Doncaster Safeguarding Adults Board



Bi Annual Report 1st April 2021 to 31st March 2023

DSAB Sign off	12 th March 2024
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Chairs Welcome

Hello all and welcome to this annual report that stretches across the achievements by DSAB from 2021 to 23. I am pleased to say that I joined as chair towards the end of this period and continue in this position to date.

This report provides a comprehensive overview of our status regarding safeguarding and outlines our plan for the direction from 2023 onwards. It is crucial for us to increase our pace and work towards achieving our priorities for 2023/24 and beyond. I am excited to be part of this journey and collaborate with others towards achieving our goals.

Jane Geraghty
DSAB Independent Chair



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Introduction

This report sets out to cover the work of the Doncaster Safeguarding Adult's Board (DSAB) for the two-year period from 1st April 2021 to 31st March 2023 as part of the requirements in the Care Act 2014 for Safeguarding Adult's Boards to publish an annual report.

The law says that we must publish a report every year to say what we have done to achieve our priorities and how our members have supported us to do this. So, this report says who we are, our Delivery Plan, and progress from April 2021 and March 2023.

What is the Safeguarding Adults Board

The SAB is a statutory partnership between the Council, Police, NHS, Probation, Fire Service and other organisations such as Healthwatch Doncaster, that work with adults with care and support needs in our city. The job of the Board is to make sure that there are arrangements, in Doncaster, that work well to help protect adults with care and support needs from abuse or neglect.

The Care Act 2014 requires all local authorities to have a Safeguarding Adults Board that will provide assurance of the effectiveness of local safeguarding arrangements and partners to help and protect adults with care and support needs in its area.

Safeguarding Adult's Boards (SAB) must:

- Publish a strategic plan for each financial year setting how it will meet its objectives and what partners will do to achieve this.
- Publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each partner has done to implement the strategy as well as detailing the findings of any safeguarding adults' reviews.
- It must conduct any safeguarding adults review in accordance with Section 44 of the Act. A Safeguarding Adult Review takes place when agencies who worked with an adult who suffered abuse or neglect, comes together to find out how they could have done things differently to prevent harm or a death.

'Safeguarding is everyone's business'

As the statement says safeguarding is the responsibility of all organisations within Doncaster.

Safeguarding Adults means stopping or preventing abuse or neglect of adults with care and support. needs. Adults with care and support needs are aged 18 and over and may:

- have a learning disability
- have a mental health need or dementia disorder
- have a long or short-term illness
- have an addiction to a substance or alcohol; and/or
- are elderly or frail due to ill health, disability or have a mental health illness.

Partnership Working in Doncaster

The partnership and safeguarding arrangements within Doncaster ensures close links with Doncaster's Children's Safeguarding Partnership and Safer Stronger Doncaster.

Doncaster Safeguarding Childrens Partnership (DSCP)

The Doncaster Safeguarding Childrens Partnership oversees the multi-agency safeguarding arrangements for children. It has a similar function to the DSAB. Both partnerships may work together when supporting families, or if information is required regarding support to an adult who has a child. In Doncaster the arrangements in place ensure closer working between the DSCP and DSAB through the work of the Joint Board, and the support from the joint Safeguarding Business Unit (SBU).

Safer Stronger Doncaster (SSDP)

The Safer Stronger Doncaster Partnership works to reduce crime and disorder in Doncaster's communities. The Partnership involves members of the police, council, probation service, NHS and a range of other public sector and voluntary agencies.

A key theme for the partnership is awareness and providing services for domestic abuse. Domestic Abuse can affect the whole family including children and adults. For this reason, the Domestic Abuse Strategy (2021-2024) includes a priority to support and keep victims, including those with care and support needs, survivors & families safe through the sharing of information with both the DSAB and DSCP. SSDP provides assurance to the Joint Board (see below) regarding domestic abuse strategy.

Doncaster's Safeguarding Arrangements for Adults

Here we detail the arrangements for the Doncaster Safeguarding Adults Board (DSAB) for the period under review. This two-year period saw changes within the governance and supporting structure for the DSAB aiming to strengthen the partnership arrangements for safeguarding in particular regarding adults, children, young people, and their families.

Chief Officers Safeguarding Overview Group (COSOG)

DSAB is overseen by the Chief Officers Safeguarding Overview Group. This is a strategic group at Chief Executive Level, from the 3 statutory partners, namely City of Doncaster Council, South Yorkshire Police, and the Integrated Care Board. COSOG oversees the partnership's safeguarding arrangements aiming to ensure improvements in children and adult safeguarding work, focusing on cross-cutting issues such as transitions and whole family working. (Appendix 1 – Membership). The 3 statutory partners have oversight across both the DSAB and DSCP with the aim that the partnerships are overseeing and seeking assurance on the safeguarding arrangements in Doncaster.

COSOG's Focus:

- 2021/22 review of the Doncaster Joint Children and Adults Partnership arrangements and update on the work and progress of the Doncaster Partnership Improvement Board as an outcome from the external evaluation commissioned by DMBC and Doncaster Childrens Services Trust (DCST), that led to the need to establish an Improvement Board separately.
- 2022/23 children social care improvement plan, changes under the Integrated Care Board and learning from children and adult reviews.

The Chair, at the start of this period, was appointed as Interim Chair for both the DSAB and DSCP. COSOG were tasked reviewing the options regarding chairing arrangements during this period. The Chair proposed options at the November 2021 meeting ahead of the Interim post coming to an end. The consensus at COSOG was for two separate Chairs to ensure the right balance for both adults and children's boards moving forward. Following the Chair's departure in April 2022, COSOG decided to continue with a separate chair for each of the two boards.

Role of the Independent Chair

The Chair of Doncaster's Safeguarding Adults Board is accountable to residents of Doncaster to ensure that people living in Doncaster are offered the right support and services to safeguard adults with care and support needs. The Chair has to ensure the Board completes the statutory annual report and has a strategic plan.

During the 2021/23 period, there were notable changes in chairing responsibilities. In April 2022, the previous Interim Chair stepped down from their position. This prompted statutory partners to reflect on the arrangements for chairs and the impact under the Children's Working Together guidelines 2019. After careful consideration by Chief Officer Safeguarding Overview Group (COSOG), it was decided to have separate chairs, and the Independent Chair for DSAB was appointed in October 2022. In the period between April and October, the role of chair was fulfilled by the Director of Adult Social Care in an interim capacity.

The Joint Board

The Joint Board aims to promote effective safeguarding practices for whole family working by exploring opportunities for collaborative partnership working across the DSAB and DSCP. The Joint Board endeavours to establish strong connections between issues affecting both children and adults, thereby enabling an integrated approach that encompasses all ages.

A review of the Joint Board's effectiveness conducted in April 2021 concluded that there is a strong commitment to partnership working in Doncaster, with a focus on supporting families and young people by forging closer links across the two demographics. Despite challenges posed by natural disasters¹ and the Covid pandemic, the review recommended the continuation of the Joint Board, with a clear and well-defined delivery plan outlining key priorities, actions, milestones, and lead responsibilities that will enable the Board to achieve its goals and ensure success.

In 2022/23 there was a period of change in Chairing for the Joint Board that was co-chaired by the Director or Adult Social Care and Director of Children Social Care. In September the Independent Scrutineer for the DSCP was appointed and the Chair for DSAB was appointed in October. For the period 2022/23 the focus of the Joint Board was to progress on the identified priorities Transitional Safeguarding, and Whole Family Working. The third priority identified was domestic abuse with arrangements in place for assurance reporting from SSDP (see page 6).

During this year the work of the Joint Board included:

Directions Panel 6 months Pilot

This panel was endorsed by both the DSAB and DSCP regarding young people at risk of exploitation who transition from Children's services to Adult services in particularly those of care leaving age. These young people may present as some of the most vulnerable young people in our community. Effective transitions for young people at risk / experiencing sexual and criminal exploitation involve a planned and careful journey. Adult services are notified about these referrals in advance of their 18th birthday to enable planning for possible transition. This is to ensure all of the relevant, current documentation is received from Children's services to Adult services. Therefore, that everyone has a clear and holistic picture of the situation.

The purpose of the panel is to strengthen and support safeguarding arrangements for transitional 18–25-year-olds. From April 2022 to March 2023, 12 cases were presented of young people at risk of exploitation.

¹ Flooding disaster that affected large areas of Doncaster during November/December 2019

Practice Example Adult Y

Young Person Y had experienced sexual abuse from a young age and some of this had been within her own family. Y's sibling had also died from a drug overdose and was at risk of sexual exploitation. Y's grandmother's partner was in prison for sexually abusing her. Y had also been subject to abuse from people that were connected to her mother.

The panel discussed the concerns around poor relationships within the family and coercion and controlling Y for their own ends. Y had a period of positive changes for three months, however then disclosed more sexual activity for money and abusive relationships with several men. One of the barriers for support was to pull in the wider agencies and services of support.

