Report to the Board of Directors, 30th March 2017
Safeguarding Adults, Mental Capacity Act, Learning Disabilities and Domestic Violence

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).

In April 2015 The Care Act (2014) came onto statute in England. This included 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 represented 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.

Practice now concentrates on the wishes of the vulnerable adult[1]. The enquiry must be person led and outcome focused, there must be engagement with the adult and / or their

[1] Vulnerable adult is defined as anyone over the age of 18 who is or may be in need of community care services by reason of disability, age or illness; and is or may be unable to take care of unable to protect him or

carer, offering choice and control, leading to an improvement in quality of life, wellbeing and safety.

The local Safeguarding Adults Boards have a statutory duty to work 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 Caldecott 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 Caldecott Guardian should be involved.

The Care Act introduced statutory Safeguarding Adults Reviews (similar to Serious Case Reviews for children) 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 Deputy Chief Nurse manages the team, who consist of a Lead Nurse for Safeguarding Adults, 0.6 wte Safeguarding nurse, a mental capacity and mental health trainer, who also leads on the Deprivation of Liberties Safeguards (DoLS). Affiliated to the team are an Independent Domestic Violence Advocate, who works at RSCH and is employed by RISE (a domestic violence charity) and the Learning Disability Liaison Nurses, who work in BSUH and are employed by Sussex Partnership Trust.

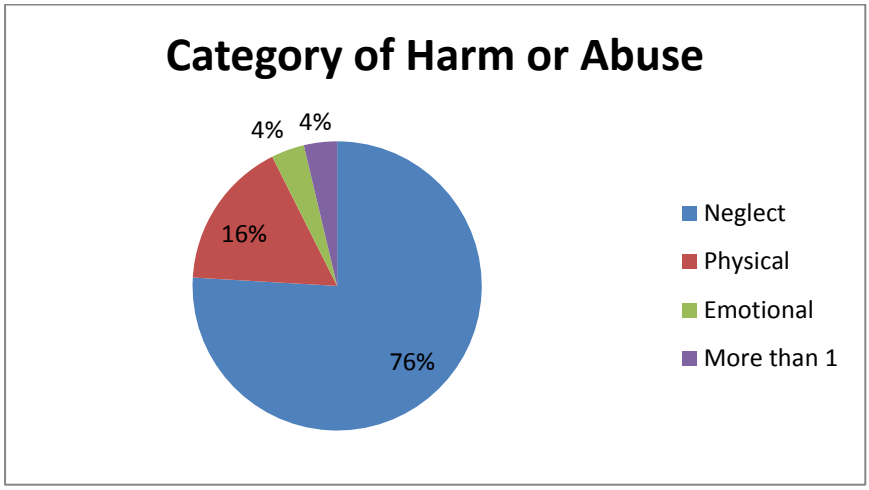
The BSUH Safeguarding Committee meets on a quarterly basis, bringing together Safeguarding Children, Adults, Domestic Violence and Learning Disabilities; there is attendance from all the clinical directorates. The Deputy Chief Nurse is a member of both the West Sussex and Brighton and Hove Adult Safeguarding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

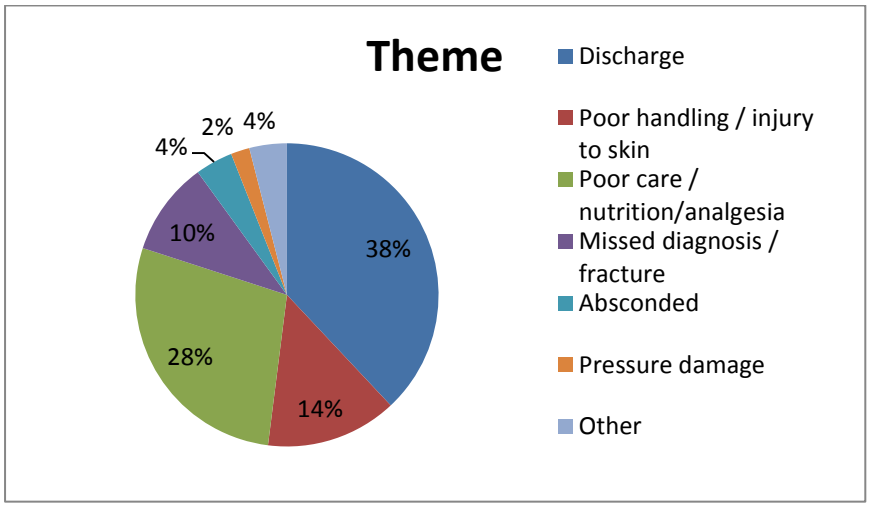
Adult Safeguarding is a standing item on the agenda for monthly for the Practice Improvement Meeting and the Nursing and Midwifery Management Board. This concentrates on the learning from Safeguarding incidents and changes to practice and procedures including DoLS, MCA, Domestic Violence and Learning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

