Annual Report

2020-21

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 2020/21;
- 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'

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.

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: Empowerment, Prevention Proportionality, Protection, Partnership and Accountability. Read further information about the six safeguarding principles.

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, Domestic violence, Sexual abuse, Psychological abuse, Financial or material abuse, Discriminatory abuse, Organisational abuse, Neglect and acts of omission and Self-neglect. Read further information on the signs, symptoms and indicators of each type of abuse

2. Foreword

Keith Perkin, Independent Chair – Somerset Safeguarding Adults Board

In my first foreword for the 2019/2020 annual report, I wrote that the coronavirus pandemic will remain as an influencing factor for the foreseeable future in protecting people who are at risk of abuse and neglect. The challenges that faced colleagues during a protracted time when we were constrained in our activity continue, and in many cases exacerbated as we now move into a period of greater freedom. However, what remains is the passion, professionalism and dedication within Somerset to safeguard those adults who need our help. During our Board meetings throughout the year, it was both a privilege and humbling to hear the experiences of those who are directly involved in providing that support to vulnerable adults. It certainly provided a valuable insight into not only the challenges faced, but how colleagues quickly adapted to new ways of working, both within their own agency and in partnership.

One of the statutory responsibilities for Safeguarding Adult Boards is to commission and publish reviews into people who die or are seriously harmed through abuse or neglect. This year the SSAB published 2 Safeguarding Adult Reviews, and more detail into these reviews are included in this report. I am pleased that the Board has put into place mechanisms to ensure the learning from these reviews are implemented. Every death in such circumstances affects families and those directly supporting them, and I would like to thank all those who have contributed to the reviews in such an open and transparent way.

The report identifies that there was a reduction in safeguarding concerns on the previous year. We need to be cautious about that data given 2020/2021 was such an unusual year. Many people are abused or neglected in their homes. The pandemic raised unique challenges in identifying such abuse, and as a Board we need to continue to listen, learn

and connect with those who are at risk of suffering abuse or neglect so we can develop a true picture of the harm being caused in order to protect.

The priority areas for the SSAB moving forward remain the same. Listening and learning is key to improving safeguarding practice. Enabling people to keep themselves safe is important to prevent or minimise the risk of abuse, but it is also important to recognise that there are some people who are unable to keep themselves safe. It is these people we need to work together in partnership to ensure they can live their lives free from harm.

In recognising that 2020/2021 was such a challenging year for individuals and agencies who are responsible for safeguarding those adults who are at risk of abuse and neglect in Somerset, I would like to thank all who have worked so tirelessly in ensuring our most vulnerable are kept safe.

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 2021:

Name	Organisation	Job Title
Keith Perkin		Independent Chair
Stephen Miles		Business Manager
Lead Statutory Partners		
Mike Prior Victoria Caple	Avon & Somerset Constabulary	Superintendent Partnership Liaison Manager
Sandra Corry Val Janson	NHS Somerset Clinical Commissioning Group	Director of Quality and Nursing Deputy Director of Quality and Nursing
Mel Lock Anna Littlewood David Partlow	Somerset County Council	Director, Adult Social Services Deputy Director, Operations Strategic Manager

Partner Members		
Paul Chapman	Care Quality Commission	Inspection Manager
Deborah Penny	Carers' Voice Somerset	Carers' Voice Somerset Partnership Board Officer
Hamish Robertson Lucy Martin	Department for Work and Pensions	South West Group Senior Safeguarding Leader, Department for Work and Pensions Partnership Manager for Bristol and North Somerset Department for Work and Pensions
Anne Harrison	Devon & Somerset Fire and Rescue Service	Prevention and Safeguarding Manager
Janet Quinn	Devon, Somerset and Torbay Trading Standards Service	Trading Standards Project Officer

Helen Orford	Discovery	Managing Director
Kathy Smith	Golden Lane Housing	Housing Officer
Hannah Gray	Healthwatch Somerset	Healthwatch Somerset Manager
Julie Bingham	LiveWest (rep. housing providers)	Executive Director Housing Support
Tracey Aarons	Mendip District Council (rep. District Councils)	Deputy Chief Executive
Liz Spencer	National Probation Service	Head of the National Probation Service - LDU Somerset Cluster NPS South West Region, Her Majesty's Prison and Probation Service
Rosie Luce	NHS England and NHS Improvement	Regional Safeguarding Lead / Assistant Director for Quality and Safeguarding
Charlotte Brown	NHS Somerset Clinical Commissioning Group	Designated Nurse for Safeguarding Adults
Simon Blackburn	Registered Care Providers Association	Chief Executive
Richard Pitman	Rep. people who use services and the Voluntary Sector	Chief Executive – Compass Disability
Nicola Kelly	Somerset Care Ltd	Head of Quality and Clinical Governance
Lucy Macready	Somerset County Council (Public Health - Community Safety)	Public Health Specialist – Community Safety
Cllr David Huxtable	Somerset County Council	Lead Member – Adult Social Care
Alison Bell	Somerset County Council (Public Health)	Consultant in Public Health
Julia Mason	Associate Director of Safeguarding	Director of Safeguarding

Amanda Robinson	South Western Ambulance Service NHS Foundation Trust	Safeguarding Business Manager
Anna Temblett	Swan Advocacy	Somerset Area Manager
Bernice Cooke Glen Salisbury	Yeovil Hospital NHS Foundation Trust	Deputy Director Quality Governance, Patient Safety and Safeguarding Head of Safeguarding Team

Board attendance

The Safeguarding Adults Board met on 3 occasions during 2020/21 – June, October and February.

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

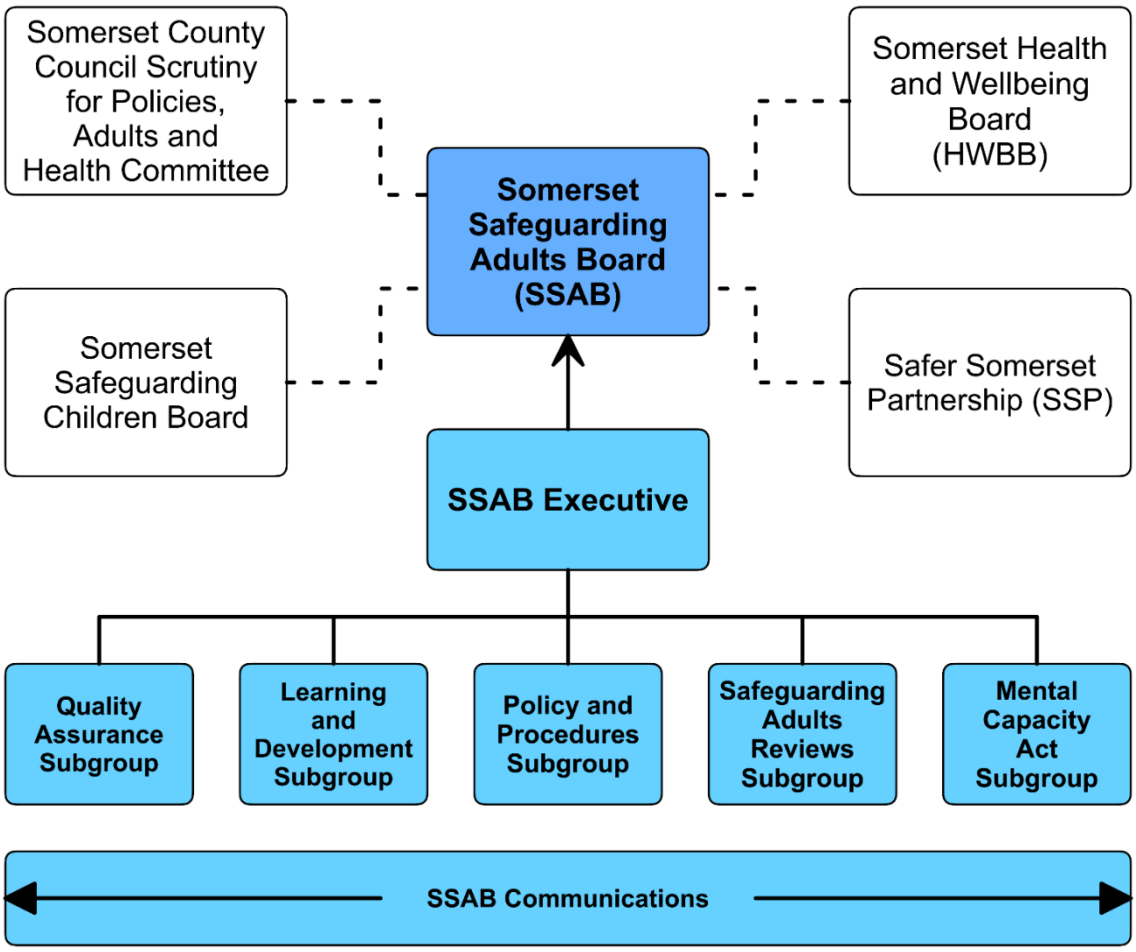
Organisation	Attendance
Avon & Somerset Constabulary	100% (3/3)
Care Quality Commission	100% (3/3)
Carers' Voice Somerset	0% (0/3)
Department for Work and Pensions	100% (3/3)
Devon & Somerset Fire and Rescue Service	66% (2/3)
Devon, Somerset and Torbay Trading Standards Service	0% (0/3)
Discovery	66% (2/3)
District Council representative	100% (3/3)
Golden Lane Housing	100% (3/3)
Healthwatch Somerset	100% (3/3)
Housing representative	66% (2/3)
Marie Curie Somerset & Dorset	33% (1/3)
National Probation Service	33% (1/3)
NHS England and Improvement (South West)	33% (1/3)
NHS Somerset Clinical Commissioning Group	100% (3/3)
Public Health	66% (2/3)
Public Health (Community Safety)	100% (3/3)
Registered Care Providers Association	0% (0/3)
Representative of people who use services	0% (0/3)
Shared Lives South West (Somerset)	66% (2/3)

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

Somerset Care Ltd	100% (3/3)
Somerset County Council	100% (3/3)
Somerset NHS Foundation Trust[2]	100% (3/3)
South Western Ambulance Service NHS Foundation Trust	0% (0/3)
Swan Advocacy	100% (3/3)
Voluntary sector representative	66% (2/3)
Yeovil Hospital NHS Foundation Trust	100% (3/3)

In June 2020 the Board received an audit report produced by the South West Audit Partnership (SWAP) that found that there "has been inconsistent attendance at SSAB meetings by certain partners, and instances where deputies who do not have sufficient seniority have attended in place of the main representative" and while the SSAB has fully implemented all the recommendations made by auditors there has still been inconsistent representation by some members.

Board structure as at 31/03/2021



[2] On 01/04/2020 Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust merged to form the Somerset NHS Foundation Trust

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

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

4. Safeguarding in numbers

All information in this section, other than the number of concerns raised by the adult themselves, is drawn from the Safeguarding Adults Collection (SAC) statutory return that Somerset County Council submitted to NHS Digital in May 2021. Comparative data with other Local Authorities is expected to be released by NHS Digital during the autumn.

How much abuse and neglect was reported during 2020/21?

Safeguarding concerns reported to the Local Authority in 2020/21

2776 concerns were reported. This was a drop of 262 (8.62%) compared to the previous year

Of the 2776 concerns, 17 (0.61%) were raised by the adult themselves. This compares to 19 (0.63%) in 2019/20.

Safeguarding concerns received that required a statutory response

2020/21
1144
Section 42 enquiries
(37.66% of all concerns received)

2020/21
832
Section 42 enquiries
(29.97% of all concerns received)

832 (29.97%) of concerns resulted in an enquiry under Section 42 of the Care Act (2014). This was a decrease of 312 compared to the previous year. In addition, a further 46 non-statutory enquiries were carried out.

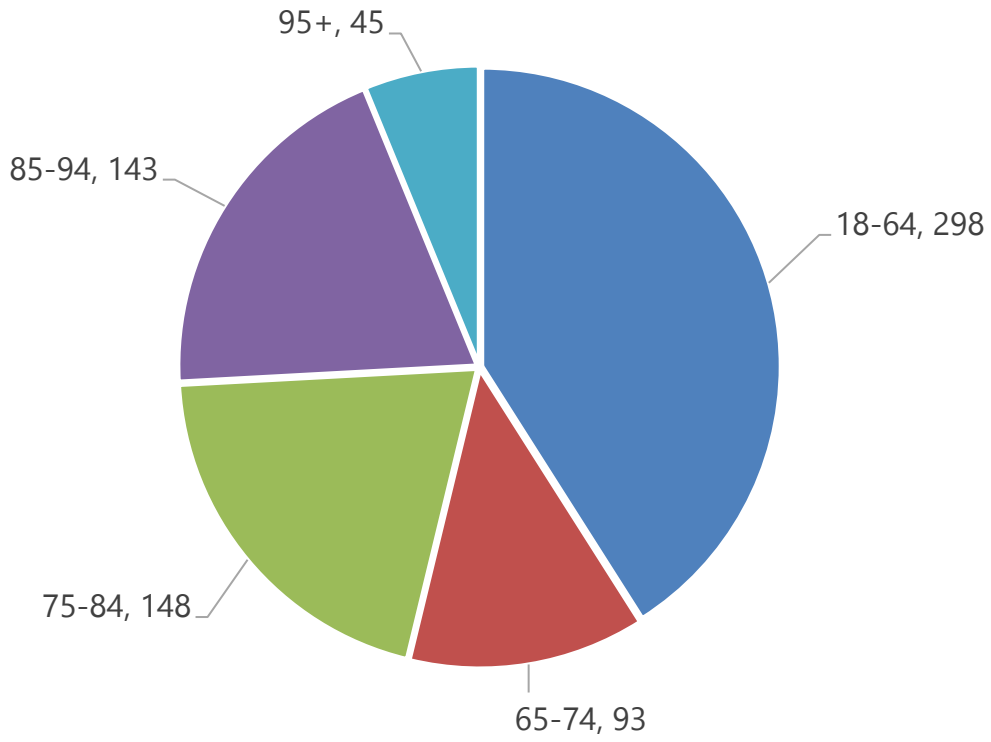
Who was at risk of abuse and neglect in 2020/21?

The majority of individuals that required a statutory response were female

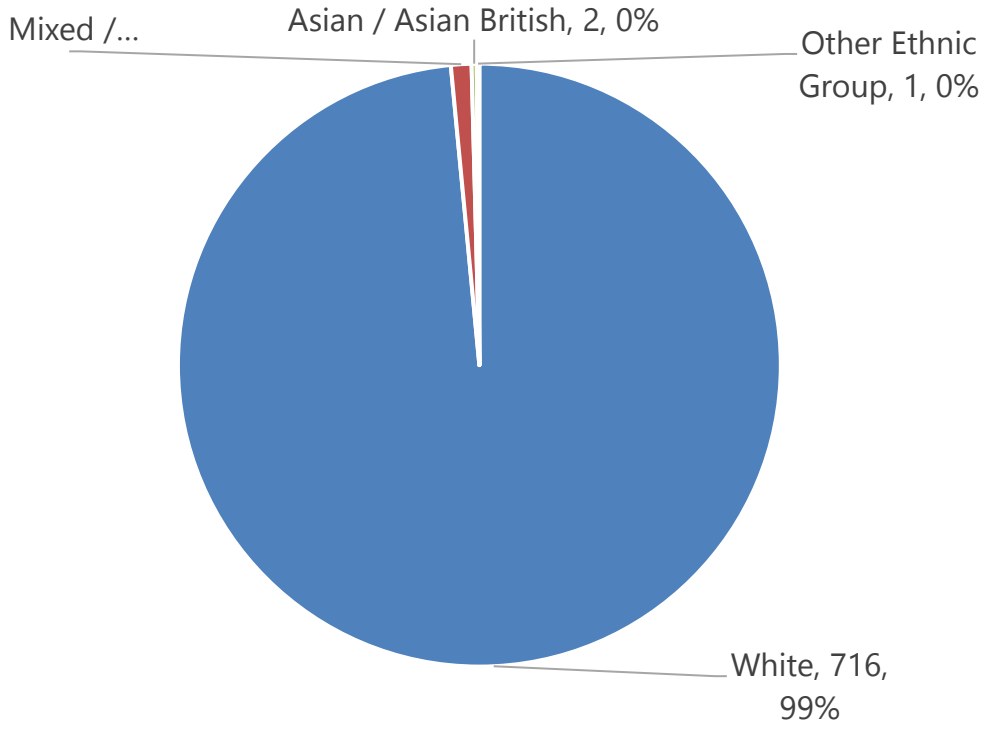
Females
405
(55.71%)

Males
322
(44.29%)

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

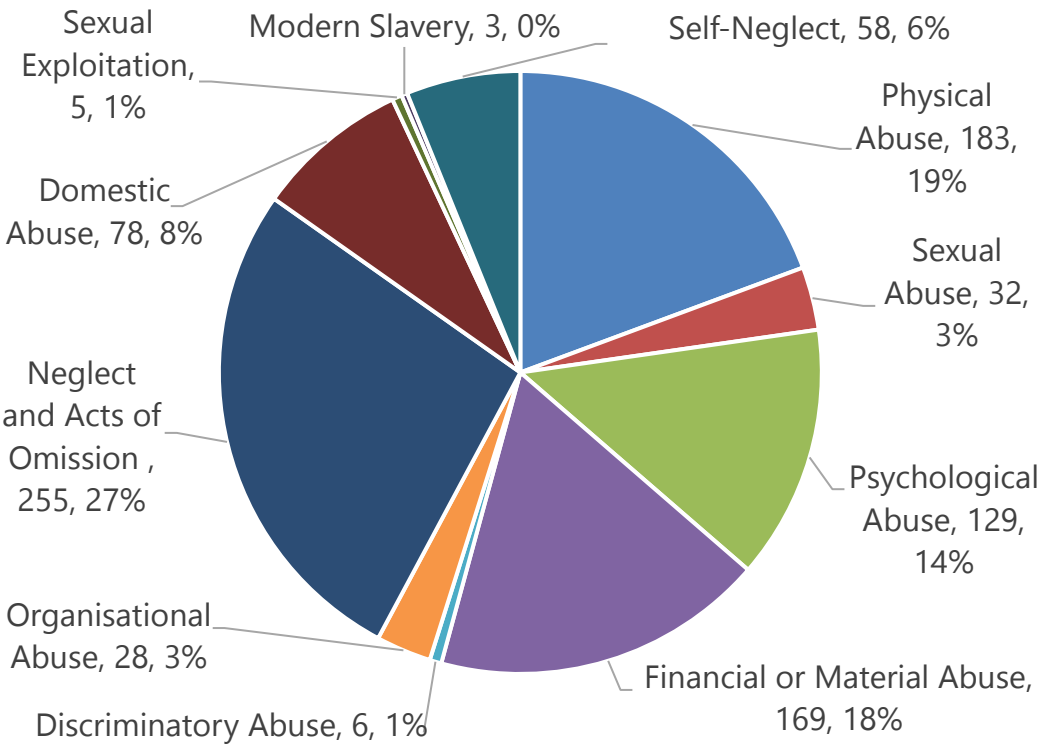


The majority of individuals where the concern resulted in an enquiry under section 42 of the Care Act (2014) were from white ethnic backgrounds

