Gateshead Safeguarding Adults Board

Annual Report

2022/23

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Introduction

It is widely understood that the Japanese symbol for crisis is the same as the symbol for opportunity. Crisis is dangerous and frightening, no more so than in the safeguarding arena but it also, as the Japanese have understood for centuries, presents an opportunity for change.

We've heard the word crisis a lot in recent years and months; a global public health crisis, a national mental health crisis, a cost of living crisis. The pressures and challenges that these crises cause are well understood and exacerbated when combined, there is no doubt that we are in a crisis of crises.

Phil Conn, Chair, Gateshead SAB (2019-2023)

As my time as chair of the Safeguarding Adults Board in Gateshead comes to an end my principle reflection is that Gateshead persistently seeks to find opportunity within crisis. This year we have seen innovation, collaboration and involvement in equal measure and this report offers a flavour of that and suggests a persistence and determination to ensure that no matter what the challenges are, we will always do our utmost to safeguarding our most vulnerable.

Innovation is apparent in the case study from Tyne and Wear Fire and Rescue service, highlighting the importance and value of working in partnership, pulling on the strengths and resources of each other. It's clear from the outcome that without the drive of those involved to think differently, to try new approaches, that things could have turned out very differently.

Safeguarding adults' week was a real highlight this year, the best for some time in my own opinion and credit must go to those who worked hard to organise it. The week saw a host of agencies holding a variety of briefings and training sessions and it was a thrill to see these so well attended. Collaboration on focus weeks like this not only raise the profile and importance of safeguarding adults (as seen in the lighting up of the millennium bridge), but also builds understanding, relationship and shared aims, which can only be a good thing for Safeguarding Adults in Gateshead.

The People at the Heart initiative launched this year with huge ambitions, principally to draw together those services engaging people facing multiple disadvantage and strive to improve provision. A core principal of this initiative is to improve the efficiency of forums and communication, ensuring the people at the centre of discussions remain central. This principal is rooted firmly in the principles of the care act; Empowerment, protection, prevention, proportionality, partnership and accountability. The initiative will need full support and the energy of the board and all its partners if it is to achieve its aims.

One of things that really stands in this report is the enthusiasm for the professional curiosity and trauma informed practice seminar delivered by Lads Like Us. The feedback from this sessions is overwhelmingly positive and once again highlights the importance of the voices of people

with lived experience. Gateshead understands this importance well but we could all do more to ensure that those voices are embedded across our strategy and delivery.

There has been quite a lot of change in the last twelve months, those changes bring opportunity, especially as we've welcomed exceptional colleagues into the board and in leadership positions across our safeguarding partnerships. I'm pleased to be handing over the chair to Nic Bailey who will be an excellent leader of the SAB at a crucial point in time. Nic has a wealth of experience and ability perfectly suited to drive the board forward, she will however need the full support of everyone, my own experience suggests she'll have it in droves.

I'm proud to have been involved with Gateshead Safeguarding Adults Board for the last 4 years, I leave knowing that it will continue to innovate, collaborate and involve and will find opportunity in every crisis.

Phil Conn
Chair, Gateshead SAB (2019-2023)

Safeguarding Adults 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 2022/ 23.

The report outlines the internal governance structures for each statutory partner and an update on what they have achieved during the year.

There is an overview of the work of the two subgroups; the Quality, Learning and Practice group who work on learning and reviewing safeguarding practice and standards and the Safeguarding Adult Review and Complex Case group who are responsible for actioning safeguarding adult review (SAR) referrals. We have provided data on the number of safeguarding concerns received and Section 42 enquiries undertaken.

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 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.
- it must conduct any Safeguarding Adult Reviews.

The aims of adult safeguarding are to:

- 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 SAB 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 SAB and our Gateshead Safeguarding Children's Partnership (GCSP).

In law, the statutory members of a SAB are defined as:

- the local authority.
- the local police force.
- the Integrated Care Board (ICB).

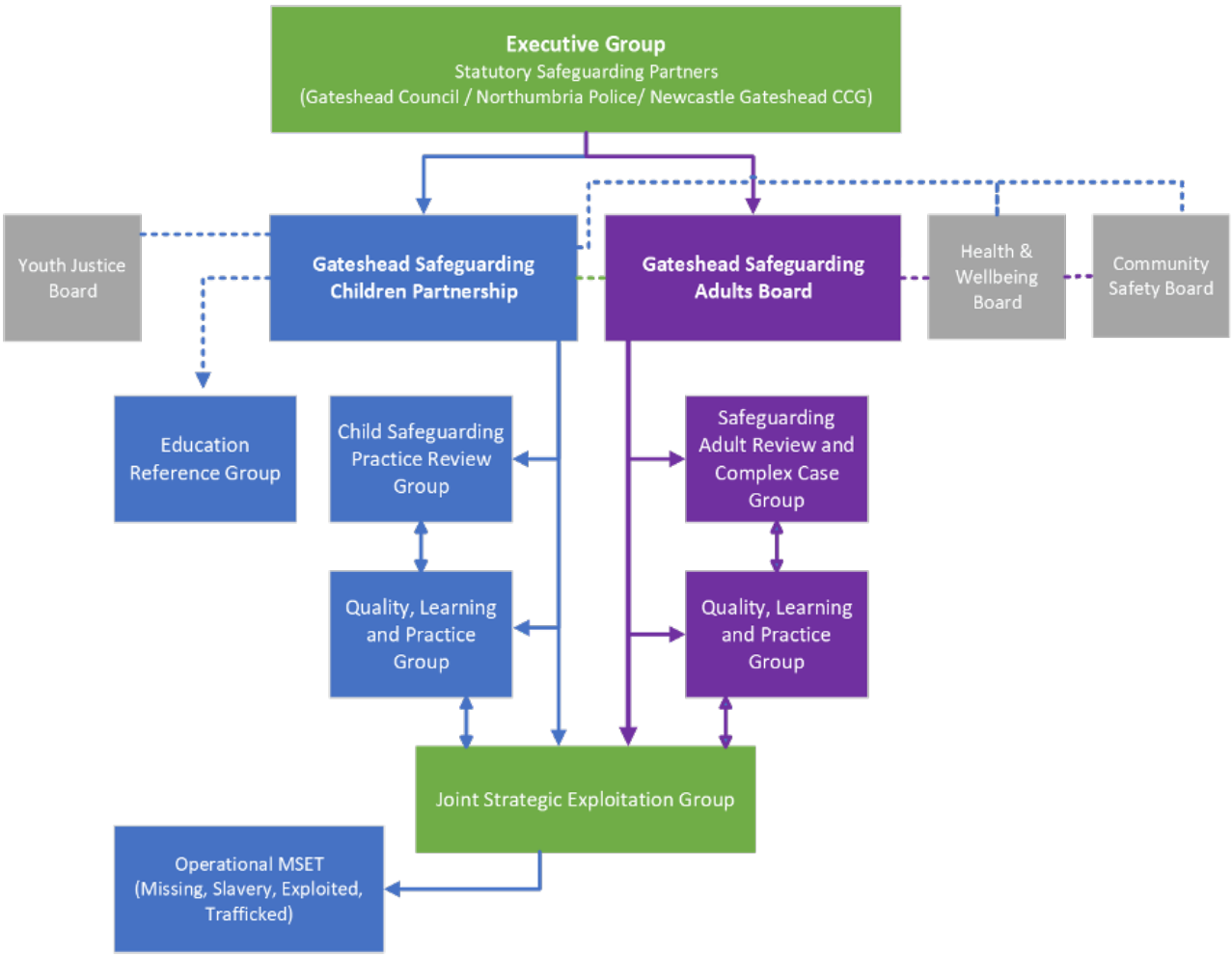
In Gateshead, we recognise the importance of the contribution made by all our partner agencies and this is reflected by the wider Board membership (correct as of June 2023):

- Gateshead Council
- Northumbria Police
- Northeast and North Cumbria ICB, – on behalf of NHS England, North East
- Ambulance Service and incorporating GP lead for Adult Safeguarding
- Lay Members
- 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
- Oasis Community Housing
- Connected Voice Advocacy
- Department for Work and Pensions (DWP)
- Healthwatch Gateshead

Healthwatch Gateshead feel that this annual report demonstrates that Gateshead Safeguarding Adults Board have focused delivery this year and this has led to some good outcomes for the people living in the borough. Healthwatch Gateshead welcome the continual collaboration with partners to ensure that resources are used effectively, and we support the continued aim to protect an adult's right to live safe, free from abuse and neglect.

Gateshead SAB Structure

The Gateshead SAB 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).



