Issue 9, Dec 2018

Newsletter

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

This is the 9th edition of our newsletter, and we hope those who have received copies since its launch continue to find it a useful resource and an interesting read. Since the publication of our last newsletter we have completed work on, and published, our Annual Report for 2017/18.

As the year draws to a close we have begun work on the development of our new Strategic Plan which you can read more about on page 4, and on planning for our annual conference that will take place in early May 2019 – look out for more information and booking information in the New Year.

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.

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

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News from the SSAB

September and December 2018/19

The SSAB has met twice since the last newsletter was published, on 10/09/2018 and 06/12/2018. Agenda highlights include:

- Receiving an update on progress made against recommendations since the publication of our Mendip House Safeguarding Adults Review;
- Receiving an update on work following a thematic review of rough sleeping incidents in Taunton;
- An update from Devon, Somerset and Torbay Trading Standards Service;
- Agreeing changes to the format and structure of the Board that will see the Board move to meeting three times a year with an expanded membership;
- Signing off the 2017/18 Annual Report
- Receiving an update on the integrated safeguarding service for Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust;
- Receiving a report from Somerset's Mental Health Crisis Concordat Group that included confirmation that no individual that required a place of safety under sections 135 or 136 of the Mental Health Act has been placed in Police custody in Somerset since December 2017;
- Beginning work in September on our 2019-22 Strategic Plan, and receiving the first draft in December.

The Survivor Pathway

Sexual abuse and violence take place at all levels of society, regardless of age, social class, race, religion, sexuality or disability. Over the past eight years the number of sexual offences recorded by police across the South West has more than doubled from 4,346 in 2010/11 to 11,968 in 2017/18. Public Health England worked with Somerset and Avon Rape and Sexual Abuse (SARSAS), and the Office for Sexual Health, with funding from NHS England, to develop the South West Survivor Pathway. It is an invaluable online resource designed to support professionals working with survivors - and their families, friends, colleagues and employers - to help them access services across the South West.   Using the Survivor Pathway website, professionals, survivors, carers and concerned others will be able to navigate quickly and easily through the services available in the area nearest to them. The website is free to use and updated regularly to provide a one-stop-shop directory of the range of specialist sexual violence services from across the South West. The website is intuitive to use, guiding users to the correct services as a first step in providing the right service to an individual.

Further information

The Survivor Pathway

Does your organisation have a domestic abuse workplace policy?

The Prince's Responsible Business Network

The Domestic Abuse Workplace toolkit developed by Business in the Community, in partnership with Public Health England, has been recently launched as one of a suite of eight toolkits covering topics such as mental health, sleep and recovery, and drugs, alcohol and tobacco.

An estimated 1.9 million adults aged 16 to 59 experienced domestic abuse in the last year. Two women each week and one man each month are killed in England and Wales by a current or former partner. Domestic abuse is a hugely destructive problem and we have a collective responsibility to tackle it. Employers have an important role to play in society's response to domestic abuse.

Employers owe a duty of care to employees and have a legal responsibility to provide a safe and effective work environment. Preventing and tackling domestic abuse is an integral part of this and this toolkit, sponsored by The Insurance Charities offers guidance and support.

An estimated **1.9 million adults** aged **16 to 59** experienced **domestic abuse** in the last year[1]

Abuse is not just about **physical violence** – it can also be **emotional, sexual and economic**[4]

NO

Two women are killed each week by a current or former partner[1]

86% of **HR leads** agree that employers have a **duty of care to provide support** to employees on the issue of domestic abuse[3]

1 in 4 women and **1 in 6 men** suffer from domestic abuse in their lifetime[1]

There was an average of **less than one disclosure** to employers* over the previous 12 months, which suggests **not enough employees feel supported** to raise the problem[3]

Only 5% of organisations have a **specific policy or guidelines** on the issue[3]

62% of children exposed to domestic abuse are directly harmed[6]

The cost of domestic abuse to business is estimated at **£1.9 billion a year** due to decreased productivity, time off work, lost wages and sick pay[2]

Domestic abuse takes place at **all levels of society**, regardless of gender, social class, race, religion, sexuality or disability[5]

54% of employers said that it caused the quality of an **employee's work to suffer** and **56%** said it led to **absenteeism**[3]

*within medium and large organisations

Sources: 1 Ons.gov.uk People, population and community • 2 S.Walby, The Cost of Domestic Violence, 2009 • 3 'Domestic Violence and Abuse: Working together to transform responses in the workplace', Durham University for The Vodafone Foundation, 2018 • 4 Gov.uk • 5 Department of Health • 6 SafeLives (formerly CAADA) Policy Report (2014). In Plain Sight: Effective help for children exposed to domestic abuse

Further information

Download the toolkit from [The Prince's Responsible Business Network]

New Strategic Plan for 2019-2022

The Somerset Safeguarding Adults Board is required by The Care Act 2014 to produce and publish a strategic plan for each financial year. The report must set out what the Board intends to do over the next year to help and protect adults at risk of abuse and neglect in Somerset during that timeframe. In common with many other Safeguarding Adults Boards, the Board chose to develop a three-year plan, that has been refreshed annually, in 2015. We are now reaching the end of that plan.

