NHS
Surrey Downs
Clinical Commissioning Group

Governing Body
29th July 2016

Safeguarding Adults in Surrey Annual Report

Agenda Item 17 Paper 13	
Author:	Helen Blunden Designated Nurse for Safeguarding Vulnerable Adults in Surrey.
Executive Lead:	Steve Hams, Director of Clinical Performance and Delivery
Relevant Committees or forums that have already reviewed this paper:	N/A
Action required:	To agree
Attached:	Annual Report Appendix 1- Mental Capacity Act Training Feedback
CCG Strategic objectives relevant to this paper:	CCG's are statutorily responsible for ensuring services they commission are safe and have efficient safeguarding process embedded in practice.
Risk	There are risks identified around capacity that have been identified on the Risk Register
Compliance observations:	**Finance:** Surrey CCGs will need to look at their own internal capacity to meet their statutory obligations for Adult Safeguarding, or the Surrey collaborative will need to look at increasing the Adult Safeguarding team
	Engagement: Patient and public feedback is key to understanding the quality and experience of commissioned services. The CCG monitors its commissioned providers in respect of performance in this area.

	Quality impact: Safeguarding Vulnerable Adults is integral to Patient Safety
	Equality impact: Safeguarding applies to the whole population
	Privacy impact: None identified in this paper
	Legal: None identified in this paper

EXECUTIVE SUMMARY

The purpose of the report is to provide the CCG with information and assurance that it is fulfilling is responsibility to safeguard and promote the welfare of vulnerable adults. It includes key challenges, risks and mitigating actions which have been highlighted within the Quality and Performance Report on an exception basis throughout the year.

Surrey Downs CCG are the hosts for Adult Safeguarding under the Surrey Collaborative commissioning arrangements therefore, once approved for submission to the Surrey Downs Governing Body by the Quality Committee, the report will be shared with all the Surrey Clinical Commissioning Groups to take through their own internal governance process.

Key issues to note:

- The Care Act 2014 put for the first time adult safeguarding on a statutory footing, with effect from 1 April 2015. This has led to additional work that is still in progress to ensure that this is reflected in Commissioner and Provider polices and processes.
- Lack of resilience in adult safeguarding resource when emergency/ unexpected or unforeseen events occur; as noted on the risk register
- Increased workload involved in provider failures to meet statutory safeguarding requirements, and the increased number of provider failures
- Surrey CCGs need to relook at their own internal capacity, to support the work of the safeguarding lead in line with their own regulatory responsibilities
- Resource implications to support the MASH; this is being discussed within the MASH project Board, and will need agreement across the Surrey Collaborative

Recommendation: The Governing Body is requested to agree the report.

Date of paper	20th July 2016
For further information contact:	Helen.blunden@surreydownsccg.nhs.uk

NHS
Surrey Downs
Clinical Commissioning Group

Safeguarding Adults in Surrey

Year End Report March 2016

1. Introduction

1.1 This report on adult safeguarding in Surrey combines activity in quarter 3 & 4, and includes key information from throughout the year, summarising the work that has been carried out across Surrey on behalf of all 6 Surrey Clinical Commissioning Groups (CCG).

1.2 The purpose of the report is to provide the CCG with information and assurance that it is fulfilling its responsibility to safeguard and promote the welfare of vulnerable adults. It includes key challenges, risks and mitigating actions.

2. Background

2.1 All adults have the right to live their lives free from abuse and neglect. Clinical Commissioning Groups have particular responsibilities to safeguard patients who may be unable to protect themselves from abuse or neglect. The safety and welfare of vulnerable adults is of paramount importance to all the CCG's in Surrey.

2.2 Surrey Downs CCG (SDCCG) supports the six Surrey CCGs in discharging these responsibilities through a hosting arrangement. The Designated Nurse for Safeguarding Vulnerable Adults in Surrey (hereafter referred to as the Designated Nurse) is employed by SDCCG under a service level agreement (SLA), which details the principles, accountabilities and responsibilities for the Designated Nurse to work collaboratively across all the CCG's in Surrey. The SLA establishes that the Designated Nurse should represent all the health trusts on the Surrey Safeguarding Adults Board, including its sub groups, and act as an expert health representative on Serious Case Reviews and Domestic Homicide Reviews. This includes the implementation and monitoring of current and future legislation relating to adult safeguarding.

