Issue 15, Oct 2021

Newsletter

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

This is the 15th edition of the Somerset Safeguarding Adults Board (SSAB) newsletter, and we hope those who have received copies since its launch continue to find it a useful resource and an interesting read.

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

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

In this issue:

News from the SSAB

Since the last newsletter was published the SSAB has met on 12/10/2020. Agenda highlights included:

- An update on discriminatory abuse in Somerset from Stand Against Racism & Inequality (SARI)
- Discussing learning for Somerset from a national review of Safeguarding Adult Reviews from April 2017 to March 2019
- Receiving a briefing on the Prevent Annual Report
- Receiving a briefing from the Board's Performance & Quality Subgroup on the SSAB's Performance Report.
- A discussion of the development of our next strategic plan for 2022

At its meeting in October 2019 the Board made a decision to publish the minutes of Board meetings in full from that meeting onwards, with the exception of redacting confidential information relating to an individual (for example where someone has spoken about their experience of being safeguarded). Notes are published on the **SSAB Website** retrospectively following sign-off at the next meeting.

Annual Report for 2020-21 Published

We published our annual report for 2020/21 on 07/10/2021, along with a one-page summary.

Introducing the report our Independent Chair, Keith Perkin, wrote:

"The challenges that faced colleagues during a protracted time when we were constrained in our activity continue, and in many cases exacerbated as we now move into a period of greater freedom. However, what remains is the passion, professionalism and dedication within Somerset to safeguard those adults who need our help. During our Board meetings throughout the year, it was both a privilege and humbling to hear the experiences of those who are directly involved in providing that support to vulnerable adults. It certainly provided a valuable insight into not only the challenges faced, but how colleagues quickly adapted to new ways of working, both within their own agency and in partnership…. In recognising that 2020/2021 was such a challenging year for individuals and agencies who are responsible for safeguarding those adults who are at risk of abuse and neglect in Somerset, I would like to thank all who have worked so tirelessly in ensuring our most vulnerable are kept safe."

Further information

- **Annual Report**
- **One-page summary**

SSAB Self-Audit 2021

The SSAB self-audit 2021 has now closed, and results were collated on 05/10/2021 and are now being analysed.

We would like to extend our thanks to all who have taken part and we look forward to sharing a summary of the results once they have been reviewed by the Board.

Guidance and leaflets

Since our last newsletter we have published a new leaflet:

- **Mate Crime**

We are also in the process of developing additional materials to raise awareness of this type of abuse.

Reminder: Your Adult Safeguarding Experience Feedback Form

In our last newsletter we wrote about this initiative and would like to say a big thank you to everyone who has provided feedback so far. It would be great if readers could continue to promote this opportunity within their organisations to encourage further responses.

Somerset County Council's Adult Safeguarding service would like hear feedback not just from people who have been supported by adult safeguarding services, and their carers, but also from those who advocate or support them on a professional basis.

The forms below have been developed with support from Healthwatch Somerset, and Somerset County Council's Adult Safeguarding service will offer support to people in completing these if they are unable to access electronic versions.

- **Adult Safeguarding Service Questionnaire for adults who have been supported by safeguarding services**
- **Adult Safeguarding Service Questionnaire for carers, relatives or friends**
- **Adult Safeguarding Service Questionnaire for Advocates, IMCAs and Providers)**

The information received by the County Council will be reported regularly to the Somerset Safeguarding Adults Board.

Save the Date: Stop Adult Abuse Week and Joint Online Conference Workshops

Stop Adult Abuse Week will take place from Monday 15th to Friday 19th November with a theme of Creating Safer Cultures.

As part of this weeklong campaign, which is aligned with the National Safeguarding Adults Week, there will be series of jointly held online workshops that will be free to access for any practitioner working with adults across Somerset, North Somerset, South Gloucestershire, Bristol and Bath & North East Somerset.