The Board began work on a new strategic plan, which it is proposing lasts for three years again, with an annual business plan that sits underneath it. The draft plan contains some areas that are ongoing, for example, work emerging from the Mendip House Safeguarding Adults Review, as well as new areas of focus, such as young people transitioning to adulthood. The Board's role is to have an oversight of safeguarding arrangements, not to deliver services, and as such the draft includes a range of areas in which it will seek assurance that arrangements are working, and if changes are needed have oversight of their implementation.

The development of this draft strategy reflects the agreed priorities of Board members who attended a workshop in September. It has also been informed the findings to emerge from audits, learning to emerge from Safeguarding Adults Reviews, and the analysis of comparative performance data.

We recognise that we can achieve more by working collectively in partnership and commit ourselves to the objectives contained within it. The proposed overarching priorities within our new strategy are:

1. Listening and learning

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

2. Enabling people to keep themselves safe

- People are aware of what abuse is and how to keep themselves and those that they care for safe
- People know what to do if they think that they are experiencing abuse or neglect
- The number of inappropriate referrals is reduced through people raising other types of concern in an appropriate way

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

- Organisations, including the third sector, work together to ensure that multi-agency arrangements are effective, and that people who are unable to keep themselves safe are supported in the least invasive way
- Policy and guidance reflects best practice and takes a positive approach to risk
- There is effective working across local, regional and national partnerships on areas on mutual interest

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

- Somerset has an effective Safeguarding Adults Board which fulfils its statutory

responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning
- The Board uses data appropriately to understand where risk exists within the system
- The Board can demonstrate progress through the regular monitoring of performance and a robust self-audit process

The first draft of the new plan was considered by SSAB Board members in December 2018 and can be viewed via the link below. We welcome any comments that readers of our newsletter may have by 11th January 2019 and have provided a link below to send them to us.

Further information

Read the draft plan

Send us any comments you have on the draft plan

Business Manager Blog

Stephen Miles, SSAB Business Manager

It's been a busy time for the SSAB since our last newsletter, aside from the work mentioned elsewhere in this newsletter we have also been working on our annual self-audit, keeping the Guidance for Safeguarding Adults in Somerset and other polices up to date, formally presenting our Annual Report, planning our conference, developing Mental Capacity Act guidance that we hope to publish in the New Year, identifying learning from services cases and continuing to monitor performance across the system in Somerset. I therefore want to take the opportunity to thank our partners, individually and collectively, for all the time they give to help the Board with its work. I also want to thank everyone who responded to our recent information request about people placed in to Somerset by external commissioners that you can read more about on page 9.

Meanwhile, the festive season is fast approaching and the SSAB has not been immune to receiving emails asking for help transferring large sums of money from abroad, invoices for work that it did not commission, transfers to bank accounts it doesn't have and courier tracking emails for goods it has never ordered. We've received calls about accident's we don't remember having and news that we've won the jackpot on a number of foreign lotteries, but decided to #TakeFive before running out to buy the champagne. The common thing with all these emails is that they are trying to obtain information – by replying, retweeting, liking, clicking on a link or opening an attachment that installs malicious software. That's why the messages are vague or promise 'something for nothing' in order to get the reader to open the attachment to see what the invoice is for, click the tracking link to see what the delivery is, or ask them to provide information that enables a payment to be made. We've therefore included information about current scams in an article below and I encourage anyone who wants to know how to help those they work with, care for family members and themselves avoid being scammed to take a look at the Friends Against Scams website that includes free eLearning.

Finally, if you have a few minutes please take the time to take a look at the first draft of our Strategic Plan for 2019-22 and let us have any comments that you have. The last date for feedback on is 11/01/2019 after which we will begin work to finalise it. Thank you in advance.

I look forward to continuing to work with you and the Board in the New Year and beyond.

Let's Make it a Bad Christmas for Scammers

We previously included information about scams in our March issue and are highlighting this area again as Christmas is a time when scamming activity often increases, and different types of scam that are emerging all the time.

Why should we be worried about scams?

Financial scamming can have seriously damaging consequences on individuals and society. The impact is often underestimated. Becoming involved with a scam can be a life-changing event, AND can be a major factor in the decline of health in older people

What can the impact be on individuals?

Scams can cause long lasting or permanent damage to an individual's health and quality of life. Many individuals experience injury to their confidence and trust, and some people are left with the psychological effects of stress, anxiety, fear, depression and shame. Individuals may deny their involvement and others may blame them.

