Somerset County Council
Scrutiny for Policies, Adults and Health Committee
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Somerset Safeguarding Adults Board Annual Report 2018/19

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Division and Local Member: All

1. Summary

1.1. The Somerset Safeguarding Adults Board (SSAB or the Board) operates as an independently-chaired, multi-agency body under The Care Act 2014. It became statutory from April 2015.

1.2. The Board's role is to have an oversight of safeguarding arrangements within the County, not to deliver services or become involved in the day to day operations of individual organisations, including those of Somerset County Council.

1.3. The Board is required by The Care Act 2014 to produce and publish an Annual Report each year. The report must set out what has been done to help and protect adults at risk of abuse and neglect in Somerset during that timeframe. It provides an opportunity to both reflect on achievements over the past year and to formally identify priorities for the year ahead. It also offers a chance to demonstrate the Board's fulfilment of its role and ongoing commitment to safeguard vulnerable adults in the county.

1.4. The purpose of this report is to present the Board's Annual Report for the 2018/19 financial year to the Scrutiny for Policies, Adults and Health Committee.

2. Issues for consideration / Recommendations

2.1. The Scrutiny for Policies, Adults and Health Committee to review and consider the Somerset Safeguarding Adults Board's 2018/19 Annual Report (Appendix A).

2.2. The Scrutiny for Policies, Adults and Health Committee to note progress highlights during 2018/19 to date

2.3. The Scrutiny for Policies, Adults and Health Committee to continue to promote adult safeguarding across the County Council and in the services that are commissioned

3. Background

3.1. The main objective of the SSAB is to seek assurance that local safeguarding arrangements and partner organisations act to help and protect people aged 18 and over who:

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

3.2. Safeguarding is everybody's business, and the Board has a strategic role that is greater than the sum of the operational duties of the core partners. It means protecting an adult's right to live in safety, free from abuse and neglect.

3.3. Assurance in relation to Adult Safeguarding Arrangements in Somerset

The SSAB undertook its annual multi-agency organisational self-audit process during the autumn of 2018. In a change to previous years a new section was added to support the monitoring of learning from Safeguarding Adult Reviews. In addition, acknowledging that, as noted by the Committee during 2017/18, there are inherent weaknesses in any self-audit process, we strengthened the auditing process for 2018/19 through the incorporation of a peer challenge element, chaired by the SSAB Independent Chair, that scrutinised the submissions.

The results were reviewed by the SSAB's Quality Assurance subgroup, which included representation from Healthwatch, which was followed by the peer challenge day.

Key organisations (*Avon and Somerset Constabulary, Discovery, NHS Somerset Clinical Commissioning Group, Somerset County Council, Somerset Partnership NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust*) assessed their confidence of compliance across 32 specific areas, providing evidence to support their rating and detailing any actions to be undertaken to ensure improvement and who would be responsible for it.

Overall the results of the audit identified that confidence had improved in 13 areas and deteriorated in 9 of the 132 measures that could be directly compared to the previous year. Areas of development identified through the audit and peer challenge processes centred on:

- Ensuring the voice of people who experience safeguarding is heard and listened to within processes
- Confidence in the embedding and following-up of recommendations from Safeguarding Adult Reviews.
- The frequency and quality of supervisory processes
- The application and understanding of the Mental Capacity Act across the whole adult workforce

Please see Appendix A, p38, for more information about the audit.

In addition to the self-audit process throughout the year work has been undertaken with partner organisations with commissioning responsibilities following the publication of the Mendip House Safeguarding Adults Review on 08 February 2018. This work identified that, for services commissioned by or on behalf local commissioners, there is confidence that issues are understood, work is underway to address them, and that progress is being monitored to manage risk in this area.

There has also been a significant amount of activity in relation to services commissioned within Somerset by external commissioners, following the identification of low levels of confidence in this area. This has included writing to all residential care and nursing care services in Somerset asking for the details of all placements made by external commissioners, and when a face-to-face review had last been completed. This was then followed up by writing to 36 Safeguarding Adults Boards asking them to seek assurance where one or more of their members were responsible for placements that had not been reviewed for two or more years. A summary of this work has been included on page Appendix A, p43.

Overall the SSAB is able to report to the committee that:

- Overall confidence in compliance is improving, however safeguarding activity by its nature is an inherently risky area from which risk can rarely, if ever, be removed.
- Those areas where development is required are understood and work is taking place; the exception remains where services are commissioned by commissioners external to Somerset with regard to which we believe we can now quantify the number of placements; however, action is required on a national level to address the broader concerns highlighted by the Mendip House Safeguarding Adults Review.

