Annual Report

2017-18

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 2017/18;
- 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, www.ssab.safeguardingsomerset.org.uk, 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. A copy will also be shared with the Chief Officer of the Clinical Commissioning Group.

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 2017/18.

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

I believe that, both as a Board and as the individual organisations that make it up, we can demonstrate that we make a difference, to the lives of those we are here to safeguard and support; and to those partner organisations who work to safeguard adults at risk.

During the year we published a Safeguarding Adults review, Mendip House, that has national significance. We will continue to pursue the recommendations made within it during the coming year. You can read more about this on page 44. We have also continued to focus on improving the overall effectiveness of our board in its efforts to better coordinate activity, to learn from events locally, regionally and nationally, 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 on making the safeguarding process more personal to the specific needs of the adult at risk, on emphasising preventative work, and on encouraging a whole family approach and greater awareness of the crucial period of transition from childhood into adulthood. We have sought to hear the voice of the adult at risk and their families or carers. 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.

This 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 key 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 have strong levels of commitment from partners to make it happen.

I look forward to the coming year and the fruition of the further enhancements we are putting in place to increase our scrutiny of assurance confident that we will continue to improve and make a real difference.

Richard Crompton
Independent Chair
Somerset Safeguarding Adults Board

3. The Board

Safeguarding is everybody's business

The Board's role is to have an oversight of safeguarding arrangements, not to deliver services

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.

The Boards' 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; and
- are experiencing, or at risk of, abuse or neglect; and
- (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.

The Board 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.

Membership of the Board

Board members as at 31 March 2018:

Somerset Safeguarding Adults Board		
Name	**Organisation**	**Job Title**
Richard Crompton		Independent Chair
Stephen Miles		Business Manager
Lead Statutory Partners		
Stephen Chandler Mel Lock	Somerset County Council	Director, Adult Social Services Director of Operations
Sandra Corry Deborah Rigby	NHS Somerset Clinical Commissioning Group	Director Quality, Patient Safety and Nursing Deputy Director Quality, Patient Safety and Nursing
Mike Prior	Avon & Somerset Constabulary	Superintendent

Partner Members		
Sue Burn	Care Quality Commission	Inspection Manager
Denise Dearden	Devon, Somerset and Torbay Trading Standards Service	Trading Standards Project Officer
Luke Joy-Smith	Discovery	Managing Director
Emily Taylor	Healthwatch Somerset	Healthwatch Somerset Manager
Mark Coates	Liverty, formerly Knightstone Housing (representing Housing Services)	Director of Supported Housing & Empowerment
Tracey Aarons	Mendip District Council (representing District Councils)	Deputy Chief Executive
Alison Wootton	Musgrove Park Hospital	Acting Director of Patient Care
Claire Evans	National Probation Service	Senior Probation Officer
Nick Rudling	NHS England South (SW)	Deputy Safeguarding Lead
Simon Blackburn	Registered Care Providers Association	Chief Executive
Lucy Macready	Somerset County Council (Public Health - Community Safety)	Public Health Specialist – Community Safety
Cllr David Huxtable	Somerset County Council	Lead Member – Adult Services
Christina Gray	Somerset County Council (Public Health)	Consultant in Public Health
Richard Painter	Somerset Partnership & Taunton and Somerset NHS Foundation Trusts	Director of Safeguarding
Sarah Thompson	South Western Ambulance Service Trust	Head of Safeguarding and Staying Well Service
Bernice Cooke	Yeovil District Hospital	Head of Governance and Assurance

Board attendance

The Safeguarding Adults Board met on 3 occasions during 2017/18 – June, December and March.

A meeting was scheduled for September 2017 but was cancelled due to unforeseen circumstances. In brackets below is the number of times each organisation was represented during the year at these meetings[1]:

Organisation	Attendance
Somerset County Council	100% (3/3)
NHS Somerset Clinical Commissioning Group	100% (3/3)
Avon & Somerset Constabulary	100% (3/3)
Care Quality Commission	33% (1/3)
Devon, Somerset and Torbay Trading Standards Service	0% (0/3)
Discovery (new member from December 2017)	100% (2/2)
District Council representative	100% (3/3)
Healthwatch Somerset	67% (2/3
Housing representative	67% (2/3
Musgrove Park Hospital	67% (2/3
National Probation Service	33% (1/3)
NHS England	33% (1/3)
Public Health	67% (2/3
Public Health (Community Safety)	100% (3/3)
Registered Care Providers Association	67% (2/3
Somerset Partnership NHS Foundation Trust	100% (3/3)
South Western Ambulance Service Trust	0% (0/3)
Yeovil District Hospital	100% (3/3)

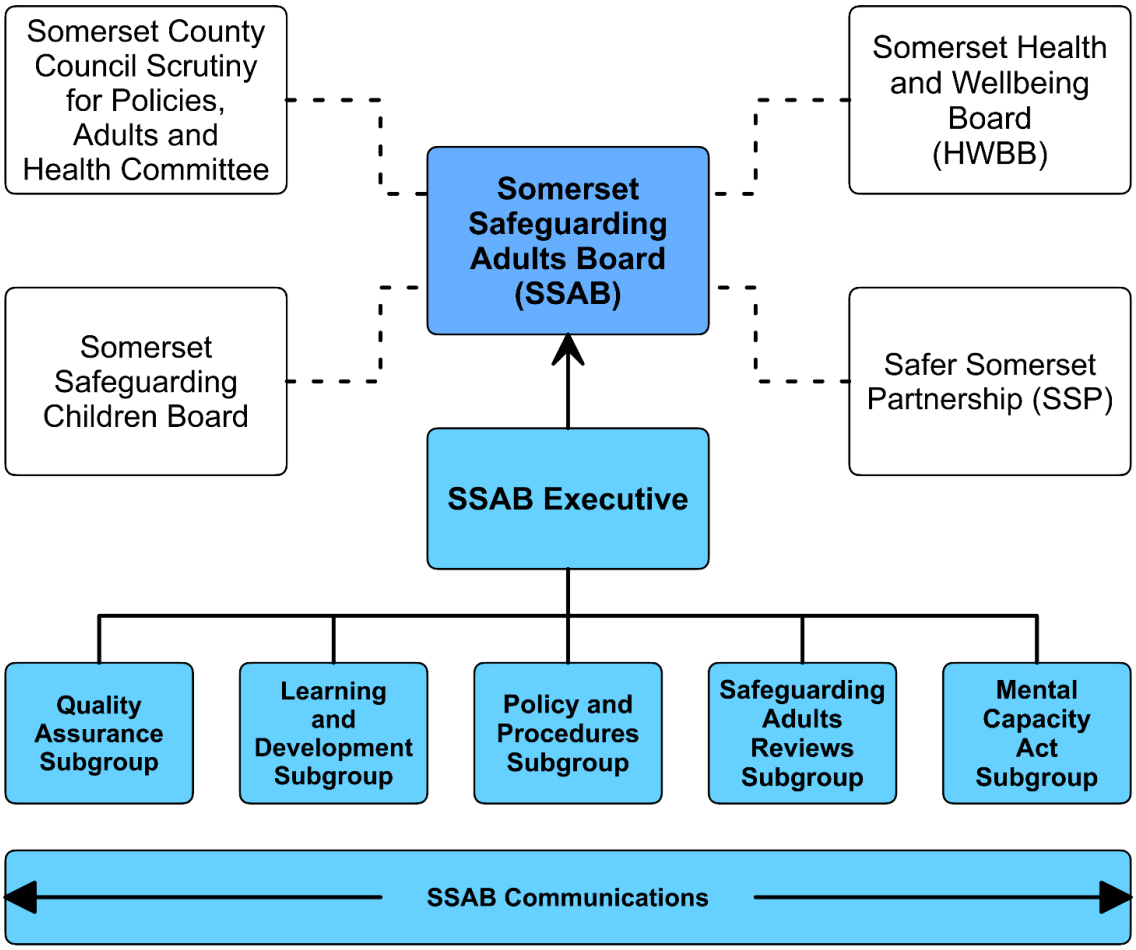
District Council Safeguarding Leads and local Housing Providers are also engaged via quarterly Safeguarding meetings established separately during the year, which the SSAB Business Manager routinely attends and contributes to.

The SSAB meets on a quarterly basis and is supported by an Executive group and a number of 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

[1] By the agency representative themselves or an appropriate agency substitute

the Board as an identified multi-agency need to strengthen local application, and knowledge, of the Act.

Board structure



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, and are:

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.

Read further information on the signs, symptoms and indicators of each type of abuse

Case Study

Joan was her 70's and was being taken advantage of by a woman in her 30's who had befriended her through a mutual acquaintance. It was believed that she gave her money from certain tasks, but she started going to Joan's address and demanding money and also met her just after she withdrew her pension money from the post office. Joan found it difficult to refuse her requests for money.

Initially Joan was reluctant for any intervention but after the woman stole her purse she decided that she would accept assistance. In order to address the issue a member of the Safeguarding Team convened a meeting between Joan, her social landlord, the local Police Community Support Officer, the care agency and a health trainer from the local surgery. Her landlord installed CCTV in order to gather evidence of harassment and further potential theft and also put in an alarm. The heath trainer offered to help with re-housing (Joan had additional health conditions identified during this time) and accompany Joan to

get her pension. The PCSO also helped with legal support and taking statements. The woman was arrested and charged with theft.

On release conditions will be placed on her not to visit Joan's property.

4. Safeguarding in numbers

How much abuse and neglect was reported during 2017/18?

Safeguarding concerns reported to the Local Authority in 2017/18

4196 concerns were reported, a drop of 1255 from the previous year as a result of work to reduce the number of repeat and inappropriate referrals

2016/17
5451
Concerns

2017/18
4196
Concerns

Safeguarding concerns received that required a statutory response

1798 (42.85%) of concerns reported to the Local Authority resulted in a statutory response compared to 2045 (37.52%) as a result of less inappropriate referrals being received

2016/17
2045
Section 42 enquiries
(37.52% of all concerns received)

2017/18
1798
Section 42 enquiries
(42.85% of all concerns received)

Who was at risk of abuse and neglect in 2017/18?

The majority of individuals that required a statutory response were female

Females
908
(60.61%)

Males
590
(39.39%)

The majority of individuals that required a statutory response were aged 65 and over, and over 98% were from white ethnic backgrounds

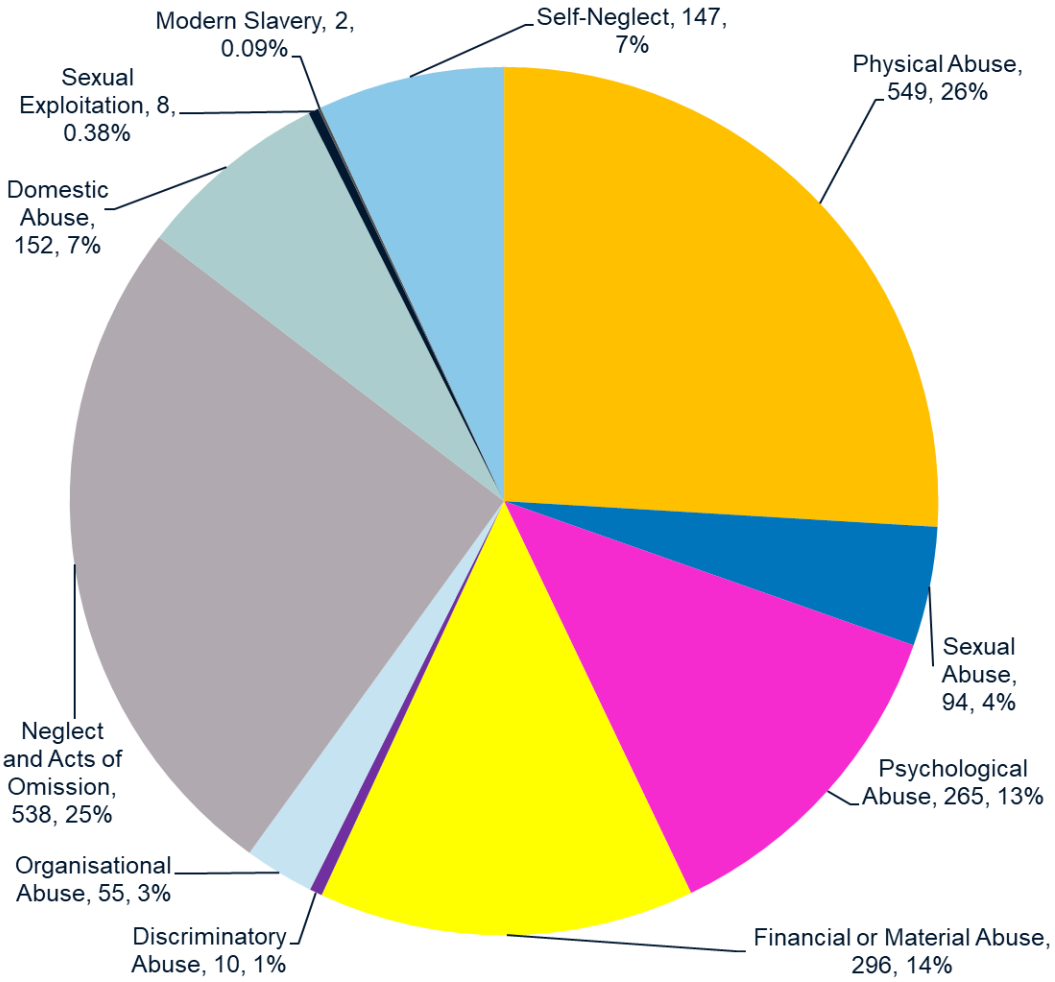
Aged 18-64
545
(36.38%)

