Gateshead Safeguarding Adults Board Annual Report 2023/24

Gateshead Safeguarding Adults Board

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Gateshead Safeguarding Adults Board

Introduction from our Independent Chair

I am very pleased to welcome you to the annual report for Gateshead Safeguarding Adults Board.

Why an Annual Report

This is an important time of the year for Gateshead Safeguarding Adults Board as we have both a legal duty to produce an annual report and a strategic plan. They work well together as the annual report outlines how we have met the challenges we set ourselves the previous year and the strategic plan helps to set out the journey that the Board is on in future years. It is rare that we can say things are complete or finished and rightly so, we will always strive to build on what we have achieved to ensure we aim for better things year on year. The annual report holds the detail of how the Safeguarding Adults Board is governed, structured and works, it includes our strategic priorities and outlines our achievements towards those priorities.

My First Year

This has been my first year as the independent chair for Gateshead's Safeguarding Adults Board and the production of the annual report offers an opportunity to pause, to reflect and to take stock of our achievements. As a Safeguarding Adults Board we have had ongoing change with the structures across our statutory and non-statutory Safeguarding Adults Board partners, however this has not impacted in any way on the immense commitment, drive and collaboration demonstrated across the Safeguarding Adults Board partnership. I feel we have continued to mature and develop together and have started to really 'own' our collective responsibility for the effectiveness of our partnership work. This is demonstrated in how we challenge, support and hold each other to account and within the strong governance and learning framework we have developed as a board. We are working hard together to ensure we embed the learning from Safeguarding Adults Reviews, and other reviews where vulnerable adults feature. The complexity of some people's lives and situations means an ever more coordinated multi agency response is required to help people remain safe and well. The journey to learn from this type of situation has become increasingly prominent and features heavily within our plans for 2024/25.

Committed to Care

The Care Act 2014 challenged Safeguarding Adults Boards and its members to work in person-centred ways that involve listening to the person at risk, ensuring they are involved within decisions about their own safety and wellbeing, and seeking the changes they want wherever possible. Gateshead Safeguarding Adults Board is committed to really listening to people and we have involvement and person centeredness as an ambition that runs through each of our 5 strategic priorities. Over the next year this approach will set the direction for how the Board needs to work, and the expectations for how individual services must work to provide individuals with help and protection across Gateshead.

Listening

As a Safeguarding Adults Board, we have initiated work this year to seek advice, to listen and to learn from people and their families who have been involved in safeguarding directly. This and ongoing work with our community and voluntary sector will help to equip and set the direction for how the Safeguarding Adults Board can make safeguarding truly personal. Each year we will take further steps towards being truly citizen-led in our work.

Partners

As the Gateshead Safeguarding Adults Board Chair, I would like to take the opportunity to thank everyone for their work to help and protect adults in Gateshead. I offer thanks to the Safeguarding Adults Board partners for their commitment and that of their colleagues as this enables the Board to continue to take important strides forward. The Safeguarding Adults Board and its subgroups are made up of committed individuals who go the extra mile each and every week to support the Board's various subgroups and workstreams – these are often the people who 'make it happen'.

Thank you

It is with regret however, that I rarely get the opportunity to thank in person frontline workers across all services and agencies in Gateshead for all they do to support individuals to be safe and to feel safe. It is important we recognise that it is only with the support of frontline teams, services and practitioners that we achieve our ambitions of Gateshead being a safe place for everyone.

Better Practice

As a Board we regularly hear about new initiatives and services that will make a difference, we hear about examples of excellent practice through individuals and teams who explore every opportunity in difficult circumstances, to help and minimise the risk to people they support.

Working Together

In practice we can only move forward together by listening, by being inclusive and by valuing and respecting each other's unique contribution to safeguarding. The level of work and commitment from partners, from frontline workers to volunteers, unpaid family carers, and those within our communities has been amazing. Together we are making a difference.

Nicola Bailey
Independent Chair, Gateshead Safeguarding Adults Board

Safeguarding in Gateshead

Welcome to the Gateshead Safeguarding Adult Board Annual Report. Within the report you will find information on the Boards strategic vision and priorities and an overview of the key outcomes from 2023/ 24.

The report outlines the board priorities/ambitions for the previous year, what we have done to achieve these in part through our subgroup work. The report outlines the Safeguarding Adults Board governance structure and the 3 statutory partner governance structures as they relate to safeguarding adults, internal governance structures for each statutory partner and an update on what they have achieved during the year.

The Board has three core duties:

- to publish a strategic plan for each financial year.
- to publish an annual report detailing what the Board has done during the year.
- conduct any Safeguarding Adult Reviews (SARs).

The Gateshead Safeguarding Adults board works to protect an adult's right to live safe, free from abuse and neglect. Ensuring people and organisations work together to prevent and stop both the risks and experience of abuse or neglect. At the same time, we need to make sure that the adult's wellbeing is promoted. This includes, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action, making safeguarding personal.

The aims of adult safeguarding

- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- stop abuse or neglect wherever possible.
- safeguard adults in a way that supports them in making choices and having control about how they want to live.
- promote an approach that concentrates on improving life for the adults concerned.
- raise public awareness so that communities, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect.
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and how to raise a concern about the safety or well-being of an adult.
- address what has caused the abuse or neglect.

Gateshead Safeguarding Adults Board

The Gateshead Safeguarding Adults Board became a statutory body in April 2015. The Board's vision for adult safeguarding in Gateshead is:

'Everybody in Gateshead has the right to lead a fulfilling life and should be able to live safely, free from abuse and neglect – and to contribute to their own and other people's health and wellbeing'.

The Board is responsible for assuming the strategic lead and overseeing the work of Adult Safeguarding and Mental Capacity Act arrangements in Gateshead. Within Gateshead we have an Independent Chair to enhance scrutiny and challenge.

The Board has a comprehensive Memorandum of Understanding, which is updated annually, and provides a framework for identifying roles and responsibilities and demonstrating accountability. Our Safeguarding in Gateshead website www.gatesheadsafeguarding.org.uk provides a wealth of information about our Safeguarding Adults Board and our Gateshead Safeguarding Children's Partnership (GCSP).

Gateshead Safeguarding Adults Board Membership

Statutory Membership

In law, the statutory members of a Safeguarding Adults Board are defined as:

- the local authority (Gateshead Council)
- the local police force (Northumbria Police)
- the Integrated Care Board (Northeast and North Cumbria Integrated Care Board (NENC ICB))

Gateshead Council

NORTHUMBRIA POLICE

NHS North East & North Cumbria

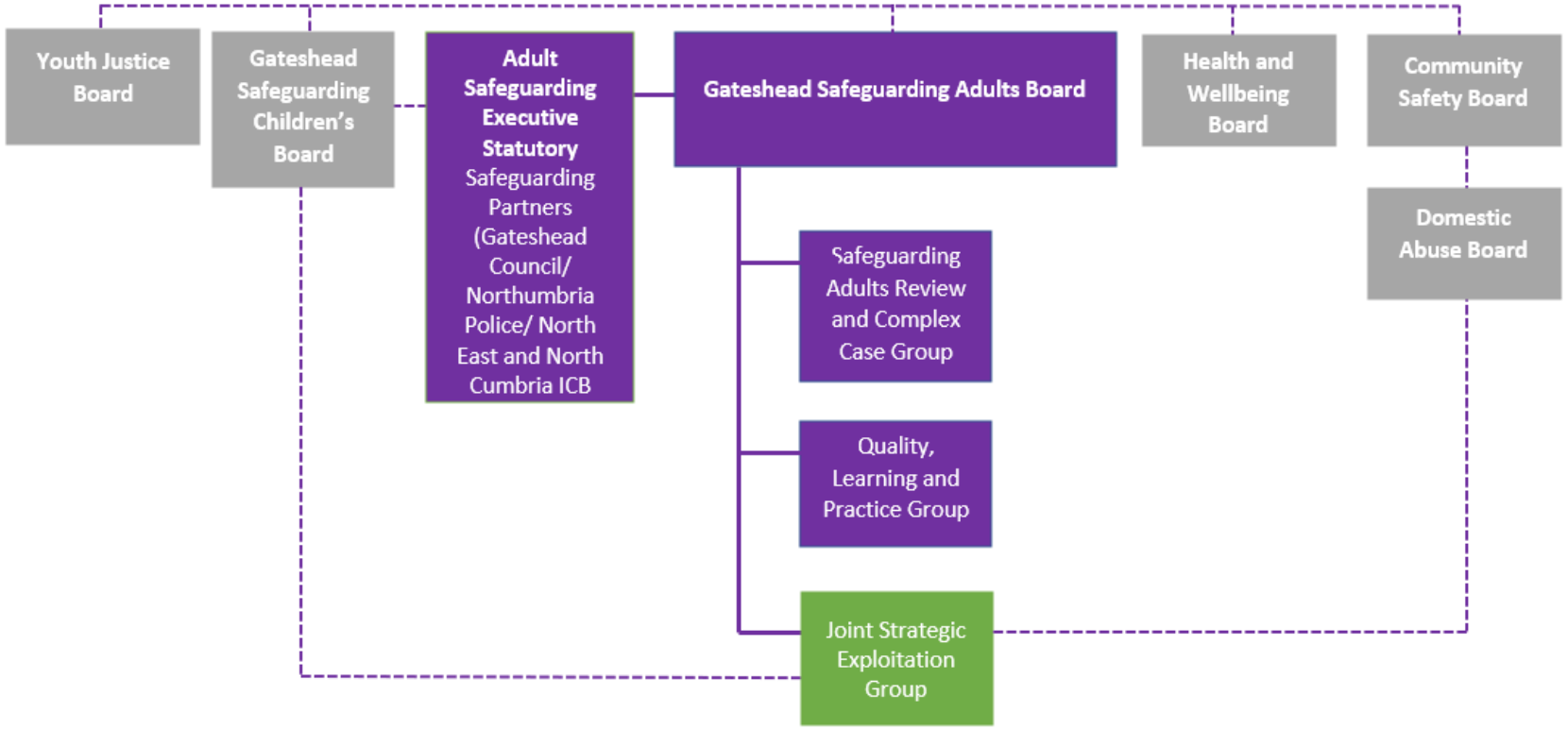
Wider Membership

In Gateshead, we recognise the importance of the contribution made by all our partner agencies and this is reflected by the wider Board membership (correct as of June 2024):

- North East Ambulance Service
- Gateshead Health NHS Foundation Trust (GHFT)
- South Tyneside and Sunderland NHS Foundation Trust (STSFT)
- Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust (CNTW)
- Gateshead College
- Tyne and Wear Fire and Rescue Service (TWFRS)
- Probation Service
- Connected Voice (Advocacy)
- Department for Work and Pensions (DWP)
- Healthwatch Gateshead
- Your Voice Counts (Advocacy)

Gateshead Safeguarding Adults Board Structure

The Gateshead Safeguarding Adults Board sits within a clearly defined structure and has close links with other local multi-agency partnerships including the Health and Wellbeing Board, Community Safety Partnership and Gateshead Safeguarding Children's Partnership (GSCP).



Partner Governance Arrangements and Scrutiny 2023/24

Board members are responsible for ensuring that governance and scrutiny arrangements for Safeguarding Adults are incorporated within the structure of their own organisations, and that there are mechanisms for disseminating and sharing information from the Safeguarding Adults Board. The governance and scrutiny arrangements for the three statutory partners include:

Gateshead Council

- The Health and Wellbeing Board receive an annual update from the Safeguarding Adults Board Independent Chair upon publication of the annual report as do the Care, Health and Wellbeing Overview and Scrutiny Committee.
- The Safeguarding Adults Board Independent Chair meets on a quarterly basis with the Portfolio holder for Adult Social Care to provide updates on the work of the board.
- The Gateshead Council Internal Audit service provide assurance that the Board and Gateshead Council are meeting their statutory duties.
- A weekly workbook and report is circulated to practice leads and team managers highlighting key areas of safeguarding, detailing latest comparator information and trends over the last 12 months, and the previous 3 years.
- A monthly Senior Management Team meeting take place which is dedicated to performance management. The performance dashboard is used to highlight areas of good performance and areas for improvement are shared, actions are discussed and set wherever necessary through the senior management team meeting.

- A dedicated Group Management Team (GMT) focusing on finance and performance is held monthly with relevant senior leaders, where the activity from the previous steps are presented, actions and progress discussed, and further analysis and actions are agreed and taken forward.
- Safeguarding information is presented to the Gateshead SAB on a quarterly basis a dashboard has been developed which covers safeguarding data relevant to the board this is to provide assurance to the board of good practice and actions taken on areas of improvement.

Northeast and North Cumbria Integrated Care Board (NENC ICB)

NHS North East & North Cumbria

- The ICB Chief Nurse holds the lead for the safeguarding portfolio.
- ICB internal assurance is provided via safeguarding reports to the Area Quality Sub Committee who report to the Quality Safety and Risk Committee (Quarterly).
- Reports provide local updates on the work of the safeguarding partnerships and ensure that key safeguarding risks, issues and developments are reported within the ICB.
- Reports also outline activity relating to Safeguarding Adult Reviews (SARs) Domestic Homicide Reviews (DHRs) and other non-statutory reviews such as Appreciative Enquiries.
- The ICB also has a Safeguarding Senior Leadership Group which coordinates and leads the development of Safeguarding arrangements across the ICB, reporting and escalating issues to the ICB where appropriate and has a key role in leading on assurance and development.
- Governance and scrutiny arrangements will continue to evolve under the new Integrated Care Board arrangements.

Northumbria Police

- All learning from national and local serious case reviews are scrutinised through the Organisational Learning Board and the organisational learning log.
- The organisational learning log is focused on the importance of identifying learning opportunities and drivers, embedding the value of lessons learned, and helping the organisation to become focused on the importance of continuous learning.
- Each Area Command and Department has a responsibility to consider drivers for lessons learned and to encourage organisational learning within their areas of business.
- The organisational learning log is submitted to the Organisational Learning Board for discussion and agreement of new actions, and to ensure organisational wide learning has been considered.
- Agreed recommendations and actions from the relevant ODG or board will be managed by the assigned learning owner.
- Areas of learning and best practice that require Force wide communication or change are escalated through Strategic Management Board.

Gateshead Safeguarding Adults Board Sub-Group Arrangements

Quality, Learning and Practice (QLP) Group
(Chaired by a senior manager from Gateshead Council)

The Quality, Learning and Practice Group is responsible for:

- Monitoring and reviewing performance data and driving forward quality via the quality assurance framework, case file audits and monitoring inspection recommendations.
- Collating and reviewing recommendations from statutory Safeguarding Adult Reviews and discretionary reviews and has oversight of multi-agency safeguarding training.
- Ensures that the Multi Agency Safeguarding Adults policy and procedures and supporting practice guidance continue to be fit for purpose.
- Keeping up to date with national policy changes that may impact upon the work of the Safeguarding Adults Board.
- The development and implementation of the Communication and Engagement strategy.

