# The Work of Our Members

## Somerset Council – Adult Social Care

**Achievements during 2023/24:**

We are proud of the many developments and successes achieved and progressed over the last twelve months. Examples of particular note include:

- The delivery of a **Local Government Association Assurance Peer Challenge** in March 2024 to support our continuous improvement and readiness for a future Care Quality Commission (CQC) assessment of our service provision and quality. The peer process included a focus on how the Local Authority ensures safety across the Somerset system and involved members of the local Safeguarding Adults Board. Feedback was positive about service improvement, support for staff and the leadership and values instilled within the Council's Safeguarding Adults service, partnership working, and found good evidence of how we apply 'making safeguarding personal' principles. The full and final report is published on the Council's website and details many areas of strength, as well as recommendations for continued focus. We continued to maintain a detailed self-assessment and evidence library as part of our local assurance work and readiness for external regulation.
- A significantly enhanced **practice development and management oversight offer** to support our workforce and local assurance activity, introduced and overseen by our Principal Social Worker and Principal Occupational Therapist. This work has included the launch of a refreshed Practice Quality Framework which is aligned to a monthly auditing schedule and informed by people who draw on our services. It has also included the introduction of clear competency frameworks to support the continued professional development of our operational staff, the implementation of a new policy and process to support learning from serious incidents, and the establishment of a monthly Practice Quality Board which monitors the experience and feedback of people using our services, tracks audit outcomes and informs robust action planning.
- The progress of our adult social care **transformation programme, 'My Life, My Future'** which seeks to build on the strengths we have in Somerset to deliver high quality, person-centred services that promote independence and wellbeing. The programme

centres on five core workstreams (*reablement; outcomes from decision making; data visibility and control; progression and enablement; and preparing for adulthood*), and we continue to see positive results across all areas of the work. Examples include a 30% increase in the number of individuals accessing reablement, meaning 15 more people every week are benefitting from a chance to improve their level of independence in their own home. Additionally, exploring more creative ways to meet people's care and support needs through our peer and enhanced peer forums has resulted in a reduction in the volume of new homecare and direct payment packages started across the county.

- The **restructuring of our operational social care service**, which included the introduction of specialist learning disability teams and the creation of a new Practice Development Advanced Practitioner role holding responsibility for providing high quality practice education to social work students and newly qualified social workers as well as progressing practice improvement activity to improve ways of working and outcomes for people.
- **Levels of unmet home care need have vastly improved** and are being sustained at very low levels, despite demand remaining significant. This is consequent to a variety of focused market-shaping commissioning and workforce related activity and is benefitting system 'flow' as well as local residents. The quality of our care market as judged by the CQC exceeds national and regional averages.

**What have the challenges been?**

- As a new Unitary Council (created April 2023), and in common with many other Local Authorities across the country, we face a **very challenging financial position.** In November 2023, Somerset Council declared a 'financial emergency' which has resulted in the introduction of significant local financial controls to reduce overspend and identify future savings opportunities. This has included the launch of a voluntary redundancy programme and the start of a re-design of our organisational structure. Whilst a balanced budget has been set for the coming year, based on current forecasts, there remains a high likelihood of ongoing budgetary pressures facing the Local Authority and some difficult decisions ahead.
- The service continues to face some **workforce shortages** particularly in key operational roles which has resulted in greater reliance on locum staff to cover critical vacancies and has had some impact on performance and productivity, including addressing waiting lists for assessment and review. Despite this, our focus on productivity and transformation has seen our teams completing 30-40% more work, and we have sought to mitigate some of the workforce capacity risk through our 'grow your own' offers, our focus on converting agency staff to permanent, and investing in international recruitment with 12 Social Workers recruited from overseas- we have recently commenced the recruitment of a third cohort.

**Planned work for 2024/25 to support the SSAB's Strategic Plan**

- Adult Social Care has a clear improvement and delivery plan in place to support our own Strategic ambitions; this is overseen by our Assurance Board and includes a **focus on 'ensuring safety, preventing abuse and neglect, and identifying risk early through effective local safeguarding arrangements'**.
- Our service continues to contribute financially to the Board through the **employment of an independent Chair and dedicated Business Manager, and to the commissioning of and contribution to Safeguarding Adults Reviews**. Our staff also maintain **active involvement in support the Board's subgroups, Executive and Board**, including the provision and analysis of detailed performance reports of relevance of safeguarding across Somerset.
- Our own commitment to, and focus on, **practice quality and the lived experience of people receiving care and support** in the county directly supports the SSAB's strategic plan for 2024-27 in relation to 'community engagement' and to the 'promotion of the Mental Capacity Act'. Our audits include a focus on 'Safeguarding People' and the lawful application of the MCA, and our service has a 'Working Together Board' to enhance opportunities for co-production.
- In relation to '**Transitional Safeguarding and Exploitation'**, our Adult Social Care service is ensuring investment in 'preparing for adulthood' in order to achieve more ideal outcomes for young people transitioning from children's to adults' services and enhance effective partnership working. We are also actively contributing to the development of an all-age exploitation strategy through our support of the Somerset Strategic Safeguarding Forum and data analysis contribution to ensure the strategy is evidence-based and informed.

## NHS Somerset Integrated Care Board (ICB)

**Achievements during 2023-2024:**
NHS Somerset Integrated Care Board (ICB) Strategic Safeguarding Adults team continue to monitor and obtain assurance regarding the quality of the safeguarding adults arrangements for services commissioned by Somerset ICB. This is done in a number of ways which includes data collection, a review of annual safeguarding reports, assurance visits and providing attendance at our Trusts' safeguarding committees.

Successful recruitment of a Named Professional for Safeguarding in Primary Care, Pharmcy, Ophthalmology and Dentistry, has ensured that targeted support, advice and training to primary care organisations that have been identified as requiring additional support is now provided, along with seeking assurance of the safety and effectiveness of their safeguarding adults' arrangements. To support this role a safeguarding associate has been successfully recruited into post to start in May 2024.

Mandatory safeguarding adults training has been provided by the safeguarding team through the GP Safeguarding Leads training day which is held three times a year. We further support colleagues working in primary care to maintain their safeguarding knowledge by providing an ongoing rolling programme of best practice meetings and supervision plus production of a ICB Safeguard newsletter and informative bulletins with current updates and resources providing useful and educational signposting. Despite the significant ongoing demands placed on primary care the above sessions continue to be well attended; demonstrating commitment across primary care to provide effective support to adults who need safeguarding.

Throughout 2023/24 our NHS Somerset ICB strategic safeguarding team have worked with partner agencies locally and regionally in relation to implementation of the following legislation, which places statutory duties on the ICB as a specified authority:

• Anti-Social Behaviour, Crime and Policing Act 2014 - work is ongoing to develop a multi-agency Information Sharing Agreement and agree an associated process that will ensure the ICB fulfils its statutory duties in relation to this legislation

• Domestic Act 2021 – building on multiple workstreams focusing on domestic abuse, which was led by Standing Together, NHS England and the Home Office, the ICB convened a working group looking at how to improve the health system response to domestic abuse

• Police, Crime, Sentencing and Courts Act 2022 - worked with health system and multi-agency partners, to explore how the ICB can meet its statutory duties in relation to the Serious Violence Duty, such as inclusion of local health data in the Avon and Somerset Violence Reduction Partnership Strategic Needs Assessment.

The ICB Strategic Mental Capacity Act (MCA) and Deprivation of Liberty (DoL) Lead has supported the revisions to the Somerset Treatment Escalation policy and associate documents. He has also worked with the local authority MCA lead on an audit to help inform future development across the Somerset Health and Social Care system and gains assurance from our providers regarding MCA training and developments.

The NHS Somerset ICB Continuing Healthcare (CHC) Safeguarding, Quality and Court of Protection (CoP) team have continued to work closely with the local authority safeguarding and quality teams in identifying and working with providers where quality / safeguarding concerns are identified.

