Somerset Safeguarding Adults Board
MINUTES – FINAL

8 October 2019 (09:30-12:30)

Bridgwater Room, Bridgwater Police Centre

Present:

- Richard Crompton (RC) – Independent Chair, Somerset Safeguarding Adults Board (SSAB)
- Charlotte Brown (CB) - Designated Nurse for Safeguarding Adults, NHS Somerset Clinical Commissioning Group
- Julia Burrows (JB) - Associate Director of Safeguarding, Somerset Partnership NHS Foundation Trust and Taunton & Somerset NHS Foundation Trust
- Victoria Caple (VC), Lighthouse Safeguarding Unit Partnership Manager, Avon and Somerset Constabulary
- Orla Dunn (OD), Consultant in Public Health, Somerset County Council
- Sue Follett (SF) – Business Support, SCC (note taker)
- Kathy Gilmore (KG) - Executive Director Housing Support, LiveWest
- Cllr David Huxtable (DH) – Cabinet Member for Adult Social Care, Somerset County Council
- Lucy Macready (LM) – Safer Communities Manager, Somerset County Council
- Stephen Miles (SM) – SSAB Business Manager, Somerset County Council
- Stephen Ogilvy (SO), Lead Independent Mental Capacity Advocate – SWAN Advocacy
- Richard Painter (RP) – Director of Safeguarding, Somerset Partnership and Taunton & Somerset NHS Foundation Trusts
- Dave Partlow (DP) – Strategic Manager, Mental Health and Safeguarding representing Mel Lock
- Richard Pitman (RPi) – Compass Disability Services (representing people who use services and the voluntary sector)
- Debbie Rigby (DR) – Deputy Director of Quality, Patient Safety and Governance, NHS Somerset Clinical Commissioning Group
- Glen Salisbury (GS) – Head of Safeguarding Yeovil Hospital NHS Foundation Trust (representing Bernice Cooke)
- Luke Joy-Smith (LJS) – Managing Director, Discovery
- Chief Inspector Lisa Simpson (LS) – Avon and Somerset Constabulary (representing Mike Prior)
- Anna Temblett (AT) - Somerset Area Manager, Swan Advocacy

Also in attendance:

- Alex Raikes MBE (AR) – Director, SARI (Stand Against Racism & Inequality) (items 1-3)

Apologies:

- Mel Lock (ML) – Adults & Health Operations Director, Somerset County Council
- Bernice Cooke (BC) - Head of Clinical Governance and Assurance, Yeovil District Hospital NHS Foundation Trust
- Claire Evans (CE) – Senior Probation Officer, National Probation Service
- Nicola Kelly (NK) - Head of Quality and Clinical Governance – Somerset Care
- Tracy Aarons (TA) – Deputy Chief Executive, Mendip District Council
- Simon Blackburn (SB) – Chief Executive Officer, Registered Care Providers Association
- Deborah Bilton (DB), Named Safeguarding Professional for Adults, South Western Ambulance Service NHS Foundation Trust (SWASFT)
- Lucy Martin (LMa)- Partnership Manager for Bristol and North Somerset, Department for Work and Pensions
- Sally Newell (SN) - Inspection Manager, Somerset, West Dorset and East Devon Team, Care Quality Commission (CQC)
- Janet Quinn (JQ) - Trading Standards Officer, Devon, Somerset and Torbay Trading Standards
- Amanda Robinson (AR) – Safeguarding Business Manager, South Western Ambulance Service NHS Foundation Trust (SWASFT)
- Kathy Smith (KS) - Housing Officer - Golden Lane Housing
- Liz Spencer (LS) - Head of the National Probation Service - LDU Somerset Cluster NPS South West South Central Division Her Majesty's Prison and Probation Service
- Healthwatch Somerset (new representative yet begin in post)
- Alison Wootton (AW) – Deputy Director of Patient Care, Taunton & Somerset NHS Foundation Trust

Circulation:

All Board Members, plus:

- Sandra Corry - Director of Quality, Safety and Governance, CCG

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:**	
	RC welcomed members to the meeting, introductions were made and apologies noted above.	
2	**Safeguarding Personal Case Study**	
	Unfortunately, when [Redacted] went to pick[Redacted] up today [Redacted] was ill and therefore unable to attend the meeting. **Action**: SM to arrange for [Redacted] and [Redacted] to come to the February 2020	**SM**

