# TOPIC ASSURANCE REPORT

NHS Somerset NHS Foundation Trust

**Quality and Governance Assurance Committee**

| REPORT DETAILS | |
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| **Topic** | **Safeguarding Adults Annual Report** |
| **Topic Lead** | Heather Sparks, Strategic Lead & Named Professional for Safeguarding Adults |
| **Exec Lead** | Hayley Peters |
| **Governance Link support** | Lincoln Andrews |
| **QAG meeting date** | |
| **Period covered** | April 2022 – Mar 2023 |
| **Previous level(s)** | Blue |
| **Specialist / oversight group** | Safeguarding Committee |

| ASSESSMENT | |
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| **Recommended level** (Separate levels - an interim measure) | |
| **Musgrove, Community, MH&LD services** | **Yeovil District Hospital** |
| **Blue** | Not included within this report. Outgoing HoS for YDH completed end of year report for YDH |

**Recommendation(s) for QAG follow-up**

- The re-establishment of an audit programme, noting that auditing has intentionally been placed on hold during this reporting period
- Review of policies pending or overdue according to the review date
- Onward mitigation of the risk associated with multiple systems in the context of safeguarding review

| TOPIC SCOPE AND OVERSIGHT | |
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| **Scope of the topic** | **What is covered**<br>The scope of safeguarding adults is broad and multi-faceted, covering a plethora of workstreams. To give some perspectives there are ten identified adult abuse types categorised within the Care Act 2014, these being physical, psychological/emotional, financial, domestic abuse, organisational, neglect/acts of omission, self-neglect, modern slavery, discrimination, sexual. Prevent is also covered under safeguarding – identifying and reducing the risk of radicalisation. The Strategic Lead & Named Professional for Safeguarding Adults is the Prevent Lead for the Trust.<br><br>**Limitations to what is covered**<br>Due to the broad aspect of safeguarding adults, and limits on capacity, the Safeguarding Service is unable to undertake targeted work across the whole of the Trust, nor develop specific workshops for each abuse type.<br><br>All topics are covered within the safeguarding adults' level 3 training to which all line managers and senior leads are mapped, as well as the e-learning for health safeguarding adults' level 1 & 2 training. Priority focus for safeguarding CPD workshops and additional learning is given to identified learning needs from Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) in |

addition to any wider national agenda.

**Specifics on which aspects of the organisation are covered (the default being all services throughout the whole organisation) including specific arrangements addressing individual areas.**

All Trust colleagues have roles and responsibilities for safeguarding adults, and for patients in our care who are at risk of or suffering from abuse. This is in line with the RCN Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) to which all staff are mapped.
Adult Safeguarding: Roles and Competencies for Health Care Staff | Royal College of Nursing (rcn.org.uk)

**Safeguarding Adult Reviews (SAR)** - Within the scope of this report 2022/23 the Trust Safeguarding Service received requests for information for three potential statutory Safeguarding Adult Review (SAR) cases and in addition referred three cases of self-neglect to the Somerset Safeguarding Adults Board (SSAB) for consideration for SAR. The SSAB were already considering two other self-neglect related deaths, therefore made the decision to hold a thematic review for 5 cases of self-neglect. In all the self-neglect SARs, the Trust had contact with the individuals and opportunities to intervene were missed. SAR TM and SAR KS were agreed by the Somerset Safeguarding Adults Board (SSAB). The Trust received 4 recommendations from these reviews, of which two were joint recommendations with other agencies.

As a result of this learning the Trust Safeguarding Service relaunched it's CPD Self-Neglect Workshop in quarter 1 2023/24 to the neighbourhood teams. It is anticipated that this workshop will be extended to the Trust's Mental Health Services in quarters 2-4 2023/24. Additionally, Self-Neglect is a key safeguarding adult priority within the new Safeguarding Service Strategy 2023-2026.

**Domestic Homicide Reviews (DHR)** - Within the scope of this report the Trust's Safeguarding Service received notification of 9 Domestic Homicide Reviews (DHR's). Internal Management Reviews (IMR's) and chronologies were submitted for 7 DHRs. At the time of this report, notification for requests for a further two chronologies and IMRs is pending. Initial primary learning for the Trust from current DHRs relates to Domestic Abuse Routine Enquiry (DARE) and awareness of domestic abuse referral pathways for minor injuries units.

Development and launch of Domestic Abuse Routine Enquiry (DARE) Continual Professionals Development (CPD) workshops in quarter 4 2022/23 were delivered to Trust Mental Health Services. Plan to deliver workshop to Minor Injuries Units and Emergency Departments by quarter 3 2023/24, in addition to providing DARE train the trainer workshops to enable wider dissemination of the DARE workshop. Collaboration and discussion with the Trust's Suicide Prevention? Lead regarding including the links between domestic abuse and suicide/suicidal ideation, within clinical risk management training.

**Sexual Safety** – The CQC report on Sexual safety on mental health wards (2018) concluded that sexual incidents are commonplace on mental health wards, that they affect both staff and patients and that they may cause significant and lasting distress. The Trust's Mental Health Services have developed a Standard Operating Procedure for Sexual Safety on Mental Health Inpatient Units.

The Trust's Safeguarding Service, in collaboration with the Trust's Risk Team has

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| | identified, through Radar reporting and contacts to the Safeguarding Service Duty Team, that this issue is not solely occurring within our mental health units, but also within our acute hospital wards. This has resulted in the Trust making safeguarding referrals, some of which have resulted in s42 safeguarding enquiries.<br><br>In collaboration with the Risk Team and Associate Director for Patient Care for Mental Health and Learning Disability we have developed a Sexual Safety Best Practice Group (Trust wide) to help address the issue of sexual safety of patients in our care, and of our colleagues. The Safeguarding Service is developing a Sexual Safety Policy (due to be ratified in quarter 2 2023/24), the Best Practice Group will be developing sexual safety information leaflets / posters for patients and colleagues. To date a sexual safety information video for colleagues has been developed.<br><br>As part of a wider 'health' initiative the Trust will work collaboratively with the Integrated Care Board and other health partners as part of a wider 'health' objective regarding sexual safety across the health system.<br><br>**Outline of topic-relevant links to strategy and other high-level Trust objectives.**<br><br>In line with the wider Trust mission our aim is to support the health and wellbeing of patients in our care through ensuring that any risk of abuse or disclosure of abuse receives a robust and coordinated response, by supporting our colleagues by cultivating an inclusive culture of kindness, respect, and teamwork.<br><br>In line with Trust Safeguarding Strategy, we aim to support our colleagues to deliver the best care and support through a compassionate, inclusive, and learning culture. We do this by ensuring Trust colleagues have a working knowledge of safeguarding adults through mandatory training and through the support and guidance from our safeguarding duty team, to ensure the safety of patients in our care.<br><br>Key priority areas identified for safeguarding adults within our Safeguarding Service Strategy 2023-2026 are Domestic Abuse & Domestic Abuse Routine Enquiry and Self-neglect. As stated above, the Safeguarding Service is working in collaboration with other key partners across the Trust in the development of a Sexual Safety Strategy. The aim of these key safeguarding adult strategies is to ensure we support the Trust's strategic objective in developing a high performing organisation collectively delivering the vision of our Trust regarding patient care and wellbeing, reducing inequality, responding well to complex safeguarding needs. |
| **Reporting Structure/ Specialist Group oversight** | For Safeguarding Service assurance framework and governance structure please see Appendix 1<br><br>The Safeguarding Committee (SC) is a formally constituted Committee within the Trust's integrated governance structure and reports to the Quality Assurance Group as part of the Trust's assurance framework. The committee meets quarterly.<br><br>The SC has delegated authority from the Trust Board to oversee and monitor the Safeguarding of Adults, Children and Young People, Domestic Abuse, Prevent, MAPPA and MCA and DoLs arrangements for the Trust and to ensure that all safeguarding functions are embedded in the governance structures of the organisation.<br><br>The Committee has the authority to request information of relevance to its remit and to require the co-operation of all colleagues associated with achieving its purpose |

