CITY OF YORK
Safeguarding Adults Board

Annual Report 2025-26

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.

For more information visit: **safeguardingadultsyork.org.uk**





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Foreword

It is my pleasure to present the City of York Safeguarding Adult Board (CYSAB) Annual Report for 2025-26.

This report reflects the collective commitment, dedication, and hard work of our partners across York in ensuring that adults with care and support needs are protected from abuse and neglect and are supported to live safe, healthy, and independent lives. Safeguarding is everyone's responsibility, and the achievements outlined within this report demonstrate the strength of our partnership approach and our shared determination to put the voice and experience of adults at the centre of everything we do.

The report reflects on our achievements over the last 12 months and highlights the key areas of work undertaken during the first year of delivering the new Strategic Plan 2025–2028. The Board has continued to strengthen its strategic oversight of safeguarding arrangements, promoting learning, accountability, and continuous improvement across all partner agencies. Key priorities during the year have included homelessness and rough sleeping, exploitation and Adults who experience multi-disadvantage. We have also continued to develop our understanding of issues such as self-neglect, domestic abuse, mental health, and inequalities, recognising the importance of early intervention and collaborative working in achieving positive outcomes.

We continue with our focus to enhance the quality of safeguarding practice, and we have been busy this year embedding the learning from our two published Safeguarding Adults Reviews, to ensure meaningful improvements for adults and their families.

While there is much to celebrate in this report, we recognise that safeguarding remains a dynamic and evolving area of work. As we look ahead, we are closely monitoring the expectations that will come from the newly formed National Safeguarding Adult Board. In the meantime, the Board will continue to provide leadership, challenge, and assurance, ensuring that safeguarding remains a priority across our system and that adults in York are supported to live free from abuse, neglect and harm.

The Board remains committed to listening to the experiences of people who use services, carers, and communities. Their insights help shape our priorities and challenge us to continually improve the way we deliver safeguarding support. We know that effective safeguarding is not just about protecting people from harm but about empowering individuals to make informed choices, maintain independence and achieve the outcomes that matter most to them.

I would like to extend my sincere thanks to all Board members, practitioners, volunteers, carers, and community organisations whose dedication and professionalism contribute to safeguarding adults across York. Their commitment to partnership working continues to make a real difference to the lives of many people.

I hope this report provides assurance regarding the effectiveness of adult safeguarding arrangements in York and offers valuable insight into the progress we have made together during 2025-26.



Jane Timson

Independent Chair, City of York Safeguarding Adults Board (CYSAB)

1. About the Board

Who we are

The City of York Safeguarding Adults Board (CYSAB) is a statutory and multi-agency partnership that leads the strategic development of safeguarding adults work across York as specified in the Care Act 2014.

The CYSAB includes three core statutory members:

- City of York Council
- NHS Humber and North Yorkshire Integrated Care Board
- North Yorkshire Police.

Our membership is also made up of nominated lead representatives from a wide range of non-core partner agencies, who actively contribute to the work of the Board.

Board Membership

The Partnership Board draws strength from diverse representation across statutory and community sectors, including:

- Healthwatch York
- North Yorkshire Fire and Rescue Service
- Probation Service Yorkshire and Humber
- York and Scarborough teaching hospitals NHS Foundation Trust
- Tees Esk and Wear Valley NHS Foundation Trust (TEWV)
- Change Grow Live
- York Centre for Voluntary Service
- Yorkshire Ambulance Service
- Department for Work and Pensions
- Elected Members
- City of York Public Health
- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- York Advocacy Hub
- Safer York Partnership
- City of York Safeguarding Children's Partnership
- City of York Housing and Communities
- Independent Care Group

What we do

The work of Safeguarding Adults Board is directed by legislation – the Care Act 2014. The Act sets out the core purpose of the Board is to ensure that local safeguarding arrangements are effective and take account of the views of the local community. The Board also seeks assurance that safeguarding practice is person-centred and outcome focused. The purpose of the CYSAB is to help safeguard people who have care and support needs. Its main objective is to improve local safeguarding arrangements to ensure partners act to help and protect adults experiencing, or at risk of, neglect and abuse.

Our statutory duties

The SAB has three core duties, in accordance with the Care Act 2014:

1. Develop and publish a strategic plan setting out how we will meet our objectives and how our member and partner agencies will contribute
2. Publish an annual report detailing how effective our work has been
3. Commission Safeguarding Adults Reviews (SARs) for any cases which meet the SAR criteria

CYSAB continues to work collaboratively with partner organisations receiving support both from financial contributions and through staff resource to the adult safeguarding board. As governance arrangements change within the CYSAB, this work remains under active review to assess current and future resource commitments.

Recognising the challenges of delivering responsive safeguarding services with limited resources, CYSAB remains focused on making strategic and efficient decisions aligned with the priorities of the CYSAB Strategy. In response to these pressures, the executive group of the CYSAB are in development of a business case aimed at addressing resource challenges, particularly for the number of Safeguarding Adult Reviews and supporting the operational demands of the Board. This work will continue into 2026-27, ensuring CYSAB is equipped to maintain effective safeguarding oversight and coordination.

Contributions from statutory partner organisations

City of York Council: £64,000

North Yorkshire Police: £32,000

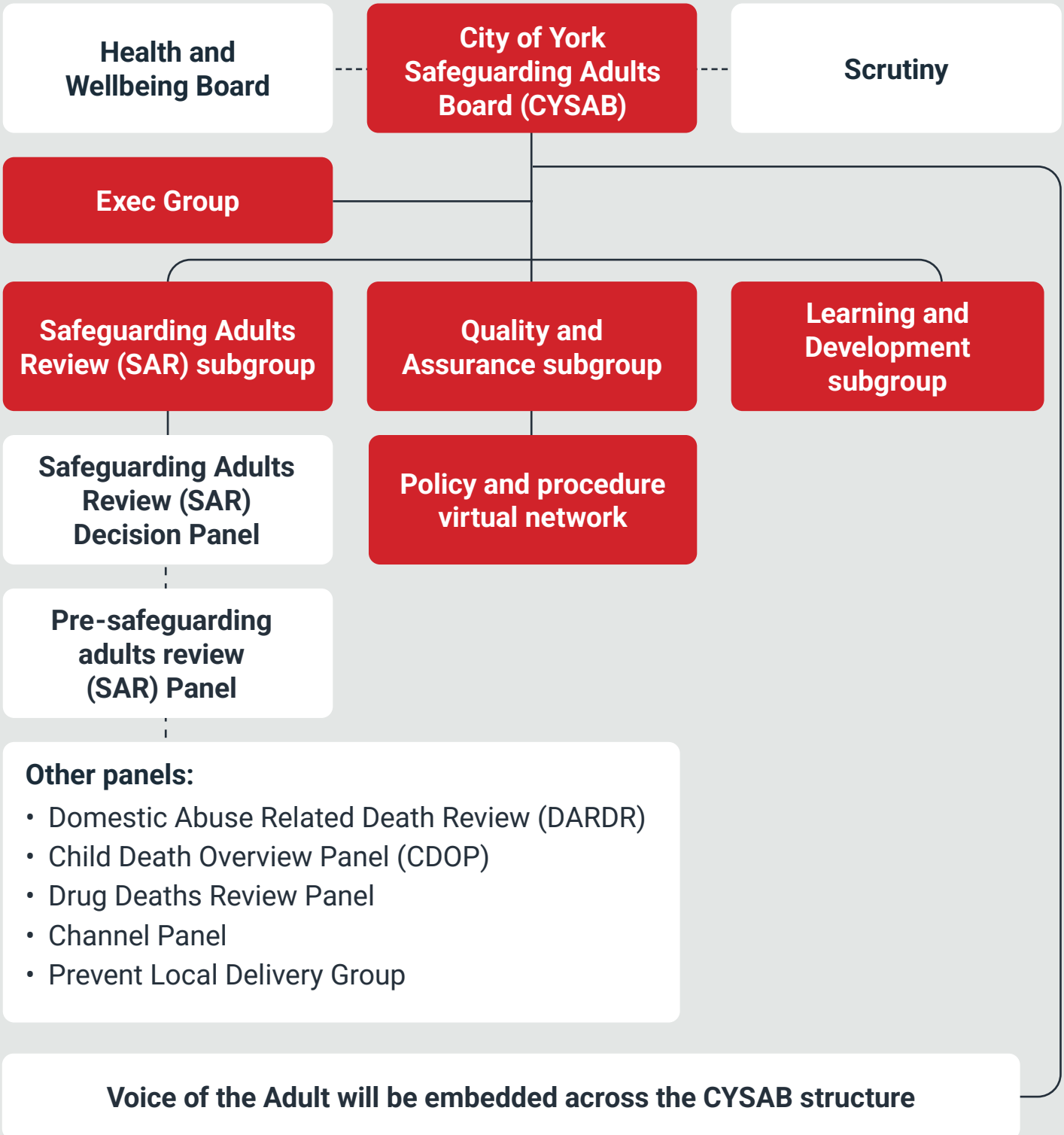
Humber and North Yorkshire Integrated Care Board (ICB): £32,000

CYSAB Budget total: £128,000 for 2025-26

How we function

As a Board we meet four times a year and have four sub-groups. These are the Executive Group, Quality and Assurance, Safeguarding Adults Review and the Learning and Development.

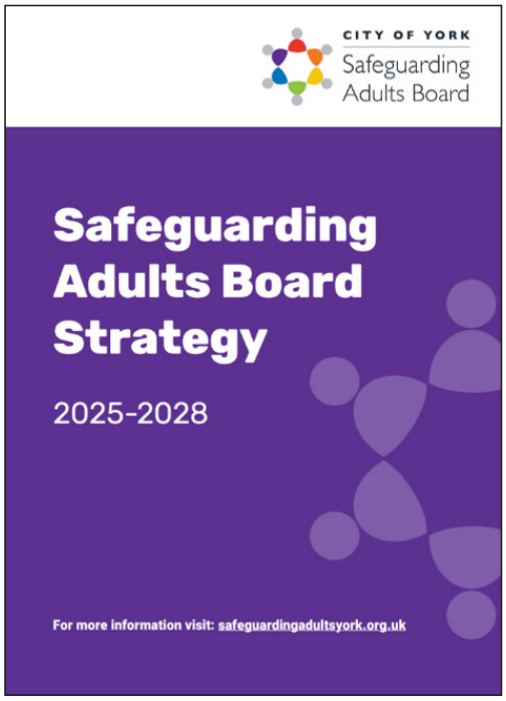
The governance structure of the CYSAB is below, including how we feed into other boards and processes:



2. What the Board has achieved at a glance

CYSAB has developed a number of practice guidance resources during 2025-26 to help support partners working to support adults with care and support needs who may be at risk from abuse or neglect.

New strategy for 2025-28



The York Safeguarding Adults Board developed its 2025-2028 Strategic Plan by reviewing evidence gathered over the previous two years, including learning from Safeguarding Adults Reviews (SARs), partner challenge events, safeguarding data trends, legislation, research, best practice guidance, and feedback from partner organisations. This evidence-based approach helped identify the key issues affecting adults at risk across the city and informed the Board's priorities for the next three years.

The Board's vision is for individuals, communities and organisations to work together to ensure that people in York can live fulfilling lives free from abuse and neglect, recognising that safeguarding is everyone's responsibility. To achieve this, the plan focuses on three strategic priorities: improving prevention, awareness and engagement; promoting learning, reflection and practice improvement; strengthening multi-agency safeguarding responses for adults at risk of exploitation, those experiencing rough sleeping or homelessness, and individuals affected by self-neglect and hoarding.

Reviewed governance structure

The Board undertook a review of its governance structure during 2025-26, which involved observing existing arrangements, attending Board and subgroup meetings, and discussing how effectively the current structures supported the Board's statutory responsibilities. As part of this process, the Board considered its membership, governance arrangements, constitution and subgroup structure, while also identifying opportunities to strengthen multi-agency participation, improve decision-making processes and ensure that safeguarding activity remained aligned with the requirements of the Care Act 2014.

The review highlighted several areas for improvement, including reducing duplication within Safeguarding Adults Review (SAR) processes, strengthening oversight of SAR action plans and ensuring that learning from reviews leads to measurable improvements in practice. Consideration was also given to clarifying the roles and responsibilities of existing subgroups, enhancing quality assurance and performance monitoring, strengthening engagement with people with lived experience through opportunities to hear the voice of the Adult, and exploring whether additional arrangements were needed to support multi-agency learning, development and policy implementation. The overall aim was to create a more streamlined, effective and accountable governance structure that supports continuous learning and improved safeguarding outcomes for adults in York.

Set up focused task and finish groups to look at exploitation, rough sleeping or homelessness and self-neglect and hoarding

The CYSAB Self Neglect Task and Finish Group has played a significant role in establishing a more consistent and coordinated approach to self-neglect across York. Through the development of new pathways, guidance, risk management arrangements and workforce resources, it has laid the foundations for improved multi-agency working and earlier intervention with adults at risk of serious self-neglect. The group has developed a comprehensive Self-Neglect Pathway, the creation of a Multi-Agency Risk Management (MARM) framework, the incorporation of learning from the Self-Neglect Safeguarding Adults Review (SAR), and the establishment of the foundations for improved multi-agency practice, workforce development and future performance monitoring. Together, these developments represent a significant step forward in York's approach to preventing and responding to self-neglect.



Delivered focused workshops to look at rough sleeping and homelessness



The CYSAB held two focused workshops in December and February 2025-26 facilitated by expert professionals on rough sleeping and homelessness to strengthen safeguarding arrangements for adults experiencing homelessness and rough sleeping, particularly those facing multiple disadvantages, complex trauma, poor health, substance misuse and social exclusion. The group's work was shaped by learning from recent homeless deaths in the city and aimed to improve partnership responses, accountability and outcomes through multi-agency collaboration. The group successfully brought partners together to create a shared vision for improving outcomes for adults experiencing homelessness. The group identified key system strengths and gaps, promoting a Housing First and trauma-informed approach, strengthened multi-agency collaboration, and began developing practical solutions around prevention, early intervention, high-risk case management and safeguarding oversight. The work has helped ongoing strategic work already established by the local authority, looking at long term solutions in preventing homelessness and rough sleeping to create a more coordinated, person-centred and preventative response to homelessness across York.

Safeguarding weeks

During 2025, the City of York Safeguarding Adults Board (CYSAB) contributed to two significant safeguarding awareness and learning programmes: The first was safeguarding Week 2025 (June 2025), delivered jointly across North Yorkshire, York, Hull and East Riding.



The second was National Safeguarding Adults Week 2025 (November 2025), delivered in partnership between the City of York Safeguarding Adults Board and North Yorkshire Safeguarding Adults Board under the national Ann Craft Trust campaign.

The June programme was built around the theme “Safeguarding is Everybody’s Business” and provided a comprehensive programme of free learning opportunities for professionals, volunteers and members of the public. The aim was to raise awareness of abuse, neglect and exploitation, promote professional curiosity and strengthen safeguarding practice across all sectors. CYSAB delivered and supported four specialist adult safeguarding sessions including:

- Learning from a recent Safeguarding Adults Review (SAR)
- Operation Soteria: Transforming Responses to Rape and Sexual Offences
- Person in a Position of Trust (PiPoT)
- Self-Neglect Practice Guidance for York and North Yorkshire.

In November, CYSAB partnered with North Yorkshire Safeguarding Adults Board to deliver National Safeguarding Adults Week, supporting the Ann Craft Trust theme of “Prevention Starts Now: Act Before Abuse”. The campaign focused on shifting safeguarding from a reactive response to a preventative approach by encouraging organisations, professionals and communities to identify risk early and take action before harm occurs.



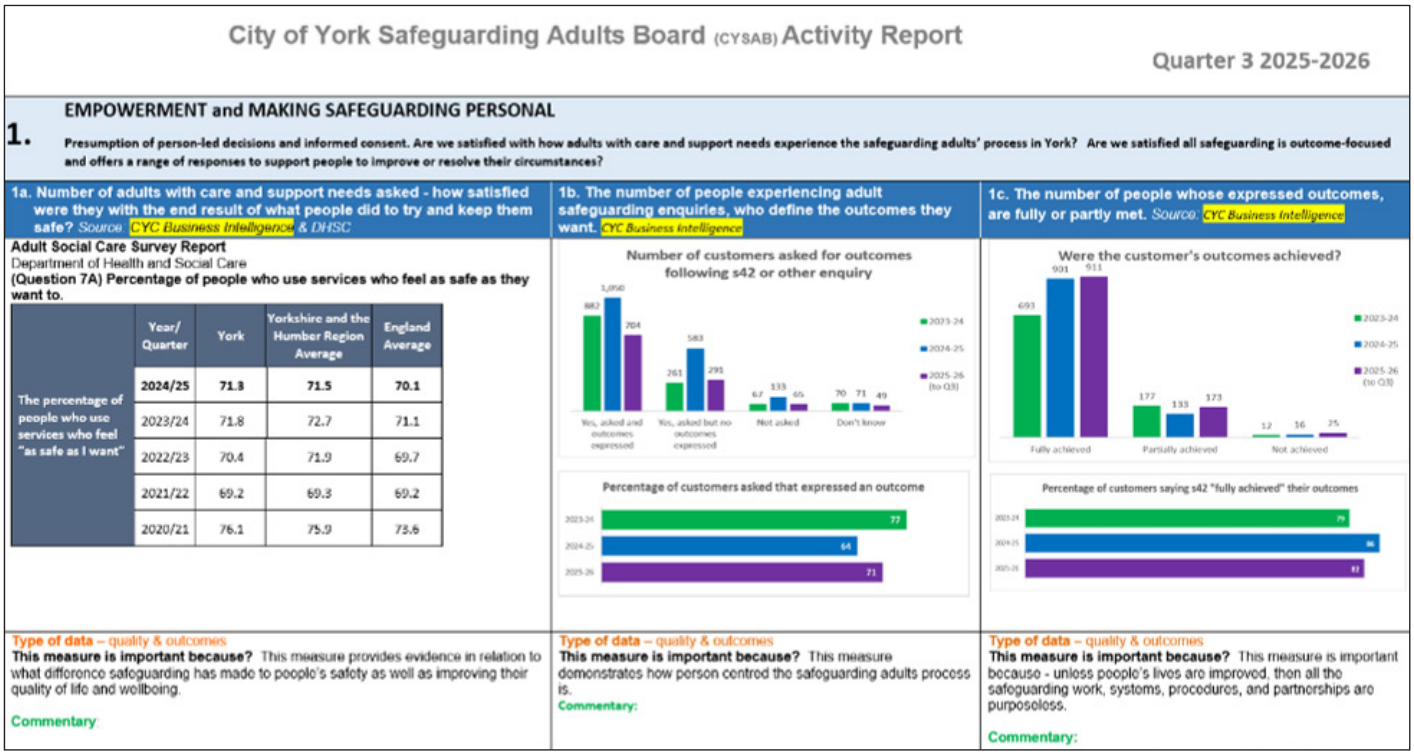
CYSAB hosted two lunchtime learning events:

- Learning from Safeguarding Adult Reviews, covering themes such as professional curiosity, the Mental Capacity Act, complexity, information sharing and lessons from Covid-19
- Understanding PiPoT (Person in a Position of Trust), supporting agencies to respond appropriately to concerns about professionals, students and volunteers working with adults with care and support needs.