3.4. Key Achievements 2018/19

During 2018/19 the Somerset Safeguarding Adults Board concentrated its efforts on improving its overall effectiveness in order to better coordinate activity, learn from serious cases locally, regionally and nationally, progress actions from the Mendip House Safeguarding Adults Review; and raise its local profile and the value of what it offered through high quality communications with both professionals and the public. Particular highlights worth noting during the year are as follows:

a) The SSAB again actively supported and contributed to "Stop Adult Abuse Week" during June 2018 with other Boards in the Avon & Somerset Constabulary area, a rogue traders initiative by Trading Standards during October 2018 and ran a social media campaign over the Christmas period - #12DaysOfSafeguarding – that saw significant engagement. Overall, we saw engagement via social media and through our website grow significantly during the year.

b) The Board continued to develop its Mental Capacity Act multi-agency subgroup, established in 2017/18 in direct response to learning to emerge from recent case reviews and audits, to enhance local understanding and application of the Act. The Mental Capacity Act has been repeatedly highlighted as an area of high risk locally, regionally and nationally. Particular areas of risk relate to people with fluctuating capacity, or those with an executive disfunction. Nationally, this had led to staff being criticised for both taking inappropriate action in some cases, and inaction in others, and it is therefore no surprise that staff frequently express a lack of confidence in this area of practice. While the SSAB will continue to promote greater understanding across the system in Somerset it remains one of the riskiest areas of practice. The work of the Subgroup included:

   - Developing content for the SSAB website to support practice improvement in this area across the Somerset system, including an MCA competency framework
   - Monitoring the application of Deprivation of Liberty Safeguards
   - Considering the implications of the Mental Capacity (Amendment) Bill (now act following Royal Assent in May 2019) for the Somerset system

c) We worked closely with the Somerset Safeguarding Children Board, Children's Trust and other agencies to support the development of a shared Think Family Strategy for Somerset, which was launched in May 2018, and strengthened links between both Safeguarding Boards on matters of shared interest, including transitions and tackling sexual exploitation.

d) The Board's Policy and Procedures subgroup developed new-online Safeguarding Guidance. These are available on the SSAB website for anyone to access and have been actively promoted by the Board. The Subgroup has also developed:

- A new information sharing agreement and supporting guidance in line with the new General Data Protection Regulations
- A revised Adult Safeguarding Risk Assessment tool
- A revised Service Monitoring Checklist
- A revised summary guide for care and support staff and volunteers
- A revised Communications Strategy

e) In addition to the significant activity outlined above following the publication of the Mendip House Safeguarding Adults Review:

- The SSAB Independent Chair, the Chair of the South West Regional Chairs Group and the SSAB Business Manager met with officials from the Department of Health and Social Care and the Local Government Association
- The SSAB Independent Chair and Business Manager met with four of the six families of people placed at Mendip House following concerns that the commissioners who placed their loved ones in Somerset had not been in contact prior to the Review being published.
- The Association of Directors of Adult Social Services and the Local Government Association published an advisory note in November 2018 regarding the "Arrangements and recommended ways of working for local authorities that are responsible for commissioning services (placing authorities) for adults with social care needs who are in out of area care and support services" that the SSAB contributed to.
- The SSAB Independent Chair wrote to the Department of Health and Social Care and Local Government Association to progress the implementation of the recommendations in March 2019.

f) The SSAB proactively engaged in work within the region to develop practice guidance and resources following a regional review of Safeguarding Adults Reviews published in 2017/18

g) During the latter pat of the year the SSAB developed its new strategic plan for 2019-22.

h) The Safeguarding Adults Review (SAR) subgroup continues to routinely consider new referrals. During 2018/19 it commissioned one Independent Reviewer to consider a case, work on which continues.

