Dorset Safeguarding Adults Board

Annual Report 2023-2024

The Safeguarding Adults Boards bring together all public, voluntary and community sector agencies across BCP and Dorset with the aim of working together to protect adults at risk from abuse, harm, or neglect. We achieve this through joined up strategic leadership and collective accountability.

Welcome to the Dorset Safeguarding Adults Board 2023/2024 Annual Report. The Board meets jointly with the BCP Safeguarding Adults Board and shares all subgroups of the Board. This enables us to work efficiently with our partners across the NHS and Police, and also with the many other public, voluntary and community sector agencies. A separate Annual Report is provided as we have constitutionally retained separate Boards enabling us to have place-based meetings where required.

The primary role of a safeguarding adults board is to ensure that all public sector agencies work together to ensure that adults with care and support needs in the area are protected from abuse, harm, and neglect; where because of their care and support needs they are unable to protect themselves. The Care Act 2014 sets out that Safeguarding Adults Boards (SABs), should agree a local safeguarding strategic Business Plan and set out in the Annual Report how it has delivered that plan. The Board must also commission a Safeguarding Adults Review, (S44 of the Care Act) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Safeguarding Adults Boards must also arrange a Safeguarding Adults Review if an adult in its area has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect. and must ensure that partners demonstrate how they work together so that lessons learned impact the future delivery of services to those with care and support needs.

In 2023 the Dorset SAB published SAR Simon – with recommendations of national significance regarding the transfer of GP records between different countries and counties within the UK. We also concluded SAR Elizabeth, and it was agreed that this would not be published. Summaries from these reports are included in this annual report.

During this year, the Board continued to hold alternate Board meetings in-person and held several events:

- In May 2023 productive meetings were held in respect of the LGA Adult Social Care Peer Review. This was commissioned by Adult Social Care in Dorset to ensure support in identifying any issues in preparation for forthcoming CQC assessment of adult social care. The Board participated in the review and the outcome was helpful in providing assurance about the effectiveness of safeguarding delivery by adult social care and assurance for the Board about the partnership working to deliver effective services to protect those with care and support needs.
- I attended NHS England regional Mental Health Homicide Review Workshop as it is essential that in commissioning any reviews, we work effectively with partners to ensure that the learning is delivered by the most appropriate organisation.
- This SAB has been proud to include representatives from Housing on our Board for a number of years. In July 2023 we hosted an event for registered housing providers attended by colleagues from the local authority, adult social care safeguarding, and learning & development teams as well, importantly, as many registered social housing providers. Attendees formed a Housing & Safeguarding Reference group enabling them to have a forum to share ideas & experiences. A second event was held in January 2024 for all pan-Dorset Registered Housing Providers with Professor Michael Preston-Shoot presenting on the theme of Adult Safeguarding & Homelessness. The event focussed on the need to identify and use evidence-based practice, ensuring that everyone works across agencies and thinks ‘team around the person’. Rachel Young (Pause Dorset) spoke about the housing issues for working with women whose children are removed. Regular engagement with housing has been welcomed and this network is proactively sharing learning. The SAB has now agreed to facilitate an annual event.
- In July 2023, the first face-to-face CEG meeting was held, providing networking opportunities to improve understanding of the important roles which the voluntary and community sector hold in promoting awareness of safeguarding. Effective engagement with and between community groups enabled participants to showcase their work, forging strong working relationships, understanding each other’s remit.
- We delivered training during the year on the role of the Safeguarding Adults Board, for 200 Dorset staff.

In September 2023 I undertook prison visits to HMP Portland and HMP The Verne, accompanied by the Dorset Council Adult Safeguarding Lead/Service Manager - S117 Hub. HM Prison & Probation Services are represented on the Board and there is much to do to ensure that the Board has assurance that the Care Act responsibilities for prisoners with care and support needs are delivered. This is the responsibility of the local authority which commissions support from healthcare providers based in prisons. Given the numbers of those in prison with mental health needs and the high proportion of prisoners who are neurodivergent; we also commenced work to ensure that preparation for release takes account of the services which will need to be available. This supports individuals and importantly is a matter for public protection.

Our subgroups have seen some changes in chairing arrangements due to changes in personnel but by the end of this reporting year a degree of stability has been achieved. This year saw the establishment of an additional subgroup of the Board - the Mental Capacity Act & Deprivation of Liberty Safeguards (MCA/ DoLS) Subgroup (referred to later in this report) – important for the Board's assurance, this will help address the fact that issues regarding mental capacity assessments and executive function are recurring themes in very many safeguarding interventions and reviews.

I established a quarterly meeting for the Chairs of the Board's subgroup chairs in September 2023 to ensure that partnership working Improved. We are now seeing how the outcomes and learning from safeguarding adult reviews are also reflected in the audit plans for the Quality Assurance subgroup. There is also an improved understanding of the importance of engagements with colleagues in the voluntary and community sector across all groups

Productive working continues between the Board and NHS Dorset and during the year I met regularly with the NHS Dorset Safeguarding Leads including discussion about the pilot CQC Inspection of the Integrated Care System, progress on SARs across the NHS system and revised Pressure Ulcer Guidance.

During the year we updated policies and procedures - including our Board Constitution, Communication Strategy, and Document Retention Policy. Regular review ensures good governance and clarity of understanding across the partnership.

February 2024 saw improved capacity within the Board's business team with recruitment of a Project Officer to enable focus on key tasks including delivery of more effective communications and delivery of a new website which will be act as a reference point for safeguarding practitioners as well as providing accessible information for the public.

At the close of the year, we facilitated a Board development event in March 2024, which gave us the opportunity to review and update our 3-year strategy and all partners made a commitment to engage in 'horizon scanning' during the year ahead.

I would like to thank all those who have contributed to safeguarding adults, with dedication, hard work and strong leadership from across our partnership. In particular I would like to thank our Boards' Business Team, who have each contributed significantly to delivery of our work.

Siân Walker-McAllister, Independent Chair

Safeguarding Adults

Safeguarding adults is about protecting the rights of people with care and support needs to live in safety, free from abuse, harm and neglect.

If you are concerned about a person who is over the age of 18 years, who has care and support needs, and you feel they are being abused or at risk of abuse from another person, you should seek help for them.

