Northamptonshire

Safeguarding Vulnerable Adults Board

Annual Report

April 2011 – March 2012

The Northamptonshire Safeguarding Vulnerable Adults Board is a partnership between:

East Midlands Ambulance Service NHS Trust
Kettering General Hospital NHS Foundation Trust
NHS Milton Keynes and Northamptonshire
Northampton General Hospital NHS Trust
Northamptonshire Association of Registered Care Homes
Northamptonshire County Council
Northamptonshire Fire and Rescue
Northamptonshire Healthcare NHS Foundation Trust
Northamptonshire Local Involvement Network (LINk)
Northamptonshire Police
Northamptonshire Probation Trust (MAPPA)
St Andrew's Healthcare
University of Northampton
Users and carers (through LINk)

Northamptonshire Safeguarding Vulnerable Adults Board promotes the right of every individual to be free from abuse, exploitation, intimidation and violence.

A vulnerable adult is a person aged 18 years or over "who is or may be in need of community care services by reason of mental or other disability, age or illness

and

who is or may be unable to take care of him or herself, or is unable to protect him or herself against significant harm or exploitation."

'No Secrets' 2000

Contents

Page

Message from the Independent Chair of the Board

As Independent Chair of the Northamptonshire Safeguarding of Vulnerable Adults Board (SOVA) I am pleased to introduce our Annual Report for 2011-12. This Annual Report provides a summary of national and local developments and our priorities in the safeguarding of adults at risk of abuse and significant harm in Northamptonshire, whether they live in their own homes, residential or nursing care settings or hospitals. It gives us the opportunity to reflect on the achievements of the past year but also to consider how we, as a Board, will move forward in the coming year to ensure that our focus and our priorities are aligned with the Governments principles and intentions in relation to Safeguarding Adults.

Over the last 12 months the Board's achievements have been considerable and reflect the quality of relationships and the strength of commitment across the partnership. Amongst these achievements I am particularly pleased with the following:

- Increasing engagement with those who have experienced abuse or neglect and as a consequence have been supported through the safeguarding team. The strength of the Service Users and Carers sub-group enables future developments to be shaped by their personal experiences;
- Progress towards the development of integrated safeguarding arrangements through the creation of a co-located multi-agency safeguarding hub (MASH) – to ensure the early sharing of information and risk assessment for children and adults safeguarding.
- Greater integration and collaboration with the Local Safeguarding Children's Board Northamptonshire to respond to complex and multiple needs of families, children and young people;
- Embedding the learning from Serious Case Reviews through improvements and developments across the partnership.

The seriousness of safeguarding investigations means that despite achievements we can never be complacent. We see the number of people requiring support to safeguard themselves continuing to increase each year. High profile televisions programmes, a number of Serious Case Reviews and inquiries in Northamptonshire and elsewhere, have highlighted the unacceptable risks of neglect and the physical abuse that people with learning disabilities and older people can face in care services and hospitals. Our developments strengthen our ability to safeguard the rights and safety of those in need of our support. We have set ourselves ambitious targets for 2012/13, as we remain committed to safeguarding the rights and safety of our citizens.

The safeguarding adults agenda is much broader than just protecting adults at risk. It is also about allowing adults to live their lives and make decisions, whilst taking reasonable measures to ensure that risks of harm are minimised, particularly in light of the personalisation of care and support around the needs of the individual. Prevention is seen to be a key part of the work of the Board both now and in the future.

The Government has signalled its intention following a report from the Law Commission and publication of the Care and Support Bill to place Safeguarding Adult Boards on a statutory footing similar to that already in place for Safeguarding Children Boards. The timing of such a change from the current 'No Secrets' guidance to a new statutory body remains undecided. Nonetheless, the strength of the partnerships across Northamptonshire and the commitment to raising the profile of safeguarding with members of the public means the SOVA Board is well placed to respond to future challenges.

Marie Seaton

Independent Chair
Northamptonshire Safeguarding Vulnerable Adults Board

1 INTRODUCTION

1.1 Under 'No Secrets' (2000) guidance, the Department of Health determined the local authority to be the lead agency for safeguarding vulnerable adults. However, all agencies continue to share responsibility to ensure the promotion of safety and welfare of vulnerable adults. The inter-agency Northamptonshire Safeguarding Vulnerable Adults (SOVA) Board shares responsibility for the strategic direction of local safeguarding arrangements and the translation into practice of safeguarding best practice, following local procedures. The Law Commission's review of adult social care law, culminating in the Health and Social Care Act 2012, recommends making Safeguarding Adults Boards statutory in order to hold all agencies more accountable. The Safeguarding Adults Board is well placed to create strong links and develop protocols with other multi-agency boards and partnerships with regard to areas of shared concern e.g. the Local Safeguarding Children's Board (LSCBN) around the 'Think Family ' agenda and 'safeguarding across the generations' and Community Safety Partnerships. It will be expected to feed into the Health and Well-being Board from April 2013.

1.2 The Annual Report of the Northamptonshire Safeguarding Vulnerable Adults Board is produced to inform individuals who use health and social care services, their families and carers, elected members, those who work in social and health care, all partner agencies and residents of Northamptonshire. It outlines the progress made during the year April 2011 – March 2012 and how local and national developments have influenced this. The safeguarding data provided in Section 8 confirms more than a one third further increase in safeguarding referrals and workload compared to last year, rising from an annual total of 2403 in 2010/11 to a total of 3216 for 2011/12.

2 NATIONAL CONTEXT

2.1 Towards the latter part of 2010/11 and arising out of the publication of the Consultation Review of 'No Secrets', the Government set a clear direction for the future of safeguarding practice within the NHS and social care. The agenda is around early detection and prevention, risk management and protection, for which it published a number of sets of Department of Health (DH) guidance between November 2010 and March 2011 (see Appendix 4).

2.2 <u>Statement of Government Policy on Adult Safeguarding May 2011</u>

In a Statement on 16 May 2011, the Coalition Government set out its policy on safeguarding vulnerable adults, building on 'No Secrets', which itself is expected to remain statutory guidance until at least 2013. The policy objective is to prevent and reduce the risk of significant harm to vulnerable

adults from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion. The Government affirms that safeguarding is everybody's business with communities playing a part in preventing, detecting and reporting neglect and abuse. It believes the State's role is to provide vision and direction and ensure that the legal framework is clear and proportionate whilst maximizing local flexibility and without being overly prescriptive. The Government wants local authorities and local multi-agency partnerships to provide leadership in moving towards less risk-averse ways of working, and to concentrate on outcomes instead of focusing on compliance. This means local multi-agency partnerships should support and encourage communities to find local solutions.

The Statement included a set of six principles for use by Local Authority Social Services and housing, health, the police and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements. It also described, in broad terms, the outcomes for adult safeguarding, for both individuals and agencies and outlined the next steps.

The six principles are as follows:

- Empowerment – presumption of person-led decisions and informed consent.
- Protection – support and representation for those in greatest need
- Prevention – it is better to take action before harm occurs
- Proportionality – proportionate and least intrusive response appropriate to the risk presented.
- Partnership – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse
- Accountability – accountability and transparency in delivering safeguarding.

The above principles, which should be translated into customer outcomes, should be used by agencies and Safeguarding Boards to benchmark existing adult safeguarding arrangements and to measure future improvements.

There is very close tie-in between the Government's statement and the earlier Advice Note of the Association of Directors of Adult Social Services (ADASS) (2.3).

2.3 Association of Directors of Adult Social Services (ADASS) - Advice Note

This paper was produced in April 2011 to provide a framework for the Directors of Adult Social Services in their leadership role regarding adult safeguarding. However, the framework would also be useful to partner agencies e.g. from the health and police sectors. The vision of ADASS is that Safeguarding Adults Boards/Partnerships lead the work in communities to ensure that local agencies and the wider community can:

- Develop a culture of zero tolerance of abuse
- Raise awareness about abuse
- Prevent abuse from happening wherever possible
- Where abuse does happen, support and safeguard the rights of people who are harmed to:
  a) Stop abuse continuing
  b) Access services they need, including advocacy and post-abuse support
  c) Have improved access to justice

ADASS also affirms that outcomes are central to all that is done. This encompasses:

- Effective preventative work (e.g. awareness in the public, staff and customers)
- Good quality local services which prevent abuse and afford dignity and respect
- Personalised care responses which enable people at risk to weigh up the risks and benefits of their options.
- Systems and services which have the person concerned at their heart and enable them to define their desired outcomes and address the cause of harm or abuse
- Effective access to criminal and/or restorative justice.

ADASS states that any outcomes framework must be understandable, accessible, clear and person-centred and shared with the wider public. The focus on outcomes needs to be embedded at all levels – from operational to strategic, rather than a preoccupation with process. Most importantly, in the safeguarding context, is the focus on the individual concerned defining the outcomes they want themselves and working with the person, in their own

context, to negotiate the levels of risk enablement and safeguarding that are appropriate to them.

At its annual development day, whilst recognising the increasingly severe financial constraints, rising demographics and a seemingly growing culture of people not looking after one another, the Board agreed it shared the vision contained in the ADASS document with pro-active prevention at its heart. This vision was to provide the basis of the Board's business plan for 2011/12.

2.4 Care Quality Commission (CQC)

The Care Quality Commission is the single, integrated regulator for health and adult social care in England to ensure care services are meeting government standards. This includes services provided by the NHS, local authorities, private provider companies and voluntary organisations – whether in hospitals, care homes or in people's own homes. Part of CQC's remit is also to protect the interests of people whose rights have been restricted under the Mental Health Act.

As a result of national exposure by the 'Panorama' programme in June 2011, the CQC commenced an investigation into allegations of abuse by staff in a private hospital for people with learning disabilities and challenging behaviours. The review concluded that there had been a systemic failure on the part of the hospital and its owners to protect people and to report and investigate allegations of abuse. CQC went on to review all of the rest of the provider's services.

This nationally reported case led CQC to review and inspect 150 services with similar characteristics for people with Learning Disability. It also conducted its own internal management review with the intention of making recommendations relating to how CQC ensures that safeguarding alerts and whistle-blowing information are handled.

Subsequently, the Department of Health began a wide-ranging performance and capability review of CQC itself, resulting in a series of recommendations which included strengthening procedures and establishing a central e-mailbox to capture whistle-blowing information, logged by a new dedicated team as well as improving the cascade of information to inspectors and monitoring of their actions. Alongside these improvements there were changes in what is reportable and what a care home would be expected to report back and to whom; a requirement to improve communication channels; the implementation of learning from a Leicestershire Serious Case Review published in Feb 2011 and a review of capacity within the CQC. A particular focus in monitoring Provider compliance was to be on:

CQC Outcome 4: Care and Welfare of people who use services.

People should get safe and appropriate care that meets their needs and supports their rights.

CQC Outcome 7: Safeguarding people who use services from abuse.

People should be protected from abuse and staff should respect their human rights.

CQC Outcome 16: Assessing and monitoring the quality of service provision.

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.

2.5 Vetting and Barring Scheme

The Protection of Freedoms Bill, published in February 2011, included a review of the Vetting and Barring Scheme, previously introduced in October 2009, which brought in criminal sanctions to prevent barred persons from volunteering or working with vulnerable groups. The key future changes included under the Bill will be:

- Abolishing the registration and monitoring requirements of the Vetting and Barring Scheme.
- Redefining the scope of 'regulated activities'.
- Abolishing 'controlled activities'.

The provisions also mean that the services of the Criminal Records Bureau and Independent Safeguarding Authority (ISA) will be merged and a single, new non-departmental public body created. The new organisation will be called the Disclosure and Barring Service with a planned operational date from December 2012.

However, until the Bill completes its passage through Parliament and receives Royal Assent during 2012 to become the Protection of Freedoms Act and the new arrangements are established by 2013, the existing responsibilities of employers and the ISA will remain in force as introduced in October 2009. These include:

- A person who is barred from working with children or vulnerable adults will be breaking the law if they work or volunteer, or try to work or volunteer, with those groups.

- An organisation which knowingly employs someone who is barred from working with those groups will also be breaking the law.
- Any organisation working with children or vulnerable adults which dismisses a member of staff or a volunteer because they have harmed a child or vulnerable adult, or would have done so if they had not left, must tell the Independent Safeguarding Authority.

2.6 Safeguarding adults in the NHS

In February 2010, the Department of Health published 'Clinical Governance and Adult Safeguarding - An Integrated Process', which aimed to encourage NHS organisations to develop local robust arrangements which would streamline systems to ensure that clinical governance and adult safeguarding become fully integrated.

The implementation which began during 2010/11 has been further developed during 2011/12, following additional DH publications produced in March 2011. These were targeted at health service practitioners, managers, boards and commissioners in order to achieve good outcomes for patients (see Appendix 4).

In July 2011, an initial meeting was convened to scope the approach to be adopted in Northamptonshire then piloted for three months. During this period 4 safeguarding investigations were managed using the local framework. Each investigation was concluded with a multi-agency case conference and a 'Being Open' meeting, involving the relevant Health Provider where required. The learning from this pilot has been translated into an agreed procedure to manage the interface between Serious Incident reporting in NHS services and Inter-agency Safeguarding Procedures (see appendix 2).

The implementation of this approach enabled us to address the recommendations from an Independent Case Review conducted this year.

The NHS Operating Plan 2011/12 and the Clinical Commissioning Group guidance of the NHS Commissioning Board make clear that safeguarding children and adults remains a priority for the NHS. Future new commissioning structures must demonstrate effective management of these critical functions. The statutory duties of Primary Care Trusts to safeguard children and adults will transfer to Clinical Commissioning Groups under the Health and Social Care Act 2012.

2.7 Safeguarding adults in health and adult social care

The document, 'Vision for Adult Social Care: Capable Communities and Active Citizens' In November 2010, published by the Department of Health, set out a new direction for adult social care, putting personalised services and customer outcomes at the centre. The section on protection made it clear that vulnerable people should be protected when they are unable to protect themselves and that this should not be at the cost of people's right to make decisions about how they live their lives.

On the same day, the DH published a briefing paper 'Practical approaches to safeguarding and personalisation', setting out how personalisation can contribute to more effective safeguarding through stronger, whole community approaches (Big Society) and well-designed self-directed support processes. The focus is on prevention and reducing the risk of harm and abuse through effective and proportionate risk management involving individuals and communities.

Personalisation is not expected to replace the need for adult safeguarding systems and procedures for vulnerable adults who are unable to keep themselves safe because of their situation or circumstances.

The vision of Northamptonshire Safeguarding Adults Board to have effective partnerships to ensure the safety of all vulnerable adults in the county will be expressed in personalisation terms within the strategic theme of using peoples experience of safeguarding to inform good practice. This is ongoing work through customer experience and outcomes, empowerment, training, public engagement and localism.

2.8 Six Lives / Death by indifference

In February 2012 MENCAP published a Progress Report entitled "Death by indifference: 74 deaths and counting". This was five years after publishing its original Report "Death by indifference" (2007) which had highlighted the tragic consequences of healthcare inequalities experienced by six people with learning disabilities, resulting in their deaths. In turn this had triggered the Six Lives Report (2008) by the Parliamentary and Health Service Ombudsman, updated in 2010 by the Six Lives Progress Report.

In its latest report, MENCAP has called on the Government to ensure that:

- annual health checks become a permanent part of the GP contract to ensure early detection of health conditions

- all health professionals act within the law and get training around their obligations under the Equality Act and Mental Capacity Act so they can put this into practice when treating patients with a learning disability
- regulatory bodies such as the Care Quality Commission, General Medical Council and Nursing and Midwifery Council conduct rigorous investigations and deliver appropriate sanctions where health professionals clearly fail in their obligations to patients with a learning disability
- the NHS complaints process is overhauled: it is not fit for purpose, it is time-consuming and defensive, and it does not enable the NHS to learn important lessons quickly enough to prevent further deaths
- acute learning disability liaison nurses are employed by every acute service and are linked to senior leadership who have a strategic role in supporting ward staff to make reasonable adjustments
- a standard hospital passport is made available to all people with a learning disability
- all hospitals sign up to Mencap's *Getting it right* charter and put in place the good practice that we all know saves lives

Northamptonshire has a programme of annual Big Health checks for people with learning disability and learning disability liaison nurses are in place.

Partnership work between customers, the Learning Disability Partnership Board, Mencap, NCC and Northants Police has developed a 'Keep Safe' Card Scheme for anyone in the county with a Learning Disability. The scheme is designed to make people more aware of their personal safety, to encourage reporting of crime, especially hate crime, and seek help if they need it. Over 800 people have registered. When the individual registers for the Keep Safe card they are given access to the Northamptonshire Police Disability Line.

Keep Safe Places, displaying the Keep Safe logo, have also been introduced as part of the scheme. So far there are 65 Keep Safe places, including hospitals, libraries, shops and other services.

2.9 Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards (DoLS) have been in place since 2007 as part of the Mental Capacity Act 2005 to provide legal protection for those vulnerable people who are, or may become, deprived of their liberty when this is in their best interests. The safeguards also prevent arbitrary deprivation and give people the right to challenge a decision. The legislation set out a

procedure for care homes and hospitals to obtain authorisation to deprive an individual of their liberty with effect from April 2009.

