Report to the NHS Somerset Integrated Care Board on 1 December 2022

Title: Safeguarding Adult Annual report to the Somerset Safeguarding Adults Board 2021 / 2022	**Enclosure G**

Version Number / Status:	1 / Final
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Summary and Purpose of Paper

- Detail the arrangements in place to safeguard adults in the ICB and the services we commission.
- Set out the context for safeguarding adults arrangements in the Somerset health system.
- Demonstrate how Somerset ICB is fulfilling its statutory safeguarding adults responsibilities.
- Report on governance and accountability arrangements within the ICB, and the ICB role in the Somerset Safeguarding Adult Board (SSAB) and its sub groups.
- Highlight achievements and identify current safeguarding adult risks in provision within health services
- Provide assurance that the safeguarding adult 2020/2021 objectives were completed
- Identify the ICB's 2022/202 safeguarding adults objectives
- The impact of the restoration /recovery phase of the Covid pandemic on the ability to safeguard adults.

Recommendations and next steps

The NHS Somerset Integrated Care Board is asked to note the content of this report and the objectives for the safeguarding adults team for 2022/2023.

The Somerset ICB Safeguarding adults team will continue to work collaboratively at a local, regional, and national level to improve the quality of and strengthen safeguarding children and child death review arrangements, where necessary mitigating organisational and partnership risk.

Impact Assessments – key issues identified	
Equality	Commissioning and delivery of high quality and accessible statutory health services to meet the safeguarding needs of adults will ensure this cohort will not be disadvantaged in comparison with their peers who do not experience the same vulnerabilities.
Quality	This report reflects on the quality and impact of safeguarding adult practice. The past year has been without precedent in terms of the scale and volume of challenges for the safeguarding system; with even more importance on the need

<table>
<tr><td></td><td colspan="4">to take stock and learn in order to influence the quality and outcome of adults and carers' experiences of safeguarding adults practice.</td></tr>
<tr><td>Safeguarding</td><td colspan="4">Statutory safeguarding adults responsibilities of the ICB and the services it commission are considered throughout this report.</td></tr>
<tr><td>Privacy</td><td colspan="4">Information sharing processes are already established; there are no breaches of privacy expected.</td></tr>
<tr><td>Engagement</td><td colspan="4">Meeting statutory safeguarding adults requirements is a shared responsibility. The safeguarding adults team works closely with ICB colleagues, the services commissioned by the ICB and all key partners of the Somerset Safeguarding Adults Board (SSAB) and the Safer Somerset Partnership (SSP) to ensure these are met.</td></tr>
<tr><td>Financial / Resource</td><td colspan="4">Resources required to implement and support statutory safeguarding adults requirements are in place.</td></tr>
<tr><td>Governance or Legal</td><td colspan="4">The provision of statutory safeguarding children requirements are governed by the following legislation and statutory guidance:
Care Act 2014
Sexual Offenses Act 2003
Serious Crime Act 2015
Counter Terrorism and Security Act 2015
Modern Slavery Act 2015
Data Protection Act 2018
Safeguarding children, young people and adults at risk in the NHS: Safeguarding Accountability and Assurance Framework 2022
Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff 2018
NHS Prevent training and competencies framework 2022
Domestic Abuse Act 2021
Mental Capacity Amendment Act (2019)
Police, Crime, Sentencing and Courts Act 2021</td></tr>
<tr><td>Sustainability</td><td colspan="4">Working with all our partners in the local, regional and national safeguarding system, the safeguarding adults team aim to deliver a sustainable and effective healthcare system for Somerset, which routinely includes the need to safeguard and promote the welfare of adults at risk of harm and abuse.</td></tr>
<tr><td>Risk Description</td><td colspan="4">The following risks on the ICB Risk Register are associated with the safeguarding adults agenda:
Implementation of Liberty Protection Safeguards - Risk 327 – score 15
Prevent compliance in Trusts - Risk 440 – score 6
ICB strategic Safeguarding Service provision – Risk 368- score 9</td></tr>
<tr><td rowspan="2">Risk Rating</td><td>Consequence</td><td>Likelihood</td><td>RAG Rating</td><td>GBAF Ref</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
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Annual Report Summary: 2021/22

The Somerset Safeguarding Adults Board (SSAB) became statutory in 2015 under the Care Act (2014)

One of the responsibilities of the SSAB is to undertake Safeguarding Adult Reviews

The SSAB has three statutory partners that the Care Act (2014) says must be members:

- Somerset County Council
- NHS Somerset Clinical Commissioning Group*
- Avon & Somerset Constabulary

Other key organisations that work with adults in Somerset also have a representative on the SSAB.

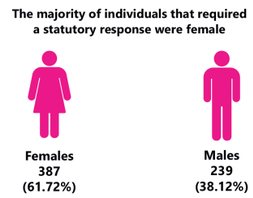
All our members are listed on our website

571,600 people lived in Somerset at the time of the 2021 Census (Source: 2021 Census)

An estimated 141, 900 are aged 65 and over (Source: 2021 Census)

2265 safeguarding concerns were raised with Somerset County Council

This led to 627 safeguarding enquiries under Section 42 of the Care Act (2014)



The majority of people that required an enquiry under Section 42 of the Care Act (2014) were female

The most common risk type was Neglect and Acts of Omission which accounted for 26% of risks

The most common location where people were identified as being at risk was their own home (52%)

Most people were at risk of abuse or neglect from someone that they knew

In 167 cases the adult at risk was assessed as lacking capacity to make decisions related to the safeguarding enquiry

The majority of people (94%), or their representative, were asked what their desired outcomes were

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

In 93% of cases the risk was removed or reduced.

We published one Safeguarding Adult Review this year

'Matthew'
Safeguarding Adults Review:
Final Report

'Matthew' had serious health conditions, but neglected his own heath and wellbeing. He was due to be admitted to a community hospital but changed his mind at the last minute

We published an animation called 'Tricky Friends' and a leaflet about Mate Crime, guidance on disclosures of non-recent abuse and a webinar on professional curiosity

We have worked with other SABs in the region to develop and undertake a joint audit which we coordinated

We continued to see people using our website, and engaging with us using social media

Read our Annual Report in full

* On 01/07/2022 NHS Somerset Clinical Commissioning Group was replaced by the Somerset Integrated Care Board

Annual Report

2021-22

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 2021/22;
- 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 along with a one page summary 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

As Independent Chair for the Somerset Safeguarding Adults Board, I am pleased to be able to introduce our annual report for 2021/2022.

Although a statutory responsibility for the partnership to publish an annual report, it is also an opportunity to highlight not only the valuable service that agencies in working together provide to those who experience, or are at risk of harm or abuse, but also of the challenges they face in today's society. We cannot forget that although out of the Coronavirus 19 lockdown, all partners continue to face specific challenges emanating from the pandemic and more recently an increasing cost of living environment.

Through the work of the Performance & Quality Assurance subgroup, we are now in a better position to better understand and respond to emerging risks and performance issues. This work is still developing, but already we are seeing remedial action being taken to identify and take action to improve outcomes for those who need safeguarding support.

The Learning & Development and Policies & Procedures subgroup has worked hard during the last 12 months in difficult circumstances to ensure partners and those who work directly with people to receive up to date information, guidance, and advice.

A critical responsibility for a Safeguarding Adult Board is the commissioning of Safeguarding Adult Reviews. These reviews are fundamental for the adult safeguarding system in Somerset to learn from tragic and untimely deaths or serious harm of those who need care and support. The SSAB published one review during this reporting year but has also published briefings on other cases.

The Board has heard directly from people & groups who work directly with people who have suffered abuse or harm. These opportunities have enabled leaders to understand the difficulties & barriers to safeguarding in partnership, but also how professionals have come together to improve the lives of those we serve.

I would like to express my sincere thanks to the commitment shown by partners and those who work so hard to help adults in need of safeguarding support over the last 12 months. I am reassured partners work together to do their best to safeguard adults at risk of harm or abuse. We cannot be complacent, and I am confident that the level of commitment shown this year will enable safeguarding practice in Somerset to improve over the next 12 months.

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 of 31 March 2022:

Name	Organisation	Job Title
Keith Perkin		Independent Chair
Stephen Miles		Business Manager
Lead Statutory Partners		
Dickon Turner Alison Jenkinson	Avon & Somerset Constabulary	Superintendent Partnership Liaison Manager
Val Janson	NHS Somerset Clinical Commissioning Group[1]	Director of Quality and Nursing
Mel Lock Brickchand Ramruttun	Somerset County Council	Director, Adult Social Services Assistant Director, Adult Social Care Operations

Partner Members		
Paul Chapman	Care Quality Commission	Inspection Manager
Lynn Matthews Ali Porter MBE	Department for Work and Pensions	Advanced Customer Support Senior Leader, Avon, Somerset and Gloucestershire Somerset and Hinkley Partnership Manager
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
Becky Arrowsmith Kathy Smith	Golden Lane Housing	Head of Housing Housing Officer
Gillian Keniston-Goble	Healthwatch Somerset	Healthwatch Somerset Manager

[1] * On 01/07/2022 NHS Somerset Clinical Commissioning Group was replaced by the Somerset Integrated Care Board

Julie Bingham	LiveWest (rep. housing providers)	Executive Director Housing Support
Charlotte Holland	Marie Curie Somerset	Clinical Nurse Manager
Tracey Aarons	Mendip District Council (rep. District Councils)	Deputy Chief Executive
Liz Spencer Claire Evans	National Probation Service	Head of Somerset Probation Delivery Unit (PDU) Senior Probation Officer
Rosie Luce	NHS England and NHS Improvement	Regional Safeguarding Lead / Assistant Director for Quality and Safeguarding
Julia Mason Emma Read	NHS Somerset Clinical Commissioning Group	Designated Nurse for Safeguarding Adults Deputy 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
Amanda Maggs	Shared Lives South West	Team Leader – Somerset
Nicola Kelly	Somerset Care Ltd	Director of Care
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
Rachel Handley	Somerset County Council (Public Health)	Consultant in Public Health
Rich Painter	Somerset NHS Foundation Trust	Director of Safeguarding
Amanda Robinson	South Western Ambulance Service NHS Foundation Trust	Safeguarding Business Manager
Jacob Ayre	Swan Advocacy	Head of Services
Bernice Cooke Glen Salisbury	Yeovil Hospital NHS Foundation Trust	Head of Governance and Assurance Head of Safeguarding Team

Board attendance

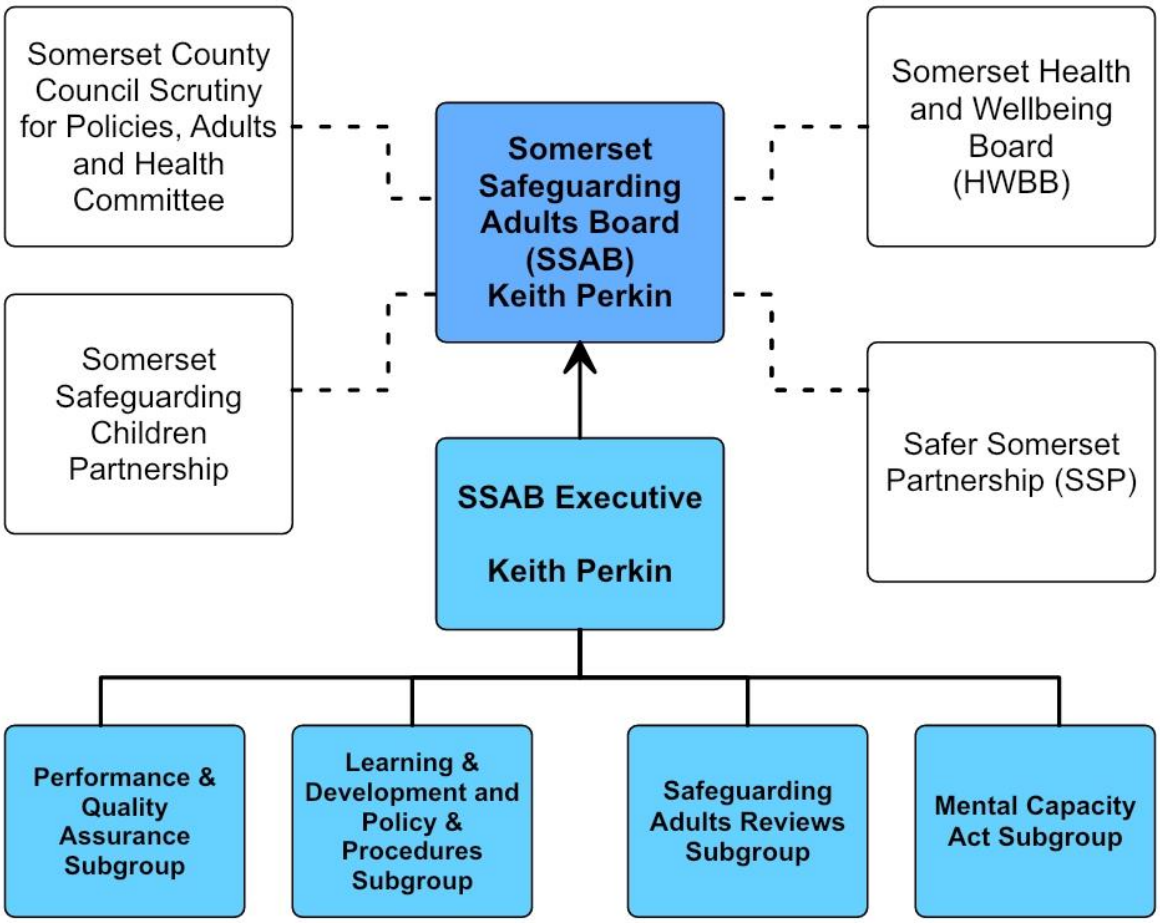
The Safeguarding Adults Board met on 3 occasions during 2021/22 – June, October and February.

In brackets below is the number of times each organisation was represented during the year at these meetings[2].

Organisation	Attendance
Avon & Somerset Constabulary	66% (2/3)
Care Quality Commission	0% (0/3)
Department for Work and Pensions	100% (3/3)
Devon & Somerset Fire and Rescue Service	33% (1/3)
Devon, Somerset and Torbay Trading Standards Service	0% (0/3)
Discovery	100% (3/3)
District Council representative	100% (3/3)
Golden Lane Housing	66% (2/3)
Healthwatch Somerset	66% (2/3)
Housing Representative	66% (2/3)
Marie Curie Somerset	0% (0/3)
National Probation Service	100% (3/3)
NHS England and Improvement (South West)	66% (2/3)
NHS Somerset Clinical Commissioning Group	100% (3/3)
Public Health	100% (3/3)
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)
Somerset Care Ltd	100% (3/3)
Somerset County Council	100% (3/3)
Somerset NHS Foundation Trust	100% (3/3)
South Western Ambulance Service NHS Foundation Trust	0% (0/3)
Swan Advocacy	100% (3/3)
Voluntary sector representative	0% (0/3)
Yeovil Hospital NHS Foundation Trust	100% (3/3)

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

Board structure as at 31/03/2022



During 2021/22 the following change were made to the Board's subgroup Structure:

- The previously sperate Policy & Procedures and Learning & Development subgroups were merged
- The Quality Assurance Subgroup had the monitoring of Performance across the system added to remit.

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

How much abuse and neglect was reported during 2021/22?

Safeguarding concerns reported to the Local Authority in 2021/22

2020/21
2776
Concerns

2021/22
2265
Concerns

This was a decrease of 511 (18.41%) compared to the previous year.
Of the 2265 concerns, 4 (0.18%) were raised by the adult themselves. This compares to 17 (0.61%) in 2020/21.

Safeguarding concerns received that required a statutory response in 2021/22

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

2021/22
627
Section 42 enquiries
(27.68% of all concerns received)

This was a decrease of 205 (24.64%) compared to the previous year. In addition, a further 30 non-statutory enquiries were carried out.

