

**WEST MIDLANDS NHS BOARD LEADS
ADULT SAFEGUARDING SEMINAR
HELD ON 20TH JANUARY 2010**

SEMINAR REPORT

1. SEMINAR PURPOSE

This regional seminar was aimed at NHS Trust board members from PCTs, Acute and Mental Health Trusts with the lead for Adult Safeguarding. The aims and content of the seminar were shaped in consultation with a number of NHS safeguarding board leads within the region and included:

- Reviewing current statutory and partnership responsibilities and anticipating how these may be enhanced in response to the No Secrets Review
- Providing an opportunity for local NHS economies to informally assess how effective their systems, structures and processes are to contribute to local and regional assurance intelligence
- Sharing examples of good practice to inform wider adoption
- Provide an opportunity for networking and knowledge sharing
- Identify any further common learning and development needs at individual, board, organisational and partnership level

2. PROGRAMME

The programme included:

1. An overview of the key messages for the NHS in the No Secrets consultation responses
2. An update from the Department of Health on national progress
3. An example of practice from an Acute Trust
4. An example of practice from a Mental Health & Social Care Trust
5. Small group discussions to reflect on current local arrangements
6. Whole group discussion to share learning, perspectives from different parts of the NHS system, the common challenges and transferable learning
7. A plenary session for participants to comment on what they had gained, what action they planned and what would be helpful in future regional development activity to inform recommended points for action.

3. SEMINAR PARTICIPANTS:

There were over 30 participants in the seminar, with representation from PCTs (in both provider and commissioner roles), Acute Trusts, Mental Health Trusts and the WM Ambulance Service. The full participant list can be found at **Annex A**.

4. SUMMARY OF KEY INFORMATION & KNOWLEDGE SHARED

Presentations and supporting information from the seminar are available at:

<http://www.wmrdc.org.uk/children-and-families/adult-safeguarding/>

4.1 Keren Corbett, Programme Consultant, NHSWM RDC gave a brief overview of the key messages for the NHS following the No Secrets consultation and outlined the aims, content and style of the seminar. Key messages for the NHS were:

- Safeguarding was not widely understood nor embedded as a concept
- There is a need to ensure that all parts of the NHS are engaged in adult safeguarding practices and developments
- There is a need to implement clear organisational leadership structures that identify PCT Board Level expectations, an Executive Board lead for safeguarding, an operational lead, and safeguarding coordinators linked to the wider multiagency safeguarding team.

4.2 Anna Morgan, National Programme Manager, No Secrets, Department of Health, gave an update on the Governments Response to the consultation and work underway including:

- The recent announcement of an interdepartmental ministerial group on Safeguarding Vulnerable Adults
- Strengthening the local governance of safeguarding by putting Safeguarding Adults Boards on a statutory footing
- Issuing new refreshed multi-agency guidance.
- Within the DH, a range of work was underway on clarifying the role of SHAs & PCTs, developing suggested Performance Indicators, and developing specific guidance for nurses and GPs in collaboration with NMC & RCGPs.
- The DH welcomed contributions from the regions in this work and recommends the development of SHA led networks for the local NHS safeguarding community.

4.3 Jennifer Robinson, Lead Nurse- Older Adults, Walsall Hospitals NHS Trust gave a brief presentation and led a discussion on the Acute Trust perspective, including some of the challenges identified and work underway to address them. Key points included:

- The need to get training embedded as mandatory and as part of induction, including access to multi agency training
- Empowering front line staff to understand professional and employment obligations and the level of conduct required to safeguard patients within their care and making safeguarding everyone's business.
- Increasing staff knowledge and awareness regarding the recognition of adult safeguarding
- Integration of safeguarding into current reporting systems to fully implement clinical governance structures
- Establishing formal reporting to Trust Board

4.4 Allan Craig, Social Care Director, Sandwell Mental Health & Social Care NHSFT, gave a brief presentation and led a discussion on the Mental Health Trust perspective, including the challenge of interpreting the safeguarding agenda within

the context of all service users being vulnerable and the overlaps in legislation and practice with CPA, MCA, DoLS and clinical governance. Key points included:

- Variable awareness within the organisation
- Link to incident reporting to pick up unreported safeguarding issues
- Increasing demand- 10 fold increase in alerts linked to raised staff awareness
- Alerts arising in the following types of adult abuse: Financial, Emotional, Physical (particularly on inpatient wards), Forced marriage.
- Success factors included board sign up, nominated adult safeguarding post, joint training, links with LA safeguarding team and recognizing links with Children's safeguarding, e.g. domestic violence.