**What have the challenges been?**

One of the main challenges faced is ensuring learning from reviews is embedded into practice when staff across the health and social care system are experiencing low staffing, increased workload and reduced resources. Actions taken to achieve this with minimal additional time pressures for practitioners include promoting lunch and learns, short briefings in newsletters and highlighting the learning in existing meetings, regular safeguarding supervision and training events. Gaining assurance that learning had been embedded is an ongoing focus for work over the next year.

**Planned work for 2024-2025 to support the SAB's strategic plan.**

Community engagement: We work with system partners to ensure whole system learning and development for health including policy development and other work streams. A particular focus for this year has been to improve the health response to domestic abuse. Strong partnerships have been formed across the health system to establish ways in which this can be achieved in Somerset.

Understand and manage Self-neglect: We have contributed to the newly revised SSAB self-neglect practitioner guidance alongside the SSAB lunch and learn session to promote this. The guidance has been promoted across the health sector, through supervision, at meetings and in newsletters. The MCA lead has delivered workshops alongside the MCA lead for Somerset NHS Foundation Trust and the local authority as well as creating MCA guidance, (including exec impairment / self-neglect guidance) which is due to be published shortly.

Promotion of the Somerset Safeguarding Adults Board: We continue to promote the role of the safeguarding adults board across all internal and external services and organisations within the health sector. Through training, supervision, self-assessments and quality visits we seek information and assurance from the partnership about how learning is shared within their organisations and how this is improving practice.

## Avon and Somerset Constabulary

**Achievements during 2023-2024:**

Police internal changes have included a new area commander in D/Supt Lisa Simpson and hand over of the Adults at Risk portfolio to a new Force lead DCI Tom Herbert, providing continuity and ongoing support to the SAB for Somerset. This has made progress to improve police understanding and data in relation to demand and future planning for specific cohorts of our communities who are at risk. Improving relationships between the SAB and policing to help share data and understand the demand, action and support between partner agencies involved in the support to Adults at Risk. This has been through greater engagement outside of the SAB meetings and a collective meeting with the SAB chairs across the policing area. (Planned for August 5th).

A new Partnership Data Manager has been employed recently to help and support the management and consistency of data sharing across the partnerships in Avon and Somerset who is engaged in the development of demand modelling and sharing for Adults at Risk and safeguarding.

Both Local Tasking Meetings (LTMs) led by the Neighbourhood Teams in both East and West Somerset have a strong geographical focus around safeguarding which prioritises high Threat Harm Risk cases - all problem-solving plans are now discussed in this 2-week forum to make sure preventative and intervention work stays on track. The feeder 'Priorities' meetings are police led but supported by community safety partners and this 'reactive' forum ensures a coordinated approach to high harm community issues (including adult safeguarding).

**What have the challenges been?**
The understanding of the definition of Adults of Risk across the force remains limited and training has been and continues to be distributed to increase this awareness. As such, the data is not clear and consistent. Work continues to improve this is detailed in the next section.
A current challenge for the "priorities meetings" is the level and extent of engagement by some organisations - not all the relevant agencies routinely attend. That makes collaboration challenging and especially difficult in making sure the lead agency is coordinating activity.

**Planned work for 2023-2024 to support the SAB's strategic plan.**
Planned work for next 6 months is the development of the 'Priorities' process in the Neighbourhood tasking process to ensure that it is consistent across the county and that the right partners at the right level are engaging in all age multi-agency problem solving. This is an important step as it will ensure an engagement framework which is the same for all areas in Somerset. This will be the central focus for the NH policing in working with other agencies. We have currently seconded an Inspector to work with the Violence Reduction Partnership to shape the process and make sure our model connects into the wider community safety partnership
Improvements are being made to the understanding and collection of police data and distribution of data across the SABs across the force. A consistent product will help the distribution of the data and bring clarity around the gaps and understand of this cohort of individuals within our communities. Furthermore, the feedback on the actioned referrals between agencies will support future interventions to identify the cohorts most at risk and where interventions can have the highest impact on mitigating risks they are exposed to
Somerset Safeguard Children Partnership are starting to develop the understanding of an all-age exploitation needs assessment and police will be heavily involved in the development and implementation to assist join understanding across the area.
A new Safeguarding and Vulnerability Risk assessment (SVR) is being developed, implementation of training and launch to take place in the Autumn. This will help to streamline safeguarding requests, understanding of demand and capture all concerns of vulnerability across children and adults to reduce the gaps and increase awareness of vulnerability across the strands from Domestic Abuse, exploitation, sexual abuse and self-neglect, to name a few.

## South West Advocacy Service (SWAN)

**Achievements during 2034-2024**

SWAN have:

- supported 53 adults through the safeguarding process this year. 13 referrals were made through IMCA safeguarding and 40 came through as Care Act referrals.
- reported 34 safeguarding concerns during the past year. The most prevalent form of abuse reported was self-neglect.
- contributed to 4 SARs during the year.

All SWAN advocates are aware that they play a vital role in safeguarding by both reporting and supporting clients through the safeguarding process. Somerset advocates continue to report safeguarding appropriately. It is significant that all genres of advocacy are represented in our reporting as it demonstrates the effectiveness of our internal training and in developing professional curiosity among all our advocates.

Advocates report feeling confident to raise safeguarding concerns and have good knowledge of the processes both internal and external for doing this. Advocates have been persistent in raising their concerns and have in some cases repeated referrals for the same client when there has been no response.

SWAN delivered part of a webinar at Stop Adult Abuse Week in November regarding the role of the advocate in safeguarding, this focussed on a case study about self-neglect. There was positive feedback from the social workers who attended.
SWAN attend and report to both the SSAB and the Sub MCA SSAB meetings.

Through expansion of our self-advocacy projects amongst the homeless community and clients with profound learning disabilities we hope to create further safeguards for vulnerable groups.

**What have the challenges been?**

Routes to safeguarding advocacy: We continue to work with ASC to ensure safeguarding referrals are made through the Care Act route and avoid any delay for the client due to obtaining capacity assessments.

Working in partnership: We want to work more closely with our partners in the Somerset ASC safeguarding team to ensure that advocates can see clear outcomes from the safeguarding referrals they have made.

**Planned work for 2023-2024 to support the SAB's strategic plan**

Feedback from our clients: As a result developing and expanding our self-advocacy and co production provision in Somerset we intend to create a mechanism whereby we feedback from the experts by experience within our Somerset consultation group regarding their experiences and views of adult safeguarding within Somerset.

We feel the voice of the person who has been safeguarded needs to be amplified and we would like to support people with lived experience to report directly to the board through our self-advocacy work.

We feel that in this way we are best able to uphold the 6 safeguarding principles and support the strategic plan.

## Somerset Care

**Achievements during 2023-2024**

Systems and Processes:

- Camascope – a new medication management system was launched in Residential services. This enables better visibility for Managers to identify promptly any medication related issues to quickly enable action to be taken to prevent any harm.
- We have developed and implemented several different processes to provide greater organisational overview of risks in services.

- A new Key Performance Indicator tracker was developed which highlights high risk services and is based on a set criteria which includes whistleblowing, complaints and safeguardings raised against us as well as clinical indicators. Data is pulled from various existing systems to give an overall risk score per service and enables organisational oversight and benchmarking. This enables us to be more agile and focus support on services at higher risk.
- Following identification, services are given additional focus and support from the internal multidisciplinary team (MDT) to create an improvement plan. Progress is reviewed at weekly Focus Home MDT meetings to assess effectiveness of support provided and to amend as appropriate.
- A process of sharing information among all staff, including those working at 'ground level' was introduced via daily Flash meetings. This includes all staff groups in a service. This ensures staff are made aware of any shared learning, safeguarding concerns or new measures to be introduced to reduce risk.
- Furthermore, safeguarding incidents that meet an internal 'high priority' trigger are reported on and discussed at Board level via the bi monthly Board Quality Committee meeting.