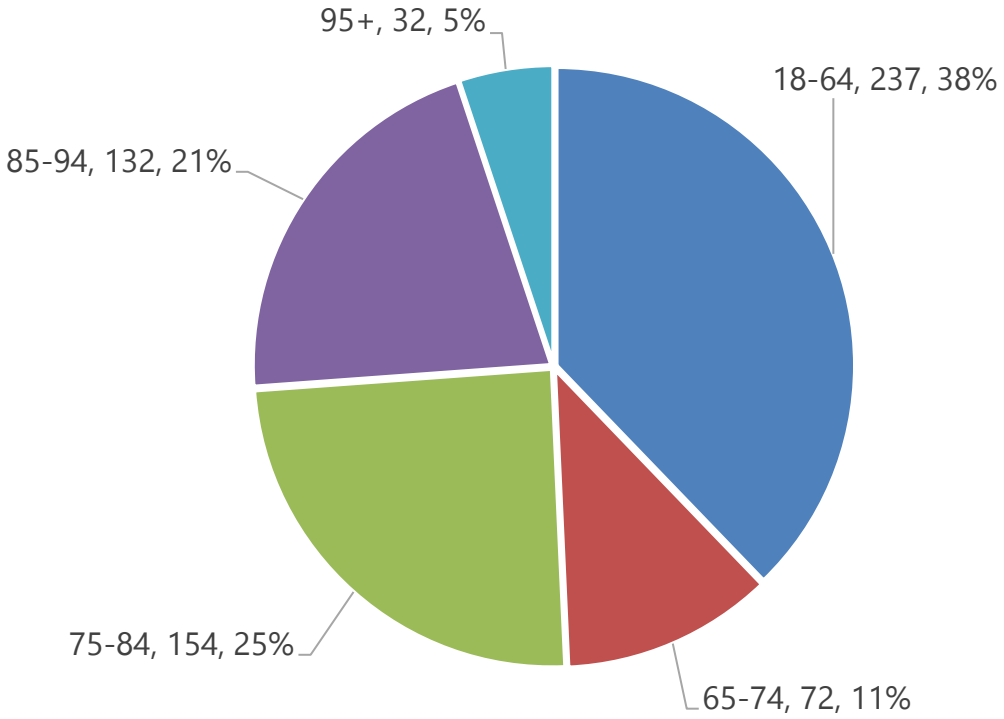
Who was at risk of abuse and neglect in 2021/22?

The majority of individuals that required a statutory response were Female

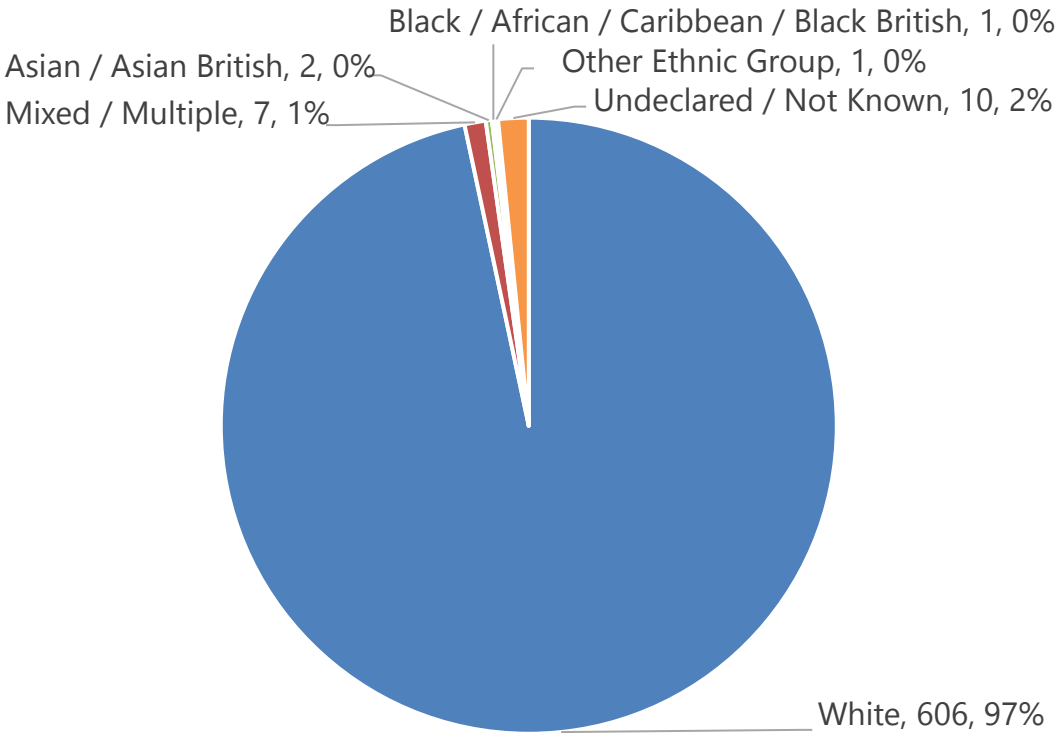
Females
387
(61.72%)

Males
239
(38.12%)

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

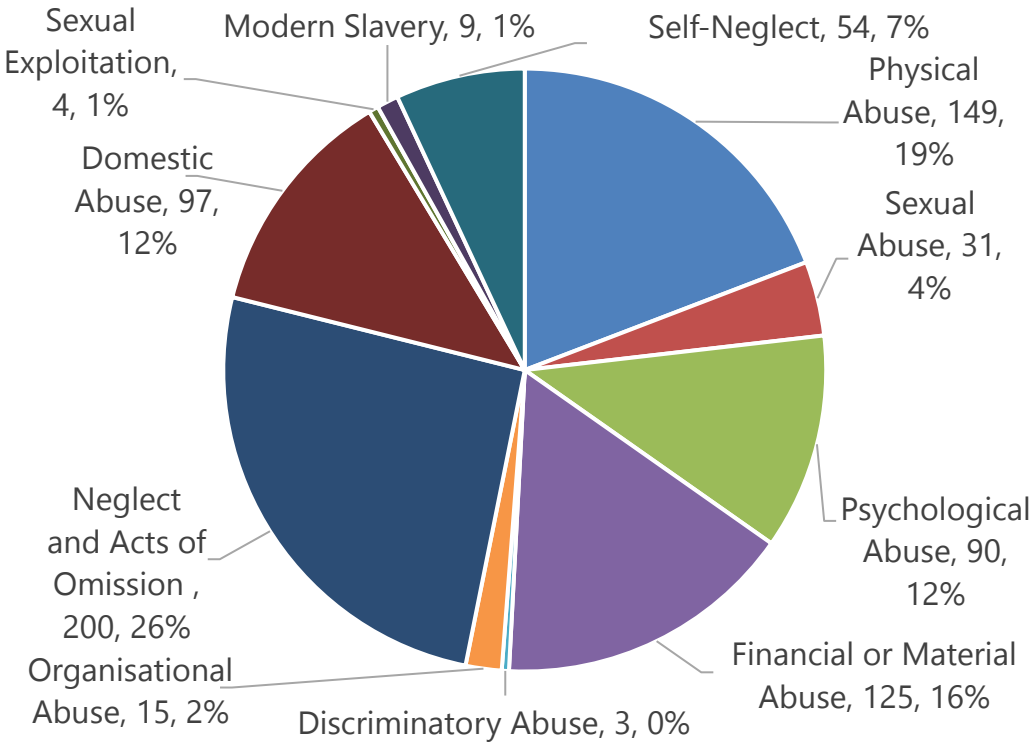


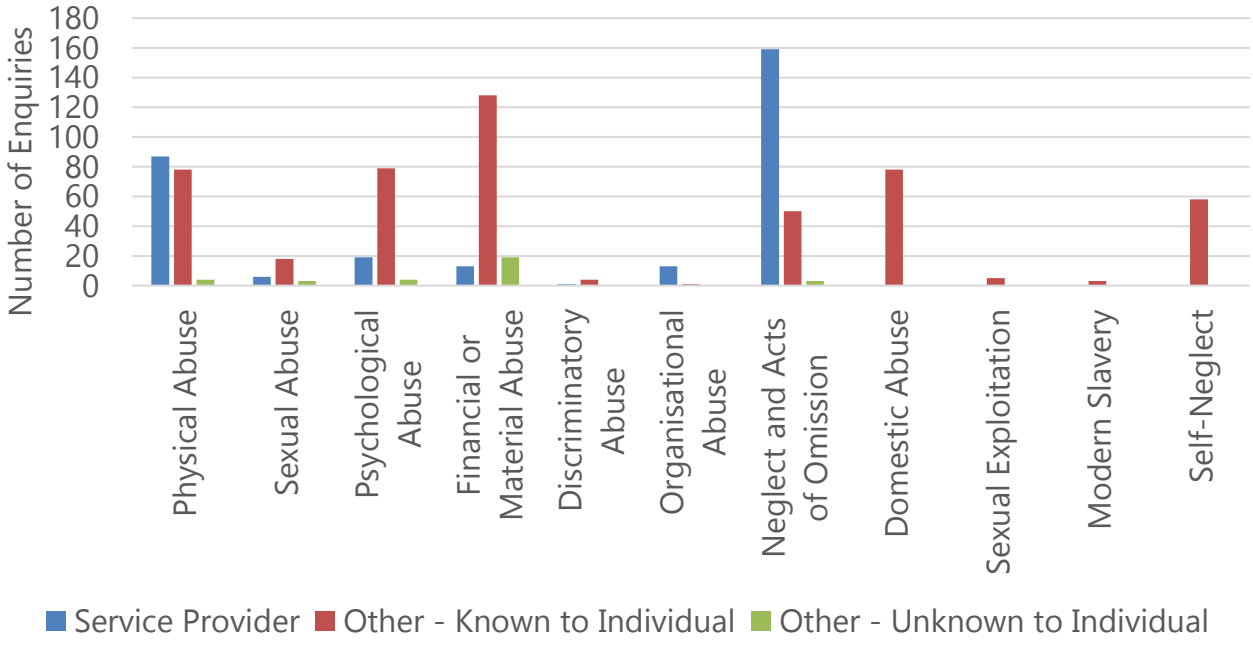
The majority of individuals where the concern resulted in an enquiry under section 42 of the Care Act (2014) were from white ethnic backgrounds



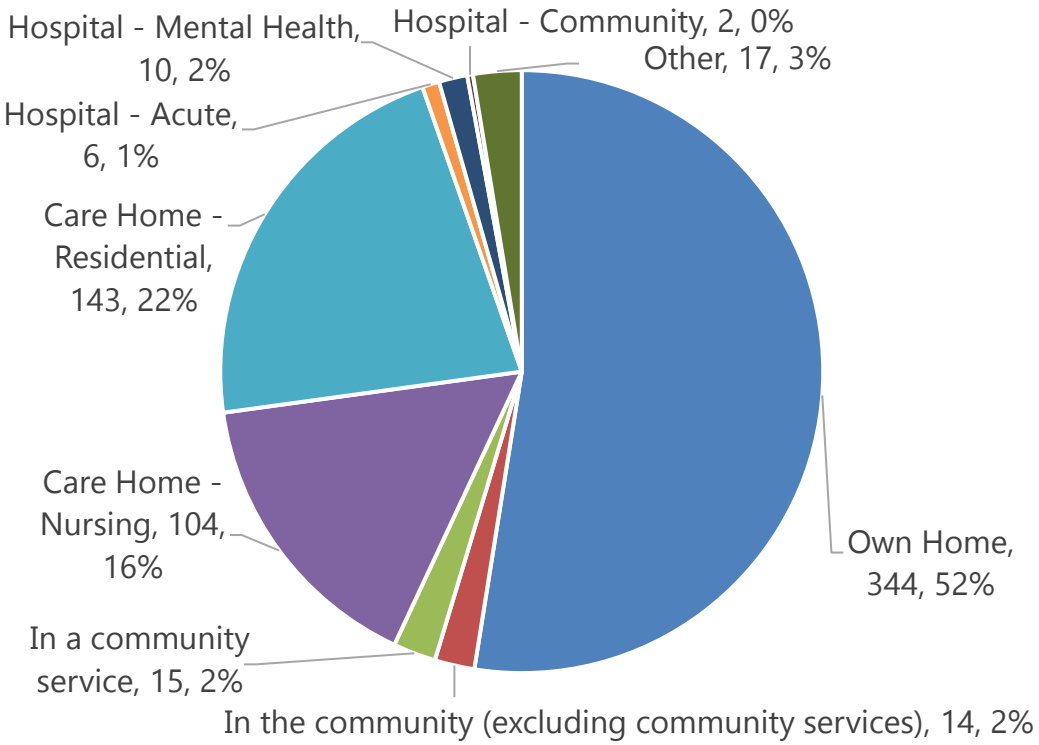
Type of abuse and source of risk

The most common risk type was Neglect and Acts of Omission, which accounted for 26% of risks, followed by Physical Abuse at 19% and Financial or Material Abuse at 16%.



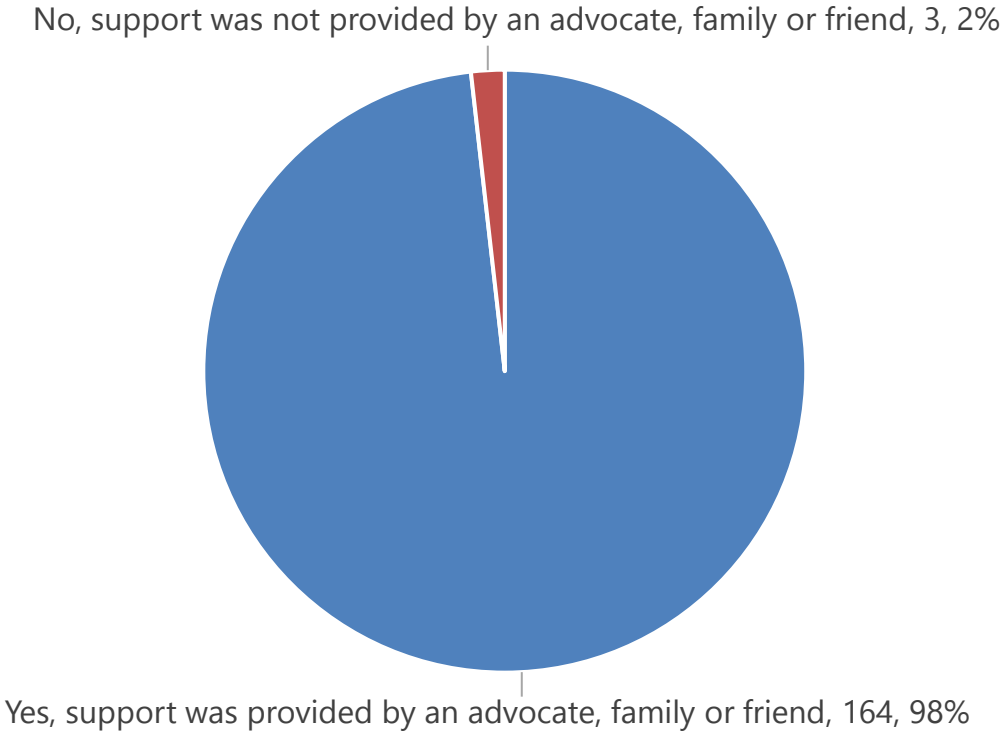


The most common location where people were identified as being at risk was in their own home (52%), followed by in a residential care home (22%)



