Annual Report 2014-15

Contents

Acknowledgements and thanks to all representatives of partner agencies who have contributed to this report

SOMERSET SAFEGUARDING ADULTS BOARD

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

1. Welcome from the Chair

I am pleased to present the Annual Report from the Somerset Safeguarding Adults Board (SSAB) for 2014-15. This annual report outlines the activity undertaken as individual agencies and in partnership to make a difference to adults at risk during the past year.

Working together has never been so important, as the profile of adult safeguarding continues to improve.

For the first time, our responsibilities are enshrined in statute, signalling the importance that is now attached to this crucial area of social policy. The role of the Board, and my role as its Independent Chair, is to hold to account the statutory partners and others who work together to ensure adults at risk in Somerset are safe in their homes and communities. Most importantly, we are determined to put the principles of Making Safeguarding Personal at the heart of everything that we do.

Over the past year, Somerset has worked together with North Somerset, Bath and North East Somerset, Bristol, and South Gloucestershire in the development of a joint safeguarding policy which has been adopted by each of their Safeguarding Adults Boards. This has helped to establish a set of consistent understandings about the purpose and principles of adult safeguarding across agencies and boundaries. We have also worked in partnership with the Local Safeguarding Children Board to commission a review into the deaths of vulnerable young adults, an overview of which can be found within this report.

We recognise there is more to be done to improve our performance as a Board, including tightening up our governance processes, strengthening our quality assurance and performance management activity, and putting the needs and expectations of those we serve at the forefront of our work.

I would like to thank members of the Board for their work during this reporting period, and particularly the frontline practitioners and managers across Somerset for their dedicated work in safeguarding adults at risk.

Richard Crompton
Independent Chair, Somerset Safeguarding Adults Board

2. Who we are and what we do

Adult safeguarding is the process of protecting adults with care and support needs from abuse or neglect.

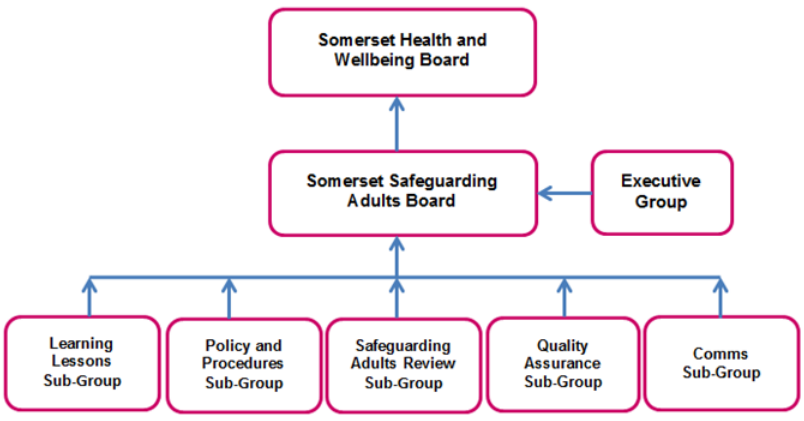
The Somerset Safeguarding Adults Board (SSAB) is a statutory body established by the Care Act 2014. Its main objective is to protect all adults in its area who have needs for care and support and who are experiencing, or at risk of, abuse or neglect against which they are unable to protect themselves because of their needs.

To this end, the Board works to:

- Assure local safeguarding arrangements are in place.
- Assure safeguarding practice is centred on the person and focused on outcomes.
- Work collaboratively to prevent abuse and neglect wherever possible.
- Ensure agencies and individuals give timely, proportionate responses when abuse or neglect has occurred.
- Assure safeguarding practice is continually improving and enhancing the quality of life of adults in its area.

The Care Act 2014 provides for three core members of the board - the local authority, the police and the clinical commissioning group. The Board is also supported by a range of other key partner agencies and stakeholders.

The SSAB meets quarterly, with representation from a wide range of partner agencies and groups. The Board has recently clarified its structure, and is supported by five multi-agency sub-groups which act as the 'engine rooms' of the Board's activity.



Subgroup Purpose

Learning and Development subgroup
Establishing a multiagency perspective of Safeguarding Adults training, learning and development needs and ensuring lessons learned are reported to the Board and influence policy changes

Policy and Procedures subgroup
Producing policy, procedures and guidance that maximise outcomes for adults at risk

Safeguarding Adults Review subgroup
Ensuring the Board meets its statutory requirements in relation to Safeguarding Adults Reviews

Quality Assurance subgroup
Establishing and maintaining performance management arrangements for the Board

Comms subgroup
Promoting awareness of Safeguarding Adults within and across agencies and the wider community (ad hoc basis)

The Care Act outlines three primary functions for a Safeguarding Adults Board:

1) it must develop and publish a strategic plan setting out how it will meets its objectives, and how member/partner agencies will contribute to these;
2) it must publish an annual report detailing how effective its work has been;
3) It must commission safeguarding adult reviews (SARs) for any cases meeting the criteria for these. *The Act introduces SARs, previously known as Serious Case Reviews.*

3. Safeguarding in numbers

Safeguarding activity

The marked upward trend in the level of referrals received by Somerset County Council, noted in previous reports, has continued in 2014-15.

All of these referrals require skilled professional decision-making in order to assess risks of harm and to identify appropriate actions to both ensure the person's safety and to investigate the concerns raised.

Although the County Council remains responsible for leading this decision-making, the effective safeguarding of vulnerable people necessarily requires effective working relationships with a range of partner organisations, including care providers and the person themselves.

Overall activity levels

	Referrals received	% Change from previous year	Meeting investigative threshold	% referrals meeting investigative threshold	Concerns fully or partially substantiated	% fully or partially substantiated
2014-15	3,692	+48%	1,189	32%	767	65%
2013-14	2,500	+19%	944	38%	675	72%
2012-13	2,096		676	32%	425	63%

The 1,189 incidents investigated in 2014-15 related to 714 individuals.

Of these 714, 511 were already known to the Council, mostly because they were in receipt of care services.

Although there has been a significant increase in the referral level, the proportion of concerns meeting the investigation threshold remains similar to previous years accounting for about a third of referrals received.

The high proportion of investigations resulting in concerns being either partially or fully substantiated suggests the process of making threshold decisions is working well.

Many of the referrals not investigated under safeguarding do result in an assessment of care needs instead.

Category of main support needs

	Physical disability, frailty and sensory impairment	Learning disability	Mental Health	Other	Total
2014-15	474	139	23	78	714
2013-14	390	181	33	166	770

Many of the people in the first column will be older people, including those with dementia.

Ethnicity of individuals referred

	White	Black	Asian	Mixed	Undeclared / Not known	Total
2014-15	641	1	2	2	68	714
2013-14	680	4	1	2	83	770

Referrals by type of alleged abuse

	Physical	Sexual	Financial	Psychological/ Emotional	Neglect	Institutional	Discriminatory	Total
2014-15	411	63	162	229	270	43	11	1,189
2013-14	230	34	149	143	273	114	0	943

It is important to note that a referral about an individual may raise concern about more than one type of abuse. For example, psychological/emotional abuse is often reported with another form of abuse or neglect.

Referrals by location of alleged abuse

	Care Home	Own Home	Hospital	Service in community	Other	Total
2014-15	570	467	27	22	101	1,189
2013-14	543	306	16	33	45	943

The referrals about concerns in care homes related to allegations against members of care staff as well as other vulnerable people in the home.

The great majority of concerns arising in people's own homes involve allegations against members of their families or other people known to them. Only a small proportion relate to paid domiciliary care staff.

Referral conclusions

	Fully substantiated	Partially substantiated	Inconclusive	Not substantiated	Investigation ceased by person	Total
2014-15	562	205	173	214	35	1,189
2013-14	485	190	111	133	24	943

Result of actions taken under safeguarding procedures

	Risk reduced	Risk removed	Risk remains	No Action Taken	Total
2014-15	587	415	176	11	1,189
2013-14	439	406	91	7	943

In 84% of cases, the risk of the specific circumstances which caused the concern were either reduced or removed.