In practice there is, in a number of instances, a link between Safeguarding, Complaints and Serious/Moderate Incidents. As a result the Deputy Chief Nurse attends the Serious Incident Review Meeting monthly, provides supervision for the head of complaints and gives advice on an ad hoc basis to the Patient Safety Team.

herself against significant harm or exploitation. Categories of abuse include; physical, psychological, sexual, neglect, self-neglect, domestic, financial, organisational, discriminatory and modern slavery.

Safeguarding Activity April 2016 to Feb 2017
Section 42 Enquiries





There were 50 Section 42 "Causing others to undertake enquiry" investigated by the team which is broadly similar in numbers to 2015/16 (54 cases in the same period of 2015/16). Discharge is a recurrent theme (38%) and the team work closely with Adult Social Care and the Head for Nursing for Discharge to review discharge practice. As an outcome from one Section 42 Enquiry relating to poor discharge, the patient's family provided photographic images of an elderly patients being discharged in inadequate clothing for the weather, which they offered to be used for training purposes. These have been used in multiple sessions for Nurses, HCAs and Doctors as an effective illustration of the lack of dignity in some of our practices.

Neglect (which often includes allegations of omissions in care or poor discharge) accounts for 76% of the allegations of abuse (compared to 64% in 2015/16). There has been a reduction in allegations about individual staff members in 2016/17 and one HCA was dismissed for alleged sexual abuse of a vulnerable patient, this individual was reported to the Disclosure and Barring Service (DBS) and is subject to an on-going police investigation. BSUH participated in the Safeguarding Adults Board (SAB) multi-agency "rough sleeper review" of homeless deaths in Brighton and Hove. Of the 20 people identified 18 were known to BSUH in the two years preceding their death. In addition to the "rough sleeper review", Brighton and Hove SAB conducted a statutory Safeguarding Adults Review following the death of Mr X. Both of these highlighted the complexities relating to the care and

safeguarding for people identified as homeless who have physical and mental health needs, and the difficulties of managing self-neglect.

BSUH is currently participating in the West Sussex SAB statutory review following the unexpected death of a patient at The Dene in Oct 2015. The patient had been discharged from BSUH four days prior to their death. A Serious Incident investigation was completed by BSUH in August 2016 and HM Coroner's inquest is expected to take place mid-2017. Whilst the patient had complex mental health needs, significant failings in the care provided by BSUH have been identified and an action plan developed to address these. The final SAB report is likely to be published in the summer.

Achievements and Learning

Mouth care

Following a Safeguarding Investigation at the end of 2015, a multi-disciplinary group was formed to improve the delivery of mouth care within the Trust. This steering group has been fully established for 12 months and BSUH has been successful in securing funding from Health Education England (HEE) to deliver an initiative called Mouth care Matters. This is a Health Education England initiative to improve the oral health of hospitalised adult patients. A Mouth Care Matters Trust Lead was appointed in November 2016. Baseline audits have been conducted and ward and classroom based training sessions on mouth care for nursing staff and over 800 members of staff have received this education. A new tool for Mouth Care Assessment has been introduced along with a referral system for Mouth Care Support. There is already clear evidence of improvements in practice and a further audit will commence in April 2017.

Domestic Abuse

In previous years Domestic Homicide Reviews highlighted the need to improve staff knowledge and skills regarding recognising and responding to domestic abuse. Raising awareness and improving practice was a key objective for 2016/17
Following the discharge of a patient who had been a victim of domestic violence, the Lead Nurse Safeguarding Adults and the Health Independent Domestic Violence Advisor (HIDVA) conducted an audit of the actions taken by BSUH. Their findings demonstrated the increased awareness and responsiveness of BSUH staff and have been presented at a safeguarding / domestic violence and abuse conference attended by both BSUH and external colleagues.

