Annual Report

2021-22

Contents

1. Introduction 3
2. Foreword 5
3. The Board 6
4. Safeguarding in numbers 11
5. Safeguarding Adults Reviews 17
   'Matthew' Safeguarding Adults Review 18
   Updates on reviews published in previous years 21
6. Our priorities for 2022/23 25
7. Board Budget 26
8. Our work during 2021/22 27
   Priority Area 1: Listening and learning 27
   Priority Area 2: Enabling people to keep themselves safe 31
   Priority Area 3: Working together to safeguard people who can't keep themselves safe 33
   Priority Area 4: Board Governance 34

Appendix 1: The Work of Our Members

1. Introduction

The Somerset Safeguarding Adults Board (SSAB or "the Board") is required under the Care Act 2014 to produce an annual report each year.

The report must set out what we have done during the last year to help and protect adults at risk of abuse and neglect in Somerset.

Our annual report tells you:

- The profile of adult safeguarding in 2021/22;
- How we have done in delivering our objectives during the year;
- The findings and impact of any Safeguarding Adults Reviews we carried out;
- The contributions of our member organisations to adult safeguarding;
- Our priorities looking forward.

This report will be published along with a one page summary on the SSAB website, www.ssab.safeguardingsomerset.org.uk, for all partners, interested stakeholders and members of the public to access.

As required by the Care Act, it will also be shared with the Chief Executive and Lead Member of the Local Authority, the Police and Crime Commissioner and the Chief Constable, the local Healthwatch organisation, and the Chair of the Health and Wellbeing Board. A copy will also be shared with the Chief Officer of the Clinical Commissioning Group.

It is expected that those organisations will consider the contents of the report alongside how they can improve their contributions to both safeguarding in their own organisations, networks and in partnership with the Board.

'Working in partnership to enable adults in Somerset to live a life free from fear, harm and abuse'

What is adult safeguarding?

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, whilst at the same time making sure that the adult's wellbeing is promoted.

The aims of adult safeguarding are to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Stop abuse or neglect wherever possible
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.

Who is an adult at risk?

An adult at risk is someone who is over 18 years of age who, as a result of their care and support needs, may not be able to protect themselves from abuse, neglect or exploitation. Their care and support needs may be due to a mental, sensory or physical disability; age, frailty or illness; a learning disability; substance misuse; or an unpaid role as a formal/informal carer for a family member or friend.

The Safeguarding Principles

The work of the SSAB is underpinned by six safeguarding principles, which apply to all sectors and settings including care and support services. The principles inform the ways we work with adults, and are: Empowerment, Prevention Proportionality, Protection, Partnership and Accountability. Read further information about the six safeguarding principles.

What is abuse?

Abuse is when someone treats an adult in a way that harms, hurts or exploits them. It can happen just once or many times; it can be done on purpose or by someone who may not realise they are doing it.

Abuse and neglect can include: Physical abuse, Domestic violence, Sexual abuse, Psychological abuse, Financial or material abuse, Discriminatory abuse, Organisational abuse, Neglect and acts of omission and Self-neglect. Read further information on the signs, symptoms, and indicators of each type of abuse

2. Foreword

Keith Perkin, Independent Chair – Somerset Safeguarding Adults Board

As Independent Chair for the Somerset Safeguarding Adults Board, I am pleased to be able to introduce our annual report for 2021/2022.

Although a statutory responsibility for the partnership to publish an annual report, it is also an opportunity to highlight not only the valuable service that agencies in working together provide to those who experience, or are at risk of harm or abuse, but also of the challenges they face in today's society. We cannot forget that although out of the Coronavirus 19 lockdown, all partners continue to face specific challenges emanating from the pandemic and more recently an increasing cost of living environment.

Through the work of the Performance & Quality Assurance subgroup, we are now in a better position to better understand and respond to emerging risks and performance issues. This work is still developing, but already we are seeing remedial action being taken to identify and take action to improve outcomes for those who need safeguarding support.

The Learning & Development and Policies & Procedures subgroup has worked hard during the last 12 months in difficult circumstances to ensure partners and those who work directly with people to receive up to date information, guidance, and advice.

A critical responsibility for a Safeguarding Adult Board is the commissioning of Safeguarding Adult Reviews. These reviews are fundamental for the adult safeguarding system in Somerset to learn from tragic and untimely deaths or serious harm of those who need care and support. The SSAB published one review during this reporting year but has also published briefings on other cases.

The Board has heard directly from people & groups who work directly with people who have suffered abuse or harm. These opportunities have enabled leaders to understand the difficulties & barriers to safeguarding in partnership, but also how professionals have come together to improve the lives of those we serve.

I would like to express my sincere thanks to the commitment shown by partners and those who work so hard to help adults in need of safeguarding support over the last 12 months. I am reassured partners work together to do their best to safeguard adults at risk of harm or abuse. We cannot be complacent, and I am confident that the level of commitment shown this year will enable safeguarding practice in Somerset to improve over the next 12 months.

3. The Board

Safeguarding is everybody's business

The Board's role is to have an oversight of safeguarding arrangements, not to deliver services

The Somerset Safeguarding Adults Board (SSAB) is a multi-agency partnership which became statutory under the Care Act 2014 from 1st April 2015.

The role of the Board is to assure itself that local safeguarding arrangements and partner organisations act to help and protect adults in its area.

This is about how we prevent abuse and respond when abuse does occur in line with the needs and wishes of the person experiencing harm.

The Boards' main objective is to assure itself that local safeguarding arrangements and partner organisations act to help and protect people aged 18 and over in the area who:

- have needs for care and support; and
- are experiencing, or at risk of, abuse or neglect; and
- (as a result of their care and support needs) are unable to protect themselves from either the risk of, or experience of, abuse or neglect.

The Board has a strategic role that is greater than the sum of the operational duties of the core partners, overseeing and leading adult safeguarding across the county and interested in a range of matters contributing to the prevention of abuse and neglect. The Board does not work in isolation, nor is it solely responsible for all safeguarding arrangements.

Membership of the Board

Board members as of 31 March 2022:

Name	Organisation	Job Title
Keith Perkin		Independent Chair
Stephen Miles		Business Manager
Lead Statutory Partners		
Dickon Turner Alison Jenkinson	Avon & Somerset Constabulary	Superintendent Partnership Liaison Manager
Val Janson	NHS Somerset Clinical Commissioning Group[1]	Director of Quality and Nursing
Mel Lock Brickchand Ramruttun	Somerset County Council	Director, Adult Social Services Assistant Director, Adult Social Care Operations

Partner Members		
Paul Chapman	Care Quality Commission	Inspection Manager
Lynn Matthews Ali Porter MBE	Department for Work and Pensions	Advanced Customer Support Senior Leader, Avon, Somerset and Gloucestershire Somerset and Hinkley Partnership Manager
Anne Harrison	Devon & Somerset Fire and Rescue Service	Prevention and Safeguarding Manager
Janet Quinn	Devon, Somerset and Torbay Trading Standards Service	Trading Standards Project Officer
Helen Orford	Discovery	Managing Director
Becky Arrowsmith Kathy Smith	Golden Lane Housing	Head of Housing Housing Officer
Gillian Keniston-Goble	Healthwatch Somerset	Healthwatch Somerset Manager

[1] * On 01/07/2022 NHS Somerset Clinical Commissioning Group was replaced by the Somerset Integrated Care Board

Julie Bingham	LiveWest (rep. housing providers)	Executive Director Housing Support
Charlotte Holland	Marie Curie Somerset	Clinical Nurse Manager
Tracey Aarons	Mendip District Council (rep. District Councils)	Deputy Chief Executive
Liz Spencer Claire Evans	National Probation Service	Head of Somerset Probation Delivery Unit (PDU) Senior Probation Officer
Rosie Luce	NHS England and NHS Improvement	Regional Safeguarding Lead / Assistant Director for Quality and Safeguarding
Julia Mason Emma Read	NHS Somerset Clinical Commissioning Group	Designated Nurse for Safeguarding Adults Deputy Designated Nurse for Safeguarding Adults
Simon Blackburn	Registered Care Providers Association	Chief Executive
Richard Pitman	Rep. people who use services and the Voluntary Sector	Chief Executive – Compass Disability
Amanda Maggs	Shared Lives South West	Team Leader – Somerset
Nicola Kelly	Somerset Care Ltd	Director of Care
Lucy Macready	Somerset County Council (Public Health - Community Safety)	Public Health Specialist – Community Safety
Cllr David Huxtable	Somerset County Council	Lead Member – Adult Social Care
Rachel Handley	Somerset County Council (Public Health)	Consultant in Public Health
Rich Painter	Somerset NHS Foundation Trust	Director of Safeguarding
Amanda Robinson	South Western Ambulance Service NHS Foundation Trust	Safeguarding Business Manager
Jacob Ayre	Swan Advocacy	Head of Services
Bernice Cooke Glen Salisbury	Yeovil Hospital NHS Foundation Trust	Head of Governance and Assurance Head of Safeguarding Team

