# Somerset Safeguarding Adults Board

## Annual Report 2011 - 2012

## Contents

## Chairperson's introduction

Safeguarding often makes the headlines for all the wrong reasons. The reporting of the abuse uncovered at Winterbourne View and the neglectful care provided to elderly hospital patients in Staffordshire is still fresh in all our minds. These cases have made us all the more aware than ever of the need to protect adults are risk from abuse and neglect.

Here in Somerset the publication of the Parkfield Serious Case Review in May 2011 highlighted the need for services to be vigilant in protecting the interests of our most dependent and vulnerable citizens.

During the year the Safeguarding Board has noticed a further increase in the reporting of safeguarding alerts, as levels of awareness amongst members of the public, professionals and community groups increased. A recent conference arranged for housing providers and community groups highlighted the important role local communities have in both reducing the isolation that can cause abuse and in ensuring individuals receive the support they need.

The Safeguarding Board has also spent time this year considering the response provided to alerts. This has included improving the quality of the information given to people who raise these issues and making sure that individuals are fully involved in the safeguarding process. A joint policy has also been agreed between the County Council and health organisations to improve the reporting of safeguarding issues in health settings.

The commitment to safeguarding remains strong, despite the high level of change being experienced across organisations. The Board will continue to monitor the impact further changes may have on the multi agency response to safeguarding concerns. It is however clear that protecting vulnerable adults from harm and abuse remains a fundamental commitment across all the organisations represented Board.

As we enter another year, I look forward to working with the Board to meet the challenges that lie ahead.

## Safeguarding adults in Somerset during the past year

During 2011/12 the new SAB and safeguarding structure has become fully established but has been subject to some minor revision. At the beginning of 2012 a decision was made to merge the Safeguarding Operational (local social care leads) and the Health Operational sub-groups. One of the original functions of the Health group, the quality assurance relationship between NHS Somerset and the Health provider services (Musgrove Park and Yeovil District Hospitals, Somerset Community Health and Somerset Partnership) had been moved to other forums and the remainder of this group's agenda largely duplicated that of the Social Care Leads group.

As a number of Board member organisations go through processes of restructuring there are likely to be further changes in the representation at meetings of the Board and its sub-groups. Through their executive leads, members organisations have confirmed their commitment to giving a high priority to adult safeguarding work through this period of change. The organisations primarily affected in this way are:

> ***Somerset Partnership*** – now a combined Mental Health and Community Health trust working to integrate the systems of the two different organisations including the safeguarding structure
> ***Avon and Somerset Constabulary*** who have restructured their public protection unit function across the force area moving into a single Safeguarding Co-ordination Unit (SCU) based in Taunton; and
> ***Somerset County Council*** moving towards becoming a primarily commissioning organisation and reviewing management structures accordingly. The County Council's Lead Commissioner for Health and Social Care is Clare Steel and this post incorporates the statutory Director of Adult Social Services (DASS) role. In Somerset the holder of this post will be the Board chair.
> **Advocacy organisations** – following the awarding of an overarching contract for advocacy services to a new consortium Total Advocacy led by A4E, participation on the work of the Board will be reviewed.

Following the passing of the Health & Social Care Act in 2012 a number of significant changes affecting adult safeguarding are under development. Primarily the health commissioning activities currently performed by NHS Somerset will become the responsibility of the new Clinical Commissioning Group led by General Practitioners. The development of effective links between the SAB and the new commissioners will be a key task for the coming year. The Health & Social Care Act is due to come into effect in April 2013.

The Board proposes a review of its structure and membership later in 2012/13 when the impact of these changes becomes clearer.

The Deprivation of Liberty (DOLS) Service will be directly affected when the NHS Somerset Supervisory Body responsibility in relation to hospitals passes to Somerset County Council.

### Use of the Court of Protection

Nationally there has been an increased use of the Court of Protection over recent months for making welfare decisions for people who lack capacity. In Somerset a small number of cases considered under the safeguarding procedures have resulted in Court of Protection applications. This trend is likely to continue and guidance is currently being developed for social care professionals about the complicated evidence requirements for any application.

## The work of the sub-groups

**Serious Case Review and Learning Lessons sub-group**
The group have monitored progress in implementing the actions from the two Serious Case Reviews completed in early 2011; N – a woman with learning disabilities who died in one of the acute hospitals; and the Parkfields Care Home. Almost all recommendations from these reviews have been implemented by partner organisations. There have been no referrals for a Serious Case Review during 2011/12.

Following a domestic homicide in July 2011 the Board members were involved in a decision that the case in question did not meet the criteria for conducting a Serious Case Review.

The group has overseen and commented upon the various drafts of the Serious Case Review policy and procedures due to be published during the summer of 2012 and the new policy and procedures documents makes clear the links between the Serious Case review and Domestic Homicide Review processes. The national guidance for DHR's was implemented in 2011. The responsibility for decisions about DHR's rests with the chair of the Safer Communities Group.

This group has been chaired by a police representative but this has proved rather difficult and the group has asked the Executive Leads Group to consider how to identify a new chair.

**Policy and Practice sub-group**
This group has led the work on the development of the new Somerset policy and procedures document, 'Safeguarding Adults at Risk in Somerset' which is due for publication in July 2012. The adoption of the label 'Adult at Risk' to replace 'Vulnerable Adult' is in line with recommendations from the Law Commission about a revision of legislation social care services, which are to be included in a new social care bill during the current parliament.

The membership of this group will need to be reviewed in line with the organisational changes referred to above.

**Training and Awareness sub-group**
The two main activities undertaken by this group in 2011/12 have been:

a) the development of a competency framework for all staff and volunteers whose work involved or affects adults at risk. This framework is an adaptation of that published by Bournemouth University in 2010, and sets out the knowledge and skills expected by staff with different levels of responsibility within the Safeguarding process. All partner organisations will be using the framework to identify training needs and to review and develop current training programmes; and

b) organising a safeguarding conference in March 2012. This was attended by over 100 people from a range of backgrounds, including housing organisations, charities and neighbourhood watch schemes. The conference aimed to highlight the shared responsibility for protecting adults at risk between state bodies such as the County Council, the Health Service and the Police on one hand and members of the public and community organisations on the other. Feedback was generally positive and a number of helpful links have been established as a result.

**Mental Capacity Act sub-group**
This group has linked together work by various organisations implementing the MCA and has monitored the work of the IMCA (Independent Mental Capacity Advocate) Service. Some organisations have carried out audits of MCA implementation. This group is chaired by the safeguarding leads from Musgrove Park Hospital and the Community Health arm of Somerset Partnership. Co-ordination links between this group and the main Board need to be developed further.

**Combined Safeguarding Operational sub-group**
This group now comprises representatives with operational responsibilities from the main social care and health organisations and is chaired by the SCC Operations Director for Health and Social Care. The group functions primarily as an information sharing and consultation forum for practice matters. In the past year this has included providing feedback on drafts of the new safeguarding adults policy.

## Activity Report for April 1st 2011 to March 31st 2012

The statistics in this report have been gathered using Somerset County Council's AVA (Abuse of Vulnerable Adults) database. This database is used for the collation of safeguarding statistics for the annual report for the Department of Health. The information required by the DoH concerns all safeguarding referrals made to the local authority about the possible abuse or neglect of a vulnerable adult by another person or persons. In Somerset, the Safeguarding Adults Board has decided that the formal safeguarding process should also be used in cases of significant self-neglect.

The table below summarises the referral numbers for April 2011 – March 2012 and makes comparisons with previous years.

The self-neglect numbers have continued to fall, in part because managers have made decisions not to use the label 'safeguarding' for some of the complex multi-agency decision making meetings used in these situations. There has been a degree of inconsistency as to how these decisions have been made and to address this the new Somerset Safeguarding policy provides more detailed guidance for managers about the use of the safeguarding process for self-neglect cases.

The trend in the numbers of situations referred to Somerset County Council or Somerset Partnership continues in an upward direction with an increase of approximately 25% over the previous year. Of the referrals which do not result in a safeguarding investigation the majority are redirected within Somerset County Council or Somerset Partnership for a community care assessment. However there are still some weaknesses in the reporting of the outcomes of investigations and this is being addressed by the County Council. Somerset County Council will continue to provide the Safeguarding Adults Board with summaries of activity levels during the year.