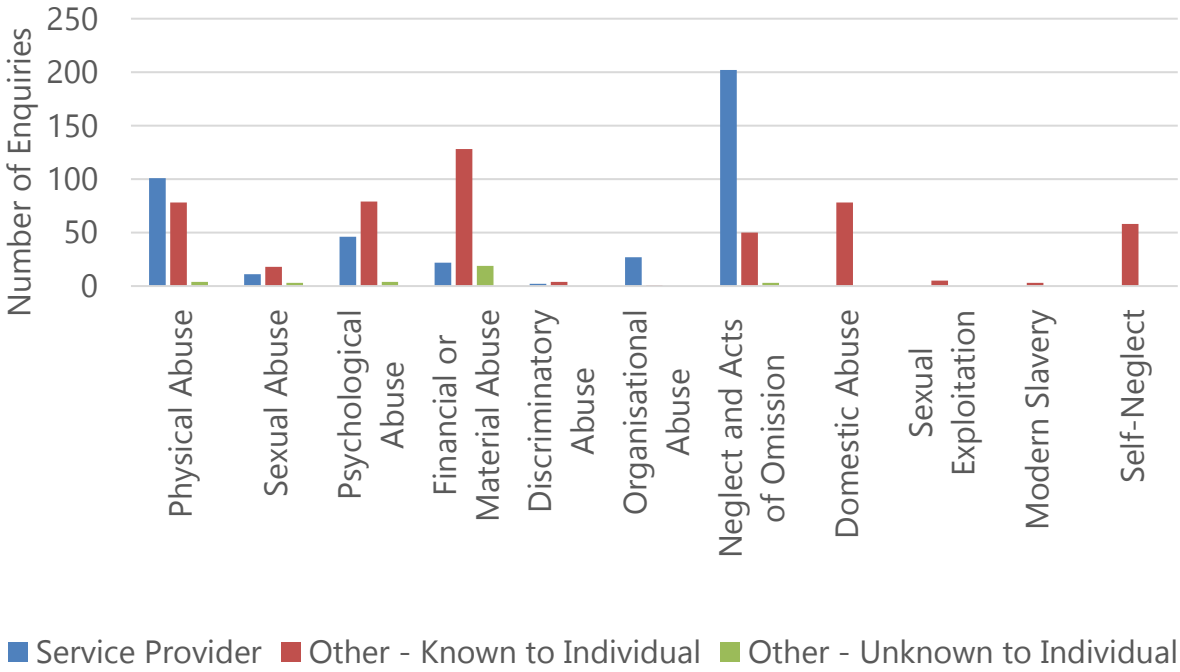


Type of abuse and source of risk

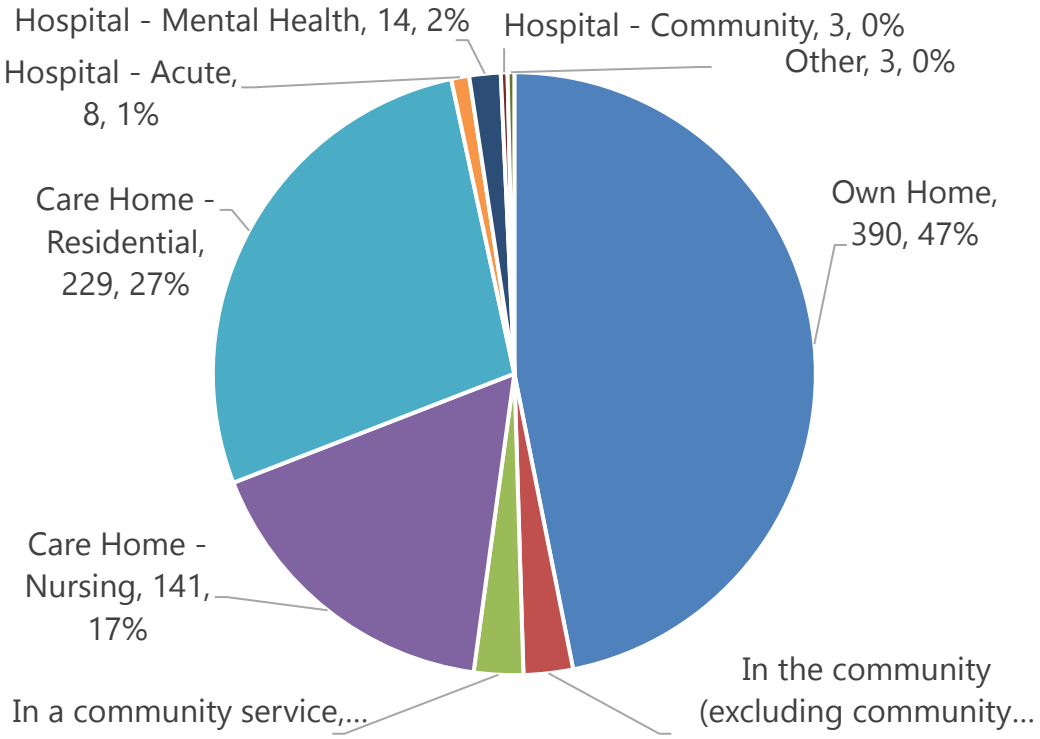
The most common risk type was Neglect and Acts of Omission, which accounted for 27% of risks, followed by Physical Abuse at 19% and Financial or Material Abuse at 18%.



All cases of Organisation Abuse and the majority of cases of Neglect and Omission and Organisational 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 other than physical abuse

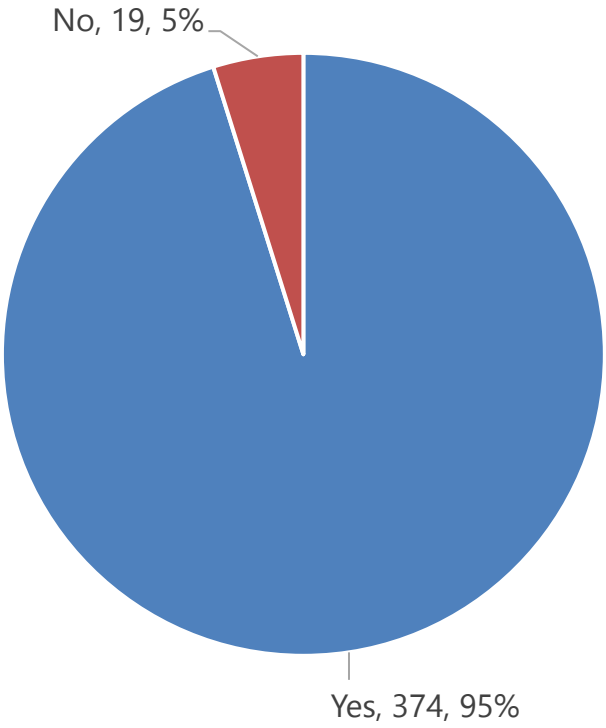


The most common location where people were identified as being at risk was in their own home (47%), followed by residential care homes (27%)



Mental Capacity

In 393 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

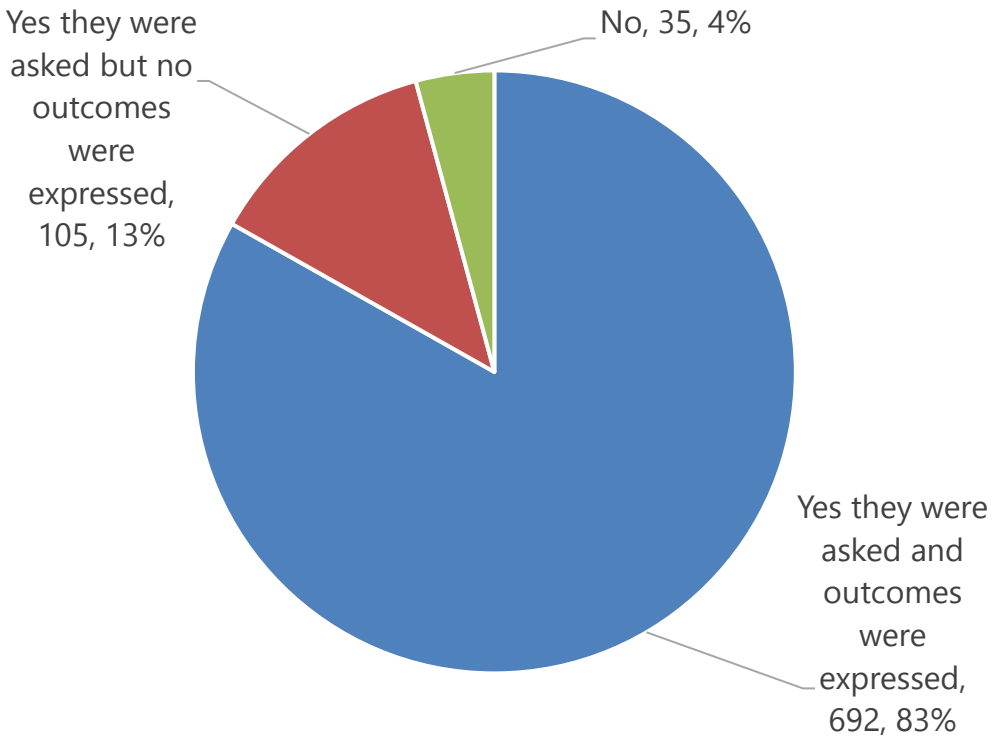


Making Safeguarding Personal

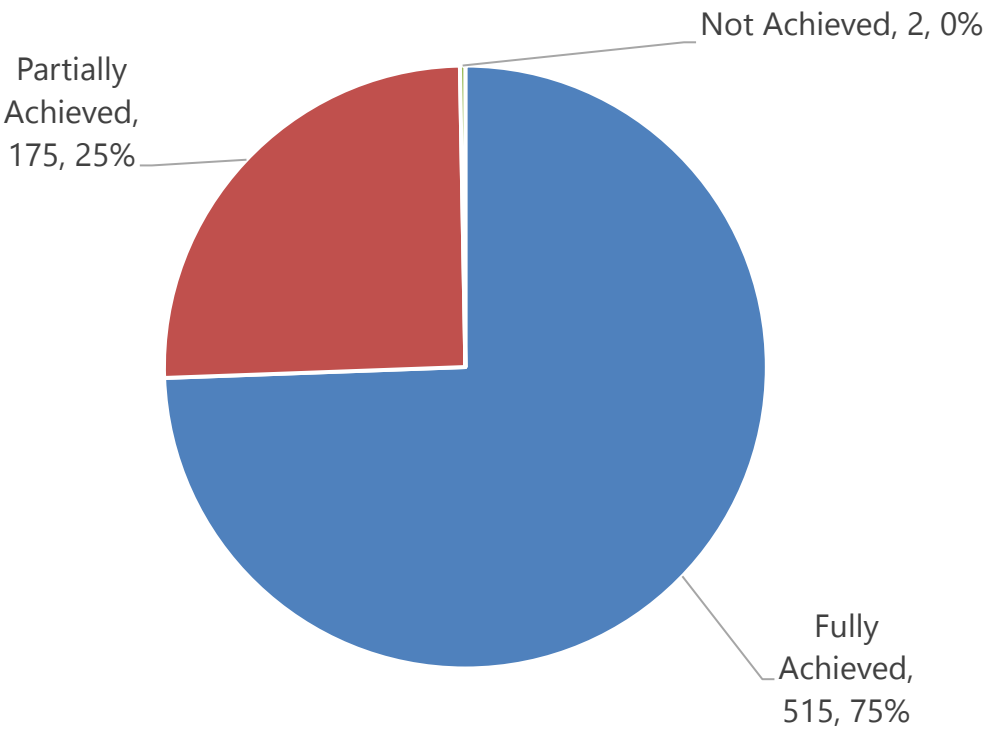
What does Making Safeguarding Personal mean?

Making Safeguarding Personal (MSP) is about having conversations with people about how we all 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.

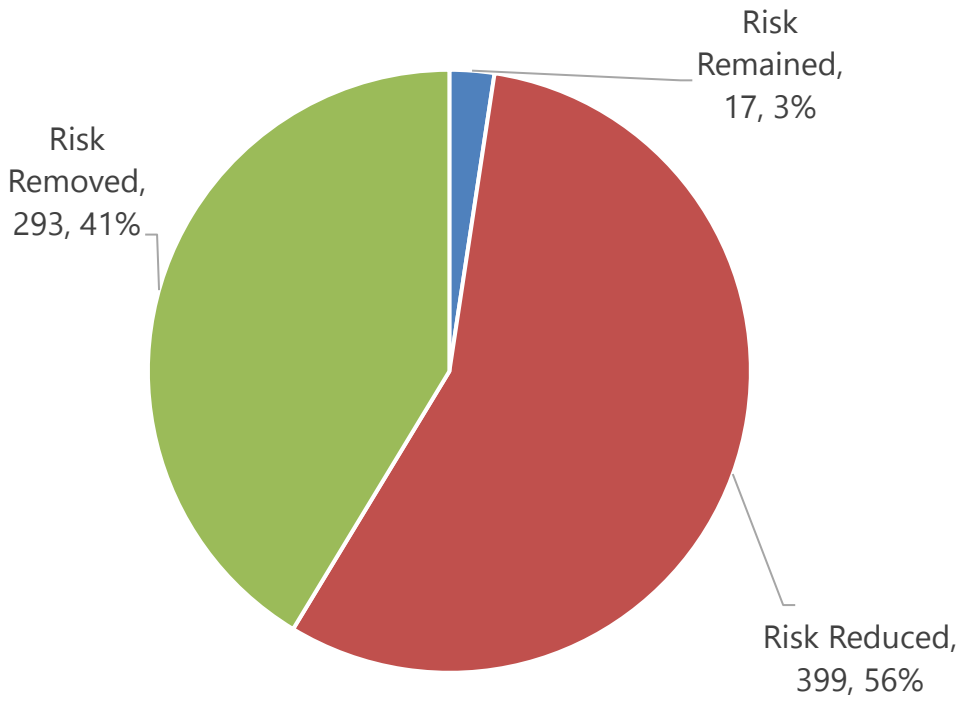
The majority of people, or their representative, were asked what their desired outcomes were



In 99.71% 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)



5. Our work during 2020/21

The SSAB identified the following four objectives within its Strategic Plan for 2019-22:

1. Listening and learning
2. Enabling people to keep themselves safe
3. Working together to safeguard people who can't keep themselves safe
4. Making sure we do what we said we would do

During 2020/21 the Board's work was significantly impacted by the Coronavirus Public Health Crisis, and while it continued to carry out its statutory duties it did suspend the developmental work of its Subgroups so that partner organisations could focus on their response to the crisis. The Board then reprioritised the work of all subgroups as part of its recovery plan. In addition, during the Public Health Crisis, the Board has provided support to the wider health and care system by hosting a "Coronavirus updates for Somerset Adult Care Providers" page on its website that has been updated daily with the latest guidance since early April 2020. It has also supported work to manage the distribution of Personal Protective Equipment to organisations, and to provide a weekly briefing to care providers.

Priority Area 1: Listening and learning

What SSAB said it would do	What the SSAB did
Develop consistent and effective processes and communication channels to inform our work. We will do this by using the views of, and learning from, people who have experienced safeguarding and their carers, both provided directly to the Board and through partner organisations, including the third sector.	• Following receipt of a report by Healthwatch Somerset at the end of 2018/19 the Board has been working with Somerset County Council, as the agency with lead responsibility for adult safeguarding, to monitor the implementation of the agreed actions. While some progress was made with this, the new arrangements for the gathering of feedback were not able to be put in place during 2020/21 due to the resources required

What SSAB said it would do	What the SSAB did
	needing to be prioritised to support the Council's response to the Coronavirus Public Health Crisis. However, since the end of the financial year progress has been made, the feedback process is now available for anyone to use, and we expect to report the feedback gained through it in our next annual report. • The Board has continued to monitor the extent to which people are reporting their desired outcomes have been achieved as part of its performance reporting mechanisms. Figures for the 2020/21 year are shown in Section 4 (page 12) with 99.71% of people, or their representatives, reporting their desired outcomes had been wholly or partially achieved. • Due to the coronavirus pandemic, during 2020/21 we were not able to arrange for anyone who had direct experience of safeguarding in Somerset to talk to the Board in person due to the on-going restrictions, however we hope to be able to resume inviting people during 2021/22. However, to ensure an effective link between senior leaders on the Board & those who provide a direct safeguarding service,

What SSAB said it would do	What the SSAB did
	practitioners have presented to the Board on the challenges they have faced over the last 12-18 months.
Develop mechanisms to identify and share best practice to improve safeguarding practice. This will include commissioning and supporting Safeguarding Adults Reviews (SARs), and learning emerging from other local, regional or national reviews. It will also include using an expanded range of methodologies to undertake SARs, including, where appropriate, the adoption of accelerated approaches used elsewhere to identify learning more quickly.	• Best practice continued to be routinely identified and shared on a regular basis through the SSAB website, social media and Somerset County Council's weekly care provider bulletin, which the Board has been supporting the production of. • Due to the Board supporting other communications work in response to the Coronavirus Public Health Crisis, we continued to publish, albeit on a reduced capacity, a newsletter. The Board intends to resume its normal newsletter schedule during 2021/22. • The Quality Assurance subgroup has been monitoring the levels and types of safeguarding concerns for adults at risk throughout the year, including working to understand any variations compared to the previous two years. While there were some variations in the types of abuse being reported the Subgroup was satisfied that the system in Somerset was responding to referrals appropriately.

What SSAB said it would do	What the SSAB did
	• The Social Care Institute for Excellence (SCIE) has designed a new process called 'SARs in Rapid Time' that it began piloting during 2020/21. After consideration the Board agreed to use a variation on the process based on an adapted version of the tool developed by SCIE, due to concerns that the pilot's proposed timescales would be unworkable for some partners. This adapted tool is being used for all new SAR referrals from March 2021 onwards.
Deliver multi-agency Safeguarding Adults learning opportunities to raise the profile of adult safeguarding, address areas of practice improvement and share lessons learnt from Reviews.	• Unfortunately, due to the impact of the Coronavirus Public health crisis, the Board's 2020/21 annual conference was cancelled. Given the ongoing uncertainty about 'in-person' events the Board will be supporting a sub-regional week of virtual daily events during the National Safeguarding Adults Week in November 2021.
Identify learning for the adult safeguarding emerging from the ongoing Coronavirus public health crisis, including if there are any new and/or emerging Safeguarding Adults priorities that have arisen both as a result of the pandemic and the reducing lockdown measures	The Board and its Executive Group has been regularly monitoring the response of the system, which appears to have responded effectively and no significant additional priorities have emerged to date. This monitoring has included the Board's Independent Chair observing meetings, for example The Vulnerable People's

What SSAB said it would do	What the SSAB did
	and Care Providers meetings in order to gain assurance that partners were working together to effectively support people with care and support needs. At its meetings in October and February the Board invited front-line professionals from Somerset NHS Foundation Trust, Yeovil Hospital NHS Foundation Trust and Somerset County Council's Safeguarding Service to speak to the Board about the experience of front-line services during the pandemic and learning for the wider system. While this did result in problem solving discussions between partners to resolve specific issues, they did not result in additional priorities for the Board The Board has also supported work by the Local Government Association and Association of Directors of Adult Social Services to gain additional insight in to safeguarding data during the Coronavirus Public Health Crisis nationally, and the Board wishes to thank Somerset County Council's safeguarding service for its support with this work.

Priority Area 2: Enabling people to keep themselves safe

What SSAB said it would do	What the SSAB did
Raise public awareness of: • the different types of abuse • how people can keep themselves and those that they care for safe, including on-line • how to seek support when they or others are experiencing abuse or neglect	• 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. • At the beginning of the Coronavirus Public Health Crisis the Board developed summary guidance for volunteers involved in Coronavirus support groups on what to do if they had a safeguarding concern, as well as promoting guidance developed nationally. • New public facing materials have been developed by the Policy and Procedures Subgroup which have been promoted with partners and via social media. These include: ○ What is Abuse and Neglect ○ What happens after abuse or neglect is reported ○ What is a Planning Meeting ○ What is a Safeguarding Adult Enquiry ○ What is a Review Meeting ○ Preparing for a safeguarding meeting ○ Mental Capacity • As in previous years each Safeguarding Adult Board in the Avon and Somerset
Through partner organisations, including the third sector, provide bespoke information to specific groups/sectors that are identified as being at greater risk	

Constabulary area undertook to promote adult safeguarding through the annual 'Stop Adult Abuse Week'. The focus in 2020/21 was "Looking after your community"

- 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, including National Safeguarding Adults Week, along with the signs, symptoms and indicators of abuse and neglect (which form part of a regional multi-agency policy).
- The SSAB once again ran a campaign on social media - #12DaysOfSafeguarding - over the Christmas and New Year period, that saw good levels of engagement.
- The SSAB continues to maintain 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 averaged 3508 users each month (including users of a Coronavirus updates for Somerset Adult Care Providers page that the Board has hosted for the system) following on from the significant growth that was achieved during previous

	years. New content has continued to be added and existing content has continued to be reviewed by the Board's Policy and Procedures Subgroup.
Work together with Devon, Somerset and Torbay Trading Standards Service to raise awareness of financial abuse and scams	• The SSAB has raised awareness and promoted initiatives throughout the year. This included using social media to alert people of 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. • The Board has featured information about scams and financial abuse in its newsletter, and promoted initiatives by Devon, Somerset and Torbay Trading Standards and National Trading Standards, for example to care providers through the Coronavirus updates for Somerset Adult Care Providers page, and in the weekly briefing for care providers that it has supported.
Work together with the Safer Somerset Partnership and Avon & Somerset Constabulary to support work to reduce the harm caused by abuse such as County Lines	• The SSAB has actively promoted the recent County Lines campaign, the #NoClosedDoors2020 domestic abuse campaign and promotes

activity, domestic abuse and modern slavery.	information about Modern Slavery produced by the government and national charities • The SSAB Business Manager is an active member of the Somerset Domestic Abuse Board
Develop a communication plan that is aligned with local, regional and national campaigns. The development will include a review of how public messages have been disseminated through the Coronavirus Public Health Crisis to identify if there are other methods that the Board could consider adopting.	A Communications Plan was developed with support from Somerset County Council's Communications Team. This work was delayed due to a lack of capacity earlier in the year, and was therefore not completed until March 2021.