Mental Capacity

In 167 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

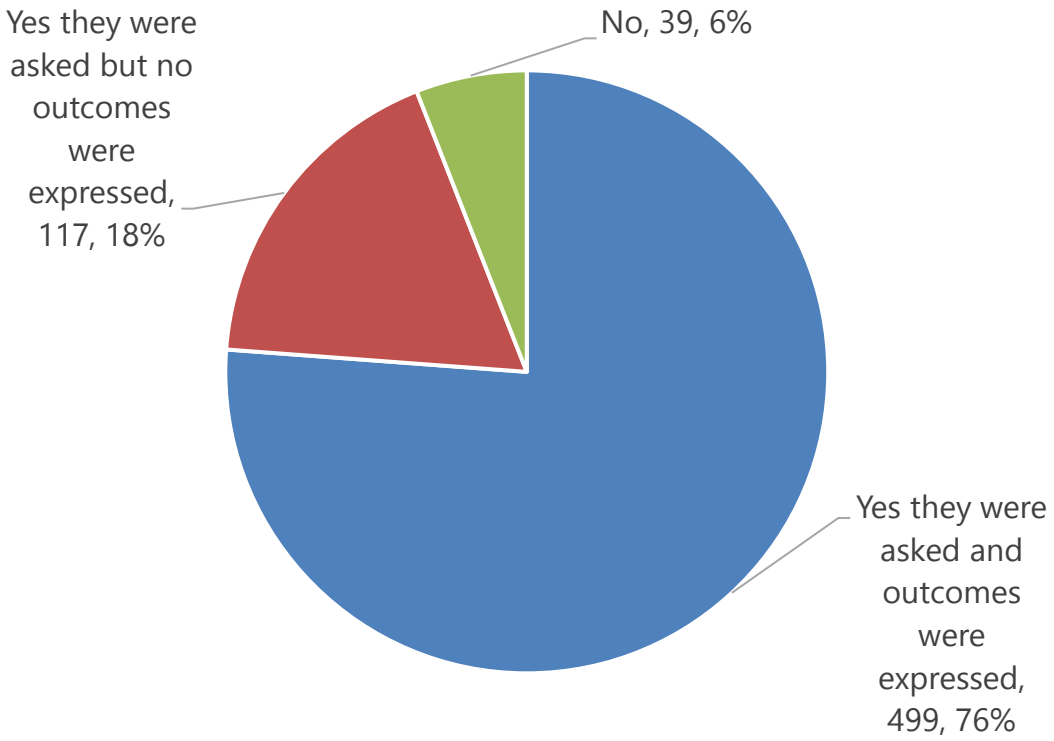


Making Safeguarding Personal

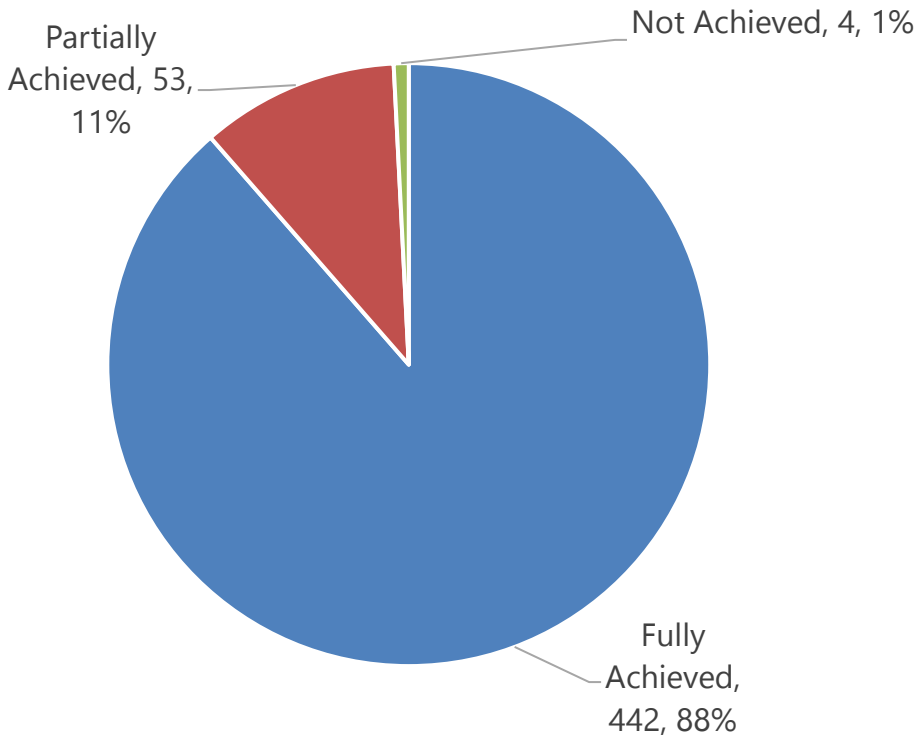
What does Making Safeguarding Personal mean?

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.

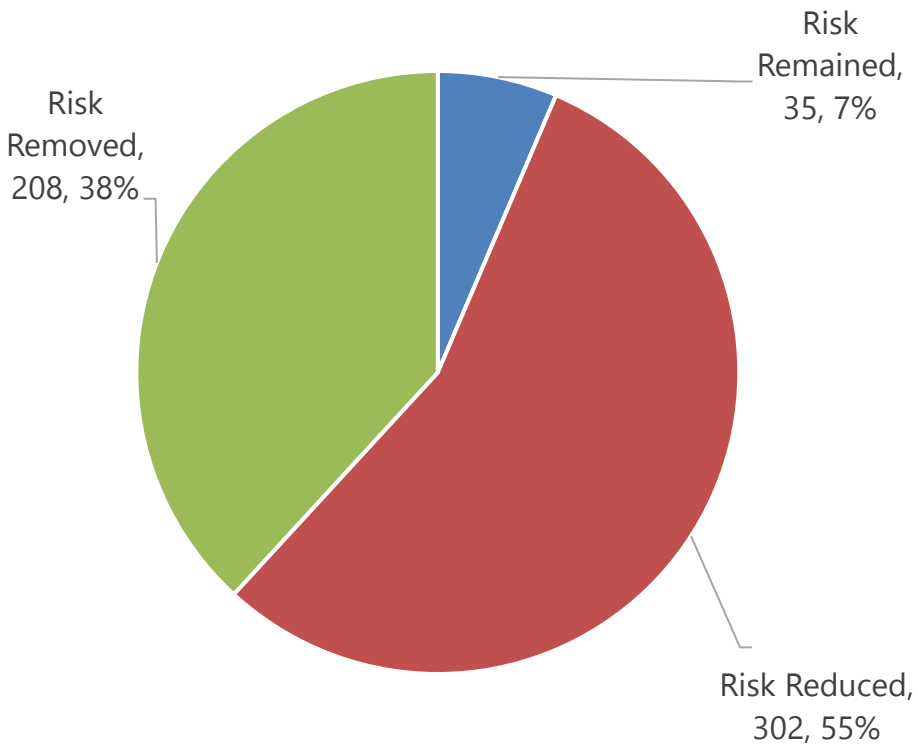
The majority of people, or their representative, were asked what their desired outcomes were



In 99% 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. 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.

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.

One Safeguarding Adults Reviews concluded during 2021/22, and this is 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.

'Matthew' Safeguarding Adults Review

Background

A report was published by the Somerset Safeguarding Adults Board on 14/12/2021 and documents the events leading up to Matthew's death (pseudonym), in hospital, in January 2018.

Matthew had a history of multiple and complex health problems, including substance misuse, type two diabetes, chronic obstructive pulmonary disease (COPD) and skin infections. The day before his admission to the hospital where he died, Matthew had declined a planned admission to a community hospital and was found at home drifting in and out of consciousness by staff employed by a care agency. Matthew was admitted to the emergency department with pneumonia and type 2 respiratory failure. Hospital records state that he had been bedbound for a long period of time and had become unable to roll causing pressure damage to his skin.

Prior to his death, organisations were attempting to support Matthew in relation to his history of neglecting his own health and well-being. Matthew's case highlights the difficulties organisations face in supporting people with complex health and social care needs, who want to maintain their independence and decision making.

Findings and areas for learning and improvement

Responding to changes in need: Matthew was clearly deteriorating for several weeks leading up to his death. A short period of access to 24-hour care may have provided an opportunity to work with Matthew and could have prevented some of his early deterioration. A successful planned admission to a care home placement or a community hospital may have provided an opportunity to work more effectively with Matthew to prevent further deterioration. Neither happened. Professionals should take into consideration information that indicates that an adult's health and/or situation is on a deteriorating trajectory and respond in a timely way.

Involving other organisations: While the safeguarding response was considered to have been appropriate when referrals were made, it is unclear

why concerns were not raised about Matthew's physical health much earlier in 2017. The professionals supporting Matthew were clearly concerned, but they appear to have attempted to manage the situation themselves until a critical stage was reached. Professionals should involve the other professionals and/or organisations that are/need to be involved in supporting an adult in multidisciplinary approaches and meetings in order to avoid 'firefighting' concerns in isolation.

Multi-Disciplinary Meetings: While there was a multi-disciplinary meeting in March 2017, no notes appear to have been taken and opportunities were not taken for all those involved in supporting Matthew to meet again to consider how to support him. A record must be made of all meetings, actions and who has/the organisation that has responsibility for carrying them out. This record must be shared with all the professionals/ organisations that are involved to avoid working in isolation.

Joint Working: The review identified learning that, in situations where multiple organisations are working to enable someone to be transported that requires specific logistical arrangements, this should be coordinated by a single individual/organisation, with all organisations taking ownership and accountability for ensuring that the elements they are responsible for are delivered. There should have been agreement of a lead agency and/or professional to co-ordinate the transfer.

If plans change: When plans change, each professional/ organisation has a responsibility to inform the professional/organisation with the agreed coordination responsibility. This serves to ensure that changes to the agreed plan can be communicated to all the professionals/ organisations involved so that everyone is aware and can agree any new actions that are required. For example, in Matthew's case his decision not to be admitted to the Community Hospital when the ambulance arrived to take him, should have been communicated to all involved, who then should have reconvened to reassess the risk and agree the next plan of action.

Recording when an adult's capacity is considered: While in no way suggesting that Matthew did not have capacity at any point, at different times during the period under consideration, professionals had said that they had questioned if Matthew had the capacity to make some of the decisions that he was choosing to make. Unfortunately, the recording of information relating to this was poor. Professionals should record all occasions where an adult's capacity has been considered and why. Where there is a concern about the

decisions an adult is making, consider how the underlying reasons for this can be explored with the adult and record this.

Decisions about health and care when an adult is incapacitated: Matthew had clearly expressed a view to multiple professionals that he did not wish for his family to be involved in his life or know about his health. However, on admission to hospital his family was contacted. It is unclear whether the staff who made the decision to involve Matthew's family in decisions about the ending of his treatment were aware of his wishes at the time. If an adult who has previously expressed a clear wish that their family should not be involved in decisions about their health and care becomes incapacitated, professionals should arrange for the involvement of an Independent Mental Capacity Advocate (IMCA) in relation to this decision.

Recommendations where further assurance is being sought the recommendation has been completed or implemented:

	Summary of Recommendation
1	That the Somerset Safeguarding Adult Board ensures that the learning from this Review is shared with: • All providers of domiciliary care operating in Somerset • The Somerset Registered Care Provider Association (RCPA) • The Care Quality Commission • The Local Medical Council • Employees of Somerset County Council's Adult Social Care Service • Employees of Somerset NHS Foundation Trust • NHS Somerset Clinical Commissioning Group • NHS England and NHS Improvement
2	That Somerset County Council and NHS Somerset Clinical Commissioning Group undertake an exercise to evaluate current capacity within the registered care homes in Somerset to support adults with bariatric needs and, should any gaps be identified, develop a plan to address them.
3	That Somerset County Council's Adult Social Care service provides the Somerset Safeguarding Adults Board with evidence that its staff are aware of the process of how to initiate the process for applying for Continuing Healthcare funding, and the local policies and procedures related to doing so.
4	That Somerset County Council, and Somerset NHS Foundation Trust, ensure that there are appropriate arrangements in place to: • Ensure that an adult's wishes are sought, known and understood in any safeguarding process

	• Share, and where appropriate escalate, concerns about an adult's responses with other professionals that are involved in supporting them • Allow professionals to balance the adult's rights, in line with the Care Act (2014), Human Rights Act (1998) and Equality Act (2010), with an assessment of any risks posed.
5	That all Somerset Safeguarding Adults Board member organisations actively promote "What to do if it's not Safeguarding?" within their organisations, and remind staff of the importance of clear minutes being taken of any multi-disciplinary meetings that take place (which include clear actions allocated to named professionals/organisations and shared with all involved in the meeting); and of any capacity assessments undertaken.
6	That where a complex transfer is being considered that involves multiple organisations a lead professional is identified (in most cases this will be an employee of the organisation with the lead responsibility for commissioning the adult's care and support) to coordinate the process, ensure decisions are made in a timely way and that actions are both allocated to named individuals and followed up on to ensure that they have been carried out as agreed. They should also act as the point of contact if the plan cannot be carried out as agreed.
7	That Somerset NHS Foundation Trust and Yeovil Hospital NHS Foundation Trust review their policies and guidance for staff in relation to circumstances where an adult is unable to express their wishes for themselves, but have previously expressed a clear wish that their family should not be involved in decisions about their care.

Updates on reviews published in previous years

The SSAB Executive Group monitors the progress of work to address the recommendations made by all SARs each time it meets, and requests evidence that any action has been completed before agreeing that it has been completed. Progress updates regarding those recommendations that were outstanding as at 01/04/2021 are included below:

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

The review made 12 recommendations, of which 7 were still open on 01/04/2021. As at 31/03/2022 the status of each was as follows:

Recommendations where assurance has been received that the recommendation has been completed or implemented:

	Summary of Recommendation
1	That the SSAB ensures that the learning from this Review is shared across the local system
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.

Recommendations where further assurance is being sought the recommendation has been completed or implemented, or where audits have been requested to test compliance:

	Summary of Recommendation
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.
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 individual's 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.
7	Where a provider of care and support to adults has concerns about an individual self-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.
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.
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.
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.

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

The review made 10 recommendations. As at 31/03/2022 the status of each was as follows:

Recommendations where assurance has been received that the recommendation has been completed or implemented:

	Summary of Recommendation
1	Written guidance is produced, or where already available reviewed, by Somerset County Council and Somerset NHS Somerset Foundation Trust for use by all staff tasked with finding appropriate accommodation for people with complex needs. This SAR should also be shared with other commissioning agencies who were not involved in the case in order that they are aware of the learning from this case.
2	That decision-making processes for commissioning services for individual adults are reviewed by Somerset County Council, and Somerset NHS Foundation Trust to ensure that they produce timely decisions, and that the process is shared with the person themselves and, where applicable and appropriate, those who are important to them.
4	Written guidance is produced by Somerset County Council and Somerset Foundation Trust that details the required content of care plans in circumstances when the care of an adult with complex needs is transferred to another setting (including where the commissioner is employed by another organisation that has a delegated role).
5	That all organisations involved in providing care and support to Damien ensure that Mental Capacity Act training of their staff addresses the influence of coercion and exploitation on people with complex needs,

	and that quality monitoring processes are used to test that it is being addressed in practice.
6	All organisations involved in the care of Damien should review their risk assessment processes, considering the key areas highlighted in the report.
7	All organisations involved in the care of Damien should review the training that their staff undertake in respect of risk assessment and management to ensure that it addresses the issues identified in this SAR.
9	Somerset County Council and Somerset NHS Foundation Trust should reinforce the requirement that, where adults with complex needs have given consent to involve family in their care or where they lack the capacity to decide about family involvement, but it is considered in their best interests to involve them.

Recommendations where further assurance is being sought the recommendation has been completed or implemented, or where audits have been requested to test compliance:

	Summary of Recommendation
3	That the Somerset Safeguarding Adults Board seeks assurance from Mendip District Council, Sedgemoor District Council, Somerset West and Taunton District Council, South Somerset District Council, and Somerset County Council that there is a shared commitment to joint action across local government, health, social care and housing sectors in Somerset to support the needs of adults with autism.
8	The Somerset Safeguarding Adults Board should write to the Safer Somerset Partnership to ask it to review how information is brought together and shared in order to inform risk management, in particular in relation to the role of MAPPA where an adult is experiencing mental ill-health, and to implement any changes identified as a result.
10	That the Somerset Safeguarding Adults Board seeks assurance that organisations are able to demonstrate that assessments are holistic.

6. Our priorities for 2022/23

The Board recognises more can be achieved by working together in partnership, and has identified four strategic objectives for it's strategic plan for 2022-2025, which will be refreshed annually:

1. **Listening, learning and Improving:**
   - The principles of Making Safeguarding Personal are embedded in every-day practice across the system so that safeguarding is person-led, outcome-focused, enhances involvement, choice and control, and improves quality of life, wellbeing and safety.
   - We use learning and best practice from within Somerset and elsewhere to enhance practice across the Somerset system.
   - We will be open to constructive criticism, and take appropriate action to reduce risk and improve safeguarding practice within Somerset.
   - Professionals are focused on prevention and, where appropriate, proactive intervention
2. **Enabling people to keep themselves safe:**
   - People are aware of what abuse and neglect 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 a way that works for them in line with the principles of Making Safeguarding Personal
   - Policy and guidance reflect best practice and takes a positive approach to risk
   - There is effective working across local, regional and national partnerships on areas of mutual interest
4. **How the Board Works:**
   - 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.

