Somerset Safeguarding Adults Board

Annual report 2009

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1 Chairman's Remarks

This year has seen steady progress in the work of the Somerset Safeguarding Adults Board, in trying to make Somerset a safer place for its most vulnerable residents. Following the public furore around the tragic death of Baby Peter, it seems like safeguarding has never been higher on the agenda. This level of media interest could be seen as a threat. For safeguarding adults however, long a neglected area of safeguarding work, I think it offers an opportunity to raise awareness of these issues and by so doing make vulnerable adults in Somerset safer.

This year has also seen a review of "No Secrets Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse". This review was led by four government departments who sought the views of members of the public, professionals and organisations. The Somerset Safeguarding Adult Board contributed to the consultation, offering its vision of safeguarding work in the future. The consultation provided clear messages: that safeguarding arrangements are not always meeting the needs of those it is seeking to protect; that the legislative framework needs reviewing; and that there needs to be greater responsibility on organisations to work together. The government's response to these messages will be published early in 2010 and will influence the work of the Safeguarding Board during the next year.

The raised profile of safeguarding adults work across the country is also reflected here in Somerset. Agencies are identifying specialist safeguarding posts, and investing in safeguarding training within their organisations. This has considerably helped the work of the Board in getting its messages out, and ensuring there have been appropriate and coordinated responses to new legislative demands such as the Mental Capacity Act and the Deprivation of Liberty Safeguards. During the next year the Board will need to consider how these investments can be built on to provide a strong multi-agency resource. The appointment of a Safeguarding and Mental Capacity Act Co-ordinator in the County Council has been crucial for the implementation of the Board's action plan. Achieving our objectives for this year would have been far more challenging had this role not been in place. The level of work around safeguarding will continue to increase so it is crucial that the Board has the resources in place to support its future work. We will consider resource needs in our forward plan.

Reflecting on the year I feel my message is a traditional one. Much has been done in Somerset to safeguard vulnerable people, but much more remains to be done. I look forward to reporting next year on the further improvements we have made, particularly around how we have engaged with service users to improve the quality of their experience of the safeguarding process.

Finally I would like to thank everyone working with safeguarding situations for their continuous and sustained work throughout the year. It is their work every day that is enabling vulnerable people in Somerset to maximise their independence and choice free from harm or abuse by others. I hope that they agree with my view that while safeguarding work is challenging it is also highly rewarding

David Dick, November 2009

2 This Year's Achievements

The Safeguarding Adults Board

During the year we have seen a growth in the membership of the Safeguarding Board. Most of the key agencies in Somerset are now part of the Board and this multi agency approach has been crucial in ensuring that safeguarding issues are effectively addressed. The Board members have worked hard this year to raise the profile of Safeguarding Adults in their agencies, championing the work within their staff groups and ensuring clear governance arrangements are in place between the Board and their organisation. The way the learning from the Serious Care Reviews has been implemented across agencies reflects the effectiveness of these governance arrangements.

Whilst the increased involvement of agencies is to be welcomed, there is a need to review the way that the Board works to ensure that it does not become cumbersome or unwieldy. It is also important that we enhance the voice of those we are working to protect and their advocates. In January 2010 the Board will be spending a day together to discuss the best structure for the future.

Board Sub Groups - Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DOLS) came into force on 1st April 2009. Preparation for the implementation was co-ordinated by a multi-agency steering group in which both the areas supervising bodies, Somerset County Council and NHS Somerset were represented by senior managers. Both organisations committed project development capacity to the extensive structure development and training tasks as required during the preparation phase.

A joint operational policy was agreed between Somerset County Council and NHS Somerset which combines the administrative functioning for the two Supervisory Bodies in a single DOLS Co-ordinator post. There are sixteen trained Best Interest Assessors across the various specialist adult teams. Fourteen of these are Social Workers employed by Somerset County Council working in Adult Social Care, Learning Disability and Mental Health Teams and two of them are nursing staff employed by NHS Somerset. Twelve doctors have undertaken training to carry out DOLS assessments.

As well as training these assessors, a high volume of training has been undertaken with Care Home Providers – the Managing Authorities for DOLS, social care teams and health and social care professionals across the County.

Activity Levels

As with most areas of the county, the level of requests for assessments has been significantly lower than predicted by the Department of Health. The main reason for this is thought to be limited levels of awareness among Managing Authorities. The figures for the Somerset Supervisory Bodies are as follows:-

APRIL – SEPTEMBER 2009

Somerset County Council

No of Queries	No of Initial Assessments	No of Full Assessments	No of Authorised Assessments
38	3	5	1

NHS Somerset

No of Queries	No of Initial Assessments	No of Full Assessments	No of Authorised Assessments
5	1	3	0

To address this low number of applications for authorisation a new round of awareness raising activities involving the DOLS Co-ordinator and the Best Interest Assessors is being planned. The aim is to keep up the awareness and knowledge of the safeguards across the health and social care community in Somerset.

Board Sub Groups – Policy and Practice

Formerly known at the Policy Editorial Group, this sub group changed its name in June 2009. The group now not only advises on the development of the multi-agency policy but also updates the publicly available policy document.

During the last year the group has focused on updating the safeguarding toolkit. This provides the guidance for all staff responsible for investigating and chairing safeguarding situations. Having recognised the importance of having a toolkit that met the needs of all the professionals involved in safeguarding, the group spent time consulting with the wide range of people working in safeguarding situations. The revised toolkit provides clearer guidance around roles and responsibilities in safeguarding; ensures decisions are clearly documented and provides information about how strategy meetings should be conducted. The toolkit will be shared with professional staff early in 2010 and will also be available on the Internet.

The group's next task is to undertake a revision of the existing policy document. This revision will need to reflect the changes that are likely to occur during the next year, including;

- The future format of the Safeguarding Board
- The outcome of the "No Secrets" review
- Governance arrangements between Somerset County Council and Somerset Partnership.

Board Sub Groups – Training and Awareness Raising

During the last year the Training and Awareness Raising group has focused its work on revising the training resources available to all those working with safeguarding situations. The courses available to health and social care staff have been adapted to ensure there is a clearer link between training and practice. An additional day has

been introduced for safeguarding investigators. This day is aimed at staff that have done the initial training and completed safeguarding investigations. It offers them an opportunity to update their knowledge and reflect on their learning. The group is also currently revising the training available for the Chairs of Safeguarding meetings, and has introduced additional training for minute takers.

Much of this year's training has been aimed at supporting provider services with safeguarding concerns. Awareness training is offered through both taught and e-mail courses. Laptops have been made available through Care Focus to enable providers to offer the e-learning programme to staff in their workplace and within their normal working hours. Sessions have also been provided to managers and owners of services on Managing Safeguarding Incidents. The take up for all this training has been high. The training group has also ensured that the Social Care NVQ programmes available across the County are linked into the SCILS website and the safeguarding training it provides.

This sub group is also responsible for developing the awareness of safeguarding in Somerset. As part of this work it has started to review the available public information. A revised version of the *Stop Abuse* leaflet has been produced, and the group is now considering how other forms of publicity could be used to spread the safeguarding message throughout Somerset's communities.

During the last few months the group has also been involved in the development of a "Positive Risk Taking" approach in Social Care Services. The links between risk taking and safeguarding concerns are being explored to ensure that they are appropriately managed in a personalised service.

Safeguarding in Somerset

Somerset County Council was pleased to get a "good" rating on behalf of the Safeguarding Board when it was assessed by the Commission for Social Care Inspection on its lead role for safeguarding adults early in 2009. The inspectors saw that we take safeguarding seriously in Somerset. They felt there were prompt and effective responses to safeguarding issues when they arose. The level of inter-agency working and the effectiveness of the Safeguarding Adults Board were highlighted. But perhaps most importantly they could see that all the agencies involved in safeguarding have a real desire to learn from experience and from our mistakes. There is much in the report that we can feel good about, we are doing the basics very well. However we were clear with the inspectors that we are on a journey, and much still needs to be done. The inspection highlighted key areas where we need to improve – in being clearer about decision making, recording better in our files and collating clearer data, so we can use this to base our practice on evidence of local needs. We have accepted all these points, and you can see actions to address them within the action plan of the board.

We have worked hard to get key messages out across the health and social care sectors about safeguarding, the Mental Capacity Act and the Deprivation of Liberty Safeguards. Summary information leaflets have been developed and cascaded. Training sessions have raised skills and awareness. The inspectors noted these

good efforts but identified that the safeguarding message needs to be getting out further to volunteers and others who might be able to spot abuse and respond appropriately. We have actions planned to ensure that we get this message out.

Work Levels

From April 2009 safeguarding concerns in Somerset have been recorded on a new database system. This system will enable us to provide the information needed by the Department of Health. More importantly, it is able to provide better information about the level, type and nature of safeguarding concerns. Having this information will assist the future development of safeguarding. Identifying areas where further work or resources are needed.

The Department of Health information does not identify self neglect as an element of safeguarding. The recommendations from one of the Serious Case Reviews conducted this year was that the safeguarding process should always be used when there is evidence of self harm or self neglect, accompanied by concerns about the person's mental capacity. Following this recommendation Somerset has decided to record situations where the level of concern about the nature or extent of the self neglect has lead to the safeguarding process being used. This information will be held on a separate database.

The table below details the number of safeguarding concerns reported to Somerset County Council for the six months between April and September 2009 in comparison with the numbers for the previous twelve months.