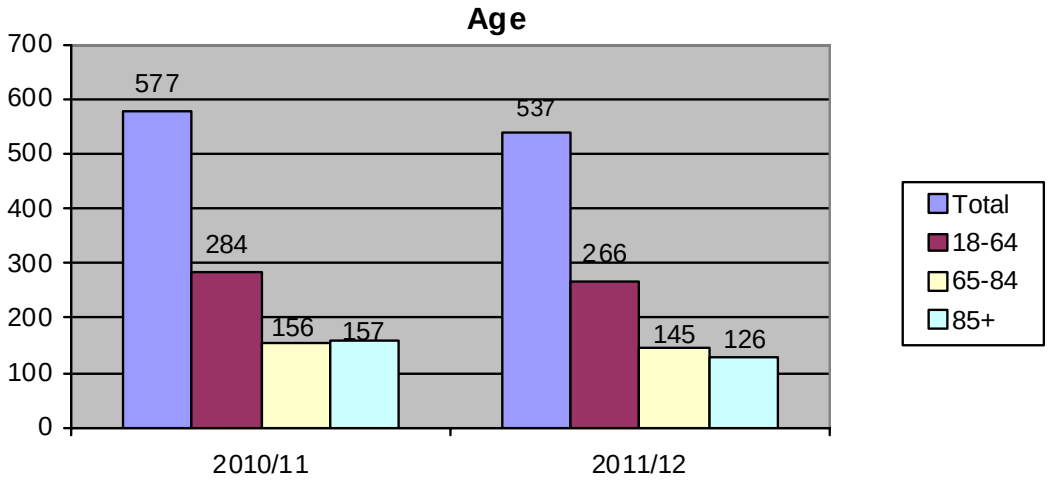
Accurate comparison of these figures with those of other local authorities is still under development but initial indications from the first comparison exercise based upon 2010/11 statistics suggest that Somerset is in the mid-range of local authorities. However, the initial exercise has highlighted such wide variations in reported activity that it would not be wise to draw too many conclusions.

The following tables show a breakdown of information relating to the 577 investigations reported to the DoH. Of these, 497 (85%) concerned people already known to Somerset County Council and 43 (7.5%) concerned people placed in care homes in Somerset by other local authorities.

Further analysis is required of the proportion of these investigations which concluded that allegations were wholly or partly substantiated and this will be reported to the Board before its next meeting.

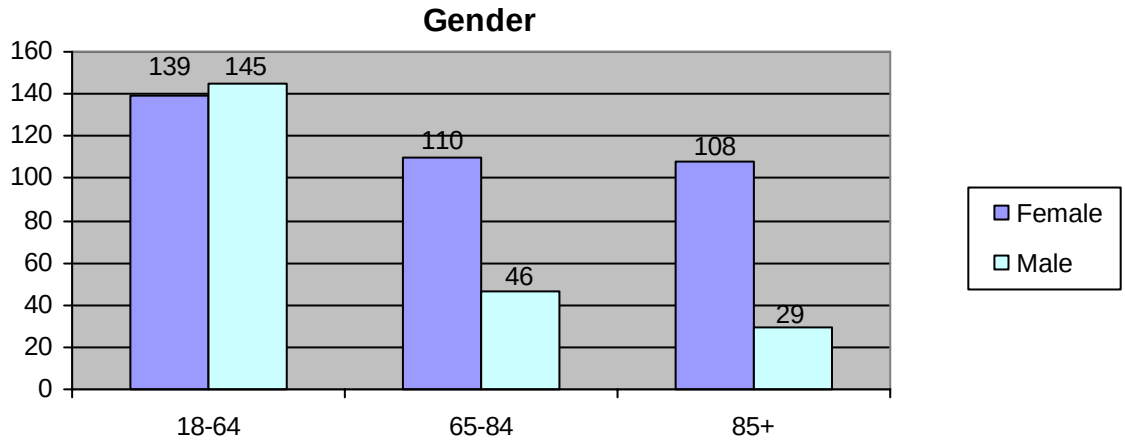
Of the 284 referrals in the 18-64 age group the majority (75%) concerned adults with learning disabilities. This level of reporting probably reflects the extensive training and awareness raising undertaken within the learning disability services.

**Referrals by Age group**




**Gender**

A noticeable, but not unexpected pattern in the figures shows that with increasing age an increasing the majority of referrals are for women.




Although this may be partly explained by the demography of these age groups, research has shown that men are less likely to disclose that they have been subject to abuse or neglect. Awareness raising activities will need to take this into account in the effort to reduce barriers to reporting.

**Ethnicity**

As in previous years the majority of service users identified themselves as White British (96%) with all other ethnic origins recorded in only 9 referrals (1.6%). More work is needed to increase awareness of safeguarding among minority ethnic groups in Somerset and the Training and Awareness sub-group is working on versions of

public information documents in a range of languages including Polish and Portuguese. An easy read version is also in preparation for people with limited literacy skills.

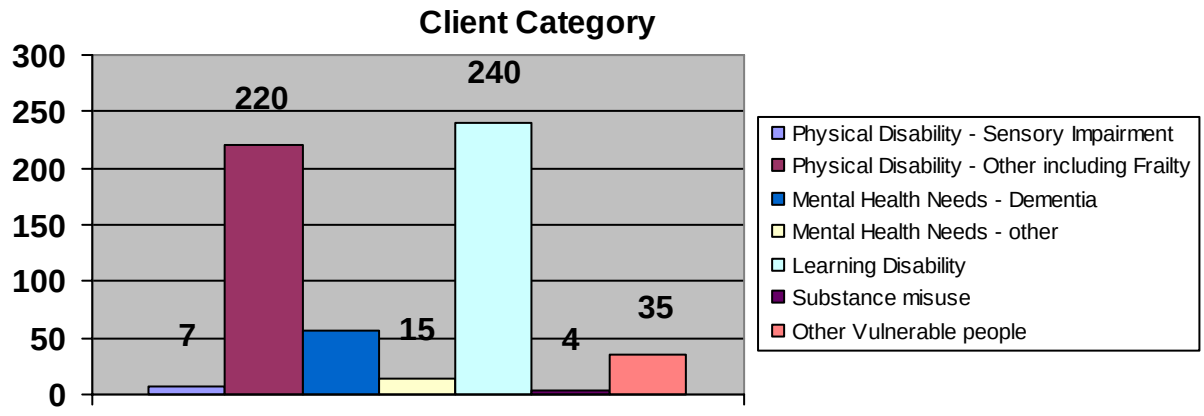
| Ethnicity | |
|---|---|
| White – White British | 553 |
| White – White Irish | 1 |
| White – Any other White background | 1 |
| Mixed – White and Black Caribbean | 4 |
| Other Ethnic Groups – Any other Ethnic Group | 3 |
| Not Stated – Refused | 3 |
| Not Stated – Information not yet obtained | 12 |

**Client Category**

Referrals concerning adults with learning disabilities have shown a considerable increase in the past year – from 148 in 2010/11 to 240 in 2011/12 – and these now account for 42% of all accepted safeguarding referrals. The reason for this significant increase is not clear. Further analysis of information about these cases will be undertaken and reported later in 2012.

Service Users identified as having a physical disability – including frailty – are the other major group, representing 38% of referrals. The majority of these individuals, not surprisingly, are in the 75+ age range.

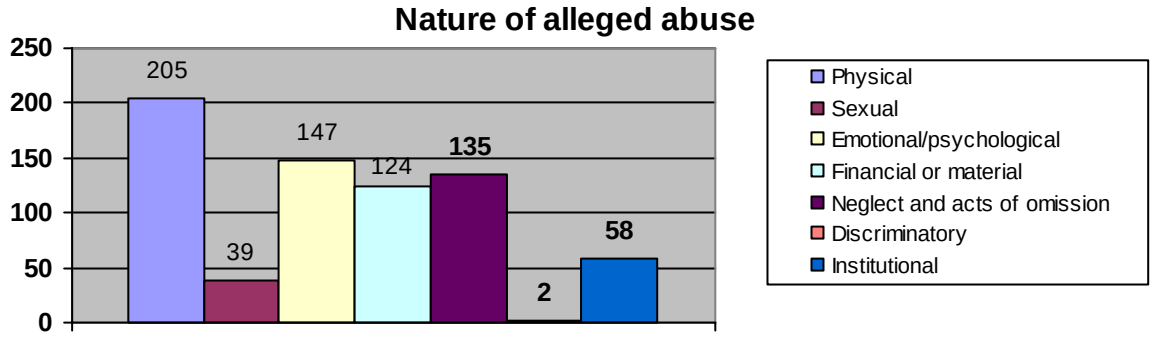
The increase in referrals for people who fall into the 'substance misuse' category anticipated in the last annual report has not materialised – 7 in 2010/11, 4 in 2011/12. Of some concern is the low level of safeguarding referrals in relation to people with mental health problems other than dementia. Following training and awareness-raising within Somerset Partnership's Community Mental Health Teams numbers had risen last year – to 48 in 2010/11 – but have fallen back to only 15 in 2011/12. As the Partnership's safeguarding team have been contacted about a significantly greater number of situations than this it is likely that this is a recording rather than a practice issue. The Board will ask Somerset Partnership to analyse this information.