Safeguarding Adult Review and Complex Case (SARCC) Group

(Chaired by a senior manager from Northeast and North Cumbria ICB)

The Safeguarding Adults Review Group (SARCC) will:

- Consider Safeguarding Adult Review (SAR) referrals, commission reviews and subsequently monitor their progress.
- Oversee discretionary reviews into cases that do not meet the criteria for a SAR, where the group feel that there are multi-agency lessons to be learned.
- Collate and review recommendations from SARs and other reviews, ensuring that achievable action plans are developed and that actions are delivered.
- Provides a forum to discuss complex Safeguarding Adult cases that require additional scrutiny and support.

Joint Strategic Exploitation Group (JSEG)

(Chaired by a senior officer from Northumbria Police)

The Joint Strategic Exploitation Group is a sub-group of both the Safeguarding Adults Board and the GSCP.

The Police chair undertakes this role across the Northumbria Police Force footprint (6 LA areas) which promotes sharing of learning and best practice and connectivity across the region in identifying emerging trends or concerns.

The remit of the group is to lead on the development of strategic work in relation to all aspects of exploitation, including but not limited to: Sexual Exploitation; Criminal Exploitation; Modern Slavery and Trafficking and Missing.

Task and Finish Groups

- The Board and the three sub-groups regularly commission time limited task and finish groups to undertake specific pieces of project work.

Subgroups Highlight Reports

In 2023 the board requested all subgroups to prepare and present a report at each board meeting. The report covers 4 main areas:

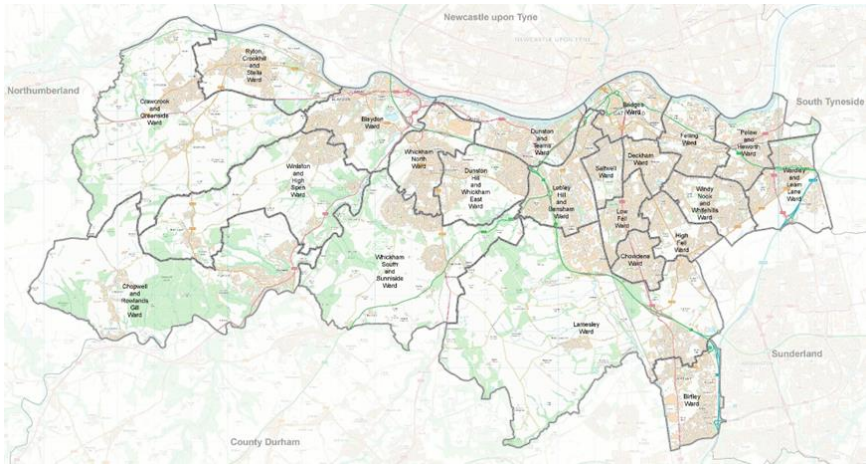
- What is working well?
- What is not working well?
- What difference are we making?
- Potential Risks

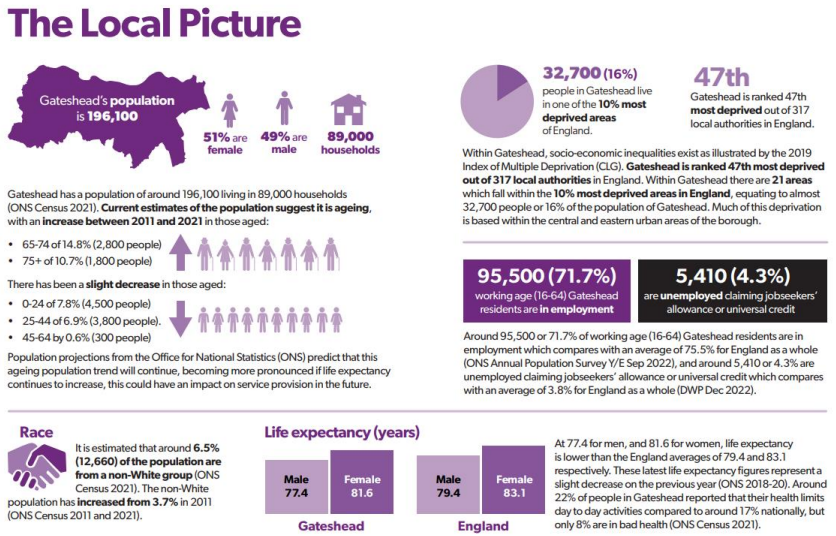
This allows each subgroup to raise the profile of its work and share good practice and outcomes, whilst also highlighting any potential risks to the board so that remedial action can be taken, by the board or by its partners.

The Local Picture

The demographics of Gateshead place additional pressures on health and social care, policing, ambulance services and the private, voluntary and independent sector who support the residents of the borough.

The Gateshead Safeguarding Adults Board plays a pivotal role in supporting its partner agencies to meet their responsibilities in relation to safeguarding alongside their statutory responsibilities and their role in service delivery.





NB This infographic is based on 2022 data

Strategic Priorities and Key Actions

The Strategic Plan 2019-2024 was approved by the board in April 2019 and contained five strategic priorities:

1. Quality Assurance
2. Prevention
3. Communication and Engagement
4. Operational Practice
5. Mental Capacity

The board has worked to complete the key actions identified within the plan.

For further information on the key actions for each priority go to Appendix 2.

This is the final year of the Strategic Plan in its current format. The board have worked collaboratively to develop and agree its future strategic priorities, the Strategic Plan for 2024 – 2027 is now available on the Website.

What we achieved in 2022/23

The annual report must demonstrate what the Safeguarding Adults Board and its members have done to carry out and deliver the objectives of its strategic plan. The following slides give an overview of the work of the board and its subgroups over 2023/24.

Annual Quality Assurance Challenge Event

(Quality Assurance)

The board held its annual challenge event in September 2023. All statutory partners were represented at the event along with wide representation from other agencies. The focus of the event was to:

- Agree the boards governance and accountability arrangements. The board has developed a governance framework
- Review membership and strengthening engagement
- Develop the Strategic Plan and Future Priorities for the Safeguarding Adults Board.
- Agree the format of the Gateshead Safeguarding Adults Board annual report.
- Review the data which is presented to the Gateshead Safeguarding Adults Board.

The boards Strategic Plan for 2024-2027 was developed from the feedback from partners during the event. Partners were asked to deliver a short presentation on:

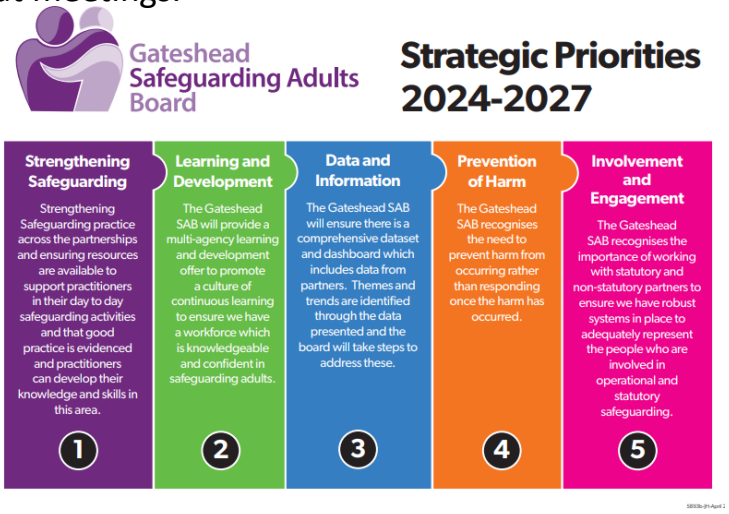
- What is working well
- What is not working well (obstacles, barriers and system pressures)
- What the 3 priorities should be from that agency's perspective

The priorities for the new Strategic Plan for 2019-2024 were agreed as:

- Strengthening Safeguarding
- Learning and Development
- Data and Information
- Prevention of Harm
- Involvement and Engagement

The outcomes from this plan will be shared in the 2024/25 annual report.

Following the event the board started to develop its governance and assurance framework to ensure there was clear evidence of accountability across the partnership. The framework was agreed by the Board in June 2024. Governance data is contained with the Safeguarding Adults Board Data Dashboard to ensure all board meetings are quorate and to ensure we have broad partnership attendance at meetings.



The Gateshead Safeguarding Adults Board, Community Safety Partnership and the Gateshead Children's Safeguarding Partnership have worked over 2022/ 23 to improve and strengthen engagement across the partnerships. See Linking with Other Parts of the System Slide for further information.

It was agreed that the annual report should be in a format which is easily accessible and contains the relevant information to evidence the board has worked to meet its strategic priorities and capture the wider work of the partnership.

The board and the local authority performance team began work to improve the Safeguarding Adults Board Data Dashboard which was historically very data heavy. The Dashboard now contains graphs and charts which are used to identify areas of concern and where further analysis is required. Dashboard now contains data from Northumbria Police, TWFRS, Health as well as training information, communication and engagement and assurances around out of borough placements. Work continues to develop the Data Dashboard to ensure it provides useful information, data and assurance to the board.

Prepare Gateshead Safeguarding Adults Board for the CQC Inspection

(Quality Assurance)

The Safeguarding Adults Board has received regular updates on progress with the preparations for the LA CQC Assurance inspections which Safeguarding Adults Boardwill include “How Gateshead ensures safety within the system”:

- The Safeguarding Adults Board has provided information which has been included in the local authority self-assessment and the Local Authority Information Return (LAIR) which will form part of the CQC overall Assurance Framework.

- The Safeguarding Adults Board Independent Chair and Business Manager took part in the LGA ASC Preparation for Assurance Peer Review which took place in March 2023, and supports the local authority’s preparations for the formal CQC assurance inspection from the position of a ‘critical friend’. The challenge involved exploring the local authority's ambitions and performance and helped to highlight improvements and where effective practice can be shared more widely.

“New Independent Chair has introduced appropriate challenge within the board, with SARs progressed, better use of data and a Learning Register” feedback from LGA ASC Preparation for Assurance Peer Review

Feedback from the LGA ASC Preparation for Assurance Peer Review

Following the peer challenge the board were provided with feedback which suggested that further work needed to be undertaken on:

- Developing a robust governance framework
- Developing a risk register to ensure the board was aware of and able to monitor any risk which may prevent it from meeting its statutory responsibilities
- Monitor learning from SARs and ensure assurances are received from partners on the learning identified following reviews is acted upon.
- How do we know people in Gateshead are safe, how do people in Gateshead tell us what makes them feel safe.
- Review and improve our SAR process

Understanding Safeguarding

(Operational Practice)

The number of inappropriate safeguarding concerns being received by the Local Authority Safeguarding Team in 2023/24 continues to remain high. In response to this the Safeguarding Adults Board developed the Understanding Safeguarding guidance which aimed to provide practitioners with clear guidance on when they should raise a safeguarding concern.

The guidance details the safeguarding concern criteria as defined in the Care Act 2014, and if the case does not meet the criteria what actions the practitioner can take such as requesting an initial care assessment or request a care and support review. The guidance promotes the use of multi-disciplinary meetings as way to bring practitioners together to support an individual.

The guidance gives case examples which help practitioners to reflect on cases they may have had and to consolidate and embed the learning from the guidance.

Exploitation Awareness

(Prevention, Communication and Engagement, Operational Practice)

Following the completion of a learning review in 2022 the NENC ICB Exploitation Nurse developed a short video on Exploitation Awareness, which was launched during 2023/24.

The learning review of a young adult male identified that he had been the victim of exploitation. The video illustrates how to recognise exploitation and also that consideration should be given to gender bias, that exploitation extends beyond the age of 18 and that it often may seem consensual. Helping to recognise the factors which make an individual more susceptible to exploitation is a key feature of the video, along with practical steps that practitioners can take to support someone. The video also raises the complex issue of executive dysfunction and how to deal with capacity issues, all things which were factors in the learning review conducted by the SARCC subgroup.

The short video is available on the Gateshead Safeguarding Adult Board Website and can be used for any of our multi-agency partners to highlight with employees, volunteers and the public the dangers of not recognising exploitation.

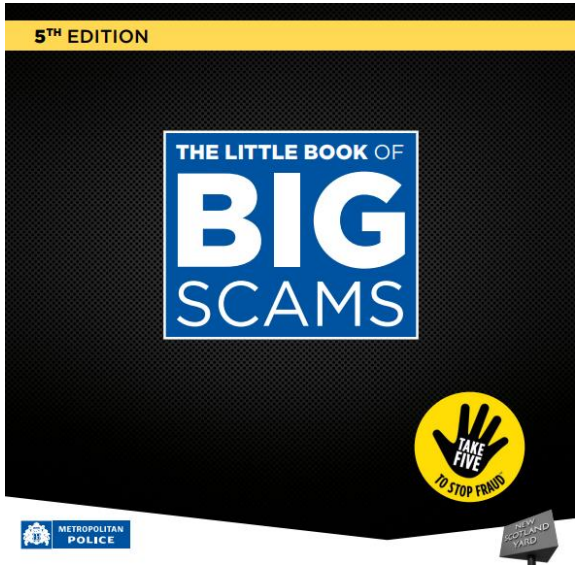
Financial Abuse and Scams

(Prevention, Communication and Engagement)

Following a presentation and discussion at the QLP subgroup in April 2023 from the Gateshead Trading Standards Team information advice and guidance was added to the Safeguarding Adults Board website on the Financial Abuse and Scams page.

The information was aimed at supporting the public to recognise scams, who to do if they have been scammed and how they can support others by becoming Scam Champions or Scam Marshalls.

This additional information enhanced the information already provided on financial abuse and the guidance provide in the care act statutory guidance.



Multi-agency Learning and Development Gap Analysis

(Prevention)

In February 2023 the QLP sub-group were tasked with reviewing the Safeguarding Adults Board multi-agency training offer through undertaking a training gap analysis to review the multi-agency training offer, identify the safeguarding training which partners were providing for their workforce, identify any gaps in our training offer, agree how to provide assurances to the board that multi and single agency safeguarding training is the required quality and standard and discuss the possibility of interagency working and sharing resources.

A task and finish group was set up with representatives from Northumbria Police, NENC ICB, Gateshead Council Safeguarding Adults Team, Gateshead Council Housing Services, TWFR and Gateshead Recovery Partnership.

The group are planning to present their report and recommendations at the board meeting in September 2024.

Partnership Reduction of Exploitation and Missing (Previously MSET)

(Prevention and Operational Practice)

The JSEG was involved in the regional review of Missing Sexually Exploited and Trafficked (MSET) procedures, which was undertaken towards the end of 2023 and start of 2024. The aim of MSET, introduced in 2018, was to have a corporate approach across the 6 LA's to safeguard and protect those children who were regularly going missing and at risk of or suffering from sexual exploitation. Through the review it was agreed that adult cases would be included in the revised processes.

Partners in Gateshead were key to a multi-agency task and finish group to consider improvements to the system so that the process was standardised across all six LAs in the Northumbria Police area; to include adults in the process; to be outcome focussed; to not only focus on the victim, but also on the offender to remove/resolve the issue and the location.