Activity Levels

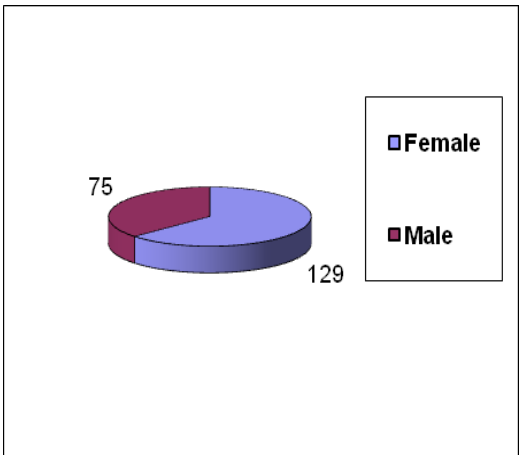
	April – September 2009	April 08 – March 09
Situations that have gone through the safeguarding process.	204	320
On-going work	33	85
Self neglect	119	Included in figures given above
Total	**356**	**415**

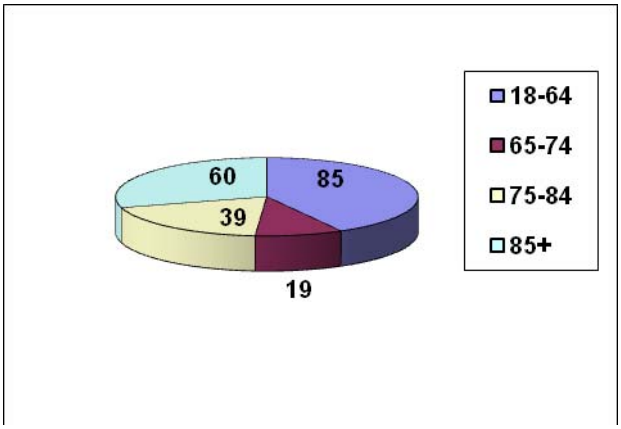
All of the information provided in the rest of this section relates to the 204 concerns that have been through the safeguarding process between April and September 2009. It provides us with a snap shot of the work we have done and identifies some areas where further examination is required.

Age and Gender

These figures show that the majority of our referrals relate to people over 65. The largest number of referrals per age group is however for those aged 18 – 65. This group has had 85 referrals, 51 of these were for adults with a learning disability.

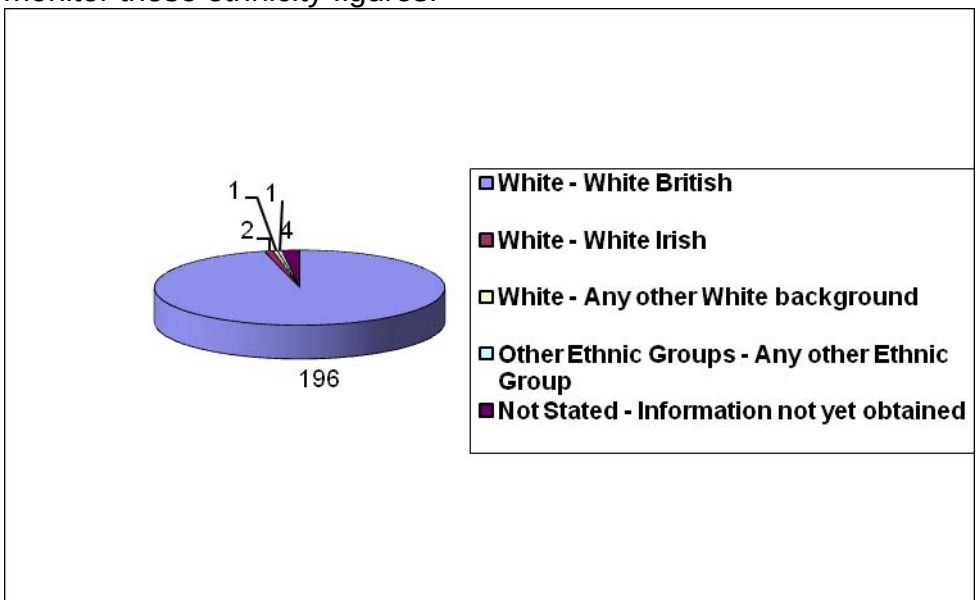
The majority of safeguarding concerns we received were about women. With the highest number of referrals being for women between 18 – 65. It is important to note that we have seen an increase in the number of men being referred, particularly in the 18-65 age category.





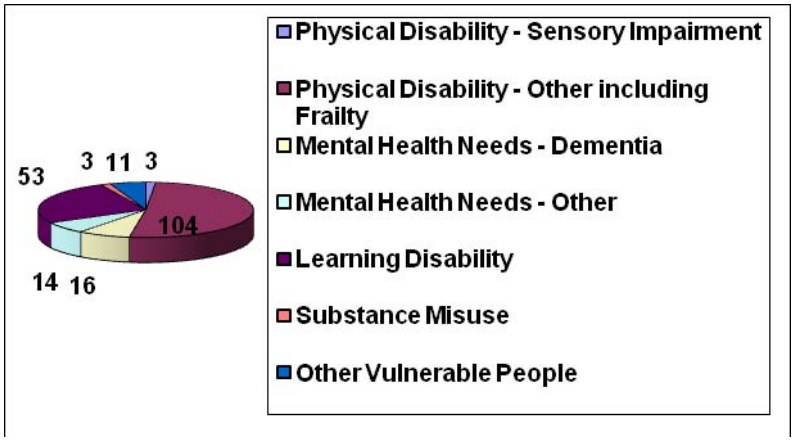
Ethnicity

Over 99 per cent of the people we have safeguarded have described themselves as white, predominately white British. There is no one from a black or minority ethnic group. The 2001 census indicated that over 3 per cent of the population aged over 18 in Somerset was from a black or minoirty ethnic group. During the next year the Training and awareness sub group will be considering how we can ensure the safeguarding message reaches all the communities in Somerset and will continue to monitor these ethnicity figures.



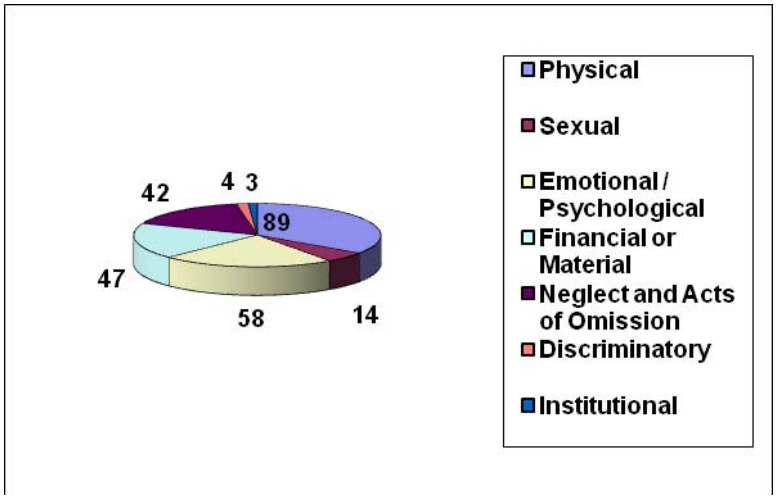
Client Category

The Department of Health have requested information on client category that is not age related. Therefore there is no reporting for older people. The majority of safeguarding referrals are for people described as having a physical disability. Of the 104 people with a Physical Disability – other, 92 of them are over 65. All 16 of those with Mental health needs- Dementia are over 65.



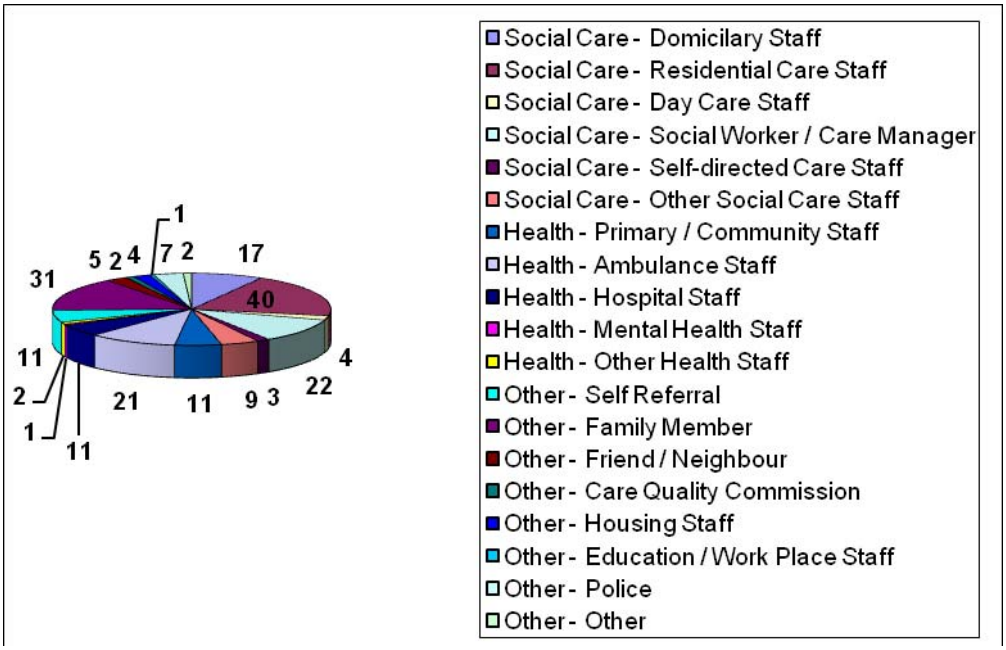
Nature of the abuse

Physical abuse was most frequently alleged during the six months of data collection. Emotional or psychological abuse and financial abuse were also frequently cited.



