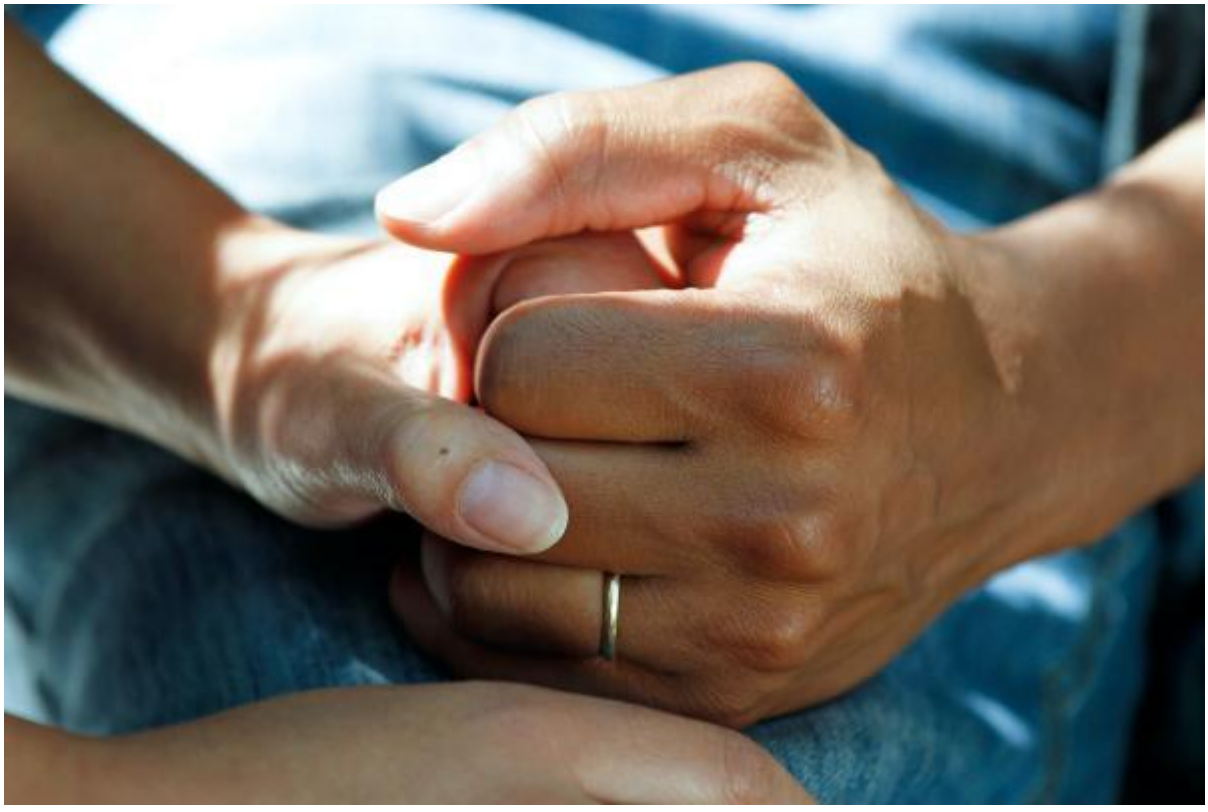
2021-2022 ANNUAL REPORT

NSSAB



Message from the Independent Chair

This will be my final annual report for the North Somerset Safeguarding Adults Board- SAB, which I have had the pleasure to be the independent chair for the past 6 years. In that time, there have been many challenges, but none so great as all partners have experienced during the pandemic.

Pressures on services have been immense but, despite these, safeguarding vulnerable adults in our communities, has continued to be delivered.

As you will see within the Safeguarding Adult Review – SAR, section of the report, the pandemic has had a significant effect in areas of abuse and self-neglect. In the past twelve months, we have commissioned 5 as defined in Section 44 Care Act 2014. These reviews, which are hugely important, are very time-consuming adding further pressure on all the organisations involved.

At the time of writing, none of the final reports have yet to be competed, but where appropriate, they will be published in due course. The object of these reviews is to learn where partnership practices could be improved to prevent, or at lease reduce, the risk of similar occurrences.

During the past year, we have developed a very ambitious, but achievable 3-year strategic plan a prime focus of which is preventative safeguarding.

A major achievement during 2021 – 22, is the agreement to have, and the appointment of a dedicated SAB manager. This, together with a restructuring of the Board and its subgroups, has enabled us to become more strategic as evidence by our 2022 – 2025 plan. I will watch the implementation of that plan with interest.

I am confident that my successor will take over a committed, ambitious and partnership focussed SAB and I offer all Board partners and subgroup members, my thanks for your commitment to Safeguarding in North Somerset. It has been my pleasure.

Tony Oliver, Independent Chair, North Somerset Safeguarding Adults Board.

Introduction

North Somerset Safeguarding Adults Board is a statutory body, established by the Care Act 2014.

The Care Act 2014 Statutory Guidance stipulates that:

14.133 - The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out at paragraph 14.2.

14.2 - The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Safeguarding Adults Boards have three core duties. They must:

- it must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this
- it must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action
- it must conduct any safeguarding adults review in accordance with Section 44 of the Act.

The annual report summarises the achievements and challenges during the year 2021/22, informs on the Safeguarding Adults Reviews that have been initiated during the year and outlines the Board's strategic objectives for 2022-2023.

The Board

The Board is chaired by an independent chair. It meets quarterly and it is supported in its work by subgroups, made up of members from the partnership, of which there are 6:

1. Safeguarding Adults Review
2. Quality and Performance
3. Learning and Development
4. Policies and Procedures
5. Mental Capacity
6. Tackling Adult Exploitation.

The Board is supported by a Board Manager.

Board Membership during 2021-2022

North Somerset Council	Trading Standards
Bristol, North Somerset, and South Gloucestershire CCG (BNSSG CCG)	Department for Work and Pensions (DWP)
Avon and Somerset Police	Housing Provider – Alliance Homes
Avon Fire and Rescue	Housing Provider – Curo Group LTD
University Hospital Bristol and Weston (UHBW)	Housing Provider – Anchor Housing (Vacant)
Avon and Wiltshire Mental Health partnership (AWP)	Safe Link
Sirona Care and Health	Marie Currie
Vita Health Group	Care Home Provider (Vacant)
Public Health (Vacant)	CQC (once a year)
National Probation Service	We Are With You

The Funding Arrangements of the Board

Partner contributions:

North Somerset Council	19560
Avon and Somerset Constabulary	7128
Bristol, North Somerset and South Gloucestershire CCG	18000
Total	**44688**

Cost of SARs are shared equally between the three strategic partners of the Board.

Impact of COVID

During 2021-2022, COVID continued to place pressure on services with various risks identified including staff shortages due to COVID, and mandatory vaccination requirements. At different time several care homes in North Somerset were closed to admissions for these reasons at the same time. Inevitably this will have had implications for timely discharges and placements.

Attendance at Board and subgroup meetings were affected by the busyness of services.

Health services were also put under significant pressure with people needing acute hospital services as a result of complications arising from covid. At the same time acute services were under pressure to discharge people as quickly as possible. Ambulance services also struggled with the additional demands placed upon them and this resulted in ambulances queuing to discharge patients into hospital. Although these difficulties were not in themselves a fit with the criteria for safeguarding, some people were no doubt put at risk as a result.

COVID has impacted people's mental health. Discussions took place in the Board about the fit between safeguarding and suicidality.

The Board heard from North Somerset Council that COVID resulted in better outcomes for rough sleepers. The expectation to accommodate all people who were sleeping rough rather than just vulnerable people resulted in better engagement with detox and rehabilitation services and positive move on for 50 % of people.

COVID also restricted contact with service users due to their vulnerability, and contact was restricted by service users themselves for fear of catching the virus. The situation has resulted in a continued increase in certain types of abuse caused because people are hidden from sight, including domestic violence, and self-neglect; two cases of domestic violence were referred to the Board for consideration to commission a Safeguarding Adults Review (SAR), and two self-neglect cases met the criteria for a Safeguarding Adults Review (see sections on annual data, self-neglect and Safeguarding Adults Reviews for further information).

Whereas restricted visits limited the ability to monitor services or engage directly with adults at risk, there were other measurable benefits. Some patients engaged better than during 'normal' times. For example, different ways of working introduced due to COVID resulted in improvements for a person displaying serious self-neglect and hoarding. Weekly telephone contact and walking meetings or meets in the park were maintained by the social worker. Continuing to invest this time in building and maintaining a relationship enabled the person to build a sufficiently trusting relationship with the social worker that they social worker was able to support the person to re-engage with their family and with a solicitor.

Remote meetings benefited a person with mental health problems as they would have been unable to come to meetings face to face due to the pressures of them and at times not being mentally well enough. By doing it online they were able to attend but also walk out when they needed to and keep coming back in and out of the camera at their own choosing. This gave Adult Social Care snippets when we could engage them and speak directly to them to understand what was important to them. Through these meetings risks were reduced and we've started on the road to helping them achieve their aim of 'getting their life back'.

