Somerset Safeguarding Adults Board

Annual report 2012-13

Contents

Chairperson's introduction

Safeguarding Adults in Somerset in the past year

The past year has seen a continuation of the increasing levels of safeguarding activity as well as the public levels of concern about the treatment of those who are dependent upon others for their care. This is a national trend and is to be welcomed and reflects public and staff awareness and preparedness to report concerns.

The legal status of adult safeguarding work continues to be a topic of national discussion and there is optimism that many of the recommendations of the Law Commission proposals on adult care services will provide a more robust underpinning for Adult Safeguarding nationally and in Somerset. The proposals in the Care Reform Bill include:

- Setting the Adult Safeguarding Board on a statutory footing
- Establishing a legal duty for the local authority to investigate concerns about the abuse or neglect of vulnerable adults

The transfer of responsibility, under the Health and Social Care Act, for the Deprivation of Liberty Safeguards in hospitals from the Primary Care Trust to Somerset County Council in April 2013 was managed smoothly. This provision under the Mental Capacity Act is a vital protection for the increasing number of people who lack the mental capacity to make significant decisions about their daily life, living and care arrangements. The Deprivation of Liberty Safeguards as currently formulated apply only to residents in care homes and hospital patients. Overall levels of DOLS applications and activity in Somerset have slightly increased. An increase is expected as care providers are trained and understand how to apply the very positive Deprivation of Liberty process in the best interests of their patients and residents. An appeal judgement to be heard in the Supreme Court in October 2013 may provide greater clarity and thus greater consistency of application across the country.

NHS organisations in Somerset have worked hard to raise the profile of adult safeguarding in their organisations, but levels of reporting of safeguarding concerns/incidents to the local authority remain low. It is anticipated that the Clinical Commissioning Group will work closely with the Trusts in the coming year to establish the appropriate understanding and processes that involve the local authority safeguarding team at an early stage.

In 2012/13 the Board published its locally revised policy and procedure document 'Safeguarding Adults at risk in Somerset' which will be revised in early 2014.

Although there have been no Serious Case Reviews in Somerset in 2012/13 a small number of multi-agency Significant Event Audits (SEA) have been undertaken.

The organisation of the Board itself has undergone some changes. Restructuring of senior management affected several Board member organisations since the last report and so Board membership has changed. Member organisations have underlined their commitment to effective safeguarding by the establishment of clearer lines of responsibility and representation at the Board. The newly established

membership revised the Board groups/meetings structure and the Clinical Commissioning Group have ensured that a commissioning GP representative is a member of the Learning the Lessons sub-group.

In spring 2013 the Board took the significant decision to appoint an Independent Chair, recruiting in autumn 2013. The national trend is for 3 year appointments of Independent Chairs to Adult Safeguarding Boards and Somerset wants to take advantage of the challenge and fresh perspectives offered by such a post, to assist the Board to continually improve adult safeguarding in Somerset. Each of the statutory partners will contribute to the costs of the Independent Chair, again strengthening the ownership of the Board and its effectiveness by member organisations.

In summary, this has been a year of flux within Board membership, due to significant organisational change, but the commitment to safeguarding has been strengthened, not weakened during the year. I look forward to working with the Board and other stakeholder groups to increase our effectiveness in adult safeguarding in the coming year.

Clare

2012-13 Safeguarding activity report

Summary

There is a significant change in how we are presenting statistical information in this year's report. Previous reports have analysed information about alerts or referrals but for this report we have been able to look in greater detail at those concerns which have been wholly or partly substantiated and to make a comparison with similar information from 2011-12.

The last reporting year for safeguarding activity has seen a significant increase in concerns brought to the attention of Somerset County Council and requiring decision-making and investigation as shown in the table below. This increase is typical of most local authority areas and when adjusted for population size safeguarding activity levels in Somerset are broadly in line with comparable areas. This pattern of year on year significant increases in referral rates is posing a significant workload challenge to all local authorities.

A sizeable proportion of the increase in the number of investigations and substantiated concerns relates to improved recording processes for the investigation of whole service concerns but the significant initial referral increase continues to highlight raised levels of awareness especially among professional staff. Not surprisingly an increased willingness to report concerns may be related to the raised profile of adult abuse and neglect arising from the Stafford Hospital and other investigations. Interestingly though we have not seen a significant increase in alerting by relatives of vulnerable people themselves.

There is currently much work underway within the NHS to ensure that where safeguarding concerns about hospital care arise these are appropriately identified and reported to the local authority to provide a degree of external scrutiny. The range of internal investigation processes do not often use the language of 'safeguarding' so this is proving to be a challenge. SCC is working closely with the hospital services on this because the current level of reporting (only 4 concerns in this 12 month period) is not felt to be at all accurate.

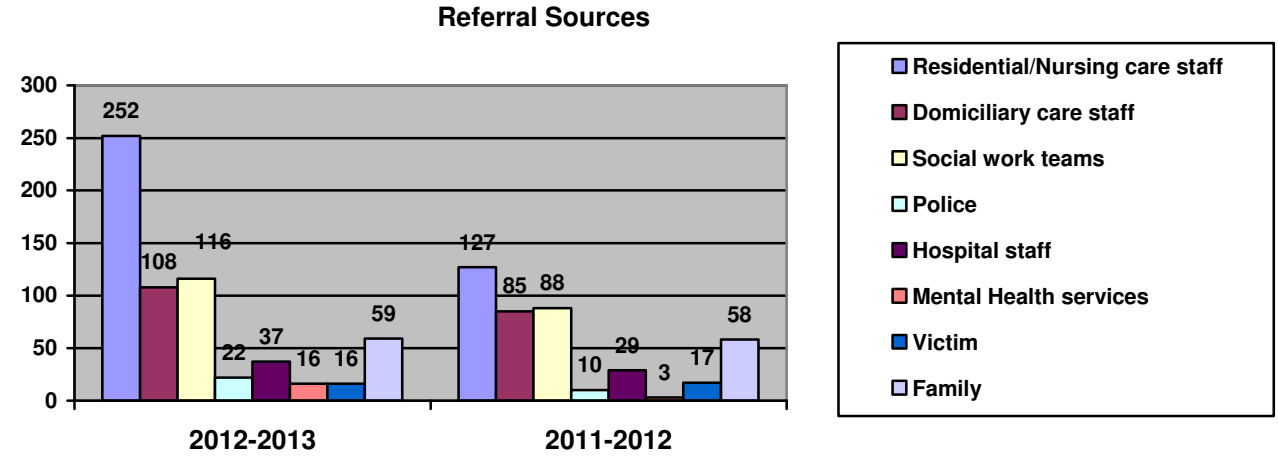
Activity Levels

	Individual Safeguarding alerts	**Accepted for safeguarding investigation**	**Whole or partly substantiated concerns** [note 1]
2011/2012	1400	577	352
2012/2013	**2096** [note 2]	**676**	**425**
% change	+50%	+17%	+21%

note 1 – A single alert or investigation may address more than one concern
note 2 – 10 whole service investigations affected a further 204 people

