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St Christopher's Annual Safeguarding Report 2019-2020

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Final

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St Christopher's statement in relation to safeguarding

Safeguarding is the golden thread that draws together so many aspects of St. Christopher's work. The principles that underpin safeguarding also underpin much of palliative medicine and social care:

- The need to empower patients and carers,
- To work in partnership,
- To work to protect patients and carers from unwanted and inappropriate interventions
- To prevent harm happening in the first place
- To hold ourselves to account through the effective use of governance and annual reports
- To ensure we take a proportional response to risk and risk aversion

The requirement to safeguard vulnerable adults and children is enshrined in both The Care Act and The Children's act. There are significant differences in the context and statutory requirement for safeguarding adults and children, with an overarching objective for both of enabling adults and children to live a life free from abuse. High profile cases for adults and children have highlighted shortfalls when health and social care organisations fail to keep people safe. In the hospice environment and considering the whole person and their context holistically, we encounter a wide range of safeguarding issues.

This report reviews our safeguarding activity for the period April 2019 – March 2020, and updates our current arrangement for meeting our duty to safeguard people needing hospice provision. The paper introduces changes in legislation and guidance. We recommend actions going forward into 2020-2021 to be agreed within our clinical governance structure.

It is important to note that as a result of COVID Lockdown commenced on the 23rd March 2019 and this may have a slight impact on our data and certainly will have an impact of data in Q1 2020

1. POLICY UPDATE

We operate under the Adult and Child Safeguarding Boards of our local authority – Bromley.

St Christopher's operates its safeguarding commitment through both Adult and Children's Safeguarding Policies.

This report reviews activity on 2019-2020 and the Safeguarding Adults Policy would have required refreshing with the introduction of the Liberty Protect Standards in 2020 however, due to COVID, these have been delayed. The Safeguarding Adults Policy has, however, been updated early in Q1 2020.

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2. SAFEGUARDING LEAD & GOVERNANCE STRUCTURE

The governance structure for safeguarding reflects responsibility at all levels, and this has remained in place over the last year.

- Gill Baker is the designated Board member with accountability for safeguarding.
- The Executive Team lead is Amanda Mayo, Care Director
- The Operational Lead is Vincent Docherty, Head of Patient and Family Support.

Our 1350 volunteers have a huge part to play in safeguarding and, as a result, we invited the Strategic Volunteering Lead to join the group

Operationally the organisation has a team of experienced social workers, who provide advice and support to the hospice and community teams. It is usually the social worker who will lead casework when there are serious safeguarding issues. The identification of safeguarding concerns has continued to increase over the 2019-2020 period – see detail below. This reflects the growing confidence of members of the multi-disciplinary team so that they deal with initial concerns, and that team managers across the hospice recognise their responsibility in keeping patients and families safe.

The quarterly Safeguarding, MCA and DOLs committee was established in September 2016, and reports to the Patient and Service User Safety committee. It has met four times in the 2019-2020 time period. Reports are overseen and signed off by the Quality and Governance board. This annual report is presented to the board of Trustees.

Adult Safeguarding boards are a statutory formal strategic partnership, with running costs in Bromley shared by the London Borough of Bromley and the Bromley Clinical Commissioning Group. St Christopher's is an active member of the board.

3. SAFEGUARDING TRAINING AND COMPLIANCE

Review of safeguarding training requirements across the organisation
From April to July 2019 a comprehensive review of safeguarding training requirements - explicitly linked to the Intercollegiate Guidelines - was conducted. This allowed a differentiation of training content and complexity to be planned appropriate to the target audience roles and responsibilities. The completion of a Safeguarding Adults Risk Assessment Tool (SARAT) led to the identification of a key priority in our safeguarding practice - Workforce and Training – ensuring we meet our training commitments to volunteers and staff associated with the inter-collegiate document.

