Issue 10, April 2019

Newsletter

Working in partnership to enable adults in Somerset to live a life free from fear, harm or abuse

This is the 10th edition of our newsletter, and we hope those who have received copies since its launch continue to find it a useful resource and an interesting read. Since the publication of our last newsletter we have been working on our new three-year strategic plan which you can read more about on page 3. We are also looking forward to welcoming colleagues to our annual conference on 01/05/2019, which you can read more about on page 2.

To the new subscribers who've recently signed up to receive copies of our newsletter, a very warm welcome and our thanks for your interest in being part of our local safeguarding community in Somerset.

We always welcome any suggestions for improvement, requests for future content or any contributions you'd like to make.

In this issue:

News from the SSAB

March 2018/19

The SSAB has met once since the last newsletter was published, on 25/03/2019.

Agenda highlights include:

- A very powerful presentation by a family member of someone who experienced being safeguarded;
- Receiving a presentation on pilot work undertaken by Healthwatch Somerset to gather feedback from people who have experienced being safeguarded;
- Receiving an update on work undertaken by Somerset Partnership NHS Foundation Trust on sexual safety on mental health wards;
- Agreement of a proposal to form a joint subgroup focused on the exploitation of both children and adults in partnership with the Somerset Safeguarding Children Board;
- An update on the progress of the Learning Disabilities Mortality Review (LeDeR) programme in Somerset;
- A presentation on a new approach to using data to map safeguarding enquires and agreement to form a task and finish group to explore how to use data across the partnership;
- Monitoring the progress of our Strategic Plan for 2016-19
- Finalising our new Strategic Plan for 2019-22.

SSAB Annual Conference

Our annual conference will take place on 01/05/2019 at the Edgar Hall, Somerton

The conference, primarily aimed at safeguarding leads working for organisations that operate within Somerset, is intended to provide an opportunity to learn about current and emerging areas of safeguarding work to inform organisational safeguarding practice.

The agenda for the day includes:

- Sexual Consent
- The Mental Capacity Act
- Current scams and rogue trader practices
- Disability Hate Crime
- Female Genital Mutilation
- A thematic review of street deaths in Taunton
- The Liberty Protection Safeguards
- Domestic abuse and coercion and control

SOMERSET SAFEGUARDING ADULTS BOARD

Annual Conference 2019

01/05/2019

Places cost £40 per delegate (plus VAT and booking fee), and includes a light buffet lunch and refreshments

Book your place

New Strategic Plan for 2019-2022

The Somerset Safeguarding Adults Board is required by The Care Act 2014 to produce and publish a strategic plan for each financial year. The plan must set out what the Board intends to do over the next year to help and protect adults at risk of abuse and neglect in Somerset during that timeframe. In common with many other Safeguarding Adults Boards, the Board chosen to develop a three-year plan, that will be refreshed annually, for 2019-2022

The development of our new strategy reflects feedback we received from readers of our December newsletter. It has also been informed the findings to emerge from audits, learning to emerge from Safeguarding Adults Reviews, and the analysis of comparative performance data.

The proposed overarching priorities within our new strategy are:

1. Listening and learning

- Safeguarding is person-led, outcome-focused, enhances involvement, choice and control, and improves quality of life, wellbeing and safety
- We use learning to enhance practice across the system in Somerset
- We learn from when things go wrong, both in Somerset and elsewhere, and take appropriate action to reduce risk

2. Enabling people to keep themselves safe

- People are aware of what abuse is and how to keep themselves and those that they care for safe
- People know what to do if they think that they are experiencing abuse or neglect

3. Working together to safeguard people who can't keep themselves safe

- Organisations, including the third sector, work together to ensure that multi-agency arrangements are effective, and that people who are unable to keep themselves safe are supported in the least invasive way
- Policy and guidance reflects best practice and takes a positive approach to risk
- There is effective working across local, regional and national partnerships on areas on mutual interest
- The number of inappropriate referrals is reduced through people raising other types of concern in an appropriate way

4. Making sure we do what we said we would do

- Somerset has an effective Safeguarding Adults Board which fulfils its statutory responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning
- The Board uses data appropriately to understand where risk exists within the system
- The Board can demonstrate progress through the regular monitoring of performance and a robust self-audit and peer challenge processes

Our strategic plan was considered by Somerset County Council's Scrutiny for Policies, Adults and Health Committee on 03/04/2019, and we have incorporated the Committee's feedback in to an updated version which we have published on the SSAB website and will be working to until it is finalised. The final version of the plan will be published following consideration by the Somerset Health and Wellbeing Board which will not meet until after local elections have taken place in May.

