Annual Report

2022-23

Contents

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 2022/23.
- 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 Integrated Care Board.

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 6 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

Michael Preston-Shoot, Independent Chair
Somerset Safeguarding Adults Board

As the new Independent Chair of the Somerset Safeguarding Adult Board, I am pleased to introduce our Annual Report. The aim is to give an insight to our activity over a 12-month period, and the collective response of our partners to the issues of neglect and abuse of adults with care and support needs in Somerset.

Like many areas across the Country, we have seen first-hand how health and social care systems have had to cope with unprecedented demand, increasing complexity and, at the same time, manage the repercussions of the COVID pandemic, and workforce recruitment and retention pressures.

The SAB itself maintained its focus on a virtual basis and continued to deliver the objectives of its 3-year strategic plan and improving the effectiveness of the Board (listening and learning, enabling people to keep themselves safe, working together to safeguard people who can't keep themselves safe, and enhancing how the Board works). I am pleased to report that we have recently launched a refreshed 3-year strategic plan for 2023-2026, and would like to thank everyone involved for their contribution in setting our clear priorities for the immediate future.

Safeguarding adults is a legal and ethical responsibility. We need to remind ourselves and raise awareness widely that abuse and neglect are real.

We have a website, which is being enhanced further, and active social media engagement to support adult safeguarding awareness and practice. Your feedback would be very helpful in improving the Board's work.

In the meantime, my sincere thanks to everyone involved in safeguarding adults in Somerset.

Safeguarding is everybody's business

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

The Board

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 Board's 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 Somerset Safeguarding Adult Board Annual Report 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 2023:

Name	Organisation	Job Title
Michael Preston-Shoot		Independent Chair
Natalie Green		Business Manager
Lead Statutory Partners		
Dickon Turner Alison Jenkinson	Avon & Somerset Constabulary	Superintendent Partnership Liaison Manager
Shelagh Meldrum Sarah Ashe	NHS Somerset Integrated Care Board	Director of Quality and Nursing Associate Director of Quality and Nursing
Mel Lock Emily Fulbrook	Somerset County Council	Director, Adult Social Services Deputy Director, Adult Social Care Operations

Partner Members		
Paul Chapman	Care Quality Commission	Inspection Manager
Lucy Divers	Department for Work and Pensions	Advanced Customer Support Senior Leader, Avon, Somerset and Gloucestershire
Caleb Stevens	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
Julie Bingham	LiveWest (rep. housing providers)	Executive Director Housing Support
Jai Vick	Mendip District Council (rep. District Councils)	Deputy Chief Executive

Liz Spencer Claire Evans	National Probation Service	Head of Somerset Probation Service Senior Probation Officer
Julia Mason Emma Read	NHS Somerset Integrated Care Board	Designated Nurse for Safeguarding Adults Deputy Designated Nurse for Safeguarding Adults
Hilary Robinson	Registered Care Providers Association	Chief Executive
Richard Pitman	Rep. people who use services and the Voluntary Sector	Chief Executive – Compass Disability
Hayley Nicholls	Shared Lives South West	Team Leader – Somerset
Trudy Craig	Somerset Care Ltd	Director of Care
Lucy Macready	Somerset County Council (Public Health - Community Safety)	Public Health Specialist – Community Safety
Cllr Heather Shearer	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
Jonathan Searle	Swan Advocacy	Head of Services

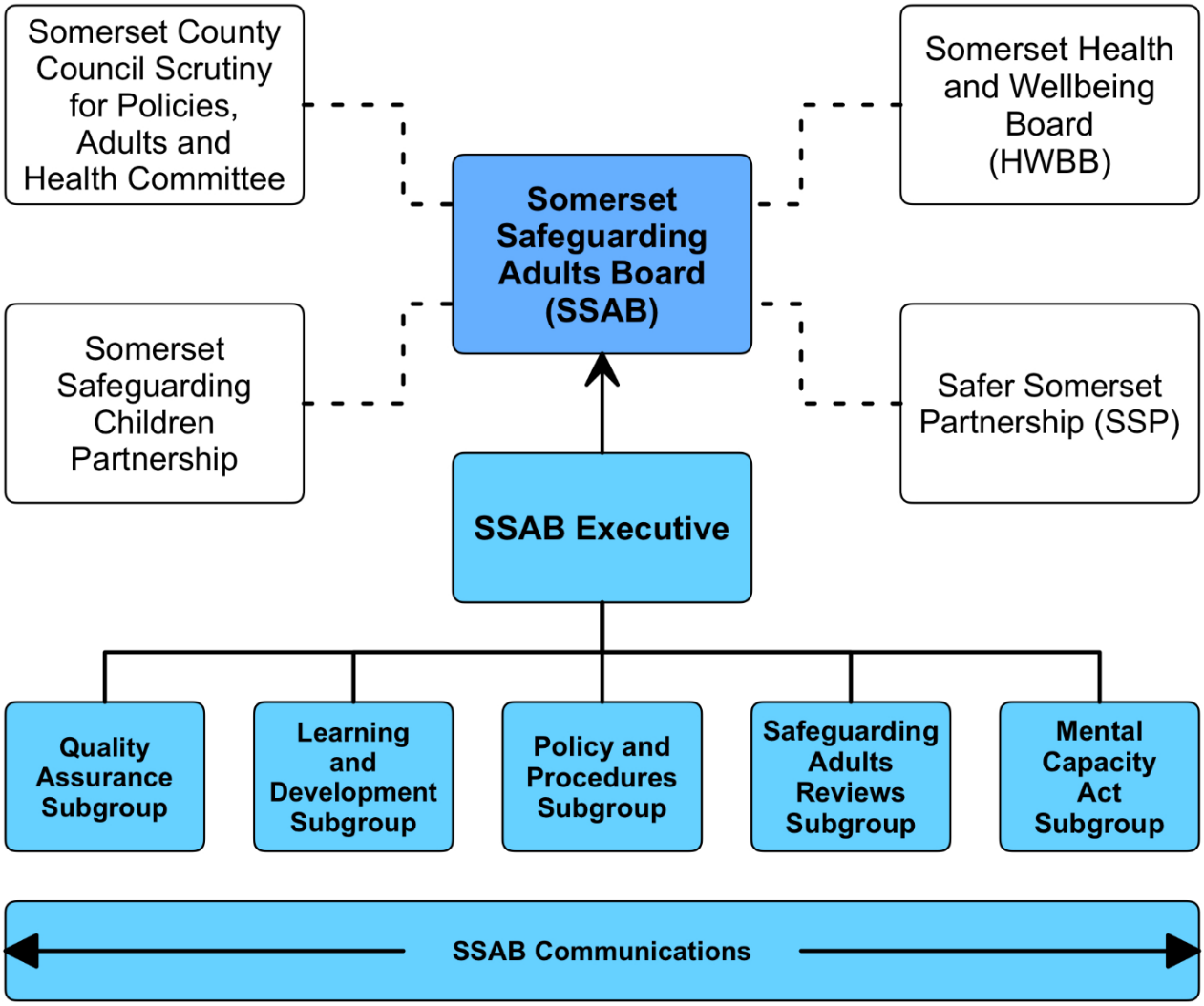
Board attendance

The Safeguarding Adults Board met on 3 occasions during 2022/23 (June, October and February).

