2016-17 Annual Report

Contents

1. Introduction

The Somerset Safeguarding Adults Board (SSAB or "the Board") is required under the Care Act 2014 to produce an annual report each year.

The report must set out what we have done during the last year to help and protect adults at risk of abuse and neglect in Somerset.

Our annual report tells you:

- The profile of adult safeguarding in 2016/17;
- How we have done in delivering our objectives during the year;
- The findings and impact of any Safeguarding Adults Reviews we carried out;
- The contributions of our member organisations to adult safeguarding;
- Our priorities looking forward.

This report will be published on the SSAB website for all partners, interested stakeholders and members of the public to access.

As required by the Care Act, it will also be shared with the Chief Executive and Lead Member of the Local Authority, the Police and Crime Commissioner and the Chief Constable, the local Healthwatch organisation, and the Chair of the Health and Wellbeing Board.

It is expected that those organisations will consider the contents of the report alongside how they can improve their contributions to both safeguarding in their own organisations, networks and in partnership with the Board.

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

2. Foreword

Richard Crompton, Independent Chair – Somerset Safeguarding Adults Board

It is a great privilege to write this foreword to the Annual Report of the Somerset Safeguarding Adults Board for 2016/17.

This is now my fourth year as the independent chairman and it has been a great pleasure to see the Board develop over that time.

I believe that we can now demonstrate that we make a difference, both to the lives of those we are here to safeguard and support, and to those in all of our partner organisations who work in the field of adult safeguarding.

We have concentrated upon improving the overall effectiveness of our board in its efforts to better coordinate activity, to learn from events, particularly where we have got things wrong, and to raise our profile and the value of what we offer through good quality communication with professionals and the public. Specifically we have concentrated upon making the safeguarding process more personal to the needs of the adult at risk, upon emphasising preventative work, and upon encouraging a whole family approach and awareness of the crucial years of transition from childhood into adulthood. We have really tried to hear the voice of the adult at risk and, wherever possible, members of their family. I pay particular tribute to those who have helped us to do this by sharing intensely personal and difficult stories and experiences that we can learn from and improve our practice.

The report is published on behalf of all members of the Board, and provides partners with an opportunity to reflect upon achievements over the past year, and formally identify plans and priorities for the year ahead. As the independent chairman, my role is to provide leadership and constructive challenge to ensure that members work effectively together, adding value to adult safeguarding. As the Board has matured, the openness and willingness to both challenge and be challenged has developed and that culture is vital if we are to truly learn and improve to meet the challenges ahead. Those challenges will be significant. The changing demographics locally and nationally, and continued budgetary pressures on all agencies make joint working all the more important. In Somerset we have created the right environment for that work to take place and we have high levels of commitment from partners to make it happen. I look forward to the coming year confident that we will continue to improve and make a real difference.

3. The Board

The Somerset Safeguarding Adults Board (SSAB) is a multi-agency partnership which became statutory under the Care Act 2014 from 1st April 2015. The role of the Board is to assure itself that local safeguarding arrangements and partner agencies act to help and protect adults in its area.

This is about how we prevent abuse and respond when abuse does occur in line with the needs and wishes of the person experiencing harm. Its main objective is to assure itself that local safeguarding arrangements and partner organisations act to help and protect people aged 18 and over in the area who:

- have needs for care and support
- are experiencing, or at risk of, abuse or neglect
- (as a result of their care and support needs) are unable to protect themselves from either the risk of, or experience of, abuse or neglect.

It has a strategic role that is greater than the sum of the operational duties of the core partners, overseeing and leading adult safeguarding across the county and interested in a range of matters contributing to the prevention of abuse and neglect. The Board does not work in isolation, nor is it solely responsible for all safeguarding arrangements. Safeguarding is everybody's business. The Board's role is to have an oversight of safeguarding arrangements, not to deliver services.

Membership of the Board *(as at March 2017)*

Somerset Safeguarding Adults Board		
Name	**Organisation**	**Job Title**
Richard Crompton		Independent Chair
Niki Shaw		Business Manager
Lead Statutory Partners		
Stephen Chandler / Mel Lock	Somerset County Council	Director, Adult Social Services Director of Operations
Deborah Rigby	Somerset Clinical Commissioning Group	Deputy Director, Quality, Patient Safety and Governance
Richard Kelvey	Avon & Somerset Constabulary	Detective Superintendent
Partner Members		
Alison Wootton	Musgrove Park Hospital	Deputy Director of Patient Care
Bernice Cooke	Yeovil District Hospital	Head of Governance and Assurance
Richard Painter	Somerset Partnership NHS Foundation Trust	Head of Safeguarding
Angela Powell	National Probation Service	Senior Probation Officer
Denise Dearden	Devon & Somerset Trading Standards	Trading Standards Project Officer
Sue Burn	Care Quality Commission	Inspection Manager - Somerset
Jacqueline Briggs	Healthwatch Somerset	
Simon Blackburn	Registered Care Providers Association	Chief Executive
Christina Gray	Somerset County Council	Consultant in Public Health
Lucy Macready	Somerset County Council	Public Health Specialist – Community Safety
Sarah Thompson	South Western Ambulance Service Trust	Head of Safeguarding and Staying Well Service
Tracey Aarons	Mendip District Council (representing District Councils)	Deputy Chief Executive
Sonia Furzeland	Knightstone Housing (representing Housing Services)	Director of Landlord Services
Cllr William Wallace	Somerset County Council	Lead Member – Adult Services

Board attendance levels

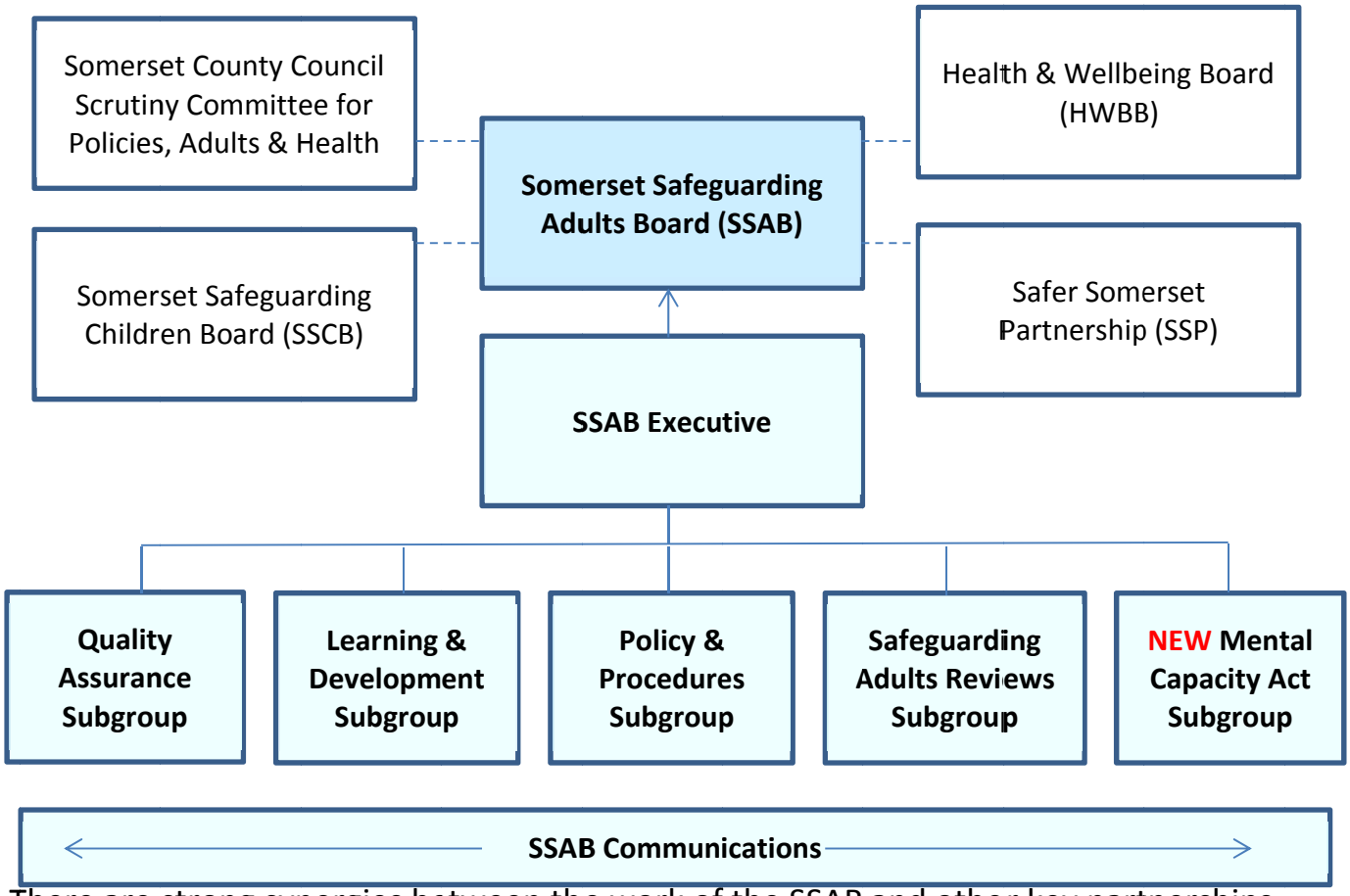
The Safeguarding Adults Board met on 4 occasions during 2016/17 – June, September, December and March. In brackets below is the number each organisation was represented during the year at these meetings *(by the agency representative themselves or an appropriate agency substitute)*:

Somerset County Council – 100% attendance (4/4)
Somerset Clinical Commissioning Group – 100% attendance (4/4)
Avon & Somerset Constabulary – 100% attendance (4/4)
Musgrove Park Hospital – 100% attendance (4/4)
Yeovil District Hospital - 100% attendance (4/4)

Somerset Partnership NHS Foundation Trust – 100% attendance (4/4)
National Probation Service – 75% attendance (3/4)
Devon & Somerset Trading Standards – 100% attendance (1/1) – *new member*
Healthwatch Somerset – 50% attendance (2/4)
Registered Care Providers Association – 50% attendance (2/4)
Public Health (Community Safety) – 75% attendance (3/4)
South Western Ambulance Service Trust – 25% attendance (1/4)
District Council representative – 66.6% attendance (2/3) – *new member*
Housing representative – 50% attendance (2/4)

District Council Safeguarding Leads and local Housing Providers are also engaged via quarterly Safeguarding meetings established separately during the year, which the SSAB Business Manager routinely attends and contributes to.

The SSAB meets on a quarterly basis and is supported by an Executive group and a number of multi-agency subgroups, which convene frequently to progress the ambitions and strategy of the Board. A new Mental Capacity Act subgroup was established in early 2017 at the request of the Board as an identified multi-agency need to strengthen local implementation of, and knowledge of, the Act.



There are strong synergies between the work of the SSAB and other key partnerships in the locality, including the statutory Safeguarding Children Board, Health and Wellbeing Board and local Community Safety Partnership.

It is important the Board has effective links with these groups in order to maximise impact, minimise duplication and seek opportunities for efficiencies in taking forward work.

The Safeguarding Principles

The work of the SSAB is underpinned by six safeguarding principles, which apply to all sectors and settings including care and support services. The principles inform the ways we work with adults.

