Derbyshire Safeguarding Adults Board

DERBYSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT APRIL 2021-MARCH 2022

We will all work together to enable people in Derbyshire
to live a life free from fear, harm and abuse

www.derbyshiresab.org.uk

@DerbyshireSAB

Introduction from the Independent Chair

As the Independent Chair of the Derbyshire Safeguarding Adult Board, I am pleased to introduce all readers to our Annual Report. The aim is to give an insight to the activity over a 12-month period, and the collective response of our partners, to the issues of neglect and abuse of adults with care and support needs in Derbyshire.

One my roles is to hold all partner organisations to account as to how they respond individually and collectively, and I am pleased to report that believe I have seen a collective approach through the work of the partnership Board at a strategic level and within the subgroups and work streams; this report should give you that assurance too. 2021/2022 has been another challenging year for everyone with the recovery from the pandemic and we are still seeing the impact. I have asked for and received assurance from partners over the past two years that adult safeguarding within their organisation is still a priority, and by reading the individual contributions from partners I believe they demonstrate that it is.

Our Strategic plan and priority areas of Making Safeguarding Personal, Quality Assurance and Prevention have been our focus and there is clear evidence within this report that we are delivering, using the six principles of adult safeguarding: Empowerment, Protection, Prevention Partnership, Proportionality, and Accountability for the basis of that focus. It is important to stress that the policies and procedures of our Board allow for a personal approach; each adult suffering abuse or neglect is an individual and the safeguarding response will be about achieving the best possible outcome for that person.

We aim to improve day by day and are challenging ourselves to improve. Our quality assurance process continues to improve, and it is my belief that work around the complexities of adult safeguarding in Derbyshire is on a sound footing.

The safeguarding of adults is very important, and we need to remind ourselves and educate others that abuse and neglect are real. We have a very good website and social media engagement to support those messages and details can be found within the following pages.

I wish to thank all those involved in adult safeguarding at this stage especially my Board colleagues and the team supporting the Boards work. It just leaves me to say please be kind to each other and remember that:

“Adult Safeguarding needs to be everyone’s responsibility”

