Somerset Safeguarding Adults Board

Annual report 2013-14

Chair's foreword

I am pleased to present the Annual Report of the Somerset Safeguarding Adults Board for 2013/14

In the foreword to last years report Clare Steel drew attention to the decision to appoint an independent chair for the Board in line with the national trend. It is my honour and privilege to be that first independent chairman having been appointed in January of 2014. I am committed to using my position to help develop adult safeguarding though seeking individual and collective assurance from all of the partners, learning from events which have occurred both here and elsewhere, and by encouraging closer strategic working to achieve better outcomes for those who use our services.

I am immensely grateful for the support of the previous chair Clare Steel. I also appreciate the openness and candour of all Board members and their respective organisations. It is clear from the reports within this document that there is huge energy and commitment from all Board partners and a real desire to develop our joint approach to make this county an even safer place for those in need of safeguarding. It is also clear that activity levels and referrals continue to increase reflecting the national picture.

During the first few months of my tenure I have been able to meet with all of the agencies and organisations who make up the Board and we have agreed that it is time to re-state a clear ambition for the Board and to identify and work on a small number of crucial areas in order to improve our collective contribution to adult safeguarding. I look forward to developing these ideas and building them into a work programme as we enter next year.

I have also had early discussions with the independent chair of the Safeguarding Children Board and we recognise the importance of closer working practices and joint approaches, particularly in the crucial area of transition from childhood to adulthood.

Finally, the forthcoming year will see the Care Bill receive Royal Assent and we, like all other Boards, are keen to get to grips with the new legislation and guidance in order to take full advantage of the statutory responsibilities that are being placed upon us.

I look forward to addressing all of these issues in the year to come.

Richard Crompton

Somerset County Council – Adult Social Care service

Summary of organisational developments affecting adult safeguarding and how the focus upon this area of work is maintained

Safeguarding adults at risk is a key priority for Somerset County Council with the responsibility for investigating and leading on safeguarding concerns heldby the Adult Social Care Service. During 2013-2014 we have continued to see a significant rise in both the level of reported safeguarding concerns and those accepted as requiring a safeguarding investigation. This increase continues to place additional pressures on Adult Services resources, but senior managers in the service closely monitor this key area of work to ensure that our resources are being appropriately targeted on supporting this work.

During the last year the number of alerts received by the Council have increased from 2300 (2012/2013) to 2800. This rise represents a 22% increase on the previous year. These alerts are received from members of the public and professionals about situations where they are concerned that there may be an adult at risk. Managers in the Adult Social Care Service review every safeguarding alert and decide if further action under the safeguarding policy is required. If required investigations under the multiagency safeguarding policy are undertaken and safeguarding plans appropriate to the needs of the individual put in place. The numbers of referrals that have been accepted for a safeguarding investigation has also increased this year from 880 (2012/2013) to 943 a 7% increase. The activity each safeguarding alert generates has created a pressure on Community Teams and to manage this additional demand the teams have reconfigured their duty teams, ensuring that there is a rigorous process is place to respond to concerns and provide a positive outcome for the individuals involved.

This year has also seen an increase in the number of concerns being reported within a whole service. These are complex situations with safeguarding concerns that could potentially affect all the residents in a care home or all of the customers of a community service. Somerset has a well established process for managing whole service issues that includes providers, health organisations, the Care Quality Commission and Adult Social Care. These issues require a high level of multi-agency co-operation and the allocation of resources, sometimes for an extended period of time. In the last year there have been a small number of situations where work has been undertaken with a provider for over 12 months to ensure that safeguarding and quality issues are resolved. Considerable work has also been undertaken this year to develop a Quality Monitoring Process that works in conjunction with whole service safeguarding concerns to ensure that appropriate and timely responses are provided to both quality and safeguarding issues.

Safeguarding situations that relate to individuals have also increased in terms of their complexity. This has required involvement for a range of other agencies in Somerset to support the investigation process, for example the Police, Finance and Benefits staff and the Clinical Commissioning Group have supported investigations into concerns about emotional and physical abuse as well as supporting investigations into concerns regarding financial mismanagement. Members of the safeguarding team in Adult Social Care continue to monitor the quality of decision making and recording in the safeguarding process.

During the last year applications made to the Court of Protection for welfare decisions have also continued to increase. These applications are made when an individual does not have capacity to make a decision regarding their well being, and the County Council has not been able to agree a way forward with family members. Welfare applications made this year have been about where a person should live and how their care is provided. The rulings by the Court of Protection are providing key learning locally and nationally on how Local Authorities need to improve their practice in relation to safeguarding and this is being imbedded into the work in Somerset.

Reporting arrangements for safeguarding issues presented a challenge to the organisation this year due to the new reporting requirements of the Department of Health Safeguarding Adults Return (SAR) and the need to adapt our processes to match this. Changes in national reporting has also meant that providing a comparison of data this year with previous years is difficult as not all the reporting fields are the same. With the rise in demand across the whole service in Safeguarding alerts and the complexity of the presenting issues it has also proved more challenging to report on activity in the detail we would have liked. Further work is planned to analyse if we are improving our practice in terms of responding and getting timely and appropriate safety plans in place

Local Authorities now have the responsibility for managing safeguarding issues in health settings, including hospitals. This continues to be an area where further work is needed to ensure that safeguarding issues are appropriately reported and investigated in these settings. This needs to include how we monitor what happens to Somerset residents who are in hospitals outside of Somerset. In April 2013, the County Council became the supervisory body for Deprivation of Liberty Safeguards (DOLS) in hospital settings with responsibility passing from NHS Somerset to the Council.

In April 2013 the Adult Social Care Service changed its management structure in recognition of the growing requirements around safeguarding and a Service and Operations Manager role was developed over the course of the year to lead on safeguarding and risk management within the service. This post is responsible for the work of the safeguarding team (which includes the support to the Safeguarding Board) and for the work undertaken by frontline staff in Adult Social Care around safeguarding and complex risk management issues. The post holder also has responsibility for the Financial Assessment and Benefits (FAB) and Client Finance teams.

Training and other development activities undertaken within the Organisation

Somerset County Council has a safeguarding training programme for its Adult Social Care staff. All social work staff are required to undertake investigation training and then have this updated every two years whilst Team Managers who chair our safeguarding meetings have to complete refresher training every year. Attendance at this training is monitored by the Learning and Development Team and gaps in skills have been identified in conjunction with the Safeguarding Team. Adult Social care staff are also expected to attend mandatory Child protection training. The Safeguarding Team continue to share their expertise with other professionals. Training is provided to social work students on safeguarding in practice and the team attend Professional Development Groups for Adult Social Care staff across the county. This ensures that social workers and occupational therapist receive regular updates on safeguarding practice, explore the lessons learnt from safeguarding

audits, and discuss developments in the application of the Mental Capacity Act. Work is underway to develop a resource pack for front line practitioners including locum social workers.

The Adult Social Care Service has continued to supported the training of staff on the awareness of domestic violence within the Service through domestic violence multi-agency risk assessment training and generic awareness domestic abuse training. The County Council also provides training for social care and health providers on both safeguarding and mental capacity. The courses run by the Council for social care providers on managing a safeguarding incident and completing DOLS applications continue to be well attended. Adult Social Care has also planned a research project to understand people's views on safeguarding and if the safeguarding intervention for them achieved the outcome they wanted.

Contribution to the work of the Board and its sub-groups

The County Council has representatives on all the Board sub groups; there is also an Adult Social Care representative in addition to a Commissioning representative on the Board. Staff from the Adult Social Care Service chair two of the Board's subgroups and provide the administrative support to the Board and the majority of the sub groups. In anticipation of The Care Act 2014 requirements for an Adult Safeguarding Board, the need for the Board to appoint an independent chair was identified. The work on the job description for the Chair was undertaken in 2013 and in November 2013 Richard Crompton was appointed, taking up his post in January 2014.
The Adult Social Care Service continues to lead the Operational Safeguarding sub group. This group provides the opportunity for those involved in the day to day management of safeguarding concerns to meet together to discuss learning and develop good practice.

Planned safeguarding activities for 2014/2015

The County Council has a lead role in implementing many of the actions listed in the Safeguarding Adults Board work plan. As well as supporting the Board's action plan the Adult Social Care Service has identified a number of key areas of work for 2014/15:
- Implementing the changes to practice and policy required in response to the Supreme Court ruling on the Cheshire West deprivation of liberty case
- Ensuring the Somerset is compliant with the enquiry and support planning requirements of The Care Act 2014
- Ensuring that the key aspects of the national guidance on making safeguarding personal is implemented.
- Supporting the Local Authority responsibilities and reporting mechanisms across all Health settings in Somerset by developing a triage model

Issues for the Board's consideration during the coming year

- The Board to consider what it needs to do to be compliant with the Care Act
- Continue Consolidation of independent chair role including links with South West Regional chairs and local children's safeguarding board
- The Board to consider what support/resources it needs to manage its business successfully and how this is best commissioned.

Report completed by:
Julia Ingram, Interim Safeguarding and Risk Management Service and Operations Manager.

Safeguarding activity summary for 2013-14
This year has seen the continuation of the strong upward trend in the numbers of safeguarding concerns referred to Somerset County Council and a smaller increase in the numbers of these cases which require an investigation by the Council or one of its partners.