Board attendance

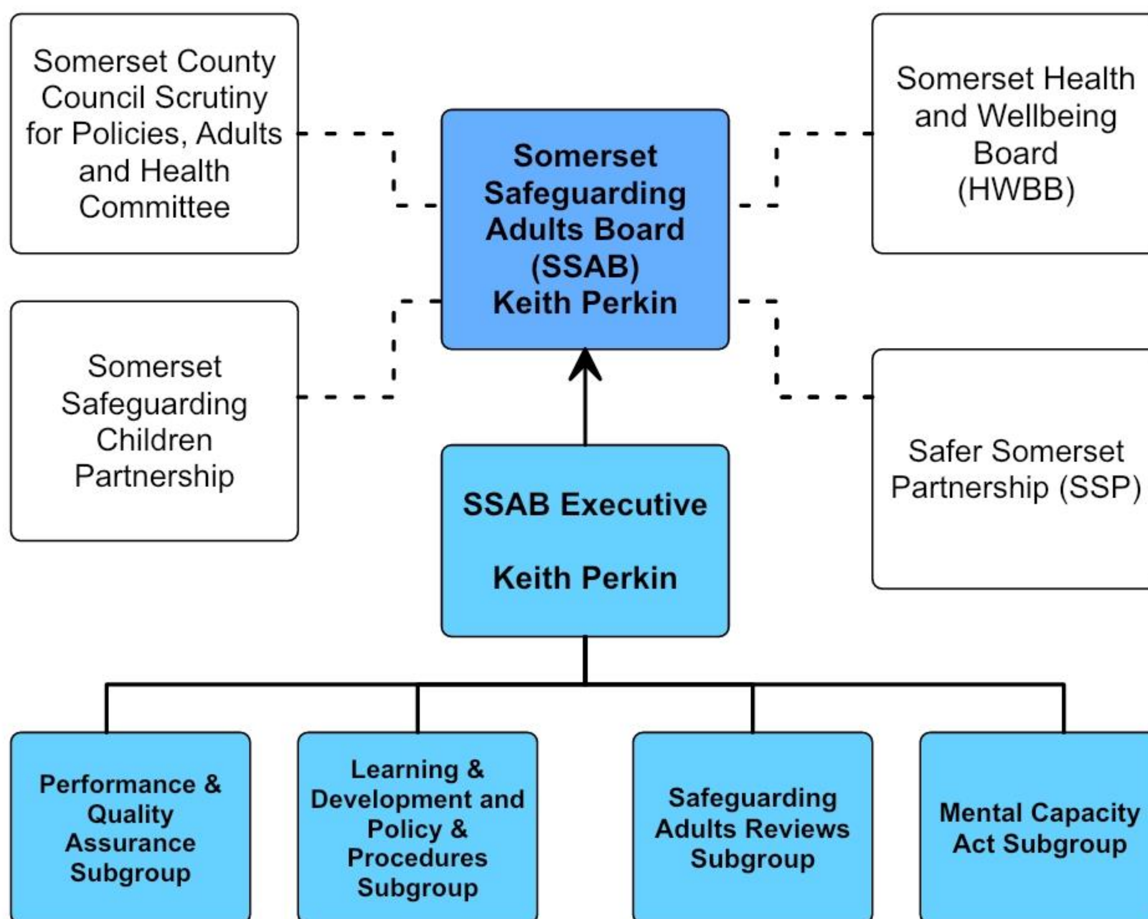
The Safeguarding Adults Board met on 3 occasions during 2021/22 – June, October and February.

In brackets below is the number of times each organisation was represented during the year at these meetings[2].

Organisation	Attendance
Avon & Somerset Constabulary	66% (2/3)
Care Quality Commission	0% (0/3)
Department for Work and Pensions	100% (3/3)
Devon & Somerset Fire and Rescue Service	33% (1/3)
Devon, Somerset and Torbay Trading Standards Service	0% (0/3)
Discovery	100% (3/3)
District Council representative	100% (3/3)
Golden Lane Housing	66% (2/3)
Healthwatch Somerset	66% (2/3)
Housing Representative	66% (2/3)
Marie Curie Somerset	0% (0/3)
National Probation Service	100% (3/3)
NHS England and Improvement (South West)	66% (2/3)
NHS Somerset Clinical Commissioning Group	100% (3/3)
Public Health	100% (3/3)
Public Health (Community Safety)	100% (3/3)
Registered Care Providers Association	0% (0/3)
Representative of people who use services	0% (0/3)
Shared Lives South West (Somerset)	66% (2/3)
Somerset Care Ltd	100% (3/3)
Somerset County Council	100% (3/3)
Somerset NHS Foundation Trust	100% (3/3)
South Western Ambulance Service NHS Foundation Trust	0% (0/3)
Swan Advocacy	100% (3/3)
Voluntary sector representative	0% (0/3)
Yeovil Hospital NHS Foundation Trust	100% (3/3)

[2] By the agency representative themselves or an appropriate agency substitute

Board structure as at 31/03/2022



During 2021/22 the following change were made to the Board's subgroup Structure:

- The previously sperate Policy & Procedures and Learning & Development subgroups were merged
- The Quality Assurance Subgroup had the monitoring of Performance across the system added to remit.

There are strong synergies between the work of the SSAB and other key partnerships in the locality, including the statutory Safeguarding Children Board, Health and Wellbeing Board and local Community Safety Partnership.

It is important the Board has effective links with these groups in order to maximise impact, minimise duplication and seek opportunities for efficiencies in taking forward work.

4. Safeguarding in numbers

How much abuse and neglect was reported during 2021/22?

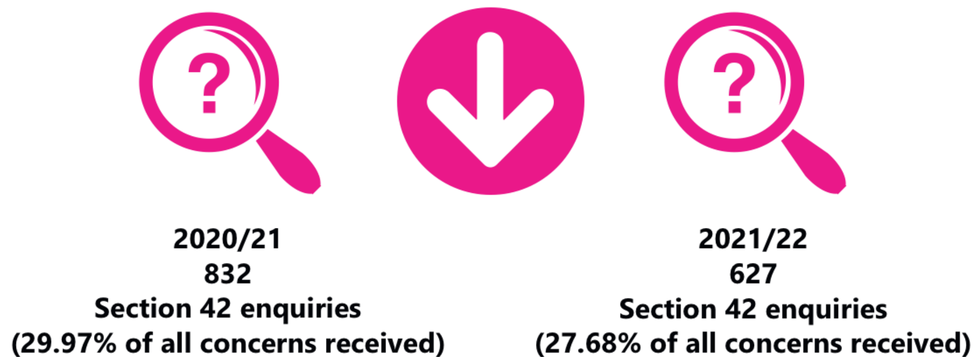
Safeguarding concerns reported to the Local Authority in 2021/22

2020/21
2776
Concerns

2021/22
2265
Concerns

This was a decrease of 511 (18.41%) compared to the previous year.
Of the 2265 concerns, 4 (0.18%) were raised by the adult themselves. This compares to 17 (0.61%) in 2020/21.

Safeguarding concerns received that required a statutory response in 2021/22



2020/21
832
Section 42 enquiries
(29.97% of all concerns received)

2021/22
627
Section 42 enquiries
(27.68% of all concerns received)

This was a decrease of 205 (24.64%) compared to the previous year. In addition, a further 30 non-statutory enquiries were carried out.

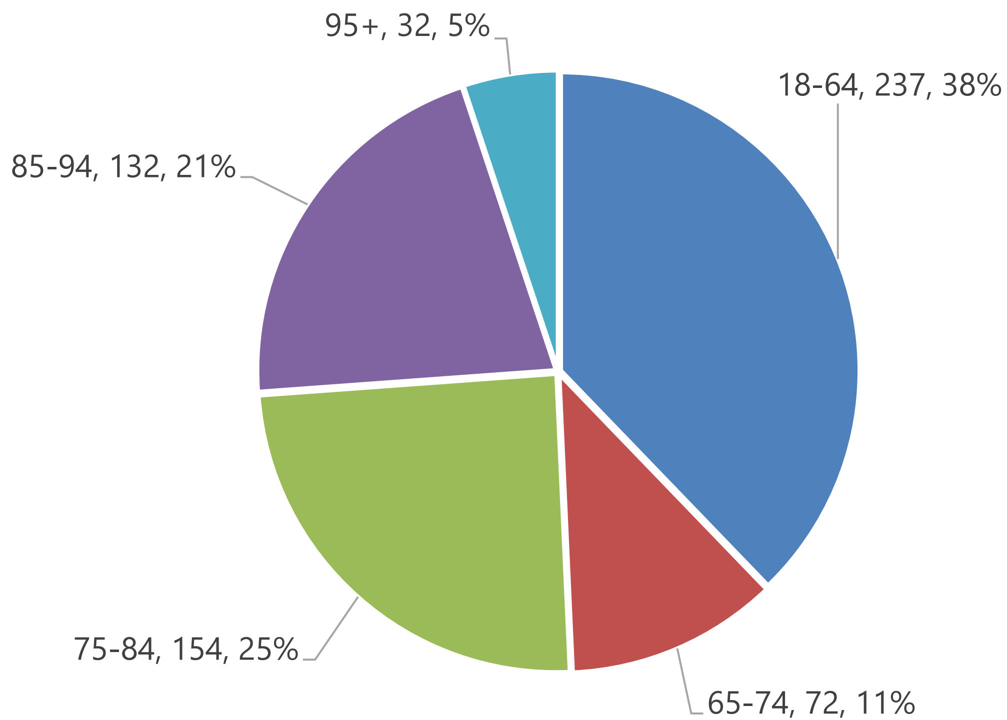
Who was at risk of abuse and neglect in 2021/22?