7. Board Budget

		2021/22	
SOURCE OF FUNDS		**CONTRIBUTIONS £**	%
Somerset County Council	- SAB Manager & Independent Chair	56,184	57.6%
	- Safeguarding Adults Reviews	5,160	5.3%
Avon & Somerset Constabulary	- SAB Manager & Independent Chair	15,900	16.3%
	- Safeguarding Adults Reviews	5,170	5.3%
NHS Somerset Clinical Commissioning Group	- SAB Manager & Independent Chair	10,000	10.2%
	- Safeguarding Adults Reviews	5,170	5.3%
TOTAL CONTRIBUTIONS		**97,584**	**100.0%**
APPLICATION OF FUNDS		**EXPENDITURE £**	%
PAY (including overheads)			
Safeguarding Board Manager		61,345	65.9%
Independent Chair		15,923	17.1%
Non pay			
Safeguarding Adults Reviews		15,500	16.6%
Insurance		49	0.1%
Equipment – IT hardware		70	0.1%
BT charges/mobile charges		258	0.3%
TOTAL EXPENDITURE		**93,145**	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.

8. Our work during 2021/22

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 2021/22 the Board's work was, for the second year in succession, significantly impacted by the Coronavirus Public Health Crisis, and while it continued to carry out its statutory duties much of the developmental work of its Subgroups was reduced so that partner organisations could focus on their response to the crisis. In addition, during the Public Health Crisis, the Board continued to provide support to the wider health and care system by hosting a "Coronavirus updates for Somerset Adult Care Providers" page on its website that was updated daily with the latest guidance from Mary 2020 until it moved to a provider webpage hosted by Somerset County Council at the end of 2021. It also supported work to manage the administration of Covid-19 grant monies to care providers trough to March 2022, and to provide a weekly briefing to care providers until this was also transferred to Somerset County Council.

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	• Following receipt of a report by Healthwatch Somerset at the end of 2018/19 the Board worked with Somerset County Council, as the agency with lead responsibility for adult safeguarding, to monitor the implementation of the agreed actions. Following delays caused by the Coronavirus Public Health Crisis the new feedback process was put in place at the beginning of May 2021.

What SSAB said it would do	What the SSAB did
their carers, both provided directly to the Board and through partner organisations, including the third sector.	• Feedback levels to date, while higher than the previous system achieved cumulatively over 5 years, have been lower than hoped despite promotion to, and by, partner organisations. • Feedback has been incorporated in to a newly developed SSAB Dashboard which is managed by the Performance and Quality Assurance Subgroup, and presented to the Board each time it meets. • 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 2021/22 year are shown in Section 4 (page 11) with 99% of people, or their representatives, reporting their desired outcomes had been wholly or partially achieved. • Due to the coronavirus pandemic, during 2021/22 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 intend to resume inviting them from our October 2022 meeting onwards. • To ensure an effective link between senior leaders on the Board and those who provide a direct safeguarding service, the Board received presentations from the Lighthouse Safeguarding Unit and care providers on the challenges they have faced, as well as written feedback from the family of Damien who were unfortunately unable to join the meeting in person.
Provide multi-agency Safeguarding Adults learning opportunities to raise the profile of adult safeguarding, address areas of	• Best practice continued to be 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 supported the production of during the year.

What SSAB said it would do	What the SSAB did
practice improvement and share lessons learnt from Safeguarding Adult Reviews.	• 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 has now resumed its normal newsletter schedule. • The Performance and 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, it was satisfied that the system in Somerset was responding to referrals appropriately. • The Board led a regional webinar on "Promoting Safer Cultures" during the national Safeguarding Adults Week in November 2021, and a webinar on "Professional Curiosity" in March 2022. Surveys were carried out before and after the Professional Curiosity webinar to gauge the impact and identify topics for future webinars.
Implement the recommendations of "Analysis of Safeguarding Adult Reviews April 2017 – March 2019" that are applicable to individual Safeguarding Adults Boards, and contribute to regional and national workstreams for others where appropriate.	• A presentation on the findings of the National Analysis was presented to the Board in October 2021 • All recommendations for local Safeguarding Adults Boards have been RAG rated and are being monitored by the Board's SAR Subgroup • To date, of the 18 recommendations that apply to local Boards 11 have been completed and 7 remain outstanding. Of those outstanding: ○ One is contingent on work that is taking place nationally, that will then need to be implemented locally

What SSAB said it would do	What the SSAB did
	○ One relates to public information that is in the process of being developed both locally and nationally ○ One relates to a recommendation that has national, regional and local elements which require further exploration to establish what work needs to be completed by the SSAB ○ Four relate to assurance within the local system, which the Board's Performance and Quality Assurance Subgroup is working to establish whether the information is already available in a different from before considering additional auditing activity.
Identify learning for the adult safeguarding emerging from Covid-19, 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 with no significant additional priorities emerging. The Board has also supported work by the Local Government Association (LGA) 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. During the year, the Performance and Quality Assurance subgroup and Executive Group reviewed two national reports produced by the LGA that showed comparative data for Somerset with other areas. At present Somerset appears to be an outlier in terms of a declining number of referrals compared to other areas. Analysis suggests that this is as a result of the significant work that has been undertaken by Somerset County Council's Safeguarding Service, the SSAB and Somerset Direct over recent years

What SSAB said it would do	What the SSAB did
	to improve understanding of adult safeguarding criteria, and reduce or redirect the previously high numbers of inappropriate safeguarding contacts. However, additional monitoring will take place during 2022/23 to test this analysis and provide assurance to the Board.

Priority Area 2: Enabling people to keep themselves safe

What SSAB said it would do	What the SSAB did
Work together with the Safer Somerset Partnership, and Somerset Safeguarding Children Partnership to supported work to raise awareness of, and reduce the harm caused by 'Hidden Harms', and abuse associated with County Lines activity, domestic abuse and modern slavery. Implement that Board's communication plan, developed during 2020/21 which is aligned with local, regional and national campaigns.	• The Board has continued to be represented on, and support the work of other Boards. This included promoting information about Domestic Abuse as the Domestic Abuse Act was implemented, and the inclusion of learning from Child Safeguarding Practice reviews in its October newsletter. • New public facing materials have been developed by the Policy and Procedures Subgroup which have been promoted with partners and via social media on Mate Crime, and the Board was also kindly given permission by another Safeguarding Adults Board to adapt an animation to go alongside it called 'Tricky Friends" • New public facing materials that were published on 31/03/2021 have continued to be promoted. • As in previous years each Safeguarding Adult Board in the Avon and Somerset Constabulary area undertook to promote adult safeguarding through the annual 'Stop Adult Abuse Week'. From 2021 it was agreed that this would move to November to coincide with the National Safeguarding Adults week promoted by the Ann Craft Trust.

- Throughout the year the SSAB worked to raise awareness of abuse and neglect. This 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, which 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 4234 sessions each month following on from the significant growth that was achieved during previous years. New content has continued to be added, and existing content reviewed, by the Board's Learning and Development & Policy and Procedures Subgroup.
- The SSAB Business Manager was unable to progress the implementation of the new Communications Plan consitently due to needing to prioritise other work for the Baord and support the system response to Covid-19. However, funding for additional permanent support has been secured and it is expected that this will enable this to be revisited in 2022/23.
- Social media activity has been lower than in previous years, and has primarily focused on promoting information created by other organisations, however this is expected to return to previous levels during 2022/23.

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

What SSAB said it would do	What the SSAB did
Seek assurance from the Somerset care home sector on compliance with the NICE Safeguarding adults in care homes guideline, and work was a partnership to support the sector to address any gaps identified	• All care homes were invited to complete the NICE baselining tool in in Quarter 2, however the number of responses was very low, and work on this has not been progressed following advice from the National Chairs Network which had raised concerns with NICE about the guideline. • This position will be reviewed should a revised guideline be released.
Seek assurance on preparedness for the implementation of the new Liberty Protection Safeguards	• The introduction of the Liberty Protection Safeguards has been postponed, and the government has not yet published a revised implementation date with the secondary legislation still being consulted on at the time of writing. • The Board's Mental Capacity Act Subgroup has continued to monitor performance with respect to the application of the Act and the existing Deprivation of Liberty Safeguards (DoLS)
Seek assurance on the safeguarding arrangements for adults with learning disabilities, including, but not limited to, the recommendations made by the	• The Provider Collaboration Review published by the Care Quality Commission did not make any specific recommendations for the Somerset System in relation to adult safeguarding, and therefore there were no actions for the Board to seek assurance regarding. • The SSAB Independent Chair sought assurance from NHS Somerset CCG and Somerset County Council that learning identified through national

Care Quality Commission following its Provider Collaboration Review	workstreams following a high-profile Safeguarding Adults Review published by the Norfolk Safeguarding Adults Board was being taken forward in a timely way.

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.

	2020/21	2021/22	% Change
Total applications	2576	2881	+12%
From Care Homes	1596	1782	+12%
From Hospitals	1007	1099	+9%
Assessments completed	664	672	
Authorisations granted	628	634	
Authorisations not granted/ of which not assessed	2085/2054	1984/1939	

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.
- During the main period of the pandemic there was a move towards carrying out assessments remotely in many cases. During this period assessors were required to develop new assessment skills to ensure the people being assessed were able to participate as fully as possible.

- Since the autumn of 2021 there has been a move back to assessing in person and this is now the practice in many assessments.

Community Deprivations of Liberty

These are situations where a person who lacks capacity to make decisions about their care arrangements needs to be cared for in a restrictive manner but is not in hospital or a care home. An example would be a supported living service. For these people any deprivation of liberty requires authorisation form the Court of Protection. SCC has a system for identifying and prioritising such applications and is currently seeking to increase staffing resources for this to progress more swiftly.

Liberty Protection Safeguards

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 was a significant delay in the publication for consultation of the Code of Practice and secondary legislation which was then further affected by the Coronavirus Public Health Crisis resulting in the consultation not starting until 17/03/2022. As a result, a new start date is yet to be published for the implementation of the legislation.

Somerset County Council has submitted its response to the consultation on the new MCA and Liberty Protection Safeguards Code of Practice and has worked closely with NHS partners on this. A response to the consultation is expected from the government in the Autumn at which point we anticipate the announcement of a new start date for the scheme.

In the meantime, Somerset County Council's DoLS service has continued to prioritise for DoLS assessment those situations which are most critical and to ensure that, despite the practical challenges that were 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: Board Governance

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 monitoring of the implementation of recommendations of published SSAB SARs is a standing item at each meeting of the Board's Executive Group. • The Learning & Development and Policy and Procedures Subgroup has the monitoring of reviews undertaken locally, regionally, and nationally to identify learning within its role. • The SSAB Independent Chair also follows up national and regional learning with the Executive Group – for example seeking assurance on the Somerset system's position with regard to national trends and in initiatives. • Learning from elsewhere continues to be shared with the system via social media and newsletters
The Board has arrangements in place to monitor performance against a range of measures from across the partnership and, in addition, to understand where risks exist within the system in order to seek assurance on the implementation of action(s) to address them.	• All recommendations from the South West Audit Partnership of the SSAB, which were reported in our 2020/21 Annual report, were signed off as having been completed by the Executive Group at the start of the year. • A new, comprehensive, Performance Dashboard has been developed by the Performance and Quality Assurance Subgroup which is being updated quarterly and circulated to all Board members in advance of every meeting. This is expected to have additional measures added from partners during 2022/23. • The Board has led on work with the four other Boards in the Avon & Somerset Constabulary footprint to introduce a new shared audit tool. This

was issued in August 2021 with a closing date for submission of October 2021. A summary of the audit has been provided below.

SSAB Annual Self-Audit 2021/22

- As part of the development of the new tool, it was agreed to move to a biennial audit cycle, with a focus on areas of improvement in the intervening year
- All SSAB members were invited to complete the audit during Quarter 2021/22 comprising of 23 areas of safeguarding practice across 7 themes, and to submit this for initial discussion by the Quality Assurance Subgroup ahead of a peer challenge process that will take place in 2022/23.
- The audit was also published on the SSAB website for any organisation to use internally.
- The key themes assessed within the audit related to:
    - Leadership
    - Evidence of Policy in Practice
    - Safer Recruitment, including people in a position of trust
    - Learning and Development, including learning from SARs
    - Making Safeguarding Personal
    - Exploitation
    - Transition
- A total of 17 organisations completed the self-audit, a significant increase over previous years
- The organisations that returned an audit were:
    - Avon and Somerset Constabulary
    - Department of Work and Pensions
    - Golden Lane Housing
    - Healthwatch Somerset
    - LiveWest
    - Mendip District Council

  - Missing Link, Next Link and Safe link
  - NHS England and Improvement
  - NHS Somerset Clinical Commissioning Group
  - Somerset and Avon Rape and Sexual Abuse Support
  - Somerset Care Ltd
  - Somerset County Council - Adult Social Care
  - Somerset County Council - Public Health Commissioning
  - Somerset NHS Foundation Trust
  - SWAN Advocacy
  - The Knoll Nursing Home
  - Yeovil District Hospital NHS Foundation Trust
- Overall, an aggregated total of 391 responses were received from the 17 organisations. Those areas where a response was not received were primarily where an area was not applicable to an organisation. For example, a number of the questions were only applicable to organisations with a commissioning function.
- Themes emerging from the audit have been considered regionally to identify areas that can be taken forward jointly, for example in the production of joint guidance.

Due to the change of template, which resulted in a smaller number of more focused questions, this audit was not comparable to the previous audit.

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

The Work of Our Members

Somerset County Council

We welcome this Annual Report as an opportunity to look back over the past year and look to the new year ahead. Adult social care (ASC) covers a wide range of activities to help people who are older or living with disability or physical or mental illness (aged 18 plus) to live independently and stay safe and well. Our Somerset Adult Social Care plan is focused on Promoting Independence & adopting person-centred approaches. Our ambitions are to support people in Somerset to:

- Be able to remain in their own homes for as long as possible;
- Recover and return home from hospital quickly;
- Reduce our use of out of county placements by ensuring we have a sufficient range of mixed economy provision;
- Enable people and their carers to tell us what 'good' looks like for them and help design their support;
- Have equal access to mainstream support within their local community;
- Have tailored assistance to support where they need it;
- Have enabling conversations focused on their strengths and to offer informed choice.

During 2021/22, Adult Social Care in Somerset:

- Received an average 5,874 contacts per month via our call centre) for care and support related advice or activity
- Completed over 6,700 assessments and 6,000 reviews of individuals care and support needs
- Undertook 684 Safeguarding Enquiries, reducing or removing the identified risk in 93% of cases
- Supported over 90% of individuals aged 65 and over to be discharged back home from hospital each month
- Sourced 16,159 hours worth of home care for people assessed as requiring care and support at home
- Had over 4,650 open clients in receipt of a Local Authority Adult Social Care service.