3. The Care Act 2014

3.1 The Care Act 2014 placed adult safeguarding into primary legislation for the first time, consolidating previous legislation and guidance into one new act, and replacing the No Secrets 2000 guidance. The statutory obligations as described in the Act commenced from 1 April 2015. The NHS is one of the three statutory organisations in adult safeguarding (along with the local authority who remain the lead organisation and the Police.) The publication of the public consultation of and therefore the final draft of the Care and Support Statutory Guidance were delayed. See link below:

https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

3.2 As has been previously reported due to the delay in the publication of the Statutory Guidance, the redrafting of the Surrey Multi Agency Safeguarding Adults Procedures was also delayed and as a consequence not completed and in place by 1 April 2015.

3.3 A further consequence of this was that the CCG Safeguarding Adults Policy could not be updated reflecting the multi-agency procedures until those were completed. The updated Policy was presented to the SDCCG Quality Committee at the September meeting. The policy was then distributed to the other Surrey CCGs to be incorporated into their own policy documents, and presented to their Quality Committees in Quarter 3. The updated Policy is now on the websites of all Surrey CCG's with the exception of North East Hampshire and Surrey CCG, who are incorporating both Surrey and Hampshire policies together

4. Surrey Safeguarding Adults Board (SSAB)

4.1 The SSAB now meets quarterly (previously met three times year). The Designated Nurse has attended 2 of the 4 Board meetings, being absent from 2 due to planned sick leave and competing diary commitments. The Head of Quality as Surrey Downs CCG Executive Lead for Adult Safeguarding was in attended 3, and the Interim Director of Clinical Practice attended the final meeting of the year that neither the Designated Nurse nor the Head of Quality were able to attend.

4.2 Sub Groups

4.2.1 The Board, sub groups and Board members all work to the Strategic Plan published by the Board

http://www.surreycc.gov.uk/__data/assets/pdf_file/0004/52933/SSAB-Strategic-Plan-2015-16.pdf

In March 2016 the Board held a "Support and Challenge" event which looked at the strategic plan. It was agreed that the plan had been over optimistic in its vision, and the event looked at redefining the Boards Strategic Plan and agreeing a list of priorities that are deliverable by the Board and its members. A follow up event is to be held in April to confirm the outcomes of the day, with the view to submitting the new plan to the Board at its April meeting. This will be reported on in the Half year report April – September 2016.

4.2.2 The SSAB now has five sub-groups: Training, Serious Adult Reviews (previously known as Serious Case Review), Policy and Procedures, Quality and Audit and the Health sub groups.

The Safeguarding Adults Review sub group (previously known as serious case review) only meets when cases have been referred for review by the group; this group met twice during this year, the Designated Nurse attended one, but was on sick leave for the second meeting. No Safeguarding Adults Reviews have been commissioned by the Board this year.

The remaining sub groups meet 4 times each year. The Quality Assurance and Audit committee only met twice, having 2 meetings cancelled due to other diary commitments of the Chair and other members of the Group, thereby not being quorate. The Designated Nurse has only been able to attend 2 meeting of the remaining groups, and 1 of the health sub group, due to a combination of sick leave and annual leave, and other diary commitments. Where possible the Designated Nurse will contribute to meetings via communication with the Chairs in advance, and review minutes of meeting she is unable to attend.

The Health sub group is a new group this year, Chaired by SDCCG's Head of Quality and it was planned that the group met on the same day as the Children's Safeguarding sub group, with an overlap section between the 2 sub-groups to look at issues which impact on both adults and Children. This has proved unwieldy, and it now envisaged that the 2 sub-groups will have a joint meeting once a year.

5. Safeguarding Adults Reviews. (Previously Serious Case Reviews)

5.1 The Care Act 2014 requires Safeguarding Boards to conduct Safeguarding Adult Reviews under S44 of the Act;

http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted

None have been commissioned by the Board this year.

