Somerset Safeguarding Adults Board
Draft minutes

13 October 2020 (09:30-11:30)

Microsoft Teams

Present:

- Keith Perkin (KP) – Independent Chair, SSAB
- Val Janson (VJ), Deputy Director of Quality and Nursing, NHS Somerset Clinical Commissioning Group (representing SC)
- Superintendent Mike Prior (MP) – Avon and Somerset Constabulary
- Mel Lock (ML) - Director of Adult Social Services, Somerset County Council (until item 6)
- Tracy Aarons (TA) – Deputy Chief Executive, Mendip District Council
- Anna Temblett (AT), Area Manager, Swan Advocacy
- Ann Bilham, Shared Lives South West
- Charlotte Brown (CB), Designated Nurse for Safeguarding Adults, NHS Somerset Clinical Commissioning Group (MM representing)
- Bernice Cooke (BC) - Head of Clinical Governance and Assurance, Yeovil District Hospital NHS Foundation Trust
- Paul Chapman (PC) - Inspection Manager, Care Quality Commission (South West England)
- Councillor Giuseppe Fraschini (representing DH)
- Hannah Gray (HG) – Manager, Health Watch Somerset
- Julia Mason (JM) - Associate Director of Safeguarding, Somerset NHS Foundation Trust
- Julie Bingham (JB) – Regional Manager Neighbourhoods, Live West
- Kathy Smith (KS) - Housing Officer, Golden Lane Housing
- Lucy Macready (LM) – Safer Communities Manager, Somerset County Council
- Lucy Martin (LMa)- Partnership Manager for Bristol and North Somerset, Department for Work and Pensions
- Steve Veevers (SV) - Steve Veevers, Director of Transformation, Discovery
- Hamish Robertson (HR), Hamish Robertson South West Group Senior Safeguarding Leader, Department for Work and Pensions
- Sarah Reynolds (SR), Somerset Care (representing NK)
- Stephen Miles (SM) – SSAB Business Manager

Attendees for specific items:

- Lesley Rankin (LR), Safeguarding Professional for Adults and Children, Somerset NHS Foundation Trust
- Louise Britt (LB), MCA and DoLS Practitioner, Yeovil Hospital NHS Foundation Trust

Apologies:

- Sandra Corry - Director of Quality, Safety and Governance, NHS Somerset Clinical Commissioning Group (VJ representing)
- Becky Arrowsmith (BA) – Golden Lane Housing (KS representing)
- Darren Peters (DP) - Area Manager, Devon and Somerset Fire and Rescue Service
- Cllr David Huxtable (DH) – Somerset County Council Cabinet Member for Adult Social Care (GF representing)

- Claire Evans (CE) – Senior Probation Officer, National Probation Service
- Hannah Webber (HW) – Safeguarding Officer, Devon and Somerset Fire and Rescue Service
- Kate Norris (KN) - Clinical Nurse Manager, Marie Curie Somerset & Dorset
- Nicola Kelly (NK) – Head of Quality and Clinical Governance, Somerset Care
- Victoria Caple (VC) – Avon and Somerset Constabulary
- Luke Joy-Smith (LJS) – Managing Director, Discovery (SV representing)
- Deborah Bilton (DB) - Named Safeguarding Professional for Adults, South Western Ambulance Service NHS Foundation Trust (SWASFT)
- Simon Blackburn (SB) – Chief Executive Officer, Registered Care Providers Association
- Richard Pitman (RPi) - Compass Disability Services (representing people who use services and the Voluntary Sector)
- Deborah Penny (DP) - Carers' Voice Somerset Partnership Board Officer, Somerset County Council
- 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)
- 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
- NHS England South West

Circulation:

All SSAB Board Members

Retention of notes

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There is currently no Highlighted text to be redacted in the published notes

Item		Action by
1	**Welcome, introductions and apologies:**	
	Members were welcomed to the meeting by KP, introductions were made and apologies noted as above.	

