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Somerset Health and Wellbeing Board

Thursday 23 November 2017
11.00 am Luttrell Room - County Hall, Taunton

To: The Members of the Somerset Health and Wellbeing Board

Councillor Christine Lawrence (Chairman)
Councillor Frances Nicholson (Vice-Chairman)
Councillor David Huxtable
Councillor Linda Vijeh
Councillor Amanda Broom
Councillor Sylvia Seal, South Somerset District Council
Councillor Gill Slocombe, Sedgemoor District Council
Councillor Jane Warmington, Taunton Deane Borough Council
Councillor Keith Turner, West Somerset District Council
Councillor Nigel Woollcombe-Adams, Mendip District Council
Nick Robinson, Clinical Commissioning Group
Dr Ed Ford, Clinical Commissioning Group (Vice-Chairman)
Mr Mark Cooke, NHS England
Judith Goodchild, HealthWatch
Stephen Chandler
Trudi Grant
Julian Wooster

Issued By Julian Gale, Strategic Manager - Governance and Risk - 15 November 2017

For further information about the meeting, please contact Julia Jones or 01823 359027 jjones@somerset.gov.uk

Guidance about procedures at the meeting follows the printed agenda.

This meeting will be open to the public and press, subject to the passing of any resolution under Regulation 4 of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

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AGENDA

Item Somerset Health and Wellbeing Board - 11.00 am Thursday 23 November 2017

*** Public Guidance notes contained in agenda annexe ***

1 **Apologies for absence**

To receive Board Members' apologies

2 **Declarations of Interest**

3 **Minutes from the meeting held on 28 September 2017** (Pages 5 - 8)

The Board is asked to confirm the minutes are accurate**.**

4 **Public Question Time**

The Chairman will allow members of the public to ask a question or make a statement about any matter on the agenda for this meeting.

5 **Safer Somerset Partnership Annual Report** (Pages 9 - 34)

To consider the report

6 **Somerset Safeguarding Adults Board Annual Report 2016-17** (Pages 35 - 84)

To consider the report

7 **Somerset Safeguarding Children's Board Annual Report 2016-17**

To consider the report
Item now deferred

8 **Annual Report of the Director of Public Health** (Pages 85 - 136)

To consider the report

9 **Annual Health Protection Assurance Report** (Pages 137 - 158)

To consider the report

10 **Somerset Health and Wellbeing Board Forward Plan** (Pages 159 - 160)

To discuss any items for the work programme. To assist the discussion, attached is the Board's current work programme.

11 **Any other urgent items of business**

The Chairman may raise any items of urgent business.

Guidance notes for the meeting

1. **Inspection of Papers**
Any person wishing to inspect Minutes, reports, or the background papers for any item on the Agenda should contact the Board's Administrator Julia Jones. Telephone: (01823) 359040 or email jjones@somerset.gov.uk . They can also be accessed via the council's website on **www.somerset.gov.uk/agendasandpapers**

2. **Minutes of the Meeting**
Details of the issues discussed and recommendations made at the meeting will be set out in the Minutes, which the Board will be asked to approve as a correct record at its next meeting. In the meantime, information about each meeting can be obtained from Julia Jones. Telephone: (01823) 359027 or email jjones@somerset.gov.uk

3. **Public Question Time**

If you wish to speak, please tell Julia Jones, the Board's Clerk, by 12 noon the (working) day before the meeting - (01823) 359027 or email jjones@somerset.gov.uk

At the Chairman's invitation you may ask questions and/or make statements or comments about any matter on the Board's agenda – providing you have given the required notice. You may also present a petition on any matter within the Board's remit. The length of public question time will be no more than 30 minutes in total.

A slot for Public Question Time is set aside near the beginning of the meeting, after the minutes of the previous meeting have been signed. However, questions or statements about any matter on the Agenda for this meeting may be taken at the time when each matter is considered.

You must direct your questions and comments through the Chairman. You may not take direct part in the debate. The Chairman will decide when public participation is to finish.

If there are many people present at the meeting for one particular item, the Chairman may adjourn the meeting to allow views to be expressed more freely. If an item on the Agenda is contentious, with a large number of people attending the meeting, a representative should be nominated to present the views of a group.

An issue will not be deferred just because you cannot be present for the meeting. Remember that the amount of time you speak will be restricted, normally to two minutes only.

4. **Exclusion of Press & Public**

If when considering an item on the Agenda, the Board may consider it appropriate to pass a resolution under Section 100A (4) Schedule 12A of the Local Government Act 1972 that the press and public be excluded from the meeting on the basis that if they were present during the business to be transacted there would be a likelihood of disclosure of exempt information, as defined under the terms of the Act.

5. **Committee Rooms & Council Chamber and hearing aid users**

To assist hearing aid users the following Committee meeting rooms have infra-red audio transmission systems (Luttrell room, Wyndham room, Hobhouse room). To use this facility we need to provide a small personal receiver that will work with a hearing aid set to the T position. Please request a personal receiver from the Board's Administrator and return it at the end of the meeting.

6. **Recording of Meetings**

The Council supports the principles of openness and transparency, it allows filming, recording and taking photographs at its meetings that are open to the public providing it is done in a non-disruptive manner. Members of the public may use Facebook and Twitter or other forms of social media to report on proceedings and a designated area will be provided for anyone who wishing to film part or all of the proceedings. No filming or recording will take place when the press and public are excluded for that part of the meeting. As a matter of courtesy to the public, anyone wishing to film or record proceedings is asked to provide reasonable notice to the Council's Monitoring Officer (Julian Gale on 01823 359047) so that the Chairman of the meeting can inform those present.

We would ask that, as far as possible, members of the public aren't filmed unless they are playing an active role such as speaking within a meeting and there may be occasions when speaking members of the public request not to be filmed.

The Council will be undertaking audio recording of some of its meetings in County Hall as part of its investigation into a business case for the recording and potential webcasting of meetings in the future.

A copy of the Council's Recording of Meetings Protocol should be on display at the meeting for inspection, alternatively contact the Committee Administrator for the meeting in advance.

THE HEALTH AND WELLBEING BOARD

Minutes of a meeting of the Health and Wellbeing Board held in the Luttrell Room, County Hall, Taunton on Thursday 28 September 2017 at 11.00am

Present: Cllr C Lawrence (Chairman), Cllr D Huxtable, Cllr L Vijeh, Cllr A Broom, Cllr N Woollcombe-Adams, Cllr S Seal, Cllr G Slocombe, Cllr J Warmington, Cllr K Turner, Dr Ed Ford, S Chandler, T Grant, N Robison, M Cooke

Other Members present: Cllr T Munt

Apologies for absence: Cllr F Nicholson (Vice-Chairman), J Goodchild and J Wooster

283 **Declarations of Interest** - Agenda Item 2

None

284 **Public Question Time**

There were no public questions.

285 **Better Care Fund Plan 2017-19** – agenda item 5

The Director for Adult Social Care, Stephen Chandler, introduced the report about the Better Care Fund aimed at supporting the integration of health and social care. He explained that both the Council and the Clinical Commissioning Group had progressed the plan and it was submitted to NHS England on 11 September 2017 in line with the assurance timeline. Feedback had been received that the plan was clear and had met the national criteria to progress through the assurance process.

Discussion points raised included:

- The Home First service went live on 4 September and there would be an update on how well this was performing at a later date.
- There were early suggestions that the BCF plan would get approval.
- Home First scheme was working well but delayed transfers of care still needed careful monitoring
- Mr Chandler encouraged members to inform him of both good and bad points about the new service

The Somerset Health and Wellbeing Board received the report for information and noted:

- **the Better Care Fund (BCF) plan had been signed off by the Chair of the Health and Wellbeing Board on behalf of the Health Wellbeing Board**
- **the agreed BCF plan has been submitted to NHS England**
- **the next stage of the BCF assurance process as set out**
- **The board's role in monitoring the progression and implementation of the BCF plan 2017/19.**

The Health and Wellbeing Board took note of the recommendation of the auditors with regard to updating the Boards constitution and took the decision to progress this.

286 **Healthwatch Annual Report** – Agenda Item 5

Morgan Daly from Healthwatch Somerset introduced the annual report which updated on progress and achievements during the past year. It had been a year of change, development and challenge across health and social care. Changes included the early supported discharge for stroke patients which Healthwatch had previously helped to evaluate.

Points highlighted in the discussion included:

- Healthwatch had formally supported the proposal to create a university in the County
- There had been close working with Somerset Rural Youth Project to empower young residents to have a say about a wide range of important health and social care issues
- A range of different people had been spoken to for their views and included residents in care homes
- Residents showed little appetite for visiting unfamiliar GP practices or seeing a professional who was not a GP, however the majority would favour contact with a nurse in the event of a GP being unavailable
- Volunteers had taken a close look at mental health inpatient services which had resulted in recommendations which are being used to monitor the quality of mental health services for local people
- More than 10,000 people had been reached on social media which had helped to bring in younger volunteers

The Chair thanked Healthwatch for all the work that had been undertaken.

It was noted that there was a new provider for Healthwatch and it was agreed a formal letter of thanks should be sent to the previous provider.

The Somerset Health and Wellbeing Board formally acknowledged the annual report.

287 **Joint Strategic Needs Assessment (JSNA) 2018 and Health and Wellbeing Strategy** – Agenda item 7

Public Health Specialist Pip Tucker introduced this item and explained that the JSNA for 2018 was currently under preparation following endorsement from the Health and Wellbeing Executive on 6th September. The production of an updated Health and Wellbeing Strategy will be informed by evidence gathered from Somerset JSNAs.

Points raised in the debate included:

- There would be consideration of broad areas of health and care information such as inequalities, deprivation, housing, vulnerable young people, mental health, transport and planning.

- Housing and Mental Health were seen as a critical areas to look at
- The importance of lining up emerging timescales and processes to help with prioritisation
- Conversations between partner organisations were crucial
- Consideration for areas of high need and healthy living centres
- It was suggested that a place based theme but looking at people within the place could be best approach
- The information gathered was usually for county level but it could also be done at district level

Officers were thanked for their work so far on this and it was agreed to inform members of the date of the Health and Wellbeing conference, where this subject would be discussed further, when this was known.

The Somerset Health and Wellbeing Board agreed the direction of the JSNA to support the production of the new Health and Wellbeing Strategy.

288 **Children and Young Peoples Plan update –** Agenda Item 8

Report author Fiona Phur presented the report which reported on progress of year 1 of the Children and Young People's Plan (CYPP) 2016-19. This included information of each of the 7 improvement programmes which are designed to improve outcomes for vulnerable children and their families.

Further information highlighted from the report included:

- More information and training was being delivered across the workforce and partners
- Systems and processes were improving
- There was quarterly reporting to the Children's Trust Executive
- There remained much to do and the focus was on delivering the CYPP over the next two years.

Further discussion on this item included:

- Amendments were suggested for both the report and the CYPP dashboard to make it clearer for the next update
- Whether progress was county wide or if there were certain areas with problems
- Members were informed that although there was different results for different issues – no area was glaringly behind the others
- Monitoring visits appeared to indicate that improvements had taken place
- The emotional health and wellbeing of children
- The current consultation taking place regarding Children's Centres

The Somerset Health and Wellbeing Board acknowledged the significant work that had been undertaken to date.

289 **Somerset Health and Wellbeing Board Forward Plan 2016/17**

The Board considered and noted the Forward Plan.

The meeting finished at 12.38pm.

Chair
Health and Wellbeing Board

Somerset Health and Wellbeing Board

23rd November 2017

Safer Somerset Partnership: Annual Report Summary

Lead Officer: Liz Spencer, National Probation Service, Chair of the Safer Somerset Partnership
Author: Lucy Macready Public Health Specialist Community Safety
Contact Details: 01823 359146

Report Sign off	**Seen by:**	**Name**	**Date**
	Relevant Senior Manager / Lead Officer	Trudi Grant	13.11.17
	Cabinet Member	Christine Lawrence	13.11.17
	Monitoring Officer (Somerset County Council)	Julian Gale	14.11.17
Summary:	Each year, similar to the other strategic partnerships in Somerset, the Safer Somerset Partnership produces an Annual Report designed to raise understanding and awareness of the Partnership, its progress and key activities over the past year. It also includes an overview of future priorities and funding allocations which is detailed further in appendix A. In 2016/17 key activities and achievements included are: One Teams, County lines and Organised Crime Groups, Modern Slavery, Somerset Drug and Alcohol Partnership progress, Hidden Harm and Domestic abuse. The report also summarises how the Partnership has responded to key events including Counter Terrorism, the fire at Grenfell Tower and the Hinkley Point C project. The full safer Somerset Partnership Annual Report is available at www.somerset.gov.uk/ssp		
Recommendations:	**That the Somerset Health and Wellbeing Board agrees and endorses the Safer Somerset Partnership Annual Report 2017 (shown at Appendix B)**		
Links to Somerset Health and Wellbeing Strategy	Some groups and communities systematically experience poorer health than others. These are, in the main, often the same group who experience victimisation or are prone to offending. The Community Safety agenda overlaps with Health and Wellbeing work streams but in particular, theme 2 of the Somerset Health and Wellbeing Strategy - *Families and communities are thriving and resilient.*		

Financial, Legal and HR Implications:	There are no financial, legal or HR implications arising from this report
Equalities Implications:	Equalities Impact Assessments are carried on specific pieces of work that relate to services and our communities, however, no assessment has been conducted in relation to providing the Board with this report.
Risk Assessment:	N/A

1. Background

1.1 This report summarises the report, paying attention to subjects pertinent to the Health and Wellbeing Board's agenda.

1.2 The Safer Somerset Partnership was developed in 2011/12 as a single county wide partnership for delivering duties under the Crime and Disorder Act (1998).

1.3 The purpose of the Partnership is to provide strategic direction, leadership and improve the effectiveness of the delivery of Community Safety in Somerset, make effective links to other strategic partnerships and deliver against its statutory duties.

1.4 The Partnership's structure is outlined in background paper 1, with thematic priorities delivered by designated sub groups. There are also crime types that are better dealt with on a wider, Avon and Somerset level.

1.5 The Partnership has a range of statutory duties which are detailed in background paper 1, the Annual Report.

- Community Safety Strategic Assessment
- Community Safety Plan
- Annual Community Safety Scrutiny Committee
- Domestic Homicide Reviews
- Reducing Reoffending

1.6 The Partnership's activities and achievements 2016/17

One Teams
In early 2017, the Safer Somerset Partnership agreed to provide County wide strategic leadership and oversight (not governance) of the One Teams in Somerset. There are now One Teams covering 12 of the most deprived communities in Somerset, including three new teams being established in Williton/Minehead, Hamp and Burnham. All of the One Teams have the same shared vision *"To work in Somerset's most vulnerable communities and provide co-ordinated front-line multi-agency working to efficiently provide sustainable solutions for families and individuals that prevent problems escalating and costs increasing to the public sector."*

The One Team model continues to evolve and will become more refined with the help of the new coordinator who is tasked with improving standards for working between 2017 and 2020.

County lines and Organised Crime Groups
County lines activity typically involves gangs from large urban areas travelling to smaller locations (such as a county town) to sell Class A drugs, with a degree of sophistication, utilising remote call centres and networks to make it difficult for public agencies to detect.

County lines gangs pose a significant threat to vulnerable adults and children, upon whom they rely to conduct and/or facilitate the criminality. 'Cuckooing' residents, using their homes to run their business is a common feature. Exposure to gang exploitation has the potential to generate emotional and physical harm.

In the summer of 2017, for the first time, police colleagues met with local partner agencies to consider how not only to disrupt the groups from causing harm in Somerset but also, how the crime is prevented in the longer term.

Also persisting in Somerset, is the impact of Organised Crime Groups; people working together on a continuing basis for a particular criminal activity/ies. Police teams are now sharing local Serious and Organised Crime Profiles with the Partnership and are supporting the development of a mechanism by which local agencies can together, tackle these types of criminals in the form of a multi-agency Somerset Disruption Panel.

Modern Slavery
This is a cross cutting agenda for a number of strategic partnerships in Somerset with the Safer Somerset Partnership providing a leadership role. It is often linked to Organised Crime Groups (OCGs) and cuts across the Partnership's activity for disruption serious and organised crime.

The Modern Slavery Act 2015 contains 2 main modern slavery offences, punishable by up to life imprisonment:
1. Slavery, servitude and forced or compulsory labour
2. Human trafficking

Types of Modern slavery include:
- Sexual Exploitation
- Domestic Servitude
- Forced Labour
- Debt Bondage
- Organ Harvesting
- Criminal Exploitation
- Child Trafficking

In the past year, as part of the Avon and Somerset Anti-Slavery Partnership, work has taken place to improve the profiling of modern slavery across Somerset and consider the strategic direction which includes a focus on prevention activity.

Somerset took part in the Modern Slavery National Referral Mechanism pilot project for improving the way that potential victims of modern slavery were identified and referred for support. Trained staff continue to provide this referral service.

Somerset Drug and Alcohol Partnership
This year we were pleased to see the performance of our specialist services improve quarter after quarter, finishing the year as one of the best performing in the country in terms of getting people into treatment and onto recovery. Congratulations must go to all the staff, peer mentors, service users and their friends and families who have worked so hard to make Somerset a 'recovery county'.

Targeted work with young people and protecting children from the harms of adult substance use continue to be very high priorities and the Somerset Drug and Alcohol Partnership is committed to a 'think family' approach which focused not only on the adults issues, but on the impact on children who may be exposed to this.

During the coming year the partnership will continue to progress work started this year on the impacts of mental health and substance use, as well as the impacts of substance use within offending. Commissioners within the partnership will also be engaged in the re commissioning of specialist Drug and Alcohol Services as the current contract draws to an end. Intelligence gathering and engagement has been undertaken and procurement will take place over the next eighteen months with a new service in place by April 2019.

Domestic abuse
During 2016/17 a great deal of work has been undertaken to improve the quality of the domestic abuse system across Somerset. The Partnership redesigned its Somerset Domestic Abuse Board, with new membership and fresh direction with the primary aim of providing quality assurance across the system and with help from the Somerset public Health team, works to a specially designed score card.

A key activity of the Board has been to review Somerset's Multi-agency Risk Assessment Conferences (MARAC) to help embed the MARAC principles in to existing safeguarding practices in order to create a system that is more child and family centred.

Hidden Harm
A report produced by Somerset County Council Public health, defined hidden harm as the actual and potential effects of parental substance misuse (drugs and alcohol), domestic abuse and mental health issues on dependent children. The aim when considering Hidden Harm is to 'intervene early with vulnerable children and young people in order to improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. It is anticipated that early intervention will bring benefits to the individual during childhood and into adulthood but also improve his or her capacity to parent'.

Treatment of substance misuse, domestic abuse and mental health involves a range of stakeholders and service providers at any one time. In complex cases the involvement in assessments of practitioners from different specialist services will result in a better understanding of how parental problems impact on family functioning and parenting capacity. Robust professional links, joint protocols and

procedures between children's and adults' services will help to ensure collaboration during assessments and service provision. The significant impact of the trio of domestic abuse, substance misuse and mental health on the health and wellbeing of children and families is well evidenced; and the need for effective joint working is crucial.

Domestic abuse, mental health and substance misuse specialist services have been running combined workshops with staff to enable to them to better work together to identify complex individuals with multiple needs, as early as possible and then support to identify children at risk as a result of this.

1.7 Reponses to key events

Counter Terrorism (Prevent)
The Partnership oversees the work of the Somerset Prevent Board and in turn, the Channel process in Somerset. Somerset County Council takes a leadership role in this work and reports on a quarterly basis.

Highlights of the report *Embedding Prevent in Somerset*, which audited the progress in all 'specified authorities' July 2017 include:

- 'specified' agencies have done extremely well in embedding their duties with only a small number of tasks left outstanding
- All agencies have cascaded and/or attended training on prevent. There are still more to train, but the means to achieve this are embedded and sustained.
- Almost every school in Somerset has completed training which is a great achievement. However, schools still feel they need support in this topic, particularly when needing to discuss radicalisation with children

From assessing Channel cases to date, it is clear that these individuals can have other vulnerabilities and in some cases, experience of receiving other services which may include social care. Work has been underway to improve the way that the Channel process aligns with safeguarding processes that are already in place, including the Multi-Agency Safeguarding Hub (MASH) to ensure that the client is supported in the most appropriate and timely way, whilst appropriately assessing and responding to their needs, vulnerabilities and risk.

Grenfell Tower
In the wake of the tragic fire at London's Grenfell Tower in June 2017, the Partnership requested an assurance briefing from Devon and Somerset Fire and Rescue Service, which stated:

- Fire safety legislation, (Regulatory Reform (Fire Safety) Order 2005), applies to a wide range of building occupancies; this includes the common areas of high rise residential premises.
- The responsibility for ensuring that the requirements of the above legislation are met lies with the building owners.
- Devon and Somerset Fire and Rescue Service (DSFRS) has a duty to enforce the Regulatory Reform (Fire Safety) Order 2005.
- DSFRS have a robust, fire safety inspection strategy to ensure that a suitable of level of compliance is achieved in all buildings (where the legislation applies), especially where the risk of loss of life is highest.
- In light of the fire at Grenfell Tower, in London, fire safety risk information held by DSFRS, has been reviewed for all known high rise premises in Devon and Somerset. Following this review, a bespoke risk based inspection programme

also commenced, with a view to confirming that the current status of the building, and to give assurance to residents
- The Service continues to carry out high rise exercises and multi-agency exercises to assist in training and preparation for similar incidents.

Hinkley Point C Project
The Somerset Hinkley Community Safety Group, facilitated by Sedgemoor District Council now meets each month, with a larger meeting every quarter to consider local impacts on community safety. This group involves EDF, local authorities, South West Ambulance Trust, police and the fire service. The Safer Somerset Partnership has asked for regular reports to keep up to date with progress and impacts.

1.8 Performance against priorities, new priorities and grant funding

Below is a list of priorities set for the Partnership between 2014 and 2017. Performance against these can be found in background paper 1.

- Improve links to other partnerships, interagency collaboration and understanding of services
- Prevent the escalation of violent crime and abuse by supporting victims and working with perpetrators
- Focus on targeted Anti-Social Behaviour
- Focusing on Families through Early Help
- Identify opportunities and approaches that Improve mental wellbeing and the emotional resilience of people in Somerset
- Break the cycle of offending/abuse through an engaged multi-agency response to targeted/identified groups

A new set of priorities have been approved for 2017-2020.

- Priority 1: Protect people from the Harm of Domestic and Sexual Abuse
- Priority 2: Identify and Prevent the Exploitation of Vulnerable People
- Priority 3: Identify and Support those with Inequalities and vulnerabilities, which can lead to poorer health outcomes and increased risk taking behaviours
- Priority 4: Meet our Statutory Duties [Reducing Reoffending and Domestic Homicide Reviews]

The Partnership has allocated a grant made available by the Avon and Somerset Police and Crime Commissioner against each of these. An overview of this allocation is available in Appendix A

2. Consultations undertaken

2.1. The Safer Somerset Partnership representatives were all consulted in the content of the Annual Report and given opportunity to amend and provide feedback on two separate occasions.

3. Background papers

3.1. Safer Somerset Partnership Annual Report 2017 (Appendix B)
Available at www.somerset.gov.uk/ssp

3.2. Safer Somerset Partnership Plan 2017-2020.
Available at www.somerset.gov.uk/ssp

Appendix A

Funded Services/projects aligned to Partnership Priority

The Avon and Somerset Police and Crime Commissioner allocated grant funding to be allocated the Partnership for the years 2017/18 – 2019/20. The table below illustrates how the chosen services and project align with this Plan's priorities.

Service/Project	Linked Priority
Positive Lives (previously Housing Support for Offenders – Complex Adults Design Group). This is a continuing project essential for supporting high risk of harm and high risk of reoffending offenders.	Priority 3: Identify and Support those with Inequalities and vulnerabilities, which can lead to poorer health outcomes and increased risk taking behaviors Priority 4: Meet our Statutory Duties [Reducing Reoffending and Domestic Homicide Reviews]
One Team Development projects Two-part project to 1. Assist the Safer Somerset Partnership in quality assurance of One Teams 2. Embed consistency of standards where required whilst ensuring the continuation of locally led teams 3. Assist the Mendip team transform from a 'virtual' to a face to face meeting structure by adding some coordination resource	All priorities
Vulnerability Pathways – systems review A one off system review, independently chaired, designed to consider the various vulnerability pathways in Somerset and assess areas for change and improvement. Not starting until year 2/3	Priority 2: Identify and Prevent the Exploitation of Vulnerable People
Project SHE A SHE diversion worker will work across Somerset (based in Bridgwater). The aims of SHE are to : - Improve safety for those who are themselves victims/vulnerable - Improve access to, and engagement with, support - Reduce number of arrests/ re arrests - Reduce number of remands/ short custodial sentences - Reduce re offending - Improve outcomes for children and families through prevention.	Priority 1: Protect people from the Harm of Domestic and Sexual Abuse
CSE Prevention Support to young people who are at risk of sexual exploitation and/or criminal exploitation. Focus on the 'push' factors such as abuse, bullying or family conflict and the 'pull' factors like grooming in order to quickly and effectively combat the underlying causes of running away and prevent problems escalating.	Priority 1: Protect people from the Harm of Domestic and Sexual Abuse

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Safer Somerset Partnership

Feel Safe, Be Safe

Safer Somerset Partnership Annual Report 2016/17

Contents

Forword

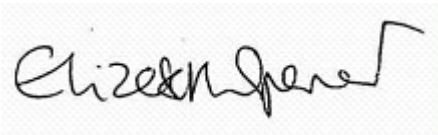
This is my second annual report as Chair of the Safer Somerset Partnership (SSP) which covers an extended period from April 2016 to October 2017.

The last year has seen some significant changes to the way the Partnership is structured and there has been a strengthened role in quality assurance across the community safety 'system'. Late 2016 saw the re-invigoration of the Somerset Domestic Abuse Board which is making great progress in quality assurance, with a new scorecard and set of principles. A key piece of work that started in 2016 as a consequence of this new directive, was a review of Somerset's Multi-Agency Domestic Abuse Conferences (MARAC).

In 2015, a number of us were named as 'specified authorities' under the Counter terrorism and Security Act, which required the embedding of these duties in our day to day practice. The Somerset Prevent Board, in this period, oversaw an audit of all these agencies to give the Partnership assurance that these duties were being effectively implemented.

What has been evident in this past year is the continued enthusiasm and commitment by all of our stationery partners. This is evident in the consistent level of good attendance across all agencies and the diverse and vibrant debate that always makes for a worthwhile and interesting Partnership meeting.

Going forward, I look forward to achievement more cross-collaboration with our key strategic partnerships, with which, we now have a protocol for working together in the knowledge that our agendas are always inter-related and making best use of our combined resources.



Chair, Safer Somerset Partnership

1. Introduction to the Partnership

The Safer Somerset Partnership was developed in 2011/12 as a single county wide partnership for delivering duties under the Crime and Disorder Act (1998). This report summarises key activities and achievements in the past 12 months as well as outlining our vision for 2017/18.

The purpose of the Partnership is to

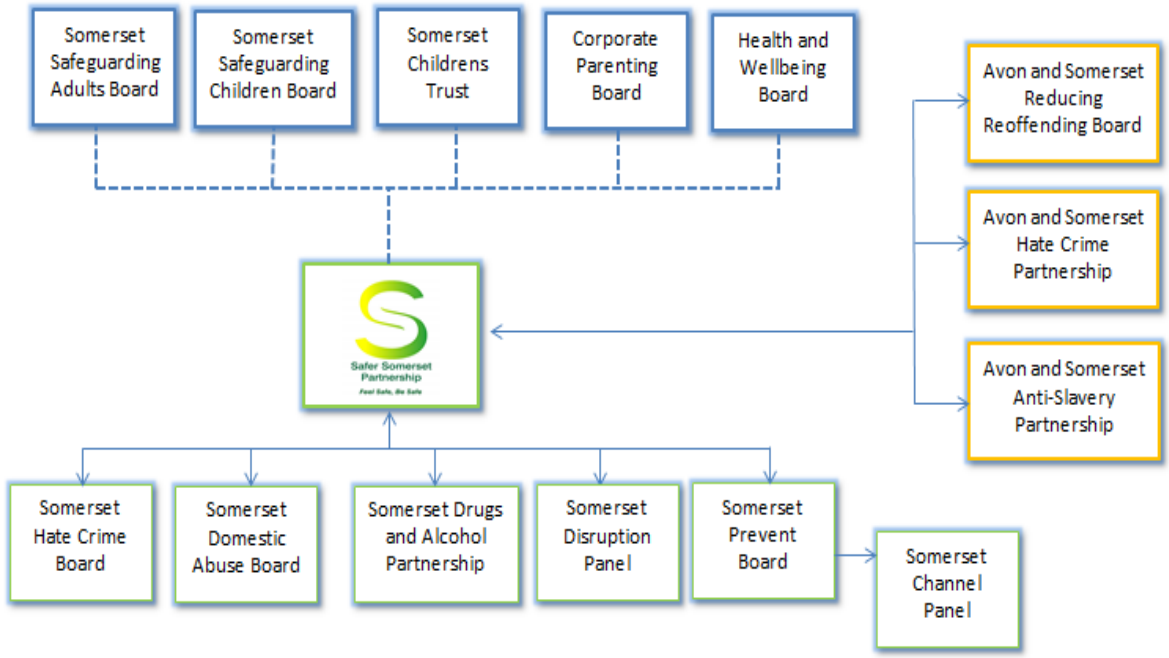
- provide strategic direction, leadership and improve the effectiveness of the delivery of Community Safety in Somerset
- Make effective links to other strategic Partnerships, ensuring there is a strong voice for Somerset's priorities and interests on other relevant partnerships and work streams aligning to the Protocol for Working Together document
- Ensure that the statutory responsibilities of the Partnership are addressed effectively.

1.1 Membership

The membership of the board currently consists of all statutory partner agencies under the Crime and Disorder Act (1998) [later amended by the Police and Justice Act 2006) these are

- All Local Authorities
- Avon and Somerset Constabulary
- Devon and Somerset Fire and Rescue Service
- National Probation Service
- Community Rehabilitation Company
- Somerset Clinical Commissioning Group
- Also, with a Duty to Cooperate, the Avon and Somerset Police and Crime Commissioners office

1.2 The Structure



The Partnership is positioned amongst a number of strategic partnerships across Somerset, including the safeguarding children and adults Boards, and the Health and Wellbeing Board.

Across the police force area, there are a small number of Avon and Somerset wide groups which are based upon shared priority areas of work.

In order to deliver our local priorities, sub groups are set up within Somerset. For ad hoc problem solving, task and finish groups can also be commissioned by the Partnership.

1.3 Statutory duties

The partnership and its constituting partners have a wide range of statutory duties. The sections summarises the activity undertaken this against the key duties for which the Partnership, is responsible;

Community Safety Strategic Assessment
Traditionally, the community safety strategic assessment is a document produced through a resource intensive and time consuming process involving all statutory partner agencies.

This year, a decision was made to modernise the process, producing data sets that are accessible at all times of the year by all agencies. Rather than a document, data is set out on line along with a summary of key community safety issues. The assessment can be found on the Somerset Intelligence website www.somersetintelligence.org.uk

Community Safety Plan

The community safety plan sets out the Partnership's priorities over a three year period, but can be refreshed each year. Priorities are determined by trends in data identified within the strategic assessment process, community intelligence and professional feedback by our stakeholders. The Priorities and Action Plan for 2017 onwards can be found in section 6.

Community Safety Scrutiny committee

Local authorities have a duty to scrutinise community safety work. For Somerset County Council, the community safety scrutiny sits within the agenda of the Place Scrutiny Committee. The next community safety meeting will take place in December.

Domestic Homicide Reviews

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.

The act states:

Domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

In summary, the Partnership's duties are:

1. Chair of Partnership holds responsibility for establishing whether a DHR should be take place.
2. The Partnership should appoint an independent chair of panel.
3. On receiving the Overview Report, the Partnership will agree the content of the overview report, executive summary and action plan and make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate
4. On receiving clearance from the Home Office Quality Assurance Panel, the Partnership should publish the report
5. monitor the implementation of the actions set out in the action plan;

CSP has a leading role to identify and disseminate common themes and trends across review reports, and act on any lessons identified to improve practice and safeguard victims (s.109/110).

Number of Domestic Homicide reviews in Somerset to date

Since DHRs became a statutory responsibility in April 2011, the Safer Somerset Partnership has received 20 notifications of deaths to consider for a review. Of those, 9 have led to a formal DHR, and a further 2 to an 'informal' review. One notification has its decision 'pending' as to whether a review should take place. Of the 11 reviews, 2 are currently in progress (report not submitted to the Home Office), and 4 have their action plans in progress.

Key Learning from Domestic Homicide Reviews

There are many themes common to Somerset's DHRs and the 2016 national Standing Together and Home Office learning lessons from DHR reports. Additionally, many of these are also repeated in the 2016 Avon and Somerset wide review of DHR's, which considered common lessons arising from the DHRs within the force area. The recurring lessons from that included:

i) Communication – To be improved across agencies and with our communities about awareness of domestic abuse and services available; including for diverse groups and friends/ family
ii) Policies – All agencies needed to have an effective policy in place and implement it consistently
iii) Domestic Abuse Training – To be improved, including consideration of multiple needs and diverse groups
iv) Information Sharing – To be improved
v) Multi Agency Risk Assessment Conferences (MARAC) – Greater consistency in approach, representation and monitoring of actions

Reducing Reoffending

The Policing and Crime Act 2009 required community safety partnerships to formulate and implement a strategy to reduce reoffending and for statutory partners to consider reducing reoffending in all their duties.

In the last 12 months, The Safer Somerset Partnership agreed to join others in the force area to form an Avon and Somerset wide Reducing Reoffending Board. This Board is currently haired by the Police and Crime Commissioner and meets quarterly.

Main activities this year are:

- Produced a force wide strategy
- Consider a small number of projects across the Force area which will provide an opportunity to develop news of ways reducing the potential to reoffend and identifying new cohorts to support, making the agenda more partnership centered.
- Reviewing Integrated Offender Management

2. The Partnership's activities and Achievements 2016/17

2.1 One Teams

In early 2017, the Safer Somerset Partnership agreed to provide County wide strategic leadership and oversight of the One Teams in Somerset. There are now One Teams covering 12 of the most deprived community areas in Somerset, including three new ones being established in Williton/Minehead, Hamp and Burnham. All of the One Teams have the same shared vision:

"To work in Somerset's most vulnerable communities and provide co-ordinated front-line multi-agency working to efficiently provide sustainable solutions for families and individuals that prevent problems escalating and costs increasing to the public sector."

The One Team approach and ethos fits well with the Safer Somerset Partnerhsip's purpose to improve the effectiveness of the delivery of Community Safety in Somerset.

During 2017, the SSP supported a funding bid from the One Teams for Police and Crime Commissioner funding to fund an overarching Co-ordinator post. The purpose of this post is to provide capacity to ensure consistency and quality across Somerset where necessary and to strengthen partnership commitment, information sharing, recording and sharing of actions, performance monitoring and other areas that require focus. The post started in September 2017 and is already starting to make progress on these areas.

There has been significant endorsement of the One Team model this year. It received a 'Highly Commended' in the 2017 MJ Achievement Awards under the 'Delivering Better Outcomes' category and an evaluation of the Taunton Deane One Team model by Professor Allyson MacVean from Bath Spa University evidenced that it made real differences in the community. The report saying

> "If the One Team model is delivered effectively it demonstrates significant cost savings and social benefits for service providers and local communities….The One Teams, while dealing with the immediate crime/social issues for their areas also prevent more destructive, pervasive and persistent crime/social problems from developing."

The One Team model continues to evolve and will become more refined with the help of the new Coordinator over the next year.

2.2 County lines and Organised Crime Groups

County lines activity typically involves gangs from large urban areas travelling to smaller locations (such as a county town) to sell Class A drugs, specifically crack cocaine and heroin. The majority of these gangs function with a degree of sophistication, utilising remote call centres and networks to make it difficult for public agencies to detect.

