Somerset Safeguarding Adults Board

Serious Case Review

concerning

Parkfields Care Home

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EXECUTIVE SUMMARY

This is the report of a Serious Case Review of the events at Parkfields care home that resulted in the conviction in April 2010 of the home's registered manager, Rachel Baker, for misappropriation of drugs, manslaughter and perverting the course of justice. Staff members had raised concerns in January 2007 that led to an extensive police investigation, which covered the care of ten older people then resident or formerly resident at the home, and Mrs Baker's own medical care. The purpose of the Serious Case Review (SCR) was to find out whether there were lessons to be learned about the way that professionals and agencies work together to safeguard adults in the period up to January 2007.

All the organisations relevant to this situation were represented at senior level on the Review Panel, which was chaired by an independent person. Each organisation carried out a full review of its involvement, and those reviews were the basis for the review panel's discussions and recommendations.

The report has four main elements after the introductory sections: good practice that was noted, lessons that have been learnt, changes in policy and practice that have been made since the events, and recommendations for action to improve adult safeguarding further. The passage of time since the events means that many improvements have already been put in place by the agencies involved and these are referred to both in the report and in the action plan, as are relevant national policy changes.

The report concludes that, even if the necessary improvements identified during the course of the review had been in place at the time of the events, it is not clear that these could have come together at any point to identify the true nature of the manager's behaviour. They might have had an impact on one or more aspects of the course of events but, viewed together and with hindsight, actions or events which at the time were not individually of serious concern may seem more obviously abnormal and demanding of a strong response, than was evident at the time.

A key point relating to this is that policies, procedures and regulatory systems are generally designed to identify incompetence, poor practice and poor management and can do this very effectively. They are not designed to identify or prevent deliberate criminal actions of the sort that emerged in this case. This report suggests that any changes to such systems need to strike a careful balance. They need to ensure objectivity, to enable concerns to be pursued effectively and to be mindful of the risk of deliberate deviant behaviour, but not to be so onerous that they impede the delivery of good care that is timely and responsive to individual needs or prevent good professional relationships from flourishing.

It is clear that lessons have been learnt by all the organisations involved, both through this SCR process, and through their own responses to the events at the time. The report makes twenty one recommendations for action that the review panel believes can further improve the safeguarding of adults and the action plan sets out each agency's responses to all the recommendations.

1. INTRODUCTION

This report has been commissioned by Somerset Safeguarding Adults Board under its procedure for conducting Serious Case Reviews. The procedure requires that "*A Serious Case Review should be undertaken when:*

- *A vulnerable adult dies (including death by suicide)* ***and*** *abuse or neglect is known or suspected to have contributed to their death. In these circumstances the Safeguarding Adults Board should always carry out a review about the way agencies and professionals worked with the vulnerable adult.*
- *A vulnerable adult has suffered:*
    - *A possible life-threatening injury through abuse or neglect*
    - *Serious sexual abuse*
    - *Persistent, serious and permanent damage to health or development through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard vulnerable adults*
    - *Serious abuse takes place in an institution or when a number of abusers are involved."*

The purpose of a Serious Case Review as stated in the procedure as follows: "*The purpose of having a Serious Case Review is not to investigate, or to blame. It is to find out whether there are lessons to be learned about the way that professionals and agencies work together to safeguard vulnerable adults by:*

- *Making sure the procedures of all agencies work well*
- *Improving the way agencies work together*
- *Developing new and better ways of working*
- *Producing an Overview Report which brings together all the agency Reports and suggests ways of doing things better.*

This report deals with the care of residents at Parkfields residential home in Butleigh, Somerset. The Somerset Safeguarding Adults Board decided to establish a Serious Case Review following a three year police investigation and the Crown Court trial of Mrs Rachel Baker, the Registered Manager of Parkfields, who was also a Registered Nurse. During the course of the trial Mrs Baker admitted that she had become addicted to pharmaceutical opioid drugs. The trial concluded with her being found guilty in April 2010 on ten counts of misappropriation of residents' controlled and other drugs, one count of perverting the course of justice and one count of manslaughter of one resident of the home. The circumstances clearly met the criteria for a Serious Case Review and, once the criminal proceedings were complete, the Review Panel started its work in August 2010.

The Terms of Reference for the review are attached at Annex 1.

2. SUMMARY OF EVENTS

2.1. At the time of the events that led to this Serious Case Review being commissioned, Parkfields Care Home was registered to provide support to sixteen older people. It was situated in the village of Butleigh in Somerset and drew the majority of its residents from the Glastonbury/Street area of Somerset. The home had self funded residents and those funded by the Local Authority. As well as the residential beds the site also contained several self contained

bungalows, these were not part of the registration, but it appears a level of support was provided by the care home staff to those living in these properties.

2.2. The registered owners of the home were Mr and Mrs Baker senior, but the day to day running of the Home was undertaken by their son and daughter in law, Leigh and Rachel Baker. Rachel Baker was the registered manager of the home. Parkfields had a positive reputation in the local community. Its last inspection report from the Commission for Social Care Inspection, dated 13th June 2006, had been good and the Home had well established links with health and social care staff in the area.

2.3. The investigation into events at Parkfields began in January 2007 following concerns raised by care staff in the home. An extensive police operation followed and Rachel Baker was later charged with the murder of two of the home's residents. She was also charged with a series of drug offences and with perverting the course of justice. At her trial in 2010 Rachel Baker was cleared of the murder of both residents, but was found guilty of the manslaughter of one of them. She also admitted to ten counts of possessing class A and C drugs and to perverting the course of justice. She was sentenced on 21st May 2010 to ten years' imprisonment.

2.4. In parallel with the start of the police investigation, Somerset County Council, NHS Somerset, the Commission for Social Care Inspection and Somerset Partnership NHS Trust worked jointly over three months to ensure that appropriate care and support continued to be provided to the residents of Parkfields and to keep their relatives informed. They also prepared for a possible home closure and, finally, moved into multi-agency work on the urgent closure of the home and the safe movement of the residents to new homes in early 2007.

3. THE SERIOUS CASE REVIEW PROCESS AND ORGANISATIONS INVOLVED

3.1. Once the Safeguarding Board had decided that a Serious Case Review (SCR) should be undertaken, an independent Chair was identified to lead the process. The review was carried out by a multi-agency panel of senior representatives from all the organisations involved in the case. The panel agreed the Terms of Reference for the SCR and the process for completing Individual Management Reviews (IMRs).

3.2. Individual Management Reviews were submitted from:

Somerset County Council

NHS Somerset

South Western Ambulance Services NHS Foundation Trust

Somerset Partnership NHS Foundation Trust

Care Quality Commission (successor to Commission for Social Care Inspection and Healthcare Commission)

3.3. Information to support the work of the review was supplied by Avon and Somerset Constabulary.

3.4. The police investigation eventually involved ten former and current residents of Parkfields. The review Chair wrote to all the relatives who had been involved in

the events and to the two staff who had raised the concerns that led to the investigation, to inform them about the Serious Case Review. She also offered them the opportunity to talk to her directly about the work of the review and any issues they wanted particularly to bring to the review's attention. Some of them took up this opportunity or wrote a letter expressing their views.

3.5. The information that needed to be considered in the course of the SCR was both substantial in volume and complex. It dealt with the individual care relationships with each resident and the medical care of Mrs Baker as well as the activities of and relationships between the organisations involved. These factors all contributed to the length of the review process.

3.6. Individual Management Reviews were then the basis for detailed discussion and mutual challenge by the whole panel in order to fulfil the purpose of the SCR: to identify the lessons that can be learnt and agree the actions needed to improve ways of working. The remainder of this report sets out the results of those discussions.

4. IDENTIFICATION OF GOOD PRACTICE

4.1. In any review process it is as important to identify good practice that needs to be maintained and developed as it is to identify shortcomings to be corrected. In this case there were a number of particular examples to note where individuals took responsible professional action in response to what they had observed or been told.

4.2. District Nurses alerted their senior managers as soon as they became aware of the fact that the home manager was acting outside her remit by providing nursing care to residents of a residential home not registered for nursing care. They also raised the issue with the home manager herself.

4.3. The home manager had a long history of migraine which had shown a marked increase in frequency and severity since 2004. The GP who took over her care in early 2006 referred her to a consultant neurologist very early in his attempts to manage her migraine symptoms, attempted to speed up her appointment on more than one occasion and took telephone advice from neurology prior to her first appointment.

4.4. The community pharmacists noted the pattern of prescribing to the home manager and contacted the GP on at least two occasions to discuss alternatives to the use of pethidine in treating the symptoms of intractable migraine.

4.5. The receptionist/ dispensing staff at Glastonbury surgery alerted a GP when they noticed that requests for prescriptions by the home manager began to escalate substantially. The GPs reviewed the management of her migraine and ceased prescribing opioid injections within days of this alert from members of the practice team.

4.6. A Community Psychiatric Nurse raised concerns about the level of prescribing to one resident directly with the GP, resulting in a reducing dose.

4.7. Once CSCI had been contacted by the staff raising concerns (the "whistleblowers") quick and appropriate action was taken in response.

5. LESSONS LEARNT

5.1. Lessons have been learnt by all the organisations involved, both through this SCR process, but also more immediately from their own responses after the events at Parkfields. This should be clear in what follows below and in the recommendations and actions that are proposed in response to that learning. The learning is set out under a number of key themes that are then carried through into the recommendations and action plan.

