NHS Herts Valleys Clinical Commissioning Group

Board Meeting In Public

5th November 2015

Title	Safeguarding Adults at risk from abuse Annual Report	**Agenda Item: 10.2**
Purpose (tick one only)	Approval ☐ Discussion ☐ Information ☒ Consideration ☐ Noting ☐	
Responsible Director(s) and Job Title	Diane Curbishley – Acting Director of Nursing and Quality	
Author and Job Title	Tracey Cooper - Head of Adult Safeguarding	
Recommendations/ Action Required by the Committee	To note this report	
Classification *Is this report exempt from public disclosure? (ie. FOIA or DPA)*	No	
Impact on Patients/Carers/Public	The report provides a review of the previous 12 months	
Engagement with Stakeholders/Patient/Public	None	
Links to Strategic Objectives	**Objective 2**: To improve the quality of services and deliver better patient outcomes and experience	
Board Assurance Framework *Does this report provide evidence of assurance for the Board Assurance Framework?*	2.1 Risk that we do not deliver on all NHS Constitutional pledges, key national targets and priorities	
Does this report mitigate risk that is included in the Corporate Risk Register?	No	
Resource Implications	Not applicable	
Equality and Diversity (Has an Equality Analysis been completed?)	There are no implications	
Legal/Regulatory Implications	To comply with legal requirements of The Care Act 2014	
Sustainability Implications	Not applicable	
NHS Constitution	**Principle 3:** The NHS aspires to the highest standards of excellence and	

	professionalism **Principle 4**: The NHS aspires to put patients at the heart of everything it does
Report History	Quality and Performance Committee – 30th July 2015
Appendices	None

NHS
Herts Valleys
Clinical Commissioning Group

NHS
East and North Hertfordshire
Clinical Commissioning Group

HERTFORDSHIRE SAFEGUARDING ADULTS ANNUAL REPORT 2014/15

Contents

1. Introduction

The purpose of this Annual report for 2014 - 2015 is to assure the Board of the progress the CCG has made in relation to adult safeguarding and outline the priorities for 2015/16. It will also provide assurance that the Head of Adult Safeguarding is actively leading the delivery of HVCCG safeguarding adult responsibilities and will inform the committee of any gaps and the measures being taken to address these.

2. Head of Adult Safeguarding

The key areas of focus of the Adult Safeguarding work programme for 2014 – 2015 included;

- Developing a CCG strategy, to set out the CCGs priorities and deliverables for adult safeguarding
- Providing General Practice adult safeguarding education
- Monitoring and reporting on provider's safeguarding adult activity and performance
- Leading the health aspect of adult safeguarding investigations
- Leading the agenda on domestic abuse

3. Hertfordshire Safeguarding Adult Board (HSAB)

The Care Act 2014 places Safeguarding Adults Boards on a statutory basis, similar to Safeguarding Children Boards, and will require each Board to produce an Annual Report in consultation with their local community/ies which will have to be presented to specified bodies, including the local authority and the local Health watch, as part of a process of scrutiny and accountability.

The eighth and final HSAB Annual Report to be written in its current format was published in October 2014. The report contained the agreed Strategic Objectives which formed the basis of a new three year Business Plan, 2014 - 2017 which had been developed by the CCG and other statutory partners. The HSAB is compliant with the Care Act.

In January the HSAB participated in a topic scrutiny session with members of the County Council including the CCG Director of Nursing & Quality and the Head of Adult Safeguarding. The table below sets out a number of observations and recommendations which were made following this process. These will be monitored by the Scrutiny Committee of the County Council and reported to the HSAB.

Recommendations:	**Outcomes/further action:**
• To be kept informed of progress in implementing the Care Act requirements and the financial situation of the board.	• For the Independent Chair of the HSAB to action
• To be advised of the outcomes of	• For the Independent Chair of the HSAB to

the HSAB Away Day on 24 April. • That a scrutiny of HSAB becomes an annual scrutiny, mirroring that of the HSCB, commencing in June/July 2016. • To provide members with a structure chart of HSAB showing how members and activities fit together.	action • For HCC Head of Scrutiny to implement and provide the HSAB with an outline of the programme in advance • For the Independent Chair of the HSAB to action

A statutory Strategic Safeguarding Adult Board has been established made up of the core membership identified in the Care Act legislation. This board will provide direction to the Safeguarding Adults Operational Board. The CCG is represented on both of these boards.
In February 2015 the Hertfordshire Safeguarding Adult Board (HSAB) successfully recruited an Independent Chair for a one year term that commenced in March and agreed the funding of the boards activities for the year.