As a result, a new process was agreed – Partnership Reduction of Exploitation and Missing (PREM) which will put the onus on each local authority to gatekeep cases, which will give back several hours back to partners and ensure a multi-agency problem solving meeting to work together to reduce risk, tackle perpetrators and disrupt hot spot locations. The PREM meeting will be chaired by a Detective Inspector from the Prevention Department, Northumbria Police to ensure a corporate and consistent approach. Following agreement to proceed on this basis in June 2024, a roadshow, training and raising awareness with partners will be undertaken in summer 2024 before the new process is launched in the autumn of 2024. The impact of this new process will be monitored at a strategic level.

Transitional Safeguarding

(Prevention and Operational Practice)

The JSEG oversaw and supported the review of the vulnerable adolescents' services and supported the developing of a new group which will report into the JSEG - the Contextual Safeguarding Group is chaired by the JSEG deputy chair and Local Authority's Practice Lead for Innovation, Transformation and Vulnerable Adolescents. This group collectively informs and influences updates to the JSEG. It focuses on 5 key strands of work: Safeguarding of individual young people; Development of safeguarding places and spaces; Response to child protection; Transitional safeguarding; and Serious Youth Violence.

The Safeguarding Adults Board Business Manager attends the meetings and is the chair of the task and finish group for Transitional Safeguarding.

Learning and Development

The Safeguarding Adults Board provided a wide range of learning and development activities during 2023/24, these sessions were linked to learning from SARs, themes from SG Adults week and the core multi-agency training programme.

Learning from Safeguarding Adult Reviews (SARs)

(Quality Assurance and Prevention)

The board continues to offer learning and development opportunities which reflect the learning from safeguarding adult reviews, this includes local and national cases. The board delivers multi-agency interactive workshops which allow practitioners to hear about cases which have been the subject of a review or inquiry and the learning from these. The sessions allow time for practitioners to reflect on the cases and to undertake group work to support their understanding of the key issues and the learning which can be drawn from the cases considering how different actions could have changed the outcomes for individuals.

The board also provides learning and development which covers specific areas of practice development where additional support is required for practitioners. During 2022/23 the board delivered:

- An introduction to the Mental Capacity Act and Practical Application of the Mental Capacity Act
- Self-Neglect
- Mate Crime
- Fire Safety
- Professional Curiosity

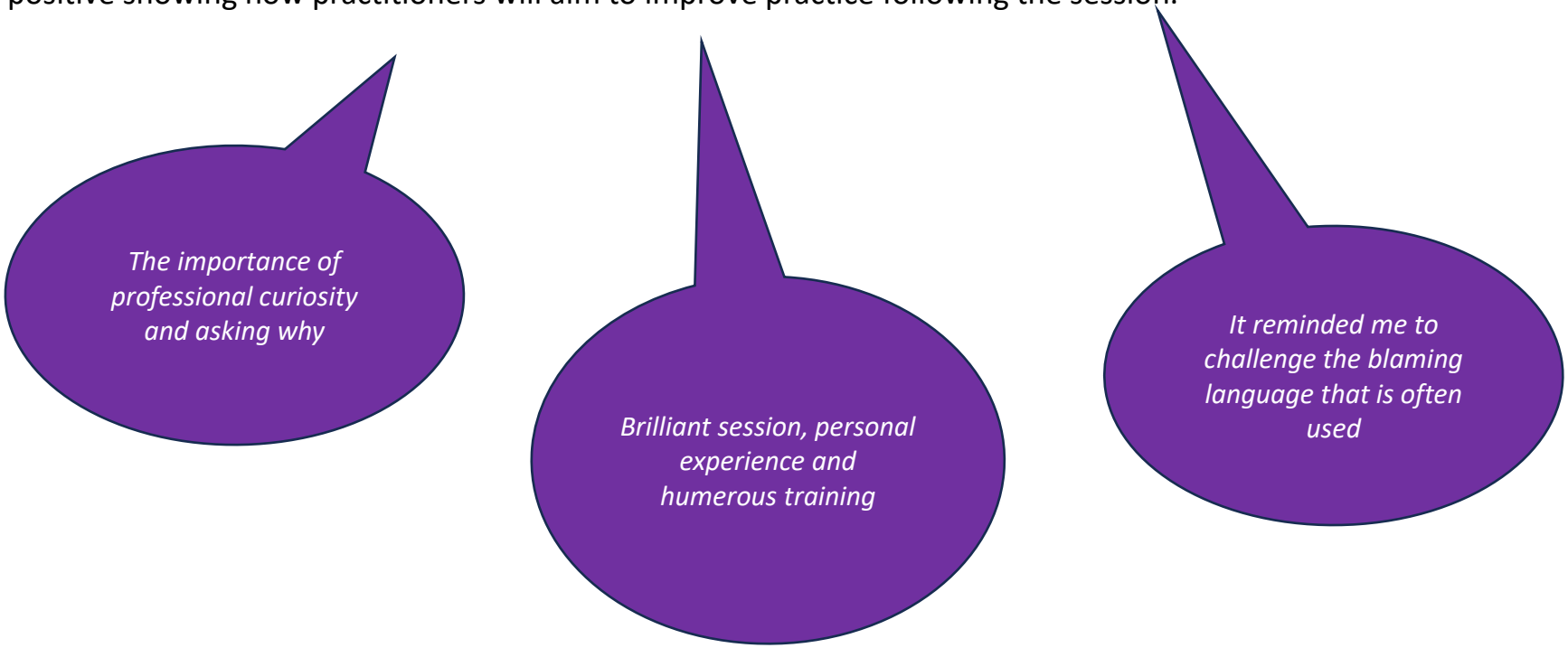
See the Training Slide for further information.

Learning and Development

(Quality Assurance end Prevention)

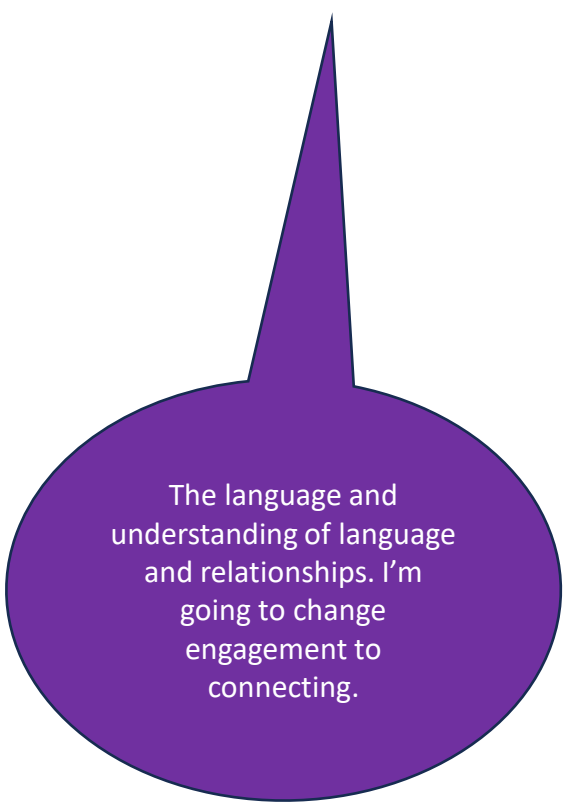
Trauma Informed Practice and Professional Curiosity

As part of our objective to support trauma informed practice the Safeguarding Adults Board welcomed Lads like Us, Danny and Mike back to Gateshead January 2024. Sharing their lived experience as children and adults trying to navigate the care system, adult social care, mental health services, drug and alcohol services amongst dealings with the police and a prison sentence. The honest and sometimes shocking accounts provided by Danny and Mike, are interlaced with humour and a sense that something good must come from their experiences. With 84 practitioners from 20 agencies in attendance from across Gateshead the session was well received, and the feedback was positive showing how practitioners will aim to improve practice following the session.



Toxic Stress: The Road to Poor Outcomes

We also invited Andi Brierley to present to practitioners during 2022/ 23 his session Toxic Stress: the Road to a Poor Outcome, was an insightful session which helped practitioners to understand how children who experience stress in childhood, from family breakdowns, domestic abuse and abuse can go on to be dysfunctional adults. The session based on Andi's own experiences was a powerful reminder of the damage which can be done and the effects of childhood trauma and as adult practitioners we should always consider what has happened to this person in their past.



During 2023/ 24 the Safeguarding Adults Board Business Unit developed, delivered and commissioned some training to enhance the multi-agency core offer.

Understanding Safeguarding

Following the development of the Understanding Safeguarding Guidance the Safeguarding Adults Board Business Manager supported by representatives from the Local Authority Safeguarding Team delivered a series of short briefing sessions to introduce the guidance. The sessions aimed to provide an overview of the informal and formal responses to safeguarding adults in Gateshead. The development of the Understanding Safeguarding sessions was in response to the high number of inappropriate safeguarding concerns received by the local authority safeguarding team. The need to raise awareness of the statutory safeguarding criteria and to ensure practitioners are aware of their responsibilities to safeguard the individuals they work with was a key focus of the sessions.

Safeguarding in the Real World

The Safeguarding Adults Board worked with Handcrafted a charity based in Gateshead provide training, holistic support and supported housing across Gateshead to provide three training sessions.

The Safeguarding in the real-world session aimed to give practitioners the opportunity to talk about how safeguarding works in practice and to explore some of the dilemmas they face on a daily basis. Gaining first hand advice and guidance from a member of the safeguarding team to improve their knowledge and practice in safeguarding.

Professional Curiosity

Professional curiosity is often highlighted in SARs as an area of development for practitioners. In light of this the board commissioned a session which focussed on supporting practitioners to develop skill sin professional curiosity, gathering the information and gaining the full pictures, recognising disguised compliance and challenging decision making.

196 Attendees
95 Agencies represented

Training for the Voluntary, Community and Social Enterprise Sector

The Safeguarding Adults Board recognised the need to increase the knowledge and understanding of safeguarding in the voluntary, community and social enterprise (VCSE) sector following the completion of the Thomas safeguarding adult review and the Henry local learning review.

The Thomas SAR recognised the response from the locality hubs in supporting Thomas during the last few months of his life, whilst for Henry who was not known to statutory services community, voluntary and non-statutory services had provided him with a huge amount of support over approximately 14 years before his death.

The Safeguarding Adults Board and Gateshead Safeguarding Children's Partnership Business Managers worked with locality co-ordinators to develop a sessions which met the specific needs of the VCSE sector, including the role of trustees and working with the charities commission with the first session due to be delivered in April 2024.

Core Training
(Prevention)

The Gateshead Council Workforce Development Adviser worked with the Safeguarding Adults Board, Gateshead Safeguarding Children's Partnership (GCSP) and the Community Safety Partnership to produce a comprehensive training offer for 2023/24. Training courses advertised within the directory are free of charge to practitioners and volunteers within Gateshead. Training has been delivered virtually and face to face to allow delegates to choose the most convenient method of learning to suit their job role.

Multi-agency training and awareness raising for 2022/23:

	Number of Courses	Number of learners
Level 1 Safeguarding Provider Training	2	36
Level 2 Safeguarding Adults Reporting Concerns	4	103
Level 3 Undertaking Enquiries	4	51
Introduction to Mental Capacity	4	56
Practical Application of Mental Capacity Act	1	24
Interactive Safeguarding Adult Review Workshop	2	28
Advocacy Awareness Sessions	4	100

Mental Capacity Training

The need to strengthen the support for practitioners in understanding the Mental Capacity Act, carrying out mental capacity assessments and recording of assessments has been evident from learning reviews which have been undertaken. The board continued to offer Introduction to MCA and Practical Application of MCA during 2023/24 as part of its multi-agency offer.

This offer will be enhanced during 2024/25 with the delivery of sessions on Executive Dysfunction, the course was piloted in 2022/23 and is now delivered by multi-agency partners. The session will provide an overview of executive dysfunction, the impact it has on decision making and the complexity / obstacles to assessment.

Your Voice Counts delivered Advocacy Awareness training which aimed to give individuals legal right to advocacy under the Care Act 2014, the Mental Capacity Act and the Mental Health Act 1983.

Responses from impact evaluation questionnaires highlighted the positive impact that the training had on learners' thinking and practice.

Safeguarding Adult Week 2023

(Prevention and Communication and Engagement)

Gateshead Safeguarding Adults Board Safeguarding Adults Week ran from 20th to 24th November 2023. The week is supported and promoted by the Ann Craft Trust and the theme for the week was prioritising the welfare and wellbeing of yourself and others, with each day of the week focusing on a specific theme:

- What's My Role in Safeguarding Adults?
- Let's Start Talking – Taking The Lead on Safeguarding in Your Organisation
- Who Cares For The Carers? Secondary and Vicarious Trauma
- Adopting a Trauma Informed approach to Safeguarding Adults
- Listen, Learn, Lead – Co-Production With Experts by Experience

Gateshead Millennium Bridge lit purple on Monday 20th November 2023 to mark the start of safeguarding week providing a visual symbol for safeguarding adults.

Networking Event

A variety of activities took place during the week to raise awareness of various aspects of safeguarding adults:

Gateshead Safeguarding Adults Board hosted a Networking Event to open the week. The event provided an opportunity for anyone working with adults across Gateshead to meet representatives from organisations who are working to safeguard adults who are at risk, learn about the work they are doing and share information and good practice.

There were presentations from:

- Connected Voice and Your Voice Counts – Advocacy Providers
- Admiral Dementia Nurses
- Northeast and North Cumbria Integrated Care Board
- Gateshead Carers Association
- The Hoarding Network
- Locality Team, Promoting Locality working

"Really well organised day , lots of information and networking - excellent event"

During the week a range of sessions ran to support learning during SG week these sessions were open to book by anyone in Gateshead who works with adults:

Tyne and Wear Fire and Rescue Service "I didn't know the fire service did that"

TWFRS delivered a session which gave an over of the services they offer, including Safe and Well visits and community engagement activities, their work to Improve the number and quality of partner Safe and Well referrals and build on the good reputation of the service to reach marginalised individuals and groups.

Learning from SARs – Sandra, Lorel and Kerilyn's Story

The Safeguarding Adults Board were pleased to welcome Lorel, Sandra's daughter to co-facilitate this session based on the SAR which was undertaken by Merton Safeguarding Adults Board. Sandra had a history of mental health illness and was alcohol dependent, her daughter talked openly about the struggles her and her sister faced in supporting their Mum and the impact on them of the lack of recognition as them as young carers. The SAR learning included an absence of partnership working, confusion re: Sandra's mental health, mental capacity, risk assessments not completed, poor system response re: self-neglect & addiction, missed opportunities to safeguard Sandra and escalate concerns and Sandra's daughters' needs were not considered.

"Powerful session to highlight the experiences from a service users' perspective"

Looking after the Practitioners – Self Care and Wellbeing

The session delivered by Rockpool CIC focused on vicarious trauma and compassion fatigue and the effect on practitioners of working regularly with trauma and human suffering. The session offered practical advice on self-care and recognising stress responses to maintain wellbeing.

Making Safeguarding Personal (MSP)

This session was developed by the local authority safeguarding team and gave practitioners an overview of the Care Act Statutory Guidance and their role in MSP, ensure safeguarding is person centred and focuses on the individual's identified outcomes.

"Really good informative session, good discussions" (MSP)

Toxic Stress: The Road to Poor Outcomes

See Learning and Development Slide from for more information.

Re-Routing Your Neural Pathways - A Guide to Building Resilience

This session aimed to help participants consider how to re-train our brains to break habits and build resilience.