To report a safeguarding concern in the Dorset Council area contact:

01305 221016

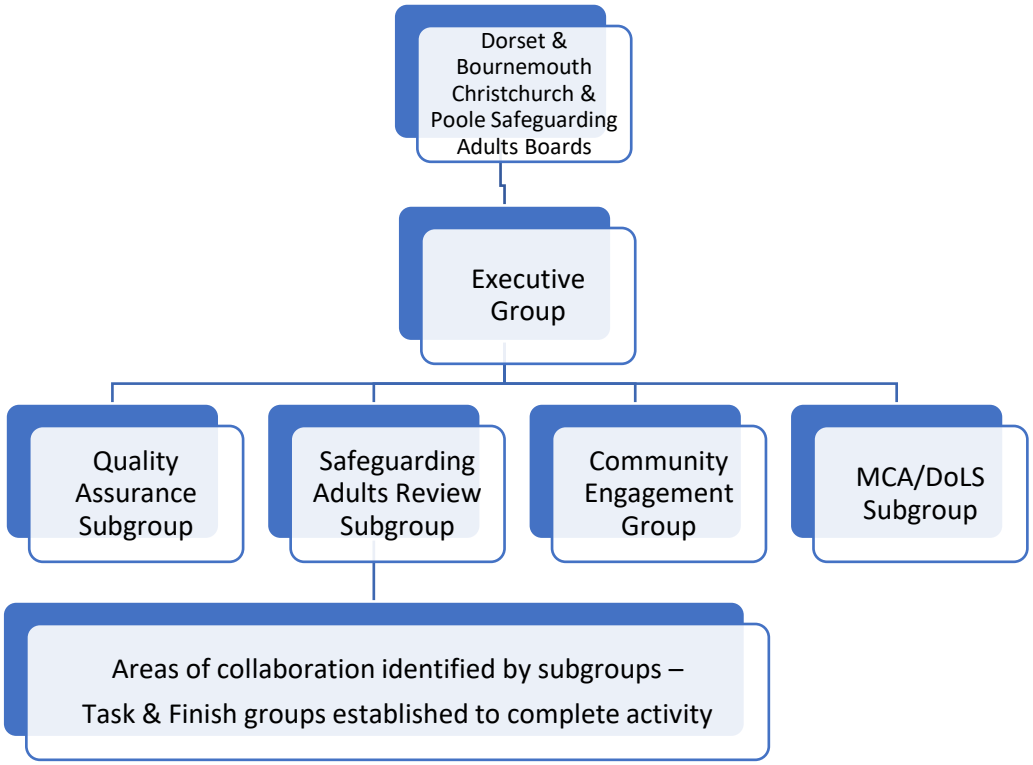
During evenings and weekends, telephone 01305 858250

Dorset Council

In an emergency dial 999. If the person is not in danger now, dial 101.

If you are not sure what to do, or need some advice, there are people who can help. You can talk to your GP or nurse, a social worker, a police officer or your key worker. They will help you to respond to the concerns.

Structure of the Dorset & BCP Safeguarding Adults Boards



Dorset & BCP Safeguarding Adults Boards Budget 2023-2024

The Dorset & BCP SABs maintain a working budget to enable them to undertake their work and the priorities identified in the business plan. Each year, contributions are received from statutory partners to support this work. During 2022-2023 the two Boards merged the Business Units and subsequently the budgets.

During much of 2023-2024, the Business team was carrying a vacancy for a Project Officer and a part time Administrator resulting in an underspend on staffing. During this year the SABs held 5 in-person events, so cost for venue hire had increased since the previous year.

The Dorset and BCP SABs are grateful for the financial support of our partners which enables us to carry out our work.

BCP Council	£70,000
Dorset Council	£70,000
NHS Dorset	£38,745
Dorset Police	£19,404
Total	**£198,149**

Dorset Council - Safeguarding Activity & Performance Information 2023-24

S42.1 Concerns received

5673* Concerns received
(Top 3 Referral Sources were Residential Care Staff, Domiciliary Care Staff, Social Care Worker)

Dorset Council

2023-2024

Progressed to a S42.2 Enquiry

390* S42.2
2217* Other safeguarding enquiries
(this is what needs to happen to make sure someone is safe)

*Volumes of concerns and enquiries are published in the Safeguarding Adults Collection by NHS Digital Safeguarding Adults, England

Breakdown of S42.2 Enquiries

Top 4 Sources of Risk

41% Service Provider – Private sector
15% Relative/family carer
13 % Other private sector
12% Known individual not related

Top 4 Types of Abuse

46% Neglect & Acts of Omission
11% Physical
11% Financial
7% Psychological

Top 4 Locations of Abuse

44% Own home
33% Care home (Residential)
11% Care home (Nursing)
5% Supported Living

Outcome of Concluded S42.2 Enquiries

(when risk identified)
Risk Removed = 26%
Risk Reduced = 69%
Risk Remains = 6%

Gender & Age

Women (63%) are nearly twice as likely to be the subject of a S42.2 Enquiry in Dorset than men (35%) over all age groups. (There is a notable increase for women over the age of 85.)

*Volumes of concerns and enquiries as published in the Safeguarding Adults Collection by NHS Digital [NHS England Digital - Safeguarding Adults, England, 2023-24]

Strategic Plan for 2023-2026

The Dorset and BCP Boards strategic aim is to ensure adults are safeguarded by empowering and supporting them to make informed choices and decisions (Making Safeguarding Personal).

Preventative work in safeguarding	**Seeking assurance on safeguarding practices**	**Assurance on delivery of 'Making Safeguarding Personal' (MSP).**
Prevention Aim: Continued development with partners of preventative work in safeguarding.	**Accountability Aim:** Continuing to seek assurance on safeguarding practice across system partners.	**Partnership working Aim:** Assurance on delivery of 'MSP' using a whole family approach.
We will: • Review learning from SARs from DBCPSAB & other Boards and revisit thematic learning from reviews to inform preventative work with adults with care and support needs. • Ensure we always take account of the experiences of people who use services or receive safeguarding interventions. • Seek assurance on an annual basis from partners that learning is embedded in the work of all frontline staff in all services in line with our Training & Development strategy. • Ensure that the Boards' subgroups are able to provide evidence of system learning and working to deliver preventative work. • Ensure there is good multi-agency working with a contextual safeguarding approach to preventative work with people who are homeless. • Improve use of data from all partners to enable us to identify trends which influence preventative work across all agencies.	We will: • Continuously develop how we receive assurance as governance frameworks evolve across every statutory partner. • Ensure data is understood/ used to identify themes for every partner to progress in their safeguarding work; that information and learning is shared across the system. • Work in partnership across the safeguarding children and community safety partnerships to ensure that complexities of 'Transitional Safeguarding' are understood well. • Seek assurance on delivery of safe and person-centred practice in private mental health hospitals and for all placements of people outside our area. • Seek assurance that 'Think Family' practice across all agencies is embedded. • Continue to seek assurance on health & social care practice and provider care quality. • Seek assurance that the system is working to safeguard people via the new national policing initiative, 'Right Person, Right Care'	We will: • Seek assurance from all partners that Making Safeguarding Personal (MSP) is embedded throughout all agencies' safeguarding work. Seeking evidence that people have opportunity to express their outcomes at every stage in their safeguarding journey. • Involve people in the work we do **– r**eview how we communicate more widely with people and listen to and act upon the voices of those who have experienced safeguarding interventions. • Deliver our communication/ engagement strategy to the widest audience with the support of the voluntary and community sector through our Community Engagement Subgroup. • Ensure that the Quality Assurance subgroup continues to audit application of MSP and provides data which evidences that application of MSP is embedded.

