Annual Report 2025-2026 Partner Content

Contents

Adult Social Care

Achievements during 2025-2026

Between April 2025 and April 2026, Somerset Council's Adult Safeguarding Service continued to strengthen safeguarding arrangements, workforce development, policy and practice improvements, strong multi-agency partnership working, and improved governance and oversight. Key achievements included an improved programme of safeguarding and mental capacity training, refreshed tools and guidance (including escalation routes and Somerset's Safeguarding Pathways Guidance), and active engagement with the Somerset Safeguarding Adults Board (SSAB) and wider partners to identify risk, share learning, and drive improvement.

Audits and quality assurance

Continued use of the Adult Social Care Practice Quality Framework (PQF) and monthly auditing approach to support consistent, safe and ethical practice.

Refreshed the audit programme for concerns resolved by the Contact Centre.

Worked jointly with the Quality Assurance Team to share safeguarding learning and provider intelligence, identify emerging risk themes, and coordinate targeted support and challenge with providers to strengthen safe practice and reduce risk.

Training delivered and workforce development

Refreshed delivery and monitoring of the Adult Social Care safeguarding training offer, which has been informed by learning from reviews and supported by compliance and attendance reporting.

Adult Social Care safeguarding training delivery including an Adult Social Care Somerset Council Safeguarding Procedures webinar that is delivered monthly and is part of the mandatory training offer for Adult Social Care and the Contact Centre Safeguarding Team.

Corporate completion of Introduction to Safeguarding Adults e-learning progressed during late 2025, with 2,890 staff completing the module in the reported period.

Regular CPD sessions led by the Practice Development Advanced Practitioner which included learning from the self-neglect thematic review.

CPD sessions were delivered to the Contact Centre Safeguarding Team.

Policy/procedure updates and practice guidance

Continued strengthening of safeguarding screening and recording including use of the SSAB risk decision-making tool and new guidance at the front door.

Improved consistency in pathway decisions through the introduction of a Triage Manager role.

Strengthened escalation and feedback mechanisms for external referrers (including improved routes for partners to challenge or follow up screening outcomes), supporting transparent and responsive safeguarding pathways.

Launch of Somerset's Pathways Guidance which includes processes for meetings that are part of the Safeguarding pathway.

Partnership initiatives and multi-agency learning

Active contribution to SSAB governance and assurance activity, including Performance and Quality Assurance arrangements, and participation in system forums to share learning, trends and practice updates.

Continued focus on learning from Safeguarding Adults Reviews (SARs) through dissemination and embedding activity, supported by multi-agency workstreams and practice learning mechanisms.

Performance improvements and strengthened oversight

Strengthened governance and accountability through established assurance routes, including performance and quality oversight reported through SSAB performance reporting and internal assurance mechanisms through Somerset Council's Assurance Board.

Continued focus on improving quality and outcomes through Making Safeguarding Personal (MSP) approaches, with routine monitoring of outcomes and experience measures through safeguarding reporting.

Improved timescales for pathway decisions in the Triage Team.

- Improving the quality of feedback to referrers.

What have the challenges been?

Over the last year, key challenges have included maintaining consistent, timely and well-evidenced decision-making at the front door in the context of continued demand and complexity; ensuring shared understanding of thresholds and effective information-sharing across partner agencies; and strengthening confidence and consistency in applying the Mental Capacity Act (including where there may be coercion, control, undue influence or fluctuating/executive capacity).

Awareness raising has been taking place to promote understanding of safeguarding as set out in the Care Act 2014 versus concerns about welfare.

The service has also continued to respond to high-risk and often multi-factorial themes reflected in system priorities and learning (including homelessness, domestic abuse and exploitation, self-neglect and health-related vulnerabilities), which can require sustained, coordinated multi-agency risk management.

The biggest challenge facing the Safeguarding Service is recruitment. There have been significant Social Work vacancies. There are promising signs of improvement with 3 newly qualified Social Workers having been recruited to start later in 2026.

Embedding safeguarding as everyone's business across the system, including workforce capability and emphasis on prevention, continues to be a challenge.

Planned work for 2026-2027 to support the SAB's strategic plan

Somerset Council's Adult Safeguarding Service will focus on delivering activity that supports the Somerset Safeguarding Adults Board (SSAB) Strategic Plan 2025–2028. Work will prioritise prevention and early help, effective multi-agency risk management, consistent application of the Mental Capacity Act (MCA), learning from Safeguarding Adults Reviews (SARs), and meaningful involvement of people with lived experience to strengthen practice and improve outcomes.

1) Community engagement

Strengthen opportunities for people with lived experience to influence safeguarding service design and improvement, including involvement in reviewing information materials and practice guidance.

Improve the accessibility of safeguarding information by promoting confidence in reporting concerns and understanding safeguarding pathways.

Continue to work with partners and community networks to raise awareness of safeguarding, thresholds and the role of safeguarding in supporting adults at risk.

2) Homelessness

Support delivery of learning and improvement actions arising from the SSAB homelessness thematic review, including strengthening referral pathways, decision-making and multi-agency responses for adults experiencing homelessness.

Build practitioner confidence across Adult Social Care and wider partners in recognising safeguarding risks linked to homelessness (including self-neglect, exploitation and health-related vulnerabilities) and using appropriate escalation routes.

Maintain and strengthen links between Adult Social Care safeguarding, Housing and homelessness services to support timely, coordinated safeguarding responses.

3) Domestic abuse and exploitation

Work with partners to strengthen recognition, reporting and professional response to domestic abuse and exploitation affecting adults (including older adults), ensuring safeguarding interfaces effectively with other pathways and risk management forums.

Contribute to system-wide work to align approaches to exploitation across the life course, including links to all-age exploitation arrangements and relevant partnership strategies.

Promote consistent use of tools, guidance and escalation routes to support effective multi-agency working in high-risk cases.

4) Transitional safeguarding

Strengthen partnership arrangements that recognise safeguarding risks for young people and young adults as they transition into adulthood, ensuring pathways are clear and coordinated.

Support continued development and assurance of transition pathways for those who may require safeguarding, with a focus on consistency of practice and shared understanding across agencies.

Work with partners to increase practitioner awareness of transitional safeguarding and how to respond when Care Act duties do not apply, but risks remain significant.

5) Promotion of MCA and its use

Continue to strengthen understanding and application of the MCA, including capacity assessment, best interests' decision-making, and the interface between safeguarding, coercion/control, undue influence and exploitation.

Support development and review of resources, guidance and learning activities related to MCA (including executive functioning and self-neglect), ensuring they remain current and accessible to practitioners.

Use quality assurance and learning routes (including audits and thematic learning) to identify where further support is needed and to target training, briefings, and reflective practice.

