2022-2023 ANNUAL REPORT

NORTH SOMERSET SAFEGUARDING ADULTS BOARD

NSSAB

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Introduction from the Independent Chair Teresa Bell

Welcome to the NSSAB annual report for 2022/23, a year which encompassed some changes for the Board. I was pleased to be appointed as Independent Chair for NSSAB in September 2022 following a handover from the outgoing Chair, Tony Oliver, who had steered the Board for 6 years, including, of course, during the unique challenges of the pandemic. We welcomed our new Board Manager, Liz Langson, who joined in November 2022. Liz and I have been working closely with Board partners to ensure that the core duties of the Board work effectively, whilst reviewing and refreshing the focus of the Board in the light of current pressures and risks, both locally and nationally.

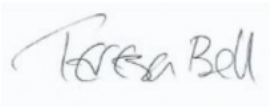
Our annual report shows what the Board aimed to achieve during 2022 to 2023 and what we have been able to achieve. It provides a summary of who is safeguarded in North Somerset, in what circumstances and why. This helps us to know what we should be focussing on for the future in terms of who might be most at risk of abuse and neglect and how we might work together to support people who are most vulnerable to those risks.

Safeguarding Adults Reviews (SARs) are a statutory duty for SABs when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk. During the past year the Board has been overseeing SARs for cases which met the criteria, as well as commissioning a Thematic Review into cases which had a shared theme of self-neglect. The recommendations from these reviews have individual action plans which are monitored by the Board to ensure improvements are made as needed and inform priorities for our business plan.

Partner support for NSSAB is evident in the engagement in the Board's work and a successful development event was held to review and refocus the work of the partnership. The Board's updated strategic plan and priorities are presented in this report.

Discussions have begun about how the Board can engage more directly with people with lived experience, so that their voices inform our priorities and practice. Community engagement will be a particular focus for the year ahead.

I am privileged to be working with such a committed and ambitious partnership in North Somerset to achieve our shared ambitions for making North Somerset a safe place for all residents.



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:

- 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
- 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
- conduct any safeguarding adults review in accordance with Section 44 of the Act.

The annual report summarises the achievements and challenges during the year 2022/23, informs on the Safeguarding Adults Reviews that have been finished and published during the year and outlines the Board's strategic objectives for 2022-2023.

The Board

The Board meets quarterly and it is supported in its work by subgroups, made up of members from the partnership, of which there are 7:

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

The Core Partners group consists of a representative from each of the partnering agencies: North Somerset Council, Avon and Somerset Police, BNSSG ICB. The Board is supported by a Board Manager.

Board Membership was refreshed and currently consists of:

NSSAB Independent Chair	North Somerset Council (NSC), Head of Service Head of Early Intervention and Prevention
North Somerset Council (NSC), Assistant Director, Adult Services and NSSAB Deputy Chair	North Somerset Council (NSC), Trading Standards
NSSAB Manager	North Somerset Council (NSC), Principal SW
NSSAB Business Support Officer	North Somerset Council (NSC), People and Communities
Avon Fire and Rescue	Public Health
Chief Inspector, Avon and Somerset Police	Sirona Care and Health
Partnership Liaison Manager (LSU), Avon and Somerset Police	Alliance, Director of Customer Services
Detective Inspector, Avon and Somerset Police	We Are With You
Voluntary Action North Somerset (VANS) - Voluntary Sector Representative	South Western Ambulance Service NHS Foundation Trust (SWAST)
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Safeguarding Lead	Care Quality Commission (CQC)
ICB Designated Professional/Nurse for Safeguarding Adults	North Somerset Council (NSC), Executive Member
North Somerset Weston-Super-Mare Integrated Care Partnership (ICP) Delivery Director	Lay Member / Independent Member
Deputy Director of Nursing and Quality, Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)	Health Watch
Integrated Care Board (ICB) Head of Safeguarding	Provider Representative - Vacant
National Probation Service	Children's Representative - Vacant
North Somerset Council (NSC), Director, Adult Services	Housing Representative - Vacant
North Somerset Council (NSC), Safeguarding Adults Team Manager	Service User Representative - Vacant


NHS
Bristol, North Somerset
and South Gloucestershire
Integrated Care Board


AVON & SOMERSET
CONSTABULARY


North
Somerset
Council


Sirona
care & health


AVON
FIRE & RESCUE


Probation
Service
South West


CareQuality
Commission


Alliance
homes


NHS
South Western
Ambulance Service
NHS Foundation Trust


VOLUNTARY
ACTION
NORTH SOMERSET


we are
with you

The Funding Arrangements of the Board

Funding for the NSSAB is provided by the partner organisations. The budget funds the cost of the Independent Chair, Board Manager, Board Administrator. Presently Safeguarding Adults Reviews are shared equally between the three core partners. The budget for 2023 – 2023 can be seen below:

Partner contributions:

North Somerset Council	£34,260
Avon and Somerset Constabulary	£7,128
Bristol, North Somerset and South Gloucestershire ICB	£25,150
Total	**£66,538**

Safeguarding Adults Reviews (SARs) Summary

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. Section 44 of the Act requires Safeguarding Adults Boards (SAB) to undertake a Safeguarding Adult Review (SAR) in specific circumstances and places a duty on all Board members to contribute in undertaking the review, sharing information and applying the lessons learnt.

The law requires local SABs to arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk.

The purpose of a SAR is not to hold any individual or organisation to account as there are other processes available for that purpose; they are about learning lessons for the future. SARs ensure that SABs get the full picture of what happened, so that all organisations involved can improve as a result.

NSSAB has a SAR Committee which meets monthly to consider referrals for a review, the progress of pending SARs, and any other regional/national SARs from which learning can be derived for local partners. Where referrals do not meet the threshold for a SAR, the

Committee explores opportunities for alternative learning practices, whether it is the sharing of information, or raising awareness of certain matters.

During 2022 – 23, we published a report of a Thematic Review into three cases involving Self Neglect:

Stan, Charlotte, and Philip

NSSAB recognised that there were consistent themes to be analysed and understood in the way in which partners worked together for people who are perceived to be at risk through self-neglect. An independent reviewer, Professor Michael Preston-Shoot, was commissioned to look at the circumstances of three people where self-neglect may have been a contributing factor to their death.
NSSAB has included self-neglect as a priority in its strategic plan and intended that the thematic review should move beyond familiar findings, to focus on what lessons were still to be learned about working with people who self-neglect. It was agreed that reflective chronologies would be requested from the services involved, covering especially the final twelve months of their lives. A reflective learning event was held in which practitioners, operational managers and strategic managers were invited to discuss the evidence-base for working with people who self-neglect. The focus here was to consider alignment of policy and practice in North Somerset with the evidence-base, what enabled alignment and where the obstacles or barriers were to best practice. Recommendations from the review have formed the basis of an action plan aimed at improving future practice.

A further two SARs were progressed towards publication in 2023/2024. These were:

Abi and Kim

This review looks at the circumstances surrounding deaths by suicide of two women on an inpatient ward at Cygnet Hospital Kewstoke. A review was originally commissioned in July 2021 after Abi's death. Between the SAB's first contact and the time of the appointment of the review author, Kim died by suicide on the same hospital ward and it was considered appropriate for the reviewer to look at both of these incidents.

As both women died while resident in North Somerset, as this is where the hospital is based, NSSAB have commissioning responsibility for both SARs and S42 enquiries under the Care Act. Specific areas of focus and scope of the SAR aimed to understand the events leading up to the deaths of both Abi and Kim, with a specific focus at the time of the review around the culture, management and relationships of the inpatient ward. It also aimed to consider the practice of out of area placements.

NSSAB worked in partnership with the team from Cygnet Hospital Kewstoke in the review and in developing the resulting action plan.

The review is due to be published in June 2023.

Colin

Colin suffered a severe stroke in May 2020 which led to him being hospitalised and later placed in a nursing home, where he was found deceased, having taken his own life in January 2021. During his time at the nursing home, Colin regularly expressed his desire to return home and specifically that he did not wish to be living in a nursing home for people with dementia, because he did not have dementia.

The review scope included consideration of the decision making to place Colin in a nursing home registered for people with dementia and consideration of whether Colin was ever offered the opportunity to realistically contribute to the placement decision.

The review process commenced December 2021 and concluded September 2022. The Executive Summary is to be published in July 2023 and includes recommendations made by the Independent Reviewer and a summary of actions taken by NSSAB partners as a result of the review.

NSSAB wishes to convey again our sincere condolences to the families and friends of those people at the centre of the SARs. We are determined to ensure that the learning from the reviews into their deaths will be embedded to improve partnership working to prevent similar tragic circumstances.