Increased compliance for safeguarding training
At each quarterly committee meeting in the 2019-20 period the figures for safeguarding related training compliance were presented and analysed. This year has seen a much better joined up approach to the presentation of training and how we capture attendance at compulsory training events. The inter collegiate document provided a stimulus for the significant improvement in training statistics. The appointment of Amanda Mayo as Director of Care and her previous safeguarding background within various CCG's has been a major factor in how the training compliance has been transformed. Compliance of volunteers has also started to be

actively monitored including agreeing levels of safeguarding training for each volunteering role undertaken in the organisation and refreshing their training booklet.

The increase in compliance for salaried staff has been outstanding in this period and has been noted at the St Christopher's Board. See below for data related to training compliance demonstrating increasing compliance;

Module	MCA/DOLS	CHILDREN Level 1	CHILDREN Level 2	CHILDREN Level 3	ADULTS LEVEL 1	ADULTS LEVEL 2	ADULTS LEVEL 3
Mar-19	69.0%	62.8%	50.0%	66.7%	74.3%	71.0%	40.0%
Apr-19	69.2%	63.4%	50.0%	100.0%	72.3%	73.8%	75.0%
May-19	74.4%	69.1%	67.4%	100.0%	77.0%	72.0%	12.1%
Jun-19	72.3%	77.8%	32.2%	28.6%	81.8%	86.4%	13.3%
Jul-19	73.7%	88.3%	39.0%	20.0%	89.0%	86.3%	9.1%
Aug-19	75.2%	92.6%	67.8%	20.0%	93.5%	88.6%	9.1%
Sep-19	78.2%	93.1%	79.7%	100.0%	93.2%	92.0%	91.7%
Oct-19	78.5%	92.6%	81.4%	100.0%	92.6%	92.6%	91.7%
Nov-19	78.4%	92.6%	79.8%	100.0%	92.1%	91.1%	91.7%
Dec-19	76.6%	91.7%	78.6%	100.0%	92.0%	90.0%	83.3%
Jan-20	79.5%	93.9%	90.6%	100.0%	95.1%	91.9%	83.3%
Feb-20	79.6%	94.7%	91.9%	100.0%	95.5%	92.0%	83.3%
Mar-20	79.1%	94.7%	91.9%	100.0%	95.1%	90.3%	76.9%

4. POLICY

Safeguarding Adults and Children's Policies Updated
Significant acknowledgement has to be made to both the CCG and Bromley Safeguarding Services for the successful completion of this work. Both policies are now fit for purpose and consider the challenges of contemporary safeguarding practice within south London. As well as updating the policies we developed two practice guidance documents to assist staff and volunteers. Both documents are subject to immediate update if as a result of a Serious Incident or a SAR there is a need to provide further guidance or clarity.

5. CASE STUDIES SUPPORTING LEARNING

Introduced case studies to the committee meetings
This introduction has brought to life the actual safeguarding experiences of patients, carers and staff. Case studies – linked to identified themes and trends - have allowed

more in-depth scrutiny of cases and better governance from Trustees and committee members. They illustrate the stories behind the statistics. They have included -

- The content, task and structure of a best interest meeting held in a hospice ward setting.
- The chronology that led up to a child safeguarding referral being made for suspected neglect, linked to the lack of guardianship plans for a child. A 53-year-old grandmother was admitted onto the wards for terminal care. She had been diagnosed with an aggressive and terminal form of pancreatic cancer. Events and disease progression had simply moved too fast. She held a special guardianship order (SGO) in relation to her 5-year-old grandnephew. The child's mother was the daughter of the patient. Previous legal proceedings had been progressed by Kingston due to the child's mother having significant mental health and substance misuse issues. There was no involvement of the child's father. The patient was now disclosing that no plans had been made for the future guardianship of the child. Kingston and Croydon local authority were in conflict as to who should lead – the child was originally living in Kingston but was now living with their grandmother in Croydon. Grandmother's closest friend from childhood was identified by the grandmother as being the preferred person to take over guardianship. Kingston and Croydon local authorities stated the other was responsible for assessing the case. This resulted in a lack of timely action being taken. A formal child safeguarding referral was made as an informal fostering arrangement was at risk of developing. As the child was now living in Croydon it was eventually decided that Croydon would take responsibility.