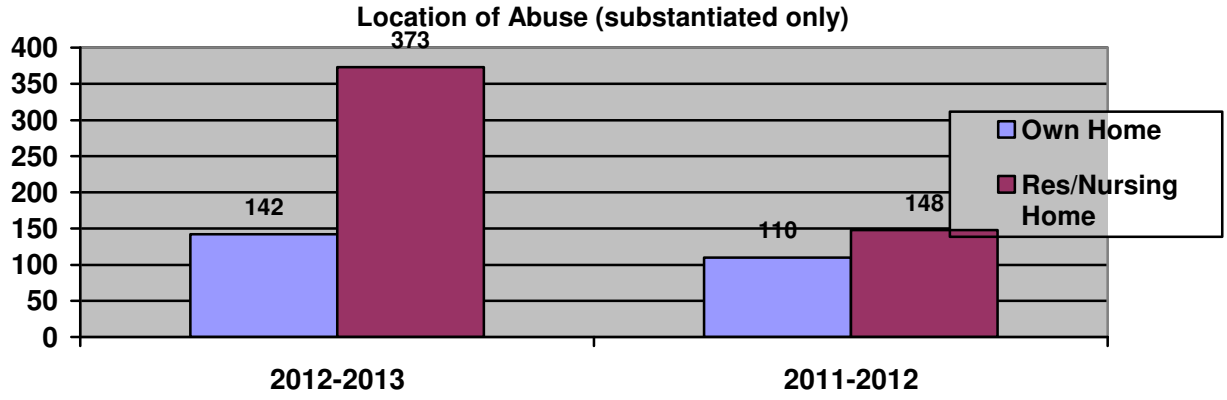
Referral sources

The vast majority of safeguarding alerts continue to be from various professional groups including care providers. This reflects an ongoing commitment across all organisations to provide staff with relevant training and establishing a culture of positive reporting. There have been small but encouraging increases in alerts made by police and hospital staff. Alerts by victims themselves remain low but not necessarily surprisingly so. Perhaps of more concern is that alerts made by relatives and other members of the public show little increase from a low starting point. This probably reflects the fact that awareness raising activity has been largely focussed upon professional groups and partner organisations who work with vulnerable people rather than with the general public.



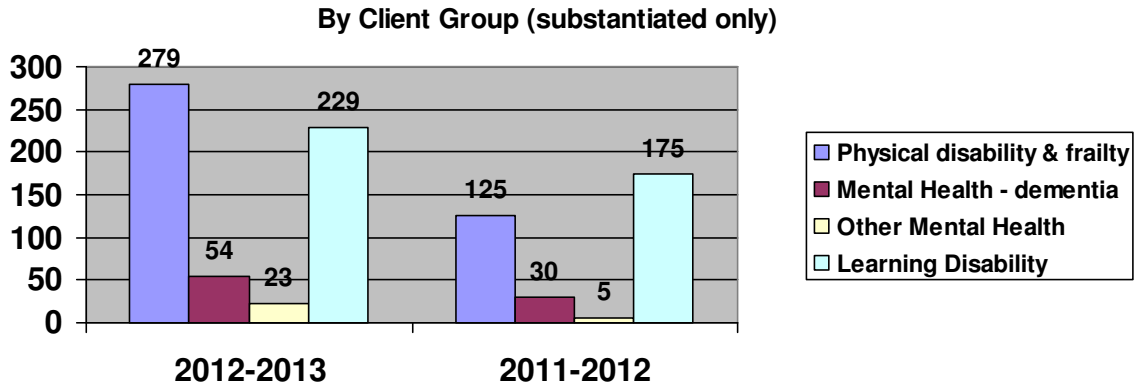
Location of abuse/neglect

As in previous years the majority of substantiated concerns occur in residential and nursing settings. Clearly this is not representative of the proportion of the population of vulnerable people who live in these settings but is probably a consequence of the high level of professional focus on such services. Inevitably abuse or neglect occurring in a person's own home is less likely to be observed and reported but awareness raising with a wide range of groups including GPs and volunteer organisations as well as the public may do something to address this. The significant increase in substantiated concerns in the past year reflects in part the more accurate recording of neglect concerns when a service is providing poor quality care.



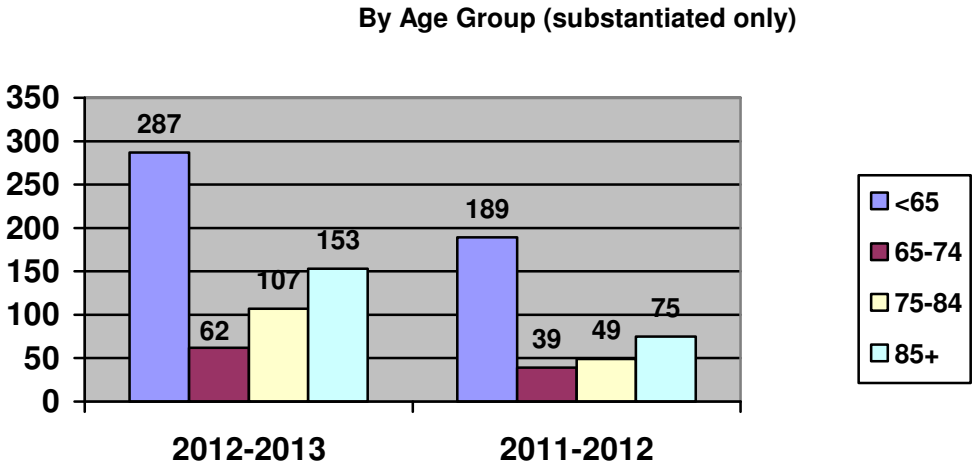
By Client Group

Again as in previous years there has been a disproportionately high level of safeguarding concerns identified and substantiated for adults with learning disabilities. The continued low numbers of safeguarding concerns relating to people with mental health problems other than dementia – mainly adults of working age – needs further analysis but may reflect the working practices in the Community Mental Health Teams describing protection work in terms of complex risk management rather than using the label 'safeguarding'.



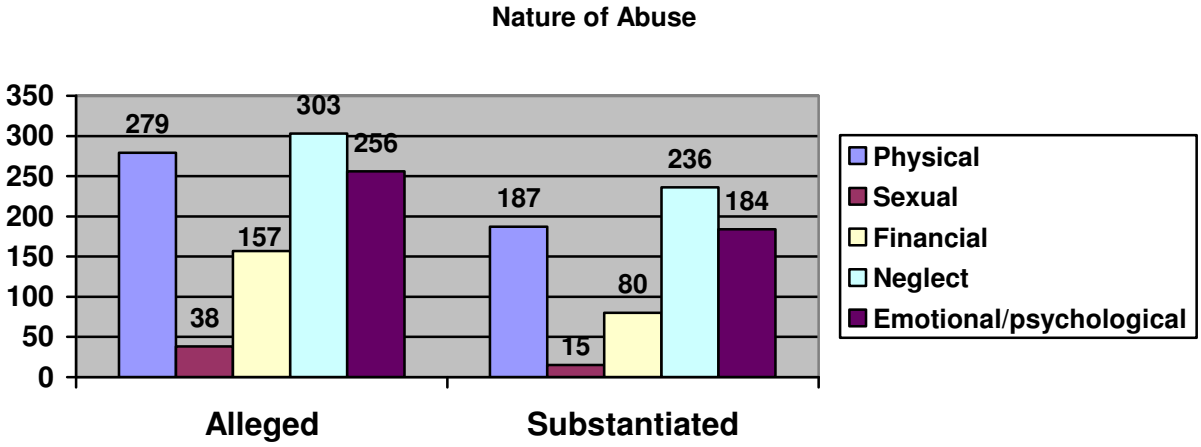
By Age Group

The significant majority of the under 65 year olds figure is accounted for by the presence of learning disability concerns as explained above. As in previous years the older groups show a pattern of increasing safeguarding concerns as people age and become more dependent, that is, more vulnerable.



