Annex A-1:

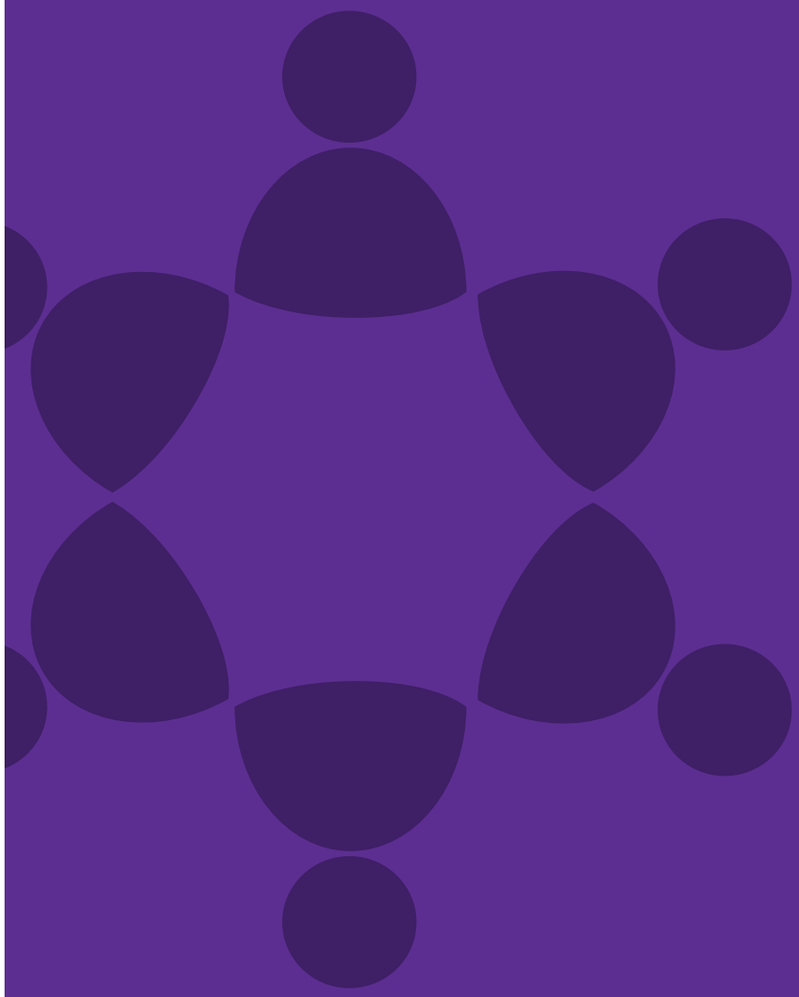
CITY OF YORK
Safeguarding Adults Board

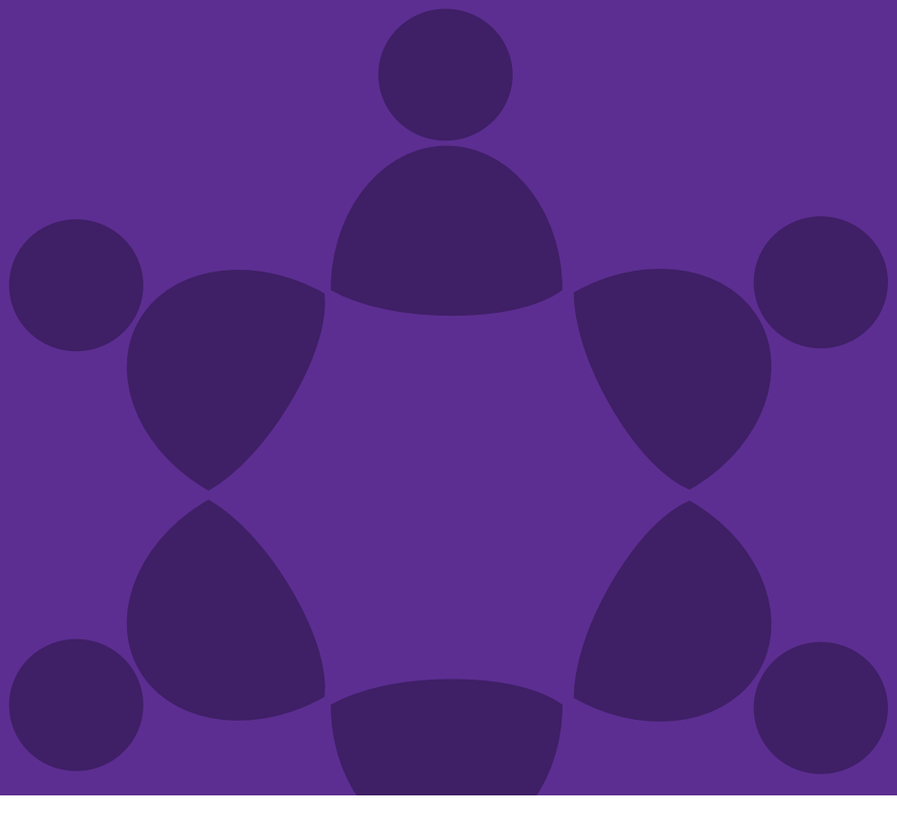
Annual Report 2024-25

OUR VISION

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

For more information visit: safeguardingadultsyork.org.uk





Contents

Foreword

I have been the Independent Chair of the City of York Safeguarding Adults Board (CYSAB) since July 2024, taking over from the previous Chair Tim Madgwick. I have been made to feel very welcome in York and would like to thank the partnership for embracing changes to arrangements of the Board. Considerable work has taken place to increase the membership and improve governance of the Board during 2024-25 which is demonstrated in our partner updates.

Throughout this annual report it is clear there is a real commitment to the challenge of safeguarding adults with care and support needs. I am pleased to present some of the hard work delivered by the CYSAB partners in this annual report. Partners across York continue to meet the challenge of safeguarding adults with care and support needs and show commitment to improve the outcomes for those adults' facing risks, helping to prevent abuse and neglect.

During 2024-25 we have developed our strategic priorities for the next three years and completed a Safeguarding Adults Review (SAR), working hard to embed learning and continued to work on several other SARs. We will continue to work as a partnership, and I would like to thank colleagues working to ensure the Board not just fulfils its statutory duties but also play key roles in improving the quality of life for some of the most vulnerable in our communities.

Jane Timson

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

1. About the Board

Who we are:

The City of York Safeguarding Adults Board (CYSAB) is a statutory and multi-agency partnership that leads the strategic development of safeguarding adults work across York. As specified in the Care Act, the CYSAB includes three core statutory members:

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

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

What we do:

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

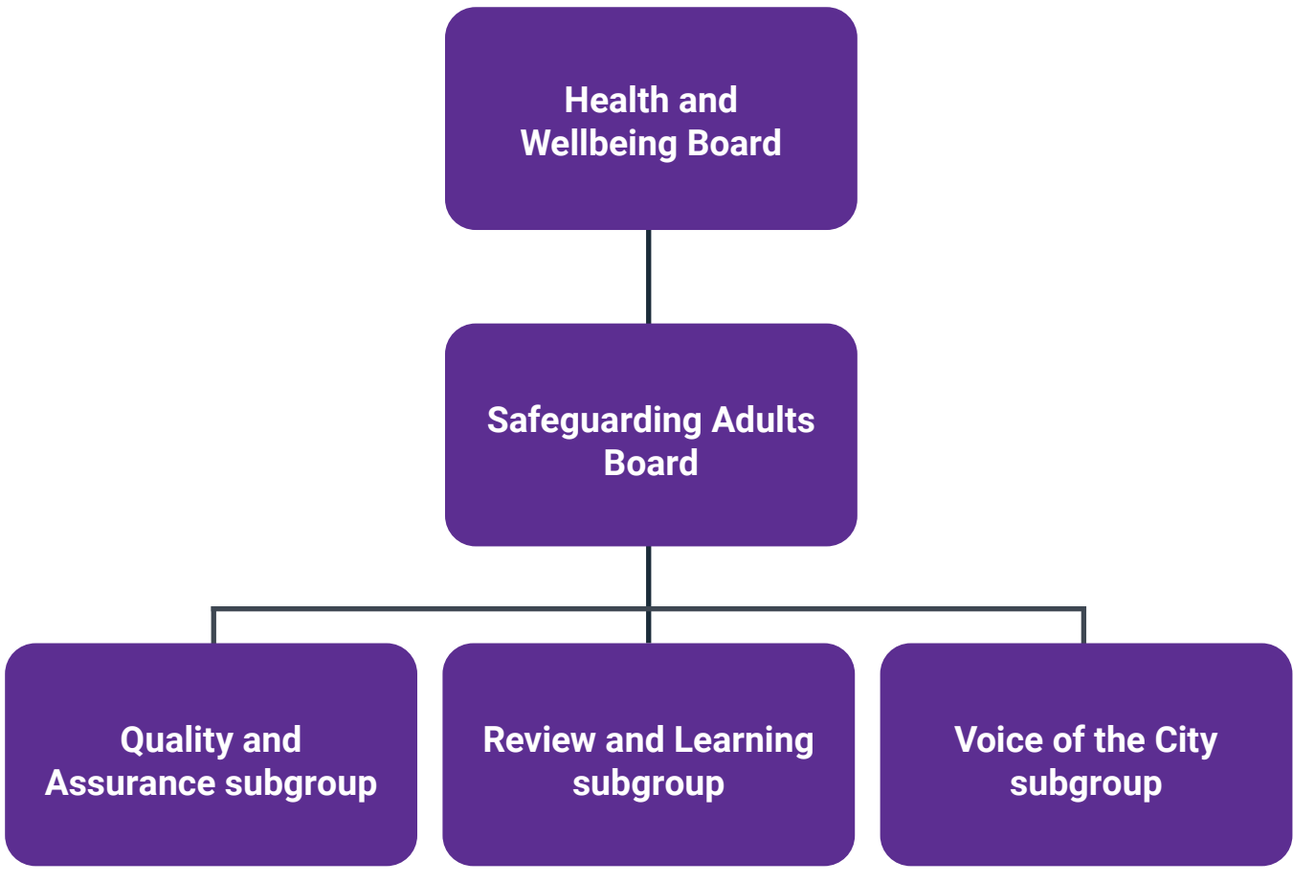
Our statutory duties:

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

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

How we function:

As a Board we meet four times a year and during 2024-25 we had four sub-groups. These were the Executive Group, Quality and Assurance, Review and Learning and the Voice of the City.



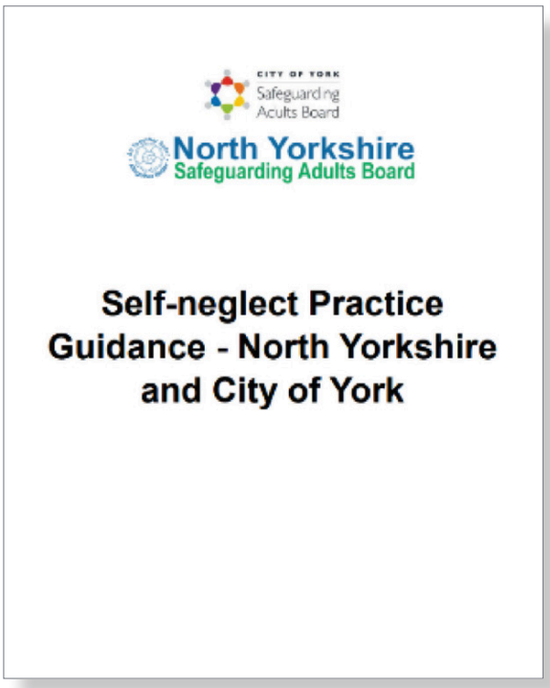
2. What the Board has achieved at a glance

CYSAB has developed a number of practice guidance resources during 2024-25 to help support partners working to support adults with care and support needs who may be at risk from abuse or neglect.

Self-neglect Practice Guidance

Self-neglect is an extreme lack of self-care. It is sometimes associated with hoarding. It may be a result of other issues such as alcohol and substance use. Engaging with the person is crucial. There is a need to offer support without causing distress, and to understand the limitations to interventions, if the person does not wish or is not able to engage.

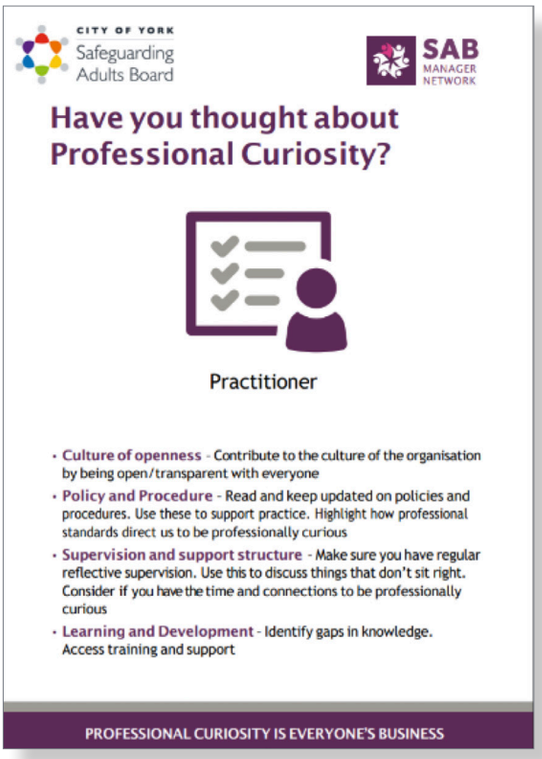
North Yorkshire and City of York SABs have worked together during 2024-25 to develop a Self-neglect Practice Guidance for all professionals working with adults with care and support needs, and their carers. Please see the link to this guidance on the CYSAB website: trixcms.trixonline.co.uk/api/assets/wynyy-cityofyork/5b3b1e5f-660b-4400-8bfd-cce2df470278/self-neglect-practice-guidance-nysab-and-cysab-june-25.pdf



Professional Curiosity Guidance

In order to support adults with care and support needs who are at risk of abuse or neglect, professionals need to be curious about the signs and symptoms of abuse and neglect. To do this effectively organisations and practitioners need to consider professional curiosity, looking beyond what they see at face value and building relationships with adults they are supporting.

CYSAB have adopted Professional Curiosity practice guidance originated from the national Safeguarding Adults Board (SAB) Managers

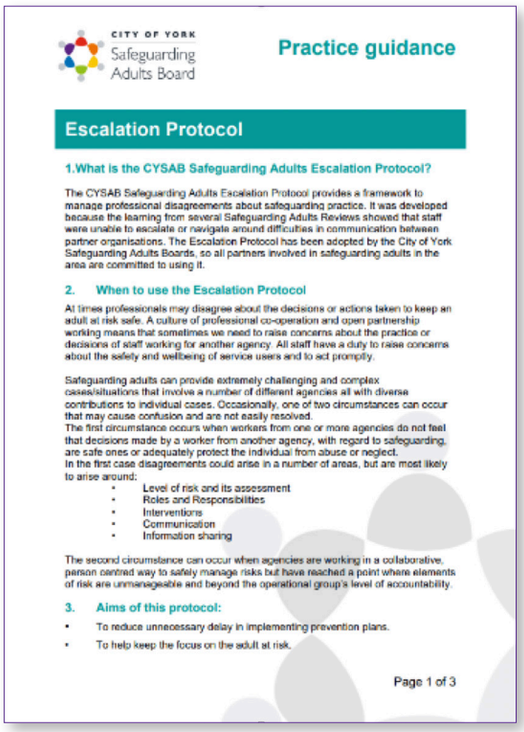


network, which considers different aspects of professional curiosity from the perspective of organisations, managers and practitioners. The guidance is easy to use and looks at how to effectively build a relationship with adults who may need a more wide-ranging set of support than first considered. Please see the link to this guidance on the CYSAB website

trixcms.trixonline.co.uk/api/assets/wynyy-cityofyork/0a3a3b8f-c73a-449d-848a-f1ffdd6c0d04/professional-curiosity-resource-june-2025.pdf

Escalation Protocol

The CYSAB Safeguarding Adults Escalation Protocol provides a framework to manage professional disagreements about safeguarding practice. It was developed because the learning from several Safeguarding Adults Reviews showed that staff were unable to escalate or navigate around difficulties in communication between partner organisations. The Escalation Protocol has been adopted by the CYSAB, with all partners involved in safeguarding adults in the area committed to using it.