Continuous promotion and support in the appropriate use of the legislation for adults who lack capacity and who receive care or treatment in either residential/nursing care or in a hospital setting is a priority for the DoLs Service in Northamptonshire. The interface with the Mental Capacity Act and use of the Mental Health Act as an appropriate alternative continues to develop alongside useful case law which serves to inform professional practice.

2.10 Independent Mental Capacity Advocate (IMCA)

The Mental Capacity Act 2005 came fully into force in October 2007, providing a legal framework for acting and making best interest decisions on behalf of people aged 16 and over who lack capacity and may not be able to make decisions for themselves. The Act is supported by a Code of Practice and created an additional role of Independent Mental Capacity Advocate (IMCA), who is someone appointed to support a person who lacks capacity to make decisions and has no one to speak for them.

An IMCA may be instructed to support someone who lacks capacity to make decisions in respect of adult protection cases, whether or not family, friends or others are involved. In partnership with Advocacy Alliance, VoiceAbility is contracted to provide generic and statutory advocacy services across Northamptonshire.

3 LOCAL CONTEXT

3.1 Locally, a more seamless approach to safeguarding adults at risk has evolved with increased ownership, follow-up and escalation of operational issues as required. In addition, great strides have taken place in gathering intelligence around safeguarding matters. The following key safeguarding improvements from the combined action plans for the Council and its partners, developed out of the CQC Inspection (2010) and Annual Performance Assessment (2010), were achieved within timescale and fully signed off during 2011/12:

- greater publicity for community safety initiatives e.g. Home Fire Safety checks for all customer groups; Keep Safe and Safe Places Scheme for customers with a learning disability.

- systems for monitoring training need/ uptake and refresher training – this is well embedded in all sectors with training remaining free to Provider agencies.

- formal protection plans have increased in number and become mandatory and assessments of mental capacity required to be recorded on customer records.

- developing a robust framework to screen and risk manage all referrals, using a proportionate and appropriate response. The focus of the Professional Practice and Procedures sub-group has been key to achieving this objective and remains alert to the ongoing need to strengthen this area and keep it under review.

- The use of detailed data about safeguarding activity and trends for the purposed of strategic planning is developing and work in progress. Agreement was reached to commission a shared database within NCC to gather data around issues arising within care providers.

- The Board's profile amongst operational staff has been raised through visits to the Safeguarding Team, increased operational visibility by certain Board members and visits to the Team by those new to strategic posts as part of their induction.

- The exception to the above has been the Board's business plan for 2011/12.

3.2 At its development day, the Board reflected on its achievements and effectiveness using the Government's six safeguarding principles (2.2). Some strategic priorities were identified for incorporation into a business plan for 2011/12. Four main strategic themes and associated priorities emerged: a) developing and assuring best practice; b) using people's experience of safeguarding to inform good practice; c) working closely together to further strengthen multi-agency commitment to safeguarding; d) developing training and public awareness.

3.3 The intention to develop the business plan, with a strong desire to involve service users closely in process, suffered significantly from demand and capacity issues for all organisations.

3.4 The Board recognises it has run a serious risk of challenge during the past year without one in place and is committed to rectifying this for the 2012 - 2015 period.

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4 THE NORTHAMPTONSHIRE SAFEGUARDING VULNERABLE ADULTS BOARD

4.1 Purpose and membership

The Northamptonshire Safeguarding Vulnerable Adults (SOVA) Board, led by an Independent Chair since 2009, exists to provide strategic leadership for effective local safeguarding arrangements. With senior representation from partner organisations, the inter-agency Board offers a mechanism to vigorously discuss, develop and action the clinical and practice changes required for high quality safeguarding service delivery. The forum ensures that policies, procedures, protocols and guidelines reflect national policy and expected best practice. During the year the Board has also received presentations, for example, around the Think Family Approach to Safeguarding, Integrated Safeguarding Arrangements and the changes in access to housing and personal benefits introduced under the Housing and Welfare Reform Bill, in recognition of the potential impact on vulnerable people. In addition, in its role as lead agency for the Community Safety Partnership (CSP), NBC also delivered a presentation on Domestic Homicide Reviews. It is a statutory obligation of CSPs to undertake a safeguarding review when an abuse-related homicide occurs. The safeguarding aspects of such reviews will be overseen by both Children and Adult Safeguarding Boards.

Members of the Board and their nominated deputies remain those who work at a strategic level and others with a more operational, front-line focus. Membership is drawn from health providers and commissioners across the health sectors, Police, Probation Trust (for multi-agency public protection arrangements - MAPPA), Fire and Rescue Service, University of Northampton, and branches within the County Council. A representative from the Northamptonshire Association of Registered Care Homes (NORARCH) attends on behalf of a section of the independent care home sector. Some SOVA Board members are also members of LSCBN. It is a challenge to achieve consistent and regular representation at all Board and sub-group meetings in the present economic climate which puts pressure on all agencies. The Board decided to meet bi-monthly for a trial period of 6 months from April 2012 to be reviewed in September 2012.

The Housing sector is not yet represented on the Board although approaches were intended. Much work has been undertaken with GP's locally although they also have no representative on the Board. The Board, however, will be reporting into the Health and Well-being Board from April 2013 as will the Children's Safeguarding Board. The future relationship between all three Boards will be crucial, with potential for mutual scrutiny.

Public engagement continues to be an essential element for adult safeguarding. Users and carers have been represented on the Board and are members of the User and Carer sub-group. A representative from Northamptonshire Local Involvement Network (LINk) is a Board member. The Care Quality Commission, as regulator for both the NHS and adult social care, still has observer status on the Board, attending on an annual basis or by arrangement at other times.

All members of the Board are required to report to the respective Boards or management groups within their own agencies on the work of the SOVA Board with an agreed mechanism to ensure that policies and procedures are signed off by individual partner agencies as required.

The following sub-groups support the Board's work:

- Training
- Professional Practice and Procedures
- Quality Assurance and Performance
- Users and Carers
- Serious Case Review

All five sub-groups have a regular meeting cycle and are chaired by members of the Board, with other members drawn from across partner agencies. Task and finish groups, involving wider groups of staff across agencies, are convened as required for specific matters.

Links between the adult and children's safeguarding Boards were taken forward during 2011/12 through contact between the respective Chairs in order to further explore opportunities to develop joint protocols around the 'Think Family' agenda and 'safeguarding across the generations' as well as to achieve efficiencies. There is an ongoing commitment to joint training. However, at the annual Board development day a consensus was reached that it was not yet appropriate to merge the adult and children's Boards or sub-groups during 2011/12 due to concerns that the safeguarding adults' agenda may be marginalised within the statutory children's safeguarding agenda.

During 2011/12 work progressed to explore the longer-term integration of the business support function between the SOVA Board, the Local Safeguarding Children Board for Northamptonshire (LSCBN) and the Children and Young Peoples Trust. Whilst not yet achieved it remains the stated intention to do so.

As part of its own restructure during 2011/12, Northamptonshire County Council created a new joint Directorate for Children and Adults under a single

Director and appointed a Head of Safeguarding and Quality Assurance for Children's and Adults Safeguarding.

4.2 The Training Sub-group

The training sub-group is well-established and has a key role to play in ensuring that staff are trained to recognise and report abuse. The sub-group fulfils this role by producing and overseeing the delivery of single and multi-agency training and comprises of representation across the local authority, health, police and other relevant partners.

The training sub-group has made considerable progress during the last year and achievements include:

- The launch of three e-learning packages (Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards) in January across health and social care. E-learning is now delivered by Embrace. This has included GPs, dentists, care homes and domiciliary care
- The completion of small 'task and finish' groups to review refresher training and training materials/content for Level 1 and 2 training. This has ensured that there is consistency and quality of training provided across all organisations
- The introduction of other associated safeguarding topics – Prevent, MAPPA, MCA and DoLS – within the wider safeguarding training agenda.
- The revision and re-commissioning of Level 3 multi-agency training in light of staff feedback

In terms of planning for 2012/2013, the key priorities include:

- Continued early engagement and the sensitive process of involving service user and carers in training
- Revision of the training sub-group's terms of reference in light of other associated safeguarding topics
- Revision of the safeguarding strategy, to ensure that the development needs of staff working with vulnerable adults have been agreed and that there is a broad range of training initiatives in place appropriate to work settings.
- Multi-agency safeguarding adults annual conference

Information on inter-agency safeguarding training is currently available through the NCC internet via the Safeguarding Vulnerable Adults page.

4.3 The Professional Practice and Procedures Sub-group

During 2010/11 operational requirements dictated the need to develop shared documentation and refresh guidance. Considerable progress has been made on these and all the documentation is accessible on the NCC safeguarding web page.

The key objective for the sub group in 2011/12 has been to develop best practice tools in the screening and risk management of all referrals. The focus of this work has been to identify mechanisms which are both appropriate and proportionate. The group evaluated a number of national and regional best practice examples and agreed to adopt and implement the following in order to strengthen the screening and investigation processes:

- Proportionate responses to concerns arising within Health and Social Care Services – criteria for levels of response
- Serious Incidents and Safeguarding Adults - an integrated approach
- Risk assessment matrix for screening referrals

The sub group also reviewed action plans arising from Independent and Serious Case Reviews and the Strategic Plan for 2010/12 to ensure any practice requirements were reflected in the inter-agency procedures and other related documents.

The sub group revised its Terms of Reference and work plan and sought to strengthen the membership.

The work plan was to include identifying mechanisms to respond to whole service concerns and institutional abuse together with the development of practice guidance in order to underpin the inter-agency procedures which are available on the Safeguarding Adults Procedures and Forms webpage on the NCC Internet.

4.4 The Quality Assurance and Performance Sub-group

The sub-groups work-plan has been updated considerably in the past year and the group is currently developing a Quality Assurance Framework. This framework will be for the audit and management of quality issues related to the multi agency policy and procedures for the Northamptonshire Safeguarding Vulnerable Adults Board. Membership on the group continues to be consistent from all agencies.

Data capturing and reporting continue to be monitored following the development of the Data Insight pack with specialist support from

representatives from NCC. Work is currently underway to look at IT systems to capture institutional trends and the progress of this project is being reported to the group as regular agenda item.

4.5 The Users and Carers Sub-group

The key purpose of the Carers and Users sub-group is to represent the vulnerable adult community by raising awareness of issues relating to safeguarding, and to ensure that the voice of users and carers is heard. Despite losing a couple of members in the summer, including the Chair, we have continued to meet regularly throughout the year. Our membership includes carers and users, an expert by experience, representatives from the voluntary sector and key staff from NCC. We are currently actively working to build a more robust and diverse membership to include representatives from a range of user groups.

In order to help identify current issues which concern users and carers, and to inform our work, we have spent some of our meetings hearing from a number of the Safeguarding leads about their role and work practices, and how they involve users in the design and delivery of their services. We have also heard from representatives from the LINk who talked about their role and their 'Enter and View' work in care homes, and we've heard from the Sharing Lives service manager. Regular updates from some of the Health Leads and the Training Lead are now standing items on our agenda. We have also examined and discussed a variety of recent national reports and consultations, and current concerns such those raised by the Winterbourne View documentary. We have also made links with other groups with whom we share a common agenda, and who we can work in partnership with; including the Learning Disability Partnership Board's Keep Safe Group and the Carers' Partnership.

From this collective information we have identified gaps that we feel the group can contribute towards which includes:

- **Lack of awareness with users and carers in identifying what good quality care looks and how they can get issues addressed**. We have contributed towards the Care Home Checklist which is published annually in NCC's *Care Homes Directory*, and we are currently putting together from scratch a checklist on 'What Good Quality Care Looks Like' for NCC's booklet *Your Guide to Living Independently.* We have also asked NCC Commissioning if we can have some input into the re-tendering process for Domiciliary Care Providers, with a view to enabling customers and family carers to feedback independently on the quality of their services and thereby inform the safeguarding agenda.

- **Improving the safeguarding process and experience for vulnerable people and their carers**. We are working on putting together a qualitative questionnaire for people to complete following a safeguarding investigation, the answers to which can be used to improve the experience and process for people
- **Active involvement of users and carers in Safeguarding Training**. We are still working towards a DVD to be used during training sessions, and would like users and carers to personally contribute in training sessions when possible.
- **Raising awareness and training around safeguarding for users and carers.** We plan to work with the training lead to set up some specific and accessible safeguarding awareness training for users and carers.

4.6 SCR SUB GROUP

The Serious Case Review sub-group was first established in December 2010. The core function of the group is to consider referrals when a vulnerable adult dies and abuse or neglect is known or suspected to be a factor in their death as outlined in the Northamptonshire Serious Case Review Guidance 2009.

In the past year the sub-group has revised its Terms of Reference and standardised the supporting documents which underpin the process. The role and responsibilities of the group are to fulfil the duty of the Northamptonshire SOVA Board by:

- Reviewing cases at a level appropriate for learning, incorporating the East Midlands approach (Appendix 3), in addition to those cases which meet the criteria for Serious Case Review (SCR) and to ensure inter-agency learning across Northamptonshire.

- Providing advice on all aspects of Serious Case Reviews to the SOVA Board.

- Ensuring that Serious Case Reviews are completed to a consistently high standard and within agreed timescales, in line with national guidance and Northamptonshire Serious Case Review Guidance 2009.

- Ensuring that the recommendations and action plans arising from these are implemented by the Board and partner agencies..

- Identifying any difficulties with the implementation of the Action Plan and alerting the SOVA Board.

- Gaining assurance from partner agencies that internal reviews of practice have been conducted.

- Identifying and disseminating learning from local and national Serious Case Reviews for both adults and children in collaboration with the Local Safeguarding Children's Board.

- Promoting an environment of shared learning.

During 2011/12 the sub-group received three referrals for consideration. Whilst two of these did not meet the criteria, it was still recognised that there were lessons to be learnt and the group made a number of recommendations where practice could be improved across agencies. The third referral was considered for serious case review, pending further information.

In September 2011 the sub-group signed off the completed action plans for the two SCRs commissioned in 2010/11. The group has been keen that the learning from reviews is disseminated within and across all agencies and this will be considered as part of their future work plan.

There were no Serious Case Reviews undertaken during 2011/12, however, the SOVA Board did commission an Independent Review on a previous complex case concerning a younger adult known as 'MC'. The findings of this review resulted in a total of 9 recommendations which were collated into an action plan. This action plan has been monitored by both the Board and the Serious Case Review sub-group, requiring all the agencies involved to provide evidence of implementation of the recommendations. The Independent Review was published on the Northamptonshire County Council Safeguarding web pages in October 2011.

4.7 Additional sub-groups

Two additional sub-groups continue to be convened on an ad-hoc basis as required. The Communications & Public Engagement and Legal sub-groups are joint groups with colleagues from children's safeguarding and enable collaborative work in these areas. The legal department at the County Council has provided support to the Board as required; external legal support would be sought in the event of a potential conflict of interest.

5 REVIEW OF ACHIEVEMENTS IN 2011/12

5.1 Adult safeguarding work continues to have a much broader remit than adult protection, alongside wider community safety. This includes Hate Crime/Hate Incidents; Multi-Agency Risk Assessment Conference (MARAC); interpersonal/domestic violence and the PREVENT (anti-terrorism) agenda (see Appendix 4). It also embraces Domestic Homicide reviews and the suicide prevention strategy. The actions outlined in the business plan, contained within the Charter and Strategic Plan 2010/12, were achieved ahead of anticipated timescales but with an ongoing commitment to: involving and learning from the experience of users and carers; raising pubic awareness; training; shared learning and keeping processes and procedures under review. A clear response to the PREVENT agenda was delayed due to changes to the national strategy during the year but will become a priority for 2012/13.

The Board remains keenly aware of the continuing serious financial pressures being experienced by all agencies which are expected to last for a number of years yet. In response, Northamptonshire County Council and Health Providers have been and continue to go through radical restructures within their organisations. It continues to be a major challenge for partners to maintain the required resources (staff and services) and expertise to prevent vulnerable adults from 'falling through the gaps' in the face of demographic and financial pressures. It will require further sustained commitment and innovation on the part of all agencies represented at Board to continue to work closely together to mitigate the impact of such swingeing cuts.

5.2 <u>Procedures and Practice Guidance</u>

Serious Case Reviews: Having participated in the East Midlands region review of adult protection Serious Case Reviews, the Board adopted the principles of the new model which subsequently emerged for considering complex cases. As a consequence, the Safeguarding Procedures were refreshed and the Serious Case Review guidance became a stand alone document.

Safeguarding Notification (referral) and outcome (conclusion) forms have undergone no changes during 2011/12 but there is a need to update them again to capture data around referrals for PREVENT/Hate Crimes/MAPPA/ referrals on the interface between Serious Incidents and Safeguarding Adults and referrals to the Serious Case Review sub-group. These are expected to be in place during 2012/13.

The full year effect of improved data capture following the updating of the forms in 2010/11 should be seen in the end-of-year data for 2011/12, with its impact for local performance indicators and the identification of potential trends.

The *Safeguarding Toolkit,* introduced as operational guidance for frontline staff, has undergone no further amendments during 2011/12 since last year's inclusion of protection plans as mandatory and evidencing in case records that mental capacity has been appropriately considered and recorded. The latter may have contributed to this year's rise in IMCA referrals.