In addition, North Yorkshire Fire and Rescue Service delivered a week-long programme covering: hoarding, fire prevention, identifying safeguarding concerns, older drivers, prevention and early intervention, supporting vulnerable adults in social housing and care settings.

Together, the two programmes demonstrated CYSAB’s commitment to making safeguarding everyone’s responsibility while strengthening the partnership’s focus on preventing harm before it occurs.

Creation of a Data activity report to look at Safeguarding Activity



City of York Safeguarding Adults Board (CYSAB) Activity Report

Quarter 3 2025-2026

1. EMPOWERMENT and MAKING SAFEGUARDING PERSONAL

Presumption of person-led decisions and informed consent. Are we satisfied with how adults with care and support needs experience the safeguarding adults' process in York? Are we satisfied all safeguarding is outcome-focused and offers a range of responses to support people to improve or resolve their circumstances?

1a. Number of adults with care and support needs asked - how satisfied were they with the end result of what people did to try and keep them safe? *Source: CYC Business Intelligence & DHSC*

Adult Social Care Survey Report
Department of Health and Social Care
(Question 7A) Percentage of people who use services who feel as safe as they want to.

	Year/ Quarter	York	Yorkshire and the Humber Region Average	England Average
The percentage of people who use services who feel "as safe as I want"	2024/25	71.3	71.5	70.1
	2023/24	71.8	72.7	71.1
	2022/23	70.4	71.9	69.7
	2021/22	69.2	69.3	69.2
	2020/21	76.1	75.9	73.6

Type of data – quality & outcomes
This measure is important because? This measure provides evidence in relation to what difference safeguarding has made to people's safety as well as improving their quality of life and wellbeing.
Commentary:

1b. The number of people experiencing adult safeguarding enquiries, who define the outcomes they want. *CYC Business Intelligence*

Type of data – quality & outcomes
This measure is important because? This measure demonstrates how person centred the safeguarding adults process is.
Commentary:

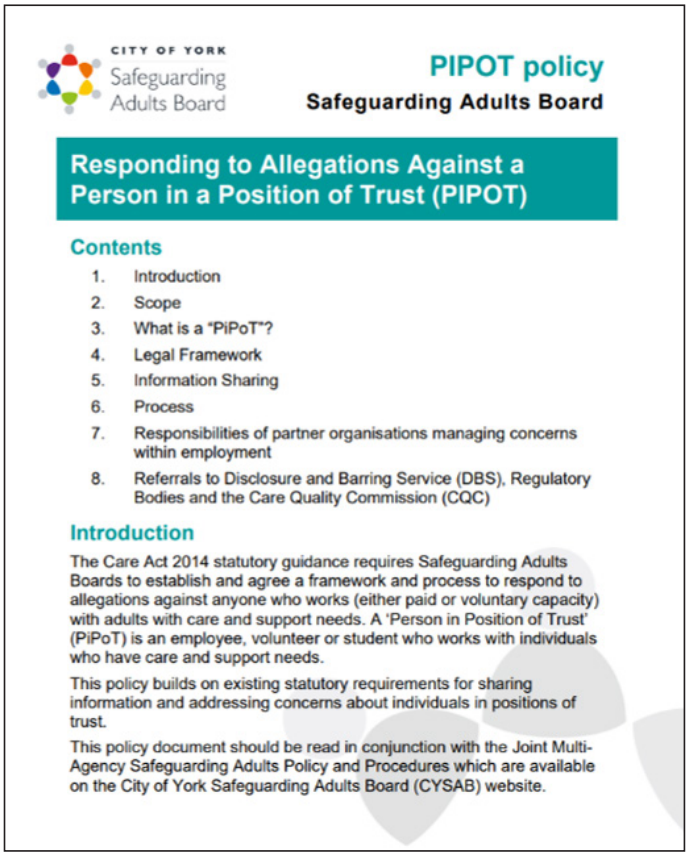
1c. The number of people whose expressed outcomes, are fully or partly met. *Source: CYC Business Intelligence*

Type of data – quality & outcomes
This measure is important because? This measure is important because - unless people's lives are improved, then all the safeguarding work, systems, procedures, and partnerships are purposeless.
Commentary:

The City of York Safeguarding Adults Board (CYSAB) Activity Report was set up in 2025-26 and is designed to provide a comprehensive overview of how effectively agencies across York are working together to safeguard adults with care and support needs. It acts as a performance and assurance framework, bringing together data from partner organisations to monitor safeguarding activity, identify trends and risks, and evaluating whether safeguarding arrangements are delivering positive outcomes for residents. The report is structured around the six Care Act safeguarding principles of Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability, ensuring that safeguarding practice remains person-centred, outcome-focused and compliant with statutory responsibilities.

The report also supports the Board's 2025-2028 strategic priorities, particularly around adults at risk of exploitation, rough sleeping and homelessness, and self-neglect and hoarding. By collating quarterly information on safeguarding concerns, enquiries, abuse types, service quality, safeguarding reviews, workforce training, and multi-agency performance, the report enables the Board to scrutinise effectiveness, identify areas requiring improvement, and drive learning across the partnership. It provides evidence for quality assurance, governance and decision-making, while also contributing to the Board's statutory annual reporting requirements and helping partners understand the experiences and outcomes of adults who access safeguarding services in York.

Developed a PIPOT Practice Guidance



CITY OF YORK Safeguarding Adults Board

PIPOT policy

Safeguarding Adults Board

Responding to Allegations Against a Person in a Position of Trust (PIPOT)

Contents

1. Introduction
2. Scope
3. What is a "PiPoT"?
4. Legal Framework
5. Information Sharing
6. Process
7. Responsibilities of partner organisations managing concerns within employment
8. Referrals to Disclosure and Barring Service (DBS), Regulatory Bodies and the Care Quality Commission (CQC)

Introduction

The Care Act 2014 statutory guidance requires Safeguarding Adults Boards to establish and agree a framework and process to respond to allegations against anyone who works (either paid or voluntary capacity) with adults with care and support needs. A 'Person in Position of Trust' (PiPoT) is an employee, volunteer or student who works with individuals who have care and support needs.

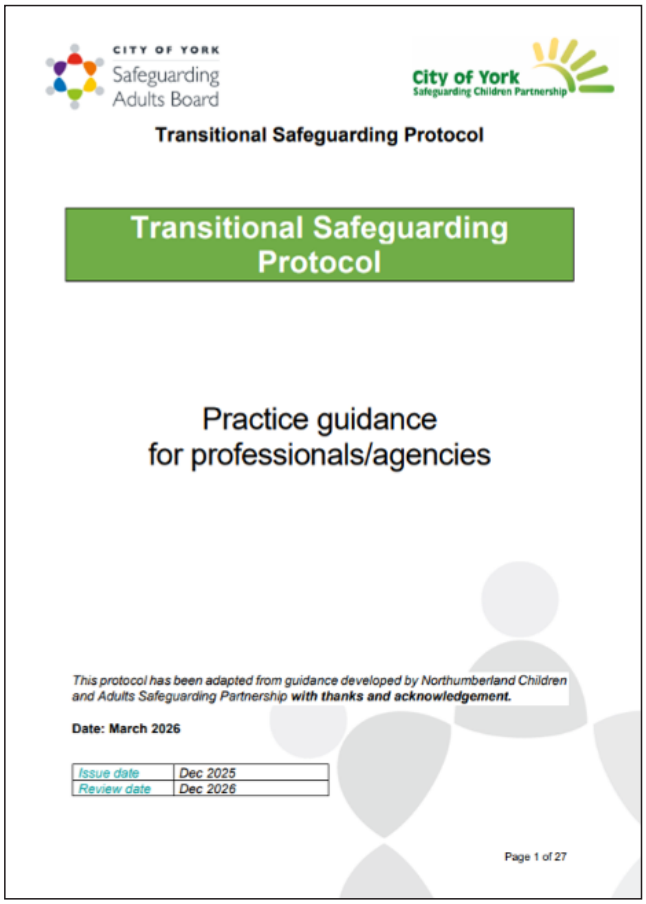
This policy builds on existing statutory requirements for sharing information and addressing concerns about individuals in positions of trust.

This policy document should be read in conjunction with the Joint Multi-Agency Safeguarding Adults Policy and Procedures which are available on the City of York Safeguarding Adults Board (CYSAB) website.

The Person in a Position of Trust (PiPoT) referral mechanism was established during previous years for York and in 2025-26 a PiPoT policy was created which provides a framework for managing allegations, concerns or information about individuals who work, either in a paid or unpaid capacity, with adults who have care and support needs and whose role places them in a position of authority, influence or trust. The policy is intended to ensure that organisations respond appropriately when there are concerns that a worker, volunteer or student may have harmed, exploited or abused an adult or child, committed a criminal offence, or behaved in a way that indicates they may pose a risk to adults at risk of harm. Importantly, concerns may arise from a person's professional role or from their behaviour in their private life, and the focus is on assessing and managing any potential risk to adults with care and support needs.

The policy promotes a proportionate, transparent and multi-agency approach, balancing the need to protect adults at risk with fair treatment of the person who is the subject of the concern. Employers retain primary responsibility for investigating and managing allegations, while safeguarding partners support information sharing, risk assessment and decision-making where appropriate. A key aim is to ensure that relevant information is shared between organisations to prevent individuals who may pose a risk from moving between roles undetected, while also ensuring compliance with legal duties such as safeguarding enquiries, employment procedures, referrals to professional regulators and, where required, the Disclosure and Barring Service (DBS). Ultimately, the PiPoT framework strengthens safeguarding by promoting safer organisations, professional accountability and robust risk management across the partnership. For more information, please visit **safeguardingadultsyork.org.uk/information-professionals/people-positions-trust**

Reviewed and relaunched the Transitional Safeguarding Protocol



The Transitional Safeguarding Protocol developed by the City of York Safeguarding Children's Partnership and CYSAB has existed since 2024 and in 2025 partners from Children and Adult services reviewed how it works operationally as organisations have worked in this area and the mechanisms set up to support young people have adapted and improved with new legislation including Working Together.

The Transitional Safeguarding Protocol sets out how agencies in York work together to support and protect young people aged 16 and over who may continue to face safeguarding risks as they move from children to adult services. It recognises that abuse, exploitation, trauma, neglect and other vulnerabilities do not suddenly end when a young person turns 18, and that differences between children's and adults' safeguarding systems can leave young people at risk of "falling through the gaps". The protocol aims to ensure effective information sharing, timely referrals, joint planning and collaborative working between Children's Services, Adult Social Care and wider partner agencies. Its focus is on maintaining continuity of support, reducing risks, and preventing young people from experiencing a "cliff edge" in services as they approach adulthood.

The protocol promotes a person-centred, trauma-informed and strengths-based approach, underpinned by the principles of Making Safeguarding Personal, contextual safeguarding and partnership working. Transition planning begins from age 16 through consultation between children's and adults' safeguarding teams, with increasing involvement from Adult Social Care from age 17.5 and formal transfer of responsibility at age 18. The guidance emphasises the importance of understanding exploitation, mental capacity, wellbeing, cultural and social factors, and the ongoing impact of trauma. Ultimately, the protocol seeks to ensure that vulnerable young people receive coordinated, flexible and effective safeguarding support that continues seamlessly into adulthood, helping them achieve better outcomes and remain safe.

assets.publishing.service.gov.uk/media/69fb1c28d0e316a40f269a5b/Working_together_to_safeguard_children_2026_a_guide_to_multi_agency_working.pdf

Maintained a public facing website

The CYSAB website has continued to improve during 2025-26 with dedicated pages for public and professionals with links to policy and procedures, resources and SAR reports and 7-minute briefings. The City of York Safeguarding Adults Board website provides information and accessible guidance on safeguarding adults with care and support needs. The website explains what adult abuse and neglect are, how to recognise the signs of harm, and what actions individuals can take if they are concerned about the safety or wellbeing of an adult. There are lots of resources for residents, carers, families and communities promoting awareness of safeguarding issues and providing clear routes for reporting concerns. A prominent feature of the site is the “Raise a Concern” function, which helps people access support and report potential abuse or neglect quickly and appropriately.



The website also supports professionals by providing access to safeguarding policies, procedures, practice guidance, multi-agency resources, safeguarding adults reviews, training materials and information about the role and work of the Safeguarding Adults Board. The website supports the Board’s role in preventing abuse, improving safeguarding practice, raising public awareness and ensuring that both professionals and members of the public can access the information they need to protect adults at risk in York. **safeguardingadultsyork.org.uk**

3. What does our data tell us?

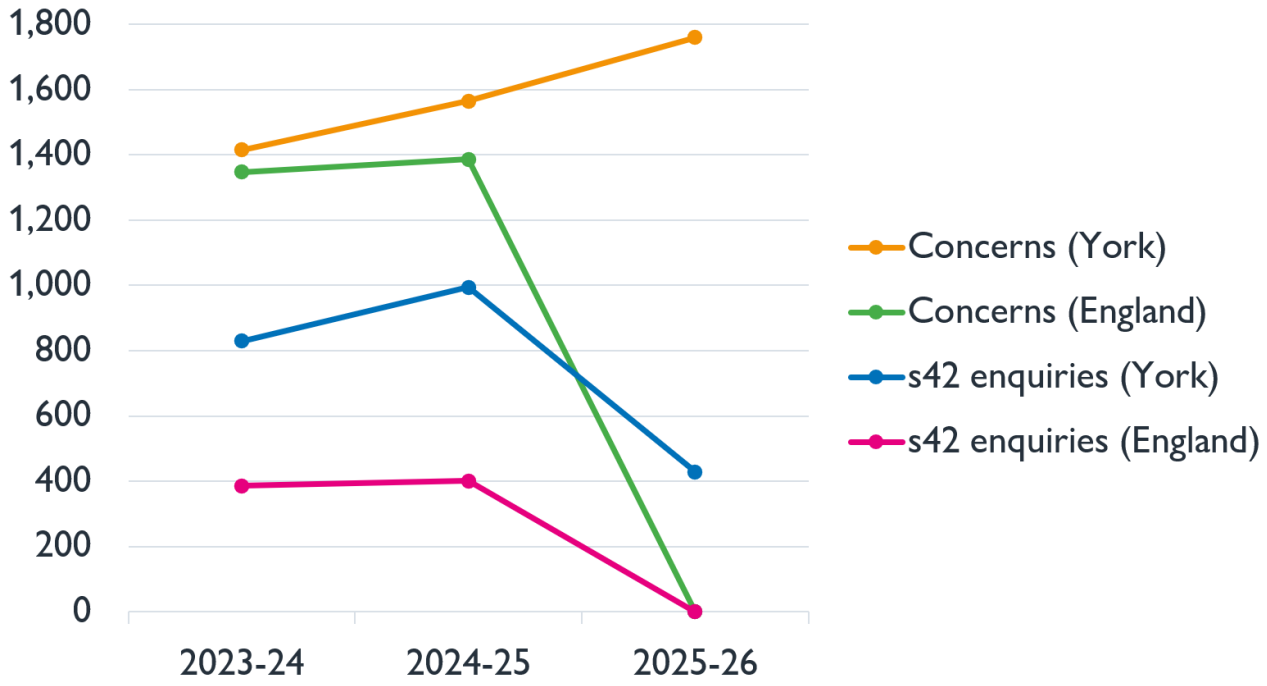
This section outlines our key safeguarding activity data relating to our safeguarding arrangements, and any arising themes and observations.

The full data set is published on the NHS Digital website: digital.nhs.uk/data.

Safeguarding activity over the last three years

Safeguarding activity	2023-24	2024-25	2025-26
Safeguarding concerns reported	2,438	2,735	3,088
s42 enquiries completed	1,428	1,738	752
Other enquiries completed	18	10	13
s42 enquiries as % of safeguarding concerns — York	58.6	63.5	24.4
s42 enquiries as % of safeguarding concerns — England	28.7	28.9	TBC

Safeguarding concerns / Section 42 enquiries per 100,000 adults, 2023-24 to 2025-26



Adult population (mid-year estimate)	2023-24	2024-25	2025-26
York	172,168	174,801	175,501
England	45,691,677	46,161,380	46,877,209

Overview:

- There was an increase of 13% in the number of safeguarding concerns recorded in 2025-26, compared with 2024-25. There has been a 27% increase in safeguarding concerns recorded in York since 2023-24.
- In 2025-26 24.4% of safeguarding concerns resulted in a section 42 enquiry and this number was substantially lower than in 2024-25. The reason for this is that in previous years, where work had been done that met the threshold for a section 42 (s42), but the enquiry was not undertaken, this was counted as a s42 enquiry, which made Yorks "concern to s42 conversion rate" in previous years considerably higher than those in other Local Authorities (LA). In order to be in line with the practice adopted by other LAs, a decision was made that York would no longer include that work done that met the threshold for a s42 but where the enquiry was not undertaken as "s42 enquiries", and thus as a consequence the number of "s42 enquiries" recorded dropped considerably in 2025-26 compared to 2024-25.
- We continue to work with partners about what constitutes a 'good safeguarding referral' and direct partners to the guidance published in our online policy and procedures (**wynyy-cityofyork.trixonline.co.uk**)
- Whilst the number of individuals involved in safeguarding enquiries has remained stable, there has been a slight increase in 'other' enquiries. In accordance with the Care Act 'other' enquiries are those where there is no duty to undertake enquiry, but the local authority deems it to be the most appropriate and proportionate response to the circumstances
- In 2025-26, two Safeguarding Adults Review (SAR) were published. There are a number of SARs currently in progress. Further information on SARs is available on **page 54**.

