# Somerset Safeguarding Adults Board

# Annual Report 2010/11

## Contents

## 1. Chair's Foreword

I am pleased to introduce this year's report on the work of the Somerset Safeguarding Board. I took over as Chair of the Board in the autumn of 2010 and have learnt a great deal during the last few months about the range of safeguarding work that is undertaken in Somerset. In his forward to last year's report, my predecessor, David Dick, commented that "much had been done to safeguard vulnerable people, but much more remained to be done". That is still the case this year. The work of the Safeguarding Board is ongoing. New challenges arise, whilst previous learning is used to strengthen practice.

During the last year the Board has adopted a new structure to support its future work. Two serious case reviews were commissioned during the year: one review was completed in February 2011 and its key findings are detailed later in this report, the second review will be published in May 2011. The various agencies invited to contribute to these reviews have participated fully and the process of learning has been a productive one.

Information about the safeguarding work undertaken across Somerset is now available to the Board. It provides information on the issues being raised, the action taken and, most importantly, what outcome is achieved for the individual. Last year the Board committed to increasing the involvement of service users in the safeguarding process. An audit into the involvement of service users and their representatives at safeguarding meetings is currently being undertaken and Board members are currently working with the South West Safeguarding Adults Project Officer to develop a service user forum. The engagement of service users in the Boards work will remain as a key priority for the coming year 2011/12.

All of the organisations on the Board are experiencing high levels of change and increased pressure on resources. Yet each one would acknowledge that protecting vulnerable adults from harm and abuse is fundamental to their organisational purpose. The challenge we continue to face is how to do this effectively both as individual agencies and collectively as a Board. We need to continue to hold ourselves and each other to account for the work we do to safeguard adults. I look forward to working with the Board through all the challenges that I am sure will arise during the coming year.

Clare Steel
Service Director, Adult Social Care

## 2. Safeguarding In Somerset – Moving Onwards

### The National Background

In November 2008 the Law Commission produced a scoping report into the work it was about to undertake on the legal framework used by adult social care. The report recognised that the legislation for safeguarding adults needed to be reviewed. Unlike children's safeguarding, there is no clear legal framework in place. Instead there is a complex range of legislation and guidance that has to be considered by those seeking to protect an individual from abuse. Somerset's Safeguarding Adults Board contributed to the consultation undertaken by the Law Commission in May 2010. The results of this consultation were published at the end of March 2011 and the Safeguarding Board await with interest the Law Commission's final report into Adult Social Care due in May 2011.

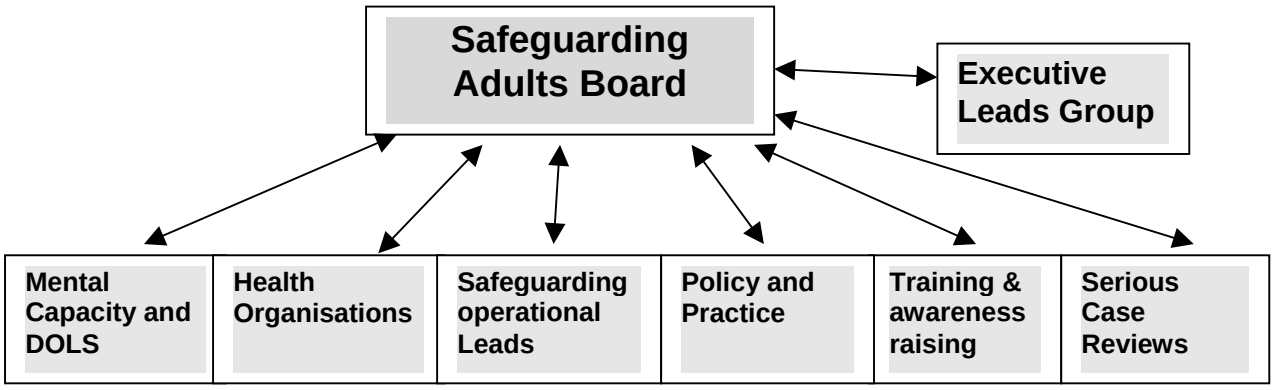
It is hoped that the Law Commission report will contain some reference to the function and membership of safeguarding boards. In January 2010 a government statement had indicated that legislation might be introduced to put adult safeguarding boards on the same statutory footing as children's boards. The 2010 election, however, has lead to a delay in work on this and we are awaiting further information from the government about the future role of safeguarding adult's boards.

The proposals contained in the Health and Social Care Bill 2011 will have an impact on safeguarding work during the next year. The membership of the Safeguarding Board is likely to change as NHS organisations adapt in line with the requirements contained in the Bill. During this time of change health organisations are being reminded of their responsibilities for safeguarding. The Department of Health have recently published guidance on safeguarding in health settings (*Safeguarding Adults: The role of health services*, 14th March 2011), clarifying the boundaries between clinical governance, complaints and safeguarding. The guidance also reminds health organisations that safeguarding issues should be referred to local authorities for decisions under the safeguarding process. The 2010 Comprehensive Spending Review is also leading to changes within organisations. The commitment to safeguarding in Somerset, however, remains high and during the year additional resources have been committed to providing safeguarding posts in key organisations.

During the last year there have been a number of legal cases around the use of the Mental Capacity Act and the Deprivation of Liberty Safeguards. The case that has highlighted particular issues is that of G v E (involving Manchester City Council).In this case Manchester City Council was found to have acted unlawfully when it removed a 19 year old man with severe learning disabilities from the care of a woman who had looked after him for several years within her own family. The judgement criticised the city council for failing to comply with the deprivation of liberty safeguards and omitting to seek a welfare decision from the Court of Protection about where he should live. The case emphasises the importance of welfare decisions being proactively referred to the Court of Protection, rather than waiting to see if a decision is challenged.

## The Safeguarding Board

During the last year membership of the Board had continued to increase. Although the Board recognised that this multi agency involvement was vital, it also acknowledged that the size of the Board was impeding its ability to work effectively and in December 2010 the Board agreed to change its structure. A main decision making Board was created supported by an Executive Group and a number of small sub groups. The sub groups have representatives from a range of agencies working together to strengthen the multi agency guidance, improve practice and support innovation. The Executive Group supports the Board's work by assisting to resolve any difficulties and ensuring that safeguarding is given the appropriate resources and priority within key organisations.




Details on the agencies represented in the Board's structure can be found in Appendix 3.

This new structure has been in place for three months. The sub groups are chaired by representatives from a variety of agencies and multi agency involvement with all aspects of the Board's work remains high.

## Training and Development

This sub group of the Board was established to co ordinate safeguarding training and awareness activities. The group has representatives from care providers, training organisations plus health and social care agencies. There is a safeguarding training programme in place across all agencies, with courses tailored to meet the requirements of staff working in a variety of settings. For example:

- staff in all agencies undertake awareness training and know how to raise a concern
- managers in care settings and health organisations undertake training on investigating concerns
- in Social Care, as the lead agency, staff are trained in investigating concerns and chairing safeguarding meetings.

In February 2011, a significant event audit undertaken into the management of a concern in a nursing home identified the need for further training for the chairs of safeguarding meetings. The audit highlighted the need for chairs to ensure that the minutes of safeguarding meetings are clear and that actions are clearly noted, recording both the timescale for the action and the responsible individual. The training for chairs was immediately revised and the update training will have been provided to all the chairs by the end of July 2011.

The training sub group is currently revising the training strategy, focusing on key professionals, such as general practitioners, who need to receive additional information about their responsibilities for safeguarding. Each organisation will also ensure that there staff are aware of who to contact if they need support with a safeguarding issue.

The Somerset Safeguarding Board has been involved in the development of a national safeguarding competency framework. This will be used by Board members to benchmark each agency's safeguarding work, enabling the Board to identify areas that need further development.

The training group also take responsibility for awareness raising. This includes the organisation of the annual safeguarding conference. This year's conference, to be held in the autumn 2011, has a focus on housing providers, ensuring they are aware of safeguarding as well as other aspects of community safety. The conference will include information about the Keeping Safe Scheme. This scheme is due to begin in the West Somerset area in June 2011. The scheme will provide identified places in the community, where people with learning disabilities can ask for help if they are having problems. It could be an everyday difficulty such as a lost key or wallet or support with a more serious matter such as bullying or theft. Participating businesses are provided with window stickers so people know where to ask for help, and staff are trained to respond quickly and correctly. People using the scheme have booklets explaining how it works and introduction cards which have enough detail for staff to summon extra help if it is needed.

**Policy and Practice**

This group is responsible for ensuring that the multi agency policy is updated and that the practice guidance supports staff in undertaking safeguarding work. During 2009/10 the toolkits used by frontline staff were updated. In February 2011, a significant event audit identified that the "Whole Service" toolkit needed to be further revised to reflect changes in the Care Quality Commission's regulatory approach and to distinguish commissioning issues from safeguarding concerns. The revision is currently in draft form and is due to be completed in August 2011. The audit in February 2011 also identified a need for a clear process around the management of concerns about pressure care. NHS Somerset, Somerset Community Health and Somerset County Council have been developing a revised procedure. Currently in draft form it is hoped this will be approved by the Board in September 2011.

Case file audits continue to be undertaken and the results are shared with this group. These audits indicate that safeguarding work is undertaken well in Somerset, but the complexity of work is increasing. Some of this complexity arises in situations where

the individual does not have the capacity to lead the decision making in the safeguarding process. Whilst knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards appears to be good amongst social care staff, a recent Serious Case review and significant untoward incident have highlighted a lack of knowledge amongst health staff in particular general practitioners and hospital based staff. The judgement relating to G v E (involving Manchester City Council) has also emphasised the importance for all staff working with adults to have an understanding of the Mental Capacity Act. In particular the importance of:

- Recognising when you are the decision maker
- Ensuring the best interest decision record is completed for key decisions
- Referring situations for a welfare decision by the Court of Protection when a dispute is developing between professionals and the friends or families of a service user.

The policy and practice group are currently updating the section on the Mental Capacity Act within the safeguarding policy. Work is also being done with the training group to ensure that health professionals receive further training on the Act.

**Deprivation of Liberty safeguards (DOLS)**

DOLS Statistics for 2010/2011

| | Applications | Assessments | | Length of authorisations granted | | | Funding source | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Urgent | Standard | < 3 months | 3-6 months | 12 months | Self | SCC | PCT |
| **NHS Somerset** | **5** | **5** | **0** | **1** | **0** | **0** | **n/a** | **n/a** | **5** |
| **SCC** | **53** | **40** | **13** | **9** | **20** | **4** | **15** | **32** | **6** |

The Deprivation of Liberty safeguards were introduced in April 2009. Referrals and assessments have gradually increased during the last two years. In 2009/10 there were 40 assessments undertaken, while, as the table above shows, in 2010/11 there have been 58 assessments completed. This activity level is broadly in line with other local authority areas in the South West region and nationally. A full report of the national data will be produced by the NHS Information Centre, probably in July 2011, at which point it will be possible to do some more detailed analysis and comparison.

