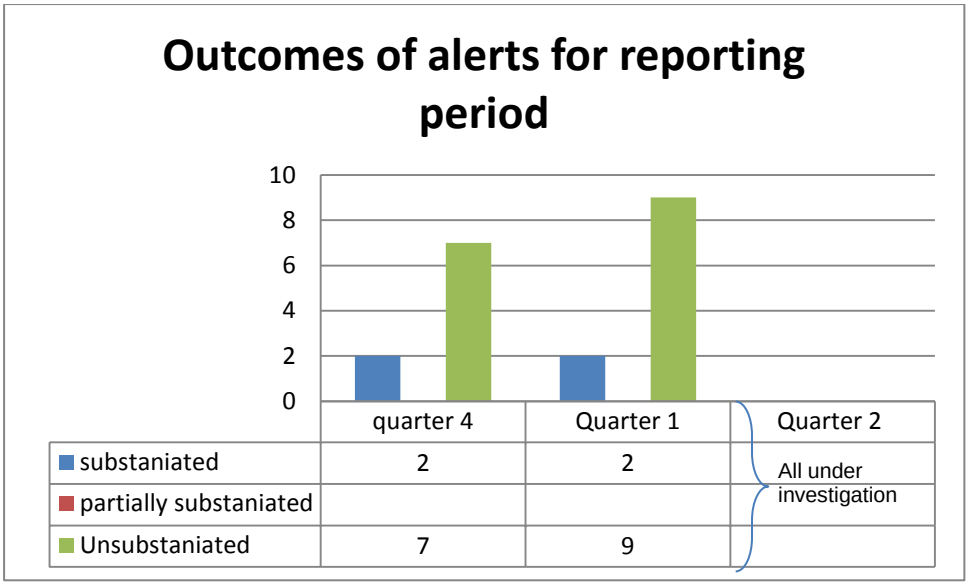
5.7 The themes identified in alerts that were partially substantiated were underpinned by medicines management, manual handling and supervision of an individual who lacked capacity. The themes identified in the alerts that were substantiated were around pressure care, management of relatives who posed a risk to an individual and discharge planning. ,

5.8 Lessons learnt included reviews of patients with complex long term conditions and their medication management.

5.9 Work continues between the CCG, RBCHFT and Bournemouth Local Authority to ensure information around alerts, investigations and outcomes is shared in a timely manner. To support this development the Adult Safeguarding Nurse attends the monthly multi agency safeguarding meeting at the Trust, which is chaired by the Deputy Director of Nursing.

Poole Hospital NHS Foundation Trust

5.10 There have been 30 alerts throughout the reporting period, 24 have been completed and 20% of all alerts remain open and ongoing.



5.11 Themes of alerts that have not been substaniated have been identifed as being associated with effective communication between wards and staff, discharge process, pressure area care, and meeting indivudals needs.

5.12 Themes identified within safeguarding alerts that were substantiated were underpinned through meeting the needs of individual's learning disabilities, effective communication and the application of the mental capacity act in practice.

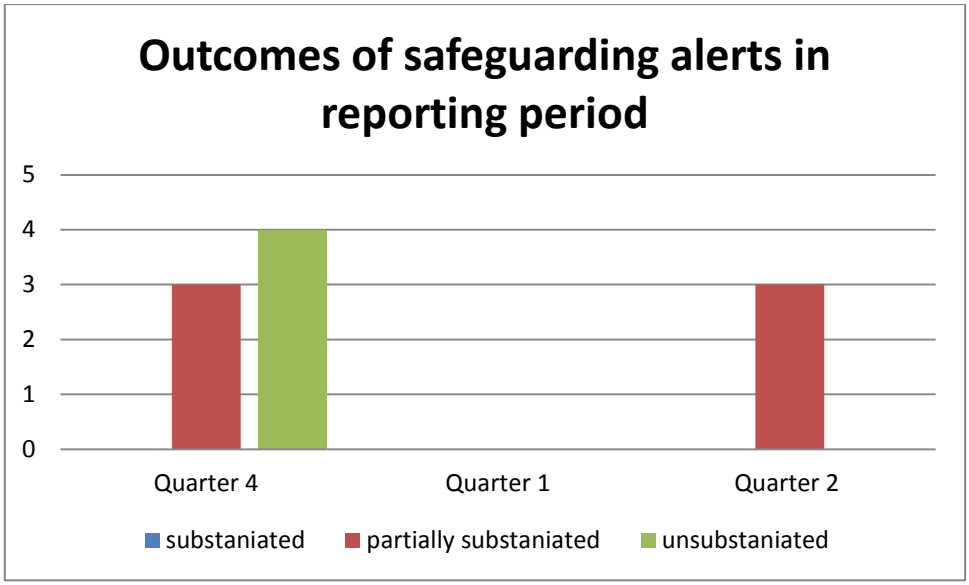
5.13 Lessons learnt from the safeguarding activity within the Trust have been around the application of the Mental Capacity Act and giving consideration to engaging the next of kin. Issues around discharge planning have been reviewed and the learning will be addressed and monitored through the three monthly safeguarding meetings and contractual meetings.