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| | and responsibilities.<br><br>Additional reporting / assurance mechanisms:<br>• Monthly to the Integrated Care Board (ICB) via their Safeguarding Dashboard<br>• Quarterly to the Somerset Safeguarding Adults Board Performance and Quality Assurance Subgroup<br>• Quarterly reporting to NHS Digital Prevent Submissions<br>• Yearly to the Quality and Governance Assurance Committee |

| **COMPLIANCE REQUIREMENTS** | |
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| **Regulation**<br><br>**CQC Fundamental Standards** | The CQC has five Fundamental Standards, these being Safe, Effective, Responsive, Caring, Well-led.<br><br>Health and Social Care Act 2008 (regulated Activities) Regulations 2014 Safeguarding Compliance Standards: Regulation 13: Safeguarding service users from abuse and improper treatment.<br><br>Summary from the regulation:<br><br>*"Providers must have robust procedures and processes to prevent people using the service, from being abused by staff or other people they may have contact with when using the service, including visitors. Abuse and improper treatment include care or treatment that is degrading for people and care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint."*<br><br>*"Where any form of abuse is suspected, occurs, is discovered, or reported by a third party, the provider must take appropriate action without delay. The action they must take includes investigation and/or referral to the appropriate body. This applies whether the third party reporting an occurrence is internal or external to the provider".*<br><br>There are referral Pathways in place for Safeguarding Adults, Domestic Abuse, Prevent.<br><br>Mapping to the CQC Key Lines of Enquiry to safeguarding adults:<br>Safe (S3): Are there reliable systems, processes, and practices in place to keep people safe and safeguarding from abuse?<br><br>The Trust has the following procedures and processes regarding safeguarding adults:<br>• Managing allegations against staff That Constitute Safeguarding Concerns for Patients SOP July 2023<br>• Safeguarding Adults Policy 2022<br>• New Sexual Safety Policy (currently under development)<br>• Domestic Abuse Policy (patients) 2023<br>• Supporting Colleagues who are experiencing Domestic Abuse Policy 2023<br>• Prevent: Safeguarding from Radicalisation Policy.2022<br><br>Safe (S4): How are the risks to people who use services assessed, and their safety monitored and maintained?<br><br>Safeguarding Adult training identifies risk indicators for abuse and neglect. The Trust's Safeguarding Service Duty Team provide advice via their single point of |

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| | contact. Colleagues are advised to refer to the Safeguarding Adults Board Adult Safeguarding Risk Decision Making Toolkit.<br><br>Within the incoming CQC Single Assessment Framework, a new quality statement features as part of the provider commitments under the Safe domain:<br><br>*'We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.'*<br><br>The work of the safeguarding service and the ethos for safeguarding throughout the Trust align with these core aims. |
| **Legislation** | The primary legislation relating to safeguarding adults is as follows:<br><br>**The Care Act (2014)**<br>The Care Act 2014 sets out a clear legal framework for how local authorities and other agencies should protect adults at risk of abuse and/or neglect. In respect of legislative requirements, Sections 42 to 47 of the Care Act places safeguarding on a statutory footing.<br><br>The Trust's Safeguarding Service addresses these duties by:<br>• Advice and support regarding safeguarding adult concerns / referrals, primarily via our Duty Team Single Point of Contact (SPOC)<br>• support / advice on undertaking s42 safeguarding enquiries.<br>• Representation at local Safeguarding Adult Reviews and Domestic Homicide Reviews<br>• Dissemination of learning from Safeguarding/Domestic Homicide Reviews and provision of Safeguarding Adult Training as per the Intercollegiate Document.<br><br>**PREVENT (section 26 of the Counter Terrorism and Security Act (2015)**<br>The NHS Standards Contract requires all NHS funded providers to demonstrate their compliance with the requirements of the PREVENT duty. This includes:<br>• Ensuring the Trust has a PREVENT Lead (the Strategic Lead & Named Professional for Safeguarding Adults is the PREVENT Lead for the Trust)<br>• Include in Policy and Procedure, and comply with, the principles contained in the Government Prevent Strategy- this is in place.<br>• Trust representation at Channel Panel / Prevent Board (the Strategic Lead & Named Professional for Safeguarding Adults is the PREVENT Lead for the Trust)<br><br>**Domestic Abuse Act 2021**<br>The Domestic Abuse Act came into force in April 2021. The Act places domestic abuse within statute for the first time, providing a statutory definition of domestic abuse. Domestic abuse is an abuse category under the Care Act 2014 and therefore sits within the safeguarding scope for the Trust.<br><br>**Domestic Violence Crime and Victims Act (2004) – Part 1(9)**<br>Section 1 (9) of the Domestic Violence Crime and Victims Act sets in statue the |

requirement of the establishment and conduct of reviews (domestic homicide reviews). Domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect (including suicide). The Trust's Strategic Lead & Named Professional for Safeguarding Adults ensures that it meets its statutory duties regarding Domestic Homicide Reviews.

**Modern Slavery Act 2015**
The Modern Slavery Act is a far-reaching piece of legislation that consolidates previous slavery and human trafficking offences, by introducing new preventative measures, support systems and a regulatory body. Modern slavery is a category of abuse under the Care Act 2014, and therefore sits within the scope of the Safeguarding Service.

**Human Rights Act (1998)**
Human rights are intrinsic to all safeguarding work. The Trust is responsible for recognising and adhering to its legal obligations as set out in the Human Rights Act 1998. The Trust's Safeguarding Service is responsible for ensuring that all safeguarding advice that they give to Trust colleagues does not breach an individual's human rights, unless that breach is lawful and proportionate, for example in line with the Mental Capacity Act (2005), Mental Health Act (1983, revised 2007), GDPR and the Data Protection Act (1998).

**Equality Act (2010)**
The Equality Act (2010) legally protects people from discrimination in the workplace and in wider society and is therefore relevant to safeguarding adult work and intervention. Discrimination is an abuse type as defined by the Care Act (2014), and therefore sits within the scope of Safeguarding for the Trust.

**Mental Capacity Act (2005) / Mental Capacity Act Codes of Practice**
The MCA and Code of Practice provides a framework for the application of the Mental Capacity Act (2005) into everyday practice when caring for patients with diminished capacity. The Trusts MCA & DoLS Lead is responsible for this area of work and this sits within the scope of Safeguarding for the Trust.

**Deprivation of Liberty Safeguards (DOLS)/ DOLs Codes of Practice**
Provides a framework for the Deprivation of Liberty Safeguards into everyday practice when caring for patients with diminished capacity, whose care and treatment may amount to a deprivation of liberty. The Trusts MCA & DoLS Lead is responsible for this area of work and this sits within the scope of Safeguarding for the Trust.

**Multi-Agency Public Protection Arrangements - MAPPA (Criminal Justice Act, 2003)**
Whilst MAPPA is not 'Safeguarding' per se, the Trusts Director of Safeguarding has assumed responsibility for ensuring the Trust meets it statutory duties as a 'Duty to Cooperate Agency' and is a member of the local Multi Agency Public Protection Arrangements Strategic Board. The 'Duty to Cooperate Agency' responsibility arises from the Trust being a provider of health services. MAPPA is the framework of statutory arrangements to manage and reduce risk presented by sexual and violent offenders within the community, with the aim of reducing risk of re-offending and ensuring public protection. The Director of Safeguarding has proposed additional resource into the Safeguarding Advisory Service to fully support all of the Duty to Cooperate requirements. This is currently being considered by the Trust Executive Directors.

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| **National Guidance**<br><br>**Assessment or accreditation** | DHSC Care Act: Care and support statutory guidance (Updated 1 June 2023)<br><br>RCN (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff<br><br>DHSC (2022) NHS Prevent training and competencies framework guidance.<br><br>NICE Domestic violence and abuse. Quality standard [QS116] Published: 29 February 2016 - This quality standard covers services for domestic violence and abuse in adults and young people (aged 16 and over). It includes identifying and supporting people experiencing domestic violence or abuse, as well as support for those who carry it out.<br><br>Home Office (2023) Modern Slavery: Statutory Guidance for England and Wales (under s49 of the Modern Slavery Act 2015) and Non-statutory guidance for Scotland and Northern Ireland. Modern Slavery: Statutory Guidance for England and Wales (under s49 of the Modern Slavery Act 2015) and Non-Statutory Guidance for Scotland and Northern Ireland (publishing.service.gov.uk) |

## INTERNAL ASSURANCE – Summary information generated within the organisation

| Assessing guidance and measuring the topic internally | |
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| **Self-Assessment of national guidance implementation** | DHSC Care Act: Care and support statutory guidance (Updated 1 June 2023)<br>Assurance: Safeguarding Adult Policy and training - training compliance data. Safeguarding. It is anticipated a Safeguarding Adults audit will be undertaken qtr 3-4 2023/24 following proposed change of process from qtr2 2023/24.<br><br>RCN (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff<br>Assurance: Review of mapping/re-mapping; Training compliance data 2023.<br><br>DHSC (2022) NHS Prevent training and competencies framework –<br>Assurance: Completion of Training Needs Analysis and training compliance data. Quarterly reporting to NHS Digital. Development of Prevent Delivery Plan 2023.<br><br>NICE Domestic violence and abuse. Quality standard [QS116] –<br>Assurance: Domestic Abuse Policy; Domestic Abuse Audit. Domestic Abuse Development plan scheduled for Qtr 2 2023/24; DARE workshop.<br><br>There was no bi-annual SSAB self-assessment requested within this financial year. However, current collaborative work with the ICB is ongoing regarding an action plan resultant from the SSAB self-audit 2021/22.<br><br>Key areas of development include:<br><br>a) *Empower staff and volunteers in your organisation to use multiagency escalation of risk and professional differences policies. Your organisation is assured that these are being used effectively to aid everyday practice.*<br><br>Collaborative working with SSAB subgroup and ICB Designate Nurse for safeguarding adults to review and update current SSAB Resolving Professional Differences Process. Once completed, this will be shared across the Trust via various means. |

*b) What systems and support are in place to ensure that professional curiosity is demonstrated in practice?*

The Trust has a 7-minute briefing document for Professional Curiosity. Professional Curiosity is also addressed via Safeguarding Adults Level 3 training. The Trust's Safeguarding Service Duty team ensure their advice and guidance encourages colleagues to be professionally curious in their work with patients where there are safeguarding concerns. Furthermore, the volume of enquiries the Duty Team receives into the single point of contact is an indicator that Trust colleagues are being professionally curious, regarding safeguarding concerns, within their daily practice.