Age

Age band	2023-24	2024-25	2025-26	% change 2023-24 to 2025-26
18–64	570	677	812	**42**
65–74	171	217	213	**25**
75–84	319	365	425	**33**
85–94	366	401	428	**17**
95+	106	102	102	**-4**
Not Known	5	5	1	**-80**

Sex

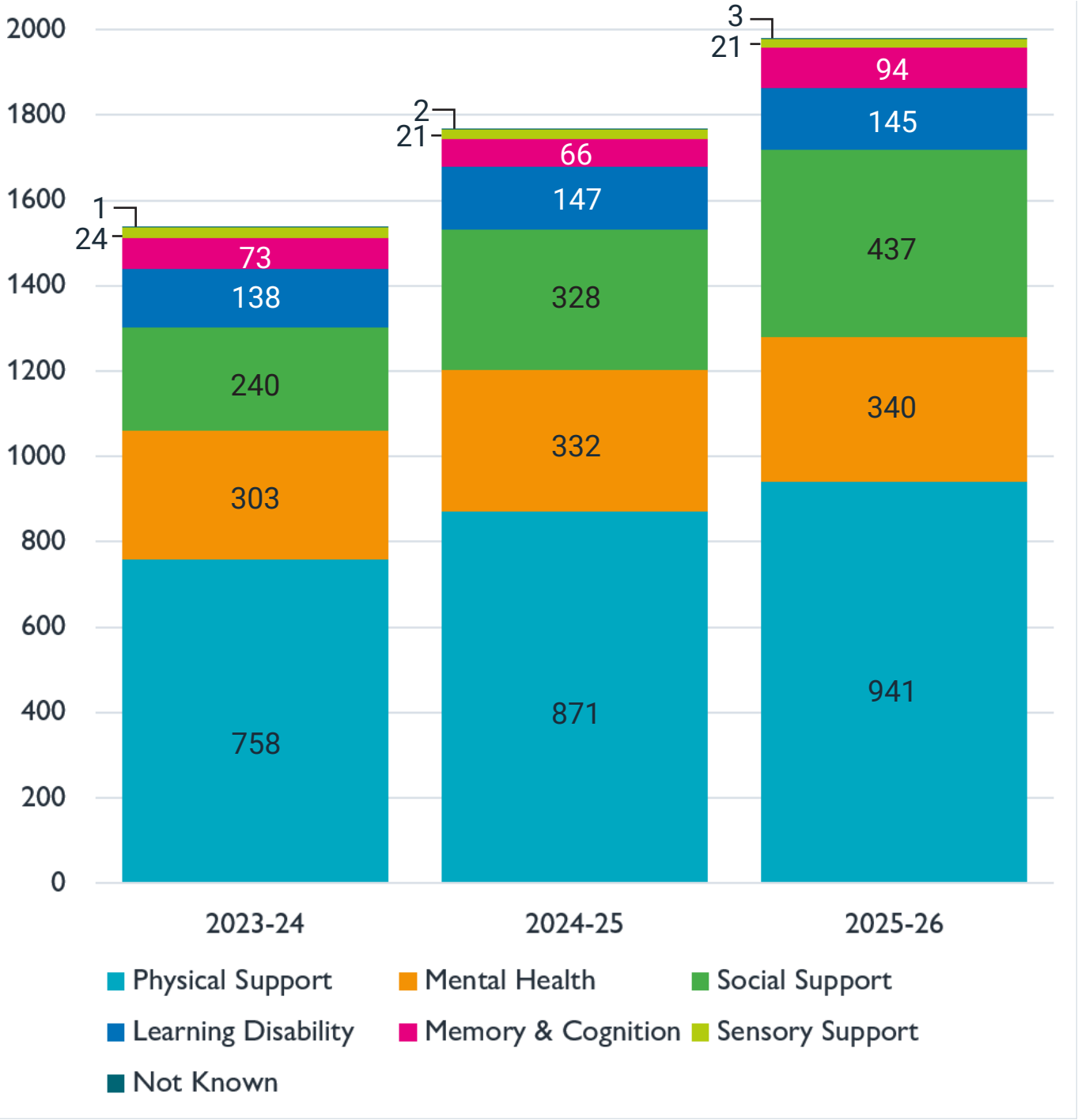
Sex	2023-24	2024-25	2025-26	% change 2023-24 to 2025-26
Male	568	667	764	**35**
Female	906	1000	1,141	**26**
Not known	63	100	76	**21**

Ethnicity

Ethnic origin	2023-24	2024-25	2025-26	% change 2023-24 to 2025-26
White	1,354	1,488	1,732	**28**
Other	39	47	68	**74**
Refused/Unknown	144	232	181	**26**

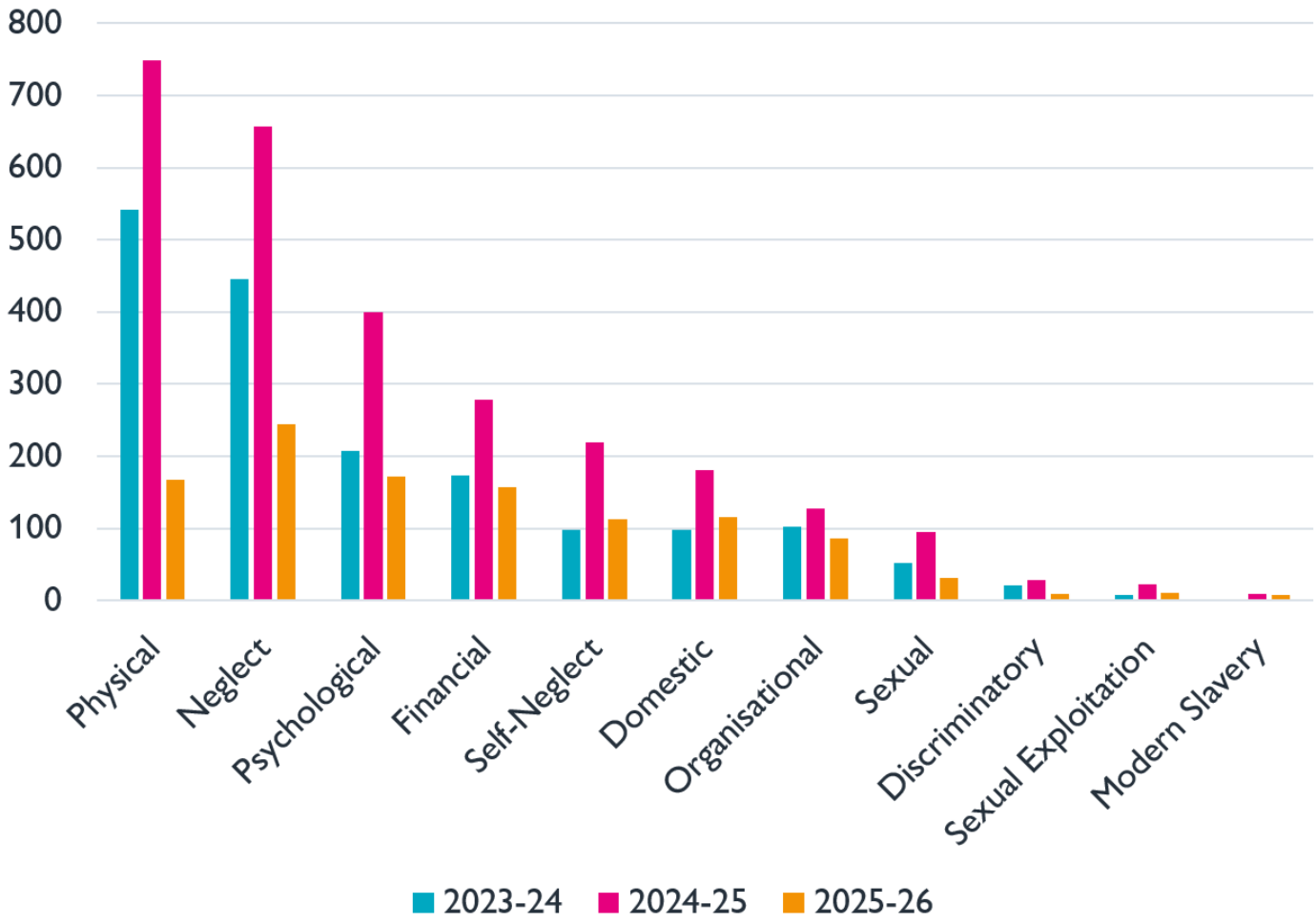
The biggest percentage increases in concerns in recent years have been amongst those aged 18 to 64, and by males, although older people and females are still more likely to be the subjects of concerns. Although the number of concerns reported by ethnic minorities has increased, they still make up a relatively small proportion of all concerns, broadly in line with the proportion of adults in the York population that have ethnic minority backgrounds.

Individuals involved in Safeguarding Concerns by PSR, 2023-24 to 2025-26



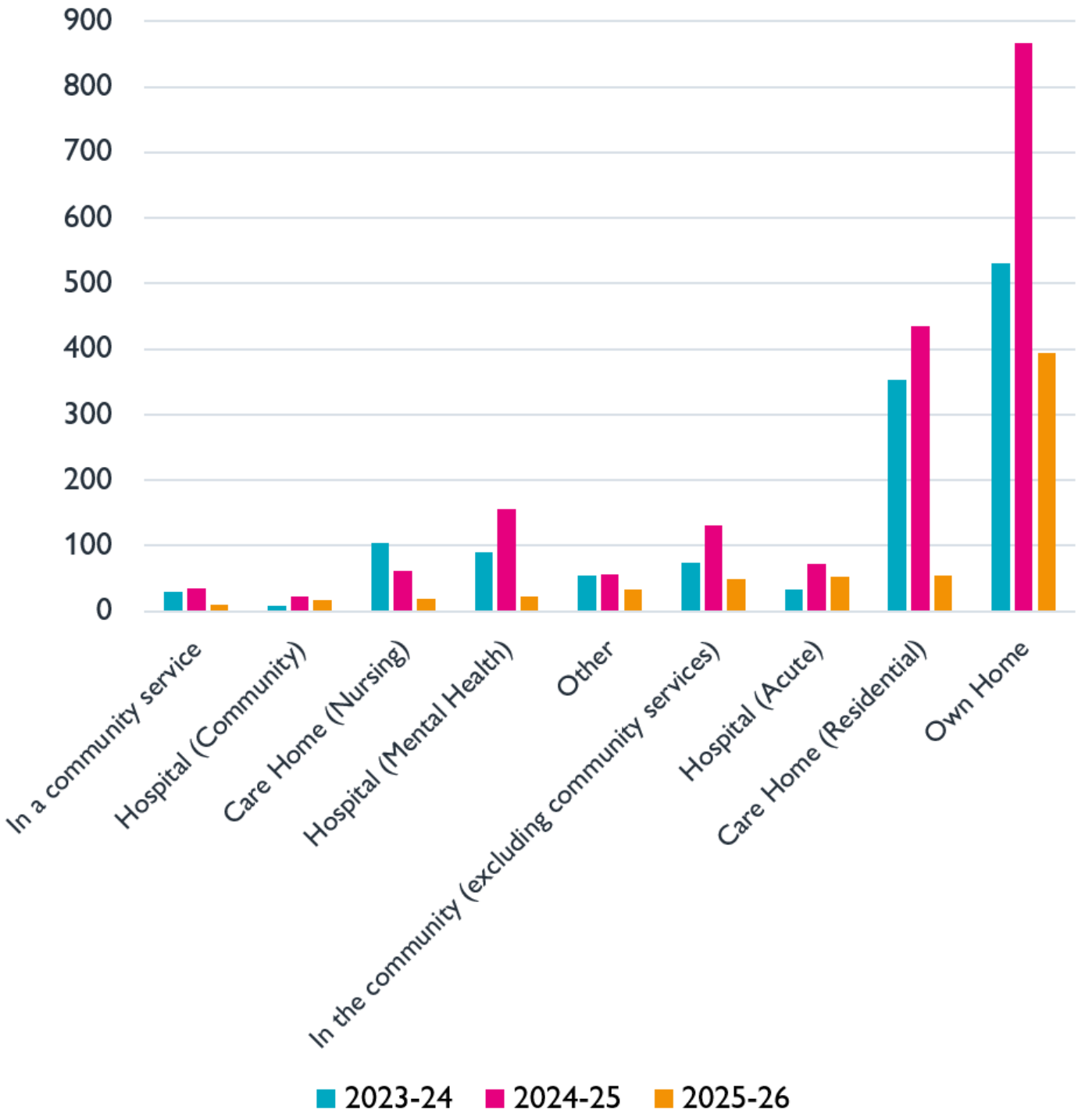
Approximately 50% of safeguarding concerns each year have been reported by people with physical support issues, although there has been a notable increase during recent years in the number recorded with Social Support issues.

Section 42 enquiries by type of abuse investigated, 2023-24 to 2025-26



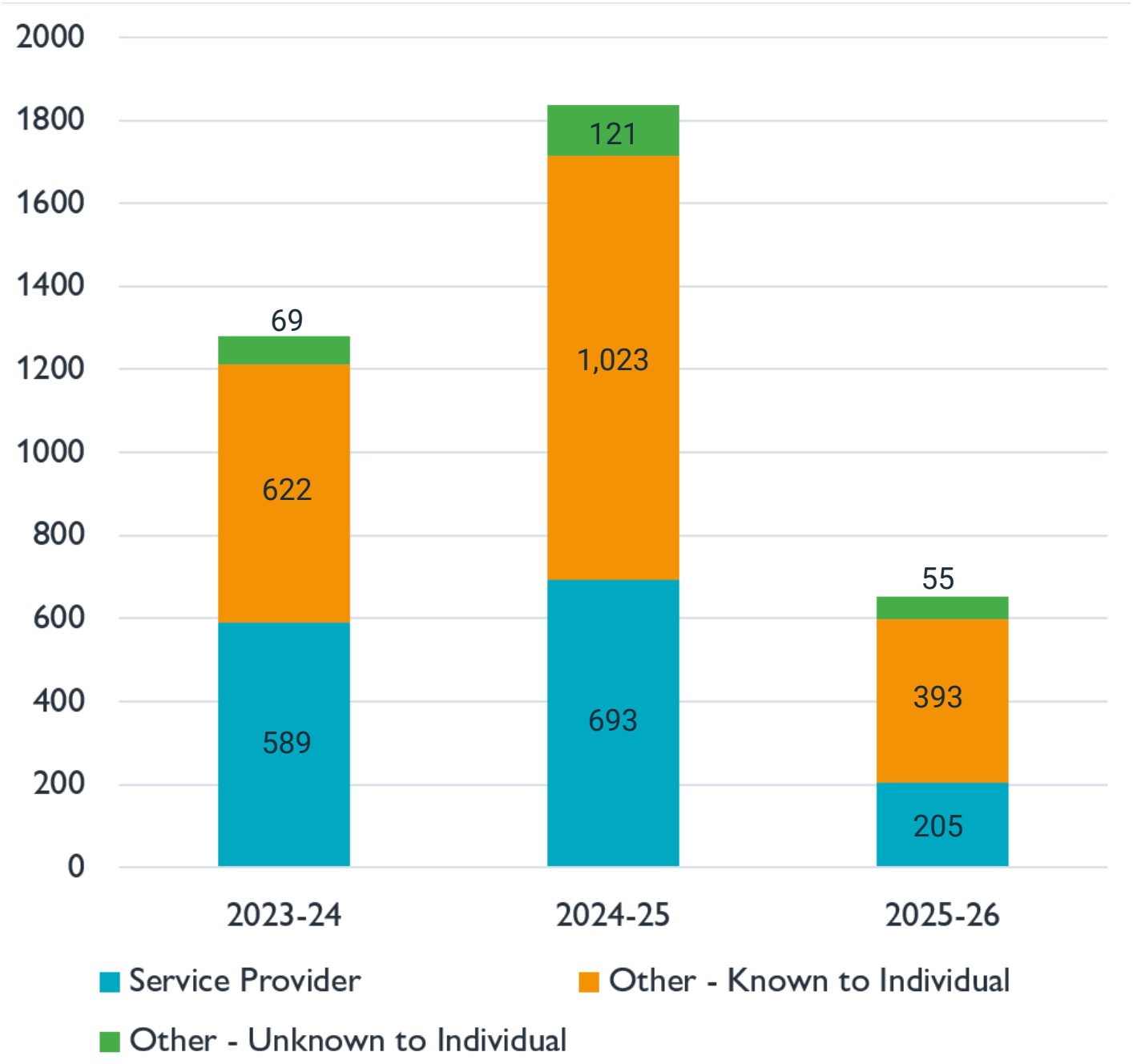
- Physical abuse was the most common type of abuse recorded in 2024-25 Neglect was the most common type of abuse recorded in 2025-26 whereas in 2023-24 and 2024-25 physical abuse was most common.
- In 2025-26 psychological abuse was investigated more often than physical abuse.
- There has been targeted work undertaken to ensure multiple abuse types are being captured appropriately, although the reductions in numbers recorded in 2025-26 are as a result of the change in definition of what constitutes a section 42 enquiry. (see page 18).