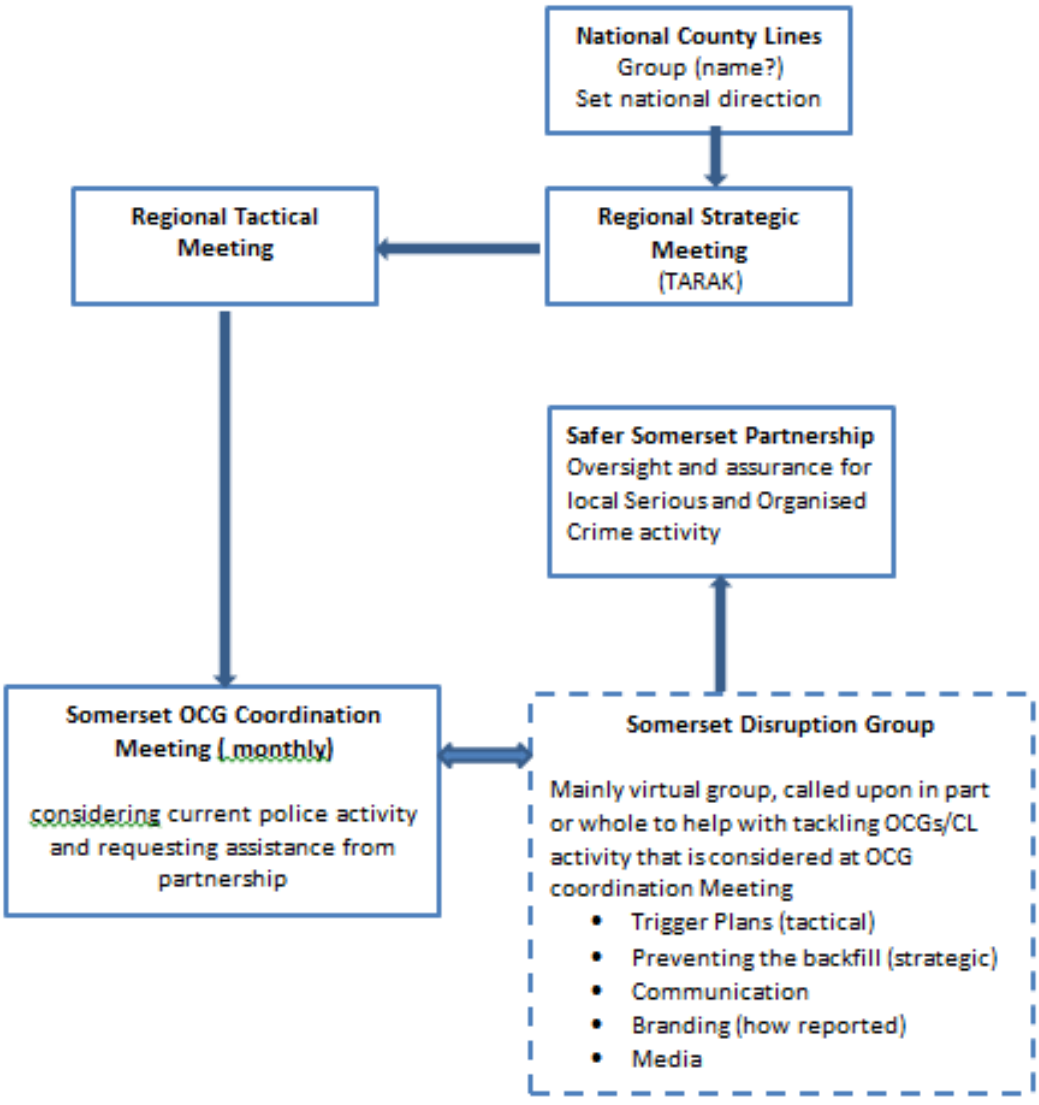
County lines gangs pose a significant threat to vulnerable adults and children, upon whom they rely to conduct and/or facilitate the criminality. 'Cuckooing' residents, using their

homes to run their business is a common feature. Exposure to gang exploitation has the potential to generate emotional and physical harm.

In the summer of 2017, for the first time, police colleagues met with local partner agencies to consider how not only to disrupt the groups from causing harm in Somerset but also, how the crime is prevented in the longer term.

Also persisting in Somerset, is the impact of Organised Crime Groups; people working together on a continuing basis for a particular criminal activity/ies. Police team are now sharing local Serious and Organised Crime Profiles with the Partnership and are supporting the development of a mechanism by which local agencies can together, tackle these types of criminals.

The chart below illustrates the new meeting structures that are being developed in Somerset to tackle county lines and OCGs in Somerset.



2.3 Modern Slavery

Modern Slavery is a cross cutting agenda for a number of Strategic partnerships in Somerset with the Safer Somerset Partnership providing a leadership role.

Modern Slavery is linked to Organised Crime Groups (OCGs) and cuts across the Partnership's activity for disruption serious and organised crime.

The Modern Slavery Act 2015 contains 2 main modern slavery offences, punishable by up to life imprisonment:

1. Slavery, servitude and forced or compulsory labour
2. Human trafficking

Types of Modern slavery include:
- Sexual Exploitation
- Domestic Servitude
- Forced Labour
- Debt Bondage
- Organ Harvesting
- Criminal Exploitation
- Child Trafficking

In the past year, as part of the Avon and Somerset Anti-Slavery Partnership, work has taken place to improve the profiling of modern slavery across Somerset and consider the strategic direction which includes a focus on prevention activity.

Somerset took part in the Modern Slavery National Referral Mechanism pilot project for improving the way that potential victims of modern slavery were identified and referred for support. Trained staff continue to provide this referral service.

2.4 Somerset Drug and Alcohol Partnership Update

Key Issues and Challenges
Due to changes across the public sector the Somerset Drug and Alcohol Partnership no longer has a pooled budget, however all partners continue to be committed to joint working. This year the partnership has focused on improving pathways in a number of key areas. These include mental health and substance use; offending and substance use; and pregnancy and substance use.

This year we were pleased to see the performance for our specialist services improve quarter after quarter, finishing the year as one of the best performing in the country in terms of getting people into treatment and onto recovery. Congratulations must go to all

the staff, peer mentors, service users and their friends and families who have worked so hard to make Somerset a 'recovery county'.

In response to national concerns about an increase in Drug Related Deaths and an audit and review group has been established which looks at these deaths. To date this audit suggests that Somerset has not seen the increase in drug poisonings reported elsewhere, which suggests that our services are doing and excellent job. What is apparent from the review however is that many of the deaths in Somerset are premature deaths from natural causes related to harmful drinking.

Targeted work with young people and protecting children from the harms of adult substance use continue to be a very high priorities and the Somerset Drug and Alcohol Partnership is committed to a 'think family' approach which focused not only on the adults issues, but on the impact on children who may be exposed to this.

A new challenge this year has been the exposure of vulnerable people to a national network of drug dealing known as 'county lines'. Members of Somerset Drug and Alcohol Partnership, including our specialist services have worked together as part of a multi-agency response to protect individuals and provide support and treatment.

Key priorities for the coming year
During the coming year the partnership will continue to progress work started this year on the impacts of mental health and substance use, as well as the impacts of substance within offending. Commissioners within the partnership will also be engaged in the re commissioning of specialist Drug and Alcohol Services as the current contract draws to an end. Intelligence gathering and engagement has been undertaken and procurement will take place over the next eitheeen months with a new service in place by April 2019.

2.5 Domestic abuse
During 2016/17 a great deal of work has been undertaken to improve the quality of the domestic abuse system across Somerset. The Partnership redesigned its Domestic Abuse forum to become the Somerset Domestic Abuse Board. This Board, with new membership and fresh direction has the primary aim of quality assurance across the system and with help from the Somerset public Health team, works to a specially designed score card.

A key activity of the Board has been to review Somerset's Multi-agency Risk Assessment Conferences (MARAC).

MARAC is a partnership approach, with a core objective to share
Information about high risk domestic abuse victims, perpetrators and families. This involves a number of agencies, including children Social Care, Police, Housing, specialist domestic abuse services and mental health services. There are four MARACs in Somerset; these are Taunton, South Somerset, Mendip and Sedgemoor.

A challenge not confined to Somerset, have been raised including the reducing resources to support the process, versus increased caseload and the fact that MARAC stands alone yet surrounded by a range of other safeguarding processes.

Senior officers across key agencies involved with MARAC are considering a new model of working that will be piloted in Somerset by the end of 2017. It is hoped that this new model will bring resilience and sustainability to the way agencies work together to support victims and their families from domestic abuse, by embedding the principles of MARAC in to current safeguarding processes in the County. In this way, agencies will be able to work more effectively, reduce double-handling of cases and respond to families experiencing high risk domestic abuse in a more timely way.

2.6 Hate crime and community Cohesion

Hate crime continues to impact on local communities and with increased numbers of BME communities moving in to Somerset, the impact of Hinkley C and the increased number of UK terror attacks, the rates of hate crime is estimated to rise.

The Partnership agreed in 2016 to set up a new sub group specific to Hate crime and community cohesion. As well as agreeing a local comprehensive strategy, work has been undertaken to consider victims pathways for hate crime after some community intelligence received to suggest that individuals do not report because they did not believe that they would be treated well by the authorities.

As a result, a new set of materials have been produced for practitioners and the community that aims to a) raise awareness of hate crime b) where to report it and c) what to expect when you do so. These materials will be launched on Hate Crime awareness week (October 14th-21st) and will be made available on a new hate crime webpage www.somerset.gov.uk/hatecrime

2.7 Hidden Harm

Make sure domestic abuse, mental health and substance misuse specialist services work together to identify as early as possible and then support complex individuals who face multiple issues ('Hidden Harm'), to identify children and families at risk as a result of this and to work together to safeguard the children and reduce the risks to everyone involved including perpetrators of domestic abuse.

An internal Somerset County Council draft report considered Hidden Harm, defined as the actual and potential effects of parental substance misuse (drugs and alcohol), domestic abuse and mental health issues on dependent children. The aim when considering Hidden Harm is to 'intervene early with vulnerable children and young people in order to improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime. It is anticipated that early intervention will bring benefits to the individual during childhood and into adulthood but also improve his or her capacity to parent'.
Treatment of substance misuse, domestic abuse and mental health involves a range of stakeholders and service providers at any one time. In complex cases the involvement in assessments of practitioners from different specialist services will result in a better understanding of how parental problems impact on family functioning and parenting

capacity. Robust professional links, joint protocols and procedures between children's and adults' services will help to ensure collaboration during assessments and service provision. The significant impact of the trio of domestic abuse, substance misuse and mental health on the health and wellbeing of children and families is well evidenced; and the need for effective joint working is crucial.
[Hidden harm needs assessment 2015]

2.8 Communications

The Safer Somerset Partnership has no dedicated business unit. Therefore partner agencies must carry out these functions within business as usual. As part of this, a communications protocol has been developed, which stipulates how partnership communications should be handled in the event of a news piece that spans across all agencies. In addition, a dedicated webpage for the Partnership is now live, used as a hub for further information and links to other work streams. www.somerset.gov.uk/ssp

3. Reponses to key events

3.1 Counter Terrorism

2017 has seen a high number of terrorist attacks across the world, including 3 in the UK so far. Whilst there have, fortunately, been no attacks in Somerset or in nearby locations, vigilance is still vital.

The Partnership oversees the work of the Somerset Prevent Board and in turn, the Channel Process in Somerset. Somerset County Council takes a leadership role in this work and reports on a quarterly basis.

In July 2017, the report Embedding Prevent in Somerset was produced which explores how agencies across Somerset are embedding their duties under the Counter terrorism and Security Act 2015. Highlights are:

- 'specified' agencies shave done extremely well in embedding their duties with only a small number of tasks left outstanding.
- All agencies have cascaded and/or attended training on prevent. There are still more to train, but the means to achieve this are embedded and sustained.
- Almost every school in Somerset has completed training which is a great achievement. However, schools still feel they need support in this topic, particularly when needing to discuss radicalisation with children

The Somerset Prevent Board has just approved its latest Prevent Plan and are looking to develop in the area of community engagement.

Channel Processes
From assessing Channel cases to date, it is clear that these individuals can have other vulnerabilities and in some cases, experience of receiving other services which may include social care. Work has been underway to improve the way that the Channel process aligns

with safeguarding processes that are already in place, including the Multi-Agency Safeguarding Hub (MASH) to ensure that the client is supported in the most appropriate and timely way, whilst appropriately assessing and responding to their needs, vulnerabilities and risk.

3.2 Grenfell Tower

In the wake of the tragic fire at London's Grenfell Tower in June 2017, the Partnership requested an assurance briefing from Devon and Somerset Fire and rescue Service. This was received in a timely manner and was considered at the July Safer Somerset Partnership meeting. In summary it stated:

- Fire safety legislation, (Regulatory Reform (Fire Safety) Order 2005), applies to a wide range of building occupancies; this includes the common areas of high rise residential premises.
- The responsibility for ensuring that the requirements of the above legislation are met lies with the building owners.
- Devon and Somerset Fire and Rescue Service (DSFRS) has a duty to enforce the Regulatory Reform (Fire Safety) Order 2005.
- DSFRS have a robust, fire safety inspection strategy to ensure that a suitable of level of compliance is achieved in all buildings (where the legislation applies), especially where the risk of loss of life is highest.
- In light of the fire at Grenfell Tower, in London, fire safety risk information held by DSFRS, has been reviewed for all known high rise premises in Devon and Somerset. Following this review, a bespoke risk based inspection programme also commenced, with a view to confirming that the current status of the building, and to give assurance to residents
- The Service continues to carry out high rise exercises and multi-agency exercises to assist in training and preparation for similar incidents.

3.3 Hinkley Point C Project

In 2017, the Hinkley C project commenced after a long period on uncertainty. Preparation work has taken place by all agencies over the years to consider potential impacts of Hinkley on community safety and now, these assumptions are beginning to be realised.

The Somerset Hinkley Community Safety Group, facilitated by Sedgemoor District Council now meets each month, with a larger meeting every quarter to consider local impacts on community safety. This group involves EDF, local authorities, South west Ambulance Trust, police and the fire service. The Safer Somerset Partnership has asked for regular reports to keep up to date with progress and impacts.

4. Performance against former Priorities

The table below summarises performance against the Partnership's priorities from 2015-2017.

Priority	Key Achievements/activities/challenges
Improve links to other partnerships, interagency collaboration and understanding of services	There is now a Joint Operating Protocol between the key Strategic Boards in Somerset which is designed to improve communication and understanding between the Boards and set out areas of common interest. The Chairs of the strategic boards also meet on a quarterly basis to explore further, opportunities for collaboration and integration.
Prevent the escalation of violent crime and abuse by supporting victims and working with perpetrators	Somerset County Council's commissioned service is now in year three and has been extended to a further 2 years and is working effectively to meet this objective in relation to domestic abuse. Violent crime rates have been monitored by the Partnership and rates remain relatively static yet high. Somerset's One Teams are key to the prevention agenda, considering early reports of community unrest and deviant and criminal behaviour. Work was also carried out to improve the rate and quality of the use of the DASH RIC – the risk assessment tool for victims of domestic abuse which has resulted in a vast improvement.
Focus on targeted Anti-Social Behaviour	The Partnership monitored the use of ASB tools and powers over this two year period. The police team in charge of anti-social behaviour continue with a high case load of requests for the use of sanctions in local communities as to local authorities. Community Protection notices in particular have been increasing, although this is most probably linked to the effective utilisation of this tool in county lines activity.
Focusing on Families through Early Help	This priority focussed on improving the awareness amongst partner agencies in the importance of early help in preventing crime and disorder in Somerset. A measure of this was to improve the numbers trained in utilising the Early Help Assessment and also, actual rates of assessments completed which increased significantly over the two year period.

Identify opportunities and approaches that Improve mental wellbeing and the emotional resilience of people in Somerset	This priority was difficult to turn in to measurable activity. Part of the reason for this was the lack of sustained representation on the Partnership by the Somerset Clinical Commissioning Group. Work began to gain momentum in the last six months with
Break the cycle of offending/abuse through an engaged multi-agency response to targeted/identified groups	In developing this performance framework, a number of measurable objectives were created. 2016 saw a flurry of achievements but the momentum of the first year was lost. This was due to a number of reasons: • In 2016/17, the Impact team underwent a number of changes and lead officers left • The vision was that the Partnership would have a clearer role in Integrated Offender Management however, this was not progressed • Reducing reoffending, strategically, was being planned at an Avon and Somerset level, so it was assumed that this work would be dealt with in part, elsewhere. Delays in the planning of this Board meant that work slipped.

5.Our Priorities 2017/18

The Safer Somerset Partnership produces a three year rolling Community Safety Plan. It is refreshed each and year and for the first time, the Partnership has linked its own plan with the Police and Crime Commissioner's Plan to produce a joint summary document.

Lessons learned from the previous performance framework is that performance needs to be more fluid due to the changeable nature of the community safety agenda. Priorities will be refreshed where necessary each year with an improved set of SMART objectives.

Actions set out on the 'plan on a page' in annex A will be added to the Safer Somerset Partnership's performance Scorecard which is monitored quarterly.

6. Funded services 2017-2020

The Avon and Somerset Police and Crime Commissioner allocates funding to the Safer Somerset Partnership on an annual basis. This year, for the first time, funds have been committed for three years to allow the partnership to support services in a more sustainable and meaningful way. The table below illustrates how the funds have been allocated which aligned with the new Partnership priorities.

Service/Project	Total per year	Provider
Positive Lives (previously Housing Support for Offenders – Complex Adults Design Group). This is a continuing project essential for supporting high risk of harm and high risk of reoffending offenders.	£65,000*	Julian House
One Team Development projects Two-part project to 1. Assist the Safer Somerset Partnership in quality assurance of One Teams 2. Embed consistency of standards where required whilst ensuring the continuation of locally led teams 3. Assist the Mendip team transform from a 'virtual' to a face to face meeting structure by adding some coordination resource	£44,167*	Somerset County Council and Mendip District Council
Vulnerability Pathways – systems review A one off system review, independently chaired, designed to consider the various vulnerability pathways in Somerset and assess areas for change and improvement. Not starting until year 2/3	£3,251*	Police and Somerset County Council
Project SHE A SHE diversion worker will work across Somerset (based in Bridgwater). The aims of SHE are to : - Improve safety for those who are themselves victims/vulnerable - Improve access to, and engagement with, support - Reduce number of arrests/ re arrests - Reduce number of remands/ short custodial sentences - Reduce re offending - Improve outcomes for children and families through prevention.	£33,926	The Nelson Trust
CSE Prevention Support to young people who are at risk of sexual exploitation and/or criminal exploitation. Focus on the 'push' factors such as abuse, bullying or family conflict and the 'pull' factors like grooming in order to quickly and effectively combat the underlying causes of running away and prevent problems escalating.	£65,000	Somerset Youth Offending team
*Annual average cost over the three years (annual amount varies)		

Annex A: Priorities 2017/18

Priority	Action	Lead	Deadline
1: Protect people from the Harm of Domestic and Sexual Abuse	Implement improvements to current MARAC process	DA Board	March 2018
	Through project SHE, establish baseline figure for rates of female offenders who also experience or offend in relation to domestic abuse	The Nelson Trust	September 2018
2: Identify and Prevent the Exploitation of Vulnerable People	Explore links between Hate Crime Offenders and radicalisation by collaboration between hate crime services and the Prevent Team by formalizing a process for sharing suspect information when appropriate	Police Prevent Team	May 2018
	Explore Interventions when supporting vulnerable people in the Channel programme with learning disabilities	Prevent leads	January 2018
	Modern slavery training for other Partnership agencies to be considered	Chair of ASP	March 2018
3: Identify and Support those with Inequalities and vulnerabilities, which can lead to poorer health outcomes and increased risk taking behaviors	Scoping exercise for a) minority communities and b) community based organizations	Equalities team	June 2018
	Agree mechanism to enable One Teams to receive support for dealing with vulnerable people	One Team cooridnator	November 2017
	Safer Somerset Partnership to have regular updates on progress made within Hinkley C development – particularly with regards to demand and exceptions.	Hinkley Community Safety group	Quarterly
	Explore methods for improvement community engagement in local communities	Hate Crime Chair	September 2017
	Preventative work with communities in deprived areas regarding road safety.	Somerset One Team Cooridanator	September 2018
4: Meet our Statutory Duties [Reducing Reoffending and Domestic Homicide Reviews]	SSP to have oversight of local MAPPA arrangements to have assurance that the needs of vulnerable adults are being appropriately considered	SCC	Ongoing
	Have assurance that each partner agency has a process for implementing DHR recommendations	Domestic Abuse Board	December 2017
	Influence the Avon and Somerset Reducing reoffending Board agenda to account for Prevention of offending	SSP Chair/SCC	April 2018

Somerset Safeguarding Adults Board Annual Report 2016/17

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Cabinet Member: David Huxtable, Cabinet Member, Adult Social Care
Division and Local Member: All

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Office (Director Level)	Stephen Chandler, Director for Adult Social Services	20.9.17
	Cabinet Member / Portfolio Holder (if applicable)	Cllr David Huxtable	20.9.17
	Monitoring Officer (Somerset County Council)	Julian Gale	14.11.17

1. Summary

1.1. The Somerset Safeguarding Adults Board (SSAB or "the Board") is required by The Care Act 2014 to produce and publish an Annual Report each year. The report must set out what has been done to help and protect adults at risk of abuse and neglect in Somerset during that timeframe. It offers an opportunity to both reflect on achievements over the past year and to formally identify priorities for the year ahead. It also provides a chance to demonstrate the Board's fulfilment of its role and ongoing commitment to safeguard vulnerable adults in the county.

2. Recommendations

2.1. The Health and Wellbeing Board:

- **Reviews and considers the Somerset Safeguarding Adults Board's 2016/17 Annual Report (Appendix A), and pays particular attention to the contained information regarding Safeguarding Adults Reviews (SARs) p31**
- **notes progress highlights during 2017/18 to date**
- **continues to promote adult safeguarding across the County Council and in the services that are commissioned**

3. Background

3.1. The SSAB operates as an independently-chaired, multi-agency body under The Care Act 2014. It became statutory from April 2015. Its main objective is to seek assurance that local safeguarding arrangements and partner organisations act to help and protect people aged 18 and over who:

- have needs for care and support;
- are experiencing, or at risk of, abuse, neglect or exploitation;

- are unable to protect themselves from the risk of, or experience of, abuse or neglect as a result of their care and support needs.

3.2. Safeguarding is everybody's business, and the Board has a strategic role that is greater than the sum of the operational duties of the core partners. It means protecting an adult's right to live in safety, free from abuse and neglect.

3.3. Key Achievements 2016/17

During 2016/17 the Somerset Safeguarding Adults Board concentrated its efforts on improving its overall effectiveness in order to better coordinate activity, learn from events, and raise its local profile and the value of what it offered through high quality communications with both professionals and the public. Particular highlights worth noting during the year are as follows:

a) We have published and promoted a range of documentation and guidance to help strengthen safeguarding responses. This includes the production of:
   - an Adult Safeguarding Risk Assessment tool to assist practitioners in considering the vulnerability of an adult at risk and the seriousness of the abuse that is occurring, against the impact of the abuse and risk of it recurring. The tool is now used within training and by frontline staff to assist them in robust decision-making.
   - self-neglect practice guidance, informed by learning and research to emerge from a regional conference.

b) We have re-invigorated our public-facing 'Thinking it? Report it' campaign to coincide with the annual World Elder Abuse Awareness Day each June. In 2016/17 this included the development of a short animated film to raise awareness of abuse and neglect, and how individuals can seek help and support. This has been viewed hundreds of times. The Board also launched an appeal for interested individuals to publicly pledge their support to safeguard vulnerable adults, which continues to gather signatures.

c) We have strengthened ways to promote learning from serious cases, through the development and wide distribution of Practice Briefing Sheets and through hosting our first multi-agency Learning Event to over 100 frontline professionals to communicate the themes and lessons learnt from Safeguarding Adults Reviews (SARs). 97% of attendees reported feeling confident about taking the learning from the event and applying it to their own role and practice. Overall attendees particularly valued the opportunity to hear first from service users and family members, and learning from their experiences.

d) We have bolstered links and opportunities for closer engagement with other existing partnerships and Boards to improve join-up, reduce duplication and develop collaborative ways to improve outcomes for local residents. This has included the production of a Joint Partnership Protocol and the hosting of six monthly Partnership Chairs meetings, as well as specific work around safeguarding transitions and supporting vulnerable care leavers. The SAB Manager is also an active member of the national SAB Managers' Network, sharing good practice, research and ideas.

e) We have launched our own dedicated website which has helped provide a platform to promote our work and direct interested parties to information or resources. Over 3,600 individuals accessed the website during 2016/17, 40% of which were returning visitors. The Board is also now on twitter which has enhanced its reach and influence, and offered new engagement opportunities. Visit: www.ssab.safeguardingsomerset.org.uk

f) Board Members contributed to the second annual SSAB Effectiveness Survey in the autumn of 2016, with results revealing improved performance against all 12 quality standards when compared with the previous year's figures. Key strengths were identified in relation to the Board's leadership and coordination of adult safeguarding policy and practice across agencies, and the sense that partners work in an atmosphere of cooperation, mutual assurance, accountability and ownership of responsibility:

"The Board is able to engage in challenging discussions but operates in a respectful and cooperative environment. The impact of having a dedicated Business Manager has been significant in strengthening Board relations and driving progress over the past year".

Areas requiring our continued attention centred on the use of data, information and intelligence to identify risks and trends, and ensuring mechanisms are in place to ensure the views of people at risk of abuse and their carers inform the work of the SSAB.

3.4. Key Progress to date, 2017/18

Our priorities for the year continue to centre on prevention, making safeguarding personal, adopting a Think Family approach, and enhancing the Board's effectiveness. Of particular note so far this year:

a) The Board has created a new multi-agency sub-group (Mental Capacity Act) to enhance local understanding and application of the Act. This was in direct response to learning to emerge from recent case reviews and audits.

b) We have implemented a Safeguarding Experience service user/carer feedback form to help ascertain the effectiveness of safeguarding responses and support. Feedback to date has been overwhelmingly positive, including the following response: *"From initial referral to response, the communication from the safeguarding service was understanding, informative and thorough. The timeframe of response was exceptional, questions were answered and advice was thorough".* We have also invited service user stories to inform the Board's understanding and appreciation of people's journeys through the process.

c) We have worked closely with the Somerset Safeguarding Children Board, Children's Trust and other agencies to support the development of a shared Think Family Strategy for Somerset, which will be published by the end of the financial year, and have strengthened links between both Safeguarding Boards on matters of shared interest, including transition and tackling sexual exploitation.

d) We have commissioned a Safeguarding Adults Review following the closure of a Somerset Care Home following a large-scale safeguarding enquiry into the abuse and neglect of its residents. A workshop was held in late October 2017 to extract the recommendations and formalise the report. The review process is being independently led and overseen by Dr Margaret Flynn.

e) Local Policy and Procedures are being updated in partnership with regional colleagues to ensure standards are clarified and refreshed in light of more recent statutory developments or good practice; these will be made more easily accessible on the Board's website through interactive access.

f) A new, full-time Business Manager has been appointed to support the Board's on-going development and activity. Stephen Miles took up post in September and is looking forward to supporting the SSAB on its onward journey.

4. Implications

4.1. **Legal implications** The Care Act 2014 represented the most significant change to adult social care in more than 60 years, putting people and their carers in control of their care and support. For the first time the Act placed Safeguarding Adults, and the role and functions of a Safeguarding Adults Board, onto a statutory framework from 1st April 2015.

4.2. **Financial implications** The majority of the Safeguarding Adults Board funding is provided by Somerset County Council, with contributions from Avon & Somerset Constabulary and Somerset Clinical Commissioning Group. Safeguarding Adults Reviews (SARs) are resourced by the partnership as and when required. The number of safeguarding concerns received by Somerset County Council remains high, impacting on Adult Social Care resources. Work is being taken forward across the Service to better manage demand and ensure people receive the appropriate help at the right time, from the right service. DoLS continues to be extremely challenging, both locally and nationally, consequent to the considerable increase in referrals following the outcome of Cheshire West in March 2014.

The SSAB continues with its decision not to professionally print the Annual Report to save on costs. Reports are publically available on the website www.ssab.safeguardingsomerset.org.uk

4.3. **Risk implications** Safeguarding activity by its nature is an inherently risky area and has the potential to bring a Council's reputation and rating into discredit and the wider safeguarding system into question. The Annual Report, a legal requirement by the Care Act 2014, provides partner agencies and the public with assurances that adult safeguarding is being monitored and scrutinised in Somerset. The Board also has a robust risk register in place which identifies and tracks risk.

4.4. **Partner organisations** Somerset Safeguarding Adults Board benefits from strong partnership commitment. Agencies represented on the Board had the opportunity to detail their achievements and contributions in 2016/17 and all Board members are encouraged to take the Annual Report through their own internal governance routes.

5. Background papers

5.1. Appendix A – Somerset Safeguarding Adults Board Annual Report, 2016/17

2016-17 Annual Report

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 2016/17;
- 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 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.

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

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

2. Foreword

Richard Crompton, Independent Chair – Somerset Safeguarding Adults Board

It is a great privilege to write this foreword to the Annual Report of the Somerset Safeguarding Adults Board for 2016/17.

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

I believe that we can now demonstrate that we make a difference, both to the lives of those we are here to safeguard and support, and to those in all of our partner organisations who work in the field of adult safeguarding.

We have concentrated upon improving the overall effectiveness of our board in its efforts to better coordinate activity, to learn from events, particularly where we have got things wrong, and to raise our profile and the value of what we offer through good quality communication with professionals and the public. Specifically we have concentrated upon making the safeguarding process more personal to the needs of the adult at risk, upon emphasising preventative work, and upon encouraging a whole family approach and awareness of the crucial years of transition from childhood into adulthood. We have really tried to hear the voice of the adult at risk and, wherever possible, members of their family. I pay particular tribute to those who have helped us to do this by sharing intensely personal and difficult stories and experiences that we can learn from and improve our practice.

The report is published on behalf of all members of the Board, and provides partners with an opportunity to reflect upon achievements over the past year, and formally identify plans and priorities for the year ahead. As the independent chairman, my role is to provide leadership and constructive challenge to ensure that members work effectively together, adding value to adult safeguarding. As the Board has matured, the openness and willingness to both challenge and be challenged has developed and that culture is vital if we are to truly learn and improve to meet the challenges ahead. Those challenges will be significant. The changing demographics locally and nationally, and continued budgetary pressures on all agencies make joint working all the more important. In Somerset we have created the right environment for that work to take place and we have high levels of commitment from partners to make it happen. I look forward to the coming year confident that we will continue to improve and make a real difference.

3. The Board

The Somerset Safeguarding Adults Board (SSAB) is a multi-agency partnership which became statutory under the Care Act 2014 from 1st April 2015. The role of the Board is to assure itself that local safeguarding arrangements and partner agencies act to help and protect adults in its area.

This is about how we prevent abuse and respond when abuse does occur in line with the needs and wishes of the person experiencing harm. Its 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
- are experiencing, or at risk of, abuse or neglect
- (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.

It 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. Safeguarding is everybody's business. The Board's role is to have an oversight of safeguarding arrangements, not to deliver services.

Membership of the Board *(as at March 2017)*

Somerset Safeguarding Adults Board		
Name	**Organisation**	**Job Title**
Richard Crompton		Independent Chair
Niki Shaw		Business Manager
Lead Statutory Partners		
Stephen Chandler / Mel Lock	Somerset County Council	Director, Adult Social Services Director of Operations
Deborah Rigby	Somerset Clinical Commissioning Group	Deputy Director, Quality, Patient Safety and Governance
Richard Kelvey	Avon & Somerset Constabulary	Detective Superintendent
Partner Members		
Alison Wootton	Musgrove Park Hospital	Deputy Director of Patient Care
Bernice Cooke	Yeovil District Hospital	Head of Governance and Assurance
Richard Painter	Somerset Partnership NHS Foundation Trust	Head of Safeguarding
Angela Powell	National Probation Service	Senior Probation Officer
Denise Dearden	Devon & Somerset Trading Standards	Trading Standards Project Officer
Sue Burn	Care Quality Commission	Inspection Manager - Somerset
Jacqueline Briggs	Healthwatch Somerset	
Simon Blackburn	Registered Care Providers Association	Chief Executive
Christina Gray	Somerset County Council	Consultant in Public Health
Lucy Macready	Somerset County Council	Public Health Specialist – Community Safety
Sarah Thompson	South Western Ambulance Service Trust	Head of Safeguarding and Staying Well Service
Tracey Aarons	Mendip District Council (representing District Councils)	Deputy Chief Executive
Sonia Furzeland	Knightstone Housing (representing Housing Services)	Director of Landlord Services
Cllr William Wallace	Somerset County Council	Lead Member – Adult Services

Board attendance levels

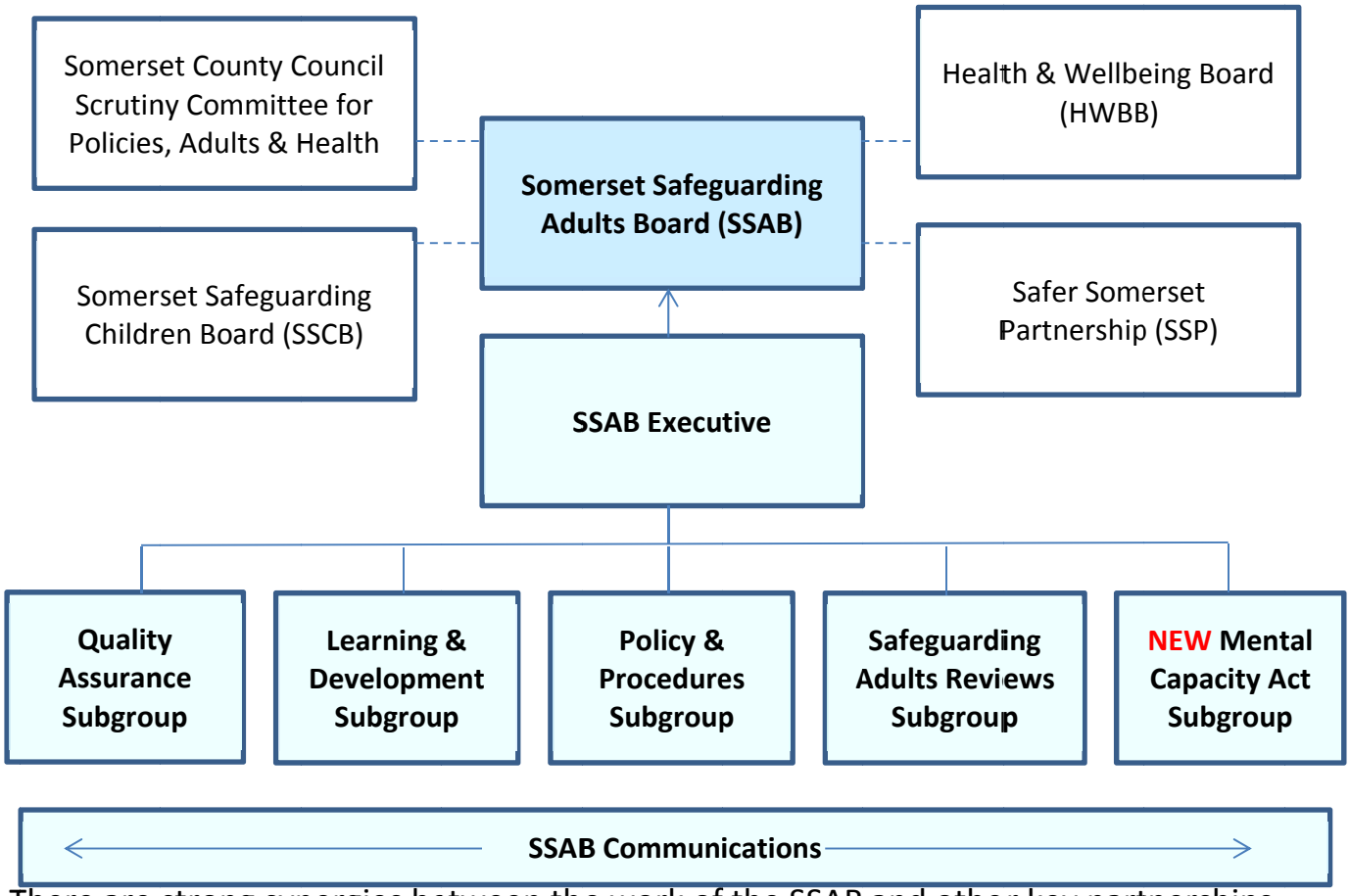
The Safeguarding Adults Board met on 4 occasions during 2016/17 – June, September, December and March. In brackets below is the number each organisation was represented during the year at these meetings *(by the agency representative themselves or an appropriate agency substitute)*:

Somerset County Council – 100% attendance (4/4)
Somerset Clinical Commissioning Group – 100% attendance (4/4)
Avon & Somerset Constabulary – 100% attendance (4/4)
Musgrove Park Hospital – 100% attendance (4/4)
Yeovil District Hospital - 100% attendance (4/4)

Somerset Partnership NHS Foundation Trust – 100% attendance (4/4)
National Probation Service – 75% attendance (3/4)
Devon & Somerset Trading Standards – 100% attendance (1/1) – *new member*
Healthwatch Somerset – 50% attendance (2/4)
Registered Care Providers Association – 50% attendance (2/4)
Public Health (Community Safety) – 75% attendance (3/4)
South Western Ambulance Service Trust – 25% attendance (1/4)
District Council representative – 66.6% attendance (2/3) – *new member*
Housing representative – 50% attendance (2/4)

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

The SSAB meets on a quarterly basis and is supported by an Executive group and a number of multi-agency subgroups, which convene frequently to progress the ambitions and strategy of the Board. A new Mental Capacity Act subgroup was established in early 2017 at the request of the Board as an identified multi-agency need to strengthen local implementation of, and knowledge of, the Act.



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.

1. **Empowerment** – the presumption of person-led decisions and informed consent, supporting the rights of the individual to lead an independent life based on self-determination

2. **Prevention** – It is better to take action before harm occurs, including access to information on how to prevent or stop abuse, neglect and concerns about care quality or dignity

3. **Proportionality** – proportionate and least intrusive response appropriate to the risk presented

4. **Protection** – support and representation for those in greatest need, including identifying and protecting people who are unable to take their own decisions or to protect themselves or their assets

5. **Partnership** – local solutions through services working with their communities. Communities have a part of play in preventing, detecting and reporting neglect and abuse.

6. **Accountability** – accountability and transparency in delivering safeguarding, with agencies recognising that it may be necessary to share confidential information, but that any disclosure should be compliant with relevant legislation.

What is adult safeguarding?

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

The aims of adult safeguarding are to:

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

Who is an adult at risk?

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

What is abuse?