Devon and Somerset Fire and Rescue Service

Achievements during 2025-2026

Governance:

Following the development of Devon & Somerset Fire & Rescue Service's (DSFRS) internal Steering Group and Safeguarding Board over the last two years, the groups have been further supporting governance arrangements around SARs and other reviews. This will ensure that learnings and recommendations from SARs are embedded within the Service and the progress of these will be monitored. This work has also been linked with the Service's wider work around the Safeguarding Fire Standards and will help us achieve the desired outcome of "being a service that actively promotes the Safeguarding of those in its community and its employees and volunteers," and to be a service that "collaborates appropriately with others to ensure a coordinated approach to Safeguarding."

Training:

DSFRS have completed training and input sessions to key departments within the Service, including Business Safety and Road Safety. This is to ensure that each member of staff has the relevant and proportionate level of Safeguarding understanding to act on any concerns they encounter within their roles.

Reviews:

A data reporting system has been created to analyse information gathered from DSFRS's internal Safeguarding cases. This has enabled the Service's Safeguarding Team to examine key themes and risk areas as well as review breakdowns on data by geographic/ local authority area. This is an internal system to be used temporarily during the procurement process of a new digital system.

What have the challenges been?

Delays for digital referral form:

Previous plans for the implementation of a digitalised internal Safeguarding referral form have experienced unforeseen delays due to the need for more watertight restrictions on the data gathered and stored from the form. Improvements have been made to the current form to gather additional information and aid the DSFRS Safeguarding Team in triaging more effectively.

Long call waits times:

The DSFRS Safeguarding Team have experienced long wait times when phoning through to Somerset Social Care, sometimes reaching upwards of 50 minutes, which has impacted our availability to deal with new incoming referrals and other pieces of work.

Planned work for 2026-2027 to support the SAB's strategic plan

Safeguarding Drop-In Sessions

Development of online Safeguarding 'drop in' sessions specifically aimed at operational fire crews to provide a forum for discussing key safeguarding themes and answering questions in an informal setting. These sessions are set to begin in the autumn.

Updated Safeguarding Training

DSFRS's mandatory e-learning training package has been reviewed and updated, ready to launch to the Service in late Spring. This will ensure every member of staff receives up-to-date safeguarding messaging and education on key themes and risk factors.

Homes in Somerset

Homes in Somerset can demonstrate a strong and maturing safeguarding approach during 2025-26. Despite increasing demand and complexity, we have continued to strengthen our systems, partnerships and practice, ensuring residents are supported to live safely.

The Safeguarding Policy (2023–26) remains compliant and is undergoing review to align with Somerset Council's approach and will be provided to our Board for approval at their meeting in November 2026.

Achievements during 2025-2026

This year we have seen an increase in the complexity of safeguarding cases, particularly in domestic abuse and vulnerability. While case volumes remain relatively stable, the acuity and risk profile of cases have increased, requiring more intensive intervention and partnership working.

We have continued to maintain strong relationships with external partners and our ability to access homes and provide intelligence has been recognised as a key strength by multi-agency partners, enabling safer engagement with vulnerable residents. Our achievements include:

• Strong governance and oversight frameworks maintained with regular Board reporting.

• Continued multi-agency partnership working including MARAC, fire service and specialist support providers.

• Achievement of DAHA Gold accreditation demonstrating high standards in domestic abuse response.

• Improved identification of safeguarding concerns, particularly domestic abuse and vulnerability.

• Strengthened tenancy sustainment approach enabling earlier intervention and improved risk management.

• Enhanced monitoring of hoarding cases and structured partnership referrals.

• Improved triage and risk assessment for hate crime cases.

What have the challenges been?

Over the past year we have seen:

• Increasing complexity of customer vulnerability and support needs.

• Rising demand in domestic abuse cases.

• Workforce safety risks linked to higher-risk tenancies.

• System capacity pressures across partner agencies.

• Organisational transition and alignment with Somerset Council housing services.

Planned work for 2026-2027 to support the SAB's strategic plan

Learning from complex cases, including external scrutiny and partner feedback, continues to inform ongoing service improvements.

Policies and procedures continue to evolve to reflect emerging risks and best practice.

1: Concerns were raised about a tenant's wellbeing due to poor property condition, hoarding, lack of food, financial difficulties, and declining health. The Tenancy Sustainment Officer became involved due to the level of vulnerability.

Homes in Somerset took a proactive, multi-agency approach. Safeguarding and GP referrals were made, and although there was initial reluctance from Adult Social Care, we advocated for the tenant until the case was accepted.

We worked directly with ASC to clear the property and improve living conditions. White goods were provided by Homes in Somerset, and immediate support was put in place, including weekly food bank collections. A longer-term support plan was introduced to help with shopping, food access, and money management.

The property is now in a safe and improved condition, with ongoing support in place. Regular inspections and welfare checks ensure the tenancy is sustained. The tenant is now more socially engaged and no longer living in isolation.

2: Concerns were raised due to a tenant with dementia repeatedly going missing, storing and consuming out-of-date food, concerns regarding the condition of the property and being unable to manage finances after losing access to their bank card.

Homes in Somerset took immediate steps to support the tenant's wellbeing, putting practical measures in place to help them remain safe and sustain their tenancy. We worked with the GP surgery, who had also identified concerns, and coordinated support through internal ILS services. A micro provider was arranged to provide hands-on support, and we assisted in resolving rent arrears and restoring access to funds for essential spending. We also supported improvements to the property condition to ensure it was safe and suitable for the tenant's needs by spending time removing items from the property with the tenants consent.

The tenant now has a micro provider and carers in place, along with a pendant alarm for added safety. Adult Social Care continue to provide ongoing support, and the tenant is regularly engaging with ILS services. The tenancy is now stable, with appropriate support in place to help the tenant manage safely moving forward.

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust

ACHIEVEMENTS DURING 2025-2026

Somerset NHS Foundation Trust provides a number of health services across the county of Somerset. Services include two acute hospitals, thirteen Community Hospitals (including seven Urgent Treatment Centres), community services including district nursing, and a range of mental health and learning disability services.

The Safeguarding Advisory Service consists of professionals from a range of backgrounds including nursing, mental health nursing, health visitor, midwifery and social workers, who provide support and guidance to around 15,500+ colleagues who deliver or support our patient services. The service continues to highlight the principles of 'Making Safeguarding Personal' and embedding the 'Think Family' approach, generally incorporating a person-centred approach to safeguarding adults.

During the financial year 2025/26, the Safeguarding Advisory Service Duty Team supported colleagues with 8,022 safeguarding enquiries received into the single point of contact, relating to both adults (4237) and children (3785).

The Safeguarding Advisory Service continues to review how colleagues recognise and respond to concerns relating to self-neglect. Self-neglect is covered within the safeguarding Adults Level 3 training, plus we provide an additional Self-Neglect CPD workshop.