- Monday 15th November at 12.30- 1.30pm – Emotional Health and Wellbeing
- Tuesday 16th November at 12.30-1.30pm – Trauma informed Practice
- Wednesday 17th November at 12.30-1.30pm – Gambling Awareness
- Thursday 18th November at 12.30-1.30pm - Exploitation of Adults
- Friday 19th November at 12.30-1.30pm – Safer Cultures

Further information

- **Find out more and register**

Save the Date: Reprovide in Somerset – working with Perpetrators of Domestic Violence

Reprovide is a free Domestic violence intervention programme for male perpetrators of domestic abuse. Barnardo's have been running weekly face to face groups successfully since July 2020. They are running a virtual session for referring professionals in Bath, Somerset and North Somerset.

Dr Nate Eisenstadt from the University of Bristol Research team and the Somerset Reprovide team will give an overview of the research and an update about the programme.

This session will take place on:

- Thursday 25th November at 10.00-11.00am

Further information

- **Register**
- **Information about Reprovide's research and programme**
- **Contact Reprovide: reprovide@barnardos.org.uk**

Review into Resident-to-Resident Harm

In August, the Social Care Institute for Excellence (SCIE) published a review into resident-to-resident abuse (RRA) in care homes and other residential settings.

The commissioning of this report reflects a core area of concern often highlighted by staff within care homes, particularly in those where secure accommodation is provided, and where people have been sectioned under the Mental Health Act.

The report sought to identify where best practice is currently demonstrable to share such examples for learning but, unfortunately, evidence of good practice was hard to locate.

Despite this, the report remains valuable for its exploration into this issue and is highly significant for being a UK-based research study in an area where limited research has been previously available. Its focus on RRA between people with learning disabilities and other groups, rather than older people like the traditional literature on this topic, makes its publication especially important.

The report categorises the types of this abuse, examines its prevalence, identifies risk factors and areas for future research, providing both information concerning the prevention of RRA, interventions on how to address it, and potential case studies.

In summary the report suggests the categorisation of RRA into the following groupings: verbal, physical, sexual, violation of privacy and taking/damaging another's belongings. They noted the link between these types of RRA to bullying and highlighted this as particularly present in care homes for older people.

A key finding of the report was the lack of documentation of this form of abuse and the apathy of some staff towards this issue, who may view it as inevitable within these settings. The report advocates for greater research into how widespread RRA is, although it suggests that from the evidence currently available, that it is prevalent.

The report identifies both resident and environmental characteristics which increase the risk of RRA occurring. Resident characteristics include dementia, mental illness, behavioural symptoms, and a history of aggressive or negative interactions with others. Environmental factors include crowded

environments, inadequate staffing levels, lack of staff training, high numbers of residents with dementia, a lack of meaningful activities, crowded common areas and excessive noise.

This work provides important recommendations for how these risk factors may be mitigated through addressing environmental considerations and care practices.

Further information

- **Download the full report**

Wash your hands of Coronavirus Scams!

Among the difficulties Covid-19 has brought into our lives, Trading Standards has seen an increase in scams as fraudsters are trying to exploit fear and uncertainty surrounding Covid 19.

Common COVID scams to look out for:

- Criminals targeting older people on their doorstep and offering to do their shopping. Thieves take the money and do not return.
- Doorstep cleansing services that offer to clean drives and doorways to kill bacteria and help prevent the spread of the virus.
- Email scams that trick people into opening malicious attachments, which put people at risk of identity theft with personal information, passwords, contacts, and bank details at risk.
- Fake online resources – such as false Coronavirus Maps – that deliver malware which can infiltrate a variety of sensitive data.
- Companies offering fake holiday refunds for individuals who have been forced to cancel their trips. Fake websites set up to claim holiday refunds.
- Fake sanitisers, face masks and Covid19 swabbing kits sold online and door-to-door. These products can often be dangerous and unsafe.
- Telephone scams, including criminals claiming to be your bank, mortgage lender or utility company.
- Illegal money lenders preying on people's financial hardship, lending money before charging extortionate interest rates and fees through threats and violence.