The majority of individuals that required a statutory response were Female

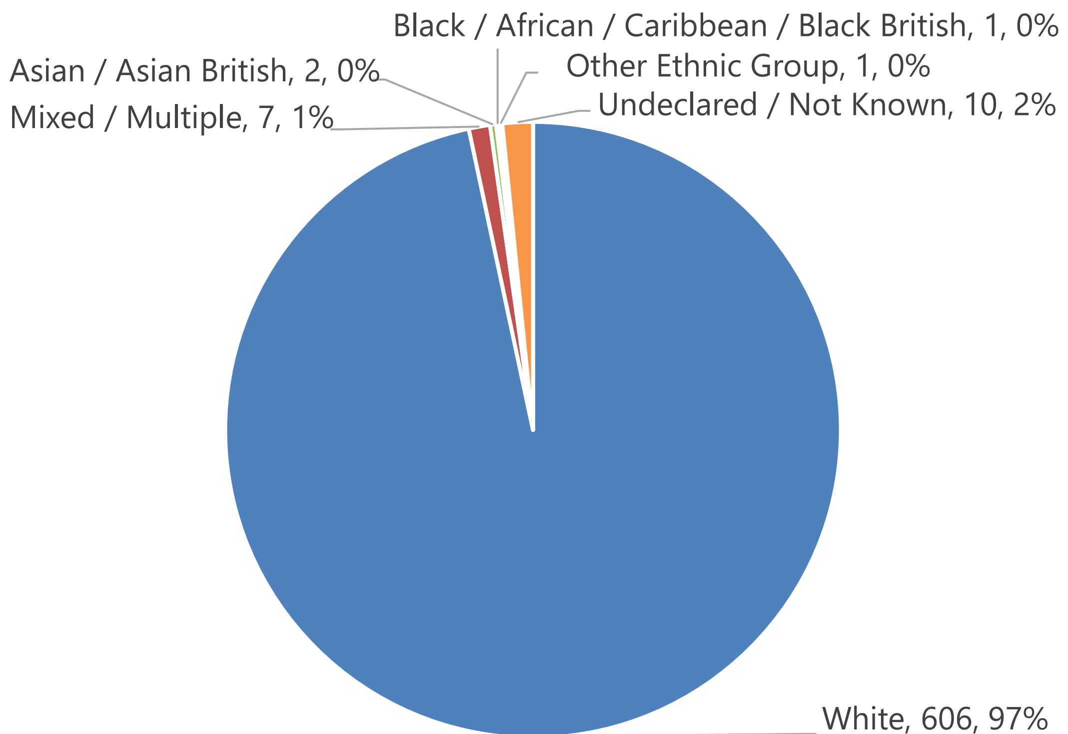
Females
387
(61.72%)

Males
239
(38.12%)

The majority of individuals where the concern resulted in an enquiry under section 42 of the Care Act (2014) were aged 65 and over

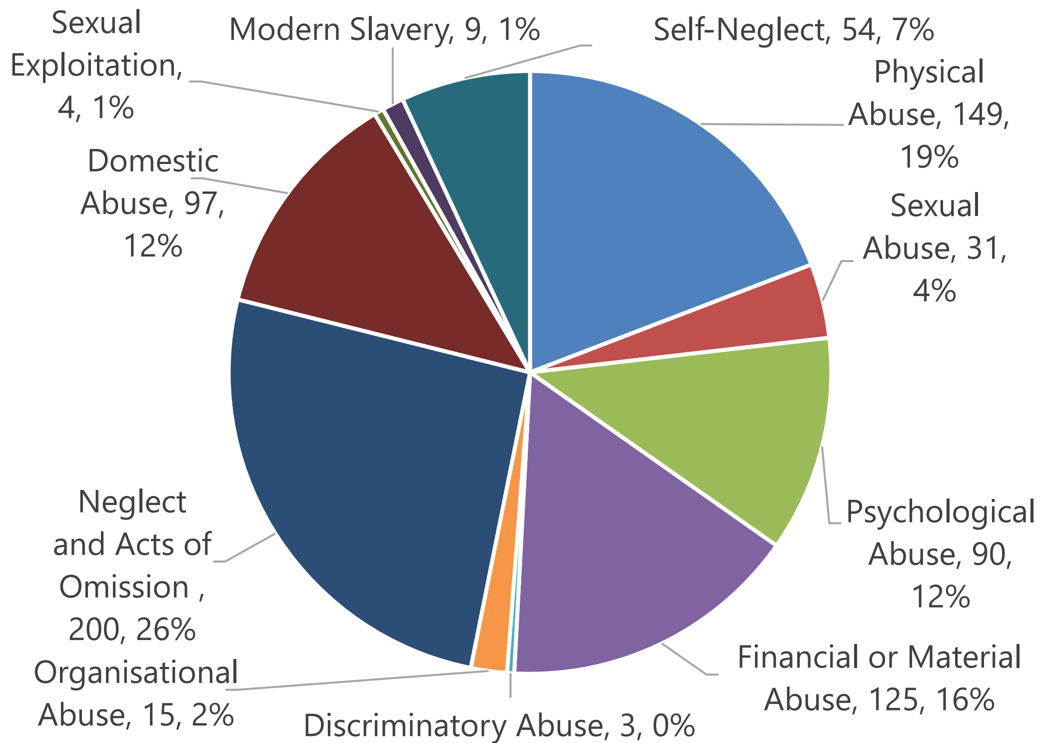


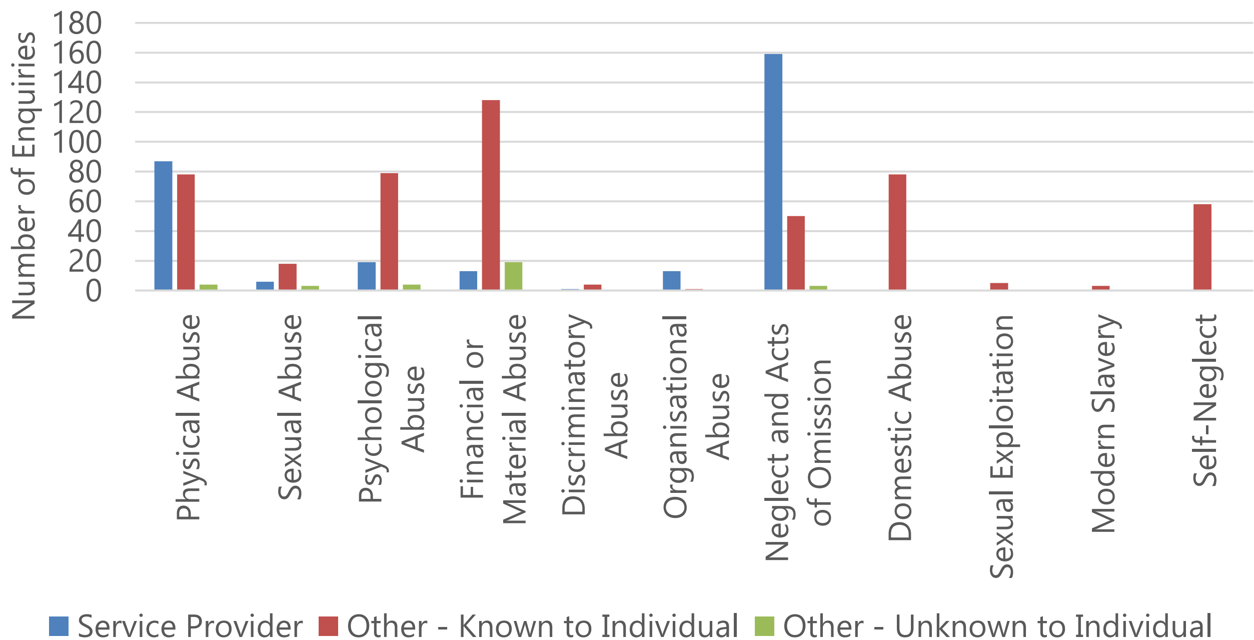
The majority of individuals where the concern resulted in an enquiry under section 42 of the Care Act (2014) were from white ethnic backgrounds