The Safeguarding Advisory Service continues to review how the Trust responds to domestic abuse, and how best our colleagues can support victims and perpetrators of domestic abuse. Domestic abuse is covered in our mandatory Safeguarding Adults and Safeguarding Children Training, in addition to various CPD modules.

S42 Safeguarding Enquiries - From quarter 3, 2024/25 the Safeguarding Advisory Service introduced a new process for monitoring and supporting colleagues with statutory s42 Safeguarding Enquiries assigned to the Trust to complete. This process included the development and availability of s42 skills sessions, development of Learning Logs regarding s42 enquiry related learning / recommendations, a tracking system that helps to ensure deadlines are met in a timely manner and actions are implemented. This process and learning logs will enable the Safeguarding Advisory Service to identify any emerging themes regarding areas for improvement in patient care. Since the implementation of this new process, we have seen a reduction in s42 enquiries raised against the Trust by approximately fifty per cent in financial year 2025/26.

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

We continue to meet our statutory duties regarding Prevent and Channel. The Trust is currently compliant with its mandatory Prevent training at Levels 1 – 3 and is compliant with the Prevent Core Duty Standards for Health Providers.

Safeguarding Champions – The beginning of March 2025 saw the first formal meeting of the Safeguarding Champions, which led to an enthusiastic and motivated group of colleagues who will be promoting best practice and positive safeguarding intervention across the trust.

The role of a Safeguarding Champion is to actively lead and promote safeguarding within their team. Their main role is to advocate for and implement safeguarding practices to protect children and vulnerable adults from harm, abuse, or neglect. They contribute to creating a culture of safety and shared responsibility, ensuring that safeguarding concerns are taken seriously.

The Safeguarding Champion role is crucial in ensuring a safe environment for vulnerable individuals and helping to address safeguarding issues effectively.

The Trust currently has 51 safeguarding champions, representing teams from across the Trust and endeavour to increase our group of Safeguarding Champions across the Trust.

Safeguarding Stars – The Safeguarding Stars initiative was launched in May 2021 to recognise colleagues for good practice and positive outcomes for children, adults at risk, and families. The initiative reinforces the principle that safeguarding is everyone's responsibility, supports learning from the safeguarding training programme, and reflects the Safeguarding Advisory Service's commitment to actively promoting good practice across the Trust.

To date, the Safeguarding Advisory Service has awarded 155 stars to colleagues across the Trust, with 29 awarded this year (April 2025 – March 2026).

Domestic Abuse Champions – The Safeguarding Advisory Service has relaunched the Trust-wide domestic abuse champion network. This provides an opportunity for colleagues with an interest in domestic abuse to develop their skills and knowledge in this area.

Domestic Abuse training development – The Safeguarding Advisory Service continues to provide and expand its domestic abuse training offer. Currently we provide a face-to face Domestic Abuse Awareness session, DASH skills workshop (recorded webinar), newly developed Domestic Abuse Development Day (running 4-6 times per year). In development are further modules / skill sessions, including the impact of domestic abuse on children, DA training for managers.

Safeguarding CPD workshops / skills sessions – in addition to the development of domestic abuse training, the Safeguarding Advisory Service have developed and provide CPD workshops for Self-Neglect, Multi-Agency Risk Management (MARM) process, s42 safeguarding enquiry process, Self-Neglect. In development is a skills session for responding to disclosures of non-recent abuse.

All of our CPD sessions have been developed as a result of learning from SAR's and DHR's in addition to colleague feedback and demand, as a means to their professional development.

Patient Record System(s) - In Quarter 4 2025/26 the Trust secured a contract for a single patient record system, which is anticipated to go live in 2028. It is anticipated that a single patient record system will provide a centralised record of a patient's health information, enhance clinical safety and decision-making, support patient-centred care, and significantly reduce the administrative burden.

WHAT HAVE THE CHALLENGES BEEN?

Staff changes, staff sickness and some vacant posts within our Safeguarding Advisory Service continue to add to the pressures of maintaining a proactive and responsive service. This has been managed by prioritising our statutory duties and temporarily withdrawing the 'Teams' facilitated drop-in Consultation Clinic and Duty Team Ward Liaisons.

The drop-in clinics enabled 'instant' response from the duty team for complex safeguarding case discussion. It is hoped that this can be reimplemented in the future. Colleagues are still able to access advice and support from the Duty Team single point of contact.

The ward liaisons with our Adult Acute Services and Community Hospitals, entailed bi-annual / quarterly face-to-face ward visit by a Duty Team Member allocated to that specific ward. It is hoped that this initiative can be reinstated in the future, but will be dependent upon competing demands, coupled with the practicalities of the number of acute wards and community hospitals to be covered, in addition to the geographical area.

The Safeguarding Advisory Service continues to see an increasing demand 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.

PLANNED WORK 2026-2027 TO SUPPORT THE SAB's STRATEGIC PLAN

1. Community Engagement

The Safeguarding Advisory Service continually promotes, via the duty team, training and safeguarding newsletter, the importance of seeking the patient's voice where there are safeguarding concerns about them.

The Safeguarding Advisory Service continues to work with the Trust's Patient Engagement and Involvement Team to consider ways in which patient view of safeguarding involvement could be ascertained.

The Trust's Patient Engagement and Involvement Team work closely with patients, carers and healthcare professionals to enhance health services. Their commitment to patient and family-centred care (PFCC) ensures that patients and their families are actively involved in care

decisions and service development. The team prioritises listening to feedback to continuously improve our services.

Community Mental Health Services work utilise a co-production model via their Recovery partners, also called Experts by Experience – these are people who have lived experience of mental health difficulties and / or who have experience of caring for someone a mental health difficulty. Colleagues and Recovery Partners work through the process of co-production to enhance services.

The Mental Health Service Lived Experience Support Team is a small, dedicated team committed to empowering patients through engagement, training, and support. Lived experience is a powerful tool for change and improvement; they work closely with patients, service users and carers to help them develop and contribute to mental health service improvement as Experts by Experience (EbE). By providing the right guidance and support, they enable patients to share their insights, contribute to service improvements, and influence mental health service development in positive and meaningful ways.

2. Homelessness

The Trust provides a Homeless and Rough Sleeper Specialist Nursing Service that provides outreach physical nursing care for people experiencing homelessness, rough sleeping or living in temporary / vulnerable accommodation within Somerset.

They are a team of experienced nurses, paramedic, mental health nurses, experienced health workers, peer support workers, and an administrator that covers Taunton, Sedgemoor, Mendip, and South Somerset. They accept referrals from any service, including RSI teams, Somerset Council, mental health teams, GPs, hospitals, police, probation, HMPs, MIUs and A&E.

The team can support patients to engage with SDAS, Dual Diagnosis, Probation, Mental Health Teams and Community services such as social care, food banks and the CAB.