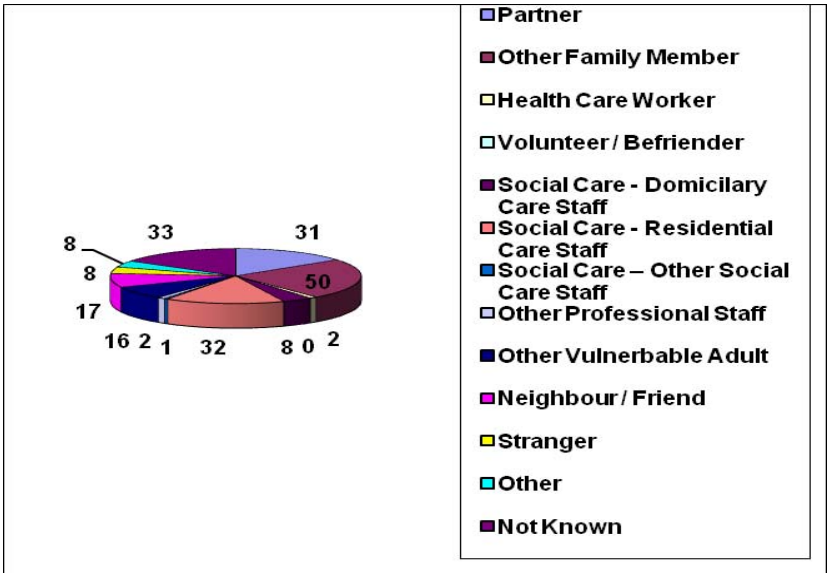
Source of referral

Last year the majority of our safeguarding referrals came from staff working in the Health Service. For the first six months of this year the highest numbers of referrals have come from residential care staff. It is interesting to note that 31 referrals have come from family members. The level of family referrals will be monitored during the next six months to see if there is a link between referral levels and the growing awareness of safeguarding issues amongst members of the public.



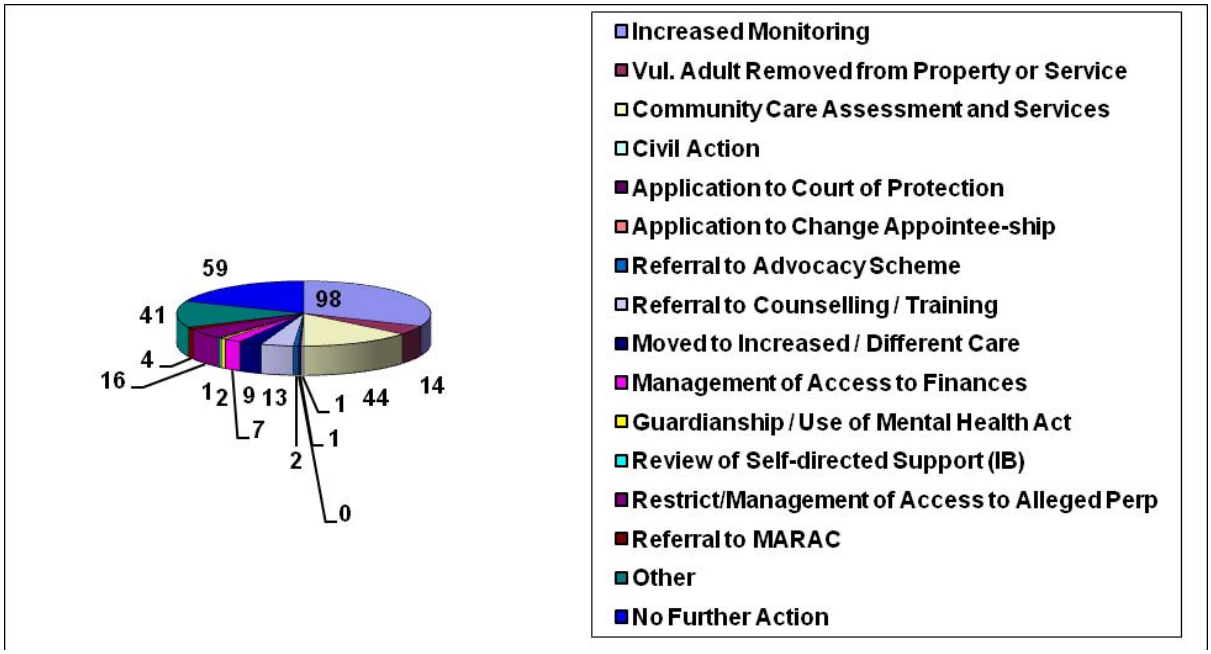
Perpetrator

This is the first time that we have provided information on the relationship between the alleged perpetrator and the victim. Out of the 204 safeguarding situations completed, 50 of the alleged perpetrators were family members. In 33 cases, the individuals were not known to the victims or had no relationship or link with them.



Outcomes for victims

This is the first time we have reported on outcomes for victims. 98 of people received additional monitoring, 44 had a community care assessment which resulted in services being provided. Further investigation is needed about the 49 people whose outcome was no further action. It is important we understand if this was due to: choice not to receive further support; an allegation that was not substantiated; or if there was a lack of supportive services available to the victim.



3 This Year's Learning

Quality Recording

During the last year the Board has focused on how we can evidence the quality of our safeguarding work. This challenge was also picked up by our inspectors - how can the Board be assured that safeguarding services across Somerset are of a high standard? In response to this we have:

- Improved our individual records by introducing a safeguarding section where all the information about a safeguarding concern can be held
- Strengthened our recording by providing a clear decision making process within the safeguarding procedures
- Established case file audits to learn from practice

Practitioners have welcomed all of these changes. Staff members have reported that they are clearer about how the safeguarding policy works in practice. The case file audits have been particularly successful with practitioners welcoming the feedback and learning they have gained through the process. While we have been able to successfully share this learning within teams, the challenge for the coming year is how we can share this more widely to drive forward best practice for everyone working with safeguarding concerns.

Service User involvement

One of our main challenges for the coming year is to increase the involvement of service users in the safeguarding process. This year we held a "Staying Safe" Day in March, looking at community safety and safeguarding issues for people with learning disabilities. This has lead to the planned development of a *Being Safe* handbook, and highlighted the importance of this issue for people with a learning disability. But we have more to do. We need to ensure a greater voice for service users and their representatives on the Board. We also need to hear about the "lived" experience of the safeguarding process from the individuals themselves. Part of our action plan is to develop a service user audit that enables us to draw on these experiences to further improve our work.

Serious Case Reviews

This year has also seen Serious Case Reviews (SCRs) and Significant Event Audits become established practice. Three SCRs have been completed and two further ones are being planned to start early in 2010. The various agencies invited to contribute to these reviews have participated fully and the process of learning has been a productive one.

The key learning points from the SCRs are:

- Staff in adult social work and Community Mental Health teams would benefit from additional guidance on the use of the safeguarding process with people who are at risk of harming themselves and whose mental capacity may fluctuate.

- Information about how risk of harm has been assessed should be shared with other agencies working with the person wherever possible.
- The supervision process in community teams should automatically include regular evaluation of the complexity of the work undertaken and review whether the case allocation remains appropriate to the skills and experience of the worker.
- The safeguarding process should always be used when there is evidence of self harm or self neglect accompanied by concerns about the person's mental capacity.
- General Practitioners should be provided with guidance about their role in the safeguarding of vulnerable adults.
- Training on the Mental Capacity Act should be prioritised for staff in the emergency services.
- Communication links between the out of hour's doctors and the ambulance service must be strengthened.
- Emergency service personnel need to be aware of how to access other services to support a person in the community.
- The emergency services to develop a protocol for addressing issues of non-compliance with transportation when hospitalisation is required for a person who lacks capacity.
- Revised guidance about the conducting of serious case reviews is needed to ensure their timely completion and the appropriate involvement of the relatives of people who have died.

As the last learning point indicates the policy and procedure for undertaking SCRs has come under a degree of independent scrutiny following concerns raised during a review. The Safeguarding Board have therefore asked the Safeguarding Co-ordinator to draft a revision to the guidance for discussion by a working group in the spring of 2010 with final agreement coming to the Board by the summer of 2010. The Board is aware that the review of *No Secrets* may also make recommendations about the management of SCRs and this would need to be reflected in any revisions made. It is important that the new guidance clarifies the Board's responsibility to oversee the implementation of actions plans and to ensure SCRs are closely linked with any other post-incident investigation processes.

Implementation of the learning points from SRC's are currently monitored by the Safeguarding Board. Agencies are asked to regularly update the Board on the action they have taken. During the next year an additional sub group – The Serious Case Review sub group will be established. This group will be responsible for the commissioning and conduct of reviews. The sub group will also monitor the implementation of review action plans and ensure the learning is shared throughout the agencies and groups working with vulnerable adults in Somerset.