5.2 However, the Board did publish the Executive Summary, in March 2016, of a Serious Case Review, commissioned prior to the introduction of the Care Act, which looked at the circumstances of events which led to the assault by one resident (Mr J) of another (Mr Y), in a care home, which ultimately contributed to his death in November 2013.

http://www.surreycc.gov.uk/__data/assets/pdf_file/0007/84454/160120-SCR-Mr-J-and-Mr-Y-Exec-Summary-2016.pdf

This report made 12 recommendations which will be monitored by the Business Management Group of the Board.

6. Key safe policy, implemented April, reviewed September minor adjustments

6.1 Following the death of Mrs Gloria Foster, a Surrey Downs resident in February 2013, a Serious Case Review was published which has been reported on in previous reports. One of the actions from that review was to develop a Key Safe Policy. The Designated Nurse wrote this policy which was ratified by the SSAB in April 2015. See link below for policy.

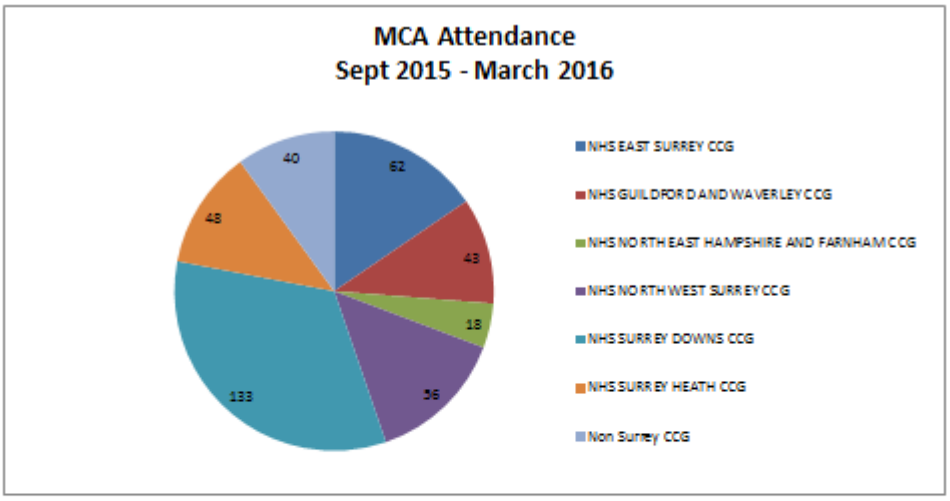
http://www.surreycc.gov.uk/__data/assets/pdf_file/0004/58756/SSAB-Key-Safe-Protocol-FINAL-1.0-April-2015.pdf

This was reviewed in September 2015 by the Policy and Procedures sub group, which recommended some minor adjustments to the wording as requested by some partner agencies. These were agreed by the Board.

7. Mental Capacity Act 2005 (Including Deprivation of Liberties Safeguards)

7.1 Concerns about the understanding, implementation, application and documentation have been a recurring theme identified in Serious Case Reviews both in Surrey and nationally, particularly within primary care. In March 2015, SDCCG, as host for Adult Safeguarding, successfully bid for monies from NHS England specifically to address this issue. Initially a sum of money was given to the SSAB to hold an event in April 2015. This was attended by 120 delegates from all agencies, partners, and NHS and private providers, with speakers from both the local and national arena.

7.2 Additionally, SDCCG contracted with Edge Training and Consultancy LTD, to deliver bespoke MCA and DOLs training, with a programme specifically tailored to address GP surgeries and their staff. Between September 2015 and March 2016 14 half day training events were held across Surrey, attended by 400 delegates



CCGs	No. of attendees
NHS EAST SURREY CCG	62
NHS GUILDFORD AND WAVERLEY CCG	43
NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG	18
NHS NORTH WEST SURREY CCG	56
NHS SURREY DOWNS CCG	133
NHS SURREY HEATH CCG	48
Non Surrey CCG	40
TOTAL	**400**

The feedback from these sessions has been phenomenally positive, and a further 4 events are to be held in April and May 2016. An evaluation of the feedback is attached in Appendix 1.