Statistics summarised by: Chris Hamilton, Somerset County Council
August 2015

4. Board Member Reports, 2014-15

Somerset County Council – Adults and Health Service

Like most other Safeguarding Board member organisations, Somerset County Council continues to face significant challenges in meeting the increased demands for its services. Despite this, the Council has reinforced its commitment to the delivery of safe services and to the effective protection of people at risk of harm.

In order to fully implement the Care Act 2014, and to prepare for anticipated future levels of demand for services, the Council has begun to reorganise its social care provision in a number of ways. Of specific relevance to the SSAB is the decision to move away from the current operational arrangements *(safeguarding assessment and decision-making dispersed around the various social care teams)* to a centralised team. The anticipated benefits from this change will be that decision-making will be more standardised because it will involve a smaller number of managers. The service will also be in a stronger position to effectively implement the Making Safeguarding Personal elements included in the Care Act. All aspects of the safeguarding process, from information gathering, to reporting and the coordination of whole service investigations, should be carried out more consistently. There will be changes to reporting practice from 1st April 2015 and the new team arrangements will be fully in place by September 2015.

The appointment in January 2015 of George O'Neill, as Principal Social Worker for Adults with a remit to oversee the quality of social work services and the safeguarding and risk management responsibilities of the Council, is evidence of its commitment to maintaining high practice standards. George is now a member of the SSAB along with the (Interim) Director of Adult Social Services (DASS), Kim Curry. The permanently appointed DASS will automatically be a member of the Board.

During the year, the new Service and Operations Manager post with responsibility for safeguarding and risk management has been developed.

As part of the smaller group of local authorities whose policing services are provided by the Avon and Somerset Constabulary (Somerset, North Somerset, Bath and North East Somerset, Bristol, and South Gloucestershire), Somerset County Council managers have contributed to the development of a joint safeguarding policy which has been adopted by all five SABs. This establishes a set of consistent understandings about the purpose and principles of adult safeguarding across agencies and boundaries. Each local area retains its own frontline operational arrangements. The policy has been written in light of the statutory guidance of the Care Act and is hosted on the County Council's Safeguarding Adults webpages: http://www.somerset.gov.uk/adult-social-care/safeguarding/report-an-adult-at-risk/

Somerset County Council has taken a lead in the appointment of a dedicated SSAB Business Manager to provide support to Richard Crompton, as Independent Chair, and to facilitate the effective working of the Board and its re-formed subgroup structure. The appointed person will take up post on 1st September 2015.

Court of Protection

During the last year applications made to the Court of Protection for welfare decisions have also continued to increase. These applications are made when an individual does not have capacity to make a decision regarding their wellbeing, and the County Council has not been able to agree a way forward with family members. Welfare applications made this year have been about where

a person should live and how their care is provided. The Council have also continued to make applications to the Court for authority to manage the financial affairs of people who lack capacity to do this themselves and who do not have relations or friend who can take this on. Some, but not all, of the decisions to apply for financial authority have arisen from safeguarding concerns about financial exploitation.

Learning from Court of Protection is used to improve social care practice and is disseminated to County Council staff through formal training routes as well as specific guidance. During this year it has been necessary to ensure that social care staff understand fully the relationship between safeguarding procedures and mental capacity decision making. A focus on this has been incorporated into revised safeguarding and new Mental Capacity Act training courses and reinforced within the new regional Safeguarding Adults policy.

Deprivation of Liberty Safeguards (DoLS)

As with most other local authorities in the country, Somerset County Council has struggled to manage the more than tenfold increase in the number of DoLS applications following the clarification provided by the Supreme Court in March 2013. In response, the Council has made additional resources available to establish a small team of full time assessors supported by some additional administrative capacity. The DoLS team have used guidance produced by the ADASS to establish a robust system for the prioritisation of new applications to ensure that the most critical situations are assessed as quickly as possible. In early 2015 the Department of Health has announced a further one off grant to local authorities for 2015/16 to help address the current pressures.

The DoLS team continue to provide technical advice and guidance to health and social care professionals as well as to care providers and members of the public whose relatives are affected by the safeguards.

Training and other development activities undertaken

All Somerset County Council staff in social care teams are required to complete the appropriate level of safeguarding training and to attend regular refresher events. Other training which is compulsory includes Mental Capacity Act, Domestic Violence and Child Protection. All attendance at training is closely monitored by the Learning and Development Team.

During 2014/15, the safeguarding training programme provided to County Council staff has been thoroughly revised in anticipation of changes to be brought in by the Care Act 2014. A contract re-tendering process has taken place resulting in some changes to the delivery of the course for team managers and other decision-makers from January 2015. The training programmes for all staff will be further revised during 2015 in light of the planned creation of a centralised safeguarding team.

All social care team meetings and Continuing Professional Development (CPD) activities continue to promote good understanding of adult safeguarding.

There has also been the creation of a new 2 day course on the Mental Capacity Act for all social care staff whose roles involve leading or participation in decision-making for adults who may lack capacity. All staff in the Council's adult social care teams will be required to attend this training by the summer of 2016. A refresher programme will be developed during 2015.

Deprivation of Liberty Safeguards assessor numbers continue to increase with social work and OT staff attending 3 or 6 month Best Interests Assessor qualification courses at the University of

the West of England in Bristol. All social work staff in the Community Mental Health Teams who undertake training to become Approved Mental Health Professionals (AMHP) also complete a Best Interests Assessor qualification. All currently active DoLS assessors have attended the required annual update training.

The DoLS and Mental Capacity Act (MCA) team have developed and delivered a programme of MCA training to all managers in the County Council's Care Provider service for people with learning disabilities.

Quality audit of safeguarding decision-making has continued to be carried out by members of the safeguarding team. In addition, quality checks of care records are an element of regular practice supervision received by all staff. Somerset County Council will develop a more structured quality audit process linked to work undertaken by one of the SSAB's subgroups.

A safeguarding practitioner's guide, originally developed with locum social workers in mind, has now been distributed to all members of social care teams.

Contribution to the work of the Board and its subgroups

Somerset County Council is represented on the Board and its subgroup structure by senior commissioning and operational managers with safeguarding responsibilities:

- Director of Adult Social Services / Lead Commissioner for adults and health
- Principal Social Worker for adults
- Service and Operations Manager for Safeguarding and Risk Management.

The Council's Service Manager for Community Safety is also a Board member, providing a link with multi-agency domestic violence services.

During this year, the Council's Safeguarding and Mental Capacity Act Coordinator has continued to provide a support function to the SSAB and its Chair. The new post of SSAB Business Manager will replace this involvement in the coming year.

Planned safeguarding activities and developments, 2015-16

- Establishment of the centralised Safeguarding Adults service, including a quality audit and performance process;
- Establishment of the SSAB Business Manager post;
- Embed the changes introduced by the Care Act, in particular the emphasis on Making Safeguarding Personal;
- Continue to review and update staff training programmes;
- Develop a Mental Capacity Act Policy and practice standards.

Issues for the Board's consideration during the coming year

- Engaging effectively with service users and carers.
- Establishing an effective quality assurance and performance framework.
- Increase in amount of Safeguarding Adults Reviews.

Report prepared by: Chris Hamilton and George O'Neill

Somerset Clinical Commissioning Group

NHS Somerset Clinical Commissioning Group (CCG) has been strengthening its commissioning arrangements for adult safeguarding during 2014/15.

Recent cases, including Mid Staffordshire NHS Foundation Trust, Winterbourne View and the Lampard report, have highlighted the importance of having robust Safeguarding policies and procedures in place. The Government reforms of the NHS place patients and the quality of their care at the heart of what we do, with a commitment to patient choice, control and accountability; this includes support and protection for those in the most vulnerable situations.
Health services are a key component of safeguarding and the local CCG is one of the three core statutory partners of the SSAB. The CCG is in the best position to ensure that NHS providers meet their responsibilities through its commissioning arrangements. Somerset CCG have a responsibility to ensure that service specifications, invitations to tender, service contracts and service level agreements promote dignity in care and adhere to local multi-agency safeguarding policies and procedures.