Joint Strategic Partnership Executive Group

The Joint Safeguarding Partnership Executive (SPE) group provides strategic oversight of both the SAB and GSCP. The Safeguarding Partnership Executive includes the three statutory partners, the SAB Chair, the GSCP Independent Scrutineer and the GSCP and the Business Managers of the SAB and the GSCP. The SPE ensures that the statutory responsibilities of the SAB are being met, whilst delivering quality outcomes.

Gateshead SAB Sub-Group arrangements

Quality, Learning and Practice 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. The QLP collate and review recommendations from statutory Safeguarding Adult Reviews and discretionary reviews and has oversight of multi-agency safeguarding training. The QLP aims to ensure that the Multi-Agency Safeguarding Adults policy and procedures and supporting practice guidance continue to be fit for purpose. The Group has responsibility for keeping up to date with national policy changes that may impact upon the work of the SAB. The Group also has responsibility for 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) consider Safeguarding Adult Review (SAR) referrals, commission reviews and subsequently monitor their progress. The SARCC may also 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. It will collate and review recommendations from SARs and other reviews, ensuring that achievable action plans are developed and that actions are delivered. The SARCC also provides a forum to discuss complex Safeguarding Adult cases that require additional scrutiny and support.

Joint Strategic Exploitation Group

(Chaired by a senior officer from Northumbria Police)

The Joint Strategic Exploitation Group is a sub-group of both the SAB and the GSCP. The group is responsible for overseeing all work with respect to all aspects of exploitation including modern slavery, criminal exploitation, sexual exploitation, trafficking, missing and female genital mutilation in Gateshead.

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

Partner Governance Arrangements and Scrutiny 2022/23

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 SAB. The governance and scrutiny arrangements for the three statutory partners include:

Gateshead Council – The Care, Health and Wellbeing Overview and Scrutiny Committee receive updates from the SAB and key pieces of work are submitted to Cabinet. The SAB performance dashboard and annual mandatory Safeguarding Adults Collection are scrutinised within the Adult Social Care performance clinic and strategic items are shared with the Children,

Adult's, and Family Group Management Team. The Gateshead Council Internal Audit service provide assurance that the Board and Gateshead Council are meeting their statutory duties.

Northeast and North Cumbria Integrated Care Board (NENC ICB) – 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.

Strategic Plan 2019 - 2024

The Gateshead Strategic Plan 2019/24 was approved by the SAB in April 2019. The five-year plan incorporates five strategic priorities:

- Quality Assurance
- Prevention
- Communication and Engagement
- Operational Practice
- Mental Capacity

This is the final year of the Strategic Plan in its current format the board will develop and agree its strategic priorities for 2024 – 2027 during 2023.

Key Activities 2022/23

The Annual Report must demonstrate what both the SAB and its members have done to carry out and deliver the objectives of its strategic plan. Some of our key activities for 2022/23 are documented below and are aligned to the following SAB Strategic Priorities.

Quality Assurance

- Develop training for front line practitioners that is guided by learning from reviews and inquiries.
- Prepare our SAB for the new CQC regulatory model and assessment framework which is expected to commence in April 2023

Prevention

- Become Adverse Childhood Experiences (ACE) / Adult Attachment / trauma informed.
- Revise the Self-Neglect Practice Guidance note and deliver updated multi-agency practitioner training.
- Develop a more flexible training programme, to include more e-learning and virtual learning opportunities.

Communication and Engagement

- 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.
- Widely promote our Safeguarding website and social media presence.
- Implement our Safeguarding Adult Champion Scheme.

Operational 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.

Mental Capacity

- 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. (See training)

Quality Assurance

Learning from SARs and other Enquiries

During the year there have been seven SAR interactive workshops attended by 82 practitioners covering 4 reviews. The interactive workshops are an opportunity for practitioners to hear about SARs, reviews, and inquiries, both local and national. 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. During 2022/23 the following cases were used in the interactive workshops:

July 2022

The Stephen SAR was conducted by the Teeswide SAB and focused on the death of gentleman with a learning disability at the age of 56. Stephen had follicular lymphoma, however he contracted Covid and died of Covid pneumonitis.

The SAR Interactive workshop focused on working in partnership with families, partnership working between agencies, shielding people with health conditions during Covid, tenancy decisions for people with a learning disability, the availability of specialist services during the pandemic and understanding by practitioners of Lasting Power of Attorney (LPA) and Mental Capacity Act assessments.

> ***"It allowed me to reflect on current practice, policies and procedures and their importance."***

October 2022

The Mrs VC Appreciative Inquiry was undertaken by the Gateshead Safeguarding Adult Review and Complex Case (SARCC) Subgroup. Mrs VC lived in care home in Gateshead, during the first four months of her stay within the care home the family were happy with her care. Concerns were subsequently raised by the family with respect to how the home and partners responded to her deteriorating physical and mental health and associated increased care and support needs.

The objectives of the inquiry were to determine good practice and areas for improvement in:

- Communication between partner agencies.
- Communication with Mrs VC and family representatives.
- Care and treatment (with a focus upon medication management, needs assessment, weight, and nutrition).
- Managing concerns/complaints.

> ***"It was a great opportunity to reflect on the importance of establishing a person's needs and to prioritise when people are in nursing care for respite purposes."***

The SAB Quality, Learning and Practice Sub Group have been tasked with taking forward the recommendations from the inquiry including, developing guidance for front line staff to encourage hosting multi-disciplinary team meetings when a person's physical and/or mental health is declining, develop the MCA training programme, develop and implement 'Making Safeguarding Personal' training to enhance our approach to engaging/communicating with adults and their representatives and develop and implement an adult concern decision making tool to support practitioners to raise concerns utilising the most appropriate pathway.

January 2023

The Adult N SAR was undertaken by Newcastle Safeguarding Adults. Adult N was a vulnerable dependent drinker and had a long history of alcohol and illicit drug misuse. This was a complex case with Adult N suffering with both physical and mental health issues, being the victim of domestic abuse and having an acquired brain injury after being knocked over by a vehicle.

Some of the recommendations from this SAR are being taken forward in Gateshead in response to the rise in the number of safeguarding referrals in relation to vulnerable dependent drinks with complex needs. Work is being undertaken in partnership with Public Health to explore the implementation of the Blue Light project in Gateshead and training on Mental Capacity and Executive Dysfunction has been delivered with further sessions to follow.

April 2023

A Learning review was carried out by the Safeguarding Adults and Complex Cases Subgroup following the death of a young man in 2022. The young man had a diagnosis of Paranoid Schizophrenia a mild Learning Disability, and a suspected Acquired Brain Injury. There was a longstanding history of involvement with psychiatric services including three admissions to psychiatric inpatient units.

Following discharge from hospital following detained under S3 of the Mental Health Act he was supported in his own accommodation by a supported living service. His mental health started to deteriorate when he began to misuse drugs and there were concerns of exploitation and home invasion.

The learning review identified several areas for development, including understanding of when to instigate an MDT prior to crisis and when to request unplanned reviews, recording of mental capacity and best interest decisions, recognising, and responding to potential exploitation, clarity about what information to share and when and recognising and responding to self-neglect.

"It's always great to have these sessions and to be able to look at the work we do in order to improve, support and develop".

CQC Assessment Framework

In June Steph Downey, Service Director, Integrated Adults and Social care service provided a presentation on the reform of Adult Social Care and the forthcoming CQC assurance inspections. SAB partners have a key role to play within the CQC assessments and it was agreed that a standing agenda item should be added to the board agenda to allow for relevant updates to be provided to partners.

The key theme for the board will be "How local authorities ensure safety" and how as a partnership it can support in the provision of evidence around safeguarding enquiries, reviews, Safeguarding Adults Board, safe systems, pathways and continuity of care. Feedback was given on the peer assessment review which was an opportunity for the LA to fully understand strengths and develop action plans giving a clear trajectory for future developments.

SAB Dashboard

During 2022/23 the QLP Group reviewed the information provided on the Safeguarding Adults Board performance dashboard. Feedback from partners:

- Overall, the data is helpful.
- Ensure Making Safeguarding Personal (MSP) is more prominent within the report. It is a requirement within the Care Act to monitor and report on MSP.
- Provide information on which agencies are submitting SG referrals and how many progress to a concern or an enquiry, this will help identify where targeted support and guidance is required.
- Provide data on independent advocates, when they are requested to support people through the Section 42 enquiry process.

The Quality Assurance Team are working to amend the dashboard to ensure the feedback from partners is incorporated into future report. The introduction of the new case management system Mosaic, will support improvement in the recording and.

The report continues to support partners to develop an understanding of key safeguarding adult themes and trends. This is compared with the regional safeguarding dashboard to help determine if we are an outlier in any aspects of safeguarding, and to support regional/ partnership working.

Priorities for 2023-24:

- Ensure analysis of the data is carried out to provide meaningful feedback to the SAB and partner agencies.