4. Internal audit

Adult safeguarding went through an internal audit in July 2014 and was rated as amber / green. There were a small number of medium and low risk recommendations in relation to having the draft strategy ratified and HSAB activity which included:

- Complete and sign off the adult safeguarding strategy
- Complete GP adult safeguarding training
- Update CCG risk register

These recommendations have now been completed.

5. Serious concerns

The Head of Adult Safeguarding working in partnership with the Local Authority Head of Adult Safeguarding reviewed the serious concerns process of the HSAB multi-agency policy and produced a draft version. A work shop was then held with key partners and the CCG was represented by the Director of Nursing & Quality and the Heads of Adult Safeguarding and Quality Improvement. Following the workshop the Head of Adult Safeguarding produced a further version of the serious concerns process which was agreed at a second workshop. The new policy has now been signed off by the HSAB.

The following are systems and processes developed as part of the serious concerns process to monitor quality, contract compliance and to support provider improvement.

Improving the quality of care needs to be addressed on three fronts.

I. **Preventative activity**: Developing a care and support market economy that delivers care to required standards.

II. **Pro-active work:** Supporting improvements and raising standards through identifying and tackling emerging concerns in the quality of care and support.
III. **Responsive work**: Collaborative and assertive approaches to managing concerns when the care provided by a service to adults who are at risk of harm is causing them to experience, or be at risk of, abuse or neglect. This initiates the serious concerns process

This process is used for services which are regulated by the Care Quality Commission (CQC) and for care and support services that are not regulated but provide a service to adults at risk of harm, for example day services.
The process applies to both health and social care provision; it includes concerns about NHS providers, independent hospitals, and services directly delivered by HCC.

The serious concerns process provides an overarching framework which will ensure a coordinated response with:

- All aspects of the investigation planned
- Organisations and individual professionals clear about their respective roles and responsibilities

There have been 5 care homes and 2 home care providers within Herts Valleys subject to the serious concern process in 2014-2015. This compares with 7 residential homes and 5 nursing homes in the serious concerns process in the 7 month period September 2013 – March 2014.

The reduction in the numbers is due to work described earlier and will be followed up through the Strategic Quality Improvement Group which has been formed by the Head of Adult Safeguarding and Head of Quality Improvement in partnership with colleagues from the Local Authority, Police and Care Quality Commission. The purpose of this group is to establish and maintain a multi-agency coordinated approach to the safeguarding and quality agendas to support the commissioning of care home and home care services across Hertfordshire. The group is chaired by the Head of Adult Safeguarding and the objectives of the group are:

1. To develop and implement a proactive partnership approach to strategic quality monitoring which is based upon benchmarking and clinical evidence.

2. To provide an oversight of the care home and support at home market by effectively sharing information across relevant health and social care services to prevent provider failure.

3. To share responsibility and set goals for quality and service improvement throughout the care home and support at home market in Hertfordshire.

4. To share and deploy resources and processes across health and social care in pursuit of quality improvement

5. To own, manage and mitigate as far as possible commissioning risks with regards to provider failure and the responsibilities under the Care Act 2014.

6. To ensure effective decision making and accountability for the agreed actions

7. To provide direction and guidance to the contracting monitoring / CQC group.

8. To escalate concerns to relevant boards

9. Develop a system of learning and improvement in response to thematic concerns

The table below outlines some of the issues and interventions that form the basis for the Serious Concerns investigations. The homes are required to produce and implement an action plan which is monitored by CCG, CQC and HCC staff.

Type of service	Overview of concerns	Outcome
Care mark Home Care Provider	• Poor care planning • Complaints management • Non-compliance with 3 CQC regulations • Incidents not being escalated	• Serious concerns process September – March now closed • CCG Clinical Quality Improvement Lead has visited the Head Office to review care plans and improvement. • New manager appointed • Additional visits undertaken by HCS and CCG Clinical Quality Lead to assess standards of care plans • Phased increase in packages of care • Improvement in staffing levels, care plans and training
St. Agnells, Care Tech Learning Disability Residential Care	• Whistleblowing allegations regarding care of residents • Auditing of training • Deprivation of Liberty Safeguards (DoLS) issues • Financial irregularities	• CCG Head of Adult Safeguarding undertook an early morning unannounced visit to the home to check whether staff were getting the service users up at an appropriate time • Serious concerns process from February to June 2015 • Training and financial audits undertaken by HCS • Service improvement plan in place monitored by LA commissioners and Community Learning Disability Team
The Lodge Residential Care	• Lack of person-centred care approaches • Poor quality of care delivery to service users including a large number of service users who lack mental capacity and are not able to	• Medicines management training provided by Head of Quality Improvement • Clinical risk assessment training provided by Head of Quality Improvement