4.5 Small Group Discussions to reflect on current local arrangements.

Participants were asked to group into Acute Trusts, PCTs and Mental Health Trusts. Each group had a recorder and a chair who undertook to summarise the discussion and feedback a few key points to the wider group. Groups were asked to address the following issues:

- Assessing confidence in current arrangements & identifying opportunities to share learning, practice, methodology, tools
- Identifying areas of risk
- Identifying any learning and development needs of board leads

The key feedback points are listed below. More detailed discussion notes are available at **Annex B**

Acute Trusts

Confidence in current arrangements: Variable. Need to refine processes for incident reporting to ensure effective triggers in place. KPIs/ performance dashboard from SHA welcomed to record trends & provide benchmarking. WMAS have some training development & point of contact expertise to share.

Areas of Risk: Ensuring effective, regular board reporting
Ensuring staff training is embedded and reflected in practice
Sufficient dedicated capacity for the agenda

Development needs: Guidance on role of Trust board lead & training (across the board/organisation). KPIs & Performance dashboard in context of sharing & developing practice
Exploring regional approaches to training development & validation to ensure transferability
Exploring the value of a PING system in A&E/ other settings

Mental Health Trusts

Confidence in current arrangements: Variable. Progress is being made evidenced by higher levels of reporting. Staff awareness is being raised and the safeguarding agenda is increasingly complementing & being driven in synergy with CPA, MCA, DoLS etc.
Increased co-operation with Trust risk teams and partner agencies.

Areas of Risk: Ensuring effective, regular board reporting. Need to refine processes for incident reporting to ensure effective triggers in place. Reporting every incident would be an overwhelming ineffective workload e.g. repeated attempted attacks from one inpatient to another on the same day. There is a need to refine assessment of risk, resulting in the appropriate response. A balance needs to be found between the extremities of view concerning what constitutes Safeguarding. There are different places of perceptions origin, such as that of the Police and that of MH Services. There are different principles in operation between Adult and Child services.

Development needs: Support to refine the quality of training. Clarity of agency roles & responsibilities. Underpinning local governance arrangements, annual board report. Ensuring sensitivity to the context in developing risk assessment.

PCTs

Confidence in current arrangements: Variable. Both commissioner and provider perspectives informed this discussion. Major concern re capacity & capability given the range of competing priorities. Need to integrate processes, data and systems. Commissioning and contracting seen as a lever for improvement. Several areas offering to share policies, tools and softer learning.

Areas of Risk: Role definition - a need for defined roles and not tagging this agenda on. Ensuring effective, regular board reporting. Primary care seen as a risk area, particularly engaging and training GPs. The potential costs of developing effective safeguarding processes, systems and roles. Sufficient dedicated capacity for the agenda to fulfil provider and commissioner responsibilities.

Development needs: Guidance on role of board lead & training requirements across the organisation. Support in developing information sharing arrangements. Access to a national evidence base comparable to that available for commissioning and providing for children's safeguarding. Need to develop a common language.

Feedback and the ensuing questions and discussion allowed for sharing the themes common to all NHS organisations and for further sharing of approaches and solutions.

4.6 **The whole group discussion and plenary session** were merged and allowed ideas to be generated in response to some of the risk and development areas identified. Several areas for further national and regional development were identified. The DH in collaboration with SHA Safeguarding Adult Leads had developed a draft paper outlining the role of SHAs and PCTs in Safeguarding Adults and some draft performance indicators for SHAs and PCTs to consider adopting. These documents were broadly welcomed by participants, and final versions would ultimately inform the new guidance. Regionally, further learning and development activity such as a regular network was felt to be of value by many participants, as was regular knowledge and information sharing (e.g. a webpage containing relevant resources including sharing local tools, policies etc). The possibility of a conference to widely raise awareness was also discussed.