Out of Borough Placement Update

Following the initial investigation into Whorlton Hall, the local authority as a commissioner needs to review how they ensure people placed outside of Gateshead have the same safeguards as someone who placed in a health or a care service within Gateshead where there is more robust local monitoring. The LA Quality Assurance Team provided information on the number of people placed out of borough. However, it was agreed that additional information should be provided to the board such as the overall outcomes of the reviews and concerns around safeguarding with the providers who are being commissioned.

It was proposed that the board should be provided with assurances that processes have been put in place to monitor out of borough placements but looking through a wider lens and jointly reporting on those people who are placed. Work is now being undertaken jointly between colleagues from performance teams in both the Council and the ICB. A suite of information will be made available to be presented to the board and board members will then be assured that out of borough reviews are taking place and robust processes are in place.

Prevention

Professional Curiosity and Trauma Informed Practice

As part of our objective to support trauma informed practice the SAB welcomed Lads like Us, Danny and Mike to Gateshead in March. Danny and Mike shared 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.

Lads Like Us, Danny and Mike

They use their experiences to demonstrate the need for practitioners to adopt a trauma informed approach built on professional curiosity. 60 representatives from partner agencies attended the session and the feedback was exceptional.

Danny and Mike will be visiting Gateshead again in November 2023 as part of the Safeguarding Adults week programme of events.

"Today I asked a service user if they had any childhood trauma that was hindering their recovery."

"Excellent lived experience training. The lads were down to earth but honest and open."

"This is the most thought provoking, humbling training I have been on throughout my entire career. There wasn't a power point in sight, just raw honesty and brutal reality of the impact services (good and bad) can have on an individual's life."

"Incredible training, I have worked in substance misuse since 2007 and can categorically say this training has had the most impact and has been the most thought provoking to improve practice within this subject matter.

Thank you to both or sharing your stories and using your trauma to make a positive difference for the future."

Self-Neglect Guidance

In November the Northeast Region of ADASS (Association of the Directors of Adult Social Services) launched their Self Neglect 7 minutes guides and animation, highlighting the key issues around aspects of self-neglect. The launch coincided with Safeguarding Adults week and Webinar and several bite-sized information sessions – all delivered by nationally recognised professionals and academics in their chosen fields of expertise and all with the overarching theme of self-neglect.

Gateshead SAB have a page of information on Self Neglect alongside the 7-minute guides and a link to the "What to do about Self Neglect" animation. The bite-size guides are intended to complement over-arching Self-Neglect practice guidance and support front-line practitioners in their response to self-neglect cases. to reflect the information provided in the ADASS seven minutes guidance and animation.

Training

The Gateshead Council Workforce Development Adviser worked with the SAB, Gateshead Safeguarding Children's Partnership (GCSP) and the Community Safety Partnership to produce a comprehensive training offer for 2022/23. 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
Safeguarding Adults Reporting Concerns Level 2	11	140
Introduction to Mental Capacity	4	65
Practical Application of Mental Capacity Act	3	65
Missing, Slavery, Exploitation and Trafficking (MSET) Training	1	17
Executive Dysfunction and the MCA	1	23
Lads Like Us Professional Curiosity and trauma Informed Practice	1	60
Interactive Safeguarding Adult Review Workshop	7	80

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 continues to offer Introduction to MCA and Practical Application of MCA as part of its multi-agency offer. This offer has been enhanced during 2022/23 with the delivery of a session on Executive dysfunction and the MCA practice short. The session provided an overview of executive dysfunction, the impact it has on decision making and the complexity / obstacles to assessment. Following the positive evaluation of the session a task and finish group has been established to develop the training further and to ensure it meets the requirements of all partners.

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

> ***"Great information for cases currently working on and ways of implementing this in future cases."***
>
> (Practical Application of MCA)

> ***"Excellent session will have a significant impact on my skills of intervention with clients, and in report writing."***
>
> (Executive function and MCA)

> ***"Really beneficial hearing from service users and not just professionals."***
>
> (Lads Like Us, Professional Curiosity and Trauma Informed Practice)

> ***"Really detailed interactive training very helpful!"***
>
> (SAR Interactive Workshop)

> ***"I will use the knowledge from this training in my practice to identify risk and support people with care needs".***
>
> (Safeguarding Adults Reporting Concerns, Level 2)

The new Learning Hub booking system was introduced in May, this allows all partners to search and book on to courses and receive email updates on new courses when they are published, delegates can also download their certificate once the course is complete.

Priorities for 2023-24:

- Develop training resources using different approaches, including recorded webinars, dictated PowerPoints and podcasts.
- Offer further training on adopting a trauma informed approach to safeguarding.
- Establish a Mental Capacity Act Training programme which will support the skills and knowledge in the practical application mental capacity assessment.

Communication and Engagement

Safeguarding Adults Week

Gateshead SAB Safeguarding Adults Awareness Week was held in November 2022 to coincide with the national safeguarding adult awareness events co-ordinated by the Ann Craft Trust. The overall theme this year was 'Responding to Contemporary Safeguarding Challenges' with each day of the week focusing on a specific theme, including exploitation and county lines, self-neglect, creating safer organisational cultures, elder abuse, domestic abuse in tech-society.

There was a variety of activities which took place during the week to raise awareness of various aspects of safeguarding adults:

- Gateshead Millennium Bridge lit purple on Monday 21st November to mark the start of safeguarding week providing a visual symbol for safeguarding adults.
- Gateshead Safeguarding Adults Team hosted a safeguarding information stand was erected in the foyer of the Civic Centre. Leaflets, information, and purple ribbons were available to mark the event and raise awareness.
- The QE Hospital Safeguarding Team had safeguarding stall in the main entrance of the hospital with a wide variety of information, leaflets, posters, and freebies to promote safeguarding.
- Briefings and training sessions ran during the week:
    - An Introduction to Cuckooing (Home Invasion) (Ann-Maria Mitchell, ASSET Team Manager)
    - Regional County Lines Exploitation Training Event (Northumbria Police)
    - Virtual Self Harm Webinar (Ann Craft Trust)
    - What to do about Self-Neglect – Learning from Best Practice. This included the launch of the 10 seven-minute guides and the "What do to about Self-Neglect" animation (ADASS)
    - Safeguarding Vulnerable Dependent Drinkers (Anne Thomson, SG Team Manager)
    - Making Recruitment Safer (Disclosure and Barring Service)
    - Elder Abuse Webinar (Hourglass, Hosted by Durham SG Unit)
    - How practitioners can contribute to safer cultures in their organisation (Ann Craft Trust)
    - Fire Safety Webinar (TWFR)
    - Transitional Safeguarding Webinar (Northumberland SG Unit and NWG) Network)

STSFT Safeguarding Team actively engaged within Safeguarding Adult's week demonstrating positive multi-agency working with good engagement from STSFT staff. Representatives from local domestic abuse services and the STSFT Domestic Abuse Housing Alliance engaged with members of the public and staff at the Domestic Abuse stall with positive engagement from the public, especially when participating in the "What's your red flag" activity.

STSFT Safeguarding Week

Gateshead Health Foundation Trust had an information stand in the QE Hospital, to engage with staff and the public raising awareness of various safeguarding topics and the work of the team.

In the run up to and during safeguarding week there were updates and information provided on Twitter @GatesheadSafe:

- 15 tweets relating to activities
- 14 new followers (total number is now 971)
- 10,600 tweet impressions

Website

Gateshead SAB 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 Fire Risk, Self-Neglect and Safeguarding Adults Week.

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 Twitter account @GatesheadSafe which has over 900 followers and is a useful platform to share our resources and new initiatives.

Safeguarding Champions

Our Safeguarding Adult Champions scheme continues to be a useful mechanism for sharing information and raising awareness about safeguarding adults in Gateshead. We have 131 Safeguarding adult Champions representing 52 organisations, teams and establishments across Gateshead. The champions are responsible for raising awareness about safeguarding adults within their own organisation, ensuring that all staff and volunteers are familiar with the Gateshead multi-agency policy and procedures, disseminating updates and being a single point of contact for safeguarding adults.

The Safeguarding Champions annual forum took place with representatives from 13 organisations across Gateshead. The session covered some of the themes of SG week and gave the champions an update on the Gateshead SG workstreams and future plans. There was a meet and greet session to allow champions to chat to people working within safeguarding, including the SG Co-ordinators, representatives from the ASSET Team, Connected Voice, TWFRS and People @ the Heart. There were presentations on the role of advocates, learning from positive practice (joint working between ASSET and TWFRS, see case study), the blue light project and closed cultures.

The champions were asked to provide feedback on the support they require to be able to fulfil their role. This feedback has been developed into an work plan to provide the requested support, this is progressed and monitored through the QLP sub group.