Checks and Balances in Systems and Professional Relationships

5.2. At the centre of these events is the, very unusual, figure of a trusted professional Registered Nurse, who broke the law and failed to uphold her Code of Professional Conduct; who allowed the needs of her addiction to take precedence over the needs of the vulnerable older people for whom she was responsible, resulting in the serious neglect and abuse that was exposed in the criminal proceedings. A key element of the context for the panel's discussions was the fact that policies, procedures and regulatory arrangements are generally designed to be capable of identifying incompetence, poor practice and poor management and can do this very effectively. They are not, however, designed to identify or prevent deliberate criminal actions and the implications of this are referred to later in this section.

5.3. Professional working relationships tend to be conducted on a similar basis, since it is generally possible to expect that colleagues are acting professionally and in good faith. Staff at every level have a responsibility to be alert to and question incompetence, poor practice and poor management, but are much less likely to infer from their observations or concerns that a colleague is taking deliberate harmful and criminal steps.

5.4. In addition, this particular home and manager were well-regarded by the local community, from which many of the residents were drawn, by residents' relatives and by professional colleagues. The Commission for Social Care Inspection always had good feedback from service users and relatives when they conducted their inspections and inspection outcomes were generally good. General Practitioners working with the home's residents felt able to rely on the manager's judgement about individual residents' health needs to a great extent, including in matters about palliative care at the end of life. She was also considered to be an "expert patient" in relation to her own medical care, and her views about her treatment needs were respected.

5.5. There was substantial contact between representatives of the organisations involved in the review and Parkfields, and Individual Management Reviews and the review panel discussion did identify necessary improvements in process or practice. If these had been in place and implemented at the time they might have improved the checks and balances in the system and relationships and have had an impact on one or more aspects of the course of events. However, the review concluded that it is not clear whether and how these could have come together at any point to identify the true nature of the manager's behaviour. Viewed together and with hindsight, actions or events which at the time were not individually of serious concern may seem obviously abnormal and demanding of a strong response, when they would not have seemed so at

the time. Nevertheless, it is essential to act on the identified key areas for improvement and these are set out in paragraphs 5.6 – 5.15 below.

5.6. The home manager was a registered nurse but, as the manager of a residential care home that was not registered for nursing care, she should not have been providing nursing care to residents, which should have been provided by community nurses. The District Nurses noticed this breach of the regulations and raised it at different times over a number of years with the home manager herself, their manager and relevant GPs about their individual patients, but the issue was not resolved. This had two specific effects:

- Referrals to the District Nursing service were lower than average for a home of this sort, so there was less professional nursing input to the home and less knowledge of the residents' range of needs and how they were changing;
- The home manager had more direct involvement in residents' nursing care than was usual or appropriate.

GPs were not aware of the different regulations governing the provision of nursing care in nursing homes and residential care homes.

5.7. The home manager's provision of nursing services, in breach of regulations, to the residents contributed to Parkfields taking on or continuing to care for people whose needs potentially exceeded the home's registration since it masked their level of dependence. The review panel noted that in some cases health or social care staff had advised families that Parkfields was not appropriate for their relative's level or type of need, but its strong local reputation had led them to choose it anyway. In addition, some residents' needs increased sufficiently during their time at Parkfields to have justified review of their placement and possibly moving elsewhere for appropriate nursing care to be provided. If a review had decided to give priority to continuity of care at Parkfields then District Nurses should have been asked to provide the necessary nursing care.

5.8. Residents' families understandably valued Parkfields' apparent ability to provide continuing care through to the end of life. Some professionals also regarded this positively for individuals, and GPs, for example, had confidence in the home manager's advice and her apparent ability to manage their patients' nursing care. However, those involved did not identify that collectively the resident group had begun to exceed the registered role of the home, with consequent risks to the quality of care they received and risk of breach of regulation.

5.9. Procedures were in place at the time for review of the three-bed contract that Somerset County Council (SCC) had with Parkfields and for individual reviews of residents, which were carried out by the council's link social worker for Parkfields. In addition, there were twice yearly liaison meetings between the link social worker and home manager, joined on some occasions by the district nurse and/or community psychiatric nurse.

5.10. Reviews for which SCC was responsible were completed regularly, but appeared not to meet the standards required at the time in respect of the recording of the review and its outcome, so it is not evident that standards about the involvement of the resident, comprehensive consideration of the resident's social and health care needs and links with other professionals

involved with their care were met. The practice of the link social worker carrying out all reviews with a particular home could be positive in developing a working relationship, but limited the range of social workers having contact with any particular home.

5.11. The liaison meetings were not well recorded, and the outcomes of the discussions do not appear to have been linked to the individual resident's adult social care file. They provided an overview of the home's residents, including discussion of changing dependency levels, but it was not clear how the findings had been followed up, for example by referral to health services, such as District Nursing. It was also hard to track links between the review and liaison discussions. Better implementation of the procedures would have created a clearer picture of individual residents' situations and of the home's resident group as a whole.

5.12. Part of ensuring that there are appropriate checks and balances in a situation is the identification and management of conflicts of interest. In this case such a conflict existed in the home manager having the same GP as the residents of the home. General Medical Council best practice guidelines advise avoiding the provision of general medical services to close friends or colleagues. Where it is not possible to avoid this completely then appropriate clinical supervision needs to be in place to mitigate the potential associated risks. In this case the conflict of interest was not identified and therefore not managed.

5.13. More broadly, the review recognised that the strong reputation of Parkfields and its manager, and the trust placed in her had almost created a "closed system" of relationships. Concerns raised by staff in the home through their line managers were referred to the home manager, and GPs' confidence in the home manager's views about her residents' needs meant that they tended to refer queries raised with them back to her for an expert nursing opinion. Social workers and psychiatric nurses participating in liaison meetings were generally dealing with the manager, as would be usual in that kind of setting, but do not appear to have been consistently balancing her views by direct contact with residents or their relatives at these points. The overall impression is that the expectations of cross-checking opinions and proposed care arrangements that were in policies and procedures at the time were not being consistently applied; habitual confidence was over-riding critical inquiry and persistent questioning when concerns were identified.

5.14. The home's relationship with the statutory regulator, from the establishment of the National Care Standards Commission in 2002, reflected the generally good reputation of Parkfields and its manager. The home consistently met the majority of required standards, no concerns were expressed by the home's staff or residents and there was no information from other sources to raise concerns. The home manager was considered to be a respected person with a long-established good reputation. However, as a result of the police investigation it is clear that she had become adept at misleading people.

5.15. The purpose of a regulatory inspection is distinctly different from a criminal investigation. It focuses on monitoring compliance with required standards and achieving improvement where necessary, and the depth of inquiry is designed to fulfil that role. Its scope is strictly defined so, for example, while it has now emerged that residents in the bungalows at Parkfields were receiving care from

staff of the home, they were not at that time registered premises. While they might properly have raised questions in inspectors' minds, they would have needed to have had good reason to demand access to them. No system of regulation will, on its own, detect or prevent an individual who is intent on hiding criminal behaviour.

5.16. In the light of this range of issues, the SCR panel discussed at length what changes needed to be made to create systems and promote behaviour that provide appropriate checks and balances in relationships between organisations and individuals. These need to ensure objectivity, to enable concerns to be pursued effectively and to be mindful of the risk of deliberate deviant behaviour, but not to be so onerous that they impede the delivery of good care that is timely and responsive to individual needs or prevent good professional relationships from flourishing.

5.17. This was a complex balance to try and strike and the further learning reported below, the developments since 2007 and the recommendations of this review all have something to contribute to such a system. It also requires individual professionals, whatever their work setting, to be alert at all times to signs of potential abuse or anomalous behaviour and events and to be prepared to pursue their concerns to a conclusion.

5.18. In the report of the Victoria Climbié Inquiry, Lord Laming made the following comment: "*…..The concept of "respectful uncertainty" should lie at the heart of the relationship between the social worker and the family. It does not require social workers constantly to interrogate their clients, but it does involve the critical evaluation of information that they are given. ….. social workers must keep an open mind."*[1] The learning from this review, which applies to all the professional groups involved, is that cultivating an approach that also includes an element of respectful uncertainty in relationships between professional colleagues, within the normal framework of trust and confidence, is probably a necessary foundation for effective safeguarding work with adults.

Training and Policy Implementation

5.19. The paragraphs above refer to a number of training and policy issues, but several other specific learning points about training needs were noted by the review panel. The different types of care homes, whether they were registered for nursing care or not, and the implications of this in general, but in particular for the role of any registered nurse on the staff of the home, were not widely understood by the professional groups involved, other than the District Nurses. This needs to be included in the general training of all health and social care professionals.

5.20. It was not clear that GPs were sufficiently aware of risks and policies about abuse of vulnerable adults and their specific responsibilities within those policies. Safeguarding doesn't seem to have been the context for considering the concerns that they did identify at the time about some residents' medication needs and use. They need to take up the training opportunities that are now available.

[1] The Victoria Climbie Inquiry 2003, paragraph 6.602

5.21. Some individuals who had received safeguarding training felt that it had tended, when dealing with possible neglect or abuse by paid carers, to focus on the actions of front line staff and that the actions and impact of managers needs to be equally addressed. Training since the events had helped district nurses, for example, to be more alert to seeing how single incidents might build into a pattern, and to question appropriately information provided to them. So this element of training needs to continue for all relevant professionals.

Medicines management

5.22. The prescription, management and use of a variety of drugs, including controlled drugs, was obviously central to these events, and related both to the care of the residents at Parkfields and the care of Mrs Baker herself. There are important learning points on a number of issues and some of them also relate to the issues of trust and alertness to unusual practice discussed above.