Priority Area 3: Working together to safeguard people who can't keep themselves safe

What SSAB said it would do	What the SSAB did
Work as a partnership to identify guidance and standards for areas of new and evolving adult safeguarding practice to keep people safe and minimise risk of harm, while supporting them to live their lives as they wish	• The Board's Policy and Procedures Subgroup has continued to monitor and update the information on the Board's website. • During 2020/21 development of new guidance was temporarily paused due to the impact of the Coronavirus Public Health Crisis on the capacity of partners to participate in this work.

	• The following new guidance was produced during the year, and has been published on the Boards website:
	  ○ Medication Management Guidance for Providers
	  ○ An Organisational Abuse Policy developed on behalf of the region
	• The Policy and Procedures Subgroup began developing guidance for staff working with adults who may make disclosures regarding alleged non-recent incidents involving children following the publication of the 'Luke' Safeguarding Adults review (see page 37).

Work jointly with the other strategic Partnership Boards in Somerset to keep people safe from harm and improve their health and wellbeing in support of the prevention agenda, reducing duplication of effort and maximising effectiveness.	• Effective working relationships between the key partnership boards that have oversight of the work undertaken to support the residents of Somerset ensures a clearer understanding of respective roles and responsibilities, improved joined up working between partners, reduced duplication, and opportunities to develop collaborative efforts to improve the resilience of Somerset communities, families and individuals. The SSAB continued to support these arrangements during 2020/21 • The Board has received updates at its meetings during

	the year on work taking place to prepare for the Domestic Abuse Act (2021) • 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, Somerset LeDeR Steering and Quality Assurance Groups and the Suicide Prevention Advisory Group.
Enhance local understanding and application of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (and the replacement Liberty Protection Safeguards). This will include seeking assurance that the application of the principles of the MCA, including the need to safeguard people who are deprived of their liberty, are being complied with.	• Due to the impact of the Coronavirus Public Health Crisis and an associated postponement of the introduction of the Liberty Protection Safeguards nationally until April 2022, work was paused for the majority of the year and did not restart until quarter 4. While the implementation of the Safeguards sits with partners with responsibility under the Mental Capacity Amendment Act (2019), the Board has a key role in seeking assurance on the arrangements that are put in place. • The MCA Subgroup continued to monitor content published on the Board's website, and considered key issues in relation to the Mental Capacity

	Act and the Coronavirus Public Health Crisis. • The MCA Subgroup continued to monitor performance with respect to the application of the Act and Deprivation of Liberty Safeguards. However, this remains a high-risk area for all SABs in terms of consistency of practice
Work jointly locally, within the region, and through national networks, to both develop our local approaches to safeguarding adults within the wider system, learn from others, and share good practice and learning.	• The Board is represented on regional groups by the Independent Chair and Business Manager, who also attends national meetings with other Business Managers. • The Board volunteered to lead work on behalf of the region to take forward the development of Organisational Abuse guidance. • The Board's Business Manager volunteered to work with colleagues within the region to develop a new self-audit tool for use in 2021. The aim of this tool is to reduce the burden on partners who work across two or more SABs. • The Board contributed to submissions made nationally by Business Managers and Independent Chairs to the National Institute for Health and Care Excellence (NICE) guideline on Safeguarding adults in care homes.

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 (DHSC). 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 as shown in the following table showing Somerset's figures.

	2019/20	2020/21	% Change
Total applications	2784	2576	-7%
From Care Homes	1952	1596	-18%
From Hospitals	832	1007	+21%
Assessments completed	741	664	-10%
Authorisations granted	678	628	-7%
Authorisations not granted/ not assessed	2035/ 1999	2085/ 2054	+2% / +3%

Explanatory notes:

- A high proportion of the 'Authorisations not granted/ not assessed' were the result of death or discharge from hospital or care home prior to assessments taking place. The majority of the cases actually assessed resulted in an authorisation being granted.
- While the number of referrals decreased the capacity to complete assessments also decreased, as staff from Somerset County Council's DoLS team were redeployed to support the Council's response to the Coronavirus Public Health Crisis. Assessments were also required to take place remotely, one of the disadvantages of which is that each assessment will take longer to complete than through a visit.

In May 2019 the Mental Capacity (Amendment) Act 2019 received Royal Assent and the proposed date for the implementation of the Liberty Protection Safeguards - to replace the current DoLS scheme – was set as October 2020. However, there has been significant delay in the publication for consultation of the Code of Practice and secondary legislation which has been further affected by the Coronavirus Public Health Crisis and is not now expected to be published until June 2021. The Department of Health and Social Care has therefore advised local authorities and NHS bodies that the implementation of the legislation will be postponed until April 2022.

In the meantime, Somerset County Council's DoLS service has continued to prioritise for assessment those situations which are most critical and to ensure that, despite the practical challenges created by the Coronavirus Public Health Crisis – for example needing to carry out assessments remotely – the quality of assessments and authorisations remains high. Somerset has continued to take a proactive stance in taking cases to the Court of Protection for review and decision-making when there are objections or disagreements. The Council works closely with Swan Advocacy to ensure that, whenever necessary, vulnerable people who lack capacity are provided with the support of a qualified advocate.

Priority Area 4: Making sure we do what we said we would do

What the SSAB said it would do	What the SSAB did
Monitoring the implementation of best practice, standards, policies and actions emerging from Reviews (including, but not limited to, SARs, Serious Case Reviews, Domestic Homicide Reviews, and Learning Disability Mortality Reviews)	• The progress monitoring of the implementation of recommendations of published SSAB SARs is a standing item at each meeting of the Board's Executive Group. From January 2021 the Independent Chair began reviewing progress at the mid-point between Executive Group meetings. • The Executive Group has reviewed the recommendations of a national report Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 , published by the Local Government Association, against the Boards current position with regard to each recommendation that relates to it. Work to address the gaps identified is being managed by the Board's SAR Subgroup.

	• Learning from elsewhere continues to be shared with the system via social media and newsletters
Monitor the implementation of recommendations made by the South West Audit Partnership in its audit of the SSAB's work (April 2020) and actions identified from the 2020 SSAB members survey	Please see page 35 for a summary of the audit and the Board's response to it.
Monitor performance across the system	• The Board's Quality Assurance Subgroup has continued to monitor performance quarterly. • The Board's Mental Capacity Act Subgroup continues to monitor advocacy take up and Deprivation of Liberty Safeguards referrals.
Develop effective processes which use data as part of an 'intelligent safeguarding' approach to understand where risks exist within the system and seeks assurance on the implementation of action(s) to address it	• This remains an area for development as only limited progress was made during 2020/21 • Rather than attempting to look at this approach across all areas of safeguarding an adapted approach is being used to focus on specific areas to identify shared information going forward. This work is being led by the Board's Quality Assurance Subgroup.
Review work led by Public Health Somerset on arrangements for people with multiple vulnerabilities, and seek assurance that appropriate arrangements are in place to address any weaknesses in the	This work was initiated by Public Health Somerset during 2019/20, but as a result of the Coronavirus Public Health Crisis services and resources were put in place that superseded the work that was originally planned, and it therefore ceased.

adult safeguarding system identified through this.	The main finding prior to the work being superseded was that there were no systemic weaknesses identified in the safeguarding system itself, and that where issues were identified these were due to individual professionals not following safeguarding processes correctly. As a result, the Board has continued to promote good safeguarding practice across the system, including its "What to do if it's not Safeguarding" process, and will also be including a specific question in its 2021 self-audit process to test understanding across the system.
Support Somerset County Council Elected Members and Somerset County Council Committee functions to better understand their roles and responsibilities in effectively scrutinising and monitoring the effectiveness of the Board in protecting adults at risk from abuse, and maintain links with NHS England and Improvement	• The SSAB's presentations to the Health and Wellbeing Board and Scrutiny for Policies, Adults and Health Committee that normally take place in the spring were postponed. • The SSAB therefore made a single presentation to each committee during 2020/21 – to the Scrutiny for Policies, Adults and Health Committee on 12/11/2020 and the Health and Wellbeing Board on 23/11/2020. • The SSAB also reported to NHS Somerset Clinical Commissioning Group's Governing Board on 25/03/2021. • NHS England and Improvement South West are represented on the SSAB and receive copies of Safeguarding Adult Reviews in

order to promote the sharing of learning across the region.

SSAB Annual Self-Audit 2020/21

- Like many other SABs in England, SSAB did not complete its usual annual self-audit process in 2020/21 due to the ongoing impact of the Coronavirus Public Health Crisis on partners capacity to participate in the process.
- The SSAB has provided a significant contribution to the development of a new self-audit tool that will be used to complete a coordinated audit between five SABs within the region during 2021/22 in order to minimise the burden on partners. The results of the audit will be reported in the next annual report.

South West Audit Partnership (SWAP) Audit of the SSAB

During the spring of 2020 the SSAB was independently audited by the South West Audit Partnership, and also conducted an effectiveness survey of members. While the audit highlighted a number of areas for improvement the overall finding was that the Board has satisfactory arrangements across key areas to ensure that it operates as an effective partnership, and at the Board meeting on 12/06/2020 members agreed actions to take work forward to address the findings.

The recommendations include:

- A review of the Terms of Reference for the Board and all of its Subgroups, and the expectations on its members
- The inclusion of a standing agenda item for the Executive Group to ensure that all strategic actions are equally owned and resourced by the Board partner
- For any subgroup meetings that are cancelled or postponed to be reported to the Board each time it meets
- For self-referral data to be considered by the Quality Assurance Subgroup
- For the Quality Assurance Subgroup to progress Somerset County Council's implementation of the feedback process proposed by Healthwatch Somerset in 2019.

- For the Board to consider the results of the effectiveness survey with a view to improving confidence levels in the identified areas of lower confidence

The implementation of the recommendations has been monitored by the Boards Executive Group and reported to the Board each time it has met. All recommendations have now been completed although one, recommendation five, was only completed in May 2021.

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, and the quality assurance of review reports. The subgroup is chaired by a Detective Inspector from Avon & Somerset Constabulary's Major and Statutory Crime Review Team.

Where a case meets the criteria, and it is not possible to demonstrate the necessary degree of independence from within the partnership, the Subgroup will oversee the appointment of an independent, external Chair and/or Review Author. Where independence can be demonstrated from within the partnership, for example where the review can be chaired by a senior representative from a partnership agency with no involvement in the case, the Board has developed a local review process which is similar to that used by some other Boards.

Two Safeguarding Adults Reviews concluded during 2020/21, and these are summarised below. A further eight reviews are at different stages, and are being progressed by the Board's SAR Subgroup. None of these Reviews relate to the Coronavirus Public Health Crisis.

'Luke' Safeguarding Adults Review (published 18/08/2021)

Summary

Luke (pseudonym), aged 67 at the time of his death in 2018, had been a resident in a care home for about 18 months, and had a long history of neglecting his own health and well-being before he moved there. Luke had Type 2 Diabetes and had experienced a number of traumatic events in his life and, although Luke died from a diabetic foot ulcer, the focus of the report was on how agencies worked together in their approach to Luke and concerns about his mental capacity and neglect of his own wellbeing. When Luke moved to the care Home he weighed 47.3kg with a Body Mass Index (BMI) of 19[3], and weighed 30.8kg with a BMI of 11[4] when he was admitted to hospital prior to his death.

[3] Body mass index is a value derived from the mass and height of a person. The BMI is defined as the body mass divided by the square of the body height, and is expressed in units of kg/m², resulting from mass in kilograms and height in metres. If an individual has a BMI below 18.5 then they are considered to be underweight.

[4] A BMI of 11 is considered to be dangerously low.

Prior to moving to the care home, Luke's self neglecting behaviours were being described in documentation as a "lifestyle choice", and that Luke was making "informed decisions" to live in the way that he did. Following the move to the care home Luke was considered to have the capacity to make decisions that were clearly having a negative impact on his health without exploration, resulting in referrals not being made to health professionals that would otherwise have been.

Shortly after moving to the care home Luke made a disclosure about alleged incident of non-recent child on child sexual touching to his social worker. They discussed this with their manager, but it was not referred to Somerset County Council's Children's Social Care Services.

Key considerations for practice identified in the review

1. Luke's history of self-neglect and assessments of his mental capacity

- Luke was placed in a care home to protect him from self-neglect, which he had a long history of, and the impact this was having on his health. It appears to have been assumed that, by virtue of being placed in a registered care environment, he would be protected from his behaviours.
- Assessments undertaken at the time of Luke's move to the care home gave only brief summary information about his history. These summaries were then appended to with new information which, though referring to Luke's history of self-neglect, did not provide the level of detail that would be necessary to provide context to the care staff and other professionals now attempting to support him.
- It is unknown as to the extent to which Luke's history of traumatic loss and mental ill-health impacted on his decision making both before and after he moved to the care home. The combination of all of these factors could well have had an impact on his day-to-day life and may have been part of the reason he self-neglected. However, this doesn't appear to have ever been explored in any depth or discussed with Luke.
- While the Mental Capacity Act is clear that capacity should be assumed unless someone has concerns otherwise, concerns should have been identified about Luke's decision making by some of his responses, in particular to treatment for his ulcers. It is inappropriate

for Principle 1 of the Act to be used to avoid considering whether someone may need help to make a decision where there is evidence that they may be struggling with their capacity. In addition, consideration should also be given as to whether further exploration is required where an adult appears to be making repeated unwise decisions.

- In Luke's case his capacity was described as fluctuating on multiple occasions by multiple professionals, and in this type of situation it can be beneficial to consider a longitudinal approach in order to establish a better understanding of the person and how they can be best supported to make a decision.
- Giving care that is restrictive (as long as it is the least restrictive available) is not a breach of human rights - but is a mechanism to uphold them, of which the right to life is one. The state may interfere with one human right if it can demonstrate through evidence that by doing so it is upholding another (e.g. the right to life). In Luke's case the care home's staff defaulted to upholding one right without adequately considering the impact on another, or attempting to explore or evidence why a different decision should be made in Luke's best interests.

2. Luke's wound Care

- Almost every aspect of Luke's care seemed to be 'owned' by the care home and, to a lesser extent, his General Practitioner with little involvement from other professionals or organisations. As a result, there did not appear to have been any concerns raised, conversations with or the involvement of, other professionals and specialist services in order to better support Luke until his health had deteriorated very significantly.
- Overall, the documentation of Luke's wound care by the care home was poor leading to gaps in records. Recording practice should be founded on a position that if something hasn't been recorded it didn't happen, and tested through auditing processes.
- The dressings on Luke's wounds should have been applied in a way that made it less likely that he would access the wounds given the known risks of his picking at/infecting them.
- The Somerset Diabetes Foot Integrated Pathway should be followed at all times. During the autumn of 2017 Luke's wound was

deteriorating, but no referral was made, and this was a missed opportunity for specialist input into Luke's care.

3. Multi-agency involvement in Luke's care and support

- Opportunities were missed to initiate a multi-disciplinary discussion. This would have allowed concerns to be shared which don't appear to have been, as well as alternative approaches to be considered and specialist referrals made as required.
- There will always be the inherent risk of an individual 'falling through the cracks' in any process that assumes that another professional and/or organisation will take-over responsibility for a case where there has been no hand-over. While such a hand-over need not be bureaucratic there does, as a minimum, need to be a discussion between the releasing and accepting professionals/organisations. Confirmation that hand-over has been agreed and the date on which it takes place should then be recorded.
- NHS Somerset's Continuing Health Care (CHC) Team do not provide a care management function for people who are in receipt of Funded Nursing Care and the responsibilities of the registered nurses within a care home therefore include the identification of any new or changing health need, along with making an onward referral to the appropriate health service; either directly with that service or where appropriate through the general practice. If the care home is not content with the response from a health service, they can escalate to the manager of a service, General Practitioner or where appropriate through the Patient Advice and Liaison Service (PALS).

4. Luke's weight

- When recording information about an individual's weight, all providers of residential care and nursing care operating in Somerset should record the actual weight and the unit of measurement at the time of documenting the calculation, as well as the BMI, in order to mitigate against the potential for mathematical errors in calculations. Where someone cannot be weighed physically, and the Measuring mid-Upper Arm Circumference (MUAC) is used in place of the individual's weight, the measurement should be recorded. In addition, if an adult's BMI is requested by a General Practitioner or other health professional, their weight should also be provided

alongside the BMI, or if the MUAC has been provided in place of the BMI then this should be clearly stated.

5. Disclosure made by Luke

- The disclosure should have been referred to Somerset County Council's Children's Social Care Service at the time. While the ages of the children allegedly involved and the small amount of information which Luke provided does not indicate whether this was persistent harmful or exploratory childhood behaviour, a referral should have been made so that it could be considered in context with any other information available and assessed.

