Annual Report

2018-19

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 2018/19;
- 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 2018/19. This is now my sixth 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 real 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 have continued to pursue the recommendations made in the Mendip House Safeguarding Adults Review that we published at the end of the previous year, including undertaking work to seek assurance of local practice when people are placed outside of Somerset; and establish how many people have been placed in to Somerset and when they were last reviewed. You can read more about this on page 40.

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. We have also introduced new online guidance on safeguarding adults in Somerset, which is accessible to both professionals and the public. We have sought to hear the voice of the adult at risk and their families or carers, including through two people coming and sharing their experiences with the Board at our meetings in

September and March. I pay particular tribute to them and everyone else who has helped by sharing intensely personal and difficult experiences that we can learn from to help us 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, which are outlined in our new 3-year strategic plan.

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, including through the introduction of a peer challenge element to our self-auditing process, and that culture is vital if we are to truly learn and improve to meet the challenges ahead. Those challenges continue to be significant, but changing demographics locally and nationally, and continued budgetary pressures on all organisations, make joint working all the more important.

This is my last annual report as the Independent Chair of the Board as I will stand down towards the end of the calendar year. I firmly believe that in Somerset we have created the right environment for partnership working and have strong levels of commitment from all partners to make it happen; and I look forward to seeing the good work that Somerset has put in place built on in the coming years, and welcoming a new Independent Chair once appointed.

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 organisations 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 2019:

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 of Quality and Nursing Deputy Director of Quality and Nursing
Mike Prior Victoria Caple	Avon & Somerset Constabulary	Superintendent Partnership Liaison Manager

Partner Members		
Daniel Lloyd / David Walker	Care Quality Commission	
Janet Quinn	Devon, Somerset and Torbay Trading Standards Service	Trading Standards Project Officer
Luke Joy-Smith	Discovery	Managing Director
Emily Taylor	Healthwatch Somerset	Healthwatch Somerset Manager
Kathy Gilmore	LiveWest	Executive Director Housing Support
Tracey Aarons	Mendip District Council (representing District Councils)	Deputy Chief Executive
Nick Rudling	NHS England South (SW)	Deputy Safeguarding Lead
Anna Temblett	Swan Advocacy	Somerset Area Manager

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
Orla Dunn	Somerset County Council (Public Health)	Consultant in Public Health
Richard Painter	Somerset Partnership & Taunton and Somerset NHS Foundation Trusts	Director of Safeguarding
Amanda Robinson	South Western Ambulance Service NHS Foundation Trust	Safeguarding Business Manager
Bernice Cooke	Yeovil Hospital NHS Foundation Trust	Head of Governance and Assurance
Deborah Penny	Carers' Voice Somerset	Carers' Voice Somerset Partnership Board Officer
Kathy Smith	Golden Lane Housing	Housing Officer
Lucy Martin	Department for Work and Pensions	Partnership Manager for Bristol and North Somerset Department for Work and Pensions
Nicola Kelly	Somerset Care Ltd	Interim Head of Quality/Operations Manager Nursing
Richard Pitman	Representing people who use services and the Voluntary Sector	Chief Executive – Compass Disability
Liz Spencer	National Probation Service	Head of the National Probation Service - LDU Somerset Cluster NPS South West South Central Division

Mandy Davies	Devon & Somerset Fire and Rescue Service	Safeguarding Manager

Board attendance

The Safeguarding Adults Board met on 4 occasions during 2018/19 – June, September, December and March.

In brackets below is the number of times each organisation was represented during the year at these meetings[1].

Organisation	Attendance
Avon & Somerset Constabulary	75% (3/4)[2]
Care Quality Commission	0% (0/4)
Carers' Voice Somerset	33% (1/3)[3]
Department for Work and Pensions	33% (1/3)[3]
Devon & Somerset Fire and Rescue Service	N/A – new[3]
Devon, Somerset and Torbay Trading Standards Service	50% (2/4)
Discovery	75% (3/4)
District Council representative	50% (2/4)
Golden Lane Housing	100% (1/1)[3]
Healthwatch Somerset	50% (2/4)
Housing representative	0% (0/4)
Musgrove Park Hospital	100% (4/4)
National Probation Service	100% (4/4)
NHS England	0% (0/4)
NHS Somerset Clinical Commissioning Group	100% (4/4)
Public Health	100% (4/4)
Public Health (Community Safety)	50% (2/4)
Registered Care Providers Association	0% (0/4)
Representative of people who use services	66% (2/3)[3]
Somerset Care Ltd	0% (0/2)[3]
Somerset County Council	100% (4/4)
Somerset Partnership NHS Foundation Trust	100% (4/4)

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

[2] Avon & Somerset Constabulary attempted to join one meeting remotely but was unable to due to a technical issue

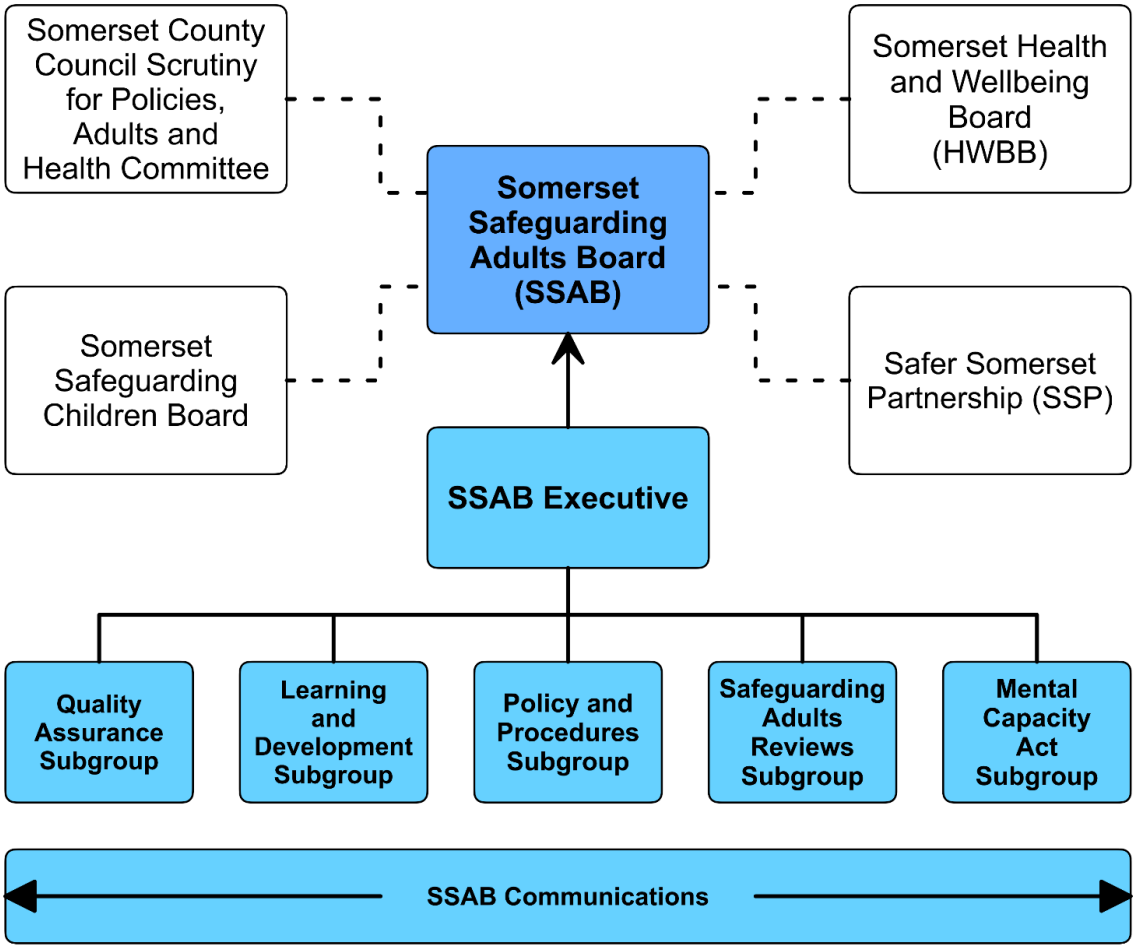
[3] Organisation that joined the board part-way through the year

South Western Ambulance Service NHS Foundation Trust	0% (0/4)
Swan Advocacy	66% (2/3)[4]
Voluntary sector representative	66% (2/3)[4]
Yeovil District Hospital	100% (4/4)

During 2018/19 the SSAB met on a quarterly basis, supported by an Executive Group and a number of subgroups, which convened frequently to progress the ambitions and strategy of the Board.

The SSAB has agreed that in future years it will meet 3 times a year – in June, October and March, with an expanded membership of the Board and more frequent meetings of the Executive Group.

Board structure



There are strong synergies between the work of the SSAB and other key partnerships in the locality, including the statutory Safeguarding Children

[4] Organisation that joined the board part-way through the year

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, internet 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

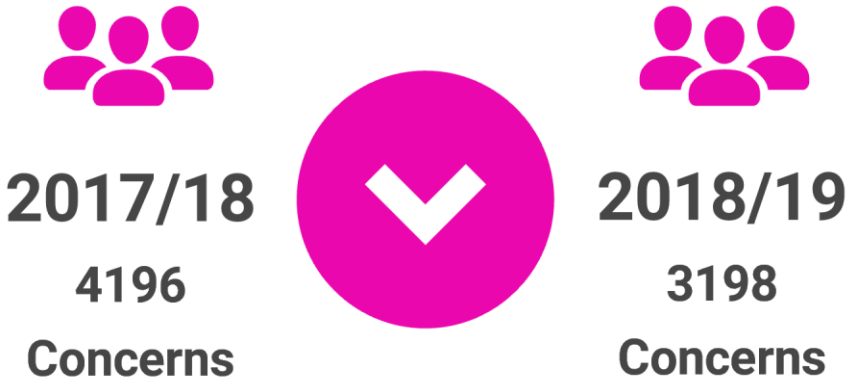
- **Modern slavery** – including slavery, human trafficking, forced labour and domestic servitude, traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment
- **Discriminatory abuse**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

4. Safeguarding in numbers

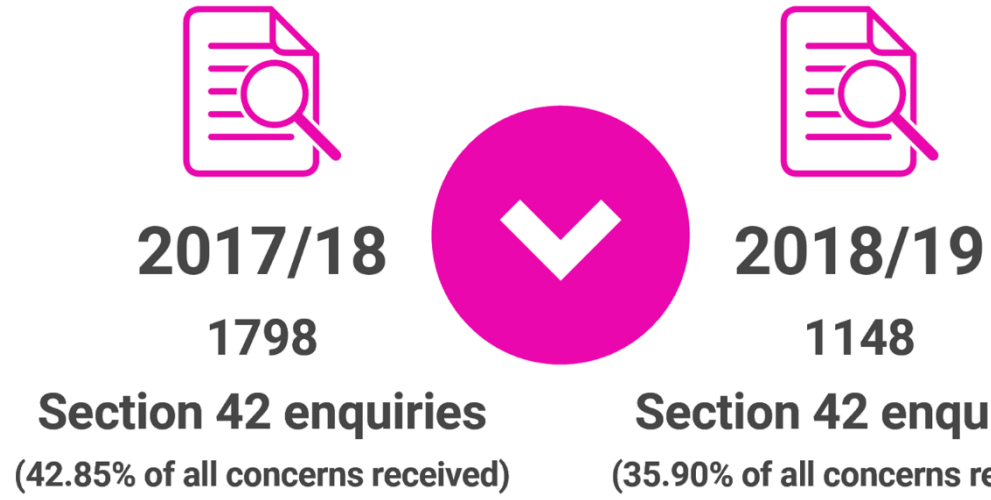
How much abuse and neglect was reported during 2018/19?

Safeguarding concerns reported to the Local Authority in 2018/19



3198 concerns were reported. This was a drop of 998 compared to the previous year

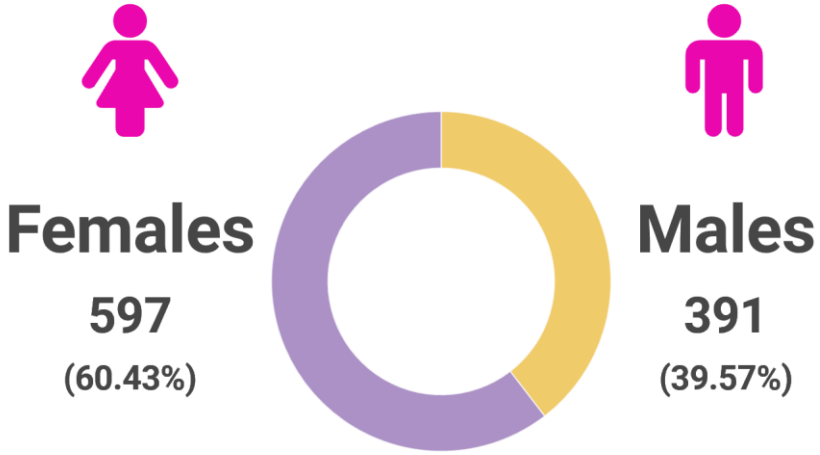
Safeguarding concerns received that required a statutory response



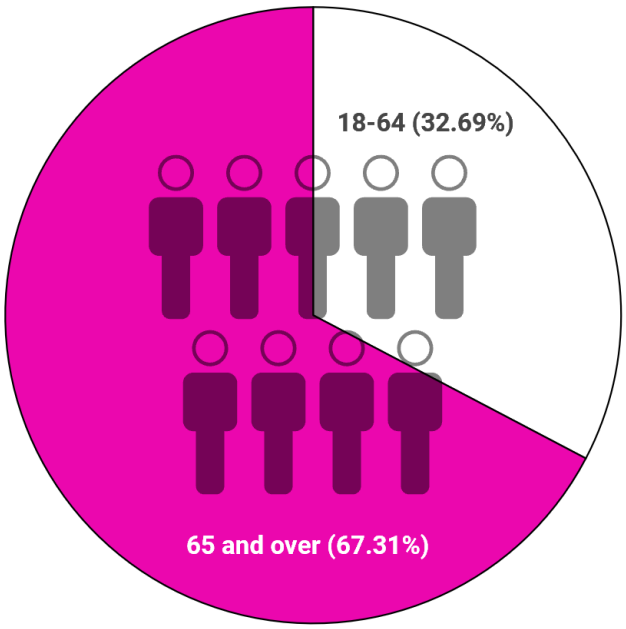
1148 (35.90%) of concerns resulted in an enquiry under Section 42 of the Care Act (2014)

Who was at risk of abuse and neglect in 2018/19?