2	**Notes of previous meeting and matters arising (12 June 2020) and action tracker**	
	The minutes of the meeting held on 12/06/2020 were **agreed** as accurate, and the proposed redactions to the version for publication to protect the anonymity of the individual who spoke about their experience at a previous meeting were agreed. **Action:** SM to publish redacted version on the website. The action tracker was reviewed and it was **agreed** that all the actions related to agenda items, had been completed or superseded.	**SM**
3	**The experience of professionals working in adult safeguarding – Louise Britt, Yeovil Hospital NHS Foundation Trust and Lesley Rankin, Somerset NHS Foundation Trust**	
	KP introduced this item, and LF and LB, which is the first of three perspectives on adult Safeguarding during the Coronavirus pandemic in the absence of being able to arrange for someone who has experienced being safeguarded speaking to the Board during this time. Arrangements have also been made for front-line professionals from the police and County Council to speak at the next two meetings. LB and LR talked to the Board about their roles, experiences (positive and negative) of working on the front-line, and the challenges they face. The following key points were noted: LB: • Challenge faced: Variances in the understanding of what is meant by capacity, consent and information, as well as the need to keep the person themselves central to any safeguarding concern. • Challenge faced: Information gathering from different organisations, using different systems and, currently, not being able to visit other professionals in person. • Challenge faced: The lack of understanding of each other's roles sometimes experienced between health and social care professionals. An example was given of a case where the initial information indicated that the actions by a social care provider were of significant concern, but on further enquiry it transpired that good practice had been followed. • Challenge faced: Promoting choice, particularly where both health professionals and families want to protect people even if this is in conflict with the persons choices where they have capacity to make the decision. For example, where the intervention that will likely have the best clinical outcome is not what the person wants. • Positive: There is good multi-agency working with the Council's adult Safeguarding Service, for example when trying to build a picture of someone's circumstances, support needs, what is already in place and which other professionals are involved when looking potential interventions. • Positive: Trust staff are very good at highlighting early indicators of concerns so that preventative approaches can be considered. • Positive: Having professionals with both a health and social care background in the team, as it helps to provide a balanced view.	

- Helpful in the future: A system/approach for gathering and sharing 'soft-intelligence' about low-level and/or patterns of concerns when the Trust is seeing different people come in with similar concerns which may indicate that something is not quite right.
- Helpful in the future: Closer links with quality monitoring functions within the Local Authority and Clinical Commissioning Group

LR:

- LR highlighted similar challenges to those explained by LB
- Challenge faced: Helping colleagues to understand that discharge planning for an individual is separate to responding to adult safeguarding concerns, and should start on admission rather than as a last-minute decision-making process.
- Positive: Undertaking some safeguarding supervisions remotely using Microsoft Teams with other professionals has been beneficial – it has also cut down on travel and allowed contact to be more frequent, which professionals have found positive.
- Positive: Safeguarding colleagues that have been redeployed within the Trust during the pandemic have helped to get messages about safeguarding out into the teams and services they have been redeployed to.
- Positive: The Trust has a 'High impact group' that looks at people who make frequent contact with hospital services, this incudes safeguarding representation and works well.

The following points were made in discussion:

- KP asked how working practices had been adapted due to lack of face to face contact?
    - LB felt that, generally, working with people virtually has largely been successful, there were some concerns from some staff about how it would work early on, for example where an adult has experienced domestic abuse, but the experience has been positive.
- KP noted that it was interesting to note that shorter, more frequent, opportunities for safeguarding supervision appeared to be working well
- CB observed that a significant amount of thought and work appears to be going in to taking a preventative approach, which was positive, and asked what the volume of work in terms of preventing situations form escalating.
    - LR said that on most days the majority of work will be in relation to prevention and information gathering. LB agreed with this, adding time spent trying to focus on understanding what the person wants.
- CB asked LB and LR if they felt that, as a system, we have the right mechanisms for information sharing, and are they working, to have a multi-agency discussion where we are worried about someone?
    - LB felt that virtual ways of working have definitely helped with this, and should continue to help going forwards now that everyone had got use to them, particularly when looking at really complex cases where many different professionals need to be involved to help keep the person safe. LR agreed with this, also highlighting that these were the type of cases discussed by the high-impact group that had been established by the Somerset NHS Foundation Trust.