> *The victim was a male in his early twenties who required surgery for a fractured leg following an assault by his boyfriend. He was also noted to have a laceration to his head and bite marks to his arm. He was able to identify the assailant. He initially declined to access support as a victim of domestic violence whilst in the Emergency Department (ED) but subsequently discussed his circumstances with the nurse in Recovery over 24hours later. Several areas of good practice were highlighted:*
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> - *Response to the disclosure in ED – detailed documentation by the nurse to evidence the support offered and actions taken, and on-going conversations with the patient.*
> - *Response to the disclosure in Theatres Recovery – referrals made to both HIDVA and Safeguarding Adults Team to ensure follow up.*
> - *On-going support on the ward - nursing staff worked with both patient and HIDVA as part of discharge safety planning.*
> - *Making Safeguarding Personal – victim's wishes and choices were respected at all times with staff role modelling empowering behaviour.*

- *HIDVA support included work with victim to better understand abusive v healthy relationships. Also provided a greater awareness of support for male and LGBT victims.*

Safe Bathing

The Safeguarding Adults Team worked with the Patient Safety Team to develop a Trust wide policy on safe bathing following a serious incident where a patient with sensory impairment in their feet, sustained significant burns when their feet were bathed in hot water drawn from taps in a non-patient area. Water temperature is maintained at a much higher level than in patient areas to inhibit the growth of bacteria. This policy was implemented in December 2016.

Patients wandering from wards

Two safeguarding enquiries relating to patients under Deprivation of Liberty Safeguards (DoLs) were investigated in July 2016. Both patients left their respective wards (that were normally kept locked) without nursing staff being aware. It became apparent that visitors, voluntary staff and other members of Trust staff who were not aware of the needs of these particular patients had inadvertently left entrance doors open (or opened the doors for them). Vigilance in the observation of patients with dementia and/or on a DOLs has been incorporated into training. In addition, a simple advisory poster was developed to alert all visitors, staff and volunteers that their patients wore their own clothes and to check with a member of ward staff before letting anyone in or out of the ward. There have been no further incidents reported.

DATIX

Work to improve the recording of safeguarding enquiries and concerns on the Trust DATIX system commenced this year. This means that Safeguarding data can be triangulated with Patient Safety and Complaints. Additional documentation relevant to investigations, such as; reports, photographs and statements are now linked and can be accessed on line. Further work needs to be undertaken to enable a more detailed interpretation of themes and trends.

Training

Compliance with mandatory training for Safeguarding Adults stands at 72% (end of February 2017). This falls short of the Trust target for Stat/Man training compliance, however this is higher than for previous years and continues on an upward trajectory.

From Oct 2016 Nursing and Midwifery Induction has been extended to include a 'Safeguarding Day' which incorporates all the statutory requirements for both Safeguarding Adults and Children and Mental Capacity Act training. In addition, the day provides education from the Learning Disability Liaison Nurses and the Dementia Nurse Specialist.

A similar programme has been developed for the clinical mandatory safeguarding update training for 2017. The training is interactive involving group work and discussion, and is based on case scenarios from previous safeguarding enquiries. E-learning is also available should staff be unable to attend face to face sessions.

The Lead Nurse Safeguarding Adults has written a Learning and Development Strategy to be approved by BSUH Safeguarding Committee on 24th March 2017. The strategy identifies the different requirements for different staff groups and reflects the competences specified in the NHS England Intercollegiate Document and also the NHS England competences for Prevent.

Coastal West Sussex CCG undertook an audit of safeguarding adults training at PRH in January 2017. The audit focused on the competences required for Level 1 and level 2 training in line with the NHSE intercollegiate document, and was completed by observation of the training delivered as part of Nursing and Midwifery Induction. Feedback from the audit was positive with all competency requirements achieved. There were no actions required to improve the training but a recommendation given to improve the number of attendee evaluations completed.

Policy

There have been changes to BSUH policy

- The Mental Capacity Act policy (incorporating Deprivation of Liberty Safeguards) was approved in March 2016.
- The Safe Bathing of Patients Policy was approved in December 2016
- The Mouth Care for Adult Patients Policy is currently being drafted and will be presented at the Clinical Policies Steering Group in April 2017.

