



Annual Report 2023-24

OUR VISION

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

For more information visit: safeguardingadultsyork.org.uk



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Foreword

I have been the Independent Chair of the City of York Safeguarding Adults Board since 2018 and this is my last year as I retired in May 2024. Pressure on safeguarding services still remains across the city as a result covid recovery and the cost-of-living crisis. The resilience of safeguarding services has remained consistent throughout 2023-24 and the individuals and teams across the partnership have continued to work incredibly hard to deliver effective outcomes for adults with care and support needs, their families and carers.

Mental health and self-neglect are still significant areas of need including pressure from adults who are vulnerably housed or facing homelessness. We have continued to work as a partnership to meet the needs of these areas and I would like to pay tribute to colleagues across all services in adult safeguarding, who have continued to play a vital role in improving the outcomes for those adults facing these risks, helping to prevent abuse and neglect.

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.

The Board has been fortunate enough to increase the support for running of the board and has successfully appointed a new

Business Manager who starts in May 2024. This will add a much-needed resource to allow the Board to meet its ever-increasing workload and support the increase in referrals for safeguarding adults reviews. The pressure on colleagues has been significant over the last few years, and so it is vital for the future of safeguarding services that both within the partnership and in individual organisations, we find a range of ways to support colleagues well into the future.

I am pleased and proud to have got the Board into the position it is now and wish to thank all my colleagues and partners who have come along with me on this journey. With the capability of the new Board Business Manager and a new Independent Chair I can see the Board going from strength to strength as I step down to make way for positive changes.



Tim Madgwick

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, that is, the City of York Council, NHS Humber and North Yorkshire Integrated Care Board, and 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:

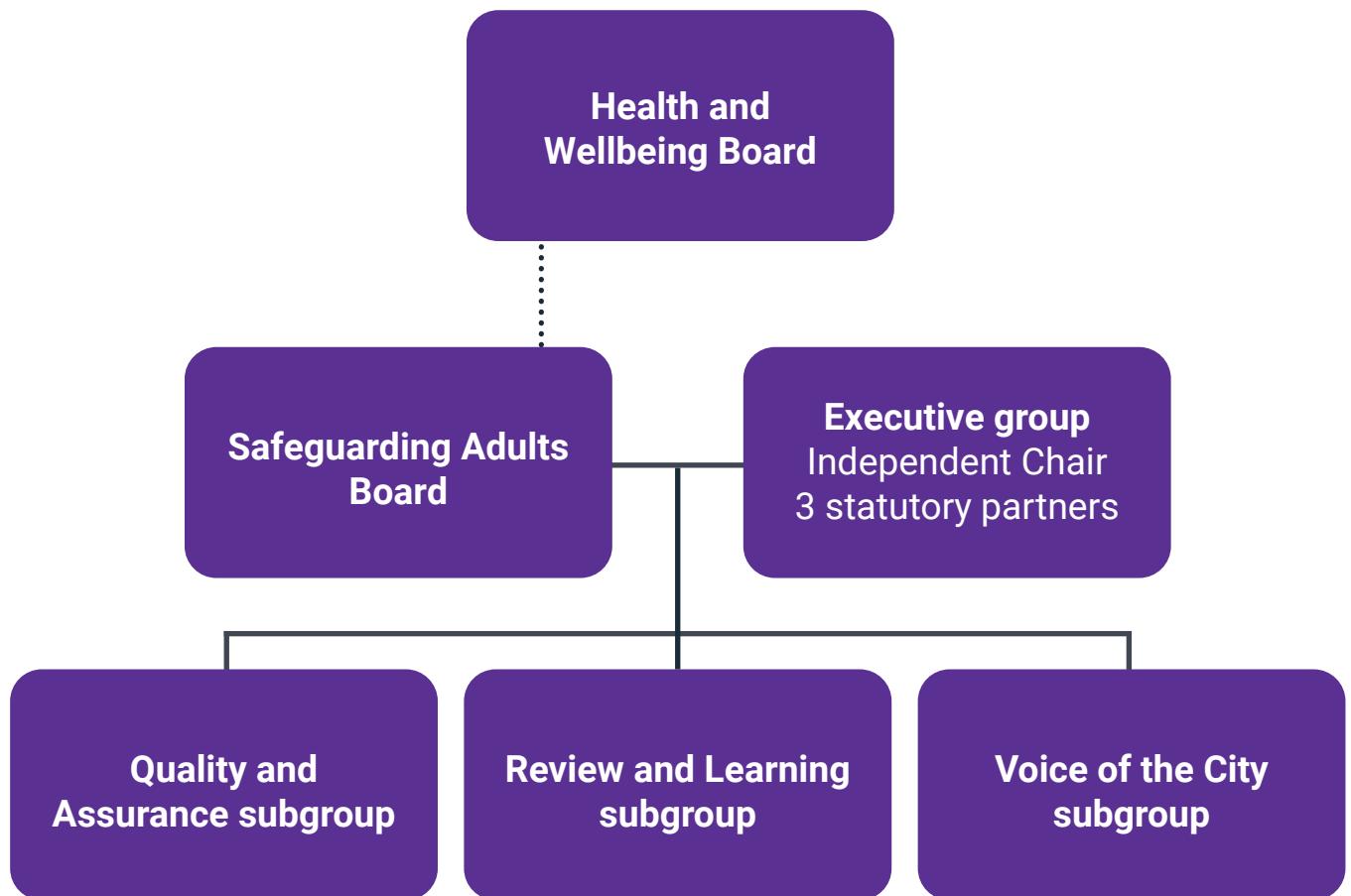
The SAB has three core duties, in accordance with the Care Act 2014:

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 have four sub-groups. These are the Executive Group, Quality and Assurance, Review and Learning and the Voice of the City.



2. The Voice of the Adult

J is a young adult who has several complex mental health issues, and experienced childhood trauma and abuse. J is estranged from their family and has a limited support network. J has been well known to Adult Safeguarding and other services; they have difficulties with attachment and abandonment issues and struggle to build positive relationships with professionals due to feeling let down by services previously.

Getting safeguarding and support

J was referred to safeguarding due to concerns regarding contact with their previous abuser, and they were also experiencing harassment. J felt unsafe in their home, and this led to them sleeping in vulnerable accommodation and placing them at further risk of harm and exploitation.

What did the adult want to happen

J expressed that the outcomes they wanted to achieve from the safeguarding process were to be rehoused away from their current neighbourhood, and to receive trauma informed therapy from mental health professionals, who have often discharged them from services. A key outcome they also described was to be listened to without feeling judged.

What was achieved for the adult

A number of partners were involved in the safeguarding enquiry in addition to the City of York Safeguarding team, including Independent Domestic Abuse Service (IDAS), Primary Care (GP), City of York Local Area Communities Team and Housing Team, in addition to City of York mental health services. A series of safeguarding and multi-disciplinary meetings were held.

The safeguarding worker advocated on J's behalf and was able to challenge the assumptions of others, with an emphasis on trauma informed practice. The worker met with J on various occasions including face to face and telephone contact, and this led to a positive and trusting relationship being established.

J is now receiving input from mental health services and has been rehoused. As part of the safeguarding process J was provided with a range of support including practical support with budgeting and managing their accommodation. J is also no longer in contact with their previous abuser.

Voice of the person

J gave some brief feedback during face-to-face meetings but, they struggled to articulate their thoughts when speaking in person, so they chose to provide further feedback in a letter, about what the safeguarding

support has helped them achieve. J was invited to attend the safeguarding meetings but they were happier for their safeguarding workers to advocate their wishes and views on their behalf. J described how things have changed for the better for them and that they are now safe.

“

J feels their voice has been heard and is now hopeful that they can trust professionals, and that they want to help.

J emphasised that they were spoken to like a 'normal person'.

'You've genuinely made me feel so heard and understood and like I can tell you anything without judgement. You've helped me do things that I never thought I would be able to do.'

'Because unlike other professionals you genuinely do help and care. Others deserve that too, especially since you make people feel safe and I am safe now.;

'Thank you for all your help over the last year, I am so lucky to have been able to meet you, you have changed things for the better for me. To have someone I can trust and rely on to understand me, listen to me and be there for me. You've proven to me that good people do exist, and that despite my frequent doubts, you have made me feel worthy of kindness. You've always made me feel no matter what I tell you, I will always be heard and empathised with.'

'You have made a difference to my life, not just being safe and managing things better, you've proven that I am able to be cared about, liked. Which as you know, is something I believed wasn't possible for me. The fact that you have managed to change my way of thinking, my ability to trust people, to open up and not feel judged or ignored, is something I cannot be more grateful for.'

- J

3. What the Board has achieved at a glance

Transitional safeguarding protocol:

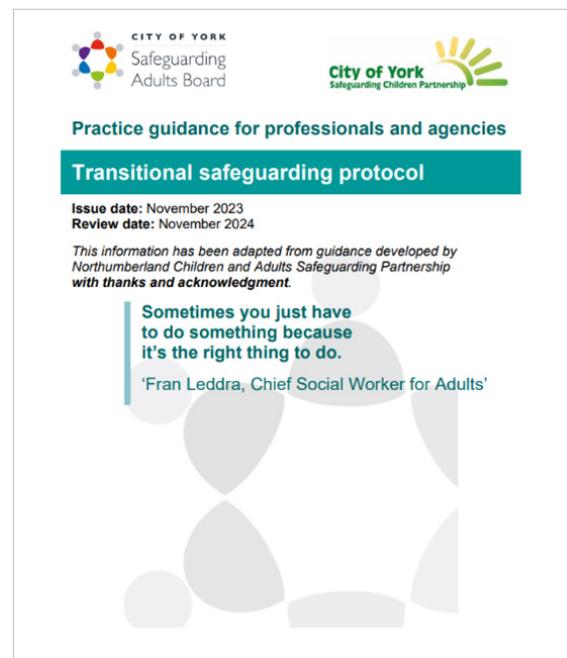
Developing an all-age approach to safeguarding is a key priority for the Board, who recognise that abuse and neglect is likely to continue post 18 years old, and that adults at risk are targeted due to their vulnerability irrespective of age.

Learning from reviews has found that transitioning from childhood to adulthood can be extremely challenging and complex, particularly from a safeguarding perspective. It is recognised that to respond to these complex risks and harms there is a need to safeguard young adults more effectively, to avoid them falling between the thresholds and legal frameworks.

During 2023-24 the SAB developed and published a Transitional Safeguarding Protocol, which was endorsed by both the CYSAB and the Safeguarding Childrens Partnership (CYSCP).

