ANNUAL REPORT 2017-18

Bournemouth & Poole Safeguarding Adults Board – working in partnership to develop, share and implement a joint safeguarding strategy to protect adults at risk from abuse, significant harm or neglect. We will achieve this through strategic leadership and accountability.

Safeguarding is Everybody's Business

Version 31 07 2018

INDEPENDENT CARE PROVIDERS

VOLUNTARY SECTOR

Foreword from the Independent Chair

I am pleased to introduce the annual report of the Safeguarding Adults Board for 2017-18.

Within the report you will find the contributions made by many of the members of the Board to effective safeguarding. This year has seen organisations

- developing the quality of training,
- implementing measures to improve the identification of safeguarding
- and formalising multi agency approaches to risk management.

Furthermore, the 5 sub-groups of the Board have each added value by completing programmes of work within the annual business plan. These are set out in the section on 'Key Achievements' within the report.

An important role of the Board is to seek assurance that organisations are taking all steps possible to safeguard vulnerable people.

The quality assurance group has monitored the level of safeguarding concerns, identifying trends and bringing to the attention of the Board action that is being taken in respect of the small number of care providers whose performance falls below acceptable standards.

A report was completed by the training sub group to assure Board members that the level of training provided to staff in their respective organisations is appropriate to the roles being undertaken.

Members of the Board have visited one another's offices and hospitals to learn more about their work and report back on their approach to safeguarding.

These line of sight visits have been complemented by presentations at formal Board meetings on the findings of Care Quality Commission inspections, the Pan Dorset Mortality Review Group and the LeDeR programme (focusing on deaths of people with a learning disability).

It is not expected that all safeguarding concerns will lead to a formal enquiry. However, in 2017 the Board commissioned an independent audit to examine comparative rates of Section 42 enquiries in each local authority area. In Poole, for example, in 2016-17 57% of concerns had proceeded to a Section 42 enquiry compared with a rate of 34 % in Bournemouth and 11% in Dorset. The report confirmed that such differences are not primarily related to demographic factors, but more to team organisation, interpretation of procedures and staff supervision. This is not just a local issue but one that is shortly to be examined via a national survey. The audit found aspects of good practice that can be shared across the 3 authorities and each will now produce an action plan to ensure statutory requirements are fully met and to deliver more consistent practice across the county.

I am pleased to note the continuing impact on levels of risk where enquiries are undertaken. In Poole in 96% of cases risk was removed or reduced. In Bournemouth the figure was 85%. In each authority where adults were asked if the outcome they wanted had been achieved, 62% said yes.

Looking forward the Board has identified 4 overarching issues which are a priority for organisations to address.

1. Support the development of a more robust independent provider market that will lead to fewer safeguarding concerns.

2. Reduce the instances of people with care and support needs being victims of domestic and sexual abuse through better integration of domestic abuse and safeguarding practice.

3. Help to establish 'working with the whole family' as standard practice.

4. Evidence that lessons from Safeguarding Adult Reviews and Domestic Homicide Reviews really have changed the way we work

The Safeguarding Board is working closely with other partnerships to achieve these aims.

2 conferences organised jointly with the Local Safeguarding Children's Boards (LSCB) in February promoted the theme of whole family working. These events attracted national speakers and were attended by over 450 staff.

A task and finish group involving both the LSCBs and the Community Safety Partnerships is examining ways to combine and embed the learning from a variety of reviews within day to day safeguarding practice.

I am aware of the challenging financial constraints faced by all members of the Board. Nonetheless partners have maintained a strong commitment to adult safeguarding and the majority have consistently provided financial and staff support to the Board.

I would like to express my gratitude to the staff of the Board's business unit – the outgoing and incoming Business Managers, Training Coordinator and Management Support Officer – for the knowledge, experience and organisation they bring to their roles. I am equally appreciative of the time given by the chairs of sub groups in leading their areas of activity.

Barrie Crook

July 2018

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EXECUTIVE SUMMARY

The Bournemouth & Poole Safeguarding Adults Board has been working towards delivering the strategic objectives set out in the three-year Strategic Plan encompassing the period from April 2015 to March 2018.

This Annual Report seeks to examine the activities of the Safeguarding Adults Board and its members from April 2017 to March 2018, the final year of the three-year Strategic Plan.

The achievements of the Board and its member organisations are showcased under the headings of Effective Prevention, Effective Safeguarding, Effective Learning and Effective Governance.

The report looks at some of the trends identified by analysis of safeguarding data as well as future challenges in store for the coming year.

In the appendices to the report are some examples of safeguarding cases demonstrating the work carried out by partners, as well as copies of the posters used in the Board's campaign against adult abuse.

1. ABOUT US

Who are we?

The Bournemouth and Poole Safeguarding Adult Board has been the partnership body for Safeguarding in Bournemouth and Poole since its inception eight years ago. It is a partnership Board with senior representatives from those organisations listed at the front of this document.

The overarching purpose of a Safeguarding Adults Board is to help and safeguard adults with care and support needs. We aim to stop abuse or neglect wherever possible and prevent harm occurring. We strive to address the causes of abuse or neglect. Our work includes raising awareness of safeguarding issues so these can be identified, and supporting affected people in making choices to resolve issues.

Our Mission

This Board exists to protect adults at risk from abuse, significant harm or neglect.

We will achieve this through strategic leadership and collective accountability.

Our Structure

The Bournemouth and Poole Safeguarding Adults Board is comprised of representatives from the Local Authorities, Health, Police, Emergency Services and Probation as well as from the voluntary and independent sector.

The Board has an Independent Chair, who also fulfils this role for the Dorset Safeguarding Adults Board which helps facilitate the close alignment of the two Boards in their quest to safeguard adults Pan Dorset. The Board has 5 subgroups which are comprised of members from the Bournemouth and Poole Safeguarding Adults Board and the Dorset Safeguarding Adults Board:

- Policy and Procedures
- Training and Workforce Development
- Quality Assurance
- Safeguarding Adult Reviews
- Executive Group

What we do

The overarching purpose of a Safeguarding Adults Board is to help and safeguard adults with care and support needs. The Bournemouth and Poole Safeguarding Adults Board seeks to assure itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance. The Board seeks assurance that Safeguarding practice is person-centred and outcome-focused and that partners work collaboratively to prevent abuse and neglect where possible.

In the event that abuse or neglect have occurred, the Board calls on agencies and individuals to give timely and proportionate responses so that lessons can be learned to inform the preventative agenda.

Safeguarding practice ought to improve and enhance the quality of life of adults in the area.

Core duties

SABs have three core duties. They must:

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

The six safeguarding principles

All safeguarding activity should have at its core these six principles:

Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability.

2. SAFEGUARDING ADULT REVIEWS

Safeguarding Adults Boards have three core duties; as well as the development and publication of a strategic plan and annual report Safeguarding Adults Boards are responsible for the commissioning of safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

It is important to note that a death does not need to have occurred for a SAR to take place, although sadly a death will have occurred before a Domestic Homicide Review (DHR) is undertaken. The responsibility for commissioning new DHRs now sits with the local Community Safety Partnerships, although completed reports are still quality assured by the Safeguarding Adults Board.

The Safeguarding Adult Review Subgroup of the Board is comprised of members from Bournemouth, Poole and Dorset and meets twice per quarter to review those cases where serious harm has occurred or may have occurred. This subgroup examines cases presented for consideration and works collaboratively with partner agencies, requesting full and frank contributions from partners in order to systematically assess whether a SAR ought to be commissioned.

The objective of any SAR is not to apportion blame but to extract the key learning points from a potentially tragic or shocking occurrence with a view to fulfilling the aims of effective learning and safeguarding, and above all in this context prevention of a recurrence.

In the year 2017/1 there were no new SARs commissioned in Bournemouth and Poole, nor indeed in Dorset county.

The SAR Subgroup has overseen progress on several ongoing SAR and Domestic Homicide Reviews (DHRs), including one review which is a joint SAR/DHR.

The SAR Subgroup report their findings to the Board, and collaborate with the other subgroups of the Board to ensure that the golden thread of learning from SARs or DHRs:

- Is channelled into training;
- Is reflected in the policies and procedures of the Board;
- Is quality assured to evidence that it is making a difference.

3. DATA ANALYSIS

Safeguarding data is examined by the Quality Assurance subgroup on a quarterly basis. The group looks at data from each of the local authorities as well as health and police.

Data analysis can also give reassurance that the number of concerns is steady; if this is not the case any unusual activity levels can be identified and the reasons investigated.

Data analysis allows the Board to draw comparisons with other areas with similar demographics as well as with the national picture.

The Quality Assurance subgroup produces a quarterly report to the Board to identify trends and make recommendations about whereto target preventative actions.

Figure 1 below illustrates the 2-year trend of safeguarding concerns raised in Bournemouth and Poole.

During the period covered by this annual report, April 2017 to March 2018, the peaks and troughs are mirrored quite closely in both authorities. Bournemouth continues to receive 2 to 3 times as many concerns as Poole.

