NHS
Somerset
Clinical Commissioning Group

Report to the NHS Somerset Clinical Commissioning Group on 25 March 2021

Title: Somerset Safeguarding Adults Board Annual Report	**Enclosure F**

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Clinical Lead:	Charlotte Brown; Designated Nurse for Safeguarding Adults
Author:	Safeguarding Adults Board Publication

Summary and Purpose of Paper

The Somerset Safeguarding Adults Board (SSAB) is required, under the Care Act 2014, to produce an annual report. Somerset CCG is a core member of the SSAB and has a duty to co-operate with the activities of the Board.

The purpose of the SSAB is to assure itself that local safeguarding arrangements and partner organisations act together to protect adults in the Somerset Area who need safeguarding.

This enclosure is presented to the Governing Body as the CCG an annual assurance report about Safeguarding Adults in the Somerset CCG area. The Chair of the Somerset Safeguarding Adults Board will be attending this meeting to present the report.

Recommendations and next steps

The Governing Body is asked to Endorse the content of the report; and in particular the progress made towards the aims and objectives of the Strategic Plan along with the outcomes of Self-Assessment Audit undertaken by key members of the SSAB.

Next Steps to Note

The Somerset Safeguarding Adults Board's priorities for 20/21 were set as

1. Listening and Learning
2. Enabling People to keep themselves safe
3. Working together to safeguard people who can't keep themselves safe
4. Board Governance

Progress against objectives and the strategic plan is monitored by the SSAB executive subgroup; of which the CCG is a core member. Key areas of the Boards activity are routinely reported through the CCG Patient Safety and Quality Assurance Committee. Any areas of significant risk will be reported to the governing body by exception.

Impact Assessments – key issues identified				
Equality	No key issues identified. The aim of safeguarding adults is to protect the rights of all those who are unable to protect themselves because of their care and support needs			
Quality	See priorities for 20/21			
Privacy	No issues identified			
Engagement	The report refers to an engagement activity led by Healthwatch during which feedback was sought and collated from people who used safeguarding services			
Financial / Resource	The CCG is required to undertake a number of functions to support the Safeguarding Adults Board.			
Governance or Legal	The paper related to the CCG's statutory responsibilities under the Care Act 2014. No conflicts are identified			
Risk Description	No risk applicable specifically to the Somerset Safeguarding Adults Board			
Risk Rating	Consequence	Likelihood	RAG Rating	GBAF Ref

Annual Report

2019-20

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 2019/20;
- How we have done in delivering our objectives during the year;
- The findings and impact of any Safeguarding Adults Reviews we carried out;
- The contributions of our member organisations to adult safeguarding;
- Our priorities looking forward.

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

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

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

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

2. Foreword

Keith Perkin, Independent Chair – Somerset Safeguarding Adults Board

I had the privilege of becoming the Somerset Safeguarding Adults Board Chair in January 2020, following on from Richard Crompton. I would like to thank Richard for his valuable contribution to safeguarding vulnerable adults in Somerset over the previous six years. With his leadership and the joint efforts of all partners, it is clear that those in need of safeguarding, are receiving excellent support to keep them safe.

However, there is always more we can do, and 2020 has brought the care and support to vulnerable adults to the forefront of our work and thinking. As Independent Chair, I have a responsibility to ensure that partners work together to keep people safe. The coronavirus pandemic has impacted on so many, whether you are in need of care and support or if you work with those who need your help. I would like to pay tribute to all those who have been working tirelessly during the pandemic to keep vulnerable people safe. I know it hasn't been easy, but the fantastic partnership work happening in Somerset is a consistent message that I hear.

This report sets out our 3 year strategic plan. I am keen to develop how we continue to listen to the views of those who receive a safeguarding service, to make it even better, and tailored to individuals. The coronavirus pandemic has led to restricted face to face meetings, and changes in working practices. As a Board we need to learn how we adapt to ensure people can receive support when required, but also how people can keep themselves safe. Somerset is fortunate in having excellent partnerships. This will be even more critical as we move into 2021, with statutory and voluntary organisations needing to work together to protect those who are unable to keep themselves safe.

One of the Boards statutory responsibilities is to carry out and publish Safeguarding Adult Reviews. Although no such reviews were published this year, we have learnt from other types of reviews, whether they were local, regional or national. Board members were enthused about the

safeguarding outcomes when a victim of 'County Lines' spoke directly about their experiences in a recent Board meeting.

I am pleased that the SSAB is a proactive partnership, and is innovative in how it safeguards vulnerable people. The Board has published an Adult Safeguarding Learning and Development Framework and also guidance on Allegations Against People in a Position of Trust. Both will be valuable in improving the service provided to those who need our support.

The Board also held a successful conference which covered a wide range of safeguarding matters. This was complemented by a focus on the Mental Capacity Act during 'Stop Adult Abuse' week.

The coronavirus pandemic will remain as an influencing factor in our work for the foreseeable future. Despite the challenges and risks this brings to us all, the safeguarding of those who have care and support needs who are at risk of harm and abuse will continue to be at the heart of the service we provide. I am confident that those who provide this support will continue to meet the demands of this unprecedented challenge.

Keith Perkin

Independent Chair

Somerset Safeguarding Adults Board

3. The Board

Safeguarding is everybody's business

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

The Somerset Safeguarding Adults Board (SSAB) is a multi-agency partnership which became statutory under the Care Act 2014 from 1st April 2015.

The role of the Board is to assure itself that local safeguarding arrangements and partner organisations act to help and protect adults in its area.

This is about how we prevent abuse and respond when abuse does occur in line with the needs and wishes of the person experiencing harm.

The Boards' main objective is to assure itself that local safeguarding arrangements and partner organisations act to help and protect people aged 18 and over in the area who:

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

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

Membership of the Board

Board members as at 31 March 2020:

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

Partner Members		
Paul Chapman	Care Quality Commission	Inspection Manager
Deborah Penny	Carers' Voice Somerset	Carers' Voice Somerset Partnership Board Officer
Lucy Martin	Department for Work and Pensions	Partnership Manager for Bristol and North Somerset Department for Work and Pensions
Vacant as at 31/03/2020	Devon & Somerset Fire and Rescue Service	Safeguarding Manager
Janet Quinn	Devon, Somerset and Torbay Trading Standards Service	Trading Standards Project Officer
Luke Joy-Smith	Discovery	Managing Director
Kathy Smith	Golden Lane Housing	Housing Officer
Hannah Gray	Healthwatch Somerset	Healthwatch Somerset Manager
Julie Bingham	LiveWest (rep. housing providers)	Executive Director Housing Support

Tracey Aarons	Mendip District Council (rep. District Councils)	Deputy Chief Executive
Liz Spencer	National Probation Service	Head of the National Probation Service - LDU Somerset Cluster NPS South West South Central Division
Rosie Luce	NHS England and NHS Improvement	Regional Safeguarding Lead / Assistant Director for Quality and Safeguarding
Charlotte Brown	NHS Somerset Clinical Commissioning Group	Designated Nurse for Safeguarding Adults
Simon Blackburn	Registered Care Providers Association	Chief Executive
Richard Pitman	Rep. people who use services and the Voluntary Sector	Chief Executive – Compass Disability
Nicola Kelly	Somerset Care Ltd	Head of Quality and Clinical Governance
Lucy Macready	Somerset County Council (Public Health - Community Safety)	Public Health Specialist – Community Safety
Cllr David Huxtable	Somerset County Council	Lead Member – Adult Services
Alison Bell	Somerset County Council (Public Health)	Consultant in Public Health
Richard Painter	Somerset Partnership & Taunton and Somerset NHS Foundation Trusts	Director of Safeguarding
Amanda Robinson	South Western Ambulance Service NHS Foundation Trust	Safeguarding Business Manager
Anna Temblett	Swan Advocacy	Somerset Area Manager
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 2019/20 – June, October and February.

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

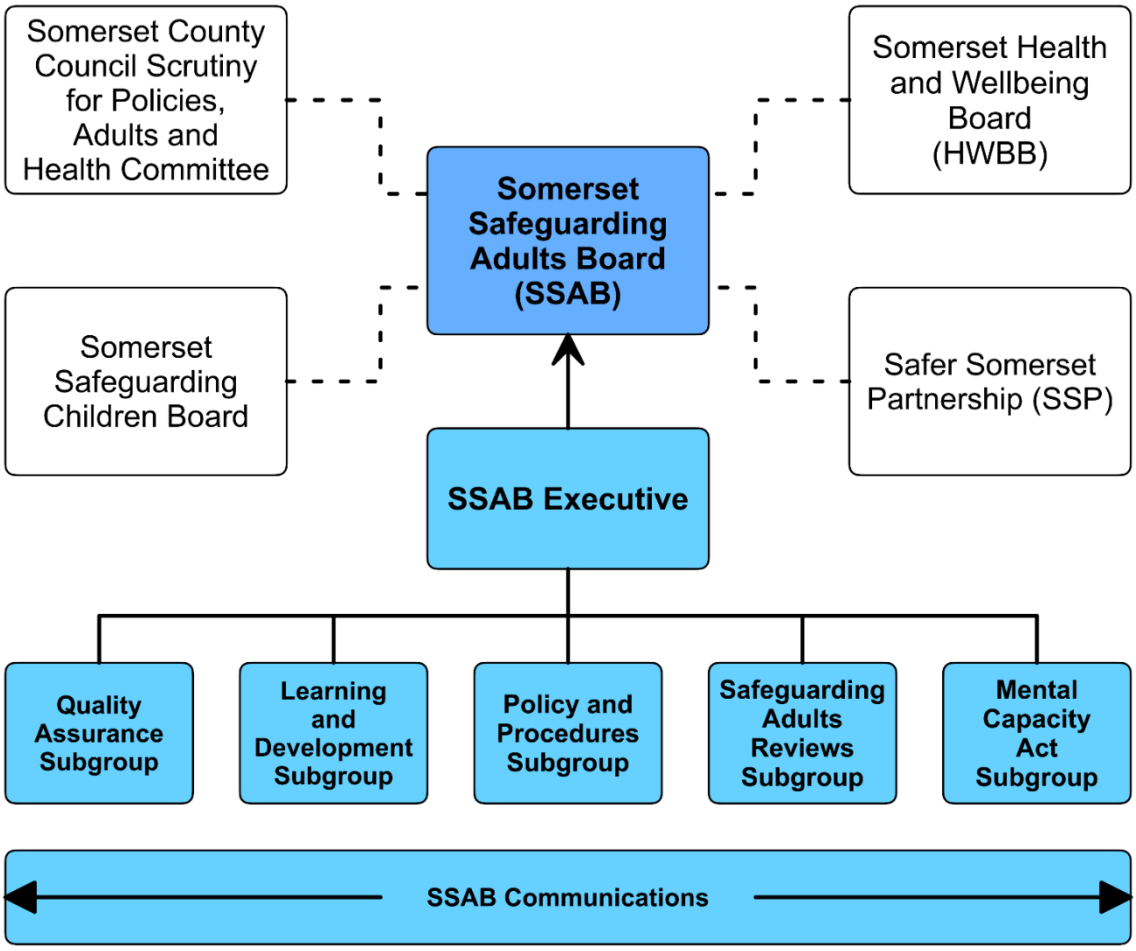
Organisation	Attendance
Avon & Somerset Constabulary	100% (3/3)
Care Quality Commission	0% (0/3)
Carers' Voice Somerset	0% (0/3)
Department for Work and Pensions	33% (1/3)
Devon & Somerset Fire and Rescue Service	0% (0/3)
Devon, Somerset and Torbay Trading Standards Service	0% (0/3)
Discovery	100% (3/3)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

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

[2] One meeting missed while the Healthwatch Somerset Manager post was vacant

In June 2020 the Board received an audit report produced by the South West Audit Partnership (SWAP) that found that there "has been inconsistent attendance at SSAB meetings by certain partners, and instances where deputies who do not have sufficient seniority have attended in place of the main representative" and the Board will be implementing actions to address the recommendations made by auditors in relation to this finding during 2020/21.

Board structure



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

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

The Safeguarding Principles

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

1. **Empowerment** – the presumption of person-led decisions and informed consent, supporting the rights of the individual to lead an independent life based on self-determination
2. **Prevention** – It is better to take action before harm occurs, including access to information on how to prevent or stop abuse, neglect and concerns about care quality or dignity
3. **Proportionality** – proportionate and least intrusive response appropriate to the risk presented
4. **Protection** – support and representation for those in greatest need, including identifying and protecting people who are unable to take their own decisions or to protect themselves or their assets
5. **Partnership** – local solutions through services working with their communities. Communities have a part of play in preventing, detecting and reporting neglect and abuse.
6. **Accountability** – accountability and transparency in delivering safeguarding, with agencies recognising that it may be necessary to share confidential information, but that any disclosure should be compliant with relevant legislation.

What is adult safeguarding?

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

The aims of adult safeguarding are to:

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

Who is an adult at risk?

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

What is abuse?

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

Abuse and neglect can include:

- **Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint, inappropriate physical sanctions
- **Domestic violence** – psychological, physical, sexual, financial, emotional abuse, so called 'honour' based violence
- **Sexual abuse** – rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure, sexual assault, sexual acts to which the adult has not consented or was pressured into consenting
- **Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation, unreasonable and unjustified withdrawal of services or supportive networks
- **Financial or material abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions; the misuse or misappropriation of property, possessions or benefits
- **Modern slavery** – including slavery, human trafficking, forced labour and domestic servitude, traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment

- **Discriminatory abuse** – including forms of harassment, slurs or similar treatment (because of race, gender and gender identity, age, disability, sexual orientation, religion)
- **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting, such as a hospital or care home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practices as a result of the structure, policies, processes and practices within an organisation
- **Neglect and acts of omission** – including ignoring medical, emotional or physical care needs; failure to provide access to appropriate health, care and support or educational services; the withholding of the necessities of life, such as medication, adequate nutrition and heating
- **Self-neglect** – covering a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. A decision on whether a safeguarding response is required will depend on the adult's ability to protect themselves by controlling their own behaviour.

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

What does Making Safeguarding Personal mean?

Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded.

MSP about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process. The extent to which local services are adopting an MSP approach has been monitored by the SSAB via its annual organisational self-audits, designed to give assurance to the Board of local practice.