This framework provides early opportunities to identify the most appropriate pathway for a young person, facilitating joint working, and ensures appropriate referrals and signposting take place in a timely manner to reduce safeguarding risks. Planning has been underway for a joint Board development session to take place and partnership in June

2024, focusing upon embedding and operationalising this protocol across the partnership, and to drive forward this work at a strategic and practice level.



There is also ongoing work to set up multi-agency operational and strategic arrangements to align transitional safeguarding and Preparation for Adulthood approaches. There is a CYSAB commitment to monitor and oversee progress on this work moving forward, and ensure outcomes and impact are measured.

Joint multi-agency safeguarding adults policy and procedures

We have built on the work undertaken in 2022-23 when the CYSAB launched their multi-agency online Safeguarding Adults Policy and Procedures across all agencies. These procedures were produced as part of a regional consortium, and this year we have developed our local contacts and resources section which contains a range of CYSAB referral, process and guidance resources. A local '[People in Positions of Trust](#)' (PiPoT) process has also been launched, and an online PiPoT referral form.

These multi-agency policies and procedures are a valuable safeguarding resource, which are reviewed and updated bi-annually based on national policy, publications and best practice. Moving forward we want to continue to promote these resources, to raise awareness and use of these procedures across all partner agencies. The policies and procedures can be found at the following website: wynyy-cityofyork.trixonline.co.uk

Safeguarding adults guidance and practice resources

During 2023-24 the SAB has developed and published a range of guidance and practice resources. This includes some key guidance for practitioners and organisations about 'How to make a good safeguarding referral', a 'Safeguarding adults and falls protocol', and a range

of 7 minute briefings. A number of easy read leaflets and posters have been produced, and a series of public animations, created with other national safeguarding boards, including 'Tricky Friends', 'What to do about Self-neglect' and 'Hidden Harms'. These resources are available on both the [Resources section](#) of the CYSAB website and online procedures.



Practice guidance for professionals and agencies

Making a 'good' Safeguarding Adults referral

Safeguarding Adults is everyone's responsibility. Timely, accurate and well-constructed referrals help agencies work together to keep adults with care and support needs safe.

Purpose of this guidance:
To provide professionals and agencies with guidance about what constitutes a 'good' safeguarding adults referral, to support timely and robust assessments and responses to safeguarding concerns.

Top tips – don't forget to include:

- What have you **seen**? (where, when) What have you **heard**? (when, who from)
- Basic information about the adult(s) at risk. What **care and support needs** do they have? Why are they unable to protect themselves from the abuse/neglect or the risk of it? Do they have **mental capacity** to make decisions about keeping themselves safe/other relevant decisions (please specify)?
- Basic information about the person alleged to be causing the abuse or neglect. Do they have any care and support needs? Do they work with children or vulnerable adults? Are they in a **position of trust**? Do you know if they have a **history of posing a risk to others**?
- Why are you worried? What **abuse/neglect** is the adult(s) at risk of or experiencing? This could include (but not limited to) physical, emotional, sexual, neglect, financial, organisational, self-neglect, modern slavery, exploitation or discrimination. Has



Practice guidance for professionals and agencies

Safeguarding Adults and Falls Protocol

Issue date: October 2023
This information has been adapted from guidance developed by Newcastle Safeguarding Adults Board with thanks and acknowledgement.

Developing multi-agency data and information

During this year, initial discussions have taken place with partner agencies to map what safeguarding data is available across the safeguarding sector, and how this can be reported into the Board.

Work has taken place to update the online safeguarding referral to ensure we are capturing appropriate referral sources and information from partners, to inform the development of a multi-agency dashboard.

This work is a key priority and area of development for the Board in 2024-25 to ensure key safeguarding trends and themes can be identified and responded to.



Continued partnership working

The SAB structures and subgroups have worked well to provide multi agency forums in which safeguarding can be discussed.

Partners have reported benefiting significantly from these groups in identifying ways to address gaps or multi-agency shared risk, in particular through the Learning and Review subgroup and Rapid Review group.



4. What does our data tell us?

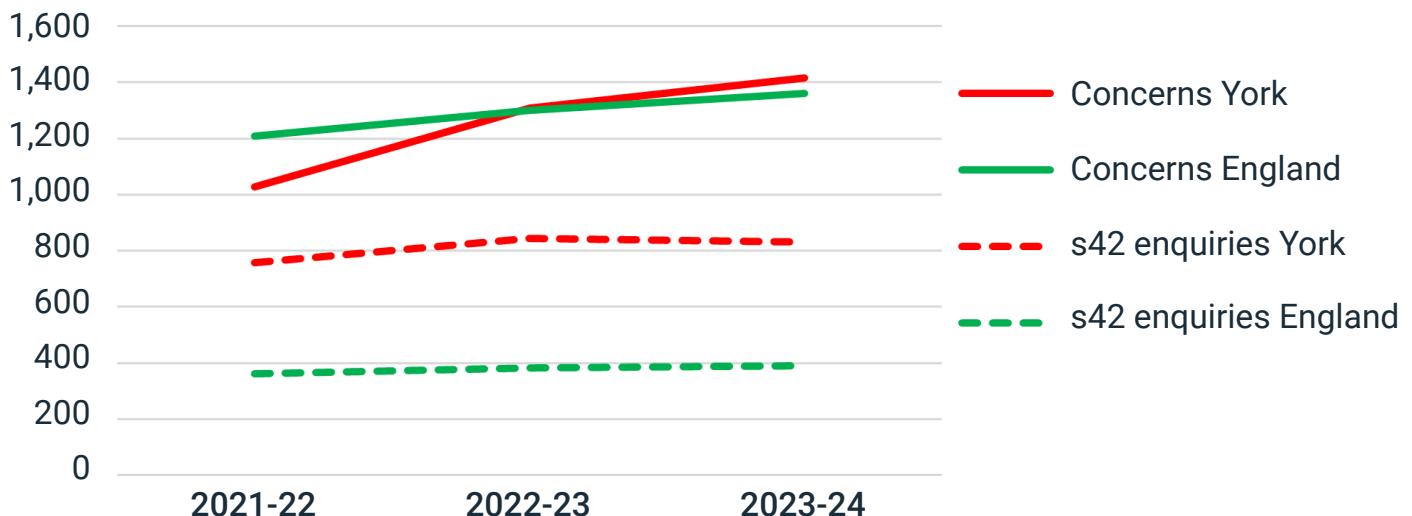
This section outlines our key safeguarding activity data relating to our safeguarding arrangements, and any arising themes and observations.

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

Safeguarding activity over the last three years			
	2021-2022	2022-2023	2023-2024
Safeguarding concerns reported	1,715	2,219	2,438
Section 42 (s42) enquiries completed	1,266	1,431	1,428
Other enquiries completed	9	12	18
Section 42 enquiries as % of safeguarding concerns - York	73.8	64.5	58.6
Section 42 enquiries as % of safeguarding concerns - England	29.9	29.5	28.7



Safeguarding concerns / Section 42 enquiries per 100,000 adults, 2021-22 to 2023-24



Overview:

- There has been a continued increase (10%) in the volume of safeguarding concerns received, compared with the previous year. There has been a 42% increase in safeguarding concerns reported in York since 2021-22.
- During 2023-24 58.7% of safeguarding concerns resulted in a section 42 enquiry, which is lower than previous years, but is significantly higher than the England average of 28.7%. During this year we have undertaken some further work with partners about what constitutes a 'good safeguarding referral' and have published some guidance around this.
- Whilst the number of individuals involved in safeguarding enquiries has remained stable, there has been a positive increase in 'other' enquiries. In accordance with the Care Act 'other' enquiries are those where there is no duty to undertake enquiry, but the local authority deems it to be the most appropriate and proportionate response to the circumstances
- The CYSAB will continue to work with Adult Social Care to identify and analyse any key trends or anomalies in the next year.
- There were no Safeguarding Adults Reviews completed during 2023-24, however the Review and Learning subgroup have led and overseen two ongoing Safeguarding Adults Reviews.

Safeguarding demographics by age

Age band	2021-2022	2022-2023	2023-2024	% change 2021-22 to 2023-24
18-64	487	576	570	17
65-74	106	147	171	61
75-84	223	305	319	43
85-94	316	354	366	16
95+	68	77	106	56
Not Known	0	3	5	N/A

Safeguarding demographics by sex

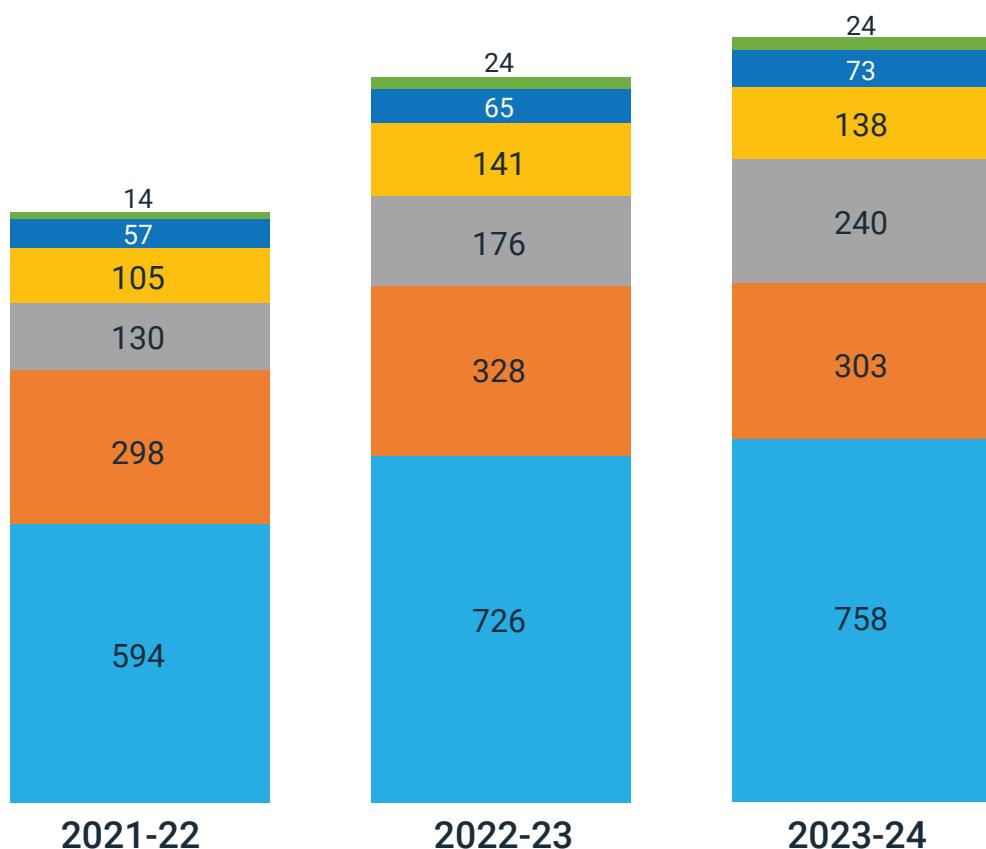
Sex	2021-2022	2022-2023	2023-2024	% change 2021-22 to 2023-24
Female	716	900	906	27
Male	476	548	568	19
Not known	8	14	63	688

Safeguarding demographics by ethnic origin

Ethnic Origin	2021-2022	2022-2023	2023-2024	% change 2021-22 to 2023-24
White	1,100	1,323	1,354	23
Other	15	22	39	160
Refused/Unknown	85	117	144	69

The increase in concerns in recent years has mainly been driven by 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.

