CITY OF YORK

# Safeguarding Adults Board

## Annual report 2021/2022

# Contents

Introduction to City of York Safeguarding Adults Board Annual Report

It is my pleasure to present the Annual Report for 2021/22 and highlight just a few of the key points of progress over the last twelve months.

The SAB is not an executive Board responsible for the delivery of services (like a hospital Trust Board) but an independent body assuring itself as far as possible that safeguarding services in the City of York for vulnerable adults are robust and collectively meeting statutory guidance.

I have been Chair of the Board for the last four years and during unprecedented times, with nearly half of that time in the unique situation that the City of York and of course the whole country was struggling to deal with the coronavirus pandemic.

The pandemic has created huge pressures across the health service & social care and as result the impact on adult safeguarding has and will be considerable for some time to come. We have seen considerable increases in demand over this twelve-month period, however I would urge people if they have concerns about a vulnerable adult please do not hesitate to report them.

The Board has an updated strategic plan which can be read on the new Adult Safeguarding website https://safeguardingadultsyork.org.uk

The website has information on a range of differing forms of abuse and if anyone has any doubt about a safeguarding issue then it can be a very useful source of information.

Within the last twelve months two Safeguarding Adult Reviews have been published and there is a third subject to investigation.

Safeguarding Adult Reviews (SARs) are a statutory duty under the Care Act for Safeguarding Adults Boards (SABs) to undertake.

This is when:

- an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

- an adult is still alive but has experienced serious neglect or abuse and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of having a Safeguarding Adult Review is not to reinvestigate or to apportion blame, it is to:

- establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults,
- review the effectiveness of procedures,
- inform and improve local inter-agency practice,
- improve practice by acting on learning, and,
- highlight good practice.

The reviews are published on the website and the Board has the responsibility to ensure the recommendations are then completed https://safeguardingadultsyork.org.uk/sars

As a Board we currently have concerns not only about the demand placed on those charged with delivering safeguarding services but also the increase in complexity of those cases.

Against that background I would like to pay tribute to my colleagues on the Board and everyone concerned in delivering frontline safeguarding responses in the City of York. Their professionalism and commitment ensures that some of the most vulnerable adults in the City are properly protected from harm.

# INTRODUCTION TO THE ANNUAL REPORT

NHS Vale of York Clinical Commissioning Group – Partner Contribution to City of York Safeguarding Adults Board Annual Report 2021-2022

NHS Vale of York Clinical Commissioning Group (CCG) has been proud to be a statutory partner of the City of York Safeguarding Adults Board. The CCG Chief Nurse has Board membership as the CCG Executive Lead for Safeguarding and as such has provided members with regular updates on the delivery and huge success of the Covid-19 vaccination programme and the forward plan for the current and future delivery of healthcare for the City of York and North Yorkshire in the new Integrated Care System. The Designated Professional also attends the Board and has played an active role in multiple workstreams, chairing partnership subgroups and supporting multiple safeguarding enquiries and learning reviews.

CCG transition to Integrated Care Board (ICB)/Integrated Care System (ICS) – Humber and North Yorkshire Health and Care Partnership.

The Health and Care Act places the Integrated Care Board (ICB) and Integrated Care Systems (ICS) onto a statutory footing from 1 July 2022 replacing CCGs as the statutory partner for safeguarding. Throughout 2021-2022 the previously established Humber, Coast and Vale Safeguarding Health Professionals Network have worked with the ICS Interim Chief Nurse to develop a proposal for a safeguarding structure and leadership arrangement across the ICS. The draft arrangements were subsequently approved by the ICB Executive and by NHS England in October 2021. Central to the new arrangements has been recruitment to a transitional lead role to embed safeguarding as priority; maintain momentum and progression; and provide ongoing and future assurance to partners. From 1 July 2022 the CCGs will close down and statutory safeguarding responsibilities will transfer to the new organisation Humber & North Yorkshire Health & Care Partnership (humberandnorthyorkshire.org.uk)