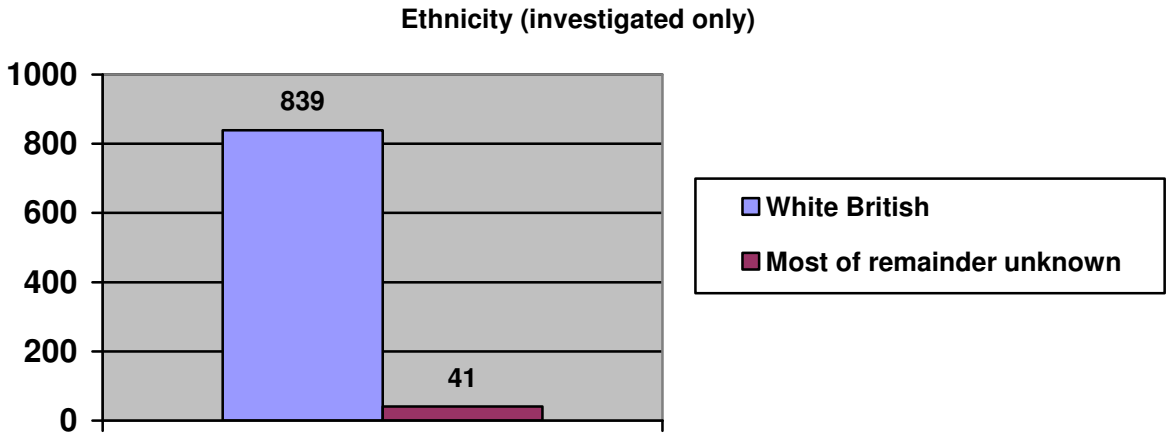
Nature of abuse

The overall distribution of types of abuse or neglect is similar to previous years with neglect being the single largest category closely followed by physical abuse. It is important to note that in any given investigation there may be more than one type of concern present. Quite frequently emotional or psychological abuse is identified as a secondary category to other types of abuse or neglect. Alleged and substantiated sexual abuse continues to be at a low level but the potential personal barriers to acknowledging and reporting this type of concern need to be recognised. The doubling of substantiated financial abuse concerns also reflects a national trend. Most financial abuse and neglect occurs to victims over the age of 65



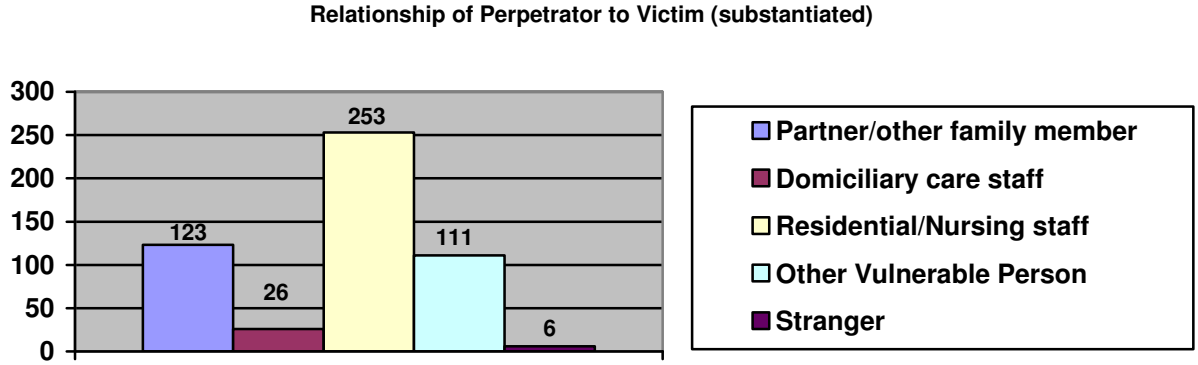
Ethnicity

The extremely small number of substantiated concerns where the victim was identified as not being white British reflects broadly the ethnic make up of the population of Somerset. This should not be a cause for complacency and we must continue to consider the needs of non-British and non-English speaking members



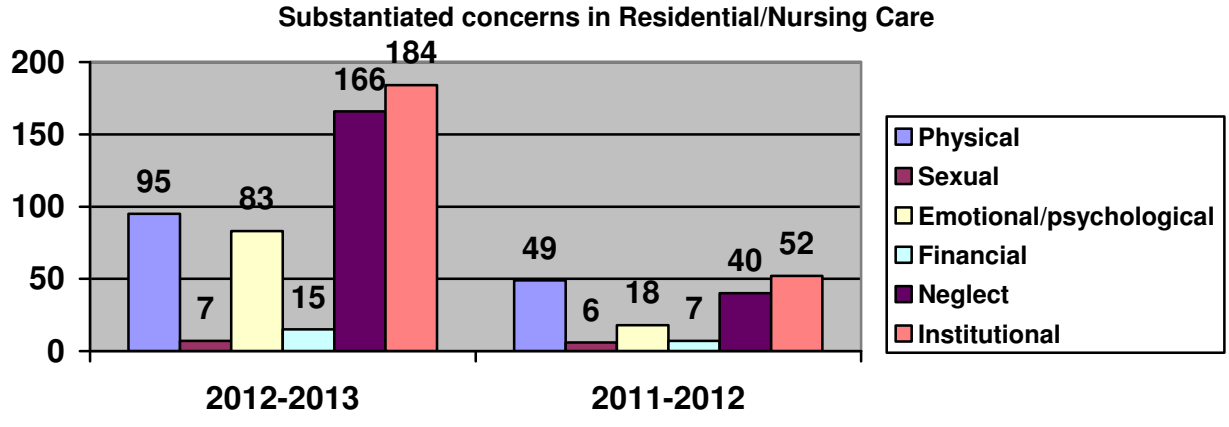
Relationship of perpetrator to victim

In the majority of cases of substantiated concerns the person responsible is someone with a caring responsibility – either a relative or a paid carer. Most of the 'other vulnerable person' category relates to people with learning disabilities living in group care settings. There are a number of specialised services in Somerset for people who have learning disabilities and significant behavioural needs. Compatibility in such settings poses a significant challenge to care providers and a number of investigations have been undertaken where care providers have not managed compatibility well. An additional challenge for Somerset County Council managers leading such investigations is that quite a high proportion of the people with these challenging needs have been placed in Somerset by other local authorities. The levels of co-operation from these authorities in resolving compatibility problems are variable.



Substantiated concerns in residential and nursing homes

As in previous years we provide a simple breakdown of the substantiated concerns in residential and nursing homes. The majority of these concerns have been raised by care home staff themselves. The significant category of 'institutional abuse' refers to those services which adopt institutional practices which put people at risk or actually result in neglect. These are investigated as whole services so a single substantiated issue is amplified in the statistics by recording the number of individual service users affected. The 184 such substantiated concerns in 2012/13 arose from only 10 separate investigations. The improved recording of these whole service investigations in 2012/13 accounts for much of the increase shown below. Further work is needed to improve this data.



Deprivation of Liberty Safeguards service report

Summary and Analysis of Deprivation of Liberty Safeguards (DoLS) activity from April 2012 to March 2013 for SCC and NHS Somerset Supervisory Bodies

	Applications	Assessments		Length of authorisations granted			Reviews	Funding source			
		Urgent	Standard	< 3 months	3-6 months	12 months		Self	SCC	PCT	Joint SCC/PC
Hospitals	**23** (8)	**20** (8)	**2** (0)	**12** (4)	**0** (0)	**0** (0)	**3** (0)	**n/a**	**n/a**	**23** (8)	**n/a**
Care homes	**50** (46)	**33** (27)	**17** (19)	**7** (2)	**19** (17)	**5** (5)	**7** (2)	**7** (10)	**32** (21)	**6** (8)	**2** (7)

2011/12 figures in brackets

Year totals for comparison:
2009/10 40 assessments
2010/11 58 assessments
2011/12 54 assessments
2012/13 73 assessments

73 assessments equates to approximately 1.7 per 10,000 adult population based upon the 2011 census.

