NHS England

SAFEGUARDING ADULTS AT RISK IN LONDON - A STOCKTAKE

REPORT TO SUPPORT THE SAFEGUARDING ADULT SUMMIT

STEPHAN BRUSCH
NHS England | [London Region]

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FORWARD

With NHS England now in it's third year, the first anniversary of the Care Act 2014 that put adult safeguarding on a statutory footing and the recent House of Lords Debate on the Mental Capacity Act, I wanted to use the opportunity to reflect on what is emerging from all our work that was undertaken to safeguard the individual and identify any themes in learning where we identified that we could do better.

This report looks at, examines, and covers London's array of organisations getting better at protecting adults at risk of harm and neglect, recognising when harm occurs and supporting the individual to ensure they are safeguarding themselves.

In my role as strategic lead for Safeguarding Adult and Children in London, I wanted to ensure that we learnt the lessons from local reviews; examining what went wrong if an adult at risk was harmed or died because of neglect; a person was killed by a patient who was in receipt of mental health services or an individual was killed by a partner or family member.

I also wanted to take the opportunity to reflect on our London wide CCG assurance work, the quality assurance process embedded across London, as well as the work by the Care Quality Commission and Safeguarding Adults Boards.

We have strong partnerships with CCGs and Local Authorities across London, as demonstrated by the multi-agency policy and procedures to safeguard adults at risk, I now want to use this learning to identify potential gaps but also opportunities we can tackle at a London level. I hope that this report contributes towards that journey.

Vanessa Lodge

Director of Nursing North Central and East London
NHS England (London Region)

INTRODUCTION

This report was commissioned by NHS England to shine a spotlight on the safeguarding adult system in London, and provide a brief overview of the lessons learned in London over the past three years since NHS England came into being.

The Safeguarding Vulnerable People in the NHS -Accountability and Assurance Framework (NHS England 2015) is clear that it is NHS England's responsibility to ensure that the health commissioning system, as a whole, is working effectively to safeguard adults at risk of abuse or neglect. To that effect it is vital that NHS England provides leadership support to the safeguarding professionals, so that they are able to fulfil their crucial role across the local health and social care economy. It is important that evidence and learning is made more easily accessible.

This report, in conjunction with the safeguarding adult summit, aims to do this with a view to share the lessons that have been learned, but also to go further and to agree jointly, the owned next steps and future actions. Successes such as the development of the London Multi- Agency Adult Safeguarding Policy and Procedures (2015) and the subsequent launch event demonstrates the importance of doing something once for London, rather than 33 times across every Safeguarding Adult Boards.

For this report the following information and investigation were included:

- Five Safeguarding Adults Reviews
- 19 Domestic Homicide Reviews
- Four Mental Health Homicide Reviews
- 161 Preventing Future Death Notices
- 26 CQC inspections of NHS and Foundation Trusts
- 75 CQC inspections of GP practices
- Deep Dive into the Commissioning Arrangement of CCGs (2015)
- Safeguarding Adult Audit completed by 112 organisations (2014)

To complete the stock-take, NHS England will produce a subsequent data and evidence report, in order to develop a comprehensive repository of learning and thereby contribute to the improvement to protect adult at risk.

EXECUTIVE SUMMARY

This reports considers and reviews the learning that took place from 161 Preventing Future Death Notices and 28 formal reviews made up of Domestic Homicide, Mental Health Homicide and Safeguarding Adult Reviews. The report analyses the emerging themes and the 496 recommendations generated by this investigation.

The report also aims to triangulate the learning from the recent deep dive into the Clinical Commissioning Groups (CCGs), the safeguarding adult audit work and 101 inspections undertaken by the Care Quality Commission.

Each section of the report discusses and analyses the emerging themes and identifies the lessons learned and recommendation that are relevant to London or local partnership.

What is evident is that organisations are under increasing pressure with clear capacity issues to provide personalised health and care to meet the complexity of the needs of London's patients and people. This holds particularly true for mental health organisations.

Not having the time to care and undertake essential tasks, can lead to fatal consequences as demonstrated across the investigations reviewed. The lack of time allocated to undertake a robust holistic assessment of the person led, in many cases, to undiagnosed health problems, miscalculation of risk to themselves or other and missed underlying vulnerability. These assessments should consider risk, their previous history, their circumstances and living arrangements.

Lack of detail in completing observation and handing over of, and sharing of information, often contributed to poor handovers or discharges and subsequently led to poor decision making in others because it was based on incomplete information. This too resulted often in harm in to the individual.

20 per cent of recommendations from the reviews, and outcomes from the other work, identified issues in the workforce regarding staff knowledge or sufficient capacity to undertake their work which included safeguarding individuals. The soon to be published intercollegiate guidance, which is a renewed strategic focus on how to develop competencies across the NHS, may be a useful tool for staff involved in safeguarding. Further, assuring that time by staff spent in training is maximised, through robust quality assurance of delivery and content of training is also important.

Across all reviews and deep dive reviews, the issue of supervision and reflective practice emerges. It is important to provide the dedicated safeguarding workforce with time to reflect on their role as much as it is to strengthen supervision in mainstream setting and ensuring that safeguarding in its widest sense is discussed and reflected upon.

It should be noted that there are good strategic partnerships in place, supported by local Safeguarding Boards and evident in the CCG assurance. Nonetheless the inter-professional communication and decision making remain a key focus in every review. Supporting the huge number of organisations involved in safeguarding to communicate effectively with each other is not without its challenges. There could be strategic support in embedding information sharing protocol, awareness raising around the sharing of information in line with the Data Protection Act. An area to focus on still includes raising safeguarding alerts, and this also needs to become a focus. Actions to improve and work such areas may include forming alliances with other networks, to ensure that the importance of safeguarding and the sharing of information is shared by all.

LEARNING FROM REVIEWS AND INVESTIGATIONS

Safeguarding Adult Reviews (SAR):

The purpose of a SAR is to 'promote effective learning and to set improvement actions to prevent future deaths or serious harm occurring again'. Safeguarding Adult Reviews (SAR) were formally established under section 44 of the Care Act 2014. The purpose is not to hold any individual or organisations to account, as other processes exist for that purpose, for example but not exclusively, criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation run by the Care Quality Commission (CQC) and the Nursing and Midwifery Council.

The Care Act 2014 states that: A Safeguarding Adult Board (SAB) must 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, members of it 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,
- The adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other 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). Each member of the SAB must co-operate in, and contribute to, the carrying out of a review under this section with a view to:

- identify the lessons to be learnt from the adult's case, and
- apply those lessons to future cases.

Following a recent scoping exercise of Local Authorities' websites, it became evident that there are currently nine serious case reviews in process and of those five have been published within the past three years. As the numbers are quite small this report also references the 'London Joint Improvement Partnership (JIP): Learning from Serious Case Reviews on a Pan London basis' (2012).

Adults at risk

In total there were six individuals involved in the five SARs (three male and three females). Ethnicity was not recorded in four SARs and in one case the ethnic background of the adult was Ethiopian. In two of the SARs the person died of underlying health issues; there were two homicides- a father was killed by his son and one husband killed his wife before committing suicide and one person committed suicide.

Preventability and Predictability

One review found that the suicide was not thought to be preventable or predictable. Two SARs stated that it was not possible to conclude that actions from any agency could have stopped the two homicides from taking place, though it did recognise that better joined up working may have had a greater positive impact on the families' lives. The remaining two SARs did not comment specifically if the death was avoidable. All SARs identified key systematic issues and made subsequent recommendations to improve these.

KEY ISSUES

Making Safeguarding and service provision personal

The key challenges that emerge are around how organisations, in partnership with other agencies are able to meet the changing, and increasingly complex needs, of individuals who may or may not have capacity to make decisions about their care. Each individual within these reviews had their own issues, such as being agoraphobic, having disengaged from services because they felt let down, mental health issues, alcohol abuse, dementia and dealing with a terminal illness. Key learning from these reviews would conclude that care needs to be adjusted to take account of people leading complex lives and to make the safeguarding process more personal.

Blurred Lines

The reviews highlighted the difficulties that staff encountered in providing care to individuals that balances risks with their right to autonomous decision making. The blurred lines are between capacity and lack thereof, for example in a person who self-neglected herself, or one who suffered from depression were difficult to judge for staff. The interface between failure to provide good quality of care and when this becomes a safeguarding issue was also present within the reviews and concerned all sectors reviewed (acute, primary care, community, care and nursing homes). In two SARs staff did not investigate pressure ulcers in order to understand the root cause of these occurring and had this quality issue been inspected, they would have shown that there was general concern about the care provided, thus triggering a safeguarding referral.

In another SAR, the importance of providing a person with dignified palliative care and or therapeutic input when faced with news of a terminal illness were not balanced with the risk to the individual not providing these.

Safeguarding proceedings

Three SARs identified that staff lacked understanding of safeguarding proceeding and therefore didn't utilise these to protect the individual from harm. In some instances, whilst concerns were identified, these were not taken forward due to staff lacking training in safeguarding.

Partnership working and information sharing

Four of the SARs identified the lack inter-professional and organisational sharing of information as an issue, leading to a lack of person centred care, poor risk assessment and assessment of health and care issues. Underpinning this was also a lack of partnership working. A misunderstanding of roles and responsibilities across the partnership featured in one SAR and in another two SARs, the lack of actively referring to other agencies to meet the identified need/s. For example:

- A referral for psychotherapy for a person struggling to cope with a terminal illness was not followed up
- An individual who was dealing with depression, alcohol abuse and who was at risk of eviction from her home.

The lack of the family voice and organisations acting on concerns that they raised about their relatives was also present in one SAR.

Discharge planning was poor in two SARs. Discharge policies and procedures were not followed, follow up arrangements did not happen and information provided was inadequate and incorrect. One individual's discharge was rushed twice and also lacked social work input, the SAR author summarised that the speed of discharge took precedence over a safe discharge. This was particular concerning given that the person was on a ward specialising for geriatric medicine and he was discharged to a care home that wasn't prepared to deal with his increased nursing need.

The pan London review of 18 SARs undertaken by London Councils in 2012 found that 83 per cent of SARs identified significant issues with multi-agency working and communication and 94per cent highlighted information sharing and handling issues.

Mental Capacity Act (MCA)

The lack of adherence to the Mental Capacity Act (MCA) was cited in four reviews. The SARs found that understanding of the legislation, including the Deprivation of Liberty Safeguard (DOLs) was inconsistent across the health economy and it was not used to safeguard the individual. An example of this was the critical decisions made by doctors about a person with dementia without a comprehensive mental capacity assessment or involvement of the next of kin.

One principle of the MCA is "the right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions". One SAR found that a patient was not provided, and or confronted with, difficult information about the consequences of her decision making, including details on how her self neglect, which led to the development of 13 pressure ulcers, could lead to the loss of her life.

The challenges and limitation of the Mental Health Act and MCA are identified within two SARs and were particularly relevant for mental health organisations, London Ambulance or the police. Organisations were limited in how they could respond as a person's risk to their safety were not deemed sufficient to require them to be formally detained under the MHA and they were deemed to have capacity to refuse voluntary

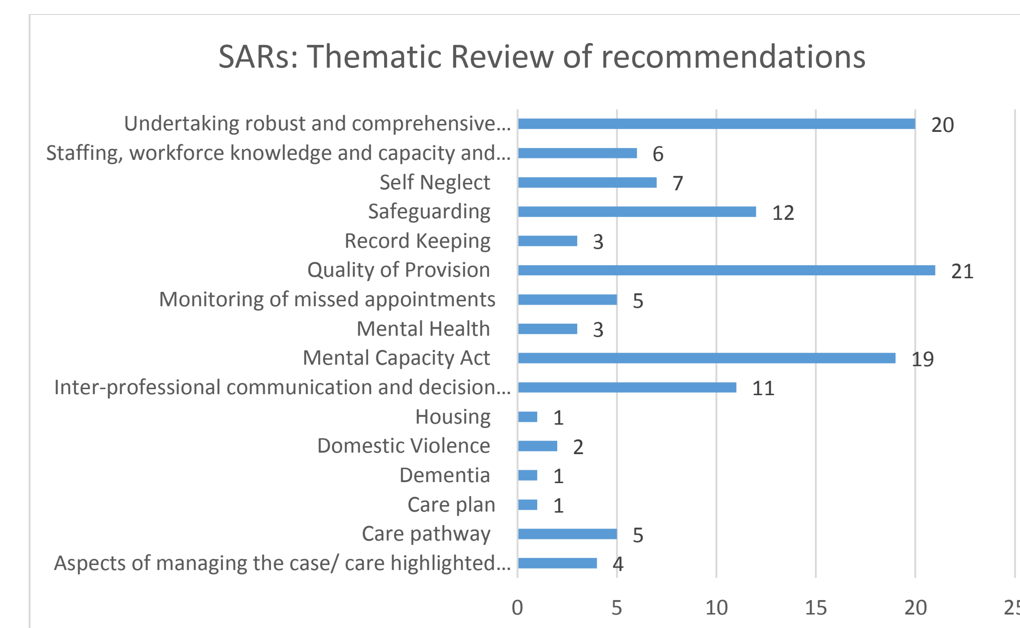
hospital admission. Clearly these were vulnerable individuals who ended up killing a relative or themselves.