Dorset County Hospital NHS Foundation Trust

5.14 There have been eight adult safeguarding alerts for DCHFT throughout the reporting period.

5.15 The wider themes from the safeguarding alerts within DCHFT this reporting period were regarding call bells not being in reach causing an individual to get up from their chair and fall.

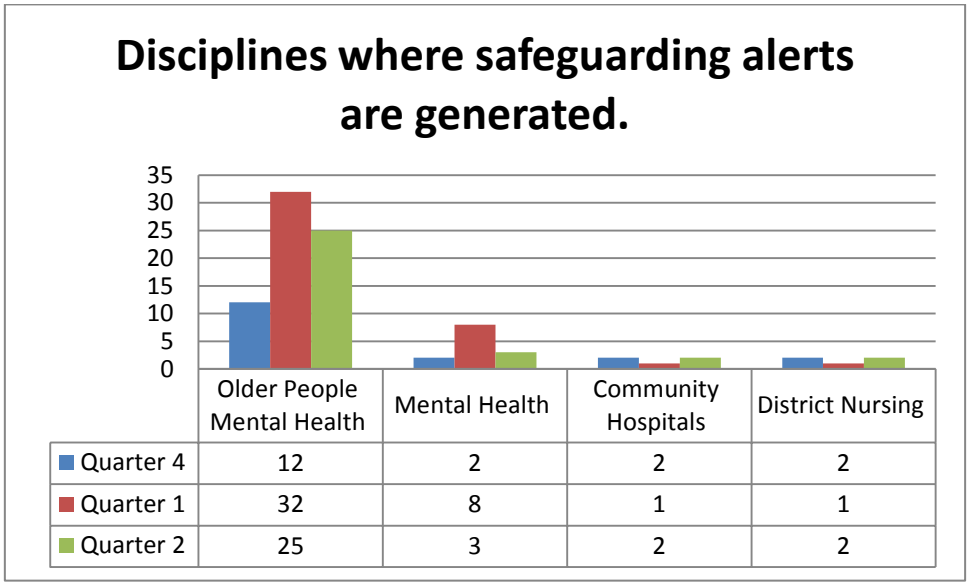
5.16 DCHFT submits a cause for concern to the Local Authorites based within the hospital. The Local Authority then review each referral and gather information prior to the alert being submitted as an actual safeguarding alert, which could be the rationale for the smaller number of alerts being registered.



Dorset HealthCare University NHS Foundation Trust

5.17 There have been 96 alerts throughout the year from DHUFT, which inlcude Community Health, Mental Health and Learning Disabilities teams.

5.18 Eighty-three (83) have been completed, 13.5% of alerts remain outstanding waiting further investigation and conclusion.



	Older People Mental Health	Mental Health	Community Hospitals	District Nursing
Quarter 4	12	2	2	2
Quarter 1	32	8	1	1
Quarter 2	25	3	2	2

5.19 There were five alerts received for community nursing, one has been substantiated which was underpinned by poor coordination of care, and lack of robust communciation between services.