Thresholds: The safeguarding thresholds paper, originally introduced in 2010, has been kept under continuous review and revision in order to continue to refine the initial screening and risk assessment process. A revised threshold framework, adapted from the ADASS North East Risk Matrix, has been introduced to continue to ensure that the safeguarding response is appropriate and proportionate to the concern. This enables investigation under the safeguarding process by the Safeguarding Adults Team to be appropriately reserved for vulnerable adults at the highest risk. It continues to have an extremely beneficial effect on reducing the average number of days for completing a safeguarding investigation to well under the 28 day timescale for all but complex or exceptional situations.

The Northamptonshire Inter-agency Safeguarding Procedures for responding to allegations of abuse and/or neglect of vulnerable adults were adjusted to take account of the introduction of the Serious Case Review guidance as a stand-alone document following the adoption of the East Midlands Serious Case Review four-stage model.

Pressure ulceration: the reporting process for patients with pressure ulceration continues to be kept under review. It continues to assist operational staff report what mitigating actions are being taken to address all grades of skin care concerns i.e. Grades 2, 3 & 4. It becomes a safeguarding concern when skin care concerns are not being addressed i.e. where no mitigating action is being taken or where appropriate help is not available, as this may potentially highlight poor or possibly abusive practice. Reporting also provides information as to where occurrences of skin care concerns are being identified more frequently and therefore, where intervention may be most needed.

5.3 Partnership working

Positive partnership working continues at all levels, from Chief Executive level down to frontline workers, in response to safeguarding concerns – in consultations, in strategy meetings, protection planning and monitoring. Joint Implementation of lessons learnt from serious case reviews occurs across all agencies. It is also reflected in monthly information sharing meetings with operational safeguarding leads as well as in Board sub-groups. However, operational changes within the Care Quality Commission, as regulator, have had an impact on the frequency of their meetings with NCC. CQC has redefined its 'patches' within each region. Northamptonshire now spans two CQC 'patches' and has relationships with two CQC Business Relationship Managers. The intention is to reinstate the quarterly meetings.

The current partnership with NHS Milton Keynes and Northamptonshire for the statutory DoLS service will continue until the end of March 2013. At this point NCC will take statutory responsibility for the whole service.

The framework of the Care Home Escalation Policy is regularly in use as part of information sharing meetings and continues to inform commissioning colleagues and operational staff in their response to, and management of, large-scale and complex institutional concerns. It is used, to differing extents, at times of termination of local care home provider contracts; local care home closures and where there may be the potential for care home closure by a provider with a national profile e.g. Southern Cross.

There have been two successful local criminal prosecutions against care home providers where financial abuse has taken place, involving partnership working with Northamptonshire Police. A positive relationship exists with the Police but it remains a challenge to secure successful prosecutions in cases of alleged neglect and/or physical abuse. This is particularly so in customer groups where the position of 'credible witness' may not be secure enough for the Crown Prosecution Service to proceed with confidence. There is evidence that the Police themselves have a much better understanding of the application of the Mental Capacity Act in investigations.

Pressure care - Northamptonshire has established a Tissue Viability Forum in the light of the Midlands and East Strategic Health Authority announcing its ambition to eliminate all avoidable pressure ulcers by December 2012. Group membership consists of representation from health, social care and safeguarding and feeds into the programme board which is hosted by the Cluster PCT/Clinical Commissioning Groups. In Northamptonshire the two CCGs will be Nene CCG and Corby CCG which should be operational from April 2013.

5.4 Publicity and Information

The effect of stories in the national and local press continues to have an impact on safeguarding activity in Northamptonshire, with further higher levels of referrals received during 2011/12 - an increase of 34%. With customer involvement, the process of redesigning specific safeguarding leaflets began and generic information leaflets incorporated a safeguarding section. NCC safeguarding web pages were expanded. Opportunities to raise awareness of safeguarding have been taken through attendance at internal and external forums during the year

6 SERIOUS CASE REVIEWS – LESSONS LEARNT

6.1 A Serious Case Review (SCR) can be undertaken when a vulnerable adult dies (including death by suicide) **and** where **substantial** abuse or neglect is known or suspected to be a factor in their death. SCRs are not enquiries or re-investigations into cases, nor is their purpose to apportion blame. There is no legal requirement to undertake a SCR in adult safeguarding. The purpose of a serious case review is to establish whether there are lessons to be learnt from a particular case about the way in which local professionals and organisations work together to safeguard and promote the welfare of vulnerable adults. Northamptonshire SOVA Board supports serious case reviews as an essential part of service development which can lead to important changes to policy and practice to improve safeguarding arrangements in the future. The SOVA Board owns lessons learnt.

6.2 The action plans from the two SCRs which were commissioned during 2009/10 and both concluded during 2010/11 were signed off by the Serious Case Review sub-group and the SOVA Board during 2011/12. There has been full commitment by all agencies to disseminate learning for staff arising from these action plans.

6.3 There is no comprehensive framework for the management and process of potential adult SCRs either nationally or locally. Northamptonshire took part in the review of all SCRs in the region commissioned by the East Midlands Joint Improvement Partnership (EMJIP) in July 2010. Using learning from the regional cases, the project, hosted by Leicestershire County Council, introduced a new four stage approach to provide more options in safeguarding adults and be more cost effective, less time-consuming, ensuring learning is disseminated and actioned in a timely manner.

The four levels of review processes of the new model are:

- Level 1 – Serious Case Review
- Level 2 – Significant Incident Learning Process
- Level 3 – Peer Review
- Level 4 – Individual Agency Review

Northamptonshire SOVA Board decided to adopt the principles of the new model during 2011/12 (Appendix 3).

6.4 No SCRS were commissioned during 2011/12, however the Serious Case Review sub-group considered any potential SCRs against the new model during this time. Using these principles, it commissioned one Independent Overview report for a complex safeguarding case which had occurred prior to the model's introduction. The Overview Report of this Independent report was published in October 2011.

6.5 Recommendations for the SOVA Board and individual agencies from the Independent Overview report published in October 2011(customer with a learning disability):

Recommendation 1
The SOVA Board requires Kettering General Hospital Trust and Northamptonshire County Council, to report to the Board, the actions which they have taken in light of the investigation, both in terms of the procedures and how services have been revised to improve the outcomes for service users who may have impaired mental capacity.
Recommendation 2
The SOVA Board should to review whether it is satisfied that local agencies, particularly health and social care providers, are aware of their responsibilities to raise safeguarding alerts, and whether any refresher training or guidance is needed.
Recommendation 3
The SOVA Board should to review whether the local safeguarding procedures, need to include more specific guidance regarding identifying and raising safeguarding issues in regulated settings, including hospitals.
Recommendation 4
The SOVA Board should to remind local safeguarding organisations that safeguarding investigations need to consider the risks posed to other vulnerable adults, in any given situation and not just risks for those who are the subject of the investigation.
Recommendation 5
The SOVA Board should to consider how it can be assured that all local agencies are complying with the local procedures and whether there are sufficient routes for individual workers, to raise problems of compliance, within or across agencies, where their initial concerns are not acted upon.
Recommendation 6

The SOVA Board should to review the local procedures, in terms of the guidance they provide about how safeguarding investigations apply where the individual has died. This should include issues of pace, considerations of other potential victims and the role of the police in investigating these situations.

Recommendation 7

The SOVA Board should to review the current procedures (December 2010), to ensure that they provide sufficient guidance on setting and retaining the focus of safeguarding investigations, and how safeguarding investigations relate to any internal management/serious incident reviews associated with the case, ensuring that they run simultaneously. Included in this review by the SOVA Board, should be whether they provide sufficient guidance on identifying the lead investigating agency, as opposed to the coordination role, which will always sit with NCC. The initial strategy discussion/meeting should clearly identify a nominated Case Lead and consider whether any other roles are required, including family liaison and media leads, and also which is the most appropriate agency to act in that lead role.

Recommendation 8

All the individual agencies and the SOVA Board, should consider how they can routinely monitor and thus be regularly assured, that all safeguarding and associated complaint processes are being delivered in a timely manner.

Recommendation 9

The SOVA Board should to progress the new regional framework for determining the level of review that is needed to consider lessons in safeguarding cases and adapt the local procedures accordingly.

Additional recommendation for KGH

Kettering General Hospital Trust should review whether it is satisfied that any future commissions of independent medical reviews will include all the relevant records, at the outset and be clear about timescales for completion.

7 PARTNERSHIP CONTRIBUTIONS TO ADULT SAFEGUARDING IN 2011/12

7.1 This section highlights the developments and achievements in adult safeguarding identified by partner agencies during 2011/12.

7.2 Northamptonshire County Council (NCC)

Across the Council, safeguarding has continued to have a high profile in relation to all staff e.g. induction days and large Council events. The launch of the new e-learning package (Embrace) for safeguarding has been widely promoted both across the Council and is freely available to all Independent providers and the voluntary sector.

During 2011, the Council underwent a restructure and introduced a new Target Operating Model across the organisation. Adult and Children's

Services were brought together under one Directorate in recognition of the benefits of whole life services and the development of a seamless pathway between children and adults in areas such as disability, prevention, safeguarding and Transitions. Some of the proposals within the new model resulted in changes to Children's and Adult Safeguarding. A Head of Service for Safeguarding and Quality Assurance for Children's and Adult Safeguarding was appointed with an intention to combine the services. In further recognition of the needs to safeguard and support vulnerable young people with disabilities through their journey into adulthood, a new NCC team was also created to focus on the needs of those young people aged 14 – 25years. This is known as the Transitions Team.

In August 2011 the central Review Team was combined with the Safeguarding Adults Team in recognition that their tasks and responsibilities were in intrinsically linked in the safeguarding and protection of vulnerable adults. The review team's remit was extended to include all customers in receipt of a community care package or individual budget. This development, coupled with the continued collaborative working with commissioning colleagues in both Health and Social Care, has enhanced our information sharing processes and strengthened our systems for review, contract compliance and quality monitoring.

It has been another demanding year for the Safeguarding Adults Team with a 34% further rise in the number of notifications (referrals) received. This demonstrates the continued effectiveness of training, awareness-raising and the confidence of staff in recognising and reporting safeguarding concerns. Nevertheless the challenge for the service remains managing the demand in an effective and timely manner with limited resources.

The analysis of the data for 2011/12 shows that only 50% of these referrals went forward for investigation. However the administrative task involved with tracking and recording of all notifications and outcome forms is an enormous task in itself. Further work will be required during 2012/13 to refine the existing screening and business processes ensuring that only the most complex and high risk safeguarding situations appropriately remain with the safeguarding team.

The thresholds framework introduced in 2010 has had a very positive effect in addressing the management of the increasing volume of notifications received year on year. In light of the Government statement in May 2011, a review of the screening process and framework was undertaken. This highlighted the need for the screening and investigation process tool to be strengthened in order to support staff to make proportionate and defensible decisions concerning risk management. A number of best practice tools were introduced to assist with the implementation of the six key principles at the point of

screening. This has allowed the team's expertise and capacity to be focused where it is needed most and enabling appropriate diversion of some safeguarding activity to other internal and external teams or commissioners. Nevertheless, the Safeguarding Team continues to investigate the majority of all safeguarding referrals made (approx. 75%). The average timescale for completion of investigations remains around 20days.

The Safeguarding Team continues to provide advice, support and consultation directly to internal and external investigators and colleagues or via the NCC Safeguarding Champions and external Safeguarding Leads.

The engagement of advocacy and the application of the Mental Capacity Act has improved, thereby enabling staff to support customers in reaching their individual preferred outcome. Customer or advocate views on the outcome of a safeguarding event for the individual are routinely recorded on the outcome form (SA6).

7.3 All NHS organisations

The local health economy is well represented on the SOVA Board with senior officers from all NHS organisations in the county as active members of the Board. All NHS organisations have their own executive leads for safeguarding and adult safeguarding committee structures to enable safeguarding to be cascaded through their organisation and embedded in clinical practice. Each organisation has prepared its own safeguarding report which details specific safeguarding activities, achievements and future actions.

7.4 NHS Milton Keynes and Northamptonshire

The Health and Social Care Act 2012 has radically transformed how health services will be delivered. By April 2013, Clinical Commissioning Groups (CCG) will be responsible for the majority of health service commissioning.

In 2011, NHS Milton Keynes and Northamptonshire clustered. Currently, the Primary Care Trust Cluster Chief Executive remains responsible for ensuring that duties to safeguard adults and children within Northamptonshire are discharged effectively across the health economy. From April 2013, these duties will pass to Northamptonshire and Corby CCGs.

Within this time of change, NHS Milton Keynes and Northamptonshire safeguarding team have continued to deliver the objectives set out in their

safeguarding strategy (2010-2013) and have ensured that safeguarding is embedded into the approach to monitoring and improving quality with its providers. Their roles provide leadership, quality assurance and specialist advice on safeguarding adults to the Cluster Primary Care Trust, CCGs and across the health economy, working in partnership with Northamptonshire County Council. The Head of Safeguarding attends the serious case review sub-group of the Northamptonshire SOVA Board. The Professional Lead facilitates the training group and attends both the Quality and Professional Practice sub-groups.

The attainments for 2011/2012 include:

- The introduction of the 'Safeguarding Adult's: Self-assessment Framework (SAAF) for Healthcare Services' which was published by the Department of Health in 2011. This now forms part of quality contracting across Northamptonshire health services. A review with the Strategic Health Authority was held in February, which provided the opportunity to identify areas of progress, innovation and good practice for both commissioners and providers. Areas of improvement were identified and action plans are in place.

- Quality monitoring visits through site visits to wards or departments across the health economy to obtain additional assurance that safeguarding, Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) are embedded into practice

- NHS Midlands and East have published 'Safeguarding Adults,' a series of prompt cards for staff working in health services. Topics included categories of abuse, information sharing, assessing capacity. These have been distributed widely across the health economy, including GPs and dentists.

- E-learning has been launched in conjunction with the training sub-group. This provides a consistent approach and awareness of safeguarding adults, the Mental Capacity Act 2005 and the DoLS across both health and social care.

- NHS Milton Keynes and Northamptonshire have provided leadership and support across the health economy following the revision of the Prevent strategy in July 2011. The Department of Health has made Prevent a clear priority for healthcare organisations to have policies and procedures in place to protect vulnerable people form being drawn into terrorism

- The Health Providers Forum meets on a quarterly basis and is facilitated by the Professional Lead. Two extraordinary meetings with the Local Authority have taken place during the last year surrounding the integration

of the clinical governance process and safeguarding. A protocol has been developed and there is now a clear process for safeguarding, serious incidents and complaints which involves working in partnership with the Local Authority Safeguarding team.

The DoLS provision is within the Mental Capacity Act 2005 and places a duty on Primary Care Trusts to assess and authorise the deprivation of liberty of patients within hospital settings. Within Northamptonshire DoLS is delivered on behalf of NHS Milton Keynes and Northamptonshire by Northamptonshire County Council. However the Cluster Primary Care Trust retains responsibility for the final authorisation. The Care Quality Commission 2010/2011 report suggests that within the National Health Service, there is still a lack of understanding about the DoLS framework and this is evidenced by the significant under-reporting by hospitals. NHS Milton Keynes and Northamptonshire are working with providers to ensure that awareness and training is provided. Assurance that providers are complying with statutory duties forms part of the SAAF.

With the approval of the Health and Social Care Bill 2012, the statutory supervisory body of DoLS will move from the Cluster Primary Care Trust to the County Council by April 2013.

Priorities for 2012/2013 are:

- Maintain resilience of safeguarding arrangements during a period of significant change and prepare for safe transitions to the new commissioning structure
- Continue to engage with GPs to ensure they are aware of their professional obligations, in order to be Care Quality Commission (CQC) compliant against Outcome Seven
- Ensure that the smooth transition of the Primary Care Trust's responsibilities of the DoLS legislation is transferred to Northamptonshire County Council, but at the same time continue to work with providers to ensure compliance with the Mental Capacity Act 2005 generally
- Review the existing NHS Milton Keynes and Northamptonshire safeguarding strategy in light of the new safeguarding arrangements to include Prevent, domestic abuse and public protection

7.5 East Midlands Ambulance Service NHS Trust (EMAS)

During 2011-2012 there have been a number of key achievements in relation to safeguarding:

- 90% of staff have received safeguarding education for the second consecutive year. 2011/12 focused around the 'Think Family' agenda and additionally included Learning Disability and Dementia education modules. The MCA and Dignity in Care are an integral part of the modules. EMAS NHS Trust has a workforce that has the knowledge, skills and experience to appropriately safeguard patients and the public thereby improving patient safety and staff well being
- The ongoing development of the Learning Disability agenda. There is continuous and progressive stakeholder engagement with much focus on the equality delivery scheme, to ensure reasonable adjustments are made for our service users. In particular the CD ROM and Workbook 'The Ambulance Service and Me' has been very well received.
- Positive review and feedback from the CQC, the SHA and PCT following a CQC inspection and subsequent compliance and assurance visits linked to the completion of the Safeguarding Adult Self Assessment Framework.
- Safeguarding progress and achievements have been showcased at regional events such as the East Midlands Safeguarding Celebration Event in March 2012 and the SHA Launch of the Learning Disability Toolkit in December 2011.
- Expansion of the Team's resources to include a new post, Head of Safeguarding demonstrating the Trust's ongoing commitment to the developing safeguarding agenda.
- Over 411 staff have been recruited as dignity champions and more than 80% of these have direct patient contact.
- Participation in the task and finish group which developed the Safeguarding Adults prompt cards which have been funded and published by NHS Midlands and East.
- Adult Lead completed the first Safeguarding Adults Leadership Programme which is a national pilot.