At the end of the seminar most participants had formulated some thoughts on early actions they wanted to undertake within their organisations. These included:

- Feedback to local board
- Build stronger links with commissioners

- Challenge the current membership of working groups that link to the Safeguarding Agenda
- Link with clinical governance on lack of referrals this year
- Disseminate the seminar information,
- Undertake baseline assessment of current safeguarding arrangements to clearly identify gaps and risks
- Combination on the Adult and Child Safeguarding actions/strategies process. Review our local structures · Incident review ·
- Training needs/gap analysis

5. SEMINAR OUTCOMES

The seminar was well attended with good representation from different sectors of the NHS regionally. Around 50% of participants completed evaluations of the seminar and these were positive indicating it had been a useful investment in learning time. A copy of the evaluation summary is available at **Annex C**.

There is wide recognition that the safeguarding adult agenda requires significant work to embed across the NHS system, alongside recognition that there is scope to ensure that transferable learning to expedite change from Children's Safeguarding is distilled and disseminated.

Emerging examples of practice "worth sharing" were informally identified and these will be collated and shared via a dedicated webpage at:

<http://www.wmrdc.org.uk/children-and-families/adult-safeguarding/>

Participants welcomed the SHA taking a lead in areas such as defining KPIs, potentially developing a performance dashboard and supporting benchmarking, providing future development activity, supporting getting standardised training on a mandatory basis and mainstreaming through workforce development leadership.

Keren Corbett
Programme Consultant- Children & Families Service Development
NHSWM Regional Development Centre

**WEST MIDLANDS NHS BOARD LEADS
ADULT SAFEGUARDING SEMINAR
HELD ON 20TH JANUARY 2010
Attendance**

Name	Position	Organisation	Email
Allan Craig	Social Care Director	Sandwell Mental Health and Social Care NHS FT	allan.craig@smhft.nhs.uk
Ann Becke	Non-Executive Director	Dudley Group of Hospitals	Ann.becke@dgoh.nhs.uk
Anne Coyle	Interim Assistant Director Treatment and Care	Walsall Community Health	Anne.coyle@walsall.nhs.uk
Claire Bonniger	Divisional Nurse Director (Acting)	University Hospitals of Coventry and Warwickshire	claire.bonniger@uhcw.nhs.uk
Dawn Wardell	Acting Director of Nursing	George Eliot Hospital NHS Trust	dawn.wardell@geh.nhs.uk
Debbie Edwards	Head of Clinical Standards and Patient Experience	Wolverhampton City PCT	debbie.edwards@wolvespct.nhs.uk
Denise McMahon	Director of Nursing	Dudley Group of Hospitals	denise.mcmahon@dgoh.nhs.uk
Dr Jo Leahy	Acting Medical Director	Telford and Wrekin PCT	jo.leahy@telfordpct.nhs.uk
Helen Inwood	Deputy Chief Nurse	University Hospital of North Staffordshire NHS Trust	helen.inwood@uhns.nhs.uk
Jackie Lynton	Associate Director Quality and Nursing Directorate	South Staffordshire PCT	jackie.lynton@southstaffspct.nhs.uk
Jane Smith	Deputy Director of Nursing	Worcestershire Acute Hospitals Trust	jane.smith@worceacute.nhs.uk
Jo Corbett	Lead Nurse Safeguarding Adults	South Staffordshire PCT	jo.corbett@southstaffspct.nhs.uk
Jo Galloway	Deputy Director of Nursing, Quality and Safety	NHS Warwickshire	jo.galloway@warwickshire.nhs.uk
Joan McHugh	Solihull Safeguarding Adults development Manager	Solihull NHS Care Trust	joan.mchugh@solihull-ct.nhs.uk
Julie Bassett	Head of Safeguarding	West Midlands Ambulance Service	julie.bassett@wmas.nhs.uk
Julie Hendry	Director of Nursing and Midwifery	Mid Staffs NHS FT	julie.hendry@midstaffs.nhs.uk