Tips to help protect yourself and others from scams:

- Ask any unexpected visitors for ID.
- Try to rely on trusted contacts for any help that you may need or consider using a service from a **'Buy with confidence'** business if you can't get a personal recommendation.
- Trust your instincts and say no to any offers that seem suspicious.
- Be wary of unexpected emails or texts and don't clicking on links or attachments. Always go to the organisation's website to check correct information and contact details.
- Never give out personal or financial information to people you don't know.
- Look up contact details yourself rather than using given over the phone.
- Only make online payments if there is a padlock symbol in the browser and you have carefully checked the site and website address for inconsistencies.

Further information

- **Report scams and get advice through Citizens Advice.**
- **Report scams to Action Fraud or on 0300 123 2040**
- **Further information on Coronavirus scams**
- **Follow Trading Standards on social media for updates**

Adapted from information produced by the Devon, Somerset and Torbay Trading Standards

New Safeguarding Guidance from Alcohol Change UK

In September, Alcohol Change UK published a new guide on "How to use legal powers to safeguard highly vulnerable dependent drinkers".

The guide aims to answer practitioners calls for additional information about applying the Care Act 2014, Mental Capacity Act 2005, and Mental Health Act 2007 to help people who without action are at risk of serious danger, including neglect, abuse, and untimely death.

The guide introduces when these three pieces of legislation can be used, but also the limits of them, in order to enable professionals to feel fully empowered to properly, proportionately, and confidently use legal powers to safeguard highly vulnerable dependent drinkers in their care.

This guide shows us how effective a coordinated effort between positive interventions and correctly applied legal powers can be to help people to be safer, healthier and achieve positive long-term outcomes not only for the person, but also their families and wider community.

Some key messages from the guidance include:

- The Care Act (2014) does apply to people with alcohol problems and the guidance on self neglect can be useful.
- The Mental Capacity Act may be used when someone is under the effects of alcohol
- Although there are challenges in applying the Mental Capacity Act to people who are chronic drinkers, the concept of "executive capacity" can be helpful.
- The Mental Capacity Act excludes people who are only dependent on alcohol, but can be used with people who have other mental or behavioural disorders coming from their drinking.
- People cannot 'choose' or 'like' an abusive or self-neglecting lifestyle. This is a myth.

Further information

- **Read the Briefing**

Business Manager Blog

Stephen Miles SSAB Business Manager

In my last blog I said that we would be trying to get back to our three-monthly cycle of newsletters after our much-delayed issue in August, and we've managed it. I hope you find our newsletters useful, and any comments - both what you like and what could be better, are always welcome.

Like most colleagues I found that the mythical reduction in work over the school summer holidays didn't appear yet again this year – if it ever really existed beyond some rose-tinted view of our early working lives! I managed to take a break this year, a UK stay rolled over from 2020 that included a visit to a colleague that I'd not seen since February 2020, but aside from that I've been focused on starting to try to catch up on some of the work we had, in common with many others, put to one side in order to support the system during the pandemic. But the pandemic isn't over, tens of thousands of people are still testing positive every day, and families are still losing loved ones.

At the end of September, the SSAB welcomed a new colleague, Marion Nuttall, who has joined us for six months to help us take our work forward between now and March, and has produced much of this newsletter and will also be helping us to increase our communications work. One of the first things Marion has done is to add a **LinkedIn profile** for the SAB.

As a Board we unfortunately have a number of Safeguarding Adult Reviews (SARs) underway, at least one of which we expect to publish before the end of the year. You can read more at the bottom of this page, but one of the things that strikes me most about the learning from SARs nationally is the disproportionate number of SARs involving self neglect compared to both referrals and enquiries under section 42 of the Care Act (2014). Further work is needed to gain a deeper understanding nationally, but what was clear to me when I was working on the SAR for '**Luke**' was that self-neglect is not a 'life choice' and is frequently associated with a trauma that time and compassion is needed to explore with the person. Our self-neglect guidance was updated in preparation for the publication of 'Luke' and you can read it **here**.

Finally, in November myself and colleagues are looking forward to taking part in a series of workshops being organised by the five Boards that work within the Avon & Somerset police area as we've once again been unable to hold an annual conference as in previous years. You can find out more how to book a place on page 3.