8. Surrey County Council Home Closures

8.1 Surrey County Council's (SCC) cabinet confirmed plans in March 2015 to close the 6 residential care homes they currently run. This was following a consultation process first announced in November 2014. The Designated Nurse is acting as a Critical Friend to SCC during this process.

http://www.surreycc.gov.uk/social-care-and-health/care-and-support-for-adults/get-involved/cabinet-to-decide-on-future-of-councils-older-peoples-homes

8.2 The aims of both health and social care, locally and nationally, are to support people to remain independent and well for as long as possible in their own homes. At the point where a person's needs cannot be suitable met safely in their own homes, their care needs are more complex than they may have been historically, and they generally require care that can only be met in a nursing setting rather than residential setting. The homes currently owned and run by Surrey County Council [built between 1970 and 1990] were built to meet very different needs than today's care market requires, and were not designed nor are conducive to appropriate

adaptations to meet the new standards expected either by regulators, service users, or their families. These 6 homes are currently underutilised, and therefore the decision was made to close these facilities, through a phased process over 3 years.

8.3 Brockhurst Elderly Resource Centre, Ottershaw (NWSCCG) and Longfield Resource Centre, Cranleigh (G&WCCG) were the first of homes to close, with all residents having been transferred to appropriate homes of their choosing by the end of September 2015. Dormers Resource Centre, Caterham (ESCCG) and Cobgates Resource Centre, Farnham (NEHFCCG) are in the second phase with plans to close in the summer of 2016, with Park Hall Resource Centre, Reigate (ESCCG) and Pinehurst Resource Centre, Camberley (SHCC) in the final phase, due to close in the summer of 2017.

9. Provider Failure

9.1 Following the more vigorous CQC inspections of care homes. More providers are now being judged as 'inadequate'. Where a provider is found to be inadequate, warning notices may be issued and the service will be placed into 'special measures.

http://www.cqc.org.uk/sites/default/files/20150401_special_measures_guidance_ASC.pdf

The special measures framework is designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate. Its purpose is to:

- *Ensure that providers found to be providing inadequate care significantly improve.*
- *Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.*
- *Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example to cancel their registration*. (Taken from the CQC guidance, link above).

9.2 Where a provider is placed into special measures, the local authority together with the CCG will look at the provider under the Provider Failure Protocol. That is not to say that the service is expected to fail, but to ensure that in the unfortunate event the provider is unable to raise its service to an

acceptable standard, the commissioners are in place to know about the needs of the residents and have plans to transfer them to alternative, appropriate accommodation in a timely way

9.3 This should not be viewed as a negative step. Under the powers set out in Section 2 of the Local Government Act 2000 known as the 'well-being powers' SCC has a power to promote the wellbeing of people in its area. By working together, the local authority, CCG, the CQC, the provider and other partners aim to promote the wellbeing of residents, and improve the care given.

9.4 Under the Provider Failure Protocol, the local authority is the lead agency for residential homes, and health lead in the event of a failure of a care home with nursing. A number of care homes have been placed into the provider failure protocol, with the Designated Nurse representing the local CCG in the process, and Chairing in the case of care homes with nursing.

9.5 During the period at the beginning of the year whilst the Designated Nurse was on planned sick leave, a care home in Camberley closed. This was due to the provider's business plan to demolish the building and replace it with a purpose built facility. The Director of Quality and Nursing for Surrey Health CCG coordinated the closure process of that home.

9.6 Following a CQC inspection in April 2015, a care home in Merstham (East Surrey CCG) was placed into "special measures". A follow up inspection in January 2016 found little or no improvements, and the CQC advised Commissioners that it intended to issue a Notice of Proposal to cancel the Registration of the service. In February, there was a multi-agency meeting under the Provider Failure Protocol where it was decided that the commissioning authorities would begin reviewing their residents with a view to finding alternative placements within 56 days. This meeting was jointed Chaired by the Designated Nurse and Area Director for the East locality of the Local Authority. This process was challenging as the majority of the 24 residents were funded by London Boroughs. The proprietor then advised the Commissioners and the CQC that he intended to close his service within 28 days. The statutory authorities worked together, reviewing and identifying appropriate alternative placements, and all the residents were relocated by the 28th day.