Appendix A

Somerset Safeguarding Adults Board (SAB) Action Plan 2008 – 2010

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
Involving Service Users					
To work with the four main advocacy provider organisations to develop a plan for regular consultation exercises on safeguarding and community safety issues	The views of service users are evidenced in the work of the SAB and its sub-groups	A4E, Advocacy in Somerset, Somerset Advocacy, Age Concern	April 2010	Safeguarding Co-ordinator	In progress
As part of the safeguarding case audit seek to evaluate service user involvement and learn from their experiences where appropriate		SCC	From July 2009	Safeguarding Co-ordinator	In progress
As part of the review of contracting arrangements with the advocacy	Advocacy providers and their staff have a clear understanding of key	A4E, Advocacy in Somerset,	April 2009	Safeguarding Co-ordinator/ Head of Service,	Complete

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
providers, clarify expectations re safeguarding and identify training needs of advocacy staff.	safeguarding issues and appropriate channels for addressing concerns.	Somerset Advocacy, Age Concern		Partnerships and Community Development	
Raising awareness of safeguarding					
Develop and distribute widely publicity poster on abuse of adults	Members of the public and staff working in services in contact with the public know about how to raise a safeguarding alert	All	April 2008	Safeguarding Co-ordinator	Completed
Collaborate with other local authorities in the region on a public information campaign about safeguarding	Greater public awareness and understanding of the abuse and neglect of vulnerable adults and how to address concerns	All	July 2009	Somerset County Council (SCC);	In progress
Hold a Safeguarding workshop for the Learning Disability (LD) Partnership Board	Greater public awareness and understanding of the abuse and neglect of vulnerable adults and how to address concerns	LD service Somerset Advocacy	March 2009	Head of Service – Adults with Learning Disabilities/ Advocacy Services	Completed

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
Contribute to the cost of developing a new DVD resource on safeguarding for service users.	An accessible learning resource	SCC	April 2009		Complete
Review Somerset County Council internet information on development of the new SCC website. Ensure effective links are available between partner agencies' websites		SCC	March 2010	Safeguarding Co-ordinator	In progress
Governance					
Establish a governance link for the Safeguarding Adults Board, reporting to the Safer Communities Group		SCC	April 2009	Chair of the Safeguarding Board	Complete
Make an effective link between the Safeguarding and Community Safety	Safeguarding is seen by all agencies as an integral part of community safety	All		Chair of the Safeguarding Board	Complete

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
strategies including Domestic Abuse					
Development and implementation of the Quality Premium (QP) policy to support improved quality in care homes	• Clear links are made between the QP and Safeguarding processes • Action plans for 'Poor' rated homes lead to improvements in quality	SCC, Care Quality Commission (CQC), Care Focus, providers		Head of Service – Adult Social Care	Completed
Develop a more comprehensive, more evaluative annual SAB report format	Safeguarding work across all partner agencies in Somerset can be effectively evaluated	All	December 2009	Safeguarding Co-ordinator	Complete
Following an independent Serious Case Review (SCR), establish a comprehensive risk management strategy for Adult Social Care (ASC) and LD to include staff training as well as systems	Staff in the ASC and LD services have appropriate levels of understanding and skill in assessing and supporting clients who may pose a risk to themselves or to the public.	SCC – ASC & LD	March 2010	Head of Service – Adults with Learning Disabilities	In progress

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
and integrated into the personalisation of services. Link into existing community risk management strategies such as Multi Agency risk Assessment Conference (MARAC) and Multi Agency Public Protection Arrangements (MAPPA)					
Review the practice of Serious Case Reviews (SCR) and Significant Event Audits (SEA)	Improved links into practice development and training content		February 2010	Safeguarding Co-ordinator	
Introduce an element of arms-length audit of the quality of safeguarding work within Somerset County Council to supplement existing quality checks by Team Managers	• Managers have clear information about the quality of safeguarding work • Examples of good practice collated and shared		July 2009	Safeguarding Co-ordinator	Completed

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
Develop a formal feedback loop for agencies to report to the SAB on how learning from SEAs and SCRs has been shared and used		All	January 2010	Safeguarding Co-ordinator	In progress
Feedback to the No Secrets review by the SAB		All	January 2009	Chair of the Safeguarding Board	Completed
Examine the safeguarding work and structures in other local authorities with a view to making recommendations to the SAB about how to develop this work in Somerset	Safeguarding in Somerset benefits from knowledge of developments elsewhere	All	SAB development day Jan 2010	Safeguarding Co-ordinator	In progress
Make sure safeguarding is at the centre of planning for the personalisation of services	• A clear system for assessing and recording risk factors and supporting service users to make risk			Chair of the Safeguarding Board	In progress

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
	decisions • Reviews scrutinize the effectiveness of risk management				
Implement revised multi agency Single Assessment Process (SAP) review document	Staff conducting reviews in residential or nursing homes will be able to evaluate in greater detail the quality of care provided and highlight safeguarding concerns effectively	SCC ASC		Group Manager – Adult Social Care	Completed
Following initial pilot extend the use of this to LD Services	ditto for LD Services	SCC LD		Head of Service – Adults with Learning Disabilities	In progress
Training and Staff Development					
Establish a Safeguarding Adults Board sub-group for training	Agencies' training is linked in an over–arching strategy	SCC	February 09	Training Manager	Complete

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
Draw up a comprehensive record of Safeguarding training and awareness raising activity by all partner agencies for inclusion in the annual SAB report	ditto	All	January 2010	Training Manager/ Safeguarding co-ordinator	In progress
Revise the content of current training at Levels B – Investigation and C – Decision-making	The training for frontline staff and managers is closely integrated with the Safeguarding policy and incorporates learning from SEA's, SCRs, and practice audits.	SCC, Somerset Partnership PCT	January 2010	Training Manager/ Safeguarding co-ordinator	In progress
Consider the need for a specific safeguarding training module for care home managers similar to Level B	Senior staff in care homes are able to contribute to the investigation of safeguarding issues and to provide leadership for their care staff.	SCC Care Focus Care providers	December 2009	Training Manager/ Safeguarding co-ordinator	Complete – delivery from June 09

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
Develop a consolidation module for Level B	Staff involved in investigating safeguarding concerns have the opportunity to reflect on their practice a short while after completing Level B training	SCC Somerset Partnership PCT	July 2009	Training Manager/ Safeguarding co-ordinator	Complete
Safeguarding Vulnerable Groups Act implementation briefings to the SAB		All	April 2009	HR Manager – Somerset County Council	In progress On going briefings being provided
Establish an annual workshop for Team Managers and Safeguarding leads	Team Managers have an up to date knowledge of developments in safeguarding and an opportunity to share their own learning with colleagues	SCC/Somerset Partnership/PCT	September 2009	Training Manager/ Safeguarding co-ordinator	Completed as part of training revision

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
In conjunction with the SCC legal services develop a practitioners' information sheet about key legislation to supplement the legal section in the policy document		SCC	September 2009	Safeguarding Co-ordinator	Decision not to progress with this.
Establish a six monthly briefing meeting between legal services and service heads	Legal Services to report on trends in requests for legal advice and learning from recent cases	SCC/ Somerset Partnership	April 2009	Director – Community Directorate	Completed 1st in June 09
Increase awareness of MARAC and MAPPA processes among social work teams. Ensure process for how to access these is clear		SCC/Somerset Partnership	April 2010	Safeguarding Co-ordinator	Complete

Tasks	Desired outcome	Agencies affected	Timescale	Lead responsibility	Status
Recording Safeguarding					
Ensure that Safeguarding issues are fully addressed in the development of SCC's new electronic record system		SCC	July 2009	Safeguarding Co-ordinator	In progress – system not due until late 2010
Ditto Mental Capacity Act incl. the Deprivation of Liberty Safeguards		SCC	July 2009	Safeguarding Co-ordinator	In progress – system not due until late 2010
Make sure that individual case files adequately reflect whole service safeguarding issues		SCC	April 2009	Safeguarding Co-ordinator	Completed

Appendix B - Agency Reports

1. NHS Somerset

Introduction and Policy Context

This report provides an overview of arrangements and strategic framework for Safeguarding adults for health services in Somerset and demonstrates how NHS Somerset has discharged its responsibilities to safeguard vulnerable adults at risk of abuse, and to promote prevention of abuse, across the health services it commissions.

Safeguarding policy development and implementation, and clinical oversight are specialised and require detailed understanding of the multi agency relationships that support them. Safeguarding should be everybody's business and accountabilities are clear across NHS Somerset with well-defined processes in place. This annual report for 2008 -09 demonstrates that good progress has been made in ensuring that safeguarding adults policy and practice are implemented across commissioning and provider functions, with clear accountability and governance arrangements in place to support this.

In 2001, the Department of Health issued 'No Secrets' guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. This document provides guidance to local agencies who have a responsibility to investigate and take action when a vulnerable adult is believed to be suffering abuse. It also provides guidance on the development of local inter-agency policies, procedures and joint protocols.

During 2008, all NHS trusts in Somerset participated in the consultation to review 'No Secrets', and identified the following key issues to support implementation of safeguarding adults policy practice in NHS Trusts:

- executive leadership for safeguarding adults
- sufficient capacity to take forward the safeguarding adults agenda
- clear reporting processes linked to incident reporting processes and
- clear pathways for receiving and responding to safeguarding alerts for care homes
- consideration of the requirement for a duty to cooperate on safeguarding adult's issues
- consideration of inclusion of quality indicators for safeguarding adults in the Quality and Outcomes Framework for general practice

All NHS Trusts in Somerset have the following key features in place at and organisational or strategic level for safeguarding adults:

- executive leadership and commitment to the importance of safeguarding adults from the risk of abuse
- a clear line of accountability within the organisation for work on safeguarding adults from the risk of abuse

- service development that takes account of the need to safeguard and promote the welfare of all adults and is informed, where appropriate, by the views of adults from the relevant groups such as older people, people with learning disabilities
- staff training on safeguarding adults, for all staff working with or (depending on the agency's primary functions) in contact with patients and the public
- safe recruitment procedures in place
- effective inter-agency working to safeguard adults from risk of abuse
- effective information sharing

The discharge of these responsibilities is also reflected in the Core Standards of the Health and Social Care Standards and Planning Framework for 2005-08 (National Standards, Local Action).

The Care Quality Commission annual health check requires Primary Care Trusts and NHS Trusts to provide assurance that they comply with the Core Standards of Standards for Better Health (DH 2006). Primary Care Trusts and NHS Trusts are required to provide assurance that they comply with the core standards and in particular core standards 10a and 10b covering employment checks and professional codes of practice which relate to arrangements to safeguard adults.

Safeguarding Arrangements within Somerset Primary Care Trust

Board Lead

The Director of Nursing and Patient Safety is the executive lead with responsibility for safeguarding adults. There is a GP Patient Safety Lead within the Nursing and Patient Safety Directorate to lead on safeguarding adults issues in relation to general practice.

Contracting Arrangements with Foundation Trusts

NHS Somerset has included quality standards for safeguarding adults in all Foundation Trust contracts that are derived from the 'No Secrets' guidance, together with standards C10a and C10b from Better Standards for Health DH 2004 for safe recruitment and professional regulation.