Domestic Violence

Domestic violence featured in the three SARs and involved two homicides (the murder described in one SAR had it occurred 3 weeks later it would have fulfilled the criteria for a statutory Domestic Homicide Review). One SAR stated that organisations did not spot the strong parallels to traditional domestic violence scenarios within the relationship between a son and his father. The agency that was aware (the police) did not trigger a Multi-Agency Risk Assessment Conference (MARAC). In another review there was a lack of understanding and formal guidance in how to work with families where coercive behaviour exists. A history of domestic violence within a young woman's family and her relationship with her partner were also prominent in a person's suicide.

RECCOMMENDATIONS FROM THE ANALYSIS

The five SARs generated a total 121 recommendations. All recommendations were reviewed and allocated an overarching theme, for example 'undertaking robust and comprehensive assessments'. A second theme was then also allocated that described what organisations were asked to improve or develop, for example 'training and practice development' or providing information or guidance.



17per cent of the recommendations fell within the category of **quality of provision**. The recommendations aimed to:

- improve how dignified palliative care services are being provided
- ensure that the person is receiving appropriate care relating to hydration and tissue viability

- develop accurate care plans that include pain management, medication management and dietary needs
- improve awareness in how to respond to risk or concerns in service provision and how to escalate these
- provide adequate emotional and mental health support to people who receive the diagnosis of a terminal illness
- enhance assurance that locally commissioned enhanced GP services meet their service specification in terms of providing input into nursing care homes.

Closely aligned to the quality of care, 16per cent of recommendations aimed to **strengthen the assessment process and to ensure that this is robust and comprehensive**. The majority of recommendations were around how staff assess, identify and respond to risk to individual patients or clients. It also concerned how organisations improve the comprehensiveness of assessment through:

- increased partnership working
- accessing historical records
- recognising the importance of assessing not just medical factors, but to include psycho-social aspects.

The recommendations also aimed to strengthen the GP assessment of individuals within a nursing care home, through strengthening the 'ward round'. Furthermore, the review required that that the changing need of individuals should be responded to appropriately through increased assessments following admissions and discharges (for example following a discharge from acute to care home provision).

15 per cent of recommendations related to improving the legal literacy of organisations and individuals with regards to the **Mental Capacity Act** and to ensure that patients who are deemed to lack capacity are benefitting from this safeguard. The recommendations related to practice development and training and the improvement of mental capacity and best interest assessments.

Improving **safeguarding competencies** was the aim of 10 per cent of recommendations. Predominantly this was around improving training and practice development in staff across the sectors to better understand their roles and responsibilities within protecting adults at risk. The recommendations also aimed to strengthen the interface of safeguarding and:

- domestic Violence
- pressure Ulcers
- risk assessments
- self-Neglect
- Serious Incidents (SI), especially when an individual may be an adult at risk and or at risk of self-harm or suicide.

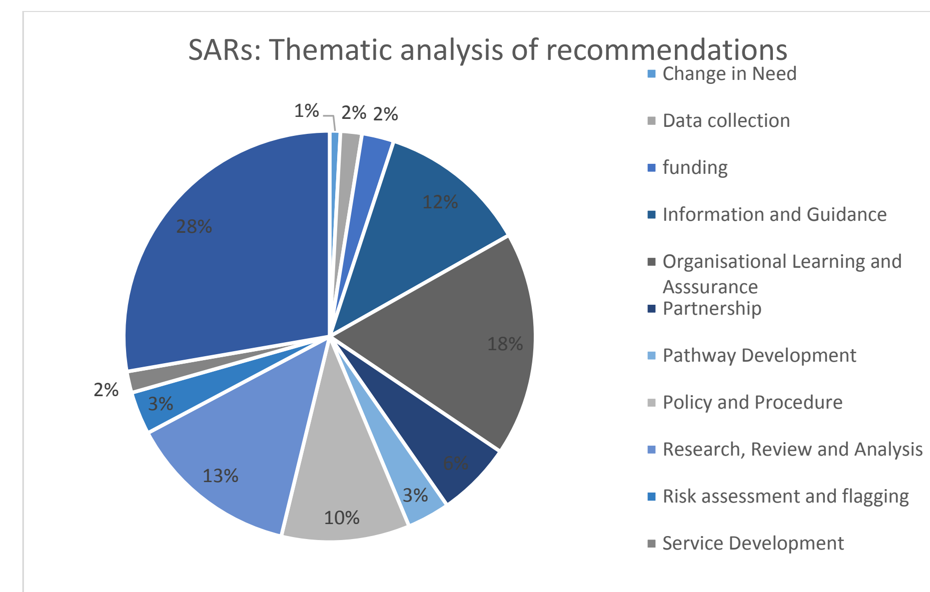
10 per cent of recommendations were about improving **inter-professional communication and partnership working**. Strategic actions were identified to support partners to lawfully share information better across the local partnerships, but also to further enhance knowledge of the roles and responsibilities of different sectors and organisations. The aim of the recommendations was also to ensure that there are improved discharge processes and patient outcomes (where there is a change in need) and if more than one organisation is providing care along this care pathway. Operational recommendations aimed to address multi agency working through clearer referral pathways, such as sending referrals and following up on them and also how information is shared with families and the next of kin.

Smaller number of recommendations were around addressing **capacity and workforce** issues within organisations, such as weekend cover and demand on the a service. They also related to how organisation provide assurance to the local safeguarding board that lessons have been learned.

Particular issues also emerged around improving the care and care pathway of:

- people with dementia,
- individuals with mental health problem
- people who self neglect themselves
- monitoring of missed appointments (either because a person lacks capacity, or has capacity but choosed to not engage).

OPPORTUNITIES FOR SHARED ACTIONS ACROSS LONDON



With 28 per cent of recommendations falling within the category of training and practice development, there is a clear theme on how workforce development incorporates the need for training on:

- safeguarding
- mental Capacity Act

- domestic Violence
- self-Neglect
- risk assessment

Sharing of lessons learned and best practice across partnerships and London also featured greatly within the reviews. Therefore, there is an opportunity to co-design a workforce and training program aligned to the soon to be published intercollegiate guidance for safeguarding adults.

18 per cent of recommendations relate to organisations providing assurance on safeguarding and wider quality issues, either through their commissioning and procurement processes, their internal board function or through reporting directly to the Safeguarding Adult Board. Maybe not surprisingly the majority of recommendations were about ensuring that the lessons learned from the SAR and or the Internal Management Review (IMR) were learned by that organisation. The safeguarding summit on March 17 2016 and this accompanying report are designed to ensure that the key lessons learned are made widely and more easily available. Further work could be undertaken to provide strategic leadership in how to better integrate the safeguarding system into clinical governance and quality development at organisational board level.

Although learning took place as part of the serious case review, various sectors and care agencies were requested in 13 per cent of recommendations to further **review or analyse** particular issues that emerged. In particular, organisations were required to undertake case file audits on:

- how mental capacity or best interest decisions are being made
- identifying auditable ways to record how discharge decisions are being made
- measuring improved outcomes in personalized care plans
- self-neglect

More strategic joint partnership actions for boards were around recording and measuring incidences of self-neglect and review effectiveness of local procurement arrangements. Case audit or other tools should be shared across London to equip other organisations to undertake similar work.

The request for development **information and guidance** underpinned 12 per cent of recommendations. The call was to improve availability and accessibility to information to improve awareness on the:

- Mental Capacity Act
- Responsibilities regarding safeguarding and also how to engage, for example GPs in serious case reviews
- Managing a person’s hydration
- Pressure ulcers, their early identification, treatment and care and how to escalate and align this to safeguarding processes
- How to work with someone who disengages from services and the monitoring of missed appointments.

- Undertaking comprehensive and multi-agency risk assessments and assessments
- Guidance on self-neglect

Again there could be opportunity to co-design information and guidance to complement the pan London safeguarding policy and to avoid duplication of efforts at local level.

DOMESTIC HOMICIDE REVIEWS (DHRS)

Domestic Homicide Reviews were established under Section 9(3) of the Domestic Violence, Crime and Victims Act 2004. The purpose of these reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic homicides and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working
- This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

Within London, there are currently 64 Domestic Homicide Reviews (DHR) that are at various stage of development, of these, 18 DHRs have been published and are available on local borough websites.

Victims and perpetrators

Age Range

The age of the 18 victims ranged from 22 -86 years, with four DHRs not stating the age of the victim. The perpetrators age range was from 24-69 years. With 83 per cent (n~15) of the majority of the victims were female, with only 17 per cent (n~3) being male. In contrast 83 per cent of the perpetrators were male and 11 per cent (n~2) female. Therefore most of the homicides reviewed were male on female killings, with only one male killing another man and two females killing a male victim.

Ethnicity

Two of the victims were identified as white British (11 per cent) and this is the

highest ethnicity group within these reviews, with single cases being reported from a number of other ethnic backgrounds. Unfortunately, three DHR did not report on the ethnicity of the victim.

With regards to the perpetrators, the highest group, with two cases, are Black British individuals equating to 11 per cent of the perpetrators. As with the victim's ethnicity, there are single cases reported from a number of ethnic backgrounds, including white British. It is important to highlight that the most recent Census Data for London (2011) stated that 45 cent of Londoners are White British. Therefore, this group appears to be under represented within these DHRs, both in terms of perpetrator and victims.

Background to relationships

In 44 per cent of the cases the perpetrator was an ex-partner of the victim. The relationship status ranged from having dated for a short while, having had a long term relationship, being married and to the perpetrator being the father of the child involved. In four cases a parent was killed by their son- the mother in three of these homicide. Two homicides took place within a current relationship and one male murdered his mother in law. There were 21 children involved in 10 domestic homicides their ages ranging from 14 months to 17 years. Including relationship and underlying dynamics is therefore crucial to identify within assessment processes.

Predictability and Preventability

Within the concluding statement of the 19 DHRs, the panels stated in four cases that the deaths could have been avoided; in 12 DHRs the panel agreed that the homicide could not have been prevented; two DHRs was unable to determine the predictability and another stated that the homicide was not preventable whilst questioning that a more robust response could have made a difference.

The DHRs that concluded that the death was preventable are:

- Croydon 'Adult H'
- Hammersmith 'GH'
- Lewisham 'AB'
- Lewisham 'WX'

The reason why the other DHR were not predictable and thereby preventable were:

- Due to the perpetrator only having used general service and there was little known about him.
- Due to the victim having only just arrived in the country and was with the perpetrator for a very short while and it is extremely unlikely she knew the extent of his domestic violence history or the severity of his mental illness.
- Too little was known by agencies about perpetrator's abuse and violence towards the victim
- The limited engagement family members had with statutory services did not invoke concerns of domestic abuse amongst the professionals encountered.
- There was little involvement of statutory agencies and no early warning signs of aggression or violent behaviour available to any statutory or voluntary agency before this killing.

KEY ISSUES AND MISSED OPPORTUNITIES

Most DHR described key incidences or missed opportunities that were deemed by the panel to be of significance to the homicide and may have had an impact on the outcome. Below, is a list of missed opportunities that were identified as part of the DHR conclusions.

Key issues within the DHRs that could have been prevented

The toxic trio featured in all four DHR cases that could have been prevented. The term has been used to describe the issues of domestic violence, mental ill health and substance misuse, which have been identified as a common feature in adult and children safeguarding as a key indicator of risk. In three of the reviews more assertive management of the perpetrator's mental health were deemed to have mitigated the risk of the homicide. In two of the reviews the chairs of the review identified the lack of connection and understanding between domestic violence and safeguarding processes (children and adults) as a key issues.

Safeguarding Processes

One DHR stated that 'there were several key incidents when protection and support could have been afforded to the person and these opportunities were missed. Another concluded that it was 'regrettable that the adult and child did not receive a level of support that could have prevented this death occurring'. Many statutory sector agencies had considerable contact with those involved in these homicides. This review has revealed a number of agency failings including recognising the potential for domestic violence, adult and children safeguarding concerns and the connection of mental health with these issues.

For example, many opportunities were missed for risk assessments to include the vulnerability of the mother. Threats had been made by the perpetrator against her, especially when unwell, yet he was discharged to his mother's home despite the fact that there were significant events, such as reduction of his anti-psychotic medication and transfer of care. The DHR highlighted the limited understanding and connection between the response to adults at risk and domestic violence.