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

Organisation	Attendance
Avon & Somerset Constabulary	100% (3/3)
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	66% (2/3)
Golden Lane Housing	33% (1/3)
Healthwatch Somerset	100% (3/3)
Housing Representative	100% (3/3)
Marie Curie Somerset	0% (0/3)
National Probation Service	66% (2/3)
NHS Somerset Integrated Care Board	100% (3/3)
Public Health	100% (3/3)
Public Health (Community Safety)	100% (3/3)
Registered Care Providers Association	33% (1/3)
Representative of people who use services	0% (0/3)
Shared Lives South West (Somerset)	0% (0/3)
Somerset Care Ltd	0% (0/3)
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	33% (1/3)
Voluntary sector representative	0% (0/3)
Yeovil Hospital NHS Foundation Trust	100% (3/3)

Board structure as at 31/03/2023



During 2022/23 the following change were made to the Board's subgroup Structure:

- The previously combined Learning & Development and Policy & Procedures Subgroup were separated into two distinct subgroups.

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 ('Somerset 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, and this is something we are keen to strengthen further.

3. Safeguarding in numbers

How much abuse and neglect was reported during 2022/23?

Safeguarding concerns reported to the Local Authority in 2022/2023

2021/22
2265
Concerns

2022/23
2184
Concerns

There was a decrease of 81 (3.6%) safeguarding concerns compared to the previous year; a continued downward trend. Of the 2,184 concerns, 4 (0.18%) were raised by the adult themselves, which was also the number in 2021/22.

Safeguarding concerns received that required a statutory response in 2022/2023

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

2022/23
643
Section 42 enquiries
(29.44% of all concerns received)

This was an increase of 16 (2.6%) compared to the previous year. Additionally, a further 43 non-statutory enquiries were carried out.

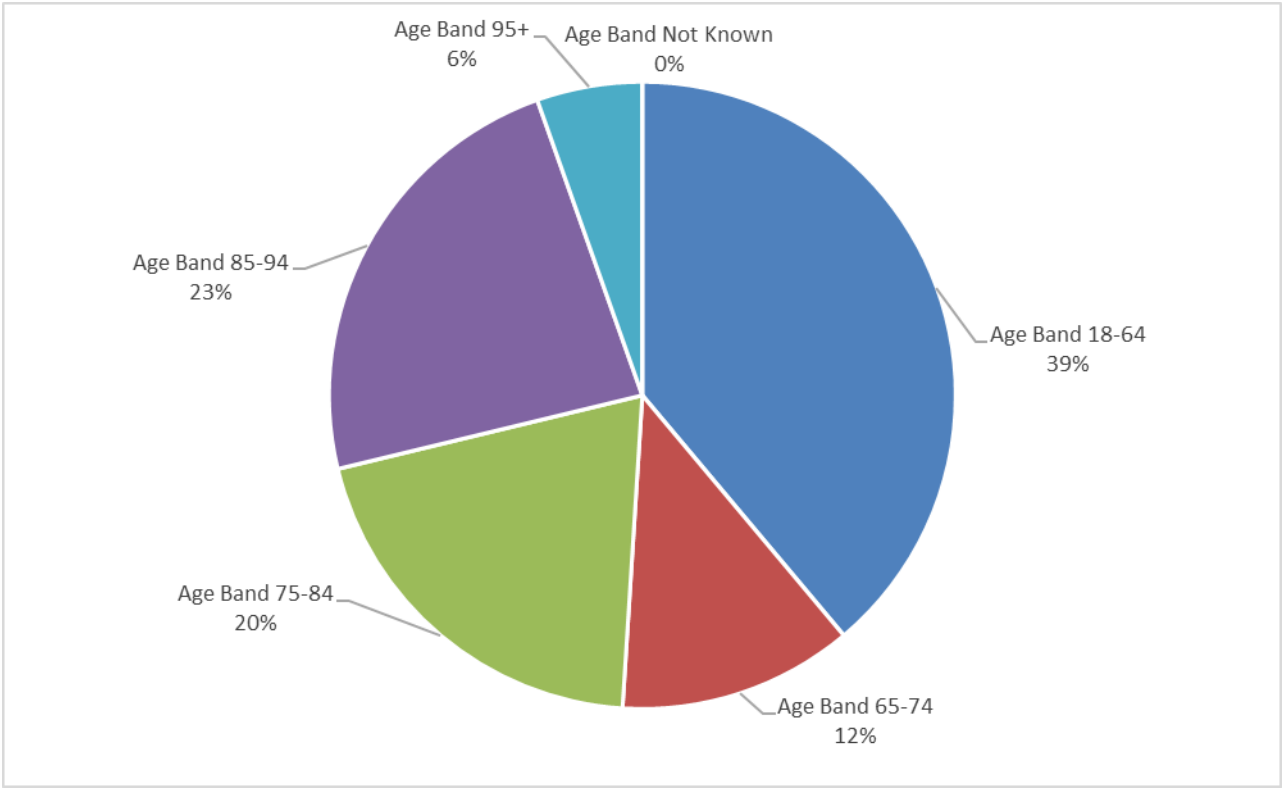
Who was at risk of abuse and neglect in 2022/2023?

The majority of individuals that required a statutory response were male

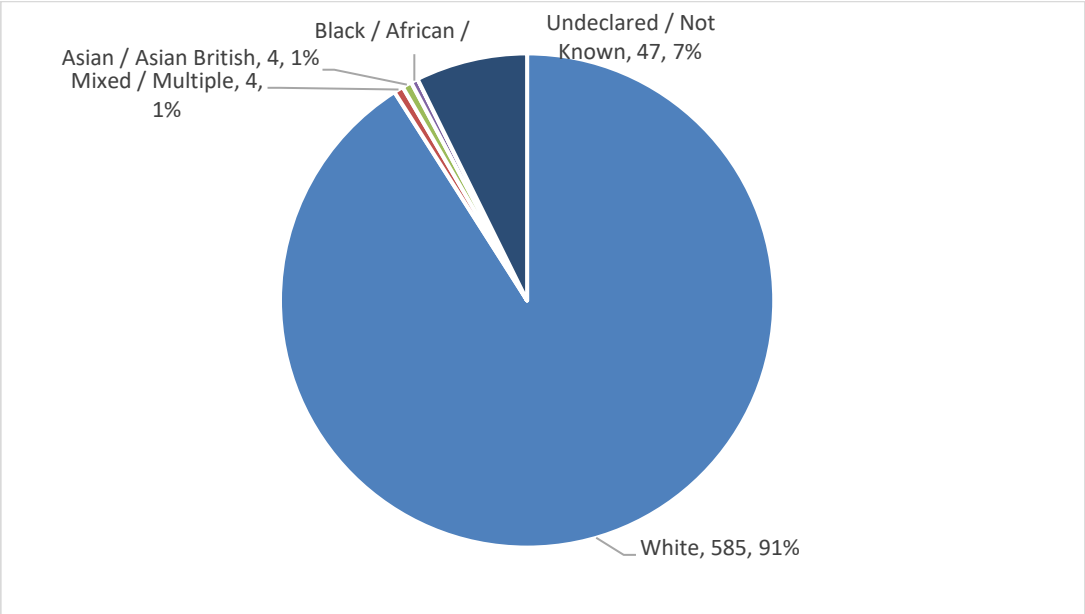
Females
275
(42.77%)

Male
368
(57.23%)