5.23. The most general learning point is the need for policies and procedures that identify and require action on unusual patterns of prescribing, whether that involves the type of medication being used for a particular purpose or their dosage and frequency. In this case some GPs and some staff of Somerset Partnership Trust (SPT) queried the high levels of prescriptions to some residents, but there was no obvious way in which these concerns and any pattern that might have emerged from them could be brought together. Within this general point specific issues that emerged were that policies at the time about the use of syringe drivers were not sufficiently comprehensive (this has now been corrected) and the signature lists that record those providing nursing care did not include all those involved in doing so.

5.24. A more specific feature of this case was the number of repeat prescriptions issued because, for example, the original ones had been lost. It was clear that stronger controls over the issuing of repeat prescriptions for opioids and benzodiazepines were required. Once the concern about repeat prescriptions had been identified in the home manager's case, action was taken to change the pattern of prescribing for her. Regular review by the GP of any patients being prescribed these kinds of drugs would provide an additional safeguard against risks of individual dependency and of misuse.

5.25. The review also noted that, at the point where her GP suggested a review of the use of opiod drugs to treat the home manager's migraine, she had changed her GP practice, so the review did not take place at that point. GPs were aware both of the managers' personal health treatment and of her professional role. While, for the reasons discussed above, it is unlikely that they would have suspected criminal action on her part, it is essential that GPs should seek advice about any concerns about the possible abuse of prescription drugs by a professional colleague from the Accountable Officer at the PCT or its successor body.

5.26. The regulator, CSCI, had inspected the home's management of medication regularly as part of the overall inspection regime and standards had been met or, where minor infringements were identified, these had been corrected. The arrangements at the time were, however, dependent on the home manager giving an honest account of the drugs being used in the home and inspectors were not informed about the presence of controlled drugs on the premises.

This learning needs to be applied in the further development of the regulatory arrangements by CQC.

Availability, Use and Sharing of Information

5.27. A number of learning points were identified in the review about how information was recorded, subsequently used and shared, or not, between different agencies. Some issues are about whether there are effective systems in place, and others are about how individual or group working practices develop.

5.28. At the time of the events, systems to link office hours and out of hours medical contacts was not sufficiently strong to track easily the GP contact with The home manager about her own health needs and the resulting prescriptions. It was therefore not easy to keep an overview of her treatment. Similarly, when she changed her GP practice, firstly she did not notify her original GP of this and the records were transferred through the usual administrative process without any comment from the GP. The records that were transferred did not contain the detail of the frequency of prescription of controlled drugs, so her new GP was not alerted early to this issue. Steps clearly need to be taken to improve information transfer so that any patient's needs can be seen as a whole.

5.29. In terms of achieving an overview of the residents' care and support needs, it has already been noted above that the recording of reviews and liaison meetings did not meet expected standards, and that links from those discussions to individual resident files were not consistent. District Nurses and other visiting staff to Parkfields tended to rely on the accounts of staff at the home or the manager, and the District Nurse team professional records for the individual, for current information about the resident's care rather than refer to care plan. There also seemed to be some confusion about whether it was possible to get access to the care plan. While it is natural to look to staff working with residents for an up to date account of care, it is also important to cross-refer to the intended plan so as to see the overall pattern of need and responses to it. In this case, it might also have identified anomalies in the care record.

Raising Concerns (Whistle blowing) and staff support

5.30. It emerged from the review's work that a range of staff in the agencies concerned were not, at that time, well-informed about how to raise concerns (to blow the whistle) about failures of care and/or professional conduct. Relatives had also felt they lacked information about this and about the role of the regulator and that this needed to be included in the information all homes provide to residents and their relatives.

5.31. The whole set of circumstances set out above indicates what a serious and difficult decision it would have been for staff of the home to blow the whistle when they felt they must act on their concerns. Making allegations about a home manager's conduct is difficult in any circumstances and in this case the concerns were particularly serious and entirely out of line with the manager's reputation both in the home and in the local community. The review noted these difficulties, the fear of not being believed and the penalties that whistle blowers can pay in terms of loss of employment and the risk of hostility from colleagues and others who do not share their view.

5.32. Systems to inform all staff about how to carry out their professional responsibility to raise concerns that they identify, and then to support them well when they do so are therefore very important, right through, where necessary, to the court case. The review noted that the new regulatory arrangements increase the importance of this kind of reporting so CQC needs to give careful consideration to the experience and views of whistle blowers in finalising these arrangements.

5.33. Beyond the specific action of raising the concern, all staff involved in the investigation of alleged abuse and the actions that follow need to be supported by their employer and/ or professional organisation. They will not only be continuing to work with people in a very disturbing situation, but may also be questioning their own contribution to the events or fearing the impact on them. Social care staff do not at the moment have a professional body at national level, and the need for this was raised by one of the staff.

Organisational change

5.34. The review panel was very conscious of the pace and range of organisational change that affected almost all the agencies involved in the review. During the period under review the regulatory organisation had changed twice, primary care trusts had been formed and then reorganised, district nursing services had had two changes of management arrangements out of hours service arrangements had changed more than once and the social services department had changed its responsibilities.

5.35. It is well-documented that changes in organisation structure and personnel increase the risk that policies and procedures will not be effectively implemented and that information will not be appropriately exchanged. There was no evidence to suggest that change had a specific impact on the course of events in this case, but key organisations need to be aware of and successfully manage the risk that its continuing impact could affect capacity to implement proposed improvements (see below paragraphs 6.23 and 6.24)

6. CHANGES IN POLICY AND PRACTICE SINCE THE EVENTS

6.1. The passage of time since the original events means that there have been changes in national policy and practice that are relevant to the themes identified above and have already strengthened systems and standards. Local policy and practice has also, in many cases, already been reviewed and revised in the light of the Parkfields events. These changes are summarised here to supplement the issues raised in the recommendations.

Checks and balances in Systems and Professional Relationships

6.2. Somerset County Council reviewed a number of its policies and practices in the light of initial learning from the events at Parkfields, covering all stages of a person's placement in a care home. The process for commissioning placements now requires Adult Social Care Placement Panels to monitor the level of needs of those being admitted into care homes to ensure they fit the registration requirements.

6.3. The Council's policy about reviewing individual people in residential care was improved in 2007 and revised further in 2009. The new policy provides a more comprehensive and holistic process that includes: looking at care home records, meeting with the resident (either alone or with an advocate) and meeting the resident, family/friends and care staff from the home. There is a new reporting process in place for any concerns about a care home and residential reviews are discussed in supervision sessions.

6.4. The new approach was adopted simultaneously by Somerset Partnership and in 2008 by NHS Somerset, including information on quality being shared across these organisations. Information from these individual reviews is also used by the Placement Panel to ensure that changing individual needs get appropriate support from social care and health services and that, if they exceed the registration category of the home, a change of placement is discussed.

6.5. The range and seniority of contact with specific homes has also been extended by:

- moving away in 2008 from the practice of having a designated social worker link to residential and nursing homes, resulting in more social workers being involved in placements and reviews;
- contract reviews being chaired by Service and Operations Managers, who are part of the senior management team. Requirements for recording these reviews have been strengthened.
- Senior representatives of adult social care (commissioning and assessment and care management), CQC, Somerset PCT, Somerset Partnership Trust and Somerset Community Health meet together regularly to manage Safeguarding and Care Quality concerns in Care Homes. These meetings are viewed by CQC and the Association of Directors of Adult Social Services (South West) as exemplar practice and informed a regional protocol on how equivalent organisations across the region work together to safeguard care home residents.

Training and policy development

6.6. Somerset County Council revised its safeguarding training to emphasise the importance of recognising safeguarding issues in both community and residential settings. A safeguarding officer post was established, linked with the social care managers with a lead responsibility for safeguarding in each of Somerset's localities, to ensure that advice and support was available to social care professionals.

6.7. The Adult Services Recording Policy – Practice Quality Audit Guidance and principles of good recording and record sampling were produced in 2008. They set higher standards across the board for case recording and review and for audit of this practice by senior managers.

6.8. NHS Somerset has also updated its Record Keeping Policy in 2010, which strengthens standards for recording in case notes and also requires regular audits of record keeping.

6.9. A national policy on End of Life Care has been introduced. This means that all patients requiring palliative care should be registered on the GP practice

palliative care register and practices should hold regular meeting to review the care and treatment provided to all such patients. All patients requiring end of life care should have their care managed on the Liverpool Care Pathway to provide appropriate management of symptom control using evidence based practice

6.10. CQC specifically requires of care homes that people should be supported to make choices about their care and treatment and this includes making choices about where they would prefer to die. End of life care should be planned for each person and the service should make sure resources are available to meet that plan.

6.11. Vulnerable adults training, introduced since these events on a multi-agency basis, is now routinely available to a wide range of health and social care staff as well as many managers of care providers in the independent sector. District Nurses commented that the training had enabled them to be more aware of how isolated incidents may form part of a pattern and to be more sceptical about what is presented at face value.

Medicines Management

6.12. New, more stringent regulations for the safer management of controlled drugs came into effect nationally from 1st January 2007. These regulations include:

- the development of Controlled Drugs Local Intelligence Networks (CDLINs) set up by Primary Care Trusts (PCTs)
- the appointment of a Controlled Drugs Accountable Officer in each PCT
- comprehensive local policies and systems to implement the regulations, including auditing and communicating prescribing patterns.

6.13. These arrangements between them have created a clear route for the reporting of any concerns regarding a care home manager or other professional who had become addicted to controlled drugs, and a forum at the CDLIN where other agencies can be alerted to the problem. The new arrangements provide substantial assurance to primary care practitioners and the Accountable PCT that prescribing anomalies of the sort that appear to have occurred in this case could not continue for a prolonged period.