CITY OF YORK Safeguarding Adults Board

Practice guidance

Escalation Protocol

1.What is the CYSAB Safeguarding Adults Escalation Protocol?

The CYSAB Safeguarding Adults Escalation Protocol provides a framework to manage professional disagreements about safeguarding practice. It was developed because the learning from several Safeguarding Adults Reviews showed that staff were unable to escalate or navigate around difficulties in communication between partner organisations. The Escalation Protocol has been adopted by the City of York Safeguarding Adults Boards, so all partners involved in safeguarding adults in the area are committed to using it.

2. When to use the Escalation Protocol

At times professionals may disagree about the decisions or actions taken to keep an adult at risk safe. A culture of professional co-operation and open partnership working means that sometimes we need to raise concerns about the practice or decisions of staff working for another agency. All staff have a duty to raise concerns about the safety and wellbeing of service users and to act promptly.

Safeguarding adults can provide extremely challenging and complex cases/situations that involve a number of different agencies all with diverse contributions to individual cases. Occasionally, one of two circumstances can occur that may cause confusion and are not easily resolved.
The first circumstance occurs when workers from one or more agencies do not feel that decisions made by a worker from another agency, with regard to safeguarding, are safe ones or adequately protect the individual from abuse or neglect.
In the first case disagreements could arise in a number of areas, but are most likely to arise around:

- Level of risk and its assessment
- Roles and Responsibilities
- Interventions
- Communication
- Information sharing

The second circumstance can occur when agencies are working in a collaborative, person centred way to safely manage risks but have reached a point where elements of risk are unmanageable and beyond the operational group's level of accountability.

3. Aims of this protocol:

- To reduce unnecessary delay in implementing prevention plans.
- To help keep the focus on the adult at risk.

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This protocols can be found on the CYSAB website: trixcms.trixonline.co.uk/api/assets/wynyy-cityofyork/35a04ac0-efb8-4a77-933b-3778ec24301f/city-of-york-safeguarding-adults-board-escalation-protocol-may-2025.pdf

Strengthened partnership working

This year, we have welcomed Department of Work and Pensions (DWP), York Advocacy Hub and Probation Service Yorkshire and Humber to be part of the CYSAB. These agencies all help bring diversity to the board, with a role in supporting adults and this has benefited the CYSAB structures and subgroups which have worked well to provide multi agency forums in which safeguarding can be discussed.

Improved Governance structures

The CYSAB recruited a new role of a SAB Business Manager during 2024-25 which has overseen a number of improvements to how the CYSAB functions with reviewed subgroup structures and increased oversight of the safeguarding adults' reviews process.

Safeguarding weeks

We ran two successful public facing safeguarding weeks contributing to local and regional learning events held online – one in June and one in November.

Maintained a public facing website

The CYSAB website has dedicated pages for public and professionals with links to practice guidance and policies, procedures, videos and 7-minute briefings. The CYSAB website also has information about different types of abuse and how to raise a concern about adult who may be suffering from abuse or neglect: safeguardingadultsyork.org.uk

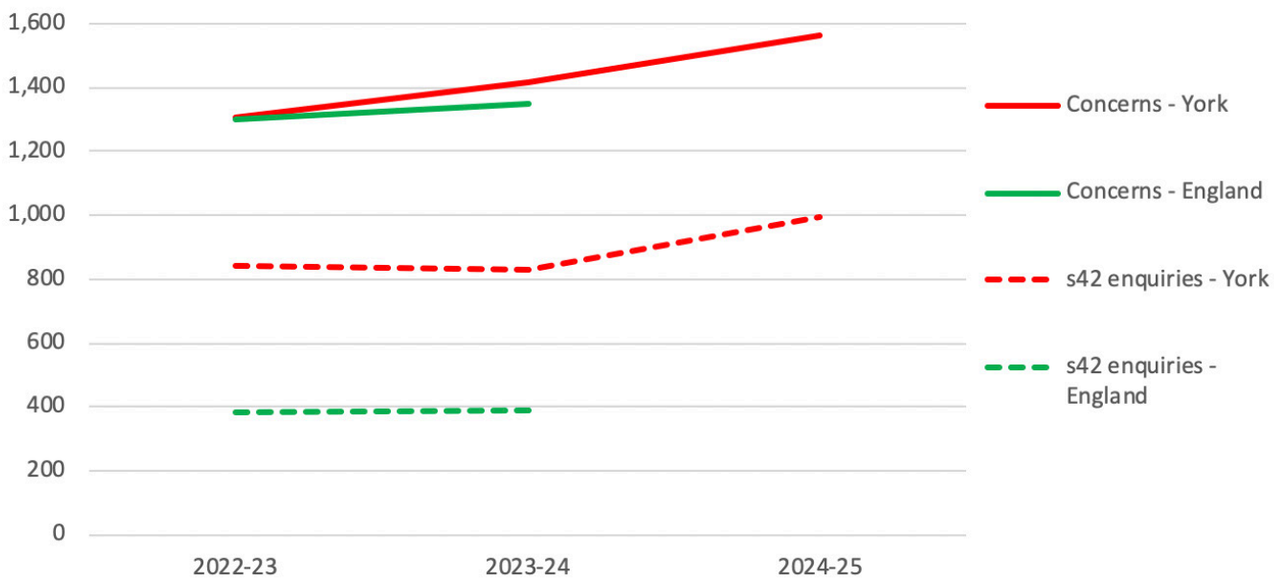
3. What does our data tell us?

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

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

Safeguarding activity over the last three years			
Safeguarding activity	**2022-23**	**2023-24**	**2024-25**
Safeguarding concerns reported	2,219	2,438	2,735
s42 enquiries completed	1,431	1,428	1,738
Other enquiries completed	12	18	10
s42 enquiries as % of safeguarding concerns - York	64.5	58.6	63.5
s42 enquiries as % of safeguarding concerns - England	29.5	28.7	Not available at time of print

Safeguarding concerns / Section 42 enquiries per 100,000 adults, 2022-23 to 2024-25



Overview:

- There has been a continued increase of over 10% in the number of safeguarding concerns received, compared with the previous year. There has been a 42% increase in safeguarding concerns reported in York since 2021-22.
- In 2024-25 63.5% of safeguarding concerns resulted in a section 42 enquiry, which is higher than the previous year. We continue to work with partners about what constitutes a 'good safeguarding referral' and direct partners to the guidance published in our on-line policy and procedures (wynyy-cityofyork.trixonline.co.uk)
- Whilst the number of individuals involved in safeguarding enquiries has remained stable, there has been a slight reduction in 'other' enquiries. In accordance with the Care Act 'other' enquiries are those where there is no duty to undertake enquiry, but the local authority deems it to be the most appropriate and proportionate response to the circumstances.
- In 2024-25, one Safeguarding Adults Review (SAR) was published. There are a number of SARs currently in progress, including a thematic review in respect of self-neglect.

Safeguarding demographics by age				
Age band	**2022-23**	**2023-24**	**2024-25**	**% change 2022-23 to 2024-25**
18-64	576	570	677	**18**
65-74	147	171	217	**48**
75-84	305	319	365	**20**
85-94	354	366	401	**13**
95+	77	106	102	**32**
Not Known	3	5	5	**67**

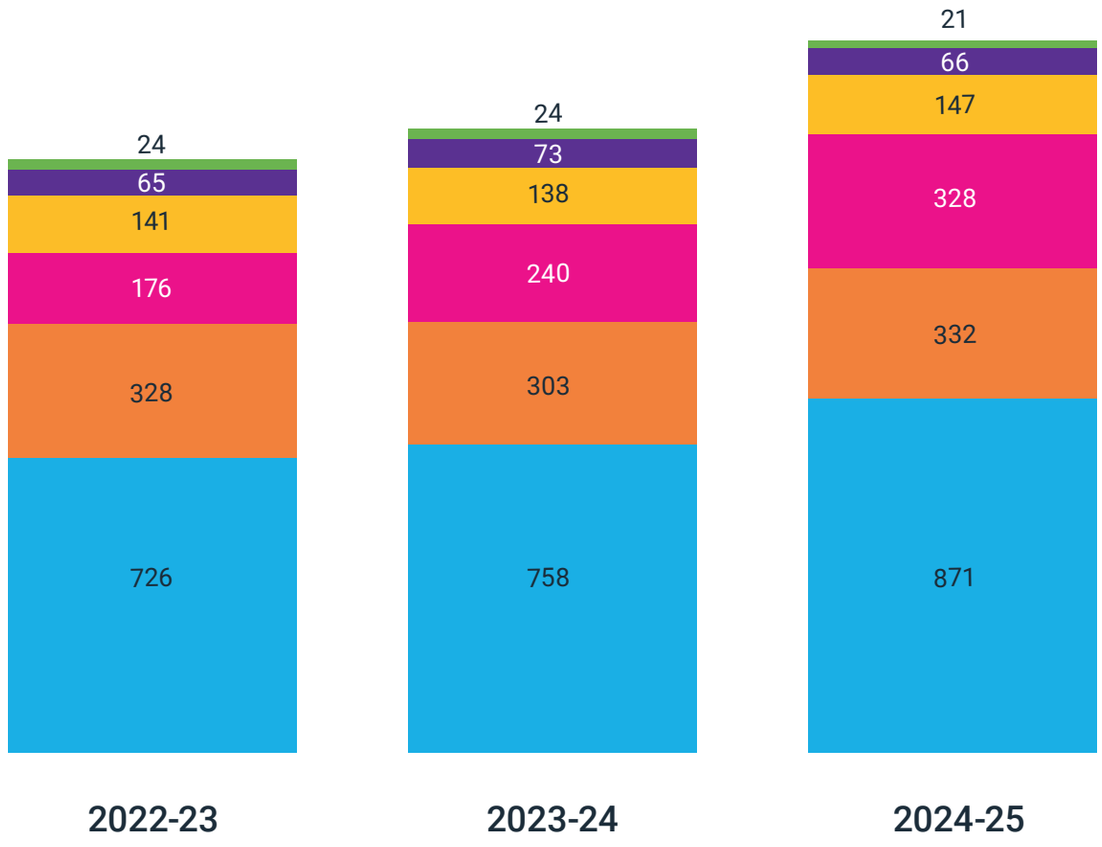
Safeguarding demographics by sex				
Sex	**2022-23**	**2023-24**	**2024-25**	**% change 2022-23 to 2024-25**
Female	548	568	667	**22**
Male	900	906	1,000	**11**
Not known	14	63	100	**614**

Safeguarding demographics by ethnic origin				
Ethnic Origin	**2022-23**	**2023-24**	**2024-25**	**% change 2022-23 to 2024-25**
White	1,323	1,354	1,488	**12**
Other	22	39	47	**114**
Refused/Unknown	117	144	232	**98**

There has been an increase in concerns in recent years for those aged 65-84 and 95 or over, and by females. Although the number of concerns reported by ethnic minorities has increased, they still make up a relatively small proportion of all concerns, in line with the proportion of adults in the York population that have ethnic minority backgrounds.

Primary support reason (PSR)

Individuals involved in safeguarding concerns by PSR, 2022-23 to 2024-25



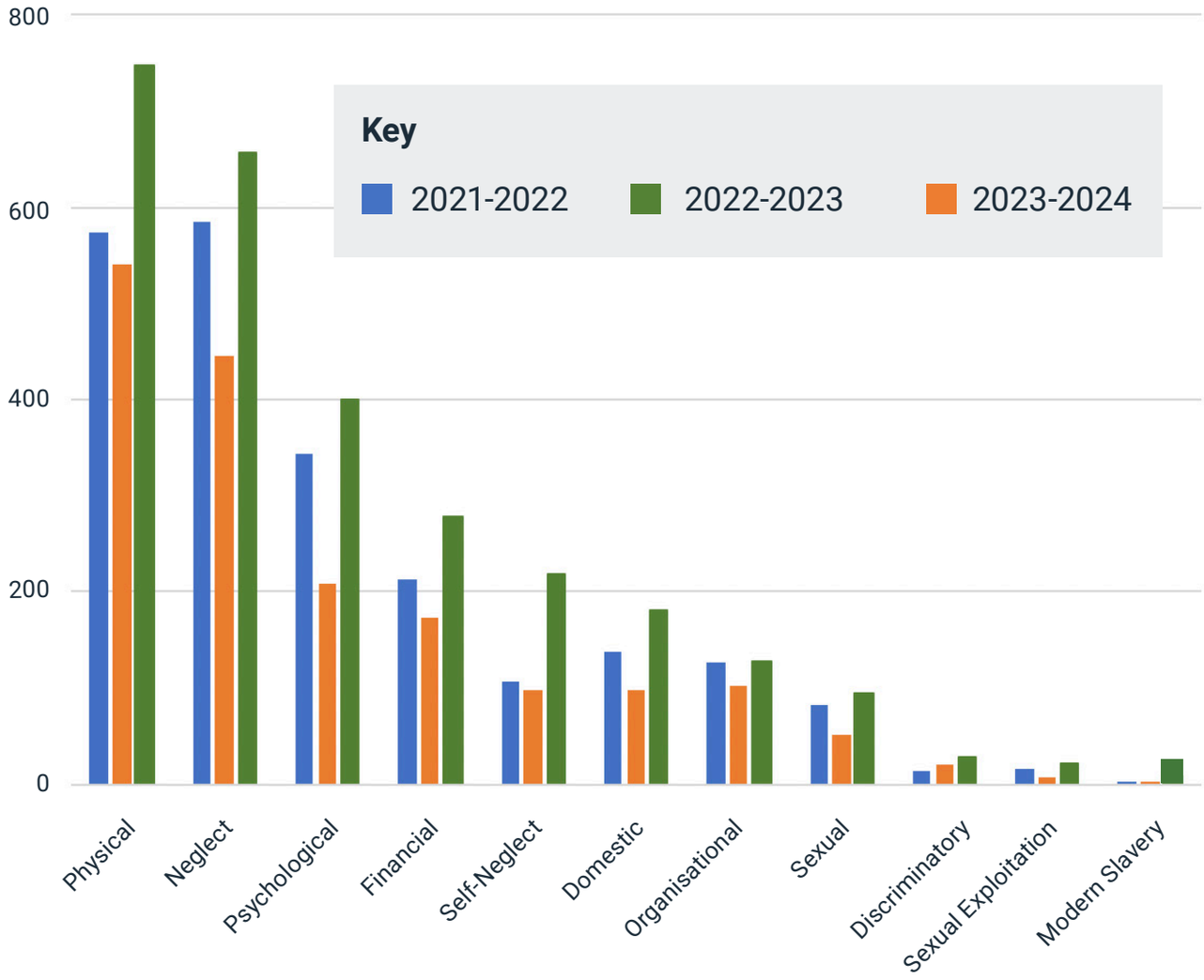
Key

- not known
- sensory support
- memory and cognition
- learning disability
- social support
- mental health
- physical support