## Nature of 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 commonly reported issue (205) with significant numbers of emotional and financial abuse. Neglect and acts of omission have shown a further increase this year 2010/11 = 111; 2011/12 = 135 but there has been a reduction in reports of sexual abuse 2010/11 = 57; 2011/12 = 39. There has also been an increase in reports of institutional abuse 14 in 2011/11 58 this year. Institutional abuse occurs when a care services adopts practices which result in abuse or neglect of service users. It is not easy to draw simple conclusions from this increased figure because the labelling of a concern in such a manner is somewhat inconsistent in part because it is likely to be retrospectively applied by whoever is responding to the referral.

Financial abuse is known nationally to be under reported so efforts to raise awareness of this issue continue to be a high priority.




Note: more than one type of abuse may be reported in the same referral

## Source of referral

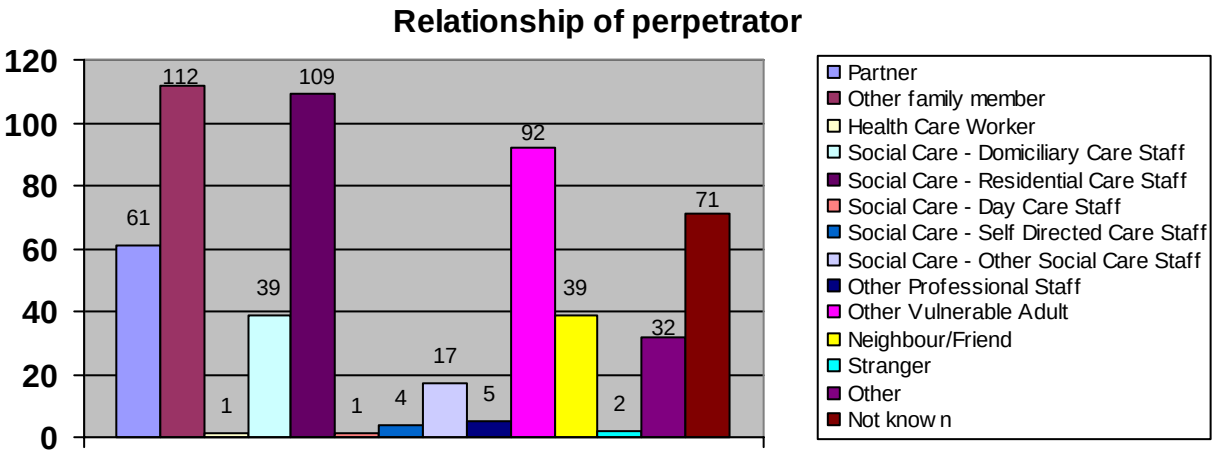
As in previous years the majority of safeguarding referrals are made by professional staff, notably in residential and domiciliary care settings (212 referrals combined). About 15% of referrals (86) were made by the person experiencing the harm or by family members, friends, or another member of the public. In addition to the extensive safeguarding training undertaken by many professional staff there remains a need to continue seeking to raise awareness among members of the public and community organisations such as Churches and Voluntary groups who are in contact with vulnerable individuals.

## Location of alleged abuse or neglect

Almost 40% of concerns related to incidents occurring in the person's own home and just over 30% in nursing or residential homes. These figures do not correlate with the proportion of the population who live in these settings – only a small percentage of the population lives in care homes. The disproportionately high number of care home referrals is more likely to be indicative of the levels of awareness and scrutiny in these settings rather than a higher incidence of actual abuse or neglect.

## Relationship between victim and perpetrator

This past year there have been shifts in the numbers of alleged perpetrators who are partners or relatives (down from 197 to 173) and who are residential or domiciliary care staff (up from 88-148) when compared with last year. A significant movement has been an almost doubling (48-92) of the number of alleged perpetrators who are described as being another vulnerable adult. This may have arisen from advice to learning disability social work teams who had previously been labelling service user to service user abuse differently, but this statistic would benefit from further analysis.




## Outcomes for victims

As in previous years the most frequently recorded outcome for victims of abuse or neglect remains an increased level of monitoring of their situation by the various agencies involved. New community care assessments and services were provided in 109 situations. Fifty three people moved from their property or care service as part of the protection plan and on 49 occasions the contact between the victim and perpetrator was restricted in some way.

Increased recognition of domestic abuse among older people has been anecdotally evident from audits of safeguarding cases although very few safeguarding cases have resulted in MARAC referrals. A programme of training for social care staff on domestic abuse may influence this during the coming year. In a few, but increasing number of cases, the use of the Court of Protection for difficult decisions has been a safeguarding outcome.

## Conclusion of the safeguarding process

Of all referrals accepted as requiring safeguarding investigations 352 (61%) were wholly or partly substantiated. 130 (23%) were not substantiated and 95 (17%) were inconclusive. Somerset County Council will continue to monitor the recording of conclusions and will develop a report to enable more detailed analysis of the situations where allegations have been substantiated.

## Two examples of safeguarding in practice

These examples highlight the complexity of much safeguarding work and the need for effective multi-agency relationships and procedures. They provide a context within which to view the statistical information.

### Case A

Mr & Mrs Smith are a couple in their eighties who have a highly fractious and argumentative relationship, which results in aggressive and animated behaviour, often physical, directed one against the other. Mr Smith has a diagnosis of Dementia which renders him less able to control his behaviour. Mrs. Smith does not appear to have insight into Mr. Smith's physical needs and psychological limitations.

To this day, they remain fiercely independent as well as highly suspicious and critical of any outside involvement in their affairs. However, their health and mobility has significantly worsened since retirement, further restricting their ability to be involved in outside activities and they now spend most of their time at home together.

There is a care package for personal care needs and Direct Payments in place so that they can have a break from each other or together to lessen their social isolation.

The Police are actively involved and both have been arrested and bailed following physical assaults on each other. Bail conditions have placed restrictions on contacting each other and have usually resulted in Mr. Smith being removed to a place of safety such as local residential care homes. A number of different homes have been used.

During these stays Mrs. Smith appears to demonstrate 'a strong feeling of abandonment and could not tolerate being at home alone'. This manifests itself by Mrs. Smith ringing agencies asking where he is, presenting at the care home and verbally abusing both Mr. Smith and professionals. More recently Mr. Smith has initially requested no contact from his wife who has resulted in care providers and other professionals having to impose this request. There have been recorded incidents of Mrs. Smith assaulting a member of residential care staff. One occasion Mrs. Smith's behaviour was threatening to the extent the police were called to remove her.

The SCC Emergency Duty Team (EDT) are updated when an incident has occurred and have been actively engaged in providing support during evening and weekends to safeguard this couple. This has often meant engaging with care homes in the area and the Police to provide a place of safety at short notice.

Shortly after these incidents Mr & Mrs Smith state they wish to return to live together. Both have been assessed as having capacity to make this decision.

Mr and Mrs Smith have been both been considered as victims and perpetrators by the Multi Agency Risk Assessment Committee (MARAC), the meeting for addressing concerns about domestic abuse.

## Case B

Barry is an older man who was admitted to hospital. During this time he raised concerns about the care received from his sister and primary carer with whom he had lived with for 10 years. She supervised contact with professionals and had imposed a regime of unnecessary and inappropriate care which went against medical advice. The Social Worker involved was concerned that Barry was being abused financially, physically, emotionally and psychologically. This is the kind of situation where agencies and individual professionals need to work closely together to understand and respond effectively. It was important to identify at an early stage who might be able to influence Barry's carer's behaviour. Despite some initial difficulties the Police, NHS community health and SCC worked together to gain access to Barry at his home address and to offer him the opportunity to move away from his carer which he readily accepted. The move to a care home has enabled Barry to think about his future and with assistance he has been able to make contact with former friends and take charge of his own finances.