	• KP asked LB and LR is there was anything other agencies could do to help them in their toles? ○ LR felt that it would be beneficial to have clarity about who contact can be made within other organisations to get a response in a timely manner as this can sometimes be frustrating, time consuming, and of little benefit to the adult. As a system we all need to make ourselves available to each other in as an efficient and speedy manner as possible – this doesn't need to be formal mechanisms, more informal conversations that allow concerns to be discussed and escalated rapidly. LB concurred with this. • MP emphasised the need to look at vulnerability across the system, and understand who else is concerned and trying to help the adult so that a coordinated approach can be taken by all. • **Action:** KP to raise learning highlighted by LB and LR with the Executive Group. KP thanked LB and LR on behalf of the Board for their time, and they left the meeting.	**KP**
4	**Consideration and sign-off of revised Terms of Reference for the Board and Executive Group**	
	Both sets of Terms of Reference were **agreed** without amendment. **Action**: SM to publish the Board Terms of Reference on the website.	**SM**
5	**Update on Violence Reduction Unit**	
	LM gave an update on the Violence Reduction Unit (VRU) for the Board's information. This included: • The VRU is in its second year • Avon & Somerset Constabulary committed to funding all police staff in the second year, however, due to the impact of Covid-19 these staff were initially redeployed earlier in the year. This led to a delay in some of the work being progressed as originally planned. • The focus is on the 5 priorities of the VRU • There is a multi-agency data group, which got up and running from September 2020 due to Covid-19 related delays, to look at the evidence base for interventions and take a multi-agency view. • The majority of individuals and groups that have been highlighted are in relation to county lines. • One challenge is that there seems to be less confidence within organisations to sharing information about adults than children – much of this appears to be related to circumstances where consent is required. LM has asked for a data sharing agreement used in another area where information is currently shared on a 'live' basis to see if something similar could be taken forward in Somerset. • Campaigns undertaken include domestic abuse, county lines and knife crime • LM is currently reprofiling the budget to make sure that remaining funds are allocated to priority areas • In terms of the future, while the VRU is currently grant funded by the government, much of the work can be embedded and LM is looking at how it can be sustained going forward. Discussion and comments noted:	

	• MP highlighted that the grant funding had been allocated by the government because of concerns about knife related violence across the country. Much of the work in Somerset is preventative, and making interventions before someone is a victim. While this approach is about knife violence, it is also an approach that can be used with other types of vulnerability • VJ asked if there was any other support that is needed from an adult perspective? ○ In response MP felt that the message from the discussion today is that this approach of looking at vulnerability is applicable to other areas of work with adults, including but not limited to safeguarding. • CB highlighted that NHS England and NHS Improvement has recently established a serious violence and contextual safeguarding group, which includes representation from all the Clinical Commissioning Groups in the South West. The initial meeting earlier in October recognised the potential of the type of work described by MP and LM, and while the work is in its early stages there is enthusiasm to progress it. CB also noted that, in terms of information sharing, while the legislation was clear for children, acknowledgment needs to be given that when working with adults the legal framework is different and there will inevitably be challenges where adults may be making what professionals consider to be unwise decisions and the issues this can create in terms of then needing to understand their capacity to make the decision under consideration. This includes their capacity to consent to share information, and it is therefore not simply a case of assuming that the same approach can be taken as with a child – the law is clear that there are specific circumstances when information can be shared without consent, but where these do not apply it needs to be sought. • KP asked LM to clarify the issues around lack of confidence in relation to information sharing. MP explained that this might, for example, be where a victim of violence has been involved in criminal behaviour themselves and won't give consent to share information. • CB noted that, from speaking to Trusts there is also an issue where aggregated data is asked to be shared – for example details all the incidences of injury and assault seen by an A&E department, as in most cases consent will not have been sought at the time of attendance. • BC asked LM for assurance around particularly vulnerable groups of children, including care leavers, CAMS and SEND and how these groups were being considered by the VRU, which LM gave. • GF raised specific concerns about policing outside a primary school, which MP agreed to follow-up with him outside of the meeting.	
6	**Delivering our strategic plan: Section 1, Listening and learning**	
	KP introduced this item and asked that the Board have an open discussion about this section of the plan, about how they felt as a partnership around the desired outcomes and any additional actions they felt were needed to progress this. KP asked members to consider where they thought the Board was in terms of the desired outcomes, what good looked like, how do we know where we are, what do we need to improve and any examples of good practice that they are aware of. Discussion and comments noted:	