What we achieved in 2023-2024

In our strategy we said…	This is what we did
Continued development with partners of preventative work in safeguarding	• Continued working with Partners and received updates from Dorset Police on 'Right Care Right Person' approach for working with vulnerable people • Ongoing work with the Community Engagement Group (CEG) to facilitate shared learning and awareness of safeguarding • Good partnership working with NHS Dorset and production of a revised local Pressure Ulcer Guidance, this was added to the Safeguarding Adults Procedures • Delivered and published Three '7 Minute Learning' reviews on 'Multi-Agency Risk Management (MARM) processes', 'Safeguarding and Hospital Discharge' and 'Learning from BCP SAR Aziza' • Delivered with partners, 4 x bite-sized videos, published on the Boards' websites, providing an overview of the MARM process • Revised and updated the Safeguarding Adult Review (SAR) Referral form ensuring clarity and understanding about SAR referrals by agencies, enabling better-informed decisions as to whether the criteria is met for commissioning a SAR • A Transitional Safeguarding Position Statement was published, written to ensure that agencies understand the needs of young people who are moving from Children's services and need support from Adult Social Care and other services • Established the Housing & Safeguarding Reference group and arranged delivery of learning about 'Adult Safeguarding and Homelessness'
Continuing to seek assurance on safeguarding practice across system partners	• Delivered Safeguarding Adult Reviews on Simon and Elizabeth, continuing to seek assurance through implementation of action plans • Produced and published the Dorset & BCP SAB Communication Strategy • The QA and CEG subgroup Terms of Reference were updated • Subgroup Chairs and Deputies met quarterly to share practice and work together more effectively.
Assurance on delivery of 'Making Safeguarding Personal'	• Making Safeguarding Personal (MSP) was a key feature of the Boards' Development session in March 2024, with workshops on this theme and discussions around why it is important for all partners to embed this into practice • The focus on application of MSP is always included within terms of reference for safeguarding adult reviews and thus is reflected in recommendations • QA subgroup will be undertaking an audit and review of MSP again in the next year to ensure it is embedded into practice.

Reports from the Chairs of the Subgroups for 2023-2024

Community Engagement Subgroup (CEG)	CEG has continued to welcome an increased membership and more consistent attendance at meetings and events, contributing to the strategic plan. It is Chaired and Vice-Chaired by two Voluntary & Community Sector (VCS) representatives from BCP and Dorset Council areas, bringing together a wide range of skills and knowledge of the wider sector in Dorset. The CEG is working towards achieving the priorities outlined in the Safeguarding Adult Boards' 2021/24 Strategic Plan and continues to have a focus on informed and preventative work with safeguarding. This involves talking to various groups about how to ensure that people with care and support needs are kept safe. CEG has received presentations from Prama Care, People First Dorset and the Safeguarding Board business managers, looking at various themes such as hoarding, self-neglect and 7-minute learning reviews to help organisations and volunteers understand how they can support someone where there may be a safeguarding concern. CEG Refreshes and reviews good safeguarding practices within the VCS and shares these findings and learning across the sector. CEG has worked with the subgroups and the board to ensure that the VCS is recognised as often being the first point of contact for Dorset residents and that the sector often initiates reporting a concern when supporting adults in the community.
Safeguarding Adult Review (SAR) Subgroup	The Safeguarding Adult Review (SAR) subgroup met on 7 occasions throughout 2023/2024. Until December 2023, the chair was Sarah Webb from BCP Council. From January 2024 a new chair, Kirsten Bland from NHS Dorset was appointed. During 2023/2024 the SAR subgroup facilitated the publication of a safeguarding adult review - SAR Simon, available from the Dorset Safeguarding Adults Board website Safeguarding adults review - Learning from the circumstances around the death of Simon (dorsetcouncil.gov.uk). SAR Elizabeth was also approved by the Board. The subgroup has considered 8 referrals for a SAR over the last year and four of these met the criteria for commissioning a SAR.
Quality Assurance (QA) Subgroup	The Quality Assurance (QA) Subgroup met on 4 occasions throughout 2023/2024. Initially, the subgroup was co-chaired by Jonathan Price (Dorset Council) and Liz Plastow (NHS Dorset). In May 2023 Simon Hester was appointed to co-chair after Liz Plastow left NHS Dorset. Tanya Dawson-Sheehan (Dorset Council) has chaired the subgroup, with Simon Hester as Deputy Chair since November 2023 The subgroup has welcomed updates and demonstrations of the 'Dorset Insight and Intelligence Service' (DiiS) Safeguarding Dashboard, commissioned by NHS Dorset but not intended for use only within the NHS. Discussions as to how partner agencies can be involved and use this new database are ongoing. During the year the group discussed the case recording systems of partner organisations, as detailed recording enables more accurate records. In Section 42 Enquiries more than one abuse type can be recorded enabling more detailed analysis. Analysis of volumes of concerns received provided assurance to the SABs regarding the terminology used in both LA areas.

	Throughout the year the subgroup has undertaken a progressive audit concentrating on Self-Neglect. The most frequent abuse type in both LA areas (and nationwide) is Neglect and Acts of Omission. In November findings from the qualitative audit on Self-Neglect were presented from a variety of subgroup member organisations and others including the Fire & Rescue Service and voluntary and community sector. This provided rich information on what is going well and what improvements could be made; and identified common themes on 'wish lists' which will be examined further. The subgroup identified that the volume of advocacy referrals was lower than expected and will continue to examine the underlying reasons in the next reporting year. The QA Workplan was reviewed and updated with all tasks identified in the SAB strategic plan enabling the subgroup to track and plan our work and where required collaborate with other subgroups. Audit work undertaken by the QA Subgroup in previous years identified the need for greater understanding of the MARM process and promotion of the fact that any agency can convene a MARM meeting. Further progress on training materials for staff was made during this reporting year.
MCA/DoLS Subgroup	During this reporting year a new subgroup of the Boards was created in response to ongoing strategic discussions about the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and the proposed forthcoming change of law to deliver Liberty Protection Safeguards (LPS) which will be introduced by the Mental Capacity (Amendment) Act 2019. In April 2023 the Department of Health and Social Care announced that implementation of LPS would be delayed "beyond the life of this Parliament". Board partner organisations had been planning for some time in order to prepare practitioners for the changes in legislation and how these would impact on practice. In December 2023 the Board discussed a review of the governance of MCA / DoLS and unanimously agreed a proposal to convene a Mental Capacity Act Subgroup of the Board to provide consistent governance framework for all partners. Draft Terms of Reference were available at this meeting with some amendments approved at the March 2024 meeting. Betty Butlin from BCP Council Adult Social care was appointed the Subgroup Chair and the first meeting will take place in Q1 of the next reporting year.