Progress made since publication

The review made 12 recommendations. The implementation of these is being monitored by the Board's Executive Group each time it meets. As at 31/03/2021 the status of each was as follows:

	Summary of Recommendation	Status
1	That the SSAB ensures that the learning from this Review is shared across the local system	Evidence awaited from one organisation, but otherwise complete
2	That the Community Podiatry Service raises awareness of the Somerset Integrated Foot Pathway and supporting Diabetic Foot Infection Guidelines (PEDIS) with: • All residential care and nursing care providers operating in Somerset • All GP Practices in Somerset	Assurance received that this recommendation has been completed.
3	That NHS Somerset CCG provides guidance about recording capacity and information on the tools that are available to GPs in Somerset, for GP practices to assist them in recording information regarding an individual's capacity to an appropriate level of detail.	Assurance received that this recommendation has been completed

4	That Somerset County Council provides guidance about recording mental capacity, and information on the tools that are available, to all providers of Care and Support to adults operating in Somerset to assist them in recording information regarding an individual's capacity to an appropriate level of detail.	Assurance received that this recommendation has been completed
5	That the Community Podiatry Service confirms the contact that they have had with an individual to their GP when closing a case, unless the closure is because the person has died.	Assurance received that this is complete other than for the completion of an audit by the responsible partner to test compliance
6	That, when recording information about an individual's weight, all providers of residential care and nursing care operating in Somerset record the actual weight and the unit of measurement at the time of documenting the calculation, as well as the BMI, in order to mitigate against the potential for mathematical errors in calculations. Where someone cannot be weighed physically and the Measuring mid-Upper Arm Circumference (MUAC) is used in place of the individuals weight the measurement should be recorded. In addition, if an adult's BMI is requested by a GP or other health professional, their weight should also be provided alongside the BMI, or if the MUAC has been provided in place of the BMI then this should be clearly stated.	Compliance to be checked as part of the annual Quality Assurance cycle undertaken by partners with commissioning functions, with a reporting date of 18/08/2021.
7	Where a provider of care and support to adults has concerns about an individual self-	Compliance to be checked as part of the

	neglecting these should be documented alongside details of any capacity assessments, and the approaches used to explore the reasons for their behaviour and support them to address their self-neglect that are tailored to their individual needs and circumstances.	annual Quality Assurance cycle undertaken by partners with commissioning functions, with a reporting date of 18/08/2021.
8	If a provider of care and support to adults is experiencing difficulty in confirming capacity because of lack of engagement, and the consequences of the decision outcome could result in harm to the person, then they should have arrangements in place to escalate this to the relevant Commissioner or Somerset County Council's Safeguarding Service for advice; or to call a Multi-Disciplinary Team meeting as appropriate to the circumstances of the case.	Compliance to be checked as part of the annual Quality Assurance cycle undertaken by partners with commissioning functions, with a reporting date of 18/08/2021.
9	That, on advising that a re-referral be made for memory assessment, that Somerset NHS Foundation Trust provide clear criteria to the adult's GP for when this should be considered within any discharge letter.	Responsible partner to undertake audit to test compliance, with a reporting date of 18/08/2021.
10	That Somerset County Council's Adult Social Care Service and NHS Somerset Clinical Commissioning Group issue jointly agreed guidance to staff employed by Somerset County Council's Adult Social Care service on the role of NHS Somerset's Continuing Health Care Team where an individual is in receipt of Funded Nursing Care and, specifically, the circumstances in which advice and/or involvement should be sought from specialist health services, and from	Assurance received that this recommendation has been completed

	where it should be sought. It should also include an escalation process for if advice and/or involvement is sought but declined	
11	For the SSAB's Policy and Procedures Subgroup to review its existing self-neglect guidance to ensure that the fact that it is applicable to the specific circumstances where there are concerns about an adult living in a registered care environment self-neglecting is explicit.	Completed at the end of the 2019/20 financial year and published
12	For the SSAB's Policy and Procedures Subgroup to develop guidance for staff working with adults who may make disclosures regarding alleged non-recent incidents involving children with the Somerset Safeguarding Children Partnership.	In progress

Damien Safeguarding Adults Review (published 31/03/2021)

Summary

Damien (pseudonym) died aged 33. Damien had a long history of contact with mental health services, and had diagnoses of Asperger's Syndrome and Attention Deficit Hyperactivity Disorder (ADHD). He had a learning difficulty, misused a variety of substances, and his vulnerability was exploited by others who stole from him and misused his home for their own purposes. Trying to meet the dual requirements of protecting both the public and Damien from harm, at the same time as allowing him to live his own life with as few restrictions as possible, tested services in Somerset. Damien died in hospital in July 2015 as a result of an attempt to take his own life, and had been discharged from an acute mental health ward to a residential care home two weeks prior to his death. In the last fifteen

months of his life, he was detained under Section 2 of the Mental Health Act on three occasions.

A Safeguarding Adults Review was originally completed in 2016, but was never published and an extension was commissioned following new information emerging from a Coronial process in 2018. The new, extended report, superseded the original and has been published in full.

Key considerations for practice identified in the review

1. Finding appropriate accommodation

It may be difficult to identify appropriate accommodation for people with complex needs who are being discharged from an acute mental health service. The review identified that professionals should consider the following:

- Who decides (or how is a decision made) that a placement is able to provide appropriate care?
- What checks can be carried out to assess suitability and what information is available to guide professionals involved in the process? For example, perhaps with the Care Quality Commission (including reading inspection reports) or with commissioners. How might practitioners assess the suitability of possible new placements?
- What is regarded as good practice in identifying and securing a placement?
- Who should visit possible placements?

Once a placement has been identified the discharge process should not be unnecessarily delayed by the process of securing funding. The pathways for securing funding should be clearly understood and timely. It should also be shared with all those who are relevant including the adult and their family (where the adult agrees, or if in the adult's best interests if they are unable to make a decision about family involvement). The delay and difficulty in finding an appropriate place for Damien to live during his last admission to hospital sits in a context of several different types of accommodation over the years, some of which were more successful than others, and from which learning could have been drawn to inform future placements.

With regard to the involvement of the adult in the process of identifying appropriate accommodation, it will be important to determine the lawful basis on which the person will live there in order that their right to liberty is

upheld. Is this with the person's consent? Is the person required to reside in a certain setting because of lawful requirements under the Mental Health Act? If not, and if there is doubt that the person has the capacity to consent to the living arrangements, it will therefore be necessary to formally assess that person's mental capacity to make decisions when there are signs that their decisional capacity might be impaired and, if the individual is assessed as lacking the capacity to make decisions about their placement, to implement a best interests decision-making process.

2. Discharge/ transfer of care processes

When the care of people with complex needs is transferred to a placement outside of an acute mental health service the following need to be considered:

- Ongoing monitoring/ follow up: who by and when
- The daily activities that the individual needs, and the help that the individual needs in respect of these daily activities
- The pace of discharge and whether a phased discharge would be appropriate to this individual's needs
- Where the individual has agreed to family involvement, or if they lack capacity to make a decision about family involvement and it has been decided that family involvement is in their best interests, how the family (and who in the family) will be included in the process of transferring care.

3. Mental capacity assessments

Adults with complex needs and/ or subject to coercion and exploitation may not have the capacity to make some major decisions, and it may be advisable where there is doubt or conflicting information regarding mental capacity in relation to a particular decision to carry out and document a mental capacity assessment. Should assessment find that a person does not have capacity in relation to a particular decision, this does not mean that the person's wishes and preferences will not be respected, as they should be taken account of in Best Interests decisions.

4. Risk assessment and risk management processes

The risk assessment process in Damien's case after his care was transferred did not take account of incidents that were happening in the placement. These incidents were not communicated to the relevant mental health professionals.

A contributory factor in this lack of communication may have been that some assessments took place over the telephone.

5. Keeping high-risk adults safe from exploitation

Damien's vulnerability to coercion and exploitation was recognised as a risk but there was no plan to safeguard him. While Damien had a learning difficulty rather than disability, these factors and their impact on the behaviours he exhibited should still have been recognised.

The Royal College of Psychiatrists 2014 document[5] "Good practice in the management of autism (including Asperger syndrome) in adults" has a section on offending behaviour which is relevant to Damien and one pertinent point is included below:

"A naive misinterpretation of social relationships may leave an individual open to being drawn into illicit relationships as well as to intimidation and exploitation. Limited emotional knowledge can hinder the development of a mature understanding of adult situations and relationships so that, for example, feelings of social attraction or friendship are misinterpreted as the stronger emotion of love".

6. Partnership working, communication with/ involvement of family and holistic assessment

Damien's family identified a lack of communication with them and were not involved in key decisions, particularly those relating to transfer of care and risk assessment/ risk management.

They identified a lack of holistic assessment, in particular that Damien's strengths and vulnerability to exploitation were not addressed, and that care plans did not capture Damien as an individual.

A learning point for all professionals is to encourage discussions with people with complex needs about who they would like to be involved, and to what extent.

Progress made since publication

Due to this Safeguarding Adults Review not being published until the end of the 2020/21 financial year a progress report will be included in the next annual report.

[5] See https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr191.pdf?sfvrsn=4cd65cde_2&sfvrsn=4cd65cde_2

7. Our priorities for 2021/22

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 from within Somerset and elsewhere to enhance practice across the system in Somerset.
   - Identified best practice will be embedded throughout the partnership
   - We will be open to constructive criticism, and take appropriate action to reduce risk and improve safeguarding practice.
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 or others 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 on mutual interest
   - The number of inappropriate referrals is reduced through people raising other types of concern in an appropriate way
4. **Board Governance:**
   - 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

You can read our 2021/22 Strategic Plan in full on our website.

8. Board Budget

		2020/21	
SOURCE OF FUNDS		**CONTRIBUTIONS £**	%
Somerset County Council	- SAB Manager & Independent Chair	46,702	59.6%
	- Safeguarding Adults Reviews	1,333	1.5%
Avon & Somerset Constabulary	- SAB Manager & Independent Chair	20,900	24.2%
	- Safeguarding Adults Reviews	1,333	1.5%
NHS Somerset Clinical Commissioning Group	- SAB Manager & Independent Chair	10,000	11.6%
	- Safeguarding Adults Reviews	1,333	1.5%
TOTAL CONTRIBUTIONS		**81,601**	**100.0%**
APPLICATION OF FUNDS		**EXPENDITURE £**	%
PAY (including overheads)			
Safeguarding Board Manager		61,297	75.1%
Independent Chair		15,930	19.5%
Non pay			
Safeguarding Adults Reviews		4,000	4.9%
Insurance		55	0.1%
Equipment – IT hardware		12	0.0%
BT charges/mobile charges		307	0.4%
TOTAL EXPENDITURE		**81,601**	100.0%

An agreement remains 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 Our Members

NHS Somerset Clinical Commissioning Group

Our key aim for safeguarding adults is ensuring that Somerset Clinical Commissioning Group (CCG) and its commissioned providers protect the rights of adults to live free from abuse and neglect; working in partnership with other agencies in a way that supports adults in making choices and having control about how they want to live.

Somerset CCG commissions healthcare for the people of Somerset and we work in partnership with our NHS trusts, GP practices and other health services in relation to safeguarding adults; providing strategic leadership to enable the NHS in Somerset to work collaboratively with all other partners of the Somerset Safeguarding Adults Board. We also seek assurance of providers' compliance with safeguarding requirements. This is done in a number of ways; which includes data collection, a review of annual safeguarding reports, assurance visits and providing attendance at our Trusts' safeguarding committees.

Maintaining Business As Usual During the Pandemic

Despite the additional pressures on our Trusts during the pandemic, they have been able to continue, remotely, to provide a safeguarding advice and support service to staff working in the trusts. They have also been able to continue to share monthly data to provide us with assurance about their safeguarding adults responsibilities.

Following a review against national guidelines, Somerset CCG increased our Safeguarding Adults provision this year; appointing a Named GP for Safeguarding Adults and a Deputy Designated Nurse for Safeguarding Adults. The Named GP and Deputy Nurse work alongside the Designated Nurse for Safeguarding Adults.

The expansion of our safeguarding adults provision has brought particular benefits to colleagues working in primary care.

GP practices now have access to the Named GP for advice and support about people living in complex circumstances. The Named GP has supported a number of GP practices and enabled them to work with other agencies to respond effectively by preventing abuse or reducing harm.

With this additional resource, we have also been able to offer targeted support, advice and training to primary care organisations that have been identified as requiring improvement by the Care Quality Commission, along with seeking assurance of the safety and effectiveness of their safeguarding adults arrangements.

Despite the pandemic, we have been able to support colleagues working in GP practices to maintain their safeguarding knowledge by providing virtual safeguarding training, best practice meetings and supervision. In September 2020, we were able to provide a whole day's training on safeguarding, consent and decision making to over 60 staff. All the above sessions have been well attended; demonstrating commitment across GP practices to provide effective support to adults who need safeguarding.

This year, the CCG continued to be an active partner in the work of the Safeguarding Adults Board. We have provided representation at all Somerset Safeguarding Adults Board meetings, Executive Group meetings and all five subgroups. The CCG Designated Nurse for Safeguarding Adults chaired two of these subgroups. We have also taken an active role in Safeguarding Adults Reviews; supporting the commissioning, report development and publication of the two SARs that have been published this year.

The CCG secured two sources of funding which we are using to improve how the NHS Hospitals, Community Services and GP practices respond to people are experiencing domestic abuse and use these services. We used the funding to provide two Health Liaison Domestic Violence and Abuse Advocates within the Somerset Integrated Domestic Abuse Service. Their role is to support and educate staff working in our Trusts and GP practices. They can also offer a face to face service for people experiencing Domestic Abuse. Our Trusts are also supporting this initiative by each employing a substantive Domestic Abuse Coordinator who will work in partnership with the Health Advocates.

In 2021 to 2022, we will monitor the referral rates to our Domestic Abuse Services from the Trusts and GP practices to evaluate if this work has improved the identification of, and response to Domestic Abuse and Violence in Somerset.

In February 2021, the government published a White Paper 'Integration and Innovation; working together to improve health and social care for all.' This policy documents proposals for how NHS organisations will work as an integrated care system; in partnership with local authorities. We have worked with our Trusts to develop a plan that will enable more integrated working in relation to all aspects of Safeguarding in the Somerset CCG area.

The Work Of Our Continuing Healthcare Team

Somerset CCG funds a number of individuals to receive their care in a care home or from domiciliary care providers. We have continued to work with these providers during the pandemic to proportionately maintain the functions that are necessary to ensure the safety and wellbeing of the people we fund, whilst not impeding the essential work by providers to keep residents as safe as possible from Covid-19 illness and infection during the pandemic.

We continued with business as usual by pressing forward with an agenda to ensure that dysphagia training is mandatory across all providers, with a particular focus on learning disability services. Dysphagia is when a person has difficulty swallowing because of a particular illness or condition. People who have dysphagia are at higher risk of choking on food and fluids. One of the reasons we have supported this agenda is because choking incidents are a theme that has emerged in a number of Learning Disability Mortality Reviews (LeDeR) in Somerset.

We have undertaken twenty eight Section 42 enquires this year; when requested to do so by the County Council and made one referral for a Safeguarding Adults Review. We have worked together with the Local Authority to complete three whole service concerns processes for providers in Somerset.

Our CHC team seek assurance from our care home providers in the form of a data collection return; our Quality Assurance Framework (QAF). This year, the team further developed the content of the QAF so it can be used for services that provide

care for people with learning disabilities. This framework has been jointly agreed by the CCG and Somerset County Council and will be rolled out in mid-2021.

Mindful of the impact of the pandemic on care homes, we offered a break to nursing home providers in completing these quarterly returns to allow focus on their planning and response to the pandemic.

We continued to undertake quality checks for those services for which there were significant concerns about the safety and quality of their service. This work identified one provider that was failing to provide safe and effective care in a number of areas. This prompted a response from the wider health and social care system to address the issues and prevent any further incidences of abuse and neglect.

In the first wave of the pandemic, alongside the Local Authority, our CHC team worked intensively with any providers where there were concerns about the quality of care to bring as many placement beds as possible back into the market to assist the Somerset Covid-19 Response.

In relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), we commissioned a package of Higher Level MCA training. Over seventy of our CHC staff attended this training to prepare them for the implementation of the Liberty Protection Safeguards.

We funded a secondment post within the CHC team to address the need for a legal framework for those people who are deprived of their liberty in a community (rather than a care home) setting. This will provide a safeguard against any disproportionate restrictions for people who are CHC funded and living in these settings. We have also continued to make applications to the Court of Protection when there is objection to, or disagreement with the care arrangements for a person that we fund.

Our Work To Support The Pandemic

The CCG were able to meet all of our duties and responsibilities in relation to safeguarding adults during the pandemic.

Our Safeguarding Adults Team also worked some hours outside their usual roles to support the wider response to the pandemic. This included providing some redeployed hours for direct patient care in hospitals during the first wave. In addition, clinical members of the team have been supporting the mass vaccination programme since its implementation; working shifts as registered nurses/doctors administering vaccinations and training lay people to administer the vaccines.

The CCG Safeguarding Adults team completed or contributed to a number of pieces of work to enable colleagues in health and social care to apply the principles of adults safeguarding and the Mental Capacity Act during the pandemic. This was to enable Safeguarding Adults to remain a priority during the pandemic. Some examples are provided below;

- We reviewed a number of clinical pathways, documents and guidance to ensure they complied with the Care Act (2014) and the Mental Capacity Act (2005)
- The Named GP provided written guidance to colleagues working in GP practices about how to manage virtual consultations safely from a safeguarding point of view
- The team provided written guidance to GP practices about Treatment Escalation Plans to enable them to comply with the Mental Capacity Act

The Safeguarding Adults team also supported the CCG to respond to concerns raised during the first wave of the pandemic about the completion of Treatment Escalation Plans (TEPs). Along with other colleagues in the CCG, we looked into the concerns and were able to provide assurance that GP practices in Somerset were undertaking TEPs in a manner that was compliant with the Mental Capacity Act (2005), Human Rights Act (1998) and the Equality Act (2010) and that decisions about peoples future treatment were made on an individual basis. We continue to support the work that is ongoing in relation to Treatment Escalation plans, using the learning identified during the enquiries to support improvements.

The pandemic highlighted Domestic Abuse as a national issue of concern. Throughout the pandemic, we have worked closely with our Local Authority and other partners to monitor and respond to the effects of Domestic Abuse. For example,

our pharmacies have supported a number of national initiatives to enable victims of Domestic Abuse to find a safe space to talk about what is happening to them and seek help. People can go to a pharmacy and 'Ask for Ani'. These three words will alert the staff member in the pharmacy that the person needs help. The staff member will then guide them to a private consulting room where they can be put in touch with specialist services. The CCG supported this initiative by working with pharmacies so they have information about local domestic abuse services that offer practical interventions such as seeking alternative accommodation and taking legal proceedings to prevent perpetrators contacting victims.

Our priorities for next year will be to prepare for the implementation of the Liberty Protection Safeguards, to continue our improvement work for Domestic Abuse and to apply the proposed arrangements of an integrated care system to our response to adults who are experiencing abuse and neglect.

Examples of How We Made a Difference- Case Studies

Our CHC team undertook a routine review of a person that had recently become eligible for funding. The person lived in a care home. The review identified that the person was subject to unnecessary restrictions and these were causing the person distress. One of the reasons for this happening was that person was not in the most appropriate setting to meet their needs and therefore the staff did not have the skills to care for him. We worked with the person and their family to find alternative arrangements where he became less distressed. We shared this information with colleagues in the County Council, and worked with the county council to support the care home to improve and arrange for checks to be made on other people in the service who were at risk.

A member of our contracts team was responding to a request for funding for a specific service for a person. The worker was concerned that the patient was at risk of financial exploitation and was being coerced and controlled by a family member. We offered the person some alternative arrangements in relation to the funding to protect against financial exploitation. The CCG safeguarding team shared this information with the person's GP who was able to invite them in for an appointment to talk about what was happening to them which enabled them to access the appropriate support.

A GP practice contacted the CCG Safeguarding team for advice about a complex family situation. An appropriate process was in place to support a child at risk, but the GP was concerned about an adult in the family at risk of Domestic Abuse. The adult had a learning disability. As a result of the advice, the GP was able to call a multi-agency meeting to discuss all those at risk in the family, and as a result the adult was provided with support from the domestic abuse service.

Avon and Somerset Constabulary

- Detective Superintendent Lisa Simpson was appointed as the new thematic lead for Adults at Risk in February 2020. Lisa is part of the Investigations directorate and also holds the RASSO portfolio.
- The Adults at Risk Delivery plan was created and embedded into the 20/21 Constabulary Single Delivery Plan which was launched in April. This combined all directorate, department and thematic plans into one data base allowing the force to more easily understand the scale of improvement and change activity happening across the organisation. Further to that we have undertaken a self–assessment exercise against the NPCC 2020-2022 National Vulnerability Action Plan (NVAP)
- The NVAP framework provides the structure by which we can assess how well we are addressing and responding to vulnerability across all the crime types and strands. Rather than viewing each of the 15 vulnerability strands in isolation, the new approach will sit the strands under the overarching NVAP (see below. Each activity in the AAR delivery plan has been aligned to one of the 16 NVAP actions.