Aged 65 and over
953
(63.62%)

Type of abuse and source of risk

The most common risk type was physical abuse, which accounted for 26% of risks, followed by Neglect and Acts of Omission at 25%

In 70.18% of cases the source of risk was recorded as someone known to the individual, but not in a social care professional capacity



Case Study

Dave is a young man in his twenties who has a diagnosis of learning disabilities and poor mobility. A referral was received from Dave's General Practitioner (GP). Dave has reported to his GP that his mother, who he lives with, had been slapping him and hitting his legs with her walking sticks. Dave is socially isolated and has been calling emergency services regularly stating he is going to self-harm or is having suicidal thoughts.

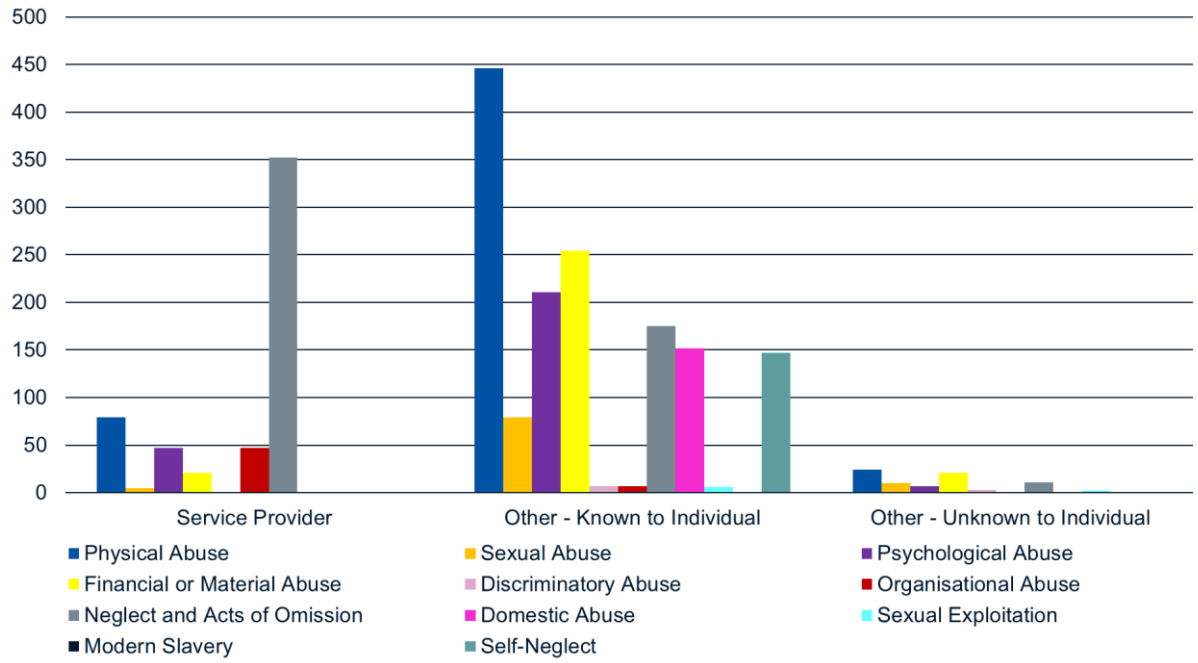
Following multiple meetings with Dave at his GP surgery, he expressed his wish to move out of his mother's property. Dave wanted support to share this information with his mother. Dave's social worker supported

him to hold a meeting with his mother and to express his wish to move out and live independently. A referral was made to his local Adult Social Care Community Team for a full assessment of need for Dave to look at possible options for housing.

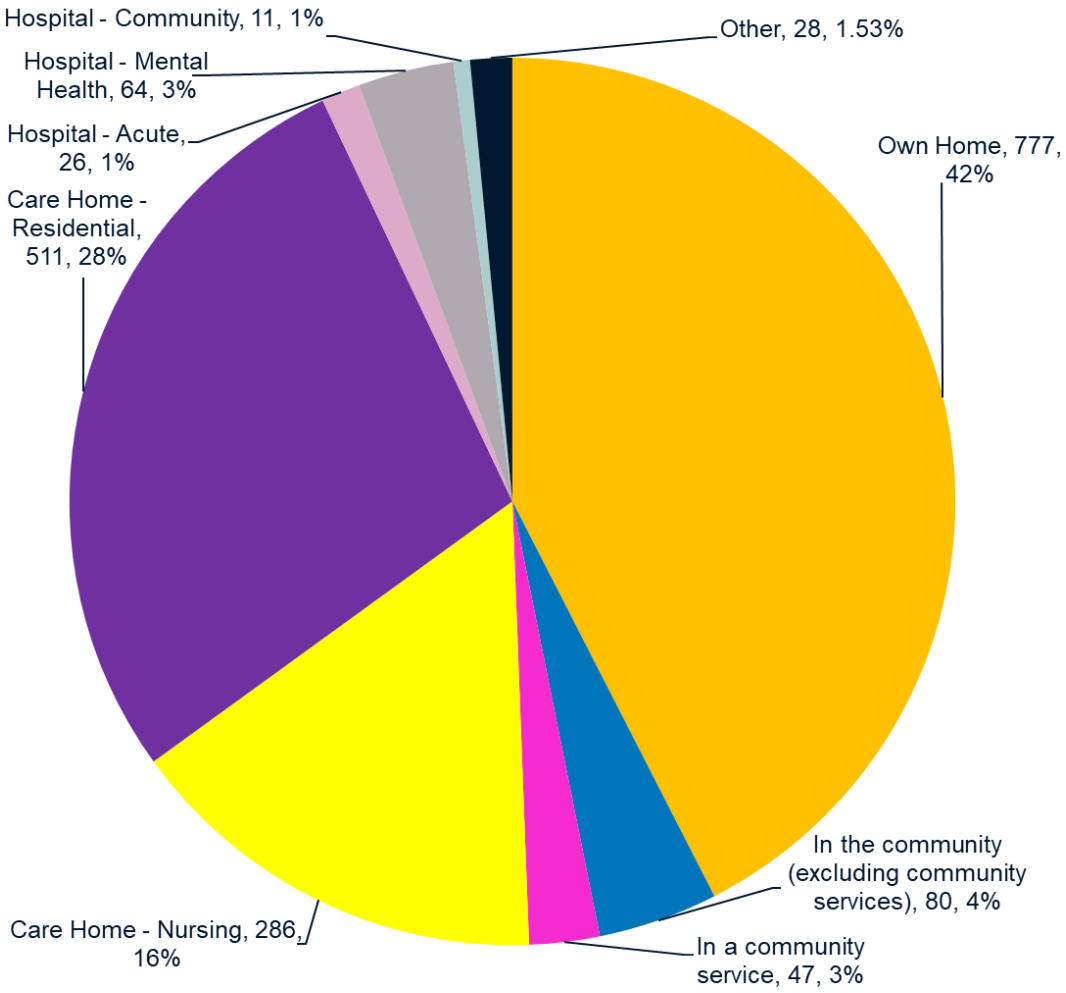
A meeting was held between Dave, his social worker, GP, learning disability psychologist, mental health worker about his calls to emergency services. It was identified that his calls were made as a result Dave's social isolation and it was agreed to help Dave to access the community.

Dave was assessed as being eligible for extra care housing. He has now moved into a self-contained flat in an extra care housing scheme with a package of care including day services to minimise social isolation. Dave is now no longer at risk of physical abuse from his mother and his calls to emergency services have significantly reduced.

The majority of cases of Neglect and Omission (65.43%) and Organisational Abuse (85.45%) were recorded as being caused by a Service Provider. Other people known to the individual, but not in a social care professional capacity, were the most common source of risk for all other types of abuse

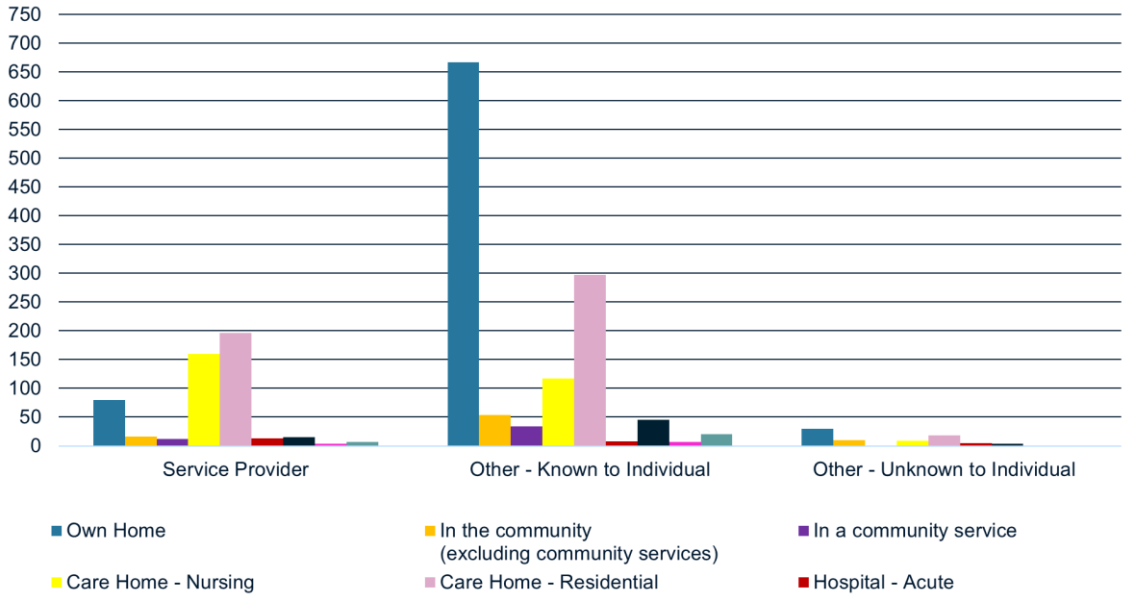


The most common location where people were identified as being at risk was their own home (42.46%) followed by residential care homes (28%)