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

Abuse and neglect can include:

- **Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint, inappropriate physical sanctions

- **Domestic violence** – psychological, physical, sexual, financial, emotional abuse, so called 'honour' based violence

- **Sexual abuse** – rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure, sexual assault, sexual acts to which the adult has not consented or was pressured into consenting

- **Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation, unreasonable and unjustified withdrawal of services or supportive networks

- **Financial or material abuse** – including theft, fraud, internal scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions; the misuse or misappropriation of property, possessions or benefits

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

- **Discriminatory abuse** – including forms of harassment, slurs or similar treatment (because of race, gender and gender identity, age, disability, sexual orientation, religion)

- **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting, such as a hospital or care home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practices as a result of the structure, policies, processes and practices within an organisation

- **Neglect and acts of omission** – including ignoring medical, emotional or physical care needs; failure to provide access to appropriate health, care and support or educational services; the withholding of the necessities of life, such as medication, adequate nutrition and heating

- **Self-neglect** – covering a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. A decision on whether a safeguarding response is required will depend on the adult's ability to protect themselves by controlling their own behaviour.

Safeguarding Case Study 1 – Amrin's story

Background: Amrin, 26, is an educated woman who has studied law. In 2015 she moved from Bangladesh to the United Kingdom. Her marriage was arranged and conducted over Skype. She faced pressure to send money home to her family and to work several jobs so they can apply for British Citizenship. Her husband is also pressuring her to have a baby so they do not have to leave the country. Although she has shared this with her family in Bangladesh, they are conservative in their views and have encouraged her to continue with the situation. Amrin lives in fear of her husband and worries she will be deported.

Safeguarding Concern: A GP contacts the Local Authority reporting that her patient, Amrin, had visited the practice the previous day with her husband for an asthma review. As Amrin walked into the room, ahead of her husband, she had whispered something to the GP. The GP asked the husband to wait outside whilst she completed the asthma review. Amrin then disclosed two incidents of assault at the hands of her husband, the most recent being the night before. She reported being hit and having an injury to her left arm. Amrin did not want to go to the Police but wanted safeguarding services involved to help her to escape the situation.

Safeguarding Response: Working jointly with the GP, a Safeguarding Officer arranged to meet Amrin at the Surgery; she had been invited to attend an extended asthma clinic – this involved the support and confidentiality of Surgery staff as Amrin's husband always accompanied her to any appointments. Staff asked him to remain in the waiting room for the duration of the clinic, giving Amrin an opportunity to meet privately with the Safeguarding Officer. A full disclosure was made. Evidence of honour-based violence, domestic violence, sexual assault and modern slavery was shared. Immediate risk assessments and protection plans were instigated. Amrin had a mobile phone so was provided with emergency numbers for the domestic violence service, refuge services, and the Safeguarding Officer's contact number. She was encouraged to call 999 if she feared for her life, and she gave consent for the Safeguarding Officer to speak with other agencies in the meantime.

Amrin and the Safeguarding Officer had arranged to meet at her place of work the following day to conclude their conversation and plan her opportunity to leave safely. It was apparent that Amrin had been further assaulted during that time; both sexually and physically. The Safeguarding Officer secured Amrin's trust and sought permission to seek additional support from the Safeguarding Coordination Unit of the Police. Two plain clothed police officers were deployed immediately and attended Amrin's place of work. With compassion and care, they spoke with Amrin and offered her options of what she could do next. Amrin's husband was arrested at their home during this time. She was supported to collect her personal belongings from her home and was taken into police protection for her own safety. Her husband, on arrest, made further threats to Amrin's life.

Amrin was supported by agencies to receive medical treatment and victim support. She is now safe.

4. Safeguarding in no's

How much abuse and neglect was reported during 2016/17?

- 5,451 concerns were reported to the Local Authority during the year
- 2,045 concerns (37.5%) of abuse or neglect required us to provide a statutory safeguarding response
- The majority of concerns were raised from local care providers or the police

Who was at risk of abuse and neglect in 2016/17?

- 59% of adults at risk during the year were female
- 58% of adults at risk were aged 65 or over
- 46% had a physical support need, 33% had a social support need, 16% had a learning disability need, and 4% had a mental health need
- 98.7% were people from white ethnic backgrounds

What were adults at risk from during 2016/17?

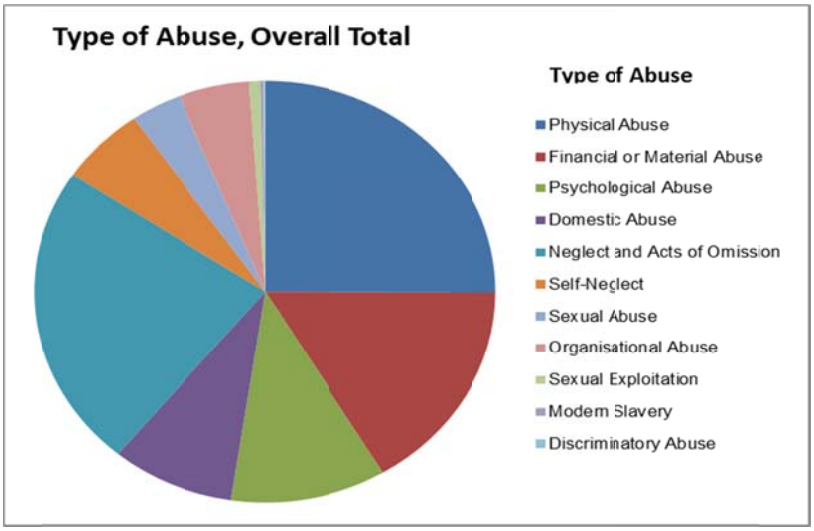
- The most common risk type was Physical Abuse, which accounted for 25% of risks, followed by Neglect and Acts of Omission at 23%
- In 68% of cases the source of risk was recorded as 'Other Known to Individual' compared to 26% 'Service Provider' and 5% 'Other Unknown to Individual.'
- The majority of Neglect and Omission cases (70%) were recorded as being caused by the Service Provider. Other people known to the individual, but not in a social care professional capacity, were the most common source of risk in every other location.
- The location of risk was most frequently the home of the adult at risk (42%) or in a Residential Care home (23%) or a Nursing Care Home (20%).

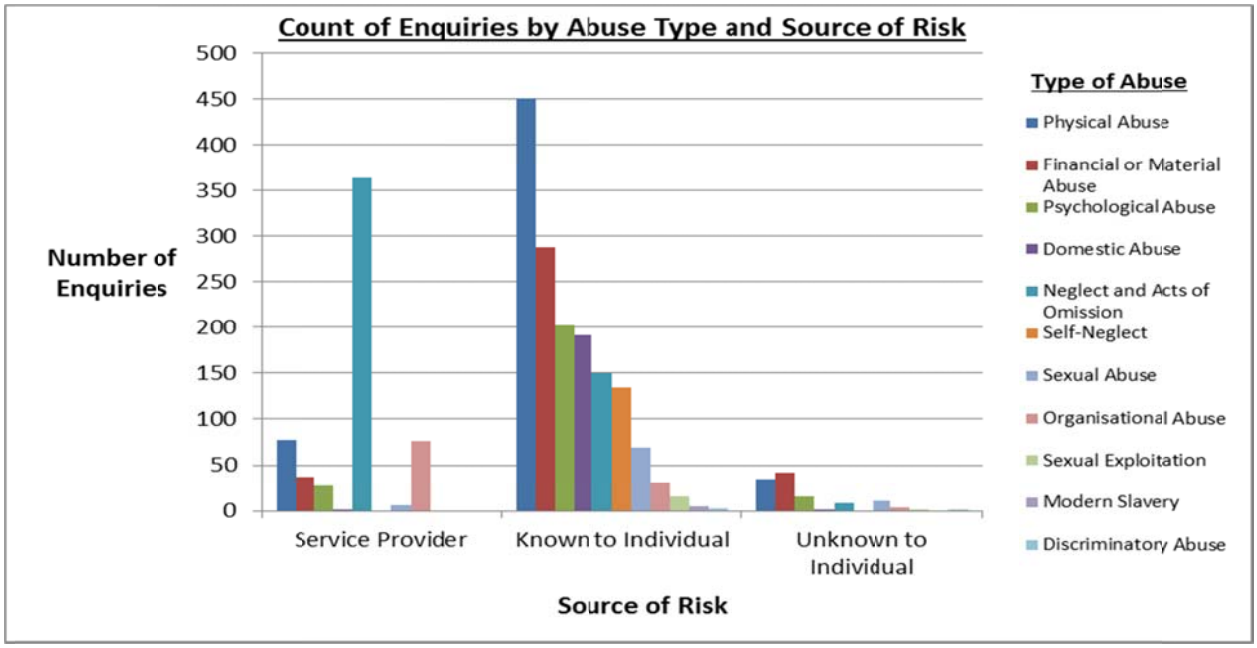
What did we do to protect people during 2016/17?

- For the vast majority of investigations (91%) action was taken and the risk was either reduced or removed. Following our investigations, adults remained 'at risk' in 9% of cases, often because they wanted to maintain their relationship with a family member who is abusing them.
- Where individuals were asked, 96.5% were had their desired outcomes either fully or partially achieved
- 86% of people who used social care services said services help them to feel safe and secure[1].

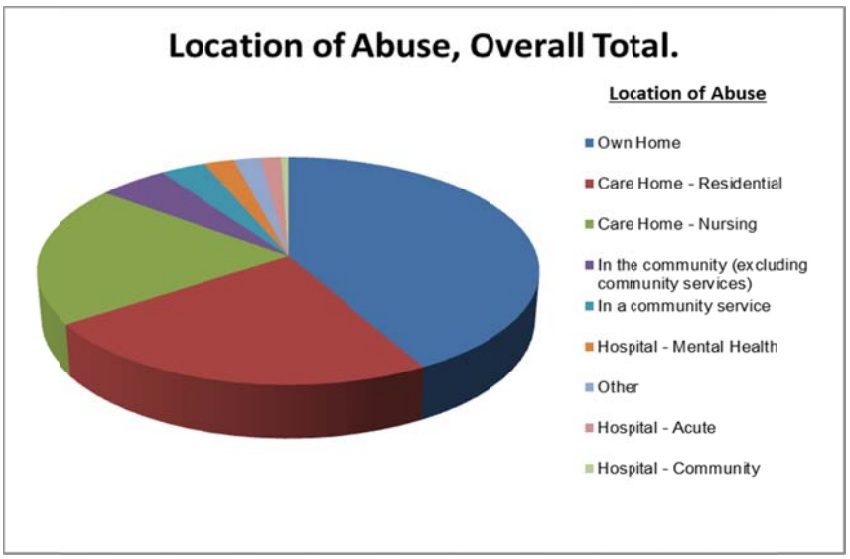
[1] Adult Social Care Outcomes Framework (ASCOF) data

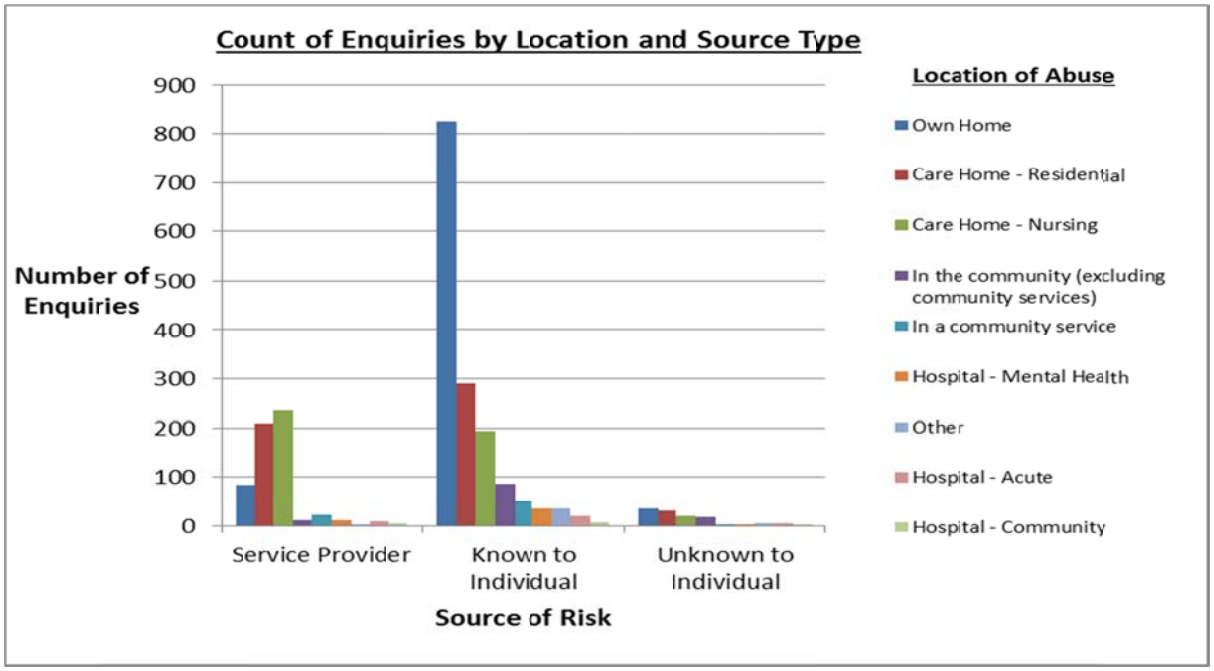
Type of abuse and source of risk



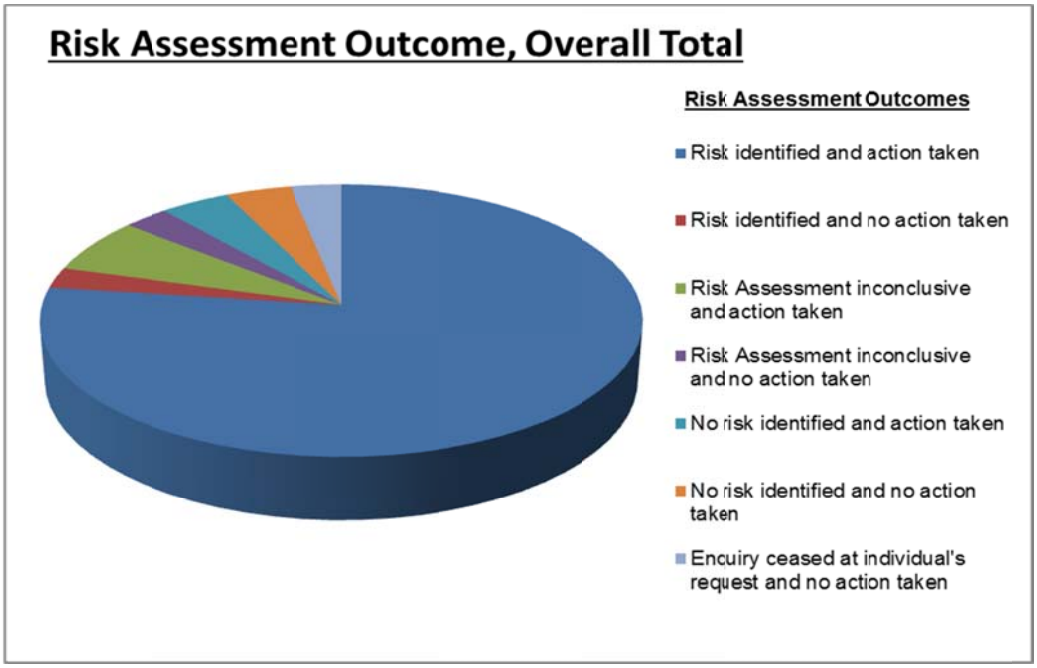


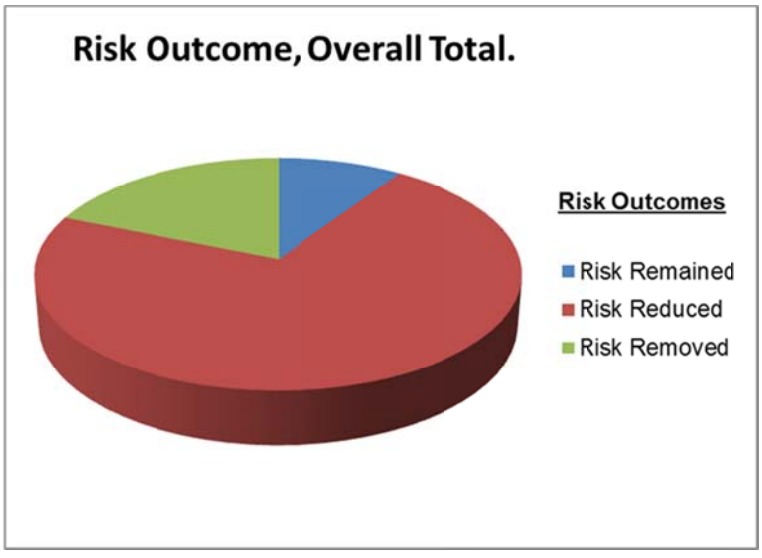
Location of abuse





Risk Assessment Outcomes





5. Our work, 2016/17

The SSAB identified the following four objectives within its Strategic Plan for 2016-19:

1. Prevention
2. Making Safeguarding Personal
3. Think Family
4. SSAB Effectiveness

Priority Area 1:

Prevention

What SSAB said it would do (2016-2019)

1. We will develop and promote an Adult Safeguarding Risk Assessment Tool to support and guide frontline practitioners in identifying vulnerability and assessing risk

2. We will continue to raise public awareness of abuse and neglect via the Board's 'Thinking it? Report it' campaign

3. We will ensure high quality training is available locally, enhancing knowledge of safeguarding issues and improving practice

4. We will develop and promote self-neglect practice guidance to assist practitioners in both identifying and responding to the issue

5. We will work in partnership with other Boards and groups in order to maximise impact, minimise duplication and seek opportunities for efficiencies

6. We will take steps to protect vulnerable adults at risk from sexual exploitation, modern day slavery, radicalisation, and financial abuse

7. We will monitor progress in relation to the Mental Health Crisis Concordat

What SSAB did:

1. The Policy & Procedures subgroup oversaw the development and promotion of the Adult Safeguarding Risk Assessment Tool, which was published in April and is available on the Board's website. It is designed to assist practitioners in considering the vulnerability of the adult at risk and the seriousness of the abuse that is occurring, *and* the impact of the abuse and risk of it recurring. The tool is now used

within training and also by frontline practitioners to assist them with decision-making.

2. An important role of the SSAB is to raise public awareness so that communities play their part in preventing, identifying and responding to abuse and neglect. The SSAB originally launched its 'Thinking it? Report it' publicity campaign in November 2015. During 2016/17, the campaign was re-launched to coincide with June's World Elder Abuse Awareness Day (WEAAD), a time when the international community pledges to tackle the abuse of older people. In recognition of this, the SSAB developed a short animated film to increase understanding of the types of abuse and neglect that can be suffered by vulnerable adults, and how to seek help. The video is available on the Board's website and has received hundreds of views. The SSAB also called upon individuals to sign up to a public pledge to report concerns if they suspect someone to be at risk, in recognition that safeguarding adults is everyone's business. The pledge is available in postcard format and electronically via our website, and is routinely promoted at events.

   A 'Thinking it? Report it' campaign Evaluation Report compiled by Lambeth Communications (the company commissioned to deliver the SSAB branding, logo and original campaign activity in September 2015) in the Autumn of 2016 found it had reached over 2.9 million people through the variety of communication channels used. The strong networks the SSAB has was found to have been a tremendous support in this awareness raising and promotion.

3. It is the responsibility of all organisations to ensure they have a skilled and competent workforce who are able to take on the roles and responsibilities required to protect adults at risk and ensure an appropriate response when adult abuse or neglect does occur. At this current time, the Somerset Safeguarding Adults Board does not provide single or multi-agency safeguarding training. Recent Safeguarding Adults Reviews (SARs) have flagged training needs as a common theme and recommended the SSAB Training function be strengthened – this is something that will continue to be explored during the coming year. The SSAB hosted its first multiagency Practitioner Learning Event (June 2016 & Think Family Workshops (from July 2016) which have been well-received; there is an appetite for more opportunities and the Board will deliver another cross-agency conference, aimed at organisational Safeguarding Leads, during the coming year.

4. Self-Neglect Practice guidance was published by the SSAB in June 2016, having been informed by learning to emerge from the March 2016 ADASS Regional Conference. This was shared with housing providers in July 2016, and featured in the July SSAB Newsletter. In March 2017, the Board agreed to make use of district-based Social Exclusion Panels to assist in supporting the management of complex self-neglect cases, particularly where hoarding exists.

5. Effective working relationship between the key partnership boards that have oversight of the work undertaken to support our population will ensure a clearer understanding of respective roles and responsibilities, improve joined up working between partners, reduce duplication, and develop collaborative efforts to improve the resilience of Somerset communities, families and individuals.

   In August 2016, a 'Working Together Protocol for the Strategic Partnership Boards in Somerset' was officially signed off to support effective working arrangements between the Somerset Health and Wellbeing Board, Somerset Children's Trust, Somerset Safeguarding Children Board, Somerset Safeguarding Adults Board, Somerset Corporate Parenting Board, and the Safer Somerset Partnership. Joint Partnership meetings now occur on a six-monthly basis to enhance relationships and explore opportunities, chaired by the County Council's Chief Executive and attended by Board Chairs and supporting Business Managers/Officers. The first meeting took place in December 2016, with the next scheduled for June 2017.

   The SSAB is also represented on a number of other multi-agency partnerships, including the Prevent Board and Domestic Abuse Board.

6. In contrast to Children's Services, there are no specific statutory responsibilities in relation to adult sexual exploitation. Whilst the 'Sexual Violence against children and vulnerable people National Group Progress Report and Action Plan' made some reference to adults as victims, these are not translated into specific actions or responsibilities. Nationally, there is a risk of sexual exploitation being ignored by adults' services and seen as a 'children's issue' only. This is clearly not the case; young people will be transitioning into adult care, and those in the care of adults' services may be affected by the impact of sexual abuse or exploitation as an adult – as the SSAB learnt from a serious case review last year. Similarly, adults receiving care and support from adult social care may have children themselves who may be at risk of CSE. During the past year, the issue of the sexual exploitation of vulnerable adults, particularly those with learning disabilities who may be less able to distinguish between abusive and consenting relationships, has featured within a Practitioner Briefing Note, and was explored at the SSAB's Learning Event in June. The SSAB has also sought membership to the SSCB's multi-agency CSE Subgroup and will join discussions in June 2017.

   Care and Support Statutory Guidance, issued under the Care Act 2014 by the Department of Health, specifies Modern Slavery as a specific type of abuse and neglect. Modern slavery encompasses human trafficking, slavery, servitude and forced or compulsory labour. During the year, individuals across Community Safety, Social Services and the Police in Somerset have supported the Home Office's National Referral Mechanism Pilot to support and benefit potential victims of modern slavery. Training has been received in acting as Slavery Safeguarding Leads

and Multi-Disciplinary Panel Members. The topic has also been promoted via the SSAB website, newsletter and twitter feed.

Prevent forms one of the four strands of Contest (the others being Pursue, Prepare and Protect) the United Kingdom's Strategy for Counter Terrorism, part of the Counter-Terrorism and Security Act (2015). The Prevent Duty supports the 'specified authorities' where there may be risks of radicalisation in Somerset. Fundamentally, it challenges the ideologies that support extremism and terrorism and those who promote it through Safeguarding, and utilises a multiagency approach. In April 2016, SSAB Members received a training presentation from the Police County Prevent Lead, which outlined the objectives of Prevent and promoted the factors that can contribute towards vulnerability towards radicalisation. The SSAB is also represented on the local multi-agency Prevent Board.

Financial abuse is the illegal or unauthorized use of a person's property, money, pension book or other valuables. During the year, links have been strengthened with Devon & Somerset Trading Standards, and a representative is now a formal member of the Board. The organisation attended the Board's Practitioner Learning Event in June 2016 to raise awareness and share materials; the SSAB supported and promoted Scams Awareness month in July and featured scam awareness in its July newsletter. The SSAB has also commitment to promoting trading standards activity as part of June 2017's Stop Adult Abuse week, with its 'safe at home' focus.

7. The SSAB receives detailed updates on progress in relation to the Mental Health Crisis Care Concordat activity as a standing agenda item at each of its quarterly meetings. This work is designed to enhance the response of partner organisations and improve the experience and outcomes of people in mental health crisis by ensuring services in Somerset are appropriately commissioned and resourced to deliver 24/7 crisis response for patients and carers in the most appropriate settings, including their own homes. The SSAB Manager has been invited to participate in its 'Think Differently, Do Differently' subgroup during the coming year, which will focus on how - as a system – we can explore approaches regarding a small cohort of individuals frequently in crisis who present with high level, multiple, complex needs; an issue that has been identified from reviews of both local and national serious cases.

Next Steps 2017/18 (Prevention)

a) Plan promotion events and activities to coincide with June 2017 World Elder Abuse Awareness Day and regional 'Stop Adult Abuse' week (safe at home focus)

b) Work with Devon & Somerset Trading Standards to address financial abuse and scams

c) Seek enhanced assurance of local agency training delivery, take-up, application and impact

d) Deliver an annual conference focused on raising the profile of adult safeguarding, addressing known areas of practice requiring improvement, sharing lessons learned from case reviews, and offering a selection of focused workshop sessions to organisational Safeguarding Leads

e) Establish and oversee the work of a local multi-agency Mental Capacity Act Forum, to enhance local understanding and application of the Act

f) Continue to monitor progress in relation to the Mental Health Crisis Care Concordat and its 'Think Differently, Act Differently' subgroup in order to improve the experience of people in mental health crisis by ensuring services are appropriately commissioned and resourced.

g) Work with other strategic partnership boards in Somerset to keep people safe from harm and improve their health and wellbeing in support of the prevention agenda, reducing duplication of effort and maximising effectiveness

Priority Area 2:

Making Safeguarding Personal

What SSAB said it would do (2016-2019)

1. We will promote the principles of Making Safeguarding Personal and evidence user experience

2. We will collect, analyse and report on the themes to emerge from Safeguarding Adults audits as a means of developing local practice and overseeing improvement activity

3. We will monitor and support the effective use and understanding of the Mental Capacity Act, and the Deprivation of Liberty Safeguards (DoLS)

What SSAB did:

1. Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and

working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process. The extent to which local services are adopting an MSP approach has been monitored by the SSAB via its annual organisational self-audits, designed to give assurance to the Board of local practice.

The Board's Quality Assurance subgroup has also supported the development of a 'Safeguarding Experience' feedback process, which will launch in the Spring of 2017 and will capture responses from individuals, and their carers, about the extent they felt listened to, informed about what was happening and why, whether or not they feel safer as a result of the intervention, and their levels of satisfaction with the engagement.

The Board has also been monitoring the extent to which people are reporting their desired outcomes have been achieved as part of its performance reporting mechanisms. Figures for the 2016/17 year have consistently been above 85%, and we await national comparative data due to be published in October 2017 to determine how we benchmark against other areas.

2. To support local agencies, the SSAB adopted an Organisational Adult Safeguarding Self Audit Tool to help it evaluate the effectiveness of internal safeguarding arrangements, and to identify and prioritise any areas in need of further development to support local organisations in their continuous improvement of adult safeguarding work. Results from the audit process were analysed by the subgroup and formally presented to the SSAB Board in December 2016. The audit revealed areas of high confidence across the system to be in relation to participation to the Board itself and multi-agency working, but some areas of concern in relation to local application of the Mental Capacity Act, the extent / impact of adult safeguarding training and the capturing of equalities information to inform safeguarding responses. The SSAB has also secured a group of multi-agency frontline professional volunteers to form adult safeguarding audit groups; this will be progressed during the coming year.
3. The SSAB receives quarterly updates from the MCA (Mental Capacity Act) & DoLS (Deprivation of Liberty Safeguards) Manager, who has been chosen to chair the South West forum of local authority MCA/DoLS leads and participates in a national leads forum each quarter. As referenced previously, the poor application of the MCA has featured as a theme to emerge from both local and national case reviews, and audits. In December 2016, the Board approved the establishment of a new subgroup - a local Mental Capacity Act forum - which will work to embed the empowering aims of the legislation.

The Deprivation of Liberty Safeguards have been in operation since April 2009. Since April 2013 with the end of the Primary Care Trusts, the functioning of the safeguards has been the sole responsibility of local authorities. Referrals for assessment and authorisation showed a steady year on year increase until the end of 2013/14. This was part of a pattern of very inconsistent use of the safeguards nationally which was criticised in the March 2014 report by the House of Lords select committee into the implementation of the Mental Capacity Act. The committee's conclusion was that the DoLS scheme was cumbersome and difficult to understand, and therefore that it was not an effective protection of individuals' human rights and should be re-drafted. The proposed replacement scheme known as the Liberty Protection Safeguards was published by the Law Commission in March 2017. Their full report and summaries and impact assessment can be found at the following link: http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

At the time of writing, it is not clear what the Government intends to do with the proposals and there are still some significant concerns from local authorities about the affordability of the new scheme.

Defining deprivation of liberty

In March 2014 the Supreme Court handed down its judgement in two cases (P v Cheshire West and Chester Council; P and Q v Surrey County Council) which focussed upon the definition of deprivation of liberty itself. The clarified definition – often referred to as the 'acid test' – has made it easier to understand how deprivation of liberty should be assessed but in a way which has resulted in a very significant increase (approximately ten-fold) number of applications made to local authorities and to the Court of Protection itself. The Law Commission proposals do not alter this definition in any way so the number of people to be covered by the new scheme is unlikely to be reduced.

Next Steps 2017/18 (Making Safeguarding Personal)

a) We will ensure the views of services users, carers, frontline staff and Board Members inform the work of the SSAB:
   - We will implement the Safeguarding Experience service user/carer/provider feedback process and monitor responses on a quarterly basis
   - We will introduce and invite service user stories to Board meetings

b) We will ensure individuals experiencing safeguarding concerns have appropriate and timely access to advocacy through the promotion of advocacy services and knowledge

c) We will establish multi-agency Adult Safeguarding Audit Groups to help the Board quality assurance local practice and service delivery, and improve quality, performance and learning

Priority Area 3:

Think Family

What SSAB said it would do (2016-2019)

1. We will work in partnership to support vulnerable young people in making the transition between children's and adult services

What SSAB did

1. We recognise that multi-agency, flexible and coordinated services, with an underpinning 'Think Family' ethos, are most effective in improving outcomes.

   During the past year, the SSAB has sought to strengthen links with the Somerset Safeguarding Children Board in promoting a 'Think Family' approach. In July 2016, the two respective Board Managers initiated a series of 'Think Family' themed, practitioner focused sessions across the county. The sessions serve as an opportunity for informal two-way dialogue between frontline staff and the two statutory Boards, and have enabled discussions to take place that both complement and inform local priorities. Subsequent sessions have concentrated on care leavers and, more recently, transitions to adulthood ('Choices for Life').

   In addition, the SSAB has worked together with the Somerset Safeguarding Children Board (SSCB) to support more effective transition for young people leaving care or on the cusp of care through the development of Intervention and Resource Panels, which began in August 2016. This builds on learning to emerge from the joint

Learning Review into the deaths of vulnerable young adults (completed in 2014, and published in the autumn of 2015).

A new joint-funded Manager has also taken up post to directly support the Transitions vision across children's and adult services.

Next Steps (2017/18)

a) We will support the development of a multi-agency Think Family Strategy for Somerset

b) We will work with other Strategic Partnership Boards in Somerset to keep people safe from harm and improve their health and wellbeing in support of the prevention agenda, reducing duplication of effort and maximising effectiveness; this will include work to better support victims of exploitation, coercive control and grooming

Priority Area 4:

SSAB Effectiveness

What SSAB said it would do (2016-2019)

1. We will invite an external peer review of the SSAB and respond to any learning recommendations that emerge

2. We will initiate an annual Adult Safeguarding organisational self-audit process

3. We will commission and participate in Safeguarding Adults Reviews (SARs), ensuring learning is widely shared and action taken across agencies to address identified concerns or embed good practice

4. We will develop and actively promote a dedicated website for the SSAB to serve as a useful source of information for the general public, wider workforce, and Board members

5. We will issue regular newsletters as a means of sharing information and improving local awareness of adult safeguarding matters with both professionals and the wider public, encouraging and enabling feedback

6. We will ensure the views of services users, carers, frontline staff and Board members informs the work of the SSAB and are used to inform and develop local practice

7. We will use data, information and local intelligence to identify risks and trends and formulate action in response

8. We will ensure policies, procedures and practice guidance are reviewed to reflect new or emerging legislation, policy or learning, including revised Care and Support guidance

9. We will deliver a multi-agency SSAB Training event to support the knowledge and development of our members

What SSAB did

1. Due to financial pressures facing local services, a Peer Review was not commissioned for the SSAB during 2016/17. An independent Chair, John Bolton, is currently supporting the Local Authority in strengthening its performance arrangements. The SSAB Chair, Richard Crompton, has been invited to attend quarterly strategic meetings and in September 2016 submitted a report from the SSAB outlining both strengths and self-assessed areas for development for scrutiny and consideration.

2. A organisational self-audit process was developed via our Quality Assurance subgroup and issued to member agencies for completion by end of June 2016. It has also been made available to other interested parties on our website. Analysis was completed during the autumn and presented to the SSAB Board in December 2016. Plans are in place to repeat the exercise during the coming year.

3. The Safeguarding Adults Review (SAR) Subgroup has overseen and commissioned a number of SARs and learning reviews during the year – please see Section 6 of this report for further detail.

4. A cornerstone of the SSAB's work is the provision of information to the public, potential and actual service users, staff working in partner agencies and others interested in adults' welfare. A significant amount of work has been undertaken during the year to raise the profile of the Safeguarding Adults Board locally, improve the ways in which we communicate with the wider public and with multiagency professionals, and to raise local knowledge of how to prevent abuse or neglect.

   Within budget and on scheduled, the SSAB launched its own dedicated website (www.ssab.safeguardingsomerset.gov.uk) in April 2016. The site has helped provide a platform to promote work of Board and direct interested parties to key information and resources in order to reach a bigger audience and support public and professional knowledge of adult safeguarding matters. During 2016/17, our website was accessed by 3,629 individual users (40% of which were returning

visitors), and had 15,679 individual page views. Spikes in website usage were evident in April (following official launch of the site), mid-June (World Elder Abuse day and Stop Adult Abuse week) and November (following the launch of the safeguarding adults electronic referral form, which was used as the source of 83% of 'professional' safeguarding concerns by April 2017).

The SSAB also joined twitter to enhance our reach, influence and engagement opportunities. The Board now has over 290 followers and routinely participates in debates and promotion activities.

5. The SSAB has continued to issue newsletters on a regular basis to several hundred professionals and stakeholders across frontline services; these are also forwarded on through other existing internal agency communication routes. Our website now enables people to register for the newsletters and, since this functionality was created, an additional 90 individuals have signed up to receive the briefings. The newsletters outline updates from the Board, national and local adult safeguarding news and developments, and lessons to emerge from practice and reviews.

6. The SSAB has established links with existing service user and carer groups in the county, as well as with Healthwatch Somerset, with its Business Manager attending to present on the work of the partnership during the year. The Quality Assurance Subgroup has supported the development of a 'Safeguarding Experience' feedback form, due for implementation in the spring of 2017, and arrangements are being made to commence 'Safeguarding Stories' as a standing agenda item for Board meetings during 2017/18.

   The Board has also sought to learn from the direct experiences of service users and their families or carers; it has benefitted significantly from their contributions to both local Learning Events, SARs and practitioner briefing sheets and we are keen to develop this further during the years ahead.

7. Considerable work has been undertaken to enhance the data and information available to the SSAB and its Quality Assurance Subgroup from its member agencies; this has helped identify issues requiring resolution. Reports are now routinely received from Adult Social Services, the Deprivation of Liberty Safeguards lead, the Constabulary's Safeguarding Coordination Unit, Care Quality Commission and other key services.

   Analysis was also undertaken of the national 2015/16 comparative Safeguarding Adults Collection data, published in October 2016, which highlighted both strengths of Somerset's safeguarding processes and areas requiring further attention.

Additionally, Board Members contributed to the second annual SSAB Effectiveness Survey in the autumn of 2016, with improved performance against all 12 effectiveness standards when compared with the previous year's figures. Key strengths were identified in relation to the Board's leadership and coordination of adult safeguarding policy and practice across agencies, and the sense that partners work in an atmosphere of cooperation, mutual assurance, accountability and ownership of responsibility. Areas requiring greater attention centred on the use of data, information and intelligence to identify risks and trends, and ensuring mechanisms are in place to ensure the views of people at risk of abuse and their carers inform the work of the SSAB. The findings of this survey, which will be repeated on an annual basis, have informed the Board's risk register and our strategic plan for the year ahead.

8. The role of our Policy and Procedures subgroup is to produce, maintain, develop and review policy, procedure and practice guidance to improve outcomes for adults at risk in Somerset. During the year, the subgroup has developed and published a Service Monitoring Checklist to assist practitioners in considering and recognising potential indicators of concern across the following six criteria:

- Leadership and Management
- Staff behaviour and attitudes
- Behaviours and interactions of residents
- Isolation and lack of openness
- Service design, delivery and make up
- Environment and basics of care.

It also prepared self-neglect practice guidance to serve as a multi-agency guide to issues of self-neglect and to offer procedural guidance for frontline workers. The guidance has been developed in direct response to requests for assistance in managing this complex issue from local housing providers, and was enhanced by learning to emerge from Safeguarding Adults Reviews and the 2016 regional ADASS South West Conference in March 2016.

It has monitored and supported the refresh of regional multi-agency Safeguarding Policy in light of the revised statutory guidance – published June 2016 – in partnership with other local Safeguarding Adults Boards, and has supported the review of a range of policy or procedural documents in partnership to assist the Board in delivering its functions effectively, including:

- An Escalation Policy
- The local Business Failure process
- Adults at Risk meeting documentation and templates
- The Whole Service Concern process

- The development of an electronic professionals referral form
- Learning to emerge from the ADASS Guidance on out of area adult safeguarding arrangements.