Our contracting process has been refreshed in 2014/15 to reflect the requirements of the Care Act 2014. We have supported the outcomes-focused, person-centred safeguarding practice through 'Making Safeguarding Personal'. Using the national NHS contract we have in addition developed local quality indicators, transfer and discharge for care arrangements and a schedule to strengthen the reporting of safeguarding.

Patient experience of care is a key measure of provider performance. We monitor complaints both formal and informal, NHS Choices feedback, Friends and Family test, local and national patient experience surveys to gauge experience of care. We have regular meetings with all our providers to review their performance against the quality indicators within the contract, which includes numbers / types of pressure ulcers, falls assessment, nutrition and hydration assessment using the Malnutrition Universal Screening Tool (MUST) and actions and links with the harm free care recoding of the National Safety Thermometer. In addition, in 2014 all our lead providers signed up to the national 'Sign up to Safety' campaign.

<u>Training and other development activities undertaken</u>
NHS Somerset CCG is committed to monitor safeguarding training, development of our own staff and to ensuring that training is embedded in the commissioned services in Somerset. In 2014/15, through the contracting management process, Somerset Partnership NHS Trust reported that an average 93% of staff received Safeguarding Adults training, Taunton & Somerset NHS Foundation Trust reported that 87.8% of staff received Safeguarding Adults Training and Yeovil Hospital NHS Foundation Trust reported 63.4% of staff received Safeguarding Adults training.

The CCG has an Executive lead for Safeguarding Adults, a GP lead and Lead Nurse for Safeguarding Adults. The CCG as commissioners have supported training in a variety of ways over the past year. We obtained funding from NHS England for embedding the application of the Mental Capacity Act (MCA) and DoLS. The achievements as an outcome of the additional funding has been the development of clinical leads for MCA to support safeguarding leads and provide clinical expertise and leadership to medical staff in acute trusts. Resource training for health staff (i.e. junior doctors, nurses) to enable access to e-learning in acute and community trusts. We have funded an audit of Care Home staff knowledge and understanding of the MCA and training additional Best Interests Assessors (BIA) within Somerset CCG to support Continuing Health Care. We have worked with the Local Medical Committee (LMC) and GP education trust to deliver training to GP's and Practice staff on Mental Capacity Act and

Deprivation of Liberty Safeguards (DoLS) with the objective of providing practical skills in implementing the legislation.

All NHS Providers are required as part of our contracts to have safeguarding, DoLS and whistle blowing policies and implement the Duty of Candour.

Public Awareness

The CCG currently displays 'stop abuse' leaflets produced by the Local Authority in its building reception area. Somerset CCG's website home page has links to Somerset County Council and Healthwatch to signpost support for service users and their families.

In November 2014, two key requirements came into force in the NHS – the Duty of Candour and the Fit and Proper Person test. The Duty of Candour describes a legal requirement to be open and honest with people when something goes wrong with their care and treatment. The Fit and Proper Person test outlines what providers should do to make clear that directors are responsible for the overall quality and safety of care. We are monitoring the Duty of Candour through our contracts with providers.

In April 2015, the new Care Quality Commission (CQC) fundamental standards for all care come into force and will replace the existing essential standards of quality and safety. The CCG monitors implementation of the Duty of Candour by all NHS providers through our oversight and monitoring of all Serious Untoward Incidents and all NHS Providers have complied with the duty.

Learning from experience

The NHS Continuing Healthcare Team has been involved in supporting 19 care homes for whom concerns have been raised in respect of CQC essential standards and 12 individuals in receipt of full CHC funding for whom full safeguarding referrals were made. Of the 19 care homes with nursing found to require improvement or had one or more episodes of non-compliance in 2014/15, 7 had 'major' non-compliance and required a whole service concern strategy approach, these included issues such as staffing, management, nutrition, hydration, delivery of health care to meet people's needs and safeguarding. Four homes were served with warning notices or enforcement action, 12 care homes were found to have 'minor' concerns or not in breach of regulations and required follow up through a quality monitoring or contract review process. These related to issues such as record keeping, infection control, the environment, quality assurance systems and recruitment procedures.

The requirement for a care provider to report concerns and incidents is embedded in the NHS contracting process. For the range of private providers, concerns are recorded centrally and facilitate identification of patterns of concern. We review all our Serious Incident Requiring Investigation (SIRI) root cause analysis and consider safeguarding, and duty of candour principles. The outcomes and learning are reviewed by a panel led by the CCG including a lay member and learning is shared with relevant partner organisations. During 2014/15 161 SIRIs were reported from health providers, this is higher than 2013/14 when a total of 128 SIRIs were reported. The highest prevalence of incidents for 2014/15 was in the areas of Pressure Ulcers, Slips/trips/falls and Unexpected deaths (includes Suicides/Suspected Suicides).

A Complex Cases panel oversees arrangements for bringing people back from out of county hospital placements to a community setting. This work has been successful and we have only one person remaining in a specialist hospital placement out of county. We are working with Somerset County Council to develop a bespoke placement for this individual. In January 2015 we participated in the "Improving Lives" programme group review on the current placement and care

of a client who had been an inpatient at Winterbourne View Care Home who is now settled in a local placement with regular contact with their family. This update formed the final part of the project and will inform the overall learning and outcomes from the process. Importantly, it will allow NHS England to aggregate specific themes from each of the reviews and highlight what key successes have been achieved for people along with identifying some of the continued barriers. The main learning from the review for Somerset CCG related to the individual's management, and for consideration of alternatives to medication for behavioural and therapeutic interventions, Implementation of a wider community involvement for the individual and consideration of their future needs and placements. Specific areas for further development included the advocacy arrangements for residents in care homes, dental care for residents and staff training to support learning disability and epilepsy.

NHS Somerset CCG coordinates safeguarding commissioners' forum which meets quarterly to review implementation of learning from serious case reviews, takes an overview of training, and considers the impact of national policy and judicial review. This forum shares its outcomes with the SAB. We are an active member of the Learning Lessons Group to review learning specifically from serious incident that occur relating to one or more health provider and the National Network Adult Safeguarding. We also support the Multi Agency Public Protection Arrangements (MAPPA) and Prevent Strategy. We are members of the Somerset MAPPA programme group and Prevent Board.

Contribution to the work of the Board and its subgroups

CCGs have a statutory duty under the Care Act 2014 to be members of local Safeguarding Adults Boards, working in partnership with local authorities to fulfil their safeguarding responsibilities. Wider CCG initiatives to safeguard patients and staff include work streams on issues such as transition of children and young people with complex needs into adult services, meeting the needs of patients with a learning disability, female children of women with female genital mutilation (FGM) and patients with dementia.

Since 2009 care homes and hospitals have had to seek authorisation from their Local Authority if they need to deprive an individual in their best interest as part of their care and/or treatment. The Health and Social Care Information Centre (HSCIC) currently collects data from Councils, the information is published quarterly by the HSCIC, during 2013/14 the numbers of DoLS applications in Somerset was 95, during 2014/15 this increased to 1248. The increase is due to the judicial review in March 2014 by the Cheshire v Cheshire West.

NHS Somerset CCG is an active participant of the Board, challenging arrangements to drive improvements. The organisation is committed to supporting the changes in the core duties of the SSAB required by the Care Act. This includes implementing effective learning, improvement and performance assessment frameworks. Somerset CCG has participated in two serious case reviews during the last year, with a further three to be progressed in 2015.

Serious Untoward Incidents / Safeguarding Incidents reported: There was serious untoward incident reported by NEW Devon CCG in respect of the placement of a young man with learning disabilities out of area into a Somerset learning disability care provider. This gentleman choked and aspirated on food and was admitted to a local hospital where he subsequently died. A full investigation was led by NEW Devon CCG with a safeguarding strategy oversight from Somerset County Council and Somerset CCG. This incident identified learning about the importance of all commissioners undertaking a robust quality assurance of the placement including discussion with the local commissioner to review. There was also the need for recognition by the commissioners that when an individual needs change, ongoing reassessment of needs to ensure that the

placement is still appropriate, Communication, clinical expectation and oversight, record keeping being clear enough and having a clear way of knowing escalation of symptoms, LD transitional information and knowledge, the delay in holding a further formal safeguarding, failure to inform the local CHC team of the placement, registration with a local GP and failure to share the safeguarding review with the commissioning authority. An action plan has been developed by NEW Devon in respect of the learning and this will be shared with the Safeguarding Adults Board.