Remember:

- Financial scamming is a crime and can affect anyone. It is vastly under reported and the true scale of the financial loss and other impacts is unknown.
- Enabling people to keep themselves safe from scammers can be beneficial to people's health and independence
- Factors such as loneliness, social isolation, poverty and cognitive impairment can make people more vulnerable to responding to financial scams or fraudulent schemes.
- Older people are targeted by certain types of scams such as doorstep, mail, telephone and investment scams.
- Cognitive impairments, such as dementia, can interfere with an individual's financial capacity. Those with dementia may not have the skills to judge risk and can find it more difficult to apply precautionary measures to decision making which puts them at increased risk of responding to a scam.

Some of the most prevalent scams at the moment include:

- contactless card fraud
- online shopping and ticket scams
- Callers, emails or websites claiming to be a government agency when they're not
- pension scams
- investment scams, including cryptocurrency investment fraud
- subscriptions traps or free-trial scams
- computer scams
- Council Tax re-banding and business rates scams
- advertising scams
- 'vishing', 'phishing', and 'smishing' – these are types of phone, text message and email scams.
- Invoice scams
- Social media scams

Further information

The Devon, Somerset and Torbay Trading Standards Service
National Centre for Post-Qualifying Social Work and Professional Practice resources on financial scamming
Friends Against Scams

Learning Lessons

National: Norfolk Safeguarding Adults Board, Case E

Background

Ms E died aged 95 in Norfolk & Norwich University Hospital in November 2016. The Coroner's verdict was that she died of bronchopneumonia and hypothermia noting that she had not received antibiotics prescribed by her GP the previous day, and that the care home's boilers were broken, resulting in the use of portable heaters. The Coroner concluded that "The evidence does not reveal which developed first or to what extent these two issues contributed to her death."

The care home in which Ms E lived prior to her death was an old poorly-insulated building with high ceilings and large rooms. Its heating and hot water ran on two boilers dating back to the 1960s, which were run alternately for short periods in order to produce the full load of the output required for the building. There was a history of concerns regarding legionella risks dating back to 2013. One boiler failed in the early summer of 2016, leaving the home reliant on the second, which itself failed in October 2016, and, as a result, the home lacked hot water and heating for a number of weeks. Both boilers had been the subject of condemnation notices issued in 2013. Temporary measures were in place at the time of Ms E's death, and were being monitored by the Care Quality Commission (CQC) and the Quality Assurance team of Norfolk County Council's Adult Social Care Department.

Following inspections by the CQC that resulted in 'Inadequate' ratings, and the involvement of multiple agencies that is documented in the report, the owner took the decision to close the home in April 2017 and the last resident moved out on 31st May 2017.

Conclusions

The Review's conclusions, which have been summarised below, highlight significant concerns with the care home, multi-agency working and a lack of professional curiosity by some of those involved in the case:

- As a resident in a care home that failed to meet health and safety standards, Ms E's care is likely to have been significantly compromised by the absence of adequate heating and hot water for a period of three weeks prior to her death.
- The care home did not make timely and adequate arrangements for her and other residents' comfort and safety during that period, and the temporary arrangements in place in themselves posed risks to health and safety.
- The care home had a history of care standards deemed by CQC to require improvement, and a series of safeguarding referrals and complaints from 2012 onwards provided further evidence of compromised care standards.
- GPs had concerns about delays in the care home securing prescribed medication.
- The deteriorated state of the care home environment, which only fully came to light in inspections after Ms E's death, showed evidence of chronic under-investment in the fabric of the building.
- Care practices in the home were inconsistent: records, care plans and risk assessments were found to be inadequate.
- It appeared that none of the agencies routinely involved in the care home pieced the information together to build a holistic picture of the risks involved in its mode of operation.

The cumulative picture of safeguarding concerns does not appear to have emerged or been questioned. GPs treated individual residents but perhaps did not see the bigger picture relating to the home overall; believing their concerns did not reach a safeguarding threshold, they were unsure of where to address them and therefore did not. Such omissions can be seen as arising from a lack of professional curiosity that allowed the home to remain under the radar in terms of the need for any proactive risk management.