9. In April 2017, SSAB members attended a training event and received presentations from local leads on Prevent, Female Genital Mutilation, learning to emerge from Domestic Homicide Reviews locally, and early help thresholds across children's services. A number of members also attended the Practitioner Learning Event in June.

Next Steps (2017/18)

a) Undertake annual Adult Safeguarding organisational self-audit process, enabling the Board to hold members agencies to account, monitor implementation of previous year's identified actions and gain assurance of the effectiveness of local safeguarding activity

b) Commission, participate in and support Safeguarding Adults Reviews (SARs), ensuring learning from both local and national reviews is widely shared and action taken across agencies to address identified concerns or embed identified good practice

c) Use data, information and local intelligence to identify risks and trends, and formulate action in response, to include monitoring of SSAB communication tools

d) Ensure policies, procedures and practice guidance are reviewed to reflect new or emerging legislation, policy or learning, and made more easily accessible to frontline services via the SSAB Website

e) Support Elected Members and Committee functions to better understand their roles and responsibilities in effectively scrutinising and monitoring the effectiveness of the Board in protecting vulnerable adults from abuse

f) We will enhance local assurance mechanisms through the implementation of a peer challenge process in order to increase SAB member understanding of each other's work and methods of service delivery and identify opportunities to strengthen multi-agency working

Safeguarding Adults Practitioner Learning Event

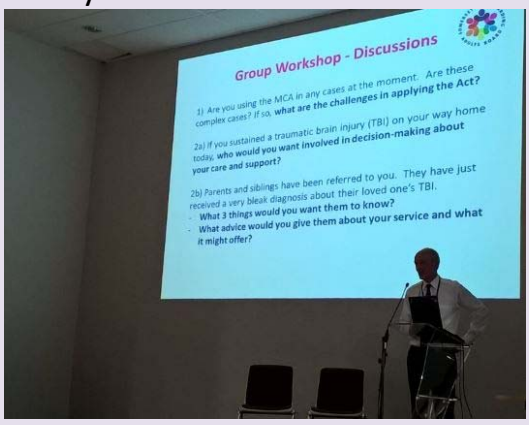
The SSAB delivered its first multiagency Practitioner Learning Event in June 2016 to over 100 frontline professionals to communicate the themes and lessons learnt from recent serious cases.

Feedback from attendees revealed that:

- 94% felt the overall event had been good or excellent;
- 90% felt the venue and facilities had been good or excellent;
- 97% felt the registration and booking arrangements had been good or excellent;
- 87% felt the length of the event had been good or excellent;
- 82% felt the opportunities for networking had been good or excellent;
- 91% agreed or strongly agreed that all subject matter was presented clearly and effectively;
- 97% felt confident about taking learning from the event and applying it to their own role, and
- 92% agreed or strongly agreed that all speakers had presented the subject matter clearly and effectively.

Overall, attendees particularly liked:

- Hearing from service users and families the vast majority of attendees specifically referred to Alyson's speech and Fred's presentation as having been the most valuable part of the day;
- The chance to explore and discuss the use of the Mental Capacity Act in complex cases;
- The opportunity to come together as a multi-agency group; attendees told us they would welcome more events like this in the future.



(L) Chairman addressing audience

(R) Group workshop discussions

6. Safeguarding Adults Reviews

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

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

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

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

The SSAB has a multi-agency SAR subgroup whose role it is to ensure statutory requirements are met in relation to reviews. The subgroup is chaired by the Director of Adult Social Services.

During 2015/16 the SAR Subgroup:

- **monitored progress in relation to ongoing reviews and considered potential cases against the criteria** for conducting one. It has also overseen the appointment of independent, external Chairs and Review Authors; this supports the SARs credibility, and can help to create a more conducive environment to facilitate and encourage discussion amongst involved stakeholders. The SSAB has been fortunate in securing high-profile and well-regarded Chairs to oversee its recent reviews, and is grateful for their input and contribution.
- worked in partnership with the Policy & Procedures subgroup to produce a **Learning and Improvement Policy**, replacing the former Serious Case Review policy that existed, clarifying local arrangements for SARs, and ensuring learning and improvement is better embedded in practice. The Policy was formally ratified in February 2016.

- **ensured the presentation of completed reviews** to the Safeguarding Adults Board for formal acceptance and to agree plans for publication and implementation, including the dissemination of learning across the locality.
- **commenced work to explore how the SAR process can better align with / support other statutory review processes**, such as child Serious Case Reviews or Domestic Homicide Reviews.

Two Safeguarding Adults Reviews concluded during 2016/17:

Tom, June 2016

A Serious Case Review was commissioned by the SSAB following the death of 'Tom' who took his own life in 2014, aged 43. Tom had sustained a traumatic brain injury in a road traffic accident in his early twenties and suffered from depression and drugs and alcohol abuse.

The independent report concluded that, despite numerous contacts with many health and care professionals and the concerns of family members, he was not provided with appropriate support.

It highlights a lack of joined up working across social care, health bodies and drug and alcohol services, with none taking a lead role in determining a coordinated, multi-agency response and missing opportunities to intervene in an integrated way.

Key considerations for practice arising from the review:

- **Supporting people with brain injuries** - **capacity assessment**: Tom's circumstances highlight the fraught boundaries between personal responsibility, public obligation and the assumption of mental capacity. Mantell (2010) has argued that an assumption of mental capacity is risky because a person's severe brain injury usually results in a degree of cognitive impairment'

- **Working with people with multiple and complex needs** - Working with people with multiple and complex needs, across agencies, has to hinge on coordinated assessment, care management and working with the risk of harm together

- **Adopting a Think Family approach:** Little was known about Tom's life before he sustained his brain injury. Although his family was an obvious source of information, their role as reflected in contacts with services became one of pleading for engagement and help.

Action taken on the back of Tom's Safeguarding Adults Review

- Tom died in June 2014; in April 2015 the Care Act put adult safeguarding on a statutory footing for the first time, and in May 2014 a dedicated countywide safeguarding service was established by the Local Authority in May 2015. The

service receives all safeguarding concerns and makes threshold decisions regarding whether referrals meet the criteria for statutory safeguarding enquiries under the Care Act 2014, or require other assessment and support. It undertakes direct safeguarding enquiry and investigation work, and oversees enquiry work undertaken by other agencies. This centralised model ensures greater consistency in decision-making.

- The Mental Health Social Care service has been re-designed and management responsibilities, previously delegated to Somerset Partnership NHS Foundation Trust, have returned to the Local Authority from October 2016. The focus of the new service will be a promoting independence community-based, recovery-focused, and needs-led rather than diagnosis driven. Reflecting upon the Care Act 2014, the service will support individuals with significant needs irrespective of whether they meet secondary care clinical eligibility, which will broaden the group of individuals able to access a specialist service.
- The SSAB delivered a multi-agency Practitioner Learning Event in June 2016, attracting over 100 frontline staff from 19 different agencies and focused on lessons to emerge from Tom's case and another case which concluded in January 2016. Headway Somerset and one of their clients were invited to present specifically on brain injury and its effects and impacts, and Tom's sister was also able to present, alongside the report author, on the family's own experience. 97% of respondents reported feeling confident about taking the learning from the event and applying it to their role. Local trainers were in attendance and have received main themes and learning points so they can refer to the case within training activity in Somerset to reinforce lessons learnt and apply theory to practice.
- The Board developed a Practice Briefing Note, which has been widely disseminated and promoted, detailing the main learning points to emerge from the review. The content of this document was agreed in partnership with the independent review author, Margaret Flynn. Adult Social Care staff have been actively encouraged to use the briefing sheet within team meetings and supervisions as part of reflecting on, developing and strengthening local practice.
- Acquired Brain Injury has featured as an 'awareness topic' within the Board's newsletter, which also promoted national practice guidance on working with people with acquired brain injury. Both were published on the Board's website and also promoted via its twitter account to raise local appreciation of the issue.
- The case was presented to District Council leads and the local Housing Providers group in July 2016 by the Safeguarding Adults Board's Business Manager, who attends on a quarterly basis to enhance awareness of safeguarding developments

across these agencies.

- The Board has continued to promote adult safeguarding issues and how to report concerns to the general public and wider workforce across all member agencies.
- In December 2016, the SSAB confirmed its approval for a local multi-agency MCA Forum to be established. The group will act as a subgroup to the Board with responsibility for supporting the local implementation of the Act and embedding the empowering aims of the legislation. The group will also provide the Board with assurance about the effectiveness of implementation across organisations and make recommendations about future development. Additional training has been provided to Local Authority staff on the Mental Capacity Act 2005. Since April 2015, staff receive two days' worth of training on the Mental Capacity Act delivered by an Independent MCA & Safeguarding trainer and consultant. Court of Protection Legal Training courses have been delivered to staff by Albion Chambers, and guidance and checklists are available on staff intranet pages for all Adult Social Care staff to access.

Damien, September 2016

Damien had diagnoses of Asperger's Syndrome and ADHD. He had a mild learning disability and misused a variety of substances, causing him to come into frequent contact with the police and mental health services. His vulnerability was exploited by others who stole from him and misused his home for their own purposes. Meeting the dual requirements of protecting both the public and Damien from harm, at the same time as treating him as capacitous and allowing him to live his own life with only the necessary oversight and control, tested services in Somerset. In the last fifteen months of his life he was detained under Section 2 of the Mental Health Act on three occasions. He was also made subject to Multi Agency Public Protection Arrangements (MAPPA). Damien died in hospital in July 2015 following an incident of self-strangulation in the residential unit that had been his home for two weeks following discharge.

Key considerations for practice arising from the review:

- **Supporting transition between inpatient mental health settings and community / care home settings:** A key issue affecting transition is a lack of integrated and collaborative working between mental health and social care services, practitioners based in hospitals and those in the community, which can result in inadequate and fragmented support for people using mental health services

- **Supporting families, parents and carers:** Good communication leads to better coordinated care and better experiences

- **Follow-up support:** The consequences of a poor transition can be very serious for the person and their family or carers. National evidence tells us that the first three months after hospital discharge continue to be a period of high suicide risk

- **Promoting Person-centred practices** By working in a person-centred way, we can ensure people are truly listened to and are kept at the heart of all decision-making

Figure 1: The four principles of person-centred care

Action taken on the back of Damien's Safeguarding Adults Review

- In partnership with Damien's family, the SSAB produced, published and promoted a Practice Briefing Sheet highlighting the central themes to emerge from the review. The briefing document was published in the Board's March 2017 newsletter and was shared with local trainers to ensure it informs learning and development.
- The SSAB has promoted person-centred thinking tools via its website and publications to further embed a Making Safeguarding Personal approach across Somerset.
- The Board intends to further promote the case at its 2017/18 Learning Event aimed at local Safeguarding Leads following the conclusion of a Coroner's Inquest expected summer 2017.

7. Our priorities 2017/18

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

1. **Prevention**: focused on ensuring adults at risk are identified early and have their needs met promptly and effectively, and that multi-agency practitioners are supported in identifying and responding to adult safeguarding concerns. It is better to take action before harm occurs.
2. **Making Safeguarding Personal**: focused on embedding an approach to safeguarding that is person-led, outcome-focused, enhances involvement, choice and control, and improves quality of life, wellbeing and safety.
3. **Think Family:** focused on adopting an approach to safeguarding which considers impact on the whole family, in recognition of themes to emerge from recent serious cases and local needs assessments.
4. **Board Effectiveness:** focused on taking further steps to ensure Somerset has an effective Safeguarding Adults Board which fulfils its responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning.

You can read our 2017/18 Strategic Plan in full via the following link:
http://ssab.safeguardingsomerset.org.uk/wp-content/uploads/SSAB-Strategy-2016-19-updated-2017.pdf

Safeguarding Case Study 2 – Jack's story

Background: Jack, 80, lives alone in a mobile home in Somerset. He is well-spoken, educated and with much life experience.

Safeguarding Concern: An electrician, who wished to remain anonymous, contacts the Local Authority with concerns about Jack, whom he had visited as he was having problems with his electrics. The electrician reported not being prepared for what he had seen upon attending Jack's home. Papers were piled up on the floor, knee-deep. There were rodent droppings everywhere. Dirty pots and pans were stacked up in the kitchen. Jack used several electric heaters but had blown the fuse panel and burnt some of it out. The place smelt strongly of fumes. The electrician advised Jack not to use more than one heater as it was not safe, and warned him of fire risks. He remained concerned about the level of risk and Jack's understanding of his advice, and requested someone visit to assess the situation.

Safeguarding Response: A Safeguarding Officer contacted Jack and arranged to visit him at home. She was shocked and concerned on visiting due to the obvious disrepair of the property, potential fire risk and extent of hoarding. A full risk assessment was carried out with Jack, who was encouraged to participate fully. The Officer utilised risk assessment tools commonly used by the Fire Service to assess the level of neglecting risk, and Jack engaged fully with the conversation and conclusion of risk. The Safeguarding Officer deemed him to have a good appreciation of the inherent risks in his living conditions and was seeking to change his circumstances. Permission was given to speak with his only living relative – a nephew – who also shared the concerns for Jack.

Safeguarding Outcome: Jack accepted the concerns of the Safeguarding Service and acknowledged he could not continue living in the accommodation. He declined a Home Safety Check from the Fire Service and support to help sort his belongings, but did agree to temporary accommodation whilst waiting for a longer-term option to become available.

Jack went on to sell his land and has since purchased a bungalow. He has no current social care needs and is living an independent life.

8. Board Budget

		2016/17		2017/18	
SOURCE OF FUNDS		**CONTRIBUTION £**	**%**	**PROJECTED CONTRIBUTION £**	**%**
Carry Forward		5,000			
SOMERSET COUNTY COUNCIL	- SAB MANAGER & CHAIR	45,840	51.8%	43,420	45.1%
	- SAFEGUARDING ADULTS REVIEWS	16,160	18.3%	8,000	8.3%
AVON & SOMERSET POLICE	- SAB MANAGER	15,900	18.0%	18,900	19.6%
	- SAFEGUARDING ADULTS REVIEWS	550	0.6%	8,000	8.3%
SOMERSET NHS CCG	- SAB MANAGER	10,000	11.3%	10,000	10.4%
	- SAFEGUARDING ADULTS REVIEWS			8,000	8.3%
TOTALS		**93,450**	100.0%	**96,320**	100.0%
APPLICATION OF FUNDS		**EXPENDITURE £**	**%**	**PROJECTED EXPENDITURE £**	**%**
PAY					
SAFEGUARDING BOARD MANAGER		54,760	54.5%	55,320	56.3%
INDEPENDENT CHAIR		16,980	16.9%	17,000	17.3%
NON PAY					
SAFEGUARDING ADULTS REVIEWS		16,710	16.6%	24,000	24.4%
ADASS THEMATIC REVIEW				300	0.3%
BRANDING & WEBSITE		10,640	10.6%	100	0.1%
ROOM HIRE		1,370	1.4%	1,500	1.5%
TOTALS		**100,460**	100.0%	**98,220**	100.0%
OVERSPEND		**7,010**		**1,900**	

9. The work of key members 2016/17

- **We have invested considerable focus on enhancing the effectiveness of local safeguarding processes and timescales within our dedicated safeguarding service.** There has been a clear emphasis on developing operational and business processes to enhance the efficiency and effectiveness of local service delivery and operational performance. At the start of the 2016/17 financial year, 42% of pathway decisions were made within the target 2 working day timeframe; since September 2016 performance has consistently exceeded the 97% target, with Quarter 4 data standing at 98.4% overall. This has been achieved through attention on data, enhanced scrutiny and validation of information, and robust engagement with referring agencies to enhance the quality of safeguarding referrals.
- **We have seen safeguarding conversion rates increase over the course of the financial year** from 40.5% in April 2016 rising to 52% by March 2017; we will continue to work in partnership with the wider Board and referring agencies to further improve understanding. We have worked closely with Avon & Somerset Constabulary to support their introduction of the BRAG risk assessment process in order to enhance knowledge of referral routes and sources of support, both within local services and across the broader community
- **We have developed our approach to high-risk care leaver transition using the adult safeguarding framework** and are working closely with the Leaving Care Service to enhance information-sharing and information, advice and guidance
- **We continue to provide trouble-shooting support to both non-CQC regulated and CQC regulated providers** to ensure identified quality concerns do not escalate into major operational or safeguarding issues. The proportion of good or better regulated care settings in Somerset exceeds national, regional and peer group averages.
- **We have introduced a new, secure, electronic safeguarding referral form, launched with care providers at an RCPA Conference in November 2016.** The new form helps to streamline and simplify the referral process and enhance the quality of the information received. Data demonstrates the e-referral form is being well and increasingly utilised by (mainly) providers of care and support services, accounting for 83% of all 'written' referrals received via Somerset Direct by April 2017. Feedback about the form also revealed people were finding the online referral form a useful and preferable option to standard phone/email reporting.
- **We have funded the full development and on-going hosting costs of a dedicated SSAB website** which went live in April 2016; this has proved invaluable in supporting the promotion and further progression of the Safeguarding Adults Board
- **We have developed a local, interactive CQC Ratings Mapping Tool** to support local stakeholders, and inform performance monitoring and benchmarking activity; this is now publically available via: http://www.somersetintelligence.org.uk/care-quality-commission-ratings.html
- **We have actively contributed to regional Quality Surveillance Group meetings** and ADASS (Association of Directors of Adult Social Services) Safeguarding Leads meetings, sharing local intelligence and learning for the benefit of other areas. We ensured good attendance from both Local Authority Adult and Childrens Services at the SSAB's June 2016 Learning event, and have promoted the practice briefing sheets and newsletters widely across the Council in order to develop practice and enhance awareness.

- **We have delivered a range of safeguarding-related training and development opportunities for staff within Adult Social Services:**
  - Recognising Adult Abuse (Contract started in November 2016) – 7 (half day) courses ran total of 52 people trained
  - Enquiry Skills – 3 courses (2 x 2 day course & 1 x 1 day refresher) total of 33 people trained
  - Leading Decision Making – 4 courses (2 x 2 day course & 2 x 1 day refresher) total of 41 people trained
  - Mental Capacity Act – 12 courses (2 day course) ran total of 144 people trained

  Additionally, staff within the safeguarding service and/or Learning Disability teams have benefitted from independent externally-led training in subjects such as Coercive Control, and in Mental Capacity and Sexual Consent.
- **We have worked to ensure that NHS Providers meet their safeguarding responsibilities** through strengthening our commissioning arrangements and closer monitoring of contracts
- **Our contracting process in 2016-17 reflected the requirements of the Care Act 2014** and supported outcomes-focused, person-centred safeguarding practice through 'Making Safeguarding Personal' and 'Think Family'

NHS
Somerset
Clinical Commissioning Group

- **We have facilitated a working group consisting of our NHS providers to align and strengthen NHS Safeguarding Services and Policies.** The group is collaborating to provide a core training package and schedule that can be both provided by and accessed by all NHS providers
- **We have been active participants in all Somerset Safegaurding Adult Boards meetings**, and provided representation on all the board's sub groups. We have contirbuted to the content of development plans, policies and protocols relating to the SAB. We have also supported all the Safeguarding Adult Reviews. We display 'Thinking it? Report it' leaflets and posters in our reception areas across all NHS Trusts, primary care and the CCG. The SSAB newletters have been disemminated across the CCG, all NHS Trusts and Primary Care
- **We have funded development of multi-agency safeguarding training** to deliver integrated and standardised level 3 training for health and care professionals jointly with North Somerset CCG. In 2016/17, through the contract management process, Somerset Partnership Trust reported an average 97% of staff receiving Safeguarding Adults training, Taunton & Somerset NHS Foundation Trust reported 91% and Yeovil Hospital reported 95% of staff who have received Safeguarding Adults training
- **We have worked with the Somerset GP Education Trust to deliver training** to GP's and Practice staff on safeguarding adults, focussing on learning to emerge from the Safeguarding Adult Reveiws commissioned by SSAB during 2016/17 with application of the learning to primary care
- **We have contributed to both the strategic and operational processes working with care homes** when there have been serious safeguarding concerrns and supported the process of two Nursing and one Learning Disability home closures in 2016/7
- **We commissioned an independent review into our commissioning arrangements** following the closure of a learning disability home. As a result of the review, we have amended our processes and developed tools to assess the quality of a service prioir to placement and assess the quality of our reveiws of people in receipt of Continuing Healthcare
- **The Care Home Support team have contributed to the development of Safeguarding, Mental Capacity and Deprivation of Liberty Safeguards practice with care home** and have delivered 34 workshops to increase staff confidence and competence in deciding when

to raise safeguarding concerns, and to implement the Mental Capacity

- **We have encouraged staff to attend regional and national safeguarding learning events** to disseminate good practice, and all NHS providers are required to have safeguarding, DoLS, and whistle-blowing policies and to implement the Duty of Candour as part of our contract management
- **We have worked with our providers and adult social care to ensure safeguarding alerts are raised and managed in a coordinated way**. In 2016-17, the CCG responded and took part in 45 whole service safeguarding or quality improvement meetings for care homes with nursing
- **We have a centralised Incident reporting system (Datix)** to enable us to review concerns and outcomes raised by health care professionals. During 2016/17, 120 serious incidents were reported from health providers – higher than 2015/16 when 94 incidents were reported. The highest prevalence of 'incident types' remain apparent/actual/suspected self-inflicted harm, there were 11 cases directly related to safeguarding.
- **We are using Care and Treatment reviews in line with NHS England best practice** to involve families and experts by experience in planning care that will achieve the aspirations of people with a learning disability and prevent the need for hospital admission at times of crisis

- **We provide professional policing services, working with partner agencies, in order to keep people safe from harm**. This includes working to prevent Adults at Risk from becoming victims of crime, investigating crimes against them, bringing perpetrators to justice and managing offenders.
- By way of **context**, the Constabulary identified 795 'Safeguarding Adult flagged crimes' and 481 'Safeguarding Adult flagged incidents' in Somerset during 2016/17, falls of 9% and 16% respectively on the previous year
- **Our first responders and specialist interviewers undertook refreshed training for responding to sexual assault.** Both courses relate directly to Adults at Risk. New police recruits and Police Community Support Officers also received this training, all of whom had safeguarding woven into their initial training.

- **We introduced a two year pilot Control Room Mental Health Triage Scheme**. Mental Health nurses are based in the Police Control Room, enabling the Constabulary to meet mental health needs at the first point of contact, ensuring that intervention takes place at the earliest possible moment. Access to both Police and Health information databases ensures that decisions made from that point onwards are fully informed and best placed to manage risk. 874 consultations were completed in March 2017, with Section 136 detentions being avoided on five occasions.
- **With partner agencies, we carried out a review of the process through which a patient travels when Section 136 of the Mental Health Act is being considered** in Avon and Wiltshire, and have developed a model process that is to be tested and piloted to contribute to the prevention of patients' deterioration into crisis. This work could have benefits for Somerset in due course.
- **We are an active partner in five Multi-Agency Safeguarding Hub arrangements based on local authority areas** - enabling us together to provide the best safeguarding response. The Somerset Adults MASH is developing to a case review and strategy model.

- **We are introducing a risk assessment process to support officers and staff in sharing information more effectively with partners**, helping vulnerability concerns to be referred internally to our Victims & Safeguarding Team and then onwards to partner agencies. This risk assessment process, known as BRAG (Blue, Red, Amber, Green), is designed to improve our understanding of Adults at Risk, safeguarding and vulnerability in a wider context, helping us to consider why information is being shared and how partners are expected to act upon that information.
- **We made effective use of our Constabulary Management Board** to carry out assurance work. For example, the February 2017 meeting focused on Adults at Risk and amongst other things examined: Adults at Risk and Missing Person Demand; Mentally ill people who are reported 'missing' from health-based settings; Missing Persons with a Learning Difficulty - Bristol Assurance Report; and the development of a Delivery Plan for Adults at Risk.
  We actively contributed to multi-agency learning through Safeguarding Adults Reviews and Domestic Homicide Reviews across Avon and Somerset and at the end of 2016/17 the Constabulary held two current recommendations from two Safeguarding Adults Reviews, one of which related to a case in Somerset. Progress in implementing recommendations is monitored by our Safeguarding Theme Leads Group and Constabulary Management Board.

- **We have appointed a Deputy Safeguarding Lead for NHS England SW**. Primarily this post will support the whole safeguarding agenda and the ongoing priorities as directed by the National Safeguarding Steering Group.

We have funded numerous projects in local SW CCGs. These include:

- Developing outcome focused regional standards and an assurance tool for CCGs to hold their providers to account in a systematic way with agreed regional benchmarks and evidence criteria. This includes PREVENT, FGM and CSE standards;
- Working with the regional police led Child Sexual Exploitation (CSE) project, provide bespoke nursing leadership to the development of the tool kit and standard operating procedure that will support all professionals in understanding CSE and how to spot it. This includes a "fast track" programme to refer children and young people to a bespoke mental health service;
- Developing a supervision structure and tool kit to support nursing home leaders and their staff in delivering safeguarding supervision within and between nursing homes and improving standards;
- Developing a tool kit to support healthcare professionals in writing Independent Management Reviews (IMRs) including primary care colleagues using audit methodologies and best practice evidence;
- Supporting a local Female Genital Mutilation (FGM) theatre group to deliver the message to young girls in schools and youth clubs and provide a safe place to discuss the issues they face;
- Provide dentists with bespoke safeguarding training that is tailored to their needs and meets their CQC requirements and provide a tool kit for senior dentists to supervise others in safeguarding issues;
- Regional events and training opportunities for designated nursing professionals for Looked after Children and those leading the delivery of the Slavery and Trafficking agenda.

Throughout 2016 and into 2017, NHS England South West has delivered a range of learning experiences for Primary Care

colleagues through e-learning licenses. In addition, the use of the GP reflective tool has been widely shared across all GPs which encourages GPs to look at real cases either with their local practice or as part of multi-agency team discussions. This is supporting the increased engagement by GPs within local case review and case conference processes in their local areas and supporting other GPs via local networks.

Throughout 2016 each CCG has been asked a standard question at each quarterly assurance meeting as part of their routine Key Lines of Enquiries (KLOEs). These questions have covered:

- Their assurance process and governance of their providers;
- Their plans and requirements to deliver the recommendations in both the Goddard and the Wood reports;
- How do their board members demonstrate competencies in line with the requirements within the Intercollegiate Documents;
- Bespoke safeguarding questions as required from CQC inspections or other alerts or investigations.

This assurance process has been developed to ensure all CCGs provide the right level of Board and Executive assurance to their local safeguarding systems and commissioned services and an action plan is now in development with each CCG for improvement in 2017/18.

NHSE SW has a detailed work plan for 2017/18, the key drivers include:

- Improved governance and assurance arrangements of its commissioned services
- Strengthened strategic leadership for safeguarding in SW NHS organisations
- Delivery of the national safeguarding priorities which include; Prevent, Modern Slavery, Child Sexual Exploitation (CSE), Deprivation of Liberty Safeguards (DoLS), Child Protection Information Sharing project (CP-IS), Looked After Children (LAC) and Female Genital Mutilation (FGM). As well as supporting the Independent Inquiry into Child Sexual Abuse (IICSA), the safeguarding reforms in child safeguarding and Unaccompanied Asylum Seeking Children (UASC).
- Supporting STPs in the SW to ensure that the safeguarding agenda remains a priority in local service development.

Taunton and Somerset NHS
NHS Foundation Trust

- We are continuing to work with our partners in health to co-ordinate our approaches to safeguarding training. This will establishing a consistent approach across organisations with an increased scope for joint working.
- A new Learning Framework for Safeguarding has been produced to reflect our multi-agency work on co-ordinating training. We are aiming to implement this new programme as soon as the multi-agency planning has been completed.
- We have been working to improve staff awareness of the Mental Capacity Act. This work has been primarily focused on increasing the number of senior staff who have undertaken our Mental Capacity Act for decision makers e-learning. We have made significant progress, but we will continue to drive this work forward to include an increasing range of hospital staff.
- We have implemented our new vulnerable adult audit programme. This programme covers adult safeguarding, Learning Disabilities, the Mental Capacity Act and restrictive care. This audit approach includes a qualitative notes audit combined with a staff survey.

- We have hosted a Domestic Abuse worker in the Trust to support victims of domestic abuse. This was a fixed term position using funding from the Police and Crime Commissioner. This post was supported by the Somerset Integrated Domestic Abuse Service.
- Funding has been agreed to support the employment of an Independent Domestic Abuse Advisor for the Trust. Discussions about this new role will commence with Somerset Integrated Domestic Abuse Service to ensure that this new post gives our victims of domestic abuse the best possible levels of support.
- We have played an active role on the Safeguarding Adult Board. This has included membership on a number of the Boards sub-groups and the Executive Group.
- We have continued to participate in Safeguarding Adult Reviews and Domestic Homicide Reviews.
  We have a work plan to improve safeguarding in the Trust. This plan is supported and overseen by our Safeguarding Committee. Our success against this plan is reviewed at the Trusts Quality Assurance Committee.

- We have fully integrated the safeguarding team, including the Trust Learning Disability Lead and the Trust Independent Domestic Violence Advisor

- We have engaged the full-time services of an IDVA to work in conjunction with the Safeguarding Team
- We Have commenced Routine Enquiry as part of the Screening Process for Domestic Abuse with in the Emergency Department for all patients aged 16 +
- We have situated the team in one office with a Single Point of Access contact number, which means all Trust staff know who to contact with any safeguarding/ Mental Capacity/ IDVA and Learning Disability concerns/questions
- We have delivered combined Adult and Children Safeguarding training, incorporating 'think family' to all staff levels of the organisation through the Mandatory and Induction training programme
- We have updated the trust intranet safeguarding page incorporating Adult and Children Safeguarding resources available for all staff to access.
- The safeguarding team provide advice, training, ad hoc supervision and support to all staff across the trust.
- The Mental Health Lead for the Trust is co-located in the safeguarding office, enabling seamless communication and information sharing between the safeguarding team and mental health lead.
- We continue to provide targeted training to wards and departments on understanding the Mental Capacity Act and DoLS processes
- We Promote SSAB news and awareness campaigns through our in house e bulletin and intranet.
- We Have developed a rolling modular level 3 training programme (adult and children) , which enables staff to attend modules lasting 2 hours.

- We continue to actively responded to serious case reviews, section 42 requests and where safeguarding concerns have been identified
- We have amalgamated the Child and Adult Safeguarding strategies into one strategy thereby strengthening our approach to safeguarding
- We are working with the partner organisations to develop a county wide training strategy.
- We have commissioned an external review of the Children and Young People unit (for over 18's). The recommendations of this review will be considered and actioned as appropriate.

We have both Executive and Non-Executive Safeguarding representation on the Trust Board

RCPA
REGISTERED CARE PROVIDERS ASSOCIATION LTD

- We have developed a training day in conjunction with Research in Practice for Adults (RiPfA) to be delivered to care providers on a rolling basis. The training is aimed at Managers within care organisations and seeks to promote safeguarding within the Making Safeguarding Personal Framework.
- We have continued to be a source of advice and support to our members in relation to safeguarding matters.
- We collaborated with the Somerset County Council Safeguarding and Quality team in delivery of the 2016 RCPA Annual Conference. The team delivered two workshops on the Council's safeguarding policy and procedures, and contract quality.

- We have refreshed all of our staff training in line with the Care Act 2014.
- Our staff training strategy has been reviewed and updated to ensure that staff receive the appropriate level of training required. There is now mandatory e-learning as well as face to face training covering Adults at Risk, Children and Young People, Child Sexual Exploitation, PREVENT, Domestic Abuse and MARAC and Mental Capacity Act 2005.

Knightstone

- We have increased the hours of our Safeguarding and Mental Health Specialist role. This role has provided additional staff training and advice to staff, which has led to an increase in appropriate referrals to Adult Safeguarding and a decrease in inappropriate referrals.
- A new recording system has been implemented to capture all internal safeguarding alerts and the outcomes. This is in line with 'Making Safeguarding Personal' and also gives an auditing tool to capture training needs.
- There has been an external review commissioned to assess all of our practice around safeguarding. The actions from this are due to be completed by the end of October.
- The internal safeguarding alert forms have been amended to adding outcome desired by the customer, this supports person centred practice – 'Making Safeguarding Personal'.
- We have been active participants in SSAB meetings.
- All policies have been updated to reflect changes brought in by the Care Act 2014.
- Continue to use a dedicated page on our workplace Yammer to highlight changes, share news and updates and also share free additional training for staff to complete.

- We have actively contributed to DHR and Safeguarding reviews where appropriate and have utilised any learning as applicable.
- There have been Internal Management Reviews carried out where we have concerns and where we may be able to learn from our past actions with customers to ensure best practice and to prevent safeguarding issues from arising.

- We have developed an Integrated Safeguarding Service that covers Safeguarding Adults, Safeguarding Children, Multi- Agency Risk Assessment Conferences (MARAC), Multi- Agency Public Protection Arrangements (MAPPA) and PREVENT, (a strand of the Governments CONTEST strategy working with counter-terrorism). The integrated safeguarding service embeds the 'Think-Family' model as the basis for all of its work across the Trust and with our partner agencies.
- We have developed an Integrated Safeguarding Steering Group that considers all of the areas that the Safeguarding Service is responsible for and reinforces the 'Think Family' approach.
- We have developed a safeguarding adults team generic mailbox for our service which has been mirrored by our Somerset County Council (SCC) colleagues, thus enabling clearer communication between us and our SCC safeguarding colleagues.
- We produced name badge stickers for every member of the Trusts 4,000 staff that incorporates the single point of contact (SPOC) number for the Safeguarding Service. The Integrated Safeguarding Service provides telephone advice and guidance service and ad- hoc supervision to staff across all of our services.
- We have developed Safeguarding intranet pages that provide a useful resource for staff. These have internal and external links incorporated within them for all of the forms and documentation staff will need.
- By reconfiguring our existing resources we have strengthened our professional safeguarding team to further enhance the skills mix of the team to provide appropriate responses to concerns from our vast array of community and mental health services.
- Staff have reported increased confidence in the support and training they receive. Up until March 2016 there was one level of safeguarding adults training provided in-house for all staff and we have already trained over 93% of staff. From April 2016 we started to provide higher level training (Level 3) to targeted staff groups to enhance their learning and understanding further and incorporate learning from safeguarding adult reviews and other reviews undertaken.
- Accessing the Safeguarding Service for advice and support via the new single point of contact number has proved really popular. Staff are evidently becoming more aware of potential patient safeguarding issues from the increased profile that safeguarding now has in the Trust. This has been evidenced by a fourfold increase in safeguarding contacts to the team over the last year and increased referrals to the Somerset County Council Safeguarding team.
- We have worked closely alongside our police and Somerset county council safeguarding adult colleagues to develop the weekly safeguarding adults Multi- Agency Safeguarding Hub (MASH) meetings. We already have daily MASH meeting established with Children

Social Care and the Police.

- We worked closely with the SCC Safeguarding Team to co- produce joint Level 3 safeguarding training for all of the staff working within the integrated social care and health community learning disability teams.
- We have completely revised our safeguarding training provision to reflect the Care Act 2014 and the Royal Colleges Intercollegiate Guidance. The trust now provides in-house Levels 1- 5 safeguarding training and has been successful in a bid for NHS England one-off funding to provide safeguarding adults training across the health community of Somerset & North Somerset.
- We have actively contributed to several Safeguarding Adult Reviews and Domestic Homicide Reviews with our partner agencies.
- We are actively involved in the work of the Safeguarding Adult Board and all of the sub-groups, working hard with our board and sub group colleagues to improve safeguarding services across Somerset.
- In addition to the trusts Executive Director responsible for safeguarding we have a Non- Executive Director responsible for safeguarding as well as a Named Doctor for Safeguarding Children supporting the work of the Safeguarding Service and providing appropriate internal challenge.
- The Head of safeguarding has been leading a project with our health partners in Somerset to consider closer alignment of safeguarding services across the health community. The Directors of Nursing in the three provider Trusts are actively supporting this project.
- We have come together as districts and created the District Councils Safeguarding Group which meets quarterly, shares best practice and develops joint initiatives to safeguard vulnerable people.
- We have trained existing and new staff across our organisations to increase understanding of safeguarding responsibilities and routes for referral.
- We have actively contributed to several Safeguarding Adult Reviews and Domestic Homicide Reviews with our partner agencies, and changed policies and procedures where learning from these has indicated this would be beneficial.
- We have trained elected members to understand their safeguarding duties and to act as champions within the community.
- We have reviewed and updated our safeguarding policies and protocols
- We have used the One Team model to provide active support to safeguard vulnerable people.
- We have created safeguarding champions in our organisations who have has increased training on safeguarding matters and who act to provide support and guidance to other staff.
- We have developed and implemented Prevent Action Plans to help stop vulnerable people being drawn into terrorism and harm.
- We are delivering the Positive Lives Programme, with partners, to support vulnerable adults with complex needs gain stable, safe accommodation.

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.