There was a serious case review notified by the Somerset Safeguarding Adults Board during 2014–15 and this case review has not yet concluded.

Planned safeguarding activities and developments, 2015-16

During the year we have reviewed our contracting processes to ensure we are Care Act compliance, we need to review our policies and procedures in line with the recommendations of the Somerset Multi Agency policy. Future plans include:

- Specific targets around decision making and the MCA;
- Ensuring the consent process with lead providers is compliant with the MCA and that all staff are trained in the MCA and undertake Best Interests Assessments. This will be monitored through our contracting process and quality assurance visits;
- Ensuring all people in receipt of Continuing Health Care are considered against DoLS criteria as part of the annual review process regardless of care setting;
- Developing mechanisms for feedback from people who use NHS Services who have been through a safeguarding process, as well as the ongoing feedback about satisfaction with services;
- Focusing on improving reporting of quality in Care Homes with Nursing through a joint project with Somerset County Council and a newly developed Care Home Support Team, with the implementation of a central database on performance measures.

Issues for the Board's consideration during the coming year

- To increase the service user voice in the SSAB plan.
- We would support the Board having its own website for the public to access information and signpost how they can be involved.
- The CCG has received feedback about a need for training for managers/senior clinicians working for private providers to support them in developing skills undertaking investigations and, in particular, identifying learning to improve practice for the future. The CCG would like the SSAB to consider initiating a specific piece of work to address this need.

Report prepared by: Debbie Rigby

Avon and Somerset Constabulary

During 2014/15 Avon and Somerset Constabulary made significant improvements to the operational and strategic response to dealing with incidents involving vulnerable adults, and the safeguarding of adults who are potentially vulnerable.

By way of context, the Constabulary recorded 417 Safeguarding Adult Crimes and 1004 Safeguarding Adult Incidents in Somerset during 2014/15, increases of 97% and 74% respectively on the previous 12 months. The number of Domestic Abuse Crimes recorded in the county for 2014/15 was 2761, representing an increase of 15% on the previous financial year, with 7318 Domestic Abuse Incidents being recorded, an increase of 20% compared with the previous year.

In October 2014, the Constabulary introduced a new Operating Model, a 'One Team' approach with the vulnerability of the victim and/or the risk presented by the offender being the key factor in the allocation of the investigation, rather than the crime type.

One Team tasking identifies and highlights the most vulnerable victims and high risk offenders via the Daily Pacesetter which is chaired by a Gold Commander. Investigations work as One Team but with distinct areas of specialism (Protect, Solve and Convict) with Protect incorporating Public Protection investigations. These Investigations teams are made up of a mix of specialisms, but are not 'generic'. Specialist expertise is thereby retained with the ability to task the right resources according to the type of investigation needed, as well as to pool resources when necessary.

The Southern Safeguarding Coordination Unit (SCU) acts as the central point of contact for all safeguarding issues and referrals in Somerset, including cases involving vulnerable adults. The Safeguarding Coordination Unit links patterns in order to proactively safeguard victims, and works directly with partner agencies, including Adult's Social Care and Health. They undertake risk assessments of all incidents and intelligence received, make decisions, partnership referrals and hold strategy discussions.

On 1 October 2014, the Force introduced its Integrated Victim Care service: "Lighthouse". This new service ensures that vulnerable, intimidated or persistently targeted victims receive a tailored, coordinated and consistent service. Each victim now has a Victim & Witness Care Officer (VWCO) automatically allocated to their case. The VWCO remains allocated to the case from the point of initial report, through the investigation and to the end of any subsequent Criminal Justice process. The VWCO ensures that the victim receives a comprehensive needs assessment, where possible within 24 hours of the crime being reported. The VWCO may share the needs assessment with particular agencies and organisations to ensure the victim has access to support services that may be appropriate for them, as part of a proactive handover package that ensures the needs of the victim are understood, and that they do not have to repeat themselves.

Training and other development activities undertaken

We want everyone within the Constabulary to know and understand their role and responsibility for victim care, be able to identify vulnerability and recognise the part they play can impact on the victim's journey through the criminal justice system. The Constabulary therefore has an ongoing programme of vulnerability training.

In conjunction with SARI (Stand Against Racism & Inequality), we delivered in November 2014 a conference entitled 'Policing for Disabled People' to frontline officers which covered: Autism & the Criminal Justice System; Alzheimer's & Dementia; being a wheelchair user – impacts and barriers and how the police service can be accessible; Mental Health; sensory impairments; contributions from Disability Advisory Group (DIAG); and panel discussions with service users.

Report prepared by: Carolyn Belafonte

Somerset Partnership NHS Foundation Trust

The Trust has a Head of Safeguarding who manages an integrated Safeguarding Service that covers: Safeguarding Adults; Safeguarding Children; Multi-Agency Risk Assessment Conferences (MARAC); Multi-Agency Public Protection Arrangements (MAPPA); PREVENT *(the NHS statutory response to the Government's CONTEST Counter Terrorism Strategy)* and Domestic Homicide Reviews (DHRs).

The Safeguarding Team has established two team bases: one within the new Bridgwater Police Centre as part of the Multi Agency Safeguarding Hub (MASH), alongside the police safeguarding coordination unit (SCU) and Children's Social Care; the other within Holly Court in Yeovil. The team provide safeguarding adults, children, MARAC, MAPPA and PREVENT cover across the county.

The Trust's Safeguarding Adults at Risk Policy has been revised and restructured to reflect the major changes and developments to safeguarding adults as a result of the Care Act 2014 and the new Safeguarding Adults Board joint policy.

Other relevant policies, protocols and strategies relating to safeguarding adults and children are currently under review and development.

The broadening access of the RiO patient record system by staff across the Trust will further enable the safeguarding service to embed the 'Think family' approach and alerts added improve patient, staff and public safety.

The structure and resourcing of the Trust Safeguarding Service has been reviewed and has led to some posts being re-banded to enable better utilisation of the available resource.

Training and other development activities undertaken
Level 1 (formerly A) safeguarding adults training rates have been sustained at over 92% throughout the year. It is a mandatory requirement for all new staff and is undertaken at induction.

A Level 2 safeguarding adults e-learning package has been developed for all staff working in adult Services.

The Trust facilitated minute takers training for Safeguarding Strategy meetings on behalf of the Somerset County Council Safeguarding Adults Team

In response to feedback following a recent safeguarding children and children looked after review by the CQC, Level 3 safeguarding children training is now being provided to targeted groups of adult services staff in community mental health teams, MIU's and inpatient mental health settings. This also reflects the safeguarding service commitment to embedding the 'Think Family' approach across the Trust.

The Safeguarding Children Training Strategy and Policy is currently under review and will become a combined Safeguarding Adults and Children Training Strategy and Policy to reflect a 'Think Family' approach.

Somerset Partnership has completed one internal management review whilst participating in one Serious Case Review (to be known as Safeguarding Adult Reviews post the implementation of the Care Act from 01.04.15) in the last year. Two further potential Safeguarding Adult Reviews are currently being considered by the Somerset Safeguarding Adults Board.

The Trust has been involved in three Domestic Homicide Reviews during the year.

The practice of reviewing significant local incidents will continue and any lessons learnt will be disseminated to Trust staff and the wider Health community as appropriate.

Public awareness
The Trust developed a Safeguarding Adults Poster in partnership with the Somerset County Council Safeguarding Adults Team that was produced and distributed to all of the Trusts sites as well as being provided to the SCC Safeguarding Adults Team who utilised this in their own sites.

Contribution to the work of the Board and its subgroups
The Trust is represented on the Safeguarding Adult Board by the Head of Safeguarding and all of the Boards Sub-Groups by members of the Trusts Safeguarding Team. The trust is committed to working together with other Board and sub-group members towards ensuring adults in Somerset receive an excellent safeguarding service.