This summary is based upon the Council's statutory return to the Department of Health and upon comparisons with other local authorities nationally. Figures for comparison are drawn from the Annual Report for 2013-14 published by the Health and Social Care Information Centre in September 2014. This report can be found by clicking on the following link:

http://www.hscic.gov.uk/searchcatalogue?productid=16190&q=safeguarding+adults+annual+report&topics=0%2fSocial+care&kwd=S&sort=Relevance&size=10&page=1#top

Overall activity levels

	Safeguarding referrals received	Accepted as meeting the threshold for investigation	Substantiated fully or partially
2013-14	2800	944	675
2012-13	2300	880	630
% change	+22%	+7%	+7%

The 944 incidents which were investigated related to 770 different individuals. Of these, 566 were already known to the Council mostly because they were in receipt of care services.

Category of main care needs

Physical disability, frailty and sensory impairment	Learning disability	Mental health	Other	Total
390	181	33	166	770

Many of the people in the first column will be older people including those with dementia. About 20% of the people in the learning disability (32) were people placed in care services in Somerset by other local authorities.

Ethnicity of individuals referred

White	Black	Asian	Mixed	Undeclared/not known	Total
680	4	1	2	83	770

Referrals by type of alleged abuse

Physical	Sexual	Financial	Psychological	Neglect	Institutional	Total
230	34	149	143	273	114	943

Referrals by location of alleged abuse

Care home	Own home	Hospital	Service in community	Other	Total
543	306	16	33	45	943

The referrals about concerns in care homes relate to allegations against members of care staff (283) as well as other vulnerable people in the home (247).
The majority of concerns occurring in people's own homes (255) involve allegations against members of their families or other people they live with. A small proportion (31) relate to paid domiciliary care staff

National comparison
Percentage of allegations occurring in care homes and people's own homes

	Somerset	England
Care home	58%	36%
Own home	32%	42%
Other settings	10%	22%

Referral conclusions

Substantiated fully	Substantiated partially	Inconclusive	Not substantiated	Investigation ceased by person	Total
485	190	111	133	24	943

National comparison
Percentage of investigations

	Somerset	England
Substantiated partially or fully	72%	43%
Inconclusive	12%	22%

Result of actions taken under safeguarding procedures

Risk remains	Risk reduced	Risk removed	No action taken	Total
91	439	406	7	943

National comparison
Percentage of safeguarding referrals where action taken has reduced or removed the identified risks

Somerset	England
90%	57%

Statistics summarised by Chris Hamilton, Safeguarding Co-ordinator, SCC

Somerset Partnership NHS Foundation Trust

Summary of organisational developments affecting safeguarding and how the focus upon this area of work is maintained

The Trust has undergone significant service redesign following Somerset Partnerships acquisition of Somerset Community Health in 2011. The Trust is moving towards a model of integrated services within four geographical divisions across Somerset as well separate county wide Management of Inpatient Services & Crisis Teams and the Children & Young People Services.

The three previously separate Safeguarding Teams for Children, Adults in Mental health Services and Adults in Community Health have moved into one Safeguarding Service within the Nursing & Patient Safety Directorate. The Executive Lead for Safeguarding in the Trust is the Director for Nursing & Patient Safety. Since October 2013 the new Head of Safeguarding has been working closely with the team and with partner agencies to develop the Multi- Agency Safeguarding Hub model. To date the Trust has a Safeguarding Children Nurse, A Safeguarding Adult at Risk Team Leader, a Safeguarding Adult Nurse and a Safeguarding Administrator based at Wellington House in Taunton. They are working alongside the police Safeguarding Coordination Unit, Children's Social Care and Somerset Direct. Other members of the Safeguarding Team have bases within the divisions across the county.

The Trust has a Multi- Agency Risk Assessment Conference (MARAC), Multi Agency Public Protection Arrangements (MAPPA) and PREVENT (part of the Governments Anti-Terrorism CONTEST Strategy) Lead, who is an integral member of the Trusts Safeguarding Services. This role started as a pilot project and has now become a highly valued and respected multi- agency link between services. This role enables trust representation at all of the MARAC, MAPPA and PREVENT meetings held within Somerset. The Head of Safeguarding is a member of the MAPPA Strategic Management Board (SMB) for Somerset and the MAPPA Health Sub-Group.

A review of the reporting Safeguarding Adults at Risk process was led by the Head of Safeguarding with partner agencies and commissioners. This has led to the development and implementation of a clearer Safeguarding Adults at Risk Referral Pathway that aims to provide clearer guidance for the allocation and management of the referrals coming in via Somerset Direct for all provider services.

The Safeguarding Adults Team Leader has led the further development of safeguarding resources across the Trust. This includes the new intranet site with improved safeguarding pages and links, safeguarding toolkits for practitioners and extending the number for the quick reference guides available to all staff.

The Trust previously had two Safeguarding Steering Groups for Adults and Children. These have now been amalgamated to ensure that safeguarding is considered holistically and systemically, not only across services but in the response from services to the adults and children with whom we work. The Safeguarding Steering Group reports to the Trusts Clinical Governance Group on a quarterly basis and the Trust Board on an Annual basis. Regular scheduled safeguarding audits are carried out to further provide the trust and

commissioners with assurance.

Following a review of the Safeguarding Champions role across Community Health Services and the Team Leads for Safeguarding in Mental Health Services, these two groups have now been amalgamated to ensure that knowledge, skills and best practice is facilitated through regular quarterly meetings with the Head of Safeguarding and the Safeguarding Adults Team Leader. All services aim to have a Champion or Team Lead who has the opportunity to receive additional safeguarding training to enable the development of local expertise.

The Safeguarding Adults at Risk Policy has been completely revised to reflect the organisational changes within the trust, the new referral pathway and new practice flow charts in accordance with the Somerset Safeguarding Adults at Risk Policy (2012.) It has also now been made more user friendly for patients and staff. The Trust continues to review and revise all of the safeguarding related policies. This has led to the development of a 'No Response Policy' and 'Domestic Abuse Policy' in recent months, as well as a review and update of the Managing Allegations Against Staff (in the context of the Safeguarding Children and safeguarding Adults at Risk) Policy.

Attendance continues by members of the Safeguarding Team at various governance and clinical groups across the trust ensures that safeguarding is considered in all areas of the organisation at all levels. For example; the Serious Incidents Requiring Investigation Review Group, Pressure Ulcer Working Group, Clinical Policy Review Group, Francis Operational Group and End of Life Care Group.

Safeguarding updates have been provided to the Heads of Division for dissemination in their areas.

A regular Safeguarding feature has been devised in the staff newsletter- 'What's on in Sompar.'

Ongoing roll out of the patient record system 'RIO' continues across community hospitals with further safeguarding specific developments being incorporated and under continual review.

All safeguarding incidents and DATIX reports are reviewed by the safeguarding team.

Training and other development activities undertaken within the organisation

A review of the training strategy and the training provision has been undertaken to ensure the training reflects the required competency's and incorporates lessons learnt.

Safeguarding Adults at Risk induction training (basic awareness) has been established for all new staff joining the Trust as a mandatory requirement.

Level A training is available to all staff across the Trust.

Working together to Safeguard Adults at Risk (formerly Level A+) is delivered in partnership with Somerset county Council to a multiagency staff group. This is particularly

targeted at Safeguarding Champions.

Level B is provided to workers in Community Health Teams via Somerset County Council.

Level C is provided to Team Leaders in Community Health Teams via Somerset County Council.

Bespoke safeguarding training is available to teams across the Trust as part of team development either on request or in response to a significant event.

The current Safeguarding Adults at Risk staff training rate across the Trust is 90%.

Application of key learning from Serious Case Reviews and other review processes

The Head of Safeguarding or the Team Leader for Safeguarding Adults are always actively involved in any Serious Case review process involving the Trust. The lessons learnt are disseminated through various fora such as; incorporated in staff training, updates via Heads of Division, newsletters and memos.

Reviewing of referrals made to the safeguarding team and the outcomes from those referrals continues through regular meetings with the Somerset County Council Safeguarding Officer.

Contribution to the work of the Board and its sub-groups

The Head of Safeguarding is a member of the Somerset Safeguarding Adults Board (SAB.)

The Head of Safeguarding and Team Leader for Safeguarding Adults represent the trust between them on all of the SAB Sub-Groups.

The Team Leader for Safeguarding Adults and other Trust representatives from operational services
Continue to attend the Local Safeguarding Leads Group led by Somerset County Council.

The SAB Learning Lessons Sub-Group is linked to the Training Sub- Group. Both are attended by the Team Leader for Safeguarding Adults at Risk.

Planned safeguarding activities for 2014-15

The Safeguarding Training Programme to be further reviewed and developed.

Complete the actions identified by the recent independent Safeguarding Audit in April 2014- Target date July 2014. An internal Safeguarding Adults at Risk audit to be undertaken as part of the internal auditing programme November 2014- February 2015.

Ensure that a clear understanding is disseminated to all relevant staff groups of the Mental

Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) This will include the Trusts safeguarding Team being involved in the production of a professional training DVD.

To develop a singular Trust Safeguarding Development Plan that incorporates all of the existing action plans currently in existence for different aspects of the safeguarding service.

Issues for the Board's consideration during the coming year

Implications of developments in MCA and DoLS for all agencies affected.