Adult Feedback from S.42 Enquiry Survey

The Adult Voice Project was created to capture the voice of individuals who have gone through Care Act Section 42 Enquiries, where a safeguarding concern is identified and requires further investigation, in order to capture the outcomes for the adult involved. This is an essential aspect to inform safeguarding arrangements and developments. This project aimed to gather data from a wide variety of adults who had experiences of safeguarding services, to identify what works well, and what needs improvement. Only a very small number responded and agreed to carry out the survey (10 people agreed). Some of those that completed the survey explained that they were unaware that it was a safeguarding process that they had been involved with which made having the conversation at times confusing for the person.

More than half of the people who responded to the survey were satisfied with their safeguarding assessment and outcomes. Communication was flagged as an area for improvement, especially in explaining the safeguarding process and discussing next steps. Those who were dissatisfied with the process felt that there was a lack of progression and contact made. The majority of people felt that people worked well together during the safeguarding process. It was highlighted that the individuals' ability to understand the process of a safeguarding assessment needs to be taken into account, including any additional needs they may have, i.e., hearing impairment, and their capacity at the time of the assessment.

Although the data collected has allowed for insight and learning, it is only a small fraction of the possible data that could have been collated. This is due to a significant number of barriers, which have now been identified and will inform future adult surveys to gather a greater sample size.

Key Facts for 2021/2023

Adults 245,423

65+ 60,324

Number of concerns raised during the year

21/22

1945

22/23

1955

0.5%

Increase in the number of concerns raised

During 2022/23



72% Of individuals were involved in expressing what they want to achieve through their safeguarding enguiry compared to 63% in 2021/22

This remains a key indicator of the Making Safeguarding Personal initiative.



1955



800 per 100,000 adults

concerns about suspected neglect or abuse were reported to the council during 22/23.

There remains a high awareness of arrangements for reporting concerns about vulnerable adults in Doncaster

Number of S42 **Enquiries** commenced during the year

21/22

22/23

892 546 39%

Decrease in the number of enquiries started

(down from 892 compared to last year)

Number of S42 enquires involving alleged **Physical Abuse**

21/22 85 (10%)

22/23 45 (8%)



Enquiries that involved service providers

21/22 - 43%

22/23 - 47%

Gender split of those involved in a S42 Enquiry



Not Known

1%

2022 41% 58% 2021 46%

54% 0%



Number of S42 Enquiries with abuse or neglect occurring in the person at risk's home

(by total type and location)

21/22 - 434 22/23 - 314

Number of S42 enquiries involving allegations of neglect

Self Neglect

Omission

21/22 85 (10%)

22/23 80 (14%)

Neglect/Acts of

21/22 415 (50%)

22/23 275 (46%)

Proportion of ethnicity of individuals involved in S42 **Enautries**

White British

Black & **Minority Ethnic**

21/22 -86.5% 1.2% 22/23 -86.7% 1.6%

(22/23)

45%

Concluded enquiries list the source of risk as someone known to the person at risk

The age group of those involved in a S42

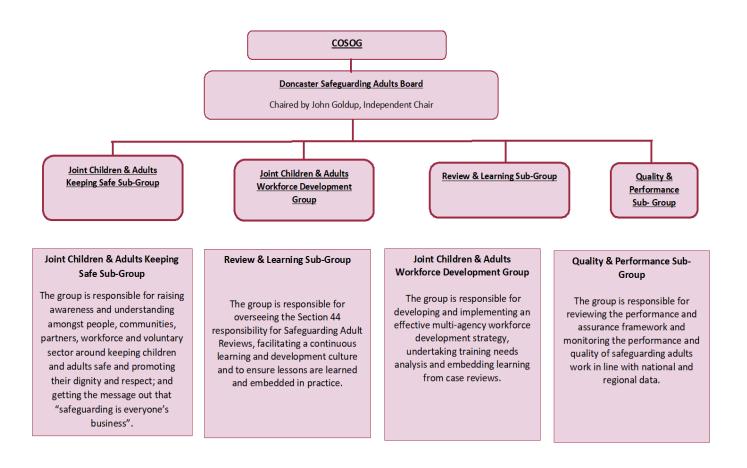
Collection Year	18-64	65-74	75-84	85-94	95+	Not Known
2022/23	32%	14%	27%	21%	5%	0%

DSAB Structure

DSAB Structure 2021/22

To manage work effectively, Doncaster's Safeguarding Adults Board (DSAB) has a range of subgroups, each with a clear term of reference, action plan and reporting arrangements to the DSAB. The members of subgroups can draw in wider expertise from partner agencies and communities of interest that are not members of the SAB. (Appendix 2 - DSAB membership).

For 2021/22 the subgroups included Joint Children & Adults Keeping Safe Sub-Group, Review & Learning Sub-Group, Joint Children & Adults Workforce Development Sub-Group and the Quality & Performance Sub-Group.



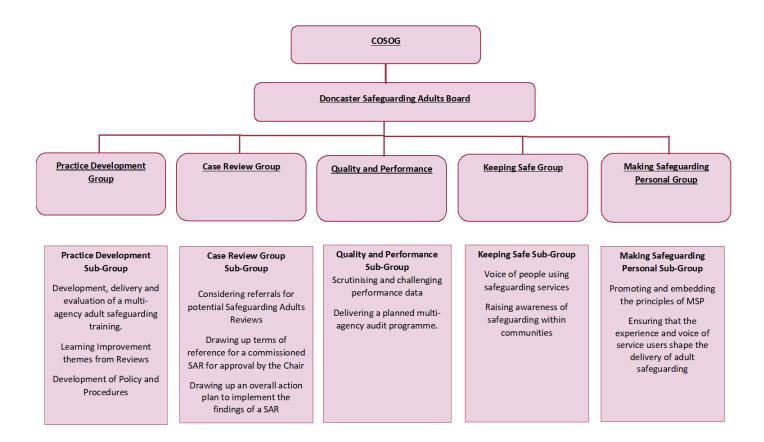
DSAB Structure 2022/23

The review of the DSAB arrangements revised the terms of references to give DSAB a focus on:

- Promoting the principles and practice of Making Safeguarding Personal in all agencies
- Ensuring that the experience and voice of adults at risk are central to all its work
- Finding effective ways to engage with and learn from front line practitioners
- Maintaining a clear line of sight into front line practice
- Monitoring and challenging safeguarding performance in Doncaster across all relevant agencies

• Ensuring the dissemination and implementation of local and national learning across the adult safeguarding system in Doncaster

Following the review there were changes to the DSAB structure and supporting sub-group arrangements.



DSAB Board members are responsible for maintaining oversight of safeguarding arrangements in the city, ensuring these arrangements meet the needs of the people of Doncaster and reflect the voice of the community. The Board is led by an Independent Chair appointed by the local authority who reports to the Director of Adult Social Care.

Safeguarding Business Unit (SBU)

The Safeguarding Business Unit (SBU) is an integral part of the Doncaster Safeguarding Adults Board (DSAB) and supports the DSAB, the DSCP, and its partners. It is often referred to as the driving force behind the DSAB. The SBU works closely with all partners and sub-group Chairs to ensure that agreed priorities and actions are carried out on time. The SBU oversees and facilitates all aspects of the DSAB and collaborates closely with the Chair. Additionally, the SBU is responsible for supporting the work of the Doncaster Safeguarding Children Partnership (DSCP), and Joint Board.

In 2021/22, the SBU underwent a restructuring. This was due to the statutory responsibilities of Doncaster Council, Doncaster Children's Services Trust (regarding child safeguarding), Doncaster CCG (now ICB), and South Yorkshire Police, for the DSAB and DSCP arrangements. Prior to the restructuring, support for these arrangements was delivered separately, with Doncaster Adult Social Care hosting DSAB business support arrangements and Doncaster Children Services Trust managing the DSCP business support arrangements.

A review of the Safeguarding Board arrangements in Doncaster took place in June 2020 and identified the benefits of joining up the business support function for both DSAB and DSCP. The review highlighted the need for better coordination and integration between Boards and their business functions to support an all-age safeguarding agenda.

Roles within the previous Business Units in 2021/22:

DSAB Business Unit

- Safeguarding Adults Board Manager
- Learning and Development Manager
- Policy and Performance (vacant)
- Business Support Officer

DSCP Business Unit

- Safeguarding Children Business Manager
- Policy and Performance Officer (vacant)
- Training Manager
- Business Support Officer (2 posts)

Following a prolonged consultation period (that ended March 2021) with partners and staff, it was agreed to establish a joint Safeguarding Business Unit. The following roles were identified for the unit:

- Joint Strategic BSU Manager
- 2 Deputy Managers (1 for DSAB, 1 for DSCP)
- 3 Safeguarding Development Officers
- 3 Safeguarding Business Support Officers

The recruitment of permanent staff proved challenging during this period. The permanent Joint Strategic Manager post remained vacant with the role being filled by an Interim manager. This was post was successfully recruited to permanently in August 2021. Only 2 of the 3, Safeguarding Development Officer posts were filled after multiple rounds of recruitment. Again 2 of Safeguarding Business Support Officer posts were filled by staff internally to Doncaster Council. This level of vacancies would continue into 2023/24.