Type of service	Overview of concerns	Outcome
	articulate their needs. • Medication management	• Weekly visits and out of hours visits by HCS and Head of Quality Improvement and Head of Adult Safeguarding • Care planning training for all staff Head of Quality Improvement, provided by to improve understanding of patients needs • Inappropriate placements moved in collaboration with HPFT. • Serious concerns process lifted November 2014. • Outcome: staff more confident and systems and processes in place.
Lawn Lane, Local Authority in-house provider	• Financial irregularities • Poor leadership • Lack of systems and processes	• Serious concerns process commenced February 2015 and completed in June 2015 led by HVCCG • HCS finance undertook audit of service users • Review finances of service users • View sought from Police regarding potential charges • CCG Head of Adult Safeguarding and Assistant Director of Health Integration met with HCS Operations Director to discuss the quality issues and performance of Head of In-House Service provision
Bournhall Ave, Local Authority in-house provider	• Confidence in the management on site • General engagement with service	• Serious concerns process commenced February 2015 and completed in June2015 led by HVCCG

Type of service	Overview of concerns	Outcome
	users • Lack of offering choice • General poor practice which includes no handovers between shifts and a divided team • Poor communication between staff.	• Visits undertaken by Community Learning Disability Team and the Operations Director • CCG Head of Adult Safeguarding and Assistant Director of Health Integration met with HCS Operations Director to discuss the quality issues and performance of Head of In House Service provision.
Helping Hands LTD (Watford) Home care provider	• Non – compliance with CQC essential standards including safeguarding adults • Training • Care planning • Management of complaints • staffing	• CQC contacted all service users • Head of Adult Safeguarding ensured that CHC reviewed services users • Serious concerns process March - September now closed • Financial reviews by LA • Police undertook financial checks
Priory Grange Nursing Home	• Staffing • Training • Care delivery and planning • Environment	• Serious concerns process March – June now closed • Head of Adult Safeguarding and the Head of Quality Improvement visited the unit a number of times during transition of services to ensure that a quality service was being delivered. • Unit for physically disabled closed and patients transferred to appropriate establishments. • New unit where 8 patients were transferred was visited by CCG Clinical Quality Improvement Lead to assess quality • Continuing Health Care followed up patients funded through CHC

Type of service	Overview of concerns	Outcome
		• Full contract visit to new unit

6. NHS Serious Incidents

There have been 25 safeguarding adult serious incidents reported by NHS Commissioned services 2014 - 2015. The serious incidents are reviewed by the Head of Adult Safeguarding who also attends provider organisations safeguarding adult committee's to discuss these serious incidents and review the implementation of the identified learning.
In previous years the number of serious incidents in relation to adult safeguarding incidents has been significantly higher as grade 3 and 4 pressure ulcers were routinely declared as serious incidents and also investigated under the safeguarding procedures. As a result of this the Head of Adult Safeguarding developed practice guidance for when a pressure ulcer should be investigated under the adult safeguarding procedures as well as a serious incident and this now forms part of the Hertfordshire Safeguarding Adult Board policy.

The table below sets out the overview of the incidents for each provider.

Provider	Type of incident	Actions / learning
HCT 10 serious incidents	Unexplained bruising x1	Family and carers to always be informed of any injuries Individual members of staff received supervision of practice
	Medication management x 3	Care home discharge checklist developed by CCG Head of Quality Improvement OOH Specialist Palliative Care Nurse available at weekends
	Allegation of neglect x 2	Therapy staff to have reflective session
	Unexpected death by suicide	Case being reviewed under the HSAB safeguarding adult review policy
	Pressure Ulcer care x 3	A Standard has been set that full core assessments will be completed within 24 hours. Care plans should be reviewed following any change in a patient's condition. Review undertaken of pressure ulcer relieving documentation
WHHT 9 serious incidents	Allegation of abuse by nursing staff x 3	The ward to have a dementia champion The need of accurate record keeping reinforced with staff
	Pressure ulcer management	Need to make safeguarding referrals within timescales Need for clear care planning
	Restraint of patient lacking capacity	Audit of MCA practice undertaken by Director of Nursing Audits and action plan reviewed by CCG Director of Nursing & Quality and Head of Adult Safeguarding Training commissioned by CCG Head of Adult Safeguarding as part of MCA action plan
	Medication management	Standardised induction programme for agency staff

Provider	Type of incident	Actions / learning
		Wards to keep a central log of agency staff who have been assessed as competent
	Vulnerable patient absconded	Discharge Lounge systems and processes changed to improve communication with ward staff
HPFT 5 serious incidents	Suicide whilst under the care of the Care and Treatment Team	Awaiting action plan and final report
	Attempted suicide whilst an inpatient	Review of ward ligature risk assessment and management plans. Adequate multidisciplinary input into patient assessments
	Pressure ulcer management	All staff to be trained in pressure ulcer management Service evaluating the on-going specialist support for physical health needs
	Unexplained fall resulting in fracture	Awaiting final report
	Assault on a member of staff	Evidence seen on CCG Quality visit that risk management being put in place.