## Safeguarding in Primary Care

Safeguarding training has been delivered to almost 1000 staff working in primary care settings across York and North Yorkshire. As Primary Care Networks (PCNs) have become established with new roles in care co-ordination and social prescribing, so the reach of the training to frontline practitioners has expanded. Topics in the 2021/22 programme have included making effective safeguarding referrals with a particular focus on capturing the voice of the adult and making safeguarding personal. Building on learning and a recommendation from a North Yorkshire Domestic Homicide Review Emma www.nypartnerships.org.uk/dhr NHS Vale of York CCG published a new stand-alone Domestic Abuse Policy for CCG employees and for GP Practices/Primary Care. Learning from the review has been shared extensively across health networks and training in the 2022/23 programme for Primary Care includes a focus on the new Domestic Abuse Act, the new Domestic Abuse policy and how to identify and respond to cases of domestic abuse in practice situations. In response to lack of knowledge and poor application of the Mental Capacity Act being a regular feature in learning reviews, a narrated presentation on the practical application of the Mental Capacity Act in Primary Care was developed in 2021 by the Named Nurse. The content and format of the presentation have been positively received by practitioners. The Primary Care Safeguarding Training Guidance has also been updated providing a valuable reference for Primary Care staff to identify what level of training they require to meet the safeguarding duties and responsibilities of their roles.

## Health Partners

The Health Partnership Group has continued to meet virtually on a quarterly basis providing an effective platform for discussion of local and national safeguarding issues and a mechanism for sharing best practice. The Health Partnership Group have established a safeguarding supervision forum over the last year providing a safe space for specialist practitioners to bring complex issues for discussion with their peers. The partnership has been strengthened with the inclusion of military health colleagues and in October 2021 Designated Professionals presented at a Military Safeguarding Conference covering issues from both the children and adult safeguarding agenda to raise awareness and support colleagues in their vital roles in military families and communities. A bi-annual dedicated safeguarding training and peer support group for

private providers of health care is now well-established and connectivity is expanding year on year. Presentations to the group this year have included domestic abuse, self-neglect, and the Mental Capacity Act. Health groups are supported through sharing of a Safeguarding Adults Bulletin which is positively received for bringing together key issues in one place and reducing email traffic for busy practitioners.

Care Homes and Safeguarding

Support provided to care homes and domiciliary care providers has been a significant feature of the work of CCG in 2021/22 and the Partners in Care network has expanded to include a new quarterly forum designed specifically around the needs and challenges of care providers who support those with learning disabilities and autism. A particular success has been the roll-out of the Immedicare service delivered in partnership with Airedale NHS Foundation Trust and technology experts Involve Visual Collaboration Ltd. The service offers video enabled clinical support for care homes, allowing care homes to connect directly with a clinical hub offering medical advice and guidance 24/7, 365 days/year. The service allows frail and elderly residents to be clinically assessed in their own surroundings, lessens anxiety, and helps to prevent unnecessary visits to hospital and long waits. The service offers care homes an extra layer of resilience and builds staff confidence and most importantly addresses health needs in a timely way reducing the risk of neglect.

The Designated Professionals and Nursing and Quality Team have continued to work closely with partners to address safeguarding and quality concerns in a small number of care homes whilst also working strategically to address risks and learn lessons from emerging themes, trends and safeguarding reviews. Implementing the recommendations from a Review completed into the learning from a care home closure will be a key priority in 2022/23.

Learning disability and autism safe and wellbeing reviews

As part of the NHS response to the Norfolk Hospital Cawston Park Safeguarding Adults Review (SAR) concerning the deaths of Joanna, Jon and Ben, a national review has been undertaken to check the safety and wellbeing of all people with a learning disability and autistic people who are being cared for in a mental health inpatient setting. Working with partners NHS Vale of York CCG completed 100% safe and

wellbeing reviews within the tight timescale that had been set providing necessary assurance and achieving a priority focus on addressing any concerns for individuals that were highlighted. Transforming Care – Mental Health, Learning Disability and Autism is an ongoing key programme of work for the ICS and more information is available at

Humber & North Yorkshire Health & Care Partnership (humberandnorthyorkshire.org.uk)

Liberty Protection Safeguards

The Mental Capacity (Amendment) Act 2019 introduced Liberty Protection Safeguards as a proposal to replace the current system in place for authorisation of Deprivation of Liberty. The CCG have been working with regional colleagues to respond to the Government consultation on the new Mental Capacity Act Code of Practice which includes the provision for Liberty Protection Safeguards. The new proposals include significant changes to the current processes and represent key changes for the most vulnerable in our care. This will be a priority focus of work for 2022/23 with potential for implementation of key system changes during that time.

LeDeR – Learning from Lives and Deaths

This programme is now in its fifth year and on 23rd March 2021, NHS England published their first LeDeR policy 'Learning from lives and deaths-People with a learning disability and autistic people' (LeDeR). This policy, set out for the first time for the NHS, the core aims and values and the expectations of different parts of the health and social care system in delivering the programme from June 2021. The policy also introduced the inclusion of autism into the programme which came into effect in January 2022. The policy including as easy read version can be found at: https://www.england.nhs.uk/learning-disabilites/improving-health/mortality-review/

Individuals with a learning disability, their families and carers, have been central to the development and delivery of the programme both nationally and locally. LeDeR reviews continue to be cognisant of other review processes such as Safeguarding Adult Reviews (SARs) and the Serious Incident Review process to reduce distress to families and carers and avoid duplication wherever possible. The death of an individual with a learning disability does not automatically trigger a safeguarding response, however, at any point through the LeDeR review

process, if safeguarding concerns are identified, the local area safeguarding process would be followed. The first combined Annual Report for the six CCGs in Humber and North Yorkshire for 2021/22 will be published on the website from July 2022

Humber & North Yorkshire Health & Care Partnership (humberandnorthyorkshire.org.uk)

## City of York Council Annual Report update

Over the last year City of York Council has strengthened its approach to safeguarding adults through additional recruitment of dedicated safeguarding staff. This is enabling us to both manage increased demand and strengthen our processes. This means there is now more dedicated resource to support enquiries including those being undertaken by partners so that we ensure the quality and timeliness of these.

Alongside this a new safeguarding adults campaign has been launched and this is encouraging everyone in York to help prevent and stop the abuse of adults by learning more about it.

The council's 'Know the signs' campaign is urging people to learn more about the different kinds of abuse which adults can face, how to spot the signs of it taking place and, if seen or suspected, how to report it.

There is an increased focus on making safeguarding personal. As we have emerged from lockdowns related to the pandemic we are increasing our face to face contacts to support people at risk in our community. Alongside our colleagues from the integrated care board, we are undertaking more proactive visits to care settings, encouraging improved and earlier reporting of concerns from staff relatives and residents.

City of York Council has had a real focus on learning and changing practice this year. New systems have been introduced to track and collate all feedback, complaints, issues from Safeguarding Adults

Reviews, and performance information, turning these into learning opportunities for front line staff and managers. These learning opportunities have included improving how we use the mental capacity act and transitional safeguarding.

City of York Council – Public Health update

The City of York Council have developed a Local Domestic Abuse Partnership Board in response to the local authority statutory requirements within the Domestic Abuse Act. This has led to the development of a joint Safe Accommodation strategy with NYCC, in addition to the commissioning of an in-depth needs assessment to assess local safe accommodation provision and provide recommendations for a public health preventative approach to domestic abuse. Adopting this preventative approach to DA will support in addressing continued increases both reported DA incidents by North Yorkshire Police and referrals to specialist services following the pandemic. Through further strengthening partnerships with NYP, CYC now received ward level data on DA recorded incidents and crimes to aid with targeting preventative resources more effectively. CYC have also commissioned additional resources within the IDAS Hub to assist with effectively managing the increase in referrals, whilst also commissioning multi-agency training to professionals across the city to support with aiding understanding with identifying signs of abuse, including coercive and controlling behaviour.

City of York Council have also obtained White Ribbon UK Accreditation, highlighting their commitment to tackling male violence towards women. This work has included the development of a three year action plan that will include work regarding internal HR processes, working with licencing relating to providing DA support to entertainment venues and working with schools to include DA within the health relationships aspect of the Relationships and sex education (RSE) and health education curriculum.

City of York Council – Public Protection update

Public Protection is the City of York Council's name for the environmental health, trading standards and licensing services. Our officers have been trained to identify and report the signs of abuse as they undertake their activities.

Trading standards officers receive reports of scams and try to prevent people becoming victims of them. We have seen many new scams emerging through the pandemic from cures and treatments to the virus itself, as well as more traditional scams simply targeting people who have become more isolated and vulnerable at home. In the last year, officers have been providing talks to community groups about scams to help them ‘spread the word’ of the signs to look for. We have also been working, with Trading Standards colleagues in the Yorkshire and Humber Region, at improving the information we receive on potential financial abuse and personalising our response to their situation.

Environmental health officers undertake visits at restaurants, take-aways and other premises in the city. Officers are busy inspecting the hundreds of premises which could not be visited during covid lockdowns and whilst they are looking to ensure the food being served is safe to eat, and things like allergens are properly labelled they are also looking for signs of potential modern slavery and abuse.

Licensing officers issue licences that many businesses are required to hold to trade, but have also introduced a number of initiatives to help safeguard vulnerable adults. The team have been working with the police to improve the safety of women and girls in the night-time economy. Work includes helping to prevent the spiking of drinks, and promoting the ‘ask for Angela initiative’ through which someone in need can discretely ask staff at the premises for help.  The Taxi Licensing team have strengthened the compulsory safeguarding training given to drivers in respect of the signs of ‘county lines’ abuse. We have also undertaken a survey which identifies a shortage of taxis in York and have undertaken a publicity campaign and free training programme to successfully increase the number of taxi drivers. We are working towards increasing the number of hackney carriage vehicles in the city by the end of the year.

Since January 2020, when the United Kingdom's first coronavirus cases were identified, the pandemic has been a significant and highly unusual factor in policing. As lockdown restrictions were eased in 2021, NYP were able to review, develop and implement new practices which enhance and strenghten existing teams.

The Partnership Hub within NYP hold the portfolios for Community Safety, Mental Health, and young people.

Some of their highlights are as follows.

- The operational mental health advisor team is specifically to offer help and support to their colleagues when they are dealing with crimes and incidents where mental health is a factor. There is an officer allocated to each command area.
- The Hate Crime team review all hate crime reports to ensure victims receive the best service including those crimes being investigated by colleagues. Training is also offered to colleagues and outside agencies.
- The Problem-Solving Team (PSP) and Problem-Solving Champions provide a force wide resource across the three command areas which includes the City of York with the primary focus on facilitating a multi-agency collaboration to solve local problems. Dedicated officers are assigned from Serious and Organised crime, Domestic Abuse, Sexual Abuse and exploitation and Fraud.

The Safeguarding Team within NYP have Portfolios that cut across all areas of Policing, some of those being Domestic Abuse Stalking and Harassment, Sexual Violence and Abuse (Safeguarding) Child abuse and adult abuse, MAPPA (Police and Probation), MATAC (Multi-Agency Tasking and Coordination) and MARAC (Multi-Agency Risk Assessment Conferences for high-risk domestic abuse teams) the list is not exhaustive.

Highlights include.

- A new Stalking team has been established to offer advice and support to officers investigating crimes of stalking and harassment. Stalking investigations can be very complex and involve some of the most vulnerable people in our community and so the team have introduced 'Stalking clinics' to ensure officers are maximising opportunities within investigations.
- Over the last year North Yorkshire Police, alongside partners IDAS (Independent Domestic Abuse Service) HMCTS (Her Majesty's Courts & Tribunals Service) Edgehill University and CGI have

been working collaboratively as part of ‘Project Shield’, a multi-agency pilot scheme aimed at preventing harm by delivering an improved service around the enforcement of non-molestation orders. This Pilot will be fundamental in joining the dots between civil and criminal courts and the use of technology in protecting victims from domestic abuse and preventing further victimisation.

The main objectives of the pilot include:

- Improve the Safeguarding services offered by North Yorkshire Police, Courts, and its partners to victims/survivors of domestic abuse.
- Publish Non-Molestation Orders (NMO) on the Police National Database (PND) so they can be viewed by police forces nationally regardless of the area they were obtained.
- Record and evidence the fact the NMO has been served on the respondent to remove ambiguity or defence that could frustrate positive police action.
- Link NMO’s to other records held in PND to support investigations, identify, assess, and manage risk and assist frontline staff to intervene sooner.
- Using the national Police National Database, explore the possibility of using the current search capability to create a national NMO register.

North Yorkshire Police has carried out the administration effort for Safeguarding Week 2021 when a new format had to be found to deliver the content for both safeguarding professionals and members of the public. This resource was again provided in 2022 when across the safeguarding partnerships of county, city and East Riding 55 on-line learning sessions were scheduled for the week 20-24 June. The safeguarding content was wide-ranging and provided a great opportunity for professional and public engagement. Over 3,500 attendees registered to attend across the week’s sessions. Elements of the week’s content are being provided as videos via YouTube. Feedback from participants indicate that 99% of attendees thought the week provided a good learning opportunity, 93% found the content engaging and 96% found the content informative.

North Yorkshire Police have fully supported the Safeguarding Adults Board (SAB) and it’s subgroups over the last year with the new Rapid Review Panel pilot that looks at our (multi-Agency) response to adult safeguarding concerns received by the Local Authority and the Review & Learning group is an example of multi-agency collaboration, this work continues to develop.

CITY OF YORK
Safeguarding
Adults Board

# Review and Learning sub-group update

One of the core duties for a Safeguarding Adult Board is that *it must conduct any safeguarding adults review in accordance with Section 44 of the Act* Care and support statutory guidance - GOV.UK (www.gov.uk)

During 2021-22 the City of York Safeguarding Adults Board have completed and published two Safeguarding Adults Reviews (SARs). Each of the reviews involve a life lost in circumstances where we have identified that there were lessons to be learned. The recommendations from both reviews were accepted in full and actions have been taken and changes implemented since their publication. The Board would like to extend their sincere condolences to the family and friends of the two individuals and also extend thanks to all partners involved in supporting the review process.

SAR Mr A Safeguarding Adults Review for City of York Safeguarding Adults Board (safeguardingadultsyork.org.uk)

SAR Mr Z Safeguarding Adults Review: report into the circumstances surrounding the death of Mr Z. (safeguardingadultsyork.org.uk)

# Tees, Esk and Wear Valleys NHS Foundation Trust

York SAB Annual Report - TEWV

The suite of safeguarding training now in place incorporates both adult and child safeguarding to encourage a Think Family approach when faced with safeguarding concerns. Whilst this has been successfully delivered via e-learning and virtually via Microsoft Teams the team is planning to create and share several bitesize safeguarding videos/voice over presentations to increase the awareness across the trust of key areas of safeguarding. Initially to commence with the topic of domestic abuse and the impact of parental mental health and then expand further. This will form part of the teams work plan for 22/23. Training data is monitored by services and the Safeguarding and Public Protection team have oversight of this in their quarterly meeting.

The trust has actively participated in the Liberty Protection Safeguarding consultation response and will be looking to developing policies and procedures in line with the legislation. There is an intention going forward to have a trust wide policy that will link in with the wider ICS areas that's we sit within. Liberty Protection Safeguardnig will be added to the Trust risk register and will be providing all staff with appropriate training in preparation for implementation in 2023. There is also a commitment to host a Mental Capacity Act conference and a review of the Mental Health Act team structure around any new roles related to Liberty Protection Safeguarding

As part of the Trusts 'journey to change' initiative the safeguarding team has been aligned to the new Governance arrangements and structures within the organisation. This alignment reflects the importance of developing a stronger partnership approach and accountability in the prevention of abuse. The realigned devolved responsibility will be an enabler to focus and develop further safeguarding work with local services, improve community safety and the development of more targeted measures to share intelligence qualitive data and performance management with partners.

Safeguarding link professionals are in place across the organisation who attend regular meetings regarding safeguarding developments, getting information back to services, have extra training in topics such as self-neglect/domestic abuse.

In addition, part of the Trusts 'journey to change' embeds a clear goal to be a great partner and this includes having a shared understanding of the need and the strengths of our communities by working in an innovating way across organisations boundaries to improve services and in doing so be widely recognised for what has been achieved together as a partnership.

The Safeguarding team have also started to publish the briefings from Multi Agency reviews through the Trusts learning library to improve the sharing of learning across the trust and because of attendance at the daily patient safety huddles within the Trusts Patient Safety team there has been an increase in the number of SAR notifications been submitted to the Local Authorities where potential multi agency learning has been identified

There is a joint transition panel in place which aims to appreciate the divergent needs of young people transitioning into adult services. All young people 17.6 months and above have a co-produced transitions plan

to identify their needs and the likelihood of which service can meet these needs.

The organisation has been an active participant in the LeDeR (Leaning Disability Mortality Review Programme) North Yorkshire steering group across the Local Authorities / Clinical Care Groups /ICS. This has included carrying out several focused reviews including those with a diagnosis of autism as outlined in recent guidance.

The focused reviews carried out reflected an open culture of shared learning and exploring both the positive and negatives of practice in order that consideration of how to improve practice could be explored. These discussions are multi agency and crucially involve the carers of the deceased (other family members can also be involved if they wish) to provide open and honest communication in order to consider learning for each organisation. Whilst this initiative is at an early stage in the process initial thoughts is this is reflective of an impressive desire to improve the care and will continue to develop and be prioritised in the coming year .

Within the Trusts Adult Mental health services, they have developed the Care and Engagement approach – Co production of the Carers Charter. This assists with identifying the safeguarding needs of the carer and a training package has been developed. It recognises the importance of spending time with the key carers to meet their needs as well as meeting the needs of the patient.

# York and Scarborough Teaching Hospital NHS Foundation Trust

Safeguarding Adults Board – Annual Report 2021/22

As a provider of health care, York and Scarborough Teaching Hospital NHS Foundation Trust (referred to as the Trust) is committed to safeguarding adults in our care.

The Trust is required to provide assurance to and participate with other external agencies /commissioners to ensure a multi-agency approach to maintaining the safety of patients both in and out of acute services.

The Trust's Safeguarding Adults Team (referred to as the team) provides safeguarding adults advice, support and administration for staff that suspect, know of or observe abuse of adults.

It also provides support and advice to staff on the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS), the PREVENT duty and caring for patients with Learning Disabilities.

COVID – 19

The pandemic has however seen an increase in the following areas:

- Domestic Abuse
- Mental ill-Health
- Self-neglect

Strategic and Operational Adult Safeguarding

The Safeguarding Adult team has executive leadership from the Chief Nurse. This is essential in achieving success in the delivery of the safeguarding agenda Trust wide.

Operationally the Safeguarding Adult team offer expert advice to staff and volunteers who have concerns about the welfare of an adult. The team is available to all staff and volunteers between the hours of 09:00-17:00 Monday to Friday.

The introduction of daily review of 'DATIX' system has enabled a preventative approach to managing Safeguarding and also by datixing safeguarding concerns raised against the Trust which gives a wider awareness and collection of data.

Deprivation of Liberty Safeguards (DoLs) legislation – Liberty Protection Safeguards

The Mental Capacity (Amendment) Act 2019 introduced proposed changes to the arrangements and responsibilities for authorising deprivation of liberty known as 'Liberty Protection Safeguards'.

The Trust has worked with other agencies to respond and plan for the implementation. The Trust have also developed an Implementation plan with the Trust audit team.

CQC Inspection

The CQC visited the York Site on 29th March 2022. They visited 7 wards . An overview of our preliminary findings were presented to the

senior team on 31/03/22. During the inspection the CQC saw incomplete, inconsistent mental capacity assessments in patient records that was not in line with legislation. This included examples of staff making decisions on patients' behalf. There were no care plans for people in the records we reviewed experiencing dementia and confusion

In summary the following actions are ongoing

1) Increased visible support on wards as part of the Ward Wander programme to start May 2022
2) Awareness raising project in terms of resources available when the safeguarding team are not (Out of hours for example) May 2022
3) Scoping exercise of position in other similar Trusts and practice sharing to improve adherence.
4) The development of an Improvement Group - to start July 2022
5) Improved data collection to evidence that MCA is acknowledged in care planning - to be included

Training

Training packages have been changed to the NHS LfH e-learning packages with the introduction of additional MCA/DOLS packages. This provides nationally consistent packages transferrable from trust to trust. Additionally stand-alone e-learning packages for MCA/DOLS provide a more in depth level of training than previously. The team in complying with the generic Trust stance of reducing face-to-face training recognise that the participatory element does not comply with the recommendations set by the intercollegiate document which is why it now featuring on the risk register.

healthwatch York

## Healthwatch York Annual Report update

- Recommended that there was a need to apply a targeted approach due to capacity and funds - e.g. where do improvements most need to be made

- Suggested a blanket safeguarding training approach across all sectors
- Asked for clarity in regards to which parts of the safeguarding process, and systems, can be changed, and the capacity/willingness to implement changes
- Explored the current method of assessing the experiences of those that have gone through the safeguarding process - does this offer a true account of individuals experiences?
- Took learnings from another Healthwatch (Sussex) that worked with the council to explore lived experience - do's and don'ts, ethics, method, cost of project, staffing needed
- Learned from previous safeguarding reports and suggested that historic safeguarding reports are picked at random to explore key themes such as; where an opportunity is missed, where a first referral is made (and by who) and any other key themes that come from it
- Attended and promoted safeguarding training and webinars across VCSE and health sector, and to the public
- Supported the promotion of safeguarding posters and information via our magazines, bulletins, social media and mailouts
- Contributed to CQCs new approach to assessing care homes - included the boards views in this. Also ensured this assessment reached the right people across the council and Clinical Commissioning Group.

# Summary of Adult Safeguarding data collected 2021/22

1. The Safeguarding Adults Collection (SAC) is an annual statutory return for DHSC that summarises the safeguarding activity (concerns raised and section 42 enquiries carried out) that takes place within local authorities each year.

2. The number of adult safeguarding concerns received in 2021-22 was 1,715. This represents a 32% increase on the number of concerns received during 2020-21 (1,299). The number of concerns in Q4 (473) was 14% higher than the average seen during Q1-Q3 (414), a pattern also seen in 2020-21.

3. Of the 2021-22 concerns, 1,266 (74%) of them progressed to a section 42 enquiry. This is higher than the percentage that progressed during 2020-21 (70%), and is due to a change in practice first enacted in 2020-21.

4. Almost two-thirds of all concerns raised during 2021-22 involve women, and over a third of those involved women aged over 85. Men involved in concerns tended to be younger, with around one-fifth aged over 85 and around half involved those under the age of 65.

5. Those with physical disabilities comprised just over half of all safeguarding concerns during 2021-22, but the percentage of all concerns reported by this group fell. “Other Vulnerable People” accounted for an increasing percentage of all concerns compared with 2020-21.

6. The main type of risks faced by those involved in enquiries during 2021-22 were of neglect and physical risk, which accounted for about half of all enquiries. The most likely setting for a risk during the year was a person’s own home (usually about half of all risks), with care homes (nursing and residential) accounting for about a third. Service providers were investigated in about half of all enquiries, with other people known to the person of concern investigated in nearly all other enquiries.

7. In the vast majority of cases (between 81% and 88% in each 2021-22 quarter) the enquiry concluded with the risk identified and action taken. The risk was either reduced or removed in around 95% of all cases. People expressed an opinion in around 60% of cases during 2021-22 (lower than in 2020-21), and in around three-quarters of cases they said that the enquiry “fully achieved” their desired outcome (about the same as in 2020-21). There were very few enquiries that concluded that outcomes for people were “not achieved”.

# The last word

The 2021/22 year was dominated again by the issues coming from the pandemic but has been exacerbated by the difficulty in recruiting staff in all sectors of adult social care and then the developing cost of living crisis which is set to gather pace throughout 2022.

As can be seen by the detail in many of the updates included in this annual report we have seen significant increases in demand with teams having to work in different ways to ensure they provide the level of care and support required to ensure that the needs of individuals are met. The demand trends suggest we will see an increase in many of the areas identified with the safeguarding strategy and a continued rise in the complexity of cases which can be extremely time consuming.

Going into 2022/23 there is an ongoing requirement to ensure that resourcing levels are regularly reviewed to maintain the support the legislation requires.

There will also be an urgent need to proactively visit care home facilities across the city to ensure safeguarding standards are being met.

Because of restrictions created by the pandemic we will go into 2022/23 with a desire to re-establish a peer review process to seek to identify ways in which we can improve safeguarding and deliver against the key priorities within the three-year strategy.

I make no apologies for reiterating my thanks to all the individuals from all the partners agencies who despite so many challenges have every day throughout the last year sought to deliver and wherever possible improve the level of safeguarding. It is testimony that there is still a very high percentage of people who state the outcomes they were seeking in raising a safeguarding concern have been met and it is our ongoing commitment that despite the rising demand we will do everything we can to ensure that we make safeguarding personal.

Tim Madgwick
Independent Chair