Further information

Our draft strategic plan

Mendip House Safeguarding Adult Review in the news

Mendip House, a former care home in Somerset that the SSAB published a Safeguarding Adults Review in February 2018, has been in the news again following an announcement by the Care Quality Commission to fine National Autistic Society, which operated the home. Coverage included:

- The Guardian on 07/03/2019 and 10/03/2019
- BBC Somerset on 12/03/2019 (listen at 1:35:30 and 2:35:00)
- The i on 10/03/2019
- Letter from the Shadow Cabinet Minister for Mental Health and Social Care to the Care Quality Commission

On 05/03/2019 Richard Crompton, SSAB Independent Chair, wrote for a second time to the Secretary of State for Health and Social Care and the Chair of the Local Government Association Community Wellbeing Board to progress the national recommendations that were made in the report, which representatives of the Minister of State for Care had previously indicated could potentially be addressed through the, as yet unpublished, Social Care Green Paper. The letter also requested that the recommendations made in a recent advisory published by the Local Government Association and Association of Directors of Adults Social services, that the SSAB was involved in developing, be put on to a statutory basis and applied to all commissioners, not just those employed by Local Authorities.

In addition, following on from the information request to all providers of residential care and nursing care that we included in our December newsletter, we have written to all Safeguarding Adults Boards that had a member who had placed someone in Somerset who had not received a timely review to ask them to seek assurance from their members.

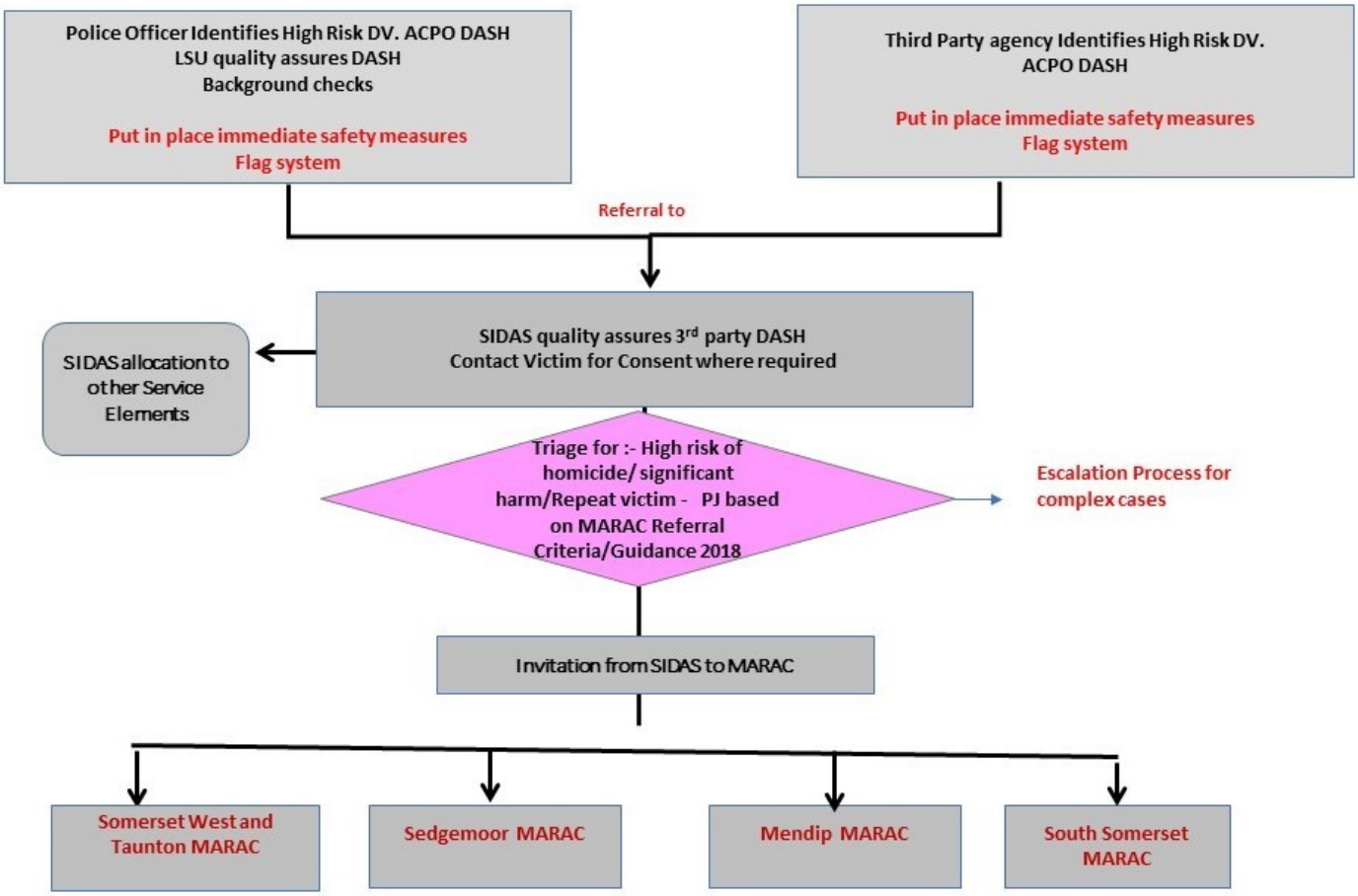
Changes to MARAC

Some significant changes have been made to the Multi-Agency Risk Assessment Conference (MARAC) process from 01/04/2019.