*c) What work is being done within the organisation to engage with people who have a lived experience, in particular adults with protected characteristics or underrepresented communities? What challenges have you identified and how has the organisation overcome them?*

Currently considering how to undertake targeted work relating to safeguarding and underrepresented groups – identify challenges / barriers to engaging with safeguarding services. It is anticipated that this work will begin in qtr. 3 or 4 2023/24.

*d) Adults with care and support needs who are transitioning into or between adult services are being supported effectively*.

The Trust Safeguarding Service has redeveloped existing resources to enable the recruitment of a Band 7, full-time, Exploitation and Transitions Lead post. The Trust also has Transitions lead in the Children, Young People and Families Service Group.

**Safer Somerset Partnership Domestic Abuse self-assessment undertaken in Qtr 1 2022/23.**

**Key area of note**:
Assessment statements –
"*Our Organisation/Agency has a routine question in relation to domestic abuse on our service user referral forms."*

The Trust does not have a blanket domestic abuse routine enquiry (DARE) process at referral / assessment.

Work is underway to address this via the introduction of a Domestic Abuse Routine Enquiry (DARE) workshops. Initially the workshops were rolled out in qtr. 4 2022/23 to the Trust's Mental Health Services and achieved a 17% attendance (225 Staff trained) within that time.

Qtr. 1 2023/24 a review of the workshop (including staff feedback) will be undertaken with a view to roll-out to Emergency Departments and Minor Injuries Units and ultimately more widely across the Trust. This will be a significant undertaking, made more difficult by Domestic Abuse training not currently being mandatory.

*"Our Organisation/Agency has in place a Domestic Abuse training program for all staff delivered to an appropriate level depending on their role".*

Currently domestic abuse training is not mandatory. In order to address this a Domestic Abuse Awareness e-learning module was developed and incorporated into

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| | the Safeguarding Adults Levels 1-3 Local Processes e-learning module, therefore including the module within already established mandatory training. As a result of this 91.5% of staff have now received Domestic Abuse Awareness during 2022/23 financial year (initially just 17% from staff mapped to safeguarding adults L3 which does have a domestic abuse section). |
| **Audit and Measurement – key findings** | No safeguarding adult audits were undertaken during this financial year (2022/23), this was to enable prioritising collaborative organisational and strategic planning with the ICB regarding service and process development (both collective and individual), in addition to prioritising workstreams related to the high number of Safeguarding Adult Reviews and Domestic Homicide Reviews during 2022/23. It is anticipated that this work will better inform future audits and possible cross-system 'health' audits in this coming year.<br><br>The Trust Safeguarding Service continues to provide:<br>• Safeguarding adults and Prevent training data to the ICB, via their monthly ICB Dashboard.<br><br>• Prevent training and referral data quarterly to NHS Digital via their online portal, which is shared with the ICB and Trust Safeguarding Committee for assurance.<br><br>**Section 42 safeguarding enquiries**<br>Within the financial year covered by the scope of this annual report, ten section 42 safeguarding enquiries were raised against the Trust. The concerns related to organisational abuse, neglect/acts of omission, physical abuse, sexual abuse.<br><br>**Table 1: section 42 safeguarding enquiries raised against the Trust 2022/23** |

| Quarter | No of s42 against the Trust | Abuse type | Brief outline | outcome | Assurance |
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| 1 | 2 | 2x neglects/acts of omission | LD patient – failure to make reasonable adjustments | No outcome received to date | Trust is rolling out Oliver McGowan training which will help address issue of reasonable adjustments Trust RCA |
| | | | LD patient – weight loss – failure to account for reasonable adjustments | substantiated | |
| 2 | 3 | 1 x sexual | MH ward – female patient alleged sexual assault by bank staff | substantiated | Development of sexual safety Policy and sexual safety strategy and information leaflet/posters for patients |
| | | 1 x organisational | Acute ward MPH – unlawful detention – DOLS not applied | substantiated | Ward given bespoke refresher training on DoLs/MCA |
| | | 1 x physical | Acute ward (LD | No outcome | Concern |

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| | | | patient)– MPH – rough handling by bank agency staff | received to date | reported to agency |
| 3 | 4 | 2 x organisational | Absconded from MH ward whilst on s3 | Unsubstantiated | Broken door lock repaired |
| | | | Absconded from Acute ward whilst on DoLs | Partially substantiated | Ward given bespoke refresher training on DoLs/MCA |
| | | 2 x neglect/acts of omission | LD patient – lack of reasonable adjustments | No outcome received to date | Oliver McGowan training |
| | | | Hospital acquired pressure damage MPH – short staffed on ward, reliance on HCA/agency | substantiated | Email to TVN lead to consider review of PU training. PU Policy being updated. |
| 4 | 1 | Neglects / acts of omission | Hospital acquired pressure damage MPH | substantiated | As above. Emerging theme of hospital acquired PU reported to TVN lead. |

This information clearly evidences the importance of the need for colleagues to prioritise and be compliant with their mandatory safeguarding training (and all mandatory training regarding patient care and clinical risk).

All s42 enquiries raised against the Trust are reported to the Integrated Care Board (ICB) via their Safeguarding Dashboard in addition to the Trust Safeguarding Committee.

**The Trust's Domestic Abuse Audit** was started in qtr. 1 2022/23, however due to the high demand of MARAC (weekly Multi – Agency Risk Assessment Conferences with minimum 20+ cases to research /review/ action) and participation in the Domestic Homicide Reviews, completion of the audit was postponed until qtr. 1 2023/24, therefore is yet to be signed off. However, an outline of the draft report is set out below.

Clinical audit objectives:

- To ensure the Trust has an effective process for referrals for domestic abuse in line with the Trust Domestic Abuse Clients' Policy
- To ensure the referral forms are of a good quality and contain enough information about the client and their situation to satisfy a referral to SIDAS
- To ensure the risks are accurately recorded on the client record.

**Table 2: Compliance rate of 90% was met in all but two standards**.

| **STANDARD** | **COMPLIANCE %** *and denominators / numerators* |
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| When a concern regarding domestic abuse has been identified, a DASH Risk Assessment must be completed | 95% (n=54/57) |

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| If the client declines to undertake the DASH assessment and / or SIDAS/MARAC referral, the following should be given to the client:<br>a) Contact details for the Local Domestic Abuse Support Line 0800 69 49 999<br>b) Somerset Survivors Website www.somersetsurvivors.org.uk | a) 4/4<br>b) 3/4 |
| If the client declines to undertake DASH assessment and / or SIDAS/MARAC referral consider whether a referral to MARAC needs to be made on professional judgement | 2/4 (50%) |
| The referral form should contain a minimum of the following information to be of a good quality:<br>a) Consent<br>b) Safe contact details<br>c) Referral information<br>d) Demographic of the person causing harm<br>e) Actuarial risk (DASH score)<br>f) Risk(s) clearly identified | a) 95% (n=54/57)<br>b) 91% (n=52/57)<br>c) 58% (n=33/57)<br>d) 91% (n=52/57)<br>e) 91% (n=52/57)<br>f) 91% (n=52/57) |
| The duty team should quality assure the referral form to an acceptable standard | 91% (n=52/57) |
| The following should be updated on the client record:<br>a) risk alert/risk flag<br>b) risk information | a) 21% (n=12/57)<br>b) 89% (n=51/57) |
| The actions taken for the client must be documented on the client record | 95% (n=54/57) |
| Any additional safeguarding or child protection issues should be considered | 100% (n=57/57) |

The second and third reported compliance levels/standards have been shaded in grey due to them being informed by very small numbers (3/4 and 2/4 respectively), therefore these figures are insufficient to support a clear conclusion about the standard of practice for these measures.