Somerset Health and Wellbeing Board

23 November 2017

Annual Report of the Director of Public Health 2017 – End of Life

Lead Officer: Trudi Grant, Director of Public Health
Author: Pip Tucker, Public Health Specialist
Contact Details: 01823 359 449

	Seen by:	Name	Date
Report Sign off	Relevant Senior Manager / Lead Officer (Director Level)	Trudi Grant	01/11/17
	Cabinet Member / Portfolio Holder (if applicable)	Christine Lawrence	01/11/17
	Monitoring Officer (Somerset County Council)	Julian Gale	01/11/17
Summary:	The production of an Annual Report is a statutory requirement of the Director of Public Health (shown at Appendix). This year's report looks at the care required by people in the last year of life. It shows how this needs to be seen as far more than simply medical, and includes emotional and spiritual support from family and communities, and how families and friends themselves need to be supported. The report shows how an inevitably very difficult time can be made more bearable with the right preparation.		
Recommendations:	**The Health and Wellbeing Board is asked to:** • **Take opportunities to raise awareness amongst partner organizations, and the public, of the end of life issues raised in the report, especially in making preparations by discussing end of life with family and friends.** • **Encourage cooperation and coordination between providers of end of life care. This includes members of the Board and other health providers.** • **Recognize the importance of strong communities in supporting families facing bereavement.** • **Recognize the vital contribution of carers, especially families, at end of life, and the great sensitivity required at this time.** • **Recognize how appropriate housing can make end of life care easier to provide.**		

Links to Somerset Health and Wellbeing Strategy	The report's implications support all three themes of: 1. People, families and communities take responsibility for their own health and wellbeing. 2. Families and communities are thriving and resilient. 3. Somerset people are able to live independently for as long as possible.
Financial, Legal and HR Implications:	Production of the report is a statutory requirement; there are no direct legal, financial or HR implications of the recommendations.
Equalities Implications:	By its nature, the subject of the report applies particularly to older people. The report describes the need for sensitivity to individuals' wishes, especially linked to religious belief and practice.
Risk Assessment:	Not to produce a report would be a failure to fulfil a statutory duty.

1. Background

1.1. This report follows the 2016/17 Joint Strategic Needs Assessment report on 'Ageing Well', in which it became clear that ageing well required preparation for a dignified death. This report covers the patterns and trends in deaths in Somerset and the ways in which dignified death can be helped in more detail than was possible in that report.

2. Consultations undertaken

2.1 This report has drawn upon the views and accounts of a range of people who have experienced the loss of family members in the county. These people have been drawn from patient groups in the county. We have also spoken to a range of professionals working in the End of Life sector in Somerset in primary and secondary care, St Margaret's Hospice and the ambulance service.

3. Implications

3.1. End of life brings into sharp relief the importance of individual responsibility and preparation, community support and working together to support good health, which includes, wherever possible, a 'dignified death'. This shows how health and care professionals need to move the conversation with the public and patients away from simply reacting to need and towards a broad view of health, wellbeing and self-reliance.

4. Background papers

4.2 The Annual Report of the Director of Public Health is at Appendix A.

End of Life

Annual Report of the Director of Public Health for Somerset 2017

Introduction

Last year I showed how dramatically health has improved over 80 years in Somerset. Infectious diseases that were once major killers have been almost eliminated through improved hygiene, sanitation and vaccination. These changes have meant that we are generally living longer, and our deaths are more likely to come from lifestyle related conditions such as cardiovascular disease and cancers and those usually associated with increased age such as dementia. Many people live for a long time with these conditions, and the 'end of life' can be an extended period. This is a difficult time for the individuals concerned, and for their families, and the health and care needs are complex.

This is not a guide to providing end of life care. In this report I want to play my part in raising the profile of this vital part of life. Looking at end of life from a public health perspective, I want to describe:

- Describe the **trends** in the numbers, causes and places of death in Somerset
- Consider how end of life is currently supported in the county overall, and how individuals, families, health and care services can contribute to making end of life as **peaceful and dignified as possible**
- Highlight how the whole health and care 'system' can **work together** to provide the best possible care.
- Emphasise the role of **compassionate communities** in providing wider support.
- Encourage us all to **prepare** for the end of life, making preparations such as Power of Attorney and Advance Care Plans.

Public health is concerned with the health and wellbeing of the whole population from pre-pregnancy to end of life. Just as we look to give every child in Somerset the best start in life, and adults to have the opportunity to be healthy and productive for as long as possible, so the final months should be viewed as contributing to the overall quality of a life well-lived.

The data supplement that accompanies this report can be found at the following link:

http://www.somerset.gov.uk/organisations/departments/public-health/

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SECTION 1 – Death in Somerset

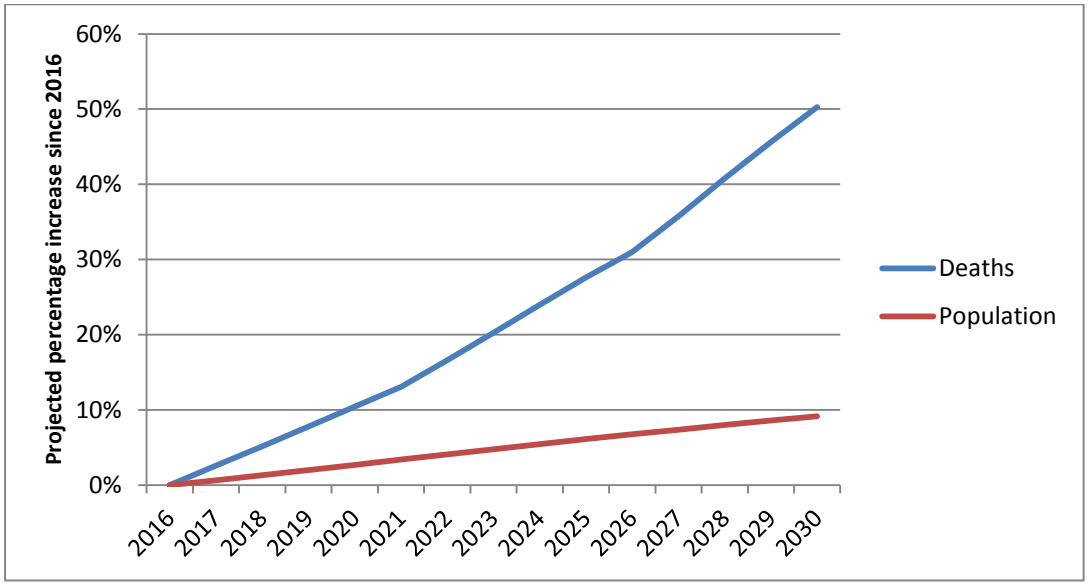
In this section we will look at some of the facts and figures about death and dying in Somerset. Examining these statistics can help us get a better understanding of the scale and nature of the issue and help guide our response.

Numbers of deaths

In last year's report I described Somerset in the 1930s. Then there were about 3,700 deaths each year in the current county area. Although life expectancy has risen considerably since then, that number has risen to about 6,115 deaths in 2015 (the last year for which we have figures). This is simply because of the increasing population, which has grown from just over 290,500 in 1936 to 545,400 in 2015, an increase of 88%. The number of deaths has only risen by 41%, because people now live much longer than they did then.

When we look at likely trends in the future, the ageing of the 'baby boomer' generation born after 1945 means that the numbers of deaths each year is expected to rise dramatically, and much faster than the population total.

Figure 1: Projected Numbers of Deaths (source: Public Health Somerset)

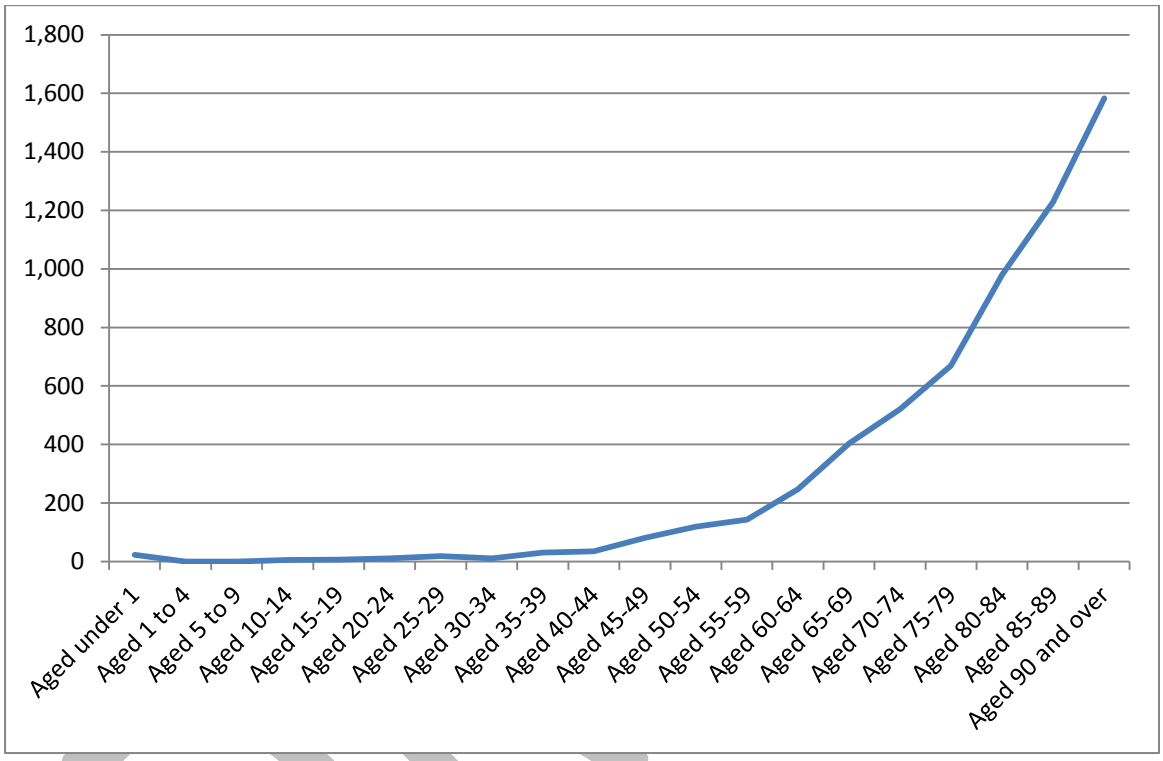


There is clearly a great deal of uncertainty in any projection of this sort, but this graph demonstrates that simply in terms of numbers, end of life care will become a more prominent issue for health and care in Somerset over coming years. There were 6,020 deaths in Somerset in 2016; that is projected to rise to over 9,000 by 2030.

Age at death

Figure 2 shows the age at which people died in Somerset in 2015. Nearly three quarters of all deaths were of people aged 75 or older, and more than 90% were of people aged 60 and over. Only 1.7% were of people aged under 40. In this report I will concentrate on the care of older people approaching death. This is not to overlook the needs of young people – many of which are the same of course, but I will focus on the large majority of those reaching the end of their life as, for this issue, this is where the greatest challenge for the county lies.

Figure 2: Age of death in Somerset 2015



Causes of Death

Figures 3 and 4 show the leading causes of death in Somerset in 2015 for men and women. Cancers, circulatory diseases and heart disease are the main causes of death in Somerset, mirroring the national prevalence. By sex, the broad patters are similar, although cancer is the leading cause for men, and circulatory diseases for women. It can also be seen that diseases of the nervous system – mostly dementia and Alzheimer's disease – are more significant causes of death for women than for men. Notably, many of the conditions that cause death may only do so after a protracted period of illness, with major implications for end of life care.

Figure 3: Leading causes of death, Men in Somerset 2015

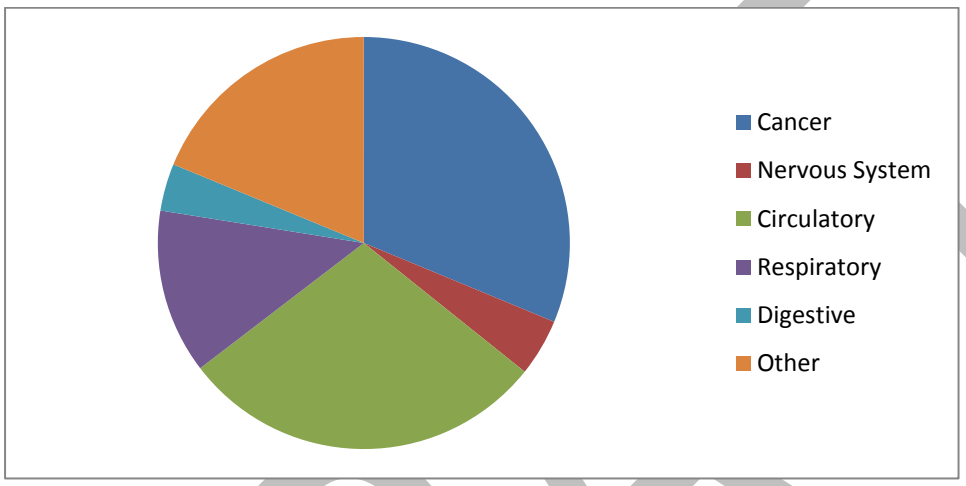
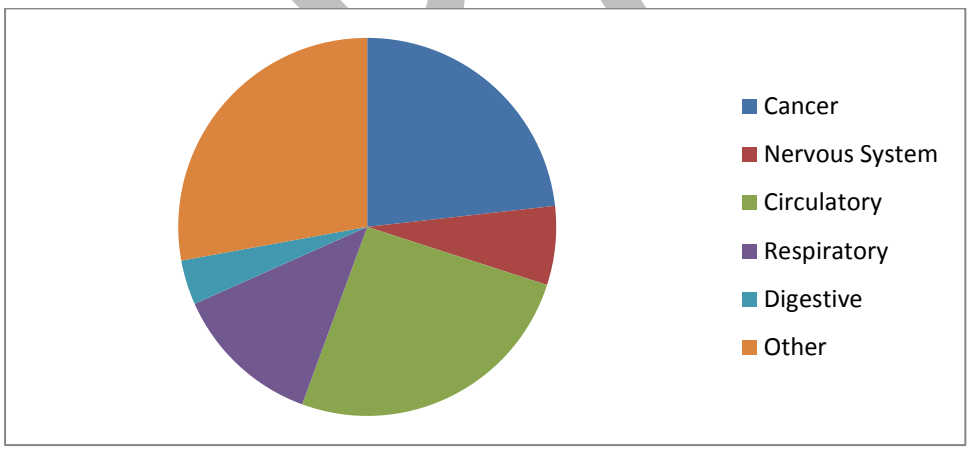


Figure 4: Leading causes of death, Women in Somerset 2015



Figures 5 and 6 below looks at the differences in the causes of deaths in Somerset over the past 10 years. There were 5,482 deaths in 2007 and 6,042 in 2016. The key points to pull out from this is that the proportion of deaths that were attributed to dementia (including Alzheimer's) in 2016 was 13%, more than double the percentage from 2007 of 6%. Those attribute to circulatory disease, coronary heart disease and stroke accounted for a smaller proportion of deaths in 2016 than in 2007

Figure 5: Proportion of deaths by underlying cause of death 2007-2016

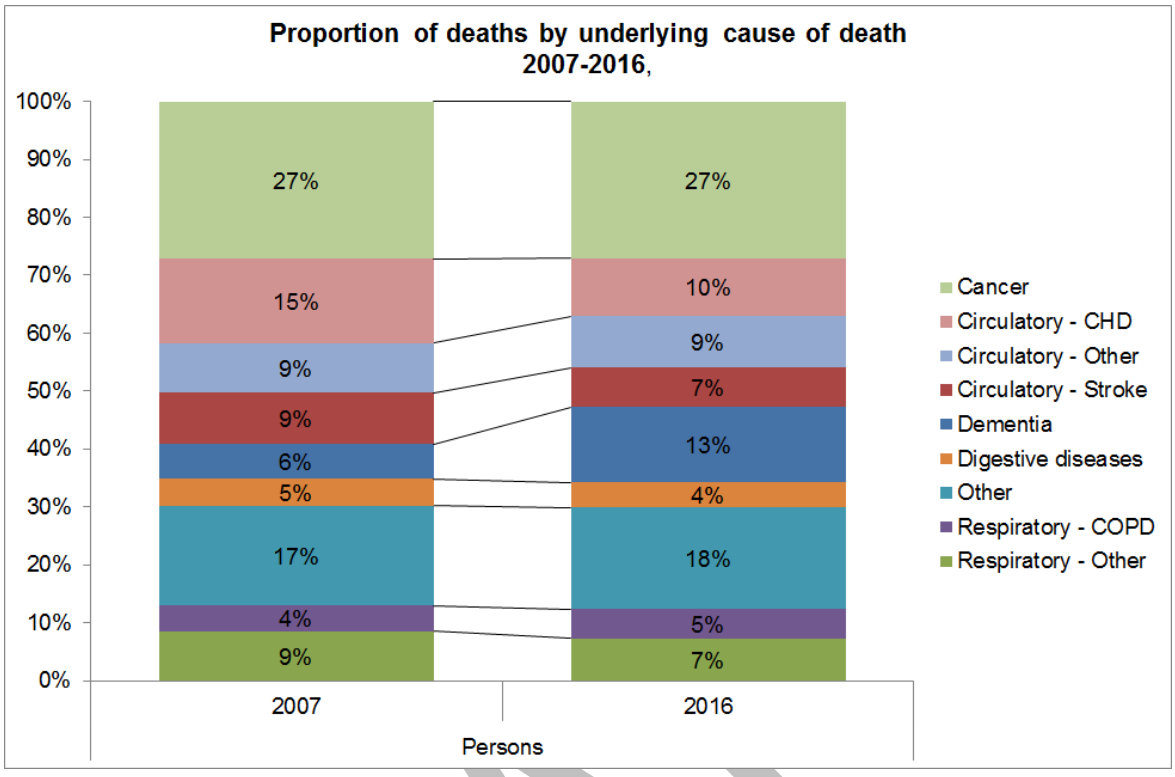
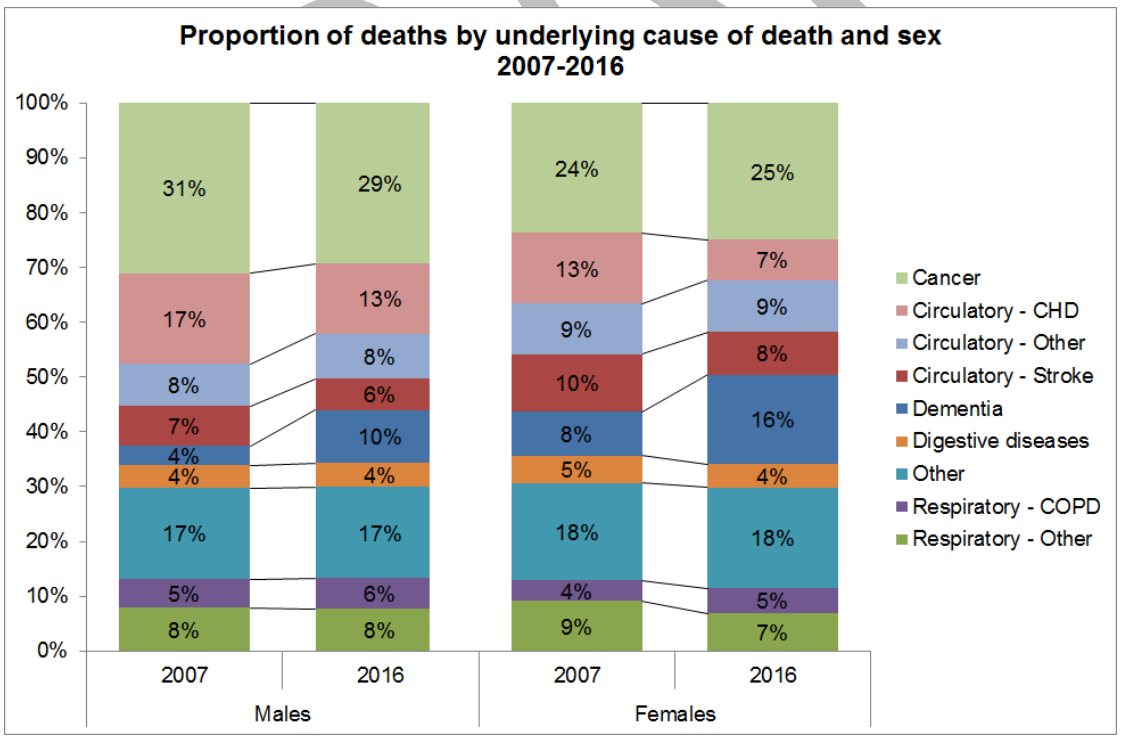


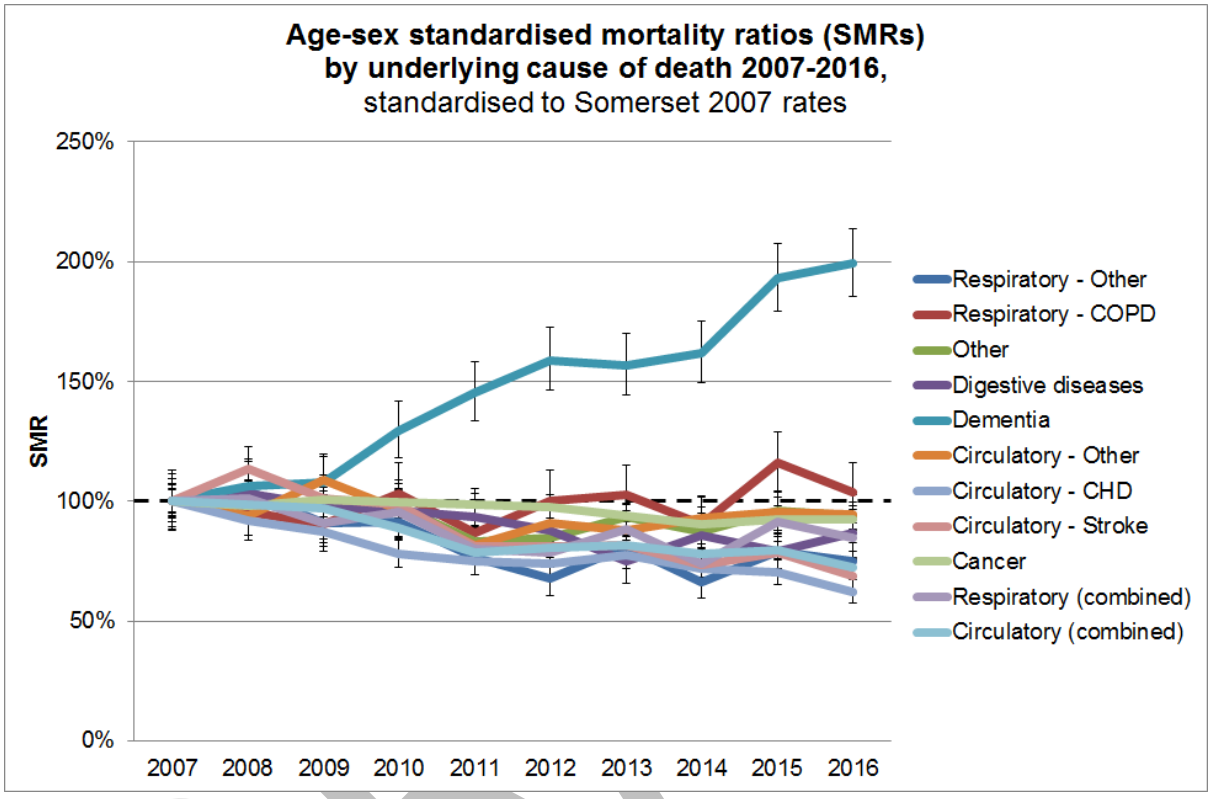
Figure 6: Proportion of deaths by underlying cause of death and sex 2007-2016



 Deaths used in the production of these charts that occurred prior to 2015 and prior to 2011 have been adjusted. This is to account for coding changes introduced by the Office for National Statistics (ONS) at these times.

By standardising the data to the 2007 Somerset rates, we can consider how many deaths due to each condition would have been expected for the 2016 population size and structure. Figure 7 shows clearly that the dementia mortality rates have been steadily increasing over the past ten years and were around twice as high in 2016 than they were a decade ago. Mortality rates due to all other underlying causes have significantly declined over this period.

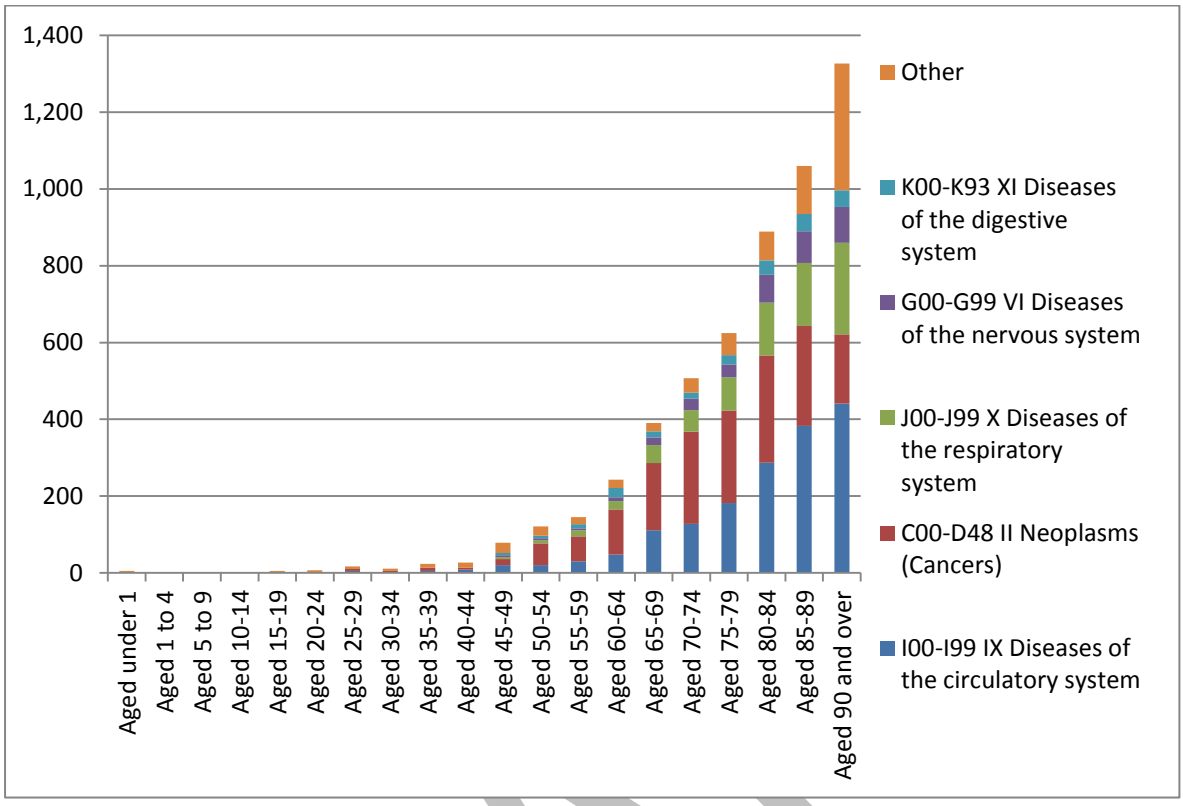
Figure 7: Age-sex standardised mortality ratios



Source: Primary Care Mortality Database Copyright © 2017, re-used with the permission of The Health & Social Care Information Centre. All rights reserved and Office for National Statistics (ONS) mid-year population estimates.

Figure 8 shows the same broad categories of cause of death by age for men and women together in the same graph. Cancer is the biggest killer for people aged between 50 and 80, and at older ages circulatory and respiratory disease and diseases of the nervous system rise in significance.

Figure 8: Major causes of death in Somerset by age, 2015 (Source: ONS Mortality Statistics)

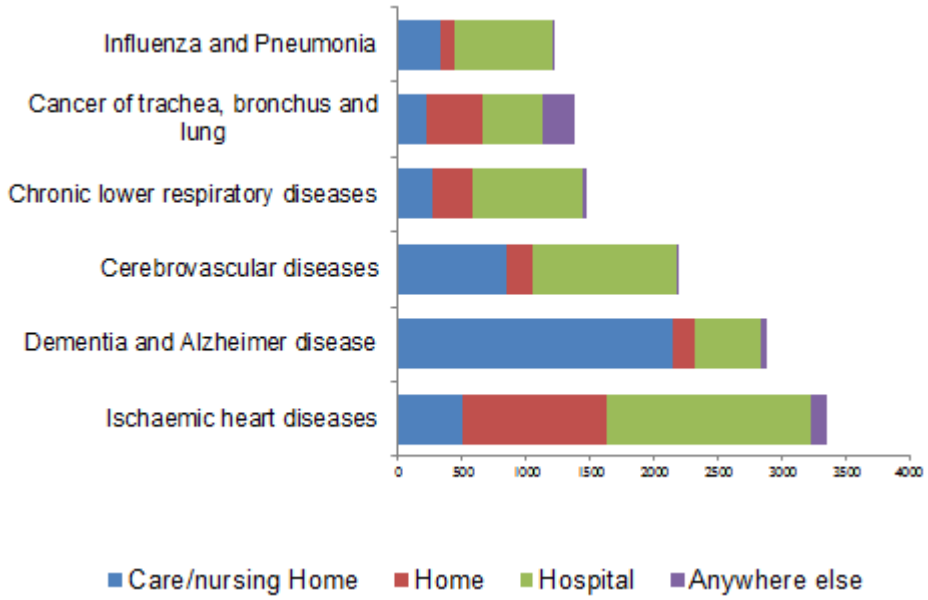


These statistics summarise the number of deaths, age and cause of death per year. Looking at this across the entire population rather than simply by conditions informs the nature of care and support that are needed by people approaching the end of their lives in Somerset. Most of the people in near end of life are older and have long term conditions that people live with for many years until death (which may, indeed, be the immediate result of a different condition entirely).

Place of death

Perhaps most noticeable in Figure 9, looking at the place people die, is that the largest proportion (40%) is in hospital, even though we know that about 66% of people in South West England would choose to die at home, and only about 4% would choose a hospitali. And despite falling as a proportion over time, hospital is the most common place of death for those not dying of cancerii. In this report, I want to look at ways in which more people are able to die in the place of their choosing. It is also striking that a very large proportion of the dementia and Alzheimer's deaths are in care homes. This situation reflects a number of issues including the nature of the disease and the degree to which support in our communities is able to cope with some of the issues relating to more advanced neurological disease.

Figure 9: Place of death by cause of death



Alzheimer's and Dementia

The rates of dementia are often thought to be underestimates, the number of people with the condition in the county is projected to rise by 75% by 2035 to reach approximately 12,000. In Sedgemoor the number is expected to rise by 83%, compared to an increase of 70% for England as a whole. The relatively low death rate from dementia is likely to be associated with low diagnosis and not recognising it as a cause of death. The process of dying from dementia is different from other conditions as individuals at the end stage of dementia often lose interest in food because they lose their sense of taste and their hunger drive. This can lead to malnourishment and being investigated for a cause of weight loss and admitted to hospital with complications such as infection. It is frequently this that is then documented as the leading cause of death with the dementia often not recognised.

There is a risk that communication problems associated with dementia may mean that such patients suffer more discomfort and pain during the period of end of life, this point can also apply to people with learning difficulties, of course. The drawn out development of dementia may mean fewer people make advance care plans than is the case for people who receive the shock of a cancer diagnosis, for instance, yet the impact on the family can be considerable as the disease affects behavior as it progresses.

The funding system also makes dementia more challenging for providers than, for example, cancer, with a far higher proportion of the costs falling to social care rather than the NHS. That means that it is means tested and costs are therefore more likely to fall on the individual or the family. Whilst there is no cure for dementia, people with the condition may live in steady decline for many years. Patients may require support in the basics of life, putting much of the physical burden, too, on carers within the family. Such pressure, particularly on an ageing spouse coping with his or her own failing health can lead to both needing social care support. With dementia set to increase in coming years this will be a growing challenge for end of life care in Somerset.

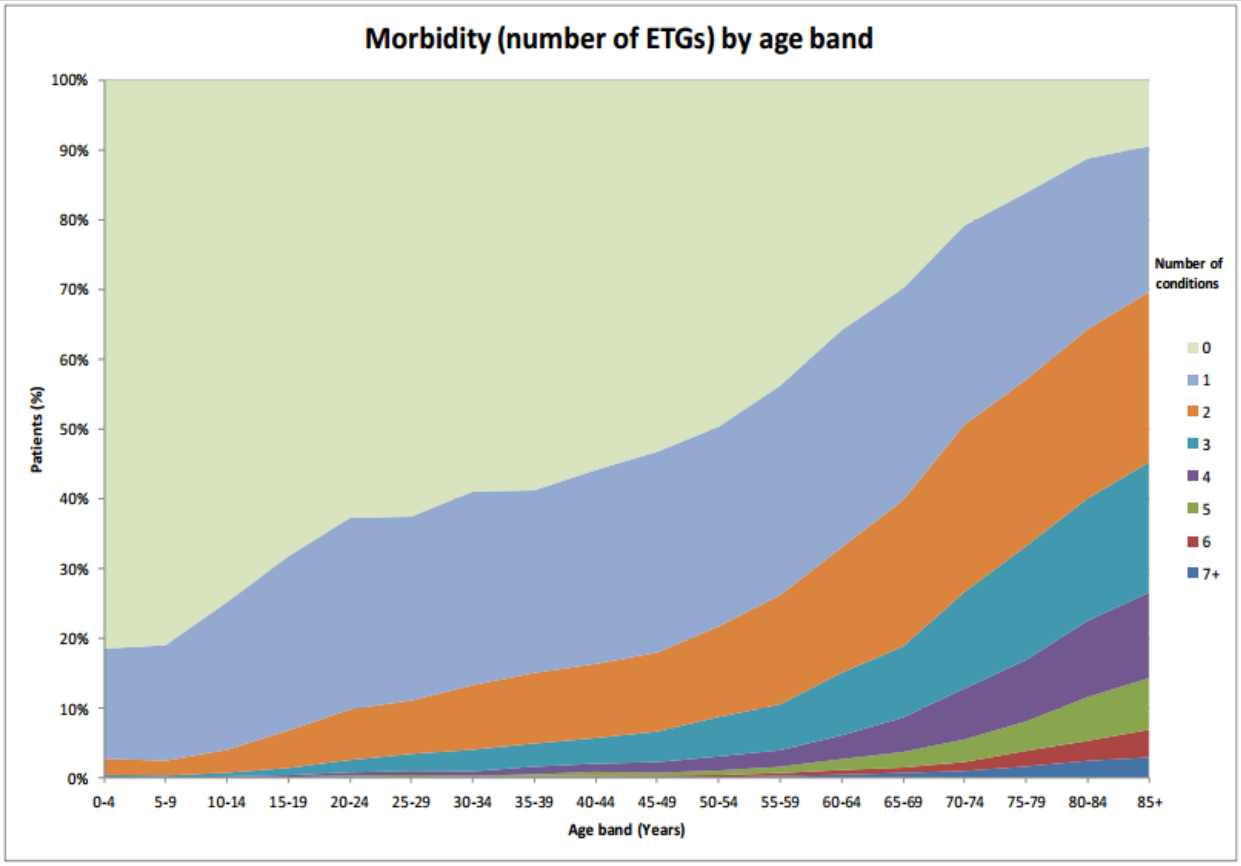
Long term conditions and multimorbidity

When infectious disease was the leading cause of death, there were typically two ways in which illness could run its course. Either someone would recover from the disease, even if with some long term effects, or they would die. In the 21st century, with more deaths from long term conditions such as dementia, cancer and chronic kidney disease, as shown in Figure 2, there are many people who live with gradual deterioration for years. Of course, over such a period it may be that the long term condition is not eventually the direct cause of death.

Perhaps more significantly for treating and managing end of life care, many people will develop more than one condition and show 'multimorbidity'. These patients, often referred to as 'complex', offer significant challenges to treatment because of the interaction between the different conditions or the treatments being provided. As a simple example, taking the medicine needed to manage cancer is far more difficult to manage for someone with dementia than someone without. And as a rather different example, in the past people would often have just 'one shot' at being treated for cancer, whereas now a far wider range of treatments is possible. Radiographers in Somerset report that people with late stage cancer now have different symptoms from people previously and some of those symptoms may have been caused by the treatments that were given 15 or even 20 years earlier.

Figure 10 uses data from the 'Symphony' project to show how the incidence of long-term conditions increases with age. By the age of 70, about half of the Somerset population has a long term condition, and by the age of 85 more than 40% have three or more. As the population structure ages so we can expect more people to have these complex conditions to live with.

Figure 10 Multimorbidity by age band in Somerset 2015



We will return to the issue of multimorbidity in the next section in relation to end of life care.

Despite the huge advances in treating disease, death is one certainty in life and it cannot be indefinitely postponed. Understanding and recognizing the process by which the body turns itself off can avoid intrusive, painful and ultimately fruitless efforts to extend the life of someone close to an expected and natural death.

Summary

This section has provided some background information on deaths, and the significant reasons for deaths, at a population level. End of life is something that all families have to face at some point. It is often an emotional and stressful time, just as birth often is, but there are things we could do as a community and as a health and social care system to try and reduce the impact of end of life and make it as dignified and peaceful as possible. Achieving this is absolutely better for the individual, the family and the system. I now want to describe what end of life care is, before considering what more we could do in the future to ease the experience of end of life.

SECTION 2 - End of life care

Evidently, those facing the end of life need support of many kinds. Some is medical, some is emotional and some practical. The burden can be so heavy that the carers themselves, particularly family members, can need their own support. In this section we will look at an overview of the end of life care provided in Somerset and give a brief overview of the types of help that can be provided before considering whether we can do more to make end of life care in Somerset as dignified and peaceful as it can be.

We know that the majority of people would prefer to die at home if they could, and hospital is the least preferred place of death; despite this, less than half (48%) of people actually do die at home in Somerset. We need to consider why this is the case? Firstly, it may be because the death is sudden and unexpected, and the patient is taken to hospital for urgent treatment. Such cases are sadly inevitable. Secondly, the patient, carer or family may feel more secure in hospital knowing that professional care and treatment is nearby and always on call, especially for conditions such as chronic obstructive pulmonary disease (COPD) which can exacerbate rapidly. For all the preparations made in advance, patients and family may find that the illness simply cannot be treated at home: changes in behaviour, or loss of bladder and bowel control, can lead to a serious reassessment of need. Thirdly, some deaths might have come about because the patient's wishes were not made clear in advance, or were not known to those responsible for their care at the end of life. In these circumstances someone may be taken to hospital and admitted as an emergency for treatment that may add little to the length of life. This issue is considered in more detail below.