3. Domestic Abuse (and exploitation)

The Trust's Safeguarding Advisory Service takes domestic abuse very seriously and has undertaken a number of measures to improve colleagues' skills, knowledge and confidence in the recognition and response to domestic abuse. In summary, we continue to strengthen the Trust's response to domestic abuse by reviewing practice, supporting both victims and perpetrators, and embedding domestic abuse awareness within mandatory safeguarding training.

Development is underway for a Trust-wide domestic abuse champion network to build colleague expertise and capability. In parallel, the domestic abuse training offer continues to expand, including awareness sessions, DASH skills workshops, a Domestic Abuse Development Day, and further modules in development focused on the impact of domestic abuse on children and domestic abuse training for managers.

Additionally, the Trust has domestic abuse Polices for both patients and colleagues and a named Domestic Abuse and Sexual Violence Lead.

Transitional Safeguarding (and exploitation)

The Safeguarding Advisory Service has a dedicated Child Exploitation, Transitions and Modern Slavery Lead who works across services to ensure transitional safeguarding is a considered factor where safeguarding concerns are identified for young people transitioning from our child services into adult services.

The Trust's Mental Health Service has a Connect 18 Team who work with young people transitioning from our Child and Adolescent Mental Health Services into our Adult Community Mental Health Services.

MARAC (multi-agency risk management conference) - Following concerns raised by the Safeguarding Advisory Service with the Community Safety Partnership Chair in Q1 2025/26, a review of the MARAC process in Somerset was undertaken. This led to the establishment of a MARAC Steering Group and a review of the MARAC Protocol and representation. As part of this work, the Trust strengthened its contribution by increasing MARAC representation from one to four representatives. This has enhanced the Safeguarding Advisory Service's duty team's expertise in domestic abuse and ensures colleagues contacting the SPOC receive expert, evidence-based advice and guidance.

Safeguarding Stars - From the implementation of the Safeguarding Stars initiative, the Safeguarding Advisory Service has awarded 155 stars to colleagues across the Trust, with 29 awarded this financial year (April 2025 – March 2026). Stars are awarded to colleagues who have demonstrated safeguarding in practice, taking action(s) to safeguard adults and children in our care.

NHS Somerset

Somerset NHS Integrated Care Board

Achievements during 2025-2026

Despite a challenging year for Integrated Care Boards (ICBs) due to ongoing NHS restructures, NHS Somerset ICB's Safeguarding Team has continued to deliver robust oversight and assurance of adult safeguarding arrangements across all services commissioned by the ICB. This

assurance is gained through a range of activities, including data collection, review of annual safeguarding reports, quality assurance visits, and attendance at safeguarding committees within provider organisations.

Key achievements over the reporting period include:

Workforce Development and Capacity Building: The Continuing Health Care (CHC) team is now fully supported by the Strategic Safeguarding Team within the ICB. Through training and supervision delivered by the safeguarding team, CHC staff have been upskilled in recognising and escalating safeguarding concerns. Collaborative working with the CHC Court of Protection Deprivation of Liberty (CoP DoL) function has also widened the knowledge and skillset of the wider ICB Safeguarding Team.

Training and Support for health safeguarding leads: Mandatory safeguarding adults training continues to be delivered via GP Safeguarding Leads Training Days, held three times annually. A rolling programme of best practice meetings, safeguarding supervision, newsletters, and bulletins continues to support knowledge retention and ongoing professional development in primary care. Despite workforce pressures, attendance remains high, reflecting a strong commitment across primary care to safeguarding responsibilities.

Statutory Duties and Legislative Implementation:

The Safeguarding Team has worked with local and regional partners to implement key pieces of legislation that place statutory duties on the ICB:

Anti-Social Behaviour, Crime and Policing Act 2014: Progress continues on a multi-agency Information Sharing Agreement devised by Somerset Council, which will ensure the ICB fulfils its statutory responsibilities.

Domestic Abuse Act 2021: The ICB has worked alongside multi-agency partners to strengthen the MARAC process in Somerset.

Police, Crime, Sentencing and Courts Act 2022: Collaborative work with health partners has supported compliance with the Serious Violence Duty, including contributing local health data to inform the Avon and Somerset Violence Reduction Partnership's local and regional Strategic Needs Assessments.

Modern Slavery Act 2015: The ICB has been part of an Avon and Somerset task and finish group aiming to create a single health Modern Slavery escalation protocol.

Mental Capacity Act (MCA) and Deprivation of Liberty (DoL)

The ICB has focused upon its core duties and legal responsibilities specific to deprivation of liberty (dol) considerations. The ICB was instrumental in developing a data set to be used for internal governance and regional reporting of AACC funded cases. This enabled benchmarking

in 2025, evidencing a strong position in respect of authorised community dol compared to parters in the region and cluster.

In line with its responsibilities set down in NHS Southeast London Integrated Care Board v JP & Ors \[2025\] EWCOP Somerset ICB has proactively engaged in the comprehensive review of AACC Prolonged Disorder of Consciousness (PDOC) cases to determine if Clinically Assisted Nutrition and Hydration (CANH) continues to be in a person's Best Interests.

What have the challenges been?

Uncertainty surrounding the Integrated Care Board (ICB) restructure over the last year has been challenging. As the organisation adapts to new structures, there will be a necessary shift in focus toward maintaining core statutory safeguarding functions, as required by national duties for ICBs to provide strategic safeguarding leadership, assurance, and oversight across the system.

Ongoing staffing shortages, high workloads, and limited resources across the health and social care system continue to present challenges in providing a robust, system-led response to safeguarding adult workstreams. This includes a significant increase in activity relating to Safeguarding Adult Reviews and Domestic Homicide Reviews.

Planned work for 2026-2027 to support the SAB's strategic plan

Homelessness

The ICB will continue to implement learning from the thematic review on homelessness, ensuring all areas of the health system embed changes to practice. This includes promoting an understanding of the unique risks faced by those experiencing homelessness and rough sleeping and ensuring revised escalation processes are widely known and understood.

Domestic Abuse and Exploitation

The ICB will continue to support the work led by the Local Authority on the all-age exploitation strategy. The ICB will also work with a regional non-fatal strangulation task and finish group to ensure adults at risk of abuse and neglect are considered within this workstream.

Promotion of MCA and its use

The ICB will continue to support Primary Care and CHC with MCA implementation and the utilisation of pathways for accessing the Court of Protection, particularly in the context of executive dysfunction and/or self-neglect.

Avon and Somerset Constabulary

Avon and Somerset Constabulary

Achievements during 2025-2026

The restructuring into the Basic Command Unit (BCU) model has provided consistent and visible leadership across uniform policing, including both patrol and neighbourhood teams, throughout Somerset. This has enabled stronger collaboration across the organisation to prioritise vulnerability and risk.

