

Meeting:	Brighton and Sussex University Hospitals NHS Trust Board of Directors
Date:	29th March 2016
Board Sponsor:	Chief Nurse
Paper Author:	Deputy Chief Nurse – Patient Experience
Subject:	Safeguarding Adults, Mental Capacity Act and Learning Disabilities

Executive summary

The purpose of this report is to appraise the Board of the main developments in the national and local safeguarding adults agenda since April; to provide assurance of how the Trust fulfils its statutory duties with respect to safeguarding vulnerable adults, including those lacking mental capacity and those with learning disabilities.

This report demonstrates that:

- Safeguarding adults and promoting their welfare continues to be addressed and developed in BSUH
- The Trust is committed to meeting the statutory requirements of the Care Act 2014.
- The Trust is able to demonstrate a safe service, acknowledges and addresses the challenges relating to safeguarding vulnerable adults.
- The Safeguarding adults team can demonstrate strong partnerships with the Local Authority, CCGs and Coroner's Office.
- The Safeguarding Adults Committee has continued with its responsibility to ensure that the internal governance arrangements.
- Learning from Safeguarding enquiries has led to improvements in practice and governance in relation to the Safeguarding Adults agenda in BSUH.
- Systems, processes and policies are constantly under review to ensure that they comply with local and national guidance

Links to corporate objectives	Describe how report supports the Trust corporate objectives: excellent outcomes; great experience; empowered skilled staff;
Identified risks and risk management actions	The purpose of this paper is to outline the local and national requirements in relation to safeguarding adults.
Resource	None

implications	
Report history	Safeguarding Adults 22 nd March 2016
Appendices	One

Action required by the Board

The Board is asked to discuss and note the report and the arrangements in the Trust to discharge its responsibilities in respect of safeguarding adults

Report to the Board of Directors, 29th March 2016

Safeguarding Adults, Mental Capacity Act and Learning Disabilities

1. Introduction

Adult safeguarding is the process of protecting adults with care and support needs from abuse and neglect and the key responsibility lies with Local Authorities (in partnership with the Police and the NHS).

On 1 April 2015 the Care Act (2014) came into statute in England. This includes statutory requirements in relation to Safeguarding Adults, for the first time in British law.

Requirements include to:

- Make enquires, or ensure others do, if it believes an adult is subject to (or at risk of) abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so by whom.
- Set up a Safeguarding Adults Board (SAB) with core membership from the Local Authority, the Police and the NHS (specifically the local clinical commissioning groups). The SAB can request membership by other relevant local organisations. This was already in existence in Brighton and Hove and West Sussex. These boards continue to have representation from all NHS providers including BSUH.
- The SAB has a strategic role that oversees and leads adult safeguarding across the locality. The main objective of the SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults at risk of abuse.

The three core duties of the SAB are:

- Publish a strategic plan for each financial year
- Publish an annual report outlining its achievements and objectives
- Conduct Safeguarding Adult Reviews (SARs) in accordance with Section 44 of the Act

The statutory guidance enshrines the six principles of safeguarding.

- 1) Empowerment presumption of person-led decisions and informed consent
- 2) Prevention it is better to take action before harm occurs
- 3) Proportionality least intrusive response, appropriate to level of risk
- 4) Protection support and representation for those in greatest need
- 5) Partnerships local solutions through services working with their communities
- 6) Accountability and transparency in delivering safeguarding.

Section 42 of the Care Act represents a major change in practice; moving from a process-led to a person centred approach, emphasising an approach based on risk assessment, which takes into account an individual's preferences, circumstances, and lifestyles to achieve a proportionate tolerance of acceptable risks to the individual.

This personalisation represents a major changes from process led to person centred enquiries. Practice now concentrates on the wishes of the vulnerable adult. The enquiry must be person led and outcome focused, there must be engagement with the adult and / or their carer , offering choice and control, leading to an improvement in quality of life, wellbeing and safety.

There are new duties for Safeguarding Adults Boards to work more closely and to share information to enable protection of individuals, all the Chief Executive officers of statutory

organisations in Brighton and Hove and West Sussex have signed an information sharing agreement.

This is consistent with the principles set out in the Caldicott Review published in 2013 ensuring:

- that Information will only be shared on a “need to know” basis
- Confidentiality must not be confused with secrecy
- Informed consent must be obtained, however if this is not possible or will put the person at further risk, it may be necessary to override this.
- Where an adult has refused consent to share information, the organisation must decide if there is an overriding public interest that would justify sharing the information, and where possible the Caldicott Guardian should be involved.