Section 42 enquiries by location of abuse investigated, 2023-24 to 2025-26



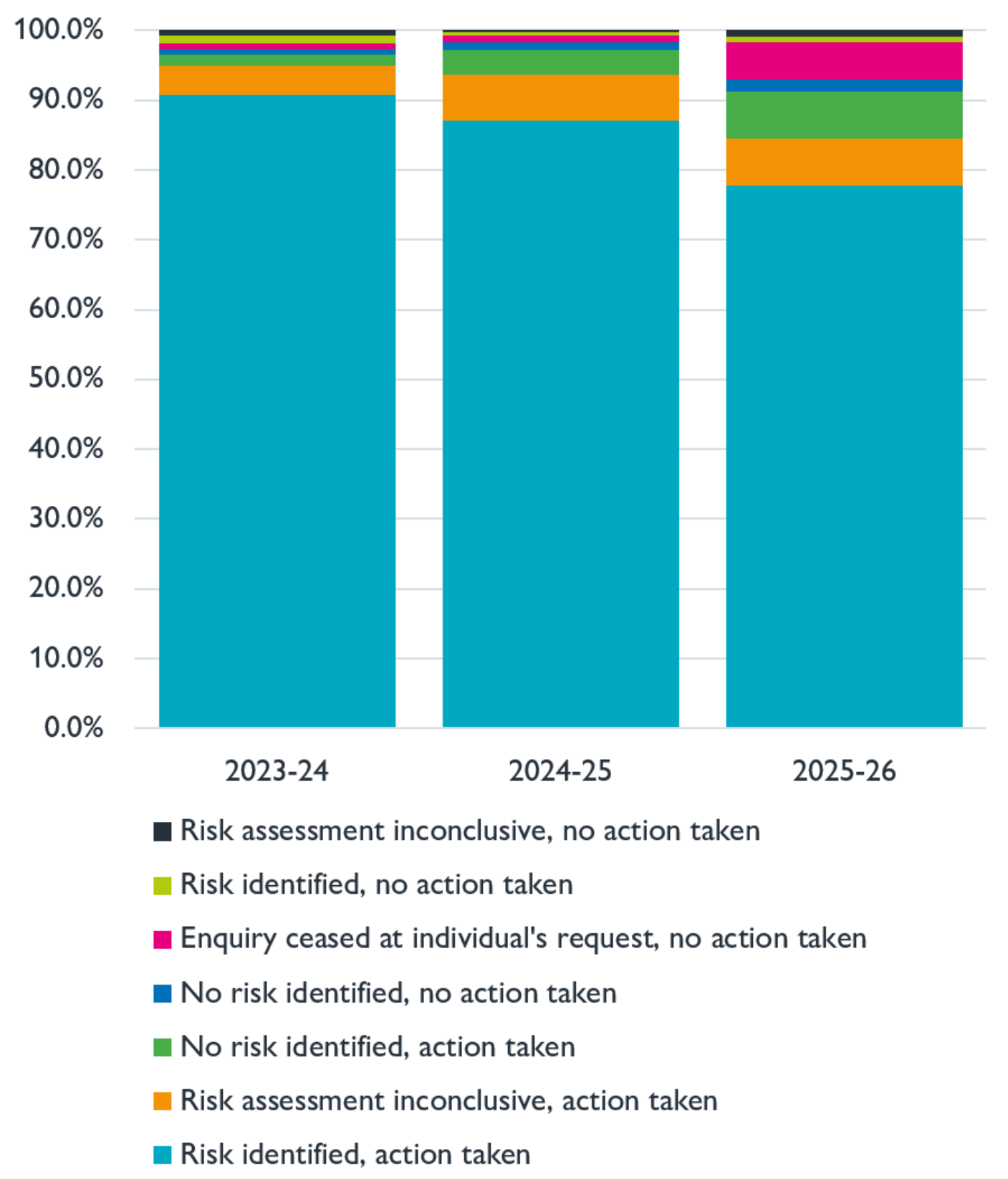
An individual's "own home" is increasingly more likely to be the setting investigated by a s42 enquiry: 60% of completed s42s in 2025-26 had an individual's "own home" as a setting, up from 47% in 2024-25. Only 11% of s42 enquiries had a care home as a setting in 2025-26, down from 27% in 2024-25.

Section 42 enquiries by source of risk, 2023-24 to 2025-26

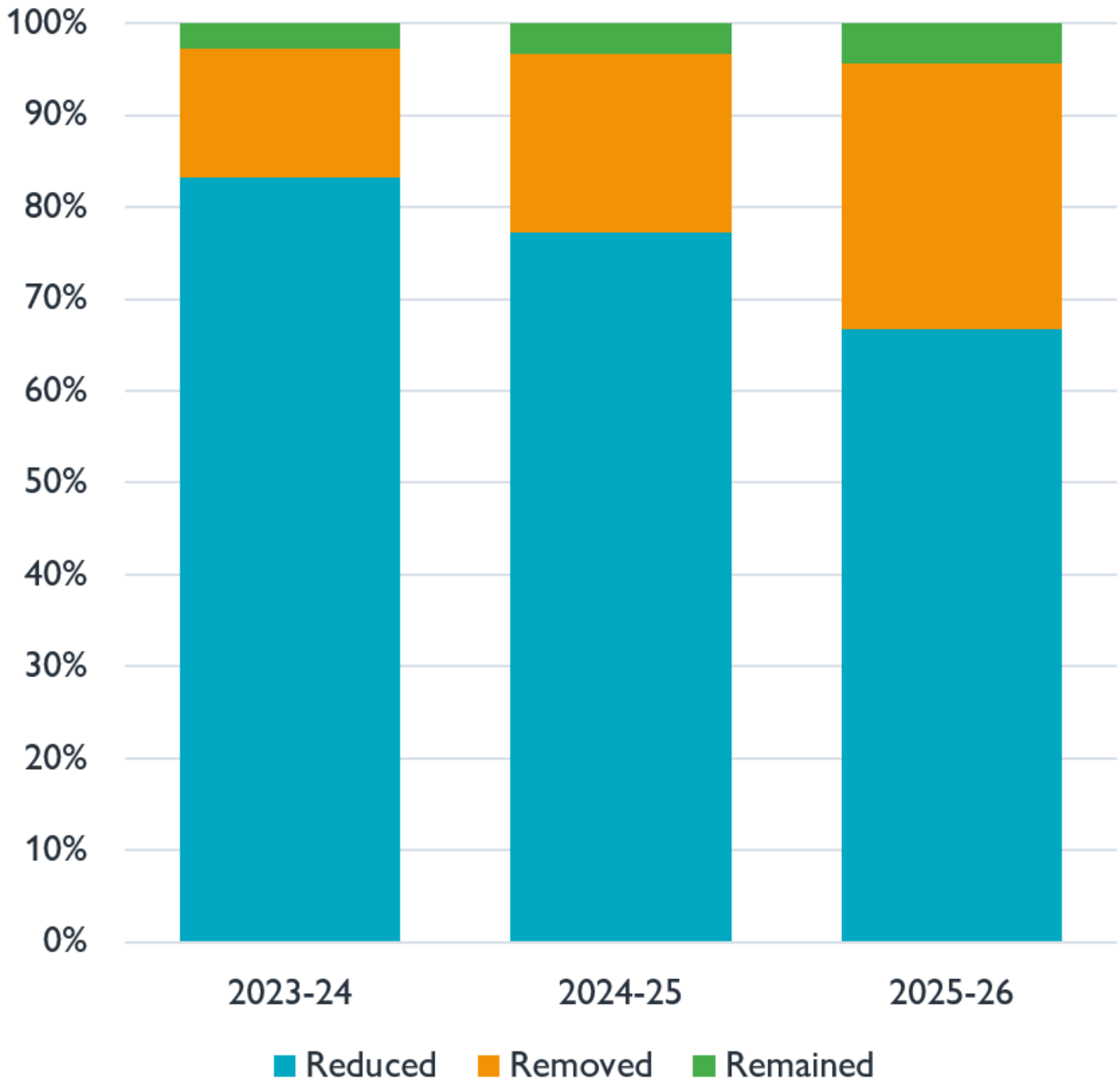


The most likely source of risk to an individual continues to be someone known to an individual.

Outcomes from Section 42 assessments, 2023-24 to 2025-26



Change in risk where identified by Section 42 enquiry, 2023-24 to 2025-26



- A risk was identified, and action taken, in 78% of enquiries during 2025-26, which represents a significant decrease compared to the previous two years.
- There was a notable increase in the percentage of enquiries where a risk was not identified but action was taken in 2025-26 compared to previously.
- Where a risk was identified, it was more likely to be removed during 2025-26 than during previous years; the likelihood of a risk remaining in 2025-26 was similar to 2023-24 and 2024-25.

In 2025-26, there were 653 completed section 42 (s42) enquiries; in 38 of them it is not recorded whether or not the subject was asked for their opinion.

91% of individuals involved in section 42 enquiries were asked to express an outcome.



Of the 615 s42 enquiries in 2025-26 where there is information as to whether the subject was asked for their opinion, in 560 (91%) of them, the subject was asked for an opinion.

83% of individuals expressed their outcomes when asked.



Of the 560 s42 enquiries in 2025-26 where a subject was asked for an opinion, in 465 (83%) of them an opinion was expressed.

Where an opinion was expressed, in 363 (78%) of the 465 enquiries the subject said the s42 “fully achieved” their aims, and in a further 97 (21%) of them the subject said the s42 “partly achieved” their aims.

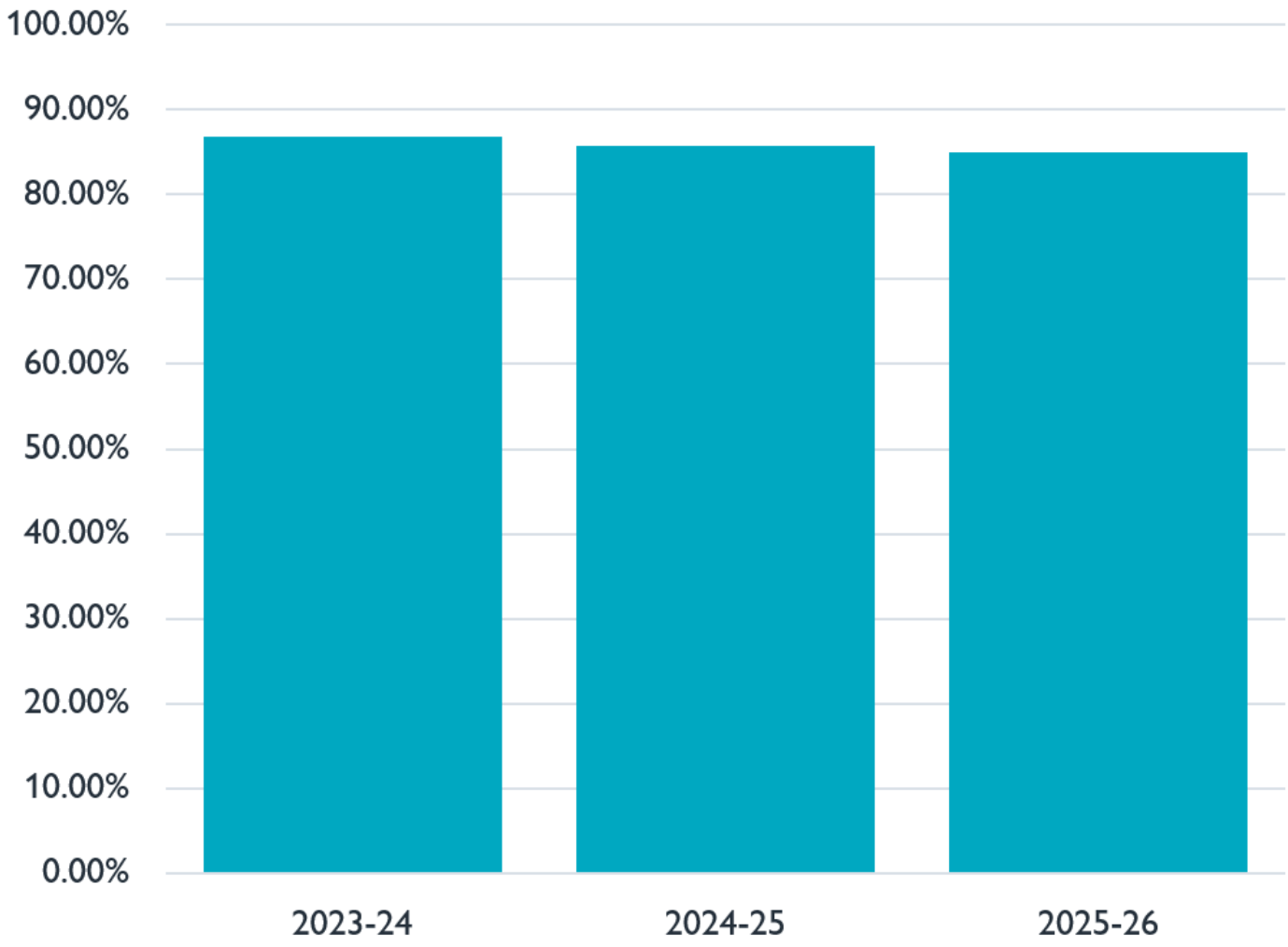
27% lacked capacity to be involved in section 42 enquiries.



In 87 of the 653 completed section 42 enquiries during 2025-26 it was not recorded or known whether the subject lacked capacity.

In the other 566 s42 enquiries where there is information recorded about whether the subject lacked capacity or not, in 153 (27%) of them the subject was considered to have lacked capacity to participate.

85% of people lacking capacity who had an advocate, family or friend at s42 enquiry during 2025-26. This was in line with previous years.



4. Our Strategic Plan 2025–28

In order to meet the needs of adults in the City of York we have developed three areas of focus for our strategic plan which has guided the way we work together as a Board during 2025-26 and over the next two years to safeguard our communities and the safeguarding areas we want to strengthen which include:

1. Prevention, awareness and engagement
2. Learning, reflection and practice improvement
3. Strengthening multi-agency safeguarding responses to:

Part 1: Adults at risk of exploitation

- We will create an exploitation task and finish group to explore multi-agency safeguarding responses to adults at risk of exploitation, including developing and implementing pathways, guidance and protocols to support individuals who experience multiple disadvantage to help mitigate risk faced by individuals.
- We will further embed the need to report concerns about any person in a position of trust (PIPOT) and ensure that pathways to address concerns are embedded in practice.
- We will seek assurance about the quality of services and practice by the development of a multi-agency dashboard to help SAB identify themes and trends across the partnership

Part 2: Adults at risk of self-neglect and hoarding

- We will create a task and finish group to explore multi-agency safeguarding responses to adults at risk of self-neglect to help create a clear accessible pathway for identifying concerns and to assess and respond to self-neglect, which will include a multi-agency risk management protocol.

Part 3: Adults at risk of rough sleeping and homelessness

- We will create a task and finish group to explore multi-agency safeguarding responses, by engaging with specialists to explore what good looks like to develop and implement pathways, guidance and protocols to provide a more joined up response to those that are rough sleeping or homeless.

The Strategic Plan for 2025 to 2028 can be downloaded in PDF format on the CYSAB website.



5. How have partners responded to our areas of focus in our Strategic Plan 2025 -28?

The CYSAB continued to strengthen its membership arrangements during 2025 – 2026 despite Integrated Care Boards (ICBs) and Healthwatch facing disruption driven by a national mandate to cut ICB running costs by 50% and challenges faced by Health watch partners in terms of sustainability.

The CYSAB held a face-to-face challenge panel event in January 2025 which helped to build relationships and identify future priorities. Below are some of the highlights from some of our partners and how they met our objectives for the year.

5.1. Prevention, Awareness and engagement

What we said we would do over the next three years:

- We will collaborate with community groups to promote safeguarding awareness and to develop tailored approaches to prevention to increase safeguarding knowledge and awareness within targeted groups.
- We will develop and deliver public messages and promote safeguarding awareness campaigns aimed at the public providing clear guidance and support for those that raise concerns.
- We will maximise safeguarding week engagement, promoting it with multi agency contributions to present a variety of online sessions to support our priority.

City of York City Council Adult Social Care (CYC ASC)

As part of the work support the public make good referrals City of York Council (CYC) has led on the drafting of guidance to help people make good referrals.

CYC has targeted a range of groups, developing relationships with York University to raise awareness in the student population and has worked with organisations including the hospice to support safeguarding during end-of-life care.

Safeguarding week has been used as a platform to support the safeguarding community with priority areas including self-neglect, multi-agency risk management, transitional safeguarding and the roll out of guidance on employers' responsibilities to protect adults where there are allegations about a person in a position of trust (PiPoT).

Humber and North Yorkshire Integrated Care Board (HNY ICB)

Humber and North Yorkshire ICB have:

- Provided statutory leadership to CYSAB through Director Level and Designated Professional representation
- Embedded safeguarding responsibilities across the health system, with a focus on equity, inclusion and access
- Ensured learning from Safeguarding Adults Reviews (SARs) and Domestic Abuse Related Death Reviews (DARDR) were shared across health partners through provider forums, supervision and professional networks
- Offered system support and strategic safeguarding leadership to the Military Health Safeguarding Network to strengthen safeguarding responses for serving personnel, veterans and their families

The NHS Safeguarding Accountability and Assurance Framework (due for review in April 2026) is embedded within the ICB safeguarding structures: **england.nhs.uk/long-read/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs/**

North Yorkshire Police (NYP)

Operation Soteria is how a force is going to transform its response to rape and The NYP Violence Against Women and Girls (VAWG) sergeant has been highlighting adult safeguarding concerns and multi-agency training opportunities through our internal messaging Viva Engage. This has included posts on self-neglect and hoarding as well as a campaign over the festive period on the '12 days of VAWG'.

Public facing communications have been published on the following topics:

- A new 'Harassment and stalking' section on the NYP website, with crime prevention advice and a bespoke reporting form
- Domestic Violence Disclosure Scheme (DVDs) myth buster published in June
- Sexual Violence Awareness Week 2 to 6 February 2026

Social media content focusing on:

- Dispelling myths about rape and sexual assault
- Spiking awareness in relation to vapes, smokes, Spiking – it's not only drinks
- Male victims encouraged to come forward Sexual violence happens to men.
- Shared local Independent Domestic Abuse Service (IDAS) video: Three independent sexual violence adviser or advocate (ISVA)s answering common questions An Independent Sexual Violence.
- Article by our local Independent Domestic Abuse Service and our Soteria team about our joint working with Independent Sexual Violence Advisor/Advocates and victim and survivors' panel. This considers how Survivor Voices are Influencing Police Responses to Rape and Serious Sex Offences.