## Deprivation of Liberty Service

### Legislative developments

The Health and Social Care Act will come into force in April 2013 and in relation to the DoLS service will mean that all supervisory body responsibilities for hospitals will be transferred from NHS Somerset to Somerset County Council. As much of the administration a support for the DoLS in Somerset is already shared the transition is not likely to be problematic. The joint DoLS policy between the supervisory bodies will need to be revised in the light of this change.

### Summary and Analysis of Deprivation of Liberty safeguards (DOLS) activity from April 2011 to March 2012

| | Applications | Assessments | | Length of authorisations granted | | | Funding source | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Urgent | Standard | < 3 months | 3-6 months | 12 months | Self | SCC | PCT | Joint SCC/PCT |
| **NHS Somerset** | **8 (5)** | **8 (5)** | **0 (0)** | **4 (1)** | **0 (0)** | **0 (0)** | **n/a** | **n/a** | **4 (4)** | |
| **SCC** | **46 (53)** | **27 (27)** | **19 (13)** | **2 (9)** | **17 (20)** | **5 (4)** | **10 (15)** | **21 (32)** | **8 (7)** | **7** |

(2010/11 figures in brackets)

On the basis of a calculation from the beginning of April to the end of March the total number of assessments can be seen as:

2009/10 40 assessments
2010/11 58 assessments
2011/12 54 assessments

Although there had been a marked increase in applications from the first to the second year of the DoLS scheme this has not been sustained into the third year, 2011/12.

### Client group representation in requests for DOL applications in Somerset

| | Somerset CC | NHS Somerset |
|---|---|---|
| Learning disability | 5 | 0 |
| Older people (inc. dementia) | 37 | 0 |
| Other mental health | 4 | 2 |
| Phys Disability | 0 | 6 |

In terms of activity levels across the South West region there are differing levels of Health and Social Service DOLS applications for 2011/12 for example:

| Area | Applications | Population (adult) thousands approx. |
|---|---|---|
| Cornwall | 225 | 444 |
| Dorset | 131 | 336 |
| Bristol | 184 | 368 |
| Devon | 168 | 625 |
| Wiltshire | 154 | 370 |
| South Gloucestershire | 141 | 214 |
| Somerset | 54 | 430 |
| Bath & NE Somerset | 28 | 150 |
| Plymouth | 48 | 215 |
| Bournemouth & Poole | 147 | 260 |
| Torbay | 30 | 112 |

Based on the population figures Somerset has the lowest activity per head of adult population in the South West. The disparity in levels of DoLS activity is replicated nationally but in Somerset the DoLS service will work closely with some of the other authorities in the region to understand these differences

The DoLS process relies on the Managing Authorities, (MA) to identify that they may be depriving someone of their liberty and applying to the Supervisory Body (SB) for authorisation. This in turn requires a good understanding of a rapidly evolving area of case law which even the courts find difficult to define. Consequently there still is a degree of uncertainty as to when MAs need to apply for a DOL that runs the risk of being completely inappropriate or of greater concern failing to apply when it is clear that the Managing Authority should do so.
As in the last SAB report, the picture across the county continues to be one of differing levels of awareness. A correlation between the awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty, (DOLS) is significant in as much that it dictates the willingness as described earlier to refer for advice and guidance. Poor awareness would seem to equate to low referrals. This was highlighted in 2010/11 and remains a concern.

The understanding of the significance of the MCA Code of Practice in guiding good practice for care providers remains patchy. In particular there is a lack of understanding of the powers that the MCA gives to providers to provide the care/treatment for a person who cannot consent.

Knowledge remains patchy as to how the MCA protects care providers against liability. Evidence of the process of capacity and best interest assessments within care homes remains poor. There is a lack of clarity in the mind of residential/nursing homes as to the role of the Independent Mental Capacity Advocate, Lasting Power of Attorney and the concept of advanced decision making. These roles although not widespread are becoming increasingly significant in day to day operations and likely to increase in the future.

Overall awareness of the MCA has a bearing on the how operational services approach the need for DOL authorisation requests. The lack of knowledge in some cases makes it difficult for care providers to be decisive in the implementation of care plans and to insist on the participation of professionals from other agencies when considering a reassessment of complex care plans for those clients who cannot make best interest decisions for themselves. The term Deprivation is sometimes seen as a negative concept as opposed to the positive attitude attributed to safeguarding. The word “Deprivation” can be equated negativity or as a failure of care which inhibits services from approaching external agencies to discuss the possibility of DOLS.

The number of applications from hospitals increased from 5 to 8 and again all hospital referrals relate to acute hospitals with an absence of referrals from psychiatric in patient units. The issue of the informal patient placed in a psychiatric hospital but who might not have capacity to consent to treatment but nevertheless have some sort of restriction remains a concern. It may well suggest that the expectation from staff is that anyone needing to be detained in hospital would naturally fall under the provision of the Mental Health Act.

**Current Activities**

The safeguarding team continues to inform commissioners and providers of adult social care about MCA/DOLS. With residential/care homes we continue to discuss the links between a good understanding of awareness of the Mental Capacity Act and practice. We are meeting with all Adult Social Care Teams across the county and offering advice and guidance. However ongoing training is still required to increase the awareness of the MCA across the board and this is currently being offered to all care providers by:

1) Contacting those homes about which SCC or partner agencies have significant quality or safeguarding concerns. The provision of support in applying the Mental Capacity Act has been offered as part of a broader support programme involving Care Focus. A special emphasis has been placed on the need to consider capacity and potential best interest decisions when working with vulnerable residents who may lack capacity to make decisions in their own best interests and to evidence the decision making process with clear record keeping. To date thirty homes have been contacted in this way.

2) The safeguarding and MCA team has been working closely with the IMCA service whose activities bring them into contact with a wide rage of care services.

3) Care Focus through its established network of care providers have invited members of the team to attend their Learning Exchange Networks (LENs) to discuss and clarify aspects of the MCA/DOLS.

4) In order to keep track of the contacts that have made with care providers, with ourselves, Care Focus or the IMCA service; we have developed a spread sheet. This will enable us to be aware of any providers for which no contact in any form has been made in regard to MCA/DOLS and help to prioritise future contacts.

5) In the last 6 months there have been 41 enquires relating to DOLS/MCA for which we have responded by providing advice and guidance.

6) Conducting a confidence audit among SCC social care staff about their use of the Mental Capacity Act. This audit combined with close reading of case records where issues of mental capacity are likely to be present will form the basis for targeted training later in 2012/13. This will inform us on training needs for the future.

**Future Activities**

1) The safeguarding team will continue to provide targeted support and guidance to managers of care provider services and will run a series of events across the county focussing upon the use of the Mental Capacity Act as a sound basis for care planning.

2) A detailed audit of restrictive practices in the local authority homes for people with learning disabilities and complex behavioural needs

3) To develop training opportunities for SCC and Somerset Partnership staff involved in welfare decisions for people who lack capacity

4) To develop a local guide for families and carers in connection with the MCA.

5) To continue to research and update case law and make any changes available to all operational staff in adult social care.

6) To continue to work closely with Care Focus and make use of their county wide contacts to promote the Mental Capacity Act and DoLS.

**Personnel**

Best interest Assessors numbers have remained fairly stable, although there are difficulties for some BIAs who, due to increased responsibility find the time to devote to DOLS assessments problematic. To address this 2011/12 has seen an additional 6 members of Adult Social Care staff and 2 AMHPs completing BIA training. The addition of new BIAs give a total of 25 qualified BIAs. There are 9 Medical Assessors available including two new ones in the learning disability service.. Overall the county is well placed to cover DOLS assessments within statuary time scales. The post of Mental Capacity Officer has been filled which has enabled the County Council to devote more time to general awareness raising across Somerset

**Administration**

The administration of the DOLS process for both Somerset County Council and NHS Somerset continues to be well managed by our DoLS administrator whose experience with the complex paperwork and arranging assessments has ensured that all have been completed within statutory timescales. The close liaison with the Mental Health Act administrators to identify Doctors as assessors continues to work effectively.

# Reports by Board member organisations

## Somerset County Council, Adult Social Care

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

Safeguarding vulnerable adults continues to be a key priority for Somerset County Council. The responsibility for investigating and leading on safeguarding concerns is held by the Adult Social Care Service. This year the service has noted both an increase in the level of reported safeguarding concerns and the complexity within these situations. The increasing work is placing a pressure on the service, but this is being closely monitored by senior managers with resources being focused on supporting this essential area of work.