Issues for the Board's consideration during the coming year
A priority need is for the SAB's Policy and Procedures sub-group to devise guidance that gives clarity of roles and responsibilities at a more operational level than the Board's current Joint Safeguarding Adult at Risk Policy is able to provide.

Report prepared by: Richard Painter

National Probation Service

The National Probation Service is a new member of the SSAB.

Training and other development activities undertaken
All staff employed by the National Probation Service are recruited using national civil service recruitment policies. DBS checks are made on every staff member and extended security vetting is required for staff in key posts.

New staff joining the National Probation Service receive training on safeguarding as part of their induction. All frontline staff know how to report an adult safeguarding concern. The expectation is for staff to make any safeguarding referral on the same day information is received. All actions are recorded and observable by line managers. All frontline staff managing a caseload have 6 weekly clinical supervision by an experienced Senior Probation Officer, identifying safeguarding concerns and managing risk being the primary focus.

Frontline staff also attend all multi-agency information sharing meetings regarding safeguarding. Information sharing decisions follow legislative guidelines and made on a case-by-case basis under the guidelines of public protection and the prevention of crime.

Public Awareness
All frontline staff have received National Probation Service briefings on the new Care Act. All offenders managed by the service are given information to confirm that they will be treated with dignity and respect and are given information about how they can complain. Offenders are usually interviewed alone. Offenders managed by the service can request an appointment with their Probation Offender, or that officer's line manager, at any time. Any offender at risk of self-harm going through the criminal justice system is assessed and identified by probation staff so that the courts and prison service is aware. Any vulnerable adult at risk of being manipulated into extremism or radicalisation are managed under the PREVENT agenda in liaison with all local partner agencies.

Probation Officers routinely give offenders information of local support groups to adults they manage deemed to be at risk. Every year all adults managed by the service complete an anonymous survey seeking their views.

Learning from experience
The survey of offenders seeking their views of how the National Probation Service has treated them informs practice. Any relevant learning from serious case reviews is shared with front line staff in bi monthly practice development sessions and team meetings. Lack of knowledge in any area of safeguarding practice is identified and addressed during supervision. It is recognised that a priority for the National Probation Service is how to evidence that a sustained improvement in practice has been achieved.

Contribution to the work of the Board and its subgroups
As a new member of the Board, the National Probation Service's contribution to its work has been minimal to date. The National Probation Service is experienced in identifying safeguarding concerns and managing risk in a collaborative way with other agencies, so is well placed to offer a particular level of expertise.

Planned safeguarding activities and developments, 2015-16
- It will be important for the National Probation Service to continue to apply the learning from serious case reviews into operational practice. Sustained improvements in practice then needs to be evidenced.
- In our resource challenged times, the National Probation Service needs to ensure attendance at multi-agency safeguarding meetings are prioritised.
- The National Probation Service will need to ensure front line staff continue to make appropriate and high quality referrals to Adult Social Care and probation staff need to know how to challenge constructively should referrals not be acted upon in a timely way.
- Prevention of harm will continue to be a priority, to be met by the ongoing engagement with adults this service works with, to signpost people to secure help and support at the earliest opportunity.

Issues for the Board's consideration during the coming year
- Multi-agency training in adult safeguarding needs to be assessed so that the Adult Safeguarding Board can be assured that this training has an impact on multi-agency operational practice.
- Priorities agreed by the Board need to have clear action plans which clearly sets out what work will be done by each agency to tackle each priority.
- A key issue will also be to ensure the Care Act 2014 requirement for local authorities to provide social care for adults in prison and approved premises is achieved.
- The Prevent agenda needs to be integrated into safeguarding procedures (to including internet safety) so that all front line staff are aware of the referral process for vulnerable people.

Report prepared by: Angela Powell

Taunton & Somerset NHS Foundation Trust

Over the last year, we have continued to develop and review our policies and processes for safeguarding adults.

We have completed a full review of our Safeguarding Adults at Risk Policy to reflect some organisational changes and to ensure that we now include all of the guidance from the Care Act and the Care and Support Statutory Guidance from the Department of Health.

During the last year, we have also updated the Trusts Supervision of Patients at risk of Harm policy; the Use of Restraint and Restrictions policy and the Wandering Patients policy.

Other key developments over the last year have been; improvements to our audit processes for vulnerable adults; revision of our Deprivation of Liberty Safeguards processes and the revision of all training presentations to reflect the Care Act.

We are also working with the County Council and Knightstone Housing to establish a hospital Independent Domestic Violence Advisor service to support victims of domestic abuse who attend the hospital. This service has a particular focus on the Emergency Department and the Maternity Unit.

Our safeguarding work is managed through an active plan of work that is overseen by the Trust's Safeguarding Committee. Our progress and success in achieving our plans is monitored through the regular Safeguarding Committee and through regular reporting and an annual report. This is supplemented by an ongoing audit programme looking at the Trust staff awareness of our policies and procedures. An audit of notes is also part of our audit programme. This has a focus on our care of patients with a learning disability.

Training and other development activities undertaken
Staff training continues to have Safeguarding Adults as a mandatory subject for induction and ongoing updates.

Our current compliance with mandatory training for Safeguarding Adults is 87%. Work has started to make our safeguarding adult training suitable for use for the introduction of the new Care Certificate for staff induction.

We have also continued to work towards increasing our training of senior staff in the use of the Mental Capacity Act. We will support this work further by employing an administrator to support this training programme.

We are currently looking at our training plans for safeguarding for the coming year including moving to a three level training programme.

Public Awareness
Public awareness of Domestic Abuse has been improved through the distribution of leaflets and through the use of posters with domestic abuse contact information to help people access support. There has been particular focus in the Accident and Emergency department.

Learning from experience
We have not taken part in any serious case reviews related to safeguarding over the last year. We have taken part in the Domestic Homicide review process and have made changes to our processes in response to the learning from these reviews.

All learning from Safeguarding is taken forward and monitored at the Trust Safeguarding Board and is integral to the Trust framework for continuous learning across the hospital.

Contribution to the work of the Board and its subgroups
As a partner the Trust has actively contributed to the work of the Safeguarding Adult Board, this includes the development of the Board and the Strategic Plan for the SSAB in accordance with the care act.

Planned safeguarding activities and developments, 2015-16
Our priorities over the next year are:

- To build on our work to establish an Independent Domestic Violence Advisor to support victims of domestic abuse and further develop our policy to support this work across the Hospital.
- To work with our partner agencies to establish a new training programme for safeguarding adults that is consistent across health services in Somerset.
- To continue focus on training and supporting staff in the application of the Mental Capacity Act.
- To embed our safeguarding training as part of the new Care Certificate induction programme.
- To contribute actively to the work of the Somerset Safeguarding Board and implementation of the strategy for Somerset.
- To consider all new guidance and legislation and change our processes and policies to reflect the most up to date advice, guidance and legislation.
- To constantly learn from safeguarding investigations, incidents and complaints so we can continue to improve the services and support we offer to the most vulnerable people in the community who use our services.

Issues for the Board's consideration during the coming year
We have no specific issues we wish to raise with the board at this time. We look forward to continuing to work closely with the board and its sub-groups to improve adult safeguarding across Somerset.

Report prepared by: Duncan Marrow

Yeovil District Hospital NHS Foundation Trust

This year has seen significant developments in the Safeguarding Adults Team within Yeovil District Hospital (YDH).

The Acute Learning Disabilities Liaison Nurse moved to a permanent position mid-year (June 2014). This provided the Trust with the opportunity to review the Safeguarding Adults Team structure within YDH. The Safeguarding Adults Lead is now also the lead for the YDH Acute Learning Disabilities Liaison Service (ALDLS). A new post, Safeguarding Adults Practitioner, was successfully recruited to and this supports the Safeguarding Adults and Learning Disabilities work programme in the Trust. In addition, we have recruited a Safeguarding Nurse on a fixed term contract to enable the Safeguarding Adults Lead to focus on the Mental Capacity Act development work funded by the Clinical Commissioning Group (CCG). Both new team members are Learning Disability Nurse qualified, thus strengthening our ALDLS further and providing additional resources for caseload management of safeguarding concerns raised with YDH.