The need for other services becoming involved in the Multi -Agency Safeguarding Hub alongside Somerset Partnership NHS Foundation Trust, Somerset Childrens Services, Somerset Direct and the Safeguarding Coordination Unit of Avon & Somerset Police.

Report completed by: **Richard Painter – Head of Safeguarding**
Vanda Squire- Team Leader for Safeguarding Adults at Risk

Date: 15.5.14

Avon and Somerset Constabulary

Summary of organisational developments affecting safeguarding and how the focus upon this area of work is maintained

During 2013/14 Avon and Somerset Constabulary made significant inroads into improving the operational and strategic response to dealing with incidents involving vulnerable adults, and the safeguarding of adults who are potentially vulnerable.

'Integrated Victim Care' is a joint project between the Constabulary and the Office of the Police and Crime Our aim is to bring together all the key roles and organisations involved in providing services to victims, including crucial third sector partners, to create a more cohesive, end-to-end approach. The new model will reduce complexity and duplication within our systems, and provide victims with a single-point of contact to ensure they are engaged and supported during their journey

The programme involves a number of detailed work packages, with complex interdependencies, and challenging timescales. Our ultimate goal is t**o** place the voice of the victim at the heart of our service, through effective collaboration, cohesion and innovation amongst service providers that ensures victims feel engaged and supported during their journey.

Within our organisation, we want everyone to know and understand their role and responsibility for victim care, be able to identify vulnerability and recognise the part they play can impact on the victim's journey through the criminal justice system.

This will be achieved through activity being delivered as part of the programme, but also through some of the work going on to support delivery of the PCC plan for 'putting victims at the heart of the Criminal Justice System'.

In Feb 2014 we launched the Safe Places scheme across Avon and Somerset to help people feel safe and supported when they are out and about in the community. Locations such as local shops, cafes or libraries that are signed up to the scheme, provide a recognisable safe place for people to seek advice, reassurance and help.

The scheme will help people get out and about in their community but with the reassurance that there is help available should they need to deal with difficult situations. This could be anything from getting lost, losing a mobile phone or feeling harassed or bullied.

More specifically in Somerset representatives from the Southern Safeguarding Co-ordination Unit (SCU) met with Maxine Walton to discuss the volumes of referrals being made by ASC to Somerset Direct. This resulted in an informal operating protocol being established so that incidents met appropriate thresholds for referral. As such internal process were amended to ensure thorough review by SCU to ascertain the appropriateness and relevance of the referral, and also ensure all police checks are completed prior to submission.

Quarterly meetings are now in place to discuss any emerging issues/ leaning.

Training and other development activities undertaken within the organisation

The network of Safeguarding Champions established last has further developed, and multiple training sessions have been held throughout the year.

A training programme focusing on all aspects of vulnerability is being developed and will be rolled out across the force during 2014/15.

Application of key learning from Serious Case Reviews and other review processes

We are awaiting the learning of 2 Vulnerable Adult Serious Case reviews from 2013/14 and will ensure any learning from those is contained with the 2014/15 work plan.

Previous police actions from a 2012 SCR have been implemented and commented on in last years submission.

Contribution to the work of the Board and its sub-groups

Detective Superintendent Rachel Williams sits on the board.

Detective Inspector Lindsay Shearlock attends the Learning the Lessons sub group.

Inspector Caroline Howard and a member of the HQ PPU Policy Team attend a South West Regional Safeguarding Adults Group.

Planned safeguarding activities for 2014/15

Last Year a 'Series of 'Policing Diverse Communities' Conferences were developed in conjunction with SARI. 2 have been held in 2013/14 that related to Race & religiously motivated Hate Crime. A further two have been developed entitled 'Policing for Disabled People' and will take place in September and November 2014 at the Tacchi-Morris Arts Centre in Taunton. Below is a summary of the topics to be covered

- Autism & the Criminal Justice System – What is it, how to recognize it & how it impacts victims and offenders
- Alzheimer's & Dementia - What is it, how to recognize it & how it impacts victims and offenders
- Being A Wheelchair User – Impacts & Barriers & how Police can be accessible
- Mental Health – Key definitions. Myths and Stereotypes
- Sensory Impairments – Impacts & Barriers, myths & stereotypes
- Input from Disability Advisory Group (DIAG)
- Panel discussions with Service Users.

The purpose of the conferences is to improve the awareness and confidence of police officers to recognize disability hate crime advise on how they can be more effective when investigating it, as well as proving them with a general understanding and appreciation of issues is impacting the lives of disabled people. Input into the content and presentations have been made by Somerset Sight, Headway & Compass Disability.

Report completed by: Amanda Lloyd **Date: 01/07/2014**

Somerset Clinical Commissioning Group

Summary of organisational developments affecting safeguarding and how the focus upon this area of work is maintained

From April 2013 Somerset CCG has held statutory responsibility for the commissioning of health services in Somerset. The changing health landscape as a result of NHS reforms brought new challenges for safeguarding in respect of the ability of the new NHS structures to embed safeguarding practice in their systems and to ensure alignment and collaboration across the new systems. In particular, NHS England Area Team is the commissioner for primary care services. Somerset CCG works closely with the Bristol, North Somerset, Somerset, and South Gloucester Area Team to assure safeguarding arrangements in primary care under the CCG duty to improve the quality of primary care.

Lessons from inquiries such as Mid Staffordshire Foundation Trust and the failures in commissioning identified through Winterbourne View have highlighted the need to make safeguarding integral to care. Prosecutions by the courts; enforcement measures by regulators and adverse media attention, all demonstrate the high cost to services, staff and patients, where there are failures in safeguarding patients, and also the high cost to the health and psychological and emotional needs of individual patients and their families.

Somerset CCG has been guided by Safeguarding Adults: the Role of Commissioners, published by the Department of Health in 2011, on the fundamental actions required of commissioners in relation to safeguarding adults.

The final report of Robert Francis, QC and Chairman of the inquiry was published on 6 February 2013. The Inquiry examined the commissioning, supervisory and regulatory bodies of Mid Staffordshire hospital between January 2005 and March 2009. The Inquiry built on Robert Francis's earlier report, published in 2010, following the independent inquiry into failings within the Trust over the same period.

The Inquiry found that the suffering at Mid Staffordshire was as a result of serious failings on the part of the Trust Board which failed to listen to patients and staff and 'failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.'

The CCG has worked with local providers through the relevant clinical forums and networks to ensure that they have considered and provided an appropriate response to the Francis Report. In particular, there has been a strong focus from commissioners on when providers should be raising a safeguarding alert in respect of commissioners or concerns about healthcare. The approach to transparency of reporting on Safe Staffing in all NHS Trusts will provide further evidence to identify when an alert should be raised.

As commissioners the CCG has worked with providers to continue to foster a culture of openness and to support, and develop staff to provide a safe high quality care for the people of Somerset. All Trusts are implementing the Duty of Candour and apologizing to parents and their families when mistakes have been made.

The CCG has pro-actively monitored, investigated and taken appropriate action in respect of all concerns that has been raised in respect of quality or patient safety in the

commissioned services in Somerset. Somerset CCG included quality standards for safeguarding adults in all provider contracts that are derived from the 'No Secrets' guidance, together with standards from Outcome 7 of the Care Quality Commission Essential Standards Health.

Monitoring of contract compliance and performance against these agreed Standards is undertaken through the attendance at Clinical Quality Review Meetings, or via contract monitoring arrangements. Each provider is required to evidence activities relating to safeguarding adults including staff attendance at safeguarding training. Implementation of action plans arising from serious case reviews are also monitored at these forums.

Training and other development activities undertaken within the organisation

During 2013/14 Care Focus was commissioned by Somerset CCG to provide safeguarding Adults at Risk Awareness Sessions to all staff within GP Practices.

A total of 67 sessions were delivered to practices, seven practices did not receive the training. Reasons reported for not accessing the training were because they had already arranged safeguarding training themselves or chose to arrange for themselves. GPs and their staff valued the opportunity to determine the format of the session and it has been clear that the flexibility offered in terms of delivery aided engagement. The vast majority of sessions were delivered in an informal atmosphere with extensive opportunity for discussion.

Application of key learning from Serious Case Reviews and other review processes

NHS Somerset CCG was not asked to take part in any Serious Case Review during 2013/14.

During the year we oversaw the investigation of a total of 175 serious incidents of patient harm across NHS providers where the CCG is the lead commissioner for the services. Of the 175 incidents, 9 were classified as the most serious grade 2 incidents, of which 5 were 'Never Events'. The grade 1 incidents largely consisted of pressure ulcers, falls and attempted or completed suicides in the community. Somerset CCG works closely with all NHS providers to promote reductions in patient harms arising from pressure ulcers, falls and suicide. The CCG oversees the implementation of lessons learned from serious incidents to improve services within NHS Trusts and shares the learning across the health community through the publication of the quarterly Safetynet Newsletter.

Contribution to the work of the Board and its sub-groups

Somerset CCG will continue to participate as an active member of the Somerset SAB, supporting the transition onto a statutory footing to safeguard adults at risk.

When required we support the Serious Case Review process and actively contribute to the SAB including attending the Learning Lessons Sub-Group.

Planned safeguarding activities for 2014/15

The CCG has pro-actively monitored, investigated and taken appropriate action in respect of all concerns that has been raised in respect of quality or patient safety in the commissioned services in Somerset. We will continue to strengthen and build on the current arrangements to ensure that the patient voice is heard.