Karen Hunter	Head of Quality and Patient Safety	NHS Worcestershire	karen.hunter@worcestershire.nhs.uk
Lezli Feeney	Risk Manager	NHS Telford and Wrekin	lezli.feeney@telfordpct.nhs.uk
Liza Walsh	Associate Director of Nursing, Quality and Therapies	Heart of Birmingham PCT	liza.walsh@hoptpct.nhs.uk
Margaret Harries	Lead Nurse Older Adults	University Hospital Birmingham NHS Foundation Trust	margaret.harries@uhb.nhs.uk
Neil Brimblecombe	Director of Quality and Professional Practice	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	neil.brimblecombe@sssft.nhs.uk
Teresa McGougan	Interim Head of Professional Governance	NHS Stoke on Trent	teresa.mcgougan@stoke.nhs.uk
Tony Arrowsmith	NED	West Midlands Ambulance Service	tony.arrowsmith@wmas.nhs.uk
Anna Morgan	Senior Policy Lead	Department of Health	
Carol Goodwin		North Staffordshire Combined Healthcare NHS Trust	Carolea.goodwin@northstaffs.nhs.uk
Denise Williamson		Shropshire County PCT	Denise.williamson@shropshirepct.nhs.uk
Frances Colley	Associate Director of Nursing	SBCH	Frances.colley@sbpct.nhs.uk
Jenny Robinson (representing Brigid Stacy)	Lead Nurse, Older Adults	Walsall Hospitals NHS Trust	Jenny.robinson@walsallhospitals.nhs.uk
Joan Williams		North Staffordshire Combined Healthcare NHS Trust	Joan.williams@northstaffs.nhs.uk
Karen Farrell (in place of Denise Price)		NHS South Birmingham	Karen.farrell@sbpct.nhs.uk
Sandra Coates (representing Jackie Jones)		Burton Hospitals NHS Foundation Trust	Sandra.coates@burtonft.nhs.uk

Discussion notes from small groups:

Acute Trusts

Assessing confidence in current arrangements:

The policies and processes are in place in regard to incident reporting, but safeguarding issues are not always picked up from the reports. It was suggested that all incident reports should be screened. There is a need to monitor feedback on all incident reports- pathways need to be linked together, especially if the incident report is raised about an issue not within the Trust.

A tool should be developed to trigger identification of safeguarding issues that should be referred to a safeguarding nurse. There are some triggers already (e.g. pressure sores, bruising, dehydration) but these should be increased. These triggers have already been helpful in identifying particular nursing homes as having difficulties.

There needs to be a collaboration on these issues, could set up a working group to do this, either actual or virtual. The SHA could be in a position to do this, it could be web based so that everyone can access it. Not each Trust has a dedicated safeguarding nurse, but in areas that they do, value added has been noticeable. The lead must be a dedicated role, not an add-on to an existing job, as the safeguarding agenda is increasing. The ambulance trust has appointed a lead and is in the process of appointing a safeguarding team. Job descriptions of these leads could be shared.

There can be a variety of ways to address the safeguarding lead and team structures depending on the size of the Trust, existing structures etc, but the outcomes should be the same. There should be attempts to standardise the training across the patch so it doesn't need to be repeated as people work with other agencies, it was agreed the training should be mandatory for all staff at a basic level and different levels mandatory for certain job groups.

Identifying areas of Risk:

A quarterly report is made to the board. There should be monthly reporting and be a part of the dashboard. If dedicated leads are identified, then initially reporting is likely to increase. Trends and actions on the reports will need to be developed. A KPI should be identified and the dashboard can reflect the reporting by area, groups etc.

How do we evidence that the training is embedded in practice? Staff need help in interpreting the policies. Training will help, but what makes it real is going onto ward areas and working with staff to identifying the patients to whom safeguarding may apply.