The trust has seen an increase in the number of alerts and referrals being raised through safeguarding. This is in line with national reporting figures which have also shown an increase. This is partly due to raised awareness within the organisation regarding safeguarding issues, and also due to an increased public awareness. A number of these referrals, once reviewed with the Local Authority's social care team, may not be thought to be safeguarding but will have identified a need for additional care provision or be a practice issue that highlights a need for additional training or education.

The Safeguarding Team received 346 patient referrals in 2014/15 (average of 33 per month, an increase from 27 per month the previous financial year) either related to safeguarding concerns,

referrals for learning disability patients, advice around mental capacity act or in relation to Deprivation of Liberty Safeguarding Applications. As a team we have managed 63 individuals with learning disabilities in 2014/15 (26 female; 37 male; 20 as outpatients and 43 as inpatient referrals).

Training and other development activities undertaken

Safeguarding Adults training is provided at 3 levels. During corporate induction all staff receive Level 1 Safeguarding Children and Adults awareness training. Non- clinical staff then attends mandatory level 1 training mandatory every 2 years. Level 2 Safeguarding Adults training is provided to all clinical staff on a two yearly basis. Level 3 training is provided for Matrons and other senior nurses and medical staff. This training includes providing an understanding of how to carry out safeguarding investigations, the Mental Capacity Act updates and Deprivation of Liberty Safeguards processes and case law updates. The content of this training is reviewed annually to ensure information is current and any learning from Serious Case Reviews be shared. Additional sessions are held for medical staff and individual departments as required. Awareness sessions have recently been held for the Council of Governors and for the Trust Board.

We provide a monthly Health WRAP workshop session open to all staff (but with a focus on high risk areas such as ED, EAU and Ward 10) to raise staffs awareness of their responsibilities in relation to the PREVENT agenda. The Emergency Department leads on the programme of training specifically related to the issue of domestic abuse and provides sessions to all ED staff all those with a relevant professional interest.

It has proven challenging to deliver the numbers of training sessions needed to achieve compliance above 80% and other methods of delivering Safeguarding training are being examined including the development of workbooks and e-learning.

Public Awareness

We have carried out a Learning Disabilities Scoping exercise where we invited learning disabilities patients and their family / carers into YDH to inform them about the current Acute Learning Disabilities Liaison Service that we provide, gain feedback around their personal experiences of care in YDH and work together to identify how we may develop the service further with their continued input. We are currently working on the actions agreed at that meeting and a follow-up meeting is planned for later in 2015.

Learning from experience

Following on from the Supreme Court ruling Cheshire West v P 2014 the Trust has reviewed and updated its Deprivation of Liberties Safeguards policy and guidance. The existing processes in place that assist staff in the identification, application and management DoLS applications have also been reviewed and additional guidance has been developed to assist staff in completing the DoLS application forms. The Trust has seen an increase in the number of DoLS applications from 9 in 2013-2014 to 40 in 2014-2015 which reflects the increase in demand nationally.

Following on from the House of Lords Select Committee Report on the Mental Capacity Act (2014) and the Government's response "Valuing every voice, respecting every right: Making the case for the Mental Capacity Act" the Trust was successful in acquiring funding from the CCG to provide a programme of training aimed at updating clinical staff knowledge in relation to the MCA. This project commenced in September 2014 and consisted of a baseline audit, development of a training programme and roll-out of targeted training alongside external speaker provided by legal firm Bevan Brittan. Further work to embed knowledge and responsibilities in relation to the MCA is planned for the summer of 2015.

The YDH Safeguarding Adults Policy has been updated to reflect the changes to safeguarding adults in anticipation of the implementation of the Care Act 2014 from April 2015. All training has been updated to ensure staff are aware of the changes as set out in the Care and Support statutory guidance 2014 and a number of presentations have been provided by the Safeguarding Adults Lead to key staff including the Trust Board, Hospital Management Team, Clinical leadership Group and at a Trust wide Governance session.

Contribution to the work of the Board and its subgroups

In 2014/15 the SSAB has undergone a period of review following the appointment of a new independent chair.

The Trust, as a key provider agency, has been actively involved in supporting the ongoing development of the board. This has taken the form of attendance at Board development days and work planned for the implementation of the Care Act 2014.

In 2015/16 the Trust will be utilising the SSAB's 2015-2016 work plan to assist in the prioritisation of safeguarding work within the Trust.

Planned safeguarding activities and developments, 2015-16

Item	Date Due	By Whom
To regularly review and update current policies and develop new as required in relation to the service.	Ongoing	Safeguarding Adults Lead
Plan to develop and integrate safeguarding child and adult team structures within YDH following changes in personnel within Safeguarding Adult team.	Ongoing	Associate Director of Patient Safety and Quality
To continue to develop and refine data capturing systems to accurately record safeguarding activity, DoLS applications and outcomes	Ongoing	Safeguarding Adults Lead
To work with Communications Team to develop Easy Read information for patients with LD	December 2015	Learning Disabilities Lead
Review and evolve existing processes in relation to Domestic Abuse concerns within YDH	April 2016	IDVA Safeguarding Adults Lead
Review and update PREVENT policy, training strategy and intranet to reflect the new statutory PREVENT duties as from 1st July 2015	September 2015	PREVENT Lead
To develop a robust audit programme for Adults at Risk, Learning Disabilities Reasonable Adjustments, DoLS process and Training provision	December 2015	Safeguarding Adults Lead + Learning Disability Lead
Develop plans to ensure patients are at the centre of adult safeguarding process and have strong voice in decision making. Explore options on how this can be achieved as part of the making safeguarding personal agenda.	Ongoing	Safeguarding Adults Lead

Issues for the Board's consideration during the coming year

- YDH would welcome clarity on definition of training levels and requirements to reflect changes set out in the Care Act 2014, to include incorporation of the new PREVENT training strategy requirements.
- Clarity on agencies involvement in carrying out enquiries on behalf of the local authority. Guidance on what this will entail, reporting guidelines (timescales / structure of report), training for staff likely to be expected to carry out enquiries on behalf of the local authority.
- Closer links to PREVENT work being carried out in the county.

Report prepared by: Maddie Groves and Julia Hendrie

South Western Ambulance Service Trust (SWAST)

SWAST are aligned to 28 Adult and Child Safeguarding Boards within the operational area. The trust endeavors to maintain relationships with all these organisations in the interests of their responsibility to safeguard but due to the complexity and unique coverage, an efficient and pragmatic approach needed to be agreed. Following National Guidance, the trust continues to work with the Boards under a 'memorandum of understanding' agreement to maintain communication relationships with all Boards.

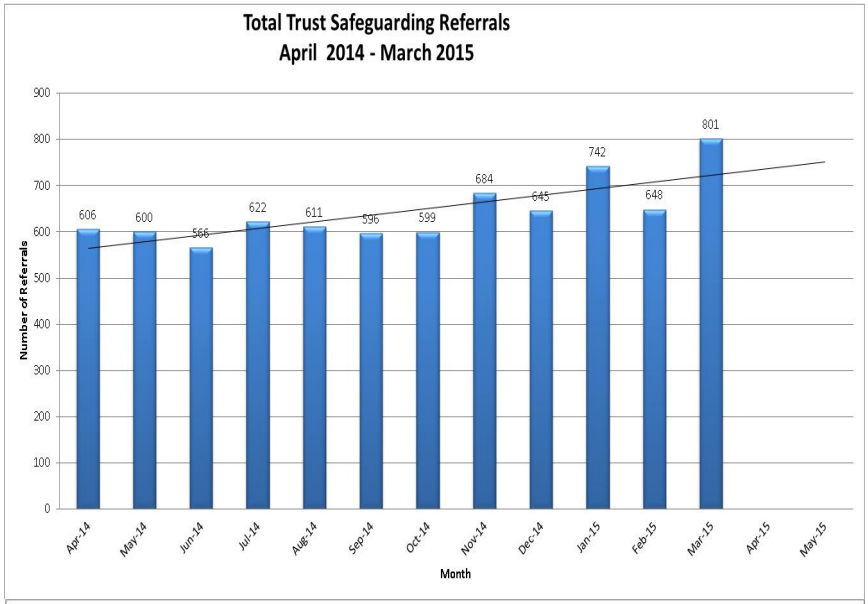
In order to further evidence multi agency working and other areas of work, activity data has been collected by each member of the team on a monthly basis and collated for the first time this year.