- The days that followed the first reports of the care home's boiler failure were a critical point at which interagency communication, information sharing and coordination were required. Instead, this period was characterised by delay and lack of clarity about who could and should be taking what action, and who could and should be coordinating the efforts of the agencies involved. No action was routed through safeguarding until Ms E's death. There were delays in individual agencies action to investigate within their own acknowledged remits. Contributing to the lack of clarity was the national Memorandum of Understanding, delineating the responsibilities of CQC and Environmental Health in relation to health and safety in care homes, which the report makes specific recommendations regarding
- As the agencies' various investigations and inspections took place during November 2016, a much wider picture of risks in the care home emerged, awareness of which gave rise to divergence of opinion between agencies about how those risks should be managed. While safeguarding strategy meetings that took place between November 2016 and May 2017 became a generally positively viewed forum for communication and information-sharing about the actions each agency was taking, this group was not in a position to establish a consensus on a shared strategy or to require agencies to operate in a specific way. Nor did it act as a dispute resolution route in relation to the fundamental differences of opinion about intervention.
- The GP surgery lacked clarity on where low-level concerns judged not to reach a safeguarding threshold should be addressed. CQC inspectors involved in the early notifications and discussions of the care home's boiler failure did not escalate the matter for management review in a timely way.

Recommendations

The report makes 23 recommendations. Many are specific to Norfolk, and one relates to the national Memorandum of Understanding delineating the responsibilities of CQC and Environmental Health in relation to health and safety in care homes. The SSAB Learning and Development Subgroup will be reviewing the report in the New Year to consider the question 'could this happen here' and identify any local recommendations for Somerset.

Further information

Read the report

Local: Somerset Safeguarding Children's Board, 'Family A'

Background

The subjects of the 'Family A' Serious Case Review, published in November 2018, are three children who suffered significant harm as a consequence of chronic neglect and sexual abuse. There are records of neglect from Children's Social Care, schools, police and health agencies that span the last 15 years since referrals were first made to Children's Social Care in 2003. The formal

investigation of allegations of sexual abuse is more recent and began with a disclosure by the oldest child in 2017.

The parents are a married couple, both local to the area. The extended family of one of the parents lived close by and they were occasionally involved in the care of the children. The mother was recognised as the dominant partner in the relationship and the one with whom professionals had the most contact. The mother had often been hostile and aggressive towards professionals and did not want any interference in how she chose to raise her children. The husband has a more passive personality and all the professional contact with him indicated that he shared his wife's view of professional involvement but would often take the line of least resistance rather than direct confrontation.

There was a history of all family members becoming involved in anti-social incidents in their community, sometimes resulting in altercations with neighbours and damage to property.

Neglect is the most common form of child maltreatment in the UK, it is also the most difficult for professionals to effectively engage with and produce long-lasting and sustained change in the family environment. In this case, the impact of neglect was evident in the physical standards in the home, anti-social behaviour in the community, poor school attendance, behavioural issues when the children were in school, failed healthcare appointments, and exposure to sexual abuse, parental violence and parental drug taking.

Although primarily concerned with the involvement of services for children the need for all organisations, including those providing services to adults, to 'Think Family' is highlighted by the report, as is the need to guard against the optimism bias. In particular, it highlights that the Housing Association that owned the property that the family lived in appears to have had little engagement in the concerns about material standards in the home (until later on in the period under review), but instead had a narrow focus on anti-social behaviour and rent arrears.

Further information

Read the Review

Somerset Think Family Strategy 2018-2019

Local: Progress of work following the SSAB Mendip House Safeguarding Adults Review

Background

The Somerset Safeguarding Adults Board published the Mendip House Safeguarding Adults Review (SAR) in February 2018. The SAR was written by Dr Margaret Flynn, who made recommendations for national changes to the commissioning and monitoring arrangements when people are placed in to services outside of their local area. On receipt of the Review the Board added a recommendation that it seek assurance from local commissioners on the arrangements for Somerset residents when they are placed in services outside of the County.

What has happened since the Review was published

- Local commissioning leads met on 06/03/2018 to begin work on seeking assurance regarding the relatively small number of Somerset residents placed into services outside of Somerset. This work continues and is being monitored by the SSAB Executive Group.
- The SSAB wrote to the Department of Health and Social Care, Local Government Association, Care Quality Commission and Care Provider Alliance.