6. AUDIT

Making safeguarding personal (MSP)

In June 2019, a Making Safeguarding Personal audit/analysis was undertaken. This comprised review of 10 safeguarding referrals and subsequent actions. Seven of these were in relation to parents and three in relation to carers.

Key issues and service user feedback are given below -

- MSP - **Self-neglect** - all referrals were in relation to patients and or carers who lacked capacity to make decisions about personal hygiene and home environments. In the main St Christopher staff members were concerned with living environments and how these were precluding other agencies becoming involved. The dilemma for staff was around their natural tendency to do something whilst service users often put their sense of independence and happiness above their personal safety and environmental health.
- MSP - **Financial abuse** – Many service users used the phrase "I just feel stupid and naive" and "I don't want other people to fall for such a stupid line." The lessons from an MSP perspective was the damage this type of abuse has on the patients or carers sense of self-esteem and confidence. For many the damage has been done and involving the police or social services only adds to their distress and abuse.

This work led to the identification of clear goals for future practice development

- Need to be clear we have pursued consent and identified what is important to the person not the staff team

- Risk awareness and risk consciousness
- Defensible decision making not defensive decisions
- Ensuring there is a clear focus on prevention and early intervention before "pressing" the referral button

7. STAKEHOLDERS

Involvement of CCG Safeguarding Leads in meetings
The involvement of the CCG leads has allowed external enquiry and analysis to the work and reports of the committee and also increased governance arrangements. . An example of the influence can be seen in how we now closely monitor the source of our safeguarding alerts within the organisation to ensure safeguarding is genuinely everyone's business. The influence of the CCG leads was seen in the use of Intercollegiate Guidelines to provide clarity and structure to developing differentiated levels of safeguarding training according to role and responsibility.

8. INVOLVEMENT OF THE SAFEGUARDING BOARD

Increased visibility at the LB of Bromley Safeguarding Adult Board (LBBSAB)
St Christopher's representation attends the LBBSAB quarterly meetings and is now involved in the Combined Services Intelligence Group (CSIG) meetings. The organisatIon also took an active role in the BASB Workshop on identifying priorities and goals of the boards work in the coming year. The BSAB workshop identified the following "3 pillars" to inform the overall 3-year strategy –

1. People and Outcomes
2. Leadership, Accountability and Performance
3. Organisations, Professions and Community

St Christopher's has been a key member of the LBBSAB project group on the introduction and support of Liberty Protection Safeguards - LPS's - planned for October 2020.
The Orpington social work team members attended both the Bromley Children and Adults annual conferences held at The Warren.
We submitted ourselves to intense peer scrutiny when we presented our SARAT to the BSAB.
The hospice took an active role in the events planned for the safeguarding awareness week events, both in The Glades and in other venues e.g. bereavement help points.

9. DEVELOPMENT OF EDUCATION ON THE INTRODUCTION OF LIBERTY PROTECTION STANDARDS (LPS)

This work arose out of a successful MCA Conference held in July 2019 on the theme of the Mental Capacity Act at the end of life. Alex Ruck Keen led the day and it was both a commercial and qualitative success. Subsequently St Christopher's has presented at two national conferences – in Manchester and London – alongside Alex Ruck Keen on the practical introduction of the LPS's within hospice and hospice at home settings.

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10.COMPLETION OF THE SAFEGUARDING ADULTS RISK ASSESSMENT TOOL (SARAT)

This audit of safeguarding practice and culture within the organisation was very time consuming but productive. We followed the structure of the BSAB audit tool which focusses on 7 key standards with a Red, Amber and Green rating. We do not view a current green rating as indicating no further work is needed, indeed a great deal of effort and commitment is needed to ensure we do not become complacent.