DSAB Delivery Plan

The delivery plan and priorities were agreed by the Joint Chair in April 2021, from the areas of focus identified in the 2020/21 annual report which highlighted a drop in safeguarding concerns, which was a different picture nationally compared to children that saw an increase similar nationally.

The April 2021 draft delivery plan and priorities were agreed upon and served as a roadmap for the collective efforts of the partners.

The impact of Covid-19 and winter pressures has also been significant, as evidenced by the partners' response in January 2022. The pandemic has affected us all, and it has been especially challenging for vulnerable individuals and families.

There was also a decline in the number of people accessing training, even virtual training offered, and no multi-agency case file audit. The Chair responded to this as a key priority within the Delivery Plan.

A statutory requirement for the DSAB is to request the completion of an annual self-assessment. Partners were requested to complete this for 2022/23 in March 2023 but not for 2021/22. Not all partners submitted their returns therefore the assessment was incomplete and was not formally reported on.

2021/22 Priorities and what has been achieved.

The Chair consulted with DSAB members in April 2021 to agree the priorities for 2021/22. These were decided based on learning from a recent review published (Adult F page 22).

Priority	Achievements	To progress	Subgroup responsible
Priority 1	Case file audit – to review	To continue to provide quarterly	
Improving the recording of	the quality of safeguarding	reports and focus the next audits	
Safeguarding Concerns –	concerns and S.42	on MSP and S.42 Enquiries.	
to use national guidance	Enquiries. This has helped	Multi-agency involvement has not	
and review records so that	improve practice within	been consistent. The SA Hub	
the right information is	the SA Hub and develop	Quality Officer adopted a different	
received to support	practice standards.	approach through having single	Quality and
people with a	Quarterly reports are	agency discussions of themes	Performance
safeguarding concern	shared to highlight good	identified in the audits.	
raised.	practice as well as any	Impact has been the improvements	
	gaps.	of recording on the MOSIAC	
		system, and the development of	
		practice standards for the SA Hub.	
Priority 2	Self-Neglect Policy –	The Policy was approved by DSAB	
Ensure that people who	established a multi-agency	and members however buy-in and	
self-neglect receive the	self-Neglect Working	adopting the policy has raised	

right support and that services have a process in place including staff training.	group tasked reviewing local and national safeguarding reviews where self-neglect was a feature. It also looked at the themes from cases across different agencies. The themes were used to review the Self Neglect policy that was approved April 2022.	concerns as to whether this can be used across different organisations in Doncaster.	Self-Neglect Working Group
	The Policy and training programme and launch event have raised awareness of Self Neglect. There has been a slight increase in the reporting of cases to the SA Hub.		
Priority 3 Making Safeguarding Personal – everyone in involved in their safeguarding concern and staff regularly ask people what they want to see happen.	User Voice Survey A pilot project to capture the views of people through their safeguarding concern. Only a small number of people were able to participate. This may be due to contact being made a few months after the concern was raised. However, the feedback has been useful to start to identify improvements to the safeguarding process.	The initial proposal included other agencies to support the survey. However due to capacity this was not possible. The Development Officers in the BSU undertook the interviews from a list of people who had been through the safeguarding process.	Joint Keeping Safe Sub-Group
	MSP Survey for Practitioners An MSP Survey undertaken in October 2021 that was led by Council Adults Health and Wellbeing. Only small number responded with over 60% knowing what responsibilities they have for safeguarding adults. 50% stated they received feedback from concerns and only half were asked to contribute to S.42 Enquiries.	Only a small number of responses received that did not reflect input across other organisations. However, the data was used to inform planning training courses.	Joint Workforce Group

Priority 4. To ensure the embedding, dissemination, and evaluation of learning from the full range of quality performance and assurance activity.	Analysis of the dashboard has highlighted the improvement in the recording of outcomes for people and carrying Mental Capacity assessments. The learning from the Case File Audit is shared across agencies to inform practice. Practitioner Forum – joint for adult and children's practitioners. These moved to online in 2021.	On-going work to improve the data in the dashboard. Due to the impact of the pandemic attendance at the Practitioner Forums dropped in 2022 and both Chairs have asked for a review of the purpose of the forum.	Quality and Performance Sub-Group
Priority 6	The Self Neglect Policy is	A number of policies are out of	
To ensure all policies and	being reviewed as part of	date requiring reviewing. These has	
procedures are reviewed	the Self Neglect Working	been highlighted as a risk.	Quality and
and updated to support	Group.		Performance
services.	Options for improving the		Sub-Group
	Safeguarding Review		
	Process were reviewed.		

Priorities and Achievements 2022/23

The priorities below were carried over from the previous year after the DSAB reviewed whether they were still relevant and progress to be made.

Priority	Achievements	To progress	Subgroup responsible
Priority 1	Subgroup established in	The subgroup developed 2	
Promoting and embedding	September 2022 and lead	actions, 1 to embed the	
the principles and practice	by the Assistant Director	User Voice Survey within	
of Making Safeguarding	for Adult Social Care, with	the safeguarding process	
Personal across the adult	a focus on principles and	and second to agree the	
safeguarding system in	practice of Making	MSP Charter for agencies	
Doncaster and ensuring	Safeguarding Personal	to help support them	Making Safeguarding
that the experience and	across the adult	meet the required	Personal Sub-Group
voice of service users	safeguarding system in	standards for the MSP	
shapes the delivery of adult	Doncaster ensuring that	approach.	
•	the experience and voice		
safeguarding across that	of service users shapes the	The Chair of the DSAB had	
system	delivery of adult	approached Healthwatch	
	safeguarding across the	Doncaster to lead on the	
	system.	survey. However due to	
		reduced capacity after the	
		pandemic, Healthwatch	

Priority 2 Engagement with and learning from front line practitioners to develop, deliver and evaluate a multi-agency adult safeguarding training programme and revising and keeping multi-agency policies and procedures up to date.	The Practice Development Group first met September 2022 and led on a Training Needs Analysis for both practitioners and organisations. This survey captured what training practitioners attended, what organisations offered, what type of courses would be most suitable and topics to include in the development of a training programme.	was unable to provide resources for this project. A working group was actioned to agree the standards for the MSP Charter. The response to the survey was low. Further work required to gather single agency training data. Review of the outstanding policies and on-going to progress these. On-going work to review the Self Neglect Policy that was agreed in April 2022. The working continued to meet to progress launch and training.	Practice Development Sub-Group
Priority 3 Review referrals for potential Safeguarding Adults Reviews and making a recommendation to the DSAB chair on whether a SAR should be commissioned. If that statutory criterion is not met, identify the areas of potential significant learning to be achieved through a SAR.	The Case Review Group continues to meet monthly to review requests for a Safeguarding Review. Throughout this period, it received 8 requests of which it was agreed to carry out a single agency review and a Safeguarding Review where the group felt it met the criteria. The Independent Chair also offered further scrutiny to ensure decisions met the criteria and learning was not missed.	Making decisions within 28 days timescale was not met on more than occasion. This was due to not receiving all the information required to make a decision.	Case Review Group
Priority 4 Ensuring that the Board has a clear line of sight into	In 2022 the Quality and Performance subgroups key area of improvement	Areas of improvement to data has been highlighted through the case file audit.	

front line practice. Scrutinising and challenging performance data and raising any significant issues by exception to the Board.	has been the performance summary and data collection. The subgroup has worked to improve the quality of the data and draw where there are gaps. For example, meeting the outcomes identified for the adult. The data showed a number of people where their outcomes were met or unsure whether they were met. A deeper dive into the records ascertained that some people had died, some errors with recording and some who lacked capacity. The findings were shared with the SA Hub to improve recording which has had a positive impact.	A revised proposal to carry out the audits was proposed in Jul 2022 with a focus on safeguarding concern decision and safeguarding enquiry information.	Quality and Performance Sub-Group
Priority 5 To raise awareness and understanding amongst people, communities, partners, workforce and voluntary sector around keeping adults safe and promoting their dignity and respect; and to take action to ensure that people and communities are consulted and, where possible, engaged as partners in the work of the Doncaster Safeguarding Adults Board. To develop a Communication and Engagement Strategy together with people and communities and ensure that the actions arising from this are put in place.	Developed a detailed programme for Safeguarding Week 2022 with regional and local partners. Focus on engaging with the community and start the review of the Engagement and Communication Strategy. Updates of the KS forum that is co-ordinated by Healthwatch.	Attendance at the subgroup was often low that impact on progress especially the review of the Engagement and Communication that was not completed in this period.	Keeping Safe Sub-Group

Safeguarding Events

Safeguarding Week 15th to 19th November 2021

The lifting of Covid restrictions allowed for some events to take place in venues face to face, while others continued to be held online. This enabled the Safeguarding Week in Doncaster to proceed with the participation of various local groups and organisations, including Askern Community Hub, Doncaster Wellbeing team, RDASH, South Yorkshire Fire and Rescue, South Yorkshire Police, and Doncaster Royal Hospital, in partnership with the Safeguarding Business Unit and Healthwatch Doncaster.