Andy Searle

Independent Chair| Derbyshire Safeguarding Adult Board

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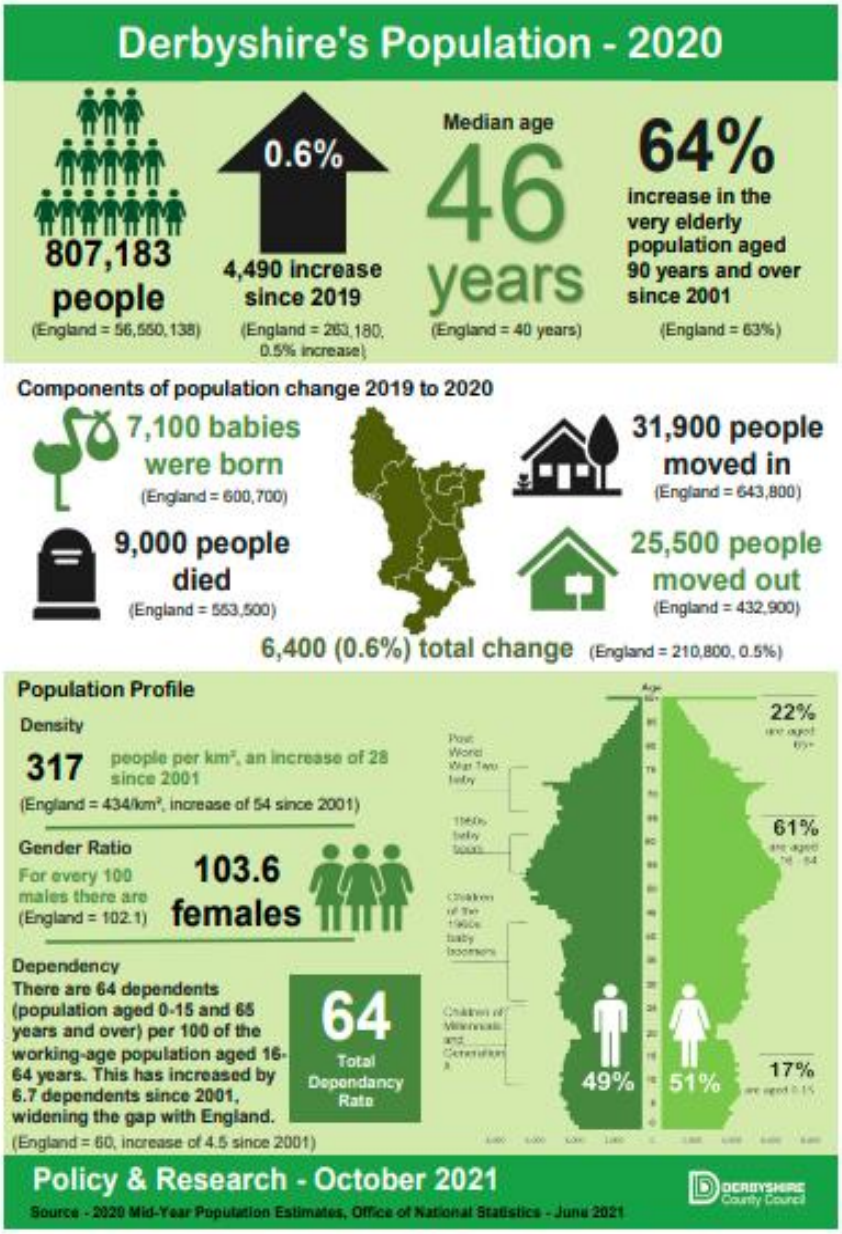
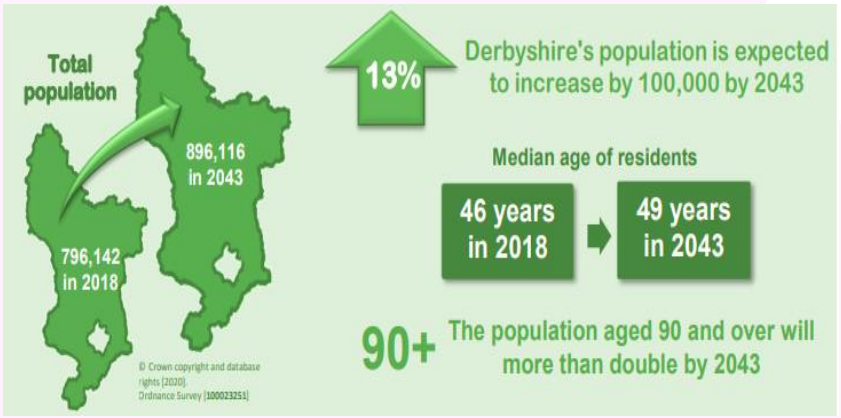
Demographic information

Derbyshire lies in the centre of England covering 630,366 acres. Derbyshire is a large diverse county with several heavily built-up towns alongside large sparsely populated rural areas. A large part of the North and West of the county falls within the Peak District National Park.

Derbyshire's estimated population of 807,183 people in 2020 is a 0.6% (4,490) increase since 2019. The latest population projections (2018 based) predict that by 2043 the county's population will increase to 896,100. Overall Derbyshire has an increasingly ageing population, particularly in Derbyshire Dales. 22% of people in the county were aged 65 and over in 2018, by 2043 this will increase to 27%.

51% of the population are female and 49% are male. Life expectancy is 83 years for women and 79 years for men. 96% of Derbyshire residents are White British, 2% are White non-British, 1% are Asian/Asian British





and 0.4% are Black/Black British.

20% of Derbyshire residents have a long-term health problem or disability. 15% of the working age population have a long-term health problem or disability. Derbyshire households with lone adults will rise from 30% in 2018 to 33% in 2043.

Information source Derbyshire Observatory – Population and Households

Local background and context

Derbyshire is a two-tier authority comprising of the county council and eight district and borough councils. Several agencies work in partnership across both Derbyshire and Derby City, including the Police, Clinical Commissioning Group, Fire and Rescue Service, Ambulance Service and Probation Service.

Derbyshire and Derby City Safeguarding Adults Boards are separate Boards but have joint Policies and Procedures in place. The latest Derbyshire and Derby Safeguarding Adults Policies and Procedures can be found on the DSAB website.

Governance Arrangements and Legislative Context

The Derbyshire Safeguarding Adults Board (DSAB) Board membership is made up of senior leaders from key agencies responsible for safeguarding adults with care and support needs in Derbyshire. From April 2015 the Local Authority, CCG and Police have been required to be statutory members of the Board in accordance with the Care Act 2014 but in Derbyshire the Board is attended by a number of key organisations.

