Somerset Safeguarding Adults Board Minutes

10 February 2022 (09:30-12:30)

Microsoft Teams

Present:

- Keith Perkin (KP) Independent Chair, SSAB
- Mel Lock (ML) Director of Adult Social Services, Somerset County Council
- Val Janson (VJ) Director of Quality and Nursing, Somerset Clinical Commissioning Group
- Richard Painter (RP) Director of Safeguarding & Patient and Family Centred Care, Somerset NHS Foundation Trust
- Cllr David Huxtable (DH) Somerset County Council Cabinet Member for Adult Social Care
- Claire Evans (CE) Senior Probation Officer, National Probation Service (representing Liz Spencer)
- Joanne Hawkins (JH) Quality Improvement Lead for Safeguarding, Somerset CCG
- Kathy Smith (KS) Housing Officer, Golden Lane Housing
- Rachel Handley (RH) Consultant in Public Health, Somerset County Council
- Helen Orford (HO) Managing Director, Dimensions
- Bernice Cooke (BC) Deputy Director Quality Governance, Patient Safety and Safeguarding, Yeovil Hospital NHS Foundation Trust
- Jacob Ayre (JA) Head of Service, Swan Advocacy
- Lucy Macready (LM) Safer Communities Manager, Somerset County Council
- Nicola Kelly (NK) Director of Care, Somerset Care
- Nicola Fensham (NF) Deputy Safeguarding Lead, Mendip District Council (representing Tracy Aarons)
- Hayley Nicholls (HN) Shared Lives South West (representing Amanda Maggs)
- Jonathan Searle (JS) Somerset Service Manager, SWAN Advocacy
- Ali Porter (AP) Somerset and Hinkley Partnership Manager, Department of Work and Pensions
- Stephen Miles (SM) SSAB Business Manager
- Marion Nuttall (MN) SSAB Assistant

Apologies:

- Superintendent Richard Turner (RT) Avon and Somerset Police
- 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
- Tracy Aarons (TA) Deputy Chief Executive, Mendip District Council
- Alison Jenkinson (AJ) Partnership Liaison Manager, Lighthouse Safeguarding Unit (LSU), Avon and Somerset Constabulary
- Julie Bingham (JB) Regional Manager Neighbourhoods, LiveWest
- Paul Chapman (PC) Inspection Manager, Care Quality Commission (South West England)

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

Redactions: Item 3 has been recorded in a way that protects the anonymity of "Damian's" family when these notes are published

Item		Action by
1	**Welcome, introductions and apologies:**	
	Members were welcomed to the meeting by KP.	
2	**Notes of previous meeting and matters arising (October 2021) and action tracker (papers 1 and 2)**	
	The minutes of the meeting held on 12/10/2021 were agreed as accurate, with no proposed redactions to the version for publication. **Action:** Minutes to be published on the website. The action tracker was reviewed, and it was confirmed that the majority of the actions were progressing, including that: Action 6 would be discussed later in the meeting, Action 12 is being picked up the SSAB Performance and Quality Assurance subgroup (P&QA), and **Action:** Action 14 to be added to the agenda of the next Board meeting (16/06/2022).	**SM** **SM**
3	**Learning from SARs – feedback from "Damien's" family to the Board (paper 3)**	
	As "Damien's" family member was unable to attend the Board meeting due to work commitments, a letter from them (Paper 3) was circulated to attendees prior to the meeting. KP encouraged all attendees to read the document and in particular to read aloud the last paragraph. KP stated that the letter is an important reminder to professionals of their responsibility to families and the impact that Safeguarding Adults Review's (SAR's) have on families.	
4	**Presentation on the results of the 2021/22 Self-audit (presentation)**	
	KP thanked all organisations and individuals who had completed the self-audit assessment tool and emphasised the value of their contributions. SM gave a detailed presentation which covered the findings from each question as well as recommendations for SSAB member organisations. This included: <u>Positives</u>: • Significant increase in responses received (9 in 2019 to 17 in 2021). • Strength of regional work/sharing to date and that this is expected to continue. • Lots of examples of good practice within individual organisations.	