The week kicked off with the Celebrating Safeguarding Awards Ceremony, where residents of Doncaster, including adults and children's services, and community groups, showcased their efforts in safeguarding people. We received a total of 20 nominations from various services and members of the public. Two members of the public won an award following a nomination after they intervened to help a victim of domestic abuse being brutally attacked. During the event, the revised Keeping Safe Leaflet was launched. This leaflet was designed by a group of young people and is the first joint DSAB and DSCP leaflet that shares information on accessing services for both adult and children safeguarding.

There was a focus on holding more regional events. The South Yorkshire Launch event took place at Northern College in Barnsley and allowed for hybrid working, with over 15 people attending in person and 20+ joining online via MS Teams. The event presented the revised South Yorkshire Principles and Approach, which have been recently reviewed to include updated versions for Self-Neglect, PIPOT (Persons in Positions of Trust), and Organisational Abuse.

Safeguarding Week 21st to 25th November 2022

The start of 2022 Safeguarding Awareness Week in Doncaster, again saw the Celebrating Safeguarding Awards and the South Yorkshire Launch Event take place. There were also 2 regional conferences on Self-Neglect and 'Ey Up Dad', which put a real focus on making safeguarding personal and a spotlight on engaging the men in children's lives.

Alongside these larger regional events, there were opportunities to learn about many aspects of safeguarding and importantly where and how to seek help, such as Prevent Duty, Female Genital Mutilation, Physical and Mental Wellbeing, Safer Sleeping.

A range of activities, and information sharing events, took place in Doncaster throughout Safeguarding Awareness Week, both in person and online. This included 3 large events (South Yorkshire Self Neglect Conference, 'Ey Up Dad' Conference and South Yorkshire Launch Event and a range of workshops and social media posts.

There was an increase in nominations for the joint Safeguarding Awards event, with 32 being submitted from a range of services and organisations, including public facing services and voluntary groups. In total 9 awards were presented, and 16 stalls were held around the venue to promote services across the partnership.

Neglect and Us Conference March 2022

The aim of the conference was to increase community awareness regarding the topics of neglect and self-neglect. The conference was held online with the goal of delivering an engaging and diverse event suitable for all perspectives. A virtual coffee morning was organised to allow interaction between attendees despite the technological barriers, as well as workshops.

Despite the challenges of the online format, -this was during covid restrictions - and was the DSAB's first online conference, there was a good take up across the partnership with 45 attendees. Although the proportion of community members was not high, there was a lot of networking throughout the day, providing agencies with insights into community work. It was encouraging to see a wide range of agencies involved, upholding the values of multi-agency working, which is not only essential from a professional perspective but also to portray to the community.

Practitioner Forum

The Joint Practitioner Forum, chaired by the DSAB and DSCP Chairs, provided a direct link between practitioners and the work of the DSAB and DSCP. It was a platform for sharing good practices and concerns, and for the Chairs to share key areas of practice such as learning from reviews and the priorities of the Board.

Forums were held in June and December 2021, with a wide range of practitioners in attendance reflecting a strong partnership in Doncaster. The June forum saw 39 people, and 24 in December with both events held virtually. Key points of discussion included the impact of the pandemic on services, multi-agency practice, and whole family working. An increase was noted in mental health issues, which is having an impact on children and young people, families, and staff. There is also a need to assess and manage the impact on staff mental health and well-being, particularly with regards to the different ways of working that have developed due to the pandemic. This includes assessing ways in which things could have potentially been done better.

Self-Neglect and Hoarding Conference July 2022

A virtual conference was organised due to the pandemic. The purpose of the conference was to educate, reflect and review the issue of self-neglect and hoarding nationally and locally, from a variety of perspectives. In line with the localities model, the event was to ensure those in attendance were working with all- adults, children, and their families, in a holistic manner.

There were 121 attendees including speakers and facilitators which was a significant increase on the previous conference. The conference was well attended by a broad range of practitioners, and this was due to those within the partnership sharing and forwarding on the details of conference within their service areas and social media.

Good Practice Example - Adult B

Story of Impact and Difference

Adult B was a twenty-nine-year-old man with a longstanding history of self-neglect, environmental neglect and mental health issues precipitated and manifested from a traumatic childhood. As a result of his difficulties Adult B led an isolated existence unable to trust or engage with professionals concerned about him. A safeguarding enquiry for Adult B by the Safeguarding Adult's Hub in April 2022 was completed due to the insanitary conditions Adult B was living in, and his inability to engage with Housing, Mental Health Services and Environmental Health.

What worked well

- Social workers ability to build up a longstanding and trusting relationship with Adult B by visiting the property multiple times.
- A multiagency approach around Adult B and to improve partnership working.
- Adult B engaged and participated well with two professionals in his care. This was due to their flexibility and non-assertive style of engagement. An empowering approach that enabled Adult B to open up and talk about how he felt. Adult B's voice was then highlighted further in Self Neglect meetings and subsequent planning.
- Through continuous effort and commitment to supporting Adult B achieve a better quality of life Adult B was given hope for the future. Connecting with staff then aided his trust with services to work through his desired outcomes and priorities, one stage at a time.

Practice Example - Adult C

Familial Domestic Abuse

Adult C had attended the emergency department via ambulance due to an overdose. Whilst there Adult C disclosed that they were a victim of familial domestic abuse.

Having been physically assaulted by a family member, following an overdose, Adult C felt unable to cope with the abuse any longer. Adult C struggled to come to terms with the abuse but over time, by building up trust and rapport, the domestic abuse liaison officer, was able to discuss the possibility of completing some paperwork needed to identify what support agencies could provide to Adult C.

The domestic abuse liaison officer was concerned as it was not suitable for Adult C to stay in hospital, and they had nowhere safe to go as the abusive family members had effectively disowned Adult C. Because of the culture of their traveller community, Adult C had no other support networks to help keep safe on discharge.

What worked well

Eventually, the domestic abuse liaison officer managed to find an emergency refuge which would be able to accept Adult C on the same day if transport could be found to get Adult C to the refuge.

The domestic abuse liaison officer was able to take the time to sit with Adult C and build up rapport and trust ensuring that they were able to offer Adult C best support possible – focusing on making safeguarding personal to the adult.

Safeguarding Adult Reviews

A Safeguarding Adult Review takes place when agencies who worked with an adult who suffered abuse or neglect, come together to find out how they could have done things differently to prevent harm or a death. A SAR does not seek to blame anyone; it tries to find out what can be changed so that harm is less likely to happen in the future in the way it did to other people. A review must take place if the following criteria are met:

- There is reasonable cause for concern about how agencies worked together to safeguard the adult; AND
- The adult died and the SAB suspects the death resulted from abuse or neglect.

The adult is alive, and SAB suspects the adult has experienced abuse or neglect.

The Case Review Group that oversees the SAR activity continued to meet and increased its meetings to monthly in order to respond to the increase in SAR Requests received. During 2021/22, 12 requests were received, and for the period 2022/23, 8 requests were received. Out of these 3 were agreed to meet the SAR Criteria.

There was a delay in responses to SAR requests during 2021-2023. The main contributing factor was the timeliness and detail of the information provided by agencies in order for CRG to make a decision / recommendation as to whether the SAR criteria is met. Agencies also reported capacity issues in sending information due to the increase in SAR Requests, and overall SAR activity.

Table: Timescales of decisions made once SAR Request received

Within 1 month	Within 1 to 2 months	Within 2 to 3 months	Within 3 to 4 months	Within 4 to 5 month
6	0	2	3	2

3 Safeguarding Reviews were published between 2021 and 2023. All of these exceeded the timescale of completion. The majority due to receiving and collating findings for the reports. For one report the reviewer could not meet agreed timescales due to caring responsibilities and the impact of Covid.

Adult F

(Published 16th June 2021)

Adult F was found deceased in the bungalow he lived in December 2019. He was 51 years old. He had sustained injuries consistent with an assault. Three males were later convicted of his murder or manslaughter. Some of these males were also involved in a previously reported Hate Crime during which Adult F received abuse relating to his sexual orientation. Adult F's compromised mobility and high risk of falls made it challenging for him to attend appointments. Adult F's GP practice did not appear to make a link between his compromised mobility and the fact that the practice was situated 13 miles away from his home when responding to his failure to attend appointments.

There was a lack of focus on Adult F's mental capacity, and no exploration of the increasing number of services Adult F was declining which could be injurious to his physical and mental health. Adult F's self-neglecting clearly put him at risk of a range of adverse health outcomes including premature death. However, there appeared to be little professional consideration of self-neglect or exploration of invoking the Doncaster Multi-Agency Self-Neglect and Hoarding Policy. Adult F's vulnerability to abuse or exploitation by others may have been masked by the perception that he was a perpetrator of anti-social behaviour.

Key Learning

- An audit of the safeguarding concern process to ensure that appropriate recording of referrals as well as highlighting repeat referrals. Practice standards have been developed for staff.
- Learning from the review has been used to review the Self Neglect Policy and Risk Model to assist agencies with self-neglect cases.