The statutory guidance requires organisations that are members of a SAB to identify ‘Designated Adult Safeguarding Managers (DASMs)’. In BSUH this is Director of Human Resources.

The DASM is responsible for:

- the management and oversight of individual complex cases
- coordinate incidents where there is an allegation made against a member of staff/ volunteer or student
- keeping in touch with counterparts in partner agencies
- highlighting how their organisation prevents abuse and neglect from taking place
- providing advice and guidance within the organisation
- referrals to the DBS and other governing bodies CQC/ GMC/ NMC/ HCPC
- Ensure systems are in place to support staff regarding investigations
- Recording systems are in place regarding decision making and recommendations
- Link with LADO (Local Authority Designated Officer)

Three additional categories of abuse in relation to adult safeguarding are identified in the Act; Modern Slavery, Domestic Abuse, and Self-neglect. ‘Organisational Abuse’ has replaced ‘Institutional Abuse’.

The Act introduced statutory Safeguarding Adults Reviews (previously Serious Case Reviews (SARs)) commissioned by SABs. Their purpose is to learn lessons, and thereby improve practice and interagency working. Agencies must provide information as required by SARs.

2. Safeguarding Adults in BSUH

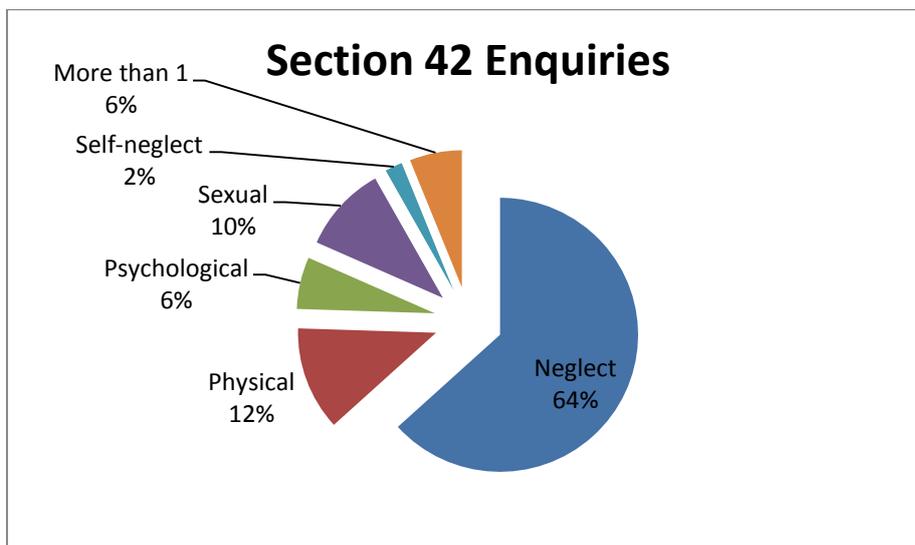
The Safeguarding Adults agenda is a key component of Patient Experience and Safety in BSUH. The Associate Director who led the safeguarding team left the Trust in June 2015. The Deputy Chief Nurse – Patient Experience is managing the team, which has been restructured to improve the education in relation to Mental Capacity (MCA), Deprivation of Liberties Safeguards (DoLS) and Mental Health.

The BSUH Safeguarding Committee meets on a quarterly basis, bringing together Safeguarding Children, Adults, Domestic Violence and Learning Disabilities, there is attendance from all the clinical directorates. The Deputy Chief Nurse is a member of both the West Sussex and Brighton and Hove Adult Safeguarding Boards and team members participate in sub committees of both Safeguarding boards.

Adult Safeguarding is a standing item on the agenda for monthly for the Practice Improvement Meeting and the Nursing and Midwifery Management Board. This concentrates on the learning from Safeguarding incidents and changes to practice and procedures including DoLS, MCA, Domestic Violence and Learning Disabilities.