The picture across the country has continued the pattern of differing levels of activity which is not easily explained in demographic terms. It is reasonable, though, to draw a broad conclusion that those areas with more dedicated staff time for awareness raising tend to generate the most assessments. Understanding of DoLS in Somerset remains patchy. Training has been offered to all care providers, but whilst take up has been good, there remain some providers who have not attended any training. Somerset County Council have recently created a new DoLS and Mental Capacity Act officer post. One of the main tasks of this role is to undertake visits to Residential Care Homes and provide additional awareness raising events.

The number of assessments in hospitals remains very low. Some of the hospital referrals have been inappropriate, showing a poor understanding of the legislation. NHS Somerset have discussed these referrals with the hospitals involved and suggested further training be provided. All the hospital assessments relate to acute hospitals, there have been no applications from psychiatric in-patient units. Again this is a similar pattern to elsewhere in the country, mainly due to the expectation that almost everyone who might need to be detained in a psychiatric unit would fall under the provisions of the Mental Health Act rather than the Mental Capacity Act. Some recent case law has prompted some questioning of this position in relation to informal patients who lack capacity but no definitive resolution has been determined. The Supervisory Bodies - NHS Somerset and Somerset County Council, are in discussion with Somerset Partnership Trust to clarify the impact of the case law on psychiatric in patient units.

There has been a low level of turnover among the DoLS assessors. There are currently 14 Best Interest Assessors and 10 Mental Health Assessors available in the County. Some new Best Interests Assessors have completed their training and a further six Somerset County Council social work employees will undertake the course at the University of the West of England from September 2011 – March 2012. Update training is currently being provided to the current Best Interests Assessors and the Medical Assessors.

The administration of the DoLS processes for both Somerset County Council and NHS Somerset Supervisory Bodies continues to be operated very effectively via a system operated jointly by Somerset County Council's DoLS administrator and the Mental Health Act administrators in Somerset Partnership. Although there have been some points in the year where assessor availability has been more limited, the two Supervisory Bodies have met the set timescales. This may prove more of a challenge with a further increase in assessment numbers.

Included in the provisions of the draft Health and Social Care Bill currently under discussion in parliament is the transfer of the DoLS responsibilities from health to local authorities. If introduced, this will affect the process for authorising DoLS in hospital settings, with the Law Authority replacing NHS Somerset as the supervisory body.

**Health and Safeguarding Leads sub groups**

Both of these groups take responsibility for ensuring that the multi agency policy is being implemented by staff across Health and Social Care. During the last year the resources allocated by organisations to safeguarding work has increased. Yeovil District Hospital have recently appointed a safeguarding officer to lead the work within their trust (this post reflects the role already undertaken by the safeguarding officer at Musgrove Park Hospital). The two acute trusts have also worked together to fund a Learning Disability Liaison Nurse. The Liaison Nurse will ensure that people with a learning disability are supported during their time in hospital and communication between the hospital and the community is maintained. This is a role that was identified as being needed during a Serious Case review undertaken by the Board this year.

In the County Council, the safeguarding resource has been extended by the creation of two additional specialist posts - a safeguarding officer and a DoLS and Mental Capacity officer. Both these posts will be managed by the Safeguarding and Mental Capacity Act Co-ordinator. Safeguarding posts are also in place in Somerset Community Health and Somerset Partnership. NHS Somerset also have a member of staff who takes a lead in responding to concerns in health settings. Somerset County Council and Somerset Partnership also have a number of operational managers who take the "lead "role for safeguarding in their localities. They provide the first point of contact for frontline staff seeking advice on safeguarding issues.

In 2010, Somerset County Council received an excellent rating from the Care Quality Commission in the area of personal dignity and respect. This area includes safeguarding and the report stated that:
*Building on a strong base the council and its partners have delivered further significant improvements to safeguarding arrangements and activities. Partnership arrangements are strong and embedded and the council is recognised as an expert on safeguarding, with public and private sector organisations turning to it for advice and direction. The efforts of the Safeguarding Board to raise and maintain levels of awareness have been successful with increased levels of reporting and more perpetrators being prosecuted*. Assessment of Performance Report 2009/10 available from
http://www.cqc.org.uk/_db/_documents/CAPA10_somersetassessmentofperformancereport10.pdf
This success would not have been possible without the close co-operation that exists between the safeguarding leads.

**Activity Report**

Work Levels

Since April 2009 safeguarding concerns in Somerset have been recorded on a new database system. This system enables us to provide the information on safeguarding referrals needed by the Department of Health. More importantly the database is now being used to provide regular reports to the Safeguarding Adults Board about the level of referrals, types of abuse and the outcomes for victims following safeguarding intervention.

The table below details the number of safeguarding concerns reported to Somerset County Council for the last year. The table also contains information about the activity levels for the previous year 2009/10. What these figures indicate is that our safeguarding referrals have remained around the same level as last year, but there has been a decrease in the number of self neglect cases where the safeguarding process has been used. Somerset has been collating data on self neglect following a recommendation from a Serious Case Review undertaken in 2009. Situations where the level of concern about the nature or extent of the self neglect has lead to the safeguarding process being used are recorded on a self neglect database. Further analysis is currently being undertaken to explore the reasons behind the significance difference in reported numbers of self neglect cases.

Social care staff continue to report that the level of safeguarding work is increasing. Although the number of safeguarding referrals recorded on the database does not appear to support this, information from social care records show that there has been an increase in the number of contacts received about safeguarding issues. Contacts are a record of any telephone calls or letters received by the County Council. When these contacts appear to be raising a safeguarding issue the details are passed to a manager in social care and further information is gathered. A decision is then made as to whether this is an issue that should be investigated further under the safeguarding policy or should receive some other form of support from social care. Between 2010/11 the County Council received 1193 safeguarding contacts. Of these 659 were considered to be safeguarding issues that needed to be considered under the multi agency safeguarding process. 12 of these referrals were about the same safeguarding concern, but reported by different people or organisations. 108 of these referrals related to concerns about self neglect where the individual lacked the capacity to make decisions about their well being. Although these contacts may not result in the use of the safeguarding process, they do need information to be gathered and discussions held.

Activity Levels

| | April 09 - March 10 | April 10 - March 11 |
|---|---|---|
| Completed work recorded for the Department of Health | 511 | 516 |
| Self neglect | 182 | 108 |
| Total | **693** | **624** |

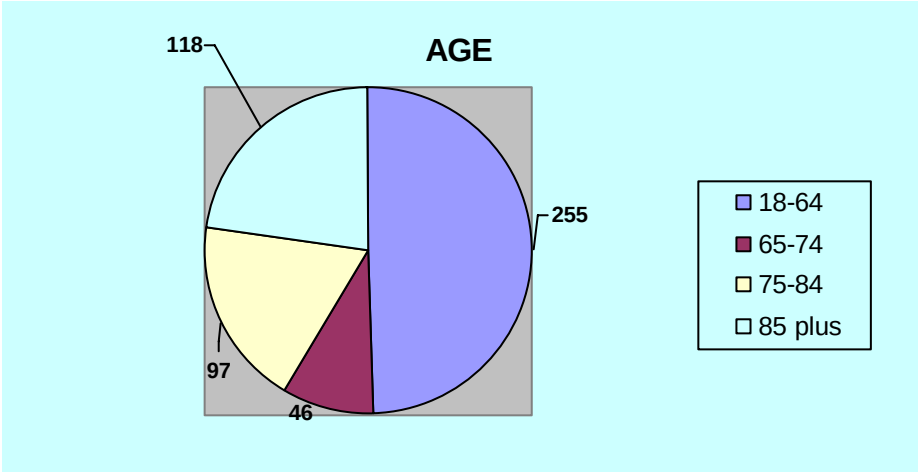
We cannot currently compare our figures with other local authorities. The first country wide reporting to the Department of Health in September 2011 identified differences in the information used for reporting and further guidance was issued. All authorities are due to submit their reports for 2010/11 to the Department of Health at the end of July 2011. It is hoped that benchmarking information will then be available for the Board to consider in September 2011.

All the information reported below is taken from the information collated for the Department of Health. It therefore refers to the work undertaken in the 516 cases that have been supported through the multi agency safeguarding process.

Age and Gender

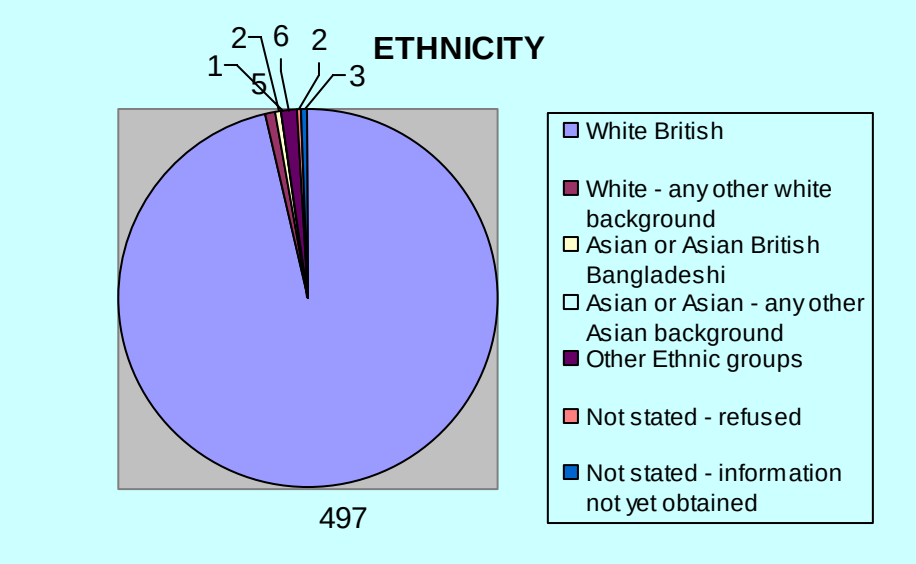
During the year we dealt with 255 safeguarding investigations concerning people aged between 18 – 64. Of these 139 concerns related to people with a learning disability. These figures are higher than the previous year and reflect the work that has been undertaken around identifying safeguarding issues in long term work undertaken by the Learning Disability teams. Referrals for people aged 85 plus have decreased this year to 118. In last years report it was noted that the high level of reporting (164) was due to a number of concerns in residential environments. Concerns in these settings have decreased this year and this will have contributed to this fall in activity.