Item		Action by
	meeting.	
3	**Notes of previous SSAB Meeting held on 11 June 2019:**	
	The minutes of the meeting held on 11 June 2019 were agreed as accurate. Update on actions: P5: SM sent notes of the March 2019 meeting to [Redacted] who spoke to the Board about [Redacted] experience. P5: Making Safeguarding Personal Case Study on sexual safety in MH wards from Somerset Partnership NHS Foundation Trust: JB confirmed that this was passed to RP to circulate a copy of the case study in writing. P5: Establish link with Andy Lloyd re: DWP involvement: No update received from LMa as yet. P6: Sexual Safety on Mental Health Wards: The photo was changed to now include both males and females. It was explained that a reference to Somerset & Avon Rape & Sexual Abuse Support (SARSAS) was not added as suggested because the leaflet needed to be concise, and it was felt The Bridge was the more appropriate service to deal with self-referrals for people that want to report an incident of sexual harassment or assault in these circumstances (as well as other services included on the leaflet). P6: MH Crisis Concordat update: AK was unable to attend this meeting but **provided SM with a report after papers had been circulated that will be included with today's minutes and invite AK to attend the next meeting to give a verbal update.** P7: SWASFT engagement with the SSAB: RC confirmed this subject will be discussed at the next Regional Chairs Meeting. P8: Self-Audit Sub-Regional Tool: this has been updated by the QA Subgroup, shared and organisations are currently working to complete it. It has also been published on the SSAB Website. P9: 2018/2019 Annual Report: The Report has now been published on the SSAB Website. P13: Nominations for the Task and Finish Group re Intelligent Safeguarding: one further nomination received bringing the total to 3, but RC highlighted that if the Board wishes to take this forward there needs to be greater engagement. **Action**: Any further nominations to be sent to SM. P14: DToC: DR was actioned to consider how to issue DToC information to the Executive Group regularly. DR updated that she and CB have discussed this, the matter is still ongoing as it is complex. This was about how, as a Health organisation, they ensure and consider safeguarding arrangements on an individual's discharge from an acute setting; this tends to be considered on admittance but there are many factors to consider, e.g. concerns within the home, how to	**SM** **ALL**

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	record, how act on this, etc. Need to know what the Discharge Liaison Teams within acute hospitals are thinking about this. DH said people are being assessed when at home, rather than in the hospital setting, where they befit from being in a familiar environment. CB referred to a recent learning review for a person involved in a SAR, where in this case the hospital setting was a good opportunity to have an assessment away from any potential coercion, or other form of abuse, in the home setting. It is an opportunity whilst in a planned emergency, safe environment to have an oversight and to ensure nothing is missed. DR said this is not about stopping an individual going home, it is more about finding out whether a person is being abused or neglected, to then if necessary, safeguard them. DH agrees in terms of safeguarding, but the aim is to avoid discharges being unnecessarily delayed. DR said this is not about delaying, but about identify concerns that have arisen. RC added that we do need assurance, particularly in an environment where there is rapid discharge from hospital, that nothing is missed, the Board would like clarity of this. **RP will link with the Discharge Liaison Team, will consider all and take appropriate action.**	**RP**
4	**Hate Crime in Somerset – Alex Raikes MBE, Stand Against Racism & Inequality:**	
	Alex Raikes (AR), MBE, from Stand Against Racism & Inequality (SARI) gave a presentation about incidents of hate crime in Somerset. Hate crime is a significant issue and AR is looking to position this firmly with the various organisations here today. AR began by introducing SARI, following which a short video about racism was played to the meeting, discussion ensued with the following comments being noted: • SARI was established 1988. In 2012 its remit was widened to be there for victims of all hate crime. • AR would like people to be as proactive in their day to day jobs as possible; whilst working with vulnerable communities, discrimination and prejudice can feature greatly. • Contact work with specialist partners has been built; whilst working with other strands as the remit has widened, there are huge amounts of different needs, and specialist partners know their services well. • Case work involves delivering services to victims and supporting victims. A support plan is agreed, and key areas are explored / worked through, e.g. housing, health and wellbeing. • In Somerset SARI is there to offer support for hate crime, and also offer free training sessions for agencies. • Partners with the diversity trust to provide support with advice and delivering empowerment work.	