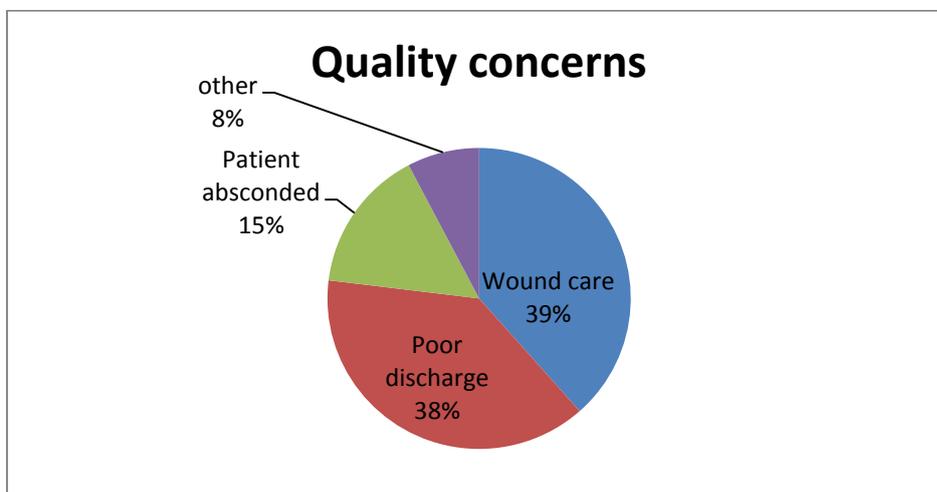
In practice there is often a between Safeguarding, Complaints and Serious/Moderate Incidents and as a result of learning from a complaint about Safeguarding procedures, the Serious Complaints and Safeguarding Meeting chaired by the Chief Nurse has been established, to ensure that these investigations run smoothly, that themes are identified (whether concerning a particular aspect of care or a particular clinical area) and lessons are learnt. In addition, the Deputy Chief Nurse attends the Serious Incident Review Meeting monthly and gives advice on an ad hoc basis to the Patient Safety Team

Safeguarding Activity April 2015- February 2016 - Section 42 Enquiries



Quality Concerns

The team also investigate concerns, not raised by the Local Authority as Section 42 safeguarding enquiries but referred as provider quality concerns. Themes are similar to those raised as Section 42 enquiries are usually of less severe impact or the patient has stated that they do not wish further investigation to be undertaken, however the BSUH Safeguarding team consider there will be lessons to learn.



Themes:

There were 54, Section 42 'cause to undertake enquiry' investigated by the team, this represents this is broadly similar in numbers to 2014. 64% of the allegations related to the category of neglect. Themes include discharge planning, in particular relating to poor communication of the patient's pressure damage and ensuring appropriate referrals were made to manage this on discharge. Additional themes related to poor nutrition and hydration and also poor oral hygiene.

The team investigated 13 quality concerns mostly relating to allegations of poor discharge planning including poor communication with family / care home staff; and also pressure damage / poor discharge relating to wound care.

There has been an increase in allegations against staff concerning sexual or physical assault, all but one have found no evidence of this. One allegation is currently part of a disciplinary investigation. Learning outcomes include the need to improve communication with patients with sensory and/or cognitive impairments particularly when carrying out personal care.

The Deputy Chief Nurse is working with HR to ensure that there is a fair and transparent process for all staff who have allegations made against them.

Achievements and Learning

A regular newsletter is now produced and circulated to all staff, this includes a 'Lessons Learnt' feature.

Raising awareness and supporting victims of domestic violence and abuse remains an ongoing area of focus. The Lead Nurse Safeguarding Adults and the Health Independent Domestic Violence Advisor (HIDVA) have provided training for HR and Occupational Health to recognise and respond to concerns where a member of staff may be the victim of domestic abuse.

Patients 1st Newsletter, produced by Patient Safety, in March 2016 is 'Sophie's Story', this highlights domestic abuse and actions undertaken in BSUH.