- High levels of confidence were demonstrated in identifying learning and mitigating Covid-19 related safeguarding challenges.
- All organisations recorded having training on the Mental Capacity Act (MCA) or this being under development if relevant for their service.
- All organisations stated they had effective processes in place to manage concerns and allegations for people in a position of trust.
- Most organisations said they had robust and safer recruitment procedures and practices as well as processes for staff supervision.
- Evidence of work done within organisations internally to engage with people with protected characteristics.

<u>Areas for Improvement:</u>

- Confusion regarding "whistleblowing" and what this mean in different organisations indicated work needed around mitigating barriers (perceived or otherwise) to reporting concerns.
- Explicit inclusion of safeguarding in organisational strategies.
- Resolving professional differences guidance to be reviewed to see if can be made clearer.
- Greater consistency suggested in what is meant by the use of the term "supervision".
- All organisations should be considering how learning from all SARs is relevant to them, not just those in which they have an involvement.
- Work identified around improving feedback collection from people with lived experience.
- Work identified around raising awareness of Professional Curiosity (a webinar is currently being developed by the Learning and Development subgroup for delivery in March 2022).
- Some organisations indicated that strengthened/ more specialised training around adult exploitation would be beneficial.

<u>Challenges</u>:

- Concerns around Liberty of Protection Safeguards (SSAB MCA subgroup will be reviewing following publication) given lack of guidance from Central Government to date.

SM gave an update on ongoing discussions regarding a moderation process and that the previous "peer challenge" approach would be unsuitable due to the increase in responses. SM stated that an upcoming meeting has been scheduled between himself, KP and Niki Shaw (Strategic Manager SCC Quality and Performance) to discuss how to take this forward. SM stated once an approach is agreed all responding organisations will be contacted.

KP commented that the role of the SSAB is to gain assurance across the system and the audit provides an opportunity to shape the SSAB's next Strategic Plan using focused local learning. KP highlighted that this is particularly welcome as the recommendations concern themes which commonly arise as areas for improvement. KP stated that individual agencies hold the responsibility to resolve the areas that they have self-rated as red or amber for and that this would be followed up in between audits now that the Board was moving from an annual to a biennial cycle. KP noted the benefit of working with regional Safeguarding Adults Boards/ Partnerships to take forward work from this. KP stated that the Board's role is to look at improvements across the system, and it is important that the

	instances of best practice which have emerged from the audit are disseminated alongside learning. KP noted that the upcoming meeting with SM and NS would include a discussion about how to do this. **Action**: Any attending organisations which have suggestions about how examples of best practice/ learning identified through the audit process could be best shared to contact the SSAB via ssab@somerset.gov.uk. KP thanked SM for the presentation and reiterated his thanks on behalf of the Board to all organisations which submitted a response and to MN for her work in collating them. No questions were asked. The presentation received positive feedback from several attendees during the meeting. **Action**: Presentation slides to be circulated following the meeting.	**ALL** **SM**
5	**Safeguarding Quality Improvement**	
	KP welcomed JH to the meeting and asked her to introduce herself and her role. This introduction included: • Her new role is as the Quality Improvement Lead for Safeguarding across the SSAB, Somerset Safeguarding Children and Safer Somerset Partnerships. • She has recently returned following a period of redeployment to support the response to Covid-19. • The role is on a secondment basis for 18 months. • The role's focus is on delivering Quality Improvement (QI) projects using QI methodology to support the areas/ learning for practice identified from Domestic Homicide Reviews, SAR's and Serious Incidents (SI's). JH had pulled together a list of specific areas for improvement to apply QI methodology which she shared with the meeting. The Safeguarding Themes for QI projects relating to SARs included: • Professional curiosity • Self-neglect • Adherence to the Mental Capacity Act/ Executive decision making and diminishing capacity • Silo working/ absence of information sharing • Under recognised Domestic abuse • Record keeping • Reflective practice and supervision The diagram shown also included streams on themes from Child Safeguarding Practice reviews, Domestic Homicide reviews and Serious Incidents/ Section 42's. JH mentioned the opportunity to triangulate this improvement work, as certain themes run across each stream. Challenges: • Need to strengthen relationships with relevant professionals and improve stakeholder engagement. JH welcomed any suggestions for help/ support from attendees. **Action**: MN to send JH list of attendees to aid making connections. • Different organisations will inevitably have different priorities. • Potential Difficulties in checking the sustainability of the improvement once the project ends.	**ALL to note** **MN**

