

## **Safeguarding Adults Annual Report**

April 2016 – March 2017

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# Safeguarding Adults - Annual Report 2016/17

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## 1. Introduction

The purpose of this report is to provide assurance to the trust that it is fulfilling its statutory responsibilities in relation to safeguarding adults and to provide a review of recent service developments, highlighting areas of ongoing work and any risks for noting.

## 2. The Statutory Context

Adult safeguarding practice has come into sharp focus for all NHS organisations in the wake of large scale enquiries such as the Mid Staffordshire Foundation Enquiry, the *Francis Report (2013)* and the Lampard report on Saville enquiry (*Lampard K & Marsden 2015*). With the introduction and implementation of the Care Act (2014) on 1<sup>st</sup> April 2015 safeguarding adults now operates within a legal framework.

Since April 2010 all health organisations have to register and comply with Section 20 regulations of the Health and Social Care Act 2008, meeting essential standards for quality and safety. The Care Quality Commission periodically assesses the performance of all health care providers.

## 3. Governance

During 2016/17 the safeguarding adult team was restructured and joined with the safeguarding children team to become one team managed by the Head of Safeguarding to provide a more 'think family' approach to safeguarding. The post of safeguarding adults' co-ordinator was reduced to 0.8 whole-time equivalent (WTE) from full time when the post became vacant and re-banded to a band 7 in order to allow another safeguarding named professional in the team. The named executive for safeguarding adults in the trust is the Director of Nursing and Governance. The structure for the safeguarding team and lines of responsibility are attached at Appendix1.

The safeguarding adult group chaired by the Deputy Director of Nursing, leads and monitors safeguarding work within the trust and meets quarterly. This is a formal sub-group of the Safety, Experience and Clinical Effectiveness Group (SECEG) which reports to the Quality Executive Group (QEG) and ultimately to the Trust Board. The board also receives a monthly update on safeguarding cases of concern.

The Head of Safeguarding chairs monthly safeguarding named professional team meetings where shared visions, standardised practice and future plans are agreed and monitored. An annual plan on a page, written by the team, clearly identifies work priorities and continuous improvements to be achieved (attached as Appendix 2). There are currently 2.8 whole-time equivalent (WTE) adult safeguarding named professionals posts divided between three staff members and 6.8 WTE posts for child safeguarding. The team is supported by three part-time administrative posts and is based at two locations, St Marks Hospital in Maidenhead and Wokingham Hospital in Wokingham. The

Specialist Practitioner for Domestic Abuse works within the safeguarding team. The Head of Safeguarding works as a full time manager for the whole team.

The Deputy Director of Nursing attends the quarterly East and West Berkshire health economy safeguarding groups chaired by the Directors of Nursing for the East and West Berkshire clinical commissioning groups (CCG's). The Head of Safeguarding and the named professionals attend the East and West named and designated safeguarding groups, chaired by the designated nurses for child protection, which report to the health economy safeguarding groups. The purpose of these groups is to communicate local and national children's safeguarding issues. These meetings encourage shared learning from safeguarding practice and include case discussion and monitoring of action plans from inspections, safeguarding adult reviews and partnership reviews to provide assurance.

#### 4. Assurance Processes

CCGs are expected to ensure that safeguarding is integral to clinical and audit arrangements. This requires CCGs to ensure that all providers from whom they commission services have comprehensive and effective single and multi-agency policies and procedures to safeguard children and vulnerable adults, and that service specifications drawn up by CCGs include clear service standards for safeguarding which are consistent with local safeguarding board policies and procedures. The trust completes a contracted annual self- assessment audit for the CCGs in September each year, to provide assurance to commissioners that safeguarding standards are met. Following submission the Head of Safeguarding meets with commissioners to discuss the audit and answer sample questions.

#### Safeguarding Audits

Audit is an effective means of monitoring compliance with policy and procedure as well as analysing the effectiveness of current practice. Two audits were undertaken during 2016/17

Audit	Completion
Audit of safeguarding response to alleged sexual assault/inappropriate behaviour on mental health inpatient wards	Complete
Audit of Mental Capacity Act assessments on mental health wards	Complete

## **Audit 1 – Audit of safeguarding response to alleged sexual assault/inappropriate behaviour on mental health inpatient wards**

The safeguarding team undertook this audit following a perceived increase in sexual abuse incidents taking place on mental health inpatient units.

The audit concentrated on sexual abuse, including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts or sexual acts that the vulnerable adult has not consented to, or could not consent, or was pressured into consenting. This also includes sexual exploitation or sexual grooming of young people.