1. **Empowerment** – the presumption of person-led decisions and informed consent, supporting the rights of the individual to lead an independent life based on self-determination

2. **Prevention** – It is better to take action before harm occurs, including access to information on how to prevent or stop abuse, neglect and concerns about care quality or dignity

3. **Proportionality** – proportionate and least intrusive response appropriate to the risk presented

4. **Protection** – support and representation for those in greatest need, including identifying and protecting people who are unable to take their own decisions or to protect themselves or their assets

5. **Partnership** – local solutions through services working with their communities. Communities have a part of play in preventing, detecting and reporting neglect and abuse.

6. **Accountability** – accountability and transparency in delivering safeguarding, with agencies recognising that it may be necessary to share confidential information, but that any disclosure should be compliant with relevant legislation.

What is adult safeguarding?

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, whilst at the same time making sure that the adult's wellbeing is promoted.

The aims of adult safeguarding are to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Stop abuse or neglect wherever possible
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.

Who is an adult at risk?

An adult at risk is someone who is over 18 years of age who, as a result of their care and support needs, may not be able to protect themselves from abuse, neglect or exploitation. Their care and support needs may be due to a mental, sensory or physical disability; age, frailty or illness; a learning disability; substance misuse; or an unpaid role as a formal/informal carer for a family member or friend.

What is abuse?

Abuse is when someone treats an adult in a way that harms, hurts or exploits them. It can happen just once or many times; it can be done on purpose or by someone who may not realise they are doing it.

Abuse and neglect can include:

- **Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint, inappropriate physical sanctions

- **Domestic violence** – psychological, physical, sexual, financial, emotional abuse, so called 'honour' based violence

- **Sexual abuse** – rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure, sexual assault, sexual acts to which the adult has not consented or was pressured into consenting

- **Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation, unreasonable and unjustified withdrawal of services or supportive networks

- **Financial or material abuse** – including theft, fraud, internal scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions; the misuse or misappropriation of property, possessions or benefits

- **Modern slavery** – including slavery, human trafficking, forced labour and domestic servitude, traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment

- **Discriminatory abuse** – including forms of harassment, slurs or similar treatment (because of race, gender and gender identity, age, disability, sexual orientation, religion)

- **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting, such as a hospital or care home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practices as a result of the structure, policies, processes and practices within an organisation

- **Neglect and acts of omission** – including ignoring medical, emotional or physical care needs; failure to provide access to appropriate health, care and support or educational services; the withholding of the necessities of life, such as medication, adequate nutrition and heating

- **Self-neglect** – covering a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. A decision on whether a safeguarding response is required will depend on the adult's ability to protect themselves by controlling their own behaviour.

Safeguarding Case Study 1 – Amrin's story

Background: Amrin, 26, is an educated woman who has studied law. In 2015 she moved from Bangladesh to the United Kingdom. Her marriage was arranged and conducted over Skype. She faced pressure to send money home to her family and to work several jobs so they can apply for British Citizenship. Her husband is also pressuring her to have a baby so they do not have to leave the country. Although she has shared this with her family in Bangladesh, they are conservative in their views and have encouraged her to continue with the situation. Amrin lives in fear of her husband and worries she will be deported.

Safeguarding Concern: A GP contacts the Local Authority reporting that her patient, Amrin, had visited the practice the previous day with her husband for an asthma review. As Amrin walked into the room, ahead of her husband, she had whispered something to the GP. The GP asked the husband to wait outside whilst she completed the asthma review. Amrin then disclosed two incidents of assault at the hands of her husband, the most recent being the night before. She reported being hit and having an injury to her left arm. Amrin did not want to go to the Police but wanted safeguarding services involved to help her to escape the situation.

Safeguarding Response: Working jointly with the GP, a Safeguarding Officer arranged to meet Amrin at the Surgery; she had been invited to attend an extended asthma clinic – this involved the support and confidentiality of Surgery staff as Amrin's husband always accompanied her to any appointments. Staff asked him to remain in the waiting room for the duration of the clinic, giving Amrin an opportunity to meet privately with the Safeguarding Officer. A full disclosure was made. Evidence of honour-based violence, domestic violence, sexual assault and modern slavery was shared. Immediate risk assessments and protection plans were instigated. Amrin had a mobile phone so was provided with emergency numbers for the domestic violence service, refuge services, and the Safeguarding Officer's contact number. She was encouraged to call 999 if she feared for her life, and she gave consent for the Safeguarding Officer to speak with other agencies in the meantime.

Amrin and the Safeguarding Officer had arranged to meet at her place of work the following day to conclude their conversation and plan her opportunity to leave safely. It was apparent that Amrin had been further assaulted during that time; both sexually and physically. The Safeguarding Officer secured Amrin's trust and sought permission to seek additional support from the Safeguarding Coordination Unit of the Police. Two plain clothed police officers were deployed immediately and attended Amrin's place of work. With compassion and care, they spoke with Amrin and offered her options of what she could do next. Amrin's husband was arrested at their home during this time. She was supported to collect her personal belongings from her home and was taken into police protection for her own safety. Her husband, on arrest, made further threats to Amrin's life.

Amrin was supported by agencies to receive medical treatment and victim support. She is now safe.

4. Safeguarding in no's

How much abuse and neglect was reported during 2016/17?

- 5,451 concerns were reported to the Local Authority during the year
- 2,045 concerns (37.5%) of abuse or neglect required us to provide a statutory safeguarding response
- The majority of concerns were raised from local care providers or the police

Who was at risk of abuse and neglect in 2016/17?

- 59% of adults at risk during the year were female
- 58% of adults at risk were aged 65 or over
- 46% had a physical support need, 33% had a social support need, 16% had a learning disability need, and 4% had a mental health need
- 98.7% were people from white ethnic backgrounds

What were adults at risk from during 2016/17?

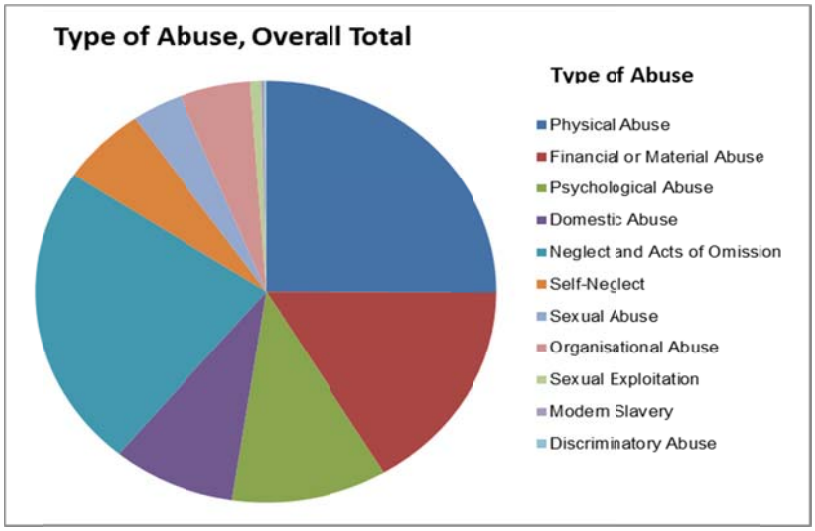
- The most common risk type was Physical Abuse, which accounted for 25% of risks, followed by Neglect and Acts of Omission at 23%
- In 68% of cases the source of risk was recorded as 'Other Known to Individual' compared to 26% 'Service Provider' and 5% 'Other Unknown to Individual.'
- The majority of Neglect and Omission cases (70%) were recorded as being caused by the Service Provider. Other people known to the individual, but not in a social care professional capacity, were the most common source of risk in every other location.
- The location of risk was most frequently the home of the adult at risk (42%) or in a Residential Care home (23%) or a Nursing Care Home (20%).

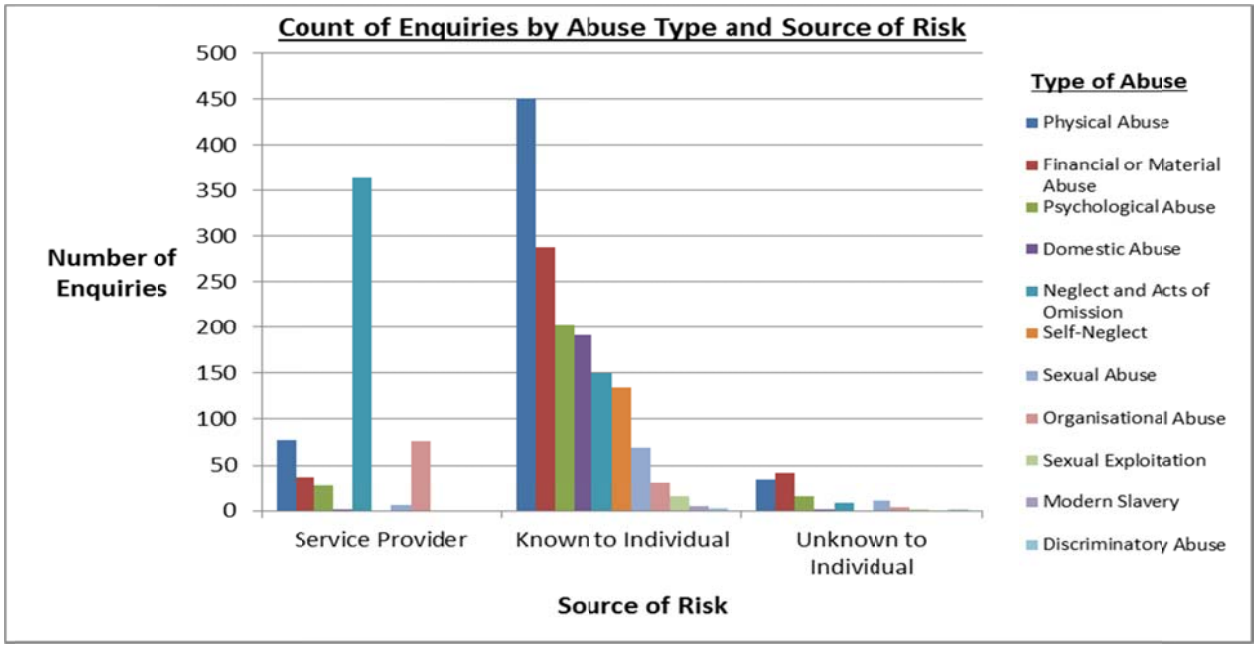
What did we do to protect people during 2016/17?

- For the vast majority of investigations (91%) action was taken and the risk was either reduced or removed. Following our investigations, adults remained 'at risk' in 9% of cases, often because they wanted to maintain their relationship with a family member who is abusing them.
- Where individuals were asked, 96.5% were had their desired outcomes either fully or partially achieved
- 86% of people who used social care services said services help them to feel safe and secure[1].