Mental Health

Two DHR panels concluded that the death may have been prevented if there had been a mental health assessment undertaken (there were opportunities for this to happen). If these had been completed, then it would have been likely to have resulted in the perpetrator being hospitalised so that his condition could have been monitored and treated effectively. For the other perpetrator treatment and support could have been provided that would have reduced his risk to himself and others. Contributing factors in these homicides were also:

- the lack of provision of appropriate housing for the perpetrator to manage the risk he presented
- the lack of risk assessment focusing on the family and the risk he posed to them
- information sharing with other organisations through MARAC or MAPPA.

Prior to the homicide described in one DHR, the perpetrator's family contacted the police and the GP surgery with concerns about his deteriorating mental health. Despite an evident indication that he posed a danger to himself and to others, the referral process was not completed for a mental health support.

Professional Curiosity

A consistent theme across almost all DHRs was the lack of professional curiosity by staff involved in safeguarding. Professionals did not explore the victim's relationship and home life, nor ask directly about domestic violence. Had this been explored the victim may have then been given the opportunity to talk about what may have been happening with her partner, and be offered support.

For example, in one DHR, while both partners of the marriage sought help with their relationship from the GP practice they had in common, available written records do not indicate how doctors checked out whether there were potential concerns of domestic abuse, any advice given to the victim about keeping safe or how it was ensured that couples counselling was appropriate and effective.

Information Sharing

Information sharing featured in nine DHRs as a key issue, but was also highlighted in all reviews. A common thread in reviews, one DHR found that the failure of agencies to effectively share information, and the lack of communication between agencies meant that the risks were not recognised and managed.

An example of this, is that one DHR noted that agencies referred to a mental health team as having a 'silo mentality'. The sharing of information described within these DHRs is complex and relate to inter and intra organisational working and have a direct impact on staff's behaviour. For example, a police officer who attended a domestic violence incident in the household did not hold the full information on the extent of the perpetrator's history relating to domestic violence and mental health concerns. Had the police officer known this he is likely to have intervened more assertively.

There were issues described in the review around the flow of information, for example between a GP and probation services. In this case an offender was sentenced to attend a substance misuse treatment program, but then failed to follow up on this. Subsequently this was not communicated amongst those two organisations. Collective failure of agencies to ascertain and respond to the people's needs and the risk they posed are also described. In one case this left the person effectively homeless and in a vulnerable and unsupported position.

Information handling was also a key issues, with poor record keeping highlighted such as files being incomplete and lost. This impacted on new workers coming into contact with the person as they did not receive an appropriate handover.

Mental Health and risk assessment

Preceding some homicides, there were clusters of risk indicators: problematic drinking, threats of suicide and threats to kill, set against the situational indicator of contested imminent separation. The risk to the victim was not identified by the professionals. The DHR highlighted the challenge facing professionals who are not providing a specialist domestic violence service, but who are consulted by those at risk from domestic violence. Recognising this risk within the busy day to day environment of a public facing service is a significant issue identified within the DHRs.

Toxic Trio

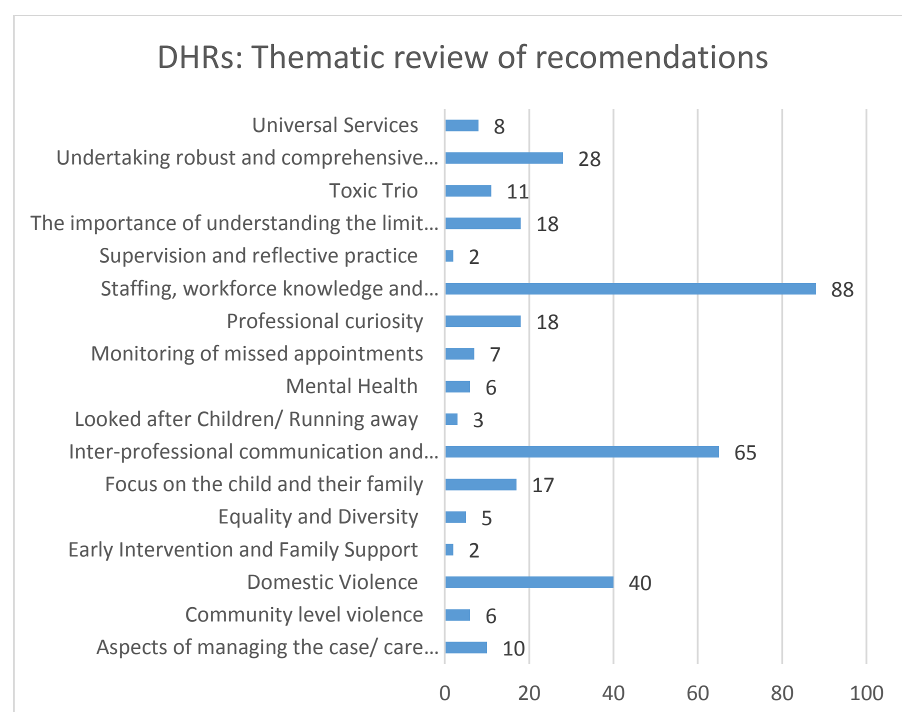
There was clear evidence of 'The Toxic Trio' of drugs and alcohol, mental health and domestic abuse combining to create the circumstances that led to some of the victim's death. The issues of substance misuse and mental health were also not recognised as part of a 'disastrous nexus' with domestic violence. There had been opportunities to identify the risk to the victim but no remedial actions were taken in a number of reviews. The review outlined shortfall in the following areas:

- There was a failure to transfer the mental health care of the perpetrator effectively
- Services were aware that he did not take his medication to manage his mental health
- His past history was not appropriately explored and did not inform risk assessments

- There was a failure to identify the victim as an adult at risk
- Unclear referral and care pathway between substance misuse and mental health services.

Recommendations

The 18 DHRs generated a total of 334 recommendations to local partnerships (Domestic Violence Strategy Boards, Local Safeguarding Children and Adult Boards), mainstream services and dedicated domestic violence service providers, as seen below.



Not surprisingly the majority of recommendations (with 26 per cent) were to improve the workforce, staffing and capacity issues in organisations and to improve the understanding of domestic violence within services, through better assurance. This included either the development of DV policies where they didn't exist, to strengthen them or review their efficacy via audits and reviews. Within general practice there was calls to embed the IRIS system (a signposting and support service) to strengthen guidance to primary care practitioners. Enhanced oversight of GP understanding through contractual levers and appraisal and revalidation was also called for.

In general, the recommendations asked for strategic partnership and all sectors to improve the knowledge of their staff through organisational development mechanisms (such as included DV responsibilities into supervision, personal development plans and job descriptions) and to have board level oversight that this is happening. Organisations were also asked to reflect on the lessons learned within the DHR and to roll out DV training and integrating this into wider training around safeguarding children and adult training.

Opportunity for shared action across London

20 per cent of recommendations addressed issues around **partnerships, how information was handled, shared within organisations and with other key partners** to inform risk assessments and decision making. Often the recommendations addressed the shortfall in care and referral pathways, especially for individual with alcohol and substance misuse who also have a mental health problem. Improving the system for sharing safeguarding concerns between emergency departments, social services, the police and local authorities was also a key theme.

Strengthening of MASH, MARAC and other risk sharing groups to ensure attendance of relevant agencies, including GP was also a common feature in the recommendations.

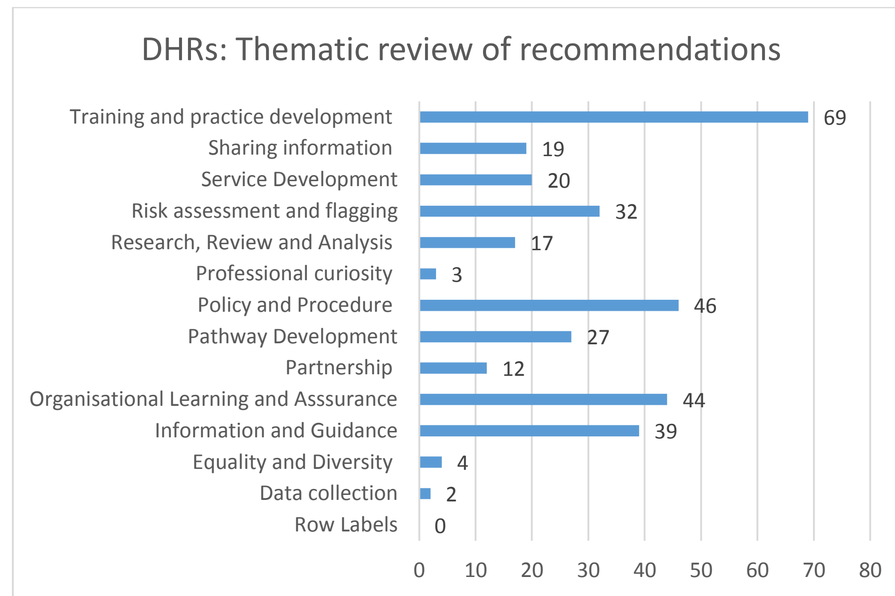
11 per cent of recommendations were directly related to **domestic violence** and were generally focused on increasing knowledge and awareness of staff so they have a better understanding of the complex nature of dynamics of coercive behaviour, and domestic violence within families and relationships. Recommendations also focused on increasing awareness in the general public and to challenge the stigma that is still sometimes attached to domestic violence. This is to support potential victims, and perpetrators to come forward and seek support from services.

Around 8 per cent of recommendations aimed to strengthen the **assessment processes**. Mainly this related to the identification of risk through comprehensive shared risk assessment. It was also around the better assessment of underlying mental health issues such as depression and recognising mental health issues within housing sector for example. Integrating domestic violence questions into wider assessment frameworks were also required.

20 per cent of recommendations relating to training and practice development through improved quality and roll out of domestic violence training and ensuring that this is cross referenced to safeguarding adult and children training. This was also around awareness raising campaigns and information and guidance to staff to improve their professional curiosity and understanding of DV in its complexity (including toxic trio) and the interface with adult and children safeguarding processes. Greater joined up action across London could reduce multiplicity of local efforts.

13 per cent of recommendations called for improvement in policies and procedures linked to the NICE guidance on domestic violence and within all sectors (housing, workplace, GP etc). The recommendations also related to cross referencing relevant procedures and policies between children and adult safeguarding, child sexual exploitation and domestic violence.

London-wide forums should discuss the issues of domestic violence and there should be opportunities to design and develop a joint awareness raising campaign underpinned by a quality assured training program that is aimed at staff and the public.



MENTAL HEALTH HOMICIDE REVIEW (MHHR)

In April 2013 NHS England became responsible for commissioning independent investigations into homicides (sometimes referred to as mental health homicide reviews) that are committed by patients being treated for mental illness. The purpose of an independent investigation is to review thoroughly the care and treatment received by the patient so that the NHS can:

- be clear about what – if anything – went wrong with the care of the patient
- minimise the possibility of a reoccurrence of similar events
- make recommendations for the delivery of health services in the future

An independent investigation is carried out separately from any police, legal and Coroner's proceedings. It is done by an independent, expert organisation, which is given access to all the information and reports about the individual patient's care and treatment (within the usual patient confidentiality rules), and who can also request interviews with any NHS staff involved.

As outlined in the NHS Serious Incident Framework (NHS England 2015) the criteria for an independent investigation to be carried out is:

- To investigate the care and treatment of patients and establish whether or not a homicide could have been prevented and if any lessons were learned for the future
- Increase public confidence
- Provide an assurance framework for those trusts providing specialist mental health services and a platform for demonstrating learning from action plans.

A final report is prepared as part of the investigation process and this is shared with the NHS organisations that were responsible for the care of the patient, as well as the families of the victim and the patient. The NHS organisations involved are required to produce a plan that clearly sets out the actions they will take in response to the report from the investigation.

There was a total of three Mental Health Homicide Reviews (MHHR) published in London since the inception of NHS England (London Region).

Preventability

All three MHHR found that the homicide was not predictable and therefore not preventable. One review did find that with hindsight more could have been done to fully understand the risk that the patient posed and to manage this risk more accordingly. Another review found that although systemic weaknesses were identified, there was nothing in the presentation of the person involved during his contact with mental health services that was indicative of the homicide. Also, if these weaknesses were not present the homicide could not have been prevented.

KEY ISSUES

Care Programme Approach (CPA)

All three MHHR identified some weakness in the Care Programme Approach (CPA). One Review found 'fundamental weaknesses', including inadequate social circumstances assessment and a lack of a carers' needs assessment. The investigation panel in another MHHR found that the CPA meetings and relevant records prior to discharge from a medium secure unit did not provide the necessary level of information that would have properly facilitated the discharge into the community. Another patient felt 'contained by being care coordinated under the CPA, the review suggested that rather than completely discharging the person from the service, it would have been beneficial for him to remain on the caseload.