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

Type of abuse investigated by Section 42 enquiries

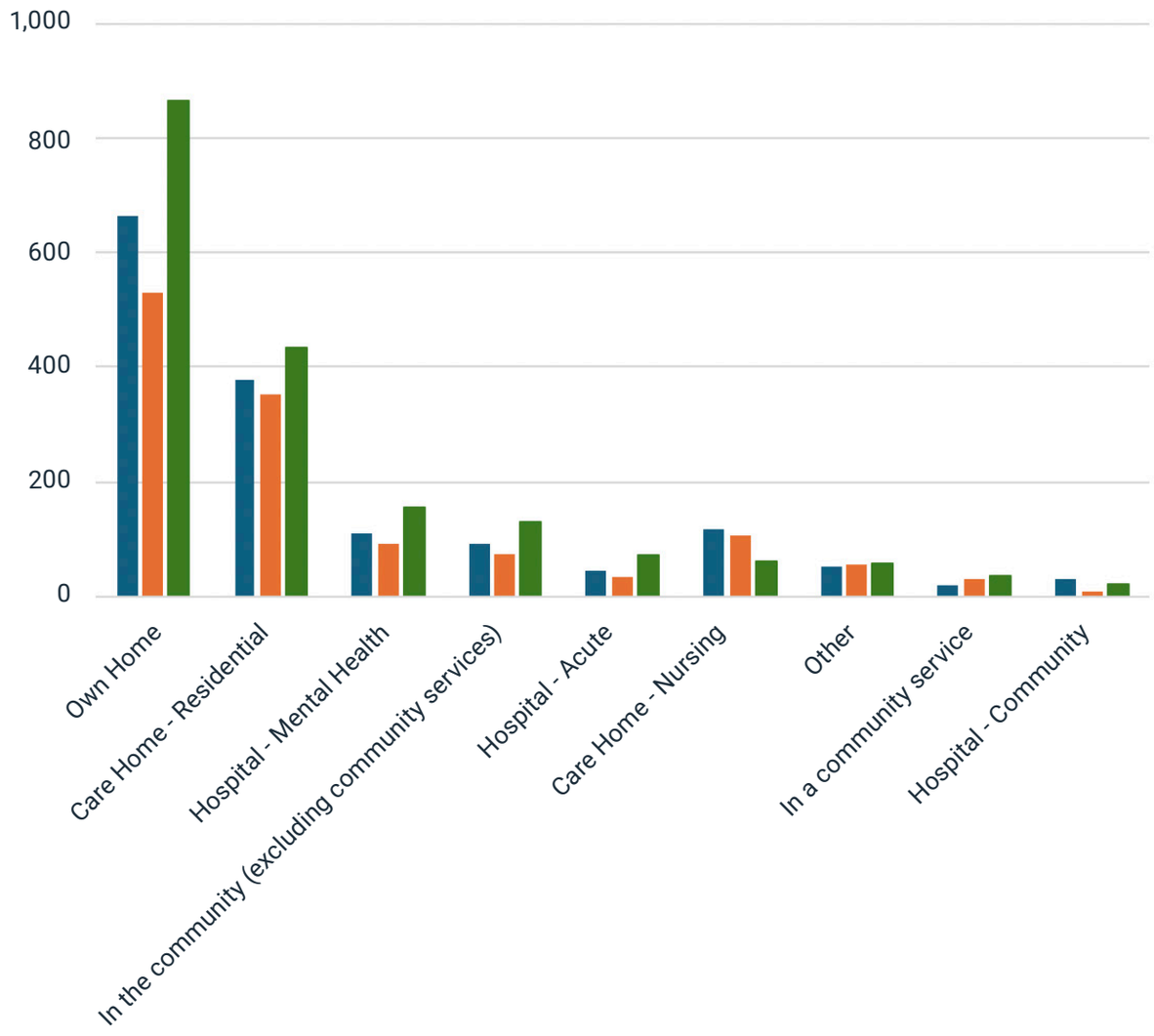
Section 42 enquiries by type of abuse investigated, 2022-23 to 2024-25



- Physical abuse was the most common type of abuse recorded in 2024-25. whereas in 2021-22 and 2022-23 this was neglect.
- There has been targeted work undertaken to ensure multiple abuse types are being captured appropriately, this is reflected in 2024-25 figures as there has been an increase in all types of abuse.
- The largest proportionate increase in types of abuse was in respect of self-neglect. Modern slavery also saw a large percentage increase from 2 in 2023-24 to 9 in 2024-25

Location of abuse in Section 42 enquiries

Section 42 enquiries by location of abuse investigated, 2022-23 to 2024-25



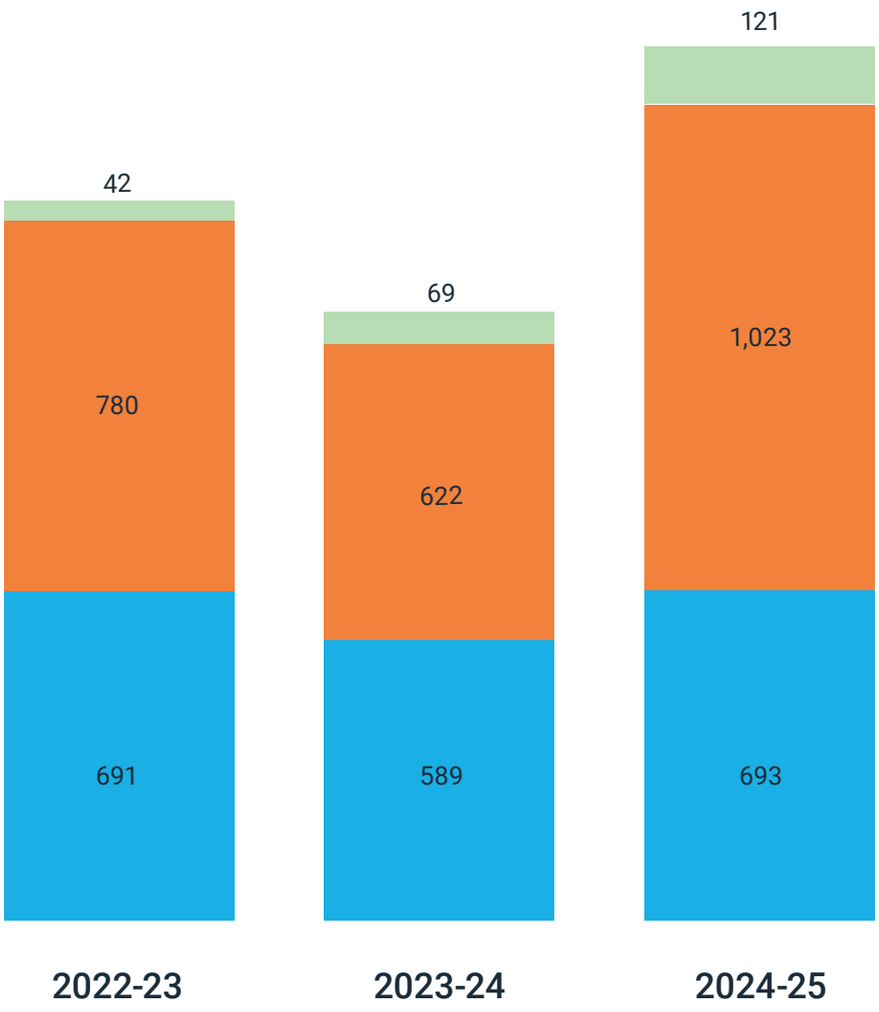
Key

2021-2022 2022-2023 2023-2024

An individual's "own home" continues to be the most common location of abuse, followed by a care home or a mental health hospital.

Source of risk

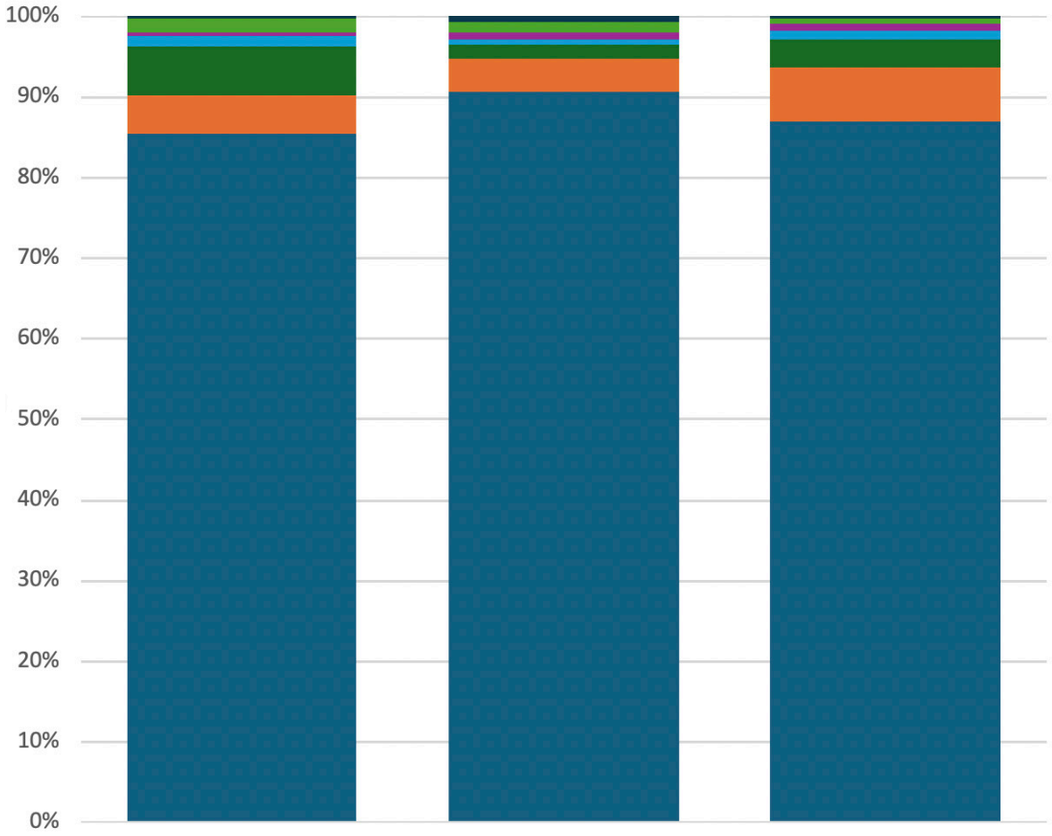
Section 42 enquiries by source of risk, 2022-23 to 2024-25



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

Risk outcomes

Outcomes from Section 42 assessments, 2022-23 to 2024-25



Key

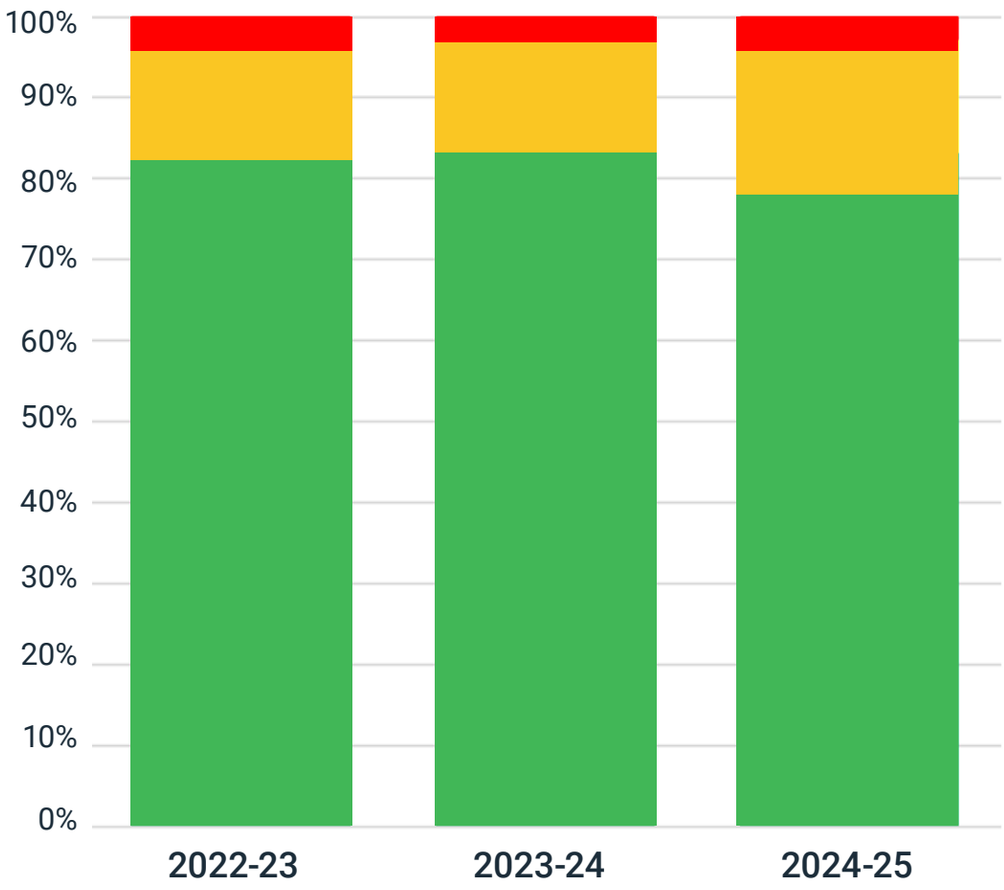
- no risk identified, no action taken
- risk identified, no action taken
- risk assessment inconclusive, no action taken
- risk assessment inconclusive, action taken
- enquiry ceased at individual's request, no action taken
- risk identified, action taken

A risk was identified, and action taken in 87% of enquiries during 2024-25, which represents an increase compared to the previous two years.

There is an increase in risk assessment inconclusive, but action taken in 2024-25.

Where a risk was identified this was reduced in 77% of cases and removed in a further 20% of cases; in only 3% of cases did the risk remain during 2024-25.

Change in risk where identified by Section 42 enquiry, 2022-23 to 2024-25



Key

remained removed reduced

Making safeguarding personal

92% of individuals involved in section 42 enquiries were asked to express an outcome.

64% of individuals expressed their outcomes when asked.

43% lacked capacity to be involved in Section 42 enquiries.

4. Our strategic priorities for 2023-25

Within CYSAB's strategic priorities for 2023-25, we have embedded the six principles as set out in the Care Act.

The six principles	
Empowerment	Promoting person-led decisions and informed consent.
Protection	Support and protection for those in greatest need.
Prevention	It's better to act before harm occurs.
Proportionality	Proportionate and least restrictive/intrusive.
Partnership	Working together.
Accountability	There is a multi-agency approach for people who need safeguarding support.

Strategic priorities

1. To develop an all-age approach to safeguarding which maximises the potential and skills of teams and reduces the risks to young people transferring between services

2. Preventing abuse and neglect by adopting best practice, locally, regionally, and nationally. Ensuring that all the learning from SARs are implemented in a timely manner.

3. To ensure that commissioners and service providers ensure a consistent high quality of care.

4. To ensure the person is clearly heard and create opportunities for an approach where co production is at the heart of future safeguarding policy.

5. Agencies (like health and social care providers) must prove they provide good quality services and be asked to prove this.

6. Work together with the City of York Council Community Safety Partnership, to support work to raise awareness of, and reduce the harm caused by 'Hidden Harms,' and abuse associated with County Lines activity, domestic abuse and modern slavery.

