ANNUAL REPORT 2018-19

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 12 08 2019

NOTE: The Board has been known as the Bournemouth, Christchurch & Poole Safeguarding Adults Board since 1st April 2019.
This report is for the period immediately preceding this change and therefore the Board is referred to as the Bournemouth & Poole Safeguarding Adults Board.

DORSET & WILTSHIRE
FIRE AND RESCUE

INDEPENDENT CARE PROVIDERS

VOLUNTARY SECTOR

Introduction from the Independent Chair

In 2018-19 the Safeguarding Adults Board, working together with the Dorset Board, has

- Strengthened the joint work between safeguarding and community safety partnerships
- Focussed upon areas for improvement identified in reviews and audits
- Engaged more widely with providers, service users, carers and the public
- As well as maintaining important 'business as usual' activities

There has been a refresh of the multi-agency procedures, now including a protocol for large scale enquiries and information sharing guidance in the light of GDPR. A specific section in the procedures now sets out the approach to be taken between Safeguarding Adult services and MARAC when an individual in need of care and support is subject to domestic abuse.

There has been greater outreach to the community via information stalls at the Emergency Services day and other local events.

Organisations have responded to an independent examination of decision-making in respect of section 42 enquiries and increased their own auditing of cases to oversee improvements in practice. There is nonetheless still scope for greater consistency across the local authorities in respect of the proportion of concerns that become subject to an investigation. This position may be assisted in the coming year by national development work on this issue.

Internal audits also focus upon Making Safeguarding Personal i.e. how far individuals are asked about the safeguarding outcomes they would wish to see and to what degree these have been realised. The recorded figures are still at a relatively low level and would therefore benefit from further analysis. However more detailed case studies show that staff are attentive to the need to involve individuals in choices about their care and to assess capacity clearly.

I am pleased to note the continuing impact on levels of risk where enquiries are undertaken. In 81 % of cases in Bournemouth and 97% of cases in Poole risk was removed or reduced.

Concern about the low use of advocacy in safeguarding enquiries has been monitored by the quality assurance sub-group via meetings with both the provider and commissioners.

A new 3 year training strategy has been agreed. A training framework has been developed for adoption by statutory agencies which addresses the lessons learned from reviews in terms of risk assessment, risk management and information sharing. Business Managers and training leads of the SABs, Safeguarding Children Boards (LSCB) and the Community Safety Partnerships (CSP) meet regularly to develop a combined approach to embedding shared lessons from reviews.

A number of training sessions have been run across the county on contracture management, following the findings of a Safeguarding Adult Review (SAR) in Dorset in 2017.

There has been increased engagement with carers and service users through the Bournemouth and Poole Learning Disability Partnership Board (LDPB), especially in relation to the SAR in respect of 'Harry'. More detail in respect of this SAR/DHR (Domestic Homicide Review) is set out later in this report. Prior to a resumed inquest into his death an independent audit was commissioned to establish current practice in respect of adults with learning disability who are subject to domestic abuse. More detailed work on involving specialist domestic abuse services in such cases is incorporated into the 2019-20 business plan.

A specific meeting was convened to brief providers about the learning from the 'Harry' SAR. In addition the Boards engaged as usual to consult providers about their new business plan and emerging safeguarding concerns. This was also an opportunity to advise them about the safe use of emollients following the death by fire of a resident locally.

The Boards have also widened the scope of deaths and serious incidents where they consider if a SAR should be commissioned. In the past year two deaths of rough sleepers have been evaluated and referrals have been received from the Learning Disabilities Mortality Review programme.

Members of the Boards have been briefed on the progress of preparations for Local Government Reorganisation and continued to make line of sight visits to one another's offices and hospitals. The initial transition to the new authorities has been planned thoroughly with good liaison between Dorset, Bournemouth and Poole concerning the transfer of adult social care cases from Christchurch.

It is perhaps inevitable that such major change and continuing resource pressures on member organisations have adversely affected attendance at some sub-group meetings. I am nonetheless grateful for the continuing commitment of members to the activities of the Board.

For 2019-2020 the Boards have determined to focus development work on three overarching priorities

- Further alignment of safeguarding and domestic abuse interventions
- Contributing to effectively tackling exploitation, including county lines and
- More targeted approaches to preventing neglect and self neglect

Once again I express my gratitude to the staff of the Board in Bournemouth and Poole and chairs of sub groups whose diligence and enthusiasm underpin all that the Board has achieved this year.

Barrie Crook

August 2019

Contents

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 2018 to March 2021.

This Annual Report seeks to examine the activities of the Safeguarding Adults Board and its members from April 2018 to March 2019, the first 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 for what is now the Bournemouth, Christchurch & Poole Safeguarding Adults Board.

In the appendices to the report are some examples of feedback and safeguarding cases demonstrating the work carried out by partners.

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 nine 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:

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.

The SAR Subgroup report their findings to the Board, and collaborate with the other subgroups of the Board.

The SAR Subgroup has overseen progress on several ongoing SARs and Domestic Homicide Reviews (DHRs). The learning from these cases is distilled via the Shared Learning group which is attended by the Business Manager and Training Coordinator from the Board as well as their counterparts in the Dorset Safeguarding Adults Board, the Children's Boards for Bournemouth, Poole and Dorset and the Community Safety Partnerships for the area. The Shared Learning group link with the subgroups to ensure the learning is included in training and reflected in the policies and procedures of the Board; there are clear pathways to enable this.

In the year 2018/19 there was one new SAR commissioned in Bournemouth and Poole. The circumstances of the case are complex and it has been decided to proceed with a joint SAR/DHR/MAPPA review in order to gather information and commission a thorough review so that learning can be shared.

'Harry' SAR/DHR

March 2019 saw the publication of the joint SAR/DHR Report into the death of 'Harry', a young man with learning disabilities who was murdered in 2015 by two people known to him who are referred to as 'John' and 'Karen' in the report. Both are currently serving life sentences for Harry's murder.

Although the report had been completed and had been granted Home Office approval for publication, this was postponed until the conclusion of the criminal justice process and Coroner's Article 2 inquest into the murder. The Coroner recorded that Harry had been unlawfully killed.

The report and related documents can be found on the Board website:

Introduction to the Safeguarding Adult Review and Domestic Homicide Review into the death of 'Harry'
Joint SAR and DHR Final Report into the death of 'Harry'
Executive Summary of Joint SAR and DHR into the death of 'Harry'
Multi Agency Action Plan following the death of 'Harry'

A number of important themes for learning and improvement have been highlighted through the review:

Information sharing

Risk assessment and management

Mental capacity

Engagement with the perpetrators

The impact of social media

Mate crime

Information sharing is a recurring theme in SARs and DHRs. It is important that all agencies accurately record information when a person is at risk and share this with partners also involved with the individual. Where incidents are treated in isolation it limits the ability of agencies to see the bigger picture of the various risks that an individual may be exposed to. It is important to recognise that risks change and to reassess when changes in circumstances occur.

There is a dilemma balancing the rights of the individual with capacity and their prerogative to make unwise decisions and being able to protect them. Working together with individuals professionals can take steps to ensure that a person has capacity to make decisions for the specific situation they are in, recognising that capacity can fluctuate.

The perpetrators who murdered Harry were themselves known to various agencies. Growing up Children's Services had been involved in Karen's life and her transition to adulthood was complicated. John, too had a degree of emotional ill health and presented a risk to himself and others which was not fully assessed. After Harry's death the Multi Agency Risk Management process

was introduced and is used widely by agencies. This process would now be another vehicle by which John's risk and need could have been assessed

Social media is how Harry first became acquainted with Karen. Harry was keen to develop friendships, especially with women and after meeting Karen online arranged to meet her in person just a few days later. Social media is a useful way to communicate and engage with others but poses many risks.

Dorset Police have been involved to advise people with learning disability on how to keep safe online. This theme remains part of the Bournemouth and Poole Learning Disability Partnership's Keeping Safe work plan and an event is planned for 2019 focussing on social media exploitation and domestic abuse. The Safeguarding Adults Board highlighted the risks of social media to a person with learning disability and how they should be reported through its poster campaign.

For a time Harry and Karen were in a relationship. Harry had previously been assessed as having capacity to engage in a sexual relationship. Karen became pregnant and Harry was unsure if he was the father of her child. Once Karen formed a relationship with John, Harry was subject to frequent bullying and abuse by text on his phone, including messages threatening to kill him.

Harry's murder has been linked to 'mate crime' as Harry believed that Karen and John were his friends. Mate crime is a form of crime in which the perpetrator befriends a vulnerable person with the intention of then exploiting him/her financially, physically or sexually. Perpetrators may take advantage of the isolation and/or vulnerability of their victim to win their confidence. Harry was a young man with a learning disability who was being supported to live independently in the community. He was abused by Karen and John not only emotionally and physically, but also financially.

The abuse escalated to the point where Harry was held against his will in Karen's flat.

