

Somerset County Council  
Scrutiny for Policies, Adults and Health Committee  
– 12 October 2022

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## **Somerset Safeguarding Adults Board - Annual Report 2021/22**

Lead Officer: Keith Perkin, Independent Chair, Somerset Safeguarding Adults Board

Author: Niki Shaw, Strategic Manager, Quality & Performance, Adult Social Care

Contact Details: [NXShaw@somerset.gov.uk](mailto:NXShaw@somerset.gov.uk)

Cabinet Member: Cllr Heather Shearer, Cabinet Member for Adults

Division and Local Member: All

### **1. Summary**

- 1.1** Adult safeguarding is everyone's responsibility. Safeguarding means protecting people's right to live in safety, free from abuse and neglect. The Somerset Safeguarding Adults Board Annual Report (*see attached appendices*) outlines adult safeguarding activity and performance across the county between April 2021 and March 2022.
- 1.2** The Annual Report is presented each year to the Scrutiny Committee in the interests of promotion, transparency and accountability, as well as being shared with the Chief Executive and Lead Member of the Local Authority, the Police and Crime Commissioner and Chief Constable, Healthwatch Somerset, and the Chair of the Health and Wellbeing Board (as is legislatively required). It is also shared with NHS Somerset leads.

### **2. Issues for consideration / Recommendations**

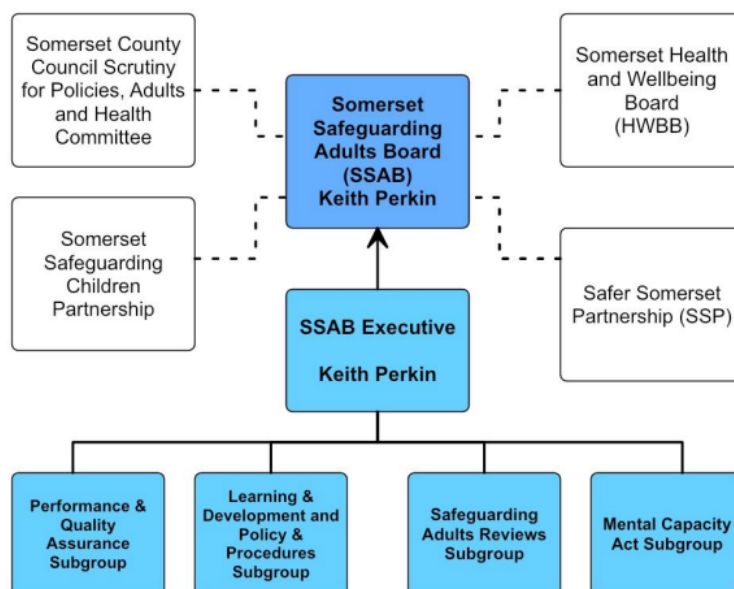
- 2.1** Scrutiny Committee to receive and consider the 2021/22 SSAB Annual Report.
- 2.2** Scrutiny Committee to continue to encourage all elected Councillors to actively support adult safeguarding across the Local Authority and Somerset's local communities, promoting awareness of the resources and support available via the SSAB website: [Somerset Safeguarding Adults Board – Somerset Safeguarding Adults Board \(safeguardingsomerset.org.uk\)](http://SomersetSafeguardingAdultsBoard-SomersetSafeguardingAdultsBoard(safeguardingsomerset.org.uk))

### **3. Background Information**

- 3.1** The Somerset Safeguarding Adults Board (SSAB) is a statutory body established by the Care Act 2014. It is made up of senior people from organisations who have a role in preventing the neglect and abuse of adults. The main objective of the Board 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** SABs have 3 statutory functions:
- To develop and publish a [strategic plan](#) setting out how it will meet its objectives and how members will contribute to these;
  - To publish an annual report detailing how effective its work has been;
  - To commission Safeguarding Adults Reviews (SARs) for any cases meeting the criteria for these.

**3.3** Somerset's SAB is independently Chaired by Keith Perkin, who took up post in January 2020. His role is to support and challenge the commitment and vision of the Board and its partners with a main focus on how agencies effectively work together to safeguarding, prevent and reduce the risk of abuse and neglect. The Board also has a Business Manager and some administrative support available to it to help facilitate the effective work of the Board and its subgroups:

**3.4 Board structure as at 31/03/2022**



**3.5** The SSAB'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. *As such, any questions from committee members regarding operational matters, including individual safeguarding enquiries, are best directed to the representative of the organisation that has the lead for this work.*

## **4 Key SSAB updates and highlights**

**4.1** The work of the Board during 2021/22 continued to be impacted by the need for member organisations (and our SSAB Manager) to prioritise their capacity and response to the pandemic and the associated health and care system pressures arising from it. Despite the demands and capacity challenges faced by the sector, our partner organisations have shown enormous commitment to continuing to help adults in need of safeguarding support and have supported progress activity across a range of priority areas. The Board is keen to highlight the following information for Scrutiny awareness:

- a) Somerset has seen a **declining rate of safeguarding concerns contrary to national trends, and fewer Safeguarding enquiries being undertaken as a result.** Analysis suggests this is as a direct result of the significant work undertaken over recent years to improve understanding of safeguarding criteria, and more effectively triage or re-direct the previously high number of 'inappropriate' safeguarding contacts to more suitable settings or teams. *The SSAB has recently convened a task and finish group to review this in more detail, working closely with Somerset Direct*

*(the Council's front door/call centre) and colleagues from business intelligence teams to confirm that both reporting and recording, and practice and assurance, remains where we need it to be.*

- b) In common with national trends, the majority of individuals involved in a safeguarding enquiry are **over 65 and female**. The **most common risk type is 'neglect and acts of omission'**, followed by physical abuse, and financial or material abuse. The **most common location where people were identified as being at risk continues to be a person's own home**, followed by a residential care home
- c) Somerset is proud of its commitment to 'Making Safeguarding Personal' and continues to secure **valuable feedback direct from service users, carers and advocates via its safeguarding questionnaires developed in partnership with Healthwatch Somerset**. As of end of March 2022, satisfaction levels were highest from service users (100% satisfied with the outcome of the safeguarding work), followed by IMCAs/Advocates (88%); more could be explored to enhance the experience of friends/relatives/carers in safeguarding activity (50% satisfied with outcome), particularly where younger adults are involved. Direct quotes have included:

*"My negativity, which was total, has been transformed to positivity which has never happened before in my life"*

*"An overwhelming sense of wanting to ensure my mother was in safe hands – nothing was beyond debate to achieve this goal"*

*"I have the full picture – one that allowed me to make an informed decision about how best to proceed. Nothing was forced on me".*

*"Sam and the team brought life into my life and made me feel better...I am very happy with the friendliness and support that has been provided to me. They have listened and done everything they can, and now it is up to me to make my future life work".*

- d) The SSAB continues to **raise the profile of adult safeguarding and share best practice** via its website, social media channels and internal/external newsletters and briefings. The Board led a regional webinar on 'Promoting Safer Cultures' during National Safeguarding Adults Week in November 2021 and a webinar on 'Professional Curiosity' in March 2022. *Plans underway to deliver a regional webinar on 'Elder Abuse' this November and to host a Conference in the Spring of 2023.* New public facing materials on Mate Crime have been developed via the SSAB's Policy and Procedures subgroup, alongside the adoption of a [short animation](#) to help people understand what good friendships are, when they might be harmful and what people can do to reduce their risk of exploitation.
- e) The SSAB coordinated an annual organisational self-audit of effective safeguarding activity and, more recently, conducted a repeat **SSAB Effectiveness Survey** of its members focused of the nationally-agreed characteristics of well-performing and ambitious safeguarding partnerships. The survey identified a range of strengths (*including Board culture and leadership, proactive and responsive safeguarding activity, and clear policies and protocols*) as well as some opportunities for future

development and continued attention (*including improving service user/carer involvement and influence, and seeking more opportunities to prevent abuse and neglect from occurring*).

- f) One **Safeguarding Adults Review** was published during 2021.22 ('[Matthew](#)'). However, in common with the national and regional picture, Somerset has seen a rise in SAR referrals and is progressing a number of other reviews and debriefs.

## 6. Looking to the future

- 6.1 The SSAB published its 2022-2025 Strategic Plan in May 2022. The Plan is publicly available on its website and can be accessed via this link: [SSAB-Strategic-Plan-2022-25-Final-For-Publication.pdf \(safeguardingsomerset.org.uk\)](#). The most recent summary page of the SSAB's Performance & Quality Report is shared (Appendix D) highlighting current performance against each Strategic Plan strand.

## 7. Implications

- 7.1 **Financial implications:** The majority of the SSAB's funding is provided by Somerset County Council, with contributions from Avon & Somerset Constabulary and NHS Somerset. 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 SSAB's core budget. The SSAB continues with its decision not to professionally print the Annual Plan or Report to save on costs and environment impact. All reports are publicly available on the website.

- 7.2 **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.

In February 2021 the government announced an intention to develop a new assurance framework for adult social care; proposals included a new duty for the Care Quality Commission to assess local authorities' delivery of their statutory adult social care duties from April 2023 onwards. The proposal was formalised in the Health and Care Bill, receiving Royal Assent in April 2022. Whilst the inspection framework and methodology has not yet been published, the emerging scope will very likely include a focus on 'Ensuring Safety', and will include consideration of SAB effectiveness in the local area.

- 7.3 **Risk implications:** Safeguarding activity by its nature carries inherent risk and has the potential to bring a Council's reputation, and the wider safeguarding system, into question when failings occur/are identified. The Annual Plan and Report, both a legal requirement by the Care Act 2014, provide partner organisations and the public with assurances that adult safeguarding is being monitored and scrutinised in Somerset. The Board also maintains and monitors its own risk register.