6.14. The comparatively small volume of controlled drugs usually in use in care homes has meant that their awareness of these new regulations and structures may be relatively low. It is important for PCTs and other partners in the CDLIN to raise its profile with care homes and highlight their responsibilities to report concerns.

6.15. At local level, one of the surgeries involved has carried out a detailed review and strengthened practice systems and prescribing to minimise the risk of these kinds of events occurring again. They will share this learning with colleagues across Somerset Health Community.

6.16. South Western Ambulance Service Trust (SWAST) Medicines Management policy has been updated to reflect the wider changes in this (re GP out of hours prescribing). All SWAST policies referred to in the course of their IMR have been subject to regular review and have been updated during 2010.

Raising concerns (Whistle blowing) and staff support

6.17. CQC is currently in the process of developing a new national policy for the raising and handling of concerns and the disclosure of information under The Public Interest Disclosure Act 1988, popularly known as the "whistle blowing law". The intention is to provide a process through which concerns can be raised and offer protection to those raising such concerns.

6.18. Staff at Somerset Partnership Trust are aware of where they should report any concerns including the local authority and their own Line Manager and are now better aware of the role of CQC, in these matters.

6.19. NHS Somerset and Somerset Community Health reviewed and strengthened the local Whistle Blowing Policy during 2010, which was ratified and implemented in March 2011.

6.20. The inclusion of social care workers in regulation by a professional body is under consideration at national level in the context of "Enabling Excellence"[2].

Organisational change

6.21. There have been a number of changes in the regulatory framework for care homes and related activities since these events. The biggest single change has been the creation of the Care Quality Commission (CQC) as the new independent regulator of health and social care in England. It became operational in April 2009 and is responsible for the regulation, to the same new essential standards of safety and quality, of all health and adult social care, whether provided by the NHS, local authorities, private companies or voluntary organisations. CQC's responsibilities will extend to dentists and private ambulances in 2011 and to GPs in 2012.

6.22. With this new, unified structure have come two significant changes of approach.

- The primary focus is on the outcomes being achieved for people and, in making their assessments, inspectors are looking at the care received and people's experience of it rather than looking for policies and procedures in place. More weight is given to what people who use services are saying and to the observation of care.
- The assessment of compliance with standards set is now continuous rather than set by fixed frequency of inspection. Regularly updated information on services held in a quality and risk profile for each provider enable inspectors to respond swiftly to concerns raised from any source. Planned reviews take place at the frequency required by the assessment of risk in each provider based on this overview.

6.23. A number of the issues identified in the SCR process are expected to be more easily captured by the new scope of registration, the standards themselves and the new approaches to regulation. Examples of this are:

- The registration of GPs will require them to meet 16 essential standards. All practices will therefore have to check, among other things, their approach to issues such as the involvement of service users,

[2] Enabling Excellence – Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers; Department of Health 2011

collaboration with others providing services, safeguarding practice and the management of medicines, all of which are relevant to the Parkfields events.

- The systems for death notifications now in place will flag up to inspectors when notifications from any provider are either above or below expected rates and where no notifications have been received.
- New questionnaires that enable people receiving care and their carers to contribute their views to CQC inspectors are being piloted and are sent direct to the person concerned, rather than via the care home manager. Staff and service users will have an opportunity to speak to inspectors in confidence when they visit a service.

6.24. The arrangements for registering new managers continue to be stringent requiring a range of information about identity, conduct, skills, experience and health as well as formal references and checks. Applicants are also interviewed.

6.25. Changes continue in other organisations, most noticeably in the NHS, where Primary Care Trusts are to be wound up, and their functions distributed. In Somerset, the County Council will take over responsibility for public health, community services are transferring to Somerset Partnership Foundation NHS Trust and the PCT's commissioning responsibilities will largely pass to consortiums of GPs. In addition, all public organisations are facing a period of very serious financial pressure.

6.26. The review panel was concerned about the risks to consistent practice and strong working relationships that arise in times of change. All agencies need to manage successfully any risk that change and pressure on resources could pose to the successful implementation of the good practice that is in place and developments proposed as a result of this review.

7. RECOMMENDATIONS

Checks and Balances in Systems and in Professional Relationships

7.1. Bodies responsible for the training and continuous professional development syllabuses of health and social care professionals working with care homes should include information on the accountability of registered nurses who are also care home managers.

7.2. Care home providers must only accept residents who fall within their registration category and need to have clear arrangements in place for monitoring and responding to residents' changing needs. Commissioners and contract managers also need to be alert to patterns of admissions and changing needs.

7.3. Whenever the Care Home manager is a patient at the same practice that also provides medical care to the residents in the Home, the Practice should ensure there is good clinical supervision of the relationship between the two in order to mitigate potential conflicts of interest and associated risks. This will need specific attention in small rural practices.

7.4. Reviews of residents' care should be holistic and include information from all relevant professionals who should be involved. Consideration needs to be given to extending the NHS arrangements for proactive review of medication in nursing homes to residential care homes and how this information can be included in care reviews.

7.5. The Nursing and Midwifery Council may wish to review the arrangements for the validation of the CPD records of nurses employed in more isolated settings such as care homes.

7.6. CQC needs to raise public awareness of the role and scope of the new regulatory system through all appropriate channels.

7.7. CQC should take the findings of this review into account in finalising its revised inspection arrangements and in particular:

- Professional staff in health and social care settings, including care homes, need a clear understanding of the remit and functioning of the new, intelligence and risk based regulatory system.
- The arrangements for regulating and inspecting medication management of both controlled and non-controlled drugs
- The protocol between CQC and the Association of Directors of Adult Social Services (ADASS) about coordination of their respective roles needs to be widely disseminated and clear guidance issued about its local use to ensure strong linkages in the commissioning and regulation of care services.

Training and Policy Implementation

7.8. NHS organisations should review the safeguarding training required for different health professionals to ensure they are appropriately competent. In view of forthcoming registration requirements, GP practices would be well-advised to ensure that at least one GP is trained and regularly updated to a high level of competency.

7.9. Safeguarding training should stress to all professionals their duty to be alert to risks to vulnerable adults in all settings including residential homes and to discuss concerns with their organisation's safeguarding lead.

It is imperative that GPs seek advice regarding any concerns about possible abuse of prescription drugs or other substances by professional colleagues with the relevant professional lead at the PCT or its successor body.

7.10. The appropriate agencies should ensure that national policy on end of life care is implemented in all care settings.

Medicines Management

7.11. All relevant bodies and key professional prescribers should be reminded of their statutory requirements under the Controlled Drugs (Supervision of Management and Use) Regulations 2006 and in particular:

- To share information with the PCT accountable officer and be an active member of the Local Information Network

- Of their professional and statutory duty to raise concerns and if they involve the management or use of controlled drugs to raise these concerns with the appropriate accountable officer
- Of the DH Care Home alert and the requirements to review the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. A plan for effective joint working should be established, including auditing on-going progress
- Concerns about the management of controlled drugs in care homes should be raised with the accountable officer at the PCT and with CQC at the earliest stage.

PCTs should consider control measures over repeat prescribing of opiates and benzodiazepines in primary care.

7.12. Further consideration needs to be given as to how the perspective of care home providers can be represented on the CDLIN.

7.13. Organisations should ensure that the current policy on record keeping in relation to drugs administration is implemented and audited.

Availability, Use and Sharing of Information

7.14. A more robust expectation about the sharing of concerns between General Practitioners when a patient moves to another practice should be established, as should strong communication links between daytime and out of hours doctors, especially in relation to prescribing decisions.

Practices may wish to develop a flag system for notes of new patients to ensure that the receiving GP reviews them on receipt to address the issue of potential dependency. This would include a specific review of the patient's use of opiates, benzodiazepines or other controlled drugs in the 12 months prior to transfer.

7.15. In line with regulations, individual records need to be kept safe and accessible to relevant professionals and all organisations should ensure they seek and consult those records when considering patient care and treatments.

Raising Concerns (Whistle blowing) and Staff Support

7.16. CQC must ensure that the current system for receiving information from whistle-blowers is effective, accessible and responsive to the concerns of those wishing to report such issues.

7.17. All agencies should consider the effectiveness of arrangements for supporting whistleblowers including those within care provider organisations.

7.18. An appropriate senior professional experienced in staff support and professional accountability should be designated by chief officers of organisations whose staff are affected by significant events such as a serious criminal investigation. This person should have a remit to co-ordinate and lead a system of staff support which is ongoing if necessary until all relevant processes have finished.

7.19. Safeguarding Boards should include in their regular monitoring report the adequacy of advice and support arrangements for all professionals working with vulnerable adults.

Organisational change

7.20. The management of changes in the structure of the NHS, notably the demise of the Primary Care Trusts, needs to ensure continuity of:

- the monitoring of prescribing patterns currently carried out by the Controlled Drug Local Intelligence Networks (CDLINS) continues.
- The Accountable Officer role

7.21. As partner organisations undergo rapid and substantial change in response to national policy and financial constraints, the effectiveness and sustainability of important systems such as the safeguarding system, controlled drugs management arrangements and holistic oversight of vulnerable adults in residential settings should be included in impact assessments and risk management.

8. IMPLEMENTATION

The Safeguarding Board is asked to accept this report and its accompanying Action Plan as the basis for implementing the further changes the review identified as necessary.