3.5. Key Progress, 2019/20

We have begun working to our new strategic plan for 2019-22, which was published in June following feedback form both this Committee and the Somerset Health and Well-being Board. Of particular note to date:

a) The Quality Assurance Subgroup has reviewed the SSAB's self-audit tool against a tool developed sub-regionally and agreed to trail this tool for 2019/20, with the addition of 8 questions from our previous tool to audit the implementation of learning from serious cases. The audit was launched in August 2019 and, once again, all partners have been invited to complete it.

b) The SSAB held its third multi-agency annual conference for safeguarding

leads in May 2019. Attendees represented a broad range of organisations from across the health and social care sector. The conference was well received, with feedback on the day indicating that participants felt that it would have a positive impact on their practice.

c) The Board's Policy and Procedures subgroup has reviewed and enhanced its online guidance, and will be publishing updated guidance over the coming months on a number of areas including self-neglect. It has also considered guidance developed regionally on allegations against people in a position of trust which we expect to be published in the coming months.

d) The SSAB has, once again, led the development of a new sub-regional Joint Safeguarding Adults Multi–Agency Policy in partnership with colleagues in Bristol, Bath & North East Somerset, North Somerset and South Gloucestershire to ensure standards are clarified and refreshed in light of more recent statutory developments or good practice. This was published in June 2019.

e) The SSAB actively supported and contributed to "Stop Adult Abuse Week" during June 2019 with other Boards in the Avon & Somerset Constabulary area. This year the focus of the week was the Mental Capacity Act which had been highlighted as an area for development by all the Boards involved, and the SSAB published promoted information on this area of work as well as running a 'Myth Buster' promotion on the day that it led. A new, national, week focusing on Safeguarding Adults is being proposed to take place in November each year which the SSAB will be supporting.

f) The Mental Capacity Subgroup has begun work to ensure that the Somerset system is as well prepared as possible for the introduction of the new Liberty Protection Safeguards which are expected to be implement during 2020/21. This will be a significant area of work for the subgroup over coming months.

g) The SSAB is continuing to pursue the implementation of recommendations from the Mendip House Safeguarding Adults review. This has included supporting the implementation of a notification process for external commissioners to use when placing in to Somerset, and involvement with wider regional work to agree a single regional approach. The SSAB executive group is also continuing to seek assurance when people are placed outside of Somerset by local commissioners

h) The SSAB's Learning and Development Subgroup has developed a 'framework' that identifies the safeguarding knowledge that staff working at different levels within organisations should have which it expects to publish during the autumn of 2019, and continues to routinely consider learning from Safeguarding Adult Reviews regionally and nationally.

i) The Safeguarding Adults Review (SAR) subgroup has continued to routinely consider new referrals, and now includes representation of a 'SAR Champion' that is part of a regional network that is working to develop best practice. During the year to date the Subgroup has continued to monitor one ongoing Review and there are currently four referrals for which locally led Learning review approaches are at different stages. The first of these, relating to a referral that did not meet the threshold for a Safeguarding Adults Review to be commissioned, but which was considered likely to result in the identification of valuable learning, is expected to be published once considered by the Board at its next meeting.

4. Implications

4.1. **Legal implications** The Care Act 2014 represented the most significant change to adult social care in more than 60 years, putting people and their carers in control of their care and support. For the first time the Act placed Safeguarding Adults, and the role and functions of a Safeguarding Adults Board, onto a statutory framework from 1st April 2015.

4.2. **Financial implications** The majority of the Safeguarding Adults Board funding is provided by Somerset County Council, with contributions from Avon & Somerset Constabulary and Somerset Clinical Commissioning Group. Safeguarding Adults Reviews (SARs) are resourced by the partnership as and when required and an agreement is now in place between the three statutory partners to resource all SARs from outside the Boards core budget. In addition, a new approach that we have begun to develop of asking a senior representative from partner organisation that has not had involvement in a case to chair a locally led approach is likely to reduce the number of instances when an Independent Reviewer needs to be commissioned.

The SSAB continues with its decision not to professionally print the Annual Report to save on costs. All reports are publicly available on the website www.ssab.safeguardingsomerset.org.uk including this Report.

4.3. **Risk implications** Safeguarding activity by its nature is an inherently risky area and has the potential to bring a Council's reputation and rating into discredit and the wider safeguarding system into question. The Annual Report, a legal requirement by the Care Act 2014, provides partner agencies and the public with assurances that adult safeguarding is being monitored and scrutinised in Somerset. The Board also has a robust risk register in place which identifies and tracks risk.

4.4. **Partner organisations** Somerset Safeguarding Adults Board benefits from strong partnership commitment. Agencies represented on the Board had the opportunity to detail their achievements and contributions in 2018/19 and all Board members are encouraged to take the Annual Report through their own internal governance routes.

5. Background papers

5.1. Appendix A – Somerset Safeguarding Adults Board Annual Report, 2018/19

5.2. SSAB Strategy 2019-22:

Note For sight of individual background papers please contact the report author