There should be a laminated flow chart of key elements in all areas of care, displayed in each care area. In the ambulance service, there is a single point of contact and each member of staff have been given a key ring with the telephone number on. A workbook has been issued to all staff; they have an e-learning training package. A weekly briefing takes place on safeguarding and this in itself has led to an increase in referrals. The ambulance service needs to get better at letting providers know when a referral has been made about one of their patients, this should be done as part of the handover of care.

Learning and development of board leads:

The guidance will be very helpful. What is reported needs to be the same across each area. The contents of each area should be shared with all areas. How do we share effectively? Sharing may need to be facilitated.

It is felt there is a role for the SHA to develop and validate the training and define the role of a safeguarding lead. Who are SHA leads for developing the Safeguarding programme. How do people get access to them, what resources do they have, how do we get commonality across all areas?

Mental Health Trusts – Staffordshire and Sandwell

Allan Craig had given an overview of Sandwell in his presentation

Staffordshire –

- A Safeguarding Board has been established
- Stoke and Staffs have an executive board that stretches across the economy

- Reported instances are monitored, to help raise awareness
- There is cooperation with the Risk Team
- An annual programme of work consists of-
 - Mandatory training with Child Protection (although this tends to be child focused)
 - An annual report to the board
- There is integrated working with staff from social services, with section 75 in mind
- The quantity of mandatory training results in time issues, concerning factors such as capacity and the releasing of staff

Gaps-

- Reporting every incident would be an overwhelming workload
- There should be an assessment of risk, resulting in the appropriate response
- A balance needs to be found between the extremities of view concerning what constitutes Safeguarding. There are different places of perception origin, such as that of the Police and that of Services
- There are different principles in operation between Adult and Child
- It is often about stopping behaviours, rather than breaking relationships which could be seen as the cause

Issues-

- Mental illness isn't stagnant, nor easily defined
- Mental illness does not necessarily mean the individual is incapable of informed choice
- There is a tendency towards large responses to patient surveys
- 'Element of risk' needs clarification
- There is no unified system, but most authorities have something in place, such as a Risk Assessment Framework
- A mental health diagnosis does not necessarily describe the individual
- Diagnoses can often change when a new consultant is brought in
- Enquiries regarding abuse should not be part of a regulated, verbatim question

Primary Care Trusts

Assessing confidence in current arrangements:

PCTs have the complexity of addressing safeguarding as both a commissioner and provider and progress or confidence in addressing the agenda varied.

Also partly dependent on wider partnership- e.g. Telford & Wrekin have a robust SAB and training is multi-agency & mandated.

Capacity to manage the agenda varied. Some areas have created safeguarding teams; other areas aspire to this or have added the responsibility on to existing roles.

Identifying areas of Risk:

In some areas safeguarding is not yet embedded in culture.

Board reporting and awareness was also variable. Some areas had established quarterly reporting.

Many areas have not yet developed KPIs and capacity to undertake review and audit varied.

Primary Care was seen as a risk area- particularly engagement and training of GPs.

Learning and development of board leads & offers to share learning:

Awareness raising defining roles and responsibilities.

The guidance is welcomed and the suggested KPIs were felt to be helpful to consider as a menu, with PCTs selecting those that would assess performance in locally identified key risk areas. Stoke have developed a briefing note for Primary Care.

Is reported needs to be the same across each area. The contents of each area should be shared with all areas. How do we share effectively? Sharing may need to be facilitated.

There has been some work on reporting/trigger thresholds e.g. Grade 2 pressure sores (SBPCT)

In Birmingham the 3 PCTs are jointly commissioning Continuing Care and have developed a shared framework to monitor and manage quality of care in Nursing Homes.

Other examples of practice included an operational group including SLTs, Dietetics etc to establish reporting processes where concerns established.

Worcestershire has established a quarterly reporting process for providers for Children and Adult safeguarding and has incorporated core statements into service specs.

**WEST MIDLANDS NHS BOARD LEADS
ADULT SAFEGUARDING SEMINAR
HELD ON 20TH JANUARY 2010
Evaluation Feedback**

How useful / relevant did you find this event?