The majority of our safeguarding referrals (330) relate to women. We have seen an increase in referrals for men in the 18- 64 category. The highest level of disparity between referrals for women and men is in the 85 plus data where there a ration of 3:1. The 2009 mid year population estimates for Somerset show that in comparison with the overall population, there is a bias towards women in the safeguarding figures. The Board will be considering what action could be taken to ensure that men are aware of the safeguarding support available and how this can be accessed.



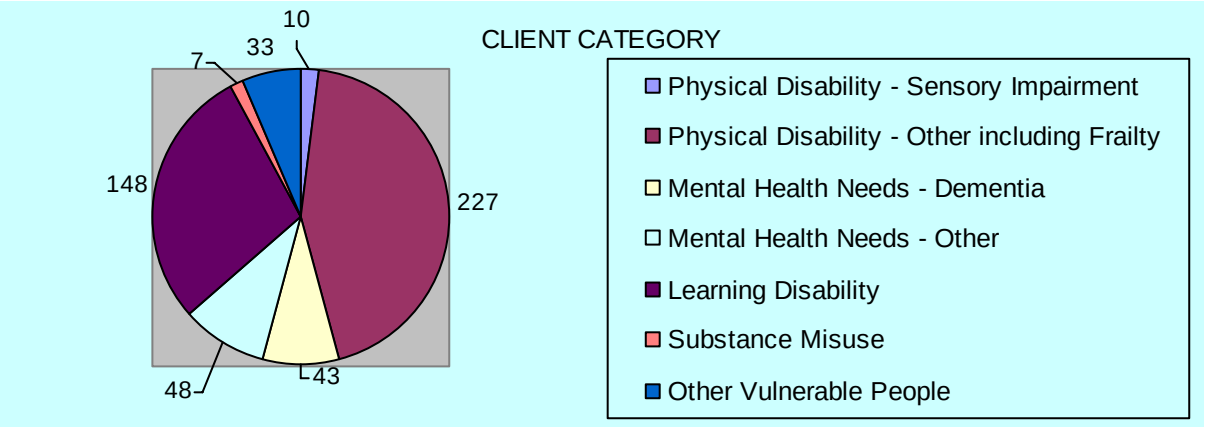

Ethnicity

The majority of service users identified themselves as White British. There has however been an increase in the number of referrals from minority ethnic groups. The 2001 census indicated that over 3 per cent of the population aged over 18 in Somerset was from a black or minority ethnic group. This year 1.7 % of the safeguarding referrals relate to minority ethnic groups. The Training and Awareness sub group were asked in September 2010 to ensure that safeguarding information was provided to organisations working with minority groups. This increase in referrals may reflect the work they have done, but further work is needed to increase the knowledge of safeguarding across all the communities in Somerset.




Client Category

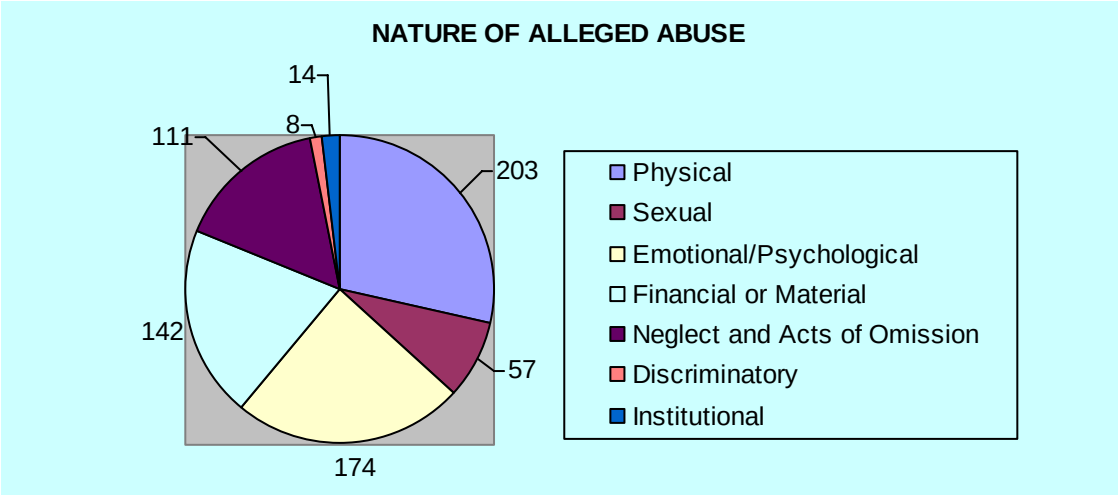
The Department of Health have requested information on client category that is not age related. Reporting is therefore based on the nature of their disability. The majority of safeguarding concerns relate to people with a physical disability, but there has also been an increase in the number of concerns reported for people with a learning disability. During the year, the safeguarding lead in Somerset Partnership Trust has ensured that the guidance on safeguarding in mental health has been implemented. The number of referrals with people defined as having Mental Health needs ( not dementia) has increased from 23 in 09/10 to 48 in 10/11. The safeguarding board has also recently approved guidance relating to safeguarding for people with alcohol and drug issues. This has resulted in a small increase in referrals for people with a substance misuse, but it is anticipated there will be a further increase next year.



Nature of the alleged abuse

Safeguarding concerns often include a range of abuse. An individual may be financially abused, but also be neglected or emotionally abused. When reporting on abuse, we therefore record all the abuse identified in an individual's situation. Physical abuse continues to be the most frequently reported form of alleged abuse with 203 reports during the year. There has also been an increase in the reports of emotional abuse (174 reports) and financial abuse (142). Reports of neglect or acts of omission have also increased (111 this year ) – these relate to situations where an paid or informal carer is not providing the support needed by an individual.

The referrals of institutional abuse have decreased from 72 in 2009/10 to 14 reported incidents this year.




Source of referral

This year's information shows referrals coming from a range of professional groups, including 78 from Domiciliary staff, 86 from residential staff, 80 from social care staff and 184 from health care professionals in community and hospital settings. There has been a noticeable increase in referrals from the Police, with 24 referrals recorded during this time. Last year the decrease in referral from domiciliary staff was noted, the increased figures in this report suggests that the work undertaken with domically agencies around reporting concerns has been successful.

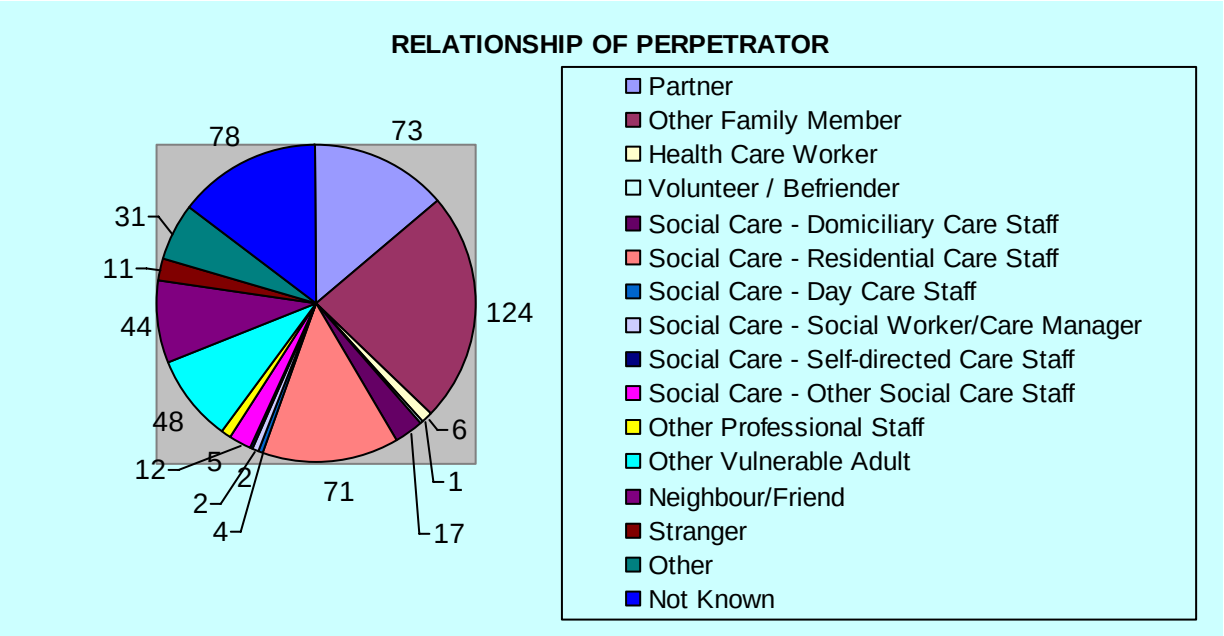
Referrals from service users, families and other members of the public have also increased with 100 referrals received from them during the year.

Location of Abuse

The largest number of referrals (264) relates to abuse that has occurred in the individuals own home. Abuse in residential settings was identified in 135 situations, whilst there were 43 referrals related to concerns in supported accommodation.

Relationship of Perpetrator

This year's figures continue to record that the majority of perpetrators are family members/partners or friends and neighbours. 124 referrals were received where the alleged perpetrator was a family member and there were 73 situations of abuse by a partner. The number of vulnerable adults who were identified as a perpetrator has also increased, with 48 perpetrators identified as falling into this category. The number of perpetrators identified as working in residential care has fallen from last years figure of 158 to 71 this year.




Outcomes for victims

The main outcome from the safeguarding process for victims is an increase in monitoring from a variety of agencies, including the health service, social care and the Police. 155 victims received an assessment and services by social care, whilst in 59 situations access to the alleged perpetrator was restricted.

There is also a high level of reporting of "no further action" with 113 outcomes reported in this way. The Board is currently undertaking a sample of case files to clarify why no action was taken. This audit is still in progress and will report to the Board when completed. It is important we understand whether this lack of action reflects: individual choice not to receive further support; an allegation that was not substantiated; or if there was a lack of supportive or appropriate services available to the victim.

Conclusion of the safeguarding process

The information on the conclusion of the safeguarding process identifies how many allegations of abuse were substantiated during the safeguarding investigation. This year 179 allegations were substantiated, 120 were partly substantiated and 113 not substantiated. In December 2010 concerns about the level of not determined or

inconclusive cases reported during the first six months of the year were raised at the Board and it was agreed that a sample of cases that resulted in an outcome of inconclusive would be reviewed during the year to identify the learning they offer about the safeguarding process. This audit is currently in progress but the initial learning suggests that the level of inconclusive reports is due to a lack of clarity amongst staff about the definitions. Based on this initial learning, information about the definitions, including practice examples have been shared with staff members.