Working Partnership with the Local Authority Partnership working with the local authority

The Deputy Chief Nurse and Lead Nurse Safeguarding Adults work closely with the Safeguarding Adults Board (SAB) in Brighton and Hove and West Sussex to ensure that BSUH continues to meet its statutory requirements for safeguarding adults.

The safeguarding team regularly attend subgroups of the SAB:

- MCA and DoLS
- Quality Assurance
- Learning and Development

The subgroups have delegated statutory duties from the SAB with regard to multi-agency participation in case reviews, practice audits, development of multi-agency training, sharing learning and recommendations to improve safeguarding for the residents of Brighton and Hove and West Sussex.

Developments in progress

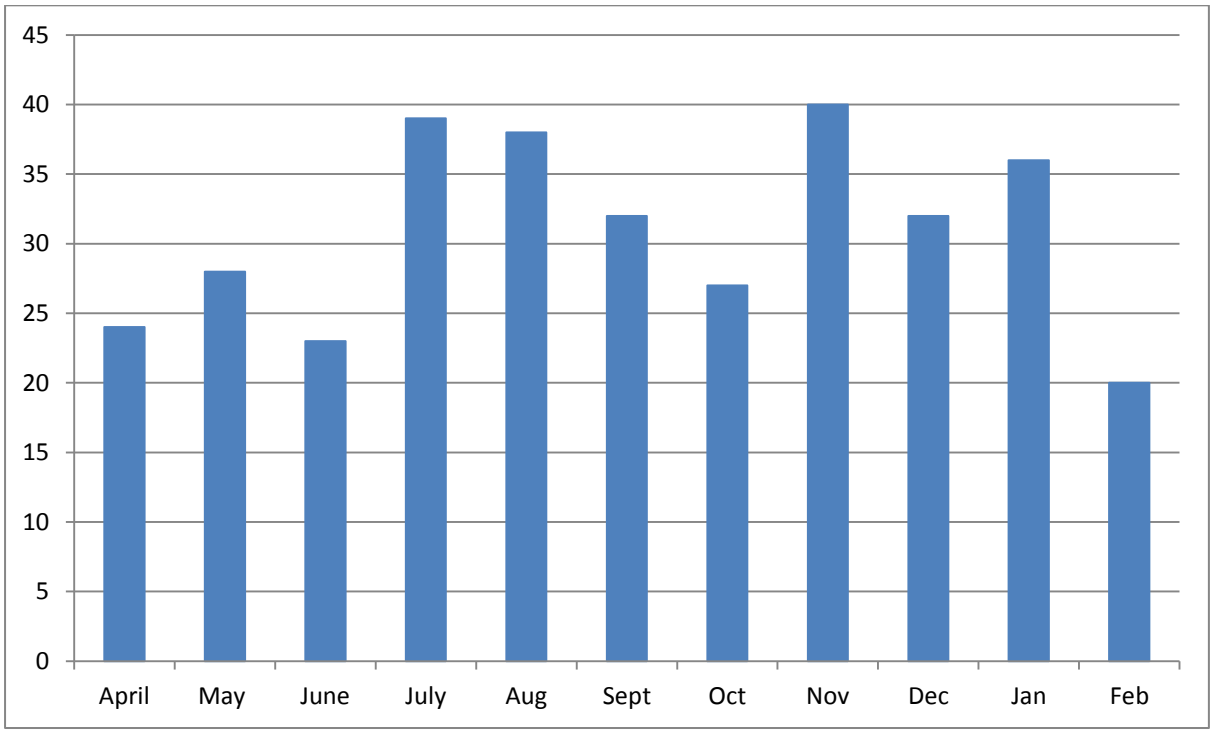
The Lead Nurse Safeguarding Adults has initiated a multi-agency working group with safeguarding colleagues in the CCG and Sussex Community Foundation Trust and other partner organisations to include RISE and Action on Elder Abuse, to raise awareness across Brighton and Hove as part of World Elder Abuse Awareness Day in June 2017
The safeguarding team continue to review and update training to reflect developments in legislation and also learning from safeguarding enquiries. In addition to Level 1 and Level 2 training, specialist level 3 training is to be developed and implemented in line with the learning and development strategy.

