Safeguarding Adults Extraordinary Board Meeting

24 July 2024, 09:30-12:30

Present:

- Michael Preston-Shoot (MPS) Independent Chair, SSAB
- Bethany Briers-Jones (BBJ) – Tenancy Sustainment Officer, ABRI Housing
- Carolyn Smith (CS) – Principal Social Worker, Strategic Lead for Safeguarding and DOLS
- Claire Gilbert (CG) – SWAN Advocacy
- Dameon Caddy (DC) – SAR Author, Item 5 only
- Gillian Keniston-Goble (GK) – Manager, Healthwatch Somerset
- Helen Orford (HO) - Managing Director, Discovery
- Hilary Robinson (HR) – CEO, RCPA Ltd
- Julia Mason (JM)- Designated Nurse for Safeguarding Adults, NHS Somerset Integrated Care Board
- Kate Spreadbury (KS) - SAR Author, Item 2 only
- Louise Mclellan (LMc) – Safeguarding Officer, Devon and Somerset Fire and Rescue
- Margaret Flynn (MF) - SAR Author, Item 3 only
- Natalie Green (NG) - SSAB Business Manager
- Niki Shaw (NS) – Acting Director - Strategy, Transformation & Performance, Adult Social Care, Somerset Council
- Philip Boyce (PB) - Safeguarding & Closed Cultures, Care Quality Commission
- Sarah Ashe (SA) – Associate Director of Quality and Nursing, NHS Somerset Integrated Care Board
- Simon Lewis (SL) - Head of Housing, Somerset Council
- Trudy Craig (TC) – Head of Quality and Governance, Somerset Care Ltd
- Vikki Holloway (VH)
- Wendy Dootson (WD) – Head of Safeguarding, Somerset NHS FT

Apologies:

- Bob Champion (BC) – Healthwatch Somerset
- Claire Evans (CE) – Senior Probation Officer, National Probation Service
- Deborah Bilton (DB) – South Western Ambulance Service NHS Foundation Trust (SWAST)
- Emily Fulbrook (EF) – Service Director, Adult Social Care Operational Services, Somerset Council
- Kathy Smith (KS) Housing Officer, Golden Lane Housing
- Lisa Simpson (LS) – Superintendent, Avon and Somerset Police
- Lucy Macready (LMa) - Public Health Specialist, Community Safety, Somerset Council
- Melanie Thompson (MT) - Corporate Safeguarding Lead, Livewest
- Rachel Handley (RH) - Consultant in Public Health, Somerset Council

- Sarah Wakefield (SW) - Lead Member for Adult Social Care, Somerset Council
- Shelagh Meldrum (SM)- Chief Nursing Officer, NHS Somerset Integrated Care Board
- Sue Lancaster (SL) - Advanced Customer Support Senior Leader, Avon, Somerset and Gloucestershire, Department for Work and Pensions

Circulation:

All SSAB Board Members

Retention of notes

The master set of these notes and background papers are held by SSAB Business Manager. Please destroy your copy when you have finished with it and use the master set for future reference.

Item		Action by
1	**Welcome, introductions and apologies:**	
	Members were welcomed to the meeting by MPS.	
2	**SAR Family W**	
	The SAR (Safeguarding Adult Review) for Family W was discussed extensively during the meeting. The SAR reviewed a family's situation, in which Helen died from a COVID-19 infection whilst being treated for injuries arising from an accident. Helen lived with her son, who controlled her life for some years before and there were also concerns how Helen's money was being used and how she was prevented from accessing regular medical care. Her son had a previous mental health diagnosis and appears to be living in his own home with minimal contact with organisations. **Involvement of Family**: Statutory guidance encourages involvement from family, wherever possible; the SSAB has decided to not invite the son to participate in this SAR, as involving him would have been very detrimental to his mental health. **Recommendations**: The following recommendations were **agreed**: • The SSAB is recommended to share the learning from this SAR with the Safer Somerset Partnership. • The SSAB is recommended to seek assurance that the Safer Somerset Partnership develops the guidance and development opportunities below:	**SSAB L&D** **SSAB L&D**