Harry had been advised not to continue seeing Karen and John but decided to return to the flat again believing they were his friends. He was murdered there in May 2015.

The impact of Harry's death on his family, friends and those who knew him cannot be overestimated.

The Independent Chair has met with Harry's family and expressed condolences to them.

The Board is committed to working together to help prevent such tragedies. The recommendations from the report have been implemented and further training is planned for staff. An easy read version of the Synopsis of Learning has been commissioned so that other adults with learning disabilities can access this report.

3. DATA ANALYSIS

Safeguarding data is examined by the Quality Assurance subgroup on a quarterly basis. The local authority data is based on the Safeguarding Adults Collection (SAC) return.

The QA subgroup looks at data from each of the local authorities as well as health and police. By examining data together common themes or indeed anomalies can be identified.

For some time there have been ongoing efforts to align the safeguarding data in Bournemouth and Poole and to examine any differences therein, and whether these are due to differing practice or recording, or other factors.

Each local authority has its own case management system which presents a challenge when making comparisons however the volumes of concerns and Section 42 Enquiries are illustrated below.

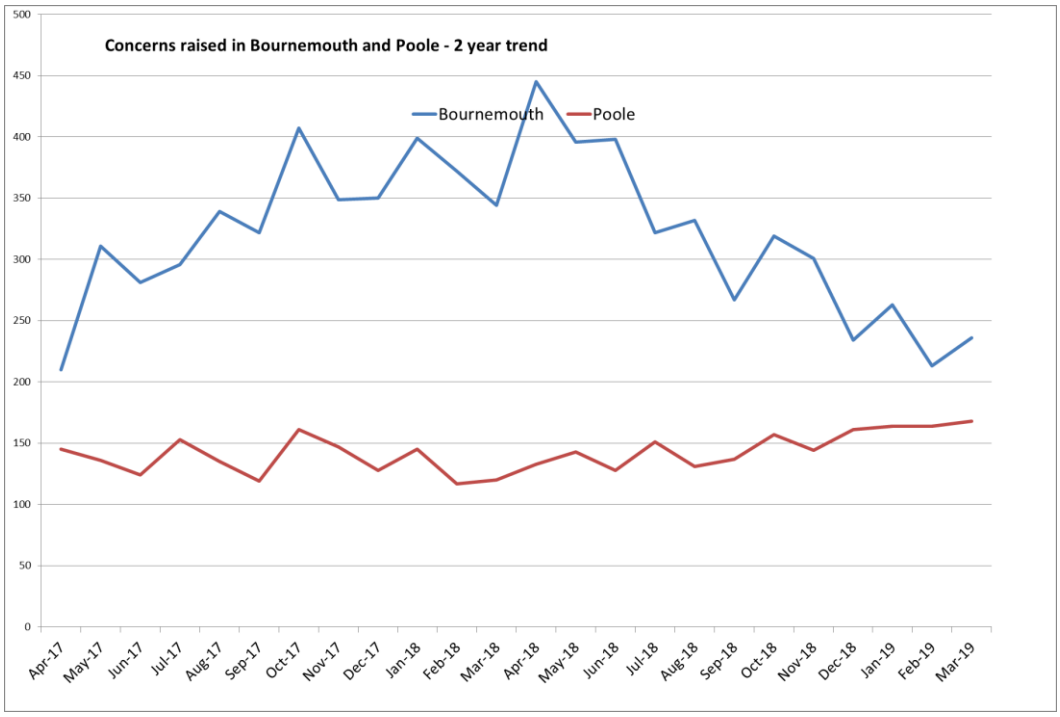


Figure 1

During the last two years the volume of concerns received in Poole has remained fairly consistent. The trend in Bournemouth has been more varied. The high volumes in April and May 2018 can be attributed to two large scale enquiries which saw greater numbers of concerns raised, the decrease in the months that followed suggested that the volume of concerns received was then more reflective of what was to be expected.

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

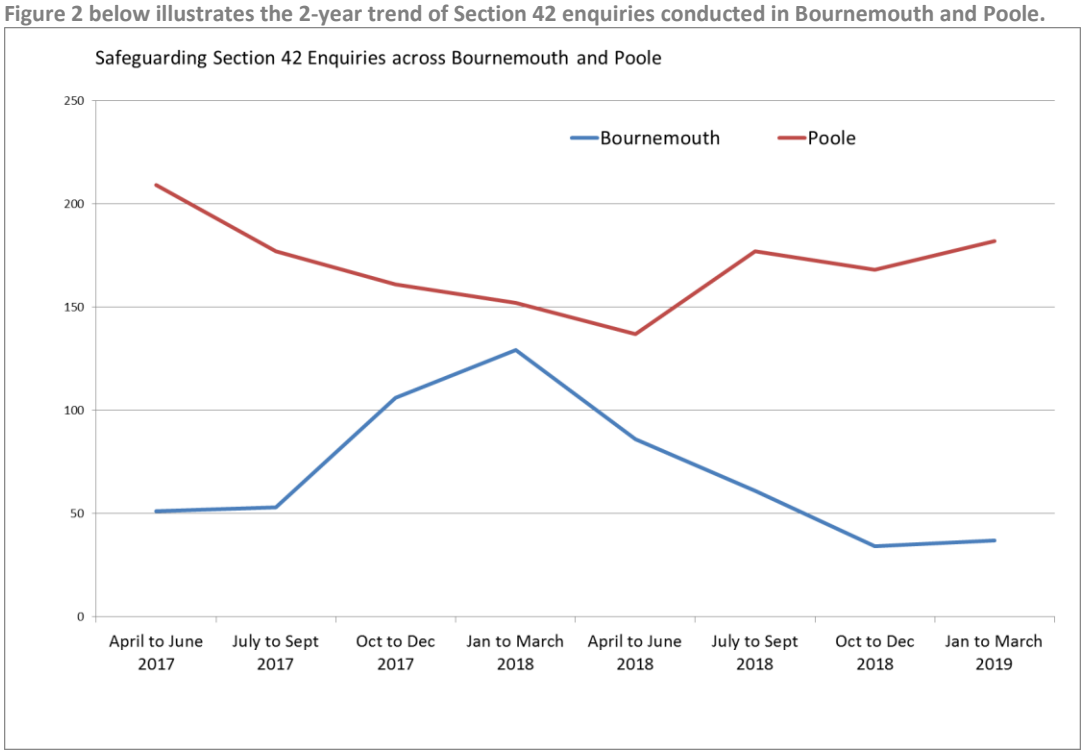


Figure 2

While Bournemouth receive many more concerns this graph illustrates that Poole in fact have more Section 42 Enquiries.

The proportion of enquiries converted to Section 42 continues to be higher in Poole, usually around a third whereas in Bournemouth the proportion converted to Section 42 is typically lower, perhaps around 10 to 15%. In Bournemouth there also tends to be a small proportion of concerns (around 5%) converted to Other Safeguarding Enquiries.

It is anticipated that over time there will be an increased conversion rate of concerns to Section 42 enquiries in Bournemouth, and a lower conversion rate to Other Enquiries.

On the following pages there is an overview of some of the data for Bournemouth & Poole and the **5580** concerns received in 2018-19 resulting in **812** Section 42 Enquiries.

In both authorities, for concerns and enquiries, females consistently outnumber males.

In Bournemouth there tend to be more people in the 18 to 64 age group, usually almost half of concerns, whereas in Poole it is usually closer to a third in this age group.

The most common location of abuse is in a person's own home, audits have been carried out in the last year to ensure that recording is accurate. One hypothesis is that as significant numbers of

people are supported to stay at home this will imply a rise in incidents occurring there whereas staff are on hand and policies are in place to help prevent incidents in residential settings.

The most common type of abuse is Neglect and Acts of Omission. This reflects the national picture although percentages in Bournemouth and Poole tend to hover a few points above the national average of 32%[1]. Further work is planned to better understand this type of abuse in order to reduce incidents where possible.

Physical and financial abuse are usually the next most prevalent types of abuse. Other less common types of abuse such as organisational abuse and modern slavery have their own categories on the SAC return to ensure that they are recorded appropriately where they are identified.

There is much emphasis on Making Safeguarding Personal and it is encouraging that when desired outcomes are expressed in the majority of cases these are fully or partially met (usually over 90% in both authorities). Further work is ongoing to ensure greater a proportion of people are asked for their views, although it is recognised that it may not always be possible or appropriate to ask due to issues of capacity or where a person has become too unwell.

Risk assessment is looked at in the QA subgroup and in a large majority of cases risk is reduced or removed, usually upwards of 90%.

It has been noted at Board meetings that a better understanding of the reasons behind the figures will be a useful step to improving safeguarding. Efforts to improve the data presented to the Board are ongoing. In the next reporting year as the local authorities become one BCP Council further research into other areas with a similar profile will be undertaken.