The publication of our SARs can be found by visiting our NSSAB website here: https://nssab.co.uk/safeguarding-adult-reviews-sar

Examples of safeguarding work undertaken in Adult Social Services 2022 – 2023

Safeguarding Adults Team – James Wright, Team Manager:

NSSAB has a strategic intention to develop its approach to Transitional Safeguarding and to ensure that its approach is 'Trauma informed'.

Last year, the council undertook a safeguarding enquiry in connection with a young adult. The outcomes for this young person were transformed through a transitional and trauma informed approach.

A historical interpretation of the statutory criteria would have resulted in the council making the decision that the young person's care and support needs were relatively minor and therefore did not affect their ability to protect themselves. This is because the young person did not have significant learning disability, mental ill health or physical or sensory impairments. They did however, have a significant history of childhood neglect and abuse.

By working together with local adult education provider who knew the young person well, the safeguarding adults officer was able to build a good relationship with them. They identified that as the young person had been through the care system, there was need to take a transitional approach and for the council to act as a parent would. Effectively, we were flexible with our interpretation of what constituted care and support needs. This led to a multi-agency safeguarding plan being put in place.

As the safeguarding officer developed a better understanding of the young person's childhood experiences, it became clear that they had experienced significant trauma. Through research and the support of staff within the learning disabilities team with specialist knowledge of trauma informed practice, our approach to enabling the young person to protect themselves fundamentally shifted.

Whereas we had at first focussed on accessing education on the subject of maintaining personal safety and making safe decisions, a trauma informed approach dictated that we consider the young person's hierarchy of need. As such, we considered whether the young person first had their basic needs met; food, water, and safe accommodation. We then moved on to consider whether they had safe or nurturing relationships around them. These were important steps in building a foundation; for a trauma informed approach tells us that only once this is in place and secure, would they be able to take more advanced steps toward independence and education in building their ability to make safe decisions and judgements around appropriate relationships.

Ultimately a trauma informed care needs assessment led to the local authority agreeing to fund a placement for the young person in a care facility where they are now successfully building the foundations upon which everything else will come. There have been no further safeguarding concerns raised for this young person since. A trauma informed, transitional response has significantly reduced the risk to them, it has achieved their desired outcomes and stopped 'revolving door' referrals.

Quality Monitoring Team – Sharon Cooper, Team Manager:

The Quality Monitoring (QM) Team monitors and assesses care provider performance against North Somerset Council contracts and frameworks, and in line with relevant legislation, guidance and standards. Providers include care homes and domiciliary care services. The team has a programme of annual visits, review visits, as well as carrying out ad hoc or urgent safeguarding visits when required.

It is well-established with knowledgeable and skilled officers who have built up effective professional relationships with providers in North Somerset. Although the team are assessing the quality and safety of the care provision, the QM role is also seen by providers as a supportive one; with the QM officers offering support and guidance to improve services.

The following is feedback received by the team on their interactions.

‘Good to see the positive comments on Home and Grace. We achieved this with your help.’

Residential Care Provider #1

A number of providers welcome QM visits to help identify areas for improvement prior to any Care Quality Commission (CQC) inspection of services and published ratings.

‘I would just like to say how lovely it has been at all 3 service visits to feel supported by you and relaxed with the process NSC uses for these visits which I feel is a supportive one to care homes rather than a fault-finding mission.

My staff and residents across my services have all said they enjoy showing off the home and that they do not feel on edge when NSC and yourself visits.

I imagine with you and your team’s roles that sometimes people can feel uneasy or on edge just because of the nature of the role/visit but in fact, all of your team, I have met have been lovely and understood pressures in social care. Each one I have met has been highly supportive over the 9 years I have worked for [provider] and I often feel home managers should use your visits as a dry run for CQC I know this is how I view them.

I love reading your reports as it reminds me of how amazing my team are even on the bad days and reminds me why I love my job.’

Residential Care Provider #2

A number of providers have received an improved inspection rating from CQC attributable in part to the support that the service has received from the QM Officer. In some instances, the QM team input has assisted providers to make significant improvements in practice to enable them to address organisational safeguarding concerns, ensuring a safer service for service users.

‘I just wanted to pass along some compliments mainly about [QMO].

[QMO] was extremely helpful and supportive while I was working for the [Care home], even though I know by time I joined it was difficult…

Once again, I wish to pass my thanks on and wish you all the best too.'

CQC rating improved from Inadequate to Requires Improvement

The current position regarding CQC ratings of NSC contracted services shows a good quality provider market – based on CQC ratings at Q3 2022 for all providers (n119 rated):

- Outstanding 1%
- Good 88%
- Requires Improvement 10%
- Inadequate 1%

The QM Team are currently trialling a new online electronic platform – Provider Assessment and Market Management Solution (PAMMS), it is part of a regional project to help standardise the quality assessment and rating across Local Authorities and provide information to help manage the provider market.

Work continues to further develop the interface and joint working between the QM Team and the Safeguarding Service to ensure a coherent and effective response to issues identified with local NSC contracted providers. Current processes are working well to ensure a relevant response is made to challenges around the quality and safety of local care services.

Service Development – Fiona Shergold, Head of Service:

The Wellness service aims to help improve and sustain the physical and mental wellbeing of people across North Somerset, allowing them to remain as independent as possible in their own home and communities.

- The Wellness Service is a FREE service to residents of North somerset over the age of 18.
- The service is provided by Access Your Care in partnership with North Somerset Council.
- The service operates between the hours of 09:00 and 22:00 seven days a week.
- Referrals will be processed between 09:00 and 17:00 Monday to Friday (except bank holidays).

The aims of the Wellness Service are:

- Checking that a person feels safe and secure
- Maintaining a person's independence in the community
- Reducing social isolation
- Signposting people to wider community resources where appropriate
- Exploring the benefits of Technology Enabled Care (TEC)

People will be offered tiered support dependent upon their desired outcomes.

Adult Social Services – Housing Solutions – Sarah Stillwell, Head of Service:

Over the past 12 months we have been focused on implementing long term solutions that can end homelessness. Wherever possible the solution to homelessness should focus on providing permanent homes rather than temporary accommodation. Complex and multiple needs often mean it is much harder to find suitable move-on and off-the-street offers. RSI 5 Funding has been approved along with confirmation of our 3 year ask of £932,477. This allows continuation of services for rough sleeping interventions and lets us focus on upstream prevention with both Outreach and In reach work taking place.

It is recognised that there is no one solution to end rough sleeping, however the following interventions are now active in North Somerset. Milton Brow (Curo) Rough Sleeper Project – Low support. 2 HMO's with a capacity of 7 beds for singles.

Housing First (Alliance) – High support. 5 Single flats.

Housing Led (Curo) – High Support. 6 Single flats.

Clarence Park Lodge (YMCA) – Low support. 1 HMO with 3 beds.

Street 2 Settled Partnership – Quarterly Partnership meeting, in the last year the partnership has reviewed and approved a new Charter.

BillyChip offers a unique safe and secure platform which allows the public to directly donate to rough sleepers without the fear of their donation being mis-used for drugs or alcohol. We attempted to get the scheme started at the beginning of 2023, but found few takers amongst the outlets that were approached (1 out of 9). We look forward to welcoming the BillyChip Scheme into North Somerset, with a renewed drive this year.

Somewhere-to-Go – We continue to work closely with STG who provide a day centre for the homeless and rough sleepers, including meals, essential clothing, showers and ablutions. Prior to the covid pandemic they also provided a Night Assessment shelter with 12 beds in a dormitory style setting. We are currently engaging with them to explore options for a SWEP (Severe Weather Emergency Provision).

Three things we are working on to improve safeguarding adults:

Reviewed the pathway for people reporting safeguarding concerns, ensuring they are received by trained people that can appropriately respond. Supporting decision making in a timely manner and assessment under section 42 where appropriate.

Embedded the centralised safeguarding team, recruitment to posts, development of roles within the team to effectively use resource in managing demand.

Worked effectively with Quality Monitoring regarding whole home safeguarding enquiries.

Examples of safeguarding work undertaken by Avon and Somerset Police 2022 – 2023

The grip, governance and leadership around vulnerability continues to develop and strengthen to further improve our force response. The governance structure has developed to include regular quarterly meetings at both strategic and tactical levels and quarterly reporting to our Confidence and Legitimacy Committee, and the Police and Crime Commissioner's (PCC) Governance and Scrutiny Board. The content of the report is focussed on the priority National Vulnerability Action Plan actions as identified through the last self-assessment process, as well as progress updates on ongoing work and performance deep-dives into several of the vulnerability themes each time, covering all within each 12 month period.

In the last 12 months there has been a review and refresh of the leads for the themes with some staff moving into new positions which has enabled an assessment of the capacity for each theme. This has resulted in growth in the leadership of the Domestic Abuse (DA) theme and the introduction of a deputy to the force lead for overall vulnerability being introduced as well to improve capacity.