Two Safeguarding Adult Reviews (SARs) were approved by the Board in 2023-2024

SAR Simon - Simon, a white British man was aged 71 when he died, experienced mental ill health throughout his adult life, and on several occasions received inpatient hospital treatment to help him become mentally well again. He gained great insight into his own mental health and became 'an expert by experience', using his experience to mentor and advise others.

After a long period of being well Simon moved from Dorset to Scotland to pursue his love of art by taking a foundation course. In Scotland he received treatment for physical illness that for various reasons impacted his mental health, to the extent that he was detained and admitted to a psychiatric hospital for over a year. During this time the Covid-19 pandemic began, and Simon could not see his family for 9 months. Together they decided he would return to Dorset to be closer to them. The authorities in the Western Isles made no formal arrangements regarding Simon's move so his family were left to manage this alone, and unfortunately the restrictions in place at the time meant that when Simon did arrive at the care home in Dorset, he could not see family immediately.

Agencies involved with Simon - Dorset Council and NHS primary and secondary health services, had no information about him, and the care home had minimal information. For the first three weeks following Simon's move back to Dorset, he was left without support for his complex needs due to the need to isolate (Covid guidance) and the lack of information shared. The organisations working with Simon subsequently struggled to support him.

Although the care home was deemed a 'place of safety', Simon's perception was different, and he did not feel safe. Despite the failure of a plan of least restriction being put in place after a Mental Health Act (MHA) assessment there was no contingency plan about re-assessment of Simon's mental health and no planning or resource to provide him with the 'wrap around' care that may have helped him to feel safe in the care home. Practitioners did their best to find and share information, but there was no multi-agency meeting involving all who knew Simon or could offer guidance on working with him. His supportive family was not involved in his care by the community mental health team. Simon died by suicide six weeks after arriving in Dorset, he left notes explaining his fears about his fate in the care home.

Learning from the review has highlighted the need for:

- Careful Planning for transitions between areas together with reciprocal communication
- Strengths-based approaches to practise – Agencies should always consider who is available to support the person?
- Person-centred approaches – Agencies should always aim to understand the person and what lies behind the decisions they make.
- Making contingency plans - *Shared contingency plans to support a person who is mentally unwell, but not detainable under the Mental Health Act (MHA) 1983, should stipulate under what circumstances a further assessment under the MHA should be considered and who is responsible for initiating it. Family and friends can be an important source of information to support contingency plans, their input should be sought as a priority.*
- Effective Multi-agency working

One of the findings from the review of national importance is that there appears to be no system for transfer of electronic records between GPs in different UK countries. The SAB has escalated this issue via the regional and national SAB Chairs Networks and is awaiting a response from DHSC.

Link to the report: Safeguarding Adults Review - Learning from the circumstances around the death of Simon

SAR Elizabeth - During 2023-24, the SAB completed a SAR relating to a woman in her 40s who was found deceased. She had longstanding mental health problems and alcohol dependency related to trauma experienced as a young adult. Later, her life had become more settled as a result of parenthood and abstinence from alcohol. At the start of the Covid-19 pandemic, however, she experienced a sequence of distressing events, including flashbacks to past traumatic events, which resulted in multiple crises of acute distress and, on occasion, a return to alcohol. Multiple agencies were involved in supporting her.

During this period, she arranged for her child to be cared for by a family member, a placement that was later secured through child safeguarding action.

Learning from the review has resulted in a series of recommendations for improvements in the following aspects of safeguarding practice across the partnership. These are:

- trauma-informed practice.
- collaborative care models uniting mental health, primary care and substance use services
- recognition of adjustments necessitated by Autistic Spectrum Disorder
- improved pathways for interagency information-sharing
- better use of interagency decision-making forums such as Multiagency Risk Management meetings
- clarification of distinctions between safeguarding, MARM and agencies' own risk management pathways
- improved understanding and use of the Mental Capacity Act 2005
- improvement in whole-family approaches where the needs of both children and adults are being met
- improvements to children's social care practice in kinship placements and support for parents in distress
- amendments to inaccurate information recorded in agency records
- learning events to disseminate learning and to review outcomes of action on improvement priorities.

The Dorset and BCP Safeguarding Adults Boards are made up of senior representatives from the following agencies:

Our Statutory Partners

BCP Council

Dorset Council

Dorset Police

NHS Dorset

Local Authority representatives from Dorset and BCP Councils include senior officers from Adult Social Care and Housing as well as Cabinet Members for Adult Social Care.

Our Board Member Organisations

NHS Dorset HealthCare University NHS Foundation Trust

NHS Dorset County Hospital NHS Foundation Trust

NHS University Hospitals Dorset NHS Foundation Trust

Volunteer Centre Dorset

NHS England

NHS South Western Ambulance Service NHS Foundation Trust

Dorset & Wiltshire Fire and Rescue

healthwatch Dorset

Department for Work & Pensions

CAN Community Action Network

Probation Service

HM Prison Service Public Sector Prisons

HMP Guys Marsh

HMP Portland

HMP The Verne

Dorset Council

Achievements during 2023-2024

Dorset Council continues to ensure that Making Safeguarding Personal principles are fully embedded and captured throughout all safeguarding enquiries. During 2023-24 this has included a key system change to enable individuals' views to be evidenced at the start of their safeguarding journey, ensuring their voice is consistently heard and recorded clearly.

A specific focus has been given to 'Transitional Safeguarding' with the establishment of a Task & Finish group co-chaired by Adults and Children's services. This has enabled consideration to how young adults who have experienced harm and trauma as a child can be effectively supported into adulthood to remain safe. A transitional safeguarding pathway is in development.

We continue to engage with our local communities to raise awareness of adult safeguarding and how to seek support where there are concerns that an adult with care and support needs is at risk of or is experiencing abuse and neglect. This has included the delivery of 2 community events. One in partnership with Dorset Community Action Network to engage with voluntary and community partners in the Weymouth, Portland and Dorchester area. A further event was delivered to Weldmar Trustees and Members.

Training & Development

- 17 Essential Adult Safeguarding Skills Courses delivered throughout year to ***255*** attendees.
- 5 Mandatory Adult Safeguarding Annual Updates delivered to ***247*** staff, providing a focus to local safeguarding practice, learning from SARs, whole family approaches and transitional safeguarding developments.
- Housing Options Team improved its staff induction, to embed safeguarding ensuring all staff undertake safeguarding e-learning and 'Essential Safeguarding Skills' 1-day course, as well as the mandatory annual safeguarding updates. Safeguarding has also been added as a standalone discussion on all caseworker's 121s to ensure that it is at the forefront of the work that officers undertake.
- Adult safeguarding quarterly webinars delivered to partners across the Pan Dorset region focussing on Cyber Influence and social media; the impact of Incels; Lasting Power of Attorneys (delivered by Office of the Public Guardian); Understanding Domestic Homicide Reviews and the launch of the Dorset Council, Missing Persons Protocol (developed in partnership with Dorset Police). A total of **467** colleagues have attended these webinars. A further session was also provided by REACH Drug and Alcohol Services to provide updates on the support they provide.
- During National Safeguarding Adults Week (in November 2023) further webinars, delivered by Bournemouth University included positive stories from social work practice and Child & Adolescent to parent violence and abuse. A wellbeing session was also provided focusing on the importance of staff looking after themselves, in order to better look out for others.
- This year's 15th Mental Capacity Act Conference – 'Power, Choice and Control' was attended by over 300 delegates. Alex Ruck Keene KC (Hon) delivered a session entitled 'Grappling with Deprivation of Liberty' with other sessions focusing on self-neglect, coercive control and Consent & Capacity.