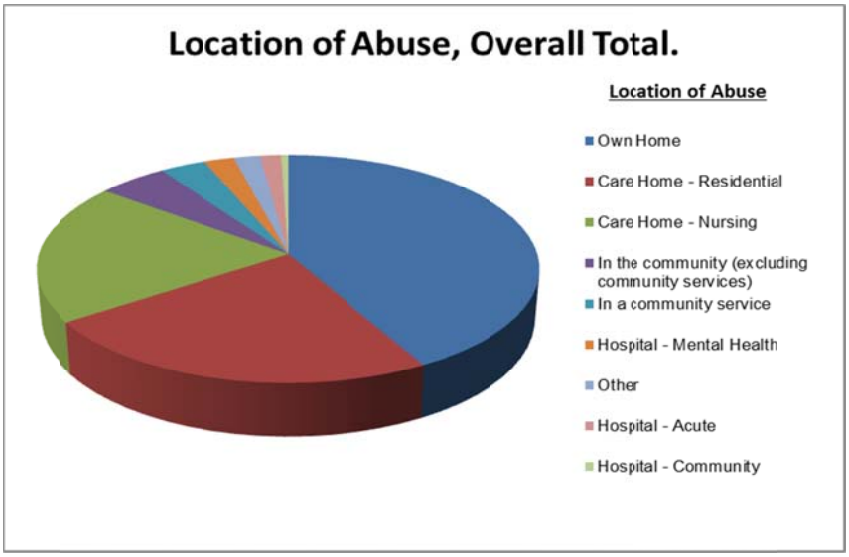
[1] Adult Social Care Outcomes Framework (ASCOF) data

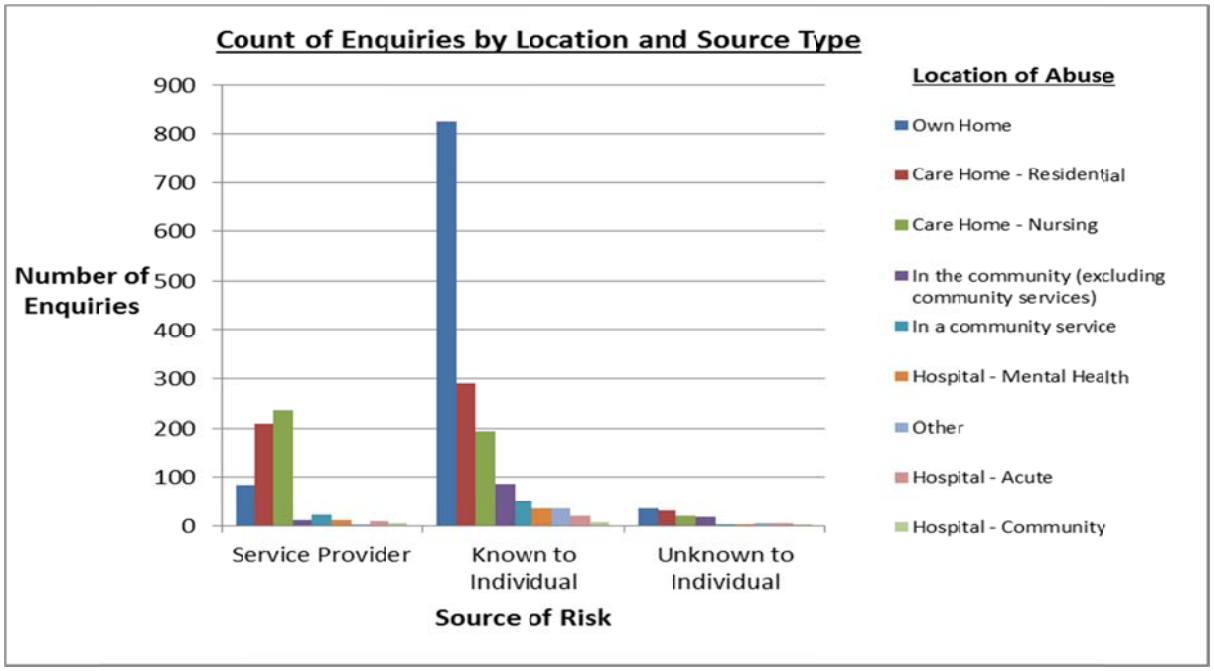
Type of abuse and source of risk



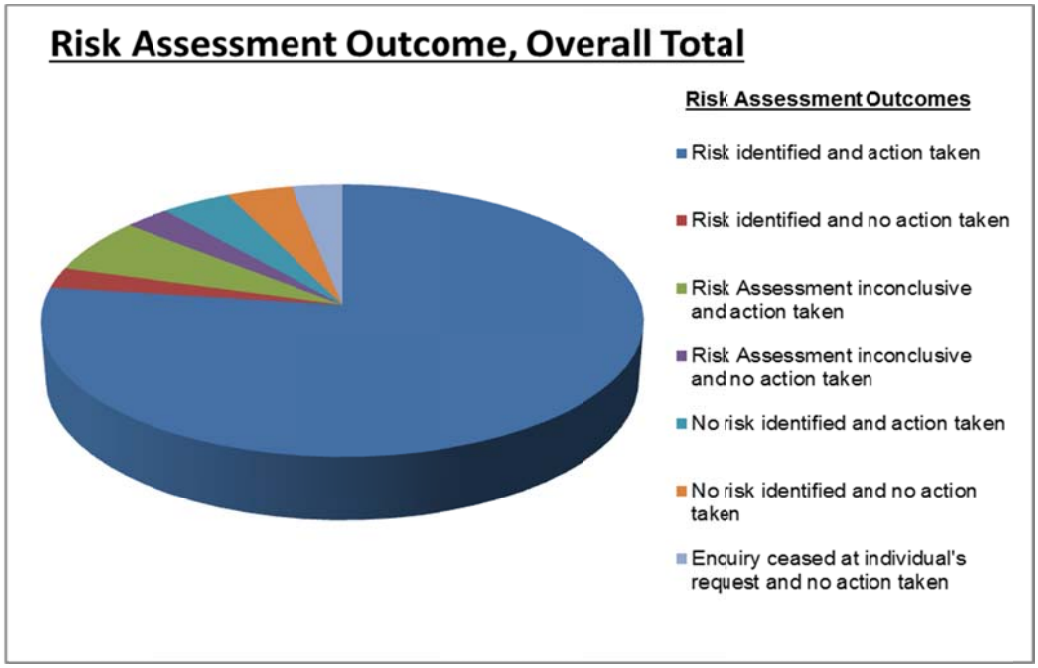


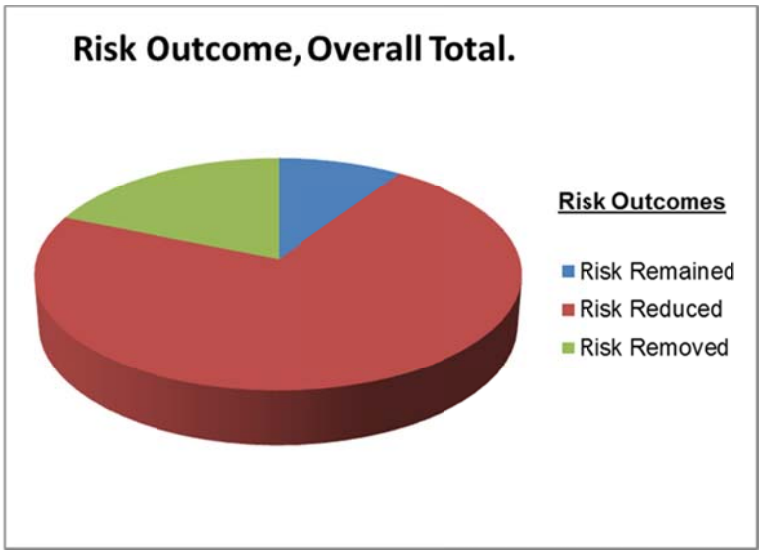
Location of abuse





Risk Assessment Outcomes





5. Our work, 2016/17

The SSAB identified the following four objectives within its Strategic Plan for 2016-19:

1. Prevention
2. Making Safeguarding Personal
3. Think Family
4. SSAB Effectiveness

Priority Area 1:

Prevention

What SSAB said it would do (2016-2019)

1. We will develop and promote an Adult Safeguarding Risk Assessment Tool to support and guide frontline practitioners in identifying vulnerability and assessing risk

2. We will continue to raise public awareness of abuse and neglect via the Board's 'Thinking it? Report it' campaign

3. We will ensure high quality training is available locally, enhancing knowledge of safeguarding issues and improving practice

4. We will develop and promote self-neglect practice guidance to assist practitioners in both identifying and responding to the issue

5. We will work in partnership with other Boards and groups in order to maximise impact, minimise duplication and seek opportunities for efficiencies

6. We will take steps to protect vulnerable adults at risk from sexual exploitation, modern day slavery, radicalisation, and financial abuse

7. We will monitor progress in relation to the Mental Health Crisis Concordat

What SSAB did:

1. The Policy & Procedures subgroup oversaw the development and promotion of the Adult Safeguarding Risk Assessment Tool, which was published in April and is available on the Board's website. It is designed to assist practitioners in considering the vulnerability of the adult at risk and the seriousness of the abuse that is occurring, *and* the impact of the abuse and risk of it recurring. The tool is now used

within training and also by frontline practitioners to assist them with decision-making.

2. An important role of the SSAB is to raise public awareness so that communities play their part in preventing, identifying and responding to abuse and neglect. The SSAB originally launched its 'Thinking it? Report it' publicity campaign in November 2015. During 2016/17, the campaign was re-launched to coincide with June's World Elder Abuse Awareness Day (WEAAD), a time when the international community pledges to tackle the abuse of older people. In recognition of this, the SSAB developed a short animated film to increase understanding of the types of abuse and neglect that can be suffered by vulnerable adults, and how to seek help. The video is available on the Board's website and has received hundreds of views. The SSAB also called upon individuals to sign up to a public pledge to report concerns if they suspect someone to be at risk, in recognition that safeguarding adults is everyone's business. The pledge is available in postcard format and electronically via our website, and is routinely promoted at events.

   A 'Thinking it? Report it' campaign Evaluation Report compiled by Lambeth Communications (the company commissioned to deliver the SSAB branding, logo and original campaign activity in September 2015) in the Autumn of 2016 found it had reached over 2.9 million people through the variety of communication channels used. The strong networks the SSAB has was found to have been a tremendous support in this awareness raising and promotion.

3. 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. At this current time, the Somerset Safeguarding Adults Board does not provide single or multi-agency safeguarding training. Recent Safeguarding Adults Reviews (SARs) have flagged training needs as a common theme and recommended the SSAB Training function be strengthened – this is something that will continue to be explored during the coming year. The SSAB hosted its first multiagency Practitioner Learning Event (June 2016 & Think Family Workshops (from July 2016) which have been well-received; there is an appetite for more opportunities and the Board will deliver another cross-agency conference, aimed at organisational Safeguarding Leads, during the coming year.

4. Self-Neglect Practice guidance was published by the SSAB in June 2016, having been informed by learning to emerge from the March 2016 ADASS Regional Conference. This was shared with housing providers in July 2016, and featured in the July SSAB Newsletter. In March 2017, the Board agreed to make use of district-based Social Exclusion Panels to assist in supporting the management of complex self-neglect cases, particularly where hoarding exists.

5. Effective working relationship between the key partnership boards that have oversight of the work undertaken to support our population will ensure a clearer understanding of respective roles and responsibilities, improve joined up working between partners, reduce duplication, and develop collaborative efforts to improve the resilience of Somerset communities, families and individuals.