The Board meets quarterly and takes a strategic lead in the protection of adults with care and support needs. The DSAB voluntarily submit themselves to the Improvement and Scrutiny Committee of Derbyshire County Council as an added element of independent oversight and the Independent Chair, on behalf of the Board has regular contact with the local authority at Strategic Director Level.

The appointment of the Independent Chair is the responsibility of the local authority Strategic Director or equivalent in consultation with other Statutory Partners. The Care Act 2014 made the forming of a SAB a statutory requirement of a local authority from April 2015. The effectiveness of the DSAB is reliant on collaborative working between Board members and partner agencies and other local and regional boards. Agencies are placed under a duty by the Care Act 2014 to cooperate with a SAB. The DSAB is independent which enables it to provide effective scrutiny of local adult safeguarding arrangements.

Statutory functions of Safeguarding Adults Boards

- To develop and publish an Annual Report detailing the activity of the Board over the previous year.
- To have in place a Strategic Plan setting out how the Board will meet agreed strategic objectives.
- To carry out Safeguarding Adults Reviews (SARs) in accordance with Section 44 of the Care Act.

The DSAB also has a wider remit with both a preventative and developmental focus on safeguarding adults including the following:

- The development of multi-agency safeguarding adult policy, procedures, and practice guidance
- Ensuring front line staff and managers across the partnership access high quality training, relevant to their role, which has a positive impact on their practice
- Overseeing the continued development of services to empower and support adults in Derbyshire to make their own choices and that any interventions are proportionate and the least intrusive response to the risk presented
- The identification and promotion of positive safeguarding practice
- Raising awareness of how to recognise and report abuse and neglect with the community in Derbyshire, using accessible and easy to understand formats and information.
- To be accountable and transparent to professionals and the public by making the

function and work of the Board accessible to all.

- Respectfully challenging each other to provide the best safeguarding services possible.
- Providing assurance around qualitiative and quantitative performance information with regards to safeguarding adults.
- Working with other Partnership groups and Boards collaboratively to improve the wellbeing of our citizens including Derby and Derbyshire Safeguarding Children Partnership, Derbyshire Health and Wellbeing Board, Derbyshire Safer Communities Board, East Midlands ADASS Safeguarding Adults Community of Practice, National Safeguarding Adults Board Managers Network and Derby City Safeguarding Adults Board.

Safeguarding Principles

The six principles of Safeguarding Adults are set out in the Care Act 2014 and the DSAB views each principle with equal importance in the effective safeguarding of adults

Empowerment	People being supported and encouraged to make their own decisions and give informed consent.
Prevention	It is better to take action before harm occurs.
Proportionality	The least intrusive response appropriate to the risk presented**.**
Protection	Support and representation for those in greatest need.
Partnership	Services working together and with their communities to prevent, protect, detecting and report abuse and neglect.
Accountability	Transparency in safeguarding practice.

Our Vision

We will all work together to enable people in Derbyshire to live a life free from fear, harm and abuse

Strategic Plan and Priorities 2021/2022

The DSAB three-year Strategic Plan for 2019-22 was agreed by Board members in June 2019 and focusses on three strategic priorities: Making Safeguarding Personal, Prevention and Quality Assurance. The subgroups of the DSAB have each developed business plans linked to these priorities, which form a composite business plan to support the Strategy. The business plans are reviewed quarterly by the subgroups and are presented to the Board for oversight and assurance.

DSAB Strategic Priorities 2021/2022

Making Safeguarding Personal (MSP)

Prevention

Quality Assurance

DSAB Budget

During 2021/2022 the Board was funded by Derbyshire County Council Adult Social Care and Health, Derbyshire Police and Derby and Derbyshire CCG. There is a separate, smaller DSAB budget called the Vulnerable Adult Risk Management (VARM) Hoarding Grant which can be accessed to provide practical support for Adults in the VARM process. This budget is funded

by Derbyshire County Council Adult Social Care and Health, Derbyshire Fire and Rescue Service and Derby and Derbyshire CCG, who each contribute £3000 to make up this £9000 budget. Further information about the VARM hoarding grant can be found on the DSAB website and in the separate VARM annual report 2021/22.

DSAB Budget Contributions 2021/2022

Derbyshire County Council Adult Care	£59,011.17
Derbyshire CCG	£36,000
Derbyshire Police	£36,000
	£
Total Amount Spent:	**131,011.17**

Safeguarding Adult Review (SAR) expenses are not counted within the above budget and the cost is split three ways between the three statutory partners of the DSAB (Derbyshire Police, DCC Adult Social Care and Health, and Derby and Derbyshire CCG). The total expenditure for safeguarding adult reviews during 2021/22 was **£2400**.