1. Leadership - Rated as green – clear leadership - safeguarding seen as golden thread that brings many elements together. Owned from trustees to volunteers. Local, regional and national leadership role of St Christopher's in palliative and end of life safeguarding practice
2. Organisational responsibilities - Rated as green - Strong context to safety and safeguarding in governance committees throughout the organisation. The Executive Team and Board of Trustees send a consistent and continuous message that safeguarding is everyone's responsibility and that we have a zero tolerance to abuse and neglect.
3. Workforce and training - Rated as green – The SARAT process allowed for a clear differentiation to be made between workforce issues and training issues. The latter has been addressed and will need ongoing commitment to ensure we evidence what we offer.
4. Interagency working - Rated as green - Mature and long-lasting relationships in place. Role of St Christopher's as a charity and reliable partner. Work across the voluntary, NHS and adult social care. Partnership with other charities.
5. Diversity - Rated as green - Specific issues to be captured via St Christopher's Clinical documentation system on protected characteristics of the people we refer. Unique insight into the more marginalised groups in urgent need of safeguarding – the street homeless, people with NRPF's
6. Communication - Rated as green - Duty of candour policy, procedure and register in place. Capturing patients and carers voices. Understanding our partners and their roles and responsibilities Build on best interest meeting minutes
7. Safeguarding Adult Reviews – SAR - Rated as green - We have been actively involved in two BSAB -SAR's - one involving a detailed chronology and management overview reflection. Learning from these SARs were to review how we can share our learning following safeguarding debriefs. We now conduct learning panels to address the sharing of learning and to review complaints and concerns.

The process of completing the SARAT allowed the organisation a much-needed opportunity to reflect on how actual evidence reassured or challenged the organisations understanding of our safeguarding practice throughout the hospice. The introduction of a new electronic patient and carer record system, Systm1, has provided strong evidence and robust audit trails that will allow more frequent and objective audits and analysis of safeguarding practice to take place. An example of this can be seen in the reporting for the first time in 2019-2020 of how many best interest assessments had taken place, the number of best interest meetings, the number of family meetings etc.

11. MULTI DISCIPLINARY TEAM - Education Sessions

These Wednesday morning sessions have been invaluable in bringing together doctors, nurses, physios, OT's, social workers, SALT, chaplaincy and therapy staff. There have been regular sessions on DOLS's, Mental Capacity Act issues ie decision specific capacity assessments, the structure of best interest meetings and both adult and child safeguarding issues.

12. Increased compliance with CQC requirements

The CQC inspection in late December 2019 was conducted along key lines of enquiry - KLOEs. Safeguarding practice came under the generic theme of safety. Within the overall CQC rating of Outstanding, safety was assessed as Good. The staff that CQC staff spoke to were found to understand how to protect patients (and indeed carers) from abuse. There were systems in place for managing safeguarding referrals which were described as "in line with current best practice."

13. Pressure ulcers:

The Patient and User Safety committee review any serious incidents that occur for patients within the organisation.

Any Category 3 or above, pressure ulcers, that have developed while a patient has been cared for within the Inpatient Unit, are raised as a clinical incident on the hospice Incident Reporting System (Sentinel). The nursing management team undertake an Root Cause Analysis (RCA), which incorporates a safeguarding investigation. This process required by the London Safeguarding Guidance 2016. All of these incidents are reviewed at the bi monthly tissue viability group.

The duty of Candour policy is also followed, with patients and or their families being notified of the ulcers development. The incident is also reported to CQC. The duty of Candour policy is followed if the RCA outcome is that the pressure ulcer was avoidable.