NYP have been involved in various activities including:

- Outreach events attended by Inclusion Team around force including events for the Deaf community, Refugee drop ins and religious groups (Jewish and Muslim groups) to highlight NYP access and develop relationships
- Independent Advisory Groups (IAG), inclusion team attendance at York/Selby IAG and County Command IAG
- Joint police and Office for Policing, Fire, Crime and Commissioning (OFPCC) pop up events, directing public to the emergency services community survey to share views on NYP and North Yorkshire Fire and Rescue Service (NYFRS) including safeguarding
- Inclusion Team is contributing to the Whole systems approach (ensuring everyone is safeguarded) practice in York and North Yorkshire

City of York Public Health

- Domestic Abuse Engagement Officers have delivered awareness sessions to over 300 community leaders and volunteers, with evaluation indicating an improvement in their understanding of the definition of domestic abuse and its prevalence in York.
- Targeted work was undertaken to raise awareness of domestic abuse and support services within the LGBTQ+ community. Outcomes include an increase in professionals' confidence and knowledge in identifying and responding to domestic abuse, and an improvement in relationships with leaders within this community.
- Several domestic abuse focused workshops were delivered as part of safeguarding week. Topics included domestic abuse and suicide.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- The Safeguarding and Public Protection Team continue to provide a daily duty support line and planned specialist safeguarding supervision available to all Trust staff for timely and practical advice and support.
- The Safeguarding and Public Protection Team continue to promote awareness and understanding of the Safeguarding Adults Board in mandatory safeguarding training. In addition, they have provided bespoke training to clinical services on request and regularly offer development sessions to Safeguarding Link Professionals across the Trust (over 25-26, the agendas for the development sessions were driven by survey feedback from the Link Professionals on the safeguarding topics they felt would be helpful to cover).
- The safeguarding and Public Protection Team send regular bulletins to clinical services which include learning from multi-agency reviews and promotion of information and training opportunities provided by the Safeguarding Adults Board.
- The Safeguarding and Public Protection Team is contributing to a TEWV communication workstream to improve multi-agency communication, challenge common myths, and support staff understanding of consent, confidentiality, and appropriate information-sharing.

- The Safeguarding and Public Protection Team have actively engaged with National Safeguarding Week delivering a range of activities across TEWV impacting patients, visitors, and staff. Feedback from engagement activities was reported as positive, with examples shared demonstrating improved understanding, reassurance and access to appropriate support.
- Throughout 2025-26, the Trust have worked alongside the family of a patient who lost his life to suicide in 2021 on the campaign 'Chris's Voice'. The campaign aims to raise awareness of the patient and family voice, reduce the stigma associated with mental illness, and eliminate judgement with materials produced to promote this throughout the Trust. The campaign work also focuses on encouraging and supporting clinicians to raise any concerns they may have about care decisions made.

York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTHFT)

York and Scarborough Teaching Hospitals NHS Foundation Trust continues to support the prevention of abuse and neglect through a combination of safeguarding leadership, workforce development, specialist practitioner support and multi-agency partnership working. During 2025-26, safeguarding activity focused on promoting early identification of risk, supporting staff to recognise safeguarding concerns, strengthening a Think Family approach and enhancing support for patients with complex needs across clinical services.

Key developments included safeguarding training and supervision, pre-birth planning processes, specialist domestic abuse provision and ongoing engagement with multi-agency safeguarding partners. The YSTHFT 's Integrated Safeguarding Group provides oversight of safeguarding risks, themes and learning, supporting continuous improvement and assurance. In addition, Safeguarding Week and wider staff engagement activities have helped raise awareness and reinforce safeguarding as a shared responsibility across the organisation.

Probation Service Yorkshire and Humber

The Probation Service have supported work with vulnerable adults through our work with:

- York Women's Centre and St Giles
- Supporting those with substance misuse issues
- Ensuring safeguarding adult representation at MAPPA L2 meetings
- Making appropriate referrals to Safeguarding Adults team.
- Ensuring staff have completed their mandatory safeguarding adults learning.
- Ensure staff are making referrals to Reconnect who provide healthcare pathways from prisons to the community.
- Have a Senior Probation Officer who holds the Single Point of Contact (SPOC) role for safeguarding adults.

We continue to raise awareness with staff around safeguarding adults including promoting campaigns such as safeguarding week.

City of York Council Housing and Communities

The Homelessness Strategy group (made up of multidisciplinary partners from across York) were involved in two workshops, facilitated by Imogen Blood Associates. The workshops had two main aims: discuss two cases resulting in death escalated to SAB to discuss how/if they could have been avoided, and to discuss Housing First as an option for the multiply excluded client group and how this works in practice.

- Collaborative effort from many agencies, with Police, Probation, NHS, Housing and Third Sector partners all present and contributing
- Ensured understanding of process and conditions to escalate to SAB across partners

North Yorkshire Fire and Rescue Service

- Delivered prevention-focused outreach activities in communities, raising awareness of fire safety.
- Supported and actively promoted Safeguarding Week, contributing to multi-agency planning and delivery of online sessions.
- Delivered or contributed to webinars during Safeguarding Week, focusing on key themes such as vulnerability and early intervention.
- Supported early intervention initiatives that aim to prevent harm before it occurs, particularly among vulnerable individuals and communities.
- Used insight and data to identify priority groups for targeted prevention activity and tailored messaging.

York Centre for Voluntary Services and Healthwatch York

We disseminate information to the Voluntary, Community and Social Enterprise sectors as and when we receive.

During Safeguarding week, we:

- Posted on our training and events page (150 views)
- Shared in Voluntary Voice (reach 1430, click throughs 8)
- Shared in Members' Update (reach 429, click throughs 5)

We provide safeguarding advice and guidance to our 360 member VCSE organisations – approximately 80 pieces of advice over the year. We also share policy templates and check in all one-to-one meetings that good safeguarding practice is in place.

We have a safeguarding leaflet on our website and deliver a basic safeguarding course for groups who have staff/ volunteers who would struggle to access the online training. It also allows for group discussion which has benefits.

5.2. Learning, reflection and practice improvement

- We will establish a learning and development subgroup to implement a learning and development training strategy to disseminate learning and help further develop confident practice for all those who have a safeguarding role.
- We will find ways to capture lived experience of safeguarding and engage with families and front-line staff so they can inform practice improvements

City of York City Council Adult Social Care (CYC ASC)

City of York Council has worked with partners to learn, reflect and improve practice. CYC has appointed practice development leads in safeguarding alongside other important areas of practice. Understanding the voice of those who have experienced abuse or neglect has been key to this, using these case studies to inform and improve practice.

CYC has increased auditing, developed supervision guidance, and updated safeguarding training. As a result, changes have been made to better support those contacting and supported adult social care, improving the identification and response to safeguarding concerns

New multi-agency guidance has been developed and issued to staff, including for transitional safeguarding

- Task and finish group Multi Agency Risk Management (MARM)
- Task and Finish group Transitional SG and launch
- Practitioner group for one minute learning guides
- Sense check and feedback making a good Safeguarding referral
- Case studies in the safeguarding team
- Workshops regarding MARM and risk

Humber and North Yorkshire Integrated Care Board (HNY ICB)

Humber and North Yorkshire ICB have:

- Provided Safeguarding System Leadership across NYY ensuring the ICB meets its statutory responsibilities for safeguarding.
- Fulfilled statutory responsibilities in relation to safeguarding review oversight through ongoing use of the NHS Safeguarding Case Review Tracker (S CRT). The S CRT is a national system enabling ICBs to record, track and monitor safeguarding related statutory reviews, including Safeguarding Adults Reviews (SARs), Domestic Abuse Related Death Reviews (DARDRs) and other multi agency safeguarding reviews.
- Contributed to national and local assurance through the NHS Safeguarding Integrated Data Dashboard.
- Maintained Designated Professional leadership, oversight and support across health system safeguarding arrangements.
- Facilitated quarterly Health Professional Group meetings to share emerging risks, learning and priorities with Named Safeguarding nurses and professionals.
- Facilitated quarterly group supervision for Named Professionals across NHS providers.
- Delivered safeguarding forums for private health providers to support learning and system engagement.
- Provided targeted safeguarding advice and leadership across NHS funded services.
- Offered specialist safeguarding support and advice to primary care.
- Ensured all GP practices retained a named safeguarding lead.
- Promoted use of the Adult Safeguarding: Roles and Competencies for Health Care Staff framework Royal College of Nursing (RCN) 2024 to support workforce confidence and competence, reinforcing safeguarding as a professional and organisational responsibility: **rcn.org.uk/adult-safeguarding-roles-and-competencies-for-health-care-staff** and Royal College General Practitioners (RCGP 2024) Safeguarding Standards for General Practitioners **rcgp.org.uk/learning-resources/safeguarding-standards**
- Supported dissemination and implementation of SAR learning.

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

- Maintained attendance at safeguarding forums in provider organisations and facilitated Keep-in-Touch meetings with provider safeguarding leads.
- Used learning from Learning from Lives and Deaths (people with a learning disability and autistic people) Reviews (LeDeR), deaths reviews and safeguarding data to inform improvement.
- Maintained active links with regional and national safeguarding networks including the Safeguarding Adults National Network.
- Completed the CYSAB safeguarding audit.
- Represented the ICB across multiple partnership forums, including MAPPA, MARAC, Prevent and Serious Violence Duty.
- Promoted use of the NHS Safeguarding Guide to support consistent safeguarding practice and assurance.
- Maintained clear executive accountability for safeguarding, overseen by the Executive Director of Nursing.
- Supported a culture of continuous learning, adaptability and system improvement.

North Yorkshire Police (NYP)

NYP chair the newly formed CYSAB Learning and Development subgroup and continue to engage in the Safeguarding adults review process for York through multi agency discussion and engagement.

Training features in our tactical delivery meetings and we seek to identify new opportunities to develop or refresh existing and new training. This has been evident in the adoption of the AWARE mnemonic in adult Public Protection Notice (PPN)'s which has been shown to improve standards in children's PPN performance.

North Yorkshire Police have contributed to Safeguarding week and are scheduled to deliver inputs on:

- **Op Soteria:** delivering change in rape and sexual offence investigations
- **Operation Encompass:** an early-intervention safeguarding partnership that requires police forces to notify schools before the next school day about any domestic abuse incidents involving a student

- **Operation Choice:** drugs early intervention and prevention
- **Introduction to Modern Slavery**
- **Knife Crime:** education and prevention
- **Vulnerable Adults and Modern Slavery in a Multi-Agency Context:** Operation Pottery: A Case Study

City of York Public Health

Public Health take the lead on Domestic Abuse for York, and a framework has been developed to link Adult Social Care workforce training needs to domestic abuse. Roll out of training is due to commence summer 2026.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- The Safeguarding and Public Protection Team attend and actively contribute to the Safeguarding Adults Board learning and development subgroup.
- The Safeguarding and Public Protection Team continue to provide mandatory safeguarding training which staff are required to attend every 3 years as a minimum and is regularly reviewed and updated. They have also provided bespoke training to services on request, regularly offer development sessions to Safeguarding Link Professionals across the Trust (over 25-26, the agendas for the development sessions were driven by survey feedback from the Link Professionals on the safeguarding topics they felt would be helpful to cover), and actively engaged with National Safeguarding Week delivering a range of activities across the Trust impacting patients, visitors, and staff. Feedback from engagement activities was reported as positive, with examples shared demonstrating improved understanding, reassurance and access to appropriate support.
- The TEWV Safeguarding Adults Policy was fully reviewed and updated during 25/56, with associated policies, procedures, and processes to support staff to remain confident and effective in safeguarding practice.
- TEWV has robust patient safety processes in place to promote learning from incidents.

- Both the Safeguarding and Public Protection Team and clinical services continue to be actively involved contributors to Safeguarding Adults Reviews, multi-agency audits, and other multi-agency and Safeguarding Adults Board forums and sub-groups to support continuous learning and improvement. Learning from all of these is distributed across TEWV via bulletin, TEWV intranet, Link Professionals, and quality standards forums.
- Internally, the Safeguarding and Public Protection Team continue to have active involvement in TEWV groups and forums such as the organisation learning group, patient learning and experience group, and quality standards meetings which promote learning and sharing of that learning across the Trust.
- The Safeguarding and Public Protection Team continue to have regular, data driven, deep dives of Trust safeguarding data to drive learning and complete multiple annual audits of safeguarding practice. Throughout 2025-26 audits were completed as follows: clinical audit of adult safeguarding and prevent (prisons), audit of safeguarding referrals to local authorities for adults and children, clinical re-audit of domestic abuse procedure, clinical audit of adult and child concerns, and service evaluation of patient, parent, or carer experience of safeguarding.
- The Patient and Carer Experience Team reviewed 5114 instances of feedback, including patient / carers sense of safety, for the North Yorkshire and York area; This showed 95.35% positive responses, 1.8% negative responses, and an overall rating of 4.75/5. 64.9% of reviews were provided by people of a white / white British ethnicity but the data remained similar across all ethnicities.
- MCA training sessions were provided during 2025 which were co-delivered by the Mental Health Legislation Team and an expert by experience who shared their experience of capacity assessment and how they or their loved one's may have been supported to make their decision or how their situation could have been improved.
- Child and Adolescent Mental Health Services (CAMHS) now have a member of staff employed in the role of Patient/ Carer participation and engagement to strengthen our collaboration with families working with the Trust.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- The Involvement and Engagement Team support monthly involvement groups including staff, patients, carers, and statutory and 3rd sector partners across the North Yorkshire and York area in addition to quarterly forums for patients and carers and a monthly Co-creation Board meeting that has regular feedback sessions looking at specific pieces of co-creation work.
- The Safeguarding and Public Protection Team undertook a patient experience service evaluation to inform future practice.
- Throughout 2025-26, the Trust have worked alongside the family of a patient who lost is life to suicide in 2021 on the campaign 'Chris's Voice'. The campaign aims to raise awareness of the patient and family voice, reduce the stigma associated with mental illness, and eliminate judgement with materials produced to promote this throughout the Trust.
- The Trust Safeguarding Adults Policy was fully reviewed and updated during 25/56, with associated policies, procedures, and processes to support staff to remain confident and effective in safeguarding practice.
- The Patient Safety, Experience and Learning Group have and are focusing on communication and engaging in service level change work specific to confidentiality and information sharing and Parent/Carer Engagement in care. This involved 2 service pilots that are being taken forward in to testing and developing approaches that start to address issues in a way that would be scalable to other services.
- In mental health services for older people, clinical services and the safeguarding and public protection team have reviewed their spread of safeguarding professionals to ensure a link professional per team, they have an identified link to the safeguarding and public protection team and protecting time support attendance at development sessions.
- In mental health services for older people community teams, the B5/B6 development framework has been developed to include capturing competencies around safeguarding and confidentiality and staffs' role regarding safeguarding including processes and escalation routes. This has been continued into similar ongoing work in liaison psychiatry services.

York Centre for Voluntary Service (CVS) and Healthwatch York

Through co-production York CVS and Healthwatch York hear from adults about their experiences. Some of these will include examples of decisions made by adult safeguarding partner agencies which have a detrimental impact on the wellbeing of adults. An example is the closure of the local eating disorders service. We feed this back through various channels, in this instance, through the York Mental Health Partnership.

York and Scarborough Teaching Hospital NHS Foundation Trust (YSTHFT)

York and Scarborough Teaching Hospitals NHS Foundation Trust has continued to embed learning from Safeguarding Adults Reviews (SARs), complex safeguarding cases, audits and partnership reviews. Learning themes identified during the year included professional curiosity, information sharing, application of the Mental Capacity Act, self-neglect and the management of complex safeguarding risks.

In response, YSTHFT has updated policies, training programmes, supervision arrangements and safeguarding guidance. Learning and improvement activity is overseen through the Integrated Safeguarding Group and reported through established governance processes, supported by safeguarding audits, thematic reviews and supervision. Priorities moving forward include continued focus on professional curiosity, Mental Capacity Act practice, information sharing and safe discharge arrangements, alongside evaluation of the impact of implemented improvements.

Probation Service Yorkshire and Humber

Lead Senior Probation Officer (SPO) to contribute to Learning and Development subgroup.

Safeguarding Adults training is offered at national level and is mandatory in the Probation Service to be repeated every 3 years.

We have developed a lived experience initiative called ‘Engaging People On Probation’. There is a local group and there are plans to explore regional options for those with Lived Experience to share experiences.

City of York Council Housing and Communities

CYC Housing and Communities has provided resources and support to the CYSAB in delivering multi agency workshops considering safeguarding needs of adults with care and support needs who experience rough sleeping and homelessness. These were well attended and received leading to practice improvement and provided a space for partners to learn and reflect about what works well in York and what the gaps are. Partners learnt more about Housing First and reflection on two homelessness cases to understand what could have been done differently through strong partnership working and provided an opportunity for discussion of what that means in practice. CYC Housing and Communities continues to be represented on the CYSAB and its subgroups.

North Yorkshire Fire and Rescue Service

- Contributed to the development and establishment of a multi-agency learning and development subgroup to strengthen safeguarding practice.
- Share learning from Safeguarding Adults Reviews (SARs), audits, and case studies to inform improvements in frontline practice.
- Actively engaged frontline staff in feedback processes to understand challenges and identify areas for improvement.
- Embedded a new Learning, Development and Risk meeting internally to ensure learning is translated into practice through updated policies, procedures, and operational guidance

5.3. Part 1: Adults at risk of exploitation

What we said we would do to strengthening multi-agency safeguarding responses to Adults at risk of exploitation:

- We will create an exploitation task and finish group to explore multi- agency safeguarding responses to adults at risk of exploitation, including developing and implementing pathways, guidance and protocols to support individuals who experience multiple disadvantage to help mitigate risk faced by individuals.
- We will further embed the need to report concerns about any person in a position of trust (PIPOT) and ensure that pathways to address concerns are embedded in practice.
- We will seek assurance about the quality of services and practice by the development of a multi-agency dashboard to help SAB identify themes and trends across the partnership agency contributions to present a variety of online sessions to support our priority.

Case study

The Voice of the Adult

TEWVs Perinatal Mental Health Team identified, managed, and coordinated safeguarding concerns where a mother was the patient receiving care.

The safeguarding needs of the adult

- This family consisted of Mum, Dad, and their baby born in March 2025, living together in North Yorkshire and supported by the Perinatal Community Mental Health Team (CMHT), Health Visiting, Early Help, and Occupational Therapy.
- Concerns centred on emerging coercive and controlling behaviour from Dad, including threats to involve Social Services when Mum expressed wanting to leave the relationship.
- Mum presented with significant vulnerability due to her trauma history, limited support network, social isolation, and reduced day to day functioning, which affected her ability to leave the house and maintain routines. There was potential emotional impact on the baby, alongside unclear childcare arrangements as Mum returns to work. Mum has a history of suicidal ideation but reported no current thoughts.