7. CCG Strategy

The Head of Adult Safeguarding has developed a CCG adult safeguarding strategy which has been shared with key partners. The aim of the CCG strategy is to:

- Keep people safe and free from potential or actual abuse or neglect
- To be a leading county in adult safeguarding

The vision is to support and embed adult safeguarding processes within all the commissioned services, and to embark on a programme to sustain and improve adult safeguarding in line with the Commissioning Strategy and local priorities related to adult safeguarding and the Care Act 2014. The strategy was ratified at the CCG Board meeting in November and an action place was developed and will be ratified by the end of June 2015.

8. GP training

The Head of Adult Safeguarding completed a programme of GP training to a number of clinical staff from each practice within the 4 localities. As part of this work a register of GP Safeguarding Leads is now in place and will be reviewed annually.

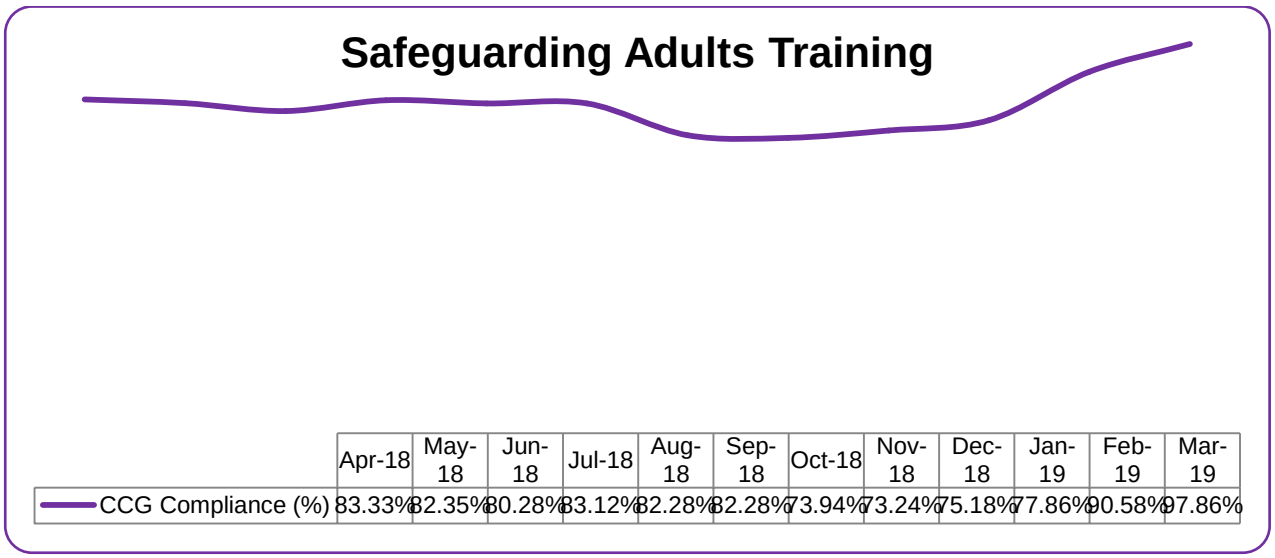
9. CCG staff training

As part of mandatory training all CCG staff are required to complete the safeguarding adult training module and safeguarding adult training is delivered by the Head of Adult Safeguarding as part of the induction programme 6 times a year.

10. Directorate Compliance Rate Tracker

Compliance with Safeguarding Adults training declined from October 2014 due to the transfer of around 60 CSU staff into the CCG and agency/interim workers on assignments lasting 6+ months being required to undertake training. There was various restructures that took place during 2014 – 2015.

Directorate	Compliance rate
Finance	100%
Nursing & Quality	100%
Communications	100%
Board	85%
CHC	54.55%
Contracting & Resilience	83.33%
Corporate Services	100%
GP Leads	33.33%
Human Resources	100%
Medicines Management	92.86%
Strategy	100%
Planning & Performance	100%



11. Prevent

Prevent is one strand of the Government's counter terrorism strategy and Channel is a multi-agency approach to identify and provide support to individuals who are at risk of being drawn into terrorism and forms a key part of the Government's Prevent strategy. The health sector has a non- enforcement approach to prevent and focuses on the protection for vulnerable individuals. Heath care professionals may meet and treat people who are vulnerable to radicalisation. The key challenge for the health organisations is to ensure that, where there are signs that someone has been or is being drawn into terrorism; health care workers can interpret the signs correctly, are aware of the support that is available and are confident in referring the person.