Regional SAR Champions

Gateshead continues to contributed towards the work of the North East Regional SAR Champion network which was established to ensure learning from SARs and other enquiries is shared across the North East region. This group has been very proactive and succesful work to date includes:

- The North East SAR Champions were asked by SCIE to help to support the invigoration of the National Champions at the SCIE Quality Markers / SAR Methodologies Workshop on 13th July 2022. This gave the group the opportunity to:
  - Provide an overview of how the SAR Quality Markers can be used effectively to embed learning and influence practice through the SAR Process.

- Give insight into the culture change that needs to take place to move to a systems change process of learning.
- Provided an opportunity to showcase the regional SAR library.

- Gateshead continues to hos the North East SAR Library via Teams which provides a comprehensive library of shared SAR learning.
- The SAR Champions have been working to learn more about parallel processes (to SARs) in relation to Learning Disability Mortality Reviews (LeDeR). Further information has been requested from the ICB in terms of governance, commissioning of reviews, training for reviewers, the review process, disseminating learning, publication and the annual report. Once this information is received, further discussion will take place around how we can use the interface effectively within the SAR Process (where appropriate).
- In response to the high numbers of fire deaths and injuries across the region, many of which have involved people with care and support needs a Fire Risk task and finish group has been created. Gateshead is a member of the group alongside the 4 regional fire and rescue services. The group works to share learning from the cases and promote fire prevention information and guidance, the group are working on the development of a fire prevention/ risk video for the public and practitioners.
- The North East Quality Markers checklist was updated inline with the guidance from SCIE. The checklists have been adopted in Gateshead to assist in ensuring that recommendations from the National SAR Analysis for sector led improvements are implemented.
- Work continues to develop the easy to read/ access guide for service users around "Safeguarding - What Happens?" which will provide clear information around what happens during the safeguarding process. This guide is being co-produced with experts by experience.

People @ the Heart (P@TH)

P@TH is Gateshead's multiple and complex needs transformation initiative. P@TH is a programme to support system change in Gateshead for people with multiple complex needs (MCN). It is not a project designed to work directly with people but to support and bring together the existing services in a more collaborative way.

P@TH Launch event 2022

The initiative was officially launched on 6th December 2022 at an event at Gateshead Civic Centre which was attended by representatives from various agencies across Gateshead including, Gateshead Domestic Abuse Team, CBC Workforce Initiative, Health Federation, Handcrafted, Housing, Adult Social Care, Gateshead Recovery Partnership, Edberts House, Community Mental Health services, ASSET.

There are very clear links between P@TH and the learning from some reviews which have been undertaken by the SAB. These workstreams include, professional peer training & support, community involvement, reduction in use of inappropriate emergency services, addressing professional prejudice, hospital to rehab transitions and community withdrawal management,

prison transitional work and new operating model for immediate response as preventative approach to DRD & near misses.

The SAB is represented at the P@TH Programme Board by the SAB Business Manager and the SAB receive regular updates on progress from the Programme Manager, Suzanne Henderson.

Operational Practice

Adult Concern Decision Making Tool

In response to the increase in the volume of adult concerns, and an increase the complexity of safeguarding adult cases. An Adult Concern Decision Making Tool was developed and published in June 2022. The tool has now been in operation for 12 months and the Board will now undertake a review of the impact of the tool in terms of data and a survey of users on the usefulness of the tool.

Maintain compliance with Deprivation of Liberty Safeguards

Gateshead Council, as DoLS Supervisory Body, continues to remain legally compliant and there are no local backlogs.

Gateshead Council remains committed to investment in the DoLS staff team responsible for the processing and managing of all DoLS applications, ensuring there is the ability to meet most of our demands "in-house", thereby improving efficiency.

Organisational Abuse

The Northeast Safeguarding Adults network have highlighted to the national safeguarding network the need for national guidance on organisational abuse. This follows inconsistent approaches to how partners work together to manage and respond to cases of organisational abuse. A regional task and finish group has been established to undertake some regional benchmarking on organisational abuse and Gateshead are participants of this group. In Gateshead we are piloting a new procedure for how we respond to organisational abuse. To support this process, Gateshead Council have invested in a new safeguarding co-ordinator and safeguarding support assistant to respond to organisational abuse cases.

Preparation for implementation of Liberty Protection Safeguards

The landscape with respect to the proposals for the introduction of the Liberty Protection Safeguards via the Mental Capacity (Amendment) Act 2019 during 2022/23 remained fluid and was closely monitored by partners within Gateshead. Following the announcement at the beginning of April 2023 of the indefinite pause of the Department of Health and Social Care that the implementation of the LPS, The Mental Capacity (Amendment) Act 2019 will be "delayed beyond the life of this Parliament" the board have refocused their attentions to embedding the Mental Capacity Act and providing focused support to practitioners on this.

Melony Bramwell, Service Manager (Safeguarding, Protection & Social Work Standards), has been appointed as the Chair for the National DoLs Network. The Network provides strategic guidance to local authorities nationally and will be strengthening links with ADSS, LGA and DHSE around the upcoming and coming changes around the LPS. This direct link into the network gives the SAB access to up to date and relevant information on progress with the LPS.

Our Performance 2022/ 23

Safeguarding Adults Headline Performance

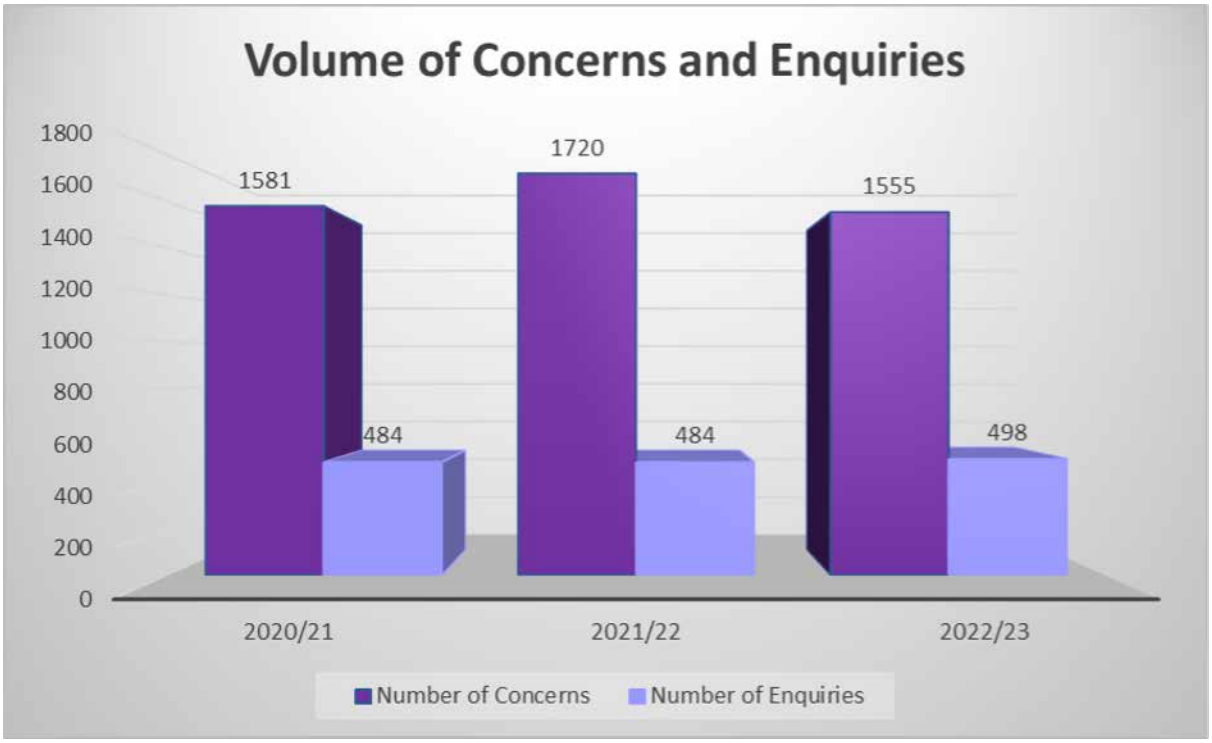
A summary of the headline performance information is provided below.

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 2022/23 there were 1555 Safeguarding Adult Concerns which led to 498 Section 42 Safeguarding Enquiries. This demonstrates a reduction in the number of concerns from the previous year. The number of S42 enquires continues to remain at a consistent level.