Individuals involved in safeguarding concerns by PSR, 2021-22 to 2023-24

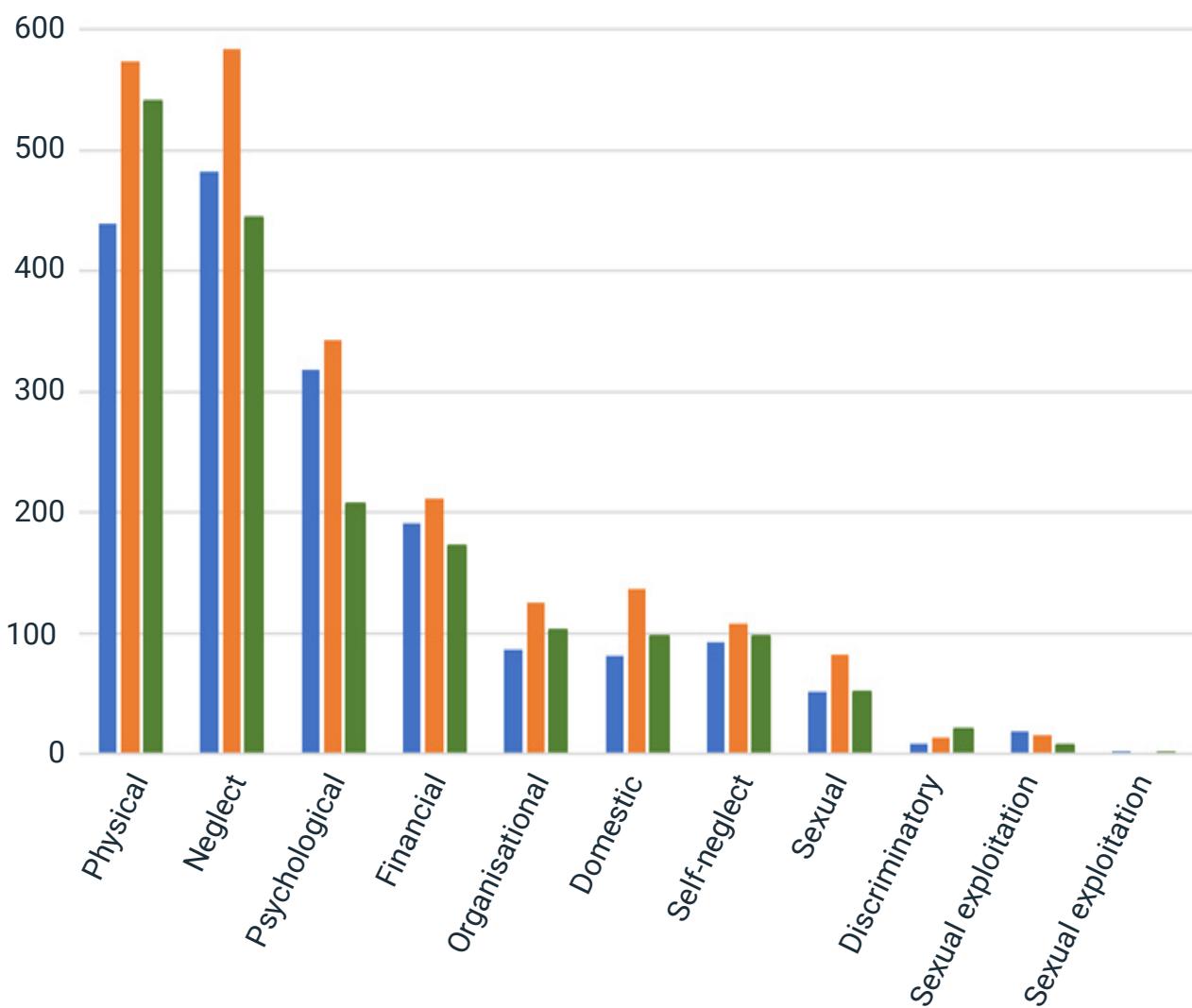


Key

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

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

Section 42 enquiries by type of abuse investigated, 2021-22 to 2023-24

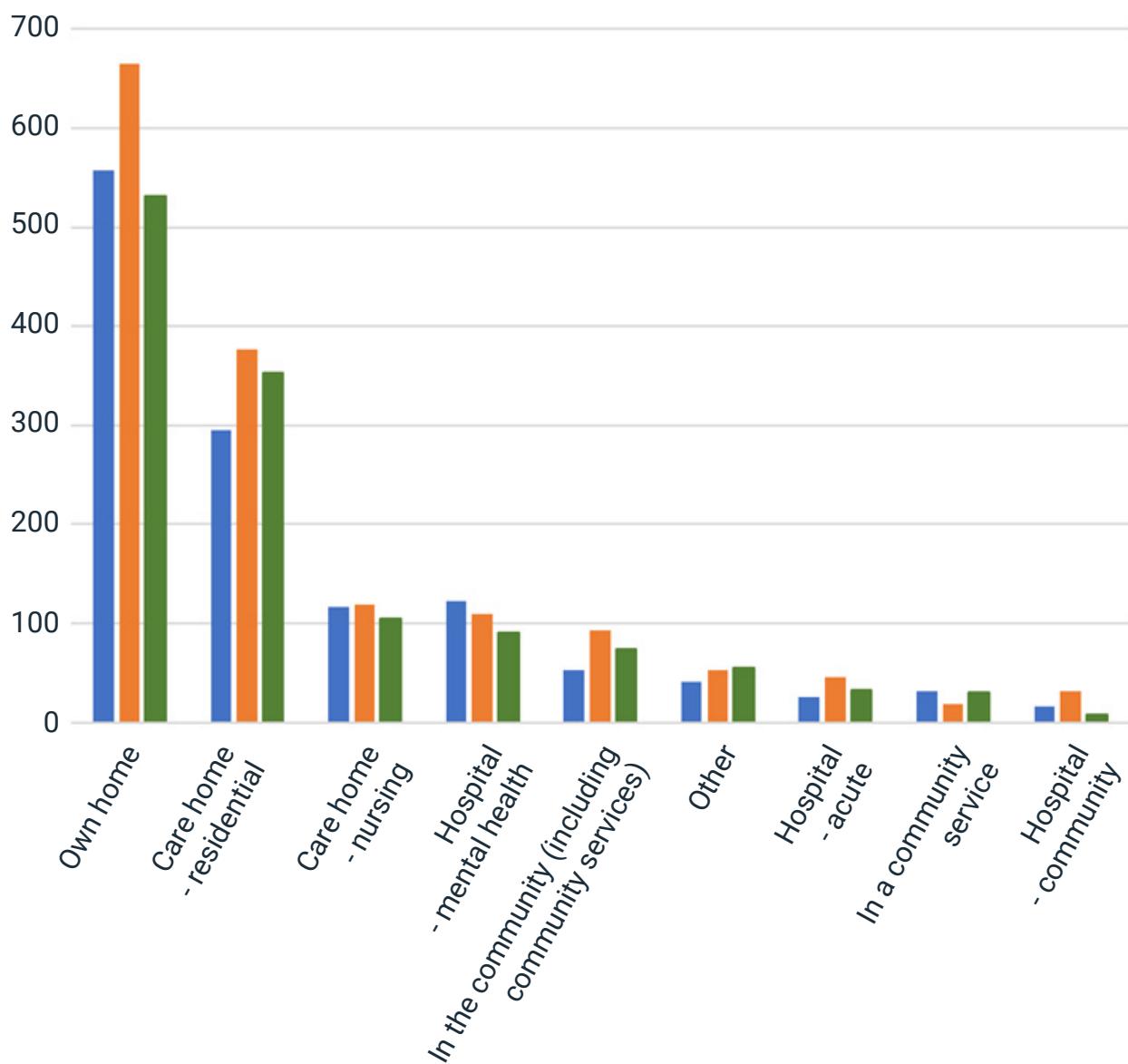


Key

■ 2021-2022 ■ 2022-2023 ■ 2023-2024

Neglect and physical abuse was the most common type of abuse recorded in 2023-24, and similarly in 2021-22 and 2022-23 this was neglect. Almost all forms of abuse have lower counts in 2023-24 than in 2022-23, and there is work being undertaken to ensure multiple abuse types are being captured appropriately.