5. Meeting our objectives for the year – partner highlights

The CYSAB has developed its membership during 2024 – 2025 with new partners coming on board including Probation Service (Yorkshire and Humber), Department of Work and Pensions (DWP) and renewed links with existing partners including Leeds and York Partnership NHS foundation Trust, North Yorkshire Fire Rescue Service (NYFRS) and the Independent Care Group representatives. A face-to-face challenge panel event was held in January 2025 which helped to build relationships and identify future priorities. Below are some of the highlights from some of our partners and how they met our objectives for the year.

The voice of the adult sections interspersed within the partner highlights provide some examples of safeguarding work that has been undertaken by our partners. Agencies often worked in a multi-agency and co-productive way to achieve better outcomes for the adults receiving safeguarding support. All names have been anonymised to protect the identity of the adults.

1 2 3 4 5 6

1 To develop an all-age approach to safeguarding which maximises the potential and skills of teams and reduces the risks to young people transferring between services.

The Voice of the Adult

The safeguarding needs of the adult

Tessa is a young adult who suffered a death of a close family member. She had endured a challenging life. She used substances and regularly attended the local Emergency Department (ED) with injuries relating to self-harm. The death of Tessa's family member had a massive impact on her and she had made it known to the ED staff that the York ED was where she wanted to die. This created a great deal of anxiety to the ED team who have built up a relationship with Tessa and want to care for her when she was unwell.

Reducing the risk

Tessa had significant mental health support during the week but not at weekends, which was when she presented to ED. Whilst in the department Tessa would continue to attempt to harm herself and ligatured herself to such an extent she needed intensive care support.

In order to reduce the risks and consider the impact of Tessa's care and support needs the Acute Trust developed (with the support from Mental Health staff), a robust ED Risk management plan. This included prioritising Tessa's attendance and reducing her length of time in the department when possible. A room was made available which was checked for self-harm/ligature risks and Yorkshire Ambulance Service agreed to provide a "pre-alert" to ED staff to prepare the safer room for Tessa's arrival. The impact on staff was considerable and there was anxiety associated with every attendance.

What was achieved for the adult

There was close work between the ED and the community mental health team supporting Tessa but the usual methods to support her in a calm environment did not always transfer to the highly active ED. The Hospital Community Nurse began visiting Tessa with her Mental Health worker and Tessa attended ED just twice following this. The meetings included discussion regarding current risks and giving Tessa a voice to escalate her concerns around her treatment and was asked to comment on proposed improvement plans, policies and assessment. She did this with enthusiasm and has become a valuable stakeholder for our Mental Health Improvement plan.

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

Implementation of the transitional safeguarding guidance, working closely with children's services to identify and support young people has been key to delivering this priority. There has been an Increase in numbers of young people supported through the transitional safeguarding approach, reducing the need for long term services.

This approach has been reinforced through safeguarding week transitional safeguarding and human rights training in addition to mandatory training for all ASC practitioners.

Both operational and strategic groups are in place to support preparation for adulthood and CYC has agreed a new role to coordinate this.

NHS Humber and North Yorkshire Integrated Care Board (HYNICB)

Humber and North Yorkshire ICB safeguarding training delivered to Primary Care in York and North Yorkshire follows an all-age approach and in 2024-25 included a wide focus on learning from child and adult reviews.

The ICB Safeguarding Professionals work closely as a team across

the children and adult's agenda. To support an all-age approach and maximise the skills of the team, the new structure for the ICB safeguarding function proposed combined roles for safeguarding practitioners below the Designated Professional role, i.e. all roles include adults, children and children in care.

In addition, the ICB Safeguarding Policy was revised combining previously separate policies for children and adults and thus supporting employees to consider an all-age approach.

To raise awareness and improve the knowledge and skills of the health workforce the ICB held a virtual conference in October 2024 for health practitioners and partner agencies. The conference covered Exploitation, Online Safety and Transitional Safeguarding, as well as a session on staff welfare and well-being. We were very fortunate to have some excellent speakers.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

The Trust Safeguarding and Public Protection Team cover both Safeguarding Adults and Children. We have practitioners who have expertise and experience in both safeguarding children and adults. This supports a Think Family approach.

During 2024-25 the Trust have been reviewing the current safeguarding supervision arrangements and in 2025-26 have a plan to extend the offer for all age safeguarding supervision to a greater number of services.

A crisis phone line for all ages is now in place, calls are triaged and transferred to the most appropriate service. Work with 16–25-year-olds is underway with a Young Adults Steering Group within TEWV to drive this forward.

The Trust has recently employed 2 new Autism Specialists that work across North Yorkshire and York, covering all ages to support people with accessing our Services – transitions is one part of work they have been looking at

There is an ongoing review of clinical models in the trust to ensure we have seamless transitions across services and continuity of care.

York and Scarborough NHS Foundation Trust

The Trust Safeguarding Adult and Children Team merged in 2022 and work closely with a Think Family approach. Daily Emergency Department attendances are reviewed by both adult and children safeguarding specialists with joint safeguarding actions implemented where necessary.

Leeds and York Partnership NHS Foundation Trust (LYPFT)

The LYPFT safeguarding team is multi-professional team, comprising of Nurses and allied health professionals. The safeguarding team model is based on the think family model and comprises of Head of Safeguarding, Named Nurse Safeguarding Children and Adults and four Safeguarding Specialist Practitioners Adults and Children.

York Advocacy hub

York Advocacy Hub (YAH) has an all-age approach to safeguarding that ensures protection for individuals across different life stages. Here are some of our key steps that were used during 2024-25:

Understand the Needs of Different Age Groups – our safeguarding measures are tailored to children, young adults, adults of working age, and older people, recognizing their unique vulnerabilities and requirements.

Legal and Policy Frameworks – ensure compliance with relevant safeguarding laws, such as the Care Act 2014, Mental Capacity Act 2005, and Mental Health Act 1983, which outline advocacy rights and responsibilities.

Training and Awareness – we equip advocates with the necessary skills to identify and respond to safeguarding concerns effectively. This includes understanding signs of abuse, neglect, and exploitation across all age groups.

Integrated Safeguarding Practices – we promote collaboration between our advocacy service, healthcare providers, social services, and emergency services to create a holistic safeguarding network.

Person-Centred Approach – safeguarding should respect individuals' rights, wishes, and beliefs while ensuring their safety. Our advocacy services empower individuals to make informed decisions about their care.

Monitoring and Continuous Improvement – we regularly review safeguarding policies and practices to adapt to emerging risks and ensure effectiveness.

Probation Service Yorkshire and Humber

Young people transitioning from Youth Offending Services to adult probation are allocated to specialist practitioners. This team offers enhanced supervision and support, with input from other agencies and regular reviews are held. In addition, there is a Probation Officer seconded to the Youth Justice team who can provide a handover and interface between both agencies. Multi-Agency Public Protection Arrangements (MAPPA) guidance around those who are MAPPA eligible and transitioning to adult services is available and being implemented. There are close links with Children's safeguarding to promote contextual safeguarding.

City of York Council Public Protection

A new taxi licensing policy has placed even greater focus on safeguarding on adults and children alike. For example, Disclosure and Barring Service (DBS) checks are now required of staff in key roles for taxi operators, not just on the licensees themselves. Furthermore, taxis have to be wheelchair accessible to help deal with unmet demand from customers who require them.

North Yorkshire Fire and Rescue Service (NYFRS)

NYFRS has an all-age safeguarding approach across the service, ensuring that all staff are trained in safeguarding procedures relevant to both children and adults. This includes regular updates and refresher training to maintain awareness of safeguarding and best practice. 2024-25 saw a new role in service, a 'Youth and Schools Engagement Manager' who also brings skills in youth engagement. The service now contributes to multi-agency safeguarding arrangements through participation in both the Safeguarding Adults and Children Boards, as well as the Multi-Agency Child Exploitation meetings and other subgroups.

To reduce risks for young people we deliver targeted interventions such as our 'Fire Safe' programme. This initiative supports young people who have been involved in fire-setting behaviours, helping them understand the risks and consequences while promoting safer choices.

NYFRS works closely with partners ensuring that vulnerable individuals of all ages receive appropriate support and that risks are identified and reported appropriately.

2 Preventing abuse and neglect by adopting best practice, locally, regionally, and nationally. Ensuring that all the learning from Safeguarding Adults Reviews (SARs) are implemented in a timely manner.

Voice of the Adult

The safeguarding needs of the adult

Adult A was open to mental health services and family had lasting power of attorney to manage finances. Adult A was unwell and at risk of financial exploitation, as well as psychological abuse in the form of coercion and control and emotional abuse from developing conflicts within the family groups. Relationships had become complex, often emotional, leaving adult A torn between family members. This presented many challenges for the care team, Adult A and their family. The care team needed to consider safeguarding, family conflict/challenge, cultural and spiritual needs, mental capacity, best interests as well as legal, ethical and moral dilemmas.

What was achieved for the adult – Risks and impact

The complexity of the situation was great and required careful navigation for the clinical team. However, the care team recognised and acknowledged the complexity of the case and did not disregard the challenges facing them. The team ensured that they held the adult at the centre of their care, ensuring that they assessed capacity to enable them to make decisions regarding their care where they could. The team used a systemic practice approach to work with the family to ensure that everyone was supported to understand the impact on Adult A and what needed to happen to meet their needs. The Multi-Disciplinary Team then developed an effective communication strategy that supported effective and safe information sharing that was sensitive to the cultural needs of the family and supported reduction in risk.

Safeguarding public protection team consulted on a complex case

There was evidence of clear leadership within the team which supported multiagency and multidisciplinary working. When there was a specific safeguarding issue the safeguarding public protection team were contacted for advice and support. Advice from the safeguarding team was clear, concise and relevant in supporting the team to plan interventions and manage complexity including appropriate safeguarding actions advised.

What was the outcome

This resulted in positive outcomes for Adult A where they were effectively safeguarded, and care delivered in collaboration with their family.

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

CYC has rolled out improved frontline guidance about making good referrals. There has also been improved mental capacity act and home invasion (cuckooing) training. Multi agency meetings are in place in relation to organised crime to identify adults at risk, resulting in increased numbers of people where concerns are raised to CYC to participate early in safety planning. The new ASC safeguarding training emphasises the duty to work with adults at risk of harm to prevent this in addition to the work following allegation of abuse or neglect.

CYC staff have participated in Safeguarding Adults Review (SAR) learning events and are updated on key lessons through 7-minute briefings. Internal practice learning events have been held in relation to the published SARs which have increased awareness around home invasion, the need for increased sharing of information and joint working.

North Yorkshire Police (NYP)

Operation Soteria is how the NYP is going to transform its response to rape and serious sexual offences (RASSO) investigations. Operation Soteria is not gender or age specific.

In June 2024 NYP held an internal Operation Soteria symposium event with external partners to detail what we needed to do as part of our transformation plan. As part of this event, we had a question-and-answer session where we posed a number of areas to our partners to seek ideas and thoughts as to engagement and what gaps they have that we can work jointly on. Operation Soteria is not just about victim outcomes but also challenging and disrupting repeat suspects – so focusing on prevention and intervention.

As part of the sexual offences repeat suspect procedure(SORPs) we are presenting to the Multi Agency Tasking and Coordination executive board in June 2025 with a view to discussing suspects who do not meet the criteria for charge, have linked offences/intelligence and are not suitable to be considered for a civil order to have the multi- agency response to suspects to reduce harm- prevention and intervention.

Operation Soteria is a transformation plan as to our response and this is seen as nationally best practice to follow the programme of change. The multi-agency response would be as part of either a statutory or non-statutory requirement as part of an investigation which is embedded into a process. (i.e. Local Authority Designated

Officer (LADO), Public Protection Notice (PPN), Person in a position of trust (PIPOT) etc.)

We have the non-contact sexual offences policy which was published on the police portal in October 2024 in response to the Angiolini recommendations.

The Rape and Serious Sexual Offences (RASSO) scrutiny panel has now moved to the North Yorkshire and York Police Fire and Crime Commissioner to be chaired independently and to hold the police to account. This is a multi-agency meeting and will scrutinise outcomes where it is a police decision to take no further action for contact and non-contact offences. As part of this meeting outcomes will be shared and compared to national data. There is a caveat attached to this that comparative data to most similar forces will be subjective as forces across the UK are at different stages of implementation.

Operation Soteria has built in metrics for deliverables as part of the transformation and implementation plan. There are set key measures which has been provided by the national operating model products, but we have also included others for each area of action.

Substance use as part of offences is also included as part of the RASSO plan but at a tactical level. This may be of relevance when considering partnership approach to the SORPS's process.

The principles of Operation Soteria are "victim centred", "Suspect focused" "Context led". Linking to the ELAINE SAR undertaken by North Yorkshire Safeguarding Adult Board, the context of the offence is considered but in a positive way so as not to impact on the victim but to understand the narrative and focus on what enabled the suspect to commit the offence against the victim. This recognises the context of the offence and that a victim often makes decisions that keep them at risk when in a compromised situation.

RASSO is linked across with the safeguarding unit departments and as part of this we have access to recommendations that are made at a strategic and tactical level.

Peer review is available through other national policing networks for Operation Soteria. The recommendations from His Majesty's Inspectorate of Constabulary and Fire Rescue Services (HMICFRS), super complaints and recommendations from other authorities are considered as part of the RASSO strategic and tactical requirements for delivery.

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Humber & North Yorkshire Integrated Care Board (ICB)

The ICB has supported the dissemination and implementation of learning from safeguarding adult reviews (SARs), helping to identify areas for improvement and implement system-wide changes.

Continuing an all age and family approach the learning shared from safeguarding reviews has included the following messages to primary care and partners across the health network:

- the PAMIC tool (a procedure for assessing and responding to the impact of parental mental ill health on children)to assess risk and provide appropriate support;
- the #AskMe...campaign to encourage professionals to have the conversation with new and expectant parents; and
- the ICON programme which helps people caring for babies to cope with crying.
- learning from James SAR (by North Yorkshire Safeguarding Adult Board)– James was 18 years old when he died and learning focused on gaps that were identified in his care as a child and as an adult.
- Multi-Agency Public Protection Arrangements (MAPPA) updates
- The Serious Violence Duty

Hot Topics training materials were developed collaboratively to ensure relevance to the local population of York and North Yorkshire. Through delivery of the programme, frontline professionals have been equipped with tools to identify and escalate concerns.

Also included in the training was the newly developed clinical safety and safeguarding guidance following the national roll-out of online access to GP records for those age 16 years and over. Online record access is available here - clinical safety and safeguarding

In 2024-25 the new framework for investigating incidents related to patient safety Patient Safety Incident Response Framework (PSIRF) has been fully implemented by NHS providers replacing the previously used NHS Serious Incident Framework (2015). The PSIRF sets out the approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety within the NHS. The Designated Professionals have continued to support the cross-over with statutory frameworks in safeguarding and a joint approach

taken by CYSAB and NHS providers working together has avoided duplication and unnecessary distress to the individuals involved and/or their families.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

Further development of the Organisational Learning Group in the Trust has been underway which is strengthening the way we share learning across the organisation. We continue to share any safeguarding learning through our Services/Care Groups and in forums like the Quality Standards Groups in the organisation. Exploration of extending the means of communication continues to improve the availability of different types of learning.

York CVS (Centre for Voluntary Service)

Staff members at York CVS continue to undertake safeguarding training to a level that is appropriate for their role (between levels 1-3).

As a membership organisation supporting the voluntary and community sector, we provide training sessions for our members and continue to offer voluntary, community and social enterprise (VCSE) organisations with advice on safeguarding.