   In August 2016, a 'Working Together Protocol for the Strategic Partnership Boards in Somerset' was officially signed off to support effective working arrangements between the Somerset Health and Wellbeing Board, Somerset Children's Trust, Somerset Safeguarding Children Board, Somerset Safeguarding Adults Board, Somerset Corporate Parenting Board, and the Safer Somerset Partnership. Joint Partnership meetings now occur on a six-monthly basis to enhance relationships and explore opportunities, chaired by the County Council's Chief Executive and attended by Board Chairs and supporting Business Managers/Officers. The first meeting took place in December 2016, with the next scheduled for June 2017.

   The SSAB is also represented on a number of other multi-agency partnerships, including the Prevent Board and Domestic Abuse Board.

6. In contrast to Children's Services, there are no specific statutory responsibilities in relation to adult sexual exploitation. Whilst the 'Sexual Violence against children and vulnerable people National Group Progress Report and Action Plan' made some reference to adults as victims, these are not translated into specific actions or responsibilities. Nationally, there is a risk of sexual exploitation being ignored by adults' services and seen as a 'children's issue' only. This is clearly not the case; young people will be transitioning into adult care, and those in the care of adults' services may be affected by the impact of sexual abuse or exploitation as an adult – as the SSAB learnt from a serious case review last year. Similarly, adults receiving care and support from adult social care may have children themselves who may be at risk of CSE. During the past year, the issue of the sexual exploitation of vulnerable adults, particularly those with learning disabilities who may be less able to distinguish between abusive and consenting relationships, has featured within a Practitioner Briefing Note, and was explored at the SSAB's Learning Event in June. The SSAB has also sought membership to the SSCB's multi-agency CSE Subgroup and will join discussions in June 2017.

   Care and Support Statutory Guidance, issued under the Care Act 2014 by the Department of Health, specifies Modern Slavery as a specific type of abuse and neglect. Modern slavery encompasses human trafficking, slavery, servitude and forced or compulsory labour. During the year, individuals across Community Safety, Social Services and the Police in Somerset have supported the Home Office's National Referral Mechanism Pilot to support and benefit potential victims of modern slavery. Training has been received in acting as Slavery Safeguarding Leads

and Multi-Disciplinary Panel Members. The topic has also been promoted via the SSAB website, newsletter and twitter feed.

Prevent forms one of the four strands of Contest (the others being Pursue, Prepare and Protect) the United Kingdom's Strategy for Counter Terrorism, part of the Counter-Terrorism and Security Act (2015). The Prevent Duty supports the 'specified authorities' where there may be risks of radicalisation in Somerset. Fundamentally, it challenges the ideologies that support extremism and terrorism and those who promote it through Safeguarding, and utilises a multiagency approach. In April 2016, SSAB Members received a training presentation from the Police County Prevent Lead, which outlined the objectives of Prevent and promoted the factors that can contribute towards vulnerability towards radicalisation. The SSAB is also represented on the local multi-agency Prevent Board.

Financial abuse is the illegal or unauthorized use of a person's property, money, pension book or other valuables. During the year, links have been strengthened with Devon & Somerset Trading Standards, and a representative is now a formal member of the Board. The organisation attended the Board's Practitioner Learning Event in June 2016 to raise awareness and share materials; the SSAB supported and promoted Scams Awareness month in July and featured scam awareness in its July newsletter. The SSAB has also commitment to promoting trading standards activity as part of June 2017's Stop Adult Abuse week, with its 'safe at home' focus.

7. The SSAB receives detailed updates on progress in relation to the Mental Health Crisis Care Concordat activity as a standing agenda item at each of its quarterly meetings. This work is designed to enhance the response of partner organisations and improve the experience and outcomes of people in mental health crisis by ensuring services in Somerset are appropriately commissioned and resourced to deliver 24/7 crisis response for patients and carers in the most appropriate settings, including their own homes. The SSAB Manager has been invited to participate in its 'Think Differently, Do Differently' subgroup during the coming year, which will focus on how - as a system – we can explore approaches regarding a small cohort of individuals frequently in crisis who present with high level, multiple, complex needs; an issue that has been identified from reviews of both local and national serious cases.

Next Steps 2017/18 (Prevention)

a) Plan promotion events and activities to coincide with June 2017 World Elder Abuse Awareness Day and regional 'Stop Adult Abuse' week (safe at home focus)

b) Work with Devon & Somerset Trading Standards to address financial abuse and scams

c) Seek enhanced assurance of local agency training delivery, take-up, application and impact

d) Deliver an annual conference focused on raising the profile of adult safeguarding, addressing known areas of practice requiring improvement, sharing lessons learned from case reviews, and offering a selection of focused workshop sessions to organisational Safeguarding Leads

e) Establish and oversee the work of a local multi-agency Mental Capacity Act Forum, to enhance local understanding and application of the Act

f) Continue to monitor progress in relation to the Mental Health Crisis Care Concordat and its 'Think Differently, Act Differently' subgroup in order to improve the experience of people in mental health crisis by ensuring services are appropriately commissioned and resourced.

g) Work with other strategic partnership boards in Somerset to keep people safe from harm and improve their health and wellbeing in support of the prevention agenda, reducing duplication of effort and maximising effectiveness

Priority Area 2:

Making Safeguarding Personal

What SSAB said it would do (2016-2019)

1. We will promote the principles of Making Safeguarding Personal and evidence user experience

2. We will collect, analyse and report on the themes to emerge from Safeguarding Adults audits as a means of developing local practice and overseeing improvement activity

3. We will monitor and support the effective use and understanding of the Mental Capacity Act, and the Deprivation of Liberty Safeguards (DoLS)

What SSAB did:

1. Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and

working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process. The extent to which local services are adopting an MSP approach has been monitored by the SSAB via its annual organisational self-audits, designed to give assurance to the Board of local practice.

The Board's Quality Assurance subgroup has also supported the development of a 'Safeguarding Experience' feedback process, which will launch in the Spring of 2017 and will capture responses from individuals, and their carers, about the extent they felt listened to, informed about what was happening and why, whether or not they feel safer as a result of the intervention, and their levels of satisfaction with the engagement.

The Board has also been monitoring the extent to which people are reporting their desired outcomes have been achieved as part of its performance reporting mechanisms. Figures for the 2016/17 year have consistently been above 85%, and we await national comparative data due to be published in October 2017 to determine how we benchmark against other areas.

2. To support local agencies, the SSAB adopted an Organisational Adult Safeguarding Self Audit Tool to help it evaluate the effectiveness of internal safeguarding arrangements, and to identify and prioritise any areas in need of further development to support local organisations in their continuous improvement of adult safeguarding work. Results from the audit process were analysed by the subgroup and formally presented to the SSAB Board in December 2016. The audit revealed areas of high confidence across the system to be in relation to participation to the Board itself and multi-agency working, but some areas of concern in relation to local application of the Mental Capacity Act, the extent / impact of adult safeguarding training and the capturing of equalities information to inform safeguarding responses. The SSAB has also secured a group of multi-agency frontline professional volunteers to form adult safeguarding audit groups; this will be progressed during the coming year.
3. The SSAB receives quarterly updates from the MCA (Mental Capacity Act) & DoLS (Deprivation of Liberty Safeguards) Manager, who has been chosen to chair the South West forum of local authority MCA/DoLS leads and participates in a national leads forum each quarter. As referenced previously, the poor application of the MCA has featured as a theme to emerge from both local and national case reviews, and audits. In December 2016, the Board approved the establishment of a new subgroup - a local Mental Capacity Act forum - which will work to embed the empowering aims of the legislation.

The Deprivation of Liberty Safeguards have been in operation since April 2009. Since April 2013 with the end of the Primary Care Trusts, the functioning of the safeguards has been the sole responsibility of local authorities. Referrals for assessment and authorisation showed a steady year on year increase until the end of 2013/14. This was part of a pattern of very inconsistent use of the safeguards nationally which was criticised in the March 2014 report by the House of Lords select committee into the implementation of the Mental Capacity Act. The committee's conclusion was that the DoLS scheme was cumbersome and difficult to understand, and therefore that it was not an effective protection of individuals' human rights and should be re-drafted. The proposed replacement scheme known as the Liberty Protection Safeguards was published by the Law Commission in March 2017. Their full report and summaries and impact assessment can be found at the following link: http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

At the time of writing, it is not clear what the Government intends to do with the proposals and there are still some significant concerns from local authorities about the affordability of the new scheme.

Defining deprivation of liberty

In March 2014 the Supreme Court handed down its judgement in two cases (P v Cheshire West and Chester Council; P and Q v Surrey County Council) which focussed upon the definition of deprivation of liberty itself. The clarified definition – often referred to as the 'acid test' – has made it easier to understand how deprivation of liberty should be assessed but in a way which has resulted in a very significant increase (approximately ten-fold) number of applications made to local authorities and to the Court of Protection itself. The Law Commission proposals do not alter this definition in any way so the number of people to be covered by the new scheme is unlikely to be reduced.

Next Steps 2017/18 (Making Safeguarding Personal)

a) We will ensure the views of services users, carers, frontline staff and Board Members inform the work of the SSAB:
   - We will implement the Safeguarding Experience service user/carer/provider feedback process and monitor responses on a quarterly basis
   - We will introduce and invite service user stories to Board meetings

b) We will ensure individuals experiencing safeguarding concerns have appropriate and timely access to advocacy through the promotion of advocacy services and knowledge

c) We will establish multi-agency Adult Safeguarding Audit Groups to help the Board quality assurance local practice and service delivery, and improve quality, performance and learning

Priority Area 3:

Think Family

What SSAB said it would do (2016-2019)

1. We will work in partnership to support vulnerable young people in making the transition between children's and adult services

What SSAB did

1. We recognise that multi-agency, flexible and coordinated services, with an underpinning 'Think Family' ethos, are most effective in improving outcomes.

   During the past year, the SSAB has sought to strengthen links with the Somerset Safeguarding Children Board in promoting a 'Think Family' approach. In July 2016, the two respective Board Managers initiated a series of 'Think Family' themed, practitioner focused sessions across the county. The sessions serve as an opportunity for informal two-way dialogue between frontline staff and the two statutory Boards, and have enabled discussions to take place that both complement and inform local priorities. Subsequent sessions have concentrated on care leavers and, more recently, transitions to adulthood ('Choices for Life').

   In addition, the SSAB has worked together with the Somerset Safeguarding Children Board (SSCB) to support more effective transition for young people leaving care or on the cusp of care through the development of Intervention and Resource Panels, which began in August 2016. This builds on learning to emerge from the joint

Learning Review into the deaths of vulnerable young adults (completed in 2014, and published in the autumn of 2015).

A new joint-funded Manager has also taken up post to directly support the Transitions vision across children's and adult services.