4. Safeguarding in numbers

How much abuse and neglect was reported during 2019/20?

Safeguarding concerns reported to the Local Authority in 2019/20

2018/19
3198
Concerns

2019/20
3038
Concerns

3038 concerns were reported. This was a drop of 160 compared to the previous year

Of the 3038 concerns, 19 were raised by the adult themselves.

Safeguarding concerns received that required a statutory response in 2019/20

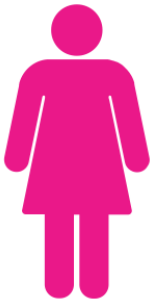
2018/19
1148
Section 42 enquiries
(35.90% of all concerns received)

2019/20
1144
Section 42 enquiries
(37.66% of all concerns received)

1144 (37.66%) of concerns resulted in an enquiry under Section 42 of the Care Act (2014). This was a small decrease compared to the previous year but. In addition, a further 36 non-statutory enquiries were carried out.

Who was at risk of abuse and neglect in 2019/20?

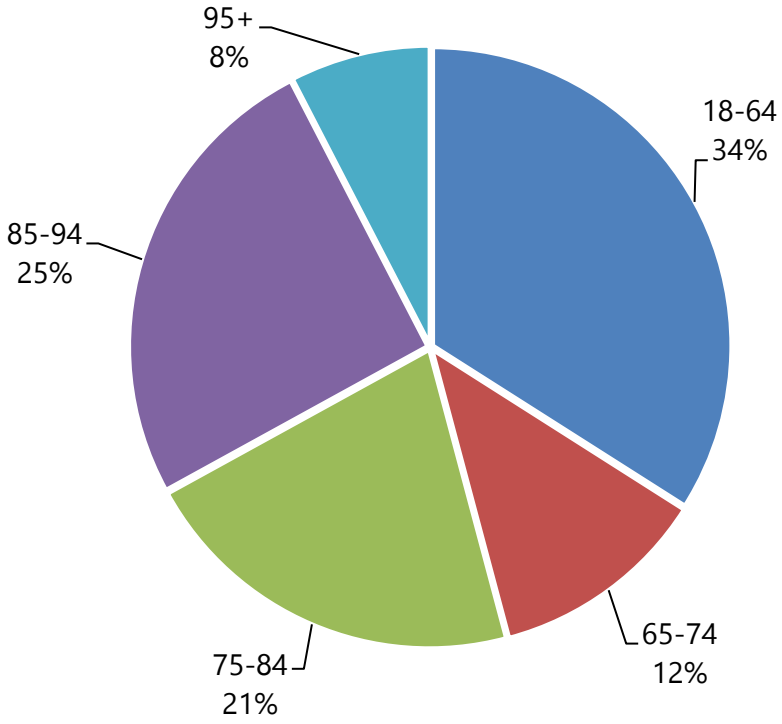
The majority of individuals that required a statutory response were female



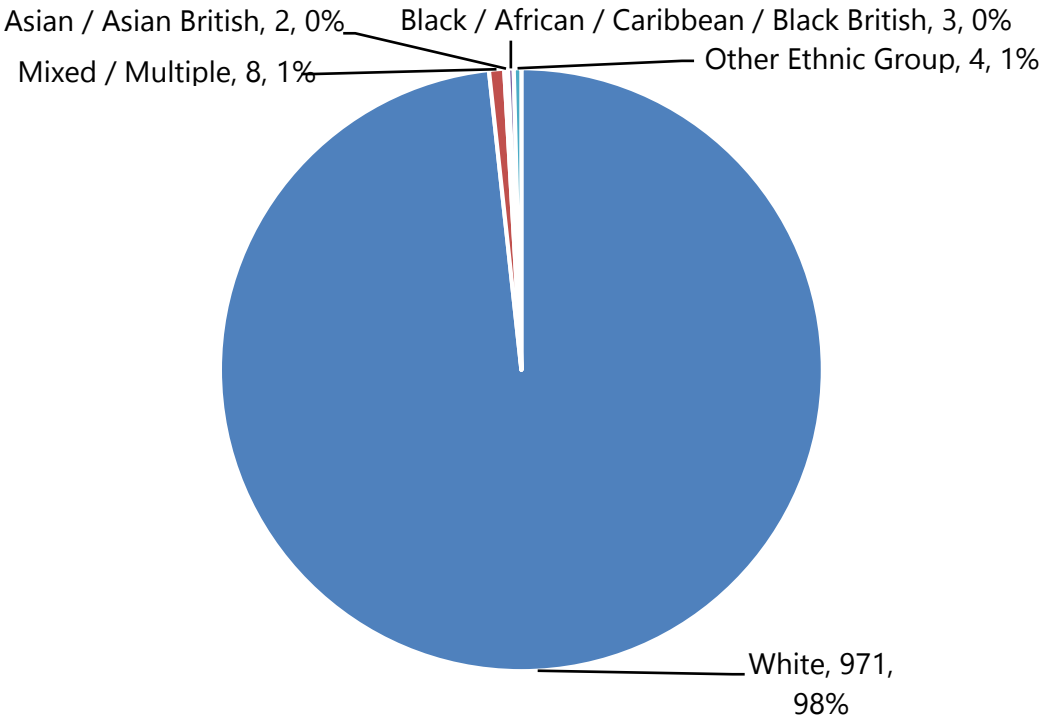
Females
570
(57.69%)

Males
418
(42.31%)

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

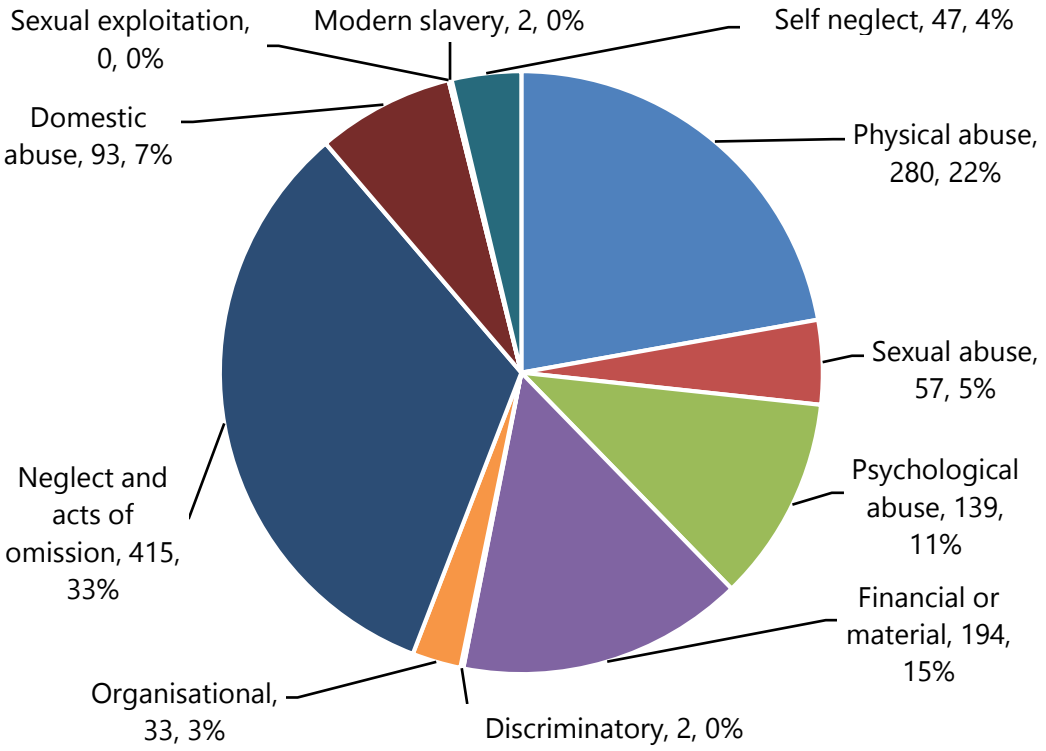


The majority of individuals where the concern resulted in an enquiry under section 42 of the Care Act (2014) were from white ethnic backgrounds

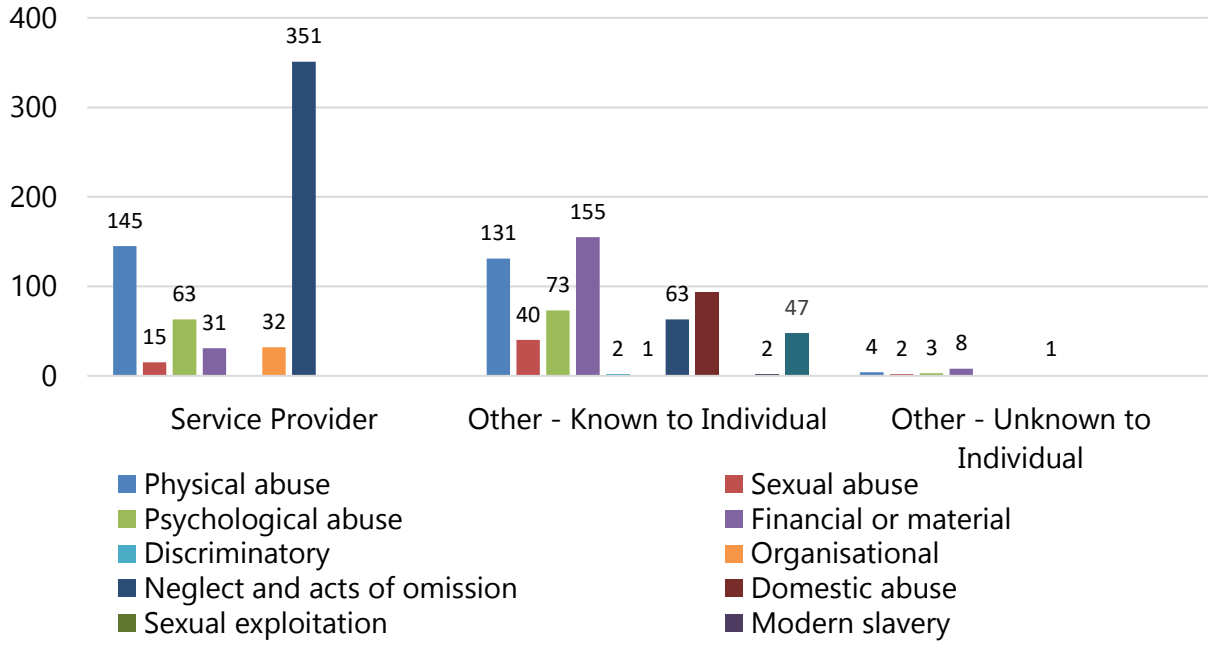


Type of abuse and source of risk

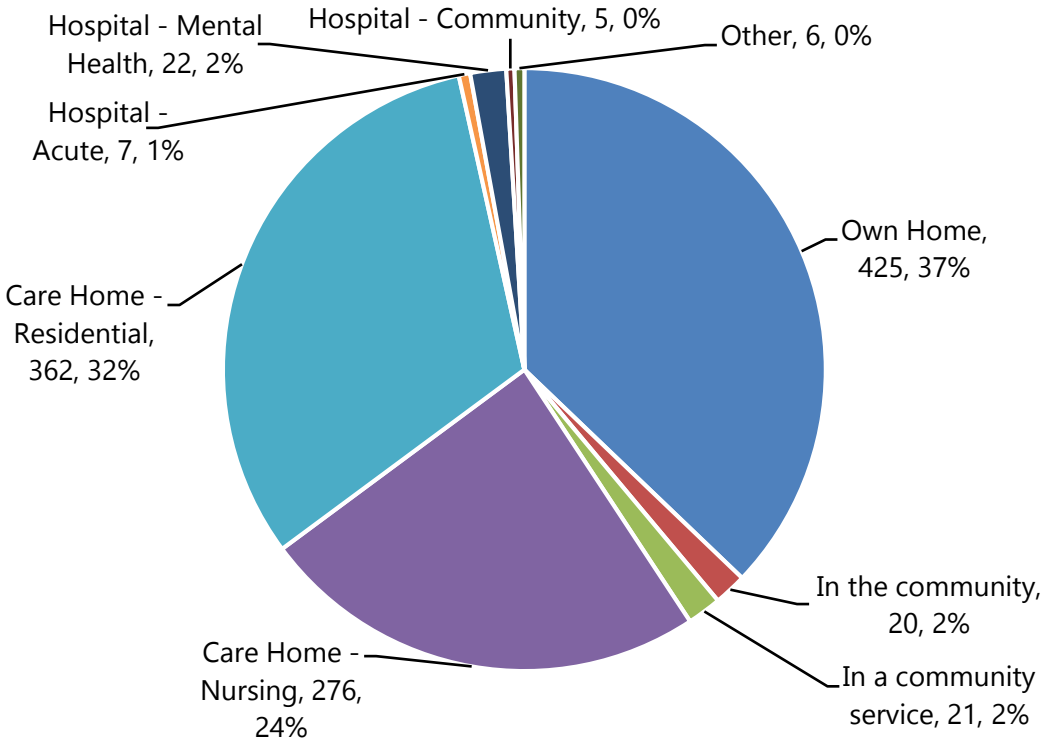
The most common risk type was Neglect and Acts of Omission, which accounted for 33% of risks, followed by Physical Abuse at 22%.