Healthwatch York (as part of CVS) have escalated issues through the CYSAB, including flagging concerns around the system.

York and Scarborough NHS Foundation Trust

The Trust has robust processes in contributing and learning from Safeguarding Adults Reviews (SARs), Domestic Homicide Review DHRs, (now renamed to Domestic Abuse Related Death Review) and Learning from Deaths of People with a Learning Disability and Autistic People (LeDeR) reviews. There is escalation and subsequent trust wide escalation of recommendations following review. This has informed the development of 25/26 Core Priorities which are underpinned by the Board's delivery plan.

Leeds and York Partnership NHS Foundation Trust (LYPFT)

Learning from SARs is shared via the LYPFT intranet. Situation Background Analysis Recommendations (SBAR) briefings are created in response to learning, also at the LYPFT link practitioner's forum and clinical governance, meetings via the safeguarding bulletin. Learning from local regional and national SARs is used to update mandatory safeguarding training and considered by practitioners as a reference point when giving advice, support or safeguarding supervision.

York Advocacy Hub

York Advocacy Hub (YAH) now actively participates in the City of York Safeguarding Adults Board to ensure that vulnerable individuals are represented in decision-making. We provide training for advocates to recognise signs of abuse and neglect and ensure that lessons learned from SARs are swiftly integrated into local policies and practices.

Regionally YAH collaborate across agencies with regional health and social care providers to create a unified approach to safeguarding. We contribute to regional frameworks for advocacy interventions to ensure consistency in safeguarding practices, regularly reviewing cases and SARs to identify trends and improve responses.

Nationally our advocacy service contributes to national safeguarding policies by sharing insights from SARs and frontline experiences. We contribute to public awareness campaigns through being part of Mind, who run national campaigns around issues impacting the whole of the UK. We keep abreast of legislative changes and ensure that our advocacy service aligns with national safeguarding laws, such as the Care Act 2014.

By embedding these best practices, our advocacy service creates a robust system that prevents abuse and neglect while ensuring that lessons from SARs lead to meaningful improvements.

Probation Service Yorkshire and Humber

All Practitioners complete Adult Safeguarding training, and as it is required learning, it is repeated every 3 years. Training covers awareness and understanding of all aspects of abuse, neglect and exploitation.

The role and responsibility of a Probation Practitioner in respect of safeguarding, and how to raise safeguarding concerns, are covered in briefings at a local level. Similarly, relevant information from SARs is cascaded to Practitioners at a regional and local level. The Probation Policy Statement, Safeguarding Adults at Risk in the Community is available to all Practitioners and contains relevant links and guidance. Learning around self-neglect has been promoted across the team this year.

City of York Council Public Protection

The training for new taxi drivers has been refreshed and strengthened by an adult safeguarding training specialist to include greater emphasis on county lines. The children's society have recognised our taxi training an example of best practice.

NORTH YORKSHIRE
FIRE & RESCUE SERVICE

North Yorkshire Fire and Rescue Service (NYFRS)

The North Yorkshire Fire and Rescue Service (NYFRS) is committed to preventing abuse and neglect by embedding safeguarding best practice at local, regional and national levels. As a service we continually work towards meeting the Fire Standards for Safeguarding, which requires effective policies and procedures to be in place.

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

We maintain strong links with both Children's and Adults Safeguarding Boards and are active contributors to Multi-Agency Child Exploitation (MACE) arrangements. The Safeguarding Manager, Head of Prevention and Early Intervention, and Senior Director are all engaged with these boards and contribute to Safeguarding Adult Reviews (SARs) when requested.

In addition to responding to external reviews, the Service has strengthened its internal learning processes. This year, we expanded our Fire Fatality Review process into a broader Serious Incident Review model, allowing us to capture learning from a wider range of incidents. This ensures that safeguarding lessons are identified and implemented in a timely and meaningful way.

3 To ensure that commissioners and service providers ensure a consistent high quality of care.

Voice of the Adult

Getting safeguarding and support

Angie, an adult in her 60s living in supported accommodation with continuous one-to-one support, was experiencing concerns around personal care, self-neglect, and possible institutional neglect. Advocacy York has visited Angie multiple times, working to build trust, and left her an easy-read leaflet to help explain the advocate's role. The advocate attended her care assessment and spoke independently with Angie's mum and support staff to understand their concerns, and participated in safeguarding meetings, noting outcomes and supporting follow-up actions.

What did the adult want to happen

The City of York Council wanted to establish whether or not Angie had views on whether she wanted to remain in her current flat. Angie has made her views known by replying to a question "do you like living here" and responding with "happy". Angie is content in her residence and enjoys the company of certain support workers, who she has developed good relationships with.

What was achieved for the adult

Angie's undiagnosed Autism and possible childhood trauma significantly impacted her sensory needs, particularly around bathing and nail care. A trusted support team has helped trim her toenails, with progress toward hair washing and fingernail trimming. Plans were in place to replace the bath with a shower, pending a Learning disability occupational therapy assessment. A Canary system (a home health monitoring system) monitors sleep patterns to assess the need for waking night support, while sleep hygiene support is being considered. Tools like a dementia-friendly clock, communication book, and whiteboard (with photos of professionals) were used to improve routine and engagement. Angie began to express herself through writing, revealing possible trauma links. A budget was approved to redecorate her accommodation and install air conditioning, as she avoids open windows and fans. This work is ongoing, with further actions expected.

Voice of the person

Angie engaged well with her core support team and was pleased with the redecoration plans. The work is ongoing, with hopes for more direct contact over time as advocacy was limited by Angie's lack of trust, as she only tolerated the advocate for brief moments. There were risks of her becoming verbally hostile or throwing items, so visits could only occur with a support worker present in the background. Support for Angie continues.

City of York City Council Adult Social Care

To ensure that commissioners and service providers maintain a consistently high quality of care, City of York Council (CYC) have adopted a more integrated approach with the NHS. This includes the signing of a Section 75 agreement and the restructuring of the CYC commissioning team to facilitate collaboration.

CYC's Adult Social Care (ASC) has developed a provider failure policy, and a lesson learned process. These initiatives align with the organisational abuse inquiry process, offering an opportunity to review our working relationships and conduct safeguarding briefings with service providers.

Our ongoing early alert process and meetings, along with the newly developed 'person-centred approach to professional visits in care homes,' support a preventative strategy for identifying low-level concerns. The early alert meetings enable multi-agency information sharing regarding issues and quality concerns.

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

Humber and North Yorkshire Integrated Care Board (HNY ICB)

The ICB continues to champion a culture of collaboration, supporting multi-agency safeguarding and reflective practice sessions that bring partners together to share insights and continuously improve our collective response. The designated professionals receive quarterly restorative supervision from an independent specialist provider and facilitate quarterly individual and group supervision for safeguarding professionals in health provider organisations. The ICB safeguarding supervision policy was revised in 2024-25 to reflect the importance of safeguarding supervision in supporting management of complex cases.

The designated professionals for Safeguarding Adults also facilitate quarterly health professional group meetings in which key safeguarding updates are disseminated and discussed by health partners. Areas covered in 2024-25 have included drug and alcohol related deaths, sexual safety, domestic abuse and the person in a position of trust (PiPoT) procedures. In addition, a private providers safeguarding forum is held twice yearly in which independent health providers can gain important safeguarding updates from the ICB leads.

As a statutory partner of CYSAB, the ICB continues to embed safeguarding responsibilities across the system, providing strategic representation at CYSAB Board by the Director of Nursing for Core Statutory Partnerships and/or Deputy Director of Safeguarding, with regular contributions from Designated Professionals for Safeguarding Adults.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

In 2024-25 NICHE undertook a Phase 2 Assurance Review of Practice and Governance which focused on patient safety incidents, complaints and safeguarding events. The Trust received the final report 'Assurance review of practice and governance' which was published in Dec 2024.

It found:

- Good level of assurance that the governance of quality concerns is compliant with expected standards
- Good level of assurance that the overall governance of quality is compliant with expected standards
- CQC inspection of Crisis, Liaison Health Based Places of Safety was carried out in June 2024. Report was published on 7th February 2025 and the rating we received was 'Good'.

The report highlighted:

- That people using the service said they felt safe, and that staff were kind, compassionate and respectful.
- Patients said they had appropriate risk assessments in place which were regularly updated and that they, and their carers had been involved in creating them.
- Staff shared a vision and culture, worked with capable and compassionate leaders and there were sound structures in place for staff to speak up.

Some areas of learning development were identified which included elements of:

- Training
- Management of medicines
- Workforce wellbeing
- Call waiting times

These form part of a Trust wide action plan.

York and Scarborough NHS Foundation Trust

The Trust is required to produce a Safeguarding Annual Report as directed by the NHS England Adult Safeguarding Roles and Competencies for Health Care Staff 2024.

The Trust Safeguarding remit is aligned to the key elements of the NHS England Safeguarding Accountability and Assurance Framework (SAAF). The purpose of the SAAF is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations in the following areas:

- Leadership
- Workforce
- Training
- Systems
- Partnership collaboration
- Service Development

York and Scarborough Teaching Hospitals NHS Foundation Trust is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the Children's Act 2004, the Care Act 2014 and other statutory and national guidance. The safeguarding roles, duties, and responsibilities of all organisations in the National Health Service (NHS) including the Trust, are laid out in the NHS England 'Accountability and Assurance Framework' (2022).

The Trust is highly committed to safeguarding with a strong culture of safeguarding vulnerable individuals of any age that have contact with services – either as patients, visitors, or staff. Therefore, robust governance processes are in place to ensure that services delivered are responsive to and are enacting Safeguarding multi-agency policies and procedures for all patients in our care who are at risk of, or are experiencing, abuse.

The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding. These have been fulfilled and enhanced throughout 2024-25.

Leadership is defined at executive level with the Trust Chief Nurse holding executive ownership of Safeguarding. The executive lead also acts as Named Senior Officer for allegations made against staff. There is a requirement for a Non-Executive Director to also hold the Safeguarding portfolio. The Board have been approached and there will be a Non-executive Director nominated by April 2025.

The Head of Safeguarding and Complex Needs provides strategic

direction for adult, children's and maternity safeguarding and supports the Chief Nurse in the executive role. The role of Named Senior Manager for allegations against staff is fulfilled by the Head of Safeguarding and Complex Needs, who also attends the CYSAB and City of York Safeguarding Children Partnership (CYSCP).

The Named Professionals provide the organisation with operational advice, support, and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes. They are supported by safeguarding practitioners/advisors.

The SAAF leadership element states that it is a requirement the NHS provider Boards of Directors receive a Safeguarding Annual Report, and this report is evidence of compliance in this requirement.

Leeds and York Partnership NHS Foundation Trust

The safeguarding team work with a range of providers known as the provider collaborative to ensure quality care and safeguarding responses are provided.

The patient safety team provide updates and assurances to the provider collaborative in response to any patient safety incidents that occur in the service they provide and assurances regarding the learning responses.

York Advocacy Hub

Our commissioners and our advocacy service ensure we provide high-quality care through several key strategies which include:

Regulation and Monitoring – for the commissioners, organizations like the Care Quality Commission set standards and conduct inspections to assess LA services. As a service, every 3 years we are assessed by the Quality Performance Marker process, an award we've held for the duration of our contracts.

Legal Frameworks – our advocacy service follows guidelines such as the Care Act 2014 to ensure individuals receive appropriate support.

Training and Skills Development – our advocates receive ongoing training to improve their ability to support individuals effectively.

Collaboration and Co-Production – working with client, their families, and other stakeholders helps shape our advocacy service.

Data Collection and Quality Improvement – Regular monitoring and

feedback mechanisms help refine our service and maintain high standards.

City of York Public Health

All Public Health commissioned service providers submit their Safeguarding policies as part of procurement process. These are reviewed annually through contract monitoring arrangements.

North Yorkshire Fire and Rescue Service (NYFRS)

The NYFRS supports the delivery of consistent, high-quality care by working in close partnership with service providers and community organisations.

The Service has invested in a Partnership Manager who leads on collaborative prevention work, recognising that fire safety requires a multi-agency approach. Many individuals at heightened risk of fire are known to other services but not yet to us; by working together we can intervene earlier and reduce risk of fire and harm.

To support this, we have launched a Home Fire Safety Visit (HFSV) Referral Partnership, encouraging organisations across health, housing, care, and the voluntary sector to join. This enables professionals working with vulnerable individuals including those with disabilities, memory loss, substance dependency, or unsafe living conditions to refer them for free fire safety visits. Referral partners receive training, resources, and access to data and support, helping ensure that those most at risk are identified and protected. During 2024-25 NYFRS received 1743 referrals for a HFSV from partners and delivered 30 training sessions.

Through these partnerships and targeted engagement, the service is helping to build safer homes and more resilient communities, while supporting providers to deliver care that is not only high quality, but also safe and preventative.

4 To ensure the person is clearly heard and create opportunities for an approach where co production is at the heart of future safeguarding policy.

Voice of the Adult

Getting safeguarding and support

This case illustrates the significance of trust-building and understanding the individual's circumstances in addressing issues of hoarding and self-neglect. An adult developed a positive relationship to allow them to receive safeguarding support related to self-neglect. The adult was reported to the police by his bank due to concerns over potential financial exploitation, as a large amount of money had been withdrawn from his account in a short period.

Attempts to visit the adult at home were unsuccessful, as they were never present during multiple visits. A social worker observed that their home was cluttered with many board games, and neighbours complained about the large pile of games in the front yard, estimated to be six feet high.

What was achieved for the adult

During this time, a member of the public expressed concern to the safeguarding team about an adult frequenting her coffee shop who shared the same first name as the individual being sought. The social worker engaged with them at the coffee shop, where they showed reluctance for support but eventually agreed to let the social worker accompany them to his home. Upon arrival, the home was found to be in disrepair, lacking heating and electricity, with a broken boiler and water damage causing mould. The adult's living conditions were deemed uninhabitable, leading to immediate support from the social worker who helped him to suitable alternative temporary accommodation and assisted him in acquiring necessary clothing and toiletries.

Through continuous engagement, the social worker learned that the adult's compulsive need to collect board games and poker chips stemmed from childhood experiences and trauma, counting was a coping mechanism he used. Recent life changes, including the loss of his mother, job loss due to the pandemic, and increasing isolation had caused an increase in compulsive behaviours over a period.

What did the adult want to happen

They ultimately chose not to return home and was supported in selling his property and moving into a private supported living scheme with a carer supporting them weekly.

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

In order to capture the lived experience of Adults CYC are establishing better co-production, including through development of a co-production strategy.

Co-production has been a key feature of the development of how we approach preparation for adulthood across children and adult services.

Making Safeguarding Personal continues to be central to operational delivery of safeguarding working within the practice model and ability to provide support and supervision of staff.

Humber and North Yorkshire Integrated Care Board (HNY ICB)

In July 2024, the Royal College of Nursing published the second edition of Adult Safeguarding: Roles and Competencies for Health Care Staff. In line with ICB strategy for safeguarding learning the Safeguarding Team developed and commenced delivery of a comprehensive training package for ICB practitioners required to meet level 3 competencies, these included registered practitioners across the nursing and quality team.

In October 2024 new standards for safeguarding in General Practice were launched. The RCGP safeguarding standards require General Practitioners to complete a yearly safeguarding level 3 update which encompasses adults and children and includes training on Domestic Abuse. The revised guidance and support tools have been well-received by clinicians.

Whilst not achieving full co-production the training packages do emphasise the voice of the adult and use case examples to support learning.