MARAC is a partnership approach, and its core objective is to share information about domestic abuse victims, perpetrators and families. This involves a number of agencies, including Adult Social Care, Children's Social Care, Police, Housing, Education, specialist domestic abuse services and mental health services.

MARAC is designed to only consider victims who are at risk of serious harm being inflicted in the immediate future. If a Domestic Abuse Risk Assessment (DASH) scores 14 points or more this is considered high risk and should be referred for a MARAC. If a lower score is reached, professional judgement may be applied by speaking directly to the Somerset Integrated Domestic Abuse Service who will consider the referral. The completed DASH Risk Indicator Checklist should help to evidence why the referrer believes that there is an imminent event which is life-threatening, traumatic or life-changing to the victim. This maybe from what the victim has told them or be in their professional opinion.

All agencies should now only send MARAC referrals to the Somerset Integrated Domestic Abuse Service (SIDAS), and not the police as they no longer have the MARAC co-ordination function. The new process is shown in the flowchart below:



There are four MARACs in Somerset: Somerset West and Taunton, Sedgemoor (these were previously held as a single meeting, but have now reverted to separate meetings), South Somerset and Mendip.

Over the next few months, a facility called "Professional Choices" will be implemented to improve the sharing of information.

Further information

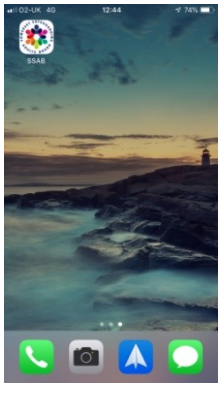
Domestic abuse section of our Guidance for Safeguarding Adults in Somerset

Somerset Integrated Domestic Abuse Service

Get the SSAB Website on your phone or tablet

We have made some changes to our website to allow it to behave like an app on your phone and tablet. Our hope if that by making this change people will have easier access to the information and guidance that we have produced when they are mobile working.

The change we have made works for all Android, Apple or Windows devices and we have produced a short guide on how to set it up.



Putting the Mental Capacity Act into Practice

The SSAB Mental Capacity Act Subgroup has developed a new section for our website with information and guidance on both the Metal Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). These pages have been created to provide a starting point for individuals and organisations across Somerset who wish to understand their responsibilities in relation to people who may lack mental capacity to make decisions for themselves.

Mental Capacity Act 2005

The pages, which the subgroup will regularly update as well as adding to over time, contain guidance documents produced by County Council and NHS organisations in Somerset, as well as a number of links to documents produced nationally, either by government or by other local authorities or charities.

Some of the information is shared with professionals in mind, but our intention has been to develop the information in a way that is as accessible as possible to members of the public who wish to understand this area better.

Further information

Putting the Mental Capacity Act into Practice

Business Manager Blog

Stephen Miles, SSAB Business Manager

Since our last newsletter the two big pieces of work for the Board have been to develop our strategic plan for the next three years and plan our annual conference that will take place on 01/05/2019. We have moved this a little later this year, following some nervous moments last year when we were hit by the 'Beast from the East' not long beforehand. I'm really looking forward the agenda for the day which is again varied with the intention of representing the breadth of safeguarding work, including a presentation on disability hate crime by Mark Brookes, who you may have seen promoting the #ImwithSam campaign.

Our Independent Chair, Richard Crompton, presented our strategic plan to Somerset County Council's Scrutiny for Policies, Adults and Health Committee on 03/04/2019 where we received positive feedback and suggestions for changes which we have incorporated into our latest draft. The final version won't be published until June, as the final stage is for it to be considered by the Somerset Health and Wellbeing Board which isn't scheduled to meet until after local elections in May.

The day-to-day work of the board has included work on a new version of our Safeguarding Adults Multi–Agency Policy which we share with five other Board in the region and which will be published shortly once signed off. We have also continued to keep our website up to date and added new content to the site around differentiating between quality and safeguarding concerns and a new section that has been developed by our Mental Capacity Act Subgroup. In terms of our website we've seen a huge growth in usage over the last year – from 694 users in March 2018 to 3249 in Mach 2019. We've also seen similar increases in our followers on Social Media, following

on from the high level of engagement we saw in of #12DaysOfSafeguarding initiative over the festive period. However, we also recognise that there is always more we can do so if there is something you feel is missing or could be better please let us know.