Risk Assessment

Two reviews found that there were issues with risk assessments. For example, historical risk factors were not taken into account in an Early Intervention Service and a Community Mental Health Team did not have in place properly managed processes to routinely handle and clinically scrutinise new referrals. The review concluded that there was a lack of involvement by the consultant in how to manage this case. In another though the clinician was on the 'look out' for further risk indicators, these were not registered or documented according to best practice guidance.

The Investigation Panel found that in relation to one patient there were several areas of concern regarding the identification of risk, the recording of relevant information, the sharing of information, and the management of risk by the agencies involved. Information in past clinical records were not utilised nor were standard risk forms completed properly.

One MHHR found that there were weaknesses in how information was shared

across the police, probation service, mental health service and the ambulance service. As is often the case, all held information about the person that would have helped inform a joint risk-assessment. Better working between the services could have helped to identify and manage the person's risk better.

Discharge planning

Two MHHR identified the discharge planning as an issue to be reviewed. The third identified the discharge planning as good practice but found weaknesses in the care delivery following the discharge to the community. There were poor record transfers to inform the new teams following discharge, such as a failure to provide records of CPA meetings, missing care plans and a list of medication or details of treatment (including psychological treatment). There was also a lack of clarity described in one MHHR in regard to the roles and responsibilities of the Community Team Manager and Consultant, regarding the patient's transfer to the community.

Workforce, capacity and their assurance

A theme in all MHHR is the pressure on mental health teams and capacity issues. The investigation describe that a patient was moved between four wards during his 4-week in-patient stay, which appear indicative of the pressure on in-patient beds. Heavy caseloads and the geographical spreads of an Early Intervention Service also impacted on the team to act in its specialist function. This impacted on the clinical leadership and clinical supervision provided to staff. Another MHHR also suggested that the lack of management of caseloads and appropriate supervision meant that poor executed CPA process, recording and omission of risk were not identified by the senior clinical team. This then meant that clinical standards were difficult to uphold and that there was a failure to collect 'appropriate information with systematic recording and processing of that information, to enable the formulation of relevant care plans, which are then delivered effectively'.

A further issue described is the role of the care coordinator in one MHHR, the role and position was undermined by the late allocation of the role to the patient. The only direct contact with the forensic services and the patient prior to discharge was at the CPA meeting on the day he left the ward. There were further issues around information provided to the care coordinator and the report suggested that the core role of care coordination within the framework of CPA was not recognised.

Two MHHR identified that too much responsibility was placed on the patient to contact the mental health team if there were problems. This was despite the fact that one patient was new to the service but had a history of risk behaviours and another patient tended to locate the cause of his problems externally and the MHHR queried whether he had enough insight into his own condition to recognize when he needed psychiatric help.

Medication

The importance of monitoring medication (Clozapine) was not recognised in care plans found in one review. The patient had treatment resistant schizophrenia and physical sensitivity to this drug, which made the management of his psychotic illness more complex. Another MHHR found that there was a lack of monitoring of the patient compliance with his medication regime, including information sharing with his GP regarding collecting prescriptions. Given that he was not collecting these, it might have triggered a more assertive approach by the mental health team.

Recommendations

The three MHHR generated a total of 41 recommendations from the Independent Investigation report for the mental health trusts to consider. All recommendations were reviewed and allocated an overarching and a secondary theme.

17 per cent of the recommendations related to undertaking of more **robust assessments** with regards to the risk that is posed but also regarding diagnosis (for example where the clinician is uncertain about a clinical diagnosis of a patient's mental health problem). The recommendations aimed to improve the standard of practice within clinical teams and also required the clinical team to share the outcome of these risk assessment with other involved in the care of the patient. One recommendation also aimed to strengthen the comprehensiveness of assessment to include social circumstances of the person and a carer's needs assessment. The effectiveness of the recommendations should be assured through reflective practice and supervision as well as regular audits undertaken by the clinical leadership group.

The use of **supervision and reflective practice** to strengthen and maintain clinical standards, full utilisation of the Care Programme Approach (CPA) and risk management was the theme of 17 per cent of the recommendations. The recommendations suggested that the supervision process should include the scrutiny of current samples of actual care delivery and that actual cases are being reviewed. Organisations were also requested to have assurance mechanism in place to ensure that this is taking place. In general, there was a consistent theme of supervision to strengthen clinical outcomes for patients.

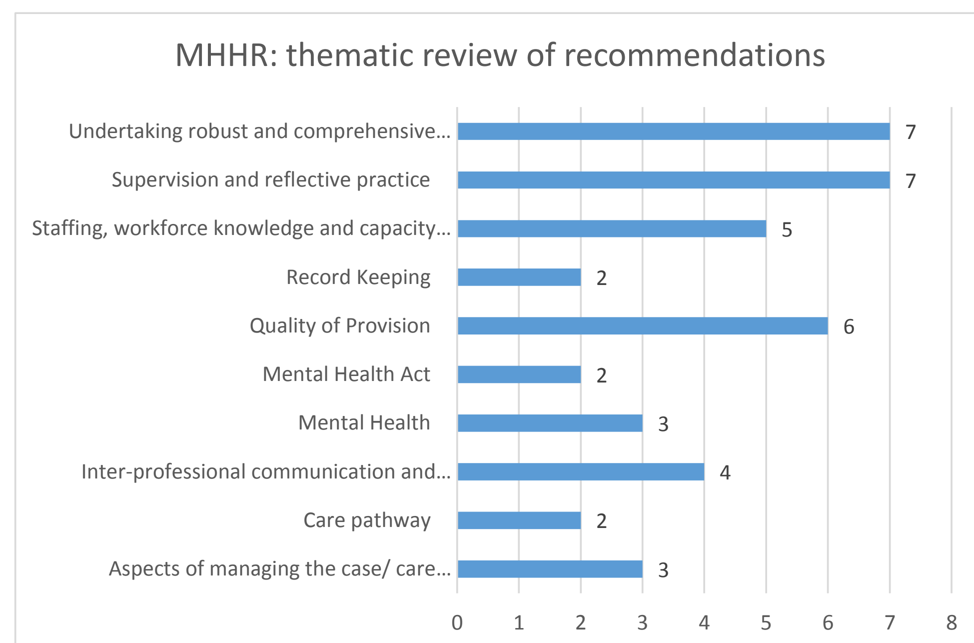
Recommendations relating to the quality of provision, workforce, capacity and their assurance focussed on:

- Further embedding the CPA within clinical teams
- Outline responsibilities and expectations of the clinical leadership
- Producing care plans that reflect a comprehensive understanding of the current psychiatric, social, family circumstances and risk characteristics of the individual
- The use and sharing of information to enhance clinical decision-making
- Strengthening of the Clinical Governance process, including the use of audits to audit compliance.

Smaller number of recommendations related to the improvement of:

- The setting out of minimum standard for the role of the care coordinator

- Record keeping, including recording of discussions about patients when their symptoms, diagnosis and treatment has been considered and any subsequent action that have been agreed
- Discharge planning protocol and associated checklist to be used for every discharge
- The management of medication, integrated into the CPA process



Opportunities for shared actions across London

The majority of recommendations related to mental health trusts strengthening their organisational oversight and assurance mechanism. This included:

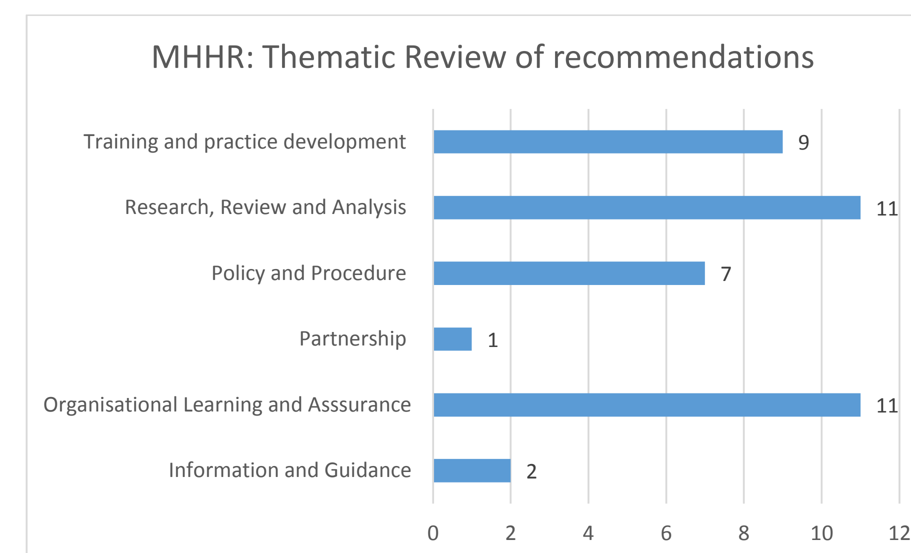
- Oversight of supervision and reflective practice
- Checking that the CPA process is robust and includes risk management
- Risk assessments and management plans are completed within an agreed acceptable timeframe and are reviewed at significant points of clinical decision making for all patients
- Taking a more assertive approach to medication compliance, such as teams monitoring of medication compliance in patients, including checking that prescriptions have been collected.

The Mental Health Trusts involved were asked to improve their training and practice development in order to improve effective working within teams, with a focus on the Mental Health Act, record keeping and CPA process. The recommendations in particular highlight the importance of group and individual supervision to facilitate learning.

In order to assure the board and other organisations, the trusts were also requested to undertake further audits and review of their current systems and improvement actions. In particular audits were requested to test:

- Supervision chain is identifying and addressing any deficiencies in the quality of care being delivered to patients.
- That training incorporates the positioning of the CPA process
- To ensure that teams assessing and caring for psychiatric patients are producing care plans that reflect a comprehensive understanding of the current psychiatric, social, family circumstances and risk characteristics

Mental Health Trusts and their commissioners, may want to ensure that lessons learned, and recommendations taking forward are shared across London.



PREVENTING FUTURE DEATH NOTICE (PFDN) FOR ADULTS

The Coroners (Investigations) Regulations 2013 requires coroners to report on actions to prevent other deaths. These reports are not published until the coroner has considered all the documents, evidence and information that, in the opinion of the coroner, are relevant to the investigations.

The coroner must send a copy of the report to the Chief Coroner and organisations such as NHS trusts or the commissioning body, Local Authority, Government Department or other agency who in the coroner's opinion should receive it and who are in a position to take positive actions. The Chief Coroner may publish a copy or a summary of the report. Organisations or people receiving a PFDN are under a duty

to give a response in order to prevent other deaths. The response must detail any actions that have been or are proposed will be taken place in response to the report and set out timetable of the actions, or an explanation as to why no action is proposed.

The Chief Coroner is currently working to upload all Reports made since 25 July 2013 on the Court and Tribunals Judiciary website (https://www.judiciary.gov.uk/subject/prevention-of-future-deaths/).

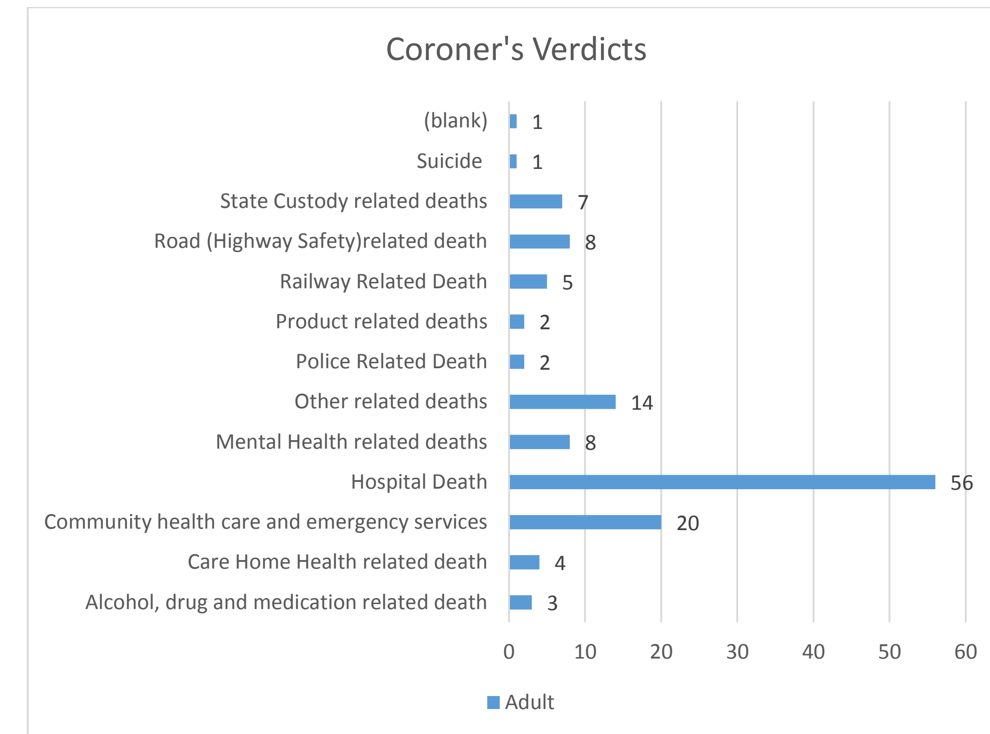
These reports have been screened for those inquests undertaken by a coroner in London or where London's organisation were the recipients of the PFDN. A total of 161 PFDNs were identified as meeting the inclusion criteria and these were entered into a database (full table included in appendix one).