"Thank you for the session. I felt my mood lift and found it very useful to apply in practice"

Friday Friends - Mate Crime

Presented by the Lawnmowers Theatre Company, a theatre company ran by for and with people with learning disabilities who explore the issue of mate crime through a live show. The training involved a 20-minute showing of their play called "Friday Friends." This play highlights the risks that People with Learning disabilities face and how vulnerable they can be. This was followed by a discussion about what true friendship means and how people vulnerabilities can be exploited.

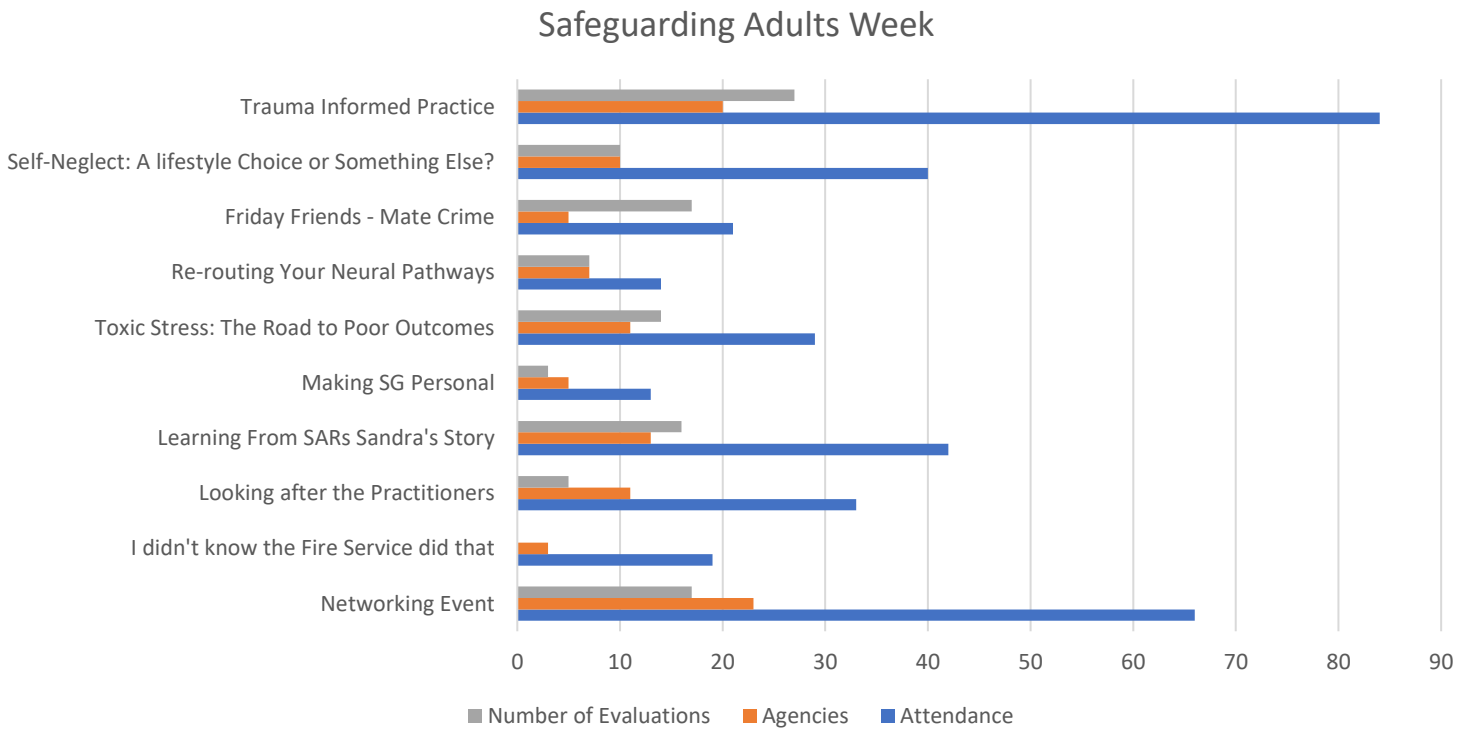
"Great session. Very informative and helps with reflective practice. I feel all AHP/Medics should attend"

Self-Neglect – Lifestyle Choice or Something More

This session developed and presented by the Local Authority ASSET Team Manager, aimed to reframe how we support people who self-neglect. The session gave a clear overview of the difference between a lifestyle choice and self-neglect, the causes of self-neglect and how to support people.

Trauma Informed Practice

See the Learning and Development slide for more information.


Safeguarding Adults Week
Trauma Informed Practice
Self-Neglect: A lifestyle Choice or Something Else?
Friday Friends - Mate Crime
Re-routing Your Neural Pathways
Toxic Stress: The Road to Poor Outcomes
Making SG Personal
Learning From SARs Sandra's Story
Looking after the Practitioners
I didn't know the Fire Service did that
Networking Event
0
10
20
30
40
50
60
70
80
90
Number of Evaluations
Agencies
Attendance

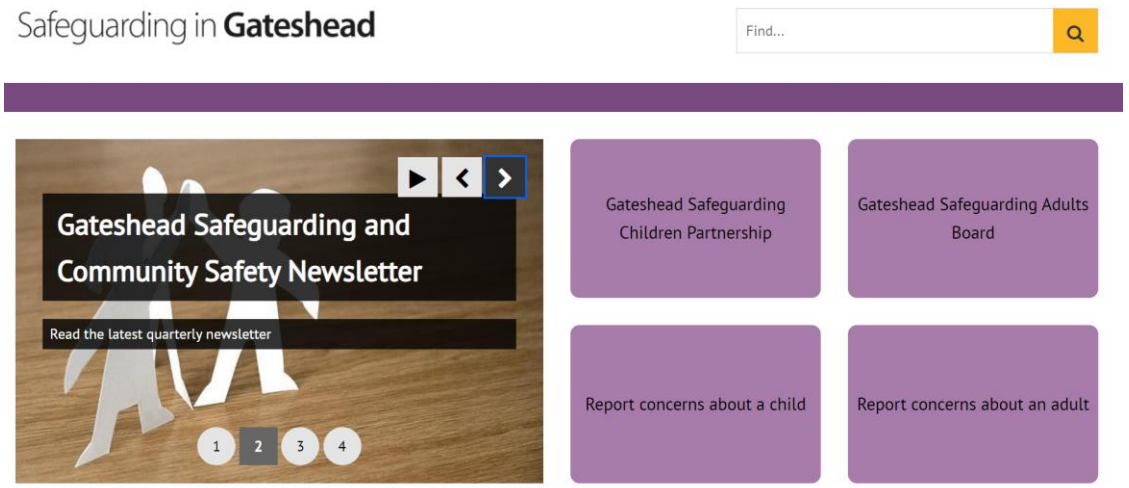

Connected Voice
Connecting People Supporting Action

Website

(Communication and Engagement)

Gateshead Safeguarding Adults Board continues to maximise opportunities to ensure that our resources are accessible to our partners and workforce. Our Safeguarding in Gateshead website www.gatesheadsafeguarding.org.uk is kept up to date and during this year there has been new information added on Exploitation, Financial Abuse and Scams and Understanding Safeguarding.

Our online multi-agency policy and procedures has a useful local practice resources and local guidance section which includes a wealth of information such as our 7-minute briefings and an online video and learning library. We have an active 'X' account @GatesheadSafe which has over 900 followers and is a useful platform to share our resources and new initiatives.



Our Performance 2023/ 24

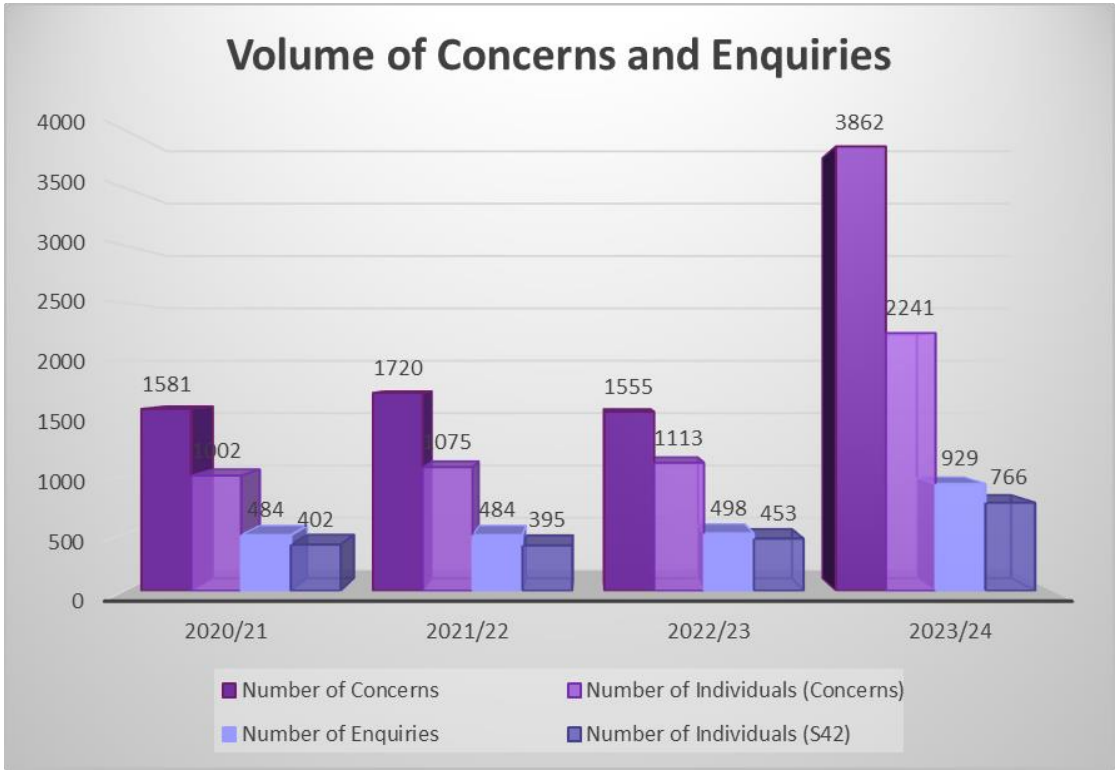
Volume of Concerns and Enquiries

For a Concern to progress to a Section 42 Enquiry it must meet the statutory criteria. The Safeguarding duties apply to an adult who:

- Has needs for care and support (whether the local authority is meeting any of those needs).
- Is experiencing, or at risk of, abuse or neglect.
- As a result of those care and support need is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

In 2023/24 there were 3862 Safeguarding Adult Concerns which led to 929 Section 42 Safeguarding Enquiries. This demonstrates a significant increase in the number from 2022/23. During 2023/24 the Safeguarding Team introduced a change in process introducing a triage model for dealing with safeguarding concerns. This saw a significant increase in the volume of concerns. The change in process ensures the recording of safeguarding concerns is in line with statutory guidance. Recording of cases which meet section 42 criteria, but risks were managed was revised and this has also demonstrated an increase in S42 enquiries.

See slide 67 for further information on the bespoke strategic safeguarding support from the Local Government Associations Partners in Care and Health programme, which led to the new triage model being implemented permanently.



In percentage terms, 24% of Concerns led to a Section 42 Enquiry. The number of concerns progressing to an enquiry remains lower than both the 2023/24 NE (47.1%) and England (29.47%) averages.

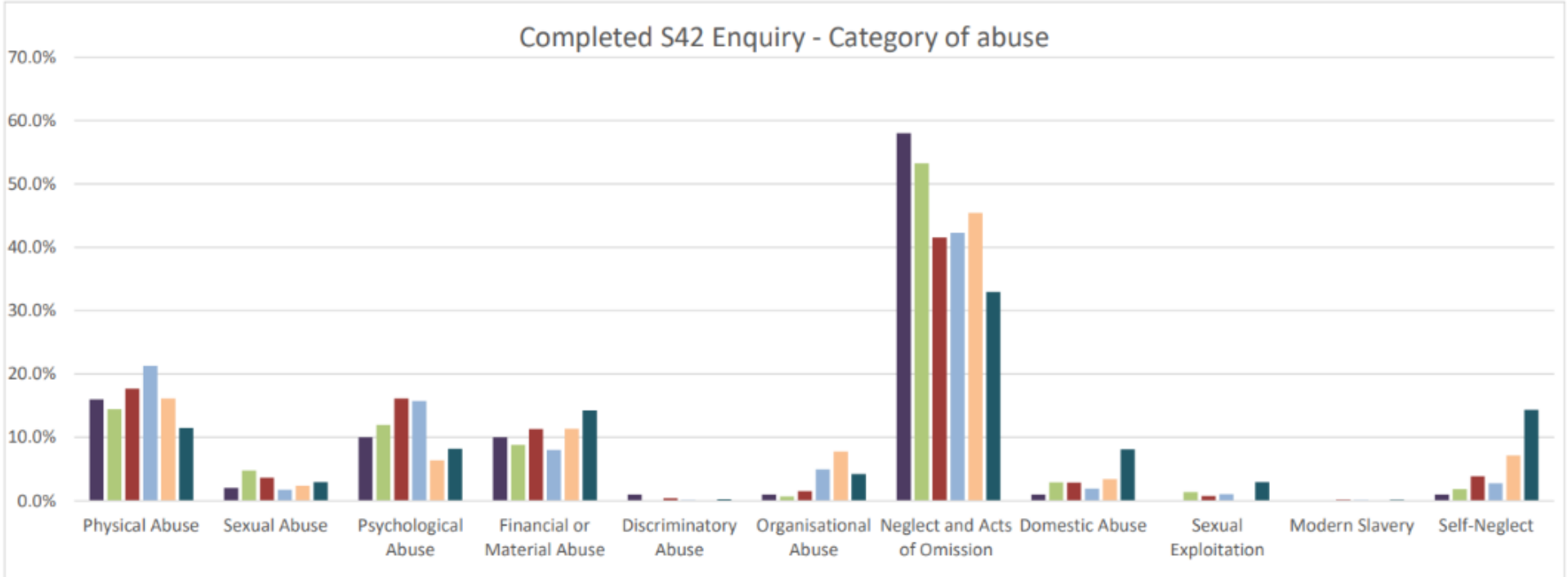
The change in process and introduction of the triage process saw the volume of concerns significantly increase during 2023/24 from the previous years. It has also resulted in an increase in the number of s42 enquiries. This data also shows that a large proportion of concerns do not progress from a safeguarding concern and that people have received multiple concerns in the reporting year

Work continues to improve the knowledge and understanding of practitioners in what constitutes a safeguarding concern and in providing a robust process for low level concerns.