Any sexual activity on a mental health ward is not acceptable due to vulnerabilities of the patients, and their ability to consent. The trust must be confident that all instances of sexual abuse are managed appropriately and in a timely manner to reduce the risk of harm, ensure any victim of abuse is supported and reduce the risk of reoccurrence.

The audit identified several areas where policy had not been followed.

- Policies were not being adhered too, namely the Safeguarding Adults from Abuse (Local Policy) CCR089 and The Management of Sexual Relationships involving In-Patients in the Mental Health setting Policy CCR029.
- Incidents of this nature are not being sent to the local authority routinely for investigation in line with the Pan Berkshire Policies & Procedures.
- Risk assessments are not being updated routinely for the victim or perpetrators involved in these incidents.
- Staff are not systematically triangulating the risk for these incidents.
- Care plans for victims and perpetrators are not systematically being updated/ completed following these incidents.
- RIO progress notes for victims and perpetrators do not reflecting the incident on Datix.
- Transferable risk not being identified, which means that there is on-going risk to other vulnerable adults.

Recommendations from the audit were as follows:

- Repeat audit findings for October 2015 to March 2016 data by September 2016.
- The safeguarding team to check RIO for assurance and not rely on Datix alone to ensure actions taken are followed through for all sexual assault incidents.
- To develop Standard Operating Procedure guidance for staff detailing expectations of sexual assault/inappropriate behaviour management.
- To discuss individual safeguarding issues raised in greater detail.
- To determine the role of the safeguarding lead within Prospect Park Hospital.

There was a re-audit in September 2016 which showed an improvement in some of the actions being taken to safeguard patients following these incidents. The percentage of cases meeting the

standard increased in 9 of the standards selected for the audit. Three standards remained the same and five standards decreased in the number being met. An action plan was put in place. In December 2016 a safeguarding adult named professional (mental health) was recruited into the safeguarding team to promote safeguarding in Prospect Park Hospital and a safeguarding named professional visits the wards daily to follow-up on safeguarding incidents and work with staff to improve standards.

## **Audit 2 – Audit of Mental Capacity Act Assessments**

An audit was undertaken at the end of Quarter three to assess where services are at in regards to undertaking mental capacity assessments. 10 sets of notes were randomly audited, covering all CCG areas, to assess the quality of the mental capacity assessments being undertaken and to determine if decisions were being made which required a formal assessment of capacity.

- All 10 service users had a capacity assessment on admission appropriately using the updated capacity assessment tool. All were of high quality.
- 3 of the 10 service user's notes indicated that significant decisions were taken which required capacity. Of these 3 service users, 2 had high quality mental capacity assessment, one had it noted that they had capacity (very clearly), but no assessment was undertaken.

There appears to be a good understanding of the Mental Capacity Act across the trust and its use is becoming embedded within the mental health inpatient unit. Within community physical health wards there is an understanding of patient consent however the use of the Mental Capacity Act (MCA) within larger decision making is not implemented in the majority of incidents and when it is implemented the documentation of the assessments is poor. Significant work had been undertaken over the previous 6 months to develop the mental capacity assessment form, implement a champion system on the community wards as well as a revamp of the training. The audit indicated that further work is required to embed this practice

### **Recommendations from the audit:**

- 1: Clinical Directors from the relevant localities have been informed of those patients who require a capacity assessment
- 2: The implementation of the MCA needs to be owned on a local level, rather than being centrally managed. It is recommended that this audit is discussed at the PSQ and ownership for improvement to be held between the Clinical Director and service manager.
- 3: The mental capacity champion role is not yet embedded. Further support is required to empower the champions to challenge clinicians when the MCA is not being implemented when it should.
- 4: The review of the teaching and training of the MCA should continue.

### **Audits planned for 2017-2018**

Audit	Completion Due
Audit of failure to return from section 17 leave from inpatient wards	October 2017
Making Safeguarding Personal	November 2017
MCA audits x 3	January 2018

Named professionals for safeguarding adults also participate in multi-agency safeguarding audits required by each of the SAB's as part of membership of quality and performance/effectiveness sub-groups. Examples include a self-neglect audit undertaken by Slough and a dementia audit undertaken in west of Berkshire.

### Supervision

All adult safeguarding named professionals receive safeguarding supervision from the Head of Safeguarding in West Berkshire on a minimum quarterly basis. They also receive an annual appraisal which is reviewed after six months.