Virtual meetings resulted in improved attendances at multi-agency meetings, and this has become routine practice in many areas of work.

Safeguarding enquiries made better use of multi-agency working for example by using existing visits from professionals to monitor and report on services or to engage with adults at risk, thus reducing anxiety and confusion by the introducing new people into the person's life.

The epidemic saw closer collaboration between partners through pooling skills and resources to manage what was a difficult situation, and this has served as a trial for integrated commissioning and integrated working practices, as is required by the Health and Care Act 2022.

Examples of safeguarding work undertaken in 2021 – 2022

Example Provided by the Police

AGENCIES INVOLVED	• Alliance Homes • Avon and Somerset Constabulary • Avon Fire and Rescue Service • North Somerset Council Adult Social Care • Horizon Health Centre • We Are With You
BACKGROUND	JP, a 54 year old male was brought to attention of the Police by Avon Fire and Rescue in May 2020. Concerns related to a number of small fires at the address and the general welfare of the individual including impairment through alcohol. It was noted that the property was in an extremely bad condition, dirty, with a lot of empty alcohol bottles evident. Alliance Homes and Police identified that a number of complaints had been received from neighbours regarding JP shouting obscenities and expletives from his flat, having an adverse impact on the lives of local residents and raising tensions within the local community.

	Despite frequent offers of support from Police, Horizon Health Centre, Adult Social Care and We Are With You and attempts to fully assess the situation, JP continually refused to open the door to his flat, respond to any attempts to contact him by text, letter or phone or engage with services including those to which he had been referred through his GP. Consistent failure to attend assessments or to engage with agencies attending his home address in an effort to support him, together with understanding that JP had capacity meant that required support to JP could not be provided. Following a number of Police visits (although unable to gain entry) and a letter from Alliance Homes, complaints from neighbours to the and Alliance Homes stopped. On this basis and because there was nothing further agencies could do without the active engagement of JP; the case was closed by the One Team. However, a few months later Avon Fire & Rescue were called to the property again and having entered the property found JP on the floor half dressed, incoherent and with cuts to his arms (self-harm). The significant risk of fire and self-neglect was again identified. A further referral to the One Team was made.
ONE TEAM APPROACH	The One Team ensured a range of immediate and agency-coordinated actions to ensure the safety of JP and neighbours and to reduce local tensions. (Note: actions summarised below relate to all referrals relating to JP). Alliance Homes arranged for required repairs to be made. They also wrote to JP concerning his behaviour in relation to complaints received and the incidence of small fires in the property. In line with procedures, this was escalated to the serving on a notice on him when the initial letter failed to bring about the needed changes in behaviour. An injunction was awarded with positive requirements for JP to maintain a decent standard of cleanliness inside the property. Required safeguarding referrals relating to serious self-neglect were submitted by the Fire Service (and a further submission by both Fire and Ambulance Services following the second incident). The Fire service also attempted a Home Fire Safety Check, but JP again did not engage. However, smoke alarms had been previously checked and found to be working and JP had been given an information leaflet about not cooking when drunk. Diary sheets were delivered by Police to neighbours so that the extent of issues regarding abusive language and shouting could be obtained and discussed at a case review meeting. The Police also tasked a PCSO to continue to try to make contact with JP on a regular basis and ensured other regular unannounced visits to

	ensure ongoing welfare. A number of planned joint Police and other agency visits were also undertaken. Food bank vouchers were provided by both Alliance Homes and the Police. We Are With You ensured regular attempts to encourage JP to engage. Horizon Health Centre and their mental health lead practitioner, Adult Social Care and an Alliance Homes Social Prescriber also made regular attempts to contact and engage with JP.
OUTCOMES	After months of persistent but coordinated approaches by the One Team agencies, and in particular, the PCSO who managed to establish a strong relationship of Trust over time with JP, continuing even when JP was not actively a case on the One Team agenda, and the mental health team based at Horizon Health Centre, as of January 2021, JP is now actively engaging with provision of a range of mental health and well-being, social and economic re-integration services. He is currently working with Horizon Health Centre, We Are With You, Adult Social Care, Alliance Homes Income team and the Alliance Homes Social Prescriber. JP is now 11 days drink free and has attended a number of AA meeting appointments, with a key worker being assigned. His physical health is being monitored on a weekly basis by the Horizon Health centre and JP is seeking support to stop smoking. He is being supported to ensure that he is receiving and managing his benefits, arrangements are being made to carry out work in the flat (within the limitations currently in place due to Covid) and he is being supported to write a CV so that he is able to seek work through the Job Centre, who the social worker has already contacted on his behalf. Whilst it remains early days, it is hoped that this progress will continue.
CONCLUSION	This outcome has been achieved because of the information shared and actions taken by a range of agencies working together over a period of time to resolve the challenges identified. This has been strengthened by the personal commitment demonstrated and time outside of meetings given by team members in particular, and their wider teams, to address root causes and find solutions. Importantly, multiagency knowledge of progress against agreed actions means that each agency coming into contact with JP is able to remind him of the importance of attending his next

	appointment with other agencies or answering the phone to them because a call is due. The willingness of agencies, particularly during the restrictions placed on agency activity during the Covid 19 pandemic, to step outside their normal model of service delivery and to persist with a number of different approaches in an effort to improve the situation for and safety of JP and also that of his neighbourhood has been key. This case study demonstrates the importance of multiagency problem solving and partnership working. It also demonstrates that services need to consider those individuals for whom attendance at a location outside of their home may not, particularly in the early stage of crisis, be appropriate. Simply stopping service provision to these individuals and a reliance on organisational procedures and process rather than finding alternative approaches, whilst understandable due to demand pressures, leaves individuals and neighbourhoods vulnerable.

Example Provided by Adult Social Services

Mrs X was 67yrs old and known to have abused alcohol for most of her adult life. Her property was unkempt, and complaints were being received from neighbours about the smell emanating from the property and the general state of the house and garden. Concerns were also raised by the GP practice about Mrs X neglecting her care and health.

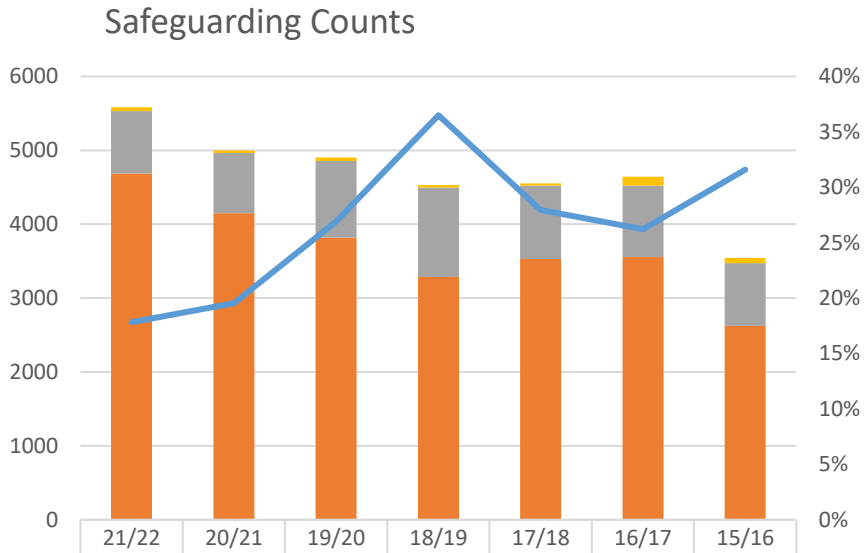
A practitioner worked with Mrs X over a long period of time to address the substance misuse, engaged housing related support services to help with property maintenance and arranged a gardener to tackle the overgrown garden which had started to attract youngsters from the local area. The practitioner also put Mrs X in touch with local charities providing lunch clubs and social activities and arranged for a charity to take Mrs X shopping every week. Our wellbeing service was put in place and meant that Mrs X was receiving weekly welfare checks by a wellbeing practitioner. The structure put in place tackled the root cause of Mrs X difficulties, this being social isolation and loneliness. It enabled Mrs X to address her alcohol addiction and see a purpose in life and in doing so tackled the self-neglect she had suffered for many years.