10. TIAA Internal Report

10.1 The review of safeguarding adults' arrangements was carried out on behalf of the CCG Collaborative in July 2015 as part of the planned internal audit work for 2015/16. Based on the work carried out by TIAA, an overall assessment of limited assurance was made of the overall adequacy of the arrangements to mitigate the key control risk areas

10.2 The final report was made available to Surrey Downs CCG on 1st October and a further verbal briefing on its findings was given to the CCG Quality Leads and to the CCG's Quality Committee.

10.3 The key findings of the audit team were that:

"The implications of the Care Act 2014 are significant, putting adult safeguarding on a statutory basis for the first time. The framework to provide assurance to the Governing Body and wider health economy that it is fulfilling its statutory responsibility to safeguard and promote the welfare of vulnerable adults is immature"

This related primarily to:

- Risk Management
- Safeguarding policy and procedures
- Assurance received from providers
- Disclosure and Barring Service (DBS) checks and training.

The overall assurance assessment as a result was that there was limited assurance based on the evidence reviewed by the audit team.

10.4 An Action plan was been put in place and submitted to the SDCCG Audit Committee, in December 2015. The Action plan is regularly updated, and reviewed by the Quality Leads of all 6 CCG's. Many actions have now been closed, but risks remain around actions linked to lack of available resources to support them.

11. Multi Agency Safeguarding Hub (MASH)

11.1 As has been referenced in previous reports, the Designated Nurse was involved in carrying out research for the Home Office looking at Multi Agency Safeguarding Hubs. The final report was published by the Home Office in July 2014, and was entitled "Multi Agency Working and Information Sharing Project". The full report can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338875/MASH.pdf

11.2 The current MASH is based at Guildford Police Station where it receives, reviews and acts on police notifications for vulnerable adults and children. The existing five partner agencies (Surrey Police, Children's Service, Adult Social Care, Adult Mental Health and Victim Support) are co-located and share information to make better decisions on risk and onwards pathways.

11.3 The MASH development represents new and better practice as promoted within:

- Working Together to Safeguard Children, 2013
- Munro Review of Child Protection, 2011
- No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, 2000
- Statement of Government Policy on Adult Safeguarding, 2013
- Care Act 2014.

11.4 Following a review of the current MASH, it has been recognized that the current arrangements are not meeting the original aim. A Consultancy Company was appointed in to review and re-launch the MASH, to meet all the aspirations of the statutory agencies, but also to ensure that both adults and children at risk follow the same pathway through the partner agencies, starting at the MASH. The MASH will be the main single point of entry used for all contacts to ensure effective coordination of support and or intervention at the earliest opportunity.

11.5 The coordination of the development of the MASH is now being led by Surrey County Council, with the key strategic Partners being GWCCG as hosts for Childrens Safeguarding and the Police. This has led to the re design of the MASH to include the Early Help Programme.

11.6 At present to emphasis is on developing an effective Children's MASH, but Strategic Lead for Adult Social Care and the Designated Nurse continue to work both the Programme and Development Groups to promote the importance of Adult Safeguarding inclusion in the MASH.

11.7 A Business plan has been tabled, to redevelop the MASH at Guildford Police Station. The Designated Nurse will continue to update the CCG's in future reports.

12. Domestic Homicide Review

12.1 Within the Service Level Agreement is stated that the Designated Nurse is expected to provide expert advice to Domestic Homicide Reviews (DHR). However, these are commissioned by the Community Safety Partnerships, and it has become apparent that they are not always aware of the Designated Nurse's role in this process. There are therefore some DHR that have been undertaken with Surrey that the Designated Nurse has either not been involved in or may not be aware of.

12.2 As has been previously reported, a number of reports have been submitted to the Home Office for Quality Assurance, but there are considerable delays in the reports being returned to the Community Safety Partnership. As reported in the half year report, a review into the death of a woman at the hands of her partner in the Surrey Heath area was resubmitted to the

Home Office in October 2015, no feedback has been received from the Home Office at the time of writing this report.

12.3 Similarly as reported in the half year report, the report into the deaths of 2 women in the Farnham area had been held pending investigations by the Independent Police Complaints Commission. This has now been completed and submitted to the Home Office.

12.4 This report highlighted issues with around the guidance of fire arms licencing and the links to GP references. Within this year a further death of a woman by firearms in the East of Surrey occurred, and the Designated Nurse has worked with the Named GP for Adult Safeguarding, to make recommendations to strengthen the guidance. The same recommendations were made in both reviews, and will be shared with NHS England and the CCGs when the reports have been approved by the Home Office.