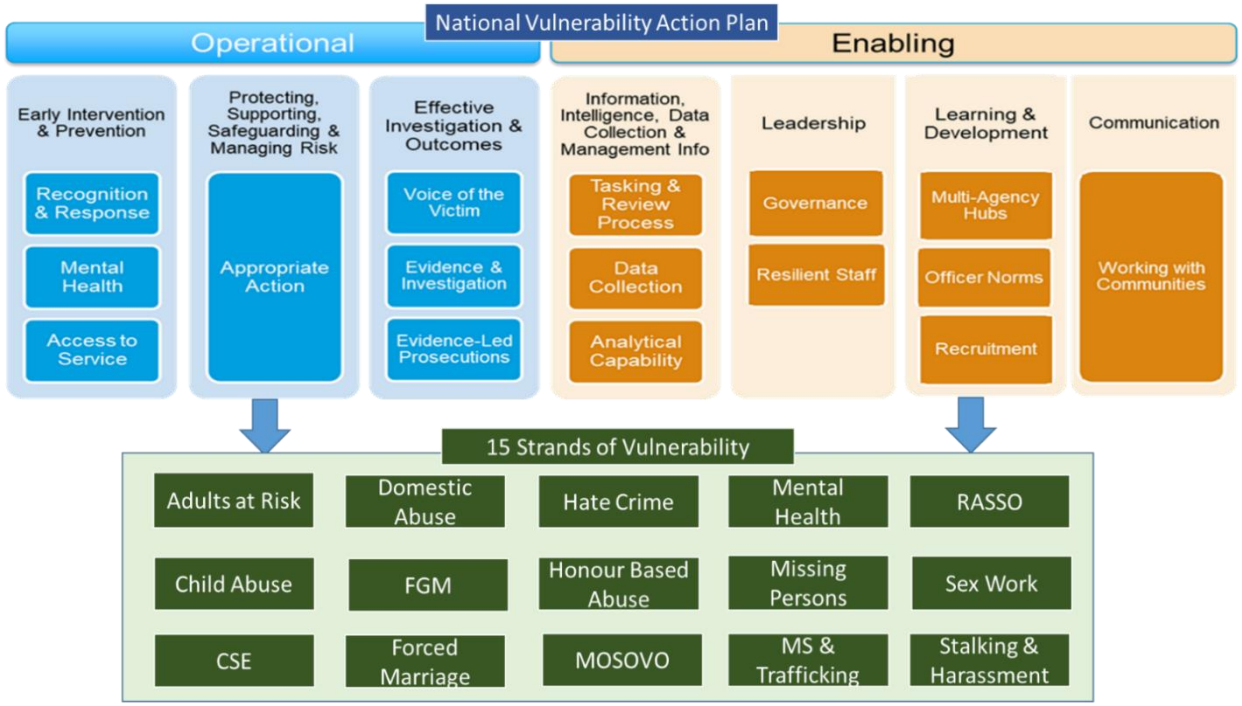


Fig 1

NVAP Actions

Early Intervention & Prevention		
2.1.1	Recognition and Response	Ensure that recognising and responding to vulnerability is everyone's business, especially at first point of contact
2.1.2	Mental Health	Acknowledging that mental health (MH) can impact across all forms of vulnerability. Forces to consider in their assessment of vulnerability as to whether indicators of MH are apparent and signpost/refer accordingly.
2.1.3	Access to Services	Ensure all staff know where and how to access service provision for all strands of vulnerability, especially at the local neighbourhood level.
Protecting, Supporting, Safeguarding and Risk Management		
2.2.1	Appropriate Action	In response to identified risk, ensure staff understand and utilise appropriate referral pathways including how to access partner provisions and are empowered to challenge or escalate decisions

Information, Intelligence, Data Collection and Management of Information		
2.3.1	Tasking and Review Process	To ensure that strategies and Force Management Statement cover all strands of vulnerability
2.3.2	Data Collection	Data collected in support of local responses to vulnerability is of high quality, supported by policy, training and accountability
2.3.3	Analytical Capability	Develop analytical capability and capacity to identify high risk areas of vulnerability in order to target intervention/prevention activity, including identification of emerging threats such as cyber, elder abuse, modern day slavery, transitional safeguarding and vulnerability to radicalisation
Effective Investigations and Outcomes		
2.4.1	Voice of the Victim	Develop clear processes to ensure that "the voices of vulnerable victims and witnesses" are heard
2.4.2	Evidence and Investigation	
		Develop competent frontline police and staff responders who use professional curiosity to ensure that the early investigation is maximised to gather best evidence
2.4.3	Evidence-Led Prosecutions	Develop and utilise in more effective ways early evidence gathering techniques and the use of "evidence-led" prosecutions in all appropriate cases (wider than DA and child abuse)
Leadership		
2.5.1	Governance	To optimise governance arrangements regarding vulnerability (in-house and multi-agency) to ensure synergy regarding understanding of threat, barriers, good practice, gaps and related forward work plans
2.5.2	Resilient Staff	Instil a supervisory approach at all levels throughout the organisation that encourages debriefing/review and a learning culture with a mind-set of "What did we do well?"
Learning and Development		
2.6.1	Multi-Agency Hubs	Ensure that MASH/multi-agency unit staff (where implemented) fully understand the principles relating to vulnerability and professional curiosity and that it is embedded within MASH/multi-agency processes
2.6.2	Officer Norms	Recognise that officer norms will change from exposure to aspects of criminality/vulnerability and that these need to be re-set so that thresholds of acceptability are maintained
2.6.3	Recruitment	To ensure recruitment practices show/test understanding of vulnerability for potential new employees entering the service
Communication		
2.7.1	Working with Communities	To work with communities to build confidence, improve understanding and increase reporting especially with groups affected by structural inequalities

Fig 2

Key performance indicators (KPI's) for each of the 15 vulnerability strands are used to support the business leads to monitor activity, inform decision making and report on performance. This is submitted quarterly to the Constabulary Management Board (CMB)

For Adults at Risk establishing these KPI's proved problematic. The constabulary have been providing all SSAB's with quarterly performance reports. These were based on a Safeguarding Adults (SA) local qualifier being added to an occurrence in Niche [Niche is a records management system used by the Police]. This qualifier should be added to any incident involving an Adult at Risk. However, significant unexplained increases in both crimes and incidents were noticed in the performance reports. A dip sample of SA flagged incidents concluded that the (SA) local qualifier was being used interchangeably with an alternative Vulnerable Adult (VA) national qualifier and often combined with Domestic Abuse (DA) and/or Mental Health (MH) qualifiers. This meant the mechanism for identifying an 'Adult at Risk' had become blurred within general vulnerability associated largely with victims of domestic abuse and those suffering a mental health crisis. Whilst we are assured that there is an improving nature in our teams to understand and focus on 'vulnerability', in doing so they are flagging anything with an element of any vulnerability with the SA qualifier. As such the performance reports were no longer representative of the 'Adult at Risk' demand on Police and a decision was made to stop sharing this data.

New performance reports based on the throughput of work to the Lighthouse Safeguarding Unit (LSU) have been drafted and shared with all boards for comment, a copy of the proposed report can be seen in Fig 3 below:

Adult at Risk Quarterly LSAB Performance report
Quarter 4 (Date Range)

Adults at Risk (AAR)	12 Months Rolling				Latest Quarter (starting)			
	Current	Previous	Change	% Chg	Jan-21	Jan-20	Change	% Chg
Number of AAR referrals going into the LSU								
Number of referrals going from LSU to Adult Social Care								
Number of AAR Strategy/M ash discussions								
Number of occurrences in a Care home								

Number of referrals going from LSU to Adult Social Care	12 Months Rolling			Latest Quarter (starting)		
Victim Age	Current	Previous	Change	Jan-21	Jan-20	Change
Aged 18-24						
Aged 25-49						
Aged 50-75						
Aged Over 75						
Not Known						

Number of referrals going from LSU to Adult Social Care	Offence Group (12 Months Rolling)					
Forcewide						
B&NES						
Bristol						
North Somerset						
Somerset						
South Glos						

Number of Reports at a Care Home	Offence Group (12 Months Rolling)					
Forcewide						
B&NES						
Bristol						
North Somerset						
Somerset						
South Glos						

Fig 3

In Jan 2021 D/Supt Lisa Simpson presented an Adult at Risk paper to CMB and the Police Crime Board (PCB) in order to provide the Chief Officer Group and the Office of the Police and Crime Commissioner (OPCC) with assurance of the Constabulary approach to Adults at Risk (AAR). The paper covered 5 areas which had been jointly scoped with the OPCC

1. Understanding our current and future demand in relation to adults at risk

2. How adults at risk are identified and supported at a local level
3. Investigating crimes in relation to adults at risk
4. Victim support and safeguarding for adults at risk
5. Working with partners

This is the first time Adults at Risk has been the subject of an Assurance paper for CMB and was an opportunity to provide an honest account of where we feel we are in our approach to AAR from an investigate and safeguarding perspective and to address the areas we need to improve. The report proposed 9 recommendations which were all accepted by CMB, and these will form the backbone to improvement activity in 2021/22

- **Recommendation 1:** Agree a new internal definition and identification of an Adult at Risk
- **Recommendation 2:** Before the Niche update takes place in 2022 a review of how qualifiers are managed and their permissions is recommended to take place. Currently anyone can put them on and anyone can take them off, and whilst this issue is not specific to AAR it impacts on many other areas.
- **Recommendation 3:** To commission the Open University with a specific piece of work around understanding our demographic and future demand from AAR and older people.
- **Recommendation 4:** To agree the following recommendations made in the BRAG[6] AAR Assurance report.
  - Additional training should be given to staff in relation to the BRAG which should include:
    - Why, when and how to use the BRAG tool, including consequences of not.
    - How to access guidance to support use of the BRAG tool.
    - Pathways for onward referrals for vulnerable individuals and understanding who is responsible for what (including when officers should make referrals directly).
  - The force should define the term 'Adults at Risk' and use consistent terminology and thresholds when referring to Adults at Risk.

[6] Blue Red Amber Green (BRAG) is an assessment used to provide a tiered approach to assessing vulnerability)

  - The force should agree governance procedures for tagging/qualifiers, including who adds them, when and under what definition, with specific reference to use of safeguarding flags.
  - Address lack of mental health and substance abuse pathway for support for vulnerable people.
  - Implement a review process to ensure that cases referred to LSU with no onward referral are not just closed with no action from anyone.
  - Consider a mechanism for officer feedback on the quality of BRAG completion to help improve quality and instil confidence in using the BRAG.
- **Recommendation 5:** Develop a more proactive approach to AAR and CL, such as looking at hot spots for CL activity and cross-referencing with partnership data to understand who may be at risk from cuckooing.
- **Recommendation 6:** Conduct a larger dip sample of investigations to bolster the findings from the few cases looked at in the AAR scrutiny panel.
- **Recommendation 7:** From the dip sample findings build a clear AAR pathway within the allocation policy and link clear, prioritised training subjects.
- **Recommendation 8:** Review LSU correspondence to assess how accessible letters might be to AAR victims, and look at whether adapted/simplified versions of correspondence could be implemented.
- **Recommendation 9:** Conduct a focus group with officers to explore if victim history is viewed or if the approach is one of isolated incident review.

In relation to **Recommendation 6** – since February the Audit and Inspection team have been collaborating with key stakeholders across the force to produce a comprehensive audit methodology. A deep dive audit of over 250 Adult at Risk occurrences will begin in June 2021, followed by a series of focus groups with officers and staff across the force. The findings from both will further identify the areas to focus our training and improvement activity.

A new crime allocation policy has recently been implemented which includes guidance for staff who have attended and / or investigated incidents, that necessitate onward allocation. There is a two-stage decision making process to determine whether or not a crime should be onward allocated to the Investigations Directorate. The primary decision making stage considers whether or not the victim possesses characteristics which need specialist skills to secure best evidence. Unlike the old allocation policy it specifically references the Adult at Risk Care Act Definition and determines that any investigation involving an AAR should be allocated to Investigations irrespective of the seriousness of the offence. This will ensure a CID oversight much earlier in the investigative process and mean they are the gatekeepers of a far greater proportion of AAR investigations.

All Care home locations are now flagged with a care home marker in STORM & Niche. This is the first time since moving to Niche we are able to report on incidents/offences taking place in these locations, helping neighbourhood teams quickly identify areas of concern or patterns of abuse. We are still looking at a ways of automating the maintenance of these records and we have an outstanding SAR recommendation to widen this to include Supported housing, and are still exploring options on how this could be best achieved.

The Case Review Team that manage all SAR/SCR and DHR's activity are now aligned to the Investigations Directorate. They consist of 1 x FTE DI, 1 FTE DS, 2 police staff along with a pool of 4 zero hours staff available for rapid review / IMR's. The number of SAR's the force has been involved in in 2020/21 is shown in the below table.

	Safeguarding Adult Reviews				
	Referrals made (by Police)	Awaiting Decision	Commissioned	Completed	Declined
B&NES	2				
Bristol	5	1			2
North Somerset	3				2
Somerset	7	2	3		23
South Gloucestershire	1	1	3		1
TOTAL	18	42	6		78

Fig 4

There are currently 9 outstanding SAR recommendation most of which are incorporated within AAR Assurance paper recommendations.

The new manager of Lighthouse in Somerset reports that the situation in relation to Adults at Risk in Somerset has been largely stable over the last 12 months. The MASH is working effectively and that cases discussed are appropriate with an average of 3 to 4 discussed each week. Somerset and B&NES are the only 2 areas in the force to have an Adult MASH.

Finally, we do not feel that Covid-19 had an adverse impact on our service delivery. We worked differently, but we didn't stop providing any service. We know there are likely to be hidden victims out there who have been more hidden than usual as we have seen this in other areas such as domestic abuse and a spike in child protection concerns as schools returned. There have been no issues flagged nationally or regionally about impact of Covid-19 on policing in this area, but the forthcoming audit of cases could provide a greater insight into this.

Somerset County Council

This Annual Report presents us with an opportunity to look back over the past year, reflect on the challenges, our achievements and the progress made, and highlight our ongoing ambitions for the months and years ahead.

Our Pandemic Response – ensuring care and support arrangements in place

2020/21 proved to be unprecedented and challenging for all individuals, services and organisations in so many ways, but has also served to demonstrate why adult social care activity, including safeguarding, is so vital and valuable. It has reminded us of the importance of collaboration, communities, and of the care, support and protection of those who need some help the most. For all the difficulties the pandemic has presented, there has also been significant learning and innovation to emerge from it, and there is much we can be proud of as a workforce, and as a service, that has continued to improve lives and promote person-centred working throughout.

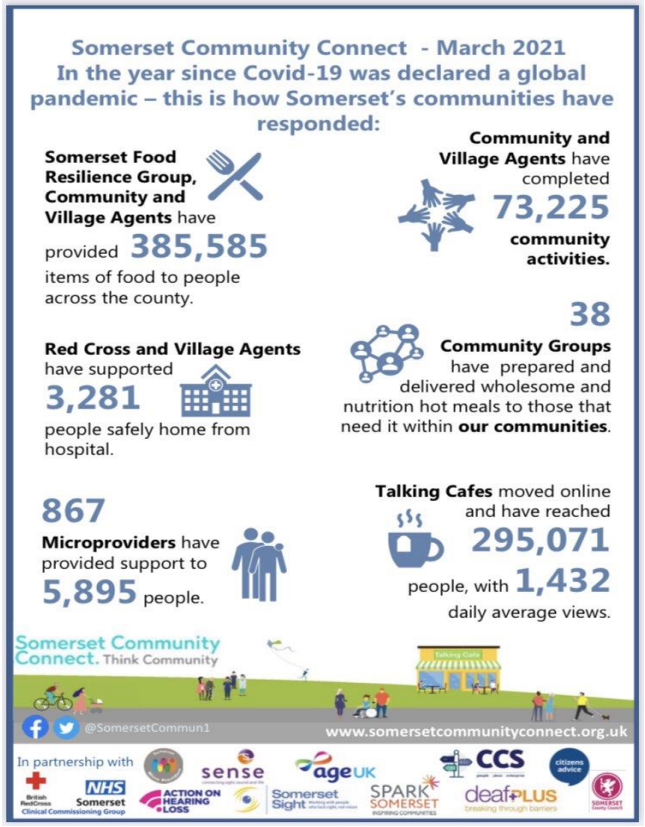
The range of measures that were introduced in response to the Covid-19 pandemic had a considerable influence upon the work of Local Authorities and NHS Trusts. The implementation of The Coronavirus Act enabled Local Authorities to apply and make decisions at person centred level about who is most in need of care and who might need to have care and support withdrawn in order to make sure those with highest need are served. Adult Social Care in Somerset implemented a Covid-19 Professional Decision Making Framework, reviewed on a routine basis alongside our Contingency Plan. We ensured our workforce was fully updated with the legal changes and their implications on practice. Training was given surrounding the Ethical Framework and the European Convention on Human Rights to ensure our staff were clear and confident in their practice, professional decision making and accountability throughout the pandemic.

Our Adult Social Care Service formed increasingly close links with partners across health and the wider community and voluntary sector, to deliver the kind of care and support services that people both want and need. It has also continued to

invest in strong engagement with the independent care provider market, with the quality and extent of Somerset's Adult Social Care Covid-19 support and response activity being recognised nationally.

Together with Public Health and Clinical Commissioning Group colleagues, Adult Social Care has worked hard with local care settings to support them in managing and responding to the unique pressures presented by the pandemic, and to take all possible steps to mitigate and prevent the spread of the coronavirus. Adult Social Care quickly established a COVID-19 Incident 'Room' staffed to serve as a central advice point and information repository, with a dedicated phoneline and email address to provide pragmatic support. Out of hours capacity was provided at peak periods and when required. The service also continues to produce and distribute regular 'provider briefing' communications, sharing latest national and local guidance, advising of key developments, and providing responses to frequently asked questions. In addition, a dedicated provider webpage was established to host and manage information flow and promote the range of support available to the care sector; the service is currently in the process of creating a more permanent and user-friendly website for care provider engagement now and beyond the pandemic in recognition of its value. The service has also supported care provider colleagues with increased funding from the outset, coordinated and delivered PPE during national shortages, and with Acute Hospital colleagues, established a 'bank' of staff available to support the sector at points of crisis. It has coordinated and overseen significant work in monitoring the Capacity Tracker and the distribution of the ASC Infection Control fund ring-fenced grant and the Workforce Capacity Fund, supporting adult social care providers to reduce the rate of COVID-19 transmission and support wider workforce resilience.

Social care, health and voluntary organisations have continued to work together to address social care needs at the very earliest stage. Community and Village Agents, part-funded by the Council, work closely with our social work teams to help people find solutions that allow people to live as independently as possible in their own homes and communities. This service (see right) has been praised for its 'innovative approach to care' by the Social Care Institute of Excellence.



The pandemic has also highlighted more than ever the vital role that carers play in our communities. Somerset Carers (Carers Support Service) has extended the role of all Village Agents to ensure carers are supported by all (+63 agents as opposed to the 5 assigned carers agents). Over the last 12 months, 796 carers have been supported. Carers have also benefitted from a dedicated helpline and information website www.somersetcarers.org

Supporting carers continue to be a high priority for Adult Social Care in Somerset, and for that reason we continue to push forward the Carer Continuous Improvement Programme in partnership with Somerset Clinical Commissioning Group, contracted service providers and carers themselves.

Adult Social Care has also worked closely with Learning Disability providers to ensure they had the right support in place to meet the needs of individuals they were supporting. At times this meant an increase in support due to the impact the restrictions had on individuals' daily life and routine. Many of the day provisions closed due to Government guidelines and restrictions; we worked with families and carers to ensure they had the support they needed and, where required, put alternative solutions in place. We supported in making reasonable adjustments for individuals and were able to utilise open

spaces to enable individuals to access throughout the lockdown period. Easy read guidance surrounding the pandemic and restrictions was also shared across local health and care services, as well as with service users, families and carers.

Our Adult Safeguarding Activity

Safeguarding adults at risk has remained a key priority for Adult Social Care throughout the pandemic, with the service continuing to operate as 'business as usual' throughout, meeting all core duties and statutory responsibilities. Somerset County Council has the lead role for adult safeguarding in Somerset, which it primarily discharges through its dedicated Adult Safeguarding Service.

Each year, the Local Authority submits a statutory return as part of the Safeguarding Adults Collection (SAC) which records details about safeguarding activity for adults aged 18 and over in England, reported to, or identified by, Councils with Adult Social Services Responsibilities; the collection includes demographic information about the adults at risk and details of the incidents that have been alleged. In line with national trends emerging, our data suggests that there was an overall reduction in the number of safeguarding concerns raised with the County Council during 2020/21 when compared with 2019/20. We know in Somerset that the pandemic has influenced how registered care providers have reported safeguarding concerns to the local authority. In April 2020 the referral rate from provider settings reduced at a time when provisions were focusing on meeting the changing demands of their client group.