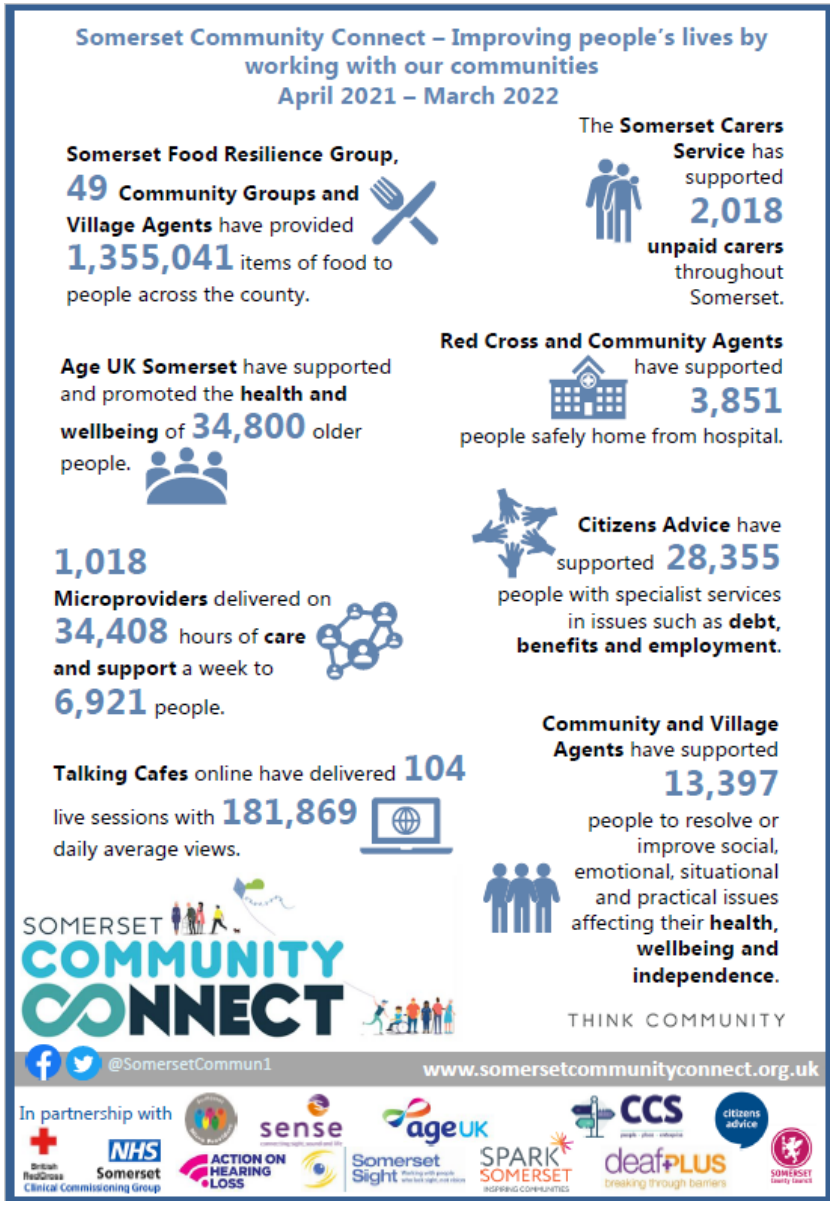
This year's national Adult Social Care Survey indicated that the overall satisfaction rate of people who use local services with their care and support has risen to 67.3%; latest data also reveals there has been a rise in the proportion of clients who report feeling safe (67.7%) and who think that the services they receive help them to feel safe (89.7%)

Social care, health and voluntary organisations have also 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.

During 2021/22, Somerset Community Connect supported the local population in a variety of ways, as evidenced by the infographic (right).

Adults Social Care has continued to actively support local care providers during the year, with practical advice, guidance and routine communications concerning latest COVID implications. We have also continued to significantly invest into our Proud to Care Somerset initiative to help raise the profile of working in care and promote it as a career.



However, Adult Social Care services are facing a number of cost and demand pressures, nationally, regionally, and locally:

- There is a rising cost of social care which is driven by two main factors: increasing demand for services and rising costs of providing them.
- Somerset's population is growing faster than national averages with almost all of our growth being of elderly persons outside the working age population.
- Adult Social Services have faced an increase of requests for care and support from older people and disabled people of working age as society opens up after COVID-19.
- There is growing demand for help with mental health issues, domestic abuse, homelessness; more people seeking help because of carer breakdown.
- The inter-dependence of social care and NHS: Supporting more people awaiting hospital admission / being discharged from hospital.
- A national Long-term workforce plan needed: key challenges persist across the care sector in recruitment, retention and turnover.
- More care at home is being delivered, but this is not keeping pace with increasing demand and complexity of need.
- More people waiting for assessments, care and support, or reviews, with some internal recruitment challenges and staffing vacancies;
- Concerns about care provider sustainability on the back of the pandemic.

The service has struggled with recruitment into our frontline operational roles and remains reliant on a large number of locum staff; despite this our recruitment activity continues, supported by a new ASC Workforce Strategy and Action Plan.

Our Principal Practice leads for Social Work and Occupational Therapy launched an Adult Social Care Practice Quality Framework in November 2021 to more clearly set out our expectations of practice standards. In addition, in January

2022, we launched a new adult social care stakeholder feedback form to actively seek feedback about the experiences people have had. This is providing us with invaluable insights into what we are doing well and where we can enhance our offer and provision.

Our Adult Safeguarding activity

Safeguarding adults at risk work has remained a key priority for Adult Social Care throughout the past year and whilst we have continued to see a decline in the number of concerns raised with us, the severity and urgency of the situations being reported has increased.

A large proportion of safeguarding concerns come to our attention via a third party, rather than from the person themselves. Over the coming year we would like to enhance awareness among people living in Somerset about how they can alert us to their needs to ensure that people know who to contact and how they will be supported when they do. We have continued to work with voluntary and community based services to raise awareness and to equip more people to recognise, respond and report abuse and neglect in their communities.

The majority of concerns are raised by registered care provider settings, with neglect and acts of omission being the highest category of abuse that reported to us (accounting for 25% of all enquiries). We continue to work directly with care homes to understand the needs of residents and to support them to prevent abuse and apply learning from situations to avoid harm from occurring.

There has been a small increase in the number of concerns relating to self-neglect in the past 12 months. This has led us to commission bespoke self-neglect and hording awareness training for our teams to help upskill in this is specific area. We know that working with people who self-neglect takes time and can be very specialist work.

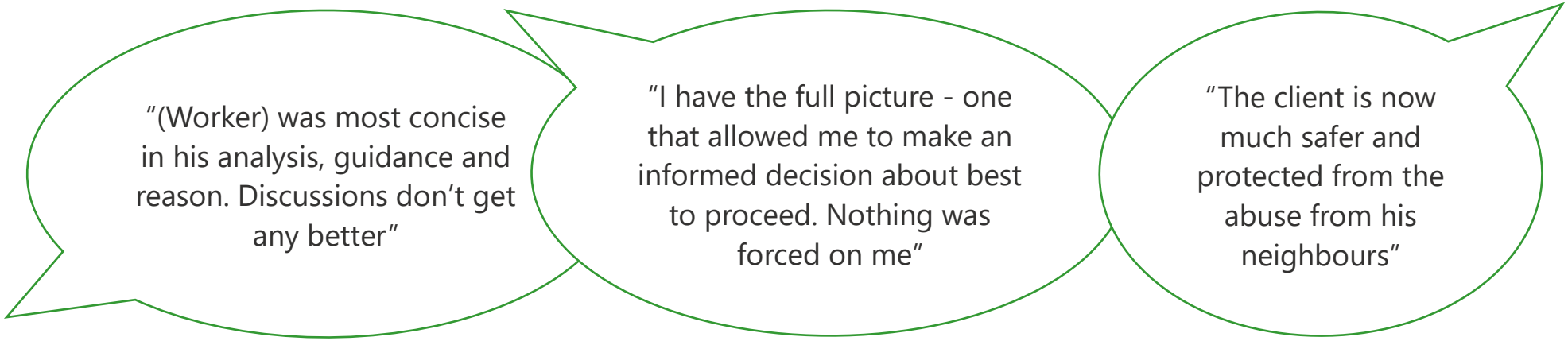
Our work remains busy and varied, balancing the volume of concerns coming into Somerset Direct with getting the outcome of the enquiry right for people. We have experienced some enquiries taking a longer time to resolve in the past year. Our information suggests there are many factors to this, including the complexity of the safeguarding

concerns that need resolving, the availability of other professionals to support a protection plan or our own staffing resource allocation challenges. Our staffing group has changed over the past 12 months with some moving to new positions in other teams. We have therefore welcomed new social workers into the service. We have also experienced extended periods of staff absence in the team.

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

- In 94% of safeguarding enquiries undertaken in Somerset during 2021/22, the identified risk was reduced (56%) or removed (38%).
- When an individual was asked and expressed a desired outcome from the safeguarding intervention, 99% of outcomes were either fully or partially achieved in completed statutory s42 enquiries, and in 100% of non-statutory safeguarding enquiries.

The Somerset Safeguarding Adults Board worked with Healthwatch to devise a service user feedback questionnaire in May 2021. Satisfaction levels are currently highest from service users (100% satisfied with the outcome of the safeguarding work), followed by IMCAs/Advocates (88%). The service is working with the Board to consider what more can be done as a system to enhance the experience of friends/relatives/carers in safeguarding activity (50% satisfied with outcome), particularly where younger adults are involved as part of transitions activity and preparing for adulthood.



Safeguarding Adults Case Study – Supporting Harry

Kelly supported Harry by building trust and by supporting his strengths. When she first met Harry, he lived alone in a warehouse surrounded by his personal belongings, work tools and clutter. The concerns raised from environmental health were about how he was living stating support was 'beyond their service and he needed to move', with obvious signs of self-neglect. Harry felt people were not listening to him. Kelly supported Harry to make contact with housing to talk about his options. On the day of the appointment he did not want to go ahead with it so instead Kelly

supported Harry to clear some of his recycling rubbish and take it to the tip. With Kelly's support they loaded her car and Harry was pleased with the impact this made.

Kelly arranged for Harry's rubbish to be collected so that he could start to see a difference in the warehouse. They agreed a skip would be best due to the volume of clutter. Harry agreed and worked to fill the skip.

Kelly's views on working with Harry; 'I feel I have built a relationship with Harry and feel this has been achieved by him feeling I am listening to him, not telling him what to do and by listening and having everyday conversations with him, allowing him to speak and listening to what is important to him.'

Harry has agreed to be rehoused and continues to be supported by a housing officer to find suitable living accommodation for him. He has also accepted a referral to audiology to review his hearing impairment and tinnitus.

The focus of this work between Harry and Kelly has been about building trust, rapport and a human connection; this has taken time. There have been times when progress, or sticking to the plan, has been slow but the sense of achievement felt by Harry has been real.

He has responded positively to the practical approach Kelly was able to adopt in her interaction with him and he has always been in control of what happens next – relationship based social work.

Kelly has facilitated opportunities and talked to him about options but has been clear in her approach that he is in the driving seat to make the changes.

During 2021/22, the ASC Safeguarding service received a total of 9 complaints, a reduction when compared to the two previous financial years.

The most common initial cause for the complaint was logged as a 'failure to do something' or 'communication by service'. All complaints have resulted in learning outcomes that have been brought back into the service to avoid the actions from occurring again.

In the latter part of this reporting year, positive engagement has taken place with SWAN Advocacy, our Safeguarding Service and other leads to explore and address identified low advocacy referral rates in Somerset. This has promoted healthy conversation and partnership working, with positive steps taken to promote and encourage referral to advocacy services when the person needs support within a safeguarding enquiry.

As a service we ensure that the Local Authority continues to commission and deliver exceptional safeguarding adult training to our workforce. However, in line with other organisations, the Covid pandemic has continued to have a significant impact on attendance rates with a number of last minute cancellations due to pressures within teams or sickness absences/vacancies. We have also seen a rise in partial attendance which means we are unable to reflect courses as being complete.

Looking to the future

The landscape for health and social care is changing which brings with it both opportunities and challenges. The implementation of the Health and Social Care White paper, the Integration white paper and the development of Integrated Care systems brings with it a focus on:

- The voice of those with lived experience at the heart of service and community design.
- Integrating Housing into local health and care strategies
- Drive greater adoption of technology and achieve widespread digitalisation
- A quality social care workforce fit for purpose
- Support to unpaid carers

Integrated Care is about giving people the support they need, joined up across local councils, NHS and other partners, removing traditional divisions.

Legislative changes for a Health and Care bill to build on the collaborations between the Health and Social Care system to better service our residents. The bill will:

- Focus on removing the barriers to become truly integrated care system
- Remove bureaucracy which makes decision making difficult
- Have a system that is more accountable and responsive to the people who work within it and the people that use it

On current timeframes, and subject to Parliamentary business and successful passage, the plan is that these proposals for health and care reform will start to be implemented in 2022

From April 2023 the government also intend to introduce a duty for the Care Quality Commission to independently review and assess local authority performance in delivering their adult social care duties under part one of the Care Act 2014. Work is underway to prepare for this assurance and assessment activity, but 'Ensuring Safety' is a likely key line of focus with implications for both the Local Authority and the Safeguarding Adults Board in Somerset.

NHS Somerset Clinical Commissioning Group

Our key aim for safeguarding adults is ensuring that the 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. This report describes the range of activities and developments that the safeguarding adult's team have undertaken to support the design and delivery of effective safeguarding adults arrangements across Somerset.

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.

The CCG safeguarding adult team structure incorporates the statutory roles of Designated (and Deputy) Designated Nurse, Named GP, and administrative staff. There is a separate safeguarding provision available specifically for the CCG Continuing Health Care team as set out later in this report.

The Named GP for Safeguarding Adults post has been vacant since quarter 2 2020 /21, and we face ongoing recruitment challenges due to the unprecedented demand still being experienced by Primary Care. The Designated Nurse for Safeguarding Adults was also vacant for a period of 3 months due to a gap in the previous postholder leaving and the replacement starting. Whilst this ongoing gap in safeguarding adults' provision has had an impact for colleagues working in primary care the Designated Nurse for Safeguarding Adults and her deputy have worked closely with other safeguarding colleagues within the CCG to ensure GP practices still have access to advice and support about people living in complex circumstances. We also continue to offer targeted support, advice and training to primary care organisations that have been identified as requiring additional support, along with seeking assurance of the safety and effectiveness of their safeguarding adults' arrangements.

The main responsibilities of the CCG Safeguarding Adults team are to:

- To enable the CCG to seek assurance from its commissioned services that they are delivering a comprehensive and effective safeguarding service and are compliant with statutory duties, guidance, and policy.
- work with NHS hospitals, community services and other commissioned providers and monitor how they support adults who need safeguarding, including how they work with other agencies. We work collaboratively with our partners and key partners in the system for example the Council and police.
- promote the welfare of adults at risk of abuse and neglect through working together with organisations via the Somerset Safeguarding Adults Board and the Safer Somerset Partnership.
- Setting out the expectations in relation to Safeguarding Adults for services commissioned by Somerset CCG.
- Monitoring and obtaining assurance with regard to the adequacy and quality of the safeguarding adults arrangements for services commissioned by Somerset CCG. 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 and recovery

The ongoing challenge since March 2020 has been the delivery of training and supervision during the Covid pandemic. Ensuring that CCG staff have the required competencies to carry out their responsibilities for safeguarding adults has been through a culture of learning across the system, which includes provision of safeguarding supervision and learning and development opportunities. Mandatory safeguarding adults training has been provided by all or part of the safeguarding team through the GP Safeguarding Leads training day held virtually in twice a year and virtual sessions provided as part of the GP Education Trust training programme. We further support colleagues working in GP practices to maintain their safeguarding knowledge by providing an ongoing rolling programme of best practice meetings and supervision plus production of a CCG Safeguard newsletter. Despite the significant ongoing demands placed on primary care the above sessions continue to be well attended; demonstrating commitment across GP practices to provide effective support to adults who need safeguarding. The development and dissemination of the 6 weekly 'The Safeguard' CCG newsletter has contained key safeguarding adult updates, learning and useful documents and tools to support safeguarding adult's practice.

Despite the significant additional pressures on our Trusts during the ongoing pandemic and recovery phase, 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.

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 four subgroups.

We have also taken an active role in Safeguarding Adults Reviews; supporting the commissioning, report development and publication of the seven SARs that have been opened and progressed throughout this year.

CCG secured one off funding which has been used this year to improve how the NHS Hospitals, Community Services and GP practices respond to people are experiencing domestic abuse and use these services. We provided two Health Liaison Domestic Violence and Abuse Advocates within the Somerset Integrated Domestic Abuse Service for a period of 1 year. Their role was to support and educate staff working in our Trusts and GP practices. They also offered a face-to-face service for people experiencing Domestic Abuse. Our Trusts supported this initiative through their substantive Domestic Abuse Coordinators post who worked in partnership with the Health Advocates. This project ended March 2022 and is now being evaluated to ascertain what went well, what we learnt through provision of this posts and what next steps will be in relation to support for Primary care in relation to Domestic Abuse.

During the pandemic and recovery phase that has occurred during 2021/2022, the CCG Safeguarding Adults team have prioritised the need to support acute, community, and primary care services together with partners across the system in the most meaningful way possible. Maintenance of statutory safeguarding adult's functions and provisions have continued as outlined in the Care Act (2014) and the NHS Safeguarding and Accountability framework (2019). As we have moved into the recovery/restoration phase, 'normal' service delivery is resuming, but is hampered by ongoing significant additional pressures being experienced across the health and social care system. Despite this Somerset CCG has continued to receive assurance that commissioned services are meeting their statutory responsibility to safeguard and promote the health and wellbeing of adults at risk of / experiencing harm / abuse. Assurance has been obtained throughout the pandemic and will continue through the recovery phase and beyond.