NHS England have developed a Prevent Training and Competencies Framework which will enable a consistent and proportionate approach to Prevent awareness raising throughout the NHS. In response to this framework the Head of Adult Safeguarding who is the CCG Prevent Lead, received training from the Hertfordshire Constabulary's Prevent Lead and then provided Prevent basic awareness training as part of the induction programme as well as basic awareness training for existing staff, between October and March via team meetings. The rate of compliance at the end of March 2015 for CCG was 77%. The Head of Adult Safeguarding will continue to provide this training for the remaining staff through learning lunches.

The Counter Terrorism and Security Bill received Royal Assent on Thursday 12 February and places Channel on a legislative footing as part of this Act, and comes into force on 12 April. Channel is intended not only to prevent terrorism but to protect people who are vulnerable to being drawn into terrorism. Both the Safeguarding Children's team and the Head of Adult Safeguarding are members of the Channel panels. The Channel Panel meets monthly to discuss individuals who have been referred as being at risk of radicalisation and require protection plans to be put in place. At the end of March 2015 there were 4 protection plans in place and 10 referrals for discussion by the panel. Interventions range from treatment

for Post Traumatic Stress Disorder and referral to Childrens Services. The role of the CCG Prevent Lead is to ensure that NHS provider services undertake any required actions and to advise on adult safeguarding issues.

12. Domestic Abuse

A review was undertaken by Co-ordinated Action Against Domestic Abuse (CAADA) commissioned by the Police and Crime Commissioner, the Domestic Abuse Strategic Programme Board and the County Community Safety Unit to undertake a review of service provision for domestic abuse in Hertfordshire.

The CAADA report was received by the Police and Crime Commissioner and the Domestic Violence Strategic Programme Board in December 2014. The report highlighted a significant number of issues relating to commissioning of services especially Independent Domestic Violence Advocates, the role and function of the Strategic Board, and referral pathways. A working group was formed and an action plan developed which included:

- Developing the vision and structure of the board
- Development of strategic objectives
- Identifying work streams and how these will be taken forward
- Establishing governance and assurance systems and processes

An Executive Domestic Abuse Board is now place and the CCG is represented by the Director of Nursing & Quality. The Head of Adult Safeguarding is the CCG representative on the operational Domestic Abuse Partnership Board and the Vice Chair of the Domestic Homicide Review sub group and is leading the review of recommendations and actions from domestic homicides to establish themes and trends which can guide the development of strategic objectives and service improvement. The Head of Adult Safeguarding is also part of the Commissioning sub group and has successfully recruited to a Senior Commissioning Manager within the Local Authority who will work with the Commissioning Group to procure and commission a robust Independent Domestic Violence Advocate Service as a priority. The Head of Adult Safeguarding will develop the quality measures as part of this process.

13. Domestic Homicide Review

There was one domestic homicide review commenced in 2014 - 2015 following an incident in Watford. The Head of Adult Safeguarding is a panel member and monitors progress to ensure that recommendations and actions are achievable for health organisations.

14. Mental Capacity Act and Deprivation of Liberty Safeguards

A deprivation of liberty which safeguards a person lacking capacity must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation or Court of Protection order under the Deprivation of Liberty Safeguards (DoLS) in the Mental Capacity Act (2005), or(if applicable) under the Mental Health Act 1983.

In March, the Supreme Court handed down a judgement referred to as Cheshire West. The judgement is significant in lowering the threshold in the determination of whether arrangements made for the care and

or/ treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty.

The Cheshire West judgement has been significant in lowering the threshold in the determination of whether arrangements made for the care and or/ treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty.

The key points from the Supreme Court Judgement are:

- A Revised test for deprivation of liberty which is; the person is under continuous supervision and control **AND** is not free to leave, **AND** the person lacks capacity to consent to these arrangements.

The Implications / Actions for the CCG are to:

Seek assurance from provider organisations that they have sought legal advice regarding the ruling and are aware of the implications for their organisation

- Ensure that the Continuing Health Care team seek legal advice in terms of commissioning care packages for the domestic setting which might constitute a deprivation of liberty

The lowering of the threshold has increased the applications to the Local Authority Supervisory Body by Managing Authorities, such as hospitals, as they are required to make more applications for DoLS assessments. This has resulted in delays with processing applications and so this means that Managing Authorities will be depriving patients of their liberty without authorisation. To mitigate this HCC recruited a number of additional staff to deal with the increased work load.