In comparison with other local authorities in the South West Somerset's level of DoLS activity in 2012-13, when adjusted for adult population size, is by far the lowest. This confirms the belief that there are a significant number of situations similar to the ones we do assess but which are not referred for assessment.
This is likely to be related to the very variable levels of understanding among care providers and hospitals but this is recognised as a national rather than a Somerset specific problem. The minimal increase in care home applications is of concern especially in light of the efforts to raise awareness in this sector.
A notable difference is that some Supervisory Bodies have received a significant number of DoLS applications from in-patient psychiatric services, especially those caring for older people. Of the 23 hospital applications in Somerset only one came from a psychiatric service.
Early indications since April 2013 suggest an increase in DoLS activity but this will need to be monitored closely.

Nationally the variable rates of use of the safeguards remains a major concern to the extent that some commentators have questioned whether the Safeguards can be said to be fully compliant with Article 5 of the European Convention. The absence of a legislative definition of deprivation of liberty has become increasingly problematic

as the Courts have sought to define it in a way which increases complexity. The Supreme Court will hopefully provide some clarification when it hands down its judgement in the Cheshire appeal case in the early part of 2014.

Chris Hamilton June 2013

Member organisation reports

Somerset County Council, Adults and Health

Summary of organisational developments affecting 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 held by the Adult Social Care Service. 2012-2013 has seen another significant rise in the level of reported safeguarding concerns and those accepted as requiring a safeguarding investigation. This increase continues to place additional pressures on Adult services but this key area of work is closely monitored by senior managers within the service in order to ensure resources being targeted on supporting this essential area of work.

During the last year the number of alerts received by the Council have increased from 1400 (2011/2012) to 2300. This rise represents a 64% increase on the previous year and is typically reflected in other areas of the country with similar population sizes as Somerset. 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. Adult Social Care managers review every safeguarding alert on a daily basis and decide if these alerts require further action under the safeguarding policy. Concerns are investigated as required under the safeguarding policy and safeguarding plans appropriate to the needs of the individual are put in place. The numbers of referrals that have been accepted for a safeguarding investigation has also increased this year from 585 (2011/2012) to 880 a 50% increase.

The number of complex safeguarding situations being managed by local teams is also increasing with a marked increase in 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, CQC 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. Individual safeguarding issues have also increased in complexity. These typically involve a range of investigations conducted with our partner agencies into: concerns about financial mismanagement; investigations into the care being provided to an individual or the environment in which a person lives.

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 application made this year have been about where a

person should live and how their care is provided. During the year the Council has developed a range of information about the Court of Protection process that the Safeguarding Board has been able to share with health and social care organisations as well as family members, advocacy groups and the individuals themselves.

Members of the safeguarding team in Adult Social Care continue to undertake case audits on a regular basis looking at both the paperwork and the decision making involved in the safeguarding process. Cases are discussed with the individual staff members and the learning and good practice is shared across the whole service through training events and professional development groups. This supports the work currently being undertaken by the Board into customer involvement.

Reporting arrangements for safeguarding issues continue to improve and more regular reporting has
meant that senior managers in the Adult Social Care Service are able to monitor the demand for safeguarding investigations more closely, identify any areas that need further development and ensure that investigations are being undertaken within agreed timescales. The introduction of new timescales for the key stages of the safeguarding process has lead to an improvement in the time taken from alert to the completion of a safeguarding action plan. Safeguarding activity reports continue to be shared both within the County Council and with the Safeguarding Board. These reports provide information about the range of safeguarding issues arising in Somerset and evidence how resources are being used.

Local Authorities now have the responsibility for managing safeguarding issues in health settings, including hospitals. It is recognised that this is an area where further work is needed to ensure that safeguarding issues are appropriately reported and investigated in these settings. In April 2013, the County Council will become the supervisory body for Deprivation of Liberty Safeguards (DOLS) in hospital settings with responsibility passing from NHS Somerset to the Council. The Safeguarding Board has confirmed that it will provide a level of scrutiny to the implementation of the Mental Capacity Act (including DOLS) rather than delegating this role to the MCA/DoLS subgroup.

In April 2013 the Adult Social Care Service will change its management structure in recognition of the growing requirements around safeguarding and a new senior manager role will be created to lead on safeguarding and risk management within the service. This post will be 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. As part of the restructuring advanced practitioners in the service will be providing additional support to social care teams on operational decision making particularly around areas of safeguarding practice.

Training and other development activities undertaken within the organisation

Somerset County Council has an extensive safeguarding training programme for its Adult Social Care staff which has been extensively revised over the last year. A new training database is now in place to support this and has improved the recording of staff that have undertaken “refresher” training, provides additional assurance that all the relevant staff have completed the training required for them to fulfil their safeguarding responsibilities. During July 2013, all of the Adult Social Care managers will receive training on the updated whole service procedure.

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.

The Adult Social Care Service has supported the training of staff on raising 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.

During July and August mandatory safeguarding training will be provided to all County Councillors, sharing information about the responsibilities of Councillors and the work of the Safeguarding Board.

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

During 2012/13 Adult Social Care continued to contribute to the learning the lessons sub group. Recommendations or actions from significant event audits have been implemented and the learning from Serious Case Reviews undertaken nationally, have lead to changes in practice within the service. As the group has had a particularly focus on the learning from the Winterbourne Review Serious Case Review Adult Social Care have been working with health colleagues to review the support provided to people with a Learning Disability. The revised multiagency safeguarding policy is now published and contains clear commitments to inform whistleblowers of the outcome of safeguarding investigations.

Adult Social Care contributed to the research undertaken by Nottingham University on the support for older people experiencing domestic violence. This work was commissioned following a domestic homicide and the training

that was recommended in the research, focusing on the identification and management of domestic violence amongst older people is now being undertaken by staff from across the service.

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 on the Board and the Executive Group. Staff from the Adult Social Care Service chair three of the Boards subgroups and provide the administrative support to the Board, the Executive Group and the majority of the sub groups. In anticipation of the Care and Support Bills requirements for an Adult Safeguarding Board, the Council has advised the Board that an independent chair should be recruited. It is anticipated that work on the job description for the Chair will be undertaken during the summer of 2013.

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 2013/2014

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 2013/14:

- Planning the appointment of an independent chair for the SAB and learning lessons subgroup
- Establishing LA responsibilities and reporting mechanisms across all health settings in Somerset
- Setting up an effective means for SAB to engage with service users and members of the public
- Establish the board's MCA/DoLS scrutiny and assurance mechanism

Issues for the Board's consideration during the coming year

- Delegation of tasks to include all members of SAB
- Consolidation of independent chair role including links with SW regional chairs and local children's safeguarding board
- Establishing links with the Health and Well Being Board.

Report completed by:
Martin Turner, Service and Operations manager for safeguarding and risk management, Adults and Health, Somerset County Council

6th September 2013

Somerset Partnership NHS Foundation Trust

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

The changes within the NHS have seen the profile of Safeguarding continue to increase. This is reflected within the Somerset Partnership - Safeguarding Adult at Risk activity, where safeguarding concerns and alerts continue to increase across all services within the organisation.

MAPPA and MARAC referrals have increased from all services within the organisation; this is reflected in the increased numbers of meetings each month attended by the MARAC & MAPPA Co-ordinator and other safeguarding team staff. Due to the increasing numbers of serious Domestic Abuse incidents over the last eighteen months the amount of MARAC meetings has doubled to four per month.

The role of the Safeguarding Leads and Champions covering all Trust services continues to develop and is supported by the safeguarding team. They receive support, training and updates via bi- monthly meetings. These meeting are now very well attended.

The safeguarding team has participated in a pilot led by SCC looking at safeguarding triggers. The pilot looked at DATIX reporting and the consideration for reporting for safeguarding. Two of the community hospitals were selected- Dene Barton and West Mendip Community Hospitals. The findings and report from the pilot will be published shortly.