## 5. Safeguarding Adults Boards

There are four Safeguarding Adult Boards (SAB) serving Berkshire: West of Berkshire SAB serving Reading, West Berkshire and Wokingham; Bracknell SAB, Royal Borough of Windsor and Maidenhead SAB and Slough SAB. The trust are represented at all boards with, the Deputy Director of Nursing sitting on the board in the West of Berkshire and the relevant Locality Director sitting on each of the 3 East boards.

Section 44 of the Care Act puts a duty upon the Safeguarding Adults Board (SAB) to arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

- There is reasonable cause for concern about how the SAB, its members or other persons with relevant functions worked together to safeguard the adult, and
- The adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Or

- If the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The Head of Safeguarding sits on the safeguarding adult review (SAR) panels for each of the Safeguarding Adult Board areas. Named professionals for safeguarding adults sit on each of the

quality and performance/effectiveness sub-groups and on the learning and development groups in East and West Berkshire. They also sit on Modern Slavery and Violence against Women and Girls Sub-committees.

### **Safeguarding Adult Review's/Domestic homicide reviews/Partnership reviews**

During 2016/17 there were a number of safeguarding adult reviews, partnership reviews and homicide reviews in which the Trust contributed to the multi-agency learning process. Learning from the reviews has been incorporated into group scenario work in the Trust's safeguarding adults training

### **Safeguarding Adult Reviews (SARs)**

#### **Bracknell**

A female adult who lived alone and was known to mental health services became unwell. Her family increasingly raised concerns, about her delusional behaviour, to primary care and to mental health services the day prior to her death. A fire started in her flat and she suffered critical injuries from which she died in hospital. The learning includes working with risk, engaging positively with families and carers, communication systems and fire risk referrals. Fire risk assessment and referral pathways have been added to all safeguarding training in the trust as a result of this review. The hoarding scale has been circulated to staff and information about the use of flammable creams and risk to patients.

A review has been commissioned to identify any multi-agency learning following the death of a 71 year old man with a learning disability. The gentleman lived in supported accommodation and died in hospital following a deterioration of his physical health, leading to a number of hospital admissions. The review is in progress and will look at learning around application of the Mental Capacity Act and the way agencies communicated with each other about his care.

### **Partnership Reviews**

#### **Slough**

A review took place to consider the care received by a gentleman with learning and physical disabilities who was admitted to Prospect Park Hospital in December 2016. The mental and physical health of the gentleman rapidly deteriorated during the week prior to his admission and he was seen by numerous agencies including mental health, community team for people with learning disabilities, respite care, GP, hospital services and ambulance service. The review highlighted the need to better co-ordinate the service between the crisis team and the community disability team and an action plan is in progress.

### **West of Berkshire**



A thematic review took place following the death of a gentleman Mr X. Mr X had a learning disability and there were issues identified around complex relationships, interdependencies and possible domestic abuse/coercive control between Mr X and his two brothers. Mr X was interviewed by police in October 2016 on a voluntary basis in relation to an allegation of historical sexual abuse. The interview was delayed due to difficulties identifying an appropriate adult. Mr X was found dead in his flat two days later. Learning was identified around complex case management, capacity assessments and multi-agency working.

### **Bracknell**

A nineteen year old man with a learning disability was admitted to Champion ward, from his residential school in Herefordshire, when his health deteriorated rapidly following uncertainty about his next placement. His health further deteriorated and he was transferred to Royal Berkshire Hospital. No learning was identified for trust services from the review.

### **Domestic Homicide Reviews**

#### **Wokingham**

A domestic homicide review is in progress following the death of a lady with advanced dementia, who was killed by her husband. The couple had been married for over sixty years and the husband was the main carer for his wife. The couple had some support from care agencies and their two daughters. The husband was diagnosed with cancer and was undergoing treatment, which affected his physical wellbeing and ability to care for his wife. The victim was known to the memory clinic and the community matron service. The review is ongoing.

#### **Mental Health Homicide Review**

#### **Slough**

#### **Joint Serious Case Review and Mental Health Homicide Review**

A child died with his mother when she jumped in front of a train. It is believed his mother committed suicide and the child died with her. The mother was in receipt of mental health services and was a mental health inpatient for a period prior to her death. The Mental Health Homicide Review was completed in December 2016 and has not yet been published. The serious case review found that the child's death was not predictable or preventable and there were no recommendations for agencies from the review. A learning event was held for staff and a multi-agency conference across East Berkshire on forced marriage and other harmful practice and exploitation will be held November 2017.