In March 2014 the CCG secured funding to support providers in embedding the use of the Mental Capacity.

The CCG will continue to work with local providers through the relevant clinical forums and networks to ensure that they consider and provide an appropriate response to the Francis Report to include the implementation of recommendations from Hard Truths; the journey to putting patients first to include:

- Transparent monthly reporting of ward-by-ward staffing levels and other safety measures
- All providers will clearly set out how patients and their families can raise concerns or complain, with independent support available from local Healthwatch or alternative organisations.
- Providers will report on complaints data and lessons learned.
- A statutory duty of candour on providers, and a professional duty of candour on individuals through changes to professional guidance and codes.

The CCG continues to support a collaborative approach in Somerset and promote a zero tolerance culture to pressure ulcers in order to safeguard patients and to improve the outcomes experienced by patients at risk of developing pressure ulcers.

We will monitor the use of deprivation of liberty safeguards within providers in Somerset, and as a member of the SAB to ensure individuals are not deprived of their liberty without appropriate safeguards in place. In addition we will monitor the impact of the ruling on the capacity and capability of organisations to meet the requirements for assessment.

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Report completed by: Deborah Rigby – Deputy Director Quality, Safety and Governance

Date: 28 October 2014

Care Focus South West, Community Interest Company

Summary of organisational developments affecting safeguarding and how the focus upon this area of work is maintained

As an organisation, our audience has grown from registered care providers to include housing, health, community, volunteers, the public etc.
All staff are expected to have an understanding of safeguarding and on-going learning is provided through team meetings, supervision and training.

Training and other development activities undertaken within the organisation

Care Focus was commissioned by Somerset CCG to deliver safeguarding training to the 75 GP practices in Somerset. This was delivered at a time convenient to the practice (often lunch-time or early evening) and was attended by all staff disciplines e.g. GP's, admin, pharmacists, district nurses.
As part of Care Focus' community interest, we have invested in both Village Agents and Healthwatch by providing safeguarding training to the volunteers and staff, free of charge.

Care Focus is commissioned by Somerset County Council to engage with care providers in the county to improve quality. This is both preventative and remedial and occurs through meetings at the home or provider site, workshops, meetings and Learning Exchange Networks. Safeguarding is both a key and continuous area of focus.

Care Focus supports Somerset County Council with the promotion and delivery of learning and development opportunities and training.

Application of key learning from Serious Case Reviews and other review processes

Care Focus' role is to ensure the key areas of learning from serious case reviews is disseminated to all care providers. This is undertaken through either producing, in partnership with SAB and SCC, an easy to read 'key points' sheet or distributing the review report. These are circulated through email and available on the Care Focus website as well as being discussed with providers at meetings, networks and events.

Contribution to the work of the Board and its sub-groups

Care Focus is a member of the Board, Lessons Learned and Training sub-groups.
We actively contribute through our involvement in the development of programmes, projects, supporting events, conference etc.

Planned safeguarding activities for 2014/15

Supporting raising public awareness through increased promotion.
Promotion of national helplines and smart phone apps etc that support individuals and organisations with increased understanding and raising alerts.
Continued support to care providers.

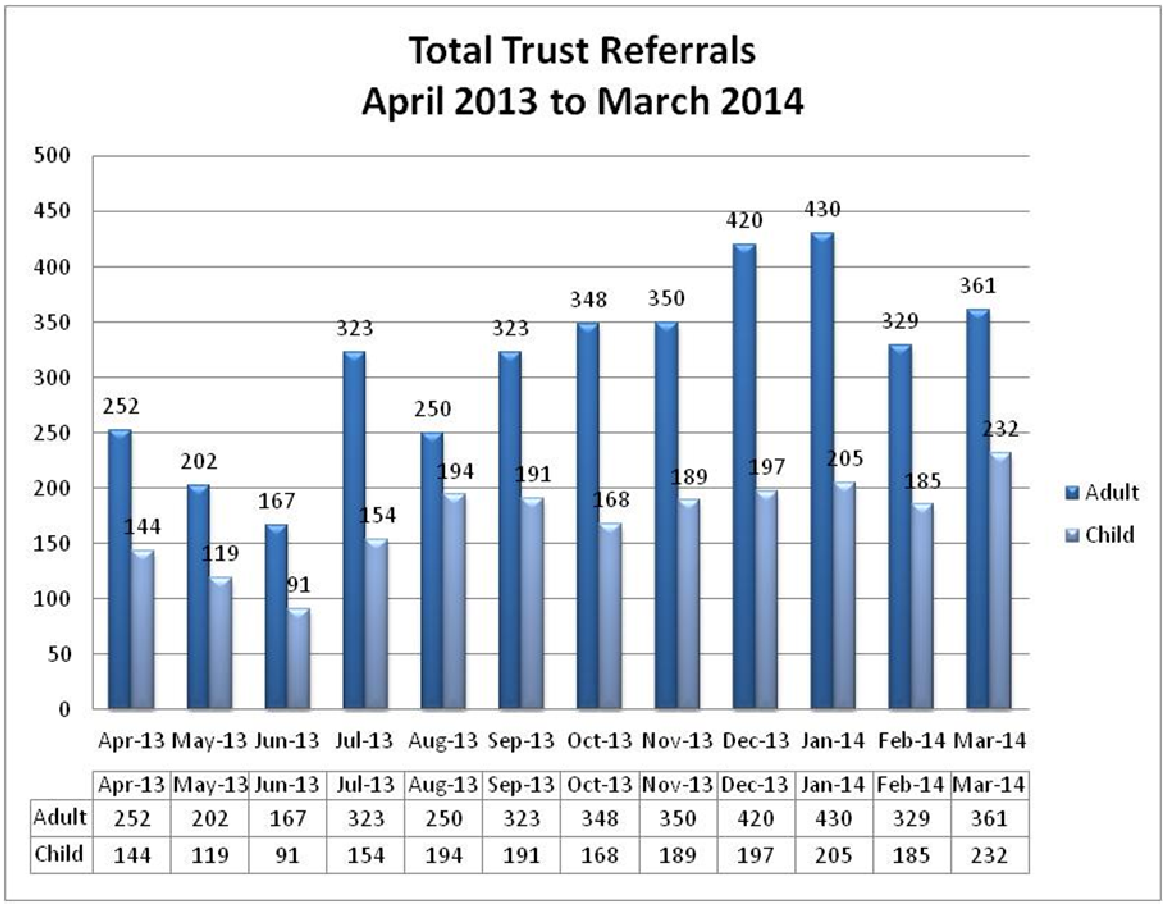
Increase support to health providers. Development of training and support to housing providers. Promotion of learning and development opportunities. Increased distribution of 'Keeping safe in your own Home' brochure.
Issues for the Board's consideration during the coming year Training offer to health, social care and housing providers.

Report completed by: Claire Waddon **Date: 23rd June 2014**

South Western Ambulance Service – Sarah Thompson Head of Safeguarding

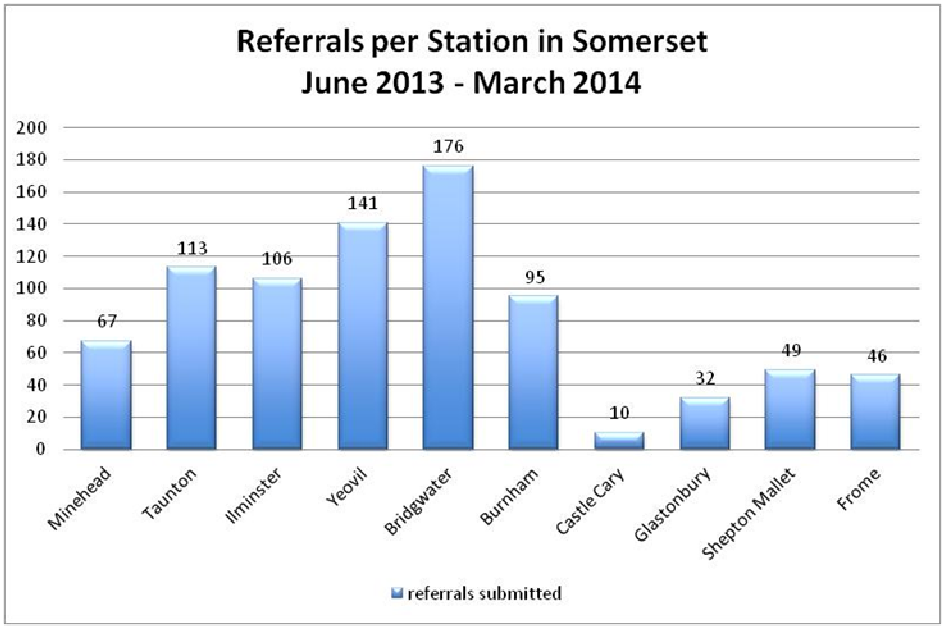
Summary of organisational developments affecting safeguarding and how the focus upon this area of work is maintained

8.1 The number of adult and children referrals are shown in the graph below.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Adult	252	202	167	323	250	323	348	350	420	430	329	361
Child	144	119	91	154	194	191	168	189	197	205	185	232

8.2 3755 (63%) were adult referrals and 2069 (27%) were for children..