Learning Lessons

National: National Analysis of Safeguarding Adult Reviews April 2017 – March 2019

Background

This is the first national review of Safeguarding Adult Reviews (SARs) since the implementation of section 44 of the Care Act (2014) which established this duty for Safeguarding Adults Boards in England. The report:

- Includes published and unpublished reviews
- Builds on previous studies undertaken in individual regions, including the South West
- Considers learning from 231 reviews in a 245-page report, including reviews undertaken in Somerset

Quantitative Analysis

The report includes a quantitative analysis, broken down by region.

In this analysis the report identifies types of abuse that are often related, in that the occurred alongside each other in the SARs considered, for example:

- sexual exploitation and sexual abuse
- physical and emotional abuse
- Domestic, financial, physical, and emotional abuse

It also identifies types that are do not consistently occur alongside other types, for example neglect [and acts of] omission

The analysis also identified that:

- Cases of self-neglect make up a much higher proportion of SARs in comparison to the number of enquires under section 42 Care Act (2014) (p.13).
- A similar difference in age groups, with a much higher proportion of SARs being about people aged under 65, whereas the majority of enquires under section 42 Care Act involve people aged 65 and over (p.56).
- Some types of abuse, including discriminatory, financial, neglect [and acts of omission] and self-neglect are more likely to be associated with the individual dying (p.53).
- Partners, relatives or friends were perpetrators in many of the different types, although the most common perpetrator across all types is self (related to self-neglect cases) (p.68).

It also found that what also emerged from a detailed reading of the 231 reviews is the significance of the impact of a life event, such as loss of a parent. That impact may well be hidden from view, at least initially, and highlights both the importance of time to establish a trustworthy relationship and skill in sensitively exploring emotional distress." p.60

The analysis questions whether reviews and oversight of care provision, in whatever setting it is offered, are sufficient robust, and whether health, housing and social care practitioners express sufficient professional curiosity and authoritative doubt when they have the opportunity to intervene to prevent abuse and neglect, or protect individuals from significant harm (p.71)

Qualitative Analysis

- In the qualitative analysis the report identifies examples of good (p81-98) and poor (p99-170) practice across four domains:
  - The adult – direct work with the individual
  - The Team around the Adult – Interagency Working
  - The Agencies around the Team – Organisational Behaviour
  - SAB Governance

A summary of this analysis is shown in the four tables below, where "n" is the number of reviews where a theme was identified in good practice, poor practice or recommendations:

Themes relating to direct work of staff with individuals

Top good practice themes	n	Top poor practice themes	n	Top recommendation themes	n
Responding to health	56	Mental capacity	138	Risk assessment	72
Personalisation	53	Risk assessment	134	Mental capacity	64
Continuity	37	Safeguarding	115	Working with caregivers	62
Care/support	36	Working with carers	111	Care/support	56
Safeguarding	32	Care/support	110	Personalisation	47
Mental capacity	32	Responding to health	99	Responding to health	45

Themes relating to interagency working

Top good practice themes	n	Top poor practice themes	n	Top recommendation themes	n
Information-sharing	53	Case coordination	168	Case coordination	126
Case coordination	45	Information-sharing	162	Information-sharing	96
Safeguarding	37	Safeguarding	115	Safeguarding	76
Legal literacy	5	Procedures	53	Procedures	54
Record sharing	3	Legal literacy	44	Record sharing	27

Organisational themes

Top good practice themes	n	Top poor practice themes	n	Top recommendation themes	n
Management scrutiny	10	Staffing/workloads	64	Training	90
Commissioning	6	Management scrutiny	63	Commissioning	65
Specialist advice	4	Training	54	Quality assurance	48
Staff support	4	Resources	49	Policy/procedures	42
Quality assurance	4	Commissioning	49	Records/recording	38

SAB Governance themes

Top good practice themes	n	Top poor practice themes	n	Top recommendation themes	n
SAR management	3	Self-neglect policy	15	Learning dissemination	75
SAB procedures	2	Escalation policy	14	Quality assurance	50
Learning dissemination	1	Risk policy	9	Training	39
Membership	1	SAR management	9	Self-neglect policy	34
Training	1	M/capacity policy	8	Other procedures	33

Recommendations

The report makes 29 recommendations, and these are summarised on page 217 of the report. A total of 11 of these are national, while 18 are for local Safeguarding Adults Boards (although xx of these have a national or regional dimension to them, for example where something to be developed nationally then needs to be implemented.