## 3. Safeguarding in Somerset – This Year's Learning

### Serious Case Reviews

The purpose of a serious case review is not to apportion blame but to find out whether there are lessons to be learned about the way that professionals and/or agencies work together to safeguard adults. During the last year the Safeguarding Board has commissioned two serious case reviews.

The review into the events at Parkfields Care Home is due to be published in May 2011. Parkfields was a residential care home for older people, with residents funded privately and by Somerset County Council. In January 2007 staff members raised concerns that led to an extensive police investigation, which covered the care of ten older people then resident or formerly resident at the Home. The Police also investigated the medical care provided to the Home Manager, Rachel Baker. In April 2010 Rachel Baker was prosecuted for misappropriation of drugs, manslaughter and perverting the course of justice. This review is being chaired by an independent Chair, Margaret Sheather. It has been agreed that a full copy of the review will be made publically available once it has received Board approval.

The other serious case review undertaken this year considered the events surrounding the death of a woman with learning disabilities. N was a woman with severe learning disabilities and complex health needs who died in hospital from complications from a medical condition. She had limited communication abilities and probably lacked capacity to consent to hospital admission and treatment for the condition.

Over a period of eight months N had multiple admissions into an acute hospital with the same condition. The review concluded that numerous opportunities to make a clear decision about appropriate treatment were missed. Despite the likelihood of the condition recurring if not treated, her repeat admissions did not lead to an increased sense of urgency among the health practitioners involved. There were numerous social care and health practitioners involved in N's care but no-one held responsibility for overall co-ordination of the range of services she required. Liaison between the community services and the hospital were not effective.

Due to the complexity of her needs it may not have been possible to prevent N's death arising from the repeated episodes of her condition. However, had a clear treatment decision been made at the appropriate time it may have been possible to avoid the trauma of further emergency hospital admissions and to ensure that the end of her life was more comfortable.

The key issues identified in the review were:

- A care pathway for adults with learning disabilities and complex health needs needed to be developed. This pathway should outline the role of the Acute LD Liaison Nurse based in Yeovil District and Musgrove Park Hospitals, clarify the nature of the provision of support to in-patients with learning disabilities provided by care providers and ensure that the Somerset Health Passport for people with learning disabilities is used appropriately.
- Interim arrangements for the co-ordination of complex acute admissions and discharges for people with a learning disability should be put in place immediately.
- The roles of the social work care manager and health coordinator within the Community Teams for adults with a learning disability should be reviewed to address the gaps identified by the review.
- Care providers in the Council's learning disability services need to have clear guidance on how to escalate concerns about effective medical treatment and follow up.

In last year's annual report the need to revise the serious case review guidance was noted. Work on new guidance was begun, however both serious case reviews have identified further learning points about the conduct of reviews. In particular how best to involve families or whistleblowers in the review process and the implications of data protection for the publication of the serious case review report. It has therefore been decided to delay the revision of the guidance until September 2011, when both reviews will have been completed.

The serious case sub group will continue to monitor the implementation of the serious case review action plans. It will also receive requests for serious case reviews, share information from agency investigations that have a safeguarding implication and ensure that lessons learnt from reviews undertaken nationally are considered by the Board.

**Service User involvement**

In our previous Board report we acknowledged that one of our main challenges was to increase the involvement of service users in the safeguarding process. We have struggled to find a way that service users can be meaningfully involved in the work of the Board. Drawing on the expertise of other Local Authorities in the South West we are currently working with the South West Safeguarding Adults Project Officer to develop a service user forum. An audit is currently also being undertaken into the involvement of service users and their representatives at safeguarding meetings. The Board has asked for information on how many service users are involved in meetings, the reasons for their absence and what alternative methods of involving the individuals are used if they are not present at the meeting. The findings from this work will be reported to the Board in December 2011.

## Safeguarding in Somerset – Future areas of Work

The profile of safeguarding adults work is increasing. The national picture presented at the start of this report will change again during the coming year. The awaited governmental statement on safeguarding adults will require action and the recently published guidance on safeguarding in health settings will need further consideration. Thresholds will need to be agreed between the local authority and health organisations on safeguarding reporting by health organisations. The recommendations from serious case reviews will need to be implemented, and the involvement of service users in safeguarding must be strengthened. So there is much more to be done. The Safeguarding Work Plan in Appendix 1 provides information on the key areas for the Board during the coming year.

# SOMERSET SAFEGUARDING ADULTS BOARD
# ACTION PLAN

**Appendix 1**

| Task | Responsibility of | Timescale | Progress at 01/07/11 |
|---|---|---|---|
| Establish the new structure for the Board and its sub-groups | SAB | July 2011 | All groups have met at least once |
| Produce an Board report for 2010/11 for publication | SAB | July 2011 | Proposal to Mar 11 SAB |
| Develop a standardised benchmarking framework for use across SAB partner agencies and use this as a basis for an integrated annual reporting format | Executive Leads Group | March 2012 | |
| Develop a plan based upon regional guidance for ensuring the effective engagement by the Board with service users | | | |
| Agree threshold guidance for when concerns raised in any health setting should be reported to Somerset County Council as safeguarding | SCC, NHS Somerset | | |
| Establish a combined multi-agency staff training plan based upon the safeguarding competency framework | Training and awareness-raising s-g | Nov 2011 | |
| Organise an annual awareness-raising conference | ditto | June 2011 | POSTPONED to autumn 2011 |
| Develop an awareness-raising strategy for various professional groups and political representatives | ditto | Sept 2011 | Discussion by Training sub-group on July 1st |
| Develop safeguarding training modules specifically for trainee and newly qualified social workers | SCC + SomPar safeguarding co-ordinators | Sept 2011 | Feb ’11 Agreement made with SCC L&D team about timescale for introduction |

| Task | Responsibility of | Timescale | Progress at 01/07/11 |
|---|---|---|---|
| Produce a revised policy and procedure document for Serious Case Reviews and other learning lessons exercises | SCR s-g | Sept 2011 | In draft |
| Develop a specific action plan format to enable the SAB and others to monitor the implementation of Serious Case Review recommendations | ditto | July 2011 | For presentation at July SAB |
| Complete the Parkfields SCR | ditto | May 2011 | Complete |
| Produce a revised version of the Somerset multi-agency safeguarding adults policy to take account of the SAB restructuring and the key changes in the provision of community health services | Policy revision s-g | Nov 2011 | Started – researching good practice examples |
| Further develop the links between safeguarding and community safety activities including domestic violence | SCC safeguarding co-ordinator and SAB community safety rep | | SCC community safety rep on the Training and Awareness sub group |
| Develop more effective communication links with the police as part of the restructuring of the Public Protection Units | SCC safeguarding co-ordinator | | Awaiting police decision on restructure |
| Establish the SCC safeguarding and MCA team | SCC safeguarding co-ordinator | July 2011 | Safeguarding and MCA officer posts now filled. Team complete in Sept. |
| Complete the data collation for annual submission to the statutory Abuse of Vulnerable Adults (AVA) database | SCC safeguarding co-ordinator | July 2011 | Submission date delayed by DH to mid July 2011 |
| Ensure the development of the new SCC client record system is appropriately set up to enable collation of safeguarding data for the AVA submission from 2012. | SCC safeguarding co-ordinator | March 2012 | |

| Task | Responsibility of | Timescale | Progress at 01/07/11 |
|---|---|---|---|
| Establish formal links between adult safeguarding and the development of personalised services | SCC safeguarding co-ordinator | | |
| Participate in the piloting by Avon & Somerset Constabulary of the strategy to protect vulnerable people from anti-social behaviour | SCC, SomPar | | CH has attended initial ASB steering group South Somerset |
| Progress the development of a multi-agency safeguarding trigger protocol | Executive Leads Group + Health organisations s-g | | |
| Develop further guidance about the investigation of whole service safeguarding concerns and its relationship with commissioning processes | SCC Safeguarding Co-ordinator | October 2011 | Not started |
| Undertake further Deprivation of Liberty Safeguards awareness-raising activities in relevant partner organisations including hospitals and care homes | NHS Somerset and SCC Supervisory Bodies | March 2012 | In progress – new MCA post holder to focus on this |

**Appendix 2**

# 1) SOMERSET PRIMARY CARE TRUST

# SAFEGUARDING ADULTS ANNUAL REPORT 2010 -11

## 1. Staff Training and Development in Training

Safeguarding adults training is now incorporated in the Trust induction programme. Further Safeguarding training with District Nurses has been undertaken in order to offer support with review processes and identification of how they interlink with Safeguarding.

Continued use of NHS Somerset Safetynet bulletin to identify how multiagency working contributes towards the safeguarding process.

## 2. Awareness raising activity with service users and members of the public

There have been a number of improvements made to the management of Funded Nursing Care(FNC) which have served to significantly raise awareness in Safeguarding Adults, acting as an early warning tool and allowing triangulation of information from a variety of perspectives.

FNC reviews serve a function as a background resource, either to feed into the safeguarding process once it is underway or to gather information that when considered collectively may indicate concerns with regard to a whole service concern. It would be expected that if there were levels of concerns raised in one review that met the threshold of safeguarding that the process of safeguarding would be well underway before the review reached NHS Somerset.

When the FNC reviews are processed any concern no matter how minor is recorded in a database. Examples of information may include weight loss, wounds, falls, record keeping and comments by resident and relatives. This might then trigger or support a safeguarding process as these recorded concerns may be indications of poor care, poor nutrition or lack of supervision as examples. If a specific concern is raised about one resident, the review database can be used to establish if other residents have been affected and to help decide if there is or isn't a whole service concern.

The information contained in this database has been used to support whole service reviews in Somerset PCT area in the last year. In addition if there is a whole service concern the reviews can be used to identify individuals who may be potentially at risk so that this can be assessed and strategies put in place to safeguard if necessary.

The database information is anonymised and then shared with commissioning at the local authority in order to supplement their knowledge base. The content of FNC reviews are also used to intervene early if there are concerns around the management plan for health needs. All reviews are passed to the Vulnerable Adult (VA) Lead for Somerset Community Health who will follow up these issues. For example if a review indicates that a person has lost weight but does not indicate the

management plan for this then the VA lead will ask for the reviewer to follow up this up and provide an update. This will ensure appropriate diets and referrals are being made, to prevent further weight loss in that individual. The aim of this, along with ensuring people needs are met, is to put in place a process for addressing unmet needs before they escalate into a safeguarding concern
The incident reporting and FNC reviews and follow up process supplement and provide evidence for the safeguarding process, but also has a function to raise awareness, identify issues with quality early and address the with the aim of preventing escalating into safeguarding.