All NHS provider organisations undertook a number of actions to comply with this ruling:

- Dip sampling of Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) documentation.
- A MCA/DOLS newsletter for Bed based MCA/DOLS champions.
- A DOLS checklist developed and available on the safeguarding adult intranet page.
- Establishing a system that the Safeguarding team are notified of all patients who require 1 to 1 care so that consideration can be given as to whether a DoL is required
- Patients with mental health problems are referred to the RAID team, who review the patient from a mental health perspective and inform the safeguarding team if they think a DoLS is required.
- All relevant teams issued with a briefing on the implications of the decision for HPFT.
- The CQC briefings on this case have been circulated to all relevant staff.
- Some of the applications have been assessed and deemed to be ineligible for DOLS so Mental Health Assessments have taken place to ensure the lawful deprivation of liberty of these patients.

These actions are partly responsible for the increasing number of applications being made this year compared with previous years.

The number of DoLS applications and authorisations for 2014 - 2015 are set out below benchmarked with the previous year:

Provider	No of DoLS applications made 2013 - 2014	No of DoLS applications authorised 2013-2014	No of DoLS applications made 2014 - 2015	No of DoLS applications authorised 2014 - 2015
WHHT	6	2	158	32
HCT	2	2	44	17
HPFT	7	0	451	253
ENHT	19	7	98	17

Due to the substantial increase in the numbers of applications being made following the Cheshire West judgement there has been significant delays in assessments and notification of outcomes for authorisation. The reasons for the difference between the numbers of applications made compared with the numbers authorised are due to patients regaining mental capacity before the application is completed or the patient being discharged. The Local Authority Supervisory Body has taken action to manage the delays and organisations have reported this issue to their Boards and placed it on their risk registers.

15. Mental Capacity Action Plan 2014 – 2015

In March 2014 the House of Lords Select Committee published their final report following a post legislative scrutiny of the Mental Capacity Act 2005 (MCA). This concluded that while the MCA was well thought through, there is a lack of awareness and lack of understanding. The report identified issues with the implementation of the MCA across health and social care sectors due to paternalism and risk aversion. The report also found that the Deprivation of Liberty Safeguards (DoLS) were not fit for purpose and should be replaced that are easier to understand and implement.

Responding to the recommendations set out in the report NHS England Hertfordshire and South Midlands Area Team allocated each CCG with money to support MCA and DoL development. Herts Valleys CCG received £54,771 and East and North Herts CCG received £51,284. The CCG Directors of Nursing and Quality agreed to pool the money and the Head of Adult Safeguarding developed and implemented the action plan below.

The CCGs are required by NHS England to demonstrate the following outputs by the end of the financial year to enable NHS England demonstrate their contribution to the Government's plan as well as ensuring value for money.

- Submission of a self-assessment summary report for 2014/15.
- Submission of a case study from the CCG for sharing through the national programme, this should highlight MCA good practice in implementing the least restrictive option
    - Numbers of health professionals trained as Best Interest Assessors (BIAs) in 2014/15

Herts Valleys CCG and East & North Herts CCG Mental Capacity Action Plan

Recommendation	Action	Timescale	Lead	Outputs
A self-assessment summary report should be completed from each CCG for the period 2014/15.	Review MCA section of the CCG self-assessment audit tool used for assurance visits to provider organisations.	Completed	TC	Submission of a self-assessment summary report from each CCG for the period 2014/15.
	Send out self-assessment tool to Directors of Nursing of provider organisations November / December 2014	Completed	TC	Self-assessment from: WHHT HCT HPFT ENHT
	Review submissions and identify non-compliance Follow up at assurance visits	Completed	TC JN SR	Adult safeguarding annual assurance visits to each provider completed January 2015. Actions will be monitored by TC at provider Safeguarding Committees
	Produce summary of provider organisations self-assessments	Completed	TC	Summary of self-assessments including compliance, gaps and proposed future activity
	Identify an Independent Provider to undertake scrutiny and challenge work across provider organisations and identify gaps and agree a proposal	Completed	TC	12 days' work to be undertaken days' May – July 2015 £8,000
		Completed	TC	Completed scrutiny and challenge work and action with recommendations.