Somerset has seen a rise in the proportion of safeguarding enquiries relating to self-neglect (in 2019/20 3.75% of enquiries related to this risk type, but in 2020/21 this figure had increased to 7%). We believe this to be partly a direct influence of the increase in community responses – neighbours and relatives looking out for each other, volunteers providing support etc – during the peak of the pandemic response and will continue to closely monitor. As a service we have recognised the increase in self-neglect and hoarding situations across Somerset and acknowledge that people experiencing these risks often require

a skilled and extended service from us. We know that the timescales for working with people who are self-neglecting is governed by them and their willingness to make change.

Within the county there has been a robust multiple agency response to meet the demand of domestic abuse during the lockdowns and as easing of lockdown has occurred. The Adult Safeguarding Service is proud to continue to support the Safer Somerset Partnership multiple agency response to meet the demand of Domestic Abuse in Somerset during the lockdowns and as easing of lockdown has occurred. Whilst the Somerset Domestic Abuse system has experienced a slight increase in reported incidents of Domestic Abuse it is not on a par with the national reporting picture. We continue to support the Safer Somerset Partnership's statutory duty to undertake Domestic Homicide Reviews and to implement learning across adult social care. We are taking care to analyse and respond to the emerging need of people over the age of 70 years who may be experiencing Domestic Abuse from a partner, cared for or adult kin.

We have been able to achieve some positive overall outcomes for those being supported through a Safeguarding enquiry over the last year:

- In 97% of safeguarding enquiries undertaken in Somerset during 2020/21, the identified risk was reduced (57%) or removed (40%).
- When an individual was asked and expressed a desired outcome from the safeguarding intervention, 99.6% of outcomes were either fully or partially achieved.
- 95% of people assessed as lacking the mental capacity regarding their safeguarding needs were supported by an advocate, family or friend to ensure that their voice is heard as part of the enquiry.

To provide governance and oversight of the standard of practice in the Service, quality assurance audits are undertaken both internally and as part of the SSAB's Quality Assurance subgroup. The feedback from these audits has continued to be positive, as has the learning, to develop and further enhance the service delivered. The Somerset Safeguarding Adults Board has 'Listening and Learning' as a key overarching Strategic Plan priority, and places specific emphasis on the need to encourage

and actively seek feedback from people who experience adult safeguarding and their carers. Consequently, the Council's Adult Safeguarding Service have been working with Healthwatch to devise a way to capture service user feedback and launched 3 x feedback forms (directed at anyone who has recently received support from the Adult Safeguarding Service) in the Spring of 2021.

Safeguarding Adults Case Study

Sam, a Social Worker in the Council's Adult Safeguarding Service, has recently worked with DF, a 67 year old gentleman with Learning Disabilities.

DF was being targeted by neighbours living in the flat above him. They were using his flat, his phone and 'borrowing his money'. When they were not using his flat, they would torment him by shouting at him and tapping on his windows which made DF fearful in his own home.

Sam collaborated with those involved in supporting DF, including an Adult Social Care Practitioner from the social work locality team, the care provider for DF, Housing, an Anti Social Behaviour officer, the local Police Community Support Officer, and DF's GP.

DF's desired outcomes were for his neighbours to no longer go to his flat or torment him. Working collaboratively, the following protection plan was put in place:

- Carers to report any incidents of neighbours in DF's flat to 101
- DF to lock his door, use his door chain and spy hole before opening the door (chain provided by ASB officer)
- DF to ask who is at the door before he agrees to open it or not
- DF to use his piper line when he needs support to ask the people to leave
- Deane helpline to ring 101 on DF's behalf if required

- Letter to be sent to tenants from Anti-social behaviour team at SWT, tenants spoken to on numerous occasions by Housing Officer and ASB officer
- Increase in care hours from 7 to 11 hours
- DF to contact 101 if he needs to

Upon speaking to DF at the end of the enquiry he told us:

- he feels safer now because of the help received during this enquiry.
- he is now locking his door and using his door chain. He is asking people who they are before they come in and did so with the recent GP appointment.
- DF informed me that when his neighbours knocked, he said "excuse me, who is that". DF said they couldn't come in and he would get the police, and they walked away. This is a real achievement for DF.
- DF consented to a referral to a Village agent to try to source a volunteer to visit him at home, on a befriending basis.

This is a good example of collaborative working to achieve a great outcome for DF, empowering him to say no and safeguard himself.

Throughout 2020/21, 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. This work is enhanced by our close working partnerships with the Care Quality Commission, NHS Somerset Clinical Commissioning Group, Somerset Partnership NHS Foundation Trust and our care provider network. Our ethos being that 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.

The Service has also been very fortunate to link with local and national continued professional development and training events. This ranging from Modern Slavery, Self-Neglect, Trauma informed practice, learning from research and safeguarding adult reviews in other LA areas. In addition, as a service we have made use of the virtual world and invited other services, specialisms and experts, in to share their knowledge with us and foster stronger links with multiple organisations. Some of these include Devon & Somerset Trading Standard, SARI, Devon & Somerset Fire Service, Somerset Drugs and Alcohol Services as well as independent specialists in safeguarding.

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 2020/21 safeguarding training was delivered virtually and the cohort size was reduced to a maximum of 12 learners as a result.

Course and duration	Attended
Recognising adult abuse (St Thomas training) ½ day - virtual	July 20 – 12 (inc 2 x attendees from Somerset Direct) Jan 21 – 10 (inc 3 x Leaving Care, 1 x Somerset Direct) **Total: 22 staff**
Developing safeguarding practice (St Thomas training) 1 day (converted to 2 x half day virtual)	May 20 – cancelled due to COVID Sept 20 – 8 Sept 20 – 10 Feb 21 - 9 **Total: 27 staff**
Making Safeguarding Enquiries (St Thomas training) 2 & 1 day follow up (converted to 3 x ½ days virtual plus 1 day follow up)	July 20 – 10 Jan 21 - 11 **Total: 21**
Locality Leads workshop (facilitated by Safeguarding leads) ½ day – virtual	Oct 20 – 7 Nov 20 - 12 **Total: 19**
Safeguarding Master class – open to Service Managers and Commissioning 1 day	**Total: 0** Workshop postponed until September 2021 due to COVID
Safeguarding CPD quarterly drop in/ workshop ½ day	Oct 20 – 12 Nov 20 – 11 March 21 – 8 **Total: 31**
Understanding Brain Injury (facilitated by Headways UK)	April 20 – cancelled due to COVID March 21 – 12 **Total: 12**

Bespoke learning commissioned on behalf of the Safeguarding Service

Course and duration	SSAB staff group	Attended
The Mental Capacity Act and Self-Neglect (facilitated by Edge Training and Consultancy) 1 day (delivered virtually via 2 x ½ days)		March 21 – 24 (inc staff from Mental Health, Somerset Independent Plus) **Total: 24**
Modern Slavery (facilitated by Unseen) ½ day		Nov 20 – 28 (inc staff from Mental Health, Leaving Care, SSAB Partners) **Total: 28**

The Safeguarding Service has also taken the opportunity link with groups, networks and local communities to raise awareness and the profile of adult safeguarding. Undertaking sessions to raise awareness with Somerset County Cricket, SPARK volunteers, Talking Cafés, GP networks, Primary Care Networks, Avon & Somerset Police and internally with Somerset Direct, social care Locality teams and Health Interface Services.

Looking to the future

The Adult Social Care sector faces real challenges. Covid has added significant additional need, activity and challenges to an already over-stretched, under-resourced set of services. Councils up and down the country are now facing significant pressures as rising numbers of people are seeking help, care and support (from both older adults and disabled people of working age) as society starts to open up again. Nationally and local there is growing evidence of 'carer breakdown' where families have coped for over a year without respite but are no longer able to carry on without assistance. The inter-dependence of social care and the NHS has never been starker, with Local Authorities supporting growing numbers of individuals awaiting hospital admission or being discharged from hospitals, with increasing numbers going on to have a social care package of support. There are also well-known challenges across the sector relation to pay, recruitment, retention and turnover, highlighting the importance of a long-term national workforce plan. Care market sustainability is a continued concern and vital in mitigating risks of unmet care need. Such trends are unsustainable and together with counterparts across the country, we are calling on Government to outline its plans for social care reform and funding.

At a more local level, we are seizing opportunities for continued collaboration and integration, looking forward to developing our links with neighbourhoods, understanding what is happening amongst our communities and with our partners to drive home the preventative aspect of adult safeguarding – helping our communities to keep safe and promote inclusivity.

NHS England and NHS Improvement (NHS E&I) – South West

We recognise that all communities and every aspect of both children and adult services have been affected by the Covid-19 pandemic, it has been an exceptional year for all of us. The Covid-19 pandemic has also disrupted professional and supportive services relationships with children, families, carers and adults with care and support needs.

Forced to stay at home during the pandemic, some families have reported a positive impact in spending more time with loved ones. In contrast, others have found the experience very isolating and lonely or feel unsafe. They raised further concerns about the impact on mental health and emotional wellbeing for all ages, and the resilience of families across the paid and unpaid workforce.

Strengthening leadership and partnership collaboration

During 2020/21, NHS England and NHS Improvement have been central to coordinated responses during the pandemic. Solid multi-agency leadership and strategic direction focused on improving our central coordinated efforts to gain clarity regarding the problem(s) needing to be tackled across our communities, to keep vulnerable citizens safe during the Covid-19 pandemic. We have set-up the first SW Regional Serious Violence & Contextualised Safeguarding (all ages) Data and Information Sharing Group, securing regional leadership and collaboration across PHE, policing, community safety partnerships, violence reduction units and local safeguarding partnerships, linking strategic priorities and Joint Strategic Needs Assessments for violence and abuse. The group have produced a SW Regional Serious Violence & Contextualised Safeguarding Information Governance Framework.

Early in the pandemic we restructured to deliver programmes of support through various groups, ranging from regional joint Covid-19 Gold calls, Health Outbreaks & Operational Pressures, Infection Prevention & Control (IPC), pathology, clinical cells, establishing care sector networks and the regional ethical referral groups, restructuring our regional safeguarding governance arrangements to improve collaborative data sharing and problem-focused analysis. This has provided core groups to oversee issues and challenges to keep citizens safe. In turn, we were supporting our communities including the care and independent

sector, designated and named professionals for safeguarding, as well as the workforce supporting Nightingale hospitals, front line staff and individuals seeking guidance and advice, providing peer support for NHS volunteers, test and trace centres, swab test sites as well as mass vaccination sites.

We continued to act as a key link between national, regional and local systems and practitioners and have been involved in the National Safeguarding Adults Network and working with both the Regional SW Safeguarding Adults Board Chairs and SW Safeguarding Adult Health Network, to tackle emerging or continued challenges.

Challenges

Impact on assessments

The year has also been a year where health and social care assessments have been deferred nationally and in the SW region, placing further challenges for adults with care and support needs and families accessing Care Act assessments.

People eligible for NHS Continuing Healthcare (CHC) continued to receive support and case management by the systems CHC teams, despite the assessments of new referrals being stood down between 31st March and 31st August 2020, and with some CHC workforce redeployed to front line care. Our system CHC teams adapted processes, introducing supportive methods to continue to oversee the care of NHS CHC eligible people such as direct access telephone access and telephone support calls. Those people who needed urgent review of their care plans but were vulnerable and isolating, were supported using virtual technology allowing urgent reviews to continue to take place. Health and social care CHC teams worked in partnership strengthening relationships and communication, to ensure people who were unable to be assessed during the pandemic were discharged from hospital in a timely safe manner and supported people to stay at home preventing a hospital admission. Discharge hubs were established which allowed appropriate advice and sign posting using CHC workforce and social care workforce to support hospitals with the discharges linking to the community services available. This included the support of

people in the final days of life wishing to go home from hospital or remain at home, supported with an adapted short form individual personalised care plan, using personal health budgets (PHB) to speed the process and pilot end of life PHBs.

A recovery and restoration programme for deferred NHS CHC Assessments and Care Act assessments commenced in October 2020, where health and social care joined to work on the outstanding assessments. Some systems found this very challenging when workforce had been redeployed, unable to return or increasing their workforce resulting in limited success. We worked on a regional recovery workforce plan engaging with Nurse returners offering webinars and pastoral support to return to nursing, gaining huge success leading to CHC teams increasing their workforce to meet the demand and allowing registered nurses to come back to the NHS.

We offered a Covid-19 response call every week for CHC leaders across health and social care to strengthen communication, sharing national policy updates, encouraging peer engagement, sharing learning from practice and exploring new ways of working. We also arranged senior leadership ADASS and CCG Director of Nursing calls to ensure key messaging, cascade of policy information and joint working principles were maintained during the pandemic.

Keeping focus on specific people who have protected characteristics

Nationally and regionally we have also completed our Safeguarding Equality Impact Assessment, to ensure that the needs of people with protected characteristics, as well as those experiencing health inequalities, have been considered and actioned during the pandemic.

The increased vulnerability of people with a learning disability was identified early into the pandemic and reinforced by the LeDeR national review of deaths of people with a learning disability during the Covid-19 pandemic. This report highlighted key actions that were felt to reduce the risks for this group of people. The majority of the suggested actions had already been considered and actions implemented, including the rollout of RESTORE2 and RESTORE2 Mini, to improve early identification of deteriorating health by social care staff. The report did help to raise awareness across the wider health and social care

community and led to increased senior leadership involvement and inclusion of people with a learning disability as a priority group.

Virtual working has improved the ability to network across systems and we have experienced increased collaborative working. An example of this is specialist learning disability services and primary care services with commissioners working together in a Call to Action to improve the uptake of Annual Health Checks for people with a learning disability. These checks are a good means of identifying health problems early and ensuring the right support is being offered. In quarters 1 and 2 we saw a marked reduction in the number being provided however, following the Call to Action and excellent work in local areas, the number has increased to near or above last years number.

Direct Commissioning

We have been supporting the national work led by the National Quality Lead Nurse for Health and Justice, regarding safeguarding within the prison estate. A guide to wellbeing & safeguarding support in prisons is due to be published on the NHS Futures platform, and work is ongoing with Health Education England to design safeguarding training specific to prisons. This element of the work will commence in 2021/22 (May 2021).

Covid-19 Oximetry in the secure and detained estate

The Direct Commissioning Health and Justice Team have supported the prisons across the SW including Dartmoor to have oximetry monitoring to support the earlier detection of (silent) hypoxia and further help the reduction in mortality and morbidity from Covid-19. All prisons in the SW can use the self-monitoring resource, which is equivalent of the oximetry @home programme.

Our SW NHS Safeguarding Workforce

In the summer of 2020, our NHS safeguarding workforce profile demonstrated over 55% of our safeguarding workforce is above the age of 50. Keeping citizens safe through workforce succession plans and securing opportunities to skill up the SW

workforce has also been a key focus during 2020/21. Collaboration with Health Education England has resulted in a successful bid and subsequent development of a regional accredited safeguarding module, to commence Autumn 2021.

Some challenges for safeguarding adults with care and support needs remaining for 2021/22.

- We seek to work collaboratively to improve service pathways for our most vulnerable members of society and their families, particularly children and young people with learning disabilities, special educational needs and disabilities and those who are moving into adult services.
- We have planned a focus piece of work during 2021 to examine the pandemic's impact on children in care and care leavers living in the South West.
- Direct Commissioning are planning to roll out the RESTORE2 to recognise early soft signs of deterioration, both across the health care team and non-clinicians such as prison staff.

Somerset Care

At Somerset Care we value our involvement in the Somerset Safeguarding Adults Board and have used this multi-agency learning to drive organisational improvement through our own safeguarding committee. Membership of our committee draws on the knowledge and experience of individuals from across our diverse range of services and has a reporting line to the Board via the Quality Committee. Updates are cascaded to all services following meetings of the Quality Committee to facilitate shared learning from any incidents or other areas discussed. This ensures that any actions are followed up to prevent reoccurrence. The safeguarding sub-committee has continued over the last twelve months bi-monthly and has focused on the following priorities:

- Throughout 2020 our services have been impacted by the Covid-19 pandemic and our work focused on developing a digital risk monitor across our Care Home, Community and Realise services to ensure that interruptions to care delivery were minimised and risks from community and service transmission of the virus had robust contingency plans and control measures in place and were escalated promptly to all stakeholders and partnership organisations in an open and transparent way.
- Dynamic risk assessments were undertaken with all customers and residents to ensure that those who were being impacted either mentally or physically from reduced contact with their loved ones were supported to have essential visits in their own rooms with the appropriate control measures in place. Technology was harnessed early on to ensure we maintained communication through the use of the Relsap, Facetime and Skype. Garden visits under the cover of Gazebo's were available throughout the summer months in accordance with Government guidelines and we introduced dedicated screened visiting 'PODs' in the Autumn which enabled all residents to continue to receive visitors safely.
- During the course of the Pandemic as an organisation we have developed and built on effective relationships with our Adult Social Care and Health colleagues which has been imperative to ensure our customers and residents receive the care and support they need and their wishes are respected, whilst aware of the restrictions and limitations of our partners in enforced changes in ways of working. Early on in the Pandemic we worked collaboratively in registering a Nightingale Care Home for residents that were Covid-19 positive and no longer needed Hospital care. This was prior to the designated Care Home scheme and ensured that adults at risk received the nursing care they required whilst keeping the risk of transmission out of our Care Home environments.
- In our Care Homes, the restrictions enforced through the Pandemic, where people were in effect removed from their communities, introduced a risk of a closed culture forming. As CQC state, a closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones. Along with our other initiatives to maintain contact in innovative ways with loved ones, we implemented a leadership programme for our managers and leaders and a customer engagement schedule, the "Always Events" to ensure that despite the restrictions there was positive and open engagement between staff and with people using the service and

their families to find out what mattered to them and what improvements they would like the organisation to make. These initiatives along with "time to talk sessions" and "frazzled café's" have been implemented and rolled out across the whole organisation to engage with staff and people who use our Community and Realise services.

- An outcome of these engagement events has been the review of our whistleblowing policy, to make the wording more accessible for our staff teams, to reflect our organisation values and to introduce the role of speak up champions across our services. Alongside the whistleblowing policy, in February 2021 we opened consultation with our recognised trade union to introduce a new set of People Policies that incorporate our Values and Behaviours. As part of our Values to 'Do the Right Thing', through the pandemic, it has been more important than ever for us to foster cultures of trust, fairness and inclusion. We recognise that our people policies play an important role in supporting these cultures by outlining the responsibilities of both Somerset Care Limited and our colleagues. We know that People policies can positively impact on employee motivation, our reputation and the ability to attract and retain talent. By having the right policies in place, with the right implementation, they can support the attitudes and behaviours needed so that we can continue to deliver quality care.
- We recognise that sometimes it feels difficult to raise concerns and colleagues may feel reluctant to speak up. We want to support a culture where colleagues feel they have the confidence to have open conversations with managers and contribute to good working relationships and great customer care, which is why we have introduced a new Equality, Diversity and Inclusion Policy (with supported online learning) and a new Grievance Policy, which commits to Somerset Care ensuring a safe workplace in which everyone is treated fairly and all colleagues stay true to our Values and Behaviours.
- These new policies encourage and support all colleagues at Somerset Care Limited to raise their concerns and 'speak up when things aren't right' and never walk past something that they're not happy with; all colleagues should expect to be listened to, with their views heard and respected.
- We have introduced Pulse Surveys across all of our Services on a 6-monthly basis. This survey is a check-in, providing a pulse check on topics such as employee satisfaction, job role, communication, relationships, and work environment. As well as set questions, the Survey provides employees with the opportunity to improve their experience of working for

Somerset Care by telling us what would make a difference to them. With the feedback, we can develop the right people strategies to make Somerset Care a great place to work, with the mission to support people to live the life they choose.