Example Provided by the Clinical Commissioning Group

An example of a positive safeguarding intervention was initiated by a GP who reported to the CCG safeguarding team concerns regarding a nursing home where potential organisational safeguarding issues had previously been raised and supported. The CCG safeguarding team worked proactively with the

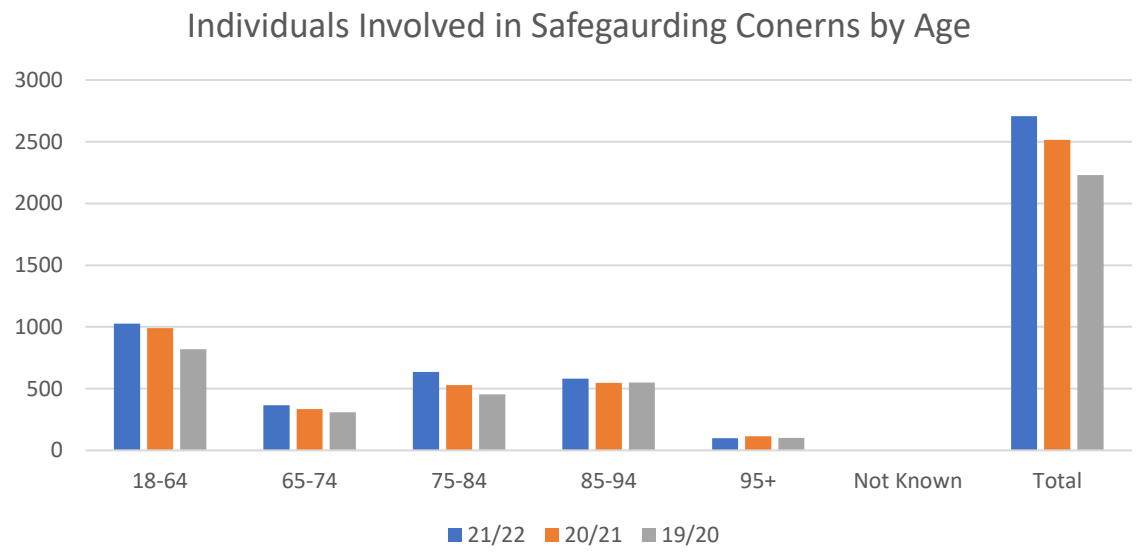
Local Authority Safeguarding team and a multiagency meeting was called with all those professionally involved attending. Joint visits by the CCG safeguarding team and Continuing Health Care nurses (CHC) had previously been completed to the home which included reviewing the care and treatment needs of funded care residents. A multiagency meeting was held where both primary and secondary care health providers expressed their concerns, for the health and wellbeing of vulnerable and end of life residents in the Nursing home. It was asked that Funded Care and End of Life Care case managers jointly review their service users face to face to get a more holistic view of people and the care they were receiving. The GP expressed her thanks for the response to their concerns and the enhanced support offered to her patients. The open lines of communication and responsiveness between agencies in this case was evident.

Safeguarding Adults Data 2021-2022



	21/22	20/21	19/20	18/19	17/18	16/17	15/16
Total Number of Other Safeguarding Enquiries (Active in year)	52	33	44	33	30	121	69
Total Number of Section 42 Safeguarding Enquiries (active in year)	845	817	1039	1211	994	964	851
Total Number of Safeguarding Concerns (received in year)	4688	4147	3818	3285	3528	3556	2624
NHS Digital Conversion Rate	18%	20%	27%	36%	28%	26%	32%

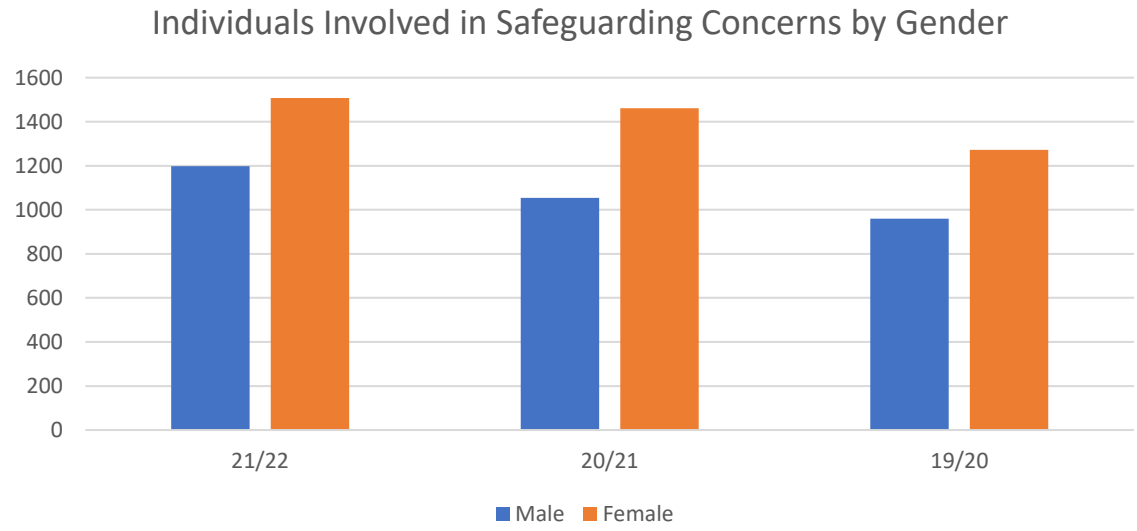
Safeguarding concerns have increased continuously since 2019-2020. The data does not indicate a marked increase in concerns during the pandemic. There were surges in concerns in 2019-2020 (14% more than in 18/19) and 2016-2017 (26% more than in 15/16).



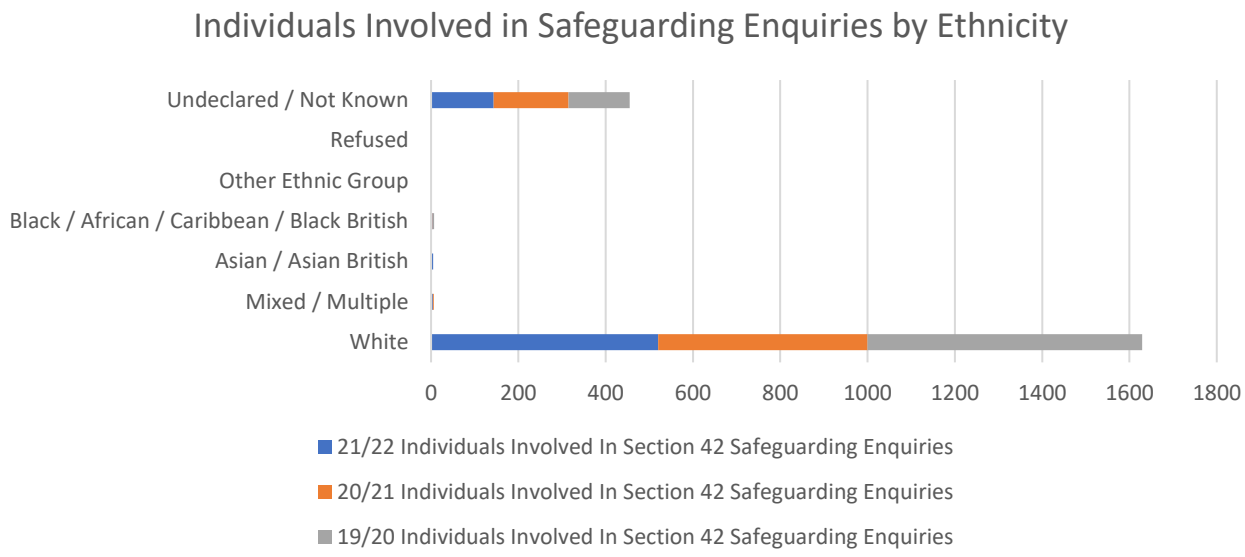
In 2021/22 Concerns were raised for 2704 individuals compared with overall concerns of 4688, suggesting repeat referrals of 1.7 referrals per person.

- 22% of concerns for 18-64 years old resulted in a safeguarding enquiry or other enquiry.
- 27% of concerns regarding 65-74 years old led to an enquiry.
- 31% of concerns related to 75-84 years, 24% of concerns related to 85-94 olds, and 27% of 95+ old resulted in a safeguarding enquiry or other enquiry.