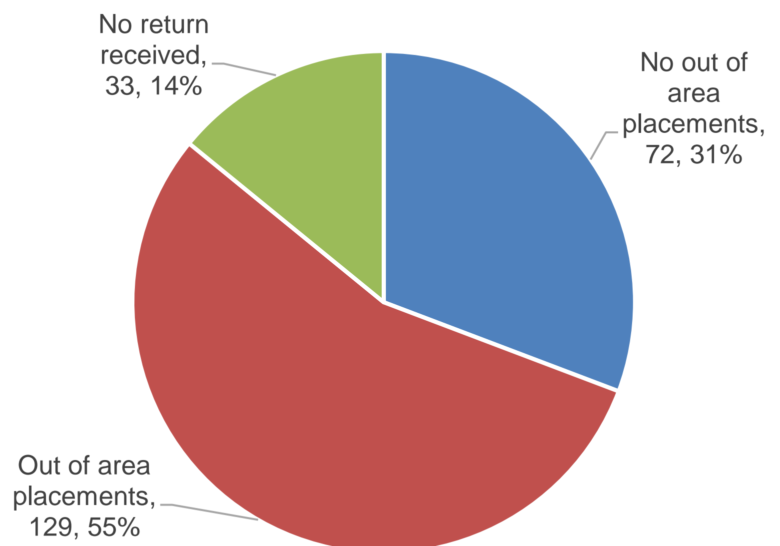
- The SSAB Independent Chair, the Chair of the South West Regional Chairs Group and the SSAB Business Manager met with officials from Department of Health and Social Care and Local Government Association on 07/06/2017. Officials suggested that, at that point, the imminent publication of a Social Care Green Paper would present an opportunity to take the recommendations forward. The Green Paper has not yet been published and is not now expected until the New Year.
- The SSAB Independent Chair and Business Manager met with four of the six families of people placed at Mendip House following concerns that the commissioners who placed their loved ones in Somerset had not been in contact prior to the Review being published.
- The SSAB has written to all residential care and nursing care services in Somerset asking for the details of all placements made by external commissioners. We have included more information on this below.
- The Association of Directors of Adult Social Services published an advisory note on 27/11/2018 that the SSAB contributed to.

Placements Made in to Somerset by other Local Authorities and Clinical Commissioning Groups

How many returns were received?

The SSAB wrote to all 234 locations registered with the Care Quality Commission to provide residential care and nursing care in Somerset

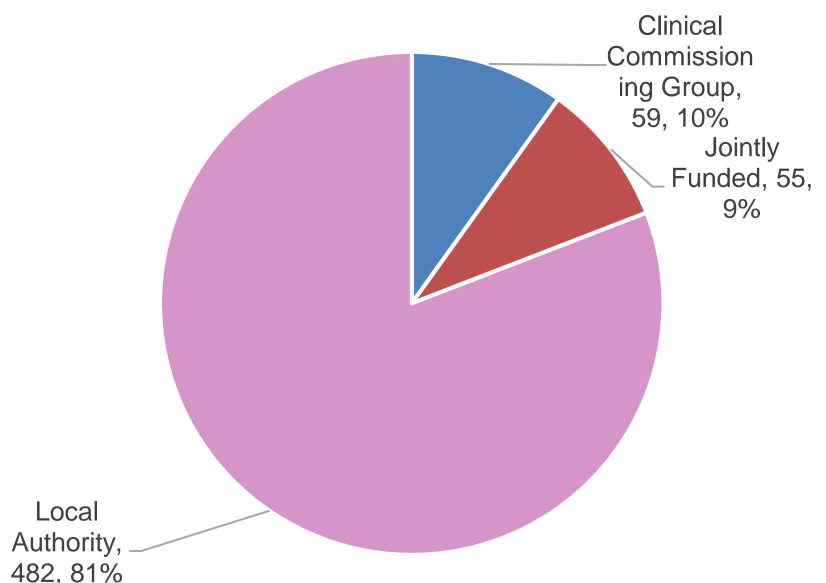
If your services received a letter and did not respond we would grateful if you could to enable us to get a complete picture.



Who is funding the placements?

Of those people placed in to Somerset, the majority had been placed by Local Authorities.

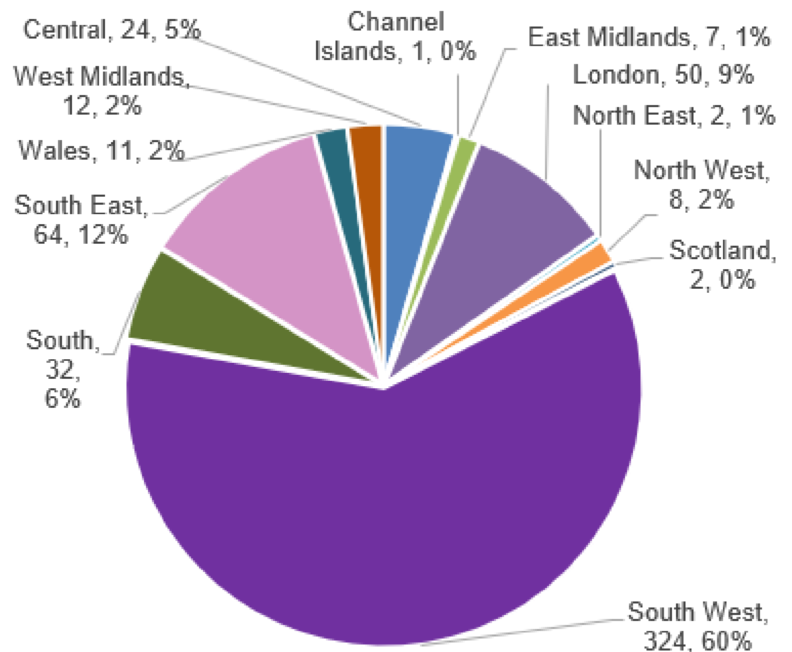
Of the 55 placements that were jointly funded, 12 of these were funded by another local authority and NHS Somerset CCG. The usual reason for this happening is when someone is placed in to an area and then develops health needs afterwards.