End of Life and admissions to acute and community hospitals

An admission to hospital can be, literally, life-saving. It is though, despite the efforts of many, often not a pleasant event, particularly if it is an emergency admission. For someone who is close to death with a long-term, life-threatening condition, it may be a source of unnecessary suffering for little gain. We have looked at the patterns of admission for people in the last year of their lives, the large majority of which is direct to acute hospitals. This helps us understand what factors beyond immediate clinical need are involved, and suggests ways in which more rounded, 'whole person', care might be possible.

There were an average of 3.2 admissions to hospital (planned or emergency admission) in the year prior to death for all people who died in 2013-2015. Only 20% of those who died did not have an admission in the year prior to death. Excluding those with no admission, the average number of admissions in the final year was 4.1. People who died during 2013-15 spent on average 22.4 days in hospital in the year prior to death.

For *emergency* admissions only, there were on average 2.3 in the year prior to death for all those who died in 2013-2015, although that includes 37% with no emergency admissions. Excluding those without emergency admissions, the average was 3.7 in their last year. Those people who died during 2013-15 *and* had an emergency admission spent an average of 27.5 days in hospital after they were admitted.

Figures 11 and 12 below show the patterns of emergency admissions for the main condition-related causes of death. For all conditions, except Alzheimer's and dementia, the majority of patients had at least one emergency admission in their last year of life.

Figure 11: Percentage of patients never admitted as an emergency in last year of life

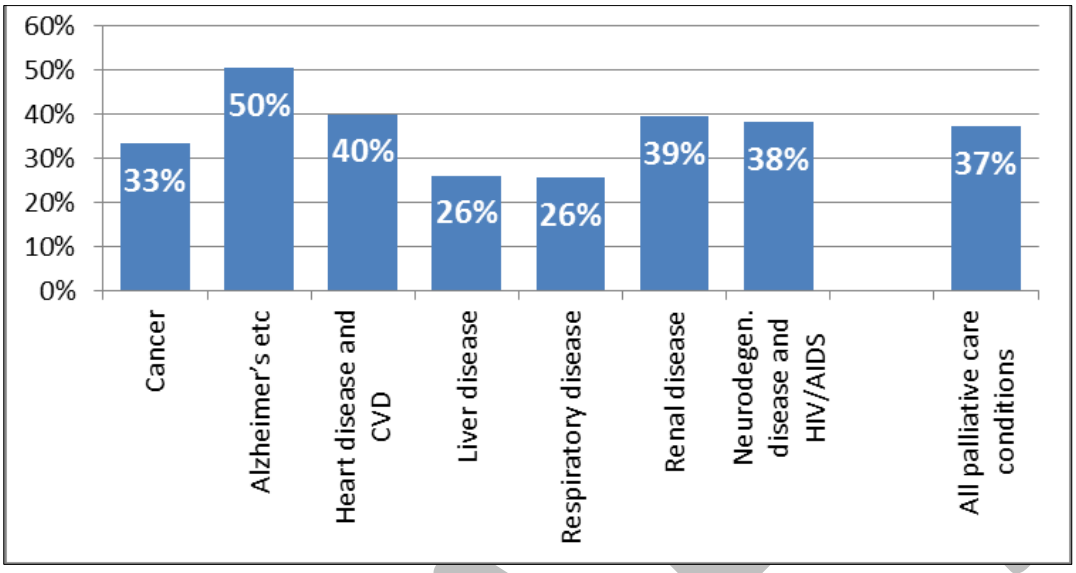
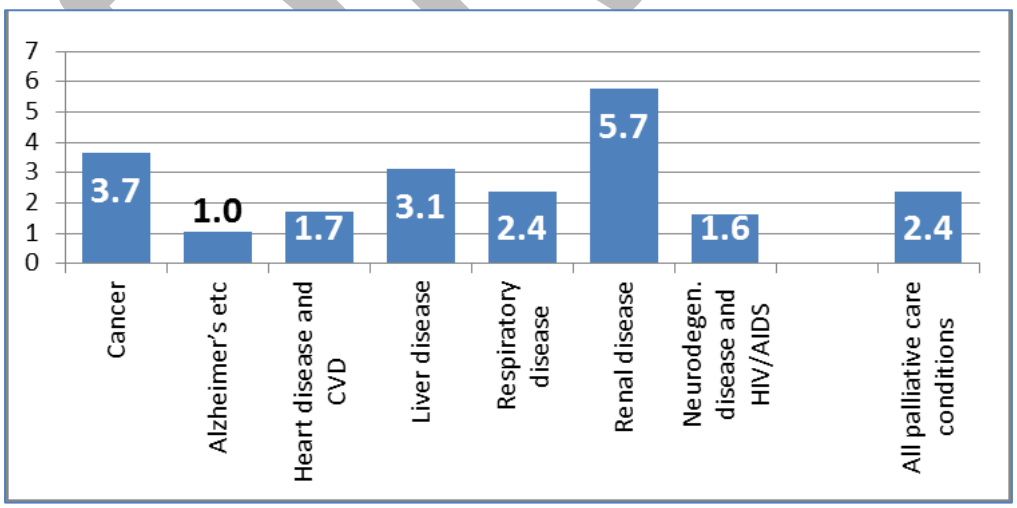


Figure 12 uses the same categories of disease, but this time looks at the average number of admissions for each disease category. Although renal disease is responsible for comparatively few deaths (all genito-urinary disease accounted for 113 out of the 6,115 death in 2015), it is striking that the average number of admissions was nearly six. Cancer is a major killer however, but cancer patients had 3.7 emergency admissions on average – perhaps suggesting that there better support processes are in place for cancer, that could y be learning opportunities to be applied to end of life care for other conditions.

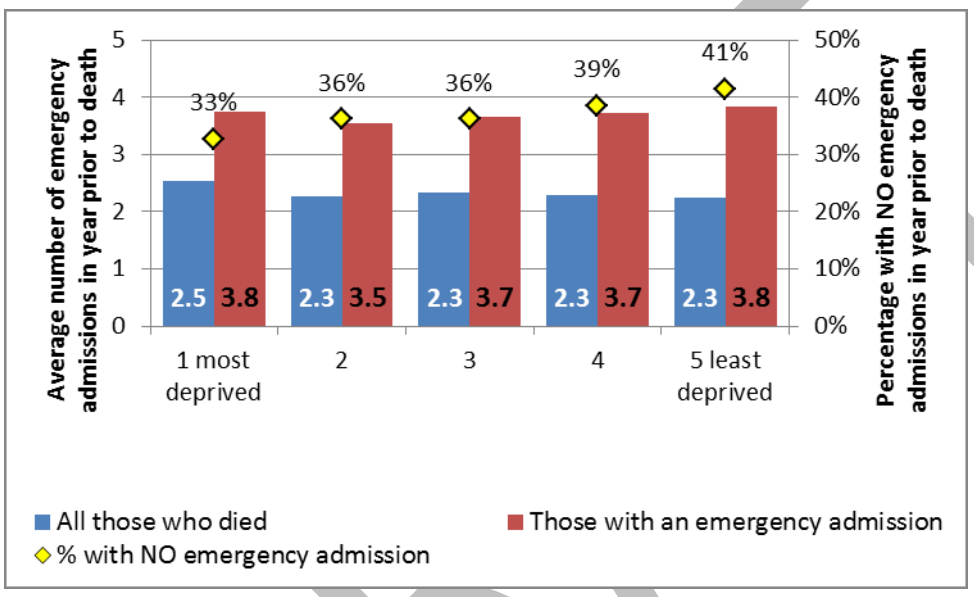
Figure 12: Average number of emergency admissions in last year of life



It is important that we give consideration to any inequalities that may exist in relation to end of life care. Figure 13 considers the rate of emergency admission by deprivation. People who had lived in a more deprived area were more likely to be admitted as an emergency than those who lived in a less deprived area. The percentage that had no emergency

admission ranged from 41% in the most deprived quintile of areas to 33% in the least deprived quintile. There are a number of possible reasons for this inequality. Firstly, it could be because predominantly deprived areas are in our more urban areas, where access to District General Hospitals is easier. Secondly, it may also be because people in more affluent areas have more financial and social capital, and more access to information than those in deprived areas. They are therefore more likely to be able to make appropriate preparations that help avoid emergency. Thirdly, the inequality may reflect the nature and complexity of the patients' illness. We know that people who live in the more deprived areas of Somerset experience a higher prevalence of almost all conditions, we also know that they are significantly more likely to experience multimorbidity.

Figure 13: Emergency admissions by deprivation



Alzheimer's/dementia deaths place the least burden on emergency admissions and those that produce the most are kidney disease, cancers and liver disease. The latter are more linked to lifestyle factors such as smoking/obesity/alcohol and are strongly associated with deprivation. It is no surprise therefore that the emergency admissions are higher for people who live in areas of higher deprivation. There are two ways of reducing emergency admissions, whether they are at end of life or not, the first is to detect disease early and manage the condition proactively where possible, the second is to prevent the condition in the first place and therefore the need for an emergency admission. There is scope to reduce emergency admissions by placing a greater focus on both of these forms of prevention. As highlighted by the Reform think tank for the NHS[iii], effective preventative activity, which does not further increase inequality, needs to be done systematically and at scale and pace.

Inequality in end of life care is not only in relation to deprivation, of course. The Care Quality Commission looked at the outcomes for different groups in 2016[iv]. Gypsies and travellers, and people whose first language is not English, found it harder to have their wishes met. People with learning difficulties need more time and preparation to understand the options open to them at end of life, and also need to be given more time to express their wishes. People with Down's syndrome are at increased risk of developing dementia, and those with both conditions will often need an extended period of support to express what they want to happen to them.

Identifying End of Life

In order to make preparations for death, there needs to be an assessment of when it is deemed that a person is at the end of life. This, like all predictions, can be hard to do. The progress of cancer is often rather predictable (which helps in end of life planning); the Care Quality Commission identified 'people as conditions other than cancer' as a group who may not receive the best care as a result. Dementia can progress very slowly and it may be hard to know the right point to shift from managing the condition to preparing for death.

The Gold Standards Framework (GSF) developed by the Gold Standards Framework Centre in End of Life Care, aims to promote quality, coordination and organisation in end of life care, leading to better patient outcomes. The GSF formalises best practice and provides an indicator of what 'good' looks like in end of life care.

The framework gives clinicians three ways of identifying whether a patient should be treated as being at the end of their life. One of them is a list of general indicators as seen in Table 1 below.

Table 1: General Indicators of Being at End of Life (Gold Standards Framework)

- Decreasing activity – functional performance status declining (e.g. feeding, bathing, grooming, dressing, continence, toileting, mobility & coping with stairs), limited self-care, in bed or chair 50% of day) and increasing dependence in most activities of daily living
- Co-morbidity is regarded as the biggest predictive indicator of mortality and morbidity
- General physical decline and increasing need for support
- Advanced disease - unstable, deteriorating complex symptom burden
- Decreasing response to treatments, decreasing reversibility
- Progressive weight loss (>10%) in past six months
- Repeated unplanned/crisis admissions
- Sentinel Event e.g. serious fall, bereavement, transfer to nursing home
- Serum albumen <25g/l (this blood indicator shows poor liver function)
- Considered eligible for DS1500 payment (Disability Living Allowance or Attendance Allowance for the terminally ill)

The second way uses specific indicators for particular conditions such as the development of secondary malignant growths for cancer, speech problems in neurological diseases and incontinence for dementia.

The third, and simplest test combines the various indicators with clinical judgement in the 'surprise' question:

'Would you be surprised if the patient were to die in the next few months, weeks, days?'

If the patient shows the general or specific indicators, or the answer to the 'surprise' question is, 'no', then the clinician or carer should go on to consider what measures 'might be taken to improve the patient's quality of life now and in preparation for possible further decline'.

The next part of this section considers what some of those measures may be, starting with palliative care.

Medical support - Palliative Care

It is worth drawing out here that the decision to treat an individual palliatively should ideally involve the patient and/or family however care planning for individuals who have lost capacity is rarely done and therefore the responsibility for decisions relating to treatment rests with the senior clinician. In the community this is the GP, but discussions should also involve the family wherever possible. Often decisions are made to treat people rather than manage them palliatively which may not be in their best interests. This issue will be considered further later in this report.

It is important that when discussing treatment options with people that we focus on what could be done as well as what might not be done so patients and families can make an informed decision about the options. For example, when discussing an admission to hospital with someone at the end of their life, what could be done for them at home if they chose not to go to hospital should be discussed also, such as pain control etc. Sometimes there is a belief that agreeing a ceiling of treatment escalation means there will be no more treatment at all.

Much of the medical treatment given to people with life-limiting conditions will, necessarily, be specific to that condition We will not consider the condition-specific treatments here, important as they can be to the individuals concerned, but focus specifically on what's termed 'Palliative Care'.

There are a number of treatments that come under the umbrella of 'palliative care', which try to reduce the painful and unpleasant effects of disease, or of other treatment, rather than trying to cure the illness. Palliative care puts more emphasis on maximising the quality of life than extending its length (although this may be an effect). It is often provided alongside more conventional 'treatment', such as chemotherapy for cancer. By reducing the impact of pain or discomfort it can enable patients to live something closer to a normal life. This can also help the patient's carers, and might make the difference between being able to live at home or needing to be in hospital.

In his book Being Mortal, Atul Gawande describes the treatment of an elderly patient with many long term conditions, including the cancer that would eventually lead to her death. The cocktail of drugs she received made her condition even more complex. When she was treated by a gerontologist, who looked at the needs of the whole person rather than the individual illnesses, it became clear that her greatest distress came from the state of her feet, which reduced her mobility and so her independence. Treating her feet, rather than the more 'serious' conditions, did not extend her life, perhaps even the reverse, but contributed far more to the quality of the life she had left.

Often in medicine, each specialty treats the patients' range of needs, illnesses and symptoms independently, it's the way medicine has developed over the years and we rely on this approach to provide us with the very best, very specialist care. There are times however, where this very specialist approach may not be best for the patient and at the end of life is potentially one of those times.

End of Life Care in Hospital

Palliative and end of life care should ensure the whole person and those important to them are cared for no matter where. Hospitals are a place of safety and in Somerset are open all hours. A feeling of safety is a key element of good end of life care. In Somerset the acute hospitals have made great improvements to their end of life care in recent years. Their shared aims are for hospice level support and care for those who choose to die in a hospital. For those who do not want to be in hospital to be safely supported either at home or in a place of care. Hospitals provide the specialist equipment and expertise when needed, and work with communities to join up the care as much as possible.

Hospitals are taking a leading role in planning for the future. An admission to hospital is likely to be a point of inflection in someone's health, such as being diagnosed with a life limiting illness or be assessed as deteriorating from an existing chronic condition. This recognition should be discussed as appropriate and the patient's needs as a person considered. Taunton and Somerset Trust has introduced a specific discharge summary for those with life limiting illness to record the start of these conversations and allow community practitioners - professional and volunteer - to continue this 'what is important to you' approach when back at home. Yeovil District Hospital has strong links with the symphony complex care teams who can also aid whole-person care and facilitate wellness. This planning starts an approach that can be supported by projects such as the Marie Curie conversation volunteers who consider the person and their thoughts by asking, amongst other key questions, 'What is important to you now and in the future?' They are trained to elucidate and communicate wishes and wants for end of life care which can enhance the professional decisions within advance care planning. This approach enhances a person's dignity in ensuring they as a person are communicated throughout their care, wherever it is taking place. This home based, non-clinical work is led by the person themselves.

Drug treatments

These can reduce the impact of, for example:

- Pain
- Nausea and Vomiting
- Breathlessness (Dyspnoea)
- Respiratory Tract Secretions
- Restlessness and Agitation

Whilst these are rarely life-threatening in themselves, they can all be the most noticeable effects of the terminal illness and be the greatest contributors to poor quality of life for the patient, as well as family and carers. They can also arise suddenly and distressingly, so, administration of drugs such as Midazolam for breathlessness for example can be hugely comforting.

Many people, especially perhaps cancer patients, may need palliative drugs such as opiate painkillers delivered continuously. This is typically done using a syringe driver, one of which is shown in Figure 14. Although far from necessarily the case, they are associated by many people with the final stage of illness, with a perception that once set up they will remain in place until the death of the patient. Other treatments, such as steroids and sub-cutaneous fluid, can, with training, be administered at home by family members.

Figure 14: Syringe Driver (Source: Oxfordshire CCG)

Despite the benefits that can be gained from such drug treatments, our expectations have to be managed. Pain can be treated and minimised but no physician can guarantee a painless death, conversely, the grief of bereavement should not be added to by feelings that a loved one has endured unnecessary suffering. Good communication – reassuring the patient and, even more, the family, that the best possible care is being provided is the key to ensuring this balance.

Providing palliative medicine is often rather more complex than other medicine, and there are a few techniques that make it easier and safer.

- **MAR charts (Medicines Administration Record).** This tells paramedics, called to someone's home at the end of life, what drugs can (and can't) be used
- **Just in case boxes**. These contain the correct medicines to treat the patient at home.
- **Message in a Bottle**: 'a sticker on your fridge and the inside of your front door tells paramedics that a bottle can be found inside the fridge. This will contain essential personal and medical details. Bottles are free of charge and can usually be obtained from your local chemist'[v].
- **MedicAlert**: a registered charity that provides an identification system for individuals with medical conditions and allergies. This is usually provided in the form of a bracelet or necklet, which you purchase. The scheme is supported by a 24-hour emergency telephone service[vi].
- **'Comfort calling'**. This is when GP, nurse, or out of hours doctor calls can give reassurance, even if no new treatment is needed.

'Self help' as part of Palliative Care

Palliative care need not be simply medical. As the Motor Neurone Disease Association describe:

'People living with MND have found the following helpful:

- *doing something physical, like gardening, with assistive equipment to help you stay active for as long as possible*
- *planning a trip, event or holiday (many travel providers provide accommodation adapted for people with disabilities)*
- *seeking out experiences with family and friends that will provide lasting memories*
- *using speech and communication aids to help you maintain communication and social contact should your ability to speak and gesture be affected*
- *listening to music or going to music therapy sessions*
- *having physiotherapy, with a qualified physiotherapist who has experience of MND*
- *having hydrotherapy, where exercise is assisted and supported in water to help you move and flex joints safely*
- *trying one of the many complementary therapies with a qualified and registered practitioner'*

We will consider the ways in which families and communities can provide tremendous support to people at the end of life further in this report however, it is clear from this list that there are many forms of help that do not require medical intervention from clinicians.

Individuals facing the end of life can have many things to deal with, from examining the meaning of life to practical matters of finance and planning. These issues can feel overwhelming and it's important that a wide range of patient concerns are considered during palliative care. The section below outlines the Integrated Palliative Outcomes Scorevii, which brings these together in a single, simple form.

Integrated Palliative Outcomes Score

Firstly, patients are asked what their main concerns are, of whatever type. This 'open' question is important, as it puts the patient at the heart of the assessment. Whatever the medical conditions may be, if the patient is most concerned about the welfare of a pet dog, for instance, then this is what has the greatest impact on wellbeing. There is a second question that asks about the severity of symptoms such as drowsiness and shortness of breath. The remainder of IPOS moves on to a wide range of potential concerns, as shown in Figure 15.

Figure 15: Questions from the Integrated Palliative Outcomes Score

Q3. Have you been feeling anxious or worried about your illness or treatment?

Q4. Have any of your family or friends been anxious or worried about you?

Q5. Have you been feeling depressed?

Q6. Have you felt at peace?

Q7. Have you been able to share how you are feeling with your family or friends as much as you wanted?

Q8. Have you had as much information as you wanted?

Q9. Have any practical problems resulting from your illness been addressed? (such as financial or personal)

Q10. How did you complete this questionnaire?

The wider use of IPOS in Somerset, ideally undertaken weekly, offers a good way of tracking a patient's wellbeing that may not be the same as the purely 'medical' process. Even more helpfully, perhaps, it can help open up the difficult conversations that can really help understand the patients' needs. It reminds professionals that they are treating human beings, making it harder to fall into the trap of treating symptoms rather than the person. It may even help give professionals the bravery to speak honestly about a prognosis. For patients, it may be a chance to raise issues that can be causing considerable concern but that seem to be outside the remit of the specialist looking after them. Many end of life care professionals take a consistently broad view of patient wellbeing, and have a strong desire take on responsibilities relating to wellbeing as well as medical needs.

Providers of End of Life Care

End of life care is wide ranging and stretches far beyond the traditional NHS organisations. Below is a summary of some of the main support for end of life that is provided outside of the NHS.

Carers

Supporting the broad range of needs for someone at the end of life takes a lot of work. And the bulk of that effort tends to fall on family carers – typically, but not exclusively, a spouse or children. Carers in the family help people stay at home and reduce emergency admissions. This is consistent with the 'just in case' admissions of rural elderly identified in last year's JSNA on rural Somerset: whereas for most age groups there are higher admission rates from urban areas, reflecting generally greater health need, the rates are higher from rural areas for the over 75s. The isolation of older rural people means clinicians and paramedics admit them at a lower threshold than for people living closer to acute hospitals.

As a former GP who had also cared for two close family members at the end of life told us;

'Being a carer is a wonderful thing'.

But it is exhausting work, and formal support can be limited: as someone else described it:

'this very poorly paid 24/7 job, lots of forms to fill in, but bear in mind, you don't get any holidays, there are no days off, no clock watching, work every weekend, work every bank holiday, oh yes, and don't forget the night shift'

Another said that the formal support available means:

'Carers are only entitled to four nights sleep a week'.

There is no doubt caring for someone is a challenging and demanding role. The changing patterns of health needs that we described in the introduction – more people living with long term conditions – affects carers just as much as the cared for and carers themselves often have their own long term conditions to manage as well as managing the needs of their loved ones. In addition to carers pre-existing conditions, the health of carers themselves can deteriorate as a result of caring for another individual, in particular the mental and physical health impact of isolation and loneliness can be a significant determinant of carers' health and wellbeing. There are approximately 43,000 unpaid carers in Somerset (we do not know how many are caring for people at the end of life). Of these, 3,500 are in bad or very bad health, and of these 1,500 provide at least 50 hours of care each week.

Voluntary carers, overwhelmingly family members, make an invaluable contribution to end of life care, and are frequently in great need of support. Supportive, compassionate communities can help carers in practical ways, such as cooking meals or night-sitting (for which someone might have to pay £180), but also in maintaining social contacts for people who can otherwise become isolated.

Employers, too, have a role in supporting carers. Good employers can help carers through flexible working arrangement, signposting to the sources of support we describe in this report and, when the time comes, helping the bereaved. As we have seen, caring for someone who is terminally ill is time-consuming and exhausting, and can take people away from work for a long time; a considerate employer can help a carer return to work at their own pace and resume their contribution to society.

Hospices

The modern hospice movement began with the work of Dame Cicely Saunders in the 1960s. She recognised that beyond the medical, palliative, element of treatment, the whole person's psychological and spiritual needs, and those of their family, needed to be taken into account. Hospices in Somerset are charities and are therefore not an NHS organisation. They do receive funding from the NHS for their services but they principally rely on money raised through donations, and their charity shops.

Hospices are not only concerned with cancer, despite the common public perception that this is the case. Cancer is important, not only because it remains the leading cause of death in the UK (if all cancers are taken together), but because it can be a condition that leads to a lengthy and relatively predictable period of decline. Palliative care for cancer typically requires symptom control, including managing the side-effects of medication that has been

prescribed to deal with the cancer itself. Such work normally takes place within multi-disciplinary teams to address the range of the patient's needs.

Although many people associate hospices with their buildings, most of the care that they provide is not residential, and all palliative care consultants are based in the community. The north east of Somerset is served by Dorothy House Hospice, and the north west by Weston Hospice. The large majority of the county's population is in the catchment of St Margaret's – in Taunton and Yeovil – and for that reason alone I will concentrate on their work in this report.

St Margaret's Hospice has 24 in-patient beds, but is typically helping with the care of 450 people at any one time. Of the 6,000 or so deaths in Somerset each year, about 3,500 will have contact with St Margaret's. The support includes much out-patient treatment: in recent years, St Margaret's has seen a fourfold increase in their contact with care homes. Some support is, of course, medical, but in line with seeing the whole person's needs, it includes help in writing 'last minute' wills, arranging weddings and preparing for funerals. Underlying this support is a desire to empower the patient, including using DVD recordings of others in the same position describing how they manage their conditions most effectively.

St Margaret's provides a 24 hour telephone advice line that has run since 2011 – necessary when the need for help can strike at any time of the day or night. It is predominantly used by patients and carers in the out of hours periods, but there are now increasing numbers of calls from care homes, too, and more staff are being allocated to the service.

Care Homes and Nursing Homes

There is a wide range of provision between largely 'residential' care homes and more intensive help available in nursing homes, with dementia by far the most common cause of additional care needed in these environments. There are a high proportion of deaths in care homes, many of which will have been associated with some form of palliative care. There is a similarly a wide range of reasons that people will find themselves in care homes at the time of death. It should not be assumed that everyone who dies in a care home is as a 'resident': it is thought that one third of the deaths are of temporary residents. A frequent pattern is that of a death in residential care being of someone with dementia as an underlying factor, even if an infection may be the immediate cause; this may well be someone who has been cared for at home, perhaps by a surviving spouse, but who can no longer manage in that environment. The move away may be prompted by a crisis, such as a fall or infection, and may be seen at the time as 'temporary' rather than 'end of life'. It is not unusual for someone to be moved to a care home due to the ability of the carer to cope, rather than the patient's illness.

Unfortunately though, even in care homes, there are cases when people are admitted to hospital inappropriately. We heard of one case where a GP had said that a care home resident was close to death, and likely to die within 24 hours. Sadly, the care home staff, confronted with the bodily changes at the end of life, did not have the confidence to let her die, and called for an ambulance. She died shortly after being admitted to hospital, but now had to be classified as an unexpected death, so her body was kept in the hospital mortuary rather than being released to the family. Unfortunately, this is a situation which is not uncommon in Somerset.

In the last 8-12 weeks of life a patient may become eligible for Continuing Health Care. This means that all care and support at home can be funded by the NHS, rather than by the County Council adult social services team. This enables more help to be given, but we heard that some people find the process of applying for CHC to be cumbersome.

As is no doubt clear already, end of life care typically involves long periods of low level illness, interspersed by occasional crises. The confidence needed to accept the progression of expected deaths, both at home and in care homes of residents should not be underestimated. More could be done to improve the planning and support of end of life to help carers and care home staff at times of crisis. Frequently at these times, the ambulance service plays a vital role, however this can often result in an emergency admission to hospital that may have been avoided. Support such as the Somerset Hospice case study detailed later in this report could provide really significant support to carers and care home staff.

Approaching death

When death is near, awareness of cultural and religious differences is significant[viii]. Even though individuals differ, there are certain religious features, such as that in Buddhism, many will want to die with a clear mind, even if that means more pain, and in Hinduism sacred images, flowers and Ganges water may help provide the right atmosphere for the progression of the soul to the next state of existence. We heard that many of the people and families who were best able to cope with death were sustained by their strong religious convictions.

It is important that we are clear of what a normal, 'healthy', death is like. The Dying Matters Coalition, set up in 2009, by the National Council for Palliative Care (NCPC) aims to promote public awareness of dying, death and bereavement. They identify certain signs in the last few weeks, days and sometimes hours of life that indicate when someone is preparing to die (see box below). Recognising what these sign are can help both families and staff to prepare for what is to come.

SIGNS THAT DEATH IS NEAR (from Dying Matters)

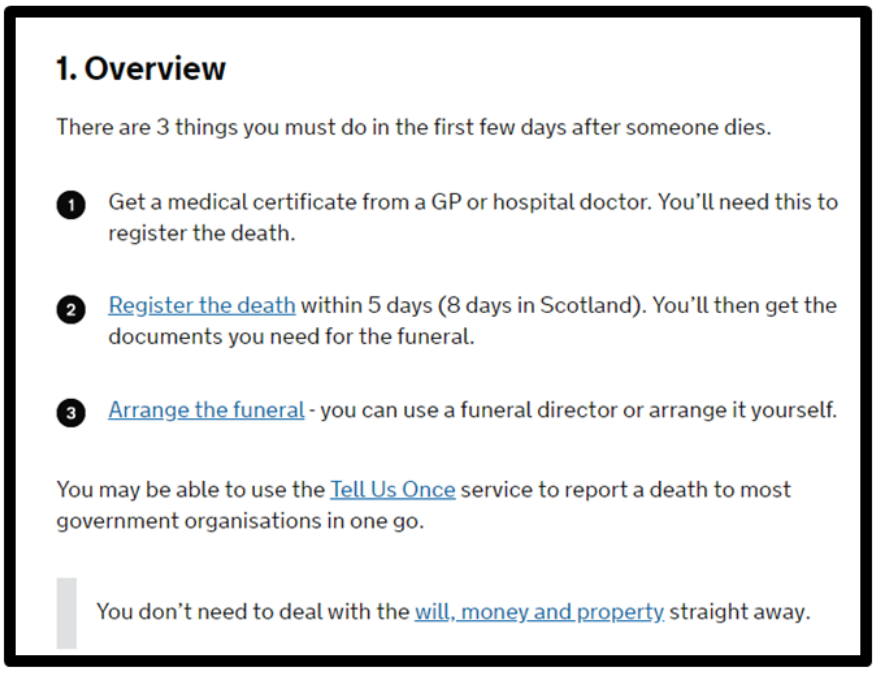
When someone starts to die, these are the signs that indicate death is nearing:

- Physical **changes:** in older people, skin can become paper-thin and pale, with dark liver spots appearing on hands, feet and face. Hair can also thin and the person may shrink in stature. Teeth can discolour or develop dark stains.
- Their **external world begins to diminish** until the dying person no longer wants to leave the house or their bed and may not want to talk very much. Their mood, character and behaviour may change. For example, some may become uncharacteristically anxious. Others who have held atheist views may suddenly want to explore religious or spiritual teachings.
- Increased **sleep:** the person begins to sleep for long periods. This can be distressing for relatives, but it's important to understand that even the mildest physical exertion for someone approaching death can be exhausting, and for the moment all effort is being put into staying alive. Nearer the end, the dying person may increasingly drift in and out of consciousness.
- Appetite **reduces:** the body knows it no longer needs fuel to keep it going so those who are dying often lose their desire to eat or drink. They can begin to lose weight, sometimes rapidly. It's important not to force food or drink onto someone who no longer wants it. But do take guidance from the nursing staff.
- **Changes of expression:** the person may start to talk about 'leaving','flying', 'going home', 'being taken home', 'being collected', 'going on holiday' or making some kind of journey. They may also begin to express heart-felt gratitude to their carers and to their family as a preparation to say their farewells.
- Special **requests:** the dying person may want something special such as to visit a particular place, or to be surrounded by their favourite flowers. They may want to hear certain music, to have family photographs nearby or to make contact with someone who has been important in their lives.

Bereavement

Bereavement, and care for the bereaved, is an important topic in its own right and applies at least as much to those sudden deaths, or deaths of young people, as to older people dying with long term conditions who are the subject of this report. Care for those who are (or know they soon will be) bereaved is an important part of end of life care. It starts with advance care planning and legacy work. A person needs to consider what their legacy will be; what stories they would and perhaps would not like to be told - even to people they will never meet. As they plan for their death and express their wishes, this is hard. It will allow those who will care for them to ensure they have the best possible individualised care as they die. Without this planning people will always try to their best but may not engage an individual's wishes to a full extent. This can adversely affect the bereavement of their loved ones. Bereavement should be considered as a process which leads to establishing and showing resilience toward a 'new normal'. A 'normal' when a person builds a life after the death of another, when the bereaved person will function in society and so reduce the burden on social and statutory networks. Good bereavement care, either facilitated or delivered, should be considered preventative activity for poor mental health. The Gold Standards Bereavement Care tools provide guidance and training, particularly to improve the experience of those whose loved ones die at home rather than hospital.

Figure 16: Immediate tasks on bereavement (from gov.uk website)



1. Overview

There are 3 things you must do in the first few days after someone dies.

1. Get a medical certificate from a GP or hospital doctor. You'll need this to register the death.
2. Register the death within 5 days (8 days in Scotland). You'll then get the documents you need for the funeral.
3. Arrange the funeral - you can use a funeral director or arrange it yourself.

You may be able to use the Tell Us Once service to report a death to most government organisations in one go.

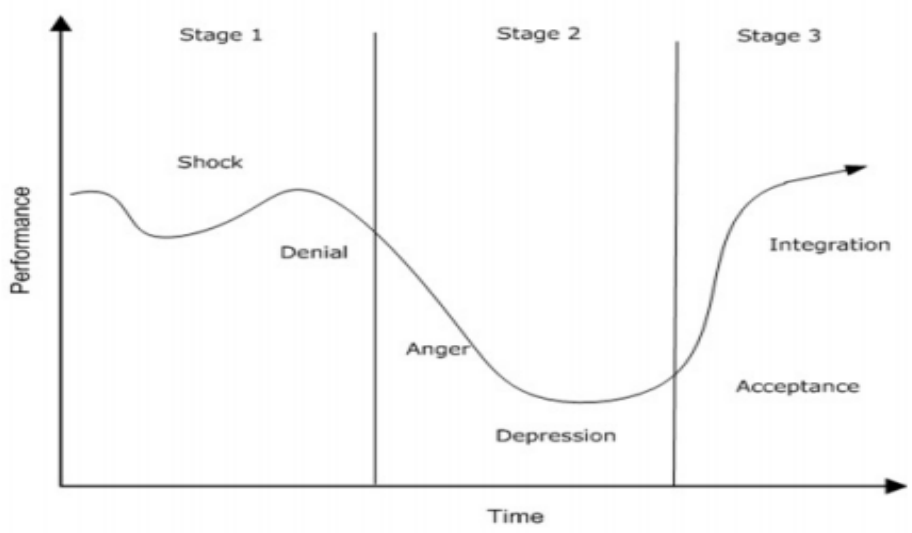
You don't need to deal with the will, money and property straight away.

St Margaret's Hospice is one agency that supports the bereaved. This includes help with the practicalities such as those immediate tasks shown in Figure 16 and longer term issues such as getting back to work and probate. (The six month time limit for probate may be a major source of stress and worsened mental health for some people). St Margaret's also helps with the potential isolation of the family, changes in family dynamics and risks to mental health – beyond the inevitable grief – that can be associated with bereavement. Other voluntary agencies, such as the Citizens' Advice Bureaux and Macmillan (founded in Castle Cary) are also involved in providing help.

Somerset's approach to bereavement care is less coordinated than it could be. Commissioning has attempted to ensure a support service is available to primary care, but this may not be able to cater for needs associated with clinical incidents, unexpected or traumatic deaths. It is challenging to describe fully a simple grief service or pathway for people who may need support beyond normal and healthy grief. All families will experience a death. Not all will need extra help in recovering their 'normal' after it, but for those who do, local services should be integrated and complementary so people can access appropriate support when needed.

Figure 17 shows the 'change curve'[ix], which shows a typical route taken by someone through a traumatic event, such as bereavement. It is thought that 'Everyone goes through these stages. But not consistently, not at the same pace and sometimes not even in the same order.' *(Palliative care professional).*

Figure 17:The Kübler-Ross 'change curve'



The bereavement emotions shown in Figure 17 can be overwhelming, and are hugely different from each other. Care for the bereaved requires great patience and great sensitivity to someone's varying needs. These may vary with different cultural or religious traditions, such as the speedy burial of the body in Islam and Judaism that does not apply in Christianity. They may also vary with personal preference - for some people, swift removal of reminders of the person who has died can be part of the coping process. This may be clothes, for instance, but also equipment associated with the last months and days, such as 'hospital' beds and lifting equipment. For others, though, a degree of continuity can be important, and well-meaning carers wanting to remove this equipment can be intrusive and distressing.

Bereavement is a huge subject in itself, and can only be touched on here. But importantly, how someone dies can have a big impact on how their family and friends are able to cope in their grief, and a dignified death is clearly easier to come to terms with. For some bereaved, grief can become entangled with concern about poor care – real or perceived – in a painful and angry mixture. Dame Cicely Saunders said

'How people die remains in the memory of those who live on.'

This is an important message to be kept in mind by all who care for the dying. In public health we stress the value of prevention; that is usually in preventing ill-health but applies equally to preventing unnecessary distress.

Summary

I hope I have given some flavour of the range of activities that come under the umbrella of 'end of life care', from the medical, through to the social and emotional support provided by carers and families, and to the needs of those carers and families when they have to come to terms with the death of a loved one.

The prospect of our own death, or the loss of a family member, are experiences as profound as we ever face as human beings and the above only gives a superficial description of some of the issues involved. In the following sections we hope to show how working together, drawing on community resources and making early preparations to prevent more serious consequences later, can make the inevitable end of life more acceptable and bearable.

SECTION 3 – How could we improve the end of life experience in Somerset?

Public health is concerned with the health and wellbeing of whole populations. Of all 'health conditions', death is the one that every one of us will experience and should therefore rightly be considered, not only on an individual need basis, but also from a population basis. Taking a whole population perspective on end of life can help us all think about the 'big picture' of end of life, the preparation for it, the care that is provided to the individual and support to the carer and family. In preparing this report many examples of good practice have emerged in Somerset as well as areas where we could do much better. In this section we will consider what more we could do as a county, drawing on our own local experiences as well as good practice from elsewhere. We have grouped these proposals under the headings of supportive communities and being prepared and working together

Supportive Communities

A survey by Dying Matters in May 2017 found that only 16% of people in this country thought that end of life care should be a matter solely for professionals, suggesting that as a society we are open to taking a broad view of the resources available and accepting of the notion that responsibility for end of life care lies with the whole system, not just at one particular door.