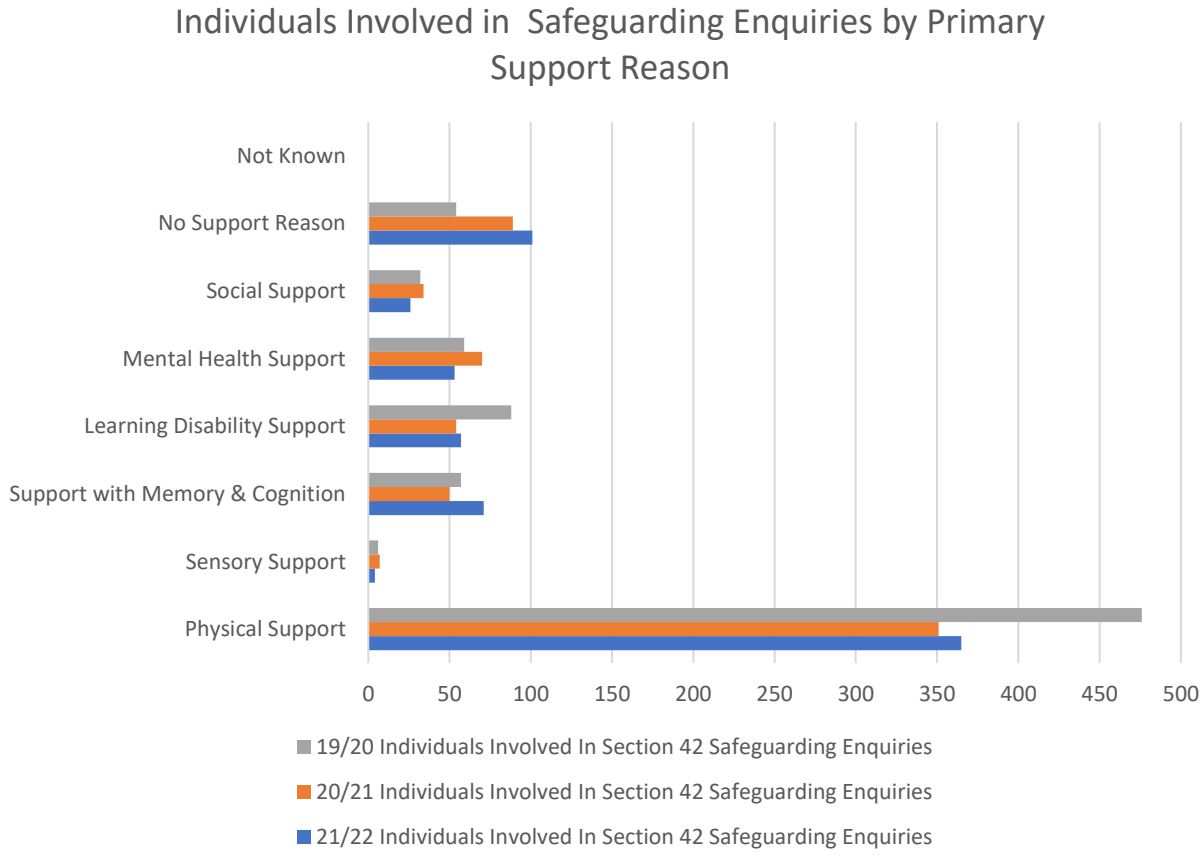
This suggests that community partners are looking out for vulnerable adults but may also indicates a lack of understanding of what constitutes a safeguarding concern as defined by the Care Act. This highlights the need to raise awareness of prevention through signposting to appropriate services.

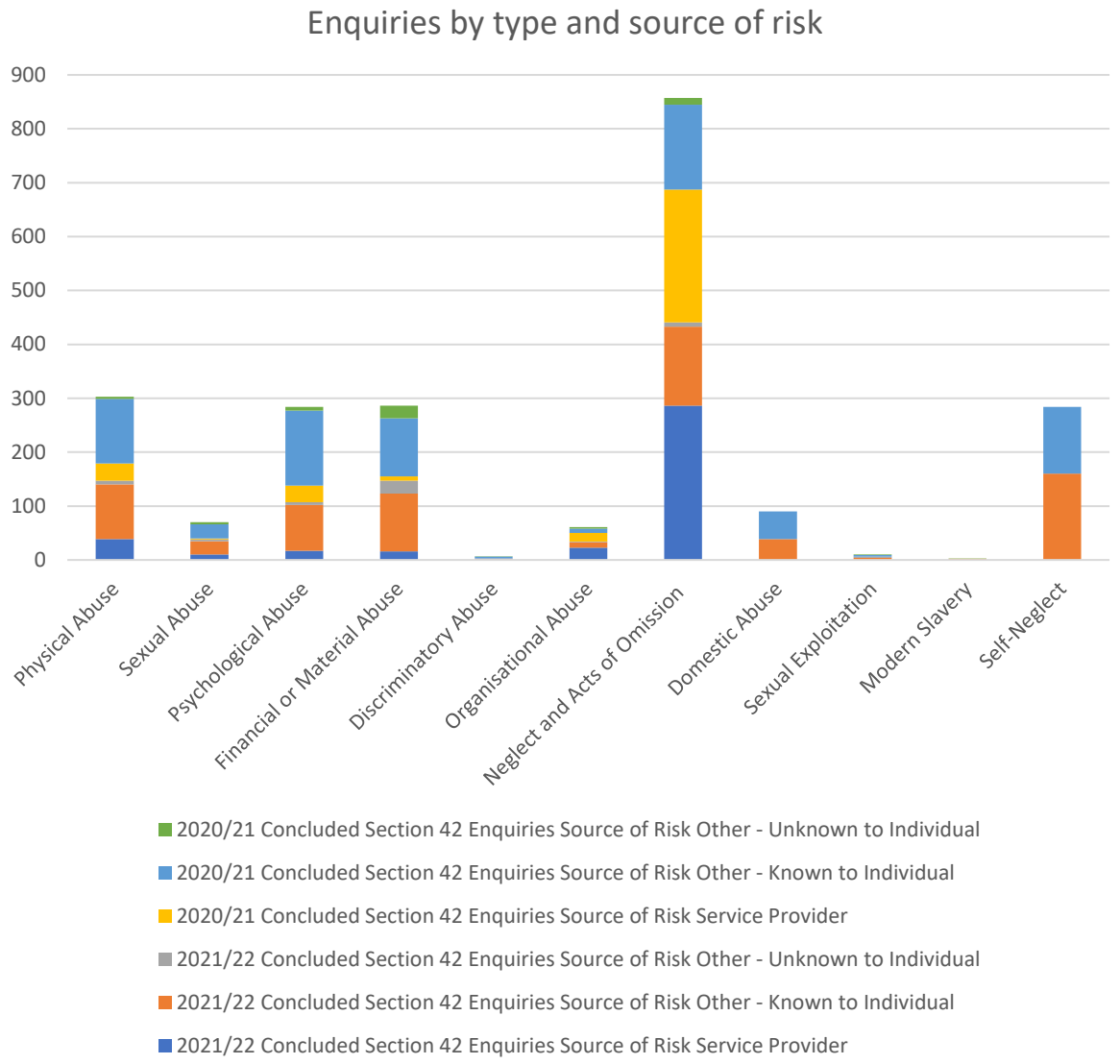


Females received a higher number of concerns as has been usual over the last three years, 28% of which led to an enquiry. 24% cases concerning males led to an enquiry.



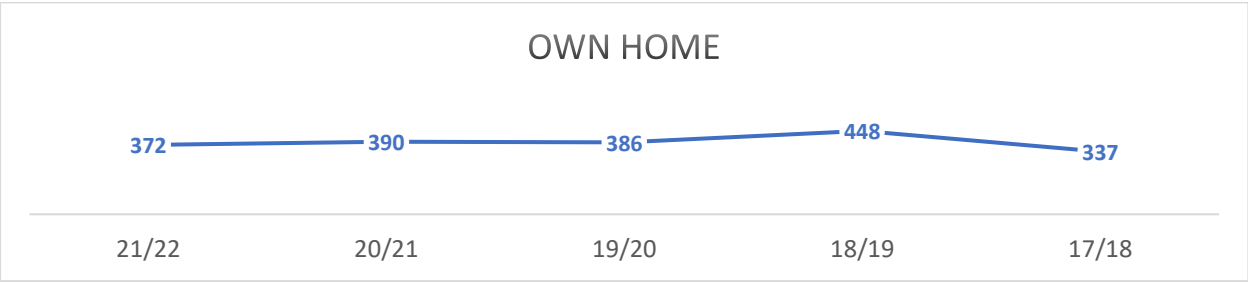
The ethnic group for whom the most enquiries were undertaken is White British. The largest group for whom safeguarding enquiries were undertaken is people with physical support needs.