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

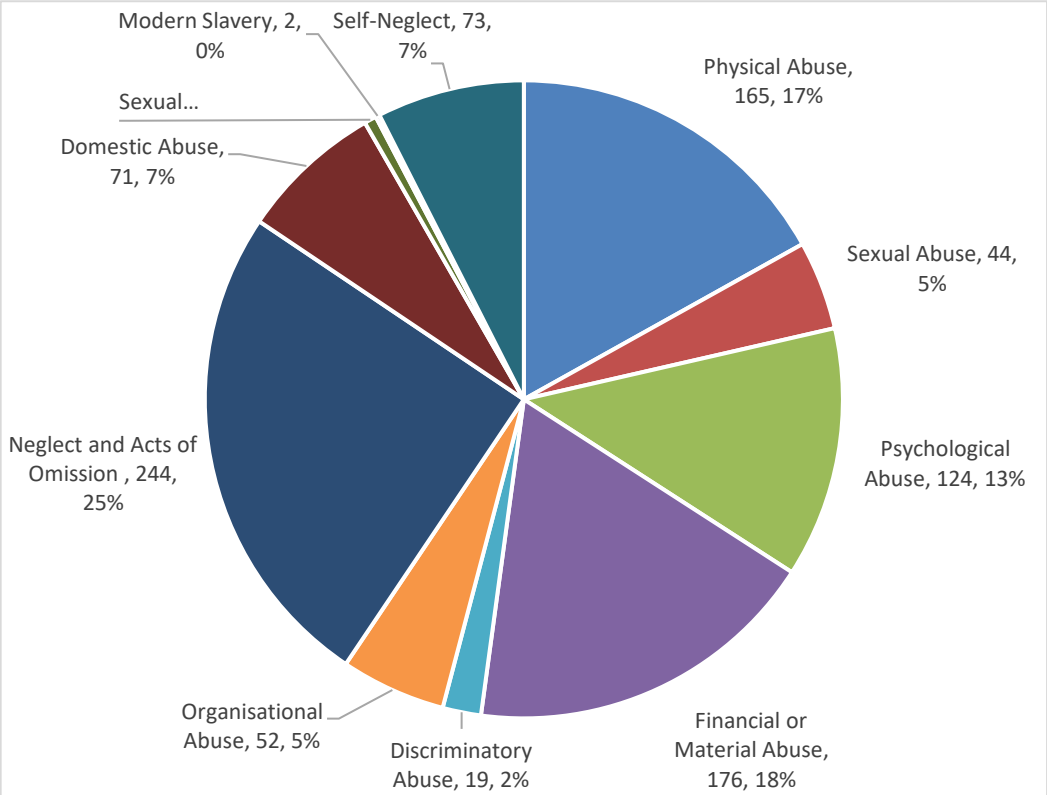


The majority of individuals where the concern resulted in an enquiry under section 42 of the Care Act (2014) were from white ethnic backgrounds:

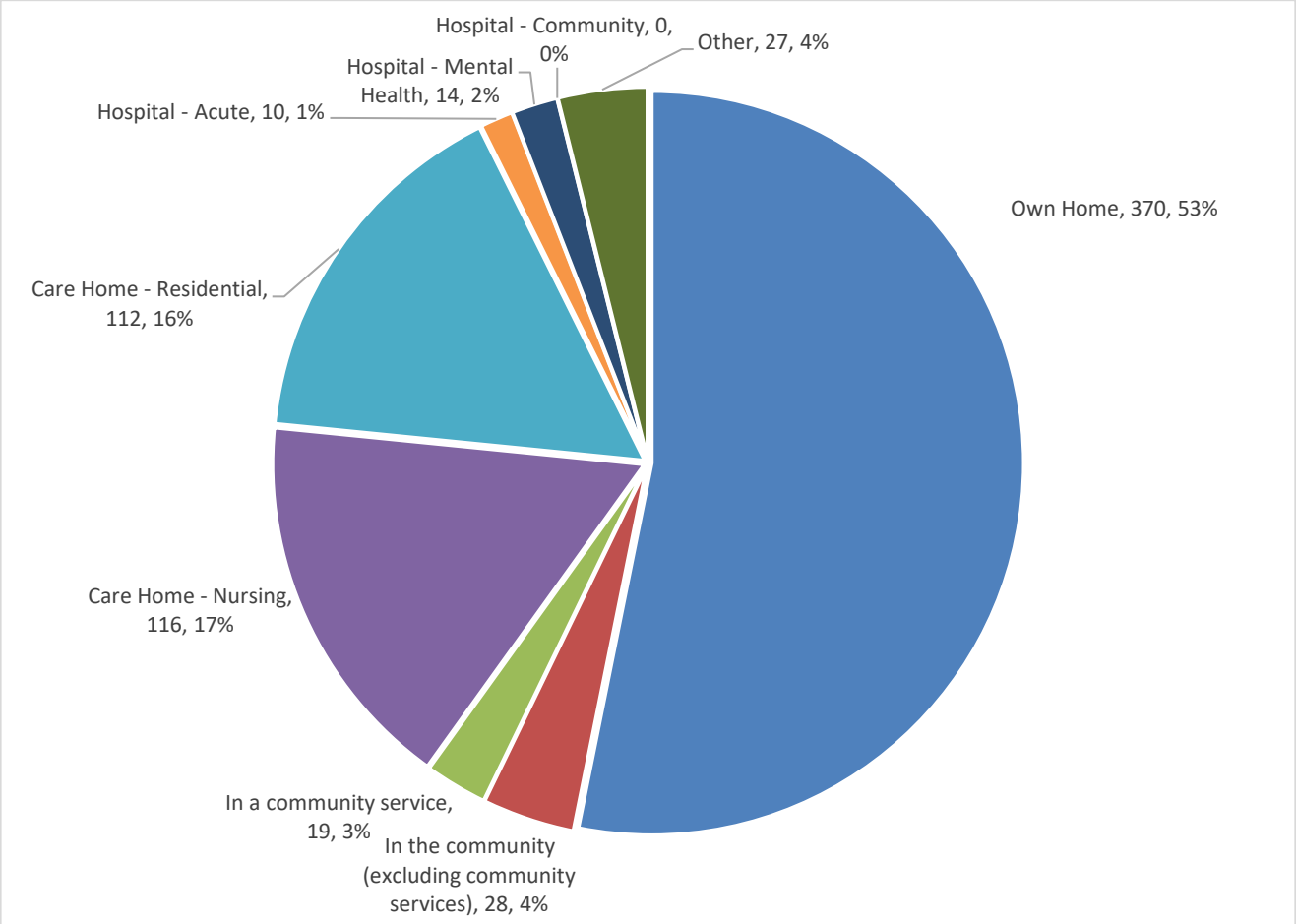


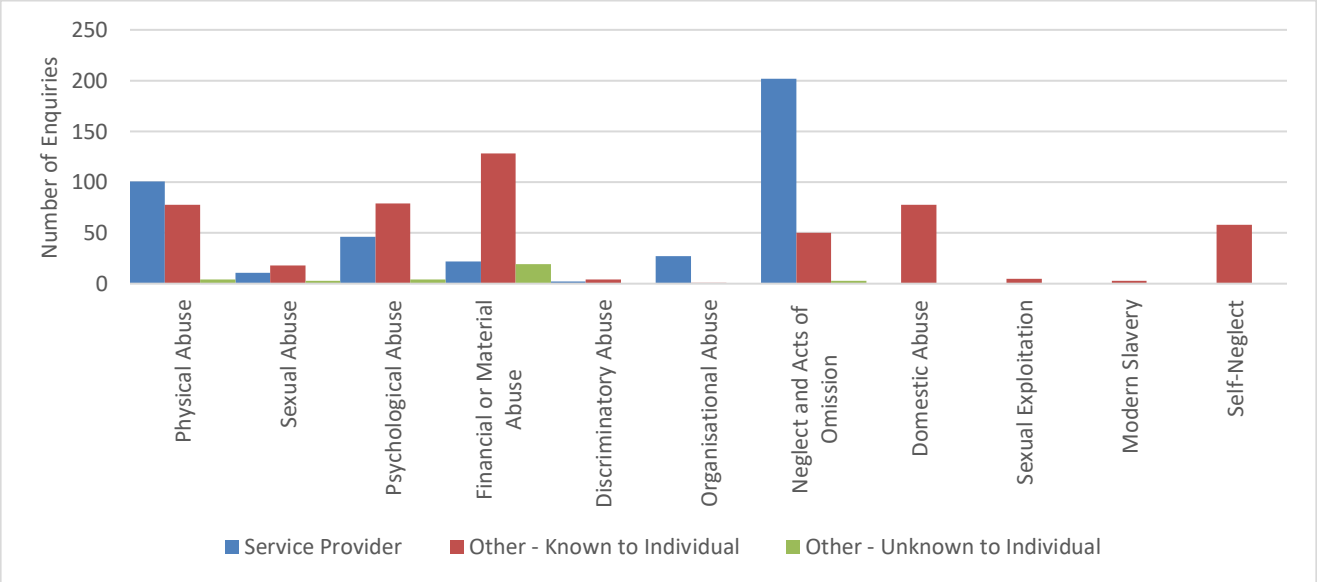
Type of abuse and source of risk

The most common risk type was Neglect and Acts of Omission, which accounted for 25% of risks, followed by Financial or Material Abuse at 18% and Physical Abuse at 17%.



The most common location where people were identified as being at risk remains their own home (53%), followed by in a nursing care home (17%)





Mental Capacity

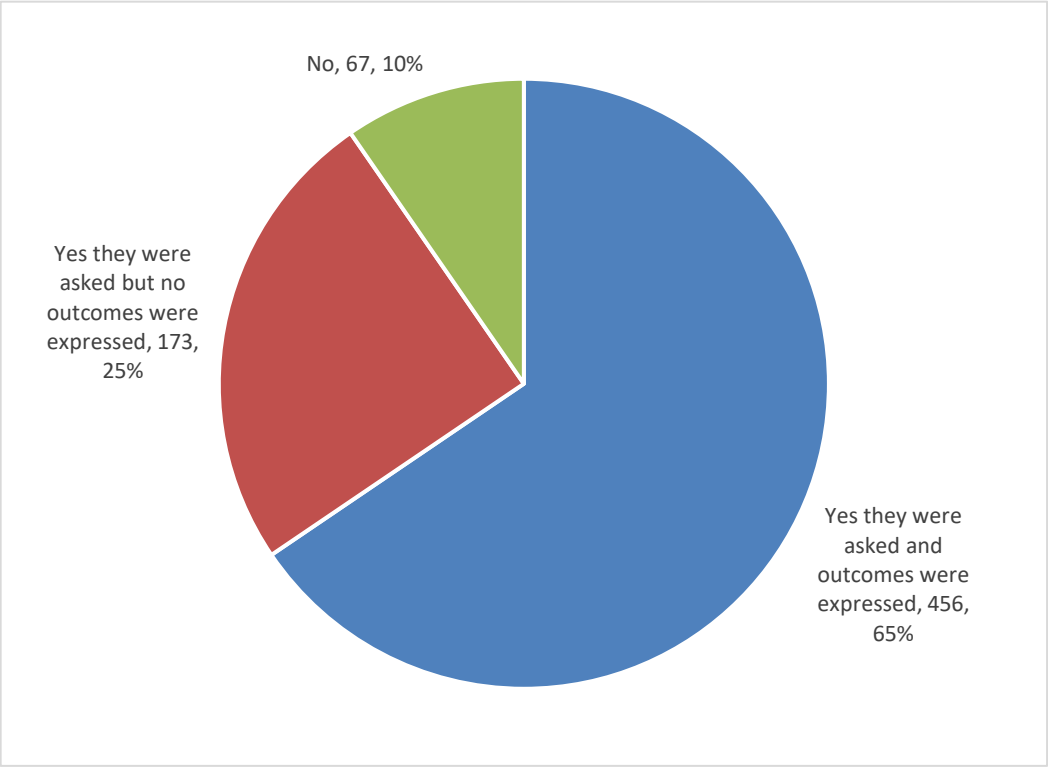
In all 113 cases the adult at risk was assessed as lacking capacity to make decisions related to the safeguarding enquiry. In all cases, the individuals were supported by an advocate, family member or friend.

Making Safeguarding Personal

What does Making Safeguarding Personal mean?

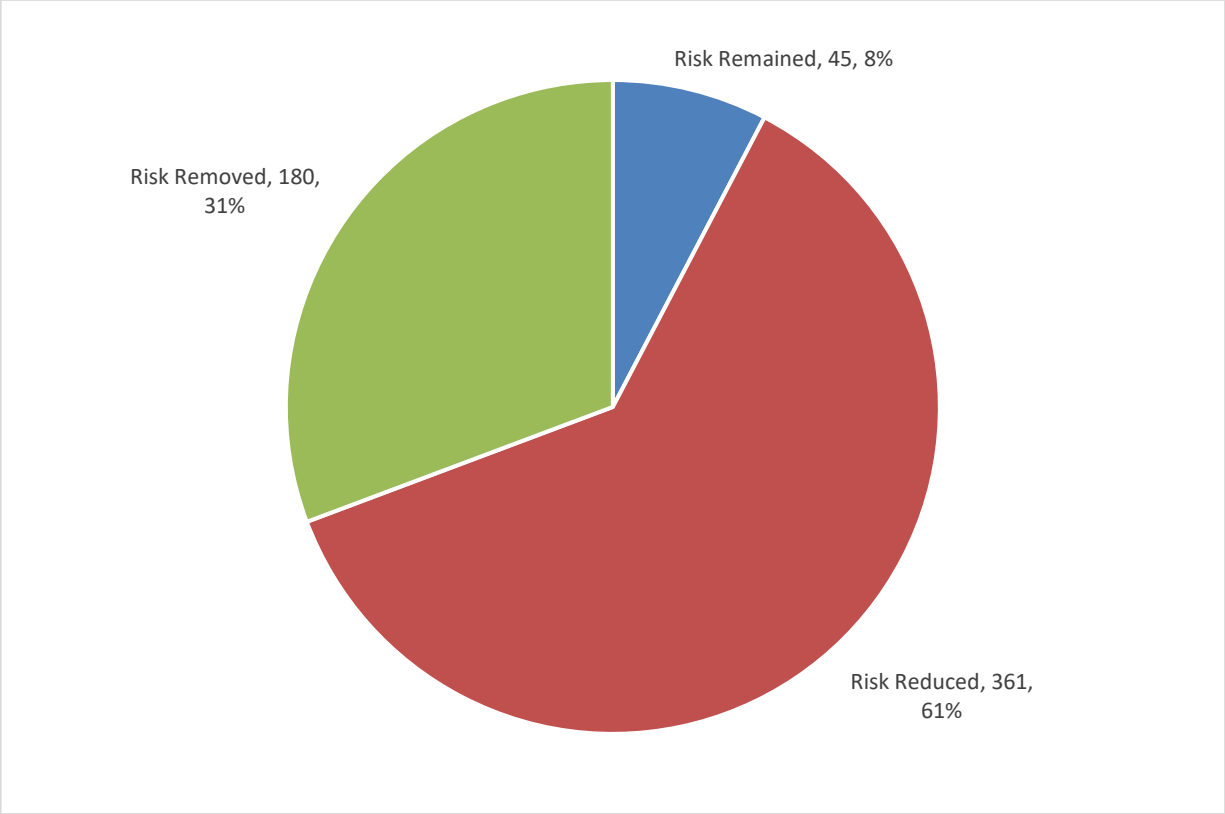
Making Safeguarding Personal (MSP) is about having conversations with people about how we all might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives 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 continue to promote 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 100% of cases where desired outcomes were stated these were fully achieved

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



4. SSAB Effectiveness Survey

The Board monitors the effectiveness of the Board itself as part of its routine quality assurance framework arrangements and in order to support the Board's continuous improvement. During March 2023, all Board and subgroup members were encouraged to respond to a survey to assist the subgroup in benchmarking current Board performance and determine any areas requiring further development.