What was achieved for the adult

- Protective factors included Mum's strong engagement with services, a warm bond between her and the baby, positive interactions with Dad and baby (though limited assessment), and Mum's acceptance of IDAS (Independent Domestic Abuse Services) information and openness to using it. Returning to work had also improved structure and routine.
- Actions taken included completing the DASH (Domestic Abuse, Stalking and 'Honour'-based abuse) and PAMIC (Parental Adult Mental Health Impact on Child) assessments, directly named and discussed coercive behaviour with Mum, provided relationship safety resources, coordinated with Early Help, updated safeguarding documentation, and attempted engagement with Dad, who declined involvement.

What was the outcome

Professional judgement was that while there was no evidence of immediate physical harm, the combination of Mum's vulnerability and Dad's emerging controlling behaviours created a dynamic situation requiring ongoing monitoring. Intervention through Perinatal Community Mental Health Team (CMHT) and Early Help was appropriate, with clear escalation pathways if risk increases. Safeguarding was to be reconsidered if concerns escalated, and childcare arrangements would continue to be clarified as part of ongoing support.

City of York City Council Adult Social Care

City of York Council have led the work with partners to establish and embed person in a position of trust (PIPOT) process, enabling organisations to more confidently manage risk in this area.

Recognising the risk of exploitation posed by serious and organised crime, CYC have actively engaged with North Yorkshire Police on a city wide and neighbourhood basis to share intelligence, plan and act to protect those at risk of exploitation. This has included specific work to combat county lines.

The transitional safeguarding guidance and structures implemented to support the approach provide the pathway that enables services to continue to support young people who are at risk of exploitation to be supported as they enter adulthood.

Strong working relationships have been established between the Safeguarding and Contracts team and other stakeholders to assess priorities and inform Quality Assurance visits and schedules effectively.

Humber and North Yorkshire Integrated Care Board (HNY ICB)

Humber and North Yorkshire ICB have:

- Supported learning from SARs and reviews where multiple-disadvantage, trauma and adverse experiences are evident
- Promoted reflective supervision and curiosity in safeguarding practice with the emphasis on sharing concerns and escalating issues that block progress
- Influenced provider safeguarding strategies and workforce development
- Delivered trauma-informed training to help professionals who support at-risk adults to understand trauma (including Adverse Childhood Experiences), promote compassionate, person-centred practice, and strengthen confident safeguarding across the health system. To date, 15,783 professionals and volunteers have been trained across the ICB footprint and 96% of participants report an increase in their knowledge of trauma-informed practice, highlighting the programme's effectiveness in building confidence and capability across the workforce.

North Yorkshire Police (NYP)

NYP are involved in various work to tackle exploitation experienced by both adults and children and have worked with the CYSAB to develop a CYSAB Exploitation task and finish group to consider adults at risk of exploitation which will develop further in 2026-27 and we have agreed to chair the exploitation task and finish group. This will consider the following:

- Identify opportunities to share horizon scanning across partner agencies
- Use local and regional expertise, shared knowledge and data to understand current trends and areas of need
- Link into existing good practice and adapt/enhance where necessary, seeking assurance on an effective joined-up approach
- Identify pathways, guidance and protocols needed for the multi-agency partnership to identify and respond to adults with care and support needs who are experiencing or at risk of exploitation
- Make recommendations to the SAB in relation to exploitation
- To develop a robust multi-agency response to prevent and address exploitation using the four P methodology - prevent, protect, prepare and pursue. Including
  - » Identifying people who are or at risk of being exploited
  - » Making effective interventions to support people who are exploited
  - » Identifying perpetrators and disrupting their activity and address the conditions locally that foster exploitation.
  - » Develop pathway, practice model, workforce development and assurance processes to achieve this.

Probation Service Yorkshire and Humber

We have contributed to a CYSAB exploitation task and finish group.

We identify those at risk of exploitation throughout standard risk assessments, and these individuals have a flag added to their record – at risk adult, and/or cuckooing.

Our action would be to refer to ASC for assessment if concerns were highlighted.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- The Safeguarding and Public Protection Team attend and contribute to the Safeguarding Adults Board exploitation task and finish group.
- The Safeguarding and Public Protection Team continue to provide a daily duty support line and planned specialist safeguarding supervision available to all Trust staff for timely and practical advice and support.
- The Safeguarding and Public Protection Team continue to promote awareness and understanding of the Safeguarding Adults Board and associated guidance and protocols in mandatory safeguarding training. In addition, they have provided bespoke training to clinical services on request and regularly offer development sessions to Safeguarding Link Professionals across the Trust.
- The safeguarding and Public Protection Team send regular bulletins to clinical services which include learning from multi-agency reviews and promotion of information, resources, and training opportunities provided by the Safeguarding Adults Board.

York and Scarborough Teaching Hospital NHS Foundation Trust

The Trust has contributed to the CYSAB 2025–26 priority of Strengthening multi-agency safeguarding responses for adults at risk of exploitation through robust partnership working, strengthened governance, and improved early identification and response pathways. Multi-agency engagement is identified as a core organisational strength, with effective collaboration across safeguarding adults' processes supporting coordinated and proportionate responses to risk, including exploitation. This is underpinned by strengthened safeguarding adults' governance, including the integration of MCA/DoLS oversight, and the appointment of a Named Nurse for Safeguarding Adults to enhance leadership, oversight and system connectivity. The impact of specialist roles such as Domestic Abuse Liaison Practitioners has improved staff confidence, increased referrals, and strengthened links with external agencies, supporting earlier identification of

vulnerable adults. The Trust continues to monitor safeguarding activity and emerging risks through established governance arrangements to inform service improvement and partnership responses, while continued participation in Prevent activity and safeguarding pathways demonstrates a proactive and collaborative system approach to protecting adults at risk of exploitation.

North Yorkshire Fire and Rescue Service

Supported the development and implementation of clear pathways, guidance, and protocols to improve identification, referral, and support for adults at risk of exploitation.

Embedded the importance of identifying and reporting concerns relating to People in Positions of Trust (PiPoT) within organisational policies and frontline practice.

Developed a Managing Allegations against Staff: Abuse or Harm process

Participated in audits, reviews, and partnership discussions to provide assurance on the quality of safeguarding practice and service delivery.

Promoted information sharing and joint working to ensure timely, coordinated responses for adults at risk.

5.3. Part 2: Adults at risk of self-neglect and hoarding

What we said we would do to strengthening multi-agency safeguarding responses to Adults at risk of self-neglect and hoarding:

- We will create a task and finish group to explore multi-agency safeguarding responses to adults at risk of self-neglect to help create a clear accessible pathway for identifying concerns and to assess and respond to self-neglect which will include a multi-agency risk management protocol.

Case study

The Voice of the Adult

The safeguarding needs of the adult

Patient with no formal diagnosis of dementia but definitely some kind of cognitive impairment following a history of having strokes was referred to Social Prescriber. When the social prescriber went out to see the patient it became apparent that this person was:

- not managing their shopping and had out of date food in the fridge
- not managing their own finances
- not attending appointments

There were appliances in the home that were broken.

Getting safeguarding and support

The social prescriber completed a safeguarding referral as it felt unsafe for this person to be left alone as they were not managing day to day and there were concerns about self-neglect.

What was achieved for the adult

The safeguarding team responded to this the day after the referral was made and they linked them in with Adult Social Care and a social worker was then allocated. They have looked into their care needs and put in the adequate support as well as seeing if there is anything further which can be done to support, for example:

- This person was digitally isolated and also suffered with hearing loss, so the Adult Social Care and Social Prescribing teams supported the installation of a new landline phone which is loud and flashes when it rings so that this person can engage in appointments more easily.

City of York City Council Adult Social Care

A task and finish approach has been established, resulting in the development of practice tools to identify and respond to self-neglect, alongside bespoke training to staff on this issue.

In addition, multi-agency risk management is being strengthened. Guidance, processes and pathways have been developed and shared with partners through safeguarding week.

North Yorkshire Police (NYP)

- We have contributed to the CYSAB thematic SAR and developed NYP guidance on Hoarding
- The dedicated Adult DS in VAT is developing a self-neglect and hording toolkit alongside the fire service, including the hoarding tool (clutter image ratings) to support front line officers and raise awareness.
- There is now an Appearance, Words, Activity and behaviour, Relationships and dynamics, and Environment 'AWARE' guide and pro forma for officers completing Safeguarding referrals Public Protection Notices (PPN's). All resources can now be accessed via the 'Adult safeguarding button' on the knowledge hub.
- The dedicated Adult safeguarding team within the Vulnerable Adult Team (VAT)work with partners where there are concerns of self-neglect. The team work with neighbourhood policing teams, GP's and other services, such as living well through Planning meetings to support people at risk of self-neglect.

Humber and North Yorkshire Integrated Care Board (HNY ICB)

Humber and North Yorkshire ICB have:

- Promoted awareness of self-neglect as a safeguarding concern through professional forums (Health Partnership Group and Private Providers Forum) and safeguarding case supervision
- Supported and promoted person centred and trauma informed responses to self-neglect

- Supported s.42 enquiries featuring self-neglect and provided professional advice and challenge to support proportionate and compassionate responses
- Considered the impact of inequality, exclusion and cumulative disadvantage in safeguarding reflection and learning
- Supported the delivery of SARs and shared learning where self-neglect and hoarding featured as key themes.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- The Safeguarding and Public Protection Team continue to provide mandatory safeguarding training which includes how to recognise and report signs of abuse and self-neglect.
- The safeguarding and Public Protection Team send regular bulletins to clinical services which include learning from multi-agency reviews of self-neglect cases.
- The Safeguarding and Public Protection Team continue to provide a daily duty support line and planned specialist safeguarding supervision available to all Trust staff for timely and practical advice and support – including consideration of self-neglect.

The Safeguarding and Public Protection Team is contributing to a Trust communication workstream to improve multi-agency communication, challenge common myths, and support staff understanding of consent, confidentiality, and appropriate information-sharing.

York and Scarborough Teaching Hospital NHS Foundation Trust

The Trust has contributed to the CYSAB 2025–26 priority of strengthening multi-agency safeguarding responses for adults at risk of self-neglect and hoarding through early identification, strengthened governance, and collaborative partnership working. Safeguarding adults' activity and oversight arrangements have been enhanced through integrated governance structures, including strengthened MCA/DoLS oversight and the appointment of a Named Nurse for Safeguarding Adults, supporting improved coordination of complex cases often associated with self-neglect. High safeguarding supervision compliance provides a

critical forum for reflective discussion, risk recognition and escalation of self-neglect concerns, while robust audit and information-sharing processes (including CP-IS and pathway audits) enable earlier identification and multi-agency response planning. The contribution of specialist roles, particularly Domestic Abuse Liaison Practitioners, has further increased staff confidence in recognising vulnerability and engaging with partner agencies, supporting more proactive and coordinated responses. This is complemented by consistent multi-agency engagement and a "Think Family" approach, ensuring that risks associated with self-neglect and hoarding are managed holistically across services and in partnership with system stakeholders. Learning from self-neglect reviews has informed work relating to complex decision-making, executive functioning and Mental Capacity Act practice.

York Centre for Voluntary Services and Healthwatch York

Our Social Prescribing team has raised questions about how to ensure safe discharge for people who hoard, including appropriate pathways and roles and responsibilities of professionals within this.

Probation Service Yorkshire and Humber

Contribute to a task and finish group – raise awareness of self-neglect and hoarding. We feel there is a potential gap in our knowledge and skill around this – would benefit from some bespoke training in this area and will look at options to facilitate this through partnerships.

North Yorkshire Fire and Rescue Service

Worked collaboratively with partners (e.g. adult social care, health, housing, emergency services) to strengthen coordinated safeguarding responses.

Promoted early identification of self-neglect and hoarding behaviours through training and awareness

Delivered or supported training and briefings to improve understanding of hoarding.

5.3. Part 3: Adults at risk of rough sleeping and homelessness

What we said we would do to strengthening multi-agency safeguarding responses to Adults at risk of rough sleeping and homelessness:

- We will create a task and finish group to explore multi-agency safeguarding responses, by engaging with specialists to explore what good looks like to develop and implement pathways, guidance and protocols to provide a more joined up response to those that are rough sleeping or homeless.

City of York City Council Adult Social Care (CYC ASC)

CYC adult safeguarding has worked with colleagues raising awareness of the need to use the safeguarding adult review process where required in relation to homelessness.

As a result, increasing issues related to homelessness are referred into this process.

CYC adult safeguarding has strengthened relationships with street navigators, resulting in joint approaches to safeguarding homeless adults at risk.

Humber and North Yorkshire Integrated Care Board (HNY ICB)

Humber and North Yorkshire ICB have:

- Supported the development of the City of York Homelessness and Rough Sleeping Strategy 2024-29
- Contributed health leadership to multi agency discussions relating to homelessness and rough sleeping
- Promoted trauma informed approaches for adults experiencing homelessness
- Shared learning from SARs where homelessness and exclusion featured as key themes.

Probation Service Yorkshire and Humber

Probation Services contributes to the Rough Sleeping and Homelessness task and finish group.

There are good existing pathways available to People on Probation at risk of homelessness

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- Ongoing community transformation work continues to reduce the barriers to people of no fixed abode accessing services with the introduction of walk-in community hubs.
- The Trust have Trauma Informed Care Leads and Complex Emotional Needs Specialist Practitioners who have supported North Yorkshire Council on Trauma Informed practice within housing projects and wider initiatives.

York and Scarborough Teaching Hospital NHS Foundation Trust

York and Scarborough Teaching Hospitals NHS Foundation Trust recognise that people experiencing homelessness and rough sleeping may face multiple and complex health and safeguarding challenges. During 2025-26, the Trust continued to work with local authority, housing, mental health, substance misuse and voluntary sector partners and contributed safeguarding expertise to multi-agency discussions relating to homelessness and complex discharge planning to support vulnerable individuals accessing healthcare services.

Safeguarding, discharge planning and referral processes provide opportunities to identify housing-related risks and facilitate access to appropriate support services. While discharge remains an area of ongoing improvement both locally and nationally, the Trust has continued to strengthen governance, partnership working and oversight arrangements to support safe and effective discharge planning for individuals experiencing homelessness or other social vulnerabilities. Where concerns relating to abuse, neglect, exploitation or self-neglect are identified, staff are expected to consider safeguarding pathways and multi-agency support arrangements as appropriate.

City of York Public Health

The Public Health domestic abuse team have been involved in the rough sleeping and homelessness workshops and development of this area of work.

We continue to support delivery of effective Multi Agency Risk Assessment Conferences (MARAC) and Domestic Abuse Housing Alliance (MARACs and DAHA) accreditation.

The Public Health domestic abuse team have been involved in the rough sleeping and homelessness workshops and development of this area of work.

North Yorkshire Fire and Rescue service

While Fire and Rescue Services are not regulated in the same way as health and social care providers, we are subject to inspection by His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS), which assesses our effectiveness, efficiency, and people practices which includes Safeguarding.

We also work towards meeting the national Fire Standards, including the Safeguarding Standard, which sets out clear expectations around service quality, governance, and continuous improvement and we complete the CYSAB self-assessment audit.

Our Safeguarding Policy is aligned with National Fire Chief Council (NFCC)and local guidance and was recently reviewed through an internal audit which concluded that we have a robust safeguarding policy and procedure in place.

To further enhance service quality, we have new roles such as a School and Youth Engagement Manager and a Partnership Manager, who help us improve our engagement with young people and strengthen multi-agency working. These roles support early intervention and ensure our services are responsive to community needs.

Through active participation in local safeguarding boards, regional and national forums, and the development of initiatives like the Home Fire Safety Visit Referral Partnership, we ensure our services are not only high quality but also collaborative, preventative, and inclusive.

The Service maintains high standards of safeguarding through a strong focus on quality assurance and continuous professional development. All staff receive safeguarding training appropriate to their role. This ensures that safeguarding remains embedded in day-to-day practice across the organisation.

During the most recent HMICFRS report NYFRS scored Good in Preventing Fires and Other risks specifically detailing:

The service has an effective process to respond to safeguarding concerns

Staff we interviewed told us about occasions when they had identified safeguarding problems. They told us they feel confident and trained to act appropriately and promptly. All staff receive safeguarding training, which includes how to report concerns about both adults and children. The service has a dedicated safeguarding officer to support and oversee processes.

York Centre for Voluntary Services and Healthwatch York

York CVS hosts a homelessness network which brings together 25 voluntary, community and social enterprise sector organisations who work with people who are homeless. Together the group share intelligence and provide mutual support as well as identifying gaps in services which could potentially cause further harm to people who are homeless. The group is currently exploring the gaps in out of hours services with a view to addressing this in partnership with City of York Council.

City of York Council Housing and Communities

Housing and Communities supported work stemming from the rough sleeping and homelessness workshops to support the CYSAB. Attendance led to an organic make up of members of task and finish group. Key people already involved and understanding of SAB, but gave a focus and new perspective on this complex issue

- Safeguarding as a standard agenda point on Homelessness Strategy group

- Specialists from partner agencies involved and abreast of developments, with a focus on stronger partnership and joined up response to complex issue
- SAB meetings involving key partners, MARAC process etc.