Somerset produced 835 referrals which is the area with the second highest amount of activity. Dorset and Somerset produce 36.5% of all the activity.

Training and other development activities undertaken within the organisation

14.1 The Director of Nursing was appointed in March 2014 to replace the previous interim Board Lead for Safeguarding

14.2 With this appointment, the Safeguarding Service workforce has reached full establishment to include a full time Named Professional to the North Locality successfully recruited and commenced on October 2013.

14.3 Successful recruitment to recruit an additional band 4 position (senior administrator) to support the existing band 3 administration assistant, commenced December 2013.

14.4 Despite the challenges of the limited workforce at some points in the year, all SCR information was relayed as appropriate.

14.5 The safeguarding referral system is more sophisticated to produce quality data.

14.6 A successful Peer Review took place in Feb 2014.

14.7 All frontline staff have been offered level 2 training in safeguarding with an overall attainment of 90% staff attendance.

14.8 All new 111 or 999 staff have had safeguarding training as part of their induction programme.

14.9 A training programme for OOH GP's commenced in March 2014 with other dates set through the coming year.

14.10 The Safeguarding Manager took part in the 'drinking heads' public health campaign to alert the public to the effect of drinking when looking after a child. This was highlighted on BBC spotlight and in posters on public transport.

14.11 The 111 and 999 Hubs have dedicated safeguarding champions.

14.12 A safeguarding referral audit was completed which has shaped the referral process.

14.13 The managing allegations policy has been embedded in the operational services.

14.14 Domestic Abuse training has been agreed on the SME training for 2014-15 and the clinical tutors have been trained in preparation for the sessions.

Application of key learning from Serious Case Reviews and other review processes

6.1. We have met recommendations set by several safeguarding boards due to the commitment of the trust to safeguarding training e.g. South Gloucestershire – we were able to inform this board that we had completed our 4 actions following a DHR (domestic homicide review).

6.2. This demonstrated good triangulation from the safeguarding service implementing a training need analysis for DA training, the training department recognising the need and the safeguarding board being satisfied with the implementation.

Contribution to the work of the Board and its sub-groups

2.1 SWASFT are aligned to 28 Adult and Child Safeguarding Boards within the operational area. The trust endeavours to maintain relationships with all these organisations in the interests of their responsibility to safeguard but due to the complexity and unique coverage, an efficient and pragmatic approach needed to be agreed.

2.2 Following National Guidance, the trust has proposed to work with the Boards under a 'memorandum of understanding' agreement to maintain communication relationships with all Boards. These are outlined below:

- The Safeguarding Manager will attend the Boards by exception and/or sub groups as appropriate.
- The trust will remain fully engaged with the Child Death Review Process. (Front Line staff who have attended a child death will be invited to attend these meetings supported by the Named Professional safeguarding leads.)
- The Safeguarding Manager or her deputy will attend the Child Death Overview Panel (CDOP) meetings in each LSCB.
- The trust will co-operate with the Serious Case Review (SCR) process as they arise either by providing a chronology, information of contact or a full individual management review,(IMR),depending on the involvement of the

Ambulance Service.

- The Safeguarding Manager will attend as part of the SCR Panel as appropriate.
- The trust will attend or provide information, as appropriate to adult/child case conferences
- The trust will attend or supply information to Strategy meetings after a child/adult has died or is seriously injured.
- The trust will co-operate with audits as appropriate e.g. the section 11 audit requests or as part of a research group.
- In addition, the trust may be represented on task and finish groups which directly effect the workings of the ambulance service egg trigger groups, drug and alcohol forums and conveyance of mental health patients

2.3 For the latter part of this year, the work of the Boards has been divided per locality, since the commencement of the Director of Nursing, between the Safeguarding manager and herself with deputisation from the named professionals

Planned safeguarding activities for 2014/15

15.1 The priorities for the Safeguarding Service were decided at the team meeting in March 2014.

15.2 These are:

- Ensuring the completion of a centralised recording system for safeguarding training across all departments.
- Ensuring the appropriateness and quality of safeguarding referrals.by the recruitment of a triager
- Work plan to be guided by the Peer Review
- Embed the Prevent agenda
- Research in to child death and the response for frontline practitioners
- Implications from the Care Bill making adult safeguarding statutory
- Expansion of the Mental Health agenda
- Consider the safeguarding service in the new Nursing and Governance structure

Issues for the Board's consideration during the coming year

4.1 Due to the nature of the safeguarding 'business' there are many other medians used to assess performance including outside monitoring bodies such as the Care Quality Commission, the clinical commissioning groups and this year in a Peer Review undertaken in February 2014 by London Ambulance Service and South Central Ambulance Service.

4.2 The positive themes from the Peer Review were:

- *The Deep Dive reports at Quality Governance Committee are an example of good practice*
- *Professional support for the safeguarding leads is in place and working effectively*
- *Numerous staff and managers reported how effective and important the safeguarding manager has been since her arrival*
- *The named professionals were praised during the review for the engagements with partners*
- *There is effective triangulation between the Trust Board, operational staff and the safeguarding service*
- *Action learning from serious case reviews is built into training programmes and communicated across SWASFT as appropriate by regular updates to the clinical news or Trust Bulletin*
- *SWASFT have clearly developed safeguarding processes and procedures considerably in the last year and this is largely down to the expertise and knowledge of the safeguarding manager and commitment of the whole team*
- *The way the Trust has handled the acquisition has aided the development of the safeguarding service.*

4.3 The 11 recommendations from the Peer review are outlined in an action plan –

4.4 The Service has undertaken a referral audit in June 2013.This base line audit provided a marker for improvement in information sharing practice between our staff and external care services agencies, general practitioners and nominated safeguarding professionals.

4.5 The findings of the safeguarding referral audit contributed to the development of a single referral system across the newly integrated trust.

4.6 It identified good practice and indicated areas for improvement. It measured the quality of the information provided via the various methods of submission and from all grades of staff across all areas of the trust.

4.8 Evidence of double handling and fruitless submission of incomplete forms were identified providing an opportunity for the safeguarding team to rectify the situation, target training and raise standards

4.9 It indicated where the safeguarding referral process was being used inappropriately and enabled the safeguarding team to redirect non-safeguarding concerns to existing pathways (i.e. right care, falls and frequent caller pathways) thus ensuring that our service users get the most appropriate support to promote and maintain their health and wellbeing.

4.10 Information regarding the type and nature of our most common types of referrals was used in future staff training, providing support and guidance on the management of these situations (e.g. welfare, parental incapacity and mental health issues)

4.11 Finally it gave the safeguarding team an opportunity to review its data management, ensure security of patient identifiable information and ensure that the information captured is appropriate and managed efficiently.

Report completed by: Sarah Thompson 19/6/14

Taunton and Somerset NHS Foundation Trust

Summary of organisational developments affecting safeguarding and how the focus upon this area of work is maintained

We are continuing to develop and revise our policies that relate to vulnerable adults. We are currently updating our Safeguarding Vulnerable Adults policy to include organisational changes in our internal processes. This follows a decision to have a wider organisational involvement in safeguarding with less reliance on a single adult safeguarding lead. This has led to wards being responsible for making their own safeguarding referrals and the ward Matrons having a greater role in supporting the wards and providing advice. The Matrons have had training in their new role in supporting ward staff. This change means that we now have a much broader organisational involvement with safeguarding and Mental Capacity.

We have started a review of our restrictive care practices in light of the recent Supreme Court ruling on Deprivation of Liberty as well as the new Department of Health guidance "Positive and Proactive Care".

Our focus upon safeguarding is maintained by the Clinical Lead for Safeguarding Adults, the Matrons and the Trusts Safeguarding Committee. The Trust has also appointed a non-executive lead for safeguarding to represent adult safeguarding on the Trust Board.

The safeguarding work is managed through an active plan of work that is overseen by the Safeguarding Committee. Our progress and success in achieving our plans is monitored through the regular Safeguarding Committee and through an annual report. This is supplemented by an ongoing audit programme looking at the Trusts staff awareness of our policies and procedures.

Training and other development activities undertaken within the organisation

Safeguarding continues to be part of Trust Induction and Corporate Essential Update training programme. Training sessions for Safeguarding and Mental Capacity are run every month as well as tailored training being provided regularly for the Emergency Department and Bank Staff.

Our key training focus this year has been aimed at Mental Capacity Act Training for senior doctors. This work has been supported by the Trusts Medical Director. We are working towards having a Medical Lead for Mental Capacity to strengthen our training and awareness.

Application of key learning from Serious Case Reviews and other review processes

We have completed work on our Learning Disability policy, which now reflects issues raised at a multi-agency review, which centred primarily around discharge processes.

A review of our Domestic Abuse policy and procedure is also underway which includes findings from a recent Domestic Homicide Review.

Contribution to the work of the Board and its sub-groups

The Trust continues to be represented at the Safeguarding Board and at the Operational Sub-Group of the Board. As required we have also contributed to short running groups that have been asked to look at specific multi-agency safeguarding issues.

Planned safeguarding activities for 2014-15

Our plans for the coming year include a review of our restrictive care policies and procedures in light of recent national developments. We are also planning to amend our processes around Deprivation of Liberty in consultation with the County Council Deprivation of Liberty Office to ensure our practice is in line with the recent Supreme Court ruling. Within our work on developing our DoLs processes we will be giving a larger role to the Matrons in considering and authorising applications. This will broaden our current engagement and allow us to increase our authorisations in line with the Supreme Court's judgement. Specific Training for the Matrons around DoLs is currently being arranged.