Continued use of NHS Somerset Safetynet bulletin to identify how multiagency working contributes towards the safeguarding process.

## 3. Safeguarding Adults Alerts in relation to Health Services

During 2010 -11 a number of safeguarding adults alerts have been raised in relation to NHS provided services. These have been raised through a number of referral routes in relation to care for vulnerable adults in general hospitals, in primary care and by community health services. The referral source by provider type is set out in Table 1 below. Some referrals related to the care provided to a vulnerable adult across the patient pathway from primary care to secondary care and this accounts for the difference between the total number of referrals as 6 and the total number of providers where safeguarding alerts had been raised as 10.

Table 1: Referral Source by NHS Provider Type

| Referral Source | | NHS Provider type | |
|---|---|---|---|
| Community team for adults with learning disabilities | 4 | Acute trust | 4 |
| Family of person with a learning disability | 1 | Primary Care | 5 |
| Independent Mental Capacity Advocacy Service (IMCA) | 1 | Community health services | 1 |
| Total | 6 | Total | 10 |

## 4. Safeguarding Adults Alert investigation process

All of the safeguarding alerts reported by NHS Somerset are those that have been made directly to NHS Somerset as the lead commissioner of health services for the population of Somerset. NHS Somerset has overseen the investigation process for each alert raised.

All acute trusts are responsible for undertaking their own internal investigation and providing a copy of the investigation report to the commissioner. A GP safety lead is asked to undertake an investigation with general practice for safeguarding alerts raised in relation to primary care. Where an alert has been raised about care

provided across the patient pathway a final investigation report is compiled to provide lessons learned across the patient pathway.

One safeguarding alert was reported as a serious untoward incident by the NHS provider and the investigation of this was undertaken in accordance with the National Patient Safety Agency National Framework for Reporting and Learning from Serious Untoward Incidents monitored by NHS Somerset as the commissioning primary care trust. This safeguarding alert was also the subject of a multi agency serious case review commissioned by the Somerset Safeguarding Adults Board.

## 5. Lessons Learned for Improvement in Care

Action plans for implementing the lessons learned are reviewed with NHS providers through the quality monitoring meetings held with each NHS provider as part of the contract process, for those within Primary Care these are overseen by the GP patient safety lead.

Key recommendations being taken forward as a result of the safeguarding alerts in health services are as follows;

1. Safeguarding adults training for general practice has been commissioned from the GP education trust. This training will include case scenarios based on the investigations undertaken.
2. Safeguarding adults training for general practice will include the communication skills required for assessing, diagnosing and treatment planning for people with a learning disability.
3. All Foundation Trusts and Somerset Community Health were required to provide revised training strategies for implementation of the Mental Capacity Act 2005 following the peer review of care of people with a learning disability in hospitals undertaken in September 2010. NHS Somerset is overseeing implementation of these training strategies through the quality monitoring meeting with all NHS providers.
4. a short summary of the information that GPs need to know about patients, will be provided for carers of people with a learning disability, who may act as advocate to patients with GPs.
5. All safeguarding alerts are summarised as anonymised case studies for inclusion in the NHS Somerset Safetynet newsletter which is circulated to all NHS providers, primary care medical practitioners, dentists, pharmacists, and optometrists.
6. An audit will be undertaken of the uptake of the local enhanced service for people with a learning disability, by general practice. This will include audit of the quality standards in the service specification which cover training and named GP arrangements.
7. A multi agency working group has already met to develop a care pathway for people with a learning disability who have identified health needs.

Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust have jointly appointed a learning disability liaison nurse. This nurse will take forward plans to implement use of the ‘Working Together’ document and patient passports for people with a learning disability in both acute trusts. The liaison nurse will also take forward training for care of people with a learning disability in

both trusts and set up processes to identify all people with a learning disability being cared for in hospital or who are coming into hospital to ensure that appropriate care planning is put into place.

## 6. Sharing learning and implementing actions from Serious Case Reviews

New guidance has been developed and disseminated for Care homes and NHS Somerset have developed a Nursing Home Closures policy.
Revision to Serious Untoward Incident Policy and National Patient Safety national framework for reporting and learning from SUIs which identify Grade 3 and Grade 4 pressure ulcers, all Providers have commenced reporting on these.
Mental Capacity act implementation, following the peer review of acute care for people with a learning disability, NHS Somerset in its role as Commissioner has required both acute trusts to provide a training strategy and implementation is monitored through the quality monitoring meetings.
Serious Case Reviews are a standing agenda item on Health Operation Sub Group for discussion and action at quarterly meetings

The findings and recommendations from a Serious Case review relating to a client with Learning Disabilities (LD) have now been raised in a countywide meeting where a joint programme of work has been agreed to ensure that issues related to consistency of primary care provision, flagging of LD and the use of special message forms to improve communication between providers, development of an acute care pathway for implementation and overview by a jointly appointed acute LD Liaison Nurse and the sharing of information resources across both health and social care providers will enhance the delivery of health services to those with Learning Disabilities.

## 7. Safeguarding Adults Board Work Plan

Work continues through the Health Operation Sub Group on development and implementation of a trigger policy.
Deprivation of liberties requests to Somerset 2010-11 5 requests, four undertaken 1 authorised. An additional Best Interest Assessor has been trained within NHS Somerset

## 8. Key issues for the development of effective Safeguarding in Somerset

All of the actions from the Safeguarding Adults alerts raised in relation to Health Services in respect of improving care for people with a learning disability have been included as part of a Commissioning for Quality Improvement and Innovation standard in the contract for both acute trusts. This means that payment in the contract is withheld until evidence is provided that the quality improvement has been achieved.

During 2011 – 12 NHS Somerset will be working with all NHS providers and with Somerset Multi agency Safeguarding Adults Board to develop a Policy on Safeguarding Alerts in Health Services to ensure that there is a clear framework for identifying vulnerable adults in health services and agreed criteria for when a safeguarding alert should be raised. This will need to include consideration of raising safeguarding alerts when serious untoward incidents are reported but also when

complaints raised and where there may have been sub optimal care provided to a vulnerable adult. It will be important to ensure that this process is embedded across all organisations and that responsibility does no rest with safeguarding adults leads alone.

**Deborah Gray**
**Associate Director of Nursing & Patient Safety**

## 2) Somerset Partnership NHS Foundation Trust

## Annual Report for the Somerset Safeguarding Adults Board April 2010- March 2011

Somerset Partnership is committed to Safeguarding Vulnerable Adults across Somerset and has developed a service and structure that reflects this commitment and ensures active participation in the work of the Safeguarding Adults Board as identified below.

| Group | Representative | Title |
|---|---|---|
| Executive Safeguarding Adults Board | Diana Rowe | Director of Operations, Deputy Chief Executive |
| Safeguarding Adults Board | Richard Painter | Safeguarding Lead for Adults & Children |
| **Subgroups:** | | |
| Serious Case Review | Richard Painter | Safeguarding Lead for Adults & Children |
| Social Care Operational | Ian Douglass | Head of Service - Older People & Learning Disabilities/ Head of Professional Social Work |
| | Sue Smith | Named Patient Manager |
| Health Operational | Ian Douglass | Head of Service - Older People & Learning Disabilities/ Head of Professional Social work |
| | Gareth Rowlands | Named Nurse for Safeguarding Adults & Children |
| Training & Awareness Raising | Jess Henry | Learning & Development Manager |
| MCA Implementation | Nick Woodhead | Mental Health Act Co-Ordination Manager |
| Policy Review | Richard Painter | Safeguarding Lead |

In September 2010 a comprehensive external audit of Safeguarding across the Trust was completed, it concluded: "The Trust has established a robust control framework for safeguarding, including a dedicated Safeguarding Team, a training programme and a comprehensive reporting and monitoring system. The grading given to the Trust was **Green** and added: "The Board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective".

In comparison all the other Trusts audited in the previous year, Safeguarding was assessed as Amber (66%) and Red (33%).

## 1. Staff Training and Development in Safeguarding

During 2010/2011 in accordance with the restructuring of the Safeguarding Adults Board, Somerset Partnership has developed the approach to Safeguarding Vulnerable Adults Training. Safeguarding training has been established as a mandatory requirement for all Trust staff and a programme of 3 yearly refresher training has been put in place.

The Trust Safeguarding Lead and Named Nurse for Safeguarding provide Level A Safeguarding Vulnerable Adults training combined with Level 1 Safeguarding Children Training to staff at all levels. The Safeguarding Lead has contributed to the provision of multi- agency training for practitioners and Trust staff have attended Level B and Level C training to support them in their respective roles.

The Safeguarding Lead and the newly appointed Named Doctor for Safeguarding Adults undertook a joint training session with medical staff in relation to clinical risk management and safeguarding that was well received. This will be reviewed and considered as a regular part of Trust training by the Safeguarding Steering Group.

**Table 1. Training completed April 2010- March 2011**

| | |
|---|---|
| Level A Safeguarding Vulnerable Adults (Combined with Level 1 Safeguarding Children) | 557<br>( 81 % of all Trust staff have now completed this training) |
| Level A+ Multi-agency SVA | 75 |
| Level B Multi-agency SVA | 14<br>(3 pending) |
| Level C Joint Adult Services Social Care and Somerset Partnership Training for Managers | 3<br>(5 pending) |
| Safeguarding and clinical risk assessment | 10 |
| SVA Workshops and National Conferences attended by the Safeguarding Lead and Named Nurse | 4 |

In a recent internal audit undertaken by the Safeguarding Lead it was identified that in the coming year there needs to be an emphasis on increasing attendance at Level B training for practitioners. Attendance at level A and C has been acceptable over the last year, therefore additional emphasis on Level B training will endeavour to raise awareness, increase confidence in individuals' roles in the Safeguarding process and generally enhance service provision. More manager nominations for level C will be encouraged when the training is next delivered.

## 2. Public Awareness and information sharing

The Safeguarding Team has ensured that Stop Abuse Posters are prominently displayed in public areas across the Trust.

The Named Nurse for Safeguarding developed a leaflet that is available on all adult wards relating to safeguarding children. This covers what inpatients can expect if there is concern raised regarding children.

In addition, availability and promotion of Domestic Abuse materials has been increased by the Safeguarding Teams Domestic Abuse Professional who has been in post since August 2010. This role is combined with being the Trust Lead for Multi Agency Risk Assessment Conferences (MARAC), Multi Agency Public Protection Arrangements (MAPPA) and the 'Prevent' Forum representative (Countering violent extremism - Home Office led initiative). The Trusts role and profile in these Multi-Agency Public Protection Forums ensure that appropriate information and plans are shared between agencies to protect our patients, staff and the public.