Number of pressure ulcers (April 2019-March 2020)

Unavoidable Pressure ulcers	10
Avoidable Pressure Ulcers	0

Action and learning from these incidents, have been the ongoing need for staff to be aware of how to record and document wound assessments on our Clinical system, Systm1, using photographic evidence to support assessment. Inpatient annual updates continue to support this need.

The London guidance also requires that the hospice team to communicate with referring teams, the need for a safeguarding investigation, for any patients who are admitted into the inpatient unit who have a grade 3 or above ulcer acquired outside our care ie in the community or acute setting. This remains a problematic process due

to the wide referral process across 5 CCG's and large teaching hospitals, where patient's ulcers are at high risk of deterioration.

14. KEY PLANS for 2020-21

- The integral role of guardianship plans within the advance care planning – ACP - process is a priority for development work in the next year
- Implementation of the Liberty Protection Safeguards - LPS
- Continuing to improve education and training
- Monitor the impact of Covid 19 on the safeguarding statistics

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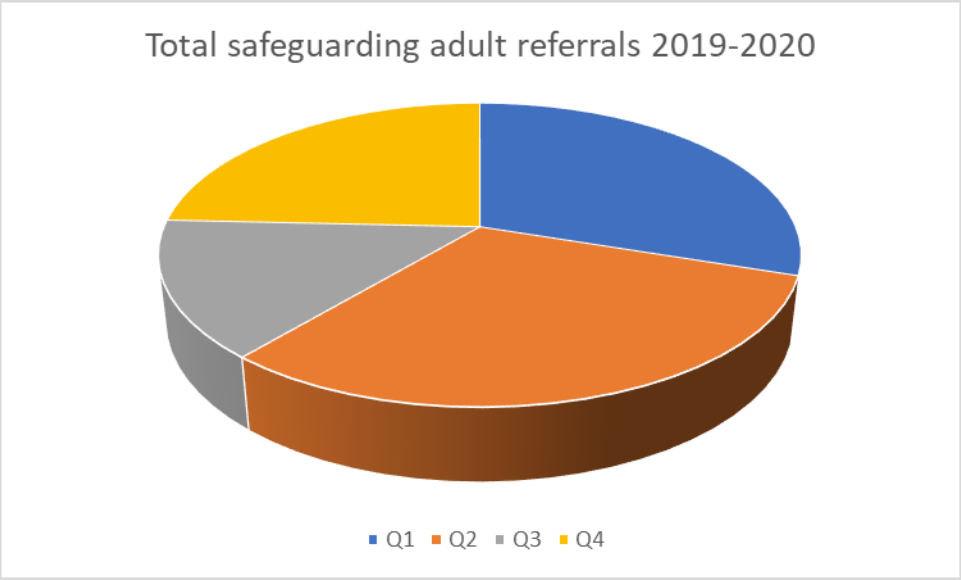
14. SAFEGUARDING ADULTS

The chart and table below identify the numbers of safeguarding alerts made in 2019-2020

Adults	Q1 2019	Q2 2019	Q3 2019	Q4 2020
Total Referrals	31	32	15	25



As in all previous annual safeguarding reports neglect and self-neglect represent the highest number of adult safeguarding alerts. Using SystmOne, there were 103 safeguarding referrals raised to local authorities between April 2019 and the end of March 2020 an increase of 8 – from 2018-19. This 7.8% increase is much lower than the 63% increase from 2017-2018. The majority of these alerts were to Bromley Local Authority but safeguarding referrals were made to all of the 5 London boroughs we serve.