Section 42 enquiries by location of abuse investigated, 2021-22 to 2023-24



Key

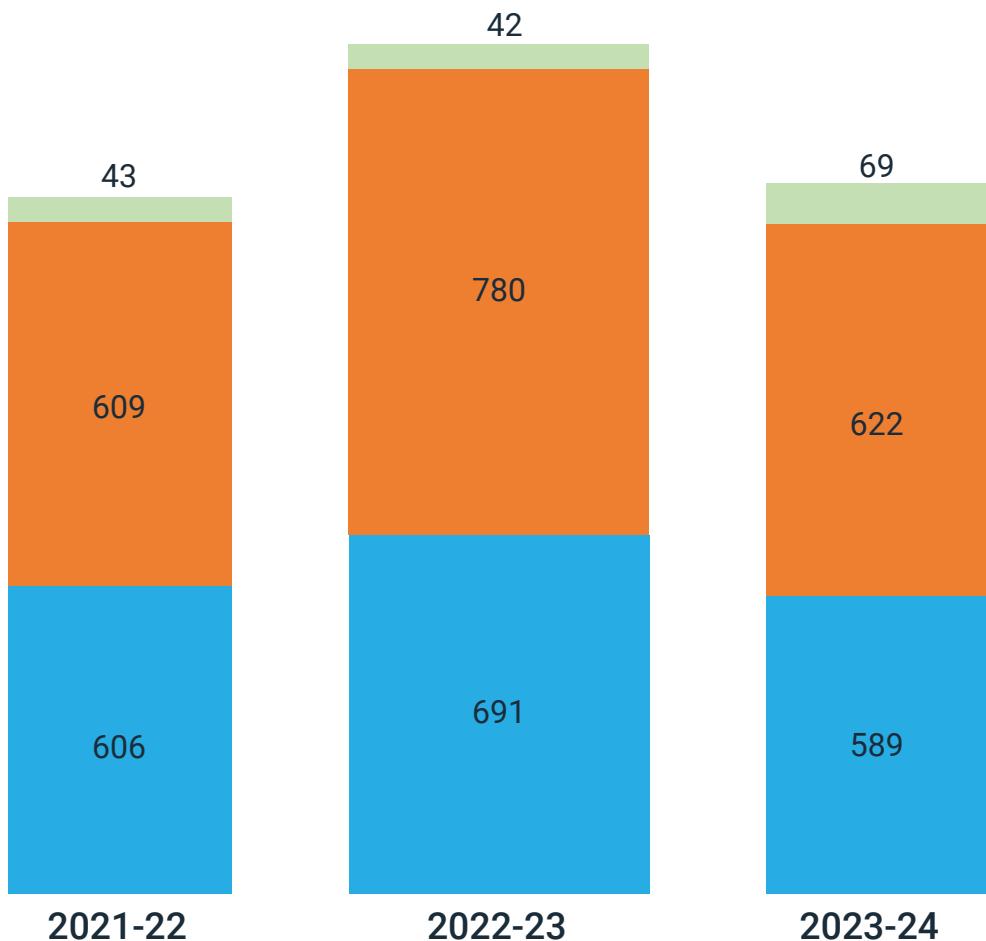
■ 2021-2022

■ 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.

Section 42 enquiries by source of risk, 2021-22 to 2023-24



Key

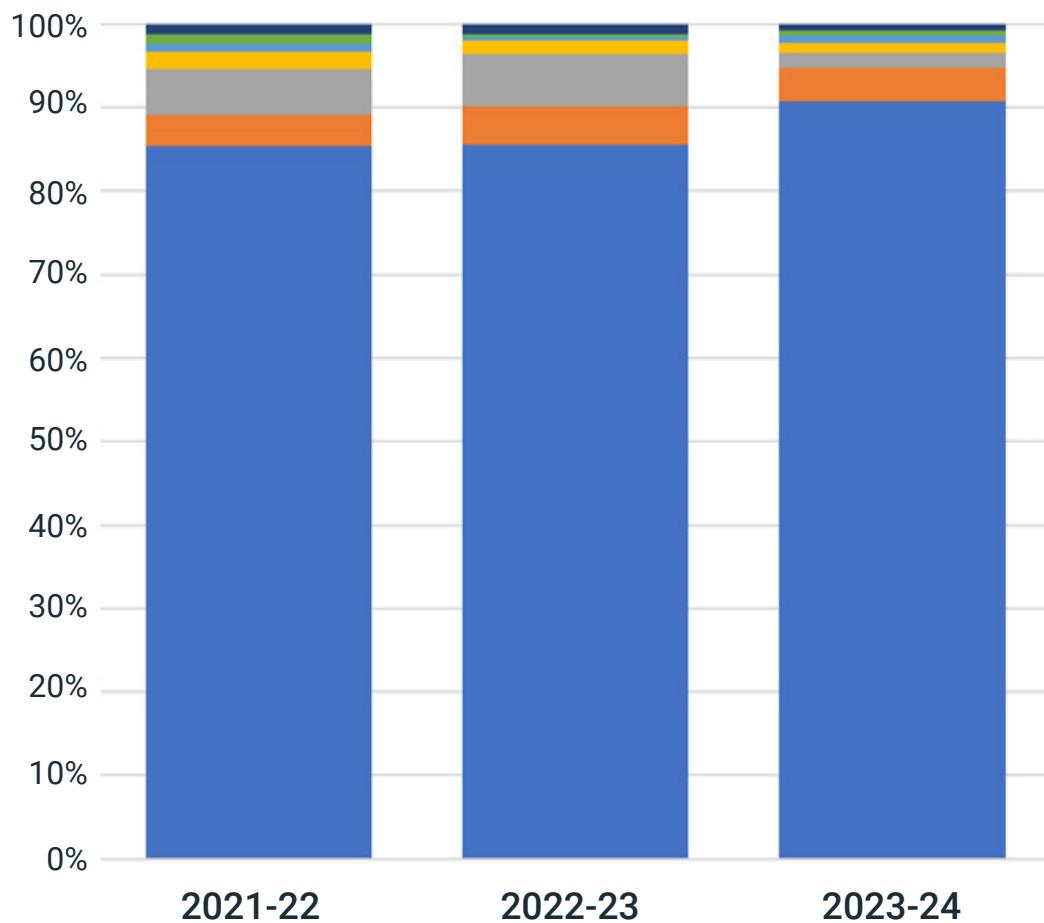
■ Other -
unknown to
individual

■ Other -
known to
individual

■ Service
provider

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

Outcomes from Section 42 assessments, 2021-22 to 2023-24



Key

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

A risk was identified, and action taken in 86% of enquiries during 2023-24, which represents an increase compared to the previous two years.

Change in risk where identified by Section 42 enquiry, 2021-22 to 2023-24



Where a risk was identified this was reduced in 83% of cases and removed in a further 14% of cases; in only 3% of cases did the risk remain during 2023-24.

94%

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

77%

of individuals expressed their outcomes when asked.

46%

lacked capacity to be involved in Section 42 enquiries.



5. Our strategic priorities for 2023-24

We have embedded the **SIX PRINCIPLES** as set out in the Care Act:

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 adult is clearly heard and create opportunities for an approach where co production is at the heart of future safeguarding policy.
- 5 To ensure a robust governance and challenge ethos ensures effective quality assurance and performance management processes.
- 6 Work together with the City of York Community Safety Partnership, to support work to raise awareness of, and reduce the harm caused by 'Hidden Harms', and abuse associated with County Lines activity, domestic abuse and modern slavery; reducing duplication of effort and maximising effectiveness.

6. Meeting our objectives for the year - partner highlights



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.



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

CYC ASC have led on the development and agreement of a joint transitional protocol with the Children's Safeguarding Partnership. Operationally they have worked with children's services and other partners to implement these arrangements.

This has involved setting up and leading a strategic and operational group to oversee this work, reporting to the CYSAB on a regular basis. This approach has involved aligning with the Preparation for Adulthood protocol work, to ensure there is a consistent, safe and all age approach to young people transitioning into adult services and support.





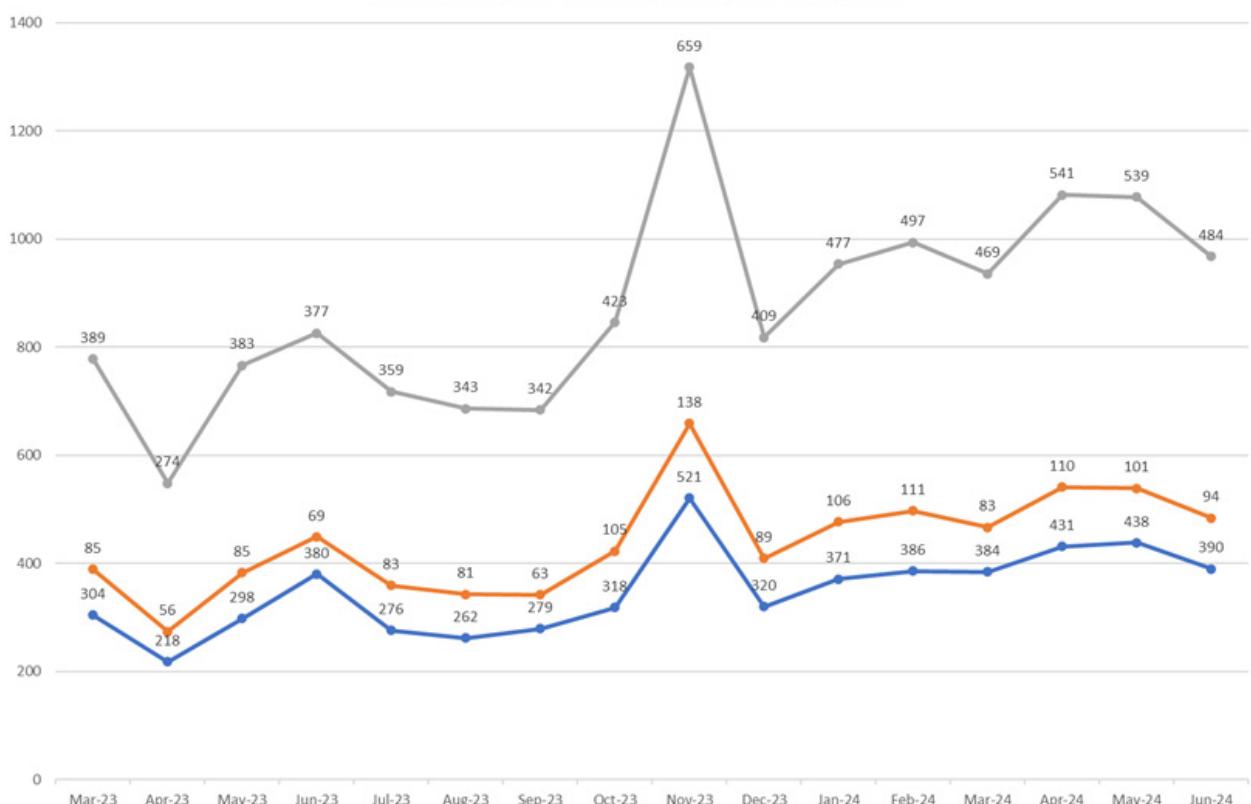
North Yorkshire Police (NYP)

The NYP Vulnerability Assessment Team (VAT) acts as the conduit through which all child and adult safeguarding concerns are referred, thus providing a consistent, joined up approach for adults, children and young people transferring between Social Care Services.

Referrals are received from a range of partners as well as from front line officers and staff. All referrals are jointly triaged with statutory partners, assessed, and actioned as required.

Co-location and partnership working enhances information sharing to better serve young people transferring between services. The VAT is omnicompetent, providing resilience across all its teams, across York and North Yorkshire, across adult and children, to maximise all opportunities to safeguard the vulnerable whatever their age. The graph below demonstrates the number of reports produced by the team for both adult and child safeguarding concerns. Due to the way this data is collated, it is not possible to separate adult reports from the overall total.

