Torbay and Devon Safeguarding Adults Partnership

Annual Report 2022/2023

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Section 1: Chair's Foreword

1.1 Paul Northcott – Independent Chair

In the last twelve months all of the Board members have continued to work hard to deliver our statutory obligations and improve practice across all of our 2022/2023 priorities. As a Board we have made a conscious decision to focus on the progression and completion of safeguarding adult reviews. These reviews play an integral part of our assurance process and they allow us to work with frontline staff, managers and families to not only identify areas of improvement but also best practice.

As the Independent Chair of the Board I have personally witnessed the impact that these reviews have had on the partnership resources who had to balance these responsibilities with their operational commitments. We have continued to receive the support of those senior leaders who sit on the Board to fully explore these cases and there has been a concerted effort to deliver the outcomes and recommendations from these reviews. We are committed to not only ensuring that the learning from these cases is being embedded across both Torbay and Devon but we will also check that we are making a difference to frontline practice. This work will be carried out through our Quality and Assurance subgroup and will be routinely reported back to the Board.

Over the last twelve months the Partnership has been flexible in the way that it has developed its workplans and these have been regularly reviewed by the Board members. The outcomes from these pieces of work are evident in the content of this report and have included the publication of an information sharing protocol and improved multi-agency training that reflects local cases.

Our subgroups continue to transition to their new terms of reference and adapt to meet the changes in staff and workloads that we have encountered. Those that attend the subgroups have remained strong in their commitment to the Board.

The Community Reference Group continues to play an important part in ensuring that the work that is carried out by the Board remains grounded and meets the needs of the communities that we serve.

I would like to take this opportunity to thank all of the agencies for their contribution to the Board.

Section 2: Our Purpose

The Torbay and Devon Safeguarding Adults Partnership (TDSAP) is the collective name for the partners that work with the Board to safeguard adults across Torbay and Devon.

The TDSAP provides strategic leadership for adult safeguarding across Torbay and Devon and is independent, with an independent chair.

The core objective of the Safeguarding Adults Partnership, set out in section 43(2) of the Care Act 2014, is to help and protect adults in its area in cases where an adult has care and support needs and;

- They are experiencing, or at risk of experiencing, abuse or neglect; and
- As a result of those care and support needs, they are unable to protect themselves from either the risk of or the experience of abuse or neglect

The TDSAP acts as the key mechanism for agreeing how agencies work together to safeguard and promote the safety and wellbeing of adults at risk and/or in vulnerable situations. It does this by co-ordinating what each of the TDSAP members does and ensures that they do it effectively.

Section 3: Our Structure

The TDSAP has established a meeting structure to undertake work on behalf of the Partnership.

The TDSAP has two groups reporting into the Board namely the Safeguarding Adults Review Core Group and the Operational Delivery Group.

Reporting into the Operational Delivery Group are three sub-groups namely the Learning and Improvement sub-group, the Performance and Quality Assurance sub-group and the Community Reference Group. These meetings will continue to be supported by the Partnership Practice Lead, Partnership Business Manager and Partnership Co-Ordinators.

TDSAP Organisational Structure

Section 4: Our Partnership Members

4.1 Statutory Partners

The Statutory Partners of the TDSAP are:

Devon and Cornwall Police	Devon County Council
Torbay Council	NHS Devon ICB

4.2 Partners

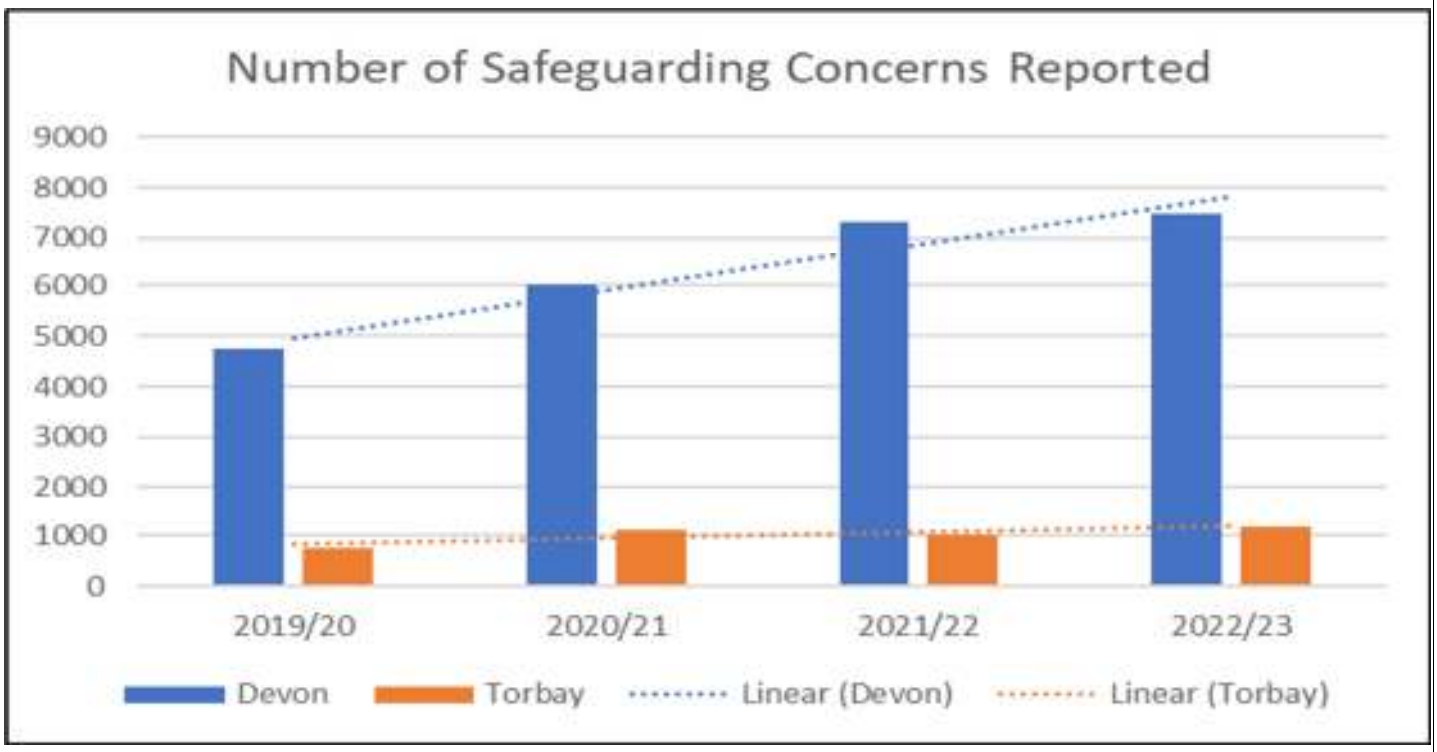
Other partner members of the TDSAP are:

Torbay and South Devon NHS Foundation Trust	Devon Partnership Trust
Royal Devon University Healthcare NHS Foundation Trust	NHS England/Improvement
University Hospitals Plymouth NHS Trust	Housing Representative
Livewell Southwest	Devon & Somerset Fire & Rescue Service
South Western Ambulance Service Foundation Trust	Care Quality Commission
The Department of Work and Pensions	Voluntary and Community Services Representatives
HM Prison Service	Healthwatch
The Probation Service	The Heart of the South West Trading Standards
District Councils	

Section 5: Safeguarding Activity

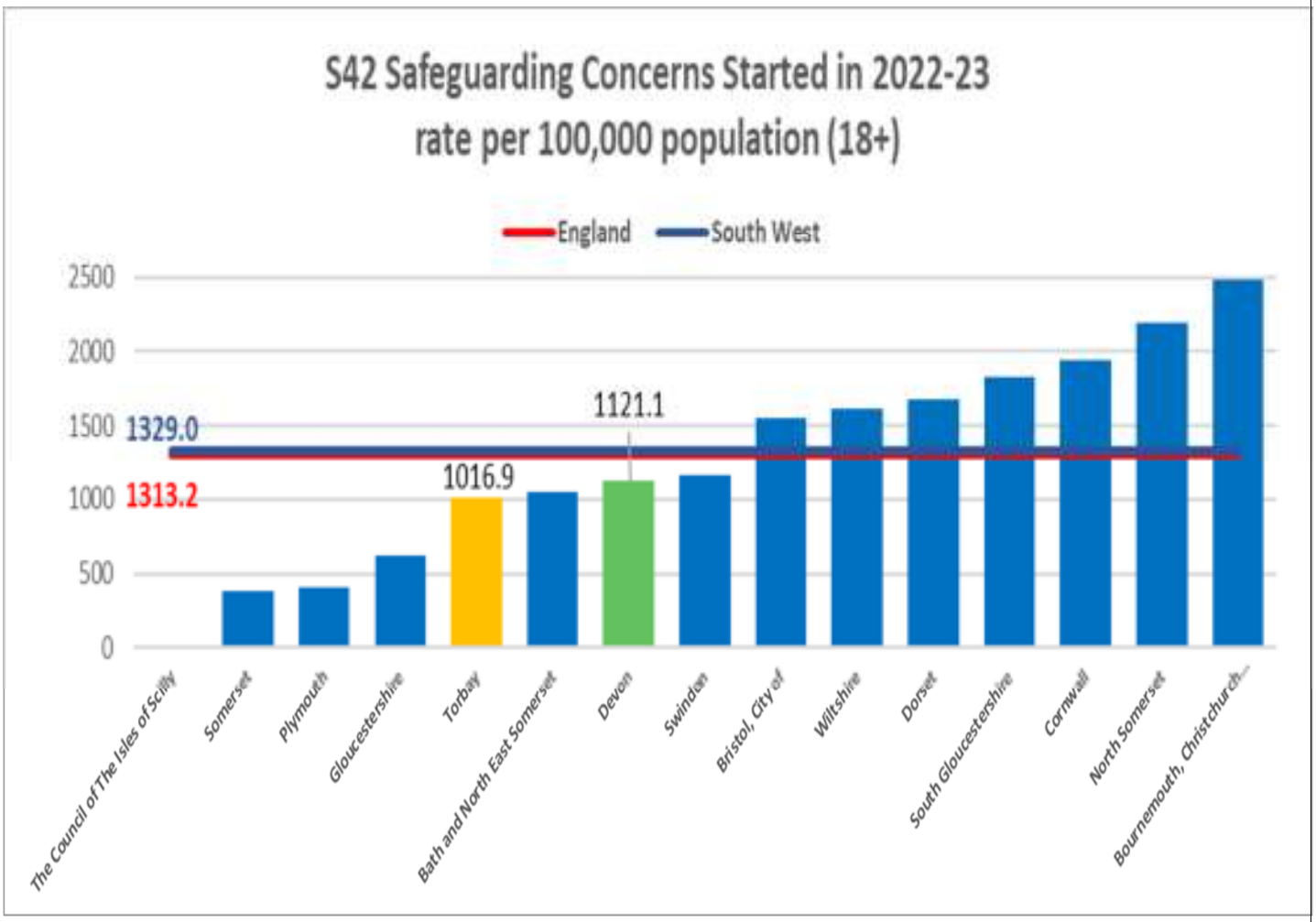
The data below is routinely monitored through the Performance and Quality Assurance (PQA) Sub Group and by Board members, to identify trends and areas for additional scrutiny. This includes variances against national and comparative area data. The data has been included in this report to demonstrate the safeguarding activity over the 2022-2023 period

5.1 Section 42 - Safeguarding Concerns



The linear trend in the number of safeguarding adults' concerns is Devon is upwards but has flattened between 2021-22 and 2022-23. The numbers of concerns have been rising because of a combination of concerted action to address the low rate of reported concerns compared to the national figures and national guidance published in 2020 standardising practice of what constitutes a safeguarding concern. This did not mean that previously concerns were not being responded to, but that they were being directed to more appropriate pathways, for example to receive an assessment of needs.