Training :

- Oliver McGowen Training was mandated and has been introduced organisationally. Part 1 has been undertaken with 84% compliance currently. Our Realise service, which supports people with learning disabilities have all completed tier 1 and tier 2 training and can provide peer support. One of our Realise customers has recently been taking part in delivering our Oliver McGowan Training as an Expert by Experience Coach which has enhanced staff experience.
- MCA Webinars were created by the Somerset Care Quality Team and delivered across the Organisation to upskill and enable staff to practically apply the theory. Chris Hamilton SCC MCA and DoLs service Manager, attended an Operation/Quality meeting to discuss DoLS and clarify expectations which has led to a review of our current Policies and practice.
- Level 3 safeguarding training via an NHS provider was undertaken by 12 senior staff and 6 staff went onto complete a CPD accredited qualification. The Safeguarding Lead also achieved level 4 CPD accredited qualification which has provided greater support to services in terms of advice and guidance.
- Staff have attended regional safeguarding provider engagement events – this provided networking opportunities and has improved relationships with the safeguarding team, with Managers being more inclined to reach out for advice and guidance, especially regarding cases which do not meet criteria for a section 42.

- Significant work has been undertaken regarding staff knowledge of the IDDSI Framework and risk of Choking. The process for recording this in our services has been strengthened so staff can get the right information at point of care.
- A training webinar was developed and recorded for staff regarding practical methods of managing choking and a choking risk assessment was created and introduced. All service users have one completed and this is reviewed on a monthly basis with referral for SALT assessment should the score indicate this need.
- Policies: Self-neglect has been included as part of Induction and scenarios introduced to help colleagues discuss and increase their understanding of self-neglect. A Self Neglect Policy has been created and implemented which includes methods to consider if not reaching a safeguarding threshold. This includes a clear process and MDT action agreement form to ensure responsibility is allocated and is accountable.
- The Somerset Decision making tool has been rolled out as part of the Safeguarding Policy and process review and is already proving beneficial to managers enabling them to raise or not raise a case based on evidence.

**What have the challenges been?**

Organisational structure changes :

- Significant changes to organisational structure in terms of roles and changes in Executive Leadership Team has meant there are changes in ways of working and different levels of focus. In addition, there has been a change to the organisations portfolio of services which has impacted on risk and has potentially caused an increase in safeguarding scrutiny.
- This has also impacted on the organisational meeting schedule and difficulty in maintaining separate safeguarding meetings. Safeguarding is now discussed at the weekly integrated Quality and Operations meetings enabling greater responsiveness and as mentioned, reported to the Board on a bi- monthly basis.
- Oliver McGowen Training:
- Has been difficult to implement due to number of disparate staff and the planning of Tier 2. There is still no defined group of staff roles that need to undertake this higher level. This is still under discussion at Senior Leadership level.

**Planned work for 2024-2025 to support the SAB's strategic plan**

- The organisation has no separate safeguarding audit. We are planning to work with other stakeholders to learn from their audit dataset to develop our own with an aim to be able to share at SSAB.

- We are currently involved in a Self Neglect Thematic review – The outcome of this this will be interrogated for shared organisational learning.
- Our aim is to reintroduce some further training to complement the mandatory learning to encourage discussions about safeguarding issues. We continue to target work with individuals and teams to improve compliance. We plan on introducing and relaunching a learning module which encourages reflection on scenarios to enable staff to put the theory into practice.
- We plan to review the current stakeholder feedback process to further strengthen it by creating a questionnaire based on the CQC Quality 'I' and 'We' statements which will include how safe a service user feels and how included they are in their care and treatment plan.
- We have commenced work on the introduction of monthly star chart analysis to Residential services following successful utilisation in the Realise service. This is being piloted in 3 of our Residential services currently. This will then be set up on our Radar Compliance system and will check that escalations have been made appropriately and actions identified to support the Service user.
- We have commenced work with an external consultancy company to review our Subject access request policy and processes to ensure current process meets best practice.
- We are rolling out access to Radar (Compliance system), to WayAheadCare – who currently report via paper based method. This will enable organisational oversight of all risks within the service and highlight themes across the organisation as a whole.
- We are currently developing a re-admission assessment tool for Managers and Trusted Assessors to use to enable safe transition back to Care homes from other settings such as Hospitals. This has come as a direct result of a number of incidents where residents have been readmitted with missing crucial information which in some cases has led to an unsafe discharge requiring emergency remedial input or readmission to Hospital.

**Achievements during 2023-2024**

We have had a busy year taking feedback from members of the public about their experiences in health and social care. We have published eight reports on different topics over the year and represented our local communities as an independent voice on a number of different strategic boards including the SSAB.

As a member of the SSAB we completed the Regional Adult Safeguarding Self-Assessment Tool in December 2023.

**What have the challenges been?**

Healthwatch Somerset is a hosted organisation and we were re-commissioned by Somerset Council at the end of 2023. This has resulted in a new host being contracted. The staff have TUPE'd across to a new employer and have moved offices in Bridgwater.

The Advocacy People, who are our new host, are a charity based in Hastings. They believe in a society where people feel in control of their lives and are confident to speak up and people who can't speak up for themselves have someone in their corner to speak for them. This ethos fits well with our work in Healthwatch Somerset.

Planned work for 2024-2025 to support the SAB's strategic plan.

We will continue to engage with our local communities and share their stories with our stakeholders including Somerset Council. This will help to improve the SSAB policies, systems and processes by understanding what matters to them.

## Somerset NHS Foundation Trust

**Achievements during 2023-2024**

April 2023 saw the merger of the legacy Somerset NHS Foundation Trust with Yeovil District Hospital Foundation Trust, to form the new Somerset NHS Foundation Trust (SFT). Somerset NHS Foundation Trust provides a number of health services across the county of Somerset. Services include two acute hospitals, thirteen Community Hospitals, community services including district nursing, and a range of mental health and learning disability services. We believe that the broad range of services we offer within one organisation puts us in a better position to provide mental and physical health services for the population of Somerset, helping people to enjoy healthier lives with

improved equitable access to the specialist care and treatment they need, when they need it. The newly formed Trust is supported by around 13,500 colleagues who deliver or support our patient services.

Following the merger, The Trust's Safeguarding Advisory Service developed a Safeguarding Strategy that outlines our key priorities for 2023 – 2026 and reviewed the structure of the service. The Safeguarding Advisory Service Duty Team provides an advisory service for staff across the organisation where there are safeguarding concerns for patients in our care. During the financial year 2023/24 the service has supported staff with 10,252 safeguarding enquiries relating to both adults and children.

Drop-In Consultation Clinic - As part of the restructuring of the Safeguarding Advisory Service, Quarter 3 2023/24 saw the introduction of the Duty Team Consultation Clinic, which provides, via Teams, an 'online' direct and immediate link for Trust staff to the duty team for complex case discussion and advice. Non-urgent enquiries are facilitated via a single point of contact telephone line and email address.

The Safeguarding Advisory Service has reviewed its mapping of staff requiring Level 3 Safeguarding Adult training, the outcome of which will be an increase in staff accessing this training as part of their mandatory requirement. The Safeguarding Advisory Service Learning and Development Lead contributes to the induction training of our overseas nurses.

We continue to highlight the principles of 'Making Safeguarding Personal' and embedding the 'Think Family' approach, generally incorporating a person-centred approach to safeguarding adults.

Staff across the Trust now use the Local Authority e-form for Safeguarding Adults referrals. This has helped to prevent delay in referrals being sent to the Local Authority for their triage decision.

SFT continues to support the wider system safeguarding agenda, working collaboratively with safeguarding partners in health, social care and police and maintains its representation at Safeguarding Adult Reviews, Domestic Homicide Review, Channel Panels, SSAB Board and sub-groups and other relevant local and regional forums/networks.

We continue to review how the Trust responds to domestic abuse and have specialist domestic abuse practitioners within the Safeguarding Advisory Service. We continue to promote Domestic Abuse Routine Enquiry via workshops, supervision and via contacts to the Safeguarding Advisory Service duty team.

**What have the challenges been?**

Staff changes, staff sickness and some vacant posts have added to the pressures of maintaining a proactive and responsive service.