Number of reports written by the report writing team



Key

■ No of reports written NYC ■ No of reports written CYC ■ Total

NHS Humber and North Yorkshire Integrated Care Board (HYNICB)

The safeguarding training delivered to Primary Care in York and North Yorkshire follows an 'all age' approach and in 2023-24 included a focus on review processes in safeguarding children (Arthur and Star National Panel Review); engaging with fathers; child sexual abuse; and domestic abuse experienced by people with disabilities. Almost 1000 staff working in primary care settings have accessed the training delivered by the Humber and North Yorkshire Integrated Care Board (HNY ICB) safeguarding team in York and North Yorkshire, which is a lower number than last year but remains consistent with previous years.



North Yorkshire Fire and Rescue Service (NYFRS)

'Transitional safeguarding' has been had added to the consideration within our review of existing, and development of new, youth engagement activities and interventions. A new Youth and Schools Engagement Manager, who is a skilled youth engagement practitioner has been recruited and is supporting the service to improve our understanding and approaches in this area.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

The Trust safeguarding team follow the Think Family principles in many areas of its work. Although we have professionals in the team who are aligned to children's or adults much of our work covers both.

This supports us as an organisation when providing support to our services in embracing the Think Family approach. One of the strategic Trusts priorities is to 'improve consideration of the impact of parent / carer mental health needs on children'.

The Key driver is for improvements in clinicians considering the potential impact of parental / carer mental health on children and / or consistently documenting that this has been considered with the appropriate level of detail and regular review. This work started in 2023-24 and will continue into 2024-25. The Trust delivers joint safeguarding adult and children mandatory training at all levels, aligned to the Intercollegiate documents for adults and children's.

The Trust also supports the promotion of the Think Family agenda. Over 2023-24 the training packages have been reviewed and have evaluated very positively with an average score of 4.5/5 consistently.

York and Scarborough NHS Foundation Trust

The Trust Safeguarding Adult and Children teams integrated in August 2022. The integrated team works collaboratively to deliver a Think Family approach to all patients. Adult patients attending our hospital (whether admission or attendance at emergency department) are reviewed for any child affected by an adult in our care.

The team works closely with the trust Transition Nurse and Mental Health Transition Nurse to ensure seamless safeguarding into adult services.

The Safeguarding Liaison Nurse's role continues to support 16-17-year-old young persons on adult wards to ensure any safeguarding risks are managed and staff on the ward have a holistic awareness of their patient.

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.



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

CYC ASC highlights for 2023-24 include the review and pilot of two new CYC safeguarding adults training courses. The online referral has been reviewed to ensure it captures the correct information to inform timely and robust decision making in relation to our section 42 duties. To further support, this guidance has been developed for all agencies around safeguarding and falls and how to make good safeguarding referrals. Development of the online referral and case recording system to capture referring information has been undertaken, to support the identification of any multi-agency themes.

CYC ASC have also:

- delivered briefings to elected members in relation to safeguarding adults, safeguarding children and domestic abuse duties, which continues to be available to elected members as a recording.
- rolled out the Oliver McGowan e-learning training, and are now developing our Tier 2 training offer, to provide the CYC ASC workforce with the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability.

- developed a new quality assurance framework and audit tools and schedule to assure the quality of practice across the service. This includes a safeguarding adults audit tool.
- developed, consulted on, and rolled out a new practice framework for adult social care practitioners. Safeguarding is the golden thread running through the practice model and Making Safeguarding Personal is key to this approach and ensuring practitioners have the tools and resources to support adults at risk, to promote their safety and achieve their outcomes.
- revised their local safeguarding adults process and timescales and have updated our case management system to reflect this
- added local content and safeguarding resources to the online multi-agency safeguarding adults procedures and work has continued to embed these across the service.
- circulated a range of Safeguarding Adults Review (SAR) learning information from national and regional networks, and these have also been shared with practitioners via the Principal Social Worker teams channel.

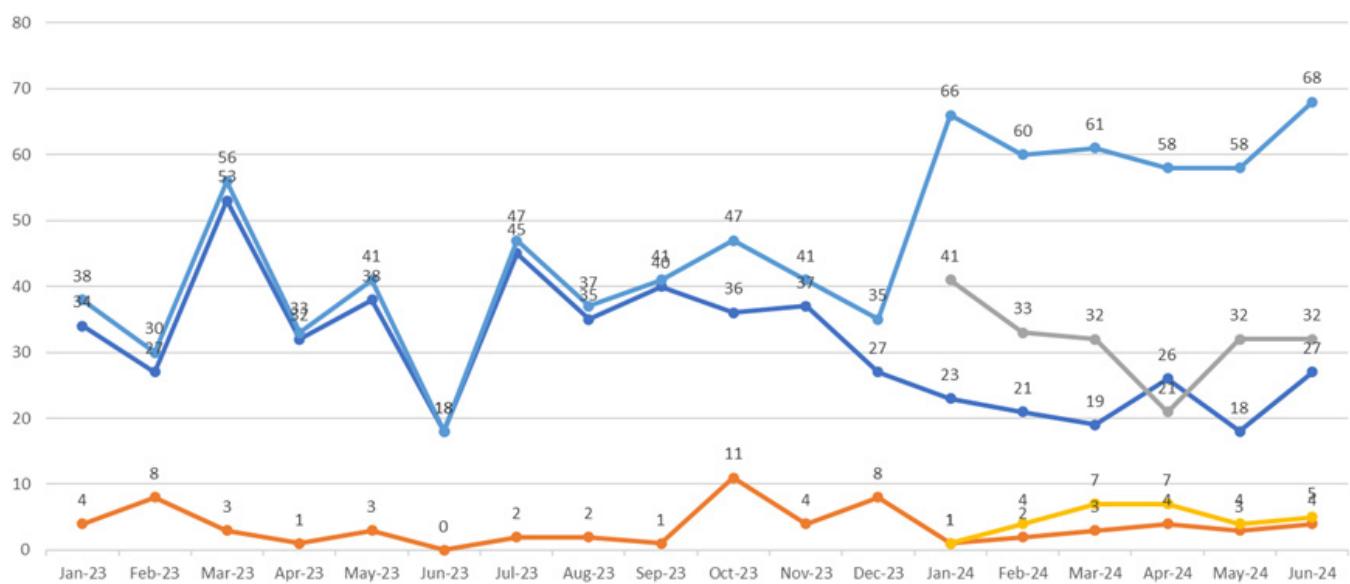


North Yorkshire Police (NYP)

In the past year the Adult Mash (Multi-Agency Safeguarding Hub); a dedicated Adult Safeguarding Hub, has been developed within NYP (one Detective Sergeant and two Police Constables), who continue to jointly screen adult safeguarding referrals with Health, Adult and Mental Health Services. The team deal with all adult safeguarding referrals, thus ensuring continuity and consistency. The aim is to work with partners to develop an Adult MASH and work is ongoing to see how this can be achieved.



Adult planning meetings in the last 12 months



Key

	Adult planning meeting NYC		Adult planning meeting total
	Outcome Review meetings CYC		Outcome review meeting NYC
	Adult planning meeting CYC		

This graph demonstrates the range of adult planning meetings across both North Yorkshire and York. **Please note:** Data regarding Outcome Review Meetings has only been recorded since the introduction of the Adult Safeguarding Hub in Jan 2024.

- Safeguarding Adults Reviews (SARs): NYP's Adult Safeguarding Manager reviews all cases known to the police where an adult with care and support needs has suffered a serious incident or who may have died following a serious incident or had care and support needs. During 2023-24 the Police made 24 referrals for review at the Section 44 Panel meeting where agencies discuss and identify if any of the cases meet the threshold for a SAR or Learning.
- CYSAB are fully committed and supportive of the SAR process and the associated Review and learning subgroup.

NHS Humber and North Yorkshire Integrated Care Board (HNYICB)

- The Director of Nursing for the York area of the ICB continues to support the work of the CYSAB and attend strategic meetings. The ICB safeguarding team at place continue to represent the ICB and actively support the health contribution to safeguarding partnership meetings across the city. The Designated Nurse Safeguarding Adults chairs the Review and Learning subgroup for CYSAB.
- In York and North Yorkshire, the ICB safeguarding team at place have a well-established Health Partnership Group meeting which is held quarterly and a communication network of NHS and independent health providers. It is through these established systems that learning from reviews and best practice is shared.
- In August 2023 the ICB safeguarding team at place were requested to offer support following a major incident at a GP Practice in North Yorkshire. The incident, an arson attack and assault caused significant damage and resulted in the temporary relocation of staff and services. The Designated Professionals responded in a timely way to provide support to affected staff and worked with colleagues in the ICB Primary Care team and the Local Medical Committee (LMC) to start the process of gathering information and learning from the incident. This was one of a number of incidents which posed risk to those working in and those accessing primary care. This has led to a review of how people with vulnerabilities themselves but who also pose a risk to others are managed safely in their access to healthcare.
- Over the last year the NHS has launched a new framework for investigating incidents related to patient safety. The Patient Safety Incident Response Framework (PSIRF) replaced the 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 england.nhs.uk/patient-safety/incident-response-framework. The Designated Professionals for Safeguarding have been involved in training and supporting the cross-over with statutory frameworks in safeguarding. As implementation of PSIRF progresses and where a concern is raised into both frameworks it is hoped that a joint approach taken by CYSAB and NHS providers working together may help avoid duplication and unnecessary distress to the individuals involved and/or their families.

North Yorkshire Fire and Rescue Service (NYFRS)

Key roles with the Fire and Rescue service, including the Head of Prevention, Senior Director, and Safeguarding Manager are connected with Safeguarding Adults Board and can contribute to SARs as requested. The Fire and Rescue Service, has further developed approaches review and have expanded the Fire Fatality Review process to a Serious Incident Review process, enabling learning from a broader spectrum of events. A key change in this process has been to embed the Safeguarding Manager and safeguarding as a key reflective issue. The Safeguarding Manager is also fully embedded in regional and national working groups/forums, enabling continuous learning and improvement into the heart of those reviews.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- Following the Whorlton Hall Safeguarding Adult Review, and a response for assurance nationally, one example of changes to practice was the cultural assessment work that took place across the Trust. A tool was developed to assess the risk of closed cultures within our inpatient services. This has since progressed and questions around closed cultures have been incorporated into our peer review tool alongside the Care Quality Commission (CQC) quality statement.
- The Trust held an internal Safeguarding Adults week in June 2023 dedicated to self-neglect after recognising this was a particular area that featured in Safeguarding Adults Reviews. As part of this briefings were developed on Learning from SARs, Mental Capacity Act and Executive Functioning, resources, toolkits and training which comprised of resources from other Safeguarding Adult Boards/ Partnerships. Additionally, a self-neglect training session was devised and delivered and continues to be available to Trust staff as a recording.
- Monthly safeguarding bulletins are sent out across the Trust.
- Partnership bulletins sent out to Trust via Safeguarding Link Professionals.
- Learning from reviews are shared routinely through the trust safeguarding and public protection committee and the 2 care groups for dissemination across the trust. The trust also has a learning library whereby reviews that have involved TEWV are saved and accessible to all trust staff.