Communities are starting to be more proactive in taking more responsibility for improving the health and wellbeing of their local population, but matters to do with death, dying, loss and care in communities is not yet widely considered.

A Compassionate Community approach helps to shift our thinking from a largely traditional medical approach to end of life, to an approach which considers a greater role for the community alongside medicine, in providing genuine support, care and information.

Compassionate Communities can provide support for the physical, psychological, social and spiritual challenges at the end of life, but importantly the approach also aims to achieve openness toward those affected by death, dying, and loss. We heard, for example, about Porlock, where someone collapsed at another's funeral. This led to a community drive to fund and install two defibrillators, one at each end of the village – recognizing the time it might take some residents to get from one end to the other. Notwithstanding the value of the defibrillators, the discussion of death and the community links forged may have been even more valuable.

There is no question that compared to many other countries the NHS provides the UK with a strong and effective, publicly-funded system of healthcare for all periods of life. In other countries such as Albania, by contrast, a terminal diagnosis leads to responsibility for care being passed to the family and community. This has led to very active community networks in Albania as there is little else to depend upon. Surely the approach which would provide the best quality care would be one which uses strong community support alongside and very much in partnership with the exceptional services we receive from our NHS.

South Petherton

South Petherton, a large village between Yeovil and Chard in South Somerset, demonstrates how a community, in this case the parish, can work together to support its members, with end of life care an essential part of supporting people throughout the life course.

In South Petherton the parish council works alongside the local hospital, the GP practice, health coaches, the village agent, eight 'micro-providers' of care and a palliative care nurse specialist. The local area actively seeks out people who are more isolated in the village, often these people are isolated by their caring duties. Activities such as annual street parties are not specifically intended to improve end of life care, but the neighbourliness that this encourages has real benefits. As well as the vital business of helping foster social contact, community support can include simple but essential practical help such as walking the dog and mowing the lawn. Statutory services cannot cover all the needs of a family with a member needing end of life care: an active, supportive community can reduce the reliance on these services.

At a conference for Dying Matters Week in May this year, Tom Barber, working in communities in South Petherton as part of the Symphony project, highlighted three important elements to a community partnership for end of life care. They are:

- Information sharing in person - important in developing local relationships and ensuring there is clarity
- Local solutions to local problems – often these are the most creative and low cost
- Creating a road map for wellbeing and resilience.

South Petherton shows how end of life care is a matter for families and communities, not just the medical specialists. A Compassionate Communities approach can really help in times of considerable stress and emotional turmoil, possibly like no other part of society can.

Figure 18: South Petherton village centre

Volunteers

There is clearly already an important role played by volunteers in end of life care, but this is valuable, often rewarding work which could potentially be increased. Just as there is a shortage of suitable paid staff reported by hospices, often more volunteers are also in short supply. Greater cooperation between hospices, Macmillan, Marie Curie and others could make more effective use of the resources available.

Volunteers can contribute in vital ways that are beyond the scope and perhaps even awareness of professionals. One example is the work of the Cinnamon Trust, which provides volunteer dog walkers for housebound people with pets. This means that the pets can stay at home and contributes enormously to the quality of life of someone who is very ill.

Marie Curie – Volunteer Companions and Helpers

In 2014, Marie Curie launched their companion service at Musgrove Park hospital, aiming to improve the experience of people who die in hospital and emotionally support their families. By recruiting, training and supporting 25 specialist volunteers, the service provides patients and their families with emotional support and someone they can talk to at this difficult time. This also helps support the hospital nurses. The volunteers are trained in patient confidentiality, safeguarding, communication skills, and issues concerning bereavement and loss. The Service has received more than 500 referrals since it launched in July 2014 compared to a target of 75 referrals a year. The service is now offered 12 hours a day, seven days a week, including bank holidays, to all 20 adult wards within Musgrove Park Hospital, with patients often referred by nurses who notice their lack of visitors. This is, however, the only hospital in Somerset to offer the service.

"I am sure you already know that comfort and support is so much needed during difficult periods and I would like to say how grateful we were for the kindness and care shown to us"
Bereaved family member

Marie Curie volunteer helpers work in the community, giving practical support to patients at home, such as taking them to the doctor, but most of the help is simply to be there and provide emotional comfort. This can include continuing conversations about Advance Care Planning that started in hospital, in a more relaxed atmosphere allowing for clearer thought. The visits are usually at a regular time as best fit the patient's needs.

Such volunteer support involves 'coming alongside people', and 'de-medicalizes' the patient's condition. Talking about oneself as a person, talking about poetry or the news, rather than just an illness, gives identity and dignity. But it is not always easy, and at the base involves a recognition that 'We can't fix it'. Volunteers need to be trained, and local businesses support by offering rooms for this to happen in. But more resources are needed, and the companion service cannot be made available overnight when, as we have seen, things can be at their hardest.

As ever, this can all be rewarding for the volunteer as well.

'A quite unexpected "benefit" I have experienced on occasions, is a deep sense of profound peace and tranquillity, which comes from sitting quietly for up to three hours, often just gently holding a patient's hand and reassuring them of your presence.'
Companion volunteer.

Marie Curie
Care and support through terminal illness

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'A quite unexpected "benefit" I have experienced on occasions, is a deep sense of profound peace and tranquillity, which comes from sitting quietly for up to three hours, often just gently holding a patient's hand and reassuring them of your presence.'
Companion volunteer.

Housing and homelessness

The links between housing and its impact on health are well established and this applies equally as strongly during the end of life. Well-designed housing can mean that people are not forced out of their home because of illness. Features such as wet rooms, wider doors, level access, joist that can take hoists to help lifting are of less advantage to those in good health, but come into their own for those who require adaptations to maintain independence.

There are many positive examples of where changes to the home make a significant difference to enable people to stay at home. The case below is just one example using some of the adaptations that can be needed.

'Most modern homes are not intended to be a hospital ward, but ours was for a full 12 month, or at least one and a half rooms, but where do you put the furniture that you have to move, to get the hospital bed into the family home? Somehow or other you do. This move included using the neighbour's garage because ours is full, but not with the transport vehicle. This bed also included an air mattress and with it came a Nebulizer, Oxygen Concentrator, Mobile Hoist, (try pulling or pushing this when loaded on a carpet) a Rotunda, Electric operated lift & rise arm chair, to help get the patient upright, Shower chair, (eventually, for the wet room) outdoor Wheelchair, mobile Commode and a couple of ramps for the back door, later on two ceiling hoists. Because of the Oxygen Concentrator the local fire service has to be informed that the device is in the home. Thank goodness for modern devices, like wireless door bells, the wife would have the push button bit downstairs in her bed and the ding dong bit was plugged in by my bed upstairs.'

'*We got financial help to get a wet floor put in, what a difference that made to the wife, to have a decent daily shower and wash twice a day.'*

I am very grateful to a member of the Somerset Engagement Advisory Group for this account.

The design of buildings has a major impact on health and independence. A greater focus on achieving Lifetime Homes Standards would for new housing, even if just for selected properties would be a significant step forward.

Homeless people have a typical life expectancy of only 55 years. Facing the end of life they are often admitted to hospital as the obvious place of safety. This may not be comfortable for them and they often discharge themselves early; hostels may be based on the idea of 'recovery' and be similarly inappropriate. However, in researching for this report, we heard of one case where a homeless man was able to work with health professionals to develop his own Advance Care Plan, and expressed clearly that he did not want to die in hospital. Instead, arrangements were made for him to stay with his brother, which he did until his death.

St Margaret's Hospice actively pursues links with the homeless population and the traveller community in the county. As Ann Lee, the chief executive wrote:

> *'According to Homeless Watch, for many in the homeless community, early life experiences are shaped by a difficult upbringing, whether this is related to sexual, physical or substance abuse, or even living in relative poverty with a lack of opportunity. As a result of these experiences, homeless people are more likely to have a combination of chronic physical and mental health issues and substance misuse problems, which can often mean that they require some of the most complex palliative care.'* [x]

Being, or caring for someone, at end of life brings many things into sharp focus, including facing challenges about the way we live our lives. The role that stronger communities can play in providing support to the dying and their families is not very different from that supporting young families or those who are lonely, we need to listen carefully to the needs and wishes of individuals and not assume that one size fits all. Planning our communities and local environments with a recognition of the ageing population structure, and consequent rise in the total number of deaths, will help us be prepared for future challenges.

Being Prepared

Whilst we all know that we are going to die, we put that awareness to one side in everyday life. There are psychological and cultural barriers to thinking about or discussion our deaths. Our lives, though, and not just at the end, may be more fruitful if we remain more aware of our mortality. Many people talk of having a 'bucket list' of things we would like to achieve or experience in our lives, one can presume that the greater this list is checked off the more accepting we may be of the end of our lives. As well as the 'bucket list' however, further preparation could help us to die with dignity and peace. In order to die with dignity we have to really know ourselves, and what we value, and communicate that to those closest to us.

Putting awareness of our death to one side means that much can be overlooked – for example we heard of a case where a couple had simply assumed that they would be buried. However, the shortage of burial plots meant that they had to rethink, and that led to new ideas about where they would want their ashes scattered. A dignified death involves respecting an individual's wishes – and only thinking and talking about death can bring them to the fore. We consider below the sort of preparation to be made when receiving a terminal diagnosis, before moving onto the more general preparation that we can all make.

Preparation for the terminally ill

The idea of a woman's choice in childbirth has become entirely accepted and having a birth plan is now the norm. The attitudes and planning relating to death however has been much slower to change. We cannot pretend that being prepared for a death will prevent it being unpleasant, painful or distressing; but it may make it *less* unpleasant, painful and distressing.

Figure 19: End of Life Choices (from St Margaret's Hospice)

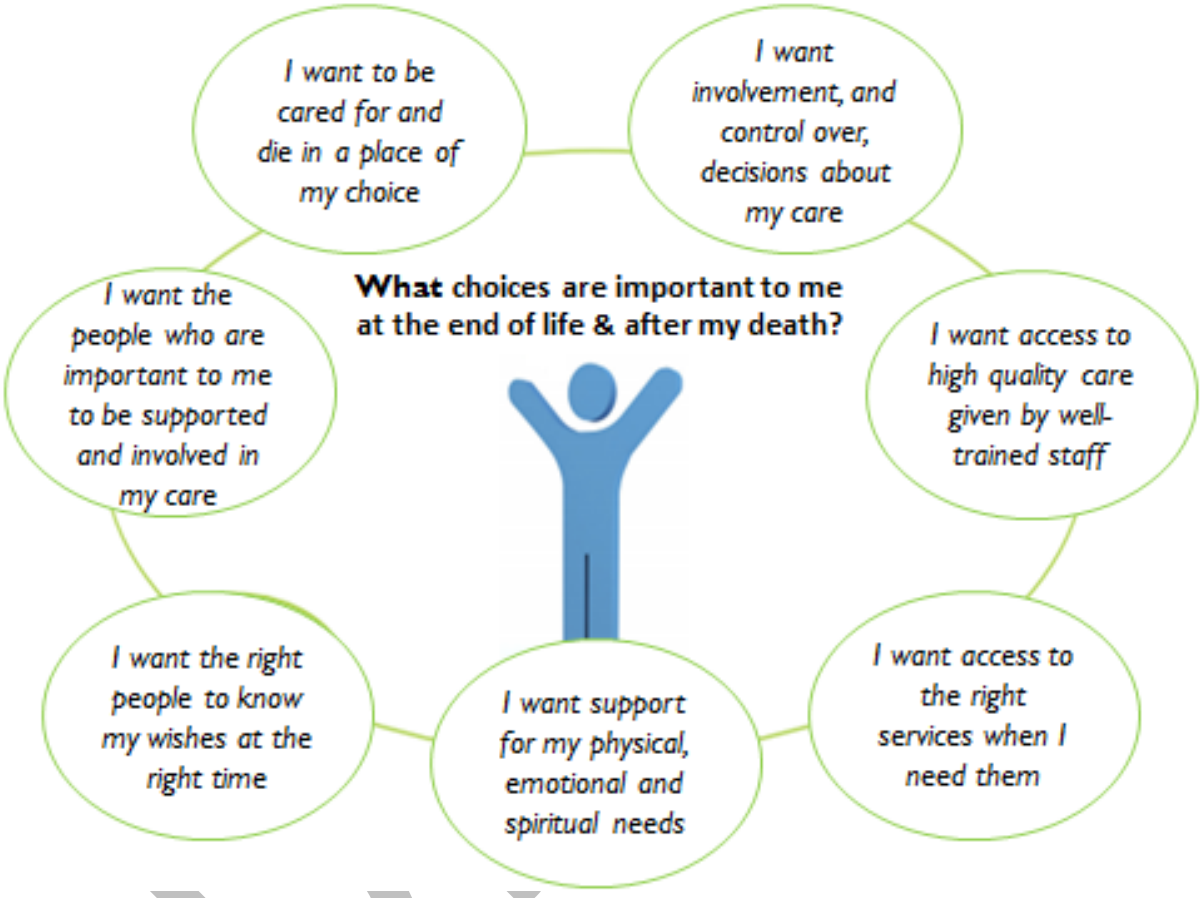


Figure 19 shows diagrammatically the sort of assertions made by people receiving end of life care, and the range of choices that can be made in preparing for death.

Advance Care Planning (ACP)

For individuals and families, the sort of preparation required is covered by the Advance Care Plan, for Somerset this is the document called 'Planning Ahead'. Of those who have completed an ACP, 80% die in the place of their choice. This is partly a result of using the ACP itself, but mostly it is because it means that the patient has thought about the future, and usually has had the difficult conversations with family about treatment. The medical elements of ACP are in some ways the least important, but planning includes the 'Treatment Escalation Plan', which shows when new treatments should, or should not, be brought in, according to medical need and patient wishes.

We heard one example of a life-long Somerset farmer who had, in the course of a family lunch, explained how he would not want to be left incapacitated and housebound as a result

of illness. When he had a serious stroke and could not communicate, his family were able to tell the physicians that he should not receive surgery that would, at best, restore only a small fraction of the quality of his active, outdoor, life, and so he was able to die at a natural pace.

The falling proportion of deaths in hospital is thought to be linked to the increased use of ACP, and it is hoped that it should also lead to fewer admissions, fewer tests and fewer intrusive investigations in the last year of life. The efforts being made to use the 'number of days spent out of hospital in the last 90 days of life' as a good indicator of quality for End of Life Care is to be applauded.

Advance Care Planning can be undertaken at any time, of course, but tends to be done when the medical opinion is that a condition is life-limiting, which may still be some time from the end of life itself. It includes such decisions as whether to have a 'Do not attempt cardio-pulmonary resuscitation' (DNAR) notice. For some people, the acceptance of imminent death means that they prefer not to have intrusive resuscitation procedures attempted, in the belief that they are likely to add little to the length of life and that they would prefer to let the illness take its own course. This is especially the case for people whose quality of life is diminished by illness. Others, of course, wish for everything to be attempted that might keep them alive for any length of time. ACP means that professionals know how to respond in accordance with the patient's wishes.

The ACP document 'Planning Ahead' has been produced in Somerset and is the way in which most professionals encourage patients to consider and record their wishes for end of life. It works well, but for some the 'Stanford letter'[xi] or a phone app may be better – the important thing is to do the thinking and let others know.

Figure 20: Advance Care Planning in Somerset

Simple good organisation can make life and death easier for all, with medication, contact details and advance care plans up to date, accessible and legible. Doing this 'in hours' can make things much more manageable for those working out of hours. Many of the difficult situations are out of hours, the night-time can often be the hardest, but that does not mean we need to look at out of hours services to improve matters.

The work done at East Quay medical practice in Bridgwater provides an excellent example of this, the practice has a real focus on encouraging families to use advance care planning. The practice has a robust system in place to ensure this planning is completed and all the loose ends in making arrangements are tied up. Elsewhere, other professionals also undertake a similar role including village agents and Mendip Health Connectors. In Frome, the Health Connectors undertake 'eco-mapping' of the support available, helping to link them with the people who need them.

The relief advance care planning brings to relatives and carers should not be underestimated, as well as reducing the burden of care placed on GPs. The following case study provided by Dr Ed Ford, Somerset GP and Chair of Somerset Clinical Commissioning Group demonstrates just how important they can be from a patient and family perspective.

Case Study – Provided by Dr Ed Ford

My patient was prone to seizures and had lost capacity and the family were extremely anxious about her care. We had a frank conversation about what the family expectations were for her care. They wanted her kept comfortable at all costs and appreciated that she would not want to be kept alive at all costs.

We discussed the types of treatment that would be suitable or not. We all agreed that resuscitation, admission to the Intensive Care Unit, dialysis or force feeding with a tube would not be appropriate for her if she ever required them. We did however agree that we could treat her with antibiotics for simple infections but if she were ill enough to need hospital for an infection then treatment would cause her distress and possibly be futile so we should treat her palliatively in the nursing home. We also discussed what we would do if she had an accident and broke her hip. Likewise, we agreed not to send her to hospital and keep her in bed appreciating that this would be a terminal event so we would manage it as such. Lastly, we discussed medication and what we were treating. We agreed to keep her on her anti-epileptic drugs but we reviewed all other medication and agreed to stop them unless they were managing symptoms. Hence we stopped her statins and other secondary prevention drugs.

Since this discussion, the family have been clear about the care and have felt more confident, not needing to contact me as frequently about new symptoms etc. We all know the plan and are comfortable with any potential outcome. Whilst these discussions are detailed and do take time, an hour invested for this case and many others will undoubtedly save a number of hospital admissions for the patient and provide considerable reassurance to the family.

Another potential benefit of Advance Care Planning is organ donation. Individuals may choose to donate organs, or not, for a wide range of very personal reasons. In English law, the current[xii] presumption is that consent for donation has not been given if the patient's wishes are not known, so cases where people's wishes have not been expressed during their lifetime may result in missed opportunities that can be literally lifesaving. Practitioners will often try to raise the issue with families at the time of death, but this can be the most difficult time to do so.

An individual's legacy takes many forms, and some people find writing 'all about me' or making recordings of themselves helps them prepare for death. And even if painful initially, it can help the bereaved come to terms with their grief.

End of life care is complex, and some patients and families may be more able to negotiate their way through the system than others. Those with the fewest resources of economic and social capital are often least able to make their wishes for the end of life known or put into practice. Whilst this report aims to promote good end of life care for everyone in Somerset,

it is particularly important that support is provided to those people who are least able to make the preparations needed for the end of life on their own.

Like any plan, advance care planning is only useful if the plan is actually used and adhered to. The Goldline case study below was set up by Airedale NHS Foundation Trust as an alternative to the NHS out of hours 111 service for patients on an end of life care plan. It is a good example for Somerset to follow as this area too includes significant rural areas where the simple distance between patients, practitioners and services makes effective care a challenge. It is also acknowledged there are still people who are excluded from the benefits of modern technology who are no less deserving attention, but where possible communication solutions using technology should be supported and promoted.

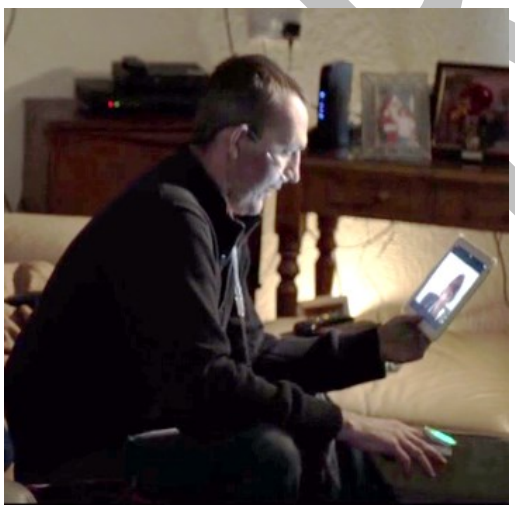
Goldline

The Goldline service provides patients or carers with support 24 hours a day, every day of the year. The nurses operating the service have access to the advance care plan and, via telephone or Skype, are often able to provide the advice or reassurance needed without requiring a doctor's visit or admission to hospital.

About two thirds of the calls are during the night, which reflects the reduced availability of other professionals at that time, but also when the strains of being terminally ill, or caring for someone who is, can be the most pressing. As Stephen Lock, one carer who used Goldline, states simply:

'You do need help, you know; you really do, you can't do these things on your own.'

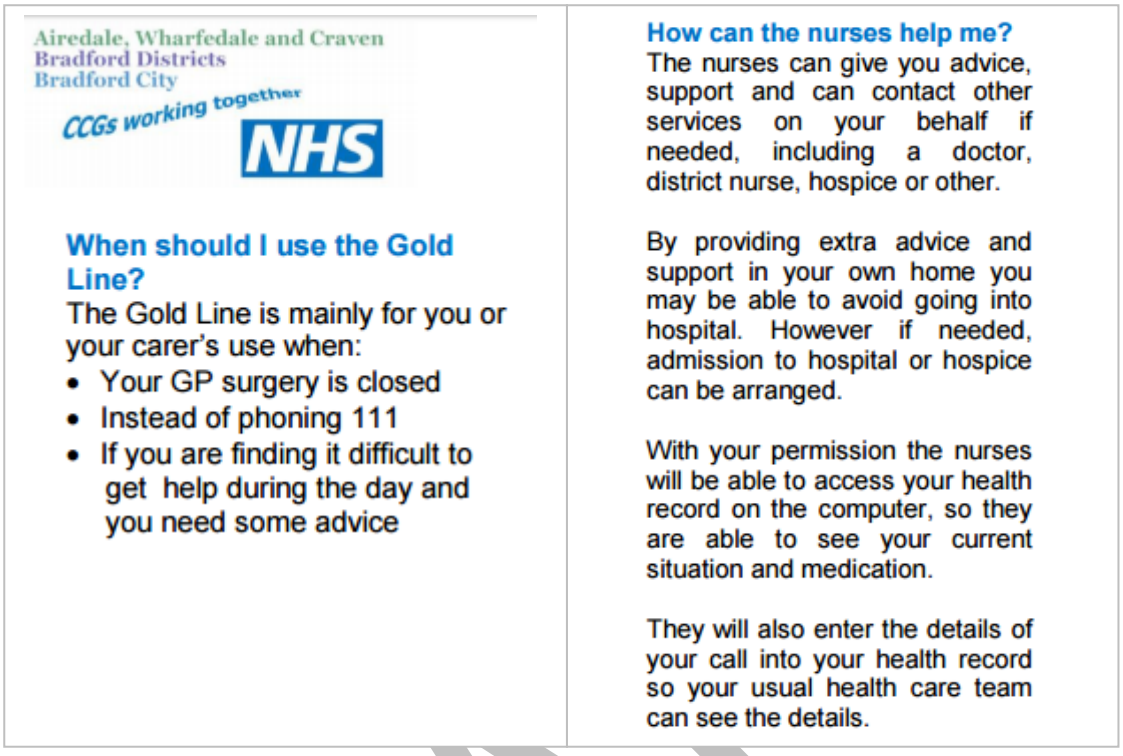
Figure 21: Patient calling Goldline (Airedale NHS Foundation Trust)



Goldline allows the range of professionals to see the patient's electronic records – with the patient's permission, of course. For the patient and carer, one of the greatest advantages is the sharing of information. Stephen Lock described the first time he called the Gold Line when caring for his partner Bea:

'I first rang Gold Line a couple of days after Bea had come home, just to ask about the drug that she was on. It was a fairly minor little question but it meant that we didn't need to go anywhere, we just rang one number, we didn't need to figure out "should I ring the GP, should I ring the pharmacy?"'

Figure 22: Goldline guidance to users from the Airedale NHS Foundation Trust Website



Airedale, Wharfedale and Craven
Bradford Districts
Bradford City
CCGs working together
NHS

When should I use the Gold Line?

The Gold Line is mainly for you or your carer's use when:

- Your GP surgery is closed
- Instead of phoning 111
- If you are finding it difficult to get help during the day and you need some advice

How can the nurses help me?

The nurses can give you advice, support and can contact other services on your behalf if needed, including a doctor, district nurse, hospice or other.

By providing extra advice and support in your own home you may be able to avoid going into hospital. However if needed, admission to hospital or hospice can be arranged.

With your permission the nurses will be able to access your health record on the computer, so they are able to see your current situation and medication.

They will also enter the details of your call into your health record so your usual health care team can see the details.

We know that some elderly people in rural Somerset are admitted to hospital 'just in case' – unquestionably well-meant, but also a further source of stress for the patient and family, as well as a cost to the already stressed health and care services.

Goldline has been shown to reduce avoidable admissions to hospital for people receiving end of life care, by shifting care away from hospitals and into the community. The impact of Goldline seems striking. Nationally only 20% of people die at home, whereas for Goldline patients the figure is 40%. Some of this effect may be because of the types of patient and condition being cared for, but even so this does suggest that similar approaches could help reduce the hospital requirements for end of life care, and most importantly provide a better death for the terminally ill, and their families, in rural areas.

Deprivation of Liberty

One consequence of failing to make preparations is 'Deprivation of Liberty', and the associated Deprivation of Liberty Safeguards (DOLS). This is a procedure prescribed in law where it is necessary to deprive people of their liberty who lack capacity to consent to their care and treatment in order to keep them safe from harm. Such a procedure can take time and delay providing appropriate care to people at the end of life, especially those with dementia. It is better to put arrangements in place when patients or service users are still in a position to make decisions themselves. This can be promoted through raising awareness of end of life issues.

Preparation for us all

A diagnosis of serious illness, either for ourselves or a family member, is shocking. It may also be an opportunity to rethink priorities, and make preparations for the future. It may not though, be the best time to think in a logical and rational way, it is easier to make those preparations whilst still in good health. Below are some simple actions that all adults can take to make the end of our lives more manageable for ourselves and our families. These should be advocated by professionals.

Making a Will

The most obvious preparation, perhaps, is to make a will. Without one, the process of managing an estate can be expensive but also very onerous, as described by 'Brian' to the BBC in 2016, following the death of his cousin.

> *'We had to pay £240,000 in inheritance tax so that hurts. If he had gone to a solicitor or a nice little company which I've used, they would have sorted all that out for him. It took two years of my life. I really took it on as a bit of a challenge really, and I felt obliged to do it because we were fairly close, and I just felt I had to do it. I think my message to everyone would be to please make a will, because then you can give your money to the people of your choice.'*

A survey by YouGov in 2015 suggested that only 38% of British adults had made a will.[2]

Lasting Power of Attorney

For end of life care in particular, Lasting Power of Attorney can be vital.

> 'A lasting power of attorney (LPA) is a legal document that lets you (the 'donor') appoint one or more people (known as 'attorneys') to help you make decisions or to make decisions on your behalf. This gives you more control over what happens to you if you have an accident or an illness and can't make your own decisions (you 'lack mental capacity').'[3]

This power can be over financial affairs, or healthcare, or both. It means that decisions about end of life care, such as whether to undertake painful or risky medical procedures, can be taken by someone you have chosen, rather than by a court.

Talking to others

Practical preparations rely on us having the impact of our deaths in mind, when often it is something we tend to try to put to one side. There are increasing efforts being made by those such as Dying Matters[4] to bring awareness of death back into our lives, as it was in Victorian times. 'Death cafes', where people can spend a short time talking about death in a relaxed atmosphere have been held in parts of the country and in Somerset earlier this year. These events could prepare and inspire us to support a compassionate communities approach, make our own preparations and work together to enable more people to die according to their wishes.

Figure 23: A death cafe in Manchester

Working together

Providing end of life care is complicated and difficult, and requires the skills of many specialists, taking the example of Motor Neurone Disease I would like to highlight some of the complexities people at the end of life and their carers' experience.

The Motor Neurone Disease (MND) Association suggests that someone diagnosed with this terminal condition is likely to come into contact with the following 16 types of people, and to this list should be added many more including paramedics, volunteer supporters and the patient's own GP.

- MND consultant
- Specialist palliative care team members
- Neurology or MND specialist nurse
- MND coordinator
- Community nurse
- Speech and language therapist (SLT)
- Dietician
- Physiotherapist
- Occupational therapist (OT)
- Counsellor
- Psychologist or neuro-psychologist
- Pharmacist
- Complementary therapist
- Wheelchair service representative
- Social worker
- Benefits adviser

In Somerset, these people would be working for numerous different organisations, including the acute hospital trusts, Somerset Partnership, the hospices, Somerset County Council and the Department of Work and Pensions. Although 16 roles are described, there may be more than 16 people doing the work. Such a number and range of people cannot work as an effective team, they have to work as a collection of specialists and try and achieve co-ordination.

Palliative and end of life care in Somerset is adapting to integration with a consortium funded, CCG led, consultant body and increasing co-production of services which aim to wrap around a person and those important to them. Face to face care and its continuity will be improved by shared ownership and goals for end of life care. People do not do well if they are ill in isolation, services must reflect the journey of understanding, adjusting, hoping and coping when they have an illness which has shortened their life.

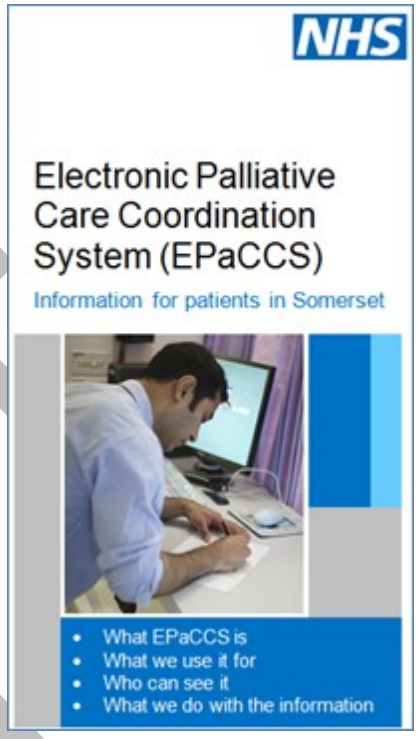
One of the most frustrating things for all of us is having to tell the same story many times. If it's a good story it gets tedious, if it's a story about the end of life for yourself or a loved one, it's often tied up with emotions such as stress, sadness and fear and is therefore not a story you want to be repeating too often. Quite rightly, the public generally assumes that even though professionals often work within different organisations, that shouldn't stop us talking to each other. As a carer told us:

'Why didn't the local Out of Hours Doctor know about the phone call? Was because it was diverted to the NHS Direct number, so they were not involved within the story?'

Co-ordination of care

For patients with multiple conditions the coordination of care becomes of paramount importance. Part of the success of Goldline is the coordinating role that the senior nurses are able to provide.

Figure 24: EPaCCS leaflet



Effective coordination of care for all end of life patients in Somerset is what we should be striving to achieve. For example, Somerset is working hard to introduce a common 'Treatment Escalation Plan' to be used by all involved in care. The coordinator role can be taken by different professionals depending on the circumstance; it may be the GP, a nurse in the practice or hospital, or a professional from a hospice. Every person, and every death, is different and so we should not try to enforce a single model of care on anyone; rather we must have a framework towards which the whole system works for end of life care otherwise better coordination will be impossible.

Palliative Care Co-ordination in Somerset

In Somerset the Electronic Palliative Care Co-ordination System (EPaCCS) is used to hold information about patients' illness, treatment, next of kin and wishes in a form that can be updated and viewed by those involved in providing care. Although undoubtedly a self-selected group, it is striking that only 7% of those patients with EPaCCs will die in acute hospitals. The information held in EPaCCS is available to Out-Of-Hours staff through their operating system and includes the patient's advance care plan, indicating which treatments they do or do not want to receive in particular circumstances. Making information available easily to out-of-hours staff is a particularly good way of reducing 'over-treatment'; in the absence of other information a physician will naturally seek to do everything to prolong a patient's life. We heard of a case where someone was administered a high dose of antibiotics and taken into hospital, only for the hospital consultant to know the next day that the patient had asked to avoid such intensive treatment at the end of life. The low rate of deaths in an acute hospital achieved by using this system is an excellent result and use of the system needs to be much more widely spread.

Unfortunately, at present, this information cannot be viewed by the hospices as they, like care homes, are outside the NHS. Perceived difficulties in sharing the right information in the right form, to the right people is an impediment to many staff working in the health and social care system. Whilst some progress has been made in recent years in appropriate information sharing, far more can be achieved help to fulfil the wishes of individual patients and their families. Sadly, not all the records needed are even kept electronically, and these paper records are often slower and more difficult to share.

The issue of appropriate sharing of data is highlighted as a problem not just in end of life care but across many aspects of care. It is an issue significant confusion and frustration for staff and requires far greater consideration and action across the whole health and social care system. I will return to this issue in the final section of this report.

Co-ordination for professionals

Sparsely populated as it is, West Somerset has 47 people per square kilometre; New Mexico by contrast has just six. It is perhaps unsurprising that New Mexico has led the way in using information technology to bring widely separated clinicians together to support each other in end of life care in the 'ECHO' project (Extension of Community Healthcare Outcomes).

Outlines in the case study below, Hospice UK is committed to the ECHO model, as is St Margaret's locally, and this way of working is being extended across the county. End of life care requires both the expert skills of specialists and a broad overview of patient need, and technology can enable the necessary communication between all those who contribute.

'ECHO started as a way to meet local healthcare needs. Sanjeev Arora, M.D., a liver disease doctor in Albuquerque, was frustrated that thousands of New Mexicans with hepatitis C could not get the treatment they needed because there were no specialists where they lived. He created Project ECHO so that primary care clinicians could treat hepatitis C in their own communities. Launched in 2003, the ECHO model™ makes specialized medical knowledge accessible wherever it is needed to save and improve people's lives. By putting local clinicians together with specialist teams at academic medical centers in weekly virtual clinics or teleECHO™ clinics, Project ECHO shares knowledge and expands treatment capacity.'[1]

Figure 25: Sanjeev Arora, founder of ECHO

Summary

In this section we have considered a wide range of working practices, drawing from examples of good practice locally, nationally and internationally. What is clear is that there is some exceptional practice in end of life care in Somerset but this practice is often not fully rolled out across the county.

Overwhelmingly there are three themes which emerge:

- The need for preparation is a message for all of us. It is clear that good preparation can reduce some of the stresses associated with end of life and can help increase the possibility of patients wishes being fulfilled.

- End of life is far from just a medical issue. The social, emotional, practical and spiritual support that can be achieved through the development of a more Compassionate Communities approach far exceeds what could ever be achieved through support from health and social care services and can help provide very innovative solutions to the very sensitive and diverse wishes of the dying.

- The importance of working together to achieve coordination between the huge range of specialists and carers who provide end of life care. Good communication and the ability and willingness to share information is critical to achieving this.

SECTION 4 - Conclusions and Recommendations

'Are you able to contemplate your death and the death of those closest to you? Accepting the fact of death, we are freed to live more fully. In bereavement, give yourself time to grieve. When others mourn, let your love embrace them.'

Advices and queries (Society of Friends).

Death is very different for everyone, and sensitivity to individuals' and families' wishes is paramount in avoiding unnecessary offence. Some people may want to be fully conscious, some prefer to slip away with analgesics easing the pain. Some want the windows open, others to have their dog on their laps. Sometimes the circumstances are not necessarily or wholly in our own gift, but where they are it is a sign of respect to the dying to have their wishes fulfilled.

The bereaved, too, may have very different responses. Some will want to see bulky equipment such as hoists and 'hospital beds' taken from home as quickly as possible (even if just for practical reasons such as playing host to the wake); others need a period of delay to come to terms with the death before this is done. Some people want to get through dealing with the will and probate immediately, but for some people the six month limit on probate can be too hurried and can have a significant impact on mental health.

There are many examples of where patients and their families had been supported hugely by professionals and communities at the end of life. Although, this is a time when great sensitivity is required and what may be normal, hurried activity can seem brusque and thoughtless to the family. People in such circumstances are naturally less tolerant of bureaucracy than in more normal times. Issues such as car parking charges at hospitals, that can be annoyances on other occasions, can be deeply upsetting when visiting a dying relative. Professionals need to consider that they need to care for patients' physical, mental, social and spiritual wellbeing, which can be difficult, especially under pressure of time in the middle of the night.

Being able to die with dignity is something we would all aspire to, regardless of where we die. The quote below from one carer described his terminally-ill wife's experience in hospital is just one example, and there will be many more positive examples of where people have been supported to die with dignity, but this example shows that we have not always got this right:

> *'There was one occasion, a few days later, when things had slightly improved, when the bed pan was wanted and the nurse told her to soil the bed, 'because I am busy' was the answer and 'we will clean you up later'. Where has the compassion and dignity gone to these days?'*

There is much that can be drawn from this report and below highlights some of the main conclusions and provides recommendations as to how we can improve end of life experience in Somerset.

For everyone

- **Breaking the taboo**

  Talking about the death of loved ones is difficult, often emotional and, as such frequently avoided. Becoming more open about death can help prepare us and ease the situation when it does arise. It can help give people peace of mind and enable us to ensure we make the most of the time we have.

- **Preparation**
  Making preparations, such as power of attorney or making a will, may seem morbid, but done in advance, rather than at a time of crisis, can make end of life more bearable, especially for relatives and carers. This only has to be done once and revisited occasionally – there is no need to think about it all time.

- **Realistic expectations**
  We cannot expect end of life – for ourselves or our loved ones – to be painless or stress-free. Accepting that can make the tribulations somewhat more manageable.

- **Sources of support**
  Whilst the range of needs at end of life is huge, so is the range of support available. In the annexe to this report are contact details of many sources of support operating in Somerset.

For Communities and Voluntary Sector groups

- **Stronger Communities**
  The importance of strong, vibrant communities in providing support to individuals, carers and families at the end of life should not be underestimated. This is particularly the case in supporting carers, who can otherwise become very isolated.

