Belfast Health and Social Care Trust

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Belfast Health and Social Care Trust

Adult Safeguarding

Annual Position Report

2023/24

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SECTION 1

Introduction

The Belfast Health and Social Care Trust annual Adult Safeguarding Position Report reviews three core themes contained in Adult Safeguarding Prevention and Protection in Partnership Policy (2015) and Operational Procedures (2016): Prevention, Partnership and Protection.

The annual report for 2023/24 provides an overview of assurance arrangements, SPPG Data Activity returns and a commentary in relation to challenges and achievements relating to Adult Safeguarding throughout the Belfast Health and Social Care Trust.

As noted in the previous annual reports, the Northern Ireland Adult Safeguarding Partnership (NIASP) officially stood down in December 2019. Belfast LASP progressed Adult Safeguarding at a local level in the absence of strategic direction or an agreed work plan for this reporting period. Following this, the Transformation Board and Interim Adult Protection Board became operational and established an action plan, which continued into 2023/24.

SECTION 2

Adult Safeguarding Governance Arrangements

The Belfast Health and Social Care Trust (BHSCT) operate in accordance with the Regional Adult Safeguarding: Prevention and Protection in Partnership Policy (2015), Regional Adult Safeguarding Operational Procedures (2016) and the Regional Policy Protocol for Joint Investigation of Adult Safeguarding Cases (2016) and local Adult Safeguarding Policy and Procedures.

The Executive Director of Social Work has accountability for the assurance arrangements pertaining to the delivery of the Belfast Trust's statutory functions including Adult Safeguarding and is the BHSCT Adult Safeguarding Champion.

The Trust Adult Safeguarding Specialist (TASS) post has been vacant since August 2022, as staff have been redeployed to provide additional supports in relation to Muckamore Abbey Hospital. However, additional supports provided by a Divisional Social Worker (temporarily supporting the Executive Director of Social Work), has mitigated against the impact of this vacancy.

The Operational Directors for each service area are accountable for the service delivery response to adult safeguarding matters within their respective Directorates.

The Trust Adult Safeguarding Committee sits within the BHSCT Integrated Governance and Assurance Framework. The purpose of the Adult Safeguarding Committee is to provide assurance to the Clinical and Social Care Governance Steering Group around the effectiveness of the work of its groups, as referenced within in the Integrated Governance and Assurance Framework.

The Executive Director of Social Work / Trust Adult Safeguarding Champion chairs the Belfast Trust Adult Safeguarding Committee.

In this reporting period, the Adult Safeguarding Committee has endeavoured to meet bi monthly. However, on occasions meetings had to be rescheduled due to the requisite quorum not being achieved. These meetings took place on the 28/7/23, 28/9/23, 6/12/23 and 18/4/24.

The membership of the Adult Safeguarding Committee consists of representatives from all directorates within Belfast Trust and includes Nursing, Medics, Allied Health Professionals, alongside Human Resources and Finance colleagues. Recently a number of Non-Executive Directors from the BHSCT Trust Board have also attended the meeting. All members have a responsibility to contribute to the delivery of Adult Safeguarding within the Trust, focusing upon key priorities in relation to prevention, early intervention and protection.

The Terms of Reference of the Adult Safeguarding committee outlines the core duties and responsibilities in relation to Adult Safeguarding & Adult Protection, emphasising Adult Safeguarding is everyone's business.

The Adult Safeguarding Committee, when providing advice to the Clinical and Social Care Governance Steering group, will ensure the effectiveness of their group by:

- Ensuring that the work of the groups meet their responsibilities as outlined in their Terms of Reference
- Support the identification, review, and escalation of Risks associated with the group/sub-committee purpose.
- Provide regular Assurance updates as per the Integrated Governance and Assurance Framework and their individual Terms of Reference to allow scrutiny of ongoing Trust Assurance arrangements-

    - First line of assurance will be provided through the group members based on service level reviewing incident data, risk registers, improvement work, reports on the routine system controls and other management information, review of caseloads, safety briefs, minutes of meetings, peer reviews, leadership walk rounds, self-assessments, patient/service user feedback.
    - Second line of assurance will be reported through audit and other reports.

- Review the adequacy of relevant Key Policies and ensuring their timely update
- The Adult Safeguarding Committee's responsibilities will centre on providing assurance with regard to the effectiveness of the Trust's adult safeguarding organisational arrangements and processes and include the following:

    - To provide assurance that suitable Trust-wide arrangements are in place to support staff in the recognition of and response to safeguarding concerns across all service areas
    - To provide assurance that suitable Trust-wide arrangements are in place for the planning and delivery of safe and effective safeguarding services to meet the assessed needs of adults at risk of harm and adults in need of protection
    - To provide assurance that appropriate arrangements are in place to identify and meet the training needs of the Trust workforce with regard to safeguarding adults relative to their service delivery remits
    - To provide assurance that the learning from external reviews, Serious Adverse Incidents (SAIs), RQIA inspection recommendations, Judicial Review, Audits and other learning processes pertaining to adult safeguarding are disseminated and actioned as necessary across the Trust
    - To provide assurance that all relevant Trust policies relating to the safeguarding of adults are considered by the members of the Committee prior to formal approval being sought
    - To provide regular updates to the Clinical and Social Care Governance Steering Group and Assurance Committee on the areas of work addressed by the Adult Safeguarding Committee
    - To provide oversight of adult safeguarding activity and assurance that activity is consistent with the regionally agreed DOH Policy.
    - Any concerns regarding the carrying out of the above duties should be brought to the attention of the Clinical and Social Care Governance Steering Group in the first instance.

In the absence of the TASS, the temporary Adult Safeguarding Development post continued to support the work of the Adult Safeguarding committee alongside her post as service manager within Learning Disability until Jan 2024. In addition, a Divisional Social Worker (DSW) supporting the Executive Director of Social Work has facilitated the development of a more detailed Belfast Trust Adult Safeguarding Action Plan and progression of work streams.

The previous Adult Safeguarding Position Paper outlined two temporary posts within Strategic Adult Safeguarding; these included an 8a Nurse Adult Safeguarding Lead for Hospital settings and a Band 7 Social Worker/ Training & Implementation Manager for Paris Community Information System. The Band 7 Training & Implementation manager moved to another post within Learning Disability from September 2022.

Over the past twelve months, the 8a Nurse Adult Safeguarding Lead for Hospital Settings was extended on a temporary basis working primarily on a dedicated Adult Safeguarding Action plan for Acute General Hospitals within Belfast Health and Social Care Trust.

The Divisional Social Worker, currently supporting the Executive Director of Social Work, operationally manages the 8a Nurse Adult Safeguarding Lead for Hospital settings. In addition, she has progressed the Trust Adult Safeguarding action plan, been involved with other key priorities including Domestic Homicide Reviews, Trust wide audits, representing the Trust on regional groups and chairing the Adult Safeguarding leadership Group and other adult safeguarding work streams.

It is important to note the strategic posts remain at 'risk posts' because of a lack of funding for strategic Adult Safeguarding work. The continuation of these posts are critical to progress the Adult Safeguarding committee action plan.

The Belfast LASP is a multi-agency group that continues to meet on a quarterly basis. Previously the Belfast LASP delivered on strategic priorities as detailed in the NIASP Strategy and Annual Action Plan, alongside any additional priorities identified by the Belfast LASP. However, with the review of Adult Safeguarding structures in Northern Ireland and the establishment of the new Transformation Board and Interim Adult Protection Board, Belfast LASP currently focuses on local priorities in the promotion of prevention and early intervention. The Executive Director is now the chair of the Belfast LASP.

Current Internal Adult Safeguarding Arrangements

Within Adult, Community & Older Peoples Service (ACOPS), Mental Health (MH) and Learning Disability (LD) divisions, the Trust have nominated specialist trained Adult Safeguarding staff undertaking the roles of Designated Adult Protection Officer and Investigating Officer.

The Adult Protection Gateway Team (APGT) provides a gateway / protection response for the Older People (OP) service area and Physical and Sensory Disability (PSD) service area. The APGT continues to operate a two tier function to provide a central

point of contact for external referrals and facilitates all adult protection investigations for all referrals from Older Peoples Services and Physical Health and Sensory Disability meeting the 'Adult in Need of Protection' threshold. Referrals that require a protection response are allocated to APGT Designated Adult Protection Officers (DAPOs) and Investigating Officers (IOs) for investigation. To provide this service the APGT has the following compliment of staff: Temporary (at risk) B8B Service Manager, B8A Assistant Service Manager, B7 DAPOs, B6 IOs and 1 B7 Nurse Specialist. However, throughout 2023/24 the APGT has experienced significant workforce pressures with a number of posts remaining vacant at the end of the reporting period.

The Physical Health & Sensory Disability and Older Peoples Service continue to manage 'adult at risk of harm' referrals through the provision of Alternative Safeguarding responses, professional assessment and risk assessment. The community teams within the Older Peoples Services and Physical Health and Sensory Disability services hold specialist trained Adult Safeguarding staff as Designated Adult Protection Officers and Investigating Officers.

Acute hospital settings within ACOPS have a multifaceted role in Adult Safeguarding. Acute Hospital SW departments receive referrals from a range of Hospital departments, screen referrals and transfer referrals to the relevant service area, team or Trust. The Social Work Department for Acute Hospitals have specialist Trained Adult Safeguarding Staff as Designated Adult Protection Officers and Investigating Officers.

Within the Mental Health Division Adult Safeguarding structures operate a localised Adult Safeguarding Team, which consist of one Adult Safeguarding Lead (8a) and two DAPO's who conduct complex Adult Protection investigations for teams who require DAPO involvement and investigations meeting a specified Adult Protection criteria.

Mental Health Adult Safeguarding is managed within a localised Adult Safeguarding team, Community teams and Hospital teams where the aligned DAPO applies the regional thresholds to all adult safeguarding referrals in relation to 'Adult at risk of harm' and 'Adult in need of Protection'. They also undertake Joint Protocol consultations with PSNI.

Within the Learning Disability Division a central point of referral has been developed. This team has a dedicated DAPO who screens all Adult Safeguarding referrals in line with the regional Adult Safeguarding Prevention and Protection in Partnership Policy (2015). This team then allocates the case to the respective DAPO either within Muckamore Abbey Hospital (MAH) or within the community either to put in place an alternative safeguarding response or to investigate the referral.

The LD Adult Safeguarding service is managed by a dedicated 8B Adult Safeguarding Service Manager (unfunded) and two Adult Safeguarding Leads (8A) (one of which is unfunded) who provide operational support and oversight.

In addition, the community Service Manager and the 8a Community Operational mangers (both DAPO) have responsibility for managing Adult Safeguarding through their individual community LD teams. The community LD service have a temporary 8a Adult safeguarding lead, Band 7 SW team leaders who also undertake DAPO

responsibilities and other Senior Practitioners/ DAPOs. Within the Community LD teams Social Work and Community Nursing staff are trained as Investigating Officers

The MAH team consists of three Senior Social Work Practitioners with DAPO responsibilities (B7) and two Social Workers with Investigating Officer responsibilities (B6). Within the community, several Senior Practitioners undertake DAPO responsibilities along with a number of SW and nursing staff who undertake the IO role.

Across all Divisions within Adult Services individual teams are operationally accountable to their Adult Safeguarding Lead (8A), Service Manager (8B) through to Co-Director and Director level which hold operational responsibility for Adult Safeguarding and Adult Protection. Furthermore, each division has a Divisional Social Work lead (8C) who holds professional responsibility; this includes the adherence to Adult Safeguarding Policy and operational procedures.

SECTION 3

Achievements and Challenges

The following section will outline the key achievements and challenges faced over the past twelve months in relation to protection, partnership and prevention.

The Belfast Health and Social Care Trust and the Belfast LASP are fully committed to delivering on the:

- Adult Safeguarding Prevention and Protection in Partnership Policy (2015)
- Adult Safeguarding Operational Procedures: Adults at Risk of Harm and
- Adults in Need of Protection (September 2016)
- Protocol for Joint Investigation of Adult Safeguarding Cases (August 2016)

The Belfast Health and Social Care Trust continue to operate to the strategic direction as set out in the regional Adult Safeguarding policy for the development of Adult Safeguarding and Adult Protection within the HSCT. This reporting period continued to see developments in the area of Adult Safeguarding and Adult Protection as set out by the Interim Adult Protection Board action plan with the continuation of regional task and finish groups. Strategic direction provided by the SPPG and strategic initiatives from the Interim Adult Protection Board and Transformation Board influenced strategic Adult Safeguarding within BHSCT over this period.

Adult Protection Bill –Draft Legislation- Department of Health

This reporting period saw the review of the Draft Adult Protection Bill, which is led by the Department of Health and overseen by the Adult Safeguarding Transformation Board, chaired by the Chief Social Worker for Northern Ireland.

Over this period the regional Trust Adult Safeguarding Specialists, Adult Safeguarding leads, and members of the SPPG attended regular meetings as part of the Adult Protection Bill work stream.

Belfast Trust also prepared a response to the Adult Protection Bill costing exercise. To date no agreement has been made in relation to the outcome of the funding request. Significant resource will be critical to implementation and service delivery of adult safeguarding within the Trust, as this is a service which is currently significantly underfunded.

Currently, decisions are being made in relation to the development of the Statutory Guidance, which will sit alongside the new Adult Protection Bill. It is anticipated that the Trust Adult Safeguarding leads and TASS will contribute to the quality assurance of it once the Statutory Guidance has been drafted.

Regional Groups

There are 5 work streams connected to Interim Adult Protection Board. The Trust has representatives at a number of them. These include-

a. Data and Performance

b. Learning and Development

c. Policies and Procedures.

d. User and Carer Group

e. Serious Case Review

In addition, the Regional TASS meetings have been attended by the Strategic Safeguarding lead until Jan 24 and since then by the DSW supporting the Executive Director of SW.

The Interim Adult Protection Board restarted the regional work stream focusing upon Policy and Procedures chaired by the Chief Inspector of the PSNI and SPPG Lead. The regional work stream refocused the review of the current protocol for Joint Adult Safeguarding Investigations (2016), with a review of AJP threshold, draft policy and revised Joint Protocol forms. This work has now been completed.

Adult Safeguarding & Trust Board Assurance framework/ Corporate Risk Register

Adult Safeguarding is recorded on the Trust Board Assurance risk register with core areas of risk identified. This is outlined in relation to the following themes:

- *"Risk to the safety of service users and Trust (corporately) due to a lack of awareness and understanding of obligations in relation to adult safeguarding, as detailed in regional Policy, Procedure and Joint Protocol;*
- *A lack of consistency in relation to how Policies and Procedures are applied;*
- *Lack of staffing resource in some areas which impacts on the timeliness of investigations and*
- *Increasing demand for Adult Safeguarding (ASG) training*".

A key challenge throughout this reporting period, as referenced in the service area reports (see Section 5), was related to workforce pressures. Some areas have experienced high sickness levels and vacant posts. There are also a number of unfunded posts across the Divisions. The number of referrals and the complexity of the cases continues to increase which puts pressure on a depleted workforce. Workforce pressures have also affected the quality of service delivery and staff ability to undertake work to a suitable standard within appropriate timescales. Steps have been taken to address the workforce on a temporary basis through 'at risk' posts, recruitment through expressions of interest, support groups, additional training and through external recruitment.

As outlined below significant work has been undertaken to raise awareness of how to recognise and respond to an adult safeguarding concern especially across the hospital sites which is more than likely resulted in a higher number of referrals being generated from these areas during this reporting year.

Significant work has been undertaken and each service area now have ready access to their data. This has been key in allowing them to analyse their data in the context of other information, to identify trends, patterns and any risks for their areas.

Compliance and consistency in approach with the regionally agreed policy and procedures remains an area of focus for the Trust in light of the BSO audit, internal audits and the low number of referrals from some service areas within the Trust. In order to mitigate against this as outlined below substantial work has been completed to raise awareness through updated information on the LOOP, aide memoires, notice boards, leaflets and other tools for staff in addition to staff training and supports.

A series of assurance and control mechanisms are in place to mitigate the risks, which look at:

- Adult Safeguarding Governance,
- Adult Safeguarding assurance frameworks
- Development of Adult Safeguarding data
- Training needs,
- Directorate teams' regular surveillance and reporting
- Weekly governance meetings with SMT
- Baseline Audit and follow up random unannounced visits to facilities to measure compliance

This is subject to quarterly review and updated by the Trust Adult Safeguarding Committee and Trust Board Assurance Committee.

1. PROTECTION

Trust Adult Safeguarding Future Structures:

Due to the fragmented adult safeguarding structures within BHSCT, there is a commitment from the BHSCT Executive Team to review existing operational arrangements and associated governance and assurance arrangements with a proposed model for change. In the context of the COPNI report, CPEA report and the large-scale historical investigation in Muckamore, along with the Governance and Leadership Report, such reports are key drivers for the review of adult safeguarding structures and governance arrangements.

The Adult Safeguarding structures within the Trust remains a key priority of the Trust Adult Safeguarding action plan. Further review was undertaken this reporting year

including a workshop with Divisional Social Workers to consider a range of options. There has been some delay with this proceeding due to the need to prepare for the Trust 'go live' to Encompass and due to workforce pressures. A further workshop is being planned to progress this action. It should be noted that significant investment will be required if the proposed structures are accepted and implemented.

Given the ongoing declining trajectory in the use of ABE/ PIA, going forward consideration is also being given to a centralised management and governance of this across Divisions.

Adult Safeguarding Leadership Meetings

Since the retirement of the Trust TASS these meetings were put on hold however over the reporting period the DSW, supporting the Executive Director of SW, has re-established and chaired these meetings. Given the importance of ensuring that Adult Safeguarding is 'everyone's business', the membership was reviewed to not only include SW leads across the Trust but senior manager representatives from across the Divisions in the Trust. The purpose of these meetings has focused on reviewing the Trust Adult Safeguarding Action plan, taking forward operational and strategic developments, providing strategic regional and internal updates, sharing any learning from audits, SAI's etc and discussing adult safeguarding data and analysis.

The Leadership group met on the following occasions: 28/6/23, 24/8/23, 26/9/23, 10/11/23 and 19/2/24. Some meetings had to be cancelled and or rescheduled due to the inability to meet a quorum due to other Trust pressures associated with the implementation of Encompass.

The Trust has an Adult safeguarding action plan, which is taken forward by five work streams. These include-

1. Governance
2. Hospital
3. Data and IT
4. Awareness and Experience
5. Learning and Development

DSWs or Adult Safeguarding (ASG) Leads chair these groups. They report to the Leadership Group, who in turn reports to the Trust Adult Safeguarding Committee. These groups have made significant improvements throughout the reporting year, which will be highlighted in this section and in the prevention and partnership sections of this report.

Adult Safeguarding Data and Activity

As noted in previous Adult Safeguarding position reports, Adult Safeguarding data continued to be collated manually by all divisions. The current retrieval arrangements

are time consuming. Within the reporting period, a number of significant changes have been made in relation to this to improve how data is collated, analysed and presented.

Guidance has been provided to Adult Safeguarding staff in relation to the completion of the SPPG data collation tool. In addition, a new process has been implemented whereby all data is now quality assured via the DSW for each service area before being forwarded to the Strategic Adult Safeguarding Team. On receipt of this information the strategic team collate and quality assure the Adult Safeguarding data prior to submission to the Strategic Performance Planning Group. This improved approach has led to more accurate, consistent and timely reporting. However, a number of issues remain in relation to the SPPG return and clarity is being sought from them.

As part of the Data and IT work stream, in preparation for 'go live' to encompass on 6th June 2024, BHSCT Adult Safeguarding representatives have-

- attended the regional Adult Safeguarding Encompass group
- liaised and visited SET, who have already gone live to encompass, to learn lessons and ensure a seamless transition onto Encompass.
- attended bespoke Adult Protection Encompass training
- been working with encompass for resources to be made available to ensure staff in BHSCT are aware of the referral process once Encompass launches.
- attended individual meetings with Encompass representatives and regional colleagues in relation to reporting requirements to ensure regional consensus regarding regional dataset requirements.

In order to strengthen governance arrangements, the Adult Safeguarding Governance work stream has created a composite database by which operational Adult Safeguarding teams will record their Adult Safeguarding activity. This has been developed by informatics, has been agreed by all Adult Safeguarding leads, and is currently being piloted in Learning Disability services. Initial feedback is positive. Once fully implemented across divisions, this database will allow for rapid, accurate, collation of data and improved analysis of patterns, trends and possible risks. Further, there are plans to also implement a mechanism whereby decision making by local Adult Safeguarding champions will be collated centrally, again improving governance arrangements within BHSCT.

Work has continued over the reporting period to embed the improvements in relation to Adult Safeguarding in hospital settings. The Lead for Adult Safeguarding, a temporary 8A Nurse position, has continued in post; advancing an action plan to progress Adult Safeguarding within hospital settings with the oversight of a Divisional Social Worker. The hospital work stream has had a significant achievement early in this reporting year through the implementation of the ground breaking Adult Safeguarding referral app in the adult general hospitals. In the absence of these areas having access to the PARIS computer system, this has ensured a robust referral mechanism.

Consequently, staff have reported that they are clearer about the process and they have indicated that the app is user friendly, less cumbersome, standardised, and

enables them to digitally record the information in a much more concise and accurate way. This has resulted in staff being able to spend less time with paperwork enabling them to use their time more effectively in direct patient care.

Through the implementation of the app, rich data is now available in a standardised and central manner, which allows for the development of a monthly adult safeguarding activity report for all hospitals within BHSCT. This is the first time such a report has been possible. This report has had various iterations and now provides the following information-

- The number of referrals per service area, referral themes, and screening decisions including the rationale.
- The type of abuse
- The category of the person alleged to have caused harm.
- It tracks referrals through time

This monthly report is disseminated via the Leadership group and Adult Safeguarding Committee through to Assurance Committee. It allows divisions and teams to review activity on a monthly basis, in respect of a number of fields, and undertake an in-depth analysis of the data in the context of other information available within their areas to identify possible patterns, trends, or risks. Each division report that they hold live governance or assurance meetings within their service areas where this data is discussed and analysed.

This initiative has been put forward for a Chairman's Award and we await the outcome of this application.

Audits

Throughout the reporting year, there has been a renewed focus on the importance of completing audit cycles so that the Trust has an understanding of compliance against the Regional Policy and procedures and so that learning can be shared across the Divisions to enhance practice and improve service delivery.

During this year there continued to be an increase by 102% of alternative safeguarding responses. Throughout last year and this year, there has been an ongoing focus on threshold application and the implementation of the APP suite of forms on Paris CIS. Adult Safeguarding staff now operate to the threshold of 'Adult at risk of harm managed through alternative safeguarding response' and 'Adult in need of protection requiring an Adult Protection investigation'. Prior to the implementation of the APP forms on Paris in June 2022, some divisions were conducting safeguarding investigations for referrals meeting the 'adult at risk of harm' threshold. As a result, the overall Trust total number of investigations in 2022/3 incorporated Adult Protection investigation figures and safeguarding investigation figures. This count operated outside of the regional policy. As a result, the data for this reporting year 2023- 2024 reflects the regional policy for 'Adult in need of Protection' resulting in an adult protection investigation.

The Safeguarding Leads recognised the need to ensure application of the Regional Policy and Procedures in relation to threshold criteria for 'at risk of harm' and 'adult in need of protection cases' and undertook audits within their own respective areas (see Section 5). However, it was also recognised that it was important to understand if there was consistency in the application of thresholds across all the Divisions. This led to an extensive audit being completed in October 2023. The DSW, supporting the Executive Director of SW, led the audit along with the DSWs and ASG leads across the Divisions.

This audit highlighted that there was generally a consistent approach to thresholding across all Divisions with consensus agreed to what constituted No Further Action (NFA), an Alternative Safeguarding Response (ASR), and an Adult Protection investigation (AP). There was also useful discussion and then agreement between the DSWs and ASG leads in relation to Key Performance Indicators (KPIs) that could be implemented across the Trust. These have now been agreed with the Executive Director of SW and are due to be implemented in the next reporting period.

The audit also highlighted a number of areas for improvement which included the need to: improve recording; improve staff understanding of the terms NFA, ASR and adult protection; record on the appropriate APP form rather than elsewhere in the general case notes; have Trust wide agreed Key Performance Indicators (KPI); and to intervene in a more timely way. This audit has resulted in two bespoke Adult Safeguarding training sessions being completed with DAPOs, IOs and Adult Safeguarding Champions (ASCs) where the outcomes, recommendations and the agreed KPIs flowing from the audit were shared across the Divisions. The feedback from these bespoke training sessions was extremely positive.

In addition, the draft guidance and Alternative Safeguarding Response aide memoire and template drafted last year was re circulated. Although it was anticipated that this draft threshold guidance, would be piloted in a number of Divisions across the Trust this year unfortunately, it was only piloted in one area largely due to workforce pressures. This pilot will be carried forward to the next reporting period.

The Governance work stream have done considerable work in standardising audit templates and agreeing with Divisions for quarterly adult safeguarding audit cycles to be completed across all service areas. This work stream has agreed for quarterly audits to take place throughout the year using a standardised audit tool to ensure compliance with the regional policy and procedures.

The first audit took place in March 2023 in relation to compliance with APP3 and 4. This involved a random audit of five files from each division for the period 1st October 2023 to 31st January 2024. The audit was completed by peers across the Divisions with Adult Safeguarding Leads completing the audit of files for another Division. Key learning was identified from the audit, which was in relation to the need for better recording to demonstrate that service users/carers wishes and views are sought and documented and; specific details regarding capacity and human rights considerations are recorded. A repeated learning theme centred on recording the decisions made and the need to explicitly outline the rationale for same. It was also recommended that each Division should continue to complete Adult Safeguarding file audits to ensure compliance against the regionally agreed forms. The learning from this audit has been

shared with the service areas, DSWs, Adult Safeguarding Leads and members of the training department at the quarterly meeting. The findings and learning identified from this audit is due to be disseminated to safeguarding staff at the next DAPO and IO forums and through a newspaper via the SW Governance department.

Another audit, planned for June 2024, has been stood down due to encompass 'go live' but two further audits, in respect of the other APP forms, are planned for the remaining reporting year.

In addition, the DSW and ASG nurse lead worked with Directorates to complete a Base line audit of Adult Safeguarding and each division conducted internal audits. Key priorities were identified from the base line audit and further audits are planned for the next reporting period.

BSO Internal Audit of Adult Safeguarding

As part of the Annual Internal Audit Plan, BSO completed an audit of the management of Adult Safeguarding during January 2023 and February 2023. The audit was conducted within the Adult Community and Older Persons Service (ACOPS) and Mental Health Division. There were a number of recommendations made by BSO, which included-

- The need for regular reporting to the Trust Board in a timely way
- The Clinical and Social Care Governance group should ensure their Terms of Reference (TOR) are agreed and operate per the assurance framework
- The Trust should ensure reporting mechanisms are in place regarding safeguarding to include data sets on referrals, investigations, themes and learning
- All third line assurance reports regarding adult safeguarding e.g. RQIA reports should be shared across all Directorates, action plans developed and reported through the governance structures and learning disseminated
- There should be a clear training strategy and plan in place to deliver, monitor and manage training and renewals in line with the NI Adult Safeguarding Partnership.
- Compliance with required training should be monitored to ensure that all staff are appropriately trained. The number of staff trained and percentage of training still outstanding should be centrally recorded.
- Current processes across all teams should be reviewed to ensure all teams use the same tracking mechanisms to track referrals and record information to ensure that timeliness of management can be ascertained.
- The Trust should ensure each department reconciles their referrals on a timely basis to DATIX, to ensure all incidents are recorded on Trust systems.
- A range of key performance indicators to monitor the timeliness of actions in the referral process should be introduced.
- The Trust should ensure that a standard model in relation to the management of adult safeguarding referrals is put in place to allow more streamlining of processes, data and associated governance.

- The Trust should review training and ensure all teams are aware of the documentation to be completed and ensure all is completed on a consistent basis. A regular check should be undertaken by management to ensure the forms are all completed consistently.

As a result, a substantial amount of work has been completed to date. This has included-

- The development of an Adult Safeguarding composite dataset, which has been built by informatics and is currently being piloted within LD services.
- ACOPS, MH and LD continue to report Adult Safeguarding activity that is quality assured through the DSW for each Division. This is then collated and further assured through the Adult safeguarding strategic team before forwarded to SPPG on a monthly basis.
- A Monthly report detailing Hospital activity is now compiled and disseminated. This has been agreed by Executive Team and is reported bi-annually to the Trust Assurance committee.
- The Adult Safeguarding (ASG) position report 2022/23 was completed and presented to Clinical and Social Care Governance group in January 2024
- The TOR for the Clinical and Social Care Governance group have now been reviewed and agreed.
- A new data set for adult safeguarding was developed and presented at the QMS in August 2023. This will continue to be enhanced by information from the composite data set and the hospital report.
- New arrangements have just been developed whereby the SW Governance Lead will triangulate information from Corporate governance, RQIA reports and share learning via the Adult and Children's Safeguarding Committees
- As there was no consistent method, whereby all professional staff availed of L2 and 3 training a scoping of training needs took place. Following a paper being submitted, the Executive Team agreed to a resource of Band 7 and Band 3. These posts are currently being recruited.
- All staff undertaking adult safeguarding training record this on learn HSCNI. Managers are also able to view the training records of direct reports. The training records referenced can be centrally reported on and all divisions have responsibility to report compliance and outstanding numbers to the ASG Committee.
- A DATIX and adult safeguarding review paper was completed and the Executive team have agreed for additional mandatory questions to be added to DATIX, which should assist in capturing Adult safeguarding activity.
- An audit of thresholds for adult safeguarding has been completed and proposed KPIs identified and agreed by EDSW. Learning has been shared through bespoke DAPO/IO training sessions on 23 and 24 April 24
- A Structures paper has been completed which is currently being reviewed and further DSW workshops with EDSW are being scheduled.
- Quarterly meetings have been scheduled between ASG leads and Trainers to discuss how learning from audits, RQIA reports etc can be incorporated into forums and training

- Audit cycles have been scheduled for the incoming year.

Ongoing progress against these actions is reported through the Adult Safeguarding Committee.

Adult Safeguarding in Outpatients

There have been a number of developments in relation to Adult Safeguarding within BHSCT outpatient department during this reporting period.

The Outpatient Liaison Nurse (Adults and Children's Safeguarding) left post and there are no current plans to recruit into the post. The Adult Safeguarding Lead for Hospitals (8A nurse) has built on the work completed by the Outpatient Liaison Nurse by completing a number of bespoke training sessions within outpatient departments focussing on identifying and reporting abuse.

Alternative arrangements have been put in place and the members of the S.A.F.E forum (which was specific to outpatients departments) have been incorporated into the wider "Adult Safeguarding Link Staff" system. During this reporting period, progress has been made with a considerable number of outpatient's staff completing the adult safeguarding Level 3 training. The outpatient referral pathway has been reviewed and it has been agreed that outpatient departments use the standardised Adult Safeguarding noticeboard, and the standardised adult safeguarding manual that has been developed.

2. PARTNERSHIP

The Belfast Local Adult Safeguarding Partnership (Belfast LASP)

The Belfast LASP continued to meet each quarter over the reporting period 2023/24. Like the previous year, all Belfast LASP meetings took place on a digital platform and enabled LASP members to receive updates in relation to Adult Protection developments in line with the Transformation Board and interim Adult Protection Board.

Like the previous years, the prevalent concern of the Belfast LASP related to the lack of regional strategic direction and engagement with the Community and Voluntary sector within the proposed reform of Adult Protection structures with the Transformation Board and Interim Adult Protection Board.

The Belfast LASP Chair is now the Interim Executive Director of Social Work/ Adult Safeguarding Champion. A workshop was arranged in March 2024 to provide opportunity for the members to meet in person, review the terms of reference and begin to look at the action plan for the year ahead. A further meeting has been scheduled in June 2024 to progress this work.

Adult Safeguarding Training

A significant amount of work has been completed by the learning and development work stream. The Levels of training referred to below are per NIASP Training Framework.

1. Level 1 – a training video has been produced and is now part of Belfast Trust's "on-boarding", induction programme for all staff new to the Trust. This has been a significant development in terms of moving from a two and a half minute animation to a 20-minute video. This ensures staff are aware of regional policy and local policies in respect of the safeguarding of children and adults. In this reporting period, 7417 staff completed this training.
2. Level 2 Awareness Training and Level 3 Line Managers Training – the demand for this training across the Trust (outside of social work and social care) continues to outweigh the capacity of the WLDI service. As a corporate responsibility, a resource has been identified for WLDI to recruit an additional Band 7 Learning and Development Coordinator and Band 3 Admin support. These posts are ready to go to recruitment.
3. Level 3 ICT solution – the regional group of Adult Safeguarding Training leads are at the end stage of developing an animation that will be a pre-course requirement for level 3 training. A key focus in 2023 – 2024 was facilitating Level 3 training to nursing staff /AHP in acute hospital and community settings (n = 638). These staff are required to undertake a full day refresher every 2 years so these numbers will require refresher places 2024 / 2025. There continues to be demands from other hospital / nursing setting and facilitation has been agreed for AHMIC staff April 2024.
4. Level 4 (Investigating Officer) and Level 5 (Designated Adult Protection Officer) training – training materials are routinely reviewed and updated to reflect developments in Adult Safeguarding, learning from Serious Case Reviews and operational developments.

During this reporting year, 9368 staff attended a range of safeguarding training provided over 88 programmes in 2023-2024. 282 of these staff were AHPs compared to 2650 staff in 2022-2023.

There has been a significant increase in attendance at Adult Safeguarding training in this reporting period (9,368) in comparison to last year. This is primarily due to the inclusion of reporting on Level 1 training in these figures, which is mandatory for all staff joining the organisation. At this point the Trust are not able to report on how many of these staff are outside of the social work and social care workforce but suffice to say it is most of this number. This resource has helped raise awareness of adult safeguarding within the organisation.

There has been a reduction in other safeguarding training activity compared to 2022/23 reporting period (1735 staff trained over 143 programmes) however, it should be noted that this increase in 2022/23 was due to the demand and additional provision of Level 3 training to Nursing and Allied Health Professionals. This ongoing demand from staff outside of the social care/work profession far outweighs the capacity to deliver. The Trust is considering how to respond to this demand.

As per previous reports since the 2016 policy, there has been ongoing demand for Adult Safeguarding training (Level 2 and Level 3) across the organisation without additional resources to support full implementation.

The demand for Level 2 Awareness and subsequent refresher training has continued over the past year. The WLDI service is required to prioritise social work and social care staff, therefore the position remains unchanged in that there are only limited places available to non- social work/social care staff. Meeting the training needs of this diverse range of staff remains a significant workforce challenge.

The Level 2 Adult Safeguarding mandatory awareness raising (3-hour course) and Level 2 Refresher training continues to be provided twice monthly to attempt to meet this demand and staff can choose to attend either an in-person session or a "live" session on Microsoft Teams. As staff need to be compliant with both the Northern Ireland Adult Safeguarding Partnership Training Framework (NIASP) and RQIA requirements WLDI Service facilitate this by providing bespoke sessions on request. Demand for these training sessions continues to increase.

A key focus in 2022 – 2023 was meeting the demand for Level 3 training to nursing staff /AHPs in the acute hospital and community settings (n = 638). These staff are now required to undertake a full day refresher every 2 years and these staff will require refresher places 2024 / 2025. There continues to be demand from other hospital / nursing settings and facilitation has been agreed for staff within the Acute Mental Health Inpatient Centre in April 2024.

The WLDI also continues to respond to operational requests for urgent training outside of the Adult Safeguarding training calendar each year e.g. Designated Adult Protection Officer (DAPO) training in Dec 2023.

Support groups continue to be facilitated, namely the quarterly DAPO and IO groups and these will be amalgamated in 2024, which will reduce pressure on facilitator and operational staff time. Line manager (Level 3) support groups will continue to be facilitated by the WLDI Service to ensure that staff are kept up to date in addition to their 2-year refresher training.

The WLDI Service has also facilitated Adult Safeguarding Champion groups when requested and will continue to support Trust operational staff to disseminate key Adult Safeguarding messages to this group and explore any issues such as referral pathways, thresholds that this group might have.

Support Networks- Internal and External

The internal line manager support groups continue to be facilitated by the training team on a quarterly basis to ensure that level 3 staff are kept up to date in addition to their 2-year refresher. This year there was a particular focus on interim protection planning, DHRs and a spotlight on Adult Family Violence.

The training team have also facilitated external Adult Safeguarding Champion groups when requested and will continue to support Trust operational staff to disseminate key adult safeguarding messages to this group and explore any issues such as referral

pathways, thresholds that this group might have. There was only one session this year with the external champions which provided updates on strategic developments, domestic abuse legislation and provided an overview on DHR and good practice recommendations.

DAPO & IO Forums:

The DAPO and IO Support Groups have continued to take place quarterly over this reporting period. Staff and Managers reported the ability to attend via Microsoft teams has increased engagement across all Adult Safeguarding Staff. The forums have covered a range of topics namely:

- Domestic Abuse WAFNI - *Legislation updates*
- Overview of new DOH legislation and updates
- Adult Protection Bill Overview
- DHRs
- *Managing risk: social workers' intervention strategies in cases of domestic abuse against people with learning disabilities*
- *Hate crime*

In addition, a workshop on Protection Planning was arranged on 23rd June 2023 for DAPO/IO group.

It has been agreed that given the content of the DAPO and IO forums is largely the same that in the next reporting year that the quarterly DAPO and IO groups will be amalgamated which will reduce pressure on facilitator and operational staff time. Their focus is to ensure that all adult safeguarding staff are updated on operational developments and that specific training needs can be addressed. The Adult Safeguarding Training Lead continues to work closely with Adult Safeguarding Leads in each service area to agree the focus for the forums and are provided in partnership. There will be additional forums that will focus on learning from audits and action plans.

An Investigating Officer (IO) /Designated Adult Protection Officer (DAPO) Central Register and MS Teams channel has been developed with each service area responsible for recording IO/DAPOs. This will record training completed and date completed and thus assist managers to monitor compliance with training.

MARAC/ Domestic Abuse

MARAC continues to take place on a fortnightly basis chaired by the PPU Detective Sergeant. MARAC migrated onto a digital platform in March 2020 with the onset of COVID and has continued to take place virtually over the reporting period. Two additional meetings took place in the Belfast area in addition to scheduled meetings. This was a temporary measure to address a backlog of MARAC referrals.

Domestic Abuse referrals have increased within BHSCT compared to the previous reporting year. With the roll out of Encompass for recording Trust activity in Northern Ireland, DASH assessments and MARAC referrals can be completed using this system in the future, which would improve recording of data across all service areas.

MARAC representatives within Adult Safeguarding are located within three divisions; Learning Disability, Mental Health and ACOPS. The APGT Service Manager as an interim arrangement took on the role of MARAC representative for ACOPS (OPS, APGT & PHSD). Although consideration had previously been given to centralising the MARAC role and having one MARAC representative for all Adult Services, given the rise in MARAC referrals this would not be operational and will be reviewed as part of the ongoing review into the adult safeguarding structures within the Trust. In addition, the MARAC role is not resourced and this is an additional aspect of the adult safeguarding leads responsibilities. In the interim, each service area retain responsibility of attendance at MARAC.

There was an independent review of existing MARAC processes completed by Leonard Consultancy in July 2023. The Trust awaits further direction from SPPG as to how recommendations from this work are to be implemented.

Domestic Abuse resources for the public.

In recognition of the importance of providing materials for the public, BHSCT have set up a co-production working group comprising of BHSCT representatives from Adult Safeguarding, Personal & Public Involvement Team, the Equality & Planning Team and Children's Services alongside partner agencies; Women's Aid, Men's Advisory Project, Rainbow Project, NEXUS, ASSIST NI, and PSNI. The aim of the project is to create information that people with lived experience of domestic abuse and sexual violence:

- would find useful,
- is in a format that is useful to them, and
- that will not increase their level of risk.

Scoping has been undertaken by partner agencies and arising from the outcome of this, resources are now being developed e.g. posters, a leaflet, and enhanced information on the BHSCT website.

Domestic Homicide Reviews

Since the introduction of Domestic Homicide Reviews in 2020 the BHSCT have been involved in ten DHRs to date. Only two of these reports have been published. A small number of BHSCT Senior Managers have compiled reports on behalf of the BHSCT and a small number of managers have participated in Domestic Homicide Reviews panels within the region. The Trust has implemented an internal Domestic Homicide Review Oversight Group to take forward BHSCT actions and learning related to

DHR's. Significant progress has been made in relation to a number of the actions relating to the BHSCT. This group reports through to the Adult Safeguarding Committee.

The Trust have provided awareness raising training for staff and provided additional training on issues related to action plans and recommendations from the reviews. The Trust has not received any additional funding and the costs have had to be met from underspend in other areas.

The learning from DHRs have prompted the Trust to fund Licences for the 8 stage Domestic Homicide Timeline Training.

In order to allow for triangulation of data a working group with representatives from the various service areas and Corporate governance have agreed a number of key SW and social care themes arising from SAIs and DHRs.

Adult Safeguarding Champion Forum for External Agencies

The Belfast Trust Adult Safeguarding Development Officer continued to deliver support network for Adult Safeguarding Champions of external regulated facilities within the Belfast Health and Social Care Trust catchment area. During the reporting year, one meeting took place and they continue to be provided as required.

Pressure Damage

The production of guidance in relation to the interface between pressure damage and adult safeguarding is a long-term agenda item. During this reporting period, it was agreed the BHSCT Adult Safeguarding Lead for Hospitals (8A nurse) would lead on this regional piece of work. A workshop was held in November 2023, and arising actions have been underway. Until the guidance is completed, the Trust continues to manage pressure damage on a case-by-case approach using established BHSCT processes and decision making guidance; agreed between Adult Safeguarding and colleagues within Tissue Viability services within the BHSCT.

Falls

Based upon the Newcastle Safeguarding Adults Board "Safeguarding Adults and Falls Protocol: When is a slip, trip or fall a safeguarding adult issue?" BHSCT Adult Safeguarding Lead for Hospitals (8A nurse) scoped production of guidance for use within Northern Ireland. Feedback received agreed this would be beneficial. A working group was established, a draft produced, and pilot implementation has now taken place in two phases; a non-acute hospital rehabilitation ward, and in the BHSCT statutory ACOPS homes. The guidance has been well received. Amendments have been made based on feedback received, and phase three pilot will take place following Encompass launch; the details of this are yet to be finalised. The regional TASS group has been kept up to date, with a view to possible regional adoption in due course.

Human Trafficking & Modern Slavery

The Trust Adult Safeguarding Development officer represents BHSCT on the DOJ NGO engagement group in relation to Human Trafficking and Modern Slavery.

During the reporting period, BHSCT Strategic Team liaised with Hope for Justice, a non-profit organisation that aims to end human trafficking and modern slavery, to secure access to their free awareness E-Learning, specific to Northern Ireland. "Modern Slavery and Human Trafficking In Northern Ireland: Know It, See It, and Respond To It"

Volunteer Now

Volunteer Now continues to be a core member of the Belfast Local Adult Safeguarding Partnership (LASP) and regularly provides updates in relation to training and developments. Volunteer Now continue to deliver on their regional contract to provide Adult Safeguarding training for the Community and Voluntary Sector.

The Adult Safeguarding Lead for Belfast HSC Hospitals (8A nurse) provided input into the Volunteer Now "train the trainer" course.

Policing and Community Safety Partnership (PCSP)

The Belfast Trust Adult Safeguarding Specialist (TASS) was a core member of the PCSP, however following the TASS retirement in August 2022 and no recruitment of this post, there was no longer a rep for Belfast Adult Safeguarding in the South Belfast DPCSP. This role is fundamental in highlighting the role of PCSP in relation to the Prevention and Protection in Partnership Policy and the Trust is currently reviewing membership.

Interface with Human Resources

The Adult Safeguarding Governance work stream has continued to hold meetings with HR representatives and Adult Safeguarding Leads during this reporting period concerning the interface between HR processes and Adult Safeguarding. A draft protocol is near completion however; competing workloads, impending Encompass implementation, and the launch of a new regional HR disciplinary policy have all had an impact on the progression of this piece of work.

Adult Safeguarding Link Staff

The Adult Safeguarding Link staff system has continued to mature over the reporting period with a continued aim of embedding Adult Safeguarding within wards/ facilities/ departments. There are currently 232 link staff within the BHSCT. The support forums continue to be co-chaired by the Lead for Adult Safeguarding in BHSCT Hospital Sites

(nurse role) and an operational Social Work Adult Safeguarding Lead. Link staff also continue to avail of updates/ peer support via a dedicated MS teams channel, email circulation list membership, and direct support from Lead (nurse) for Adult Safeguarding in BHSCT Hospital Sites as required.

3. PREVENTION

Position Reports

As noted in previous Trust Adult Safeguarding position reports the external ASC position reports for external regulated facilities remains an area of priority. The Position reports enables an Adult Safeguarding Champion for each regulated facility to collate their annual data, analyse and draw on areas of learning and need relating to Adult Safeguarding and Adult Protection. This report is primarily an accountability report for the organisation. The ASC external support forum has previously provided support and guidance to ASC's in commissioned services in relation to this.

While BHSCT would like to be in a position to review and analyse all position reports in all services that it commissions, this has not been possible because no additional funding resource has been provided. It remains the opinion of the Trust Adult Safeguarding strategic team that a resource is required to review and analyse all regulated facilities ASC position reports by BHSCT Adult Safeguarding as assurance and governance arrangement. The BHSCT is therefore currently reviewing Adult Safeguarding structures with the aim of proposing Adult Safeguarding governance and assurance arrangements, which would be responsible for reviewing a proportion of the ASC position reports.

The Trust, as a commissioner of services, have made it clear to organisations as part of the contractual process that they must adhere to adult safeguarding policy and procedures and complete an annual position report. The Trust reserves the right to request position reports of individual organisations and will do this in situations where there is particular concerns relating to a service.

ASC Forum/Line Manager Forum

Belfast Trust Adult Safeguarding Development Officer alongside the Trust Adult Safeguarding Training Lead continue to deliver the BHSCT internal ASC/Line Manager Forums. The membership of the Adult Safeguarding Champion/Line Manager forum are BHSCT Employees who are trained to Level 3 ASC/Line Manager training as per the NIASP training framework 2016. This forum takes place on a quarterly basis, following the same format as the DAPO & IO support groups. The purpose of the internal support group is to provide strategic and operational Adult Safeguarding updates, facilitate peer support, provide learning opportunities and share information. This forum has been well received by Trust Adult Safeguarding Line Managers.

Keeping Adults Safe Programme

This programme continues to be delivered by Volunteer Now within the Belfast LASP area.

Keeping YOU Safe programme- Facilitators training

WLDI delivered two sessions this year to both Trust and LASP members. This is a train the trainer programme that allows trained staff to deliver key adult safeguarding keeping you safe training. The facilitators are trained and then deliver adult safeguarding awareness to service users within Belfast Trust.

Awareness Raising

Adult Safeguarding Awareness raising has continued during the 2023-24 reporting period. The strategic Adult Safeguarding team delivered bespoke Adult Safeguarding awareness raising sessions to a range of departments within BHSCT. This was delivered across disciplines promoting awareness raising and referral pathways within the Trust.

Adult Safeguarding Awareness week

The Strategic Adult Safeguarding Team and Adult Safeguarding Lead trainer delivered a 5-day learning event, 20-24th Nov 24, to promote National Adult Safeguarding Awareness week. These events were delivered via MS Teams. The following topics sessions were delivered to BHSCT staff and members of organisations aligned to Belfast LASP partner agencies:

- “Transforming the response to older victims of domestic abuse.” (Dewis Choice/Aberystwyth University) with a focus on The Co-existence of Dementia and Domestic Abuse.
- “Transforming the response to older LGBTQ+ victims of domestic abuse.” (Dewis Choice/Aberystwyth University)
- Domestic Abuse Advocacy Service (ASSIST NI)
- Domestic Abuse (Belfast & Lisburn Women's Aid)

Adult Safeguarding Resources to raise awareness

During the reporting year, there has been a substantial amount of work undertaken in the development of Adult Safeguarding materials to assist staff and the public including patients, service users and carers to recognise, respond and report adult abuse. Information produced during the period included:

- User guides, aide memoires, and video guides e.g. completing an APP1, protection planning

- Flowcharts detailing referral pathways, escalation pathways etc.
- The Loop has extensive information
- Standardised manuals are now available online and within the wards.
- “Awareness raising” sessions; both open sessions, and sessions targeted towards specific service areas.
- Adult Safeguarding link staff network established
- A domestic violence conference in Dec 2023 with various external and internal speakers.
- A domestic abuse pocket size guide for staff

There has also been active collaboration with external providers to secure training in relation to human trafficking/ modern slavery, and domestic abuse/ sexual violence.

In order to enhance and improve engagement with the service users, carers, patients and the public, materials were also created collaboratively with the working group, PPI plain English group, and TILLI as follows:

- Standardised noticeboards detailing how to identify and report possible abuse. These include information in easy-read format and other languages.
- Pop up banners have been erected across hospital and community facilities.
- BHSCT Website information has been significantly increased
- Adult Safeguarding infographic, and the launch of two videos via social media “What is Adult Safeguarding?” and “Adult safeguarding noticeboards”.
- A leaflet has been produced and distributed detailing, “What happens after you raise a concern that you, or someone else, has been abused?”
- “Seniors booklet” updated

A co-production project has recently commenced with external stakeholders in relation to the creation of information about domestic abuse for the public.

Adult safeguarding Information has also been updated for external professionals including the “GP toolkit” which is a directory for GPs detailing BHSCT services.

This work has also been forwarded for a Chairman’s award and we await if this is successful.

Service User Feedback

BHSCT recognise the importance of seeking, and learning from, service user feedback. Work has been undertaken to enable collation of service user feedback; gathered independently from operational teams in order to promote open and honest feedback.

A scoping exercise was undertaken to collate service user feedback templates used by the operational Adult Safeguarding teams. These were analysed and a standardised feedback survey produced. The Adult Safeguarding Governance work stream including the Adult Safeguarding leads reviewed the template, the PPI readers group was consulted, amendments made as required, and a final template agreed.

Options are currently being explored in relation to gathering this feedback, such as utilising telephone, text message, and Encompass once service users have access to the MyChart app which will be progressed through the next reporting year.

The service areas were fully engaged in the 10,000 More Voices Project. The outcomes have been shared and a regional action plan has been agreed and shared with Trusts.

SECTION 4

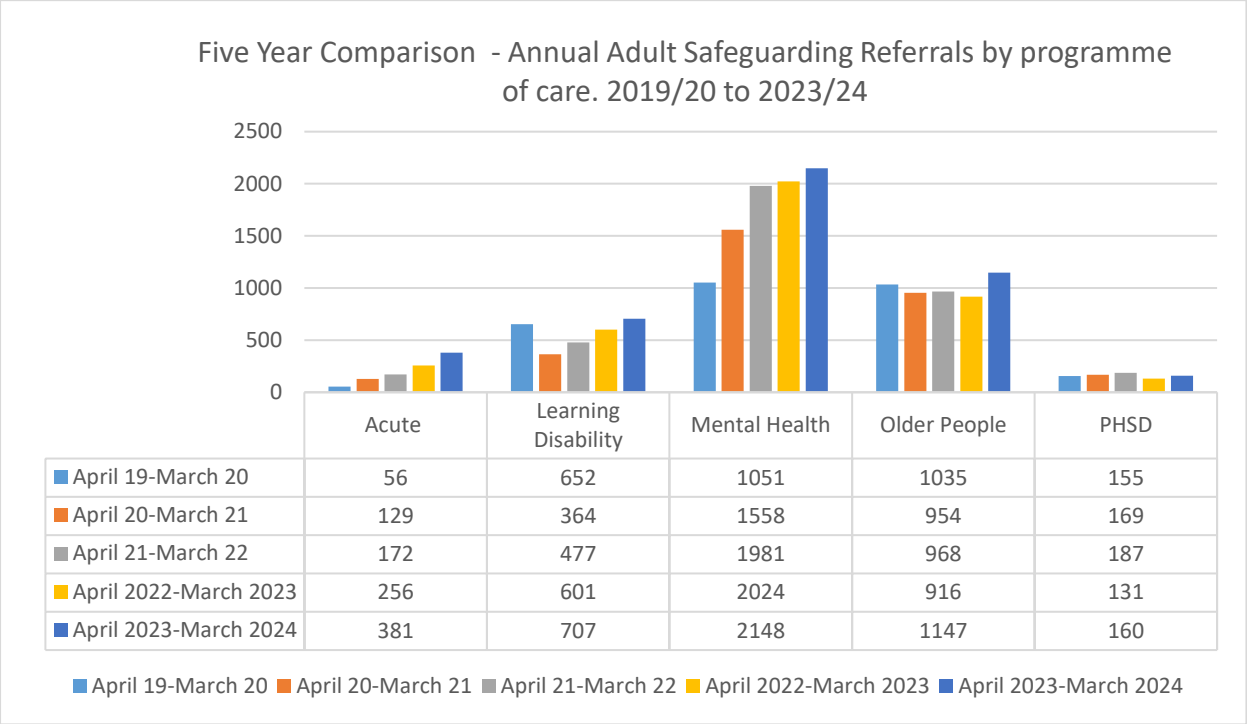
BHSCT Adult Safeguarding Activity Returns

The data in this section is in relation to ASG referrals across BHSCT. The data for OPS and PHD differs from that provided to SPPG because SPPG require only data in relation to APP1s which with section three completed (by a gateway service). Therefore, the data below does not include referrals to ACOPS community social work teams, which have been screened as no further action or as an alternative safeguarding response at section 2 by local DAPOs. As there is no central gateway team for BHSCT, MH services have DAPOs within their teams who complete section 3 in respect of all their referrals as do LD, who have now introduced a central gateway team who screen referrals at section 3 of the APP1; therefore, the data below for MH and LD reflects the activity within their service.

It should be noted that the SPPG return requests that a referral is designated to a programme of care unfortunately as a number of service users do not fit into any specific programme of care the Adult Protection Gateway Team hold these cases but these are not reported through the SPPG template and therefore not contained in the data below. These issues in relation to data collation have been forwarded to the SPPG and we await their response.

Chart 1 illustrates there was an increase in Adult Safeguarding referrals received by the BHSCT from 3928 Adult Safeguarding referrals in the last reporting period to 4,543 referrals from April 2023- March 2024. This was a 16% increase (615) in referrals. There was an increase in referrals across all the programmes of care with the biggest increase in referrals to the Older People's service by 231 from 916 last year to 1147 this year. This was followed by Acute Services by 125 and then Mental Health by 124 referrals. The increase in referrals across all divisions may be related to the significant work undertaken by the Trust to raise awareness of adult safeguarding through training and through developing a range of resources for staff and for our service users and carers.

Chart 1:



	Acute	Learning Disability	Mental Health	Older People	PHSD
April 19-March 20	56	652	1051	1035	155
April 20-March 21	129	364	1558	954	169
April 21-March 22	172	477	1981	968	187
April 2022-March 2023	256	601	2024	916	131
April 2023-March 2024	381	707	2148	1147	160

As Charts 2, 3 and 4 demonstrate, there has been a 34% reduction in adult protection investigations to 639 and a 102% increase in alternative safeguarding responses when compared to the last reporting period across the BHSCT. There has been a reduction in protection investigations across all Divisions from 297 to 175 in Learning Disability, 475 to 295 in MH and from 169 to 147 within Older People's Service when compared to last year.

This, more than likely, has been related to an ongoing focus on threshold application and improved screening of APP1s and the implementation of the APP suite of forms on Paris CIS. Adult Safeguarding staff now operate to the threshold of 'Adult at risk of harm managed through alternative safeguarding response' and 'Adult in need of protection requiring an Adult Protection investigation'. Prior to the implementation of the APP forms on Paris in June 2022, some divisions were conducting safeguarding investigations for referrals meeting the 'adult at risk of harm' threshold. As a result, the overall Trust total number of investigations in 2022/3 incorporated Adult Protection investigation figures and safeguarding investigation figures. This count operated outside of the regional policy. As a result, the data for this reporting year reflects the regional policy for Adult in need of Protection resulting in an adult protection investigation.

The number of referrals screened as No Further Action (NFA) across the Trust has remained largely the same as last year. Mental Health recorded the highest number of referrals screened as NFA at 52% (1113) over this reporting period, followed by ACOPS (OPS and PHD) at 34% (452) and then LD at 25% (177).

The number of Alternative Safeguarding Responses (ASR) this year has increased by 102% across all service areas with 50% (355) of Learning Disability, 34% of Mental Health referrals (740) and 52% of ACOPS (685) referrals resulting in an alternative safeguarding (ASR).

Within Mental health, a large number of referrals are generated through the inpatient units. Many of these referrals are screened as alternative safeguarding responses or NFA as at times the service user is unwell when the referral is created, which will be screened when the person's mental state improves. In addition, a significant number of referrals relate to historical abuse, which the Trust will now designate as NFA, (after referral to Police) unless there are other safeguarding responses required.

25% of Learning Disability referrals (175) resulted in an Adult Protection investigation in comparison to 14% (295) in Mental Health and 14% (169) in ACOPS. Learning Disability continues to experience the highest number of Adult Protection investigations. This is likely related to the higher number of service users who lack capacity within this service and a high proportion who reside in group settings including the Learning Disability hospital.

All areas continue to apply the regional thresholds in relation to 'at risk of harm' and 'in need of protection'. Given the focus this year and the significant work undertaken in relation to thresholding, how staff apply the thresholds is much improved than in the previous reporting period resulting in 102% increase in ASR with a 34% decrease in AP investigations when compared to last year.

The recording of protection plans activity remains an area of focus. Data for this reporting period indicated there is variation in interpreting the SSPG Data requirement. The data presented in Chart 3 suggests there is a disparity in investigations commenced and protection plans implemented. This may be a result of staff implementing an interim protection plan at point of screening the Adult Protection referral. However, clarification has been sought from the SPPG in relation to data descriptors and all staff were informed in December 2023 that interim protection plans are no longer to be included and only those attached to a protection investigation should be collated in the SPPG data return.

Chart 2:

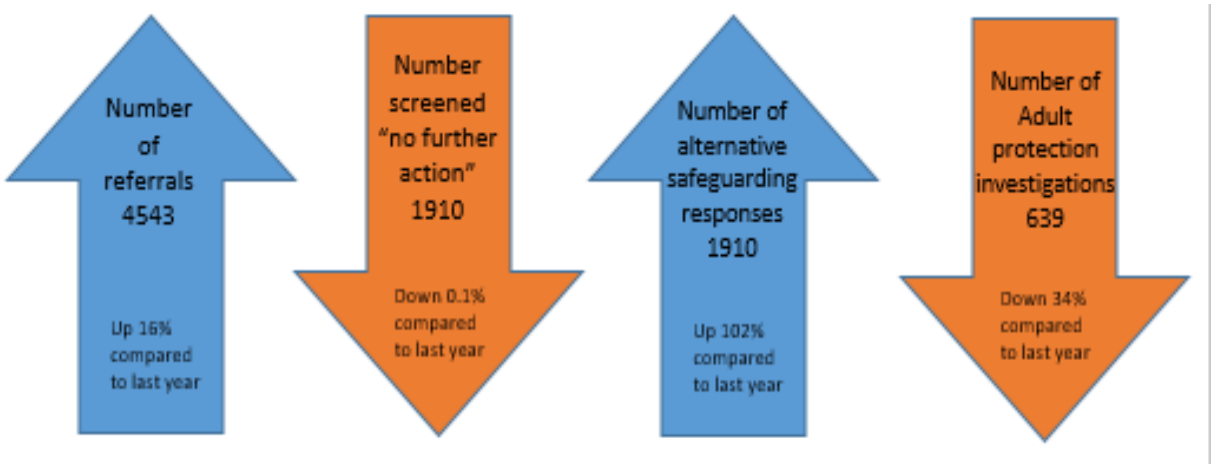
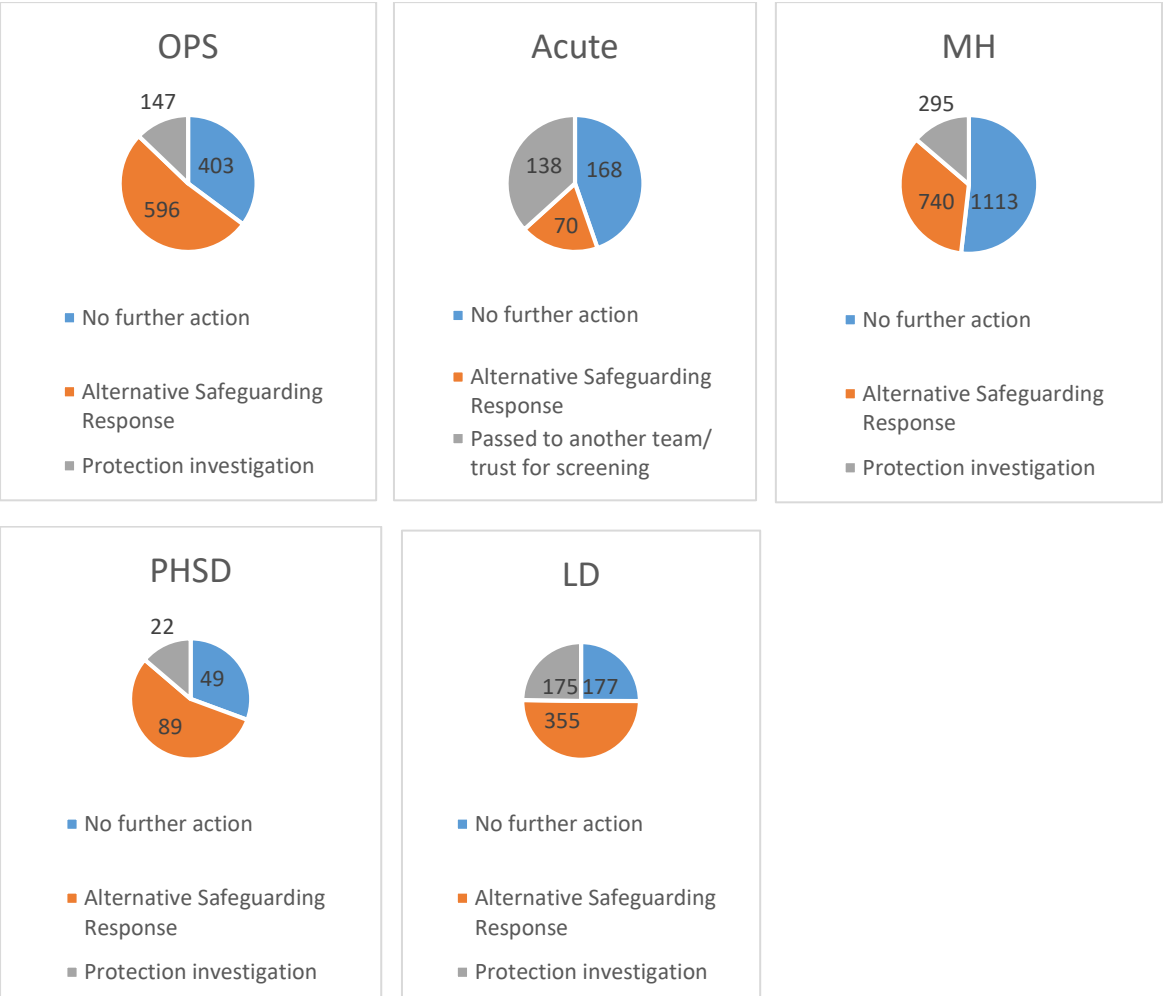


Chart 3:

	Five Year view of Adult Safeguarding activity (2019-20 to 2023-24)																								
	Investigations					Protection Plans					Joint Protocol					PIAs					ABE Interviews				
Years	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24
Acute Sector	11	9	7	0	0	9	21	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disability	232	157	325	297	175	150	300	340	308	187	10	25	7	11	19	4	3	4	4	1	0	2	2	3	3
Mental Health	554	560	569	475	295	352	473	520	370	330	9	4	8	7	8	2	4	2	1	4	0	4	0	0	0
Older People	663	414	376	169	147	554	211	242	124	187	27	32	30	16	4	21	15	7	5	2	5	1	1	7	2
PSD	89	75	46	26	22	70	39	43	16	25	4	3	3	3	2	1	5	2	2	4	1	3	1	0	4

**Please note all investigations completed for the acute sector are contained within the data for the programme of care for which the patient is the 'best fit.'

Charts 4



As Charts 3, 5 and 6 demonstrate there has been a steady decline in the number of Joint Protocol cases with a further 11% reduction this year from 37 to 33. Despite this decline, there has been a slight increase by 3% in consultations with the PSNI from 501 last year to 515 this year. The number of Pre Interview Assessments and ABE interviews completed remained similar to the last reporting period at 11 and 9 respectively.

The vast majority of investigations are single agency Social Services and this year there has been a slight increase in them when compared to last year from 209 to 261. Similarly, there has also been an increase in single agency PSNI investigations from 89 last year to 111 this year.

Chart 5

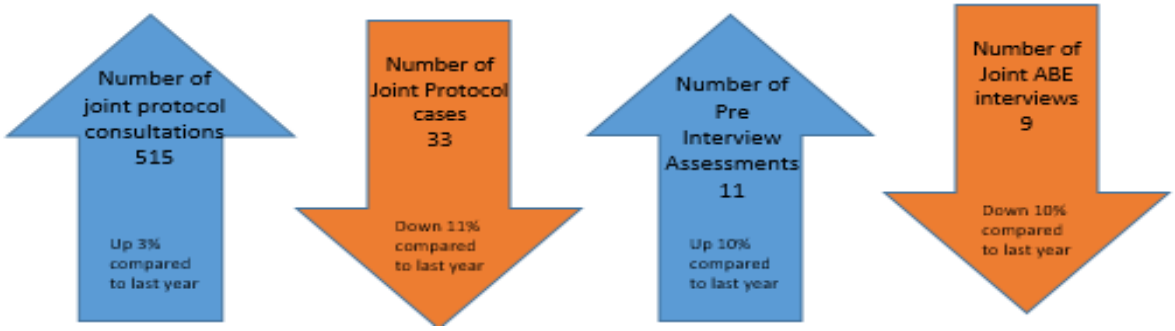
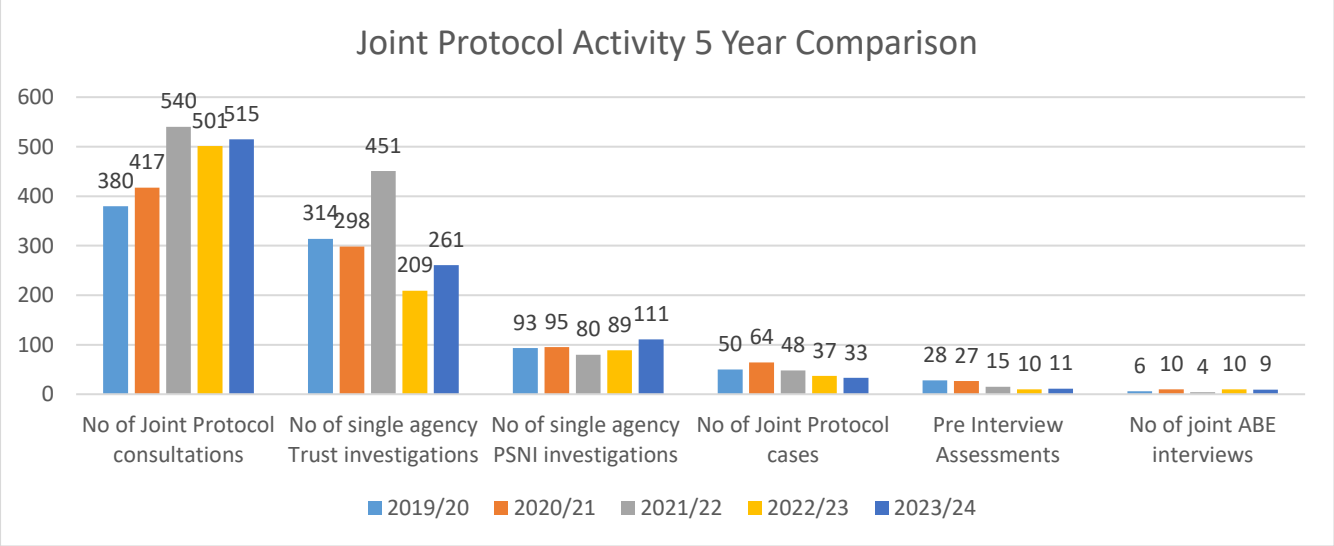


Chart 6:



As Chart 7(A) and 7(B) below illustrate, by far the greatest referral source is self at 29% followed by regulated care home (14%) and then by Acute general hospitals (10%) and mental health hospitals (9%).

This year there has been a reduction in self-referrals by 12% in comparison to a significant increase in referrals being generated by Acute Hospitals by 111%, regulated care providers by 74% and adult mental health by 12%.

Over the last three reporting years acute hospitals has increased the number of adult safeguarding referrals identified each year. This accounted for 8% of referrals reported within the Trust. It is likely this increase is as a direct result of the significant work undertaken to raise awareness within the acute sector, for example link staff attached to the units, aide memoires, standardised manuals, leaflets, notice boards and pop up banners etc.

Chart 7 (a):

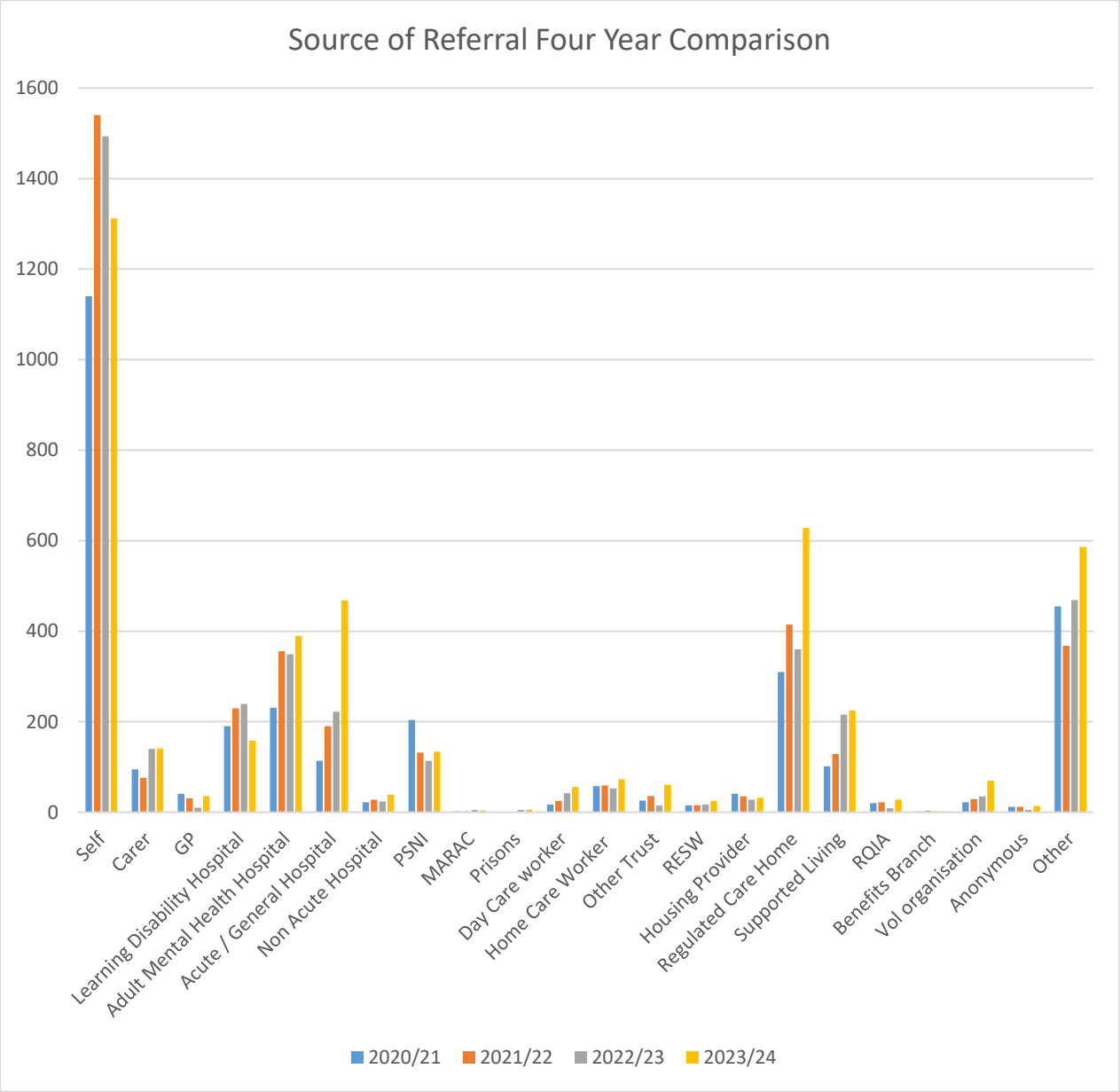


Chart 7: (B)

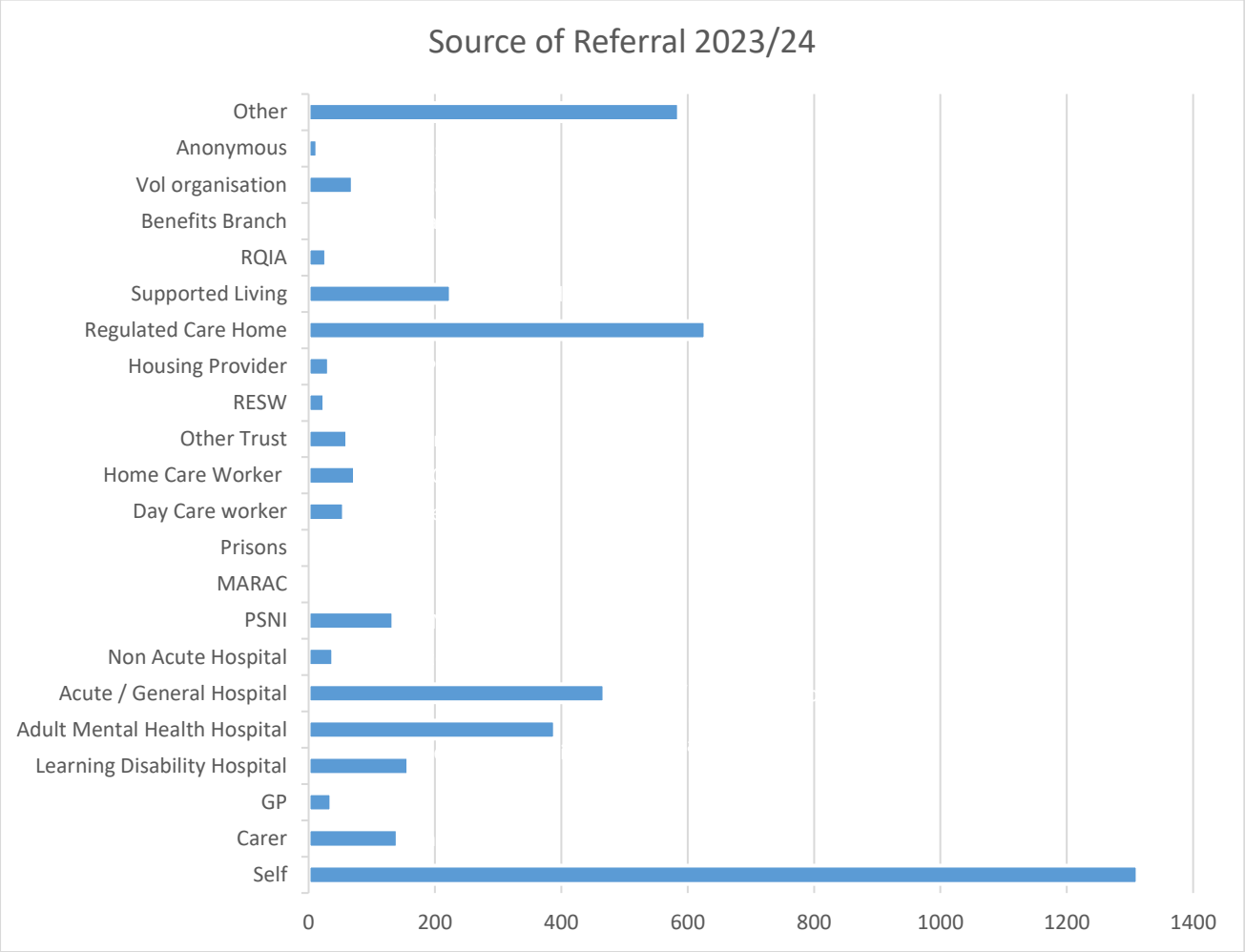


Chart 8 illustrates, like the previous reporting years, physical abuse is the highest type of abuse reported across all Divisions at 39%. Chart 8 illustrates that Mental Health continues to have the highest levels of physical abuse reported at 37% followed by sexual abuse at 29% and then Psychological at 19%.

ACOPS (OPS and PHSD) continues to have the highest proportion of physical abuse (44%) and then followed by financial abuse at 17%.

This pattern has continued over the last three reporting years.

Physical abuse remains the highest recorded category of abuse across all service areas, accounting for 41% of referrals. This is in keeping with the previous reporting period.

Chart 8:

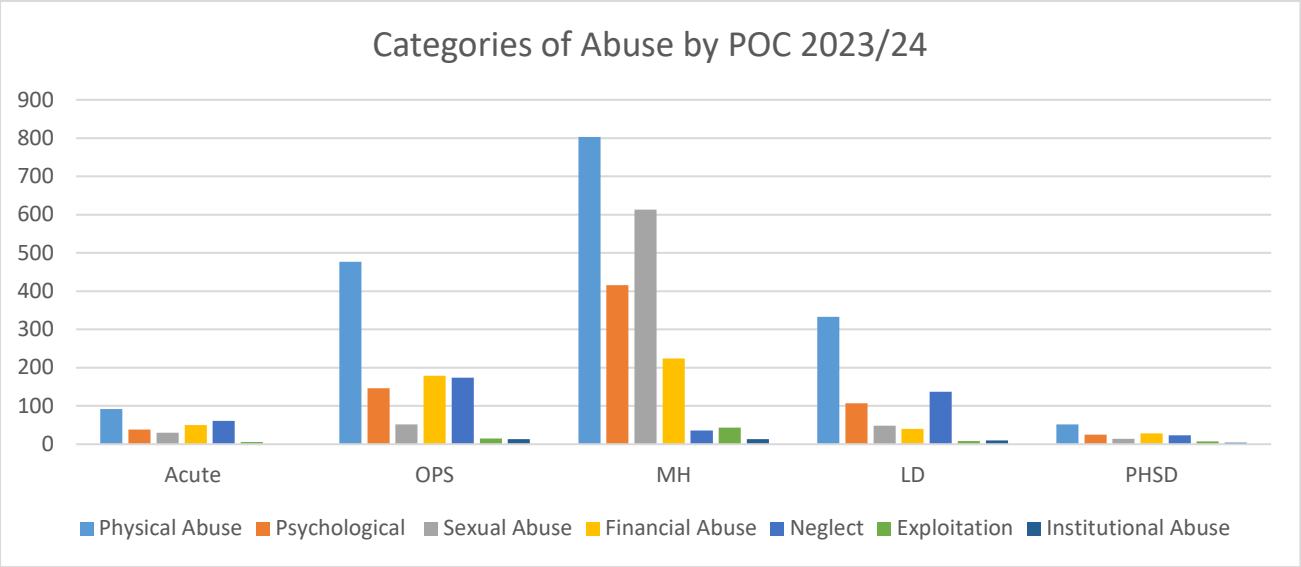
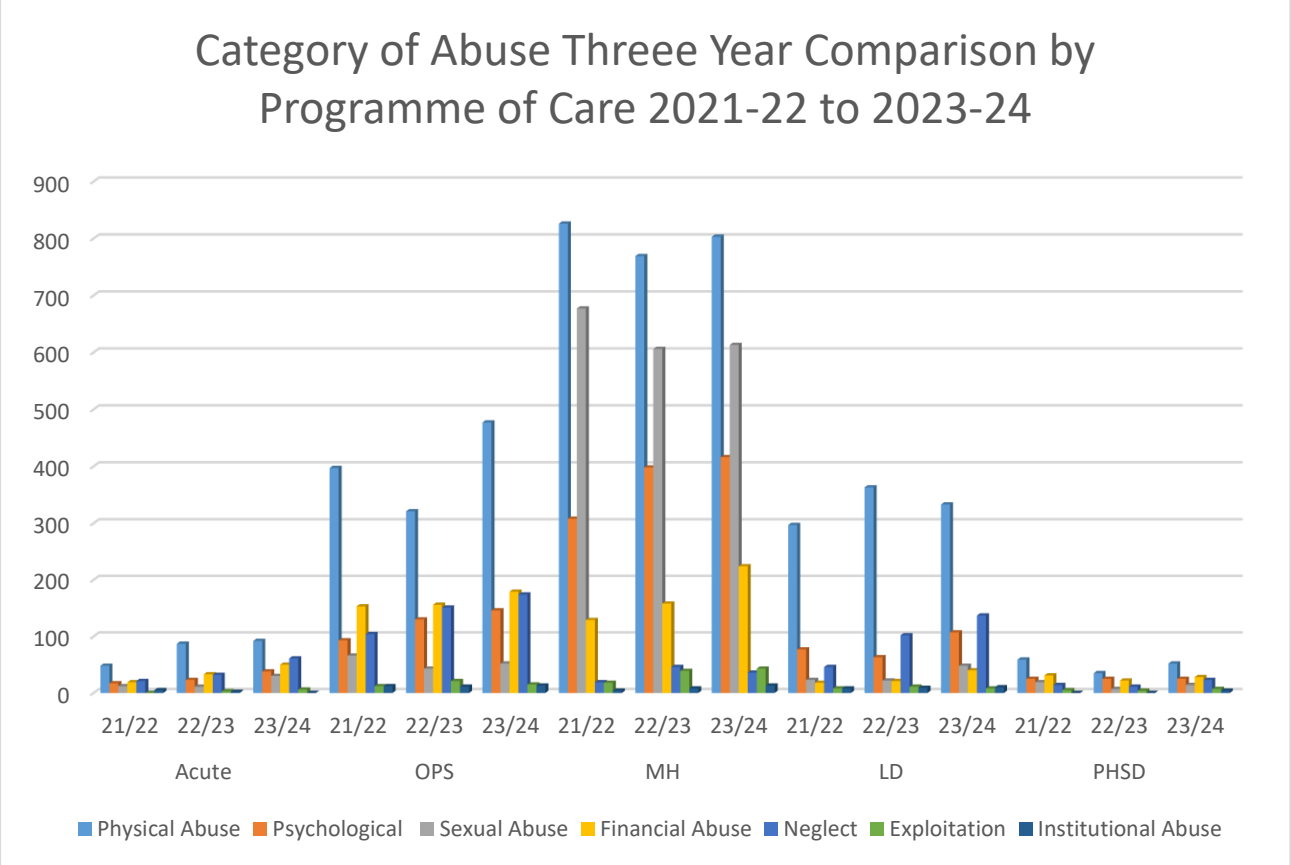


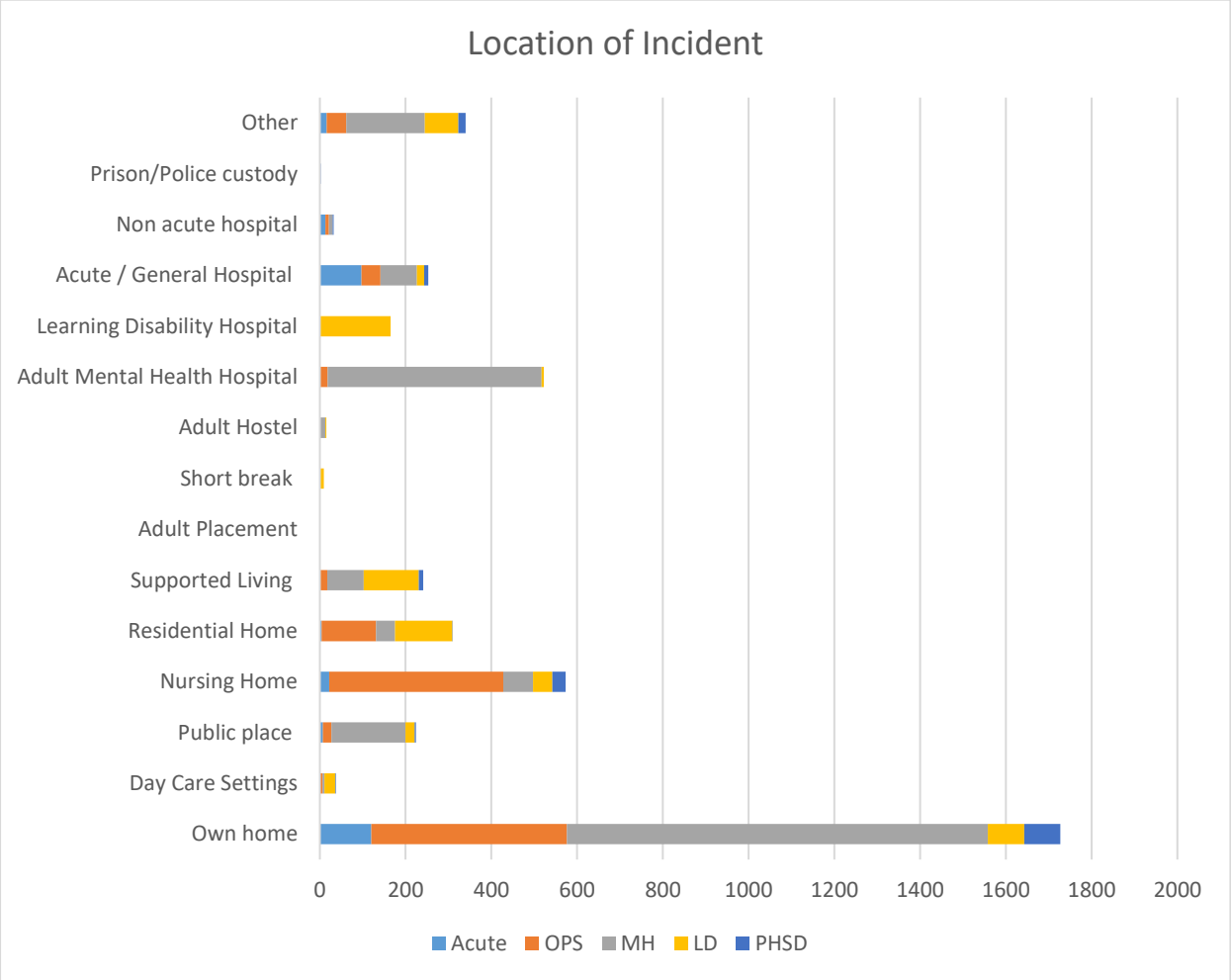
Chart 9 displays a three-year comparison of category of abuse by programme of care. The second highest form of abuse is sexual abuse (17%) followed by psychological at 16% followed.

Chart 9:



As Chart 10 shows the vast majority of incidents continue to predominantly occur within a person's home (38%) followed by nursing home (13%) and then within an adult mental health hospital (11%).

Chart 10:



Charts 11-12 show there has been a significant increase in the number of referrals, which have occurred in short breaks (125%), in acute hospitals (116%), non-acute hospitals (113%) and nursing and residential homes by 62% and 68% respectively.

In contrast, there has been a significant reduction in the location of abuse occurring in Adult Placement by 96% and Prison/ Police custody by 60%.

Chart 11:

Location Incident Occurred		
Own home	1727	0.5%
Day Care Settings	37	27%
Public place	224	72%
Nursing Home	573	62%
Residential Home	310	68%
Supported Living	241	2%
Adult Placement	1	98%
Short break	9	125%
Adult Hostel	15	7%
Adult Mental Health Hospital	522	26%
Learning Disability Hospital	165	27%
Acute / General Hospital	253	116%
Non acute hospital	32	113%
Prison/Police custody	2	60%
Other	340	7%

It is not surprising, as chart 12 illustrates, this year that there has been a significant rise by 42% in sexual violence and domestic abuse referrals when compared to last year. This is in line with PSNI data, which has seen an increase in domestic violence incidents across our society. Modern Slavery and human trafficking has also seen an increase by 80% in referrals when compared to the last reporting period.

The increase in referrals may also be related to the significant amount of work undertaken by the Trust to raise awareness about domestic violence. This has included a Domestic Violence workshop, promotion of domestic violence training, development of tools to assist staff in recognising, responding and reporting domestic abuse. The LOOP also contains up to date information on changes in the legislation regarding domestic violence and abuse.

Chart 12:

SECTION 5

Service Area Reports

This section details the individual service area reports for-

1. Mental Health
2. Adult Protection Gateway Team
3. Learning Disability

1. Mental Health

Mental Health continues to receive large numbers of APP1 referrals from within teams and externally. The total number of APP1 referrals from April 23-March 24 was 2148, a 5% increase from 2023. However a large number of referrals did not meet a protection threshold and were therefore screened as either No Further Action for Safeguarding (52%) or as Risk of Harm through Alternative Responses (34%). 295 (14%) cases were screened under the threshold of Protection, but not all cases progressed to full protection investigation. This was due to service users not engaging in the investigation process with the allocated IO or withdrawing consent to a protection investigation after the screening process.

There has been an increase in Risk of Harm through Alternative Responses screening in the Division of 125%. This is partly due to improved screening of APP1's as per threshold guidance but also due to screening of historical incidents which require reporting to PSNI only, where there is no risk requiring a protective response within this category. Going forward, historical abuse allegations will be screened as No Further action for Safeguarding where there is no further risk to the individual. This will be in keeping with regional screening of these referrals.

Domestic abuse incidents amounts for a high number of physical abuse referrals particularly across Mental Health teams. These referrals are self-reported, referral by external voluntary agency or can be generated following a MARAC meeting where a case is open to a Mental Health team. These APP1 referrals are screened in the protection threshold. In the reporting period, 34 cases were referred to MARAC from Mental Health.

Inpatient referrals also accounts for high numbers of APP1 referrals across the physical, sexual, financial and psychological abuse categories within acute settings, however not all referrals received require a safeguarding response, with low numbers screened in the protection investigation threshold. A high number of referrals within acute Mental Health inpatient settings are historical abuse allegations or risk management issues at ward level which require an alternative safeguarding response due to mental health presentation. Reported APP1 incidents can also occur outside of the acute setting i.e. during periods of agreed community leave.

There has been an increase in Joint Protocol investigations within Mental Health within the reporting period. 8 Joint Protocol investigations were agreed following AJP1 consultation with CRU. All of these investigations were in respect of staff allegations but were not thematically related to a particular unit or service. The new Joint Protocol Policy has not yet been agreed, therefore teams continue to make referrals to CRU under the Protocol for Joint Investigations of Adult Safeguarding Cases 2016.

Mental Health previously completed two audits of Adult Safeguarding cases per year. Since April 2024, Mental Health will be engaging in a schedule of four audits of Adult Safeguarding with all Programmes of Care per year. Learning from audits is shared with staff for ongoing improvement and development of staff. Workshops for learning are also offered across all Programmes of Care. In the reporting period, one of the Learning outcomes from audits was in respect of protection planning, therefore workshops were offered to all staff in protection planning with the Learning and Development team and the Adult Safeguarding Leads. These workshops were well attended with positive feedback. A further workshop was provided for staff regarding individual audit findings within service areas. This included a review of good practice in making contact with service users, recording standards in adult safeguarding, recording of screening outcomes, rationale for decision making and standards for sharing of screening decisions with relevant others.

Mental Health acute adult safeguarding data is collated for looking at patterns, trends and risk management at ward level for safeguarding. Current trends and patterns within acute wards highlight repeat referrals for service users who are acutely unwell, including increased referral rates for female service users who are acutely unwell. DAPO's in Mental Health hospitals offer regular information sessions to ward staff in recognising and reporting adult safeguarding issues to ensure appropriate and timely reporting of safeguarding incidents.

Adult safeguarding continues to be completed within core teams within Mental Health. Mental Health therefore continues with workforce planning to ensure that there are appropriate numbers of IO/DAPO trained staff within service areas to undertake the IO/DAPO role. This also includes ensuring there are appropriate numbers of Joint Protocol staff trained to undertake PIA and ABE interviews.

Mental Health plans to meet with teams regarding their adult safeguarding data on a Bi-monthly basis to analyse and track trends and patterns for adult safeguarding within their areas. This information will be beneficial for Governance/quality assurance, workforce planning, learning and service improvement.

2. Adult Community and Older Peoples Services (ACOPS)

Outline of Data – Adult Protection Gateway Team

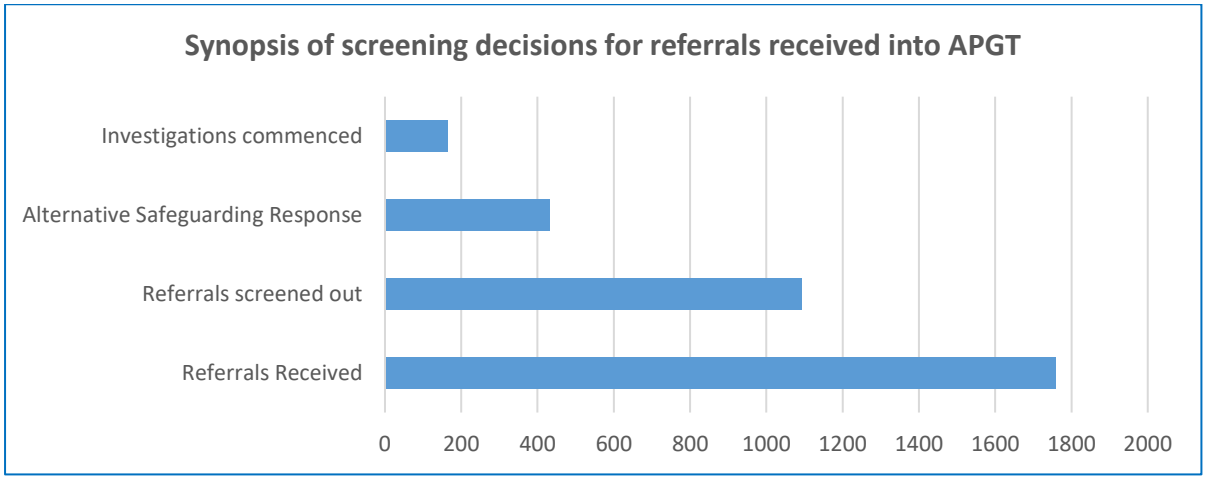
The APGT receive referrals in the form of telephone calls, emails and more formally through APP1's from both internal and external agencies. These include referrals in

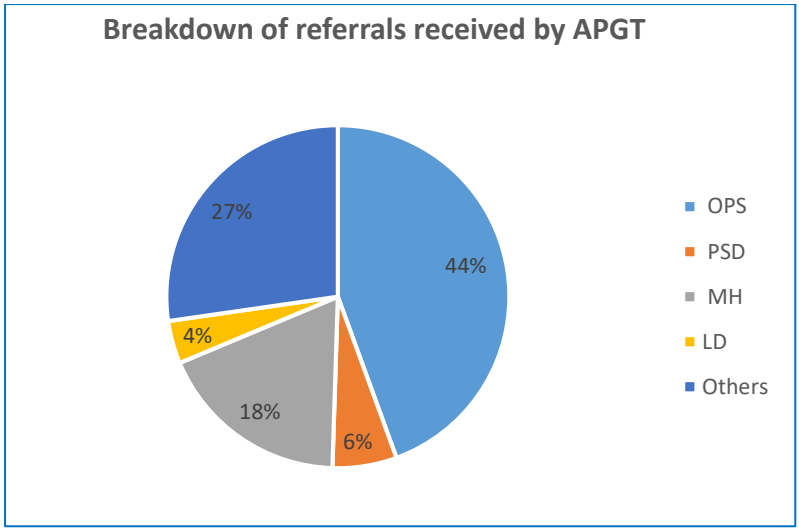
relation to ‘welfare concerns’. The APGT have to review the information and decide if it constitutes an APP referral or to signpost the referral agent to other services within the Trust or outside the organisation. A significant percentage of these will not be screened by an adult Safeguarding Champion before they come to the APGT. A number of referrals would not be known to anyone within the Trust and therefore the ‘best fit’ approach is used to designate them to a programme of care. However in a number of cases the case is not accepted by another programme of care and so the APGT continue to manage these cases. In the SPPG returns it is necessary to designate the referrals to a programme of care. Unfortunately as they do not fit with any programme of care these cases are not reported through to SPPG and thus the SPPG returns are not a true reflection of the APGT activity. Discussions have taken place with SPPG in relation to this issue and the BHSCT is awaiting a formal response from them in relation to this query.

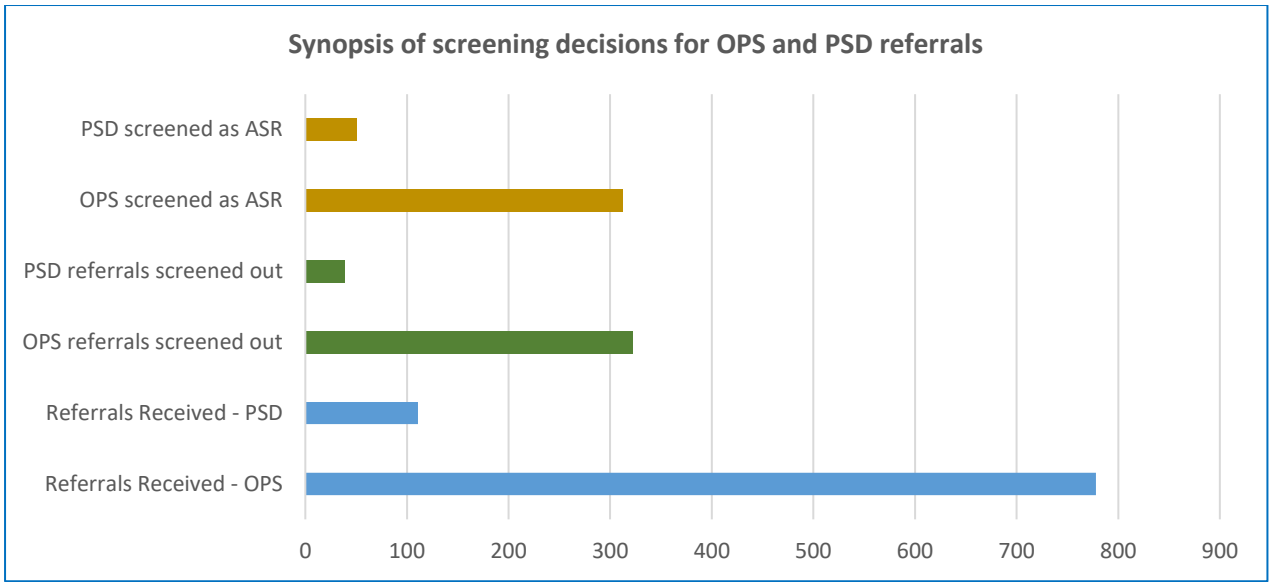
In the last reporting period (April 2023 to March 2024), 1758 referrals were made to the Adult Protection Gateway Team duty system. 62% (1092 referrals) of these referrals were either:

- Screened as no further action under adult safeguarding processes.
- Transferred to another team (either Learning Disability or Mental Health) for screening or follow up. This accounted for just over one fifth of the total number of referrals (387 referrals or 22%).

In addition to this, 24.6% (432) of referrals to APGT were screened as requiring an alternative safeguarding response. 169 referrals resulted in an adult protection investigation.







There was 781 referrals from OPS to the APGT, which accounts for 44% of the total number of referrals. Of these referrals, 322 were screened as No Further Action and 312 were screened as requiring an alternative safeguarding response.

There was 111 referrals from Physical Health and Disability, accounting for 6% of the total number of referrals. 39 of these referrals were screened as No further action and 50 screened as requiring an alternative safeguarding response.

There are a further 65 referrals that have resulted in an Adult protection investigation but as the service user did not fit into any programme of care the APGT continued to hold the case but are not included in the current SPPG recording template.

Outline of Data – Community and Hospital Teams

A number of referrals are screened through the local community and hospital SW teams. These cases, which do not meet the threshold for 'in need of protection' or that require to be transferred to another Trust are managed at a local level as no further

action or as an alternative safeguarding responses. There were 418 referrals from the community social work teams (OPS – 369 and PSD – 49). Of these 418 referrals, 22% (OPS – 81 and PSD 10) were screened as No Further Action and 75% (OPS – 275 and PSD – 38) were screened as requiring an alternative safeguarding response.

Analysis of APGT Data

The number of referrals screened as No Further Action remains constant from the previous reporting period. In 2022/2023, 39% (410) of referrals received by APGT were screened as requiring no further action within safeguarding processes. When excluding transfers of referrals to Learning Disability and Mental Health, there was 40% (705) referrals to APGT that were screened as No Further Action in the reporting period 2023/2024. The percentage of referrals screened as requiring an alternative safeguarding response has decreased from 40% (415) in 2022/2023 to 24.5% (432) in 2023/2024. However, the actual number of referrals screened as requiring an alternative safeguarding response has remained steady.

The majority of referrals remain within the Older People's Services (44%). There was a drop in the number of referrals from the previous reporting period, with 916 referrals received in 2022/2023 to 778 referrals in 2023/2024. There was a decrease in the number of referrals screened as not requiring a safeguarding response with 348 referrals (38%) in 2022/2023 to 322 (41.3% of OPS referrals) on 2023/2024. There was also a decrease in the numbers of referrals screened as requiring an alternative safeguarding response from 376 (41%) in 2022/2023 to 312 (40% of OPS referrals) in 2023/2024.

The number of referrals screened as not requiring a safeguarding response was 39 (35% of PSD referrals) in 2023/2024, compared with 63 (48%) in 2022/2023. The comparison of referrals screened as requiring an alternative safeguarding response is 51 (46%) in 2023/2024 and 45 (34%) in 2022/2023.

Key learning from audits, SAI, complaints, RQIA.

The service area developed an action plan following recommendations from a NIPSO investigation report. The actions derived from this report have been accepted and achieved. These actions include focus on reflective learning in relation to the complaint, practice development, training and learning regarding policy processes and procedures.

Recommendations from a recent SAI has included the dissemination of a learning letter regarding the importance of requesting the timelines from care home information software / I.T. systems to facilitate robust investigation.

APGT have engaged in an audit of APP3 and APP4. This audit is across adult safeguarding in the Trust and ACOPS awaits outcomes and recommendations.

There has been an audit in relation to thresholds in adult safeguarding, with a view to ensuring consistency across teams and service areas. In addition, teams (including one in the Physical and Sensory Disability Programme) engaged in a pilot project regarding alternative safeguarding response thresholds.

Any challenges / risk and actions taken to address

The service area continues to experience a number of challenges, including:

- Workforce pressures within social work and social care services. The Adult Protection Gateway Team has experienced significant, consistent and prolonged staff shortage due to long-term sick leave and vacancy.
- Substantial work related to the screening and management of new referrals.
- Delay in decision making from PSNI / PPS.

Staffing

The service area has experienced sustained staffing shortages due to vacancy and long-term sick leave, which has affected the team's ability to meet all its duties and responsibilities. Efforts made to recruit into vacant positions had some limited success. Recently, a band 8a and a band 7 DAPO were recruited through the EOI process. A number of actions have been put in place to manage risk and ensure the continuation of a safe service. These include:

- Staff have access to a senior member of staff for support, discussion and escalation of issues and concerns twice daily.
- Additional support from the Divisional Social Worker and Principal Social Workers, including supervision.
- Some adult protection investigations returned to the Community Social Work Teams for completion until situation within APGT stabilises.
- Review of vacant caseloads to enable prioritisation of casework.
- Support from other teams in the Trust to ensure that investigations are re-allocated if APGT staff are not in post.
- Plans to support the team and reduce sickness absence via Staff Wellbeing Strategy.

A consequence of contingency measures to ensure that all adult safeguarding work is managed within ACOPS, is the additional pressure placed on Community Social Work Teams. Some adult protection investigations have been allocated within community teams to ensure timely response. In supporting the Community Social Work Teams, APGT will co-work cases requiring joint protocol investigations and provide support and advice. Issues will continue to be escalated through the daily Safety Huddle.

Management of referrals

APGT is a central hub for all external referrals, as well as receiving referrals from internal sources. The data presented illustrates that a significant proportion of the APGT work is in relation to the management of new referrals received by the team. Whilst 62% of the referrals in the reporting period were transferred or screened out of APGT, it needs to be noted that there is significant activity surrounding this. The APGT have a duty of care to each of the service users referred and there is a high level of diligence in the screening process. It has been difficult to capture and articulate this level of activity. In addition, demand on APGT has increased as work within the Trust

has progressed to encourage recognition and identification of adult abuse within hospital settings.

To assist with the management of referrals received, the APGT embarked on a duty pilot project at the end of December 23. Two I.O. posts were uplifted to B7 DAPO following EOI exercises and the focus of these is the management of duty and short-term investigations. The pilot will be reviewed, but staff shortage has interrupted the pilot in its original, intended structure.

The APGT has embarked on a piece of work to review its current processes. Process mapping has commenced to identify areas that require consideration and streamlining, and to inform the development of standard operating procedures.

Work identified in the previous Adult Safeguarding Position Report remains ongoing and includes working within the Trust and with external agencies regarding appropriate referrals and / or referral pathways.

Interface with PSNI / PPS

As per the previous Position Report 2022/2023, the Division continues to experience delays in terms of the interface with PSNI, with regards Joint Protocol decision-making and later, upon completion of investigation awaiting outcomes from the Public Prosecution Service.

Assurance Controls

The staffing crisis has affected the lines of accountability and the first line of assurance within the teams. A supportive framework is in place and includes Principal Social Work providing supervision and support to DAPOs and I.Os. There is an unbroken line of accountability to the Director of the Adult Social Care and Community MDTs Division and the Executive Director of Social Work via the Collective Leadership Team. The recruitment of the band 8a post will strengthen the line of accountability and the first line of assurance. In addition, there is planned daily opportunity for APGT staff to discuss and escalate issues and concerns to a senior manager.

Service User and Carer Feedback
The service area were fully engaged in the 10,000 More Voices Project. The outcomes have been received and disseminated. The regional action plan has been agreed and shared with Trusts.

3. Adult Learning Disability Service.

Adult Safeguarding (ASG) activity

During this reporting period, 2023 – 2024, the Learning Disability service has received 707 safeguarding referrals which is 18% (106) increase from the last reporting period. Across the service area there has been a 41% decrease (122) of those referrals

screened as meeting a protection threshold. This decrease could be attributed to resettlement of service users within MAH and more effective screening of referrals and robust care plans /protection plans in place across the service.

There has been a significant decrease in referrals from MAH site. This is attributed to the successful resettlement of MAH patients into the community. Additionally, with the presence of ASG staff in MAH there is a noted improvement of relations between ward staff as the ASG team is easily accessible to staff and incidents can be discussed to ensure appropriateness of referrals onto the central point of referral.

Community settings have experienced an increase in adult safeguarding referrals in comparison with the previous reporting year with community referrals amounting to 73% of the total referrals received. 52% of these referrals have been screened as an Alternative Responses and 25% were screened as meeting an Adult Protection Threshold.

In comparison to last year, the highest referral source in the community is from regulated facilities, which account for 30% of the referrals. However, the location of incident indicates that the majority of referrals occurred in residential facilities and supported living. This is an area of focus for the service area.

Location of ASG incident.

Supported Living	Residential Home	Nursing Home	General Hospital	AMHIC	Adult Placement	Day Care	Own Home	MAH	Public place	Short Breaks	other
115	155	45	17	5	4	26	82	148	19	8	83

When examining the category of abuse reported to the LD central gateway service, physical abuse remains the highest, with the second highest category reported as neglect.

There continues to be a disparity between Joint Protocol consultations progressing to Joint Protocol investigations as decisions to progress to Joint Protocol investigations can change or be regraded over the course of an investigation period.

Assurance controls in place.

MAH

There are a number of assurance mechanisms in place across the MAH site. CCTV in communal areas remain in place and, as a level of assurance there is contemporaneous viewing of CCTV which is in turn feeds into weekly quality assurance meetings. The quality assurance meeting is attended by an Adult Safeguarding DAPO and MAH Nurse Manager. Should concerns be identified a safeguarding referral will be progressed. Furthermore, weekly ward meetings continue to take place, these are attended by ASG staff, Nurse Managers and recruitment agency representatives. The purpose of the weekly ward meetings is to update and

review existing or new adult safeguarding concerns relating to staff on patient incidents.

A Central point of referral remains in operation and the team is located within the MAH site.

There continues to be a focus on the resettlement of patients in MAH into community settings across the trust which has inevitably led to a decline in adult safeguarding referrals across the MAH site.

An audit into the safeguarding processes at MAH was undertaken for the period January 2023 – June 2023 and completed in September 2023. A further audit is to commence July 2024.

Bespoke Adult Safeguarding training continues to be delivered by the ASG DAPO within the MAH site, the frequency of such is often during the induction of new staff but is also available upon request.

Community LD

For the community sites, there are weekly governance meetings with commissioned services, which are attended by care management, community social work and an ASG lead. This provides an oversight of ASG concerns arising within the independent service sector and ensures a shared approach to safeguarding. As noted previously there has been a marked increase in ASG referrals for regulated facilities namely those from the Independent Service Provider sector. A number of these referrals relate to concerns regarding the operational and management of facilities and to ensure service user safety focused reviews have been introduced and completed across two locations. Furthermore, the continuation of quality assurance visits and unannounced visits remains in place and the outcomes of such are recorded and shared across the service area.

Further assurance controls have been put in place with regard to the training and skill mix of staff across the community social work teams and in the course of the last reporting year a total of 7 staff have completed the DAPO training and 10 have completed the IO training. The collation and review of staff training needs are routinely reviewed and are kept within a centralised MS Teams tracker to ensure accessibility. ASG leads continue to provide a consultative role to DAPO and IO colleagues within the community settings and have undertaken audits into the adult safeguarding processes.

Across the LD service area the daily safety huddles remain in place to ensure that high risk cases and or concerns are escalated and that there is a joined up approach to patient and service user safety. Additionally, the introduction of quarterly audits across all Trust adult safeguarding services has provided a mechanism to draw a cross comparison of adult safeguarding processes across adult services and will seek to ensure a standardised approach to adult safeguarding across the board. Learnings from these audits will be shared and discussed via bespoke IO and DAPO and or DAPO/IO forums on a quarterly basis.

The entire LD service is currently piloting the Master data set from March 2024. This pilot has been further extended amendments have been made. Learning from this pilot will feed into the Governance work stream before implementation across other Divisions.

Key learning from audits, SAI complaints, RQIA etc

There are no current SAI's relating specifically to safeguarding processes however, the adult safeguarding leads have and involvement in a number of SAI's that have a safeguarding component to them.

The service area continues to receive and respond to complaints regarding Adult Safeguarding processes. Key learnings from complaints and SAI's are discussed and shared at team meetings.

RQIA recently provided their inspection report for an unannounced visit in MAH on the 10th January 2024 which included a review of the Adult Safeguarding Processes which concluded that there were no areas of improvement required.

Challenges/ risks and actions being taken to address

A key challenge for safeguarding remains recruitment and retention of staff to stabilise the ASG workforce across the learning disability service. Within the LD gateway team there continues to be significant resource challenges with two IO positions currently vacant and one DAPO on long-term sick leave. Additionally, there has been no replacement for the ASG service manager post (vacant since Jan 2024) and the position of an ASG lead remains temporary and unfunded. Recruitment continues to be sourced via the social work bank and HR recruitment. There has recently been the request to identify support from the community teams to assist the gateway team given the staffing challenges.

Within the community teams there continues to be significant challenges regarding complex and high profile Adult Protection Investigations which is having an impact on the workforce and the ability to meet the demands under ASG processes. The increase in referrals for community sites has also applied significant pressure to community teams as they are working to a backlog of ASG work that has derived from a high staff turnover rate from 2021-2 and absences inclusive of sick leave and annual leave.

Training for DAPO and IO's remains a priority and the service has a checker in place to monitor the training achievements and requirements. Within the last year, seven staff have completed the DAPO training and ten staff have completed the IO training. Five staff completed the Joint Protocol training in November 2023.

There are also a number of Adult Protection cases open that require attention that is adding to the pressure across the service area. Community Social Work Team have

been able to secure temporary support via social work and nurse bank to assist with the back log of ASG work.

The implementation of Encompass on the 6th June 2024 has added to the pressure across the LD service area and it is anticipated that there may be changes to processes following the 'go live date'. Staff have been attending the required training and plans are in place to liaise and learn from colleagues in SET ASG central referral who have already implemented encompass.

Preventative work

The LD gateway team is delivering bespoke ASG training to ward staff in MAH. This is facilitated by the ASG DAPO in relation to the induction of new staff and is also available on request.

Community Teams continue to monitor and review the ASG training requirements of staff to ensure that staff have access to the relevant ASG training.

Service user/ carer feedback

The views of service users and carers remain an important aspect of the safeguarding process and their views are sought routinely throughout an investigation. Upon the closure of an Adult Protection Investigation service users / carers are informed by way of a closure letter and invited to submit their views, feedback or concerns.

Key achievements

The recent RQIA inspection report for MAH made no recommendations for improvement. The LD ASG central point of referral has continued and has been developed further to include the piloting the new master data set.

In conjunction with this a number of adult safeguarding audits have taken place e.g. individual ASG audits within the LD service, mock inspections across all of adult services, threshold audit and quarterly audits. The outcomes of such has been shared and key learnings identified. The commencement of bespoke IO and DAPO workshops to share the finding and learnings of quarterly audits will be of further benefit as staff will be encouraged to embed good practice and there should be further assurance around the standardisation of ASG processes across the Trust.

Within the community care management service have reported full compliance with the statutory requirement for annual review for all residents within a regulated facility similarly, the community social work teams have reported an increase in the numbers of service users who have a Social Work Assessment and Comprehensive Risk Assessment completed. This serves as a further assurance mechanism that there is a significant improvement towards compliance with core statutory functions.

SECTION 6

Trust Adult Safeguarding Action Plan 2023-24 (Summary)

In order to achieve the Trust action plan a number of work streams have been established. These include-

- Governance to include ASG structures and implementation of Regional Strategic priorities
- Data and IT
- Learning and Development
- Hospital
- Awareness and Experience

Action:	**Update**
Review of current Adult Safeguarding Structures	Structures paper is currently being reviewed. Further workshops being set up.
Adult Safeguarding learning and Development. Trust wide training needs scoped.	Band 7 and Band 3 funding agreed to undertake Level 3 ASG training. Level 1 and 2 training developed. Monitoring compliance with training being established. Support forums – now have an agreed agenda and include opportunity for learning from audits to be disseminated
Adult Safeguarding Workforce	Scoping of workforce underway. Costing paper submitted to DOH in relation to implementation of AP Bill.
Encompass Readiness	Go live in June 2024. Attendance at Encompass Groups including with regional ASG leads
Adult Safeguarding Data Collation and Analysis	Internal ASG app developed. Monthly Hospital report and composite data set developed for community services, which is currently being piloted. More consistency in completion of SPPG data returns.
Review compliance with Adult Safeguarding Policy & Procedures	BSO action plan almost completed. Ongoing quarterly audit cycles across all ASG teams now established. Threshold audit completed, APP3 and 4 audit completed. Further audits planned.
Service User Engagement	Draft Service user feedback form developed and due to be piloted in the next reporting period 2023/24

Interface between Adult Safeguarding and other Trust processes	HR and ASG Working group established and draft protocol developed
Joint Protocol	New policy completed through Regional working group.
Adult Safeguarding in Hospital Settings and Community Settings	Significant work progressed in relation to Adult Safeguarding Ward Manuals, aide memoires implemented, Notice Boards and Pop up banners located in hospital settings etc. Information uploaded to LOOP which includes pathways, up to date information regarding legislation, ASG pathways etc.
Ensure current partnership working arrangements are maintained and strengthened	LASP continues quarterly- review of TOR and action plan underway
Adult Safeguarding Champion Forum	Established groups meeting every quarter
Trust Adult Safeguarding line Manager Support Group	Quarterly meetings established
Review and strengthen Trust wide Adult Safeguarding Governance arrangements	Governance arrangements established working group
Review current arrangements for current Adult Safeguarding Shared Learning and ensure there is a robust system in place for shared learning	Established standing agenda at DAPO & IO forums and line manager forums, Adult Safeguarding leadership group and ASG committee. Triangulation of data from SAIs, DHRS etc to be presented at the ASG Committee.
Implementation of the recommendations from COPNI	Ongoing
Implementation of the CPEA recommendations	Ongoing
Adult Safeguarding Champion Position Reports	Outstanding
Adult Protection Bill	Trust continues to take forward requests from the Department of Health in relation to the Draft Adult Protection Bill via regional platform and Trust responses required. Trust continues to be represented at the regional work streams.