- The Trust has a newly developed organisational learning meeting held monthly to share relevant learning from reviews (including safeguarding, complaints, internal reviews, CQC etc) and review relevant action being taken to address key themes.
- North Yorkshire, York and Selby Fundamental Standards Group and the Care Group Governance and Assurance Support Program (GASP) work that contributes to Key focus areas reflected in TEWV safety priorities including workforce, length of stay, restrictive interventions, formulation safety planning, environmental safety, report out, ward routine future ways of working, workforce development and leadership oversight. Examples of positive impact of this work has included significant reduction in restrictive interventions and a consistent increase in patient's reporting feeling safe within the inpatient care. The ongoing program of work will continue the collective learning and quality improvement to continually improve patient care, carer experience, staff experience and optimise ward to board communication and information flow.



York Community Voluntary Sector



- Staff members at York CVS continue to undertake safeguarding training to a level that is appropriate for their role (between levels 1-3)
- Training sessions for members and continues 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 are currently involved in 13 statutory SARs and 2 Domestic Homicide Reviews (DHRs) with our local authorities, all at various stages within the review process. Each SAR will generate a final report with recommendations and action plans which will be overseen by the SABs and monitored at the Trust Learning from Deaths Group.
- There is representation at the Board's Rapid Review Group and Learning and Review Group – an escalation of a community occurrence was identified through this route, and this enables sharing amongst agencies including our Emergency Department. For example, including in training "Professional Curiosity" and "Robust documentation".

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



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

CYC ASC have developed a provider failure policy and also a lessons learned process. This is aligned with a new organisational abuse enquiry process. This has provided an opportunity to review working relationships and undertake a safeguarding briefing with service providers. The ongoing early alert process and meetings, and the newly developed 'person approach to professional visits in care homes' support a preventative approach to identifying low level concerns. Good working relationships have been established between the Safeguarding and Contracts team and other stakeholders to assess priorities and help inform Quality Assurance visits and schedules.



North Yorkshire Police (NYP)

Domestic abuse victims: NYP's Domestic Abuse (DA) team engage with vulnerable victims of DA. Domestic Abuse Officers assess every referral submitted by our front-line officers, engage directly with victims and signpost to specialist services such as IDAS. Victims of sexual offences are referred to Independent Sexual Violence Advisers (ISVAs). Whilst reports of Independent Domestic Abuse Service (IDAS) incidents have reduced in recent years, those graded as high risk have increased.

Domestic abuse victims			
	2021-2022	2022-2023	2023-2024
Incidents	11386	11756	11195
High Risk grading	1994 (17.5%)	2136 (18%)	2337 (20.8%)

The data shown above relates to both York and North Yorkshire. Given that victims and perpetrators may live across York and North Yorkshire, it is important to present the data across the entire force area.

NHS Humber and North Yorkshire Integrated Care Board (HNYICB)

The ICB has continued to develop as a new organisation in 2023-24 and guide its workplan and workforce through transformation humberandnorthyorkshire.org.uk/nhs-humber-and-north-yorkshire-integrated-care-board-marks-one-year-of-transforming-healthcare.

In the areas of domestic abuse and the health offer to Care Leavers targeted work has been completed to scope what is currently in place to provide assurance, deliver consistency, identify gaps and learn from good practice.

As part of an ongoing programme of work a HNY ICB wide Domestic Abuse and Sexual Violence forum has been established to bring together health providers, share good practice and provide peer support in these challenging areas of safeguarding. As part of the work the ICB signed up to the NHS England Sexual Safety Charter launched in September 2023 england.nhs.uk/long-read/sexual-safety-in-healthcare-organisational-charter and encouraged health providers to do the same.

York and Scarborough NHS Foundation Trust

The governance of the Trust Safeguarding Team is via the Trust Integrated Safeguarding Group quarterly meeting. This is attended by the Designated Nurse for Safeguarding Adults from the ICB. This affords external challenge and scrutiny.

Internally the Integrated Safeguarding Group reports to the Patient Safety and Clinical Effectiveness Group and then onto the Trust Quality Committee. Within the meeting progression of the work of the Trust Safeguarding Team is presented and where necessary challenged where there are risks to the organisation.

Safeguarding is also a standing item at the Trust weekly Quality and Safety meeting where care groups escalate any safeguarding matters, and the team can raise ongoing concerns that are a risk to patient safety.

City of York City 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.

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



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

- CYC ASC have embedded a survey developed by Healthwatch into our safeguarding practice and case recording system. This provides individuals and their representatives with an opportunity to provide feedback regarding their experience of the safeguarding adults process at the point procedures end.
- Safeguarding and Adult Social Care teams continue to ask individuals for their views and desired outcomes (94% 2023-24).
- CYC ASC also undertook a mystery shopper exercise and as a result made improvements to the website so that safeguarding information was more accessible.
- CYC ASC Communications team also produced a range of easy read material (leaflets/posters) during safeguarding week, which were circulated and published with a series of animations (safeguardingadultsyork.org.uk/resources-2/leaflets-and-posters).
- Moving forward CYC ASC are developing their approach to co-production and research, supported by people with lived experience and the Curiosity Partnership.



North Yorkshire Police (NYP)

- **Policy and procedure:** NYP support a wide range of safeguarding policies internally, as well as supporting multi-agency partnership service level agreements and policies such as the Safeguarding Adult Procedure. Policies and procedures have a victim focus and are subject to equality impact assessments. NYP's Operational Pledge has been in place since 2023, to provide assurance to any members of our workforce experiencing domestic abuse that their case will be dealt with in confidence. Equally, where members of our workforce are identified as perpetrators, they will be investigated thoroughly as would any other individual.
- **Community engagement:** The NYP DA team worked with partners to engage innovatively with communities to raise awareness of abuse. NYP collaborated with IDAS to deliver a Christmas campaign this year, delivering a Christmas themed postcard to public spaces frequented by women, such as hair salons. The

postcard identified behaviours that amount to domestic abuse, including controlling and coercive behaviour, and signposted the help available from IDAS.

NHS Humber and North Yorkshire Integrated Care Board (HNYICB)

- Through delivery of healthcare to our population HNY ICB has identified key priorities for safeguarding in the Joint Forward Plan with a focus on addressing the needs of victims of abuse. These include Domestic Abuse, Serious Violence Duty, and the health offer to Care Leavers - humberandnorthyorkshire.icb.nhs.uk/wp-content/uploads/2023/07/Joint-Forward-Plan-How-we-will-deliver-our-strategy-from-2023-to-2028.pdf
- The safeguarding conference being planned for June 2024 opens with a session from a victim/survivor of domestic abuse, who will share his family's story of coercive control and domestic homicide.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- The Trusts 'Journey to Change' sets our commitment to co-create a great experience for our patients, carer and families; to co-create a great experience for our colleagues and to be a great partner.
- The Trust has invested in appointing Lived Experience Directors and further enhancing the lived experience roles within the organisation to enhance the voice of patients including children and young people.
- The Co-Creation leads are employed to increase the voice of patients.
- TEWV safeguarding team are working with the Co-creation leads to consider how the safeguarding team can use lived experience in the work we do.

North Yorkshire Fire and Rescue Service (NYFRS)

NYFRS must comply with a series of national Fire Standards, one of which is Safeguarding. This standard includes working in accordance with a Person-Centred Approach, and working to a national Person-Centred Framework. To ensure support and governance around this compliance, the Service has a quarterly Safeguarding Compliance Group, which is chaired by a Director.

York and Scarborough NHS Foundation Trust

The Trust Safeguarding Adults Policy and Procedures and the safeguarding adult training is underpinned by Making Safeguarding Personal to ensure Safeguarding is done with not to a person. Staff raising concerns on behalf of the patient are supported to discuss with the patient where possible, using the legal framework of Mental Capacity Act (MCA) to underpin and apply in practice, if required.



York Community Voluntary Sector

York CVS's activities incorporating Healthwatch continue to engage with the CYSAB at a strategic level which ensures that the voice and needs of safeguarding adults in the community is heard. During 2023-24 the Healthwatch Lead for Safeguarding chaired the CYSAB Voice of the City Subgroup.

5

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

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

- A provider failure policy and a lessons learned process has been aligned with a new organisational abuse process.
- CYC ASC have contributed to a multi agency self assessment under Working Together 2023 (Section 11) and Governance audit undertaken by the City of York Safeguarding Children's Partnership (CYSCP), and regionally with North Yorkshire SAB and Community Safety Partnership (CSP). This has provided us with an opportunity to benchmark our arrangements and identify any gaps.
- The CYC Contracts and Quality Improvement Managers continue to apply the Provider Assessment and Market Management Solution (PAMMS) Quality Assurance tool to assess levels of quality services are being delivered across York.
- The CYC All Age Commissioners, Contract and Quality Improvement Managers and Brokerage teams continue to review and assess our internal processes and procedures and include these in any new services commissioned. We also monitor key performance indicator's (KPIs) with providers and additional support where improvements are required.



North Yorkshire Police (NYP)

- Multi Agency Risk Assessment Conference (MARAC) and Multi agency Tasking and Coordination (MATAC) report into a joint MARAC/MATAC Steering Group, which is held quarterly and provides partnership scrutiny.
- Domestic Abuse (DA) data is shared via the DA Local Partnership Board, where themes and trends can be considered in a multi-agency setting.
- Learning and good practice from the DA Scrutiny Panel is shared with front line officers within North Yorkshire Police and work is underway to share this information more widely, via the Community Safety Partnership (CSP).
- NYP has recently been subject to a His Majesty's Inspectorate of Constabulary and Fire and Rescue HMICFRS Point, Evidence, Explanation, Link (PEEL) Inspection (2023-2025), where its gradings demonstrated a marked improvement from the last inspection in October 2022. The force was graded as good for "Protecting Vulnerable People" in October 2023, compared to being graded as "Requires Improvement" in 2022. In relation to "Preventing Crime and anti-social behaviour and reducing vulnerability" it was graded as good in October 2023, compared to "adequate" in 2022.