Initial findings from the domestic abuse audit.
Key areas for improvement:

- Inconsistency of recording across multiple electronic patient record systems to ensure risk of domestic abuse is identified, recorded, and shared.
- Inconsistency in notification from SIDAS of the outcomes of Trust made referrals. This learning point is outside of our control but has been raised as a concern with the SIDAS manager.

Key strengths identified:

- The duty team are quality assuring referrals to an acceptable standard, and there is evidence of good practice.
- In every case there was evidence that additional safeguarding or child protection issues had been considered.
- In 95% of cases, the actions taken were clearly recorded within the client's electronic record.

| **Policy and assurance of meeting policy standards** | |
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| **Policy and review status** | • Safeguarding Adult Policy – in date – review due July 2025<br>• Domestic Abuse Policy – in date - review due November 2023<br>• Supporting Colleagues who are Experiencing Domestic Abuse – in date (minor updates 2022) – review due September 2025<br>• Safeguarding: Prevent Policy – in date – review due May 2024<br>• MAPPA policy – review complete March 2023, pending approval |

- Sexual Assault Disclosures Protocol – in date – review due May 2025
- Disclosures of Alleged Non-Recent Abuse Standard Operating Procedure – in date – review due May 2025
- Modern Slavery Protocol (new) – pending safeguarding committee sign off (qtr 2 2023/24)

We are currently developing a new Sexual Safety Policy. It is anticipated that this new Policy will be finalised in qtr 3 2023/24.

**Monitoring policy compliance**

Summary of policy compliance monitoring assurance, **in line with the defined monitoring arrangements within the relevant policy or policies.**

**Safeguarding Adults Policy**

| Element for Policy monitoring | Monitoring method | Monitoring frequency | Arrangements for responding to Shortcomings and tracking delivery of planned actions | Comments / plan to address monitoring element / frequency not met |
|---|---|---|---|---|
| Safeguarding referral process, raising concerns and referrals for high-risk cases | Audit: safeguarding referrals – effectiveness safeguarding referral process<br>- criteria regarding s42 enquiries/ appropriate application of thresholds<br>- check quality and appropriateness of referrals | Minimum three yearly | Development of action plan<br>Reporting to safeguarding committee and IQAB<br>Identification of training needs. | Audit to be completed qtr 4 2023/24<br><br>Safeguarding referral process will be changing in qtr.3 2023/24.<br><br>Training needs analysis following merger with YDH |
| Safeguarding referral pathway and Raising a safeguarding adult concern | Non-referred cases. Snapshot quality monitoring (average 20 cases per year) to check:<br>Appropriateness of contact<br>Evidence of risk assessment prior to contact<br>Effectiveness/quality of Safeguarding team screening and advice | Annually | To form part of main audit.<br>Development of action plan as required.<br>Reporting to safeguarding committee and IQAB | No audit completed. Plan to complete audit in qtr 3 2023/24<br><br>Process of escalating to the local authority when a safeguarding referral is declined (resolving professional differences). |
| Making safeguarding personal (MSP) | Review of safeguarding adult referrals to determine client involvement in decision making process regarding safeguarding referrals (included as part of safeguarding referral audit). | Annually | To develop action plan if needed<br>If shortcomings identified, to reinforce importance of client involvement via training, safeguarding supervision and staff newsletter.<br>Reporting to safeguarding committee. | No audit completed this year, however monitoring via regular review of data recording on safeguarding referral spreadsheet. Evidence of MSP present. |
| Training | Collation of data for | Monthly, | Monthly ICB | To continue with |

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| competencies and requirements | mapped training compliance and competencies | quarterly and annually | Dashboard, quarterly to safeguarding committee Annually – Topic Assurance report | current assurance reporting structure |

Safeguarding Adult Referral Pathways are being reviewed in quarter 2 2023/24. Liaison with our Local Authority partners is scheduled for quarter 1 2023/24. This review is required due to the increasingly high volume of contacts the Duty Team single point of contact receives and the recognition that current process and pathways instigated in 2018, following the merger between Somerset Partnership and Taunton and Somerset Foundation Trust, are no longer robust and potentially puts patient safety at risk due to the current process/pathway causing delay in submission of safeguarding referrals.

**Domestic Abuse Policy**

| Element for Policy monitoring | Monitoring method | Monitoring frequency | Arrangements for responding to shortcomings and tracking delivery of planned actions | Comments / plan to address monitoring element / frequency not met |
|---|---|---|---|---|
| Domestic abuse referral process | Audit: domestic abuse referrals | Bi-annually | Development of action plan. Reporting to safeguarding committee Identification of training needs | Audit competed |
| training | Not mandated – however DA awareness can be monitored via safeguarding training compliance rates | monthly | Monthly ICB Dashboard. Increase number of training sessions | In April 2023 – introduction of DA awareness into SGA e-learning modules levels 1-3 to ensure all staff have DA awareness training |
| Domestic homicide review panel meetings | Trust representation at DHR panel meetings | As required | Reporting process in place via Trust's Safeguarding Committee | In 202/23 provided representation for 8 new DHR's at panel meetings in addition to continuing DHR's from previous years. |
| Marac meetings | Trust representation at MARAC meetings | Approx 4 per month | Reporting to Safeguarding Committee and Topic Report | Weekly attendance at MARAC meetings Contribution to MARAC development with safer somerset partnership Representation at DA Board. |

Domestic Abuse referral process and pathways will be reviewed in quarter 2 2023/24. This is to accommodate the newly proposed referral pathways being instigated by Somerset Integrated Domestic Abuse Service (SIDAS) and MARAC. Discussions with SIDAS and Safer Somerset Partnership colleagues is scheduled

to begin during quarter 1 2023/24. Domestic abuse equated to 32% of contacts into the duty team single point of contact in financial year 2022/23.

**Supporting Colleagues who are Experiencing Domestic Abuse**

| Element for Policy monitoring | Monitoring method | Monitoring frequency | Arrangements for responding to shortcomings and tracking delivery of planned actions | Comments / plan to address monitoring element / frequency not met |
|---|---|---|---|---|
| Support provision | Audit relating to colleague domestic abuse related contacts to HR to ensure correct process followed | Minimum 2 years - to People Governance Committee<br><br>Responsibility for HR manager | If the People Governance Committee identifies a concern, they will oversee the development of an action plan or escalate as appropriate to the Director of People Services | It was anticipated that this Policy would be transferred to People Services / HR but this has not yet been possible, therefore no audit completed as this data is not collected by the safeguarding service. |

Colleagues experiencing domestic abuse are supported by line managers, people services and can receive advice from the Trust's DA Lead. They will also receive signposting to local domestic abuse support services. Colleagues are unlikely to meet referral criteria for an adult safeguarding referral unless they have care and support needs and are unable to keep themselves safe because of those needs. Primarily this is why this Policy would be best placed with HR / People Services.

Plan to liaise with HR/people services in qtr 4 2023/24 to discuss viability of transfer of this Policy to them.

**Prevent (safeguarding from radicalisation) Policy**

| Element for Policy monitoring | Monitoring method | Monitoring frequency | Arrangements for responding to shortcomings and tracking delivery of planned actions | Comments / plan to address monitoring element / frequency not met |
|---|---|---|---|---|
| Safeguard and support those at most risk of radicalisation through early intervention, identifying them and offering support and onward referral as appropriate | Audit:<br>- Prevent enquiries to safeguarding Service SPOC<br>-recording of concern on electronic patient records<br>- Appropriate onward referral | Minimum 3 yearly | • Development of action plan<br>• Reporting to Safeguarding Committee<br>• Identification of training needs | No audit completed due to low level of Prevent referrals (see summary below).<br>As assurance all Prevent referrals are QA by duty team and shared with Prevent Lead |
| Colleagues aware of their role in preventing vulnerable people from being exploited for terrorist purposes. The Counter Terrorism and Security Act 2015 | All colleagues to have completed the appropriate level of Training. Data received from training department regarding compliance. | Monthly/ quarterly | Monthly ICB DASHBOARD data reporting, NHS Digital Prevent Data reporting | End of year Prevent training compliance<br><br>Level 1&2 – 92.3%<br>Level 3 – 92.2% |
| Partnership working - Collaboration with external agencies, | Providing Trust representation at Local | yearly | Reporting to IQAB through annual audit | Attendance at monthly Channel Panel, quarterly |

| | | | | |
|---|---|---|---|---|
| fulfilling Prevent duty to attend Channel Meetings | Channel Panel Meetings | | | Prevent Board, quarterly south west Prevent network meetings, quarterly attendance at Community Safety Partnership meetings |

During 2022/23 the Trust made four referrals to Prevent for consideration for Channel Panel. At time of writing this report, one referral was accepted into Channel, two were declined, one outcome pending.