Finally, it was interesting to see Mendip House hit the news again during March, when the Care Quality Commission announced that it had fined the National Autistic Society which operated the home. Coincidently at the same point, and without any prior knowledge of the announcement of the fine, Richard Crompton was writing to the Secretary of State for Health and Social Care and the Chair of the Local Government Association Community Wellbeing Board to progress the national recommendations made in the report, which had been indicated might at least in part be addressed by the Social Care Green Paper when we met with representatives of the Minister of State for Care in June 2018. The latest on the Green Paper is that is has been delayed again, but we remain hopeful that the recommendations will be addressed once it is published in due course.

I look forward to continuing to work with you and, and hopefully meeting you if you are coming to our conference.

Learning Lessons

National: 'Colin'

Background

This Safeguarding Adults Review has been undertaken by a local Safeguarding Adults Board (SAB) in England, but has been shared anonymously in order to protect the identities of those involved.

Colin was a man in his early twenties who lived in supported living accommodation. He had a learning disability and some physical problems. Colin was murdered by peers in the local community.

Colin had been in foster care as a child and had special educational needs. He made the decision to move to supported living accommodation to develop his independence. However, records show that Colin had less independence in the supported living environment than he did when he lived with a foster carer.

With the help of his foster carer, Colin began to develop his relationship with family members, which continued until his death.

A psychologist's report for Colin gave insight into his development and recommended preparatory planning for independence. Unfortunately, no such work was undertaken with Colin until shortly before his death. Instead, the provider continued to rely on a voluntary agreement with Colin, who was deemed to have capacity to make health and welfare decisions, that he would not go out unaccompanied.

Over time, Colin began to exhibit more disruptive behaviour and some violent incidents ensued, culminating in the Police being called when carers felt that they were unable to manage his behaviour.

In the weeks and months prior to Colin's death, he started asserting his right, as an adult, to go out into the community unaccompanied. Colin began to socialise with a large group of people of a similar age, and with similar vulnerabilities. Late-night incidents occurred, including in an incident

where Colin was a victim of an assault, with an unsubstantiated 'throwaway' comment made that Colin was a paedophile.

Colin continued to associate with the same wider group after his assault and was subsequently killed by two of his peers.

Key Learning

Transitional planning and risk management: As it had been established (by the MCA assessment in Oct 2011) that Colin had capacity to make decisions about going out unaccompanied, there should have been greater emphasis on preparatory work to develop his independence in the community and effectively manage risks. This work should have commenced from early in his placement with the Supported Living Provider, rather than waiting until very shortly before Colin (not unpredictably) started asserting his right as an adult, to go into the community without supervision.

Staff knowledge of MCA and DoL / DoLS: All care and support staff working in accommodation-based services for people with learning disabilities should:

- Have at least a basic understanding of Mental Capacity Act (MCA) and Deprivation of Liberty (DoL / DoLS) as they apply to their resident group
- Know which residents are / are not subject to DoL
- Have clear and practical guidance on what actions they can take to lawfully restrict liberty where care amounts to a deprivation of liberty, or the Court of Protection has authorised a DoL.
- Have a clear understanding of the lawful rights of residents who have capacity to consent to care and treatment, to freedom of movement.
- For residents with such capacity, have strategies and skills to support residents to evaluate and manage any potential risks arising from decisions to go out unaccompanied.

Care Plan Reviews: When a provider of accommodation and support services makes a specific request for a care plan review, there is a responsibility on Adult Social Care managers and commissioners to urgently and positively respond to that request. In the absence of an appropriate and timely response, the provider should follow this up and (if necessary) escalate the matter with more senior managers.

Involving families in review processes: The value of engaging supportive family members in support planning and risk management processes should not be under-estimated. With the consent of the adult in question, consideration should always be given to inviting family members to attend review and planning meetings and generally to have an active input into these processes. Decisions not to involve family members in this way should be recorded, along with a clear rationale for the decision.

Violent incidents in care and support settings: If there is evidence of a pattern of violent incidents involving people with care and support needs (as perpetrators and / or victims) in a supported living or care home environment, this should be considered as a potential safeguarding issue. Whether there should be any formal police action against perpetrators who are also service users is a matter for police professional judgement, based on the unique circumstances of each incident. This judgement should be informed by discussions with the victim and with other professionals with responsibility for care and support planning. Even if the decision is for no formal police action, confirmed incidents of assault should be recorded as crimes.

Inter-agency communications and professional challenge: Where there are safeguarding concerns, effective and timely communication, care planning and risk assessment processes are of paramount importance. These are matters which should be recognised as having joint ownership,

rather than 'tasks' to be passed from one agency to the other. If one of the agencies does not carry out agreed actions, professional challenge should be applied by the partner agency.
Inter-agency communications, care plan reviews and contingency planning: Poor communications from Supported Living Provider staff to police officers contributed significantly to a difficult situation becoming out of control, with an outcome of a vulnerable and partially sighted young man being forcibly restrained and arrested, with the use of an irritant spray. This should have been recognised as further reason to urgently review Colin's care plan, to include:

- Contingency planning for Supported Living Provider staff and Police responses, in the event of similar incidents happening in the future.
- Consideration of whether the Supported Living Provider was suitably equipped to meet Colin's support needs and adequately manage the risks which were highlighted by this incident.