Categories of Abuse

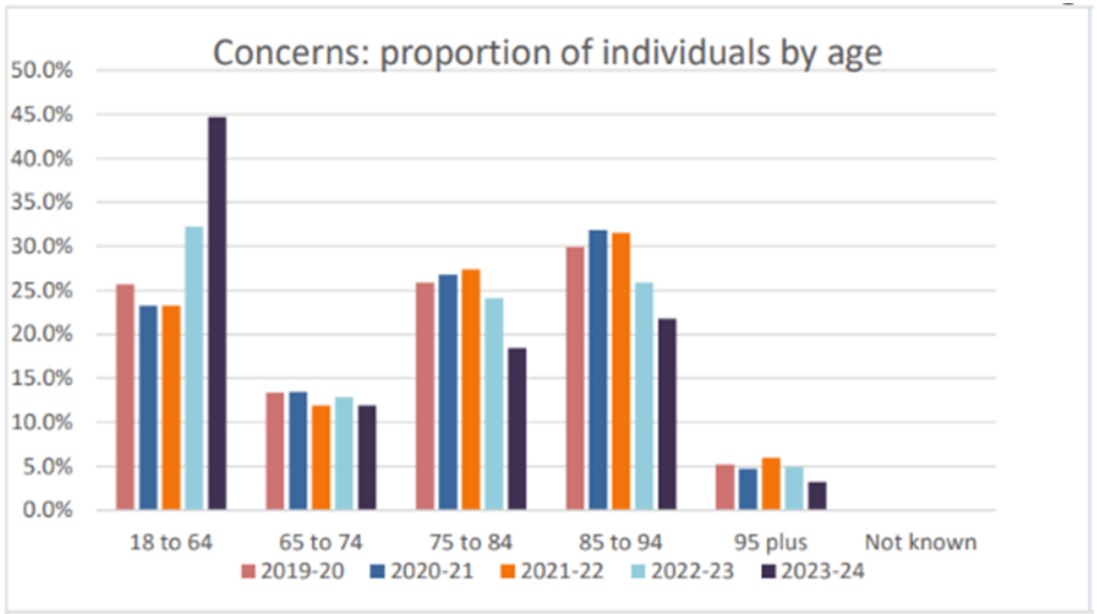
Utilising a count of completed Section 42 Enquiries, and allowing for multiple recording of abuse, the most common category of abuse in Gateshead continues to be Neglect and Acts of Omission which represented 34.9%. In a change to previous years the second most common category was Financial and Material abuse (15.9%) an increase of nearly 4% from the previous year, followed by Physical Abuse (13.5%) a reduction of nearly 5% from the previous year.

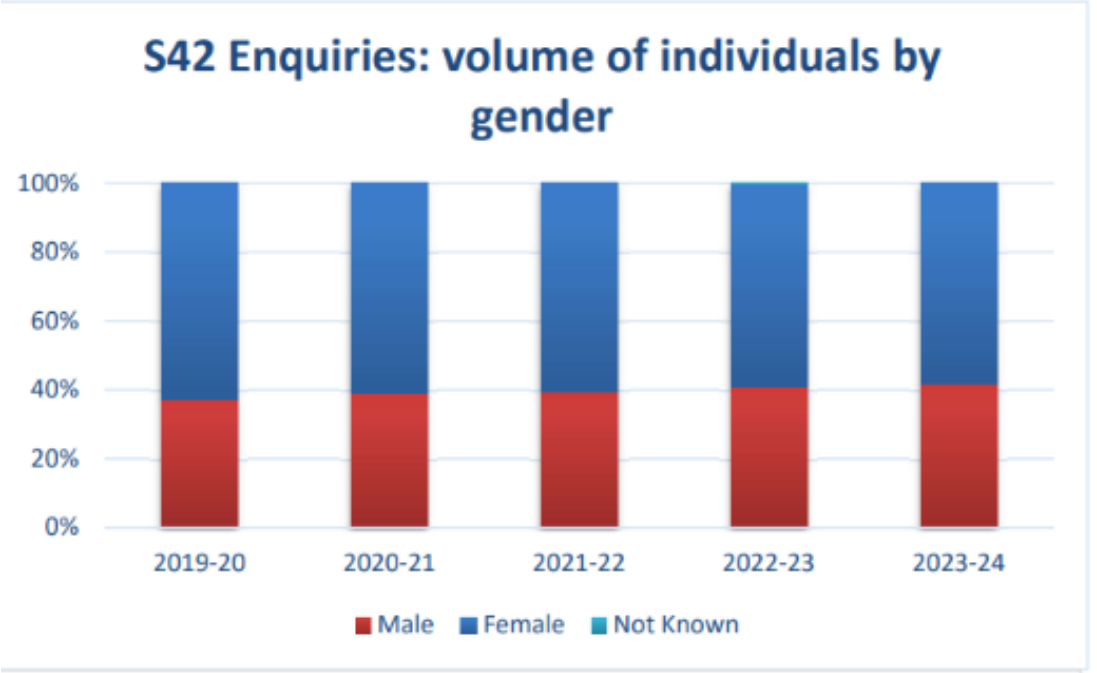
Financial and Material abuse has been added to the Safeguarding Adults Board Data Group action plan for further analysis and investigation.



Demographics

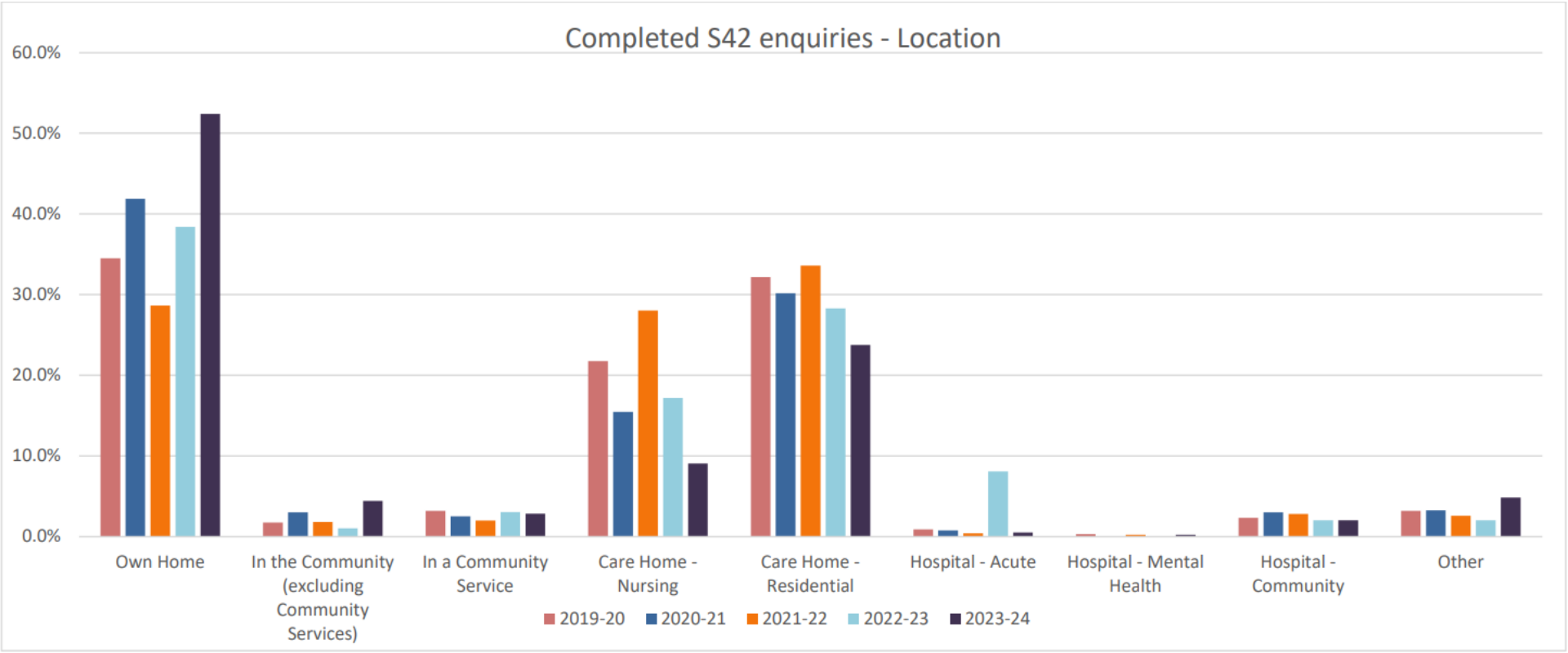
In Gateshead in 2023/24 44.7% of section 42 enquiries were for adults aged 18 to 64 which is an increase of over 12% from the previous year. The other age groups saw smaller reductions from the previous year. As a proportion this is now closer aligned to regional and national figures for this age group (43-50%). The gender split is consistent throughout recent reporting years and is aligned to national and regional figures which show a 60:40 split in gender. Proportions of primary support reasons remain consistent with previous years and national data.





Location of Abuse

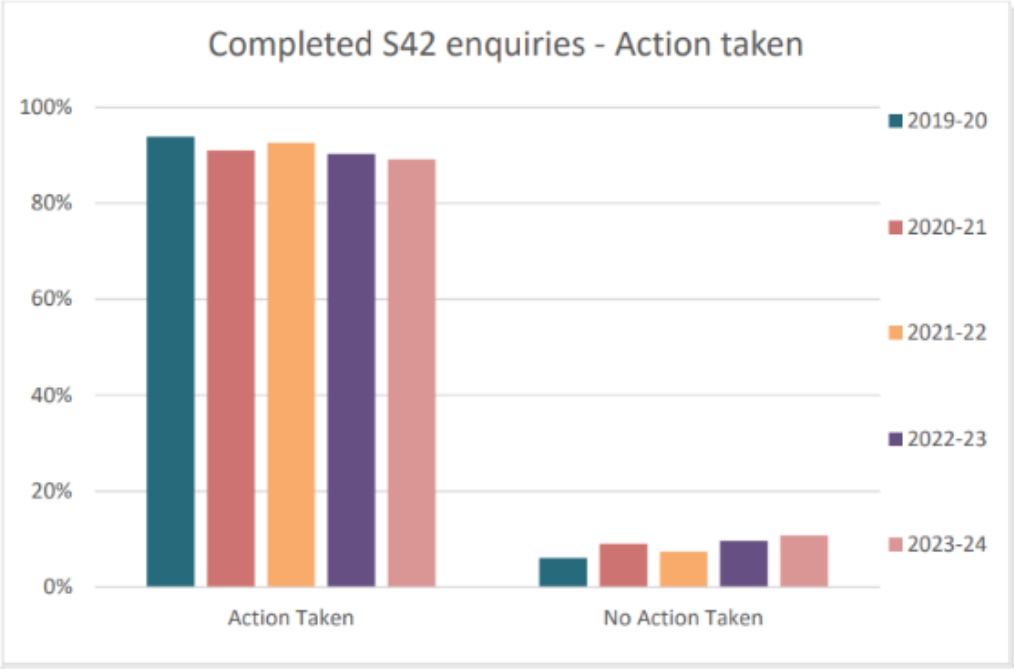
The reporting year saw a shift in location of s42 enquiries where a greater proportion were in a person's own home (52.4%). This could be linked to the increase in the proportion of concerns coming from the 18-64 age group and the likelihood this age group do not reside in a care home. This also aligns our proportions to the previous national and regional figures which is around 45-50%.

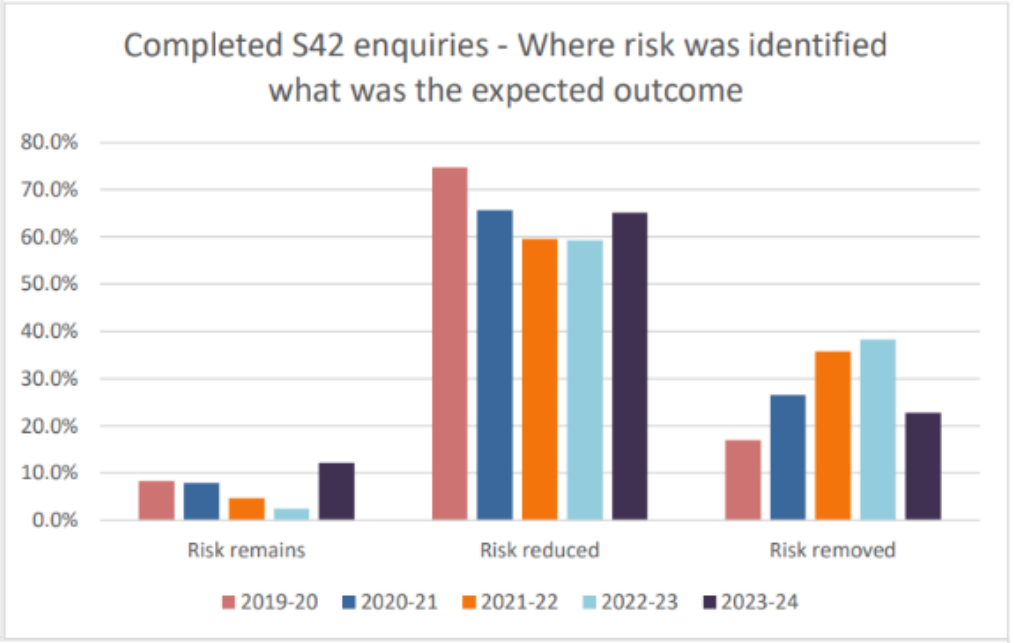


Concluded S42 Enquiries

The proportion of Action Taken from concluded s42 enquiries is equivalent to regional and national figures however this is the lowest for Gateshead in the past 5 years (Highest 94%, lowest 89.2%).

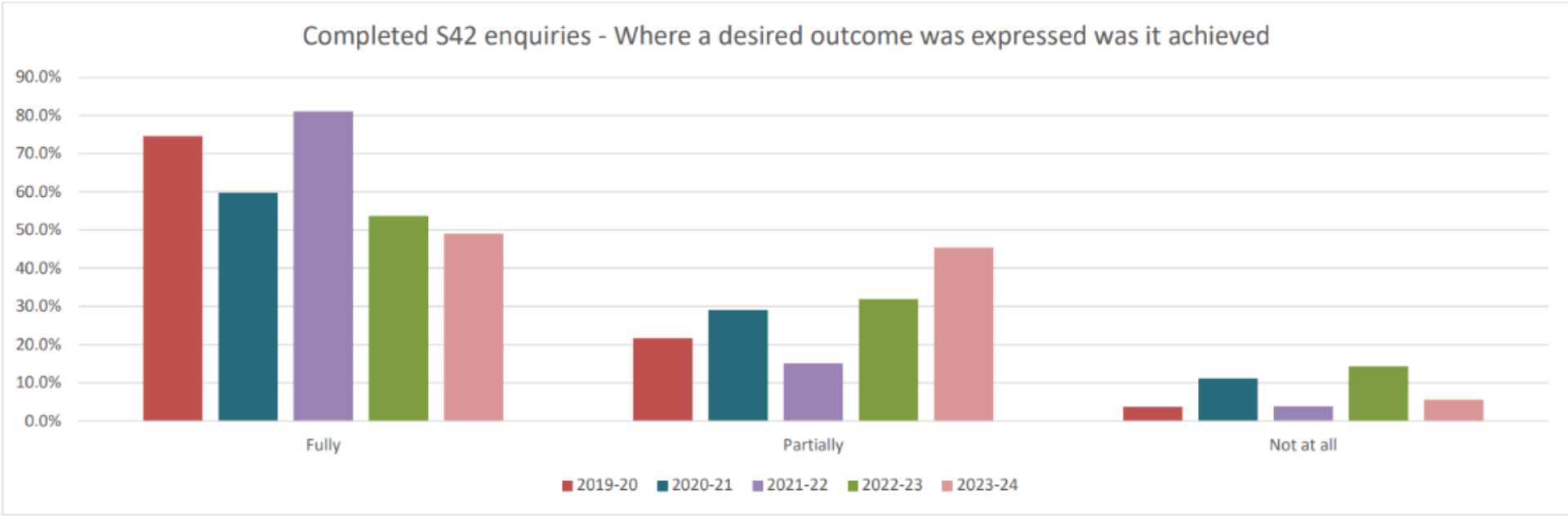
Concluded s42 enquires where the risk remained (12.1%) is the highest it has been in the past 5 years and is slightly higher than previous national and regional figures (5-9%).