Monitoring of contract compliance and performance against these agreed Standards is undertaken through the attendance at each NHS Trust Safeguarding Forum. Each NHS Trust is required to provide a work plan in respect of safeguarding adults, to ensure staff attend safeguarding training and to participate in serious case reviews when these arise. Implementation of action plans arising from serious case reviews are monitored at these forums.

Members of the Nursing and Patient Safety Directorate attend each NHS Trust Clinical Governance Committee and monitor implementation of the action plans and safeguarding adult's policy and practice. Any concerns arising in relation to safeguarding performance would be addressed at the quarterly performance meetings with NHS Trusts

Contracting Arrangements with Independent Contractors

The National Quality and Outcomes framework for general practice includes outcomes for safe recruitment and supervision and appraisal of professional staff. These are monitored through contract meetings with each general practice and through the Quality and Outcomes Framework assessments. The standards within the Quality and Outcomes Framework do not include specific standards in relation to safeguarding adults practice.

NHS Somerset has addressed safeguarding adults practice with individual practices that have participated in serious case reviews or where safeguarding adults' incidents have arisen. These general practices have been requested to undertake a significant event audit in relation to the incident.

As a result of participation by general practice in serious case reviews, there have been a number of lessons learned. These include the importance of providing safeguarding adults training for general practice and the development of "hand-held" information for GPs and their staff.

Information on the Multi Agency Safeguarding Adults policy has been provided to all general practices, together with a link to the website. Key priorities for 2009–10 will be the development of hand-held information on the policy for general practice staff, and also provision of training for general practice.

During 2009-10 there will also be development of safeguarding adult's standards for inclusion in the clinical governance frameworks for Dentistry, Community Pharmacy and Optometry.

Safeguarding Adults Issues in Independent Nursing Homes

NHS Somerset commissions NHS funded Continuing Healthcare placements in care homes and commissions NHS funded Nursing Care in Nursing Homes. The NHS Somerset Funded Nursing Care Coordinator and the Vulnerable Adults Lead (Somerset Community Health) work closely together to address vulnerable adults and safeguarding alerts for care homes in Somerset, to safeguard the care provided to residents. Joint attendance at all safeguarding adults meetings is maintained to ensure a co-ordinated response.

The Somerset Community Health Vulnerable Adults lead is supplied with the details of all continuing healthcare patients in order to enable early instigation of urgent reviews of care, if required, in response to safeguarding adults' alerts.

A key priority in 2009 – 10 will be the development of a policy that sets out the responsibilities of health services for responding to safeguarding adults' alerts in care homes and the arrangements in place for assuring the quality of care provided for residents funded through NHS funded Continuing health care and for residents funded through NHS funded Nursing Care.

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
During 2008 -09, NHS Somerset employed a project worker for implementation of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The project worker provided training in the Mental Capacity Act 2005 for General Practices in

Somerset. 59 practices have received training and the remaining practices have received an information pack.

A successful seminar was held on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards at Musgrove Park Hospital, Taunton for medical staff, health professionals and general practitioners during November 2008. The project worker also reviewed all policies and where necessary updated this in line with the Mental Capacity Act.

The project worker worked in partnership with the Safeguarding Adults Lead at Somerset County Council and with the Continuing Healthcare Manager in NHS Somerset to implement the responsibilities for Deprivation of Liberty Safeguards in Somerset. NHS Somerset is the supervisory body for Deprivation of Liberty Safeguards for all hospitals in Somerset for the healthcare commissioned for patients registered with a Somerset GP. Two best interest assessors have been trained and arrangements for medical assessments to be undertaken have been put in place.

NHS Somerset has participated in reviews of the Independent Mental Capacity Advocacy (IMCA) service. During 2008 -09, the number of referrals to the IMCA service for serious medical treatment has been low. These referrals will be monitored across all commissioned services during 2009 – 10 to ensure that there is an improvement in this position following the training programmes provided across all services.

Serious Case Reviews
NHS Somerset has participated in three serious case reviews coordinated by the Somerset Safeguarding Adult's Board in 2008-09. NHS Somerset has been represented on the panel for each of these serious case reviews and ensured that all of the relevant health services have participated in the review.

An action plan has been developed to monitor the implementation of the recommendations from serious case reviews by all NHS providers. The health recommendations include:

- the provision of health advice on sudden unexpected death from epilepsy,
- raising awareness of safeguarding adults issues in general practice, and
- improved communication about vulnerable adults across primary and secondary care.

Trust Board Assurance for Safeguarding Adults Arrangements

The Quality Improvement and Patient Safety Committee receives safeguarding adults' exception reports at the committee meeting. Exception reports are made in respect of the implementation of action plans from serious case reviews.

The Quality Improvement and Patient Safety Committee provides a quarterly report on patient safety which includes safeguarding adults to the NHS Somerset Integrated Governance Committee and an Annual Report for Safeguarding Adults is provided to the NHS Somerset Trust Board.

NHS Somerset will be strengthening the quality monitoring arrangements for all NHS Trusts during 2009-10.

Summary and Recommendations

This report provides evidence of the arrangements in place to safeguard adults in all NHS Trusts in Somerset, and of the improvements made in policy and practice. The following priorities for arrangements for safeguarding adults have been identified for 2009 –10:

- provision of training for safeguarding adults for general practice staff
- monitoring of attendance at safeguarding adults awareness training for all eligible staff and development of a training plan that identifies those staff who require advanced training in safeguarding adults in all commissioned services
- development of a policy for responding to safeguarding adults alerts in care homes and assuring the quality of care provided for residents funded through NHS funded Continuing health care and for residents funded through NHS funded Nursing Care
- continued participation in serious case reviews when these arise
- participation in multi agency audit of vulnerable adult cases
- development of data collection arrangements by all commissioned services

Lucy Watson
Deputy Director of Nursing and Patient Safety

2. Somerset Community Health

This report identifies the function and work undertaken by the Somerset Community Health Lead for Safeguarding Vulnerable Adults, and relates to the information requested by the Somerset Safeguarding Board.

The report also identifies areas of work under review and development.

Executive Leadership

As the Somerset Community Health progresses as an arms length organisation, it is its intention to strengthen the leadership arrangements for safeguarding through enhanced reporting structures and systems.

Specific forums being established are:

- Safeguarding Implementation Group (SIG) (Lead by the Lead officer for Children and Young Peoples' services)
- Safeguarding Vulnerable Adults Working Group (Lead by the Lead for Safeguarding Vulnerable adults

It is the intention of the groups to consider, communicate and implement all aspects of the safeguarding agenda, prompted though legislation and from directives driven nationally and locally. These groups become effective from October 2009.

Governance Arrangements

Within Somerset Community Health the governance arrangements for Safeguarding Vulnerable Adults are included within the Integrated Clinical Governance.

A quarterly report is produced by the Lead for Safeguarding Vulnerable Adults for the Interim Head of Adults Services, to present at the Safety Quality Improvement Development Group (SQUID).

Other risk management arrangements are through the incident reporting systems – DATIX

Policy Development

Local policies under development are:

- Somerset Community Heath 'No response'. A policy which reflects the Somerset County Councils policy of the same name

Safeguarding guidance and support tools have been developed to support staff when making decisions of capacity and best interests of their patients.

Draft Deprivation of Liberty guidance for a Managing Authority, with a quick reference check list.

Training

Recent work with the organisation's training provider has ensured the training offered to Somerset Community Health staff is consistent with training provided by other private and public sector organisations to their staff and reflects the Somerset safeguarding processes and procedures.

Awareness Raising Sessions

To raise awareness of the safeguarding, the Safeguarding Adults lead is now attending Locality Managers and Heads of Services meetings to discuss this topic and offer advice and support as required.

From the meeting, the Safeguarding Adults lead has responded to requests for training and this has been designed to be more area and profession specific and delivered within each locality.

Supervisions / Debriefing

Any staff who have been involved with a safeguarding concern are contacted regularly and offered an opportunity for debriefing. Although the take up for face to face meetings is low, with only a few staff wanting to discuss the cases they have been involved in, there is an increase of telephone contact.

Debriefing documentation, similar to that used by Somerset County Council - Adult Social care, has been developed to support this process

Participation in serious case reviews/lessons learnt
Current work, which has resulted in actions from lessons learnt, includes working with the Lead for Minor Injury Units to identify frequent users of the services and information sharing procedures

Other Developments

Development of a database which provides information of the referrals into the service, the outcomes and any gaps in services.

Continued attendance of the locality meetings.

To further develop the debriefing sessions.

To develop a strategy to ensure the safeguarding agenda is sufficiently considered within the overall organisation development and to ensure national guidance is implemented.

To discuss the development of a network of staff to act as link workers on the safeguarding agenda, who have enhanced skills on this topic.

Continuation of work with the NHS Somerset commissioning Lead for funded nursing care.

To audit the effectiveness of staff in promoting and preventing abuse and reporting

safeguarding concerns.

To continue to work with Somerset County Council on the following work streams which will support the awareness raising for safeguarding :

- the Safeguarding Vulnerable Adults ‘trigger’ protocol
- Somerset Safeguarding Policy development
- Somerset Training development programme
- public awareness sessions

And the work streams of Somerset Community Health:

- end of life care/palliative care
- essence of care

Vanda Squire
Lead for Safeguarding Vulnerable Adults

3. Taunton And Somerset NHS Foundation Trust

Introduction

This paper outlines the significant developments achieved at Taunton and Somerset NHS Foundation Trust over the last twelve months associated to safeguarding adults. The appointment of a full time Clinical Lead has been instrumental in the delivery of all safeguarding adult initiatives.