North Yorkshire Fire and Rescue Service

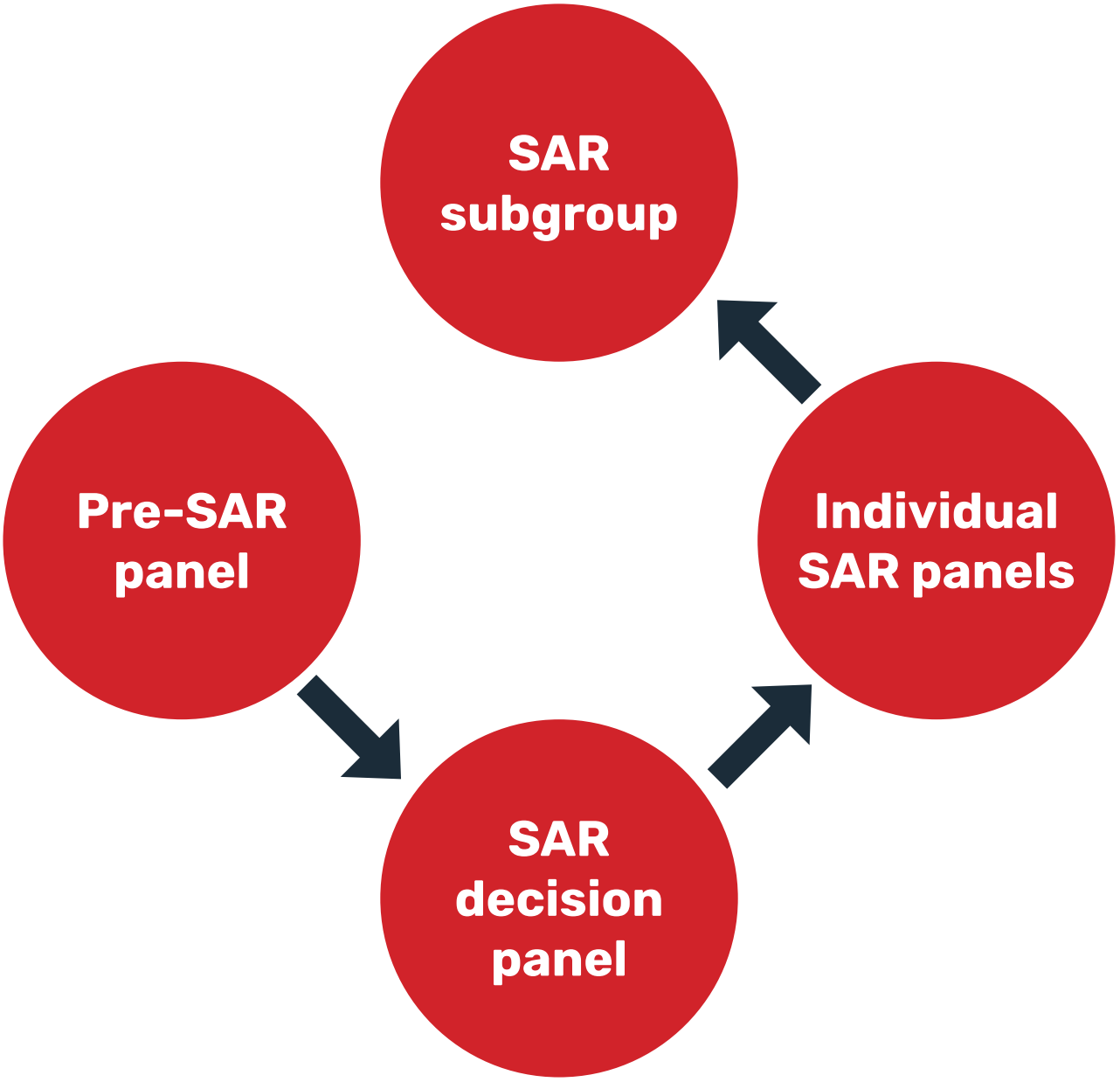
The Service works closely with the City of York Council Community Safety Partnership to raise awareness of and reduce the harm caused by Hidden Harms, including County Lines activity, domestic abuse, and modern slavery. These issues often affect the most vulnerable in our communities and require a coordinated, multi-agency response.

We contribute to strategic discussions and operational planning through our involvement in local safeguarding boards, Multi-Agency Child Exploitation (MACE) meetings, and regional forums. Our staff are trained to recognise signs of exploitation, abuse, and neglect, and understand how to respond appropriately and refer concerns into the Community Safety Partnership.

The Service also supports early intervention through initiatives such as the Home Fire Safety Visit Referral Partnership, which enables professionals across sectors to refer individuals who may be at heightened risk. This helps us reach people who may not otherwise come into contact with fire services and ensures they are protected in their homes.

6. Safeguarding Adults Reviews (SARs)

The CYSAB set up a new governance structure for considering Safeguarding Adults Reviews (SARs) in 2025-26, which has allowed for separation of decision making on whether or not a SAR referral meets the SAR criteria and oversight of SAR work including the implementation of recommendations.



The Pre-SAR panel meets monthly and is made up of the statutory partners, which are the local authority, Police and Integrated Care Board and more recently representatives from Public Health drug and alcohol services and other partners when required. The Pre-SAR meeting considers cases that may need to be referred as a SAR referral. The CYSAB also developed an online version of the SAR referral form which makes it easier for anyone to make a referral for a SAR. This can be viewed at **safeguardingadultsyork.org.uk/safeguarding-adult-reviews/make-safeguarding-adults-review-referral**

A SAR Decision Panel has met monthly throughout 2025-26 to consider cases which may fit the criteria for a Safeguarding Adults Review under section 44 of the Care Act when SABs must arrange a SAR if 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."[1] and make a recommendation to the Independent Chair of CYSAB, who makes the final decision.

The quarterly SAR subgroup is now able to concentrate on the learning from SARs and monitor the implementation of the SAR recommendations.

Two SAR were in 2025-26 including Catherine SAR and a thematic Self Neglect SAR involving seven cases of self-neglect.

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1 Care and support statutory guidance - GOV.UK (gov.uk)

Catherine SAR

Catherine was a 79-year-old woman with long-standing Type 1 diabetes, anxiety, depression and a rapidly developing cognitive decline later diagnosed as Lewy Body Dementia. In May 2020, following a significant deterioration in her mobility, memory, continence and ability to manage her diabetes independently, she was admitted to York Hospital. After assessment and rehabilitation, it was agreed that she could no longer safely live at home and she was discharged to a residential care home. Throughout this period, Catherine experienced increasing anxiety, low mood, loss of independence and frequent expressions of wanting to die, which were distressing for both her and her daughter, who held Health and Welfare Lasting Power of Attorney.

The review found that diabetes management was not consistently prioritised once Catherine became dependent on others for her care. There were multiple shortcomings across hospital, primary care and care home services, including inconsistent blood glucose monitoring, insulin administration errors, poor record keeping, communication failures between organisations, and problems obtaining essential insulin supplies. Following changes to her diabetic treatment and increasing blood glucose levels, warning signs of deteriorating diabetic control were not acted upon effectively. In July 2020, after the care home ran out of short-acting insulin and Catherine became

severely unwell, she was admitted to hospital with diabetic ketoacidosis (DKA), which was considered the primary factor leading to her death.

The SAR concluded that while there were significant lessons regarding diabetes care, communication and discharge processes, there was evidence of good practice in relation to the Mental Capacity Act, with Catherine generally being involved in decisions about her care and treatment. The review also found that earlier involvement of specialist mental health services following her dementia diagnosis may have provided additional support. During her final admission, Catherine repeatedly expressed a wish to refuse treatment and die. Complex discussions took place involving mental health, palliative care, safeguarding and legal teams regarding her capacity and best interests. Although a decision was eventually made to recommence treatment, Catherine died peacefully on 8 July 2020 with her daughter at her bedside. The review made recommendations to improve diabetes pathways, strengthen referrals to specialist mental health services, and promote wider use of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process to support meaningful end-of-life care discussions.

Thematic Self-Neglect SAR

This themed Safeguarding Adults Review examined the circumstances of seven older adults in York who died between 2023 and 2025 and were found living in conditions of extreme self-neglect and/or hoarding. The adults shared many common characteristics, including living alone, experiencing social isolation, poor physical and mental health, frailty, bereavement, cognitive decline, and reluctance to engage with services. All were living in homes that were unsafe or unfit for habitation, with issues including severe clutter, hoarding, poor hygiene, lack of heating or utilities, inadequate nutrition, and untreated health conditions. The review found that self-neglect was often not recognised or recorded by professionals, despite clear signs that the adults were struggling to care for themselves.

A central finding was that there were repeated missed opportunities for agencies to identify risks, intervene earlier and work collaboratively to safeguard the adults. Professionals frequently described homes as merely “cluttered” or “untidy” rather than recognising hoarding and self-neglect as safeguarding concerns. Referrals were often not followed up, safeguarding procedures were not consistently used, and concerns raised by hospitals, primary care, housing providers, emergency services and community professionals were sometimes overlooked or minimised. The review also found that mental capacity assessments were often used to justify case closure when adults declined support, rather than being used proactively to explore risks, vulnerability and executive functioning. Hospital discharge processes were a particular area of concern, with some adults being discharged back into unsafe living environments despite known risks.

The review concluded that significant improvements are needed across the safeguarding partnership to strengthen the response to self-neglect and hoarding. Key recommendations include improving professional awareness and training, promoting earlier safeguarding referrals, strengthening recording and information sharing practices, improving discharge arrangements for adults returning to unsafe homes, and ensuring more robust use of the Mental Capacity Act. The review also emphasised the importance of trauma-informed, relationship-based practice, recognising that self-neglect and hoarding are often rooted in complex life experiences, poor mental wellbeing, loss, trauma and fear of losing independence. The overarching message is that earlier recognition, greater professional curiosity and more coordinated multi-agency responses could help prevent future harm to vulnerable adults living in circumstances of severe self-neglect.

Ongoing SARs

The CYSAB has also been co-ordinating 3 other SARs in 2025-26 which will be completed in 2026-27. The findings of these will be publicised in 2026-7 annual report but early lessons have been acted upon to prevent abuse and neglect in the future.

The learning from completed SARs continues to be embedded to improve practice across the Adult Care sector workforce. The completed SAR reports and 7-minute briefings are available on the CYSAB website safeguardingadultsyork.org.uk/sar

The three Statutory partners of CYSAB met monthly during 2025-26 for a Pre-SAR panel which looked at 34 cases during the year to assess whether these should be referred for a SAR. Of these 34 cases several went on to be referred for a SAR which allowed all partner agencies, including non-statutory organisations to provide more detail regarding each case. This provided a robust mechanism for identifying and checking cases allowing discussion between all partners to ensure learning opportunities were not missed.

13 cases were referred to the SAR Decision Panel for SAR consideration.
The table below highlights the decisions made regarding these SAR referrals.

Cases discussed at the Pre-SAR panel	SAR referrals considered in 2025-26	SAR referrals approved for statutory SAR	SAR referrals not approved
34	13	5	8

Any learning from all the cases considered by the CYSAB groups that did not meet the criteria for a SAR, was cascaded and actioned upon by CYSAB partners and individual organisations.

This year partners where asked a number of questions on the impact of SARs on their agency including

- What has improved?
- How has this improved?
- What has been the impact and how is this evident?

It is clear that learning from SARs has been considered across partner agencies and a number of changes and improvement continue to be implemented to help prevent similar situations from occurring in the future. A more detailed summary of how SAR learning has and continues to be embedded by partner agencies across York has been added to the business plan for next year. This will help to identify how we are meeting recommendations, where the gaps are and priorities to focus on.

The impact of SAR learning on services from our partners at a glance

This year we asked agencies what impact has the learning from recently published SARs in York had in their organisation. Below are some of the improvements partners have made in response to the SAR recommendations and some of the impacts from SAR learning for each SAR. The links to further information on the individual SARs can be found on the links below.

Catherine SAR

Full Report:
safeguardingadultsyork.org.uk/downloads/file/39/catherine-sar-report-2025

7 Minute Briefing:
safeguardingadultsyork.org.uk/downloads/file/42/catherine-sar-7-minute-briefing

City of York Adult Social Care

Improvements

City of York Council has introduced new guidance and standards for recording.

An assurance forum has been introduced which supports the quality of care and support planning, including for people with complex needs. Training in mental capacity has been updated.

Audits have enabled CYC to identify further work to improve our approach. Improved systems are in place to improve support planning and good case recording.

Impact

The assurance forum has drawn out examples of good practice where good assessment and support planning has resulted in good, personalised and safe support for people.

York and Scarborough Teaching Hospital NHS Foundation Trust

Learning Identified

The review highlighted learning relating to the management of long-term health conditions, information sharing, professional curiosity, safeguarding oversight, discharge planning and the importance of recognising wider vulnerabilities and safeguarding risks alongside physical health needs.

Changes Made

In response to the review, YSTHFT has strengthened safeguarding oversight through policy review, workforce development, safeguarding supervision and governance reporting. Learning from the review has been incorporated into safeguarding training and shared across clinical services through established governance routes.

YSTHFT has also undertaken targeted improvement work relating to diabetes safety, including completion of a Patient Safety Incident Investigation into missed doses of insulin and the introduction of quality improvement initiatives to strengthen insulin administration and patient monitoring. Learning has additionally informed wider discharge improvement work, including thematic review of discharge-related incidents and implementation of actions aimed at improving communication, medication management and discharge planning.

Evidence of Impact

The diabetes safety improvement programme has demonstrated a reduction in missed doses of insulin, improvements in the timely administration of insulin and a reduction in hypoglycaemic events, with further improvement cycles planned. A Diabetes Safety Group is also being established to provide ongoing oversight and governance.

A YSTHFT-wide thematic review of discharge processes has been completed, identifying key improvement actions and strengthening organisational oversight of discharge-related risks. Findings have informed both Trust and system-wide improvement plans and continue to be monitored through governance processes.

Further Assurance Required

YSTHFT will continue to monitor implementation of actions arising from the review through the Integrated Safeguarding Group and relevant governance structures. Ongoing assurance activity will include audit, review of safeguarding and discharge-related themes, monitoring of diabetes safety improvement work and evaluation of workforce development initiatives to ensure learning is translated into sustainable improvements in practice

Humber and North Yorkshire Integrated Care Board (HNY ICB)

Improvements

There is an improved pathway now in place to support the safe discharge of patients with diabetes. The ReSPECT tool is now in place across NHS providers.

The full impact of these improvements has not yet been measured.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

Improvements

TEWV has strengthened its approach to diabetes management through the introduction of dedicated diabetes training, accredited e-learning programmes, updated medication safety guidance, and ongoing review of inpatient diabetes policies. Diabetes management has also been subject to audit and action planning to improve compliance with care standards. In addition, safeguarding learning has been embedded through regular quality assurance audits, communication improvement workstreams, specialist supervision, and the sharing of SAR learning across the organisation to support good record keeping, information sharing and reflective practice.

Impact

These actions have improved staff knowledge and awareness of diabetes care, strengthened governance and oversight of clinical practice, and reinforced the importance of accurate documentation and effective multi-agency communication. The integration of SAR learning into training, audits and governance processes provides greater assurance that lessons identified within the review are being translated into practice, supporting safer care delivery and continuous service improvement.

Thematic Self-Neglect SAR

Full Report:
safeguardingadultsyork.org.uk/downloads/file/23/mr-z-safeguarding-adults-review
7 Minute Briefing:
safeguardingadultsyork.org.uk/downloads/file/20/7-minute-briefing-mr-z

York and Scarborough Teaching Hospital NHS Foundation Trust

Improvements

Professional recognition of self-neglect and early safeguarding response

- Many of the responses to the Catherine SAR and Julie SAR recommendations have helped YSTHFT address the findings in the thematic self-neglect SAR and to recognise self-neglect with professional curiosity is an identified area for continued development, YSTHFT has targeted improvement actions in place demonstrating progress, strengthening staff confidence to deliver more inquisitive, reflective and person-centred safeguarding practice.
- YSTHFT has strengthened visibility of safeguarding within Emergency Department pathways and discharge processes.

Hospital discharge and unsafe home environments

- Enhanced safeguarding visibility in Emergency Department and discharge pathways identified as a priority.
- Daily audit processes and monitoring of Emergency Department activity.
- Risks explicitly recognised and escalated within governance.
- Discharge pathway risks remain, though they are clearly identified and actively mitigated.

Mental Capacity Act (MCA) and decision-making

- Strengthened MCA and DoLS governance through integration into safeguarding structures.
- Introduction of assessment-based MCA training approaches to improve application.
- Clear recognition that training compliance remains an active risk with mitigation in place.

Workforce capability, training and professional curiosity

- Revised training models aligned to updated national guidance (Intercollegiate 2025).
- Learning from rapid reviews and complex safeguarding cases embedded into training and standard operating procedures.
- Training compliance, workforce capacity and discharge pathway risks remain, mirroring some SAR themes, though they are clearly identified and actively mitigated.

Impact

Professional recognition of self-neglect and early safeguarding response

As with the Catherine SAR and Julie SAR learning has been embedded into training, audit and safeguarding assurance processes, providing confidence in continued service improvement and patient safety

Hospital discharge and unsafe home environments

- Awareness of discharge risk now explicitly identified and governed
- Stronger assurance mechanisms than those described in SAR (where risks were often missed)

Mental Capacity Act (MCA) and decision-making

- Improved leadership oversight and governance of MCA
- Demonstrates movement from reactive use (as in SAR) to structured governance and learning

Workforce capability, training and professional curiosity

- Improved practitioner support and reflective practice
- Clear infrastructure for embedding SAR learning into frontline delivery
- YSTHFT has made progress against the key findings of the Self-Neglect SAR, in strengthening governance, improving escalation and embedding learning into practice.
- Improved identification, escalation and prevention indicate progress against missed opportunities highlighted in the SAR
- Stronger governance, supervision and partnership working directly address system fragmentation seen in the review
- Enhanced MCA governance, audit processes and training models show clear response to SAR learning

Enhanced training, supervision, and governance arrangements provide stronger assurance than the practice described within the SAR, while supporting improved professional curiosity, decision-making, and partnership working. Although training compliance, workforce capacity, and discharge pathway risks remain recognised organisational challenges, these are actively monitored and mitigated through established governance and assurance processes.

Humber and North Yorkshire Integrated Care Board (HNY ICB)

Improvements

The ICB has supported the development of the CYSAB pathway for self-neglect and will support the launch when that is agreed.

The action specific to Humber and North Yorkshire ICB has not yet been completed as the ICB restructure has led to a current pause in engagement with the safeguarding leads in primary care.

City of York Adult Social Care

Improvements

There has been improved awareness of the issue of self-neglect and how this needs to be responded to.

Guidance and practitioner tools have been developed. Training specifically related to the SAR has been rolled out. In addition, CYC has developed a self-neglect training module which is rolled out to staff. Further training included elected member training is planned.

Case studies of good practice have been developed and shared within adult social care and with the wider leadership team in the council

Impact

Greater recognition of self-neglect as a safeguarding issue has increased the number of people being referred and supported.

North Yorkshire Police

Improvements

North Yorkshires Police now have an Adults tactical delivery group with a standing agenda which includes SAR updates, SAR actions for NYP, Suicide Prevention and Safeguarding Board Priorities. The group is developing significantly as demand with Safeguarding adults which has grown certainly over the last 5 years.