Key achievements, highlights, and progress

Listed below are some of our key achievements during 2021/2022

- Eight **DSAB newsletters** were produced, widely disseminated for professionals, and published on the DSAB website (DerbyshireSAB.org.uk). In addition to the standard quarterly newsletters, special edition newsletters were produced for important events such as National Safeguarding Adults Week and World Elder Abuse Awareness Day. Two of the newsletters were produced by the MCA subgroup to support frontline staff with understanding the Mental Capacity Act.

Connect to Protect campaign

As part of World Elder Abuse Awareness Day on 15th June 2021 the DSAB office launched the 'Connect to Protect Derbyshire' campaign. The focus of the campaign was encouraging people to make contact with adults who could be vulnerable in our community and may have lost touch with family, friends and services due to the COVID-19 pandemic. #ConnecttoProtectDerbyshire

Equality, Diversity, and Inclusion

The DSAB is committed to embedding the core values of equality and diversity in all safeguarding adults work. An equality and diversity vision statement was adopted by the Board during 2021-22.

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. Safeguarding adults is everybody's business. Everybody is different and diversity will be celebrated and respected. Everybody will be treated fairly, with accessible information, advice and support to help stay safe and maintain control of their lives."

A task and finish group has been meeting throughout 2021/22 to discuss Equality and Diversity. The work of this group has continued into 2022. Policy, procedures, and practice guidance documents are being reviewed to ensure that they appropriately refer to equality and diversity issues, and a training course has now been developed. It is anticipated delivery will commence in the last quarter of 2022.

The DSAB has a leaflet called, '**Advice if you or someone you know is being abused, neglected or exploited'**. The leaflet has been translated into four languages - English, Polish, Romanian and Urdu.

The DSAB has an animated film which gives an overview of the many ways abuse can take

place and explains how to report concerns. It is available with subtitles in English, Polish, Romanian, Simplified Chinese and Urdu, and there is also a version featuring a British Sign Language interpreter. To accompany the animated film, an adult safeguarding guide, 'Adult Safeguarding-what to do if someone is abusing you or someone you know', was produced, which can be downloaded from our website.

To help clarify the VARM process in Derbyshire there are two podcasts - 'What is VARM?' and 'VARM Case Study' - which have been collaboratively produced and explain how the process works, which are available in British Sign language format.

Easy-read guide to keeping safe from abuse and neglect

An easy-to-read guide has been produced by the DSAB Service Manager with help and feedback from the Derbyshire Learning Disability Partnership Board. The aim of the guide is to explain abuse and neglect using images and easy to understand information to help start conversations about safeguarding with adults who have care and support needs. The leaflet has been designed for sharing with adults who have learning difficulties or learning disabilities, but it can be used with all adults.

'Tricky Friends' animation

Tricky Friends' is a 3-minute animation developed to help people to understand what good friendships are and when they might be harmful It's important that people with learning disabilities and autism, those who have cognitive difficulties, and children and young adults, have positive opportunities to make and maintain friendships. This animation can be used to

start those conversations and keep adults safer while enjoying their friendships. A British Sign Language version is available. Norfolk Safeguarding Adults Board kindly allowed the DSAB to use and adapt this video.

COVID-19

Since the start of the COVID-19 pandemic in early 2020, the Board has monitored the impact of the pandemic on safeguarding arrangements. The DSAB Risk Register was reviewed and updated during 2021-22 at DSAB Core Business Group meetings, and a risk assurance plan was closely monitored in relation to COVID-19. Quarterly assurance reports were requested from DSAB partner agencies to highlight areas of risk linked to the impact of COVID on the ability of agencies to respond to their safeguarding responsibilities. Although during 2021/22 restrictions have gradually eased, the Board continues to use data and qualitative information to try to understand the impact of the pandemic on safeguarding arrangements.

The pandemic has changed the way DSAB operates, with the use of new technologies. DSAB Board and subgroup meetings have continued to take place via Microsoft Teams and DSAB training courses and webinars have also taken place via Microsoft Teams which has seen an increase in attendance.

The COVID19 page on DSAB website was updated during 2021-22 to continue to provide both the public and professionals with advice and support in relation to the pandemic. The page contains links to BSL information and information in different languages to assist Derbyshire citizens who do not use English as their first language.