Priorities for 2012-13 include:

- Review of policy and procedure.
- Signing up to Dementia Action Alliance with action plan/pledge, building on existing achievements.
- Face to face education and supporting communications and resources regarding Domestic Violence and Abuse and Prevent.
- Increased partnership working and awareness raising with staff regarding Mental Health and in particular self harm and suicide.
- Partnership working including with service users and carers.

7.6 Northamptonshire Police

20011/12 has seen considerable development in the world of adult safeguarding. The force has increased its resourcing within this portfolio, appointing a Detective Inspector to oversee Hate Crime, Vulnerable Adults, Missing Persons and the Referral Unit. This post provides continuity in both partnership working and investigation standards. In addition, the Domestic Abuse Unit has also grown to improve the management of high risk offenders and safety provisions for victims, with full recognition of the risk and vulnerabilities within this area of work. The joint working arrangements with the Adult Care Team (ACT) at the County Council have been enhanced, alongside phased plans to improve the in-force referral process and the introduction of adult referrals into the proposed Multi Agency Safeguarding Hub (MASH). All have contributed to an increased awareness and activity aimed at safeguarding.

In the autumn of 2012 the Protecting Vulnerable Persons department is expected to move to the newly-built Criminal Justice Centre where co-location with partners such as the County Council 'Out Of Hours' Team will further positively impact upon safeguarding.

7.7 Kettering General Hospital NHS Foundation Trust (KGH)

KGH has continued to strengthen its work with partner agencies to promote and protect the well-being of vulnerable adults. The Trust is represented on the Safeguarding Adults Board by the Director of Nursing and Quality. The Named Nurse for Safeguarding Adults is a member of two of the Board sub-groups. KGH actively participates in the NHS Northamptonshire Markers of Good Practice Reviews/ Self Assessment and Assurance Framework Reviews and Quality Monitoring Visits. Good progress has been made in all areas - safeguarding adults, mental capacity and deprivation of liberty safeguards.

The Trust has a Safeguarding Adult Committee, chaired by the Director of Nursing and Quality. This is attended by senior staff from across the Trust. Membership also includes the Professional Lead for Safeguarding Adults from NHS Northamptonshire and patient representation is through LINKS. This forum provides direction and has a monitoring function for both adult safeguarding and mental capacity agendas. The group reviews and monitors safeguarding activity in the Trust, including training, and implements actions from investigations and the Safeguarding Board.

Safeguarding adults training is mandatory for all staff at a level appropriate to job role. Training is in a variety of formats including face to face taught sessions and e-learning (level 2) and DVD with information leaflet (Level 1). There has been a considerable focus on training and at the end of March 2012 85% of

staff requiring level 1 training had an up to date competency and 70% of staff requiring level 2 had an up to date competency. This represents a significant improvement. Mental Capacity Act training is also in place and provides staff with an awareness of the MCA and Deprivation of Liberty Safeguards (DoLS) to ensure they have the knowledge and skills to apply the principles and work within the legislation. 62% of staff have undertaken MCA/DoLS training. Training remains a high priority, supported and monitored by the Trust Board.

Awareness of Deprivation of Liberty Safeguards is increasing and KGH have made six urgent authorisations and standard authorisation requests.

There has been a sharp increase in activity in relation to safeguarding referrals. 172 safeguarding adult referrals were made by KGH staff under multiagency procedures. This represents a two fold increase in referrals in comparison to the previous year. This reflects improved knowledge and understanding of safeguarding concerns and the multiagency reporting procedures.

Work to safeguard patients with a learning disability and/or dementia continues to build momentum through the KGH Learning Disability Forum and the Dementia Steering Group. Each ward and department now has a resource folder to support staff caring for patients admitted with these and we have introduced the ability to highlight patients with a learning disability and/or dementia on the patient administration system allowing Matrons an overview of where patients with additional needs are within the Trust. This facilitates a review of care plans to ensure that patients needs are met through enhanced communication and support.

7.8 Northampton General Hospital NHS Trust (NGH)

Northampton General Hospital NHS Trust (the Trust) is committed to protecting the welfare of vulnerable adults and responding promptly when abuse is suspected. In addition the Trust has set its own internal policies for promotion of good practice and training arrangements

GOVERNANCE PROCESSES

Trust Safeguarding of Vulnerable Adults Steering Group

The Safeguarding of Vulnerable Adults Steering Group provides leadership to the Trust on all matters relating to the strategic and operational delivery of safeguarding adults.

Safeguarding Assurance Group

The Safeguarding Assurance Group (SAG) was formed during this financial year to ensure effective management of all Safeguarding of Vulnerable Adult (SOVA) notifications that occur within and are notified against the organisation. SAG ensures that robust systems and processes are in place to support a timely investigation process, monitors outcomes; action plans and ensures lessons learnt are disseminated through other Trust Forums and Groups

CARE QUALITY COMMISSION (CQC) REVIEW OF COMPLIANCE (JUNE 2011)

The CQC made an unannounced visit to the Trust in June 2011 to gain assurance that the Trust was compliant with both the protection of vulnerable adults and other essential standards.

Findings of the Review

Outcome 7A

The Trust was found to be compliant with regard to outcome 7A. The CQC reported that the Trust took allegations of abuse seriously and staff were aware of the appropriate action to take to ensure that patients were protected from harm.

Outcome 4

The CQC did report a minor concern regarding the quality of care experienced by patients who are less able to communicate.

Actions taken by the Trust

In response to the minor concern raised by the CQC in relation to outcome 4, the Head Nurse for Medicine (CQC outcome lead), the Acute Liaison Nurse for Learning Disabilities and the Safeguarding Adult Lead developed an action plan to address this which was reported to the Healthcare Governance Committee. The action plan is now complete and a follow up audit has been undertaken.

Nursing and Midwifery Quality Priorities 2011/2012

The Trust selected “Safeguarding of Vulnerable Adults”, as a Nursing and Midwifery Quality Priority for 2011/2012. The Trust identified the need to improve communication with specific patient groups i.e. between patients with a learning disability and healthcare staff. Improvement leads were identified and they developed tools (care bundles) that have been implemented to enable the Trust to achieve this outcome.

COMMISSIONER REVIEWS

The Trust has participated in NHS Northamptonshire's commissioner reviews during 2011/12. The reviews have demonstrated that NGH has consistently met all its requirements.

Quality Monitoring Visit November 2011

The Trust participated in a monitoring visit undertaken by the PCT safeguarding lead. The PCT reported:

- Strong evidence that staff are taking an active interest and embracing the principles of safeguarding
- Strong evidence that staff are aware of who the safeguarding adults lead is and contacting her on a regular basis for advice and support
- Strong evidence that staff are aware of the Mental Capacity Act and this is considered especially in areas of consent to treatment
- Strong evidence that staff are adopting a holistic approach to patients and involving other agencies when there are concerns, i.e. Police, Inter-agency Safeguarding Team.

SELF ASSESSMENT AND ASSURANCE FRAMEWORK (SAAF)

In October 2011 the Trust undertook a self assessment regarding Safeguarding Adults. The Self Assessment and Assurance Framework (SAAF) provides external assurance to both the Strategic Health Authority and the commissioners. The assessment also gives assurance to the Trust that there is an effective safeguarding process in place.

Self Assessment Review February 2012

- A review of the Trust's self assessment was undertaken jointly by both the Strategic Health Authority and PCT Safeguarding Leads.

The Review Findings

- Effective safeguarding procedures and good interagency partnership working.

- Integration of safeguarding process within existing clinical governance process.

- Effective Leadership for safeguarding from the Director of Nursing as the executive lead.

- Formal tracking system in place for specific patient groups i.e. Patients with a learning disability and dementia.

- Patient tracker system in place which monitors the quality of care and experience received by patients with a learning disability.

- Process in place to review common trends and themes regarding safeguarding referrals against the Trust and take appropriate action when required.

- The Prevent agenda is incorporated into Mandatory safeguarding training.

- Training has shown an improvement in both Safeguarding Adults and Mental Capacity Act training. The Medical Director had supported the induction of both mandatory subjects for all medical staff.

TRUST ACTIVITY DATA 2011/2012

The Trust has a responsibility to protect vulnerable adults from abuse and to report it if it occurs. There has been over 70% increase in safeguarding referrals by the Trust for this year.

Safeguarding Alerts raised by NGH

112 alerts were raised by staff regarding patients within our care, 84 required full investigations.

Safeguarding Alerts raised against NGH

During the same period there have been 23 alerts raised against NGH. The alerts include referrals made by the Trust regarding safeguarding allegations within the Trust.

5 of the safeguarding alerts raised against the Trust were upheld, the remaining 18 were unfounded.

LESSONS LEARNT SOVA RASIED AGAINST THE TRUST

Through the alerts raised against the Trust recurrent themes have been identified in relation to patient care.

Common Themes Identified:

Discharge

The alerts highlighted that the Trust didn't always communicate relevant information regarding a patient's discharge The Trust has formed a discharge group which has been tasked with looking at the discharge pathways for both elective and emergency patients. The remit of the group included the concerns that have been raised through the alerts.

Pressure Ulcers

The Trust has identified that initial assessment regarding the condition of the patients skin or pressure areas are not always documented. An improvement plan has been launched to reduce pressure ulcers within the Trust to zero by December 2012. Part of this project includes the development of assessment and standards of documentation on admission. This will also provide evidence regarding a patient condition on admission if the Trust is required to investigate any safeguarding concerns.

Mental Capacity Act and Deprivation of Liberty 2010/2011

The Trust has applied on 3 occasions for authorisation to deprive a patient of their liberty under the Mental Capacity Act. The Trust was granted both urgent and standard authorisation for the two patients. The third application was not granted as through assessment it was found that there was sufficient care planning and procedures in place.

SERIOUS INCIDENT AND SAFEGUARDING

The Trust had been involved in a serious incident which related to safeguarding during the year 2011/2012.

The incident involved the care and treatment of a patient with moderate learning disabilities.

Action Plan

An action plan in relation to the recommendations from the Serious Incident report has been produced and all actions have been implemented within the Trust. Regular updates on actions taken and implementation have been made through the Safeguarding of Vulnerable Adults Steering Group.

PATIENTS WITH A LEARNING DISABILITY

The Trust has recognised the importance of ensuring that they provide accessible and equitable healthcare to patients with a Learning Disability.

Acute Liaison Learning Disability Nurse

Since August 2011, the Trust has contributed half of the costs of the Learning Disability Liaison Nurse to enable the post to be full time. This has resulted in access to expertise and enabled a programme of strategic developments to be put in place.

PATIENTS WITH DEMENTIA

The Trust's multi-disciplinary Dementia Care Action Committee was established in February 2011 with the agreed aim to improve the experience of patients with dementia and the quality of their care while at NGH. The Committee developed a comprehensive action plan based on national and local strategies and have met monthly to deliver the plan. The Committee have developed a detailed action plan for 2012/13 to embed and build on the achievements to date

EDUCATION & TRAINING

The SOVA Lead provides the following training within the Trust in conjunction with the Training and Development Department.

Safeguarding Adults

Level 1

This training is mandatory for all staff. During 2011/2012 **98.31%** of staff received Level 1 SOVA training.

Level 2

Level 2 safeguarding training is a mandatory training requirement for specific staff groups. During 2011/2012 **110%** of all staff received Level 2 SOVA training.

Level 3

5 members of the senior nursing staff who are involved in conducting SOVA investigations have received Level 3 training.

Mental Capacity Act (MCA) Training

Training is offered to specific staff groups. During 2011/2012 **139.36%** of staff received Mental Capacity Act training.

Prevent Training

In order for the Prevent agenda to be addressed in health the Home Office and the Department of Health have devised a training programme for staff (Health Wrap).

A training plan has been devised for the delivery of Prevent WRAP training and **17.6%** of staff who require training have been trained to date. Prevent awareness training commenced in February 2012 and is being presented within all Safeguarding Adults training sessions as a matter of course.

TRUST PRIORITIES 2012/2013

The Trust is committed to protecting all vulnerable people from abuse and in line with the Northamptonshire Safeguarding Vulnerable Adults Board's charter and strategic plan (2010-2112), the Trust will be addressing the following priorities within 2012/2013:

1. Fully implement the Prevent Agenda through training and policy within the Trust by year end.

2. Investigate whether an electronic system for identifying vulnerable patient groups could be implemented.

3. Further integrate the process for managing and learning from safeguarding incidents and serious incidents within the Trust's clinical governance structure.

4. Increase the use of the Hospital Passport for vulnerable groups as monitored through the ward based dashboard and LD Audit Programme.

5. Monitor and record patient experience within the Safeguarding process on a quarterly basis within the Trust.

6. Ensure safeguarding and MCA training levels meet Trust targets throughout the year, and implement the SOVA competency framework in all ward areas.

7. Introduce a process for clinical supervision for staff involved in safeguarding adult incidents by July 2012.

8. Improve the induction process for temporary staff by June 2012 and audit quarterly.

7.9 Northamptonshire Healthcare NHS Foundation Trust (NHFT)

On the 1st July 2011 the Northamptonshire Provider Service (NPS) amalgamated with NHFT and the Terms of Reference and membership of the Trust Safeguarding Group has undergone review. Now the two organisations have merged the safeguarding teams have met and a structure has been developed to ensure the safety needs of the service users, families, local community and the Trust are fulfilled. Within the Team there is a designated Senior Matron for Public Protection whom is responsible for delivering the PREVENT agenda, raising allegations and domestic violence. This role provides support to clients and staff within the organisation and has an interface between different agencies.

Safeguarding training is available within NHFT in a variety of formats including face to face, E Learning and an information leaflet. Level 2 Safeguarding Adults Training is mandatory for all staff working at Band 5 or above. All staff receives safeguarding training level 2 at Induction.

The Safeguarding function of the organisation is directed and monitored by the Trust Safeguarding Group. The Group meets monthly and has set agenda items to discuss issues such as performance using the Self Assurance Assessment Framework (SAAF), Audit, HR issues and training.

The safeguarding agenda continues to gather pace and NHFT continues to support the local safeguarding agenda for Adults. There are always opportunities to improve and develop and the Safeguarding Team strives to ensure this takes place. The transfer of NPS to NHFT has gone smoothly so far with opportunities now to deliver a more integrated and responsive safeguarding service for Adults.

7.10 Northamptonshire Association of Registered Care Homes (NORARCH)

NORARCH represents a section of the independent care home sector. Members report that they are becoming more accustomed to the safeguarding process and describe it now as a more constructive experience. Representing NORARCH on the Safeguarding Board has highlighted that keeping vulnerable adults from harm involves much wider issues than that experienced within the boundaries of the care home sector and we have benefitted from exposure to this.

7.11 Northamptonshire Fire and Rescue Service (NFRS)

Northamptonshire Fire and Rescue Service take safeguarding responsibilities seriously and protecting the community is important to us. Our people, the community, diversity and continuous improvement are at the heart of our core values.

We have trained our staff on safeguarding and the key responsibilities, as we value continuous improvement as a core value we have undertaken an audit of our safeguarding practice. This has identified areas for improvement and so we have action plans in place to make those further improvements.

Our plans for 2012/13 will include continuation of training on safeguarding and referrals, continuous improvement to the recording of the referrals made and continued improvement of the robust feedback mechanisms.

7.12 Multi Agency Public Protection Arrangements (MAPPA)

This year has seen steady progress in the strategic and operational links between SOVA and Northamptonshire Probation Trust. The partnerships have been enhanced with regular participation from managers participating and making valuable contributions to the Northamptonshire Multi Agency Public Protection arrangements (MAPPA).

Managers and practitioners from Safeguarding vulnerable adult teams have participated in multi agency training events on MAPPA throughout the year. This has led to a greater understanding of the role of the criminal justice agencies which in turn has enabled closer working relationships between agencies.

There have been a number of cases managed under both MAPPA arrangements and within Northamptonshire Probation Trust where the active participation of staff from Adult Social Care has made a key contribution to dynamic risk management of offenders. This has been evidenced on the MAPPA level 3 panels and at MAPPA level 2 meetings with considerable success when the skill knowledge and expertise of Adult Social care has played a significant part in risk management arrangements.

In 2012 - 13 we anticipate building further on the partnerships between the agencies as the understanding of Safeguarding Vulnerable Adults is translated into active multi agency cooperation in this key agenda.

7.13 Northamptonshire Local Involvement Network (LINk)

Northamptonshire Local Involvement Network (LINk) has sought to become more involved in the SOVA Board during 2011/12 and would wish to continue through 2012/13 in order to promote the community voice, but equally to raise awareness of the risks of abuse and mistreatment of vulnerable adults in the community.

Northamptonshire LINk promotes awareness of safeguarding and particularly in the inspections of care homes, also on ward inspections in our acute hospitals, but also in areas of social care out in the community. The information from the Safeguarding Board helps us understand the potential risks and the challenges many people have and how these vulnerable persons, carers and families should they come to LINk for advice and sign-posting.

During 2011/12 the Safeguarding Board has remained focused, cohesive and integrated at a time of great changes in the NHS and local government, when many organisations are splintering. Maintaining partnership working and bringing in contributions from GP Consortia would seem one of the major challenges ahead.