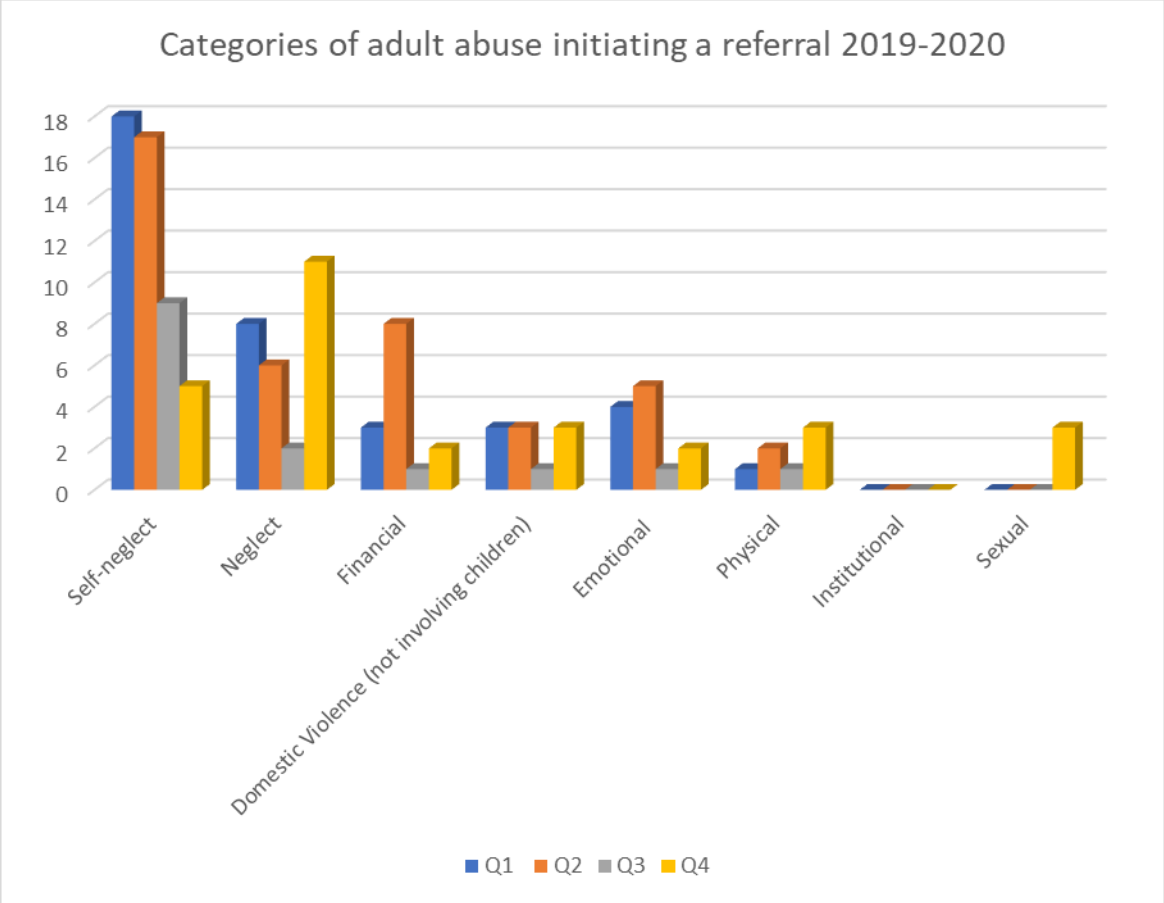
The work of the hospice with homeless people has been a significant development over this year and in no small part explains the continued increase in the identification of self-neglect concerns. Similarly, the Bromley Care Coordination – BCC – service is with vulnerable frail elderly people who are often not aware that they have gradually become self-neglecting and agree to additional support from local authority colleagues.

a. Categories of adult abuse initiating a referral 2019-2020

	Q1	Q2	Q3	Q4
Self-neglect	18	17	9	5

Neglect	8	6	2	11
Financial	3	8	1	2
Domestic Violence (not involving children)	3	3	1	3
Emotional	4	5	1	2
Physical	1	2	1	3
Institutional	0	0	0	0
Sexual	0	0	0	3

Please note that there were more categories of abuse than the 103 individuals affected