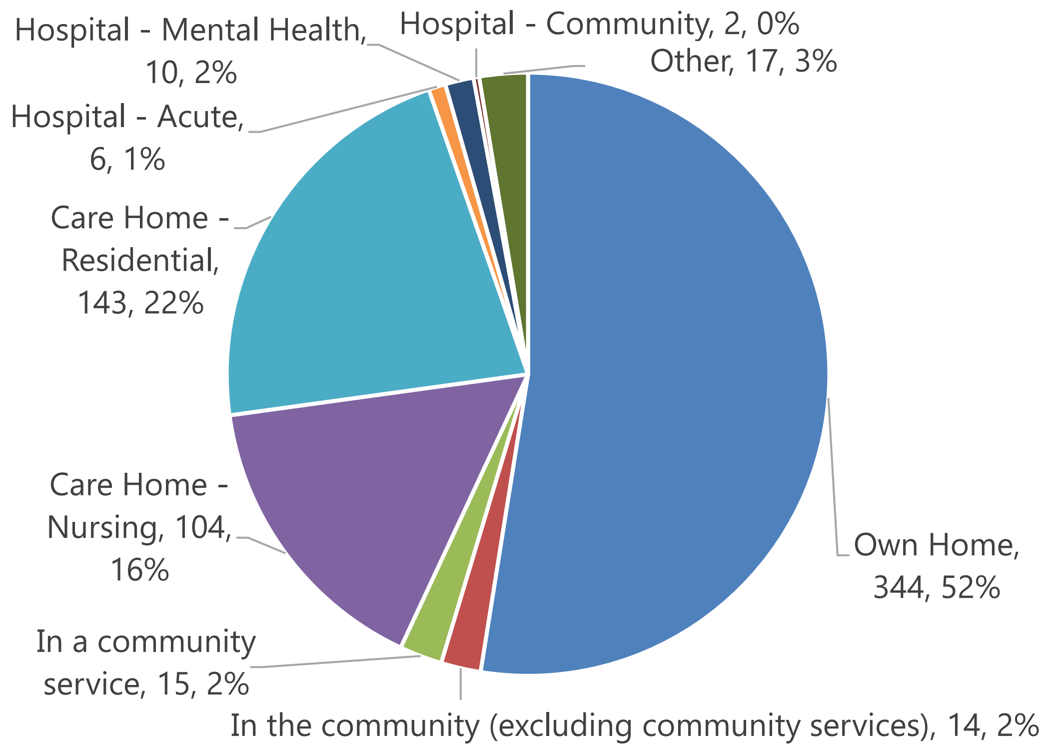
Type of abuse and source of risk

The most common risk type was Neglect and Acts of Omission, which accounted for 26% of risks, followed by Physical Abuse at 19% and Financial or Material Abuse at 16%.



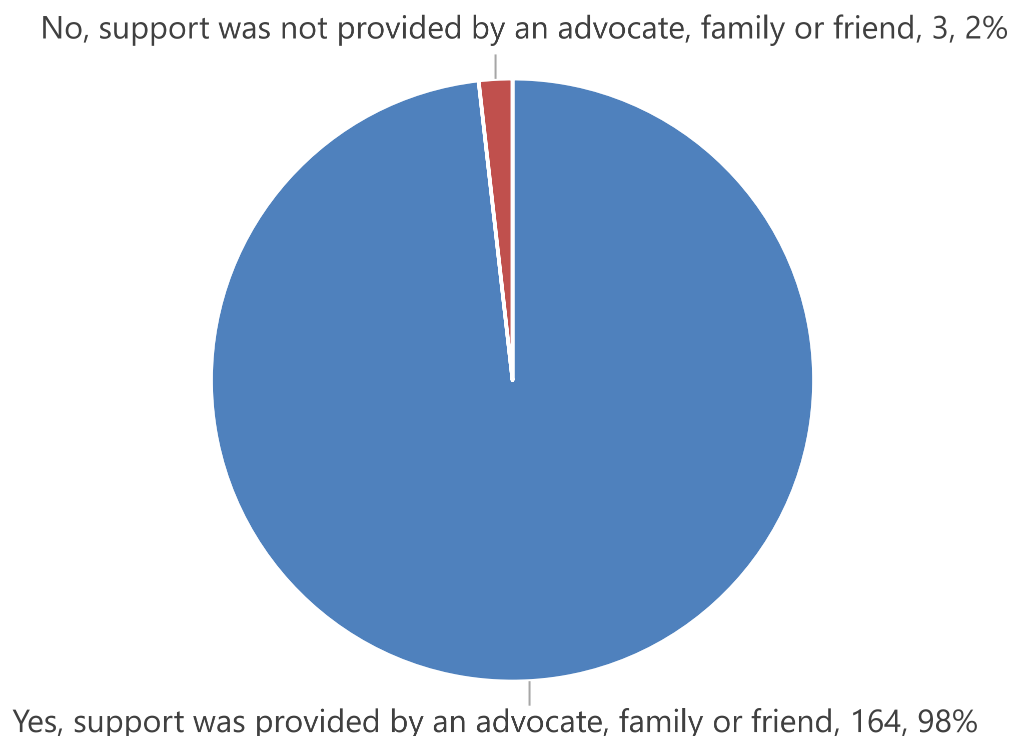


The most common location where people were identified as being at risk was in their own home (52%), followed by in a residential care home (22%)



Mental Capacity

In 167 cases the adult at risk was assessed as lacking capacity to make decisions related to the safeguarding enquiry.
In the majority of these cases they were supported by an advocate, family or friend

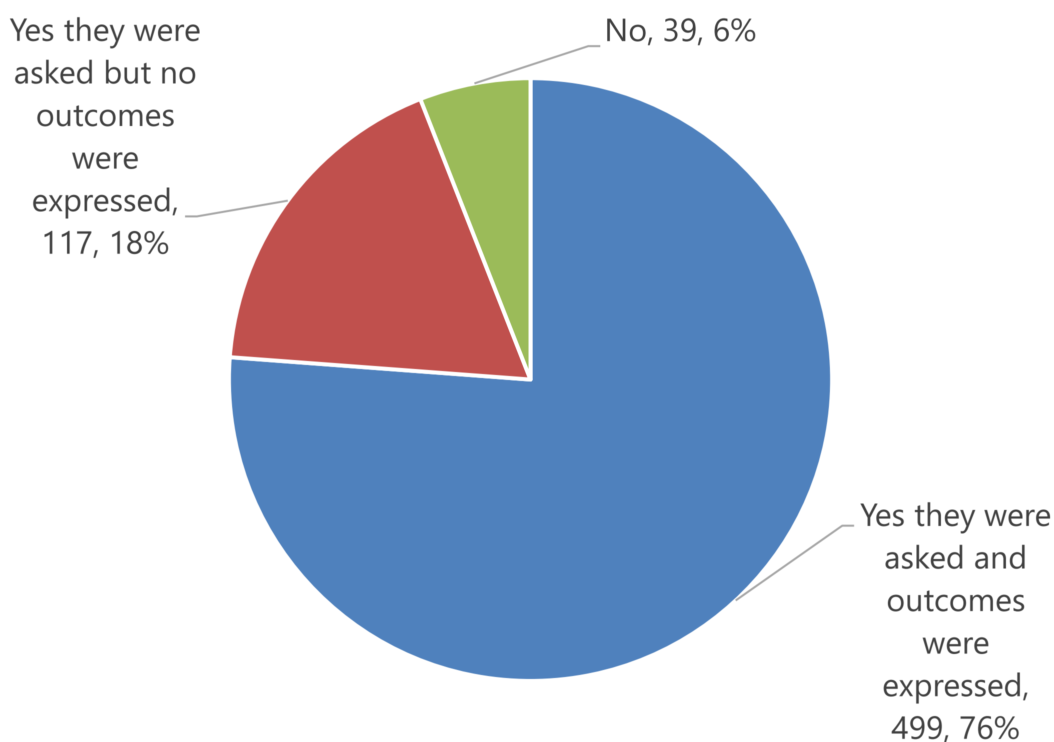


Making Safeguarding Personal

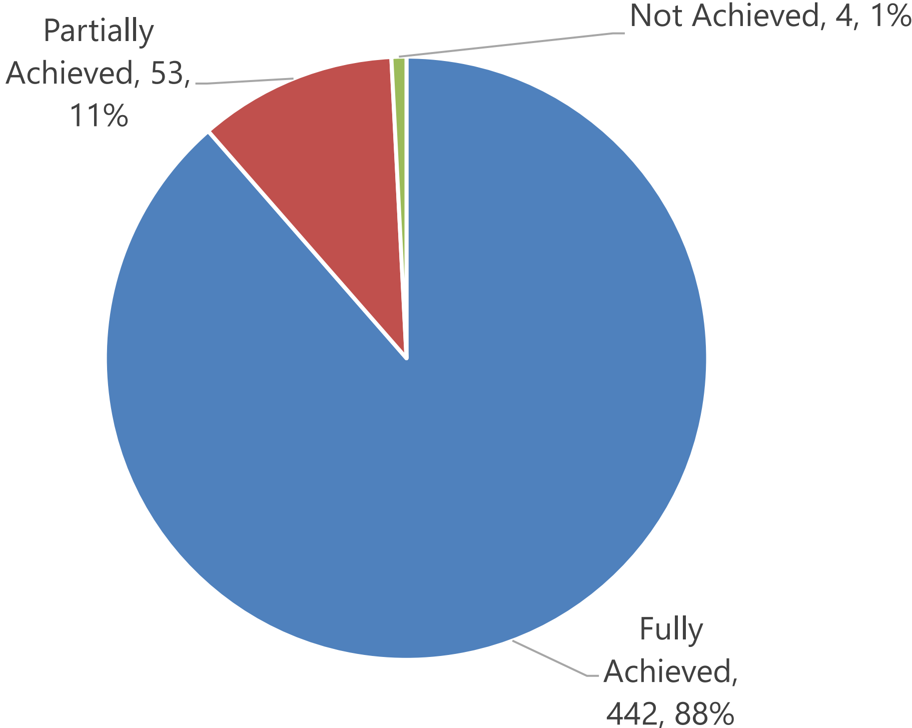
What does Making Safeguarding Personal mean?