SFT has seen an increasing demand on its Safeguarding Advisory Service regarding its participation and contribution to Safeguarding Adult Reviews, Domestic Homicide Reviews, Child Section 47 Strategy Discussions, single and multi-agency learning from incidents including Child Safeguarding Practice Reviews, in addition to the year-on-year increase in contacts to this service. This is coupled with the additional challenge of capturing data across numerous recording systems.

A Trust wide pressure on the system, as replicated throughout the NHS nationally, including time for staff to be released from their duties in order to complete training. This in turn impacts on training compliance rates.

**Planned work for 2023 -2024 to support the SABs strategic plan**

To explore how best to adopt and incorporate the SSAB Self-Neglect guidance and toolkit into Trust safeguarding processes; including providing staff with the knowledge and confidence to support patients in our care, who are at risk of, or experiencing self-neglect.

A focus on Transitional Safeguarding, utilising an integrated, collaborative approach in considering how we can work together to ensure a coordinated approach to Transitional Safeguarding under the current co-existing, but separate, binary structures of safeguarding adults and safeguarding children.

Working towards improving knowledge, skills and practice relating to transitional safeguarding, including multi-agency working utilising the Multi-Agency Risk Management (MARM) approach to risk management and risk mitigation.

To continue to share learning from Safeguarding Adult Reviews via mandated safeguarding training, supervision, staff communications networks and bespoke, targeted workshops.

To continue to promote the ethos of ‘Making Safeguarding Personal’ and ‘Think family’ and ensure staff embed this within their everyday practice by embracing a safeguarding in practice approach to their roles and duty of care.

To work in collaboration with the Trust's MCA and DoLs lead to improve practice and legal literacy in relation to the Mental Capacity Act 2005.

To ensure patients on our care, and our staff, are and feel 'Sexually Safe'. We aim to do this via the development of a Sexual Safety Policy, information leaflets, and associated learning materials.

The Trust's Learning and Development Department are currently in the process of mapping staff across the Trust to the Oliver McGowan training relative to their roles and responsibilities. This will be a mandated training

## The Probation Service

**Achievements during 2023-2024**

New Head of Service – recruitment of new Head of Service on 29th January 2024 following the retirement of previous Head in November 2023.

Recruitment of Trainee Probation Officers - The Probation Service continues to increase the intake of new trainee Probation Officers to strengthen its workforce.

HMIP – in the Autumn of 2023 Somerset PDU underwent an inspection. Whilst there were found to be areas of improvement in relation to Court work and risk assessment/management, the inspection found that Somerset PDU's ability to provide effective and consistent services to meet the needs of people on probation, and prevent further offending, was a strength. They worked successfully and cohesively with partner agencies, such as the local authority, to deliver programmes and support victims. Staff were found to be highly motivated and determined to support people on probation and victims of crime.

Domestic Abuse and Child Safeguarding Enquiry Hub – the Southwest region has now established a Domestic Abuse and Child Safeguarding Enquiry Hub. The Enquiry Hub facilitates quality information sharing arrangements with other agencies like the Police and

Children's Services; in Somerset work has taken place to establish direct access to some Police and Children Services databases for staff in the Enquiry Hub.

Reporting – service users/offenders living in the area of Chard previously reported to Yeovil where transport links are problematic. Management of these cases has now been transferred to the Taunton Team which has proved far more beneficial in terms of travelling logistics. Somerset provides reporting centres in Frome and Wells to support meeting with those offenders located in the Mendips.

Somerset Safeguarding Adults Board – Somerset PDU has provided ongoing representation at these meetings.

**What have the challenges been?**

End of Custody Supervised Licence (ECSL) – this is a scheme which has been introduced in order to try and combat the current pressures around prison capacity. Under the scheme certain offenders, in certain prisons, are now eligible for release on licence up to 70 days ahead of their automatic release date. This has impacted on Probation Staff, particularly with regard to effective release planning.

Probation Reset implementation – Probation Reset is an organisational policy that has been implemented to alleviate Probation workload pressures. The focus of these measures also aims to target our resources where they have the most impact i.e. at the start of the sentence.

Probation Reset changes mandate that Probation Practitioner contact with an offender is suspended in the final third for all Community Orders and Suspended Sentence Orders with Rehabilitation Activity Requirement and all licences. The changes also mandate the suspension of contact during the Post-Sentence Supervision period.

There are some offenders who are exempt from these changes and usual contact will continue (those subject to MAPPA, those assessed as posing a Very High risk of serious harm. Those where there is a Child Protection Plan in place, those managed by the National Security Division).

Initial implementation of the Probation Reset changes has impacted upon the workload of staff and has been a significant 'change' for them to navigate.

Closure of Taunton Crown Court - due to structural issues the Crown Court has had to be closed for 9 months, this has led to Probation Staff and defendants having to travel to North Somerset Magistrates' Court where Taunton are now sitting temporarily.

Staffing issues – there have been periods of staffing shortages which have led to high workloads. These have now somewhat improved, particularly as a result of recruiting additional probation officers. It is hoped that Probation Reset changes will improve things further.

**Planned work for 2024-2025 to support the SAB's strategic plan**

*Priorities for Somerset PDU in 2024-25:*

- Improve the quality of assessments, including those done at Court and ensure that initial sentence plans are completed in a timely manner. This will be supported by delivering SEEDS2 and embedding a reflective practice environment.
- Ensure that all necessary Domestic Abuse and Safeguarding checks are completed promptly to support effective risk assessment and management. This process will commence in our Courts and be continued by Sentence Management.
- Ensure that interventions and requirements are implemented and enforced appropriately to support rehabilitation and successful completion of orders and licences. This will be facilitated by the implementation of a POD Model across the PDU.
- Ensure people on probation are receiving the right levels of contact, including Home Visits; ensuring all are seen at least monthly face to face and those assessed as posing a Very High/High Risk of Serious Harm are seen at least weekly.
- Implement Probation Reset and seek opportunities to improve efficiency and achieve manageable workloads.
- Continue to build an inclusive culture that promotes professional standards, wellbeing and tackles unacceptable behaviour, utilising the Human Factors approach.

Office adjustments - environmental audit reports have been carried out by the National Autistic Society for Somerset, Taunton and Bridgewater offices; work is now underway to consider recommendations and make necessary changes/adjustments to our building/office environments.

SDAS – work is underway to develop the working relationship and practices with SDAS. This is with the aim of improving' the delivery of Alcohol Activity Requirements (ATR's), Drug Rehabilitation Requirement's (DRR's) and Mental Health Treatment Requirements (MHTR's). The is now a Health and Justice Partnership Worker to support all of this work.

MARAC – continued good partnership working and attendance at MARAC. Somerset PDU has now embedded a 'MARAC POD'.

Regular attendance at Adult Safeguarding Board meetings - Nationally, the effectiveness of joint working, including information sharing and communication, are themes from learning reviews. Therefore, we have a shared priority to ensure that joint working is effective to safeguard adults. Continued engagement with ASC subgroups, including Task and finish subgroups.

Domestic Homicide reviews – continued engagement with this process - The key purpose is to enable lessons to be learned from homicides where a person is killed because of domestic violence, abuse or neglect.

## Abri Housing

**Achievements during 2023-2024**

Newly appointed Safeguarding officer-taking on:

- Operations-champions across the group
- Escalation and monitoring of cases
- Promotions
- Attendance at groups
- Audit our internal reporting system (SSSS) to ensure cases are being reviewed quarterly.
- Safeguarding Lead can now look more strategically at the group wide approach, compliance and attendance at SAR etc.
- Newly formed Safeguarding management steering group-looking at all our board priorities-what's happening in LA's/ lessons learned. First two meetings in January and April have taken place and will continue as 'in person' quarterly meetings.

Shared lessons learned already being seen:

- Will now attend all Adults and Children's care/ support/ safeguarding meetings when invited. In the past we had only attended where housing issues, following a case in Hampshire we will now attend all first meetings to establish where/ when and if we need to be involved.
- Welfare checks introduced on customers where 'no access 'given. Priority to those with known vulnerabilities-be professionally curious-gain access.
- Compliance-Area's rated amber or red (SSAB tool) being addressed through internal steering group to ensure we work to improve our standards where we can during the coming year.