In Somerset East, this leadership has been complemented by the introduction of a monthly, in-person early intervention meeting between Neighbourhood Policing Teams and key partners. Attendees include outreach GPs, nursing staff, housing services, substance misuse services (SDAS), and voluntary sector organisations such as Fair Frome. These meetings provide a structured forum to share information on individuals at risk, particularly vulnerable homeless persons, enabling each agency to contribute insight and agree timely interventions. This has improved the speed and effectiveness of safeguarding responses, allowing officers to take immediate, practical action supported by partner agencies. This model has proven highly effective in strengthening joint understanding of vulnerability, facilitating earlier intervention, and ensuring that individuals receive coordinated support from the most appropriate services.

Effective use of BRAG and DASH continues to embed a more structured and risk-aware approach to decision making. This has been supported by a clear improvement in quality assurance checks across Somerset, strengthening governance and consistency, as evidenced by the successful closure of the AFI (area for improvement) relating to risk assessments.

The development of the partnership Qlik application, due to go live in 2026, represents a significant step forward in improving data accessibility for partners. This will enhance collective decision making and support more informed strategic planning, ensuring a shared understanding of demand, risk and outcomes across agencies.

The Crime Review Team has undertaken a comprehensive review of all SARs over the past five years, identifying key themes and areas for learning. This work allows us to move beyond isolated learning from individual cases towards a more cohesive and systematic approach, strengthening organisational oversight and driving continuous improvement.

We now have established mechanisms and processes that mean we are routinely identifying when a SAR may be required. However, there remains an opportunity to further develop operational understanding of both SARs and DHRs, ensuring staff at all levels are confident in recognising triggers and contributing effectively to the review process.

What have the challenges been?

Understanding and visibility of the needs and risks affecting the older and rural populations in Somerset remain a key challenge. Somerset has a significant number of rural and geographically isolated communities, which can make vulnerability less visible and engagement more difficult. Available data in this area is limited and is likely influenced by underreporting of crime and safeguarding concerns, meaning the true scale of risk may not be fully captured.

There is a clear need for partners to collectively improve how this information is identified, shared and analysed, in order to better understand patterns of vulnerability and harm. The introduction of the partnership Qlik data application has the potential to support this by improving access to police data, enabling more effective analysis, and helping to highlight hidden demand within older and rural populations.

Planned work for 2026-2027 to support the SAB's strategic plan

As outlined under Section 3, priority 'A' of the strategic plan, there is a clear requirement to strengthen how data is collated and shared across organisations in order to better understand the prevalence and nature of domestic abuse, with a specific focus on older people. The development of the partnership data application (previously discussed) will be a key enabler, providing improved and more consistent access to police data for safeguarding partners. This work will support a more comprehensive understanding of risk, harm and hidden demand, particularly within older and more vulnerable cohorts, and will assist partners in making more informed collective decisions. The delivery of this application is a priority for both DCI Claire Millington, in her role as force wide thematic lead, and Superintendent Katie Geal, as the Somerset lead. Both are newly appointed to their respective roles and are committed to embedding improved data sharing and insight as a foundation for delivering the SAB's strategic objectives over the coming year.

Our commitment to consistently attend multi-agency meetings also meets several of the points outlined in the strategic plan.

1. Multi-agency safeguarding of vulnerable adult sex workers (Somerset West).

Neighbourhood teams have worked proactively with partners, including specialist charities such as UNSEEN, to safeguard vulnerable adult sex workers identified across Bridgwater and surrounding areas. This has included joint operations (e.g. Op Breakthrough), where officers have used permitted entry powers alongside partner agencies to access addresses, assess risk, and offer pathways into support such as the National Referral Mechanism (NRM).

In several cases, individuals were offered immediate safeguarding interventions, including relocation to safe accommodation and ongoing support from partner organisations. Where individuals were initially unwilling to engage, officers continued to take proportionate safeguarding action, including use of immigration powers where appropriate to remove individuals from harmful environments, and submission of “duty to notify” referrals to ensure that risk remained visible to partners.

This work demonstrates a consistent, trauma-informed and partnership-driven approach, balancing enforcement with safeguarding, and ensuring that even where engagement is limited, opportunities to protect vulnerable individuals are maximised.

2. Targeted safeguarding through partnership coordination (Somerset East)**Neighbourhood** Policing Teams have strengthened safeguarding outcomes through closer coordination with local partner agencies, particularly for vulnerable and marginalised groups such as individuals experiencing homelessness.

Through structured partnership engagement, officers have been able to identify vulnerability at an earlier stage and ensure individuals are connected to the most appropriate support services. This has included practical interventions such as referrals to substance misuse services, access to healthcare provision, and direct support through community organisations.

This coordinated approach ensures that information held across agencies is brought together to create a fuller picture of risk, enabling timely and proportionate safeguarding responses and reducing the likelihood of individuals falling through gaps in provision

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Probation Service

Achievements during 2025-2026

Somerset Probation Delivery Unit has continued to support the priorities of the Somerset Safeguarding Adults Board (SSAB) through effective multiagency working, a focus on prevention and risk management, and active engagement in safeguarding activity across the system.

The PDU has maintained consistent representation at SSAB and its subgroups, recognising the importance of partnership working, learning from reviews, and effective information sharing. Practitioners have contributed regularly to MAPPA, MARAC and wider multiagency forums, ensuring that safeguarding risks are identified early and managed collaboratively.

There has been a continued emphasis on supporting individuals with complex needs, particularly those experiencing multiple disadvantage. Work through forums such as the Homelessness Prevention Team (HPT) has enabled coordinated responses for people at risk of homelessness, both pre and post release, supporting safer outcomes for vulnerable adults.

Engagement with the Probation Service's internal Health and Justice Partnership (HJP) function has supported improved access to healthcare and substance misuse services. The HJP works across probation regions to strengthen links with health services and local authorities, improve continuity of care between custody and community, and support practitioners in identifying appropriate referral pathways. This contributes to addressing vulnerabilities linked to safeguarding risk, exploitation and self-neglect.

Joint working with safeguarding partners has also supported practitioner development, particularly through shared learning from multiagency reviews and casework. This has strengthened understanding of safeguarding thresholds, escalation pathways and the application of frameworks such as the Mental Capacity Act.

The PDU has maintained a strong focus on improving the quality and consistency of practice, including strengthened management oversight of high-risk cases, clearer expectations around enforcement and escalation, improved recording, and continued emphasis on professional curiosity. This supports effective identification and management of issues such as domestic abuse, exploitation, self-neglect and vulnerability linked to mental capacity.

The PDU has also engaged with national transformation under Our Future Probation Service (OFPS), including the implementation of digital tools and wider service reforms. These developments support improved access to information, reduce administrative burden and enable practitioners to focus more time on engagement, risk management and safeguarding activity.

What have the challenges been?