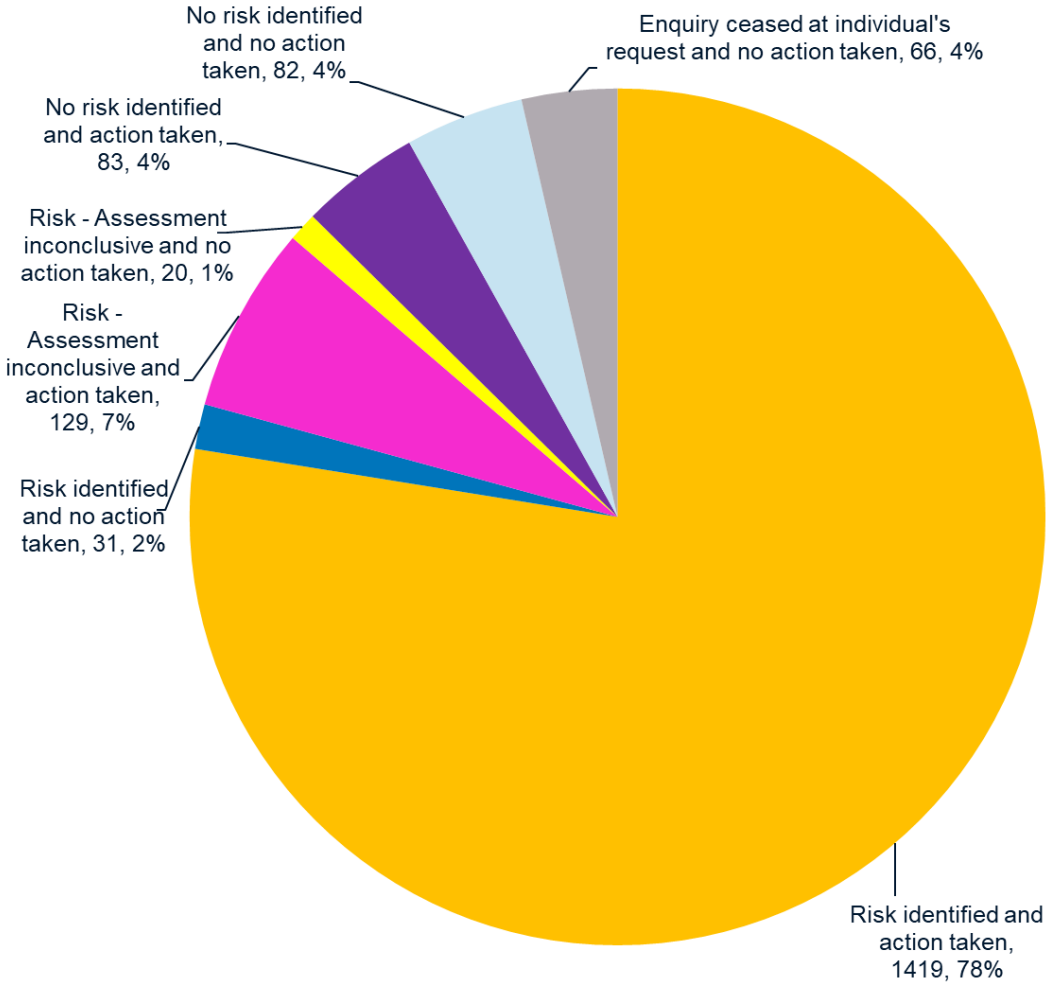
THINKING IT?
REPORT IT
Working Together to Stop Abuse

In 61.64% of cases where people were identified as at risk in a residential care home the source of the risk was not the Service provider

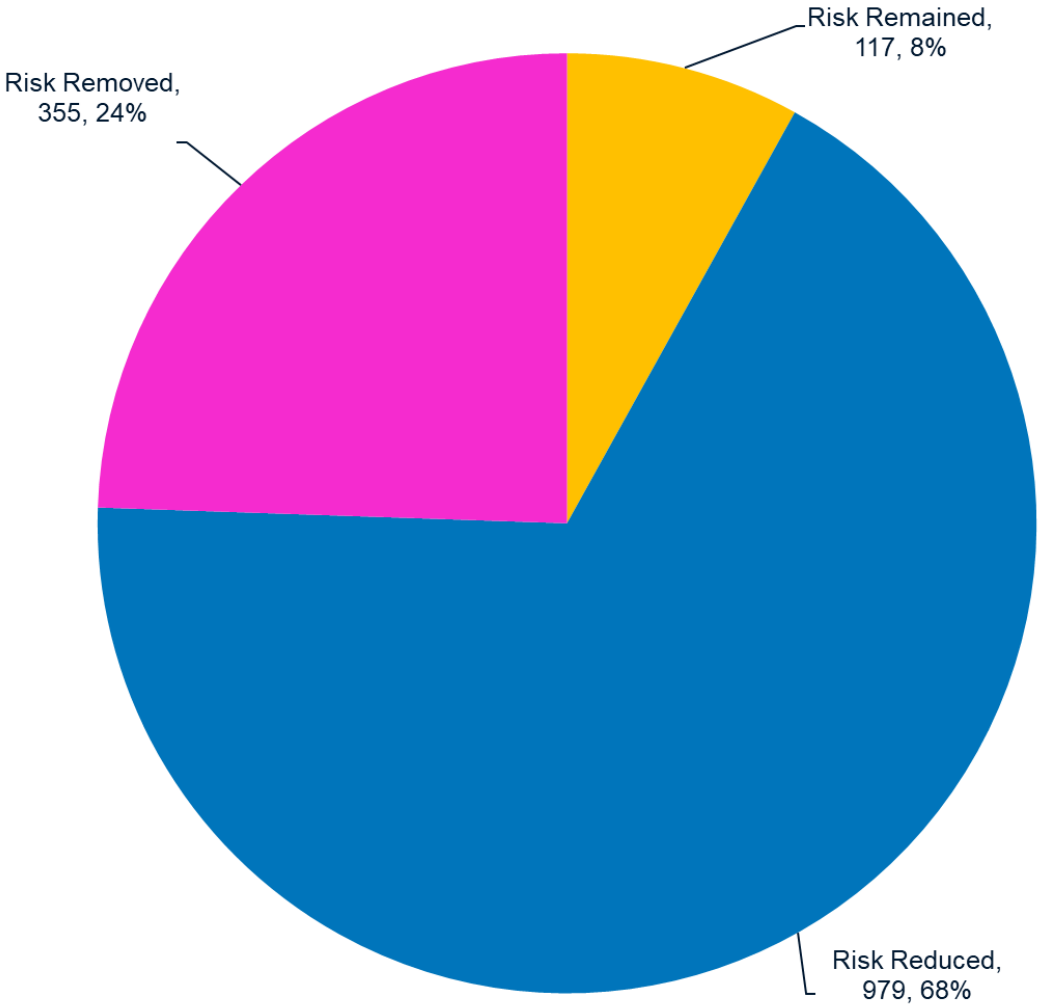


What did we do to protect people during 2016/17?

Most enquiries (77.54%) resulted in the risk being identified and action taken



In most cases the risk was either reduced or removed (91.94%). Following our enquires, adults remained 'at risk' in 8.06% of cases, often because they wanted to maintain their relationship with the person who was abusing them



Case Study

Mr Smith lives at home with his wife and has the early stages of dementia.

A safeguarding referral had been sent by the police following concerns for Mr Smith's safety as he was walking along a busy road in the dark and cars were swerving to avoid him. When Mr Smith was picked up by the police, he was unable to remember where he lived. This was accepted as needing a safeguarding enquiry: he was unable to protect himself, appeared to have care and support needs and was at risk of harm.

Mr Smith lives with his wife who was struggling to provide the support needed to keep him well and safe at home. Mr Smith has a son who

lives in a nearby town and was trying to support his father to remain at home.

A safeguarding meeting was held with the professionals involved, Mr Smith and his family, the police and Community Mental Health Team. The meeting concluded that Mr Smith did not have capacity to keep himself safe when walking on the road and his family felt that it is important to allow Mr Smith to continue to leave his house and go out in the community.

The safety plan that was put in place following the meeting considered the following: Mr Smith wearing a high vis jacket, to explore a tracking system, to explore what support Mrs Smith needed in the home and for Mr Smith to have an assessment of need to assist with his personal care.

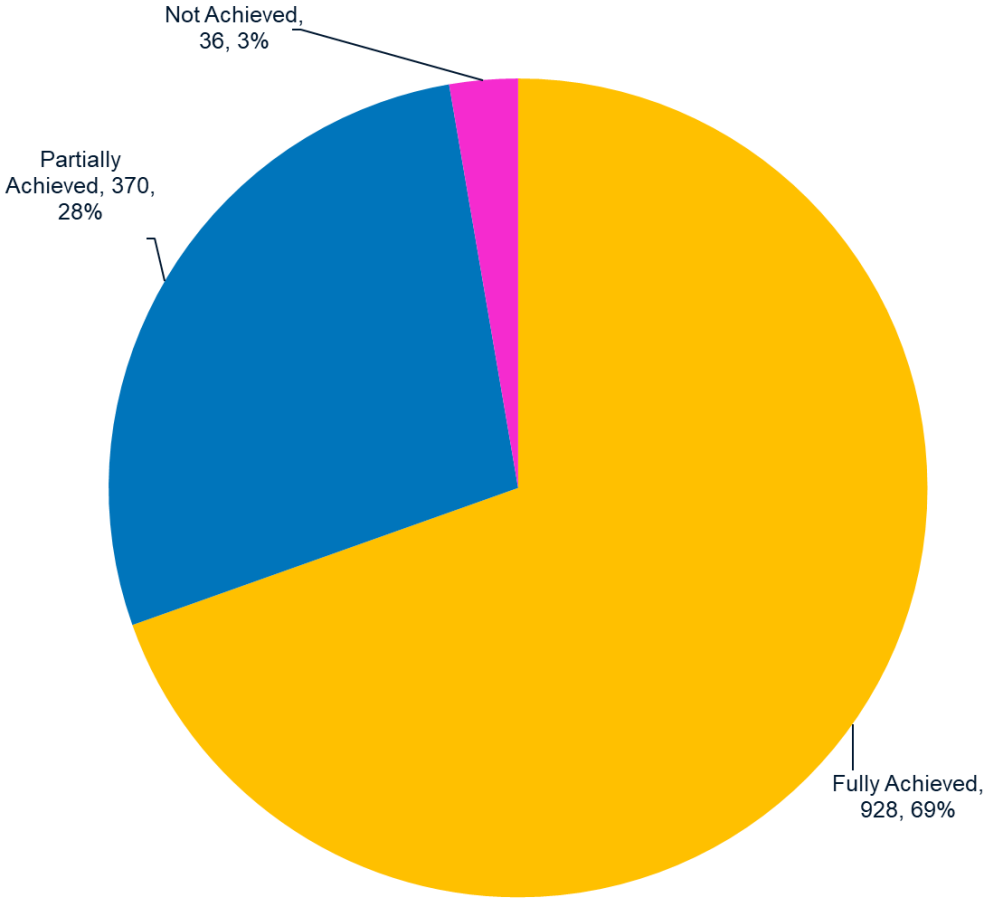
The police worked with the mental health worker and information was shared as there needed to be more exploration of risks involved for Mr Smith when he was in the community, in how to keep himself safe and how to reduce other risks, such as the risk of financial exploitation, that had been identified by family.

Following a further safeguarding meeting a plan was put in place with care package arranged for Mr Smith. This included: the police could phone the son when they are contacted, a tracking device and high vis jacket reduced the risks, a bus pass to be put in place. The meeting also looked at who was best placed to monitor this and how this could be fed back to the allocated worker.

The safety plan allowed Mr Smith to remain at home, with the family having the support they needed. Day care opportunities were put in place to allow Mr Smith to have social support as this was an important part of his life. Mr Smith's son planned to take him out on activities and he attends regular day care. A care package was also provided by the adult social care team to assist with personal care.

Contacts to the police have been reduced as the safety plan has reduced the incidences of Mr Smith walking along the road and he is having support to keep himself safe when out in the community, allowing him to remain at home with his wife.