During the last year the number of alerts received by the Council have increased from 1193 (2010/11) to 1481. These alerts are reports from members of the public and professionals about situations where they think there may be a safeguarding issue. The managers in Adult Social Care review every safeguarding alert and decide if it requires further action under the safeguarding policy. The Adult Social Care managers are also responsible for ensuring that any concerns that require action under the safeguarding policy are investigated appropriately and safeguarding action plans are followed. The work in this area has also increased this year with the number of safeguarding investigations undertaken rising from 516 in 2010/11 to 577 in 2011/12.

The complexity of safeguarding issues being managed is also increasing. Some complex situations have occurred in “whole service concerns” where there are safeguarding issues that could potentially affect all the residents in a care home or all the customers of a community service. Somerset has a well established process for managing whole service issues that includes providers, health organisations, CQC and Adult Social Care. During the last year, however, concerns around quality of care and staff knowledge in whole services, have required an increased level of multi-agency co-operation and the allocation of resources for an extended period of time.

Individual safeguarding issues have also increased in complexity. These situations have required a range of investigations – for example, police investigations into concerns about financial misuse, and investigations into concerns about the care being provided or the environment in which the person lives. In the last year the number of applications made to the Court of Protection for welfare decisions has increased. These applications have been made when it has not been possible to agree with family members about the way to resolve or manage a safeguarding issue, and the individual concerned does not have the capacity to make that decision. These welfare decisions have been about where the person should live and how their care is provided. During the coming year, the Adult Social Care Service will be producing more information on the Court of Protection process for

staff members, families and individuals.

The safeguarding team in Adult Social Care continue to undertake case audits on a quarterly basis. These audits look at both the safeguarding paperwork and the decision making involved. Cases are discussed with the individual staff members but the learning and good practice is shared across the whole service through training events and professional development groups. To support the work currently being undertaken by the Board into customer involvement

During the last year the reporting arrangements for safeguarding issues have also been strengthened. Reports based on the Department of Health information (the information shown in the *activity* section of the main report) are now produced on a quarterly basis rather than six monthly. Increasing the frequency of reporting has allowed senior managers in the Adult Social Care service to monitor the demand for safeguarding investigations more closely, identifying any areas that need further development and ensuring that investigations are being undertaken within agreed timescales. Last year it was noted that the recording of safeguarding investigations in residential and nursing homes needed to be improved. A new way of recording this information was introduced resulting in an increase in reports from 135 (2010/11) to 209 this year. The safeguarding activity reports will be shared both within the County Council and with the Safeguarding Board to inform discussions about safeguarding issues in Somerset and evidence how resources such as Social Care staff time are being used.

As part of the new reporting system, the service has introduced timescales for undertaking key stages of the safeguarding process including: initial decision making on an alert; the investigation process and the time taken from alert to the completion of a safeguarding action plan. These timescales were agreed with Team Managers, who felt that they would support the monitoring of safeguarding work both within the teams and across the service.

During 2010/11 Local Authorities took on the responsibility for managing safeguarding issues in health settings, including hospitals. In Somerset we have agreed a policy with health organisations about how these safeguarding issues will be reported and investigated. Next year's Annual Report will therefore be able to report on the level and nature of safeguarding investigations undertaken in health settings.

In April 2013, the County Council will also become the supervisory body for Deprivation of Liberty Safeguards (DOLS) in hospital settings. This responsibility will be transferring from NHS Somerset. During the coming year, work will be undertaken to enable a smooth transfer, ensuring that hospital staff are aware of their responsibilities to report any potential deprivations to the County Council. To support the Council's work around the Mental Capacity Act and the Deprivation of Liberty Safeguards a new post has been established within the Social Care Service. This post, of DOLS officer, is responsible for managing the DOLS process for the Council and ensuring that staff across the health and social care community are aware of their responsibilities under the Mental Capacity Act.

In the next year the Adult Social Care Service will be changing its management

structure. In recognition of the growing requirements around safeguarding a new senior manager role will be put in place by April 2013 to lead on safeguarding and risk management within the service. This senior manager will be responsible for the work of the safeguarding team (which includes the support to the Safeguarding Board) and for the work undertaken by frontline staff in Adult Social Care around safeguarding and complex risk management.

**Training and other development activities undertaken within the organisation**

Somerset County Council has an extensive safeguarding training programme for its Adult Social Care staff. Last year, the safeguarding report noted that additional training courses had been put in place to support staff across the Adult Social Care Service. This included revising the training available for the chairs of safeguarding meetings and providing additional training for our occupational therapists and adult social care workers. The whole service procedure, also mentioned in last years report, has been updated and training provided to the senior managers across the Adult Social Care Service.

This year we have revised our awareness level training, supplementing an e-learning programme with team based awareness sessions. The Safeguarding Team have also linked with local universities to provide training to Social Work students on safeguarding in practice. These training sessions have also provided an opportunity for the service to confirm the training needs of newly qualified staff. The safeguarding team have attended Professional Development Groups across the county to update social work and occupational therapy staff on safeguarding practice, explore the lessons learnt from safeguarding audits, and discuss developments in the application of the Mental Capacity Act. A safeguarding training database has been developed, to enable the safeguarding team to record the training undertaken by individual staff members and assist in the prioritisation of future training.

During the year, the Adult Social Care Service identified the need to increase the understanding of domestic violence amongst older people and how this linked with the safeguarding process. Two new courses have been commissioned – one to raise the awareness of domestic violence within the Service and the second focused on social workers undertaking the domestic violence multi-agency risk assessment.

The County Council also provides training for social care and health providers. This training includes sessions on both safeguarding and mental capacity. The courses run by the Council for social care providers on managing a safeguarding incident and completing DOLS applications, have been particularly well attended. Training has also been provided to County Council commissioning staff on identifying safeguarding issues and to health and social care providers on the use of the Mental Capacity Act.
Staff from social care were also involved in the recent conference arranged by the Safeguarding Board for housing providers and communities groups.

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

The County Council is represented on the Serious Case Review – Learning the lessons sub group. This group has focused on the implementation of the action plans from the two serious case reviews undertaken in 2010/11. The actions for Adult Social Care in the Parkfields Review have been completed and the only outstanding action from the N review will be completed by July 2012. The newly revised multi-agency safeguarding policy, due for publication in July 2012 contains a clear commitment to inform whistleblowers of the outcome of safeguarding investigations.

The learning from significant event adults have also been included in the Adult Social Care Safeguarding Action Plan and shared with other organisations through the sub group. This includes learning about the importance of considering the impact of physical health on a person's behaviour. Following the initial learning from Winterbourne View the Adult Social Care Service is participating in the South West's whole service information sharing process and has agreed with NHS Somerset how safeguarding concerns in commissioned health services will be reported and investigated.

The County Council is jointly funding research by the University of Nottingham into domestic violence amongst older people. This research was commissioned after a domestic homicide and aims to provide information about the prevalence of domestic violence amongst people aged over 65 and consider how services could be improved to support the needs of older people. The research findings will be shared with the Safeguarding Board.

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

The County Council has representatives on all the Board sub groups; there is also an Adult Social Care representative on the Board and the Executive Group. Staff from Adult Social Care Service chair three of the Boards subgroups and provide the administrative support to the Board, the Executive Group and the majority of the sub groups.

The recent decision by the Safeguarding Board to combine the health and social care operational groups has been welcomed by social care staff. This sub group provides the opportunity for safeguarding leads involved in the day to day management of safeguarding concerns to meet together to discuss learning and develop practice.

## Planned safeguarding activities for 2012/13

The County Council has a lead role in implementing many of the actions listed in the Safeguarding Adults Board work plan. As well as supporting the Board's action plan the Adult Social Care Service has identified four key areas of work for 2012/13:

- To revise the safeguarding arrangements in place with the Avon and Somerset Constabulary to reflect the new arrangements for the force wide Public Protection Units. This will include agreements on referrals, conducting interviews and access to police support in safeguarding concerns
- To ensure that safeguarding is embedded in the development of personalised care. This will include revising the advice and support provided to individuals commissioning their own care and strengthening the safeguarding expectations for services commissioned by the County Council
- To support the Safeguarding Board in undertaking a peer review/audit focused on one area of safeguarding work
- To work with NHS Somerset to transfer the statutory responsibility for the Deprivation of Liberty Safeguards in Health settings to the County Council by April 2013

## Issues for the Board's consideration during the coming year

1. Governance of the Safeguarding Board – The safeguarding Board reports to the multi-agency Safer Communities Group on a six monthly basis. As this arrangement has not been reviewed for some years, the Board may wish to take the opportunity to consider its governance arrangements, taking into account the changes being made to organisations represented on the Board.