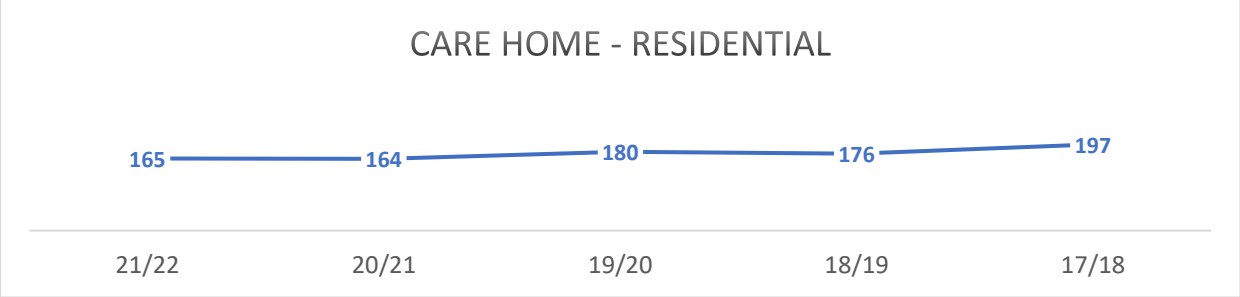


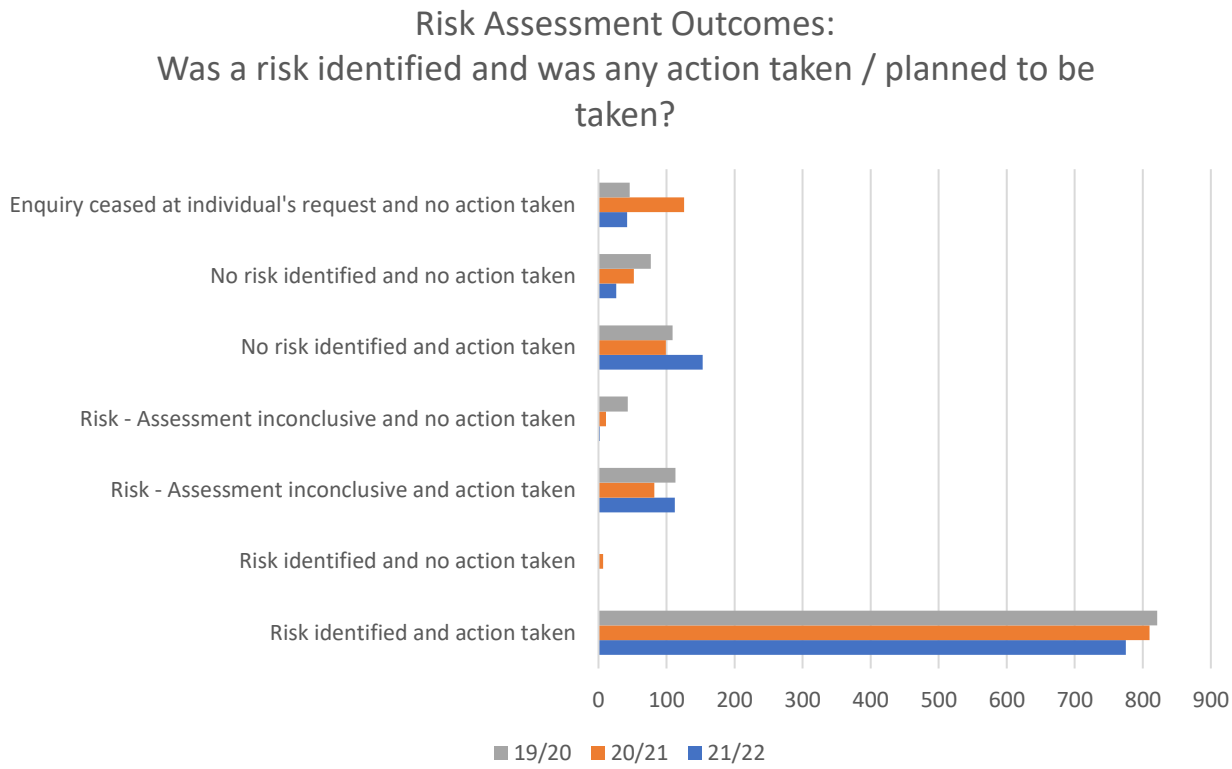


The most frequent category of abuse for which concerns were raised was neglect, 441 up from 416. The other categories of abuse for which more than 100 enquiries were conducted were Physical Abuse (147 – marginally reduced from 20-21 whose figure was 156), Psychological Abuse (107-significantly reduced from 177 in 20-21), Financial Abuse (147, up from 139 in 20-21) and self-neglect (up significantly from 124 in 20-21, to 160).

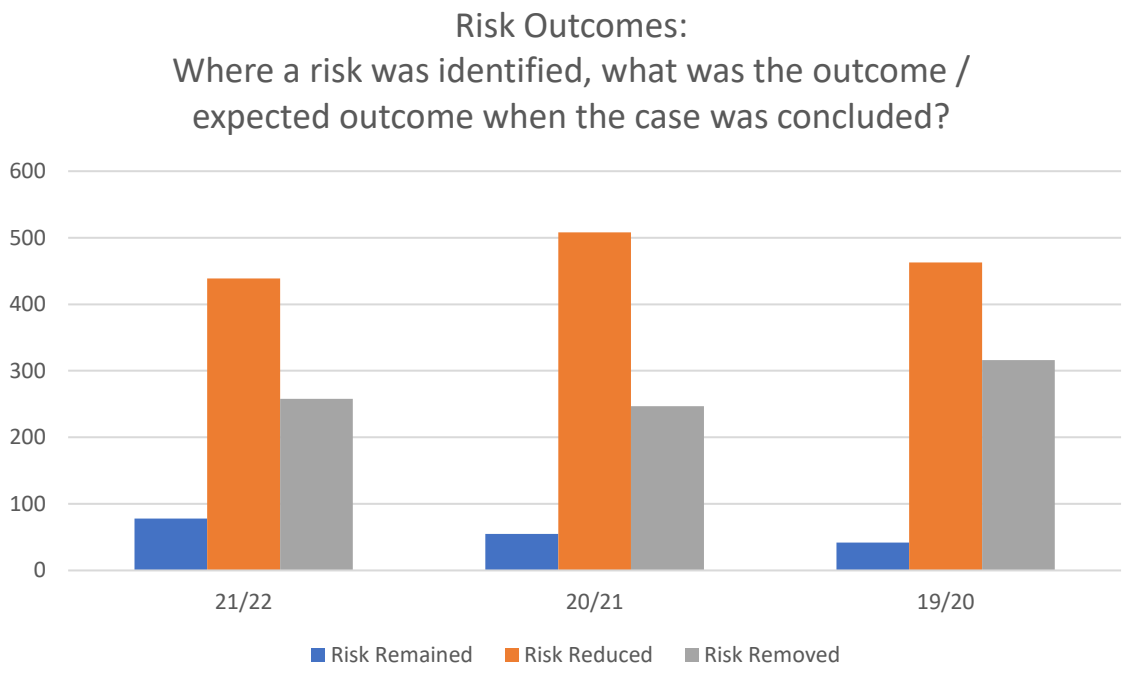
The two graphs below show data over the years where abuse occurred in a person's own home, and in a care home.

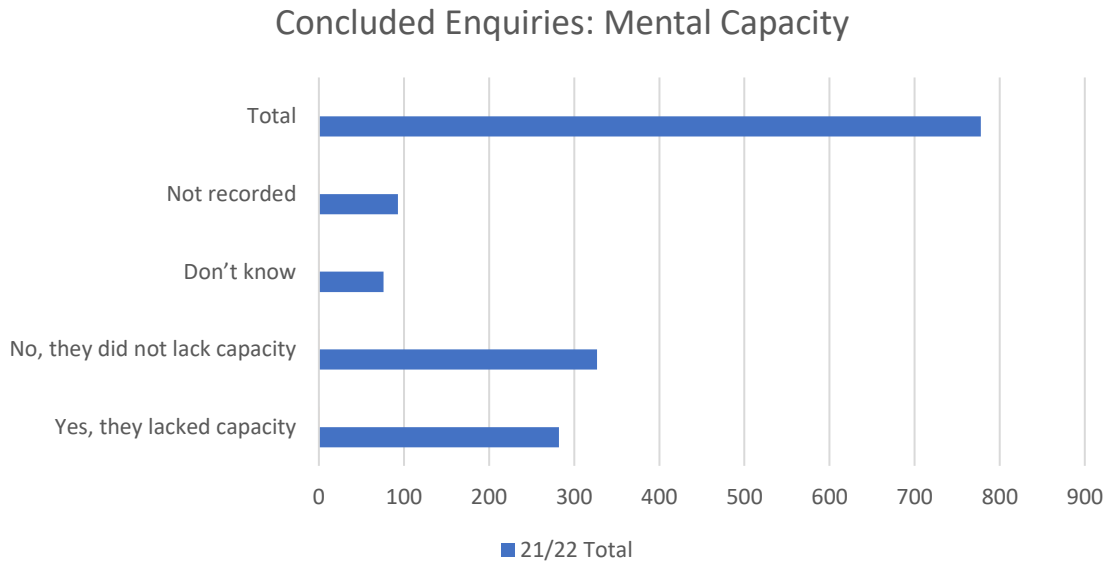






An enquiry can identify risks, or no risks Risk assessments may also be inconclusive but needs maybe identified. This can result in supportive actions. Risk enquiries can cease at the request of a capacitated adult. In over half of the enquires risks were identified and actions were taken and as seen below in a small number of cases risks remain.