[1] https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/annual-report-2017-18-england

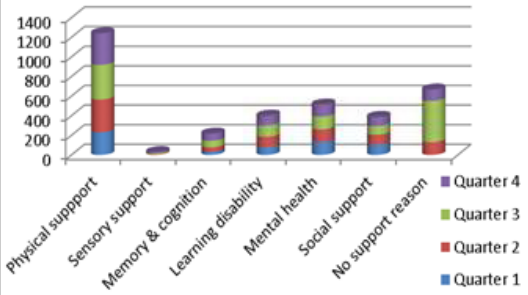
The 2018-19 Safeguarding Adults Collection report has not yet been published

Safeguarding Activity & Performance Information 2018/2019 Q1-4

No. of concerns received by B&P
5580 (Activity counts, not individuals)

Q1=1646 Q2=1339
Q3=1387 Q4=1208

Primary support reasons for individuals involved in safeguarding concerns



Progressing to section 42 Enquiries
(No. of individuals)

812

Males	Females
Q1 =72	Q1=136
Q2=81	Q2=136
Q3=72	Q3=115
Q4=64	Q4=136

Location of abuse

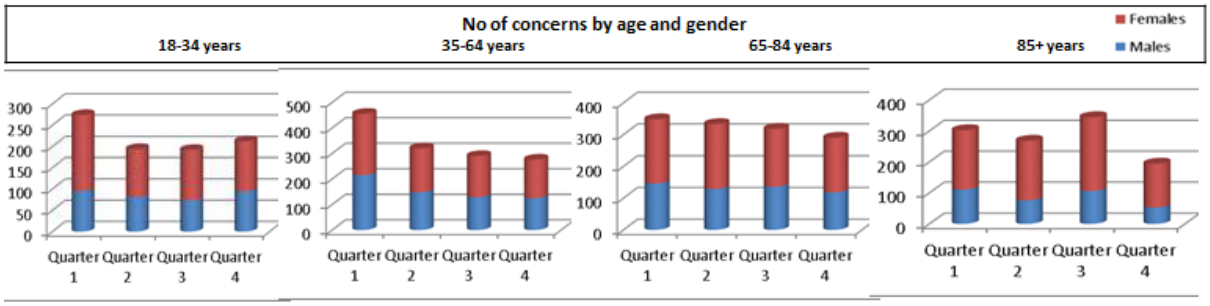
In the persons own home

Q1 = 61%
Q2 = 53%
Q3 = 57%
Q4 = 55%

Other identified high risk areas
Q1 Mental Health hospital 29%
Q2 Care Home- residential 21%
Q2 Care Home- nursing 9%
Q3 Care Home- residential 20%
Q3 Care Home- nursing 5%
Q4Care Home- residential 16%

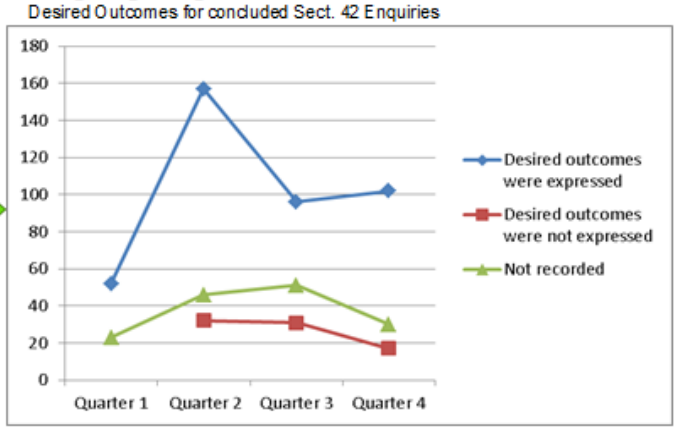
Across all locations of abuse
57% were known to the individual
34% were known to a service provider

No of concerns by age and gender

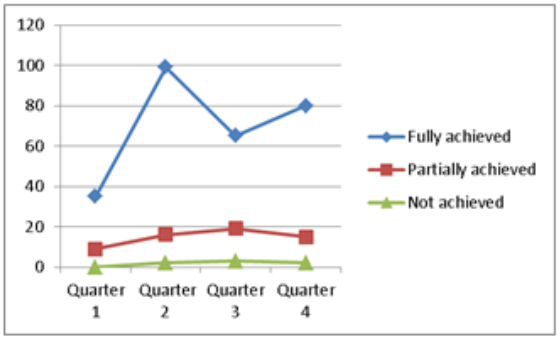


Most common types of abuse recorded in Section 42				
	Q1	Q2	Q3	Q4
Neglect/ Acts of Omission	68	115	95	88
Physical	11	57	41	30
Financial/ material	2	61	38	23
Domestic Abuse	5	27	19	16
Psychological	7	23	19	16
Sexual	2	14	15	18
Modern slavery	0	1	0	0

Making Safeguarding Personal:
Desired Outcomes for concluded Sect. 42 Enquiries



Making Safeguarding Personal:
Achieved Outcomes for concluded Sect. 42 Enquiries where expressed



Safeguarding Adult Reviews	Numbers (Individuals who died)
Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	1 x aged 75-84 years

4. KEY ACHIEVEMENTS AND FUTURE CHALLENGES

During 2018-19 the Board worked towards achieving the priorities set out in the Strategic Plan for 2018-2021.

Support the development of a more robust independent provider market that leads to fewer safeguarding concerns

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

In February at the Lighthouse in Poole over 70 attendees heard from the Independent Chair, who encouraged engagement with the Board and asked them to consider how the Board can support them in their work. The Fire Service gave a presentation on the dangers of emollient creams especially for smokers; this very practical topic followed the sad death of a gentleman in the area and it is hoped that this awareness-raising will help prevent similar incidents. Attendees also heard from an expert on Domestic Abuse and were guided through some of the types of abuse to look out for, whether they were providing residential or domiciliary care, as this close working relationship means carers are well placed to spot warning signs. Attendees were reminded too of the prevalence of domestic abuse and to be alert to the possibility that some of their staff may also be victims, and given advice on how to support them.

As well as the annual provider event the Board were involved in a Learning Disability provider event in November to consider concerns providers might have as a result of the 'Harry' SAR/DHR.

Reduce the instances of people with care and support needs being involved in Domestic Abuse and improve the interface between Domestic Abuse and Safeguarding

In Appendix 2 there is further information about an independent audit of cases where adults with learning disabilities were experiencing domestic abuse.

Nationally there has been some concern regarding the classification of Domestic Abuse when the victims are elderly, in the past agencies may have recorded as 'safeguarding' incidents which ought to have been classed as Domestic Abuse. Locally much has been done to address this issue. The Business Manager attended a conference looking at this issue in greater detail and shared the learning with colleagues.

Help to establish working with the whole family as standard practice

Following the very successful 'Think Family' conference in the previous year there was a Listening Event in October for practitioners. Speakers from Waltham Forest Safeguarding Partnership who had started to embrace this ethos before Dorset, Bournemouth and Poole helped facilitate the event, attended by a very wide range of people working to safeguard children and adults including social workers, addiction services, health professionals, police, teachers.

Evidence lessons from SARs and DHRS really have changed the way we work

The Business Teams from the Safeguarding Adults Boards, Safeguarding Children Boards and Community Safety Partnerships have formed a Shared Learning Group to look at themes from SARs and DHRs. This group links with subgroups, in particular Training & Workforce Development around learning and also with the Policy & Procedures group in case any learning necessitates an amendment to the pan Dorset safeguarding procedures.

Other achievements to note:

The 7 minute learning tools have been successfully used to share learning on contractures, pressure ulcers, neglect, and fire safety and are available on the board website.

The Business Team attended several pop up events including the Emergency Services and Family Fun days in Bournemouth and Poole in summer and in a retail setting in winter. For the first time branded merchandise was purchased and the investment proved to be a way of engaging with the public and raising the profile of the Board.

Advocare
The Board held an extraordinary meeting to examine the Advocare report and recommendations. Some work was undertaken to provide assurance that the issues raised by the group at the time (pre Care Act) would not occur in the present day, due to changes in practice.

Learning Disability Partnership Board (LDPB)
The June Board meeting was attended by several members of the LDPB and the Board agreed to sign up to People First Forum's Bill of Rights. The Business Manager then attended the LDPB and gave a presentation on the Safeguarding Adults Board. Due to ongoing work with the Harry SAR/DHR the Independent Chair attended several LDPB meetings to speak to the group about some of the details around what had happened to 'Harry' and the Coroner's inquest.

The Business Manager became a full member of the LDPB and a member of their Keeping Safe subgroup. This has strengthened the links between the Safeguarding Adults Board and the LDPB.

Local Government Reorganisation (LGR)
During the year Bournemouth and Poole local authorities were involved in intense preparations for LGR. The Safeguarding Adults Board was involved in some of the workstream planning meetings. The Board also needed to prepare by ensuring that the name and logo of the Board were amended and that the Board website was updated to reflect the new arrangements. Further work will be undertaken to amend Board documents to reflect the new local authority.

Development session
In December a Board development session was held which checked progress and contributed to the Board's priorities for the coming year.