This work is especially beneficial given the Board has recently appointed a new Independent Chair (January 2023) and can allow the feedback to serve as a both a baseline at the start of his tenure as well as inform Board development plans.

The 12 statements contained within the Effectiveness Survey reflect those outlined within the national Adult Safeguarding Improvement Tool, developed in 2015. The tool outlines the characteristics of well-performing and ambitious partnerships and has continued to be utilised and recommended as a means of self-assessment as well as in peer reviews and challenge.

The results of this survey can also inform and contribute to local assurance activity band sector-led improvement work associated with the new CQC Assessment of LA Statutory Duties from April 20232 onwards, which will include a focus on how the Council works to ensure safety within the system.

Key **strengths** identified within survey feedback centred on:

- Multi-agency collaboration, engagement and commitment; effective working relationships.
- Knowledgeable and experienced new Independent Chair.
- Well-organised and efficient business unit/manager.
- SSAB Communications and profile.
- Policy and procedure activity and guidance.

Areas emerging within the survey feedback as requiring **further attention or development** centred on:

- Developing further links with other existing or emerging partnerships and local Boards.
- More focus on transitional safeguarding and contextual safeguarding.
- Continued concerns re: over-reliance on a small number of key individuals across statutory services to progress and deliver Board activity.
- More regular engagement from partners in subgroups as there is not always balanced representation.
- Ensuring best use of available resources by maintaining a focus on core priorities/statutory remit, and activity that is most impactful at a time of recognised change, capacity and demand pressure internally and externally.
- Combining resources to commission a variety of safeguarding training to meet needs.
- Seeking more proactive opportunities to prevent abuse and neglect, as well as learn from it.

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 has been 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.

Two Safeguarding Adults Reviews and a Joint Death Review were concluded during 2022/23, and these are summarised below. A further thirteen 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.

Susan' Safeguarding Adults Review

Background

A report was published by the Somerset Safeguarding Adults Board on 16/08/2022 and documents the events leading up to Susan's death (pseudonym), in November 2017.

Susan was middle-aged and had a significant health condition that required daily medication. She lived with a close family member in Somerset. The family member strongly disagreed with medical professionals about the diagnosis and treatment of Susan's health condition, which they also expressed to the SSAB when contacted. However, as part of the SAR process the SSAB requested that her medical records be reviewed which concluded that the diagnosis was correct.

Following concerns that Susan's family member might be withholding her medication, or coercing her not to take it, it was arranged for a care provider to support her with this. This was self-funded. However, Susan continued to experience a number of hospital admissions related to her health condition.

During approximately the last six months of her life, some professionals began to raise concerns that Susan might be a victim of domestic abuse. During this time Susan's family member cancelled her care, her social worker left their role, and she was not allocated a new one as she was considered to have a relatively low-level of care and support needs and had been self-funding the visits from carers.

Key considerations for practice identified in the review:

Alleged coercion and control experienced by Susan

While Susan's death predates the Domestic Abuse Act (2021), the information considered by the SAR portrayed a high level of alleged controlling behaviour by a family member over time. All professionals should ensure that, if there are concerns about potential coercion and control (or any other form of abuse) taking place, attempts should be made to speak to the person on their own about the issues of coercion as well as the presenting medical issues. If there are differences in opinion between professionals and family members who are alleged to be using coercive and controlling behaviours (or any other domestically abusive behaviours) to influence someone, then multi-disciplinary meetings should take place so that decisions are informed by the whole multi-disciplinary team.

In Susan's case some professionals appear to have based their decisions on information received from Susan and her family member. Professionals themselves should guard against being coerced in to accepting explanations that do not fit with other information and use professional curiosity rather than accepting information on face value.

Susan's capacity to make decisions in relation to her medication:
While it was correct to conclude that Susan was not eligible for an authorisation under DoLS based on her medical condition, it was incorrect to assume that this therefore meant that she had capacity in relation to decision making about her medication. As a result, her capacity in relation to this was never formally considered.

If there is a belief that a family member may be misinformed about a condition then, attempts should be made with the person's consent to talk to the family member about this or invite them to a multi-disciplinary team meeting, so that their concerns can be considered in the context of other information that is available.

Pharmacies should have guidance in place to alert a patient's GP if prescribed medications, that could result in poor outcomes if not taken, are not being collected.

The multi-agency response:
In Susan's case the multi-agency response was fragmented and characterised by multiple missed opportunities to jointly consider and respond to concerns that Susan may be experiencing coercion and control.

The withholding of medication is a recognised form of physical abuse that is directly referenced in Care and Support Statutory Guidance; however, this was not adequately recognised by the professionals involved in Susan's care and support. The result of this was that, when concerns were raised, they were either not followed up on at all, or where they were it was not as a safeguarding concern.

Professionals, and organisations with safeguarding responsibilities, should ensure that concerns about abuse are considered. A change in patterns of behaviour should trigger an escalation and the convening of a professionals meeting.

‘Mrs L’ Safeguarding Adults Review

Background

In this case, a SAR was not commissioned but similar principles were applied to a Practitioner Debrief and Learning event held with the individuals and organisations involved in Mrs L’s care and support that considered information relevant to this case. The key messages contained in this briefing reflect the learning to emerge from this.

A report was published by the Somerset Safeguarding Adults Board on 16/08/2022 and documents the events leading up to Mrs L’s death (pseudonym), in August 2019.

Mrs L was in her late seventies, and the incident occurred when a controlled medicine which she was prescribed was not included with her other medication when she moved from a care home in Somerset to one in another area of the South West region.

The move was due to it being determined that Mrs L needed the support of a specialist provider, and in the period prior to the transfer she was being supported by an external agency which was working alongside care home staff. Mrs L’s family felt that the reasons for the transfer were not fully explained to them at the time. There was approximately a 4-month period between the need for a new care home being identified, and the move taking place.

Following the move there was a delay in Mrs L being registered with a new General Practitioner (GP), having been deregistered from her GP in Somerset. This resulted in a delay in her being prescribed replacement medication.

Key considerations for practice arising from the review:

Communicating about changes

In Mrs L’s case the move took place relatively quickly after a Best Interests meeting had been convened, with the intention of reducing her anxieties. This may have created the perception that it was being rushed in the absence of clear communication about the process with her family and likely timescales once there was an option for a Best Interests meeting to consider. When considering a change of placement such as this, it is important to ensure that there is appropriate and clear communication about why a change is needed, the proposals and decision-making process with the adult and those who are important to them/involved in decision making. This should include giving the adult and those who are important to them/involved in decision making appropriate time to absorb information, and then checking to ensure that those who are not health and social care professionals understand the points at which

processes may slow down/speed up, and why. This should be done in a timely way to ensure that nobody feels surprised when this happens, and to also provide the adult and those who are important to them/involved in decision making, with opportunities to consider options and ask questions.