Where individuals were asked, 97% said that they had their desired outcomes either fully or partially achieved



5. Our work, 2017/18

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	What the SSAB did
We will plan promotion events and activities to coincide with June 2017 World Elder Abuse Awareness Day and the regional 'Stop Adult Abuse' awareness week, and continue to promote our Thinking it, Report it campaign	An important and ongoing 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, which it again promoted during June 2017 to coincide with World Elder Abuse Awareness Day and the regional 'Stop Adult Abuse' awareness week. As in previous years each Safeguarding Adult Board in the Avon and Somerset Constabulary area undertook to promote a different area of safeguarding work to maximise the reach of this work during 'Stop Adult Abuse Week' with the SSAB focussing on scams. This included information on how to spot the different types of scam and advice on what to do if they

What SSAB said it would do	What the SSAB did
	thought that they, or someone that they know, were being scammed. Throughout the year the SSAB has worked to raise awareness of abuse and neglect. This has included using our website and growing social media profile to promote local and national publications and initiatives, along with the signs, symptoms and indicators of abuse and neglect (which form part of a new regional multi-agency policy, the development of which was led by the SSAB). The SSAB has participated in, published and promoted a regional review of Safeguarding Adults Reviews as well as supporting the work of the ongoing Independent Inquiry in to Child Sexual Abuse (IICSA). Our newsletters have covered diverse topics ranging from County Lines to the Learning Disabilities Mortality Review (LeDeR) Programme. The SSAB also maintains a website that contains information on its structure and work, as well as the its publications and links to those of other organisations.
We will work together with Devon & Somerset Trading Standards to address financial abuse and scams	In addition to focused activities around scams and financial abuse during June 2017, the SSAB has raised awareness and promoted initiatives throughout the year. This included using social media to alert

What SSAB said it would do	What the SSAB did
	people when we become aware of a specific scanning activity in the local area, raising awareness of the different types of scams, promoting information from Devon, Somerset and Torbay Trading Standards and national initiatives such as Friends Against Scams. We have featured information about scams and financial abuse in our newsletters and were fortunate to be able to arrange for Professor Keith Brown, a national expert on financial abuse and scams, to speak at our conference in March 2018.
We will seek enhanced assurance of local agency training delivery, take-up, application and impact, and find ways to more closely align agency training functions	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, and work has instead focused on organisations working together to align agency training functions, which will continue during 2018/19. The SSAB has tracked the implementation of learning from local Safeguarding Adults Reviews, and has put in place arrangements

What SSAB said it would do	What the SSAB did
	to identify any local learning and actions emerging from reviews undertaken elsewhere. Practice guidance on 'Carrying out effective reviews and visits with providers' was produced following learning from the Mendip House Safeguarding Adults Review and was published in March 2018. This was shared with partners and promoted in our March newsletter and via social media. Please see Section 6 of this report (page 44) for further detail about the Mendip House Safeguarding Adults Review.
We will deliver a multi-agency Safeguarding Adults conference to raise the profile of adult safeguarding, address areas of practice requiring improvement, share lessons learnt from case reviews, and offer workshops to local Safeguarding Leads	The SSAB held its second multi-agency annual conference for safeguarding leads in March 2018. Attendees represented a broad range of organisations from across the health and social care sector. The conference was well received, with feedback on the day indicating that participants felt that it would have a positive impact on their practice. Please see page 27 for further detail about our conference.
We will establish and oversee the work of a Somerset Mental Capacity Act (MCA) Forum to enhance local understanding and application of the Act	The Mental Capacity Act (MCA) Forum has been established as planned and has been undertaking work to enhance local understanding and application of the Act. This has included:

What SSAB said it would do	What the SSAB did
	• Leading a session at the annual conference • Developing soon to be published content for the SSAB website to support practice improvement in this area across the Somerset system • Developing proposals to audit compliance.
We will monitor progress in relation to the Mental Health Crisis Concordat and its 'Think Differently, Act Differently' subgroup to improve the experience of people in mental health crisis by ensuring services are appropriately commissioned and resourced	The SSAB receives updates on progress in relation to the Mental Health Crisis Care Concordat activity. 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

SSAB Annual Conference 2018

The Conference

The SSAB held its annual conference on 9 March 2018 at County Hall in Taunton. The agenda covered a diverse range of topics encompassing the full breadth of the SSABs work, including:

- Financial abuse and scams
- Learning from the Mendip House Safeguarding Adults Review
- Enquires in Care Homes
- The Mental Capacity Act
- Modern Slavery
- County Lines and cuckooing

- Child sexual exploitation (focused on learning for adult services)
- Safeguarding people with an acquired brain injury

Feedback

A feedback form was provided to each attendee on the reverse of their agenda asking them to rate the venue, programme, impact on their practice and value for money of the conference on a scale of 1 to 10 with a further three questions that asked for narrative feedback on the conference content. A total of 45 feedback forms were received.

Attendees gave a mean average rating of:

- 7.87 out of 10 for the venue.
- 8.24 out of 10 for the programme
- 7.96 out of 10 for the impact on the practice
- 8.43 out of 10 for value for money

Overall, attendees particularly liked:

- The presentation form Professor Keith Brown on financial abuse and scams, indicating that it was both engaging and provided good information to support their practice in this area
- The presentation from Dr Margaret Flynn on the Mendip House Safeguarding Adults Review and learning from serious cases
- The opportunity to come together and network as a multi-agency group, with attendees telling us that they would welcome more events like this in the future, suggesting a diverse range of potential topics.

SSAB Independent Chair addressing the annual conference

All presentations from the conference are available on the SSAB website

Next Steps 2018/19 (Prevention)

a) We will plan promotional events and activities to coincide with June 2018 World Elder Abuse Awareness Day and the regional 'Stop Adult Abuse' awareness week, and continue to promote our 'Thinking it, Report it' campaign
b) We will work together with Devon, Somerset and Torbay Trading Standards Service to address financial abuse and scams
c) We will seek enhanced assurance of local agency training delivery, take-up, application and impact, and find ways to more closely align agency training functions
d) We will deliver a multi-agency Safeguarding Adults conference to raise the profile of adult safeguarding, address areas of practice improvement, share lessons learnt from Reviews, and offer workshops to local Safeguarding Leads
e) We will continue to oversee the work of a Somerset Mental Capacity Act (MCA) Forum to enhance local understanding and application of the Act
f) We will the monitor progress of the Mental Health Crisis Concordat and its 'Think Differently, Act Differently' subgroup to improve the experience of people in mental health crisis.
g) We will review assurance arrangements for all Somerset residents placed by or on behalf of Somerset Commissioners, and monitor the implementation of actions identified through this work
h) We will establish the number of people who have been placed in to services in Somerset by commissioners from other parts of the UK, our confidence in their assurance and monitoring arrangements, and monitor the implementation of actions identified through this work
i) We will ensure that there are appropriate arrangements in place across the Somerset system for people with complex needs who do not require Adult Safeguarding

Priority Area 2: Making Safeguarding Personal

What SSAB said it would do	What the SSAB did
We will ensure the views of service users, carers, frontline staff and Board members inform our work: • We will implement a Safeguarding Experience service user/carer/provider feedback process and monitor responses on a quarterly basis to enhance the effectiveness of safeguarding activity • We will introduce and invite service user stories to Board meetings and conferences	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 supported the development of a 'Safeguarding Experience' feedback process, which launched in the Spring of 2017 to 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 number of responses received has been low but the feedback positive. This broadly replicates the experience of other SABs over a similar period and we are looking at other ways of gaining feedback. 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 2017/18 year are shown on Page 21 with 97% of people reporting their desired outcomes had been wholly or partially achieved.
We will ensure individuals experiencing safeguarding concerns have appropriate and timely access to advocacy through the promotion of advocacy	Improvements have been seen in the data for people with safeguarding concerns accessing advocacy, and work during the year has identified that some of the previous concerns highlighted many have been as a result of

services and knowledge, and monitoring of data	issues with the reporting / recording of this data which were resolved during the course of 2017/18 resulting in the improved performance shown in Section 4 (page 14). The Somerset County Council Safeguarding Service has strengthened links with the Council's contracted provider of advocacy service and meets bi-monthly to promote the Service.
We will establish multiagency Adult Safeguarding Audit groups to assist the Board in quality assuring local practice and service delivery, improving quality, performance and learning	Work on auditing areas of safeguarding practice evolved over the course of the year and has been incorporated in to the work plan for the SSAB Quality Assurance subgroup for 2018/19. The Subgroup will be will be auditing randomly selected cases each time it meets, and providing written feedback on its findings.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) have been in operation since April 2009. Since April 2013 the functioning of the safeguards has been the sole responsibility of local authorities. Each year all local authorities make a statutory return about DoLS activity to the Department of Health and Social Care. At a national level the statistics continue to confirm that the system is not working as it should because large numbers of requests for assessment cannot be addressed, and the Government is proposing that the current arrangements are replaced by new Liberty protection arrangements from 2020. In summary, information for Somerset shows that application and processing rates remain level; the proportion of short authorisations granted remains level (these are usually cases where there is some objection by the person); the proportion of authorisations completed in under 1 month (from application to signing off) is improved over the previous year.

Next Steps 2018/19 (Making Safeguarding Personal)

a) We will ensure the views of service users, carers, frontline staff and Board members inform our work:
   - We will monitor service user, carer and provider Safeguarding Experience feedback process and monitor responses on a quarterly basis to enhance the effectiveness of safeguarding activity
   - We will invite service user stories to Board meetings and conferences.

b) We will ensure individuals experiencing safeguarding concerns have appropriate and timely access to advocacy through the promotion of advocacy services (including both Independent Mental Capacity and Mental Health Advocacy) and knowledge, and monitoring of data

c) We will work jointly within the region and through national networks to both develop our approach to Making Safeguarding Personal and share good practice and learning with others, making use of tools developed by the Local Government

Priority Area 3: Think Family

What SSAB said it would do	What the SSAB did
We will support the development of a multi-agency Think Family Strategy for Somerset	The SSAB actively contributed to the development of the Somerset Think Family Strategy that is expected to be signed off by the Somerset Children's Trust in early 2018/19. Through its leading role in the refreshing of the regional Joint Safeguarding Adults Policy the SSAB has worked to ensure that Think Family principles were incorporated in to this policy and looks forward to working to support the implementation of the new strategy during 2018/19.
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.	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 September 2017, the 'Working Together Protocol for the Strategic Partnership Boards in Somerset' was refreshed. The protocol supports 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 have continued to 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 SSAB is also represented on a number of other multi-agency partnerships, including the Somerset Safeguarding Children Board's Child Sexual Exploitation Subgroup, Domestic Abuse Board, District Councils Safeguarding meeting, Somerset Housing Providers Safeguarding meeting and Suicide Prevention Advisory Group.

Next Steps 2018/19 (Think Family)

a) We will support the implementation 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	What the SSAB did
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	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 March 2018. 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 for development in: • Training, competence and confidence around application of the MCA • Ensuring staff supervision policies and practice support effective safeguarding • Person-centred care / Making Safeguarding Personal • Outcome-focused safeguarding • Prevent *Please see page 40 for further information about the self-audit.*

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	The Safeguarding Adults Review (SAR) Subgroup has overseen one SAR – Mendip House - during the year. Pease see Section 6 on page 44 for further detail.
Use data, information and local intelligence to identify risks and trends, and formulate action in response, to include monitoring of SSAB communication tools	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. Analysis was also undertaken of the national 2016/17 comparative Safeguarding Adults Collection data published by NHS Digital, which highlighted both strengths of Somerset's safeguarding processes and areas requiring further attention. A cornerstone of the SSAB's work is the provision of information to the public, people who already or could potentially use services, 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.

The SSAB website 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 2017/18, our website was accessed by 5,929 individual users (3,629 in 2016/17), and had 21,815 individual page views (compared to 15,679 in 2016/17). Spikes in website usage were evident in mid-June (World Elder Abuse day and Stop Adult Abuse week) and on 8 February (the publication of the Mendip House SAR) when 322 users accessed the site.