5.20 The alert that currently remains open is in the investigation phase, themes identifed are pressure area care.

5.21 There have been a total of 13 alerts from mental health services and 69 alerts from older peoples mental health servcies througout the reporting period.

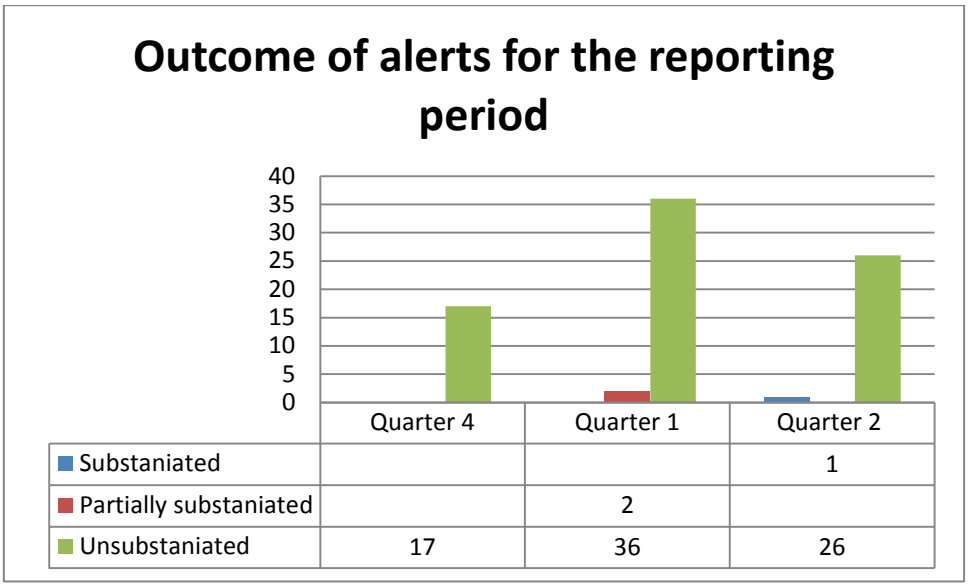
5.22 A large percentage of the alerts from the older people mental health services are around low level patient on patient assault, or due to the complexity of the individuals mental health needs. This has been addressed through a multi disciplinary route, and processes have been put in place to risk assess and manage the indivdual complex needs.

5.23 Themes from the mental health providers are around individuals who have been deemed to be acutely mentally unwell at the time of the alerts, and allegations are made that have been unsubstaniated. Staff engaged in the alerts have been suspended pending investigation and an internal HR process has been followed.

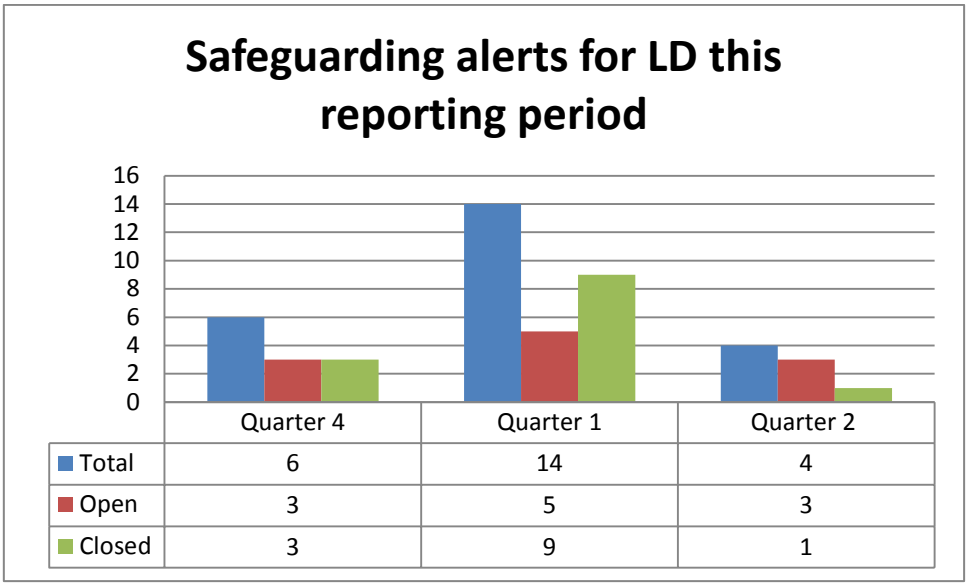
5.24 There have been five alerts from community hosptials during the reporting period. The themes from the alerts that have been unsubstaniated were around possible restriant, however evidence show all actions taken, did not actually indicate a restrictive method. Other themes were around patients feeling they had to wait for someone to help them, and staff were always busy, again this has been addressed by the Trust.