The revised Somerset County Council (SCC) Safeguarding 'Adults at Risk' Policy and supporting guidance 2012 has been distributed and promoted across the Trusts services. The Somerset Partnership internal Safeguarding Adults at Risk Policy reflects the changes in the overarching SCC Policy.
The safeguarding team remain focussed upon reviewing and updating existing resources: intranet, quick guides, templates and toolkits.

Job descriptions now contain a specific section detailing the responsibilities relating to safeguarding adults.

Training and other development activities undertaken within the organisation

A draft competency framework (taken from the Bournemouth University competency framework) agreed with the Somerset Partnership Learning & Development team has been introduced as an additional management/supervision tool across the organisation.
The mandatory level - A training package has been reviewed. The training also included MARAC, MAPPA and PREVENT awareness.
Attendance is currently at 91% with the aim for 95% compliance.
A multi-agency training session called 'Working Together' (previously A+) continues to be delivered to all key agencies. This provides an enhanced level of skills and knowledge for those staff in community services that will or may be required to

support any safeguarding investigation.

Mental Health Services manage the entire safeguarding adults at risk process and undertake the investigations. Due to this current difference in commissioning arrangements staff from Mental Health services are identified to attend the level B and level C training via Adult Social Care.

The Trust now has Four trainers that can deliver Health Wrap (PREVENT) and has been delivered to 100 members of staff, with a roll out programme underway.

The safeguarding team has developed and provided targeted, local training to individual teams as required across all services. There has been a very positive response for this training that has also included an emphasis on the Mental Capacity Act.

MAPPA training has been delivered to Mental Health Team managers.

Domestic abuse awareness has been increased by utilising the recent Nottingham University research.
The South West Ambulance Service (SWAST) Safeguarding Trigger work with Somerset Partnership and SCC has been re-established. This will lead to a future work stream over the next year to enhance the current safeguarding adults at risk multi-agency liaison.

A Guidance flowchart has been developed to assist staff in identifying when to report a pressure ulcer as a safeguarding concern.

The MAPPA and MARAC Coordinator continues to develop key links with Avon and Somerset Police and there is increased intelligence being shared across the organisation.

The Department of the Health 'Self-Assessment Tool' and accompanying Action Plan continue to be reviewed by the Safeguarding Adults Steering group.

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

The Winterbourne view action plan has been fully implemented across all relevant Trust services.

Out of county Quality Placement Reviews are now undertaken routinely, with a new post being created to ensure this is given priority.

Nursing placement reviews are collated centrally and reviewed to ensure quality care is being delivered and that any concerns are flagged to NHS Somerset/CHC team and ASC.

Special placement memo continues to be circulated; this informs all relevant staff if problems are emerging in a home.

Effective reporting processes are in place to ensure safeguarding concerns are reported within the agreed timeframes to the lead organisation.

The safeguarding team are represented at the quality review meeting attended by ASC and CQC.

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

Somerset Partnership NHS Foundation Trust is represented at the follow group:
SAB
Sub Groups:

- Safeguarding Leads
- Training and Development
- Policy Development
- Lessons learnt
- MCA/DOLS (disbanded during this year)

Planned safeguarding activities for 2012/13

- A Head of Safeguarding started in post on the 30th September 2013.
- A review of the safeguarding team structure is underway to ensure there is a robust, consistent and structure to support all services.
- The Safeguarding team has transferred to the Nursing and Patient Safety Directorate.
- Information gained from completing the NHS Thermometer is considered alongside Datix, PALS, Serious Incidents Requiring Investigation (SIRI) and near misses to identify opportunities to take a proactive approach to safeguarding and to support any early indicators.
- Unannounced ward and service visits that have identified learning in respect of safeguarding awareness and training and will inform planning over the coming year.
- The Roll out of Rio across the organisation is on target for completion.
- There is a planned revision of the DOLS policy and expected to be finalised in November 2013.

Issues for the Board's consideration during the coming year

1. Plan to manage the increased level of Safeguarding Activity in the Trust.
2. Implementation of Francis recommendations into Trust activity.
3. Maximise the opportunities presented by the integration of our service on Patients safety.
4. Open access for all staff to share information about People refereed to our services

Report completed by: Richard Painter, Vanda Squire and Clare Woodhead
Date: 8/10/2013

Avon and Somerset Constabulary

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

During 2012/13 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.

A working group led by an Assistant Chief Constable was established to pull together a cohesive response towards Safeguarding Adults (SA) and to ensure that lessons are learnt from Serious Case Reviews and other national agendas. The group's action plan is divided into seven key business areas:

- Policing Response
- Dealing with detained Persons
- Recording and Investigation
- Pattern Identification and Pattern Analysis
- Communication and Training
- Partnership Engagement
- Environmental Scanning

Furthermore a network of Safeguarding Champions has been established across the force made up of front- line Constables and Police Community Support Officers who help and support the Public Protection Unit to identify and protect vulnerable people across the force area. Their role is to

- Improve the quality of safeguarding to protect vulnerable people
- Increase the trust and confidence of 'vulnerable people'
- Liaise both internally and externally, actively developing links with locally based services or groups who support or who can be engaged in supporting
- Promote awareness of safeguarding matters
- Promote the role of the local policing Safeguarding Champion internally and externally
- Highlight safeguarding issues for consideration in developing local crime and disorder strategies

Training and other development activities undertaken within the organisation

Through the working group, Safeguarding Vulnerable Adults training is being developed for the force area. An initial e-learning awareness package has already been produced which is aimed at all staff who may come into contact with SA issues and further in-depth specialist training for PPU and other

appropriate staff is in progress.

Numerous training days have taken place specifically for the Safeguarding Champions

The force is also building relationships with the National Autistic Society to improve the understanding and awareness of officers when dealing with Adults within the Autistic Spectrum. Similar relationships are also being formed with the National Dementia Society.

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

A significant achievement in relation to SA is the identification of all premises in the Constabulary area where vulnerable people reside (including vulnerable children) and the introduction of appropriate flagging markers to identify them within crime recording systems. This will enable us to develop processes around pattern identification and analysis and also inform response protocols.

A separate project has also been completed enabling any reported incident or crime with a vulnerable adult as a victim or suspect to be flagged. This ensures that Safeguarding Co-ordination Units undertake the correct referrals and interventions, as well as maintaining an overview of the investigations.

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

Detective Superintendent Geoff Wessell sits on the board.

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

DI Shearlock and a member of the HQ PPU Policy Team attend a South West Regional Safeguarding Adults Group.

Planned safeguarding activities for 2012/13

A Hate Crime and Safeguarding conference is being organised for March 2014 to raise awareness amongst Avon and Somerset Constabulary staff. This is being delivered by SARI with other guest speakers and will have a strong focus on Disability Hate Crime.

Planned roll out of the Safe Places Scheme for people with learning disabilities in all districts across the Force. The aim of the scheme is to create a supportive environment to help disabled people feel safer and be safer when out in public places.

To implement a system so that when a repeat SA victim or offender is identified, the investigation receives a higher priority and status, and to embed this process into tasking and performance management. To develop response protocols for concerns within premises and improve communication channels between Beat Teams and Vulnerable Persons premises Further more localised training to be rolled out, including across the Somerset area.

Report completed by: Amanda Lloyd **Date: 06.09.2013**

NHS Somerset/Somerset Clinical Commissioning Group

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

NHS Reforms

The changing health landscape as a result of NHS reforms brought new challenges for safeguarding in respect of the ability of the new structures to embed safeguarding practice in their systems and to ensure alignment and collaboration across the new systems. Changes such as the demographics of vulnerable patients, the plurality of providers and the range of settings in which care is provided present new challenges for commissioners in assuring the safety of patients.