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	• SARI is trying to be as representative as possible, in ages, languages, in order to have lots of different perspectives in how to tackle types of injustice. • Definition of hate crime: criminal offence perceived to be towards a person's ethnicity, sexual orientation, gender reassignment, religion, disability; it is down to the individual whether they perceive it to be person-centred hate crime. • Mate crime is a major type of hate crime, that particularly affects vulnerable people. • A point in relation to mate crime is that it can be seen as a potential precursor to another offence, e.g. where low level things might not get recognised and then escalate. • The Equality Act 2010 lists nine protected characteristics. • 'Groupthink' is where a team could be unconsciously forming a group opinion of a person; this should be avoided, and the person must be seen as an individual. • Hate crime takes many different forms, genocide, violence, discrimination, acts of prejudice, prejudiced attitudes. Need to stop before reaching the next stage, e.g. stop use of dehumanising terms in schools rather than leave it, to prevent active attacks on a person. • The crime survey is reported every year to give statistics, and every three years there is a countrywide survey, hate crime was on a fast increase, and although still increasing has tapered off a little. • Avon and Somerset is one of the best areas of recognising and recording hate crime. • SARI usually open around 500 cases per year. • Race crime is relatively high in Somerset. • Hate crime can take the form of other types of crime that are perpetrated against individuals because of their race, sexuality, disability etc - other types of incident to look out for and consider if they are connected includes vandalism of cars, malicious complaints, criminal damage, etc • A rise in anti-Semitism has been seen. Individuals are less likely to be targeted if they are Christian, Buddhist, but more likely if Hindu, Sikh. • Mental Health is another area that is targeted, and people can also develop mental health issues as a result of what has happened to them; most issues occur around the home, or schools. • Travelling on buses can be a vulnerable time for children and adults with a learning disability. • Learning has occurred from nationally high-profile cases. Cases have occurred since in Bristol, but there has been improvement in stopping hate crime earlier on. Learning in agencies has been significant, but	

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	just one case is too many. Many cases are underpinned by vulnerability as well as hate. • DR explained a recent case; this was about being anti-Christian, where the individual's thoughts were very disordered, rather than being a long-standing view. • Following terror attacks a reaction is often seen. • Racist language has increased, particularly since the Brexit referendum result. • RC referred to numbers regarding on-line crime; AR confirmed that more and more cases are coming to light, many people do not report on-line abuse to SARI other than if it is part of a wider case. There is an increasing percentage of on-line crime not being reported. It is recognised that a lot of people experience abuse in their lives, but manage it, rather than report it. • In terms of mate crime DR mentioned that we see very vulnerable people, who get easily befriended, e.g. cuckooing, there is probably an enormous number of vulnerable people who have difficulty making friends and therefore sometimes make the wrong friends. AR emphasised that SARI want these cases reported. • Training, and good ways of tackling what exploitation looks like, is available. • RC spoke about a SAR where the individual ultimately took their own life, he was befriended by people who abused him. RC emphasised that all organisations need to make sure case review processes are available to look at and address hate crime. • Sometimes individuals hold the inappropriate friendships in high regard, so we have to keep them in view, increase insight and build evidence to keep the person safe. • RC pointed out that within the business of this Board there are a number of aspects of hate crime that sit within its remit, but that it was primarily a responsibility of the Community Safety Partnership. • AR is part of a Somerset Group which will promote work around hate crime awareness week, including mate crime awareness. • Clarity is needed in terms of what this Board can do to make a difference. AR suggested that all organisations should be ensuring that their staff are able to recognise and respond to hate crime. • RP asked if work was being done regarding inter-sexuality. AR gave an example of a Muslim LGBT Group and as groups are beginning to form, links are being built regarding inter-sexuality. If an individual is LGBT and Muslim it is difficult to speak out. • VC referred to the report circulated with the agenda, indicating that the response from Lighthouse and Police Safeguarding Unit is now much	