For NHS and Care organisations

- **Talking about death**
  There is still an understandable stigma about death, and this can hold back making the best long term decisions. End of life is, of course, a very difficult time and we can't stress enough the importance of sensitivity.

- **Sharing information**
  The integration of health and care is something that we are working towards in Somerset, and end of life care is an integral part of this progress. There is a need to explore the extent to which we can share information legally to benefit patient care and maximise the opportunities. This is an issue of confusion within the Somerset system

and one whereby each organisation seems to have different sharing thresholds.

- **Using technology**
  Systems such as St Margaret's Hospice Care Line, Goldline, EPaCCS and ECHO help patients, carers and professionals have access to support from health services, particularly out of normal working hours. In a large rural county, use of technology and phones to keep people connected and supported at this difficult time is paramount and should be embraced to a far greater extent by health and social care services.

- **The spectrum of care**
  The medical support available in EoLC is clearly crucial and is able to reduce the pain of an inevitable process. The needs of the dying also range from the very practical, such as managing finances, to the spiritual. Support in all these issues is available but can be uncoordinated.

In summary, the principal aim of using the Annual Report of the Director of Public Health to focus on end of life was to raise awareness of the growing importance of a peaceful and dignified end of life as an integral part of the whole life course.

In 'accepting the fact of death', I hope that we can indeed make life more full but I also hope that this report can encourage us all to be sensitive and prepared.

Sources of Support in End of Life Care in Somerset

Alzheimer's Society (Dementia)	https://www.alzheimers.org.uk/ 0300 222 1122
Dorothy House Hospice (Mendip area)	https://www.dorothyhouse.org.uk/ 01225 722 988
Dying Matters	http://www.dyingmatters.org/
Macmillan Cancer Care	https://www.macmillan.org.uk/ 0808 808 00 00
Marie Curie	https://www.mariecurie.org.uk/ 0800 090 2309
Motor Neurone Disease Association	https://www.mndassociation.org/ 0808 802 6262
NHS Choices	http://www.nhs.uk/Planners/end-of-life-care/Pages/End-of-life-care.aspx
Somerset Carers' Network	http://www.somersetcarers.org/ 01749 836633
Somerset Choices	https://www.somersetchoices.org.uk/adult/information-and-advice/carers/end-of-life-care/
Somerset Clinical Commissioning Group	http://www.somersetccg.nhs.uk/about-us/how-we-do-things/palliative-care/
St Margaret's Hospice	https://www.somerset-hospice.org.uk/ 0845 070 8910
Weston Hospicecare (North Sedgemoor)	http://westonhospicecare.org.uk/ 01934 423 900

Acknowledgements

I could not have written this without the help of the many people who have shared their experience of the end of life in their personal and professional capacity. I am very grateful, and hope I have represented them fairly. I am also very grateful to members of the Somerset Public Health team who have helped with the analysis and editing of the report.

I would like to thank:

Dr Chris Absolon; Bob Champion; Julia Bearne; Jac Burns; Jacq Clarkson; Dr Charlie Davis; Brian Dean; Louise Finnis; Dr Ed Ford; Christina Gray; Jack Layton; Ann Lee; Dr Tom McConnell; Joy Milliken; Joanne Stonehouse; Pip Tucker; Chris Turner; Laura Wilson.

Endnotes

[i] http://www.endoflifecare-intelligence.org.uk/resources/publications/lp_and_place_of_death

[ii] https://discover.dc.nihr.ac.uk/portal/article/4000673/an-end-of-life-strategy-probably-improved-choice-of-where-to-die-for-people-with-severe-respiratory-disease

[iii] http://www.reform.uk/wp-content/uploads/2017/03/Brochure-Web.pdf

[iv] Care Quality Commission, A different ending, our review looking at end of life care (2016) (www.cqc.org.uk/news/stories/different-ending-our-review-looking-end-life-care-published

[v] https://www.mndassociation.org/wp-content/uploads/2015/07/eol09-advance-care-planning-and-advance-decisions.pdf

[vi] *www.medicalert.org.uk*

[vii] www.pos-pal.org

[viii] https://www.stgeorges.nhs.uk/wp-content/uploads/2017/01/Faith-at-end-of-life.pdf

[ix] Kübler-Ross, *On death and dying,* 1969.

[x] Life - And Death - On The Streets | HuffPost UK. Available at: http://www.huffingtonpost.co.uk/ann-lee1/life-and-death-on-the-str_b_13167898.html. (Accessed: 24th May 2017)

[xi] https://med.stanford.edu/letter.html

[xii] An 'opt-out' system was proposed by the Prime Minister in October 2017.

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Somerset Health and Wellbeing Board
23rd November 2017
Report for Information

Annual Health Protection Assurance Report

Lead Officer: Author: Alison Bell/ Jessica Bishop
Contact Details: AZBell@somerset.gov.uk jfbishop@somerset.gov.uk 01823 359663

Report Sign off	**Seen by:**	**Name**	**Date**
	Relevant Senior Manager / Lead Office (Director Level)	Trudi Grant	3/11/2017
	Cabinet Member / Portfolio Holder (if applicable)	Christine Lawrence (Cabinet Member)	6/11/2017
	Monitoring Officer (Somerset County Council)	Julian Gale	3/11/2017
Summary:	The Somerset Health Protection Assurance Report (Appendix A) documents the progress made during the last 12 months and the identified priorities for the next year. In summary, the Director of Public Health has a high degree of assurance that measures are in place to protect the health of the Somerset population. There are still a number of areas of concern, which are captured on the SCC JCAD risk register system. There are still some major system changes on the horizon that impacts on the overall resilience of the health and social care system and its ability to respond robustly to outbreaks and incidents.		
Recommendations:	**That the Health and Wellbeing Board notes the report and endorses the priorities proposed for 2017/18:** **1. Overall System Resilience** **2. Flu Immunisation** **3. Antimicrobial Resistance** **4. Air Quality** **5. TB**		
Reasons for Recommendations:	The priorities have been identified by Forum members, in collaboration with the Director of Public Health, as key issues that need to be addressed, if the DPH is to be assured that suitable arrangements are in place in Somerset to protect the health of the population.		

Links to Somerset Health and Wellbeing Strategy:	Links to priority 2 by improving the resilience of individuals and communities to infections and other threats to public health.
Financial, Legal and HR Implications:	This is a statutory role of the Director of Public Health acting on behalf of the Secretary of State for Health.
Equalities Implications:	There are no equalities implications arising directly from accepting this report. The identified priorities for the coming year will help to address health inequalities. In particular, achieving higher rates of immunisations for children looked after and other priority groups will improve health outcomes in these sub-populations. Air pollution impacts disproportionately on those who live in the worst affected areas, which in Somerset tend to be those inner urban areas with high levels of motor traffic, which will tend to contain housing disproportionately occupied by people from lower socio-economic groups.
Risk Assessment:	Failure to address the identified priorities could lead to the Director of Public Health being unable to fulfil her role of being assured about arrangements in place to protect public health in the county.

1. Background

1.1. The Director of Public Health (DPH) of Somerset County Council has a statutory duty to seek assurance that measures are in place to protect the health of the Somerset population. In order to make sure that the DPH is fully informed about the work of partners and can be so assured, the Somerset Health Protection Forum was created in March 2013.

2. Options considered and reasons for rejecting them

2.1. Considered and not relevant.

3. Consultations undertaken

3.1. This report has been consulted with the Health Protection Forum Members.

4. Financial, Legal, HR and Risk Implications

4.1. There are no equalities implications arising directly from accepting this report. The identified priorities for the coming year will help to address health inequalities. In particular, achieving higher rates of immunisations in children in care and other priority groups, will improve health outcomes in these sub-populations.

Air pollution impacts disproportionately on those who live in the worst affected areas, which in Somerset tend to be those inner urban areas with high levels of motor traffic, which will tend to contain housing disproportionately occupied by people from lower socio-economic groups. Addressing air pollution in Somerset towns is largely concerned with minimising the impacts of motor vehicles, with implications for land use and transport planning.

5. Background papers

5.1. Somerset Health Protection, Strategic Action Plan. 2017-18 (Appendix B)

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Somerset Health Protection Assurance Report 2016/17

November 2017

1. INTRODUCTION

The Director of Public Health (DPH) of Somerset County Council has an assurance role in relation to health protection within Somerset. Health Protection seeks to prevent or reduce harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation[1].

The Somerset Health Protection Forum comprises of a number of professional partners who hold health protection responsibilities and has a collective role to provide assurance on behalf of the DPH and the Health and Wellbeing Board.

The purpose of this report is to give an overview of the work that has taken place in Somerset during the past 12 months, key risks and issues, and priorities looking ahead into the next 12 months.

1.1 Health Protection Forum

The purpose of the Somerset Health Protection Forum is to provide assurance on behalf of the population of Somerset that there are safe and effective plans and systems in place to protect population health. This includes communicable disease control, infection prevention and control, emergency planning, environmental health, screening, immunisation, sexual health, air and water quality and safety.

It provides a mechanism for multi-agency working and professional discussion in relation to achieving effective and efficient management of health protection systems and processes across Somerset, including consideration of opportunities for joint action. It is important to note that the Forum does not duplicate operational arrangements for responding to incidents. Rather it provides an opportunity for strategic overview of health protection issues, including the identification of gaps that have arisen during the restructuring of health and public health services, gaps in capacity of the system to respond and challenge to partner organisations in the system.

Within the last report, it was reported that a low attendance at the Health Protection Forum meeting was being experienced due to competing priorities of members. Subsequently, a review of the Health Protection Forum took place early 2017 and members were consulted regarding the future of the group and how to meet the statutory requirements and make this a useful forum for partnership working. This review of the Forum was timely as it coincided with change of Consultant with the responsibility for Health Protection. The review concluded that the Forum should continue quarterly but an annual priority setting meeting with the Director of Public Health should take place where attendance is prioritised. Also, it was agreed that more items of interest would be included on the agenda to ensure that the Forum meetings are relevant to all members.

[1] PHE, *Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public health Functions and Entry to Premises by Local Healthwatch representatives) Regulations 2013*, 2013.

2. LOOKING BACK – 2016/7

2.1 STRATEGIC ACTION PLAN PROGRESS

To ensure that the Health Protection Forum has a focused agenda and forward plan, an annual Strategic Action Plan was developed.

The purpose of this document is to identify the health protection issues that are monitored by the Health Protection Forum and provide updates against the four priorities for 2016/17 as agreed by the Health and Wellbeing Board. These priorities were in addition to the core business of the Health Protection Forum.

Priority 1 **Overall System Resilience**
Priority 2 **Immunisation**
Priority 3 **Air Quality**
Priority 4 **Role of Public Health in responding and adapting to Climate Change**

Priority 1: Overall System Assurance

An area of concern of the Director of Public Health is the overall resilience of the health and social care system and the capacity of system to cope with additional pressures caused by severe weather, outbreaks etc. These concerns are compounded by organisational structural changes, budget cuts in many organisations, population growth and demographic change, particularly in the number of older residents.

During these times of great change, organisations need to be extra vigilant to identify areas of particular pressures and weaknesses within the system. In addition, the assurance role of the Director of Public health is especially critical to ensure that arrangements in Somerset are robust in protecting the health of the population. In the winter of 2016 Somerset had 38 outbreaks of influenza life illness (ILI) in care homes, this tested system resilience.

Key Learning: Recent events have highlighted a consensus that there needs to be more joined up, local planning amongst the health and social care organisations in Somerset and in particular, around multi- casualty planning.

It was agreed that a new planning group called the Somerset Health and Social Care Emergency Planning Group would be established and will have the purpose to ensure effective and robust response plans are in place across the health and care system in Somerset. Membership of this group includes Somerset CCG, Somerset County Council (Public Health, Adult Social Care and Civil Contingencies), Somerset Partnership, Vocare, Taunton and Somerset Acute Trust, and Yeovil Hospital Acute Trust. NHS England who are the lead for health emergency planning across the region are aware and supportive of this work

This group met in October 2017 to discuss mass casualty planning in Somerset and agreed that a framework will be developed that sits across all organisational mass casualty plans and identifies interdependencies.

Priority 2: Immunisation

There are a number of immunisation programmes that are offered to the residents of Somerset, see table 1. In general, uptake of these vaccinations are reaching the target or in line with the national average – see detail in section 2.3. However, it is important that we do not get complacent and continue to monitor progress of all programmes and identify areas that require particular attention. As part of the refreshed Health Protection Forum arrangements, it was agreed that the meetings will include several 'deep dive' assurance sessions on specified programmes.

Childhood	**Vaccine**
	Meningitis B
	Rotavirus
	Diphtheria, tetanus, pertussis, polio and Hib
	Pneumococcal (PCV)
	Hib/MenC booster
	Measles, Mumps and Rubella (MMR)
	Flu (annually aged 2-7)
	HPV
	Tetanus, diphtheria and polio adolescent booster
	MenACWY
Adult	Pneumococcal
	Flu (at risk and over 65s)
	Shingles
	Pertussis (during pregnancy)

Table 1: Current immunisation programmes:

Particular priority was given to the flu programme in 2016/17 and in preparation for the 2017/18 season, due to the complexity of the programme and the importance the programme has in reducing mortality and preventing additional pressures on the health system. The previous uptake data is detailed below in Table 2:

	Somerset (%)			DCIOS (%)			England (%)		
	14/15	15/16	16/17	14/15	15/16	16/17	14/15	15/16	16/17
Over 65s	70.6	70.5	70.5	70.6	69.6	69.1	72.7	71	70.5
At risk under 65s	47.4	42.9	48.5	46.8	43.5	45.5	50.3	45	48.5
Pregnant Women	38.2	42.5	43.9	39.6	41.0	42.3	44.1	42	44.9
Carers	36.9	36.9	46.5	42.7	37.7	39.2	-	-	-
Children (aged 2)	43.3	43.6	46.9	39.6	36.2	41.6	38.5	35.4	39.0
Children (aged 3)	43.8	43.8	46.8	41.2	39.6	42.1	41.3	37.7	41.6
Children (aged 4)	37.2	38.6	40.0	33.6	35.5	34.6	32.9	30.1	33.8
Children – Year 1	-	52.7	65.0	-	-	60.2	-	-	57.6
Children – Year 2	-	53.5	62.6	-	-	56.0	-	-	55.3
Children – Year 3	-	-	60.9	-	-	53.1	-	-	53.3

Table 2: Flu vaccination coverage of target groups

Flu vaccination of care home staff is a particular concern within Somerset, due to the number of influenza like illness (ILI) outbreaks in care homes last year. Within the health and care sectors, vaccinating frontline health and social care staff is vital in reducing the spread of flu to vulnerable service users. Care providers as employers are responsible for arranging immunisations for nursing and care staff as an infection control measure, but uptake is poor.

Ahead of the 2017/18 season, a SW regional Care Home Flu Group met to agree priority actions that can be taken to improve the uptake of the flu vaccination amongst care home staff. Rather than sourcing funding options for care homes, it was agreed that the priority should be on supporting the care homes management to understand why and how they can vaccinate staff. The following actions have been taken:

- Development of a 'Flu toolkit for care homes' which has been designed to give Care homes up-to-date guidance, information, and options for arranging staff flu vaccination https://www.england.nhs.uk/south/info-professional/public-health/infection-winter/care-guidance/
- Promotion of a flu calculator to understand the costs of the vaccine compared to sickness costs.
- Care Home survey to understand the current uptake amongst care homes and their views of vaccinating staff.

Key Learning: Rather than focusing on the funding issues related to vaccinating care home staff against flu, it was felt important to focus on changing attitudes to consider flu vaccination as a business best practice.

Since this piece of work, which occurred prior to the start of the 2017 flu season, NHS England has announced that they will be funding care home staff to receive the flu vaccine but details of how and when this will happen is not currently available (October 2017)

Priority 3: Air Quality

The Somerset Air Quality Steering Group was resurrected in summer 2015 to develop strategic level proposals for action to address traffic-related pollution. Four key priorities were identified in 2016 to develop further.

- To develop a communications strategy including website aiming to inform and influence partners, business and the public.
- Development Control, including cumulative impact.
- Transport, to include highways, local authority and 'grey' fleets, and fleets over which LAs have influence such as partners, taxis and buses.
- Air Pollution Monitoring, in particular oxides of nitrogen and PM2.5.

Capacity constraints in all local authorities have limited progress on these priorities, and on completion of the air quality strategy document. The strategy document, including recommended actions to address these priorities, will be presented to decision makers in the coming months.

To date some progress has been made:

- On starting a website to inform the public, businesses, drivers and developers, etc about what they can do to help improve air quality in Somerset in the choices they make. As an example, a link is provided to independent real world emissions testing results for new cars, which will enable prospective buyers to find out actual emissions, in addition to the lab test results provided by manufacturers. Advice is not limited to vehicles; advice on fuel for wood burning stoves is provided, for example.
- Public health has begun to comment on planning applications for major developments with a view to minimising the need to travel by car in urban areas.
- Environmental health officers have considered how best to monitor small particle pollution ($PM_{2.5}$) and will shortly recommend a portable device is purchased for use across the county to establish a picture of particulate pollution, as at present no such monitoring takes place.

Key Learning: Capacity within the Somerset local authorities is a significant issue when tackling air pollution. Working as a Somerset wide group has identified opportunities where efforts can be shared but benefits are still felt locally.

Nationally, the number of air quality management areas has increased over the last year, and government is again being challenged by pressure group Client Earth in the courts over failing to achieve air quality targets. The draft air quality plan to address nitrogen dioxide pollution advocates a range of measures to local authorities. Ministers had been urged to introduce charges for vehicles to enter a series of clean air zones (CAZs) in new cities, adding to existing plans for such measures in Birmingham, Derby, Leeds, Nottingham, Southampton, and London.

While clean air zones would not be appropriate in Somerset, any that were created in nearby cities such as Bristol and Bath would likely have an impact on Somerset residents and businesses, and thus their vehicle and transport choices.

Somerset had three air quality management areas (Yeovil, Henlade & East Reech) as part of the strategy development data from routine monitoring will be examined.

Priority 4: Role of Public Health in responding and adapting to Climate Change

During this year we have raised awareness of the need and possible actions to achieve reduction in carbon emissions to protect our population from the health implications of climate change. Incremental steps have been taken forward this year, for example, promoting active travel, reviewing the road safety strategy (which is based on the safer streets model) which includes actions around speed and promoting active travel, which will both reduce carbon emissions and identifying a PH Sustainability lead.

There is much to be done in this area and partners of the Health Protection Forum are committed to tackling this issue as individual professionals and organisations, within the limits of organisational capacity.

2.2 HEALTH EMERGENCY PLANNING

2.2.1 Communicable Disease Plans for Somerset

During 2017, there was a big push from the Local Health Resilience Partnership (LHRP) to develop a common plan template for local Communicable Disease Incident and Outbreak Operational Response Plans. It was felt that having a common plan across the LHRP geography would ensure robust and effective response arrangements by improving consistency and therefore reduce confusion and complexity for the organisations that straddle a number of different local authority boundaries e.g. police, fire, the Environment Agency, hospitals and laboratories. This template is due to be signed off by the end of 2017 and an exercise to test the plans is due to take place February 2018.

2.2.2 Health Protection Audit

In 2017, the Avon and Somerset LHRP undertook an audit for PHE on the health protection arrangements across this geography. Reoccurring issues were challenges around prescribing and treatment in care homes (in and out of hours) and prescribing for prophylactic treatment.

2.2.3 Learning from recent terrorist attacks within UK

The LHRP led a small task and finish group to assess all the learning for NHS providers from the Manchester bomb and London attacks. A final report will be presented at the LHRP Tactical Planning Group to launch the associated action plan. This learning will be shared with HPF partners in due course

2.2.4 Exercises

The Forum also has an overview of the various exercises that are scheduled across the organisations to identify appropriate representation and gaps in the exercise schedule and ensure shared learning and strengthened systems focused on Health Protection.

The exercises that have taken place in the past year include:

- Trauma Network Mass Casualty Exercise
- LHRP Health teleconference and cascade exercises

2.3 IMMUNISATIONS

2.3.1 Early childhood vaccinations

Generally Somerset childhood immunisation rates have improved. However, there is still room for improvement with not all programmes reaching 95%. See Table 3 below

The Hexavalent vaccine (6 in 1 offering additional protection against Hep B) commenced in September 2017and training had been made available to local vaccinators over the summer.

46.8% of pre-school children age 2 and 3 received a flu vaccination in 2016/17 compared to 40% national uptake rate.

Indicator	Lower threshold1	Standard2	Geography	2015/16	Q4 2016/17
3.03i - Population vaccination coverage - Hepatitis B (1 year old)			Somerset	100.0	
			England		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	90	95	Somerset	94.9	94.6
			England	93.6	93
3.03iv - Population vaccination coverage - MenC	90	95	Somerset	96.8	83.9
			England	0.0	84.7
3.03v - Population vaccination coverage - PCV	90	95	Somerset	95.3	95.2
			England	93.5	93.3
3.03i - Population vaccination coverage - Hepatitis B (2 years old)			Somerset	100.0	
			England		
3.03iii - Population vaccination coverage - Dtap / IPV / Hib	90	95	Somerset	96.4	97.1
			England	95.2	95.1
3.03vi - Population vaccination coverage - Hib / MenC boos	90	95	Somerset	94.1	95.1
			England	91.6	91.3
3.03vii - Population vaccination coverage - PCV booster	90	95	Somerset	94.1	95.3
			England	91.5	91.3
3.03viii - Population vaccination coverage - MMR for one d	90	95	Somerset	93.8	94.6
			England	91.9	91.2
3.03ix - Population vaccination coverage - MMR for one dos	90	95	Somerset	96.2	96.1
			England	94.8	95.1
3.03vi - Population vaccination coverage - Hib / Men C boos	90	95	Somerset	95.7	96.1
			England	92.6	92.8
3.03x - Population vaccination coverage - MMR for two dos	90	95	Somerset	90.8	90.2
			England	88.2	87.4

Table 3: Primary Childhood Vaccination Coverage Data

2.3.2 School aged immunisations

A significantly higher than national rate of children in years 1-3 in Somerset, received a flu vaccine at school in 2016/17. The programme is set to expand in September 2017 with children from reception to year 4 of primary school being offered the vaccine through schools including children in special educational settings. School nursing teams are delivering this programme throughout Somerset and this year Assistant Practitioners will be able to administer the nasal vaccine under the supervision of a qualified nurse.

Somerset achieved higher than national uptake rates for the MenACWY vaccination in students in year 13 and the highest coverage in the South West region. This is attributed to a collaborative approach between PHE and the LA to target communications to schools and colleges.

2.3.3 Immunisations in pregnancy

During 2016/17 43.9% of pregnant women received a flu vaccination, compared to the national average uptake of 44.9%. The vaccinations were administered by maternity and GP staff.

An enhanced programme is in place for 2017/18 with Musgrove Park Hospital, Yeovil District Hospital and Royal United Hospital in Bath offering the flu vaccine. Pertussis will also be offered to pregnant women presenting for routine antenatal care after 16 weeks.

Key Learning: Evidence has shown an increased uptake in pregnancy immunisations when offered during an antenatal appointment. A pilot study at Musgrove Park Hospital resulted in the flu vaccine uptake being doubled when offered during ante-natal clinics, scans and other appointments. All Maternity services supporting Somerset pregnant women are now offering the flu vaccine as part of routine maternity care.

2.3.4 Children Looked After

Progress has been made in the following areas against some of the recommendations in the Health Needs Assessment (HNA) exploring the lower vaccination rate in Children looked after.

- Foster carer training now includes information about vaccinations, including the role foster carers play in ensuring that children are up to date, and a leaflet advising foster carers why immunisations are important. This has been rolled out across Somerset.
- Efforts have also been made to understand why uptake is lower for CLA for vaccinations. In particular, the Rotavirus vaccine has to be received before 24 weeks and cannot be caught up at a later date as the other immunisations can. However, few children are taken into care before 24 weeks and so whether or not most children receive their rotavirus vaccine in time is up to their parents or carers and is outside the influence of the social care system in Somerset. Efforts have also been made to engage young CLA girls to discuss HPV uptake, with the aim of improving understanding of why rates are low but so far this has been declined by the young women themselves.

2.4 SCREENING

The UK National Screening Committee defines screening as “The process of identifying apparently healthy people who may be at increased risk of a disease or a condition so that they can be offered information, further tests and appropriate treatment to reduce their risk and/or complications arising from the disease or condition.”

Because the NHS invites apparently healthy people for screening and screening is based on the principle of do no harm. Healthcare professionals have to ensure individuals receive guidance to help them to make informed choices and support them through the screening process. Each NHS screening programme has a defined set of standards to ensure that services are of a high quality. The NHS and PHE are responsible for the quality assurance of population screening programmes. However, the local authority has a role to play in gaining assurance that the needs of their local population are being met, to identify where there may be issues and to ensure a reduction in inequalities in relation to screening uptake.

There are currently:
- three national cancer screening programmes (breast, bowel and cervical)
- eight non-cancer screening programmes:

- six antenatal and new-born (Foetal Anomaly, Infectious Diseases in Pregnancy, Sickle Cell and Thalassaemia, New-born and Infant Physical Examination, New-born Blood Spot and New-born Hearing)
- two adult (Abdominal Aortic Aneurysm and Diabetic Eye).

2.4.1 Cancer Screening

Breast and cervical cancer screening rates in Somerset remain above the England average, but are below the South West average at 77.4% and 74.7% respectively, compared to the target levels of 80%. Both reflect a declining trend in uptake since 2010. The bowel cancer screening rate stands at 62.2%, above the England and South West rates.

2.4.2 Antenatal Screening

Yeovil District Hospital and Taunton and Somerset Trusts perform well for most indicators within the antenatal screening programmes. The newborn bloodspot screening has improved from 2014/15 to 95.9% now taking it above the England and South West average.

2.4.3 Adult Screening

In relation to the adult screening programmes the Somerset Diabetic Eye (DESP) and the Abdominal Aortic Aneurysm (AAA) Screening programmes continue to perform well, with the latter being the highest rate in the SW at 87.1%.

2.4.4 Screening data

Screening data is available PHOF Health Improvement Indicators (indicators 2.20) and is summarised below in Table 4. More recent data is not complete and so to enable the DPH to fulfil her assurance role, this data quality needs to be worked on during the next year

Indicator	Lower threshold1	Standard2	Geography	2016
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Somerset	77.4
			England	75.5
2.20ii - Cancer screening coverage - cervical cancer (%)	75	80	Somerset	74.7
			England	72.7
2.20iii - Cancer screening coverage - bowel cancer (%)	55	60	Somerset	62.2
			England	57.9
2.20vii - Infectious Diseases in Pregnancy Screening – HIV Coverage (%)	≥ 95%	≥ 99%	Somerset	0.0
			England	99.1
2.20x - Sickle Cell and Thalassaemia Screening – Coverage (%)	≥ 95.0%	≥ 99.0%	Somerset	0.0
			England	99.1
2.20xi - Newborn Blood Spot Screening – Coverage (%)	≥ 95.0%	≥ 99.9%	Somerset	95.9
			England	95.6
2.20xii Newborn Hearing Screening – Coverage (%)	≥ 97%	≥ 99.5%	Somerset	99.7
			England	98.7
2.20xiii - Newborn and Infant Physical Examination Screening – Coverage (%)	≥ 95.0%	≥ 99.5%	Somerset	0.0
			England	94.9
2.20v – Diabetic eye screening - uptake (%)	≥ 70.0%	≥ 80.0%	Somerset	0.0
			England	83.0
2.20iv – Abdominal Aortic Aneurysm Screening – Coverage (%)	≥ 75%	≥ 85.0%	Somerset	87.1
			England	79.9

Table 4: Screening performance data

Key Learning: Nationally cervical screening coverage is declining and is at a 19 year low, with attendance going down across all age groups. Whilst the HPV vaccine protects against two of the main HPV viruses that can cause cervical cancer this accounts for only 70% of cervical cancers and so women still need to be screened. More needs to be done to raise awareness of cervical screening particularly among hard to reach groups. Many sexual health services, including Somerset, no longer provide cervical screening as part of the programme although NHS England are looking to commission this in some areas.

2.5 HEALTHCARE AQUIRED INFECTIONS

2.5.1 *Clostridium Difficile*

A *Clostridium difficile* infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics.

In 2016/17 there were a total of 97 cases and the overall *C. difficile* rate for Somerset CCG per 100,000 population was 17.79. This was the lowest rate for CCGs in the South West region

Providers are required to assess each trust attributed case to determine whether the case was linked with a lapse in the quality of care provided to the patient. Under the commissioning contract, lapses of care that contributed to a case will count towards the aggregate number of cases as the basis of which contractual sanctions are calculated

Quarterly multi-disciplinary peer review meetings are held to review providers post infection reviews and agree as to whether or not a lapse of care that could have contributed to case had occurred. The table below shows the figures for 2016/17

Health Care provider	Trajectory for 16/17	Year end figures 16/17	Lapse in care that could have contributed to the case
Somerset Clinical Commissioning Group (SCCG)	106	80	Not assessed
Somerset Partnership NHS Foundation Trust	5	0	0
Taunton and Somerset NHS Foundation Trust (T&SFT)	12	8	1
Yeovil District Hospital NHS Foundation Trust	8	9	3
TOTALS	**131**	**97**	**4**

Table 5: *C. difficile* cases **per organisation in 2016/17**

2.5.2 MRSA Blood Stream Infections

Staphylococcus aureus (S. aureus) is a bacterium that is present on the skin and is the most common cause of localised wound and skin infections. MRSA is a strain of Staphylococcus aureus resistant to many antibiotics

NHS England continues to set healthcare providers the challenge of demonstrating a zero tolerance target for MRSA blood stream infections for patients through a combination of good hygiene, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance.

In 2016/17, there were a total of 7 MRSA bloodstream infections, compared to 6 in the previous year. Following review and submission to NHS England , 5 of these cases were assigned to 'third party' (i.e. no failings of care were identified that contributed to the case). The remaining 2 case were attributed to SCCG (1) and T&SFT (1) and actions put in place to address learning identified.

The total MRSA rate for Somerset CCG per 100,000 population for 2016/17 was 1.28. This was a midrange rate (5th highest out of 12 CCGs) compared to other CCGs in the South west region.

2.5.2.1 Gram Negative Blood Stream infections (GNBSI's)

There is a national ambition to reduce Gram-negative blood stream infections by 50% by March 2021.

For 2017/18 a 10% reduction in all E coli BSIs reported is linked to the Quality Premium. Baseline data for Somerset (Jan – Dec 2016) is 489 cases, and to reach the 10% reduction target Somerset CCG should have no more than 440 cases in 2017/18. This is very challenging, particularly as two of our local acute hospital trusts have some of the highest rates of *E.coli* bloodstream infections in England. We would like assurance that our acute trusts will be complaint with the new mandatory reporting of Gram negative bloodstream infections (GNBSI) and will be addressing this through the HPF

The majority of *E. coli* bloodstream infections occur in the community, and a whole health economy approach is required to achieve the reductions required

A CCG led Somerset county wide reduction action plan and working group is in place, with representation from acute and community trusts, microbiologists, antimicrobial pharmacists and PHE. As urine is the source of 50% of all E coli BSIs, the group has agreed the following 3 key objectives for 2017/18

- Reduce the risk of and improve the management of UTIs
- Reduce prevalence of indwelling urinary catheters
- Improve urinary catheter care

Other key ambitions for 17/18 include maintaining a zero tolerance approach to MRSA BSIs and robust investigation of any case, and achieving the C diff trajectory of no more than 131 C diff cases across SCCG in 2017/18.

2.6 INFECTIOUS DISEASE

2.6.1 Infectious diseases in Somerset

The autumn of 2016 was characterised by an increase in gastrointestinal infections, the majority associated with norovirus outbreaks, although not to the same extent as in the previous year. Measles cases had declined in October after an outbreak in the South West over the summer of 2016 and from November, no further cases were confirmed.

Over the winter 38 outbreaks of flu were reported in Somerset Care Homes, this is higher number than in recent years. This was a national trend and despite the vaccine being a good match for circulating viruses and having a reasonable uptake of vaccine in the elderly, the vaccine provided poor protection. It was evident that there were very poor levels of vaccine uptake in care home staff; this has been addressed by the wider health community and recently a national initiative has been announced to enable care home staff to be immunised by the NHS.

In 2016/7 avian flu in migrating birds was also of particular concern and there were restrictions placed on domestic flocks for much of the quarter. There were three incidents of avian flu in birds in Somerset.

In the Spring, norovirus outbreaks increased again and we saw what is now a usual increase in cases of scarlet fever. Two clusters of cryptosporidiosis were investigated with 11 and 12 cases. Both were associated with visits to educational farms. Recommendations were made regarding handing of the animals, hand washing and cleaning.

Over the year there were 16 confirmed cases of meningococcal disease; ten were group W135, 4 Group B and one Group Y (one untyped). Of the cases with W135 only one was a young person under 25 years. Two pairs of meningococcal disease were investigated however they were not considered to be linked.

We have seen an increase in TB in recent years, although numbers remain very small. The three-year average number of TB case notifications in Somerset from 2014-2016 is 10 per year. The rate is 1.9 /100,000 (1.3-2.7 95% CI) compared with 5.1 (4.8-5.5) in the South West. In 2017 two complex cases have involved management by multi agency incident teams over a period of many months.

2.6.2 Hepatitis

During 2016/17 there was a national outbreak of Hepatitis A and a cluster outbreaks of Hepatitis B passed on through sexual activity, particularly but not exclusively amongst men who have sex with men (MSM).

Both outbreaks impacted areas in the South West region, including Somerset, and a number of actions were identified to control the outbreak. This included promoting vaccination in sexual health services targeting MSM through a successful social media campaign. However, there have been global shortages of vaccines for both Hepatitis A and B and consequently Public Health England have revised their immunisation recommendations to ensure access for high risk groups such as MSM and injecting drug users.

3 OVERALL SYSTEM ASSURANCE

In summary, the Director of Public Health has a high degree of assurance that measures are in place to protect the health of the Somerset population. There are still a number of areas of concern, which are captured on the SCC JCAD risk register system. This details actions to be taken and how individual situations are being managed.

4 THE AGREED PRIORITIES FOR 2017/18

As a result of the priority setting meeting held in September by the HPF with the Direct of Public Health, the following priorities were agreed

1. **System resilience**

System resilience remains the main area of concern of the Director of Public Health. There are still some major system changes on the horizon that impacts on the overall resilience of the health system and its ability to respond robustly to outbreaks and incidents.

In an attempt to ensure Somerset is able to respond robustly to outbreaks and incidents, particular focus will be given to the establishment of the Somerset Health and Social Care Emergency Planning Group. This group will have the purpose to ensure that response plans across Somerset are joined up and organisations work collaboratively to achieve resilience.

In addition, the Somerset Communicable Disease Incident and Outbreak Operational Response Plan will be finalised and tested in line with the PHE framework and plan template.

2. **Flu Immunisation**

Preparing for the 2018/19 flu season will continue to be a priority for the Health Protection Forum due to the significant impact a significant flu season can have on the entire health and social care system. The health and social care system is already under great pressure during a regular winter season so it is vital that all arrangements are in place to ensure that there is an improved uptake of the flu vaccine (especially amongst frontline health and social care workers) and organisations are prepared and resilient in the event of an outbreak.

3. **Air Quality**

A great amount of progress has been made in recent years with regards to air quality in Somerset. The Somerset Air Quality Steering Group has been meeting regularly to ensure the sign off of the Somerset-wide Air Quality Strategy and progressing with work streams in a joined up and collaborative manner. It is a priority that this momentum is continued to ensure that air pollution is tackled in a consistent and effective way across Somerset.

4. **TB**

TB has previously been a priority for the Health Protection Forum during 2014/15. This priority focused on the rollout of the Collaborative TB Strategy for England 2015-20 and establishing the TB Network for the Southwest. This TB Network continues to function with regular cohort meetings to discuss cases and outbreaks in detail, however, Somerset clinicians struggle to engage with these due to timing and location.

The TB strategy and action plan have progressed with a prioritisation exercise held at the network meeting in March 2017. Further work in Somerset is needed with commissioners to involve them in agreeing and implementing the action plan and ensuring there is equity of access to effective diagnosis, treatment, contact tracing and follow up of all patients, according to their needs.

5 CONCLUSION

In conclusion, the Health Protection Forum continues to develop and deliver against their statutory function, whilst also improving systems to protect Somerset residents health. We are seeking the Health & Well-Being Board's approval of the chosen priorities; system resilience, influenza, air quality and tuberculosis. And the commitment of their teams to furthering the impact we can have collectively on our populations health and improving outcomes

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Health and Wellbeing Board Work Programme – November 23 2017

Agenda item	Meeting Date	Details and Lead Officer
Health and Wellbeing Board Meeting (11am start)	**18th January 2018**	
Performance report		Amy Shepherd, Somerset County Council
Carers Strategy Update		Vicky Chipchase / Deborah Penny, Carers Voice
Pharmaceutical Needs Assessment		Pip Tucker, Public Health
Healthwatch Report		Healthwatch
Health and Care Integration and new models of care		
Motorneurone Disease Charter		Heather Twine, MNDA campaigner
Mental Health Champions		Louise Finis
Health and Wellbeing Board Meeting (11am start)	**1st March 2018**	
Positive Mental Health		
Integrated Personal Commissioning – update from CCG		Lydia Woodward, CCG
Discharge to Assess		
Annual Report on the progress of Autism Strategy		
Health and Wellbeing Board Meeting (11am start)	**1st March 2018**	
Health and Wellbeing Board Meeting (11am start)	**12 July 2018**	
Health and Wellbeing Board Meeting (11am start)	**27th September 2018**	
Health and Wellbeing Board Meeting (11am start)	**15th November 2018**	

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