The Trust provides appropriate representation at all Channel Panels (as per our duty). In addition to the Prevent Lead, the Trust also has a Clinical Mental Health Prevent Lead.

**Multi Agency Public Protection Arrangements (MAPPA) policy**

| Element for Policy monitoring | Monitoring method | Monitoring frequency | Arrangements for responding to shortcomings and tracking delivery of planned actions | Comments / plan to address monitoring element / frequency not met |
|---|---|---|---|---|
| Appropriate referrals are made into the MAPPA/ Potentially Dangerous Persons (PDP) process – eligibility criteria met | All referrals are screened<br>All referrals are logged<br>All referrals (and referral outcomes) are included in MAPPA update briefings to the safeguarding committee<br>Audit of MAPPA/PDP referrals | Once every two years | Update briefings and Exceptions reporting to Trust's Safeguarding Committee.<br>Inclusion (as appropriate) in to IQAB annual report | Responsibility for quality assurance of MAPPA and PDP referrals transferred to Forensic Service at the current time |
| County Wide multi-agency Quality Assurance of MAPPA referrals and MAPPA process | Trust's standing members attend MAPPA audit group | minimum once yearly | Exceptions reporting to Trust's safeguarding committee. | Arranged by the Avon & Somerset Police and Probation MAPPA coordinator, but did not occur within this financial year |
| Trust representation at Local MAPPA meetings | Trust's standing members attend twice monthly MAPPA meetings relative to the Trust being a 'Duty to Cooperate' agency | Minimum yearly | Update briefing to Safeguarding committee.<br>Inclusion in Annual IQAB report | Representation provided by Forensic Service |

During financial year 2021-22 responsibility for MAPPA was transferred to the Trust's Forensic Service who were already quality assuring MAPPA / PDP referrals and providing Trust representation at MAPPA meetings. The Director of Safeguarding resumed representation at MAPPA Strategic Management Board (SMB)to ensure 'whole Trust' representation, which the Forensic service identified was beyond their remit. It was initially anticipated that MAPPA Policy would transfer to the Forensic Service, but this did not occur for the reasons stated above (e.g., whole Trust representation).

| | |
|---|---|
| | Policy monitoring requirements regarding MAPPA processes and duty to cooperate responsibilities were maintained, through MAPPA panel membership provided by the Trust's Forensic Service and Strategic Management Board representation provided by the Trust's Director of Safeguarding.<br><br>During 2022/23 MAPPA largely sat outside of the Safeguarding Service and not under the roles and responsibilities of the Named Professional for SGA, therefore monitoring methods and arrangements were not reported to the Trust's Safeguarding Committee.<br><br>Following end of financial year review of this arrangement, it has been identified that there is a need for a specific MAPPA Lead post within the Safeguarding Service whose responsibility will be to coordinate and oversee the Trust's MAPPA duties, reporting to the Director of Safeguarding. In Quarter 1 2023/24 the Director of Safeguarding will prepare a Briefing Paper to present to the July QOPF meeting identifying the gaps within our current MAPPA provision. It is anticipated that a MAPPA audit will be undertaken in quarter 4 2023/24. |

| **Colleagues: Training and competencies** | |
|---|---|
| **Training and competency requirements** | The Trust's Safeguarding Adult training competency requirements are aligned to the RCN (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff and the Prevent training is aligned to the DHSC (2022) NHS Prevent training and competencies framework.<br><br>Compliance rates vary. The Trust's own required compliance rates are 90%, the ICB required compliance rates are 85%.<br><br>The compliance rates for Prevent reporting to NHS digital is 85%. Of note is that NHS Digital compliance rates includes bank staff, which is why compliance rates will vary between Trust figures (who don't include bank staff) and NHS Digital. |
| **Training Compliance** | In Quarter 1 2022/23 the Named Professional Safeguarding Adults, in conjunction with the Safeguarding Learning & Development (L&D) Lead undertook a training needs analysis for safeguarding adults and Prevent training.<br><br>Training compliance for Safeguarding Adults and Prevent at the end of financial year 2022-23 are shown in the tables below:<br><br>Compliance has been impacted over the last year 2022/23 due to remapping of staff and ongoing staff turnover. The continued impact of Covid 19 on workplace pressures, together with strikes and staff sickness and the decision not to chase attendance has resulted in increased non-attendance during this timeframe. To help address the non-compliance rates for Safeguarding Adults Level 3 the Safeguarding Learning and Development Lead will be providing additional sessions for the whole day training from quarter 1 2023/24, including face-to-face sessions. Of note is that the scoping of Yeovil District Hospital (YDH) safeguarding adult training in quarter 4 2022/23 (post-merger) has revealed a discrepancy in YDH safeguarding adult training. To address this a re-mapping review was undertaken resulting in 262 YDH colleagues needing to be re-mapped to Level 3. This will undoubtedly impact on our training figures once the compliance data is merged across the Trust.<br><br>We will continue to review the Safeguarding Adult training offer and add additional |

dates as required. However, of note is that we currently offer 80 places per session, but these are not filled. In order to help meeting compliance rates, colleagues need to be released from clinical duties to undertake the training as simply adding more dates does not address the issue of colleagues not booking on to training or not attending on the day.

**Table 3: Safeguarding Adults compliance rates**

| Course Name | Mar-23 Percentage Trained |
|---|---|
| Safeguarding Adults Level 1 | 94.6% |
| Safeguarding Adults Level 2 | 91.7% |
| Safeguarding Adults Level 3 | 74.8% |
| Safeguarding Adults Level 4 | 100% |

**Table 4: Prevent training compliance rates**

| Course Name | Mar-23 Percentage trained | Mar-23 Percentage trained (NHS Digital stats inc Bank staff) |
|---|---|---|
| Prevent Level 1 & 2 | 94.9% | 89% |
| Prevent Level 3 | 92.7% | 84% |

The increase in compliance rates over the past year has been as a result of a joint effort of the Safeguarding Service L&D Lead and the Trust's L&D team to highlight the Prevent training requirement across the Trust. This includes Bank Staff who are included within the NHS Digital Prevent training data collection.

Over the next financial year, as best practice, we are introducing the Preventing Radicalisation (Mental Health) Level 3 e-learning module for all mental health colleagues across the Trust mapped to Prevent Level 3. The Preventing Radicalisation (Mental Health) module has been specifically developed for this professional group and offers an introduction to the Prevent duty for mental health practitioners and explains how it aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. Completion of the module will provide an important foundation on which to develop further knowledge around the risks of radicalisation and the role that health and care colleagues can play in supporting those at risk. The training addresses all forms of terrorism and non-violent extremism. Mental health colleagues will complete this module the next time their Prevent training is due for renewal. It is anticipated that this will roll-out from June 2023.

From Quarter 1 2023/24 all YDH colleagues will be correctly mapped to Prevent training. To help avoid drop off in training compliance, colleagues who have been re-mapped will only be required to undertake the new level once their current compliance is due for renewal.

**Domestic Abuse** – Currently domestic abuse is not mandated as a stand-alone training module. However, learning from numerous Domestic Homicide Reviews

| | |
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| | has identified a key learning need for the Trust regarding domestic abuse awareness, recognition, and response. Domestic Abuse is included within the Safeguarding Adults level 3 training however this only equates to around 17% of Trust colleagues.<br><br>To address this issue, the current safeguarding adults e-learning levels 1-3 local processes module has been reviewed and revised and domestic abuse awareness incorporated into this. As a result of this change the Trust has moved from 17% of staff being trained in domestic abuse awareness to 74% at end of this financial year. *(At the time of writing this report the current figures as at end of June 2023 is 91.5% trained.)*<br><br>Learning from DHR's also included the need for domestic abuse routine enquiry (DARE) at the point of contact with any Trust service, but primarily with mental health services. In quarter 4 2022/23 we developed and delivered a DARE workshop to colleagues across our mental health services resulting in 17.37% mental health colleagues receiving the workshop (n=225 of 1295). To develop this further and to attempt wider dissemination of the workshop, the Safeguarding L&D lead has developed a train-the-trainer DARE workshop to enable mental health colleagues, who have completed the workshop, to deliver this to their teams. It is anticipated that the train-the trainer workshop will roll-out from quarter 2 2023/24.<br><br>It is anticipated in quarter 3 2023/24 the DARE workshops will be adapted for delivery to Emergency Departments and Minor Injury Units (MIUs) and embrace a trauma informed approach. The Trust's mental health services are separately developing trauma informed approach training for mental health colleagues. |

| **EXTERNAL ASSURANCE – Summary of topic-relevant feedback** | |
|---|---|
| **External Reviews / Assessments** | In September 2022 the CQC assessed the Trusts Safeguarding Arrangements as providing robust assurance:<br><br>*'The trust had robust arrangements for safeguarding adults and children. There was a clear governance structure for reporting to the trust board, with identified leads for child and adult safeguarding.*<br>*Safeguarding matters were reported to a safeguarding committee, which in turn reported to the quality assurance committee and to board in an annual report. The chief nurse was the executive lead for safeguarding, with a director of safeguarding in post. The merger of YDH and SFT provides the opportunity to create a single Integrated Safeguarding Service.'* |
| **External / Internal organisational Audits** | There were no external organisational audits for Somerset NHS FT during the scope of this annual report. The internal maternity audit of domestic abuse was undertaken in 2022-23 |
| **National Audits / Surveys** | There were no national audits/ surveys during the scope of this annual report. |

| **ENGAGEMENT AND INVOLVEMENT** | |
|---|---|
| **Colleague** | The Care Act (2014) six principles are:<br>1. Empowerment - People being supported and encouraged to make their |