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

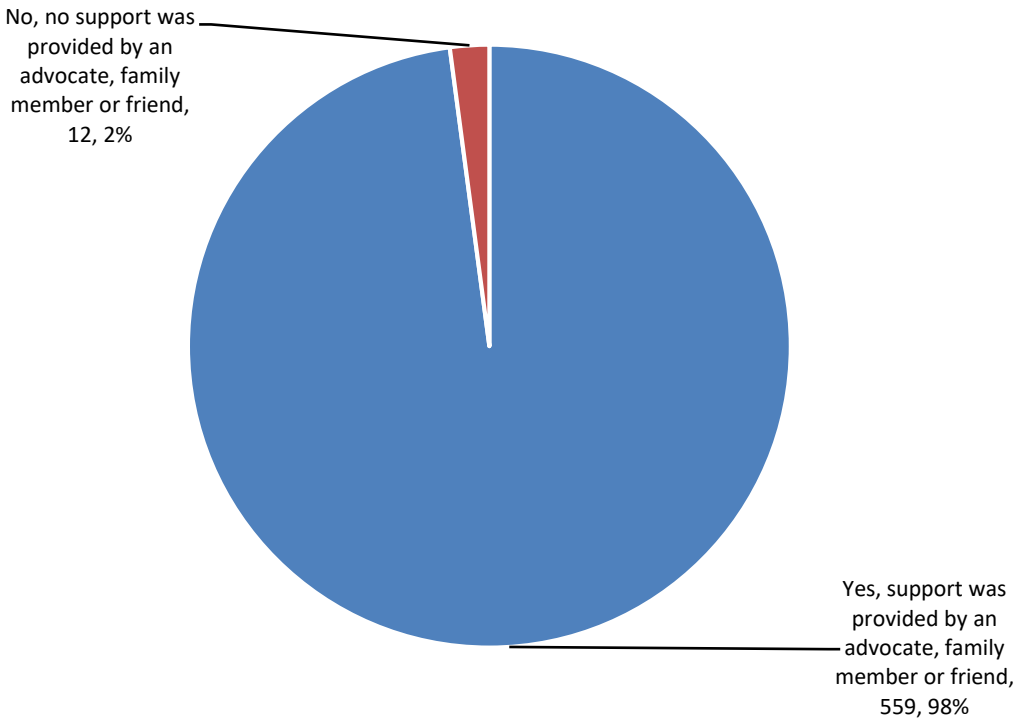


The most common location where people were identified as being at risk was their own home (37%) followed by residential care homes (32%)



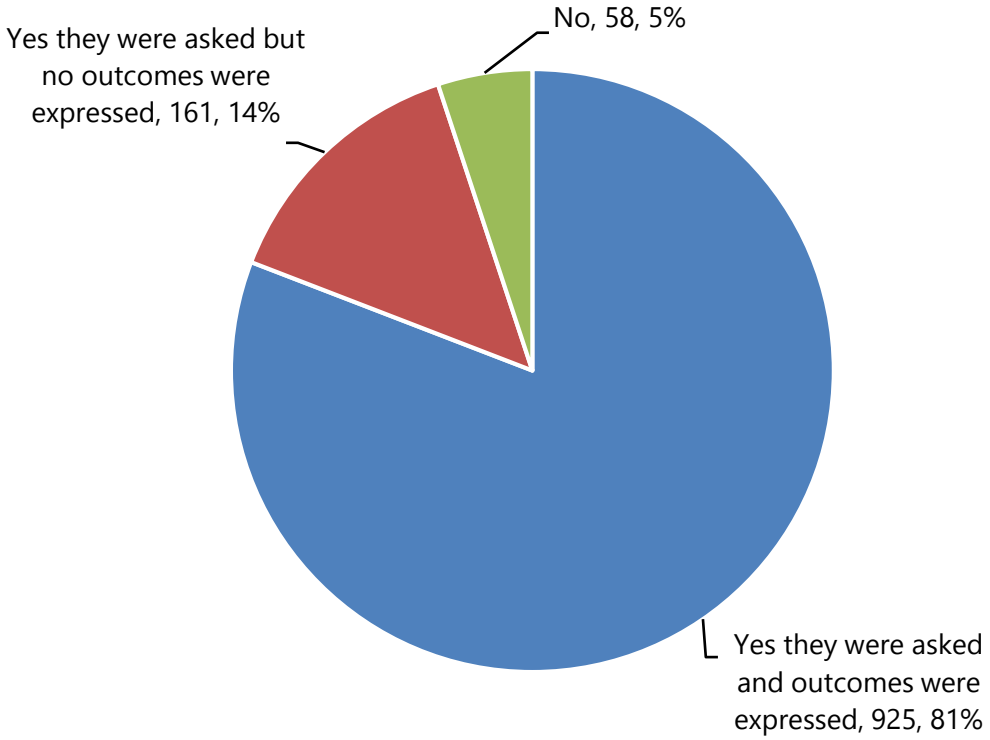
Mental Capacity

In 571 cases the adult at risk was assessed as lacking capacity to make decisions related to the safeguarding enquiry.
In the majority of these cases they were supported by an advocate, family or friend

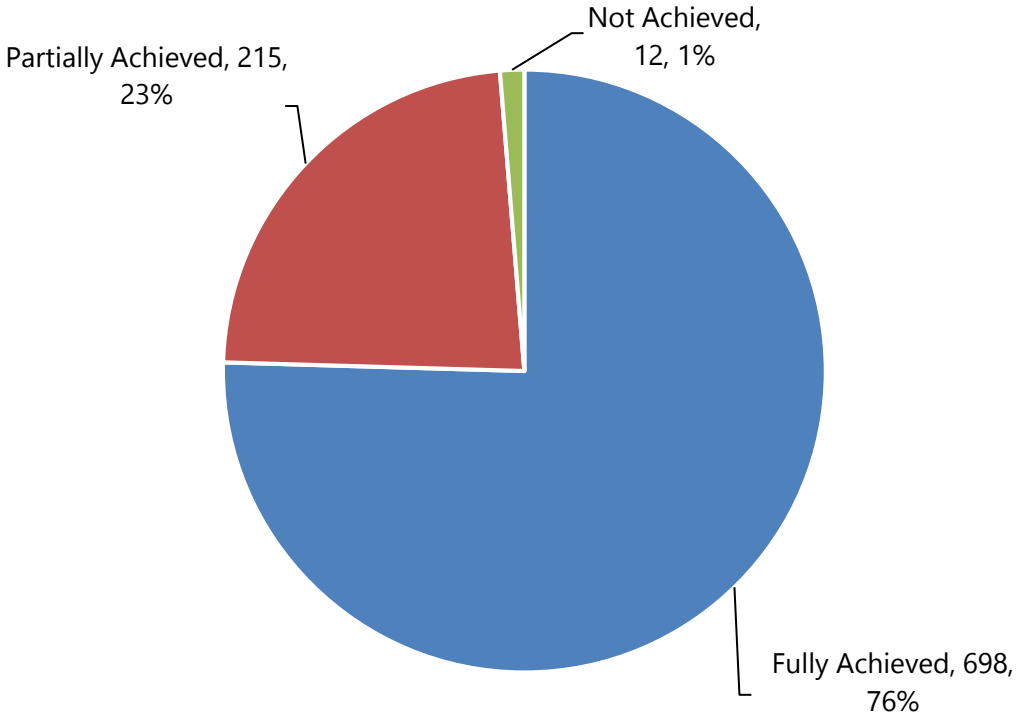


Making Safeguarding Personal

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

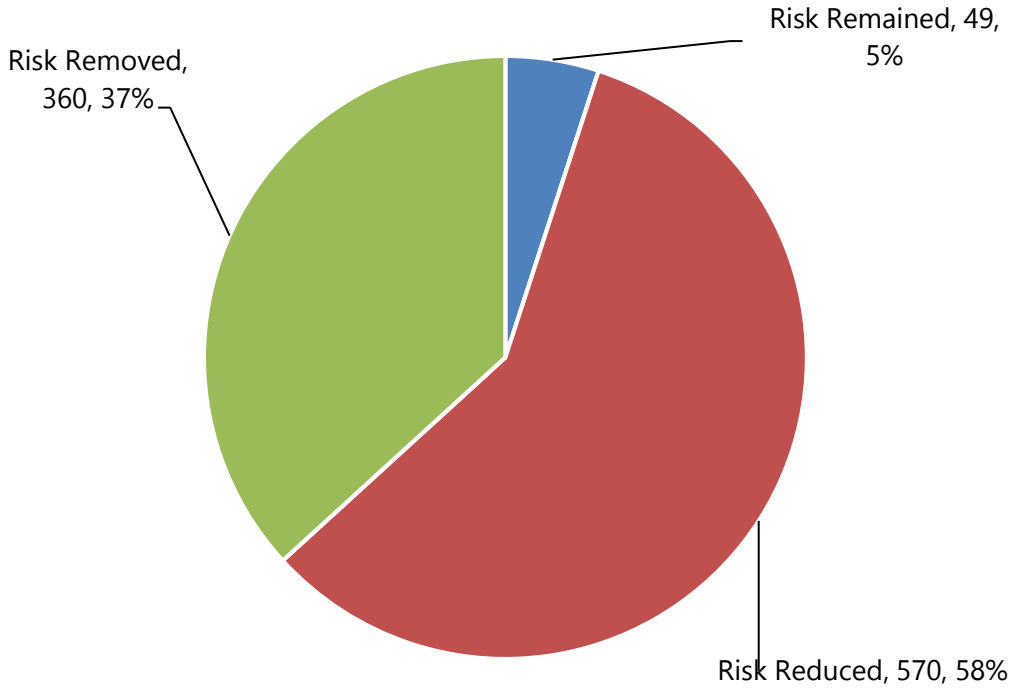


In 99% of cases where desired outcomes were stated they were either partially of fully achieved



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

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



5. Our work during 2019/20

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

Priority Area 1: Listening and learning

What SSAB said it would do	What the SSAB did
Use the views of, and learning from, people who have experienced safeguarding and their carers, both provided directly to the Board and through partner organisations, including the third sector, to inform the work of the Board	• Following receipt of a report by Healthwatch Somerset at the end of 2018/19 the Board has been working with Somerset County Council, as the agency with lead responsibility for adult safeguarding, to monitor the implementation of the agreed actions. While some progress was made with this, the agreed level of sampling of cases for follow-up contact and gathering of feedback had not been reached prior to the work being suspended to enable resources to be freed up to support the Council's response to the Coronavirus Public Health Crisis. The Board will therefore be further monitoring progress during 2020/21. • The Board has also been monitoring the extent to which people are reporting their desired outcomes have been

What SSAB said it would do	What the SSAB did
	achieved as part of its performance reporting mechanisms. Figures for the 2019/20 year are shown Section 4 (page 14) with 99% of people, or their representatives, reporting their desired outcomes had been wholly or partially achieved. • During 2019/20 one person who had direct experience of safeguarding in Somerset talked to the Board in person, and on a second the board received a written case study on behalf of someone who it was not possible to arrange to attend. While it was planned that this would be a feature of all meetings, this was not achieved this year due to one person who had been due to speak to the Board being unable to do so on the day of the meeting due to illness.
Develop, then monitor, quality assurance standards for learning and development	• A Learning and Development Framework was developed during the year by the Board's Learning & Development Subgroup and signed off and published by the Board in October 2019. • It has been agreed that the Board's Quality Assurance Subgroup will monitor the use of this framework by those partners that it is applicable to, through

What SSAB said it would do	What the SSAB did
	the Board's annual self-audit process.
Share best practice to prevent, minimise and respond to harm.	• The Board has continued to share best practice in adult safeguarding through newsletters, and it's website and via social media. • The SSAB has supported work by Somerset County Council to analyse data on the geographical distribution of different types of abuse and neglect on a weekly basis. Data is also monitored by SSAB partners at each meeting of the Board's Quality Assurance Subgroup.
Deliver multi-agency Safeguarding Adults learning opportunities to raise the profile of adult safeguarding, address areas of practice improvement, share lessons learnt from Reviews, and offer workshops to local Safeguarding Leads.	• The 2019/20 SSAB Conference took place on 01/05/2019, covering a broad range of topics related to adult safeguarding, and the presentations from the day are available on the SSAB website. • The SSAB contributed to training for commissioners and senior managers from Somerset County Council and is looking at how this could be made available more widely with Somerset County Councils Adult Safeguarding Service and Adult Quality Assurance Team.
Commission, participate in and support Safeguarding Adults	• The Board has continued to receive and consider new

What SSAB said it would do	What the SSAB did
Reviews (SARs), ensuring learning from both local and national reviews is widely shared, including supporting the development of the National SAR Library.	referrals for SARs through it's SAR Subgroup. Further information on SARs can be found on page 36. • In November 2019 the SSAB published a practice briefing for 'Kevin'. This was a serious case that while not meeting the criteria for a Safeguarding Adults Review, did result in significant learning being identified and new guidance on "What to do if it's not safeguarding?" being developed and published. • Learning from a Domestic Homicide Review (DHR 019) was summarised in the Boards September newsletter and the Board has continued to highlight learning from other Boards through a 'Learning from Elsewhere' section in each newsletter. • The progress monitoring of the implementation of recommendations of published SSAB SARs is a standing item at each meeting of the Board's Executive Group. Specific questions were also again included in the Board's annual self-audit process. Further information on the self audit process can be found on page 3436. • The SAR Subgroup routinely considers whether any referrals it

What SSAB said it would do	What the SSAB did
	receives should also be referred to the Learning Disabilities Mortality Review (LeDeR) Programme, and the SSAB Business Manager is a member of the Somerset LeDeR steering group. • While, nationally, work on a National SAR Library has not progressed as expected when the SSAB published its Strategic Plan it remains committed to supporting its development

Priority Area 2: Enabling people to keep themselves safe

What SSAB said it would do	What the SSAB did
• Raise public awareness of: ○ the different types of abuse ○ how people can keep themselves and those that they care for safe, including on-line ○ what to do if they think that they are experiencing abuse or neglect, including how to refer themselves to the County Council for safeguarding help and support ○ what to do about other types of concern; for example, service quality • Through partner organisations, including the third sector,	• An important and ongoing role of the SSAB is to raise public awareness so that communities play their part in preventing, identifying and responding to abuse and neglect. • As in previous years each Safeguarding Adult Board in the Avon and Somerset Constabulary area undertook to promote adult safeguarding through the now annual 'Stop Adult Abuse Week'. The focus in 2019/20 was The Mental Capacity Act for which resources including a series of 'Myth Busters', were developed for use during the week and

provide targeted information to specific groups/sectors that are identified as being at greater risk	also published on the SSAB website. • Throughout the year the SSAB has worked to raise awareness of abuse and neglect. This has included using our website and growing social media profile to promote local and national publications and initiatives, including National Safeguarding Adults Week, along with the signs, symptoms and indicators of abuse and neglect (which form part of a regional multi-agency policy, the updating of which was once again coordinated by the SSAB). • The SSAB once again ran a campaign on social media - #12DaysOfSafeguarding - over the Christmas and New Year period that saw good levels of engagement. • The SSAB also maintains a website that contains information on its structure and work, as well as publications and links to those of other organisations. Use of this site has averaged 2676 users each month following on from the significant growth that was achieved during 2018/19. New content has continued to be added and existing content is regularly reviewed by the Board's Policy and Procedures Subgroup.