<u>ADULT P</u>

(Published 16th June 2021)

Adult P was 67 years old and was known to have some vulnerabilities. Adult P sadly died in his home in January 2019 and was found, by police. He had lived alone in the property since 2013. Little is known of his family; he had been a coal miner and had suffered a serious head injury 2002. He is described by wellbeing officers as proud and independent and reluctant to ask for support. However, was very friendly and cooperative with wellbeing officers.

Adult P had some contact with the Wellbeing Service from 2013, primarily over finances and began to be of increasing concern over fire risk, weight loss, part clothed/ soiled presentation, and risk of exploitation by others and doubts about his mental capacity, but not about any immediate life-threatening issues. The influences of a brain injury and capacity was not taken into consideration due to this information being not widely known/unknown to all partner agencies. There was a lack of professional curiosity despite apparent deterioration in health and wellbeing.

Key Learning

The SAR identified the need for a review of the Self Neglect Policy, so it included consideration of an individual's mental capacity and the impact of Self Neglect and that it also includes neglecting oneself. The Policy was launched July 2022 with a programme of staff training.

Adult V Child W

(Published 7th March 2022)

Adult V died in April 2020 a few days after an emergency admission to hospital. V had not moved from the sofa for 2 weeks had been lying in their own urine and faeces and had not had a wash for weeks. There were pressure ulcers and severe psoriasis all over her body. Adult V had a small child who was cared for by her ex-partner who was living there. Ex-partner did not provide any care and support to Adult V. Adult V experienced trauma as a child. This impacted her involvement with services and forming relationships. She had previous children removed and also had needle phobia that affected taking medication.

Safeguarding concerns were raised by YAS & the hospital because of the apparent self-neglect.

Joint working issues were identified, particularly around:

- Disclosing missed/cancelled appointments and in a timely manner both with external partners and an internal services for single agencies.
- The impact of COVID restricting Child 'W's father accessing with Child W in the community
- Door-step visits imposed for professionals working with the family.

Key Learning

- Need for holistic 'One family approach' to ensure all family members needs are identified, including a holistic understanding of care and support needs, including historic experiences and trauma.
- Professionals need to be alert to the need to offer a carers assessment, and referral to adult social care for Care Act assessment, where a support need is identified.
- DSCP needed to establish a baseline position on when neglect toolkits should be implemented in work with children and families.
- Understanding and identifying self-neglect in-line with the Self Neglect Policy, whilst also being able to consider if what first appears to be self-neglect but can also be neglect through acts of omission by a partner/informal carer, including raising a safeguarding concern.

DSAB Budget Contributions for 2021/2023

Adults Safeguarding Board Budget Funded by:	
Don ICB via section 256 agreement	111,680
Police Crime Commissioner	28,480
Doncaster Council	130,625
Total funding	270,785

Total funding Safeguarding Board	535,830

There was no regular reporting to the DSAB or COSOG regarding the partnership's budget since 2021/22.

Partner Contributions to Safeguarding 2021/2023

Below are the achievements reported by some partners during this period (please see appendix 3 for full reports)

Department for Works and Pensions (DWP)

Department for Work and Pensions is an organisation which administers claims to benefits, while they don't have the legal duty to safeguard, and therefore no safeguarding training, they continue to raise awareness amongst our colleagues to support their vulnerable citizens. This includes raising awareness in South Yorkshire (16 Jobcentres) about Mental Health, Domestic Abuse etc which enables staff to identify customer needs and signposting effectively. DWP work closely with Local Authority colleagues to consider any relevant training for DWP staff such as attending self-neglect and hoarding awareness sessions.

Impact

Greater awareness amongst colleagues to signpost citizens using our District Provision tool (partner organisations within the local community) who can best support citizens, and greater awareness to complete of safeguarding referrals.

Moving forward DWP will continue to raise awareness with staff on complex needs including new entrants in 2023 and to work alongside partners to identify any emerging insight, relevant training available via multi agency meetings.

Advanced Customer Support Leaders to continue to support partners and citizens who have complex needs who are struggling to navigate the benefit systems where business as usual has failed.

South Yorkshire Police (SYP)

SYP progressed the following priorities within Doncaster during 2021/22:

- Increase understanding the impact of coercive control and the response to domestic abuse from frontline officers/staff though DA Matters Training.
- Improve the use and effectiveness of Domestic Violence Protection Notices/Orders.
- Introduction of the Multi-Agency Tasking and Co-ordination Tasking process to improve the management of serial perpetrators of domestic abuse and reduce offending.
- Increase the effectiveness of identifying vulnerabilities.

Achievements

DA Matters Training

It is now a force requirement for all staff and officers to complete this training. Sessions are arranged for new recruits as part of their initial training. This training discusses and explores Controlling and Coercive Behaviour.

DVPN/DVPO

A dedicated team has continued to improve the process meaning increase in applications and more awarded through court. They have also been responsible for training frontline officers/staff on the process.

MATAC

MATAC was implemented in March 2021 across South Yorkshire. Since the inception of MATAC in March 2021, there has been 101 nominals referred to the process. The process involves 27 partner agencies and serves to prevent further domestic abuse related offending, improve victim safety, improve offender behaviour, improve partnership engagement, and improve criminal justice outcomes.

Vulnerability / Adult Safeguarding Awareness

Changes to the forces electronic recording system were implemented in January 2022, making it the recording of vulnerabilities more effective. These changes have improved recognising and responding to vulnerability. Vulnerability training, 'look beyond the obvious' was provided to frontline officers to help identify and investigate vulnerability related risks and deliver the appropriate policing response.

In May 2021, a new vulnerability intranet site was launched to provide resources and guidance to officers/staff. Each district has nominated an Adult Safeguarding and Older People SPOC.

Priorities for 2022/23

Increase understanding/implementation of DA Act 2021:

- Children flagged as victims of domestic abuse.
- Revenge porn updates.
- Consent to serious harm for sexual gratification.
- Non-fatal strangulation (NFS) offence.
- CCB offence extended to include wider family and ex partners.
- Jurisdiction for offences committed abroad.
- Common assault / battery extended statutory time limits.

Increase awareness of self-neglect and hoarding. Improve the referral process to support services. Force self-neglect & hoarding procedural instruction in progress. Partner self-neglect & hoarding policies readily available to all officers/staff. SYP established a partnership working group to review the questions on the vulnerable adult referrals sent through partner agencies. Work is ongoing with IT to make necessary changes to the electronic vulnerable adult referral form.

Provide training regarding trauma awareness. Training will look not only at how trauma impacts victims across VAWG (violence against women and girls), but also how this affects the police officers and staff who investigate these offences. Funding has been secured and work is now underway to identify appropriate training.

Increase and enhance drug testing on arrest capabilities, particularly in relation to domestic abuse offences. Funding has been granted to increase drug testing of those brought to custody for 'non-trigger' offences – these are offences which do not require drug testing by law, specifically, domestic abuse, and violence against women and girls. New equipment and dedicated officers will be in place to carry out drug testing and if this is positive, the person can then be referred to further support.

Rotherham Doncaster and South Humber NHS Foundation (RDASH)

Achievements

- Review the Person in a Position of Trust (PiPoT) process to ensure they are sufficiently robust to meet the needs of the Trust. A PiPoT audit was undertaken and following this the process was streamlined and strengthened. The PiPoT Policy was reviewed and refreshed.
- Continue to utilise and adopt an approach to safeguarding that embeds and promotes the theme of Think Family. The 'Think Family' approach is woven though all support and advice given, safeguarding training and supervision.
- Develop a domestic abuse workstream for support to staff and patients, review the Domestic Abuse Policy to include the new Domestic Abuse Bill. The domestic abuse workstream developed the 'Supporting staff who are experiencing domestic abuse guidance' and 'at a glance' support cards. The Domestic Abuse Policy is in the process of being reviewed and will now include the changes from the new legislation 'Domestic Abuse Bill'.
- Sexual Safety A sexual safety Policy was developed and the workstream continued to embed sexual safety on the wards.
- Continue to develop a suite of level 3 safeguarding training packages and implement a blended approach to achieving compliance. New learning packages have been added to the safeguarding training calendar including-when poor practice becomes safeguarding, modern slavery, legal aspects and safeguarding supervisors training.
- Embed Modern Slavery and Human Trafficking into safeguarding training and practice.

Priorities for 2022/23

- Embed DA routine enquiry Through training and supervision.
- Safeguarding Adults Supervision The newly published Intercollege Document for safeguarding adults identifies the need for mandatory safeguarding adults' supervision for those staff allocated to safeguarding adults' level 3 and above
- Domestic Abuse Policy To review the update the policy to include the Domestic Abuse Act 2021
- Eliminating Mixed Sex Accommodation Policy To review and update the Policy
- To sustain positive partnership engagement with key stakeholder. To ensure the continuation of robust and transparent conversations in addressing an identifying solutions to rapidly evolving safeguarding issues.