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| **engagement** | own decisions and informed consent<br>2. Prevention - It is better to act before harm occurs.<br>3. Proportionality - The least intrusive response appropriate to the risk presented.<br>4. Protection - Support and representation for those in greatest need.<br>5. Partnership -Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.<br>6. Accountability - Accountability and transparency in safeguarding practice.<br><br>Feedback is sought from colleagues attending the safeguarding adults' level 3 training, most of which is positive with colleagues telling us that they will take what they've learnt into practice and utilise the resources shared during the training.<br><br>During the scope of this report the Safeguarding Service has not had the capacity to undertake an internal staff survey regarding the Trusts safeguarding adult systems and processes in place and the Prevent training competencies 2022. However, we do listen to feedback via emails and calls to inform our processes. |
| **Patient and public involvement** | The Trust's Safeguarding Service is not a patient facing service therefore we currently aren't engaged with focus groups, however, going forward we will consider how we can involve patients, families and carers where safeguarding referrals have been made to seek feedback regarding the current processes in place. |

| **ONGOING ISSUES & ACTIONS** | |
|---|---|
| **Current Issues** | Salient issues identified within this annual report are:<br><br>• The pause on audit that needed to be implemented due to the need to prioritise workstreams related to the high number of Safeguarding Adult Reviews and Domestic Homicide Reviews during 2022/23.<br><br>• Training compliance levels for Safeguarding Adults Level 3 continues to be at non-compliance, primarily due to the competing demands of colleagues needing to provide and prioritise patient care with needing to be released from rota's to undertake a whole day mandatory training. Additionally, pending the merger with YDH it has been identified that YDH colleagues had not been mapped to Safeguarding Adults Level 3 training. It is anticipated that this will have an impact on compliance figures for the next financial year, once YDH have been correctly mapped.<br><br>• The risks identified via the high level 'As Is' mapping for safeguarding commissioned by the Trust's improvement team, as reported in the 'Topic related Risks' section of this report. |
| **Integration status** | **Policy** – All safeguarding adult related Polices for both Somerset NHS Foundation Trust and Yeovil District Hospital were reviewed and aligned to be in place post-merger in April 2023. |

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| | **Group / committee structure, membership and reporting** – Post merger the safeguarding committee membership will include YDH colleagues as appropriate to ensure equity across the new Trust.<br><br>**Operational systems and processes (such as documentation in use)** – From April 2022 the YDH Head of Safeguarding's role was reviewed, enhanced and re-banded to enable her to work across both Trusts to ensure alignment of processes were in place prior to the merger of the two trusts in April 2023. The Duty Team manager, and Named professionals also contributed to the review of these processes.<br><br>**Internal assurance process, including audit and measurement** – No change to internal assurance processes as both organisations report to the ICB and NHS Digital, in addition to governance and an integrated safeguarding committee.<br><br>**All applicable training requirements** - Safeguarding training was reviewed and re-mapped to ensure colleagues within YDH were mapped correctly to the competencies framework and aligned with Somerset Ft staff.<br><br>Pending the merger of the two trusts, a number of the legacy YDH safeguarding service decided to retire from the service, which did initially impact on service provision. To ensure minimal disruption to colleague support across both Trusts, the safeguarding services from both trusts merged in November 2022 in preparation for the formal trust merger in April 2023. |
| **Topic-related Risks** | Current risk facing the Trusts Safeguarding Service and relevant to safeguarding adults is the impact on the duty team and service of recording across numerous systems. Relative to this is trust colleagues also having to work across multiple systems.<br><br>The Safeguarding Service formed in October 2018 ahead of the Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust merger in 2020. Since this time the team have had to work with the numerous IT systems employed by the Trusts to ensure the recording of safeguarding concerns, risks, alerts and actions are completed across said systems. The pending merger with YDH in April 2023 will introduce additional IT systems.<br><br>Prior to the pending merger the Trust improvement team commissioned high level 'As Is' mapping for safeguarding which showed a fully functional recording and reporting system to reflect the Trusts statutory requirements. The lead for the mapping completed an SBAR- 'Safeguarding As IS' in which he identifies the impact on the Safeguarding Service of having to access, review and record across the numerous electronic patient recording systems that currently exist across the Trust.<br><br>See Appendix 2 for copy of Risk Assessment. These are monitored by the Safeguarding Committee. |
| **Action plan delivery** | Action Plans for Safeguarding Adults relates largely to Domestic Homicide Reviews (DHRs), Safeguarding Adult Reviews (SAR) and Somerset |

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| | Safeguarding Adults Board (SSAB) Self-Assessment actions. In total this amounts to 16 action plans that were active within the scope of this review. Due to the high volume they have not been included within this report, however themes are reported below.<br><br>Key themes regarding the DHR's action plans are domestic abuse routine enquiry, professional curiosity, confirmation bias and Coercion and control. Action plans were in place for DHRs 030, 033, 035, 037, 038, 041, 042, 043, 045, 046. All action plans are completed apart for DHR 038 which is awaiting confirmation of any additional actions from the DHR Chair.<br><br>• Development and delivery of Domestic Abuse Routine Enquiry (DARE) workshops to trust's Mental Health Services,<br>• 7-minute briefings developed for Domestic Abuse Awareness, Professional Curiosity, and Confirmation Bias and Coercion and Control, disseminated via staff news and safeguarding intranet pages.<br><br>Key themes regarding SARs are self-neglect, legal literacy regarding the Mental Capacity Act 2005, discharge planning, referral pathways and familial domestic abuse. Completion dates for SAR actions run into the next financial year, however work is ongoing regarding recommendations / actions, some of which are multi-agency actions being coordinated via the SSAB learning and development sub-group. SARs within the scope of this review and related action plans are for SAR Susan, SAR KS, SAR TM – these are currently open. Action plans for SAR Damien, SAR, Luke, SAR Matthew are all complete and closed.<br><br>Actions taken:<br>• re-launch of self-neglect workshop – plan to deliver to trust's neighbourhood teams via webinar from qtr 1 – qtr 2 2023/24<br>• multi-agency review of referral pathways for young people leaving prison and requiring assessment for care and support<br>• dissemination of 7-minute briefing for SAR's Damien, Luke and Matthew<br>• development and dissemination of 7-minute briefing about Making Safeguarding Personal<br>• SAR TM – reviewing discharge pathways for homeless patients<br><br>Key themes regarding SSAB self-assessment action plan are:<br>1. There is an expectation that organisations working with adults consider adult safeguarding a priority<br>2. Empower staff and volunteers in your organisation to use multiagency escalation of risk and professional differences policies. Your organisation is assured that these are being used effectively to aid everyday practice<br>3. Your organisation is assured that the views of people with lived experience are gathered and accurately recorded in relation to adult safeguarding<br>4. What systems and support are in place to ensure that professional curiosity is demonstrated in practice |

| | |
|---|---|
| | 5. What work is being done within the organisation to engage with people who have a lived experience, in particular adults with protected characteristics or underrepresented communities? What challenges have you identified and how has the organisation overcome them?<br>6. Adults with care and support needs who are transitioning into or between adult services are being supported effectively<br><br>Action taken:<br>1. Trust - Training re-mapping.<br>2. Trust – duty team recording on data spreadsheet and reporting to the ICB. Multi-agency work as part of the SSAB Policy and Procedures Subgroup to review and revise SSAB Resolving Professional Differences Guidance / Process.<br>3. Quality assuring of safeguarding adult referrals to ensure patient view is sought and included<br>4. Professional curiosity is clearly demonstrated by the number of contacts the Trust's safeguarding service receives into the single point of contact, which has shown a year-on-year increase since 2018 e.g. staff are recognising concerns, making enquiry with patients and seeking advice from safeguarding service<br>5. Plan for next financial year 2023/24 to explore how best to engage with people who have lived experience.<br>6. Plan for the Trust Safeguarding Service to have a specialised Exploitation and Transitions Lead in post qtr.1 2023/24 |

## Other Supporting Information

This financial year saw a further increase in the safeguarding adult related contacts into the Safeguarding Service Duty Team single point of contact (SPOC), increasing by 7.9% to 4764 from 4413 (see table 5). Over the past financial year, contacts from the Trust's Community Services has continued to show an upward trend (increase of 3.4%), but contacts from Musgrove Hospital have reduced slightly (decrease of 6.4%). As the Safeguarding Services from both Somerset NHS Foundation Trust and Yeovil District Hospital (YDH) NHS Foundation Trust merged in November

2022 this has enabled us to begin to capture contact data from YDH which stood at 304 contacts from November 2022 – March 2023. We also record contacts from external agencies which has remained consistent at 201 (see table 6).