	• JM felt that as a system we are not confident in how much we are hearing from people who have experience safeguarding, as this is information that is difficult to capture, referencing the experience of Somerset NHS Foundation Trust. The only way it is captured by the Trust is within the referral form itself, and the Trust has tried to explore how it might capture qualitative rather than quantitative data better, and have the capacity and resources to speak to people and get their feedback in a timely way. Covid-19 has put work that had been planned to arrange for volunteers to do a follow-up call or contact to understand how people felt that the Trust had responded to a safeguarding concern on hold. JM noted that while this was one of the hardest things to evidence, and that people struggled with it across the country, that didn't detract from the fact that it was critical to listen to the person themselves about their experience. • KP agreed with JM's comments that it was a hard area to evidence, and that it did require capacity to get right, but that this didn't mean it wasn't the right thing to do. KP asked how safeguarding fitted within the Trust's more general feedback mechanisms? o JM explained that, while there were arrangements in place for general feedback, participation in any form of feedback process was always down to the individual, but that it was not as simple as adding a safeguarding element to these as only a relatively small proportion of people experienced being safeguarded, and would therefore need something more targeted which had not been achieved yet. • CB agreed that this was an issue that the Board had been struggling with for some time, and that while some people did struggle with engaging virtually, it did also bring opportunities for Board members to reach out in ways that they didn't before. CB noted the report that had been produced by Healthwatch in 2019, and that while Covid-19 had made implementing the recommended approach difficult it still remained the right starting point. o SM explained that the Boards' Quality Assurance (QA) Subgroup was monitoring the implementation of the recommended arrangements by the Local Authority, which would involve a sample of around 300 people (based on numbers last year) being contacted following the closure of an enquiry undertaken under Section 42 of the Care Act 2014. The Local Authority had started to implement this during 2019, the initial sample had been calculated, the questionnaire had been put in place and the resourcing of who would do it had been agreed ready to begin. However, all work was put on hold due to Covid-19, and that the Local Authority had told the Quality Assurance Subgroup that it intended to restart this work as soon as possible. CB suggested that this approach could also be expanded to include other organisations. **Action:** SM to take back to the QA Subgroup for consideration as to how other organisations could use the same tool to gather feedback in addition to the Local Authority. • KP queried if there were existing groups that could also help with this,	**SM**

	and asked what existed in other areas. ○ SM explained how this worked within another Board within the region, where the Board could go to a group representing people with care and support needs for feedback, but no one was aware of any similar arrangements currently existing in Somerset. • CB noted that all organisations have mechanisms to gather feedback, the problem is that people who require safeguarding will always be a relatively small subset of those that come in to contact with services, and that by the very nature of what they have experienced many will not want to revisit it. **Action**: All organisations to consider how their existing processes could be used to gather feedback from people who have experienced being safeguarded for the next meeting. **Action**: SM to arrange for feedback to be included in the Board's next self-audit and peer challenge process, including looking to include a Healthwatch representative in the peer challenge process.	**ALL** **SM**
7	**Progress update from Executive Group on the strategic plan**	
	• KP gave an update on the Safeguarding Adult Reviews (SARs) in Rapid time process that was being developed by the Social Care Institute for Excellence (SCIE). The proposed approach involved undertaking SARs in 15 consecutive working days, including information gathering from organisations and report writing. Boards that had been involved in the first stage of the pilot had not been able to achieve this. While the Executive Group was keen to progress SARs so that learning could be identified and shared as soon as possible, it did not feel that this timescale was achievable for partners at this time and had therefore decided not to take part in the pilot, but to instead look at how the tools and processes that had been developed by SCIE could be adapted to a local approach once they became available. This was supported by the Board. **Action**: Once SCIE has made the tools and processes available to Boards KP will write to all partners to explain the new process, how it will work and the timescales that they will need to respond to requests within. • JM queried whether the board could develop webinars in the absence of a conference to share the learning from SARs presented by those professionals who had been involved. SM confirmed that this was something that the Learning and Development subgroup was working to do. **Action**: CB to progress this through the Learning & Development Subgroup. There were no questions raised about any other aspect of the update.	**KP** **CB**
8	**Items for next meeting and newsletter**	
	• LM to give an update on the Domestic Abuse Act which is expected to come into effect from April 2021. • NICE guidance on Safeguarding in Care Homes (if published before the next meeting). **Action**: SM to include the Board's response with the notes. No articles were proposed for the next newsletter	**LM** **SM**
10	**Any Other Business**	

	None. KP thanked everyone for their attendance today.	
Future Board Meeting dates: 13th October 2020 – Microsoft Teams Meeting 09th February 2021 – Microsoft Teams Meeting		