Where are people placed by Local Authorities from?

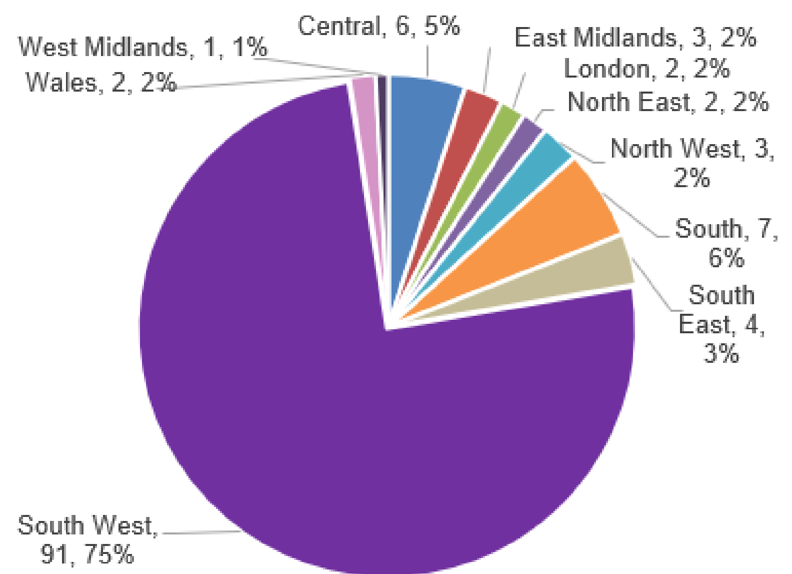
Although most people placed in to Somerset were placed by other Local Authorities in the South West region, 213 were placed from outside the region.

Overall 95 Local Authorities had placements into Somerset, including 22 London Boroughs.



Where are people placed by Clinical Commissioning Groups from?

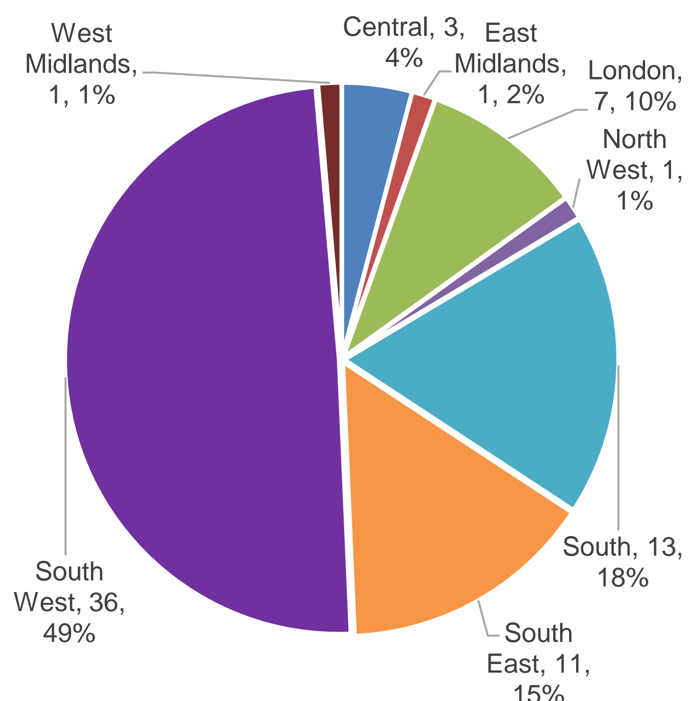
Although most people placed in to Somerset were placed by other Clinical Commissioning Groups in the region, 30 were placed from outside the region. These regional placements include people who a jointly funded by another Local Authority and NHS Somerset Clinical Commissioning Group having developed health needs following the placement being made.



Are placements made by other Local Authorities being reviewed?

Providers told us that 73 (13.5%) of people who had been placed for more than 2 years had either not been reviewed at all or had not been reviewed within the last 2 years.