Probation

The Probation Service Yorkshire and the Humber is committed to safeguarding and promoting the welfare of adults with care and support needs to keep them safe from abuse and neglect. In particular Probation focus on the needs of offenders in the community either on a Court Order or following release on licence. In Doncaster they support the work of the adult safeguarding board in 2 keyways:

- Operationally Making referrals to the LA where the Practitioners have concerns that an adult is
 experiencing or is at risk of experiencing abuse or neglect, including financial abuse, and is unable to protect
 oneself from abuse or neglect
- Strategic Attending and engaging in the Safeguarding Adult Board and relevant sub-groups of the board/ Through attendance, take advantage of training opportunities and share lessons learnt from Safeguarding Adult Reviews and other serious case reviews.

As part of the ongoing development of their staff the completion of mandatory adult safeguarding annually is a requirement of employment within the Probation Delivery Unit. Figures for this year add in year represent 85% of all Probation staff having completed this training.

A key focus of the year has been the development of the self-neglect policy review for the City. The Probation Service took an active role in this work chairing the policy development group alongside launching the policy in the annual conference.

HMPPS nationally devised a new national process to notify and review any death under supervision in the service should they occur. Working with partners to learn lessons from these tragic events is a priority for Doncaster Probation Service going forward. A significant proportion of those who have passed away on supervision are those released from custody often due to drug overdose. In response to this challenge the PDU is sourcing naloxone to be stored on site so practitioners can give this to individuals released with an issue linked to illicit substances as a means of keeping people safe.

Supporting cases with autism and learning difficulties is an area Probation are looking to improve. Evidence indicates that 20-30% of those in prison have learning difficulties or disabilities which interfere with their ability to cope within the Criminal Justice system. In response to this the Probation Service Yorkshire and the Humber region utilised commissioning funds to work in partnership with the National Autistic Society

Domestic violence and abuse is the most prominent risk factor within the PDU caseload. The impact on families and victims from abuse is often significant and very difficult to recover from. As part of Probation's ongoing ability to respond to this challenge the partnership is looking to gain direct intelligence regarding these cases. Having this capability in Probation's operational procedures will speed up information sharing and increase the accuracy and validity of risk management plans which will support vulnerable adults in our communities to remain safe.

St Leger Homes

Key Achievements

- The impact of coronavirus (COVID-19) had further measures to safeguard our customers and staff at times during COVID restrictions were required. We achieved this by reviewing our safeguarding offer and specifically our domestic abuse offer to both customers and staff by introducing a stand-alone policy and procedure. We also delivered domestic abuse training to our dedicated domestic abuse champions which has since been rolled out to all staff.
- We secured external funding for a two-year period to appoint two Mental Health Navigators who triage and support our customers who may require additional support from specialist mental health services.
- We secured funding to appoint three Domestic Abuse Housing Options Officers who work with and support customers who are fleeing their homes due to domestic abuse.
- Nationally Recognised Achievement: Domestic Abuse Housing Alliance Accreditation by becoming DAHA accredited, we have been identified as an organisation of good practice with excellent examples of work and training; we are the first housing provider to achieve this accreditation in South Yorkshire.
- Locally Recognised Achievements: Our Domestic Abuse Champions received a Safeguarding Award for the work they did in raising awareness of domestic abuse through staff and community briefings.

Next steps and key priorities for 2022-23

- Moving forward St Leger Homes aim to continue to fulfil its safeguarding responsibilities to the highest standards by:
- Maintaining our commitment to improve quality of safeguarding and support for children, young people and adults at risk.
- Build on our collaborative approach to safeguarding children, young people and adults at risk by remaining
 visible and influential through effective engagement with other multi-agency partnerships, partner
 agencies and frontline practitioners.
- Continue to be a key partner in delivering the vision for Doncaster by contributing to the work of the Boards, subgroups and task and finish groups.
- Continuing to deliver our rolling programme of safeguarding awareness and refresh training to staff and community groups. This training covers various safeguarding topics.

Moving Forward 2023

It is evident that the review of arrangements and the changes to structures, alongside not recruiting to posts within the SBU has meant that more pace and focus is needed in 2023/24 to drive the DSAB safeguarding agenda and progress work on the key priorities identified for 2023/24.

Moving into 2023/24 the following areas require some consideration:

- Covid has had an impact on the way we work but has not stopped agencies responding to safeguarding
 adults. Agencies continue to work together. However, partners capacity and resources were affected
 with not being able to give time to progress some of the priorities. For example, the delay in decision
 making for SAR reviews that was impacted by agencies not having capacity to attend meetings or send
 further information.
- Some of this has been affected by the change in Chairs especially in 2022 where there was a change in chairing that delayed the agreement of priorities.
- Changes in the BSU with struggling to recruit that had an impact for the unit to have capacity and resources to undertake its role. The BSU did not have a Strategic Manager for 5 months.
- There are areas to strengthen such as seeking assurance from partners, a key area of focus for the Chair who would like a more robust assurance framework for 2023/24.
- The learning and development offer requires improvement with a number of gaps identified from the review of SARs.
- The review of policies requires attention so that they are reviewed and updated.

There have been notable achievements such as the partnership work to agree the Self-Neglect Policy and subsequent training. For 2023/24 the focus will be the implementation and review of the effectiveness of the policy in practice.

DSAB events have been well received and offered a variety making them creative. For example, feedback from the Neglect and Us Conference:

'I have found this presentation today very beneficial in my role as a safeguarding social worker.'

'Thank you to you all for putting this together and the guest speakers. Very interesting/provoking and reinvigorates passion and commitment.'

The current Chair is keen to hear from the voice adults with lived experience and for the DSAB to include in its priority's engagement and communication with community groups across Doncaster.

There is also a commitment from both the DSAB and DSCP Chairs to take forward the priorities of the Joint Board and work with partners to commit to these.

Appendices

Appendix 1 – COSOG Membership

Chief Operating Officer,	Doncaster CCG ²
Doncaster CCG (CHAIR)	
Chief Executive	Doncaster Metropolitan Council ³ (DMBC)
DSCP Independent Chair	Doncaster Safeguarding Children's Partnership
DSAB Independent Chair	Doncaster Safeguarding Adults Board
Director of Adults Health and	Doncaster Metropolitan Council (add change of name in
Wellbeing, Adults, Health and	footnote)
Wellbeing, DMBC	
Chief Nurse	Doncaster CCG
Director of Learning	Doncaster Metropolitan Council
Opportunities and Skills	
Assistant Chief Constable for	South Yorkshire Police
Crime	
Deputy Chief Executive	RDaSH
Chief Superintendent	South Yorkshire Police

Appendix 2 – DSAB Membership

Job Title	Organisation
DSAB Independent Chair	DSAB
Lead Nurse For Safeguarding Adults	Doncaster Royal Infirmary
Head of Safeguarding	DBTH
Chief Nurse	Doncaster Integrated Care Board
Designated Nurse Adults	Doncaster Integrated Care Board
Safeguarding Nurse Consultant	RDaSH
Chief Superintendent	South Yorkshire Police
Councillor & DMBC Cabinet member for Adult	City of Donosctor Council
Social Care	City of Doncaster Council
Director of Adults Health and Wellbeing	City of Doncaster Council
AD Adult Social Care	City of Doncaster Council
Principal Social Worker	City of Doncaster Council
Strategy and Performance Improvement Manager	City of Doncaster Council
Chief Executive	St Leger Homes
Director of Housing Services	St Leger Homes
Chief Operating Officer	Healthwatch
Safeguarding Lead, South Yorkshire	Dept for Work & Pensions
Head of Probation (Doncaster)	NPS
Team Leader	VoiceAbility
Safeguarding Adult's Deputy Manager	DSAB
Safeguarding Business Unit Manager	DSAB

² This was CCG until 1st July 2022.

³ Doncaster Metropolitan Council until November 2022

Appendix 3 – Partner Achievements

DSAB Annual Report Partner template

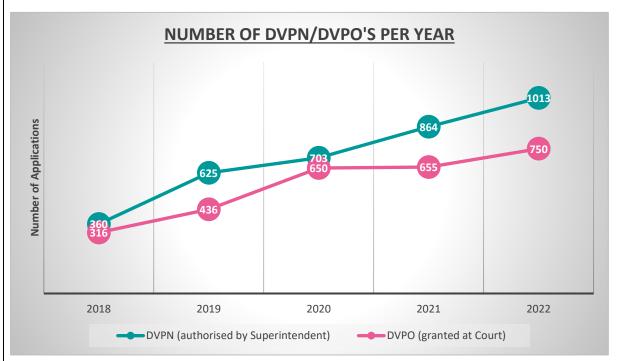
Please provide the following information, data and supporting narrative.

South Yorkshire Police

1. Analysis of Data (time period from April 2021 – March 2022)

DVPN/DVPO DATA

provided by DVPO Team (data to end of November 2022)



2. What were your key priorities and achievements during April 21 – March 22

- Increase understanding the impact of coercive control and the response to domestic abuse from frontline officers/staff though DA Matters Training.
- Improve the use and effectiveness of Domestic Violence Protection Notices/Orders.
- Introduction of the Multi-Agency Tasking and Co-ordination Tasking process to improve the management of serial perpetrators of domestic abuse and reduce offending.
- Increase the effectiveness of identifying vulnerabilities.