5.25 Themes identifed from the substaniated safeguarding activity in community hospitals were underpinned by a whistle blower, who had raised concerns around institiutional practice and attitudes of staff. This was investigated through the safeguarding process, and found not to align to the issues raised, however relevant staff were suspended during the investiagtion and an internal HR process had been followed.

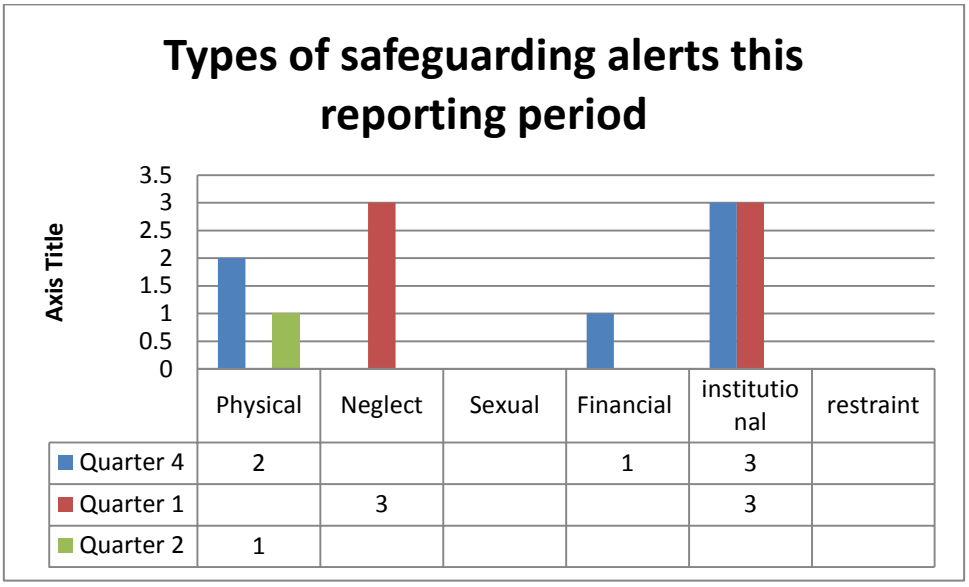
5.26 It has been noted that when there are a number of alerts being submitted around a particular DHUFT service, the Trust provides an immediate response to ensure safeguards are put in place in a timely manner to protect other patients.