In the last few months we have developed a joint Vulnerability and Violence Against Women and Girls (VAWG) delivery plan of priority actions and activities that we intend to complete within the year. These have been mapped to both the National Vulnerability Action Plan (NVAP) and VAWG Delivery plan as well as the Police and Crime Plan and several other national plans. Visibility of this is provided to all leads through Qlik (in house management system) which allows the plan to be filtered on any individual action of the NVAP and of the other plans so that activity linked to each action is clearly shown.

Through the vulnerability working groups several cross-theme work packages have been identified and work put in place to progress them. These include a review of Scrutiny Panels, a review of Protection and Civil Orders and scrutiny of the risk assessments we use. These pieces of work are all ongoing and relatively long term but will be reported on in due course with recommendations for improvements that will benefit everyone.

The innovative and ground-breaking work being done by Project and Operation Bluestone as a national pathfinder force for Operation Soteria has underpinned the development of a new National Operating Model (NOM) for rape investigation which will be launched imminently. As well as supporting improved service and performance in that specific area, the NOM will provide a benchmark and model for improved investigative standards across other types of vulnerability. The aim is to translate learning from this area across all vulnerability themes to maximise the benefits of this learning.

Our recent HMICFRS PEEL inspection found us to be adequate in the area of protecting vulnerable people. Associated with this is a specific area for improvement (AFI) which will focus some further activity specifically around the supervision of risk assessments and how we deal with Domestic Violence Disclosure Scheme (DVDS) requests. Other AFIs from other parts of the inspection will also cross over into vulnerability and drive further work, specifically ensuring a record is made when a victim withdraws their support and whether evidence led prosecution is considered, which is one of our identified priority NVAP actions.

Training

To support our Officers in understanding and recognising Adults at Risk they received a SWAY briefing which was produced in January 2023. This bite-sized training briefing included an audio input from our Force Lead for Adults at Risk, an explanation for the term, what is meant by care needs, support in recognising the signs that someone may be at risk and much more. This bite-sized training briefing was sent out to all Inspectors to be shared with Sergeants to organise team and/or individual viewings and so the exact number of viewings is unavailable.

This included the following:

- Audio Introduction from Force Lead for adults at risk Detective Superintendent Lisa Simpson.
- “Who is an adult at risk?” as defined by the 2014 Care Act.
- What is meant by care and support needs? Including The National Eligibility Criteria for those with care and support needs and steps to meet the threshold.
- Recognising the signs that someone might be an adult at risk… Detailing a repeat caller well known to police. Designed to show the victim being dealt with by an officer when they were clearly unable to respond how the officer expected them to. Highlighting what the victim found difficult and how officers’ interaction on attendance could be improved.

- Lack of capacity does NOT mean lack of investigative opportunities. Explanation of What is capacity, including an audio clip from our Mental Health Coordinator Insp Jon Owen.
- How are assumptions about capacity adversely impacting outcomes? Including a link to the Crown Prosecution Service (CPS) guidance dealing with suspects and defendants with mental health conditions and disorders.
- The Victim's Voice. Are you listening? Can you hear? Who can help?
- Professional curiosity. Is the capacity and communication skill to explore and understand what is happening, rather than making assumptions or accepting initial explanations.

In relation to other relevant training, please see the below force wide figures:

Training	Actual number of staff trained	Comment
Relevant staff have undertaken Prevent training (WRAP or equivalent)	36 (Trained 22/23)	All PIP2 Investigators receive prevent training.
Relevant staff have undertaken Domestic Abuse awareness training	116 (Trained 22/23)	40 – PIP 1 Investigator 36 – PIP 2 Investigator 40 - PIP 2 – Supervisors and Managers
Safeguarding leads have awareness of Modern Slavery/Human Trafficking	90 (Trained 22/23)	36 - PIP 2 Investigator 40 – PIP 2 Supervisors/Managers 7 – Modern Slavery Course OIC - 7
Relevant staff have undertaken complex (toxic) trio awareness training	45 (Trained 22/23)	SCAIDP course
Relevant staff have undertaken self-neglect training	76 (Trained 22/23)	40 – PIP 1 Investigator 36 – PIP 2 Investigator

		(Vulnerability training, not specifically self-neglect training)
Relevant staff have undertaken Mental Capacity Act (MCA) / Deprivation of Liberty Safeguard (DOLS) training		As above
New staff have undertaken safeguarding adults awareness training	445 (Trained 22/23)	40 - PIP 1 Investigator 241 - PCDA 154 – DHEP 10 – Detective Now

In addition, Mental Capacity Act Training is covered in the initial training for Police Constable Degree Apprenticeship (PCDA) Officers and delivered to all Police Community Support Officers (PCSO) in their initial training. Training to other Units/Teams such as Communications and Response is delivered on an ad hoc basis.

Dementia Safeguarding Scheme

A bespoke Dementia Safeguarding scheme to help safeguard people living with dementia is now into its eighth year!

The scheme, has four distinct strands:

- Near Field Communication (NFC) enabled devices allocation (wristbands, hang tags, lanyards with glow in the dark cards)
- 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’ NFC assistance devices were made available through the scheme from 2020 and over 2,000 have since been allocated through individual applications and to groups.

Over 1,000 people have signed up to the on-line Herbert protocol which means that police have instant access to crucial information such as former addresses and places frequented (along with a photo) if they are reporting missing.

Since 2020 we have secured almost **£18,000 of external funding** to buy **GPS tracking devices** along with **NFC assistance device** for people with dementia who are at risk of becoming a missing person.

This funding has come from a combination of donations from Wessex Water, Bristol Water and Western Power.

The 30 GPS trackers have been supplied by Somerset-based company, MindMe and will be allocated through referrals from our three specialist Missing Person Coordinators.

Current data shows that the **GPS tracking devices have a 96% success rate** at preventing the wearing becoming a missing person and the **NFC devices have a 93% success rate** and preventing the wearing becoming a missing person.

Inspector Stuart King established the bespoke scheme in 2015 and has been able to assist other Police forces and organisations across England, Wales, Scotland and Northern Ireland as well as internationally establish a similar scheme safeguarding people living with Dementia.

National and International Recognition (Awards)

1. In October 2022 Avon and Somerset Police were **recognised by the Bristol Dementia Action Alliance and awarded Silver Status as a Proud Dementia Aware Organisation**.
2. In March 2023 Avon and Somerset Police were **recognised by HMICFRS in the PEEL report for good working practice** with partners to protecting vulnerable people living with dementia.
3. In April 2023 Avon and Somerset Police were the **Winner of the National Alzheimer's Society Awards for being the Largest Dementia Friendly Business nationally**.
4. Also in April 2023 at the same awards Inspector Stuart King was joint **Winner of the National Alzheimer's Society Awards for his Research and Innovation into Dementia** as recognition for his work in establishing and running the Dementia Safeguarding Scheme since 2015 and assisting other forces and organisations to adopt the same scheme.
5. In May 2023 Avon and Somerset Police was the **Winner of the RDID Best RFID/IOT (other industry)** at the prestigious RFID Live trade awards in the USA for their use of GPS and NFC technology to protect and safeguard people living with Dementia.

DA Matters

To help equip Officers and staff with the necessary skills and knowledge to respond effectively to domestic abuse, 2200 Staff and Officers received the Domestic Abuse Matters Training Programme, delivered by Safe Lives national trainers. Over 50 staff from partner agencies attended, including the CPS, support agencies and Independent Domestic Violence Advocate (IDVA's). A network of DA Influencers has been developed in force to sustain the change in skills, behaviour, and attitudes by challenging inappropriate language and behaviour, checking

service delivery, giving feedback and congratulating great practice. They will also identify and act on compassion fatigue, burnout and vicarious trauma and respond to abuse within colleagues' personal lives.

Two things we did well to safeguard adults:

- Improve officers' ability to identify an Adult at Risk at first point of contact and to better understand the investigative and referral options available and where there are no referral pathways work towards a solution.
- Improve understanding of existing referral pathways that could be used when the threshold for safeguarding is not met.

Bristol, North Somerset, South Gloucestershire Integrated Care Board (BNSSG ICB)

The BNSSG Integrated Care Board (ICB) safeguarding team continue to support an effective working relationship with the Local Authority and other statutory and multidisciplinary partners within the North Somerset Safeguarding Adult Board. The ICB, as a statutory partner, provides health advice and information to support all aspects of safeguarding, reviews, investigations and interventions in meeting effective safeguarding outcomes and best practice for the North Somerset population. Where additional safeguarding interventions are required to support Care and Nursing Homes the ICB team work proactively with North Somerset Local Authority colleagues and partners to provide a multiagency approach.