Work together with Devon, Somerset and Torbay Trading Standards Service to raise awareness of financial abuse and scams	• The SSAB has raised awareness and promoted initiatives throughout the year. This included using social media to alert people of specific scamming activity in the local area, raising awareness of the different types of scams, promoting information from Devon, Somerset and Torbay Trading Standards and national initiatives such as Friends Against Scams. • The Board has featured information about scams and financial abuse its newsletters, and promoted initiatives by Devon, Somerset and Torbay and National Trading Standards.
Work together with the Somerset Community Safety Partnership and Avon & Somerset Constabulary to support work to raise public awareness of, and disrupt, County Lines activity	• The SSAB Business Manager has represented the SSAB in supporting work to establish a Violence Reduction Unit in Somerset, and the Board received a detailed update on progress at its meeting in February 2020. • The SSAB continues to raise awareness of County Lines via social media and of the work of the Violence Reduction Unit through newsletters.

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

What SSAB said it would do	What the SSAB did
Work together to make sure adult safeguarding standards keep people safe and minimise risk of harm, with policies and guidance that supports adults at risk to live their lives as they wish, whilst their rights to freedom from harm are actively supported.	• A new section on differentiating between poor care and potential safeguarding issues has been added to on-line guidance in order to help people who might otherwise have submitted a safeguarding referral for a quality issue to understand the best approach to raising it. • The Board contributed to the development of regional guidance on People in a Position of Trust. • The Board's Policy and Procedures Subgroup developed and published revised guidance on Self Neglect, new guidance on "What to do if it's not Safeguarding" safeguarding and a revised risk decision making tool (formerly threshold tool). These documents have all been published.
Enhance local understanding and application of the Mental Capacity Act and Deprivation of Liberty Safeguards (and the proposed	• The Board's Mental Capacity Act Subgroup has continued to develop the information available in the 'Putting the Mental Capacity Act into

replacement Liberty Protection Safeguards)	Practice' section of the SSAB website • Information about key issues in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards have been promoted using social media • The Mental Capacity Act was the focus of the 2019 'Stop Adult Abuse week' in June 2019. • Presentations on 'Sexual Activity and the Mental Capacity Act', 'The Mental Capacity Act', 'The Mental Capacity Act and Social Media' and the transition from 'DoLS to Liberty Protection Safeguards (LPS)' were included in the SSAB conference in May 2019.
Work jointly with the other strategic Partnership Boards in Somerset to keep people safe from harm and improve their health and wellbeing in support of the prevention agenda, reducing duplication of effort and maximising effectiveness.	• Effective working relationships between the key partnership boards that have oversight of the work undertaken to support the residents of Somerset ensures a clearer understanding of respective roles and responsibilities, improve joined up working between partners, reduce duplication, and develop collaborative efforts to improve the resilience of Somerset communities, families and individuals. The SSAB continued to support these arrangements during 2019/20

	• The SSAB has continued to be represented on a number of other multi-agency partnerships, including the Somerset Safeguarding Children Board's Child Exploitation Subgroup (whose Terms of Reference were expanded during the year to cover the ages 0-25), Domestic Abuse Board, Somerset LeDeR Steering Group and Suicide Prevention Advisory Group. It also supported work to establish a Violence Reduction Unit.
Work jointly within the region, and through national networks, to both develop our local approaches to safeguarding adults and share good practice and learning with others.	• The Board is represented on regional groups by the Independent Chair and Business Manager. A member of the SAR Subgroup is also a member of the regional SAR Champions group. • The Board's Policy and Procedures Subgroup once again coordinated a review of the Joint Safeguarding Adults Multi – Agency Policy which is shared with four other Boards • The Board agreed to lead work on behalf of the region to take forward the development of Organisational Abuse guidance

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. As with many other local authorities the numbers of applications have continued to rise, in our case by 18% over the previous year.

	2017/18	2018/19	**2019/20**	% change
Total applications	2130	2354	**2781**	+18%
From Care Homes	1645	1723	**1953**	+13%
From Hospitals	485	631	**828**	+31%
Assessments completed	705	675	**739**	+ 9%
Authorisations granted	613	593	**687**	+16%
Authorisations not granted	1155	1906	**2033**	+7%

Explanatory note: A high proportion of the 'authorisations not granted' 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.

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 been significant delay in the publication for consultation of the Code of Practice and secondary legislation which has been further affected by the Coronavirus Public Health crisis. The Department of Health and Social Care has therefore advised local authorities and NHS bodies that the implementation of the legislation will be postponed until April 2022.

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

vulnerable people who lack capacity are provided with the support of a qualified advocate.

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

What 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, SCRs, DHRs and LeDeR) through an annual audit and peer challenge process	• The progress monitoring of the implementation of recommendations of published SSAB SARs is a standing item at each meeting of the Board's Executive Group. Specific questions were also again included in the Board's annual self-audit process. • To support local agencies, the SSAB once again used an Organisational Adult Safeguarding Self-Audit Tool to help it evaluate the effectiveness of internal safeguarding arrangements, and to identify and prioritise any areas in need of further development to support local organisations in their continuous improvement of adult safeguarding work. This year it was agreed that a tool used by the other four Boards within the Avon & Somerset Constabulary footprint would be piloted, to which additional questions were added to audit the implementation of recommendations from Safeguarding Adults Reviews. A peer challenge day was planned for March 2020 to consider each organisation's submission, but had to be cancelled due to

	representatives involved needing to prioritise responding to the Coronavirus Public Health Crisis.
Implement and monitor a multi-agency quarterly performance monitoring process	Metrics on Safeguarding performance based on annual Safeguarding Adults Collection (SAC) statutory return have been adopted as a standing item by the Board's Quality Assurance Subgroup, with other organisations who are members of the Subgroup, including Avon & Somerset Constabulary, NHS Somerset CCG and NHS providers, reporting any exceptions to expected levels of organisational performance.
Use data as part of an 'intelligent safeguarding' approach to understand where risks exist within the system and seeks assurance on the implementation of action(s) to address it	This is an area where the Board has struggled to make the progress that it wished to during the year. At it's meeting on February 2020 the Board review progress and agreed that it would progress this work through a new initiative led by the Somerset Health and Wellbeing Board
Monitor progress of the Mental Health Crisis Concordat to improve the experience of people in mental health crisis.	The Board monitored progress twice during 2019/20 and, following a presentation to its meeting in February 2020, agreed that its future monitoring would be focused on the progress of the implementation of the arrangements that will supersede the Concordat with the aim of improving the experience of people in mental health crisis.

Seek assurance that young people experience a safe transition to adult services	This work was initiated during 2019/20 but had not made the progress expected before being suspended due the need for representatives to prioritise responding to the Coronavirus Public Health crisis. As part of the Board's recovery roadmap from the crisis a task and finish group will be established during 2020/21 to take this work forward.
Seek assurance that people with multiple vulnerabilities, including those who do not meet safeguarding thresholds, are enabled to keep themselves safe and, if they are unable to, organisations work together effectively to reduce risk.	There was a change to this priority during the year with work identifying pathways for people with multiple vulnerabilities being led by Public Health Somerset. As part of the Board's recovery roadmap from the crisis a task and finish group will be established to take this work forward.
Seek assurance that there are appropriate arrangements in place for people who are a risk to others, but who may also require safeguarding themselves	Unfortunately, it was not possible to take this work forward during the year as originally planned. As part of the Board's recovery roadmap from the Coronavirus Public Health crisis a task and finish group will be established during 2020/21 to take this work forward.
Seek assurance regarding the assurance and monitoring arrangements that commissioners placing people from other parts of the UK in to Somerset have in place	• This was progressed with other SABs where one or more of their members had made placements in to Somerset and had not reviewed them for 2 or more years. • Arrangements have been agreed by Local authority commissioning leads for the notification of people placed in to another area within the

	South West, which the SSAB supported work to agree along with establishing arrangements within Somerset County Council to record these notifications.
Support Elected Members and Committee functions to better understand their roles and responsibilities in effectively scrutinising and monitoring the effectiveness of the Board in protecting adults at risk from abuse	The work of the SSAB is reported to the Scrutiny for Policies, Adults and Health Committee and Somerset Health and Wellbeing Board twice yearly – at the publication of the Strategic Plan in the Spring and Annual Report in the Autumn. In order to support Elected Members, the SSAB has provided resources to members.

SSAB Annual Self-Audit 2019/20

- All SSAB members were invited to complete the audit, which was also published on the SSAB website. In a change to previous years it was agreed to pilot an audit tool used by the other Boards working within the Avon & Somerset Constabulary footprint, with the addition of a section to monitor the implementation of recommendations from Safeguarding Adult Reviews
- Organisations were asked to complete an agreed audit tool during Quarter 2 2019/20 encompassing 50 areas of safeguarding activity and practice, and to submit this for initial discussion by the Quality Assurance Subgroup ahead of a peer challenge process led by members of the SSAB Executive Group.
- Nine organisations returned a completed audit, an increase of one over the previous year. This was an increase of two organisations from 2018/19.
- The organisations that returned an audit were:
    - Avon & Somerset Constabulary
    - Discovery
    - NHS Somerset Clinical Commissioning Group
    - Public Health Somerset
    - Somerset Care Ltd
    - Somerset County Council Adult Social Care

  - Somerset Partnership NHS Foundation Trust
  - Taunton & Somerset NHS Foundation Trust
  - Yeovil Hospital NHS Foundation Trust
- A Peer Challenge day was planned to take place in March 2020 but was cancelled due to the organisations involved needing to focus on responding on the Coronavirus Public Health Crisis.
- The key features assessed within the audit related to:
  - Empowerment
  - Prevention
  - Protection
  - Proportionality
  - Partnership
  - Accountability
  - Learning from serious Cases
- Overall, an aggregated total of 396 responses were received from the 9 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 on learning from serious cases were only applicable to organisations with a commissioning function.
- Due to the change of template the only section that is comparable to previous years is 'Learning from Serious Cases'. Within this section increased confidence was shown in most, but not all areas. No areas showed a decrease in confidence.

6. Safeguarding Adults Reviews

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

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

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

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

The SSAB has a multi-agency SAR subgroup whose role it is to ensure statutory requirements are met in relation to reviews, and the quality assurance of review reports. The subgroup is chaired by Somerset County Council's Strategic Manager Mental Health & Safeguarding.

During 2019/20 the SAR Subgroup commissioned one new review and considered potential cases against the criteria for conducting one. 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 appointments of an independent, external Chair and/or Review Author. Where independence can be demonstrated form 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 new local review process. This process, which is similar to that used by some other Boards, is being used for all new reviews commissioned during 2019/20.

No Safeguarding Adults Reviews concluded during 2019/20. One SAR that was expected to conclude during 2019/20 had its publication delayed. A further three reviews are at different stages and are being progressed by the SAR Subgroup.

7. Our priorities 2020/21

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

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

- The Board can demonstrate progress through the regular monitoring of performance

You can read our 2020/21 Strategic Plan in full on our website.

8. Board Budget

		2019/20	
SOURCE OF FUNDS		**CONTRIBUTIONS £**	%
SOMERSET COUNTY COUNCIL	- SAB MANAGER & CHAIR	50,290	62.90%
	- SAFEGUARDING ADULTS REVIEWS	0	0.00%
AVON & SOMERSET POLICE	- SAB MANAGER	15,900	19.90%
	- SAFEGUARDING ADULTS REVIEWS	0	0.00%
SOMERSET NHS CCG	- SAB MANAGER	10,000	12.50%
	- SAFEGUARDING ADULTS REVIEWS	0	0.00%
CONTRIBUTIONS TO THE SSAB ANNUAL CONFERENCE		3,721	4.70%
TOTAL CONTRIBUTIONS		**79,911**	**100.00%**
APPLICATION OF FUNDS		**EXPENDITURE £**	%
PAY			
SAFEGUARDING BOARD MANAGER		58,885	76.10%
INDEPENDENT CHAIR		16,790	21.70%
NON PAY			
SAFEGUARDING ADULTS REVIEWS		0	0.00%
SSAB ANNUAL CONFERENCE		1,357	1.80%
INSURANCE		71	0.10%
BT CHARGES/MOBILE CHARGES		254	0.30%
TOTAL EXPENDITURE		**77,357**	100.00%
ANNUAL OVERSPEND / (UNDERSPEND)		**(2554)**	

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

9. The Work Of Our Members

Avon and Somerset Constabulary

Safeguarding adults and children through the COVID-19 pandemic in 2019/20

- We worked closely with partner agencies to achieve joint consideration of changed demand and risk to vulnerable adults as a result of measures to slow the spread of COVID-19, and to coordinate action, including action to deal with the anticipated spike in demand as measures are removed.
- We promptly developed and implemented through the latter part of 2019/20 a COVID-19 Vulnerability Response Tracker through which we identified increased risks to vulnerable people, and managed and monitored activity to mitigate those risks.
- We took steps to mitigate the impact upon investigative outcomes of measures to slow the spread of COVID-19, with assurance activity showing no negative impact across the 9 strands of vulnerability examined, including abuse and exploitation offences against vulnerable adults.

Safeguarding Achievements during 2019/20 in

- We established, with the Office for the Police and Crime Commissioner (OPCC) and Victims of Crime Advocacy Service (VOCAS), a cross-directorate Adults at Risk Assurance Panel. The panel is owned by the Adults at Risk Thematic lead and conducts reviews of force performance for victims and disseminates learning and good practice as appropriate. VOCAS have presented two case studies which provided useful insights (learning and positive feedback) into Adults at Risk experiences of the police. Both victims were offered the opportunity to meet with the Adults at Risk Thematic Lead to relay their experiences and resolve any issues.
- We completed an internal audit of 30 safeguarding adult investigations to provide a benchmark of comparison to assure the effectiveness of future improvement activity. Good practice was identified in relation to:
  - quality of vulnerability BRAG assessments

- victims being seen in a timely manner
- allocation of cases to the most appropriate department
- recording of victims wishes
- needs of Adults at Risk considered
- victim updates VCOP compliant

The learning identified was in relation to:

- use of Body Worn Video
- dealing with the suspect appropriately
- compliance with BRAG completion
- setting an initial investigation plan
- opportunities for ABE
- timely supervisor reviews
- positive investigative outcome

The learning identified has been disseminated to relevant departments.