The SSAB Executive Group has undertaken a gap analysis of all the local recommendations and has asked the Board's Safeguarding Adult Review Subgroup to initially take forward those where it felt that further work needed to be done, and will be regularly reviewing progress and reporting this to the Board. The SSAB has also volunteered to support work to take forward a number of the national recommendations

Read the report

National: Joanna, Jon and Ben (Norfolk)

Background

The purpose of the Safeguarding Adults Review (SAR) was to set out the experiences of three adults who died while patients at a private hospital in terms of their care management and the care and support services commissioned on their behalf. It was written by Margaret Flynn, who also wrote the SAR for Mendip House here in Somerset.

Joanna and Jon originated from London boroughs. Ben was from Norfolk. Their behaviour was known to challenge services and sometimes their families. Joanna and Jon had experienced several out-of-family-home placements. Ben had lived with his mother for most of his life.

Their placement at the hospital resulted from personal and family crises. It was the only placement which could be identified by Joanna's Clinical Commissioning Group (CCG) which had previously contacted 38 other services.

The relatives of the three adults, and those of other patients, described indifferent and harmful hospital practices which ignored their questions and distress. They were not assisted by care management or coordination activities. The families were worried about:

- the unsafe grouping of certain patients
- the excessive use of restraint and seclusion by unqualified staff
- their relatives' "overmedication"
- the hospital's high tolerance of inactivity

These all presented risks of further harm. In addition, the three patients did not benefit from attention to the complex causes of their behaviour, to their mental distress or physical health care.

Findings and areas for learning and improvement

Accountability: The setting for this SAR was a private hospital where a very high number of the placements were commissioned by out of area Clinical Commissioning Groups (CCGs), involving a variety of different funding authorities. This meant that face to face review was rare, oversight was limited, and local agencies were often unaware of the individuals placed there. This in turn impacted accountability, communication, information sharing for both the day-to-day care and any safeguarding issues. These are similar issues to those that were identified in relation to **Mendip House**, here in Somerset

Professional curiosity and challenge: Limited oversight meant that the quality of reviews, advocacy, and professional fact finding was equally limited, making challenge difficult. This finding can be applied more widely across all providers – it is essential to recognise the opportunities practitioners have when visiting, to ask questions on behalf of those who cannot. Staff must not take things they are told at face value, should ask for evidence and make sure they are listening to the voice of the person, not just the provider of the service. The report highlights how evidence of risks were noted but not acted on. Where there are evident risks, even if those are not seen as 'social care', staff must be curious and ask the questions – they may be the only one who does. **Remember: what you walk by, you accept.**

The trauma of transition: The SAR found that some of the individuals had experienced a high number of moves in their lifetimes, sometimes at very short notice. Services must consider the impact on the individual of moves from one setting to another, especially when poorly planned or rapid – how may this influence behaviour or future decisions about their environment? Place hunting in crisis situations may be unavoidable; but much more attention needs to be given to these points of transition to minimise the impact.

Meaningful support for individuals with behaviours that challenge others. Too often the focus of interventions, especially physical interventions, is to simply manage the presenting behaviours, without consideration of the root cause and potential triggers to prevent them occurring in the first place.

All behaviours are communication, and the onus is on practitioners to try and understand what it might be. Where necessary, assumptions about behaviour must be challenged to promote more individualised service responses.

The SAR noted that staff often did not recognise self-soothing or employ appropriate diversion techniques. Some of the language used to describe behaviours – "kicking off", "pushing boundaries", "histrionic", "tricky" – puts blame on the person without recognising the context.

The SAR also identified the significant lack of **meaningful activity** for patients which in itself impacted negatively on their physical, emotional and psychological health. With unstructured days, patients or service users will be bored, under-stimulated, frustrated; without exercise they may gain weight, lose muscle tone and motivation.