Pre-admission checks

When someone is moving between care homes, information must always be shared, ideally electronically, by the outgoing care home with the new one under their duty of care to the adult and recorded. This should aways be as early as possible once the arrangements for someone to move to a care home have been agreed in order to allow appropriate planning to take place. All care homes should use pre-admission checklists to support staff in ensuring that essential information is gathered about the adult. The information provided to care homes in advance of admission must provide a realistic presentation of an adults needs, regardless of whether someone is being admitted to a care home for a first time or, as in Mrs L's case, is moving between two care homes. Care homes should be mindful of those times where a new admission may present more risk, for example immediately before a public holiday, and put appropriate mitigations and contingency plans in place for if something goes wrong. Both care homes should exchange contact details to be used on the day of the transfer in the event of a problem occurring.

Medication Policy

All care homes should have a Medication Policy that includes how information about an adult's medications, and the medications themselves, must be recorded and shared if they are moving to a different care home. The policy should include information about how any unused medications should be disposed of.

Checking medication prior to a transfer between care homes

The transfer of any adult, their belongings and medication between two care homes must be seen as a shared responsibility by both care homes. Prior to the transfer taking place the outgoing care home should check to ensure that there is sufficient medication remaining to cover the time needed to register with a new GP and agree arrangements to obtain any additional supplies with the new care home if necessary. The outgoing care home must share a list detailing an adult's medication in advance of all transfers. This must be no later than 24 hours before the transfer is due to take place. Both care homes must be working with the same information about medication. If there is any change

to an adult's medication after details of it have been shared, then a replacement list of their medication should be issued immediately. On the transfer taking place, the outgoing care home must physically check all medication against the list before the adult leaves the care home, with adequate time allowed so that this is not rushed. Where, as in Mrs L's case, a controlled medication is involved, this check must not take place until it has been retrieved from where it is stored securely. On the adult arriving at the new care home the medication must be physically checked for a second time against the list that has been provided before it is put away. If the outgoing care home finds any medication that has been left, or the new care home identifies any that is missing, then they must notify the other care home immediately. If a controlled medicine is found to be missing then, if following checks, this remains the case then the police should be notified.

Registering with a new GP

While changes to GP registration are instantaneous, and therefore cannot be undertaken in advance, Care Homes must ensure that they have the information required to complete the adult's registration with a new GP before an admission takes place. The adult must then be registered with their new GP on either the same or, if the admission is after it has closed for the day, the next working day for the GP Practice following the admission. All care homes should ensure that they have an NHS email address to enable secure communication with GPs. Where, as in Mrs L's case, an adult requires a medication urgently after a transfer has taken place this should be made clear to the new GP as this should enable them to request the details be disclosed by their previous GP under the duty of care element of the Caldicott Principles.

'Robert' Safeguarding Adults Review

Background

Robert had physical health needs and there had been concerns about Robert's self-neglect in the two years prior to his death so he had been moved out of his home for six days whilst a deep clean took place. Robert was moved to other more appropriate accommodation with care and support provided, but following a review, the care ceased on 21/6/18. There was no further Adult Social Care (ASC) input and Robert had intermittent contact with the District Council Housing Department. Robert was found at his home dehydrated, hypothermic and confused on 4/2/19 by a General Practice (GP) Paramedic. Robert died in hospital on 6/3/19.

Key considerations for practice arising from the review:

Self-neglect and mental capacity

When self-neglect is evident and someone is making "unwise" decisions, be prompted to assess their mental capacity to be able to make decisions about their care and welfare. For individuals who self-neglect, consider whether a physical or mental health condition has caused an impairment or disturbance in the functioning of their mind or brain. In complex cases bring together multi-agency, multi-disciplinary thinking to explore ideas and interventions. • Be wary of closing cases without safeguards in place to spot continuing self-neglect. • Follow your organisation's self-neglect practice guidance.

The Human Rights Act 1998

Remember the need to balance the right to life (Article 2) and the right to respect for private and family life - autonomy of decision making - (Article 8) and recognise that there may be circumstances where you have a duty to protect life more than the right to autonomy. This can be challenging but attention should be given to developing an understanding of a person's previous choices, decisions and way of life, and with compassion for them rather than as an abstract exercise.

Think Family

Think how you can work with family members as partners in meeting their relatives' needs and how they may be supported to do so.

Missed appointments, avoidance and feigned compliance

When people who cannot look after themselves or self-neglect miss appointments, follow this up. Explore why and consider what support can be put in place to ensure their physical, mental health and welfare needs are promoted. Be alert to feigned compliance and avoidance. People may try to convince you that they are working with you and are motivated to "comply" with the interventions put in place by services, but in reality, they don't. If they avoid you, be curious about why.

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

	Summary of Recommendation

1	Somerset County Council Adult Social Care and Somerset Clinical Commissioning Group (for GPs) should agree a multi-agency action plan aimed at improving the understanding of the practical application of the Mental Capacity Act (to include but not limited to: that self-neglect should trigger a mental capacity assessment, that mental capacity requires assessment rather that assertion, that physical and mental health conditions may mean there is an impairment or disturbance in the functioning of the mind or brain, that mental capacity is decision and time-specific, yet should be seen as a video rather than a snapshot, that the Mental Capacity Act does not give the right to make unwise decisions). An audit tool should be used across the partnership to demonstrate that improvements have been made.
2	Somerset County Council Adult Social Care, the District Council Housing Department and the Somerset Clinical Commissioning Group (for GPs) should agree a multi-agency action plan to increase understanding and recognition of self-neglect (including ways of working with people who self-neglect as outlined in this SAR, for example that refusal of treatment can be self-neglect, that self-neglect can be reported as a safeguarding concern, that it should not be regarded as a lifestyle choice, that people who self-neglect can disguise or feign compliance) and that there is a need to involve people's families.
3	Somerset Safeguarding Adults Board should update its self-neglect practice guidance to ensure it covers the most up to date practice research including understanding childhood and other life experiences and involving families. An audit tool should be used across the partnership to demonstrate that improvements have been made. In updating the guidance, the Board should agree methods to raise multi-agency awareness of, and processes for, using legislation (Care Act, Mental Capacity Act, Human Rights Act, Mental Health Act, environmental health acts etc) to intervene to support people who self-neglect and the circumstances and risks which exceed the capability of a single agency, team or individual to manage them on their own and when there is a need to involve other agencies or teams.
4	The Somerset Safeguarding Adults Board should lead an analysis of the extent to which the policy, procedural and organisational environment in Somerset fosters effective ways of working with people who self-neglect and ask: Do agencies share definitions and understandings of self-neglect? Is inter-agency coordination and shared risk-management facilitated by clear referral routes, communication and decision-making systems? Is longer-term supportive, relationship-based involvement accepted as a pattern of work. Does training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice? When services withdraw is there sufficient risk management planning to identify and act upon any self-neglect relapse? This is something that SWT and Somerset County Councils are currently working on.