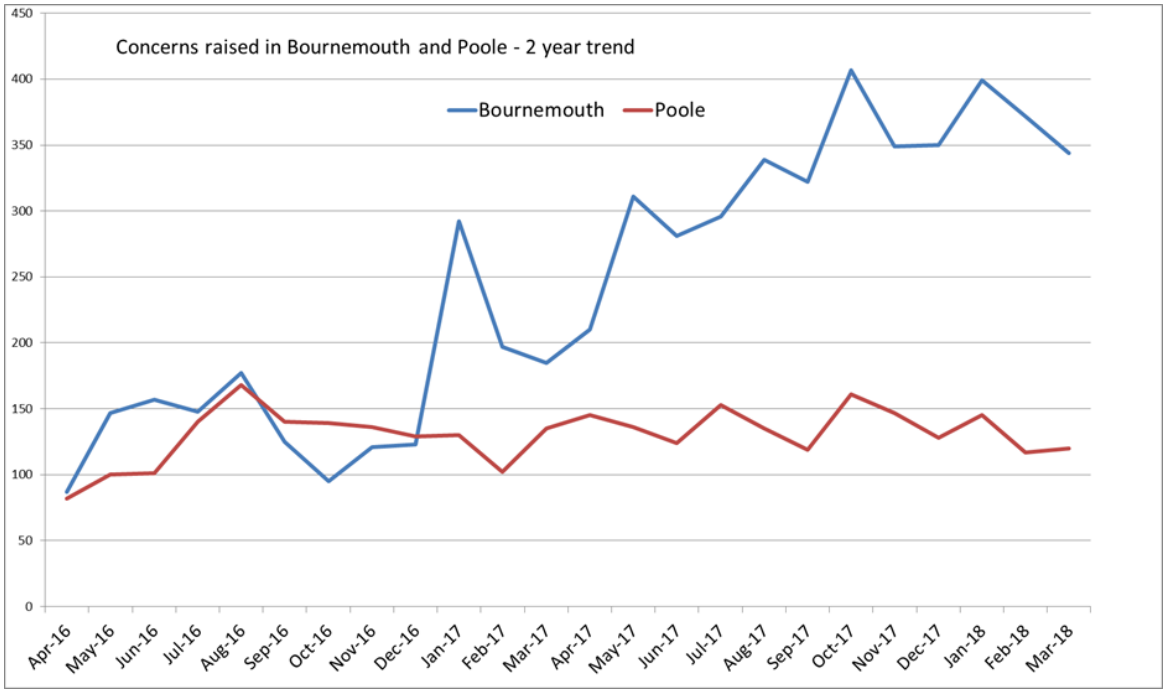


Figure 1

Figure 2 below illustrates the 2-year trend of Section 42 enquiries conducted in Bournemouth and Poole.

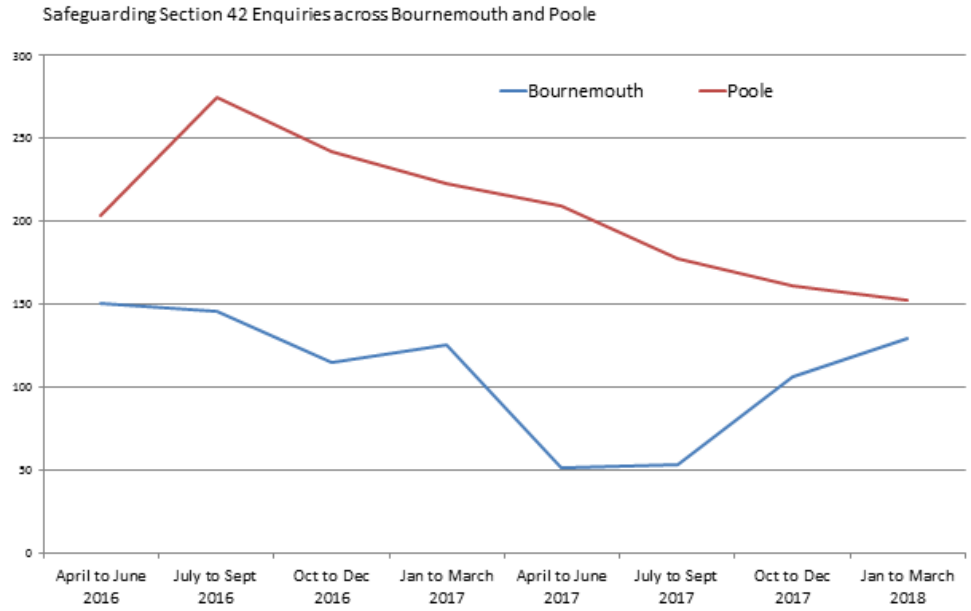
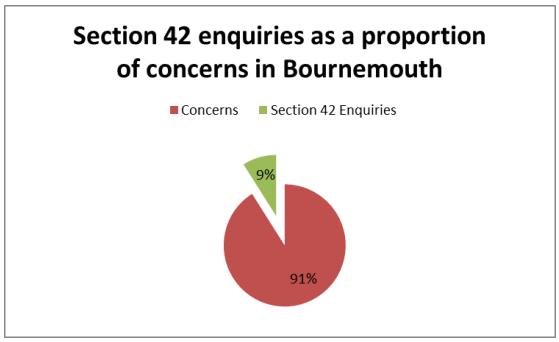
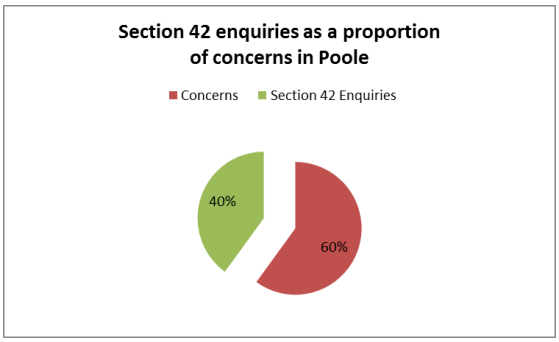


Figure 2

The proportion of enquiries converted to S42 continues to be higher in Poole than in Bournemouth. The reasons for the differences in conversion rates were examined in an audit commissioned across the 3 Local Authorities in Dorset. The findings of the audit will be analysed following publication later in 2018.

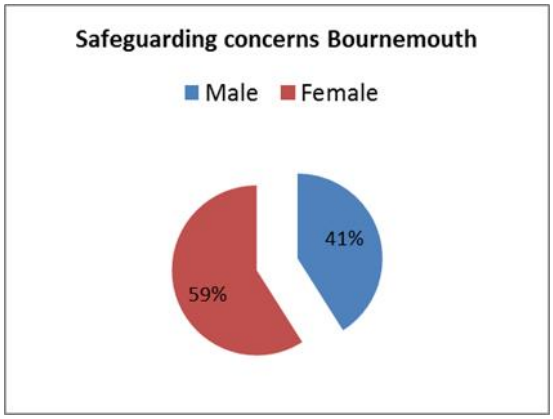


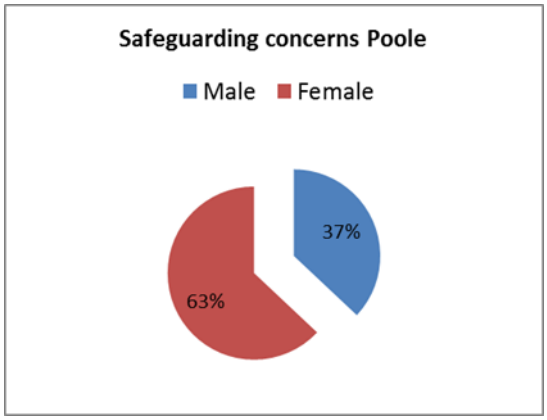


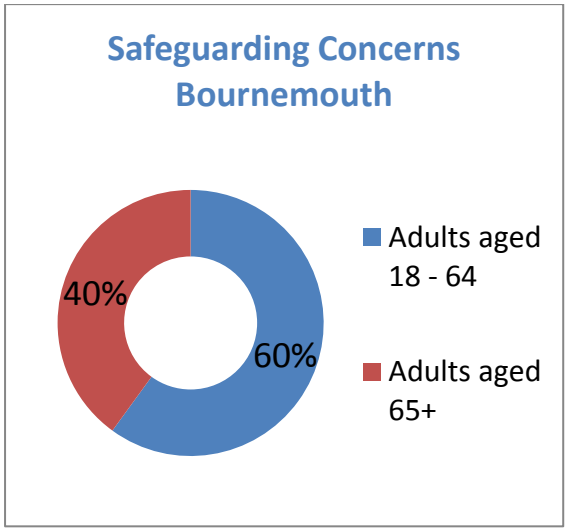
Bournemouth	***Qtr1***	***Qtr2***	***Qtr3***	***Qtr4***	***2017-18***
Concerns	*892*	*1097*	*1114*	*1115*	***4218***
Converted to Section 42	*81*	*95*	*129*	*86*	***391***
Other enquiries	*39*	*87*	*104*	*104*	***334***