31 PFDN relate to children (though four reports related to the same clinical procedure with the same recommendations) and 130 PFDN to adults. Subsequently a number of PFDN were identified as falling outside the scope of this project as they dealt with Road Highway Safety issues.

Verdicts

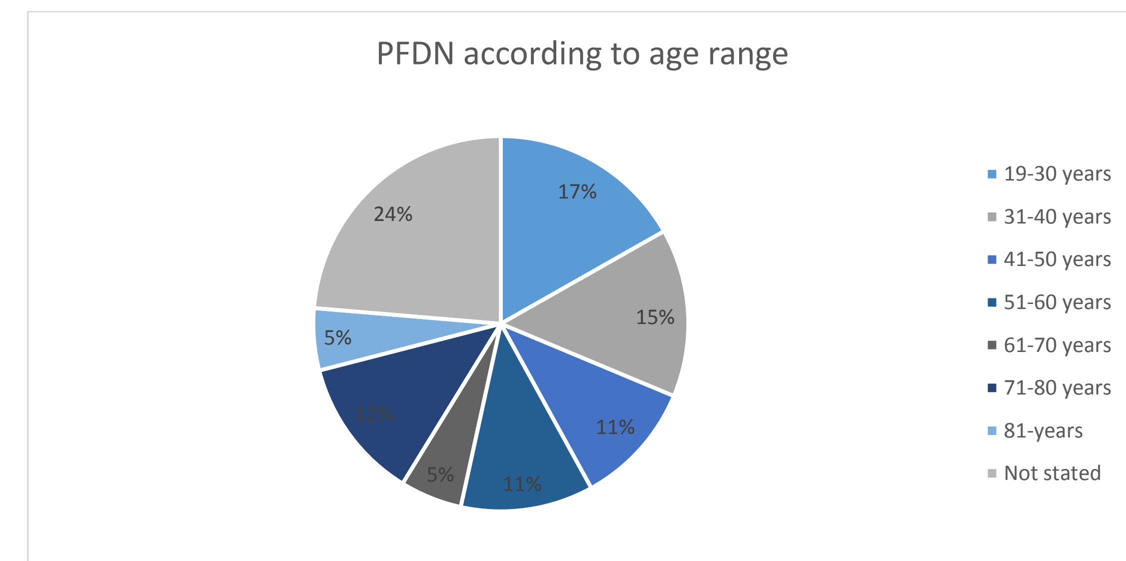
Inquests in England and Wales are held into sudden and unexplained deaths. There are a number of verdicts that can be given by the coroner and the jury and whilst this is not mandatory it is strongly recommended (for example narrative, suicide or accidental death). All verdicts have to be established to the test within the balance of probabilities except for suicide and unlawful killing, which have to be proved beyond reasonable doubt.

42 per cent of hospital deaths was the most common verdict within the reviewed PFDNs. This is followed by Community Health and Emergency Services with 15 per cent of PFDN falling within this category. It is worth noting that although there is only one verdict of suicides, the actual number is far great and subsumed in Hospital deaths.



Age Range

The PFDN represented are consistently distributed across the age ranges although, unfortunately, 24 per cent of PFDN did not state the age of the deceased. With five percent there are slightly fewer PFDN in people over 81 years of age and people between 61-70 years of age.



Analysis of the matters of concerns raised by the coroners

Each coroner within the PFDN identifies a matter of concern and requests the concerning organisation to respond and put in place remedial actions to ensure that future deaths are prevented. A total of 100 PFDN were analysed as the remaining 30 PFDN fell outside the scope of this document addressing issues such as highroad safety.

With 43 per cent 'risk assessment' and 'assessment' is by far the greatest concern identified by the coroners. Risk assessment (19 per cent of PFDN) relates to the identification of risk in mental health patients regarding suicide and self-harm, but also around falls, self-neglect and vulnerability. Assessment (24 per cent of PFDN) conveys issues regarding, for example, the diagnosis of physical health problems in people with mental health problems (diagnostic overshadowing), but also the lack of, or misdiagnosis of underlying health problems. The impact on the person due to undergoing fitness to practice assessment and fitness for work assessment are also included.

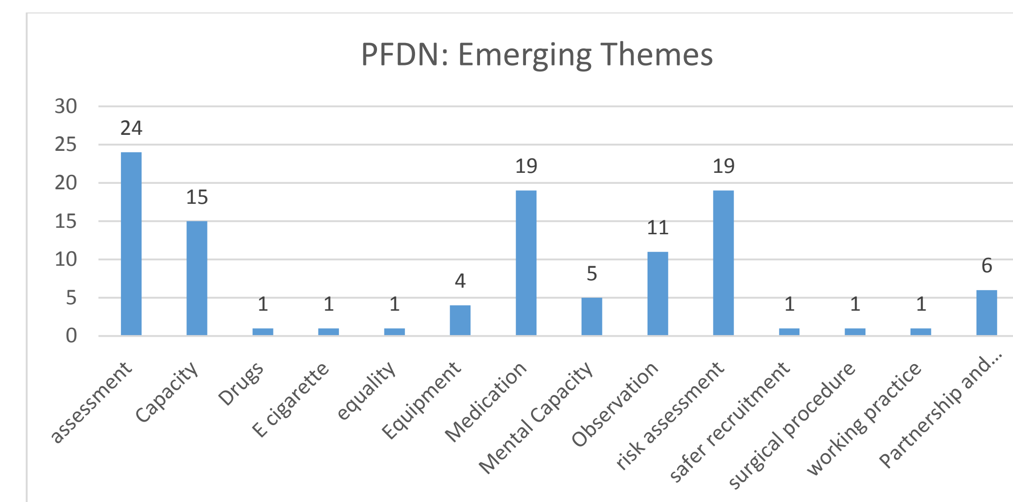
Medication issues are identified in 19 PFDN. These relate to the limit of professional knowledge around side effect, especially where the patient has co-morbidities and or mental health issues but also around the lack of physical health check undertaken- such as blood tests for glucose level in anti-psychotic drugs. Problems also identified are missing working practice, information sharing, following up on missed appointments and the hoarding of medication by patients.

Capacity within organisations to respond to increasing demands is highlighted in 15 PFDN. The problems described here are around the availability of ambulances or mental health beds and also the high caseloads held by mental health teams or domiciliary providers. In some instances, this is closely aligned to issues around observation of patient by staff, which featured in 11 PFDNs. In some cases, basic observations did not occur because of lack of leadership within the organisation, high demand on the team but also failure to understand the need to observe physical health issues such as blood testing. In many cases there were also poor record keeping, impacting on handover or clinical decision making.

Six PFDN referred to issues in working in partnership across and within organisations and to share information effectively, which is directly putting patient at risk according to the coroner. The PFDN also identified issues around lack of professional knowledge around roles and responsibilities of other organisations and assumptions what others would do.

The lack of adherence to the Mental Capacity Act (MCA) and how to support a patient that may be deemed to lack capacity is described in five PFDN. Staff awareness of the MCA in these cases was poor, with staff not considering the role of the family in determining best interest decisions. Strengthening the interface of Mental Health Act and MCA and increasing understanding of Deprivation of Liberty (DOLs) safeguard were also a matters of concern highlighted.

Smaller number of PFDN relate to the impact of faulty, non-available equipment (four PFDN), surgical procedures and working practices (one PFDN).



What this means for each sector

Mental Health

With 36 per cent of PFDN being addressed at Mental Health Organisations (Mental Health Trust and independent sector providers) this is by far the sector where most concerns were identified by the coroners. The main concerns relating to risk assessment (9PFDN), medication (6 PFDN) and capacity and partnership working (5 PFDN).

Acute Hospital

This is followed by hospital settings where coroners identified concerns in 28 per cent of PFDNs. The key issue identified relates to observation by nursing staff (6PFDN) followed by capacity to meet demand (five PFDNs) and assessment and medication (four PFDNs).

General Practice

18 per cent of PFDN were addressed to General Practice. The greatest number of concerns were around medicine management and limit to professional knowledge of potential side effects (especially when there were additional co-morbidities). Lack of partnership working with psychiatrists in managing antipsychotic drugs for a people with mental health problems. Non concordance with a medication and missing appointments by patients also featured. This is followed by lack of assessment of physical health issues (three PFDN).

London Ambulance

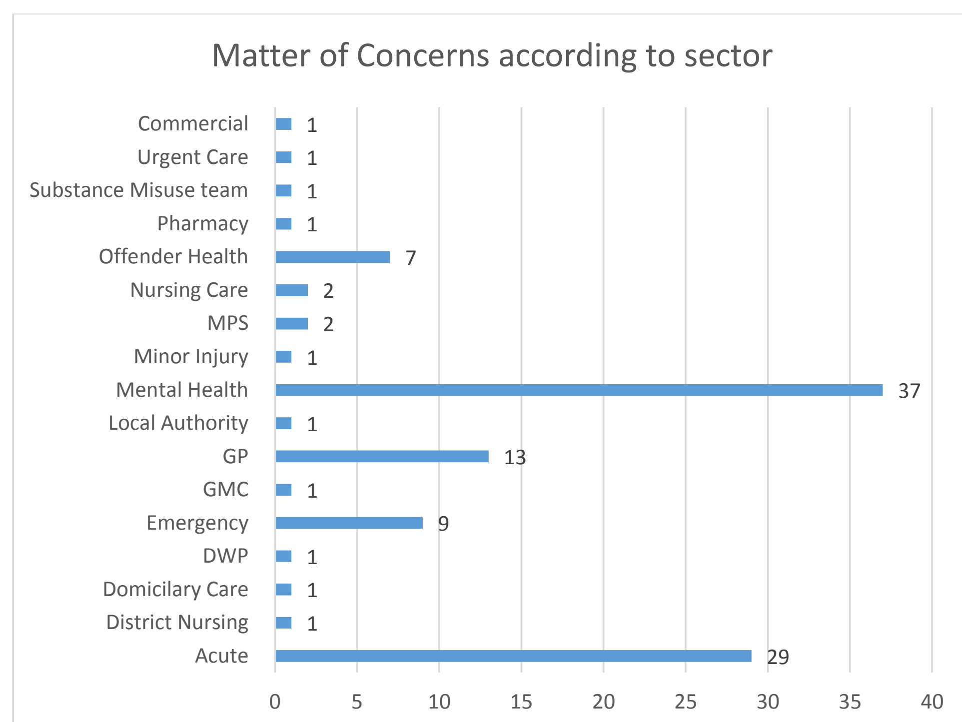
9 per cent of PFDN identified the London Ambulance Service as an organisation that needed to implement improvement. This was predominantly around capacity (three PFDN) -to have sufficient number of ambulances available, but also around risk

assessment (in terms of allocated staff responding to problems faced, when arriving at an incident).

Offender Health

Assessment and risk assessments are the main concerns in the PFDN addressed to Offender Health and Prison staff (7 per cent of PFDNs). A clear underlying issues is around information sharing to inform robust risk assessments and decision making but also around assessment of general health issues (such as smoking and smoking cessations) and the roles and responsibilities about who carries this out.

The remaining PFDN addressed in smaller number to organisations are too small a sample to draw out meaningful thematic reviews.



LEARNING FROM THE COMMISSIONING SYSTEM

Clinical Commissioning groups (ccg) - deep dive into safeguarding 2015/16

The Health and Social Care Act 2012 created CCGs as membership organisations of GP practices in order to promote the clinical leadership and local ownership of the way that health services are commissioned and delivered.

NHS England has a statutory duty to conduct performance assessment of each CCG, conducted through the assurance process. This involves formal assurance reviews carried out quarterly in line with the published framework and technical guidance, which includes a number of domains of assurance that reflect planning guidance.

As outlined in the document Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England 2015) safeguarding is a fundamental element of commissioning and therefore, is an area that forms a core part of the commissioning assurance process.

NHS England (London Region) therefore conducted a deep dive review into the CCG's safeguarding governance, arrangements and processes in order to gain a greater understanding on how safe the commissioning system is across London and how to best tailor support to CCGs going forward. The aim was to understand how well safeguarding principles have been embedded into wider components of the CCG assurance framework.

The deep dive therefore considered:

- How the CCG carries out their operational safeguarding functions against each key work stream.
- How these individual work streams are coordinated together, what controls are in place to review and manage performance (including escalation).
- What processes are in place to ensure the CCG is sighted, and prepared to manage, future developments within safeguarding
- How the CCG works in partnership with key partners and the systems in place for oversight of all of these areas

The following assurance categories are then used to assess the CCG capabilities:

Assured as outstanding:
CCG can demonstrate that it is continuing to perform well across all components of assurance. It may have some identified challenges but is proactively managed.