The Somerset multi-agency safeguarding system cell set up initially early in March 2020 by the CCG's Designated Professionals has continued to meet on a monthly basis (and more recently bi-monthly basis) providing professionals involved the opportunity to highlight and respond to challenges in the safeguarding adult's system that require a multi-agency response.

Our Safeguarding Adults Team have worked some hours outside their usual roles to support the wider response to the pandemic. This included providing some clinical members of the team to support 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;

- Generic CCG Safeguarding SPOC developed and well established.
- Supported in production of and participated in online webinars on professional curiosity as part of National Safeguarding Adults week
- We are also working closely with our CCG safeguarding children's colleagues and the Police on the establishment of a Domestic abuse notification project that aims to plug a gap in information sharing between police and primary care. A DA Administrator has been recruited and the process is anticipated to commence in the summer of 2022.
- We have been working closely with the newly created post - CCG Quality improvement lead for safeguarding to explore opportunities within the health system, including Primary Care Networks, to embed long term positive change across the health and social care system as a result of key learning from reviews, including DHRs, SARs and LeDeR. This will also include incorporating key learning from a number of projects focused on Domestic Abuse.

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.

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

Transitioning to an Integrated Care System

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.

Key to 2020 – 2021 priorities was the development of a transformational model of safeguarding across the Integrated Care System (ICS). Work has been progressed during 2021/2022 alongside key health and social care partners to identify key principles and priorities for Safeguarding across the lifespan with the potential for streamlining and reducing duplication, development of joint resources. Work moving forwards will focus on ensuring that safeguarding adults is embedded within the Somerset Integrated Care System and to undertake a review of the health safeguarding system resource with a focus on the potential for streamlining and reducing duplication, development of joint resources, increasing resilience of staff and future proofing the service (recruitment and retention, career pathways, development opportunities).

The Work of the CCG Continuing Healthcare, Safeguarding , Quality and Court of Protection team.

We have undertaken 12 s42 enquires on behalf of Somerset Council representing a 60 % reduction in referrals to the team. An explanation of the reduction in referrals may be that CHC assessors were conducting most assessments remotely in line with national guidance to manage the spread of Covid 19. From March 22 CHC adjusted its position in line with national guidance and is now undertaking most of the assessments/reviews face to face with exceptions completed remotely.

15 clinical reviews have been undertaken for people not CHC funded, but in cases where a s42 enquiry would benefit from an independent nursing review. Two staff completed a whole service visit to check service users' welfare

following allegations of serious sexual abuse – whilst there were no CHC funded service users using the service, this collaboration assisted our colleagues in seeking immediate assurance.

In contrast to the drop in Safeguarding referrals the team has seen an increase in the number of CHC enquiries completed, this quality process is used when the threshold for safeguarding has not been met and is a proactive approach to address concerns about practice standards. CHC enquiries align with Somerset Council, Service Quality feedback form (SQF) and both enquiries are supported by the joint Contract, Quality and Risk management policy.

The team have prompted a learning review for the management of a person with a Prolonged Disorder of Consciousness (PDOC). This has led to the development of a PDOC pathway in CHC and shared learning for the wider system in the implementation of the Mental Capacity Act. A training event in being planned for Autumn 2022 which will see internationally recognised experts in this field deliver a training event in Somerset to raise awareness of best practice in this specialist area.

In March 2022, the team completed an audit of the CHC teams' performance in applying the lessons learnt from Luke's SAR. The most recently completed reviews were audited from across all the 5 CHC teams (25 in total) we focused on whether weight/BMI had been accurately recorded, whether the reviews indicted that the person may lack mental capacity to consent to their care arrangements and whether self-neglect was a feature.

In addition, we reviewed the ten most recent annual contract management meeting minutes to review whether learning from Luke's SAR had been discussed with providers.

The finding from the audit were generally reassuring:

- 89 % of people had their weight accurately recorded
- 93 % of people had their BMI recorded
- 89 % of people had their Mid Upper Arm Circumference (MUAC) measured, when necessary
- Self-neglect was not indicated in any of the cases

- 60 % of Annual contract meetings evidenced a discussion about the findings of Luke's SAR.

Feedback to the CHC teams

- Not all staff were using the most up to date assessment, review, and meeting templates (latest version had prompts embedded following recommendations from Luke's SAR)
- Where old templates were being used colleagues were more likely to omit details required to evidence learning from Luke's SAR.

Over the last year, all outstanding community Deprivation of Liberty Safeguards (DoLs) applications have been submitted to the Court of Protection for scrutiny. The application process has ensured the CCG is lawfully commissioning care and enabled vulnerable people to realise the safeguards in the law when they are being deprived of their liberty. Two CHC Best Interest Assessors are now working with Somerset Council to complete outstanding DoLS assessments for people that are fully funded by CHC.

Further investment has been made in our Quality Assurance Framework, this is a joint assurance tool developed with Somerset Council, alongside the quarterly nursing returns we now have Learning Disabilities and Domiciliary Care services completing returns. This tool allows us to monitor services for changes in their performance and direct system wide support to providers to avoid a service deterioration/failure. Recent developments in the platform have improved the quality of data being produced and this has created more opportunities to work proactively to support and seek assurance from providers going forward.

Following the death of a resident in Somerset in 2019 from choking a coroner inquest has now been held. In establishing the facts of the persons death, the coroner also noted that a disproportionate number of people with a learning disability die from chocking related incidents. Consequently, a Regulation 28 report will be issued to NHS England to request that Dysphagia awareness training is made available to all Learning Disability providers across the country. In Somerset we have an eLearning package available free to health and social care colleagues and we are

working to strengthen this offer by the making practical sessions available. Once this is in place, we will embed an expectation that dysphagia awareness training as mandatory across all Somerset services and monitor compliance through QAF returns.

Avon and Somerset Constabulary

National Vulnerability Action Plan (NVAP)

The force has a strong governance process in place to manage and respond to vulnerability. The National Vulnerability Action Plan (NVAP) has now been formally adopted as the force's vulnerability framework and has aligned relevant improvement activity to the NVAP actions, this includes the adoption of 16 vulnerability strands including Adults at Risk. Each strand has a named Thematic Lead responsible for direction, focus and to continuously improve Force performance in their area. The D/C/Supt Head of CID is the vulnerability lead and responsible for leading the whole organisation's response to vulnerability. Governance is provided by the Constabulary Management Board and Police and Crime Board which receive quarterly vulnerability performance reports and updates, as well as detailed assurance reports throughout the year.

In June 2021 we completed an NVAP benchmarking exercise providing a detailed self-assessment against each of the 16 actions and for the most part we assessed ourselves as performing well in relation to the action but identified 5 as requiring work to help develop/improve.

We received positive feedback on our self-assessment with the Vulnerability Knowledge & Practice programme (VKPP) satisfied that we had illustrated promising practice against almost every action which was the highest level nationally.

Both the Avon & Somerset Adult at Risk and the Southwest Regional delivery plan are aligned to the NVAP actions, and an overarching vulnerability delivery plan is being developed to link vulnerability with the national Violence

Against Women and Girls (VAWG) strategic focus which will provide a vulnerability-wide view of issues, highlight emerging risks, threats and opportunities; and provide a better overall view of how the force is managing vulnerability.

A set of measures to monitor and report on performance for most strands of vulnerability have been established, helping identify trends, and flagging emerging risks. There are gaps one of which is Adults at Risk, and we continue to try to work with all boards to develop a multi-agency data set that would enable us to understand key risk factors and enable effective decision making. This is currently in place for children in Bristol and Somerset.

Assurance Panel

The Constabulary's Adult at Risk (AAR) Assurance Panel is now well established and is held quarterly. The ethos of the Panel is to provide scrutiny and critical challenge over the quality and effectiveness of the Constabulary's AAR investigations

- identify learning and good practice
- ensure compliance with legislation and local and national policy
- ensure a consistent response across the Force area
- increase understanding of AAR investigations across the workforce

Chaired by the AAR lead Detective Superintendent Lisa Simpson and attended by representatives from Neighbourhoods /LSU/Response/Control Room and Investigations, along with Office of the Police and Crime Commissioner and the Victims of Crime Advocacy Service (VOCAS).

Whilst the idea behind the panel is to scrutinise investigations where the victim would meet the Adult at Risk Care Act definition, we chose to step away from this model for two of the panels this year.

In October we looked at cases for vulnerable victims who did not meet the Sect 42 threshold in order to explore the varying landscape in terms of Neighbourhood capacity and referral pathways. We found an inconsistent picture which requires further examination and something we will continue to explore in 2022/23. The bulk of the cases involved

people experiencing poor mental health and as we have no direct referral pathway to mental health services further work in this area alongside the mental health lead for the force is required.

In February we looked at Domestic Abuse cases where the victim was over 65. As a force we have seen an increase in older victims of DA and have had several DHR's of this nature. We looked at 6 cases and the learning from the cases saw evidence of age bias, victim blaming language, minimisation of risk, assumptions around capacity, a lack of BRAGs for vulnerable suspects, and a need for greater professional curiosity. The DA & AAR leads will now work together to identify mechanisms to best disseminate and implement the learning. The panel also identified areas of excellence in the empathetic and professional way various call handlers responded to some complex and distressing cases.

Training

There is a recognition that vulnerability training delivered to officers and staff requires improvement whilst there are some pockets of excellence, it is not consistent across all strands and as such we carried out a mapping exercise of all current in-house vulnerability related training. At present Adults at Risk training is one of the gaps, and although we are exploring existing training packages delivered in neighbouring forces it is something we would not be in a position to roll out in the short term. In order to go some way to bridge that gap we started working on producing a Microsoft SWAY briefing which will include a general introduction to Adults at Risk and will include a scenario of an AAR alleging they have been assaulted. The scenario will firstly be played out in a way that illustrates some of the challenges faced by officers, then re-enacted with a more positive outcome highlighting the impact of trauma and the importance of language. The script has been written by a registered intermediary and play therapist and will be filmed using a police officer and an actor with a learning disability. It is intended that this presentation will be delivered 'in person' at briefings across the force.

Lighthouse Safeguarding Unit (LSU)

From an LSU perspective there have not been any significant changes in the year 2021/22.

The child focused DIRM processes review of BRAG completion in Somerset did recognise improvements in the quality of input from officers. This is likely to be indicative of improvements in BRAG completion (in a qualitative sense rather than quantitative) which would relate to Adults at Risk, but it would also be difficult to draw specific conclusions relating to Adults from the DIRM pilot process review in Somerset. Training was delivered around BRAG completion with teams across the force in the last year which is part of our drive to improve practice more widely around use of the BRAG, but again it would be difficult to draw conclusions that this training has brought about benefits specifically to Adults at Risk.

There have been detailed multi-agency discussion around the development of the MARAC process in Somerset. Whilst they don't relate specifically to Adults at Risk there is the potential that they may in future be affected by the evolution of the process. This work is being led by Lucy MACREADY at SCC who may well submit an update for inclusion in the SSAB report, but in summary work is underway to improve co-ordination of the MARAC process and triage of referrals. This is likely to also result in discussions around operational approaches, including a potential move away from four separate meetings for the different areas of Somerset and the frequency of meeting. At this stage whilst there are some agreements in principle, we are not at an implementation phase and the MARACs are functioning as they have previously.

Somerset Neighbourhood teams

The most notable issue is the development and standardisation of reactive/proactive community safety engagement across Somerset.

Over recent years Somerset West had developed a proactive capability by introducing high concentrated multi-agency 'One Teams' in small geographical areas identified as high demand locations. The theory is by focussing in areas most likely to need intervention by partner agencies (including the police), the long-term benefit will be a reduction in the

number of cases which require attention in the future. That will now be mirrored in Somerset East so for the first time we have a consistent partnership approach across Somerset

Safeguarding Adults Reviews (SAR's)

Avon & Somerset have had 5 recommendations from 3 SARs (two of which are being conducted jointly).

One recommendation relating to promoting "What to do if it's not Safeguarding?" has been completed (Somerset).

The remaining 4 are still being progressed and all relate to the joint SAR Cygnet review (North Somerset);

- 2 relate to a review of the Sudden Death policy
- 1 refers to mental health referrals in a care setting
- and the last is about how we respond / record vulnerabilities in a large care setting

Within this time period 9 SARs have been commissioned; the majority of which are waiting for Terms of Reference (TOR) and it has been noted by the Case Review team that there is often a significant delay between the commissioning of a review and the actual ToR being received.

Dementia GPS scheme

A bespoke Dementia Safeguarding scheme to help safeguard people living with dementia is now into its seventh year

The scheme, has four distinct strands:

- Near Field Communication (NFC) enabled wristband
- Dementia Safeguarding Scheme registration (also known as the Herbert Protocol) via our website
- GPS pendant allocation
- A support group available on Facebook, called 'Avon and Somerset Dementia Forum'

Thanks to charitable funding, 2,000 free 'wearable tech' wristbands were made available through the scheme in 2021 and over 1,000 have already been allocated through individual applications and to groups.

We have now secured over £9,000 of external funding to buy GPS tracking devices for people with dementia who are at risk of becoming a missing person.

Over £7,000 of the funding came from Bristol Water and Wessex Water. An additional £2,000 to buy further Near Field Communication (NFC) devices has also come from Bristol Water and Wessex Water, along with Western Power Distribution.

The 30 GPS trackers will be supplied by Somerset-based company, MindMe and will be allocated through referrals from our three specialist Missing Person Coordinators.

District Councils

- The continuation of the pandemic through the last year meant that some of the more obvious routes to identifying safeguarding issues were still limited for much of the year. The lockdowns experienced during the previous year saw considerable community activity to support vulnerable people and a co-ordinated effort by the district councils to support the community. There was also extensive work with other agencies to identify vulnerable people in a co-ordinated way not seen previously. This has benefited our work over this last year seeing a more integrated approach to supporting vulnerable adults and building a better informed preventative approach to addressing needs with the aim of reducing escalations that could become safeguarding matters. Our housing services and One Teams are strong examples of this.

- We have developed our One Team models on further over this year to build on the strong partnership working that has been taking place during the pandemic. 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 One Teams in some specific parts 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. This collaboration has helped us build resilience and capacity into our systems of support to safeguard vulnerable people.
- The district's housing teams have continued to work with partners to help vulnerable adults. The Better Futures for Vulnerable People in Somerset project, aimed at helping people with the most complex needs and chaotic lifestyles to access suitable housing, with appropriate support, reduce their vulnerability and help them build resilience, is now in its practical phase and the work taking place is helping to de-escalate issues that might otherwise become safeguarding matters. The work to support rough sleepers is also continuing with the initiative of bringing rough sleepers into accommodation, to safeguard their health and reduce the spread of coronavirus, during the lockdowns having created wider 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 including a high level of stable moves off of the streets and into accommodation.
- The year also saw the announcement of the government's intention to create a new unitary council in Somerset, replacing the five existing councils. The time scales for this are ambitious with the new council coming into being on 1st April 2023. The anticipated benefits of this, from the safeguarding arena, are of more integrated working as the services of these five organisations become merged. In this last year the work to align services and systems have commenced with workstreams focusing on community safety, safeguarding and One Team integration as part of this process.

- 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 pandemic, and has continued to be so over this last year with the rise in reports being met with rising support by our agencies.
- 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. We worked to support them to understand what to look for when they are within the community and how to quickly notify relevant officers so that concerns could be addressed promptly.
- 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 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 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 (NHSEI) – South West

Key Achievements:

1. NHSEI Regional Safeguarding Team successfully completed meetings with safeguarding professionals and senior leaders from each of the 7 Integrated Care Systems (ICSs) with a focus on system governance and readiness for ICS transformation.
2. To support succession planning and professional development of our safeguarding workforce, we have funded three training and development opportunities. This also included an opportunity for a small number of safeguarding health staff employed by Local Authorities to access e.g., Public Health Nurse Safeguarding leads. This offer comprised of two University level courses (a safeguarding module funded by a successful bid to Health Education England and the second module with a focus on supervision). The third is a wider flexible continued professional development opportunity.
3. The Regional Data Set & Information Governance Reference Group completed its main task and has developed and published the South West Regional Serious Violence and Contextualised Safeguarding Information Governance Framework 2021

Key Challenges:

1. The delays in the Liberty Protection Safeguard (LPS) consultation and lack of communication about the revised timeline and implementation posed a real challenge to planning and resource management.
2. Ensuring the South West region maintained a good oversight of safeguarding statutory reviews to ensure we are maximising learning opportunities from themes arising whilst working national colleagues to implement a new IT solution.