Review
There will be an independent review of the Safeguarding Adults Boards in BCP and Dorset. The Children's Safeguarding arrangements in Dorset have already been reviewed following the Wood

report but with LGR on the horizon it was impossible to also review the adult safeguarding arrangements at the same time.

Future Challenges

The Board will continue to work towards the objectives in the 3 year Strategic Plan and the priorities set out in the Business Plan.

Many of the Board partners are striving to continue to deliver high levels of service in the face of intense pressure on resources. As partner organisations working to achieve the same end goal, the reduction of a service in one area can lead to increased pressure in another so channels of communication need to remain open for collaborative working which benefits all.

Regardless of the outcome of the Board review it makes sense to make better use of technology available, where possible easing the burden for arguably the greatest resource, the people working together to safeguard adults.

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 from 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, 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

In recent years much effort has been focussed on aligning the Adult Social Care services in Bournemouth and Poole. In 2018-19 these efforts were redoubled with the imminent Local Government Reorganisation (LGR) to create a new local authority.

Even before LGR one post holder fulfilled the roles of Head of Adult Social Care Services, Borough of Poole and Service Director, Adult Social Care, Bournemouth Borough Council. The Joint Service Manager – Statutory Services was Safeguarding Lead in Adult Social Care across both local authorities.

The point of access to Adult Social Care in Poole was Helpdesk whilst in Bournemouth the point of access was Care Direct. Whilst this means two separate 'front doors' the Statutory Services Manager and the Operational Managers for each authority have worked closely to ensure that once contact has been made that the response, practice and outcomes for residents are the same regardless of where they live.

In October Bournemouth implemented a new case management system, MOSAIC. One of the issues with the previous system was that it did not allow for easy recording and tracking of information about providers to analyse patterns of Concerns raised about providers and manage potential large scale enquiries.

Ahead of LGR Adult Social Care workstreams were identified and meticulous planning was undertaken by project teams and task and finish groups to ensure a smooth transition on Day One.

Research into various safeguarding models nationally was undertaken and a decision was reached that both Bournemouth and Poole would retain their existing modus operandum to allow teams to cope with the demands placed upon them by LGR and to allow further consideration to be given to the pros and cons of favoured models across the country, thus learning from the experience of other areas before deciding on a new model and case management system for Adult Social Care in the new BCP Council.

Effective Prevention

Staff from Bournemouth Safeguarding Hub have developed strong links with colleagues in Contracts and other agencies such as Dorset Healthcare to formulate a Multi Agency Provider Support approach known as MAPS. The approach seeks to prevent harm occurring when standards of care in a Provider setting have fallen below acceptable levels. This approach has been written into the Board's procedures as a way of preventing Large Scale Enquiries or further harm.

Effective Safeguarding

Making Safeguarding Personal is embedded in practice in Bournemouth and Poole, the Joint Service Manager – Statutory Services has undertaken small scale audits during the year to examine how outcomes are being recorded, further focussed work on recording outcomes is planned.

Intensive planning was undertaken with colleagues from Bournemouth, Poole and Dorset to ensure the authorities were ready for day one of the Local Government Reorganisation. Decisions were taken based on assuring the smoothest transition possible for Christchurch residents, in order to keep them safe. The Service Manager for Statutory Services influenced the decision that Safeguarding Concerns should be made via Care Direct and follow the Bournemouth model of Safeguarding. Strong links between the Safeguarding Hub and Christchurch Locality were established and Dorset staff received refresher training ahead of April.

Bournemouth and Poole participated in the review of the Audit into Section 42 Enquiries completed on behalf of the Board in May 2018 by Kate Spreadbury, by providing a range of cases. After the audit was completed, the findings were reviewed and considered by the Safeguarding Lead.

Bournemouth acknowledged that their Case Recording system at the time required practitioners to complete data collection forms retrospectively and this issue was contributing to a degree of confusion of whether a case constituted a Section 42 or not. This issue has now been resolved by the introduction of a new system in October 2018, which requires practitioners to decide at the appropriate time whether they are undertaking a Section 42/other Enquiry, 'NFA' or alternative intervention.

The Safeguarding Lead concluded that some cases were mistakenly called Section 42, when in fact they were not. However, a good standard of practice was noted and effective, preventative and personalised risk management was undertaken. This practice continues, but would now be defined under 'NFA' (no further action for safeguarding) or 'other enquiry' data record.

The new BCP Council will continue to actively contribute to the Task & Finish Group which is considering issuing further guidance to staff on Decision Making, i.e. what constitutes a Section 42 or other enquiry. This work may result in internal guidance for ASC staff in BCP Council or may be presented to the Board for inclusion in Procedures. BCP Council look forward to implementing the recently-issued National guidance on this subject.

Effective Learning

The Service Manager for Statutory Services meets regularly with the Staff Development Manager and the Trainer responsible for delivering Safeguarding Training. This helps to ensure staff are receiving relevant and up to date training that ensures they are fit for practice.

Lessons learnt from SARs/DHRs and Audits are shared and then included in future training. Staff meet on a regular basis with the Training Coordinator of the Safeguarding Adults Board to share learning and plan. Learning outcomes are discussed and agreed.

Effective Governance

The Service Manager for Statutory Services has proactively taken part in the production of Independent Management Reviews (IMRs), and developed and implemented Action Plans where required.

Regular small scale audits are undertaken to provide assurance and identify examples of good practice which are fed back via the Quality Assurance sub group. The Service Manager for Statutory Services meets with the Business Manager of the Safeguarding Adults Board to examine the quarterly activity reports for Adult Social Care teams in Bournemouth and Poole and analyse the findings.

LOCAL AUTHORITIES – LEARNING & DEVELOPMENT

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

Work is ongoing to ensure consistency of training across Bournemouth and Poole and ensure course content is updated to include current themes in safeguarding.

Steps have been taken to improve the quality of course outcomes including through reduced commissioning of courses, increasing internal courses allowing course material to be tailored to the identified training needs.

Effective Prevention

Bespoke Safeguarding Essential Skills training has been provided to many external organisations including provider services, charities, community organisations and church groups.

Effective Safeguarding

A review of Safeguarding Adult Practitioners and Managers annual training updates determined that more frequent update training was needed due to developments in Safeguarding Adult practice. Update sessions were held twice yearly instead of annually.

Training was delivered on Making Safeguarding Personal and the Care Act in practice.

Effective Learning

The Safeguarding Adult Practitioner Training course aims and outcomes were reviewed leading to the launch of a new modular course in September. The new course utilises a blended learning approach with flexible modules; knowledge is closely linked to practice to enable deeper practice learning for effective outcomes in Safeguarding practice.

In line with the Board's aims a Whole Family Approach Safeguarding course was developed and delivered to other Local Authority departments including Housing and Tourism.

Learning from cases including SARs is available to Safeguarding Adult Practitioners and managers in sessions which encourage reflection on good practice and areas of development locally.

In conjunction with the Community Safety Partnership and the Safeguarding Adults Board training sessions to share the learning from the joint SAR/DHR 'Harry' will be developed and delivered.

LOCAL AUTHORITIES – HOUSING & COMMUNITIES

The Homelessness Reduction Act 2017 came into force in April 2018. This was the most significant legislative change in Housing since 1996 and sets out new duties and extends existing duties around prevention and housing advice for customers. In order to deliver this new service which aims to avoid or relieve homelessness as early as possible the local authority invested in additional staffing and reviewed customer delivery. Additional staff were recruited and working practices were revised to meet the new prevention and relief duties. Every customer receives a detailed assessment and a personal housing plan to follow which will assist in preventing or relieving their homelessness.

Further reorganisation is planned in the coming year to incorporate policy and resources to meet the housing needs of BCP residents.

There is an increase in the number of people with complex needs temporarily accommodated under a housing duty, which is possibly as a result of the new legislation and the reduction in supported housing. Options for delivering additional support for this cohort of vulnerable people whilst in temporary accommodation are being developed and funded through successful Ministry of Housing, Communities & Local Government bids.

In 2018/19 5 additional properties were purchased and 3 were built in Bournemouth to meet the needs of homeless people and Housing Register applicants.

The local authorities welcomed 3 new families under the Syrian Resettlement Programme.

Rough Sleeper Initiative

Bournemouth area were successful in bidding for additional homelessness grant funding which has enabled the following:

• Further 'Housing First' provision for the most entrenched and disenfranchised rough sleepers

• Additional outreach staff for the rough sleeper team

• Psychological intervention worker who works alongside the rough sleeper team

• A duty to refer coordinator who works with all the agencies that now have a duty to refer under Clause 10 of the Homelessness Reduction Act 2017

• A coordinator post to recruit and manage all the additional work and staffing.

This funding has been awarded under the Rough Sleeping Strategy 2018 and in line with the aim of reducing rough sleeping and ending it for good by 2027.

Housing provided safe temporary housing for Rough Sleepers in cold and extreme weather under the Severe Weather Emergency Protocol.