Somerset PDU continues to operate within a complex and demanding environment.

Increased demand linked to sentencing changes and prison capacity pressures has resulted in more individuals being managed in the community, often with complex needs. The anticipated impact of the Independent Sentencing Review (ISR) is likely to increase this demand further, requiring careful prioritisation to ensure safeguarding risks are managed effectively.

The shift within OFPS towards prioritising higher risk individuals supports public protection but requires practitioners to manage reduced contact for lower risk individuals while maintaining awareness of changing risk, particularly in relation to exploitation and vulnerability.

Access to some specialist interventions has also been constrained due to wider capacity pressures across probation and partner services. This has reduced flexibility in some cases and required practitioners to adapt their approach to managing risk and safeguarding concerns.

The pace of national reform and system change has required staff to adapt to new processes, tools and expectations while maintaining safe practice. Maintaining staff wellbeing and resilience remains a key challenge given the complexity and emotional demands of safeguarding work.

Planned work for 2026-2027 to support the SAB's strategic plan

Somerset PDU will continue to support the SSAB strategic plan through a focus on prevention, partnership and quality practice, within the context of increasing demand arising from sentencing changes and the anticipated impact of the ISR.

Key areas of focus include:

Strengthening multiagency safeguarding arrangements through active participation in MAPPA, MARAC, HPT, Safer Somerset Partnership meetings and wider forums, with a focus on effective information sharing and coordinated risk management.

Maintaining a focus on individuals at greatest risk, ensuring resources are targeted appropriately, and safeguarding concerns are prioritised.

Developing responses to homelessness and multiple disadvantage, building on the HPT model to support early identification of risk and improved accommodation outcomes.

Improving practice in relation to domestic abuse, exploitation and vulnerability, including strengthening early identification and escalation of concerns

Supporting effective transitional safeguarding, particularly in relation to prison release, with improved coordination and continuity of care

Embedding learning from multiagency reviews and joint casework, strengthening practitioner understanding of safeguarding thresholds, escalation pathways and the Mental Capacity Act, including in cases involving self-neglect and neurodiversity

Strengthening enforcement and compliance practice, recognising the link between nonengagement and safeguarding risk

Embedding digital and technological improvements under OFPS to support effective case management and decision-making

The PDU will continue to monitor and respond to the impact of wider reforms, ensuring safeguarding remains central to service delivery.

Multi-agency working continues to be a key strength within Somerset, supporting effective safeguarding outcomes for vulnerable adults.

Practitioners have worked closely with partners to manage individuals with multiple and complex needs, including those at risk of homelessness, exploitation and self-neglect. This includes working with individuals with neurodiverse needs, where practitioners have balanced

effective risk management with a person-centered approach to ensure responses are proportionate and reflective of individual circumstances.

Joint working through forums such as MAPPA, HPT, MARAC and Safer Somerset Partnership meetings has enabled coordinated planning, effective information sharing and improved communication between agencies.

The sharing and application of learning from multi-agency reviews and joint casework have strengthened practitioner confidence and supported more consistent identification and management of safeguarding concerns.

This approach supports the wider aim of ensuring that safeguarding is proactive, person-centered, and responsive to changing risk, in line with the SSAB strategic plan.

Somerset Care

connecting with people | making a difference | doing the right thing | embracing change

We support people to live the life **they** choose.

Somerset Care

Achievements during 2025-2026

Systems and Processes:

Since September 2025, responsibility for the management of formal complaints has been assigned to the Quality Team, a move from individual services managing their own complaints and being responsible for identifying learning. During the previous 3-month comparable period, June to August 2025, when individual services were managing their own complaints, a total of 16 action plans in response to issues raised across 20 complaints were implemented. In the three months following this, September to November 2025, when the quality team assumed responsibility for complaints management, a total of 40 action plans across 18 complaints were implemented. This demonstrates a heightened emphasis on learning from complaints and driving continuous improvement throughout the organisation.

A new induction programme was designed and implemented for new managers and deputy managers. The aim of this induction is to provide new leaders with a thorough understanding of organisational values, key processes, and compliance requirements, with an emphasis on

Safeguarding, enabling them to confidently assume their roles and drive continuous improvement across their teams.

A new Caldicott Guardian/DPO was appointed and accredited training undertaken. This has resulted in a review of the SAR and GDPR processes and amendments to strengthen organisational practices, to include more robust recording of the data release decision making processes, clearer Customer data privacy statement (including an easy read version) and employee data privacy statement and new RoPA.

Our electronic care planning system (Nourish) has a family portal access facility which has been implemented across all residential services. This allows instant access to care records, including the running daily record of interactions, for family, where consent from the resident has been given, or for those with POA, for those lacking capacity. This transparency enables peace of mind for the relative as they can see in real time how their relative is, what care has been provided and they can promptly address any concerns they may have with the service.

Due to issues with the medication supplier, we changed our medication contract and supplier. This was due to missing or incorrect stock, resulting in missed medications, which are reportable on our organisational compliance system, and some of which led to safeguarding concerns being raised. We now have a more reliable medication supply; we have noted a marked reduction in events of missing medication, and PAV visits (where a pharmacist from the supplier conducts a full audit of medicines management in each service) has been reinstated. This provides external assurance on our medicine management processes and identifies opportunities for further improvement.

We have strengthened our admission process for daycare residents following a medical emergency incident that occurred with a new day care customer. This process ensures clear information about a person's needs is available from day 1 as well as critical information required in the event of an emergency. This has led to a bespoke service for the individual and increased available information to share with other services in critical situations- ie emergency pack.

We have introduced an Audit validation process; this validates accuracy of key in-service audits, assesses whether the audit tells us what we want to know about organisational risk and provides guidance to services for improvement. The Audit selected to validate is determined based on known or assumed organisational risk from internal or external data – for example, a Medication Audit validation was completed in response to some Medication concerns across a number of services to assess for themes and to enable improvement plans to be developed. In this specific audit it was determined that the question set was not providing the assurance required, so this was amended to provide greater focus on the risk areas identified.

Implementation of a catering page on Connect (our intranet) has enabled direct access for the catering team and other staff to information on allergens, menus, HACCP, links to IDDsi, safety notification and recalls, and specialised menus for those on specialist diets due to choking risks.

This has improved the connection between the catering team and the rest of the care experience. Tablets were introduced into the kitchen to enable kitchen staff instant access to Nourish, the care planning system, to see individual resident's care plan and dietary needs, likes and dislikes. This provides an extra layer of safety as the Catering team can check meal orders against the needs in the care plan.