#### **Serious incidents**

Serious incidents within BHFT, where there has been a safeguarding aspect, are detailed and reported to the Board separately. The Safeguarding Team are involved in discussions where there has been an allegation against a member of staff. The team offer bespoke training sessions to services where themes are identified. The trust have a responsibility to consider any incident where

an individual with care and support needs, dies or experiences significant harm and if so a referral is made to the relevant SAB for consideration for a serious adult review.

## **6. Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS) (2007)**

The Safeguarding Adults team have led the trust's responsibility for co-ordinating and raising awareness of Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) since 2012/13.

Training to staff is facilitated by the named professionals for safeguarding adults assisted by staff who have attended the MCA/DoLS 'Train the Trainer' course. Trust staff compliancy to MCA and DoLS training was above 85% by March 2017 which exceeded the target set on the Quality Schedule.

The issue of assessing an individual's mental capacity is often a central part of the safeguarding process. Support is also often required around making best interest decisions for individuals who lack capacity to make specific decisions. An understanding of the MCA is crucial to the implementation of DoLS. As awareness has been raised, staff are more frequently contacting the safeguarding team for specific advice about the MCA.

An MCA/DoLS group has been set up during 2016/17 chaired by the Clinical Director for the Trust, to look at ways of developing staff knowledge of application of the Mental Capacity Act and application of DoLS. Six MCA champions have been appointed, one on each of the community wards to support staff in their work. This group will join the safeguarding adult group once the initial task and finish work is completed.

An audit has been undertaken by the Clinical Director and an action plan is in place. An MCA form has been added to the admission pack on the community wards as a result of the audit. One of the Named Professionals for Safeguarding Children is the named MCA/DoLS lead for the Trust.

The Law Commission carried out a full review of the current DoLS framework and found the current system to be 'deeply flawed'; they proposed that the current system be replaced with a new system, to be called 'Protective Care'. Broadly speaking, protective care had three aspects: the supportive care scheme, the restrictive care and treatment scheme, and the hospitals and palliative care scheme recommended a significantly different process. The review went out to consultation in the autumn of 2015.

There was a significant amount of feedback given regarding the proposed changes. It is anticipated that a final report and draft Bill will be published in December 2017. It is unlikely that there will be any noticeable changes to practice until 2019 at the earliest.

## DOLS Applications for 2016/17.

	Q1	Q2	Q3	Q4	Total
<b>Total number of applications received:</b>	14	23	13	15	65
<b>Applications Declined:</b>	1	0	1	2	4

	Q1	Q2	Q3	Q4
Henry Tudor Ward				
Windsor Ward			1	
Donnington Ward	1	1	1	2
Rowan Ward	8	15	4	9
Campion Unit				
Orchid Ward	3	4	6	3
Oakwood Unit	2	1	1	
Jubilee				
Rose		1		
Snowdrop				1
<b>Total</b>	<b>14</b>	<b>23</b>	<b>13</b>	<b>15</b>

All applications for DoLS require a BHFT signatory and the locality directors or their designated deputy has responsibility to ensure the application to the local authority is complete and appropriate. The Safeguarding Adults team continue to provide support and guidance to staff on DoLS applications. The CQC must be notified of all DoLS Applications and the Outcome. This should be done by the Locality Directors or agreed deputy.

There have been 65 DoLS applications during 2016/17 which is a significant rise on 2015/16 when there were 34 applications. 4 of the applications were declined as the patient was not eligible. A number of the applications ended before the assessment was made or the authorisation received. For these patients it was recorded in the record that an application had been made, but an assessment had not yet been made and the patient was being held on the ward in their best interest. Regular contact was kept with the local authorities regarding these applications

## **7. Prevent**

Prevent' is part of the UK's counter-terrorism strategy, CONTEST. The Prevent agenda is outlined in the Department of Health document 'Building Partnerships, staying safe – the Healthcare Sector's contribution to HM Government's Prevent Strategy: for Healthcare Organisations'. The trust has a duty to adhere to the Prevent strategy. Its aim is to stop people being drawn into terrorism or supporting terrorism. Terrorist attacks have continued to take place across the world in 2016/17. There was an attack in London on the 22.3.17 at Westminster, indicating that individuals are still being radicalised. The UK's terrorist threat remains at 'Severe', at the time of this report meaning a threat is 'highly likely'.

The Prevent Lead for the trust left the safeguarding team in December 2016 and two named professionals child protection who had been delivering the WRAP (Workshop for Raising Awareness of Prevent) training, stepped into the role temporarily, whilst a replacement was sought. At the time of publication of this report a new Prevent lead has been appointed.