Three things we did well in relation to safeguarding adults in North Somerset:

1. Working in partnership with the SAB manager, SAB Chair, and other statutory partners to support reviewing, updating, and implementing SAR policy and processes. This has included utilizing the ICB experience of working with other SAB's across BNSSG and linking SAB managers to inform standardized SAR practice. The requirement to review SAR processes and policy was informed by taking learning and recommendations from a self-neglect thematic review and an individual SAR, completed by North Somerset.

2. The review and improvement of the use of the Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicidal ideation and Safety assessments (HEeADSSS) in Emergency Departments in Bristol Hospitals has been a positive implementation. HEeADSSS is an acronym for a comprehensive psychosocial assessment tool identifying risk and protective factors and assists health professionals formulate a plan in partnership with a young person. The review of the use of the tool followed the learning and recommendations taken from a DHR completed by North Somerset. This learning indicated a fuller assessment of psychosocial needs of young people entering ED's, during episodes of mental health crisis, would better inform the information sharing and understanding of multiagency agencies involved as the young person returned to the community. The use of the HEeADSSS has met the requirement effectively and continues to be used to support young people attending Emergency departments at Weston General Hospital and across Bristol and South Gloucestershire.

3) The ICB have updated safeguarding level 3 training packages for GP and Primary care staff across BNSSG which includes safeguarding adults. The content of the training has been based on the learning from safeguarding issues and trends seen in safeguarding referrals, SARs and DHRs. In North Somerset, this learning has been taken to offer GP Practices bespoke discussions with the ICB Named GP's and each of the GP Practice's link clinical safeguarding leads. This has supported improved GP's understanding of safeguarding processes and increased confidence in engagement in these processes by GP's, who are recognized as valued contributors to safeguarding concerns and enquiries.

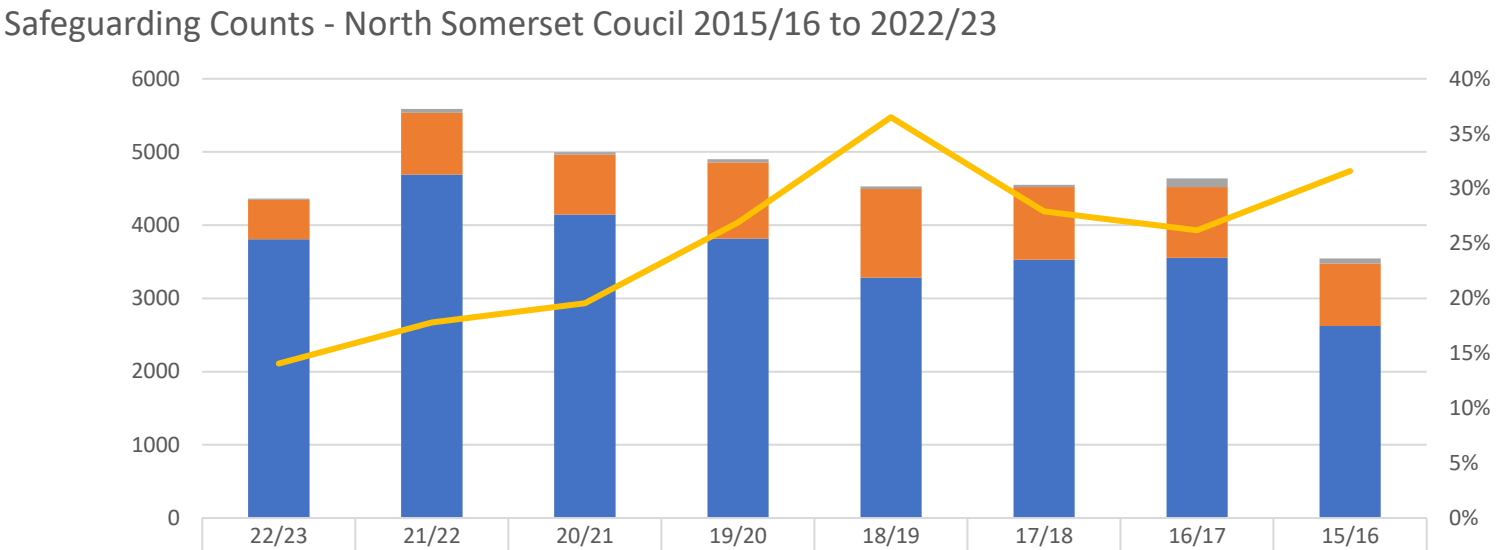
Three things we are working on to improve safeguarding adults in North Somerset:

1. Continuing to develop and provide safeguarding adult training for Primary Care colleagues in a variety of forums such as podcasts to enhance the current provision.

2. The ICB are currently recruiting three Deputy Designated roles in strengthening the capacity of the Designated Nurse role. These new roles will enable the ICB to further support participation in the essential work of each of the North Somerset SAB subgroups in developing and implementing best practice for the North Somerset population.

3. The ICB will continue to work with their health partners, North Somerset SAB and take learning from the recent LGA review, in improving methods of enabling increased representation and attendance by health service staff at North Somerset adult safeguarding meetings. This will enable the views and feedback, including the voice of the service user, to be obtained from a wider range of health services and agencies working with people in North Somerset population.

Safeguarding Adults Data 2022-2023

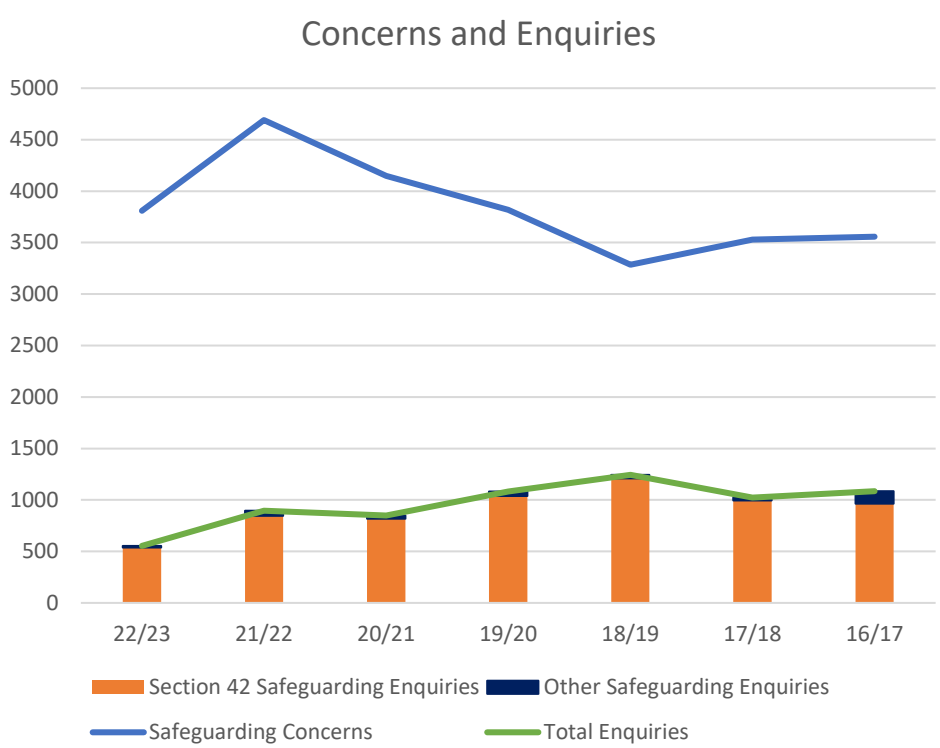


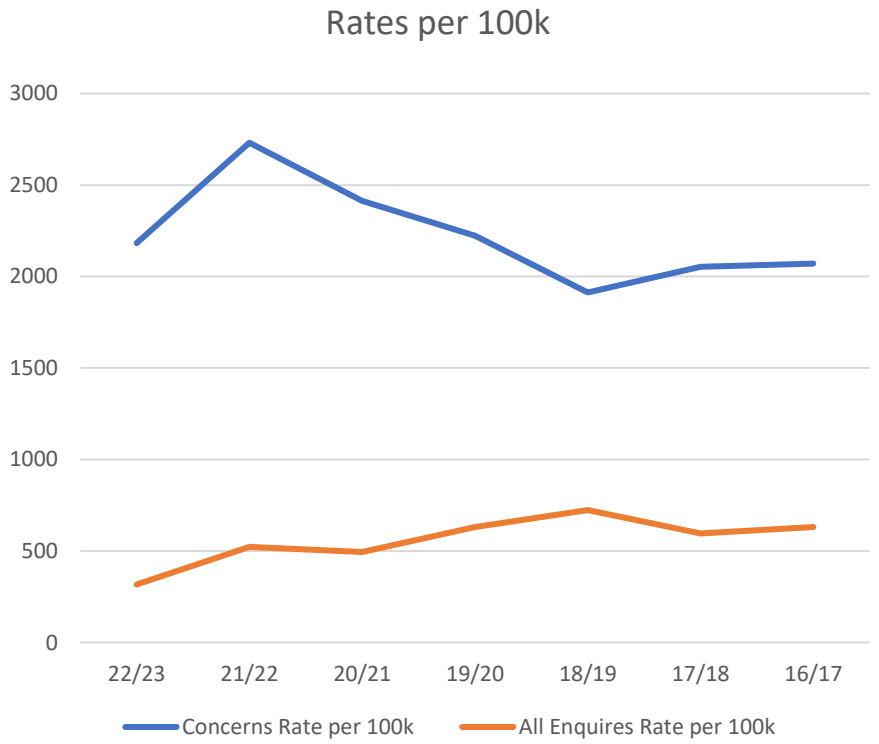
	22/23	21/22	20/21	19/20	18/19	17/18	16/17	15/16
Total Number of Other Safeguarding Enquiries (Active in year)	16	52	33	44	33	30	121	69
Total Number of Section 42 Safeguarding Enquiries (active in year)	538	845	817	1039	1211	994	964	851
Total Number of Safeguarding Concerns (received in year)	3809	4690	4147	3818	3285	3528	3556	2624
NHSE Digital Conversion Rate	14%	18%	20%	27%	36%	28%	26%	32%

Please note this table uses 2 separate scales, the total counts are on the left and the NHSE conversion rate percentage is on the right.