Executive Leadership / Governance

The Director of Governance and Nursing is the Trusts Executive Lead for Safeguarding with a governance infrastructure delivered through a multi professional Safeguarding Committee. The Safeguarding Committee has the responsibility of overseeing safeguarding issues of both adults and children, although discrete agendas enables focused work.

Policy Development

The Trust's Safeguarding Vulnerable Adults Policy was ratified in April 2008, and further revised in Oct 2008, to reflect the new clinical lead role and to meet external regulatory requirements. Policy work is underway for Mental Capacity, Deprivation of Liberty Safeguards and Patient Supervision. Further policy work will include Wandering Patients, Patient Searches and a review of the Trust's Restraint Policy forms part of the overall annual plan of work.

Strengthen safeguarding links in current policies such as Risk Management, Complaints/PALS and Serious Untoward Incidents, is also incorporated in the annual work plan

Training

The Trust's mandatory training matrix now includes updates on both Safeguarding and the Mental Capacity Act for all staff. In addition to this, awareness training sessions have taken place on a risk basis, focusing on specific wards and a variety of staff groups within the organisation.

Training work needs to develop further with a full day's training on Safeguarding, Mental Capacity and Deprivation of Liberty being developed. Plans are in place to review the Trust's engagement with the multi-agency training programme, when details of the training review have been released.

Participation in Serious Case Reviews / Lessons Learned

Within the last year the Trust has participated in a serious case review which involved issues that arose following the death of a vulnerable adult during an inpatient stay. The development of an action plan focused around the importance of documentation and how staff require concise communication in order to guide their actions around issues associated to safeguarding.

Engagement in supporting the actions required following a serious case review is also underway, which involved a sudden unexpected death in epilepsy. Information is being produced to support community staff in their management of patients at risk, to help prevent sudden unexpected death in epilepsy.

Other Developments

The main safeguarding development within the organisation during the last year has been the substantive appointment of the Clinical Lead, which has allowed a greater amount of development in policy and awareness. This has led to 69 referrals regarding concerns about abuse being received between April 2008 and April 2009, since April another 76 referrals have been received. These referrals have provided the opportunity, to work along side multi-agency partners, to put measures in place to improve the safety of the most vulnerable patients. These referrals and subsequent measures have been a great step forward from previous years. This has clearly reflected the advances in both awareness and processes within the last year.

Most recently, there has been much more consistent representation at a variety of multi-agency meetings including the Safeguarding Board, the PCT Forum and the Locality Leads meetings. Collaboration with multi-agency partners on a number of cases of concern as well as being involvement with ongoing development issues has promoted cross organisational working.

Working in collaboration with the IMCA service has been instrumental to raise awareness of their role and when there is a duty to refer to them. Referrals have increased to this service including our first referrals for serious medical treatment, although despite improvements of engagement, numbers of referrals, particularly for serious medical treatment could be improved.

Conclusion

Many achievements in relation to safeguarding processes, policy development and awareness raising throughout the organisation, has happened over the last year. Despite many successes, there is still much work to do by continuing to raise awareness and ensuring that safeguarding becomes an integral part of the Trust's processes and planning. The Clinical Lead post, Executive Lead and Safeguarding Committee places the Trust in a very good position to continue with the improvements over the next twelve months as detailed in the annual plan of work.

Duncan Marrow
Clinical Lead for Safeguarding Adults

4. Yeovil District Hospital NHS Foundation Trust

Executive Leadership and Governance

The Director of Nursing and Clinical Governance is the Vulnerable Adult lead at board level. The Trust Vulnerable Adult lead is one of the Heads of Nursing, whose role is trust wide with corporate responsibility for vulnerable adults.

Incidents are recorded via clinical governance on Uylesses.

Currently there is no Trust-wide forum for safeguarding adults, although safeguarding adults' issues are monitored through clinical governance arrangements. This will be addressed in the near future. It is intended that the governance arrangements for Vulnerable Adults will mirror Safeguarding Children with a committee that will cover incidents, training needs, and policy etc, report into the Clinical Governance Assurance Committee and produce an annual report. We would welcome NHS Somerset involvement in the planned governance structure.

Policy Development

The Vulnerable Adults Policy was updated May 2009 and now includes the Deprivation of Liberty Safeguards.

Training

Vulnerable Adults training is part of the seasonal approach to mandatory training that takes place each spring. Training folders are present in each ward and department. The IMCA service were involved in a conference at YDH raising awareness of the Mental Capacity Act. In addition briefing sessions have been held in Clinical Governance and Big Governance sessions. All of the above training sessions have also included the Deprivation of Liberty Safeguards.

Participation in Serious Case Reviews / Lessons Learned

There were no serious care reviews to report, however an internal root cause analysis was commissioned following the requirement for medical decision making on the behalf of a patient who lacked capacity and had no next of kin with out involving an IMCA. The final report is awaited.

Any Other Developments to Note

A proposal for a named nurse for Safeguarding Adults has been considered by the Trust and further work will be undertaken on the requirements of the role for submission in the annual budget setting round.

5. Somerset Partnership NHS Foundation Trust

Executive Leadership / Governance

Diana Rowe is the Executive Lead for Safeguarding.
Barrie Crow is the Non-Executive Lead for Safeguarding Adults.
Linda Nash is the Non – Executive Lead for Safeguarding Children.

Richard Painter commenced as the Lead for Safeguarding Adults & Children across the Trust on the 8 June 2009. Richard is the first point of contact within the trust for adult and children safeguarding issues and concerns.

The Lead for Safeguarding Adults works closely with the Executive Lead and Heads of Adult Services to ensure a cohesive trust wide approach to the Safeguarding Agenda.

The Named Nurse for Safeguarding Children is a statutory role that will be extended over the coming months to incorporate safeguarding adults.

Policy Development

The lead for Safeguarding Adults is currently working with the Somerset Adult Social Care Safeguarding Project Officer, reviewing Somerset Partnership NHS Foundation Trust Safeguarding Adults Policy and Procedure in parallel to the scoping exercise being undertaken for the Somerset Safeguarding Adults Policy and Procedure.

The Trust will ensure that the revised policy is accessible to all staff via the Trusts new Safeguarding Webpage. The existing policy continues to operate at the current time.

The Datix reporting system now has incorporated a specific 'Safeguarding Concerns' field. The system allows for automatically generated notification to the Safeguarding Lead and Named Nurse who will oversee the system and ensure appropriate action is undertaken and inter agency communication takes place as appropriate within the Safeguarding Adults and the Safeguarding Children Policy and procedures.
Work is underway to develop the Rio client record system in the Trust to incorporate a separate ‘Safeguarding Folder’ that will enhance further the current processes in place for Safeguarding Adults and Children.

Training

As part of the current review of Safeguarding Training by the Safeguarding Lead and Manager of Training and Development, plans are currently underway to develop a centralised mapping system for all safeguarding training undertaken. This will enable any gaps in training to be identified as they arise and for training to be provided accordingly.

A new trust wide system is being developed that will identify a Safeguarding Champion in each and every team across the trust. The Champion will act as a conduit between the team and the Safeguarding Lead and Named Nurse. The Champions working in children and young people teams will undertake as a

minimum level C Inter Agency Safeguarding training as a priority. This will be the standard for all Champions across the Trust and the aim is for this to be completed within the next 12 months.

From November 2009 the Lead for Safeguarding Adults will be providing Safeguarding Adults Awareness training in the mandatory induction program for all new staff to the trust.

There has been a determined drive in relation to Level A safeguarding adults training for all staff this year.

Participation in Serious Case Reviews / Lessons Learned

The Trust has contributed to one Serious Case Review this year that was led by Somerset Social Care. The lessons learnt from the SCR have been disseminated to the appropriate staff. The action points have led to three particular areas of focus for the Trust.

- reminders to staff responsible for care co ordination to ensure proactive communication plans involving all relevant parties are in place
- managers have been reminded of their responsibility to identify and address the support needs of staff following a traumatic or especially difficult case
- counselling services are available to all staff via occupational health

Richard Painter
Safeguarding Lead for Adults & Children
Somerset Partnership NHS Foundation Trust

6. South Western Ambulance Service NHS Trust

The South Western Ambulance Service NHS Trust (SWAST) is committed to the safeguarding adults' process at both strategic and operational level. Trust staff generated two hundred and thirteen alerts during the year 2008 – 2009, some of which proceeded to full safeguarding investigations and many of which were an early indication of vulnerability.

The work is led within the Trust by the Safeguarding Manager supported by a Paramedic Lead for Safeguarding and a safeguarding assistant.

The Trust is represented on the Safeguarding Adults Board by the Safeguarding Manager. The Trust is also involved in the evolving work with the Trigger Protocol including its operational effectiveness.

All staff receives awareness training and have access to the online training package. Further training is a priority for the coming year, as is the effective feedback of outcomes from alerts, in order to improve practice.

Mary Smeaton
Safeguarding Manager
South Western Ambulance Trust

7. Avon and Somerset Constabulary. East and West Somerset Police Districts.

Staff Training and Development in Safeguarding.

In October 2009, Avon and Somerset Constabulary will be hosting a multi agency seminar entitled ‘Policing A Society For All Ages’ the event is aimed at tackling the issues that this community are vulnerable to such as, Distraction Burglary, Elder Abuse, and increased fear of crime compared to other communities. The event will also look at what collaborative work can be done with other agencies and charities to reach our goals.

Officers from the East Somerset Vulnerable Victim Unit (VVU) provide training to the Level 2, Safeguarding Vulnerable Adults Course. This is aimed at a multi agency audience. Our input has been recognised by Professor Paul Cambridge (Kent University) who has subsequently produced a research document “Working *effectively with the Police in Safeguarding adults; Observations and lessons from Experience in Somerset “for* publication in professional journals.

Student police officers continue to get training and work experience within the VVU.

My aim is to expand this training to the Community Support Officers, who are the true link to the community.