- We introduced a 'Chat Bench' in Vivary Park in Taunton, and on the Sea Front in Burnham-on-Sea, facilitated by local Police Community Support Officer (PCSO) for World Elder Abuse Awareness Day in June 2019. The aim of the Chat Bench Initiative is to offer a practical solution for communities to help relieve loneliness. It encourages communities to adopt local benches as designated locations where anyone can stop and have a chat. The campaign was well received on our social media channels and also received coverage on local, national and international media outlets. The Sergeant responsible has since been awarded an MBE "for services to charity and to older people in South West England and South Wales" in the 2020 New Year's Honours
- Our Adults at Risk Delivery Plan was re-drafted ready for the introduction of the new 20/21 Constabulary Single Delivery Plan. This is a big step forward for the force – as previously there were a complex network of plans held in various

formats with a variety of owners. This development brings all of the directorate, department and thematic ambitions into one place, and allows the force to more easily understand the scale of improvement and change activity happening across the organisation.

Safeguarding Adult Objectives for 2020/21

- Raise awareness and improve the Force response to Adults at Risk victims by improving Officers ability to identify AAR at first point of contact.
- Identify patterns of abuse and neglect related to the same victim/location to provide early intervention against institutional abuse and prolific offenders targeting vulnerable people.
- Develop robust Problem Solving Plans around AAR victims and locations.
- Improve the quality and quantity of BRAG assessments to ensure AAR incidents are escalated appropriately.

Somerset County Council

Our work during 2019/20

- Somerset County Council (SCC) has the lead role for adult safeguarding in Somerset, which it primarily discharges through its adult Safeguarding Service.
- The Safeguarding Service (the Service) has continued to receive a high demand of referrals, the majority of which stem from private care settings across Somerset, which is similar to previous years. Our close liaison with Somerset Direct (SCC's 'front door') has positively enhanced the experience that people receive when they first make contact with the Local Authority. During 2019/20 61.19% of all contacts handled by Somerset Direct were resolved or directed to a different service that would be the most appropriate to response at this point. The Service continues to be committed to upskilling and increasing the safeguarding awareness of the call advisors. This ensures that the response at our front door signposts the alert to the most appropriate service within SCC. The Service

has also retained a direct consultation line to the safeguarding triage team and provides monthly peer supervision to maintain and enhance the quality of safeguarding screening at Somerset Direct.

- During 2019/20 38.81% of safeguarding alerts received were accepted as requiring a safeguarding response. Our ambition during 2019/20 was to reduce the number of alerts received into the service that are not accepted as needing a safeguarding response, and while there was an increase of 8.1% of we acknowledge that there will always be more work to do. An example of the type of contact where this may happen is when a caller to Somerset Direct states that they are worried that something may be a safeguarding concern but, on talking it through with them, it is identified that it isn't and a response from a different service or organisation is more appropriate.
- Our work during the year has included working with our partners in system-wide responses to concerns regarding an education/residential setting, a GP practice and choking incidents involving people with learning disabilities as well as instances of organisational wide concerns for a small number of providers.
- To provide governance and oversight of the standard of practice in the Service we are continually undertaking quality assurance audits internally and as part of the SSAB's Quality Assurance subgroup to assess the effectiveness of the Service. The Service has benefited from continued professional development learning and conferences covering topics such as mental capacity and sexual consent, MSP, defensible decision making, learning from safeguarding adult reviews undertaken locally and elsewhere, alongside formal safeguarding training and conferences regionally and nationally.
- The Adult Social Care service introduced system wide quality audits from September 2019, with safeguarding triage and enquires being discrete areas for audit. The feedback from these audits has been positive, as has the learning, to develop and further enhance the service delivered. The audits revealed particularly strong practice in relation to:
  - In 80% of audited cases there was evidence that the person or their advocate had been consulted about their wishes and desired outcomes;
  - All audited cases evidenced that advice or information had been given to minimise or prevent the risk of further harm or abuse;
  - In all but one case it was evident that actions taken were the least intrusive response to the risk presented, and clear enquiries had been completed within the service's 60 working day target timeframe;

- Where applicable to do so, audits confirmed evidence that the person/organisation posing a risk had been given the opportunity to respond to the allegations against them;
- There was good evidence that clear documentation was available outlining the protective actions taken and the protection plan in place
- In 87% of cases, auditors confirmed that the person's own strengths, family support and available community/universal services were considered when planning protective actions
- All audits evidenced that appropriate people and agencies had been involved in the safeguarding enquiry in a coordinated and timely way, either fully or in part
- Where protective actions had been declined by the person, or their desired outcomes not been met, this was been documented/considered consistently
- Where relevant, audits demonstrated that appropriate onward referrals had been made
- There was good evidence of self-auditing processes being used as part of routine learning & development

- The audits also highlighted the following opportunities for improvement:
  - Ensuring that the person's capacity to contribute to the safeguarding process was consistently documented, and consideration given to an advocate (where applicable)
  - Ensuring a sufficiency and breadth of appropriate information for any enquiries accepted and concluded at triage stage. Cases should not be closed whilst any documentation or information is awaited to confirm outcome.
- In March 2019 Healthwatch Somerset published a report looking at the way in which the Service captured the experiences, outcomes and feedback from the people we support and to temperature check the implementation of Making Safeguarding Personal (MSP) in the Service. Healthwatch piloted a 'test and learn' questionnaire with a small sample of individuals. The Service accepted the finding of the report in full, and began moving forward with implementing a process of conversations with individuals, however this work has more recently had to be paused in light of the service needing to prioritise resources to the response to the Coronavirus Public Health crisis. One of the Services main objectives as it moves forward from the crises will be to re-establish this work.

- Our links with the SSAB and the wider SSAB network is invaluable, having representation on all SSAB groups, including the executive and subgroups, as committed members to implement change across the multi-agency safeguarding adult system. We have actively participated in multi-agency peer audits of triage and enquiry standards, and been key members of the safeguarding adult reviews taking place in the County.
- We actively support the following forums: MAPPA, MARAC, MASH, PREVENT Board, High risk police liaison, CQC liaison, provider quality improvement meetings, the Safer Somerset Partnership Board and any domestic homicide reviews taking place in Somerset. We routinely triangulate and promote multi-agency learning within these forums to improve people's experience, to reduce abuse and to work preventatively across the county, including with colleagues from Children's Social Care.
- Throughout 2019/20 the service has proactively engaged with care providers across Somerset to enhance people's safety. This work closely dovetails with our Quality Assurance team to ensure that regulated and non-regulated services in Somerset consistently deliver high quality outcomes for the people they support and to act when the service falls short of our expectations. This work is enhanced by our close working partnerships with the Care Quality Commission, NHS Somerset Clinical Commissioning Group, Somerset Partnership NHS Foundation Trust and our care provider network. Our ethos being that people receiving care and support, whether in their own homes or provider settings, should be among the safest in Somerset, not the most vulnerable. To support this work, we continue to participate in quality improvement meetings, raising concern meetings and home closure processes alongside our quality assurance service and the NHS Somerset Clinical Commissioning Group Quality Assurance team.
- As a Safeguarding service we continue to be keen to work with all partners across the system, including through regional networks, SPARK Somerset and the Registered Care Providers Association. We have also been working with the Office of the Public Guardian to assist in a pilot of a new adult safeguarding approach that it has developed.
- Our 4 Safeguarding Adult Leads that were appointed during 2018/19 are settling into their roles and responsibilities.
- We have led the development of a workshop approach to training commissioners and senior managers within the Council on safeguarding, which has been supported by Somerset Direct, the Council's Quality Assurance Team and the

Safeguarding Adults Board. We have received positive feedback on the content of this approach and hope to make it available to more staff in the future, including those external to our organisation.

- As a service we are instrumental in ensuring that the Local Authority continues to commission and deliver exceptional safeguarding adult training to our workforce. During 2019/20, it commissioned and delivered the following training across Adult Social Care:

Course	Number of delegates
Recognising Adult Abuse (½ day)	29
Enquiry Skills (2 days followed by 1 day follow up)	43
Mental Capacity Act (2 day)	46
Mental Capacity Act Legal and Practice Update (1 day)	61
Sexual Activity and Mental Capacity Act (1 day)	76
LPS Information sessions (½ day)	231
Safeguarding workshop – open to Service Managers and Commissioning (1 day)	23
Locality Leads workshop (facilitated by Safeguarding leads) ½ day	16
Developing safeguarding practice (St Thomas training) 1 day	41

Objectives for 2020/21

- Fully implement the safeguarding experience feedback process that was piloted by Healthwatch Somerset
- Continue to work to increase awareness of what is/isn't an adult safeguarding, and what members of the public, professionals and providers need to do when they are worried about something
- Work with partiers to identify and address new and changing concerns emerging as a result of the Coronavirus Public Health Crisis

NHS Somerset Clinical Commissioning Group

- Our key aim for safeguarding adults is ensuring that both the CCG and its commissioned providers protect the rights of adults to live free from abuse and neglect; working effectively in partnership with other agencies in a way that supports adults in making choices and having control about how they want to live.
- The CCG works with NHS hospitals, community services and other commissioned providers and monitors how they support adults who need safeguarding; including how they work with other agencies. We do this in a number of ways including working collaboratively with our providers and with other key partners in the system for example the County Council. We provide support and strategic direction and we monitor information that has been agreed via our contractual process including a safeguarding dashboard for our community and hospital trusts; and an annual safeguarding report for all providers. The CCG monitors safeguarding adults training compliance against the 2019/20 target of 95%.

Somerset CCG has undertaken a number of specific safeguarding adult's activities this year.

- We supported our senior leadership team to maintain their knowledge about safeguarding adults. This included providing training sessions to our governing body about their safeguarding duties and briefing sessions about the Mental Capacity Amendment Act (2019). Our executive lead for safeguarding attended a national safeguarding leadership course funded by NHS England and NHS Improvement.
- We have also supported our staff who work in specialist safeguarding adults roles to maintain and extend their knowledge and expertise. This year, these staff have participated in training about safeguarding adults, domestic abuse, prevent, safeguarding leadership, exploitation, deprivation of liberty safeguards, Court of Protection, safeguarding legislation and statutory frameworks.
- By supporting training and development, we aim to ensure our staff are able to work effectively with the Board.
- A review of our CCG safeguarding adults workforce capacity was undertaken; which resulted in the agreement of funding for a new post of Named GP for Safeguarding Adults; combined with the existing post of named GP for Safeguarding

Children. This joint post will support a safeguarding 'Think Family' approach across the whole life journey. The review will inform our plans for further developments in 2020/21.

- Our Designated Nurse for Safeguarding Adults has supported national development work by regular attendance at the NHS England and NHS Improvement Safeguarding Adults National Network; which acts a clinical reference point for Safeguarding Adults for the NHS across the country.
- The CCG holds contracts with all its NHS providers and refreshed the safeguarding schedule of these contracts to ensure the content reflects current safeguarding legislation and aligns with the functions of the Safeguarding Adults Board. We also developed and implemented a safeguarding adults dashboard to monitor safeguarding activity within our trusts. Our safeguarding staff attended the Trusts' safeguarding committees to provide support, advice and to also seek assurance of safeguarding arrangements, practice and policy development.
- We have also undertaken work with our GP practices. The CCG safeguarding team undertook a training needs analysis of safeguarding adults in GP practices to inform our training strategy for next year. In conjunction with NHS England and NHS Improvement, we developed a joint safeguarding adults and children safeguarding audit tool for primary care. The roll out was paused at the onset of the pandemic and will be one of our priorities for next year.
- As a commissioner of care, we continue to work collaboratively with Somerset County Council and other partners when there are concerns about abuse or neglect within a commissioned service. For example, our Continuing Healthcare (CHC) team undertook a Section 42 enquiry in relation to a person who lived in a residential home that provides care for people with learning disabilities. The person had been visited by a health professional who had written a care plan to help the care home staff look after the person. The plan was not followed and the person experienced serious harm. The section 42 enquiry identified that staff needed further training in this particular area of care. In partnership with our community services provider, a training package was developed that is now available to all health and social care staff working in Somerset. In addition, clinical oversight is routinely provided by our CHC team into some enquiries solely being made by Adult Social Care, which has improved the quality of enquiries and the outcomes for people; through collaboration and sharing of skills. Another example of collaboration relates to situations when there are whole service safeguarding concerns about care providers. Our CHC safeguarding team worked in partnership with Adult Social Care, Children's

Social Care, and Education Services to improve the care in a service looking after young people in residential accommodation.

- By implementing proactive quality monitoring systems, our CHC team have identified when there are themes or concerns about service provision, and are working in partnership with the Local Authority to support improvements.
- In preparation for the implementation of the Liberty Protection Safeguards, as set out in the Mental Capacity Amendment Act (2019), we led a Deprivation of Liberty audit across the three trusts and the CCG. The outcome of the audit will inform how health, as a system, will implement the safeguards; when required.
- The CCG were successful in a bid for funding from the Pathfinder Consortium to support improvements in how NHS hospitals and community services respond to and support people who use our services and are experiencing Domestic Abuse. Utilising this funding, we led the Pathfinder Domestic Abuse Project across our three trusts; in collaboration with our partners. As part of the project, work to commence a Domestic Abuse Link Worker network across our hospitals and community services was initiated. The link workers will receive additional training in Domestic Abuse and can provide advice and support to colleagues who are responding to Domestic Abuse. This includes responding to people who have care and support needs. A resource pack has been developed to support the workers in a Domestic Abuse Link Role. Two Domestic Abuse training packages have also been developed to support the health workforce to identify and respond to people who are experiencing Domestic Abuse.
- The CCG is a statutory partner of the Safeguarding Adults Board, and as such has provided representation at the Safeguarding Adults Board, the executive group, and all five sub groups. The CCG has also contributed to the Safeguarding Adults Reviews and other learning reviews that the board have undertaken this year.
- The NHS long terms plan requires the CCG and Health Providers; together with Local Authorities to collaborate to ensure people receive local, joined up services, that improves outcomes and experiences for people. This collaboration is provided through an integrated care system, which includes integrated care providers. As Somerset moves towards and integrated care system in 2020/21, these developments provide opportunities for enhanced and integrated system working.