Assured as good:
There are minor concerns with the performance of the CCG but overall the CCG is well led and in good organisational health, or if a CCG has a higher level of risk this is managed effectively

Limited assurance:
CCR requires improvement and has serious, persistent and chronic performance or financial challenges and it may not demonstrate the capability of capacity to manage the associated risk to make sustained improvement on its own.

Not assured:
NHS England is satisfied that a CCG is failing or is at risk of failing to discharge its functions.

Accordingly, through the assurance process the level of support to CCG is then identified. This ranges from none required; some support may be required for specific issues, extensive from a range of provider option to formally being directed by NHS England.

Outcome

Governance, systems and processes

One area that was tested within the deep dive was the CCG's governance, assurance, systems and processes that were in place to support positive outcomes for safeguarding adults at risk and children. The areas that were tested were:

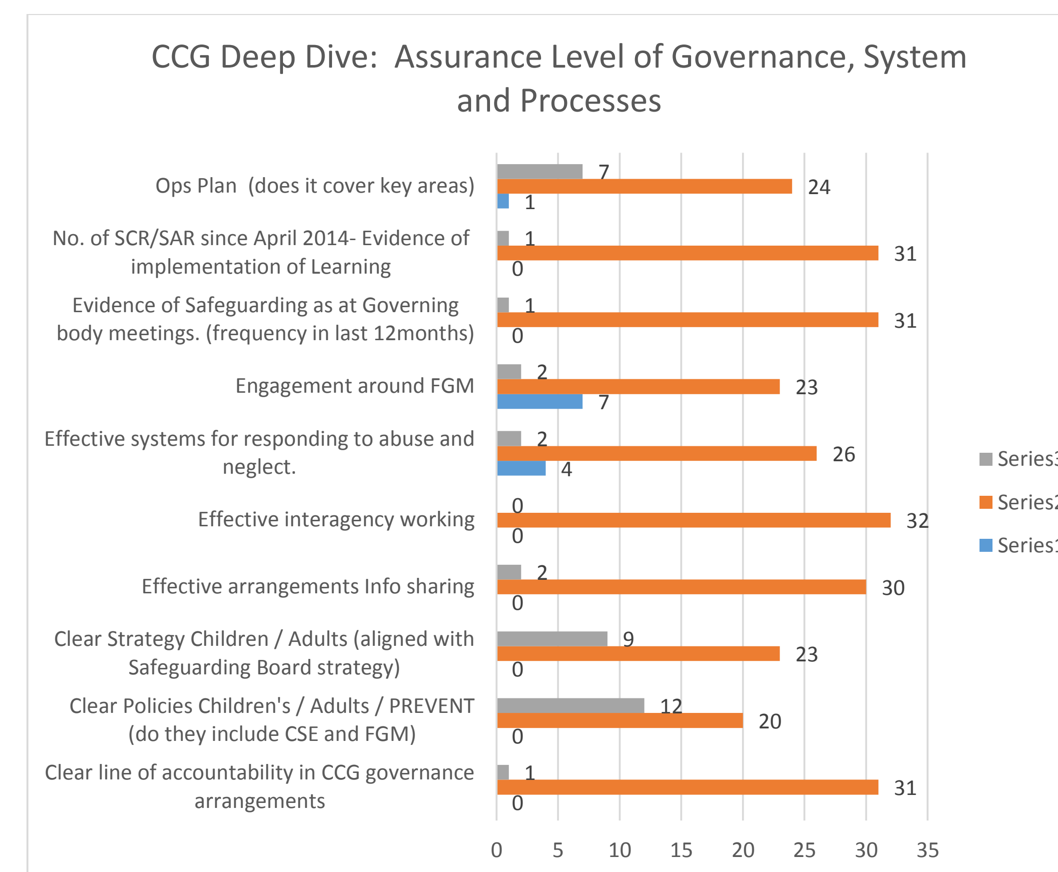
- Having in place an Operating Plan that covers the key areas
- Clear Line of accountability in CCG governance arrangements
- Evidence of Safeguarding at Governing Body meetings
- Clear Strategy that takes account of children, adults and is aligned to the relevant safeguarding board (children or adult)
- Clear policy for adult and children safeguarding that includes Prevent, Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM)
- Effective interagency working
- Effective Information sharing
- Effective system for responding to abuse and neglect
- Evidence of learning and engaging in Serious Case Review, Safeguarding Adults Reviews and Domestic Homicide Reviews
- CCG has undertaking the safeguarding adult board audit and engaged in section 11 audits
- There is evidence that the CCG progressed recommendation from the audits

As an overall rating, all CCG were assured as being good in the way they integrated safeguarding system within the wider CCG governance structure.

The area where most CCG were assured as outstanding were in 'engagement of Female Genital Mutilation (FGM)', where 21per cent (n~7) were given this scoring. This was followed by having 'effective system in place for responding to abuse and neglect, where 12 per cent achieved outstanding assurance.

The area where the most CCG only provided limited assurance was in 'having in place clear children and adult policies that make sufficient references to Prevent, FGM and Child Sexual Exploitation (CSE)'. Here 37per cent of CCGs were judged as needing to make improvements. Not having in place children and adult strategies that are aligned to the relevant safeguarding children or adult board also meant that 28per cent of CCG only provided limited assurance to NHS England. Finally, in 21per cent of CCG their Operating Plan did not cover the area of children and or adult safeguarding sufficiently to be assured as good.

The one area where all CCG were assured as good was in their effective partnership working across children and adult safeguarding.



Workforce and Capacity in CCG to lead

This area looked at how well staffed the CCG was in order to provide strategic and operational leadership across its organisation and the local health economy. The specific questions related to:

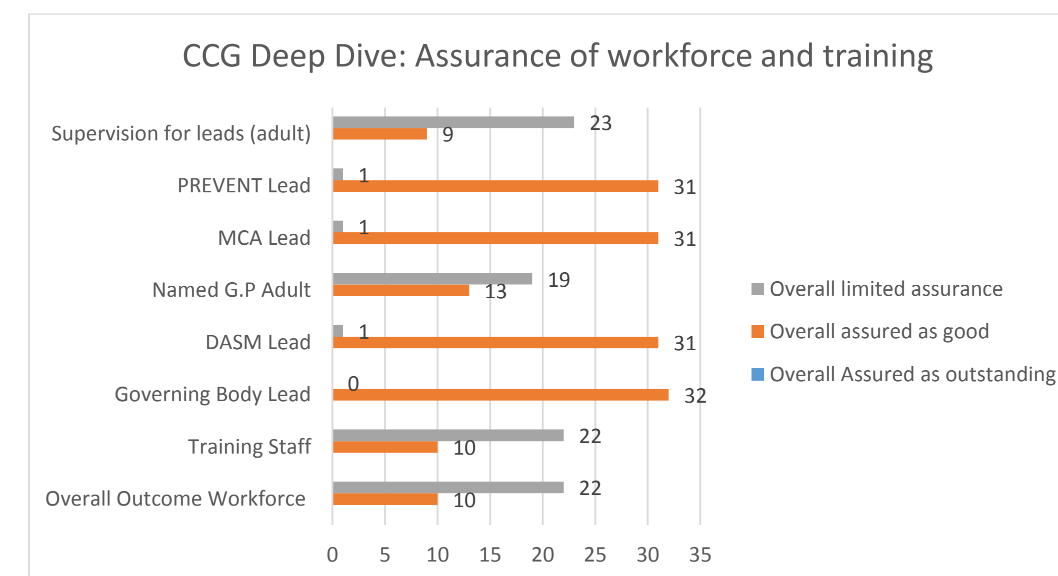
- Training of staff
- Is there a governing body lead for adult safeguarding?
- Is there a role equivalent of the designated safeguarding adult manager lead
- Is there a named GP for adult safeguarding
- Is there a Mental Capacity Act lead
- Is there a Prevent Lead
- Is there appropriate supervision for the safeguarding adult lead

68per cent of CCG were provided with overall limited assurance around their capability and capacity to lead on safeguarding.

An equal percentage of CCGs did not have sufficient safeguarding training in place for their staff in order to be assured as good. Supervision, or the lack of it, for safeguarding adult leads was an issue in 71per cent of organisations. Given the complexity of the work and the sometimes multiple portfolio that people have to manage this requires strategic attention across London.

59per cent of CCG did not have a named GP for adult safeguarding in place. Given the importance on improving capability within primary care this is also an area that could do with further improvement.

It is positive to see that all CCGs had a governing body executive lead for safeguarding and this was supported by a DASM, Prevent and Mental Capacity Lead in role in 97 per cent of organisations. Further questioning may be needed to understand if these portfolios are held within one position and the limitation and potential benefits that this may bring.



Assurance and Oversight

This outcome ascertained what assurance and surveillance of risk the CCG has put into place to monitor quality and safeguarding across the local health economy. The key line of inquiries was around:

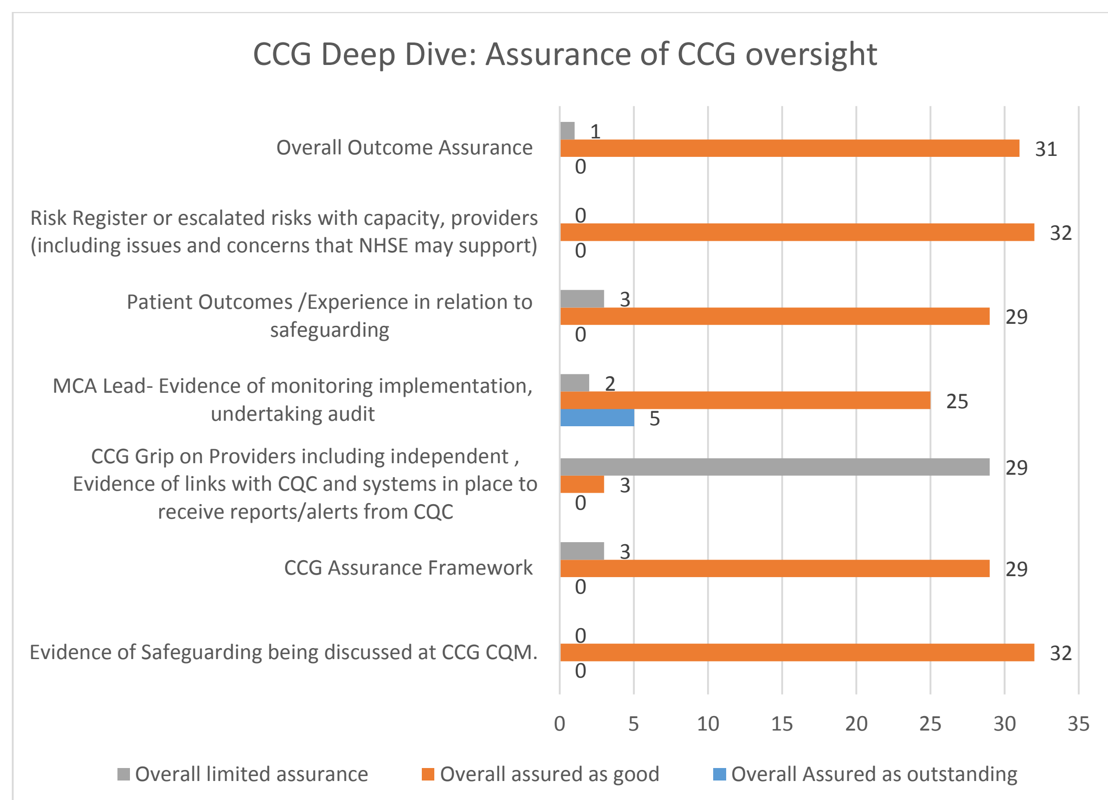
- Evidence that safeguarding was being discussed at CCG Clinical Quality and Risk Management Meetings (CQRM)
- Whether safeguarding was integrated into the CCG assurance framework
- CCG demonstrating a grip on provider performance, aligned to CQC inspections and outcomes
- Evidence of Mental Capacity work such as undertaking audits
- CCG gathering feedback and experience relating to safeguarding
- Risk register and appropriate escalation regarding provider concerns

Overall 96 per cent of CCG were assured as being good within this domain, with only one CCG being identified as needing improvement.

The two areas where all CCGs were rated as good was around having in place risk registers and escalation processes and also evidence that safeguarding was part of their Clinical Quality Review Meetings. Furthermore, the two standards where 90per cent of CCG achieved a rating of good were around embedding safeguarding into the wider assurance frameworks and also to seek feedback and gather experience in relation to safeguarding.