Engagement with families in support planning and risk assessment and management: Where people with care and support needs have a positive and supportive family (or close friend) relationship, the option of directly involving the relative (or close friend) in reviewing care and support plans and risk assessment / management strategies, should be explored regularly (as a minimum in advance of each annual review) with the service user. This should happen on a pro-active basis, rather waiting to see if the service user asks for family involvement.

Allegations of paedophilia: The incident when Colin was the victim of assault should certainly have triggered a safeguarding adult referral. A critical element of this incident was the completely unsubstantiated accusation that Colin was a 'paedophile'. It should have been recognised that, once such an accusation had gained local currency, Colin could be at increased risk from further assaults. This was particularly so, because he was continuing to associate with this group of young people. Other reviews of murders of people with disabilities have similarly highlighted that allegations of paedophilia – even when the allegations are based on no credible evidence – should be recognised as a highly significant risk factor for potential abuse and serious physical assault of the person subject to those allegations. *

** There is no evidence to support the view that Colin was murdered for these reasons.*

Regional: Analysis of Safeguarding Adult Reviews in the South West by the South West Association of Directors of Adult Social Services

Background

Thirty-seven SARs published from 2016 onwards, together with unpublished Safeguarding Adult Reviews (SARs) submitted to the South West Association of Directors of Adult Social Services (ADASS) regional SAR repository were analysed, from which clear themes (i.e. issues raised in two or more SARs) were identified.

Themes identified from SARs about Organisations

Identifying and responding to harmful environments and staff practices: 4 SARs

- Visiting staff, residents and their families need clear and simple standards about how a care home should look, feel and smell. "What does good look like." Think: Would I live here?
- All visiting staff must be aware of environment and quality of care being delivered and know how to progress concerns down a poor practice as well as a safeguarding route, they must understand how to escalate concerns. All staff must understand that they have a duty of be alert to and report safeguarding concerns.

- There is an acceptance and tolerance of poor standards, by those delivering the care and by those who witness the care giving (said of older people, people with mental health issues, people with Learning Disabilities in various SARs).
- Identification of 'what good looks' like should be supported by the development of harmonised quality assurance tools for the different professionals who carry out reviews within homes.

Making placements and Reviews: 5 SARs

- Lack of consideration of the compatibility of residents/ or of the Home's ability to meet the needs of the resident population in totality/ lack of rigour in identifying placements that will meet need, 'placement hunting', failing to check the provider competence against the service statement of purpose.
- Ensure regular face to face Reviews are carried out; the trend toward telephone reviews by all commissioners has led to a lack of 'ownership' of the person, and Home staff being in the position of an incompetent keyworker
- If placements are not meeting (or not able to meet) complex needs, ensure multi agency planning in place to support and for contingency

The relationship between host and placing authorities/commissioners: 3 SARs

- Relationships between host and placing authorities, informing host authorities of placements, information sharing, reviewing, responsiveness
- Commissioners need to work together to stimulate and create local capacity to respond to local need
- The need to regulate commissioning

Themes identified from SARs about Organisations

Self-Neglect: 21 SARs

- **Misuse or lack of use of the provisions of the Mental Capacity Act:**
  - "sufficient assessment of his capacity to make decisions in his own best interest are not clearly evidenced".
  - "Mental Capacity Act not used appropriately. Balance between right to choose, duty of care and mental capacity not appropriately achieved"
  - Assumptions about capacity, lack of professional curiosity
  - He "made decisions which made him vulnerable to significant harm. For example, he was known to associate with individuals who targeted vulnerable adults. It was assumed that" he "had the mental capacity to decide to associate with exploitative individuals".
  - "Practitioners need the confidence and support to challenge appropriately to establish capacity when it is unclear or fluctuating, and where 'unwise choices' lead to ongoing harm to the individual".
- **Misunderstanding of duties:**
  - Right to autonomy promoted over right to life, freedom from degrading treatment (duty of care)
  - Concept of vital interests not understood. Making Safeguarding Personal approaches mis-used as a reason for non-intervention.
  - Are supervisory processes and development opportunities in place to support practitioners to develop the skills they need to respectfully challenge adults who are self-neglecting?

- "There was a common lack of understanding of the Human Rights Act's qualified rights to privacy and self-determination and when this can be overruled when the individual is a risk to others or themselves. This needs to be considered on an on-going basis depending on the state of the individual's health".
- "We need to balance the entitlements of the individual with capacity to make 'unwise decisions' with appropriately assertive practice based on dignity and "compassionate persistence."