As part of assuring the individual service and the Organisation of the quality and safety of individual services, we undertake annual reviews based on the CQC KLOE's. We reviewed and amended our previous 'mock CQC inspection' to create a 'readiness review'. This presents a more positive and supportive inspection, and is more holistic, actively seeking people's experiences through questioning and observation, with a focus on how safe they feel and what difference the care they receive has made to them. This has resulted in an inspection that is less compliance biased and more experience and outcome focused. The inspection is scored based on the CQC ratings and areas for improvement identified and action plans created. These prepare the services well for any forthcoming CQC inspection and ensure risk is known and appropriate mitigations put in place.

We Introduced a targeted investigation process which is instigated where data has suggested a risk at service or organisational level– this utilises internal metrics that we collect as KPI's and through audits, complaints and whistleblowing or safeguarding events. A recent investigation highlighted a lack of understanding of restrictive practices. This resulted in a **Restrictive practice project** – to promote least-restrictive practices at Somerset Care. An audit to check understanding and application in practice was developed and piloted in one service. The goal was to ensure any restrictions beyond DoLS are lawful, appropriate, and support customers' best interests, in line with MCA, BI, and DoLS requirements. This approach safeguards service users' rights and ensures legal compliance while fostering ongoing improvement. The audit was refined following this and will be undertaken across the organisation with an aim to then create remedial training and upskilling resources.

All events including accidents, alleged abuse, complaints etc are recorded on our compliance system, Radar. This includes a section to record the investigation undertaken, identification of contributory factors and root causes, which in turn lead to the development of actions to reduce the risk of recurrence. Spot check analysis of the quality of investigations revealed an inconsistent standard and some potential missed safeguarding. As a result, an additional layer of validation before closing has been introduced by a team independent of the service to ensure an objective review. Where the investigation requires amendment, guidance will be sent to the service regarding the required improvement/information needed. The record will then remain open, until the investigation is deemed appropriate for the severity of the event. This has already resulted in more robust investigations and the creation of shared learning.

Introduction of Mental Capacity and Sexual relationship training- this has improved staff knowledge and understanding of sexual relationships between residents within the care setting

and their ability to consent to a sexual relationship. This has reduced incidents of restrictive practice and inappropriate safeguarding reports of sexual abuse to local safeguarding teams where the relationship has actually been consensual.

Challenges

Local authority rates have been a challenge in trying to maintain a safe service and being expected to do more with less. As safety remains a priority, the organisation has sought to introduce staffing structures that promote greater staff flexibility with the introduction of integrated care roles, enabling staff to be trained and competent to assist with some aspects of care, housekeeping and meal delivery. This enables staff to be deployed to whatever task is required and has reduced people having to wait for assistance.

It has also been noted that for people who are paying for their care themselves, their expectations have increased and they expect a much higher 'standard' - which is sometimes difficult to meet.

Planned work for 2026.

Work has commenced on a new MCA and Restrictive practice training resource. The aim is to improve the practical application of MCA for services. 3 levels of Training have been created with 3 levels of knowledge quiz to check understanding of theory immediately after the training session, and 3 further full competency assessments, to be carried out within the service to check practical application understanding. This is being piloted in one service in June 2026. Any required amendments will then be made prior to rolling out across the organisation.

Service Improvement Plans (SIPs) review – based on CQC key lines of enquiries to identify gaps in service level processes and to guide improvements.

Review of process for monthly governance at service level- the aim is to make this more focused on identification of key risks within a service and the development of actions to reduce those risks.

Review of Nursing services to create a directory of specialised care that the organisation can meet, including strengthening training and competence to meet those needs. This will ensure people with specific needs receive care from staff with the required specialist skills and where a specific service cannot meet those needs, an alternative placement may be suggested within the group that can.

Development of a KPI tracker for Safety and Maintenance checks to evidence compliance with regulatory and legislative requirements – giving greater organisational oversight. This will include the creation of audit to assess the quality of each individual check and that the supporting evidence uploaded is appropriate.

Success stories

We have had CQC full rating inspections of 3 of our service in the last 12 months. Both Cooksons Court and Grovelands achieved Outstanding ratings overall with Outstanding for both services in Well Led and Caring domains.

Our 3rd service, Carybrook, which was previously Requires Improvement (RI) overall following a rating of RI in Safe and Well Led domains in 2023, achieved a Good overall rating with all 5 domains being rated as good.

Our customer engagement events, in which we seek to understand what matters to the people who use our services and their families to enable us to co-produce improvements, have been well attended. These are carried out at least annually in every service so we can improve a specific service but also identify organisational trends. We continue to use the 3 basic statements to gain feedback – what do we do well, so keep doing, what do we not do well, so stop doing, what do we not do at all, so start doing. This enables open questioning using prompts and promotes free speech – nothing is off the table – and results in improvements that the service user wants rather than what we think they need.

At a recent event where there had been a lack of engagement from the Manager, it was stated 'somebody's listened to us and taken us seriously' and ' I am so glad you came and asked us what we thought, I have really enjoyed this and hope you will come back again'. The improvements the participants asked for were implemented with their involvement as a result.

We have also noted a huge improvement in the facilitation of MDT approaches to resolving specific issues with specific customers – this is now embedded in practice and is helping to reduce risk and obtain prompter support for individuals before they reach crisis stage.

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South West Advocacy Network

Achievements during 2025-2026

Number of people supported through statutory safeguarding advocacy:

During this year, SWAN has provided advocacy support to 60 clients. 54 were referred under Care Act for Safeguarding and 6 were referred under IMCA. Care Act referral numbers below demonstrate the inconsistency in Care Act safeguarding referral numbers.

Referral type/Quarter	Q1	Q2	Q3	Q4
Safeguarding enquiry/review	12	19	18	5

Other safeguarding work by SWAN

Somerset advocates raised 35 safeguarding referrals this year. Concern regarding self-neglect was the most prevalent issue. This number includes Somerset residents who have disclosed safeguarding issues to the Advocacy Support Team at point of initial contact, in addition to existing clients.

SWAN advocates continue to work with existing clients through the MARM process where relevant to the current advocacy referral.

SWAN continues to support the work of the board through attendance at SSAB board meetings. We are also report to the SSAB MCA subgroup meetings and this year have reported to the Quality and Assurance subgroup. We have worked closely with the board regarding recent SARs including contributing to the recent SAR self-neglect review.

SWAN delivers IMCA and Care Act Advocacy training across Somerset both in person and online. SWAN Delivered a lunch and learn session to Adult Social Care practitioners at the SSAB MCA forum in March on the topic of *IMCA role and criteria.*

What have the challenges been?

Raising awareness of the right to advocacy and the role of the advocate in Care Act safeguarding.

This is an ongoing process and while identified as a challenge last year, there has been little progress. Referrals have declined and concerns have been raised that Care Act clients are not having their rights upheld during the safeguarding process. Advocacy should be thought of at the earliest part of the safeguarding process to maximise the benefits to the client in having representation through the safety planning to ensure their views and wishes are placed at the centre of the safeguarding Care Act decisions.