Following an award of £20,000 to support Mental Capacity training and awareness we have started to look into the appointment of a medical lead for the Mental Capacity Act to further support training and awareness raising amongst senior clinicians. Our primary measure of success in this work will be evidence of greater engagement with the IMCA service and a rise in appropriate IMCA referrals.

Work has also started looking at having Independent Domestic Violence Advocates based in the hospital. This should lead to a significant improvement in our work with domestic abuse and also help in cases of domestic abuse involving adults at risk.

Issues for the Board's consideration during the coming year

To reconsider the discontinuation of the Mental Capacity and Deprivation of Liberty Sub-group, that provided a very useful multi-agency forum, for looking at Mental Capacity Act and Deprivation of Liberty issues.

An increased multi-agency focus specifically for DoLs seems to be required to develop a more co-ordinated approach to implementing the Supreme Court's judgement.

The group could also look at making a contribution to the national debate on the DoLs agenda.

Report completed by: **Duncan Marrow (Clinical Lead for Safeguarding Adults)**
Date: 12/05/2014

Yeovil District Hospital NHS Foundation Trust

Summary of organisational developments affecting safeguarding and how the focus upon this area of work is maintained

Yeovil District Hospital NHS Foundation Trust (YDH) continues to hold quarterly Adults at Risk Committee meetings which are chaired by the Trust Lead for Adult Safeguarding, the Associate Director of Nursing for Elective Care. This forum allows issues that are discussed at the Somerset SAB meetings to be bought back to YDH and influence the development of work streams as a consequence. The progression of this and other work (such as that identified through learning from Serious Case reviews) is monitored through these quarterly meetings.

YDH has responded to the specific needs of a growing number of patients with dementia through the development of a team which consists of the Dementia Nurse Consultant, Dementia Care Coordinator and an apprentice. These professionals are developing their specialist knowledge to include the Mental Capacity Act, ensuring its correct implementation when caring for patients with dementia. This team is linking in closely with the Safeguarding Adults Clinical Lead who continues to receive support in her role from the Discharge Facilitator and the Acute Learning Disabilities Liaison Nurse (ALDLN).

Audits have been carried out to ascertain adherence to the internal safeguarding reporting process and the information from the subsequent report is expected to shape future work plans.

Training and other development activities undertaken within the organisation

YDH continues to provide face to face safeguarding adults awareness training to all staff commencing employment (paid or voluntary) within the organisation via the induction training programme. There is also an ongoing programme of mandatory training for all staff (level 1 for non-clinical staff and level 2 for clinical staff) which has to be attended every 3 years. We have developed workbooks for each level of training as a way of evidencing all staffs understanding of the subject matter. Level 3 training is provided bi-annually, and as required, with support from external agencies such as the Local Authority, IMCA service and Legal representatives, and includes case studies examination, implementation of the Mental Capacity Act and DoLS training. We provide a monthly Health WRAP workshop session open to all staff (but with a focus on high risk areas such as ED, EAU and Ward 10) to raise staffs awareness of their responsibilities in relation to the PREVENT agenda.

The Emergency department leads on the programme of training sessions specifically related to the issue of domestic abuse and provides sessions to all ED staff but these are also open to all in YDH with a relevant professional interest.

Application of key learning from Serious Case Reviews and other review processes

The Trust continues to push forward its initiatives to improve patient safety with engagement from all disciplines following the recommendations in the Francis report. In addition the front of house team has been strengthened to ensure staff are easily accessible should relatives, carers or visitors wish to raise concerns.

Contribution to the work of the Board and its sub-groups

The Trust Safeguarding Adults lead continues to attend the quarterly Board meetings and when unable to due to annual leave ensures the Clinical Safeguarding Lead attends in her

absence. The clinical Safeguarding Adults lead also attends the operational sub-group and the ad-hoc meetings held in relation to developments in the arena of Mental Capacity.

Planned safeguarding activities for 2014-15

Currently underway is the development and appointment of a qualified Safeguarding Adults Advisor role to support the Safeguarding Adults Clinical Lead in her role.
Following the House of Lords Report Post Legislative Scrutiny of the Mental Capacity Act (2014) YDH intends to focus on embedding knowledge and understanding of the MCA via funding obtained from the CCG. This includes the funding of a specific MCA Lead post for 2 days a week for the next year with the remit of auditing current knowledge and practice, coordinating and part presenting MCA specific update training for all qualified nursing and medical staff plus final audit for evaluation of progress.
Working with the Local Authority, funding has also been obtained to provide one year of an Independent Domestic Violence Advisor (IDVA) to be based in YDH emergency department providing support to patients who may be experiencing domestic abuse, supporting staff in the development of their understanding of the issues involved and providing training as required.

Issues for the Board's consideration during the coming year

None identified at present.

Report completed by: Maddie Groves, Associate Director of Nursing for Elective Care and Julia Hendrie, Safeguarding Adults Clinical Lead
Date: 26/6/2014

Registered Care Providers Association Ltd Somerset

Summary of organisational developments affecting safeguarding and how the focus upon this area of work is maintained

The RCPA engage with and contribute to a number official forums where quality and safety is at the heart of their considerations, including the CCG Health and Social Care Quality Assurance Group, CCG Continuing Healthcare, Acute Hospital Discharge Groups, SCC Quality Policy Group. As a larger group of Local Care Associations, known as the Care Association Alliance, the RCPA engage with the ADASS Safeguarding lead and the Department of Health. The RCPA sits on the National Skills Academy for Social Care, Care Manager Development Steering Group,

Training and other development activities undertaken within the organisation

We do not deliver training directly but deliver an Annual Care Conference to the sector.

Application of key learning from Serious Case Reviews and other review processes

Key learning from SCRs and other learning are regularly shared with members via our internal Newsletter. The RCPA represents the majority of care providers in Somerset.

Contribution to the work of the Board and its sub-groups

The RCPA contributes to the work of SCC Safeguarding Adults Board, SCC Safeguarding Learning Lessons Sub Group, SCC Safeguarding Training and Awareness Sup Group.

Planned safeguarding activities for 2014/15

We plan a further 4 mini seminars for next year one of which will concentrate specifically on Safeguarding in addition to our regular Annual Care Seminar.

Issues for the Board's consideration during the coming year

Detailed and regular analysis and interpretation of safeguarding investigations to contribute to public and care sector understanding and learning.

Report completed by:
Roger Wharton
Executive Officer,
RCPA Ltd

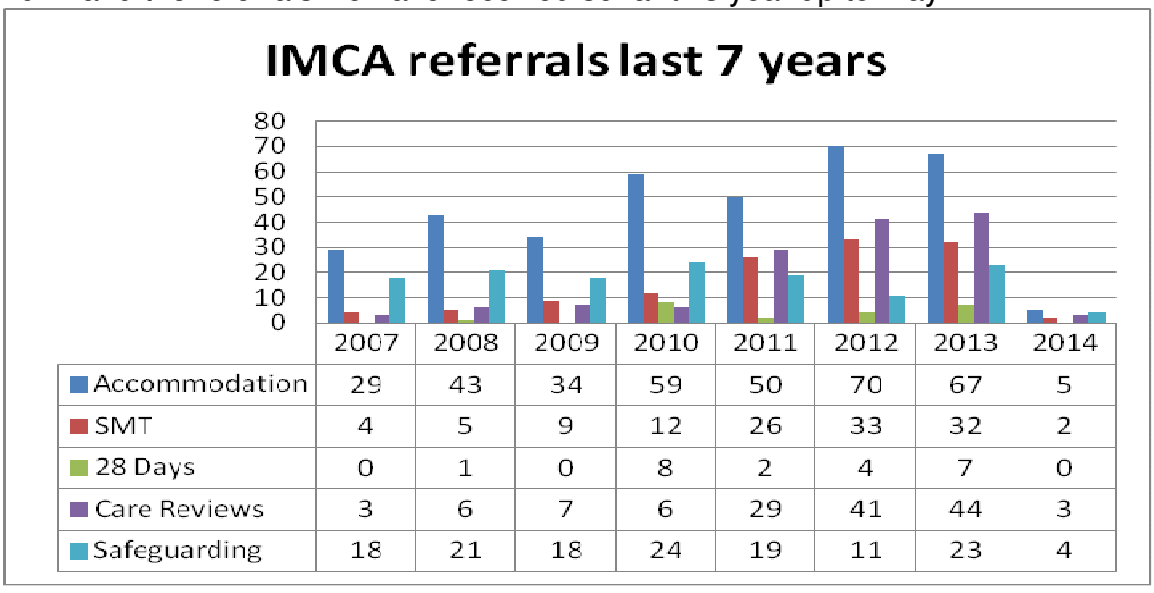
Date: 2 November 2014

Advocacy in Somerset - Independent Mental Capacity Advocacy service

What does the Independent Mental Capacity Advocacy service do?
IMCAs are there to represent and support people when they have been deemed to lack capacity to make specific decisions and they have no family, friends or unpaid carers to speak up for them. In safeguarding referrals an IMCA can be involved ven if the person without capacity is befriended.