- Involvement in the thematic self-neglect review. Review of 6 cases including two Abri housed customers.

**What have the challenges been?**
Availability-time-Staff increasingly busy. Also, lack of social workers in some area's has had an effect on our customers.
Computer systems that are not for case work-how best to use our systems for safeguarding cases.

**Planned work for 2024-2025 to support the SAB's strategic plan.**

- Dedicated training sessions on area's that effect housing ie; self-neglect/ MARM/mental capacity/ advocacy etc for all 'champion' roles of which we have 25 across the group. Budget to cover costs.
- Abri 'owned' MARM framework-to enable teams to work more efficiently across the whole group which includes many LA's.
- -Training for new staff to have safeguarding processes as part of induction/ on-boarding. This is yet to be agreed (can we set to certain roles)
- DBS checks for more job roles.
- Some Job descriptions to include Abri's safeguarding commitment.
- Boundary procedure for staff and customers to be aware of standards and code of conduct. Bespoke National safeguarding week to meet topics that we can promote both internally and externally.

**Golden Lane Housing**

Golden Lane Housing strives for a world where people with a learning disability and autism have the right support and opportunities to live fulfilled and successful lives in an environment, they feel proud and safe to call their home. Ensuring the ongoing wellbeing and safety of tenants continues to be of paramount importance and forms the very foundation of our service delivery. At Golden Lane Housing we know that when organisations work effectively together to understand the needs of individuals with concerned curiosity, we deepen our understanding of tenants' aspirations. We know what good multi-agency work looks like and we also know what good support looks like and when we align the various components, we can ensure great outcomes are achieved. Our safeguarding approach is just one key area of our work to help ensure tenants remain safe and happy in their homes and where there is a concern, it is dealt with quickly and where possible, tenants remain in charge throughout.

Housing Officers continue to take a pragmatic and person-centred approach in keeping in regular contact with tenants the organisation deems to be most at risk of abuse. In fact, there have been 3,583 separate housing management cases logged during this last year, demonstrating robust contact between Golden Lane Housing's Housing Officers and tenants, their families and support providers.

Golden Lane Housing continues to empower tenants to voice their concerns and preferences and involve them in decision-making processes regarding their care and support. Promoting a culture of respect, dignity, and person-centred support within a housing setting remains a key feature of Golden Lane Housing's approach.

During this last year we have welcomed a GLH tenant who is also the Chair of Golden Lane Housing's More Voices More Choices panel, to the role of Tenant Safeguarding Representative. Our Safeguarding Rep has been working very closely with our Head of Housing and Safeguarding to review our safeguarding policy, accompanying procedures and most importantly, hearing from our tenant about how we can ensure that every tenant in the organisation is aware of the work we do to support them in keeping safe.

The difference we continue to make at Golden Lane Housing:

During financial year 2023/24, Golden Lane Housing supported tenants with 95 'low level' safeguarding concerns. 5 of these escalated and became a formal 'concern' raised to the appropriate Local Authority. A further 37 'concerns' (a total of 42) were raised formally to 23 different Local Authority Safeguarding Boards across the country.

The largest category of concern was self-neglect and related to tenants not engaging with their support team. As a result of this, the tenants' general health and wellbeing had deteriorated. The statistics also include 3 hoarding concerns, and tenants unable to keep their home in a safe and clean condition.

The second largest category was emotional abuse. Concerns raised were due to incompatibility issues between tenants living in shared properties where altercations are taking place in communal areas and where tenants are alleged to have been perpetrators of abuse towards support staff.

Outcomes for tenants:

Our safeguarding approach enables tenants to achieve outcomes that are important to them. Monthly recording and monitoring of our safeguarding KPIs help our Housing Officers to establish and record what tenants wish to achieve by way of outcomes and how best we are therefore able to support them. Where possible, we will always include the tenant throughout the process. Where the tenant does not have capacity, we will work with those that understand the needs of the tenant and will advocate on the tenant's behalf.

Of the 42 concerns raised, 20 (48%) were deemed by the Local Authority as meeting the 'section 42 enquiry'. For those cases that were deemed as not meeting the threshold, Housing Officers continue to work with the Social Worker / duty team until they are satisfied with the outcome achieved. 30% of the concerns raised resulted in tenants either being able to remain in their own home safely with additional support or supported to move to more appropriate accommodation where their needs could be better met.
21% of cases are still ongoing with Housing Officers working proactively with key professionals to help bring about a resolution that meets the needs of the tenants. For this reason, it can take on average 6-8 months to close down a concern.

Developing the Safeguarding Network for Housing Providers:

We look forward to continuing our work with The Ann Craft Trust to support them with their national research regarding the links between cognitive ability and exploitation and we hope that this research and our involvement to date will provide new knowledge on how these issues intersect, which can inform existing policy and practice, and provide important information and resources for those who may be at risk.

Support to our colleagues:

We have a wonderful team of housing management colleagues who work with tenants on their safeguarding concerns daily and we must not lose sight of the support our colleagues need when dealing with complex and upsetting concerns. Our two monthly de-briefing sessions for colleagues to share and learn from continue to improve our service delivery.

**Livewest Housing**

**Achievements during 2023-2024**

Overall, there has been an increase of **21%** of Safeguarding Reports being raised through Assure in 23-24 (**789 cases**) in comparison to 22-23 (**625 cases**) which is encouraged as more of the workforce identify, report well and follow procedures to ensure we work collaboratively in meeting the needs of our customers. There has been an increase in the reporting of Domestic Abuse which is welcomed following a briefing in the October Operational meetings focussing on why we need to be Consumer Standard ready and be consistent with both reporting and contributing to a Coordinated Community Response (CCR) which is recognised within the Whole Housing Approach. https://assets.publishing.service.gov.uk/media/62c6df068fa8f54e855dfe31/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf Fig. 1 Below is an Annual Comparison Chart to cover Local Authorities, which LiveWest divisions have raised cases and types of Safeguarding concerns identified.

**Comparison Report**

| Year 22-23 | North 22%<br>South 78% | | Year 23-24 | | North 34% ↑<br>South 66% ↓ | |
|---|---|---|---|---|---|---|
| **Local Authority** | **Count of Loc** | % of total | **Local Authority** | **Count of L** | **% of Total** | |
| BANES | 10 | 1.6% | BANES | 23 | 3.0% | ↑ |
| Bristol | 60 | 9.6% | Bristol | 120 | 15.0% | ↑ |
| Cornwall | 278 | 44.5% | Cornwall | 255 | 32.0% | ↓ |
| Devon | 97 | 15.5% | Devon | 162 | 21.0% | ↑ |
| Gloucester | 1 | 0.2% | Gloucester | 4 | 0.5% | ↑ |
| North Somerset | 15 | 2.4% | North Somerset | 25 | 3.0% | ↑ |
| Plymouth | 73 | 11.7% | Plymouth | 63 | 8.0% | ↓ |
| Somerset | 48 | 7.7% | Somerset | 76 | 10.0% | ↑ |
| South Gloucestershire | 5 | 0.8% | South Gloucestershire | 18 | 2.0% | ↑ |
| Torbay and South Devon | 38 | 6.0% | Torbay and South Devon | 43 | 5.5% | ↓ |
| **Total** | **625** | **100%** | **Total** | **789** | **100%** | **21% increase** |

| Year 22-23 | | | Year 23-24 | | | |
|---|---|---|---|---|---|---|
| **Type of Safeguarding** | **Count of Typ** | % of total | **Type of Safeguarding** | **Count of T** | **% of Total** | |
| Domestic Abuse | 54 | 8.6% | Discrimination | 3 | 0.5% | ↑ |
| Exploitation | 45 | 7.2% | Domestic Abuse | 150 | 19.0% | ↑ by 55% |
| Financial Abuse | 11 | 1.8% | Exploitation | 46 | 5.8% | ↓ |
| Forced Marriage | 1 | 0.2% | Financial Abuse | 22 | 2.8% | ↑ |
| Hate crime | 6 | 0.9% | Hate crime | 6 | 0.7% | ↓ |
| Lacks Mental Capacity | 28 | 4.5% | Lacks Mental Capacity | 60 | 7.6% | ↑ |
| Neglect | 150 | 24.0% | Missing Person | 1 | 0.2% | ↑ |
| Physical Abuse | 36 | 5.8% | Neglect | 155 | 20.0% | ↓ |
| Psychological Abuse | 19 | 3.0% | Physical Abuse | 33 | 4.1% | ↓ |
| Self Harm | 45 | 7.2% | Psychological Abuse | 28 | 3.5% | ↑ |
| Self-Neglect | 116 | 18.6% | Self Harm | 52 | 6.6% | ↓ |
| Sexual Abuse | 27 | 4.3% | Self-Neglect | 128 | 16.0% | ↓ |
| Suicidal Ideation | 87 | 13.9% | Sexual Abuse | 19 | 2.4% | ↓ |
| | | | Suicidal Ideation | 86 | 10.8% | ↓ |
| **Total** | **625** | **100%** | **Total** | **789** | **100%** | |