In line with Making Safeguarding Personal when completing safeguarding enquiries our practitioners talk to individuals and their families and carers about what outcomes they want to achieve from a safeguarding enquiry process and where possible involve people in meetings about them. Face to face meetings are offered with individuals/families about their health and care and their experiences of safeguarding processes. The safeguarding team provide feedback and gain views on outcomes from safeguarding enquiry processes and offer face-to-face meetings when people are not happy about outcomes, ensuring actions and learning is followed up.

Our ICB Safeguarding Conference in June 2024 was held at York University and opened with the tragic story of the lived experience of domestic abuse and ultimately domestic homicide in a family, told by one of the surviving family members. This was followed by Professor Jane Monckton-Smith presenting research on the Domestic Abuse homicide timeline which was developed through research of multiple cases of domestic homicide.

The Transitional Safeguarding Workshop held virtually in October 2024 included the voices and views of young people with care experience. This supported one of the HNY ICB priorities for safeguarding young people leaving care.

The ICB leads the programme for Learning from Deaths of People with a Learning Disability and Autistic People (LeDeR). Learning from both local and national reviews is used to enhance the quality and safety of care, while also strengthening safeguarding responses for individuals with learning disabilities and autism. Crucially the ICB LeDeR Steering Group includes membership from people with Learning Disability / Autism lived experience.

The ICB encourages public involvement in planning healthcare through its engagement hub.

Get Involved: York - Humber and North Yorkshire Health and Care Partnership

Working with Healthwatch York recent involvements have included:

- Adult Autism and ADHD pathway review and Urgent Care Pathways review.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

We continue to strengthen co-creation across the organisation and embed this in everyday work for everyone.

We are the first Trust in the country to have a strategic lived experience leadership team with four strategic lived experience roles working across peer support, co-creation and our two Lived Experience Directors.

The Strategic Lived Experience Leadership Team have broadened the lived experience input across the organisation, by establishing two Co-creation Boards that work closely with our Care Boards and are shaping how we deliver services - putting patient and carer voice at its heart. As well as leading on big transformational pieces of work across the Trust, including the transition from the Care Programme

Approach to Personalised Care Planning, Culture of Care Programme and Patient Safety Partner development, in line with our updated Patient Safety Incident Response Framework (PSIRF).

In 2024-25 we have also launched our Co-creation Framework, which has been co-developed over several months with the aim of giving clear definitions, co-creation values and types of co-creation that we can use across the Trust and with our Partners.

We also employ Peer Support Workers, who have lived experience of mental illness either themselves or as a carer and these roles are continuing to grow. The quality of our peer work implementation has been recognised as a national example of positive practice

York and Scarborough NHS Foundation Trust

It is a challenge for the Trust Safeguarding Team to be a consistent contact for a person involved in a safeguarding process given the brevity of an acute admission. However overall governance of safeguarding and complex needs is very much a strategic ownership, and our governance structure includes Trust representatives who can gather patient feedback and input into service development. Our Learning Disability and Autistic service have stake holder meetings which are feed into the Complex Needs Operation Group. Healthwatch are represented on the Trust Complex Needs Assurance Group as it is the patient involvement and engagement lead.

Leeds and York Partnership NHS Foundation Trust (LYPFT)

Collaborative care planning practice is embedded in LYPFT, and it must be developed in collaboration with the adults and carers and written for the adults own understanding. Practitioners are trained to keep it simple, and up to date in terms of it being a live document and adapting to changes in adults needs. It must also be used collaboratively and shared between services involved in the adult's care. Making safeguarding personal is embedded in the safeguarding teams practice, training and advice given to practitioners. This was audited in 2024-25, and findings considered 50 Safeguarding contact forms between October and December 2024 to obtain information about the adult at risk's views and wishes.

The first objective of this audit was to assess whether the desired outcomes/views and wishes were discussed with the adult. 94% of cases showed that the desired outcomes were discussed with staff and recorded in the Safeguarding contact form. This showed an increase from the previous audit cycle, where 86% of cases demonstrated that the desired outcomes of the adult were discussed

with, and recorded by, staff. This therefore demonstrated an improvement in practice.

The second objective was to establish if the person's views and wishes were addressed. 91% of the adult's desired outcomes/views and wishes were addressed. Although a high number, this is slightly lower than the previous audit's findings, where 98% of the adult's views were addressed.

York Advocacy Hub

Our advocacy service plays a crucial role in ensuring individuals' voices are not only heard but also actively shape safeguarding policies. Here is how we try to achieve this:

- Empowering the Individual – our advocacy service prioritizes the rights, wishes, and perspectives of the person at the centre of safeguarding case. This means ensuring they understand their rights and supported in expressing their views confidently.
- Active Listening and Representation – our advocates are trained to listen to ensure the individual's concerns are understood. They then communicate those concerns effectively.
- Facilitating Inclusive Co-Production – Co-production must be embedded within safeguarding policy development by involving individuals with lived experience at every stage. This means holding meaningful consultations, co-designing solutions with them, and ensuring their input translates into practical action.
- Building Partnerships – Collaboration between our advocacy service and safeguarding professionals, community groups, and policymakers ensures that policies are shaped holistically and reflect the diverse needs of those impacted.
- Transparency & Accountability – our advocacy service champions a culture of openness, where safeguarding policies undergo continuous review based on feedback from individuals who rely on them.

York CVS (Centre for Voluntary Service)

York CVS continues to engage with the CYSAB at a strategic level. Through our activities, particularly our social prescribing work and Healthwatch York, we make sure the voice and needs of our community are heard. We are an active member of the wider subgroup structures of the CYSAB offering constructive challenge and support.

Probation Service Yorkshire and Humber

Our Policy Statement centres empowerment of the individual and their ability to make their own decisions. Therefore, consent from the individual is sought prior to referrals where appropriate, and during multi agency meetings and case discussions, space is given for the individual's views to be shared. Our plans are co-produced, and we have an engagement process to make sure the voice of the person on probation is heard.

City of York Council Public Protection

Staff working in public protection have received refresher training in interviewing witnesses, including the use of video interviews to 'achieve best evidence'.

North Yorkshire Fire and Rescue Service (NYFRS)

We recognise that effective safeguarding must be person-centred and inclusive. Wherever possible we will carry out joint visits with family/carers and any other professionals working with the person. We will ensure the person's own experiences have been listened to and take into consideration their own wishes and needs.

We also work closely with partners across health, social care, housing, and the voluntary sector through our Home Fire Safety Visit (HFSV) Partnership, which is built on shared responsibility and collaborative working. This partnership enables us to reach individuals who may be at greater risk of fire.

The Service is actively involved in regional and national safeguarding forums and contributes to SARS. Our expanded Serious Incident Review process allows us to explore a wider range of events and gather insights that help shape future prevention & safeguarding approaches.

Through these efforts, we are creating space for people to be heard, and for their experiences to inform the development of safeguarding policy that is inclusive, responsive, and co-produced.

5 Agencies (like and health and social care providers) must prove they provide good quality services and be asked to prove this.

The Voice of the Adult

Case Overview

Benjamin is an adult who has highly complex mental health needs, including autism with significant sensory sensitivities, Tourette's, Obsessive Compulsive Disorder (OCD) with severe ritualistic behaviours, and complex post-traumatic stress disorder (PTSD) stemming from childhood abuse. These conditions significantly affect his ability to communicate, self-advocate, and maintain personal safety. His history of trauma, particularly within care settings, has made it difficult for him to form trusting relationships. Through a patient and adaptive approach, the Advocate was able to build trust with Benjamin, which enabled him to disclose an incident of alleged psychological abuse by a staff member on his ward.

York Advocacy Hub Intervention

The Advocate undertook a comprehensive and person-centred approach to support Benjamin. This included detailed conversations to understand the incident, adapting communication methods to engage with another peer involved, and documenting the safeguarding concerns thoroughly. The Advocate liaised with York City Council to ensure all safeguarding processes were accessible and tailored to the adult's needs, including simplified written materials and adapted meetings. The Advocate supported Benjamin throughout the Section 42 safeguarding enquiry, helped him express his views and desired outcomes, and facilitated his engagement with both hospital investigators and the Care Quality Commission (CQC). A second safeguarding concern was raised during this process regarding another staff member.

Outcome and Reflections

Benjamin's desired outcome was achieved: both staff members were removed from the ward, and one was dismissed from the hospital. He expressed strong positive feedback, highlighting the importance of being listened to and supported throughout the safeguarding process. This case underscores the critical need for communication adaptations in advocacy work, especially for individuals with complex needs. It also highlights the value of trauma-informed, person-centred advocacy in empowering adults to speak out and seek safety within care environments.

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

CYC Commissioners follow stringent due diligence in accordance with regulatory requirements when securing providers onto the framework. This process ensures that all providers are thoroughly vetted.

The CYC Contracts and Quality Improvement Managers continue to conduct quality assurance visits to assess the level of service quality being delivered across York, utilising a Quality Assurance Framework (QAF),

The CYC Integrated Commissioning Team, Commissioners, Contract and Quality Improvement Managers, and Commissioning Officers, continuously review and assess our internal processes and procedures. These evaluations are included in any new services commissioned. CYC monitor Key Performance Indicators (KPIs) with Providers and offer additional support where improvements are necessary.

CYC Adult Social Care has developed a provider failure policy and a lessons-learned process that is aligned with the organisational abuse protocol.

Humber and North Yorkshire Integrated Care Board (HNY ICB)

In 2024/25 NHS England / NHS Digital have been developing an online safeguarding assurance dashboard for NHS providers to input their safeguarding data on a quarterly basis. The dashboard is currently limited but continuing to be developed to provide a level of assurance for commissioners. Alongside the online data input NHS providers have completed a safeguarding assurance template and met with ICB safeguarding colleagues quarterly to discuss and provide assurance against their submissions.

Designated Professionals continue to attend NHS Provider Trusts Strategic Safeguarding and Governance meetings and maintain collaborative relationships with their respective Heads of Safeguarding and Named Nurses to maintain good quality care and promote and advance safeguarding practice.

Whilst delivering safeguarding at a local level in York and North Yorkshire, the ICB safeguarding team have actively sought opportunities to learn from other areas through participation in regional safeguarding networks (such as the ICB Integrated Designated Professionals Network) and national ICB safeguarding forums (such as the Safeguarding Adults National Network). This

ensures that our approach remains benchmarked, and evidence informed. The ICB provides quarterly thematic assurance to NHS England regarding its own safeguarding arrangements.

In addition, the ICB Safeguarding Team work closely with local authority partners in supporting organisational safeguarding processes for health and care providers who are struggling to maintain safe delivery of care. Sharing soft intelligence and concerns with local authority safeguarding and commissioning team partners at an early stage helps in identifying providers who can be brought into processes to support them to return to safe delivery of care. We work closely with the ICB Quality Team who deliver training and expertise to care staff to help them to achieve safe high-quality care.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

The Trust continue to seek assurance on it practice and governance and in 2024/25 NICHE undertook a Phase 2 Assurance Review of Practice and Governance which focused on patient safety incidents, complaints and safeguarding events. The Trust received the final report 'Assurance review of practice and governance' which was published in Dec 2024.

York and Scarborough NHS Foundation Trust

The Trust participated in a CYSAB Challenge Panel in December of 2024 to assure that there were systems in place to manage PIPOT/ SARS/MCA and timely safeguarding action. As stated above quality performance of the team is monitored by the Integrated Safeguarding Group. Additionally, all responses to S42 enquiries are quality assured by the Director of Patient Safety and the Deputy Chief Nurse before submission.

Leeds and York Partnership NHS Foundation Trust

LYPFT Overall Care Quality Commission (CQC) rating is good stating that clinical governance systems were established to assess, monitor, and improve the quality and safety of the service, and manage risk, and operates effectively across the trust and were embedded in locally in most services. Staff knew and understood the values of the trust. Staff were able to give descriptions of how the values were used to underpin both individual and team good practice. We found an open and transparent culture where staff knew who the 'Freedom to Speak Up' guardian was and felt able to raise concerns without fear of retribution. Staff felt respected, supported and valued and were supported with opportunities for career progression.

The Clinical Governance Team is responsible for all aspects of clinical governance, patient safety, risk management, incident management and complaint management functions to support the delivery of high quality, safe care for all who use the Trust's services within the agreed service lines. They work closely with the heads of operations and clinical leads and report directly to the Deputy Director of Nursing.

Clinical Governance ensures that systems and processes are in place to facilitate any regulatory/statutory duties and inspections with CQC, oversees the serious incident process, risk registers and the complaints process, making sure governance assurance systems in relation to these areas are robust, to promote a learning culture with continuous quality improvement.

LYPFT achieved the Veteran Aware accreditation, by demonstrating its commitment to the Armed Forces Covenant and its understanding of the unique needs of the veteran community. This involved meeting specific standards outlined by the Veterans Covenant Healthcare Alliance (VCHA), including identifying veterans, providing staff training on veteran-related needs, and establishing links with veteran support services. The process involves an evidence-based assessment and a collaborative effort to meet the required standards.

LYPFT achieved White Ribbon accreditation; making a strategic commitment to ending men's violence against women, develop and implement a three-year action plan, and demonstrate leadership support. This involves appointing a Lead Contact and a Steering Group, establishing a senior leader as a White Ribbon Ambassador or Champion, and actively working to change cultures and behaviours.

York Advocacy Hub (YAH)

YAH demonstrate their quality through various assessments and certifications. We hold the Advocacy Quality Performance Mark (QPM), which is awarded to organisations that meet high standards in advocacy, including independence, safeguarding, and person-led services.

Other methods used to evidence quality of our service include:

- Self-assessment and policy reviews to ensure practices align with best standards.
- External evaluations, where assessors review case notes, policies, and conduct site visits to interview staff and service users.
- Feedback from client, highlighting the effectiveness and impact of

advocacy support.

- Complete outcome measures with clients
- Compliance with legal frameworks, such as the Care Act 2014 and Mental Capacity Act 2005, which outline advocacy rights and responsibilities.
- Quarterly and annual reporting to commissioners
- Quarterly meetings with commissioners
- York Mind recently gained the MQM award, which is their internal quality assessment, it's expected that all Mind's hold this award to evidence quality provision
- Stakeholder feedback

City of York Public Health

Public Health service providers who deliver services which support adults are monitored through robust contract monitoring arrangements and are held to account by commissioners.

City of York Council Public Protection

Trading Standards officers have carried out talks to groups of potential scam victims and their families to raise awareness and encourage more reporting. A survey has been introduced to identify the effectiveness of the talks, and the responses have been very positive.