Resist normalisation: The number of safeguarding concerns reported by or about providers can vary due to a range of variables, not always negative, for example a very open culture around reporting. In common with Norfolk, in Somerset, we encourage reporting and openness, and it is not unusual that, in settings which support people who have a range of complex needs, there may be a higher number of concerns involving 'minor' incidents, often requiring no further safeguarding intervention. It is important however to ensure that every incident is considered both as a unique event and also in the context of others in the same setting.

Another issue identified through the SAR was the normalisation of racist abuse towards staff by the patients. The provider did little to address this, and staff did not routinely report incidents – it became something that just had to be accepted. Such approaches can lead to toxic work environments and impacts on the care provided. The **Norfolk Safeguarding Adults Board have published a 7 Minute Briefing on this in August 2021**.

Where the victim of abuse doesn't want to 'complain'. Sometimes people who have been abused by others will say they don't want to make a fuss / don't want to make a complaint. The confidence of staff to explore this is key – does the person feel at risk in their environment, do they feel it will make things worse for them, do they think there is no point because nothing changes? Explore with them the reasoning for this, do they have any impairment to their mental capacity which could impact this decision? Helping them to understand more about safeguarding and the processes which can support them is central to responsibilities to protect those who are supported by services. Information may still need to be shared, or action taken, especially where other adults may be at risk.

Prevention: One of the fundamental principles of safeguarding is prevention. The SAR noted a number of areas where this could have been improved. Providers need to be carrying out effective risk assessments, including environmental risk, and taking action to manage known risk. Again, visiting staff have a critical role here to ask questions and see the evidence they are doing this. Most importantly, involving and listening to family and friends, welcoming them as equal partners wherever possible (and in line with the adult's wishes), using their perspectives to inform how a person's care and support is designed and provided.

Recommendations

A total of 13 recommendations were made as a result of these findings. Please refer to the SAR report for details and further information (link below).

Further information

- **Read the Review and information published alongside it**

National: Maria (Suffolk)

Background

Maria (pseudonym) aged 89 at the time of her death in 2017, had been a resident in a care home for over 2 years before she died. During her time there, she had problems with her weight and with eating, infected pressure ulcers and other infections. Maria was often in pain because of her pressure ulcers. At the end of her life, Maria was admitted to hospital with poor skin integrity, three large Grade 4 pressure ulcers on her thigh, chin and sacrum and skin tears on her arms and legs. This meant that she had extensive areas of rotting flesh.

When speaking with Maria about her experience in the care home, a social worker described her as "a very frail lady who had capacity." They recorded that Maria spoke of how care staff walked past

her door and did not look at her; that she thought 'they' believed 'she is too far gone' and 'is making a fuss'. The social worker described their first impressions of Maria as 'devastating'.

A Safeguarding Enquiry commenced following Maria's final admission to hospital. A decision to carry out a Safeguarding Adults Review (SAR) was made by the Safeguarding Adults Board (SAB) in February 2019. The focus of the review surrounded what factors contributed to why harm to Maria within the care home was not identified sooner and the effectiveness of multi-agency responses

Key considerations for practice identified in the review

While this learning was from outside of the area, we have picked out key sections of the learning and contextualised them for Somerset below:

1. **Providers should be aware of, and appropriately utilise, the safeguarding resources within the health and social care economy in its area.**
   - All practitioners working in Somerset should know how to and be capable to apply safeguarding principles in everyday practice and should be aware of the **Joint Safeguarding Adults Multi– Agency Policy** and the **online guidance** that supports it.
2. **GP practices should understand, and appropriately use, safeguarding processes to support decision making and referral.**
3. **Pressure relieving mattresses and other medical equipment should be regularly checked.**
   - It should be ensured that equipment is in a suitable condition, but also suitable for the needs of the person using the service. Where care homes are unsure, they should make specific enquiries in relation to the equipment needs of individuals to ensure that these needs are met, and if they believe that they have changed ensure that appropriate referrals are made.