CCG Case Study

- The CCG deals primarily with contracts, funding, commissioning and assurance of health providers within the Somerset area; and other than its Continuing Healthcare team has little direct contact with patients and service users. We do, however, have a duty to ensure our staff are able to recognise the signs of abuse. We also have a duty to provide an appropriate response to enable the person experiencing abuse to access the appropriate support services.
- A contract officer received a request from a provider for a bespoke funding request to enable 'Janet' (not her real name) to access a health service. The contracts officer read the reasons behind the funding request and recognised that as well as the clinical needs for the request, the circumstances suggested that 'Janet' may have been experiencing coercion and abuse by a partner. They were concerned that the partner may be preventing Janet from accessing services. The contract officer raised her concern with the CCG Safeguarding Adults Team who then contacted the provider concerned. The provider provided advised that the bespoke funding request would enable Janet to overcome the barrier of coercion and provided reassurance that the necessary steps had been taken to provide Janet with support in relation to the alleged abuse. The funding was agreed, and Janet received the health service she needed, along ongoing support from Domestic Abuse Services.

- At Somerset Care we have embraced our involvement in the Somerset Safeguarding Adults Board and have used this multi-agency learning to drive organisational improvement through our own Safeguarding Committee.
- We have revised and re-defined our company values linking these to behaviours that we would like to see all colleagues demonstrating. We worked together with all colleagues to develop these new values that are fit for our future mission and vision and will support our ambitions to grow the business and ensure that we all deliver high quality, innovative services and work together to provide person-led care to our customers. We are embedding the values in

everything that we do to ensure that we are all working in the same way, valuing each other and acknowledging when people behave in-line with our values.

- We have reviewed and revised the membership and purpose of our Safeguarding Committee to enable it to effectively monitor and evaluate the Company's processes and performance in relation to safeguarding practices and incidents. Membership now draws on the knowledge and experience of individuals from across our diverse range of services.
- The Safeguarding Committee 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 re-occurrence.
- The Safeguarding Committee has completed a full and through self-assessment of our safeguarding processes already in place. This has helped Somerset Care to identify where there may be opportunities for us to enhance our processes and to identify actions to close these gaps and to develop our policies accordingly. Implementation of these actions is being monitored closely by the Safeguarding Committee.
- We have also reviewed the safeguarding training provision and all staff are required to undertake safeguarding adults training via eLearning. Compliance is closely monitored by our Learning and Development Team. This training must be refreshed at least 3 yearly and by completing this course, staff develop greater awareness of common types of abuse and understand the role that staff play in managing the risks associated with this abuse. We have also introduced a new, enhanced safeguarding course for managers; the aim of the course is to enable managers in provider settings to fulfil their safeguarding responsibilities effectively, and to work with their partners in the statutory sector to achieve, wherever possible, the outcomes service users wish to achieve for themselves.
- Safeguarding concerns reported by our services are scrutinised by our central Quality Team and this involves analysing incidents to identify trends, as well as ensuring that steps are taken to protect any of our customers considered to be at risk and ensuring that we are working in partnership with other organisations to protect these individuals where appropriate.
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risk and ensuring that we are working in partnership with other organisations to protect these individuals where appropriate.

Somerset County Council – Public Health

- Somerset Public Health (SCC PH) team provide and commission a range of public health services, safeguarding both adults and children are at the heart of everything we do and managed through a 'Clinical Governance assurance process' each commissioned specialist service undergoes a quarterly performance review using a standardised template that details safeguarding and patient safety incidents. This details where the right support for clients has not been immediately available, what escalations have been undertaken and with what outcome.
- SCC PH receive adults safeguarding board newsletters and these are cascaded to our services to ensure that learning is shared and where there are actions for individual services identified from either Safeguarding adult reviews or inspections, progress against these are requested at each quarterly contract review
- SCC PH team members who have client or commissioning responsibilities have undertaken adult safeguarding training appropriate to their role. Additionally, during 2019/20 our sexual health promotion manager worked with the provider of adult learning disability services to provide training on sexual health, including consent and effective contraception.

Provider services

- In 2019 the public health nursing services moved into Somerset County Council, alongside other operational public health services (stop smoking and healthy weight services).

Stronger Communities Team

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

- Through the VCSE Strategic Forum website, we have shared the Adult Safeguarding Newsletter to voluntary sector organisations
- A VCSE workshop was held in July 2019 that related to Adult Social Care
- We have linked Spark Somerset our VCSE Infrastructure provider into Adult Safeguarding Team which led to Louise White running a session for voluntary sector groups to raise awareness and Spark Somerset are keen to build on this and to be able to provide further support and raising awareness sessions.
- Adult safeguarding e-learning (and associated resource links) is part of the Volunteer e-learning suite. It is available to all SCC volunteers and is now compulsory for the relevant volunteer roles (Leaving Care Volunteers, Kilve Outdoor Activity Volunteers, all Duke of Edinburgh Volunteer roles, Unstoppables Volunteer, new Voluntary Drivers, Syrian Resettlement ESOL Volunteers and Public Health Nursing Volunteers). Fifteen volunteers have undertaken this training.
- All members of the Central Volunteer Team have completed the adult safeguarding module as well
- The adult safeguarding e-learning has been reproduced in paper format, for those who do not have access to IT.
- We have also added other adult related content (Awareness of Mental Health, Dementia and Learning Disabilities, oral health and Making Every Contact Count)
- There are not many current adult facing volunteer roles, but links have been made with Adult Social Care to explore the possibilities
- When a new volunteer role is being developed, the need for adult safeguarding training is always considered.
- Through the Armed Forces Covenant we have also linked local SSAFA contacts into Adult Social Care as part of developing closer working and provided information to Somerset Direct regarding the Armed Forces Covenant.
- **Future Development**
    - Spark Somerset are organising a new programme of webinars to support some of the Covid-19 response groups they are working with and are keen to provide for volunteers an online run through of the basics of Adult Safeguarding / supporting 'vulnerable adults', plus an opportunity for some Q and A around the specific issues they might come across when delivering food parcels, fetching prescriptions etc.

Public Health Nursing

- All Public Health Nursing practitioners undertake 3 yearly adult safeguarding including PREVENT training. Accessed via the SCC learning platform and in line with SCC colleagues.
- This training supports the practitioners to know their own safeguarding responsibility including how to recognise signs of neglect and abuse and what safeguarding adult actions to take.
- Training compliance is monitored.
- PHN service have a PHN specific Incident reporting system.
- Incidents relating to safeguarding adults will be assigned for corrective/preventative actions and tracked for completion. Where indicated, thorough Root Cause Analysis will take place and learning from investigations will drive continuous improvements in safeguarding adult practice.
- The PHN Safeguarding Children team are commissioned from Somerset Foundation Trust where they work alongside the wider safeguarding children and adult service. As such the PHN Safeguarding Children service are in a position to utilise expert support and guidance from the Named Professional for Safeguarding Adults, MCA/DoLS/consent lead and Domestic Abuse Coordinator. This expertise is transferred to PHN specific adult safeguarding matters including 1:1 case advice and supervision always in line with safeguarding adult processes.
- PHN service works within the SCC Safeguarding adults at risk policy in line with other SCC colleagues where there are identified concerns or risk to vulnerable adults.
- The PHN service follow the same domestic abuse referral pathway as their partner health service Somerset Foundation Trust. This includes the quality assurance of all SIDAS referrals for PHN practitioners, mitigating against any delay to the receipt of a referral by SIDAS which contains all the relevant information needed for the victim to receive the right support service at the right time.
- A PHN specific domestic Abuse Standard Operating Procedure is being developed by the PHN service to promote and evidence a consistent and effective approach to domestic abuse. This SOP will be informed by both the Somerset Foundation Trust and the CCG domestic abuse policies both of which are respectively informed by the National Institute

for Health Care and Excellence (NICE guidance), issued the PH50 Domestic Violence and Abuse Multi-Agency Response in February 2014 with further guidance detailing high priority areas in the Domestic Violence and Abuse Quality Standard: in February 2016

- The PHN safeguarding children service promotes the importance of considering the intended or unintended consequences of domestic abuse on the entire family, "THINK FAMILY" The service both guide and direct practitioners to the evidence of impact on children and the effective use of the safeguarding children processes, alongside the safeguarding adult processes
- PHN staff where it is indicated they have a role, do actively contribute to multi agency learning through safeguarding adult reviews and domestic homicide reviews (there has be no role in the reporting period of 2019-2020).
- Learning from previous domestic homicide reviews continues to be embedded in PHN practice for example practitioners will offer follow up appointments out with the home where the abuse may be occurring.
- Domestic abuse has been identified as a complicating factor in the case of a most recent child death (2020). The involved PHN practitioners will participate in the SSCP commissioned Child Safeguarding Practice Review and identified key learning will be disseminated and time bound actions agreed to mitigate against the same tragedy in the future. Whilst the review will be focused on the experience of the child and child safeguarding related learning, the responses to safeguarding adults and children from domestic abuse are inextricably linked and wider adult safeguarding learning may require dissemination.

The Somerset Integrated Domestic Abuse Service

- Somerset Integrated Domestic Abuse Service supports victims, their families and those who cause harm to be safe and recover from their experience. The service includes a number of elements from emergency accommodation, Independent Domestic Violence Advisors (IDVAs), peer support work and Young Peoples Domestic Violence Advisors (YPVAs). The service was delivered by lives West, contracted until 31st March 2020.
- The service is based around a single hub, where clients are triaged, and allocated to the appropriate service. The hub coordinators agree this with the client to ensure they are happy and willing to participate in the support offered.

- The domestic abuse system, spanning beyond the specialist service is overseen by the Somerset Domestic Abuse Board, which includes the progress of Domestic Homicide reviews and Multi-agency Risk Assessment Conferences. Both these functions offer insight in to practice, and highlights challenges and gaps in service that can then be improved. Adults social care is a key player in these activities to ensure that any vulnerable adults is quickly identified and supported.
- As part of the SIDAS contract, the service runs regular Identifying the Signs of Domestic Abuse training for front lien staff across all agencies who feel they might benefit. There are two levels of training on offer. In addition, the Somerset Survivors website hosts information for professionals and the public.
- This year, a new process was trialled called the Domestic Abuse Triage (DAT) process, whereby, collocated staff would triage all domestic abuse reports which included children and make careful decisions as to how each should be processed between the Specialist domestic abuse service, education, police and children's social care. The process worked well to ensure cases were appropriately escalated and severely reduce the number of cases heard at MARAC meetings.
- The Somerset Domestic Abuse Board, of which the SAAB is represented, monitors a comprehensive data scorecard to demonstrate performance and rates of demand across the domestic abuse system.

The Somerset Drug and Alcohol Service

Somerset Drug and Alcohol Service offers support to adults, young people and their family and friends across Somerset who are experiencing difficulties around substance misuse. The service is designed to help reduce the harm that drugs and alcohol cause to the individual and those around them and ultimately achieve recovery from addiction and re-integration back into community life.

Somerset Drug & Alcohol Service is run by Turning Point. We create individual recovery plans from a range of services, no matter what the situation is. We offer confidential, non-judgement advice, information and support in a flexible manner. There is a significant emphasis on ensuring safety and safeguarding is our priority.

- We use learning to enhance practice internally through our Clinical Governance, Morbidity and mortality meetings. We continually to look at ways of improving our processes, including implementing new processes by reviewing when things

go wrong and looking at how we can do things differently to reduce the risk. We disseminate learning to staff from Domestic Homicide Review's, Health safeguarding partnership meetings, Suicide Prevention Partnership Board, Serious Case Reviews, Somerset Domestic Abuse Board all of which SDAS are part of.

- Somerset Drug and Alcohol Service have a full-time designated Safeguarding Manager a role which commenced May 2019. The Safeguarding Manager who is part of the senior team works closely with the YP and Families Manager supporting families around inter-generational substance misuse and seamless transitioning to adult services. Governance and oversight of safeguarding pathways/partnerships, ensuring safeguarding is a key priority for all staff/peer mentors/volunteers. They will support in delivering enhanced Safeguarding training and supporting with Safeguarding compliance/competency. SDAS regularly attend multi-agency safeguarding meetings.
- Our Safeguarding Manager has oversight of safeguarding within the service for adults and young people which includes ensuring that the service is adhering to Turning Points safeguarding processes and management system. The role provides support to managers and staff across the service regarding management of safeguarding and complex cases. Provision of training to staff, supporting in meetings and chairing of local safeguarding meetings, developing staff regarding attendance to external safeguarding meetings and report writing, promoting safeguarding within the service, developing partnerships with external safeguarding services Leading on safeguarding audits and quality checks.
  We have a robust internal SG policy which staff follow regarding any SG concerns. The service has designated safeguarding leads in each hub across the county who oversee any day to day safeguarding concerns. Our safeguarding leads attend a monthly meeting with the safeguarding manager to look at new processes, discuss new external services, new external/internal safeguarding development initiatives, safeguarding trainings, audits, performance.
- Our Safeguarding Manager will ensure the service is aligned to the Early Help assessment as detailed in SSCB's Effective Support for Children and Families in Somerset. The safeguarding manager delivers safeguarding inductions to staff, attends/chairs safeguarding meetings, oversee safeguarding audits and acts as the first point-of-contact with SSCB and SSAB.

Healthwatch Somerset

- Healthwatch Somerset enables the views and experiences of people who use services to influence and improve the way that health and social care services are provided and delivered.
- Healthwatch Somerset has statutory powers under the Health and Social Care Act 2012, to 'Enter and View' publicly funded health and social care premises to speak to people about their experiences of using the service. This allows us to create a report that identifies areas for improvement and share areas of best practice. Any potential safeguarding issues are escalated through the suitable channels.
- Healthwatch Somerset undertook three Enter and View visits in early 2020 to care home providers in Chard, Shepton Mallet and Taunton. These visits were to support Somerset County Council's care quality monitoring and findings have also been shared with the CQC. Full reports produced following our visits can be seen at www.healthwatchsomerset.co.uk
- Healthwatch Somerset uses staff and volunteers to speak to people about their experiences of health and social care. All staff and volunteers speaking to Adults at Risk are required to have completed Adult Safeguarding training and be DBS cleared.
- Healthwatch Somerset provides an information, advice and signposting service to members of the public on a variety of health and care issues. Any potential safeguarding issues are escalated by our staff and volunteers using the appropriate protocol.