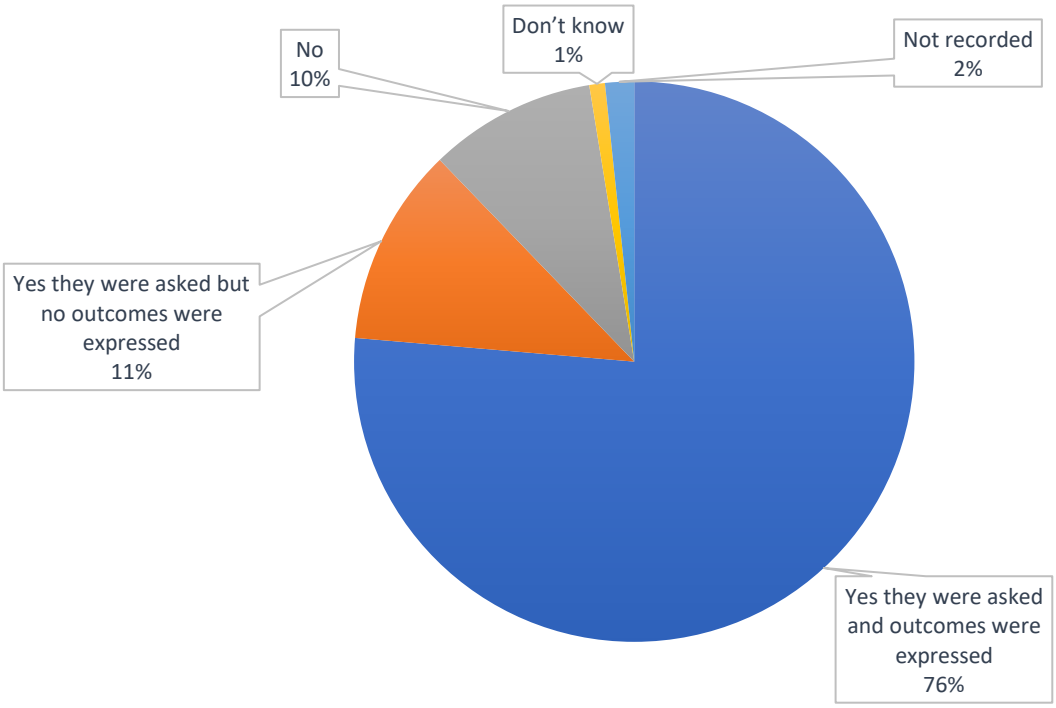




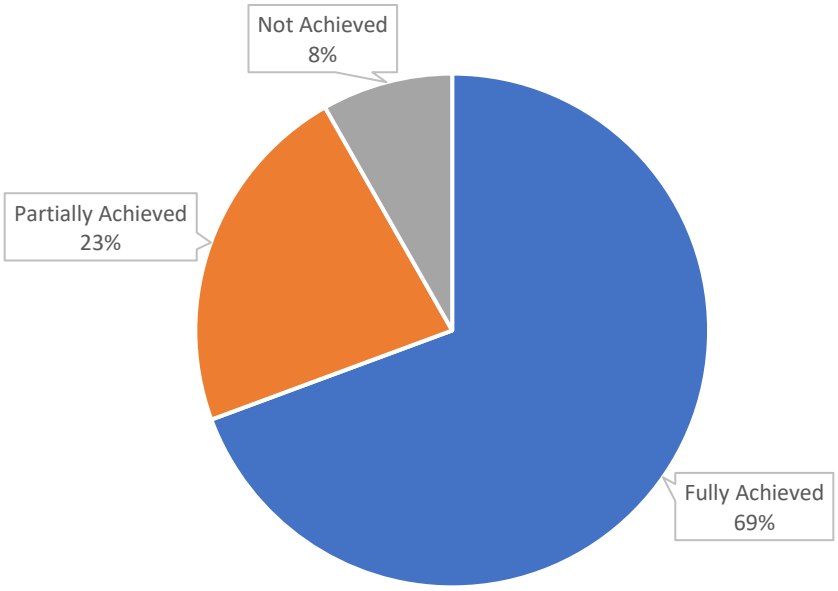
The data above shows that whereas for a larger proportion of adults, capacity was considered, for some their capacity is not recorded or not known. ASC has identified recording of capacity assessments for immediate improvement. The partnership has identified Mental Capacity as an area they would like more support with.

People must be asked what outcomes they want from the safeguarding process. As seen below, this process was largely followed, and in most cases these outcomes were fully achieved.

Concluded Enquries: For each enquiry, was the individual or individual's representative asked what their desired outcomes were?



Of concluded enquiries recorded as the adult having expressed their outcomes, in how many of these cases were the desired outcomes achieved?



OVERVIEW of the Year 2021-2022

Preventative Safeguarding

Key to preventing abuse is to empower residents with information of how to keep themselves safe and to watch out for vulnerable residents and report abuse when noticed. This was made difficult by the pandemic due to being unable to hold promotional events in person. For the same reason coproduction was also put on hold. During COVID, it is likely that residents have engaged with technology, including online catch ups with family and friends, and utilised social media platforms such as Twitter, Facebook, Tik Tok and You tube. During 2022-2023, different ways of engaging and communicating with residents will be explored.

Awareness of how to spot abuse amongst community staff and partners is important to intervening early. Partners were provided with briefings on gambling awareness, adult exploitation, and building safer cultures during the Stop Abuse Week, to support pre-emptive responses to prevent abuse or deterioration. Further awareness raising around self-neglect, specific types of adult exploitation and domestic violence will follow as the Board works through these concerns which remain priorities for 2022-2023

With regards to self-harm and suicide risks, a preventative approach is being taken by linking in with mental health, public health, and other partners. This approach will be further informed by the findings of and recommendations that arise from the three SARs where suicide is the theme. Preventative safeguarding remains a strategic objective for 2022-2023.

Safeguarding Adults Reviews (SAR)

In 2020-2021, the Board received one referral for consideration as a SAR on the theme of suicide which did not meet the criteria for a SAR.

In 2021-22, the Board received ten referrals, four of which met the criteria and SARs have been commissioned. Two cases were for self-neglect, and one for suicide in a care home,.one for suicide which occurred in the same hospital as the referral that was received in 2020-21, and for which reason the case from 2020-21 was joined to this SAR as a discretionary SAR. None of the SARs were completed at year end and therefore will be reported in greater detail in the 2022-2023 Annual Report.

For cases that did not meet the criteria for a SAR, two cases were for Domestic Violence and two other cases that were referred that did not meet the criteria for a SAR.

Two referrals were being reviewed by the Board at the end of the year (March 2022) to determine if they meet the criteria for a SAR, for which decisions are yet to be made.

The Board also considered published SAR Research and devised an action plan to support good practice.

Quality of care and support

The Quality and Performance subgroup interrogates data and responds by making recommendations to improve. They also may undertake audits to investigate the data in detail.

An audit was completed to obtain a better understanding of cases where service users had repeated safeguarding concerns raised regarding their safety. 70% of concerns were repeat concerns, 41% incidents involved multiple concerns. It was concluded that there was a need to follow up on safeguarding plans and evaluate their effectiveness. A multiagency approach was proposed for complex cases. Furthermore, a team around the family response was thought to be a helpful approach to complex family dynamics.

During this year much of the preliminary work was completed in relation to Board priorities which has informed the work plan of 2022-2023. A Self-Neglect task and finish group was set up in response to increased Safeguarding referrals in this category and self-neglect referrals for SARs which looked at how self-neglect could be prevented, who needed to be involved and what other tools were required to meet the objective. Community partners were identified. Tools are available to address self-neglect such as the Hoarding Framework, Risk Identification and risk management tools, self-neglect intervention planning support tool and an escalation policy; a Risk Management process for complex cases was proposed. The task and finish group continues to work to deliver on this priority. During the year, data-gathering and analysis was completed and supported by the policy and procedures group, to inform the priority of transitional safeguarding. This work formed the basis a project that is now being led under the auspices of the council's early intervention and prevention agenda in relation to transition of young people to adulthood Transition remains a Board priority for 2022-23. As with self-neglect transitional safeguarding identified the need for a mechanism to manage high risks.

In response to the findings from the above three areas of work, the Policy and Procedures Sub-Group drafted a Multi-Agency Risk Management process (MARM) which was presented to board in March 2022. The Board requested that the process be presented at a strategic level in each partner agency to obtain ownership so as to ensure this new approach will be embedded into day-to-day business within partner organisations.

This process fits well with reviewing and managing the safety of adults subject to exploitation (another priority for 2022-2023) that do not have care and support needs or have care and support needs but make capacitated decisions that place them at risk.

Improving Practice

The Learning and Development subgroup supported practice by arranging briefings at the multiagency good practice forum. Visitors were:

- Feb 2021 Avon and Somerset Police, to brief on referrals into the Lighthouse Unit
- Sept 2021 Next Link Domestic Abuse
- Dec 2021 North Somerset Council, to raise awareness of Financial Abuse and Exploitation
- Feb 2022 – North Somerset Council, to refresh on Prevent Strategy.