Further information

- **Read the Review**

Local: Domestic Homicide Reviews

You can read Domestic Homicide Reviews and case summaries published by the Safer Somerset Partnership here: **Domestic Homicide Reviews – Somerset Survivors**

Learning from Children's Services

We encourage our readers to have a look at the latest Learning Bulletin from the Somerset Safeguarding Children Partnership, **'Things You Should Know',** which focuses on what we can learn from examples of good practice and includes a recent safeguarding conversation, and a case study providing a family with early help.

In September, the Child Safeguarding Practice Review Panel issued a new publication for national learning **"The Myth of Invisible Men"** which concerns safeguarding children under 1 year old from non-accidental injury by a male care giver.

Key messages potentially relevant to Adult Services include that:

- Agencies should involve fathers/male carers to a much greater degree.
- It is worth remembering the key contribution that GPs can make to all aspects of multi-agency working.

Local & National News and Headlines

- Mental Capacity Law and Policy: **Coercive control, capacity and the resolution of an ethical dilemma** (October 2021)
- Home Office: **Official Statistics**: **Hate crime, England and Wales, 2020 to 2021** (October 2021)
- The Guardian: **Disability Hate Crimes in England and Wales increased 9% since start of pandemic** (October 2021)
- National Fire Chiefs Council: **Making sure your Care Home/Nursing Home is safe from fire** (October 2021)
- Somerset NHS Foundation Trust: **Developing mental health services - Our Somerset Story** (October 2021)
- Avon and Somerset Police: **New officer verification process put in place** (October 2021)
- BBC NEWS: Whorlton Hall: **Nine charged after abuse allegations** (October 2021)
- National Suicide Prevention Alliance: **World Suicide Prevention Day 2021: Promotional Materials** (September 2021)
- Dorset Echo: **Dorset Police warn public about 'cuckooing'** (September 2021)
- Home Office**: Policy Paper Release: Beating crime plan** (September 2021)
- British Transport Police: **Drugs intercepted and a car seized as BTP cracks down on County Lines activity in the South West** (September 2021)
- **SafeLives: Response to the HMIC report – police engagement with women and girls** (September 2021)
- **NICE and PHE recommend all employers give mental health training for managers** (September 2021)
- CQC Press Office: **"Why community care is the way forward"** (September 2021)
- Community Care**: Rise in safeguarding enquiries involving domestic abuse and self-neglect during pandemic** (September 2021)
- Action Fraud: **Courier fraudsters pretending to be police officers or bank officials** (September 2021)
- UK Health Security Agency: **What the Health Profile for England shows us about COVID-19's wider impact on health** (September 2021)
- The British Institute of Human Rights: **Mental Health Act: Call for "unequivocal commitment" to improve access to advocacy** (September 2021)
- Somerset and Avon Rape and Sexual Abuse Support (SARSAS): **Live Chat support now available after work on Wednesdays 6 - 8pm** (September 2021)
- Unseen UK: **Could you spot the signs of modern slavery? #SpotTheSigns campaign** (September 2021)
- Take Five: **Fake parcel delivery texts are the top 'smishing' scam** (August 2021)

Training and Development

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

Social Care Institute for Excellence: e-learning **(please note that SCIE are now charging for this content)**

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

Other resources

- **FutureLearn Safeguarding Adults Level 3 Training**
- **Friends Against Scams Practitioner E-Learning**
- **Health Education England e-Learning Mental Capacity Act e-Learning**
- **Unseen Modern Slavery training**
- **Home Office Prevent e-learning**
- **Home Office FGM (Female Genital Mutilation) e-learning**

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

Useful Safeguarding Adults Links

- **Secure professionals e-referral form**
- **Joint Safeguarding Adults Policy**
- **Somerset Adult Safeguarding Guidance**
- **Practice guidance and resources**
- **Get the SSAB Website on your phone or tablet**
- **National Safeguarding Adults Review (SAR) Library**

Get in touch

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

ssab@somerset.gov.uk

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

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

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

Or complete a secure
Professionals e-referral form

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

SOMERSET SAFEGUARDING ADULTS BOARD