15. SAFEGUARDING CHILDREN

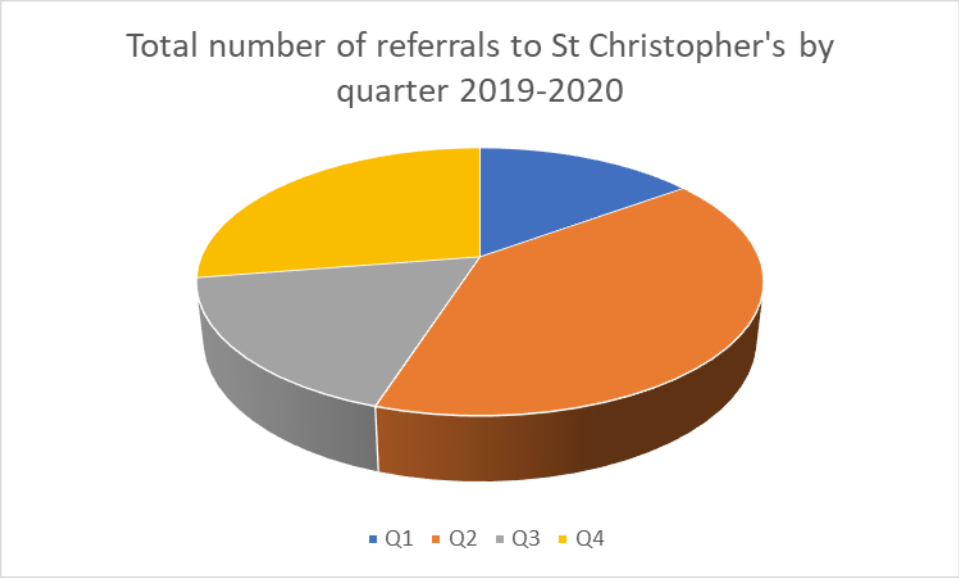
Using SystmOne there was a significant increase – 40 from 12 the previous year - in the number of children's safeguarding referrals raised to local authorities between April 2019 and the end of March 2020 The majority of the referrals were to Bromley Local Authority but all five London boroughs were referred to. The increase is linked to the adoption of the SystemOne EPR system and the better understanding of informal

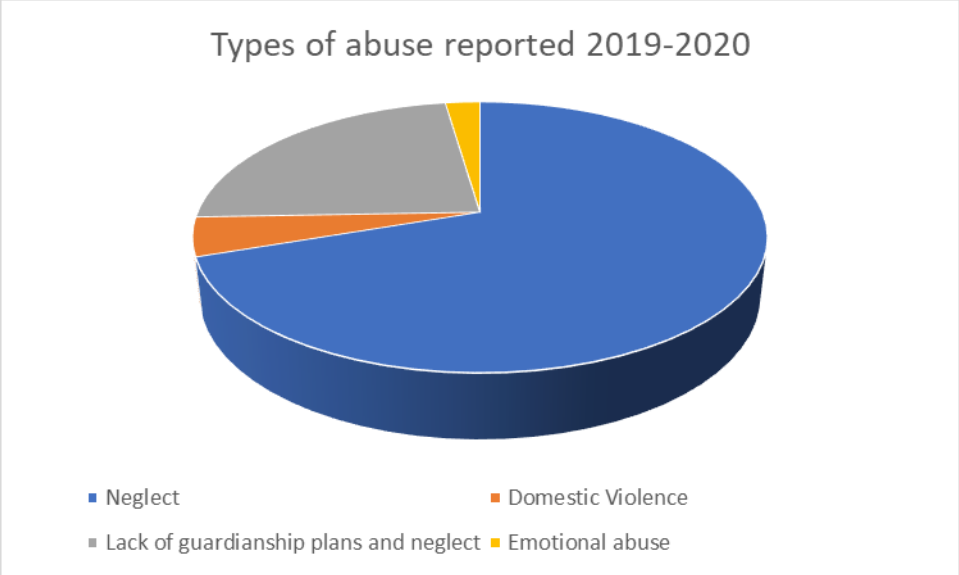
fostering arrangements needing to be assessed and approved by child and family statutory agencies.