Other Policy Work

In January 2022 the Board launched the Person in a Position of Trust (PiPoT) Framework for managing allegations against people in a position of trust. The driver for this being the Care & Support Statutory guidance which expects boards to have a framework in place against which such concerns are responded to. It addresses a 'gap' created by S.42(1) whereby a person who works in a position of trust may not have directly abused or neglected a person with care and support needs, they may have behaved in such a way inside or outside of their role, that indicates they may not be suitable to work with adults at risk. This was a significant policy development supported by all board partners, launched through an online webinar attended by over 60 people. Our data showed an immediate increase in PiPoT referrals as a result.

The Policies and Procedures sub-group has drafted an **Equality impact screen** which remains under development. It will be applied to all policy reviews and developments once sanctioned by board. The driver for this has been the increased focus on equality and racism as a result of the raised profile of the LGBTQ+ community and Black Lives Matter movement.

The 'Service Level Safeguarding protocol' underwent a thorough review in 2021 with a revised document approved by board and published in September. The review was routine and took into account the following factors:

- NICE guidance around safeguarding adults in care homes.
- Promotion of a partnership approach to addressing organisational abuse – notably the name change form 'Organisational Abuse' to 'Service Level Safeguarding' and the introduction of Risk Assessment and Planning (RAP) meetings.

- The need for (a) clarity around how whole service safeguarding decisions are made and (b) to establish a robust governance process around implementing placements suspensions and caution statuses.

Feedback from a Safeguarding Officer within the council was *"It feels much clearer now; the RAP meetings show that we are making safeguarding decisions based upon evidence''*.

Robust Governance

During this year, the membership of the Board, and the way it meets its objectives was reviewed. The changes are listed later in this report.

Board partners completed a self-assessment to evaluate how well they were doing individually and as a partnership in safeguarding people. They felt that mostly they did well individually and together to safeguard vulnerable people. They worked creatively together during COVID and effectively by pooling resources.

They identified some areas of improvement:

- Tackling self-neglect (strategic priority in 2022-23)
- Understanding transitional safeguarding (strategic priority in 2022-23)
- Embedding co-production (priority in 2022-23)
- Exploring professional curiosity
- Supporting partners with MCA (MCA/LPS implementation group will be revived in 2022-23)
- Improve working with Voluntary sector (Voluntary sector joined to Board membership and have been included in subgroups)
- Sharing best practice. A multiagency forum is in place which will be reviewed and promoted.

Partner Contribution – Annual Report 2021 – 2022

Avon Fire & Rescue Service

By Meghann Elvin and Nikki Rice, Joint Safeguarding Leads

Three things we did well to Safeguard Adults:

1. Maintained all safeguarding processes throughout the second year of the pandemic.
2. Participation in boards and connections with partners.
3. Promoting the range of services, the Fire Service can offer amongst board members.

Service User Case Example that demonstrates Impact of what we did well.

The process of safeguarding within the Fire service means that we do not have prolonged or repeated interactions with individuals or cases. However, in general we have had several examples where we have built new relationships

with agencies in North Somerset who are now notifying us around vulnerable persons and hoarding concerns, which is increasing our contact with more vulnerable members of the community.

Three things we are working on to improve to safeguard adults in North Somerset:

1. Extending and refining our training offer across the Service to extend subject knowledge and understanding of safeguarding, particularly regional priorities.
2. Put processes and procedures into place linked to the Mental Capacity Act.
3. Increasing onward referrals to appropriate agencies where a referral does not meet threshold.

North Somerset Council – Adult Social Services

By Hayley Verrico – North Somerset Council, Director of Adult Social Services

Three things we did well to Safeguard Adults:

1. Developing a response to safeguarding issues in young people aged 17-25 years, often not eligible for an adult social care service, this forms part of our commitment to transitional safeguarding.
2. Development of a centralised safeguarding team to provide a more consistent and timely response to safeguarding concerns.
3. Developed our approach to quality standards to ensure that commissioned services are robustly monitored for the quality of service delivered and that safeguarding issues are addressed as part of our contract compliance duty.

Three things we are working on to improve to safeguard adults in North Somerset:

1. Ensuring a robust response to young people entering adulthood regardless of their eligibility for an adult social care service.
2. Tackling social isolation as we know this can lead to self-neglect, hoarding and exploitation.
3. Reducing homelessness and the risk of homeless by supporting people to gain secure, long-term housing thus tackling the abuse street homelessness people receive whilst living rough.

Bristol, North Somerset, South Gloucestershire (BNSSG)

Completed by: Jenny Thompson Interim Designated Nurse Safeguarding Adults and Kirsten Bowes Safeguarding Adults Manager

Three things we did well to Safeguard Adults:

1. Working in partnership with SAB partners, CQC and multiagency organisations in supporting safeguarding issues impacting on individuals or the wider community such as organisational safeguarding, Modern slavery and the Prevent agenda.
2. Attending SAB Multi-agency meetings within the arena of Safeguarding Adults and contributing to strategies and learning and development initiatives including Domestic Abuse and Self-neglect.
3. Being the conduit between Primary care and Safeguarding adult social workers to ensure that the individuals voice is heard and achieving making safeguarding personal.

The Clinical Commissioning Group (CCG) safeguarding team are frequently involved in providing health advice and information to the North Somerset Adult Social Care team to support safeguarding interventions in Care Homes and Nursing Homes across North Somerset. Where additional safeguarding interventions are required to support Care and Nursing Homes the CCG/ICB team work proactively with North Somerset Local Authority colleagues to provide a multiagency approach.

The working relationship between CCG and the Local Authority continues to be effective, and the open dialogue has been evident in many different safeguarding scenarios.

Three things we are working on to improve to safeguard adults in North Somerset:

1. Providing up to date safeguarding adult training for Primary Care colleagues in forums such as podcasts, webinars and link safeguarding GP meetings with the CCG named GP.
2. Sharing the outcomes and learning from Safeguarding Adult reviews and Domestic Homicide reviews in learning briefs and training sessions to have a positive impact on the practice of professionals in delivering the safeguarding process to effectively support people in the population. In addition, the outcomes and learning are shared across all directorates within the ICB to influence commissioning and collaboration.
3. Continue to support the safeguarding work plans within the Local Integrated Partnerships.

Avon and Somerset Police

Completed by: Alison Jenkinson, Partnership Liaison Manager (taken from Amanda Warrener's (Improvement and Problem solving Officer for adults) paper to inform Somerset's SAB, which is relevant force wide)

Three things we did well to Safeguarding Adults:

1. The National Vulnerability Action Plan (NVAP). Now been formally adopted as the force's vulnerability framework and has aligned relevant improvement activity to the NVAP actions, this includes the adoption of 16 vulnerability strands including Adults at Risk. Each strand has a named Thematic Lead responsible for direction, focus and to continuously improve Force performance in their area. Governance is provided by the Constabulary Management Board and Police and Crime Board which receive quarterly vulnerability performance reports and updates, as well as detailed assurance reports throughout the year.

2. Assurance Panel - The Constabulary's Adult at Risk (AAR) Assurance Panel is now well established and is held quarterly. The ethos of the Panel is to provide scrutiny and critical challenge over the quality and effectiveness of the Constabulary's AAR investigations:
    - Identify learning and good practice
    - Ensure compliance with legislation and local and national policy
    - Ensure a consistent response across the Force area
    - Increase understanding of AAR investigations across the workforce.

    Chaired by the AAR lead Detective Superintendent Lisa Simpson and attended by representatives from Neighbourhoods/LSU/Response/ Control Room and Investigations, along with Office of the Police and Crime Commissioner and the Victims of Crime Advocacy Service (VOCAS). Whilst the idea behind the panel is to scrutinise investigations where the victim would meet the Adult at Risk Care Act definition, we chose to step away from this model for two of the panels this year. In October we looked at cases for vulnerable victims who did not meet the Sect 42 threshold in order to explore the varying landscape in terms of Neighbourhood capacity and referral pathways. We found an inconsistent picture which requires further examination and something we will continue to explore in 2022/23. The bulk of the cases involved people experiencing poor mental health and as we have no direct referral pathway to mental health services further work in this area alongside the mental health lead for the force is required. In February we looked at Domestic Abuse cases where the victim was over 65. As a force we have seen an increase in older victims of DA and have had several DHR's of this nature. We looked at 6 cases and the learning from the cases saw evidence of age bias, victim blaming language, minimisation of risk, assumptions around capacity, a lack of BRAGs for vulnerable suspects, and a need for greater professional curiosity. The DA & AAR leads will now work together to identify mechanisms to best disseminate and implement the learning. The panel also identified areas of excellence in the empathetic and professional way various call handlers responded to some complex and distressing cases.