Annex 1

TERMS OF REFERENCE

1. Timescales

i. The review started its work on 20th August 2010 and plans to complete it early in 2011.

ii. The timeframe of events that the review will cover is July 1999 to February 2007

2. Subjects of the Review

Relevant individuals whose contact with agencies is to be reviewed are:

a) The ten residents who were subjects of the criminal investigation
b) The Home Manager, Rachel Baker
c) Leigh Baker, Rachel Baker's husband

3. Agencies involved

Agencies contributing to the Review and the services for which they have responsibility:

Agency	**Services Subject to Review**
NHS Somerset	General Practice District Nursing Pharmacy
Somerset County Council	Adult Social Care (care management)
Care Quality Commission	Care Service Regulation by NCSC and CSCI
Somerset Partnership NHS Trust	Community Mental Health Teams
South Western Ambulance Service Trust	Ambulance Out of Hours Doctors

Avon and Somerset Constabulary services are not within the scope of this review. Their participation is primarily supportive in that they will seek to share information gathered during the criminal investigation which may assist the other agencies in reviewing their own involvement.

4. Issues to be addressed

The Review panel has agreed the following issues should be covered by the Review:

i. The remit and responsibilities of each organisation and their impact on the organisation's behaviour and activity.

ii. Whether each organisation acted to its remit.

iii. The nature and extent of each service's relationship with the care home and any organisational changes which affect the nature of the relationship.

iv. The nature and extent of individual professionals' contacts with the identified individuals.

v. Whether applicable policies and procedures were followed.

vi. Whether the policies and procedures in place at the time within and between agencies were effective, in particular whether communications systems between agencies were complete and effective, including provision for out of office hours communications.

vii. Whether appropriate arrangements were in place for individual staff members of all agencies to raise concerns and to escalate them if they were not satisfied with the response they received, and whether those arrangements were appropriately used.

viii. Any concerns that were raised in relation to the home or its residents during the period in question including the whistle blowing which led to the criminal investigation and how those concerns were dealt with.

ix. Any relevant changes to policy and practice have occurred during the period since early 2007 when the criminal investigation was instigated.

5. Agency reports

Each agency in its report will:

i. Provide a chronology of its involvement with the listed individuals and the care home itself.

ii. Address all the issues set out in 4 above in relation to each service for which it holds responsibility.

iii. Identify any further issues or concerns arising from their investigation that they think the Serious Case Review should address.

iv. Propose recommendations that the SCR should consider including in its findings

v. Identify the sources of evidence used for the report

6. Review Panel Membership

Independent Chair	**Margaret Sheather**
Somerset County Council	**Clare Steel**, Head of Service, Adult Social Care
NHS Somerset	**Mary Monnington**, Director of Delivery + **Sue Sutton**, Associate Director of Delivery
Avon & Somerset Police	**Geoff Wessell**, Detective Superintendent, Head of Public Protection + **Trevor Simpson, ex Detective Superintendent**
South Western Ambulance Service	**Norma Lane**, Executive Director of Delivery
Somerset Partnership	**Ian Douglass**, Head of Service, Older People & Learning Disabilities

Care Quality Commission	**Ian Biggs**, Regional Director, South West + **Mary Cridge,** Compliance Manager, CQC

Recommendation	Actions agreed	Lead responsibility	Timescale
1. Bodies responsible for the training and continuous professional development syllabuses of health and social care professionals working with care homes should include information on the accountability of registered nurses who are also care home managers.	**NHS Somerset** **a) That training and updating which explains the accountability of registered nurses should be included in the pre registration and post graduate training of all other healthcare professionals, particularly GP's.** **Letter to be sent to the General Medical Council, Medical Deaneries and to the General Social Care Council**	Acting Director of Nursing and Patient Safety	**By 31 May 2011**
	b) Specific guidance should be provided to General Practitioners and other relevant Healthcare professionals regarding the proper role of the registered nurse working as Manager in a residential care home setting (without nursing). **Details of proposals to strengthen training will be found in section 4.3.1 in annexe 1 of NHS Somerset's Report** **Letter be sent to the Somerset Local Medical Committee, Local Pharmacy Committee and Somerset County Council**	Acting Director of Nursing and Patient Safety	**By 31 May 2011**
	Somerset Community Health **c) Somerset Community Health will prepare a GP briefing sheet reflecting nursing accountabilities in care provision with particular reference to differences between those for residential homes and residential homes with nursing**	Clinical Lead for District Nursing - Somerset Community Health	**By July 2011**
	Not applicable to Care Quality Commission		

1. continued	**Somerset County Council** **d) The outcomes of this review will be shared with all staff in Adult Social Care through the internal information sheet.** **e) Update safeguarding training to ensure that the learning from this review is included in all future safeguarding training provided by SCC.**	Group Manager – Sedgemoor and West Somerset. Safeguarding and Mental Capacity Act Co-ordinator.	**June 2011** **June 2011**
	Somerset Partnership NHS Foundation Trust **f) Memo, with wording agreed with Local Authority and NHS Somerset, reminding professional staff, will be sent to all Somerset Partnership NHS Foundation Trust staff.**	Head of Service	**June 2011**
	South Western Ambulance Service NHS Trust **g) Check with Education and Training Leads that this is covered in Paramedic Education. If not agree an update to be included**.	Safeguarding Manager + Training Manager	**September 2011**

Recommendation	Actions agreed	Lead responsibility	Timescale
2. Care home providers must only accept residents who fall within their registration category and need to have clear arrangements in place for monitoring and responding to residents' changing needs. Commissioners and contract managers also need to be alert to patterns of admissions and changing needs.	Not Applicable to NHS Somerset		
	Not applicable to Somerset Community Health		
	Care Quality Commission **Addressed by action points 6a) and 11i)**		
	Somerset County Council **a) The report has already noted changes made to: the approval process for local authority funded placements; the residential review process. These changes have improved SCC's monitoring of admission patterns and the identification of changes in needs. SCC is currently undertaking a revision of contract performance monitoring arrangements, which will further strengthen our knowledge around admission patterns.**	Community Contracts and Partnership Manager.	**October 2011**
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
3. Whenever the Care Home manager is a patient at the same practice that also provides medical care to the residents in the Home, the Practice should ensure there is good clinical supervision of the relationship between the two in order to mitigate potential conflicts of interest and associated risks. This will need specific attention in small rural practices.	**NHS Somerset** **a) Re-circulate current (2010) GMC good practice guidance. (This is under review by the General Medical Council)** **b) Circulate revised guidance when published**	NHS Somerset GP Patient Safety Lead NHS Somerset GP Patient Safety Lead	**To be confirmed**
	Not applicable to Somerset Community Health		
	Not applicable to Care Quality Commission		
	Not applicable to Somerset County Council		
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
4. Reviews of residents' care should be holistic and include information from all professionals involved. Consideration needs to be given to extending the NHS arrangements for proactive review of medication in nursing homes to residential care homes and how this information can be included in care reviews.	**NHS Somerset** **a) Guidance to District Nursing teams and Primary Care Practices re maintenance of contemporaneous client records in the home environment –this could be included in a review of Record Keeping Policies.** **b) Guidance issued to practices re updating both sets of records when administration of injection takes place in a care home** **c) Guidance issued to practices for medicines reconciliation** **d) Guidance issued to practices on reconciliation of post discharge information** **e) PCT action plan developed and part implemented following the CHUMs report re medication use in Care Homes**	Deputy Chief Operating Officer/Chief Nurse Somerset Community Health Director of Primary Care Development NHS Somerset Accountable Officer	**Ongoing**
	Somerset Community Health **f) Somerset Community Health will make District Nursing records available for reviews of residents of residential homes, where there is District Nurse involvement in their care.** **g) District Nurses will attend residents' reviews where there is District Nurse involvement in their care.**	Clinical Lead for District Nursing, Somerset Community Health	District Nurses currently attend resident review meetings when invited by commissioners of Residential care – **Actions Complete**
	Not applicable to Care Quality Commission		

4. continued	**Somerset County Council** **h) The changes made to SCC's residential review process have been noted in the report. SCC will continue to work with NHS Somerset to ensure that any changes made to medication management in care homes by NHS Somerset are reflected in the review process and understood by social care professionals.**	Group Manager Sedgemoor and West Somerset County Council.	**On going**
	Somerset Partnership NHS Foundation Trust **i) Care Programme Approach and multi-agency review procedures are in place, with regular CPA training provided, to ensure reviews are holistic and include information from all relevant professionals.** **j) Review processes and procedures are agreed with the Local Authority and NHS Somerset. Arrangements and agreement regarding medication checks in residential care homes will be agreed with the Local Authority and NHS Somerset. Reviews in specialist nursing homes are undertaken by Community Psychiatric Nurses who do proactively review medication.** **k) As a Health and Social Care Specialist Secondary Care Trust, a range of professionals undertake care home reviews. Residential home reviews are normally undertaken by Social Workers or OT's. In these circumstances, primary care staff – eg District Nursing or GP – will be asked to check medications.**	Learning & Development Lead Head of Service	**Current** **By July 2011**
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
5. The Nursing and Midwifery Council may wish review the arrangements for the validation of the CPD records of nurses employed in more isolated settings such as care homes.	**a) The Safeguarding Adults Board (SAB) will formally ask NHS Somerset to write to the Nursing and Midwifery Council on its behalf bringing this issue to the Council's attention.**	Chair of the SAB	**June 2011**

