**Annual Report Safeguarding Vulnerable Adults 2012/13**

1. **Introduction**

Oxford Health NHS Foundation Trust has a duty to make arrangements to safeguard and promote the welfare of vulnerable adults. The Protection of vulnerable adults is not yet on a statutory footing, however, the structure and commitment of the safeguarding boards mirrors that of the children’s safeguarding agenda. The Trust is a statutory member of the Local Safeguarding Boards and makes a financial contribution to the Oxfordshire and Buckinghamshire local Authorities to ensure the continued function of the Boards.

1. **Purpose**

This is the second Safeguarding Adult’s Annual Report for Oxford Health NHS Foundation Trust and presents an overview of Trust activities in response to national and local priorities in Safeguarding Adults. The report provides evidence of compliance with CQC Outcome 7 Regulation 11 **‘**Safeguarding people who use services from abuse’.

1. **Safeguarding Adults Accountability Structure**

The Executive Board Safeguarding Leads are Ros Alstead Director of Nursing and Clinical Standards and Dr Clive Meux Medical Director.

The Safeguarding adults’ team who report to the Safeguarding Leads are:

* Deborah Humphrey: Head of Adult Safeguarding and Head of Nursing Older Adult Mental Health.
* Moira Gilroy: Senior Safeguarding Manager and practice lead Safeguarding Adults
* Julie Dale: Deputy Head of Social Care Mental health Division (Buckinghamshire County Council)
* Mary Moriarty: Safeguarding practitioner

Each of the 4 divisions has safeguarding leads and there is close working between the children and adult safeguarding teams.

A bi-monthly Trust Safeguarding Committee chaired by Director of Nursing and Clinical Standards is in place. This forum ensures robust governance of all safeguarding practice and activity across the organisation. Nominated senior divisional leads (both clinical and business support functions where appropriate) are required to evidence the contribution of their service area to ensure that safeguarding vulnerable adults is embedded in practice from front line practice to board. This includes evidencing delivery against Serious Case Review and CQC Outcome 7 action plans. The group has in place reporting arrangements to the Safety Committee and Board.

1. **Safeguarding Adults Inspections and CQC visits**

In 2012/13, three of the Trust services (Wintle Ward, Cromwell/Harding Wards and Huntercombe Prison) received an unannounced CQC inspection visit. Outcome 7 on safeguarding was reviewed in all 3 inspection visits and found to be compliant.

1. **Partnership Working**

The Trust representation at the Safeguarding Adult Boards has been clarified and there is attendance at the relevant sub groups. Feedback from the Boards is given to Divisional Directors and the Director of Nursing and Clinical Standards. Feedback also informs reporting of outcome 7 and updates. This work of the Safeguarding Adults team includes supporting delivery of plans from all Boards in line with national and local safeguarding priorities.

Examples of Partnership working during 2012/13:

* Contribution to Safeguarding Adults Boards sub group
* Investigating with the Local Authority external services where there have been concerns about the care and practice of vulnerable groups.
* Facilitation at NHS South Central’s safeguarding leaders meeting
* Work with the PCT and Local Authority to establish safeguarding thresholds in relation to violence and aggression, pressure ulcer care and medication errors.
* Attendance at safeguarding strategy meetings
* Closer working relationships with the safeguarding children’s team

1. **SIRIs / Serious Case Reviews**

There have been a number of SIRI’s that have had safeguarding concerns, these have included the following:

* Sandford ward: patient/patient sexual abuse – outcome was that the patients were managed separately. The perpetrator has now been discharged to a specialist care home with the relevant information being shared.
* Fiennes Centre: quality of care – outcome was a full action plan that was completed and signed off in a timely way.
* Kestral Ward: allegation by a patient of rape against a member of staff – outcome was that the allegation was withdrawn.
* Phoenix Ward: allegations by a patient of theft and violence against two members of staff – outcome was that the allegation was unsubstantiated.
* Kennet Ward: allegation of a member of staff having personal relationship with a patient – outcome was that the member of staff has left the Trust during the investigation. Actions have been taken to ensure the security of the unit and patients has not been compromised.
* Chaffron Ward: allegation that a member of staff had purchased items from a patient – outcome was that there was a full investigation and human resources processes were followed.

There has been one serious case review (SCR) in Buckinghamshire involving one of the CMHTs; this process is continuing into 2013/14. There have been no serious case reviews in Oxfordshire, Swindon or BANES that have involved the Trust.

1. **Training**

Safeguarding Adults:

31st March 2013: 81% of phased target of 100%

Mental Capacity Act

31st March 2013: 89% of phased target of 85%

Clinical Risk Assessment and Management (CRAM)

31st March 2013: 94% of phased target of 85%

**Actions planned to ensure that the agreed level of training is completed:**

* Between September and November 2012 the Learning and development team funded extra sessions by external trainers.
* Site specific training is being offered to suit the needs of teams that find it difficult to release staff.
* A joint training package with the safeguarding children’s team has been developed and is starting to be delivered. This will reduce the number of training sessions people need to attend and help ensure attendance at the sessions available.
* An e-learning package is available for safeguarding adults.
* Monthly monitoring of training statistics by safeguarding team.