It is anticipated that the upward trajectory of contacts to the Duty Team SPOC will continue This presents a concern for the safeguarding service who are struggling to continually meet the demands placed upon us both internally and externally.

It is anticipated that we will review Safeguarding Service processes in qtrs. 2 and 3 2023/24 with any new process development to be implemented by qtr. 4 2023/24.

**Table 5: year on year safeguarding adults related contacts to the Trusts' single point of contact**

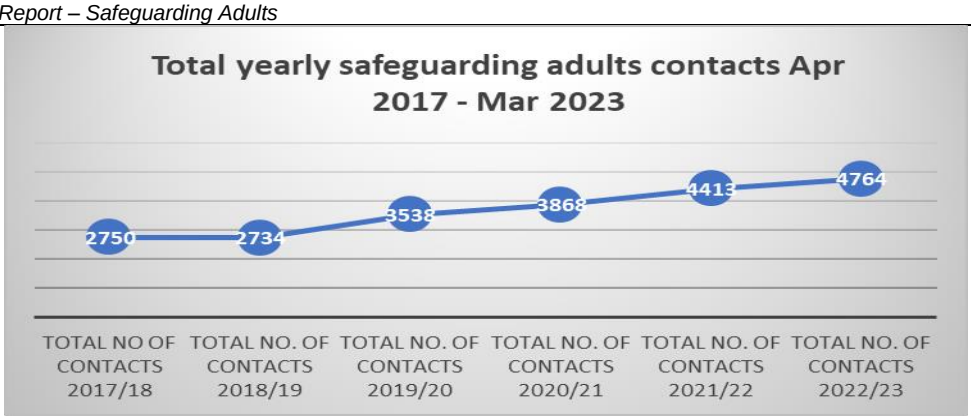
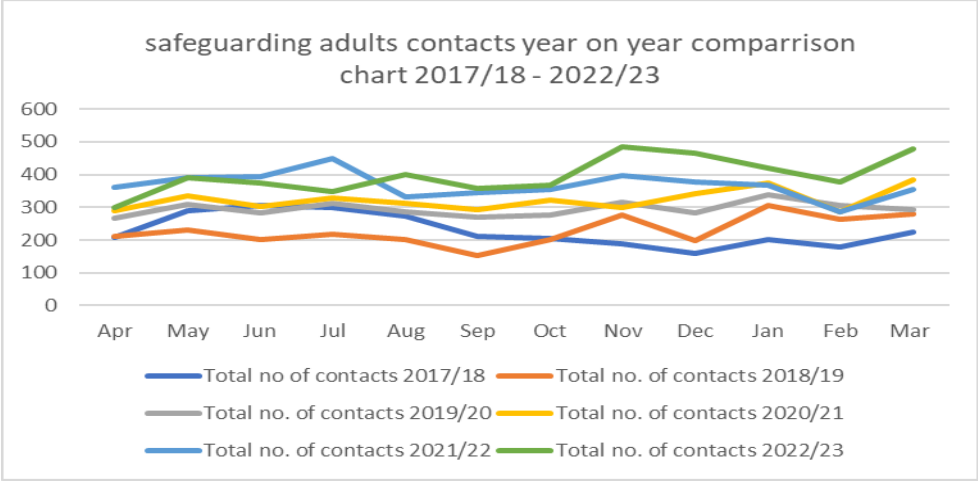
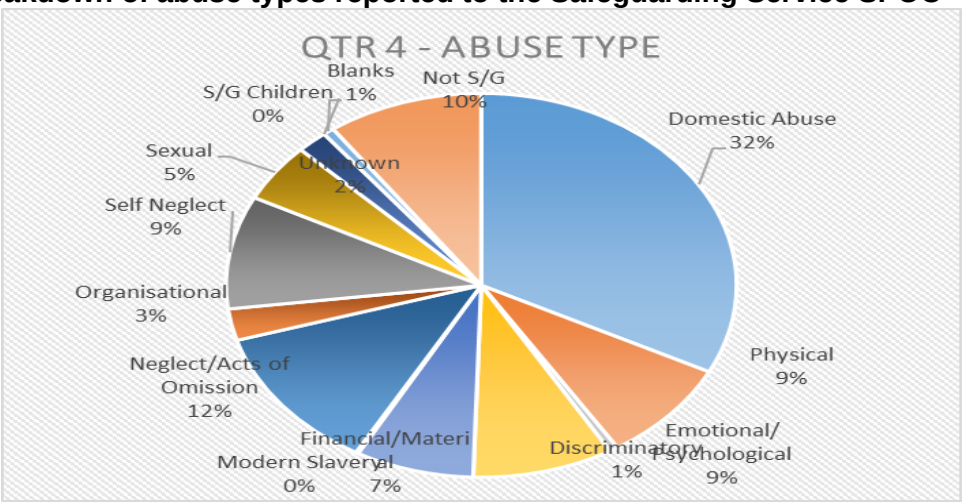



**Table 6 year on year comparison chart**




The table below shows that the highest proportion of contacts into the SPOC relates to domestic abuse at 32%, followed by Neglect and Acts of Omission at 12%, self-neglect at 9% and physical abuse and emotional/psychological abuse also at 9%

**Table 7 Breakdown of abuse types reported to the Safeguarding Service SPOC**




**Domestic Abuse**

Due to the volume of domestic abuse enquiries, the Trust Safeguarding Service has created a small domestic abuse team consisting of a Domestic Abuse lead, Domestic Abuse Coordinator, and

Domestic Abuse Researcher/admin. Of note is that this team was created from existing duty team colleagues and is not an additional resource. It has become more apparent that as a Trust and Safeguarding Service we need to invest more in domestic abuse support to ensure that the Trust can offer a robust and safe response to victims (and perpetrators) of domestic abuse at the front door. A gold standard approach would be to have a health IDVA based within each ED. During 2023/24 we will be exploring the possibility of developing a business plan to enable us to 'grow' our safeguarding service domestic abuse team.

**Safeguarding Adults**

Pending the merger with Yeovil District Hospital the Named Professional for Safeguarding Adults roles and responsibilities has been reviewed and updated to reflect the breath and complexity of the role and of the safeguarding adult agenda. As a result of this review, the post has been rebanded and retitled to Strategic Lead and Named Professional for Safeguarding Adults. This will come into effect on 1st April 2023.

**APPENDIX 1**

## Safeguarding Service Assurance Framework

### Governance Structure

Trust Board - annual

Quality & Governance Assurance Committee - annual (on behalf of the board)

Quality Assurance Group - annual

### Key Specific Committee

Integrated Safeguarding Committee - quarterly (includes ICB membership )

### Operational Oversight

Safeguarding Senior Leadership Team - fortnightly

Named Professionals Meeting - weekly

Whole Service Meetings - monthly

Daily triage of Safeguarding SPOC

**APPENDIX 2 – Safeguarding Service Risk Assessment**

# RISK ASSESSMENT FORM

| | | | |
|---|---|---|---|
| **Department, Service or Ward** | **Safeguarding** | **Directorate** | **Nursing and Care** |
| **Date of initial assessment** | **30/04/23** | **Risk Ref** | **IT impact on Safeguarding Service** |
| **Date of *this* assessment/review** | **30/05/23** | **Next review date**<br>**Or on significant change** | **Monthly** |

## Section A

| **Please give a brief description of the hazard / problem**<br>**Risk has three parts firstly exposure to a hazard / problem, secondly a measure of impact or consequence (i.e. if this exposure happened how bad could it be?) and thirdly a measure of certainty (i.e. how reasonably likely is it that this exposure to the hazard could happen?)** |
|---|

*The Safeguarding Service formed in October 2018 ahead of the Sompar and TST merger. Since this time the team have had to work around the numerous IT systems employed by the Trusts to ensure that safeguarding concerns, risks, alerts and actions are recorded on the numerous systems. The Safeguarding Service integrated with the YDH Safeguarding Team ahead with YDH in April 2023. Further IT systems and processes have now been added.*
*Prior to the recent merger the Trust improvement team commissioned high level 'As Is' mapping for safeguarding which showed a fully functional recording and reporting system to reflect the Trusts statutory requirements. The lead for the mapping completed an SBAR- 'Safeguarding As IS' stating:*

'the current state, of the systems used, are no longer fit for purpose. Ironically, given who the team are, I have to report a Safeguarding issue, in that the users are being subjected to unnecessary stress and additional work, as well as having to facilitate 'work arounds' to ensure the service is safe and is delivered to the required and expected standard. In the past, the (Sompar) Safeguarding Service used, almost exclusively, Rio, which they felt met their needs adequately. Rio has undergone a number of changes over the years and new systems have been introduced, due to changes in other departments, mergers etc. These changes have been due to the requirements of others, not the Safeguarding Service, and have actually increased the workload of all team members, as they have to access and enter data from a number of other systems such as, but not exclusively EPRo , MAXIMS, Trackcare etc.