## 8 Appendices

- 8.1 [Appendix A – SSAB Annual Report, 2021-22](#)  
[Appendix B – SSAB Annual Report Appendix \(The Work of Our Members\)](#)  
[Appendix C – SSAB Annual Report One Page Summary](#)

Appendix D – SSAB Performance & Quality Report Summary (August 2022)

# SSAB P&Q Report (Aug 2022)

## Summary of key messages



### Listening & Learning

- In 94% of 542 enquiries undertaken (2021/22), desired outcomes from the safeguarding process were sought from the individual or their representative. Where desired outcomes were expressed by individuals/their representative, these were fully achieved in 88% of cases.
- The SSAB and Safeguarding Service seeks feedback direct from service users, carers and advocates via its safeguarding questionnaires. Satisfaction levels are currently highest from service users (100% satisfied with the outcome of the safeguarding work), followed by IMCAs/Advocates (88%); More could be explored to enhance the experience of friends/relatives/carers in safeguarding activity (56% satisfied with outcome), particularly where younger adults are involved (transitions).
- Complaints regarding the ASC Safeguarding Service fell during 2021/22 from 12 (2020/21) to 9. 3 were resolved upon receipt or at first point of contact, 2 were 'not upheld' (Stage 1 outcome) and the remaining 4 await a Stage 1 outcome. 'Failure to do something' and 'communication by service' were the most common initial cause for complaint. The Service routinely monitors both compliments and complaints, and takes forward learning from investigations where desired standards haven't been met. No complaints received 2022/23 ytd.

### Enabling people to keep themselves safe

- The SSAB continues to generate high levels of interest and engagement via its comms channels: website launched April 2016 – in Year 1 it was visited 5,865 times, growing to 50,810 times over the last year.
- The % of all active adult social care settings rated 'Good' or 'Outstanding' by the CQC in Somerset is currently reported at 85.9% (July 2022). There's been a rise in the number of provider settings where we are restricting or suspending placements due to quality/safety concerns and a growing number of care home closures putting significant additional pressure on the system and adding to a challenged care market. Somerset's health & care system is also continuing to experience high levels of unmet care need and care package handbacks, primarily due to ongoing care sector workforce challenges.
- Training compliance across local health services and ASC in relation to Adult Safeguarding and Mental Capacity related activity is monitored and reported; pandemic related demand pressures noted as impacting on attendance/completion of training.
- Consultation response recently submitted regarding new MCA Code of Practice (incl Liberty Protection Safeguards) A number of concerns raised re: process and impacts.

### Working together to safeguard people who can't keep themselves safe

- Somerset has seen a declining rate of safeguarding contacts contrary to national trends and fewer enquiries undertaken as a result. Analysis suggests this is a result of the significant work that has been undertaken over many years to improve understanding of safeguarding criteria, and reduce/re-direct the previously high numbers of inappropriate safeguarding contacts, but needs testing.
- Contacts are highest from care providers and health colleagues; increasing from families. A review of 'source options' has been requested
- In July 2022, 59.2% of safeguarding contacts received via Somerset Direct were accepted as requiring a formal safeguarding response; comparing positively to a 21/22 national average conversion rate of 34%.
- Neglect & Acts of Omission remains the most common safeguarding risk type with the person's own home the most common risk location. 93% of concluded enquiries resulted in the risk being reduced or removed during 2021/22, a slight decline on last year's figures. Two thirds of safeguarding enquiries are completed within 60 days.
- Positive engagement with SWAN Advocacy, Safeguarding Service and other leads to address concerns in relation to low advocacy referral rates – action plan in place to address

### Board Governance

- Latest findings/trends relating to the 2021 organisational self-audits have been shared with the SSAB Exec and discussed as a sub-regional set of SABs. A number of recommendations have emerged and will be followed up as part of peer conversation activity later this year.
- In line with other areas of the country, Somerset's seen a sharp rise in the number of SAR referrals during the pandemic. Resourcing and responding to these in a timely way remains a challenge due to pressures on involved professionals.
- The SSAB received a reasonable assurance rating following a SWAP Audit in May 2020.
- A repeat SSAB Effectiveness Survey of Board members was undertaken in April 2022 with themes analysed and shared.
- Contributed to national survey of Safeguarding Adults Boards; 11 improvement priorities identified based on themes to emerge.
- New CQC Assurance of LA Stat Duties – Apr'23 Framework and methodology expected to be published by November 2022. SAB contribution/s central to Theme 3 'Ensuring Safety' - Safeguarding, safe systems and continuity of care
- Recruitment currently underway for replacement SSAB Business Manager

This report should not be used to make judgements about how effective local authorities are at keeping adults safe from abuse and neglect to benchmark local authorities against each other, due to the different reporting and practices used to discharge their statutory duties.