The SSAB also has a twitter account that it established during 2016/17 enhance its reach, influence and provide additional engagement opportunities. As at the end of March 2018 the Board had 523 followers (compared to 290 the previous year) and earning over 120,000 impressions from its activity. As with the SSAB website, spikes coincided with promotional events and publications with 5,075 impressions earned on the publication of the Mendip House

	SAR and a further 1,815 on the publication of the associated practice briefing. The SSAB is increasing use of this medium to promote its work, publications and local/national initiatives. 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 enables people to register for newsletters although many readers now choose to access it via twitter.
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	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, it has led a refresh of regional multi-agency Safeguarding Policy in partnership with 4 other local Safeguarding Adults Boards and begun work to revise a set of underpinning local procedures (to be published during 2018/19) and has established an annual cycle to review all SSAB policy or procedural documents and website content to assist the Board in delivering its functions effectively.

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	The work of the SSAB is reported to the Scrutiny for Policies, Adults and Health Committee and Somerset Health and Wellbeing Board twice yearly – at the publication of the Strategic Plan in the Spring and Annual Report in the Autumn. In order to support Elected Members, the SSAB has provided resources to members and offered training sessions incorporating information about the Board and its functions, as well as Safeguarding in general.
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	Work on auditing areas of safeguarding practice evolved over the course of the year and the SSAB has worked to incorporate a new peer challenge element into and an enhanced self-audit process for 2018/19.

SSAB Annual Self-Audit 2017/18

How it was undertaken

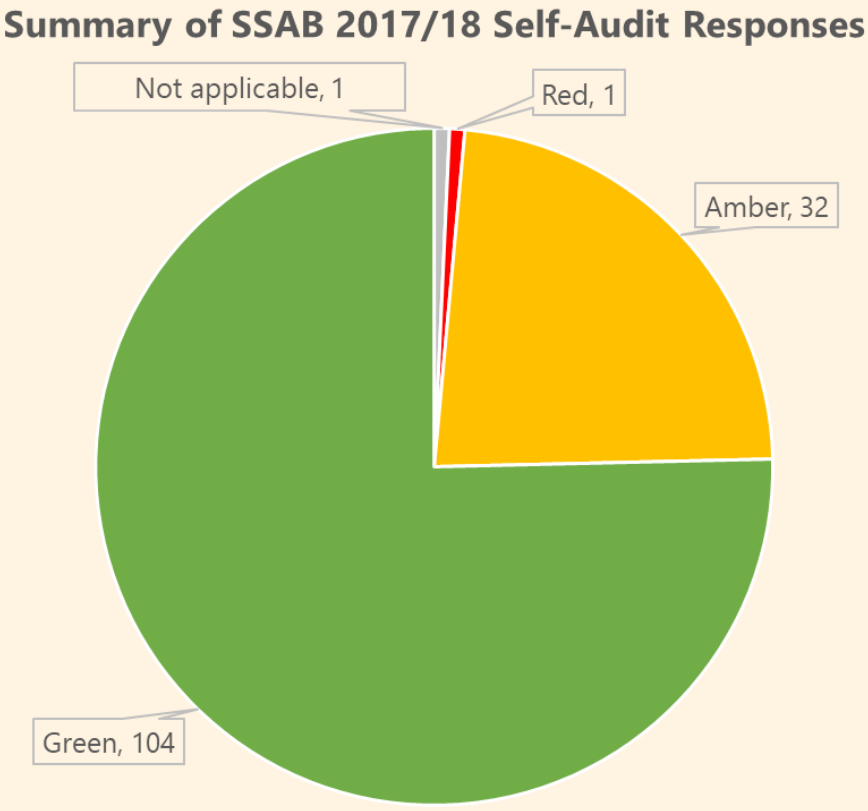
- Key SSAB member organisations were asked to refresh 2016/17 self-assessments using an agreed audit tool during Quarter 3 2017/18. There organisations that completed the Audit were:
  - NHS Somerset CCG
  - Somerset County Council
  - Avon & Somerset Constabulary
  - Somerset Partnership NHS Foundation Trust
  - Yeovil District Hospital NHS Foundation Trust

  - Taunton and Somerset NHS Foundation Trust
- The completed audits provided the SSAB with an overview of organisations' stated compliance with the selected standards. Each organisation self-assessed compliance across 23 areas relating to:
  - Leadership, strategy, governance and organisational culture
  - The organisation's responsibilities towards adults at risk
  - The organisation's approach to workforce issues
  - Effective inter-agency working
  - Addressing issues of diversity
  - Service users.
- Each organisation was asked to:
  - Assess their confidence of compliance in each area using a RAG (Read/Amber/Green) rating
  - Provide evidence to support the RAG rating they had given
  - Detail any action being undertaken to ensure improvement and who was responsible for it.
- The resulting 137 responses were then analysed[2], and considered by the Quality Assurance Subgroup

Results

- High confidence of compliance (green) was self-assessed in 104 responses
- Lower levels of confidence of compliance (amber) were self-assessed in 32 responses, including one response where a low level (red) was assessed in a single area.
- Compared to 2016/17, 19 responses showed increasing confidence of compliance while 6 showed decreasing confidence.

[2] 23 areas were self-assessed by each of the 6 organisations. One area did not apply to one organisation resulting in a total of 137 responses.



Conclusion

While each individual organisation is responsible for implementing actions identified through the self-audit not the SSAB, the 2017/18 organisational self-audit process highlighted the following aspects as key areas requiring additional focus across the partnership:

- Training, competence and confidence around application of the Mental Capacity Act
- Ensuring that staff supervision policies and practice support effective safeguarding
- Person-centred care / Making Safeguarding Personal
- Outcome-focused safeguarding
- Prevent.

Next Steps

- The SSAB quality Assurance Subgroup will undertake the next self-audit process in Quarter 2 of 2018/19
- The audit tool will have additional questions added in relation to findings from recent Safeguarding Adult Reviews
- A peer challenge element will be introduced to add greater rigour to the process.

Next Steps 2018/19 (SSAB Effectiveness)

a) Enhance the annual Adult Safeguarding organisational self-audit process (which enables 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) with a peer challenge element

b) Commission, participate in and support Safeguarding Adults Reviews (SARs), ensuring learning from both local and national reviews is widely shared, including supporting the development of the National SAR Library

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 our approach to assurance and monitoring the implementation of recommendations, actions and good practice emerging from both local and national SARs, Serious Case Reviews and safeguarding enquiries

g) Work jointly with 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 as described within the Working Together Protocol for the Strategic Partnership Boards in Somerset, as well as other Boards regionally and nationally

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 Somerset County Council's Strategic Manager Mental Health & Safeguarding.

During 2017/18 the SAR Subgroup:

- **monitored progress in relation an ongoing review and considered potential cases against the criteria** for conducting one. Where a case meets the criteria the Subgroup will oversee the appointments of an independent, external Chair and/or Review Author; this supports the SARs credibility, and helps 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.
- **ensured the presentation of a completed reviews** to the Safeguarding Adults Board for formal acceptance and agreed plans for publication and implementation, including the dissemination of learning across the locality.

One Safeguarding Adults Review concluded during 2017/18, this is detailed below:

Mendip House

On 8 February 2018, the Somerset Safeguarding Adults Board published a Safeguarding Adults Review into the mistreatment and abuse of residents by staff at Mendip House, a care home for people with autism in Somerset run by the National Autistic Society.

The Review was written by Dr Margaret Flynn, who also undertook the Serious Case Review of Winterbourne View Hospital in South Gloucestershire, and was commissioned following the conclusion of a whole service safeguarding enquiry that began in May 2016.

All the residents at Mendip House and the wider Somerset Court campus on which it was situated, were placed by over 30 different Local Authorities and Clinical Commissioning Groups as far away as Aberdeen. None of the people placed at Mendip House were Somerset residents.

In summary, the findings of the Review were that:

- The unprofessional and cruel behaviour of a "gang" of male employees at Mendip House did not suddenly occur, and action

could and should have been taken by the National Autistic Society earlier.

- Neither the history of safeguarding referrals nor Care Quality Commission inspections revealed the cruelty of employees or the failures of management oversight.
- People were placed at Mendip House as a result of the detrimental practice "place hunting" by Commissioners. It does not appear that the agencies that commissioned the placements asked searching questions about the benefits of residents being placed there, or received detailed accounts of how fees were being spent on their behalf.
- The site on which it was situated was a dated, single-site "campus" model of service provision which sourced residents with diverse support needs from around the UK.
- Care planning was poor. Decisions about continuing placements by the agencies commissioning the placements at Mendip House were not based on data such as what was being achieved with, and on behalf of, individual resident
- There can be no confidence that there is sufficient capacity in speech and language, psychology, behaviour support, learning disability nursing and psychiatry services to meet the needs of unknown numbers of adults who are placed by Commissioners outside their own localities.

In summary, the recommendations from the Review were

1. For the SSAB to write to the Department of Health and Social Care and Local Government Association to request that they:
    - prepare consultations to regulate commissioning, and include in those consultations the role of 'lead commissioner' who will assume responsibility for coordination when there are multiple commissioning bodies of a single service and a requirement to notify host Authorities when a placement is made.
    - assert a new requirement to discontinue commissioning and registering "campus" models of service provision
    - assert a new requirement for a formal consultation with Local Authorities with Social Services responsibilities and Clinical Commissioning Groups regarding all planning applications for building residential care services that would require registration

with the Care Quality Commission to operate, and to decline planning permission for types of service provision for which there is no local demand and which fail to "think small" and "think community."

2. For Somerset County Council to require commissioners to:
   - fund essential monitoring and reviewing processes;
   - fund residents' access to local health services, most particularly community health services;
   - identify a lead commissioner.
3. For the SSAB to write to Care Quality Commission requesting that it:
   - makes this it explicit in its inspection reports when it would be unlikely that it would register a campus model of service now
   - undertakes more searching inspections of campus models of services
   - does not register "satellite" units which are functionally linked to "campus" models of service provision.
4. For Somerset County Council to agree a Memorandum of Agreement hereby the aggregate-level information concerning grievances, disciplinaries and complaints, for example, gathered by providers is shared with the Care Quality Commission and pooled with that of local authorities' safeguarding referrals, the "soft intelligence" of Clinical Commissioning Groups, the police and prospective commissioners
5. The Care Provider Alliance, with the support of the Care Quality Commission and Skills for Care, issue its members with guidance on how the role of responsible or nominated individual in supervising the management of the regulated activity should be performed in respect of quality assurance and safeguarding.

In addition, the Somerset Safeguarding Adults Board added a sixth recommunication:

6. For the Somerset Safeguarding Adults Board to review assurance arrangements for all people currently placed outside of Somerset, and to monitor the implementation of any actions identified through this work.

Key considerations for practice arising from the review

- ***Individual / family***
  - See the person, and spend time with them in their environment
  - Meet / speak with families separately as part of the review process
  - Include advocates as needed, even if family members are involved; advocates support the family too
  - Ensure the person that is the subject of the review has a voice and is heard
  - Look for evidence of how people spend their time, rather than just accepting a care plan or timetable
- ***Provider***
  - Discussions need to be honest and open in terms of quality, expectations, market needs and their position
  - Providers and commissioners should work together to problem solve, support, share information and establish links across the market
  - Building positive working relationships with providers is essential, as well as monitoring. It encourages better incident reporting and earlier intervention
- ***Operational social care teams***
  - Ensure adequate preparation for reviews – this should include checking safeguarding concerns, reviewing the case notes and incident reports. Reviewing is a process, not one form, one visit, one conversation. Seek to be inquisitive.
  - Reviews can take different forms and need to be proportionate
  - Do not take information at face value – check, cross-reference. Ensure decisions about continuing placements are based on evidence, such as what is being achieved with and on behalf of individual residents
  - Health input is critical – consider opportunities to undertake joint, holistic reviews of health and social care needs where feasible
  - Observations are critical: spend time with the person and monitor the environment and staff interactions

  - The 'family test'- would you be happy walking away if your mother, father, sister, brother or other family member was living there?
  - Establish eligibility and mental capacity in relation to decisions relating to care provision / care planning
  - Ensure your documentation is proportionate and accessible.
- ***Commissioners of services***
  - Be clear about what's needed in the provider market, and what is available
  - The commissioning task is more than that of place-hunting: commissioners are stewards of the public purse and the agents of people they support; examine how fees are being spent on their behalf. Are providers delivering what has been purchased? Are specialist services delivering specialist support?
  - Notify host authorities of prospective placements in their area
- ***Quality / Contract monitoring***
  - Check the latest Care Quality Commission reports before reviewing
  - Ensure frequency of Quality Assurance monitoring and a consistent approach to contract monitoring
  - Be clear of monitoring processes and approaches for both local and out-of-area placements – can these be enhanced?
  - Aggregate information and intelligence about provider services, pool this with the host authority's safeguarding referrals and engage closely with the Care Quality Commission

Action taken on the back of the Mendip House Review

- A practice briefing has been produced, published and promoted
- The findings of the Review have been raised with the Independent Chairs of the other Safeguarding Adults Boards across the region, a number of whom indicated that there were similar SARs underway in their local areas.
- Formal letters have been written to:
  - The Department of Health and Social Care and The Local Government Association
  - The Care Quality Commission
  - The Care Provider Alliance

These letters request that each organisation takes forward the recommendations from the Review.