Within the Dorset Mental Capacity Act Team there has been a 68% increase in granted Deprivation of Liberty authorisations during 2023-2024. This is positive as this ensures that vulnerable individuals are getting access to a right of appeal to challenge their deprivations.

Established mechanisms are in place between the Safeguarding service and Quality Improvement Team to work preventatively with providers promoting early intervention, sharing of concerns and to offer support to ensure services are of the expected standard.

What have the challenges been?

We have seen a further increase in the number of adult safeguarding concerns, received with an average of 120-150 each week, compared with an average 101 per week in 2022-23. Ensuring these are risk screened and responded to in a timely manner remains a priority. Undertaking proactive preventative work is key to supporting a reduction in safeguarding concerns.

We continue to strive towards improving our understanding of self-neglect to ensure that each person receives the right support from partners across the system. We have reviewed our current safeguarding team resources and established an Adult Safeguarding Self Neglect Practitioner to provide expertise and develop wider knowledge in this area.

As part of developing better relationships between colleagues in Housing and Adult Social Care we undertook a workshop to discuss the obstacles and challenges both teams face. From those discussions, ASC and Housing have agreed to jointly fund a pilot post to lead on bridging both services and attend appropriate hospital discharge meetings to ensure no delayed discharges and. This replicates the partnership working we already have in place with a similar role with Children's Services and will improve outcomes for those people currently receiving Adult Social Care interventions.

Future organisational plans to continue work on SAB Strategic Plan priorities

- With completion of the Transitional Safeguarding Pathway, we will work closely with Children's Services to launch and embed the approach across Dorset. We will promote our approach locally and nationally to inform good practice and joined up working across the system. This will further embed a 'whole family' approach to practice across the Council and support the work of the newly launched 'Birth to Settled Adulthood' Team.
- Preventative and community engagement events will continue throughout 2024-2025 with 2 new events being planned for the East and North of Dorset.
- We will be launching quarterly Social Care Provider safeguarding webinars in June 2024 with our Quality Assurance colleagues to further embed and develop understanding and knowledge across providers. The first, co-delivered with Dorset Police will focus on Dorset Council's Missing Person Protocol and the Police 'Herbert' Protocol. We will be launching new feedback opportunities for individuals and providers to enable their experiences and views to inform service development.
- A review of the Safeguarding Service model will take place in 2024-2025 to ensure a fluid and flexible service can be offered to all residents across Dorset who have care and support needs.
- We will continue to work closely with Integrated Care Board (ICB) colleagues and other partners to further nurture a county-wide approach to the prevention of abuse and neglect. This will incorporate our commissioning strategies and a review of the Homeless and Rough Sleeping Strategy to consider progress

in key areas such as enhanced housing support and hospital settings to reduce discharge delays and the impact on patient recovery due to homelessness or unmet housing need.

Dorset Police

Achievements during 2023-2024

- The Safeguarding Hubs within each of the two Local Policing Areas (LPA's) are now well embedded, allowing strong partnerships to be developed with the Local Authority teams.
- We have seen examples of excellent cross-agency working in both local authority areas in response to potential adults at risk concerns, including modern slavery and vulnerable adults.

What have the challenges been?

- Demand for specialist resources remains strong against a limited capacity.
- The Safeguarding Hubs have seen a high turnover of resources, often as a result of internal staff promotions and other issues, which can mean having to re-train new staff and losing experience.
- The understanding of data could be improved. There are difficulties in extracting data which could assist in the identification of trends and issues which may allow earlier interventions.

Future organisational plans to continue work on SAB Strategic Plan priorities

- Dorset Police will continue to deliver 'Vulnerability' training every year for our frontline staff. This will include a focus on being trauma informed.
- Dorset Police is in the process of developing a new 'Vulnerability Strategy' and governance arrangements. It will use the findings of a recent review by the 'Vulnerability Knowledge Practice Programme' (VKPP).

Dorset Police now has a Multi-Agency Risk Management (MARM) co-ordinator role within the Safeguarding Hub and has developed a governance structure to support the partnership approach and adhere to principles and guidelines. This includes robust triage management, a process to streamline practice and meaningful supervisory oversight. This ensures a whole system approach to understand and manage risk.

NHS Dorset

Achievements during 2023-2024

Continued development with partners of preventative work in safeguarding.
During 2023/24, NHS Dorset worked with NHS provider partners across Dorset and BCP to provide local guidance for the management of pressure ulcers through the policies and procedures published by the SAB.

Continuing to seek assurance on safeguarding practice across system partners.
NHS Dorset helped led the quality assurance sub-group of the SAB during 2023/24. A highlight of this work during the year was a focus on improving safeguarding practice in self-neglect across system partners. NHS Dorset arranged for the development of a self-neglect dashboard by the 'Dorset Insights and Intelligence Service' (DiiS) to aid this work. The dashboard identifies risk factors for self-neglect in the populations of BCP and Dorset to inform the Boards' strategy.

Assurance on delivery of 'Making Safeguarding Personal.'
Safeguarding clinical leads from NHS Dorset undertook safeguarding insight visits during the year to acute and mental health settings and GP practices to meet frontline healthcare practitioners. These visits provided an opportunity to triangulate the assurances provided by commissioned NHS providers about their approach to MSP.

What have the challenges been?

There remain opportunities to improve the volume and quality of partnership data about safeguarding practice available to the NHS Dorset safeguarding leads. A new safeguarding insights and intelligence group was set up and facilitated by colleagues in the DiiS during the year. This has provided a forum for partners to discuss ways to improve the interconnection and flow of partnership data.

Future organisational plans to continue work on SAB Strategic Plan priorities

Whilst commissioning large-scale NHS healthcare services from NHS providers across BCP and Dorset, NHS Dorset also directly employs a small workforce of frontline staff who work with adults with needs for care and support and their families. The NHS Dorset safeguarding clinical leads will continue to provide training and supervision to these frontline staff. During 2024/25 the leads will focus on improving knowledge about strategies for working alongside people who self-neglect and embedding the principles of trauma-informed care into practice in the context of MSP.