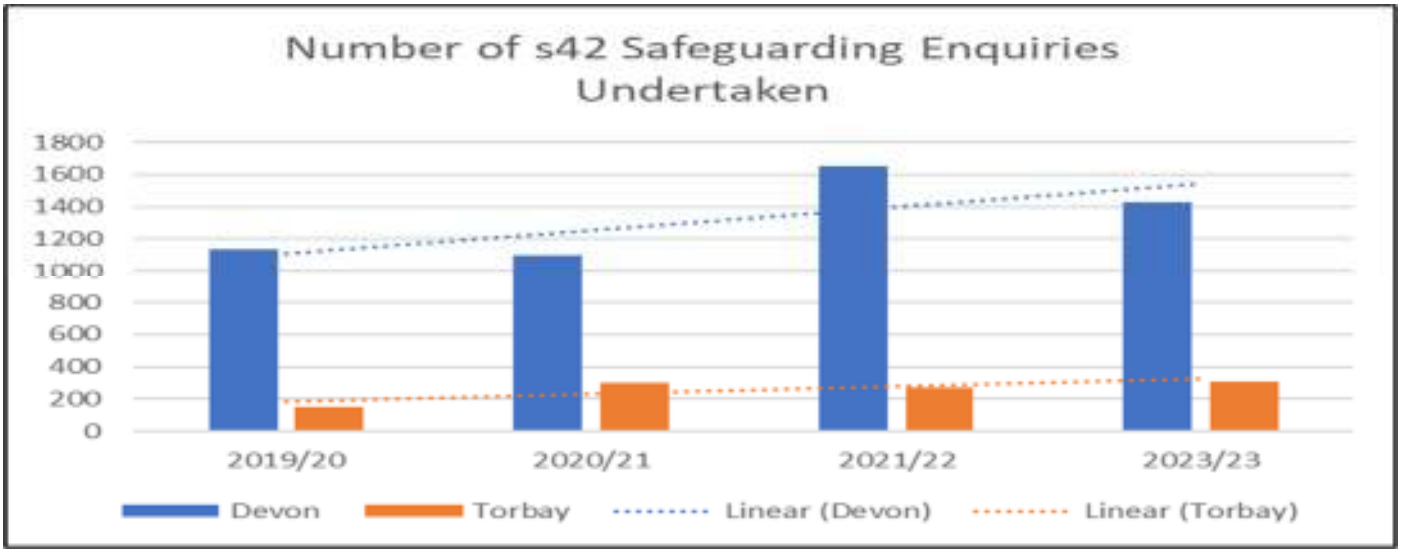
The linear trend in Torbay's safeguarding concerns is also upwards, but less marked due to smaller numbers. There was an increase in the number of reported safeguarding concerns corresponding with the publication of the national guidance in 2021/22 but this has remained at the same level in 2022/23.



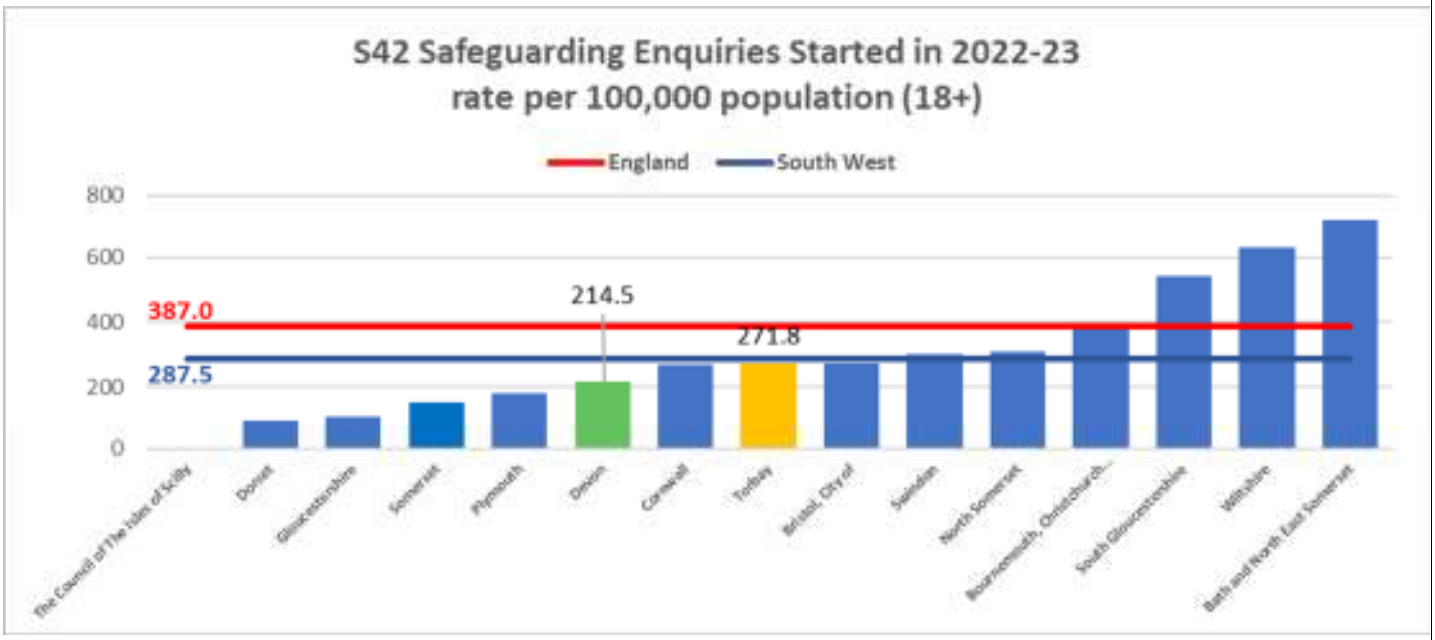
Expressing safeguarding concerns as a rate per 100,000 population (18 and over) for comparability shows Torbay's activity (1016.9) in 2022-23 was below Devon (1121.1). Both Authorities have safeguarding concern activity levels below the national (1313.2) and regional (1329.0) averages and are at the lower end of the regional comparator Authorities.

In Torbay, the safeguarding adult single point of contact service sits within the Adult Social Care Front End service. This enables the Torbay team to establish quickly if a contact is an actual adult abuse concern or should be signposted to another team to respond.

5.2 Section 42 – Safeguarding Enquiries



Numbers of S42 safeguarding enquiries (concerns that meet the threshold for further investigation) undertaken by both authorities have been on a linear upward trajectory. There is greater consistency in the annual safeguarding enquiry activity levels in Torbay than in Devon. The percentage rate for concern to enquiry in Torbay has been stable in the last 3 reporting periods.



For S42 safeguarding enquiries started during 2022-23, the Devon rate per 100,000 population (18 and over) has reduced reflecting a fall in the conversion rate between years. Both authorities (Devon 214.5, Torbay 271.8) have lower levels of comparative safeguarding activity than the national (387.0) and regional (287.5) averages in 2022-23.

5.3 Demographics

59% of individuals in Devon and 62% in Torbay involved in safeguarding concerns in 2022-23 were female. This is consistent with previous years and the national trend. This is disproportionate to the overall Devon and Torbay population, although not necessarily the elderly population which most of our safeguarding activity relates to.