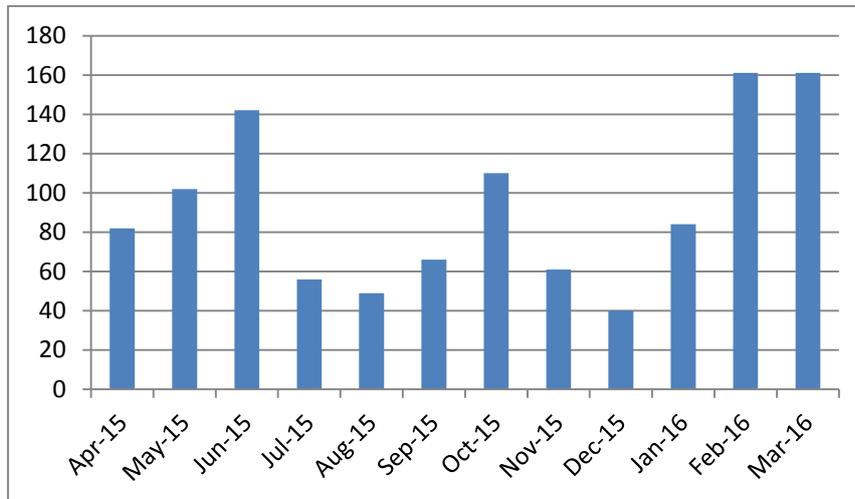
Following investigation of two safeguarding enquiries relating to discovery of unexplained bruising, a process has been developed to identify actions to be taken if unexplained bruising is discovered. Every adult ward have a laminated flow charts for ease of referral and this is included in the new Domestic Abuse Policy.

As a result of two safeguarding enquiries relating to poor mouth care a multi-disciplinary group is being established to improve the delivery of mouth care within the Trust. The first meeting of this group was scheduled for 21st March 2016.

Work to improve the way that safeguarding enquiries and concerns are recorded within BSUH has commenced. The DATIX system will be used to record safeguarding enquiries/investigations. The advantages of using DATIX is that additional documentation relevant to investigations documentation/photographs/statements can be linked and accessed on line and there will be easier, quicker interpretation of themes/trends, required actions/learning outcomes arising from Safeguarding enquires, that can be triangulated with other Patient Safety and Complaints data.

Training

Safeguarding Adults 2015-16 (including Voluntary Services)



Additional safeguarding adults training was provided to 130 medical students and 60 student nurses prior to undertaking placement within BSUH in November 2015
In addition to face to face training a workbook is available and an e-learning module is currently in development.

A recent pilot session for Bank only HCAs proved successful and will be rolled out further in 2016. The session focussed on safeguarding adults, supporting patients with a learning disability, 1to1 observation (specialling) and an introduction to the Butterfly Scheme to support patients with dementia.

All Nursing and Midwifery staff have Adult Safeguarding training as part of Trust Induction.

Policy

With the changes in the law there have been changes to BSUH policy

- The Safeguarding Adults Policy has been updated with the introduction of the Care Act and PREVENT
- The Policy for use of hand control mittens in adult patients was approved by the Clinical Policies Steering Group (CPSG) in November 2015
- The Domestic Abuse Policy was approved at CPSG in February 2016.

Working Partnership with the Local Authority

The Safeguarding Team are working in partnership with the Local Authorities in both Brighton and Hove and West Sussex, meeting monthly to review current Section 42 Enquiries and also discuss any themes or areas of concern. Both local authorities attend the BSUH quarterly Safeguarding Committee

The Lead Nurse Safeguarding Adults has recently participated in a Brighton and Hove multi-agency audit of safeguarding enquires where domestic abuse had been highlighted as a risk factor. The final report will be shared with the Brighton and Hove Safeguarding Adults Board in March. A multi-agency action plan will be developed following this.

Self- Assessment CCG

The Sussex CCGs Safeguarding Standards Assurance Tool was implemented in 2015. This tool will be completed annually and contributes to providing evidence of assurance in

conjunction with assurance site visits. The safeguarding adults and safeguarding children teams submitted evidence against the following standards:

Standard 1: Strategic Leadership

Standard 2: Lead effectively to reduce the potential of abuse

Standard 3: Responding effectively to allegations of abuse

Standard 4: Safeguarding practice and procedures

Standard 5: Staff competence

Standard 6: Safer Recruitment

Standard 7: Learning from incidents

Standard 8: Commissioning

Standard 9: Safeguarding data requested by Department of Health, LSCB

Safeguarding Adult Reviews

BSUH has a statutory duty to share relevant information with the Safeguarding Adults Board when requested to do so as part of a Safeguarding Adults Review. Since April 2015 BSUH have been requested to provide information as part of one SAR within Brighton and Hove and one SAR within West Sussex. The final outcome and recommendations are yet to be published by the Local Authority.

Deputy Chief Nurse will form part of a multi-agency SAR panel led by the Independent Chair for Brighton and Hove, this will sit for the first time in April 2016.

Prevent

Prevent is 1 of the 4 elements of CONTEST, the Government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.