Extremely useful:	10
Useful:	7
Adequate:	0
Not at all:	0

Organisation of the event

Very well organised:	1
Well organised:	13
Adequate:	3
Poorly organised:	0

Personal Learning: two key things learned from the day

- New DH announcement and key developments
- KPI's – useful
- That we are going in right/similar directions in developing Safeguarding Adults agenda
- Updated on national guidance and No Secrets agenda
- Details of new government announcement
- What is happening in other trusts
- Good practice in other areas
- All trusts have the same issues
- Formulate a number of actions that could produce fairly quick changes to support the safeguarding agenda
- New guidance
- Other learning
- Announcement of Safeguarding (DH) and all that it proposes
- Review complaints and incidents to identify safeguarding issues
- Raised my awareness of scope of safeguarding
- All trusts starting the journey of Adult Safeguarding and integration into structures
- More resources will be available to support Acute Trusts and other agencies.
- What is happening in other organisations
- Direction of travel for safeguarding
- National update and direction of travel and forthcoming publications and best practice guides
- Sharing best practice and opportunity to network
- Importance of incident review to identify potential safeguarding concerns/risks
- The importance of signing up to the Duty to Co-operate agenda
- Best practice from similar Acute Trusts
- SHA's role in safeguarding
- Broadened knowledge and perspective on Adult Safeguarding
- Up to date information sharing
- How to reflect mental health message in Safeguarding Guidance
- Good progress being made
- Different perspectives

Action Planning: two actions to implement the following day

- Assess KPI's in our organisation
- Feedback to local board
- Build stronger links with commissioners/contracting

- Continue to build on improving monitoring and referral process within NHS
- Risk Management via SUI and Incidents in relation to safeguarding
- Reporting tools
- Challenge the current membership of working groups that link to the Safeguarding Agenda
- Link with clinical governance on lack of number of referrals this financial year
- Look out for guidance
- Disseminate the information
- Baseline assessment of current safeguarding arrangements to clearly identify gaps and risks
- Arrange for review of incidents to identify safeguarding issues – but first need to agree safeguarding criteria
- Medical adult safeguarding lead confirmation of appropriate lead
- Adult Safeguarding resource website – link with Children’s Safeguarding website
- Board reporting clarity and briefing the board
- Combination on the Adult and Child Safeguarding actions/strategies process
- Strengthening links with Child Safeguarding
- Review our local structures
- Incident review
- Training needs/gap analysis
- Understanding throughout the organisation on the agenda of safeguarding
- Regular forum (networking) – quarterly focusing on best practice
- Consider linking incident reporting and safeguarding
- Board paper annual report and to capture plan for next 12 months
- Add to organisation website to include Adult Safeguarding with links to SCIE
- To renew KPI’s/tools to understand applications
- Include more info on Mental Health

Further Learning Needs

- Useful to have networking events to share good practice
- Refresher on all reports written for safeguarding would be useful – new in post and safeguarding is new agenda for me
- Further networking
- How best to implement this agenda to provide assurance that systems process are obvious
- National e-learning package
- Network development for safeguarding leads
- Expectations from CQC for Acute Trust Safeguarding.
- Board roles and responsibilities
- Report content and KPI’s
- Good practice sharing
- Key performance indicators
- Commissioning for quality in guiding safeguarding
- Evidence base for best practice – nationally to drive local provider and commissioner KPI’s
- How to standardise training across the patch
- Role definition
- SHA network

Any Other Comments

- Lunch would have been nice!
- Very informative meeting
- Would like regular networking/updating events to share good practice and concerns
- Excellent event for sharing and learning
- Room temperature
- Need u-shape set out if using slides
- A quarterly network meeting would be invaluable to share best practice
- Venue took 2 hours to reach because of traffic = 4 hours travelling – not sure what can be done because of geography of patch, but that’s a lot of time out of busy day
- Informality approach of meeting very helpful, thank you
- Fantastic event – would welcome future events e.g. summits
- Very positive focused event
- Too cold!