- The SSAB has begun work to identify levels of assurance for:
  - People placed by or on behalf of Somerset Commissioners. This work is in its relatively early stages, but we believe that we have a high degree of confidence that we understand the work that needs to be undertaken in order to ensure that there are high levels of assurance in place.
  - People placed by or on behalf of Commissioners external to Somerset. Work has begun to attempt to quantify the number of people currently placed in to services in Somerset by Commissioners external to the County. This work is in its early stages and given our experience form the Mendip House SAR and the potentially large number of commissioners involved we have low levels of confidence in the assurance arrangements for of the commissioning of these services.

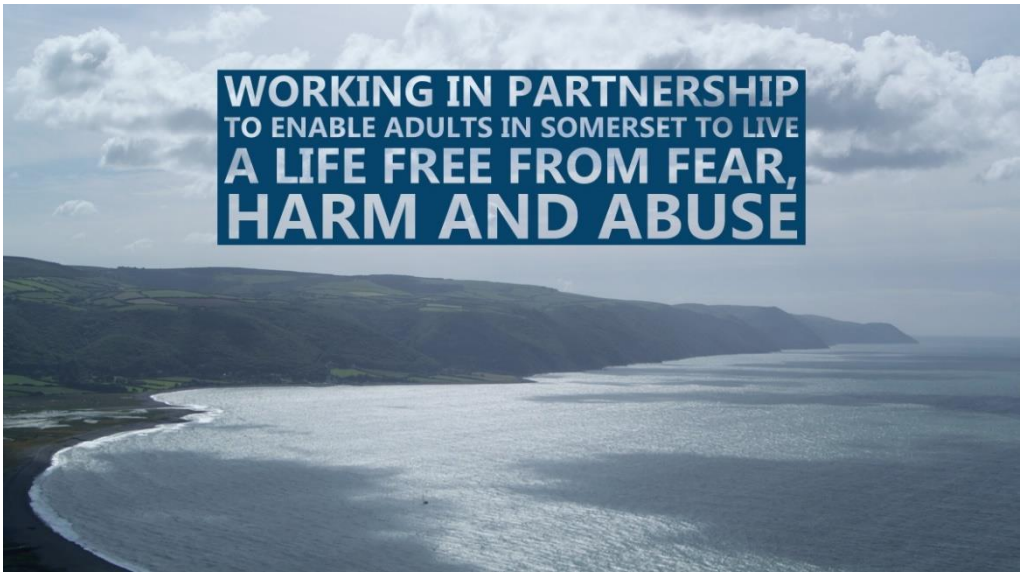
Press briefing on the publication of the Mendip House SAR

7. Our priorities 2018/19

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. This includes work in response to the recommendations of the Mendip House Safeguarding Adults Review.
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 2018/19 Strategic Plan in full here.



8. Board Budget

		2017/18		2017/18	
SOURCE OF FUNDS		**PROJECTED CONTRIBUTION £**	**%**	**ACTUAL CONTRIBUTION £**	**%**
Carry Forward					
SOMERSET COUNTY COUNCIL	- SAB MANAGER & CHAIR	33,540	44.2%	33,540	45.5%
	- SAFEGUARDING ADULTS REVIEWS	3,250	4.3%	3,250	4.4%
AVON & SOMERSET POLICE	- SAB MANAGER	18,900	24.9%	18,900	25.6%
	- SAFEGUARDING ADULTS REVIEWS	3,250	4.3%	1,360	1.8%
SOMERSET NHS CCG	- SAB MANAGER	10,000	13.2%	10,000	13.6%
	- SAFEGUARDING ADULTS REVIEWS	3,250	4.3%	3,250	4.4%
BGSW CRC LTD		990	1.3%	990	1.3%
ATTENDENCE CHARGE FOR SSAB ANNUAL CONFERENCE		2,730	3.6%	2,460	3.3%
TOTALS		**75,910**	100.0%	**73,750**	100.0%
APPLICATION OF FUNDS		**PROJECTED EXPENDITURE £**	**%**	**ACTUAL EXPENDITURE £**	**%**
PAY					
SAFEGUARDING BOARD MANAGER		46,500	57.0%	46,500	57.0%
INDEPENDENT CHAIR		15,940	19.5%	15,940	19.5%
NON PAY			0.0%		0.0%
SAFEGUARDING ADULTS REVIEWS		17,930	22.0%	17,930	22.0%
CONTRIBUTION TO ADASS THEMATIC REVIEW		300	0.4%	300	0.4%
BRANDING & WEBSITE		50	0.1%	50	0.1%
SSAB ANNUAL CONFERENCE REFRESHMENTS		650	0.8%	650	0.8%
ROOM HIRE		180	0.2%	180	0.2%
BT CHARGES		80	0.1%	80	0.1%
TOTALS		**81,630**	100.0%	**81,630**	100.0%
OVERSPEND		**5,720**		**7,880**	

The overspend during 2017/18 was primarily caused by a delay in the receipt of an invoice for a Safeguarding Adults Review undertaken in a previous year leading to these costs needing to be paid from the 2017/18 budget. A small number of invoices issued close to end of the financial year remained unpaid at year end and this income will therefore be accounted for in 2018/19.

An agreement is now in place to split the costs of any Safeguarding Adult Review equally between Avon & Somerset Constabulary, Somerset Clinical Commissioning Group and Somerset County Council separately to the Board's core funding.

9. The work of key members 2017/18

Avon and Somerset Constabulary

- We reviewed the currently independent Safeguarding Coordination Unit and Lighthouse Victim and Witness Care Unit and, in order to provide a more effective and efficient service, developed a model of one combined Lighthouse Safeguarding Unit that is to be implemented during 2018/19.
- Work has continued to develop the use of Multi-Agency Safeguarding Hub (MASH) processes across the force to support adults at risk. Each Local Authority area has differing requirements and thresholds, but we have continued the drive to standardise response in order to minimise risk. Audit tools have been developed to ensure that the correct response and performance frameworks are in place.
- The BRAG (Blue, Red, Amber, and Green) risk assessment process has been introduced Force-Wide from October 2017 to April 2018 to support officers and staff in identifying all levels of vulnerability when they attend incidents, together with clear safeguarding referral routes through our Lighthouse Hubs to assist officers in safeguarding vulnerable victims.
- Additionally, the new BRAG risk assessment being introduced and promoted within the force will likely provide greater opportunities to identify adult safeguarding issues. Combined with an expected continued increase in adult Missing People (+14% forecast increase) – the adult safeguarding demand forecast is that of a continued steady increase. This is holistically looking at safeguarding issues like hoarding to ensure that early intervention is taken.
- The Constabulary has developed many different Qlik Sense apps relating to specific areas of business, from supervisory/management apps, problem solving apps and near real time demand apps. Qlik Sense gives every victim and suspect an automatic risk rating, helping to prioritise and manage demand. Qlik Sense is being used by

1800 users across the Constabulary to manage demand, identify and problem solve high demand locations, high risk offenders and high risk vulnerable people.

- Qlik Sense also enables the Constabulary to be reasonably confident in forecasting changes in demand for many large volume crimes and incidents as per these crime types. There are apps that identify vulnerability and escalating risk in victims (Vulnerability App) together with repeat victims and areas / locations of high demand (Persistent caller matrix). All areas discuss this information on a local basis, where the people with the highest vulnerability score, mostly persistent callers, and locations are discussed with a view to problem solving the issues on a local basis using the Neighbourhood teams working with local partners.
- The force has drafted a force Adults at Risk Strategic Delivery Plan which focuses on four key themes, Prevention, Protection of Victims and Pursue Perpetrators, Partnership working, Organisational Learning/Quality Assurance. This plan incorporates actions, learning and recommendations from HMIC inspections, Safeguarding Adult Reviews, Police and Crime Commissioner Priorities and the National Vulnerability Plan.
- A new strategic lead in the Detective Superintendent Adults role has been appointed. This is Detective Superintendent Marie Wright, who is supported by her deputy Victoria Caple (Partnership and Liaison Manager) and Amanda Warrener (Policy and Review officer). This team has created the aforementioned delivery plan and will be formulating a force wide working group to achieve the strategic objectives of the plan during 2018/19.
- 6 Safeguarding Adult Review (SAR) recommendations have been actioned and closed in 20178/18, 1 of these was in relation to information sharing for the Somerset SAR - Ms C.
- 9 SAR's or Non-Statutory Adult Reviews were commenced by the Constabulary in 2017/18, 3 in Somerset.

NHS Somerset Clinical Commissioning Group

- We continue to seek assurance that National Health Service (NHS) Providers meet their safeguarding responsibilities. We do this by ensuring that safeguarding adults is embedded in our commissioning arrangements and by close monitoring of how providers fulfil their duties and responsibilities
- Our contracting process in 2017/8 reflected the requirements of the Care Act 2014 and supported outcomes-focused, person-centred safeguarding practice through 'Making Safeguarding Personal' and 'Think Family'
- Somerset Clinical Commissioning Group (CCG) has had oversight of the alliance between two of our NHS providers to both ensure this alliance enhances safeguarding services by providing a joined-up approach and to seek assurance that the duties and responsibilities of each organisation remain fulfilled
- Two safeguarding practitioners have been appointed by the CCG to support the Continuing Healthcare Assessment function. The role of the practitioners is to provide support when there are safeguarding concerns and to prevent the escalation of quality and safeguarding concerns in providers of care for Continuing Healthcare Funded Individuals
- Somerset CCG have been active participants in all Somerset Safeguarding Adult Boards meetings – with 100% attendance and provided representation on all the board's sub groups. The CCG chairs the policy and procedures sub group.
- The CCG has contributed to the Safeguarding Adults Board annual audit programme by completing the audit tool and participating in multi-agency case audit work. We have also contributed to the review of the joint Safeguarding Adults Multi Agency Policy and other policies and procedures as part of its contribution to the sub groups
- We have contributed to all Safeguarding Adults Reviews (SARs), including the SAR in relation to the National Autistic Society, Mendip House. The CCG provided representation at the practitioner learning event in relation to Mendip House and the media briefing when the SAR was published