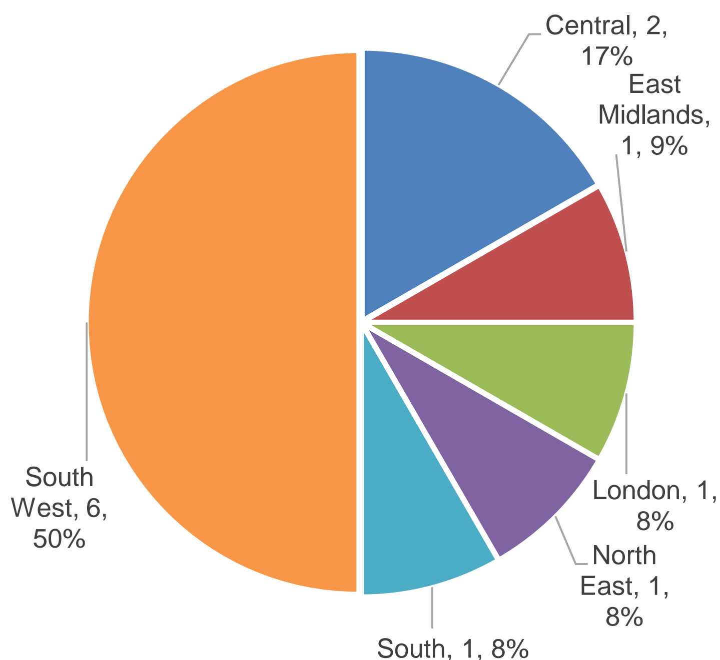
Some providers expressed frustration in their returns at the lack of interest by placing commissioners in the people they had placed in to their services.



Are placements made by Clinical Commissioning Groups being reviewed?

Providers told us that 12 (10%) of people who had been placed for more than 2 years had either not been reviewed at all or had not been reviewed within the last 2 years.

All placements that were jointly funded by another Local Authority and NHS Somerset Clinical Commissioning Group had either been made within the last 2 years or been reviewed during the same period.



Advisory issued by the Association of Directors of Adult Social Services (ADASS)

ADASS issued an advisory to all Local Authorities providing adult social care services on 27/11/2018, and a further joint piece of work is taking place to consider the issues set out in it with the NHS. In summary the advisory outlines the steps that placing Local Authorities should take to:

1. Gather local intelligence relating to the provision before making arrangements
2. Ensure the suitability of the care and support service
3. Advise the host local authority when the arrangements are made
4. Undertake face to face reviews
5. Ensure that people placed are safeguarded
6. Provide timely information to providers and set clear expectations on the information that providers will supply

The advisory also sets out that host Local Authorities should develop a system for holding information provided by placing authorities on the placements they have made in to their area.

What Happens Next?

- The SSAB Executive Group will continue to progress work to seek assurance regarding placements commissioned by local commissioners
- Local recommendations will also be considered as part of the self-audit peer challenge process
- The SSAB will be making contact with commissioners regarding overdue reviews
- The SSAB will write to Department of Health and Social Care and Local Government Association again to progress recommendations in light of the delays in the publication of the Social Care Green Paper that was originally expected to be published in the summer

Further information

Read the ADASS Advisory

Every day is different: recruitment campaign

The Department of Health and Social Care (DHSC) is developing a campaign to boost recruitment into the Adult Social Care sector. This is across all roles in the sector and across all types of social care and locations. DHSC are working closely with national bodies and trade associations, including Skills for Care on this. The Department aims to run this campaign across England in early 2019, pending the results of pilot test and learn activity which has just finished. You can see more of the campaign imagery here: http://www.everydayisdifferent.com/

You may have heard about this from organisations such as Skills for Care, or through trade press. Keep an eye out for further communication in the New Year. In the meantime, please continue to post your vacancies on the DWP Jobs website. You can also support the campaign by liking the Facebook page: www.facebook.com/everydayisdifferent

Finally, the stories of care workers and users of care services have been the most powerful campaign tool so far. If you would like to tell your story about your work in social care, or you know someone who would, please email casestudies@morecarejobs.co.uk

Here in Somerset, we actively support our Proud to Care Somerset campaign also, and recognise the fantastic contribution care workers make to the lives of local people.

Learning from Children's Services

We encourage our readers to have a look at the latest newsletter to be issued by the Somerset Safeguarding Children Board.

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

National News and Headlines

December 2018

- Have your say on the Mental Capacity (Amendment) Bill – **please note that the closing date is not fixed and could be at any point between 15/01/2019 and 24/01/2019**
- "All Together, Better" is coming to Somerset
- Learning Disabilities Mortality Review (LeDeR) publishes its December Programme Bulletin
- Opening the door to change report that looks at NHS safety culture and the need for transformation

- Blog by Kenny Gibson, Head of Safeguarding for NHS Safeguarding: Domestic violence is a crime for all seasons
- Patients Association launches nutrition checklist
- Wiltshire Trading Standards warns of Center Parcs Facebook scam
- The Guardian: 'It's a man's problem': Patrick Stewart and the men fighting to end domestic violence
- The Safer Somerset Partnership publishes the 13th issue of the Somerset Domestic Abuse Newsletter
- Blog by Lyn Romeo, Chief Social Worker for Adults: Clear standards for high quality adult social work
- Community Care: CQC to probe restraint and seclusion of people with mental health problems and learning disabilities
- National FGM Centre: FGM Medical Examination Guidance
- BBC: Muckamore Abbey seclusion room was 'dark dungeon'
- Avon and Somerset Constabulary issues alert over bogus police officer telephone scam
- Action fraud: Scammers are out to steal your pension