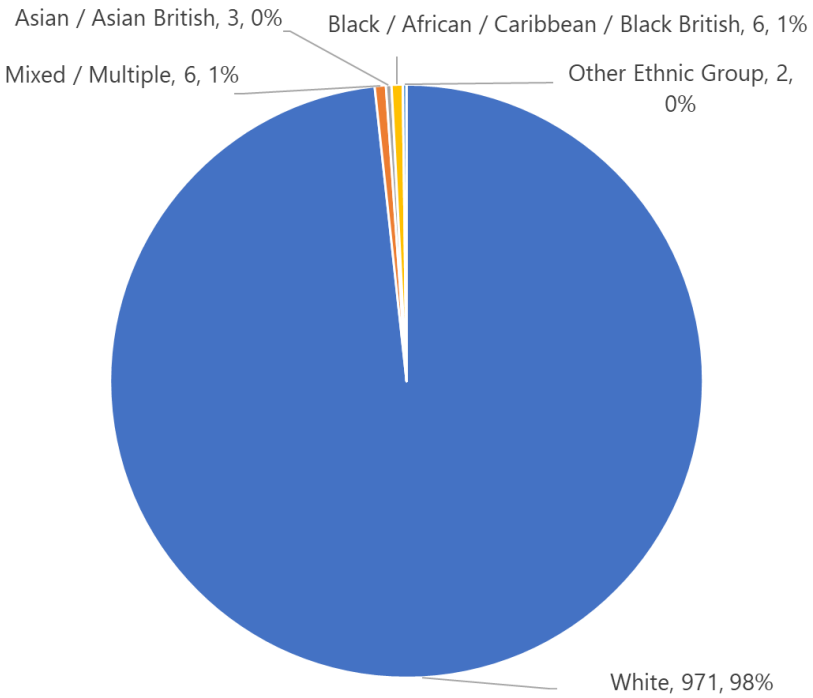
The majority of individuals that required a statutory response were female



The majority of individuals where the concern resulted in an enquiry under section 42 of the Care Act (2014) were aged 65 and over

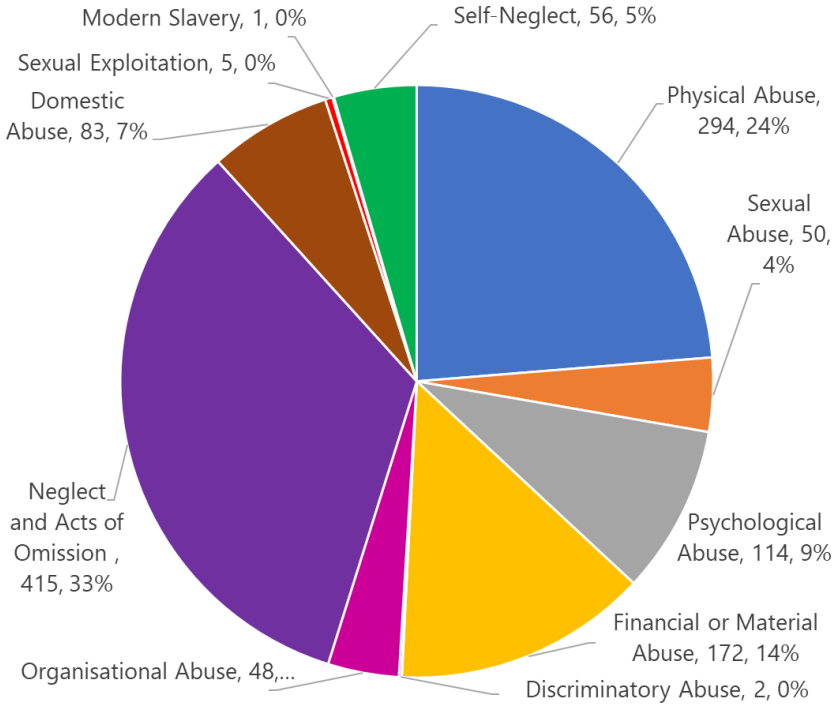


The majority of individuals where the concern resulted in an enquiry under section 42 of the Care Act (2014) were from white ethnic backgrounds

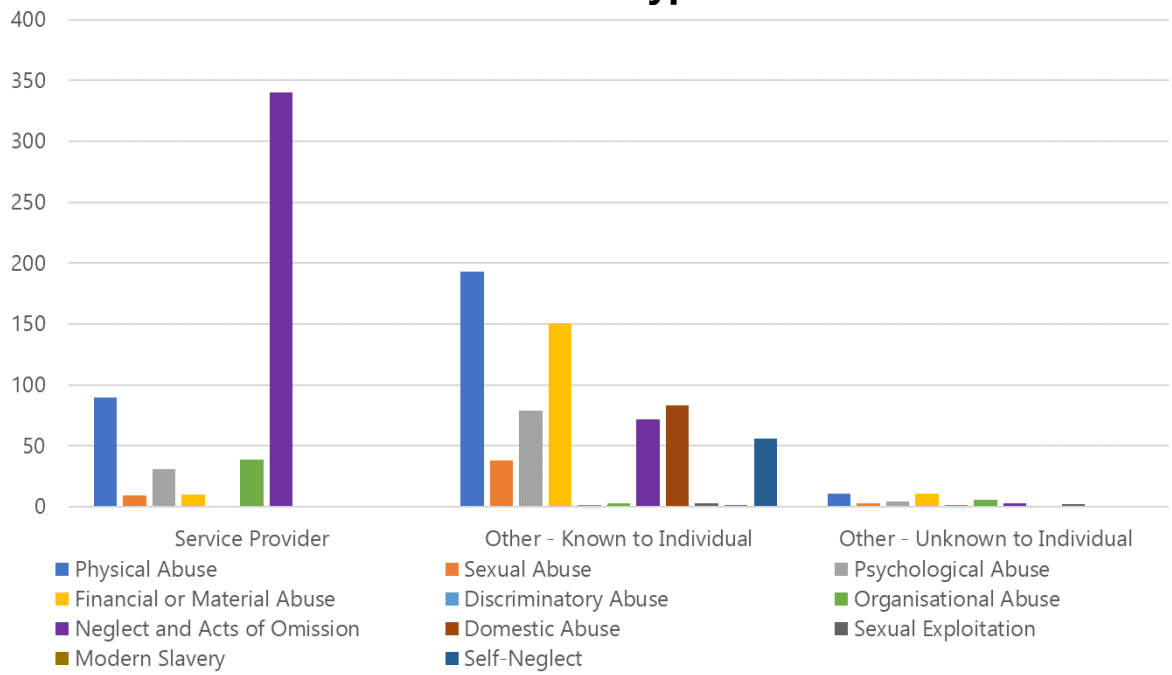


Type of abuse and source of risk

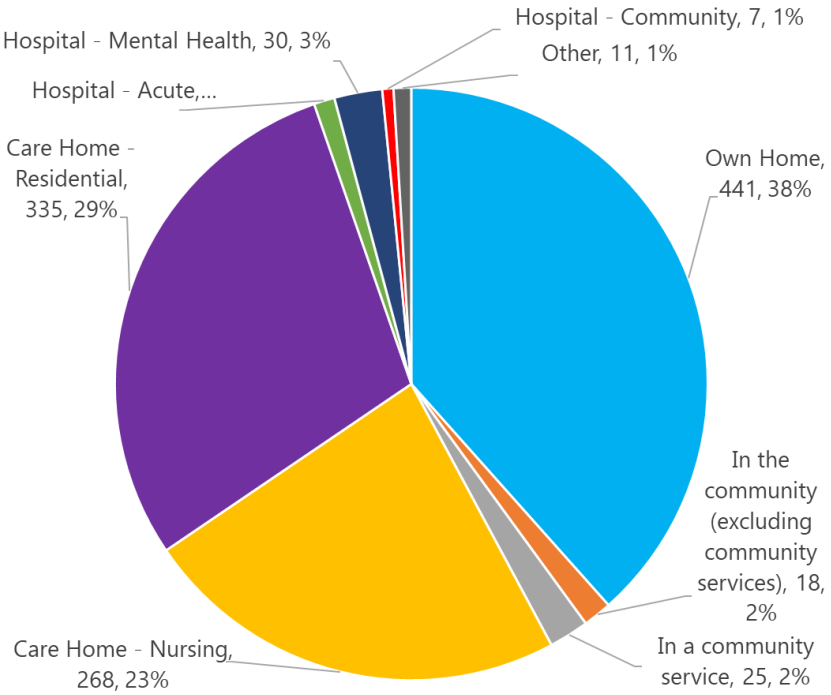
The most common risk type was Neglect and Acts of Omission, which accounted for 33% of risks, followed by Physical Abuse at 24%. This was a change from 2017/18 when Physical Abuse was the most common risk type (26%) followed by Neglect and Acts of Omission (25%)



The majority of cases of Neglect and Omission, Organisational Abuse and Sexual Abuse 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

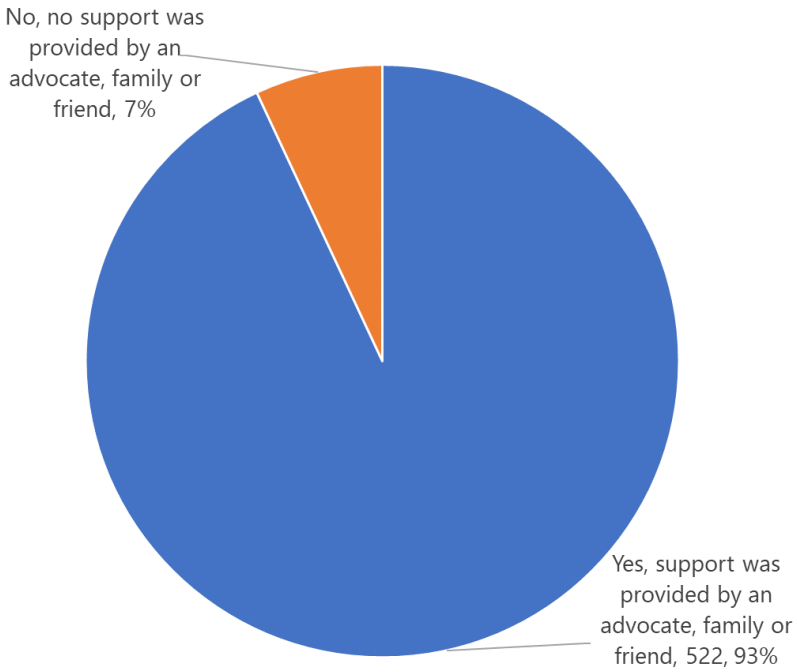


The most common location where people were identified as being at risk was their own home (38%) followed by residential care homes (29%)



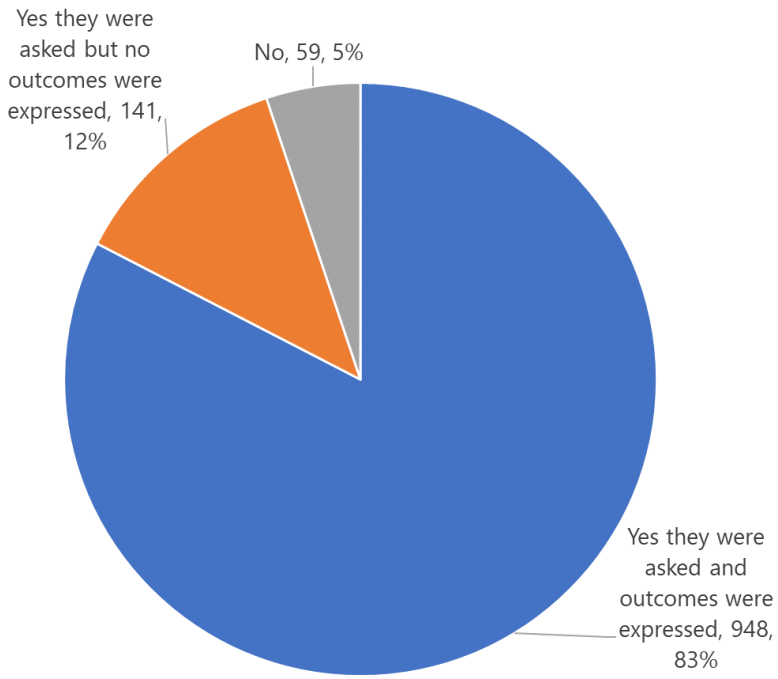
Mental Capacity

In 561 cases the adult at risk was assessed as lacking capacity to make decisions related to the safeguarding enquiry. In the majority of these cases they were supported by an advocate, family or friend

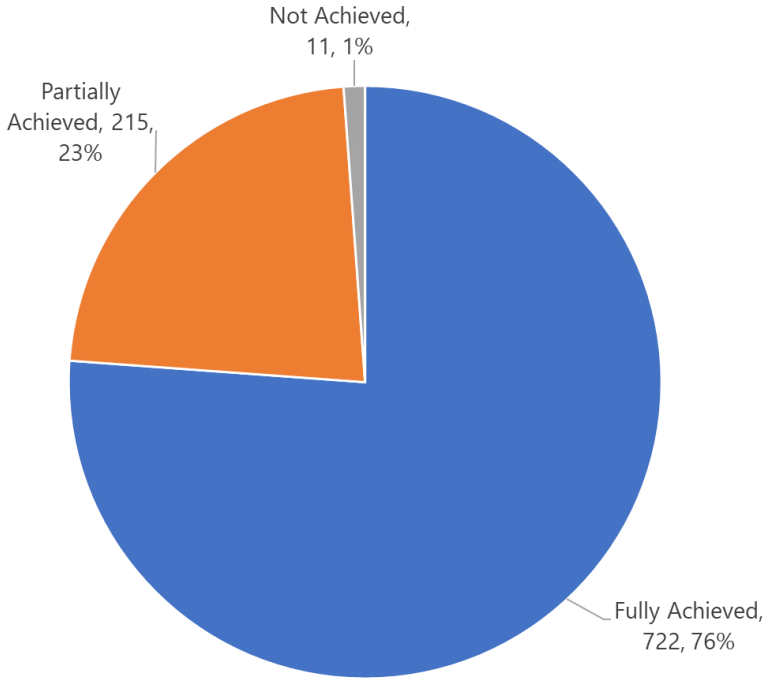


Making Safeguarding Personal

The majority of people, or their representative, were asked what their desired outcomes were