- **Lack of coordinated responses and use of agreed policies and procedures**
  - Lack of understanding of what Self-neglect is and how it is presented.
  - Lack of leadership, case coordination and full multi-agency working. Agencies supporting people 'in isolation.'
  - Limited knowledge of or use of existing Self-Neglect Policies or Escalation Policies.
  - All relevant organisations must give clear guidance to their staff about what to do when people do not attend routine visits or refuse care.
  - Fragmented communication between agencies led to missed opportunities
  - Drug misuse or dependency is not recognised as self-neglect by practitioners. There is evidence that a culture exists where individuals who self-neglect through substance misuse are considered to have made poor lifestyle choices and are therefore not treated as 'vulnerable adults'.
- **Lack of consideration of both mental and physical health needs.**
  - No regular health assessments for people with mental health issues.
  - Failure to recognise behaviours labelled as 'anti-social' as indicative of declining mental health.
  - Greater "parity of esteem" or equality between the response to mental health needs and physical health needs, must be strengthened.
- **Relationship building and work flows**
  - Lack of person-centred care and relationship-based communication
  - "Is the complexity of self-neglect cases alongside high work demand driving practitioners to task oriented activity instead of using the multi-agency self-neglect process, leaving adults at risk of harm?"
- **Working with the families of people who self-neglect**
  - Families not engaged by agencies in efforts to help
  - Misunderstanding about confidentiality
  - "Although his family was an obvious source of information, their role as reflected in contacts with services became one of pleading for engagement and help"
  - Good practice would be to gain consent to share information with appropriate family members early to avoid delay or complications later on

Exploitation: 4 SARs

- A gap in understanding of mate or disability hate crime across all vulnerable groups including people with mental health issues, substance misuse issues, as well as learning disability.
- Care Programme Approach multi-agency meetings should be held for adults with mental health needs when risks escalate, or new significant risks are identified

- Perpetrator/s of hate crime using language such as 'paedophile' or 'terrorist' should be warning signs of increased risk to victims
- Resources are developed to support adults to recognise Mate Crime and know how to report it
- An information sheet is needed for families to be provided when their relative moves into a care or supported accommodation setting about risk indicators and who to contact if they have a concern about abuse or neglect, including Mate Crime
- There is a need for understanding and practice that reflects that people with a learning disability have a right to engage in consensual sexual activity and a right to respect of their private life, but can be particularly vulnerable to sexual abuse and assault for a number of reasons.

Transitions: 7 SARs

- "Multi-agency professionals should work together in a coordinated manner around each person to raise their aspirations and achieve the outcomes that matter to them. Transition assessments should provide young people and their families with information, so they know what to expect in the future and can prepare for adulthood".

Hospital discharges: 3 SARs

- "The Board should request a review of the Multi-Agency Hospital Discharge Policy to ensure that it sets out best practice in making safe and effective arrangements for people with complex needs."
- Poor hospital discharges are a cause of issues in safeguarding, with failure of communication between health and social care being the principle contributing factor to an unsafe discharge. There can be significant human and financial costs of getting discharge wrong.
- "A key issue affecting transition is a lack of integrated and collaborative working between mental health and social care services, practitioners based in hospitals and those in the community, resulting in inadequate and fragmented support for people using mental health services"

Accommodation and circumstance transitions: 6 SARs

- Before an adult moves accommodation or their circumstances change significantly, it is essential for the appropriate agency to proactively undertake a new holistic assessment to inform plans around any needs, risks, and challenges in the new situation.
- Consideration must be given whether and how an adult's family can be involved at key transition points in their lives
- If a person is being discharged to a care home, involve care home managers and practitioners in care planning and discharge planning
- Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. Ensure the process is collaborative, person-centred and suitably paced
- Discuss the person's housing arrangements to ensure they are suitable for them and plan accommodation accordingly. Take into account any specific accommodation and observation requirements associated with a risk of suicide
- Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge.

Organisational transitions: 3 SARs

- Organisational transition – the need for SABs to be assured of mitigation against systems failure
- "All Agencies underwent significant organisational change. This resulted in changes in processes, management and recording"
- Risks created by fast transition coupled with new policies, procedures and working arrangements and compounded by low staff morale.

Preventing violence to adults at risk: 4 SARs

- Criminal Justice services
  - Probation services need to incorporate Care Act compliant adult safeguarding into all aspects of their work, the national policy needs to be updated, and training delivered.
  - Use of MAPPA: agencies should promote the range of risk data sharing mechanisms including MAPPA and PDP. Consider use of MAPPA for category 3 offenders. Pay attention to awareness of MAPPA in non-specialist police officers
- Domestic Abuse
  - There is a local lack of strategic and operational join up between domestic abuse and adult safeguarding services.

Drugs and Alcohol: 3 SARs

- Alcohol-dependent adults are particularly vulnerable and are frequently seen by emergency services, a multi-agency protocol should be established to support professionals who are called to attend adults at risk who are highly intoxicated and who pose a risk to themselves and, potentially, to others. This will support professionals to make the right decisions to protect adults from risk.
- The need for a range of staff to have access to specialist advice when assessing risk and making care and support arrangements.