Effective Prevention

Work continues to identify provision to meet the needs of BCP residents where a statutory duty to assist is in place. The offer to residents cannot be wholly reliant on the private rented sector.

Pre-eviction protocol review with Poole Housing Partnership has reduced evictions from council accommodation; further work on this is planned for the coming year.

Effective Safeguarding

Housing made referrals to the Safeguarding Adults Board's Safeguarding Adults Review (SAR) subgroup. A decision was taken not to undertake a SAR but with the subgroup Housing are looking at learning from these referrals.

B&B and Guest House accreditations were completed for all units in the BCP conurbation, ensuring Health & Safety compliance and assured service standards with proprietors. Additional checks for new premises are in place with periodic cycle of re-accreditation.

Pilot Complex Housing Resources Panel - A revised Terms of Reference for the panel to support the coordination of complex resources for those with a range of needs and behaviours which may be putting tenancies at risk and / or those who require support resource plans in place in order to access housing.

Effective Learning

Trauma-informed training was provided for housing practitioners in Bournemouth & Poole. Frontline officers have used this training to improve the quality of housing needs assessments, increase awareness of trauma and Adverse Childhood Experiences (ACEs) and to inform housing options and appropriate support. This training has been extended to the Rough Sleeper outreach team.

Effective Governance

The previously commissioned Floating Support Team delivered by BCHA in the Bournemouth area was brought in-house. This decision was made to achieve efficiencies and align with other services for a more coordinated approach.

A review of Housing-related support and services for Adults with Mental Illness and complex needs took place, further work on aligning access pathways is ongoing.

LOCAL AUTHORITIES – COMMISSIONING

Services for Adults who require Care and Support at home or in a residential setting, or community services, are commissioned under the Tender for Care and Support at Home Framework 2017-2022. Providers are contractually bound to comply with safeguarding procedures and encouraged to link with third sector providers to engage in preventative work.

The small framework of providers allows for close quality monitoring, open communication and effective market management and specialist training is offered to all contracted providers.

The contracts team have introduced client feedback into the monitoring process and any issues raised are dealt with appropriately.

Information on providers of concern is shared with the Quality Assurance subgroup.

Intelligence relating to concerns is reviewed and graded before being added to staff caseload in order to monitor and assess risk, and intervene to support providers to improve and evidence the resulting positive changes.

Effective Prevention

Practical measures in place include working in partnership with public health to offer flu vaccinations to staff thereby maintaining workforce capacity and reducing the spread of such illnesses among service users.

Increased capacity in the Independent Living Service has meant that self-funders have been able to access support in making decisions around their care, empowered to make the right choices and reassured by the advice from experienced staff.

The Provider Safeguarding and Compliance Forum meets every 6 weeks to decide how best to share information, identify gaps and changes relating to safeguarding and provider performance. Low level concerns can be shared with the aim of preventing escalation.

Effective Safeguarding

The community reablement offer at Coastal Lodge for clients who no longer required their acute hospital beds due to being medically fit, but required further support prior to returning home, enabled these people to be safeguarded effectively.

Effective Learning

Bespoke training was designed for care home residents and the staff that work with them. This included Action Learning Sets; Experiential Dementia Awareness Training using virtual reality; Dementia Communication delivered within care home settings; Resilience and Wellbeing training.

Effective Governance

The service has engaged in contingency planning including preparations for Brexit and the potential impact on staffing.

Established communication channels with providers supports the market.

2. DORSET POLICE

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

The Police have been increasingly involved in working with adults with degrees of vulnerability and have presented at the Board to share details of their project to map this work and the complexities of trying to achieve a common approach with other partners given the differing focus of each organisation. Whilst policing was traditionally associated primarily with criminal justice over time the numbers of 'Adults At Risk' as defined by the Police have increased to the point where Dorset Police, in line with other force areas, are increasingly concerned with the safeguarding adults agenda.

Organisation Business Design has led to the redeployment of staff to Public Protection areas. This has seen a growth in areas of safeguarding of one Detective Sergeant and two Police Constables.

Dorset Police are developing their approach to the use of Public Protection Notices (PPNs) and signposting to community services in order to manage the demand associated with protecting the vulnerable and statutory safeguarding. This is work in progress.

The Force Intelligence Bureau ('FIB') now focusses on an intelligence-led approach to threat, risk and harm. The FIB has a dedicated vulnerable adults desk, an analyst and a researcher, developing and supporting vulnerable adult investigations

The threats and risks to the public are changing over time, this is reflected in the work of Dorset Police and their development of internal and partnership processes to prevent and respond to concerns regarding victims of modern day slavery.

Effective Prevention

The Dorset Police Make the Difference Team completed a force-wide domestic abuse audit to identify areas for improvement. The Force has appointed a Superintendent to lead the development work identified.

National County Lines Coordination Centre supported and promoted the safe and well checks conducted by neighbourhood officers of criminally-exploited vulnerable people in West Dorset by drug dealers. This successful initiative has now been rolled out across the force area.

Effective Safeguarding

Creation of Safeguarding Referral Officers (SRO) in the Safeguarding Referral Unit (SRU). The SROs will consider all referrals of adults, Domestic Abuse and children into the SRU. The new process avoids duplication of effort and increases staff resilience.

Dorset Police make referrals to the Safeguarding Adults Review Subgroup and contribute to the assessment of referrals submitted by partner organisations.

Dorset Police have updated their Vulnerable and Intimidated Victims and Witnesses Policy and Procedure. In light of the learning from the 'Harry' SAR/DHR the policy now makes it clear that where an officer or member of staff identifies a witness who may be eligible for a video recorded interview they need to identify an officer who is trained in interviewing vulnerable and intimidated witnesses.

Several Detective Inspectors have undertaken training in Modern Slavery and Human Trafficking (MSHT).
Significant development of procedures and support has been received from National Modern Slavery Transformation Unit who undertook a case audit and provided learning. Further training for frontline staff, and for some officers to become MSHT Investigative Champions is planned for 2019-20.

Effective Learning

The College of Policing 'Look beyond the obvious' vulnerability training and communication awareness material has been implemented within Dorset Police between September and April. The objectives of this full day of training are to further improve the skills of the frontline to effectively support the complex needs of vulnerable individuals, to encourage professional curiosity and to ensure forces are better equipped to deal with the shift in demand towards safeguarding and public protection.

Effective Governance

Dorset Police focus on Crime Data Integrity in relation to Domestic Abuse, one of the Board's strategic priorities. Performance is regularly audited.

Quarterly Adult PPN data is now shared with Quality Assurance sub group which enables partners to better understand the types and volumes of PPNs. Further work is planned with police staff on identifying when PPNs need to be shared with Adult Social Care.

Dorset Police Domestic Abuse policy and procedure has been updated to reflect early learning from DHR D6.

Multi Agency Risk Management (MARM) meetings are utilised by Dorset Police. They will participate in a future audit of the use of MARM in Adult Safeguarding.

Adult At Risk triage team at Bournemouth will be further developed to manage referrals and to better direct criminal investigations. Current methods of data collection for this group are time consuming and work is ongoing to improve this.

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.

Throughout the year the CCG has retained focus on the Adult Safeguarding agenda.

Last year the Safeguarding Lead GP's developed a Quality Assurance tool for visits to all GP surgeries. This tool provides a framework for checking that robust safeguarding processes are in place; this has been further developed to include other NHS providers.

Workshops on issues such as domestic abuse, coercion and control, stalking, adolescent to parental violence, and the Mental Capacity Act have been offered to primary care workers.

A series of short films aimed at practitioners and service users regarding the Mental Capacity Act were commissioned in collaboration with Dorset County Hospital.

Collaborative efforts to develop safeguarding guidance where pressure ulcers are involved continue with the Safeguarding Adults Board.

The CCG has been developing safeguarding templates to support IT systems within GP practices and facilitate recording of information.

A visit from the NHS England National Head of Safeguarding in the autumn gave a useful overview of the national safeguarding agenda from a health perspective, a further visit is planned for May 2019.

Effective Prevention:

Complementing the Board's strategic priority of Domestic Abuse, the delivery of Domestic Abuse training to primary care, practice nurses and pharmacists has increased the awareness of the overall agenda of Domestic Abuse as well as making clear the responsibilities of staff.

The Designated Adult Safeguarding Manager (DASM) attended the Safeguarding Adults National Network and the national Mental Capacity Act huddle. They are also an active member of the following pan Dorset groups: Domestic Abuse Strategic Group, PREVENT group and the Antislavery Partnership. The CCG is represented by the DASM at the Community Safety Partnerships and has undertaken work with the Business Manager for multiagency risk assessment conference (MARAC) to review the requirements of health representation. The annual adult safeguarding training to the CCG Governing Body was delivered by the safeguarding team.

Effective Safeguarding:

Domestic Homicide Reviews have been shared across all commissioners to consider how current services are delivered and to influence commissioning arrangements. The Police and Primary Care have joined forces to consider the effective management of public protection notifications (PPNs).