Recommendation	Actions agreed	Lead responsibility	Timescale
6. CQC need to raise public awareness of the role and scope of the new regulatory system through all appropriate channels.	Not applicable to NHS Somerset		
	Not Applicable to Somerset Community Health		
	Care Quality Commission **a) As CQC implements and refines the regulatory model we will ensure that our published guidance is clear and that it explains the role of the regulator in terms of what it can and cannot do. To ensure clarity we will test our guidance with stakeholders and take account of feedback. We will continue to communicate with ministers, the media, regulated bodies, stakeholders, partners and the public.** **b) CQC will make a formal presentation to Avon and Somerset police to address misunderstandings about the role and scope of regulation.**	Chief Executive Regional Director	**August 2011** **September 2011**
	Not applicable to Somerset County Council		
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
7. CQC should take the findings of this review into account in finalising its revised inspection arrangements and in particular: • **Professional staff in health and social care settings, including care homes, need a clear understanding of the remit and functioning of the new, intelligence and risk based regulatory system.** • **The arrangements for regulating and inspecting medication management of both controlled and non-controlled drugs** • **The protocol between CQC and the Association of Directors of Adult Social Services (ADASS) about coordination of their respective roles needs to be widely disseminated and clear guidance issued about its local use to ensure strong linkages in the commissioning and regulation of care services.**	Not applicable to NHS Somerset		
	Not Applicable to Somerset Community Health		
	Care Quality Commission **a) CQC are currently undertaking a review of a range of methodology and the findings of this review will be fed into that and taken account of.** **b) CQC will promote the arrangements for the ongoing monitoring of compliance through the website and through regular communications with providers.** **c) CQC will review the guidance to staff in the assessment of outcome 9 (regulation 13 – medicines management) and prompt inspectors to ask, in all care settings, whether controlled drugs are on the premises.** **d) CQC will continue to work in accordance with the protocol through the multi agency information sharing arrangements in place nationally. The protocol will be reviewed and refined as appropriate.**	Director of Operations Delivery	**December 2011**
	Not applicable to Somerset County Council		
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
8. NHS organisations should review the safeguarding training required for different health professionals to ensure they are appropriately competent. In view of forthcoming registration requirements, GP practices would be well-advised to ensure that at least one GP is trained and regularly updated to a high level of competency.	**NHS Somerset** **a) Vulnerable Adults' enhanced training should be extended to include all GP's with particular application to GP's with a lead role with residential care homes. Safeguarding Adults Training Programme to be provided to Primary Care through the GP Education Trust** **b) Somerset Community Health may wish to review the remit of the Vulnerable Adults post.** **c) For GP Training see Recommendation 9 below**	Deputy Chief Operating Officer/ Chief Nurse Somerset Community Health	**Completed by 31 March 2012** See SCH Action Plan
	Somerset Community Health **d) Somerset Community Health will review the remit of the Safeguarding Vulnerable Adults Lead Nurse post in the light of this report** **e) Somerset Community Health will review vulnerable adults training for all their staff, ensuring the inclusion of employed medical staff**	Lead Officer for Children and Young Peoples Services	Following acquisition by Somerset Partnership NHS Trust. **Target for Completion September 2011**
	Not applicable to Care Quality Commission		
	Not applicable to Somerset County Council		

8. continued	**Somerset Partnership NHS Foundation Trust** **f) In place. Somerset Partnership Trusts' Safeguarding Policy was reviewed in September 2010. The Trust has appointed a Safeguarding Lead with a team who support and advise staff through safeguarding procedures. The Safeguarding training is undertaken by all staff.**	Safeguarding Lead	**Current**
	South Western Ambulance Service NHS Trust **g) Lessons from reviews are fed into training updates or practice updates.**	Safeguarding Manager + Lead Paramedics	**September 2011**

Recommendation	Actions agreed	Lead responsibility	Timescale
9. Safeguarding training should stress to all professionals their duty to be alert to risks to vulnerable adults in all settings including residential homes and to discuss concerns with their organisation's safeguarding lead. **It is imperative that GPs seek advice regarding any concerns about possible abuse of prescription drugs or other substances by professional colleagues with the relevant professional lead at the PCT or its successor body.**	**NHS Somerset** **a) Vulnerable Adults' enhanced training should be extended to include all GP's with particular application to GP's with a lead role with residential care homes** **Safeguarding Adults Training Programme to be provided to Primary Care through the GP Education Trust and memorandum to all GPs and LMC newsletter** **b) Any concerns that GP's may have about vulnerable adults in residential care homes:** **✓ Should be discussed with the community nursing team and/or adult social services team, and** **✓ Advice sought from the Adult Safeguarding Lead Nurse** **✓ Any concerns must be raised with the Accountable Officer** **c) Further Communication to all GP's through LMC Newsletter and SafetyNet – NHS Somerset's Patient Safety Bulletin. (Statutory Legal Duty and professional responsibility re raising concerns is regularly highlighted to GPs and Community Pharmacists on a regularly through written and direct communication)**	Acting Director of Nursing and Patient Safety Acting Director of Nursing and Patient Safety Acting Director of Nursing and Patient Safety	**Completed by 31 March 2012** **Completed by 31 March 2012** **July 2011**

9. continued	**d) The Accountable Officer should agree an action plan for the implementation of the following recommendations to be agreed with the Director of Primary Care Development and other professional leads to ensure that these recommendations are implemented across the Somerset Health community:** i) Opiates should not be available on repeat prescription unless they are reviewed and authorised by the patient's General Practitioner[s], or named alternative doctor, before a further prescription is issued ii) All currently registered patients who are being prescribed opiates by their General Practitioner should have such prescribing reviewed by their doctor iii) Benzodiazepines should not be available on repeat prescription unless they are reviewed and authorised by the patient's General Practitioner[s], or named alternative doctor, before a further prescription is issued iv) All currently registered patients who are being prescribed benzodiazepines by their General Practitioner should have such prescribing reviewed by their doctor v) A mechanism for assessing all controlled drug medication usage on a regular basis should be in place for all patients but should at least take place at an annual review vi) Self administration of controlled drugs for injection should not be considered except in some cases as part of terminal care or in specific substance abuse programmes	NHS Somerset Accountable Officer	

9. continued	vii) The use of opiates for treating symptoms of intractable migraine, on other than a one off basis, should never be initiated in Primary Care without an expert opinion of a consultant neurologist **e) Opiate prescribing guidance issued to GP practices:** i) Guidance on maximum CD prescribing quantity issued to prescribers ii) Monthly audit and challenge of potentially inappropriate controlled drug prescribing in place iii) Benzodiazepine withdrawal guidance approved and available to prescribers iv) Hypnotics guidance issued to prescribers v) Prescribing of Hypnotics is now an annual agenda item for practice medicines management meetings vi) Prescribing rates of Hypnotics is a priority indicators on the medicines management prescribing scorecard vii) Prescribing rates of opiates is a priority indicator on the medicines management scorecard viii) 2011/12 medicines management audit asks practices to review patients on high dose opiates ix) QOF rewards regular medication reviews x) Ref g)This is advised but GPs retain clinical freedom and indication for use of opiates cannot be monitored xi) by the PCT and is protected by patient confidentiality	NHS Somerset GP Patient Safety Lead/NHS Somerset Accountable Officer	

9.continued	**Somerset Community Health** **f) Somerset Community Health will ensure all staff have a clear pathway to raise concerns. Safeguarding Vulnerable Adults Lead Nurse in post, with remit to respond to all Somerset Community Health staff concerns. Safeguarding Adults training currently includes raising the awareness of staff**	Lead Officer for Children and Young Peoples Services	**Action Complete**
	Not applicable to Care Quality Commission		
	Somerset County Council **g) SCC's safeguarding training includes a specific focus on potential safeguarding issues in residential settings. The residential review form also prompts staff to inform their manager if any concerns have been identified during the review.**	Group Manager - Sedgemoor and West Somerset County Council.	**On going**
	Somerset Partnership NHS Foundation Trust **h) In place – part of Safeguarding training for all staff. The Trust's Safeguarding Team coordinates local Safeguarding Leads' meetings, and provides advice, support and consultation to staff.** **i) The Trust Safeguarding training is mandatory with additional Safeguarding training targeted to individual roles and responsibilities. The electronic patient record system enables monitoring and reporting of all safeguarding activities. There is a monthly report reviewed by the Safeguarding Lead.**	Safeguarding Lead	**Current**
	South Western Ambulance Service NHS Trust **j) This is already part of training and a significant percentage of safeguarding alerts from SWAST staff are care home related. This figure could be added to the reporting matrix and therefore will be continuously monitored.**	Safeguarding Manager/ Safeguarding Assistant	**June 2011**

Recommendation	Actions agreed	Lead responsibility	Timescale
10. The appropriate agencies should ensure that national policy on end of life care is implemented in all care settings.	**NHS Somerset** **a) All patients requiring palliative care should be registered on the GP practice palliative care register.** **Implementation of the NHS Somerset End of Life Care Strategy has strengthened and improved end of life care across health and social care including primary care.**		**First Stage Completed**
	b) Practices should hold regular Gold Standards Frameworks meeting to review the care and treatment provided to all such patients to include the relevant District Nurse[s] For at least annual review plus ongoing audit. Review of use of GSF in general practice	GP Palliative Care Lead	**By 31 December 2011**
	c) All patients requiring end of life care should have their care managed on the Liverpool Care Pathway to provide appropriate management of symptom control using evidenced based practice. **Implementation of version 6 of Liverpool Care pathway across the health community**	GP Palliative Care Lead	**By 31 March 2012**
	d) Review of End of Life Care Policy	GP Palliative Care Lead	**By 31 March 2012**
	Somerset Community Health Somerset Community Health will ensure that staff attend and contribute to Gold Standard Framework Review meetings. All District Nurses currently attend GSF meetings when invited.	Lead Officer for Adult Services	**Complete**