The NHSE Conversion Rate is the number of concerns received by the number of s42 enquiries active during the year. The enquiries active during a year may have been opened during a previous year. To this end when we are comparing our own data, we use a more direct comparison. The NHS conversion rate has been used in this report as it can be benchmarked nationally.

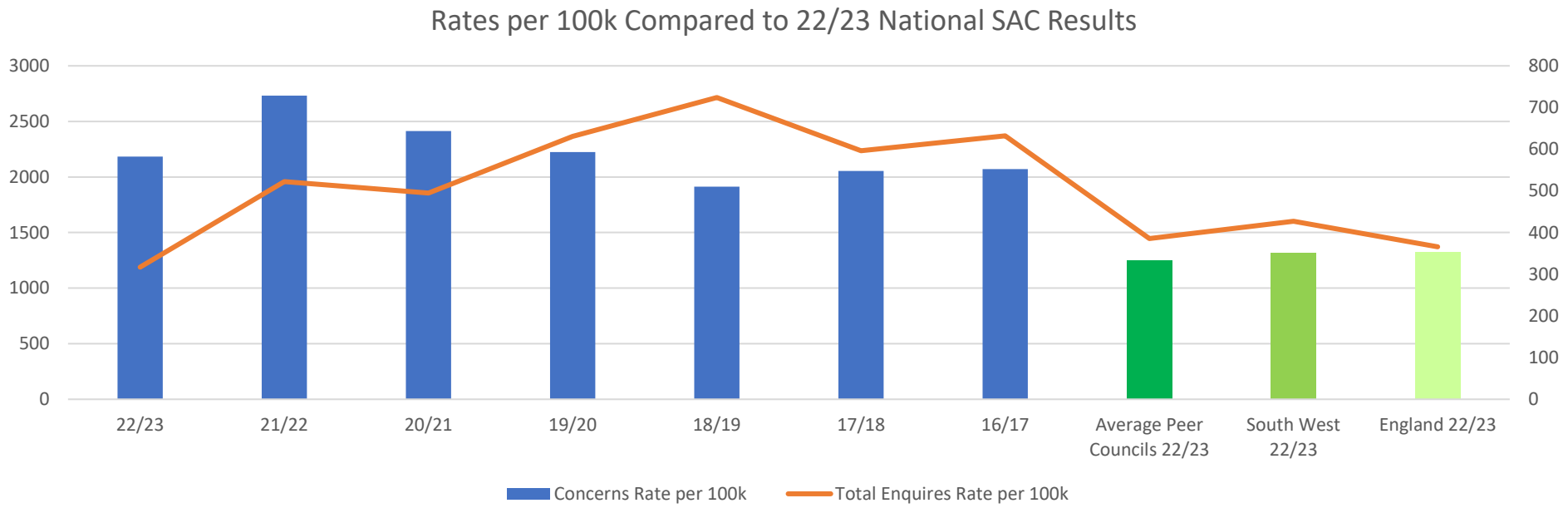
When looking at Safeguarding Counts in comparison to other councils, other regions, and England we use rates per 100,000 population, this is a national method of comparison.





This shows us that we have a high rate of concerns recorded per 100,000. The highest in our peer group, higher than the average for the group, and higher than the South West and England.

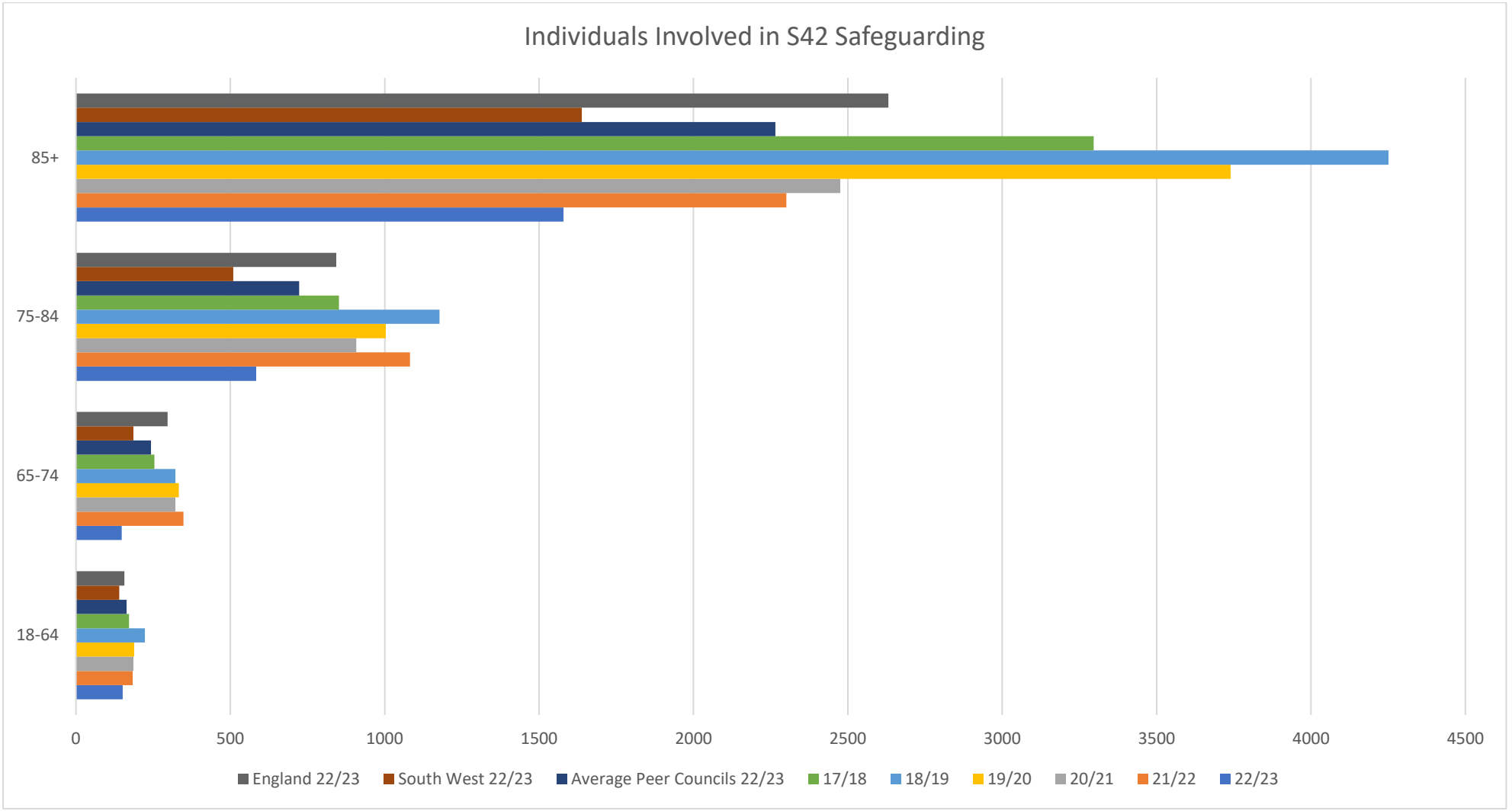
The reasons for this are quite complex. Firstly, not all Councils log a Safeguarding Concern in the same way. The North Somerset model was to take a concern at presenting information and then to apply the S42 1 criteria, other councils apply a pre concern triage model where they don't classify a concern until it is deemed to be one. Secondly, we do not know which council uses which model of concern counting.



Please note that this graph contains two separate scales the concerns are measured on the left and the enquiries on the right.