The Constabulary is exploring the possibility of “tagging “all incidents and crimes involving V A recorded on the Forces computerised crime reporting system, “Guardian “. This will allow effective identification, tracking and analytical research around V A.

Learning from Experience**.**

Safeguarding adults and VVU sits under the same Public Protection Umbrella as Domestic Violence. The Detective Inspector for the VVU will also chair the Multi agency Risk Assessment Conference (MARAC), this multi agency conference deals with high risk domestic violence victims. Increasingly referrals are being made when very elderly and physically or mentally disabled couples, who have been together for many years, are perpetrating violence to each other.
There is a need for partners and agencies to recognise theses safeguarding issues before the individuals have had their risk elevated to high, and circumstances have resulted in domestic abuse.
It is intended that the MARAC coordinator will include this in our training to other agencies.

Issues Arising.

Information sharing within the context of Serious Case Reviews is still an issue. Both nationally and regionally, police recommended to the “No Secrets “consultation that Safeguarding Adults should be on a statutory basis. Despite this East and West Somerset VVU‘s will review in details each request emanating from a Serious Case Review and always ensure that the maximum permitted participation is conducted.

Agency / Service.

Protecting Vulnerable People is an important and integral part of the Constabularies and Police authorities' vision to enable the communities of Somerset to have the highest levels of confidence in the delivery of our policing services. Protecting Vulnerable adults are included within our Protective Service plan 2008 -11. Protective services, is a term to describe a range of the most serious aspects of crime and potential threats.

The Assistant Chief Constable chairs the "Vulnerable people panel "which is attended by all District commanders. The panel are currently considering the future direction and the Forces strategic approach to safeguarding adults.

Detective Inspector Jim Bigger
East Somerset Public Protection Unit.

8. Adult Social Care – Somerset County Council

Safeguarding awareness training is provided to all Adult Social Care staff as part of their induction. All qualified social workers are required to undertake the course on Investigating Safeguarding Incident's before they begin working on safeguarding concerns. Our team managers have also undertaken the course on Chairing and Decision Making in Safeguarding Meetings. Support staff are trained on how to minute safeguarding meetings. Staff involved in giving social care advice over the telephone at "Somerset Direct" have received safeguarding awareness training. This has ensured that members of the public are asked about safeguarding concerns and given information and advice when appropriate. Senior managers in Adult Social Care have also recognised the need for them to update their training on Safeguarding and training on the management of complex safeguarding concerns has been arranged for November 2009.

This formal training is supported by locality staff briefings organised by the local safeguarding leads or the Safeguarding Co-ordinator. These briefings provide an update to all staff on changes to the policy and share the learning from significant event audits and serious case reviews.

Adult Social Care are represented on the Safeguarding Board's training sub group, and have been involved in developing the new training plan for health and social care staff.

As part of the Board's "Stop Abuse" campaign Adult Care ensured posters and information were distributed to libraries, GP surgeries and village halls.

Through our contractual arrangements we ensure our providers are aware of: the safeguarding policy; have provided their staff with training and are sharing information about safeguarding with the people that use their service. We have also used the magazine, produced by the Residential Care Providers Association - "Who Cares?" to raise awareness about safeguarding issues across the care sector.

Members of the public can also access information on safeguarding on the County Council Internet site. We are currently improving this site to ensure it is easy to access and has clear sign posting.

The learning from serious care reviews and significant event audits has influenced both our service delivery and development. Since January 2009, for example, this learning has lead to the development of guidance around managing safeguarding issues in a whole service, contributed to the revision of the way we record safeguarding information, and influenced the work being undertaken on how we audit the quality of our services.

Adult Social Care has also worked with the Learning Disability Service and Children's Social Care to develop guidance on working with parents with a disability, following a recommendation made in a Children's serious case review. We are also working on developing an approach to risk management, a learning point that was identified from a serious case review, shared via the Safeguarding Board.

Adult Social Care has ensured that the Safeguarding Board's action plan is fully integrated into its own service plan. We contribute to all the Boards sub groups, and are currently piloting both the Safeguarding database and the case file audit system.

In January 2009 the Care Quality Commission inspected the County Council's Adult Social Care Services. This inspection considered the work being undertaken by the County Council around safeguarding and concluded that the work was of a good quality. Some of the priorities for the future that were identified during the inspection, such as the collection of better data on safeguarding, has been incorporated by the Board into its action plan.

The priorities Adult Social care has identified for the coming year are reflected in the Board's action plan. The key areas for the next six months are

- Strengthening our data collection including the recording of outcomes of safeguarding concerns
- Improving the quality of our record keeping
- Ensuring that staff and providers are aware of the Vetting and Barring scheme
- Continuing the work around safeguarding and personalisation.

Helen Wakeling
Group Manager
Adult Social Care

9. Learning Disability Services - Somerset County Council

Learning Disability Services arrange and sometimes directly provide support to approximately 1600 adults with learning disabilities and their families in Somerset. Community Team Managers of the 4 multi-disciplinary community teams for adults with learning disabilities are responsible to responding to any safeguarding alerts arising for this population.

All Learning Disability staff receive awareness training about safeguarding as a mandatory part of their induction training. Qualified social workers undertake training on investigating safeguarding incidents. Community Team Managers undertake training on the chairing of safeguarding meetings and the running of the safeguarding process. In Learning Disability services, the recent appointment of 3 new team managers means that additional training will be needed in this area. Each community team has a nominated Deprivation of Liberty Safeguarding (DOLS) lead who has been trained as a best interest assessor who can contribute to DOLS assessments. All community teams (including the health practitioners within the team) have been given training sessions on the Mental Capacity Act. Safeguarding leads in the community teams attend a safeguarding practitioner's forum where best practice can be shared and policy and practice issues highlighted. Where appropriate these issues can be brought to the attention of the Safeguarding Board. Learning Disabilities services participate in safeguarding training or awareness sessions set up for adult social care as appropriate.

Team leaders of directly provided and purchased care services have been offered training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Leaflets about identifying and responding to abuse have been cascaded throughout the Learning Disability care sector.

The Learning Disability Partnership Board (LDPB) held a "Staying Safe" Day in March 2009, looking at community safety and safeguarding issues for people with learning disabilities. Representatives from the Safeguarding Adults Board, the community safety team, the police, and the ambulance service were amongst those attending the day. An action plan has been developed from the day. A key element of this is to develop a "being safe" handbook for people with learning disabilities. Progress on this will be monitored by the Partnership Board. The LDPB has also set up a "make it safe, make it happen" sub group of the board. Part of its remit is to monitor safeguarding issues for adults with learning disabilities, and it reviews relevant serious case reviews, and best practice guidance. One response to learning from a Learning Disability case is that Somerset County Council is now looking at refreshing its approach to risk management. Data shows that people with learning disabilities can be at risk in relationships. There is some pilot work going on to help people with learning disabilities in areas such as friendships, and safe use of the internet.

Information about safeguarding is in accessible formats, including a complaints procedure in easy words and symbols, and a DVD made by people with learning disabilities for people with learning disabilities about speaking up.

Learning Disability services representation on the Safeguarding Adults Board is via the chairman of the board, who is also the head of Learning Disability services, and

via Somerset Advocacy, who represent service users. It is planned that the service manager for the community teams will become a board member next year in order to improve representation and reduce conflict of interest issues.

Many of the key actions in the Safeguarding Adults Board action plan will directly impact on policy and practice for Learning Disability Services – for instance the actions around data collection, case audit and clearer decision making. In addition to this the LDPB "make it safe" plan will ensure that issues raised by service users are addressed.

David Dick
Head of Service
Adults with a Learning Disability

10. Supporting People - Somerset County Council

Staff training and Development in Safeguarding

Members of the Supporting People team have undertaken three forms of training in safeguarding adults in 2008 - 09:

- Safeguarding Induction training course
- Investigating Safeguarding Incident's
- The Quality Assessment Framework (QAF) training from SITRA to validate services for 'Safeguarding and Protection from Abuse'

Gaps that have been identified are:

- Suitable Somerset County Council training for Supporting People Service Development Officers (SDOs) with annual updates
- Accessible training for Supporting People providers that is Somerset County Council approved

Public Awareness

- Providers have been sent the Stop Abuse information to display where clients can see it
- Supporting People has produced a new procedure for providers: Reporting Major Events. Its primary purpose is not safeguarding (although some events may lead to questions about possible safeguarding issues) but it informs providers of the safeguarding process and the children's safeguarding board and reporting procedure
- The QAF validation of services by SDOs for safeguarding includes client and stakeholder involvement; during this work the profile of safeguarding will be given a high degree of importance

Learning from Experience

- Supporting People has adopted a new reporting procedure for major events to formalise and share the learning from events that may or may not involve safeguarding issues.
- The major events policy will be reviewed alongside the Serious Case Review policy to ensure consistency of approach and terminology used.
- A wider group of stakeholders are considered in planning and distribution of information by Supporting People as a result of being members of the Adult Safeguarding Board

Safeguarding Adults Board Work Plan

Supporting People took part in the review of training needs by the Adult Safeguarding Board in July 2009

Issues Arising

Non-statutory services commissioned by Somerset County Council as part of the wider stakeholder group need to have the expectation around safeguarding adults clearly outlined in their contracts and monitored through the commissioning process.

Agency/Service

Priorities for the Supporting People team 2009 – 2010

- to validate all existing provider services to evidence that standards are being met in line with the refreshed QAF 2009
- to incorporate in all new and re-negotiated contracts, clauses that relate to maintaining safeguarding standards and monitor annually

Viv Streeter
Supporting People Manager

11. Client Finances Team – Somerset County Council

Between January and June 2009 the Team has attended five strategy meetings where there have been concerns about possible financial abuse. Two have resulted in applications by Somerset County Council to the Court of Protection while in the other three Somerset County Council have been appointed by the Department for Work and Pensions to administer service users' benefits claims.