3. Mental Capacity and DoLS

Deprivation of Liberty Safeguards (DOLS) activity 2016-2017

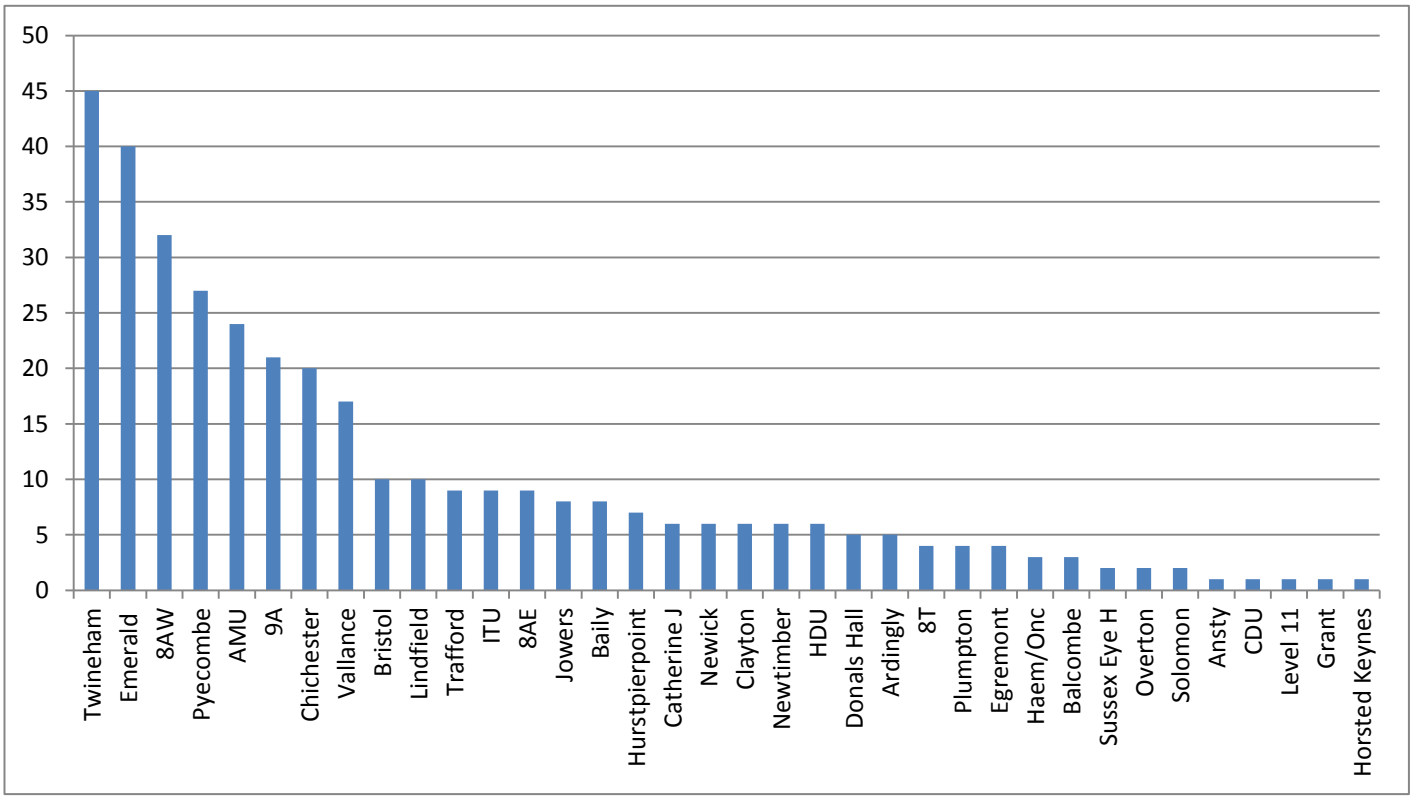
Between May 2014 and April 2015 BSUH submitted **90** DoLS applications
Between April 2015 and March 2016 BSUH submitted **241** DoLS applications
Between April 2016 and February 2017 BSUH submitted **339** DoLS applications

Deprivation of Liberty Safeguards (DoLS) BSUH by month



DoLS applications by clinical area

As awareness and understanding of the Mental Capacity Act and DoLS has improved,



BSUH has seen a year on year increase in applications to the local authority; this is a trend throughout England. In 2016/17 applications were most frequently made from the following specialities; ortho-geriatrics, dementia and neurosurgery.