2. Multi-agency funding – The County Council has appreciated the support of Board members in providing venues and chairs for some of the Boards sub groups. The Serious Case Review sub group has recently requested that consideration be given to funding an independent chair. When considering this request the Board may also wish to review how the range of work undertaken by all the sub groups can be supported during 2012/13.

**Report completed by:** **Helen Wakeling, Operations Director**
**Date: 28.06.12**

## Avon and Somerset Constabulary

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

From January 2012 Avon and Somerset Constabulary have undertaken a significant programme of change to restructure and modernise the way our Public Protection (PPU) Services are delivered.

Our objective has been to improve the way we protect vulnerable people through better co-ordinated assessment of risk, building capacity to address resilience issues, whilst at the same time delivering financial savings in this difficult economic climate where our public services are facing drastic budget cuts. For the Police there will be a 20% reduction in budget over 4 years which commenced in 2011.

The main change is the creation of three **Safeguarding and Co-ordination Units (SCUs)** - at Bristol, Keynsham (for Bath and North East Somerset and South Gloucestershire Local Authority areas) and Taunton (for Somerset and North Somerset Local Authority areas) which act as the central point for management of all information coming in and out relating to the abuse of vulnerable people and children and the offenders that commit these offences.

The SCUs have adopted consistent and streamlined risk assessment processes and information sharing and started to break down 'silo' working across different areas of abuse in recognition that child abuse, domestic abuse, and adult abuse are often interlinked with each other, which is reflected within the referrals and investigations that the Police deal with. Initially these SCUs will be police single agency units but plans are afoot to pave the way for them to become multi agency safeguarding units in the future

Vulnerable Adult abuse is no longer investigated in isolation but is managed within the newly formed PPU investigations teams, which are multi skilled to deal with a spectrum of offences. This means better identification of risk and management of cases.

Investigation Teams continue to be locally based with the exception of South Gloucestershire and Bath & North East Somerset which are co-located at Keynsham. The investigation teams covering the South are located at Yeovil, Taunton and Weston-Super-Mare. This will increase our resilience and capability to respond appropriately to all forms of Public Protection, including abuse of vulnerable adults, ultimately providing a better service to our victims.

Within the last year the Police have experienced an increase in referrals linked to care home settings and institutional issues, since the investigation into abuse of patients within Winterbourne View Hospital. This is viewed as a positive and

demonstrates the improved awareness of vulnerable adult abuse amongst the public and partner agencies. This matter is currently still under investigation, to date 11 individuals are being prosecuted for offences relating to neglect and ill treatment under the Mental Health Act. 10 have pleaded guilty to such offences and the investigation continues pending a full trial for 1 defendant.

**Training and other development activities undertaken within the organisation**

DCI Nick Papuca and other senior colleagues within the force's Public Protection Unit have drawn up a 24 point development plan under the heading "Safeguarding Adults against significant harm or exploitation". The plan is sub divided into processes, training, intelligence, performance, partnerships, learning and publicity and represents the most comprehensive commitment to address all aspects of abuse of vulnerable adults the force has ever mounted.

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

The development plan referred to above has been designed following the learning from local and national Serious Case Reviews that relate particularly to policing.

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

Avon and Somerset Constabulary are represented on the Board, the Executive Leads Group and the Serious Case Review sub group.

**Planned safeguarding activities for 2012/13**

The constabulary's focus over the next twelve months is to embed the new processes brought about by the restructure of Public Protection services across the force area whilst progressing the 24 action points contained in the Safeguarding Adults Development Plan.

**Issues for the Board's consideration during the coming year**

Organisational change in a challenging financial climate on an almost unprecedented scale is currently affecting most member organisations and agencies. The Board may therefore like to consider how appropriate and practical its current structure is given the demands faced by its members.

**Report completed by: DI Lindsay Shearlock, Southern Investigation Team, Public Protection Unit, Avon and Somerset Constabulary**

**Date: 10/06/12**

## Taunton and Somerset NHS Foundation Trust

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

We have continued to develop and revise our policies that affect vulnerable adults. A new Domestic Abuse policy has just been ratified and a Patient Search Policy (to help organise searches when vulnerable patients leave their wards) will be ratified soon. Our existing Patient Supervision policy has been reviewed and adapted; this will make it more applicable to the needs of a wider range of vulnerable patients who are at risk of harm, without increased supervision.

We have contributed to the current health thresholds work which is looking at how and when we make a safeguarding referral, following clinical incidents in the hospital and in response to complaints.

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

An audit has taken place to assess staff knowledge of vulnerable adult issues and the findings of this audit will be used to guide our future planning

Work within safeguarding is being maintained through an annual plan of work and reporting via the Trust's Safeguarding Committee, who are overseeing the Trust's safeguarding work.

**Training and other development activities undertaken within the organisation**

A champion training programme has been developed to ensure an individual from each clinical area has had extra training in safeguarding, Mental Capacity, Deprivation of Liberty, patient supervision, restrictive care and learning disabilities.

A new Learning Framework is being developed focusing on safeguarding and Mental Capacity. This will add focus on training for consultants, matrons and ward sisters. We will be looking for a 95% compliance with the training programme with the support of the learning and development department.

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

Increased training is being made part of the learning framework, which will target clinical decision makers in line with the SCR learning

A new consent form 4 has been developed in consultation with the IMCA service to guide clinicians in the use of the mental capacity act in the consent process for those patients who cannot consent to procedures or surgery. This form is being introduced as the old forms are used up.

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

Greg Dix (Executive Director of Nursing and Governance) has been representing the Trust at the Executive Leads group of the Safeguarding Board.

Lynne Street (Associate Director of Nursing) has represented the Trust on the Safeguarding Board

Duncan Marrow (Clinical Lead for Safeguarding Adults) has attended the Operational Sub-group of the Board and has been the joint chair of the Mental Capacity Act / Deprivation of Liberty Sub-group of the board (an additional report has been completed to reflect the work of this sub-group)

**Planned safeguarding activities for 2012/13**

- To incorporate safeguarding more effectively into current incident reporting and complaints management in line with multi-agency recommendations
- To ratify the Patient Search Policy
- To achieve 95% compliance with the Trusts Corporate Essential Learning programme
- To repeat staff knowledge audit every six months
- To use the newly developed reporting tool to communicate safeguarding activity with the Trust's Safeguarding Committee
- To appoint a non-executive lead for safeguarding to the Trust's Board
- Review the Trust's referral process to the Clinical Lead for Safeguarding Adults to allow a more effective use of this specialist support
- To review and revise the Trust's Using the Mental Capacity Act Policy and Deprivation of Liberty Safeguards policies, to reflect learning from the use of the existing policies.

**Issues for the Board's consideration during the coming year**

For the Board to consider a wider distribution of the board's minutes to support staff working in safeguarding, who are not board members. This would give safeguarding staff a better sense of the board's direction and plans, which would help guide their safeguarding work. Some of this information is currently lost during its cascade.

**Report completed by:** **Duncan Marrow (Clinical Lead for Safeguarding Adults)**
**Date: 15/06/2012**

## Yeovil District Hospital Foundation Trust

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

The profile and focus of safeguarding work within the organisation is maintained through the Vulnerable Adults Working Group. Feedback from external meetings is shared with the group and key messages for all staff are fed back through the divisional structure.

As a result of the raised awareness of safeguarding amongst staff and the subsequent increase of reported incidents the Safeguarding Adults Clinical Lead working hours have been increased to ensure there is sufficient time to undertake the activities the role requires.

### Training and other development activities undertaken within the organisation

The trust is required to ensure that all staff working with patients receive basic awareness training in respect of safeguarding vulnerable adults. An internal Training Needs Strategy has been reviewed and the training in the Trust restructured to include 3 levels of training:

• Level 1 – 30 minute combined introductory lecture linking in with Safeguarding Children awareness training provided to all new staff at induction plus 30 Minutes introducing the Mental Capacity Act to all Clinical staff on induction then 30 minutes mandatory updates every 2 years for non-clinical staff.

• Level 2 – all clinical staff working in contact with patients to receive this training every 2 years, which offers more detailed training on basic awareness, identifying vulnerable adults, signs of abuse and reporting structures and processes (mandatory for all staff who have contact with patients) plus Mental Capacity Act training.