	KP commented that it is welcome to see the inclusion of the SI's stream, as the National Network of Safeguarding Adults Board Chairs recently raised whether local SABs are assured that SI's are being picked up and how these link with learning from SAR's/ other local learning. KP stated that at the Systems and Quality group there was learning from Mental Health Homicide Reviews (MHHR's) from other areas and asked whether this would fit into this. VJ said that MHHR's are treated the same way as SI's by the CGG. VJ confirmed that there will be work to take forward around MHHR's in particular. JH confirmed that she is joining the group imminently. VJ added that they are linking in with colleagues at NHS England & Improvement into their Review, Learn, Improve group to gain oversight of health services that the CCG does not commission but they do. **Action**: JH to be invited back to a future Board meeting to share outcomes of the role. RP said he would be keen for Somerset NHS Foundation Trust's Safeguarding Leads and Quality Improvement Leads to meet with JH together with colleagues from partner agencies. RP asked whether a workshop could be considered to map and plan. NK similarly stated that she would like to be involved and to support JH's work. NK welcomed the suggestion from RP about a workshop.	**JH/SM**
6	**Progress update on current SSAB Strategic Plan (paper 4)**	
	SM presented a progress update covering the period since the last Board meeting on 12/10/21. This included: <u>Listening and Learning:</u> • Proposal to resume inviting people who have experienced safeguarding to speak at future Board meetings. • Board took part in webinar series for Safeguarding Adults Week and noted the good feedback received. • Incorporated feedback from the new feedback process into the SSAB Dashboard. • 'Matthew' SAR now published, with pseudonym changed and this published along in comms and with other learning in the January SSAB newsletter. • Local recommendations from the National SAR Review are being taken forward. Some delays in the national work which will affect local work contingent on this. <u>Enabling people to keep themselves safe:</u> • New public-facing leaflet on 'Mate Crime' has been published. • 'Tricky Friends' animation originally developed by Norfolk SAB has been edited to show the details for Somerset Direct and shared in SSAB Comms. It is available on the website. • SSAB's website traffic is similar to the same time the year before and this likely shows an increase as last year the website was hosting Coronavirus guidance for care providers which generated more additional traffic than it had in the year so far.	

	• Social media activity has increased since September, including good engagement to campaigns #StopAdultAbuseWeek and #12DaysOfSafeguarding. <u>Working together to safeguard people who can't keep themselves safe.</u> • Originally there was an element in the plan to look at NICE safeguarding in Care Homes guidance. However, work has paused as the National Chairs Group has advised Boards not to progress work around the guideline at this time. • Liberty of Protection Safeguards have been delayed again by Central Government. The SSAB MCA subgroup continues to monitor performance with respect to the application of the Act and existing Deprivation of Liberty Safeguards. • Independent Chair has sought assurance from Executive Group members that learning identified through national workstreams following a high-profile SAR published in Norfolk have been taken forward. <u>Board Governance:</u> • SSAB continuing to share learning from other areas in comms. • SSAB's Performance Dashboard is now in place, feedback following the presentation to the Board at its last meeting. • Board's self-audit has been completed, the results analysed and presented to the Board today. • Independent Chair has presented the SSAB's Annual Report to the Somerset Health and Wellbeing Board and the SCC Scrutiny for Policies, Adults and Health Committee. • Work is progressing on three SARs commissioned earlier in the year. More currently being commissioned. KP thanked SM for the presentation and attendees for their contributions. KP asked SM if there is a way to break down who is using the website, such as by user type and organisation. SM said that the SSAB P&QA subgroup breakdown this date by device type and page visited.	
7	**Consideration of draft Strategic Plan for 2022-2025 (paper 5)**	
	KP explained that all attendees would be placed into breakout rooms to prompt greater discussion around the plan with questions shared to lead the discussion: 1. Are there any priorities that are not clear, or which need to be reframed/reworded? 2. Is there anything missing that needs to be added? 3. Is there anything that needs to be removed? 4. What suggestions do you have for monitoring progress/demonstrating success? 5. How do you think that your organisation can work collaboratively with others, and the Board, to take forward the agreed priorities? Groups: 1-AP, KS, NF, HO, BC. 2-VJ, JH, JA, RH, LM, DH 3-RP, HN, KP, CE, JS	