A multi-agency information sharing protocol is already in place for MARAC and MAPPA. Work is currently underway by the Safeguarding Team to develop a more general information sharing protocol to assist with day-to-day safeguarding duties and responsibilities.

## 3. Learning from Experience

The Trusts Safeguarding Team has developed a range of intranet pages that are available for all staff. These include Safeguarding Adults, Children and Domestic Abuse areas. Within all of these sections there are links to practice guidance and procedures but all sections also link to useful information and lessons learnt sections to help inform and enhance practice.

The Trust also has a Safeguarding Steering Group that represents all areas of the Trusts work and an established network of Team Leads for Safeguarding. All groups meet regularly with the Safeguarding Lead to ensure that Lessons Learnt are shared and that these implement practice development. Problem solving and policy implementation experiences are shared by group members and also further inform practice and policy developments.

## 4. Safeguarding Adults Board Work Plan

Somerset Partnership is commissioned to lead on Safeguarding Vulnerable Adult work when the primary need is mental health. Therefore the work plan of the Safeguarding Adults Board is very much central to the work undertaken by the Safeguarding Team and directly influences policy and practice developments.

## 5. Safeguarding Activity levels

During the period covered by this report there has been a continual increase in the level of safeguarding work undertaken by the Safeguarding Team. The positive affect of the Level 1 training is evident in terms of raising staff awareness of

safeguarding generally but also in the raised awareness of there individual roles and responsibilities.

Practice Guidance for Safeguarding Adults was introduced in early 2010. There is clear evidence of improvement relating to the clarity and consistency of following the safeguarding processes and recording of work undertaken since the guidance was intrduced.

There is work to do to ensure that the levels of documents and SVA Monitoring Forms are truly reflective of the level of safeguarding activity evidenced through Safeguarding Progress notes. Future Update reports provided at each Board meeting will ensure that progress on this work is monitored.

## 6. Issues Arising

With the acquisition of Somerset Community Health by Somerset Partnership likely to proceed from August 2011, the Safeguarding Adults Board will need to consider implications for commissioning. Currently Somerset Partnership is commissioned to provide a full safeguarding service whereas Somerset Community Health is a referring agency and refer primarily to Adult Services and to Somerset Partnership.

Somerset Partnerships electronic patient record system can provide safeguarding activity reports currently. However it is recognised that the data could be refined to provide more specific details of exactly the type of safeguarding activity undertaken and to ensure practice is accurately reflected in records. The Safeguarding Lead has commenced work with the Trusts Information Team to refine the current data and reports available.

## 7. Priorities over the coming year

To undertake a Safeguarding Adults Self Assessment and Assurance Audit using the new Department of Health guidance and toolkit.

To review current Safeguarding Training provision using the Safeguarding Adults National Competence Framework. To make necessary adjustments to ensure compliance.

To review Somerset Partnerships Safeguarding Adults Thresholds in partnership with commissioners.

To review practice guidance for safeguarding Vulnerable adults.

To ensure that records and documentation reflect the levels of safeguarding activity recorded on patient files

Level A training programme will continue and a cycle of 3 year refresher training will follow.

Increased Level B training levels will be a focus within Somerset Partnership.

Consideration of e-learning packages to enhance training capacity of the Safeguarding Team.

To ensure a seamless transition of Safeguarding Adults work from Somerset Community Health to Somerset Partnership.

Consideration to be given regarding the provision of Safeguarding Services across the Trust and the service level agreement to be reviewed.
It will be essential to ensure that Somerset Partnerships acquisition of Somerset Community Health does not have an adverse effect upon safeguarding services provided and that opportunities are capitalised upon to ensure individual services are further enhanced.

**Richard Painter**
**Safeguarding Lead for Adults & Children**

**Diana Rowe**
**Operational Director/ Deputy Chief Executive**

## 3) Taunton & Somerset NHS Foundation Trust

This report provides a summary of the activity related to Safeguarding Adults undertaken at Taunton & Somerset NHS foundation Trust over the past year.

### 1. Staff Training and Development in Safeguarding:

The Trust continues to support staff training and development in Safeguarding Adults. The training is led by Duncan Marrow, Clinical Lead for Safeguarding Adults, and is supported by the Learning & Development Department. Training includes:
Corporate Essential Learning – an awareness session delivered to new employees and updated on a three yearly cycle.
Safeguarding Vulnerable Adults – informs all clinical staff of the issues pertaining to the safeguarding of vulnerable adults. This is part of wider training around the Mental Capacity Act, including Deprivation of Liberty Safeguards.
Future plans this year are to introduce 'Champion' training days to include safeguarding to deliver more targeted training to members of staff who will cascade and embed good practice.
A Learning Disabilities (LD) Liaison Nurse has been appointed and is due to take up a joint post with Yeovil District hospital in June, to raise awareness amongst staff and the public and support education and training.

### 2. Public Awareness:

The past year has seen the introduction of Easy Read documents, available on the Trust Internet site to include information about:
Going to hospital
MRSA infection
Screening for cancer
End of life care.
In collaboration with partner agencies the Trust is supporting the rollout of the Health Passports over the coming year. It has been suggested that the Musgrove Park Hospital logo is attached to the document to reinforce the transferability of the passport.
Referrals of concerns continue to rise to the Clinical Lead for Safeguarding indicating a greater awareness amongst staff of potential and actual safeguarding concerns.

### 3. Learning from Experience:

Following a Serious Case Review as a result of a patient with a Learning Disability dying in hospital the Trust is working through the subsequent action plan to implement lessons learnt with particular reference to the action requiring all clinical decision-makers in the hospital to be supported to understand their legal responsibilities in relation to any adults who may lack capacity to consent to treatment. The associated action is to ensure that Mental Capacity Act training based upon the hospital policy document is made mandatory for all clinical decision-makers.
An action plan following the South West Peer review of Learning Disabilities has also been developed.

Action plans are monitored through the Trustwide Safeguarding Committee Meeting. Policies are also updated as learning and developments occur.
Reviews include updating the Patient Supervision Policy to reflect changes in the assessment of clinical need for supervision, and an update in the two stage capacity assessment form in 'Using the Mental Capacity Act' for consideration at the next Safeguarding Committee Meeting.
Recent developments have highlighted the need for changes to the Learning Disability Policy following the appointment of an LD Nurse and the imminent introduction of the Health Passport. The Deprivation of Liberty Safeguards Policy is being reviewed reflect changes to the way application forms are accessed.

## 4. Safeguarding Adults Board Work Plan:

The Taunton & Somerset Annual Plan for Safeguarding Adults supports the Safeguarding Adults Board Annual Plan and is monitored through the Safeguarding Committee. Actions include strengthening governance arrangements for Safeguarding Adults with a focus on delivering education and training and improved application of the Mental Capacity Act, embedding the learning from Significant Untoward Incidents and a Serious Case Review along with their supporting policies and improving partnership working and an increase in referrals to the IMCA service. A database to record safeguarding referrals is in early development to support the incident reporting process.

## 5. Priorities:

Completion of the Department of Health Self Assessment and Assurance framework to inform future priorities to include validation from partner agencies, patient, and public groups.
Review of recent guidance from the Department of Health and Thresholds Guidance from the South West Region ADASS (Directors of Adult Social Services) with any resulting recommendations agreed via the Safeguarding Committee.
Two further policies are in development - Using the IMCA Service in Intensive Care and the Domestic Violence Policy.
Implementing the actions and monitoring the progress from the Annual Plan of work along with the LD Action Plan will continue including the introduction of Health Passports.
Safeguarding 'Champion' training to be developed and rolled out to clinical areas.

**Lynn Street**
**Associate Director of Nursing**

## 4) Avon and Somerset Constabulary
## The Districts of Somerset East and West

### 1. Staff Training and Development in Safeguarding

During 2010/2011 the Constabulary in conjunction with the National Centre for Applied Learning Technologies launched compulsory e learning training for officers on the subject of protecting vulnerable people. The training comprised five modules covering domestic abuse, honour based violence and forced marriage, missing persons, hate crime and child protection. The first four sessions are all relevant to protecting vulnerable adults and will be completed by all operational staff across the force.

Training sessions have been delivered to all operational officers across Somerset in use of the DASH risk assessment to enable accurate assessment of risk in cases of reported domestic abuse.

The Constabulary has also delivered training aimed at preventing the radicalisation of vulnerable people by violent extremists as part of the national “prevent” agenda. The training entitled WRAP, workshop raising awareness prevent has been delivered to uniform officers in Safer Stronger Neighbourhood Teams, Public Protection Unit staff and is to be incorporated into the nation training for detectives constables.

For the last two years a member of staff from the Public Protection Unit on Somerset East has been invited to speak on behalf of the police service at the Annual Safeguarding Vulnerable Adults conference held in Manchester on the subject of working with police. This follows the publication of an article in the Journal of Adult Protection covering learning by the Somerset East District in the investigation of cases involving serious abuse of vulnerable adults.

### 2. Public Awareness

Safeguarding adults sits under the same Public Protection Umbrella as Domestic Abuse. The Detective Inspector with responsibility for Public Protection on each of the two Somerset policing Districts chairs the Multi Agency Risk Assessment Conference (MARAC) addressing risk to victims of high risk domestic abuse. There are now four MARAC’s a month across Somerset East and West hearing just over 400 cases in the last reporting year. Cases involving very elderly couples or those with physical or mental disabilities are becoming increasingly common. The MARAC co-ordinator for Somerset has developed and circulated new literature for both victims and professionals explaining the MARAC process. In conjunction with BCHA Somerset Changes she is about to commence training for individual MARAC representatives from the statutory and non statutory agencies attending MARAC and has issued four separate training dates. She will then delivery single agency training to raise awareness amongst front line staff in each agency scheduled to start in July this year.

## 3. Safeguarding Adults Board Work Plan

Risk assessment. The Constabulary has now adopted the DASH risk assessment as recommended by CAADA when attending domestic abuse incidents to enable officers to more accurate assess and act on risk to victims.

Link between safeguarding and community safety strategies including domestic abuse. The Public Protection Unit Detective Inspectors sit on the Somerset Domestic Abuse Forum; the Somerset East DI was a member of the working party formed to write the Somerset Interpersonal Violence Strategy 2011 to 2014 action plan.

## 4. Issues arising

Information sharing within the context of Serious Case Reviews is still an issue for the police service. Both nationally and regionally, police recommended to the “No Secrets” consultation that Safeguarding Adults should be placed on a statutory footing. Whilst this remains unaddressed East and West Somerset will review each request emanating from a Serious Case review on a case by case basis attempting to maximum permitted participation within existing legal information sharing processes.