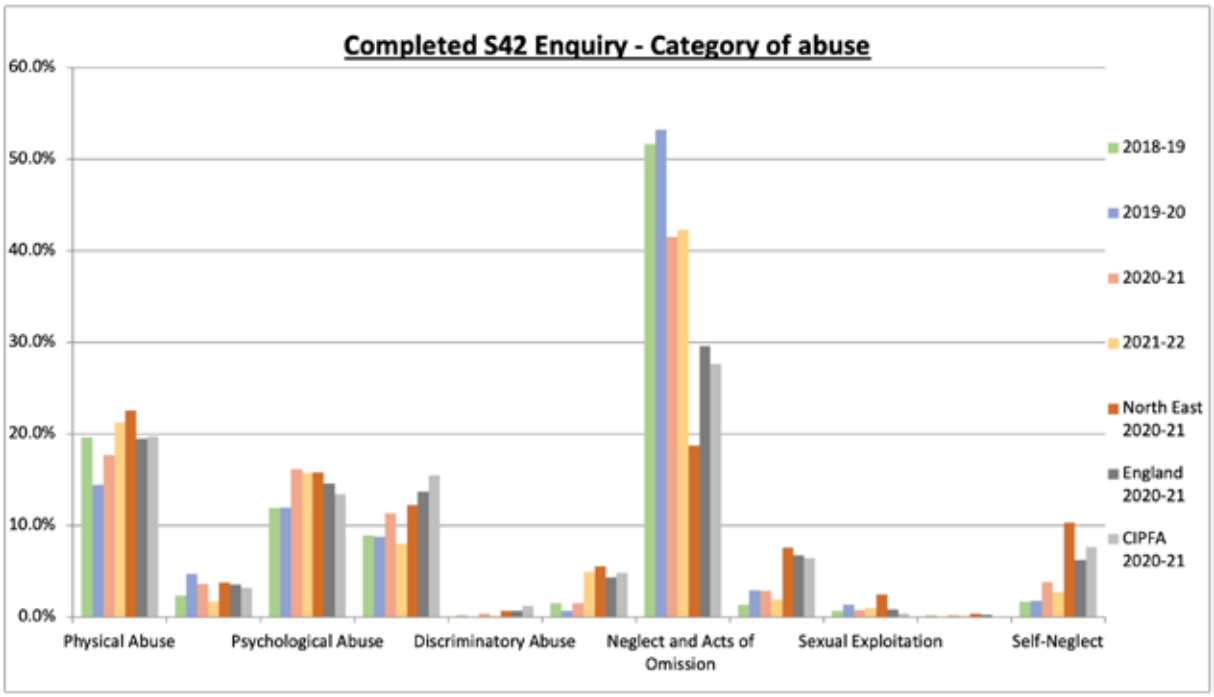


In percentage terms, 32% of Concerns led to a Section 42 Enquiry. The number of concerns progressing to an enquiry is lower than the 2020-21 NE (42.5%) and slightly higher than the England (30.6%) averages.

Categories of Abuse

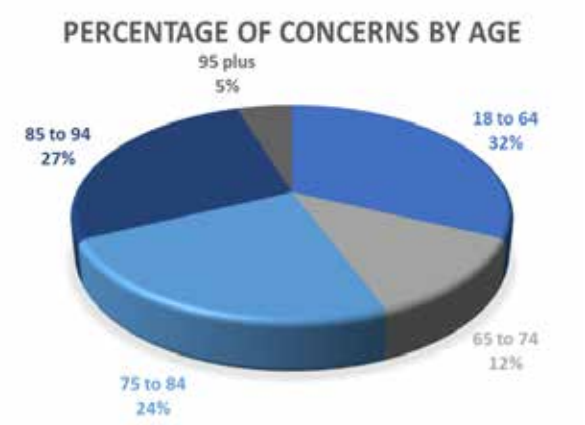
Utilising a count of completed Section 42 Enquiries, and allowing for multiple recording of abuse, the most common category of abuse in Gateshead continues to be Neglect and Acts of Omission which represented 39.4%. This was followed by Physical Abuse (17.3%) and Financial and Material Abuse (12%).

The percentage of Financial and Material Abuse cases has increased by 4.5% from the 7.5% in 2021/22. This information has prompted the QLP sub-group to prepare to undertake a case file audit to understanding the reasons behind this increase.



Age

In Gateshead, 32% of concerns were raised for adults aged 18 to 64. This is large increase from 2021/ 22 when this was 19.9%. The introduction of the Adult Concern Decision Making Tool may have had an impact on this figure as this has been widely used within residential and nursing homes.



Deprivation of Liberty Safeguards (DoLS)

For the period April 2022 to March 2023 Gateshead Council received 2246 Deprivation of Liberty Safeguard applications. This was a slight decrease in activity from the previous financial year (2351). The demands placed on local authorities in meeting statutory obligations remains high.

The highest rate for DoLS applications remains with those over the age of 65. Within Gateshead this represents 1992 applications (88.7% of all applications) for those aged under 65 and 254 (11.3%) for those under 65.

There were 384 applications which have not been authorised, due to various standard reasons. The primary reason for non-authorisation of a DoLS was down to a 'Change in Circumstances', which took place in 257 cases.

Provider Concerns

The number of provider concerns reduced to 237 in 2022/23 from 456 in 2021/22, with Medication remaining the highest reason at 21.3%. Staff issues remain high at 19.5% and this is consistent with the information around difficulty in recruiting staff in the health and social care sector. Residential and Nursing care remain the highest type of concern at 47.7% but this is decreased from 54.4% in 2021/22.

The information could also be representative of the implementation of the Adult Concern Decision Making Tool this is being widely used within residential and nursing homes.

Learning from Safeguarding Adults Reviews (SARs)

Gateshead SARs

The SARCC Group is responsible, on behalf of the Gateshead SAB, 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.

During 2022/23 the SARCC received 7 Safeguarding Adult Referrals, none progressed to mandatory SAR:

Referral 1

The young man was 26 years of age when he died in the Freeman Road Hospital in Newcastle. He had significant health issues and complex needs, having suffered significant physical harm following an overdose in 2014, this resulted in kidney and brain damage. He had a diagnosis of Asperger's, as well as psychosis, Cluster B Personality Disorder Traits, and a learning difficulty.

He was cared for by family members and due to not previously tolerating social situations well, including hospital visits, he received kidney dialysis at home. The family had been provided with carers assessment in the past.

He was admitted to the QE hospital on 13th March 2022 and subsequently transferred to the RVI in Newcastle on 19th March 2022 with scurvy, severe malnutrition and emaciation which required intensive care treatment. Significant resistance and behavioural issues made provision of essential ongoing medical treatment complex.

On 20th March 2022 a DNACPR was put in place, and he was transferred from the RVI to the Freeman Hospital in Newcastle. He passed away on 14th April 2022 with his Mam and sister present.

He had been the subject of a S42 enquiry in 2020 following admission to hospital. He had been brought into Freeman Road Hospital unconscious in a wheelchair by his sister. He was noted to be unkempt with dirty hands and fingernails responding only to pain. He was Hyperkaliaemic and suffering from septic shock he was taken immediately to ITU.

This S42 enquiry was closed as it was felt that his family had been anxious about the risk of C-19 infection in hospitals. The family had contacted professionals to seek support and appeared to be trying to find the balance between seeking help and taking his previous wishes and views into account to remain at home or to go to a hospital that he trusted. Their actions appeared to be borne of anxiety and fear and possibly a lack of understanding about how poorly he was, rather than from an intent to prevent access to medical treatment or to cause harm. A robust risk management plan was provided for the family to follow.

Partner agencies were asked to provide information on any contact they had with this young man or his family to enable the SARCC group to consider if the actions from the previous S42 enquiry were taken forward, if they were reasonable and achievable and if partners worked in his best interests around his mental capacity in relation to medical treatment, attendance at hospital and medical appointments.

SARCC Recommendation: The case did not meet the criteria to progress to a mandatory SAR as there was no evidence to link abuse or neglect to the death. The group felt that there was learning which could be taken from the case in relation to mental capacity and the use of multi-disciplinary meetings. The learning review is being drafted by partners and the actions will be progressed by the QLP Subgroup.

Referral 2

See Safeguarding Adult Review Interactive Workshops P12

Referral 3

No Further Action

Referral 4

This lady was found deceased in her flat by her father on in September 2022. She had a history of chaotic substance misuse, self-neglect, lack of self-care resulting in deterioration in health, a frequent caller to emergency services and non-engagement in treatment and care. She was 43 years old.

She had suffered a stroke in the past and struggled verbally to communicate and move around physically, she had mental health problems and several physical illnesses. She had a package of care and was open to the Mental Health Team at the time of her death. She was known to be a frequent call to emergency services.

SARCC Recommendation: See Referral 7

Referral 5

This lady passed away at the age of 47, following a cardiac arrest. She had physical disabilities resulting from an injury 20 years previously, which eventually resulted in her right leg being amputated below the knee. She was wheelchair bound, had a prolapsed disc in her back, could not weight bare, used equipment to aid her mobility, she had contracted septicaemia in her hands and feet in November 2020 and had her right hand amputated at the wrist.

She lived with her elderly mother who was her main carer in a two-bedroom bungalow, although it was noted that rehousing to a larger property was necessary to meet her long terms needs.