84% of individuals in Devon and 62% in Torbay involved in safeguarding concerns in 2022-23 recorded their ethnicity as white. The proportion of people in Devon who describe themselves as white British increases with each age group and safeguarding data on ethnicity should therefore be considered in conjunction with data on age. This data shows that most Safeguarding concerns in Devon relate to individual's aged 65 and over.

Whilst the ethnicity data for people involved in safeguarding activity in Devon and Torbay is representative of the Census 2021 population demographic it is highly likely that we are seeing under representation of other ethnic groups due to custom and cultural practice.

5.4 Location of Risk

64% of S42 enquiries pursued in Devon, and 44% in Torbay, in 2022-23 took place within the person's own home. This has been rising for both authorities over the past couple of years and for Devon is now a higher proportion than the national picture (47% in 2022-23).

Torbay has always had a higher proportion of enquiries recorded in care homes, which could be reflective of it having a higher relative proportion of care home beds. Although, there has been an increase in the proportion of Devon enquiries relating to care home settings at 20%, this remains below the national comparator (33%). There has also been an increase in the Torbay proportion to 47% in 2022-23 putting it significantly ahead of the national comparator (33%). Approximately 2 thirds of provider concerns are reported by providers themselves.

The Torbay integrated health and social care functions include making decisions on s.42 duties as well as causing out s.42 duties to its health regulated services. Where there is reasonable cause to believe that a safeguarding concern meets the s.42 duty for health regulated settings, the ICB is consulted to ensure external scrutiny and oversight of safeguarding responses. In Devon the proportion remains typical to 2021-22 at 5%. Both authorities are below the national comparator (8%).

5.5 Types of Risk

For Devon the most common sources of risk in 2022-23 were Self-Neglect (19%) and Psychological Abuse (16%). Neglect & Acts of Omission and Physical Abuse in Devon have now reduced below the national comparator. For Torbay Neglect & Acts of Omission (24%) and Physical Abuse (15%) were the most common sources of risk. This is typical to the national picture where the most common sources of risk are Neglect & Acts of Omission (32%) and Physical Abuse (19%).

5.6 Making Safeguarding Personal (MSP).

Approaches to safeguarding should be person-led and outcome-focused. In Devon (91%) and Torbay (84%) of people or their representatives were asked about their desired outcomes in safeguarding enquiries in 2022-23. In response, Torbay has created a 90% key performance indicator for this issue. Of those people who were asked about their desired outcomes, 93% of people in Devon had their outcomes met, either in full or part, with 93% in Torbay. Devon is typical to England (94%) and the South West region (94%) whilst Torbay lie just below the national and regional comparators.

Section 6: Safeguarding Adults Reviews (SARs) and our SAR Core Group

6.1 Summary

Formerly known as Serious Case Reviews (SCR), Safeguarding Adults Reviews (SARs) are a statutory duty under the 2014 Care Act for Safeguarding Adults Boards to undertake. A SAR is completed when:

- an adult 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
- an adult is still alive but has experienced serious neglect or abuse and there is concern that partner agencies could have worked more effectively to protect the adult
- Boards may also arrange for a SAR in any other situation involving an adult in its area with needs for care and support.

SARs are a way for all agencies of the partnership to identify the lessons that can be learned from particularly complex or high risk safeguarding adults cases and to implement changes to improve services.

The TDSAP has a dedicated SAR Core Group. The SAR Core Group is responsible for decision making on new SAR referrals and for managing all SARs through to completion.

The SAR Core Group membership consists of multi-agency partners who meet regularly. The SAR Core Group members include representatives from NHS Devon ICB, Torbay County Council, Devon County Council, Devon Partnership Trust (DPT), Devon and Cornwall Police and partner representatives from other organisations as required.

6.2 SAR activity during 2022/23

The TDSAP received thirteen SAR Referrals in 2022/23 from seven different partner organisations.

Following thorough consideration of these SAR referrals, the SAR Core Group decided that three of them met the criteria for a SAR review to take place, as defined within Section 44 of the 2014 Care Act.

The themes from these referrals include:

- **Mental Health** (any support that people receive to protect or promote their mental health and psychosocial wellbeing).
- **Self-Neglect** (a person being unable, or unwilling, to care for their own essential needs)
- **Substance Misuse** (Substance misuse develops when you continue to take substances which change the way you feel and think)
- **Neglect/Acts of Omission** (the failure to meet individuals basic and essential needs, either deliberately or by failing to understand these).

In 2022/23 the Torbay and Devon Safeguarding Adults Partnership completed 3 SAR's, two of which were published on the TDSAP website. Regarding the third, a decision was made by the TDSAP Board, not to publish due to the sensitive nature of its content.

With all SAR reviews, the identified learning and SAR recommendations are progressed and embedded into operational practice. The purpose of a SAR is not to reinvestigate or to apportion blame. It is an opportunity to uncover learning for all partner agencies involved and to make changes to practices in the future.

More information is available on our website about SAR Thresholds, how to complete a SAR Referral and our previously published SARs

6.3 Published SARs

6.3.1 SAR Ella
Summary of the review into the death of Ella
Ella was a 77 year old woman who was murdered in her home between the 9th and 12th January 2021 by Mr. M, an employee of an independent care provider. She had a number of health and mobility difficulties which severely restricted her lifestyle and rendered her in need of care and support.

The murder followed an allegation of financial abuse and fraud committed by Mr. M against Ella. He was suspended by the care provider but returned to Ella's home where he committed the murder.

Mr. M was found guilty following a criminal trial and on the 30th July 2021 was sentenced to life imprisonment with a minimum tariff of 30 years.

The review positively highlighted the high level of cooperation and information sharing between partner agencies and the frequent concerns expressed about how Ella's own actions were increasing risks to her safety and wellbeing.

Professionals worked successfully to maintain the spirit of **Making Safeguarding Personal** and respect Ella's wishes. However it raises the question, whether a greater exercise of professional curiosity may have revealed that the carer was going beyond his brief and nurturing an exploitative relationship with Ella.

Learning Point: Financial Abuse Given the often-hidden nature of financial abuse, agencies should be aware of the need to exercise greater vigilance, especially where supporting people with limited independence and/or mental capacity in areas of their life.

Recognising someone who may be at risk of financial abuse is important and so is recognising the characteristics of potential abusers.

Learning Point: Safeguarding Staff frequently are called upon to exercise judgment about whether to override a person's views either in their own best interests or for wider safeguarding reasons. This SAR highlighted that a safeguarding concern referral should have been made on a previous occasion in January 2020 when financial theft was alleged by a care worker.

Learning Point: Sharing Intelligence Information about potentially dishonest carers should be recorded and passed to the Police as care staff may move between health and social care settings.