Planned work for 2026-2027 to support the SAB's strategic plan:

SWAN are planning to work more closely with the safeguarding adults' team to ensure clients access appropriate support. I have scheduled regular meetings with Ranjana Sharma, manager of the Safeguarding Adults Service and have also arranged for her to attend a team meeting with the advocates. I am anticipating this will lead to a better understanding of each other's working practices.

There is a shared hope that the proposed plan will help bring more consistency to P's care and clearer boundaries around roles and responsibilities. This will need to be monitored closely to see how effectively it works in practice. If the plan does not lead to improvement, or if concerns continue, then further steps may need to be explored, including escalation through appropriate legal channels to ensure P's safety and rights are protected.

Safeguarding success stories:

1. SG was able to give her views clearly and was supported to make her own decision regarding her finances and her daughter. SG stated to both me and her Social Worker that she felt relieved, and that she could live her days without worrying about what would come next.

2. My client was able to recognise her mistakes in the past such as leaving her bag around with cash in, and assured us she would no longer do this. Also, the people who were asking for her money are in prison. We talked about certain safeguards that could be put in place such as a Ring Doorbell and alarm pendant.

NHS
South Western Ambulance Service
NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust

Achievements during 2025-2026

In March, we saw the fruition of a 2-year project improvement plan 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

The final element was the launch of the revised Safeguarding referral forms that now enables attending ambulance crews to submit their safeguarding concerns, direct to the local authority(s) in real time.

SWAST safeguarding team delivered our first Safeguarding Conference which included external subject-matter experts, and those with lived experiences, delivering sessions throughout the

day; and we also took the opportunity to highlight our SWAST colleagues who went “above and beyond” in their safeguarding duties and celebrated their commitment to practice.

SWAST safeguarding team are now included in the clinical support telephone line, enabling crews to call for advice and support from the scene; out of hours the line is managed by advanced clinicians. There is also a fortnightly group safeguarding supervision session for those who support the ‘phone line out of hours provided by the SWAST safeguarding education specialist.

Safeguarding Supervision is now available, formally through a dedicated email booking system that staff can use safely and with confidence, and staff are also asked each time they submit a safeguarding referral if they would like safeguarding supervision. The safeguarding specialists proactively reach out to staff who have been involved in significant safeguarding events (where there has been significant harm or death) to offer support and safeguarding supervision.

What have the challenges been?

Demand: during 2025/26 SWAST received 68,481 internal safeguarding referrals, an increase of 6% from 2023/24. This averages 5,707 referrals each month.

We make safeguarding referrals on 5.4% of all patient contacts (54 referrals per 1000 contacts) and of those, 72% were for adults and 28% were for children (consistent with the previous year).

Child Protection – Information Sharing (CP-IS): We developed a 7-minute briefing to support staff in its application and new national data provided by NHS digital indicates that SWAST are no-longer “outliers” in its use, moreover, demonstration that SWAST was the second highest user of CP-IS compared to other ambulance Trusts in 2025/26.

Planned work for 2026-2027 to support the SAB’s strategic plan

Coercive Control & Disguised Compliance / Domestic Abuse Policy and Process \- The SWAST Safeguarding Team are fully revising the SWAST Domestic Abuse processes and guidance and will be launching the revised process during Q1 of 2026/27, the team will then embed the new ways of working and undertake a Domestic Abuse audit, as part of the Trust audit programme during Q4 of 2026/27.

Lived experience integration / Making Safeguarding Personal (MSP) - There are many ways that SWAST can embed MSP, some of which are in place already.

During 2026/27 SWAST Safeguarding Team aim to attend community resources, such as refuge, shelter, YMCA, to offer their cohorts an opportunity to provide feedback in relation to their experiences of being Safeguarded, and their views of the ambulance service involvement in that process. This will support co-production and co-development.

In addition, the learning disability, autism and dementia lead is ensuring that people with lived experiences are included in the co-development of SWAST LD & Autism and Dementia strategies, policies and resources.

Please tell us about any safeguarding success stories: Crews were called to a concern for welfare “Elderly gentleman on a bench” at 00:48 on a Friday before a bank holiday. The patient was located, hunched over the bench, declining all interventions, saying ‘no one wants to help’, becoming increasingly frustrated. Police attended and confirmed the person was a female name Pearl (pseudonym) who was staying in emergency accommodation nearby, asking for more help following a recent cancer diagnosis. Attempts were made to contact the local authority out of hours for support without success.

The Patient Record (ePCR) stated: “UNABLE TO SAFEGUARD VULNERABLE NFA PATIENT, UNABLE TO ESCALATE TO EMERGENCY DUTY SOCIAL CARE TEAM.”

The Newly Qualified Paramedic (NQP) contacted the Safeguarding team via the Clinical Support Line. The safeguarding specialist located previous referrals for Pearl, based only on her first name and location, and a new referral was made.

The safeguarding specialist replied to the NQP: “I wanted to thank you so much, once again, for everything you did to try and ensure this vulnerable patient was safe-you went above and beyond and exhausted every avenue tirelessly and due to your efforts, this information has now been shared with adult services within 12 hours of you leaving the scene, despite not being able to get through on the local authority out of hours number.”

The NQP replied: “I am relieved that the safeguarding without demographics and little detail did come through to your team, I am grateful that this has been cross matched with a previous call and referral and escalated to Adult Social Care. I can only hope moving forward that the patient is supported whilst they are going through this uncertain time and navigating their cancer diagnosis; my primary concern was for them and their safety and well-being.

Thank you again for the time taken to reassure me and email me with an update, I hope the patient can be safe over the bank holiday until more concrete plans can be made.”

A few weeks later on a local community social media ‘chat’ group a member of the public posted: "It is with great sadness that I have to report to the community the sudden death yesterday morning of Pearl. Pearl was well known to the community because of her homeless status and her eccentric character. Pearl died peacefully in a nursing home. I am pleased to report that Pearl's final week was in a safe and happy environment, and she was surrounded by caring staff and residents. I know there have been many posts on social media about Pearl and a number of people in the community have provided her with much love and support. Rest in peace now Pearl

Thank you [to the community]"

The NQP sent the below to the safeguarding specialist: (with the extract from social media) “Following on from this incident I had to email you and share with you some information I received this afternoon whilst on station talking to the Crew. They told me that sadly the patient passed away, but that she was warm, fed and had people around her to offer support and a roof over her head in her final days and weeks. Whilst I am sad, she passed away, I am so pleased, that between all of us, we managed to get her the support, care and warmth she so badly needed in her time of absolute need. Life really is too short, and you never know just how much we have the power to help people we meet.

Thank you for your valued help and escalation with my incident, I am not sure if this was due to my safeguarding and telephone conversation to you, but I am so grateful the “system” works and that she wasn’t left and forgotten in her time of need.”