North Yorkshire Fire and Rescue Service (NYFRS)

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

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

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

To further enhance service quality, we have new roles such as a School and Youth Engagement Manager and a Partnership

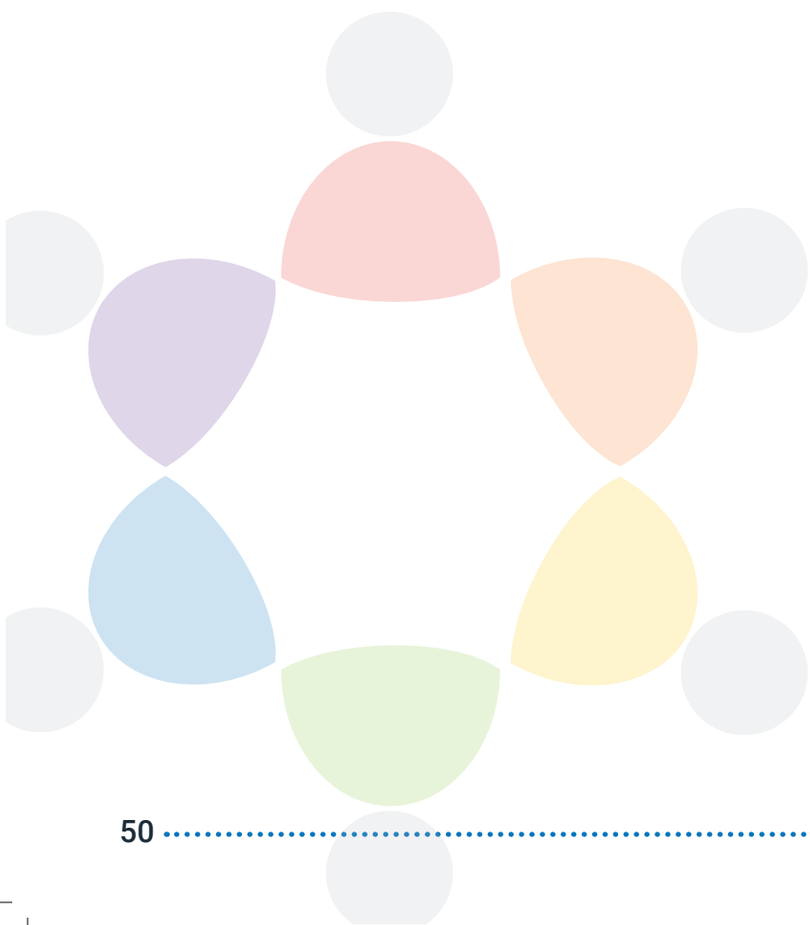
Manager, who help us improve our engagement with young people and strengthen multi-agency working. These roles support early intervention and ensure our services are responsive to community needs.

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

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

During the most recent HMICFRS report NYFRS scored Good in Preventing Fires and Other risks specifically detailing that the service has an effective process to respond to safeguarding concerns

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



6	Work together with the City of York Council Community Safety Partnership, to support work to raise awareness of, and reduce the harm caused by 'Hidden Harms,' and abuse associated with County Lines activity, domestic abuse, and modern slavery.

The Voice of the Adult

Safeguarding Needs

Concerns were raised by City of York Council regarding financial abuse of an elderly lady Patricia who was receiving end-of-life care in a nursing home. She had asked her relative to help manage her finances. The relative withdrew money from Patricia's account without holding Lasting Power of Attorney (LPA).The bank flagged the issue, prompting a safeguarding referral due to potential deprivation of assets and lack of legal authority.

Getting Support

The Care Act advocate visited the client three times, adapting to her health and fatigue levels. The advocate discussed the safeguarding concern in simple, respectful terms, ensuring the client could express her views. Patricia consistently stated she trusted her relative and felt they were the only person available to help.

The advocate worked alongside the social worker, reinforcing Patricia's views and respecting her wish to be left in peace. The social worker assessed that Patricia did not fully understand the wider financial implications, though her trust in her relative was clear.

The advocate and social worker met with the care home manager to discuss next steps, including a financial assessment following the withdrawal of continuing Healthcare (CHC) funding.

Outcome for the Adult

Patricia was supported to express her views and trust in her relative, despite limited capacity to engage with the full legal and financial context. Her wishes to be left in peace during end-of-life care were respected throughout the advocacy process. The safeguarding process was navigated with sensitivity, balancing legal concerns with the client's emotional and physical wellbeing.

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

The largest increase, proportionately, of type of abuse reported to CYC over the year has been in hidden harms.

Awareness and joint working are supported by regular meetings with partners on serious and organised crime and county lines.

CYC adults and children's services work together as part of the Children's partnership subgroup on exploitation to reduce harm in this area.

CYC adult social care has progressed work to better use information from Multi-Agency Risk Assessment Conferences (MARAC) alongside internal records to improve our safeguarding approach.

North Yorkshire Police (NYP)

NORTH YORKSHIRE
FIRE & RESCUE SERVICE

Domestic Violence Disclosure Scheme (DVDs) Panel

The Domestic Violence Disclosure Scheme also known as Clares Law became statute in its entirety in April 2023. North Yorkshire Police carried out a review of the updated guidance to ensure their current practice was aligned to the guidance and that they were meeting the statute obligations. Part of this review highlighted the need to have a Domestic Violence Disclosure (DVDS) Panel which involved key partners involved in the decision-making process to ensure victims or person who may be potentially at risk were being kept safe, this is seen as best practice.

North Yorkshire Police with the North Yorkshire Domestic Abuse Local Strategic Partnership agreed a plan to support the implementation of the DVDS panel. In 2024 the processes of writing an Options Paper, Terms of Reference, an Information Sharing arrangement, and an operating model were completed.

The DVDS panel is now fully embedded within the Police and key partners and is business as usual. The panel hears cases that are of a complex nature where the person at risk may have care, and support needs as defined in the Care Act 2014 or they may have multiple support needs that don't meet the threshold but where a disclosure is necessary and requires the expertise of the panel in how best to expedite the disclosure safely. The information , recommendations and support the partners bring to the panel is invaluable and reassuring the DVDS process is keeping our community safe.

North Yorkshire and York Multi-Agency Risk Assessment Conference (MARAC)s

Enhancing MARAC Response to Harmful Practice Cases – Developing a Standalone MARAC

Reason for the Changes - Coaction Hub, a partnership between the Asian Women's Resource Centre (AWRC) and Standing Together Against Domestic Abuse (STADA)—conducted a review of MARACs' effectiveness in handling cases involving harmful practices, particularly honour-based abuse and forced marriage. The findings highlighted

several gaps in the current MARAC process. Two of these areas are as follows:

- Structural Issues within MARAC - MARACs primarily assess domestic abuse risks, often overlooking harmful practices, which may involve multiple perpetrators and community-based abuse.
- Inadequate Discussion Time: The current meeting structure does not allow for the depth required to fully address the complexities of harmful practice cases.

The Role of 'By and for' Agencies - Specialist agencies that support Black and minoritised communities bring critical expertise but are often underutilised in MARAC processes.

These agencies face inconsistent funding and are often not core members of MARACs, limiting their ability to shape risk management strategies effectively.

Plans were put in place to enhance the MARAC response to harmful practices with the following changes being implemented:

- Dedicated Morning MARACs- All cases involving Honour-Based Abuse, Forced Marriage, and Female Genital Mutilation (FGM) will be discussed.
- Enhanced Confidentiality - These sessions will be 'Closed MARACs', with invitations limited to core MARAC members to maintain strict confidentiality.
- Extended Case Discussion Time - Each case will have an extended discussion time of 30 minutes to allow for in-depth safety planning, including multiple perpetrators and complex risk factors.
- Stronger Role for 'By and for' Agencies - Halo has confirmed its commitment to support and co-lead these changes, with the long-term goal of co-chairing the Harmful Practice MARACs.
- Halo will take the lead in developing the action plan for these cases, ensuring culturally appropriate and effective interventions.

By implementing these changes, the MARAC process will become more inclusive, responsive, and effective in addressing harmful practices, ultimately improving protection and outcomes for survivors.

Humber and North Yorkshire Integrated Care Board (HNY ICB)

As a statutory partner of CYSAB, the ICB continues to embed safeguarding responsibilities across the system, providing strategic representation at CYSAB meetings by the Director of Nursing for Core Statutory Partnerships and/or the Deputy Director of Safeguarding, with regular contributions from Designated Professionals for Safeguarding Adults.

We have supported joint working with key strategic partnerships, including the Safer York Partnership, the York Domestic Abuse Partnership, the North Yorkshire and York Prevent Partnership and respective Channel processes and the North Yorkshire and York Modern Slavery Partnership.

The ICB has actively contributed to multi-agency efforts to address areas of growing concern such as domestic abuse, with domestic abuse being an identified priority for HNYICB. Designated professionals and local providers continue to ensure engagement with the ICB wide Domestic Abuse and Sexual Violence working group.

The ICB are also engaged in the multi-agency response to the Serious Violence Duty, contributing to coordinated prevention strategies across sectors. In 202024/25, well-attended lunch and learn sessions have been arranged by the ICB to enable health staff to understand the core elements of the Serious Violence Duty.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

The Trust continues to contribute to the Safeguarding Board/ Partnership arrangements as well as the Community Safety Partnership as a key partner.

The Trust continues to review and strengthen our Joint Safeguarding Adult and Children mandatory training at all levels following any new learning or feedback. This includes raise awareness of, and reduce the harm caused by ‘Hidden Harms’, abuse associated with County Lines activity, domestic abuse and modern slavery.

We have recently re-established an internal domestic abuse training package for staff to access which further strengthens knowledge and skills across the organisation.

York and Scarborough NHS Foundation Trust

The Trust is represented at the CYSAB and contributes to subgroups. The team have also committed to delivery priorities. The integrated

work of the adult and children safeguarding team means that children affected by an adult attendance/admission have a safeguarding review on the day following attendance. The team also visits the Emergency Department daily to identify any immediate adults/children at risk.

Domestic Abuse Practitioners (DAP) funding was secured (December 2024 and January 2025) from Continuing Professional Development monies and has facilitated the recruitment of two domestic abuse practitioners. Their key priority areas are to:

- Provide training to frontline practitioners.
- Promote good practice in prevention, identification, actioning safeguarding children and adults' processes.
- Provide education to enable staff to provide timely support to victims of domestic abuse along with education/resources to support with the assessment of risk and completion of referrals to Social Care.

Leeds and York Partnership NHS Foundation Trust

LYPFT have limited involvement with City of York Council community safety partnership as they only have two small service provisions in the area. However, the safeguarding team respond to all requests from for scoping and sharing learning from SARs and promote awareness raising as required to the services in York.

York Advocacy Hub

All our advocates undergo training in relation to domestic abuse as part of their induction process, which is refreshed annually. Further to this they complete Safeguarding training which is refreshed every 3 years. County lines and modern slavery are covered within safeguarding training, as is elements of radicalisation/counter terrorism, however we are seeking for our staff more extensive County Lines and Modern Slavery training.

City of York Public Health

Public Health are a core member of the Community Safety Partnership Board and actively update board members on Domestic Abuse (DA) strategy, recommendations, and action plans. Public Health work closely with North Yorkshire Council and the Office for Policing, Fire, Crime and Commissioning to look at any duplication or overlap between DA, other Violence Against Women and Girls (VAWG) related crimes such as stalking and sexual exploitation, crimes recognised under Serious Violence Duty and county lines activity.

Probation Service Yorkshire and Humber

We have processes in place to ensure information sharing and a multi-agency approach. For example, we work closely with the Police to identify individuals at risk of exploitation, we attend and provide input to Multi-Agency Risk Assessment Conferences (MARAC) and Multi-Agency Tasking and Coordination (MATAC) meetings and have a full time Practitioner co-located within the Multi Agency Safeguarding Hub (MASH). This practitioner provides an excellent interface between Probation services and other key partners across the city, contributing to triage meetings and sharing critical information. Probation colleagues contribute to a multi-agency approach to county lines and domestic abuse. Our Multi-Agency Public Protection Arrangements (MAPPA) work is well established with excellent participation from duty to co-operate agencies to safeguard victims.

City of York Council Public Protection

Public Protection Officers identify 'hidden harms' as they undertake their environmental health, trading standards and licensing visits to businesses. We anticipate the number of potential modern slavery reports to increase with increased focus on shops selling illegal vapes.

North Yorkshire Fire and Rescue Service (NYFRS)

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

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

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

6. Safeguarding Adults Reviews (SARs)

The CYSAB Review and Learning subgroup (RLG) continued to consider cases which may fit the criteria for a Safeguarding Adults Review under section 44 of the Care Act i.e. SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult." and make a recommendation to the Independent Chair of CYSAB, who makes the final decision.

One SAR was completed in 2024-25 called the Julie SAR. Julie had a long history of complex needs including anorexia, mental health issues, substance misuse, and self-neglect. She lived in private rented accommodation in York, which became unsuitable due to her declining mobility and health. The accommodation did not meet her needs towards the end of life, and she was unable to leave the property due to her reduced mobility and health. She was known to several services throughout her life for her physical, mental health and social care needs. Julie had periods of time in hospital and rehabilitation establishments due to ongoing self-neglect, The learning from this SAR related to the need for agencies to be professionally curious, assessment of Mental Capacity and the use of Advocacy as well as complexity of Need and Information Sharing and dealing with Did Not Attend (DNA).

Two SARs, which began in 2023-24 are currently being conducted involving neglect in care settings involving older adults. The findings of these will be known in 2025-26 but early lessons have been acted upon to prevent abuse and neglect in the future.

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

The three Statutory partners of CYSAB met monthly during 2024-25 for a Section 44 panel which looked at 48 cases during the year to assess whether these should be referred for a SAR. Of these 48 cases several went to a CYSAB Rapid Review group which allowed all partner agencies, including non-statutory organisations to provide more detail regarding each case. This provided a robust mechanism for identifying and checking cases allowing discussion between all partners to ensure learning opportunities were not missed.

From these two subgroups, 13 cases were referred to the Learning and Review Subgroup for SAR consideration. The table below highlights the decisions made regarding these SAR referrals.

SAR referrals			
SAR referrals considered in 2024/25	SAR referrals approved for statutory SAR	SAR referrals approved for discretionary SAR/ Desktop review	SAR referrals not approved
13	5	1	7

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

The governance process for how SARs are referred, scoped and approved went through a review in 2024-25 which resulted in the SAR process changing which will be reported on in next year's annual report. A SAR referral form is available online and new scoping documentation is being used to gather information from partners regarding cases. The RLG has now been replaced with a SAR subgroup and a SAR decision panel as well as a Pre SAR panel which replaces the Section 44 panel. This allows more overview of the recommendations and learning identified through SARs and ensures that cases are considered in a timely and thorough manner.

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

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

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

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

This year we asked agencies what impact has the learning from published SARs in York had in their organisation. Below are some of the responses regarding the impact of SAR learning for each SAR. The links to further information on the individual SARs can be found on the links below.