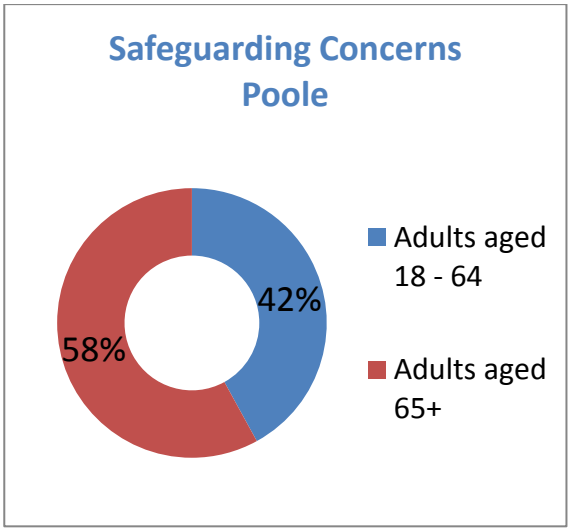
Poole	***Qtr1***	***Qtr2***	***Qtr3***	***Qtr4***	***2017-18***
Concerns	*431*	*435*	*460*	*406*	***1732***
Converted to Section 42	*222*	*172*	*157*	*152*	***703***
Other enquiries	*4*	*5*	*14*	*0*	***23***

5950	The number of Safeguarding Concerns received in 2017-18 in Bournemouth & Poole local authorities combined
1094 (19%)	The number of Safeguarding Concerns which became Section 42 Enquiries in 2017-18 in Bournemouth & Poole local authorities combined









The majority ethnicity of the local population of both Bournemouth (93%) and Poole (95%) is white and this appears to be reflected in the ethnicity of those involved in safeguarding concerns and enquiries, although in each area a number of people did not declare ethnicity or it was not recorded.

Making Safeguarding Personal

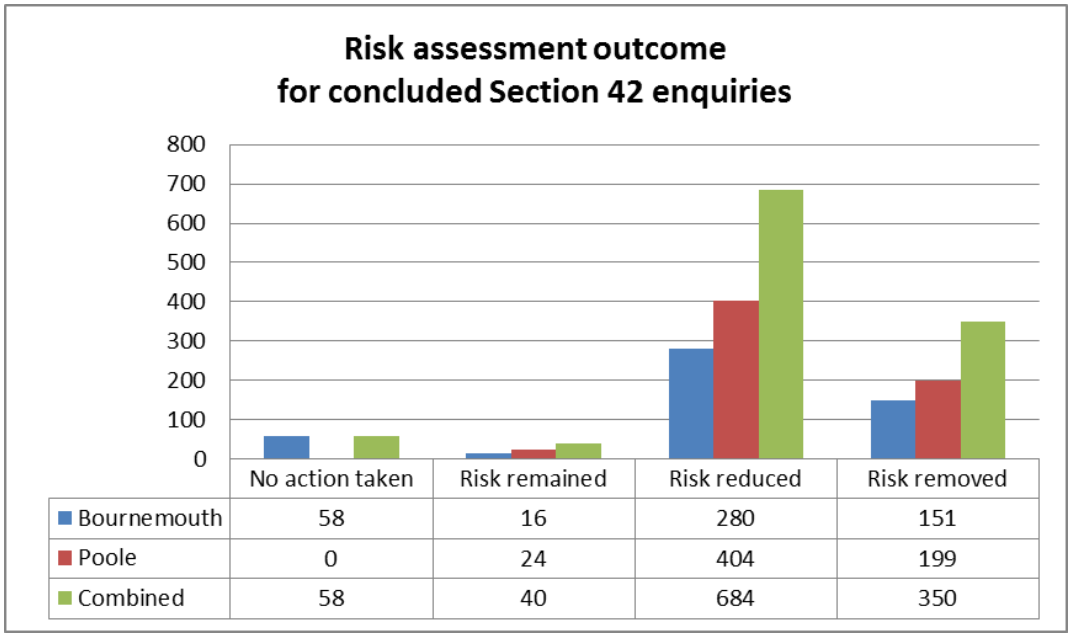
This principle has become part of the day to day fabric of both authorities, in around two thirds of concluded S42 enquiries in both Bournemouth and Poole it is recorded that individuals or their representatives were asked what their desired outcomes were.

For the new reporting year the Bournemouth & Poole Board data will be presented in a new format to facilitate interpretation of the data and identify any areas that may need further attention.

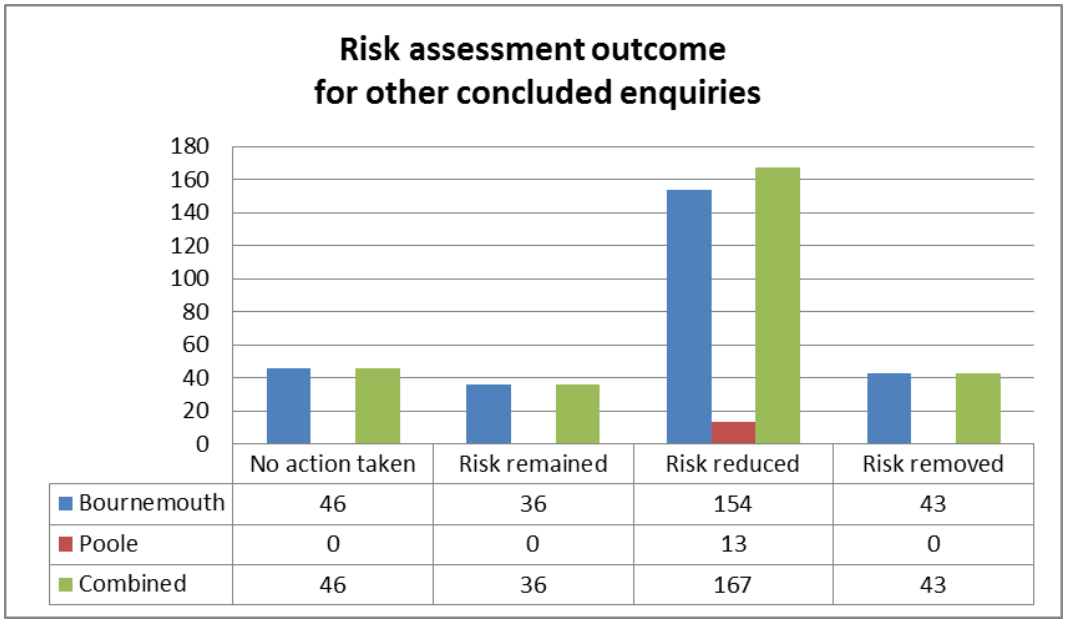
Risk Assessment Outcomes

Identifying risk is an integral part of safeguarding adults. Although not all concerns or Section 42 enquiries will involve risk beyond the immediate apparent issue practitioners are alert to the need to risk assess each case. Where risks are identified a decision needs to be reached as to whether these can be reduced or removed, working within the framework of Making Safeguarding Personal and the right of individuals with capacity to make decisions that may be considered by others to be unwise.

Below the numbers of cases where risk was identified in Bournemouth and Poole during 2017-18 can be seen, as well as the outcomes.



	No action taken	Risk remained	Risk reduced	Risk removed
Bournemouth	58	16	280	151
Poole	0	24	404	199
Combined	58	40	684	350



	No action taken	Risk remained	Risk reduced	Risk removed
Bournemouth	46	36	154	43
Poole	0	0	13	0
Combined	46	36	167	43

4. KEY ACHIEVEMENTS AND FUTURE CHALLENGES

During 2017-18 the Board worked towards achieving the priorities set out in the Strategic Plan.

Each year the Board holds a provider event to engage with care providers and hear from them regarding current challenges, and to share with them an overview of the Board's activity.

The event gives providers an opportunity to comment on or ask questions about the Board's Policies and Procedures. Themes covered included the challenges facing providers in the recruitment and retention of staff, contractures and moving and handling.

For the first time the Safeguarding Adults Boards and Safeguarding Children's Boards held joint conferences, in Bournemouth and Dorchester, on the theme of working with the whole family. The conferences were organised by the business teams who collaborated to produce a conference that was relevant to agencies working with both children and adults. Quality speakers and a range of workshops helped ensure the success of the events. Marketplace stalls from relevant organisations and targeted invitations to partners meant that attendees were presented with networking opportunities beyond their own area of expertise.

Feedback has been collected and carefully analysed by the conference team and this will inform the planning of a further Listening Event in autumn of 2018.

Towards the end of the year the safeguarding adults and children's Boards have been working more closely with the Community Safety Partnerships and going forward there will be opportunities for producing shared learning materials.

Effective Prevention

Comprehensive campaign was organised to promote Safeguarding Adults by circulation of A3 and A4 Safeguarding Adults Posters (see Appendix 3) to Churches, Church and Village halls, Banks and Building Societies, Leisure centres, Libraries, Council Office Buildings, residential care homes and centres across Bournemouth & Poole. The circulation also included voluntary groups and independent care organisations via local networks (May 2017). Arising from the campaign the independent Chair gave a short interview to Radio Solent.

