Surrey Safeguarding Adults Board

Annual Report 2023-24

www.surreysab.org.uk

Message from the Chair

Welcome to the SSAB annual report for 23/24. Our annual report shows what the Board aimed to achieve during April 2023 to March 2024 and what we have been able to achieve. It provides a summary of who is safeguarded in Surrey, in what circumstances and why. This helps us to know what we should be focussing on for the future in terms of who might be most at risk of abuse and neglect and how we might work together to support people who are most vulnerable to those risks.

During this year, the SSAB made a commitment to a strategic direction which emphasises how safeguarding risk might be managed nearer to the point at which it is identified and by applying more active multi-agency approaches. Most importantly, for our work to be informed by people's lived experience, whether as carers or people with care and support needs. We want to be confident that the work we do as a partnership can and will make a positive difference to people's lives and we recognise that no single agency can create an effective safeguarding system by itself.

Safeguarding Adults Reviews (SARs) are a statutory duty for SABs when an adult in its area dies because of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk. During the past year the Board has been managing a high number of SARs, over half of which were agreed in 2022, to be undertaken jointly with a Domestic Homicide Review process (DHR) and are due to be published in the coming year. The SSAB is committed to achieve more timely and effective ways in which to share and implement our learning from reviews and this has led to a revision of the local SAR process. The appointment of a SAR Coordinator in the last quarter of the year, working alongside our SAR Subgroup Chair and partner representatives, has been hugely helpful in bringing this ambition closer to reality.

This report contains a summary of the three SARs which were published during this year. The recommendations from these reviews have individual action plans which are monitored by the Board to ensure improvements are made as needed and inform priorities for our business plan. Our SARs evidenced some common themes: self-neglect, domestic abuse and responding to multiple and complex needs. This report highlights some of the

Message from the Chair cont.

ways in which SSAB partners have worked together to keep improving and refining our response to these issues.

The Board also needs to be assured that safeguarding adult practice is accessible to all the communities living in Surrey. Our engagement work to extend the SSAB's reach across the county has been accelerated through this year following the appointment of our Partnership Officer. This has enabled further promotion and understanding of the Board's work with communities, neighbourhoods and faith groups, to raise awareness of types of abuse and neglect and of adult safeguarding.

A very successful virtual conference was held during adult safeguarding week. Surrey Police gave a valuable opening session on their approach to adult safeguarding and investigations followed by contributions from partner agencies and national speakers, with major themes being professional curiosity, trauma informed practice and learning from safeguarding adult reviews. Throughout the year, a number of webinars and other events were run, with strong take-up from across the partnership.

SSAB partner agencies have reported on their work throughout the year, both as individual organisations and together in partnership, providing assurance that they continue to meet their safeguarding responsibilities during these ever more challenging times. I am very privileged to work with partners who demonstrate such commitment to achieving the best outcomes for adult safeguarding. I would like to thank the chairs and members of the subgroups, who work tirelessly to progress our shared priorities for adult safeguarding and also my colleagues in the SSAB core team, for their dedication and support. Last, but by no means least, I would like to take this opportunity to acknowledge the work of all practitioners, managers and carers who are committed to keeping people safe in Surrey.

This report of our work together over the last year evidences a commitment to effective partnership working, which provides a sound basis to approach our priorities for reducing the risks of abuse and neglect in Surrey. I look forward to continuing to progress our ambitions in the coming year.

Teresa Bell, Independent Chair
July 2024

Surrey's Local Context

Surrey is the 5th largest Local Authority in England, based on resident numbers, with a population of just over 1.2 million people (2021 Census data).

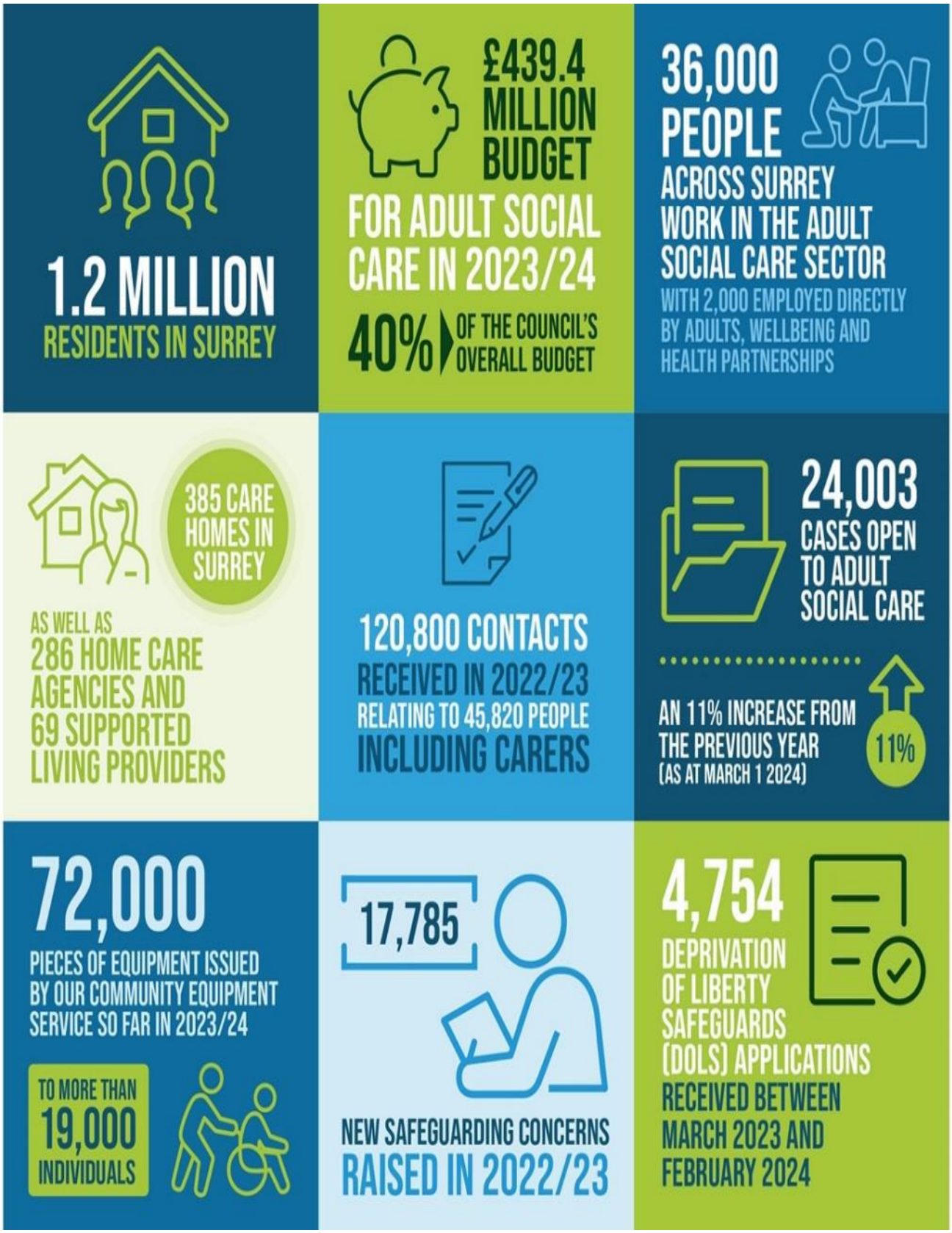
In Surrey, there is a two-tier system of local government, the county council (upper-tier local authority) and the 11 district and borough councils (lower-tier local authorities).

The composition of Surrey ranges from significant urban areas to north and rural areas to the south of the county. This creates a variety of needs across the county and the challenge of responding in a way that is relevant to each area.

In addition to a growing population, Surrey is becoming more diverse with 6% more residents in 2021 identifying as ethnic groups other than White British compared with 2011. A similar increase was seen between the 2001 and 2011 censuses and shows the shifting populations within Surrey.

Map of Surrey

Surrey's Local Context



*SCC CQC IR1 Self-Assessment March 2024

Our Story

Safeguarding Adults Boards (SABs) were established under The Care Act 2014.

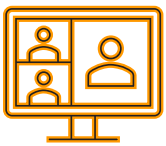
The Care Act 2014 Statutory Guidance stipulates that:

The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out below.

The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs).
- is experiencing, or at risk of, abuse or neglect.
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

9



The three core duties for SABs are to:

1. Publish a Strategic Plan.
2. Publish an annual report.
3. Undertake Safeguarding Adult Reviews.

Transparency– the SAB leads a learning culture where best practice is identified. This will be shared and recommended, and where concerns are identified these will be communicated appropriately.

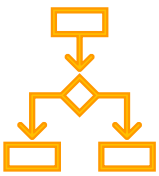
Our Story

Work collaboratively with other boards to ensure consistent messages and practice. This will include working in partnership to produce policies, campaigns and training courses that reflect the risks posed to adults with care and support needs.

Engage with the voluntary and community sector to strengthen preventative work and to broaden our understanding of who is most at risk of abuse and neglect in Surrey.

Help improve the quality of referrals for safeguarding concerns by supporting agencies to consider their practice through audits, reviews, peer learning and feedback from people with lived experience. To consider their referral processes and by working with the Local Authority to develop a feedback loop.

Provide guidance to adults with care and support needs, their families and carers, on the safeguarding process so they know what to expect and how they can be involved.

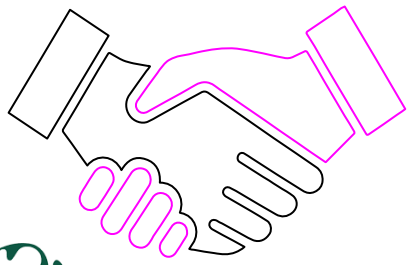


Make safeguarding personal by placing people at the heart of our work, ensuring their involvement in developing and agreeing their desired outcomes.

Partnership

The Safeguarding Adults Board (SAB) is a strategic partnership group made up of senior staff from statutory, voluntary and independent sector agencies.

The Board is facilitated by an Independent Chair and supported by a small team.



Surrey County Council

Surrey Police – With you, making Surrey safer

Frimley Health and Care

Spelthorne Borough Council

Surrey Heartlands Health and Care Partnership

NHS Surrey and Sussex Healthcare NHS Trust

Runnymede Borough Council

Surrey Age UK

Surrey Heath Borough Council

CSH Surrey

Reigate & Banstead Borough Council – Banstead | Horley | Redhill | Reigate

NHS Epsom and St Helier University Hospitals NHS Trust

Waverley Borough Council

Buckinghamshire & Surrey trading standards

Action for Carers Surrey

matrix

HM Prison Service

Surrey Fire & Rescue Service

Woking Borough Council

Elmbridge Borough Council – ... bridging the communities ...

Get active 50+ for longer, healthier, happier lives

Public Health England

Surrey Coalition of Disabled People

NHS Royal Surrey NHS Foundation Trust

Kent Surrey & Sussex Community Rehabilitation Company – Probation

Tandridge District Council

Ashford and St. Peter's Hospitals NHS Trust

healthwatch Surrey

NHS Frimley Health NHS Foundation Trust

Guildford Borough

hcrg Care Group

Mole Valley District Council

catalyst – Supporting Wellness Together

First Community Health and Care

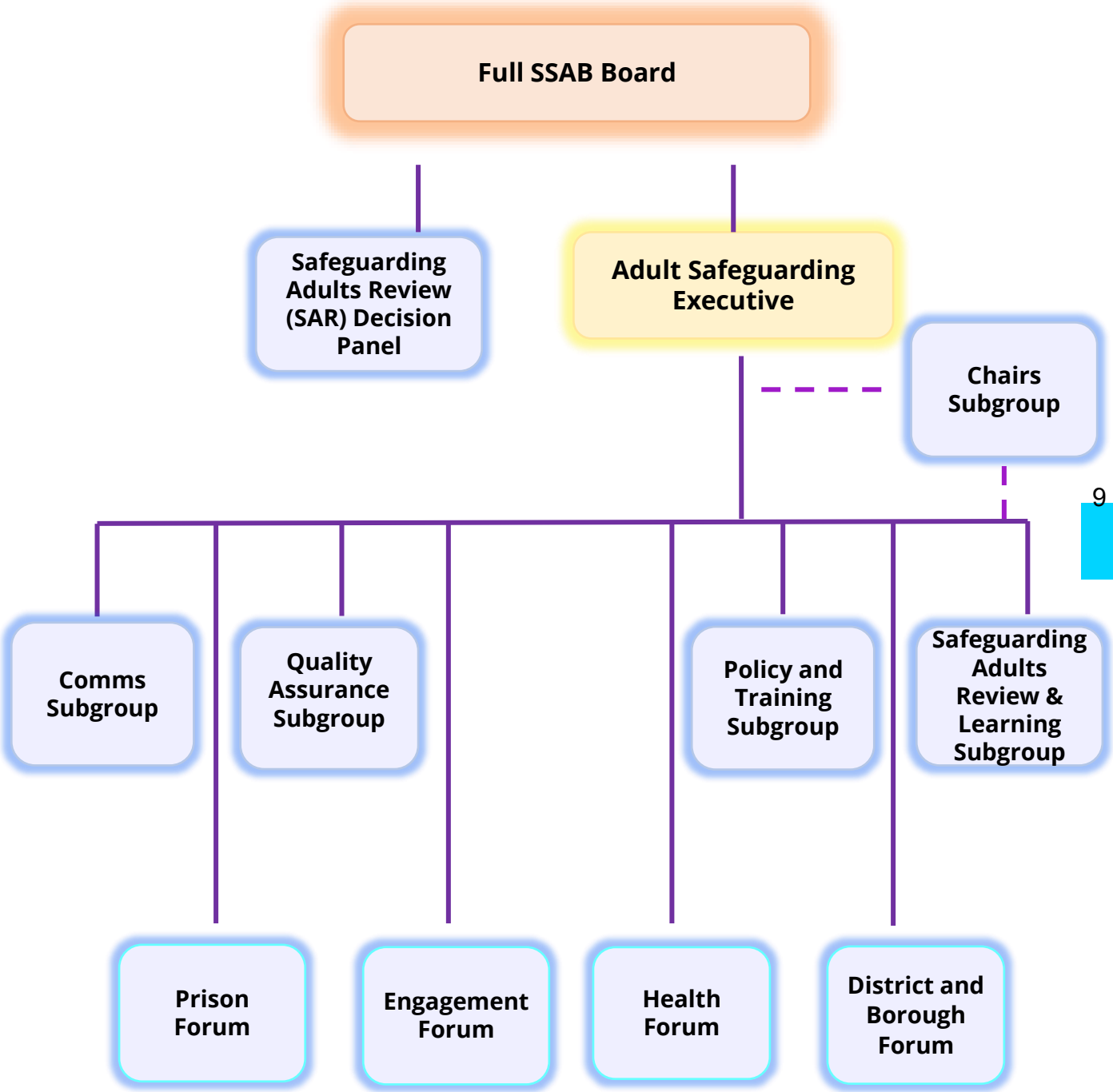
NHS Surrey and Borders Partnership NHS Foundation Trust

Office of the Police & Crime Commissioner for Surrey

Epsom & Ewell Borough Council

South East Coast Ambulance Service NHS Trust

Board Structure



How the Board works

Full Board

- The Surrey SAB meets four times a year, consisting of multi-agency statutory and non-statutory partners as well as representatives from voluntary organisations.
- The SAB works in accordance with the Care Act 2014 to agree on strategic safeguarding adults' work.
- Provides direction to all subgroups.

Adult Safeguarding Executive (ASE)

- Drives the work of the SAB between meetings
- Discusses “emerging” issues or “stuck” issues

Chairs Group

- Brings all the chairs of the subgroups together.
- Discusses emerging issues or stuck issues from their subgroup.

Safeguarding Adults Review (SAR) Decision Panel

- Considers SAR referrals, against the Care Act 2014 section 44 criteria.

Communications Subgroup

- Oversees the communication strategy of the of the Board.
- Oversees the Board publication materials.

Quality Assurance Subgroup

- Request and receives the QA data from agencies.
- Scrutinises the QA data from partners, identifies areas of best practice and/or concern.
- Raises questions on data received.

Policy and Training Subgroup

- Oversees the multi-agency safeguarding training of the Board.
- Oversees the multi-agency policy and procedures.

SAR & Learning Subgroup

- Manages the reviews once they are commissioned.
- Leads on sharing the lessons from reviews.

Prison Forum

- To provide a forum for discussion of key issues for all Prisons in Surrey.

District & Borough Forum

- To provide a forum for discussion of key issues for all District & Borough Safeguarding Leads in Surrey.

Engagement Forum

- To help to establish better engagement with all organisations across Surrey.

Health Forum

- To provide a forum for discussion of key issues for both NHS and private health providers in Surrey.

SSAB Work in 2023/24

The SSAB developed a new 3-year Strategic Plan at the start of 2022.

The priorities identified in the three-year strategic plan (2022-25) for the Surrey SAB are:

- **Prevention and Awareness**

We will deliver a preventative approach and will raise awareness of safeguarding adults across our partners and communities.

- **Communication and Engagement**

We will engage and learn from organisations, including the many voluntary sector agencies as well as the Adult and their families or carers in Surrey.

- **Quality and Improvement**

We will seek assurance from agencies and use that information to strengthen our safeguarding adults work.

- **Reflection and Learning**

We will reflect upon learning from statutory reviews and good practice using this to inform new ways of working.

The SSAB subgroups developed individual work plans as to how these priorities would be taken forward.

The following pages sets out what the SSAB has achieved against each of the priorities over the year.

Priority 1: Prevention and Awareness

During 2023/24 the SAB continued to raise awareness by providing multi-agency training which is detailed further from Pg 32.

Work continues, on the SAB website following the update in 2022/23 to make it easier to find information for both agencies and members of the public.

The SSAB webinar series continues to grow with sessions becoming more regular and covering a variety of topics which is detailed further on Pg 35.

The SSAB's outreach has extended through the year, with our engagement forum having over 50 members from a wide range of agencies in Surrey.

SSAB resources were strengthened for agencies to use in their own community networks. This included virtual resources e.g. videos, leaflets etc.

Priority 1: Prevention and Awareness

The SSAB fully supported Safeguarding Adults Week during November 2023, with a number agencies using SSAB resources to have within their own settings.

The SSAB attended several session throughout Safeguarding Adults Week, at various locations across Surrey including:

- Surrey University Campus, Guildford.
- Action for Carers
- Belfry Shopping Centre, Redhill.

Following the appointment of the new Partnership Officer, the SSAB was able to increase its awareness raising via social media, and to increase the presences of the SSAB by extending and engaging with a wider variety of agencies in Surrey.


Keeping your
loved ones
safe
from abuse and


Keeping your
loved ones
safe
from abuse and neglect
Everyone deserves to be treate
with care and respect.
If you think someone is being
abused report it now.
Call the Multi Agency
Safeguarding Hub
0300 470 91
In an emergency DIA
For further informa
surreycc.gov.uk/p


surrey
safeguarding
www.surreysab.org.uk


surrey
safeguarding


surrey
safeguarding
www.surreysab.org.uk


Keeping your
loved one
safe
from abuse and
Everyone deserves to be
with care and respect.
If you think someone is being
abused report it now.
Call the Multi Agency
Safeguarding Hub
0300 470 9100
In an emergency DIAL 999
For further information visit
surreycc.gov.uk/protectingadults


safeguarding


surrey
safeguarding
www.surreysab.org.uk


surrey
safeguarding
ADULTS BOARD
www.surreysab.org.uk

Priority 1: Prevention and Awareness

The SSAB is aware of the high number of safeguarding concerns in relation to neglect/acts of omission and within the 22-25 Strategic Plan it was agreed that the SSAB highlight these issues and develop stronger mechanisms to address these.

A key achievement over the 23/24 year was the agreement to establish establishing a SAR Coordinator role.
This role will take the lead on all SARs and joint DHRs, where appropriate review different methods for a carrying out a SAR, to extract the learning as quickly as possible.

The SSAB core team engaged with many organisations within Surrey as well as nationally and attended many multi-agency meetings to ensure that the SAB is engaged with aligned work streams as well as meeting with key personnel

- Domestic Abuse Management Board
- Surrey Adult Matters Steering Group
- Sexual Abuse Management Board
- Domestic Homicide Review Oversight Group
- Anti-Slavery and Human Trafficking Partnership
- Domestic Abuse Executive
- LeDeR[1] (Frimley and Surrey Heartlands ICB)
- National SAB Managers Network
- Surrey Safeguarding Adults Advisors

Priority 1: Prevention and Awareness

The SAB had presentations from both Surrey Heartlands ICB and Frimley ICB on their annual LeDeR reports to hear the themes identified from LeDeR reviews. A number of themes link with Board work and is being incorporated into the task and finish group regarding avoidable safeguarding concerns, particularly in relation to choking.

Regular meetings took place with Surrey Safeguarding Children Partnership to look at areas where work could be taken forward together, this relationship continues to be strengthened.
The Boards Prison forum was extended to a joint forum for the SSAB and SSCP.

Relationships were strengthened with the Health and Wellbeing Board with both board managers having regular contact to consider areas of commonality, including domestic abuse, adults with multiple disadvantages and the SAB is connected with relevant workstreams for these.

The SSAB recognised the importance of links with District & Borough Housing. A housing lead is now a member of the SAB representing all District & Borough Councils across Surrey. Links were also established with the Surrey Chief Officer's Housing Association who agreed to disseminate information to housing providers as well as have updates from any SARs.

Priority 2 : Communication and Engagement

The SSAB works with other boards including the Health and Wellbeing Board and Safeguarding Children Partnership to ensure that resources are shared, and county wide communications coordinated.

The SSAB's newsletter is subscribed to by over 4,500 people. This newsletter included an update of the wo[illegible] the SSAB has been undertaking as well as advertisi[illegible] events and resources available. The newsletter is added to the website on a quarterly basis.

surrey safeguarding ADULTS BOARD

Autumn 2023 Newsletter

SAVE THE DATES!

SSAB Adult Safeguarding Conference - November 2023

The Surrey Safegaurding Adults Board (SSAB) are pleased to announce that we will be holding our adult safeguarding conference on Wednesday 22 November 2023 .
The conference will be a great way to share information and identify local priorities for safeguarding adults and share our vision to ensure they live a life free from fear, abuse and neglect.

As we continue to build on our 2022-2025 strategy, it will be a fantastic opportunity for senior leaders through to frontline practitioners across the County to refresh their commitment to safeguarding adults and expand their networks.
Throughout the day we hope you will be able to interact with each other, engaging by taking part in informative keynote sessions which will hopefully enable you to understand and channel ideas surrounding safeguarding adults.

As the event will be virtual we hope that all agencies will be able to attend and participate in the day. Booking for this event will be advertised on the SSAB website shortly, so please hold the date in your diaries until then.

Safeguarding Adults Week 20-26 November 2023

Safeguarding Adults week is taking place from Monday 20 – Sunday 26 November 2023. Along with our conference, the Surrey Safeguarding Adults Board (SSAB) will be raising awareness of important safeguarding issues and themes across the week.

The SSAB is supporting this with its own resources, as well as those from the Ann Craft Trust.

Priority 2 : Communication and Engagement

The SSAB held its 2023 conference, on 22 November during Adult Safeguarding Week, attended by over 400 people from a variety of agencies across the county including frontline practitioners to senior managers.

The day was arranged so that attendees could come and go, without commitment to attend all day. There were six sessions throughout the day covering:

- Session 1 - Our Approach to Adult Safeguarding and Investigations by surrey Police.
- Session 2 - Professional Curiosity by Research in Practice.
- Session 3 - Unexplained injuries, neglect and acts of omissions by Surrey County Council.
- Session 5 – Learning from safeguarding reviews by SCIE
- Session 6 – The future for safeguarding adults in Surrey by the SSAB independent Chair.

There were also sessions arranged throughout the day for online networking for all attendees.

Each of the sessions were well received and well attended.

Sessions were recorded separately to enable those who were unable to attend the day/ a particular session to be able to watch the recording and have access to the slides which are available on the SSAB Website.

Priority 2 : Communication and Engagement

Surrey Safeguarding Adults Board
Conference Agenda

surrey safeguarding ADULTS BOARD

WEDNESDAY 22ND NOVEMBER 2023 | 09:30 - 16:30

This conference will be hosted virtually via MS teams - click here to register

09:30 - 09:45	Welcome Speech and Introductions by Teresa Bell, SSAB Independent Chair
09:45 - 10:45	Session 1 - Our Approach to Adult Safeguarding and Investigations by Surrey Police
10:45 - 11:05	Breakout Rooms and Networking Session
11:05 - 12:05	Session 2 - Professional Curiosity by Emily Smith, Research in Practice
12:05 - 12:30	Lunch and Networking Session
12:30 - 13:30	Session 3 - Unexplained injuries, Neglect & Acts of Omission by Debbie Potts, Surrey County Council
13:30 - 14:30	Session 4 - Domestic Abuse, Mental Health, and Trauma informed Practice by Dr Asha Patel, Innovating Minds CIC
14:30 - 14:35	Tea/ Coffee Break
14:35 - 15:35	Session 5 - Learning from Safeguarding Adult Reviews by Alison Ridley, SCIE
15:35 - 16:15	Session 6 - The future for Safeguarding Adults in Surrey by Teresa Bell, SSAB Independent Chair
16:15 - 16:30	Closing Remarks by Teresa Bell, SSAB Independent Chair

surreysafeguarding.adultsboard@surreycc.gov.uk

Page 159

Priority 3: Quality and Improvement

The SSAB agreed arrangements for quality assurance of adult safeguarding across the partnership through a self-assessment survey.

The associated questionnaires incorporate specific areas for assurance based on the SSABs priorities and strategic plan e.g. neglect and acts of omission. A bespoke QA questionnaire was developed with the prisons in Surrey.

The assurance arrangements expanded to include agencies including private health providers and hospices.

Capturing the adult's experience, especially in relation to Making Safeguarding Personal and Advocacy requirements is a key component of Safeguarding Adults work. The SSAB receives quarterly reports from Surrey County Council Adult Social Care in respect of this. The analysis of this data indicated that there were areas for improvement in relation to ensuring formal advocacy for adults and the Board held a session for all partners to raise their understanding of the requirement for this.

Priority 4: Reflection and Learning

The SAB continued focus on learning from SARs both local and national as a partnership by holding workshops as part of Board meetings. SAB members considered questions and how learning can be taken back to their agency.

9

The SAR learning summary was updated followi feedback from partners. Partners recognised the importance of the summary to assist in ensuring the wider dissemination of the learning from reviews within their agency. Good practice was recognised as a key aspect and this area has been strengthened within the learning summary documentation.

The importance of connecting with national networks including the Safeguarding Adults Chair network, Board managers network, SE ADASS network, SANN and Police networks was recognised. Partner leads were identified who will feed back to relevant subgroups on emerging issues and collective actions. Emerging themes from national networks were discussed and disseminated as appropriate.

Priority 4: Reflection and Learning

The SAR & Learning subgroup continued to take forward the recommendations from the National Analysis of SAR Reviews. The SAR tracker is continually updated with criteria to better assist the SSAB in capturing information. All reviews are added to the SAR National Library; a repository for all SARs.

9

In June 2023, a learning event was held following the publication of the Peter SAR in September 2022.

This included presentations from key agencies involved in Peters case: Health, Adult Social Care and Hope Hub, with an introduction and lesson from national best practice from the independent author.

Agenda

Welcome – Sarah McDermott SSAB Board Manager

Introduction to the Review Fiona Bateman (Author)

Agency presentations

- Health - especially role of GP and specialist where cognitive decline suspected (Dr Raja Badrakalimuthu, SABP)
- SCC Adult Social Care – Clement Guerin (Head of Safeguarding)
- Surrey Adult Matters – Julie Shaw (Senior Partnership and Programme Manager)
- Hope Hub - Mags Mercer/Camilla Spicer (Chief Executive/Head of Service Delivery)

Questions

Lessons from national best practice for frontline staff and team managers (Fiona Bateman)

Thank you and end (Sarah McDermott)

SSAB Forums

Engagement Forum

The Engagement forum has now been established for three years, meeting six monthly. The membership of this group continues to expand. Agencies who attend have found value in not only connecting with the work of the SSAB but also connecting with other agencies within Surrey. The forum looked at the following areas; Making good safeguarding concerns in Surrey and feedback from MASH, supporting of Safeguarding Adults Week, highlighting the Boards conference, gaining the voice of the adult, SSAB Updates including the annual report, SARs, webinar series, agencies feedback in relation to SSAB leaflets, the website and the resources th the SSAB has to offer, extending the invitation to join the SSAB Communications group.

Health Forum

The Health forum met six monthly and, having extended the membership to include private health providers, has been very productive. It has ensured that the health system in Surrey is kept updated on the work of the SSAB as well as allowing for peer support between NHS and private health providers. The Health forum covered the following areas over the year; NICE Guidance on Advocacy, MASH update presentation, LPS, Surrey Suicide Prevention Strategy Safeguarding Concerns Referrals to ASC, Patient Safety Incident Response Framework (PSIRF) (NHS Serious Incidents currently Section 22 current SSAB policy and Procedures).

SSAB Forums cont.

District & Borough Forum

This forum meets quarterly and covered both the work of the Surrey Safeguarding Children Partnership (SSCP) and the Surrey Safeguarding Adults Board SSAB). Key areas that this forum covered over the year included; Development Session on Neglect (Adults and Children), Domestic Homicide Update, Learning from Reviews, Policy Updates, SSCP/ SSAB QA, Updates from the SSAB including Conference, Webinars and engaging with District & Boroughs to support the SAB with Safeguarding Adults Week and communication with residents.

9

Prison Forum

The SSAB continued to strengthen engagement with the five prisons in Surrey. This remains a joint SSAB/ Surrey Children Partnership forum which is strengthening the work of the prisons in Surrey in relation to Safeguarding Adults and Children.

At times attendance from all the prisons has been variable, however those that attend find it valuable. The forum not only includes the prisons but also agencies who work within the prison setting, including health care, SCC Adult Social care prison team and provider services and Surrey Heartlands ICB. Over the past year the forum considered; Concern referral process in prisons, NHSE benchmarking, Working Together 2023, HM Inspectorate of Prison Inspections and how the SSAB can support these within Surrey, learning from SARs and Prison and Probation Ombudsmen reviews.

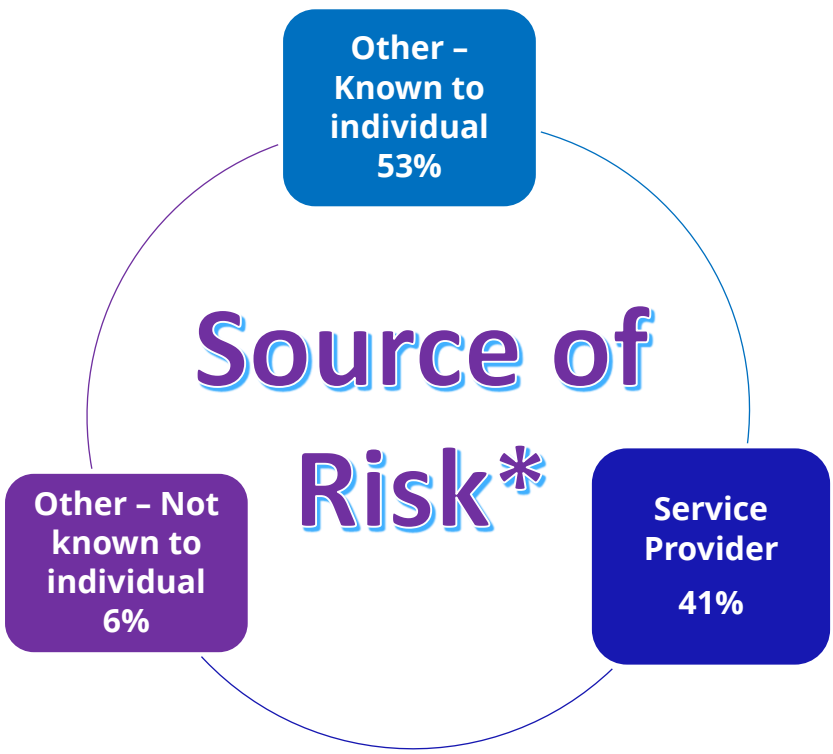
Adults in Surrey Data

Care and Support needs*

This shows the primary support need for adults for whom the safeguarding concern relates to and for those cases that met the criteria for a Section 42 safeguarding enquiry. Most adults who are the subject of a safeguarding enquiry have a need for physical support. There was a slight decrease in those concerns where the primary support was not known from 40% in 2022/23 to 37% this year.

	Physical Support	Sensory Support	Learning Disability	Memory and Cognitive	Social Support	Mental Health	Not Known
Safeguarding Concern	**34%**	**1%**	**11%**	**4%**	**3%**	**10%**	**37%**
S42 Safeguarding enquires	**38%**	**1%**	**12%**	**5%**	**2%**	**9%**	**33%**

** Source: SAC SG1d*



** Source: SAC SG2b*

This shows the analysis of where the risk originates, based on concluded S42 safeguarding enquires, with the main source of risk coming from people known to the individual.

What Abuse is happening?

This information comes from concluded Section 42 adult safeguarding enquiries

Types of Risk

Figure 10 proportions of risk for section 42 enquiries

*data taken from Microsoft Power BI – see page 13 for breakdown by abuse type

9

Type of Abuse*	2022/23	2023/24
Discriminatory Abuse	0.3%	0.4%
Domestic Abuse	7.3%	6.9%
Financial or Material Abuse	7.0%	8.1%
Modern Slavery	0.1%	0.1%
Neglect and Act of Omission	33.3%	35.3%
Organisational Abuse	15.8%	14.9%
Physical Abuse	18.9%	17.0%
Psychological Abuse	12.3%	12.3%
Self-Neglect	2.6%	2.4%
Sexual Abuse	2.1%	2.2%
Sexual Exploitation	0.2%	0.3%

** Source: SAC SG2*

The biggest change since 2022/23 was in Neglect and Acts of Omission, which remains the largest category and saw an increase from 33.3% to 35.3%. There was a smaller increase in Financial or Material Abuse (up from 7.0% to 8.1%) and a decrease in Physical Abuse (down from 18.9% to 17.0%).

What the data says about the response to abuse

962,999

Population of Surrey aged 18 and over. (*source: ONS mid-2023 population estimates from Surrey-i)

The number of safeguarding concerns made in 2023/24 in relation to 11,163 individuals. This is a 5% decrease in concerns from 2022/23.

16,854

63%

The percentage of safeguarding concerns received converted into a Safeguarding enquiry as defined in The Care Act 2014 . A slight decrease from 70% in the previous year.

9

The number of Safeguarding enquiries started in 2023/34. This is a 15% decrease from 12,335 in 2022/23, compared to an increase of 7% between 2021/22 and 2022/23.

10,508

35%

Neglect or acts of omission were a concern in over 35% of the safeguarding enquires undertaken, this is an increase from 33% in 2022/23.

The percentage where the risk remained after the safeguarding enquiry work. This is the same proportion as in 2022/23.

9%

91%

The percentage of S42 enquiries where the risk to the adult was reduced or removed. This is the same proportion as in 2022/23.

The percentage of S42 enquiries where the individual or their representative were asked about their desired outcomes. This is a decrease from 88% in 2022/23.

87%

97%

The percentage who were asked and expresses their desired outcomes and said they were fully or partially met. This is the same proportion as in 2022/23.

The percentage of s42 enquiries where the adult lacked mental capacity. Of those 91% were supported by advocate, family or friend (an increase from 88% in 2022/23)

25%

Safeguarding Adults Reviews (SARs)

The SSAB Safeguarding Adults Review (SAR) subgroup received seventeen SAR notifications during 2023/24.

Of the seventeen received, fourteen notifications were agreed to meet the SAR criteria.

Of these fourteen, four will proceed as joint DHR/SARs with the relevant Community Safety Partnership and the others will be taken forward as SARs.

The SAR & Learning subgroup continued to monitor multi-agency action plans in relation to:

- Peter[2]
- Mary[2]
- Person 1

In 2023/24 the Safeguarding Adults Review subgroup continued to oversee;

- 10 SARs from previous years.
- 11 joint DHR/SARs from previous years
- One NHSE/I London Investigation/SAR

2 Pseudonym

Published Safeguarding Adults Reviews (SARs)

The SSAB published three Safeguarding Reviews in relation to Zahra[2] , Louise[2] , and Ella[2].

Zahra was 55 years old when she died as a result of an accident in November 2020. Who came to the UK from another country in 1999. English was not Zahra's first language, and she struggled to understand English and be understood by others. Zahra may have felt isolated. It appears that Zahra began to drink large quantities of alcohol as a result.

Zahra and her husband had two children in the UK. Both were taken into care in 2011 because of Zahra's alcohol dependency and concerns of neglect. Zahra had a long relationship with alcohol and was possibly dependant since at least 2000. There were some attempts by agencies to engage with Zahra about her alcohol misuse, but Zahra refused to acknowledge that she relied on alcohol.

Leading up to her death, Zahra was struggling to cope, and her behaviour was becoming extreme. Zahra experienced domestic violence from her husband and their relationship ended at some point before 2010.

At the time of her death Zahra had a partner and there was a history of mutual domestic abuse between them. Zahra was described as leading a chaotic lifestyle and terrified of being left. She would go to extreme lengths to stop her partner(s) leaving her. One of the children said that they had acted as Zahra's carer

The SAB published an executive summary that can be found here Zahra. A muti-agency action plan was developed and will be monitored by the SAR & Learning subgroup.

2 Pseudonym

Published Safeguarding Adults Reviews (SARs) Cont.

Louise was discovered by Surrey Police to have died at home, with some evidence to suspect that this was caused by an overdose of medication. She had been known to mental health services and had recently been discharged from a psychiatric hospital admission under S2 (MHA '83) less than a week before she died. This hospital admission arose following a previous overdose attempt, whereby her son found her at home and called an ambulance, leading to her hospital admission in Epsom, initially to the High Dependency Unit and subsequently to her transfer to a psychiatric hospital for her final admission.

Louise had been in a relationship for over 10 years with a man whom she lived with, she had a son and daughter from a previous relationship. Her Partner had suffered a stroke 2 years previously and Louise reported his behaviour had changed since this time. Louise had made some allegations about domestic abuse, but these were disputed by both her children and his daughter. She was referred by the police to both Adult Services and subsequently to MARAC and local domestic abuse services following these allegations. He was arrested and bailed with conditions not to return to the family home.

Louise had previously been referred for both counselling and medication by her GP for depression and stress. Louise had also identified a legal dispute with tenants of a flat she owned as a significant cause of stress for her, which she was struggling with.

The SAB published an executive summary that can be found here Louise. A muti-agency action plan was developed and will be monitored by the SAR & Learning subgroup.

2 Pseudonym

Published Safeguarding Adults Reviews (SARs)

Ella was a 33-year-old woman who took her own life on 13th October 2018 while an informal inpatient at the Abraham Cowley Unit in Chertsey, run by the Surrey and Borders Partnership NHS Foundation Trust (SaBP).

The review looked at the care and support received by Ella during 2018, in the ten months leading to her death. It looked briefly at her background and issues of relevance outside that timescale, and Ella's parents provided a short piece to describe their child from their perspective.[9]

Ella had several episodes of care under the local mental health service during the 2010's and was diagnosed with anorexia nervosa in 2016. She had taken an overdose in 2016 with the reported intention of ending her life and was drinking alcohol to excess.

The SAB published an executive summary that can be found here Ella. A muti-agency action plan was developed and will be monitored by the SAR & Learning subgroup.

2 Pseudonym

Safeguarding Adults Reviews (SARs) Learning Events

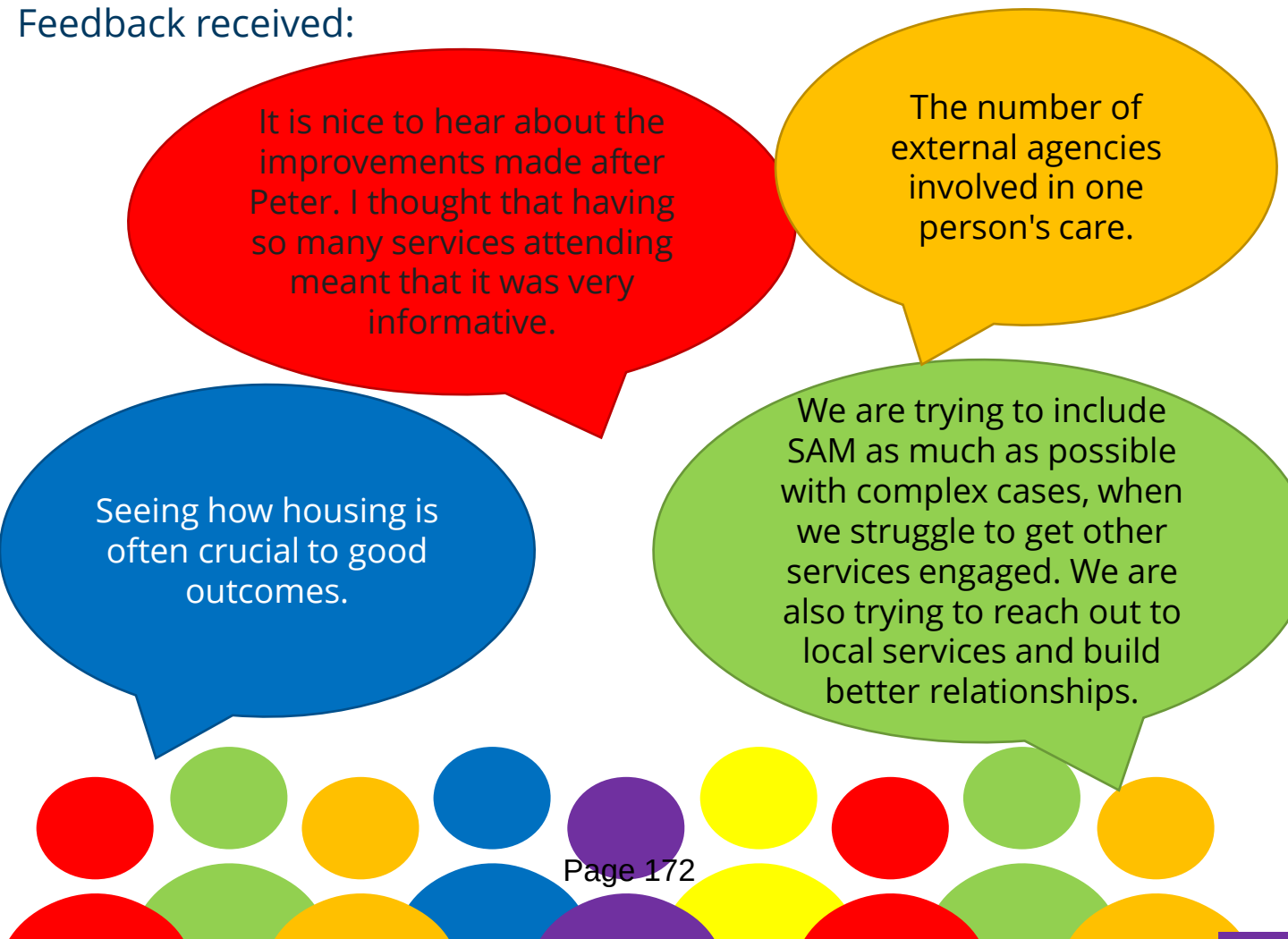
In June 2023, the SSAB held a learning event following the publication of the SAR Peter the previous year.

The event was well attended with over 30 people participating from a range of agencies across Surrey. The recording is available on the SSAB's website.

The event covered:

- A presentation from the author on the review, learning the lessons.
- A presentation from Surrey and Borders Partnership Trust (SABP).
- Surrey County Council, Adult Social Care.
- Surrey Adults Matter (SAM).

Feedback received:



SSAB Training

Contributing to Section 42 Safeguarding Enquiries

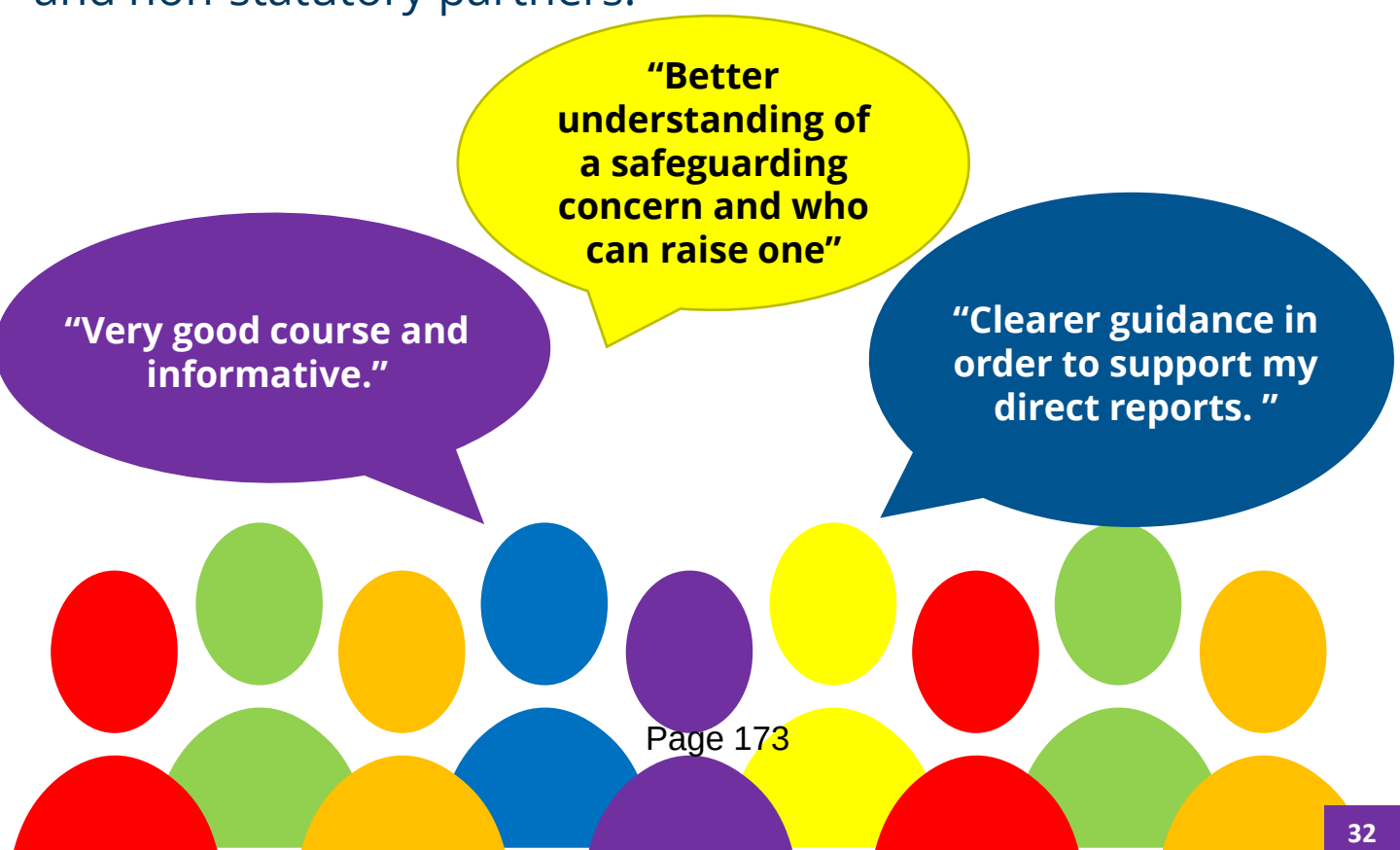
The SSAB continued to offer virtual courses following both feedback from candidates and agencies. We have continued to see greater numbers from a range of different agencies attend.

The SSAB provided a Contributing to Section 42 Safeguarding Enquiries course.

The course covers; understanding when S42 safeguarding duties apply, recognising MSP in practice, understating contributing to a S42 safeguarding enquiry, understandin roles in an enquiry, how to professionally challenge and skil to write a good quality contribution.

9

Two courses were held over the year with 22 people attending from a variety of agencies across both statutory and non-statutory partners.



Other Training within Surrey

Adult Safeguarding Essential

Following an agreement made in 2022 between the SSAB and the Surrey Skills Academy (SSA), the Safeguarding Essentials Course continues to be provided by SSA. This ensures that there is a central place for this training within Surrey for agencies.

- The Essentials course covers:
  - Meaning of 'abuse and neglect' in the context of adult safeguarding.
  - Identify who an adult safeguarding enquiry applies to and the s42 duties.
  - Types of abuse.
  - Common indicators of abuse.
  - The adult safeguarding roles of Surrey County Council, Surrey Safeguarding adults Board and other partners.
  - How Making Safeguarding Personal (MSP) works in Practice.
  - Response to disclosures of abuse and neglect effectively.
  - Correct reporting and recording of adult safeguarding concerns in Surrey.
  - The relationship between adult safeguarding, child protection and domestic abuse.
  - What happens when a safeguarding concern is reported to the Local Authority.

Other Training within Surrey

Domestic Abuse Training

Domestic Abuse Training within Surrey is centralised and the SSAB ensured that adults with care and support needs and the Care Act 2014 were incorporated into the training delivered.

During 2023/24* the following courses took place:

Course Title	Number of sessions	Confirmed attendees
Dealing with Dual Allegations of Domestic Abuse (DA) (SCSA)	2	31
Domestic Abuse, Stalking, Harassment & Honour-Based Abuse (DASH), DA Risk Assessment (DARA), Multi-Agency Risk Assessment Conferences (MARAC) (DA) (SCSA)	2	54
Domestic Abuse: Dynamics within the LGBTQ+ Population (DA) (SCSA)	1	16
Domestic Abuse: Impact on Children and Parenting Capacity (DA) (SCSA)	2	52
Domestic Abuse: Legal Framework and the Domestic Abuse Act 2021 (DA) (SCSA)	2	55
Domestic Abuse: Safely Engaging with Perpetrators (DA) (SCSA)	2	55
Domestic Abuse: The Care Act (DA) (SCSA)	2	29
Domestic Abuse: Understanding Coercive Control and the Multi-Agency Framework (DA) (SCSA)	2	60
Domestic Abuse: Young people (Peer) (DA) (SCSA)	2	44
Domestic Homicide Reviews, Safeguarding Adult Reviews, and the Homicide/Suicide Timeline (SCSA)	4	65
Economic Abuse (DA) (SCSA)	2	48
Introduction to Domestic Abuse (DA) (SCSA)	9	226
Male Survivors (DA) (SCSA)	2	20
Non-Fatal Strangulation / Suffocation (SCSA)	2	32
Stalking (SCSA)	4	48
Grand Total	**40**	**835**

*data refers to attendance from across Adults and Childrens Directorates.

The SSAB signposted to relevant training/ webinars that were provided within Surrey including:

- Healthy Surrey website
- Skills Academy
- Surrey Children's Services Academy
- Surrey Heartlands ICB Lunch and learn sessions

SSAB Webinars

The SSAB held a series of webinars throughout 2023/24 on topics including:

- Advocacy services by POhWER and Matrix. 28 candidates attended the session.
- An insight into Trading Standards in Relation to Safeguarding Adults. 70 candidates attended the session.
- An insight into the Surrey Solace Centre 63 candidates attended the session.
- An insight into preventing the abuse of older people by Hourglass. 94 candidates attended the session.

Presenter presentation slides and the recordings can be found on the SSABs Website on the webinar series page.

Feedback from participants is below

Presenter was very knowledgeable and was clear in her presentation. Keep them coming!

Delivered in an informative way. What a complicated topic. Thank you.

Very informative session, thank you. Extremely well organised

Really informative and very helpful

Very clear and thorough. The information on the equipment that can be offered is really helpful.

Was very informative - explaining the teams involved.

The slides with all the examples of the hoarding etc made the presentation very real and interesting, thank you. Your vast knowledge and experience came across , the personal approach was much appreciated. Really informative session, thank you.

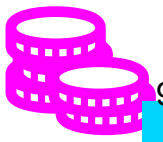
i found Liam a good speaker with sound knowledge, handling a sensitive topic very well.

Informative and very useful as I work in ASC and work with some very vulnerable clients

Pooled Budget

The SSAB was funded by partner agencies during 2023/24, Financial contributions totalled £348,605. To ensure that costs associated with Safeguarding Adults Review it was agreed that monies remaining to be carried forward from the previous year.

Partners contributions ensure that the SSAB can continue to operate, showing a significant commitment on the part of partners to work together and jointly take responsibility for decision making and running the Board. In addition to contributing financially, partners continued to contribute staff time to ensure effective working of the Board.



9

Breakdown of partners contributions *

Partner Agency	Partner Contribution 2023/24	% split
Surrey CC	£117,450	33.6%
Surrey Heartlands ICB	£117,450	33.6%
Surrey Police	£79,000	22.6%
Health Agencies	£23,050	6.6%
District & Boroughs	£11,605	3.3%
SECAmb	£10,000	2.8%
Total Contributions	£348,605	100%
Carried Forward	£117,500	
Income from training	£72.00	
Total Board Budget 2023/24	£466,177	

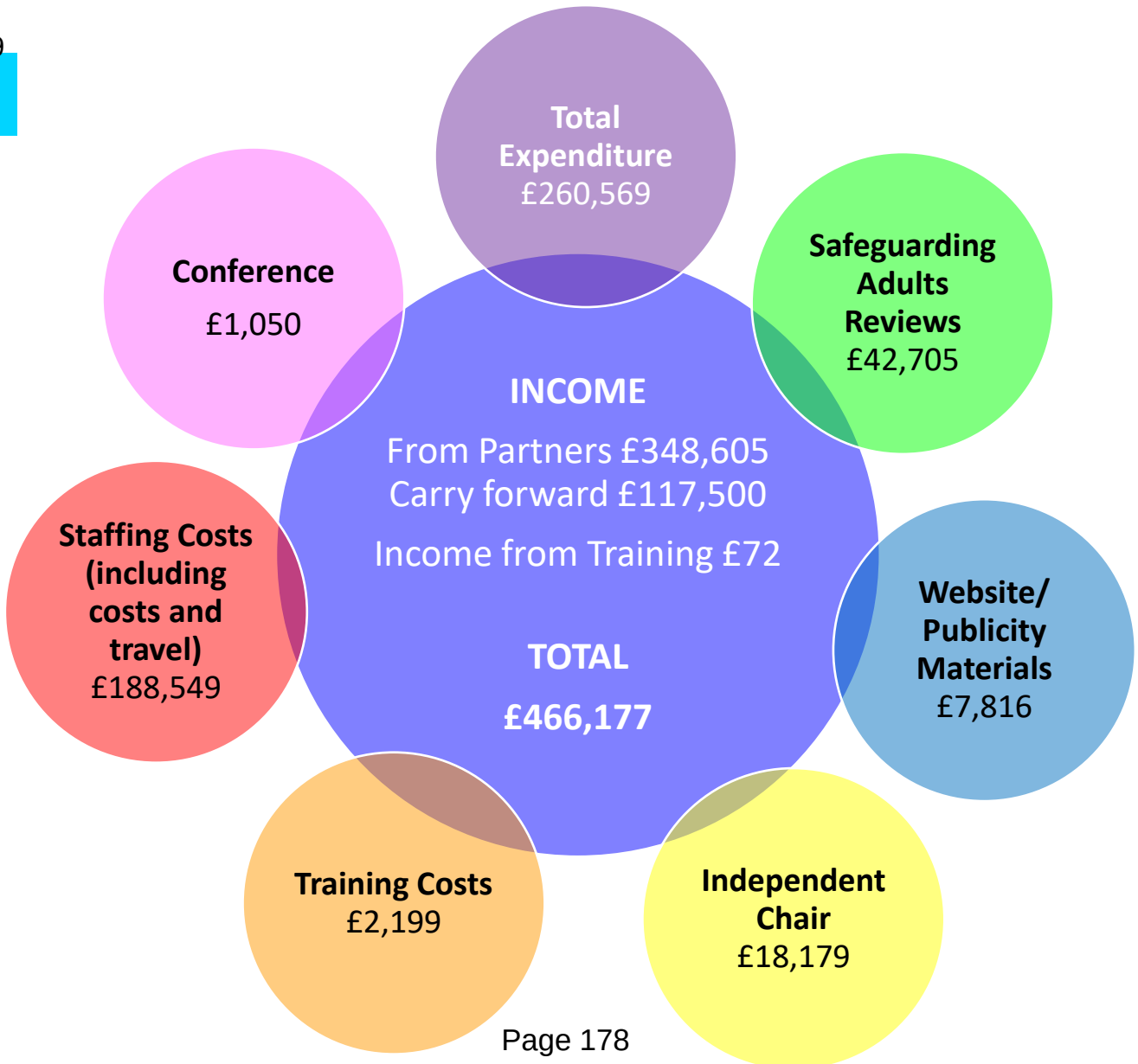
* Figures supplied by Surrey County Council Strategic Finance - HWA & PH

During 2023/24 the Board spent £260,497. The majority of our costs were on staffing, followed by the costs associated with conducting Safeguarding Adults Reviews.

Pooled Budget cont.

There was an underspend within the 2023/24 year, however the SSAB recognised that potential costs in 2024/25 would be greater due to an increase in the number of statutory reviews. It was agreed that all monies remaining within the 2023/24 budget would be carried forward into the 2024/25 budget.

Breakdown of SSAB Expenditure for 2023/24



Journey for 2023/24

The 2023/24 year is the second year of the SSABs 3-year Strategic Plan which covers 2022-2025.

The 2023/24 annual report has reported on what work has been done within the year against the priorities by both the SSAB its subgroups and task and finish groups.

Next year, moves the SSAB into its final year of the 3-year strategy and the following pages detail how the strategic priorities will be taken forward over the next year.

Journey for 2024/25

Priority 1:
Prevention and Awareness

Improve community awareness including using available opportunities to increase public involvement, and to engage media interest.

- How we will do this:
  - Incorporate into the communication strategy.
  - Continue engagement with and building on partnerships relationships – engaging with those experts by experience.

Ensure the role of carers and the challenges they face are recognised and action is taken to prevent carer breakdown and abuse/neglect.

- How we will do this:
  - Review research re generational differences of carers of asking for help/support.
  - Strengthen relationship with Action for Carers and other carer support agencies including leads in SCC Adult Social care.
  - Acknowledged a plan for learning from SARs in relation to carers.
  - Review and update SSAB resources/ website pages.

Support the use of best practice to reduce avoidable safeguarding incidents.

- How we will do this**:**
  - Establish a shared understanding of what is an avoidable (preventable) safeguarding incident.
  - Review ASC data to determine the volume of safeguarding concerns that are considered avoidable(preventable) safeguarding incidents/types of incidents.
  - Best practice examples are identified and shared.

Highlight neglect and acts of omission issues and develop stronger mechanisms to address these

- How we will do this:
  - Develop spotlight on neglect/acts of omission within SSAB website.
  - Referrers will have an awareness of the referrals they are making in regard to neglect/acts of omission and develop plans to address these.

Journey for 2024/25

Priority 2:
Communication and Engagement

Coordinate the development and delivery of an annual communication strategy that sets out what the SSAB will do. Focusing on key messages, target audiences, ensuring that the message has been delivered.

- How we will do this:
  - Continue progressing our communication strategy with key agencies and partners – via newsletters, social media and stronger links with agencies comms leads.
  - Ensure that the communication strategy includes key message and target audiences, such as homelessness and lived experience and learning from SAR reviews.

Develop a model to gain the voice of adults with care and support needs and carers, and link with existing services and groups.

- How we will do this:
  - Map existing networks that gain the voice of the adult with care and support needs and carers.
  - Work with existing networks to gain the voice of the adult/carer regards the SSAB comms work.
  - Clear pathway for homeless adults with care and support needs in regard to safeguarding concerns and gaining their voice.
  - Further develop links with existing groups to inform our quality assurance processes.

Work closely with other Boards to ensure smarter working, eliminate duplication, and share Surrey wide comms benefits.

- How will we do this:
  - Continue to consolidate relationships with other Surrey Boards/Partnerships and share communications strategies to determine cross-over.

Journey for 2024/25

Priority 3:
Quality and Improvement

Identify from audits and available data trends and research, adults in need of care and support who are or have been experiencing abuse or neglect (increase in neglect, and abuse in people's own homes) this will help drive our workplans and agenda.

- How we will do this:
  - Implementing a revised quality assurance framework.
  - Review partners audits for themes/trends and available research.
  - Adapt workplan based on findings.

Develop an assurance process to capture the voice of people with lived experience, particularly in respect of making safeguarding personal, and using this to drive practice improvements.

- How we will do this:
  - Determine existing processes for capturing adults' experiences locally/nationally.
  - Develop a Surrey process for assurance of adults' experiences based on national/local examples.

Journey for 2024/25

Priority 4:
Reflection and Learning

Disseminate learning from Safeguarding Adult Reviews and other statutory reviews to ensure that learning is embedded across the partnership.

- How we will do this:
  - Examination of QA returns for assurance purposes to include how agencies ensure this across their workplace.
  - Consider a process for multi-agency learning and how this is embedded across the agencies.
  - Develop different methods for dissemination learning.

9

Share learnings, be they good practice or areas of development.

- How we will do this:
  - Learning Summary template will be reviewed and updated as appropriate based on feedback from agencies.
  - Establish links with the DHR Coordinator who has oversight of DHRs across the country and develop consistency of approach for sharing learning.
  - Emerging issues from networks will be discussed at the SAR and Learning meetings and any required actions will be taken forward.

SSAB Member Updates

All agencies who are members of the SSAB were asked to input into this report, highlighting the work they have done over the 2023/24 year to support the work of Surrey Safeguarding Adults Board.

Surrey County Council

Adult Social Care

Adults, Wellbeing and Health Partnership (including Adult Social Care) plays an active role in Surrey Safeguarding Adults Board and participates in each of the sub-groups which form part of the wider Board's governance.

The partnership recognises the needs to strengthen Making Safeguarding Personal with an outcome focus and support for people to improve their circumstances and this is an area we have worked hard to promote during the last year with excellent results. Making Safeguarding Personal is an area outlined on the SSAB website.

A strong example of this entailed an elderly diabetic woman not being administered insulin and being fed ice cream. One of our safeguarding advisors chaired a safeguarding review meeting.

The daughter acknowledged that her views had been listened to and that the meeting had been conducted well allowing her to express her opinion and desired outcome. She welcomed the learning outcomes and agreed that is needed a holistic approach is needed outcome with complex cases, where physical needs are just as important as the mental wellbeing of the individual. The daughter was satisfied with the learning outcomes which put in place by the provider.

There have been significant staff changes within Adult Social Care during the last year. We recruited an experienced Principal Social Worker (PSW), who has a key role in raising operational standards – including in safety and risk – in partnership with the Interim Director, Practice, Assurance and Safeguarding, to develop an increased focus on safeguarding.

Whilst we have continued to receive high demand, we have worked with partners to review our approach to risk enablement and proportionate risk management as complexity has increased, We have reviewed our learning and training offers to front line staff in order to, facilitate the change.

We have empowered practitioners to undertake proportionate enquiries to ensure people are being safeguarded in a timely and person-centred way.

We have improved our training offer - providing staff with easy access to safeguarding training resources. This also links to the Surrey Safeguarding Adults Board's competency framework and guidance, ensuring that staff are aligned with local and national safeguarding standards. Our mandatory training efforts have focused on enhancing the skills and knowledge of staff through various programs, fostering inter-agency collaboration, and refining processes for handling safeguarding concerns under Section 42 of the Care Act 2014.

Surrey County Council

Adult Social Care cont.

Our mandatory training efforts have focused on enhancing the skills and knowledge of staff through various programs, fostering inter-agency collaboration, and refining processes for handling safeguarding concerns under Section 42 of the Care Act 2014.

Safeguarding Advisors are part of our locality teams and our specialist services and provide leadership. Safeguarding audits are undertaken locally with a view to disseminating the learning from them. A part of the work of our Safeguarding advisors, we have introduced targeted audits using a LGA approved tool, and we have introduced a review of our audit process across the county. This will ensure consistency of practice of help to inform lessons learnt.

Our DOLs team receives an average of 19 DOLs requests per working day. As of March 2023, there were 5,525 incomplete applications/awaiting sign off, which as of March 2024 was reduced to 3,498 –. We have undertaken a significant programme of work to triage outstanding cases, outsourcing a cohort to an external agency and training more staff as authorisers and ensured that learning from complaints and the LGSCO has been embedded into our approach. Our Academy has also developed a training programme to increase our own internal Best Interest Assessors.

9

Raising awareness is an essential part of our vision to ensure residents are 'informed' and 'able to make decisions about their lives.' We contribute to the SSAB website and have worked with SSAB to produce information for the public. Easy read safeguarding booklets were developed and tested by people with learning disabilities. These include - What is abuse, Reporting Abuse, Section 42 Enquiries, Cuckooing, Domestic Abuse, Financial Abuse, Modern Slavery, Neglect and Scams. These booklets are available from the SSAB website and published on the Council's Learning Disability and Autism Hub. This information is used by a range of people supporting individuals with learning disabilities. Each year we support SSAB's awareness raising for Safeguarding Adults Week as an opportunity to remind residents, staff and partners that safeguarding is everyone's business

We actively supported the SSAB Safeguarding Conference and one of our Safeguarding Advisers did a presentation on 'Unexplained Injuries, Neglect and Acts of Omission' at the conference in November 2023.

Challenges faced in 2023/24

- We continue to experience high demand; and the complexity of referrals has increased. Permanent recruitment is a particular challenge, and we are dependent on locum staff in a financially challenging environment.
- We are working with our workforce to embed our approach to risk enablement and proportionate risk management. Given the increase of complexity, we recognise staff require support and confidence to manage this change.

Surrey County Council

Children Social Care

Children's, Families & Lifelong Learning directorate has made significant contributions to the Board's work on adult safeguarding throughout the year.

Early Intervention and Family Support:

- **Early Support Service** (0-5 years) focuses on children with complex needs and disabilities, including those on long-term hospital stays. This service safeguards adults by supporting parents, including those with moderate mental health issues, to provide a safe and nurturing environment for their children.
- **Family Centres** (all ages) were remodelled in 2023/24, offering tailored support across various settings. Their staff are trained in GCP2 assessments and have consistently ow their behaviour impacts child well-being.
- **Family Support Programmes (FSP) and Intensive Family Support Service (IFSS)** (5-18, up to 25 with disability) provide integrated support to families with interconnected needs like housing, domestic abuse, and substance misuse. Their focus on early intervention helps prevent situations that could lead to child neglect or endangerment.

9

Supporting Young People in Transition:

- **The Key Worker Service** (0-25) supports young people with autism and learning disabilities to remain in their communities, avoiding unnecessary hospital admissions or residential placements. This indirectly safeguards adults by minimizing the burden on care systems.
- **Mindworks Surrey** offers mental health support to care leavers aged 16-25, promoting well-being and preventing long-term emotional and mental health challenges for them as adults.
- **The Virtual School** provides tailored career guidance to care leavers (18-25), helping them achieve independence and reduce potential future vulnerabilities.

Capturing Voices and Measuring Outcomes:

- **Keyworker Service:** Utilises a variety of tools like outcome stars, person-centred PATHs, and goal-based measures. They also support communication through passports.
- **Family Centres & Family Support Programme:** Regularly gather adult voices through Early Help Assessments, Outcome Stars (including Family Star Plus for parent well-being), and regular file audits. This ensures all voices, including fathers, are heard.
- **Agency-wide:** DWP grant funding supports training for managing relational conflict. Trained practitioners use early intervention tools to help families improve the lived experience for children.

Children Social Care cont.

Utilising Feedback for Improvement:

- **Audits:** Regularly analyse service user feedback through audit tools. Questions address family participation in interventions and access to assessments. Auditors utilise gathered information to assess core practice standards.
- **Care Leavers Service:** Annual surveys capture feelings on support, safety, and aspirations. Additionally, a Care Leavers Participation Group provides a platform for sharing voices and improving services.

Ongoing Work:

- Continued focus on capturing voices and utilising feedback across all services.
- Expansion of training programs to support families with various challenges.

9

- **Direct Support:** Family Centres and Family Support Programmes (FSP) collaborate with community Domestic Abuse (DA) services, providing one-on-one support in refuges and offering programs like the Freedom Programme for adults experiencing abuse. They also extend this support to refugees and asylum-seeking families in temporary accommodation.
- **Raising Awareness of New Services:** The Key Worker Service, though newly established, is actively developing communication strategies to promote wider community awareness.
- **Online Resources:** The Care Leavers Local Offer website serves as a statutory resource hub, providing information and support options for care leavers.

Challenges faced in 2024/25

1.Staff Recruitment and Retention:

- **Securing qualified staff:** Filling vacancies in roles focused on domestic abuse, mental health, and substance misuse is difficult due to consistent demand and competitive recruitment landscapes. This diverts resources from other areas and increases training burdens.
- **Family Centres & Family Support Programme:** Recruiting staff with the necessary skills to provide mental health support for adult family members while simultaneously supporting children.

2. Access to External Support Services:

- **Long waiting lists:** Limited access to mental health support for adults and neurodiversity screenings creates additional stress for families. Delays in diagnoses can hinder parents' ability to support their children, further impacting family well-being.

Surrey Police

Surrey Police is responsible for policing a varied geographical area of busy towns and rural areas with a population of approximately 1.2 million people. Surrey Police employ around 4,000 officers and staff and cover all areas of operational policing business. Major Crime, Firearms, Roads Policing, Dogs Section are collaborated with Sussex Police. All other operational teams, including Public Protection are Surrey only.

We continue to progress Our Plan which was set out by our Chief Constable, Tim de Meyer in 2023. The plan falls under four main headings: Investigations, Leadership, Problem Solving and Standards. The following are mission statements associated with the plan (please note this is not an exhaustive list) Prevention of crime, investigating thoroughly, pursuing criminals relentlessly, providing outstanding victim care, demonstrating ethical high standards and reflecting communities.

Surrey Police are active contributors to the ASE and the SSAB. The Strategic Manager for Public Protection continues to deputise for the SSAB Board and the SSAB Executive and works closely with the independent chair. The Strategic Manager also chairs the SAR Decision Panel and the SAR & Learning Group. We have previously maintained good representation at other groups such as the Quality Assurance Group and Communications Group.

Following a very successful pilot, Surrey Police have continued to operate a specialist Adults at Risk (ART) investigation team. We have witnessed significant improvements in the identification of crime relating to adults at risk and our response to adult safeguarding, this includes single and joint investigations. We continue to support and equip our staff to carry out meaningful and effective investigations by way of training and continuing professional development.

We are developing a model which will enable us to bring a number of agencies and members of the third sector together (monthly) to discuss and manage some of the complex and challenging investigations.

We will continue to be committed to pursuing opportunities to work collaboratively with our colleagues across all agencies and the third sector to improve the lived experiences of those who are victims of crime and/or require us to protect them and to seek out and identify those who neglect or abuse and bring perpetrators to justice or find proportionate and suitable criminal justice or other outcomes.

Surrey Police

We continue to face challenges alongside partners in achieving the best joint working possible, however, there is a willingness to do this as it is accepted that no one agency can act alone.

We have revisited our interview suites across the force and made significant adaptations being cognisant of recommendations made from a trauma informed and neurodiversity perspective.

Due to the ART, we have continued to look closely of the effectiveness and efficiency of investigations and safeguarding, particularly good practices for learning.

We are running daily triage meetings discussing all adult at risk cases. This is proving to be highly effective in assessing risk and improving investigation standards but also is providing an excellent platform for learning.

There is also a weekly roundup meeting for the ART which looks at any presenting challenges, encourages staff to discuss the voice of the victim and disseminate good learning.

Surrey Police use social media well to promote the importance of protecting vulnerable people.

We contributed several presentations at the Adult Safeguarding Conference, including, financial abuse and cuckooing.

Challenges faced in 2023/24

- Potential demand exceeding available resources, particularly specialist resources.
- Understanding that adult at risk investigations are often complex and potentially increasing due to a number of socio-economic factors, such as more elderly people living in the community being cared for by family or friends or people who have “befriended” the adult at risk posing risk of intended or unintended abuse and/or neglect.
- We are experiencing a more transient workforce then we have done historically which presents some challenges in stabilising and sustaining specialist staff.

Surrey Heartlands and Frimley Integrated Care Boards (ICBs)

Attendance at the SSAB Board, Subgroups and Forums.

Review of updated NHS Pressure ulcer Protocol aligned to Surrey Safeguarding Adults Protocol: Pressure ulcers and raising a safeguarding concern.

Working with the Board for Care Providers Safeguarding Audit, to gain assurance.

Top Tips/ Guidance for avoidable safeguarding concerns in development.

Working with Board to look at changes in SAR process.

9

Completed ICB QA questionnaire

ICB team contribute to DHRs/SARs/ Section 42 panel meetings

Working on a joint adults and children Was Not Brought Policy for health providers

Working on the "Stop, Look, Care" model – How to recognise a deteriorating patient, including references to persons with learning disabilities.

MCA Forum includes case discussion to hear the voice of the person.

LeDeR – webinars developed to share themes and lessons learned e.g. bowel management.

Poo matters campaign with Skills for Care.

Good bowel health with ASC Providers- Good Bowel Health event 25.8.22

The importance of good bowel management to safeguard residents.

GP Lunch and Learn

Surrey Heartlands and Frimley Integrated Care Boards (ICBs) cont.

The Surrey ICB Safeguarding newsletter includes links to the SSAB newsletter, and links and briefings about SARs upon publication.

Promote safeguarding events through the ICBs social media accounts.

Support the Board to raise awareness in the community e.g. Adult Safeguarding Awareness Week, Community Questionnaire.

ICB DA Health Forum looks at training and awareness within provider services around DA for women and children, and from minority backgrounds

Challenges Faced Moving into 2023/24

- A major challenge for the team, as well as providers is the large number of SARs and DHRs being commissioned. Whilst managing to keep apace, there is a risk that if numbers continue at the rate seen in recent years, that the ICB and providers may not be able to meet statutory responsibilities in relations to SARs and DHRs.

- Workforce capacity to deliver the identified learnings, and best practice guidelines from reviews.

NHS Acute Trusts

Frimley Health NHS Foundation Trust

In 2023/24 Frimley Health NHS Trust's has achievement Level 3 Adult Safeguarding training with compliance at 89% across the organisation. This was achieved due to strong leadership from the safeguarding team and senior nursing staff in clinical areas.

The improvement in training compliance has led to an increased awareness and understanding of adult safeguarding within the organisation and is aligned with the work of the Surrey Safeguarding Adult Board in raising awareness across the community.

An increase in the number of adult safeguarding referrals from the ward suggests an improved knowledge and understanding from staff in highlighting safeguarding concerns such as neglect or an act of omission.

The continuing work between FHFT Adult Safeguarding team, Surrey MASH, and Adult Social Care demonstrates a strong working relationship, with weekly meetings to discuss section 42 cases. This is to ensure correct information is shared, enabling clarification of any queries leading to consistent decision making. FHFT will also be undertaking an internal section 42 audit which will give emphasis on how learning is identified and shared.

9

FHFT commits to ensure hospital staff has the opportunity for continuous learning. Additional supplementary training on Mental Capacity Assessment and the Deprivation of Liberty Safeguards has been arranged to increase staff understanding. The supplementary training is delivered by an external organisation called EDGE Training and facilitated by a barrister who is an expert in this field.

FHFT is an active member of the Surrey Safeguarding Adult Board attending meetings, and Adult Safeguarding reviews. Identified learning is shared across the Trust through the Safeguarding Operational Group, Safeguarding Executive Meeting and Matron and Ward Sisters meetings plus embedded in safeguarding training.

Challenges Faced Moving into 2024/25

- FHFT is an active member of the Surrey Safeguarding Adult Board attending meetings, and Adult Safeguarding reviews. Identified learning is shared across the Trust through the Safeguarding Operational Group, Safeguarding Executive Meeting and Matron and Ward Sisters meetings plus embedded in safeguarding training.

NHS Acute Trusts

Royal Surrey Hospital Foundation Trust

The RSFT Safeguarding Adult Team has continued to deliver high levels of service, specialist signposting and strong partnership working with local agencies to adults at risk of all forms of abuse, but adults with dual diagnoses such as learning difficulties, autism, mental health or long-term physical health conditions.

The Safeguarding Adult Team referral rate has consistently increased with a total of 1106 referrals throughout the financial year 2023/4. This represents a 35% increase in referrals from the previous year. The complexity of these cases continues to increase, in line with the local and national picture. Although most referrals involve adults with care and support needs requiring a referral to Adult Social Care via the Multi-Agency Safeguarding Hub (638 referrals in 2023/24), the Safeguarding Adults Team [illegible] supporting more individuals requiring other referral pathways such as [illegible]lice, Domestic Abuse Outreach (170 referrals) and referrals for assessment of Care and Support needs under Section 9 of The Care Act for self-neglect (169 referrals).

Alongside this the RSFT secured funding in quarter 4 of 2023/24 to continue the role of the Hospital Independent Domestic Violence Adviser (HIDVA) into 2024/25. The RSFT Safeguarding Adult Team received 263 domestic abuse related referrals in this timeframe, of which 152 were supported by the HIDVA, with 58 involving police intervention due to high-risk behaviours and 32 being reviewed at MARAC within Surrey. The HIDVA also provided bespoke domestic abuse related training to clinical staff, via face-to-face domestic abuse modules within the safeguarding adult and safeguarding children's level 3 study days, bespoke training in clinical areas, and specialist support for victims and survivors from minority groups, disabled and LGBTQIA+ communities.

A focus of the RSFT Safeguarding work plan for 2023/24 was centred on improving use of the Mental Capacity Act (MCA) to safeguarding adults at risk. Initial data from the RSFT Safeguarding MCA Audit in 2023 indicated variation in confidence levels across clinical teams in use of the Act in assessing capacity, determining best interests and appropriate use of deprivation of liberty safeguards. This was followed up with a deep dive audit which reviewed more than 200 capacity assessments documented within the medical records of relevant patients.

NHS Acute Trusts

Royal Surrey Hospital Foundation Trust cont.

The RSFT contributed to Adult Safeguarding Week in 2023 through patient, staff and public facing communications throughout the week, with training opportunities available for staff. The team similarly provided safeguarding and HIDVA representation at RSFT wellbeing weeks, facilitating sessions on domestic abuse which resulted in disclosures from staff and members of the public. During November 2023, the Safeguarding Adult Team also facilitated a safeguarding conference at the Royal Surrey County Hospital Site, with 127 attendees in person and attendance from other providers and agencies online utilising a live webinar. The conference focussed on the violence against women and girls (VAWG) agenda, and included representation and signposting from a wider, intersectional approach. Speakers included experts from NHS England, Surrey Police Domestic Abuse Public Protection Unit, SARC (Surrey Sexual Assault Referral Centre), and RASASC (Rape and Sexual Assault Support Centre).

9

The safeguarding team also provide safeguarding services to the R[illegible] Community Hospitals in Cranleigh, Haslemere and Milford, including the Minor Injuries Unit, Outpatient and inpatient areas, along with support and training to Guildford and Waverley District Nursing, Community Matrons, and Allied Health Care Professionals, and wider services across the whole of the South East Coast. This wide remit enables the RSFT Safeguarding team to provide training and support across a large geographical area, ensuring that staff are aware of and able to support vulnerable adults on the peripheries community services that otherwise may not receive safeguarding input. The safeguarding team have gone on to support/ signposting a number of patients, as a result of referrals from these satellite hubs.

Challenges Faced Moving into 2024/25

- The main area of challenge for the RSFT Safeguarding Team is no funding for the essential HIDVA role within the Trust after March 2024 for the financial year 2024/25, with no ongoing assurance for funding going forward. This provided job insecurity for many in the HIDVA role across Surrey, including the RSFT HIDVA. We are very grateful to have the expert knowledge and support of the only remaining HIDVA in Surrey and acknowledge the significant impact that this has and continues to have on outcomes and experience for high-risk victims and survivors of domestic abuse but are concerned that there may not be the financial envelope to continue this work at the end of the current funding. The role of the HIDVA is embedded in policy and practice within the RSFT and is a key resource for the wider community teams.

NHS Acute Trusts

Ashford and St Peters Hospital (ASPH)

The Trust is an active participant of the SSAB, supporting this work through attending the SSAB meetings, Health Subgroup, Safeguarding Adult Review Panel, Safeguarding Adults Review and Learning group and chairing the Policy and Training subgroup.

During 2023/24 the Trust was able to contribute to the strategic plan by streamlining responses to S42 enquiries, disseminating thematic learning from enquiries and working across the multi-disciplinary hospital teams to identify areas of practice improvement.

Close working with the MASH team has seen improved focus on S42 enquiry decision making reducing the burden on both ASC and hospital clinical teams whilst ensuring that the outcomes for the patient are met.

Significant improvements in compliance levels for all safeguarding training has been seen over the year, with an increase of 20% (to 75%) for MCA and DoLS training and an increase of over 20% (to 85%) for L3 Prevent compliance. This has been achieved through close divisional oversight and the increased capacity in the safeguarding team enabling increased training provision being available.

As many safeguarding concerns are raised once the patient has been discharged from the acute Trust, it is not always possible to get this information first hand but understanding the impact on the patient (or their families) is of paramount importance to improving care and this is being used within the hospital as part of ongoing training to improve sharing of learning across the organisation. The close working relationships between the hospital safeguarding team, the adult social care team and the MASH over the year has led to improved, proportionate and consistent decision making relating to S42 enquiries.

NHS Acute Trusts

Ashford and St Peters Hospital (ASPH) Cont.

The Adult safeguarding team supported safeguarding awareness week by spending time with ward staff, highlighting thematic learning identified through S42 enquiries.

Due to the nature of the organisation, raising awareness directly in the community is challenging.

9

Due to the nature of the organisation, raising awareness directly in the community is challenging.

The adult safeguarding team work closely with the community health providers to ensure open and clear communication continues between the two organisations. The work started in 2022/23 relating to community nursing referrals has been maintained and has been a great success, this has had a positive impact on keeping people safe when they are discharged from hospital.

Challenges Faced Moving into 2024/25

- Improving training compliance has been a focus area for the past two years and whilst there have been some significant improvements seen in the past 12 months, maintaining the momentum for continued success cannot be underestimated.
- The hospital domestic abuse outreach service (HIDVA) funding has now ceased which has left a gap in service provision relating to domestic abuse support. This gap is being bridged across the wider safeguarding team and the adult safeguarding team are delivering the domestic abuse training as part of the L3 safeguarding adult session.

NHS Acute Trusts

Epsom and St Helier Hospitals

Continued support with complex cases in clinical areas to maximise the voice of the person at the centre of safeguarding. This includes inviting patient and relevant families to involve them in decisions regarding their care and ensuring that their voices are heard.

Contribution to Statutory reviews, sharing and embedding the learning through training, team meetings and other Trust-wide learning platforms and ensuring action plans are fully implemented. We also observed the national safeguarding week with various activities to raise more awareness and recognition of abuse and effectively responding to it.

9

Creation of a discharge checklist to promote safe discharges and to reduce concerns relating to discharges.

Sharing of various safeguarding leaflets/placing them at vantage points within the organisation, organising a safeguarding conference with good attendance, utilising technology to reach out to al staff members and observing the national safeguarding week with various activities.

Challenges Faced Moving into 2024/25

- Operational pressures causing numerous declaration of business continuity incidents impacted on training attendance, safeguarding supervision and information gathering for safeguarding concerns.

NHS Acute Trusts

Surrey and Sussex Healthcare NHS Trust (SASH)

To support vulnerable adults, families and carers who access services at SASH, a comprehensive training programme educates, informs and supports our large workforce to be able to identify those who are vulnerable and know what to do if they have concerns. We have used learning from statutory reviews and processes to review our practices and make improvements particularly around communication and documentation.

Our compliance of the Mental Capacity Act has improved hugely, ensuring patients are at the centre of decision making, and if they are unable, ensuring this process is as protective and safe as possible for the patient and those closest to them. This is created by improved training, internal guidance and support.

9

We started providing Level 3 safeguarding training for our workforce January 2022, we have managed to go from 0-90% compliance in t short time by implementing an ambitious programme of training days facilitated online and face to face providing training for up to 400 people at any one time

The training is ever evolving with scope to provide external agencies places in the future, and to have external agencies be a part of the day as speakers.

We have been fully immersed in Safeguarding week each year, running awareness campaigns internally, display stands, competitions, mobile roadshow and participating in external campaigns also with partner agencies. During this time, we are particularly active on social media, promoting the priorities and sending out positive messages about safeguarding at work and in the community.

Challenges Faced Moving into 2024/25

- The increasing number of vulnerable adults who do not necessarily fully meet the safeguarding definition neatly, but are extremely vulnerable perhaps due to Neurodiversity, Mental Health or Substance dependency, and being limited as to how much support is available for them.
- Increase in Domestic Abuse cases and the funding ending with no onward commissioning secured for the Hospital Domestic Abuse Advocate/Practitioner to continue the excellent work that was in place 2021-2023.

South East Coast Ambulance (SECAmb)

Over the past twelve months there has been increasing challenge to SECAmb's mental capacity practice – the challenge has come from Coroner's inquests and a recent SAR. The Trust has developed a plan to address these concerns.

Actions to address these deficits include:

- Training – focus on ability to make a decision and whether patients can carry out what they say they want to do.
- Focus on impact of executive functioning on mental capacity assessment
- Two-minute briefing on Executive Functioning to raise profile of assessing capacity in practice
- Reported into Quality Governance Group and Quality & Patient Safety Committee
- Working in partnership with students at Bexhill College to produce a short film focusing on the principles of MCA and Executive Function
- Regular attendance at local operational meetings to raise the profile of MCA, Best Interest Decision Making
- Electronic Patient Care Record update now includes the ability to better evidence MCA assessment and best interest decision making
- During 2024/25 the Trust's Clinical Audit team will undertake a review of current MCA practice .

SECAmb's Safeguarding Team became aware of a gentleman who was calling 999 with the sole purpose of being conveyed to hospital (without clinical need), to access his wife who was an inpatient. His wife had been admitted a few days before the first call, having been found at home in a very poor condition due to her unstable diabetes, and abuse and neglect over a period of time by her husband.

Multi-agency working involved meetings with SECAmb, the hospital, Police and adult social care.

Plans were put in place; the wife was kept safe in the hospital with their own security plans. A marker on the husband's address and created a plan for clinicians to discuss any calls with the Safeguarding On-Call line to determine if conveyance was necessary for clinical care and if so, whether he should be conveyed to a different hospital. SECAmb and the hospital Safeguarding Team kept in regular contact with weekly meetings.

SECAmb went on to receive 8 to 10 further calls from the husband, the plan was triggered and – when challenged – he mostly admitted that there was nothing wrong and he just wanted access to his wife. SECAmb played a significant part and worked well with other agencies to ensure the lady's safety.

Southeast Coast Ambulance (SECAmb) Cont.

As a regionally commissioned organisation SECAmb have responsibilities to numerous Boards and Partnerships across Kent, Surrey & Sussex; unfortunately, there isn't the capacity to drill down its safeguarding activity to produce localised awareness raising of each individual board and partnership.

The primary role of the ambulance service is to respond to urgent, emergency, and critical situations; recognising safeguarding concerns is generally a secondary responsibility. However, SECAmb clinicians will recognise and escalate safeguarding risks to adults and children in line with guidance based on the thresholds outlined within local multi-agency safeguarding policies and protocols.

9

Challenges Faced Moving into 2024/25

- The Safeguarding Team will continue to work closely with operational colleagues across all its services to further develop the Trust's practice in the MCA and executive functioning as highlighted in Section 2 above.

Community Providers

First Community Health & Care (FCHC)

First Community have provided consistent and proactive attendance and contribution at the SSAB Meeting and subgroups and have supported the Board in all their strategic priorities. The Adult Safeguarding Lead has been on a number of task and finish groups including the Policy and Procedures Group, Pressure Ulcer Decision Tool and the Safeguarding Adults Week task and finish group; we also had frontline staff attending the Boards conference in November 2023.

First Community has shared learning from Safeguarding Adults Reviews and been panel members on two Domestic Abuse Related Death Reviews. We have continued to ensure that safeguarding Adults remains high on the agenda and that we have a robustly trained work force who have the knowledge and skills to identify and support individuals and their families with safeguarding concerns.

9

First Community have embedded a clear routine enquiry process within the organisation to increase opportunities for people to disclose domestic abuse. Training, guidance and a recording template have been rolled out to support staff with asking about domestic abuse. An audit completed in September 2023 has demonstrated that routine enquiry was asked in 45% of first attendances (up from 17% in previous audit.

First Community has prioritised a 'Think Family' approach to safeguarding with a joint adult and children safeguarding workplan and a cohesive working relationship. We have provided joint adult and children safeguarding sessions and jointly deliver our domestic abuse training which highlights the impact of domestic abuse on the whole family.

Community Providers

First Community Health & Care (FCHC) Cont.

The First Community Safeguarding Champion role is now well established, and we have continued to recruit new enthusiastic and passionate champions who are keen to support the safeguarding agenda. Presentations from multi agency partners has supported the champions professional development and an increased understanding of safeguarding with a multi-agency approach.

First Community Adult Safeguarding Lead and the Safeguarding Champions supported Adult Safeguarding Week in November 20[illegible] by jointly hosting a stall in the Belfry Shopping Centre (Redhill) conjunction with SSAB, Surrey Police and Surrey Fire and Rescue. Discussions were had with the general public and SSAB information and merchandise was handed out to help raise awareness of Adult Safeguarding for the local population.

9

Challenges Faced Moving into 2023/24

- Ensuring that the Mental Capacity Act is well embedded and evidenced in clinical practice.
- Ensuring that Making Safeguarding Personal is embedded and evidenced in clinical practice. Capturing the outcomes wishes of the individual can be difficult to achieve in the healthcare role.

Community Providers

CSH Surrey

CSH have worked together with partner organisations to ensure service users are protected from harm.

Priority 1: Prevention and Awareness

Referrals: The safeguarding adult activity has remained at an increase in 2023/2024 with a total number 503 referrals being completed and sent to the local authority. These figures are on par with the 536 referrals made in 2022/2023. The increase in the referrals being raised by CSH reflects increasing staff knowledge and awareness of their responsibilities in this matter. The common themes included neglect, self-neglect, and domestic abuse, which were no different to the previous year.

DOLS: There has been a consistent number of DOLS applications made by staff over the reporting year. This is positive and signifies staff's knowledge base and confidence on MCA and DoLS.

eguarding Adult Training: The Level 3 Adult SG training continues to take place bi-monthly face to face. However, within Q3 the training was cancelled by the SG team, due to the low numbers of clinicians booked on the training session we have seen compliance fall below the target of 85%. Safeguarding Training is being reviewed with CSH, the training strategy and a trajectory will be a priority for 2024/2025.

Priority 2: Communication and Engagement

S42s: Over the year CSH have contributed to the S42s, which were completed by the safeguarding advisors. It was found that the common themes related to medication errors, and or deferred appointments for wound care. The Learning from Section 42 Enquiries is presented at the bimonthly Safeguarding Working Group and on monthly quality dashboard. Any required actions identified from Section 42 Enquiry continue to be recorded and monitored on Datix. However, to mitigate the risks and ensure learning is firmly in place there needs to be a multi – agency approach. The nurse consultant has liaised with ASC to look at how they can work together and progress this work in 2024/2025.

Priority 3: Quality and Improvement

Partnership working: Adult Safeguarding Team have continued to attend local and regional safeguarding networks and committees the following meetings on behalf of CSH, which are held quarterly; SSAB Health Forum; SSAB Policy and Training Subgroup; ICB Domestic Abuse Health Steering Group; ICB MCA Steering Group; Prevent Regional Meetings; Monthly networking meetings with ASC Locality Teams and Weekly networking meetings with MASH.

Community Providers

CSH Surrey Cont.

Priority 4: Reflection and Learning

Safeguarding Reviews: The safeguarding team has proactively engaged in the Safeguarding Adult Review meetings in surrey. Any learning, both local and national, is embedded within the CSHs safeguarding training to ensure that patients who receive Trust services are safeguarded from abuse.

Making Safeguarding Personal Audit: An audit was completed by the adult safeguarding team, the premise was to look at making safeguarding personal. What the audit did evidence was that staff are able to raise a concern and refer to the local authority. There were 308 safeguarding concerns identified by CSH services. In 169 of the 308 identified concerns, the patient or representative was informed about raising the concern. In 130 of the 308 identified concerns, the staff discussed with patient/representative the desired outcome of the referral. The data collected within this audit did not capture information which reflected an individual's wishes and thoughts, beyond the point of the safeguarding referral.

The objective was for the staff listened to the patient's voice throughout the safeguarding process. To ensure we can evidence as an organisation we are listening to patient's voice and making safeguarding personal. In Q2 for 2024/2025 there will be a second phase of this audit where the focus will be on a smaller pool of cases looking MSP questions where we will focus on the voice of the patient and their journey, including other practitioners involved within the care of the patient; looking at evidence of MSP within the patients notes.

Patient Safety Incident Response Framework: The implementation of PSIRF has been one of the key priorities for the strategic delivery plan for 2023/2024. The aim of PSIRF is to explore how to respond to patient safety incidents for the purposes of learning and improving, with a compassionate engagement and involvement of those affected by patient safety incidents. It is vital that both Patient Safety and Safeguarding work in partnership. There is always learning in practice on how we manage and respond to abuse. This will help teams work together, to look at how we can learn from incidents to safeguard our patients, when providing care and treatment and whilst embedding a Just culture. The PSIRF plan was presented to the ICB and received positively.

Community Providers

CSH Surrey Cont.

The Safeguarding Team along with the Patient Safety team have presented a case for the learning to the ICB, which focused on an allegation of theft this case highlighted good practice, where a safeguarding concern was appropriately raised, a Datix was completed, police involvement, patient safety and a safety huddle initiated and S42. This has been received positively by the ICB and there has now been a request to present this to NHS England for wider learning.

9

allenges Faced Moving into 2023/23

- CSH has recognised that the provision around services offered to our patients with learning disabilities needs significant improvement. A learning disabilities strategy is being developed under the NHS benchmarking standards, to look at compliance across the organisation about how we manage our vulnerable patients with learning disabilities at CSH work which will completed working with SABP the work is being led by our deputy director of quality/chief nurse. This will help our staff to be aware on how to manage LD patients within our service and our patients with vulnerabilities receive appropriate care under the NHS benchmarking standards.

- Think family is part of the strategic delivery plan, this is firmly embedded across children's services there is presently nothing in place across adults. Think Family is key as it aims to identify the needs for the whole family. The impact on children/siblings, through vulnerabilities faced through the adult/carer can have an impact and it is vital health care professionals are aware of this so the risk can be identified. The profile for think family within adults has been raised across CSH within safeguarding adults' week, with safeguarding adults training, within safeguarding champions meetings and with the safeguarding children, devising 7-minute briefings and adults team working integrated the work is ongoing.

District & Borough Councils

Waverley Borough Council

Community Services Manager Chairs the Borough and District Safeguarding Leads meeting in conjunction with SSAB and SSCP.

A council representative contributes to the Quality Assurance Subgroup.

The council completes and submits the Quality Assurance Questionnaires as requested.

We have been working with services across the council to review the recording and monitoring of safeguarding concerns / referrals and cases ensure safeguarding is embedded into their service and all officers are aware of their responsibility.

9

Safeguarding sessions have been delivered to services across the council highlighting ASC thresholds and as a partner organisation actively own / manage cases, particularly for those who do not have a care and support need or those who could require an assessment.

We encourage managers and staff to attend learning event webinars for Safeguarding Adult Reviews and also disseminate learning through the operational safeguarding group for members to cascade to their services.

Introduced an Operational Safeguarding Coordinator to work directly with services and with front line officers and lead in coordinating multi-agency interventions where necessary.

District & Borough Councils

Waverley Borough Council Cont.

A key area of change/improvement has been the establishment of safeguarding case meetings (WBC organised and led) to support the management of complex cases and bring all the partners/agencies together. This includes adults with identified care and support needs and adults.

Establishment of a central safeguarding operational group whose primary role is to review all safeguarding cases across the council on a monthly basis.

Operational Safeguarding Coordinator to work directly with services and with front line officers and lead in coordinating multi-agency interventions where necessary.

Awareness raising of the work and role of SSAB is to our staff team through articles on our by weekly cascades and sharing of relevant information

Campaigns or awareness raising from SSAB that are for the community are cascaded through our social media channels, such as Twitter / Instagram ad Facebook.

Challenges Faced Moving into 2024/25

- The council is still seeing an increase in safeguarding concerns for residents and tenants who are self-neglecting / hoarding / significant mental health issues, substance misuse and domestic abuse. This cases are complex, put pressure on resources and take up significant officer time when working with partners to achieve a positive outcome.

HMP Prison and Probation Service

All members of staff are required to complete Adult Safeguarding Training (4 hours classroom training) within the first 6 months of joining the organisation, with a refresher expected every 3 years.

This course aims to increase confidence and competence in the identification and management of complex risks and vulnerabilities, whilst operating in line with relevant legislative frameworks. A range of case studies are used to explore a series of complex adult safeguarding concerns in the context of probation practice, promoting the application of professional curiosity and person-centred approaches throughout.

Safeguarding and Police checks are made on all people managed by the service, within the first 15 days of sentence and can lead to Adult Safeguarding referrals being made, dependant on the information received.

HMIP feedback shared that: Positive and effective practice was shared w the introduction of "safeguarding heroes". This was used by leaders emphasise positive work done in public protection, drawing on examples of effective practice and was supported further by the use of staff reward and recognition.

9

User Voice, working with HM Inspectorate of Probation, had contact with 56 people on probation as part of this inspection. 38 out of 50 respondents indicated that practitioners were taking the time in induction meetings to understand the personal needs of the person on probation. This set a good foundation for supervision with the large majority of respondents stating that they understood what was expected of them whilst on probation (48 out of 51). "My induction was very informative with regards to alcohol groups and housing. There was information that was shared which was more than what I was expecting".

Promotion of Adult Safeguarding Week to all members of staff.

Safeguarding Adults related themes are shared at team meetings alongside learning from DHRs/ SARs and internal audits.

Challenges Faced Moving into 2024/25

- Workload and staffing pressures, particularly for qualified Probation Officers remains a challenge nationally for the Probation service, with recruitment campaigns ongoing.

Third Sector Agencies

East Surrey Domestic Abuse Service (ESDAS)

ESDAS has supported the board through DARDR and SAR's including developing learning events and the implementation of subsequent recommendations. ESDAS' CEO sits on the Surrey Safeguarding Adults Board and regularly works closely with the board around their policies, procedures and training.

Advocating for the voices of survivors with Care and Support Needs

Strong partnership working with SSAB and wider partners

9

Delivered Safeguarding Adult training to staff and volunteers

Supported SSAB in developing and/or delivering training

Challenges Faced Moving into 2024/25

- Increase in demand for our services as well as increased complexity of cases.
- Uncertain funding levels after 31st March 2025.

Third Sector Agencies

Luminus

We have been an active member of the SSAB, supporting the Board by being a "critical friend", ensuring that the involvement of people with lived experience is considered. During the year we amplified the voices of vulnerable adults in Surrey by summarising all the experiences that have been shared with Luminus via our work on Healthwatch; Giving Carers and Voice and the Combating Drugs Public Involvement Service. We produced a report which was shared and discussed with SSAB, Adult Social Care partners, and the Adults and Health Select Committee. This report referred back to a series of "recommendations" in our report on the lived experience of going through a safeguarding enquiry, published in 2019. The Adults and Health Select Committee used the report as part of their scrutiny of Surrey's adult safeguarding performance.

9

Our whole team has been trained in adult safeguarding, and we have refreshed our safeguarding policy. This ensures that all our staff when out and about engaging with the public are trained to listen with curiosity, spot and be confident in handling safeguarding issues. Where appropriate, we will explain safeguarding to members of the public.

Luminus is part of the Voluntary Community and Social Enterprise Leadership Group (VCSE), and we have worked this year to link SSAB officials up with that group to raise awareness to the charities working in frontline roles. Charities can also feed back to SSAB as to whether the comms materials are appropriate and relevant to their clients.

We have also worked to raise awareness of the work of SSAB with our Citizens Advice partner

Challenges Faced Moving into 2024/25

- The key challenge facing us is that people have low awareness of our existence and will not seek us out to leave feedback about safeguarding in Surrey. So it is challenging for us to gather insight.
- A second challenge is that when we do escalate a concern to MASH, we often do not get an acknowledgement or any feedback on whether our escalation was appropriate – so it is hard for us to learn and develop in this respect – or to have confidence that an escalation has been acted on.

Police and Crime Commissioners Office

Tailored support for adults experiencing multiple disadvantage: The PCC is working collaboratively with partners to fund specialist outreach workers to better support adults in Surrey experiencing multiple disadvantage. This is part of the Bridge the Gap initiative, led by Public Health as a collaborative effort involving several third-sector providers in Surrey who can support people experiencing a combination of challenges. These include contact with the criminal justice system; mental health issues; substance use; homelessness (or at risk of); and domestic abuse. Such an individual will likely have been in touch with many services, but due to complexities in their needs, can often slip through the gap or be tossed about from service to service, thereby compounding their issues, and making it difficult to access the right support. The PCC for Surrey, Surrey County Council, and a range of public service agencies and voluntary sector providers have come together to ensure co-ordinated, trauma informed and tailored support helps people to rebuild their lives and engage positively in the community.

Positive action against drug criminality and protecting vulnerable people: The PCC is co-commissioning with Public Health, a vital specialist outreach service to support victims of 'cuckooing' – a term used when someone's house is taken over for criminal activity, including dealing drugs or carrying out sex work. Victims of this predatory and exploitive practice can include people experiencing addiction, mental health issues, or with learning disabilities and can become prisoners in their own home. The service to date has taken nearly 500 referrals as part of countywide efforts to prevent this harm and to deter and disrupt perpetrators in Surrey. The service works alongside people to understand what is needed to best support them, undertaking work to help build their resilience if at risk or being cuckooed. By responding early, we are protecting and safeguarding some of the county's most vulnerable people, helping to prevent the risk property closures and minimising impact on the whole community.

Challenges Faced Moving into 2024/25

- Implementing the Serious Violence Duty is a challenge for the specified authorities. Surrey has formed a Serious Violence Reduction Partnership, with the PCC convening partners to support the right services being in place and targeted activity undertaken to prevent harm against both adults and children in Surrey.

Buckinghamshire and Surrey Trading Standards

- The total resident impact of Trading Standards disruptions is £13,867,211.
- Trading Standards interventions Health and Social Care impact £1,1,892,710.
- Trading Standards interventions residents' impact £3,402,678.
- The Prevention Team installed 22 door cameras into the hom of vulnerable residents being targeted by in person doorstep scammers.
- The Prevention Team installed 118 call blockers into the homes of vulnerable residents being targeted by cold calling fraudsters.
- The call blockers stopped 52,635 scam/nuisance calls originating from both national and international call centres.
- The call blockers saved Health and Social Care £1,053,962
- The call blockers prevented losses of £1,951,782.
- Supported 1,006 vulnerable residents saving £1,340,894.

Buckinghamshire and Surrey Trading Standards Cont.

During 2023/24 we undertook three monthly feedback questionnaires from Service users, and received the following feedback:

"I much appreciated your visit and that the call blocking device will bring more peace of mind. I had not realised just how supportive Trading Standards are, the feeling of isolation in the first instance cannot be stressed too much, but now I know how to access some support I feel better. Many thanks."

"The Truecall device has made such a difference to my elderly mother (98) and my disabled sister (70) as they can now answer the phone with confidence. As their carer I have peace of mind knowing that nobody can get through who they don't know. They were victims of a scam and the phone is now one thing I do not have to worry about. Thank you."

"Has been great. Disabled husband - don't need him stumbling to take rubbish calls."

"My life has been transformed. Now I know when the phone rings that it will be someone I know. All the regular harassment has been stopped."

Buckinghamshire and Surrey Trading Standards Cont.

Organised multiple events including delivery of 4 Safeguarding webinars utilising BSL and subtitles and partnering with Squires Garden Centres to set up multiagency advice drop in centres as part of Adult Safeguarding week.

Developed multiple materials and resources in easy read format.
Trading Standards - Surrey County Council (surreycc.gov.uk)

Have trained a total of 27,114 members of the public to be 'Scam Champions' or equivalent who in turn delivered numerous talks and presentations to community groups, organisations, places of work and sheltered housing.

Challenges Faced Moving into 2024/25

- Resources. Reductions in staffing levels mean maintaining this level of service for our residents will be extremely challenging.
- Engagement and Information Sharing between partners.

Surrey Prevent (Counter-Terrorism) and Channel Panel

The UK government's counter terrorism strategy, CONTEST, is made up of 4 strands:

- Pursue
- Prevent
- Protect
- Prepare

The aim of the Prevent strategy is to reduce the threat to the UK from terrorism, by 'stopping people becoming terrorists or supporting terrorism'.

Prevent focuses on all forms of violent extremism and terrorism and is a multi-agency approach to safeguarding and prevention.

The Counter Terrorism and Security Act 2015 introduced a new Prevent Duty. Specified authorities must have "due regard to the need to prevent people from being draw into terrorism".

It also introduced a duty for local authorities to provide support for people vulnerable to being drawn into terrorism, through Channel Panels.

Channel Panel is an early intervention scheme that supports people who are at risk of radicalisation and provides practical support tailored to individual to protect and divert them away from being drawn into terrorism.

Surrey Prevent (Counter-Terrorism) and Channel Panel cont.

In Surrey, Channel Panel hold monthly multi-agency meetings Chaired by Surrey County Council.

Between April 2023 to March 2024,

- 66.6% of the adults known to the Channel Panel had care and support needs. (Approximately the same on 2022/23)
- 44.4% of the adults known to the Channel Panel were also known to adult social care. (decrease on 2022/23)
- 55.5% were known to adult mental health services. (decrease on 2022/23)
- 44.4% had care and support needs related to mental health issues. (decrease on 2022/23)
- 22.2% had care and support needs related to substance misuse issues. (Increase on 2022/23)
- 33.3% had care and support needs related to autism. (Approximately the same on 2022/23)

This page is intentionally left blank