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	better; based on last year's figures, the numbers are rising. Over all referrals have gone down. AT noted that SWAN has not getting referrals for an advocate in many cases, only some for mate crimes attached to other referrals, but SARI is now working closely with them. • RC concluded that this has been a very helpful and informative discussion; SSAB will maintain and strengthen this link. The website and social media can be used as a form of communication. Also consider how this area is factored into the Annual Audit. • AR offered to attend this Board on an annual basis. **Action**: SM to arrange for AR to come to a meeting in the autumn of 2020. • NB: SARI has an Out of Hours phone only service.	**SM**
	Break	
5	**Discussion: Use of restraint**	
	Charlotte Brown (CB) introduced this item for discussion on the use of restraint following learning from a recently attended Safeguarding Adults National Network event run by NHS England. It involved a case example (not from Somerset) that CB introduced. The following comments were noted: • CB has recently received **the patient's story in written form and will share with Board members**. Some elements were shared with the Board today, and following this, organisations need to assure the Board that such situations do not occur within their services. • Although being diagnosed with Aspergers and Autism around the age of 6 years, this gentleman was engaging, intelligent, artistic, with excellent use of language, resulting in many not recognising that he had a diagnosis. He attended mainstream school, studied for GCSEs, and wanted to be an Illustrator. • Due to experiences in his late teens, he accessed help through the CAMHS. Also due to not receiving help in the early stages, parents felt as a child he was one meltdown away from admission to Inpatient Psychiatric Units. • On one admission, being on the ward made him ill; he was learning how to become a better criminal, how to be a dangerous inpatient. Due to learning some particular behaviours, he was locked in seclusion, restraint was used. Prior to admittance he had never taken medication, now he takes a cocktail of drugs, including Vitamin D supplements due to a lack of sunlight. The medication caused him to shake, thus being unable to draw which he loved. Whilst in seclusion he was stripped naked, left with bare feet, he was put in a small room with minimal daylight, so he was unable to tell whether it was day or night. The room was totally bare, and he was kept in it for up to 9 days at a time, being observed 24 hours a day even when using the bathroom. He was unable to see his family. Whilst being bare footed, standing in urine,	**CB**

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	his toe became infected. It was considered too dangerous for staff to enter his room. He was left for hours with painful thoughts running through his head. It is hard to view this as anything less than punishment, his mother talks about the culture of violence he was trapped within; he felt and acted like a caged animal. • It is suggested that, had issues such as those arising from Winterbourne View, been addressed appropriately, this gentleman might not have experienced such distress. • CB concluded that this is a very powerful story, and that hearing the whole story first hand was very upsetting. • While sometimes people need restraint and seclusion, as part of their therapy and for safety for themselves and others, providers need to consider how they are assured that people are being treated appropriately. • Commissioners need to demonstrate assurance that people placed out of area do not have these experiences. Sometimes on paper things look ok, but how do we really look at experiences and ensure this does not happen? • RC added that from the commissioning perspective it would be good to explore this in more detail. A bit that stood out was the comment from the mother that families are the main resource, this resonates with experiences of others, where families' voices have not been heard / listened too and consequently resulting in significant safeguarding incidents. We need to have assurance that there are appropriate mechanisms in place in Somerset, where difficult messages and people who can be challenging can be listened to. • DR commented that while restraint is monitored, are we asking the right questions in terms of repeated restraint of individuals? It is worrying that what is documented and what could be measured may not be the reality; often challenges of the family which as well as being positive, can sometimes be negative. Advocacy support is not always available in acute settings, so who is hearing this person's voice? • AT reassured that Advocates go into in-patient settings locally on a weekly basis, they visit people on seclusion. After a person has been in seclusion for 24 hours, there is a trigger that a visit is needed, to ensure they have their rights upheld whilst in seclusion; Advocates are keen to follow this up. • DH pointed out that once the sort of situation described is reached, it is extremely difficult to get the individual out of an Institution; and he was concerned about preventing them going in to an institution in the first place, e.g. to put resource into 'carers' to have more help to prevent a situation escalating. If available a local secure place would easily be filled, but we must try not to do this, as we know it leads to poor	