The Safeguarding Adult Training Coordinator presented to the Poole Neighbourhood Watch annual meeting about the role of the Safeguarding Adults Board (Nov 2017).

Effective Safeguarding

A Support and Challenge Event was held to allow members of the Bournemouth & Poole, and Dorset Safeguarding Adults Boards to share the challenges they faced and barriers to effective safeguarding and to examine the impact of partners' actions on other organisations. This helped shape the Boards' strategic priorities for the following year. (Nov 2017)

A number of Board members attended the SW ADASS Annual Conference where the findings from a thematic review of SARs were presented.

The Board's Policies and Procedures are under constant review with twice yearly updates. The Board consulted with partners throughout last year and efforts culminated in a refresh of the Procedures

being written for publication early in the new reporting year. The author worked closely with partner agencies to develop specific guidance around the Multi Agency Risk Management process which along with the policies and procedures, will be published on the Board's website.

The Communications Strategy has sought to strengthen the branding of the Board. Banners with the logos of the Bournemouth & Poole, and Dorset Safeguarding Adults Boards were purchased for use at events. Further work will be carried out to promote the Board and to engage with partners and members of the public through the Board's website.

Effective Learning

Over 250 delegates attended a half day Multi-Agency Safeguarding Conference on local SAR XYZ which took place at the Executive Business centre in Bournemouth. Representatives from health, police, local authorities, independent and voluntary groups attended. Workshops across all agencies allowed delegates to explore the learning from the key points and to ensure that changes to practice had been made. (June 2017)

Poole Adult Social care training have offered their half day SAR training where SARs which have a common theme are discussed and lessons to be learnt are explored. (May 2017)

A Modern Day Slavery conference in July 2017 run by the Safer Poole Partnership was attended by local authority staff alongside other agencies.

An ongoing project to update Safeguarding Adult Practitioners training has seen the Board working with the Safeguarding Lead in Adult Social Care and the Workforce Development teams to devise a new course with a modular approach which will allow greater flexibility in its delivery and will also allow for other groups to access individual modules or complete the full suite of three modules.

These modules are:

- Safeguarding Adults Practitioners
- Achieving Best Evidence
- Court Skills and Report Writing

A portfolio will be completed to evidence progress and application of knowledge to practice. The first Safeguarding Adults Practitioners module will run in July 2018.

In the new reporting year a Structured Debrief event facilitated by Dorset Police will be held to examine the learning from a case where a serious incident occurred but which did not meet the threshold for a Safeguarding Adults Review.

Effective Governance

A report was completed in autumn 2017 which asked Safeguarding Adults Board members to assure the Board that the Safeguarding Adult training within their respective organisations was appropriate for the roles that their staff undertook. This report was circulated to Board members and was seen

as a way in which 'Best Practice' could be shared across member groups. It also identified that any shortcomings could be monitored and addressed.

The continued use of the risk register by the Executive Group enables the Board to monitor and manage risks as the safeguarding landscape changes.

The Executive Group and the Board oversee the allocation of the budget. Expenditure to invest in safeguarding is proposed and agreed by members. The Board's finances are transparent and contributors have some input into how funds are allocated to projects. The Board sets aside funding for any Safeguarding Adults Reviews that may take place.

Throughout the year Board members have undertaken 'line of sight' visits to one another's organisations. This has enabled the Board to be better briefed and assured about partners' safeguarding arrangements.

To close

The Board and some of its partner agencies will experience a time of transition over the coming year as Bournemouth Borough Council and Borough of Poole lay the foundations for becoming part of a newly created Council along with Christchurch Borough Council under Local Government Reorganisation.

Dorset Police will be working more closely with Devon & Cornwall Police as part of a strategic alliance. NHS services will align with the Southwest Region.

Whatever the changes, it is certain that partners will continue to work together to protect adults at risk, in an environment where partners and the Board can provide support but also hold their own and other organisations to account.

APPENDIX 1 – PARTNER CONTRIBUTIONS

The Board works with partner agencies to ensure that safeguarding activity is making a difference.

The Board uses four headings (below) to look at how the work undertaken by partners contributes to safeguarding, although there is frequently overlap.

EFFECTIVE PREVENTION

Adults are safe from avoidable harm and avoidable death

Effective and early intervention using a pro-active approach which reduces risks and promotes safe services whilst ensuring independence, choice and control

EFFECTIVE SAFEGUARDING

Adults know that their concerns about safety will be listened to and dealt with at an early stage and that they are safe and in control with people who work with them

EFFECTIVE LEARNING

People working with adults are aware of their safeguarding responsibilities and have access to appropriate guidance, procedures and training. Learning form Safeguarding Adults Reviews and Investigations is disseminated to multi-agency professionals to ensure effective learning, learning transfer and continuous improvement.

EFFECTIVE GOVERNANCE

Hold partnerships to account for their contribution to safeguarding Adults at Risk: Accountabilities to the public, its constituent bodies and individuals at risk for example – hate crime, domestic abuse, mental health, sexual offences, burglary and overall quality of health services.

Partners were invited to share some details of what their organisation has done over the last year to safeguard adults; these are listed on the pages which follow:

1. LOCAL AUTHORITIES – ADULT SOCIAL CARE

The Adult Social Care services in Bournemouth and Poole are separate but increasingly aligned.

The roles of Head of Adult Social Care Services, Borough of Poole and Service Director, Adult Social Care, Bournemouth Borough Council are held by one person.

Since July 2017, the role of Safeguarding Lead in Adult Social Care has been held by the Joint Service Manager – Statutory Services. This shared role has allowed the post holder to work proactively with staff in Adult Social Care across Bournemouth Borough Council and Borough of Poole to align Safeguarding practice. This is positive for residents and partners, with regard to receiving a more consistent response from Adult Social Care. It has also allowed consideration and planning for further positive change in advance of Local Government Reorganisation in April 2019.

Effective Prevention

Staff in both Safeguarding Teams have fostered strong links with Care Direct and Helpdesk in relation to supporting colleagues with more effective prevention and signposting at the front door. The purpose of this relationship is to improve client experience and increase safety and positive outcomes. Further links with the 'front door' will need to be considered as we move towards LGR.

Effective Safeguarding

Bournemouth Borough Council's Case Recording system does not allow for easy recording and tracking of information about providers to analyse patterns of Concerns raised about providers and manage potential whole service enquiries. A new Case Recording system will be introduced in autumn 2018 which will address this issue.

In preparation for LGR, the Safeguarding Lead is engaging with staff in both Bournemouth Borough Council and Borough of Poole to explore the pros and cons of each Council's current Safeguarding model. This includes undertaking research into favoured models across the country, their pros/cons, with the purpose of learning from other LA's experiences. The purpose of this will be to provide a consistent and 'best practice' model of Safeguarding within Adult Social Care into the future

A Peer Review audit in Bournemouth Borough Council highlighted that the Hospital Team's safeguarding practice could be improved with a deeper focus on outcomes and personalisation. Discussions have been facilitated with staff on supporting people to identify outcomes and making best interests decisions where clients lack capacity to be consulted. Safeguarding is a rolling agenda item at the Team Meetings and the Manager is linking with the Safeguarding Lead to undertake a further themed audit to quality assure improvements.

The Safeguarding Lead has worked with colleagues across Bournemouth Borough Council / Borough of Poole and partner agencies to align practice with regard to Whole Service Enquiries. The purpose of this work has been to ensure a proportionate and timely response which keeps people safe and aims to support providers proactively.

Safeguarding in Borough of Poole has implemented a 'Self-Neglect Panel', which seeks to provide support and guidance to colleagues and partners in engaging with people who are at risk of harm due to self-neglect. This model is valued in Borough of Poole.

Effective Learning

Through feedback from the Bournemouth Borough Council Peer Review and from staff themselves, it became apparent that there was a need to improve opportunities to develop skills for staff undertaking the role of Nominated Enquirer. The Safeguarding Lead flagged this issue via the Peer Review Improvement Plan and through the Training and Workforce Development Sub-Group, which has led to a programme of additional training being developed.

The Safeguarding Lead has been actively involved in the production of IMR's where required and has taken a proactive approach to implementing Action Plans and considering any 'Lessons Learnt' from DHR's/SAR's – discussions are taking place with colleagues in Learning & Development across Bournemouth Borough Council / Borough of Poole regarding how we can effectively disseminate this learning to frontline staff within Adult Social Care.

Effective Governance

The Safeguarding Lead continues to work with colleagues across Adult Social Care to finalise a shared Quality Assurance Framework, which includes regular undertaking of Peer Audits, audits of practice in Supervision and feedback recommendations for changes to process through relevant SAB sub-groups. The Safeguarding Lead will feed back via the Quality Assurance sub group examples of good practice, where lessons have been learnt and actions taken.