- The ER team has developed 'lessons learned' sessions with managers on people cases managed as a development opportunity, to support managers and build their confidence with future cases and people management. The ER team work with managers to consider what could be improved in the future, working proactively to coach them on how we can achieve better outcomes. This activity, coupled with monthly reporting on trends and patterns with identified people interventions, is aimed to reduce the likelihood of encountering the same issues arising. This also enables the ER team to assess the learning needs and design appropriate training.
- A full review of safeguarding events that had been notified over the last year was undertaken to ensure that alerts were being raised when appropriate but also that where the threshold was not being met concerns were being addressed collaboratively in line with the "what to do if it's not a safeguarding" guidance. As a result of this work, training has been developed on event reporting and SMART action planning. In addition, we have engaged with our Registered Managers to understand their confidence levels in undertaking a Section 42 investigation that ensures the views of the adult at risk are central to their route cause analysis and additional interactive sessions are being developed from this feedback.

Somerset Health and Wellbeing

Somerset County Council – Public Health

Somerset County Council Public Health Team Safeguarding Adults and Children Through the Pandemic 2020/21

Somerset Public Health (SCC PH) team provide and commission a range of public health services. Safeguarding both adults and children are at the heart of everything we do and managed through a 'Clinical Governance assurance process.' Each commissioned and provided specialist service undergoes a quarterly performance review using a standardised template that details safeguarding and patient safety incidents. This review details where the right support for clients has not been immediately available, what escalations have been undertaken and with what outcome.

- SCC PH receive adults safeguarding board newsletters and these are cascaded to our services to ensure that learning is shared and where there are actions for individual services identified from either Safeguarding adult reviews or inspections, progress against these are requested at each quarterly contract review
- SCC PH team members who have client or commissioning responsibilities have undertaken adult safeguarding training appropriate to their role.
- During the pandemic SCC Public Health have ensured PH services are continuing to deliver services to clients, in a Covid-19 secure manner, where required face to face support was provided for the most vulnerable
- As care settings for vulnerable groups e.g. those people living with learning disabilities, people living with dementia or the elderly, were affected by outbreaks of Covid-19 a multiagency approach was taken to ensure consistent and co-ordinated support and advice was provided to settings. Inputs were provided from SCC Public Health, PHE, adult social care and the CCG infection control team. This was extremely well received by providers and developed in response to provider feedback over the duration of wave 1 and 2. If staffing shortages could impact the quality of care provided, ASC and CCG worked together to ensure individual's needs were met, through the provision of additional staff, often funded through the national IPC grant. When CQC reviewed the support in Somerset to people living with learning disabilities during the pandemic, the multiagency approach was recognised by providers as a strength

Provider services

The Public Health Nursing (Health Visiting and School Nursing), Smoke Free Lives Service and Healthy Lifestyles (ZING) have worked effectively together to maintain and develop a robust offer for all families during the Covid-19 pandemic. There has been minimal redeployment of staff from any of these services and therefore service delivery has been maintained in line with National and local Covid-19 guidance.

- All levels of Children Safeguarding Training have continued to be delivered for Public Health Nursing either online (e.g. webinars/ MS Teams) or e-learning. In addition, safeguarding supervision has continued to be provided both as group, individual and ad hoc sessions. Ad hoc supervision is available for all staff within Public Health via the Designated Safeguarding Lead for Children.

- Staff have continued to deliver services with specific priority for those who are most vulnerable face to face following risk assessment and using appropriate PPE
- The Public Health Nursing Service have worked in partnership with Children Services to develop and implement a Multi-agency Lead Professional Approach (MALP) which identified those children at greatest risk and agreed guidance to ensure joined up service delivery.

Stronger Communities Team

The Stronger Communities Team in Public Heath includes work with the coronavirus helpline and volunteers, the Armed Forces Covenant, support to the Voluntary and Community Sector and the Central Volunteer Team. The following has been achieved in adult-safeguarding

- Adult safeguarding e-learning (and associated resource links) is a key element of the Volunteer e-learning suite, which also includes also includes other adult related content (Awareness of Mental Health, Dementia and Learning Disabilities, oral health and Making Every Contact Count.) Completing this training is a requirement for the volunteer role, for some volunteers this has had to be produced in paper format..
- In September 2020 the Armed Forces Covenant Partnership Executive reviewed the data around the armed forces in Somerset. Current data on the Armed Forces is included in Somerset intelligence website at http://www.somersetintelligence.org.uk/armed-forces.html and is used to support improved provision for veterans and families.
- The 2021 Census - which included a question on veteran status for the first time - will be useful addition to understand the veteran population in Somerset

Somerset Drug and Alcohol Services

Somerset Drug and Alcohol Service SDAS) offers support to adults, young people and their family and friends across Somerset who are experiencing difficulties around substance misuse.

At the start of the Covid-19 pandemic SDAS quickly adapted their way of working to working remotely. This involved the temporary cessation of face to face appointments and groups. We considered the potential risks that lock downs/pandemic could cause for example the likelihood that drug and/or alcohol use may increase as people feel more stressed by being at home more.

SDAS put together a RAG rating system where the service risked assessed their most vulnerable adults and children and made contact with this cohort on a regular basis.

Staff were supported in eliciting safeguarding information from clients over the phone in the absence of seeing them in person. Workers listened to their clients to identify any safeguarding concerns and by using professional curiosity. If a safeguarding concern arose then the service used normal safeguarding escalation process.

Clients who were identified as high risk where supported face to face in a health setting or within one of our hubs. We continue our partnership working, which is more important than ever due to the limitations of being able to meet with individuals face to face. We continue to share risks with relevant agencies and any learning that may come with this.

SDAS re-introduced groups/workshops but these have been online. There has been an increase in attendance since moving to online groups. Many service users have reported that they prefer this model as it is less intrusive on their day to day living.

SDAs have reiterated to service users the importance of safe storage/and risks of not having adequate storage, parents not taking medication in front of children, storing of drug paraphernalia/alcohol. SDAS workers ascertain what safe storage measures they have /in place and send out lock boxes if required.

The safeguarding manager has been leading on raising the domestic abuse profile across the service and raising our response to domestic abuse through staff given a refresher around identifying domestic abuse and keeping them up to date around government domestic abuse initiatives. Staff have also attended Turning Points safeguarding training during the pandemic online. New staff attend SDAS safeguarding Induction during their probationary period.

SDAS clinic reviews continued however online, but invite service users in if it is felt due to the risk they need a face to face appointment.

Within the last year SDAS have become part of the Family Safeguarding Team and the Family Drug and Alcohol Court (FDAC); this is proving beneficial joint working with our colleagues.

SDAS chair a monthly midwifery meeting with the specialist midwifes at Musgrove Park Hospital, Yeovil District Hospital and Bath Royal United Hospital. Within the last year we have introduced Jack Hall our Digital and Partnership Manager to the team who is currently building new partnerships.

SDAS continue working collaboratively with mental health services, children social care, adult social care attending strategy meetings, core groups etc… the core of which is always looking at keeping our service users and families safe. SDAS hold Dual Diagnosis meetings on a regular basis and continue safe practices through our clinical governance.

Somerset Integrated Domestic Abuse Service:

Domestic abuse continues to be a priority for all councils in Somerset due to its long-lasting impact on the lives of survivors and their families. The Covid-19 pandemic had an impact on domestic abuse globally, Nationally and locally with the Government's stay at home advice creating new challenges for people experiencing domestic abuse; home is not always a safe place for everyone. This past year, the Public Health team have been monitoring this impact, preparing and ensuring specialist services are fit for purpose and

responding effectively whilst making sure that our communities were aware that services remained open during the pandemic regardless of restriction, and how to access them.

Monitoring the impact: Initially each week, but now monthly, the Somerset Domestic Abuse Task Group, made up of all councils, police, Safeguarding Boards, local support service providers and health services, meet to look at the up to date information about the prevalence of domestic abuse in Somerset, and get assurance that all services are functioning and accessible. The group also considers any new requirements which may arise due to the coronavirus, such as new ways of offering support.

Effective Specialist services: Somerset Integrated Domestic Abuse Service (SIDAS) continued to operate throughout the pandemic, supporting survivors already in service and offering support to new clients but with a mixture of face to face meetings and virtual sessions depending on the nature and level of risk to the client. Clients continued to be accepted into safe accommodation such as refuge, but additional safety protocols were put in place. Additional investment was made at the height of the Pandemic to ensure that the service had sufficient capacity.

Mindline, a support service set up by Somerset Mind, worked with SIDAS to develop a specific script to accept calls relating to domestic abuse which continues to be open 24 hours a day. Mindline is also connected to the Somerset Coronavirus Helpline.

Communications: Somerset County Council invested additional funds to enhance the #Nocloseddoors2020 campaign to ensure that anyone in the community who requires help and support for domestic abuse can access it. This included messaging on social media, radio, newspapers and local magazines and awareness raising with pharmacies.

More recent activity for the Partnership is to prepare for the ease of restrictions and the impact on domestic abuse. An example of this is the re-opening of the night time economy and the impact this might have on report of domestic abuse.

Healthwatch Somerset

Healthwatch Somerset enables the views and experiences of people who use services to influence and improve the way that health and social care services are provided.

We gather patient and public feedback about health and social care services, we identify patterns to learn what is and isn't working, and we share our findings with health and social care providers to inform change and improvement.

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. We report on areas for improvement and best practice, and we escalate potential safeguarding issues through the suitable channels. Unfortunately, due to ongoing Covid-19 restrictions, all Enter and View activity was postponed during 2020/21.

Healthwatch Somerset staff and volunteers speak to people about their experiences of health and social care. Before talking to Adults at Risk, they must complete Adult Safeguarding training and be DBS checked.

We moved all engagement activity online throughout the past year due to Covid-19 restrictions. We ensured that all online meetings with volunteers, in particular our Young Listeners, are facilitated by appropriately trained staff, with risk assessments in place and clear escalation procedures, should a safeguarding issue arise.

Healthwatch Somerset also provides an information, advice and signposting service to help the public find local health and care services and support. Potential safeguarding issues are escalated using the appropriate protocol.

Somerset NHS Foundation Trust

Somerset NHS Foundation Trust was created from the merger of Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust

The merger of the two trusts: In April 2020 Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust merged to create Somerset NHS Foundation Trust. The Trust Safeguarding Service had merged in 2018, creating an integrated Safeguarding Service that amalgamated both adult and children safeguarding. The Safeguarding Service is supported by a colleague structure that encompasses a wide range of experience, knowledge, and professional backgrounds, which has greatly enhanced the safeguarding support service that we offer to all Trust colleagues. This service embraces the Think Family approach through the provision of a core Safeguarding Duty Team Service. Safeguarding Professionals within the Duty Team are trained to provide advice and support across the lifespan. The duty team provide a single point of advice to colleagues on all elements of both adult and child related safeguarding concerns.

Impact of service: Throughout the year we have supported staff with 3869 internal safeguarding contacts/enquiries and made 183 safeguarding referrals covering all elements of safeguarding adults related work.

Safeguarding Training: The Trust Safeguarding Service has a statutory duty to ensure arrangements are made to safeguard and promote the wellbeing of adults with care and support needs, who are at risk of, or experiencing abuse. All Trust colleagues are mapped to a level of training consummate to their roles and responsibilities and in line with the Royal College of Nursing, Adult Safeguarding: Roles and Competencies for Health Care Staff (First edition: August 2018): intercollegiate document and Prevent Training and Competencies Framework 2017. As part of our work within the Trust, the Safeguarding Service has a co-ordinated approach to training, which has enabled us to launch the higher levels of safeguarding training required within the Trust to meet the Intercollegiate Document Competency Framework. In 2020 funding was approved for the creation of a new Learning and Development Lead within the Safeguarding Service with the aim of the support and further development in this area: the successful applicant began in post in April 2020.

Training delivery and attendance has been impacted by the constraints of the Covid-19 pandemic in 2020, which has meant that all face-to-face safeguarding training had to be migrated to online training delivery via 'Teams'. Despite the impact of Covid-19 affecting colleagues' ability to prioritise their training, the compliance figures for safeguarding training over the past financial year has still shown a steady increase. Furthermore, to better meet with Intercollegiate Document Competencies, safeguarding adult Level 3 training has seen further development into a full-day training offer.

Safeguarding Supervision continues to be offered quarterly to key frontline services this year, with further expansion of this provision across the wider Trust services. Due to the national pandemic, this provision has moved to facilitation via 'Teams', which has proved successful in enabling greater availability to colleagues as it does not require travel to a venue. The supervision enables discussion and learning from ongoing cases plus feedback on local / national trends in relation to all aspects of Safeguarding Adults. The Integrated Safeguarding Service Duty team also receives safeguarding supervision every two months (six per year) from the Trust's Named Professional for Safeguarding Adults and Named Nurse for Safeguarding Children.

The Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS) and Consent Lead has continued to expand the provision of Mental Capacity Act training in line with the Somerset Safeguarding Adults Board Mental Capacity Act Competency Framework. The Trust continues to work towards developing MCA awareness and competencies throughout the Trust. Preparation work is underway for the implementation of the Liberty Protection Safeguards, which is anticipated for implementation in April 2021.

The Domestic Abuse Coordinator (DAC) has been in post for a year and sits within the Integrated Safeguarding Service. The DAC has been leading on the work relating to Domestic Abuse Link-workers across the organisation, raising the profile of domestic abuse across all frontline services and improving the organisation response to Domestic Abuse. During 2020 the Covid-19 pandemic has significantly impacted on how much time could be given to the main business of the role and has meant that the majority of the DAC's time has been utilised for Trust representation at MARAC meetings. This enabled the Safeguarding Duty Team to remain focussed on responding to enquiries into our Single Point of Contact.

Multi-Agency Risk Assessment Conference (MARAC): The Trust's Integrated Safeguarding Service continues to represent the Trust at the Somerset MARAC.

Domestic Abuse – Safer Somerset Partnership: The Safeguarding Service provides Trust representation at the Somerset Domestic Abuse Board and in 2020 has also been involved with, and continues to contribute to, the Safer Somerset Partnership Domestic Abuse Covid-19 task group. The domestic abuse task group is a multi-agency group set-up to collate domestic abuse participating agency numerical data regarding domestic abuse referrals and contacts and to discuss and agree a County Wide domestic abuse initiative that could respond to any increase in domestic abuse identified across the region as required.

Prevent: The Trust continues to provide safeguarding representation at all Channel panel and Prevent related meetings and ensure frontline service representation when clients are open to our services. The Trust Prevent lead has recently stepped down from their role as deputy Channel chair following updated guidance stipulating chairs must be Local authority employees.

Somerset Safeguarding Adults Board: We continue to play an active role on the Somerset Safeguarding Adults Board. This has included membership of the Board and a number of the Boards sub-groups.

Safeguarding related enquiries: The Safeguarding Service has continued to participate in Care Act (2014) S42 Safeguarding Enquiries, Safeguarding Adult Reviews and Domestic Homicide Reviews as required; the learning from which we disseminate to Trust colleagues via several means.

The Trust Safeguarding Committee: The Trust Safeguarding Committee holds the Safeguarding Service to account in relation to our duties and responsibilities in all areas of Safeguarding, including our Safeguarding Plan, Policy requirements, review and development, and ensures that we are compliant with SSAB policy, learning and guidance. It continues to meet quarterly and has external representation and challenge provided by the CCG.

Collaborative working with external Safeguarding Agencies: Through the Integrated Safeguarding Service we are an active member of the weekly Adult Multi-Agency Safeguarding Hub (MASH). The MASH meetings are attended by Adult

Social Care, the Police and Trust Safeguarding Service Duty Team. We have maintained our close collaborative working with external agencies such as the Police, Somerset County Council Safeguarding Colleagues and the CCG.

Policy: Since the merger of the two Trusts, we have revised and merged the Safeguarding Adults at Risk Policy, Domestic Abuse Policy, the Using the Mental Capacity Act Policy. We have also developed a new standalone Prevent Policy. We currently maintain ownership of the Supporting Colleagues who are Victims of Domestic Abuse Policy; it is anticipated that this will be transferred to HR in the near future as it is a staff related policy.

Yeovil Hospital NHS Foundation Trust

Board Effectiveness

- The Trust safeguarding committee meets quarterly and is chaired by the Chief Medical Director, who holds the statutory role of Named Doctor for safeguarding Children. The standing agenda consists of: review of key performance indicators, learning to prevent reoccurrence, children and adult safeguarding updates, prevent, mental capacity and deprivation of liberty.
- The trust is represented at Adult Safeguarding Board and subgroups by the Deputy Director Safeguarding or designated deputy (Head of Safeguarding)

Prevention

- The trust board acknowledges their responsibility for safeguarding vulnerable individuals and have invested in a trust wide safeguarding service through the development of a dedicated team. The safeguarding team composition is as follows:
    - Deputy Director Safeguarding
    - Head of Safeguarding / Named Nurse Safeguarding Children
    - Named Doctor Safeguarding Children
    - Named Midwife Safeguarding Children

- Deputy Named Nurse for Safeguarding Children
- Domestic Abuse Coordinator
- Mental Capacity / Deprivation of Liberty Lead Practitioner (Post currently vacant but appointment made)
- Learning Disability and Safeguarding Adults Practitioner
- X 2 safeguarding adult practitioners
- Safeguarding team administrator.

- As an organisation we continue to support the multiagency training across the county and fully participate in the training strategy development for the Somerset Safeguarding Adults Board although it is acknowledged that the current Covid-19 pandemic has significantly impacted on internal training within this acute hospital
- Trust staff during this pandemic period have continued to identify any issues of a safeguarding nature and this is reflected in the number of alerts and referrals being raised from various departments. During this reporting period 407 safeguarding incident reports for adult patients have been made to the safeguarding team, compared to 228 for the previous reporting year. This indicates a 44% increase in our internal referral rate. This figure does not include referrals for patients with learning disabilities or domestic abuse issues. This reflects the consistent raised awareness of safeguarding the vulnerable individual within the organisation.
- Combined adult and child safeguarding training sessions are delivered by safeguarding team members at induction and statutory training to all trust staff. These sessions are aligned with the level 2 training requirements as identified in the Intercollegiate Document – Adult Safeguarding : Roles and Competencies for Health Care Staff 2018 The desired compliance rate as set as part of the CCG safeguarding contract is 85% for all levels of training, at the time of this report we are able to demonstrate full compliance with this in respect of level 2 adult and child safeguarding training, despite the current national pandemic crisis and the reduction in training opportunities. This level of training has been made available via eLearning modules and staff uptake for this has been good which has enabled the trust to meet the required compliance.
- The safeguarding team members provide safeguarding adults level 3 training modules for trust staff (as identified in the Intercollegiate Document). The modules currently 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.

- We continue to provide a quality response for victims of Domestic Abuse, sexual violence and Honour Based Violence.
- The Domestic Abuse Coordinator works in partnership with the Children Safeguarding Practitioner and specialist midwives where Domestic Violence and Abuse has been identified during pregnancy. As
- 102 Domestic abuse cases were referred to the safeguarding team during this reporting period (compared to 81 the previous reporting year). 23 of these cases were referred to MARAC or other community support agencies.
- The Domestic Abuse Coordinator works in partnership with the trust Dementia team and Safeguarding Adult practitioners in cases where it is identified that dementia is a lead factor in some domestic abuse cases. Within the organisation we have noted a continuing increase in the number of elderly patients disclosing domestic abuse due to the behavioural changes occurring in their partners due to Dementia and other medical changes.
- The Safeguarding team actively responded to serious case reviews and section 42 requests where safeguarding concerns have been identified.
- We ensure that learning from reviews are published and shared with staff through trust newsletters, safeguarding quarterly newsletter and the information is also posted on the safeguarding team page on the trust intranet.

Making Safeguarding Personal

- The Learning Disability Practitioner continues to develop and maintain links with carers and community agencies.
- 112 referrals for patients with learning disabilities were received by the Learning Disability Practitioner during the reporting period.
- As an organisation we received a number of section 42 enquiry requests due to concerns raised by Adult Social Care following issues raised by community providers around treatment for patients with a learning disability in the Emergency Department and other inpatient areas. The reviews undertaken have identified that poor communication with the patient, carer's and community providers is a predominant theme and recommendations have been made to address this issue. In one specific case the Learning Disability Liaison Practitioner worked with a Senior Sister within the Emergency

Department to arrange weekly virtual training for six weeks for the department staff. This training explored issues around communication, reasonable adjustment and patient consent, this was well received by the Nurses and Health Care Assistances s who attended.