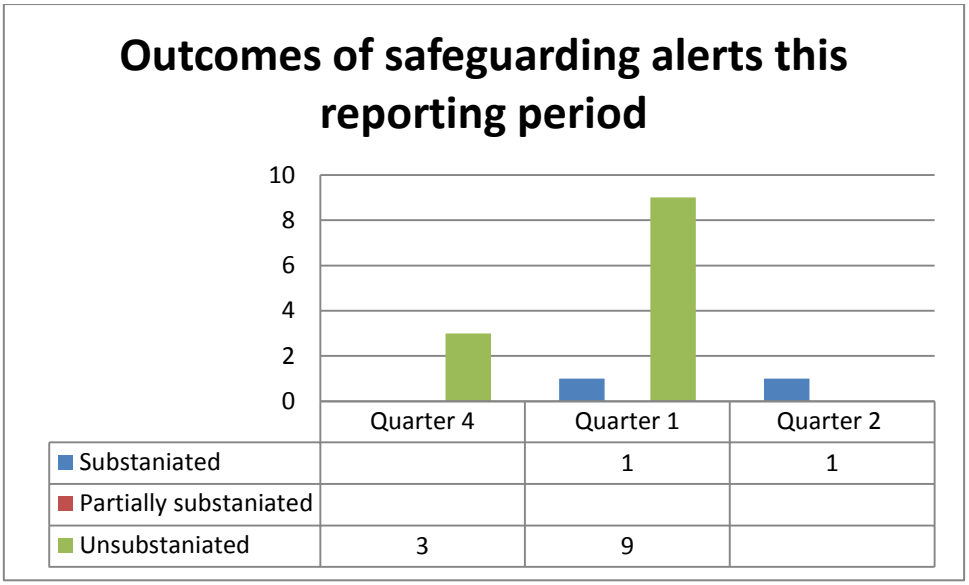


Learning disabilities



5.27 Alerts received around learning disabilites are generated from care homes and domicillary care providers. Some of the individuals involved within the alerts will be known to the integrated health and social care community learning disabilities teams.





5.28 The two alerts that have been substaniated, have been around poor supervision of individuals. Protection plans have been developed and implemented to prevent similar events from reoccuring.

6. Safeguarding Adults Board (including Domestic Violence)

6.1 The sub-groups of the Board are all working to their designated work plans which are developed in response the Board's priorities. The outcomes from these meetings are fed back into the Board.

6.2 The Board is currently reviewing the implication of the Care Act for safeguarding and considering how this will need to be addressed.

7. Serious Case Reviews/Case Audits/Pathway Fours

7.1 There have been a number of both residential and nursing care homes that have been subject to a Pathway Four whole service investigation/review around care delivery.

7.2 One learning disability care home in the Dorset County Council area has been closed during this reporting period. Although on investigation through safeguarding, the final closure was due to contractual issues and financial stability of the home.

7.3 A Serious Case Audit has been undertaken into the events leading up to the closure of this care home, and the report is due to be published soon. An Action Plan is being developed which has actions for all agencies to take.

7.4 An action plan resulting from a Domestic Homicide Review undertaken by an external investigator is in place, with the majority of the actions being for DHUFT. This is being closely monitored by the CCG.

7.5 Further actions have been identified as being required by several agencies from two other Serious Case Audits and a Serious Case Review which was carried out last year. The learning from all of these is being incorporated into the education and training programme and the Boards are considering how to ensure the learning from these cases is embedded in practise.

8. External Inspections and Reviews

8.1 The Borough of Poole engaged in a peer review process in March of this year, initial findings have been shared with the Board and was generally positive. The final published report is not yet released.

8.2 Dorset County Council is currently undergoing a major restructure across the organisation, which is due to be completed in Quarter Three, 2014/15. The development of a specialist safeguarding team has been undertaken across the county, which is led by a specialist adult safeguarding team lead; this should enhance the overall process.

8.3 Bournemouth Borough Council has reviewed its safeguarding arrangements and consideration to its future structure is under discussion.

9. Conclusion

9.1 Relationship across the CCG, Local Authorities and providers have continued to be strengthened, which will allow improved communication and information sharing to address the safety of vulnerable adults and to ensure the CCG is engaged within a timely manner. Despite this there are some specific areas across the Local Authorities that struggle with this, which is primarily due to the social work teams not fully understanding the differences between the role of the commissioner and provider of healthcare.

9.2 Improvements have been made during the reporting period to ensure that data from safeguarding, risk management and complaints known to the CCG are triangulated to ensure appropriate information is shared with NHS England.

9.3 Monthly Safeguarding leads meetings between the safeguarding commissioners and providers continue, led by the Adult Safeguarding Nurse Specialist. These meetings provide an excellent forum to allow all the safeguarding leads to meet regularly, share information around national and local policy, share good practice, and to offer supervision. Consideration has been given to extending the invitation to these meetings to Local Authority colleagues, which has been well received.

9.4 Additionally 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.

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

9.6 The number of alerts that the CCG is made aware of continues to increase from services, in particular Learning Disabilities and Mental Health.

9.7 Robust links have been developing across the Dorset CCG and the Wessex Local Area Team, which allows for any safeguarding concerns within primary care to be highlighted and discussed appropriately.

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