The area where the most CCGs being assured as outstanding was in the work around the Mental Capacity Act, here 15 per cent of CCG achieved the scoring. However, a very high number of CCG also were rated as having limited assurance in place here (78 per cent).

Maybe not surprisingly given the high number of contracted services, via Continuing Healthcare and other mechanism, there is a real issue across London in having robust systems in place that correlates CQC inspection with own contract function in order to have a firm grip on provider. 90 per cent of CCG were rated as having limited assurance in place.



LEARNING FROM THE REGULATOR

Care Quality commission:a snapshot

Inspection

The Care Quality Commission (CQC) introduced its new standard in April 2015 against all healthcare providers being assessed to ascertain their level of compliance. There are five inspection domains and associated rating of 'outstanding', 'good', 'requires improvement' and 'inadequate'. The key lines of inquiry (KLOI) are:

- Are they safe?
- Are they effective
- Are they caring
- Are they responsive to people's need?
- Are they well led?

NHS and Foundation Trust and Primary Care

In total 101 CQC reports were reviewed. This included 26 NHS and Foundation Trusts and 75 GP practices. These were reviewed and analysed in respect to how well they were doing with regards to:

- Safeguarding Adults at risk
- The Mental Capacity Act (MCA)
- The Deprivation of Liberty Safeguard (DOLs)

18 Trusts and all GP practices were inspected under the new regime. 50 per cent of Trusts and 16 per cent of GPs required improvement in order to comply with the CQC standards, 33 per cent of Trusts and 75 per cent of GP practices were deemed to be good, whilst 17 per cent Trusts and 9 per cent of GPs were inadequate. As the sample of the GP practices is very small, caution needs to be taken with regards to the judging the wider primary care system in London.

Are they safe?

61 per cent of Trusts and 33 per cent of GPs required improvements, 17 per cent NHS organisations were deemed to be inadequate, as were 11 per cent of GP practices. Only 22 per cent Trusts were rated to be good, contrasting with 55 per cent of GP practices. One GP practice was not scored across all the domains.

Are they effective?

72per cent Trusts and 76per cent of GP practices were rated to be well led (good), 22per cent NHS organisations and 17per cent of GPs required improvements and only 6per cent of Trusts and 5per cent of GPs were deemed to be inadequate.

Are they caring?

6per cent of Trusts (n~1) was rated outstanding, 78per cent NHS organisations and 91per cent of GP practices were rated as good and only 3per cent of Trusts and 5per cent of GPs were requested by CQC to make improvements. 3per cent of GPs were deemed to be inadequate.

Are they responsive to people's need?

50 per cent of Trusts but only 3 per cent of GPs needed to make improvements, 39 per cent of Trusts and 91 per cent of GPs were deemed to be good. 11 per cent Trusts were deemed to be inadequate, as were 4 per cent of GPs.

Are they well led?

47 per cent of NHS organisation and 84 per cent of GPs were rated to be well led (good), whilst
41 per cent of Trusts and 55 of GPs required improvements. 12 per cent of trusts and 9 per cent of GPs were deemed inadequate.

There was not necessarily a correlation between the overarching KLOE and how well the trust or the GP practice was doing in embedding safeguarding, the Mental Capacity Act (MCA) or the Deprivation of Liberty Safeguard (DOLs) into the organisations.

Safeguarding Adult

In approximately 57 per cent of NHS organisations and 52 per cent of GPs there were some issues around either safeguarding adults, training, awareness of staff of policies and procedures or systems to record adults at risk and safeguarding referrals. It also needs to be highlighted that within larger organisations there appeared to be variances between wards, services and teams across organisation. CQC sometime commented on how well safeguarding awareness was across an organisation except for one service line.

What good looks like according to the CQC

For those NHS organisations that were deemed to be doing well, according to the CQC, organisations and staff were able to describe in detail what actions they would take if they had a safeguarding concern and what forms to use to make a safeguarding referral. Policy and Procedures for safeguarding at risk were available and there were signs and posters for people to refer to. Staff were informed of changes to the policy via internal communication. Staff received training on safeguarding as part of their induction and it was also part of the mandatory training programme with annual refreshers. There were some positive examples where domestic violence and Female Genital Mutilation Training was also routinely provided.

There were clear referral points and information sharing protocols and the organisation (trust) was actively involved in the Safeguarding Adult Board and there were good relationships with the Local Authority.

There was a senior executive lead or a dedicated GP for safeguarding. Within Trusts this person was supported by a dedicated safeguarding committee and designated lead. Information on safeguarding were being tracked and monitored for performance. Vulnerability and adults at risk were identified and flagged on internal systems. Additional examples of practice that was seen as notable was the contribution of the learning disability liaison nurse in making services more person centred.

GP practices were deemed to do well if their staff knew how to recognise signs of abuse in vulnerable adults and children and if their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice was able to demonstrate that the team had received training on both adult and child safeguarding. For example, the practice had an induction programme for newly appointed members of staff that covered such topics as safeguarding. In general, it appeared that practices did well if there was a dedicated GP for safeguarding adults in the practice. There were a number of practices were the GP was also the lead for the clinical commissioning group and the expertise and knowledge was seen within the processes within the practice.

The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies was also considered important by the CQC. It needs to be stated however that this appeared to make more references to safeguarding children work undertaken rather than on the adult side.

The practice that did well had policies for child protection and at risk adults which included local authority and CCG contact details. Their staff were aware of their responsibilities and other agencies responsibility and there was evidence of information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

The GP practice had a clear recording and flagging system to highlight vulnerable patients on the practice's electronic records. This included key information so staff were aware of any relevant issues when patients attended appointments; for example, patients experiencing poor mental health, young mothers who were deemed at possible risk and patients living with dementia. Positive scoring on care of older people, those with mental health problem or learning disabilities appeared to have a positive influence on how safeguarding was taken forward.

The CQC also carefully examined the chaperoning policy and if staff received training and had the relevant DBS checks in place to work with vulnerable patients.

What the CQC found

In almost 50per cent of NHS trusts there were issues with workforce issues, mainly around the number of staff trained in safeguarding adults. Some reports highlighted the very low take up of safeguarding adult and children training in post graduates doctors.

In contrast only 17 per cent of the GP sample identified concerns around staffing awareness around safeguarding. Where these were identified this related to the lack of training of non-clinical and clinical staff. Interestingly there were a number of practices where the awareness of safeguarding was good, but this was not backed up by the relevant training.

In one trust that was rated inadequate the safeguarding processes and practices were not always adhered to. The CQC lacked confident that patients were kept safe and even basic security needs were met. In another trust it was the lack of access to the Whistleblowing policy that was identified as a risk to patients. In one mental health provider, CQC commented on the unacceptable variation of the use of restraint and incident reporting and requested the trust to review the problem further.

Similarly, there were a small number of GP practices that didn't have a policy or procedure for safeguarding, or some that had but they were not Care Act compliant. An even smaller number of samples didn't have the right recording and risk assessments in place to support the identification of vulnerable individuals and adults at risks.

The biggest issues for GP practices that was identified by CQC were safer recruitment practices and the DBS checks for individuals who act as chaperons to patient, or their lack of training to undertake this role. This was identified as a key issue in 39 per cent of practices.

Mental Capacity Act (MCA)

The CQC include the provider's compliance with the Mental Health Act and Mental Capacity Act in their overall inspection of the core service. The CQC do not however give a rating for Mental Health Act or Mental Capacity Act, though the finding contributes in determining the overall rating for the service.

In 67 per cent of trust there were issues with the implementation of the MCA. Mostly this was around staff awareness of the code of practice and their responsibility under the legislation. Often staff lacked the knowledge or confident to undertake mental capacity or best interest assessments. Some also thought that the Act had nothing to do with them and their clinical practice.

What good looks like according to the CQC

The CQC commented more positively around the implementation of the MCA in NHS trusts if they observed that courses were on offered and these were attended and included in staff's individual training logs. MCA was part of the induction program, there were annual refresher and it was mandatory for staff to attend. Staff could demonstrate a clear understanding of the Act, of the procedures and forms to use and who to contact if there were issues. Staff were able to describe examples where patients' capacity had been assessed, where support was given to patient to make decision and how family members were involved in best interest decisions. The organisation could also demonstrate that it was easy for patient to access Independent Mental Capacity Advocates. Clear policies and procedures around seeking consent were in place and these were accessible to staff through aid memoirs and flowcharts.

Some organisations (mental health trusts) supported staff through legal advice on the implementation of the MCA and Mental Health Act and there was clinical leadership to support the implementation. Audits of MCA were undertaken and were part of the organisation's clinical auditing processes. There was good documentation of mental capacity assessments and best interest decision within people's care records.

Within GP practices, MCA appeared to be judged on how well staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. It is worth noting that it appears that there was less scrutiny by the regulator to provide evidence of MCA training to meet these criteria. Instead evidence was sought via staff interview, availability of guidelines and evidence in patient record of mental capacity assessment and best interest decision making. Also practices did not routinely evidence that there was a clinical lead for MCA. It is the authors personal observation that this may the reason why the achievement of the MCA by practices is much higher than anticipated and also do not necessarily correlate with learning from serious case reviews and Preventing Future Death Notices.

What CQC found

In all NHS trusts where there were issues around the MCA, these related to the training provision and staff awareness, so that the consistency of implementation was patchy. This was also the case for 6 per cent of GP practices. Some mental health organisations had a poor understanding of the interface of MCA and Mental Health Act, and staff did not think of the MCA and DOLs in terms of people who were voluntarily detained in in patient settings. Some nursing staff did not feel that the MCA was relevant to their nursing care but thought that this was something that 'medics do'.

The CQC identified a lack of MCA policies in a small number of providers and found therefore that there was a breach of Human Rights, as patients were not involved in decision about their care. The lack of MCA policies was identified in two GP practices (one had a consent policy but this didn't make reference nor related to the MCA). Worryingly there were two incidents were there were inappropriate and outdated policies on resuscitation in trusts. For example, one policy stated that there was 'no ethical obligation to discuss resuscitation with palliative/end of life care patients,' and, 'when a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patients' wishes about CPR, but careful consideration should be given as to whether to inform the patient of the DNAR

decision.' This was not in line with national resuscitation council guidance which states that there should be a presumption in favour of patient involvement and that there need to be convincing reason not to involve the patient.

The CQC also found variation in record keeping of capacity assessments and regular supervision of staff that supports them in applying the legislation. In some cases, regulatory action was taken.

Deprivation of Liberty Safeguard (DOLs)

As with the MCA, CQC included DOLs in their assessment framework but does not provide a scoring.

Only 30 per cent of organisation were deemed to appropriately embedded the DOLs process within their organisation and in 26 per cent of organisation there were no comments made about the DOLs processes or training. CQC were not assessing GPs on the implementation of DOLs.

In organisation that were seen to be doing well, DOLs was included as part of the MCA training structure and training logs. There was a good identification of patient who were seen to being deprived of their liberty and the relevant authorisation had been granted or were being processed. Documentation of standard authorisation under the schedule had been completed and or renewed. Organisation were also able to demonstrate wide multi-agency decision making for applying for DOL and also understand the interface between restriction, restrained and practice that is deemed a deprivation of a patient's liberty.

Issues around DOLs were identified in organisation that had made not a single DOLs application the following year and one trust was identified as not having done so. Awareness of the process was patchy and misunderstood by staff and risks were identified that staff did not recognise when a patient was unable to give consent and they did not understand their legal responsibilities. Even though some staff in organisation had attended training on MCA and DOLs they lacked awareness on how to embed this into their clinical practice. Actions identified by the CQC were around raising staff awareness, minimising the use and risk of unsuitable restraint (in mental health organisations) and increasing the legal literacy of staff.

LEARNING FROM SAFEGUARDING ADULT AUDIT

Safeguarding Adult Audit 2014/15 Overview

In 2013/14, for the second year running, 112 organisations across London self-audited how well they were doing with regards to safeguarding adults at risk and the Mental Capacity Act. This exercise included NHS Trusts, Foundation Trusts, Local Authorities, Police, Fire and Ambulance Services, Community and Voluntary organisation, Prison and Probation services. As part of the process most local safeguarding adult's boards held a challenge and listening event to provide critical learning and feedback to organisations regarding their audits.

A joint overview report was published between NHS England and the London Chairs of Safeguarding Adults Board network. The purpose of the report was to:

- Identify the outcomes that safeguarding adult are finding the most challenging so that resources and help can be targeted to addressing these issues
- Share notable practice of what seems to be working well

The audit tool was structured around six overarching outcomes supported by number of sub objectives against which the organisation could score themselves (red, amber and green):

- Leadership, strategy, governance and organisational culture.
- The organisation's responsibilities towards adults at risk are clear for all staff and for commissioned services.
- The organisations approach to workforce issues reflects a commitment to safeguarding and promoting the wellbeing of adults at risk.
- Effective inter-agency working to safeguard and promote the wellbeing of adults at risk.
- Addressing issues of diversity
- The services can demonstrate that people who use services are informed about safeguarding adults and empowers within the organisation's response to it.