Links with Local Authority and Police remain strong. The trust is represented on all six channel panels and Prevent management meetings across the six Localities in Berkshire. Channel is an early intervention multi-agency process designed to safeguard vulnerable people from being drawn into violent extremist or terrorist behaviour. Channel works by partners jointly assessing the nature and the extent of the risk and where necessary, providing an appropriate support package tailored to the individual's needs.

Introducing Prevent into the induction programme in July 2016 has helped to increase our overall percentage of staff completing the WRAP training, from 75% to 87% of staff. This was a significant achievement for the team, who offered training to groups in their bases as well as part of the general training programme in order to make it easier for staff to access training and increase compliance.

For those that need the basic training Channel general awareness, 85% of staff have now completed it, compared to 50 % at the end of 2015/2016. Additional scheduled sessions have continued to be offered to reach staff within the organisation who have not yet been trained. The safeguarding adult Named Professional (Mental health) started with the team in December 2016 has also been trained internally by Safeguarding Team to deliver the WRAP training.

Staff have demonstrated an awareness of Prevent and its purpose, with several concerns being discussed with the Prevent Leads and some of those referrals meeting the threshold to be considered by the Channel Panel and in turn being adopted by the panel. There has been an increase in calls for advice on Prevent matters from 2015/16.

Having attended national conferences for Prevent with NHS England supported by the Home Office, it is clear the Prevent agenda is growing in light of the continued risk of national terrorist attacks. It is clear Prevent needs to be embedded into all aspects of practice. In order to do this the plan is to expand the Prevent aspect within the adult and children safeguarding refresher courses.

## **8. Modern Slavery**

There is now a duty to notify the Home Office of potential victims of Modern Slavery, this came into force in November 2015. This duty is set out in Section 52 of the Modern Slavery Act 2015 and applies to public authorities. Although health organisations are not yet compelled to notify, under safeguarding arrangements, consideration should be given to making a referral to the police or local authority, should a health practitioner have reason to believe a vulnerable adult or child is being exploited or trafficked.

A Modern Slavery Sub-group has been set up in Slough, led by Police and the Community Safety Partnership and the Named Professional for Mental Health is a working member of that group. Modern Slavery training has been offered locally and nationally and has been attended by the Named Professionals. Modern Slavery is included in all Trust Safeguarding Adult training.

## **9. Training**

As a partner of the four SAB's in Berkshire the trust is guided by the workforce development strategies' developed by the East and West Berkshire learning and development subgroups and all level 1 training adheres to the standards identified, ensuring that all staff have appropriate knowledge and competencies in relation to the:

- Potential for the occurrence of abuse and neglect
- Identification of abuse and neglect

- Safeguarding adults policy and procedures
- Requirement to report any concerns of abuse or neglect
- Internal reporting structure for such concerns

Continued training and development of trust staff on safeguarding vulnerable adults forms a primary responsibility for the safeguarding team. Lessons learned from national and local enquiries in safeguarding adults reviews have been incorporated into the trust training, programme which is delivered at two levels.

Level one training is aimed at staff whose work brings them into regular contact with patients who are in need of services, whether or not the local authority are aware of them. It comprises awareness on the different types of abuse, how to recognise signs of abuse and how to manage situations of witnessed abuse and disclosures of abuse by patients in our care.

Level two training is targeted at senior clinicians. Staff who regularly investigate and/or contribute to supporting adults at risk of abuse including safeguarding adult named professionals, attend multi-agency training at level three. This training includes multi-agency safeguarding procedures and assessing, planning, intervening and evaluating the needs of an adult where there are safeguarding concerns.

Safeguarding adults/children joint training at level one is now facilitated at Trust induction and has been well received giving a more 'think family' approach to training. All volunteers within the trust also receive safeguarding adult training as part of their induction. Bespoke training has been facilitated to hard to reach groups of staff and where particular learning has been identified.

Joint safeguarding children and adults training at level two was facilitated to community mental health team staff in September 2016 following learning from a local incident. Staff are also offered domestic abuse training from the Specialist Practitioner Domestic Abuse who sits within the safeguarding team.

A multi-agency level two refresher event was organised by one of the named professionals for safeguarding adults and included learning from local safeguarding adult reviews presented by a partner agency. Bespoke training sessions have also been facilitated to staff at Prospect Park hospital.

Compliance for level one training rose to 93.3% by March 2017 which was a significant achievement for the team, compliance for safeguarding adults training level two also rose from 40% to 66% but this remains below the target of 85%. A staff vacancy and long-term sick leave affected the ability to facilitate this training, but a plan is in place to increase compliance to 90% by December 2017.