Making Safeguarding Personal (MSP) is about having conversations with people about how we all might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing, and safety. It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process. The extent to which local services are adopting an MSP approach has been monitored by the SSAB via its annual organisational self-audits, designed to give assurance to the Board of local practice.

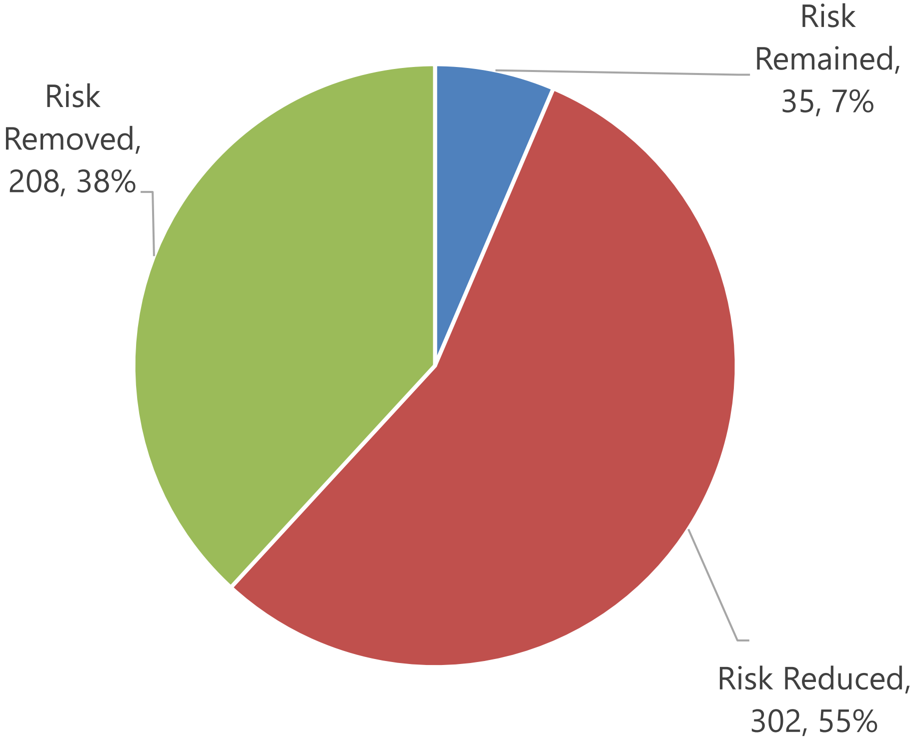
The majority of people, or their representative, were asked what their desired outcomes were



In 99% of cases where desired outcomes were stated they were either partially of fully achieved



Outcomes of enquires made under Section 42 of the Care Act (2014)



5. Safeguarding Adults Reviews

All safeguarding is complex, challenging work but this is never more so than when an individual dies or is seriously harmed through abuse or neglect. The impact on families, carers and the professionals involved should not be under-estimated, and is never taken lightly by any organisation or professional.

A vital role of the Board is to seek assurance on the effectiveness of local safeguarding activity and to ensure practice continually improves. It is required to commission Safeguarding Adults Reviews (SARs) to identify whether lessons can be learnt about the effectiveness of multi-agency working to safeguard adults at risk.

> The Care Act 2014 states that a Safeguarding Adults Review (SAR) must be arranged by the Safeguarding Adults Board when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and when there is concern that partner agencies could have worked more effectively to protect the adult. A SAR must also be arranged if an adult has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

SARs are demanding pieces of work and are dependent on the openness and reflection of agencies involved to identify what worked well and what could have been better.

The SSAB has a multi-agency SAR subgroup whose role it is to ensure statutory requirements are met in relation to reviews, and the quality assurance of review reports. The subgroup is chaired by a Detective Inspector from Avon & Somerset Constabulary's Major and Statutory Crime Review Team.

Where a case meets the criteria, and it is not possible to demonstrate the necessary degree of independence from within the partnership, the Subgroup will oversee the appointment of an independent, external Chair and/or Review Author. Where independence can be demonstrated from within the partnership, for example where the review can be chaired by a senior representative from a partnership agency with no involvement in the case, the Board has developed a local review process which is similar to that used by some other Boards.

One Safeguarding Adults Reviews concluded during 2021/22, and this is summarised below. A further eight reviews are at different stages, and are being progressed by the Board's SAR Subgroup. None of these Reviews relate to the Coronavirus Public Health Crisis.

'Matthew' Safeguarding Adults Review

Background

A report was published by the Somerset Safeguarding Adults Board on 14/12/2021 and documents the events leading up to Matthew's death (pseudonym), in hospital, in January 2018.

Matthew had a history of multiple and complex health problems, including substance misuse, type two diabetes, chronic obstructive pulmonary disease (COPD) and skin infections. The day before his admission to the hospital where he died, Matthew had declined a planned admission to a community hospital and was found at home drifting in and out of consciousness by staff employed by a care agency. Matthew was admitted to the emergency department with pneumonia and type 2 respiratory failure. Hospital records state that he had been bedbound for a long period of time and had become unable to roll causing pressure damage to his skin.

Prior to his death, organisations were attempting to support Matthew in relation to his history of neglecting his own health and well-being. Matthew's case highlights the difficulties organisations face in supporting people with complex health and social care needs, who want to maintain their independence and decision making.

Findings and areas for learning and improvement

Responding to changes in need: Matthew was clearly deteriorating for several weeks leading up to his death. A short period of access to 24-hour care may have provided an opportunity to work with Matthew and could have prevented some of his early deterioration. A successful planned admission to a care home placement or a community hospital may have provided an opportunity to work more effectively with Matthew to prevent further deterioration. Neither happened. Professionals should take into consideration information that indicates that an adult's health and/or situation is on a deteriorating trajectory and respond in a timely way.

Involving other organisations: While the safeguarding response was considered to have been appropriate when referrals were made, it is unclear

why concerns were not raised about Matthew's physical health much earlier in 2017. The professionals supporting Matthew were clearly concerned, but they appear to have attempted to manage the situation themselves until a critical stage was reached. Professionals should involve the other professionals and/or organisations that are/need to be involved in supporting an adult in multidisciplinary approaches and meetings in order to avoid 'firefighting' concerns in isolation.

Multi-Disciplinary Meetings: While there was a multi-disciplinary meeting in March 2017, no notes appear to have been taken and opportunities were not taken for all those involved in supporting Matthew to meet again to consider how to support him. A record must be made of all meetings, actions and who has/the organisation that has responsibility for carrying them out. This record must be shared with all the professionals/ organisations that are involved to avoid working in isolation.

Joint Working: The review identified learning that, in situations where multiple organisations are working to enable someone to be transported that requires specific logistical arrangements, this should be coordinated by a single individual/organisation, with all organisations taking ownership and accountability for ensuring that the elements they are responsible for are delivered. There should have been agreement of a lead agency and/or professional to co-ordinate the transfer.

If plans change: When plans change, each professional/ organisation has a responsibility to inform the professional/organisation with the agreed coordination responsibility. This serves to ensure that changes to the agreed plan can be communicated to all the professionals/ organisations involved so that everyone is aware and can agree any new actions that are required. For example, in Matthew's case his decision not to be admitted to the Community Hospital when the ambulance arrived to take him, should have been communicated to all involved, who then should have reconvened to reassess the risk and agree the next plan of action.

Recording when an adult's capacity is considered: While in no way suggesting that Matthew did not have capacity at any point, at different times during the period under consideration, professionals had said that they had questioned if Matthew had the capacity to make some of the decisions that he was choosing to make. Unfortunately, the recording of information relating to this was poor. Professionals should record all occasions where an adult's capacity has been considered and why. Where there is a concern about the

decisions an adult is making, consider how the underlying reasons for this can be explored with the adult and record this.