**What have the challenges been?**
There has been a slight decrease in reporting of Neglect and Self-Neglect (Fig.1) and the Safeguarding Lead for LiveWest has recommended a similar briefing to the workforce to focus on those types of concern as we head into the new operational year and draw out the comparisons with the monthly In house Maintenance Team Talks, as this division have the opportunities to be the eyes and ears of the organisation when they are completing day to day works with our customers.

**Planned work for 2023-2024 to support the SAB's strategic plan.**
Not all safeguarding concerns need to be escalated and we, as an organisation are continuing to work well in a Coordinated Community Response, to manage risks within the communities we work in, by sharing relevant information with police and social care, contributing and participating in Early Help, and being an essential part of MARM (Multi-Agency Risk Management) and MARAC (Multi-Agency Risk Assessment Conferences) processes for complex needs and domestic abuse. This meets both our LiveWest values and provides essential evidence for the new Regulator of Social Housing Consumer Standards which commenced 1 April 2024. In addition, 24-25 will see the start of some of our key Young People services being inspected under Ofsted, our strengthened approach to Safeguarding including how we manage Missing Persons, will be invaluable for demonstrating good practice.

South Western
Ambulance Service
NHS Foundation Trust

**SWAST**

**Achievements during 2023-2024**
During 2023/24 SWAST safeguarding team underwent an external independent review.
An improvement plan was developed and framed around 5 key deliverables:

1. Robust governance, assurance & reporting
2. Safeguarding team capacity
3. Safeguarding referral system

4. Data capture, audit and learning from incidents
5. Safeguarding education & supervision

Action against these deliverables commenced with immediate effect and significant progress has been made to date. A summary of progress is available below:

- Governance processes have been enhanced to include the Trust Safeguarding Committee that meets bi-monthly to monitor the Trusts safeguarding activity and provide assurance on safeguarding practice. The Safeguarding committee reports to the Quality Committee providing assurance and raising issues for escalation. The Quality Committee reports into the Trust Board. Safeguarding reports are provided to commissioners via Dorset ICB and The Head of Safeguarding from Dorset is a member of the Safeguarding Committee.
- The Head of Safeguarding commenced in Post on the 1st of December 2023, The Deputy Head of Safeguarding commenced in Post in April 2024 and 4 Safeguarding specialists have been appointed and are due to commence in post early in quarter 1 2024/25. There is one remaining vacancy for a safeguarding specialist. The increase of capacity will enable to team to move toward a county-based safeguarding model with safeguarding specialist aligned to the 7 SWAST localities.

Key responsibilities of the Safeguarding specialists will include:

- To be the interface between SWAST and local system safeguarding partners
- To undertake statutory reporting, attend panel meetings, monitor actions, and share learning
- To support Section 42 enquiries
- To provide advice and guidance to SWAST colleagues
- To provide safeguarding supervision to SWAST colleagues
- To provide safeguarding training and CPD opportunities
- To support the provision of assurance regarding SWAST safeguarding activities and functions

The safeguarding team have undertaken a full review of all safeguarding referral forms, forms have been revised to ensure they align to the Care Act, are provide our local authority colleagues with the information they require to facilitate triage and support our SWAST staff in raising high quality referrals. Forms are currently with IT colleagues for development.

The revised referral forms will result in increased data availability to support assurance reporting, audit and team learning and development.

During 2023/24 the safeguarding team supported an audit of the Assessment and Management of Children Under 1s, Findings were presented to both the Clinical Quality Group and Safeguarding Committee, recommendations were agreed, and a 'Rapid Read' learning resource is in development to increase awareness of raising safeguarding referrals, completing skin assessments, and sharing records with GPs. A reaudit will be undertaken to assess the efficacy of the actions.

A revised training offer is in place for 2024/25 which includes an additional 4.5 hour face-to-face safeguarding training on the development days, bespoke face to face training for the Emergency Operations Centres and enhanced two-day level 3 safeguarding training for identified senior staff groups. It recognised that the increase in compliance and competence will take time to achieve however the delivery of training will also be supported by ad-hoc learning opportunities, digital learning resources and the provision of safeguarding supervision by the Safeguarding Specialists.

**What have the challenges been?**

- Within SWAST the safeguarding team have not had the capacity to enable effective participation in partnership meetings and processes. The team have been able to meet its statutory functions however it has been difficult for the team to be present at boards and sub-group meetings or to undertake improvement activities. During 2023 a successful business case was made to increase the team capacity providing a safeguarding specialist in each county. Recruitment for this has been successful and as we enter 2024/25 the team are at full capacity.
- In April 2023 it became apparent that Private Ambulance Providers had begun using a different referral system in the previous months, this resulted in a backlog of referrals which required process.
- During summer 2023 there was a cyber-attack which affected SWAST Electronic Patient Clinical Records (EPCR) and as a result safeguarding referrals were made using an online form, this resulted in a temporary drop in referrals and also made the accessing of patient records difficult as all Trust clinical records were on paper and required manually uploading the our electronic systems and were unavailable at short notice to support the authoring of chronologies and information requests.

**Planned work for 2023-2024 to support the SAB's strategic plan**

In 2024/25 our SWAST safeguarding priorities are to deliver and embed our Safeguarding Improvement Project, improving the efficiency and quality of safeguarding services within the Trust. Whilst working with our partners in line with their strategic safeguarding plans to improve experiences and outcomes for our patient s and people being safeguarded.

**Achievements during 2023-2024**

Discovery's organisational achievements in 2023-2024 have been informed by a revised approach to listening and learning from the people we support and their families about what is important to them and for them when considering how their lives could be better. Whilst Working Together for Change (WTFC) has been conducted in the same way that it was originally conceived (outside of Discovery) for many years, this year we refreshed our approach to listening, learning and acting on the feedback received. The new approach to WTFC has provided greater insights into what people think about the services they receive, what needs to change or improve and how we can achieve those changes, together and in the spirit of co-production.

| Working Well: | | Could be better | |
|---|---|---|---|
| People we support | Families | People we support | Families |
| During 2023, people told us that what was working well for them included: | More activities happening | Sometimes not having enough support to be able to do the things they enjoy. | Improving the simple things and having consistent high standards, noting that it is very easy to let things slip |
| People we support | Retaining staff better | Some people mentioned they were not happy with the other people they live with. | Their loved ones missing out on activities due to agency colleagues not being prepared or knowing their relatives well enough |

| | | | |
|---|---|---|---|
| Going out and about and doing the things they enjoy | The quality of staff has improved | | Families to be more often seen as part of their loved one's 'team' |
| Spending time with friends and family | Communication is good and concerns are listened to | | There was also a compelling ask for Discovery to find ways to 'change the narrative in social care', in that we too often hear about the negatives or what has gone wrong in social care, but there is not enough about the positives or stories about how people's lives have been 'made better' as a result of the support they receive. Families suggested a 'System of approach', in which their voices could be promoted to influence the wider health and social care system. |
| Having more staffing support to achieve this. | Consistency of support | | |

*What we've done about it:*

People we support

- Made greater strides in finding the right support worker colleagues and most importantly, keeping them; we are now delivering 2,000 hours more support per week than we were this time last year.
- Focused on securing consistent agency colleagues and ensuring that all temporary workers get to know people better, whilst continuing to grow our own in-house agency (peripatetic) team who now provide c1,600 hours of support per week.
- Retained more colleagues – voluntary turnover improved by 4.5% and total turnover improved by 4.4% when compared to the same period last year.