Learning Point: Disclosure and Barring Service (DBS) Checks Agencies should consider and take action to fully mitigate the potential risks posed to clients from information obtained through DBS checks.
Should partner agencies have additional information not contained within the DBS disclosure they should consider this as part of the risk assessment. This would support an informed consideration of the potential risk posed by the employee.

Learning Point: Risk Assessments Where agencies have identified risks through risk assessments, there should be a clear plan as to how those risks and future behaviours will be monitored to ensure risks to clients are mitigated.

In doing this agencies should ensure robust application of their internal policies as part of the risk monitoring for example testing for alcohol and drugs misuse.

Learning Point: Care and Support Provision Clients who are isolated and lonely may be at greater risk of being exploited. The practice of having a team around a person, as opposed to a single carer, is important both for continuity of care and for protection of the client.

Care and support plans should consider the person's vulnerability and the potential risk of financial abuse.

Learning Point: Safeguarding Where a crime has been committed immediate advice should be sought from the Police. Details of an allegation of a criminal nature should not be disclosed to the person considered to pose the risk.

6.3.2 SAR Thematic Review – Self-Neglect

A summary of the individuals concerned

AA: a man in his 50s with multiple complex health conditions who died (Dec 2018) in conditions of extreme squalor less than 4 weeks after discharge from a long stay in hospital.

BB: a woman in her 70s who died (Dec 2019) in a fire while using a gas hob to provide heating. She had dementia and consumed significant amounts of alcohol. Her home was dirty and neglected and she often declined support.

CC: a woman in her 60s who died (Jan 2020) of cellulitis with sepsis. Her long-term involvement with mental health services had ceased due to staff shortages and she had disengaged from her care and support providers. CC's relative has requested she be referred to as Gilda.

DD: a woman in her 80s who died (May 2020) emaciated, covered in faeces and urine burns, malnourished and anaemic. Living a reclusive life, she had become further isolated during the Covid-19 lockdown.

EE: a man in his 50s who died (July 2020) of sepsis and renal failure. He had a range of co-morbidities and a history of serious infections, but often declined interventions and did not follow lifestyle advice. He became further isolated as a result of the Covid-19 lockdown.

FF: a man in his 50s who died (September 2020) of bilateral subdural haematoma and liver cirrhosis just a week after discharge from a prolonged hospital stay, having returned to excessive alcohol consumption and declining self-care.

Learning Point: Health and social care needs Shortcomings included failure to address alcohol consumption, particularly in the context of mental health needs; continence supplies not being

made available; delay in summoning help when unable to rouse the individual; unlawful interpretation of the mandate for care and support needs assessment; failure to escalate concerns regarding deteriorating health; failure to respond to worsening mental health. Practitioners can become accustomed to poor standards of hygiene and fail to recognise the need for proactive intervention.

Learning Point: Mental capacity Mental capacity did not receive adequate attention. In several cases involving high-risk decision-making, no capacity assessments took place and no attention was paid to the possible loss of executive function. There was an over-reliance on assumptions of capacity and on the concept of lifestyle choice.

Learning Point: Safeguarding There were shortcomings in actions to safeguard the individuals concerned and evidence that practitioners can become desensitised to extreme living conditions and fail to act. The shortcomings included both a failure to make safeguarding referrals and a failure to pursue safeguarding enquiries in response to referrals made, in some cases on erroneous grounds that indicated a lack of understanding of criteria.

Learning Point: Responses to reluctance to engage While good responses were often made to crises, there was a lack of consistent follow-up to build relationships of trust that could overcome individuals' reluctance. Service refusals or non-attendance at appointments were taken at face-value.

Learning Point: Dual diagnosis Alcohol use was accepted as an established pattern and proactive attempts to explore its origins were not made. In one case, no treatment was offered, and in the other there was no support following discharge from hospital. There appear to be both a lack of understanding of the impact of alcohol on decision-making and barriers to accessing mental health services.

Learning Point: Hospital discharge Safe discharge was compromised by a failure to secure appropriate services for the individual, resulting in an absence of continence support, reablement, mental health services, support with alcohol use, and care and support provision. These omissions impacted on the safety, health, hygiene and dignity of the individuals concerned.

Learning Point: Fire safety Fire was a significant element in the death of one individual. The risks were well recognised by family members and practitioners but were not effectively managed.

Learning Point: Work with families The family members participating in this review have all raised concerns about the extent to which they were kept informed, consulted and given advice by practitioners. They advise services to ensure there is more consistent and informative involvement with families.

Learning Point: Interagency working Where information-sharing was poor, practitioners were acting without full understanding of the situation. Serious breakdowns of communication took place, resulting in omissions and missed opportunities for interagency referrals, sometimes in potentially serious safeguarding situations. Case coordination was absent – no one agency knew the whole picture and interagency meetings did not take place, resulting in an absence of shared strategic approaches.

Learning Point: Organisational features Agencies were affected by pressures from levels of demand, staffing constraints and a lack of suitable resources. Internal systems impacted upon communications between services. Barriers existed to the provision of appropriate mental health services in the context of alcohol use. Supervision and management oversight were sometimes

missing and staff sometimes lacked understanding of self-neglect and its risks, and of how to intervene.
Learning Point: Covid-19 Three of the individuals in this review died during the Covid-19 pandemic, when restrictions on face-to-face engagement by professionals and changes to community contacts increased isolation and decreased visibility. It is not clear how risk assessment was carried out for patients advised to shield because of pre-existing serious health concerns.
Learning Point: The role of the TDSAP More work is needed to raise awareness and understanding of self-neglect, its risks and resolution pathways and to ensure that guidance on self-neglect is embedded in practice across the partnership.

Section 7: TDSAP Sub-Groups

7.1 Community Reference Group

The TDSAP Community Reference Group (CRG) brings together people with lived experience of Safeguarding and Voluntary, Community and Social Enterprise (VCSE) organisations representing people with protected characteristics across Devon and Torbay.
The purpose of the CRG is to ensure that people with lived experience and their carers remain central to the work of the partnership Board.

The CRG aims to raise awareness of Safeguarding across the VCSE sector and the general public. CRG members provide feedback on the developments and priorities of the Board as well as gathering intelligence and raising issues on behalf of people with lived experience of Safeguarding.

The CRG takes direction from the TDSAP to engage and consult with people across various communities on strategy and practice. This has included focused task and finish groups, on-line and telephone surveys and varied user led dialogue.