NHS Somerset/Somerset CCG worked closely throughout the year to ensure the seamless transition of responsibilities into the new organisation. The health commissioning activities in relation to Safeguarding Adults performed by NHS Somerset became the responsibility of Somerset Clinical Commissioning Group from April 2013.

Training and other development activities undertaken within the organisation

Safeguarding Adults at Risk; Assurance Policy for Commissioned Services

In March 2013 NHS Somerset/Somerset CCG approved Safeguarding Adults at Risk; Assurance Policy for Commissioned Services. Providing an overview of arrangements and strategic framework for safeguarding adults at risk for health services in Somerset and demonstrating how NHS Somerset/Somerset Clinical Commissioning Group (SCCG) will discharge its responsibilities to safeguard adults at risk of abuse and promote prevention of abuse across the health services it commissions.

Safeguarding Thresholds in Health

NHS commissioners need to be able to determine whether a concern raised in a provider service is progressed as a quality issue in respect of service delivery or whether there are more broader/systemic concerns that should be dealt with under the safeguarding adults at risk procedure. The thresholds for instigating the safeguarding alert process in respect of health services will need to determine where the care provided is suboptimal. Thresholds may be reached and abuse occurs when a service adopts certain ways of working which result in abuse or, more often, neglect of an adult at risk. Examples might include the sustained provision of staffing levels which are inadequate for the needs of the service users, or a cluster of pressure ulcers in a particular area or setting. The result may be to put the service users at risk of actual harm, or a failure to ensure their basic human rights to dignity and appropriate care. The risk of abuse is also greater in institutions:

- with poor management
- with too few staff
- which use rigid routines and inflexible practices
- which do not use person-centred care plans
- where there is a closed culture

Safeguarding alerts may be raised, or identified through the complaints process, incident reporting and Serious Incident Requiring Investigation procedures. Individual concerns will not always trigger a safeguarding alert, but NHS commissioners will, through contract and quality monitoring processes provide scrutiny of providers of care to identify individual concerns, or clusters of incidents that meet the threshold. Guidance of what may initiate the Safeguarding Adults at Risk procedure in health is included in the Assurance Policy for Commissioned services.

GP Safeguarding Adults at Risk Training

During 2012/13, NHS Somerset/Somerset CCG agreed to fund Safeguarding Adults at Risk training for all GP practices within Somerset. A programme has been developed and is being administered by Care Focus.

As a result of training individuals employed within GP practices across Somerset will have gained a better understanding of the following:

- Legislation, regulation, policy and procedures in relation to safeguarding adults.
- The recognition of adult abuse
- How to respond to concerns
- Who to contact when there is a concern
- Fulfilling "duty of care"
- Safe practice and keeping vulnerable adults safe

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

Winterbourne View

The BBC Panorama programme, broadcast on 31 May 2011, showed alleged abuse and ill treatment of residents at Winterbourne View, a private hospital owned by Castlebeck Care (Teesdale) Ltd which was registered with the Care Quality Commission to provide care for up to 24 patients aged 18 years and over with a learning disability. The immediate issues of safety of existing residents at the unit were addressed with the transfer of all residents to alternative accommodation and the closure of the unit on 22 June 2011. As part of the necessary process of subsequent investigation and review, a review of the role played by the NHS in the commissioning of care and treatment at Winterbourne View was undertaken.

NHS Somerset was actively involved in care management for one resident, C, throughout their placement at Winterbourne view and actively participated in care planning and ensuring that C's health needs were met. There are key learning points in respect of actively engaging with parents and family as part of the care review process, seeking out safeguarding concerns from the relevant local authority, and for provision of independent advocacy for vulnerable individuals with cognitive impairment.

During 2012/13 NHS Somerset has implemented the recommendations from the internal serious untoward incident investigation and the individual management review. A local action plan was developed, updated regularly with the actions now completed.

To implement the learning from the Winterbourne View Review a joint working group has been established, to facilitate a joined up approach between the Somerset CCG (Formally NHS Somerset) and the Local Authority (including Children's Social Care), to ensure that all those NHS funded individuals, particularly those with learning disabilities and autism, are receiving safe, appropriate and high quality care. The presumption will always be for the services provided to be local and that people remain in their communities. Within this work we will also identify the people that it is not appropriate, to move back to Somerset, the reason for this and the monitoring and reviewing arrangements for their care.

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

The Director of Nursing and Patient Safety for NHS Somerset was the executive lead with responsibility for safeguarding adults. In addition, there is a GP Patient Safety Lead within the Nursing and Patient Safety Directorate to lead on safeguarding adults issues in relation to general practice.
The Safeguarding Adults Board meets three times each year. NHS Somerset/Somerset CCG has been represented by the Deputy Director of Nursing and Patient Safety. NHS Somerset provided representation for the SAB sub groups.

Planned safeguarding activities for 2013/14

South West Pressure Ulcer Framework

The South West Quality Improvement Framework for the Prevention and Management of Pressure Ulcers has been commissioned by NHS South of England (West) and developed by an expert group for implementation within both commissioning and provider organisations. It was published in May 2012.

Pressure ulcers are considered an important part of the Safeguarding process.

A Grade 3 or 4 pressure ulcer is categorised as a Grade 1 Serious Incident requiring Investigation (SIRI). A Grade 2 SIRI may be declared at the discretion of the commissioner where a cluster of pressure ulcers has occurred in one clinical service, care setting or patient home. Such a cluster may also be the subject of a safeguarding alert. Somerset CCG will ensure the recommendations of this SW framework are implemented in Somerset through the Somerset Pressure Ulcer Collaborative.

Pressure Ulcer Peer Review

Somerset Clinical Commissioning Group, in collaboration with Somerset Partnership, Taunton and Somerset and Yeovil District Hospital NHS Foundation Trusts, will facilitated a series of peer reviews to identify provider organisations abilities to reduce avoidable pressure ulcers in patients for whom they provide care.

The aim of the Somerset Pressure Ulcer Peer Review is to make a significant impact on the speed and delivery of improvements and promotion of 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.

The objectives include:

- Establish a baseline of current practice for each participating organisation
- Identify best practice and facilitate the spread of learning
- Identify areas for action to strengthen arrangements for improvement

Winterbourne View

The working group will:

- Review the care of people already in learning disabilities or autism inpatient beds. Work with people who use services their families, and the Service Provider to develop person centred care and support plans that meet their needs and agreed outcomes, by June 2013
- Set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of Somerset individuals with challenging behaviour, by April 2014
- Establish a local register, maintained through Somerset CCG, to monitor any out of county placements made in the future, for people with learning disabilities and/or Autism
- Consider the long-term investment of resources into local services, for local people, to avoid the need for out of county placements

Mid Staffordshire NHS Foundation Trust Public Inquiry

The CCG pro-actively monitors, investigates and takes appropriate action in respect of all concerns that might arise about the quality or patient safety of any of the commissioned services in Somerset. The CCG response sets out how we will strengthen and build on the current arrangements to ensure that the patient voice is heard. This includes primary care and specialized services where close working is required with the Area Team of NHS England.

The CCG will continue to work with local providers through the QIPP programme board and through the relevant clinical forums and networks to ensure that they consider and provide an appropriate response to the Francis Report.

The CCG will also work with GP practices and ensure that they are responding to the Francis report as providers of healthcare and we will support their response through the duty of the CCG to improve the quality of primary care and the plan that we will agree with practices to achieve this.

The CCG will role model a culture of openness and honesty and transparency with our staff. The CCG organisational development plan will be reviewed and updated to reflect the feedback from our staff and to ensure that we follow through the actions that we have set out for this. As commissioners we will work 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.