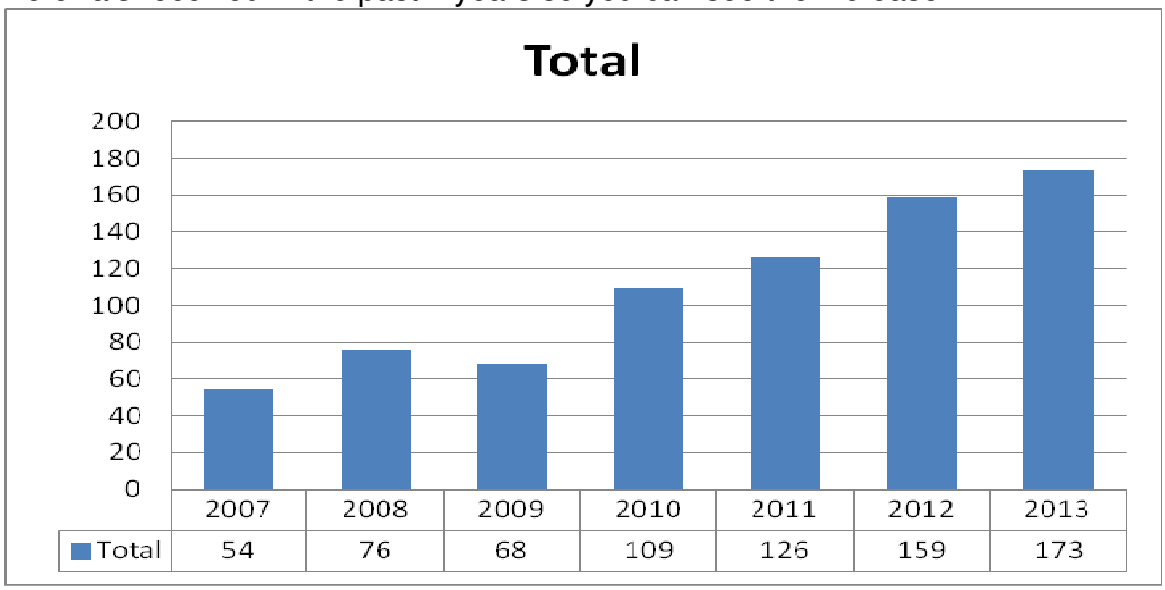
Decisions we are involved in under the Mental Capacity Act
Duty to instruct
Change of Accommodation
Serious Medical Treatment
Stay of more than 28 days in hospital
Power to instruct
Care Reviews
Safeguarding
Roles we undertake under the Deprivation of Liberty Safeguards
39A
39C
39D
Paid Representative

Referrals
This graph shows the number of referrals we have received over the past 7 years 2007 – 2014 and the referrals we have received so far this year up to May 1st.

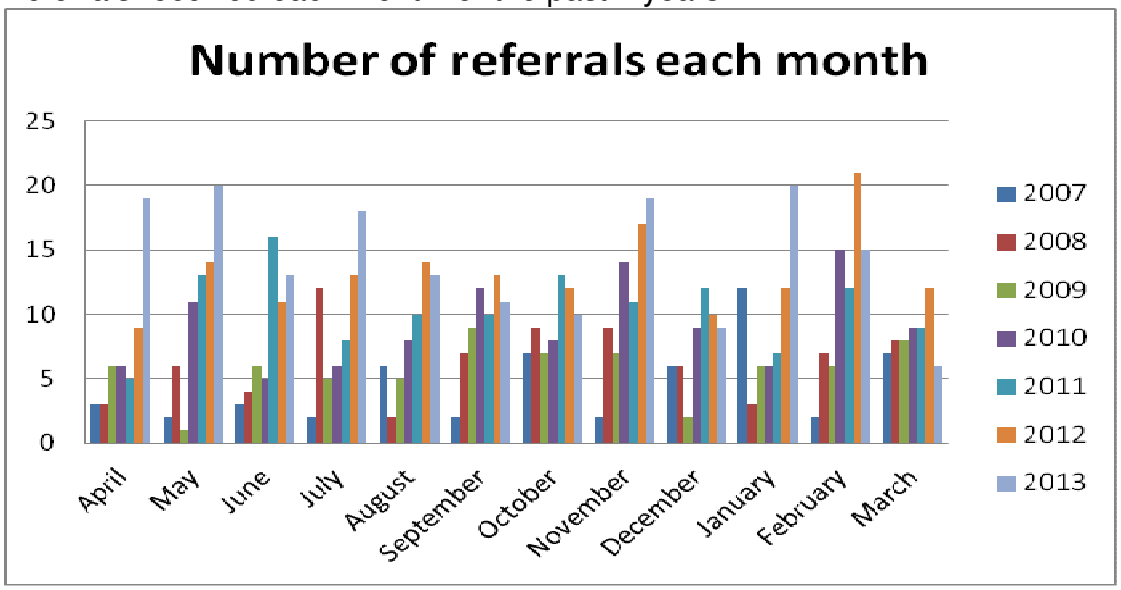


	2007	2008	2009	2010	2011	2012	2013	2014
Accommodation	29	43	34	59	50	70	67	5
SMT	4	5	9	12	26	33	32	2
28 Days	0	1	0	8	2	4	7	0
Care Reviews	3	6	7	6	29	41	44	3
Safeguarding	18	21	18	24	19	11	23	4

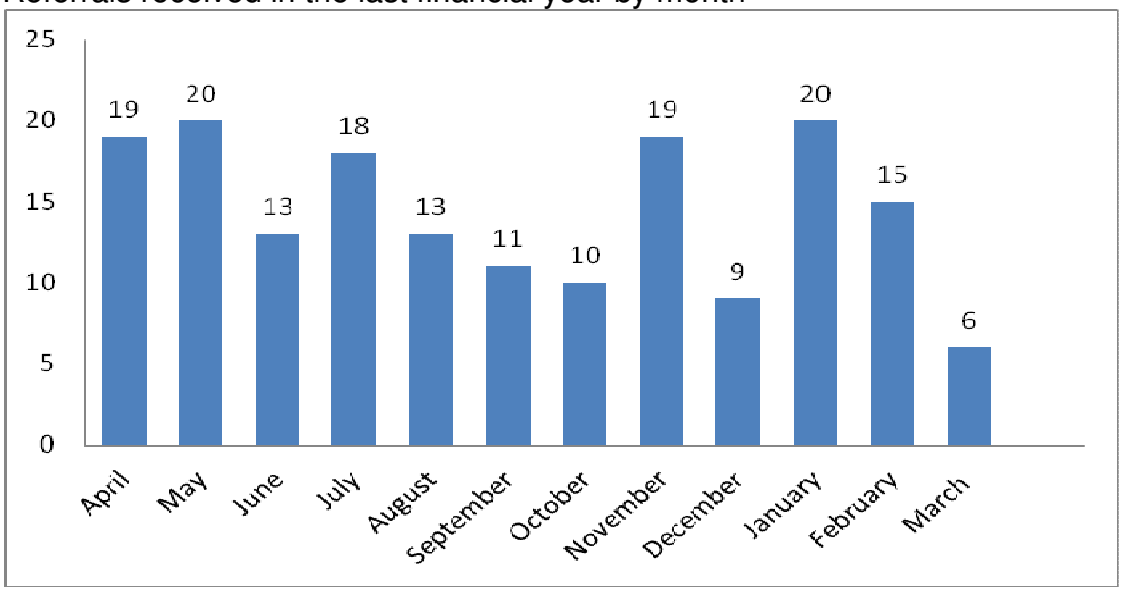
Referrals received in the past 7 years so you can see the increase.



Referrals received each month for the past 7 years.



Referrals received in the last financial year by month

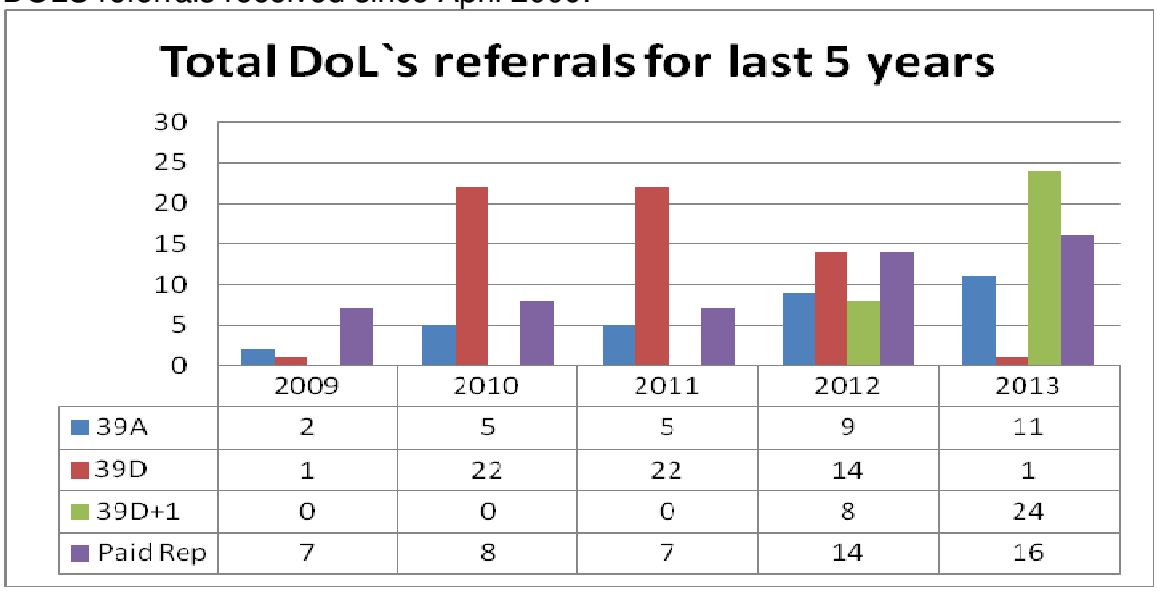


Deprivation of Liberty Safeguards

We have now been receiving Deprivation of Liberty referrals for the fifth year running. The IMCA service supports people through the assessment process, provides support for the person during a change of Representative and supports family members who take on the Representative Role. James, Sally and I also take on the Representative Role when there is no one else available to provide this.