Recommendation	Action	Timescale	Lead	Outputs
Both CCGs should identify a case study to share through the national programme, which highlights good practice in implementing the least restrictive option.	Liaise with the HCS DoLS Lead to identify cases	March 2015	TC	Provide a case study from each CCG for sharing through the national programme.
	Ensure case studies available to NHS England	March 2015		
The CCG should provide NHS England with the numbers of health professionals trained as Best Interest Assessors (BIAs) in 2014/15 for each CCG	Establish the numbers of BIAs already working in health organisations	Completed	TC	Provide NHS England with the number of BIAs in each CCG area.
	Provider organisations to identify the staff they would like trained as BIAs TC to work with the LA DoLS Lead to develop extra courses at the University of Hertfordshire. The application process will be managed by the DoLS Lead and the courses will run 2015 – 2016. These staff will then go on the BIA rota to do an assessment every month or every 2 months to maintain practice.	Completed	TC	There will be 30 BIAs trained at a cost of £45,450
Improve the level of knowledge of MCA / DOLS across health and primary care	Work with the LMC re: training for GPs. This money will be used to fund a conference in each CCG on MCA for GPs organised by LMC. TC will work with the LMC to draft the conference agenda	January 2015		Funding of 2 conferences £5000 10.4.15 – D/W Rachel Lea to meet later in the Spring to discover how this can be taken forward

Recommendation	Action	Timescale	Lead	Outputs
	Identify an independent trainer to work with provider organisations re: train the trainer approach incorporating case studies	December 2014	Independent trainer TC	Trainer to work across 3 provider organisations and Continuing Health Care Teams £6,000
	Fund a Band 7 for 1 month in the mental health trust to undertake training for specific staff groups. This post holder already exists and doing training.	May 2015	TC	£4,200 This will ensure consistency of knowledge across the organisation
	Link with any CCG initiatives that require MCA knowledge	Completed	TC	Link made with Care Home Premium and identify any training needs
Improve the level of knowledge of MCA / DOLS across health and primary care (cont'd)	Work with the independent trainer and providers to implement the proposed work	February -April 2015	TC / Independent trainer	Consistent training used across all providers Train the trainer approach implemented across all providers
	Work with Independent provider to undertake scrutiny and challenge work	May – July 2015	TC / Independent provider	Gaps identified and recommendations made for further work
	Develop a system of peer quality checks of MCA recording within services / organisations	August 2015	TC and provider MCA Leads	
	Implement the system of peer quality checks of MCA recording within services / organisations	September – October 2015	TC and provider MCA Leads	
	Develop action plan from the above work	July - August 2015	TC	Implementation of the action plan
	Identify, commission and hold a half day training for MCA Leads focussing on case law	June 4th 2015	TC	£600 CCG and provider MCA Leads will have up to date knowledge of case law

Key:

TC – Tracey Cooper, Head of Adult Safeguarding Herts Valleys / East & North Herts

JN – Jan Norman, Director of Nursing & Quality Herts Valleys CCG

SR – Sheilagh Reavey, Director of Nursing & Quality, East & North Herts CCG

The Head of Adult Safeguarding and the Director of Nursing and Quality undertook annual assurance visits to each of the following providers in December 2014 and January 2015. As part of the visit each organisation completed a self-assessment audit tool. Following the visit a letter was sent outlining the findings and recommendations which are set out below. The provider organisation then completed an action plan which the Head of Adult Safeguarding monitors through the provider safeguarding adult committees.

WHHT	Findings	Recommendations
	• The trust has a strategy in place which reflects the organisations values and is currently being reviewed incorporating actions identified from audit. • The trust has a values based appraisal system in place in which all managers have been trained. • Whistleblowing incidents and allegations of abuse against staff are reported to a sub group of the trust board. • The trust is reviewing the Raising Concerns policy in light of Saville. • The trust is proposing to change the midwifery structure to allow more posts to include specific safeguarding responsibilities. • In response to regular concerns raised regarding NHSP staff the trust holds contract meetings with NHSP to monitor and resolve concerns raised about NHSP staff. • The trust proposes to train four people in WRAP3 Prevent training.	• WHHT need to achieve the necessary training levels set out in the Quality Schedule for safeguarding adults and MCA for all divisions. • To encourage one or two junior doctors to join the train the trainer programme for MCA. • To triangulate the outcomes from serious incidents with the strategy and action plan. • The trust to consider reporting whistleblowing incidents and allegations of abuse against staff to the trust board. • The trust to ensure that adult safeguarding is embedded within appraisal and supervision processes. • The trust need to develop an improved system to monitor themes and trends emerging from adult safeguarding and quality issues Progress is being made in relation to these recommendations in particularly in relation to serious incidents and changes to the training programmes for nursing and medical staff.
HCT	• Safeguarding adults is embedded within the Quality Strategy and forms part of the Patient Safety work plan and updates are provided to the Healthcare Governance Committee. • HCT have a Learning Disability action plan through which a number of initiatives have been developed such as a 'My teeth' DVD to help people with dental visits/treatments and generally improving signage within units. • Mental Capacity is a Quality Priority for 2014/15 with an	• HCT need to achieve the necessary training levels set out in the Quality Schedule for safeguarding adults and MCA for all Business Units. • HCT to complete the process for accessing legal advice out of hours and place information in the on call folder. • HCT to develop a system and process to ensure reporting of quality intelligence within care homes. This process should also include how HCT will share this intelligence and actions that might be taken.