Concluded S42 Enquiries

Risks expected outcomes and making safeguarding personal figures have been investigated and the service has acknowledged some data quality issues which were attributed to deadlines around the new system implementation and data to be migrated. Closing the volume of enquiries on the system was prioritised over the usual quality assurance to reduce the amount of manual work when Mosaic went live.



Deprivation of Liberty Safeguards (DoLS)

For the period April 2023 to March 2024 Gateshead Council received 2840 Deprivation of Liberty Safeguard applications. This was an increase in activity from the previous financial year (2246). The demands placed on local authorities in meeting statutory obligations remains high. Gateshead are compliant with care home DoLS, and do not have a waiting list.

The highest rate for DoLS applications remains with those over the age of 65. Within Gateshead this represents 2084 applications (73.4% of all applications) and for those aged under 65, 756 (26.6%) for those under 65.

There were 729 applications which have not been authorised, due to various standard reasons. The primary reason for non-authorisation of a DoLS was down to a 'Incomplete', which took place in 564 cases.

Commissioning Concerns

The number of provider concerns increased to 262 in 2023/24 from 237 in 2022/23. Medication was the highest category in 2022/23 at 21.3%, this has significantly reduced to 7.25% in 2023/24. Standards of Care was the highest category at 15.6%, followed by Hygiene Issues 11% and then Documentation Issues at 9.5%. Staffing issues remain high at 23.7% this is an increase on 19.5% in 2022/23 and demonstrates the continued difficulty in recruiting staff in the health and social care sector.

OP Residential & Nursing establishments receive the highest number of concerns at 55% of all concerns received, this is an increase from 47.7% in 2022/23 but in line with the figures from 2021/22 at 54.4%. This is followed by Generalist Homecare with 29% of the concerns.

Challenges remain in the system in relation to the high numbers of staff turnover within the health and social care system and the impact of this. There continues to be a poor understanding of the various reporting mechanisms for reporting safeguarding concerns, commissioning concerns and quality of care concerns, which impacts on commissioning's ability to address issues. This is being addressed by the review of the decision-making tool and introduction of more robust processes for triangulating information between adult social care, health and commissioning services.

Safeguarding Adult Reviews

The Safeguarding Adults Board devolves responsibility for the undertaking of undertaking of safeguarding adult reviews to the SARCC group. In 2023/24 10 safeguarding adult review referrals were received. 4 cases were discussed by the group using the rapid review process with 2 progressing to discretionary SARs. 6 of the cases did not meet the criteria to progress to rapid review.

Vice Chair

In July 2023 the SARCC appointed a new vice chair following a change in representation at the group. Joanne Pendleton, Head of Adult Safeguarding, Gateshead Health NHS Foundation Trust took on the role.

Learning Register

The group agreed to work on the development of a learning register to record the learning from SARs and provide a tool for the QLP group to monitor the actions and updates. Work continues to develop the register further to ensure assurance information from our partners is gathered and recorded.

Cross Boundary Working

One SAR referral involved an individual who had involvement with services from Stockton, Newcastle and Gateshead. The group demonstrated excellent multi–agency and cross-boundary working through the gathering or relevant information from across all LA areas, sharing this information and facilitating a meeting to ensure all partners were engaged and given the opportunity to consider how the case should progress.

Parallel Processes

The Gateshead Coroners office was provided with a copy of the learning review report for the Adult H case, the information provided was welcomed by the Coroner and assisted in establishing whether or not an inquest should take place. The SARCC Group is responsible, on behalf of the Safeguarding Adults Board, for statutory SARs introduced by the Care Act 2014. All reviews and enquiries are reported back to the SAR Group for scrutiny and challenge. Learning from reviews is fed into the Quality, Learning and Practice Group when there are specific actions or learning that needs to be taken forward.

Learning from SARs

There are key actions undertaken following the completion of a SAR In order to ensure the Safeguarding Adults Board takes forward the learning and recommendations:

- A multi-agency action plan is developed, this is agreed by the partners and regular updates are requested by the SG Business Unit. The action plans are monitored and reviewed by the QLP subgroup and any issues with the completion of actions are escalated via the Safeguarding Adults Board Executive.
- Single agency actions are monitored via the QLP Subgroup, a monitoring tool is used to ensure all actions are responded to by agencies and any issues are escalated via the Safeguarding Adults Board Executive and senior representatives of the agencies involved.
- Multi-agency briefings are designed and delivered to all partners, sharing the case information and the recommendations and actions with frontline practitioners.
- Resources and guides are developed and published on the Safeguarding Adults Board website which provides a useful resource library for practitioners.

During 2023/24 the SARCC received 10 Safeguarding Adult Referrals, none progressed to mandatory SAR:

Referral 1 (Adult H)

Adult H passed away on 1st April 2023 at the age of 64 years, there was very little information known about him.

On 29th March 2023, a Management Officer from Karbon Homes attended Adult H's home address on a arrears visit as rent had not been paid for one month. It is reported that Adult H crawled to the front door to answer due to a 'fall' he had some weeks early, he could not remember the exact date. Adult H was short of breath and struggling to manoeuvre about. He was also very slim and did not have any food in his cupboards or heating on. The Management Officer called an ambulance.

Adult H told the ambulance crew that he had not eaten for a month due to sanctions on his benefits. He lived alone, there was no food or drink in the property, he had been sleeping on his sofa and going to the toilet there. Northeast Ambulance Service records provided this description "the patient and the home were described as unkempt, only one working light in the property no bulbs in other rooms and the heating system was turned off".

Adult H was transferred to the Queen Elizabeth Hospital in Gateshead on 29th March 2023, where he passed away two days later.

SARCC Recommendation - The case did not meet the criteria to progress to a mandatory SAR however the group felt that there was learning which could be taken from the case. See Learning from SARs for further information.

Referrals 2 & 3

Both of these referrals were in relation to ladies who were experiencing multiple complexity in the context of their alcohol use. There was sufficient evidence from local and regional SAR data and from the Second National SAR Analysis (LGA 2023) as well as local and national health data to suggest that there was a need to provide alternative approaches and care pathways for change resistant drinkers. In response to this the Local Authority have agreed to fund the implementation of the Blue Light Project which provides a model for assertive outreach and focuses on harm reduction and risk management.

SARCC Recommendation - The members of the SARCC group recommended that the cases be referenced in a thematic of cases where alcohol misuse and mental health issues were evidenced, but where the people did not have care and support needs. Work on a thematic review is being undertaken jointing with Public Health.

Referral 4

This lady passed away on 2nd November 2023 aged 30 years. She had a history of alcohol dependence and was also the victim of domestic abuse, she had mental health problems but did not appear to engage with services. The death of her mother in 2017 played a significant part in the decline in her mental health. She was often reported to be unkempt, and the condition of her home was at times concerning.

Originally from Stockton-on-Tees she had moved to Gateshead in June 2022, she had a diagnosis of Emotionally Unstable Personality Disorder and Complex Post Traumatic Stress Disorder. She was supported by mental health services (TEWV and CNTW), social care services, and treatment and recovery services. She was supported with accommodations through Gateshead Housing and was a frequent attender at A & E departments in North Tees, Gateshead and Newcastle.

She had engaged with Gateshead Recovery Partnership (GRP) and received support including dayhab, behaviour change and psychosocial interventions but had frequent relapses and continued to struggle with her alcohol use.

The SARCC group reviewed this case in January 2024, and were joined by representatives from Stockton and Newcastle Safeguarding Adults Board areas to consider how partners had worked together to provide support and, it was clear from the information provided that all partners had demonstrated good cross boundary working in light of the difficulties in engaging with this young lady.

SARCC Recommendation - The members of the SARCC group and representatives from Stockton and Newcastle agreed that the case did not meet the criteria to progress to a SAR, however the case would be considered alongside referrals 2 and 3 for inclusion in a thematic review. This action has now been superseded by the LA's funding for the implementation of the Blue Light project.

Referral 5

This case related to a gentleman who resided in a care home in Gateshead. At the time of death, the gentleman was the subject of a Section 42 enquiry relating to injuries he had sustained following an unwitnessed fall.

SARCC Recommendation - The case did not meet the criteria to progress to a SAR and the SARCC asked that a single agency review should be undertaken by the care home in response to the issues raised in the SAR referral.

Referral 6

A SAR referral was received in relation to a lady who died on 24^{h} December 2023. Adult Social Care and Gateshead Housing had worked closely to support this lady and had regular contact with her, raising their concerns with her regarding abuse and neglect by a third party. There was evidence of that the lady used alcohol and issues were raised regarding self-neglect, mental capacity and services being unable to connect with the individual. The lady had been contacted by domestic abuse services but it would appear that she refused to engage with them.

SARCC Recommendation - The cause of death at time of writing is still unknown, the SARCC have agreed to postpone a decision to process until this is available, consideration is also being given to a joint DHR/ SAR, this is pending a response to the police regarding their ongoing investigation into the case.

Referral 7

This case related to a lady who resided in a care home in Gateshead. At the time of death, the lady was the subject of a Section 42 enquiry relating to injuries he had sustained following an unwitnessed fall.

SARCC Recommendation - The case did not meet the criteria to progress to a SAR and the SARCC asked that a single agency review should be undertaken by the care home in response to the issues raised in the SAR referral.

Referral 8 (Adult J)

A Safeguarding Adult Review referral for Adult J was received from the Queen Elizabeth Hospital Safeguarding Team on 31st January 2024 following her death on 27th January 2024. Adult J lived with her daughter and grandson who provided care and support for her. She was of Polish decent and moved to the UK in 2021 following the death of her husband. She spoke no English and relied on her family to interpret for her. The referral raised concerns regarding the care that Adult J had received whilst living at home with her daughter and her grandson and the resulting pressure damage. Questions were raised regarding the family's ability to care for Adult J given her very limited mobility.

SARCC Recommendation -The case was discussed at the SARCC group meeting on 12th March 2024. Information was provided from agencies from both Gateshead and Durham, this helped the group to obtain a fuller picture of Adult J's case, who was providing care and where there were gaps in service or concerns regarding the care provided. It was agreed that although the case did not meet the criteria for a mandatory SAR that there was learning to be considered and that a discretionary SAR should be undertaken. The Assistant Director of Nursing, NENC ICB agreed to chair the practitioner session which is arranged to take place in June 2024.

Referral 9

A referral was received for this gentleman following his death on 12th March 2024. Although there was evidence that he had the appearance of care and support need no care act assessment had been undertaken. Services appeared to have worked together to try and safeguarding him, however agencies were often unable to make contact with him and if they were able to contact him and offer support he declined.

Referral 10

This SAR referral related to a lady who had suffered a double above knee amputation, following a stroke. The SARCC group were considering the case at their meeting in June, following the gathering of further information at which point it was ascertained that there had been a delay in referrals for the lady from their GP to the Vascular Team at the RVI. There was however no evidence that this delay would have changed the outcome for the lady.

SARCC Recommendations:

SARCC agreed that the case did not meet criteria to progress to a SAR, however it agreed to ask for assurance from the GP practice concerned that they have robust processes in place to ensure referrals are made in a timely manner.

Learning from SARs

Two Safeguarding Adult Review were completed during 2023/ 24.

Thomas SAR

The Thomas SAR was undertaken by an independent author with the final report and recommendations presented to the board in December 2024. The full report, presentation and Seven-Minute Briefing can all be found on the Safeguarding Adults Board Website.

There were seven recommendations from the review which covered:

1. Safeguarding Adults Board should ensure a collaborative approach by Mental Health and other services to the care of people with complex presentations.
2. Develop a multi-agency protocol on managing people that services find difficult to engage.
3. Public Health Commissioners should ensure that the needs of people with substance use disorders that services find difficult to engage are considered in local needs assessment or commissioning plans

1. Safeguarding Adults Board should ensure that agencies and individual professionals are recognising the need to safeguard individuals with challenging presentations

2. Safeguarding Adults Board should remind all professionals of the importance of considering mental capacity and executive dysfunction when working with complex and challenging clients

3. Public Health Commissioners and the Integrated Care Board should review the response to people with co-occurring disorders to ensure that it is consistent with national guidance.

4. Safeguarding Adults Board should remind all professionals of the importance of collecting accurate data on alcohol and drug use.

A multi-agency action plan has been developed from the recommendations and the actions are being monitored through the Quality, Learning and Practice Subgroup.

Gateshead Safeguarding Adults Board

Gateshead Safeguarding Adults Board
Thomas Adult C
7 Minute Guide

1. What is a safeguarding adult review (SAR)?

SARs are a statutory requirement for Safeguarding Adults Boards (SABs). Safeguarding adult practice can be improved by identifying what is helping and what is hindering safeguarding work, in order to tackle barriers to good practice and protect adults from harm. SARs are not a mechanism for investigating or apportioning blame, but for identifying learning and making recommendations to improve practice and systems.

Henry SAR (Adult H)

Although the SAR referral did not meet the criteria for a statutory review the SARCC group that there was learning to take from the case in relation to information sharing, use of multi-disciplinary meetings (MDTs), provision of informal support from VCS, professional curiosity, self-neglect and digital access to services. Single agency actions were also identified, and an action plan was drafted following a multi-agency learning review.

Terms of reference were drafted for the review and a practitioner event took place in November 2023. The review was chaired by the Director of Public Health with representation from Karbon Homes, Department of Work and Pensions (DWP), Citizens Advice Bureau (CAB), Libraries, GHFT, NEAS, Integrated Adults and Social Care Services, Northumbria Police.

Representatives shared information regarding Henry and identified the learning to be taken from the case. The learning and actions from the review is being monitored by the Safeguarding Adults Board, and assurances are being sought from partner agencies to prevent similar cases in the future.

A Seven Minute briefing for the case was produced and is available on the Safeguarding Adults Board Website.

How the Board Links with Other Parts of the System

Monthly Cross Partnership Meetings

In order to ensure effective cross partnership working between the Safeguarding Adults Board, Gateshead Safeguarding Children's Partnership, Community Safety Partnership and the Domestic Abuse Board the business managers for each partnership meet on a monthly. The meetings follow a formal agenda and are used to share information and updates on reviews, projects, changes in legislation and establish where there needs to be cross partnership working to support areas or work.

