Safeguarding Adults Board Meeting

11 March 2025, 09:30-12:30

Present:

- Michael Preston-Shoot (MPS) Independent Chair, SSAB
- Bethany Briers-Jones – Tenancy Sustainment Officer, ABRI Housing
- Carolyn Smith – Principal Social Worker, Strategic Lead for Safeguarding and DOLS
- Emily Fulbrook – Service Director, Adult Social Care Operational Services, Somerset Council
- Gillian Keniston-Goble – Manager, Healthwatch Somerset
- Jan Errington – Strategic Housing Manager, Somerset Council
- Joanne Burrows - representing Trudy Craig – Head of Quality and Governance, Somerset Care Ltd
- Karen Rees (Item 3) - SAR Hazel Author
- Katy Buckle – Service Manager, SWAN Advocacy
- Kirsty Larkins – Service Director Housing, Somerset Council
- Louise Smailes representing Julia Mason - Designated Nurse for Safeguarding Adults, NHS Somerset Integrated Care Board
- Natalie Green - SSAB Business Manager
- Rachel Donne-Davis - Health Psychologist, LeDeR, NHS Somerset Integrated Care Board
- Rachel Handley- Public Health, Somerset Council
- Shelagh Meldrum - Chief Nursing Officer, NHS Somerset Integrated Care Board
- Simon Lewis - Head of Housing, Somerset Council
- Suzy Braye (Item 2)
- Tracey Pugh – Safeguarding Officer, Devon and Somerset Fire and Rescue
- Vicky Chipchase - Head of Service, Adults, Policy, Performance and Assurance
- Wendy Dootson – Head of Safeguarding, Somerset NHS FT

Apologies:

- Ashley Fussell - Head of Somerset Probation Delivery Unit
- Gillian Keniston-Goble – Manager, Healthwatch Somerset
- Helen Orford - Managing Director, Discovery
- Hilary Robinson – CEO, RCPA Ltd
- Jane Spencer – Safeguarding Lead, Abri Housing Association
- Lisa Simpson – Superintendent, Avon and Somerset Police
- Lucy Macready – Head of Service, Community Safety, Somerset Council
- Philip Boyce - Safeguarding & Closed Cultures, Care Quality Commission
- Sarah Ashe – Associate Director of Quality and Nursing, NHS Somerset Integrated Care Board
- Sarah Hawker - Advanced Customer Support Senior Leader, Avon, Somerset and Gloucestershire, Department for Work and Pensions
- Sarah Wakefield - Lead Member for Adult Social Care, Somerset Council

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, apologies:**	
	Members were welcomed to the meeting by Michael and noted apologies.	**Michael Preston-Shoot**
2	**Self-Neglect Thematic Review**	
	Suzy Braye presented the Thematic Review on Self-Neglect, focusing on six cases where individuals died due to self-neglect. She highlighted the human stories and the importance of learning from these cases to improve service delivery, as well as several areas of good practice and identified significant learning points related to needs assessment, mental capacity, risk management, safeguarding and interagency working. The review includes 14 recommendations covering areas such as assessment tools, safeguarding pathways, advocacy, professional curiosity, mental capacity, housing shortages, interagency working, home visiting safety, training, and preparedness for external pressures. **Key Findings:** • Good practice was noted in areas such as health needs attention, risk management, family involvement, professional curiosity, and interagency communication. • Shortcomings included a focus on immediate health needs rather than holistic care, insufficient mental health attention, reactive responses, and delays in acting on information. • Issues with understanding individuals' histories, protected characteristics, and securing their views were identified. • Mental capacity assessments were often not conducted timely or thoroughly, and risk management strategies were sometimes insufficient. • Safeguarding referrals were often not made or pursued, and multidisciplinary discussions were lacking. **Recommendations:** The presentation outlined some of the recommendations: • Develop assessment tools and guidance for holistic care, monitor the impact of police welfare visit policies, improve safeguarding pathways, and increase advocacy awareness. • Boost professional curiosity and assertive outreach, record and account for equalities, and improve mental capacity awareness and practice. • Audit choking risks, review interagency working, ensure home visiting safety, and review self-neglect training content. • Consider specialist teams for complex self-neglect cases.  Thematic Review Self-Neglect.pptx	