The Team continue to receive a large number of referrals from care managers, most resulting from concerns about service users' ability to manage their own affairs but also some where there have been concerns of lower level abuse by service users' families or friends. A formal referral system has recently been introduced to ensure we only intervene where necessary. It also makes it easier to identify the appropriate action needed to resolve the issues causing concern.

The Team also advises care managers on the Court of Protection and the Office of the Public Guardian procedures for raising safeguarding issues.

Since January 2009 the Team has submitted thirteen Deputyship applications to the Court of Protection and forty seven Appointeeship applications to the Department for Work and Pensions. The current evidence indicates that the rate of referrals is continuing to increase.

Mike Withey
Personal Finances Advisor
Somerset County Council - Community Directorate

12. Community Safety – Somerset County Council

Staff Training and Development in Safeguarding

Consultation with partner agencies has identified a need for further basic and in depth training on safeguarding adults.

District councils would like basic information about recognising and referring concerns. Somerset County Council (SCC) community safety team have agreed to provide leaflets with basic advice and guidance.

Those working with vulnerable adults, particularly Independent Domestic Violence Advocates (IDVAS) require advanced training. Safeguarding Coordinator will be working with the service to ensure training is available.

Public Awareness

We are currently concentrating on getting the importance of safeguarding messages our to our partner agencies who work on a daily basis with local communities.

A community safety information and advice leaflet is under production that will be available for all public facing events. This will include information about safeguarding.

Learning from Experience

Since working with adults with learning disabilities on their concerns about community safety, the manner in which information is presented to public forums has been altered to become more picture based and an easier wording format. This will also be the case in public facing written communications.

Safeguarding Adults Board Work Plan

We will be updating our web pages once this facility is available within the County Council

Maintain representation for Community Directorate at Safer Communities group and community safety representation on the Safeguarding Board to secure links between community safety and safeguarding adults

Community safety officer for interpersonal violence to attend future SAB meeting representing both community safety and domestic abuse services.

Agency/Service

The following priorities have been identified in SCC Community Safety Safeguarding Adults Action Plan:

Short Term (3 months**):**

- Produce information/training leaflet for Crime and Disorder Reduction Partnerships (CDRPs) making them aware of their responsibly to prevent abuse of vulnerable adults.

Medium Term (6 months)

- Adult protection awareness course for Community safety teams
- Ensure all Partners have a safeguarding vulnerable adults policy in Somerset complete with reporting procedures for staff and the public in accordance with the multi agency policy
- All partners have training package/leaflet for staff
- Revise home safety referral form to add questions re. abuse
- Research into financial abuse of older people

Long Term (1 year)

- Ensure mechanism of referral for multi-agency group to refer cases ie through anti-social behaviour cases or hate crime.

Lucy Macready
Safer Communities Manager

13. Registered Care Providers Association

We are the Registered Care Providers Association Ltd representing approximately 60% of care providers in Somerset. Our purpose is to:

- Represent the interests, views and concerns of both proprietors and managers concerned with the provision of care to Commissioners of services, Government and Regulatory bodies.
- To foster and exchange ideas between members and to provide services that are of mutual benefit and assistance.
- To advise members on any matter relevant to the provision of care.
- Develop, monitor and evaluate, care strategy and policy and disseminate this to members.

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.

Training and Development

We do not provide any direct services. However, we constantly alert members to issues, experience, national and local strategies concerning safeguarding and work closely with Care Focus Ltd to promote understanding and awareness where safeguarding issues involve our members. Hitherto, our main methods of communication have been letter, the quarterly Who Cares Magazine, e-mail and the Annual Seminar. In future we will intend to focus our attention on the development of a high quality website which will enhance our ability to communicate effectively with members.

Learning from Experience

We are very interested and enthusiastic about finding ways to share experience with our members. Currently, this is undertaken informally during the Executive Officer's programme of visits to providers. Our objective for the future is to develop ways in which the Safeguarding Adults Board, Somerset County Council and the Care Quality Commission can share the results of investigations into safeguarding matters so that our members can learn from the experiences.

Safeguarding Adults Board Work Plan

The development of the Registered Care Providers Association website will enable us to link directly with the work underway with the Somerset County Council website. We welcome the invitation to join the safeguarding workshop and consider this to be invaluable to our work with our members.

Issues Arising

The Safeguarding Adults Board considers Serious Case Reviews at a high level. We propose that the Board is also invited to consider the lessons learned from

Significant Event Audits where safeguarding issues have formed the focus of the audit and that formal statistical evidence is produced.

Agency/Service

Our objective is to take the results from our proposals at paragraphs 2 and 4 and share these with our members as our core strategy to develop best safeguarding practice.

Roger Wharton
Executive Officer

14. Care Focus

Care Focus Somerset is a not-for-profit company that promotes excellence in care and aims to raise standards by supporting employers in their development of the workforce.

Activity in Relation to Safeguarding Adults

- Visits to care providers
- During one to one visits to providers, the Care Focus team has continued to highlight the Safeguarding Adults Somerset policy, inform of learning and development opportunities and signpost appropriate resources. During the six months from January to June 2009 Care Focus has continued to distribute information to all registered providers in Somerset and has undertaken a minimum of 24, one-to-one meetings with care providers each month.
- Learning and Development Opportunities
- Care Focus has promoted and facilitated the Private and Voluntary 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.
- Care Focus facilitates Learning Exchange Networks across Somerset which give Managers and Proprietors 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.
- Awareness Raising
- Information regarding Safeguarding Adults in Somerset is repeatedly promoted through features in the monthly newsletters, six monthly reviews and specific flyers. These are distributed through email, post and attendance at events across the county.
- Safeguarding Adults Board
- The CEO of Care Focus Somerset has continued to attend and contribute to meetings of the Board and the Training and Development sub-group.
- Resources
- Care Focus has continued to signpost to appropriate information and resources via Skills for Care, SCiE and Somerset County Council.
- 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.

Claire Waddon
Chief Executive Officer

15. Independent Mental Capacity Advocacy Service

Advocacy in Somerset have the contract for providing the Independent Mental Capacity Advocacy Service (IMCA). We have been providing this service since April 2nd 2007 when the service came into being.

The IMCA service has to be referred to when someone has been deemed as lacking capacity to make decisions about change of accommodation and serious medical treatment and that person has no appropriate family, friend or unpaid carer to consult with.

There are two other instances where the Local Authority may refer to the IMCA service if they feel it would be beneficial to the person concerned. They are care reviews where an unbefriended person has been in accommodation for more than 12 weeks and a review is proposed which may mean a change of accommodation, and that person lacks capacity to make that decision. The other instance is adult protection where the person lacks capacity and there have been issues of abuse or wilful neglect or where the person has abused another. Only in adult protection cases can an IMCA be involved regardless of whether there are family and friends as the family or friends may be the abusers.

During the last two years the Somerset IMCA service has received 39 referrals for Adult Protection which has been a higher amount than anticipated.
Adult Protection has been a grey area not only for the Somerset IMCA service but for other IMCA services in the South West. It is not often clear what role the IMCA is supposed to take and in some cases it's appeared that the professionals themselves aren't sure what role they are playing.

The mistake is often made that an IMCA is going to solve issues with disagreeing family members. Some professionals have tried turning a referral into an Adult Protection referral in order to get an IMCA involved to sort out families that are disagreeing with what they are proposing, even when there are no issues of abuse or wilful neglect. Reassurance is then given to the professionals that if their client lacks capacity for the specific decision then they have to go through the best interests check list which includes talking to the family and friends but not necessarily adhering to what they want, especially if it clearly isn't in that persons best interests.

Until recently there hasn't been any specific training aimed at IMCA`s however on November 24th the South West IMCA Group network have organised a day`s training where all aspects of adult protection and the involvement of IMCA`s will be covered. This will allow the IMCA services to ask questions and explore difficulties that they have been having and to get some clarification about things. This training is part of a national initiative to better inform IMCAs of their role within adult protection procedures. Hopefully by the end of this training we will have more idea of where an IMCA fits into Adult Protection referrals and where our role begins and ends.

Becky Facey
Manager
Somerset IMCA service

16. Somerset Advocacy for Adults who have Learning Difficulties

Somerset Advocacy provides individual and group advocacy support to adults who, as a consequence of the degree of their disabilities/difficulties, experience greater vulnerability than other adults.

We currently provide an independent, free and confidential service to all adults who have LD and are in receipt of, or eligible for specialist LD services provided by Somerset County Council. The issues are wide and varied but specifically concern safeguarding issues such as:

- Hate Crime/Community Safety.

- Sexual, financial, physical and emotional abuse.

- Child care proceedings where parents have LD.

- Supporting individuals when they are victims, witnesses or
- Perpetrators of crime and any consequent legal processes.

- Supporting people to make risky or unwise choices.

As an increasing number of people who have LD are supported to live ordinary lives so the number of safeguarding referrals to Somerset Advocacy increases and our role in ensuring that individuals have accessible information and the opportunity to make informed choices in line with the Mental Capacity Act Test has become significantly more focused. We have clear internal processes to guide advocates when safeguarding issues are highlighted and have developed clear links with relevant agencies in the Vulnerable Adults and Child Protection sectors.

Somerset Advocacy actively participates in the Somerset Learning Disability Partnership Board and specifically in the Make it Safe sub group which is concerned with Community Safety matters. We also participate in the Good Practice Panel which deals with cases where Restrictive Practice or Deprivation of Liberty issues may require some guidance.

Staff at Somerset Advocacy have received various training in line with our Safeguarding Policy with two named staff sharing lead responsibility for Safeguarding issues and support and supervision of staff concerned.

Mary-Ellen Harris
Chief Executive Officer