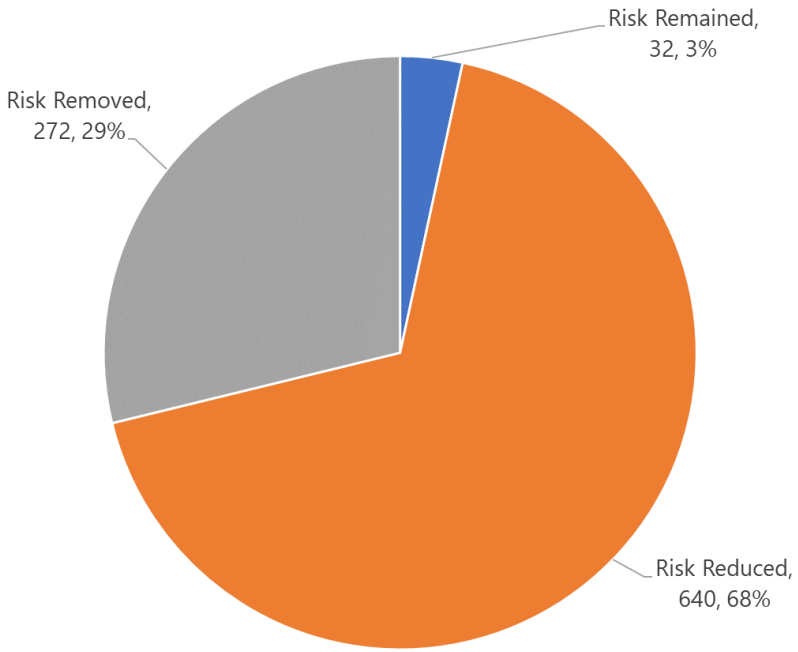


In 99% of cases where desired outcomes were stated they were either partially of fully achieved



Outcomes of enquires made under Section 42 of the Care Act (2014)

In the majority of cases the risk was removed or reduced. Where this was not the case this was usually where the person was assessed as having capacity and, for example, chose to remain in contact with the alleged abuser



Case Study

Brian is a 95 year old war veteran who is blind, underweight and very hard of hearing. Concerns were raised by a member of the community and a bank about alleged neglect and financial abuse. At the time he was living with family members, who were also the alleged perpetrators.

A member of Somerset County Council's Safeguarding Service visited Brian four times, taking him to the bank, and working very closely with Somerset County Council Adult Social care staff, as well as a Better Living Nurse through Brian's GP Practice and a Community Agent. They also worked with Brian's family, and discussed the concerns and standards of care very openly with them.

Brian provided verbal feedback directly when the support provided by the Safeguarding Service ended;

- Brian said he was asked at more than one point what he wanted to happen.
- Brian felt listened to.
- Brian said people helped in the way he wanted them to.
- Brian felt he was included in decision making.
- Brian shared the support he received was "the right amount".
- Brian feels safer.
- Brian feels people worked together to help him be safe.
- Brian stated: That he knew that the member of staff from the Safeguarding Service "has spoken to my family and that they want what is best for me." And that the member of staff "has been marvellous and very kind to me".
- Brian is happy with the result of the safeguarding work and would not have liked anything to be done differently.

Brian decided to trial a placement and the care home have said that: Brian "is such a wonderful gentleman, who is enjoying all foods, plenty of fresh tea, and conversing with staff and residents alike. He has stated he does not wish to return home as he believes he has found heaven, he only wishes he had found it sooner".

5. Our work, 2018/19

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 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	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 2018 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 information for organisations that work with people who are vulnerable to abuse this year.

What SSAB said it would do	What the SSAB did
	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 regional multi-agency policy, the updating of which was once again coordinated by the SSAB). The SSAB also ran a campaign on social media - #12DaysOfSafeguarding - over the Christmas and New Year period that saw high levels of engagement. The SSAB has promoted 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 publications and links to those of other organisations. Use of this site has increased significantly over the course of the year – from an average of 625 users each month over the first three months of the year to an average of 2982 each month over the final three months - as new content has been added.

What SSAB said it would do	What the SSAB did
We will work together with Devon, Somerset and Torbay Trading Standards Service to address financial abuse and scams	The SSAB has raised awareness and promoted initiatives throughout the year. This included using social media to alert people when we become aware of a specific scamming 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 promoted the Devon, Somerset and Torbay Trading Standards Rogue Traders week during October 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 developing a 'framework' that identifies the safeguarding knowledge that staff working at different levels within organisations

What SSAB said it would do	What the SSAB did
	should have which we expect to implement during 2019/20. The SSAB has tracked the implementation of learning from local Safeguarding Adults Reviews, and has put in place arrangements to identify any local learning and actions emerging from reviews undertaken elsewhere, including a regular 'Learning from elsewhere' section in our newsletter
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	There was no conference during the 2018/19 financial year following a decision to move it to a date in March to 01/05/2019.
We will continue to 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 was established during 2017/18 to enhance local understanding and application of the Act. Work during 2018/19 has included: • Developing content for the SSAB website to support practice improvement in this area across the Somerset system • Monitoring the application of Deprivation of Liberty Safeguards • Considering the implications of the Mental Capacity

What SSAB said it would do	What the SSAB did
	(Amendment) Bill for the Somerset system
We will the monitor progress of the Mental Health Crisis Concordat to improve the experience of people in mental health crisis.	The SSAB continues to receive updates on progress in relation to the Mental Health Crisis Care Concordat activity, which has seen progress, including confirmation in December 2018 that no individual that required a place of safety under sections 135 or 136 of the Mental Health Act had been placed in Police custody in Somerset since December 2017. 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.
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	Local commissioning leads initiated work to seek assurance regarding the relatively small number of Somerset residents placed into services outside of Somerset. This work continued during the year, and by year end had established that there were good levels of assurance for placements made by NHS Somerset CCG and Somerset

What SSAB said it would do	What the SSAB did
	County Council, with significant improvements made by the Council during the course of the year. Monitoring will continue during 2019/20 to ensure that best practice is embedded.
We will seek assurance regarding the assurance and monitoring arrangements that commissioners placing people from other parts of the UK in to Somerset have in place	The SSAB undertook a significant piece of work to establish the number of people placed in to Somerset by external commissioners and seek assurance that each person was in receipt of a timely review of their care and support needs by the organisation responsible. The results of this work are outlined on page 43.
We will seek assurance that there are appropriate arrangements in place across the Somerset system for people with complex needs who do not require Adult Safeguarding	This was a planned piece of work that was superseded during the year by work led by Public Health to consider the system's response to people with multiple vulnerabilities. The SSAB is contributing to this work and it forms part of the Board's 2019-22 Strategic Plan

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 monitor service user, carer and provider	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

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	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 during 2018/19 was, as with the previous year, very low though the feedback that was received was positive. This broadly replicates the experience of other SABs nationally over a similar period and the Board has agreed with Somerset County Council's Safeguarding Service that it will move away from this approach to a verbal conversation on closure following a report by Healthwatch Somerset that evaluated feedback processes, and which was presented to the Board in March 2019.

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 2018/19 year are shown Section 4 (page 14) with 99% of people, or their representatives, reporting their desired outcomes had been wholly or partially achieved. During 2018/19 two people who had direct experience of safeguarding in Somerset were invited to come to talk to the Board in person to replace written 'case 'studies' that the Board had previously considered. This new approach has been positively

	received by both the people themselves and the Board.
We will seek assurance that 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	Improvements have been seen in the data for people with safeguarding concerns accessing advocacy (see section 4, page 14), following work undertaken in 2017/18 that identified and resolved historical data quality issues. Swan Advocacy, Somerset County Council's contracted provider of advocacy services, has joined the Board and is also a key member of the Mental Capacity Act subgroup which has a standing item to monitor IMCA referrals.
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 Association (LGA) and Association of Directors of Adult Social Services (ADASS)	The Board has worked within regional networks to enhance local understanding and ensure that, that while MSP continues to be promoted as a distinct work area, it is not seen as something that is optional or separate from good, person centred, practice. This has taken place alongside the work undertaken by Healthwatch Somerset to evaluate feedback processes for people who have experienced being safeguarded.

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 current arrangements will be replaced by new Liberty Protection Safeguards from 1st October 2020. In summary, information for Somerset shows that applications rose by 10% over the previous year, with most other Local Authorities also reporting a rise.

	2017/18	2018/19
Total applications	2130	2354
From Care Homes	1645	1723
From Hospitals	485	631
Assessments completed	705	675
Authorisations granted	613	593
Authorisations not granted	1155	1906

Most assessments result in an authorisation being granted. Where authorisations were not grated in most cases the person had either moved or died before assessments were completed.

Priority Area 3: Think Family

What SSAB said it would do	What the SSAB did
We will support the implementation of a multi-agency Think Family Strategy for Somerset	SSAB Board members contributed significantly to the development of the strategy, which that was endorsed by the Board on 04/06/2018. Through its leading role in the refreshing of the regional Joint Safeguarding Adults Policy the SSAB has worked to enhance the Think Family principles incorporated in to this policy and has also included a 'Think Family' section in its new online Guidance for Safeguarding Adults in Somerset that was published in September 2019.

Priority Area 4: SSAB Effectiveness

What SSAB said it would do	What the SSAB did
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	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. This year additional questions were added to audit the implementation of recommendations from Safeguarding Adults Reviews and a peer challenge

	day was held that considered each organisation's submission. The audit and peer challenge processes revealed areas of high confidence across the system to be in relation to participation to the Board itself and multi-agency working, but areas for development in: • Training, competence and confidence around application of the MCA • Ensuring staff supervision policies and practice support effective safeguarding • Making Safeguarding Personal • Evidencing the implementation of recommendations form Safeguarding Adult Reviews *Please see page 38 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, including supporting the development of the National SAR Library.	The Safeguarding Adults Review (SAR) Subgroup has continued to consider referrals for Safeguarding Adult reviews. During the year it commissioned one SAR to be completed by an independent reviewer. See Section 6 on page 40 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 2018/19 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.

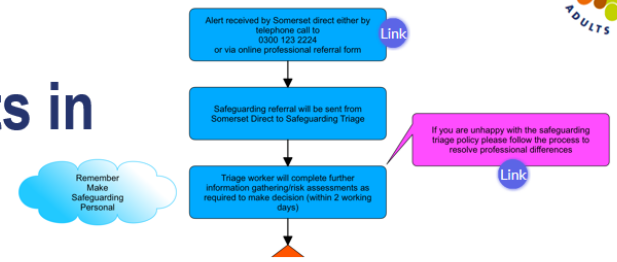
The SSAB website has had new content added and provides a platform to promote work of Board and direct interested parties to key information and resources in order to reach a bigger audience and support public and professional knowledge of adult safeguarding matters.

During 2018/19, our website was accessed by 16,005 individual users (5,929 in 2017/18), and had 40,889 individual page views (compared to 21,815 in 2017/18). The website has experienced a significant growth in visitors since the publication of its

online Guidance for safeguarding Adults in Somerset in September 2018.

The SSAB also has a twitter account that it established during 2016/17 to enhance its reach, influence and provide additional engagement opportunities. As at the end of March 2019 the Board had 739 followers (compared to 523 the previous year) earning over 131,770 impressions from its activity. Spikes coincided with promotional activity, with significant engagement from our #12DaysofSafeguarding campaign that took place over the Christmas and New Year period. 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 once again led a refresh of regional multi-agency Safeguarding Policy in partnership with four other local Safeguarding Adults Boards and has published online Guidance for Safeguarding Adults in Somerset. It has continued with its annual cycle to review all SSAB policy or procedural documents and website content to assist the Board in delivering its functions effectively. It has also considered new areas for policy and guidance that it expects to publish during 2019/20.
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.
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	Learning from Safeguarding Adult Reviews and Serious Case Reviews (undertaken both locally and elsewhere) is now a standing item for the Board's Learning and Development Subgroup, with summaries of those cases considered to have most local relevance included in newsletters. This has included information on the themes emerging from Reviews undertaken in the South West. The SSAB has representation on the regional SAR champions network, and this member of staff has also joined the SAR Subgroup that considers new referrals and monitors the progress of Reviews that are underway. The SAR Subgroup also routinely considers whether any referrals it received should also be referred to the Learning Disabilities Mortality Review (LeDeR) Programme and the SSAB Business Manager is a member of the Somerset LeDeR steering group.
Work jointly with the Somerset Health and Wellbeing Board, Somerset Children's Trust, Somerset Safeguarding Children Board, Somerset Safeguarding Adults Board, Somerset Corporate Parenting	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

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	working between partners, reduce duplication, and develop collaborative efforts to improve the resilience of Somerset communities, families and individuals. The Strategic Partnership Boards in Somerset work to a 'Working Together' protocol that was refreshed in 2017. This 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 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 has continued to be represented on a number of other multi-agency partnerships, including the Somerset Safeguarding Children Board's Child Exploitation Subgroup, Domestic Abuse Board, District Councils Safeguarding meeting, Somerset Housing Providers Safeguarding meeting and Suicide Prevention Advisory Group.

SSAB Annual Self-Audit 2018/19

- All SSAB members were invited to complete the audit, which was also published on the SSAB website.
- Organisations were asked to complete an agreed audit tool during Quarter 2 2018/19 encompassing 32 areas of safeguarding activity and practice, and to submit this for initial discussion by the Quality Assurance Subgroup ahead of a peer challenge process led by members of the SSAB Executive Group.
- Seven organisations returned a completed audit, an increase of one over the previous year. The organisations that returned an audit were:
    - Somerset County Council
    - Avon & Somerset Constabulary
    - Discovery
    - NHS Somerset Clinical Commissioning Group
    - Somerset Partnership NHS Foundation Trust
    - Taunton and Somerset NHS Foundation Trust
    - Yeovil Hospital NHS Foundation Trust
- A Peer Challenge day took place in March 2019, and the results were collated and reported to the SSAB Executive Group and Board
- The key features assessed within the audit related 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
    - Implementing learning from serious Cases (new section)
- Overall an aggregated total of 199 responses were received from the 7 organisations. Those areas where a response was not received were primarily where an area was not applicable to an organisation. For example, a number of the new questions on learning from serious cases were only applicable to organisations with a commissioning function.
- Overall across the 6 organisations that had submitted an audit previously 132 areas were directly comparable, and the Executive

Group reported that confidence had improved in 13 of these areas and deteriorated in 9.[5]

- Areas of particular concern that were identified through the peer challenge process as needing to be addressed by Board members were:
    - Ensuring the voice of people who experience safeguarding is heard and listened to within processes
    - Confidence in the embedding and following-up of recommendations from Safeguarding Adult Reviews, in particular those from 'Tom'.
    - The frequency and quality of supervisory processes
    - The application and understanding of the Mental Capacity Act across the whole adult workforce
- Work is being led by the SSAB Executive Group to address these areas

[5] 23 areas were self-assessed by 6 organisations in 2017/18. For the 2018/19 audit the wording of one question changed resulting in a responses for a total of 132 areas of safeguarding activity and practice being directly comparable to the previous year.