Next Steps (2017/18)

a) We will support the development of a multi-agency Think Family Strategy for Somerset

b) We will work with other Strategic Partnership Boards in Somerset to keep people safe from harm and improve their health and wellbeing in support of the prevention agenda, reducing duplication of effort and maximising effectiveness; this will include work to better support victims of exploitation, coercive control and grooming

Priority Area 4:

SSAB Effectiveness

What SSAB said it would do (2016-2019)

1. We will invite an external peer review of the SSAB and respond to any learning recommendations that emerge

2. We will initiate an annual Adult Safeguarding organisational self-audit process

3. We will commission and participate in Safeguarding Adults Reviews (SARs), ensuring learning is widely shared and action taken across agencies to address identified concerns or embed good practice

4. We will develop and actively promote a dedicated website for the SSAB to serve as a useful source of information for the general public, wider workforce, and Board members

5. We will issue regular newsletters as a means of sharing information and improving local awareness of adult safeguarding matters with both professionals and the wider public, encouraging and enabling feedback

6. We will ensure the views of services users, carers, frontline staff and Board members informs the work of the SSAB and are used to inform and develop local practice

7. We will use data, information and local intelligence to identify risks and trends and formulate action in response

8. We will ensure policies, procedures and practice guidance are reviewed to reflect new or emerging legislation, policy or learning, including revised Care and Support guidance

9. We will deliver a multi-agency SSAB Training event to support the knowledge and development of our members

What SSAB did

1. Due to financial pressures facing local services, a Peer Review was not commissioned for the SSAB during 2016/17. An independent Chair, John Bolton, is currently supporting the Local Authority in strengthening its performance arrangements. The SSAB Chair, Richard Crompton, has been invited to attend quarterly strategic meetings and in September 2016 submitted a report from the SSAB outlining both strengths and self-assessed areas for development for scrutiny and consideration.

2. A organisational self-audit process was developed via our Quality Assurance subgroup and issued to member agencies for completion by end of June 2016. It has also been made available to other interested parties on our website. Analysis was completed during the autumn and presented to the SSAB Board in December 2016. Plans are in place to repeat the exercise during the coming year.

3. The Safeguarding Adults Review (SAR) Subgroup has overseen and commissioned a number of SARs and learning reviews during the year – please see Section 6 of this report for further detail.

4. A cornerstone of the SSAB's work is the provision of information to the public, potential and actual service users, staff working in partner agencies and others interested in adults' welfare. A significant amount of work has been undertaken during the year to raise the profile of the Safeguarding Adults Board locally, improve the ways in which we communicate with the wider public and with multiagency professionals, and to raise local knowledge of how to prevent abuse or neglect.

   Within budget and on scheduled, the SSAB launched its own dedicated website (www.ssab.safeguardingsomerset.gov.uk) in April 2016. The site has helped provide a platform to promote work of Board and direct interested parties to key information and resources in order to reach a bigger audience and support public and professional knowledge of adult safeguarding matters. During 2016/17, our website was accessed by 3,629 individual users (40% of which were returning

visitors), and had 15,679 individual page views. Spikes in website usage were evident in April (following official launch of the site), mid-June (World Elder Abuse day and Stop Adult Abuse week) and November (following the launch of the safeguarding adults electronic referral form, which was used as the source of 83% of 'professional' safeguarding concerns by April 2017).

The SSAB also joined twitter to enhance our reach, influence and engagement opportunities. The Board now has over 290 followers and routinely participates in debates and promotion activities.

5. The SSAB has continued to issue newsletters on a regular basis to several hundred professionals and stakeholders across frontline services; these are also forwarded on through other existing internal agency communication routes. Our website now enables people to register for the newsletters and, since this functionality was created, an additional 90 individuals have signed up to receive the briefings. The newsletters outline updates from the Board, national and local adult safeguarding news and developments, and lessons to emerge from practice and reviews.

6. The SSAB has established links with existing service user and carer groups in the county, as well as with Healthwatch Somerset, with its Business Manager attending to present on the work of the partnership during the year. The Quality Assurance Subgroup has supported the development of a 'Safeguarding Experience' feedback form, due for implementation in the spring of 2017, and arrangements are being made to commence 'Safeguarding Stories' as a standing agenda item for Board meetings during 2017/18.

   The Board has also sought to learn from the direct experiences of service users and their families or carers; it has benefitted significantly from their contributions to both local Learning Events, SARs and practitioner briefing sheets and we are keen to develop this further during the years ahead.

7. Considerable work has been undertaken to enhance the data and information available to the SSAB and its Quality Assurance Subgroup from its member agencies; this has helped identify issues requiring resolution. Reports are now routinely received from Adult Social Services, the Deprivation of Liberty Safeguards lead, the Constabulary's Safeguarding Coordination Unit, Care Quality Commission and other key services.

   Analysis was also undertaken of the national 2015/16 comparative Safeguarding Adults Collection data, published in October 2016, which highlighted both strengths of Somerset's safeguarding processes and areas requiring further attention.

Additionally, Board Members contributed to the second annual SSAB Effectiveness Survey in the autumn of 2016, with improved performance against all 12 effectiveness standards when compared with the previous year's figures. Key strengths were identified in relation to the Board's leadership and coordination of adult safeguarding policy and practice across agencies, and the sense that partners work in an atmosphere of cooperation, mutual assurance, accountability and ownership of responsibility. Areas requiring greater attention centred on the use of data, information and intelligence to identify risks and trends, and ensuring mechanisms are in place to ensure the views of people at risk of abuse and their carers inform the work of the SSAB. The findings of this survey, which will be repeated on an annual basis, have informed the Board's risk register and our strategic plan for the year ahead.

8. The role of our Policy and Procedures subgroup is to produce, maintain, develop and review policy, procedure and practice guidance to improve outcomes for adults at risk in Somerset. During the year, the subgroup has developed and published a Service Monitoring Checklist to assist practitioners in considering and recognising potential indicators of concern across the following six criteria:

- Leadership and Management
- Staff behaviour and attitudes
- Behaviours and interactions of residents
- Isolation and lack of openness
- Service design, delivery and make up
- Environment and basics of care.

It also prepared self-neglect practice guidance to serve as a multi-agency guide to issues of self-neglect and to offer procedural guidance for frontline workers. The guidance has been developed in direct response to requests for assistance in managing this complex issue from local housing providers, and was enhanced by learning to emerge from Safeguarding Adults Reviews and the 2016 regional ADASS South West Conference in March 2016.

It has monitored and supported the refresh of regional multi-agency Safeguarding Policy in light of the revised statutory guidance – published June 2016 – in partnership with other local Safeguarding Adults Boards, and has supported the review of a range of policy or procedural documents in partnership to assist the Board in delivering its functions effectively, including:

- An Escalation Policy
- The local Business Failure process
- Adults at Risk meeting documentation and templates
- The Whole Service Concern process

- The development of an electronic professionals referral form
- Learning to emerge from the ADASS Guidance on out of area adult safeguarding arrangements.

9. In April 2017, SSAB members attended a training event and received presentations from local leads on Prevent, Female Genital Mutilation, learning to emerge from Domestic Homicide Reviews locally, and early help thresholds across children's services. A number of members also attended the Practitioner Learning Event in June.

Next Steps (2017/18)

a) Undertake annual Adult Safeguarding organisational self-audit process, enabling the Board to hold members agencies to account, monitor implementation of previous year's identified actions and gain assurance of the effectiveness of local safeguarding activity

b) Commission, participate in and support Safeguarding Adults Reviews (SARs), ensuring learning from both local and national reviews is widely shared and action taken across agencies to address identified concerns or embed identified good practice

c) Use data, information and local intelligence to identify risks and trends, and formulate action in response, to include monitoring of SSAB communication tools

d) Ensure policies, procedures and practice guidance are reviewed to reflect new or emerging legislation, policy or learning, and made more easily accessible to frontline services via the SSAB Website

e) Support Elected Members and Committee functions to better understand their roles and responsibilities in effectively scrutinising and monitoring the effectiveness of the Board in protecting vulnerable adults from abuse

f) We will enhance local assurance mechanisms through the implementation of a peer challenge process in order to increase SAB member understanding of each other's work and methods of service delivery and identify opportunities to strengthen multi-agency working

Safeguarding Adults Practitioner Learning Event

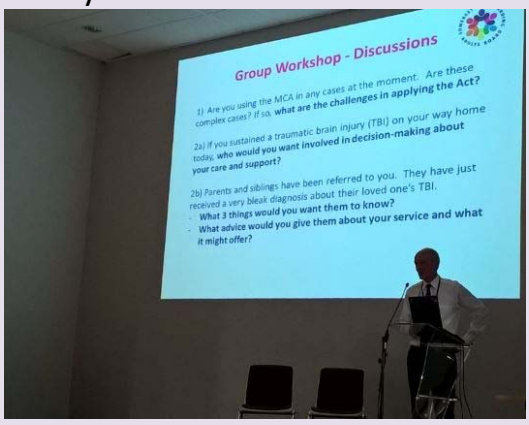
The SSAB delivered its first multiagency Practitioner Learning Event in June 2016 to over 100 frontline professionals to communicate the themes and lessons learnt from recent serious cases.

Feedback from attendees revealed that:

- 94% felt the overall event had been good or excellent;
- 90% felt the venue and facilities had been good or excellent;
- 97% felt the registration and booking arrangements had been good or excellent;
- 87% felt the length of the event had been good or excellent;
- 82% felt the opportunities for networking had been good or excellent;
- 91% agreed or strongly agreed that all subject matter was presented clearly and effectively;
- 97% felt confident about taking learning from the event and applying it to their own role, and
- 92% agreed or strongly agreed that all speakers had presented the subject matter clearly and effectively.

Overall, attendees particularly liked:

- Hearing from service users and families the vast majority of attendees specifically referred to Alyson's speech and Fred's presentation as having been the most valuable part of the day;
- The chance to explore and discuss the use of the Mental Capacity Act in complex cases;
- The opportunity to come together as a multi-agency group; attendees told us they would welcome more events like this in the future.



(L) Chairman addressing audience

(R) Group workshop discussions

6. Safeguarding Adults Reviews

All safeguarding is complex, challenging work but this is never more so than when an individual dies or is seriously harmed through abuse or neglect. The impact on families, carers and the professionals involved should not be over-estimated and is never taken lightly by any organisation or professional.

A vital role of the Board is to seek assurance on the effectiveness of local safeguarding activity and to ensure practice continually improves. It is required to commission Safeguarding Adults Reviews (SARs) to identify whether lessons can be learnt about the effectiveness of multi-agency working to safeguard adults at risk.

The Care Act 2014 states that a Safeguarding Adults Review (SAR) must be arranged by the Safeguarding Adults Board when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and when there is concern that partner agencies could have worked more effectively to protect the adult. A SAR must also be arranged if an adult has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. Please note that Safeguarding Adult Reviews were known previously as Serious Case Reviews.

SARs are demanding pieces of work and are dependent on the openness and reflection of agencies involved to identify what worked well and what could have been better.

The SSAB has a multi-agency SAR subgroup whose role it is to ensure statutory requirements are met in relation to reviews. The subgroup is chaired by the Director of Adult Social Services.

During 2015/16 the SAR Subgroup:

- **monitored progress in relation to ongoing reviews and considered potential cases against the criteria** for conducting one. It has also overseen the appointment of independent, external Chairs and Review Authors; this supports the SARs credibility, and can help to create a more conducive environment to facilitate and encourage discussion amongst involved stakeholders. The SSAB has been fortunate in securing high-profile and well-regarded Chairs to oversee its recent reviews, and is grateful for their input and contribution.
- worked in partnership with the Policy & Procedures subgroup to produce a **Learning and Improvement Policy**, replacing the former Serious Case Review policy that existed, clarifying local arrangements for SARs, and ensuring learning and improvement is better embedded in practice. The Policy was formally ratified in February 2016.