10. continued	**e) Somerset Community Health staff will contribute to the management of End of Life Care based on the Liverpool Care Pathway. District Nurses are currently fully engaged in the provision of Liverpool Care Pathway. Recruitment to "End of Life DN Facilitator" post currently in progress to strengthen engagement.**		**By August 2011**
	Not applicable to Care Quality Commission		
	Somerset County Council **f) SCC has contributed to the work undertaken on the application of the end of life policy within Somerset, and we will continue to ensure that social care staff refer individuals for end of life care in accordance with the policy.**	Service Director Adult Social Care.	**On going**
	Somerset Partnership NHS Foundation Trust **g) Somerset Partnership NHS Foundation Trust End of Life Care Policy is in place and is implemented in inpatient wards and community settings. The Trust has appointed an End of Life Care Lead Nurse who attends the Somerset Palliative Care Board and Marie Curie Stakeholder Board.** **Training is provided with primary care, and accessed by Somerset Partnership staff. Advanced Care Planning training is provided to community team staff, and all Older Persons Inpatient Wards have a nominated End of Life Care link Nurse, who have attended specific training and act as a resource to the Ward team.**	Heads of Service	**Current**

10.continued	**South Western Ambulance Service NHS Trust** **h) Flagging system in place for patients in receipt of an End of Life Care Package, when that information is shared with SWAST.**	Head of Operations, Clinical Hubs	

Recommendation	Actions agreed	Lead responsibility	Timescale
11. All relevant bodies and key professional prescribers should be reminded of their statutory requirements under the Controlled Drugs (Supervision of Management and Use) Regulations 2006 and in particular: • **To share information with the PCT accountable officer and be an active member of the LIN** • **Of their professional and statutory duty to raise concerns and if they involve the management or use of controlled drugs to raise these concerns with the appropriate accountable officer** • **Of the DH Care Home alert and the requirements to review the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. A plan for effective joint working should be established, including**	**NHS Somerset** **a) The Accountable Officer should agree an action plan for the implementation of the following recommendations to be agreed with the Director of Primary Care Development and other professional leads to ensure that these recommendations are implemented across the Somerset Health community**: • Opiates should not be available on repeat prescription unless they are reviewed and authorised by the patient's General Practitioner[s], or named alternative doctor, before a further prescription is issued • All currently registered patients who are being prescribed opiates by their General Practitioner should have such prescribing reviewed by their doctor • Benzodiazepines should not be available on repeat prescription unless they are reviewed and authorised by the patient's General Practitioner[s], or named alternative doctor, before a further prescription is issued • All currently registered patients who are being prescribed benzodiazepines by their General Practitioner should have such prescribing reviewed by their doctor • A mechanism for assessing all controlled drug medication usage on a regular basis should be in place for all patients but should at least take place at an annual review	NHS Somerset Accountable Officer	**First Phase completed** PCT action plan developed and part implemented and ongoing, following the CHUMs report re. medication use in Care Homes. **First stage Completed** **This work is continued on a phased basis throughout the year.** **Ongoing**

11. continued **auditing on-going progress** • **Concerns about the management of controlled drugs in care homes should be raised with the Accountable officer at the PCT and with CQC at the earliest stage.** **PCT should consider control measures over repeat prescribing of opiates and benzodiazepines in primary care.**	• Self administration of controlled drugs for injection should not be considered except in some cases as part of terminal care or in specific substance abuse programmes • The use of opiates for treating symptoms of intractable migraine, on other than a one off basis, should never be initiated in Primary Care without an expert opinion of a consultant neurologist: o Opiate prescribing guidance issued to GP practices o Guidance on maximum CD prescribing quantity issued to prescribers o Monthly audit and challenge of potentially inappropriate controlled drug prescribing in place o Benzodiazepine withdrawal guidance approved and available to prescribers o Hypnotics guidance issued to prescribers o Prescribing of Hypnotics is now an annual agenda item for practice medicines management meetings o Prescribing rates of Hypnotics is a priority indicators on the medicines management prescribing scorecard o Prescribing rates of opiates is a priority indicator on the medicines management scorecard o 2011/12 medicines management audit asks practices to review patients on high dose opiates o QOF rewards regular medication reviews o Ref g)This is advised but GPs retain clinical freedom and indication for use of opiates cannot be monitored by the PCT and is protected by patient confidentiality		

11. continued	**Somerset Community Health** **b) Somerset Community Health will ensure that all professional prescribers are aware of and adhere to the statutory requirements under the Controlled Drug Regulations.** The Standard Operating Procedure for Controlled Drugs has been reviewed in March 2011 to include statutory responsibilities. This has been circulated to all members of staff.	Deputy Chief Operating Officer/Chief Nurse - Somerset Community Health	**Action Complete**
	Care Quality Commission **c) Whilst not the lead for this CQC will promote this message through an article focusing on the Parkfields SCR report in the CQC bulletin to health and social care providers, on the internet and to staff on the intranet.**	Director of Strategic Marketing and Communications	**August 2011**
	Somerset County Council **d) Somerset County Council will work with NHS Somerset to consider what the expectations should be of social care staff including where and to whom concerns about medication issues should be referred.**	Group Manager, Sedgemoor and West Somerset.	**Ongoing**
	Somerset Partnership NHS Foundation Trust **e) Somerset Partnership NHS Foundation Trust takes responsibility for advising prescribing clinicians of the Trust regarding information in Recommendation 17. Staff will be advised by Medical Director and Acting Chief Pharmacist (Accountable Officer for Controlled Drugs) of their responsibilities.**	Medical Director / Acting Chief Pharmacist	**June 2011**

11.continued	**South Western Ambulance Service NHS Trust** SWAST is actively involved in the LINs across the Trust area Medicines Management Policy and Controlled Drug Policy in place.	 Trust Pharmacy Advisor	

Recommendation	Actions agreed	Lead responsibility	Timescale
12. Further consideration needs to be given as to how the perspective of care home providers can be represented on the CDLIN.	**NHS Somerset** **a) CQC and County Council are both formal members of the CDLIN.** **b) CDLIN to discuss how to represent the view of and communicate with Care home providers**	NHS Somerset Accountable Officer	**Completed** **30 June 2011**
	Not applicable to Somerset Community Health		
	Not applicable to Care Quality Commission		
	Not applicable to Somerset County Council		
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
13. Ensure that current policies, including those on record keeping and drugs administration are implemented and audited.	**NHS Somerset**	Director of Primary Care Development	**Ongoing**
	Somerset Community Health **a) The Somerset Community Health policies named in Appendix 2a should be reviewed in line with recommendations of this report and the Serious Case Review.** • **Record Keeping Standards Policy dated August 2010** • **Records Management Strategy dated 2010** • **Incident Reporting Policy dated March 2011** • **Medical Device Policy dated December 2010** • **Protocol for Admission and Discharge to the District Nursing Service dated March 2010** • **Raising Concerns Policy dated March 2011** • **Safe and Secure handling of Medicines Policy dated September 2009** • **Safeguarding Vulnerable Adults Procedure dated September 2009** • **Syringe Driver Policy dated October 2009**	Deputy Chief Operating Officer/Chief Nurse - Somerset Community Health	These will be reviewed following acquisition by Somerset Partnership. **Target date September 2011**
	Care Quality Commission Not applicable, but note that CQC have a role in monitoring the compliance of providers with the relevant regulations.		
	Not applicable to Somerset County Council		

13. continued	**Somerset Partnership NHS Foundation Trust** **b) The implementation of Somerset Partnership Foundation Trust's Medicines Policy is monitored by the Acting Chief Pharmacist and the Drugs & Therapeutic Group. The Policy defines the policies and procedures followed for the ordering, prescribing, administering, recording and dispensing of medicines. The procedures are monitored and audited by the Trust Pharmacy Team, with audit results reported to the Clinical and Social Care Effectiveness Group. All medication errors are routinely reviewed by the Safe Medicines Practice Group (a sub-group of the Drugs & Therapeutics Group) to ensure lessons are learned and disseminated. This is overseen by the Risk Group. The Clinical and Social Care Effectiveness Group and the Risk Group both report to the Audit Committee which reports to the Trust Board.**	Acting Chief Pharmacist	**Current**
	South Western Ambulance Service NHS Trust **c) Medicines Management Policy and Controlled Drug Policy in place.**	Trust Pharmacy Advisor	

Recommendation	Actions agreed	Lead responsibility	Timescale
14. A more robust expectation about the sharing of concerns between General Practitioners when a patient moves to another practice should be established, as should strong communication links between daytime and out of hours doctors, especially in relation to prescribing decisions. **Practices may wish to develop a flag system for notes of new patients to ensure that the receiving GP reviews them on receipt to address the issue of potential dependency. This would include a specific review of the patient's use of opiates, benzodiazepines or other controlled drugs in the 12 months prior to transfer**	**NHS Somerset** **a) Re-circulate Advisory documents from Counter Fraud Service including CPS advice on abuse of drugs** **Counter fraud advice issued to practices and underlined by Accountable Officer and LMC communications** **b) Review/Improve function of GP2GP electronic links so new doctor has previous doctors notes within minutes not weeks** **c) Further proposals to be developed by GP Patient Safety Lead and Accountable Officer to be presented as a working proposal to the Local Medical Committee**	Director of Primary Care Development Director of Information Technology NHS Somerset Accountable Officer. NHS Somerset GP Patient Safety Lead	**Complete** **By September 2011** **September 2011**
	Not Applicable to Somerset Community Health		
	Not applicable to Care Quality Commission		
	Not applicable to Somerset County Council		
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
15. In line with regulations individual records need to be kept safe and accessible to relevant professionals and all organisations should ensure they seek and consult those records when considering patient care and treatments.	**NHS Somerset** **a) Both the home's care records for residents and any DN records should be stored in the same location, to ensure proper cross referencing where necessary.** **b) Regular audit of the combined record should be carried out.** **c) Records of care provided by DN's and changes in the patient's condition should be entered in the GP electronic record**	Deputy Chief Operating Officer/Chief Nurse Somerset Community Health	**Refer to SCH Action below**
	Somerset Community Health **d) Individuals, if writing in DN records, should include beside their first entry in the record, their full name and designation, as required by the NHS Somerset Record Keeping Policy** **e) Both the home's care records for residents and any DN records should be stored in the same location, to ensure proper cross referencing where necessary.** **f) Records of care provided by DN's and changes in the patient's condition should be entered in the GP electronic record** **g) Regular audit of DN records should be carried out.**	Clinical Lead for District Nursing, Somerset Community Health	**Target date July 2011**
	Not applicable to Care Quality Commission		
	Somerset County Council **h) Somerset County Council requires that the individual care home records are consulted as part of the review process. Any difficulties in accessing**		**On going**