	Decisions: It was **agreed** that: • The Board accepted the report and recommendations. • The report will be published in full after redacting personal information and reaching out to Mr. X's family. • Carolyn will liaise with Suzy to record a podcast to disseminate findings and best practices. • The Board will ask Suzy to review current practice in relation to self-neglect through the lens of three new referrals. This will help assess the current state of practice and identify any remaining challenges. • A virtual summit or conference on self-neglect would be organised after the further work is completed. This would help assess how well systems are working now and disseminate best practices.	**Natalie Green** **Carolyn Smith** **SSAB Chair** **L&D Subgroup**
3	**SAR Bill and Jim Update**	
	The SAR for Bill and Jim was initially received last summer, but additional information was later discovered that had not been included in the original review. This additional information was shared with the reviewer, Margaret Flynn, who revised the report accordingly. **Revised Report:** The revised report includes changes to the findings and minor amendments to the recommendations based on the new information. **Decisions:** • The board accepted the revised report and recommendations. • The report will be published, but with an additional account of actions taken by agencies since the initial review to reflect ongoing improvements. • Natalie will ask agencies for updates on actions taken in light of the revised recommendations. • Emily will update Mel Lock about the board's decision to accept and publish the report, and Michael will discuss the publication date with Mel in their next one-to-one meeting. • The report will be published along with updated actions from agencies, ensuring that the political considerations are addressed.	**Natalie Green** **Natalie Green** **Emily Fulbrook/ Michael P-S** **Natalie Green**
4	**SAR Hazel**	
	Karen Rees was commissioned to review the SAR for Hazel to continue its development, incorporating previous information and conducting a workshop with key leads. The review focused on Hazel's history, placement, medication management, safeguarding, and risk management. **Key Findings:** • Effective practices were noted in some areas, but significant learning points were identified, including the need for better inclusion of family in-care decisions, robust GP annual health checks and improved safeguarding and risk management. • Issues with legal literacy, managerial oversight, and the use of advocacy were highlighted.	

	Recommendations: Some of the highlighted recommendations included**:** • Assurance from overseeing bodies that CQC is involved in provider concerns, gathering information on the impact of CQC's new regulatory regime, and auditing cases of choking risks. • Competency-based training frameworks for managing dysphagia, ensuring agency staff are appropriately trained, and involving family in significant care changes. • General learning briefings to remind agencies of existing guidance and ensure comprehensive training for managing dysphagia. SAR HAZEL Presentation.pdf **Decisions:** • The Board accepted the report and recommendations. • The report will be published without amendment. • Karen will write to Hazel's family to inform them of the completion and offer to share the findings. • Rachel Donne-Davis will revisit the seven-minute briefing related to the LeDeR report and ensure it is still relevant before the SAR publication. • Natalie will coordinate the publication date and ensure all relevant materials are included.	**Natalie Green** **Karen Rees** **Rachel Donne-Davis** **Natalie Green**
7	**Notes of previous meeting and matters arising (December 2024) and action tracker**	
	The minutes of the meeting held on 10/12/2024 were reviewed and **agreed** as accurate, with no proposed redactions to the version for publication. Minutes of the December 2024 Board to be published on the website. **Matters Arising:** • **Department of Health and Social Care (DHSC) Response:** No update yet on national action regarding people in positions of trust. • **ADASS Update on PiPoT:** No update available. • **Mental Capacity Act Training (SFT):** Issue not yet resolved but escalated to the Chief Nurse and Chief Medical Officer. • **Complex Case Panel:** Discussions are ongoing about creating a complex case panel involving senior leaders for complex cases where no resolution has been realised. • **Fire and Rescue Service Data:** Ongoing discussions about extracting data from the system, particularly around self-neglect and hoarding cases. • **Police Data:** Efforts continue to obtain data from Avon and Somerset Constabulary. • **Homelessness:** Conversations with Mel Lock and the Ministry of Housing, Communities, and Local Government are ongoing to address homelessness issues.	**Natalie Green**