GP Safeguarding Adults at Risk Training

Somerset CCG will monitor the rollout of training in GP practices, ensuring that individual practices have the opportunity to participate in training to meet registration requirements.

Issues for the Board's consideration during the coming year

The development of effective links between the Clinical Commissioning Group and the Safeguarding Adults Board (SAB) will be a key task for the coming year. Review of representation on the Safeguarding Adults Board and associated sub groups will be ongoing throughout 2013/14.

Report completed by:
Lynn Street, Deputy Director of Quality and Patient Safety, Somerset CCG

Date: 12 September 2013

Taunton and Somerset NHS Foundation Trust

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

We have continued to develop and revise all our policies that affect vulnerable adults. Our existing Patient Supervision policy is being reviewed and expanded to help reduce the risk of harm to patients in our care. The Trust's Learning Disability Policy is having a major review to reflect the role of our Learning Disability Liaison Nurse, to incorporate the new patient passport and to make changes to our discharge planning.

A new reporting tool has been developed to aid reporting to the Trust's Safeguarding Committee to more consistently report on activity and other safeguarding issues.

Our focus upon safeguarding is maintained by the Clinical Lead for Safeguarding Adults in conjunction with our Safeguarding Committee through an annual plan of work, regular reporting, training and policy development.

Training and other development activities undertaken within the organisation

Our training focus, through our revised Safeguarding Learning Framework, has been to concentrate on core Safeguarding and Mental Capacity issues. This has been aimed primarily at senior Nursing Staff and Consultants. We will be looking for a 95% compliance with the training programme with the support of the learning and development team.

An audit programme has been developed to assess staff knowledge of key Safeguarding, Mental Capacity Act, Learning Disability and Restrictive care issues. This is a rolling programme, which should give key information on staff understanding and how this understanding changes over time.

An audit is also taking place to review staff use of Consent Form 4 (form for patients who lack the capacity to consent). This Consent form was updated with the support of the IMCA service to improve the quality of the consent process.

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

We are currently incorporating findings from a multiagency review into our revised Learning Disability Policy. These points will be included in our implementation plan and will be reflected in our Learning Disability training.

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

The Trust is represented at the Safeguarding Board as well as the Operational and Mental Capacity Act / Deprivation of Liberty Sub Groups. The Clinical Lead for Safeguarding Adults is the joint Chair of the Mental Capacity Act / Deprivation of Liberty Sub Group.

Planned safeguarding activities for 2012/13

To complete all of our safeguarding policy updates. To improve the numbers of Consultants trained on the use of the Mental Capacity Act. We are also going to review the current internal Safeguarding systems with a view for greater Matron involvement. This should give the organisation a wider level of safeguarding support and will allow the Clinical Lead to focus more on the most serious cases as well as training and development issues.

Issues for the Board's consideration during the coming year

To consider copying the Safeguarding Board minutes to all multiagency safeguarding staff. This would help the wider safeguarding team to stay more up to date with the board's decisions, plans and developments.

Report completed by: **Duncan Marrow (Clinical Lead for Safeguarding Adults)** **Date: 09/09/2013**

Yeovil District Hospital NHS Foundation Trust

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

The profile and focus of Safeguarding work within the organisation is maintained through the Adult at Risk Committee. This Committee is attended by Social Services, named Safeguarding Lead for Children, a MARAC representative, Maternity Services representing Vulnerable Young Women, the Safeguarding Leads for the organisation, medical representation and representation from the Yeovil Academy Educational Facility. Feedback from external meetings is shared with the group and key messages for all staff are fed back through the Divisional structure. In addition a Joint Adults at Risk Committee and Safeguarding Children's Committee is held twice a year.

In order to ensure that Safeguarding concerns are shared amongst relevant staff within the organisation the Safeguarding Adults Clinical Lead has developed an electronic system for recording referrals, which can be accessed by staff within the organisation.

Training and other development activities undertaken within the organisation

The Trust is required to ensure that all staff working with patients receives basic awareness training in respect of Adults at Risk. The internal training needs strategy has been reviewed and the training delivered in the organisation has been restructured to include three levels of training:

Level 1: A 30 minute introductory lecture combined with Safeguarding Children Awareness is provided to all new staff at induction. In addition clinical staff receive awareness training on the Mental Capacity Act. Non clinical staff are also required to attend a mandatory update every two years with regards to Adults at Risk.

Level 2: All clinical staff working in contact with patients who may be Adults at Risk are required to attend mandatory training every two years. The training includes basic awareness of Adults at Risk including identifying individuals, signs of abuse, reporting structures and processes and Mental Capacity Act.

Level 3: Senior clinical staff, operational managers, matrons, site managers and on-call directors who need a deeper understanding of the processes and policies required for managing Adults at Risk, including reporting externally on cases and the Depravation of Liberty Safeguards are required to attend this training. In order to increase the number of staff undertaking their mandatory training Levels 1 and 2 training is now available either via face to face, e-learning or work books. An introduction to the PREVENT agenda is provided within this training.

The Safeguarding Adults Clinical Lead has also presented a complex case study at Trust wide Clinical Governance. This is a multi-professional forum attended by

medical, nursing and allied health professional staff. In addition a Seminar was held and hosted by the Trust's solicitors for all senior health care professionals outlining their responsibilities with regards to Mental Capacity, Depravation of Liberty and their responsibilities as professionals. The Trust PREVENT Lead has commenced a programme of HealthWRAP workshops to raise awareness of PREVENT within the organisation. The aim of the sessions is to provide attendees with an understanding of the new agenda and their role within it, the knowledge and confidence to share concerns and the ability to use existing expertise and professional judgement to recognise potentially vulnerable individuals. These training sessions are currently non mandatory. A policy detailing the PREVENT agenda within Yeovil District Hospital is currently being developed to reflect the requirements as set out in the NHS Contract. There are now policies in place for Safeguarding Adults, implementing the Mental Capacity Act and Depravation of Liberties and protecting patients who wander, with additional guidance documents for further procedural information.

Domestic abuse has been incorporated into the Safeguarding Adults Clinical Lead role for those patients who may be experiencing domestic abuse that needs to be managed under Safeguarding. There are Domestic Abuse Leads who receive development training in the Emergency Department, Women's Hospital and Main Hospital to ensure that people are properly risk assessed, referred appropriately into the MARAC process and / or Safeguarding. An awareness raising day with stands in the Emergency Department, Women's Hospital and Main Hospital on World Domestic Abuse Day was held to promote services available within the organisation and in addition, those available externally to individuals who may be experiencing domestic abuse.

Learning Disability awareness continues to be included in the mandatory Safeguarding training and additional training is ongoing to specific staff groups and for individuals. A snapshot tool has been developed to ensure more effective use of Patient's Hospital Passports on admission to Yeovil District Hospital.

Learning gained from a significant Safeguarding issue locally has resulted in the discharge process for patients with learning disabilities being reviewed and a new process is currently being embedded within the organisation.

The Learning Disability Care Pathway has been updated alongside a review of the Learning Disabilities Policy. In addition, an audit of the Learning Disabilities Liaison role within the organisation has been undertaken with the results currently being reviewed and an action plan being agreed.

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

The impact of the Francis Report has pushed forward Trust's initiatives to improve patient safety and reduce the potential of patients experiencing harm whilst in hospital. Significant work being undertaken to raise the profile of the processes available for patients, relatives, visitors and staff to raise concerns about issues relating to poor care within Yeovil District Hospital to ensure effective and timely

responses are undertaken.

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

The Associate Director of Nursing for Elective Care attends the Safeguarding Adult Board with the Clinical Lead for Safeguarding attending the Health Operational Sub Group. Both individuals feedback key messages to the Adult at Risk Committee.