- Worked with commissioners and Adult Social Care colleagues to review and formulate plans for the closure of some homes that were very poor and need lots of money to bring them to good order
- Supported people, where they were clearly poorly matched with others they lived with, to find new homes where they can feel happy and safe.

Families

- Introduced 'observations of support practice', which is helping our managers provide feedback to colleagues on the quality, standard and consistency of the support they provide,
- Enhanced our appreciative enquiry process in respect of medication events and safeguarding enquiries to inform learning and improve the quality and safety of our practice.
- Told more stories about the good things we do
- Redesigned our 'welcome' video to showcase the positive impact of social care
- Collaborated with the ICB, NHS Trust and Somerset Council and engaged in 'wider system' conversations where there are important matters relating to people with a learning disability and autistic adults in Somerset.
- Focused at every opportunity on the essential partnership with families, highlighting the vitally important role they play within a person's circle of support.

**What have the challenges been?**

One of Discovery's principal areas of focus in the last year has been in respect of those health- related matters, which may present as a greater risk of a 'never event'. The notion of Never Events is well embedded into the way we work at Discovery, with the concept deriving from the NHS and describing events that: are clearly identifiable and measurable; can result in death or significant disability; and can usually be avoided if everyone acts appropriately and follows established procedures.

Of particular focus in the last year has been: 'No one should suffer any harm as a result of a failure to administer or monitor the medication prescribed, or to follow established processes, for the relief or avoidance of constipation'.

It is believed that whilst 10% of the general population suffer from constipation, between 20-50% of people with learning disabilities are known to suffer from it (LeDeR Constipation Newsletter 2019).

Following a comprehensive audit of bowel management records conducted across Discovery during September 2023, it became evident that a number of inconsistencies presented a level of risk to the people we support who may suffer from constipation.

The audit centred on 75 individual records of people who are prone to constipation. The findings from all audits were analysed and key learning themes presented to inform wider organisational plans as well as addressing any deficits found within the process or support practice for any individual.

Through the spot checks we learned that some people we support's PRN (as and when required) laxative protocols could not be consistently followed due to the person asserting their right to privacy and dignity around toileting. In addition, we learned that some GP's (or prescribers), did not provide clear guidance about any associated monitoring arrangements, particularly in instances where the person may not communicate with words and/or decisions were required in their best interest.

Clear communication with the person's GP (or prescriber) to understand the information in a person's Bowel Management Plan and the rationale for them to be involved in developing and signing off the plan has brought some challenges that required diligence and focus to overcome. Whilst challenging, this vitally important piece of work has provided a super platform to remind colleagues of the potentially serious consequences of constipation, improved engagement with GP's and most importantly, broken down barriers to ensure that talking about poo is not viewed as a taboo.

In 2023, the organisation introduced essential constipation training as a mandatory requirement for all operational colleagues. An introduction video presented by Sheila Handley, the mother of a man who died as a result of constipation, presents a compelling call to action to ensure that this important topic remains at the forefront of our practice.

**Planned work for 2023-2024 to support the SAB's strategic plan**

Empowerment: Increase and explore different ways to work with citizens of Somerset to improve our policies, systems and processes by understanding what matters to them

Through Discovery's Community Fund, which is a social investment fund derived from a share of the organisation's year-end financial surplus and administered on our behalf by Somerset Community Foundation Trust, we are looking to support the reintroduction of self-advocacy across Somerset.
At the time of writing, grant applications are being considered, with an expectation that the organisation selected will develop a model that allows a self-advocacy group to be both financially independent and have independence of thought.

Accountability: Seek information and assurance from the partnership about how learning is shared within their organisations and how this is improving practice.

Discovery will continue to work in a manner that further embeds an open and just safeguarding culture as simply the way we work around here. In addition, by remaining curious and unguarded to learning from section 42 enquiries, never events and never event near misses as well as matters which have not met the threshold for section 42 enquiry where patterns or themes are identified, we will retain a growth mindset that applies learning in a way that minimises the risk of harm, abuse or suffering happening to others.
We will follow a strengths-based approach to safeguarding concerns. 'Nothing about me without me' must underpin safeguarding practice, providing support to help build the person's self-esteem and sense of self-worth, whilst enabling them to have confidence to make decisions and take control of their situation, even during the most troubling times in their lives.

## Somerset Council – Public Health

Public health safeguarding duty includes three main areas of service delivery: Public health Nursing and Health Visitors, Drug and Alcohol Services and Community Safety. Sexual health commissions are covered through Somerset Foundation Trust safeguarding policies, and we have not included them here. We have also included brief notes on our system work on homeless reduction.

**Achievements during 2023-2024**

**Public health nursing:**

Public Health Nursing remains committed to holistic and inclusive support for families. Our main achievements for safeguarding include our proactive engagement with fathers, robust domestic abuse response framework, partnership working with others including through MARAC, and continuous professional development through mandatory training.

**Somerset Drug and Alcohol Services:**

SDAS have secured additional funding for specialist drug and alcohol services, which has resulted in reduced caseloads for workers and sustained high completion of treatment rates, putting our provider in the top quartile nationally.

SDAS MARAC representatives have had good attendance and contributions at the weekly MARAC meetings.

Our Peer Mentor scheme is growing, and now has 30 peer mentors supporting across the service. Mentors support our clients who are undertaking detoxes and in getting to the detox /rehab unit that may be out of county. They are soon to start meeting and greeting the clients that are being released from prison. Another new initiative is around making recovery visible in the community.

The Mental Health Treatment Requirement team is a relatively new tier 2 government initiative service, led by a Forensic Clinical Psychologist. The team have close liaisons with partner agencies, such as CMHT, National Probation Service and Liaison and Diversion. They support clients who offend with low to medium mental health issues, anxiety, depression, trauma and carryout psycho educational training.

The SDAS Criminal Justice Team has grown over the last year. With a full team, they cover the east and west of the county. The team attend forums with external agencies to discuss continuity of care and how to increase numbers in service and support those in the criminal justice system to change their lives around for the better. They support in Drug Rehabilitation Requirements, and Alcohol Treatment Requirements. The team work closely with external agencies around continuity of care, they attend courts, have a presence at HMP Exeter, the Probation Service and the local police teams working together to support those in the system and to safeguard them and the public by reducing the number of offences related to substance use.

Our Dual Diagnosis leads attend monthly dual diagnosis's forum where SDAS Dual Diagnosis leads and community mental health service work together to problem solve cases where there are the dual issues and work out solutions for the clients both services are supporting.

The outreach rough sleepers' team and the harm reduction team rotas are now in place to have joint SDAS and Rough Sleepers Initiative/Outreach nurse team presence in the community to engage those hardest to reach. The harm reduction team have been providing training to Nelsons Trust, RSI staff at council, council staff, the police and local hostels.

**Community Safety**:
Community Safety Partnership has invested in North Somerset Council's data team who will carry out data work for statutory needs assessments. This team have direct access to police and other stakeholder data and as they will also provide the same service across our neighbouring councils in Avon and Somerset, we can also achieve comparator data on how we are performing across core crime categories and priority thematic items.

**Health Inequalities:**
We have continued to implement the recommendations of the Homeless Health Needs Assessment - particularly:
- Adults Social Care a. education programme around self-neglect, executive dysfunction and Care Act legislation – commissioners and operational staff. b. Need for improved data recording – e.g., housing status within Eclipse. c. Improved locality working
- Safeguarding - Somerset Safeguarding Adults Board, Somerset Council and NHS to adopt and implement NICE Guidance NG214 Integrated health and social care for people experiencing homelessness
- Working with the Coroner and Medical Examiner to improve recording, reviewing and understanding of Homeless mortality.