3. Impact (relating to what has been done)

Achievement	Impact
DA Matters Training	It is now a force requirement for all staff and officers to complete this training. Sessions are arranged for new recruits as part of their initial training. This training discusses and explores Controlling and Coercive Behaviour.
	Several 'force champions' have also been identified who provide additional advice and guidance to officers/staff who are responsible for dealing with domestic abuse. These champions attend regular CPD events to enhance their knowledge.
DVPN/DVPO	A dedicated team has continued to improve the process meaning increase in applications and more awarded through court. They have also been responsible for training frontline officers/staff on the process.
MATAC	MATAC was implemented in March 2021 across South Yorkshire.
	Since the inception of MATAC in March 2021, there has been 101 nominals referred to the process.
	The process involves 27 partner agencies and serves to prevent further domestic abuse related offending, improve victim safety, improve offender behaviour, improve partnership engagement, and improve criminal justice outcomes.
Vulnerability / Adult Safeguarding Awareness	Changes to the forces electronic recording system were implemented in January 2022, making it the recording of vulnerabilities more effective. These changes have improved recognising and responding to vulnerability.
	Vulnerability training, 'look beyond the obvious' was provided to frontline officers to help identify and investigate vulnerability related risks and deliver the appropriate policing response.
	In May 2021, a new vulnerability intranet site was launched to provide resources and guidance to officers/staff.
	Each district has nominated an Adult Safeguarding and Older People SPOC. They review data relating to adult safeguarding monthly to ensure that identified nominals are fully safeguarded. Any useful information is passed through to them for dissemination across their teams.

4. Next steps and key priorities for 2022-23?

Priority	Work done to date
 Increase understanding/implementation of DA Act 2021: Children flagged as victims of domestic abuse. Revenge porn updates. Consent to serious harm for sexual gratification. Non-fatal strangulation (NFS) offence. 	DA Policies updated to include 'new' definition. Guidance document produced for frontline officers. Training events delivered/arranged. Recording requirements, e.g., NFS disseminated.

 CCB offence extended to include wider family and ex partners. Jurisdiction for offences committed abroad. Common assault / battery extended statutory time limits. Increase awareness of self-neglect and hoarding. Improve the referral process to support services. 	Force self-neglect & hoarding procedural instruction in progress. Partner self-neglect & hoarding policies readily available to all officers/staff. SYP established a partnership working group to review the questions on the vulnerable adult referrals sent through partner agencies. This is to make the questions more meaningful and ensure that the most appropriate information is sent through at the time that the referral is submitted. The questions have been amended accordingly and are currently being piloted in the Barnsley area. Work is ongoing with IT to make necessary changes to the electronic vulnerable adult referral form.
Provide training regarding trauma awareness. Training will look not only at how trauma impacts victims across VAWG (violence against women and girls), but also how this affects the police officers and staff who investigate these offences.	Funding has been secured and work is now underway to identify appropriate training.
Increase and enhance drug testing on arrest capabilities, particularly in relation to domestic abuse offences.	Funding has been granted to increase drug testing of those brought to custody for 'non-trigger' offences — these are offences which do not require drug testing by law, specifically, domestic abuse, and violence against women and girls. New equipment and dedicated officers will be in place to carry out drug testing and if this is positive, the person can then be referred to further support.
Continue to improve the management of serial perpetrators of domestic abuse.	Since 31 st March 2022, a dedicated MATAC Co-ordination Team has been in place. They are continuing to improve the MATAC process, raise awareness and work with partner agencies.

DWP

1. Analysis of Data (time period from April 2021 – March 2022)

Department for Work and Pensions doesn't keep data in relation to safeguarding as we are an organisation which administers claims to benefits. That said, we continue to work with partner organisations and support in SAR/DHR's and lead out any learning identified for colleagues as a result.

Advanced Customer Support Senior leaders in place and attends multi agency meetings to identify and discuss any emerging themes.

2. What were your key priorities and achievements during April 21 – March 22

Department for Work and Pensions is an organisation which administers claims to benefits, while we don't have that legal duty to safeguard, and therefore no safeguarding training, we are continuing to raise awareness amongst our colleagues to support our vulnerable citizens. This includes raising awareness in South Yorkshire (16 Jobcentres) about Mental Health, Domestic Abuse etc which enables them to identify customer needs and signposting effectively. We work closely with Local Authority colleagues to consider any relevant training for our visiting officers such as attending self-neglect and hoarding awareness sessions.

3. Impact (relating to what has been done)

Greater awareness amongst colleagues to signpost citizens using our District Provision tool (partner organisations within the local community) who can best support citizens, and greater awareness to complete of safeguarding referrals.

4. Next steps and key priorities for 2022-23?

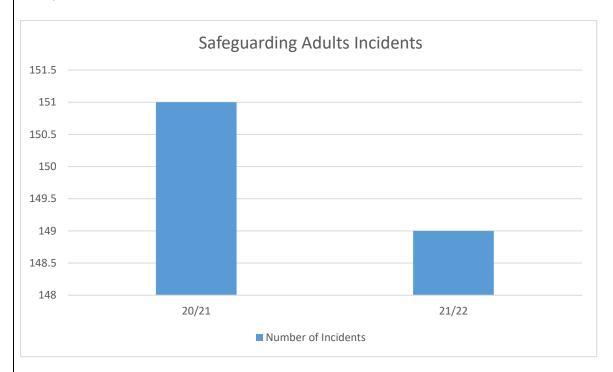
Continue to raise awareness with colleagues on complex needs including our new entrants in 2023. Work alongside partners to identify any emerging insight, relevant training available via multi agency meetings.

Advanced Customer Support Leaders to continue to support partners and citizens who have complex needs who are struggling to navigate the benefit systems where business as usual has failed.

RDASH

1. Analysis of Data (time period from April 2021 – March 2022)

Safeguarding incidents are identified by staff and alerts are generated via the Ulysses incident reporting system. The RDaSH safeguarding team have oversight of all safeguarding incidents, providing assurance that safeguarding policies and processes are being followed. The table below is a comparison of 2020/2021 and 2021/2022 data.



During 2021-2022 the safeguarding team began to monitor the themes and trends of safeguarding incidents in order to provide support, supervision and training to any 'hot spot' areas. Incidents concerned with the theme of neglect and acts of omission far outweighs other incident themes for safeguarding adults. Since the lifting of lockdown, practitioners have had access to patients that were previously hidden from professionals due to covid restrictions. Unfortunately, this has uncovered incidences of neglectful care of adults at risk.

2. What were your key priorities and achievements during April 21 – March 22

Progress against Priorities

We said	We did
Review the Person in a Position of Trust (PiPoT) process to ensure they are sufficiently robust to meet the needs of the Trust.	A PiPoT audit was undertaken and following this the process was streamlined and strengthened. The PiPoT Policy was reviewed and refreshed.

Continue to utilise and adopt an approach to safeguarding that embeds and promotes the theme of <i>Think Family</i> .	The 'Think Family' approach is woven through all support and advice given, safeguarding training and supervision.
Develop a domestic abuse workstream for support to staff and patients, review the Domestic Abuse Policy to include the new Domestic Abuse Bill.	The domestic abuse workstream developed the 'Supporting staff who are experiencing domestic abuse guidance' and 'at a glance' support cards. The Domestic Abuse Policy is in the process of being reviewed and will now include the changes from the new legislation 'Domestic Abuse Bill'.
Sexual Safety.	A sexual safety Policy was developed and the workstream continued to embed sexual safety on the wards.
Continue to develop a suite of level 3 safeguarding training packages and implement a blended approach to achieving compliance.	New learning packages have been added to the safeguarding training calendar including-when poor practice becomes safeguarding, modern slavery, legal aspects and safeguarding supervisors training.
Development of electronic systems to streamline safeguarding processes- Ulysses and SystmOne.	A SystmOne safeguarding module has been developed and the team are able to record on the Ulysses incident reporting system
Embed Modern Slavery and Human Trafficking into safeguarding training and practice.	A Modern Slavery and Human Trafficking learning package has been developed and added to the training repository.
Making safeguarding Personal.	Making safeguarding personal has been added to the SystmOne safeguarding template.

Achievements

Safeguarding week was held in November 2021. RDaSH joined partner agencies to raise awareness of safeguarding and highlight initiatives, as well as providing a range of training for professionals. The lead professionals for safeguarding Adults delivered a number of online training sessions including Modern Slavery and Human Trafficking and Sexual Safety.

Domestic abuse working group was implemented to consider the prevalence and impact of domestic abuse amongst our own staff. RDaSH employ approximately 3700 staff and it is likely, therefore, that over 1000 staff have been or are affected by domestic abuse. With this is mind, the Domestic abuse working group have written guidance for supporting staff who are experiencing domestic abuse, and this is to be

included in the Domestic Abuse policy, currently being reviewed. The working group have also produced 'at a glance' credit card sized support cards to issue to all staff.

Blended learning offer was introduced to make it easier for staff to become compliant with level 3 safeguarding children and adults training. A handbook and safeguarding training resource list were produced to aid staff in finding suitable training for their learning needs.