Decisions about health and care when an adult is incapacitated: Matthew had clearly expressed a view to multiple professionals that he did not wish for his family to be involved in his life or know about his health. However, on admission to hospital his family was contacted. It is unclear whether the staff who made the decision to involve Matthew's family in decisions about the ending of his treatment were aware of his wishes at the time. If an adult who has previously expressed a clear wish that their family should not be involved in decisions about their health and care becomes incapacitated, professionals should arrange for the involvement of an Independent Mental Capacity Advocate (IMCA) in relation to this decision.

Recommendations where further assurance is being sought the recommendation has been completed or implemented:

	Summary of Recommendation
1	That the Somerset Safeguarding Adult Board ensures that the learning from this Review is shared with: • All providers of domiciliary care operating in Somerset • The Somerset Registered Care Provider Association (RCPA) • The Care Quality Commission • The Local Medical Council • Employees of Somerset County Council's Adult Social Care Service • Employees of Somerset NHS Foundation Trust • NHS Somerset Clinical Commissioning Group • NHS England and NHS Improvement
2	That Somerset County Council and NHS Somerset Clinical Commissioning Group undertake an exercise to evaluate current capacity within the registered care homes in Somerset to support adults with bariatric needs and, should any gaps be identified, develop a plan to address them.
3	That Somerset County Council's Adult Social Care service provides the Somerset Safeguarding Adults Board with evidence that its staff are aware of the process of how to initiate the process for applying for Continuing Healthcare funding, and the local policies and procedures related to doing so.
4	That Somerset County Council, and Somerset NHS Foundation Trust, ensure that there are appropriate arrangements in place to: • Ensure that an adult's wishes are sought, known and understood in any safeguarding process

	• Share, and where appropriate escalate, concerns about an adult's responses with other professionals that are involved in supporting them • Allow professionals to balance the adult's rights, in line with the Care Act (2014), Human Rights Act (1998) and Equality Act (2010), with an assessment of any risks posed.
5	That all Somerset Safeguarding Adults Board member organisations actively promote "What to do if it's not Safeguarding?" within their organisations, and remind staff of the importance of clear minutes being taken of any multi-disciplinary meetings that take place (which include clear actions allocated to named professionals/organisations and shared with all involved in the meeting); and of any capacity assessments undertaken.
6	That where a complex transfer is being considered that involves multiple organisations a lead professional is identified (in most cases this will be an employee of the organisation with the lead responsibility for commissioning the adult's care and support) to coordinate the process, ensure decisions are made in a timely way and that actions are both allocated to named individuals and followed up on to ensure that they have been carried out as agreed. They should also act as the point of contact if the plan cannot be carried out as agreed.
7	That Somerset NHS Foundation Trust and Yeovil Hospital NHS Foundation Trust review their policies and guidance for staff in relation to circumstances where an adult is unable to express their wishes for themselves, but have previously expressed a clear wish that their family should not be involved in decisions about their care.

Updates on reviews published in previous years

The SSAB Executive Group monitors the progress of work to address the recommendations made by all SARs each time it meets, and requests evidence that any action has been completed before agreeing that it has been completed. Progress updates regarding those recommendations that were outstanding as at 01/04/2021 are included below:

'Luke' Safeguarding Adults Review (published 18/08/2021)

The review made 12 recommendations, of which 7 were still open on 01/04/2021. As at 31/03/2022 the status of each was as follows:

Recommendations where assurance has been received that the recommendation has been completed or implemented:

	Summary of Recommendation
1	That the SSAB ensures that the learning from this Review is shared across the local system
12	For the SSAB's Policy and Procedures Subgroup to develop guidance for staff working with adults who may make disclosures regarding alleged non-recent incidents involving children with the Somerset Safeguarding Children Partnership.

Recommendations where further assurance is being sought the recommendation has been completed or implemented, or where audits have been requested to test compliance:

	Summary of Recommendation
5	That the Community Podiatry Service confirms the contact that they have had with an individual to their GP when closing a case, unless the closure is because the person has died.
6	That, when recording information about an individual's weight, all providers of residential care and nursing care operating in Somerset record the actual weight and the unit of measurement at the time of documenting the calculation, as well as the BMI, in order to mitigate against the potential for mathematical errors in calculations. Where someone cannot be weighed physically, and the Measuring mid-Upper Arm Circumference (MUAC) is used in place of the individual's weight, the measurement should be recorded. In addition, if an adult's BMI is requested by a GP or other health professional, their weight should also be provided alongside the BMI, or if the MUAC has been provided in place of the BMI then this should be clearly stated.
7	Where a provider of care and support to adults has concerns about an individual self-neglecting these should be documented alongside details of any capacity assessments, and the approaches used to explore the reasons for their behaviour and support them to address their self-neglect that are tailored to their individual needs and circumstances.
8	If a provider of care and support to adults is experiencing difficulty in confirming capacity because of lack of engagement, and the consequences of the decision outcome could result in harm to the person, then they should have arrangements in place to escalate this to the relevant Commissioner or Somerset County Council's Safeguarding

	Service for advice; or to call a Multi-Disciplinary Team meeting as appropriate to the circumstances of the case.
9	That, on advising that a re-referral be made for memory assessment, that Somerset NHS Foundation Trust provide clear criteria to the adult's GP for when this should be considered within any discharge letter.
11	For the SSAB's Policy and Procedures Subgroup to review its existing self-neglect guidance to ensure that the fact that it is applicable to the specific circumstances where there are concerns about an adult living in a registered care environment self-neglecting is explicit.

Damien Safeguarding Adults Review (published 31/03/2021)

The review made 10 recommendations. As at 31/03/2022 the status of each was as follows:

Recommendations where assurance has been received that the recommendation has been completed or implemented:

	Summary of Recommendation
1	Written guidance is produced, or where already available reviewed, by Somerset County Council and Somerset NHS Somerset Foundation Trust for use by all staff tasked with finding appropriate accommodation for people with complex needs. This SAR should also be shared with other commissioning agencies who were not involved in the case in order that they are aware of the learning from this case.
2	That decision-making processes for commissioning services for individual adults are reviewed by Somerset County Council, and Somerset NHS Foundation Trust to ensure that they produce timely decisions, and that the process is shared with the person themselves and, where applicable and appropriate, those who are important to them.
4	Written guidance is produced by Somerset County Council and Somerset Foundation Trust that details the required content of care plans in circumstances when the care of an adult with complex needs is transferred to another setting (including where the commissioner is employed by another organisation that has a delegated role).
5	That all organisations involved in providing care and support to Damien ensure that Mental Capacity Act training of their staff addresses the influence of coercion and exploitation on people with complex needs,

	and that quality monitoring processes are used to test that it is being addressed in practice.
6	All organisations involved in the care of Damien should review their risk assessment processes, considering the key areas highlighted in the report.
7	All organisations involved in the care of Damien should review the training that their staff undertake in respect of risk assessment and management to ensure that it addresses the issues identified in this SAR.
9	Somerset County Council and Somerset NHS Foundation Trust should reinforce the requirement that, where adults with complex needs have given consent to involve family in their care or where they lack the capacity to decide about family involvement, but it is considered in their best interests to involve them.

Recommendations where further assurance is being sought the recommendation has been completed or implemented, or where audits have been requested to test compliance:

	Summary of Recommendation
3	That the Somerset Safeguarding Adults Board seeks assurance from Mendip District Council, Sedgemoor District Council, Somerset West and Taunton District Council, South Somerset District Council, and Somerset County Council that there is a shared commitment to joint action across local government, health, social care and housing sectors in Somerset to support the needs of adults with autism.
8	The Somerset Safeguarding Adults Board should write to the Safer Somerset Partnership to ask it to review how information is brought together and shared in order to inform risk management, in particular in relation to the role of MAPPA where an adult is experiencing mental ill-health, and to implement any changes identified as a result.
10	That the Somerset Safeguarding Adults Board seeks assurance that organisations are able to demonstrate that assessments are holistic.

6. Our priorities for 2022/23

The Board recognises more can be achieved by working together in partnership, and has identified four strategic objectives for it's strategic plan for 2022-2025, which will be refreshed annually:

1. **Listening, learning and Improving:**
   - The principles of Making Safeguarding Personal are embedded in every-day practice across the system so that safeguarding is person-led, outcome-focused, enhances involvement, choice and control, and improves quality of life, wellbeing and safety.
   - We use learning and best practice from within Somerset and elsewhere to enhance practice across the Somerset system.
   - We will be open to constructive criticism, and take appropriate action to reduce risk and improve safeguarding practice within Somerset.
   - Professionals are focused on prevention and, where appropriate, proactive intervention
2. **Enabling people to keep themselves safe:**
   - People are aware of what abuse and neglect is, and how to keep themselves and those that they care for safe
   - People know what to do if they think that they or others are experiencing abuse or neglect
3. **Working together to safeguard people who can't keep themselves safe:**
   - Organisations, including the third sector, work together to ensure that multi-agency arrangements are effective, and that people who are unable to keep themselves safe are supported in a way that works for them in line with the principles of Making Safeguarding Personal
   - Policy and guidance reflect best practice and takes a positive approach to risk
   - There is effective working across local, regional and national partnerships on areas of mutual interest
4. **How the Board Works:**
   - Somerset has an effective Safeguarding Adults Board which fulfils its statutory responsibilities, has strong leadership and governance arrangements, and promotes a culture of collective accountability, respectful challenge and continuous learning
   - The Board uses data appropriately to understand where risk exists within the system

- The Board can demonstrate progress through the regular monitoring of performance

You can read our 2021/22 Strategic Plan in full on our website.