Delivery of MCA/DoLS training and Prevent training forms part of the responsibility of the safeguarding team and is included in those sections of this report.

On-going statistics for staff numbers trained are included in the quarterly reports submitted to the Deputy Director of Nursing.

## **10. Summary**

The Care Act (2014) and Care and Support Statutory Guidance (Chapter 14-Safeguarding) has clarified our responsibilities relevant to safeguarding adults vulnerable to abuse or neglect. This legislation underpins the standards and principles of safeguarding practice at the heart of patient care at the trust and provides a legal requirement to work closely with local authorities and other partnership members of the Berkshire multi-agency safeguarding response.

The changes to terminology, categories of abuse and making safeguarding processes personal to the individual concerned are being incorporated into training and development of trust staff and volunteers and policy documents. The safeguarding team continue to work closely with external partners, developing local relationships and ensuring that adult safeguarding practices reflect local and national guidance.

Safeguarding Adult Boards have a statutory status directed by the Care Act (2014) with clearly defined roles and responsibilities to co-ordinate strategic safeguarding adult activity across all sectors and service user groups, to prevent abuse and neglect occurring and where it does, it is recognised and responded to appropriately. The SABs forms a view of the quality of safeguarding locally and challenges organisations where necessary. Senior representation on all four Berkshire SABs ensure a direct link to the Board regarding safeguarding adult concerns, enquiries and lessons learned as well as future development in practices and policies.

Application of the Mental Capacity Act is a topic that continues to be identified as an area for development both nationally and locally through SAR's, staff feedback and the recent CQC inspection.

## **11. Team Achievements 2016/17**

### **The Trust Vision**

The safeguarding team have provided evidence for the board on the key domains for BHFT to demonstrate the connection between the Trust vision and our service delivery:-

### **Striving for Excellence**

The safeguarding team have increased the amount of safeguarding training courses at level one and succeeded in raising compliance of staff to level one training to over 93% to ensure staff are

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competent to safeguard adults in Berkshire. This has been achieved by working closely with the learning and development team, carefully planning sessions to ensure easy to access locations across the trust, bespoke training to ward staff during the handover period and taking training to hard to reach groups. Compliance to Prevent training has also increased significantly to 87% this year. Two extra named professionals were trained as Prevent trainers and again training was taken to staff meetings, and bespoke sessions were held at times identified by teams. Prevent training was also added to induction to capture all new staff starting with the trust. Compliance to MCA and DoLS training has also risen to above 85% by March 2017.

### **Tailoring Care**

An action plan has been developed to strengthen safeguarding at Prospect Park hospital. A safeguarding named professional (mental health) was appointed in December 2016 to offer more one to one support to staff on inpatient wards. A named professional is present at the hospital daily to visit inpatient areas for advice and support and to oversee safeguarding. Named professionals have worked with adult social care to agree referral processes.

The safeguarding team view the front line staff and services as their customers and thus always endeavour to provide a flexible service to meet need. Telephone advice is widely used and named professionals support staff with complex cases and to challenge other agencies if they are not satisfied with the outcome of a referral where they have concerns about adult abuse. The team continue to provide tailored adult safeguarding support in practice areas where serious incidents requiring investigations (SIRI)s, have highlighted learning needs with regard to adult safeguarding practice.

### **Maximising Value**

Amalgamation of the safeguarding adult and children's teams has enabled a more joined up approach to safeguarding and an increased skill set amongst the team. Team members have increased their use of skype to reduce travel. Staff have worked together to develop a joint induction programme which includes Prevent and have piloted a joint safeguarding adults and children training at level two. This will be rolled out where appropriate to identified groups of staff. For the first time a level two safeguarding refresher forum with multi-agency speakers was facilitated and was well supported and evaluated with over 60 staff in attendance.

### **Delivering Success**

The safeguarding team and the tissue viability service worked with a multiagency group of professionals to develop a pan-Berkshire safeguarding pressure ulcer pathway. The new



procedures were re-launched in April 2016 and information went out in Team Brief. The link is available to all staff on team net.

The safeguarding team found that there was no consistency across the trust in relation to which, if any, MCA tools were being used and worked with the Clinical Transformation team to develop a single MCA tool in Rio that can be used by all services. The tool went live in 2016. It has been designed in such a way that it will be easy to replicate for services that do not use RIO.