Deprivation of Liberty Safeguards

Updates:

The Law Commission have reviewed the current DoLS regime. Proposed changes were announced in a draft Bill of Parliament on the 13th March. The review was prompted by the national increase in DoLS application and the volume of case law. Full implications of these have yet to be fully understood. However, it is likely that there will be changes to how DoLS applications are made in hospitals.

From Monday 3 April 2017 the Coroners and Justice Act 2009 will be amended so that people subject to authorisations under the DoLS) will no longer be considered to be state detention. The effect of this is that for any death that occurs on or after the 3rd April and where the deceased was subject to a DoLS authorisation the coroner will no longer have a duty to conduct an inquest in all cases.

The Court of Appeal ruling relating to the Ferreira v Coroner of Inner South London (January 2017) case has had an impact on ITU settings and this case is incorporated into up-to-date training.

A 'mock' DoLS application has been added to the DoLS intranet page, to assist staff to complete the referral to the Supervisory Body.

The specialist dementia areas at RSCH and PRH have received additional support and input from the Safeguarding team in the last 12 months regarding DoLS.

The Safeguarding team have continued to develop strong links with the local Supervisory Body's and attend the local MCA/DoLS sub-group quarterly

The lead nurse for Safeguarding Adults and the MCA/MH lead educator successfully completed Best Interest Assessor (BIA) training at Brighton University, qualifying as 'Health BIA's, and ensure their knowledge is up-to-date by attending relevant training provided.

Mental Capacity Act

Training:

Mandatory training compliance for the Mental Capacity Act is currently 70% for BSUH. This falls short of the Trust target for Stat/Man training compliance, however this is higher than for previous years and continues on an upward trajectory.

The need for a corresponding assessment of Mental Capacity regarding DNACPR decisions has been added to the training package delivered.

An application has been made to Training and Development to increase the mandatory training requirement from a one-off session to 3 yearly, in line with the Intercollegiate Document for Adult Safeguarding (2016) which recommends that all clinicians should have level 2 competencies every 3 years as 'Refresher training.' The team are currently awaiting estimates of the cost of an eLearning package and the financial implications for Learning and Development.

The MCA forms part of the revised Nursing and Midwifery induction, which has been audited by Coastal West Sussex CCG (please see Safeguarding section for details).

The post of MCA and MH lead educator is partly funded by Brighton and Hove CCG therefore has a commitment to external partnership training. This includes the delivery of full day training as part of the Sussex wide Joint Health Economy to a wide range of healthcare providers. This funding finishes at the end of March 2017.

In the new financial year, The MCA and MH lead educator will be delivering Mental Health Act training to BSUH, as well as working with the Deputy Chief nurse to develop BSUH's response to 'Treat as One' (NCEPOD 2017). This report lays out requirements to bridge the gap between mental and physical health in the acute hospital to ensure that high quality mental health care is provided. There will be significant education and training implications. The Safeguarding team provide training to BSUH Health Care Assistants as part of the Care Certificate, in the areas of Safeguarding Adults, raising awareness and reducing stigma around mental health and also training in 1-1 care ('specialling').

Clinical updates/learning/achievements

The Safeguarding team have been involved in clinical situations involving supporting clinicians through the MCA process.

The team have responded to a number of situations on the Neurosurgery Ward supporting the MDT regarding a complex MCA issues. The outcomes have been deemed the best possible by all involved.

The Safeguarding team have been involved in the After Action Review (AAR) following a number of assaults against staff on the Acute Medical Unit at RSCH by patients who are in acute alcohol withdrawal and lack capacity to understand their treatment needs. The MCA/MH lead nurse has led to a working party with Pavilions (the provider of local alcohol and drug series), pharmacy, senior nurses and a clinician to review the Trust's alcohol withdrawal pathway. The plan is to introduce evidence based practice to reduce the risk of further incidents, and to improve knowledge/understanding of the patient group of the ward as a whole.