November 2018

- Avon and Somerset Constabulary launches campaign for everyone to enjoy themselves safely this Christmas
- Which?: How to spot an HMRC tax scam
- Skills for Care: how to recruit people with convictions safely and fairly
- Care Management Matters publishes research in to loneliness and isolation in the UK
- Avon and Somerset Constabulary launches campaign to help people recognise and report modern day slavery
- Care Provider Alliance issues guidance to encourage health and social care engagement
- The Independent Inquiry Child Sexual Abuse publishes its November newsletter with news of the progress made so far this year and plans for the winter months
- NHS Digital publishes the findings from the Safeguarding Adults Collection (SAC) for the period 1 April 2017 to 31 March 2018
- Public Health England South West publishes its latest Violence Prevention e-Bulletin
- Community Care: Top tips for safeguarding adults with dementia
- Somerset Independence Plus service launched
- NHS England Easy Read Newsletter: Winter 2018-19
- Ministry of Justice: Government increases funding for rape and sexual abuse victims
- CQC: Equality and human rights - good practice resource, November 2018

October 2018

- Special edition of the Somerset Domestic Abuse Newsletter published focusing on changes to Multi-Agency Risk Assessment Conference (MARAC) arrangements in Somerset
- Get Safe Online: Be aware of what you share
- Update from NHS England on the planning for the NHS 10 year plan
- BBC: Street harassment 'relentless' for women and girls
- Blog by Christalla Tanglis, an Assessment and Enablement Officer from the Urgent Response Team at the London Borough of Barnet: Cuckooing: The exploitation of vulnerable adults
- Committee urge Government to widen forthcoming bill on Domestic Abuse
- Huddersfield grooming victims 'delivered to hell'
- Avon and Somerset Constabulary: Do you know the basics about Hate Crime?

- The Independent Inquiry Child Sexual Abuse publishes the first ever anthology dedicated to the experiences of victims and survivors of child sexual abuse
- 73 arrested as national modern slavery crackdown targets sexual exploitation
- Rightful Lives publishes letter to Equality and Human Rights Commission raising concerns over the rights abuses of people with learning disabilities and/or autism living in inpatient units
- Department of Health and Social Care publishes guides on how reasonable adjustments should be made to health services and adjustments to help people with learning disabilities to access services.
- Department of Health and Social Care: Our vision for digital, data and technology in health and care
- Hate crime action plan 2016 to 2020 published by Ministry of Housing, Communities & Local Government, Home Office, and Ministry of Justice
- CQC publishes 'State of Care' - its annual assessment of health and social care in England
- Prime Minister pledges action on suicide to mark World Mental Health Day
- Healthwatch England: Four ways carers told us they can be better supported
- NICE publishes guidance on decision-making and mental capacity
- Community Care: How social workers can spot the signs of scams
- NHS Digital publishes the findings from the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) data collection for the period 1 April 2017 to 31 March 2018
- BBC: 'Shameful' use of restraints on disabled patients
- NHS launches sepsis tool to improve efforts to tackle deadly infection

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- Healthwatch England briefing: What's it like being a carer?
- Avon and Somerset Constabulary: What is a county line?
- Care Management Matters: The role CQC has in taking decisions about registration that protect the interests of people with autism and learning disabilities
- NHS Digital launches new social care and support guide
- Visual problems after brain injury explained in new factsheet
- Learning Disabilities Mortality Review (LeDeR) publishes its September Programme Bulletin
- Matt Hancock MP: As individuals and as a country, it is vital that we support the 850,000 people living with dementia in the UK
- Justice Secretary unveils Victims Strategy
- Local area performance metrics: health and social care partners
- CQC responds to Government announcement on improving care and support for people with learning disabilities
- Blog by Dez Holmes is the Director of Research in Practice and Research in Practice for Adults: Transitional safeguarding from adolescence to adulthood
- The Guardian: Dementia patients restrained with controversial techniques

Training and Development

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

Social Care Institute for Excellence: e-learning

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

- e-learning: Adult Safeguarding Resource

- e-learning: Mental Capacity Act

Other resources

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

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

Useful Safeguarding Adults Links

Secure professionals e-referral form

Joint Safeguarding Adults Policy

Somerset Adult Safeguarding Guidance

National Safeguarding Adults Review (SAR) Library

Get in touch

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

ssab@somerset.gov.uk

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

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

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

Or complete a secure
Professionals e-referral form

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