1. **Safeguarding Adults Referrals**

In quarter 3 (2011) there was concern that Oxford Health did not raised the number of safeguarding alerts that would be expected from a Trust of this size. The safeguarding team have worked with divisions and local services to improve this service and the Oxfordshire Safeguarding Adults Board has reported at the end of 2012/13 a 100% increase in referrals from the Trust. This was commended by the Oxfordshire Safeguarding Adults Board.

Risk Notice 10 has been issued informing of the requirement from the Local Safeguarding Adults Boards to raise alerts for medication errors, patient on patient violence and aggression and all avoidable grade 3 and 4 pressure ulcers. The safeguarding adults team in the Trust has helped develop the staff’s understanding of these reporting thresholds by offering telephone advice as needed and by following up incident reports where issues are identified.

The development of a common understanding across the Trust has resulted in the understanding of the reporting thresholds in the Trust being different from those in Buckinghamshire County Council. Work is being undertaken in 2013/14 to build a common understanding in Buckinghamshire.

Evidence of awareness of safeguarding adults issues is provided in the record of contacts between the clinical teams and the safeguarding adults team. During 2012/13:

* In the Community Division it is identified that in 2012/13 only the Community IV Therapy Service had no contact with the Safeguarding Adults Team by telephone
* In the mental health division, all the older adult wards have had contact with the Safeguarding Adults Team. There is a record of one contact with Huntercombe Prison.
* There is no record of contact with the Forensic units; the contact with the Safeguarding Adults Lead in the Forensic Units was not recorded by the Safeguarding Adults Team during 2012/13. Safeguarding adults alerts were raised by the Forensic units and recorded by the relevant local authorities which indicates that discussions have taken place within the team.

1. **Information Sharing**

During August 2012, there were two identified instances where requested safeguarding reports were received late by Oxfordshire County Council (OCC). One of the delays was extended by the process of agreeing the information being shared outside of the Trust.

This potentially has consequences for the vulnerable people who are subject to the report and also for the reputation of the Trust.

**Actions to reduce delays in reports being shared**

The Safeguarding Managers in OCC have been requested to ensure that the Safeguarding Adults Team in the Trust is copied into all requests for reports.

This process has enabled the Trust’s Safeguarding Adults Team to ensure that the right person receives the request and to offer support where needed. The team are also able to remind the clinical teams when the report is due. The evidence is that when there are problems, the Trust’s Safeguarding Adults Team work effectively with the OCC team to achieve a timely resolution.

1. **Observations/Audit**

Observations

12 mental health wards have been observed during their handovers and ward rounds. The observations provide a snapshot of what is happening on each ward. It also provides the opportunity to raise the profile of the Safeguarding Adult’s Team, helping to develop the relationships with the teams. The value of the information has varied according to the nature of the ward.

The common themes that are:

1. There is explicit implementation of the frameworks provided by the Mental Health Act
2. People do consider each patient’s mental capacity explicitly
3. People are provided choice about their daily routine within the therapeutic environment
4. Safeguarding issues are considered and identified.

Mental Capacity Act (MCA) Audit

An audit of the Mental Capacity Act 2005 was completed for the Community Hospitals and Mental Health Wards in Oxfordshire.

The common themes are:

1. Nurses are considering mental capacity but do not document this in line with the MCA. Therapists and Doctors are more likely to document the assessment in line with the MCA but this is not consistent or frequent.
2. Staff are not asking patients whether they have a Lasting Power of Attorney in place
3. Staff are not asking patients whether they have an Advance Decision to Refuse Treatment in place.
4. **Restraint**

The Board receives a quarterly report on the use of seclusion and restraint. The quarter 4 report for 2012/13 summarised the use of restraint for 2012/13. The total for the year was 1371 with a mean of 114 per month. The graph below shows that the number of reported incidents increased gradually until August 2011 before falling for three months and then steadily climbing again for the last four months.

Violence and agression followed by self harm were the main reasons for restraint. The secuirty related incidents generally referred to restraints to prevent absconding.

The authors of the quarterly report submitted to the Board are analysing the information and the information is used to try to further understand the reasons for restraint and the types of restraint used.

To reduce the incidents of restraint and seclusion, the team are reviewing the current national and international work and adapting the training in line with this. They are bidding for money to support the work that needs to be undertaken. The Safer Care Programme Work will also have an influence on these figures.

**12: Key Priorities for 2013/14**

* To continue improving compliance with safeguarding, Mental Capacity Act and Prevention and Management of Violence and Aggression (PMVA) training
* To continue to support front line staff and managers in safeguarding adults practice through the provision of safeguarding advice, supervision and training.
* To continue developing system to provide advice and support the process of making safeguarding adults referrals so that Outcome 7 can be evidenced more robustly
* To work with divisions to provide assurance about safeguarding practice and to support appropriate and timely referrals to the relevant local authority safeguarding teams.

Moira Gilroy

Safeguarding Adults Manager

29th August 2013

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