The Designated Adult Safeguarding Manager has developed links with probation services to review the communication with the current multiagency public protection arrangements. They also work with the CCG Patient Safety and Risk team to review Learning Disability Mortality Review Programme (LeDeR) reviews from a safeguarding perspective.

Effective Learning:

Regular Adult Safeguarding health leads supervision sessions have been held throughout the year, which embrace supervision and learning on a monthly basis.

In line with Think Family, Legal Literacy training was provided to safeguarding health leads for children and adults and attended by the Safeguarding Adults Board.

The DASM chairs the Training and Workforce Development subgroup and supported the delivery of a presentation around safeguarding, domestic abuse and mental capacity to the Mental Capacity Act conference.

The Intercollegiate adult safeguarding competencies have been adopted throughout the health system and plans are being developed to ensure these are embedded within the next three years.

Effective Governance:

Considerable work was undertaken throughout the year to quality assure the safeguarding arrangements within GP practices and NHS providers utilising an assurance safeguarding framework for all NHS providers. This links with key lines of enquiry for CQC that embrace both children's and adult 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.

4. DORSET HEALTHCARE

Dorset HealthCare University NHS Foundation Trust 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.

Dorset HealthCare is responsible for all mental health services and many physical health services in Dorset, delivering both hospital and community-based care.

The Trust works collaboratively with Bournemouth University which benefits both staff and patients.

In 2018/19 Dorset HealthCare has invested in the development of a pocket guide for staff to improve implementation of the Mental Capacity Act. This practical tool for health practitioners offers support, suggestions and considerations designed to encourage implementation and promote best practice.

Effective Prevention

Dorset HealthCare's Safeguarding Adults Service has continued to provide advice and support to staff caring for people who were demonstrating self-neglect. Staff have made use of the Multi-Agency Risk Management (MARM) process in order to manage risk, this process has become embedded in practice in Dorset Healthcare.

In line with the Safeguarding Adults Board priority of Domestic Abuse Dorset Healthcare supported national drives such as Stalking Week and the 16 Days of Action project for Domestic Abuse. Information was made available to staff on the intranet that included national helpline details.

The Think Family Group ensures that safeguarding and promoting the welfare of children, young people and adults at risk, is integral to clinical practice within the Trust. It is also a Trust-wide forum for disseminating safeguarding learning via service safeguarding leads, addressing frontline safeguarding issues and embedding safeguarding policies and procedures into practice.

Effective Safeguarding

The Safeguarding Team has continued to provide advice and support to staff on safeguarding concerns.

Dorset HealthCare continued to support Large Scale Enquires during 2018/19. This has ranged from sharing details of care provided by Dorset HealthCare to completing joint assessments of residents' care needs with the Local Authority or attending professionals meetings. Staff also supported a task force approach led by Local Authorities to help minimise risks, collate information and support care and nursing homes that are subject to a Large Scale Enquiry. Dorset HealthCare have their own Large Scale Enquiry protocol.

Dorset HealthCare is represented at the Safeguarding Adults Board subgroups. Over the last year this has included the review of guidance around Pressure Ulcers, Falls and Nutrition with the Policy and Procedure Group contributing to the development and updating of procedures.

A document has been drafted that is designed to set out the patient journey from the point of admission to discharge for patients who lack capacity to make decisions about their welfare and residency at the point of discharge. The tool is being promoted particularly for patients where there

is likelihood of the matter being referred to the Court of Protection for a decision. The aim of the document is to support staff in following due process in these complex cases and avoid delayed discharges. A care plan document has also been developed to help manage the transition process when the Court of Protection does mandate a change of residence.

Effective Learning

Members of the Safeguarding Adults Team attended Dorset HealthCare's Prescribers' Conference and supported a safeguarding stand at Dorset HealthCare's Quality Matters Conference and the annual Mental Capacity Act conference. They regularly present at monthly Pressure Ulcer Workshops to increase awareness of Safeguarding Adults Process and the Mental Capacity Act.

Mental Capacity Act training has been delivered to Community Mental Health Teams and is in the process of being delivered to District Nursing groups.

The Safeguarding Adults and Children's Teams together with the Serious Incident Team and Quality Assurance have begun to explore how learning from DHRs, SARs and SCRs can be effectively disseminated and action plans monitored. Learning and best practice from other health trusts will be researched and used to plan a strategy around this for Dorset HealthCare.

Prevent awareness training has been provided to staff to highlight this emerging risk.

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.

The Safeguarding Adults Team continue to review all safeguarding adults incidents to ensure that concerns are raised with the Local Authority and/or the police as required and experience regarding risk management strategies is shared. A scorecard detailing the volume 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 reviewed a sample of root cause analysis (RCA) forms on pressure ulcers that had developed whilst a person is under Dorset HealthCare care and were able to provide assurance that adult safeguarding concerns are identified and raised appropriately. No further actions were identified in any of the sample cases.

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.

More robust processes are being developed for the coming year 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.

5. POOLE HOSPITAL NHS FOUNDATION TRUST

Poole Hospital provides acute services for the local population of Poole, Purbeck and East Dorset, and is the lead provider for the Bournemouth, Poole and Christchurch conurbation for trauma, maternity, paediatrics and ENT services. The staff at Poole Hospital strive to provide friendly, professional, patient-centred care with dignity and respect for all.

With a history of innovation, the Trust provides pioneering services across a range of clinical specialties and keeps safeguarding adults at the heart of its work.

Last year the Trust introduced a system of alert flags on the records of patients with learning disabilities and a resource folder with key tools to assist communication. The Trust has now built on this by developing a Learning Disability Strategy. The strategy was informed by a workshop in which 40 people representing people with Learning Disabilities, their families, informal and professional carers, the Safeguarding Adults Board, along with hospital staff came together to consider how the trust could better meet their needs in respect of 4 areas: keeping safe, staying healthy and independent, the right care and support in hospital, communication and engagement with support for families.

Poole Hospital will continue to implement the strategy over the next three years and during 2019 will provide a care-planning masterclass for staff and consider further how the health screening services that the Trust offers can be more accessible to people with Learning Disabilities.

The Trust recognises the increasing activity with respect to patients with mental health needs who attend the hospital. To support this activity a Mental Health Steering Group has been formed to provide oversight and coordination of the work to support people with mental ill health whilst receiving care in a physical health setting. Ongoing work will focus on 7 priority areas: Developing the governance framework; developing staff skills, provision of a safe environment, suicide prevention, access to specialist services, support to staff and supporting patients and families.

The Trust makes use of technology to improve working practices where possible. To simplify the process for staff when raising concerns an electronic referral form has been developed. Linked to the electronic patient record, this reduces the time taken in form completion and improves accuracy of information transfer. The form has been evaluated well by staff and the Local Authority. 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 our staff is central to prevention of safeguarding concerns both within the trust and in the community. The hospital is actively developing new recruitment strategies to prevent shortfalls in workforce. Safeguarding training is organised to ensure that it embraces the complexity and range of safeguarding concerns which arise in the community and beyond.

The hospital's elderly care unit has received national acclaim for its pioneering model of multidisciplinary care.

Effective Safeguarding

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

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

We continue 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 Learning

Poole Hospital continues to value working collaboratively with partner agencies to achieve the best outcome for patients. The hospital has strong relationships with other health leads and ensures that learning is shared with these.

The learning from safeguarding concerns and enquiries is shared through a variety of forums. Such learning from local and national events is also used throughout the trust 'update and induction training' as individual case studies to provide context to discussions and connection with staff own roles.

Further staff have undertaken the role of safeguarding champions to 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.

Training is reviewed on an ongoing basis and this year additional time has been allocated to support the understanding of the Mental Capacity Act and reform of the Deprivation of Liberty Safeguards (DoLS).

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 domain. The Trust agreed and implemented an action plan with CQC and Dorset CCG to address those areas where further improvement was required. The Learning Disability Strategy and Mental Health Plan referenced above are examples of improvements initiated by the Trust.

6. THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST

The Royal Bournemouth and Christchurch Hospitals provide healthcare for the residents of Bournemouth, Christchurch, East Dorset and part of the New Forest with a total population of around 550,000, which rises during the summer months. Some specialist services cover a wider catchment area, including Poole, the Purbecks and South Wiltshire.

The Trust strives to provide safe, caring, effective, responsive and well-led care within the Royal Bournemouth and Christchurch Hospitals and safeguarding is an important component of this.

The hospitals in the Trust have strong relationships with other health leads and ensure that learning is shared with these. The Trust also works in partnership with Pan Dorset partner agencies to promote and strive towards the priorities of the Safeguarding Adults Board and the alignment of practice in the CCG and in all Dorset Acute Trusts.

The electronic Cause for Concern form developed last year has improved confidentiality of sensitive information, and reduced misunderstandings that previously occurred due to illegible handwriting. This form is intentionally not password-protected so that the information can be seen by all staff in line with the principle that 'Safeguarding is Everybody's Business'.