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 under-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 2018/18 the SAR Subgroup:

- **Commissioned one new 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.

No Safeguarding Adults Reviews concluded during 2018/19. One SAR was commissioned during the period that is expected to conclude during 2019/20.

The last Safeguarding Adults Review that was completed was Mendip House in February 2018 in relation to which the Board undertook significant work during 2018/19.

Mendip House Progress Update

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.

The full report is available in full **here**

Progress since the Review was published

- Local commissioning leads initiated work to seek assurance regarding the relatively small number of Somerset residents placed into services outside of Somerset. This work continued during the year, and by year end had established that there were good levels of assurance for placements made by NHS Somerset CCG and

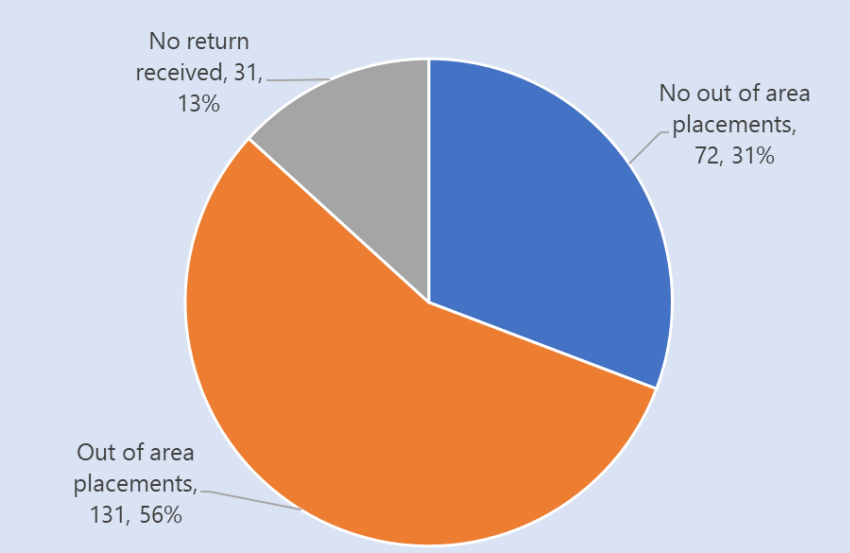
Somerset County Council, with significant improvements made by the Council during the course of the year. Monitoring will continue during 2019/20 to ensure that best practice is embedded.

- The SSAB Independent Chair, the Chair of the South West Regional Chairs Group and the SSAB Business Manager met with officials from The Department of Health and Social Care and The Local Government Association in June 2018. Officials suggested that, at that point, the imminent publication of a Social Care Green Paper would present an opportunity to take the recommendations forward. The Green Paper has not yet been published the timescale is currently unknown.
- The SSAB Independent Chair and Business Manager met with four of the six families of people placed at Mendip House following concerns that the commissioners who placed their loved ones in Somerset had not been in contact prior to the Review being published.
- The Association of Directors of Adult Social Services and Local Government Association published an advisory note in November 2018 regarding the "Arrangements and recommended ways of working for local authorities that are responsible for commissioning services (placing authorities) for adults with social care needs who are in out of area care and support services" that the SSAB contributed to.
- The SSAB wrote to all residential care and nursing care services in Somerset asking for the details of all placements made by external commissioners, and when a face-to-face review had last been completed. A summary of responses is included below.
- In January 2019 SSAB wrote to 36 Safeguarding Adults Boards asking them to seek assurance where one or more of their members were responsible for placements that had not been reviewed for two or more years. Responses continue to be followed up with a small number of Boards.
- The SSAB Independent Chair wrote to the Department of Health and Social Care and Local Government Association to progress the implementation of the recommendations in March 2019.

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

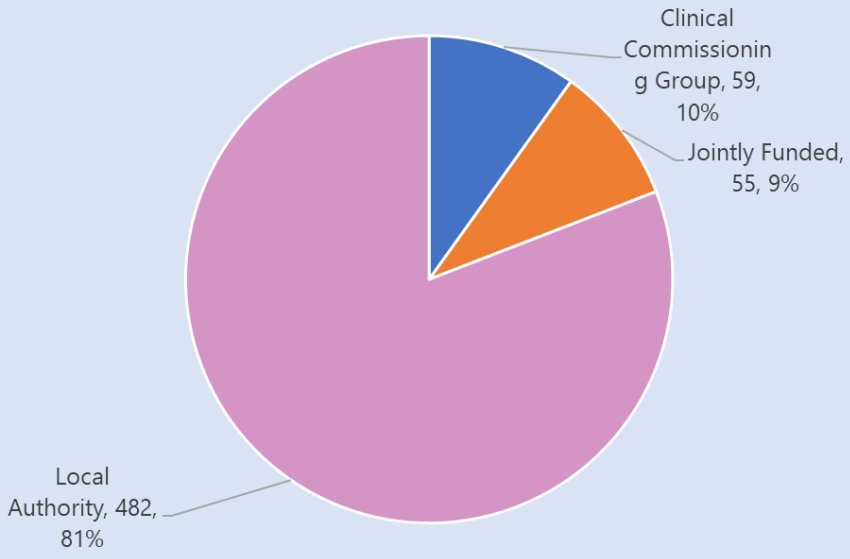
How many returns were received?

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



Who is funding the placements?

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

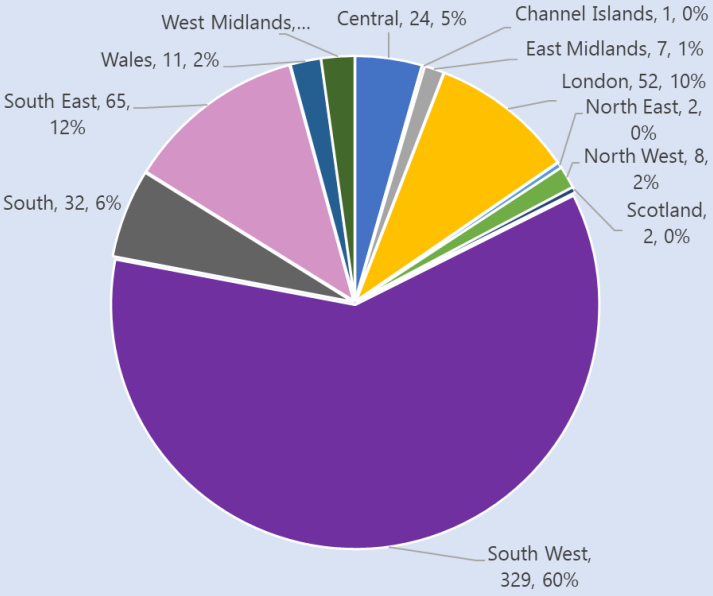


Of the 55 placements that were jointly funded, 12 of these were funded by another local authority and NHS Somerset CCG. The usual reason for this happening is when someone is placed in to an area and then develops health needs afterwards.

Where are people placed by Local Authorities from?

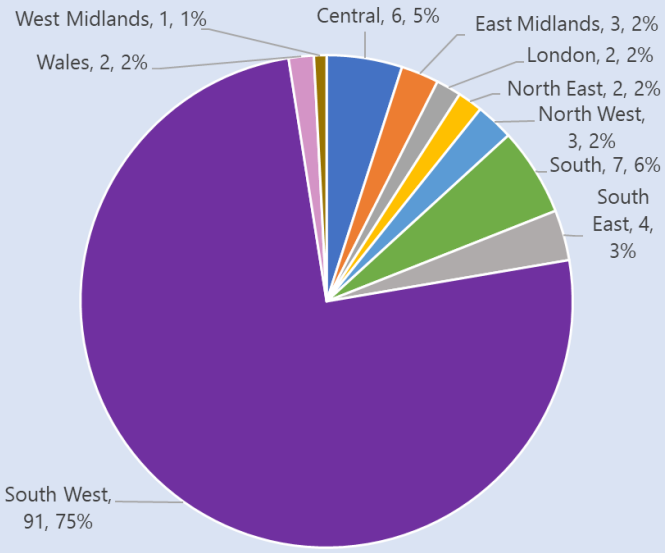
Although most people placed in to Somerset were placed by other Local Authorities in the South West region, 213 were placed from outside the region.

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



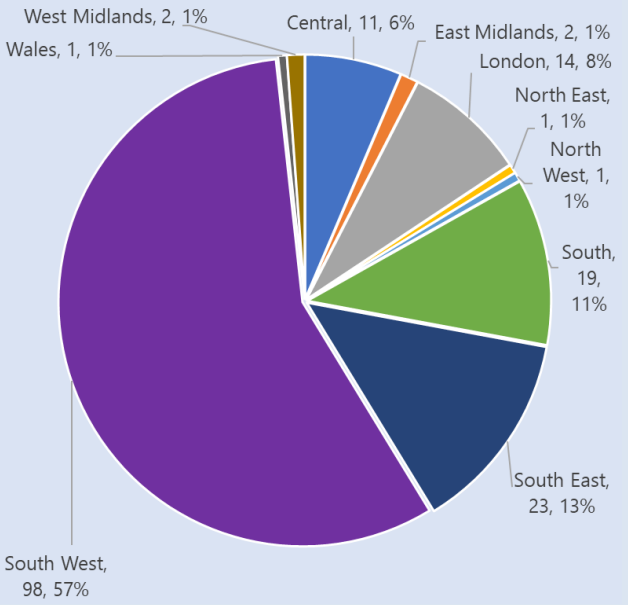
Where are people placed by Clinical Commissioning Groups from?

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



Are placements made by other Local Authorities being reviewed?

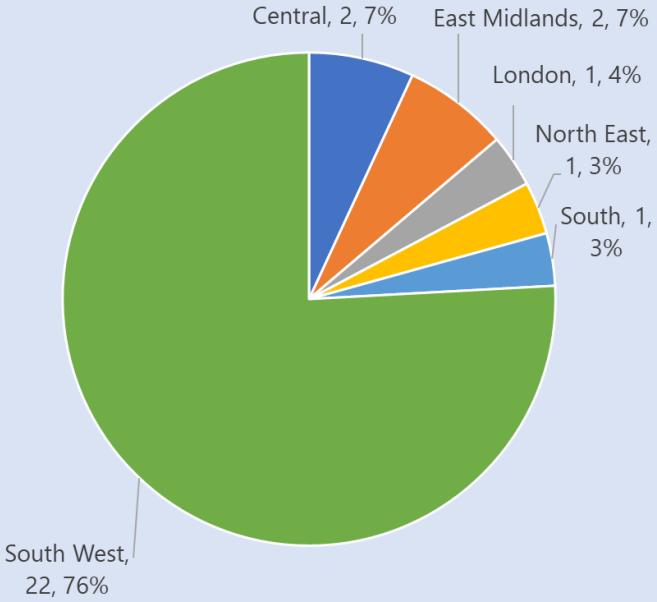
Providers told us that 73 (13.5%) of people who had been placed for more than 2 years had either not been reviewed at all or had not been reviewed within the last 2 years.



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

Are placements made by Clinical Commissioning Groups being reviewed?

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



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

Case Study

Joanne is an 18 year old woman who made contact with Somerset County Council's Safeguarding Service alleging domestic abuse against her father.

Staff from Somerset County Council's Adult Social Care and Safeguarding Services worked with Joanne who said that she wanted to:

- Move out
- Change her name
- Still have a relationship with her family
- Get a job/ go onto further education

The member of staff from Somerset County Council's Adult Social Care Service supported Joanne to contact the police, complete a Domestic Abuse Risk Assessment (DASH) and go to a Multi-Agency Risk Assessment Conference.

The member of staff from Somerset County Council's Safeguarding Service met with Joanne to:

- Improve her confidence
- Look at how she could keep herself safe through a protection plan
- Look at how she could change her name
- Support her to plan for her future

Outcomes achieved:

- Joanne's name was changed
- Joanne will be moving to a different county soon where she has secured a job on her own merits. The company are aware of her history and are giving her coaching and counselling

Joanne has said that she was very happy with the support both members of staff gave to her and her feedback was given through a voiceover at Somerset County Council's Adult Social Care Conference in in June 2019.