Over the past 12 months we have explored the subject of hidden harm, the importance of professional curiosity and the impact of data on the understanding of how to support harder to reach and protected characteristic groups.

7.2 Learning and Improvement Sub-Group

The Learning and Improvement Sub Group has continued to focus on delivering business activities centred around Learning, Improvement of Practice and the Training offer to Provider services. This Sub Group further maintains a key focus on the action planning that addresses the learning and improvement identified through Safeguarding Adults Reviews.

This Sub Group has driven the adoption of a Safeguarding Information Sharing Protocol by Partner agencies which was recently published on the TDSAP website. It is anticipated that this will promote better information sharing between Partners as an area of improvement that has been identified through a number of Safeguarding Adults Reviews.

Other learning areas also form part of the Sub Group's work which includes learning from out of area Safeguarding Adults Reviews and identifying new areas of learning where guidance and awareness raising support the protection of adults at risk. An example of this is the development of

an information page on Predatory Marriage on the TDSAP website which contains a link to a podcast that was developed locally by partners.

The Learning and Improvement Sub Group continues to monitor closely the Partnership Training Offer and uptake from Partners, including the private, voluntary and independent sectors. Demand continues to be high for all course presentations. All courses are running well, with good attendance and positive feedback from attendees. All course presentations remain virtual at this time and is reviewed on a regular basis.

7.3 Performance and Quality Assurance Sub Group

The Performance and Quality Assurance (PQA) Subgroup supports the Torbay and Devon Safeguarding Adults Partnership to take a strategic overview of the performance and quality of safeguarding activity across Torbay and Devon.

The group meets quarterly, has a clear terms of reference and a strong and robust Quality Assurance Framework, to provide the structure to ensure the group meets it aims.

The Quality Assurance Framework is underpinned by the Care Act Safeguarding Principles and includes the expectation that learning from quality assurance will be shared with partners to bring about positive change to practice and improve outcomes for adults and their carers.

The PQA supports the partnership in looking at what we do, how well we do it and what difference we make to operational systems and processes. The group particularly wishes to progress in its development to measure how embedded learning is from Safeguarding Adults Reviews conducted across Devon and Torbay and has plans for a Multi-agency case audit in quarter 4.

The group regularly reviews safeguarding adult performance data and will undertake an in-depth review of the Annual Safeguarding Adults Collection Data, which is published each September, to identify areas where specific assurance is required.

7.4 Operational Delivery Group

The TDSAP Operational Delivery Group (ODG) meets quarterly and is responsible for delivering the activities set out in the TDSAP Business Activity Plan.

The group also considers safeguarding adults multi-agency practice, process and systems across Torbay and Devon to ensure that there is effective communication and quality working practice in place. The ODG does this to ensure that members of the public and service users are protected from potential abuse and harm.

A key purpose of the ODG is to ensure that the Learning and Improvement Sub Group, Performance and Quality Sub Group and the Community Reference Sub Group report directly to the ODG on progress of priority activities from the respective sub groups.

During the past 12 months, the group has had excellent representation from across the partnership and demonstrated a strong commitment to shared ownership of the Partnership agenda. Tasks are also followed through outside of ODG meetings to ensure priorities are completed in a timely manner.

Section 8: TDSAP Priorities 2021/24

The TDSAP Board agreed four strategic priorities for a three year period from 2021 to 2024.

Updates against these key priorities are listed below:

Strategic Priority	What we have done so far to deliver this priority:
To embed the learning from safeguarding adults reviews (SARs).	Partners continue to actively contribute to the SAR Process, playing a key role in helping to identify relevant learning. Processes are embedded to ensure immediate learning is identified from SAR referrals and addressed as early as possible. Work has been undertaken with our SAR Lead Reviewers to ensure recommendations are Specific, Measurable, Achievable, Realistic and Timebound (SMART). The TDSAP regularly and actively seeks assurance and evidence from Partners against the improvements that have been embedded from SARs. The TDSAP continues to work with partners to ensure that communications are reaching the appropriate organisations and groups. The TDSAP has established a new dynamic internal process for the delivery of Safeguarding Adults Reviews. Each Safeguarding Adults Review has an underlying principle to 'Focus on the Learning' for each organisation. We regularly monitor and identify reoccurring SAR themes via our SAR Core Group. This allows partners to consider the best course of action in order to prevent reoccurrence.
To work with partners to better understand and reduce the risk of 'Hidden Harm', especially in the context of COVID 19.	A Multi-Agency Task & Finish Group has been established, with relevant partners, to focus on the 'Hidden Harm' that is usually out of sight from public view and often not recognised or reported.

	The TDSAP continues to encourage all safeguarding partners, who work with people who have needs for care and support, to exercise professional curiosity and take appropriate action. The TDSAP has updated the Terms of Reference for Multi-Agency Case Audits (MACA) to included reference to 'Hidden Harm' and 'Professional Curiosity'. A TDSAP Task & Finish Group is working to develop and deliver a podcast and animation video for partners and service representatives to better understand, encourage and support 'Professional Curiosity' and Hidden Harm.
To improve outcomes for people with needs for care and support by finding the right solution for them.	TDSAP regularly seeks assurance, via the Board and it's Sub-Groups, that partners and service representatives work together to establish more effective coordination to achieve person centred solutions. We continue to work with partners to better understand and embed creative approaches, to finding effective solutions, for people with complex lives. A Multi-Agency Risk Management Meeting (MARMM) forum has been established. This was developed and co-produced by key partners. TDSAP have developed and shared key data and information to help develop effective communications and co-ordination between partner organisations, including strengthening links with the districts and community safety partners. We will continue to focus on preventative strategies, working alongside our strategic partners, to better understand how we can avoid the need for safeguarding intervention. We will carry on our work with service representatives and commissioning partners to better understand people's needs and support them to achieve their desired outcomes.
Improving Involvement and Engagement with people in receipt of safeguarding services.	The TDSAP will continue to build on past Safeguarding Awareness Campaigns by targeting communications within our communities to raise further awareness of safeguarding. We will utilise the National Safeguarding Awareness Week to ensure we design and deliver effective key messages across our communities. We will carry on our work with key partners to improve the interface with other services, especially for those who transition from Childrens to adult services.

	We continue to ensure that partners are listened to people, valuing and responding to relatives, friends and people in the communities. The partnership continues to focus on 'Making Safeguarding Personal' to ensure that safeguarding is person-led and outcome-focussed. The partnership has invested and engaged with the Community Reference Group to ensure the 'voice of the person' is central to key partnership functions, such as the Strategic Priorities, Partnership Website and the Annual Report.