The Royal Bournemouth and Christchurch Hospitals are committed to Making Safeguarding Personal and have made improvements in the referral processes.

There is a culture of appreciating the role of staff members in safeguarding patients.

The Trust has endeavoured to incorporate the 'Think Family' ethos.

The Trust is working to develop paid carers agreement and standards in recognition of the important role of carers in the lives of their patients and how this relationship can enhance safeguarding.

Effective Prevention

The Trust is confident that the visibility of the Adult Safeguarding (ASG) Team in the hospitals on a daily basis enables staff to access the team to seek advice, or assistance in raising concerns in order to prevent instances of harm from occurring.

Analysis of quarterly data is undertaken to ensure that concerns reported by staff are appropriate. Staff receive feedback on outcomes of concerns raised in order to understand cause and effect, and either prevent repeated similar issues or have the tools to deal with theses as they arise.

Effective Safeguarding

The Adult Safeguarding Team have an "open door" policy. They work closely with Social Care partners to share concerns or advice, on a weekly basis they meet to screen referrals. There is a Trust culture of safeguarding being everybody's business.

The hospitals work in partnership with Police, Ambulance and Fire and Rescue to effectively safeguard the public.

Staff actively participate as and when required in Safeguarding Adults Reviews or other reviews.

The Trust has increased the number of Learning Disabilities Mortality Review (LeDeR) reviewers available and subsequently the number of reviews undertaken by the Trust for agencies.

Staff are aware of their Duty of Candour to the public and accountability for their actions. The Trust has a whistle blowing policy in place.

Effective Learning

The Trust target for training is 90%; however the Trust is pleased to report that Adult Safeguarding Training is continually over 95%.

The Adult Safeguarding Team attend Essential Core Skills training meetings so that the safeguarding ethos is perceived as core business.

The Adult Safeguarding Team work closely with the Training department to ensure training delivered is robust and reflects national legislation.

Effective Governance

The Trust participates in local and national safeguarding audits and initiatives, ensuring awareness of changes in legislation and adjusting practice accordingly.

The Trust Board receives quarterly and annual reports. Internally the Safeguarding Committee, which reports directly to Board, undergoes regular review and external audit.

Adult Safeguarding leads monitor, record and evaluate issues with the Deputy Director of Nursing.

The Trust is represented by the Deputy Director of Nursing or Adult Safeguarding lead nurse at Safeguarding Adults Board meetings and subgroups.

7. NHS ENGLAND AND NHS IMPROVEMENT (SOUTH WEST)

NHS England are focused on developing and maintaining strong safeguarding partnerships across health and social care to enhance how they protect, support and improve the lives of those at risk in local communities.

NHS England and NHS Improvement have demonstrated commitment to working with multi-agency partners to ensure that the interests of those at risk inform decision making. Health organisations strive not only to meet their legislative obligations, but also to listen to the voices of communities as well as those caring for them both professionally and in a caring, voluntary capacity.

The South West safeguarding team have worked in partnership with the NHS England and NHS Improvement National Safeguarding Team and local safeguarding partners to support the delivery of the national safeguarding priorities across the South West, and to support the networking of professionals across England to ensure sharing of best practice and learning from risks and issues.

As the safeguarding agenda is continuously developing, in both its complexity and scope, so too must the NHS priorities also evolve.

Effective Prevention

The South West safeguarding networks have worked with Primary Care to support the awareness of Domestic Abuse/Violence.

Effective Safeguarding

A safeguarding General Practice audit tool has been developed. Dorset have taken a lead on this work and this has received good feedback from General Practice participants.

The South Region Named GP Safeguarding Forum was first convened in March and brought contribution from partners across the South. The event was well-attended with over 30 Named GPs present and plans to expand on this forum are under way.

Effective Learning

Health Network developments across the South West have brought Clinical Commissioning Group safeguarding leadership teams together to create a community of practice and peer support. A key focus of the network meetings was to review the challenges across local areas, identify priorities and support collaboration and successes in their safeguarding work, as well as opportunities for learning from each other's good practice.

A strong focus on learning from cases both nationally and locally has been an ongoing theme in the work of the safeguarding networks. Learning from both child and adult reviews, has supported development of health and care systems across the South West.

The annual conference held in September 2018 was attended by 100 delegates from across the region. The focus of the day was exploitation and there were a range of speakers with specialist knowledge of County Lines, Prevent, Domestic Abuse and Modern Slavery.

This was followed by a Prevent Workshop in March 2019 with guest speakers from the Home Office and Police, attendees had the opportunity to work through Prevent issues local to them and to hear the journey of restorative care and support provided by the Home Office. Further workshops are planned for 2019/20.

Effective Governance

NHS England South (South West) team worked closely with local representative committees in Primary Care to raise the profile of safeguarding and identify any local or regional learning needs for Primary Care providers.

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, and is subject to independent audit.

The Safeguarding Lead meets monthly with Health Leads to share best practice.

The service is involved in a broad range of safeguarding activity and has implemented training on many topical issues including County Lines, Internet safety, Hate and Mate Crime, Domestic Abuse, Safeguarding Black and Minority Ethnic (BME) groups, Mental Capacity, Hoarding, Legal Literacy, Honour-based Violence and Homelessness.

DWFRS have made use of technology to remove barriers to reporting concerns by adding a safeguarding prompt question and a shortcut to their intranet as well as the planned development of an electronic safeguarding referral form.

The Fire Service have sought engagement with the public through social media campaigns on public intelligence gathering around Modern Slavery and Human Trafficking.

DWFRS are striving to raise the profile of the service in the safeguarding arena and ensure that partner agencies are aware of the advice and practical assistance that they can offer as part of their wider remit. Many providers and other attendees benefitted from advice from DWFRS at the Safeguarding Adults Board Provider Event.

The service continues to be challenged by the dilemma of supporting those involved in self-neglect and hoarding and works with partner agencies towards achieving positive outcomes.

Effective Prevention:

The Fire Authorities' policy and the Service's procedures adopt a 'whole system approach' to adult and children's safeguarding and they are reflected in the key principles. Safeguarding arrangements are delivered via a broad spectrum of activities including:

- Through support and promotion of both national and local safety campaigns (Prevention).
- Through specific intervention such as operational incidents, Safe and Well visits, Fire setter programmes and other children and young people (CYP) programmes.
- Multi agency training and awareness.
- Through formal safeguarding arrangements, in partnership with Local Authority Safeguarding Teams and other key agencies.

By working closely with other agencies, using information sharing to help safeguard vulnerable people and to keep others safe, including DWFRS staff.

Dorset and Wiltshire Fire and Rescue Service are increasingly sharing stations with The Police and working more closely with the Ambulance Service and have Memorandums of Understanding in place with these services.

By raising low level concerns early DWFRS aims to prevent the situations from becoming more serious.

The service has updated recruitment policies around safer recruiting and reviewed roles which require additional checks such as Disclosure and Barring Service (DBS) checks.

Effective Safeguarding:

Dorset and Wiltshire Fire and Rescue Service is committed to their duty to protect vulnerable people and work with partners to ensure processes are in place to provide the right support to those people when they need it. Staff are trained to understand their responsibilities in relation to safeguarding, and supported to deal with often challenging situations to safeguard the staff themselves.

Formal safeguarding arrangements are developed and delivered predominantly by the Safeguarding Lead who is responsible for supporting the organisation in its policy commitment to safeguarding and promoting the welfare of children, and adults at risk. To ensure organisational resilience, there is continuous cover in place for matters related to safeguarding.

The Safeguarding Lead represents the service on local sub groups and meetings where the service is actively involved in safeguarding, including Multi Agency Risk Management Meetings (MARM).

A clear training delivery plan which includes corporate induction and continuation training provides guidance to all staff and service volunteers on how to recognise when an adult with for care and support needs is either experiencing harm, abuse or neglect.

DWFRS have worked with 'You Trust' and now have Domestic Abuse Champions whom staff can approach for advice.

DWFRS make a valuable contribution to the self-neglect and hoarding panel which sets out the shared understanding across key agencies of a joined up response to very serious situations of adult self-neglect.

Effective Learning:

The Safeguarding Lead meets twice a year with Safeguarding Adults and Community Services Learning & Organisational Development Advisor. All training is discussed.

A pre and post training survey is circulated to monitor whether training has been embedded.

A survey was circulated to all front facing staff to measure to what extent safeguarding has been embedded in the service. Results were reviewed and a 99% positive outcome was achieved.

The origin of referrals is reviewed quarterly by the Safeguarding lead and Station Managers. Findings are shared with Group Managers and Area Managers with the aim of identifying any training needs.

The safeguarding lead attends Local Authority 'train the trainer' sessions.

Learning is shared with the Safeguarding Adults Board and local authorities. Staff attended the Safeguarding Adults Board provider event in February 2019 to share learning regarding the risks associated with emollient creams and the 7 Minute Learning tool on the subject has been widely shared.