- **ensured the presentation of completed reviews** to the Safeguarding Adults Board for formal acceptance and to agree plans for publication and implementation, including the dissemination of learning across the locality.
- **commenced work to explore how the SAR process can better align with / support other statutory review processes**, such as child Serious Case Reviews or Domestic Homicide Reviews.

Two Safeguarding Adults Reviews concluded during 2016/17:

Tom, June 2016

A Serious Case Review was commissioned by the SSAB following the death of 'Tom' who took his own life in 2014, aged 43. Tom had sustained a traumatic brain injury in a road traffic accident in his early twenties and suffered from depression and drugs and alcohol abuse.

The independent report concluded that, despite numerous contacts with many health and care professionals and the concerns of family members, he was not provided with appropriate support.

It highlights a lack of joined up working across social care, health bodies and drug and alcohol services, with none taking a lead role in determining a coordinated, multi-agency response and missing opportunities to intervene in an integrated way.

Key considerations for practice arising from the review:

- **Supporting people with brain injuries** - **capacity assessment**: Tom's circumstances highlight the fraught boundaries between personal responsibility, public obligation and the assumption of mental capacity. Mantell (2010) has argued that an assumption of mental capacity is risky because a person's severe brain injury usually results in a degree of cognitive impairment'

- **Working with people with multiple and complex needs** - Working with people with multiple and complex needs, across agencies, has to hinge on coordinated assessment, care management and working with the risk of harm together

- **Adopting a Think Family approach:** Little was known about Tom's life before he sustained his brain injury. Although his family was an obvious source of information, their role as reflected in contacts with services became one of pleading for engagement and help.

Action taken on the back of Tom's Safeguarding Adults Review

- Tom died in June 2014; in April 2015 the Care Act put adult safeguarding on a statutory footing for the first time, and in May 2014 a dedicated countywide safeguarding service was established by the Local Authority in May 2015. The

service receives all safeguarding concerns and makes threshold decisions regarding whether referrals meet the criteria for statutory safeguarding enquiries under the Care Act 2014, or require other assessment and support. It undertakes direct safeguarding enquiry and investigation work, and oversees enquiry work undertaken by other agencies. This centralised model ensures greater consistency in decision-making.

- The Mental Health Social Care service has been re-designed and management responsibilities, previously delegated to Somerset Partnership NHS Foundation Trust, have returned to the Local Authority from October 2016. The focus of the new service will be a promoting independence community-based, recovery-focused, and needs-led rather than diagnosis driven. Reflecting upon the Care Act 2014, the service will support individuals with significant needs irrespective of whether they meet secondary care clinical eligibility, which will broaden the group of individuals able to access a specialist service.
- The SSAB delivered a multi-agency Practitioner Learning Event in June 2016, attracting over 100 frontline staff from 19 different agencies and focused on lessons to emerge from Tom's case and another case which concluded in January 2016. Headway Somerset and one of their clients were invited to present specifically on brain injury and its effects and impacts, and Tom's sister was also able to present, alongside the report author, on the family's own experience. 97% of respondents reported feeling confident about taking the learning from the event and applying it to their role. Local trainers were in attendance and have received main themes and learning points so they can refer to the case within training activity in Somerset to reinforce lessons learnt and apply theory to practice.
- The Board developed a Practice Briefing Note, which has been widely disseminated and promoted, detailing the main learning points to emerge from the review. The content of this document was agreed in partnership with the independent review author, Margaret Flynn. Adult Social Care staff have been actively encouraged to use the briefing sheet within team meetings and supervisions as part of reflecting on, developing and strengthening local practice.
- Acquired Brain Injury has featured as an 'awareness topic' within the Board's newsletter, which also promoted national practice guidance on working with people with acquired brain injury. Both were published on the Board's website and also promoted via its twitter account to raise local appreciation of the issue.
- The case was presented to District Council leads and the local Housing Providers group in July 2016 by the Safeguarding Adults Board's Business Manager, who attends on a quarterly basis to enhance awareness of safeguarding developments

across these agencies.

- The Board has continued to promote adult safeguarding issues and how to report concerns to the general public and wider workforce across all member agencies.
- In December 2016, the SSAB confirmed its approval for a local multi-agency MCA Forum to be established. The group will act as a subgroup to the Board with responsibility for supporting the local implementation of the Act and embedding the empowering aims of the legislation. The group will also provide the Board with assurance about the effectiveness of implementation across organisations and make recommendations about future development. Additional training has been provided to Local Authority staff on the Mental Capacity Act 2005. Since April 2015, staff receive two days' worth of training on the Mental Capacity Act delivered by an Independent MCA & Safeguarding trainer and consultant. Court of Protection Legal Training courses have been delivered to staff by Albion Chambers, and guidance and checklists are available on staff intranet pages for all Adult Social Care staff to access.

Damien, September 2016

Damien had diagnoses of Asperger's Syndrome and ADHD. He had a mild learning disability and misused a variety of substances, causing him to come into frequent contact with the police and mental health services. His vulnerability was exploited by others who stole from him and misused his home for their own purposes. Meeting the dual requirements of protecting both the public and Damien from harm, at the same time as treating him as capacitous and allowing him to live his own life with only the necessary oversight and control, tested services in Somerset. In the last fifteen months of his life he was detained under Section 2 of the Mental Health Act on three occasions. He was also made subject to Multi Agency Public Protection Arrangements (MAPPA). Damien died in hospital in July 2015 following an incident of self-strangulation in the residential unit that had been his home for two weeks following discharge.

Key considerations for practice arising from the review:

- **Supporting transition between inpatient mental health settings and community / care home settings:** A key issue affecting transition is a lack of integrated and collaborative working between mental health and social care services, practitioners based in hospitals and those in the community, which can result in inadequate and fragmented support for people using mental health services

- **Supporting families, parents and carers:** Good communication leads to better coordinated care and better experiences

- **Follow-up support:** The consequences of a poor transition can be very serious for the person and their family or carers. National evidence tells us that the first three months after hospital discharge continue to be a period of high suicide risk

- **Promoting Person-centred practices** By working in a person-centred way, we can ensure people are truly listened to and are kept at the heart of all decision-making

Figure 1: The four principles of person-centred care

Action taken on the back of Damien's Safeguarding Adults Review

- In partnership with Damien's family, the SSAB produced, published and promoted a Practice Briefing Sheet highlighting the central themes to emerge from the review. The briefing document was published in the Board's March 2017 newsletter and was shared with local trainers to ensure it informs learning and development.
- The SSAB has promoted person-centred thinking tools via its website and publications to further embed a Making Safeguarding Personal approach across Somerset.
- The Board intends to further promote the case at its 2017/18 Learning Event aimed at local Safeguarding Leads following the conclusion of a Coroner's Inquest expected summer 2017.

7. Our priorities 2017/18

The Board recognises more can be achieved by working together in partnership, and remains committed to its four strategic objectives for the year ahead, based on feedback, learning and analysis of current strengths and areas for development:

1. **Prevention**: focused on ensuring adults at risk are identified early and have their needs met promptly and effectively, and that multi-agency practitioners are supported in identifying and responding to adult safeguarding concerns. It is better to take action before harm occurs.
2. **Making Safeguarding Personal**: focused on embedding an approach to safeguarding that is person-led, outcome-focused, enhances involvement, choice and control, and improves quality of life, wellbeing and safety.
3. **Think Family:** focused on adopting an approach to safeguarding which considers impact on the whole family, in recognition of themes to emerge from recent serious cases and local needs assessments.
4. **Board Effectiveness:** focused on taking further steps to ensure Somerset has an effective Safeguarding Adults Board which fulfils its responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning.

You can read our 2017/18 Strategic Plan in full via the following link: http://ssab.safeguardingsomerset.org.uk/wp-content/uploads/SSAB-Strategy-2016-19-updated-2017.pdf

Safeguarding Case Study 2 – Jack's story

Background: Jack, 80, lives alone in a mobile home in Somerset. He is well-spoken, educated and with much life experience.

Safeguarding Concern: An electrician, who wished to remain anonymous, contacts the Local Authority with concerns about Jack, whom he had visited as he was having problems with his electrics. The electrician reported not being prepared for what he had seen upon attending Jack's home. Papers were piled up on the floor, knee-deep. There were rodent droppings everywhere. Dirty pots and pans were stacked up in the kitchen. Jack used several electric heaters but had blown the fuse panel and burnt some of it out. The place smelt strongly of fumes. The electrician advised Jack not to use more than one heater as it was not safe, and warned him of fire risks. He remained concerned about the level of risk and Jack's understanding of his advice, and requested someone visit to assess the situation.

Safeguarding Response: A Safeguarding Officer contacted Jack and arranged to visit him at home. She was shocked and concerned on visiting due to the obvious disrepair of the property, potential fire risk and extent of hoarding. A full risk assessment was carried out with Jack, who was encouraged to participate fully. The Officer utilised risk assessment tools commonly used by the Fire Service to assess the level of neglecting risk, and Jack engaged fully with the conversation and conclusion of risk. The Safeguarding Officer deemed him to have a good appreciation of the inherent risks in his living conditions and was seeking to change his circumstances. Permission was given to speak with his only living relative – a nephew – who also shared the concerns for Jack.

Safeguarding Outcome: Jack accepted the concerns of the Safeguarding Service and acknowledged he could not continue living in the accommodation. He declined a Home Safety Check from the Fire Service and support to help sort his belongings, but did agree to temporary accommodation whilst waiting for a longer-term option to become available.

Jack went on to sell his land and has since purchased a bungalow. He has no current social care needs and is living an independent life.

8. Board Budget

		2016/17		2017/18	
SOURCE OF FUNDS		**CONTRIBUTION £**	**%**	**PROJECTED CONTRIBUTION £**	**%**
Carry Forward		5,000			
SOMERSET COUNTY COUNCIL	- SAB MANAGER & CHAIR	45,840	51.8%	43,420	45.1%
	- SAFEGUARDING ADULTS REVIEWS	16,160	18.3%	8,000	8.3%
AVON & SOMERSET POLICE	- SAB MANAGER	15,900	18.0%	18,900	19.6%
	- SAFEGUARDING ADULTS REVIEWS	550	0.6%	8,000	8.3%
SOMERSET NHS CCG	- SAB MANAGER	10,000	11.3%	10,000	10.4%
	- SAFEGUARDING ADULTS REVIEWS			8,000	8.3%
TOTALS		**93,450**	100.0%	**96,320**	100.0%
APPLICATION OF FUNDS		**EXPENDITURE £**	**%**	**PROJECTED EXPENDITURE £**	**%**
PAY					
SAFEGUARDING BOARD MANAGER		54,760	54.5%	55,320	56.3%
INDEPENDENT CHAIR		16,980	16.9%	17,000	17.3%
NON PAY					
SAFEGUARDING ADULTS REVIEWS		16,710	16.6%	24,000	24.4%
ADASS THEMATIC REVIEW				300	0.3%
BRANDING & WEBSITE		10,640	10.6%	100	0.1%
ROOM HIRE		1,370	1.4%	1,500	1.5%
TOTALS		**100,460**	100.0%	**98,220**	100.0%
OVERSPEND		**7,010**		**1,900**	