7. Our priorities 2019/20

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. **Listening and learning**
   - Safeguarding is person-led, outcome-focused, enhances involvement, choice and control, and improves quality of life, wellbeing and safety
   - We use learning to enhance practice across the system in Somerset
   - We learn from when things go wrong, both in Somerset and elsewhere, and take appropriate action to reduce risk
2. **Enabling people to keep themselves safe:**
   - People are aware of what abuse is and how to keep themselves and those that they care for safe
   - People know what to do if they think that they are experiencing abuse or neglect
3. **Working together to safeguard people who can't keep themselves safe:**
   - Organisations, including the third sector, work together to ensure that multi-agency arrangements are effective, and that people who are unable to keep themselves safe are supported in the least invasive way
   - Policy and guidance reflects best practice and takes a positive approach to risk
   - There is effective working across local, regional and national partnerships on areas of mutual interest
   - The number of inappropriate referrals is reduced through people raising other types of concern in an appropriate way
4. **Making sure we do what we said we would do:**
   - Somerset has an effective Safeguarding Adults Board which fulfils its statutory responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning

- The Board uses data appropriately to understand where risk exists within the system
- The Board can demonstrate progress through the regular monitoring of performance and a robust self-audit and peer challenge processes

You can read our 2019/20 Strategic Plan in full **here**

8. Board Budget

		2018/19	
SOURCE OF FUNDS		**CONTRIBUTIONS £**	**%**
SOMERSET COUNTY COUNCIL	- SAB MANAGER & CHAIR	49,056	65.4%
	- SAFEGUARDING ADULTS REVIEWS	0	0.0%
AVON & SOMERSET POLICE	- SAB MANAGER	15,900	21.2%
	- SAFEGUARDING ADULTS REVIEWS	0	0.0%
SOMERSET NHS CCG	- SAB MANAGER	10,000	13.3%
	- SAFEGUARDING ADULTS REVIEWS	0	0.0%
BGSW CRC LTD		0	0.0%
TOTAL CONTRIBUTIONS		**74,956**	**100.0%**
APPLICATION OF FUNDS		**EXPENDITURE £**	**%**
PAY			
SAFEGUARDING BOARD MANAGER		58,400	78.1%
INDEPENDENT CHAIR		16,100	21.5%
NON PAY			
SAFEGUARDING ADULTS REVIEWS		0	0.0%
SSAB ANNUAL CONFERENCE		60	0.1%
INSURANCE		60	0.1%
BT CHARGES/MOBILE CHARGES		196	0.3%
TOTAL EXPENDITURE		**74,816**	100.0%
ANNUAL OVERSPEND / (UNDERSPEND)		**(140)**	

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 2018/19

Avon and Somerset Constabulary

- The Constabulary's Safeguarding Co-ordination Unit and Lighthouse Victim and Witness Care Unit were combined into one Lighthouse Safeguarding Unit (LSU) in September 2018. This merge was in order to reduce duplication and create opportunities to increase resilience through more flexible arrangements. All police safeguarding referrals are sent to the LSU, who triage each one and share with partner agencies accordingly. The LSU also provides a single point of contact for victims qualified to receive their entitlements under the Victims Code of Practice (VCOP), and enables an assessment of their needs and a coordinated referral to specialist support services to help them to cope and recover.
- A 'soft launch' of the BRAG (Blue, Red, Amber, and Green) risk assessment process was introduced from October 2017 to April 2018. Following the establishment of the LSU in September 2018 the BRAG has become mandatory for attending officers to complete when vulnerability is identified. The BRAG supports officers to assess vulnerability when they attend incidents and enables effective information sharing with partner agencies for appropriate safeguarding interventions.
- The Constabulary continues to use a variety of applications from its data visualisation tool Qlik Sense. This enables us to identify repeat victims, patterns of offending and escalating risk and to provide an appropriate response/ intervention.
- An Adult Multi-Agency Safeguarding Hub (MASH) exists in Somerset and South Glos. and it will be rolled out to all Force areas in due course. The MASH process provides a platform for multi-agency discussion and intervention in relation to vulnerable adults who do not meet thresholds for Adult Social Care intervention.
- The Constabulary has finalised an Adults at Risk Plan which contains objectives for improvement activity aligned to our own Force Corporate Strategy, the National Vulnerability Action Plan, Making Safeguarding Personal and our Police and Crime Commissioner's priorities from the Police and Crime Plan.

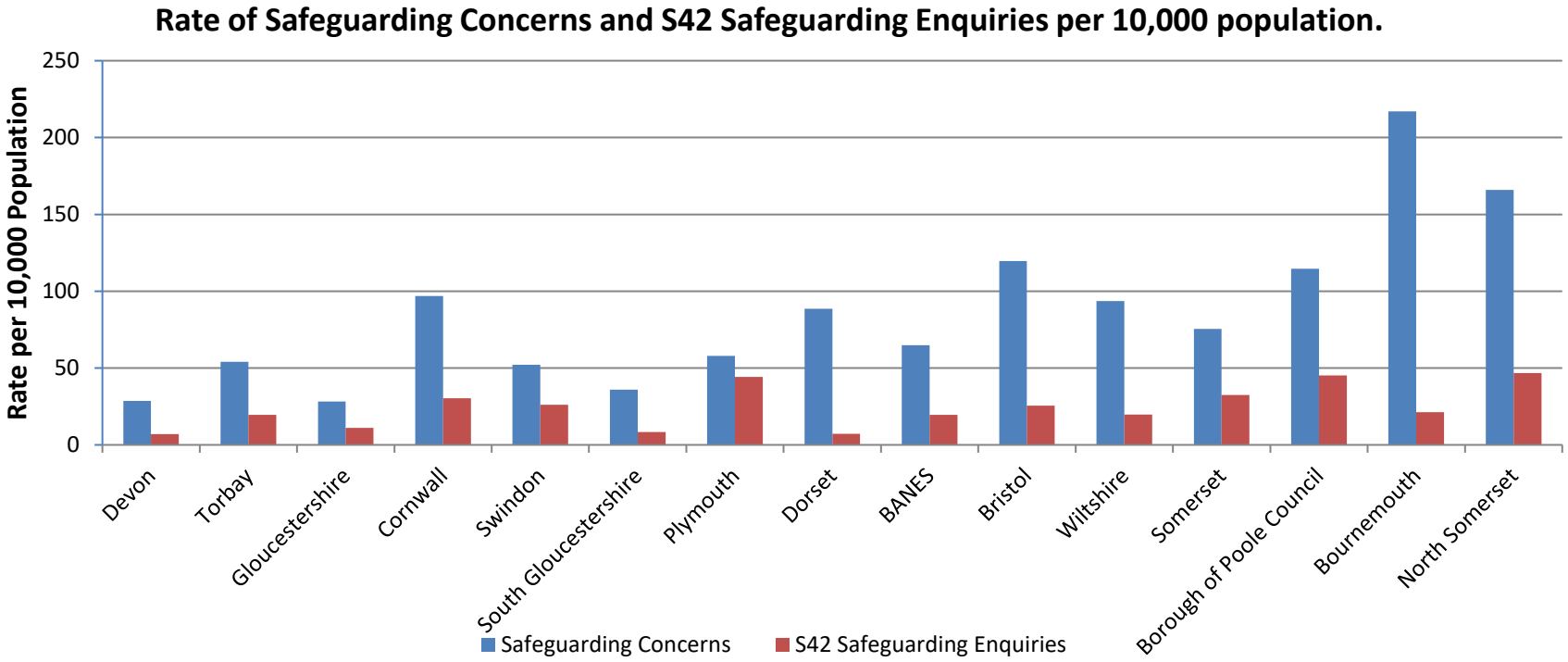
- We have established an Adults at Risk Working Group and have had two meetings this year. The Working Group is a vehicle for managing improvement activity and sharing learning across the Constabulary.
- The Constabulary has a dedicated page to Adults at Risk on our intranet created in December 2018. This is a useful 24/7 resource for officers and staff to support them in identifying vulnerability and providing an appropriate response, also containing links to relevant information.
- Since April 2018 the Constabulary has contributed to several Safeguarding Adult Reviews and has implemented some of the subsequent recommendations, however none which specifically relate to Somerset within this time period.

Somerset County Council

Our work during 2018/19

- The service has continued to receive a high demand of alerts, the majority of which stem from private care settings across Somerset. Our close liaison with Somerset Direct (the Local Authority's 'front door') has positively enhanced the experience that people receive when they first make contact with the Local Authority. As of March 2019, 60.5% of all contacts handled by Somerset Direct were resolved at this point. The safeguarding service is committed to upskilling and increasing the safeguarding awareness of the call advisors. This ensures that the response at our front door signposts the alert to the most appropriate service within Somerset County Council. Somerset Direct attend our recognising adult abuse training. They also have a direct consultation line to the safeguarding triage team and the service provides monthly peer supervision to continually drive up the safeguarding screening at the earliest opportunity.

- In March 2019, 60.9% of safeguarding alerts received were accepted as requiring a safeguarding response. SCC's conversion rate sits centrally in the south west comparison of data analysed during 2018:



- We continually measure our conversion performance as a means of monitoring our flow and managing the demand on the service. Regional and national benchmarking of 2017/18 data revealed that Somerset's conversion rate was 38% compared to a national average of 33% and a regional average of 28% for this same period of time. Our ambition during 2019/20 is to reduce the number of alerts received into the service that are not accepted as needing a safeguarding response. This will tell us that awareness of the Care Act eligibility across Somerset is good and that alerts, when received, provide us with the good quality information, at point of contact, to support a triage decision. Our continued engagement with the South West Safeguarding Network fosters stronger working alliances,

collaboration and learning through the experiences of other local authorities. Within the safeguarding adult field, Somerset are leading the way in terms of our adult safeguarding model of operating and the networks we have fostered.

- As a service we have held internal workshops covering themes of Making Safeguarding Personal (MSP), defensible decision making, practice and policy recording to ensure consistency is high, and quality is maintained, among the service. To provide governance and oversight of the standard of practice in the service we are continually undertaking quality assurance audits internally and as part of the SSAB's Quality Assurance subgroup to assess the effectiveness of the service. The service has benefited from continued professional development learning and conferences covering topics such as – mental capacity and sexual consent, MSP, defensible decision making, learning from south west safeguarding adult reviews alongside formal safeguarding training and conferences regionally and nationally. The difference these learning events have had on an individual's circumstances can be most effectively described by Jess, at the time a social worker in the service;

  Joan is a 93-year-old female. SCC have received a couple of alerts from Joan's bank concerned about the large volume of financial transactions made from her account over a 4 year period. When SCC met with Joan in the past she told us that she did not want to change the arrangement that she had with Sally, private carer, as for her the benefits of her company outweighed the financial cost of this 'care'; there was no reason to questions Joan's capacity to make this decision. So, when we received another alert from her bank, informing that Joan has made Sally a benefactor to her Will and POA I was allocated and decided to revisit the concerns in a different way. Thinking about the learning from the MSP and defensible decision-making workshop I changed how we had previously worked with Joan. Instead I spent time getting to know Joan to understand what was important in her life. It became apparent early on that Sally had made herself important in Joan's life. To the point that when Sally asked Joan to pay for a new car, clothing or some cash spends that Joan felt she was doing something to help out someone she had come to care for a great deal. One of the most influential approaches that I had with Joan was to ask her to 'show me'. This opened a discussion for her to show me how much money she had agreed to lend Sally. By going back through

Joan's bank statements with her I was able to add up how much money Joan had handed over to Sally. Taking a chronological view of her banking enabled Joan to see the impact of this. I firmly believe that Joan was groomed by Sally over a 4-year period, she had a police record and her actions to manipulate Joan were not trustworthy. In developing Joan's confidence, I have been able to support her to report Sally to the police. The police investigation found that Sally had taken nearly £250,000 over the course of 4 years from Joan. This experience has had a profound effect on Joan, she felt embarrassed and ashamed that she had been subject to abuse of this degree. The police investigation is ongoing.

- On the back of the South West Audit Partnership (SWAP) safeguarding report in May 2017, reviewed in April 2018, there has been a real drive for the remainder of 2018/19 to improve the standard and quality of the service that people can expect from the service. Our performance indicators for triage decision making and enquiry completion timescales has remained consistent throughout 2018/19, a real testament to all members in reaching outcomes with individuals.
- The Adult Social Care service introduced system wide practice quality conversations from April 2019, with safeguarding service being part of this wider consortium. The feedback from these reviews has been positive, as has the learning, to develop and further enhance the service delivered. 72% of all completed Adult Social Care audits achieved a 'high assurance' rating overall during 2018/19. The audits revealed particularly strong practice in relation to the involvement of service users and carers in our activity, and also in compliance with policy, legislation and recording practice. However, further work is necessary in enhancing our collective approach to goal and outcome-setting and in ensuring we always adopt a 'strengths-based approach' to our work.
- Applying the learning from these audits influenced the redesign of our safeguarding adult enquiry report, the new version now being widely used across Somerset. We also undertake enquiry reviews and audits as part of our service governance, this being a key performance indicator for us during 2019/20.
- During the autumn/winter of 2018/19, the adult safeguarding service engaged Healthwatch Somerset to undertake a project to review the way we capture the experiences, outcomes and feedback from the people we support and to

temperature check MSP implementation in the service. Healthwatch piloted a 'test and learn' questionnaire with a small sample of individuals. This pilot was so successful that we are committed to developing this work further and incorporating it into our safeguarding practice in the coming performance year as evidence of the personalised service we provide. This provided the service with some unexpected, but very welcome, feedback from the people who took part. https://spark.adobe.com/video/ADvlipSKAVx6G Our sincere thanks to Emily and the Healthwatch volunteers for supporting this important activity.

- Our links with the SSAB and the wider SSAB network is invaluable, having full representation on all SSAB groups, including the executive and sub groups, as committed members to implement change across the multi-agency safeguarding adult platform. We have actively participated in multi-agency peer audits of triage and enquiry standards, and been key members of the safeguarding adult reviews taking place in the county. Towards the end of 2018/19 the service was invited to join Devon County Council to provide peer review challenge on the audit part of the wider Local Government Ombudsman review. We are particularly supportive towards keeping the experience of people who have been supported central to the board members and we are very grateful to both Gavin and Rosemary for sharing their experiences with board members during 2018/19.
- Our multi-agency profile continues to develop strength. We actively support the following forums: MAPPA, MARAC, MASH, PREVENT Board, Safer Somerset Partnership Board and any domestic homicide reviews taking place in Somerset. We routinely triangulate and promote multi-agency learning within these forums to improve people's experience, to reduce abuse and to work preventatively across the county. A good example of this is our collaboration with Somerset Partnership NHS Foundation Trust and Avon & Somerset Police to review the impact of high intensity callers on agencies and implement multiagency risk management plans in response. During December 2018 the service provided intensive support to the rough sleeping project in Taunton Deane, the legacy of this accumulating in a multiagency workshop to enhance working together in partnership to prevent abuse and promote proportionate responses.