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	outcomes. • When someone is placed in a Mental Health hospital the host Clinical Commissioning Group is responsible for co-ordinating, and ensuring that everyone has 6-8 weekly visits; the question is would there be better outcomes, in visiting more? • RC suggested that SSAB explore statutory responsibilities; how intelligence is gathered, how visits are structured, how evidence is gained, how things are written up; and how assurance is gained and monitored. • RC confirmed that the local system had moved much further forward in terms of learning from the Mendip House SAR, but the national response has been poor. • CB confirmed that a lot of work has been completed locally following on from Mendip House, but we cannot get comfortable that we will never see a similar situation again, particularly where people are being placed in to services in Somerset that we don't commission with locally by external commissioners. • It was agreed that Clinical Commissioning Group and Local Authority commissioners should be invited to come to speak to the board about monitoring arrangements in 2020. **Action**: SM to arrange for June 2020 Board.	**SM**
6	**Discussion: Self-neglect and fire – learning from the Greater Manchester Fire and Rescue Service:**	
	This item was introduced by Charlotte Brown (CB) for discussion following a recent Conference where there was an interesting presentation from staff a Salford Fire Station on work undertaken about self-neglect and fire with people with care and support needs. The following comments were noted: • It was identified that, as a result of discarding a cigarette, a number of people who were non-mobile had died in a fire. • Whilst looking at a serious case review it was apparent that the people had things in common, e.g. all were living in some sort of supported living, were non-mobile, and smoked. A review of data found that there were 245 people in Salford that met the same criteria, everyone was written to, to flag the risks when disposing of cigarettes. A joint visit to all these people between social care and fire service took place. Also, more practical steps were taken, including the issue of fire-retardant bedding, fitting of sprinklers in some places. Work was done with care agencies and supported housing providers around disposing of cigarettes in a safe way when not mobile, to reduce risks. Some people gave up smoking. By working through the number of people, this has reduced the risk of serious harm. Safe and well visits jointly with Local Authority were also undertaken. • DR said this was also a known risk to Somerset, citing a case where	

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	someone died whilst attempting to smoke while attached to oxygen, as well as others using emollients for skin conditions which can heighten the risk. There are many incidences where there is an attempt to manage this, but the individual has to want to work with professionals to reduce the risks and this can sometimes be a big challenge. CB noted that in the Salford example, it was felt that by visiting jointly with Fire Service other professionals found that they were able to get people to engage better. • RC mentioned that he rarely sees representation from the Fire Service around this table; it is confirmed that a new representative has been nominated following the previous one standing down some time ago, but has yet to attend the Board. • LM added that the Devon Fire Service is making lots of changes, however, the outcome of consultation and what the configuration will look like is not yet known. It would be useful to obtain assurances from them on such issues. • DH is of the opinion that the Fire Service could attend this meeting. There has been a drop in fires / call outs, Somerset appears to be good at preventing fires, however there is a need to find out how many people fit the types of criteria referred to. RC added that clearly there is an opportunity to do something about this, **SM to ask the representative from the Devon & Somerset Fire and Rescue Service to attend the next meeting to discuss the services role and opportunity for joint working**. • CB was thanked for this very interesting item.	**SM**
7	**Practice Briefing: 'Keith' and draft 'What to do it it's not Safeguarding' guidance:**	
	Two documents were circulated ahead of today's meeting for this item, a Practice Briefing Note and Practice Guidance for everyone to explore and consider. • SM explained that the Briefing Note has been anonymised as the individual declined to be part of the process. This case did not meet the statutory criteria for a Safeguarding Adult Review (SAR), but following a substantial amount of work to establish this, it was agreed that learning had been identified which should be shared; hence the Practice Briefing and guidance. • A few days after the death of his partner, 'Keith' attempted to take his life; the attempt had a life changing impact on 'Keith'. Prior to this attempt 'Keith' was not eligible for social care services and did not have care and support needs at the time of referrals being made. • 'Keith' had a history of high-intensity contact with his GP surgery, often making multiple contacts per day. • Unsubstantiated allegations of domestic violence were made by Keith	