Updated Practice Guidance

The Derby and Derbyshire joint Policy and Procedures subgroup produced several new pieces of practice guidance during 2021-22.

1. Coercive control
2. Foetal Alcohol Spectrum Disorder (FASD)
3. Minimum standards for recording
4. Making Safeguarding Personal: myths and realities
5. Making Safeguarding Personal: Provider Managers - responding to concerns

6. Pressure Ulcer and Safeguarding Assessment Checklist (PUSAC)
7. Vulnerable witnesses
8. 'Was not brought' guidance for advice with non- attendance or withdrawal from services by the adult.

Adult safeguarding decision-making guidance update

The adult safeguarding practice guidance was updated by the Policy and Procedures subgroup to include guidance about what to do when dealing with pressure ulcers in relation to safeguarding, providing examples of lower level, medium-higher level, and serious-urgent level concerns.

Allegations against persons in a position of trust (PIPOT) podcast

In September 2021, a new PIPOT podcast was recorded to provide practitioners and managers from all DSAB partner agencies with basic information about the process and framework in Derbyshire for making allegations against a Person in a Position of Trust (PIPOT). The podcast is published on the DSAB website.

Derby University Freshers' Fair 2021

The DSAB, along with our partner agencies hosted a stall at the Derby University Freshers' Fair on 21st and 22nd September 2021. The main focus was scams awareness and cyber security, but information was also provided to students about keeping themselves safe from harm and recognising the different types of abuse.

National Safeguarding Adults Week 15th to 21st November 2021

During National Safeguarding Week the Board office arranged seven webinar sessions, all aimed at front-line practitioners and managers across our partner agencies. The webinars focused on the following subjects:

1. Fire prevention and safeguarding

2. Foetal Alcohol Spectrum Disorders (FASD) and safeguarding adults

3. Professional curiosity and the challenges of disguised compliance

4. Modern slavery awareness

5. Cyber awareness, fraud, and scams

6. Cuckooing and county lines

7. Trauma-informed practice: safeguarding adults

The webinars were attended by a total of 426 professionals from organisations across Derbyshire.

DSAB social media posts during the week were linked to key themes related to the above topics covered in the webinars to raise awareness with the public.

DSAB Website www.DerbyshireSAB.org.uk

The DSAB website was launched in September 2018. The website contains a wide range of information and resources for both the public and professionals. Since the launch the website has been updated regularly. For the year 2021-2022 the website had 55,691 pageviews, of which 44,197 were unique pageviews which represents an **increase of 9.67% (4,911) pageviews** and 16.18% (6,158) unique pageviews in comparison to the previous year.

DSAB social media @DerbyshireSAB

The DSAB Twitter and Facebook accounts were launched in September 2018 and there continues to be regular posts and activity. The social media posts promote a wide variety of information, Board events and projects as well as awareness raising on a range of safeguarding topics. The DSAB follow and support the work of other SABs nationally via social media as well as partner agencies. The numbers of Twitter followers and Facebook

fans have seen a healthy increase throughout 2021-2022, with 814 Twitter followers (increase of 21% from 673) and 438 (increase of 53% from 287) Facebook fans at the end of March 2022. For the period **1st April 2021 to 31st March 2022** the total **potential reach** of posts and shares was **118,483**. This represented an overall **increase of 47,817 (67.66%)** from the previous year. For the period **1st April 2021 to 31st March 2022** the **potential total reach** of posts/re-tweets was **2.3m**, with Q4 accounting for 798.7k. this represented an overall **increase of just over 1m (81.5%)** from the previous year.

Derbyshire District Council Safeguarding Leads group (DDCSLSG)

The DCSLSG was set up in 2017 to support the work of both the Derby and Derbyshire Safeguarding Children Partnership and the Derbyshire Safeguarding Adults Board. DCSLSG seeks to promote and safeguard the welfare of all children and adults with care and support needs within the respective District Council areas.

The DDCSLSG consists of Safeguarding Lead Officer representatives from all Derbyshire District Councils as well as the DSAB Board Manager and the Partnership Manager from the Derby and Derbyshire Safeguarding Children Partnership.

- Amber Valley Borough Council
- Bolsover District Council
- Chesterfield Borough Council
- Derbyshire Dales District Council
- Erewash Borough Council
- High Peak Borough Council
- North East Derbyshire District Council
- Rykneld Homes
- South Derbyshire District Council

The purpose of the group is to:

- support the DSAB and DDSCP in fulfilling their statutory duties by ensuring effective coordination, cooperation, and implementation at District Council level.
- promote consistency of high quality, effective safeguarding practice across District Councils.
- provide a District level forum where Councils can meet collectively to achieve positive outcomes for children and adults at risk.