7. Board Budget

		2021/22	
SOURCE OF FUNDS		**CONTRIBUTIONS £**	**%**
Somerset County Council	- SAB Manager & Independent Chair	56,184	57.6%
	- Safeguarding Adults Reviews	5,160	5.3%
Avon & Somerset Constabulary	- SAB Manager & Independent Chair	15,900	16.3%
	- Safeguarding Adults Reviews	5,170	5.3%
NHS Somerset Clinical Commissioning Group	- SAB Manager & Independent Chair	10,000	10.2%
	- Safeguarding Adults Reviews	5,170	5.3%
TOTAL CONTRIBUTIONS		**97,584**	**100.0%**
APPLICATION OF FUNDS		**EXPENDITURE £**	**%**
PAY (including overheads)			
Safeguarding Board Manager		61,345	65.9%
Independent Chair		15,923	17.1%
Non pay			
Safeguarding Adults Reviews		15,500	16.6%
Insurance		49	0.1%
Equipment – IT hardware		70	0.1%
BT charges/mobile charges		258	0.3%
TOTAL EXPENDITURE		**93,145**	100.0%

An agreement remains in place to split the costs of any Safeguarding Adult Review equally between Avon & Somerset Constabulary, Somerset Clinical Commissioning Group and Somerset County Council separately to the Board's core funding.

8. Our work during 2021/22

The SSAB identified the following four objectives within its Strategic Plan for 2019-22:

1. Listening and learning
2. Enabling people to keep themselves safe
3. Working together to safeguard people who can't keep themselves safe
4. Making sure we do what we said we would do

During 2021/22 the Board's work was, for the second year in succession, significantly impacted by the Coronavirus Public Health Crisis, and while it continued to carry out its statutory duties much of the developmental work of its Subgroups was reduced so that partner organisations could focus on their response to the crisis. In addition, during the Public Health Crisis, the Board continued to provide support to the wider health and care system by hosting a "Coronavirus updates for Somerset Adult Care Providers" page on its website that was updated daily with the latest guidance from Mary 2020 until it moved to a provider webpage hosted by Somerset County Council at the end of 2021. It also supported work to manage the administration of Covid-19 grant monies to care providers trough to March 2022, and to provide a weekly briefing to care providers until this was also transferred to Somerset County Council.

Priority Area 1: Listening and learning

What SSAB said it would do	What the SSAB did
Develop consistent and effective processes and communication channels to inform our work. We will do this by using the views of, and learning from, people who have experienced safeguarding and	• Following receipt of a report by Healthwatch Somerset at the end of 2018/19 the Board worked with Somerset County Council, as the agency with lead responsibility for adult safeguarding, to monitor the implementation of the agreed actions. Following delays caused by the Coronavirus Public Health Crisis the new feedback process was put in place at the beginning of May 2021.

What SSAB said it would do	What the SSAB did
their carers, both provided directly to the Board and through partner organisations, including the third sector.	• Feedback levels to date, while higher than the previous system achieved cumulatively over 5 years, have been lower than hoped despite promotion to, and by, partner organisations. • Feedback has been incorporated in to a newly developed SSAB Dashboard which is managed by the Performance and Quality Assurance Subgroup, and presented to the Board each time it meets. • The Board has continued to monitor the extent to which people are reporting their desired outcomes have been achieved as part of its performance reporting mechanisms. Figures for the 2021/22 year are shown in Section 4 (page 11) with 99% of people, or their representatives, reporting their desired outcomes had been wholly or partially achieved. • Due to the coronavirus pandemic, during 2021/22 we were not able to arrange for anyone who had direct experience of safeguarding in Somerset to talk to the Board in person due to the on-going restrictions, however we intend to resume inviting them from our October 2022 meeting onwards. • To ensure an effective link between senior leaders on the Board and those who provide a direct safeguarding service, the Board received presentations from the Lighthouse Safeguarding Unit and care providers on the challenges they have faced, as well as written feedback from the family of Damien who were unfortunately unable to join the meeting in person.
Provide multi-agency Safeguarding Adults learning opportunities to raise the profile of adult safeguarding, address areas of	• Best practice continued to be identified and shared on a regular basis through the SSAB website, social media and Somerset County Council's weekly care provider bulletin, which the Board supported the production of during the year.

What SSAB said it would do	What the SSAB did
practice improvement and share lessons learnt from Safeguarding Adult Reviews.	• Due to the Board supporting other communications work in response to the Coronavirus Public Health Crisis, we continued to publish, albeit on a reduced capacity, a newsletter. The Board has now resumed its normal newsletter schedule. • The Performance and Quality Assurance subgroup has been monitoring the levels and types of safeguarding concerns for adults at risk throughout the year, including working to understand any variations compared to the previous two years. While there were some variations in the types of abuse being reported, it was satisfied that the system in Somerset was responding to referrals appropriately. • The Board led a regional webinar on "Promoting Safer Cultures" during the national Safeguarding Adults Week in November 2021, and a webinar on "Professional Curiosity" in March 2022. Surveys were carried out before and after the Professional Curiosity webinar to gauge the impact and identify topics for future webinars.
Implement the recommendations of "Analysis of Safeguarding Adult Reviews April 2017 – March 2019" that are applicable to individual Safeguarding Adults Boards, and contribute to regional and national workstreams for others where appropriate.	• A presentation on the findings of the National Analysis was presented to the Board in October 2021 • All recommendations for local Safeguarding Adults Boards have been RAG rated and are being monitored by the Board's SAR Subgroup • To date, of the 18 recommendations that apply to local Boards 11 have been completed and 7 remain outstanding. Of those outstanding: ○ One is contingent on work that is taking place nationally, that will then need to be implemented locally

What SSAB said it would do	What the SSAB did
	○ One relates to public information that is in the process of being developed both locally and nationally ○ One relates to a recommendation that has national, regional and local elements which require further exploration to establish what work needs to be completed by the SSAB ○ Four relate to assurance within the local system, which the Board's Performance and Quality Assurance Subgroup is working to establish whether the information is already available in a different from before considering additional auditing activity.
Identify learning for the adult safeguarding emerging from Covid-19, including if there are any new and/or emerging Safeguarding Adults priorities that have arisen both as a result of the pandemic and the reducing lockdown measures	The Board and its Executive Group has been regularly monitoring the response of the system, which appears to have responded effectively with no significant additional priorities emerging. The Board has also supported work by the Local Government Association (LGA) and Association of Directors of Adult Social Services to gain additional insight in to safeguarding data during the Coronavirus Public Health Crisis nationally, and the Board wishes to thank Somerset County Council's safeguarding service for its support with this work. During the year, the Performance and Quality Assurance subgroup and Executive Group reviewed two national reports produced by the LGA that showed comparative data for Somerset with other areas. At present Somerset appears to be an outlier in terms of a declining number of referrals compared to other areas. Analysis suggests that this is as a result of the significant work that has been undertaken by Somerset County Council's Safeguarding Service, the SSAB and Somerset Direct over recent years

What SSAB said it would do	What the SSAB did
	to improve understanding of adult safeguarding criteria, and reduce or redirect the previously high numbers of inappropriate safeguarding contacts. However, additional monitoring will take place during 2022/23 to test this analysis and provide assurance to the Board.

Priority Area 2: Enabling people to keep themselves safe

What SSAB said it would do	What the SSAB did
Work together with the Safer Somerset Partnership, and Somerset Safeguarding Children Partnership to supported work to raise awareness of, and reduce the harm caused by 'Hidden Harms', and abuse associated with County Lines activity, domestic abuse and modern slavery. Implement that Board's communication plan, developed during 2020/21 which is aligned with local, regional and national campaigns.	• The Board has continued to be represented on, and support the work of other Boards. This included promoting information about Domestic Abuse as the Domestic Abuse Act was implemented, and the inclusion of learning from Child Safeguarding Practice reviews in its October newsletter. • New public facing materials have been developed by the Policy and Procedures Subgroup which have been promoted with partners and via social media on Mate Crime, and the Board was also kindly given permission by another Safeguarding Adults Board to adapt an animation to go alongside it called 'Tricky Friends" • New public facing materials that were published on 31/03/2021 have continued to be promoted. • As in previous years each Safeguarding Adult Board in the Avon and Somerset Constabulary area undertook to promote adult safeguarding through the annual 'Stop Adult Abuse Week'. From 2021 it was agreed that this would move to November to coincide with the National Safeguarding Adults week promoted by the Ann Craft Trust.