Dorset HealthCare University NHS Foundation Trust (DHC)

Achievements during 2023-2024

'Safeguarding adults' remains a priority in service delivery and patient safety across all service areas - mental health, learning disability and community physical health services. DHC has:

- Introduced 'DASH RIC' (Domestic Abuse Stalking and Harassment, Risk - Indicator Checklist') and 'Coercive and Controlling Behaviour' training as a response to learning from Domestic Homicide Reviews.
- Established 'Sexual Safety' task and Finish Group to improve sexual safety on inpatient mental health wards as a response to NHSE national quality improvement plan.

- Undertaken audits and developed plans to improve practice across all inpatient settings around 'Making Safeguarding Personal' including the use of the Mental capacity Act 2005.

What have the challenges been?

- Supporting staff to complete safeguarding training remains a priority but can be challenging when where there are vacancies or workload pressures.
- Measuring the impact of learning from Safeguarding Adult Reviews on frontline practice. The embedding of the Patient Safety Incident Response Framework (PSIRF) will support this going forwards.

Future organisational plans to continue work on SAB Strategic Plan priorities

Some of DHC objectives over the next year include a focus on:

- Homelessness (ensure preventative multi-agency working using a contextual approach to support people).
- Domestic Abuse (improve understanding of DA and coercive and controlling behaviours).
- Focus on Preventative safeguarding work - ensuring the principles of 'Making Safeguarding Personal' are applied in practice and continue to embed 'Think Family' into practice. This Includes knowledge and practice using the Mental capacity Act 2005.

DHC will also focus on

- improving partnership working under Multi Agency Public Protection Arrangements; transitional safeguarding and improving data collection and analysis of safeguarding activity within DHC.
- continue to provide quality assurance to the SAB that safeguarding priorities are in line with best practice and evidence positive outcomes for families. We will monitor our objectives to ensure they are delivered in line with the Board strategic plans through the Trust's bimonthly Safeguarding Group and the Trust's Quality Governance Group.

Dorset County Hospital NHS Foundation Trust

Achievements during 2023-2024

- Dorset County Hospital (DCH) throughout 2023-2024 has proactively contributed to all Safeguarding Adults Board meetings and subgroups. DCH has actively contributed to Safeguarding Adults Reviews, actioned learning and reviewed its implementation through internal audit.
- To support the delivery of the safeguarding agenda within DCH, there is a clear governance framework in place. The framework provides assurance to our commissioners & to the Safeguarding Adults Board that safeguarding is a priority throughout the healthcare system.
- Safeguarding sits within the portfolio of Director of Nursing & Quality and forms part of the Quality Strategy. There are established links from the frontline to the Trust Board of Directors with clear reporting mechanisms in place via structured internal governance committees.
- There is bespoke training for staff, supplementary to the mandatory safeguarding training, with a focus on the principle of 'Making safeguarding Personal'

(MSP) in combination with the application of the Mental Capacity Act to safeguard patients. Inclusion of the `think family` approach is adopted throughout training and advice. The Safeguarding Team offers advice and encouragement to DCH staff to have conversations with the patients/ service users, giving them the opportunity to voice their wishes, needs and outcomes, therefore reflecting the safeguarding personal agenda.

What have the challenges been?

DCH and the whole of the NHS has seen numerous challenges: staff shortages and retention, industrial action, waiting list backlog impacting on patients, financial issues, health care inequalities, social care budgetary limitations, lack of housing for patients and staff & evolving healthcare needs of an ageing population.

Future organisational plans to continue work on SAB Strategic Plan priorities

DCH has undertaken a staffing review and successfully recruited into three new roles within the safeguarding team which will offer the opportunity for qualitative project work to be undertaken, alongside operational demands. DCH has collaborated in several case management processes for Children & Young people (CYP) transitioning through to Dorset Council`s adult services. DCH has recruited a Complex Care Coordinator for CYP 0-25 who will work in conjunction with the safeguarding team to provide visible, credible professional clinical leadership, supporting the clinical management of CYP up to the age of 25yrs, with complex needs including social, emotional, and mental health needs

University Hospitals Dorset NHS Foundation Trust (UHD)

Achievements during 2023 – 2024

- Strengthened the learning difficulties portfolio to include neurodiversity.
- Continue to support the wider system safeguarding agenda, working collaboratively with safeguarding partners in health, social care, and police.
- Continued to embed the 'Think Family' approach across UHD.
- Engaged in partnership working on the policing 'Right Person Right Care' model.
- Involved families in direct 'lived experience' training stories to improve care.
- Strengthening 'Making Safeguarding Personal' in training and updating our Cause for Concern form, post local audit.
- Achieved the Key Performance indicator for safeguarding adult level 1 and 2 training at 90%, and launched level 3 Adult training, ensuring staff are well informed on safeguarding practices.
- Recruitment of a perinatal mental health practitioner.

What have the challenges been?

- The Trust has been challenged with managing the Mental Capacity Act (MCA) / Deprivation of Liberties Safeguards (DoLS) interface for patients who are medically fit but detained in the hospital for their own safety. These processes are externally managed making the application of the correct framework difficult. Partnership working to resolve this issue has begun.

- The rise in patients presenting with challenging behaviours has continued, resulting in high-cost agency nurse spend to support safe care delivery. A partnership project with Dorset Health Care NHS Foundation Trust, has begun to look at models of care.
- The management of long length of stay 'no criteria to reside' patients awaiting specialist health or social care placement.

Future organisational plans to continue work on SAB Strategic Plan priorities

The key focus of the safeguarding teams at UHD will continue to be ensuring that all our staff continue to safeguard people. We will achieve this through on-going training, education and feedback to teams aligned with partnership working to meet the systems strategic plan and objectives. Key programmes of work this year include:

- Models of care for mental health patients in the acute physical health setting.
- Furthering understanding around neurodiversity in care.
- Refining of referral pathways from UHD to ensure the person's voice is heard and they receive the best fit signposting and offers of support.
- Trust Board assurance on safeguarding practices will continue through internal governance.

Dorset & Wiltshire Fire and Rescue Service (DWFRS)

Achievements during 2023-2024

We are an active member of the National Fire Chiefs Council (NFCC) Safeguarding Workstream and work for this year has included: the launch of four new guidance documents:

- safeguarding children and adult's competency framework
- managing allegations
- positive disclosure guidance
- guidance on DBS checks for specific FRS roles following the inclusion of fire and rescue authority employees in the Rehabilitation of Offenders Act (Exceptions) Order 1975;

We participate in the NFCC workstream on hoarding and mental health awareness. We ensure that all training for staff is aligned to the principles of 'Making Safeguarding Personal'. We continually exceed our training targets across all levels and referrals continue to increase each quarter which evidences that training and campaigns are effective in embedding safeguarding into the organisation. Following an increase in incidents associated with mental health, we have updated our recording systems so we can collate accurate data on incidents related to mental health and suicide to identify possible gaps in training. This is especially relevant with the introduction of Right Care Right Person.