There is also a need to increase awareness of safeguarding in the new locality management structures of the Northamptonshire Healthcare NHS Foundation Trust (NHfT), as the 8/9 new locality managers will play an important role in community health.

Finally, despite acute funding pressures, it would still be beneficial to have a publicity campaign targeted at and through GPs/surgeries, community centres, community nursing teams, care homes, etc to increase safeguarding awareness.

7.14 St Andrew's Healthcare

St Andrew's Healthcare continues to provide mental health care for vulnerable adults and young people from anywhere in the country.

Currently the Charity has 4 sites, Essex, Mansfield, Birmingham and Northampton. At the time of this report the Charity provides 763 patients with treatment and care in a range of medium, low secure, locked and open wards. Specialist services of brain injury, Huntingdon's disease, older person care, dementia, deaf service and learning disabilities are available across all sites.

The Charity is working towards more service user involvement, recovery models of care and improvements in quality and compliance but underpinning all of the work with service users are the shared drivers of keeping service users safe and preventing exploitation of these vulnerable people.

During the year 2011 – 2012 the Charity has seen a number of organisational changes that demonstrate the commitment to improving the Governance structures of the central team supporting the divisional teams involved directly in ‘patient care’.

During the time of re-organisation the ward based teams have continued to support and protect service users who continue to exhibit challenging behaviours. The Nursing and Social Worker teams identify incidents on a daily basis and modify plans and protection plans to reduce the risk of further incidents.

Whilst all units have the potential to have periods of high levels of safeguarding incidents, evidence shows that the female admission units and the adult brain injury units have the highest level of physical aggression between each other whilst the units providing care for the elderly service users are more likely to have incidents of aggression towards staff.

There continues to be a number of allegations made by service users about staff. All of these are investigated whilst service users are supported by the advocacy or complaints service. A future piece of work is to look at the trends that arise from these types of safeguarding events.

Teams are working with multi-agency colleagues both in Northampton and beyond as part of their daily routine but this year has seen an excellent piece of multi-agency working between staff in the Women’s service, Men’s service and Northampton Maternity Unit. The pregnancy of the female service user involved staff in ‘care of the unborn’ safeguarding procedures, safe pregnancy, delivery and agreed transfer of care of the baby. The conclusion of this piece of work was recognised by both hospitals as an excellent example of ‘joined up working’.

St Andrew’s has successfully hosted visits from Tracy Keats, Safeguarding Adults Lead for NHS Milton Keynes and Northamptonshire, to the Men’s Service and the Women’s service with compliance visits to other areas on the Northampton site planned during the next 6 months.

The new governance structure includes safeguarding within the Safety Team, with a Safeguarding Lead responsible for overseeing all safeguarding across the Charity working with Social Care and Nursing teams. This central role ensures that the safeguarding agenda within the Charity is working in conjunction with the complaints process and Serious Untoward Incident (SUI) process and that safeguarding overall is monitored by senior staff.

The Care Quality Commission (CQC) has made a number of announced and unannounced visits to the Charity paying particular attention to seclusion and

prolonged segregation on the Northampton site. The Charity continues to inform the CQC of all safeguarding incidents across all sites.

The challenges for this year are:

- to create improved cohesion between Charity based services and community colleagues,
- to improve the quality of reporting internally and externally,
- to demonstrate 'joined up working' between Serious Incidents (SI), Complaints and Safeguarding processes.

Common Themes and Local Priorities for 2012/2013

Common work themes and local priority areas for attention by agencies during the year, arising from the Board development day, will be around:

- Reviewing policy and procedures
- Developing a Quality Assurance framework
- Focus on experience and outcomes for people
- Further developing Users and Carers group
- Involve users in training
- Develop an inclusive SOVA Board
- Connect with other partnerships
- Review roles and functions of the sub-groups
- Review all training provided by stakeholders
- Develop training programme
- Deliver effective training efficiently
- Develop communications strategy

The absence of a published Board work plan for 2012/13 and beyond was discussed as a matter of priority at the Board development day.

8 SAFEGUARDING ACTIVITY DATA 2011/12

8.1 Safeguarding referral rates have risen sharply over the last 5 years: 436 (07/08); 638 (08/09); 1749 (09/10); 2403 (10/11) and to 3216 from 1 April 2011 to 31 March 2012. The ongoing impact of local and national coverage of high profile cases as well as improved recognition and reporting of safeguarding situations through more staff being trained has led to even greater awareness and confidence to refer.

8.2 Safeguarding Adults activity April 2011 to March 2012

During the year April 2011 to March 2012 there were a total of **3216** notifications (referrals) into the Safeguarding Adults Team.

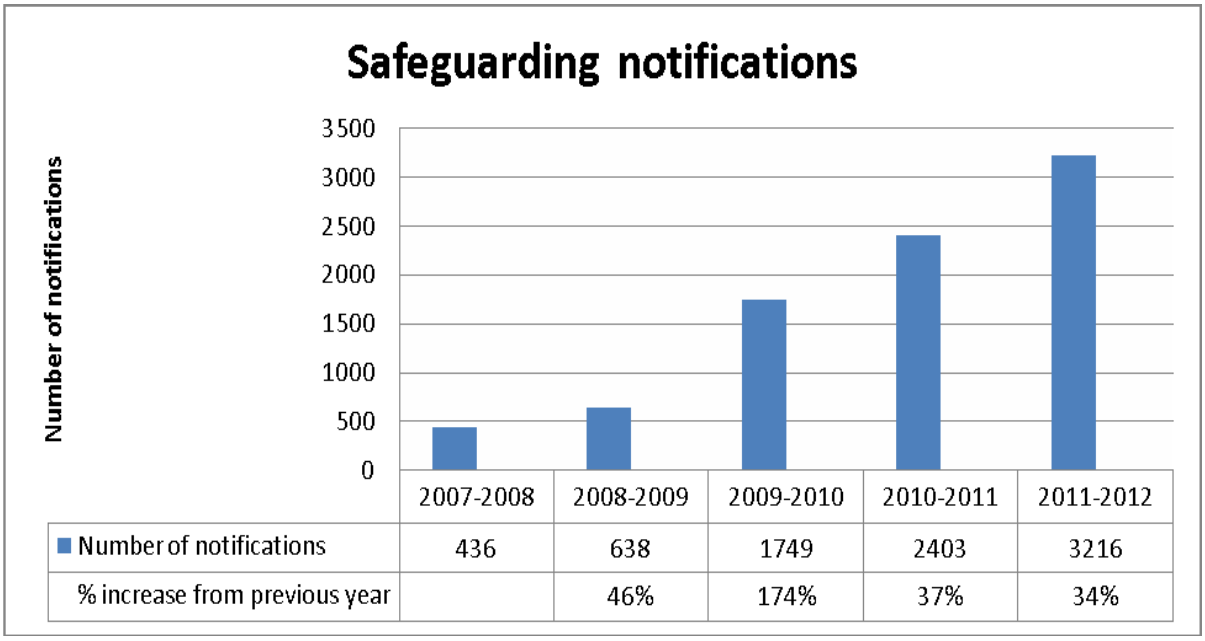
The average number of notifications received in **2011/12 per month was 268.** This is an annual increase of 34**%** from last year where the average monthly notifications received were 200. The table below shows the breakdown by month in 2011/12.

Average number of notifications received by month in 2011/12:

Month	**Number of Notifications**
April 2011	188
May 2011	201
June 2011	266
July 2011	224
August 2011	289
September 2011	224
October 2011	266
November 2011	314
December 2011	299
January 2012	293
February 2012	302
March 2012	350
Total	**3216**

Safeguarding concerns (notifications) are reported to Northamptonshire County Council's Customer Service Centre (0300 126 1000). All concerns receive an initial check by the Adult Care Team and are then fast tracked to the central Safeguarding Team where they will be screened within 24 hours. The Safeguarding Team Duty Officer, known as the 'Case Lead', will then apply the risk matrix and determine at what level of the safeguarding thresholds the notification should be progressed and by whom.

The table below demonstrates the increase in notifications over the past five years:

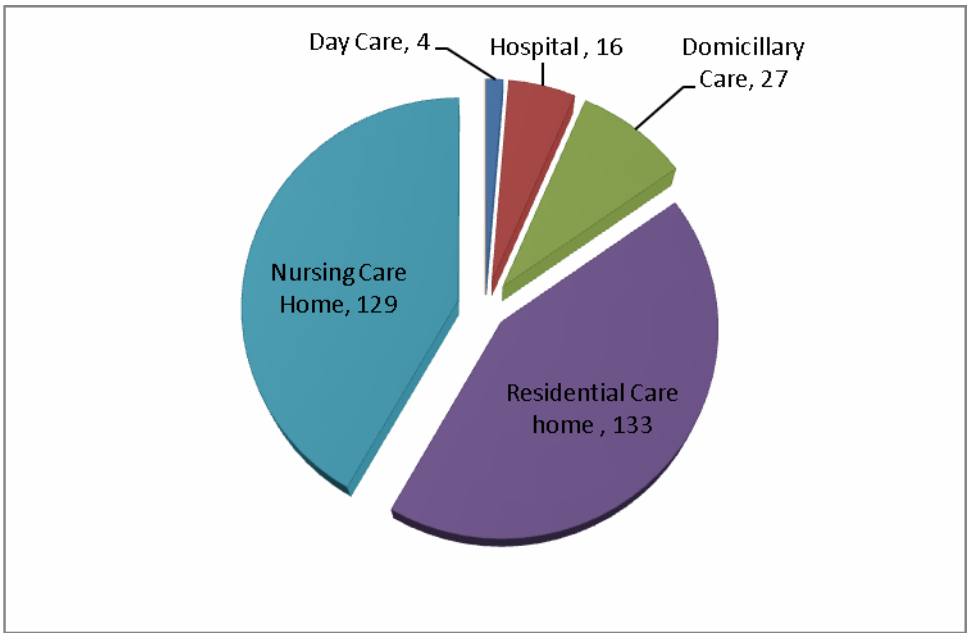


	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012
Number of notifications	436	638	1749	2403	3216
% increase from previous year		46%	174%	37%	34%

During the period 2011/12 there was a **very slight decrease in the percentage of overall referrals** about actual or suspected adult abuse or neglect compared to 2010/11. Nevertheless this still resulted in an increase of 813 referrals compared to the previous year.

All agencies have raised their response levels and introduced mechanisms to continue to meet the ongoing challenge of identifying and responding to the need to safeguard vulnerable adults from abuse and neglect.

Numbers of Referrals on Institutional Safeguarding Concerns

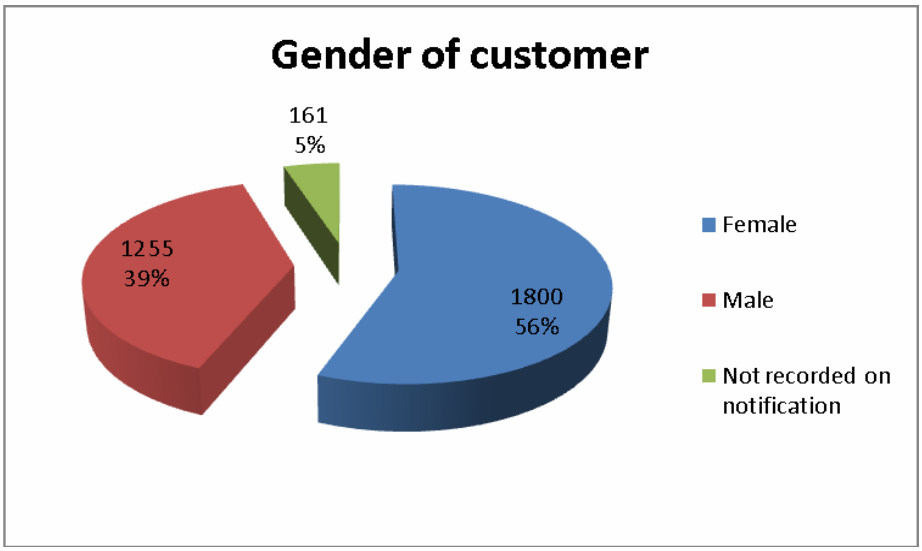


Institutional Referrals	Number
Day Care	4
Hospital	16
Domiciliary Care	27
Residential Care home	133
Nursing Care Home	129
Total	**309**

This chart shows the numbers of Institutional referrals received in 2011/12. The description of 'Institutional abuse' is taken from the 'No Secrets" (2000) guidance (Section 2.9): "neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as **institutional abuse**".

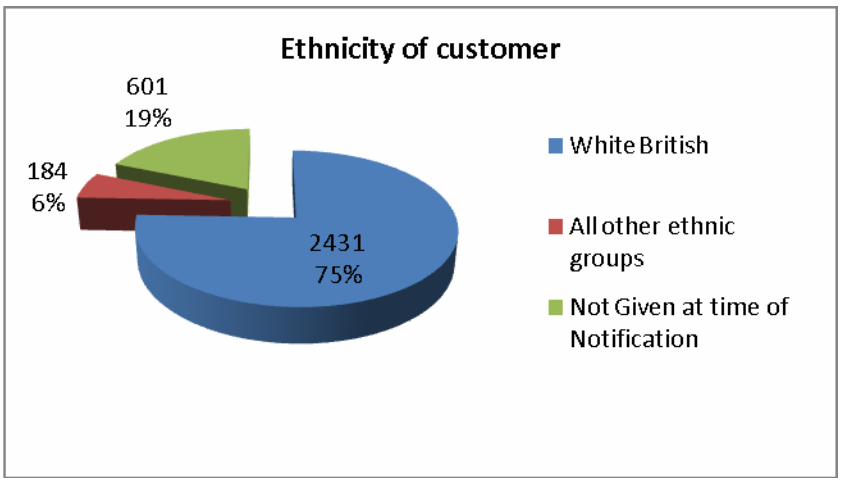
The fact that abuse has been alleged within a registered service does not in itself constitute institutional abuse. However, the possibility of institutional abuse is considered where referrals are numerous and /or involve multiple residents and / or staff members. A total of 172 referrals were the subject of such safeguarding investigations during 2011/12. These incidents varied from poor and unsatisfactory practice to more large scale concerns.

The Alleged Victim

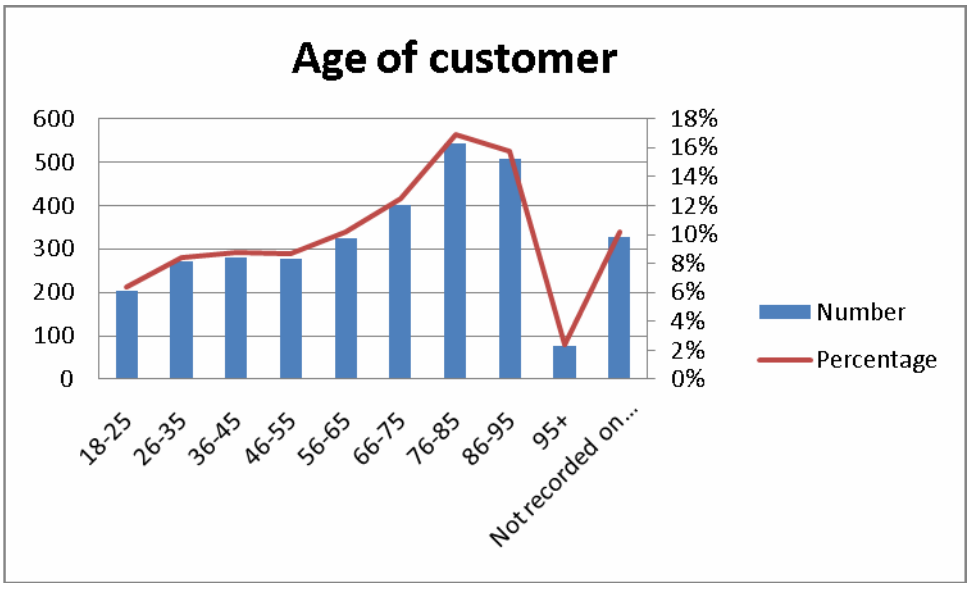


The split percentage of notifications by gender has remained virtually unchanged from last year. Referrals on females are exactly the same but overall notifications have increased by 446 compared to 2010/11. Notifications on males are down by 4% which is an increase of 232.

Overall, the numbers of victims reported reflect the split of males and females in receipt of community care services. The majority of referrals relate to people either in their own homes or within a residential or nursing care setting.