NHS Humber and North Yorkshire Integrated Care Board (HNYICB)

- All policies relating to safeguarding procedures and practice are in place and reflect the large-scale system change of HNY ICB.
- In the areas of domestic abuse and the health offer to Care leavers, targeted work has been completed to scope what is currently in place to provide assurance, deliver consistency, identify gaps and learn from good practice.
- As part of an ongoing programme of work a HNY ICB wide Domestic Abuse and Sexual Violence forum has been established to bring together health providers, share good practice and provide peer support in these challenging areas of safeguarding. As part of the work the ICB has signed up to the NHS England Sexual Safety Charter launched in September 2023 [england.nhs.uk/long-read/sexual-safety-in-healthcare-organisational-charter](https://www.england.nhs.uk/long-read/sexual-safety-in-healthcare-organisational-charter) and encouraged health providers to do the same.

- The Learning from lives and deaths – ‘people with a learning disability and autistic people’ (LeDeR) programme delivered by the ICB has published its annual report.
 - » humberandnorthyorkshire.icb.nhs.uk/wp-content/uploads/2024/06/ICB-Annual-LeDeR-Report-2023-2024.pdf.
 - » humberandnorthyorkshire.icb.nhs.uk/wp-content/uploads/2024/06/Annual-LeDeR-Report-2023-2024-Easy-Read.pdf.
- The report robustly evidences quality improvements for people with a learning disability living in York and North Yorkshire, a key outcome of focussed work has been the increase in annual health checks completed in primary care, which exceeds the target set nationally by NHS England. The ICB safeguarding team advise on LeDeR reviews where safeguarding is a feature in order that lessons can be learnt across the multi-disciplinary partnership.

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- TEWV have presented at the Board outcomes from CQC inspections and recent Nurses Improving Care for Healthsystems Elders (NICHE) review alongside update on work carried out following this and any improvement plans moving forward.
- TEWV recently submitted an annual Quality assurance framework (QAF) tool to all safeguarding partnerships which gives assurance to the partnership on the Trusts safeguarding work and highlights any areas which are of particular focus for the coming year and any areas of improvements identified in the QAF. Historically the trust has submitted the QAF at different times to different partnerships/Boards and in many different forms. We have recently reviewed this and created a generic version of the QAF tool and populated this and taken this through internal governance structure before asking the partnerships/Boards to accept this document. To date we have received very positive feedback in relation to this submission and the openness and transparency of it and how comprehensive it was. We plan to update this on a yearly cycle and submit.
- TEWV safeguarding annual report 2023-24 been completed and approved through internal governance structure.

North Yorkshire Fire and Rescue Service (NYFRS)

NYFRS comply with the Section 11 and Governance Audit. We are also required to report to a quarterly governance forum. NYFRS also has an assurance function, and is inspected by His Majesty's Inspectorate of Constabularies and Fire and Rescue Services.

York and Scarborough NHS Foundation Trust

2023 2024 saw the planning and recruitment to launch a Complex Needs Service to start co-production work in the areas of Learning Disability (LD), autism and dementia to evidence where we are engaging people with lived experience - the challenge will be about how we prove the services are of good quality.

More widely the launch of the Nursing Quality Assurance Framework, which uses a range of methodologies including the use of a quality dashboard, weekly ward manager safety check and monthly peer review audit to triangulate outcomes with workforce data, identify areas for improvement and celebrate progress. The weekly back to the floor visits serve to seek further assurance on key topics from the framework, with a focus on fundamentals of care as part of our Year of Quality. The next step is to formally build an accreditation programme which will be tested out in September 2024.

City of York City Public Health

Public Health service providers are monitored through robust contract monitoring arrangements and are held to account by commissioners.



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.



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

- **Domestic abuse:** CYC ASC have reviewed and improved their contributions to both MARAC and MATAc processes. The Adult Safeguarding team have also been provided with some bespoke training, to ensure we are recognising domestic abuse and making MARAC referrals appropriately. Further work is underway with Public Health to analyse further training needs across Adult Social Care.
- **Modern slavery:** CYC ASC have worked successfully with commissioning, health, police and home office partners to respond to modern slavery concerns within provider services.
- A series of animations (tricky friends, self-neglect and hidden harms) have been created, shared with practitioners and published on the CYSAB website.



North Yorkshire Police (NYP)

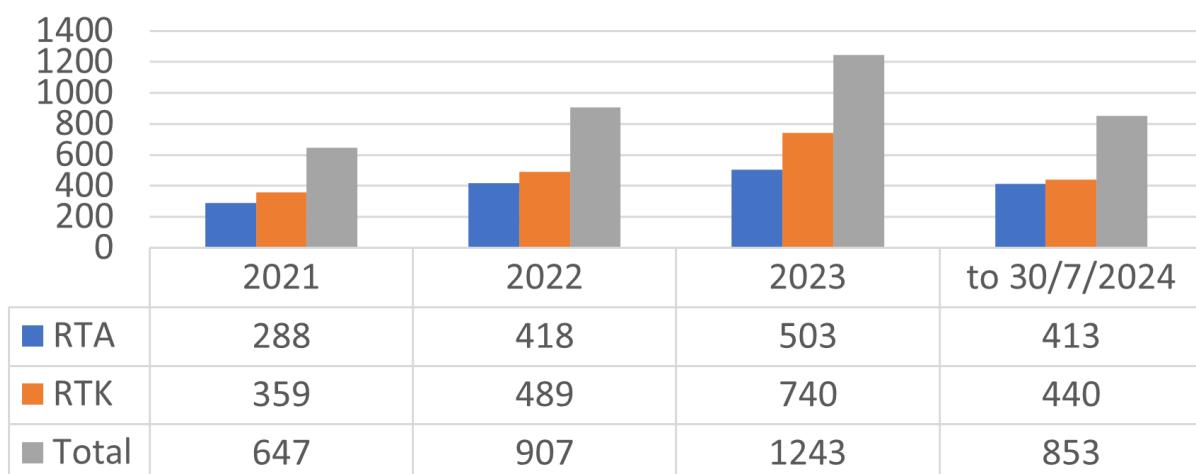
- **Domestic Homicide and Suicide Prevention:** NYP share any incidents of DA related homicide and/or suicide victims with the national Domestic Homicide Project. The aim of the project is to identify emerging trends and share any key learning. There has been 1 potential instance of a DA-related suicide and 1 potential DA-related homicide. Any potential DA-related homicide is referred to the Domestic Homicide Review (DHR) Panel for consideration.
- **Multi Agency Risk Assessment Conference (MARAC):** is the multi-agency process for keeping our high-risk domestic abuse victims within North Yorkshire safe. MARACs are convened weekly being held remotely, and whilst attendance for some agencies has improved in the last 12 months, further improving multi-agency attendance and engagement remains a key focus this year. Information sharing is critically important, and it is crucial that relevant agencies attend those cases open to them. Equally, MARAC provides a valuable opportunity for agencies not directly involved to share their wider knowledge and experience, which can enhance the safety planning for victims and their families. Only together can we ensure that every opportunity to minimise harm is seized, with absolute accountability and confidence.

- As can be seen from the below figures, MARAC cases have risen by over 50% in the last 5 years. MARAC is essential in ensuring that all agencies contribute to safeguarding victims that are not always known to the Police.

Multi Agency Risk Assessment Conference (MARAC) cases					
Year	2019	2020	2021	2022	2023
York	303	444	515	525	474
Whole Force Area	1038	1420	1745	1916	1998

- Whilst the total number of cases across the Force have continued to rise, the number of cases in York reduced by 10% from 2022 to 2023. However, the first 6 months of 2024 has seen an increase again in York, with 307 cases already discussed so far.
- Multi Agency Tasking and Coordination procedure (MATAC):** the MATAC procedure works to identify serial perpetrators of domestic abuse, aiming to prevent and/or disrupt their offending behaviour to break the cycle of domestic abuse. A key focus this year has been to improve our internal processes, ensuring our front-line officers are aware of our highest harm perpetrators living in our communities. They are tasked to engage with perpetrators to encourage them to seek help for harmful behaviours, and where appropriate, disrupt their activity and thus safeguard their victims from further abuse. Since its introduction, MATAC has adopted over 350 perpetrators, with 82% showing a lower Recency, Frequency, Gravity, Victims (RFGV) score 12 months after adoption. Since the introduction of the MATAC process, 47% of adopted perpetrators have been archived, indicating no new offences have come to light within 12 months of being archived.
- Domestic Violence Disclosure Scheme (DVDS),** is an excellent preventative tool with which to engage victims/potential victims of domestic abuse, providing disclosures to assist them in making informed choices. There has been a rise in both Right to Know and Right to Ask applications in the past 12 months. The multi-agency DVDS Panel was successfully launched in 2024. The panel considers the most complex applications, maximising information sharing and increased scrutiny of police disclosure decisions.

Domestic Violence Disclosure Scheme applications throughout North Yorkshire and York



Key

■ Right to ask ■ Right to know ■ Total

The above table indicates the total number of DVDS applications throughout North Yorkshire and York. The figure is given as a total because a victim may live in North Yorkshire and the perpetrator live in York and vice versa.



NHS Humber and North Yorkshire Integrated Care Board (HYNICB)

- The Serious Violence Duty commenced in January 2023 with a key role for the ICB as one of the specified authorities. The ICB Director of Nursing-Governance and Designated Professionals have worked with other key agencies to support the completion of the York and North Yorkshire Serious Violence Strategic Needs Assessment and the Serious Violence Response Strategy.
- Following the recommendations made in the Statutory Guidance issued under the Domestic Abuse Act 2021, the national charity Standing Together Against Domestic Abuse (STADA) has been awarded a three-year contract by the Home Office to identify and understand domestic abuse interventions across healthcare settings. In North Yorkshire and York as part of the Standing Together Crossing Pathways project our local domestic abuse specialist charity IDAS (Independent Domestic Abuse Services) have been commissioned to work with Primary Care and local

health providers. The project aims to raise awareness of domestic abuse and support services available for people in isolated rural communities. The GPs in York have also benefited as IDAS delivered workshop sessions on Domestic Abuse at a Protected Learning Time event attended overall by 160 GPs and primary care practitioners.

- The Designated Professionals have been supporting the project with their knowledge of the health network. The project is set to run until autumn 2024.
- Following cases of suspected modern slavery across North Yorkshire and York, the ICB hosted three lunch and learn sessions to raise the awareness of labour exploitation in the care sector. Over 170 people attended the sessions from a range of organisations including health, local authorities and the Fire Service.