- The CCG has completed its own internal action plan following the Mendip House SAR, which included the development and implementation of a tool kit to help identify and monitor risks in out of county, specialist and learning disability services. The CCG has shared its action plans and tools with other CCG areas in order to disseminate learning regionally
- In order to support the wellbeing of people who are placed in Somerset by an authority outside of Somerset, the CCG has developed a rolling programme of writing to all CCGs in the country reminding them to notify Somerset CCG of any placement made within Somerset. The letter also requests placing authorities to advise Somerset CCG of any known risks or the need for primary and secondary care services.
- All publications from the Safeguarding Adults Board are promoted and circulated across our providers and primary care. Examples of this include disseminating practice briefing sheets and the SAB newsletters.
- The CCG monitors training compliance from all its providers against a target of 95% achievement. We record staff level 1, 2 and 3 adult training. Somerset Partnership Trust reported an average 94.5% of staff receiving Safeguarding Adults training. Taunton & Somerset NHS Foundation Trust reported 91.9% (this only includes level 1 and level 2 data as they are developing reporting for level L3) and Yeovil Hospital reported 94.29% of staff who have received Safeguarding Adults training
- 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
- The CCG commissioned multi-agency safeguarding training to deliver integrated and standardised level 3 training for health and care professionals jointly with North Somerset CCG and this was completed in 2017/8.
- To support primary care, the CCG have commissioned the development of a package of Level 3 training for GPs which will be rolled out in 2018/9
- We have worked with our providers and adult social care to ensure safeguarding alerts are raised and managed in a coordinated way in our commissioned services for CHC patients and wider care home resident. This has included quality monitoring visits to any service of concern where the CCG fund the care for people who live there. In 2017/8, the CCG attended 36 whole service or quality improvement meetings with providers to address existing safeguarding concerns and to prevent quality concerns from escalating into safeguarding concerns

- The Care Home Support team have contributed to the development of Safeguarding, Mental Capacity and Deprivation of Liberty Safeguards practice within care homes and have delivered twenty-five workshops to increase staff confidence and competence. Thirteen have been delivered in relation to safeguarding and twelve have been delivered in relation to the Mental Capacity Act.
- We have supported staff with a specific safeguarding role to attend regional and national safeguarding learning events to identify and disseminate good practice
- All Health Trusts are now required to report on the percentage of staff trained on Prevent awareness which will be reported formally in 2018/19
- 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

Somerset County Council

- Considerable investment has been made to sustain performance across all areas of the safeguarding adult service. The service continues to focus on analysis of data collection, enhanced scrutiny, validation of information and robust engagement with referring agencies to overall enhance quality of referrals received. We are taking a proactive approach to respond to key themes and patterns that emerge to prevent identified quality concerns from escalating into safeguarding situations.
- The Safeguarding Adults Service have led and facilitated 10 bespoke safeguarding continued professional development workshops for 122 SCC staff members, including Occupational Therapists, Social Workers, Adult Social Care Workers and Service Managers.
- We have commissioned bespoke and relevant training for our staff in financial and scam awareness and mental capacity and sexual consent.

- We have made considerable advances in undertaking timely safeguarding enquiries and now have a fully operational escalation policy that supports timely conclusion of enquiries; 96% of enquiries are completed within 60 working days.
- SCC have developed and imbedded into practice a service quality assurance process to ensure that the standard of enquiry people can expect to receive is maintained at a high level.
- We have established a regional safeguarding lead forum between key partner agencies including; Somerset Partnership, Acute Hospital Safeguarding Adult Leads, Clinical Commissioning Group and Avon & Somerset Police. Furthermore, we have facilitated a multiagency safeguarding workshop to share learning across organisations.
- We participate in the South West Regional Adults Safeguarding Forum to share practice, learning and support across local authority settings.
- An audit of triage cases was undertaken in February 2018 that yielded positive results. However, we acknowledge that this only provided a snapshot and ongoing audit is needed to ensure quality. Internal triage audits will therefore be undertaken by locality leads on a monthly basis. The SSAB Quality Assurance Subgroup has also added a standing agenda item to review randomly selected cases each time it meets.
- We have continued to utilise a local, interactive CQC Ratings Mapping Tool to support local stakeholders, and inform performance monitoring and benchmarking activity; this is publicly available via: http://www.somersetintelligence.org.uk/care-quality-commission-ratings.html
- 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.
- A review project is underway to complete all outstanding social care reviews. A targeted approach is being taken based on risk and vulnerability. The project is managed via a Review Board chaired by the Director of Adult Social Services.
- The Local Authority is monitoring safeguarding information for all large umbrella organisations with multiple services. This includes the number and type of safeguarding incidents for each individual home/service and for each

overarching organisation. The Adult Safeguarding and the Quality and Performance Team monitors this on a weekly basis.

- Following the findings and recommendations of the Mendip House Safeguarding Adults Review all people with a Learning Disability who are placed outside Somerset will now have face to face reviews. In the past the Council may have asked the host Authority to undertake a review on its behalf, but this will no longer be the case.
- The council is proactively working to reduce the number of people placed outside of Somerset and on the rare occasions when a someone is placed into a service outside of the County the host Authority is being informed.
- Out of county placements have also formed a key part of our dedicated Review To Improve Lives Team's work. This team undertook a programme of reviews with the aim of supporting people to move from restrictive types of services to live within, and be valued members of, their communities.
- We have continued to actively contribute 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 have delivered a range of safeguarding-related training and development opportunities for staff within Adult Social Services:
- We have continued to fund the on-going hosting costs of a dedicated SSAB website; this has proved invaluable in supporting the promotion and further progression of the Safeguarding Adults Board.
- We have enhanced the response to safeguarding alerts at Somerset Direct. A series of development workshops have been held to up-skill the call advisors at Somerset Direct when handing safeguarding alerts focusing on their competence, knowledge and skill of handling a safeguarding concern. Somerset Direct staff now screen alerts using the Risk Tool document, endorsed by the SSAB, to ensure that our response is appropriate and timely.
- Learning from safeguarding adult enquiries, feedback, compliments and complaints has been disseminated across the organisation. In the safeguarding adult service dedicated workshops to focus on good practice, recording and outcomes have been attended by all staffing groups.

- We have continued to work closely with Avon & Somerset Police and Somerset Partnership to coordinate a multiagency decision making and response forum both with MASH arrangements and in managing individual high-risk situations within Somerset.
- We have welcomed the opportunity to share our learning from safeguarding enquiries, our knowledge of safeguarding Care Act duties and our service model across several key agencies and forums including Avon & Somerset Police, Housing, provider settings, elected members. These sessions have increased confidence and competence in organisations working with us. In addition, we have continued to work closely with registered and non-registered providers across Somerset, developing knowledge, sharing our learning from safeguarding enquiries and fostering positive working relationships.
- We have strengthened our working partnership with Avon and Somerset Police Safeguarding Co-ordination Unit by delivering workshops to improve awareness and develop closer working partnerships.
- We have active member participation in a range of multiagency forums including – MAPPA, Somerset Safer Partnership Domestic Abuse Board and we continue to support the work of the SSAB and sub-groups with representation and engagement to all the forums.

NHS England

Throughout 2017/18 NHS England South West has improved its delivery of our safeguarding responsibilities, strengthened our internal governance process, improved assurance across our CCGs, supported Designate Professionals and Safeguarding adult leads to be effective leaders and continue to work with our multi-agency partners to ensure delivery of our statutory safeguarding responsibilities and NHS England safeguarding priorities.

There have been some significant milestones achieved in improving the local NHS England safeguarding arrangements and positive relations forged in 2017/18; this is despite significant capacity spent on the operational management of new and historic high risk cases. Throughout 2018/19 the Nursing and Quality team look to build on the previous year and

continue to strengthen the SWS role in leading the safeguarding agenda across the health landscape. The below provide an overview of the key objectives and achievement of 2017/18 and the key objectives for 2018/19.

Key Objectives for 2017/18

- Effective safeguarding governance, communication and network arrangements for the SW DCO
- Establish safeguarding assurance arrangements with SW CCGs
- Develop and implement a system for overview of Statutory Reviews
- Support high profile operational safeguarding cases
- Work with Local Safeguarding Boards and Partnerships on supporting local projects and areas of concern
- Support safeguarding work steam specific projects and initiatives

Key Achievements for 2017/18

- Set-up a quarterly CCG safeguarding leads network in order to bring together safeguarding leads across the adult and children's safeguarding agendas to improve communication, share best practice and learn from statutory reviews
- Collated outcomes and evaluation of NHSE SW funded CCG led projects from 2016/17 and used the CCG network to present and share learning.
- Established an up to date distribution list to send regular updates and national information to all CCGs to disseminate through their provider organisations
- Developed a template tool to use with CCGs in order to gain assurance of delivery against safeguarding work streams to feed into quarterly regional safeguarding report.
- Established a full contact list of the 16 SW Local Safeguarding Board (LSB) chairs, business managers and administrators and attended LSB meetings where possible or necessary.
- Established links with the SW LSAB independent chair network and presented an NHSE update at their February 2018 meeting.
- Developed a tool for capturing and tracking all SW safeguarding reviews to include SARs, SCRs, DHRs.
- Ensured there is SW engagement and feedback with the NHSE national safeguarding sub-groups.

- Learnt from the Unaccompanied Asylum Seeking Children (UASC) work in South East Region and share best practice through a SW conference.
- NHSE SW attendance and input as 'health' representative on the Police led Child Sexual Exploitation & Abuse (CSE/A) quarterly Strategic Governance Group
- NHSE SW attendance and input as 'health' representative on the Police led Prevent quarterly regional group
- Engaged with the Independent Inquiry into Child Sexual Abuse (IICSA) and ensured CCGs are connected with the Truth project in Exeter. Supported through presentation at CCG network and join up with LSBs.
- Worked with NHS Digital colleagues on the Child Protection Information sharing project (CP-IS) to seek assurance from CCGs that they and their providers are signed up to and processing. In addition to supporting NHS Digital unblock barriers with Local Authorities.
- Worked with South Devon and Torbay CCG in developing a memorandum of understanding for delegated commissioning accountability to CCGs for Primary Care although the delegation did not get final approval.
- Supported and engaged in a number of high profile large scale safeguarding investigations and statutory reviews. Ensuring information was getting into the reviews and learning was being extracted and escalated to appropriate regional and national boards.
- Conducted bespoke due diligence work with a SW CCG in order to understand current position on safeguarding responsibilities and identify recommendations to improve position.
- Facilitated discussion around safeguarding and STPs/integrated care to provoke local thinking and engagement in ensuring safeguarding is featured within local developments.
- Supported local projects and issues that have emerged via LSBs; for example; pilot in Plymouth to ensure GP information is reaching child protection meetings, Dental safeguarding support following a JTAI in Bristol, specialist commissioning input into safeguarding investigation in Devon and engagement with LMC following SCR recommendation in Somerset.

Overarching Objectives for 2018/19 (which forms the basis of a detailed work plan):

To have a NHS workforce in the SW which is equipped with the skills and knowledge to fulfil their safeguarding responsibilities

- To support implementation of new legislation and guidance impacting safeguarding and ensure SWS NHS organisations are prepared for changes
- To have a clear position of safeguarding assurance in each STP area supported with evidence
- To have clear processes in place for statutory reviews; including notification of initiation, requests for information, input into panels and monitoring recommendations
- To develop and enhance working relationships with new and existing groups/systems.

Healthwatch Somerset

- Healthwatch Somerset has statutory powers under the Health and Social Care Act 2012, to 'Enter and View' publicly funded health and social care premises to speak to people about their experiences of using the service. This allows us to create a report that identifies areas for improvement and share areas of best practice.
- The last Enter and View took place on 31 May 2017 under the previous contract run by The Care Forum.
- Under the new contract, we have trained 8 volunteers and 4 staff members to conduct Enter and View.
- We are in the process of identifying services to Enter and View for the coming year. These will be identified based on concerns raised and/or partnership working with organisations who wish to work with us to understand the views of service users.