The case was discussed at the SARCC group with the main areas of concern being around the lady's mental capacity and her ability to understand the impact of her refusal of care on her health and her mother's ability to adequately carer for her. There was some evidence of self-neglect but due to the lady's capacity it was deemed to be her choice to refuse personal care.

SARCC Recommendation: The case did not meet the criteria to progress to a mandatory SAR as there was no evidence to link abuse or neglect to the death. The group felt that there was learning which could be taken from the case in relation to mental capacity, self-neglect and the ability of carers to provide the level of care necessary for relatives. The learning review has been drafted by partners and the actions will be progressed by the QLP Subgroup.

Referral 6

This was 46-year women who died at the Queen Elizabeth Hospital. She had a learning disability and was known to GHFT, CNTW and Gateshead Adult Social Care.

The case was referred to LeDeR (Learning from lives and deaths – people with a learning disability and autistic people), as the concerns raise related to a single agency and the death was not as result of abuse or neglect. The findings from the LeDeR have not yet been published.

Referral 7

This gentleman was found dead in his home in October 2022 he was 51 years old. He had a history of alcohol dependence. He was diagnosed with acquired brain injury from his alcohol use.

He had been living in Scotland, and while there Edinburgh Council had guardianship of him and he was placed in Abbeymoor Neurological Care Centre, Gateshead under a DOLS. He asked the court to rescind his DOLS. The DOLS medical assessor assessed him in May 2022 and deemed him to have capacity, with no cognitive deficits. They could not find any symptoms of a major medical disorder, noting he displayed some traits of Cluster B personality disorder (specifically narcissistic). Staff at Abbeymoor, the BIA, and the DOLS doctor all agreed he had capacity to make decisions about health, welfare, and residence, and said "any unwise decisions should be interpreted as a result of personality traits rather than as the consequence of a mental illness."

He consistently refused to accept any form of support to address his alcohol use. At the time of his death, professionals had not been able to persuade him to accept the referrals into treatment services and he had not managed any prolonged periods of abstinence since his discharge from a care setting in May 2022, his level of alcohol abuse had been described as a considerable risk to his health.

SARCC Recommendation: It was agreed that Referrals 4 and 7 should form part of a thematic review into vulnerable dependent drinkers. This work is being progressed via a task and finish group who have agreed the terms of reference for the review. An independent author will be appointed, and this work will feed into the development of services specifically to support vulnerable dependent drinkers.

Partner Updates

Adult Social Care

Quality Assurance

In October 2022 in preparation for the CQC Assurance inspections Gateshead Adult Social Care took part in a sector led improvement exercise. The CQC draft assurance framework allowed the service to assess themselves on how well they were performing against their duties under Part 1 of the Care Act 2014. This included Sections 42-43: Safeguarding enquiries and Safeguarding Adults Boards. The evidence was reviewed by an independent consultant who provided feedback on the areas of good practice and areas for improvement. ASC has developed an action plan to provide a structured approach to the areas which require improvement and is supporting actions for the SAB within this plan.

Prevention

The Gateshead Safeguarding Adults Team continue to support the delivery of multi-agency safeguarding training on behalf of the Board alongside representatives from partner agencies. (See page 18 & 19 for further information). The team have been instrumental in reviewing and refreshing the Level 1 and 2 training courses and reinstating the Level 3 course on undertaking enquiries which has been missing from the programme for several years.

The Safeguarding Team Manager and ASSET Team Manager have developed training in Mental Capacity and Executive Dysfunction and piloted the course early in 2023. This provided further insight into factors to consider in relation to mental capacity assessments when working with people with multiple complex needs often linked to alcohol or substance misuse. The success of the pilot session has led to further session being planned for the coming year.

Gateshead's ASSET Team worked in partnership with Tyne and Wear Fire and Rescue Service on a case (See page 38) involving a gentleman who was involved in 3 home fires and required dedicated, consistent and a multi-agency approach to ensure he was kept safe. This was recognised by the SAB as an excellent example of multi-agency working.

Communication and Engagement

The Safeguarding Adults Team actively supported Safeguarding Adults week in November 2022. The team staffed the safeguarding stall in the Civic Centre foyer during the week and supported the SG Champions session which focused on organisational abuse and learning from SARs.

Northumbria Police

Quality Assurance

Northumbria police have robust systems in place to ensure quality, including a triage system within the Multi Agency Safeguarding Hub.

Force wide "Vulnerability Matters" training was rolled in 2022 and continues with all new recruits and ongoing refresher training to our front-line staff. This training supports our officers to take a trauma informed approach to dealing with vulnerability and assist officers to identify vulnerable adults in the community. The force ensures a focus on vulnerability and that Protecting the vulnerable is front and centre of our force response. In addition, we are providing bespoke training sessions to our force control room call takers to ensure they can recognise and respond to vulnerability at the first point of contact and get it right. All our leadership courses for newly promoted Sergeants and Inspectors also includes an input on the strands of vulnerability which includes vulnerable adults.

Right Care Right Person

Northumbria Police are following national best practice and implementing Right Care Right Person (RCRP). This will reduce longer term demand by ensuring the public are directed to the right agency at the first point of contact. Since implementing the initial stages and triage process in January 2023 445 missing incidents have not been deployed to, freeing up officer's time to focus on higher risk incidents.

This will continue over the next year where we look to roll out a consistent version of RCRP nationally. We are currently awaiting a national partnership agreement at government level which will agree the threshold of risk for calls for service which police need to attend.

Throughout this implementation we have maintained close working relationships with our partner agencies including our mental health trusts, hospitals, and social care to ensure that we will only withdraw from some of these calls for service when they are ready and equipped to step in to support the individuals involved.

The second phase of RCRP is our hostel policy which went live on 12th June after partnership consultation. This again should reduce demand by ensuring we are responding to missing reports where there is a critical concern for the person. This policy has a robust triage system and a quality assurance follow up.

Communication and Engagement

We continue to work closely with the multi-agency partnerships and have shared learning and training over the last year in relation to the growing concerns of children and young people in the transitional period involved in serious youth violence. Our multi agency exploitation hub has attended partnership CPD days to deliver inputs on exploitation and this offer continues to be extended to support the understanding and identification of exploitation.

Through Operation Pecan we have delivered inputs on urban street gangs and continue to work with our partners to develop a focussed deterrence approach.

Operational Practice

Throughout 2022 our professional standards department delivered inputs to partners on abuse of position, relating to officer's relationships with victims and witnesses and encouraged partners to consider their own protocols and processes in relation to their own staff.

Mental capacity

Northumbria police continue our close working relationship with Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW) to operate the Street Triage team which is a mixed team of police and mental health nurses. Over the course of the last 12 months with the implementation of RCRP we have utilised the expertise of the street triage officers to spend more regular time within our control room to offer live time advice to call handlers.

We continue to offer regular training to our frontline staff regarding the application of the Mental Capacity act.

North-East and North Cumbria Integrated Care Board (NENC ICB)

The Newcastle Gateshead Clinical Commissioning Group (CCG) transitioned to NENC ICB on 1st July 2022 with the structure and governance arrangements being formalised at Executive Board Level. Richard Scott was appointed as Director of Nursing for the North Integrated Care Partnership (ICP) in December 2022. There is now a Safeguarding Executive meeting chaired by the Chief Executive Nurse which facilitates escalation of safeguarding issues to the ICP. Several additional posts have been appointed to, including an Assistant Director of Nursing for Newcastle Gateshead, having oversight of safeguarding for the North. This development will support the safeguarding agenda throughout the region.

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 Integrated Care System (ICS). A recent review of members by survey, to continue with the forum as an established network for health professionals had a positive outcome, the forum is well attended from all areas.

Prevention

Training for Primary Care staff has continued with sessions being provided online and available as a resource on the GP Team net, this includes sharing of learning from Case Reviews and promoting good practice from recommendations. Several requests are now being received from individual GP practices for Face-to-face sessions which is being reviewed in line with resource availability.

Communication and Engagement

The ICB Safeguarding Team continue to provide support and work collaboratively with multi-agency partners, including attendance at the Safeguarding Adult Broad subgroups and promotion of shared learning from reviews. The Designated Nurse for Safeguarding Adults is currently Chair of the Safeguarding Adults Review and Complex Case Subgroup (SARCC).

Partnership working includes involvement with projects supporting asylum seekers, hate crime prevention, Prevent and Safer Community Boards and Domestic Abuse Local Partnership Board.

Operational Practice

Given the significant increase in the number of care home concerns and issues identified during Covid the ICB Safeguarding, and Quality Teams have also been working with the Local Authority in Gateshead to develop an approach to organisational safeguarding which is intended to pick up concerns at an earlier point so that homes can be supported without the need to escalate concerns through the Serious Provider Concerns process. Linked to this work the ICB has scoped out an approach which builds on the multi-agency approach with GPs and will aim to strengthen communication between the care home link GP and Local Authority Safeguarding.