Section 26 of the Counter-Terrorism and Security Act 2015 places a duty on statutory bodies, in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism".

Prevent is training aimed at recognising when vulnerable individuals are being exploited for terrorist related activities. Safeguarding Adults training in BSUH has included an introduction to Prevent since Jan 2014. A more detailed awareness programme – the Workshop to Raise Awareness of Prevent (WRAP) has been developed by the Department of Health to support awareness-raising in the health sector.

The Safeguarding Adults team have 2 members accredited by NHS England to deliver the approved WRAP 3 training content. Since Summer 2015, due to concerns about radicalisation within the local community, Brighton is classified as a priority risk area and as a WRAP is considered mandatory training for clinical staff. As such quarterly returns monitoring BSUH activity relating to Prevent are submitted direct to NHS England and shared with the local CCG.

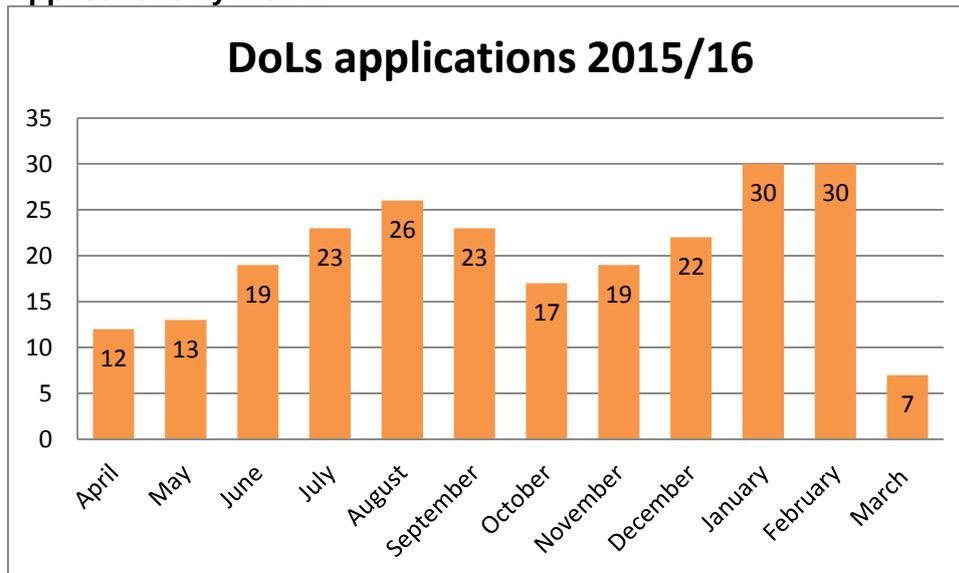
Since January 2016 to date, 152 clinical staff has attended WRAP. A programme of WRAP training is ongoing for 2016/17.

3. DoLS (Deprivation of Liberty Safeguards) activity 2015 – 2016.

There have been 241 BSUH DoLS applications from April 1 2015 – March 14th 2016, of which 22 are currently open.

- May 2014 – April 2015 **90** DoLS applications were made
- There were **95** applications from April 1st 2015 – September 30th 2015.
- **146** from October 1st 2015 – March 14th 2016

Applications by month



The 'Cheshire West' Supreme Court ruling happened in March 2014, which broadened the remit of DoLS, has resulted in a national increase in the applications.

Learning and Achievements

There have been key lessons learnt, leading to some training in specific areas.

'Messages of the week' have been distributed to all nursing staff as part of the Chief Nurse's weekly publication.