What have the challenges been?

Like many organisations, uncertainty around finances continues, bringing challenges and a need to find significant annual savings. That said, the organisation takes its safeguarding responsibilities seriously and has invested in the expansion of the safeguarding team to meet demands and ever-

increasing referrals. Challenges when making referrals can be finding support for individuals who are self-neglecting, hoarding and/ or have substance misuse issues. Given that we are seeing an increase in incidents related to mental health, we find that timely resources are lacking which can mean fire crews being delayed at incidents where they are not the right people to be dealing with the situation. Our staff are very positive about safeguarding but receiving feedback following a referral would be beneficial so they can evidence what a difference the referral may have made to an individual.

Future organisational plans to continue work on SAB Strategic Plan priorities

Prevention is always at the forefront of our work. We are reviewing and increasing training and resources, with a particular focus on mental health, safer recruitment, preventative work for people who use emollients and application of 'Making Safeguarding Personal'. To support staff working at incidents with an individual in crisis, the Joint Emergency Services Interoperability Principles (JESIP) guidance has been finalised and will be implemented soon along with negotiator awareness training being delivered to our technical rescue teams. We are also looking at the possibility of accessing other emergency service mental health support desks to support crews with a timely response when FRS is the only emergency service in attendance. This will be beneficial to staff and the individual.

HMP The Verne (Prison)

Achievements during 2023-2024

- Despite not being funded for resettlement of prisoners we have successfully re-housed the majority of prisoners in the past year on release
- We use a multi-disciplinary approach to preparing prisoners for release, recognising that this is one of the most vulnerable times for a prisoner, Weekly re-settlement meetings are held to discuss prisoners entering release and we signpost prisoners to support services ahead of release and co-ordinate with Community Offender Managers to minimise the risk of failure.
- Following introduction of the Neurodiversity Support Manager Role we now have a good understanding of the needs and vulnerabilities of the prison population with approximately 34% who are Neurodivergent. This has enabled us to put reasonable adjustments and support in place for them in education, skills and work. The overall aim being to reduce the risk of reoffending and focus on the needs of a population who have high rates of self-harm and suicidal ideation within the wider service.
- Significant steps have been taken to up-skill staff in terms of their knowledge of Neurodiversity and make HMP The Verne 'Neurodiversity friendly' for prisoners and staff.
- The Neurodiversity Support Manager has presented to the Dorset Domestic Abuse Forum to raise awareness of her work, which is as relevant to victims as it is to perpetrators.
- The Custodial Manager for Social Care has developed a positive relationship with the Local Authority. This has led to earlier identification of the support needs of prisoners and also timely Care Act referrals and assessments.
- The prison's social care unit opened this year to provide 24/7 support to prisoners with social care needs.
- 'Oxleas' our Healthcare provider has employed a Senior Occupational Therapist who will help in identification of support needs and the service we are able to deliver to prisoners on-site.

What have the challenges been?

- Ageing population with increasingly complex needs.
- We are not currently funded to provide 24/7 nursing care or palliative support.
- We are receiving prisoners much sooner after sentencing, receiving more younger prisoners, some of whom are vulnerable and susceptible to areas of risk such as grooming, county lines and have a history of substance misuse.
- Population of IPP (Imprisonment for Public Protection) prisoners is increasing and, nationally the rates of suicide among IPP prisoners are the highest. Whilst our data shows that the Verne does not reflect the national picture, we have put in place 'progression panels' and a support forum to support this vulnerable population.
- Employment opportunities for Prisoners Convicted of Sexual Offences (PCOSO) remain a challenge. Many are housed post-release in temporary accommodation 'Approved Premises' and require a period of stability before they are permitted to seek work. We know that employment is a key factor in reducing re-offending on release.
- High levels of self-harm among the prison population remains an ongoing area of safeguarding risk. For many prisoners this is an entrenched coping mechanism. However, the risk of accidental death during self-harm incidents remains high.

Future organisational plans to continue work on SAB Strategic Plan priorities

- Continue to embed staff with knowledge relating to areas of safeguarding risk i.e. grooming, self-harm, county lines.
- Ongoing training for staff regarding the Mental Capacity Act 2005 and Care Act 2014.
- Review of current Safeguarding policy to ensure that it is in line with both national and local policy and covers areas of emerging risk due to population pressure and changes in demography of the prison population.
- Continue to build links with the local community.

HMP Portland (Prison)

Achievements during 2023-2024

HMP Portland continues to run a weekly 'Release Planning Meeting' that identifies all prisoners within 12 weeks of release and checks that either accommodation is in place, or appropriate measures have been taken, such as DTR (Duty to Refer) and CRS (Commissioned Rehabilitative Services) to ensure accommodation can be provided as soon as practicable on release. Those prisoners assessed as vulnerable are prioritised and where gaps are identified, actions are taken from the meeting to provide the necessary support. This involves multi-agency working with the Prison Offender Manager and the Community Offender Manager acting as liaison between prison and community services.

HMP Portland has successfully implemented the ECSL scheme (End of Custody Supervised Licence). ECSL is an administrative and operational scheme that enables the release of eligible prisoners for a period (the Specified ECSL Licence Period) in advance of their Conditional Release Date. Those prisoners released on ECSL will be subject to the full range of licence conditions (including good behaviour) following release.

ECSL will only apply to a specified number of establishments where local population trends indicate that maintaining safe and decent conditions and future new prisoners from courts will require the implementation of this scheme. We have worked closely with probation departments to ensure that those being released under ECSL have been done so in a safe manner. Anyone who was considered to pose a risk to themselves or others, who had Approved Premises accommodation at their conditional release date but not on their ECSL date, were kept in custody until their CRD or until the bed could be brought forward.

The Community Accommodation Service level 3 has been introduced so that all prisoners will have up to 84 nights in basic accommodation provided but this is not available for those men who are released without any supervision from Probation. Those staff involved in domestic visits and family days have completed online safeguarding training.

What have the challenges been?

A shortage of staff in the Pre-Release Team and in the Offender Management Unit and a significant challenge continues to be the volume of prisoners who have been recalled to the prison who, when released at end of sentence with no Probation supervision, have very limited access to support.

HMP Portland is committed to working on this area of need to support by expanding the Pre-Release on supervision and escalate to a manager in the community when support is not being provided leading up to release. Continual changes to early release schemes have put pressure on probation, prison offender managers and pre-release teams due to tight timeframes in which individuals must be released. HMP Portland has developed a working group and strategies to support the safe release, with the pre-release team commencing work earlier than the 12 week point to ensure that all individuals are captured.