13. Resilience

13.1 The internal audit previously discussed reflects on the relative immaturity of the statutory framework around safeguarding adults and the plethora of policy and guidance that needs to be embedded to ensure that risks to Surrey residents are mitigated and that individuals are protected. It also identifies the lack of resource available that has previously been highlighted to the CCG Collaborative to undertake this strategic work, particularly when compared to the resources in place to protect children and young people.

13.2 This lack of resilience is particularly highlighted when the Designated Nurses' expertise is required for a specific piece of work for example co-ordinating a home closure, or when involved in complicated work for the Court of Protection.

14. 12 Conclusion

14.1 The Service Level Agreement (SLA) agreed by the Surrey Collaborative for the Designated Nurse has not been reviewed since 2013.In addition, the implementation of The Care Act 2014[1] on 1st April 2015 and the publication of the NHS England Safeguarding Accountability and Assurance Framework[2] in July 2015 has highlighted concerns that the current arrangement may not robustly reflect the changing legislation. The recent internal audit, (finalised in October 2015, and which therefore will be reported in Quarter 3), also highlights concerns around this resource. Due to on-going discussion around collaborative hosting arrangements, the SLA has not been reviewed.

[1] Department of Health, The Care Act, 2014

[2] NHS England Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, July 2015

14.2 A business plan had been put forward to the Collaborative, which when considered will include revisions to the SLA, hosting arrangements and available resources, which will be reported on in the future

14.3 The Designated Nurse continues to work with the Head of Quality in Surrey Downs CCG to ensure her role continues to operate and develop more strategically in line with the current SLA, and any changes in a reviewed SLA. This will enable a greater level of focus on supporting partner agencies to develop and maintain systems and processes to support their vulnerable populations

Appendix 1

Mental Capacity Act Training 2015/16 - Feedback

Overall the Mental Capacity Act training was very well received. Over 14 sessions there were 400 participants, which represents a high attendance rate. Participants were asked to complete a feedback form at the end of each session and 307 forms were completed. The feedback received was hugely encouraging.

The following data is based on the view of the 307 participants that completed a feedback form.

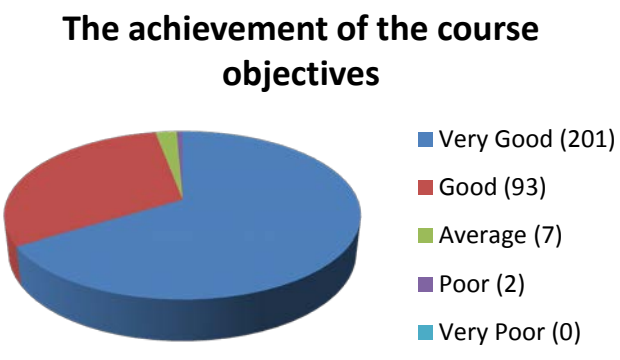
Participants were asked to rate the following statements from one (very good) to five (very poor) –

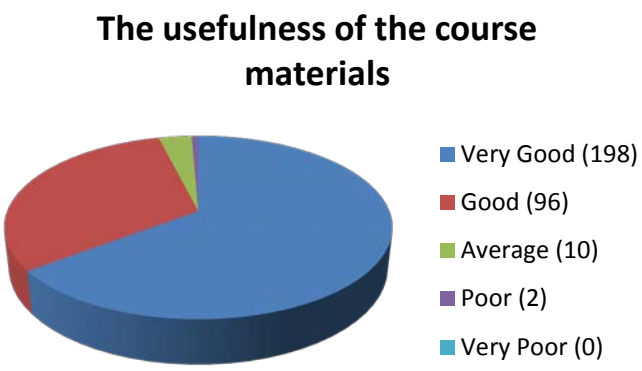
- The achievement of the course objectives
- The usefulness of the course materials
- The relevance to your work
- The opportunity to contribute your views and participate
- Clarity of presentation by the trainers
- Pace of course to your requirements.