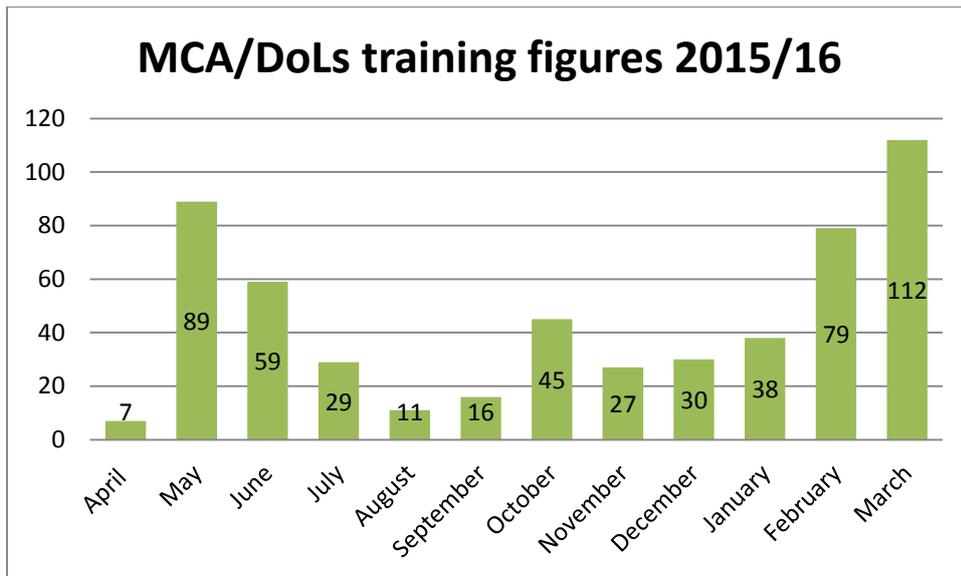
A 'DoLS process pathway' has been added to the Info-net page, as has guidance for staff on completing a DoLS application, to address confusion about the process and poor quality applications.

As part of the learning, members of the BSUH Safeguarding Adults team met Brighton and Hove H.M. Coroner. As a result of work in partnership with the Coroner's office there is a now established link with BSUH bereavement office for cross referencing when a patient subject to a DoLS dies, it is a requirement to report all such deaths to the coroner, as they are considered 'deaths in state custody'. A draft addition to the DoH DoLS guide for family and friends to reflect the need for the involvement of the Coroner is awaiting approval. A working party, chaired by the Deputy Chief Nurse, has been established regarding 1-1 Observations of patients. The MCA/Safeguarding trainer and the Head of Nursing-Patient Safety and Quality plan to conduct 'Ward Rounds' at both sites regarding the use of the 1-1 Pathway and the Observation Policy.

Together with the guidance for completing DoLS applications and the DoLS process pathway, strong links have been developed with the Local Authority DoLS offices.

MCA Training - internal

542 BSUH have received MCA / DoLS training from April 2015 – March 2016, **plus** joint training on Safeguarding Adults / MCA via Nursing & Midwifery inductions.



Ad hoc training has been provided post AAR to specific areas
 Training dates from April 2016 onwards have been sent to Communications for circulation

MCA Training - external

The Educator post is partially funded by Brighton and Hove CCG therefore there is a commitment to external partnership training. This includes GP Refresher Courses and delivery of full day training as part of the Sussex wide Joint Health Economy to a wide range of healthcare providers.

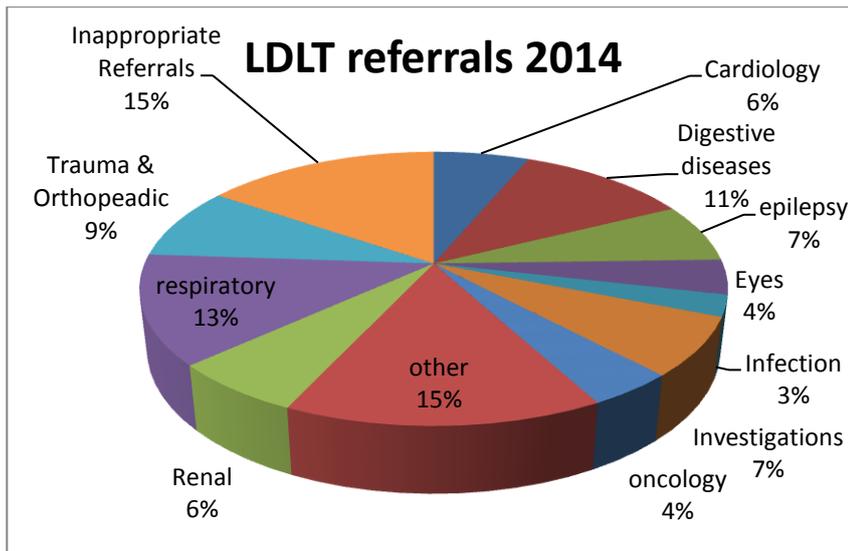
Policy

- Department of Health (DoH) guidance on DoLS (October 2015). This includes guidance to re-consider the appropriateness of a DoLS application in an end of life care. The MCA (including DoLS) policy is currently being updated and will reflect the need for case-by-case consideration of the meaning of the term 'non-negligible length of time,' especially in emergency setting and ITU.
- The new flow chart explaining the process for submitting DoLS paperwork has been added to the Mental Capacity Policy (to be approved at March CPSG)
- An updated policy for the Observation of Adult Patients with Mental Health problems was approved in May 2015, as part of learning from a Serious Incident.