An MCA task and finish group was set up to work on embedding use of the MCA and increase understanding of and application of DoLS. Six safeguarding champions have been appointed on the community wards to support the safeguarding team in improving the application of MCA and DoLS across services. Difficulty in the application to practice of the MCA act is a theme that has been present in local safeguarding adult reviews. It is recognised nationally that the MCA is not well embedded in practice across health and social care and this is an area for development across BHFT. A question about capacity has been added to the safeguarding adults section of the Datix form. There has been a significant increase in the number of DoLS applications in the trust this year which is encouraging.

### **Working across Boundaries**

The safeguarding team have continued to work closely with external agencies to improve and develop safeguarding adult practice across Berkshire. The trust are represented on all four safeguarding adult boards and on all sub-groups across Berkshire. Staff have actively participated in safeguarding adult reviews, disseminating learning to staff through multi-agency forums.

The safeguarding team organise a quarterly peer support session for all safeguarding colleagues working in health across Berkshire and host a quarterly partnership group, to which all six local authorities, both CCG leads and the acute trust leads are invited. This is an effective forum for building relationships and working together to improve practice and facilitate learning.

Named professionals meet with colleagues in social care on a monthly basis to discuss referrals and carry out investigations as required. Regular meetings have been held with police at Prospect Park hospital and a safeguarding named professional is an active member of the protocols in practice meeting at Prospect Park hospital.

### **Inspiring Others**

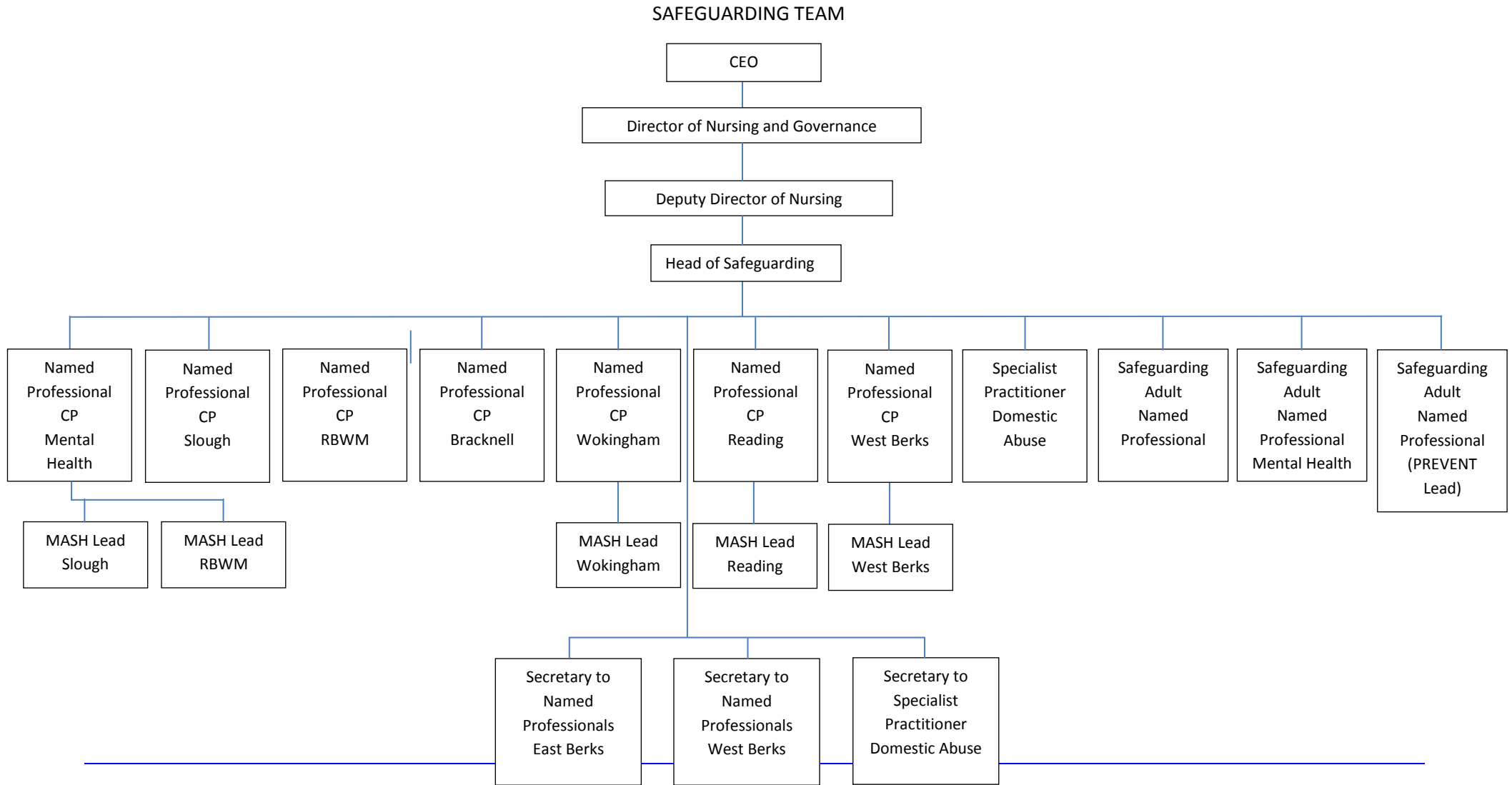
The team work closely with staff to support them to manage difficult cases giving them the confidence to challenge other professionals and agencies, where appropriate, to ensure adults in Berkshire are safeguarded. The team offer a coaching philosophy and approach to safeguarding advice and encourage professional curiosity, from front line staff, to enhance their learning and improve outcomes for adults in their care.