- During an annual appraisal with an adult social care worker, Sash, from the service, talked about working collaboratively with J, this is her experience:

  J was referred because of concerns of severe self-neglect. He was living in his late mother's bungalow and the property was soiled throughout with faeces and urine. There were lots of bottles filled with urine around his living space, rubbish and recycling piled very high, there were rats, there was structural damage to the ceiling of the property, there was no running hot water or heating as the boiler had broken. J was incontinent, and all of his clothes were soiled, the washing machine did not work therefore there was no way of cleaning his clothes. The kitchen was unusable due to all of the clutter and there were no clear routes throughout the property. J had mobility issues where he would furniture walk to mobilise throughout the property. Some days I found him crawling along the floor as he was unable to stand or mobilise. Added to this he drank a litre of Bacardi every other day and cans of lager throughout the day.
  He had no incoming money, he was living off his late mother's pension, but this was due to end as mother had passed away.
  J was socially isolated and had very little interaction with the community, he had no contact with his family. The only contact he had was with a local taxi firm who he would ring and ask them to get him alcohol, tobacco and a pizza from the takeaway shop. They would take his bank card, he would give them the pin number, they would withdraw the money he requested, buy his items and deliver them to him. He always had a running tab with the taxi firm. The taxi firm are the reason behind the safeguarding team becoming involved as they made the initial referral.
  In order to work towards minimising risks to him and achieving outcomes he wanted, myself and my locality lead made contact with multiple agencies to coordinate the approach. The agencies included; the mental health team, adult social care, GP, community agent, local vicar, FAB team, fire service, environmental health, deep cleaning agencies, benefits organisations such as universal credit and PIP, local care home and mental health hospital. This engagement led to mental capacity assessments being undertaken to assess J's understanding of his current living conditions and the associated risks. A Best Interest meeting was organised to discuss his options of care and

support, this decision now being referred to the Court of Protection. Having a multiagency approach with J ensured that his needs and lifestyle were viewed holistically and in a way that respected his right to take risks.

- As a service we are instrumental in ensuring that the Local Authority continues to commission and deliver exceptional safeguarding adult training to our workforce. During 2018/19, we commissioned and delivered the following training across Adult Social Care:

Course	Number of delegates
Recognising Adult Abuse (1/2 day)	66
Enquiry Skills Consolidation day only (4 dates c/f from 17/18) 2 day course only (4 dates - consolidation day counted in 2019/20)	 40 61
Leading Decision Making in Adult Safeguarding (2 day)	26
Mental Capacity Act (2 day)	46
Mental Capacity Act Legal and Practice Update (1 day)	61
Sexual Activity and Mental Capacity Act (1 day)	50
Self-Neglect vs Mental Health (1 day) – (safeguarding and MH only)	14
DoLS in Community Setting (for Best Interests Assessors only)	15
Financial Scamming (1 day)	19

- We welcome our trainers into the service for shadowing opportunities to experience how we work on the front line to enhance the delivery and relevance of training. Additionally, the service has taken responsibility for delivering awareness raising sessions across the county to upskill and inform teams of our learning and working model, both internal and external to the Local Authority. These have included Somerset Direct personnel, Adult social care teams, Avon and Somerset frontline Police Officers, Shared Lives carers, GP's, and private care providers. The service has supported the Registered Care Providers Association to deliver a successful provider action learning event to share the experiences of providers when working with adult safeguarding.
- Throughout 2018/19 the service has proactively engaged with care providers across Somerset to enhance people's safety. This work closely dovetails with our Quality Assurance team to ensure that regulated and non-regulated

services in Somerset consistently deliver high quality outcomes for the people they support and to act when the service falls short of our expectations. As a local authority we are particularly proud of the number of regulated providers within Somerset who have achieved good our outstanding in their CQC inspections. As of March 2019, 92.5% of Somerset's regulated settings were good or better, in comparison to 83.5% nationally. We routinely map service provider intelligence and take proactive steps to monitor and check unusual patterns of activity, or inactivity. This work is enhanced by our close working partnerships with the Care Quality Commission, Somerset Clinical Commissioning Group, Somerset Partnership NHS Foundation Trust and our care provider network. A key performance indicator for 2019/20 is our continued commitment to drive up quality and awareness to reach preventative levels with care providers. Our ethos being, people receiving care and support, whether in their own homes or provider settings, should be among the safest in Somerset, not the most vulnerable. To support this work, we continue to participate in quality improvement meetings, raising concern meetings and home closure processes alongside our quality assurance service and the CCG QA team. Janeann, a social worker in the service, shares her experience of working with individuals and her role in a highly charged emotional home closure in Somerset:

During my time spent in (setting) I was able to give the individuals and their families the care and respect they deserved in an environment where there were significant safeguarding concerns. I took the time to understand and listen to the views of residents and families. I became a protector, negotiator and mediator between residents, loved ones and the provision to ensure vulnerable residents were safeguarded and protected. For me listening to that person's journey is the starting point in me helping them to achieve the outcome that they feel is important for them. By applying a balanced perspective, I respected people's dignity and better understood their views on how they wished to be treated, fundamentally offering them the best safeguards.

The Service

- Over the course of 2018/19 the service has continued to flex its resource allocation to maintain a stable performance record whilst mitigating risk and managing the flow of alerts into the service.
- We were pleased to welcome Dave Partlow as our new Strategic Manager towards the end of 2018. Dave comes to us with 23 years of experience as an operational and consultant paramedic with South Western Ambulance Service NHS Foundation Trust, bringing his passion to deliver safe and effective services to the people of Somerset https://www.youtube.com/watch?v=CE5eIAgXpt0#action=share .
- This year we have successfully appointed 3 new safeguarding adult leads, meaning we now have a complement of 4 leads across the service. This has enabled us to strengthen the experience, capability and leadership from within the service. One of our 4 leads was appointed via our external recruitment campaign having served with Avon & Somerset Police for over 30 years https://youtu.be/GD7SgrGogl8 . We are now in the fortunate position to be able to drive through and achieve service ambitions during 2019/20.
- During 2018/19 we also welcomed 4 social work students to the service, 2 of which are supported via the Local Authority's career development pathway. Bringing students into the team can be challenging but the benefits far outweigh the negatives. Sam (right), is a student currently part way through a placement with us where we have seen her confidence grow with the learning experiences available on placement.

Sam Upham
Student Social Worker - Adult Safeguarding Team

What is your favourite thing about your job?
Meeting people. I love sitting down and talking to people about their lives.

What is the most rewarding thing about your job?
Sometimes people just want to talk so even if it means I made a difference for 5 minutes of the day, just knowing someone is happy having that interaction with me is lovely. The first thing someone told me when I started was 'make safeguarding personal'. We put everyone's thoughts, feelings and wishes into the decisions. Their life. Their decision.

Do you feel supported in your role?
Definitely! THe team I'm in are amazing - the people and the structure are great.

What 3 items would you save in a fire?
My Joules coat. Family photos. My dog Amber.

What is your favourite biscuit?
Oreos. We had a peer review group the other day in Safeguarding and someone made an Oreo cheesecake!

- Additionally, the service has been fortunate to appoint a newly qualified social worker into our workforce. Annabelle

completed her final placement with SCC knowing that her passion to work in the adult safeguarding field was her destination on qualifying. Annabelle shares her experience below. Annabelle's experience has been shared in our recruitment campaign so if you want to enjoy your role as much as Annabelle, follow this link to our Adult Social Care roles: https://www.socialcareandmore.co.uk/adults/

"I successfully completed my placement with SCC in July 2017. I had a fantastic placement, my learning journey was focussed, organised, supported, enriching and on reflection, it was a whole lot of fun! Sadly, when I qualified there were no positions with SCC, so I ventured to a different local authority. I learnt a lot with my first employer, however, I felt limited. The scope for creativity was clearly part of SCCs culture, which I couldn't help but crave. I returned to SCC as soon as a post became available and I can truly say that I have never looked forward to going to work before like I do now. Not just the team I work within, but the entire directorate are some of the most amazing, caring individuals I have ever had the pleasure of working with. SCC are so focussed on learning and development; the opportunities are endless! As well as the scope for creativity, I can confidently say that they are the best local authority I have had the privilege to represent"

- Whilst the service continues to carry some vacancies we are in a much stronger position moving into 2019/20.

Ambition for 2019/20

- Over the coming year we have great ambition to make Somerset a safer place to live and to support those in our communities who need our support to keep safe. We have a commitment to improve quality and the experience people can expect from the service. We will be undertaking targeted work with a variety of organisations, individuals and agencies across Somerset. Some of these partners include; trading standards, the fire service, south west ambulance service, micro-providers, taxi drivers, care home provisions and the royal mail to name a few.

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 reflects the safeguarding requirements of the Care Act 2014 and supports outcomes-focused, person-centred safeguarding practice through 'Making Safeguarding Personal' and 'Think Family'. The CCG has undertaken further work in 2018/19 to enhance the safeguarding data available as part of the assurance process. This has been achieved through the development of a safeguarding adults dashboard which provides a mechanism for highlighting areas of good practice and identifying any areas that need development. The dashboard was produced in partnership with the three trusts and includes information in relations to training compliance, along with information relating to the Mental Capacity Act, Deprivation of Liberty Safeguards and Prevent.
- A new job role of Designated Nurse for Safeguarding Adults commenced in December 2018 to support the CCG in delivering its statutory functions.
- The safeguarding function within the Continuing Healthcare (CHC) team has been augmented by1.5 whole time equivalents over 2018/19; including the introduction of a new post of deputy manager for safeguarding adults.
- Staff working in the CCG were supported to attend national safeguarding adults leadership events; provided by NHS England. This included an executive leadership event which was attended by the executive lead for safeguarding adults.
- 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. Going forwards, reporting will also be monitored for level 4 and those staff who have an executive role.
- Six GP safeguarding Adults Level 3 training were funded by the CCG and provided by Somerset Partnership to support General Practice. A further level three training session was provided by the CCG to Safeguarding Adult Leads in GP practices. This was held in conjunction with the safeguarding children's team. The CCG intends to undertake a training needs analysis of GP safeguarding adults training and implement a training plan on 2019/20 to support development of general practice.

- All Health Trusts are now required to report directly to NHS England on the percentage of staff trained on Prevent awareness and complied with the reporting requirements. The CCG has also provided support to the Channel panel.
- The CCG have been working with the three trusts and CHC team to prepare for the implementation of the Liberty Protection Safeguards (LPS) which is anticipated to replace the current Deprivation of Liberty Safeguards (DoLS). We funded three staff in the CHC team to undertake the qualification required to authorise a deprivation of liberty. We also included additional data reporting requirements in the Safeguarding Adults Dashboard to support the anticipated changes.
- The SSAB published a Safeguarding Adults Review in 2018 relating to the mis-treatment of residents at Mendip House. The CCG commissioned an independent review of its commissioning arrangements following disclosure of the allegations. The changes arising from the resulting action plan were embedded in 2018/19. This included an audit which provided assurance that Continuing Healthcare (CHC) assessors are recognising and responding to quality and safeguarding concerns when undertaking CHC assessments. A programme of undertaking additional quality monitoring visits for those people who are CHC funded that live in smaller services with which the CCG has limited contact is now well established. All people who are CHC funded and live in such a service have had a at least one quality monitoring visit over 2018/9.
- We have refreshed the Quality Assurance Framework that is used to monitor the quality of care given to CHC funded residents by private providers.
- We have worked collaboratively with our CHC providers and Adult Social Care to support care homes and domiciliary care services when there are concerns about the care.
- The CCG has contributed to the work of Somerset Safeguarding Adults Board as described in this annual report and chairs the policies and procedures subgroup. We also play an active part in the work of the Safeguarding Adult Review (SAR) sub group and have chaired both a SAR analysis meeting and a learning event for a case that did not require a full review during this year.
- Strengthened links with the Regional Quality Surveillance Group and SAB as a statutory lever to improve practice and help areas across partnership working.

- The CCG secured funding from a national Pathfinder fund to support quality improvement work in relation to Domestic Abuse and Violence in health settings across Somerset. The aim of this work, which will be undertaken in 2019/20, is to ensure that people who have contact with health services in Somerset receive a trauma informed response and that those with multiple disadvantages are recognised and able to access services effectively.

The CCG has set the following priorities for 2019/20:

- Supporting its providers to prepare for the implementation of the Liberty Protection Safeguards
- Develop a system wide Domestic Abuse and Violence health strategy across Somerset to ensure people who are experiencing Domestic Abuse and Violence receive an effective trauma informed response from health services; including those who may have multiple disadvantages
- Monitor the CCG and its partners progress against areas identified as needing improvement in the SAB self-audit
- A work programme to enable GP practices to ensure their staff are trained and competent in accordance with the Intercollegiate Document 'Adults and Safeguarding; Roles and Competencies for Health Care Staff (2018)
- Implement the additional safeguarding requirements in the 2019 and monitor compliance
- Relaunch of Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework and Commissioning Assurance Toolkit is expected in April 2019.

NHS England

Introduction

NHS England are focused on developing and maintaining strong safeguarding partnerships across health and social care to enhance the way we protect, support and improve the lives of those at risk in our local communities. We must always be thinking about the challenges that lie ahead.

The safeguarding agenda is continuously developing, in both its complexity and scope, our priorities must also evolve. With this focus we have identified our safeguarding priorities for 2019/20 at the end of this document.

NHS England and NHS Improvement remain committed to working with our multi-agency partners to ensure that the interests of those at risk inform our decision making and that health organisations not only meet their legislative obligations, they are also listening to the voices of communities as well as those caring for them both professionally and in a caring, voluntary capacity.

Penny Smith

Regional Head of Safeguarding - South West

Director of Nursing Leadership and Quality Improvement

NHS England and NHS Improvement – South West

NHS England and NHS Improvement Key Achievements:

- Annual conference held in September 2018, over 100 delegates from across the region attended. The focus of the day was exploitation and we welcomed a range of speakers with specialist knowledge in County Lines, Prevent, Domestic Abuse and Modern Slavery. Feedback from the delegates was very positive.
- Health Network developments across the South West. These networks brought Clinical Commissioning Group safeguarding leadership teams together to creating a community of practice and peer support. Key priorities for the network meetings were to review the challenges across their local areas, what priorities are evident to them and to support collaboration and successes in their safeguarding work, and opportunities for learning from each other's good practice.
- A safeguarding General Practice audit tool has been developed. Dorset have taken a lead on this work and this has received good feedback from General Practice participants.