The majority of safeguarding referrals were made in relation to late patient presentation to St Christopher's. Clinical and social work staff members were picking up on the urgent need to clarify child care arrangements which should have been held much earlier in the palliative journey of the patient. The integral role of guardianship plans within the advance care planning – ACP - process is a priority for development work in the next year.

Due to the high number of referrals – all in relation to this same sensitive issue – a case presentation was brought to the Q3 committee – see above.

	Q1 2019	Q2 2019	Q3 2019	Q4 2020
Total	6	16	7	11
Category of abuse	4 neglect 2 DV	All neglect	All Neglect and lack of guardianship plan(s)	10 neglect 1 emotional

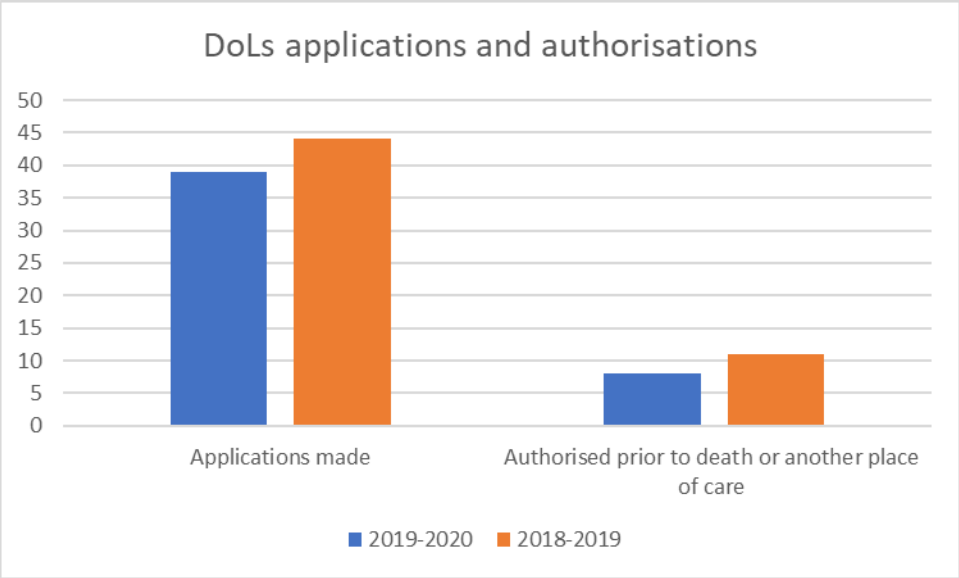




The statistics above represent individual children referred to child social services. One referral however may cover – as it did in Q2 – three families rather than 16 different households.

16.DEPRIVATION OF LIBERTY– DOLS

Over the year 2019-20 there were 39 DOLS applications sent to the 5 local authorities we serve. 8 were subsequently authorised prior to the patient either transferring their place of care or dying. There has not been any significant practice change in the number of DOLS applications made and authorised from 2019-20 – 44 applications and 11 authorisations.



17. BEST INTEREST DECISIONS

For those patients who lack capacity a best interest approach is taken. These meetings can be challenging to arrange as the Mental Capacity Act states a decision maker is clearly identified. As the Covid 19 restrictions hit home in quarter 4 there has been a significant challenge in holding BIM. The use of secure zoom meetings has helped. Often the specific decision in question is about accepting reasonable care and treatment – usually in the patient's own home. There were 64 best interest meetings held in 2019-20 in comparison to 38 the previous year.

There were a further 201 family meetings held a massive increase from the 61 on the previous year. This increase is almost certainly down to the recording practice within System1 and the practice guidance that was developed with practitioners. The figures do evidence the commitment of the organisation to listening to the thoughts, feelings and hopes of both patients and family members.

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