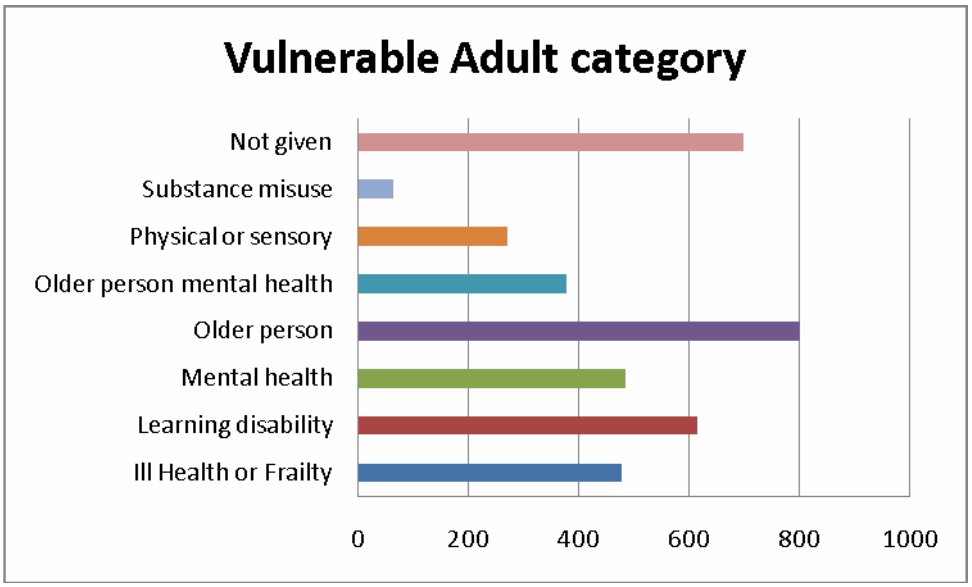


The above chart demonstrates an increase of 7% in the number of reported victims with a White British ethnicity (75%) but with an overall increase of 801 notifications in the past year. The reporting of all other ethnic groups has decreased by 1% with an overall total 184 notifications being received this year. However, it continues to be acknowledged that there is no data to demonstrate that black and ethnic minority groups are being better reached and therefore demand may continue to remain hidden. 19% of all the notifications had no recorded ethnicity which impacts on accurate analysis.



Age Range	Number	Percentage
18-25	204	6%
26-35	270	8%
36-45	281	9%
46-55	278	9%
56-65	326	10%
66-75	402	13%
76-85	544	17%
86-95	507	16%
95+	76	2%
Not recorded on notification	328	10%
Total	**3216**	**100%**

This year's figures show the spread in the age range of alleged victims reported has remained constant with only a slight variation of 1% either way. 42% of victims are within the 18 – 65 age range and this reflects the increase in the number of community referrals of people living in their own homes from 947 in 2010/11 to 1359 in 2011/12. For the first time in three years the figure for people over the age of 65 has reduced by 4% overall with the main increase occuring in the 66 – 75 age range, up from 272 in 2010//11 to 402 reported in 2011/12. The highest reported age range 76 – 85 years remains unchanged.



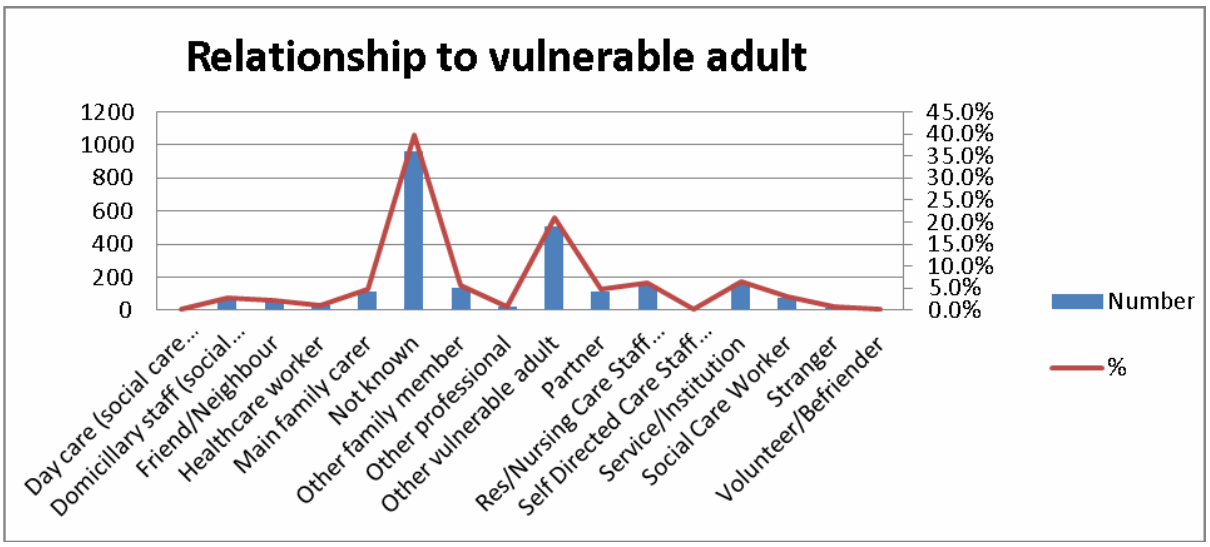
Vulnerable Adult Category	Number	%
Ill Health or Frailty	478	13%
Learning disability	614	16%
Mental health	485	13%
Older person	801	21%
Older person mental health	378	10%
Physical or sensory	270	7%
Substance misuse	64	2%
Not given	698	18%
Total	3788	100%

Nationally, figures indicate that older people are often the most vulnerable, closely followed by people with a Learning Disability. Figures reported for 2011/12 show the trend is similar within Northamptonshire. Whilst the percentage for older people has remained unchanged at 21%, the figures have increased from 598 in 2010/11 to 801 for 2011/12. The figures reported for people with a Learning Disability have increased by 100% in the past three years from 317 during 2009/10 to 614 for 2011/12.

The figures for older people with mental health have risen a further 2% from last year. Older people with mental health issues are clearly a very vulnerable group and feature in many of the large scale, complex or institutional safeguarding investigations conducted throughout the past year. We have also seen a 3% rise in notifications of vulnerable adults who are under 65 with either a learning disability or mental health problems.

The numbers referred to above include alleged victims who fall into more than one vulnerable adult category. It is a concern that the numbers of vulnerable adults referred for whom no vulnerable adult category was provided on referral has risen by approximately 10% this year.

The Alleged Perpetrator



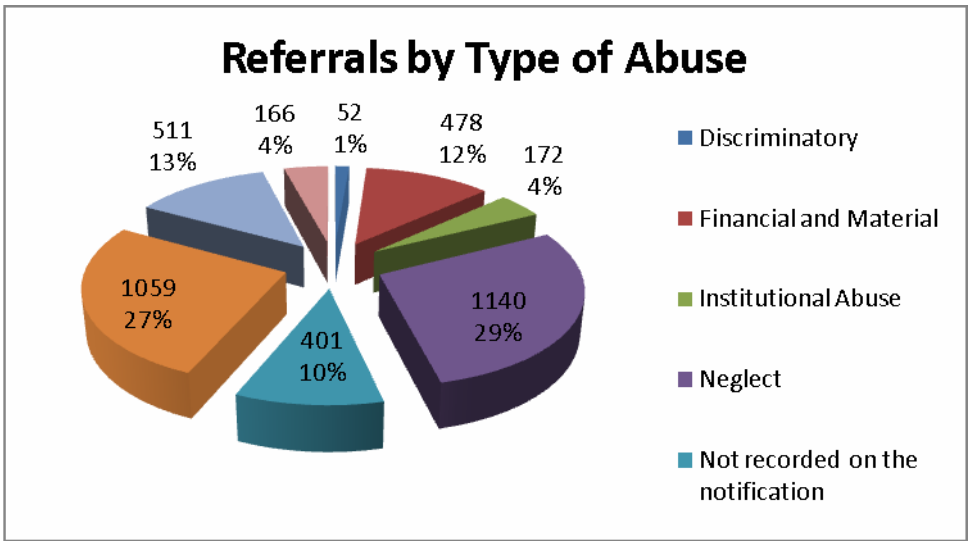
Relationship to Vulnerable Adult	Number	%
Day care (social care workers)	2	0.1%
Domiciliary staff (social care workers)	70	2.9%
Friend/Neighbour	56	2.3%
Healthcare worker	27	1.1%
Main family carer	114	4.7%
Not known	959	39.8%
Other family member	136	5.6%
Other professional	21	0.9%
Other vulnerable adult	506	21%
Partner	112	4.6%
Res/Nursing Care Staff (Social Care Worker)	152	6.3%
Self Directed Care Staff (Social Care Worker)	6	0.2%
Service/Institution	156	6.5%
Social Care Worker	75	3.1%
Stranger	16	0.7%
Volunteer/ Befriender	2	0.1%
Total:	2410	100%

With nearly 40% of this data not recorded on notification forms (SA1), it makes it difficult to draw any real comparisons to previous years. From the data available, the number of people placed in a position of trust as a “paid carer “and deemed to be an alleged perpetrator has decreased by 10% during this period from 31% in 2010/11 to 22%

The second highest reported figure of 20% relates to alleged perpetrators who are also deemed to be “vulnerable adults” and under the age of 65 with often challenging and/or complex needs, the majority living in a residential care setting. This can be a controversial issue as a proportion of the outcomes to these investigations show that the root cause relates to staffing, training and the lack of care planning by the provider.

18% of the total involves partners, main family carer, relatives, family friend and neighbours. This is a decrease of 4% but not an accurate reflection given an increase in allegations of abuse concerning people living in their own homes.

The Abuse



Type of Abuse	Number	%
Discriminatory	52	1%
Financial and Material	478	12%
Institutional Abuse	172	4%
Neglect	1140	29%
Not recorded on the notification	401	10%
Physical	1059	27%
Psychological	511	13%
Sexual	166	4%
Total:	3979	100%

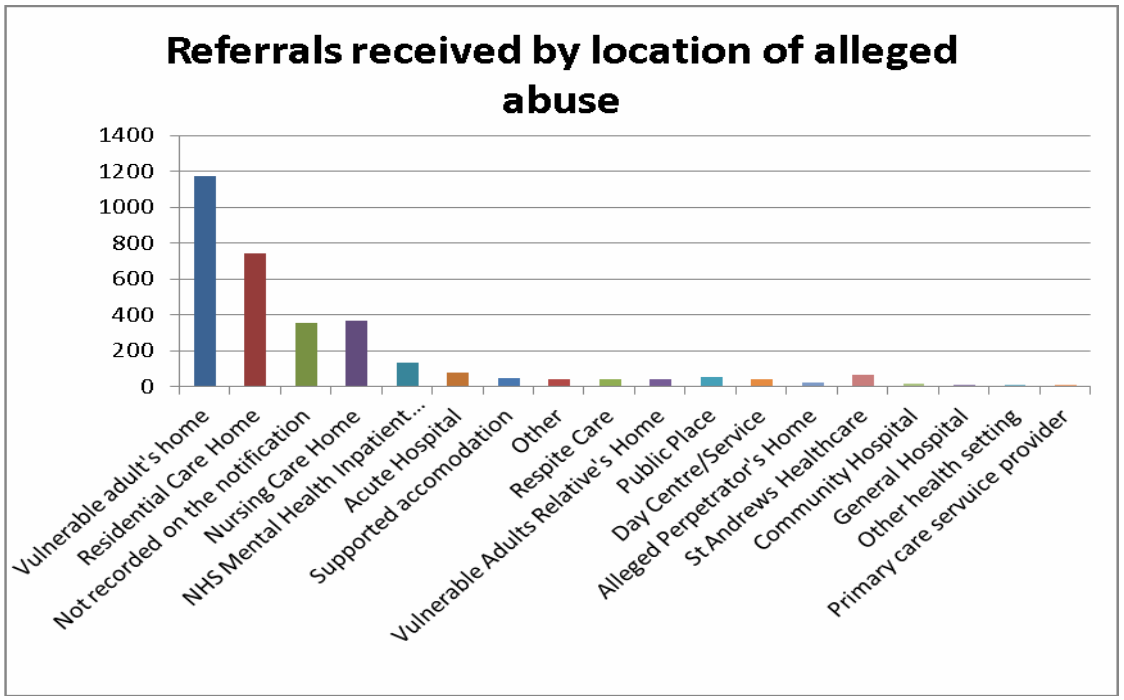
This chart shows that neglect and acts of omission were the most common form of abuse reported and increased by 2% from 807 referrals in 2010/11 to 1140 in 2011/12.

The safeguarding concerns regarding neglect include, for example, skin integrity, pressure ulcer care, nutrition and medication management

This is closely followed by physical abuse which has decreased by 1% but nevertheless has seen an increase of referrals from 848 in 2010/11 to 1059.

Whilst this figure gives cause for concern, many of the referrals come directly from Independent Providers which indicates that they are aware of the safeguarding process and the requirement to report safeguarding events and concerns. It also demonstrates that the ongoing assessment of risk and the management of care plans remains a challenge.

The Location

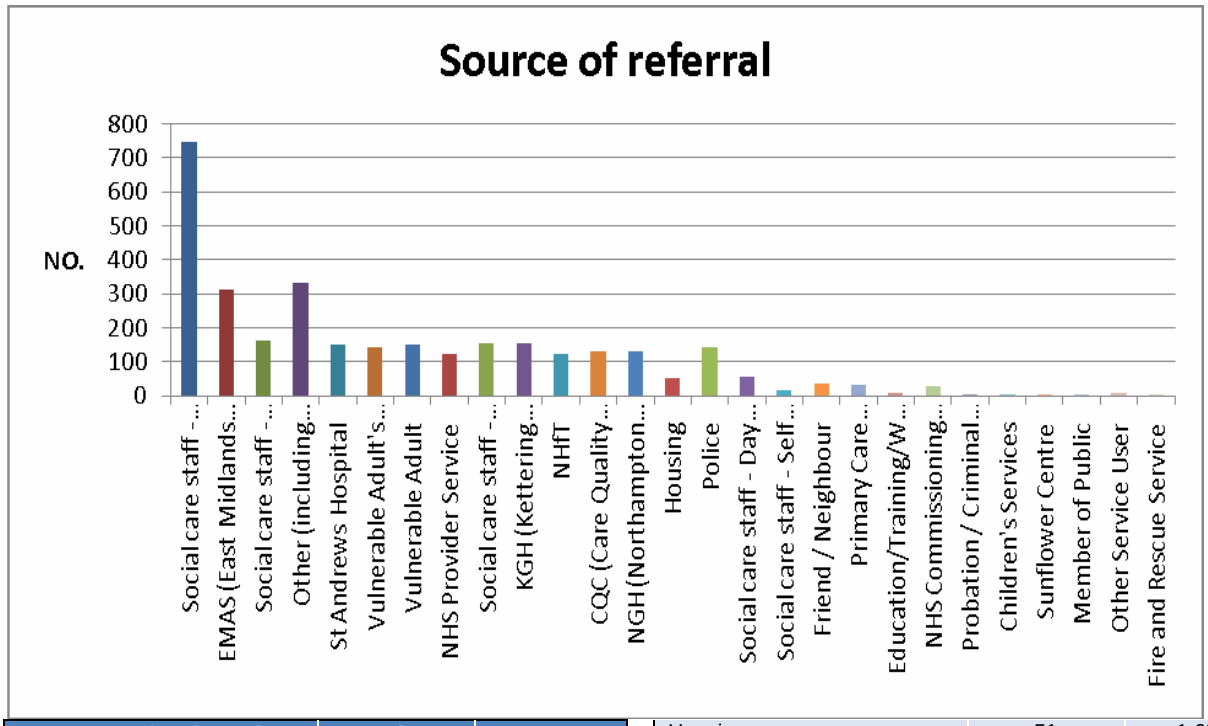


Location of Alleged Abuse	Numbers	%
Vulnerable adult's home	1175	36.5%
Residential care home	741	23.0%
Not recorded on notification	354	11.0%
Nursing care home	369	11.5%
Supported accommodation	44	1.4%
Other	41	1.3%
Respite care	43	1.3%
Vulnerable adult's relatives home	41	1.3%
Public place	51	1.6%
Day centre / service	41	1.3%
Alleged perpetrator's home	23	0.7%
Community Hospital	13	0.4%
Acute Hospital	79	2.5%
St Andrews Hospital	62	1.9%
NHS mental health inpatient setting	133	4.1%
General Hospital	1	0.0%
Other Health Setting	3	0.1%
Primary Care Service Provider	2	0.1%
Total:	**3216**	**100%**

The numbers of notifications relating to people in their own homes has increased significantly in the past three years, with referrals rising from 395 in 2009/10 to 1175 in 2011/12. This can be attributed to increased review activity and reporting mechanisms being in place, such as within EMAS, NHFT and domiciliary care services. All people, in every walk of life, whether in the course of their private or professional life, must remain alert to vulnerable adults who may be at risk of abuse and report it accordingly.

The second highest number of notifications continues to come from residential and nursing care settings, although the overall percentage has reduced from 49% in 2010/11 to 36% during this period. Key themes which emerge from these investigations point to poor leadership and/or inadequate management as well as the lack of training for staff.

The Process



Source of referral	Number	%
Social care staff – res/nursing care staff	746	23.2%
EMAS (East Midlands Ambulance Service	313	9.7%
Social care staff – Social Worker / Care Manager	164	5.1%
Other (Including Anon/NK) Not known	331	10.3%
St Andrews Hospital	150	4.7%
Vulnerable Adult's family	143	4.5%
Vulnerable Adult	152	4.7%
NHS provider service	124	3.9%
Social care staff – domiciliary staff	156	4.9%
KGH (Kettering General Hospital)	156	4.9%
NHfT	125	3.9%
CQC (Care Quality Commission)	130	4.0%
NGH (Northampton General Hospital)	130	4.0%
Housing	51	1.6%
Police	144	4.5%
Social Care Staff – Day care staff	58	1.8%
Social Care Staff – Self directed care staff	17	0.5%
Friend / neighbour	36	1.1%
Primary care (Including GP)	31	1.0%
Education / Training / Workplace Establishment	8	0.2%
NHS Commissioning Service	29	0.9%
Probation / Criminal Justice / MAPPA	4	0.1%
Children's Services	3	0.1%
Sunflower Centre	1	0.0%
Member of public	1	0.0%
Other Service User	11	0.3%
Fire and Rescue Service	2	0.1%
Total	**3216**	**100%**

The main sources of referral remain largely unchanged from the last two years with the highest number of notifications being received from registered and provider services. Some of the Health providers have merged part-way through the year as a result of reorganisation but have continued to be reported separately during this period. EMAS referrals have increased by a further 2% from 200 in 2010/11 to 313 in 2011/12. Many of their referrals are not ultimately shown to be concerns about adult abuse and do not fit the safeguarding criteria but rather relate to vulnerable people in crisis who have either been unable or unwilling to contact the appropriate support services and have dialled 999. Numbers of referrals from the police have increased by a further 2.5% in this period rising to a total 144.