An individual may have more than one enquiry about them during the year. The SAC asks us to count them once for the purposes of these tables.

As with previous counts as our number of enquiries has decreased so has our number of individuals, and rates per 100,000 population. Instances per 100,000 population for the older age groups increases as more of the older age groups tend to have care and support needs and are smaller cohorts.


Individuals Involved in S42 Safeguarding
85+
75-84
65-74
18-64
0
500
1000
1500
2000
2500
3000
3500
4000
4500
England 22/23
South West 22/23
Average Peer Councils 22/23
17/18
18/19
19/20
20/21
21/22
22/23

Individuals Involved in Section 42 Safeguarding Enquiries by Gender, Ethnic Origin and Primary Support Reason

57% Female

43% Male

82% White

1% Each: Mixed / Multiple; Asian / Asian British; Black / African / Caribbean / Black British; Other; Refused

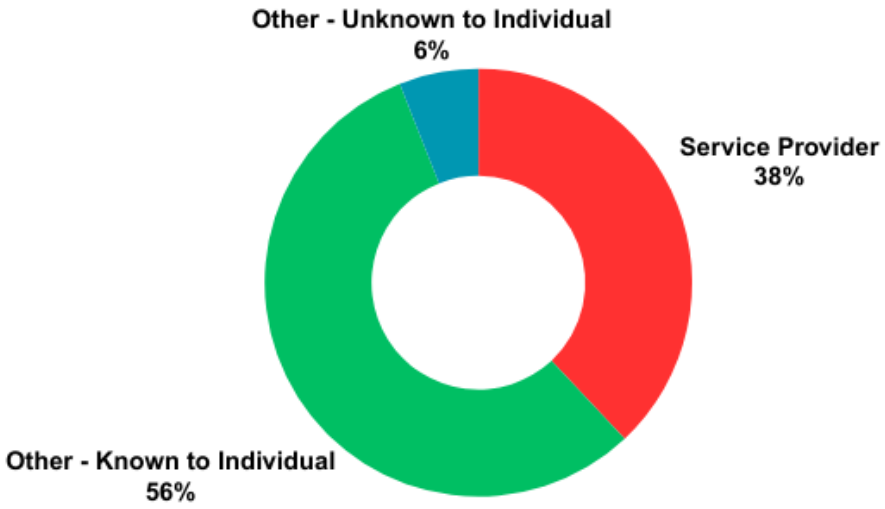
13% Undeclared / Unknown

44% Physical

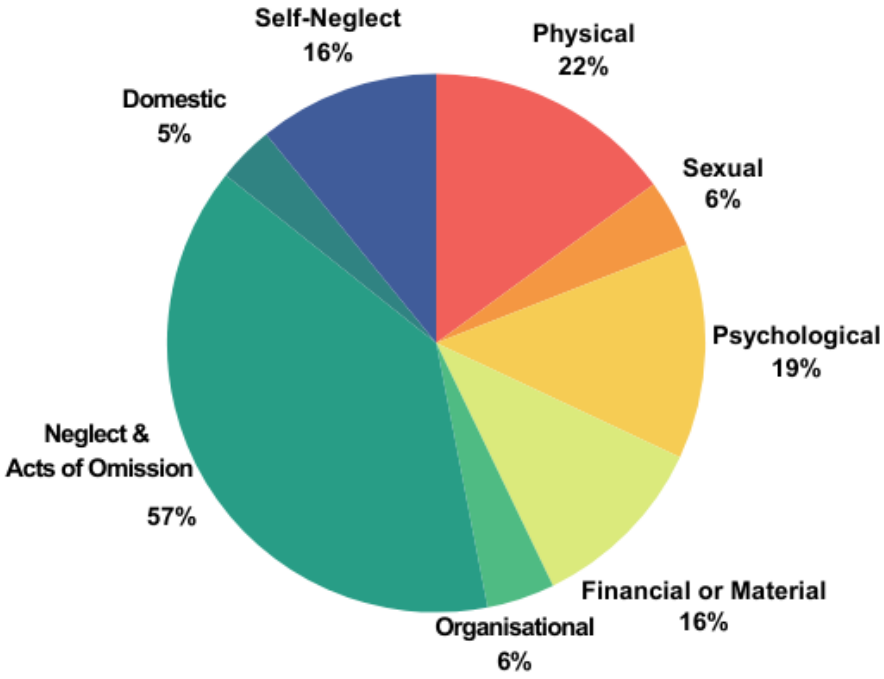
18% None
14% Learning Disability
10% Each: Memory & Cognition; Mental Health
2% Social
1% Sensory

Counts of Concluded Section 42 Enquiries

Source of Risk



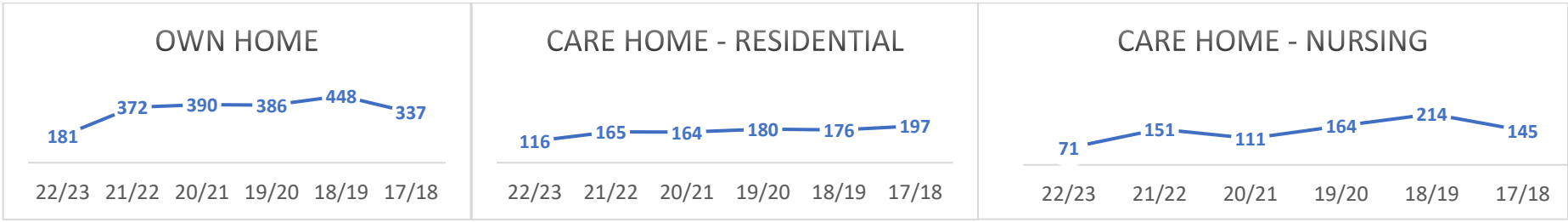
Type of Alleged Abuse as a percentage of all types



The three most prevalent locations are:

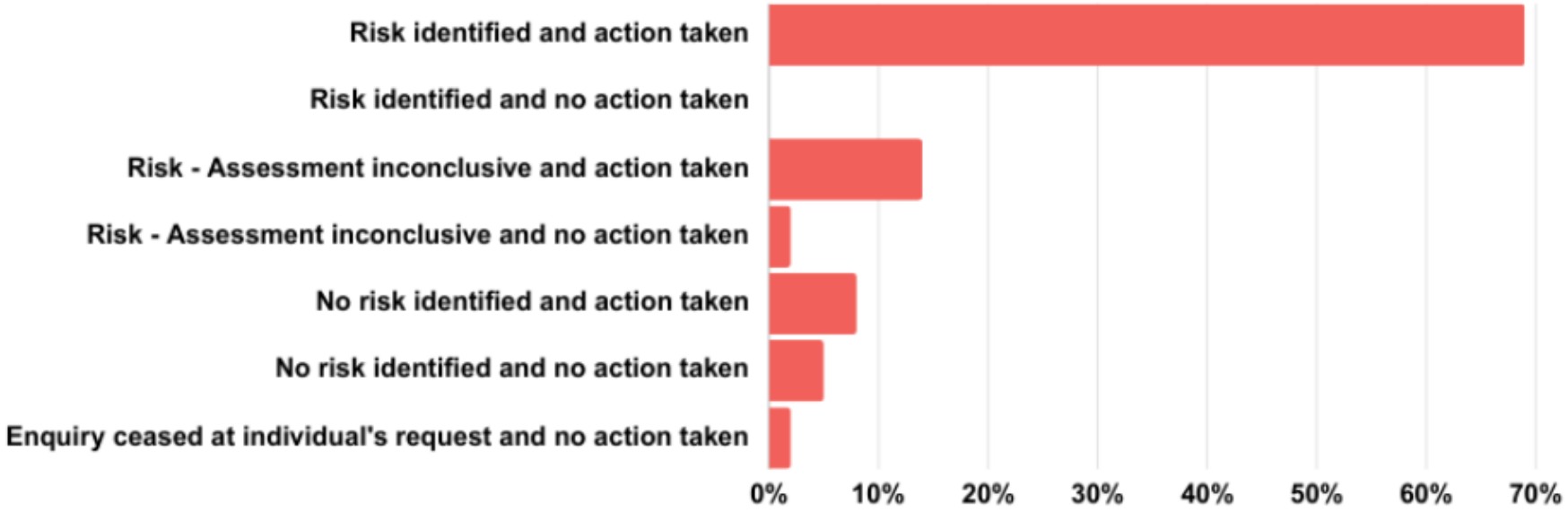
- Own Home
- Care Home Residential
- Care Home Nursing