5	Somerset County Council Adult Social Care should invite Housing and other relevant partner agencies to Neighbourhood Multi-disciplinary team meetings so that difficult cases can be shared and ideas for intervention generated and explored with the benefit of a broader skill-set and experience base.
6	Somerset County Council and District Councils should ensure that now, and in the future, with the creation of a unitary authority in Somerset from 1/4/23, that there are open channels of communication between partner agencies, clear pathways and referral points for raising concerns including safeguarding concerns, and a shared understanding of statutory powers and duties and the self-neglect policy and procedure.
7	The Somerset County Council Adult Social Care Safeguarding Team should ensure that safeguarding enquiries are made in a timely manner and are not delayed by the lack of "availability" of a staff member and have a process for allocation on the basis of risk.
8	When supporting an individual's rehousing or move to temporary accommodation, the District Council Housing Department and Somerset County Council Adult Social Care should ensure there is communication with the individual's family to avoid misunderstandings about the whereabouts of possessions.
9	GP practices should give more consideration to follow-up when patients disengage with the assessment and treatment of their medical health conditions (including disengagement with prescribed medication).

Local: 'Kathleen' Joint Death Review

Background

Following referrals to both the Safer Somerset Partnership and SSAB that did not meet the criteria for either a Domestic Homicide Review or a Safeguarding Adults Review, it was agreed that it would still be beneficial for an independently chaired review to take place to explore the learning for how agencies worked together for a period of approximately six years prior to Kathleen's (pseudonym) death. This was due to initial fact finding identifying extensive involvement by many agencies that related to domestic abuse and vulnerability.

The final report will not be published. However, a one-page briefing has been produced which identifies the following key learning from the case.

Kathleen was 75 years old, and had her adult grandson living with her. She had some long-term health conditions, and experienced domestic abuse from her

grandson. There was also alleged domestic abuse between her grandson and his same-sex (ex) partner.

Key considerations for practice identified in the review:

1. **Professionals to understand impact of Domestic Abuse on Family Members**. It is clear that the domestic abuse between her grandson and his (ex) same-sex partner led to Kathleen being also at risk (due to him living with her). Kathleen also expressed fear to professionals about this, but this wasn't taken seriously. Kathleen was asked about support networks, but no information was recorded about other family members and their level of awareness of her grandson's impact on her. It is therefore import and that professionals discuss family support with people about whom safeguarding concerns are raised.

2. **Robust System to Identify When MARAC Referrals Overlooked.** Professionals should escalate and follow up on high-risk domestic abuse cases, as part of an improved robust system being put in place to identify when MARAC referrals are overlooked, (overseen by Somerset Domestic Abuse Board).

3. **Agencies to understand impact of Coercion on Legal Interventions.** Professionals should always clarify the current status of any civil/criminal orders. Where a victim has applied to courts independently to remove an order, the impact of coercion on victims, and impact on level of risk they face, should be recognised.

4. **Professionals to ensure safe to close cases.** Professionals should not close cases of domestic abuse victims, without engage with relevant partner agencies to advise them of this and ensure some safety plan can be put into place.

5. **Professionals to complete DASH risk assessments whenever circumstances change.** The risk identified by a DASH is only ever a "moment in time", and should be repeated when circumstances have, or are likely to, change imminently which could increase risk to the victim of domestic abuse.

6. **Increase skill and confidence in completing DASH assessments in familial relationships and document conversations.**
    - Practice completing DASH assessments with colleagues to increase confidence.

- Fully record in your files, when conversations about domestic abuse have taken place.

7. **Professionals to use the SSAB "What to do if it's not safeguarding" guidance when required.** This guidance can be used for multi-agency information gathering, case discussions, and action planning where it has been determined that an adult does not require an adult safeguarding enquiry under Section 42 the Care Act (2014).

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 01/04/2022 are included below:

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

The review made 12 recommendations, of which 6 were still open on 01/04/2022. As at 31/03/2023 the status of each was as follows:

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

	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 individuals 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 31/03/2023 the status of each was as follows:

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

	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.

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
10	That the Somerset Safeguarding Adults Board seeks assurance that organisations are able to demonstrate that assessments are holistic.

Matthew Safeguarding Adults Review (published 14/12/2021)

The review made 7 recommendations. As at 31/03/2023 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 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.
4	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.
5	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.
7	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.

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
6	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. Our priorities for 2023/24

The Board recognises more can be achieved by working together in partnership and has identified four strategic objectives for its strategic plan for 2023-2026 based on learning, intelligence and feedback. The plan will be updated annually:

1: Community Engagement

Our aims:

- Strong engagement with our clients to inform our decision making.
- Move to co-production for policy and procedures.
- Working links in communities to raise awareness and confidence.

We will:

- Increase and find different ways to work with citizens of somerset to improve our safeguarding policies, systems and processes.
- Continue to develop consistent and effective processes and communication channels to inform our work. How to address safeguarding concerns when not meeting the s42 criteria.
- Develop a safeguarding network to improve engagement across somerset.
- Ensure the marketplace can provide specific care packages that our clients require to fulfil engaging lives.

2: Understand and Manage Self-Neglect

Our aims:

- People recognise when there is self-neglect.
- People know what to do if they think that they or others are experiencing self-neglect.
- Create a culture, in which practitioners are confident to apply the Mental Capacity Act.

We will:

- To have self-neglect policies and procedures which reflect best practice and current knowledge.
- Promote the application of MCA assessments to ascertain mental capacity and how self-neglect may be addressed.
- Seek assurance on the approach of the local system in supporting people who neglect their own self and well-being, and coordinate work to develop practice in this area across the Somerset system.

3: Promotion of the Somerset Safeguarding Adults Board

Our aims:

- All organisations understand the role of the Safeguarding Adults Board and how it supports assurance of safeguarding adults.
- Information and guidance are accessible and understandable for all to reference.
- Maximise engagement with both internal and external services and organisations to promote safeguarding in our communities.

We will:

- Promote the role of the safeguarding adults board across all internal and external services and organisations.
- Improve community awareness including using available opportunities to increase public involvement, and to engage media interest.
- Seek information and assurance from the partnership about how learning is shared within their organisations and how this is improving practice.
- Biennial self-audits are used to check and evidence awareness of the board and how it is supporting organisations.

4: Transitional Safeguarding and Exploitation

Our aims:

- Recognise that the needs of young people do not change or stop when they reach 18.
- Provide support for young adults who may experience exploitation post 18, who may not otherwise be eligible for a safeguarding response unless they have a formal mental health diagnosis or diagnosed learning disability.
- Align services for child and adults and encourage partnership cultures to respond better to the changing needs of adolescents and young adults.
- Have an overarching partnership which aligns our approach to transitional safeguarding, including exploitation, county line and substance misuse.

We will:

- Adopt an approach to safeguarding that moves through developmental stages, rather than just focusing on chronological age, building on best practice and learning from both adult and children's services.
- Young adults at risk, may not be covered by care act duties, we are committed to working in partnership to develop approaches to reducing risk of exploitation for all adults.
- Instigate an executive partnership board across the local system with the somerset safeguarding children partnership, safer somerset partnership and the corporate parenting board to seek assurance on local approaches. These will look to transitional safeguarding in order to ensure that young people with care and support needs are appropriately supported with respect to any safeguarding needs when they transition from child to adult services.