North Yorkshire Police have been involved with the thematic report having referred the cases included for review and provided scoping for the cases being part of the thematic review.

The implementation of the Appearance, Words, Activity and behaviour, Relationships and dynamics, and Environment (AWARE) mnemonic which captures self-neglect under the environment € section giving officers prompts of what to look out for, what to record and a link to clutter scales. More emphasis on mental capacity under the AWARE which is captured under words (W) and encourages officers to listen, be professionally curious and advises officers that capacity can fluctuate or lack capacity in certain areas.

Impact

An improved PPN (referral system for the Police) Capturing the AWARE mnemonic and capturing the wishes of the victim.

- A greater awareness of Adult Safeguarding across the force.
- It is part of the Police daily management reporting structure.
- The dedicated Adult safeguarding team within Vulnerable Adult Team (VAT) working with partners where there are concerns of self – neglect. The team work with neighbourhood policing teams, GP's and other services, such as living well through Planning meetings to support people at risk of self-neglect.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

Improvements

TEWV has strengthened its response to self-neglect through enhanced safeguarding training, awareness campaigns, professional curiosity initiatives, and ongoing support for multidisciplinary working. Learning on self-neglect, hoarding, consent, information sharing and safeguarding responsibilities has been embedded within mandatory training, supervision, specialist advice services, and communication campaigns. Additional work has also focused on improving trauma-informed practice through specialist leadership, reflective supervision, psychology support, and the development of approaches that better understand the impact of trauma, adversity and mental ill-health on engagement with services.

TEWV has also continued to strengthen MCA governance and legal literacy through a comprehensive training programme, specialist Mental Health Legislation Team support, operational oversight groups, and partnership working with advocacy services. Work to improve multi-agency communication, challenge misconceptions about consent and information sharing, and support consistent safeguarding decision-making further supports the development of more coordinated responses to adults at risk of self-neglect.

Impact

These improvements have increased staff awareness, confidence and capability in recognising self-neglect, applying professional curiosity, responding to complex behaviours, and using safeguarding processes appropriately. Enhanced trauma-informed approaches, specialist support, and reflective practice opportunities are supporting more person-centred and relational ways of working, helping staff better understand the needs and experiences of vulnerable adults.

Strengthened MCA governance, high levels of MCA training compliance, improved communication, and greater multi-agency collaboration provide increased assurance that safeguarding risks are identified, escalated and managed effectively. Collectively, these developments demonstrate progress towards addressing the key themes identified within the SAR and support more coordinated, informed and preventative safeguarding practice across the Trust.

JULIE SAR

Full Report:
safeguardingadultsyork.org.uk/downloads/file/35/julie-safeguarding-adults-review-executive-summary

7 Minute Briefing:
safeguardingadultsyork.org.uk/downloads/file/37/julie-sar-7-minute-briefing

York and Scarborough Teaching Hospital NHS Foundation Trust

Improvements

Professional Curiosity

- YSTHFT is committed to promoting professional curiosity within safeguarding practice; however, it recognises that this is not yet consistently embedded and has been identified as a learning theme within a number of Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) during 2025-26.
- In response, there has been a targeted programme of awareness raising across clinical areas, including the Safeguarding Team's "Ward Wander – Target Topic" initiative, alongside strengthened messaging within training and supervision to encourage questioning, exploration and professional challenge. Training programmes have been significantly enhanced to build staff confidence and capability in applying professional curiosity, with a focus on understanding the wider context of risk and vulnerability.
- YSTHFT continues to support reflective practice through safeguarding supervision, audit and learning from reviews, enabling staff to consider their approach, assumptions and decision-making processes. In addition, Domestic Abuse Liaison Practitioners have played a pivotal role in increasing staff knowledge, confidence and professional curiosity, particularly in recognising and responding to patients experiencing domestic abuse.
- Overall, whilst professional curiosity is an identified area for continued development, YSTHFT can provide assurance that targeted improvement actions are in place and demonstrating progress, strengthening staff confidence to deliver more inquisitive, reflective and person-centred safeguarding practice.

Mental Capacity Act (MCA) Responsibilities

- Staff capability is strengthened through structured MCA/DoLS training, supervision, and learning from safeguarding activity, audits and reviews, reinforcing understanding of the statutory framework and promoting consistent, high-quality practice. The integration of MCA and DoLS within safeguarding adults' governance has further enhanced oversight, supporting a coordinated and standardised approach across services.
- YSTHFT provides assurance that Mental Capacity Assessments are undertaken in line with current legislation, case law and best practice guidance, supported by strengthened governance, improved access to training alternatives, and ongoing audit and quality assurance processes.
- YSTHFT recognises that there are identified gaps in the application of MCA within care delivery. In response, a thematic review of MCA practice has been commissioned, with completion planned for Quarter 1 2026-27, to provide further assurance, identify areas for improvement and strengthen the consistency and quality of practice across the organisation.
- Whilst training compliance and educator capacity remain areas for continued focus, clear mitigation plans are in place, including development of alternative training models to improve accessibility and compliance, supporting continued improvement in staff confidence and application of MCA principles.

Multi-Agency Information Sharing

- YSTHFT provides assurance that safeguarding information is recorded clearly and shared in a timely manner to protect adults at risk, supported by strong governance, leadership oversight and enhanced audit processes.
- Whilst this is accepted practice within the Safeguarding Teams, there is still work to do to embed confidence in the wider staff teams. Staff are supported through training, supervision and learning from reviews and audits, promoting accurate documentation and proportionate information sharing.
- Effective multi-agency partnership working ensures information is shared appropriately across services, enabling coordinated responses and timely support.
- Overall, YSTHFT can provide assurance that information sharing and recording processes are effective and strengthening, with ongoing focus on consistency and system reliability but there is continued focus in supporting staff to ensure information is shared confidently.

Non-Attendance / "Was Not Brought"

- Strengthened visibility of safeguarding within ED pathways and discharge processes
- Embedding of learning from reviews into practice, SOPs and training.

Impact

These improvements have strengthened staff confidence to deliver more inquisitive, person-centred safeguarding practice, improved oversight of MCA decision-making, and increased assurance around the quality of safeguarding information sharing and partnership working. Learning from reviews is now more visible within emergency care, discharge pathways and frontline practice, supporting earlier identification, escalation and management of safeguarding risks. While professional curiosity, MCA training compliance, workforce capacity and consistent information sharing remain areas for continued development, robust governance, audit and improvement plans are in place to support ongoing progress.

City of York Adult Social Care

Improvements

Significant changes to the way in which adult safeguarding concerns are acted upon at first contact with the council. Improved professional oversight of decision making, more effective triaging of concerns,

Impact

Quarterly audits introduced. Positive audit findings show improved decision making, enabling concerns to be directed where they will receive the most effective safeguarding response.

Probation Service Yorkshire and Humber

Improvements

During the review it was identified that Julie would not be tried posthumously but an offence would be recorded against Julie for producing and possession with intent of a Class B drug, alongside other individuals known to her. Julie did express concern about her charges and court appearance to professionals. As such she would have benefited from support from an independent advocate.

Impact

The impact will be targeted at the Learning and Development provision who sit within His Majesty's Courts and Tribunals Service (HMCTS) regarding Professional Curiosity, when people do not attend services and information sharing. Consideration of mental health and the use of advocacy and complexity of needs.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

Improvements

TEWV has strengthened safeguarding practice through mandatory training, specialist supervision, and daily safeguarding support that promotes professional curiosity, multi-agency working, advocacy, effective information sharing, and the application of the Mental Capacity Act (MCA). MCA governance has been further enhanced through dedicated training programmes, bespoke support from the Mental Health Legislation Team, regular collaboration with advocacy services, and continued oversight through operational governance groups. TEWV has also reviewed and updated its Did Not Attend/Was Not Brought(DNA/WNB) policy and continues to raise awareness of key legal frameworks, including Section 117 aftercare.

Impact

These actions have improved staff awareness, confidence, and consistency in responding to complex safeguarding concerns, supporting more holistic and collaborative decision-making. Enhanced MCA training and governance, strong advocacy partnerships, improved information-sharing arrangements, and clearer approaches to non-engagement provide greater assurance that risks are recognised, appropriately escalated, and managed through person-centred, legally compliant, and multi-agency approaches.

7. Safeguarding priorities for some of our partner agencies for 2026-27

North Yorkshire police

North Yorkshire police aim to provide an outstanding service to the people of York and North Yorkshire to keep them safe and feeling safe. Prevent and reduce crime and antisocial behaviour. Effectively respond to, investigate and solve crimes, and manage offenders. Safeguard the vulnerable and support victims of crime in collaboration with partner agencies to protect the most vulnerable in our communities.

City of York Adult Social Care

We will focus on the following three areas:

- Embedding of the approach to multi agency risk management
- Developing the approach to safeguarding and homelessness
- Improving learning, including from SARS

City of York Public Health

Targeted work to raise awareness of domestic abuse and support available to groups who are unrepresented in reported crimes and support services. This includes adults with disabilities and older adults.

Work to increase the number of domestic abuse perpetrators accessing support.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

Key priorities identified for the Trust for Safeguarding and Public Protection are as follows:

- Policies and procedure governance maintenance.
- Specialist Safeguarding Supervision – to deliver the proposal of specialist safeguarding supervision.
- Safeguarding level 3 training review in line with national guidance, feedback and learning from reviews.
- Safeguarding learning – clear outputs to share learning and support embedding into practice. This will include a key focus on learning from the Southport Enquiry and implications for mental health services.
- Multiagency Risk Assessment Conference (MARAC) – QI focus on streamlining process across the regional areas.
- Engagement in EPR record development to support safeguarding practices.

City of York Council Housing and Communities

Housing First and multi-agency partner working, ensuring support for people experiencing homelessness and rough sleeping is in place, both within CYC and other agencies

Prevention of homelessness in the first place through a greater focus on prevention and early intervention – org-wide project group.

York and Scarborough NHS Teaching Hospital Trust

During 2026-27, YSTHFT will continue to strengthen safeguarding arrangements through a programme of quality improvement, workforce development, governance oversight and partnership working. Priorities have been informed by Safeguarding Adults Reviews, audits, thematic reviews, safeguarding activity, national guidance and emerging local risks. Progress will be monitored through established governance structures, including the Integrated Safeguarding Group, with quarterly assurance reporting to Trust committees and senior leadership teams.

Key priorities for 2026-27 include:

- Strengthening workforce capability and compliance through delivery of safeguarding adults and children training programmes, with a particular focus on achieving and sustaining compliance with Level 3 safeguarding requirements and Mental Capacity Act training. Training performance will be monitored through workforce dashboards and reported through governance arrangements.
- Embedding learning from Mental Capacity Act (MCA) and DoLS reviews through completion of thematic review action plans, targeted workforce development, re-audit activity and strengthened oversight of complex decision-making, executive functioning and safeguarding risk.
- Maintaining a sustainable safeguarding workforce by reviewing establishment, succession planning and funding arrangements for specialist safeguarding roles, including domestic abuse provision, to ensure the YSTHFT can continue to meet its statutory safeguarding responsibilities.
- Strengthening the Trust response to domestic abuse through continued delivery of specialist Domestic Abuse Liaison Practitioner services, monitoring referral activity and outcomes, evaluating impact and working with partners to identify sustainable service models for the future.
- Improving safeguarding assurance within emergency care and discharge pathways through thematic audits, review of safeguarding referrals, monitoring of discharge-related learning and implementation of actions identified through quality reviews and incident investigations.
- Embedding learning from Safeguarding Adults Reviews (SARs) through a formal action tracking process, ensuring recommendations are implemented, monitored and evaluated, with evidence of progress reported through the Integrated Safeguarding Group.
- Enhancing governance and assurance arrangements through quarterly safeguarding performance reporting, oversight of safeguarding themes and risks, and continued partnership engagement with the City of York Safeguarding Adults Board and other safeguarding partnerships.

Through these priorities, YSTHFT aims to strengthen safeguarding practice, improve outcomes for adults at risk and ensure that learning is translated into sustainable improvements across services.

Probation Service Yorkshire and Humber

This coming year are aims are to:

- Share any relevant learning to the board from our Death Under Supervision reviews.
- Increase quality of safeguarding adult referrals.
- Increase referrals to Reconnect
- Increase staff knowledge and confidence in recognising self-neglect.

Humber and North Yorkshire Integrated Care Board (HNY ICB)

As part of wider NHS Reform Integrated Care Boards have been under a process of significant rapid re-structure in 2025-26. The future purpose will be to act as system leaders and strategic commissioners who plan, fund and shape services to improve population health, reduce inequalities and deliver better outcomes across local integrated systems.

Humber and North Yorkshire ICB have reached the completion of their re-structure process and 2026-27 will see embedding of new teams and new functions as the strategic commissioner of health services for Humber and North Yorkshire humberandnorthyorkshire.icb.nhs.uk/

The ICB will maintain its statutory system responsibility working closely with the Safeguarding Adults Boards and local system partners.

As a team whilst we will endeavour to follow a 'business as usual' approach we are also having to adapt our current practice, by reviewing and streamlining what we do with the future focus of safely delivering our statutory duties for safeguarding in health as a priority.

North Yorkshire Fire and Rescue Service

We will focus on

- Safeguarding Training
- Self-Neglect and Hoarding

8. Our focus for 2026-2027

The CYSAB strategy 2025-2028 set out the priorities for three years and in its second year, 2026-27 we will focus on:

1. Prevention, awareness and engagement

- The subgroup model of the CYSAB is constantly developing to be able to adapt to the demands and emerging priorities in support of SAR recommendations and any national changes and this model will continue in 2026-27.
- Engaging with a wide audience is essential to fulfil the commitments of the CYSAB strategy which includes participation in safeguarding weeks, working with communities and other partnerships including the City of York safeguarding children's partnership, Safer York partnership and Domestic Abuse Partnership.
- CYSAB work regionally with partners from the consortium of SABs in North Yorkshire, Calderdale, Kirklees, Wakefield and Bradford, sharing our policy and procedures through Tri-x and this continues to be an important area, enabling the CYSAB to utilise local, regional and national safeguarding expertise.
- Developing the activity report, which has gone through its first year in 2025-26 will continue to ensure that the data we collate is meaningful and shows impact.

2. Learning, reflection and practice improvement

- SAR work remains a significant priority, and we will always aim to include families where possible and ensure that learning is cascaded quickly and through the whole of the CYSAB partnership. We will continue to embed learning from the Safeguarding Adult Reviews (SARs) that have been finalised in 2025-26 and the up-and-coming SARs from 2026-27. There will be a continued emphasis on ensuring that learning from SARs leads to meaningful improvements in practice. This includes strengthening how learning is embedded across organisations, increasing collective ownership of actions by partner agencies, and focusing on evidencing the impact of changes.
- With a newly emerging National Adults Safeguarding Board the CYSAB will support any key legislative changes which affect how SABs develop and expectations required.
- There will be a continued commitment to ensuring safeguarding practice is person-centred and trauma informed. This includes amplifying the voice of the adult throughout safeguarding processes and making greater use of lived experience to inform service design, policy development and learning from Safeguarding Adult Reviews, helping to ensure that services are shaped by the experiences of those they support.

3. Strengthening multi-agency safeguarding responses to adults at risk of exploitation, rough sleeping, homelessness and self-neglect

- We will continue to develop our key areas of focus below which will guide the way we work together as a Board in 2026-27 to safeguard our communities and the safeguarding areas we want to strengthen. In 2025-26 the focus was mainly on rough sleeping, homelessness; self-neglect and hoarding. In 2026-27 developing the exploitation task and finish group will be a priority also.
- **Adults at risk of exploitation:** improving transitional safeguarding remains an important area of development, with a focus on creating more effective links between children's and adults' safeguarding services. Particular attention is given to young adults aged 16 to 25 with neurodiversity, mental health needs, and vulnerabilities associated with exploitation, abuse or self-neglect, ensuring support is coordinated and responsive during key transition periods. Partners are also seeking to strengthen responses to domestic abuse, which includes recognising and responding to forms of abuse that can be hidden or difficult to identify.
- **Rough sleeping, homelessness:** the CYSAB will continue to work with colleagues focused on implementation of the new Housing Strategy with the findings from the 2025-26 workshops which highlighted the need to move towards a housing-led approach, with flexible support tailored to individual needs rather than expecting people to fit existing services, making better use of existing resources, increasing assertive outreach, strengthening support following prison release, improving links with GP services, and delivering trauma-informed training.
- **Self-neglect and hoarding:** a strong focus will remain on self-neglect, hoarding and complex risk, with ongoing work to improve pathways, thresholds and professional responses. A key priority is developing greater confidence in risk enablement and shared decision-making across agencies, while supporting frontline practitioners to navigate complex ethical, legal and safeguarding considerations. In doing this we will place an emphasis on considering impact of changes made in the first year of our strategy 2025-26, such as the new Multi-Agency Risk Management (MARM) framework.

To see the CYSAB Strategy 2025-2028 in full please use the link:
safeguardingadultsyork.org.uk/strategic-plans/strategic-plans-1

Contacts

If you are worried about an adult in York, please report any concerns via the City of York Safeguarding Adults board website **safeguardingadultsyork.org.uk**

If you would prefer to speak to someone or report information anonymously you can:

Contact the City of York Adult Social Care:

- telephone: 01904 555111, Monday to Friday, 8.30am to 5.00pm
- text telephone: 07534 437804 if you're hearing impaired.
- telephone: 0300 131 2131 for out of hours help.

Alternative formats

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Email us at: **cycaccessteam@york.gov.uk**

Call us: **01904 551550** and customer services will pass your request onto the Access Team.

Use our BSL Video Relay Service:
www.york.gov.uk/BSLInterpretingService
Select 'Switchboard' from the menu.

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我們也用您們的語言提供這個信息 **(Cantonese)**

এই তথ্য আপনার নিজের ভাষায় দেয়া যেতে পারে। **(Bengali)**

Ta informacja moze być dostarczona w twoim własnym języku. **(Polish)**

Bu bilgiyi kendi dilinizde almaniz mümkündür. **(Turkish)**

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جاسکتی ہیں۔ **(Urdu)**

CITY OF YORK
Safeguarding Adults Board