Cross cutting themes

There were some outcomes and objectives where a high number of organisation felt that they were doing well. 85per cent of organisation felt that they had good guidance and procedures for complaints and allegation in place.

An equal percentage reported that they had a senior member who was accountable for safeguarding within the organisation and 81per cent stated that their Board had a strong commitment to safeguard adults from risk. In CCG or health organisation,

this was sometimes a named GP or doctor. Further scrutiny of some submission however highlighted that a senior lead was sometimes at much lower tier within the organisation, rather than forming part of the senior leadership group.

Whilst 83 per cent of organisations felt that they demonstrated the principles of person-centred care, this needs to be viewed within the context that 61 per cent also reported that they did not involve service user. Supporting organisation what is meant by the principles of 'Making Safeguarding Personal' thus should continue to be a priority.

The outcomes across London where organisations across the sectors stated that they needed to improve were less consistent (combining red and amber scoring):

- 70 per cent of organisations felt that they needed to do more around embedding the Mental Capacity Act within their organisation.
- 57 per cent stated that training sufficient numbers of staff in safeguarding was challenging
- 56 per cent reported that they didn't involve service users in their strategic approach to safeguarding adults
- 53 per cent of organisations citing that their supervision policy did not support safeguarding adults
- 52 per cent cited that raising alerts and multi-agency partnership working was a challenge for them

Leadership, strategy, governance and organisational culture.

The majority of organisations had a senior member of staff with responsibilities for safeguarding. Within NHS trust this was predominantly an execute board level lead, such the Director of Nursing, supported by a senior staff with more operational responsibilities. Several audits highlighted however that the executive leads had not received training in safeguarding appropriate to their role.

Many organisations reported that they needed to strengthen the cross referencing of safeguarding with their corporate governance and assurance, mission statements and wider organisational policies. For example, the establishing of links between complaints, serious incidents and safeguarding issues to tell a more comprehensive story about the quality of provision did not routinely happen. Neither was the whistleblowing policy regularly used to improve openness and transparency and supporting staff to voice concerns.

Furthermore, there were issued described about the interface of quality of care, such as tissue viability and safeguarding processes.

Legal literacy and support for staff on legal advice, such as emerging case law, Court of Protection rulings and MCA and DOLs was generally not well developed. Further training and strengthening the availability of legal counsel featured greatly.

Specific issues emerged for prison and offender health team about the threshold for statutory intervention on safeguarding and tracking prisoners when there are safeguarding concerns and they have left prison.

Notable practice included

- There were a number of CCGs and NHS trust that had either a named GP, or dedicated doctor for safeguarding.
- An agreed protocol for developing and delivering principles of best practice and a supporting governance process and screening tool in relation to Safeguarding and pressure ulcers
- Duty of Candour and Clinical Quality Risk Meeting were stated to ensure that providers are regularly challenged clinically on the quality of services they provide.
- One NHS hospital trust provides legal MCA master classes twice a month and regular newsletters for staff from the trust's legal firm

The organisation's responsibilities towards adults at risk are clear for all staff and for commissioned services.

The majority of organisations felt that their policies and procedures and underpinning information sharing protocols required updating or reviewing because of changing organisational arrangements or legal changes. Not all policies referred to safeguarding and many organisation did not have clear line of accountability in place (with regards to safeguarding responsibilities).

There were very good examples on how commissioning, contracting and procurement took account of safeguarding. For example, specific key performance indicators (KPI) were monitored alongside NHS contract that included KPI relating to safeguarding. However, across London there were issues about embedding and monitoring safeguarding consistently across health and social care. Commissioners and providers both reported that the use of contracting for monitoring MCA compliance and element of Prevent (the tackling of radicalisation in vulnerable individual) was much more in its infancy. There was also an acknowledgement to further include the principle of wellbeing into contracts.

Notable practice

- Safeguarding decision tool to support decision making and safeguarding escalations
- One organisation had commissioned a specialist service to gauge user/carer experience of MCA

The organisations approach to workforce issues reflects a commitment to safeguarding and promoting the wellbeing of adults at risk.

No organisation reported that there were issues with regards to safer recruitment practice, such as deciding if posts are eligible for a Disclosure and Barring Scheme (DBS) check**.** A number of organisation reported that their mainstream job description did not make references to safeguarding to better reflect the roles safeguarding responsibilities.

Supervision and the lack of reflective practice was cited by most organisations, stating that this was not included in supervision. Strengthening the safeguarding policy so that it refers to safeguarding was identified as a key action. In general, there was a lack of understanding or framework to assess the organisational competencies in safeguarding and MCA. Weak organisational development to support staff in MCA work (assessing capacity and making best interest decisions), leading on prevention and executive training on safeguarding were identified. In general exit interviews or analysis of staff experience were not routinely carried out in order for the organisation to make improvements.

Notable practice

- Supervision policy for volunteers
- Use of Bournemouth competencies for safeguarding used in supervision
- Competency in safeguarding pilot to be evaluated and rolled out Trust wide
- In one organisation every JD included a safeguarding statement
- Poster on MCA/DOLS produced
- Trust is designing an app to disseminate MCA/DOLS information and guidance so staff have 24/7 access using smart phones or tablets
- A staff leaflet on DOLS safeguarding and a business card with numbers to report safeguarding concerns
- Prevent is being incorporated into an Induction book for all new staff and in mandatory training

Effective inter-agency working to safeguard and promote the wellbeing of adults at risk.

In general, larger organisation attended the local SAB regularly, though it needs to be acknowledged that this is a challenge for larger trusts spanning higher number of Local Authority boundaries. The main issue around attending local boards were for Voluntary Groups and Prison and Offender Health Services who not routinely attend.

Pan London learning from serious case reviews, safeguarding adults review and serious incidents did not always happen and was one of the key issues identified. Integration of various action plans from reviews were also a challenge, as was the sharing of these reports with internal boards. There was also a reported lack of interface and consistency between safeguarding and serious incidences.

Very few organisations reported that they had information sharing protocols in place that were fit for purpose. Issues identified were also practical training issues for staff to share information according to the Data Protection Act.

Engagement of organisation with Prevent and the ‘Channel’ process was deemed to be poorly developed (‘Channel’ is a key element of the Home Office’s ‘Prevent’ strategy and is a multi-agency approach to safeguarding children and adults from being drawn into committing terrorist-related activity).

Notable practice

- Care Forums to disseminate and discuss information on good practice with care providers
- Lessons learnt log disseminated across a wider group of organisations
- A service had systems in place to collate and audit safeguarding alerts, referrals, incidents and complaints
- Work currently being undertaken to integrate complaints and incidents with the safeguarding adults quality assurance
- Partnership work to develop a Hoarding Protocol, which was launched April 2014
- CCG runs a successful pressure ulcer forum that welcomes local agencies and care home attendance
- Work undertaken to help staff translate information sharing principles into practice
- One organisation is scoping and reviewing whether there is under reporting given no PREVENT alerts since implementation of the protocol
- The safeguarding team conducts research and shares information with respect to Channel referrals with the Channel Manager

Addressing issues of diversity

A significant number of organisations said that they did not collect information on diversity and equality within the safeguarding process to inform practice and strategy development.

The services can demonstrate that people who use services are informed about safeguarding adults and empowered within the organisations response to it

The majority of organisation identified the need for improvement in achieving demonstrable person centred outcomes for their population group and to seek feedback on the experience of individuals using the safeguarding service. A particular focus for development were given to enhance carer and family involvement, refining risk assessment processes and strengthening quality assurance processes.

Working in a person centred way for people who lacked capacity was an issue for nearly all organisations. The focus of actions was around improving staff skills and understanding in applying the MCA principles into their working practice.

There were particular issues around the implementation of the MCA in prison, with advocacy not being available.

Notable practice

- An aid memoire has been created for the staff to ensure they are reminded about individual involvement and/or appropriate advocacy
- Several organisations used language line and one of these routinely offered access to interpreters
- Staff were issued with pocket communication guides to help them communicate with people who have communication difficulties for example people with a learning disability or who are deaf.

OPPORTUNITY FOR SHARED ACTION ACROSS LONDON

The summary of improvement actions identified within the audit tools did outline key recommendations for consideration at London-wide level and for all organisations were to:

- Disseminate notable practice and lessons learned across London
- Develop a shared understanding and appropriate application of the Mental Capacity Act and Deprivation of Liberty safeguard by all partners
- Deliver safeguarding training appropriate to individual's role, responsibility and seniority and the evaluation of the impact of this training
- Provide supervision and reflective practice. On the hand strengthening provision of supervision for dedicated safeguarding staff, on the other ensuring that supervision in other staff groups explores the issues of safeguarding and application of the Mental Capacity Act
- Inclusion of safeguarding within all contracts when commissioning services
- Updating policies and procedures, including the pan London policy and procedures to take account of the Care Act and emerging subjects such as self-neglect, domestic violence, Modern Day Slavery, Human Trafficking, FGM and the radicalization agenda
- Raising alerts and improved multi- agency partnership working
- All job descriptions should include safeguarding statements
- Staff exit interviews should be conducted and findings analyzed
- PREVENT training responsibilities to be clarified by NHS England
- Supervision policies should be reviewed to include safeguarding

CCG and Local Area Teams

- NHS England should use the findings to work through its CCG assurance system and to work with Direct commissioners to ensure that lessons learned are better embedded in the commissioning system
- NHS standard contract should include safeguarding, MCA/DOLS

Foundation Trusts

- Monitor should take note of findings and use them to inform their role in quality by assuring themselves that robust governance structures are in place

NHS Trusts

- Trust Development Agency should take note of findings use them to inform their role in quality by assuring themselves that robust governance structures are in place
- To clarify and strengthen systems for reporting Serious Incidents when they are potentially Adult Safeguarding concerns.

Public Health and Specialist Commissioning

- Public health and specialist commissioning should adjust their quality assurance mechanisms to ensure that lessons are learned

Local Safeguarding Adult Boards (SABs)

- SABs should take account of findings and benchmark their own work against other London SABs to see where they might learn from others.
- Local partnerships should identify mechanisms for analysing information to assist early identification of safeguarding issues
- SABs should ensure lessons learnt from serious incidents and safeguarding adults reviews are disseminated
- To ensure information on adult safeguarding is accessible to all parts of the community recognising diversity.
- To make use of the Making Safeguarding Personal resources to achieve an outcome focus

FINAL REFLECTION ON EMERGING POINTS

In summary, below is a list of the cross cutting points that emerged and that could be considered at regional or local level to ensure that the strategy and work plans are considering these, or if there is opportunity to take joint actions:

Strengthening Assurance

- Supporting Commissioners and Providers to have a clear understanding of what good quality of care looks like and when poor care becomes a safeguarding issue. Also on how to assure themselves that personalised health and social care are provided in the least restrictive setting. This takes account of peoples changing need and ensure that the same person centeredness is offered to people who may lack capacity through the application of the principles of the Mental Capacity Act
- Develop a quality surveillance system for providers at local level with escalation to Quality Surveillance Group and ensure that routine data is collected.
- Specific focus on demand in mental health organisation to provide good care coordination, care program approach, assessment, clinical decision making and addressing physical health in mental health patients
- Smooth out organisational boundaries and roles and responsibilities for people with multiple problems (for example substance misuse and mental health
- Consider further roll out of multi-agency audits consider approach to impact learning

Information and Guidance

- Raise awareness of safeguarding and associated themes such as domestic violence, Prevent and self-neglect through guidance and information products.
- Increase information on domestic violence to mainstream staff backed up by awareness campaign to the public to challenge stigma
- Opportunity for strengthening of network and build alliances to embed learning
- Disseminate notable practice and lessons learned across London
- Develop a shared understanding and appropriate application of the Mental Capacity Act and Deprivation of Liberty safeguard by all partners
- Raising alerts and improved multi- agency partnership working
- Improving of legal literacy around MHA and MCA

Workforce Development

- Support organisational development including safer recruitment, use of Job Description, exit interviews and building safeguarding competencies and quality assured training.
- Develop a joint supervision strategy for safeguarding staff to ensure that there is supervision and reflective practice. On the hand strengthening provision of supervision for dedicated safeguarding staff, on the other ensuring that supervision in other staff groups explores the issues of safeguarding and application of the Mental Capacity Act
- Use the competencies of the Intercollegiate Guidance to develop competency based training on safeguarding and aligned to all relevant topics (such as Prevent, Domestic Violence, self neglect and Mental Capacity Act)
- Considering named GP role to strengthen clinical leadership
- MCA training for GP and staff leadership

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NHS England

GET IN TOUCH

england.safeguarding2016@nhs.net

NHS England [London Region]
Nursing Directorate
4th Floor, Southside
105 Victoria St, London
SW1E 6QT
London

www.england.nhs.uk