Updates

In order to ensure each partnership board receives regular updates business managers is updated updates on current ow successful adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety

Joint Safeguarding and Community Safety Newsletter

The first of the joint newsletters was circulated in Spring 2024. The newsletter provides a round-up of the news from the safeguarding and community safety boards and partnerships, along with other relevant pieces of recent local and national information. Partners are invited to provide information on safeguarding activity to include in the newsletter to provide a full overview of work and activities across Gateshead.

Appendix 1 – Partner Updates

Adult Social Care

Operational Practice

The Council successfully bid for support from the Local Government Association via their Partners in Care and Health Programme. The request was for independent support with analysis of the referral numbers, routes, and processes associated with Safeguarding Concerns and conversion to Enquiries. This resulted in a specialist LGA lead being identified to undertake analysis of Gateshead's position, which was based on several months' worth of data and analysis already undertaken by the service.

The analysis and feedback from the LGA provided an independent view of the temporary Safeguarding Triage team that the Local Authority had put in place to manage demand and ultimately confirmed that there was a need for the triage function on a permanent basis and provided the evidence base for further investment in Safeguarding capacity by the Council. The Safeguarding Triage function has now been recruited by the Council.

Preparing for CQC Assurance

The introduction of the Health and Care Act 2022 gave CQC new powers to assess how local authorities meet their duties under Part 1 of the Care Act (2014).

As part of our preparation for CQC Assurance Inspection, Adults Social Care invited the Local Government Association (LGA) to support with an Adult Social Care Assurance Peer Challenge (March 2024). The Peer challenge involved exploring our ambitions, performance, and delivery structures in a supportive way. This provided a unique opportunity to challenge the service and support our preparations for any formal CQC regulator's assurance process. In March 2024 we received notification of inspection from CQC, and they undertook the inspection in October 2024.

Other preparations included:

- In March 2024 we worked with Sarah Mitchell from ADASS who supported us with several workshops for staff and members to prepare them for the wider CQC Assurance process.
- Further preparation sessions were held in September with Alison Tombs (ADASS associate)
- Lunch and Learn sessions were scheduled around key topics, all of which were relevant to our CQC assurance visit
- Staff support sessions were undertaken where staff were able to provide some excellent examples of work they had undertaken
- Regular communication updates were provided between March and October

Case Study (Achieving Change Together Team (ACT))

S is 49 and has an acquired brain injury. She lives in a specialist care home in Gateshead and receives 24 hour care. When ACT became involved S was receiving 28 hours per week 1:1 support in addition to the standard residential care provision within the home.

ACT worked with the service provider and S herself in supporting her to express her views and aspirations. S shared that she did not enjoy going out with care staff as she did not have a good relationship with them. She would often make the decision not to go out at all and this was labelled by staff as being 'non-compliant'.

The care provider had not notified Adult Social Care that the additional 1:1 support was not always used and ACT highlighted this oversight with Commissioning colleagues. ACT were able to remove the 28 hours 1:1 support per week achieving a cost saving of £70,758 per year.

The ACT worker helped to reframe the understanding of S's needs and wishes with a person-centred approach and ensured her voice was heard. An ongoing plan is being developed with S which involved ACT Enablement workers to build her confidence, explore community assets and also consider a move to alternative accommodation in order to improve outcomes around promoting her emotional wellbeing and access to her local community.

Gateshead Quality Assurance and Performance

Linking with other parts of the system

A monthly information sharing meeting takes place between Gateshead partners. The purpose of the meeting it to share any intelligence of concerns around Quality of provision.

A meeting led by CQC is held monthly with the LA to share information and determine if actions are required either via the LA's Quality Assurance or via the regulator.

There is also a Serious Provider Concerns Process which can be triggered by any partner to share information and determine if actions are required.

There is a standard agenda item on the Regional Commissioning Group to where Provider concerns can be raised.

Northumbria Police

Quality Assurance

We have recently provided face to face training with all front-line officers between May and August on vulnerability and adult concerns , specifically covering when NOT to submit ACN's and signposting options. Alongside this we are providing feedback on good examples and poor-quality submissions to try and improve and reduce our submissions.

Operational Practice

Northumbria Police have moved to a new operating model which has seen the force move from 3 area commands to 6. This means that Gateshead now have a standalone senior leadership structure overseen by a Chief superintendent who has responsibility solely for Gateshead Local Area.

Prevention

Northumbria police introduce the prevention department which includes a standalone missing from home investigation team that sits alongside the existing missing from home coordinators. The team has contributed to a reduction in missing episodes and time missing while building rapport with most frequent missing persons and partner agencies to prevent further missing episodes. The team has also seen the introduction of a mental health inspector to oversee the right care right person process to further our preventative approach. Additionally, the MSET process moved into the prevention department and now has a dedicated inspector and detective Chief Inspector who have worked alongside multi agency partners to ensure a consistent approach and are working towards the implementation of a new model to focus on and prevent harm outside the home. RCRP has contributed to a 5.6% reduction in ACN submissions for 23/24 when compared to the previous 12 months.

We have worked alongside Safelives to deliver fact to face training to over 1500 front line staff on DA matters training. This has upskilled and educated officers on DA issues with a focus on coercive and controlling behaviour , financial and emotional abuse to give them the skills to recognise this type of abuse and deliver a high standard of service to victims and prevent further offending.

Northeast and North Cumbria ICB (NENC ICB)

The NENC ICB completed its restructure ICB 2.0 during 2023- 2024 this was finalised in April 2024. Newcastle Gateshead is managed as one delivery team under the umbrella of the larger organisation. Trina Holcroft was appointed the Deputy Director of Nursing with responsibility for Safeguarding for the North and Louise Mason Lodge was appointed as part- time Director of Safeguarding to the Executive Board.

Communication and Engagement

The Designated Nurses are working together to establish standardised and consistent processes across the region to support the work of the Local authorities, Safeguarding Boards and multi – agency partnerships. Delivery Teams report to the Safeguarding Executive meeting chaired by the Executive Chief Nurse, facilitating an assurance and escalation process for safeguarding issues across the ICP.

Quality Assurance

The Safeguarding Professionals Network continues to provide a forum for safeguarding health staff from both commissioning and providers to develop safeguarding practice and share learning across the ICS.

The ICB remain committed to training and education in the safeguarding arena and the promotion of shared learning across the Integrated Care System (ICS) Participation continues from the Designated nurse and safeguarding team to the Safeguarding Adult Reviews (SAR's) and Domestic Homicide Reviews (DHR's) with contribution to the process, sharing of learning and seeking assurance from commissioned agencies to support recommendations and actions from the reviews.

Prevention

The ICB Safeguarding Team support the Named GPs with training for Primary Care staff both online and at Face-to-Face sessions to promote good practice from case review recommendations, share learning and develop resources which are also easily accessible on GP team net (an online platform). Further support for individual practices is provided on a case-by-case basis where there are complex needs or multi – agency working where there is a requirement.

The forensic training project which was commenced in 2022 and resulted in an online Conference and resource support for health professionals has also been continued in the GP training programme with the addition of non-fatal strangulation, improving awareness of domestic abuse.

Safeguarding Adults week was promoted across the ICB highlighting themes and raising awareness.

Gateshead Health NHS Foundation Trust (GHNFT)

Communication and Engagement

Gateshead Health NHS Foundation Trust (GHNFT) is committed to ensuring safeguarding is part of its core business and recognises that safeguarding young people and adults at risk is a shared responsibility with the need for effective joint working between partner agencies and professionals.

GHNFT recognises that one of the most important principles of safeguarding is that it is 'everyone's responsibility'. Safeguarding adults and young people cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse, or neglect. Safeguarding is complex and challenging and our plans for the year ahead is to ensure our service reflects the trusts ICORE values by being Innovative, caring, open and honest, respectful, and engaging.

Operational Practice

Despite some of the issues that the team have faced, such as staffing, the increase in safeguarding activity and complex referrals. Including an increase in care and support needs, although we have seen an improvement in discharging patients back into the community with a care package or to a residential placement. Despite these challenges we have still managed to prioritise and maintain a high-quality service for the Trust, focusing on making safeguarding personal. Putting the patient at the centre of everything we do, by listening, engaging and having a good understanding of what the patient wants.

Communication and Engagement

Staff have continued to raise concerns on 1198 occasions related to mainly domestic abuse, self-neglect, neglect, physical and financial abuse. Of these 395 were shared with Adult Social Care direct, this is a significant reduction from the previous year. The concerns that are not shared with Adult Social Care direct are managed and addressed with in the hospital, working closely with other wards and departments, children's safeguarding team, community services, discharge team, housing, psychiatric liaison, patient safety, and Security.

Domestic abuse remains high priority within the Trust. The trust received 306 domestic abuse referrals between April 2023 and April 2024, compared to 314 the year before. However, there have been more complex cases. The domestic abuse concerns also include staff referrals, which 28 were staff referrals, compared to 30 the year before.

Working in partnership remains an important part of the teams work with such complex cases including self-neglect, substance misuse, complex mental health and physical needs. The team continue to play an active role and contribute to various multi-agency meetings, Safeguarding Adult Reviews, professional meetings, Domestic Homicide Reviews, MARAC, MAPPA and MATAC. Focusing on Sharing information, any key learning and implementing any recommendations made, which is vital in continuing to improve safeguarding practice within the Trust.

Mental Capacity

The Trust raises awareness of the Mental Capacity Act and continues to recognise the challenges in the application of the Mental Capacity Act, focusing on training compliance though the E-Learning package and face-to-face sessions.

The Mental health Legislation service within the Safeguarding Adults team works to ensure that professionals are working in accordance with legislation and ensuring patient safeguards are met by educating staff on the legal frameworks of the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), and the Mental Health Act (MHA). The team supports practice with the provision of training, advice, support, and policies, to ensure the rights of our patients are supported and upheld.

Quality Assurance

The team review, monitor and report all uses of the DoLS throughout the Trust. Between 1st April 2023 – 31st Mar 2024 the Trust submitted 954 DoLS applications. The submission of applications has seen a year-on-year increase with, 698 in 2022-2023, 548 applications in 2021-2022 and 420 applications in 2020-2021.

Prevention

We continue to prioritise and have focused on the level 3 safeguarding training, working closely with the learning and development team, and departments to improve our training compliance and raise the profile of safeguarding. Our training plan will continue to be priority and focus on multi-agency approach, to ensure that all staff working within Gateshead Health NHS Foundation Trust understand that Safeguarding is everybody's responsibility, and that Adults and young people are effectively safeguarded against abuse, neglect or harm and are able to develop to their full potential.

The trust has signed up to the sexual safety charter, which was launched by NHS England in September 2023. GHNFT is committed to taking a zero-tolerance approach to any unwanted, inappropriate sexual behaviours within the workplace.

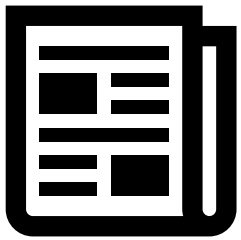
GHFT
Self-neglect, Financial & Physical Abuse - Case Study (Patient A)

Case Study

Patient A: is a 56-year male who was admitted to A&E with alcohol intoxication, suicidal ideation, malnourished, and a general deterioration in their physical health (alcohol related). Patient A has had several admissions in relation to his alcohol intake. Numerous referrals have been made to the Substance Misuse team due to his alcohol intake and falls, being vulnerable under the influence of alcohol, risk from assault, being a danger to himself, plus he had been the victim of a recent assault and things taken from his property.

Safeguarding concerns of neglect, self-neglect, financial and physical abuse have been raised and since moving into supported accommodation, he feels that the self-neglect has increased.

Patient A is assessed as being high risk of death to his health problems, due to excessive alcohol use. Referrals have been made to alcohol services, but the patient has not engaged in the past. He has not been attending hospital appointments, however due to his deterioration in his health, he will require regular contact with the liver nurses. Since being in hospital, he has been prescribed medication to support him with alcohol withdrawal symptoms and is currently alcohol free. However, whilst in hospital an MCA 1&2, Dols was required due to a deterioration in his health and assessed as lacking capacity to make decisions about his care and treatment.



GHFT
Self-neglect, Financial & Physical Abuse - Case Study (Patient A)

Patient A has expressed that he does not wish to return to his current address due to being fearful and feels that he needs more support with his needs.

Risks identified by patient:

- Buying medication off the street.
- Peer pressure from associates.
- People were stealing from property.
- Concerns noted from others about his welfare.
- House littered with empty alcohol bottles.
- People taking his money.
- Feels unsafe.
- Recent alleged physical assault.
- Non-compliant with prescribed medication.
- Frequent falls/deterioration in his health.
- Lack of support.

The risk factors identified prior to admission were greatly reduced whilst in hospital. However, it was key that professionals communicated and worked together to ensure that he was supported in the community. A referral to the social worker, housing and the alcohol team was done prior to discharge. Engagement from professionals meant that they were able to work with the patient to carry out assessments, to look at housing options and what support he required in relation to his care and support needs.

Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust (CNTW)

Operational Practice

A second Named Nurse is now a permanent post in CNTW Safeguarding and Public Protection Team. The post has increased the Trust's senior safeguarding resource and supported improved partnership working.

Safeguarding Level 3 training has remained compliant with 85% or above throughout 2023-24.

CNTW academy arranged for Daphne Franks to deliver a Trustwide session on Predatory Marriage

Communication and Engagement

Learning from local cases continues to be disseminated to Trust staff via Trust Bulletin.

The SAPP team have worked closely with locality care groups attending weekly safety meetings to support the management of safeguarding issues.

The Trust has commenced the Safeguarding Adults Audit 2024 in Q4. This will be monitored via the Trust Clinical Effectiveness Committee and SAPP group. The audit will also review how service users have been involved in safeguarding decisions.

An assurance exercise has been completed in response to Norfolk SAR Joanna, Jon and Ben. Further work is planned for 2024-2025 to overlay learning from Durham SAR from Whorlton Hall.

Quality Assurance

An assurance exercise has been completed in response to Norfolk SAR Joanna, Jon and Ben. Further work is planned for 2024-2025 to overlay learning from Durham SAR from Whorlton Hall.

As part of the NHS Patient Safety Incident Response Framework (PSRIF), CNTW have set up the Patient Safety Learning and Improvement Panel (PSLIP). This panel will join up outcomes from Statutory Safeguarding Reviews with outcomes from internal patient safety reviews to help embed all learning Trustwide.

Learning from Case reviews continues to be shared via the Safer Care and Trust Bulletins and is standing agenda item for the SAPP team to inform current practice and supervision. Learning is also shared in Trust forums such as Managers Briefing, Quality and Safe, Positive and Safe and Team meetings. Where required, bespoke training sessions are provided to individual teams to review cases in more detail and to strengthen practice.

Learning has been shared with Trust MCA lead who is reviewing learning themes and will report back to SAPP group on plans to improve practice.

The Trust is involved in Northumbria Police pilot focussed on Hate Crime. New incident classifications have been added to the Trust reporting system and incidents are reviewed by SAPP team when identified as a safeguarding issue.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

Quality Assurance

The safeguarding team have continued to work in collaboration with multi-agency partners to ensure safeguarding measures are in place and learning is shared to support and protect adults at risk and their families. Focus for 23/24 has been to further raise awareness around MSP, self-neglect, fire safety, trauma informed practice, mental capacity, executive dysfunction and professional curiosity. These themes have been shared via attendance at governance meetings, 7- minute briefings, quarterly Safeguarding link forums and bi-monthly safeguarding newsletters.