## 5. Priorities

The Public Protection Units of Avon and Somerset are presently undergoing a work force modernisation review. Key themes include future options for co-locating with partner agencies, an increase in resources to address demand and risk and a review of the mix of police officers and police support staff within the units to ensure we work efficiently and effectively in all areas of public protection.

**Detective Inspector Lindsay Shearlock**
**Somerset East PPU**

## 5) SAB Annual Report
## Somerset Community Health

This report confirms the action Somerset Community Health has undertaken arising from the Safeguarding Vulnerable Adults Board work plan from April 2010 until March 2011.

### 1. Staff Training and Development in Safeguarding

During the period from April 2010 until March 2011Somerset Community Health has undertaken significant steps to ensure all staff are clear of their roles and responsibilities in relation to Safeguarding Vulnerable Adults. To support this work a safeguarding training matrix and guidance was developed and circulated to all Managers to provide information on the level of training that their staff need to undertake. The guidance detailed that Safeguarding Vulnerable Adults training is mandatory for all clinical staff.

A training audit was carried out by the Lead for Safeguarding Vulnerable Adults to identify any gaps in the current training that is being provided in order to develop further training packages. Regular training figures were reported to the senior management team which ensured that the uptake of this training was monitored and remained high on the organisation agenda.

From June 2010 basic safeguarding awareness sessions were reintroduced into the new staff induction days. This session was reviewed and now includes a section on the Mental Capacity Act 2005 and the Independent Mental Capacity Advocate service (IMCA).

Somerset Community Health worked in partnership with Adult Social Care and Somerset Partnership to develop and deliver sessions called Safeguarding Vulnerable Adults A+ training. This training was delivered to a multiagency audience, with the aim of providing staff with the skills and knowledge to support the pre- investigation stage of the safeguarding process. In total over 50 staff within Somerset Community Health undertook this training.

Significant progress has been made in raising the profile of Safeguarding Vulnerable Adults within Somerset Community Health and a number of Champions have been identified within the Adult services. This work is ongoing and progress will continue to be monitored quarterly

### 2. Public Awareness

Somerset Community Health adds the ‘Stop Abuse’ Logo to all the Safeguarding Vulnerable Adults documentation and also displays the Stop Abuse health education posters throughout the Organisation’s buildings and hospitals.

Safeguarding Vulnerable Adults is included and recognised within the ‘Essence of Care’ initiative and is incorporated into work streams across all Somerset Community Health staff groups. There are plans to include lay representatives on this group in

the future in order to seek their views with the aim of improving services and care delivery.

The Lead for Safeguarding Vulnerable Adults for Somerset Community Health is part of a multiagency team who are organising the first Safeguarding Vulnerable Adults conference to be held in June 2011.

## 3. Learning from Experience

The recommendations from Serious Case Reviews have influenced policy, practice and training within Somerset Community Health and will continue to influence the future direction of safeguarding vulnerable adult's strategy within the organisation. Somerset Community Health has systems in place to ensure the lessons to be learnt from e.g. Serious Case Reviews are cascaded to practitioners and embedded in practice.

Action plans have been developed following incidents and are monitored by the Somerset Community Health Safeguarding Children Implementation Group and the Quality Improvement and Patient Safety Committee.

## 4. Safeguarding Adults Board Work Plan

Somerset Community Health has identified representatives for each of the Safeguarding groups. This representation ensures contribution towards the agreed work plan and the appropriate cascade of information.

## 5. Issues Arising. *Are there any matters to which you would like the SAB to address?*

Currently no, Somerset Community Health will no longer exist as an organisation from the 1 July and will be acquired by Somerset Partnership. Following the acquisition there may be areas identified.

## 6. Priorities. *Please identify key strands of work in your organisation likely to affect safeguarding during the coming year*

The following areas are likely to be the priorities for the new Organisation:

- Review of Safeguarding Vulnerable Adults Policies, Protocols and guidelines
- Review of Safeguarding Vulnerable Adults training
- Review of Safeguarding Vulnerable Adults groups and meetings

**Ethna Bashford**

## 6) Somerset County Council

### 1. Staff Training and Development

Somerset County Council has an extensive safeguarding training programme for its Adult Social Care staff. This ranges from awareness training for all staff through to training for the chairs of safeguarding meetings. During the last year the need to provide additional training to staff such as Occupational Therapist and Adult Social Care Workers was identified. Although they do not investigate safeguarding concerns, these staff members may be the main worker for the individual who is being safeguarded. This additional course ensures that they are aware of their role and responsibilities throughout the safeguarding process. Our investigator's training has now been extended to include an additional "call back" day, which is held a few months after the original training course. This provides the participants with an opportunity to reflect on their experience of safeguarding investigations and to share their learning with others.

A significant event audit undertaken this year identified some inconsistencies in the chairing of safeguarding meetings. The training for chairs has therefore been revised and extended into a two day course. Any staff member who may chair a safeguarding meeting is undergoing this update training and feedback so far has been very positive. Our senior managers have also received update training on managing whole service issues and mental capacity welfare decisions. The practice guidance on whole service concerns is being updated to reflect the changes in operational practice that have occurred during the last eighteen months. This guidance will include greater clarity about the role of commissioning/contract staff in whole service issues. Once this guidance is in place, training will be provided to the commissioning service to support its implementation.

### 2. Public Awareness

Somerset County Council has a representative on the Boards Training Sub Group. During the last year we have ensured that the reissued Stop Abuse leaflets were distributed across organisations in Somerset, particularly third sector organisations and housing providers. Following a request from the County Council, the Board agreed to focus this year's safeguarding conference on the wider agenda of keeping people safe at home. Additional support to identify speakers for the conference is being provided by staff from the community safety and supporting people services.

During the last year, the Safeguarding Co-ordinator has run a number of sessions for residential care providers on the management of safeguarding allegations and investigations. Training on the Mental Capacity Act and the Deprivation of Liberty Safeguards has also been offered to all residential and home care providers in Somerset. The Council's website has recently been updated and links to the safeguarding adult's information has been improved so the public can more easily find the information they need.

## 3. Learning from Experience

The County Council is represented on the Learning Lessons Sub Group and is contributing to the revision of the serious case review policy. During the last year, the Council has participated in two serious case reviews. The action points from these reviews have been incorporated into the Adult Social Care safeguarding action plan, which is monitored at the senior managers meetings. The outcome of the Parkfields serious case review has been shared with all of our staff through our internal magazine and has been discussed at all team meetings. The learning from significant event adults and serious untoward incident investigations have also been included in the Social Care action plan and are being implemented through changes to policies, processes and improving knowledge across the County Council and other organisations. Examples of these changes include: a flowchart to improve the response given to concerns being raised about pressure care in residential care developed by the County Council working together with NHS Somerset and Somerset Community Health; the development, within Adult Services of a positive risk taking policy, which provides a framework for the identification and management of risk. Adult Social Care has established a regular programme of auditing safeguarding records. These audits, together with information obtained from the broader ranging practice quality audits, means that Adult Social Care are able to monitor the implementation of the safeguarding policy and to provide evidence to the Board of the high quality of safeguarding work being undertaken.

## 4. Safeguarding Work Plan

The County Council has taken a lead role in implementing many of the actions listed in the Safeguarding Adults Board work plan. In this report we have already mentioned the work undertaken on improving the quality of recording, extending the training available and strengthening the safeguarding practice guidance. The development of a safeguarding database by Adult Services means that the Board is able to draw on detailed information about the level of referrals, instances of abuse and outcomes for victims and perpetrators.

The section of the work plan that the Council is still in the process of implementing is the involvement of service users in the development and auditing of the safeguarding process. Adult Social Care works closely with advocacy organisations to obtain some reflections of the safeguarding process from a user perspective, but recognises the need for further service user involvement. The Safeguarding Co-ordinator is currently working with the South West Safeguarding Project Worker to use the learning from other authorities to support the development of a Somerset group. To support this work an audit of the involvement of service users in safeguarding meetings is currently being undertaken. The result of this work will be shared with the Board.

## 5. Issues for the Board

The issues for the County Council for the coming year that would require assistance from the Safeguarding Board are:

- Whistleblowing. The County Council has agreed to lead the work on the development of practice guidance about supporting whistleblowers during the safeguarding process. This vital assurance can only be given to the public by the Board if all relevant organisations provide evidence about how they are ensuring that whistleblowers concerns are heard and investigated and that the whistleblower is supported properly.
- Transition from NHS Somerset to GP consortium. The Board will need the support of NHS Somerset to engage with GP federations as they develop in the County.
- Prosecution of safeguarding concerns. Only a small percentage of safeguarding issues result in a criminal prosecution. Could further work be undertaken with the Crown Prosecution Service and the Police to explore the reason for this?
- Multi agency funding of the Board. The new structure of the safeguarding board requires a level of administration and co-ordination to ensure that the sub groups and the Board are well supported. At present this support is provided solely by staff from the County Council, but it is difficult to sustain as the SAB work programme grows. Support from other agencies would be appreciated in chairing the groups, providing venues and providing administrative support to some of the groups.

**6. The priorities identified in the Council for the coming year are:**

- To support the revision of revised version of the Somerset multi-agency safeguarding adults policy to take account of the Safeguarding Adults Board restructuring and the key changes in the provision of community health services
- Develop further guidance about the investigation and management of whole service safeguarding concerns and its relationship with commissioning processes for staff in Adult Social Care
- To devise a policy for the management of safeguarding issues in NHS (hospital) settings. To include how these will be reported to Social Care, timescales and expectations for investigations and the links between clinical governance and safeguarding.

**Helen Wakeling**
**Group Manager, Adult Social Care**

## 7) Safeguarding Adults Board Annual Report
## Yeovil District Hospital NHS Foundation Trust

### 1. Staff Training and Development in Safeguarding

A Clinical Lead for Safeguarding Vulnerable Adults was appointed in April 2011. Prior to this a Safeguarding Adults Survey was undertaken to help understand the level of knowledge across hospital staff and to inform the training requirements of the organisation for the coming year. On reviewing the results the decision was taken to temporarily suspend the mandatory training for all staff regarding safeguarding adults and to deliver safeguarding training as a 'Stand Alone' until January 2012. The training programme planned until that time consists of the following:

One hour mandatory raising awareness sessions for all staff on Safeguarding Adults and Mental Capacity training. From January 2012 there will be more in depth training for all staff within the organisation. These will be split into three levels.

- Level 1: All staff with no direct clinical patient involvement and may consist of E-Learning. Prior to January 2012, including Safeguarding training in already existing training, is currently being explored.
- Level 2: This is for all clinical staff and will consist of one hour mandatory training which will be delivered at various times in the day and at various locations within the organisation.
- Level 3: This training will include the Deprivation of Liberty training and in depth structure behind Safeguarding. Inter-agency training is also to be arranged.