- South West Prevent workshop in March 2019 was well attended by partners from North and South. Supported by guest speakers from the Home Office and Police, attendees had the opportunity to work through Prevent issues local to them and to hear the journey of restorative care and support provided by the Home Office. Further workshops are planned for 2019/20.
- South Region Named GP Safeguarding Forum - the initial forum was convened in March and brought contribution from partners across the South. A very well attended event with over 30 Named GPs present. Further plans include a South West/South East forum in 6 months and a further pan South event in March 2020. Feedback from the event was very positive.
- A South West South rapid improvement event in November brought health and care partners together to identify challenges and areas of improvement in discharge planning and transfer of care for children and young people. Partners identified areas of good practice and shared learning and collaborated across their local areas.
- NHS England South (South West) team supported Devon safeguarding multi-agency partners to create a short film to support General Practice safeguarding.
- The South West safeguarding team have worked in partnership with the NHS England and NHS Improvement National Safeguarding Team and local safeguarding partners to support the delivery of the national safeguarding priorities across the South West, and to support the networking of professionals across England to ensure sharing of best practice and learning from risks and issues.
- The South West safeguarding networks have worked with Primary Care to support the awareness of domestic abuse/violence.
- A strong focus on learning from cases both nationally and locally has been an ongoing theme in the work of the safeguarding networks. Learning from both child and adult reviews, has supported development of health and care systems across the South West.
- NHS England South (South West) team worked closely with local representative committees in Primary Care to raise the profile of safeguarding and identify any local or regional learning needs for Primary Care providers.

Healthwatch Somerset

- Healthwatch Somerset enable the views and experiences of people who use services to influence and improve the way that health and social care services are provided and run.
- In 2018 we worked with Somerset County Council Adult Safeguarding Team on a research project that's aim was to test and evaluate a method of service user engagement that could be embedded into the adult safeguarding referral process going forward. As a result of this, service user views will be captured following Adult Safeguarding contact by Somerset County Council staff via a telephone interview. The findings will be shared with the Somerset Safeguarding Adults Board on a regular basis and used to inform service improvements.
- 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.
- Healthwatch Somerset undertook one Enter and View visit this year to Able2Achieve in Yeovil. The findings from our visit can be seen at www.healthwatchsomerset.co.uk.
- Healthwatch Somerset uses staff and volunteers to speak to people about their experiences of health and social care. All staff and volunteers speaking to Adults at Risk is required to have attended Adult Safeguarding training and be DBS cleared.

Taunton and Somerset NHS Foundation Trust

- **We have worked with Somerset Partnership Foundation Trust to bring together our respective safeguarding services**. This new Integrated Safeguarding Service has amalgamated both adult and children's safeguarding across both organisations to create one seamless Safeguarding Service. This Safeguarding Service is supported by a staff structure that encompasses a wide range of

experience, skills and backgrounds, which has greatly improved the safeguarding support we can offer across both trusts.

- **Alignment of Safeguarding Training.** As part of our work with Somerset Partnership, we are developing a co-ordinated approach to training, which will enable us to launch the higher levels of safeguarding training required within the Trust.
- **The integration of the two trusts former safeguarding teams** has enabled the development of a new 'Mental Capacity Act, Deprivation of Liberty Safeguards and Consent lead' post. This post has been in place since October 2018 and provides face-to-face support for clinicians.
- **The development of the MCA/DoLs/Consent Lead** has enabled us to expand our Mental Capacity Act training in line with the Somerset Safeguarding Adults Board Mental Capacity Act Competency Framework. We continue to work towards developing MCA awareness and competencies throughout the Trust.
- **The new Domestic Abuse Co-ordinator post** came into fruition in October 2018 and has enabled us to provide greater support for victims of domestic abuse across both Trusts. This post sits within the integrated Safeguarding service.
- **We have aligned with the current national Pathfinder Project.** The Project has provided the funding of two post for the 12 months period of the Project. These posts were recruited to in April 2019 and consists of a Complex Needs Independence Domestic Violence Provider (IDVA) and a Pathfinder Project Lead. These posts will greatly enhance the profile of domestic abuse awareness and support across both Trusts.
- **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 was launched in 2018.
- **We continue to play 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**, the learning from which we disseminate to Trust staff.

- **The Joint Safeguarding Committee (**new Governance arrangements) has replaced the previous Safeguarding Governance Groups for Taunton & Somerset and Somerset Partnership. The Joint Safeguarding Committee holds us to account with regards to our duties and responsibilities regarding all areas of Safeguarding including our Safeguarding Plan, Policy review and development, and ensures that we are compliant with SSAB policy, learning and guidance
- **Our collaborative working with external Safeguarding Agencies** has increased since the integration of the two Safeguarding teams. Through the Integrated Safeguarding Service we are able to be an active member of the weekly adult MASH meetings held between ourselves, Adult Social Care and the Police.
- **We have continued close collaborative working with external agencies** such as the Police, Somerset County Council safeguarding colleagues and the CCG.
- **We have revised the Safeguarding Adults at Risk Policy** for Sompar and Taunton and Somerset Trusts and have unified and updated them in to one overarching Policy for both Trusts. This will ensure continuity of Safeguarding Adult processes, practices, guidance and advice.

Yeovil Hospital NHS Foundation Trust

Board Effectiveness

- The Trust safeguarding committee meets quarterly and is chaired by the Associate Director Quality Governance and Safeguarding. The trust safeguarding team attend this meeting and contribute to the agenda. The standing agenda consists of:
    - Review of key performance indicators,
    - Learning (from incidents, serious case reviews) to prevent reoccurrence,
    - Children and adult safeguarding updates,
    - Prevent,
    - Mental Capacity and Deprivation of Liberty.

- To further promote the effectiveness of the safeguarding committee an operational group has been formed with staff members from varying departments attending.
- The trust is represented at Adult Safeguarding Board by the Associate Director Quality Governance and Safeguarding, and the subgroups are attended by the Head of Safeguarding or designated deputies.

Prevention

- As an organisation we continue to support the multiagency training across the county and contribute to the training strategy development for the Somerset Safeguarding Adults Board.
- Identification and reporting of safeguarding issues has continued to increase in the number of alerts and referrals being reported internally (315 during this reporting period an increase of 5% on the previous reporting period). This reflects the consistent raised awareness within the organisation regarding individual staff responsibility for safeguarding the vulnerable individual.
- The safeguarding team remain responsible for the delivery of trust mandatory training to all trust staff. This training programme meets level 2 training requirement and is a combined adult and child safeguarding training session.
- As part of the level 3 modular training programme the safeguarding team provides 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.
- The trust recognises the recommendations made in the intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff. (First edition: August 2018) and are undertaking a review of identified staff groups and their training requirements.
- The Trust Health IDVA has continued the work to consolidate the trust quality of response for Domestic Violence and Abuse, Sexual Violence and Honour Based Violence. Identified departments (e.g. Emergency Department, Midwifery) have been in receipt of a targeted training programme to enhance their professional response to these issues. The IDVA works in partnership with the Children Safeguarding Practitioner where there are cases where children have been

identified within the family to ensure a coordinated response further promoting the 'Think Family' approach to safeguarding. There has been a sustained number of reported cases (98 during this reporting period), with a number of these cases relating to the elderly population.

- Although we have an integrated team we have identified safeguarding professionals for adults and children with the necessary experience and expertise to be able to respond appropriately to the needs of vulnerable individuals.

Making Safeguarding Personal

- The Learning Disability Practitioner has maintained links with carers and agencies and has become a fundamental part of the 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. Referrals from local providers have been invaluable in being able to identify people with learning disability who are coming into or already in this hospital. There has been an 8.8% increase in these referrals on the previous reporting year. Local authority Learning Disability teams (Somerset and Dorset) contact the service to request support with complex patients who require "Reasonable Adjustments" to enable them to access the Hospital services and have a patient journey that meets their own individual needs. This has in some cases required visiting patients in the community in their home setting (with medical practitioners) to build rapport and identifying the barriers that prevent the individual from accessing the hospital. Bespoke training has been given to different staff groups on request (such as Physiotherapists). The support and guidance that is currently offered by the Learning Disability Practitioner is becoming increasingly utilised by Learning Disability providers, Social workers and Community based Learning Disability nurses who are working towards better outcomes for patients who access hospital services.
- The Safeguarding team actively responded to serious case reviews, section 42 requests where safeguarding concerns have been identified. In this reporting period we have responded to 16 section 42 enquiries from Somerset and Dorset local authorities.
- The safeguarding training programme continues to provide an integrated approach to safeguarding awareness and making it personal for the vulnerable individual.

Think Family

- The organisation continues to support the Safeguarding Boards 'Think Family' approach and this is reflected in the amalgamated safeguarding team approach to referrals

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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. This has included an ongoing series of Action Learning Sets focusing on safeguarding investigations experienced by providers. With input from the Council's adult safeguarding lead, these have been valuable in supporting learning and development in practice'

LiveWest

- 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.
- Our former safeguarding lead is now acting as a consultant providing training and support to staff in dealing with more complex cases, DHR's and SCR's. This is to provide a focussed service.
- 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 reviewed annually.
- We have a safeguarding leads group which reports in to the health and safety group, to review cases and identify learning and also check our procedures and training are working.

Golden Lane Housing

- In February this year, Golden Lane Housing launched our campaign on "It Matters" our safeguarding approach within our organisation and to our tenants: https://www.glh.org.uk/about/it-matters/
- Our tenants were involved in producing the final document "It Matters How we help to keep you safe".
- The standards aim to set a minimum level of practice consistent with operating a safe organisation for everyone involved:
  - We have robust policies and procedures in place which help us to keep our tenants safe from harm and abuse and enables our staff to know what to do if they have any concerns.
  - All staff, at all levels, throughout the organisation are inducted and trained in safeguarding vulnerable people and know that it is their responsibility to report any concerns they may have about a tenant or another member of staff.
  - All front-line staff receive additional training in helping to identify possible indicators of abuse.
  - All front-line staff receive regular supervisions where safeguarding cases are discussed and reviewed.

- If a safeguarding concern is raised by a member of staff we will notify the local authority and work collaboratively with other external agencies accordingly such as the police.
- We are committed to acting promptly, responsibly and sensitively when safeguarding issues arise, working with the individual at risk, the relevant organisations and where appropriate, families, throughout the process.
- Information regarding safeguarding cases and alerts raised to the local authority is stored securely and in line with General Data Protection Regulation guidance.
- We are a member of Mencap's Safeguarding Panel which includes staff from across the organisation and has an independent chair. The panel oversees our responsibilities.

Somerset Partnership NHS Foundation Trust

- **We have worked with Somerset Partnership Foundation Trust to bring together our respective safeguarding services**. This new Integrated Safeguarding Service has amalgamated both adult and children's safeguarding across both organisations to create one seamless Safeguarding Service. This Safeguarding Service is supported by a staff structure that encompasses a wide range of experience, skills and backgrounds, which has greatly improved the safeguarding support we can offer across both trusts.
- **Alignment of Safeguarding Training.** As part of our work with Somerset Partnership, we are developing a co-ordinated approach to training, which will enable us to launch the higher levels of safeguarding training required within the Trust.
- **The integration of the two trusts former safeguarding teams** has enabled the development of a new 'Mental Capacity Act, Deprivation of Liberty Safeguards and Consent lead' post. This post has been in place since October 2018 and provides face-to-face support for clinicians.

- **The development of the MCA/DoLs/Consent Lead** has enabled us to expand our Mental Capacity Act training in line with the Somerset Safeguarding Adults Board Mental Capacity Act Competency Framework. We continue to work towards developing MCA awareness and competencies throughout the Trust.
- **The new Domestic Abuse Co-ordinator post** came into fruition in October 2018 and has enabled us to provide greater support for victims of domestic abuse across both Trusts. This post sits within the integrated Safeguarding service.
- **We have aligned with the current national Pathfinder Project.** The Project has provided the funding of two post for the 12 months period of the Project. These posts were recruited to in April 2019 and consists of a Complex Needs Independence Domestic Violence Provider (IDVA) and a Pathfinder Project Lead. These posts will greatly enhance the profile of domestic abuse awareness and support across both Trusts.
- **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 was launched in 2018.
- **We continue to play 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**, the learning from which we disseminate to Trust staff.
- **The Joint Safeguarding Committee (**new Governance arrangements) has replaced the previous Safeguarding Governance Groups for Taunton & Somerset and Somerset Partnership. The Joint Safeguarding Committee holds us to account with regards to our duties and responsibilities regarding all areas of Safeguarding including our Safeguarding Plan, Policy review and development, and ensures that we are compliant with SSAB policy, learning and guidance
- **Our collaborative working with external Safeguarding Agencies** has increased since the integration of the two Safeguarding teams. Through the Integrated Safeguarding Service we are able to be an active member of the weekly adult MASH meetings held between ourselves, Adult Social Care and the Police.

- **We have continued close collaborative working with external agencies** such as the Police, Somerset County Council safeguarding colleagues and the CCG.
- **We have revised the Safeguarding Adults at Risk Policy** for Sompar and Taunton and Somerset Trusts and have unified and updated them in to one overarching Policy for both Trusts. This will ensure continuity of Safeguarding Adult processes, practices, guidance and advice.

South Western Ambulance Service NHS Foundation Trust

- SWASFT has responsibility for the provision of ambulance services across an area of 10,000 square miles which is 20% of mainland England. The Trust covers the local authority regions of Bath & Northeast Somerset, Bournemouth, Bristol, City of Plymouth, Cornwall and the Isles of Scilly, Devon, Dorset, Gloucestershire, North Somerset, Poole, Somerset, South Gloucestershire, Swindon, Torbay, and Wiltshire.
- The Trust employs over 4,000 mainly clinical and operational staff (including Paramedics, Emergency Care Practitioners, Advanced Technicians, Ambulance Care Assistants and Nurse Practitioners) plus GPs and around 2,800 volunteers (including community first responders, BASICS doctors and fire co-responders).
- During 2018/19 the Trust's safeguarding team was restructured to improve efficiency and accessibility. The primary change was the introduction of the Safeguarding Business Manager. The purpose of this new role is to provide a single point of contact for external partner agencies.
- There is a clear line of accountability through the Safeguarding Service to the Board of Directors:
  - The Named Professionals report to the Head of Safeguarding.
  - The Head of Safeguarding reports to the Deputy Director of Nursing and Quality.