LOCAL AUTHORITIES – LEARNING & DEVELOPMENT

The Board's business team, in particular the Training Coordinator, continues to work closely with the workforce development teams in both local authorities.

The Safeguarding Adult Practitioner Training was reviewed during the year with a view to launching a new modular course in the summer of 2018.

All of the Adult Safeguarding training delivered has now made reference to Adult Sexual Exploitation, People Trafficking and Modern Slavery and how to identify if any of these are happening and how to report.

Between October & December 2017 sixty volunteers from Sleep Safe received Safeguarding awareness training which was provided free of charge

Safeguarding training is delivered to volunteers who wish to be befrienders. This training is provided to volunteers free of charge.

Safeguarding training is delivered to manager of Provider Services on a monthly basis, these courses are heavily subscribed.

LOCAL AUTHORITIES – HOUSING & COMMUNITIES

Housing Awareness sessions are offered to staff and colleagues in other agencies so they have an overview of all the service strands and can support people to navigate the various routes into Housing services.

Over the last 2 years Housing and Communities have taken on responsibility for staff who deliver direct support to vulnerable people. This has led to a review of training and skills required to ensure staff are equipped to deal with the demands of the service.

Staff within Housing have continued to work with other agencies to ensure processes complement and support people to gain assistance with a range of issues so they may gain or sustain their accommodation.

2. DORSET POLICE

Dorset Police continue to work closely with partners to safeguard adults across Dorset.

During the last year an audit of Domestic Homicide Reviews was undertaken to identify themes with a view to learning from these and enabling preventative work.

In Bournemouth an Adults At Risk triage team is being developed. This will increase resilience in managing referrals and help direct criminal investigations.

The redeployment of staff to Public Protection is now business as usual, as is the development of internal and partnership processes to prevent and respond to concerns regarding victims of modern day slavery.

Dorset Police have been consulted on and contributed to the updated Pan Dorset MARM guidance.

Looking to the future, Dorset Police aim to develop an escalation policy, working pan Dorset to formalise effective challenge. A business manager has been appointed to manage the demand associated with protecting vulnerable people and statutory safeguarding duties.

Effective Prevention

Dorset Police continues to support local and national prevention campaigns. The reach of Dorset Police's media department is vast. An example is the creation of the #cutyourstrings campaign. This focused on raising awareness of Coercive and Controlling Behaviour. It was led by the High Sheriff of Dorset with Dorset Police, Bournemouth University, Crown Prosecution Service and Safer Poole. Other prevention campaigns have focused on the vulnerable members of our community susceptible to fraud and rogue traders.

Effective Safeguarding

The development and further planned expansion of expert police officers and staff that work within the safeguarding environment is a demonstration of the commitment of Dorset Police to protecting the vulnerable. Dedicated staff are now in place to triage criminal investigations relating to Adults at Risk. The force has future planned 'vulnerability training' for all staff on top of the routine training provided to staff members.

Effective Learning

Dorset Police are driven to improve learning practices. Practitioner learning events have taken place whereby fundamental issues have been identified whilst maintaining the engagement of the practitioners involved. Dorset Police continue to support DHR and SAR activity and seek to learn the lessons from harmful incidents. Internal practices and policies have changed and training developed in line with learning outcomes from DHR, SCR and SAR.

Effective Governance

Dorset Police continue to fully engage with partners within the SAB and relevant sub groups. Dorset Police are also committed to MARAC and chair the steering group and co-chair the pan Dorset Domestic Abuse Strategic Group. Dorset Police have taken part in multi-agency audits relating to Adults At Risk process and Domestic Abuse investigations.

3. DORSET CLINICAL COMMISSIONING GROUP (CCG)

Dorset Clinical Commissioning Group (CCG) is the main commissioning organisation for health services across the whole county of Dorset. The CCG commissions planned and emergency health care across Dorset, as well as rehabilitation, and community mental health services. The CCG has responsibility for Continuing Health Care across the county. The CCG works closely with partner members of the Safeguarding Adults Board, and in particular with Dorset HealthCare, Poole Hospital Trust and the Royal Bournemouth and Christchurch Hospitals Trust.

Effective Prevention

Throughout the year the CCG has retained focus on the Adult Safeguarding agenda. Considerable work has been undertaken around Domestic Abuse, so that the CCG can be assured that all GP practices are aware of their statutory safeguarding duties whilst securing a named lead for Domestic Abuse in each GP practice. To achieve this, bespoke training has been delivered to staff including GP receptionists as part of the "You First – Isolated Community Engagement" project.

The CCG has raised awareness among GPS and their practice staff of their duties regarding information sharing arrangements and the effective storage of patient records. Each GP practice has been allocated a secure safeguarding email, to support the safe transfer of information.

The Safeguarding Adults Board's prevention and early intervention policy has been revised and links are being created with other programmes of work, to embed preventative safeguarding as core business across the county.

The CCG has supported the development of the Multi Agency Risk Management (MARM) process and principles guidance, which supports individuals to live their life focusing on their wellbeing as opposed to harm and neglect. This work has also linked in to a wider piece of work undertaken by Dorset Police, to identify individuals who are vulnerable and at risk, but who do not meet the section 42 Adult Safeguarding criteria.

The CCG in collaboration with Dorset County Council, and Dorset Health Care delivered a number of training sessions around the MARM process to all partner agencies.

Throughout the year work has taken place on raising awareness around self-neglect and hoarding, particularly across community healthcare providers and primary care. There has been one multi-agency audit undertaken this year around an individual who was possibly self-neglecting, the outcomes of the audit showed good collaborative working amongst all partner agencies. As a learning point from the audit, although the Mental Capacity Act (2005) had been considered, gaps remained within its effective application to practice. At all opportunities, the CCG strive to work with health professionals to understand the implications of the act and the challenges of balancing it with self-determination and Human Rights.

All staff within the CCG are now requested to undertake Prevent mandatory training. The CCG is an active member of the anti-slavery partnership, and submit an annual overview of their systems and processes, to give assurance that they are not engaging in antislavery practice.

Effective Safeguarding

The CCG seeks assurance from all commissioned services that they have adequate safeguarding processes in place. The CCG collects regular data from these providers, which is then analysed and submitted to the Quality Assurance subgroup on a quarterly basis. This allows any themes or trends to be identified.

GP practices are supported by the Designated Adult Safeguarding Manager (DASM) and the lead safeguarding GPs to undertake significant event analysis and identify any required changes in practice. The DASM undertakes an annual Quality Assurance visit to the main NHS provider organisations, to review and obtain assurance on the effectiveness of safeguarding processes.

All intelligence from health and care providers in relation to incidents is checked to ensure any early issues are identified. The CCG has contributed to a number of wholescale enquiries across care homes both with and without nursing. The CCG will be supporting the development of the wholescale enquiry guidance in 2019.

All reported pressure ulcers are reviewed by the patient risk and safety team, and are effectively shared with the DASM if there are safeguarding concerns. Further guidance on this is being developed during 2018/19. The CCG has supported Dorset HealthCare in the development of their contracture pathway, which is in the process of being validated.

Through collaborative working with the SAB's and the Community Safety Partnership (CSP), the CCG has been an active member of the MARAC review and the MARAC steering group. The CCG has had an active role in Domestic Homicide Reviews, ensuring that primary care is engaged and involved as required throughout the process.

Effective Learning

The CCG continues to offer regular peer supervision sessions to all GPs, which allows them to share issues around safeguarding with their peers to develop effective methods to manage any concerns. There is a bi-monthly GP newsletter which highlights all the learning from Safeguarding Adult Reviews and Domestic Homicide Reviews.

The CCG reviews the training delivered within the NHS providers, to ensure they are meeting the essential standards for adult safeguarding, and learning from safeguarding concerns is being embedded into practice.

The DASM is involved within the Training Workforce and Development subgroup, and has contributed to two facilitated workshops around self-neglect at the joint annual safeguarding conference of the children's and adults' safeguarding boards and the Mental Capacity Act conference.

Effective Governance

There is a named executive lead for safeguarding within the CCG. The CCG has clear process in place for reporting and following up on safeguarding issues. The DASM provides regular reports to Governing Body and its sub committees. In addition, the DASM and the lead safeguarding GP present an annual report to the governing body, and provide the members with annual training to ensure they meet their statutory responsibilities for adult safeguarding.

Throughout the year, the DASM has worked with the patient safety and risk team to cross reference all clinical incidents with safeguarding information submitted by the Local Authority. This allows for triangulation of concerns.

The Safeguarding Lead GP's have developed a Quality Assurance tool for visits to all GP surgeries. This tool provides a framework for checking robust safeguarding processes in place; this has been developed to include other NHS providers. The CCG has close links and reporting pathways with NHS England.

The CCG Quality Assurance team undertake routine visits to all NHS providers. Safeguarding forms a key component of these visits, as well as contributing to the line of sight agenda. Information from the visits informs further discussions between the commissioner and provider. The Quality Assurance health care facilitators regularly undertake monitoring visits to the care homes with nursing; this information is shared with the Local Authority to provide information and assurance around the standards of care in these homes. The DASM meets regularly with the main Dorset NHS providers to have oversight of their safeguarding activity.