9. The work of key members 2016/17

- **We have invested considerable focus on enhancing the effectiveness of local safeguarding processes and timescales within our dedicated safeguarding service.** There has been a clear emphasis on developing operational and business processes to enhance the efficiency and effectiveness of local service delivery and operational performance. At the start of the 2016/17 financial year, 42% of pathway decisions were made within the target 2 working day timeframe; since September 2016 performance has consistently exceeded the 97% target, with Quarter 4 data standing at 98.4% overall. This has been achieved through attention on data, enhanced scrutiny and validation of information, and robust engagement with referring agencies to enhance the quality of safeguarding referrals.
- **We have seen safeguarding conversion rates increase over the course of the financial year** from 40.5% in April 2016 rising to 52% by March 2017; we will continue to work in partnership with the wider Board and referring agencies to further improve understanding. We have worked closely with Avon & Somerset Constabulary to support their introduction of the BRAG risk assessment process in order to enhance knowledge of referral routes and sources of support, both within local services and across the broader community
- **We have developed our approach to high-risk care leaver transition using the adult safeguarding framework** and are working closely with the Leaving Care Service to enhance information-sharing and information, advice and guidance
- **We continue to provide trouble-shooting support to both non-CQC regulated and CQC regulated providers** to ensure identified quality concerns do not escalate into major operational or safeguarding issues. The proportion of good or better regulated care settings in Somerset exceeds national, regional and peer group averages.
- **We have introduced a new, secure, electronic safeguarding referral form, launched with care providers at an RCPA Conference in November 2016.** The new form helps to streamline and simplify the referral process and enhance the quality of the information received. Data demonstrates the e-referral form is being well and increasingly utilised by (mainly) providers of care and support services, accounting for 83% of all 'written' referrals received via Somerset Direct by April 2017. Feedback about the form also revealed people were finding the online referral form a useful and preferable option to standard phone/email reporting.
- **We have funded the full development and on-going hosting costs of a dedicated SSAB website** which went live in April 2016; this has proved invaluable in supporting the promotion and further progression of the Safeguarding Adults Board
- **We have developed a local, interactive CQC Ratings Mapping Tool** to support local stakeholders, and inform performance monitoring and benchmarking activity; this is now publically available via: http://www.somersetintelligence.org.uk/care-quality-commission-ratings.html
- **We have actively contributed to regional Quality Surveillance Group meetings** and ADASS (Association of Directors of Adult Social Services) Safeguarding Leads meetings, sharing local intelligence and learning for the benefit of other areas. We ensured good attendance from both Local Authority Adult and Childrens Services at the SSAB's June 2016 Learning event, and have promoted the practice briefing sheets and newsletters widely across the Council in order to develop practice and enhance awareness.

- **We have delivered a range of safeguarding-related training and development opportunities for staff within Adult Social Services:**
  - Recognising Adult Abuse (Contract started in November 2016) – 7 (half day) courses ran total of 52 people trained
  - Enquiry Skills – 3 courses (2 x 2 day course & 1 x 1 day refresher) total of 33 people trained
  - Leading Decision Making – 4 courses (2 x 2 day course & 2 x 1 day refresher) total of 41 people trained
  - Mental Capacity Act – 12 courses (2 day course) ran total of 144 people trained

  Additionally, staff within the safeguarding service and/or Learning Disability teams have benefitted from independent externally-led training in subjects such as Coercive Control, and in Mental Capacity and Sexual Consent.
- **We have worked to ensure that NHS Providers meet their safeguarding responsibilities** through strengthening our commissioning arrangements and closer monitoring of contracts
- **Our contracting process in 2016-17 reflected the requirements of the Care Act 2014** and supported outcomes-focused, person-centred safeguarding practice through 'Making Safeguarding Personal' and 'Think Family'

NHS
Somerset
Clinical Commissioning Group

- **We have facilitated a working group consisting of our NHS providers to align and strengthen NHS Safeguarding Services and Policies.** The group is collaborating to provide a core training package and schedule that can be both provided by and accessed by all NHS providers
- **We have been active participants in all Somerset Safegaurding Adult Boards meetings**, and provided representation on all the board's sub groups. We have contirbuted to the content of development plans, policies and protocols relating to the SAB. We have also supported all the Safeguarding Adult Reviews. We display 'Thinking it? Report it' leaflets and posters in our reception areas across all NHS Trusts, primary care and the CCG. The SSAB newletters have been disemminated across the CCG, all NHS Trusts and Primary Care
- **We have funded development of multi-agency safeguarding training** to deliver integrated and standardised level 3 training for health and care professionals jointly with North Somerset CCG. In 2016/17, through the contract management process, Somerset Partnership Trust reported an average 97% of staff receiving Safeguarding Adults training, Taunton & Somerset NHS Foundation Trust reported 91% and Yeovil Hospital reported 95% of staff who have received Safeguarding Adults training
- **We have worked with the Somerset GP Education Trust to deliver training** to GP's and Practice staff on safeguarding adults, focussing on learning to emerge from the Safeguarding Adult Reveiws commissioned by SSAB during 2016/17 with application of the learning to primary care
- **We have contributed to both the strategic and operational processes working with care homes** when there have been serious safeguarding concerrns and supported the process of two Nursing and one Learning Disability home closures in 2016/7
- **We commissioned an independent review into our commissioning arrangements** following the closure of a learning disability home. As a result of the review, we have amended our processes and developed tools to assess the quality of a service prioir to placement and assess the quality of our reveiws of people in receipt of Continuing Healthcare
- **The Care Home Support team have contributed to the development of Safeguarding, Mental Capacity and Deprivation of Liberty Safeguards practice with care home** and have delivered 34 workshops to increase staff confidence and competence in deciding when

to raise safeguarding concerns, and to implement the Mental Capacity

- **We have encouraged staff to attend regional and national safeguarding learning events** to disseminate good practice, and all NHS providers are required to have safeguarding, DoLS, and whistle-blowing policies and to implement the Duty of Candour as part of our contract management
- **We have worked with our providers and adult social care to ensure safeguarding alerts are raised and managed in a coordinated way**. In 2016-17, the CCG responded and took part in 45 whole service safeguarding or quality improvement meetings for care homes with nursing
- **We have a centralised Incident reporting system (Datix)** to enable us to review concerns and outcomes raised by health care professionals. During 2016/17, 120 serious incidents were reported from health providers – higher than 2015/16 when 94 incidents were reported. The highest prevalence of 'incident types' remain apparent/actual/suspected self-inflicted harm, there were 11 cases directly related to safeguarding.
- **We are using Care and Treatment reviews in line with NHS England best practice** to involve families and experts by experience in planning care that will achieve the aspirations of people with a learning disability and prevent the need for hospital admission at times of crisis

- **We provide professional policing services, working with partner agencies, in order to keep people safe from harm**. This includes working to prevent Adults at Risk from becoming victims of crime, investigating crimes against them, bringing perpetrators to justice and managing offenders.
- By way of **context**, the Constabulary identified 795 'Safeguarding Adult flagged crimes' and 481 'Safeguarding Adult flagged incidents' in Somerset during 2016/17, falls of 9% and 16% respectively on the previous year
- **Our first responders and specialist interviewers undertook refreshed training for responding to sexual assault.** Both courses relate directly to Adults at Risk. New police recruits and Police Community Support Officers also received this training, all of whom had safeguarding woven into their initial training.

- **We introduced a two year pilot Control Room Mental Health Triage Scheme**. Mental Health nurses are based in the Police Control Room, enabling the Constabulary to meet mental health needs at the first point of contact, ensuring that intervention takes place at the earliest possible moment. Access to both Police and Health information databases ensures that decisions made from that point onwards are fully informed and best placed to manage risk. 874 consultations were completed in March 2017, with Section 136 detentions being avoided on five occasions.
- **With partner agencies, we carried out a review of the process through which a patient travels when Section 136 of the Mental Health Act is being considered** in Avon and Wiltshire, and have developed a model process that is to be tested and piloted to contribute to the prevention of patients' deterioration into crisis. This work could have benefits for Somerset in due course.
- **We are an active partner in five Multi-Agency Safeguarding Hub arrangements based on local authority areas** - enabling us together to provide the best safeguarding response. The Somerset Adults MASH is developing to a case review and strategy model.

- **We are introducing a risk assessment process to support officers and staff in sharing information more effectively with partners**, helping vulnerability concerns to be referred internally to our Victims & Safeguarding Team and then onwards to partner agencies. This risk assessment process, known as BRAG (Blue, Red, Amber, Green), is designed to improve our understanding of Adults at Risk, safeguarding and vulnerability in a wider context, helping us to consider why information is being shared and how partners are expected to act upon that information.
- **We made effective use of our Constabulary Management Board** to carry out assurance work. For example, the February 2017 meeting focused on Adults at Risk and amongst other things examined: Adults at Risk and Missing Person Demand; Mentally ill people who are reported 'missing' from health-based settings; Missing Persons with a Learning Difficulty - Bristol Assurance Report; and the development of a Delivery Plan for Adults at Risk.
  We actively contributed to multi-agency learning through Safeguarding Adults Reviews and Domestic Homicide Reviews across Avon and Somerset and at the end of 2016/17 the Constabulary held two current recommendations from two Safeguarding Adults Reviews, one of which related to a case in Somerset. Progress in implementing recommendations is monitored by our Safeguarding Theme Leads Group and Constabulary Management Board.

- **We have appointed a Deputy Safeguarding Lead for NHS England SW**. Primarily this post will support the whole safeguarding agenda and the ongoing priorities as directed by the National Safeguarding Steering Group.

We have funded numerous projects in local SW CCGs. These include:

- Developing outcome focused regional standards and an assurance tool for CCGs to hold their providers to account in a systematic way with agreed regional benchmarks and evidence criteria. This includes PREVENT, FGM and CSE standards;
- Working with the regional police led Child Sexual Exploitation (CSE) project, provide bespoke nursing leadership to the development of the tool kit and standard operating procedure that will support all professionals in understanding CSE and how to spot it. This includes a "fast track" programme to refer children and young people to a bespoke mental health service;
- Developing a supervision structure and tool kit to support nursing home leaders and their staff in delivering safeguarding supervision within and between nursing homes and improving standards;
- Developing a tool kit to support healthcare professionals in writing Independent Management Reviews (IMRs) including primary care colleagues using audit methodologies and best practice evidence;
- Supporting a local Female Genital Mutilation (FGM) theatre group to deliver the message to young girls in schools and youth clubs and provide a safe place to discuss the issues they face;
- Provide dentists with bespoke safeguarding training that is tailored to their needs and meets their CQC requirements and provide a tool kit for senior dentists to supervise others in safeguarding issues;
- Regional events and training opportunities for designated nursing professionals for Looked after Children and those leading the delivery of the Slavery and Trafficking agenda.

Throughout 2016 and into 2017, NHS England South West has delivered a range of learning experiences for Primary Care

colleagues through e-learning licenses. In addition, the use of the GP reflective tool has been widely shared across all GPs which encourages GPs to look at real cases either with their local practice or as part of multi-agency team discussions. This is supporting the increased engagement by GPs within local case review and case conference processes in their local areas and supporting other GPs via local networks.

Throughout 2016 each CCG has been asked a standard question at each quarterly assurance meeting as part of their routine Key Lines of Enquiries (KLOEs). These questions have covered:

- Their assurance process and governance of their providers;
- Their plans and requirements to deliver the recommendations in both the Goddard and the Wood reports;
- How do their board members demonstrate competencies in line with the requirements within the Intercollegiate Documents;
- Bespoke safeguarding questions as required from CQC inspections or other alerts or investigations.