Mental Capacity

Liberty Protection Safeguards (LPS) were due to be implemented from April 2022, following further delays it was announced on 5th April 2023 by the Department of Health and Social Care that the implementation of the Liberty Protection Safeguards (LPS) The Mental Capacity (Amendment) Act 2019 will be "delayed beyond the life of this Parliament" (therefore likely beyond Autumn 2024) The ICB will continue to support the improvement of and training in Mental Capacity Assessment for the current DoLs (Deprivation of Liberty) system.

Gateshead Health NHS Foundation Trust (GHNFT)

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.

Managing Demand

The trust has faced some challenges during 2022/ 23, including an increase in activity and complex referrals, an increase in care needs, and a lack of care packages and placements within residential and nursing homes. This has resulted in delays in discharges and not being able to discharge patients. Despite these challenges we have still managed to prioritise and maintain a high-quality service for the Trust.

Staff have continued to raise concerns on 1152 occasions relating mainly to domestic abuse, neglect, self-neglect, physical abuse, and financial abuse. Of these concerns 700 were shared with the local authority. The concerns that were not shared with the local authority were managed and addressed within the hospital, working closely with wards and departments, including Patient Safety, the Children's Safeguarding Team, Housing, Psychiatric Liaison and Security.

Domestic abuse remains a high priority with 314 domestic abuse concerns raised between April 2022 and April 2023, compared to 374 the previous year with an increase in the number of complex cases. The domestic abuse concerns included 30 staff referrals, which is lower as the 37 received in the previous year.

Communication and Engagement

Working in partnership remains an important part of the Safeguarding Teams work with such complex cases including self-neglect, substance misuse and complex health needs. The team continue to play an active role and contribute to various multi-agency meetings, Safeguarding Adult Reviews, 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.

Operational Practice

Over the past year we 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. Training will continue to be priority and working in partnership with our partner agencies. **See Case Study on page 33.**

Mental Capacity

The Trust continues to raise awareness of the application of the Mental Capacity Act and continues to recognise the challenges in the use of the act for practitioners. There remains a focusing on training compliance though the E-learning package of learning which is available across the trust.

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.

The Safeguarding team review, monitor and report all uses of the DoLS throughout the Trust. Between April 2022 and March 2023, the Trust had 698 DoLS applications submitted. The submission of applications has seen a year-on-year increase with 548 applications in 2021-2022 and 420 applications in 2020-2021.

Neglect and Self-Neglect – Case Study

Gateshead Health NHS Foundation Trust

Miss A lived at home with her father and her brother, she has a diagnosis of a learning disability and ongoing health concerns. A safeguarding concern was raised whilst in A&E on her admission into hospital due to:

- Learning Disability.
- Vulnerable adult.
- Patient arrived in A&E with Cellulitis.
- Patient denied having any contact with her GP.
- Patient appears to be unkempt, strong-smelling odour, incontinent of faeces, excoriated skin.
- Concerned for patients' wellbeing, health, and her dignity.
- Father and brother helping to care and support patient.

During hospital admission, there was joint working between the Safeguarding Team and the Learning Disability Specialist Nurse to establish vulnerability and care needs to facilitate safe discharge and identifying any emotional and physical support.

During admission Miss A began to refuse to mobilise; choosing to be doubly incontinent which then resulted in further moisture damage. Capacity was assessed in relation to her hospital admission. It was agreed that a DOLs was not required, however when Miss A began to refuse treatment, her capacity was re-assessed adapting communication to suit her needs.

It was established that Miss A did not have capacity to retain information in relation to treatment but understood why she was in hospital. Therefore MCA 1&2 for treatment was put in place; guidance from the MHA Lead in relation to frameworks was advised.

A best interest decision was made for all treatment to be given. Collaboration with Miss A was key to help her understand why intervention was needed. It was agreed that two hourly positional changes were to be implemented to prevent any further pressure damage; the tissue viability nurse (TVN) provided support.

Occupational Therapy and Physiotherapy were involved to support Miss A with encouragement to mobilise. Emotional support was provided in relation to low mood and to identify her wishes. Multi- agency working took place to discuss appropriate discharge plans to ensure a safe discharge.

At the point of writing, Miss A is ready for discharge and is awaiting a suitable care package and equipment. A referral to the community Learning Disability Team has been made to support with her emotional and physical health. This is a positive outcome and professionals worked together to ensure her needs were met and a safe discharge was arranged.

Probation

Prevention

Safeguarding training is a priority for the Probation Service with mandated training now being linked to staff pay progression via the annual competency-based framework. Records indicate >85% of staff have completed the training, the remaining deficit is made up of staff on long-term sick, maternity or new staff recently joining the service who have not reached that section of their training.

Quality Assurance

In addition to ensuring staff of all grades have completed relevant Safeguarding and Domestic Abuse training, all cases where there are relevant flags raising concern are subject to additional checks. This is an area of high interest for Probation Service, with regular management oversight to ensure this practice is both completed in a timely manner and is being embedded within teams.

Operational Practice

Staff completed relevant referrals to Safeguarding Services where concerns are raised, attend Section 47 meetings as required, ICPC and ongoing child-safeguarding meetings whether this is child protection or child in need.

In October 2022, South Tyneside and Gateshead Probation Delivery Unit underwent HMIP inspection where 100% of cases at sentencing stage had relevant safeguarding enquiries undertaken. Partnership working and safeguarding were highlighted as an area of strength within the PDU.

Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust

Prevention

Significant effort has been made in delivering the Level 3 Safeguarding Training across the organisation. Training sessions now run three times per week and substantial progress has been made. CNTW Academy continues to offer this training via the Microsoft Teams Platform on a weekly basis to ensure consistent compliance. A Vulnerability not age awareness session will be developed and delivered. There has been a sustained increase in safeguarding reporting demonstrating an increased awareness of safeguarding and public protection issues in Trust staff.

MCA learning themes have been shared with Trust MCA lead.

CNTW Domestic Violence training package was development by Named Nurses utilising learning from local reviews. This so far has been delivered to 300 plus staff and will continue to be rolled out via the SAPP team. CNTW have shared the learning from Domestic Homicide Reviews undertaken within the year with particular focus on addiction services who have received the Trust DV training.

Quality Assurance

Reviewed the learning from Joanna, Jon and Ben SAR and developed a Quality assurance document to provide assurance against the recommendations of the report. The assurance document will be provided to SAPP group in 2023-2024 by locality groups.

A review of the demand and capacity of the SAPP team has been undertaken and the team structure and activities reviewed leading to additional resource at Named Nurse level. Continue to review demand and capacity in light of sustained increase in reported incidents and review processes and approaches as necessary to ensure this demand can be met whilst maintaining quality.

Further work is to be undertaken to support accurate safeguarding reporting and data capture to better inform CNTW and external partners of our Safeguarding activity and allow targeted improvement work to take place.

Continue to engage with the PSIRF Implementation group and Safer Care / Safety leads who are reviewing and embedding the National Patient Safety strategy including the new incident reporting and review systems, to ensure that the classification of incidents retains relevant safeguarding Information to enable incidents to be reviewed, clinicians supported, and patients safeguarded.

Gateshead Housing

Operational Practice

Hoarding disorders feature heavily in self-neglect case both regionally and nationally. The links between hoarding and increased fire risk have been identified within SARs and learning reviews.

Hoarding Cases

Within the Housing Support service, we have supported 17 council tenants with a hoarding disorder within the last 12 months. 10 cases carried over from previous year, 7 new cases and 8 have been resolved through joint work with Adult Social Care and Housing.

The average length of time taken to resolve hoarding cases is 629 days, due to the time required to build trust with the customer and engage the right type of support to help them address their fears of disposing of collected items.

The main type of hoarding we have experienced relates to rubbish hoarding, with the main customer group being middle aged single men, who have never married or remained in the family home following the death of their parents.

'Less is More' – Hoarder Support Group

In collaboration with Northumbria University Gateshead Council has established a group of customers identified as having a hoarding disorder, from across the region to share personal experiences and help professionals to understand what type of support helped them to identify that they had a disorder and needed help and ultimately helped them to stop hoarding.

The group, which has adopted the name 'less is more' has met twice this year and a third meeting is scheduled in July. With four current group members, supported by staff from Northumbria University and Gateshead Council's Housing Support Service the group intends to establish terms of reference and encourage new members to join and share their experiences. Longer term the group would like to play an influential role in policy and procedural change within local authority services across the region, to support those with hoarding disorders.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

Quality Assurance

The rigorous programme of safeguarding audits have continued throughout 2022-23 to monitor safeguarding practice across STSFT. These have included MCA/DoLS policy adherence, MCA policy compliance for patients with a learning disability, safeguarding policy compliance (inclusive of routine & selective enquiry), procedural self-neglect guidance and threshold tool compliance and chaperone policy compliance. A safeguarding team service review was conducted via Survey monkey in December 2022. Findings were extremely positive.