NORTH YORKSHIRE
FIRE & RESCUE SERVICE

North Yorkshire Fire and Rescue Service (NYFRS)

As a Service NYFRS regularly engage in forums and meetings held by relevant partners such as North Yorkshire Police. As the Regional Chair of the Serious Violence Working Group. The Director is responsible for driving and leading a range of activity to reduce serious violence. Many service staff are trained to identify a range of hidden harms including domestic abuse, and the new two year rolling training programme for specialist prevention officers within the service, includes a broad variety of training in key areas such as domestic abuse, prevent, modern slavery and trauma. The Head of Function has been grateful for the opportunity to attend training such as Alarm Receiving Centre (ARC) training, to ensure that strategy and policy in relation to prevention, which is inclusive of hidden harms where adult abuse is potentially undetected or unreported.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- The Trust is represented in all Safeguarding Board/Partnership arrangements including subgroups/task and finish groups (Trust attendance at Safeguarding Boards/executive mtgs is 100%).
- The Trust delivers joint safeguarding adult and children mandatory training at all levels, and this includes raise awareness of, and reduce the harm caused by 'Hidden Harms', and abuse associated with County Lines activity, domestic abuse and modern slavery.

York and Scarborough NHS Foundation Trust

Managing risks relating to our patients experiencing, disclosing, or suspected to have suffered domestic abuse, county lines activity and modern slavery is the day-to-day work of the Safeguarding Team. In acknowledging the increase scope of support an application has been made to increase the team's establishment to meet the expanding scope and legislative requirements for domestic abuse which will include non-fatal strangulation and incidence of honour-based harm risk. There is currently a gap in compliance with the Safeguarding Assurance and Accountability Framework for a Named Nurse for Safeguarding Adults. This has been subject to escalation and investment requests since 2019. The establishment required to manage the Trust duty under the Domestic Abuse Act ([legislation.gov.uk/ukpga/2021/17/introduction](https://www.gov.uk/ukpga/2021/17/introduction)) and the work for non-fatal strangulation (NFS) will re-enforce this bid.



City of York City 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 and 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.



7. Safeguarding Adults Reviews (SARs)

The CYSAB Review and Learning subgroup (RLG) has 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.” Care and support statutory guidance - GOV.UK ([gov.uk](https://www.gov.uk)) and make a recommendation to the Independent Chair of CYSAB.

- Two SARs, which began in 2023-24 are currently being conducted involving neglect in care settings both involving older adults. The findings of these will be known in 2024-25 but early lessons have been acted upon to prevent abuse and neglect in the future.
- The learning from completed SARs continues to be embedded to improve practice across the Adult Care sector workforce. The completed SAR reports and 7-minute briefings are available on the cysab website safeguardingadultsyork.org.uk/sar
- The CYSAB three Statutory partners met monthly during 2023-24 for a Section 44 panel which looked at 50 cases during the year to assess whether these should be referred for a SAR. Of these

50 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, three cases were referred to the Learning and Review Subgroup for SAR consideration. One case was agreed to meet the criteria for a SAR which will be concluded in 2024-25 and two cases will be considered by the Review and Learning group in 2024-25 to see if they meet the criteria for a SAR.
- Any learning from all the cases considered by the CYSAB groups that did not meet the criteria for a SAR, was cascaded and actioned upon by CYSAB partners and individual organisations.
- A review of the SAR policy and procedure took place, which is available on the CYSAB website in the SAR section.
- The CYSAB partners took part in regional SAR learning events related to self-neglect and suicide as well as attending the Teeside thematic review of Whorlton Hall.

8. Looking ahead to next year

With increased capacity created by the appointment of the CYSAB Business Manager in 2024/25 and the new Independent Chair for CYSAB, the Board will have increased resources to deliver its new safeguarding strategy. Our partners were asked their priorities in the coming year both as individual agencies and for the Board.

Below are some of the suggested priorities for the Board to focus on:

- To develop a multi-agency safeguarding adults training offer, and quality assure partner agency training. Develop collaborative training opportunities for all levels of safeguarding practitioners with the partner agencies to improve everyone's knowledge and understanding.
- Review of governance structure and develop the engagement and accountability of partner agencies in the work of the SAB.
- To develop a multi-agency safeguarding adults performance framework/dashboard.
- To develop a robust and multi-agency Quality Assurance Framework.
- Undertake self-assessment as a Board to provide a benchmark position, to provide assurance for improvement and enable challenge where the base line is not showing improvement in compliance with the Care Act.
- To align with and develop relationships and with other partnerships e.g., Children's Safeguarding, Community Safety, Domestic Abuse Partnerships.
- To seek assurance on the embedding of the Transitional Safeguarding Protocol and multi-agency operational arrangements
- Establish a framework to revisit and track learning from SARs at regular intervals to ensure learning from SARs is embedded across agencies and to ensure that actions that support recommendations are completed with agency accountability.
- Continue to work with partners around what constitutes a safeguarding concern and ensuring clear pathways are in place.
- Develop opportunities for community engagement so that the voices of adults with lived experience are heard and help inform our future practice.
- Establish ways of responding to preventing the rise in homelessness and self-neglect.
- Establish a CYSAB multiagency escalation process to ensure all organisations are able to report issues to achieve professional resolution.

9. Safeguarding priorities for partner agencies for 2024-25

Below are some of the areas of focus for individual partners next year:



North Yorkshire Police (NYP)

Continuing to:

- Prevent and reduce crime and anti-social behaviour.
- Effectively respond to investigate and solve crimes.
- Manage offenders.
- Safeguard the vulnerable and service victims of crime.



Tees Esk and Wear Valley NHS Foundation Trust (TEWV)

- Parental/Carer Mental Health and the impact on children – increasing awareness across the organisation and seeking assurance that we are considering this and evidencing this in records.
- Strengthening of safeguarding linking the professional role across our clinical services to support clinicians.
- Safeguarding supervision across the organisation – to review existing processes and consider a revision to provide greater assurance that all relevant staff are accessing some form of safeguarding supervision.
- Multi-agency public protection arrangements (MAPPA) – further embedding the Trusts duty to cooperate responsibilities in line with MAPPA guidance.
- Quality of referrals to the Local Authority – to develop guidance and support for staff to improve the quality of safeguarding referrals made to the local authority and audit quality on a regular basis.
- Safeguarding reporting internal and external by working with the Trusts performance and CITO (patient recording system to be able to identify and analyse how what and where we report safeguard measures across the trust and partners).
- Embedding learning from safeguarding into Trust wide organisational learning.

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

- Embedding the new safeguarding adults' processes internally and raising awareness.
- Continuing to work with and support partners on what constitutes a good safeguarding referral.
- Develop domestic abuse training offer across the service to ensure practitioners can recognise domestic abuse and report appropriately.
- Develop the safeguarding adults training offer to include a wider range of training, and a multi-agency offer.
- Develop approaches to self-neglect, and to work with North Yorkshire colleagues to develop a range of practitioner resources.
- Develop understanding of safeguarding data and Intelligence.
- To improve safeguarding response based on the outcomes of safeguarding audits, through a quality assurance framework.
- To continue to embed the transitional safeguarding protocol to ensure clear pathways are in place for young people.



NORTH YORKSHIRE
FIRE & RESCUE SERVICE

North Yorkshire Fire and Rescue Service (NYFRS)

- Organisational training with a focus on more enhanced training for key staff and job roles.
- Further develop approaches around learning from serious incidents.
- Further refine our approaches to managing allegations against staff.

NHS Humber and North Yorkshire Integrated Care Board (HNYICB)

- A programme of communicating the health responsibilities under the Serious Violence Duty will be ongoing during 2024/25, alongside establishing a data dashboard around hospital admissions for knife crime injuries and alcohol/substance misuse.
- Continue work on key priority areas of domestic abuse and the health offer to care leavers.

- A safeguarding conference is in the planning stages to be held in June 2024 at University of York which will contribute to level 4 development and competencies for safeguarding specialist practitioners. The conference will focus on Domestic Abuse, Domestic Homicide and the Serious Violence Duty. We are fortunate to have secured the services of Professor Jane Monkton-Smith who is internationally renowned for her pioneering research into coercive control, stalking and domestic homicide. The findings of Professor Monckton-Smith's 2018 ground-breaking study – the Homicide Timeline: the eight stages – is a model used by police forces and agencies across the UK and Europe.
- A virtual safeguarding conference will be held in October 2024 with a focus on exploitation, online safety and transitional safeguarding.
- The HNY ICB will be working with our health providers to develop assurance against the revised Safeguarding Accountability and Assurance Framework (published June 2024) - england.nhs.uk/long-read/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs.

York and Scarborough NHS Foundation Trust

The Safeguarding Forward Strategy actioned through the Integrated Safeguarding Group will form a monitoring mechanism for assurance and a work plan underpinning service development.

Next steps are outlined in brief below:

- Domestic abuse service planning for patients and staff
- Expand workforce to meet needs of the expanding Domestic Abuse scope (which will include pathways for Non-fatal strangulation (NFS))
- Policy development



10. Our four core themes for 2024-25

1. The adults voice



1. Promote person-centred support for adults at risk of harm.
2. Hear the voice of the adult and ensure adults feel empowered.
3. Promote dignity and respect across all aspects of safeguarding.

2. Creating assurance



4. Develop a range of measures to help identify and prevent abuse.
5. Promote strong partnership working and collaboration.

3. Developing the workforce



6. Embed a culture of continuous learning and improvement to enhance safeguarding practice.

4. Learning lessons



7. Be responsive and proactive in addressing safeguarding.
8. Ensure transparent reporting in safeguarding.

11. Contacts

If you are concerned about an adult in York, please report concerns via the City of York Safeguarding Adults board website: safeguardingadultsyork.org.uk/home-page/6/raise-a-concern

The preferred method of reporting a concern is via an online form.

If you are a professional, please complete the 'raise a concern professionals form': safeguardingadultsyork.org.uk/raise-concern/raise-concern-professionals-form

If you are a member of the public, please complete the 'raise a concern residents form': safeguardingadultsyork.org.uk/raise-concern/raise-concern-residents-form

If you are a member of the public and would prefer to speak to someone or report information anonymously you can contact the City of York Adult Social Care:

Call: 01904 555111, Monday to Friday, 8.30am to 5.00pm

If you have a hearing impairment text: 07534 437804

Out of hours help: 0300 131 2131





CITY OF YORK

Safeguarding
Adults Board

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



(01904) 551550



ycc@york.gov.uk



@CityofYork



@cityofyork

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 (Polish)
własnym języku.

Bu bilgiyi kendi dilinizde almanız mümkündür. (Turkish)

یہ معلومات آپ کی اپنی زبان (بولی) میں بھی مہیا کی جا سکتی ہیں۔ (Urdu)

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

For more information visit: safeguardingadultsyork.org.uk