Local: Sharing systems and best practices in relation to Never Events by Luke Joy-Smith, Managing Director at Discovery

Background

The concept of Never Events was introduced by the NHS to describe serious incidents that should never occur. At Discovery, we think having Never Event systems in place is really important and makes a big difference in terms of reducing the vulnerability of people with learning disabilities.

We define a Never Event as:

'One that is clearly identifiable and measurable, can result in death or significant disability and is usually preventable if everyone has acted appropriately and followed procedures.'

Our Never Events

We have determined seven Never Events along with guidance as to what should be in place to make sure these situations never happen, and what our team should be doing if they are not in place.

Our seven Never Events are:

1. No person will be seriously injured as a result of faulty equipment being used.

2. No one should die as a result of choking to death on food or an edible object where there is a known risk.
3. No one we employ should work with people with challenging behaviour without the correct training.
4. No one with epilepsy will have a bath unsupervised without a risk assessment signed off at a best interests meeting.
5. No one will suffer serious harm because of a failure to report a material deterioration of health to the person's GP or another appropriate body.
6. No one will suffer adverse consequences or serious harm from failure to administer prescribed medications appropriately or from receiving the wrong medication.
7. No one should suffer any harm as a result of a failure to administer or monitor the medication prescribed, or to follow established processes, for the relief or avoidance of constipation.

All our operational team members are trained to be aware of the Never Events and what needs to be in place to prevent them. They are to report any gaps immediately to their line manager and escalate it to the local Health and Safety Adviser and Discovery Operations Director if concern remains.

We would strongly recommend putting Never Event systems in place. They have a direct impact on team members and the people we support.

"A Never Event is something that could happen but should never happen with the right measures in place. We have a person that we support 24 hours with controlled epilepsy but who hasn't had a seizure for years and is very independent. Before Discovery, we used to support them in the bath with the temperature control and washing and then leave them while we waited next door. After we conducted Never Event reports and went to the best interests panel, we updated their support plan and they would now never be left alone in the bath because of the very small chance they could have a seizure and drown."

Natasha Swaffield, Support Worker, Discovery

What if a Never Event occurs?

The protocol we have in place for Never Events is designed to establish what learning can be gathered from what has gone wrong so that it can be used across the organisation if necessary. Never Events should not be regarded as a process for determining whether the people involved in them should face any disciplinary action or undertake any sort of competency process.

If a Never Event has been thought to occur, it must be reported immediately to our relevant Locality Manager who will then direct it accordingly. We ensure that support is given to the people we support, and colleagues affected immediately. Within 72 hours, a Never Event Fact-Finding Report is completed by the Locality Manager and if it is ascertained that it was a Never Event then a meeting is held within five days with a Never Event Panel (chaired by myself as the Managing Director). At this meeting feedback and actions will be given, followed up with outcomes and lessons learnt from the Never Event which is shared across the organisation and with the relevant stakeholders.

In terms of ongoing monitoring, our Compliance Audits assess the conformity to Never Event prevention and the events and the processes related to them are reviewed on a regular basis.

In summary, since introducing this new process within Discovery we have substantially improved the reporting and management of safeguarding matters for the people we support. We believe in working together to share systems and to spread success throughout the industry and would

welcome conversations with any stakeholders to share our learning further.

Luke Joy-Smith is the Managing Directory of Discovery, a charity that provides services for people with learning disabilities in Somerset and joined the Somerset Safeguarding Adults Board in 2018

Care about recruitment

Recruitment remains one of the biggest challenges for the care sector with 120,000 projected number of additional adult social care jobs required across the South West by 2035. Turnover remains high in the South West at 33.1% and with 9,800 vacancies some employers are struggling to recruit suitable people to the sector. Skills for Care and the Registered Care Provider Association present an event for care and support providers across Somerset to find out about what support they could access to help to overcome recruitment challenges.

Delegates will hear about how:

- Links to commissioning priorities should be shaping the workforce
- Learning and development can support retention
- Having a positive workplace culture and a well-led service can help to find and keep the right people
- Key resources and agencies can support successful recruitment and retention practices

The second half of the event will be facilitated by Neil Eastwood from Sticky People, a leading professional in best practice around recruitment and retention for social care and author of 'Saving Social Care'.

This fully funded event is hosted in partnership between Skills for Care and the Registered Care Providers Association Ltd (RCPA).

Date: Thursday 16 May 2019
Venue: Holiday Inn Taunton M5, Jct. 25

Book your place

Learning from Children's Services

We encourage our readers to have a look at the latest newsletter to be issued by the Somerset Safeguarding Children Board, which will shortly become the Somerset Safeguarding Children's Partnership as part of the changes introduced in Working together to safeguard children (2018).