Section 9: Key Partner Achievements During 2022/23 Update from Partners – Three Key Achievements

Below is a selection of the key partner achievements, in relation to safeguarding adults, during the year:

9.1 Devon County Council (DCC)

Safeguarding Adults Hub - Rapid Improvement Approach: A dynamic change initiative, to improve practice and process within the three DCC Integrated Adult Social Care Safeguarding Adult Hubs. The approach focuses on team based problem solving covering waiting list, risk assessment and triaging, allocation of concerns, duty systems, recording requirements, whole service safeguarding and best practice in working with partner agencies.

DCC Integrated Adult Social Care Self-Neglect task and finish group: A cross organisational staff led task and finish group who are developing a suite of self-neglect practice resources for frontline practitioners, in response to the TDSAP Self-Neglect Thematic SAR. Resources in development include; guidance, videos, and tools to enable the practitioner to work positively and in partnership with a person who is self-neglecting, providing support and practical solutions to the issues being faced.

Falls; Medication Management and Safeguarding guidance: Working in partnership with the Devon Care Home Collaborative and representatives from the TDSAP to develop specific guidance in relation to falls and medication management. This guidance supports organisations to make decisions of when they may need to raise a safeguarding adult concern in relation to medication errors or falls. This work supported the Devon Care Home Collaborative to progress further and develop a quick guide for when to raise a safeguarding adult concern.

9.2 Torbay and South Devon NHS Foundation Trust (TSDFT)

TSDFT supports around 500,000 face-to-face contacts with patients in their homes and communities each year and we see over 78,000 people in our Emergency Department annually. A zero tolerance of adult abuse is fundamental to our approach alongside principles of equality and non-discriminatory practice.

Our services include a delegated responsibility from Torbay Council for adult social care services in Torbay including safeguarding adult legal duties.

During the past 12 months, we have especially focused on receiving qualitative feedback from people that experienced a safeguarding response through independent quality checkers. Feedback is very positive in the context of people feeling included and listened to, the process being fully explained and the value of the safeguarding response.

As a regulated service we continue to place safeguarding patients from abuse and harm as a priority. We have further extended our range of resources and training available to teams, particularly relating to the Mental Capacity Act and strengthened our use of data to support meaningful conversations within teams.

We have also reviewed our safeguarding response systems and processes which focus on person centred outcomes.

As an organisation that covers Torbay and Devon geographical boundaries we continue to see the value in the new Torbay and Devon Safeguarding Adults Partnership (TDSAP) in creating a consistency of approach in local safeguarding arrangements. We very much value being part of the TDSAP and will continue to support its arrangements as needed.

9.3 Devon and Cornwall Police

Devon and Cornwall Police tops the leader board for 999 answer times in August 2023

Monthly national performance tables are produced by the Home Office, ranking Forces according to the speed with which 999 calls are answered. At the end of 2022, Devon and Cornwall Police were 42nd out of the 44 Forces. In August 2023, we were first. The Contact Resolution Command (CRC) has been through a huge amount of change during the last few months in order to improve performance. There is still a long way for us to go; our plans targeted at improving our 101 response times and digital demand are still being implemented. However, this turnaround in 999 performance is an incredible achievement, particularly during a peak demand period, with a huge collective effort from staff across the whole of the command to achieve it.

This achievement will assist the Force in effectively responding effectively to all safeguarding issues across both Devon and Torbay.

Dedicated police line first response service Devon

The First Response Service (FRS) DEVON will launch a dedicated 24/7 all age police consult line. This line aims to provide a single point of contact for police officers to consult with a mental health crisis service. This line will go live from Monday 25 September and is applicable to people of all ages in Devon. Plymouth and Cornwall have different response service provision. The FRS Police Consult Line will provide a 24/7 designated consistent consult service for police officers to have easy access for advice and guidance with a view to reducing Section 136 detentions where appropriate. This line aims to provide a single point of contact for officers to consult with a mental health crisis service before considering the use of section 136 and information sharing requests is crisis situations. This will ensure people are accessing the right care at the right time to improve experience for service users.

Right Care Right Person

Right Care, Right Person (RCRP) is an approach designed to ensure that people with mental health and social care needs are responded to by the right person with the right skills, training and experience to best meet their needs. The principles have already been adopted in a number of areas to shape the local service delivery. (Draft National partnership Agreement – April 2023) Based on a model initiated in Humberside in 2019, and subsequently supported by Department of Health and Social Care (DHSC), National Health Service England (NHSE) and the Home Office (HO), work to adopt Right Care Right Person principles across Devon and Cornwall Police has

started. The National Partnership Agreement between Health, Social Care and Policing has been agreed and the partnership Strategic Coordinating Group has been established and all the different working groups are coming together. RCRP is NOT all about mental health. Working to understand who calls us for concern for welfare is being carried out as part of phase 1 of RCRP so we can better support adults at risk within our communities.

9.4 Devon Partnership Trust

17.5% of all safeguarding enquiries for Devon and Torbay were led by DPT clinicians in 2022-2023, this reflects our culture (and policy) where our staff are proactive in undertaking routine enquiries with all our patients. DPT staff explore whether patients have a history of abuse or neglect, proactively exploring whether they are currently safe from abuse or neglect and proactively identify where there is or may be a safeguarding concern.

High volume staff engaging in safeguarding supervision within DPT - 2928 engagements in safeguarding supervision (through the Trust central safeguarding team) in the financial year 2022-2023; all our safeguarding supervisors are trained in restorative safeguarding supervision - this is a significant improvement on the previous year.

Training compliance for safeguarding adults has improved - all registered clinicians and practitioners working for DPT are required to complete safeguarding adults training at Level 3; and we have made considerable progress towards achieving our target of 90% having this competency and feedback regarding this training is very positive.

9.5 NHS Devon

The new interpersonal trauma response service is being rolled out. It will train GPs across Devon to talk to patients about domestic abuse, sexual violence and other trauma, and offer referral into a specialist support service. The domestic abuse work undertaken by health organisations in Devon recently won a Parliamentary Award.

NHS Devon has coordinated work between Devon and Cornwall Police and the health provider delivering services within the police custody suits to enable them to have access to the Devon and Cornwall Care Record (DCCR). This will enable more effective management of detainee's healthcare whilst they are in custody.
In November 2022, an NHS England safeguarding visit took place. The team highlighted that safeguarding remains a priority during times of pressure and change within the system, and noted improved working relationships between NHS Devon safeguarding and commissioning teams across the commissioning cycle.

9.6 University Hospitals Plymouth NHS Trust

As the largest regional Hospital's NHS Trust, we are proud to share the significant investment given to the expanding Safeguarding Team, especially to Mental Capacity and DoLS subject-matter experts. Notwithstanding their support given to the 1,540 urgent applications, but our integrated "Think Family" approach remains embodied, with the wider context of adult, child and young person experiencing safeguarding and having mental capacity and/or mental health care needs too. The extended range of expertise available to clinical teams has proven to be both effective and efficient and improves the corporate assurance(s) of our collective safeguarding governance processes.

Similarly, University Hospitals Plymouth saw over 4,000 face-to-face contacts with adult patients (in a variety of settings) that were identified as experiencing, or at risk of, safeguarding harm, abuse, neglect and/or exploitation; with due care, compassion, and diligence paid to further protect, prevent, make safeguarding personal and proportionate, alongside the necessary

partnership planning and management. Progression continues vis-a-vie our domestic abuse and sexual violence workstream, with ambitions to further increase the health IDVA personnel and to adopt universally the Routine Enquiry Question (good practice recommendations identified from local, regional, and national SAR and DHR's).

Our safeguarding services has also delivered a robust package of staff training and education across the whole organisation to enable staff to feel safe in their delivery of Safeguarding being Everyone's business, moreover core-business to the diversity of all our services; in addition to the development of a new Safeguarding Supervision Policy.

9.7 Royal Devon University Healthcare NHS Foundation Trust

The Royal Devon University Healthcare NHS Foundation Trust was established in April 2022, bringing together the expertise of both the Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust.

Stretching across Northern, Eastern and Mid Devon, we have a workforce of over 15,000 staff, making us the largest employer in Devon. Our core services, which we provide for more than 615,000 people, cover more than 2,000 square miles across Devon, while some of our specialist services cover the whole of the peninsula, extending our reach as far as Cornwall and the Isles of Scilly.

We deliver a wide range of emergency, specialist and general medical services through North Devon District Hospital and the Royal Devon and Exeter Hospital (Wonford). Alongside our two acute hospitals, we provide integrated health and social care services across a variety of settings including community inpatient hospitals, outpatient clinics, and within people's own homes. We also offer primary care services, a range of specialist community services, and Sexual Assault Referral Centres (SARC).

We continue to put people at the centre of our safeguarding practice and encourage all our staff to see 'Safeguarding as Core' business.
The safeguarding and MCA teams across the north and east of the trust are working towards a fully integrated service, made possible because of My-Care, an electronic healthcare record. This has supported improved communication and safeguarding practice with information sharing and partnership working. It is enabling us to develop our systems to ensure responses are more streamlined, efficient and patient centred.

We have continued support of workforce development through education and training with a particular focus on trauma informed practice, self-neglect, domestic abuse and including the Mental Capacity Act (MCA). Our Staff have increased their understanding of safeguarding concerns and the numbers of 'concerns raised' with DCC Safeguarding Hub's has increased month on month.

The Trust was part of the team of Domestic Abuse and Sexual Violence colleagues across Devon, who have won the Excellence in Primary and Community Care Award at this year's NHS Parliamentary Awards. The award recognised the work done by NHS Devon and by the local providers who have contributed so much to the Domestic Abuse and Sexual Violence project in Devon, especially Devon and Cornwall SARC (Sexual Assault Referral Centre) and the Safeguarding teams at the Royal Devon, who work to safeguard patients and colleagues at the Royal Devon but have also provided support to other local Trusts.

9.8 Probation Service

In Devon and Torbay Safeguarding Adults training is now part of the mandatory learning in order for staff to progress up the pay scale, therefore completed at least annually.

Every quarter we run safeguarding workshops for staff which include sharing information and learning from Safeguarding Adult Reviews.

Staff have regular supervision and reflective practice sessions that enable case discussions with their manager including where there may be adult safeguarding concerns. The outcomes of any actions taken can be explored along with any further actions/options available to help the individual.

9.9 Heart of the South West Trading Standards

There is an agreement in place for all staff to undertake online scams training as part of their continued professional development (CPD), this is also the case for all new starters.

We were an active partner and panel member in relation to the SAR for Ella. We were able to help shape the learning resulting from this SAR review, which included an improved re-write to the financial abuse section of the TDSAP website.

We have strong links in place with partners and we are in regular contact with agencies, to assist in the safeguarding process, where individuals have been potential victims of scams.

9.10 Devon and Somerset Fire and Rescue Service

Devon and Somerset Fire and Rescue Service have now established an Internal Strategic Safeguarding Board . This is a multi-disciplinary board that provides a strategic oversight of all matters relating to safeguarding within the organisation including safer recruitment and training.

We continue to work with numerous partners across Devon and Somerset and we continue to carry out Home Safety Visit for adults at risk. We deliver a comprehensive “Trigger Point Awareness Package” to partners to ensure they are aware of the signs to look out for that might mean someone is at risk of having a fire. This ensures we receive referrals at the earliest opportunity and can signpost individuals to support or raise safeguarding referrals where necessary if someone is at risk of having a fire.

The safeguarding Team continue to work closely with the Home Safety Technicians who deliver Home Safety Visits, and we encourage all Home Safety Technicians to adopt a person centred approach to their visits and we particularly focus on areas around self-neglect and hoarding when providing training. The number of referrals the Safeguarding Team receive from Home Safety technicians continues to increase which means we are working towards achieving better outcomes for the communities that we engage with.

Section 10: Looking Ahead

10.1 Strategic Priorities

The TDSAP Board and its sub groups will continue to deliver the aims of the 2021-2024 strategic plan. The strategic priorities of the TDSAP remain under constant review, throughout the business year, with a full review of the three-year business plan due to take place in the spring/summer of 2024.

A copy of the 2021 to 2024 strategic priorities can be found by clicking here: Strategic Priorities 2021/2024

10.2 Forthcoming SARs

The TDSAP has already published five more SARs since April 2023, with each of these SARs identifying key system learning that will improve operational functions across the partnership.

Five further SARs are currently in progress and are due to be published by the end of March 2024.

The TDSAP has a strong track record, over a number of years, for identifying significant multi-agency learning opportunities via its SAR processes. The TDSAP will continue to work closely with partners to uncover new system learning that can contribute to improvements in practice and ultimately achieve more positive outcomes for people and their communities.

Torbay and Devon Safeguarding Adults Partnership