• Level 3 – for senior clinical and operational managers, matrons and site managers who may need a deeper understanding of the processes and policies required for reporting externally on cases (not mandatory) and a greater understanding of the Deprivation of Liberties safeguards
These training programmes are now well established and incorporate training for all clinical staff on matters relating to safeguarding vulnerable adults and the Mental Capacity Act (2005) and Deprivation of Liberty safeguards.

In addition the Safeguarding Adults Clinical lead presented a complex case study at Trust wide Clinical Governance a Trust wide multi-professional forum attended by Doctors, Nurses and Allied Health Professionals.

Learning disabilities awareness is not a mandatory requirement; however the needs

of people with a learning disability are highlighted within the trusts mandatory safeguarding training. Awareness sessions have been delivered to specific staff groups and individual support and advice is provided on an on-going basis by the learning disability liaison nurse.

The Trust is required to have a nominated Prevent lead to roll out workshops to raise awareness of Prevent within the organisation. The aim of these sessions will be to provide attendees with an understanding of the new agenda and their role within it; the knowledge and confidence to share concerns and the ability to use existing expertise and professional judgement to recognise potentially vulnerable individuals. There is also a requirement to develop working relationships with local multi-agency partnerships working on the Prevent agenda. The Prevent work is currently in its early stages within the organisation.

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

The serious case review concerning Parkfields care home was in relation to a residential care home however there was cross organisational learning for acute trusts. This included professional relationships, training, availability, use and sharing of information and raising concerns or whistleblowing. The Vulnerable adults working group discussed the recommendations with implementation of the recommendations being monitored at subsequent meetings.

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

The Trust ensures representation at the Executive Leads Board, the Safeguarding Adults board and the Health Operational sub group.

**Planned safeguarding activities for 2012/13**

The trust has taken part in the Learning Disability Week 18-22 June to raise staff awareness; there are also plans for frontline staff to attend the Inclusive Communication Environment training in the near future. The annual audit for Safeguarding is currently in progress and will help inform the training needs of the organisation going forward. A pilot has just been completed looking at harm for all reported incidents and to consider external reporting under the safeguarding umbrella to ensure transparency within the organisation. The final thresholds and pathways for reporting are yet to be confirmed.

**Issues for the Board's consideration during the coming year**

The outcomes of the CQC's care home inspections following Winterbourne View, and the publication of the final Francis report into Mid Staffordshire NHS Trust.

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| Areas for shared learning across Somerset.<br><br>Maintaining best practice whilst undergoing NHS transition to the new commissioning support organisation and clinical commissioning groups. |

**Report completed by:** **Maddie Groves, Associate Director of Nursing**

**Date: 7/6/12**

## Care Quality Commission

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

The Care Quality Commission continue to implement a revised approach to regulation, including a new regulatory framework, a new enforcement policy, new judgement framework and revised safeguarding protocol. We make annual unannounced inspection visits to social care providers, independent healthcare providers, hospices, acute hospitals, some types of ambulance services and community based services for people with mental health needs and people with a learning disability. We inspect more frequently where we have concerns. Other service types will be inspected at least once every two years. We continue to share information with health and social care commissioners and have strengthened our systems to enable the public and stakeholders to share information with us.

**Training and other development activities undertaken within the organisation**

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

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

**Planned safeguarding activities for 2012/13**

**Issues for the Board's consideration during the coming year**

**Report completed by:** **Date:**

## Care Focus

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

The Improving Quality arm of our work supports care providers with safeguarding issues.
All Care Focus staff are aware of the changes to the identification checking required for CRB's

### Training and other development activities undertaken within the organisation

We continue to promote safeguarding and share information and resources through our engagement with employers. This includes one to one visits, Learning Exchange Networks, monthly E updates and website, which has recently seen 48,000 'hits' a month.
We continue to support registered care providers, Personal Budget holders, third sector and voluntary organisations, with their understanding of safeguarding, the Somerset Safeguarding policy and the learning opportunities on offer. We continue to distribute information and resources across the public, private and voluntary sector and recently facilitated an opportunity for the training providers to meet with the Safeguarding Coordinator to discuss Somerset policy and practice.

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

During the past year, we have been involved in the summarisation of safeguarding reports to share the key areas of learning with care providers. This information is again shared through the various methods of engaging with employers and the appropriate communication streams.

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

As an active member of the Safeguarding Adults Board, and two of the sub-groups; Serious Case Reviews – Lessons Learned and Learning and Development, Care Focus recently invested time in to coordinating and facilitating a 'Safeguarding Conference' to raise awareness with communities across Somerset. Opened by County Councillor Christine Lawrence and with speakers from Safeguarding Adults Board, SCC, Somerset Partnership and the Police, the event had well over 130 attendees including Parish, District and County Councillors, Housing providers, Neighbourhood Watch coordinators and third, voluntary and private sector providers and included exhibition stands from Community Safety, Fire Service, Alzheimers Society, SCC Learning and Development Team.
Care Focus successfully one a South West contract with ADASS in 2011 to lead the production, design and distribution of the 'Keeping Safe in your own Home' guide.

Unfortunately the 7000 – 10,000 copies promised to each local authority has not yet materialised, so Care Focus met the costs of printing 1,000 copies.
We are in discussions with the Cooperative Bank regarding the possibility of introducing a 'Carers/Care workers cash card. This would allow an 'approved' person on behalf of another (who are in receipt of some type of support or care) to be the registered user of a cash/ debit card to undertake limited transactions or withdraw a limited amount of cash for that person or for shopping. There would minimise the risk of financial abuse by allowing the individual or family to closely monitor the transactions being made by individual care workers and carer's.

In exploring the various helplines and support offered to adults, we came across an article introducing the 'Silverline'. This helpline service, again backed by Ester Rantzen, is based on the same principles as 'Childline' but is aimed at the over 60's. Given our concerns regarding the gap for those between the ages of 18 and 60, we have attempted to make contact with those developing this and are awaiting a response.

**Planned safeguarding activities for 2012/13**

Continuation of raising awareness across providers and communities, promoting resources and signposting learning and development opportunities. Printing and Distributing of 'Keeping safe in your own Home' guide. On-going liaison with Cooperative bank / Silverline

**Issues for the Board's consideration during the coming year**

Costs associated with printing of 'Keeping safe in your own Home' guide.
Continued programme of awareness raising – housing / communities / voluntary organisations? Day services.
Issues and concerns regarding the risks associated with services that are not regulated or contracted with by the local authority to those purchased by DPR's.

**Report completed by: Claire Waddon, CEO Date: 25th June 2012**

## Registered Care Providers Association Somerset

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

The RCPA contribute to a number of forums such as the Somerset County Council Quality Policy Group, NHS PCT Continuing Healthcare and Health and Social Care Quality Groups.

### Training and other development activities undertaken within the organisation

We do not directly deliver training to the sector but are planning more frequent seminar events in the future which will focus on encouraging best practice across the care sector in Somerset.

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

Please see our contribution below in respect of the proposed seminar for 2012. This has taken 6 months to develop but is seen as a substantial contribution to learning in the sector.

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

The RCPA contribute to the SAB Board and 2 sub groups. We also supported the Safeguarding Conference in March 2012.

### Planned safeguarding activities for 2012/13

The RCPA will organise a Learning Disabilities focused seminar in July 2012 which will concentrate on the lessons learned from Serious Case Reviews and how to apply them in the future. We are grateful to Somerset County Council for participating in this event.

### Issues for the Board's consideration during the coming year

The RCPA would welcome continuing support from Somerset County Council at future seminar events.

**Report completed by:** **Roger Wharton, Executive Officer**
**Date: 1 July 2012**

## South Western Ambulance Service Trust

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

Safeguarding of vulnerable adults remains a key priority for the Trust across the four geographical counties that the Trust covers.
Following the retirement of the Named Professional for Safeguarding for Dorset and Somerset, planning is underway to recruit to the post.
The focus on safeguarding is maintained through the leadership of the Safeguarding Manager and involvement of all front line managers and staff. Trust staff have maintained the level of alerting of incidents giving cause for concern.
The Safeguarding Policy is subject of annual review.

### Training and other development activities undertaken within the organisation

All staff continue to have access to Safeguarding information, Learning Zones and e-learning packages via the Trust Intranet.
Articles regarding safeguarding are regularly publish in internal publications which reach all staff across the Trust.
A link to the safeguarding learning zone is sent to any staff member when a communication is sent on behalf of the safeguarding team.