**What have the challenges been?**
Public Health Nursing:
Challenges in having the capacity to carry out our supporting role in MARAC.
Drug and alcohol:
Many who have drug and alcohol needs are not engaged with services – this requires more awareness and priority from wider system partners to support these individuals where there is a more complex picture e.g. overlap between MCA/self-neglect/memory and alcohol.
Community Safety:
Somerset's MARAC has moved to an online portal to reduce administrative burden and provides clearer accountability to those organisations for their roles. However there have been delays in the roll out of this portal to ensure we get the system right, which had led to frustration amongst partners.

In addition, lack of engagement from Adult Social Care at MARAC continues due to lack of staff capacity.
Health inequalities:
There have been some challenges in implementing some of the homeless health needs assessment, including challenges in securing engagement from Adult Social Care.

**Planned work for 2024-2025 to support the SAB's strategic plan.**

Transitions is a priority theme between children's and adults and public health continue to be part of these.
Somerset strategic safeguarding forum already aware of the challenge in learning from case reviews and enabling clearer self-audit processes that align with emerging themes and recommendations. Challenge is to continue to review the embedding of any learning or changes in an ongoing way.
Community Safety plan to develop a contract for counselling for survivors of domestic abuse (children and adults) as part of domestic abuse service from 1st May.
Community Safety will also be launching Somerset's first all age exploitation needs assessment.
SDAS will continue to work o
n additional join up between drug and alcohol services and the NHS including primary care.
There will be public health input to the new Somerset Homelessness Mortality Review procedure to ensure learning and prevention themes are taken across the system.

**Achievements during 2023-2024**

Devon and Somerset Fire and Rescue Service (DSFRS) have been working hard to embed the safeguarding culture within the organisation, including the provision of Speak Up Guardians which provide staff with an opportunity to raise concerns about inappropriate or unethical behaviour that may have safeguarding implications. DSFRS also have a Whistleblowing Policy and an Allegations Management procedure. DSFRS have also established a Safeguarding Steering Group meeting involving key stakeholders across the organisation to ensure safe practices including Safer Recruitment and other procedures are in place and adhered to.

DSFRS have developed and cascaded a Tier 1 Safeguarding Training package for all staff across the organisation to complete to increase knowledge around safeguarding and ensuring clear and robust safeguarding processes are embedded throughout the organisation. This is the first time all staff have been required to complete safeguarding training and we are now building on this and developing a comprehensive training strategy in addition to a competency framework. This will cover different levels of training for staff in every department, from firefighters to admin support staff. Although the level

of training will differ depending on each role, we believe everyone in our organisation should have a fundamental understanding of the importance of safeguarding and an awareness of the role of the Safeguarding Team. This helps us to ensure that safeguarding is embedded within the organisation.

We have been working towards ensuring all our training records are held centrally to ensure we keep robust records of all Safeguarding related training that staff undertake.

We are also in the process of establishing a governance structure in relation to SAR reviews to ensure all recommendations are recorded and acted upon efficiently and to ensure learnings are cascaded out to the service.

As a service we have been working on strengthening our Safeguarding processes and ensuring that we establish closer working arrangements with partner agencies for those cases where Safeguarding thresholds are not always met and we will always ensure a Home Safety Visit is carried out where fire risks have been identified the occupant. We have a robust system to ensure that high-risk cases are responded to as a priority.

We continue to work with partner organisations, and we deliver a comprehensive 'Trigger Point Awareness Package' to partners to ensure they are aware of the signs to look out for that might mean someone is at risk off having a fire. This ensures we receive referrals at the earliest opportunity and can signpost individuals to support or raise safeguarding referrals where necessary if someone is at risk of having a fire.

A member of our safeguarding team actively attends the prevent partnership board. Taking part in discussions and sharing back relevant information to the team and service wide where needed.

**What have the challenges been?**

On occasions we may struggle to find out if a person is known to adult social care as we might lack information to progress through GDPR checks. This sometimes causes a barrier as our crews aren't always able to collate the required information whilst at a incident and we are therefore unable to share risk information. Sometimes we do hold key information as we have been in to the property when potentially all other services have not been able to get into the property or individual has not been engaging with any other services.

Sometimes whilst on the phone trying to share the information that we have seen / witnessed we have not got full consent to share the information, but this is often due to the nature of the incidents our crews might be attending it is possibly not the most appropriate time to ask for this consent. This is an area that we are working on with our staff.

Sometimes when calling through the wait times on phones can be up to half an hour, and then if we get through and we don't hold enough information this can be time taken away from triaging other referrals that we receive.

Often, we don't get much feedback following a referral. Would be good to develop the partnership working more.

**Planned work for 2023-2024 to support the SAB's strategic plan.**

Collate learning from SARS and share with wider department where appropriate.

Going forward improved working practices within the team to ensure all requests from the board to ensure our working relationship works at a high standard.

**Achievements during 2023-2024**

Devon and Somerset Fire and Rescue Service (DSFRS) have been working hard to embed the safeguarding culture within the organisation, including the provision of Speak Up Guardians which provide staff with an opportunity to raise concerns about inappropriate or unethical behaviour that may have safeguarding implications. DSFRS also have a Whistleblowing Policy and an Allegations Management procedure. DSFRS have also established a Safeguarding Steering Group meeting involving key stakeholders across the organisation to ensure safe practices including Safer Recruitment and other procedures are in place and adhered to.

DSFRS have developed and cascaded a Tier 1 Safeguarding Training package for all staff across the organisation to complete to increase knowledge around safeguarding and ensuring clear and robust safeguarding processes are embedded throughout the organisation. This is the first time all staff have been required to complete safeguarding training and we are now building on this and developing a comprehensive training strategy in addition to a competency framework. This will cover different levels of training for staff in every department, from firefighters to admin support staff. Although the level

of training will differ depending on each role, we believe everyone in our organisation should have a fundamental understanding of the importance of safeguarding and an awareness of the role of the Safeguarding Team. This helps us to ensure that safeguarding is embedded within the organisation.

We have been working towards ensuring all our training records are held centrally to ensure we keep robust records of all Safeguarding related training that staff undertake.

We are also in the process of establishing a governance structure in relation to SAR reviews to ensure all recommendations are recorded and acted upon efficiently and to ensure learnings are cascaded out to the service.

As a service we have been working on strengthening our Safeguarding processes and ensuring that we establish closer working arrangements with partner agencies for those cases where Safeguarding thresholds are not always met and we will always ensure a Home Safety Visit is carried out where fire risks have been identified the occupant. We have a robust system to ensure that high-risk cases are responded to as a priority.

We continue to work with partner organisations, and we deliver a comprehensive 'Trigger Point Awareness Package' to partners to ensure they are aware of the signs to look out for that might mean someone is at risk off having a fire. This ensures we receive referrals at the earliest opportunity and can signpost individuals to support or raise safeguarding referrals where necessary if someone is at risk of having a fire.

A member of our safeguarding team actively attends the prevent partnership board. Taking part in discussions and sharing back relevant information to the team and service wide where needed.

**What have the challenges been?**

On occasions we may struggle to find out if a person is known to adult social care as we might lack information to progress through GDPR checks. This sometimes causes a barrier as our crews aren't always able to collate the required information whilst at a incident and we are therefore unable to share risk information. Sometimes we do hold key information as we have been in to the property when potentially all other services have not been able to get into the property or individual has not been engaging with any other services.

Sometimes whilst on the phone trying to share the information that we have seen / witnessed we have not got full consent to share the information, but this is often due to the nature of the incidents our crews might be attending it is possibly not the most appropriate time to ask for this consent. This is an area that we are working on with our staff.

Sometimes when calling through the wait times on phones can be up to half an hour, and then if we get through and we don't hold enough information this can be time taken away from triaging other referrals that we receive.

Often, we don't get much feedback following a referral. Would be good to develop the partnership working more.

**Planned work for 2023-2024 to support the SAB's strategic plan.**

Collate learning from SARS and share with wider department where appropriate.

Going forward improved working practices within the team to ensure all requests from the board to ensure our working relationship works at a high standard.