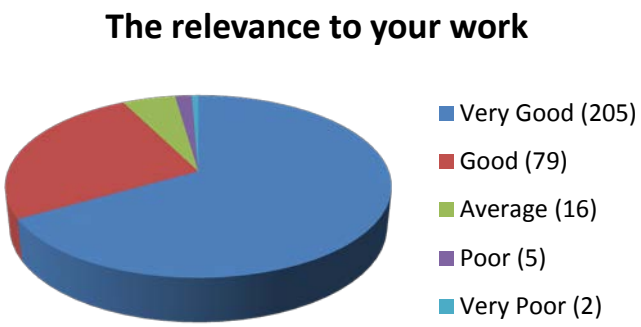
Over half the participants attending each session scored 'very good' for all six statements. The second most popular score was 'good'. Of the six statements, the only one to receive a score of 'very poor' was 'The relevance to your workload'. However, this was only scored as 'very poor' by two participants out of the 307.

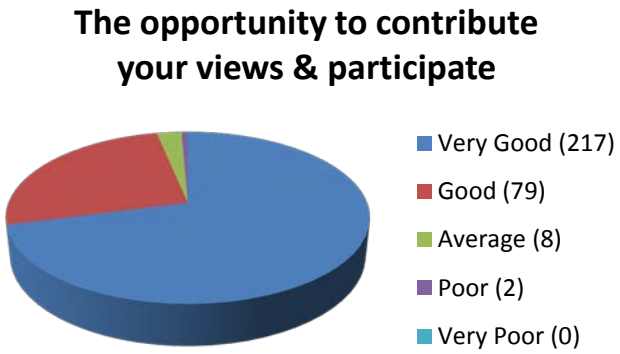
The statement 'Pace of course to your requirements' showed the greatest variation in scoring, with a higher number of participants scoring 'good' and 'average' than for the other statements. However, just over half still scored 'very good'.

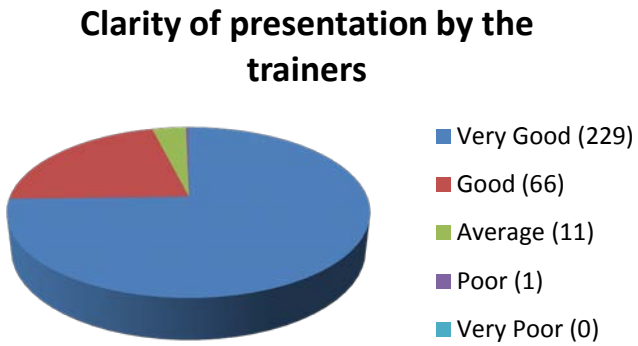
The following charts display the results for each statement –

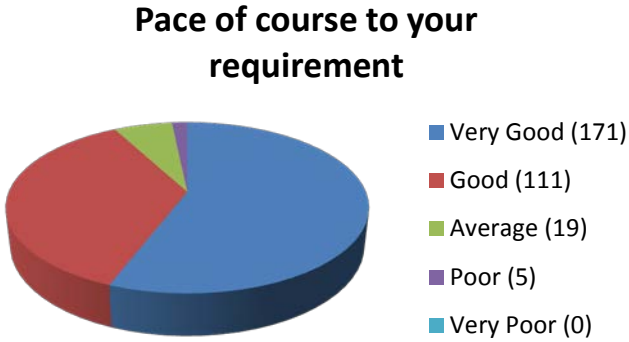












The participants were also asked to comment on what they felt was the most useful and least useful aspect of the training, as well as the impact the training will have on their working practice.

The common themes that emerged from what they thought was most useful was; the inclusion of case studies, the assessment of capacity, the best interests checklist and the general understanding and relevance of the Mental Capacity Act. Comments regarding the least useful aspect included the timing of the session being too short to cover all the topics. Particularly, a number of participants mentioned that they would have appreciated more time being spent covering Deprivation of Liberty Safeguards (DoLS).

With regard to the impact the training will have, many participants expressed that this would be high and that there would be a potential increase in their workload. In addition their record keeping will now improve and they will be feeding back their learning to colleagues. It was also stated by some that as a result of the training, they will be more cautious in dealing with patients with dementia.

General comments regarding the training overall were very positive, with many participants stating that the sessions were excellent and very well presented.