Planned safeguarding activities for 2012/13

Implementation of Action Plan from the Learning Disabilities Liaison Nurse Audit
Develop and undertake Safeguarding Adults Audit
Develop tools to provide assurance to Safeguarding Adults Board of Mental Capacity Act implementation within the organisation
Establish regular Level 3 mandatory training programme within the organisation
In partnership with the Safeguarding Adults Board, the Trust is currently exploring ways to develop thresholds for reporting incidents that occur within the organisation to the local authority
Review the Safeguarding Identification and flagging of Adults at Risk within the Emergency Department and Emergency Admissions Unit.

Report completed by:
Maddie Groves Associate
Director of Nursing, Elective Care Division
Yeovil District Hospital

Date: August 2013

Referrals
During 2012-13 we have received 159 referrals, an increase over the previous year.
Accommodation **70**
Serious Medical Treatment **33**
28 days in hospital **4**
Care Reviews **41**
Safeguarding **11**

We have now been receiving Deprivation of Liberty referrals for the fourth year running. The IMCA service supports people through the assessment process (Section 39a), provides support for the person during a change of Representative and supports family members who take on the Representative role. We have also been receiving referrals to support both the representative and the person who has been deprived of their liberty (Section 39d). The Advocates also offer the role of Paid Representative when there are no relatives or friends to take this on. There have been 45 Deprivation of Liberty referrals during 2012-13.

39A **9**
39D **22**
Paid Representative **14**

Staffing
The service continues to be staffed by one full time and one half time advocate. However due to the increase in referrals we have taken on a sessional worker who is flexible with the days she can work. All IMCAs have completed or are working towards the Diploma in Advocacy including the Deprivation of Liberty module. It's been good to be able to offer either a female or male IMCA as some people that we have had referred would prefer to have only females or only males and because we all live in different parts of Somerset we are able to share the referrals geographically which saves on time and cuts down on mileage.

Issues
Serious Medical Treatment referrals are increasing in number certainly on the rise but still remain fairly low and 28 day hospital referrals have still continued to be very low this past year, only an increase of 2 but we have been aware that more should have been referred to us. We are still finding that even after nearly 6 years the Mental Capacity Act is still not widely used or understood which can be very frustrating at times. We find that certainly in hospitals some decisions are made for people with no consideration to whether they have capacity or not and if they do lack capacity then the documentation is not found to support how the decision has been made in their best interests. We've had quite a few SMT referrals recently involving people with Learning Disabilities and in conjunction with the Learning disability Acute Liaison Nurse have expended much effort on raising awareness about MCA. Levels of awareness remain very variable which reflects the national situation but is worrying given that the legislation has been in force since for six years.
Safeguarding referrals are lower than previous years but it is unclear why this is. There is only a power to instruct not a duty in safeguarding cases but it is thought that IMCA services should be receiving more safeguarding referrals than they

currently are, this is according the Department of Health's annual IMCA report for 2011-2012, published in 2013.
We have also been receiving more referrals recently whereby it appears on the surface that an IMCA is appropriate but after doing some work we find that the person is befriended and thus does not need an IMCA as we are there instead of friends and family not as well as (except in Safeguarding). We think this may be due to confusion about whether friends can be consulted if they have no family.

Report written by Becky Facey, IMCA Service manager, Advocacy in Somerset
July 2013

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 contribute to a number of official forums where safeguarding and quality are at the heart of their considerations including the CCG Frail Elderly Programme Board, CCG Continuing HealthCare, Health and Social Care Quality Policy Group and the Somerset County Council Quality Policy Group.
Training and other development activities undertaken within the organisation We do not deliver training directly but deliver an Annual Care Sector Conference for care managers and care providers to encourage best practice across the sector in Somerset.
Application of key learning from Serious Case Reviews and other review processes Key learning from SCR and other reviews is regularly shared with our membership through an internal monthly Newsletter.
Contribution to the work of the Board and its sub-groups The RCPA contribute the main Safeguarding Board and 2 other sub groups. The RCPA responded to actions from the Safeguarding Board Work Plan by publishing the SCC Safeguarding Policy and Procedures on their website.
Planned safeguarding activities for 2012/13 The specialist Learning Disabilities conference staged by the RCPA in July 2012 was a great success with over 80 delegates attending.
Issues for the Board's consideration during the coming year The RCPA continue to welcome the support given by Somerset County Council at Conference and throughout the year.

Report completed by: **Roger Wharton, Executive Officer, RCPA Ltd**
Date: 22 August 2013

Care Focus

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

Care Focus has a Safeguarding and Quality Lead and all staff have undertaken training are kept up to date of legislation, policy changes, learning etc via supervision, team meetings and team training.

Training and other development activities undertaken within the organisation

We continue to support providers with their understanding of safeguarding, the Somerset policy and the learning opportunities on offer to workforce. We have distributed information and resources across the public, private and voluntary sector.

The Somerset County Council, 'Stop Abuse' posters, information sheets and leaflets regarding Safeguarding Adults continue to be distributed to all care providers held on the Care Focus database, including those not registered with CQC and voluntary organisations. Use of these materials are monitored during visits and if not displayed or available, addressed with the Registered Manager.

Care Focus has continued to work with all care providers, through a variety of mediums to support the development of their workforce plans, identifying any skills and knowledge gaps and signposting to appropriate level of training and courses. Care Focus has continued to signpost to appropriate resources via Skills for Care, SCiE and Somerset County Council and supported providers with the changes from CRB to Disclosure and barring.

Care Focus has continued to promote and facilitate the PVI sector accessing a range of free training from Somerset County Council, ranging from e-learning to structured sessions and covering introductory, intermediate and advanced levels.

Care Focus works closely with the Learning & Development team within SCC to promote their funded courses supporting Safeguarding. The greatest demand is for the SCC course – Safeguarding for Managers of Care Services.

Care Focus promoted this one day course through all communication methods, including our website, monthly e-updates and in employer engagement meetings with managers. Unfortunately there were no set dates or locations for this course and managers were placed on a waiting list. Care Focus was contacted by several managers who were eager to attend this course and had been waiting some time. Once dates and locations were set all the places were very quickly taken. Care Focus supported these full day sessions with a member of our team attending each date.

Care Focus facilitates Learning Exchange Networks across Somerset which gives both managers and workers the opportunity to share best practice and select specific areas of interest / learning required from a 'menu' of speakers / topics. Safeguarding is a regular discussion point within these sessions and both the Safeguarding lead and MCA lead from SCC has attended these sessions to meet and interact with the groups.

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

Distribution of reports e.g. Winterbourne.
In partnership with SAB co-ordinator, we have produced information regarding the key areas of learning and disseminated this to the private, voluntary and independent sector.
Any learning from the serious case reviews, significant events or other key information is shared with care providers as appropriate, through the various engagement methods used e.g. One to one visits, Learning Exchange Networks (LENs), workshops, events and meetings.

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

As an active member of the Safeguarding Adults Board, and the Training and awareness and lessons learned sub-groups, we have up to date information, which is shared through our website, LENs and E updates.

Planned safeguarding activities for 2013/14

Continued support to PVI sector through communications, face to face visits, meetings and specialised LENs.
Continued support to SCC with delivery of Safeguarding training and MCA training
Continued support to care providers to raise quality.
Facilitation and Co-ordination of safeguarding training for all Somerset GP practices
Raising awareness and training re: pressure sores.
Distribution and support to PVI sector re: Safeguarding Competency Framework
Continued support to PVI re: Disclosure and barring

Issues for the Board's consideration during the coming year

The Board should consider how to address most effectively the high level of demand from Care provider organisations for safeguarding training.

Report completed by: Claire Waddon, CEO 19th Sept 2013