MR A SAR

Full Report - safeguardingadultsyork.org.uk/downloads/file/22/mr-a-sar-report

7 Minute Briefing - safeguardingadultsyork.org.uk/downloads/file/21/7-minute-briefing-mr-a

Following a series of workshops in the Humber and North Yorkshire area with a focus on Mental Capacity and Self-Neglect the ICB safeguarding team have seen an increase in requests for advice and support in managing individuals with complex presentations.(Humber and North Yorkshire ICB)

This has led to roll out and implementation of the Oliver McGowan Training, systems for referral both internally and by autistic people, and health passports (York and Scarborough NHS FT)

There are more timely Deprivation of Liberty Safeguards for those most in need. More people are safeguarded through organisational abuse process. Services that have gone through the organisational abuse process have fed back positively about the process and improvements they have made as a result. (City of York Adult Social Care)

With the steps we take and commitment to providing a consistent, impactful advocacy service we hope to contribute to the prevention of cases like Mr A's. Cuckooing and county lines is included in safeguarding training for induction, and we are seeking more in-depth training to broaden our awareness further. Any indicators of cuckooing and/or county lines, our advocates will flag this to safeguarding and north Yorkshire Police (York Advocacy Hub)

The trust mental health legislation team have oversight of all adults who are detained under the mental health act and monitor renewals, section 132, Mental Health Review tribunals and Mental Health Act Managers hearings. (Leeds and York NHS Partnership Foundation trust NHS FT)

MR Z SAR

Full Report – safeguardingadultsyork.org.uk/downloads/file/23/mr-z-safeguarding-adults-review

7 Minute Briefing - safeguardingadultsyork.org.uk/downloads/file/20/7-minute-briefing-mr-z

We are seeing improved capacity assessments and better understanding of fluctuating capacity cases, although not consistently as improved awareness and understanding of applying Mental capacity assessment (MCA), but we still see basic principles not being followed, wherever we can, we try to offer awareness raising and guidance around the MCA to contribute to improving this for adults. (York Advocacy Hub)

There has been an increase in safeguarding referrals about home invasion and more people supported by staff with improved training. (City of York Adult Social Care)

Mental Capacity Act (MCA) training is mandatory for all staff, this is delivered by the Mental Health Legislation team (MHL), is 2 ½ hours long, and they monitor compliance, which is currently at 81 %. All staff are expected to attend refresher training every 2 years. The issue of executive function has been detailed in the initial MCA training and reflects case law. (Leeds and York NHS Partnership Foundation trust NHS FT)

The trust Safeguarding team provide mandatory safeguarding training and monitor compliance currently at 85 %. Cuckooing and county lines is included in the training, and it is also included in the safeguarding contact form in the service users electronic care records. (Leeds and York NHS Partnership Foundation trust NHS FT)

Improved sharing of information supports keeping people safe, as it ensures all agencies are clear about each other's role and responsibility within safeguarding and ensures that everyone involved is clear about how risks are being managed. This is evidenced by case records and risk management plans. (Probation Service Yorkshire and Humber)

JAKE SAR

Summary - safeguardingadultsyork.org.uk/downloads/file/17/sar-briefing-jake

Full Report - safeguardingadultsyork.org.uk/downloads/file/24/final-sar-jake

Review of our office environment has been completed and surgeries with NAS are available for practitioners working with those who are neurodivergent (Probation Service Yorkshire and Humber)

Autistic patients now have a service to support them help staff understand their needs (York and Scarborough NHS FT)

The Team works across services and systems to deliver clear benefits and measurable improvements of autism informed mental health care (Tees Esk and Wear Valley NHS Foundation Trust)

People with autism and highly complex needs are now living their lives supported in the community in their own homes with fewer restrictions and more opportunities. (Humber and North Yorkshire ICB)

The importance of considering reasonable adjustments is in the new updated and refreshed clinical risk training that is delivered in the trust, in conjunction with the introduction of a new risk assessment in the electronic adult's care records. Reasonable adjustment has a section in the electronic care record. (Leeds and York NHS Partnership Foundation trust NHS FT)

JULIE SAR

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

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

A 'was not brought' rather than DNA (did not attend) policy has been written and disseminated across primary care. (Humber and North Yorkshire ICB)

The recommendations are included in Core Priority Goal 1 for Safeguarding and Complex Needs Team and raising awareness of the legal framework of deprivation of liberty safeguards and professional curiosity has been embedded in training and resources (York and Scarborough NHS FT)

There is an increased number of people supported through the transitional safeguarding route. Case studies show positive outcomes in relation to young people developing the autonomy to manage risk with the support of those around them. (City of York Adult Social Care)

There is an increased number of people supported through the transitional safeguarding route. Case studies show positive outcomes in relation to young people developing the autonomy to manage risk with the support of those around them. (City of York Adult Social Care)

Professional curiosity is promoted by the safeguarding team in training and advice and support; a briefing is available to all staff in the intranet. (Leeds and York NHS Partnership Foundation trust NHS FT)

7. Safeguarding priorities for some of our partner agencies for 2025-26

North Yorkshire police

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

York Advocacy Hub (YAH)

The YHA have a number of priorities for 2025-26 including:

- raising advocacy awareness with professionals to improve understanding of our role and referral process
- improving self-advocacy skills for the mental health community in York, through the implementation of mental health self-advocacy forum, this will mirror our Learning Disability self-advocacy forum, and will focus on helping people with mental health understand the services available, the professionals within them, how to access various elements of support, understanding their rights, asking for the care and treatment they want/need and making advance directives
- our service has just joined the CYSAB and attended our first meeting, we plan to prioritise our engagement and contribution to these meetings
- keen to support the city of York, adults and services to work to reduce the number of deaths by suicide in York
- keen to support work around understanding and application of the MCA
- establishing a provision for CYC out of area deprivation of liberty (DoLs) clients with Relevant Person's Representative (RPR's) to monitor their deprivations
- prioritise how we safeguard/support people who self-neglect when their capacity is not in doubt

- prioritise transitional safeguarding and how we ensure that risks are managed when a child moves to adulthood
- work closer with system partners to reduce duplication and make the best use of our limited specialist safeguarding resource.
- assure that agencies are working well together to support the outcomes of the strategic plan.
- provide a forum for continuous learning and sharing practice with an emphasis on learning from lived experience and the voice of the Adult.

City of York Adult Social Care

Priorities for City of York Council will focus on preventing the need for care and support, developing our approach to housing and accommodation so that it supports independence and making sure that we commission and deliver services that promote fairness and equality, deliver good outcomes for people and represent best value.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

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

policies and procedures – to ensure that Trust policies/procedures relevant to Safeguarding and Public Protection are fit for purpose.

audit – to carry out audits in line with Trusts audit programme

specialist Safeguarding Supervision – to deliver the proposal of specialist safeguarding supervision.

establish current multi-agency safeguarding arrangements – to understand the current multi-agency safeguarding arrangements, attendance and governance routes within TEWV.

CYC Public Protection

We will continue to focus our activities on rogue traders who target vulnerable residents in the course of carrying out property repairs and maintenance such as roofing and guttering work as well repairs to driveways and gardening services. Working with partners we will be seeking ways to deliver a scheme for recognising traders who provide quality services as a replacement for Age UK York's Home Services Directory which is no longer supported. We will continue to provide support to scam victims and provide talks to community groups to raise awareness.

Leeds and York Partnership NHS Foundation Trust (LYPFT)

LYPFT have a number of areas which we will focus on including:

Routine enquiry and risk assessment - Routine enquiry involves asking all adults about their experience of domestic abuse and is a recurring theme in domestic homicide reviews. Safeguarding reviews at Leeds and York Partnership NHS Foundation Trust have shown that routine enquiry is not consistently used in practice. It is now embedded in the Risk and Management Plan, with an expectation that staff will carry it out when safe and appropriate. The safeguarding team continues to raise awareness through clinical governance groups, SBAR (Situation, Background, Assessment, Recommendation) briefings, lunch and learn sessions, link practitioner meetings, and duty advice calls. A planned audit will assess whether routine enquiry is being considered, completed, and its impact on adults.

Special Educational Needs and/or Disability - The Head of Safeguarding has taken strategic responsibility for the SEND (Special Educational Needs and/or Disabilities) assurance process within LYPFT. SEND applies to individuals aged 0–25 who require special health and education support due to learning difficulties or disabilities. Under the Children Act 1989, all children, including those with SEND, are entitled to protection, with their welfare being paramount. Integrated Care Boards (ICBs) must work with local authorities on Education, Health and Care (EHC) plans, and health commissioners are responsible for delivering the specified health provision. As the legislation covers up to age 25, SEND inspections may involve adult services where an EHC plan is in place. The Head of Safeguarding will ensure all LYPFT services understand their role in SEND audits and inspections and will coordinate the process.

Sexual Safety - In 2018, the CQC and NHS Improvement identified over 1,100 sexual safety incidents on mental health wards in just three months, affecting service users, staff, and visitors. In response, NHSE/I commissioned the National Collaborating Centre for Mental Health (NCCMH) to develop co-produced standards to improve sexual safety in inpatient settings. These apply to everyone in the environment—patients, staff, and visitors. At LYPFT, the safeguarding team now leads the sexual safety project, with monthly meetings and a quarterly report analysing incidents and tracking progress. This report is shared with the Trust wide clinical governance group and safeguarding committee and includes actions taken to improve safety.

York and Scarborough NHS Teaching Hospital Trust

We will engage with the workforce to identify engagement and awareness opportunities to support staff and enhance practice.

We will promote a culture of continuous learning and improvement to ensure the workforce remains confident and effective in safeguarding.

We will ensure the Team is delivering a cost effective, valuable, efficient and effective service which improves patient safety and satisfaction.

Probation Service Yorkshire and Humber

We will focus on the following three areas:

- further improve relationships with Adult Social Care, building on the learning from improvements made this year with Children's services.
- improve the quality of our referrals into services.
- contribute to 'Housing First' in the city to support those with multiple disadvantage

Humber and North Yorkshire Integrated Care Board (HNY ICB)

National reorganisation of the function of ICBs was announced by the HM Government in March 2025. The core function of the ICB will be as strategic commissioner with a focus on system leadership to improve population health, reduce health inequalities and ensure access to consistently high quality and efficient care.

As such there are a number of functions currently part of the ICB which have been identified for 'review and transfer over time'. Safeguarding is one of the functions that will be affected by this change. The ICB will still be required to fulfil its statutory responsibility for safeguarding, however, it is anticipated that there will be a radical change to what is currently in place and how this is delivered.

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

North Yorkshire fire and rescue service (NYFRS)

In 2025–26, the Service will focus on strengthening its prevention and safeguarding work through governance, workforce development, and

continuous learning. There has been an introduction of the Learning, Development and Risk Meeting, which will provide an arena to drive improvement across prevention.

The meeting will:

- Inform priorities, policies, and plans for learning and development that support prevention.
- Share learning from operational activity, community engagement, audits, and evaluations.
- Monitor and respond to risks and challenges in prevention-related activities.
- Raise concerns, identify gaps, and discuss issues affecting prevention effectiveness.
- Promote evidence-based and innovative approaches to learning and delivery.
- Evaluate the impact of current training and development activity against strategic aims.

As part of this work, the attendees will as appropriate review external learning sources, including:

- Safeguarding Adult Reviews (SARs)
- Domestic Abuse Related Death Reviews (DARDRs)
- National Organisational Learning
- Safeguarding Practice Reviews and Rapid Reviews
- Regulation 28 reports

Safeguarding Policy and Training - A review and refresh of the Service's Safeguarding Policy and Procedure will take place, ensuring it remains aligned with National Fire Chief Council (NFCC) guidance, and local frameworks. This will be supported by a refresh of safeguarding training across the organisation.

The Service will also identify new opportunities for staff development for roles involved in prevention and safeguarding. This will help ensure that staff are equipped with the skills and confidence to deliver high-quality, person-centred services.

Strengthening Partnerships and Prevention - The Service will continue to expand its Home Fire Safety Visit (HFSV) Referral Partnership, enabling earlier intervention for those most at risk. The School and Youth Engagement Manager will support improved engagement with young people.

8. Our new Strategy 2025-2028

The new CYSAB strategy sets out the priorities for 2025-2028 and next year's annual report will report on the 3 areas of focus below.

In order to meet the needs of adults in the City of York we have developed three areas of focus for our strategic plan which will guide the way we work together as a Board over the next three years to safeguard our communities and the safeguarding areas we want to strengthen:

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

- adults at risk of exploitation
- rough sleeping and homelessness
- self-neglect and hoarding

See the CYSAB Strategy 2025 – 2028: safeguardingadultsyork.org.uk/downloads/file/38/strategic-plan-for-2025-to-2028

9. Contacts

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

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

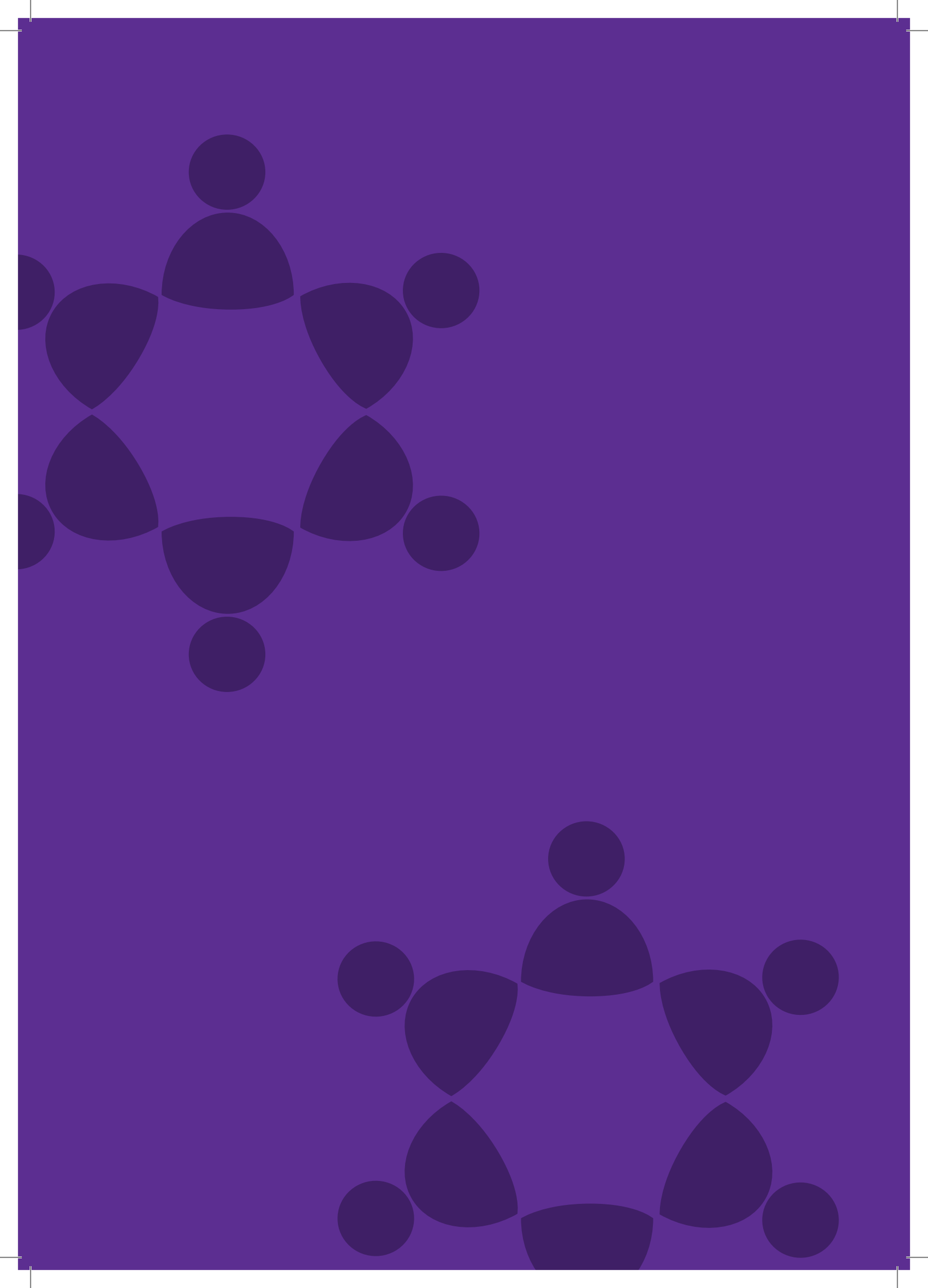
Contact the City of York Adult Social Care:

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

This document can be made available in other languages or formats if required.

To request another format, please contact us via sab@york.gov.uk


city cruises
RIVER TRIPS
Railway Station
Model Railway World
National Rail Museum



CITY OF YORK

Safeguarding Adults Board

If you would like this document in an alternative format, please contact:

(01904) 551550 ycc@york.gov.uk

It is available in the following languages:

我們也用您們的語言提供這個信息 **(Cantonese)**

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

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

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

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

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For further information: West Offices, Station Rise, York YO1 6GA

For more information visit: safeguardingadultsyork.org.uk