It should continue to be noted that, unlike many other areas, Northamptonshire has a large private mental health provider i.e. St Andrews Healthcare, which caters for individuals with complex and challenging needs, which may skew the data profile for the county.

Outcome of investigation

Outcomes	Numbers	%
Investigations:		
Substantiated	265	8.2%
Partially Substantiated	115	3.6%
Not determined / inconclusive	238	7.4%
Not substantiated	308	9.6%
Investigations subtotal	**926**	**28.8%**
NFA at initial screening*:		
NFA Not safeguarding issue	501	15.6%
Not threshold for investigation	106	3.3%
Care Management assessment required	168	5.2%
Review required	40	1.2%
Vulnerable Adult	115	3.6%
Level 2**	475	14.8%
Complaint	7	0.2%
Other LA / PCT Case	18	0.6%
Police	72	2.2%
Family Supporting	6	0.2%
Other Service Supporting	86	2.7%
Resolved Subtotal	**1594**	**49.6%**
Open investigations as at 31/03/12:		
Open to Safeguarding Team	183	5.6%
Open to external teams (Incl. Commissioning)	363	11.3%
Open to NCC locality teams	150	4.7%
Open Subtotal	**696**	**21.6%**
Total:	3216	100.0%

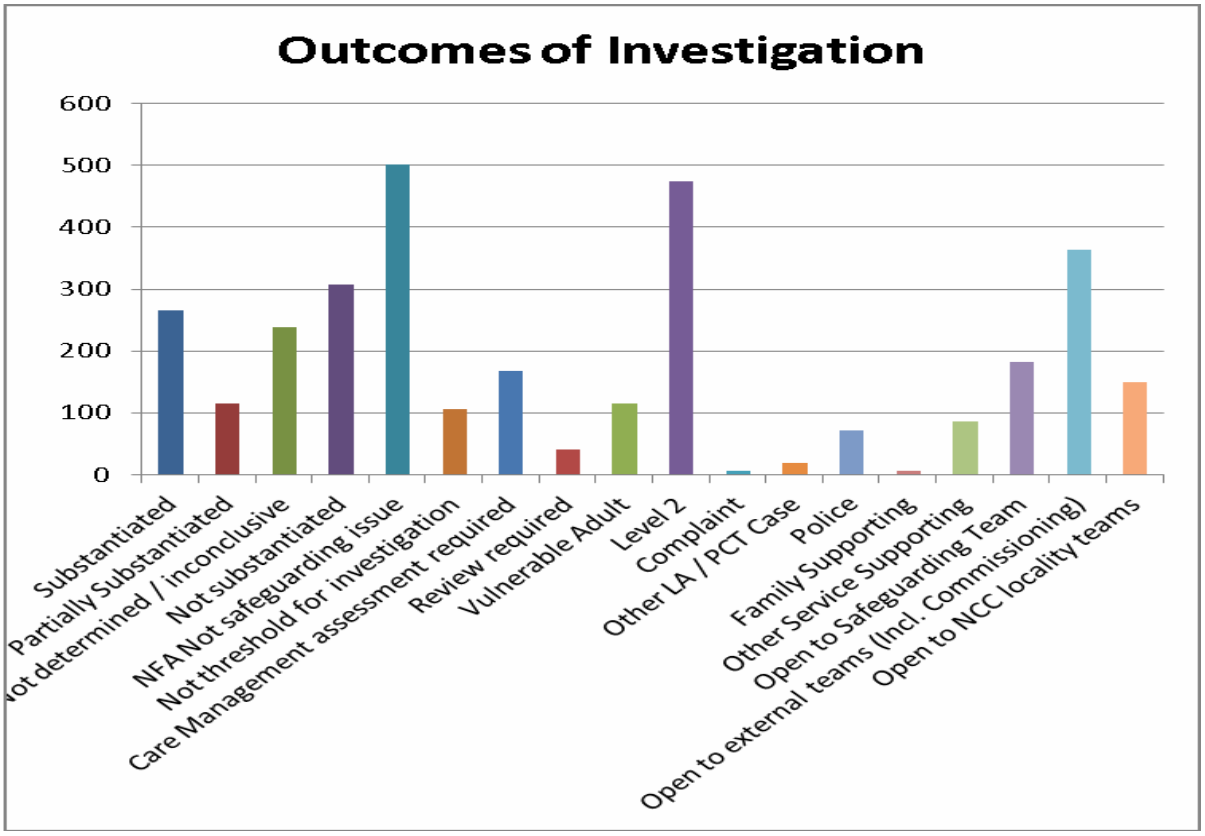
* NFA means no further action is required by the Safeguarding Team but may be required by another service or agency.

** Level 2 case means that this is a safeguarding concern but one which does not require further investigation under the inter-agency procedures. This is because, at initial screening, it is deemed to be a low level safeguarding concern, with minimal risk or an isolated incident of low harm which can be or has already been appropriately addressed by a single agency approach. Therefore it is for no further action by the Safeguarding Team.

The information on the above table and the graph below refer to the outcomes of the investigations into the 3216 safeguarding notifications received by the Safeguarding Adults Team in 2011/12. It should be noted that some of these were for situations presented as “institutional” concerns and others were repeat/duplicate notifications about the same person (524).

Outcomes were concluded on 2520 notifications (approx 79%). Approximately 21% of safeguarding referrals made up to 31 March 2012 are yet to be concluded. This is consistent with the likely timing of those notifications which may have been made towards the end of the year or where more lengthy and complex situations have yet to be concluded. Just under 12% of all safeguarding investigations were concluded as substantiated or partially substantiated.

Just over 49% of all referrals have required no further action by the Safeguarding Team but in the majority of cases have been referred on to other appropriate teams, services or agencies for input, action or monitoring e.g. Commissioning monitoring, complaint investigation, review, community care assessment. This has gone a long way to ensure that the stretched resources of the Safeguarding Adults Team are reserved for the most serious and complex situations and that the response is proportionate. The percentage of "no further actions" remains unchanged at 15% which equates to 501 referrals.



8.3 Summary of Safeguarding Activity

Again, this year we have seen a further rise in safeguarding referrals. Broadly speaking, the analysis of the data shows that there is little change in the trends compared to 2010/11 with the exception of the reported location for the alleged abuse. This could be attributed to a number of factors, increased awareness within the community itself coupled with the increased review and monitioring activity referred to earlier in the section.

Further work is required on business processes and to improve data collection and data entry. Lack of data provision remains a feature throughout all of the safeguarding data activity reporting sections and is still an important message which needs to go out to everyone in the process.

We have yet to achieve the transfer to a single, reliable database which meets the expectations and reporting requirements of all agencies. Two databases remain in use which increases the potential for loss, duplication and inaccuracy. The business support capacity within the central team has been increased to mitigate some of the data issues.

Mental Capacity Act

There has been a greater requirement to record consideration of mental capacity as well as demonstration that the Mental Capacity Act is being applied more regularly. However, despite much work being done across agencies to increase this knowledge and promote the usage of mental capacity assessments at the earliest stages of any health or social care assessment, there remains a need to continue to promote and train all staff in the benefits of and application of the legislation to protect the rights of vulnerable individuals.

Safeguarding Awareness

The further rise in safeguarding referrals during 2011/12 and the fact that the main sources of referrals have remained largely unchanged, demonstrate that there is a continued high awareness within social care and health professionals and among provider services of the need to make safeguarding referrals. It is evident from this year's data that the fairly even split between referrals which went forward for investigation and those which did not, would benefit from further analysis of whether a broader, preventative approach (Big Society) would have had an earlier and beneficial impact. Further work needs to be done to ensure that a similar level of awareness and confidence to refer exists within the general public, hard-to-reach groups and wider communities.

All agencies involved in broader prevention strategies also need to help to spread the safeguarding message.

Vulnerable Adults

The local authority has increased its staff capacity at the 'front door' in order to respond appropriately to the rising numbers of adults, considered to be vulnerable but who are not in contact with support services when first referred as being in crisis but do not meet safeguarding criteria. The numbers of such adults are increasing due to the impacts of the economic climate and the changes in housing and personal benefits. Every effort is made to achieve the earliest, short-term intervention and diversion to avoid serious harm. It is a particular challenge to respond appropriately to such adults who may be vulnerable but who are assessed as not 'lacking capacity'.

8.4 Deprivation of Liberty Safeguards

The past year has seen a significant rise in Northamptonshire around DoLS activity, compared to last year, from 74 referrals in 2010/11 to 84 referrals in 2011/12. This increased activity is not just around requests for assessments but also general enquiries about DoLS from across organisations, including the third sector. Frequently the enquiries result in a potential DoLS being more appropriately managed by a Best Interest Decision under the Mental Capacity Act, hence the reduction in authorisations.

	2010/11	2011/12
Actual referrals received by Northamptonshire DoLS	**74**	**84**
Total Referrals authorised	**52**	**44**

The majority of referrals continue to be from care homes for people with dementia; those from hospital settings mainly relate to people with head injury and dementia, where authorisations are likely to be in place for shorter periods i.e. up to one month.

8.5 Independent Mental Capacity Advocate (IMCA) Service

Here are the summary findings of IMCA activity for 2011/12 and in comparison with the years since introduction.

Table 1 - this table represents yearly comparisons of IMCA referral activity since the introduction of the Mental Capacity Act (2005) in October 2007.

Referral Statistics - yearly comparison

Table 1	2007_2008	2008_2009	2009_2010	2010_2011	2011_2012
Total referrals per year	**74**	**120**	**103**	**134**	**196**
Year Date Range	2nd April to 26th March	1st April to 23rd March	16th April to 31st March	6th April to 29th March 2011	1st April 2011-31st March 2012
Year Length in days	360	357	350	329	366
Most referrals in month	11	44	18	23	43
Average number of referrals in month	6	10	9	13	16
Least referrals in month	3	3	2	9	7
Peak month	June	May	January and October	November	October
Quietest month	January and November	January and November	April	December	December

Comment

The data shows an increasing rise of referrals to IMCA which indicates greater understanding and awareness of the role of an advocate and of the Mental Capacity Act (MCA) itself.

Table 2.

Care/Treatment Decision Requiring an IMCA Referral - yearly comparison

Table 2	2007_2008	2008_2009	2009_2010	2010_2011	2011_2012
Accomm	39	74	53	8	53
Accomm/SOVA	0	0	0	1	0
Care Rev	6	11	14	4	53
DoLs	0	0	6	2	14
n/a	7	0	0	0	0
no decision	2	0	0	0	0
POVA / SOVA	10	17	17	1	47
SMT	10	17	13	0	17
Relevant Persons / Paid Representatives	0	0	0	0	12
(blank)	0	1	0	0	0
Total cases per year	74	120	103	16	196

Comment

Last year there were concerns around the lack of referrals for IMCA involvement in accommodation reviews i.e. where, after the initial placement, planned reviews or unplanned reviews/reassessments should also require IMCA involvement. It is pleasing to note that there has been a significant rise in such referrals in 2011/12. An IMCA is may also be required when a move to different accommodation is planned to meet an individual's needs.

Greater knowledge and awareness seems to have produced improved results in the apparent referral trend

9 CONCLUSIONS

9.1 The Northamptonshire SOVA Board is now a well established partnership, united by its commitment to the protection of vulnerable adults in Northamptonshire.

Again, this has been another challenging year for all agencies who work to safeguard vulnerable adults. This is still not exceptional to Northamptonshire but reflects the position across the whole country. The partnerships, the information sharing arrangements and the refresh of policies, developed over the past three years have proved invaluable and enabled us all to achieve better outcomes for the customer, although there is never room for complacency.

Whilst no Serious Case Reviews were commissioned this year the Board has been keen to learn from the experiences and lessons learnt in other areas of the country.

Despite the fact that legislation is still not yet in place to put adult safeguarding on a legal footing, the partners on the Northamptonshire SOVA Board remain committed to ensuring that safeguarding vulnerable adults remains everyone's business and that all individuals are free from abuse, exploitation, intimidation and violence.

10 ACKNOWLEDGEMENTS

10.1 We would like to acknowledge the continued commitment provided by partner agencies to support the work of the Northamptonshire SOVA Board and to those agencies which also provide financial support to its work.

10.2 We would like to acknowledge the ongoing hard work and commitment of all staff at operational levels who play a vital part in safeguarding vulnerable adults in Northamptonshire.

APPENDIX 1

Board Member Representatives / Organisations

Title	Organisation
Independent Chair	Independent
Independent Deputy Chair	University of Northampton
Head of Public Protection Crime and Justice Command	Northamptonshire Police
Multi-Agency Public Protection Arrangements (MAPPA) Manager	Department of Public Protection Northamptonshire Probation Trust
Third Sector	Northamptonshire Local Involvement Network (LINk)
Independent Sector Provider	Northamptonshire Association of Registered Care Homes (NORARCH)
Associate Director Healthcare Directorate / Head of Social Work & Patient Protection	St Andrews Healthcare
Director of Nursing and Quality	Kettering General Hospital NHS Foundation Trust
Director of Nursing, Midwifery and Patient Services	Northampton General Hospital NHS Foundation Trust
Director of Operations Executive Nurse	Northamptonshire Healthcare NHS Foundation Trust
Associate Director of Safeguarding	NHS Northamptonshire
Clinical Quality Manager, Northamptonshire Division	East Midlands Ambulance Service NHS Trust
Head of Service Delivery	Northamptonshire Fire and Rescue
Assistant Director Planning and Commissioning	Northamptonshire County Council

Service Manager Safeguarding	Northamptonshire County Council
Safer Communities Manager	Northamptonshire County Council
Corporate Director of Adult and Children's Services	Northamptonshire County Council
Assistant Director for Safeguarding, Children and Transitions	Northamptonshire County Council
Legal Representative	Northamptonshire County Council

Appendix 2

Northamptonshire Interagency procedures

Interface between serious incidents reporting in health services and multi agency Safeguarding Adults procedures.

1. Aims and objectives

This procedure seeks to ensure effective interface between safeguarding adults procedures and procedures carried out through the serious incident investigation process for health services.

An effective interface ensures comprehensive investigation, transparency and learning across the multi-agency safeguarding adults partnership.

2. Context

Health organisations providing NHS care are required to report serious incidents to their commissioning body. Serious incidents include incidents such as serious harm, unexpected or avoidable death and abuse (inflicting or failing to act to prevent harm).

In relation to vulnerable adults, it is important to consider whether the nature of the serious incident has implications for safeguarding adults and should be investigated in line with multi agency procedures.

Integrating the processes allows:

Responses in line with requirements of multi agency safeguarding adults procedures[1], compliance with NPSA guidance 2010[2] and Dept Health guidance 2011[3]

- Enables effective communication and support to those patients and service users involved
- Enables a transparent, coordinated and comprehensive investigation
- Brings together learning for continuous improvement
- Avoids duplication of effort from multiple investigations

The attached flowchart sets out the stepped process for managing incidents.

[11] Northamptonshire SOVA Board Interagency Safeguarding Vulnerable Adults Procedures 2011

[2] National Framework for Reporting and Learning from Serious Incidents Requiring Investigation; National Patient Safety Agency, 2010

[3] Safeguarding Adults: The Role of Health Service Practitioners; DH 2011

FLOWCHART – INTERFACE BETWEEN SERIOUS INCIDENTS AND SAFEGUARDING ADULTS

Step 1	Incident occurs within a health service	Is this a safeguarding adults concern? Does an alert need to be raised?
Step 2	Referral through multi agency procedures Referral within agency through clinical risk management	Initial strategy meeting/discussion to agree protection plan; involvement of service user; the agencies/individual to be involved in investigation; initial timescales and any lead responsibilities (including where police are leading) Clinical risk informed of strategy meeting plan
Step 3	Clinical risk agree whether incident requires management as a serious incident	Notify NHS commissioners
Step 4	Review strategy meeting/discussion	Health service informs NCC safeguarding service of SI and agrees draft terms of reference, guided by NHS commissioner patient safety team as necessary. Agree timeframes according to agency requirements and complexities of the case (e.g. police investigations). Agree integration of the SI investigation into the wider multi agency safeguarding investigation e.g. sequencing. Agree arrangements for involving and supporting the service user and family Agree arrangements for communicating outcomes to the service user and family
Step 5	SI investigation	Review strategy meetings/discussions as required e.g. where new information emerges
Step 6	SI investigation report	Draft shared with NCC safeguarding service. Final SI report agreed with NHS commissioner patient safety team SI investigation report and recommendations integrated with wider multi

		agency safeguarding investigation reports.
Step 7	Case conference and 'being open'	Health service and NCC safeguarding service meet with service user/family to provide outcome in line with 'Being Open' requirements.
Step 8	Learning and outcomes	Serious incident closed by NHS Commissioners Health service implement any actions and assure learning improves outcomes.