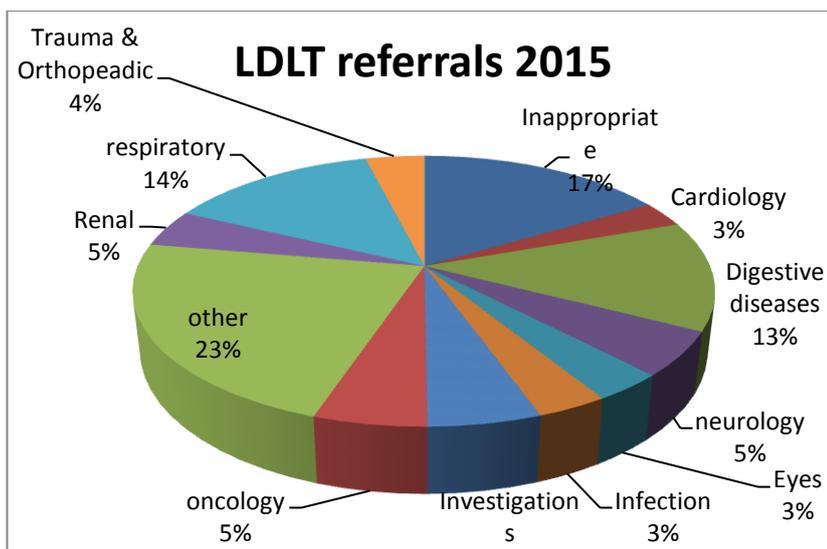
4. Learning Disabilities

Activity

Referrals for 2014: 269 inpatient and outpatient's support
 49 that were **not** People Learning Disability (PLD)
 10 PLD died in hospital



Referrals for 2015: 300 inpatient and outpatient's support
 59 that were **not** People Learning Disability (PLD)
 13 PLD died in hospital.



There has been a steady increase in referrals to the Learning Disabilities Liaison Team (LDLT) since the introduction of the service to BSUH in January 2009.

In 2014 and 2015, respiratory disease continues to be the most common single health need for PLD, closely followed by digestive diseases. This concurs with the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) report.

Inappropriate referrals account for approximately 20% of the total, these are people who do not have a diagnosed Learning Disability. LDLT will be providing information on "What is a learning disability", to assist staff in making appropriate referrals.

Training

- The LDLT work with the Safeguarding Team to provide training on the induction programme.

- There is monthly training provided for the HCA's on the Care Certificate programme.
- The LDLT provided monthly training on the MCA to nurses at the Children's Hospital during 2015
- Ad hoc Training will continue to be provided to all wards and departments on request.

Achievements and good practice

Pre- Assessment at the Hickstead Unit inform the LDLT of all elective admissions they assess. This allows plans to be implemented for individuals.

Level 9a have good knowledge and skills amongst staff in supporting people with a learning disability; the ward supported the review by Total Communication Charter assessors which led to BSUH being awarded gold standard for Inclusive Communication.

LDLT is now examining ways to capture data about the use of restraint with people with learning disabilities. National guidance from the DoH has outlined that restraints should be recorded on patient's notes.

In partnership with the community team on how we record reasonable adjustments for people with learning disabilities when accessing the acute service. Planning for electives support with the recognition, recording and provision of individual's needs but this can be problematic when attending outpatients for the first time or an emergency admission.

CIPOLD review

The Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD) was tasked with investigating the avoidable or premature deaths of people with learning disabilities through a series of retrospective reviews.

The LDLT have reported on how BSUH is implementing the recommendations from the report (Appendix 1)

Mortality Review

The mortality review for people with a learning disability as recommended in CIPOLD was undertaken in February 2016 by the Head of Nursing patient Safety, Chief of Safety and a Consultant Intensivist, supported by the LDLT. 12 people with a learning disability were reviewed who died in hospital 2015. The report when finalised will be presented at the Trust Mortality Review Group and The Safeguarding Committee.

Caroline Davies
Deputy Chief Nurse – Patient Experience
March 2016