7. Board Budget

		2022/2023	
SOURCE OF FUNDS		**CONTRIBUTIONS £**	**%**
Somerset County Council	- SAB Manager & Independent Chair	45,126	59.7%
	- Safeguarding Adults Reviews	0	0.0%
Avon & Somerset Constabulary	- SAB Manager & Independent Chair	16,139	21.3%
	- Safeguarding Adults Reviews	1,170	1.5%
NHS Somerset Integrated Commissioning Board	- SAB Manager & Independent Chair	10,000	13.2%
	- Safeguarding Adults Reviews	3,170	4.2%
TOTAL CONTRIBUTIONS		**75,605**	**100.0%**
APPLICATION OF FUNDS		**EXPENDITURE £**	**%**
PAY (including overheads)			
Safeguarding Board Manager		53,806	78.1%
Independent Chair		16,329	23.7%
Non pay			
Safeguarding Adults Reviews		-1,500	-2.2%
Insurance		66	0.1%
BT charges/mobile charges		186	0.3%
TOTAL EXPENDITURE		**68,886**	100.0%
ANNUAL OVERSPEND / (UNDERSPEND)		**-6,719**	

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

8. Our work during 2022/23

The SSAB identified the following four objectives within its Strategic Plan for 2022-2025:

1. Listening and learning.
2. Enabling people to keep themselves safe.
3. Working together to safeguard people who can't keep themselves safe.
4. How the Board Works.

During 2022/23 the Board's work was, again, 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 at times to enable partner organisations to focus on their operational response to the crisis and its repurcussions.

Priority Area 1: Listening, Learning and Improving

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 their carers, both provided directly to the Board and through partner organisations, including the third sector.	• Feedback continues to be incorporated into the quarterly SSAB performance 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 2022/23 are shown in Section 4 (page 117) with 100% of people, or their representatives, reporting their desired outcomes had been wholly or partially achieved. • During this year, the Board were pleased to be able to welcome Willie, who had direct experience of safeguarding in Somerset. He talked to the Board in person about his background and how he came to work with the

What SSAB said it would do	What the SSAB did
	Safeguarding Service to address his hoarding and how this had transformed his life. • 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 Continuing Health Care and care providers on the challenges they have faced.
Provide multi-agency Safeguarding Adults learning opportunities to raise the profile of adult safeguarding, address areas of practice improvement and share lessons learnt from Safeguarding Adult Reviews.	• Best practice has continued to be identified and shared on a regular basis through the SSAB website, social media and Council's weekly care provider bulletin, which the Board supported the production of during the year. • The Board publishes a newsletter, which may be found on its website and it is emailed to a high number of public and professional subscribers. • 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 which are received via Somerset Direct and triaged. • The Board led a regional webinar on 'Elder Abuse' during the national Safeguarding Adults Week in November 2022. It also held its first Somerset Safeguarding Conference since the pandemic with the theme of Making Safeguarding Personal in March 2023. The Conference was extremely popular and offered 10 presentations and breakout sessions throughout the day, alongside a performance by 'The Misfits' at the end of the day.

What SSAB said it would do	What the SSAB did
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 were RAG rated and are being monitored by the Board's SAR Subgroup • To date, of the 18 recommendations that apply to local Boards 14 have been completed and 4 remain outstanding, all relate to assurance within the local system, which is an ongoing piece of work, which will continue and be part of our business as usual.

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 support work to raise awareness of, and reduce the harm caused by 'Hidden Harms', and abuse associated with County Lines	• 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

activity, domestic abuse and modern slavery.	by another Safeguarding Adults Board to adapt an animation to go alongside it called 'Tricky Friends"
Implement that Board's communication plan, developed during 2020/21 which is aligned with local, regional and national campaigns.	• 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 has 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 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 7,000 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.

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 on preparedness for the implementation of the new Liberty Protection Safeguards	• The introduction of the Liberty Protection Safeguards has been postponed indefinitely, 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).

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	2022/23	% Change
Total applications	2576	2881	3280	+14%
From Care Homes	1596	1782	2111	+18.5%
From Hospitals	1007	1099	1169	+6%
Assessments completed	664	672	734	+9%
Authorisations granted	628	634	685	+8%
Authorisations not granted/ of which not assessed	2085/2054	1984/1939	2824/2778	+42%

- 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.
- The notable increase in Authorisations not granted during 2022/23 is due to a thorough data cleansing exercise which identified people who had moved or died but about whom the DoLS service had not been notified previously.
- The 9% increase in the number of assessments completed represents an improvement in efficiency across the DoLS system. There was no corresponding increase in staffing resources.
- The majority of assessments by Best Interests Assessors are completed in person. Approximately 50% of assessments by doctors are completed remotely.
- Representatives appointed when a DoLS authorisation is granted. There has been a trend in recent years towards independent advocates being appointed in an increasing proportion of cases. In Somerset we appointed advocate representatives in 505 of the 685 authorisations, which equals 74%
- Court of Protection – people subject to DoLS authorisations who are objecting to their placement arrangements are actively supported by the Council and their representatives to seek a judicial review of their circumstances. During 2022/23 approximately 30 Somerset cases were subject to CoP proceedings under s21A of the Mental Capacity Act.

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.

As part of the preparation for the Liberty Protection Safeguards a detailed exercise was undertaken to identify all of those people who will require a Community DoL application to the Court and to identify those with the highest priority. This exercise is partly complete and the Council is currently looking for ways to increase the staffing resources available to undertake these detailed pieces of work. A recently appointed member of the DoLS team has Community DoL work as half of her full-time workload.

Liberty Protection Safeguards

Following on from a detailed consultation process during 2022, on 5 April 2023 the Government announced that the LPS scheme would not be implemented during the life of the current parliament. This means that although the Mental Capacity (Amendment) Act 2019 remains on the statute book, no decision about implementation will be made before early 2025.

However, much of the preparation work for the LPS scheme can be used constructively to improve how the Mental Capacity Act and the DoLS scheme are applied. In partnership with other local authorities in the South West region and across the country, Somerset Council is actively engaged in reviewing its current deprivation of liberty system and resources to look for ways of increasing capacity.

Seek assurance on the of effectiveness of safeguarding arrangements for adults with learning disabilities, to ensure that	• 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.

Making Safeguarding Personal principles are embedded when they are being safeguarded from abuse and neglect, including that which can be experienced through inappropriate approaches to meeting their care and support needs.	• The SSAB Independent Chair sought assurance from NHS Somerset ICB and Somerset County Council that learning identified through national workstreams following a high-profile Safeguarding Adults Review published by the Norfolk Safeguarding Adults Board was being taken forward in a timely way.
Seek assurance on the approach of the local system in supporting people who neglect their own self and well-being, and coordinate work to develop practice in this area across the Somerset system.	• This is an ongoing priority area for Somerset which has been taken forward in our Strategic Plan. • The SSAB Conference included a presentation on self-neglect, which gave an insight of how to work with people who self-neglect.
Coordinate work across the local system in partnership with the Somerset Safeguarding Children Partnership to seek assurance on local approaches to transitional safeguarding in order to ensure that young people with care and	• There is now a Transitional Safeguarding Team who will be working with all services the ensure the transition of a child to adulthood is supported appropriately. • There has been a workshop at the Somerset Safeguarding Children's Partnership Conference, which members from all organisations attended, including Adult Social Care, Safeguarding Board and NHS.

support needs are appropriately supported with respect to any safeguarding needs when they transition from child to adult services	• Organisations and services are now coordinating their approach to make Safeguarding an item for all meetings and conversations in respect to young people on their journey to adulthood.

Priority Area 4: How the Board Works

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: Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), Child Safeguarding Practice Reviews (CSPRs) and Learning Disability Mortality Reviews (LeDeR), NICE and SCIE)	• The monitoring of the implementation of recommendations of published SSAB SARs is a standing item at each meeting of the Board's SAR Subgroup. • The Learning & Development 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 regarding national trends and in initiatives. • Learning from elsewhere continues to be shared with the system via social media and newsletters
Seeking evidence and assurance to demonstrate safeguarding services are delivered effectively and professionally.	• A dashboard is now presented at all SSAB Boards, with a highlight report to indicate performance and areas for action.

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