- Throughout the year the SSAB worked to raise awareness of abuse and neglect. This included using our website and growing social media profile to promote local and national publications and initiatives, including National Safeguarding Adults Week, along with the signs, symptoms and indicators of abuse and neglect (which form part of a regional multi-agency policy).
- The SSAB once again ran a campaign on social media - #12DaysOfSafeguarding - over the Christmas and New Year period, which saw good levels of engagement.
- The SSAB continues to maintain a website that contains information on its structure and work, as well as publications and links to those of other organisations. Use of this site has averaged 4234 sessions each month following on from the significant growth that was achieved during previous years. New content has continued to be added, and existing content reviewed, by the Board's Learning and Development & Policy and Procedures Subgroup.
- The SSAB Business Manager was unable to progress the implementation of the new Communications Plan consitently due to needing to prioritise other work for the Baord and support the system response to Covid-19. However, funding for additional permanent support has been secured and it is expected that this will enable this to be revisited in 2022/23.
- Social media activity has been lower than in previous years, and has primarily focused on promoting information created by other organisations, however this is expected to return to previous levels during 2022/23.

Priority Area 3: Working together to safeguard people who can't keep themselves safe

What SSAB said it would do	What the SSAB did
Seek assurance from the Somerset care home sector on compliance with the NICE Safeguarding adults in care homes guideline, and work was a partnership to support the sector to address any gaps identified	• All care homes were invited to complete the NICE baselining tool in in Quarter 2, however the number of responses was very low, and work on this has not been progressed following advice from the National Chairs Network which had raised concerns with NICE about the guideline. • This position will be reviewed should a revised guideline be released.
Seek assurance on preparedness for the implementation of the new Liberty Protection Safeguards	• The introduction of the Liberty Protection Safeguards has been postponed, and the government has not yet published a revised implementation date with the secondary legislation still being consulted on at the time of writing. • The Board's Mental Capacity Act Subgroup has continued to monitor performance with respect to the application of the Act and the existing Deprivation of Liberty Safeguards (DoLS)
Seek assurance on the safeguarding arrangements for adults with learning disabilities, including, but not limited to, the recommendations made by the	• The Provider Collaboration Review published by the Care Quality Commission did not make any specific recommendations for the Somerset System in relation to adult safeguarding, and therefore there were no actions for the Board to seek assurance regarding. • The SSAB Independent Chair sought assurance from NHS Somerset CCG and Somerset County Council that learning identified through national

Care Quality Commission following its Provider Collaboration Review	workstreams following a high-profile Safeguarding Adults Review published by the Norfolk Safeguarding Adults Board was being taken forward in a timely way.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) have been in operation since April 2009. Since April 2013, the functioning of the safeguards has been the sole responsibility of local authorities. Each year all local authorities make a statutory return about DoLS activity to the Department of Health and Social Care (DHSC). At a national level, the statistics continue to confirm that the system is not working as it should because large numbers of requests for assessment cannot be addressed as shown in the following table showing Somerset's figures.

	2020/21	2021/22	% Change
Total applications	2576	2881	+12%
From Care Homes	1596	1782	+12%
From Hospitals	1007	1099	+9%
Assessments completed	664	672	
Authorisations granted	628	634	
Authorisations not granted/ of which not assessed	2085/2054	1984/1939	

Explanatory notes:

- A high proportion of the 'Authorisations not granted/ not assessed' were the result of death or discharge from hospital or care home prior to assessments taking place. The majority of the cases actually assessed resulted in an authorisation being granted.
- During the main period of the pandemic there was a move towards carrying out assessments remotely in many cases. During this period assessors were required to develop new assessment skills to ensure the people being assessed were able to participate as fully as possible.

- Since the autumn of 2021 there has been a move back to assessing in person and this is now the practice in many assessments.

Community Deprivations of Liberty

These are situations where a person who lacks capacity to make decisions about their care arrangements needs to be cared for in a restrictive manner but is not in hospital or a care home. An example would be a supported living service. For these people any deprivation of liberty requires authorisation form the Court of Protection. SCC has a system for identifying and prioritising such applications and is currently seeking to increase staffing resources for this to progress more swiftly.

Liberty Protection Safeguards

In May 2019 the Mental Capacity (Amendment) Act 2019 received Royal Assent and the proposed date for the implementation of the Liberty Protection Safeguards - to replace the current DoLS scheme – was set as October 2020. However, there was a significant delay in the publication for consultation of the Code of Practice and secondary legislation which was then further affected by the Coronavirus Public Health Crisis resulting in the consultation not starting until 17/03/2022. As a result, a new start date is yet to be published for the implementation of the legislation.

Somerset County Council has submitted its response to the consultation on the new MCA and Liberty Protection Safeguards Code of Practice and has worked closely with NHS partners on this. A response to the consultation is expected from the government in the Autumn at which point we anticipate the announcement of a new start date for the scheme.

In the meantime, Somerset County Council's DoLS service has continued to prioritise for DoLS assessment those situations which are most critical and to ensure that, despite the practical challenges that were created by the Coronavirus Public Health Crisis – for example needing to carry out assessments remotely – the quality of assessments and authorisations remains high. Somerset has continued to take a proactive stance in taking cases to the Court of Protection for review and decision-making when there are objections or disagreements. The Council works closely with Swan Advocacy to ensure that, whenever necessary, vulnerable people who lack capacity are provided with the support of a qualified advocate.

Priority Area 4: Board Governance

What the SSAB said it would do	What the SSAB did
Monitoring the implementation of best practice, standards, policies and actions emerging from Reviews (including, but not limited to, SARs, Serious Case Reviews, Domestic Homicide Reviews, and Learning Disability Mortality Reviews)	• The monitoring of the implementation of recommendations of published SSAB SARs is a standing item at each meeting of the Board's Executive Group. • The Learning & Development and Policy and Procedures Subgroup has the monitoring of reviews undertaken locally, regionally, and nationally to identify learning within its role. • The SSAB Independent Chair also follows up national and regional learning with the Executive Group – for example seeking assurance on the Somerset system's position with regard to national trends and in initiatives. • Learning from elsewhere continues to be shared with the system via social media and newsletters
The Board has arrangements in place to monitor performance against a range of measures from across the partnership and, in addition, to understand where risks exist within the system in order to seek assurance on the implementation of action(s) to address them.	• All recommendations from the South West Audit Partnership of the SSAB, which were reported in our 2020/21 Annual report, were signed off as having been completed by the Executive Group at the start of the year. • A new, comprehensive, Performance Dashboard has been developed by the Performance and Quality Assurance Subgroup which is being updated quarterly and circulated to all Board members in advance of every meeting. This is expected to have additional measures added from partners during 2022/23. • The Board has led on work with the four other Boards in the Avon & Somerset Constabulary footprint to introduce a new shared audit tool. This

was issued in August 2021 with a closing date for submission of October 2021. A summary of the audit has been provided below.

SSAB Annual Self-Audit 2021/22

- As part of the development of the new tool, it was agreed to move to a biennial audit cycle, with a focus on areas of improvement in the intervening year
- All SSAB members were invited to complete the audit during Quarter 2021/22 comprising of 23 areas of safeguarding practice across 7 themes, and to submit this for initial discussion by the Quality Assurance Subgroup ahead of a peer challenge process that will take place in 2022/23.
- The audit was also published on the SSAB website for any organisation to use internally.
- The key themes assessed within the audit related to:
    - Leadership
    - Evidence of Policy in Practice
    - Safer Recruitment, including people in a position of trust
    - Learning and Development, including learning from SARs
    - Making Safeguarding Personal
    - Exploitation
    - Transition
- A total of 17 organisations completed the self-audit, a significant increase over previous years
- The organisations that returned an audit were:
    - Avon and Somerset Constabulary
    - Department of Work and Pensions
    - Golden Lane Housing
    - Healthwatch Somerset
    - LiveWest
    - Mendip District Council

  - Missing Link, Next Link and Safe link
  - NHS England and Improvement
  - NHS Somerset Clinical Commissioning Group
  - Somerset and Avon Rape and Sexual Abuse Support
  - Somerset Care Ltd
  - Somerset County Council - Adult Social Care
  - Somerset County Council - Public Health Commissioning
  - Somerset NHS Foundation Trust
  - SWAN Advocacy
  - The Knoll Nursing Home
  - Yeovil District Hospital NHS Foundation Trust
- Overall, an aggregated total of 391 responses were received from the 17 organisations. Those areas where a response was not received were primarily where an area was not applicable to an organisation. For example, a number of the questions were only applicable to organisations with a commissioning function.
- Themes emerging from the audit have been considered regionally to identify areas that can be taken forward jointly, for example in the production of joint guidance.

Due to the change of template, which resulted in a smaller number of more focused questions, this audit was not comparable to the previous audit.

Are you worried about someone?

If you are worried about a vulnerable adult and would like our help please don't stay silent

- **Phone Adult Social Care: 0300 123 2224**
- **Email Adult Social Care: adults@somerset.gov.uk**
- **In an emergency always contact the police by dialling 999.**
- **If it is not an emergency, dial 101**

We will make urgent enquiries to understand the situation and make decisions about what needs to be done next to make sure people are safe

We will always deal with any calls in the strictest confidence