  - The Deputy Director of Nursing and Quality reports to the Executive Director of Nursing and Quality who is a member of the Board of Directors.
- (this reporting line is due to change in June 2019 following an internal restructure and formation of a new Quality and Clinical Directorate)
- The Safeguarding Service publishes policies, strategies and procedures which Trust staff and agents must follow. New versions of policies and procedures are reviewed and approved at the Trust's Clinical Effectiveness Committee and ratified at the Trust's Quality Committee. All publications are available to staff through the Trust's intranet along with a number of safeguarding information and guidance bulletins. Some guidance is also embedded on the electronic patient care record devices (ePCR) used by frontline staff.
- It is recognised that most frontline ambulance clinicians do not undertake case-management of patients and therefore may not be exposed to sufficient safeguarding activity to develop specialist expertise during their career. The Safeguarding Services' team of professionals maintains a high level of competency in order to provide specialist support to staff.
- The safeguarding office at Trust headquarters has a primary contact telephone which is staffed during all business working hours and provides a Safeguarding Helpline for staff. The mobile telephone numbers for the Head of Safeguarding and Named Professionals are widely published on the staff intranet, noticeboards and electronic devices.
- During 2018/19 the Safeguarding Service managed 325 calls for advice from staff. This was increase of 18% compare to the previous year. This may be related to the introduction of the Safeguarding Helpline.
- During 2018/19 the Trust generated 19750 safeguarding referrals for both adults and children from approximately 1.5 million contacts with patients across emergency and urgent care services. This represents a significant increase of 33% compared to the previous year. The reason for the increase appears multi-factorial and might include an increase in staff knowledge through local training, an increase in national awareness through the media and a decrease in volume of social care services being provided by other partners. Partner agencies such as other ambulance trusts report similar increases.

- The largest theme for adults is concern about the care package in place for patients. This will often be older patients or those with a disability. Whilst many of these concerns will not reach a threshold for safeguarding with the Local Authority, the Trust recognises the value of raising concern at an early stage. Self-neglect is the most significant safeguarding concern in adults which is coherent with intelligence being shared by partner agencies.
- The Trust is subject to external scrutiny through the regulatory function of the Care Quality Commission. In addition, the Safeguarding Service voluntarily utilises occasional local scrutiny panels provided by Local Safeguarding Boards to benchmark performance.
- The Trust is aligned to 28 Local Safeguarding Adults and Children Boards / Partnership within its geographical area of operations. The Safeguarding Service endeavours to maintain relationships with all of these organisations. It is not logistically possible to attend all board and sub-group meetings. Instead, the Head of Safeguarding and Named Professionals attend a representative selection of meetings to ensure that the Trust gains exposure to as wide a range of perspectives as possible. Information from these meetings is used to inform service development and Trust policies.

Department for Work and Pensions

Department for Work & Pensions

- All front-line staff were asked to complete on-line training in Safeguarding as a mandatory exercise in the 2018/19 Operational year. It will become part of the induction process for new staff and will be reviewed annually by existing staff.
- All front-line Jobcentres staff in Somerset staff have been informed of the Somerset Safeguarding referral process and the number to call to discuss any concerns. Best practice is to put the referral icon onto desktops for easy access
- Staff have had Safeguarding presentations around the issue, to allow questions to be asked and to consolidate training.

- We now have 'Complex Needs' plans for each JCP site, which not only holds safeguarding advice but also local contacts that staff can use to signpost or contact supportive organisations for our more vulnerable customers.
- DWP is now represented on Somerset's Adult Safeguarding Board.
- DWP attended the Somerset Safeguarding annual event in 2019.
- DWP have introduced named contacts for external organisations/partners to raise concerns with, at each JCP site. These are distributed to all partners and regularly updated.

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 Discovery 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 place great importance in transparency and sharing the learning from our work, to assist others, this includes feedback from our annual safeguarding summit and Never Event protocols.

The Care Quality Commission

Our purpose and role

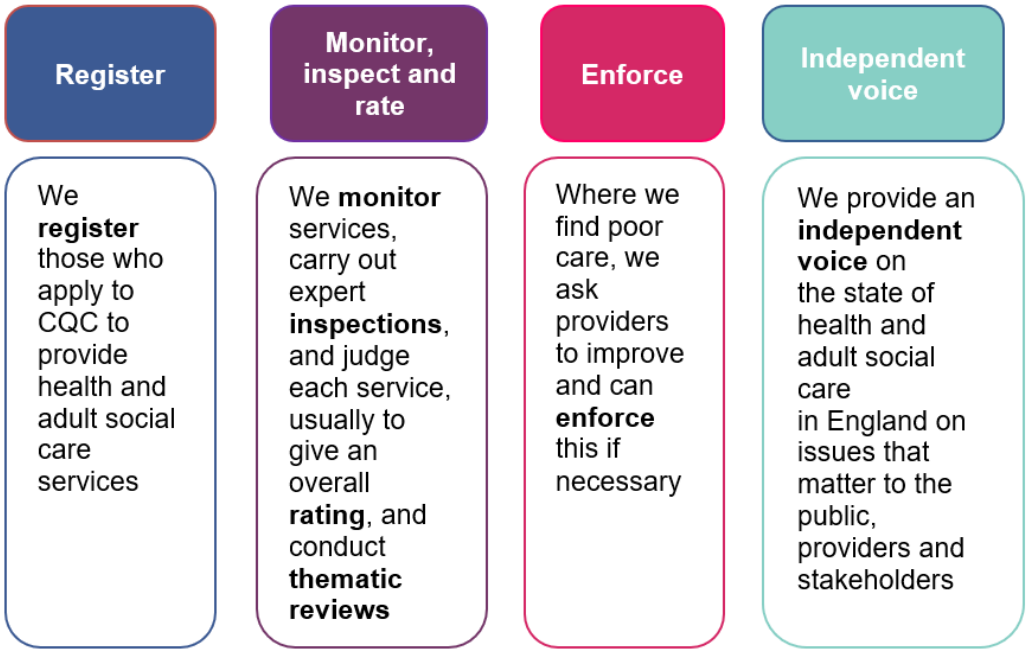
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our function is to:

- Register
- Monitor and inspect
- Use legal powers
- Speak independently
- Encourage improvement

People have a right to expect safe, good care from their health and social care services.

Our current model of regulation



Four priorities to achieve our strategic ambition

1. Encourage improvement, innovation and sustainability in care – we will work with others to support improvement, adapt our approach as new care models develop, and publish new ratings of NHS trusts' and foundation trusts' use of resources.
2. Deliver an intelligence-driven approach to regulation – we will use our information more effectively to target our resources where the risk to the quality of care provided is greatest and to check where quality is improving, and we will introduce a more proportionate approach to registration.

3. Promote a single shared view of quality – we will work with others to agree a consistent approach to defining and measuring quality, collecting information from providers, and working together towards a single vision of high-quality care.
4. Improve our efficiency and effectiveness – we will work more efficiently, achieving savings each year, and improving how we work with the public and providers.

CQC State of Care Report 2017/18

State of Care is our annual assessment of health and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve.

This year's report finds that most people in England receive a good quality of care. Our ratings show that quality overall has been largely maintained from last year, and in some cases improved, despite the continuing challenges that providers face.
Some people told us about the outstanding care they have received and how some individual services have changed their lives for the better. Others told us about the poor and sometimes disjointed care they have received.
We found that people's experiences of care often depend on how well local systems work together where they live. Some people can easily access good care, while others cannot get the support they need. They may experience disjointed care, or only have access to providers with poor services.
This builds on what we saw in Beyond barriers, our report looking at how services work together to support and care for people aged 65 and over.

5 factors affecting the sustainability of good care

The challenge for all local health and social care services is to recognise the needs of their local populations and find sustainable solutions that put people first. In this context, we have considered 5 factors that affect the sustainability of good care for people:

Access: Access to care varies from place to place across the country. Some people cannot access the services they need, or their only reasonable access is to providers with poor services.

Quality: The overall quality of care in the major health and care sectors has improved slightly. At the same time, too many people are getting care that is not good enough.

The safety of people who use health and social care services remains our biggest concern.

There were improvements in safety in adult social care services and among GP practices. But while there were also small safety improvements in NHS acute hospitals, too many need to do better. NHS mental health services also need to improve substantially.

Workforce: Workforce problems have a direct impact on people's care. Getting the right workforce is crucial in ensuring services can improve and provide high-quality, person-centred care. Each sector has its own workforce challenges, and many are struggling to recruit, retain and develop their staff to meet the needs of the people they care for.

Demand and capacity: Demand is rising, not only from an ageing population but from the increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia. Providers face the challenge of finding the right capacity to meet people's needs. Services need to plan – together – to meet the predicted needs of their local populations, as well planning for extremes of demand, such as sickness during winter and the impact this has on the system.

Funding and commissioning: Care providers need to be able to plan provision of services for populations with the right resources, so good funding and commissioning structures and decision-making should be in place to help boost the ability of health and social care services to improve.

Funding challenges of recent years are well known, and in June 2018 the government announced an extra £20.5 billion funding for the NHS by 2023/24. However, at the time of publication, there is no similar long-term funding solution for adult social care.

See full report here https://www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf

These profiles give a picture of the health and social care system in each local authority area. They bring together data to give an indication of how different services work together. https://www.cqc.org.uk/publications/themes-care/local-authority-area-data-profiles.

CQC's role and responsibilities in safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.
It's fundamental to high-quality health and social care.

Safeguarding is a key priority for CQC and people who use services are at the heart of what we do. Our work to help safeguard children and adults reflects both our focus on human rights and the requirement within the Health and Social Care Act 2008 and to have regard to the need to protect and promote the rights of people who use health and social care services.

Our role and responsibilities are:

To monitor, inspect and regulate services to make sure they meet the fundamental standards of quality and safety.

For safeguarding, we will do this by:

- Checking that care providers have effective systems and processes to help keep children and adults safe from abuse and neglect.
- Using Intelligent Monitoring of information we receive about safeguarding (intelligence, information and indicators) to assess risks to adults and children using services and to make sure the right people act at the right time to help keep them safe.
- Intelligent monitoring is how we describe the processes we use to gather and analyse information about services. This information helps us to decide when, where and what to inspect. By gathering and using the right information, we can make better use of our resources by targeting activity where it is most needed.
- We have always used the important information in statutory notifications in this way, alongside other information about safeguarding and information provided by others such as people who use services, their families and the public.
- Acting promptly on safeguarding issues we discover during inspections, raising them with the provider and, if necessary, making safeguarding referrals to the local authority and the police where appropriate.
- Holding providers to account by taking regulatory and enforcement action to ensure that they rectify any shortfalls in their arrangements to safeguard children and adults and that that they maintain improvements.

There is more information about our role and approach to safeguarding here where there is our Inspector handbook for Safeguarding and the CQC Statement on our role and responsibilities in safeguarding people http://www.cqc.org.uk/what-we-do/how-we-do-our-job/safeguarding-people

Somerset – CQC Sector data

Number of active locations, with ratings and where the CQC has taken regulatory action.

Source: CQC database as at 31 May 2019.

Number of active registered locations in Somerset

Location Inspection Directorate	Number of Active Locations
Adult social care	298
Hospitals	56
Primary medical services	162
Total	**516**

Number of active locations in Somerset and overall ratings, comparison with region and national ratings

	Number of Active Locations with Latest Overall Ratings				Total Number of Active Locations with Latest Overall Rating
Location Inspectorate	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**	
Somerset					
Adult social care	17	242	21		**280**
Hospitals	2	7	1		**10**
Primary medical services	2	56	5		**63**
Somerset Total	**21**	**305**	**27**		**353**
South West					
Adult social care	178	2,278	354	31	**2,841**
Hospitals	14	86	28	1	**129**
Primary medical services	52	519	19		**590**
South West Total	**244**	**2,883**	**401**	**32**	**3,560**
National					
Adult social care	840	18,323	3,369	282	**22,814**
Hospitals	140	871	285	32	**1,328**
Primary medical services	321	6,192	283	78	**6,874**
National Total	**1301**	**25,386**	**3937**	**392**	**31016**

CQC Regulatory action in Somerset

Number of Active Locations in Somerset Local Authority with Regulatory Actions										Total Number of Active Locations with Regulatory Actions
Location Inspection Directorate	**Cancellation of Registration**	**Compliance action**	**Impose a condition**	**Recommend Fixed Penalty**	**Requirement notice**	**Urgent imposing condition**	**Urgent variation of condition**	**Vary a condition**	**Warning notice**	
Adult social care	1	72	2	1	53			3	14	**106**
Hospitals		5			6					**10**
Primary medical services		18	1		27				2	**43**
Total	**1**	**95**	**3**	**1**	**86**			**3**	**16**	**159**

Devon, Somerset & Torbay Trading Standards Service

- Devon, Somerset & Torbay Trading Standards Service are relatively new to working with the board but are delighted to be one of the partner agencies. Providing advice and education regarding scams and rogue traders is one our key priority areas.

- We attend the board meetings which give us access to a number of different agencies we can liaise with to spread the word in our mission
- We share information on latest scams to be aware of
- We have provided advice and resources to pass onto vulnerable adults and offered to give talks to relevant groups of people to educate on the dangers of scams and how to avoid them
- We are also happy to accept direct referrals from any Somerset residents who have been affected by scams and can provide home visits and support
- We recently attended the annual conference and carried out an informative session to attendees where we also established further contacts to work with going forward

District Councils

- 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 worked with our councillors to help them understand their role in the community and what they can do to help safeguard adults who may be vulnerable.
- 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 know that we create better outcomes when we collaborate as partners and are using our One Team models to ensure that the support to safeguard vulnerable people continues to evolve and improve outcomes.

- We have continued to deliver the Positive Lives Programme, with partners, to support vulnerable adults with complex needs to gain stable, safe accommodation and have now begun to integrate this alongside the new Step Together commission to ensure that our residents in greatest need get the support that will help them reduce their vulnerability.
- We continue to work collectively, as the District Council Safeguarding Group, with representatives of SSAB to learn from each other and from activities across the country. We know that by sharing resources and learning we can provide more effective safeguarding for vulnerable adults in Somerset, particularly as many of these adults move across our boundaries regularly.
- We have worked with Avon and Somerset Constabulary to address the safeguarding of vulnerable adults from criminal gangs and their activities.
- We recognise the impact of Cuckooing and County Lines in our neighbourhoods and are working with partners to address the impact of these on vulnerable people in the county.
- 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 continued to support the PREVENT agenda to help stop vulnerable adults from being drawn into terrorism and harm.
- We recognise that the safeguarding environment is continually evolving and as a consequence we have continued to review our safeguarding policies and, where appropriate, updated them to address new issues as they arise.
- We have developed a strong relationship with our registered social housing providers, using a forum to enable them 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 Adult Social Care: adults@somerset.gov.uk**
- **In an emergency always contact the police by dialling 999.**
- **If it is not an emergency, 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 alwavs deal with anv calls in the strictest confidence