3. Maintaining momentum on regional safeguarding work programmes requiring collaboration with local NHS systems during period of extreme operational pressure where frontline services and Covid vaccination programmes were a national and local priority.

Priorities for 2022/23:

1. Supporting the transformation of CCGs to Integrated Care Boards ensuring safeguarding statutory functions remain central with good governance arrangements. Alongside this, strengthening safeguarding assurance in line with a new national assurance tool and framework.
2. We have appointed a NHSEI Regional LPS Clinical Lead for 18 months. They will develop a detailed implementation plan for the NHS to work in collaboration with other system partners to deliver a successful implementation of LPS for the South West.
3. Evaluation of the various multiagency projects we have financially supported in 21/22, in conjunction with our multiagency partners to measure impact and monitor outcomes for the Southwest population and its workforce.

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:

Listening to our Customers

The Pandemic continued to impose restrictions on our Care Home Residents ability to live the life they choose, and it was important that we heard their voice and adapted our service provision to meet what they felt was most important to them at this time. A programme of Always Events was introduced led by our Quality Team to understand what we do well, what we don't do well and what we don't do, and they would like us to! Initially these were undertaken over Zoom and as restrictions eased our Quality Team held the meetings within the services. Activities and mealtimes were a consistent theme which are understandable when their lives had been so impacted by Covid restrictions. We appointed a Catering Lead to work with our residents to improve the mealtime experience and have partnered with Reminiscence Learning to provide a forum for shared learning and best practice for our Activity Co-ordinators. These Always events are now being rolled out with our Community and Realise customers.

A new electronic care planning system has commenced roll out across our Care Homes that enables our colleagues to capture our residents voice in their care plans in real time through a handheld device. With this new system our care plans can be truly person led and empower their review of care captured through their own voice. Solutions are also already available for those who are unable to verbally communicate.

NICE Social Care Guideline (NG189)

We benchmarked our services against the NICE Social Care Guideline (NG189) and agreed the following priorities to improve the standard of our service provision:

- Our Safeguarding Policy was re-written reflecting the standards identified in the NICE guideline and in a more accessible format.

- In partnership with St Thomas training, we improved and refreshed our Managers and Deputies knowledge across the organisation on the Mental Capacity Act and how the principles are applied in scenarios that would be familiar to them.
- Medication Training for Managers, Deputies and Medication Leads has been updated incorporating roles, responsibilities and the importance of effective relationships and communication with GP's and Pharmacies in ensuring our customers and residents receive the medication they are prescribed safely.
- The use of case studies and reflective practise has been utilised at Safeguarding Sub-committees and at Safeguarding workshops held for all our colleagues.
- A structured and consistent process has been implemented for governance at service level that provides the opportunity for and encourages the best practice of challenging poor practice or discussing uncertainty around practice, discussing the difference between poor practice and abuse or neglect and sharing best practice in safeguarding, including learning from Safeguarding Adults Reviews.
- The principles from the SARs Luke and Mathew have been embedded across the organisation within the Governance at service level, audits, supervisions and is a standing agenda item at our Safeguarding Sub-committee.
- Whilst we had to adapt our methods of communication very quickly as the Pandemic hit in 2020, we recognised that our colleagues needed an easily accessible route to access information. The launch of our new intranet CONNECT in 2021 was vital to improve communication across the organisation, share learning and expand access to resources and guidance. We recognise however that our colleagues do also value something they can just pick up and read therefore we have launched a number of Newsletters in printed version alongside CONNECT.

Colleagues Wellbeing

The well being of our colleagues has been a priority as the impact of the third and fourth waves of Covid took its toll and the demand for our services increased exponentially. Wellbeing Champions have been introduced alongside Mental Health First Aiders, an enhanced employee assistance programme and a schedule of Pulse surveys and listening events

that capture our colleagues voices and what is important to them. Speak up Champions have been introduced to provide an internal route for colleagues to raise concerns and be signposted and supported as appropriate to achieve positive outcomes for both our colleagues and customers.

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.
- DSFRS team are also working really closely with the Home Safety Technicians and ensuring they adopt a person-centred approach to their Home Safety Visits. We are also encouraging them to have a professional curiosity. We have adapted our internal safeguarding referral form to ensure that the voice of the individual is captured and have a clear area where information around consent is provided. This ensures when we are making referrals through to Adult Social Care our referrals contain sufficient and relevant information.
- 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.
- We are now able to explore the option of providing additional bespoke equipment during our Home Safety Visits whereby a particular risk has been identified, for example air fryers that are a safer alternative to chip pan fryers.

- 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. This helps us to ensure that safeguarding is embedded within the organisation and helps raise the profile of safeguarding within the organisation.
- 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.

- DSFRS now have a Fire Collaboration Safeguarding Officer, this is a secondment role with Devon and Cornwall Police, whereby the post holder identifies opportunities for Home Safety visits and other Community Safety Interventions, through reviewing police data. The post older also ensures stronger partnership working. We are exploring the possibility of an equivalent post in Somerset.

Healthwatch Somerset

Healthwatch Somerset exists to speak up for local people on health and social care, to make sure that services in the county reflect the needs of the people and communities they serve. We are independent from the NHS, Local Authority and other local health and social care services, so people can talk to us confidently and freely about their views and experiences, however potential safeguarding issues are escalated using the appropriate protocol.

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 2021/22, however we do have a programme of work planned for 22/23.

Healthwatch Somerset is led by a Board of volunteers, one of whom sits on the Somerset Safeguarding Adults Board on behalf of Healthwatch Somerset and we are supported by a team of volunteers. As an organisation we ensure that our volunteers are DBS checked and appropriately trained to be able to carry out their roles. We are also active members of the SSAB performance and quality board and ensure that we read and reflect in the Safeguarding Adult Reviews as they are published.

Somerset Health and Wellbeing

Somerset County Council – Public Health

The Somerset Public Health Team

The Somerset Public Health Team (SCC PH) team provide and commission a range of public health services. Safeguarding both children and adults continues to be an essential part of our public health delivery. This report provides an overview of the process our services have in place, with some case studies and highlights.

All our commissioned services are managed through a 'Clinical Governance assurance process.' This involves all commissioned services completing a standardised report template that details clinical effectiveness, safeguarding and patient safety, and patient, public experience. These reports are reviewed quarterly by the external Somerset Public Health Clinical Governance assurance panel. Pre-covid19 levels of reporting are now being re-introduced.

Over the last two years our efforts have focused on developing and maintaining safeguarding processes across our systems during the pandemic. As we now enter a recovery period with significant changes in our system infrastructure with the ICS and the Local Government Review, we have continued to assure our existing processes but also strengthened our multiagency approach to safeguarding. Some of the changes implemented through more collaborative working are reflected in our Domestic Abuse service update.

We routinely engage in the following activities as a public health team:

- 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.
- All SCC PH team members who have client or commissioning responsibilities have undertaken adult safeguarding training appropriate to their role.

- Public health seek to build on the multiagency approach for outbreak control used to support care settings for vulnerable groups e.g. those people living with learning disabilities, people living with dementia or the elderly. Process to work jointly between SCC Public Health, UKHSA, adult social care and the CCG infection control team will be strengthened to provide a whole system health protection approach.
- Public health commissioned services take part in the SCC Safeguarding Audit tool annually.
- The Adults Safeguarding lead for Public Health, Rachel Handley, attends the Somerset Safeguarding Adults Board and the ICS Safeguarding Steering Group and has contributed to the development of the Safeguarding Adults Strategy.

Public Health Provider services

The Public Health Nursing Service (Health Visiting and School Nursing) is delivered as part of in-house operational delivery of public health services by Somerset County Council. The service work with children aged 0-19 and their parents/carers to safeguard and identify and address needs at the earliest opportunity. They assess the wellbeing of the whole family through the family health needs assessment, monitoring the growth and development of infants, children, and screening, supporting and signposting parents with specific health and social issues such as maternal and paternal mental health, parental conflict, substance misuse and issues related to the wider determinants.

- All staff complete mandatory Children's safeguarding training equivalent to a competency level 3 of the intercollegiate guidance, 95% completion rate. In addition to mandatory adult safeguarding training on-line through SCC's TLC site.
- Practitioners throughout 21/22 have also participated in additional training modules in domestic abuse, trauma informed approaches and mental health, father's mental health and father/partner engagement.
- The Named Nurse for safeguarding within Public Health Nursing and the PHN (Public Health Nursing) safeguarding team offer 3 monthly supervision, ad Hoc support and advice and quality assure all reports in relation to children's

and adult safeguarding. Practitioners also have access to 6 weekly line management supervision where caseload management and safeguarding concerns can be discussed.

- Public Health Operations have commissioned Home Start West Somerset and DadMatters Uk to employ a father coordinator to strengthen practice in relation to fathers and partners. This provides support for fathers in the transition to parenthood, and evidence demonstrates father engagement in the perinatal period also improves outcomes for children and mothers.
- Father engagement is part of the 22/22 Audit schedule for the PHN service.
- The designated lead for safeguarding children in Public Health Rachael Parker and the Named Nurse Liz Wheatley are both engaged with the SSCP subgroups, and wider ICS safeguarding forums to provide assurance and support safeguarding for adults and children.
- The service has a daily duty line in which all professional enquiries, domestic abuse notifications, A&E, SWAST and safeguarding requests are triaged and responded to.

Referrals April 21- March 22:
Adult Social Care: 0
Domestic Abuse: 16
SIDAS 15
MARAC 6
PREVENT 0
FGM 0

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

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. This is a commissioned service.

- Current and ongoing safeguarding concerns are discussed during the daily Flash Meeting and actions allocated to manage concerns appropriately and in a timely manner. Actions are followed up during the next Flash meeting. The weekly Team Meeting provides a designated section for further discussion regarding current safeguarding cases and concerns. New concerns can also be bought here for discussion within the team. Both the West and East sides of the service have Safeguarding Leads who are at Senior Recovery Worker level or above. The leads are points of contact for advice for staff and can escalate concerns if necessary to the Safeguarding Manager. Leads attend a monthly Safeguarding Meeting, chaired by the Safeguarding Manager. Specific, vulnerable clients are discussed here, such as pregnant clients, and good practice shared. Safeguarding logs are kept up to date and managed by the Safeguarding Leads.
- The service has recently increased the number of Safeguarding Audits conducted by managers monthly as staffing levels have stabilised; two audits are now completed per month, per line report. All staff receive a Safeguarding Induction where processes such as MARAC, SIDAS and adult/children safeguarding referrals are discussed and walked through by a manager. This induction is then solidified with the completion of a further safeguarding competency during the first 6 months of a staff member's start date. It is mandatory for all staff to complete these,

as well as reading and understanding the policies, Domestic Abuse, Safeguarding Children & Young People, and Safeguarding Adults.

- The service offers Safeguarding Level 1 Awareness e-learning (88% staff completions) and Safeguarding Level 2 Workshop (56% staff completions). Safeguarding leads and deputy-leads across the service have recently attended MARAC chair training. Additional Domestic Abuse has been developed by the Safeguarding Manager and is currently being rolled out across SDAS as well as adapted and delivered in Turning Point's Wiltshire service. This is delivered face to face with staff.
- Each SDAS location also houses a safeguarding notice board, which offers details of relevant agencies, appropriate for client referrals and important information, which is to hand for Recovery Workers. Safeguarding Leads keep this board up-to-date, ensuring there is the latest information available for reference.
- Staff completing safeguarding referrals are supported by a Duty Manager and the referral checked prior to submission. An incident DATIX and CQC notification is completed by a manager following any safeguarding referral. From May 2021 to date, a total of 41 safeguarding referrals have been made in relation to adult safeguarding:

  SIDAS – 18
  MARAC – 18
  ASC – 1 (Vulnerable client) and 4 (Care and Support)
  SARSAS – 1
- Changes or updates to safeguarding processes and procedures are communicated to the team via the Safeguarding Manager or leads. A recent example of this is the development of all MARAC referrals being accepted. As such, the staff group were emailed and informed of this change and advised of how to record on the information/case management system called halo. The update was then included in the following Team Meeting and will be checked during Safeguarding Audits.
- SDAS feed into and have representation at the following meetings:

- Domestic Abuse Board and will be part of relevant Domestic Homicide Reviews, Suicide Prevention Partnership Board, MARAC (in all 4 areas), Safe Lives Collaboration Workshop, SDAS Midwifery meeting with complex care midwifes from YDH & MPH, Nelsons Trust Vulnerable Women's meeting, One Team meetings, Health Safeguarding Children Partnership meeting and Topaz

SDAS Case Study

- Concerns raised for a client by a Health Care Assistant during a Wellbeing clinic appointment and communicated to client's Recovery Worker
- ASC referral completed by Recovery Worker; detailing concerns regarding financial exploitation of the client by a family member and a lack of ability to manage personal care needs and carry out tasks such as washing and food preparation
- Partnership working with both the Probation Service and Housing department at SSDC to complete the referral
- Referral accepted, client assessed, and care package offered addressing both care needs and vulnerability of exploitation
- ASC linked client with a Community Agent who has helped the client to source white goods for his accommodation
- Care package is now in place

Somerset-Wide Integrated Sexual Health Service

Somerset-wide Integrated Sexual Health Service (SWISH) provides open access for testing and treatment of sexually transmitted infections (STIs) and provision of contraception. The service provides clinics across the county, access to online STI testing and a targeted outreach team (TOT) working with adults with a higher risk of acquiring STIs and HIV, unplanned pregnancies and unsafe sexual relationships. This includes The Nelson's Trust, homelessness outreach team, Somerset Drug and Alcohol Service, Mental Health community support teams.

The service is commissioned by Public Health and provided by Somerset NHS Foundation Trust (SFT). SFT have robust safeguarding and clinical governance arrangements in place and have an in-house safeguarding team. SWISH service users are assessed and give a 'red dot' and a vulnerable adult template is completed if safeguarding concerns. If necessary, they are referred to the Targeted Outreach Team (TOT) and following assessment individuals are discussed with the in-house safeguarding team. Often the service user is already known to services e.g. mental health but SWISH have been able to provide new information or escalate new concerns.

All staff have safeguarding training and monthly safeguarding supervision facilitated by TOT. TOT have monthly meetings, and quarterly meetings with external partners.

SWISH provide a safeguarding report as part of the quarterly contract monitoring review and this is also shared with the SCC Clinical Governance Assurance Panel.

In 2021-2022:

- 94 Vulnerable Adult Templates completed
- 34 referrals were made to the Targeted Outreach Team
- 16 new referrals / discussions were made with the in-house Safeguarding Team
- 2 required EHA/MASH / multi agency discussions

SWISH Case Study

19-year-old vulnerable female presented as acute sexual assault wanting STI testing. Patient not on contraception and presented 3 days post assault.

Initial consultation established details of incident and ensured she was safe at not at risk.

Patient apprehensive about disclosing the information to police and we agreed to discuss it further at a follow up appointment. Arranged emergency contraception, determined she did not require PEPSE and booked her in for vaccinations, follow up tests out of window period and pregnancy testing.

Patient declined offer to ring the Sexual Assault Referral Centre (Bridge) but accepted their number to do this herself. She was also given information and explained about the SafeLink and SARSAS services.

At patient follow up telephone call, she expressed that she felt she trusted us to help her make a disclosure for her to the police. We had reported all the details already given to the SFT Safeguarding team and Crimestoppers.

We sensitively gathered more information from her regarding the assault, taking care to ensure she was not retraumatised. She said she wanted Swish staff to ring the police on her behalf, which we did to inform them of the assault and the perpetrators address.

Patient informed us she had accessed counselling services and was grateful for all our help.