3. Dementia GPS Scheme. A bespoke Dementia Safeguarding scheme to help safeguard people living with dementia is now into its seventh year The scheme, has four distinct strands: ·Near Field Communication (NFC) enabled wristband. Dementia Safeguarding Scheme registration (also known as the Herbert Protocol) via our website. GPS pendant allocation. A support group available on Facebook, called 'Avon and Somerset Dementia Forum'. Thanks to charitable funding, 2,000 free 'wearable tech' wristbands were made available through the scheme in 2021 and over 1,000 have already been allocated through individual applications and to groups. We have now secured over £9,000 of external funding to buy GPS tracking devices for people with dementia who are at risk of becoming a missing person. Over £7,000 of the funding came from Bristol Water and Wessex Water. An additional £2,000 to buy further Near Field Communication (NFC) devices has also come from Bristol Water and Wessex Water, along with Western Power Distribution. The 30 GPS trackers will be supplied by Somerset-based company, MindMe and will be allocated through referrals from our three specialist Missing Person Coordinators.

Three things we are working on to improve to safeguard adults in North Somerset:

1. The National Vulnerability Action Plan (NVAP). In June 2021 we completed an NVAP benchmarking exercise providing a detailed self-assessment against each of the 16 actions and for the most part we assessed ourselves as performing well in relation to the action but identified 5 as requiring work to help develop/improve.

2. Vulnerability Training. There is a recognition that vulnerability training delivered to officers and staff requires improvement whilst there are some pockets of excellence, it is not consistent across all strands and as such we carried out a mapping exercise of all current in-house vulnerability related training. At present Adults at Risk training is one of the gaps, and although we are exploring existing training packages delivered in neighbouring forces it is something we would not be in a position to roll out in the short term. In order to go some way to bridge that gap we started working on producing a Microsoft SWAY briefing which will include a general introduction to Adults at Risk and will include a scenario of an AAR alleging they have been assaulted. The scenario will firstly be played out in a way that illustrates some of the challenges faced by officers, then re-enacted with a more positive outcome highlighting the impact of trauma and the importance of language. The script has been written by a registered intermediary and play therapist and will be filmed using a Police officer and an actor with a learning disability. It is intended that this presentation will be delivered 'in person' at briefings across the force.

3. Mental Health. We have no direct referral pathway to mental health services further work in this area alongside the mental health lead for the force is required.

Going Forward to Year 2022-2023

In response to the review that was undertaken by the Board:

- The size of the Board meeting has been reduced to improve discussion and achieve outcomes
- Subgroups have been restructured. The subgroups will be required to drive the strategy of the Board and report on their progress to deliver the strategic objectives of the Board. Subgroup attendance will include partners who have a roles and responsibilities in operationalizing the work of the Board.

New Structure 2022-2023

North Somerset Council	Trading Standards
Bristol, North Somerset, and South Gloucestershire CCG (BNSSG CCG)	Housing Provider – Anchor Hanover Group (Vacant)
Avon and Somerset Police	Care Home Provider (Vacant)
Avon Fire and Rescue	CQC (once a year)
Avon and Wiltshire Mental Health partnership (AWP)	Public Health
Sirona Care and Health	National Probation Service
University Hospital Bristol and Weston	Voluntary Action

Strategic Priorities 2022-2025

The Board reviewed their strategy. The focus is:

1. Preventative Safeguarding
2. Quality of Care
3. Transitional Safeguarding
4. Domestic abuse
5. Adult Exploitation

Key Priority	Our Focus: What does this look like for us in North Somerset.	Our strategic intention	How we will know we have made a difference
PRIORITY 1 Preventative Safeguarding	**During the Covid- 19 pandemic, there has been a significant increase in adults experiencing self-neglect, neglect, domestic abuse, and other types of harm.** **Our focus for the first year of this plan is early identification and response to self-neglect. As the actions around the plan develop, we will move to address other areas of concern.**	Identification of people at risk of self-neglect and provision of support to prevent them experiencing self-neglect. Improving community awareness of self-neglect, the signs to look out for and what to do if identified. All agencies work together with the adult and with each other to try to prevent self-neglect. Agreed understanding of guidance and how we put into practice the Mental Capacity Act. Dismissing self-neglect as a "lifestyle choice" is not an acceptable explanation or basis upon which to make decisions about eligibility of support. A learning culture across all agencies where best practice is sought and embedded into daily working when responding to self-neglect. Key partner agencies to adopt a trauma informed approach to self-neglect	There will be: • Data telling us that we have identified self-neglect at an early stage. • An increase in community referrals and community activity in relation to self-neglect. • Clear understanding of lived experience of self-neglect that informs our approach. We will know this by feedback from the adult. Audit activity will not see case recording stating “lifestyle choice” as reasons for no support. • Multi-agency forums and meetings taking place to jointly share information and agree action plans. • Assurance activity to evidence improvements and best outcomes for adults. • Thematic auditing to show the development of a trauma informed approach across partner agencies.
PRIORITY 2 Quality of care and support	**Local data tells us that neglect and acts of omission are the most common category of safeguarding concerns referred by or raised in relation to our care providers.**	We will ensure that all care homes we work with are fulfilling their statutory and contractual safeguarding responsibilities. All care homes in North Somerset are up to date with relevant learning from SARs and national guidance and are accountable for the application of this within their daily practice. NSSAB will help care homes to learn from their own experience of managing safeguarding concerns. We will ensure that good quality mandatory training is delivered by all partners. We will make sure that early intervention and preventative actions / support to stop a safeguarding concern developing from a Quality-of-service issue into a safeguarding enquiry.	There will be: • Board partner assurances that organisations are working together to support residents. • Care homes evidence that relevant learning and the application of that learning is applied. • Good quality and timely safeguarding concerns raised by care homes. • Evidence of learning from training embedded into daily practice. • Cases resolved by the most appropriate SAB partner before requiring a safeguarding enquiry to commence. • Quality checks to evidence understanding of Neglect.
PRIORITY 3 Transitional Safeguarding	**Young Adults aged 16-25** **The divergence between the safeguarding children’s system and the safeguarding adult’s system creates a gap. Neither system has been designed with attention to transitioning into adulthood.**	To have an agreed understanding of ‘Transitional Safeguarding’. Transitional safeguarding will have a clear vision that is trauma and complexity informed. To develop strong links and clear communication at all levels between adults and children’s services to ensure we meet the changing care and support needs of vulnerable young adults. Young victims of exploitation will continue to receive services from relevant partners when they reach the age of 18 until at least the age of 25.	There will be: • Appropriate support for young adolescents and young adults. • Partner wide understanding of the significant difficulties experienced by some adolescents and young adults. • A clear pathway into the local authority for responding to safeguarding needs of young adults. • Evidence that victim support is clear, easy to understand, available and accessible to young adults.

Key Priority	Our Focus: What does this look like for us in North Somerset.	Our strategic intention	How we will know we have made a difference
PRIORITY 4 Tackling Adult Exploitation	**Exploitation is a hidden and complex crime which abuses the basic human rights and dignity of victims who are subject to it.** **Some of the current themes identified in North Somerset include financial scams and money lending for the 18-25 age group and some older vulnerable adults, cuckooing, county lines, sexual exploitation and people trafficking.**	Using the principles of Prepare, Prevent, Protect, and Pursue, we will: Support local partners to develop an effective strategic response to adult exploitation and threats from outside the home. Raise awareness and identification of exploitation. To develop a framework to ensure that all agencies in North Somerset work together as partners to prevent individuals becoming victims or perpetrators of exploitation. Provide support to those at risk of, or subject of exploitation. Agree and pursue a joint approach to how partners work together to identify, investigate, and prosecute individuals and groups engaged in exploitative criminal activity.	There will be: • Joint approaches to share information, identify early concerns and focus our resources in hotspot areas. • Joint actions that show we have reduced the risk of individuals becoming victims or perpetrators of exploitation. • Clear understanding of their needs, access to support and assistance to safety and recovery. • Intelligence led, targeted operations which have resulted in the disruption of and / or the prosecution of identified perpetrators and, where appropriate, evidence of the use of asset recovery legislation.
PRIORITY 5 Domestic Abuse	**North Somerset has seen a 53% increase in section 42 enquiries relating to Domestic Abuse. North Somerset also saw a 57% increase in reported concerns relating to Domestic Abuse.** **Police data highlights that in North Somerset 40.1% of all violent offences are domestic abuse related.**	Increase awareness and provision of information and training to support reporting of domestic abuse and accessing of services. Identification of domestic abuse at an earlier stage and provision of support to prevent escalation or repeated abuse. Multi-agency partnership working to identify risk early on and provide appropriate support. Provision of high-quality specialist domestic abuse support through commissioned service provider.	By implementing the North Somerset Domestic Abuse Strategy there will be: • Community and professional understanding of what domestic abuse is, the dynamics involved and know how to appropriately respond. • Increased reporting of abuse crimes to police and reducing repeated incidents. • Evidence that domestic abuse training is available to all relevant practitioners, organisations and businesses. • Equal access to services for survivors, which appropriately meet their needs across all levels of risk.