Safeguarding IR1s are reviewed by the safeguarding team to provide assurance that all appropriate actions have been taken to safeguard the person involved and to provide immediate supervision to staff where required. The team are now able to record in the managers section on the IRI which provides a record of any actions requested and completed.

Safeguarding module on SystmOne is now live which enables the safeguarding team to record contemporaneously on the patient record.

Safeguarding templates on SystmOne have been reviewed and are now a robust way of recording safeguarding concerns for both children and adults. The templates contain links to external safeguarding referral forms and allow staff to easily see any previous safeguarding concerns. Read codes embedded in the templates will allow for a more robust way of reporting safeguarding data.

Policies the PiPoT policy was reviewed and refreshed.

7 minute briefings are used to allow managers to deliver a short briefing to staff on key topics and can also be used to support reflective discussion with practitioners during supervision. The safeguarding team have both devised and disseminated briefings including:

Professional curiosity and safeguarding Adult Mental Health Services Explained Think Family

Joint safeguarding children and adults' supervisors training package

To further embed the 'Think Family' approach the team have devised a new safeguarding supervisor training package that spans both children and adult practitioners. A mapping exercise was undertaken, and places have been allocated dependant on numbers of supervisors within service areas.

3. Impact (relating to what has been done)

- Staff are aware of how and when to raise concerns about Persons in a Position of Trust.
- Staff consider the 'Think Family' approach when they have safeguarding concerns.
- Sexual safety is embedded in practice which has a positive impact on patient safety.
- Safeguarding training is individualised to each staff member. Staff have access to a wide variety of safeguarding training and can choose the subject matter according to their learning needs.
- Making Safeguarding Personal is included in the safeguarding templates, ensuring staff consider a person's wishes and feelings when raising concerns.

4. Next steps and key priorities for 2022-23

Future Priorities	How they will be achieved
Embed DA routine enquiry	Through training and supervision
Embed the electronic safeguarding referral to the team.	Through training and communications
Safeguarding Adults Supervision.	Until recently safeguarding supervision for practitioners working with adults who have care and support needs has not been universally adopted or required. This process and the associated benefits to the organisation and individuals has been widely acknowledged and recognised. The newly published Intercollege Document for safeguarding adults identifies the need for mandatory safeguarding adults' supervision for those staff allocated to safeguarding adults' level 3 and above
Domestic Abuse Policy	To review the update the policy to include the Domestic Abuse Act 2021
Eliminating Mixed Sex Accommodation Policy	To review and update the Policy
To sustain positive partnership engagement with key stakeholders	To ensure the continuation of robust and transparent conversations in addressing and identifying solutions to rapidly evolving safeguarding issues
Shift towards integrated team.	All new B7 posts will be Named Nurse/professionals for safeguarding. The team will develop skills in all areas of safeguarding. The administration team will provide cover for the whole of the safeguarding team
To explore other mediums of communicating safeguarding topics.	Consult with communications team
To explore other ways of formatting the intranet	Consult with Information Technology team
Produce case studies for use in safeguarding supervision.	Case studies to be shared with safeguarding supervisors

St Leger Homes

1. Analysis of Data (time period from April 2021 – March 2022)

Please share analysis of your data, any findings and measures taken. How are trends analysed and identified for action and outcomes measured?

During 2021 – 22 St Leger Homes identified and managed 301 safeguarding concerns, resulting in appropriate enquiries and action being taken, including any relevant and necessary partnership work required to minimise risk and deliver early intervention. The 301 cases opened resulted in 465 referrals being made to various partner agencies for support, tailored to meet the needs of the customers involved.

Following an evaluation of safeguarding data collated in 2021-22 an increase in demand for mental health, domestic abuse and homelessness services was identified. In response, we reviewed our service provision in these areas of work, resulting in a realignment of homelessness services and creating specialist roles, including Mental Health Navigators and Domestic Abuse Housing Options Officers.

In addition, we reviewed our domestic abuse provisions by working through and achieving the Domestic Abuse Housing Alliance Accreditation (DAHA), this accreditation is the UK benchmark for how housing providers should respond to domestic abuse in the UK and is recognised in the government's Ending Violence against Women and Girls Strategy: 2016 to 2020.

2. What were your key priorities and achievements during April 21 - March 22

Our key priorities during 2021-22 was to continue to deliver day to day services and respond to the impact coronavirus (COVID-19) had as further measures to safeguard our customers and staff at times during COVID restrictions were required. We achieved this by reviewing our safeguarding offer and specifically our domestic abuse offer to both customers and staff by introducing a stand-alone policy and procedure. We also delivered domestic abuse training to our dedicated domestic abuse champions which has since been rolled out to all staff.

We secured external funding for a two-year period to appoint two Mental Health Navigators who triage and support our customers who may require additional support from specialist mental health services.

We secured funding to appoint three Domestic Abuse Housing Options Officers who works with and supports customers who are fleeing their homes due to domestic abuse.

Nationally Recognised Achievement:

Domestic Abuse Housing Alliance Accreditation - by becoming DAHA accredited, we have been identified as an organisation of good practice with excellent examples of work and training; we are the first housing provider to achieve this accreditation in South Yorkshire.

Locally Recognised Achievements:

Our Domestic Abuse Champions received a Safeguarding Award for the work they did in raising awareness of domestic abuse through staff and community briefings.

The Southwest Area Housing Team received a Safeguarding Award for their work in safeguarding communities from OCG networks.

An Individual Officer St leger Homes Officer received a Safeguarding Award in recognition for the work they did around supporting the Doncaster Independent Domestic Abuse Service.

The Young People's Voice group (facilitated by St Leger Homes) designed the Keeping Safe Leaflet used by the partnership.

3. Impact (relating to what has been done)

- Reviewing and enhancing safeguarding provisions further supports customers, and communities. In addition, it demonstrates our commitment to improving the quality of safeguarding and support for children, young people, adults and families through partnership and influence, continuing our support of the Doncaster Safeguarding Children and Adults Boards.
- St Leger Homes is now recognised nationally as a housing provider of good practice with excellent examples of work and training in relation to domestic abuse.
- St Leger Homes has been recognised locally, by the Doncaster Partnership, for the work that it does in safeguarding children, young people and adults at risk.

4. Next steps and key priorities for 2022-23?

St Leger Homes will continue to fulfil its safeguarding responsibilities to the highest standards by:

- Maintaining our commitment to improve quality of safeguarding and support for children, young people and adults at risk.
- Build on our collaborative approach to safeguarding children, young people and adults at risk by remaining visible and influential through effective engagement with other multi-agency partnerships, partner agencies and frontline practitioners.
- Continue to be a key partner in delivering the vision for Doncaster by contributing to the work of the Boards, subgroups and task and finish groups.
- Continuing to deliver our rolling programme of safeguarding awareness and refresh training to staff and community groups. This training covers various safeguarding topics.

Probation

The Probation Service Yorkshire and the Humber is committed to safeguarding and promoting the welfare of adults with care and support needs to keep them safe from abuse and neglect. In particular we focus on the needs of offenders in the community either on a Court Order or following release on licence. In Doncaster we support the work of the adult safeguarding board in 2 keyways:

- Operationally Making referrals to the LA where the Practitioners have concerns that an adult is experiencing or is at risk of experiencing abuse or neglect, including financial abuse, and is unable to protect oneself from abuse or neglect
- Strategic Attending and engaging in the Safeguarding Adult Board and relevant sub-groups of the board/ Through attendance, take advantage of training opportunities and share lessons learnt from Safeguarding Adult Reviews and other serious case reviews.

As part of the ongoing development of our staff the completion of mandatory adult safeguarding annually is a requirement of employment within the Probation Delivery Unit. Our figures for this year represent 85% of all our staff having completed this training.

A key focus of the past year has been the development of the self-neglect policy review for the City. The Probation Service has taken an active role in this work chairing the policy development group alongside launching the policy in the annual conference.

HMPPS nationally has devised a new national process to notify and review any death under supervision in the service should they occur. Working with partners to learn lessons from these tragic events is a priority for Doncaster Probation Service going forward. A significant proportion of those who have passed away on supervision are those released from custody often due to drug overdose. In response to this challenge the PDU is sourcing naloxone to be stored on site so practitioners can give this to individuals released with an issue linked to illicit substances as a means of keeping people safe.

Supporting cases with autism and learning difficulties is an area of intersectionality were looking to improve our practice and capability to support. Evidence indicates that 20-30% of those in prison have learning difficulties or disabilities which interfere with their ability to cope within the Criminal Justice system. In response to this the Probation Service Yorkshire and the Humber region has utilised commissioning funds to work in partnership with the National Autistic Society. They will be supporting practitioners in Doncaster to improve our ability to manage the needs of this specific cohort pf people using our services.

Domestic violence and abuse is the most prominent risk factor within the PDU caseload. The impact on families and victims from abuse is often significant and very difficult to recover from. As part of our ongoing ability to respond to this challenge within our community the region working in partnership is looking to gain direct intelligence regarding these cases. Having this capability in our operational procedures will speed up information sharing and increase the accuracy and validity of risk management plans which will support vulnerable adults in our communities to remain safe.