- **We are working with Somerset Partnership Foundation Trust to bring together safeguarding services**. This work is bringing together adult and children's safeguarding together across both organisations. This will lead to a team with a wide range of experience, skills and backgrounds, which should greatly improve the safeguarding support we can offer to both patients and staff across both trusts.
- **Director of Safeguarding.** A Director of Safeguarding has been appointed, which enables a stronger focus on safeguarding within the organisation and will facilitate improved strategic planning for safeguarding across both trusts.
- **Alignment of Safeguarding Training.** As part of our work with Somerset Partnership, we have started work towards a co-ordinated approach to training, which will help us launch the higher levels of safeguarding training within the Trust.
- **Reinvestment has been possible due to the integration of the two trusts former safeguarding teams**. This will enable a new 'Mental Capacity Act, Deprivation of Liberty Safeguards and Consent lead' post. This post will provide more face-to-face support for clinicians as well as allowing us to expand our training for the Mental Capacity Act in line with the draft SSAB Mental Capacity Act Competency Framework.
- **We have been working to improve staff awareness of the Mental Capacity Act.** Decision-maker training for Consultants and Staff grade doctors for the Mental Capacity Act has improved, but we are aiming to raise this further with the support of the new Mental Capacity Act and Deprivation of Liberty Safeguards Lead. An internal audit is planned in June that will give a baseline and work plan for further improvements over the coming year
- **Reinvestment and reconfiguration due to the integration of the two trusts former safeguarding teams has** enabled a new contract to be established with Liverty (SIDAS), for a new Domestic Abuse Co-ordinator post. This will allow us to provide greater support for victims of domestic abuse across both trusts. This post will sit within the newly integrated safeguarding service.
- **We continue to be an active member of the West of Somerset Multi-Agency Risk Assessment Conference (MARAC).** As well as regular attendance, we have also been involved in the multi-agency development of a new approach to MARAC, which is planned to be launched later in 2018.

- **We have played an active role on the Somerset Safeguarding Adults 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 joint Safeguarding Committee with Somerset Partnership. Our success against this plan is reviewed by the Trusts Quality Assurance Groups.
- **New Governance arrangements.** The previous Safeguarding Groups for Taunton & Somerset and Somerset Partnership have now integrated to form one joint Safeguarding Committee.

Yeovil Hospital NHS Foundation Trust

- **Board Effectiveness:**
  - The Trust safeguarding committee meets bi-monthly and is chaired by the Executive Director lead for safeguarding. The standing agenda consists of: review of key performance indicators, learning to prevent reoccurrence, children and adult safeguarding updates, prevent, mental capacity and deprivation of liberty.
  - The trust is represented at Adult Safeguarding Board and subgroups by the executive lead or designated deputies.
- **Prevention:**
  - We continue as an organisation to support the multiagency training across the county and participate in the training strategy development for the Somerset Safeguarding Adults Board.
  - Trust staff continue to identify an increase in the number of alerts and referrals being raised through identified safeguarding issues. (299 during this reporting period). This reflects the consistent raised awareness within the organisation regarding safeguarding the vulnerable individual.
  - The combined adult and child safeguarding training sessions are delivered by safeguarding team members at induction and mandatory training to all trust staff

- The safeguarding team provides level 3 training modules for identified staff in respect of adult safeguarding. The modules include, Learning from serious case reviews, The Care Act, The Mental Capacity Act and Deprivation of Liberty – (this includes case reviews and documentation), Domestic Abuse, Prevent, Learning Disabilities and reasonable adjustment.
- As a result of the Health IDVA work, the Trust continues to strengthen its position and quality of response for Domestic Violence and Abuse, Sexual Violence and Honour Based Violence. The IDVA works in partnership with the Children Safeguarding Practitioner and specialist midwives where Domestic Violence and Abuse has been identified during pregnancy. The IDVA continues to strengthen relationships with statutory and non-statutory professionals and agencies / services. There has been a marked increase in the number of reported cases (99 during this reporting period), and a significant number of these cases are relating to the elderly population.

- **Making Safeguarding Personal:**
  - The Learning Disability Practitioner has developed and maintained links with carers and agencies and has become an integral part of pre-admission processes for patients with learning disabilities who require reassurance and reasonable adjustments being made to accommodate their needs for any inpatient / outpatient processes.
  - The Safeguarding team actively responded to serious case reviews and safeguarding enquiry requests under Section 42 of the care Act 2014 where safeguarding concerns have been identified.
  - We have reviewed the YDH safeguarding training programme to provide a more integrated approach to safeguarding awareness and making it personal for the vulnerable individual.
- **Think Family:**
  - As a trust we fully support the Safeguarding Boards 'Think Family' approach
  - The amalgamated Children and Adult safeguarding team has strengthened our 'Think Family' response within the Trust to identified safeguarding issues.

Registered Care Providers Association

- The RCPA have welcomed its involvement in the Safeguarding Adults Board in Somerset and has continued to promote and support care providers in the day to day implementation of policies and protocols intended to protect vulnerable adults.
- The RCPA continued to be a source of advice and support to our members in relation to safeguarding matters, offering tailored input into the managing of individual cases.

Liverty

- We have actively contributed to multi-agency learning through Safeguarding Adults reviews and Domestic Homicide reviews.
- We have continued to review the training packages offered to staff to ensure that they are fit for purpose and job role. All staff are expected to have their training refreshed every two years and this is closely monitored by our safeguarding lead. Training now also includes County Lines and Cuckooing.
- We have increased the hours of our dedicated safeguarding lead from part-time to full-time. This is to provide better training and advice and monitor all safeguarding concerns.
- 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.
- We have been active participants in SSAB and SAR meetings.
- 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 continue to carry out 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.

- All of our policies and procedures are updated annually.
- We carry out quarterly reviews with staff on our safeguarding processes, to ensure their understanding and also check our procedures and training are working.

Somerset Partnership NHS Foundation Trust

- **Our Integrated Safeguarding Service** 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). We ensure our work remains focussed on the principles of making safeguarding personal whilst continuing to embed the 'Think- Family' model as the basis for all of its work across the Trust and with our partner agencies.
- **The Trusts Integrated Safeguarding Steering Group considers** all of the areas that the Safeguarding Service and ensures that the work of the SSAB is integrated into our own work plan and service development.
- **We have worked closely with Taunton and Somerset NHS Foundation Trust** in the development of a single Integrated Safeguarding Adult and Children service across both organisations. This is currently undergoing business planning and consultation stages and is expected to fully implemented in the Autumn 2018.
- **The former Head of Safeguarding for Somerset Partnership was appointed as the Director of Safeguarding across both Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust in February 2018**. The new Director will ensure an integrated service is established to meet the need of the combined staff workforce and the clients / patients they support.
- **The Safeguarding Service has undergone further changes**, reconfiguring our existing resources, to ensure resilience within the team and ensure appropriate responses are provided to concerns raised from our vast array of community and mental health services.

- **The Safeguarding Adults Team commenced provision of Safeguarding Team Supervision to frontline teams and services across the Trust**, enabling updates of safeguarding related practice / learning from SARs etc and individual case discussion on a quarterly basis.
- **We fully participated in the completion of the second SSAB led Annual Safeguarding Audit** and utilised the findings to develop our internal Safeguarding Service Development Plan.
- **The Trust Safeguarding intranet pages continue to provide a useful resource for staff**, with internal and external links incorporated within them for all of the forms and documentation staff will need. This has been added to extensively throughout the year with relevant publications, guidance documents and useful tools and resources.
- **Staff continue to report an increased confidence in the support and training they receive**. Numbers of staff appropriately trained at levels one and two remain consistently high (93-95% throughout the year). The new Level 3 training, commenced in July 2016, reached 89% compliance by the end of 2017/2018 with the remaining staff anticipated to be trained by July 2018. This is in advance of the publication of the intercollegiate guidance expected later this year.
- **Staff continue to access the Safeguarding Service for advice and support via the single point of contact number**. Staffs are evidently becoming more aware of potential patient safeguarding issues from the increased profile that safeguarding now has in the Trust.
- **We have continued closed collaborative working with our police and Somerset county council safeguarding adult colleagues** further developing the structure and process that sits behind the weekly safeguarding adults Multi-Agency Safeguarding Hub (MASH) meetings. We are an active member of the now weekly adult MASH meetings held between ourselves, Adult Social Care and the police.
- **We led on collaborative working with Somerset CCG, North Somerset NHS Community Partnership, North Somerset CCG and Avon and Wiltshire Mental Health Partnership on a NHS England funded project** around Level 3 Safeguarding Adults training. This was rolled out across Somerset and North Somerset Health agencies

during the summer of 2017. Following the success of this work this has led to further commissioning from Somerset Clinical Commissioning Group of level 3 Safeguarding Adults training for Somerset GP's.

- **Our contribution to several Safeguarding Adult Reviews and Domestic Homicide Reviews with our partner agencies** and subsequent learning has been shared across our organisation via various means, policies reviewed / updated and incorporated into all levels of our mandatory safeguarding adults training programme.
- **Staff have positively engaged with multi agency SAR learning events** with staff providing extremely positive feedback and demonstrating a willingness and keenness to become involved in ongoing development work.
- **We continue to be actively involved in the work of the Safeguarding Adult Board and all of the sub-groups**, ensuring the safeguarding adults agenda continues to be developed and promoted not just within our own organisation but across the wider Somerset community.

HM Prison & Probation Service

National Probation Service

- All staff attend regional Safeguarding events and are encouraged to attend National learning events which assist us to disseminate good practice. 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 are working with the partner organisations to develop a county wide training strategy.
- All team members have attended training/briefing concerning Child Sexual Exploitation (CSE).
- The National Probation service have continued to participate in Safeguarding Adult Reviews and Domestic Homicide Reviews.
- We have continued to develop a supervision structure to support Probation colleagues in their referrals and work they complete with all offenders.
- We have continued to be a source of advice and support to all team members and partnership agencies in relation to safeguarding matters.
- We ensure that all safeguarding alerts and outcomes are recorded onto our systems.

- The National Probation Service attend monthly Multi-Agency Risk Assessment Conference (MARAC) meetings in order to contribute to the risk management of offenders and safeguarding of Domestic Violence victims.

Discovery

- As part of the Dimensions Group, we have a commitment to making safeguarding personal and to ensure that the people we support live safely and without fear of, or actual abuse.
- Our independently chaired Safeguarding panel has been set up to oversee our Safeguarding Strategy and Business Plan and to monitor and review performance against the identified measures and Key Performance Indicators. This includes:
  - Systems and processes, including training, policy requirements and legal responsibilities
  - Safeguarding register monitoring
  - Lessons learnt – sharing information where appropriate and making recommendations.
  - Human Resource practice in relation to safeguarding matters
  - Additionally, the records of the panel are reported to the Discovery Board

  Furthermore, the panel advises on organisational related risks and monitors DoLS and physical interventions
- Our Safeguarding Policy's purpose is to ensure that all people we support are safeguarded as far as possible from all forms of abuse. It also aims to ensure that employees understand what to do when they become aware or suspect that somebody we support has been abused. This policy promotes equality, diversity and human rights by considering that vulnerable people are more likely to fall victim to abuse than the majority of people, and directing Dimensions employees to:
  - be vigilant for and take action against all such incidence whatever the person's age, gender, ethnicity, faith, disability, sexual orientation, marital status and whether pregnant; and
  - consider discrimination on grounds of age, gender, ethnicity, faith, disability, sexual orientation, marital status or pregnancy as abuse.

- We have come together quarterly, as the District Council Safeguarding Group, with representatives of SSAB to learn from each other and from activities across the country.
- We have worked with Avon and Somerset Constabulary to address the safeguarding of vulnerable adults from criminal gangs and their activities.
- We have actively contributed to Safeguarding Adults Reviews and Domestic Homicide Reviews, in an open and transparent manner, alongside our partner agencies. We have learnt from these reviews and changes policies and procedures where the outcomes of them have shown it would be appropriate.
- We have provided regular training to our staff and elected members to keep them up to date in their understanding of safeguarding matters and their duties.
- We have developed our One Team models further to ensure that the support to safeguard vulnerable people continues to evolve and improve outcomes.
- We have continued to support the PREVENT agenda to help stop vulnerable adults from being drawn into terrorism and harm.
- We have continued to deliver the Positive Lives Programme, with partners, to support vulnerable adults with complex needs to gain stable, safe accommodation.
- We have reviewed our safeguarding policies and, where appropriate, updated them to address new issues as they arise.

- We have used the ‘Champions’ model to build capacity in our organisations and provide contact points for staff who have safeguarding concerns, as well as giving focused training to teams on key subjects.
- We have developed a quarterly safeguarding forum for register social housing providers to meet and share safeguarding concerns with us. We have also used this forum to update the providers on safeguarding matters, provide training and share best practice.

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.