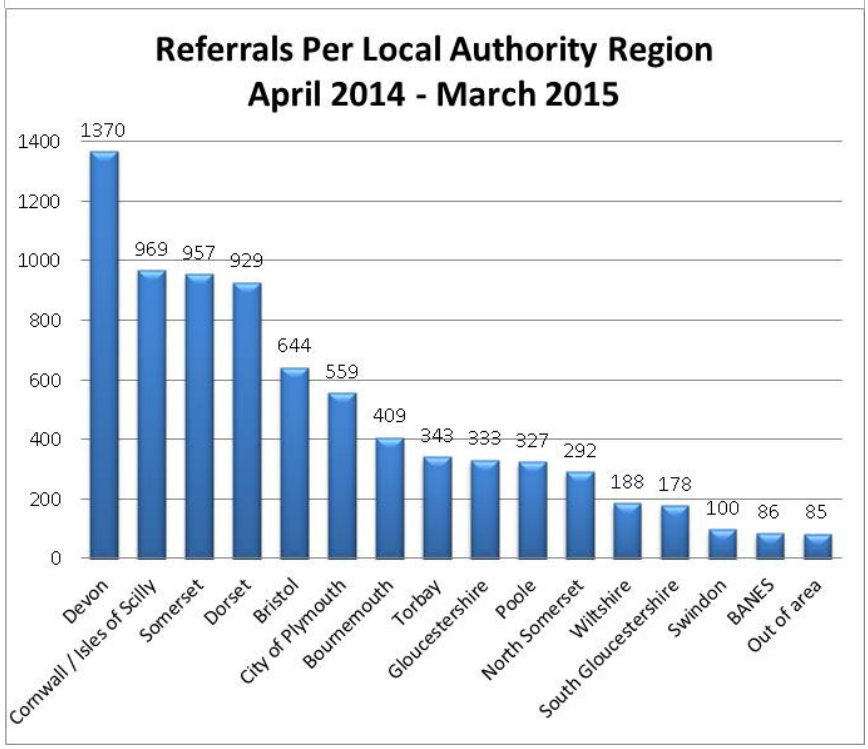
Yearly figures for the whole team are outlined below:

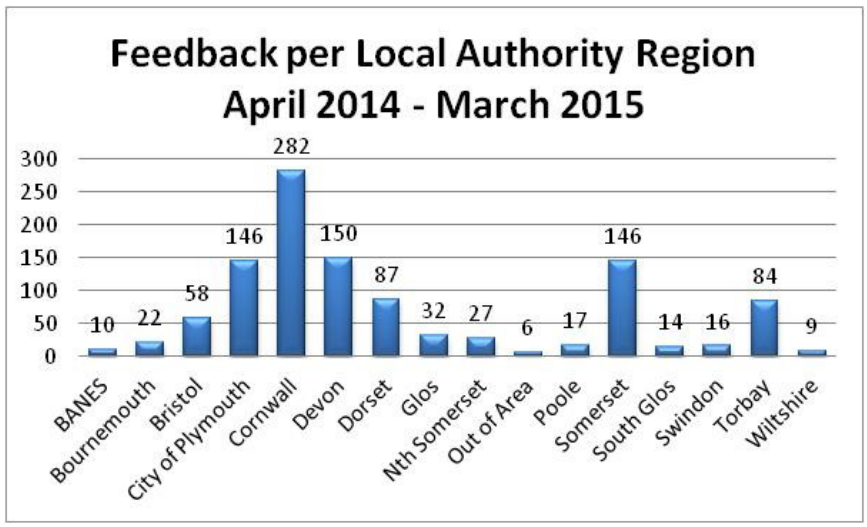
No. Child Death Reviews attended	29
No. Child Overview Panel meetings attended	30
No. Seriouos Case Reviews Researched	61
No. Serious Case Review Meetings attended	21
No. Safeguarding Board Meetings attended	57
Other Multi-Agency Meetings attended	66
Sub Group Board Attendance	10
Social Services Queries	1176
Other Agencies Queries (GP/Hosp/Police/HV etc.)	276
Staff advice calls/emails	393
No.Chronologies completed	62
No. Audit completed	81
No. Training Sessions	58
Staff Trained	724
No. Training sessions attended by Team	37
No. Supervision Sessions provided by Team	36
No. Supervision Sessions attended by Team	25
No. Safeguarding Case Investigations	60
No. Case Conferences attended	10
No. Policy Review	27

Safeguarding Referrals

In total during the year 1st April 2014 to 31st March 2015, 7,769 safeguarding referrals were submitted across South Western Ambulance Service. This is an increase of 1,945 or 33%. The trend line predicts a continued increase in the coming year. See chart below:


Total Trust Safeguarding Referrals
April 2014 - March 2015
Number of Referrals
Month
606
600
566
622
611
596
599
684
645
742
648
801
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15


Referrals Per Local Authority Region
April 2014 - March 2015
1370
969
957
929
644
559
409
343
333
327
292
188
178
100
86
85
Devon
Cornwall / Isles of Scilly
Somerset
Dorset
Bristol
City of Plymouth
Bournemouth
Torbay
Gloucestershire
Poole
North Somerset
Wiltshire
South Gloucestershire
Swindon
BANES
Out of area


Feedback per Local Authority Region
April 2014 - March 2015
10
22
58
146
282
150
87
32
27
6
17
146
14
16
84
9
BANES
Bournemouth
Bristol
City of Plymouth
Cornwall
Devon
Dorset
Glos
Nth Somerset
Out of Area
Poole
Somerset
South Glos
Swindon
Torbay
Wiltshire

Training and other development activities undertaken

A&E Service Line: The Trust has managed to reach an average 90% completion rate trust wide, as per performance target and is one of very few UK Ambulance Trusts to have achieved this. This was possible due to the agreement with operations of a 'front loading' approach from the start of 2014/15.

An agreement has been made with the operations team that 10 further days of SME 2014/15 training will be provided on overtime in North Division only, so as to increase that Division's performance to 90% also, the aim being to ensure compliance by Division as well as the Trust-wide average.

The end of year position is West =94% East 95% North = 82%

UCS/111 Service Line:

Area	No. of 111 staff	Completed	%	No. left to train
Devon	103	103	100%	0
Cornwall	50	50	100%	0
Dorset	90	89	99%	1
Somerset	38	38	100%	0

The above clearly shows that 280 members of staff were trained and that compliance with the target set for Safeguarding Training in the 111/UCS Service Line has been achieved. In addition this strategy has resulted in a saving of £100k against a penalty which is a substantial achievement.

In total the Safeguarding Service has personally trained 724 staff in total across all service lines.

The HR Business Partners have all been trained by the Head of Safeguarding in the management of allegations.

The Information Governance Team have all been trained to Level 2 by the Head of Safeguarding.

The safeguarding training for CFR's and other volunteers has been updated following the Savile recommendations. The delivery of this will be quality assured by the Named Professional West in May 2015.

OOH GP's remains a challenging area in which to achieve compliance due to the transience of this workforce. In order to mitigate this, any new recruits to this service are unable to start work unless they provide evidence of current safeguarding training (same strategy as applied to BLS/ALS).

Bespoke Safeguarding training has been delivered on request by Stations for CPD Events.

In order to address requirements for Supervision a number of staff have received a 2 day bespoke training from a specialist provider.

There has been some external interest in The Safeguarding Service delivering training. This commenced with the Head of Safeguarding delivering Managing Allegations training to 30 HR Staff at the London Ambulance Service.

PREVENT training has been agreed for 2015/16 as part of SME.