This assurance process has been developed to ensure all CCGs provide the right level of Board and Executive assurance to their local safeguarding systems and commissioned services and an action plan is now in development with each CCG for improvement in 2017/18.

NHSE SW has a detailed work plan for 2017/18, the key drivers include:

- Improved governance and assurance arrangements of its commissioned services
- Strengthened strategic leadership for safeguarding in SW NHS organisations
- Delivery of the national safeguarding priorities which include; Prevent, Modern Slavery, Child Sexual Exploitation (CSE), Deprivation of Liberty Safeguards (DoLS), Child Protection Information Sharing project (CP-IS), Looked After Children (LAC) and Female Genital Mutilation (FGM). As well as supporting the Independent Inquiry into Child Sexual Abuse (IICSA), the safeguarding reforms in child safeguarding and Unaccompanied Asylum Seeking Children (UASC).
- Supporting STPs in the SW to ensure that the safeguarding agenda remains a priority in local service development.

Taunton and Somerset NHS
NHS Foundation Trust

- We are continuing to work with our partners in health to co-ordinate our approaches to safeguarding training. This will establishing a consistent approach across organisations with an increased scope for joint working.
- A new Learning Framework for Safeguarding has been produced to reflect our multi-agency work on co-ordinating training. We are aiming to implement this new programme as soon as the multi-agency planning has been completed.
- We have been working to improve staff awareness of the Mental Capacity Act. This work has been primarily focused on increasing the number of senior staff who have undertaken our Mental Capacity Act for decision makers e-learning. We have made significant progress, but we will continue to drive this work forward to include an increasing range of hospital staff.
- We have implemented our new vulnerable adult audit programme. This programme covers adult safeguarding, Learning Disabilities, the Mental Capacity Act and restrictive care. This audit approach includes a qualitative notes audit combined with a staff survey.

- We have hosted a Domestic Abuse worker in the Trust to support victims of domestic abuse. This was a fixed term position using funding from the Police and Crime Commissioner. This post was supported by the Somerset Integrated Domestic Abuse Service.
- Funding has been agreed to support the employment of an Independent Domestic Abuse Advisor for the Trust. Discussions about this new role will commence with Somerset Integrated Domestic Abuse Service to ensure that this new post gives our victims of domestic abuse the best possible levels of support.
- We have played an active role on the Safeguarding Adult Board. This has included membership on a number of the Boards sub-groups and the Executive Group.
- We have continued to participate in Safeguarding Adult Reviews and Domestic Homicide Reviews.
  We have a work plan to improve safeguarding in the Trust. This plan is supported and overseen by our Safeguarding Committee. Our success against this plan is reviewed at the Trusts Quality Assurance Committee.

- We have fully integrated the safeguarding team, including the Trust Learning Disability Lead and the Trust Independent Domestic Violence Advisor

Yeovil Hospital Healthcare

- We have engaged the full-time services of an IDVA to work in conjunction with the Safeguarding Team
- We Have commenced Routine Enquiry as part of the Screening Process for Domestic Abuse with in the Emergency Department for all patients aged 16 +
- We have situated the team in one office with a Single Point of Access contact number, which means all Trust staff know who to contact with any safeguarding/ Mental Capacity/ IDVA and Learning Disability concerns/questions
- We have delivered combined Adult and Children Safeguarding training, incorporating 'think family' to all staff levels of the organisation through the Mandatory and Induction training programme
- We have updated the trust intranet safeguarding page incorporating Adult and Children Safeguarding resources available for all staff to access.
- The safeguarding team provide advice, training, ad hoc supervision and support to all staff across the trust.
- The Mental Health Lead for the Trust is co-located in the safeguarding office, enabling seamless communication and information sharing between the safeguarding team and mental health lead.
- We continue to provide targeted training to wards and departments on understanding the Mental Capacity Act and DoLS processes
- We Promote SSAB news and awareness campaigns through our in house e bulletin and intranet.
- We Have developed a rolling modular level 3 training programme (adult and children) , which enables staff to attend modules lasting 2 hours.

- We continue to actively responded to serious case reviews, section 42 requests and where safeguarding concerns have been identified
- We have amalgamated the Child and Adult Safeguarding strategies into one strategy thereby strengthening our approach to safeguarding
- We are working with the partner organisations to develop a county wide training strategy.
- We have commissioned an external review of the Children and Young People unit (for over 18's). The recommendations of this review will be considered and actioned as appropriate.

  We have both Executive and Non-Executive Safeguarding representation on the Trust Board

RCPA
REGISTERED CARE PROVIDERS ASSOCIATION LTD

- We have developed a training day in conjunction with Research in Practice for Adults (RiPfA) to be delivered to care providers on a rolling basis. The training is aimed at Managers within care organisations and seeks to promote safeguarding within the Making Safeguarding Personal Framework.
- We have continued to be a source of advice and support to our members in relation to safeguarding matters.
- We collaborated with the Somerset County Council Safeguarding and Quality team in delivery of the 2016 RCPA Annual Conference. The team delivered two workshops on the Council's safeguarding policy and procedures, and contract quality.

- We have refreshed all of our staff training in line with the Care Act 2014.
- Our staff training strategy has been reviewed and updated to ensure that staff receive the appropriate level of training required. There is now mandatory e-learning as well as face to face training covering Adults at Risk, Children and Young People, Child Sexual Exploitation, PREVENT, Domestic Abuse and MARAC and Mental Capacity Act 2005.

Knightstone

- We have increased the hours of our Safeguarding and Mental Health Specialist role. This role has provided additional staff training and advice to staff, which has led to an increase in appropriate referrals to Adult Safeguarding and a decrease in inappropriate referrals.
- A new recording system has been implemented to capture all internal safeguarding alerts and the outcomes. This is in line with 'Making Safeguarding Personal' and also gives an auditing tool to capture training needs.
- There has been an external review commissioned to assess all of our practice around safeguarding. The actions from this are due to be completed by the end of October.
- The internal safeguarding alert forms have been amended to adding outcome desired by the customer, this supports person centred practice – 'Making Safeguarding Personal'.
- We have been active participants in SSAB meetings.
- All policies have been updated to reflect changes brought in by the Care Act 2014.
- Continue to use a dedicated page on our workplace Yammer to highlight changes, share news and updates and also share free additional training for staff to complete.

- We have actively contributed to DHR and Safeguarding reviews where appropriate and have utilised any learning as applicable.
- There have been Internal Management Reviews carried out where we have concerns and where we may be able to learn from our past actions with customers to ensure best practice and to prevent safeguarding issues from arising.

Somerset Partnership

- We have developed an Integrated Safeguarding Service that covers Safeguarding Adults, Safeguarding Children, Multi- Agency Risk Assessment Conferences (MARAC), Multi- Agency Public Protection Arrangements (MAPPA) and PREVENT, (a strand of the Governments CONTEST strategy working with counter-terrorism). The integrated safeguarding service embeds the 'Think-Family' model as the basis for all of its work across the Trust and with our partner agencies.
- We have developed an Integrated Safeguarding Steering Group that considers all of the areas that the Safeguarding Service is responsible for and reinforces the 'Think Family' approach.
- We have developed a safeguarding adults team generic mailbox for our service which has been mirrored by our Somerset County Council (SCC) colleagues, thus enabling clearer communication between us and our SCC safeguarding colleagues.
- We produced name badge stickers for every member of the Trusts 4,000 staff that incorporates the single point of contact (SPOC) number for the Safeguarding Service. The Integrated Safeguarding Service provides telephone advice and guidance service and ad- hoc supervision to staff across all of our services.
- We have developed Safeguarding intranet pages that provide a useful resource for staff. These have internal and external links incorporated within them for all of the forms and documentation staff will need.
- By reconfiguring our existing resources we have strengthened our professional safeguarding team to further enhance the skills mix of the team to provide appropriate responses to concerns from our vast array of community and mental health services.
- Staff have reported increased confidence in the support and training they receive. Up until March 2016 there was one level of safeguarding adults training provided in-house for all staff and we have already trained over 93% of staff. From April 2016 we started to provide higher level training (Level 3) to targeted staff groups to enhance their learning and understanding further and incorporate learning from safeguarding adult reviews and other reviews undertaken.
- Accessing the Safeguarding Service for advice and support via the new single point of contact number has proved really popular. Staff are evidently becoming more aware of potential patient safeguarding issues from the increased profile that safeguarding now has in the Trust. This has been evidenced by a fourfold increase in safeguarding contacts to the team over the last year and increased referrals to the Somerset County Council Safeguarding team.
- We have worked closely alongside our police and Somerset county council safeguarding adult colleagues to develop the weekly safeguarding adults Multi- Agency Safeguarding Hub (MASH) meetings. We already have daily MASH meeting established with Children

Social Care and the Police.

- We worked closely with the SCC Safeguarding Team to co- produce joint Level 3 safeguarding training for all of the staff working within the integrated social care and health community learning disability teams.
- We have completely revised our safeguarding training provision to reflect the Care Act 2014 and the Royal Colleges Intercollegiate Guidance. The trust now provides in-house Levels 1- 5 safeguarding training and has been successful in a bid for NHS England one-off funding to provide safeguarding adults training across the health community of Somerset & North Somerset.
- We have actively contributed to several Safeguarding Adult Reviews and Domestic Homicide Reviews with our partner agencies.
- We are actively involved in the work of the Safeguarding Adult Board and all of the sub-groups, working hard with our board and sub group colleagues to improve safeguarding services across Somerset.
- In addition to the trusts Executive Director responsible for safeguarding we have a Non- Executive Director responsible for safeguarding as well as a Named Doctor for Safeguarding Children supporting the work of the Safeguarding Service and providing appropriate internal challenge.
- The Head of safeguarding has been leading a project with our health partners in Somerset to consider closer alignment of safeguarding services across the health community. The Directors of Nursing in the three provider Trusts are actively supporting this project.
- We have come together as districts and created the District Councils Safeguarding Group which meets quarterly, shares best practice and develops joint initiatives to safeguard vulnerable people.
- We have trained existing and new staff across our organisations to increase understanding of safeguarding responsibilities and routes for referral.
- We have actively contributed to several Safeguarding Adult Reviews and Domestic Homicide Reviews with our partner agencies, and changed policies and procedures where learning from these has indicated this would be beneficial.
- We have trained elected members to understand their safeguarding duties and to act as champions within the community.
- We have reviewed and updated our safeguarding policies and protocols
- We have used the One Team model to provide active support to safeguard vulnerable people.
- We have created safeguarding champions in our organisations who have has increased training on safeguarding matters and who act to provide support and guidance to other staff.
- We have developed and implemented Prevent Action Plans to help stop vulnerable people being drawn into terrorism and harm.
- We are delivering the Positive Lives Programme, with partners, to support vulnerable adults with complex needs gain stable, safe accommodation.

Are you worried about someone?

If you are worried about a vulnerable adult and would like our help, please don't stay silent.

- Phone Adult Social Care on **0300 123 2224**
- Email **adults@somerset.gov.uk**
- In an emergency always contact the police by **dialling 999**
- If it is not an emergency and you want to talk with the police, **dial 101**

We will make urgent enquiries to understand the situation and make decisions about what needs to be done next, to make sure people are safe.

We will always deal with any calls in the strictest confidence.