Future organisational plans to continue work on SAB Strategic Plan priorities

- Homelessness: lack of suitable accommodation on release has been shown to have a direct impact on mental health, likelihood of reoffending, risk of self-harm, drug and alcohol misuse etc.
- There are many measures in place within the prison to support vulnerable adults such as the CSIP (Challenge, Support and Intervention Plan), SIM (Safety Intervention Meeting), ACCT (Assessment, Care in Custody and Teamwork) document. However, where support is not there in the community, other agencies are hampered when someone has no fixed abode.
- Continue information sharing with external partners on individual risk to ensure safeguarding measures are in place both in custody and upon release.
- The introduction of resettlement fayres which involve numerous external agencies and employers. These fayres can be accessed by those working towards release.

Dorset Probation Service

Achievements during 2023-2024

- We have ensured that all practitioner staff in Dorset have undertaken training and have an understanding of the Multi-Agency Risk Management (MARM) process and that it is considered for all appropriate cases.
- All staff are required to complete mandatory training on adult safeguarding. We have also raised awareness amongst middle managers in the organisation to ensure that they are aware when consideration of a Safeguarding Adult Review (SAR) referral should be made. Learning from a SAR was utilised as part of a MAPPA (Multi Agency Public Protection Arrangements) development conference which received positive feedback from attendees.

What have the challenges been?

Ensuring continuity of care within a criminal justice system can be a challenge particularly as some people are placed in prisons outside of the Dorset area and may be assessed in other areas of the country. Prison capacity concerns has meant we've seen people released with less time to prepare for release which has been a challenge when there are needs such as social care to coordinate.

Future organisational plans to continue work on SAB Strategic Plan priorities

- We are going to promote stronger awareness of the needs and challenges related to adult safeguarding in the Criminal Justice System and improve collaboration from all partners. This will include contributing to an extraordinary board meeting of the Adult Safeguarding Board focused on Criminal Justice topics and learning.
- We aim to present learning on developing more efficient working within the MAPPA process, overcome challenges relating to managing a higher proportion of people with social care needs both in prison and the community and raising awareness of the roles such as that of the Health and Justice Coordinator in Probation.

South Western Ambulance Service NHS Foundation Trust (SWASFT)

Achievements during 2023-2024

- Effective Governance - Safeguarding Team Governance processes have been enhanced to include a Safeguarding Committee meeting bi-monthly to monitor safeguarding activity and provide assurance on safeguarding practice. The Safeguarding Committee reports to the Quality Committee providing assurance and raising issues for escalation. The Quality Committee reports into the Trust Board. Safeguarding reports are provided to commissioners via NHS Dorset Integrated Care Board (ICB) and The Head of Safeguarding from Dorset is a member of the Safeguarding Committee.
- Effective Learning - In late 2023 a review of SWASFT safeguarding training was completed by independent reviewers. The review identified the need to strengthen safeguarding training and to undertake a Training Needs Analysis to review training provided to each staff group. This action has been completed and a revised training offer is in place for 2024/25 which includes an additional 4.5 hour face-to-face safeguarding training on the development days, bespoke face to face training for the Emergency Operations Centres and enhanced two-day level 3 safeguarding training for identified senior staff groups. The delivery of formal training will also be supported by ad-hoc learning opportunities, digital learning resources, bespoke targeted training sessions and the provision of safeguarding supervision by the Safeguarding Specialists.
- Effective Prevention and Protection - The safeguarding team has undertaken a full review of all referral forms, revised to ensure they align to the Care Act, and to provide local authority colleagues with the information they require to facilitate triage of Safeguarding Concerns raised. These also support SWASFT staff in raising high quality referrals and increase availability of data to support assurance reporting, audit and team learning and development.

What have the challenges been?

SWASFT safeguarding team had limited resource and capacity during 2023/24. This, coupled with a manual referral system handling approx. 51,000 referrals in the year across the whole SW region made it challenging for the team to progress with service improvement and to be a visible partner in the wider system. This has improved following the recruitment of a permanent Head of Safeguarding, a Deputy and an additional 5 Safeguarding specialists

Future organisational plans to continue work on SAB Strategic Plan priorities

SWASFT safeguarding improvement plan was developed following an independent review of safeguarding during 2023/24. Our plan is framed around 5 key deliverables which closely align to the SABs strategic plan. These are robust governance, assurance & reporting; Safeguarding team capacity, a new safeguarding referral system, data capture, audit and learning from incidents; and safeguarding education & supervision.

A Safeguarding Story

In the previous pages Board members have shared how they have worked towards achieving the Boards' objectives. It is important to answer the '… and so what?' question - the context of how this might help safeguard an individual.

At its meetings the Board always showcases a person's story, evidencing some of the work undertaken by agencies in Dorset to safeguard people. Here is Cecily's story.

Cecily and her late husband retired to Dorset where they lived in a beautiful home overlooking the sea. Cecily owned her home and had other financial assets. Cecily had enjoyed meeting people through her work and had always taken great care of her appearance; this continued after she retired. She had a great sense of humour and enjoyed the company of others.

Cecily employed a local woman, Lena, to provide care for her over a 9-year period. Of note is that Cecily's support needs increased significantly following a hospital admission to include night care. It is possible that Lena and Cecily met when Cecily had respite in a local care home where Lena was working.

A safeguarding concern was raised by an anonymous person, who later identified themselves as someone who provided 'relief' cover when Lena was unavailable. They were fearful of Lena hence remaining anonymous. The safeguarding concerns raised included financial abuse, neglect and coercive and controlling behaviour towards Cecily.

A number of different agencies were involved including Dorset Police, the GP, an Independent Mental Capacity Advocate (IMCA), the Adult Social Care Locality Team and Children's Social Care (CSC). CSC were involved after it was alleged that Lena's child was also providing care to Cecily. There were also concerns about Domestic Abuse in Lena's household and the impact on her own child (discussed at a High Risk Domestic Abuse meeting, HRDA) as well as drug/ alcohol use. CSC advised adult safeguarding of concerns about the family which supported the adult safeguarding process and robust multi-agency risk management.

The Safeguarding Practitioner built a positive relationship with Cecily over several months to enable her to speak about the abuse and understand the coercive behaviour she was experiencing. Cecily was consulted at every stage and her views and wishes heard. After a period in hospital, Cecily was able to return to her home and was supported to identify suitable live-in carers by the hospital and locality teams. Cecily was supported by the locality team for several months to support her move home and ensure she received the right care and support including the provision of equipment and assistive technology.

This story is a good example of Multi-Agency/ System working, involving an Independent Mental Capacity Advocate (IMCA), Dorset Police, Adult Social Care Locality Team, Nursing/ GP, Mental Capacity Act Team and Children's Social Care (CSC). Making Safeguarding Personal principles were used, Cecily's views and wishes were heard at all stages of the safeguarding intervention. The safeguarding team have developed closer working relationships with the CSC Local Authority Designated Officer (LADO) and now have a clear process in place regarding how information is shared.

Thank you for reading our Dorset Safeguarding Adults Board Annual Report 2023-24.

If you would like to get in touch, please do so using the following email or telephone contact details:

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