The current outstanding areas to achieve evidence of training are:
1. Bespoke training to Governors and Patient Experience staff
2. Evidence of training to PTS staff
3. Evidence of training to 999 hub staff
4. MIU

Child Death

There have been 173 child death notifications from Local Safeguarding Children Boards in 2014-15. Of these, 124 'Form B's' have been required. Form B's are the notification form completed by the Safeguarding Service with detail of Trust involvement with the child or family. It is completed by each named professional in that area. Therefore, it would appear that the Trust has been involved in 72% of cases. The Head of Safeguarding still has some concern that not all child deaths are reported to the Service; this is an action for 2015-16.

Key progress and achievements, 2014-15

- 8 of the 11 recommendations in the peer review have been achieved and 3 are in progress.
- 2 seconded posts were agreed this year – a Band 5 Triager and a Band 7 Named Professional.
- All SCR/DHR/chronology requests were responded to in a timely fashion.
- The safeguarding referral system is more sophisticated to produce quality data.
- A successful SW Audit took place in January 2015.
- The Safeguarding Service worked with Alcoholics Anonymous (AA) to provide a raising awareness campaign across the Trust area by use of leaflets, posters etc, and as a result, the AA covered the Christmas and New Year period on the alcohol recovery bus.
- All frontline staff have been offered Level 2 training in safeguarding with an overall attainment of 90% staff attendance.
- All new 111 or 999 staff have had safeguarding training as part of their induction programme.
- All 111/UCS staff have been offered Level 2 training with an overall attainment of 99% preventing a CQUIN of 100k.
- There are now 25 safeguarding champions who are active across the Trust area.
- All Notice Boards in the North Division stations have been updated to reflect the new issues facing this agenda.
- The managing allegations policy has been further embedded in the operational services.
- PREVENT training has been agreed on the SME training for 2015-16.
- The Head of Safeguarding has been elected as Chair of the National Ambulance Safeguarding Group (NASG) this year which reports to QGARD.
- The Child Death Review Process and pack has been agreed so that all staff who attend a child death will be supported by the OO at the time of the incident in a formal process as the Form B notification will be completed at the time allowing for reflection and accurateness at the time.
- A Safeguarding Training strategy has been agreed so all Board members, Managers and Staff are able to understand more effectively what is expected of them.

Planned safeguarding activities and developments, 2015-16

The priorities for the Safeguarding Service were decided at the team meeting in March 2015. These are:

- Continue to ensure the completion of a centralized recording system for safeguarding training across all departments.

- Review the current referral system to promote a more efficient system with input from IT.
- Work plan to be guided by NASG workplan and Saville Recommendations.
- Embed the PREVENT agenda.
- Implications from the Care Act for the Trust.
- Expansion of the Welfare agenda.
- Consider a more resilient team by integrating more with the Governance Structure.
- Agree a Supervision Strategy for the Trust.
- Escalation Policy to be approved.

Report prepared by: Sarah Thompson

NHS England South, South West (NHSE SSW)

To ensure that the NHS community is working effectively as a partner with Local Safeguarding Boards, NHS England has developed a National Safeguarding Forum to work across England to offer advice and expertise to Boards on Safeguarding, Mental Capacity, Transforming Care / Winterbourne View, Prevent, National Safeguarding Reviews including Saville, and learning lessons/disseminating learning from Serious Case Reviews through the established NHSE Quality Surveillance Group.

The forum is further supported at a local level with local NHS Safeguarding forums, including membership from CCGs and Primary Care. The NHSE SSW team support the Somerset Safeguarding Adults Board with a designated lead.

There is designated support with the PREVENT agenda, with a PREVENT lead providing advice, training and awareness through the healthcare system including primary care, dental and pharmacy services and optometrists. NHS England have also provided additional funding to support this work and regional PREVENT coordinators are being aligned to the Home Office priority areas.

NHSE SSW are working in partnership with CCGs, specialist commissioning and Safeguarding leads to gain assurance and review progress with the Transforming Care/Winterbourne View Concordat to ensure that vulnerable people with learning disabilities are in the right place receiving the right care as near to home as possible. All CCGs provide good evidence and documentation of the work being undertaken and the governance of the programme in response to the Winterbourne View recommendations, including their links to local Learning Disability Forums, partnerships and Safeguarding Boards.

Report prepared by: Carole Crocker

5. What the Board did in 2014-15: a snapshot

With the Care Act clarifying the role and responsibilities of Safeguarding Adult Boards, 2014-15 has consequently been a period of transition and development for the SSAB as it has worked to ensure local compliance with legislation, enhance its effectiveness and raise its local profile.

Key activity undertaken during the year includes:

- Working in partnership with North Somerset, BANES, Bristol, and South Gloucestershire to develop a regional Safeguarding Policy, which has been adopted by the five areas. The policy will continue to be jointly reviewed and updated.

- Reviewing the Board's structure and Terms of Reference, and widening its membership and reach.

- Holding a SSAB Development Workshop (March 2015), facilitated by Margaret Sheather (Independent Chair of the Wiltshire and North Somerset SABs) to ensure Care Act compliance by the beginning of the new financial year, and determine critical priorities for the year ahead.

- Working together with the Local Safeguarding Children Board (LSCB) to conduct a Learning Review into the deaths of vulnerable young people. In recent years, there has been a growing understanding of the vulnerability for adolescents as a result of early neglect and/or abuse, and the subsequent links with high risk activities, such as alcohol and substance misuse and some criminal activities. Such early life experiences are a feature of the lives of many children who are Looked After by the local authority, or of adults who were previously looked after. Through the good links between Somerset's Leaving Care Service and care leavers, staff became aware of the deaths of several young people who had, at some stage in their lives, been looked after. Somerset's LSCB and the SSAB were already concerned about the vulnerability of older adolescents and how to provide ongoing support into adulthood. The need to explore how to improve services for vulnerable care leavers in their transition into adulthood was heightened on hearing about these early and unexpected deaths. In response, both Boards decided to jointly commission a study of the experiences of these young adults, to learn more about how services can best support care leavers in their transition into independent adulthood. The findings will be used by both Safeguarding Boards to inform and influence local practice and service delivery. The full report can be accessed via the following link:
  https://slp.somerset.org.uk/sites/somersetlscb/LSCB%20Documents/Somerset%20Learning%20Review%20into%20Deaths%20of%20Vulnerable%20Young%20Adults.pdf

- The commissioning of a Serious Case Review into the care of a young woman with a learning disability thought to have been the victim of domestic violence and sexual exploitation. The overarching aim of the review is to learn lessons that can be applied across the professional network in order to strengthen procedures and practice on behalf of those who are at most risk in future. The review is expected to complete at the end of 2015, and findings will be reported in the SSAB's 2015-16 Annual Report. *Additional reviews have also been considered for the year ahead.*

- Reviewing resourcing arrangements for the Board and seeking funding contributions to support the Board's future development and effectiveness.

6. What the Board will do in 2015-16: a snapshot

The Board's Development Day, held in March 2015, identified both strengths and areas for further development for the Board, based on member feedback:

SSAB Strengths	SSAB Areas requiring attention
• Committed people • Everyone has a voice and can contribute freely • Membership • Honesty and transparency • Welcoming, good networks • Working together • Launch-pad for addressing 'hidden harm'	• Evidencing the impact of the Board • Lack of resource • Organisation to support participation • More mutual holding to account and development • More direction and confidence • Focus on outcomes • Communications • Assurance and accountability • Involving and motivating frontline staff • Vision/action/parity with the LSCB • Links with the Community Safety Partnership • Links with partner organisations • Links with service users/carers

In response to these findings, and taking account of priorities identified by partners, the SSAB has agreed the following six strategic priorities for 2015-16:

1. **Leadership and Governance** – *focused on structure, governance and partnership arrangements*

2. **Developing the SSAB** – *focused on local effectiveness and compliance aspects for the Board*

3. **Quality Assurance and Performance Management** – *focused on strengthening and developing local performance monitoring and auditing*

4. **Safeguarding Adult Reviews** – *focused on ensuring compliance in relation to conducting reviews and developing local procedures*

5. **Making Safeguarding Personal** – *focused on ensuring the principles embedded in MSP are implemented and understood*

6. **Prevention** – *focused on reviewing information available to the public and awareness raising activities*