	○ Specific guidance on working with older people experiencing domestic abuse including additional risk assessment tools that work alongside the standard generic DASH assessment ○ A development programme which addresses child to parent abuse when children or grandchildren are adults. ○ Guidance that supports practitioners to effectively address the needs of older adults at risk who do not meet the threshold for MARAC.	
	• The SSAB is recommended to work in partnership with the Safer Somerset Partnership to ensure that the guidance and development opportunities are promoted and embedded within all health and social care organisations across Somerset.L&D	**SSAB L&D**
	• The SSAB is recommended to review MARM guidance in the light of learning from this review and consider whether best practice guidance in multi-agency or 'professionals' meetings is required.	**SSAB P&P**
	• The SSAB is recommended to re-launch the updated "Resolving professional differences" protocol with a view to encouraging confident and consistent use of escalation in a range of circumstances, for example organisations not contributing to multi-agency approaches or potential high impact risk remaining unmitigated, as described in this SAR.	**SSAB L&D**
	• The SSAB is recommended to include the necessity to address the assumption that if an ambulance called, a person is not always conveyed to hospital, in all learning materials and discussions related to this SAR.	**SSAB L&D**
	• The SSAB is recommended to ○ ask SC Adult Social Care for assurance that there will be full co-operation with future SARs. ○ develop a process to address non-compliance with s45 by any organisation or team.	**SSAB Exec**
	• The SSAB is invited to use this SAR to contribute to the DHSC as evidence of the need and framework around a Power of Entry in adult safeguarding in England.	**SSAB Chair**
	• Somerset Council is recommended to audit a range of s42 decisions to ensure that the statutory criteria of 'at risk of' abuse or neglect is considered in decision making and to consider the implications of audit findings for guidance revision or practice development.	**CS**

	• All partners are recommended to review their arrangements to support staff who feel intimidated or are threatened by the people they are serving. **Publication**: It was **agreed** that there should be an executive summary, which excludes the biographical information and just presents the circumstances the practitioners across the agencies had to confront and navigate.	**All** **KS/NG**
3	**SAR Bill and Jim**	
	The SAR for Bill and Jim was discussed, focusing on their experiences in supported living and the safeguarding concerns that arose. Bill and Jim were individuals with profound support needs who experienced significant challenges in their supported living arrangements. Their cases highlighted issues with care delivery, safeguarding, and respect for their human rights. **Safeguarding Concerns**: The review uncovered instances of inadequate care, lack of skilled staff, and neglectful practices that significantly impacted their well-being. **Human Rights and Care Management**: The review emphasized the importance of respecting and upholding the human rights of individuals with support needs and the need for effective care management to ensure their needs are met. **Advocacy Services:** The critical role of advocacy services in supporting individuals with complex needs was discussed, emphasizing the need for long-term advocacy and better understanding among professionals. This discussion underscored the importance of advocacy in safeguarding and decision-making processes. The types of advocacy were highlighted and the need to ensure that there was understanding of these across our organisations. **Recommendations**: The following recommendation were **agreed**: • that the SAB's commissioning of SARs is shaped by close attention to the Terms of Reference and the likelihood of information being available • that the (i) Care Act assessments of adults with multiple impairments be the starting point for the process of gathering and collating their history, including their history of contributing to decision-making; and (ii) the care plan reviewing process involves requesting information concerning significant health interventions,	**SSSAB SAR Subgroup** **CS** **CS**

	events and the decisions the individual can make and is supported to make. Further, Somerset County Council, as the commissioner of Supported Living services, should ensure the appropriate scrutiny of how a contract of individual support is being fulfilled, whether funded by social care or health	
	• that adults with lifelong support needs, including communication challenges, are the focus of fact-finding among Somerset providers concerning (i) their biographies and (ii) the decisions an individual can make and is supported to make.	**SSAB**
	• that this review's findings are shared with NHS Continuing Healthcare and the Integrated Care Board with a request that each should provide assurance to the SAB about (i) the governance of NHS Continuing Healthcare funding and the Foundation Trust's Continence Service, and (ii) the clinical merits of continuing to outsource training for Supported Living services, which do not employ clinically qualified staff, to unaccountable commercial companies.	**SA**
	• that the SAB should seek assurance from NHS Continuing Healthcare, the Integrated Care Board and the Foundation Trust that decisions concerning invasive clinical procedures – such as anal irrigation - concerning adults residing in Supported Living services are subject to frequent clinical monitoring and review	**SA/WD**
	• that local authority commissioning seeks to enhance supported and substituted decision-making as framed in the MCA 2005. It should address supported decision-making more explicitly in its commissioning – and monitoring frequency - of care services for people with extensive support needs.	**CS**
	• that Somerset's advocacy services demonstrate and prioritise – to their commissioners - how their real-life practice (i) advances people's participation in decision-making (ii) supports people to make decisions (iii) challenges restrictive and oppressive practices and (iv) identifies better ways to support them.	**CG**
	• that CQC reconsiders its inspection of Supported Living services as experienced by adults with lifelong support needs, including communication challenges. Its approach to anticipating and managing risks are likely to be enhanced by routine engagement with the families of people with extensive and life-long support needs.	**PB**
	Feedback: It was highlighted that there has been much change and there is now specialist knowledge and engagement within Adult Social Care, which has promoted awareness to support such individuals. From a commissioning and quality assurance perspective, there is now a dedicated care provider, quality assurance team here in Somerset, which provides the assurance within these settings. Within that team, there is a	