In addition to the above it has been planned for a presentation at Big Governance for July 2011 and a roving information table around the clinical areas is planned for from August 2011.

### 2. Public Awareness

Plans are currently being pursued to link into Carer's Week and initial thoughts include an information table in the foyer of Yeovil District Hospital providing information on lasting Powers of Attorney, Somerset Direct Aids UK etc. In addition a questionnaire may be considered to gauge opinions and knowledge of the general public and offering support and advice as required.

### 3. Learning from Experience

Safeguarding concerns were raised regarding an inpatient at Yeovil Hospital, however on investigation it appears that these concerns should have been raised through the complaints process. A case review meeting was held following a thorough investigation with all those involved in the individual's care. Organisational learning for Yeovil District Hospital was the paramount importance of clear communication with outside agencies that may not be familiar with acute clinical settings. In addition the importance of a Learning Disability Liaison Nurse within the acute setting. This post has now been successfully recruited to, which should help to ensure that the organisation is able to fully implement and embed into

the organisation the recommendations from the South West Learning Disabilities Peer Review.

## 4. Safeguarding Adults Board Work Plan

The Vulnerable Adults Working Group at Yeovil District Hospital has attendance both from the Children's Services and a MARRAC representative.

## 5. Issues Arising

As an organisation we believe we are proactive in our referrals to Somerset Direct however we would appreciate more detailed feedback in order to learn as an organisation whether our referrals were appropriate or contained sufficient detail.

## 6. Priorities

As an organisation we have a detailed work plan that is managed through the Vulnerable Adults Working Group. Key work streams from 2011/12 include the following:

- Implementation of Vulnerable Adults three to five year strategy incorporating the Learning Disability Strategy.
- Ensuring that organisational learning from case reviews is transformed to Service Improvement for Vulnerable Adults.
- To undertake an annual programme of clinical audit for both vulnerable adults and those with a learning disability.
- To improve the knowledge of all staff within the organisation with regards to Vulnerable Adults and Mental Capacity Act.

## 7) Safeguarding Adults Board
## Annual Report from the Registered Care Providers Association Ltd

The Registered Care Providers Association Ltd is a membership based organization representing the majority of care providers in the county of Somerset. RCPA Ltd provides a valuable gateway, facilitating the exchange of information and ideas and the fostering of best practice amongst its members. Acting as a voice for care providers, RCPA Ltd aims to represent the views of all its members, bringing their concerns and queries to the attention of Local Authority and NHS service commissioners as well as government and regulatory bodies.

Our annual report is set against these terms. We do not provide any direct care services to service users but, instead, work to encourage best practice throughout the care sector and thereby increase the quality of care.

### 1. Public Awareness

Whilst our work to raise public awareness is largely limited to distributing best practice advice to our members via internal newsletters, mini and annual seminars, the public facing side of our bespoke website has a much wider readership across the county and country with over 18000 page views from over 5000 visits per month. This is a powerful platform from which to inform the readership on safeguarding matters. Over time we plan to develop the website focus towards safeguarding matters so that the readership may access information and advice more readily.

### 2. Learning from Experience

The recent re-organisation of the Safeguarding Board is a welcome development which better clarifies the key strands of the work of the Board so that the results if this work may more readily be disseminated.

### 3. Priorities

We represent residential care homes and domiciliary care providers and are concerned to keep members well informed about the incidence of safeguarding matters in these specific areas of interest. The continuing development of good quality statistics about safeguarding incidents and their outcomes is seen as a priority.

**Roger Wharton**
**Executive Officer**

## 9) Care Focus Activity Report May 2011

**Safeguarding April 2010- March 2011**

### 1. Care Focus - Staff Training & Development in Safeguarding

All staff within Care Focus have undertaken or are in the process of undertaking the Kwango e-learning programme. Those staff visiting care providers have also undertaken training to the 'Managing an Incident' level.
All staff are kept up to date of legislation, policy changes, learning etc via supervision, team meetings and team training.

### 2. Public Awareness

The Care Focus Board, Strategic Partners and Operational groups are all attended by representatives of public, private and voluntary organisations across Somerset. Our website is open to all citizens and we disseminate information to a database of over 1000 stakeholders.

### 3. Learning from Experience

Any learning from the serious case reviews, significant events or other key informationis shared with care providers as appropriate, through the various engagement methods used e.g. One to one visits, Learning Exchange Networks, workshops, events and meetings.

### 4. Safeguarding Adults Board Work Plan

***Involving Service users****:* We have supported this through our engagement with those in receipt of direct payments and our collaborative working with user led, community and voluntary organisations. The Care Focus website is accessible by all.

***Raising awareness :***Information regarding all aspects of Safeguarding Adults in Somerset is repeatedly promoted and disseminated through features and updates in the monthly newsletters, six monthly reviews and specific flyers. These are distributed through email, post and attendance at events across the county.

The Care Focus website also allows providers to access a range of documents and resources, including a direct link to the SCC website, the policy itself and access to the e-learning programme.

Care Focus is currently working with SAB and SCC to organise a conference for housing providers and associated support services across Somerset. This has included designing, producing and purchasing promotional materials to raise awareness of contact details and additional support services.

***QP Policy:*** Care Focus supported SCC with the development and implementation of the QP policy across Somerset.

Until the end of June 2010, we were monitoring the quality rating of care providers and offering intensive support to those in the poor or adequate categories as well supporting those in the good and excellent categories to continue improvement and maintain the high standards. Without the star rating and given the recent changes to inspection and qualification routes, we are continuing to monitor care providers performance through published CQC reports and an internal system, which highlights lack of engagement, change of ownership / management, areas of concern etc.

***Training and Development:*** 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. The e-learning has been supported by the installation of 40 laptops and printers across care providers in the PVI sector.

The Somerset County Council, 'Stop Abuse' posters, information sheets and leaflets regarding Safeguarding Adults were 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.

Care Focus works closely with the Learning & Development team within SCC to promote their funded courses supporting Safeguarding and also has an agreement for places to be made available to any providers highlighted as having an acute need for attending courses.
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 the safeguarding lead from SCC has attended these sessions to meet and interact with the groups.

Direct Employers: We have continued to offer learning opportunities to Personal Assistants working for Direct Employers and have promoted this through a variety of mediums, including the user –led organisations, direct mail-outs and attendance and support at regional events put on by Skills for Care. We are also supporting the facilitation of the Learning Hubs held at Compass Disability. To date we have sent information via the SCC Direct payments team to approximately 1200 individuals. Previously, training has been undertaken in two cohorts with safeguarding, a key theme.

## 5. Issues Arising

Some of the main issues that have been raised from care managers include concerns and questions surrounding the changes to CRB's and the ISA. There is a great lack of knowledge on these subjects and also confusion as to what needs to be

done in relation to these topics, as changes have been underpublicized and not easy to understand.

**Claire Waddon**
**CEO**

**Appendix 3**

**Membership of SAB and SAB sub-groups**

| Group | Membership | Support officer |
|---|---|---|
| **Safeguarding Adults Board** | Clare Steel, chair<br>Helen Wakeling (ASC)<br>Richard Painter (SomPar)<br>Deborah Gray (NHS Somerset)<br>Ethna Bashford (SCH)<br>Rachel Vokes (MPH)<br>Julie Vance (YDH)<br>Mary Smeaton (SWAST)<br>Roger Wharton (RCPA)<br>Claire Waddon (Care Focus)<br>Becky Facey (AIS)<br>Mary-Ellen Harris (Som Adv)<br>Geoff Wessell (Police)<br>Matt Ayres (Police)<br>Nikki Watson (Police)<br><br>+ Mary Cridge (CQC) attending one meeting per year only | Chris Hamilton |
| **Executive Leads Group** | Clare Steel (Chair)<br>Helen Wakeling (ASC)<br>Diana Rowe (SomPar)<br>Deborah Gray (NHS Somerset)<br>Ethna Bashford (SCH)<br>Greg Dix (MPH)<br>Richard Corrigan (Police) | Chris Hamilton |
| **Policy Review sub-group** | Chris Hamilton (ASC)<br>Richard Painter (SomPar)<br>Deborah Gray (NHS Somerset) | tbc |
| **SCR sub-group** | Lucy Watson (NHS Somerset)<br>Helen Wakeling (ASC)<br>Richard Painter (SomPar)<br>Vanda Squire (SCH)<br>Mary-Ellen Harris (Som Adv)<br>Mary Smeaton (SWAST)<br>Lindsay Shearlock (Police)<br>GP representative<br>Lynn Couldwell (Domiciliary Care rep) | Chris Hamilton |
| **Training and** | Chris Hamilton (Chair) | Safeguarding |

| Group | Membership | Support officer |
|---|---|---|
| **awareness-raising sub-group** | Jess Henry (SomPar)<br>Phoebe Sherry-Watt (SCH)<br>Claire Waddon (Care Focus)<br>Mary-Ellen Harris (Som Adv)<br>Roger Wharton (RCPA)<br>Vanda Squire (SCH)<br>Lyn Couldwell (Care South)<br>Christine Hale (SCC Supporting People)<br>Suzanne Harris (SCC Community Safety) | officer (ASC) |
| **Safeguarding operational sub-group** | Helen Wakeling (chair)<br>Chris Hamilton<br>ASC lead x4<br>CMHT lead x 2 (1 OP; 1 YP)<br>Bridget Orchison (CTALDs)<br>Vanda Squire (SCH)<br>Gareth Rowlands (SomPar)<br>Duncan Marrow (MPH) | Safeguarding officer (ASC) |
| **Health organisations sub-group** | Paul Rennie (Chair)<br>Duncan Marrow (MPH)<br>Ethna Bashford (SCH)<br>Vanda Squire (SCH)<br>Ian Douglass (SomPar)<br>Gareth Rowlands (SomPar)<br>Maddie Groves (YDH)<br>Mary Smeaton (SWAST)<br>Chris Hamilton (ASC)<br>GP representation | tbc |
| **MCA/DOLS sub-group** | Helen Wakeling (ASC)<br>Chris Hamilton (ASC)<br>Paul Rennie (NHS Somerset)<br>Nick Woodhead (SomPar)<br>Becky Facey (IMCA service)<br>Vanda Squire (SCH)<br>Duncan Marrow (MPH)<br>Mary Smeaton (SWAST) invite specific to agenda<br>GP representation | tbc |
| **Miscellaneous additional participation** | Matthew Turner (LSCB) – will attend any group by invitation as required<br>+ regular meeting with Chris Hamilton to share information. | |