Safeguarding training is delivered by the trust to all students who are undertaking the Paramedic Skills course at the two Universities served by the Trust ie Bournemouth and Plymouth.

The Safeguarding function contributed to the external audit of Information Governance processes and was found to be compliant with standards.

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

Learning from reviews and incidents form a key part of the development of safeguarding practice and are reported to the Trust Board via the Quality and Governance Committee.
A Guidance document describing the process of requesting and providing transport under the MCA has been developed and adopted in a neighbouring county and is awaiting ratification by the MCA Group. This is supported internally by a Standard Operating Procedure and has built on the learning from a review undertaken in 2009

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

The Safeguarding Manager is a member of the main Board as well as the Learning Lessons sub group.

## Planned safeguarding activities for 2012/13

Mental Capacity Act training will be included on the annual training programme.

In the light of the planned merger with Great Western Ambulance Service, safeguarding arrangements and Policy will be reviewed in order to ensure consistency across the area of the Trust.
The Safeguarding function will be subject to external audit as part of the Trusts' audit programme.

## Issues for the Board's consideration during the coming year

For the Board to consider any new arrangements for safeguarding within the expanded Trust.

**Report completed by:** **Mary Smeaton, Safeguarding Manager**
**Date: 09 July 2012**

## Somerset Partnership NHS Foundation Trust

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

- The Trust is represented at the Somerset Safeguarding Adults Board & all of it's sub groups.
- Following the acquisition of Somerset Community Health In August 2011 the Head of Safeguarding Adults (HOSA)- Mental Health Directorate and the Lead for Safeguarding Adults (LSA) – Community Health Directorate have worked closely together to ensure integrated working.
- The HOSA and LSA undertook a self assessment of the Trusts safeguarding Adults Services utilising the Department of Health Self Assessment tool. This in turn has led to a combined Safeguarding Adults Action Plan to ensure integration of services.
- The HOSA and LSA have worked with Somerset Informatics to develop an IT combined safeguarding solution. This has been fully supported by the Executive Lead and is currently in the final stages of construction before it is piloted within the Trust.
- The Head of Safeguarding Adults has been involved in the drafting of the new Somerset Safeguarding Adults Policy. Once this is approved by the SAB the Trust will develop updated guidance for Trust managers and staff.
- The HOSA will be leaving the Trust in July 2012 and an interim plan for managing safeguarding adult processes will be put in place by the Executive Lead.

### Training and other development activities undertaken within the organisation

- The HOSA and LSA presented a combined interactive session at the Somerset Safeguarding Adults Conference in March 2012. Feedback was very positive from the organisations and agencies attending
- Following the acquisition of Somerset Community Health there were changes in roles in responsibilities for groups of staff across the Trust that changed training needs, thus training rates dropped to 76% in Dec 2011. From Jan-March 2012 an extensive mandatory training programme was put in place by the HOSA and Lead Nurse for Safeguarding Adults (Mental Health & Social Care). Currently 92% of all staff have up to date safeguarding training.
- From April 2012 there has been an ongoing training programme in place that aims to continue to ensure staff are trained and that safeguarding awareness is raised across all services within Mental Health & Social Care and Community Health. The new 5 hour session includes Safeguarding Adults, Mental Health Act, Mental Capacity Act, Deprivation of Liberty Standards, Consent and Prevent- the government's strategy for preventing violent extremism across the NHS.

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

- All actions following the Parkfields review are now complete for the Mental Health & Social Care Directorate & the Community Health Services Directorate.
- The Executive Lead and Head of Safeguarding Adults are both members of the Sudden Untoward Event Review Group. Learning from the reviews is disseminated via a variety of appropriate mediums to Trust staff. E.g. Newsletters, reminder memo's, manager briefings and incorporation in to training provision.

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

- The Executive Lead is a member of the SA Executive group.
- The HOSA is a member of the SAB and several sub groups.
- The LSA is a member of several SAB sub groups

**Planned safeguarding activities for 2012/13**

- The Hosa and the SCC Safeguarding Lead have been planning two workshops for managers and senior staff in Nov and Dec 2012. This will act as a joint learning and development event and will cover pertinent issues such as agency developments as well as service user involvement and working together with the police.
- Following the SAB's approval of the new Safeguarding Policy the Trust will update and develop guidance for Trust staff.

**Issues for the Board's consideration during the coming year**

- The Trust plan to develop a combined safeguarding adults and children service, similar but larger to the team in place prior to the acquisition of Somerset Community Health. Plans are for this to be progressed over the coming months**.**

**Report completed by:** **Richard Painter head of Safeguarding Adults**
**Date:** **25.06.12**

## NHS Somerset

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

NHS Somerset continues to monitor the compliance of NHS providers against quality standards for safeguarding adults. Safeguarding alerts are managed by NHS Somerset in collaboration with local partners in health and social care and reviewed at the countywide Safeguarding Adults Board at which NHS Somerset is represented. This includes individuals funded by health in nursing, residential and specialist residential home settings.

Work is underway to review the Safeguarding Adults Policy to reflect changes in the organisational structure following the transfer of Somerset Community Health, the arm's length community health service provider arm of NHS Somerset to Somerset Partnership NHS Foundation Trust, to reflect the responsibilities of a commissioning organisation.

NHS Somerset is also working closely with Somerset Clinical Commissioning Group (CCG) to ensure the seamless transfer of adult safeguarding responsibilities from April 2013, as a result of the countrywide NHS reforms. The CCGs will have specific duties to secure improvements in the quality of services, reduce inequalities in access to – and outcomes from – health services, promote involvement of patients and carers in decisions about individual care, secure advice from a range of health professionals, and cooperate with local authorities including participation on Health and Wellbeing Boards. They will be supported by the NHS Commissioning Board.

### Training and other development activities undertaken within the organisation

As part of the quarterly quality review process with providers from whom we commission services we gain assurance that staff receive appropriate training in relation to safeguarding adults to safeguard vulnerable adults from harm. Assurance is also sought regarding staff knowledge and training in relation to the Mental Capacity Act.

NHS Somerset has appointed a specialist Learning Disabilities Nurse Advisor to the Continuing Healthcare team to undertake care management responsibilities for all patients who are deemed eligible for fully funded or jointly funded packages of care. This responsibility extends to out-of-county placements for those patients in receipt of NHS funded continuing healthcare as either fully or jointly funded packages.

The Learning Disabilities Nurse Advisor will identify any safeguarding alerts / concerns made in respect of placements and will arrange to meet with the Safeguarding Coordinator at Somerset County Council to do this. NHS Somerset and Somerset County Council are working together to set up a process where the Nurse Advisor is notified directly as soon as an alert is raised.

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

NHS Somerset is still an active participant in the serious case review, involving a vulnerable adult with learning disabilities, following allegations of abuse at Winterbourne View Hospital during 2011/12. The final Serious Case Review, internal NHS Report and Care Quality Commission reports are due for publication following associated legal proceedings in August 2012. An action plan addressing issues identified for NHS Somerset has been developed and is monitored via the Continuing Healthcare Quality Monitoring Meeting.

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

NHS Somerset are represented on the Safeguarding Adults board and associated sub groups, working in collaboration with health and social care partners.

## Planned safeguarding activities for 2012/13

Progress has been made in agreeing safeguarding thresholds in health settings. In conjunction with Somerset County Council care pilots have been undertaken in Yeovil District Hospital, Taunton and Somerset NHS Foundation Trust and Somerset partnership Trust in a community hospital to review incident reporting to determine if the consequence scoring is a reliable indicator of potential safeguarding issues.

The pilot indicated the complexities associated with identifying safeguarding thresholds in health and has led to the further work to develop a protocol for raising safeguarding issues. This will be rolled out to providers in the coming year.

The Nursing & Patient Safety Directorate has developed a Safeguarding database to allow all incidents with a safeguarding element to be collated in one place to provide an overview of activity, including the status of any associated action plans. The Directorate will continue to develop and populate this in the coming year.

## Issues for the Board's consideration during the coming year

NHS Somerset will participate with Somerset County Council and other health and social care providers to fully implement the recommendations from the Department of Health Interim Report of Winterbourne View Hospital Interim Report, based on the findings of the Care Quality Commission review and the final report, due for publication in August of this year.

**Report completed by:** **Lynn Street, Deputy Director of Nursing and Patient safety**
**Date: 2 August 2012**