	lead for quality assurance of individual supported living and LD provision as well. The importance of people's biographies and their rich histories was emphasized, and the supported living provider informed the Board that they conduct quality reviews of people's support plans, looking at their history and information in terms of what people's rich history should be informing and telling us. Further awareness and understanding of supported living were further required by organisations; they don't employ medical staff, so it's important that there is focus on delegation of nursing tasks and where the responsibility for training and competency sits within that process. There was emphasis on the importance of family involvement in people's care and support and where that isn't possible, good advocacy. Advocacy highlighted that advocacy is not well understood within many professions and they work very hard to make sure that we get appropriate referrals. They provide training for organisations, in particular local authorities and social services. The CQC acknowledged that they needed to review how they inspected supported living services and highly supported the recommendation about the right of entry, which would aid their inspections. **Publication:** It was **agreed** that the SAR would be published in full, organisations would be given a window in which they can make any further observations about publication. Alongside the publication of the report, will be a response from the Board and its partners, which will offer any reflections on how agencies have already implemented the learning. Agencies are requested to submit both their observations on the full publication of the SAR and reflections on learning already implemented by 9 August 2024.	**All**
4	**SAR Peter**	
	The SAR for Peter was discussed, focusing on his experiences in a care home, his health challenges, and the safeguarding concerns that arose. **Background**: Peter had a history of alcohol misuse, leading to frontal lobe damage. He had multiple hospital admissions due to peripheral vascular disease, leading to his feet becoming gangrenous. Peter refused much of the care and treatment offered to him, leading to his death in January 2022.	

	Capacity and Legal Oversight: The Court of Protection was involved in decisions about Peter's residence and finances. Despite this, there were gaps in formal capacity assessments for specific medical treatments and care decisions. **Healthcare and Safeguarding**: There were challenges in hospital discharge processes, with some discharges occurring without adequate planning or meetings, despite Peter's complex needs and legal oversight. **Care Home and Support**: The care home provided ongoing support to Peter, despite his challenging behaviour and refusal of care. However, there were issues with the systematic raising of safeguarding concerns and the withdrawal of care towards the end of his life. **Recommendations**: The following recommendation were **agreed**:	
	• The ICB to produce guidance for primary care clinicians regarding situations warranting Court of Protection consideration, including clear pathways for seeking clinical & legal advice. This document should be submitted to the SSAB within 6 months of publication of this SAR.	**SA**
	• The Trust to carry out a review of their policy, process, and systems giving assurance as how active risk issues are communicated to and managed by discharge teams. A report detailing this should be submitted to the SSAB within 6 months of publication of this SAR.	**WD**
	• The Local Authority to arrange a qualitative peer review of self-neglect referrals whereby health related and/or financial mental capacity issues are a significant factor. This review to then be shared with the SSAB within 12 months of publication of this SAR.	**CS**
	• The Trust to arrange 2 separate workshops with the involved surgical and district nursing teams to discuss this SAR and application of the Mental Capacity Act. This to be undertaken with 9 Months of the publication of this SAR.	**WD**
	• The Care Home to provide anonymised evidence to the SSAB of using the MARM and/or resolving professional differences guidance. If opportunity does not arise naturally for the use of either, then the Local Authority should provide a hypothetical scenario to work through with the care home in order for the evidence to be produced. This to be undertaken within 18 months of the publication of this SAR.	**Care Home**
	• The SSAB should consider reviewing the MARM guidance to; a) incorporate recent imperatives from capacity-based case law judgements in a practitioner friendly manner and b) strengthen the link between it and the SSAB "Resolving Professional Differences" guidance. This action to be undertaken within 6 months of the publication of this SAR.	**SSAB P&P**

	There may be merit in considering whether a separate document on the intricacies of mental capacity might be more helpful than adding to the MARM guidance. The group felt that developing guidance for clinicians in primary care indicating a clear pathway when Court of Protection is indicated or suspected. **Publication:** It was **agreed** that: • The SAR report would be shared with Peter's sister for any comments or objections before publication. • The SSAB would seek input from the care home on the SAR report before finalizing it for publication. • Once the above actions had been completed, the SAR would be published in full.	**SSAB P&P/MCA SA** **NG** **NG** **NG**
5	**Annual Report**	
	The Board unanimously approved the annual report, indicating a collective commitment to transparency and accountability in safeguarding practices. This decision reflects the board's dedication to documenting and sharing its achievements and challenges. It was **agreed** to sign off the annual report so it can go through the governance process as outlined in the care and support statutory guidance. (Board Members)	**NG**
6	**Any Other Business**	
	Michael informed the Board that this was Niki's last Board as she is leaving Somerset Council. He acknowledged Niki's significant contributions to the Board and thanked her for her professional and unstinting efforts, which produced the detailed performance reports and quality assurance that were at the highest level.	
16:00 CLOSE		
Future Board Meeting dates 4 September 2024 09:30-12:30 via TEAMS		