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	about his partner prior to their death, but it is unclear who was abusing who due to inconsistencies in the information 'Keith' gave to different professionals. • The main lessons learned is that several organisations had concerns, however no opportunity was taken to hold a multi-disciplinary discussion, which might potentially have made steps to prevent the attempt to take his life. There is a need to put a process in place for professionals to use to convene a multi-disciplinary discussion where one or more organisations have concerns but a statutory safeguarding intervention would not be appropriate. • Subsequent to the attempt on his life 'Keith' was in hospital for an extended period; the work done around his hospital discharge was good. Issues were raised regarding potential financial and material abuse from a family member. Learning identified good engagement from the GP surgery. • SM has also shared the draft briefing with the Suicide Prevention Group who suggested a recommendation for professions to talk to people who are considered at risk of suicide about putting together a safety plan to help them keep safe at times when feeling vulnerable. • The outcome for 'Keith' was life changing, however he is very settled now with little contact with agencies. Visits / contact with 'Keith' has been attempted by SM and DR, but he has not responded, and an assumption has therefore been made that he does not want to be involved. • **Please note that prior to publication the pseudonym was changed to 'Kevin'** ***'What to do if its not Safeguarding' Guidance:*** • RC noted that 'Keith's' case has lots of parallels to that of 'Tom's' case, where a lot of good work was underway in agencies, but there was no co-ordination. • In preparing the Guidance, SM researched documents in other areas which were brought together in a draft which the SSAB Policy and Procedure Sub Group had reviewed to arrive at the document shared today. • RC proposed that there was a requirement for all organisations that are members of the Board to sign up to this type of approach, e.g. where an organisation determines safeguarding criteria is not met, to create an opportunity to meet / work together. **There was agreement with this approach.** • For those partners involved in formal safeguarding arrangements there is an agreement from a safeguarding perspective, but this document is outside of the parameters of safeguarding and would also need sign up	

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	from other organisations. The framework is for multi-disciplinary meetings, RC emphasises that i**f an organisation is asked to be present, they must arrange for someone with appropriate skills, experience and decision-making authority to attend**. • Contact information to be completed on the document if organisations are happy for this to be included; a flow chart will also be developed. • **RC asked organisations represented today to confirm if their organisation does not want to sign up to this and no objections were raised.** • RP noted that the document was not currently explicit as to whether the person themselves should be involved, and that it is powerful if the person is willing to be part of the meeting process as well as professionals. SM's assumption was that if possible the person would be part of this process, but will make this explicit in the text. **Action: SM to amend text before publication.** CB added that sometimes professional strategy meetings occur where the person is not there; this could be a starting point for agencies to share information, risks, etc, before taking the next step with their involvement. • AT queried where Advocacy would sit within this. They are unable to turn people away, but do not always know how other services work with a person. In the past Advocacy have attempted to arrange meetings, which have not occurred due to other services declining, which then brings a situation back to Advocacy to follow up. CB confirmed that an Advocate should be able to refer into the process. • DH suggested that Advocacy need to use the process contained in the guidance to escalate a case if they are not getting the response they feel is required by the circumstances. • RC suggested this is a preventative process, and as a principle, everyone should think it is a good thing. • LJS' aim is to try to work out how to refine an Early Intervention Multi-Agency Group for people supported by Discovery; need conversations and structure refinements with all partners to prevent people falling through. • RC confirmed that people support this document and asked **SM to circulate for all organisations to confirm sign-up to.** Once confirmation has been received the Practice Briefing Note will be published with this document alongside it.	**SM** **SM**
8	**Learning and Development Framework:**	
	RC gave the background to the is document. Under the Care Act (2014) SABs do not have a responsibility to provide training to the local system – some do, but many don't. When the SSAB was originally established it was agreed that it wouldn't. However, requests are frequently received for guidance on training and therefore the learning and Development	