Following findings from a staff survey, safeguarding adult and children supervision delivery has been amended, alongside the safeguarding supervision policy. Amendments aim to provide clarity on supervision requirements and the support the safeguarding team can offer to staff.

The STSFT safeguarding 23/24 annual audit cycle has been completed to provide assurance alongside the recognition of any actions to be taken to further improve safeguarding practice within the organisation. Audit activity included ED attendance and asking of safeguarding questions, MCA/DoLS procedures adherence (inclusive of when a medic has felt there were no concerns about capacity), safeguarding policy compliance (inclusive of routine & selective enquiry), procedural self-neglect guidance and threshold tool compliance and chaperone policy compliance.

The safeguarding team continue to complete a daily audit of ED attendances to ascertain if there are any missed opportunities and to gain assurance that safeguarding questions are being asked at each individual attendance. Any learning to arise from missed opportunities are Incident reported. The Named Nurse continues to attend ED Clinical Governance meetings to discuss any reported missed opportunities. The annual audit of ED attendance activity continues to be part of the safeguarding annual audit cycle.

Prevention

The Domestic Abuse Health Advocates (DAHA) continue to work alongside the safeguarding team to support staff in the identification and response to any disclosure of DA. The DAHA's are specialists working with victims of DA, targeting ward areas, ED, maternity, and community in supporting staff to recognise and respond to DA. The increased visibility of the DAHA's across the Trust has resulted in increased DA referral activity. The senior DAHA was recently shortlisted for an "unsung hero" award at the annual staff recognition awards.

The safeguarding Intranet page has been refreshed to provide staff with information and support 24/7. There is now a stand-alone Domestic Abuse section.

Recent DAHA feedback from patients include:

- "I feel very supported and am grateful for the help you have given me".
- "Thank you so much, it is good that I have been able to get "stuff off my chest" and so feel a lot better now".
- "Thank you so much for taking the time to listen to me".
- "Thank you for understanding what I am going through".

The safeguarding visibility model has been reviewed to further ensure increased face to face presence on wards and departments to further support staff and offer safeguarding supervision. This includes daily attendance at Emergency Department (ED) huddles and Paediatric ED (Monday-Friday).

Communication and Engagement

A safeguarding podcast has been published to promote awareness of the safeguarding team role, function and support that can be offered to STSFT staff and how staff can take measures to look after their patients and their own well-being.

Communication and Engagement

Safeguarding link forums and “Hot Topic” sessions are held regularly. A bi-monthly safeguarding newsletter is disseminated across STSFT and held on the Intranet. The key aim of the newsletter and link forums is to share any safeguarding learning, training courses and 7-minute briefings following SAR’s, DHR’s and CSPR’s. In 23/24, learning has been shared in relation to MCA assessment, executive dysfunction, professional curiosity, self-neglect awareness (inclusive of the use of the self-neglect toolkit), trauma informed practice, MSP, ICON Safe sleep, Caring for Migrant women, The Findaway project, Unaccompanied asylum seekers, Transitional safeguarding and preventing fire deaths. Positive feedback has been received from staff in relation to content and information within the safeguarding newsletter and following link forums, particularly in respect of the 7-minute briefings.

STSFT has signed up to the NHSE Sexual Safety Charter. The charter aims to take a systematic zero- tolerance approach to sexual misconduct and violence, keeping patients and colleague’s safe, recognising that sexual misconduct can happen to anyone anywhere.

STSFT Gateshead Talking Therapies Team attended the Gateshead Carers Gala at Saltwell Park. The event was hosted by the Gateshead Carer’s Association as part of Carer’s week. This year’s theme was “Putting carers on the map”.

STSFT Safeguarding Team continue to be active members of local partnerships ensuring representation and contribution across the Safeguarding Adult Board and where required attend subgroups.

Gateshead Sexual Health Services support the MSET meetings and support actions where intervention is required across all age groups.

Communication and Engagement

STSFT safeguarding team continue to contribute to both National and local safeguarding campaigns. These include:

- Successful roll out of events to celebrate Safeguarding Adults / Learners Week 2023 where the key theme was 'how you can prioritise the welfare and wellbeing of yourself and others. A robust programme of activity was shared with STSFT staff and partners.
- As part of "Think family" the team also participated in the Child Sexual exploitation awareness campaign 18th March 2023.
- The DAHA team launched the 16 days of Activism and the 2023 White Ribbon campaign. STSFT buildings were lit up purple / orange and white to represent the colours of Domestic Abuse and Safeguarding.

Operational Practice

The safeguarding team have maintained core business in relation to providing staff advice, support, supervision, and training. This includes hosting a single point of contact and ensuring enhanced visibility upon wards and departments to increase face to face presence in areas. This is to further support staff in their safeguarding practice and offer safeguarding supervision in action.

Training - All levels of safeguarding training have been reviewed to ensure they are aligned to both adult and children intercollegiate document and include reference to the NHS Sexual Safety Charter. Level 3 face to face "Think family" training has been refreshed to reflect learning from recent scoping's, SAR's, DHR's, CSPR's and learning reviews. Slido continues to be used to ensure sessions remain interactive. Slido enables evaluations of sessions in "real time".

Mental Capacity

The MCA / DoLS team, alongside the MCA Corporate Lead have continued to embed MCA into practice. Improvements include progression of an internal Launchpad to enable both internal and external data being readily available, contributing to robust Informatics and metrics. Furthermore, the expansion of Launchpad has led to a digitally enabled workforce, in line with recommendations within the NHS long term plan (2019). All the data is fed through internal governance processes and reported to CQC as part of CQC action plan.

STSFT now host an MCA “good practice forum”, which enables the dissemination of good MCA practice amongst staff.

MCA training has been refreshed. CPD modules have been devised which include Executive Dysfunction, MCA in Children 16–17-year-old, Capacity and DoLS, LPA/Deputyship and ADRT. There are also now a series of MCA podcasts available on the Intranet to further support staff with MCA practice.

Partner Updates – Connected Voice

During 2023/24 Connected Voice has:

Dedicated awareness sessions free to the VCSE on Advocacy and Safeguarding to explain the role and duties of advocacy in statutory and community-based advocacy services. Exploring the interface with the Care Act Safeguarding principles and the Mental Capacity Act principles of balance between empowerment and protection and risk taking for quality of life.

Dedicated free training 'Introduction to Safeguarding' an overview of the key issues about safeguarding for adults and children that every VCSE needs to know.

Improved feedback mechanisms from the VCSE to the Safeguarding board.

Improved Data Management systems to track and record safeguarding alerts, concerns and support provided by advocates to people in the community, including recording data on formal challenges to Court of Protection, Family Courts, NHS complaints and Social Care complaints.

Conducted long term research with Durham and Northumbria University into incidents of hate and anti-social behaviour, resulting in Hate Relationship terminology and a Toolkit (app) for professionals to identify when a situation is either Antisocial Behaviour, Hate Crime or repeated hate and needs to be treated appropriately. Toolkit has guidance on how to manage this in each locality with links to safeguarding teams and other useful resources.

Promoted advocacy widely across Gateshead and engaged fully in the Safeguarding Adults week campaign across the VCSE.

Connected Voice
Connecting People Supporting Action

Partner Updates – Your Voice Counts

Advocacy in Gateshead 2023/24

During 2023/2024 Your Voice Counts (YVC) provided independent advocacy services to over 1000 people in Gateshead, helping people to understand and speak up for their rights and supporting effective safeguarding adults procedures.

Promoting advocacy and raising standards

This year, YVC:

- Delivered training sessions for staff on advocacy as a preventative safeguarding tool and how and when to make an advocacy referral
- Took part in awareness raising events including presenting and holding a stall at the Safeguarding Adults Week Gateshead networking session
- Launched a range of user-friendly resources for both professional and community use, including the YVC Seven Minute Guide to Advocacy for the Gateshead Safeguarding Adults Board, Care Act factsheets, guidance on IMCA and safeguarding, and a series of NICE guides on safeguarding in advocacy, professional curiosity and trauma-based advocacy.

Partner Updates – Your Voice Counts

Using data to drive action

Data isn't just collected by YVC, it's acted on. YVC has:

- Introduced an electronic tool to capture low-level concerns and trends
- Held monthly manager reviews of safeguarding themes to address incidents and develop strategic plans
- Collected data on Section 21a challenges, tribunal applications and safeguarding outcomes to improve reporting and forward planning.

Leading and collaborating

Collaborating across the region to share good practice and develop learning is integral to YVC's aim to achieve the highest standards of advocacy work. YVC is proud to:

- Have a seat on the Safeguarding Boards in Gateshead, Newcastle and South Tyneside
- Be proactive members of the Advocacy Network and the Leaders in Advocacy Group, contributing to research and reports on topics such as inpatient care and Access to Advocacy
- Be represented by the YVC Head of Advocacy on the Improving Practice safeguarding sub-group.

Visit www.yvc.org.uk/advocacy for more information about YVC or to make a referral

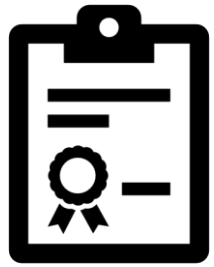
Appendix 2 - Strategic Priorities and Key Actions 2022-23

1. Quality Assurance

The Safeguarding Adults Board will continue to prioritise Quality Assurance in its widest sense. This will enable the Board to demonstrate quality and effectiveness at both strategic and operational levels. It aims to support a better understanding of how safe adults are locally and how well local services are carrying out their safeguarding responsibilities in accordance with the Care Act and the Gateshead Multi-Agency Policy and Procedures. In particular, the Board will ensure that quality is driven by learning.

Key Actions:

- Develop training for front line practitioners that is guided by learning from reviews and inquiries
- Develop and implement annual Quality Assurance challenge event
- Enhance our multi-agency approach of sharing learning with front line practitioners
- Revise the Safeguarding Adults Review Policy and Practice Guidance to include a strengthened approach to practical application of learning
- Prepare our Safeguarding Adults Board for the new CQC regulatory model and assessment framework which is expected to commence in April 2023.



2. Prevention

Prevention is one of the six Principles of Safeguarding. Within Gateshead we have prioritised preventative work and have produced a range of practice guidance notes and bespoke training courses to support our front-line practitioners. The Board would like to see Prevention at the forefront of all Policies, Procedures and Practice Guidance and woven into practice.

Key Actions:

- Develop and implement a Multi-Agency Risk Management (MARM) framework as a mechanism for supporting vulnerable residents who do not meet the statutory criteria for Safeguarding Adults.
- Support closer integration of public services across the wider Gateshead System, including the work of Public Sector Reform and the Gateshead Care Partnership. Understand and respond to potential safeguarding implications of the Health and Social Care Integration White Paper.
- Become Adverse Childhood Experiences (ACE) / Adult Attachment / trauma informed.
- Revise the Self-Neglect Practice Guidance note and deliver updated multi-agency practitioner training.
- Revise the Financial Abuse Practice Guidance note, taking into account the issues arising from implementation of Universal Credit.
- Strengthen multi-agency arrangements for Modern Slavery in Gateshead; to include awareness raising, responding to pre-planned and unplanned incidents and quality assurance.

- Raise awareness about Gateshead pathways and provision for all aspects of exploitation, and work in partnership with the new regional Victim Hub.
- Build community resilience so that our residents are better equipped to keep themselves safe from harm.
- Develop a more flexible training programme, to include more e-learning and virtual learning opportunities.
- Develop and implement organisational abuse policy and procedure.
- Improve partnership working to safeguard people who experience homelessness.
- Understand the impact of Mental Health Act reform upon the wider safeguarding agenda. Support the Gateshead community mental health transformation programme.

3. Communication and Engagement

The Safeguarding Adults Board has made significant improvements in Making Safeguarding Personal to ensure that those adults involved within the safeguarding process have their wellbeing promoted and, where appropriate, that regard is given to their views, wishes, feelings and beliefs when deciding any action. Consultation has demonstrated that there continues to be a lack of understanding about Safeguarding within the wider community, which can impact upon the effectiveness of Safeguarding Adults as a whole.

Key Actions 2019 - 24 include:

- Effectively communicate and champion our good practice.
- Enhance communication and engagement with partners and providers who are not routinely engaged with the Board and Sub-Groups.
- Promote Safeguarding Adult key messages within our communities.
- Widely promote our Safeguarding website and social media presence.
- Implement our Safeguarding Adult Champion Scheme and develop Safe Reporting Centres.
- Develop a safeguarding adult resource library which includes communication and engagement tools, including visual media aids.
- Develop mechanisms to ensure that the views of adults at risk and carers inform the work of the Safeguarding Adults Board.

4. Operational Practice

Whilst this is a Strategic Plan, the Safeguarding Adults Board must ensure that operational practice is fit for purpose. Whilst significant improvements have been introduced by the Safeguarding Adults Board and our key partners, we know from our quality assurance processes and the sharing of best practice nationally and regionally that further improvements can always be made.

Key Actions 2019 - 24 include:

- Work with the Health and Wellbeing Board and Community Safety Board to improve how our partner organisations identify and respond to complex cases.
- Refresh the Safeguarding Adults Board Multi-Agency Policy and Procedures by enhancing accessibility and simplifying the procedures.
- Enhance our approach to managing risk, to include:
    - Understanding perpetrator motivations
    - Person centred approach v managing risk
    - Identifying and responding to coercive and controlling behaviour
- Improve communication flow with referrers, providers and Adult at risk after a concern has been submitted.
- Strengthen multi-agency safeguarding transition arrangements, including procedures for responding to child to parent violence.

- Develop a shared approach to missing adults, including consideration of the use of ‘vulnerability markers’.
- Further embed Making Safeguarding Personal throughout Safeguarding Adults practice.
- Work in partnership to manage levels of demand. This will include the development of an Adult Concern decision making tool.
- Develop a Gateshead Safeguarding Adults Board People in a Position of Trust (PIPOT) Policy

5. Mental Capacity

Understanding and applying the Mental Capacity Act is central to the Safeguarding Adults process. It remains one of our most common areas for improvement in Gateshead, and beyond. Legislative changes are again on the horizon with the proposed Mental Capacity (Amendment) Bill which will reform the Deprivation of Liberty Safeguards (DoLS) and replace them with Liberty Protection Safeguards. The agenda will continue to evolve as new ways of working and case law is embedded into practice. Practitioners need tools and guidance to support them with the practical application of the Mental Capacity Act within everyday safeguarding, assessment, and care provision.

Key Actions 2019 - 24 include:

- Understand, and effectively respond, to changes within the Mental Capacity Act (Amendment) Act.
- Monitor the development of the revised Code of Practice for the Mental Capacity Act and develop a mechanism for assuring that the changes within the Code of Practice are effectively implemented within Gateshead.
- Develop and implement a programme of awareness raising for front line practitioners, providers, partners and the wider public about the application of the Mental Capacity Act.
- Explore how a health diagnosis supports the practical application of the Mental Capacity act.
- Continue to ensure that referrals for advocacy are made in accordance with the Care Act 2014.