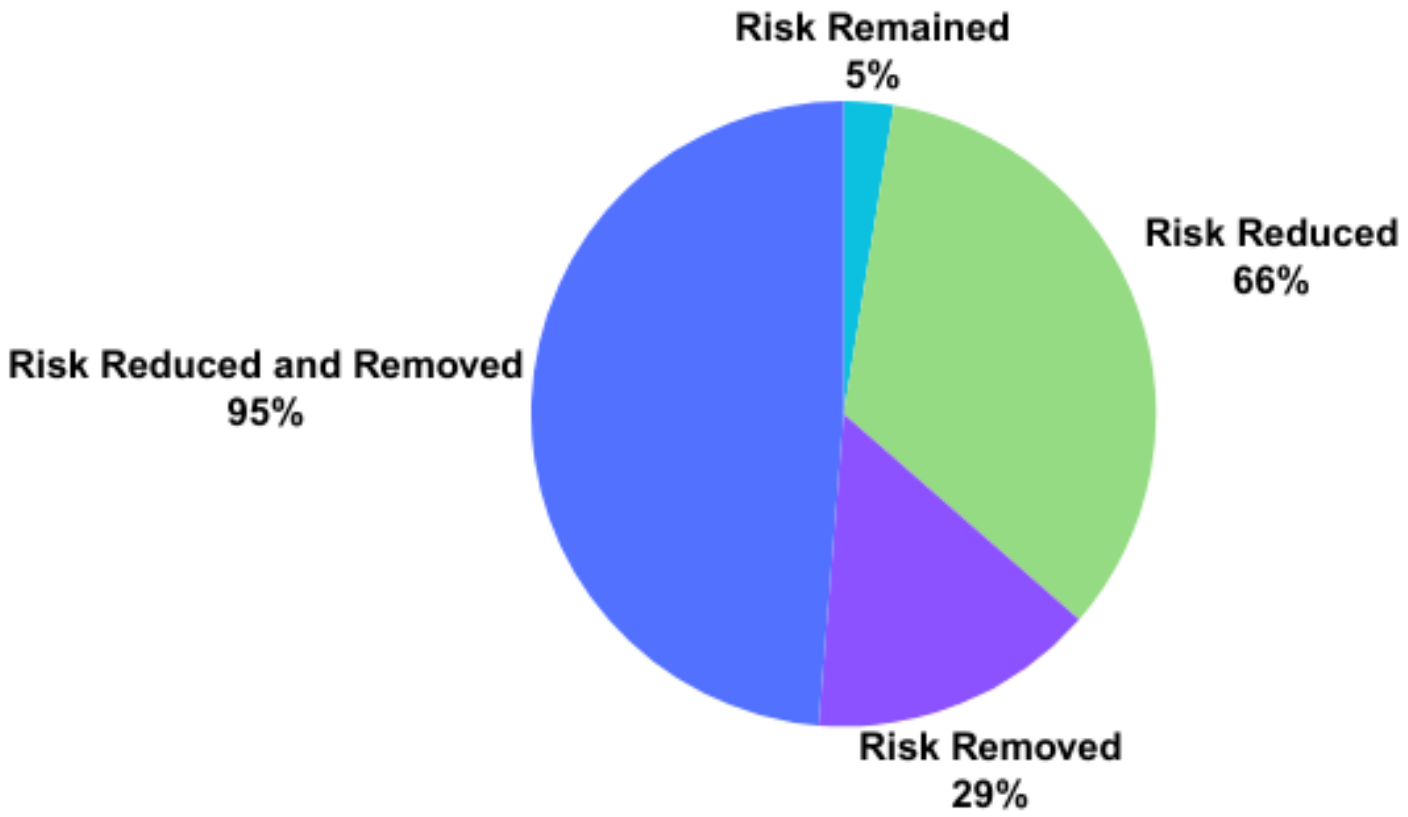
This is likely due to where people with care and support needs most commonly are.



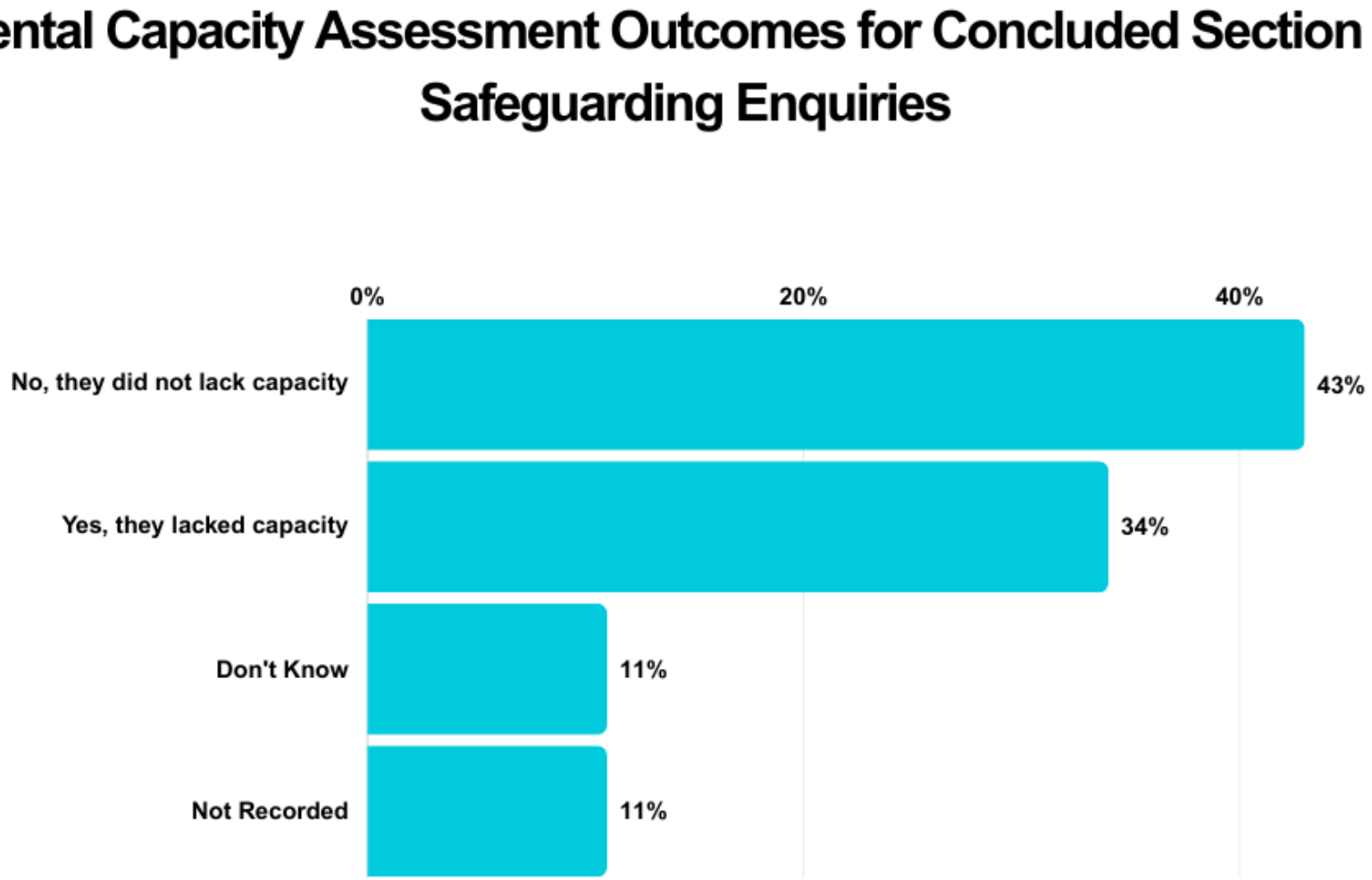
The graphs above represent numbers of concluded enquires in the top three locations rather than percentages. We know that our numbers of enquiries are potentially artificially down due to recording which may explain why there is a downward trend to all three. What we did notice was that own home as a location peaked during lockdowns, and there was a slight drop in care homes.

Risk Assessment Outcomes:
Was a risk identified and was any action taken / planned to be taken?