Effective Governance:

The Safeguarding Lead meets with Devon and Somerset FRS, Hampshire FRS and Avon FRS safeguarding leads 3 to 4 times a year to share best practice.

The Safeguarding Lead attends monthly meetings with health leads.

When selected we are involved in the Line of Sight programme.

Area Managers give strategic management representation on all Local Safeguarding Boards.

The Safeguarding lead represents the service on the National Fire Chiefs Council Safeguarding Workstream.

The service provides locality based evidence of ongoing projects and report progress and opportunities to Members of the Fire Authority through Local Performance and Scrutiny Committees (LPSC's) on a quarterly basis. This is also reported to Full Fire Authority on a 6 monthly and annual basis.

Audited as required by HRMIC FRS*. (Commenced 2018).

*Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) independently assesses the effectiveness and efficiency of police forces and fire & rescue services – in the public interest.

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

The Trust's Safeguarding Service states "We support the Trust to work with partner agencies to ensure that children, vulnerable adults, victims of domestic abuse, victims of radicalisation, victims of modern slavery and victims of human trafficking are protected from those who would seek to harm them. To achieve this, the Trust needs to ensure that its staff and agents understand how to identify signs of possible or potential abuse in patients and members of the public they come into contact with and what action to take to ensure they are adequately protected. We also support the Trust to ensure that it provides a safe service to vulnerable people."

The Safeguarding Service analyses the impact of ten core activities. These activities cover external relationships, expert advice, education, referrals, information sharing, investigations, analysis of child death, service development, managing allegations and corporate advice.

The Trust is aligned to 28 Local Safeguarding Adults and Children Boards within its geographical area of operations. The Safeguarding Service endeavours to maintain relationships with all of these organisations by attending a representative selection of meetings. The Head of Safeguarding attended the Bournemouth & Poole Safeguarding Adults Board development session in December.

During 2018/19 the Trust generated 19750 safeguarding referrals from approximately 1.5 million contacts with patients across emergency and urgent care services. This represents a significant increase of 33% compared to the previous year.

Effective Prevention

It is noted that staff interaction with service users may be such that compared to other services time spent with the person can be very limited or the person may be unwell and unable to fully communicate. Staff are encouraged and trained to use their judgement and professional curiosity to ask pertinent questions and relay safeguarding concerns to partner agencies.

During 2018/19 the Safeguarding Service received notifications for 20 Safeguarding Adult Reviews and 12 Domestic Homicide Reviews across their geographical region.

Effective Safeguarding

During 2018/19 the Safeguarding Service managed 325 calls for advice from staff. This was increase of 18% compare to the previous year. This may be related to the introduction of the Safeguarding Helpline.

SWASFT have analysed referrals and highlight that the most common reasons for safeguarding concerns were self-neglect and domestic abuse.

A specialist seminar addressing corporate safeguarding principles was delivered to the Trust's Board during 2018.

Safer recruitment and selection procedures in place in line with best practice.

Effective Learning

In preparation for delivery of a new 3-year safeguarding training strategy, the teams worked closely during 2018/19 to develop and test a new method of safeguarding training using a threading-and-embedding method. This style moves away from teaching safeguarding as a standalone subject and instead focusses on practical application through delivering core safeguarding learning outcomes whilst delivering scenario-based clinical training.

By the end of 2018-19 the Trust had achieved 92% 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.

During 2018/19 the Trust's safeguarding team was restructured to improve efficiency and accessibility. The primary change was the introduction of the Safeguarding Business Manager. The purpose of this new role is to provide a single point of contact for external partner agencies.

SWASFT's Safeguarding Policy is published on their public website.

The Trust is subject to external scrutiny by the Care Quality Commission. In addition, the Safeguarding Service voluntarily utilises occasional local scrutiny panels provided by Local Safeguarding Boards to benchmark performance.

The Head of Safeguarding is a member of the National Ambulance Safeguarding Group (NASG) which facilitates discussion and peer review between the national NHS ambulance providers.

10. NATIONAL PROBATION SERVICE

The National Probation Service in Dorset is committed to the Safeguarding Adults agenda and implements new policy and procedures, sends staff on appropriate training and undertakes a number of Quality Assurance activities as well as making appropriate referrals.

The service was subject to a full inspection in August and achieved a 'Good' rating.

Effective Prevention

The National Probation Service engages in joint working with other agencies through Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conferences (MARAC), Stalking Clinics and Professionals Meetings. Staff seek to support victims and perpetrators in order to reduce safeguarding concerns.

Appropriate use of recall, licence variation conditions and breach of community orders support prevention and safeguarding.

Effective Safeguarding

National Probation Service 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 while recognising that some of these adults may have dual roles of perpetrator and victim.

Staff make referrals into the local authority Adult Safeguarding team in relation to adults they are working with and engage in joint working and use of Care Act referrals.

Effective Learning

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

Staff undertake training in Domestic Abuse and Safeguarding – the majority of staff have completed this training.

Following a Domestic Homicide Review a Domestic Abuse audit was led by Dorset Community Safety Partnership. The outcomes are applicable Pan Dorset and demonstrated an excellent engagement and risk assessment / service delivery to Domestic Abuse perpetrators and victims within the National Probation Service.

Effective Governance

Senior management from the National Probation Service contribute to various Pan Dorset boards which seek to support adult safeguarding including MAPPA, Domestic Abuse and Sexual Violence Strategy Group, Children's Safeguarding and Community Safety and Criminal Justice Strategy Group. The Head of Service in Dorset seeks to ensure full engagement and integration across the various boards to support linked up thinking and deliver statutory responsibilities.

APPENDIX 2 – CASE STUDY AND FEEDBACK

One of the Board's strategic priorities for 2018-19 was to reduce the instances of people with care and support needs being involved in Domestic Abuse and improve the interface between Domestic Abuse and Safeguarding.

As previously mentioned in this report an audit of cases where adults with learning disabilities were experiencing domestic abuse was carried out in February and further work is ongoing to arrange workshops for practitioners.

The case study below is an example of an adult with a learning disability who found herself in an abusive marriage. Some of the multiagency approach to her case is outlined below. Some details have been changed to maintain confidentiality.

Karen is a woman with a learning disability who has been married for 2 years to Tom.

Karen confided in Adult Social Care staff that she was a victim of domestic abuse, following this she was supported to contact the police.

A DASH* risk assessment was completed and referral made to a refuge as her husband refused to leave their home.

The case was considered at MARAC and a Domestic Abuse Adviser was appointed.

Karen spent several weeks staying in the refuge, during this time Adult Social Care liaised with the refuge staff.

Karen was supported in contacting a solicitor about her case and a non-molestation order was put in place. Her husband Tom was convicted of sending abusive messages.

Adult Social Care worked with housing management to move Tom out of their home. With support from a housing officer Karen was able to return home. She felt safer with the non-molestation order in place.

Liaison was undertaken with Community Learning Disability Team and the local authority Finance department who were appointee for Karen's benefits.

*Domestic Abuse, Stalking and Honour-based violence

On a personal note, can I express my gratitude on behalf of my wife and myself for the support you have provided to my father-in-law recently. Your support has given him the confidence to speak openly about his current care arrangements.

The family have thanked the social worker for her role in resolving a serious family issue, and have complimented her on this positive outcome due to her interventions. Thank you for your good work!"

Bournemouth

Praising all the hard work and skilled interventions you have been involved with on a joint case.

I want to contact you and thank you again for a really interesting session... The students seemed really engaged and interested in both the presentation and case study, and I noticed you both had students wanting to continue to discuss things at the end of the session with you...I need to acknowledge it is not easy engaging a group of students on a Monday afternoon and I really appreciate the enthusiasm and humility you both brought to a challenging session. This fits well with their other unit on risk and complexity too.

My sincere thanks to you all for the help you have given me ...a few weeks ago I joined the exercise class at the care home which has been most enjoyable. I have now registered with a home care company. Things are looking much brighter now thanks to your sympathy and understanding of my situation and the advice and help you have given.

'I have been extremely impressed by Poole Adult Services' attentiveness and professionalism throughout my wife's time in care. 'We find it [the DoLS process] to have been satisfactory and helpful.'

Poole

I think every visitor, visit, phone call from this department has been really excellent. No-one has been hasty or disinterested and I praise everyone who has visited or written to me.

I just wanted to say a big, big, thank you for your help as following your assistance and the advice from the social worker we have been referred by the GP, seen the Adult CMHT and received a diagnosis with an action plan. We are really happy with the support we are now receiving. Until your help we were stuck in the system and going nowhere and your perseverance in getting us an answer is really appreciated. Please, if appropriate, feel free to pass this onto your manager/team. You made a real difference.

Photos from the Emergency Services Day in Bournemouth and a Partners in Care Conference.

APPENDIX 3 – SAFEGUARDING POSTERS

Below are the posters used by the Safeguarding Boards. These will be updated for the 2018-19 year with the contact details of the new local authorities. A print run in some of the most commonly used foreign languages is also planned.