	Action: Discussions from each breakout rooms to be collated and fed into the draft of the next Strategic Plan. Feedback included that groups would have benefitted from more time. **Action:** KP asked attendees to let SM know if they had further thoughts on the other questions. HO gave feedback that the breakout rooms worked well and were very useful. Suggested these are utilised in future meetings, including for single topics. Others seconded. RP sent SM a copy of the document Group 3 was using to record their thoughts (actioned during meeting).	**SM** **ALL**
8	**SSAB Updates: Performance report (presentation)**	
	SM gave a presentation and stated that the P&QA subgroup Chair has confirmed that they are happy for the document to be circulated following the meeting. **Action**: Report to be circulated. Key messages included: **Listening and Learning** • Starting to gather helpful feedback • Satisfaction rates are highest from people who report being safeguarded themselves at 100%. • Latest response received in December 2021. **Action**: Partners to repromote/ continue promoting the feedback tool. • Complaints regarding the Adult Social Care Safeguarding Service have fallen this financial year. **Enabling people to keep themselves safe** • Slow decline in the past year in the % of active adult social care settings rated 'Good' or 'Outstanding' by CQC. • SSAB continues to have very good levels of interest via its primary comms channels. • Rise in recent months of placements in Somerset being restricted due to quality/safety concerns. • High levels of unmet need and hand backs of care packages. **Working together to safeguard people who can't keep themselves safe** • Somerset continues to see a declining rate of safeguarding contacts (contrary to national trends). • Decision taken by Performance and Quality Assurance subgroup to actively promote the "Thinking It? Report It" campaign run in previous years, with additional comms around neglect and self-neglect. Board governance • Will be shortly advertising a new administrative role for the SSAB which will help with the sharp rise in the number of SAR referrals during the pandemic. • New CQC Assurance of Local Authority Statutory Duties in April 2023. • Proposal agreed to redo the SSAB effectiveness survey. **Action**: SM will contact members with further details about this and circulate findings to the Executive subgroup. SM explained that a decision was taken not to circulate the 22-page report in full in advance of the meeting on this occasion so that it could be	**SM** **ALL** **SM**

	introduced, but in future it was agreed would be so that Board members could review the summary on slide 2 and have the rest of the report to reference for any questions that might arise for doing so. **Action**: Summary will be shared after the meeting and if attendees have further questions upon review, SM will welcome the opportunity to answer. DH asked if Somerset Direct are filtering out safeguarding referrals. SM responded that contacts are triaged through Somerset Direct and if a referral needs to go to the safeguarding service it does so, with all other referrals being redirected to the most appropriate destination for them. This prevents the issue whereby there is a huge volume of referrals/ concerns which mention safeguarding being directed to the adult safeguarding service. Somerset's higher than average conversion rate to Section 42's indicates that what the service is receiving is appropriate and that this triage process is effective. KP noted that Somerset has a strong network of community agents and there has been significant work in developing "What to do if it's not safeguarding?". KP stated that he wants to ensure other partners' data, not only Adult Social Care, is recorded in the dashboard to ensure that this is multi-agency.	**SM/ALL**
9	**Items for next meeting and newsletter**	
	KP invited LM to give an update on the violence against Women and Girls bill at the next meeting (16.06.2022). **Action**: SM to include on the agenda. KP asked SM for a timescale on the newsletter. SM responded that the latest version was published a couple of weeks prior and that the plan is for the next edition to be published in April. **Action**: Any items for the next newsletter and next Board meeting to be sent to SM.	**SM/ LM** **ALL**
10	**Any Other Business/ Arrangements for future meetings**	
	KP proposed for the June meeting to be face-to-face. Acknowledged feedback received for Board meetings to alternate between being virtual/ face-to-face. KP suggested that as the Board only meets three times a year and has not met in person for two and a half years that future meetings are scheduled to be face-to-face. **Action**: SM to book a suitable room for the next Board meeting. KP thanked MN for her administrative work for the SSAB and wished her well in her move to a new role. KP wished VJ a very happy retirement and thanked her for her deep commitment to both the SSAB Board and Executive over the years.	**SM**
Future Board Meeting dates 16th June 2022, Location TBC. 09:30-12:30 13th October 2022, Location TBC. 09:30-12:30 14th February 2023, Location TBC. 09:30-12:30		