The DASM is Chair of the Training and Workforce Development subgroup of the Bournemouth, Poole and Dorset Safeguarding Adults Boards.

4. DORSET HEALTHCARE

In line with the aims of the Safeguarding Adults Board, Dorset HealthCare remains committed to fulfilling its statutory requirements to work in collaboration with partner agencies to ensure that the population of Dorset maintain their right to live their lives free from abuse or harm, wherever possible.

In 2017/2018, Dorset HealthCare has achieved this at strategic and operational levels through developing multi-agency and local policies and procedures, providing learning events, supporting conferences, raising and responding to concerns and sharing learning from real cases including: Section 42 Enquiries and Domestic Homicide Reviews (DHRs).

The Safeguarding Requirements for Dorset HealthCare are set out by Dorset Clinical Commissioning Group.

Dorset HealthCare has undertaken safeguarding activity throughout the year in line with the priorities of the Bournemouth & Poole Safeguarding Adults Board.

Effective Prevention

Dorset HealthCare has launched learning pages on the staff intranet to share learning from DHR's, Section 42 Enquiries, Serious Case Reviews, Case Audits and Serious Untoward Incidents. Links to synopses of learning are available for staff to access more detail on the cases. Summaries of the learning are also published in the electronic newsletter.

In 2017/18, Dorset HealthCare's safeguarding Adults Service has provided advice and support to staff providing care to people who were demonstrating self-neglect, where risk was managed using the Multi-Agency Risk Management, (MARM) process, over 47 new cases were supported in the financial year. This is significantly higher than the previous year and indicates that Dorset HealthCare staff are aware of their responsibilities to prevent harm from self-neglect.

The Safeguarding Adults Lead has worked with Occupational Therapists and Physiotherapists from Dorset HealthCare and Dorset County Council, to develop a Contracture Assessment Screening Tool, (CAST). The CAST was developed as an action from the 2015 Dorset Safeguarding Adults Review. The tool was shared with Care Providers at the CCG's Provider Conference in November 2017. The process to gain academic accreditation for the tool, to demonstrate its validity and reliability, commenced in Quarter 4. Discussions continue between DHC and Bournemouth University continue to clarify how this can be achieved and what staffing and financial resources will be required.

Effective Safeguarding

The Safeguarding Adults Team maintain oversight of all Nominated Enquirer reports that are completed to inform Section 42 Enquiries. Learning from the enquiries is incorporated into training presentations and added to the learning page on the intranet.

DHC's Safeguarding Team has continued to provide advice and support to DHC staff on safeguarding concerns. The amount of advice that is provided has increased on a monthly basis, with cases becoming more complex.

Dorset HealthCare supported 5 Whole Service Enquires during 2017/18. Support has ranged from sharing details of care provided by Dorset HealthCare to completing joint assessments of residents' care needs with the Local Authority, sharing information and advice on skin integrity.

Dorset HealthCare's Adult and Children's Safeguarding Teams are developing a safeguarding dashboard to be completed on one of the electronic patient recording systems. The dashboard will allow staff to record and access all safeguarding information and forms in a central place, thus improving access to information and record keeping. A pilot of the dashboard, conducted in January and February 2018, will inform final amendments prior to the dashboard scheduled launch in April/May 2018.

Effective Learning

Dorset HealthCare's Safeguarding Team worked with partners to provide a series of workshops informing attendees on the purpose of Multi-Agency Risk Management, (MARM) process. Attendees applied the MARM process to sample cases to increase their understanding of MARM, and demonstrate its effectiveness.

The Safeguarding Adults and Children's teams have reviewed the mandatory, Level 2 safeguarding training, which will be launched in April 2018. From April, staff will be required to complete a portfolio of Safeguarding Adults, Safeguarding Children's and Prevent training. Learning will revert to an integrated children's and adults package and will combine face to face learning with eLearning.

Members of the Safeguarding Adults Team attended Dorset HealthCare's Prescriber's Conference and regularly present at Dorset HealthCare's monthly Pressure Ulcer Workshops to increase awareness of Safeguarding Adults Process and the Mental Capacity Act.

Effective Governance

The Safeguarding Adults Team continue to quality assure all Nominated Enquiry Reports (NERs) to ensure that all appropriate learning has been identified and interventions are in place to reduce the risk of reoccurrence. It is the responsibility of service managers to implement action plans that are derived from the safeguarding enquires.

Dorset HealthCare's Safeguarding Adults Team continue to review all safeguarding adults incidents reported through the incident reporting system, to ensure that concerns are raised with the Local Authority and/or the police as required. The team requests clinicians to clarify interventions that are implemented to reduce risk of further concerns occurring and to share ideas and experience regarding risk management strategies.

Stronger processes are being developed with the Patient Safety Team to identify Serious Untoward Incidents that may also be a safeguarding concern. The new system will enable cases to be cross referenced and identify lessons to be learnt and shared, to strengthen current arrangements. The new process will commence in the next financial year.

A scorecard detailing the number of safeguarding concerns identified and raised by Dorset HealthCare staff is submitted to the CCG for compilation into a Health Providers report. A summary of trends identified within the concerns is also submitted for inclusion in the report.

The Safeguarding Adults Team review a sample of root cause analysis, (RCA), forms on pressure ulcers that have developed whilst a person is under Dorset HealthCare care to provide assurance that adult safeguarding concerns are identified and raised appropriately. None of theses RCA's uncovered further action to be taken.

Following an audit of Multi-Agency Risk Assessment Conference, (MARAC), Dorset HealthCare's Safeguarding Adults Team identified the need to update the DASH assessment form that is used, to incorporate the additional stalking questions which are included in the full version of the assessment. Additional good practice points will be incorporated into Domestic Abuse eLearning package that is being developed. This is in line with the priorities of the Board over the coming year.

5. POOLE HOSPITAL NHS FOUNDATION TRUST

Safeguarding continues to be central to the work of providing safe, caring, effective, responsive and well-led care within Poole Hospital and acts as an enduring thread in the delivery of their strategic objectives.

The expanding understanding of the potential threats to the vulnerable alongside an increasingly frail and elderly population with chronic health concerns mean that this work is growing year on year and becoming increasingly complex.

A regular planned meeting has been established between the trust safeguarding lead and the local authority lead to facilitate rapid review of concerns and timely access to clinicians and expert advice. It is hoped that this will reduce time taken to resolve concerns and target activity to appropriate cases.

A formal carers' agreement has been developed which will provide clarity of roles for lay and paid carers whilst patients are in hospital. This will facilitate continuity of care and recognition of the individual needs of patients.

The Trust has continued to develop its support to people with learning disabilities to ensure that a consistently high standard of care is provided in meeting individual needs.

An alert flag can be added to the records of patients with learning disabilities and a resource folder with key tools has been provided to in-patient wards which includes communication aids, assessment tools and care passports.

Looking to the future the Trust will undertake further work to embed these tools and will develop a Learning Disability Strategy to support the development of the work during 2018.

The hospital has continued its work to raise the profile of domestic abuse. This is closely aligned with the Board's priorities for the coming year.

A Safe Working Plan has been developed to support discussions with staff experiencing domestic abuse. This will provide a consistent offer to staff in supporting their safety whilst attending work.

New electronic assessment and referral systems have been developed to facilitate timely referral of domestic abuse incidences; these will be implemented later in 2018.

Poole Hospital continues to value working collaboratively with partner agencies to achieve the best outcome for patients. Further work to facilitate safe and easy transfer of information, share ideas and experience and develop consistent approaches across organisations is welcomed through the working of the Board and its subgroups.

Effective Prevention

Recruitment of a skilled workforce, with ongoing development and education of staff is central to the prevention of safeguarding concerns. New recruitment strategies are being developed to prevent shortfalls in workforce. Safeguarding training is organised to ensure that it embraces the complexity and range of safeguarding concerns which arise in our community and beyond.

Effective Safeguarding

The Safeguarding Adults and Children Lead Nurses work closely together to triangulate information and ensure that the whole family approach is considered when responding to safeguarding concerns. This is in line with the overarching strategic priority of the Safeguarding Adults Board.

Effective Learning

The learning from safeguarding concerns and enquires is shared through the monthly "60 second Update" newsletter provided to all staff.

Learning from local and national events is also used in training - case studies provide context for discussions and enable staff to connect the learning with their own roles.

Safeguarding Champions act as local links in clinical practice and help increase knowledge and confidence in wards and departments, these staff receive additional education through planned seminars with local experts. More champions are being recruited.

Effective Governance

The Trust received it's CQC inspection report in January 2018 and was pleased to receive an overall rating of 'good', this included a rating of good for the well-led category. The Trust has agreed an action plan with CQC and Dorset CCG to address those areas where further improvement was required. As part of this the Trust will be developing a Learning Disability Strategy and a Mental Health Strategy.

6. THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

Safeguarding continues to be central to the work of providing safe, caring, effective, responsive and well-led care within the Royal Bournemouth and Christchurch Hospitals Trust and acts as an enduring thread in the delivery of their strategic objectives.

The hospitals have strong relationships with other Pan Dorset partner agencies and work in partnership with them to promote and strive towards the priorities of Safeguarding Adult Board and the alignment of practice in the CCG and in all Dorset Acute Trusts.

The Trust developed an online form to report a Cause for Concern which has improved confidentiality of sensitive information, and reduced misunderstandings that previously occurred due to illegible handwriting. When staff raise a concern they can put Adult safeguarding stickers into the patients notes to alert receiving wards. It also prompts wards to ring and confirm with hospital social services that it is safe to discharge the patient to the environment where the concern was originally raised. This highlights how very simple measures can contribute to the overall safeguarding picture.

In October 2017 the Trust undertook a Mental Capacity Act (MCA) Audit to get a baseline of the current position in order to direct training and development to any areas requiring further input.

Effective Prevention

The Royal Bournemouth and Christchurch Hospitals are committed to Making Safeguarding Personal. The Trust is confident that current levels of engagement with people receiving services from them permit staff to be attuned to disclosures or observations that could indicate that someone is at risk of harm or is being harmed. Staff will respect the needs of individuals and will gain consent to report; but also understand that there are instances when it may be appropriate to report without consent in order to protect others.

Effective Safeguarding

Central to the Trust's ethos is the concept that 'Safeguarding is Everybody's Business'; effort has been dedicated to reducing barriers to any member of staff reporting concerns.

The hospitals ask staff to focus not on "safeguarding criteria" but on responding to what they see, hear or feel uneasy about by raising a concern. No password is required to input a Cause for Concern on the eForm system, making it easy for all staff to access. The form also facilitates data collection for reporting purposes. The adult safeguarding team are visible on the wards regularly, giving staff opportunity for formal and informal discussions, and they meet with staff from Adult Social Care on a monthly basis.

Effective Learning

Staff in the Royal Bournemouth and Christchurch hospitals are focused on Making Safeguarding Personal (MSP) both as an ethos that is embedded into practice as well as a stand-alone legal obligation. Making safeguarding personal focuses on consent and individual wishes; best interest outcomes within the hospitals are designed to keep a person as safe as possible to prevent abuse and neglect. The Trust has also voluntarily increased safeguarding training to Level 2 for all staff and volunteers, the vast majority (96.7%) have completed this training in the last year.

Effective Governance

The governance structure for Safeguarding adults is transparent at the Royal Bournemouth and Christchurch hospitals. We welcome visits from partner agencies to view our developments, processes and offer suggestions for improvement. We are working with the other acute Trusts in Dorset to align our practices so that information being delivered to the board can be compared equitably and we have the full support from our hospital social work safeguarding team to achieve this. We provide representation at meetings and subgroups to ensure we are aware of changes in legislation and practice.

7. BCHA

BCHA is a charity active in the South of England; they have been helping homeless and vulnerable people for 50 years.

BCHA aim to help people "off the streets, out of abuse, over skills barriers, and on to independence". During the last year a decision was made to recruit a new Head of Quality & Safeguarding who will be accountable for improving customers' outcomes and the impact of services through strategic leadership and the delivery of internal quality assurance framework including internal reviews of safeguarding, serious incidents and exclusions.

They will also be responsible for the development and promotion of best practice through coaching, developmental opportunities and the delivery of mandatory training, as well as the continuous development of experienced and skilled Relief Staff, Volunteer and Peer Mentoring Teams.

Specifically related to safeguarding they will lead on BCHA's Safeguarding policies and procedures ensuring that all local authorities' policies and procedures are effectively implemented across the organisation. They will also maintain the relationship between BCHA and external agencies.

8. DORSET & WILTSHIRE FIRE AND RESCUE SERVICE

Dorset and Wiltshire Fire and Rescue Service (DWFRS) continue to develop and embed safeguarding standards across the organisation supported by a rolling programme of training. DWFRS work in collaboration with local safeguarding boards, councils and other partners to ensure the Service is compliant with national safeguarding legislation.

Effective Prevention

Dorset and Wiltshire Fire and Rescue Service (DWFRS) adopts a 'whole system approach' to safeguarding adults and children. By working closely with other agencies DWFRS can utilise information shared to safeguard not only those with vulnerabilities but also other people including DWFRS staff.

Effective Safeguarding

Formal safeguarding arrangements are delivered predominantly by the Safeguarding Coordinator following the Safeguarding Adults Board's framework and processes. Safeguarding work undertaken by DWFRS includes assessing levels of hoarding at properties. In Poole DWFRS can refer directly to the Hoarding and Self Neglect panel.

DWFRS works closely with Dorset Police and South West Ambulance Service to highlight properties that are considered a high fire risk, enabling staff to approach those properties in a timely manner and hopefully reduce the fire risk. This includes information sharing when there is a threat of arson.

Safe and Well visits are carried out including to advise and assist victims of Domestic Abuse. Where appropriate officers can fit a fire-proof letterbox and discuss escape plans.

DWFRS engage in the MARM process to work with other agencies on safeguarding cases.

Effective Learning

The Safeguarding Coordinator has met with the Safeguarding Learning and Organisational Development Adviser within DWFRS and arranged bespoke safeguarding training for staff.

Regular meetings take place to ensure that training requirements are met and further work is planned to evidence that safeguarding training has been embedded within the organisation.

Staff from DWFRS also attended external training including conferences on hate crime, self-neglect and the Joint Conference of the Safeguarding Adults and Children's Boards in February 2018.

Effective Governance

The Safeguarding Coordinator has arranged awareness training for Duty Area Managers that sit on Safeguarding Adults Boards.

The Safeguarding Coordinator has also met with the Safeguarding Leads from other Fire and Rescue Services, namely Royal Berkshire, Hampshire and Devon and Somerset to network and share best practice. The Co-ordinator is also a member of the Safeguarding Workstream for the National Fire Chiefs Council.

9. SOUTH WEST AMBULANCE SERVICE NHS FOUNDATION TRUST (SWASFT)

The South West Ambulance Service is aligned to 14 adult safeguarding boards across the region.

During 2017-18 the Trust generated 14,500 safeguarding referrals from 1.5 million patient contact events.

During the same period the Head of Safeguarding and Named Professionals attended 59 multi-agency professionals meetings and 34 meetings of Safeguarding Adults Boards and Local Safeguarding Children's Boards.

Self-neglect emerged as a theme for adult safeguarding referrals.

During 2017-18 the Safeguarding Service received notifications for 21 Domestic Homicide Reviews, 19 Safeguarding Adult Reviews, 3 'stepped-down' SARs, and 5 multi-agency learning events across the South West.

Effective Prevention

Administrators in the Safeguarding Service identified a pattern of safeguarding referrals from ambulance staff raising concerns about incidents where staff in nursing homes had failed to recognise or react to patients with symptoms of strokes. An audit was undertaken and the results were escalated to the Commissioners Support Unit (CSU).

Effective Safeguarding

South West Ambulance Service has collaborated with a specialist charity working in the area of Adversity Related Injuries. This work focused on a potential multi-agency service development to introduce specialist counsellors to Emergency Departments who would then take direct referrals from ambulance crews. The process is currently active in London and was recognised by the Trust's Safeguarding Service as a model of best practice at a peer review meeting with London Ambulance Service.

South West Ambulance Service contributed to a multi-agency review of sudden deaths of rough sleepers in the Taunton area; some of the findings may be useful for agencies in Bournemouth & Poole.

Effective Learning

By the end of 2017-18 the Trust had achieved 97% compliance for level 1 Safeguarding training and 95% for level 2.

Effective Governance

The Trust's Safeguarding Service has produced an annual report which is required to be reviewed and approved by the Trust's Quality Committee. The report highlights the Trust's strategy for governance, education, and management of safeguarding.

10. PROBATION

The National Probation Service in Dorset is committed to the Safeguarding Adults agenda.

The NPS implements new policy and procedures, sends staff on appropriate training and undertakes a number of Quality Assurance activities as well as making appropriate referrals.

Effective Prevention

The NPS engages with victims of crime and perpetrators to seek to prevent further harm.

Effective Safeguarding

NPS staff work to support vulnerable victims of crime and to seek to reduce the risks of serious harm by perpetrators by use of one to one work and appropriate group interventions.

This includes accredited programme delivery for both convicted sexual offenders and perpetrators of domestic abuse. The NPS as responsible authority supports the safeguarding of adults via the Strategic Management Board for Multi Agency Public Protection (MAPPA SMB), working with partner agencies to reduce the risk of harm and to protect vulnerable adult victims and families.

Effective Learning

The NPS cooperates fully with the Safeguarding Adult Review (SAR) procedures in relation to known offenders, sits on panels and implements learning from all SAR's.