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	Subgroup agreed to develop a local framework that detailed the knowledge that staff in different types of roles should have, and the document presented today is the result. It was **agreed that this document will be published**, noting, as stated at the beginning of the framework, that use of the Intercollegiate Document – "Adult Safeguarding: Roles and Competencies for Health Care Staff" - published by the Royal College of Nursing will take precedence where professionals are covered by it. **Action:** SM to publish the framework and promote it in the next newsletter and via social media. Learning and Development Subgroup to review at least annually	**SM**
9	**Establishment of a Violence Reduction Unit (VRU):**	
	LM gave a brief presentation on work to establish a VRU in Somerset, following funding from the Home office via the Police and Crime Commissioner (PCC). • Somerset County Council has been allocated funding to set up a serious Violence Reduction Unit. The initial work will focus on what should this work look like, serious violence is to be tackled. Work is currently focussing on prevention and early intervention. • The Unit is set up and based at County Hall; a range of agencies have put forward officers to be involved until March 2020, including 4 x Police Community Support Officers (PCSOs), a Nurse, a Sergeant, a Manager from Somerset South West and Taunton Council, the Unit is overseen by LM • There are also clearly links to those whose role it is to engage with the most vulnerable and difficult people. • The Unit will work in a similar way to the one established in Bristol. • Every two weeks the Unit will receive data produced from information provided; this will highlight the people / families to focus on and what to prioritise. • A team meeting occurred yesterday, it is early days, lots of training for PCSOs to undertake. • The hope is to secure funding in the future for a separate project around serious and organised crime; which will offer lots of overlaps with this current project. • In terms of projects and interventions, there is a lot of guidance around this. Different methods will be used to get the messages out. • There will be work undertaken to target people going through Pathways to Independence (P2i) • Schools will have a significant focus; however, this project will not solely focus on children and young people, and will support people of all ages;	

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	but in terms of prevention the focus will be on younger people. • LM hopes that there will be funding available to further invest in this project from March 2020 onwards. • **Action: LM to give a further update at the next meeting.**	**LM**
10	**Progress from Executive Group:**	
	Action plan: We are now 6 months into the first year of new 3-year strategy. The one area still showing 'red' is making sure we do what we agreed we would do in relation to Intelligent Safeguarding, which RC noted that everyone enthusiastically agreed to form a Task and Finish Group to take this forward, however we have struggled to get enough people to start this Group, let alone finish it. Update: • 3 people have now signed up, but more are needed. As this is directly relevant RC would like to give the matter a push before his role ends, and to benefit the new Independent Chair. • Task and Finish Group to discuss how to work better together to share information; this also links with the example CB have in Salford. • NHS Somerset Clinical Commissioning Group, Somerset Partnership, and Somerset County Council are involved, and while it doesn't necessarily need all to be involved it does need sufficient involvement to begin to take forward. Involvement from the Police would be positive and beneficial. VC added that a lot of work is underway regarding data and will link in with a colleague to identify who should eb involved. **Action:** VC to provide SM with contact details once identified • SM noted that some areas of work, that were primarily about scoping where we were as a local system, have not yet commenced and that he was hoping to see preparation work on these areas begin soon; starting with Transitions. • RC recognised a considerable amount of work from various people has occurred and gave thanks.	**VC**
11	**Items for next Meeting and Newsletter:**	
	• The Newsletter was completed about 4 weeks ago, another is due for publication in December. **Any items to be sent to SM**. **Items for next SSAB Agenda:** • Update on Violence Reduction Unit • Invite Dougie to attend • Safeguarding on Hospital Discharge **Items for future meetings in 2020:**	**ALL**

Item		Action by
	• Hate Crime • Discussion with commissioners on monitoring arrangements for people places outside of Somerset and/or in to specialist hospital • VC to speak to SM including an item on welfare for a future meeting.	
12	**Any Other Business:**	
	Independent Chair – SSAB: Thanks were extended by RC, to all those around the table over the last 6 years, and feels with the help all involved, things have really moved on. Although there is still a lot more to do, RC feels that after 6 years it is time for him to move on. Interviews are occurring this Friday, when it is hoped another Independent Chair will be appointed. RC is sure the new Chair will have good support from everyone, and will certainly bring fresh eyes, a new approach and new energy. Prior to closing the meeting RC extended thanks to everyone for attending the meeting and for their contributions.	
	CLOSE	
Future Board Meeting dates: To be confirmed once a new Independent Chair has been appointed. Currently expected to be Late February / Early March 2020 – Wynford House Late June / Early July 2020 - County Hall October 2020 - Bridgwater Police Centre		