WHHT	Findings	Recommendations
	action plan to improve implementation and competency. • HCT are formalising access to legal advice for Out of Hours in response to recommendations made following a recent MASIR. This is in particular reference to contacting the Court of Protection. • HCT are compliant in all areas with CQC. • The role of Specialist Nurse for Safeguarding Adults is to be a permanent post. • The role of local safeguarding adult champions is being strengthened to improve accountability.	• HCT need to ensure that staff make appropriate safeguarding alerts, particularly in relation to care homes. • HCT need to develop an improved system to monitor themes and trends emerging from adult safeguarding and quality issues. Progress is being made with these recommendations some of which link to work regarding care homes being led by the CCG Head of Quality Improvement.
HPFT	• The Trust demonstrated that adult safeguarding forms part of the Trusts objectives and values • There is a new safeguarding team structure and the team are reviewing the current safeguarding adult systems and processes within HPFT • HPFT need to implement robust data collection systems and processes to enable effective reporting of safeguarding metrics to the CCGs. • There has been a loss of organisational memory with staff moving to new posts and recruiting new staff. There are other pressures including; the Cheshire West judgement and PARIS. • HPFT acknowledge the need to re-energise their internal quality monitoring. • The Safeguarding Lead Consultant only has one session per week to focus on adult safeguarding • HPFT have a representative for each of the Care Act groups. • The safeguarding adult policy and strategy are currently being developed.	• HPFT to audit the experiences of clients who have been subject to a safeguarding adult intervention as there is inconsistency in the way this data is collected. • To review the safeguarding adult lead Consultant's job description and number of sessions with a view to increase capacity to enable the agenda to be delivered. • The Safeguarding Lead Consultant to meet with the CCG Head of Adult Safeguarding to understand the expectations of the CCGs. • HPFT to write to the Director of Adult Social Services at Hertfordshire Community Services regarding clarification of their delegated responsibilities. • HPFT to ensure that adult safeguarding is embedded within appraisal and supervision processes. • To continue with the current review to ensure effective systems, processes and outcomes are in place to safeguard all service users. Progress has been made with these recommendations as the CCG Head of Adult Safeguarding has met with the Lead Consultant and set out expectations for that role. HPFT are working with HCS regarding the delegated responsibility.

16. Provider performance

The year-end performance for providers is set out below. WHHT have recently reviewed their adult safeguarding training with support from the Head of Adult Safeguarding and this should lead to better uptake from staff. HCT have developed in year level 3 training for their safeguarding adult champions and the Head of Adult safeguarding is part of this training programme. Until now HPFT have only been required to produce training figures for level 2 training but this will change in 2015 – 2016 when they will need to supply the same data as other providers.

Trust	Quality requirement	Threshold	Year end
WHHT	% of relevant staff who have undertaken level 1 Safeguarding adult training at induction	95%	77%
	% of relevant staff who have undertaken level 1 Safeguarding adult training every 3 years	95%	85%
	% of relevant staff who have undertaken level 2 safeguarding adult training	95%	64%
	% of relevant staff who have undertaken Mental Capacity Act training	95%	Incorporated in level 2 training
HCT	% of relevant staff who have undertaken level 1 Safeguarding adult training at induction	95%	96%
	% of relevant staff who have undertaken level 2 Safeguarding adults training annually	90%	85%
	% of relevant staff who have undertaken safeguarding adult training level 3	90%	64%
	% of relevant staff who have undertaken Mental Capacity Act training	90%	83%
	% of relevant staff who have undertaken Prevent training	95%	98%
HPFT	% of relevant staff who have undertaken level 2 safeguarding adults training	95%	94%

For 2015 – 2016 each provider will submit on a quarterly basis a completed adult safeguarding dashboard which will be monitored by the Head of Adult Safeguarding. Concerns will be escalated to the Quality Review Meetings.

17. Priorities 2015/16

- To develop and implement the safeguarding adult strategy action plan
- Working in partnership with other statutory partners lead the development of domestic abuse services

- Embed the adult safeguarding assurance mechanisms
- Develop multi-agency information sharing governance structure
- Provide on-going support and training to General Practice staff
- Implementation of the MCA action plan

Tracey Cooper
Head of Adult Safeguarding
July 2015