Their latest Learning Bulletin, 'Things You Should Know', focuses on what we can learn from examples of good practice and includes a recent safeguarding conversation, and a case study providing a family with early help.

Local & National News and Headlines

March 2019

- Community Care: "Contextual safeguarding: 'a new way of identifying need and risk"
- Cabinet Office publishes guidance to help tackle modern slavery in supply chains across the public sector
- Chief Social Worker for Adults' annual report published for 2018 to 2019
- The Learning Disabilities Mortality Review (LeDeR) Programme publishes its March bulletin
- Action Fraud warns on prevalence of ticket fraud
- Department of Health and Social Care and Department for Education announce a review of the National Autism Strategy 'Think Autism'
- NHS England publishes a case study on 'Introducing an integrated safeguarding service in Somerset'
- A 'temperature check' survey of local authority staff about implementing Making Safeguarding Personal
- Guidance on oral care added to Department of Health and Social Care guidance on reasonable adjustments for people with a learning disability
- BBC: Phone scams: Rise in fraudsters making fake HMRC calls

February 2019

- UK Parliament debates the safeguarding of vulnerable adults
- The Somerset Intelligence team has published the February edition if it's SINePost e-newsletter
- The Learning Disabilities Mortality Review (LeDeR) Programme publishes its February bulletin
- Somerset County Gazette: "Somerset woman posed as police office to fleece thousands of pounds from partially sighted 88-year-old"
- Department of Health and Social Care publishes consultation on Learning disability and autism training for health and care staff (closes 12/04/2019)
- Department of Health and Social Care publishes Strengths-based social work: practice framework and handbook
- Healthwatch Somerset publishes its February e-bulletin
- Sepsis - what NICE says
- Inside The Mind Of A Scammer: The Tactics Investment Fraudsters Use To Deceive Over 55s
- BBC: Mother of three-year-old girl becomes first person in UK to be found guilty of female genital mutilation

January 2019

- The Learning Disabilities Mortality Review (LeDeR) Programme publishes its January bulletin and a Learning into Action Bulletin about constipation
- The Guardian: You can't rehabilitate someone into society when they're locked away
- Home Office and Ministry of Justice publish 'Transforming the Response to Domestic Abuse Consultation Response and Draft Bill'
- SCIE updates its 'Safeguarding adults: sharing information' guidance
- ITV: Family of man abused at autism care home in Somerset say his life has improved beyond recognition

- The Independent Inquiry into Child Sexual Abuse launches a public awareness campaign to ensure all victims and survivors of child sexual abuse across England and Wales have the opportunity to come forward
- SCIE and NICE publish a quick guide for registered managers of care homes to help to prevent pressure ulcers
- CQC appoints new chief inspector of general practice
- BBC: Pension cold-calling ban takes effect
- Six of the most common misconceptions about scams after one farmer was conned out of £19k on the telephone
- BBC: 'They took her teeth without telling me': questions raised about the dental treatment of vulnerable patients'
- NHS Long Term Plan Published
- BBC: Elderly 'under siege' from fake HMRC and police scammers

Training and Development

It is the responsibility of all organisations to ensure they have a skilled and competent workforce who are able to take on the roles and responsibilities required to protect adults at risk and ensure an appropriate response when adult abuse or neglect does occur. The SSAB does not provide any single or multi-agency training.

Social Care Institute for Excellence: e-learning

(please note that SCIE have recently begun charging for this content)

- e-learning: Adult Safeguarding Resource
- e-learning: Mental Capacity Act

Other resources

- Unseen Modern Slavery training
- Home Office Prevent e-learning
- Home Office FGM (Female Genital Mutilation) e-learning

Real Safeguarding Stories is a learning tool dedicated to raising awareness of safeguarding issues. By telling compelling stories based upon real life events, it helps professionals understand these complex issues. Understanding and relating to these stories is the first step towards individuals and organisations being better able to support those at risk. On this website you will find a series of videos, each exploring different aspects of safeguarding – including child and adult safeguarding, and domestic abuse. These are based on the experiences of professionals working in the field and from interviews with victims of abuse. The videos are then scripted and filmed using actors in a realistic context, with each video supported by guidance to support wider training or awareness activity. Visit: http://realsafeguardingstories.com/

Useful Safeguarding Adults Links

Secure professionals e-referral form

Joint Safeguarding Adults Policy

Somerset Adult Safeguarding Guidance

National Safeguarding Adults Review (SAR) Library

Get in touch

If you have any suggestions for future topics or comments about this newsletter, please contact us via:

ssab@somerset.gov.uk

Alternatively call our Business Manager, Stephen Miles, on:
01823 359157

If you are worried about a vulnerable adult, don't stay silent

Phone: **0300 123 2224**
Email: **adults@somerset.gov.uk**

Or complete a secure
Professionals e-referral form

In an emergency always contact the police by dialling 999.
If it is not an emergency, dial 101

SOMERSET SAFEGUARDING ADULTS BOARD