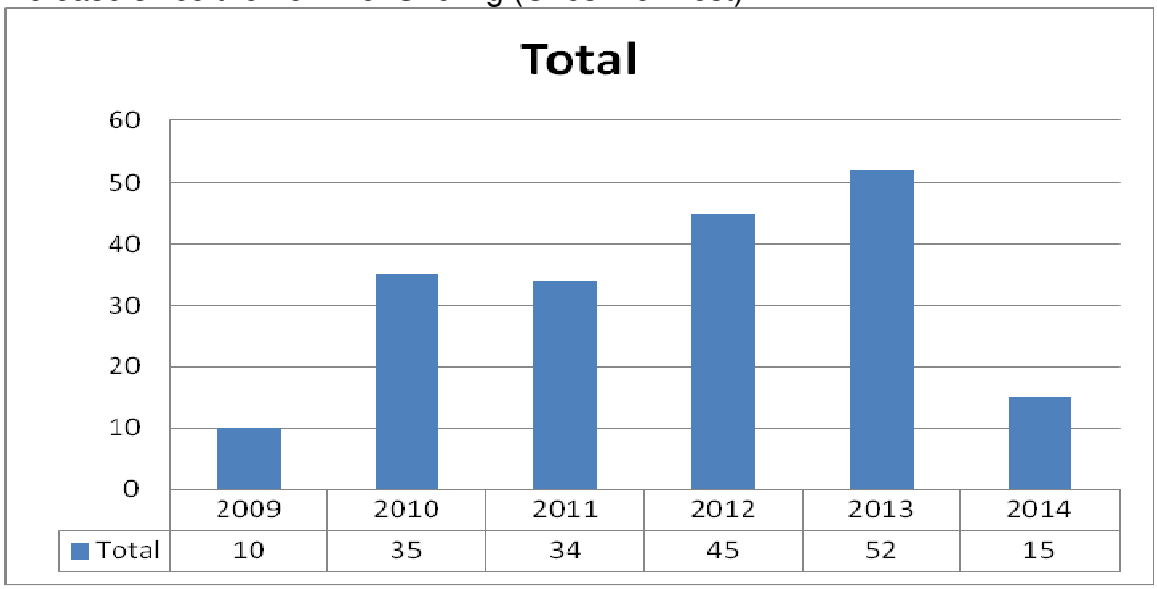
On Wednesday 19th March it was announced that the original DoL`s ruling has been overturned in the Supreme Court which in turn has now lowered the threshold for DoLS authorisations. This now means that many more people will now be deprived of their liberty under this new ruling thus meaning more referrals for the IMCA service. As you will see in the second graph below in the last financial year we had 54 DoLS referrals which is an increase from the previous year but in April 2014 alone we have had 15 referrals which is a huge increase. As the Supervisory Body refer nearly everyone to us that has been deprived of their liberty, which is seen as good practice, then we envisualise that this number will increase significantly and quickly. These referrals below are from the Somerset Supervisory Body and do not include all the out of county residents that will need to be deprived of their liberty as well.

DOLS referrals received since April 2009.



	2009	2010	2011	2012	2013
39A	2	5	5	9	11
39D	1	22	22	14	1
39D+1	0	0	0	8	24
Paid Rep	7	8	7	14	16

DOLS referrals by year including the first quarter of the current financial year showing increase since the new DoLS ruling (Cheshire West)



	2009	2010	2011	2012	2013	2014
Total	10	35	34	45	52	15

Staffing

Up until the beginning of the last financial year the IMCA service was staffed by me (Becky) and my colleague James, however since being given some additional funding we have been able to take on Sally Gough as a sessional worker. Sally has proved to be a valued member of staff and by having her on board some of the pressure that was being experienced particularly last year has been relieved. Sally has been working her way through the IMCA qualification this past year and in two weeks times will have completed the final part of the DoLS unit.

I work Monday to Friday 9-5 and James works 9-5 Mondays and Tuesdays and 9-12.30pm on Fridays. He has another job on Wednesdays and Thursdays. Both James and I are also fully qualified IMCA`s having completed the Level 3 Diploma in Advocacy which consisted of four core units and the IMCA/DOLS units.

SWIG (South West IMCA Group)
Becky continues to be the Net Work Coordinator for the SWIG meetings. Twelve IMCA services from the South West meet every three months to discuss issues that they are all having, updates and general information sharing. This group is now funded by all the IMCA services and we also have the benefit of having a Mental Capacity Act Solicitor Katie Webber, come to our meetings for free to give us updates on case law and generally give us a legal view on some cases that we may be working with. It`s great that we are all continuing this as it shows that we all find it very beneficial and a valuable resource.

Issues arising
Safeguarding referrals
In the latest IMCA Annual report from the Department of Health there has been a recommendation made – *It is recommended that local authority safeguarding coordinators consider the statistics in this report and report to their Safeguarding Adults Boards on whether safeguarding cases are receiving IMCA support where appropriate.* This recommendation was also made in the previous DoH report.

Safeguarding referrals still remain low, this is obviously a power to instruct and not a duty however could also be a benefit to the person subject to the Safeguarding process if they lack capacity. We are not sure whether people are fully aware that they have this power despite giving training around our role. Having spoken with Chris Hamilton about this we are aware that we should be receiving certainly more referrals than we are.
Although it is a power to instruct and not a duty it really can be a benefit to the person in the middle of the Safeguarding to have an Independent Advocate as so often their voice is lost even when they may have the most proactive family members involved with them. It`s important that there is someone there to keep that person at the forefront of all the decision making.

SMT referrals:
Serious Medical Treatment referrals still remain fairly low and 28 day referrals have still continued to be low this past year.
We are still finding that DNAR (Do not attempt resuscitation) is still being put on people`s notes with no assessment of capacity or best interests checklist or any documentation to support this.

Inappropriate referrals
We have been receiving a lot of referrals where the person in question is actually befriended but because the family or friends are in disagreement about the proposed decision or are disagreeing amongst themselves they have been referring to the IMCA service in the hopes that we will sort it out. The IMCA remit is clear that we only work with people that have no appropriate family, friends or unpaid carer`s to speak up for them (unless it`s Safeguarding), people in disagreement doesn't necessarily make them inappropriate to consult. Because we had an increase in these types of referrals we took this to our commissioner who was clear that we should not accept referrals for people that already have appropriate people to consult with. IMCA`s are there instead of family and friends not as well as**.** We are also finding that we are getting referrals that we start work on and then they get withdrawn, either because the person has capacity or they are in fact befriended, this can be quite frustrating at times.

Referrals too late
We have found on occasions that the referral we receive is often sent in too late for us to be able to provide the most appropriate support to the person in question. Some examples – We`ve had several accommodation referrals come in when the planned move has been going on for some time and then we get the referral with a week`s notice before the person is supposed to move, in one of those cases the decision maker actually wrote in the person`s notes that they needed an IMCA but that would only slow the process up!! I might add that when we did receive that particular referral I was able to send Sally out the next day and the report was in to the decision maker the day after that. Another referral that we received for Safeguarding was six months after the Safeguarding process started, this really isn't appropriate and especially not for the person that needs the support.

Litigation friend
We have been asked to be a Litigation friend on two occasions now, both of which we`ve turned down on the basis that we are not funded to provide this service and do not have the resources at this time to do so. This is going to become more of an issue as time goes on as more cases are going to the Court of Protection, if the person does not have any family or friends to act as a Litigation Friend then it is generally the Official Solicitor that would take this role on, however it appears that more and more IMCAs are being asked to be Litigation friends as they are seen as the most appropriate people to do this if they have no one else. The Official Solicitor is now refusing to take cases unless all efforts to find a Litigation friend have been explored mainly due to the fact the OS is incredibly busy. Unfortunately when the person needing the Litigation friend does not have anyone to take this role and it is reliant on the OS then this in turn can lead to significant delays which clearly isn't in the best interests of the person, they can be left waiting for a long time before their case goes to court and in some cases people do not have time on their side. There is a need for a Litigation friend service to speed up some of these processes, as Solicitors seem to be recommending that this should be IMCA`s if there is no one else then this will need further discussion……

Further training…
Although we have discussed previously that as a service we should stop providing training to other professionals around our role, I actually think that this does need to happen to try and prevent some of the inappropriate referrals and to make sure that those that need an IMCA are getting one as the knowledge of the IMCA role is still not widely known even after seven years!

Becky Facey, IMCA service manager, Advocacy in Somerset

END