	Action Tracker: **Completed Actions:** Actions highlighted in green were agreed to be completed and will be closed. **Ongoing Actions:** All organisations are requested to action task assign to them and update the SSAB prior to the next meeting.	**Natalie Green** **All**
8	**Strategic Plan 2025-28**	
	The Strategic Plan has been refreshed following the Development Day. It includes key priorities and actions for the upcoming years. **Actions:** It was **agreed** that: • **Homelessness:** Details will be added once the thematic review is completed and conversations between Mel Lock and relevant stakeholders are concluded. • **Domestic Abuse:** Emphasis on domestic abuse of older people, incorporating findings from recent SARs needed to be emphasized. **Subgroup Actions:** The actions from the strategic plan will be referred to the relevant subgroups for implementation.	**SSAB Exec** **SSAB Chair**
9	**Performance and Assurance Report**	
	Current Safeguarding Data for 2024/25: The Local Authority is conducting and concluding more safeguarding enquiries in 2024/25, averaging 62 per month from April to December 2024, compared to 55 per month in 2023/24. Safeguarding concerns received have increased, averaging 161 per month compared to 140 in 2023/24. The average time to complete a safeguarding enquiry has improved to 62.1 working days from 70.9 days in 2023/24. The team is focused on reducing the number of people waiting for a S42 allocation, with numbers dropping and subject to daily prioritization. **Safeguarding Adults Collection Data**: Somerset's Safeguarding Service received 1449 Safeguarding Concerns and conducted 553 enquiries involving 527 individuals. Despite fewer concerns recorded than regional and national averages, Somerset has a higher proportion of concerns that become enquiries. The approach to triaging contacts is effective, with most contacts managed by colleagues at the contact centre not classified as concerns. **Abuse Types and Locations**: 55% of enquiries were for females, and 65% of at-risk individuals were aged 65 or over. 98% of safeguarding enquiries were for white people. 'Neglect and Acts of Omission' is the most common abuse type, followed by financial or material abuse and physical abuse. 60.2% of enquiries involved the individual's home, with 79% involving someone known to the individual other than a service provider. **Risk Assessment Outcomes**: Current in-year performance is lower than the 2023/24 annual submission. In 2024/25, 76% of risks were identified and action taken, compared to 86% in 2023/24. The number of cases where the risk	

	remained unaddressed increased from 15 in 2023/24 to 66 in 2024/25. Desired outcomes were achieved in 92.2% of cases, compared to 95% in 2023/24. An annual data validation exercise explains the discrepancy between in-year performance and annual submission results. **Hate Crime in Somerset:** The SARI (Stand Against Racism and Inequality) Annual Report was produced in December 2024 with Somerset the second highest reporting authority after Bristol, with 75 referrals. Breakdown of referrals includes various types of hate crimes and incidents. One of the challenges identified is reaching people in rural areas who may not have heard of the service but need support. **Deprivation of Liberty Safeguards:** There has been an increase in applications, driven predominantly by applications from hospitals, the number of authorisations has also increased. The end-of-year waiting list figure has increased, as has the number of applications waiting more than six months. The system is not working as well as it should be, with large numbers of requests for assessments that cannot be addressed. Somerset's position is comparable with other authorities regionally and nationally. Somerset Council uses the ADASS prioritisation tool to manage the backlog and ensure compliance as much as possible. **Practice Quality Framework:** The new practice quality framework came into effect in September 2024. The January audit focused on risk and a report was presented to the February Practice Quality Board. **Complaints:** There have been 8 complaints received this year, exceeding the annual figures of the last two financial years, with two of these complaints upheld. The Ombudsman National benchmarking information shows an increase in complaints, with six complaints and three upheld. **Recommendations:** It was **agreed**: • SSAB P&Q Board to finalise the forward plan of Assurance Reports for 2025 in conjunction with the revised Terms of Reference. • SSAB P&Q Board to consider supplementary information and data for the next Performance Report to demonstrate a partnership approach. • SSAB Chair to seek a formal update on timescales for completion and submission of the requested performance report from Avon and Somerset Constabulary. SSAB Performance report slides.pptx SSAB Quarterly Performance and Assu	**Perf&QA** **Perf&QA** **SSAB Chair**
11	**Any Other Business**	
	Future Meeting on Self-Neglect and MAPPA: Further to the discussion about having a summit or conference on self-neglect, Jan suggested discussing the intersection of high-risk individuals subject to MAPPA and safeguarding concerns in a future meeting. It was **agreed** that this would be an item for the SSAB Board in the June.	**Natalie**

	Extraordinary Meeting: An extraordinary meeting is scheduled for the 7th of May at 9:30 AM to sign off additional safeguarding adult reviews, including the thematic review on homelessness. **Chair Continuation:** Michael confirmed that he is willing to continue as the chair beyond January 2026 if it is the wish of the partners.	**Natalie** **All**
CLOSE		
Future Board Meeting date: 07/05/2025 09:30-12:30 via TEAMS Extraordinary Meeting 05/06/2025 0930-1230 via TEAMS 26/09/2025 0930-1230 via TEAMS 17/12/2025 1330-1630 via TEAMS 10/03/2026 0930-1230 via TEAMS		