Community Safety

Community Safety work involves any activity that is designed to prevent and reduce crime, disorder and anti-social behaviour and reassure communities so they feel safer. Most work is done in partnership with several statutory and voluntary agencies who come together as the Safer Somerset Partnership. On the 22nd June the new Community Safety Plan will be ratified for 2022-2025 which brings new priorities for the years ahead around.

- Reduce the harm caused by domestic abuse
- Improve Somerset's response to serious violent crime

- Neighbourhood crime and anti-social behaviour

Projects that have progressing this year include the finalisation of a new modern slavery policy, and development of the Somerset integrated offender management model.

Somerset Violence Reduction Unit (VRU) has been preparing to bid for the Safer Streets Fund round 4, which, for the second time since its successful bid in 2021, will be a collaboration with North Somerset, with a focus on Violence Against Women and Girls. In addition, the VRU is also working with the Youth Offending Service to prepare a bid for funding to the new Home Office Young Women and Girl's Fund which is bring in additional capacity to services the council provides for victims of child exploitation.

COVID-19 Response Team

The public health protection team have continued to provide a robust support and response offer for outbreak control across Somerset. This service is transitioning now to return to 'pre-Covid' functions, incorporating broader public health threats as they arise but still closely monitoring the Covid situation locally, regionally and nationally.

As part of the Covid Response there were a number of new initiatives which were set up in order to support the safeguarding process. Surge testing and outbreak testing were services which were designed and set up to respond to outbreaks of Covid within different settings. These had the ability to be deployed at short notice and were designed to identify positive cases within settings and to therefore reduce transmission. In response to national shortages of LFT swabs the team stood up a training and distribution facility for key staff to be able to access tests to enable them to continue to work within health, care, education and emergency settings. In response to the weather alert warnings the team liaised with colleagues working with the homeless population to supply LFT and PCR rapid turnaround swabbing process to enable them to test people who were going to be brought into accommodation overnight and may potential be infectious.

Somerset Integrated Domestic Abuse Service

Domestic abuse continues to be a priority for Somerset due to its long-lasting impact on the lives of survivors and their families. Public Health leads on the domestic abuse strategy, policy development and commissioning, heading up Somerset's Domestic Abuse Board which is now a statutory requirement.

The Public Health team have continued to monitor the impact of the pandemic and other factors on needs, preparing and ensuring specialist services are fit for purpose and responding effectively whilst making sure that our communities were aware that services are available.

A Somerset Domestic Abuse Covid Task Group, made up of all councils, police, Safeguarding Boards, local support service providers and health services, met each month between March 2020 and May 2022 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 considered any new requirements which may arise. Whilst the meetings have now been stood down, the data capture continues due to the value this brings to continuous improvement work.

A Domestic Abuse Needs Assessment was carried out in 2021, this is as new statutory duty which informs the DA strategy. Domestic Homicide Reviews have shown that there has been a significant increase in victims over 60 between March 2020 and April 2021, influencing a new service specification to ensure that services be made accessible for older victims.

Somerset Integrated Domestic Abuse Service (SIDAS) is a commissioned service that provides support to survivors of domestic abuse and their families. The service also provides safe accommodation for those who need to flee their homes and support for those who cause harm but wish to change their behaviour. Services recently added to this offer under separate contracts include therapeutic support for children and adults and Somerset's first Sanctuary

Scheme to enable victims of domestic abuse to remain in their own homes safely, by having physical and digital adaptions made to their properties. The scheme will launch in the summer.

In an effort to increase awareness of domestic abuse and modern slavery, the Public Health team have commissioned a suite of e-learning modules which is free for all organisations who have a footprint in Somerset. In addition to this, a public facing domestic abuse and modern slavery e-learning module is also now available and free for all.

Modern Slavery: A range of agencies in Somerset will have a Duty to refer suspected victims of modern slavery and trafficking under the Modern Slavery Act. Our team have led a piece of work to assess how well the council meets its obligations and have worked with colleagues across the council to create the new Modern Slavery Policy which combines adults and children's pathways to improve access and increase understanding of how to identify concerns and make referrals.

Integrated Offender Management: It is well understood that those in touch with the criminal justice system are more likely to have a range of vulnerabilities and risk factors which lead to poorer health outcomes which adds to the reasons why some individuals continue to offend. Since 2021, the community safety team have been leading a project to design a Somerset Integrated Offender Management model, giving nominals better access to local services and bringing physical and emotional health and well-being into the process for managing prolific and high harm offenders for the first time. The task is to influence the embedding of a changed model to our criminal justice partners and to date, this advocacy role is working well, with IOM officer receiving additional training, and improving the method for assessing and responding to needs.

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

Safeguarding Adults: Our key aim for safeguarding adults is to ensure all Trust colleagues are aware of their responsibility and duty of care to safeguard those with whom we work, who may be suffering from or at risk of abuse, exploitation or neglect (including self-neglect). The Trust's Safeguarding Service is committed to safeguarding individuals in our care, across the lifespan including unborn babies, children, young people and adults, employing a 'Think Child, Think Parent, Think Family' approach.

The Trust's Safeguarding Service is facilitated by a colleague structure that encompasses a wide range of experience, knowledge, and professional backgrounds, which greatly enhances the advice that we offer to all Trust colleagues. We have clear policy and procedures in place that provide guidance to colleagues wishing to report a safeguarding concern. The duty team provide a single point of advice to colleagues on all elements of both adult and child related safeguarding concerns. We recognise safeguarding is complex and can be personally challenging. Therefore, working together in partnership across our own agency, and with external agencies, in a way that supports adults in making choices and having control about how they want to live, is key in protecting individuals from harm.

The Trust's 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 is disseminated to Trust colleagues via several means. We actively participate in the weekly Adult Multi-Agency Safeguarding Hub (MASH) meetings. The MASH meetings are attended by Adult Social Care, the Police and Trust Safeguarding Service Duty Team.

The Covid-19 Pandemic: Despite the ongoing pressures on the Trust from the impact of the Covid-19 Pandemic, the Trust Safeguarding Service has ensured 'business as usual' is maintained by continuing to work remotely, with only minimal site access, whilst still providing the safeguarding service single point of contact to Trust colleagues.

Impact of service: Throughout the last financial year the Trust's Safeguarding Service have supported colleagues with 4407 safeguarding adult contacts/enquiries, which is approximately a 13.5% increase on the previous financial year. This is in addition to the contacts received into our duty team single point of contact for safeguarding children concerns. The Trust also made 204 safeguarding adult referrals to the Local Authority covering all elements of safeguarding adults related work.

Safeguarding Training: Despite the ongoing impact of the pandemic across the Trust on colleagues' time and availability, we have continued to support colleagues to maintain their safeguarding knowledge by providing safeguarding adults Level 3 training via the virtual platform of Teams, in addition to the E-Learning for Health safeguarding adult level 1 and level 2 modules. 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.

Safeguarding Supervision We have reviewed our safeguarding adult supervision offer, prioritising key frontline services into Tier one quarterly safeguarding supervision. Remaining Trust colleagues (Tier two) can access safeguarding adult supervision as required via a weekly supervision slot facilitated by the Safeguarding Service Duty Team. The supervision enables discussion and learning from ongoing complex safeguarding concerns/work, in addition to feedback on local and national trends in relation to all aspects of Safeguarding Adults. Additionally, the Safeguarding Service receives safeguarding supervision minimum quarterly via various means including from the Trust's Named Professional for Safeguarding Adults and Named Nurse for Safeguarding Children, peer supervision, professional supervision, and restorative supervision, in addition to line management supervision.

Multi-Agency Collaboration: The Trust's Safeguarding Service provides representation at a number of safeguarding related forums including Multi-Agency Risk Assessment Conference (domestic abuse), Domestic Abuse Board, Channel Panel (Prevent), Somerset Safeguarding Adult's Board and related sub-groups.

Accountability / Assurance:

The Trust Safeguarding Committee holds the Safeguarding Service to account in relation to our duties and responsibilities in all areas of Safeguarding, including our Policy requirements, Local Action Plans, training compliance rates and Safeguarding Service development. The committee continues to meet quarterly and has external representation and challenge provided by the Clinical Commissioning Group (CCG).

The Trust is required to submit quarterly Prevent data to the NHSE Prevent Data Collections Team via NHS Digital.

The Trust shares the Prevent data with the CCG as a means of assurance and reports on this via the CCG Safeguarding Dashboard. The data includes training statistics and number of Prevent referrals. In addition to Prevent data, the Trust's safeguarding adult training compliance rates are also shared with the CCG via their Safeguarding Dashboard.

The Somerset Safeguarding Adults Board and Safer Somerset Partnership hold us to account in relation to actions resulting from recommendations arising for Safeguarding Adults Reviews (SAR) and Domestic Homicide Reviews (DHR)

A new service for Liberty Protection Safeguards (LPS) is being led and developed to cover Somerset FT and YDH. This new team will replace the Deprivation of Liberty (DOLs) and Mental Capacity Act Lead posts in both Trusts. The new team are working towards ensuring both Trusts are ready to implement LPS once it comes into force. There is currently a LPS/DOLS and MCA Lead, a Deputy and an administrator. More posts will be recruited as the government guidance becomes clearer on the expectations for NHS providers.

Yeovil Hospital NHS Foundation Trust

Board Effectiveness

- The Trust safeguarding committee meets quarterly and 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 programme, 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. The trust 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
- 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 ongoing Covid-19 pandemic has continued to significantly impact upon 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, 342 safeguarding incident reports for adult patients have been made to the safeguarding team, compared to 407 for the previous reporting year. This indicates a 17% decrease in our internal referral rate, which is reflective of the patient flow during the pandemic period. During this period, the team received 192 referrals for patients with learning disabilities and 171 referrals in respect of identified 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 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. The trust had stood down a number of training sessions throughout the pandemic period, which has resulted in a reduction of safeguarding training opportunities.

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 / disclosed during pregnancy.
- 171 Domestic abuse cases were referred to the safeguarding team during this reporting period (compared to 102 the previous reporting year). Thirty 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 dementia has been identified as a lead factor in some domestic abuse cases. Within the organisation, we have noted a continuing trend in the number of elderly patients disclosing domestic abuse due to the behavioural changes occurring in their partners due to Dementia and or other medical changes.

The Safeguarding team have actively responded two section 42 requests where safeguarding concerns have been identified. Both cases were is respect of patients with learning disabilities

We ensure that learning from reviews are published and shared with staff through trust newsletters, safeguarding quarterly newsletter and the information is published 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.
- During this reporting period, the Learning Disability Practitioner received 192 referrals for patients with learning disabilities.
- As an organisation, we received two 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, who were receiving care within inpatient areas. The reviews undertaken have identified that poor communication processes

with the patient, carers and community providers is a predominant theme and recommendations had been made to address this issue. In both cases, it was evident that primarily the actions of staff had been in the patient's best interest and reasonable adjustments had been made within the acute health care setting. There was no indication that the safe care and treatment of the patients was compromised at any time.

- 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 is strongly embedded in practice, and this had been further strengthened through the appointment of the Mental Capacity / DOLs lead. During this reporting period 492 DOLs applications were made from this trust, this is an increase in activity compared to the previous year of 442. Reassuringly this demonstrates continuing compliance and understanding of the process by staff with the requirements of Deprivation of Liberty. It is notable that during the pandemic staff have 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

- 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.
- 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.

Future Plans

With the forthcoming merger of YDH and Somerset FT, the two safeguarding teams are currently working towards an integrated Safeguarding Service. The aim is for this to be in place by November 2022. From the 1st April 2022 a single

Director of Safeguarding has been appointed to oversee the integration with the support of two Heads of Safeguarding. . The SSAB board will be updated on any future changes as appropriate.

Golden Lane Housing

Golden Lane Housing is a registered housing provider with the Regulator of Social Housing and provides supported housing for people with a learning disability and autism across England, Wales and Northern Ireland.

- Golden Lane Housing's safeguarding approach, ensuring the ongoing wellbeing and safety of tenants, continues to be of paramount importance and forms the very foundations of our service delivery. Our safeguarding approach continues to be well embedded throughout the organisation and all colleagues are aware of their responsibilities should they believe a tenant is at risk of abuse.
- Golden Lane Housing's Housing Officers continue to feedback on safeguarding related services and response times for a large proportion of Local Authorities, resulting in strengthened relationships and trust, particularly with Social Workers who are often leading on safeguarding concerns.
- Housing Officers continue to take a pragmatic and person centred approach in keeping in regular contact with tenants the organisation deem to be most at risk of abuse. Nationally there have been 4,775 separate recorded housing management cases logged during this last year, demonstrating robust contact between Golden Lane Housing's Housing Officers and tenants, their families and support network. There remains a reluctance for some tenants to meet face to face with their Housing Officer for fear of contracting the Covid-19 virus. Golden Lane Housing's approach to finding alternative technological methods in engaging with tenants continues and the use of telephone, Teams and WhatsApp applications are becoming common placed. We are committed to ensuring that we offer as many methods as possible for tenants to communicate their concerns with us with ease and confidence.

- During financial year 2021/22, Golden Lane Housing supported tenants with 117 safeguarding concerns of which 61 were raised formally as a safeguarding alert to 23 different Local Authority Safeguarding Boards – a very slight reduction when compared to 2020/21 figure of 67.
- Similar to the last three reporting years, the highest reported categories of abuse were physical (31%), self-neglect (25%) and emotional/psychological (21%). The highest number of cases (representing 34% of the total number raised) were in relation to single tenancies in cluster style self-contained accommodation with tenants having both a learning disability and mental health support needs.
- 89% of the physical abuse alerts were in relation to tenants physically assaulting support staff, of which a large proportion did not have capacity to understand the consequences of their actions. 50% of the emotional abuse alerts were due to incompatibility issues between tenants living in shared properties with the remaining 50% relating to tenants who are alleged to have been the perpetrator of abuse towards other tenants in cluster style accommodation, where altercations are taking 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.
- Golden Lane Housing's Housing Officers did not raise any concerns of Domestic Abuse, despite other providers of housing (mainly general needs) continuing to experience an increase in the number of concerns. There were no significant findings of safeguarding concerns where the risk was in relation to support staff not being able to attend to the needs of the tenants due to staff shortages.
- We want to deliver a safeguarding approach that enables tenants to achieve outcomes that are of most importance to them. Following the implementation of safeguarding KPIs, our Housing Officers can establish from our tenants what they wish to achieve and how best we are therefore able to support them. Where possible, we will always include the tenant throughout the process. Where the tenant does not have capacity, we will work with those that understand the needs of the tenant and will advocate on the tenant's behalf.

- Of the 61 alerts raised, 4 (6%) were deemed by the Local Authority as not meeting the 'section 42 enquiry' and when this happens, Housing Officers will continue to work with the Social Worker / duty team until they are satisfied with the outcome. 33 (55%) of the alerts raised resulted in tenants either being able to remain in their own home safely with additional support or supported to move to more appropriate accommodation where their needs could be better met. The remaining 24 (39%) have enquiries that are ongoing with Housing Officers working proactively with key professionals to help bring about a resolution that meets the needs of the tenants.
- During July 2022, Golden Lane Housing will receive a 3 day independent expert review of our safeguarding practice and approach delivered by The Ann Craft Trust. The review will look at how we have embedded the safeguarding policy and procedure, as well as exploring 'Making Safeguarding Personal', organisational learning, record keeping and capacity. The review will consist of a staff survey, a review of relevant policies and procedures, safeguarding data and discussions with some of our colleagues so we can be sure our approach is embedded throughout and with all staff roles.
- We continue to remain committed and excited about the support and guidance that we can offer our colleague right across the sector and beyond. Our Chief Executive and Safeguarding Deputy were invited to attend a review meeting jointly organised by The Home Office and The Department of Health and Social Care to review the scope and accessibility of the existing protections for adults at risk of or experiencing abuse in their own home by people providing their care and to review the availability and accessibility of the support for adults abused in their own home by people providing their care.
- As a provider of Supported Housing, Golden Lane Housing were invited to attend a discussion regarding the contributions the housing sector makes towards the safeguarding of adults. As one of the organisations that offer quality provision, Golden Lane Housing were invited to share contributions to this important project. The responses gathered will be themed and recommendations will be formulated alongside stakeholders and interested parties, which The Department of Health and Social Care will be putting forward to the government.