Taunton and Somerset NHS Foundation Trust

- **We have worked with Somerset Partnership Foundation Trust to bring together our respective safeguarding services**. This new Integrated Safeguarding Service has amalgamated both adult and children's safeguarding across both organisations to create one seamless Safeguarding Service. This Safeguarding Service is supported by a staff structure that encompasses a wide range of experience, skills and backgrounds, which has greatly improved the safeguarding support service that we offer to all Trust staff across both trusts. This service embraces the Think Family approach through the provision of a core Safeguarding duty team service

whereby safeguarding professionals are trained to provide advice and support across the lifespan, considering the wider impact of the abuse on wider family / carer networks incorporating contextual safeguarding approaches. The duty team are able to provide a single point of advice to staff an all elements of both adult and child related safeguarding concerns.

- **Impact of service:** Throughout the year we have supported staff with 753 internal safeguarding alerts and referrals covering all elements of safeguarding adults related work.
- **Safeguarding Training:** As part of our work with Somerset Partnership, we have developed a co-ordinated approach to training, which has enabled us to launch the higher levels of safeguarding training required within the Trust so that training provision is consistent across both organisations. Funding has been approved for the creation of a new Learning and Development Lead within the Safeguarding service who will be in post from April 2020 to support further development in this area.
- **The merger of the two trusts former safeguarding teams** has enabled the implementation of the innovative integrated Safeguarding service with generic duty team, incorporating the Think Family approach, has been in place since October 2018. The Director of Safeguarding has presented this progressive, collaborative way of working at a number of national and regional events.
- **Implementation of Safeguarding Team Supervision:** we have commenced the roll out of quarterly team safeguarding supervision to key frontline services this year and anticipate expansion of this provision in the next financial year. This compliments the revised training package now provides to all Trust staff and enables discussion and learning from ongoing cases plus feedback on local / national trends in relation to all aspects of Safeguarding Adults.
- **The MCA/DoLS and Consent Lead** has continued to expand the provision of Mental Capacity Act training in line with the Somerset Safeguarding Adults Board Mental Capacity Act Competency Framework. We continue to work towards developing MCA awareness and competencies throughout the Trust. Preparation work is underway for the implementation of the Liberty Protection Safeguards anticipated for implementation in October 2020.

- **The Domestic Abuse Co-ordinator post** sits within the integrated Safeguarding service and has been leading on the work relating to Domestic Abuse Link workers across the organisation, raising the profile of domestic abuse across all frontline services and improving the organisation response to Domestic Abuse.
- **We participated in and completed work on the Domestic Abuse Pathfinder Project.** The Project provided the funding of two posts within the Somerset Health sector for the 12 months (April 2019-March 2020). These posts were recruited to in April 2019 and consisted of a Complex Needs Independence Domestic Violence Provider (IDVA- employed and working within TST) and a Pathfinder Project Lead (employed and working within CCG). Work was undertaken to support those most vulnerable experiencing domestic abuse, had mental health concerns and other factors which reduced their ability to engage with services designed to support victims of domestic abuse.
- **We continue to be an active member of the Somerset Multi-Agency Risk Assessment Conference (MARAC).** As well as regular attendance, we have also been involved in ongoing the multi-agency development of the process most recently adapting to accommodate working restrictions imposed as a result of the COVID19 pandemic.
- **We continue to play an active role on the Somerset Safeguarding Adults Board.** This has included membership on the Board and a number of the Board sub-groups.
- **We have continued to participate in S42 enquiries, Safeguarding Adult Reviews and Domestic Homicide Reviews as required**, the learning from which we disseminate to Trust staff vis Trust newsletter, Safeguarding team supervision and through integration into all levels of the newly revised training programme.
- **The Joint Safeguarding Committee (**new Governance arrangements) replaced the previous Safeguarding Governance Groups for Taunton & Somerset and Somerset Partnership in June 2018. The Joint Safeguarding Committee holds us to account with regards to our duties and responsibilities regarding all areas of Safeguarding including our Safeguarding Plan, Policy review and development, and ensures that we are compliant with SSAB policy, learning and guidance.
- **Our collaborative working with external Safeguarding Agencies** has increased since the integration of the two Safeguarding teams. Through the Integrated Safeguarding Service we are able to be an active member of the weekly adult MASH meetings held between ourselves, Adult Social Care and the Police.

- **We have continued close collaborative working with external agencies** such as the Police, Somerset County Council safeguarding colleagues and the CCG.
- **We have revised the Safeguarding Adults at Risk Policy** for Sompar and Taunton and Somerset Trusts and have unified and updated them in to one overarching Policy for both Trusts. This will ensure continuity of Safeguarding Adult processes, practices, guidance and advice.
- **We have introduced a new policy Supporting colleagues who experience Domestic Violence** which ensures the Trust fulfils its statutory duties and has a procedure in place on how to respond to reported incidents or allegations of domestic violence and abuse involving a colleague or volunteer, whether perpetrator or victim.

Yeovil Hospital NHS Foundation Trust

Board Effectiveness

- The Trust safeguarding committee meets quarterly and is chaired by the Chief Medical Director, who holds the statutory role of Named Doctor for Safeguarding Children. The standing agenda consists of the following: review of key performance indicators, learning to prevent reoccurrence, children and adult safeguarding updates, prevent, mental capacity and deprivation of liberty.
- The Trust Safeguarding Committee reports to the Governance Quality and Assurance Committee and subsequently to the Trust Board, a Safeguarding Quality report is provided on a quarterly basis, this is also supported by an annual amalgamated adult and children safeguarding report.
- The trust is represented at Somerset Safeguarding Adult Board and subgroups by the Deputy Director Safeguarding or designated deputy (Head of Safeguarding)

Prevention

The trust board acknowledges their responsibility for safeguarding vulnerable individuals and have invested in a trust wide safeguarding service through the development of a dedicated team. The safeguarding team composition currently is as follows:

- Deputy Director Safeguarding
- Head of Safeguarding / Named Nurse Safeguarding Children
- Named Doctor Safeguarding Children
- Named Midwife Safeguarding Children
- Safeguarding Children Practitioner
- Health Independent Domestic Violence advisor
- 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.

- Trust staff are able to identify issues of a safeguarding nature and this is reflected in the number of alerts and referrals being raised from various departments, the incident reporting system is used to manage these alerts/referrals. During this reporting period 253 safeguarding incident reports for adult patients have been made to the safeguarding team. This demonstrates staff awareness of the system for raising concerns and the confidence the staff have in this system for provoking a response from the safeguarding service and for the need for safeguarding the vulnerable individual within the organisation.

- Combined adult and child safeguarding training sessions are delivered by safeguarding team members at induction and mandatory 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 safeguarding team members facilitate the safeguarding adults level 3 training modules for trust staff (as identified in the Intercollegiate Document). The modules currently include, Learning from serious case reviews, The Care Act, The Mental Capacity Act and Deprivation of Liberty – (this includes case reviews and documentation), Domestic Abuse, Prevent, Learning Disabilities and reasonable adjustment.
- We continue to provide a high-quality response for victims of Domestic Abuse, sexual violence and Honour Based Violence.
- The Health IDVA works in partnership with the Children Safeguarding Practitioner and specialist midwives where Domestic Violence and Abuse has been identified during pregnancy.
- 81 Domestic abuse cases were referred to the safeguarding team during this reporting period. 15 (18.5%) of these cases were referred to MARAC or other community support agencies.
- During this reporting period 2 cases of female genital mutilation were identified and reported by the midwifery service as per national guidance.
- The Health IDVA works in partnership with the trust Dementia team and Safeguarding Adult practitioners in cases where it is identified that dementia is a lead factor in some domestic abuse cases. Within the organisation we have noted an increase in the number of elderly patients disclosing domestic abuse due to the behavioural changes occurring in their partners / carers as a result of Dementia and other medical changes.
- The Safeguarding team actively responded to serious case reviews and section 42 requests where safeguarding concerns have been identified. In this reporting period we have participated in 3 section 42 reviews in respect of patient from Somerset and Dorset when safeguarding concerns have been raised to the organisation.
- We ensure that learning from reviews are published and shared with staff.

Making Safeguarding Personal

- The Learning Disability Practitioner continues to develop and maintain links with carers and community agencies.
- 149 referrals for patients with learning disabilities were received by the Learning Disability Practitioner during the reporting period.
- The practitioner has become an integral part of pre admission processes for patients with learning disabilities who require reassurance and reasonable adjustments being made to accommodate their needs for any inpatient / outpatient processes.
- All members of the team encourage staff members to 'listen to the patients voice' and document the patient's wishes and feelings in respect of their care needs and future planning
- Mental capacity assessment process has been embedded in practice and this has been further strengthened through the appointment of the Mental Capacity / DOLs lead. In this reporting period a total of 414 DOLs application were made from this trust to Somerset and Dorset local authorities
- We continually review the YDH safeguarding training programme to provide a more integrated approach to safeguarding awareness and making it personal for the vulnerable individual.

Think Family

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

Golden Lane Housing

- In the spring of 2019, Golden Lane Housing launched its approach to safeguarding – 'It Matters!' The approach was designed to ensure that tenants continue to understand the role that we play as their

landlord in helping to keep them safe and to further embed our open and honest culture where staff are encouraged to speak out about their concerns. Alongside IT Matters, Golden Lane Housing launched an e-campaign which gave tenants an opportunity to take part in social media and talk about the importance of keeping safe, a vital message that reached many more people with a learning disability.

- Following the implementation of outcome focused Key Performance Indicators (KPIs) in June 2019, which specifically looked at recording tenants' ability to be involved and achieve the outcomes they wish, the results continue to help shape the way we work with tenants during the safeguarding process. We use this information to help formulate our ongoing tenancy management support to tenants post safeguarding concerns, providing a more be-spoke and pragmatic approach.
- Golden Lane Housing have successfully delivered 5 safeguarding training sessions aimed at all GLH staff, including our executive team, to help raise awareness of the approach we take and the processes we follow in helping to keep our tenants safe from abuse.
- Golden Lane Housing have consulted with The Charity Commission in order to confidently identify incidents that are required to be reported to The Charity Commission and those that should be dealt with by the Local Authority Safeguarding teams. The Reporting of Serious Incidents Procedure has been amended to offer additional guidance to GLH's executive team in identifying such incidents.
- During financial year 2019/20 Golden Lane Housing's staff have raised a total of 50 safeguarding alerts across 22 different local authority areas. The two largest categories of abuse continue to reflect emotional abuse and self-neglect concerns, a steady trend regularly reported throughout the last financial year. The majority of emotional abuse cases were due to incompatibility issues between tenants living in shared properties. The remaining cases related 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, where tenants are perpetrators of abuse towards support staff. We recorded two cases relating to alleged abuse within a domestic setting.
- Golden Lane Housing promoted National Safeguarding Adults Week on 18th November 2019 and embraced this opportunity to launch the second phase of our safeguarding approach – It Matters. This was aimed at local authority

commissioning colleagues to provide them with a greater understanding of the role that we undertake as a supported landlord and clearly outlined the service that tenants can expect to receive from us should they have a safeguarding concern. Over 230 letters, safeguarding materials and emails were sent to Directors, Commissioning Managers and Social Workers at every local authority we work with.

Somerset Partnership NHS Foundation Trust

- **We have worked with Taunton and Somerset Foundation NHS Trust** to bring together our respective safeguarding services. This new Integrated Safeguarding Service has amalgamated both adult and children's safeguarding across both organisations to create one seamless Safeguarding Service. This Safeguarding Service is supported by a staff structure that encompasses a wide range of experience, skills and backgrounds, which has greatly improved the safeguarding support service that we offer to all Trust staff across both trusts. This service embraces the Think Family approach through the provision of a core Safeguarding duty team service whereby safeguarding professionals are trained to provide advice and support across the lifespan, considering the wider impact of the abuse on wider family / carer networks incorporating contextual safeguarding approaches. The duty team are able to provide a single point of advice to staff an all elements of both adult and child related safeguarding concerns.
- **Impact of service:** Throughout the year we have supported staff with 2850 internal safeguarding alerts and referrals covering all elements of safeguarding adults related work.
- **Safeguarding Training:** As part of our work with Taunton and Somerset, we have developed a co-ordinated approach to training, expanding our current training structure throughout TST so that training provision is consistent across both organisations. Funding has been approved for the creation of a new Learning and Development Lead within the Safeguarding service who will be in post from April 2020 to support further development in this area.
- **The merger of the two trusts former safeguarding teams** has enabled the implementation of the innovative integrated Safeguarding service with generic duty team, incorporating the Think Family approach, has been in place since

October 2018. The Director of Safeguarding has presented this progressive, collaborative way of working at a number of national and regional events.

- **Implementation of Safeguarding Team Supervision:** we have continued with the roll out of quarterly team safeguarding supervision to key frontline services this year and anticipate further expansion of this provision in the next financial year. This compliments the revised training package now provides to all Trust staff and enables discussion and learning from ongoing cases plus feedback on local / national trends in relation to all aspects of Safeguarding Adults.
- **The MCA/DoLS and Consent Lead** has continued to expand the provision of Mental Capacity Act training in line with the Somerset Safeguarding Adults Board Mental Capacity Act Competency Framework. We continue to work towards developing MCA awareness and competencies throughout the Trust. Preparation work is underway for the implementation of the Liberty Protection Safeguards anticipated for implementation in October 2020.
- **The Domestic Abuse Co-ordinator** post sits within the integrated Safeguarding service and has been leading on the work relating to Domestic Abuse Link workers across the organisation, raising the profile of domestic abuse across all frontline services and improving the organisation response to Domestic Abuse.
- **We participated in and completed work on the Domestic Abuse Pathfinder Project.** The Project provided the funding of two posts within the Somerset Health sector for the 12 months (April 2019-March 2020). These posts were recruited to in April 2019 and consisted of a Complex Needs Independence Domestic Violence Provider (IDVA- employed and working within TST) and a Pathfinder Project Lead (employed and working within CCG). Work was undertaken to support those most vulnerable experiencing domestic abuse, had mental health concerns and other factors which reduced their ability to engage with services designed to support victims of domestic abuse.
- **We continue to be an active member of the Somerset Multi-Agency Risk Assessment Conference (**MARAC). As well as regular attendance, we have also been involved in ongoing the multi-agency development of the process most recently adapting to accommodate working restrictions imposed as a result of the COVID19 pandemic.
- **We continue to play an active role on the Somerset Safeguarding Adults Board**. This has included membership of the Board and a number of the Boards sub-groups.