4. Learning Disabilities

The Learning Disability Liaison Team (LDLT) has undergone significant changes in 2016/17, during most of the year there has only been one nurse in post. Since February 2017, there is 2 wte working across BSUH

Mortality Review

The mortality review for people with a learning disability was recommended by The Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD 2010 - 2013) and following the premature deaths of people with mental health problems and learning disabilities in South Health (December 2015) recommended that there is a national programme of mortality reviews for people with learning disabilities. In BSUH these are now undertaken regularly and reported to the Trust Mortality Review Group.

December 2016 the LDLT and the Chief of Safety reviewed the deaths of 6 people with learning disabilities, who died in BSUH in 2016.

The review assessed the notes based on the following criteria

NCEPOD classification

2 = a. good practice
1 = b. room for improvement (End of Life care plan)
2 = c. Room for Improvement (Organisational Care)
1 = d. Room for Improvement (Clinical and Organisational Care)

Throughout the case notes there was evidence that discussion with families were taking place, with best interest decisions being taken. DNACPR forms were completed for each patient, each documenting the involvement of family members.

Learning

There needed to be better integration so that advice from the LDLT is followed. The team are working with Twineham ward and MSK directorate to promote our services and to share our learning about the case.

LDLT need to work alongside BSUH to ensure MCA assessment is being appropriately considered for people with learning disabilities with evidence of capacity assessment being documented. Finding the evidence of this in the medical notes is difficult. The LDLT will develop a capacity assessment form for people with LD, to assist clinicians.
As part of the LDLT, the liaison nurses continue to work closely with BSUH to ensure DoLS is considered and implemented for people with a learning disability when appropriate.

5. **Domestic Violence**

Background

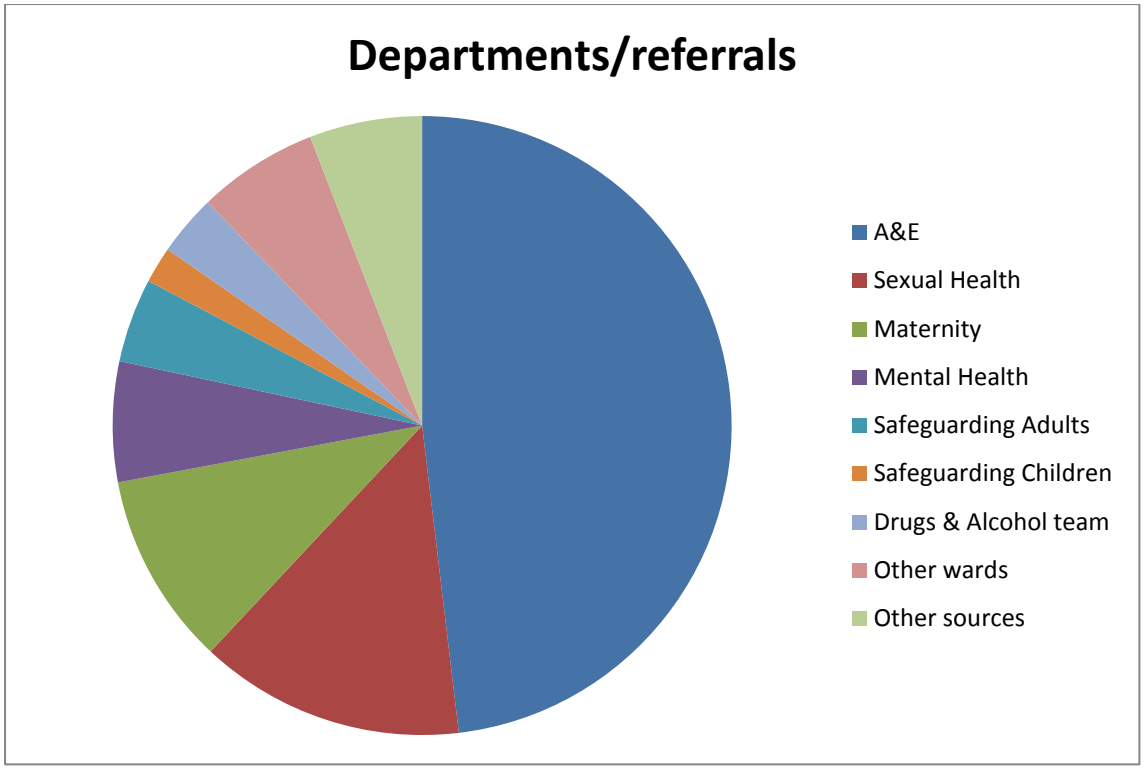
The Health Independent Domestic Violence Advisor (HIDVA) is employed by RISE and is based at RSCH five days a week (Mon –Fri) to support people identified as experiencing domestic violence and abuse (DVA) in Accident and Emergency (A&E), Maternity and Sexual Health Clinic.