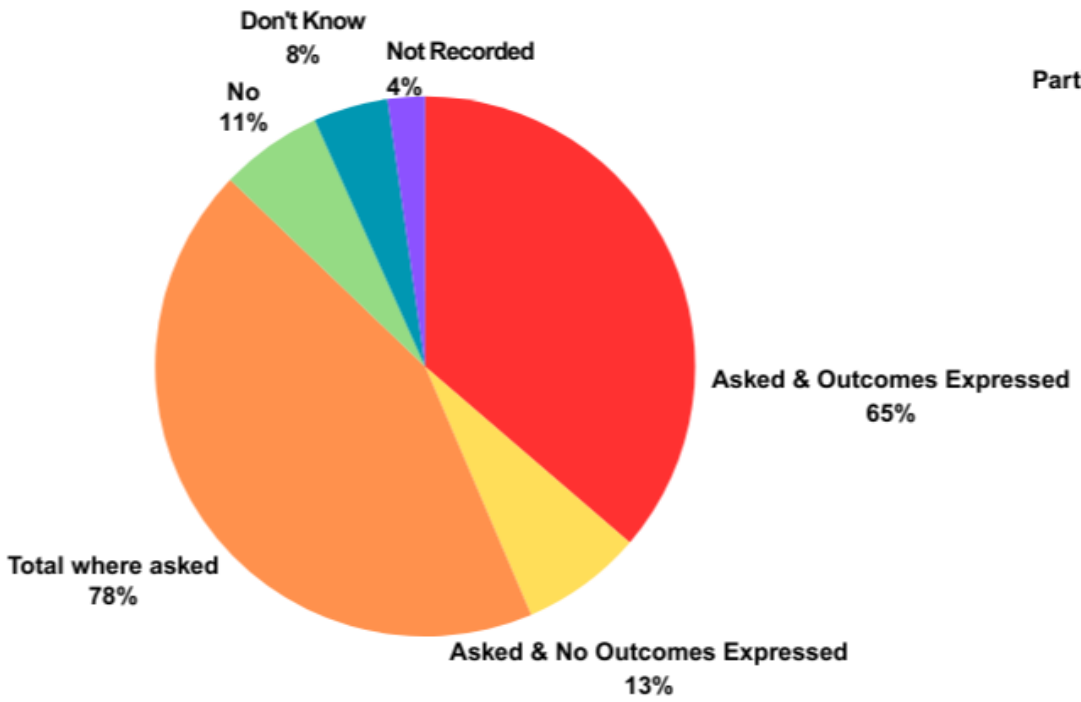


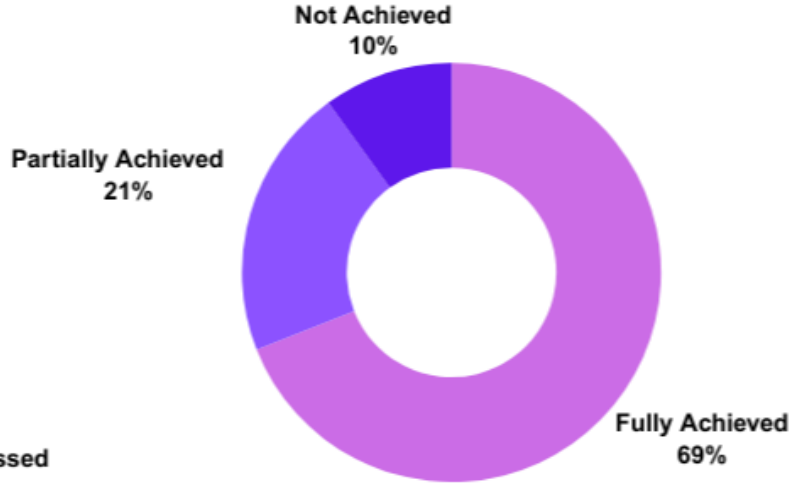
It is encouraging to see that reducing and removing risks has improved from 90 to 95% from 21/22 to 22/23. Our performance would suggest we are doing better than peer, regional and national at reducing and removing risks. However, it should be noted that this is a very broad measure in respect to reducing risk and case audit would perhaps be a more effective way to appraise the effectiveness of actions being taken.



When we have assessed capacity and the individual does lack capacity, they have been supported 100% of the time by an advocate, family, or friend. However, we 'don't know, or do not record mental capacity in 22% of enquiries. This has not improved over last year, although is better than 20/21 and 19/20.

Making Safeguarding Personal Responses for Concluded Section 42 Safeguarding Enquiries





Our performance has slipped in where we are asking peoples outcomes from being above average for the past couple of years to now.

We have set ourselves a target of achieving those outcomes fully or partially in 95% of enquires, which is in line with the average nationally. However, we have only been able to do this in 90% of cases. We will conduct case audits over the next year to determine why we were not able to meet outcomes in closer detail to get an understanding of what is happening.

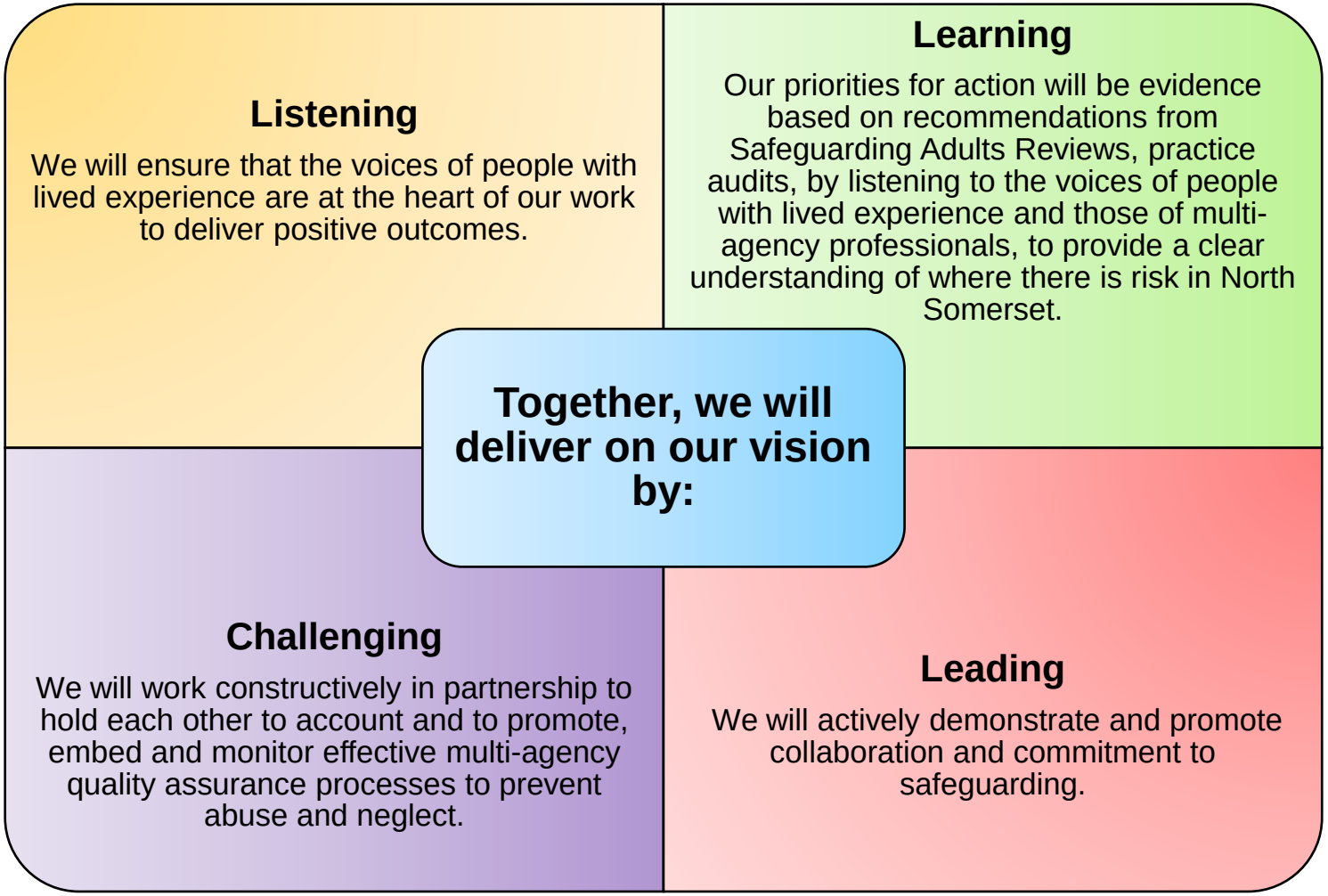
Going Forward to Year 2023-2024

Based on the feedback that we collected through an audit and our yearly development meeting we have been able to understand what the board needs to work on going forward. The NSSAB has had changes in management and leadership in the latter half of 2022 and the board is in a transition period of change and refreshing all processes.

Our business plan will run alongside this strategic plan and will go into more detail around how, by 'listening, learning, challenging and leading' we will achieve our priorities and goals. Below is an overview of what the board will be working on:

- Stable and committed membership
- Clarity and focus
- Re launching subgroups
- Website changes and updates – more inclusive
- MARM
- Join up with other boards – Children's, safer communities and other SABs locally
- Re do the constitution and MOU – clear on members roles and responsibilities – have we got the right people on the board
- Coproduction and being the voice of lived experience into the board
- Re-focus on data
- Review our strategic plan
- Audits and feedback to be strengthened – feedback included on the website
- SAR Process re-established
- Community awareness
- Learning from commissioned SARs
- Rebuilding partnership relationships
- LGA review of SABs
- Budget, resources and risks

NSSAB Strategic Intentions 2023-2026



Available in our Strategic Plan 2023-2026