Appendix 3

New Model for Serious Case Reviews launched in Leicestershire

New Process in place for Serious Case Reviews

The East Midlands Joint Improvement Partnership (JIP) Safeguarding and Dignity Board was commissioned to undertake a review of Adult Protection Serious Case Reviews (SCRs) in the region. The project was hosted by Leicestershire County Council and funded by the East Midlands Improvement and Efficiency Partnership (EM IEP).

The project started in July 2010 and five current SCRs in the East Midlands were examined in order to develop the new process. The new four stage process will provide more options in safeguarding adults and should be more cost effective, less time consuming and ensure learning is disseminated, and acted upon more quickly.

"Adult Serious Case Reviews are something of a grey area. There has never been a thorough framework in place for adult Serious Case Reviews as is the case for children. This project has been a necessary and positive first step in developing a more robust process for adult Serious Case Reviews and hopefully reducing the number of SCRs in the future. The work done so far has focused on looking at the existing research around Serious Case Reviews and making recommendations for change, however, the next phase of the project will be implementation when we can truly test viability in the real world."

Robert J. Nisbet
Programme Support to the East Midlands Safeguarding and Dignity Board
Regional Health & Criminal Justice Lead
Department of Health, East Midlands

Understanding the landscape of Serious Case Reviews

A SCR is usually conducted when an adult, who may meet the criteria for safeguarding, dies or sustains a serious injury or impairment of health as a result of abuse or neglect. There is no legal requirement to undertake a SCR in adult safeguarding. The Department of Health first published 'No Secrets: guidance on developing and implementing multi-agency policy and procedures to protect vulnerable adults from abuse' in March 2000, which gives guidance to local agencies who have a responsibility to investigate and take action when a vulnerable adult is believed to be suffering abuse. The project is timely because 'No Secrets' is currently under review.

A Time for change

At the start of the review, only three SCRs had been published in the East Midlands, a further two were due to be published in September and October 2010. In order to move forward with the project, these earlier reviews were studied alongside previously published national research.

Example of SCR Reviewed

X was a man who had epilepsy and autism spectrum disorder. He lived in Area A and came from a specialist residential unit in Area B. He died after he missed four doses of a drug he took twice a day to control his seizures. Staff at the home had made a note in the handover book that the medication was running low but new supplies were not arranged. An inquest jury found that failure to provide the drug had materially contributed to his death, as well as systemic failures around stock keeping, record keeping and a lack of significant staff training.

Area B Safeguarding Adults Board commissioned a Serious Case Review, which made the following recommendations across several 'agencies':
• Care Home: Senior Management team were not to delegate down but take responsibility and ensure staff were performing their roles appropriately. Mentoring for managers was provided as well as personal development plans for staff.

• Local Authorities: Terms of reference and staff were reviewed at Area B Quality Assurance; Placing Local Authorities needed to inform Hosting Local Authorities of placements that were being made, as well as sharing relevant information to inform the reviewing process.

• Care Quality Commission (CQC): To look at resolving the use of the terms "requirement" and "recommendation" in inspection reports. • Area B Safeguarding Adults Board: Where a serious incident occurs in a care setting, the multi-agency procedures are promptly followed in order to safeguard the other residents. The family and carers of someone who has died or had a serious injury should be contacted at an early stage in the process and kept informed throughout.

Programme Objectives

The key objectives of the programme were as follows:

i. To undertake a review of all SCRs carried out in the region, focussing on lessons learnt and provide a report to share with local adult Safeguarding Boards.

i. For the host locality, with support from the consultant, to develop a scheme for best practice in undertaking multi-agency SCRs, rather than a single agency review, which was the current form in some areas.

ii. To organise a regional conference to inform of lessons learnt from SCRs and how multi-agency reviews will make improvements to efficiency and for improved outcomes in adult safeguarding.

Limitations of the current SCR process

The review identified a number of limitations and issues with the current SCR process:

- Only one process existed for undertaking a SCR
- The cost of SCRs varies depending on the use of external chairs and authors (no set fee structure or quality standards exist for this work).
- The process was not only time consuming but there was no consistency in the length of time a review took across the local authorities.
- Safeguarding Boards developed SCR Sub Groups who had varying levels of independence.
- It was taking too long for the learning to be disseminated.
- The quality of Individual Management Reports (IMR) was variable.
- Learning could easily get lost in the process, particularly disseminating to an operational level.

The programme reviewed the five published SCRs and a new model was proposed at the Safeguarding and Dignity Board on 1 November 2010. The new model received positive feedback and the board agreed to move forward with it.

The New Model

It is proposed that there will be four levels of review processes which represent different ways of reviewing cases according to the circumstances, requiring varying levels of independence.

Level 1 – Serious Case Review

The triggers for a SCR were outlined as follows:

i. A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death

ii. A vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, or sustained serious permanent impairment to their health or development. The case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.

iii. Serious abuse takes place in an institution or when multiple abusers are involved.

iv. Death or serious harm results from alleged harassment, bullying, antisocial behaviour or hate crime.

The SCR Sub Group will decide which agencies it is appropriate to involve in the Serious Case Review, appoint a chair and appoint an independent report writer with expertise in this area. When the SCR process criteria are not reached but there are serious safeguarding implications and lessons which could be learnt, one of the three new levels proposed would take place:

i. Significant Incident Learning Process (SILP)

ii. Peer Reviews

iii. Individual Agency Reviews

The triggers for the new levels were defined as follows:

i. Where an adult who may have been in need of safeguarding dies or experiences serious harm which is not due to direct abuse but there may be concerns about their capacity to self-care and understand the consequences of not doing so.

ii. Multiple incidents or concerns which are repeatedly happening, with increasing severity and the same provider agency being consistently involved.

iii. Where serious harm and / or abuse was likely to occur but has been prevented by good practice.

The process for the three new levels is as follows:

Level 2 – Significant Incident Learning Process (SILP)

The key agencies and professionals involved in an identified case will be entitled to a half or full day event to examine the case together. Rather than an IMR, agencies will provide chronologies of events, one facilitator will chair the events and another will write up the learning. An external facilitator may be used if the complexity of the case meant it was necessary to do so. This process will involve operational staff and their managers who would own the summary of learning at the end of the process, leading to these being disseminated more quickly at an operational level. A second event would take place to review how the agreed actions had been met and how the learning was disseminated within agencies.

Level 3 – Peer Review

For this process, the SCR Sub Group would identify an individual from within the Safeguarding Adults Board to review the multi-agency working in an identified case as part of a reciprocal arrangement.

Level 4 – Individual Agency Review

The project identified that there are a number of reviewing processes undertaken around safeguarding cases within individual agencies represented within the Safeguarding Adults Board arrangements. There are valuable lessons which could be shared from other agencies, for example, the Serious Untoward Health Boards, and it may be appropriate for the Safeguarding Adults Board to have an overview of these.

It was therefore proposed that when an individual agency is conducting an investigation of this kind involving a safeguarding issue, the SCR Sub Group is advised of this to enable them to assess whether there may be transferable learning within multiagency arrangements.

Consultation Event

The new model was presented to the regional safeguarding leads at an event in November 2010 to get feedback and understand if this is a workable approach. The event was an opportunity to learn from other models and share best practice. Eight out of nine upper tier authorities were represented at the event. There was support for the four levels proposed in the new model, as well as valuable input into helping ensure the model is flexible enough to be potentially adopted across the region by different Safeguarding Board structures.

The proposed new process includes a suggestion that the SCR Sub Group will receive referrals for cases which may meet the SCR criteria, and will decide whether the criteria are reached, and which process will be the most appropriate under which to review the case. If it is agreed that the case reaches the formal SCR criteria, those agencies will then be asked to nominate a panel member. The SCT Sub Group will then agree who should chair the panel and also agree on an independent report writer. This proposed process was also well received at the event.

Next Steps

A multi-agency conference was held on 14 February 2011 to share the learning and present the model. Regional training events were held around facilitation of the SILP and in completing IMRs to support the conference. A number of keynote speakers, with national profiles around this subject area, attended the conference. A series of workshops took place to utilise the experiences of individuals and organisations within the East Midlands region.

In this way it is hoped to gain feedback on the model from those who will use it in their day-to-day working lives. This feedback will influence the final report, which will be presented to the Safeguarding and Dignity Board at the end of February and include full operational process of the SCR model for use across the region.

"We look forward to sharing the learning from this project and the new model at the conference in February. Leicestershire County Council approached the JIP Board to express interest in this project and we are delighted to have hosted this work on behalf of the East Midlands Improvement and Efficiency Partnership (EM IEP) with the Department of Health in the East Midlands.

The work done so far is just the beginning and we hope that the long-term outcome of this project will be a safer future for adults."

Laura Sanderson

Safeguarding Adults Manager

Leicestershire County Council

APPENDIX 4

Legislative background and guidance relating to safeguarding adults

2000 - 'No Secrets'

The Government published a national framework, 'No Secrets', so that councils with social care responsibilities, NHS bodies, police forces and other partners could develop multi –agency codes of practice, policies and procedures to help prevent and tackle adult abuse. It set out requirements for Adult Social Care to provide a strategic lead in the development and implementation of 'No Secrets'. Multi-agency management committees are required to monitor and evaluate the effectiveness of these arrangements and are expected to report annually on progress to the agency's executive management body.

'No Secrets' guidance is expected to remain in force until at least 2013 to allow the Health and Social Care Act 2012 to become fully implemented.

2004 - POVA Scheme and POVA list

These set out a workforce ban on those deemed unsuitable to work with vulnerable adults.

2005- 'A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work'

This Framework was published by the Association of Directors of Adult Social Services (ADASS) and sets out 11 standards for safeguarding adults.

2005- The Mental Capacity Act

The Act came into force during 2007 and provides a legal framework underpinning work with people who may lack capacity to make decisions for themselves. It makes it clear who can take decisions in which situations and how they should go about this. It also allows people to plan ahead for a time when they may lack capacity. The assessment of an individual's mental capacity is central to the adult safeguarding process. It is therefore vital that any worker carrying out an assessment of capacity is aware of the Act and its associated Code of Practice.

2006 – 'Our health, our care, our say: a direction for communities' [4]

This White Paper set out a vision to provide people with good quality health and social care services in the communities where they live. It placed a strong focus on the importance of choice, control, empowerment, dignity, respect and the right to freedom from abuse, harm or exploitation. This will be replaced by the Care and Support White Paper to be published later in 2011 which will focus on creating more personalised, preventative services in order to deliver the best outcomes for customers.

2006 - Safeguarding Vulnerable Groups Act

The Bichard Inquiry[5] called for a registration scheme, preventing those who are deemed to be unsuitable from gaining access to children or vulnerable adults through their work. The Safeguarding Vulnerable Groups Act aimed to significantly strengthen safeguarding by developing a central Vetting and Barring Scheme built on the Criminal Records Bureau (CRB), with a new Independent Safeguarding Authority (ISA) (October 2009) which would take decisions on including someone on the barred list where evidence suggests that they present a risk of harm to children or vulnerable adults.

Initial registrations with the ISA were due to commence in July 2010 but implementation of this part of the scheme was halted to allow a review by the incoming government. The review into the Vetting and Barring Scheme and the proposed changes were published in February 2011. The existing responsibilities of employers and ISA will remain in force as introduced in October 2009 until the Protection of Freedoms Bill is introduced and the changed arrangements are established by 2013.

2007 & 2011(revised) PREVENT Strategy

The PREVENT strategy is the preventative strand of the government's counter-terrorism strategy, CONTEST. The strategy was refocused following a review in 2011. It now contains three objectives: to respond to the ideological challenge of terrorism and the threat from those who promote it; to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support; and to work with sectors and institutions where there are risks of radicalisation that needs to be addressed.

[4] 'Our health, Our Care, Our Say: a direction for communities' Department of Health January 2006
[5] Bichard Inquiry

2008 - Review of 'No Secrets 2000'

In spring 2008 the Care Services Minister commissioned a consultation to review the 'No Secrets' guidance. The report on the Consultation was published in July 2009. The key messages from the participation of older people, adults with learning or other disabilities and people with mental health needs included:

a) Safeguarding must be built on empowerment – or listening to the victim's voice. Without this, safeguarding is experienced as safety at the expense of other qualities of life, such as self determination and the right to family life.

b) Everyone must help to empower individuals but safeguarding decisions should be taken by the individual concerned. People wanted help with options, information and support. However, they wanted to retain control and make their own choices.

c) Safeguarding adults is not like child protection. Adults do not want to be treated like children and do not want a system that was designed for children.

d) The participation/representation of people who lack capacity is also important.

The Department of Health responded to this review in January 2010 by setting plans to introduce new legislation to strengthen the local governance of safeguarding by establishing Safeguarding Boards in statute. The incoming government did not immediately take this plan forward, however, it introduced a number of sets of guidance to the NHS and Adult Social Care during 2010/11.

2008 - 'Safeguarding Adults: A Study of the Effectiveness of Arrangements to Safeguard Adults from Abuse'

This study by the former Commission for Social Care Inspection (now Care Quality Commission - CQC) reported on arrangements in place in England to help prevent the abuse of adults and to support those who experience abuse. The study shows:

- "Uneven progress in the development of effective arrangements by councils and care services to safeguard people;
- Variability in the quality of support provided to individuals who experience abuse;
- More needs to be done to ensure people who direct their own support on a daily basis are also able to benefit from appropriate and individually tailored safeguards;

- Actions to help prevent abuse and support better outcomes for people in the long term who have experienced abuse are variable within and across council areas and within individual care services."

2009 - Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) was fully introduced in 2009 as part of the Mental Capacity Act (2005). DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the European Court of Human Rights (ECHR) in a hospital, care home or nursing home and who are not otherwise protected or safeguarded through use of the Mental Health Act 1983 or the Court of Protection powers.

Having mental capacity means being able to understand and retain information and being able to make a decision based on that information. When someone lacks mental capacity to consent to care or treatment, it is sometimes necessary to deprive them of their liberty in their best interest in order to protect them from harm.

The safeguards are intended to protect people who lack mental capacity from being deprived of their liberty when this is not in their best interests, to prevent arbitrary deprivation and to give people the right to challenge a decision. The legislation sets out a procedure for care homes and hospitals to obtain authorisation to deprive someone of their liberty. Without that authorisation the deprivation of liberty will be unlawful. These safeguards are intended to protect individuals from being deprived of their liberty unless it is in their best interests to protect them from harm and there is no other less restrictive alternative.

2010 – Clinical Governance in Adult Safeguarding – An Integrated Process (Feb) which aims to encourage NHS organisations to develop local robust arrangements which will streamline systems to ensure that clinical governance and adult safeguarding are fully integrated.

2010 – Six Lives Progress Report (Oct) recognises that much work has been done in some organisations to improve health care for people with learning disabilities and progress has been made but good work is not embedded everywhere and serious concerns remain around 'reasonable adjustments' and assessing mental capacity.

2010 – Practical Approaches to Safeguarding and Personalisation (Nov).

Personalisation (enabling people to lead lives they choose) and Safeguarding (keeping people safe from harm) should go hand in hand, balancing choice and control with risk management, to lead the lives they choose, free from harm.

2010 - Vision for Adult Social Care - Capable Communities and Active Citizens (Nov). This policy document states the Coalition Government's commitment to safeguarding adults within its future vision for social care.

2011 – Care & Compassion? – Report of the Health Service Ombudsman on 10 investigations into NHS care of older people (Feb) outlines investigations into the standard of care provided to older people by the NHS.

2011 – Safeguarding Adults – The Role of Health Service Practitioners (Mar). This document reminds health service practitioners of their statutory duties to safeguard adults. It aims to assist practitioners in preventing and responding to neglect, harm and abuse to patients in the most vulnerable situations, providing principles and practice examples that can achieve good outcomes for patients.

2011 – Safeguarding Adults – The Role of Health Service Managers and their Boards (Mar). This document reminds health service managers and their boards of their statutory duties to safeguard adults. It aims to assist managers in preventing and responding to neglect, harm and abuse to patients in the most vulnerable situations, providing principles and practice examples that can achieve good outcomes for patients.

2011 – Safeguarding Adults – The role of NHS Commissioners (Mar). This document reminds NHS commissioners of their statutory duties to safeguard adults. It aims to assist commissioners in preventing and responding to neglect, harm and abuse to patients in the most vulnerable situations, providing principles and practice examples that can achieve good outcomes for patients.

2011 – Protection of Freedoms Bill (Feb). This Bill included a review of the Vetting and Barring Scheme. Until the Bill receives Royal Assent during 2012 and the new arrangements are established by 2013, the existing responsibilities of employers and the Independent Safeguarding Authority will remain in force as introduced in October 2009.

2011 – Domestic Homicide Reviews (Apr). This multi-agency statutory provision came into force in April 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The responsibility for establishing a domestic homicide review rests with the relevant Community Safety Partnership.

2012 – Health and Social Care Act (Mar). This Act sets out the most extensive reorganisation of the NHS, the most fundamental of which is the transfer of commissioning from soon to be abolished Primary Care Trusts to Clinical Commissioning Groups, partly led by GPs**.** The Act also transfers the statutory duties of PCTs to CCGs.