15. continued	**records are raised directly with care home providers and solutions agreed.**		
	Somerset Partnership NHS Foundation Trust **i) Procedures in place via CPA Policy and training. Written reminder to be sent to all staff undertaking reviews, and undertaking care and treatments, to ensure the Care records are consulted.**	Head of Service	**June 2011**
	South Western Ambulance Service NHS Trust **j) Issues in relation to access to records in care homes are reported via the safeguarding route**	Safeguarding Manager	Policy update **September 2011** will include this issue

Recommendation	Actions agreed	Lead responsibility	Timescale
16. CQC must ensure that the current system for receiving information from whistle-blowers is effective, accessible and responsive to the concerns of those wishing to report such issues.	Not applicable to NHS Somerset		
	Not Applicable to Somerset Community Health		
	Care Quality Commission **a) CQC is producing a new whistle blowing policy. This will be tested with stakeholders, and in particular potential whistleblowers, before introduction.**	Director of Operations Delivery	**October 2011**
	Not applicable to Somerset County Council		
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
17. All agencies should consider the effectiveness of arrangements for supporting whistleblowers including those within care provider organisations.	**NHS Somerset** **a) Review/Update Whistle-blowing Policy to include the development /review of a policy for Primary Care practitioners** **b) Further brief Guidance for Primary Care Practices to be developed by Director in collaboration with GP Patient Safety Lead**	Director of Human Resources Acting Director of Nursing and Patient Safety	NHS Somerset/SCH Policy Reviewed 2010 and ratified March 2011 **By July 2011**
	Somerset Community Health **c) Somerset Community Health will review/update Whistle-blowing Policy to ensure effective arrangements**	HR Lead Somerset Community Health	Current Whistle Blowing Policy reviewed in March 2011 **Action Complete**
	Not applicable to CQC – covered in 12 above.		
	Somerset County Council **d) There is a policy in place for whistle blowing within Somerset County Council.** **e) As the lead agency for safeguarding, SCC will review its policy on the management of safeguarding alerts and investigation to ensure that it includes arrangements for whistleblowers.** **f) Commissioning arrangements. SCC's residential care home contract requires that providers have a whistle blowing policy in place for their staff.**	Safeguarding and Mental Capacity Act Co-ordinator. Community Contracts and Partnerships Manager	**September 2011** **Ongoing**

17. continued	**Somerset Partnership NHS Foundation Trust** In place – the Trust Whistle blowing Policy was reviewed in 2010 and identifies arrangements to ensure whistleblowers are supported. The Trust Board has identified a Non-Executive Director as Whistle blowing Lead and a quarterly report is made to the Board, to provide assurance that the Policy is working effectively, and that individuals raising concerns are protected and supported.	Director of Human Resources	**Current**
	South Western Ambulance Service NHS Trust Whistle blowing Policy in place and due for review in June 2012	Director of Human Resources and Workforce Development	**June 2012**

Recommendation	Actions agreed	Lead responsibility	Timescale
18. An appropriate senior professional experienced in staff support and professional accountability should be designated by chief officers of organisations whose staff are affected by significant events such as a serious criminal investigation. This person should have a remit to co-ordinate and lead a system of staff support which is ongoing if necessary until all relevant processes have finished.	**NHS Somerset** **a) More structured senior professional support should be established to assist professionals who are closely involved immediately following the arrest and subsequent investigations.** ✓ For detail of the approach recommended, see NHS Somerset report annexe 1, 4.5 to 4.5.2 Provision of SuCceSS Service for Primary Care Professionals launched in 2009 plus the GP Patient Safety Lead roles and support from the LMC provide active support to Primary Care professionals	Director of Human Resources / GP Patient Safety Leads. To be agreed	**Completed** Systems reviewed for SCH Staff.
	Somerset Community Health **b) Somerset Community Health will review internal processes to ensure lessons of Airedale report , including professional support, are applied in all future occasions when there is a police investigation**	HR Lead Somerset Community Health	Following acquisition by Somerset Partnership **Target date September 2011**
	Care Quality Commission **c) CQC will highlight existing support arrangements as part of the general communication to staff about the outcomes of this review. CQC will ensure that when these situations arise staff are given personal support in addition to the usual support from line management.**	Chief Executive	**October 2011**

18.continued	**Somerset County Council** **d) Somerset County Council will review its current arrangements to ensure that the support required by staff is clearly recognised in relevant policies and that oversight of the support linked to a particular event is held by an appropriate manager.**	Group Manager Sedgemoor and West Somerset County Council.	**September 2011**
	Somerset Partnership NHS Foundation Trust **e) Procedures are in place. The Corporate Governance Manager leads the system to support staff through the processes.**	Corporate Governance Manager	**Current**
	South Western Ambulance Service NHS Trust **f) Guidance on Supporting staff involved in adverse incidents, complaints or claims is in place and available to all managers who are line managers.**	Risk Manager	**Currently under review**

Recommendation	Actions agreed	Lead responsibility	Timescale
19. Safeguarding Boards should include in their regular monitoring reports the adequacy of advice and support arrangements for all professionals working with vulnerable adults.	**NHS Somerset** **a) To be included in the NHS Somerset Annual Report for safeguarding adults to the Somerset Safeguarding Adults Board**	Acting Director of Nursing and Patient Safety –	**30 September 2011**
	Somerset Community Health **b) Somerset Community Health will contribute to the work of the Safeguarding Adults Board**	Lead Officer for Children and Young Peoples Services	**Ongoing**
	Not applicable to Care Quality Commission		
	Somerset County Council **c) SCC will undertake monitoring reports as required by the Safeguarding Board.**	Group Manager Sedgemoor and West Somerset County Council.	**Ongoing**
	d) SCC will continue to monitor the effectiveness of their safeguarding structure to support processionals working with vulnerable adults. This includes case file audits, discussions at professional meetings and training events.	Safeguarding and Mental Capacity Act Co-ordinator.	**Ongoing**
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
20. The management of changes in the structure of the NHS, notably the demise of the Primary Care Trusts, needs to ensure continuity of: • **the monitoring of prescribing patterns currently carried out by the Controlled Drug Local Intelligence Networks (CDLINS) continues.** • **The Accountable Officer role**	**NHS Somerset** **a) PCT will ensure the transfer of this role and responsibilities as part of the planned transition to GPCC.** DH have re-iterated the importance of supporting the Accountable Officer Role and duties during the transition phase in a communication in 'The Week' March 2011	NHS Somerset Accountable Officer Director of Primary Care Development	Transfer role and responsibilities to successor body **on or before end March 2013**
	Somerset Community Health **b) Somerset Community Health will review accountable Officer arrangements in the light of "Transforming Community Services" changes.** This has been raised with Somerset Partnership as part of the acquisition process**.**	Chief Operating Officer - Somerset Community Health	**Accountable Officer post will be in place from acquisition.**
	Not applicable to Care Quality Commission		
	Not applicable to Somerset County Council		
	Not applicable to Somerset Partnership NHS Foundation Trust		
	Not applicable to South Western Ambulance NHS Trust		

Recommendation	Actions agreed	Lead responsibility	Timescale
21. As partner organisations undergo rapid and substantial change in response to national policy and financial constraints, the effectiveness and sustainability of important systems such as the safeguarding system, controlled drugs management arrangements and holistic oversight of vulnerable adults in residential settings should be included in impact assessments and risk management.	**NHS Somerset** **a) DH have re iterated the importance of supporting the Accountable Officer Role and duties during the transition phase in a communication in 'The Week' March 2011**	NHS Somerset Accountable Officer	See above
	Somerset Community Health **b) Somerset Community Health will ensure that the recommendations of this report are incorporated into the transition arrangements for "Transforming Community Services" changes.**	Deputy Chief Operating Officer/Chief Nurse - Somerset Community Health	Report and action plan to be shared with Somerset Partnership. **Target date July 2011**
	Not applicable to Care Quality Commission		
	Somerset County Council **c) The County Council has outlined its commitments to the safeguarding of vulnerable adults in its County Plan. Adult Social Care has a number of monitoring processes in place to ensure that we are effectively safeguarding vulnerable adults. Impact and risk assessments will be undertaken before changes are made to ensure that our safeguarding responsibilities are not being compromised.**	Service Director – Adult Social Care.	Ongoing
	Somerset Partnership NHS Foundation Trust **d) Somerset Partnership NHS Foundation Trust will continue to ensure these systems remain in place for the Mental Health Care Trust. For example, in the instance of Somerset Partnership NHS Foundation Trust acquiring Somerset Community**	Director of Operations, Somerset Partnership NHS Foundation Trust	In place

21. continued	**Health, their parallel structures will remain in place for safety and any revised structures will be developed and clearly reported to all within the new organisation and external agencies.**		
	Not applicable to South Western Ambulance NHS Trust		