- **We have continued to participate in S42 enquiries, Safeguarding Adult Reviews and Domestic Homicide Reviews** as required, the learning from which we disseminate to Trust staff vis Trust newsletter, Safeguarding team supervision and through integration into all levels of the newly revised training programme.
- **The Joint Safeguarding Committee** (new Governance arrangements) replaced the previous Safeguarding Governance Groups for Taunton & Somerset and Somerset Partnership in June 2018. The Joint Safeguarding Committee holds us to account with regards to our duties and responsibilities regarding all areas of Safeguarding including our Safeguarding Plan, Policy review and development, and ensures that we are compliant with SSAB policy, learning and guidance.
- **Our collaborative working with external Safeguarding Agencies** has increased since the integration of the two Safeguarding teams. Through the Integrated Safeguarding Service we are able to be an active member of the weekly adult MASH meetings held between ourselves, Adult Social Care and the Police.
- **We have continued close collaborative working** with external agencies such as the Police, Somerset County Council safeguarding colleagues and the CCG.
- **We have revised the Safeguarding Adults at Risk Policy** for Sompar and Taunton and Somerset Trusts and have unified and updated them in to one overarching Policy for both Trusts. This will ensure continuity of Safeguarding Adult processes, practices, guidance and advice.
- **We have introduced a new policy Supporting colleagues who experience Domestic Violence** which ensures the Trust fulfils its statutory duties and has a procedure in place on how to respond to reported incidents or allegations of domestic violence and abuse involving a colleague or volunteer, whether perpetrator or victim.

Devon & Somerset Fire and Rescue Service

- Devon & Somerset Fire & Rescue Service's (DSFRS) Safeguarding Team's main area of work focusses on the safeguarding of adults and children at risk whom our staff encounter out in the community whilst undertaking their duties. This could include those whose behaviours pose a

fire risk in the home, those experiencing abuse or neglect, or those who are in need of extra support in their daily lives, to name a few.

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

Discovery

- As part of the Dimensions Group, Discovery is committed to the Making Safeguarding Personal Outcomes Framework. All colleagues are aware of the requirement to engage with people we support when a safeguarding concern has been raised; seeking their views and wishes and to be listened to throughout the process. Information is available in alternative formats to support people's understanding of the process.
- The organisation endeavours to utilise feedback from people we support in any way possible. We are committed to engaging with people we support and their representative at the earliest opportunity and to keep them central to and included in the process. This is captured on our Safeguarding Register.
- In order to improve how we capture safeguarding concerns and referrals to the Local Authority, Discovery has recruited a Safeguarding Officer whose primary role is overseeing the safeguarding registers which makes it easier to identify trends and any increase in safeguarding incidents at any particular home. This also gives colleagues a separate point of contact if they do not feel comfortable speaking with someone at the home they work at.
- We have established proactive and valued links with the Local Authority Safeguarding Team.
- Our internal A&I reporting system ensures all incidents, including safeguarding concerns are reported and acted on. Within this system, relevant business support teams can be notified of an incident immediately i.e. Health and Safety, Behaviour support.
- Our safeguarding process highlights the importance of capturing desired outcomes of incidents, duty of candour, whether the person wishes to make a complaint etc. which ensures we are adhering to the Care Act and Making Safeguarding Personal.
- During Covid-19 Government restrictions, our induction of new starters continues on a virtual platform. Minimum requirement that all new starters complete Care Certificate Standards and Licence to Operate (LTO) modules before starting their role. All colleagues are required to complete mandatory training which includes an on-line learning module on Safeguarding Adults which is pitched at level 3. Our Safeguarding Officer has been involved in the delivery of a virtual Safeguarding module to supplement online safeguarding course.

- We encourage an open, honest and transparent culture and welcome feedback from colleagues to ensure we are continuously improving.
- Safeguarding questions have been added to our exit interviews; the process of capturing feedback from colleagues leaving Discovery about any concerns they have about the safety and welfare of people they supported.
- We are undertaking specific work with a greater emphasis on looking at and capturing incompatibility issues and recognise how this can impact on people's behaviour and reactions to people with whom they share accommodation or services. We recognise that incompatibility (of people who share a service, who attend the same services or the impact of the people's environment) can lead to an increase in safeguarding concerns being raised. WE are aware that for some of the people we support, the current Government restrictions as a result of Covid-19 has had a direct impact and we are continuing to support people who are particularly vulnerable at this time and recognise the need for increased awareness during the current situation.
- Our independently chaired Safeguarding panel has been set up to oversee our Safeguarding Strategy and Business Plan and to monitor and review performance against the identified measures and Key Performance Indicators. This includes:
    - Systems and processes, including training, policy requirements and legal responsibilities
    - Safeguarding register monitoring
    - Lessons learnt – sharing information where appropriate and making recommendations.
    - Human Resource practice in relation to safeguarding matters
    - Additionally, the records of the panel are reported to the Discovery Board

  Furthermore, the panel advises on organisational related risks and monitors Deprivation of Liberty Safeguards (DoLS) and physical interventions.
- Our Safeguarding Policy's purpose is to ensure that all people we support are safeguarded as far as possible from all forms of abuse. It also aims to ensure that employees understand what to do when they become aware or suspect that somebody we support has been abused. This policy promotes equality, diversity and human rights by considering that

vulnerable people are more likely to fall victim to abuse than the majority of people, and directing Discovery employees to:

  - Be vigilant for and take action against all such incidence whatever the person's age, gender, ethnicity, faith, disability, sexual orientation, marital status and whether pregnant; and
  - consider discrimination on grounds of age, gender, ethnicity, faith, disability, sexual orientation, marital status or pregnancy as abuse.

- We place great importance in transparency and sharing the learning from our work, to assist others, this includes feedback from our annual safeguarding summit and Never Event protocols.
- Our values are embedded in the organisation; Courage being one. We are committed to developing and maintaining an open and inclusive culture which values and respects difference to enable us to reach shared goals. This includes the commitment to appropriately challenge each other, other professionals to ensure positive outcomes.
- In Discovery, we have had experience of the impact of criminal exploitation on a number of people we support; concerns were immediately addressed. Discovery endeavour to ensure people we support are safeguarded against being drawn into major crime and take immediate, appropriate action when alerted to any concerns. We have developed a link with the Serious & Organised Crime Community Co-ordinator to support proactive work in Discovery regarding Criminal Exploitation of Vulnerable Adults/County Lines with guidance developed to raise awareness across Discovery, with people we support and families. A presentation was given to the Dimensions Safeguarding Panel at the end of last year with a Discovery case study presented.
- Discovery produced guidance for colleagues which was adopted across the Dimensions Group - Criminal Exploitation of Vulnerable Adults
- Our Safeguarding Policy was updated in May 2020 to include criminal exploitation of vulnerable adults.

- The Quality & Compliance Reviewers who carry out periodic audits in our services have access to the Safeguarding Registers and make judgements about areas to audit during review visits based on intelligence gathered, including safeguarding.

The Care Quality Commission

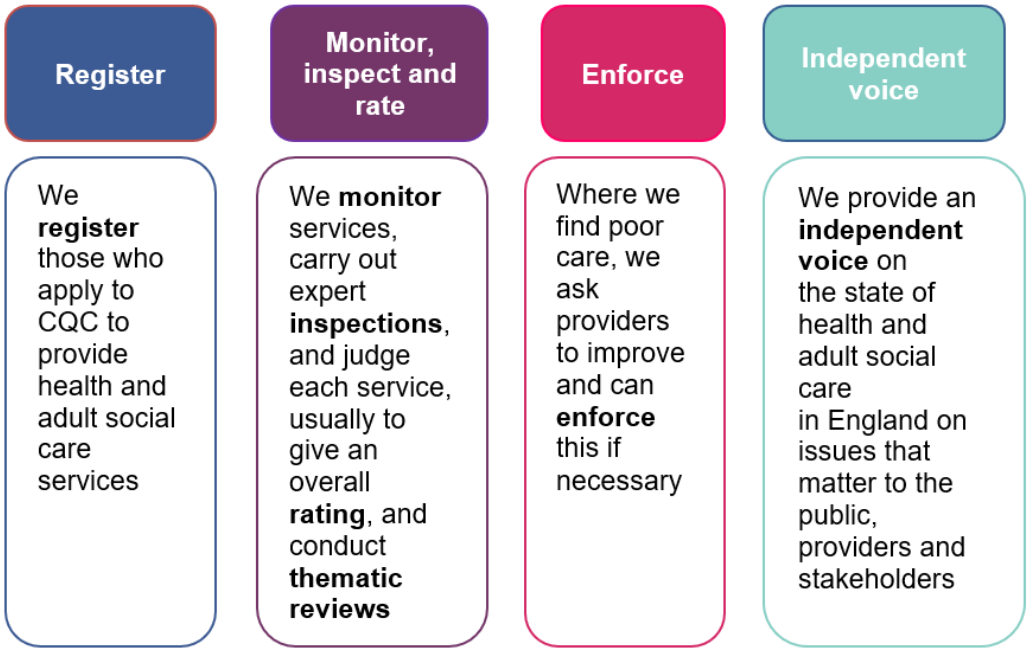
Our purpose and role

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

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

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

Our current model of regulation



Four priorities to achieve our strategic ambition

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

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

CQC State of Care Report 2018/19

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

This year's report finds that most of the care that we see across England is good quality and, overall, the quality is improving slightly. But people do not always have good experiences of care and they have told us about the difficulties they face in trying to get care and support. Sometimes people don't get the care they need until it's too late and things have seriously worsened for them.

This struggle to access care can affect anyone.

Too many people find it hard to even get appointments, but the lack of access is especially worrying when it affects people who are less able to speak up for themselves – such as children and young people with mental health problems or people with a learning disability. Too often, people must chase around different care services even to access basic support. In the worst cases, people end up in crisis or with the wrong kind of care.

A copy of the report can be found by visiting the CQC website; https://www.cqc.org.uk/publications/major-report/state-care

CQC's role and responsibilities in safeguarding

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

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

Our role and responsibilities are:

To monitor, inspect and regulate services to make sure they meet the fundamental standards of quality and safety. For safeguarding, we will do this by:

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

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

Somerset – CQC Sector data

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

Source: CQC database as at 31 May 2020.

Number of active registered locations in Somerset

Location Inspection Directorate	Number of Active Locations
Adult social care	295
Hospitals	47
Primary medical services	161
Total	**516**

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

	Number of Active Locations with Latest Overall Ratings				Total Number of Active Locations with Latest Overall Rating
Location Inspectorate	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**	
Somerset					
Adult social care	14	233	34	1	**282**
Hospitals	1	6	3		**10**
Primary medical services	1	62	3		**66**
Somerset Total	**16**	**301**	**40**	**1**	**353**
South West					

Adult social care	158	1,762	237	20	**2,177**
Hospitals	9	71	26		**106**
Primary medical services	31	431	18	5	**485**
South West Total	**198**	**2,264**	**281**	**25**	**2,768**
National					
Adult social care	1,090	18,739	3,455	271	**23,553**
Hospitals	175	1,186	311	42	**1,714**
Primary medical services	347	6,561	344	90	**7,342**
National Total	**1,612**	**26,486**	**4,110**	**403**	**32,609**

CQC Regulatory action in Somerset

Location Inspection Directorate	Recommend Fixed Penalty	Requirement notice	Vary a condition	Warning notice	Total Number of Active Locations with published Regulatory Actions
Adult social care	2	29	1	2	**31**
Hospitals		2			**2**
Primary medical services		5		2	**6**
Total	**2**	**36**	**1**	**4**	**39**

Please note that some locations may have more than one regulatory action, and the figures above may therefore not add up consistently.

District Councils

- We have seen a new cohort of councillors join us this year and have worked with them to help them understand their role in the community and what they can do to help safeguard adults who may be vulnerable. Many of them have come with little experience of safeguarding and they have been determined to understand the issues and where they can support.
- We recognise that the safeguarding environment is continually evolving and as a consequence we have continued to review our safeguarding policies and, where appropriate, updated them to address new issues as they arise. We have continued to provide regular training to our staff and elected members to keep them up to date in their understanding of safeguarding matters and their duties. We have used the 'Champions' model to build capacity in our organisations and provide contact points for staff who have safeguarding concerns, as well as giving focused training to teams on key subjects. We have 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 have developed our One Team models on further over this year to build on the strong partnership working that has been taking place. This collaboration has helped us build resilience and capacity into our systems of support to safeguard vulnerable people. The model enables us to identify quick and appropriate interventions, share appropriate information where safeguarding is a concern and act in the best interest of those concerned. Critical to the strength of the model is the variation of its application across different parts of the county to ensure that local circumstances and demographics are accommodated to ensure best outcomes.
- We have continued to work with partners to deliver the Positive Lives Programme to support vulnerable adults with complex needs to gain stable, safe accommodation. As part of this we have also worked with rough sleepers across the

county to understand their circumstances, vulnerabilities and safeguarding issues, with the aim of supporting them into suitable, safe and stable accommodation.

- We have continued to develop our strong relationship with our registered social housing providers, using a forum to enable them to meet and share safeguarding concerns with us. We have also used this forum to update the providers on safeguarding matters, provide training and share best practice.
- 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 worked with Avon and Somerset Constabulary to address the safeguarding of vulnerable adults from criminal gangs and their activities. We recognise the impact of Cuckooing and County Lines in our neighbourhoods and are working with partners to address the impact of these on vulnerable people in the county. We have continued to support the PREVENT agenda to help stop vulnerable adults from being drawn into terrorism and harm.
- 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.

Are you worried about someone?

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

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

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

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