HIDVA provides training and consultancy for staff working in three target departments.
The post is being funded by the Clinical Commissioning Group (CCG).

Service Data and Outcomes for Apr '16 – Feb '17.

REFERRALS
Number of referrals received:
TOTAL to HIDVA service – 158.
Total in the last financial year (2015/2016)– 192;
Total in the previous financial year (2014-2015) – 80.

Numbers of referrals by different departments:
BSUH A&E - 76
BSUH Sexual Health Service - 22
BSUH Maternity - 16
BSUH Mental Health Team - 10
BSUH Safeguarding Adults Team - 7
BSUH Safeguarding Children Team - 3
Drugs and Alcohol Team - 5
Other wards – 10
Other sources (self, RISE) – 9



124 (78.5%) patients engaged with HIDVA service. All those who have engaged received safety advice according to the risks/needs disclosed and those wishing further support were linked with the wider specialist service. In more complex cases HIDVA took an active part in developing a safe discharge plan and liaising with specialists in BSUH and the community.

44 (27.8%) were identified as high risk of harm from domestic violence and abuse.

It has been noted that HIDVA (in comparison with the rest of RISE team) has been receiving more referrals for DVA victims who are 65 and older – 15 referrals last year. This helped to identify a need for specialist support and closer links with adults' social care and a new post for older person's domestic violence worker has been created and the specialist has been placed with Adult Social care in Brighton and Hove and East Sussex.

Current challenges

At the end of the financial year there is a noticeable a reduction in referrals, this may be accounted for by the demand in the A&E department (A&E being the main referrer) and lack of DVA training. There are plans to ensure that A&E staff receive domestic violence training on their team days.

It has been noted that staff from other BSUH departments are becoming aware of the HIDVA post and started seeking support for their patients by contacting HIDVA/making referrals. The HIDVA can advise but does not have the capacity to support these departments.

Case study

The referral came from A&E staff when they became concerned about a young adult female patient from a BME community. The patient was unresponsive due to a psychotic episode believed to be caused by an argument with her father over an acquired mobile phone. The staff was also concerned that the parents were constantly by the patient's side unwilling to let the staff to see the patient on her own.

HIDVA worked closely with MH liaison team at the hospital. They already had some information about the family from a previous engagement. The notes left by the professionals on the patient's files mentioned controlling nature of the father's involvement in his daughter's treatment. The father minimised the incident and the state his daughter was in.

MH liaison team made the decision to section the daughter for her health and safety. The Safeguarding Adults team intervened and informed the parents that they will have to let the staff see their daughter on her own.

When the patient was transferred to a specialist hospital, HIDVA visited the patient, listened to her views and wishes, and spoke to the staff. From the information shared by the patient and the staff, after consultation with her Line Manager, HIDVA assessed the patient as being at high risk of harm from domestic violence and abuse and completed a Multi-agency Risk Assessment Conference referral (MARAC).

At the MARAC agencies have been alerted of the vulnerabilities of the client and a plan has been put in place to insure that she gets the best treatment and support needed and her views are being heard.

6. Priorities for 2017/18

- To ensure full implementation of the learning and development strategy and increase the training attendance to the Trust target.
- To develop further work on the DATIX system to enable learning from themes and trends.
- To review the team structure ensuring that it is fit for purpose and develop formalised working with the Safeguarding Children's team, given the number of areas in which there is an overlap, e.g. domestic violence, modern slavery and female genital mutilation.
- To implement findings of the Law Commission review into DoLS, Treat as One (NCEPOD) and the National Mortality Review for People with Learning Disabilities.
- To work with partners in Brighton and Hove to develop integrated working across the city for people who are homeless and for those who self-neglect.

Caroline Davies
Deputy Chief Nurse
March 2017