A new model for safeguarding visibility has been implemented to increase 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 (Monday-Friday).

The safeguarding team continue to complete a daily audit of ED attendances to ascertain if there are any missed opportunities. Any learning to arise from missed opportunities are Incident reported. The Named Nurse attends ED Clinical Governance meetings to discuss any reported missed opportunities. The annual audit of ED attendance activity forms part of the safeguarding annual audit cycle.

The safeguarding team have undertaken joint working with ED staff to expand the asking of the safeguarding mandatory questions from initial triage and make them mandatory within Same Day Emergency Care (SDEC) documentation and within the speciality transfer letter.

Safeguarding training compliance has continued to exceed the 90% organisational target and this has been maintained throughout 2022-23. The Trust continues to exceed NHS England's 85% compliance target for WRAP Prevent training and Basic Prevent Awareness training (BPAT)

Prevention

The safeguarding team have continued to work in collaboration with multi-agency partners throughout the recovery phase and longer-term impact of the COVID-19 pandemic to ensure safeguarding measures are in place and learning is shared to support and protect adults at risk and their families. Main emphasis has been around MSP, self-neglect, fire safety awareness, trauma informed practice, mental capacity, and professional curiosity. These themes have been shared via 7- minute briefings, quarterly Safeguarding Champions forums and bi-monthly safeguarding newsletters.

Safeguarding supervision sessions have been reviewed to ensure that delivery remains impactful and meaningful. A new model for safeguarding visibility has been implemented to

increase face to face presence in areas to further support staff in their safeguarding practice and offer safeguarding supervision.

All levels of safeguarding training have been reviewed to ensure they are aligned to both adult and children intercollegiate document. Level 3 face to face "Think family" training has been amended to reflect learning from recent scoping's, SAR's, DHR's, CSPR's and learning reviews. Slido is now being used to ensure that face to face sessions are more interactive and those delivering training can obtain training evaluations in real time.

MCA training has been reviewed and STSFT now utilise the National E-Learning package resulting in MCA training now being a stand-alone package.

Communication and Engagement

A bi-monthly newsletter is shared with all STSFT employees via both the team brief and through the safeguarding champion's forum. This newsletter highlights learning from SARs/DHRs & CSPRs and incorporates any regional / local updates inclusive of 7-Minute Briefings. The newsletter is held on the Trust intranet site.

STSFT Safeguarding Team continue to be active members of local partnerships ensuring representation and contribution across all meetings & groups.

The Safeguarding Team are active participants within the Complex Adult Risk Management (CARM) meetings within the Sunderland locality and Safeguarding in Partnership (SIPT) meetings in South Tyneside.

The Safeguarding Team has worked closely with the Local Authority to understand the impact and prepare for the forthcoming implementation of LPS.

STSFT safeguarding team actively participated in Elder Abuse Day (15th June 2022), attending wards and departments to raise awareness of elder abuse.

Operational Practice

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 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. Recent DAHA feedback from both patients and staff include:

- "Thank you, I do not know what I would have done if you had not been here to support me".
- "Thank you so much you have been amazing in supporting me".
- "The DAHA on duty came down to ED and was so kind and helpful and just offered to help with anything we needed. This was so kind, thoughtful and really welcomed".

The safeguarding team have worked alongside STSFT staff to further develop body map documentation to record marks, bruises and pressure damage on admission and discharge from hospital. The body maps are now incorporated into STSFT documentation, alongside a SOP to support practitioners accessing the document.

Mental Capacity

An MCA/ LPS lead, alongside an MCA Corporate Lead have been appointed to further embed MCA into practice alongside having the skills and expertise to robustly implement LPS once finalised. Improvements have been made to the MCA recording pathway on Meditech to support staff to re-consider MCA assessment and whether a DoLS is required or needs withdrawn. Community EMIS systems have been amended to incorporate MCA assessment within community records.

Connected Voice

During 2022/23 Connected Voice undertook the following in support of the SAB Strategic Plan:

- Delivered advocacy awareness session to Safeguarding team to improve referral pathways.
- Provided training to the VCSE in Gateshead on the role of Advocacy in Safeguarding 4 times in the year.
- Provided a briefing to the SAB on Nice Guidance and duties.
- Reported on safeguarding numbers throughout the year, leading to prevention and education for individuals on reporting concerns.
- Discussed safeguarding enquiries with Safeguarding team reducing alerts made that do not meet threshold Tyne and Wear Fire and Rescue Service.

Tyne and Wear Fire and Rescue Service

Prevention

Following the rise in the number of fire deaths across the region during 2022/ 23 TWFRS have been proactive in their approach to raising awareness of fire risk. TWFRS have taken over chairing of the Regional Fire Risk Task and Finish group which is looking at the provision of information advice and guidance and highlighting the risk factors in relation to age, mobility, smoking, alcohol use, use of paraffin-based emollient creams, self-neglect, hoarding, mental health, living alone and isolation. The proposal is to develop a suite of resources and a video outlining the risks and how to keep safe.

The Safe and Well visits continue to be promoted and with the launch of the new "When to Refer" card with QR code, this is now easier than ever. The Safe and Well visits are free and will cover fire escape plans, kitchen and cooking safety, electrical safety, smoking safety and candle safety but are also used as a mechanism to build engagement with hard to reach and "at risk" people. Operatives carrying out the visits are often made aware of safeguarding issues and concerns and can be an essential link to raising concerns and supporting people during the safeguarding process. Some of the excellent work between TWFRS and the local authorities ASSET team are detailed in the case study below. The Safeguarding Champions also received a fire risk briefing in March to highlight the risks and promote the Safe and Well visits.

Operational Practice

See Case Study on page 39 and 40.

Joint Working (Fire Risk) – Case Study

Tyne and Wear Fire and Rescue Service and Gateshead Council

In September TWFRS received a 999 call to a house fire in Gateshead resulting from a Carecall monitored alarm activation. Mr D was rescued from the property and conveyed to hospital suffering from breathing difficulties. The cause of the fire was accidental, and a safeguarding referral was submitted to the local authority due to concerns for Mr D including self-neglect, alcohol issues, hoarding and mental health issues.

In October fire crews were called to a second house fire at the same address. Mr D was rescued by fire crews and required hospital treatment for breathing difficulties due to smoke inhalation. A further safeguarding referral was made with the same concerns. Due to the extensive fire damage following the second fire, the property was deemed uninhabitable. Discussions were held with the Gateshead Housing Company and Mr D was relocated to a hotel following his discharge from hospital, until a new property was secured for him. He successfully moved to his new address a short time later.

On 21 December fire crews were mobilised to a fire at Mr Ds new address. Mr D was rescued and taken to hospital for treatment which resulted in a lengthy admission. Another safeguarding referral was submitted, and a request was made for an emergency meeting to be held due to the fact this was an extremely vulnerable individual; elderly, lived alone, smoker, alcohol issues. Mr D had been involved in three significant house fires over a three-month period, on every occasion he had to be rescued by fire crews and required hospital treatment.

An urgent multi-agency safeguarding meeting was held on 22 December, further meetings led to agreements by partner agencies to carry out the following action:

- As Mr D was known to smoke in bed the existing monitored alarm was extended to include the bedroom.
- Installation of a misting system (TWFRS Ultimate Protection model) within the property.
- Joint visit by Housing and TWFRS to conduct a Safe and Well check:
  - Fire retardant bedding, throw and mat issued.
  - Referral to befriending services for Mr D due to feelings of isolation.
  - Offer of referral to address alcohol dependency, this was declined by Mr D.
  - Referral to the fall's clinic.
  - Daily welfare calls from Housing Warden.

Between January and February Mr D withdrew his engagement with housing and refused daily calls from the warden. He also refused to engage with the Gateshead Recovery partnership for support with his alcohol dependency and withdrew consent for the installation of the monitored smoke alarm in the bedroom.

Continued on next page

Further safeguarding meetings were held to discuss the ongoing and increasing concerns from partners, particularly the high fire risk. Partners worked together to re-engage Mr D and because of hard work and persistence from all partners the misting system and smoke alarm were installed.

A further fire incident has occurred in Mr Ds home, however the heat detector activated causing the misting system to deploy preventing both serious damage to the property but most importantly injury to the occupier.

This case study shows how a high risk and vulnerable occupier can be protected by partner agencies working towards a common goal. Working together with determination and drive. This is an excellent example of partnership working by multiple partners to achieve a positive outcome and highlights potential best practice moving forward. Following this latest incident Mr D is currently engaging with his social worker and other partner agencies.