A particularly good example of this, multi-system workload, is the 'research for an Adult at Risk' meeting which has 18 steps and uses up to 10 different systems. Added below is the SBAR and the process maps that highlight the impact upon the team.

SBAR Safeguarding Process Concerns.doc

Safeguarding Duty Team Admin v03.pdf

Safeguarding Adults v03.pdf

Safeguarding Children 03.pdf

## Section B

## Section C

### Controls now in place

**What are you already doing to mitigate the potential hazards identified in section B?**

**The SBAR further states:**

The only reason The Safeguarding Service functions effectively is due to the commitment and professionalism of the truly dedicated staff. This is not a 9 – 5 existence where they can go home leaving work outstanding, as people's lives and wellbeing depend on them. This is having a toll on them personally and is unsustainable.

| Recommendation: |
| --- |
| The current situation needs to be addressed with an interim solution, as a matter of urgency. It is unreasonable to expect the Team to continue to work in this way and they cannot wait until the EHR is delivered. |

## Section D

### Initial Risk Rating

**What are the risks / impact associated with the issue / problem / hazard identified in section B? Take into account what you are already doing to mitigate the risk (as detailed in section D) and score using the Risk Matrix (see Risk Management Intranet)**

| Reference | Risk / impact, who this may affect and how | Risk Matrix Descriptor Letter | Consequence (1 – 5) | X | Likelihood (1 – 5) | = | Risk Rating (1 – 25) |
| --- | --- | --- | --- | --- | --- | --- | --- |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **1** | **Physical/ Psychological Harm to Safeguarding Service Colleagues** | C | **4** | **X** | **4** | **=** | **16** |
| **2** | **Quality Compliance** | F | **4** | **X** | **4** | **=** | **16** |
| **3** | **Delivery of objectives** | G | **4** | **X** | **4** | **=** | **16** |
| **4** | **Reputational Risk** | I | **5** | **x** | **4** | **=** | **20** |
| **5** | | | | **X** | | **=** | |

## Section E

**Action Plan**

**What is planned to further mitigate or eliminate the risk(s)? Actions need to be specific, achievable and time bound. This plan should be monitored until all complete.**

| Key Actions Required | By who? | By When? (Target completion date) | Progress |
|---|---|---|---|
| Line management supervision, peer supervision and Wellbeing team support all readily available | Safeguarding Leadership Team & Wellbeing Team | In place | Regularly provided |
| Informal ad-hoc support and supervision available to the team | Director and Head of Safeguarding | In place | Regularly provided |
| Consider an interim arrangement for the Safeguarding Service prior to the EHR being delivered. Consistently receive in excess of 200 new contacts to the Safeguarding Duty Team each week -based on 18 steps steps for each contact equates to in excess of 3,600 actions per week. There is on average a maximum of 5 staff each day covering duty. This equates to 720 actions per person per week or 144 per day excluding leave and sickness.<br>The suggestion is an interim measure until EHR is delivered:<br>1 x Fixed term appointment of an additional Band 6 Safeguarding Professional in the Duty Team<br>2x Fixed Term band 4 Safeguarding Researchers administrators to enable the safeguarding professionals to support Trust staff in a timelier manner to reduce risks to the safeguarding service colleagues and in turn to patients, staff and the public.<br>These roles would not be required if the Trust had a single HER. | Chief Nurse & Director of Strategic Development | June 2023 | Sent to Hayley Peters and David Shannon for consideration 30/05/23 |

## Section F

**If all the actions set out in Section E are completed, what Risk Rating(s) would you expect for the risks rated in Section D?**

| Hazard | Target Consequence (1 – 5) | X | Target Likelihood (1 – 5) | = | Target Risk Rating (1 – 25) |
|---|---|---|---|---|---|
| **1** | 2 | **X** | 2 | **=** | 4 |

| | | | | | |
|---|---|---|---|---|---|
| **2** | 2 | x | 2 | = | 4 |
| **3** | 2 | x | 2 | = | 4 |
| **4** | 2 | x | 2 | = | 4 |
| **5** | | x | | = | Press the key here if you need more |

## Section G

| What to do with the risk assessment now |
|---|
| • All risk assessments should be sent to your manager for initial review and added to the register as appropriate.<br>• If the risk score is between 1 – 6, these risks are managed locally<br>• If any risks are 8 or more this will automatically show on the Directorate Register from the departmental register.<br>• Action plan - this needs to be regularly updated until all actions are complete<br>• When the risk is either reduced to the lowest level or managed as a controlled risk this should be frequently monitored. |

## Section H

| Risk Assessment Approval | | | | | |
|---|---|---|---|---|---|
| **Assessor's Name and Role** | **Rich Painter** | **Signature** |  | **Date** | **30.05.22** |
| **Managers Comments** | | | | | |
| **Manager's Name and Role (Risk Owner)** | **Hayley Peters** | **Signature** | | **Date** | |

***Risk assessment reviewed joint form for Somerset NHS FT 01-04-2020***

# Enclosure 1

## Reference – Assurance level definitions

| Green | Blue | Amber | Red |
|---|---|---|---|
| **Definition – assurance / concern characteristics** | | | |
| Good systems of assurance<br><br>High confidence in the quality of the evidence available.<br><br>Positive findings from measurement / assessment / monitoring sources, minimal variability.<br><br>No significant concerns in the period covered. | Assurance systems in place – adequately functioning.<br><br>Sufficient confidence in the quality of the evidence available.<br><br>Acceptable findings from measurement / assessment / monitoring sources, acceptable variability.<br><br>No evidence of any significant issues in the period. Any issues /concerns are well-managed via clear, monitored plans. | Assurance systems in place – issues evident with functioning.<br><br>Lower confidence in the quality of evidence / due to gaps in information available<br><br>Findings from measurement / assessment / monitoring sources indicate concerns / variability.<br><br>Issues of concern are not accompanied by assurance of clear, monitored plans to address. | Assurance systems are not adequately designed and/or not all functioning well.<br><br>Concerning low quality of evidence, significant gaps.<br><br>Findings from measurement / assessment / monitoring sources indicate concerns warranting escalation.<br><br>Serious issues identified that present risks to the Trust and in the absence of an effective plan to address. |
| **Application of the level – guidance and conventions**<br>**The level applies when..** | | | |
| There is agreement that there is overall high confidence that all is well.<br><br>Minor issues only.<br><br>An external review today would likely find no issues. | There is agreement that sufficient confidence that all is well.<br><br>Issues can be left with the Lead to take forward.<br><br>An external review today likely to find issues are managed. | The consensus is that improvements are required before there can be fuller confidence.<br><br>Issues may require support to resolve.<br><br>An external review today may find concerns and weaknesses in managing them. | It is evident that all is not well.<br><br>Issues warrant escalation to achieve resolution.<br><br>An external review today would find concerns and would likely take action. |
| **Onward reporting conventions** | | | |
| At one year -<br>Light-touch update report | At one year –<br>Update briefing with focus on actions progress – targeting the issues previously reported and any new issues arising since | On consensus from QAG review:<br><br>At six months -<br>An update on areas of concern and position update on improvement planning<br><br>At one year –<br>An update as above accompanied by an updated assurance report | On consensus from QAG review:<br><br>Within 1 month -<br>Specific briefing provided to accountable Executive and other relevant leads or stakeholders.<br><br>Topic review meeting held 1-6 months. Aim – to support development and improvement to address issues / concerns<br><br>At one year –<br>Full updated assurance report reflecting progress and plans |
| **Templates** | | | |
| Simple update briefing | Issue-specific briefing / progress briefing | Issue-specific briefing / progress briefing<br>Assurance report (update) | Escalation briefing / progress briefing<br>and SMART plan<br>Assurance report |

# Enclosure 1