- All members of the team encourage staff members to 'listen to the patients voice' and document the patient's wishes and feelings in respect of their care needs and future planning
- Mental capacity assessment process has been firmly embedded in practice and this had been further strengthened through the appointment of the Mental Capacity / DOLs lead. Unfortunately, this team member left her post, which had left a vacancy. The post has been advertised and an applicant has been appointed and will commence in post later in the year. A member of the safeguarding team has in the interim provided support and training for trust staff. In this reporting period 442 DOLs application were made from this trust, this is an increase in activity compared to the previous year of 414. Reassuringly this demonstrates growing compliance and understanding of the process by staff with the requirements of DoLS. It is of note that during the pandemic staff continued to recognise the requirement to assess a patient's capacity and follow the appropriate guidance.
- We continually review the YDH safeguarding training programme to provide a more integrated approach to safeguarding awareness and making it personal for the vulnerable individual.

Think Family

- As a trust we continue to fully support the Safeguarding Boards 'Think Family' approach
- The amalgamated Children and Adult safeguarding team has continued to strengthen our 'Think Family' response within the Trust to identified safeguarding issues.

Golden Lane Housing

- Golden Lane Housing's safeguarding approach, ensuring the ongoing wellbeing and safety of tenants, continues to be of paramount importance and GLH are very pleased that at the start of the pandemic, the Coronavirus Act 2020 made it clear of the ongoing duty to continue to undertake safeguarding work, including for example, Section 42 enquiries, which was emphasised in the Care Act easements.
- During the unprecedented year, GLH Housing Officers have reported improved safeguarding related services and response times for a large proportion of Local Authorities across the country, resulting in strengthened relationships and trust, particularly with Social Workers who are often leading on the safeguarding concern. During the lockdown period, while dealing with the challenges of the pandemic, GLH has noted that some councils developed innovations in their practices and systems and there is substantial evidence of improved multi agency partnership work in some areas in order to achieve the best possible outcomes for tenants.
- Housing Officers continued to take a pragmatic and person centred approach in keeping in regular contact with tenants GLH currently deem to be most at risk of abuse, demonstrating increased contact between GLH's Housing Officers and tenants, their families and support providers, despite the difficulties and at times restrictions, in meeting tenants face to face. GLH's approach to finding alternative technological methods in engaging with tenants has certainly assisted in our delivery of housing management services, many of which will be carried through to our way of working once the lockdown restrictions are further eased in 2021.
- During financial year 2020/21 GLH raised 67 safeguarding alerts across 25 different Local Authority areas – an increase of 31% when compared to last year's statistics. In general, safeguarding concerns increased ever so slightly during the initial weeks of the Covid-19 lockdown period, only to return to normal levels during the summer months, and then exceed normal levels in the Autumn and the second lockdown at the start of 2021.
- The percentage distribution of types of abuse did not appear to change considerably overall, with emotional abuse and self-neglect categories continuing to represent the largest areas of abuse concerns, followed closely by physical abuse. The majority of emotional abuse concerns are due to incompatibility issues between tenants living in shared properties, with remaining cases relating to tenants who are alleged to have been the perpetrator of abuse towards other tenants in

cluster style accommodation, where altercations have taken place in communal areas and where tenants are alleged to have been perpetrators of abuse towards support staff. Self-neglect cases relate to tenants not engaging with their support team and as a result of this, their general health and wellbeing has deteriorated. The statistics also include hoarding concerns, rent arrears and tenants unable to keep their home in a safe and tidy condition. GLH Housing Officers did not raise any concerns of Domestic Abuse.

- Helping tenants to achieve the outcomes they wish following their involvement in safeguarding proceedings has always been the most fundamental aspect of GLH's safeguarding approach. It remains incredibly important that GLH employees understand the importance of ensuring tenants remain at the centre of the safeguarding process and are given opportunities to achieve the outcomes that are important to them.
- In February 2021, GLH invited tenants, their families and support providers to talk to us and share their experiences of GLH in supporting them through safeguarding proceedings. Due to the very sensitive nature of safeguarding concerns, we only approached individuals that we felt were best placed to provide constructive feedback in a sensitive and safe environment.
- One tenant felt that he had achieved a good outcome with increased support hours, whilst another tenant now receives the much needed help with his drug addiction. The family of another tenant said they felt very fortunate to have GLH as a landlord and that the Housing Officer always has their son's best interests at heart.
- There were no improvement areas identified within the feedback obtained, however it is extremely important that we continue to obtain regular feedback from customers as part of our continual improvement approach to delivering high quality services to tenants. This will form part of our safeguarding objectives delivery plan 2021/22 and will be overseen by GLH's Safeguarding Deputy.

Devon & Somerset Fire and Rescue Service

- Devon & Somerset Fire & Rescue Service's (DSFRS) Safeguarding Team's main area of work focusses on the safeguarding of adults and children at risk whom our staff encounter out in the community whilst undertaking their duties. This could include those whose behaviours pose a fire risk in the home, those experiencing abuse or neglect, or those who are in need of extra support in their daily lives, to name a few.
- Our Safeguarding Team work closely with firefighters who raise referrals for vulnerable individuals they come into contact with at operational incidents, and also our Home Safety Technicians who visit members of the public in their homes and often encounter individuals who are in need of the support of our partner agencies.
- DSFRS have an extensive network of partnerships including social care, housing providers, care agencies, Police and other local authorities across the two counties. We work with our partners on a daily basis to share information of vulnerable people to ensure they have the opportunity to access the care and support they require.
- Our Safeguarding Team also attend multiagency meetings to highlight fire safety concerns that individuals have shown and offer advice as to how to best reduce these risks.
- DSFRS are currently reviewing the safeguarding training that we provide for the organisation. This will cover different levels of training for staff in every department, from firefighters to admin support staff. Although the level of training will differ depending on each role, we believe everyone in our organisation should have a fundamental understanding of the importance of safeguarding and what it is that the Safeguarding Team do.
- DSFRS's Safeguarding Team are also currently working on creating a communications plan to broadcast important safeguarding messages to those members of staff who need to be made aware. We are working closely with our Communications Team to look at improving how we liaise with on-call firefighters who aren't necessarily always on station and what platforms we can utilise to best engage with our staff. As part of the plan, we will also be looking at how we share our partners' messages with the wider public, for example drawing attention to national awareness campaigns and using our social media platforms to highlight current safeguarding-related trends and issues. We welcome any feedback if you feel that we could be working better with your organisation to achieve this.

- DSFRS Safeguarding team have realigned roles to specialise in specific areas relating to safeguarding including Modern Slavery, Domestic Violence, Hate Crime. In addition to this the team have established links with Modern Slavery Partnerships and will share information at the earliest opportunity around any issues relating to Modern Slavery that might be identified within fire service activities with partner agencies to ensure the safeguarding of vulnerable adults. DSFRS safeguarding team have implemented monthly group supervision sessions to provide an opportunity for the team to discuss any complex cases. This ensures a level of quality assurance in addition to supporting reflective practice

---

HM Prison & Probation Service

National Probation Service

National Probation Service – Somerset Local Delivery Unit

There are three offices providing service in Somerset County Council area. Our business unit covers Somerset, Bath and North Somerset and North Somerset so our Service Delivery covers a wider geographical area. Our data is not currently disaggregated to the Somerset County Council area, although this will change in the future.

Glogan House Approved Premises is also based in Somerset, providing supervision and monitoring, in a residential setting, for those who may be a risk to the public.

NPS also has a Probation Officer who works within the Youth Offending Team

Covid-19 Response

Like all services, the pandemic has had a significant impact on staff and service users. People were being released from prison and still had to be seen by probation staff on their release. Our offices stayed open during the pandemic in Somerset, providing an in-person service, within Covid-19 guidelines, to the most vulnerable, those with no access to technology and to those who are most risky. Probation staff have been dedicated to duty, and to service to the local community. They have appreciated the working together that has taken place with partner organisations, and the services which they have been

able to access for the people they supervise. The Probation Service have also been carrying out doorstep visits throughout the pandemic.

Homelessness Prevention Task force group was set up in Somerset to address homelessness and the need for self isolation and in this we were supported by the Somerset wide homelessness response through the District Councils' and the County Council's joined up approach, which made a significant difference to the wellbeing and safeguarding of the service users, and in many cases whether they became ill.

Victim Contact Service

The Probation Service provides a contact service for victims of serious violent and sexual crime, where the offender has been sentenced to one year or more imprisonment. Our Victim Liaison Officers continue to provide this service, and did so during the pandemic via whichever method is chosen by the victim. This service ensures that the voice of the victim is put forward in relation to safeguarding, exclusion zones, non-contact conditions, public protection and release arrangements.

Multi Agency Public Protection Arrangements

MAPPA continues to be delivered in the Avon and Somerset police force area in accordance with the guidance. The meetings are still locally arranged in order to ensure that the focus is correct in terms of public protection and safeguarding related to local issues and circumstances and resources provided accordingly. MAPPA continues to be a high priority. The link is included to the MAPPA Annual Report 2019 – 2020 which is the most recent report including the statistics verified by the Office for National Statistics. MAPPA-Annual-Report-2019-2020.pdf (aspolice.net)

Unification of the Probation Service

The Service is heading towards unification, when the National Probation Service and the Community Rehabilitation Companies come together to form the new Probation Service. This will have a positive impact on our working with other agencies as there will be one identifiable service to contact and this will be delivered on a more local basis. Once unification

takes place, the local service delivery will be linked to the Somerset County Council footprint which will improve our opportunities to work within the Adult Safeguarding Board.

Department for Work & Pensions (DWP)

- In 2020 DWP introduced teams to lead work on its approach to supporting vulnerable customers. As part of this, a network of over 30 Advanced Customer Support Senior Leaders (ACSSLs) were appointed, providing an escalation route for all DWP colleagues to refer to when a customer requires some form of advanced support, ensuring that these customers are signposted or referred to the support that they need
- ACSSLs work with a range of external partners within their own geographical area, aligning support for vulnerable customers wherever possible. They have formed a network of robust links within local communities across England, Scotland and Wales that form an integral element of DWPs wider partnership agenda
- Whilst DWP does not have a legal duty to 'safeguard', we absolutely recognise the positive impact that a collaborative approach can have when supporting vulnerable customers. We continue to work across all internal teams and with our external partners to help to provide the support that customers require.

District Councils

- The year has been one where our usual ways of interacting have been altered and some of the more obvious routes to identifying safeguarding issues were limited for many parts of the year. We have had to find alternative ways of supporting people in need of help and of identifying those in need of safeguarding. The lockdowns experienced during

the year have seen considerable community activity to support vulnerable people and a co-ordinated effort by the district councils to support the community. This has been carried out in partnership with other agencies and there has been extensive work to identify vulnerable people and support them. This approach has enabled the councils to build a stronger understanding of our communities and has seen adult safeguarding issues come into greater focus, particularly regarding older adults and those with mental health issues. It has also shown the importance of agencies sharing information and working collaboratively.

- We have continued to work with partners to help vulnerable adults with complex needs to gain stable, safe accommodation. As part of this we have also worked with rough sleepers across the county to understand their circumstances, vulnerabilities and safeguarding issues, with the aim of supporting them into suitable, safe and stable accommodation. The move to bring rough sleepers into accommodation to safeguard their health and reduce the spread of coronavirus during the lockdown has given us other opportunities to work with these vulnerable people and address safeguarding matters in a way that had not previously been easily open to us. This has seen positive outcomes for many individuals.
- We have continued to work 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 worked collaboratively to address domestic abuse issues. Domestic abuse became a key concern during the lockdowns during the last year and the rise in reports have been met with rising support by our agencies.
- We have developed our One Team models on further over this year to build on the strong partnership working that has been taking place. This collaboration has helped us build resilience and capacity into our systems of support to safeguard vulnerable people. The model enables us to identify quick and appropriate interventions, share appropriate information where safeguarding is a concern and act in the best interest of those concerned. Critical to the strength of the model is the variation of its application across different parts of the county to ensure that local circumstances and demographics are accommodated to ensure best outcomes. This is tangibly seen through area specific One Teams in some of our towns, town based One Team models and Districtwide models all flourishing. The pandemic has seen the

need to adapt contacts and meetings to safeguard health but has been addressed effectively and not reduced our level of support.

- We have continued to work with our councillors to help them to understand their role in the community and what they can do to help safeguard adults who may be vulnerable. Many of them had come into their roles the previous year with little experience of safeguarding and while they actively engaged to build their understanding they were placed at the forefront of support for our communities through the pandemic. We worked to support them to understand what to look for and how to quickly notify relevant officers so that concerns could be addressed promptly.
- 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, reporting publicly on our activities. We have continued to use 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 used case studies and learning from other parts of the country to help ensure that, where safeguarding reviews have identified lessons to be learnt, that our own internal processes and actions are considered against the outcomes of those reviews.
- 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 intelligence we can provide more effective safeguarding for vulnerable adults in Somerset, particularly as many of these adults move across our boundaries regularly.
- 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 local reviews and changed policies and procedures where the outcomes of them have shown it would be appropriate.

NHS England and NHS Improvement - South West (SW)

We recognise that all communities and every aspect of both children and adult services have been affected by the Covid-19 pandemic, it has been an exceptional year for all of us. The Covid-19 pandemic has also disrupted professional and supportive services relationships with children, families, carers and adults with care and support needs.

Forced to stay at home during the pandemic, some families have reported a positive impact in spending more time with loved ones. In contrast, others have found the experience very isolating and lonely or feel unsafe. They raised further concerns about the impact on mental health and emotional wellbeing for all ages, and the resilience of families across the paid and unpaid workforce.

Strengthening leadership and partnership collaboration

During 2020/21, NHS England and NHS Improvement have been central to coordinated responses during the pandemic. Solid multi-agency leadership and strategic direction focused on improving our central coordinated efforts to gain clarity regarding the problem(s) needing to be tackled across our communities, to keep vulnerable citizens safe during the Covid-19 pandemic. We have set-up the first SW Regional Serious Violence & Contextualised Safeguarding (all ages) Data and Information Sharing Group, securing regional leadership and collaboration across PHE, policing, community safety partnerships, violence reduction units and local safeguarding partnerships, linking strategic priorities and Joint Strategic Needs Assessments for violence and abuse. The group have produced a SW Regional Serious Violence & Contextualised Safeguarding Information Governance Framework.

Early in the pandemic we restructured to deliver programmes of support through various groups, ranging from regional joint Covid-19 Gold calls, Health Outbreaks & Operational Pressures, Infection Prevention & Control (IPC), pathology, clinical cells, establishing care sector networks and the regional ethical referral groups, restructuring our regional safeguarding governance arrangements to improve collaborative data sharing and problem-focused analysis. This has provided core groups to oversee issues and challenges to keep citizens safe. In turn, we were supporting our communities including the care and independent sector, designated and named professionals for safeguarding, as well as the workforce

supporting Nightingale hospitals, front line staff and individuals seeking guidance and advice, providing peer support for NHS volunteers, test and trace centres, swab test sites as well as mass vaccination sites.

We continued to act as a key link between national, regional and local systems and practitioners and have been involved in the National Safeguarding Adults Network and working with both the Regional SW Safeguarding Adults Board Chairs and SW Safeguarding Adult Health Network, to tackle emerging or continued challenges.

Challenges

Impact on assessments

The year has also been a year where health and social care assessments have been deferred nationally and in the SW region, placing further challenges for adults with care and support needs and families accessing Care Act assessments.

People eligible for NHS Continuing Healthcare (CHC) continued to receive support and case management by the systems CHC teams, despite the assessments of new referrals being stood down between 31st March and 31st August 2020, and with some CHC workforce redeployed to front line care. Our system CHC teams adapted processes, introducing supportive methods to continue to oversee the care of NHS CHC eligible people such as direct access telephone access and telephone support calls. Those people who needed urgent review of their care plans but were vulnerable and isolating, were supported using virtual technology allowing urgent reviews to continue to take place. Health and social care CHC teams worked in partnership strengthening relationships and communication, to ensure people who were unable to be assessed during the pandemic were discharged from hospital in a timely safe manner and supported people to stay at home preventing a hospital admission. Discharge hubs were established which allowed appropriate advice and sign posting using CHC workforce and social care workforce to support hospitals with the discharges linking to the community services available. This included the support of people in the final days of life wishing to go home from hospital or remain at home, supported with an adapted short form individual personalised care plan, using personal health budgets (PHB) to speed the process and pilot end of life PHBs.

A recovery and restoration programme for deferred NHS CHC Assessments and Care Act assessments commenced in October 2020, where health and social care joined to work on the outstanding assessments. Some systems found this very challenging when workforce had been redeployed, unable to return or increasing their workforce resulting in limited success. We worked on a regional recovery workforce plan engaging with Nurse returners offering webinars and pastoral support to return to nursing, gaining huge success leading to CHC teams increasing their workforce to meet the demand and allowing registered nurses to come back to the NHS.

We offered a Covid response call every week for CHC leaders across health and social care to strengthen communication, sharing national policy updates, encouraging peer engagement, sharing learning from practice and exploring new ways of working. We also arranged senior leadership ADASS and CCG Director of Nursing calls to ensure key messaging, cascade of policy information and joint working principles were maintained during the pandemic.

Keeping focus on specific people who have protected characteristics

Nationally and regionally we have also completed our Safeguarding Equality Impact Assessment, to ensure that the needs of people with protected characteristics, as well as those experiencing health inequalities, have been considered and actioned during the pandemic.

The increased vulnerability of people with a learning disability was identified early into the pandemic and reinforced by the LeDeR national review of deaths of people with a learning disability during the Covid pandemic. This report highlighted key actions that were felt to reduce the risks for this group of people. The majority of the suggested actions had already been considered and actions implemented, including the rollout of RESTORE2 and RESTORE2 Mini, to improve early identification of deteriorating health by social care staff. The report did help to raise awareness across the wider health and social care community and led to increased senior leadership involvement and inclusion of people with a learning disability as a priority group.

Virtual working has improved the ability to network across systems and we have experienced increased collaborative working. An example of this is specialist learning disability services and primary care services with commissioners working

together in a Call to Action to improve the uptake of Annual Health Checks for people with a learning disability. These checks are a good means of identifying health problems early and ensuring the right support is being offered. In quarters 1 and 2 we saw a marked reduction in the number being provided however, following the Call to Action and excellent work in local areas, the number has increased to near or above last years number.

Direct Commissioning

We have been supporting the national work led by the National Quality Lead Nurse for Health and Justice, regarding safeguarding within the prison estate. A guide to wellbeing & safeguarding support in prisons is due to be published on the NHS Futures platform, and work is ongoing with Health Education England to design safeguarding training specific to prisons. This element of the work will commence in 2021/22 (May 2021).

Covid Oximetry in the secure and detained estate

The Direct Commissioning Health and Justice Team have supported the prisons across the SW including Dartmoor to have oximetry monitoring to support the earlier detection of (silent) hypoxia and further help the reduction in mortality and morbidity from COVID-19. All prisons in the SW can use the self-monitoring resource, which is equivalent of the oximetry @home programme.

Our SW NHS Safeguarding Workforce

In the summer of 2020, our NHS safeguarding workforce profile demonstrated over 55% of our safeguarding workforce is above the age of 50. Keeping citizens safe through workforce succession plans and securing opportunities to skill up the SW workforce has also been a key focus during 2020/21. Collaboration with Health Education England has resulted in a successful bid and subsequent development of a regional accredited safeguarding module, to commence Autumn 2021.

Some challenges for safeguarding adults with care and support needs remaining for 2021/22:

- We seek to work collaboratively to improve service pathways for our most vulnerable members of society and their families, particularly children and young people with learning disabilities, special educational needs and disabilities and those who are moving into adult services.
- • We have planned a focus piece of work during 2021 to examine the pandemic's impact on children in care and care leavers living in the South West.
- • Direct Commissioning are planning to roll out the RESTORE2 to recognise early soft signs of deterioration, both across the health care team and non-clinicians such as prison staff.

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: 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 always deal with any calls in the strictest confidence