In addition the NPS contributes to best practice arrangements for the Domestic Violence and Sexual Violence strategies groups (Dorset, Bournemouth & Poole) and supports MARAC (a multi agency approach across Dorset to work with victims of Domestic Abuse).

Effective Governance

The Head of Dorset National Probation Service is a member of both the Dorset and Bournemouth & Poole Safeguarding Adults Boards.

APPENDIX 2 – CASE STUDIES

Bournemouth and Poole have each provided a case study for inclusion in this annual report. These are examples of how agencies worked together in partnership to safeguard adults with care and support needs against within the framework of the six safeguarding principles.

Laura

Laura is a 35-year-old woman with a learning disability and a physical disability. Laura lives in a residential care home for adults with disabilities, and has a very good relationship with her mother who lives in Southampton but visits at least once a week. Laura has some difficulty communicating with others, her mother and the carers who know her well are able to understand her communication needs.

At the care home where Laura lived it was noted that Laura's leg was swollen and red. A GP was asked to see her and took the decision that Laura ought to be admitted to hospital. At the hospital, an x-ray showed that Laura had a break to her left femur. Laura told her mother that a carer had hurt her leg when delivering personal care. Laura was able to give a description to her mother enabling the care home to identify the carer. It was established that the carer was employed by an agency and was not a permanent member of staff at the home.

The incident was raised as a Cause for Concern referral by the agency that employed the carer, as well as by the hospital, and South West Ambulance Service. At the point of the referral, Laura was still in hospital after having surgery. Laura's desired outcome was to return to the home when she was well enough.

A Social Worker kept in contact with the ward staff where Laura was recovering. When staff advised that Laura was medically fit for discharge the Social Worker felt that it would be effective to use a nominated enquirer to speak to Laura on the ward and get her perspective. This was someone who knew Laura and with whom she could communicate well. Laura advised the nominated enquirer that she wanted to go back to the home as soon as possible. She stated that she liked it there, that she got on well with all of the staff, and that she didn't feel like she should have to move.

Once Laura's views had been sought, the Social Worker then spoke to the care home. The care home had followed their internal procedures to establish how Laura had come to be injured. When it emerged that the carer in question was employed by an agency the care home stated that under no circumstances would they have the same carer back to work at the home. The Social Worker contacted the agency where the carer was employed. The agency spoke to the carer involved to find out what had happened, and he confirmed that an accident had occurred while he was caring for Laura. The agency decided to undertake a full internal investigation, during which process the carer involved would not carry out any further shifts.

The Social Worker discussed the incident with Laura's mother, who in advocating for her daughter had considered what measures she thought should be in place before Laura returned to the care home. When Laura had fallen a handle on a piece of furniture had been broken, this needed to be repaired to prevent any further injuries. Laura's mother wanted to know that Laura would be supported for personal care exclusively by permanent staff who understood Laura's communication needs much better than agency staff. Laura's mother also drew attention to her care plan which stated that a 2:1 basis should be used for the majority of the time, especially for hoisting. She felt

that because Laura could sometimes be supported on a 1:1 basis that this had in practice become "the norm" when supporting Laura, including with her personal care.

The Social Worker discussed these issues with the care home, and they agreed to put measures in place around all of Laura's mother's concerns. This was followed up in writing. The Social Worker also contacted Laura's out of area social worker, who agreed with the return back to the home in light of the protective factors. Despite the severity of the incident, the Social Worker had been able to establish within the same day of the referral being raised that there was a sufficient plan in place for Laura to return home, having consulted with Laura via a nominated enquirer, and all other involved parties.

The Social Worker then completed a separate piece of work with the agency that employed the carer, before he could return to work. The agency commissioned training provided by an external provider, on record keeping, safeguarding and raising concerns, and moving and handling. The moving and handling training was both written and hands on practical training. Before returning to shift work, the carer was also supported by a home which had agreed to have him work shifts in order to shadow, and work on a double up basis, until his competencies had been checked and he was found to be fit to practice.

Empowerment	Laura's views were heard and her desire to stay in the care home was considered
Prevention	Steps were taken to prevent a recurrence of a similar incident either for Laura or any other residents
Proportionality	To remove Laura from the home where she was settled without checking her wishes would have been a disproportionate response
Protection	Agencies communicated with Laura and her mother and made changes to ensure that Laura would be protected from further harm
Partnership	The ambulance service, the care home, the GP, the hospital and adult social care all collaborated to safeguard Laura
Accountability	The care home investigated the incident and took steps along with the agency to understand what had happened

Eve

Eve was known to health and social services due to her life limiting medical condition which gave rise to very specific care and support needs and frequent medical intervention. It was through an admission to hospital that concerns arose as to the potentially negative relationship with her husband Bernard, who was observed to be aggressive and verbally abusive towards hospital staff and verbally aggressive towards Eve. Bernard also made statements about his intention to care for Eve in a way that was not consistent with her assessed needs, including rebuffing advice regarding safe moving and handling.

These concerns were shared by the hospital and assessed by Adult Social Care as meeting the criteria for a Section 42 safeguarding enquiry, and the case was duly allocated.

Eve's condition meant that at times she experienced different states of consciousness, and her ability to communicate her wishes was at times poor. As such it took multiple visits to gain her views on the concerns arising and be satisfied that these were consistent and that she had capacity at the time.

It was assessed that Eve had capacity to make the decision to be discharged from hospital back to her home where she would be cared for by her husband. At that time Eve did not wish to pursue any options in relation to additional care services or explore other accommodation options. As such a safeguarding plan was put in place seeking to maintain a close oversight of her care and wellbeing post discharge. Dorset Police were also alerted to the case should they have any contacts or need to visit the house. A separate Social Worker was allocated to Eve's husband Bernard to examine his needs as a carer. Flags were placed on the hospital system to alert Adult Social Care to any further admissions to afford further opportunities to engage with Eve in a safe place.

Eve was again admitted into hospital after a few weeks and Adult Social Care were advised of similar concerns being raised by hospital staff observing the interaction between the couple. Once again, a number of visits were undertaken to gain a clear view of Eve's thoughts and wishes. These visits were undertaken by the same Social Worker who had seen Eve a few weeks previously. Eve maintained the same view as before regarding her discharge plan – she wanted to return home to Bernard's care, she did not want to explore additional care services or alternative accommodation. As before, Eve was discharged with a safeguarding plan in place. With Eve's agreement, prior to her discharge from hospital a safeguarding worker and manager visited Bernard at home, where the concerns about his conduct and behaviour in the hospital environment were specifically discussed, highlighting that his behaviour towards hospital staff and Eve was clearly unacceptable. This served to ensure that Bernard was aware that his behaviour was being observed, and outlined to him what behaviour would be considered acceptable.

Eve was then admitted to hospital a third time. Once again, a number of visits were undertaken to gain a clear view of Eve's views and wishes and on this occasion Eve was clear that she no longer wished to be discharged into the care of her husband Bernard, she did not want contact with him and wanted to look at other options for ongoing care and accommodation. Eve did not want to progress any matters through a police route and did not disclose what her concerns were or what had changed at this time.

In support of Eve's wishes Bernard was contacted and advised that he should not contact her or the hospital ward at that time. A response plan was developed in case Bernard were to present at the hospital.

With her husband Bernard no longer engaged in her care, other family members began to visit Eve. They had no specific information to share to inform the picture but were clear that their relationship with Bernard had been strained and they had not been to visit Eve at home for a number of years.

Eve was supported to access a nursing home placement upon discharge as a place of safety that could meet her needs, and the relationship with her family flourished. Measures were put in place to ensure that her location would not be shared or confirmed should her husband make contact. She set up her own bank accounts and had her monies paid direct to her and had control of all decisions related to her care and contacts. All involved were very pleased to see real positive changes in her presentation and personality. Eve decided not to have contact with her husband and instigated divorce proceedings. Sadly, a few months later Eve became unwell and passed away from natural causes.

The family were able to take comfort from the fact that Eve had had the opportunity to make changes in her life and that during her final few months she was looking to the future and was positive, happy and fulfilled.

Empowerment	Eve's views were heard and her initial desire to stay at home was considered. When Eve changed her mind around this she was helped with the process of accessing a placement.
Prevention	Steps were taken to speak to Bernard to ascertain if Eve was at risk from him. The stresses of Bernard's role as a carer were examined.
Proportionality	Agencies noted Bernard's aggressive demeanour towards staff and Eve and spoke to him about this, giving him the opportunity to reflect.
Protection	The hospital and Adult Social Care communicated with Eve and Bernard and ultimately acted on Eve's wishes to not be discharged to Bernard's care again, therefore preventing potential harm
Partnership	Adult Social Care worked with the hospital and police in order to safeguard Eve.
Accountability	On each occasion that Eve was due to be discharged from hospital checks were undertaken to check that she had capacity to decide whether or not to return home. Details of Eve's decisions were recorded at each stage as capacity can fluctuate.

APPENDIX 3 – SAFEGUARDING POSTERS

Below are the posters used by the Safeguarding Boards: