CITY OF YORK

Safeguarding Adults Board

Annual report 2022/23

Contents

Introduction to City of York Safeguarding Adults Board Annual Report

By Tim Madgwick (Independent Chair, York Safeguarding Board)

I have been Chair of the City of York Safeguarding Adults Board since 2018 and there is no doubt that over the last two years there has been unprecedented pressure on safeguarding services across the City as a result firstly of the pandemic then more recently the cost of living crisis.

We continue to see the legacy of the pandemic in relation to many aspects of safeguarding but particularly in relation to mental health and self-neglect where specialist services are struggling to meet significant increases in demand. It is with this context that I would like to pay tribute to colleagues across all partners in adult safeguarding who despite this have continued to work incredibly hard to deliver effective outcomes for individuals, families and carers.

As a Board we have three statutory duties:

1. To publish our strategic plan.
2. To publish an Annual Report detailing the SAB has done to achieve its objectives and implement its plans.
3. To conduct any Safeguarding Adults Reviews (SARs) in accordance with section 44 of the Care Act

Membership of the Board is drawn not just from the statutory partners of the City Council, North Yorkshire Police and the Integrated Care Board who equally fund the SAB between them but also a range of key partners including York Teaching Hospital, Tees Esk & Wear Valley NHS Foundation Trust, York CVS and private sector representation.

The Board has a responsibility to ensure that potentially vulnerable people in York's population should be kept as safe as possible from abuse or neglect, whether they are a hospital patient, a care home resident or are living in their own home.

As a Board we meet four times a year and now, as a result of recent changes, have four sub-groups. These are the Executive Group, Quality & Assurance, Review & Learning and the Voice of the City.

I would like to thank colleagues working in these groups who strive to ensure the Board not just fulfils its statutory duties but also play key roles in improving the quality of life for some of the most vulnerable in our communities.

Strategic Plan for 2023/2024

OUR VISION

For individuals, communities and organisations to work together to ensure that the people of York can live fulfilling lives free from abuse and neglect and to ensure that safeguarding is everybody's business.

We will embed the SIX PRINCIPLES as set out in the Care Act:

Principle	Description
EMPOWERMENT	Promoting person-led decisions and informed consent.
PROTECTION	Support and protection for those in greatest need.
PREVENTION	It's better to act before harm occurs.
PROPORTIONALITY	Proportionate and least restrictive/intrusive.
PARTNERSHIP	Working together.
ACCOUNTABILITY	There is a multi-agency approach for people who need safeguarding support.

	Key Objectives	How will we do it?	How will we evidence this?	How will we know we have made a difference?
1	To develop an all age approach to safeguarding which maximises the potential & skills of teams and reduces the risks to young people transferring between services	A Preparing for Adulthood board has been established by CYC. There will be work streams reporting to the board that will meet on a monthly basis. One of the work streams will focus on transitional safeguarding, involving partners to develop an all age approach to safeguarding to reduce the risk of young people transferring between services. A preparing for adulthood lead has been established to oversee the work across all areas and implement the all age approach. We will review any examples where there has been an increased risk as a result of transferring between services, facilitating a culture of continuous improvement and learning to inform the approach.	The preparing for adulthood board will provide a quarterly report to the Safeguarding Board on the progress in this area. We will look at feedback from young people, their families and our workforce.	We will see a reduction in the number of concerns that come through relating to risk during the transfer between services. Feedback from young people, their families and our workforce will be positive around joint working and the management of risk in regard to the transfer between services.

	Key Objectives	How will we do it?	How will we evidence this?	How will we know we have made a difference?
2	Preventing abuse & neglect by adopting best practice, locally, regionally and nationally. Ensuring that all the learning from SAR's are implemented in a timely manner.	The Review and Learning Group meet on a quarterly basis with the purpose to encourage, support and facilitate a culture of continuous learning and improvement following the six principles of adult safeguarding and the key principle of making safeguarding personal. The Group will develop a workplan for delivery of the strategic objective which includes the process of learning, improvement and embedding best practice	The Group will provide a quarterly report to the Safeguarding Board of delivery against key actions from the workplan. The Group will summarise their contribution to learning and improvement in the SAB Annual Report. The Group will establish networks of communication to share learning as widely as possible, using the SAB website as one of the main drivers.	We will work with individuals and families to involve them in local reviews where that is possible and where they wish to do so and gain feedback on their experience. We will work with the organisations providing care and support to gain assurance that learning from reviews has led to improvement in practice. We will use learning from reviews to inform future strategy.

	Key objectives	How will we do it?	How will we evidence this?	How will we know we have made a difference?
3	Ensure that commissioners and service providers ensure a consistent high quality of care.	Partnership work between NHS, CQC, Safeguarding and NYP through Early Alert meetings will identify safeguarding concerns at a provider level. Providers evidence of safeguarding practice, policy and training of staff as recorded in Quality assurance reports and Contract Specification. Monitoring of quality through contract management process. Investigation of quality concerns at provider level.	Records of Bi-monthly meetings will evidence areas of concern and actions taken to /improve quality. Business meeting reviews to ensure recommendations and action are taken and embedded into practice.	Provider compliance with training. Evidence of quality assurance reports. Providers subject to improvement plans or restrictions on placements. Reduction in quality concerns at provider level. Increase in customer satisfaction through consultation.

	Key objectives	How will we do it?	How will we evidence this?	How will we know we have made a difference?
4	To ensure the service user is clearly heard and create opportunities for an approach where co production is at the heart of future safeguarding policy.	We will create, by working with key partners including Healthwatch, CVS and statutory agencies, an approach that stimulates feedback and views for how we can shape the safeguarding approach into the future. We will mirror the approach taken by the Mental Health Partnership in 2022 by working with the co-production champion to understand what works within the city.	The service user and their support network have been through a safeguarding process. As a result there are always opportunities to improve by empowering individuals to shape the future of the service. • Review of Healthwatch across the country to seek best practice. • Review groups currently working in York in other disciplines where support Networks are in place to avoid duplication. • Link to Innovation Unit where work on co-design currently underway to improve MH services	By supporting individuals through networks or one to one opportunities to talk openly about how they felt and were they listened to, and as a result was the safeguarding process effective in delivering appropriate outcomes. • Quality of feedback. • Evidence where change has resulted.

	Key objectives	How will we do it?	How will we evidence this?	How will we know we have made a difference?
5	A robust governance and challenge ethos ensures effective quality assurance and performance management processes.	Systems already in place.	Annual Section 11. (Section 11 of the Children Act 2004 places a statutory duty on key persons and bodies to make arrangements to ensure that in discharging its functions, they have regard to the need to safeguard and promote the welfare of children and that the services they contract out to others are provided having regard to that need. This was extended to adults in 2021 to cover Section 43 of the Care Act 2014 which requires Local Safeguarding Adults Boards to co-ordinate, and ensures the effectiveness of, what each of its members do in protecting individuals from abuse and neglect and delivering the outcomes.) and Governance Safeguarding Audit Reporting process.	Challenge and analysis to form part of the role of the SAB subgroups.

	Key objectives	How will we do it?	How will we evidence this?	How will we know we have made a difference?
6	Work together with the CYC Community Safety Partnership, to support work to raise awareness of, and reduce the harm caused by 'Hidden Harms', and abuse associated with County Lines activity, domestic abuse and modern slavery; reducing duplication of effort and maximising effectiveness.	We believe we can prevent high harm by working with others, to intervene earlier and solve problems in specific communities / places, before they escalate. Corporately we need to develop our workforce's skills to enable them to effectively carry out early intervention and prevention work in specific places, with confidence. More effective approaches to placed based problem solving will support the partnership to better identify and support vulnerable people, and to identify and target those who repeatedly cause crime/harm in our communities. Increase in problem-solving training and PSP support, including enhanced Service Level Agreements (SLA) from problem-solving teams across the partnership. Co-production of CSH purpose and principles. Creation of CSH specific PC and Sgt roles. Creation of minimum staffing for NYP CSH. All staff within the CSP will understand their responsibility in identifying and reporting safeguarding concerns.	• Annual community perception survey • Partner surveys • Feedback from Community Safety Hubs (CSH) • Problem Solving Plans PSP) Matrix Scores • Dip sampling to assess the quality of information provided by the new Tasking & Briefing system in contributing towards an increase in effective targeted activity • ORCUMA Data	Individuals in specific communities will feel safer and be safer. Individuals in specific communities/places will have more confidence that what they report generates an action focused response, giving them greater trust and confidence in the police. Joint agreed activity through problem solving plans (PSP) will be collaborative, effective and deliver positive outcomes in specific places, and for individuals. Our workforce will report that they have sufficient knowledge and skills to complete early intervention and prevention activity.

City of York Safeguarding Adults Board Sub-groups

Executive Sub-group Update by Chair Tim Madgwick

The Executive Group oversees how agencies work together and co-ordinate services, ensuring that local arrangements and partners act to help and protect adults with care and support needs. The Executive Group is responsible for ensuring that statutory requirements are met, and resources are in place to meet these. Its membership comprises of senior representatives from each of the three statutory agencies.

Key Objectives

- Oversee the governance arrangements of the Safeguarding Adults Board.
- Oversee all Safeguarding Adult Review (SAR) referrals and make recommendations to the Independent Chair as to whether a review should take place, and the most appropriate type of methodology.
- Oversee publication of SAR Executive report / summary as appropriate.
- Provide strategic direction and delegate work as appropriate to the subgroups (in line with the strategic objectives outlined within the Strategic/Business Plan).
- Scrutinise and sign-off all multi-agency policies and procedures prior to being presented at the Safeguarding Adults Board.
- Scrutinise and sign-off key documentation for the Board including the Strategic Plan, Subgroup Plans, the Annual Report.
- Prior to formal sign off, Executive Leads will seek assurance from the lead officer/subgroup chair that any documentation, including policies and procedures have been developed, consulted on, and agreed by appropriate partners, including adults with a lived experience.
- Receive assurance and progress reports from all Subgroups.
- Agree agendas for Safeguarding Adults Board meetings.
- Co-ordinate and plan development sessions.
- Promote shared accountability, partnership working, and collective ownership of the safeguarding of adults in York.

The executive sub-group has been established in 2023 and has now met twice. As described above there are many outcomes we will expect to see as all the sub-groups develop and start to deliver more detailed reports. One of the key responsibilities of the executive will be to set out

clear expectations of the work that has to be undertaken and in turn establish where current gaps exist.

There has been a great deal of work delivered by the Review & Learning sub-group in relation to the SAR's that have been completed in the last five years. As a priority, the executive have required all partners to revisit how the recommendations and learning from these SAR's has been embedded, especially during a period of many changes in personnel across all agencies.

Review & Improvement Sub-group Update by Chair Christine Pearson

Summary of the subgroup

The scope of the RLG is to consider cases which may fit the criteria for a Safeguarding Adult Review under section 44 of the Care Act i.e., *SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.* Care and support statutory guidance - GOV.UK (www.gov.uk) and make a recommendation to the Independent Chair.

What the subgroup hopes to achieve and expectations

- In 2022/23 three cases have been referred to the RLG for their consideration, two of these met the criteria and one was deemed not to meet the criteria. The two cases which met the criteria are in progress as Safeguarding Adult Reviews. The reports with findings and recommendations will be published once completed. Each of the cases involve a life lost in circumstances where we have identified that there are lessons to be learned. The sincere condolences of the members of the Safeguarding Adults Board are extended to the families of the individuals who sadly died and we are grateful to those families for their ongoing involvement and contributions to the learning process. The learning and recommendations from these reviews will be reported on in the 2023/24 annual report.

Progress to date

- Learning was identified in the sad case of the death of an adult at risk in a house fire. Whilst the case was deemed not to meet the criteria for full review partners from the Fire and Rescue Service have been working with hospital and community teams to develop

a pathway to support the safe use of specialist equipment in the home and raise awareness of fire safety checks and the importance of risk assessments.

- The scope for system learning has been widened in 2022/23 with the new addition of a Rapid Review Panel process. Following an initial pilot of three months the Panel process was adopted and meets monthly with membership from key agencies. The Panel considers cases for learning where people have died whilst homeless or vulnerably housed. These individuals often represent some of the most vulnerable in our communities, however they may not ordinarily meet the threshold for safeguarding enquiry. Emerging themes from the cases discussed are the impact on physical health and well-being of childhood trauma; poor mental health; and substance use. In 2023/24 we will share our findings with wider system partners and consider where change may be needed.

Quality & Assurance Sub-group Update by Chair Michael Melvin

The key role of the Quality and Improvement Sub-group (Q&I) is to support the Safeguarding Adults Board (SAB) in ensuring quality and assurance for the SAB and partners through a number of quality measures including audit, scrutiny of partner self-assessment and quality reports.

The group seeks assurance from partners that actions from SARs and Review & Learning group are implemented and embedded to improve practice.

Key Objectives

- Ensure operational effectiveness of adult safeguarding policies and procedures and proposal of amendments for consideration by the SAB
- Provide scrutiny to ensure that adult safeguarding policies and procedures are embedded in the practice of front line staff
- Ensure delivery of consistent and robust outcomes for adults through audit and scrutiny
- Monitor performance against the Safeguarding Adults Board work plan
- Seek assurance that learning is embedded and measure the impact on practice through audit and partner self-assessment

- Monitor action plans arising from SARs
- Provide a performance monitoring framework for safeguarding

Progress to Date

- Regional Tri-x procedures have been launched. Three training events have been held locally to train staff in these. Updates are being circulated for comments to members. Local partners guidance needs to reflect the updated procedures.
- PiPoT guidance has been developed to align with partners across North Yorkshire
- Transitional Safeguarding Workshops on preparation for adulthood have been undertaken in City of York Council. Further work planned to ensure that SAB has co-produced approach across the partnership.
- Work on provider failure has informed our approach to This will ensure there is a consistent response to organsational abuse.
- Assurance processes are underway to understand and build on the learning from Safeguarding Adult Reviews undertaken by the SAB.

Ongoing Work
The Quality and Assurance Work Group is focused on the following priority tasks:

- Completion of policy on organisational abuse
- Agreement on a Performance Framework
- Improving Assurance on learning previous SARs
- Completing Transitional Safe guarding Procedures

Voice of the City Sub-group Update by Chair Emily Douse

Summary of the subgroup

The key role of the Voice of the City subgroup is to support the Safeguarding Adults Board with understanding first-hand experiences of those who are or have been involved in adult safeguarding practices. The group will contribute to informing developments in how safeguarding services are designed, delivered, and communicated.

What the subgroup hopes to achieve and expectations
To build and develop a strong service user and carer evidence base, where the views and experiences of people are fed back to the

Executive Group and used to inform improvements to adult safeguarding in York.

- Develop a safeguarding engagement toolkit available to providers and public.
- Develop strategies and campaigns to raise awareness of adult abuse.
- Capture peoples' safeguarding experiences and outcomes to identify trends to inform the Boards Strategic Priorities in relation to prevention.

Progress to date

- Established a working group of cross sector representatives that work directly with service users. Set expectations and established an open learning culture.
- Reviewed past safeguarding meeting discussions and held a workshop with local social prescribers to identify areas of strengths and weaknesses across safeguarding processes.
- Developed a questionnaire for those who have gone through the safeguarding process based on the 'I' statements of person-centred care.
- Implemented an active live action tracker for use across sub-groups to ensure work is linked and outcomes continually assessed.

City of York Safeguarding Adults Board Partner Updates

City of York Council Adults Safeguarding

The service continues to develop its skills with a focus on quality and continuing professional development. This includes through peer supervision using learning from Safeguarding Adult Reviews and best practice in transitional safeguarding.

Improving the skill mix within the service has resulted in a new post providing a single point of contact to working with providers on lower-level concerns, developing the relationship with colleagues responsible for the quality of commissioned services to provide early sight of and resolution of these concerns.

The council has worked alongside local authorities in the Yorkshire and Humber region to agree a new multi-agency safeguarding policy, promoting a consistency of approach through the use of shared Tri-x procedures.

Further work has been undertaken to strengthen the PiPOT process, providing a clear process for staff, the tools necessary to undertake the work and ensuring that the process is aligned across York and North Yorkshire.

Work continues on campaigning to safeguard adults, including supporting members to help prevent and stop the abuse of adults by learning more about it. Strong links are being built across directorates within the council, including a focus on work with Trading Standards to prevent and respond to scamming.

Work across agencies continues to develop. In response to growing mental health concerns, Tees Esk and Wear Valley (TEWV) now participate in the daily screening of concerns alongside the City of York Council and the Police.

Strategically CYC continues to provide leadership regionally through the DASS chair of the ADASS regional Safeguarding Adults Network.

This Year has seen the development of a framework for the regulation Councils Adult Social Care departments through CQC. The quality statements that underpin this will enable CYC to evidence how we meet

our responsibilities including how we work with partners in through the Safeguarding Board.

City of York Council Public Health

Domestic Abuse

The City of York Local Domestic Abuse Partnership Board, have been working to ensuring the authentic voice of victims, survivors and their children to inform our partnership approaches. Safe Lives have also provided a Safe Accommodation Needs Assessment, which has included assessing available safe accommodation provision locally, whilst also engaging with victims and survivors accessing locally provided safe accommodation. Similarly, interviews and questionnaires with professionals across York, alongside case audits of victims engaging with all partners locally, have been utilised to develop a whole system review of the local response to tackling domestic abuse.

Further work around prevention has included the delivery of multi-agency training to professionals, which has included more than 300 professionals accessing training to date, aiding understanding with identifying signs of abuse, including coercive and controlling behaviour.

Public Health launched the Domestic Abuse Charter for City of York Council. The aim of the charter is to improve organisational culture in dealing with and reporting of domestic abuse.

Suicide Prevention

The York Suicide Prevention Delivery Group (YSPDG) continues to meet regularly, providing a platform for discussion around suicide prevention and reducing the impact of suicide on families and communities. We have undertaken a suicide audit update which provides retrospective intelligence for deaths by suicides between 2015 and 2021. The current audit helps with identifying changes in themes and trends since the last audit in 2016.

in 2022 the Public Health and Adult Safeguarding Board worked alongside the YSPDG to successfully commission suicide prevention training to professionals who have regular contact with suicide high-risk groups.

Drug and Alcohol related Deaths

The City of York Council Public Health Team have strengthen processes relating to Drug and Alcohol Related Deaths (DARDs) within York over the last year. To ensure timely reviews of any deaths, and as

previously agreed, the commissioned York Drug and Alcohol Service inform the Public Health lead as soon as they are notified of any deaths, a review is carried out by the service to understand the individual case, and other relevant partners are informed.

Within the Public Health Team, a number of deaths will be reviewed monthly, following this a regular DARDs agenda item on the contract monitoring meetings will provide an opportunity for quarterly discussion with the provider.

Nationally, the 2021 Drug Strategy: From Harm to Hope outlines the national commitment to preventing 1000 drug-related deaths by 2025. A Drug and Alcohol Related Deaths (DARDs) review guidance and action plan is currently in development and will provide further guidance to improve local systems in Summer 23.

City of York Council Public Protection Update

Trading standards officers receive reports of scams and try to prevent people becoming victims of them. In the last year, our activities have included meeting customers at HSBC bank to discuss scams and other forms of unfair trading to help them keep their money safe. We have also provided similar talks to a number of community groups. Furthermore, we have recently been provided with the details of eighteen York residents who were identified as victims of the Next Gen sweepstake scam successfully tackled by the US Federal Commission last year and resulted in partial refunds for victims worldwide. We are contacting the York residents to return their money.

Environmental health officers undertake visits at restaurants, take-aways and other premises in the city. Officers visit hundreds of premises each year 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, and have also introduced a number of initiatives to help safeguard vulnerable adults. The team have been continuing to work 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 are continuing the free training programme to successfully

increase the number of taxi drivers and help ensure vulnerable passengers have a safe method of travel around the city 24 hours a day.

North Yorkshire Police

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.

In 2022 the Police Control Strategy was updated and will run to 2024 when it will be reviewed. The Control Strategy themes are generated through the application of the national methodology for Management of Risk in Law Enforcement (MoRiLe). This assesses all police risks in terms of harm, likelihood and our organisational capability and capacity, both now and in the future. The outcome of this work is reviewed by the Chief Officer Team to ensure that the themes represent what we need to prioritise for the communities of North Yorkshire and the City of York.

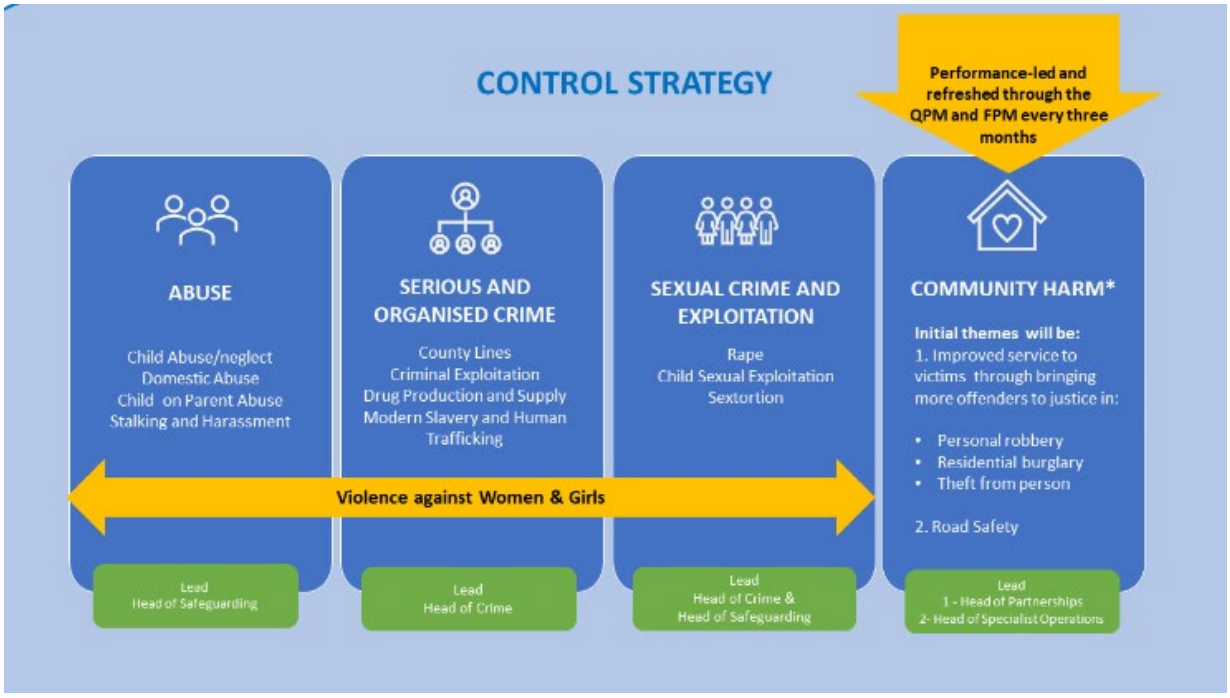

Figure 1 - Control strategy which is performance-led and refreshed through the QPM and FPM every 3 months.

The above image shows the control strategy which is divided into 4 areas:

1. *Abuse – child abuse/neglect, domestic abuse, child or parent abuse, stalking and harassment. The lead is the Head of Safeguarding*
2. *Serious and organized crime – county lines, criminal exploitation, drug production and supply, modern slavery and human trafficking. The lead is the Head of Crime*
3. *Sexual crime and exploitation – rape, child sexual exploitation, sextortion. The leads are the Head of Crime and Head of Safeguarding*
4. *Community harm – initial themes will be:*
    - *Improved service to victims through brining more offenders to justice in personal robbery, residential burglary, theft from person*
    - *Road safety*

    The leaders are Head of Partnerships and Head of Specialist Operations.

Numbers 1 to 3 include violence against women and girls.

North Yorkshire Police have invested in additional resources to Safeguarding and there is approval for further investment, which is planned late in the year, in line with the identified priorities above.

Highlights 22/23
Following the Royal Assent of the Domestic Abuse Act 2021 a further strand from the act was implemented in Summer 22.

New criminal offence of non-fatal strangulation (section 70, 7 June 2022): The Serious
Crime Act 2015 created a new specific criminal offence of non-fatal strangulation and suffocation. The offence also applies if committed abroad by a UK national (or a person who is habitually resident in England and Wales).

There are still four remaining measures which are yet to be implemented between 2023 and 2024:

- The amendment to the controlling or coercive behaviour offence
- The updated Domestic Violence Disclosure Scheme guidance
- The Pilot of Domestic Abuse Protection Notices and Orders (DAPN/DAPO) and
- A Code of Practice on data sharing on victims of domestic abuse for immigration purposes.

North Yorkshire Police have continued to provide additional investment to Safeguarding, recognising the demand increases, National drivers such as the VAWG Strategy (Violence against Women and Girls) and NVAP the National Vulnerability Action Plan
In 2022 North Yorkshire Police implemented its Vulnerability Board chaired by the ACC for Local Policing and attended by Heads of Department and aligned with the National Vulnerability Action Plan (NVAP). The National Vulnerability Action Plan (NVAP) is an evidence-based plan designed to improve policing's response across public protection and the vulnerability strands by:

- Driving long-term change by targeting key practice gaps & following the evidence.
- Reducing duplication of local and national action plans across policing.
- Maximising learning opportunities across thematic areas and action plans.
- Ensuring a whole-systems approach.

The Unwanted Prisoner Contact service
In 2021 a scheme developed by the North Yorkshire Police MATAC (Multi Agency Tasking and Coordination) team coordinator. The scheme, which involves sharing information with Prisons has been Nationally recognised as best practice, receiving media attention and receiving awards. The Scheme is now signed off by Ministers and will become National Policy.

The Unwanted Prisoner Contact service specifically for Domestic Abuse victims and preventing abusers form harassing and intimidating victims from inside prison will act immediately to contact jails and block offenders from sending any communications. A single hub for victims and agencies has been created which has dedicated call handlers who will act quickly in locating offenders and blocking contact. It will also prevent abusers from using other offenders to contact victims, by barring all contact from prison phones.

In January 23, 49.5% of requests were sent by the police and 31.5% by the victim. In February 23, referrals from the police were 47% and 39% were from the victim. A steady increase of requests from victims shows the promotional material and awareness raising amongst partner agencies for the service is getting through to those most vulnerable in our society.

The new North Yorkshire Police Stalking team

North Yorkshire Police have a new dedicated team whose primary role is reviewing cases where Stalking may or has been identified and provide advice to investigators. The team also has a dedicated safeguarding officer.

- Since 2022 the team have reviewed 336 investigations
- Since January 2023 48 cases have been adopted
- From January 2023 96 Stalking Safeguarding reviews have been completed

The Stalking team also provide training to Student Officers, The Force Control Room, Detectives and the Crime Recording Unit on Harassment and Stalking offences.

The Domestic Violence Disclosure Scheme (DVDS)

The DVDS was introduced to set out procedures that could be used by the police to disclose information about previous violent or abusive offending, including emotional abuse, controlling or coercive behaviour, or economic abuse by an individual, where this may help protect their partner or ex-partner, and any relevant children, from serious harm. Applications for disclosures increased significantly over 22/23 and are expected to rise again with the scheme becoming statute in April 2023. The two components are Right to Ask (RTA), where a person who is concerned about themselves or someone else can contact Police to apply for disclosure and Right to Know (RTK), where usually Police and Probation generate an application internally based on information known already.

Data collected for period 01/04/21 - 31/03/22	**Data collected 03/05/2023 for period 01/04/22 - 31/03/23**
RTA Applications: 344	RTA Applications: 429
RTA Disclosures: 120	RTA Disclosures: 152
RTK Disclosures: 192	RTK Disclosures: 224

Domestic Abuse Training.

North Yorkshire Police have continued their commitment to the Domestic Abuse Matters Training programme. The programme is designed and delivered by experts, specifically aimed at providing front facing response officers and staff with the tools they need to improve their response to victims of *domestic abuse*.

From April 22 to March 23 a total of 20 courses have been run and completed by staff, with further courses planned this year.

MARACs – Multi Agency Risk Assessment Conferences.
MARAC is now, a recognised vital component and multi-agency process in keeping our high-risk victims within the City of York and North Yorkshire safe. The City has good agency attendance at the meetings, which has resulted in an improved response to action planning and confidence in referring for agencies other than the Police.

The data for MARAC below is evidence to the demand and recognising and responding to high-risk victims not always known to the Police.

Year	**2018**	**2019**	**2020**	**2021**	**2022**
York	295	306	444	515	525

The Partnership Hub within NYP hold the portfolios for Community Safety, Mental Health, and young people. Some of their highlights are as follows.

The Problem-Solving Team (PST) 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 team are working alongside Safeguarding to develop a problem solving plan in relation to under-reporting of domestic violence in rural communities
- The team support on a variety of plans to support repeat victims who may be vulnerable – whether from ASB or Crime including Domestic Abuse
- The team are delivering SARA model training to officers across the force from all departments to ensure officers identify where additional support and responses are required to address repeat issues and ensure sustainable long-term solutions to protect members of our community.
- Digital PCSOs deliver Fraud surgeries and advice in a variety of formats ranging from online messages, social media, North Yorkshire Community Messenger, and face to face engagement to warn residents of current scams and risks

Mental Health Portfolio

Coordinators work on each command. They provide robust and effective links to partner agencies and are able to assist response colleagues and investigators with advice and connections when queries arise over those in custody or with advice with investigations. Their specialist knowledge of Mental Health legislation is invaluable in these circumstances. The team also provide training for officers.

Hate Crime

The hate crime officer reviews all reported hate related offences in our area. This includes contact with the complainant and also ensures that an effective investigation plan which meets force requirements has been put into place and is being actioned. This activity has led to a significant upturn in CPS charging decisions which can be evidenced from the appropriate spreadsheet.

Harm Reduction

Work is ongoing within this portfolio linked with the City of York and North Yorkshire Drug and Alcohol partnerships to look at harm reduction and diversion possibilities for those in our communities who may be substance reliant.

Licensing

Delivery of Welfare and Vulnerability Engagement Training (WAVE) to NTE venues has led to effective engagements and reduction in harm.

York & Scarborough Teaching Hospitals NHS Foundation Trust

Introduction

As a provider of health care, York, and Scarborough Teaching Hospital NHS Foundation Trust (referred to as the Trust) is committed to safeguarding patients in our care and ensuring that a legal framework surrounds care delivery to protect vulnerable patients.

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.

Internally Safeguarding is strategically governed by the Executive Integrated Safeguarding Group with assurance then provided to the Quality & Patient Safety Group (QPAS).

The annual report cites the activity of the Safeguarding and Mental Capacity Act Team (adult and child) and highlights trends which inform service development. For example, in reviewing the attendances in our

emergency departments we can identify common patient need and escalate through multi-agency working. This will not only improve safeguarding services within the Trust but by sharing with partner agencies increase safeguarding measure in other providers.

Key Points to highlight:

Mental Capacity Act Compliance
During inspections in March and October 22 the CQC (Care Quality Commission) identified that specialist support was required to improve awareness and compliance of the Mental Capacity Act.

As a result, supporting staff comply with the Act has led to:

- Workforce investment
- Trust Strategy and governance arrangements
- Improved resources
- Qualitative Audit programme
- Improved Training offer/opportunities
- Reporting/Escalation processes

Training Compliance
The Safeguarding and Mental Capacity Act Team's training portfolio is as follows:

- Safeguarding Adult L1/L2
- Prevent Basic Awareness & Level 3
- Mental Capacity Act L1 & L2
- Deprivation of Liberty Safeguards L1 & L2

(as per Adult Safeguarding: Roles and Competencies for Health Care Staff (2018))

2022 2023 saw a reduction in compliance which was due to technical difficulties with the Learning Hub. There are processes in place to monitor compliance monthly and escalate staff not compliance direct to the Care Group via routine reporting from the Safeguarding & MCA Team.

Workforce Planning
In August 2022 a re-structure consultation commenced based on a provisional structure put into effect the previous August (2021). The provisional structure proved successful in re-distributing roles without

cost and with a positive impact on productivity. As a result, the proposed structure was formalised in October 2022. It should be noted, however, that additional investment will always be within the long term plan and as such an investment request was submitted in December 2022.

Summary of 2022/2023

The key issues are described above. In summary, priorities for the Trust's Safeguarding and Mental Capacity Act Team are as follows:

- Make MCA adherence everyday business in care delivery
- Support Care Groups equip staff with training to safeguard patients in our care
- Develop and enhance support provided by the Safeguarding and Mental Capacity Act Team by investing to expand capacity

Tees, Esk & Wear Valleys NHS Foundation Trust

TEWV Care Group Boards have been developed and are now in operation across the Trust. The purpose of these Boards is to act as the custodian of the Care Group's culture, to oversee effective operational and strategic site management including the achievement of statutory duties, clinical standards and targets, the delivery of high quality patient centred care, delivery of the Business Plans and the Trust's overarching Strategy articulated in 'Our Journey for Change' They report to the Executive Director Meeting (via Managing Director being members of Executive Directors Meeting).

The subgroups of the Boards oversee the specific elements (dependent on which subgroup) of the Trust's clinical and operational services, including oversight on statutory, legal and regulatory duties, whilst delivering high quality patient centred care to support the overall delivery of Our Journey to Change.

The Care Group Director for York (& North Yorkshire and Selby) also represents the organisation on the York SAB to enable the Safeguarding Adults Boards priorities are integral to care delivery.

The Trusts priorities sit within five journeys in relation to:

- **Clinical** – how we will provide high quality, safe, kind, effective and personalised clinical care to the people we support
- **Quality and safety** – how we will make our service safer and improve patient experience through evidence-based care

- **Co- creation** – how we will seek out and act upon the voices of the people we work with to improve care
- **Infrastructure** – how the places we work, such as our hospitals and offices, the equipment we use, the information we gather and the systems and processes we put in place will support excellent patient care
- **People** – how we will ensure everyone who works and volunteers with the trust has a great experience, whether they're permanent employment, people working as bank staff or through an agency, students, or volunteers. These priority areas form the basis of our trusts business plan for 2023 to 2024 and will men our journeys turn into action that will in turn support the trust to keep delivering our goals

The Trust has strengthened the safeguarding links into clinical services as part of its realignment into the Care Groups service structure in April 2022 by aligning resources into the two Care Groups. This model reflects increasing visibility of dedicated members of the team into clinical areas for each group. Initially resources have been focused within inpatient services with the progression into the community teams going forward to further embed safeguard into practice

The Trust Safeguarding and Public Protection team (SPP) continues to provide specialist safeguarding supervision across clinical services and there are dedicated safeguarding link professionals in place across the Trust. (A safeguarding link professional is a practitioner within clinical services who will upskill further than their mandatory training to assist in 'bridging the gap' between services and the corporate safeguarding team) In addition the employment of a Consultant Psychiatrist dedicated to safeguarding adults for two sessions per week has strengthened the team buy providing knowledge base medical advice and guidance on safeguarding concerns to our medical colleagues. Given this post is not currently a nationally recognised post the role is continually evolving.

The Trust SPP team have worked alongside the developers of the new CITO system (which will be the Trust new electronic care record system) to ensure that safeguarding procedures are embedded within the flow of the system. This will give practitioners prompts and guidance throughout when there are indicators that safeguarding needs to be applied. This will complement the Trust Safeguarding training. CITO is due to go live in July 2023.

External safeguarding training is promoted through our Safeguarding Link Professionals and the Trusts dedicated Safeguarding & Public Protection e-bulletin, dedicated to training resources. The Safeguarding Level 3 training package has currently undergone a review in line with updates in legislation and the learning as a result of Safeguarding reviews with a training plan also developed based on these learning themes.

Culture assessments have been completed across the Trust. These were overwhelmingly positive, good feedback from staff and patients about staff visibility, staff attitudes of compassion and gave opportunity to pick up on poor cultures which was a minority. Concerns raised immediately re: staff attitude, gaps in staffing care groups will picked up to ensure immediate action taken and oversight and support in place. It was agreed feedback would be shared with wards and appropriate action taken via care group support with support from corporate services. The audience of the findings within the report will be tabled at the Trusts board.

Future developments to ensure there is an increase in the oversight of safeguarding concerns within clinical teams has been initiated to create a safeguarding dashboard within IIC (Integrated Information Centre). We have identified the metrics that we would want to be included and are currently waiting for this to be developed. This will enable services to extract a report of all the safeguarding concerns raised within their teams and drill down to types of abuse, referrals, outcomes etc

The Trust safeguarding team has also assisted in the review and development of the Trustwide Quality Assurance tools to ensure that safeguarding is included within these. These tools are completed monthly by clinical services to ensure compliance with safeguarding polices/procedures.

Care group specific initiatives that have safeguarding at the heart of their aim include a new care group governance and assurance support program (GASP). Responding to staff feedback we have developed a three-tier program of support designed around the concepts of reflection, buddying, mentorship and appreciative enquiry. This program will complement the trust audit program to provide full assurance of our quality of care delivery.

Humber & North Yorkshire Integrated Care Board (ICB)

The Health and Care Act 2022 placed the Integrated Care Board (ICB) and Integrated Care Systems (ICS) onto a statutory footing from 1 July 2022. The Humber and North Yorkshire ICB/ICS brings together six former Clinical Commissioning Groups (CCGs) from across the Humber and North Yorkshire region. The six former CCG teams now work *at place* in Health and Care Partnerships, the borders of which are the local authority areas Humber & North Yorkshire Health & Care Partnership (humberandnorthyorkshire.org.uk)

The City of York Safeguarding Adult Board membership with the ICB now as the statutory partner for health has remained consistent and continuous with both the Director of Nursing and Designated Nurse Safeguarding Adults remaining as the representatives. All ICB policies relating to safeguarding have been updated to reflect the large-scale system change.

Throughout 2022-2023 the ICB Safeguarding Designated Team have developed their Safeguarding Designated Professionals Network and now have an approved leadership structure in place from 1 April 2023 with a permanent Transitional Lead role to embed safeguarding as priority; maintain momentum and progression; and provide ongoing and future system assurance to partners.

The revised Safeguarding Accountability and Assurance Framework was published in July 2022 and is embedded within safeguarding systems, structures and processes in the ICB NHS England » Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework.

Safeguarding in Primary Care

The Primary Care Safeguarding Team have had a challenging year with a reduced staffing resource for much of it. Despite this challenge, in 2022/23 safeguarding training has been delivered to more than 1200 staff working in primary care settings across York and North Yorkshire which is an increase to the previous year (1000 staff 2021/22). Topics in the 2022/23 programme have included Domestic Abuse with a focus on coercive control; LeDeR – learning from the lives and deaths of people with a learning disability or autism; and safeguarding in care homes following the Learning Review published with recommendations for primary care in North Yorkshire and York https://safeguardingadults.co.uk/learning-research/nysab-learning/review-lo-care-home/

Each GP practice has a named safeguarding lead in place. Support and supervision are offered to the leads by the Primary Care Safeguarding Team through a regular meeting forum in addition to individual practitioner contacts. Engagement in the last year at meetings has been consistently high with over 250 attendees recorded. Specialist training and discussion topics have included Prevent/Channel processes, and Mental Capacity Act complex case management.

The Safeguarding Adult policy for primary care has been updated with information to support the safe implementation of the NHS programme for patient online access to health records. In addition a new primary care safeguarding assurance self-assessment tool has been developed by the Safeguarding Team. Completion by practices has supported them to assure their own processes and the themes from the combined results has identified where improvements are needed and will form the workplan for the Safeguarding Team in 2023/24.

Health Partners

The Health Partnership Group has continued to meet 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 an established safeguarding supervision forum which also meets quarterly providing a safe space for specialist practitioners to bring complex issues for discussion with their peers. A dedicated safeguarding training and peer support group for private providers of health care continues and connectivity is expanding year on year. Presentations to the group this year have included learning from Safeguarding Adult Reviews and the Mental Capacity Act. The regular Safeguarding Adults Bulletin continues to be positively received by safeguarding practitioners, bringing together key issues relevant to safeguarding, whilst reducing email traffic.

Care Homes and Safeguarding

Support provided to care homes and domiciliary care providers has continued as a significant feature of the work of the ICB in 2022/23 and the Partners in Care network and project pathways have expanded to include North Yorkshire providers. The Designated Professionals and Nursing and Quality Team have continued to work closely with partners to address safeguarding and quality concerns in a number of care homes whilst also working strategically to address risks and learn lessons from emerging themes and trends and safeguarding reviews. It

has been a key priority in 2022/23 to implement the recommendations from the review completed into the learning from a care home closure in North Yorkshire which also impacted City of York. The new PERSON form jointly developed with City of York and North Yorkshire partners launched on 1 April 2023 and enables professionals visiting care homes to share good practice and raise concerns of quality if needed. It is hoped that this will have a positive impact by sharing information at a lower level of concern allowing earlier support to be offered to providers before harm has occurred very much fitting with the Prevention principle of adult safeguarding.

20230320 Final PERSON Approach vis

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. Work has continued over the last year across the health network to improve practical application of the Mental Capacity Act (MCA) through targeted training, whilst also assessing system preparedness pending implementation of a new approach across the system. In April 2023 we were informed of the Government decision to delay implementation of any new process *beyond the life of the current Parliament*. Whilst this was a disappointing development the work on supporting system partners with MCA will continue to be progressed in 2023/ 24.

Designated Safeguarding Adults team

The two safeguarding officers in the North Yorkshire and York Safeguarding Adults team have been directly involved in 80+ section 42 enquiries (equivalent to last year's numbers). From the entrusted enquiries completed for City of York the main categories of abuse in cases with health team involvement have been neglect and omissions of care. Just over 25% of cases are recorded as more than one type of abuse which reflects the continuing complexity of cases post-pandemic. The wider team have been involved in multiple cases providing safeguarding advice and expertise by telephone and in complex case meetings. The critical nature of these cases has increased over the last year as the needs of the most vulnerable groups have increased and appropriate care provision has been further challenged

The Designated Professionals are active members of SANN (safeguarding adults national network) meetings which are led by the NHS England national team and operate on a monthly basis providing an opportunity to engage and share safeguarding issues of both national and local significance.

In addition to being an active partner of the City of York Safeguarding Adults Board the Designated Professionals actively represent the ICB in multiple partnership arenas – Prevent and Channel processes; Serious Organised Crime; MAPPA (multi-agency public protection); Domestic Abuse; Modern Slavery; Military Health; Community Safety/Safer York Partnership; and most recently the Serious Violence Duty working group.

York CVS

Due to the current pressures on Health and Care the voluntary and community sector are working with more risk, supporting individuals with higher support needs. Holding this risk within organisations in turn leads to a rise in the number of safeguarding concerns.

York CVS want partnership working and integrated care to ensure that the voluntary and community sector is viewed as an equal partner where pathways of care into the sector are co-created with the sector not without us. And that adequate resource is received by the sector to respond to these pathways of care.

York CVS would advocate for the voluntary and community sector to have access to the same training available to statutory services and for staff and volunteers to be trained to the same high standard ensuring the sector feels well equipped to respond to the current demand.

York CVS would like to continue to see an increased awareness and acknowledgement of the specialist services within the voluntary and community sector and the role they can play within Health and Care and safeguarding.

Summary of Adult Safeguarding Data collected 2022/23

Information briefing

Safeguarding Adults collection return 2022-23

1. The Safeguarding Adults Collection (SAC) is an annual statutory return for DHSC that summarises the safeguarding activity (concerns raised, section 42 enquiries carried out, Safeguarding Adults Reviews) of CYC each year. The information in this briefing summarises the main findings of this activity in York during 2022-23. A briefing will be produced at a later date that compares the extent of safeguarding activity in York with other local authority areas.
2. During 2022-23, there were 1,462 individuals involved in Safeguarding Concerns reported to CYC; 1,002 individuals were involved in section 42 enquiries that started in the year and 12 individuals were involved in "other" enquiries that started in the year. This represents a 22% increase in those involved in Safeguarding Concerns compared to 2021-22 (1,200) and a 8% increase in those where section 42 enquiries started (926 in 2021-22). Almost two-thirds (64%) of Safeguarding Concerns during 2022-23 resulted in a section 42 enquiry, which is lower than in 2021-22 (74%); the Covid-19 pandemic, which covered both 2020-21 and 2021-22, has resulted in a large number of these concerns being more complex in nature than previously, so as concerns relating to Covid have eased in the general population, the likelihood of a section 42 enquiry resulting from a Safeguarding Concern has decreased.
3. The number of Safeguarding Concerns in each age group in both 2021-22 and 2022-23 were in broadly similar proportions, with women comprising a slightly higher proportion of those who raised Safeguarding concerns this year compared with 2021-22. The likelihood of a Safeguarding concern being reported increases with age. Whilst the proportions in each ethnic group remained broadly the same in 2022-23 compared with 2021-22, those with Physical Support needs comprised the biggest group of those reporting a Safeguarding Concern this year (726 in 2022-23 compared with 594 in 2021-22); people in this group were also the most involved in a section 42 enquiry (574 in 2022-23, 462 in 2021-22). People with Learning Disabilities were the most likely to see their Safeguarding Concern result in a section 42 enquiry (75% of them did, although this was 87% in 2021-22).

4. Of concluded section 42 enquiries, as a result of the 20% increase from 1,258 in 2021-22 to 1,513 in 2022-23, there were, correspondingly, significant increases in the number that investigated domestic abuse (a 67% increase from 82 to 137); sexual abuse (a 60% rise from 52 to 83); organisational abuse (a 45% rise from 87 to 126); physical abuse (a 31% rise from 439 to 574) and in neglect and acts of omission (a 21% rise from 482 to 584). With the exception of organisational abuse and neglect / acts of omission, it was reported that the source of risk was mainly from individuals, rather than a service provider. The proportions that involved service providers and individuals, for each type of abuse, were broadly similar to those found in 2021-22.
5. The biggest percentage increases in enquiries, by the location of risk, were in community hospitals (up 94% from 16 to 31), in acute hospitals (an increase of 84% from 25 to 46), in the community (excluding community services) – up by 75% from 53 to 93, in residential care homes (an increase of 28% from 295 to 377), and in a person's own home (an increase of 21% from 558 to 665). The only locations to see decreases in enquiries were in community services (down 41% from 32 to 19) and in mental health hospitals (down 10% from 122 to 110). Service providers were the main source of risk where the enquiry focused on concerns raised in community services, care homes and in acute/community hospitals, and individuals the main risk source where concerns were raised in people's own homes, in the community or in mental health hospitals.
6. The most common outcome of a section 42 enquiry was that a "risk was identified and action taken" which occurred in 86% of enquiries (a slight increase from 85% in 2021-22). In 97% of section 42 enquiries that were completed, action was taken as a result, even if the risk assessment proved inconclusive or there was no risk identified (up from 95% in 2021-22). Where a risk was identified by a section 42 enquiry, the risk was reduced in 82% of cases, and removed in a further 14% of cases; in only 4% of cases did the risk remain (a slight decrease from the 2021-22 figure of 5%).
7. Where we have recorded it, there was a slight decrease in the percentage of people having the capacity to make their own decisions during 2022-23 (53% compared with 56% in 2021-22). However, this ability declines with age, as has been reported in previous years, with 69% of those aged 85 or over this year saying that they felt they did not have the capacity to make their own decisions, compared with 30% of those aged 18-64; both of these

percentages have increased since 2021-22 (68% and 24% respectively).

8. In 82% of concluded section 42 enquiries, the individual (or their representative) were asked for their desired outcomes; of these, 84% expressed outcomes. These are both higher than in 2021-22 (75% of enquiries asked for outcomes, with 77% of these expressing outcomes), thus reversing the falls in these percentages in recent years. Subjects were much more likely to say the enquiry “fully achieved” their outcomes (80%) compared with those asked in 2021-22 (74%). The likelihood of an enquiry “fully achieving” desired outcomes rises with age (75% of those aged 18-64 gave this response compared with 95% of those aged 95 or over). Very few of those asked (1%) said that the enquiry did not achieve their outcome, lower than in 2021-22 (2%).
9. There was one Safeguarding Adult Review carried out that took place during 2022-23, compared with two in 2021-22.

The future for York Safeguarding Adults Board 2023 and into the 2024's

The board like many across the country face a range of challenges in the coming year and there are areas of work that need considerable focus to ensure we provide the assurance required to continue to deliver safeguarding services. There will continue to be considerable pressure in relation to demand and we anticipate that areas such as mental health will be impacted for many years to come especially as the full impact of the pandemic is realized.

The cost-of-living crisis will continue to mean there are critical risks faced by some of the most vulnerable in the city. In addition, the work ongoing under the strategic direction of the Police, Fire & Crime Commissioner will hopefully see more women coming forward as they feel better supported by a determined multi agency approach to reduce violence in the future.

I look forward to the Board having improved support in 2023 by the appointment of a full-time manager. The position will be invaluable as multi agency work continues to be fully integrated and as an adult MASH (Multi Agency Safeguarding Hub) is developed in the city.

We look forward to working closely with the new Integrated Care Boards across the region to share best practice and promote the best of what is happening in York.

It is very positive that York is now part of a wider strategic partnership across the region which means we are sharing & using policies that are consistent across Yorkshire & Humberside.

The Board is also committed to working even more closely with colleagues from North Yorkshire SAB where mutual benefit can be delivered not least because many key partners work across both areas.

The Last Word

By Tim Madgwick (Chair)

This will be my final Annual Report as Chair of the Board. I have worked alongside many inspirational individuals who are totally committed to delivering effective safeguarding for the most vulnerable in the city. The volume of work that goes on across all agencies is immense, and there is a determination to continue to improve. There will always be opportunity to improve and learn lessons. York is a brilliant city for so many reasons, but we need to ensure going forward that for those who struggle and are vulnerable we provide support and services that ensure their personal safety, rights and dignity.