The team produce a 6 monthly safeguarding newsletter to bring any new guidance or learning to staff attention. This year screen savers have been developed to offer bite-sized reminders of important safeguarding topics, including domestic abuse and modern day slavery. Highlighting to staff what to look out for and where to get help.

## **12. Future Plans**

- Embed the Making Safeguarding Personal principles
- Continue to ensure that the Trusts PREVENT contractual requirements are met including the delivery of WRAP3 to identified staff groups.
- Increase understanding of application of MCA in practice
- Continue to meet safeguarding adults training level one compliance at over 90%
- Increase compliance to safeguarding adults training level two to 90%
- Commitment to contributing to an outstanding care quality commission rating through maintaining a high level of skills and knowledge of the team
- Continue to develop and maintain close working relationships with partners in social care in each of the six Berkshire unitary authorities
- Continue to provide strong representation on the safeguarding adult boards and sub-committees
- Work with colleague at Royal Berkshire Hospital Trust to develop a mental capacity act policy for the trust.

APPENDIX ONE



# Team Plan Summary 2017-2018

## Goal 1: Improving patient safety and experience

To provide safe services, good outcomes and good experience of treatment and care

- Commitment to contributing to an outstanding care quality commission rating through maintaining the high quality commission rating through maintaining the high level of skills and knowledge within the team.
- Maintain and develop safeguarding training to recognised standards for adult training and to the intercollegiate document 2014 for children, young people and families accessing Trust services.
- Continue to provide responsive children safeguarding advice to all Trust staff via the on-call advice line.
- Monitor and update compliance to Section 11 of Children Act 1989 reporting to Board and providing assurance to LSCB monitoring groups.
- Appropriately implement the Pan Berkshire escalation policy for Safeguarding.
- Access specialist training and supervision via Trust and external providers.
- Improve staff engagement in MCA assessments and DOLS
- Strengthen team knowledge of Prevent and ways to support staff

## Goal 3: Money matters

To deliver services that are efficient and financially sustainable

- To complete the review of the children's safeguarding form making key safeguarding information readily available.
- Improve the use of Skype and SMART working to reduce travel and maximise team efficiency.
- Build on the planning and delivery of joint adult and children's Level 1 training.
- Introduce joint adult/child 'think family' safeguarding training at level two for appropriate staff groups.

## Goal 2: Supporting our staff

To strengthen our highly skilled and engaged workforce

- Improve and maintain the uptake of supervision for CAMHS and the allied professions.
- To continue to develop child and adult safeguarding training programmes.
- Maintain the presence of the adult safeguarding lead during the working week at Prospect Park Hospital providing support and advice.
- Maintain and review the children's safeguarding advice line to inform future training needs.
- Continue to monitor safeguarding practice through audit and safeguarding clinical supervision.
- Maintain and improve the safeguarding page on Team net
- Continue to support staff by providing safeguarding forums and seminars, sharing learning from serious case reviews, partnership reviews and current issues including Domestic Abuse, CSE, FGM and Prevent.

## Goal 4: Working together

Understanding and responding to local needs as part of an integrated system

- Ensuring safeguarding representation at LSCB sub-groups.
- Continue to develop and establish the MASH roles in East and West Berkshire.
- Respond to specific local safeguarding initiatives by providing joint training.
- Continue to embed partnership working practices with adult and mental health staff including the children's Berkshire Adolescent Unit.
- Continue to develop and maintain close working relationships with partners in social care in each of the six Berkshire unitary authorities
- Participate in multi-agency audits, serious case reviews and partnership reviews as required.

**Our vision: To be recognised as the leading community and mental health service provider by our staff, patients and partners.**