A work plan has been developed by the group. This has been developed, taking into account the DSAB priorities. The areas covered include training and development, operational safeguarding issues/case studies, communications, policy and procedures, case file audits, and learning from reviews.

Training is currently being reviewed and is an assurance exercise is to take place to share information around the provision, delivery and attendance of safeguarding adults and children's training. The aim is for the subgroup to understand what safeguarding training each area is accessing and delivering in order to develop consistency where possible and identify gaps. This is to be completed by June 2022. Appropriate links and membership are to be established with the DSAB learning and development subgroups to ensure there is involvement in and engagement in multi-agency safeguarding training.

The subgroup is to provide contact information for each District or Borough communications lead to ensure a full contact list is collated and used for information sharing in relation to key DSAB initiatives and high-profile cases including the publication of SARs and learning reviews. Additionally, the Terms of Reference for the subgroup is to be reviewed to include information about the role, remit and service areas covered by each attendee/representation on the group.

The group is focusing on Policy and Procedures with the intention for all individual safeguarding policies across Districts and Boroughs to be merged into one overarching Safeguarding Policy which links into all Districts and Boroughs. This is dependent on all of the Districts and Boroughs agreeing to this process.

Vulnerable Adult Risk Management (VARM) Process

The vulnerable adult risk management (VARM) process was implemented in Derbyshire in 2013. The DSAB agreed the need for a process to manage risks which may arise within specific circumstances when working with adults deemed to have capacity to make decisions for themselves, but who are at risk of serious harm or death through:

- self-neglect (Care Act 2014)
- risk taking behaviour / chaotic lifestyles or
- refusal of services

The VARM Working Group sits under the Performance and Improvement Sub-Group (PISG) of the Board. The group looks at both strategic and operational matters relating to the VARM process with a key focus on the following areas:

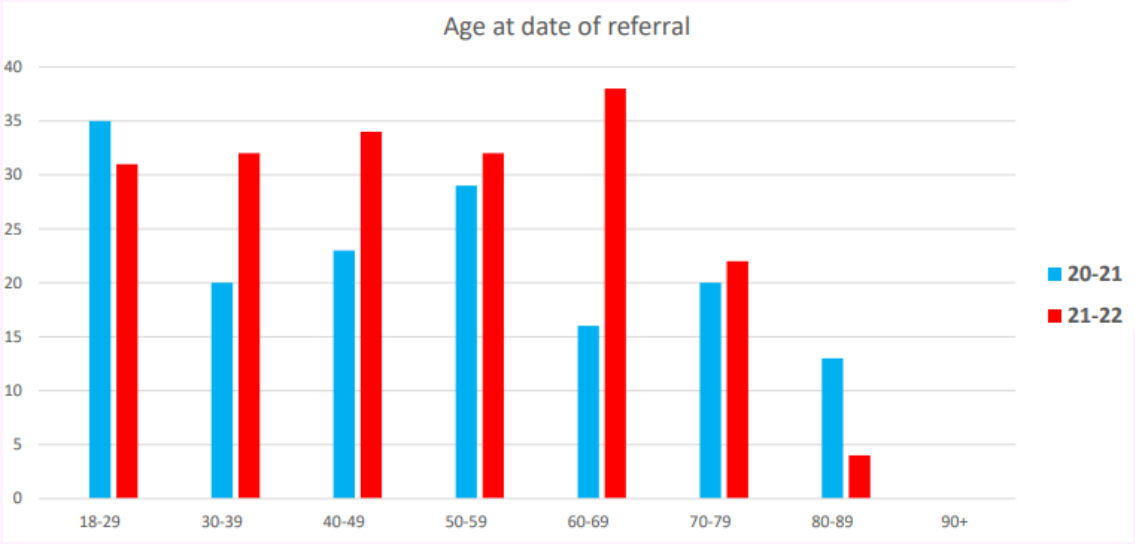
- Analysis of quarterly performance data in relation to VARM to identify areas where practice and process can be improved
- Promotion of Making Safeguarding Personal and customer inclusion within the VARM process and meetings.
- Multi-agency audits in relation to VARM as appropriate
- Annual reviews of all VARM documentation including the VARM policy and staff guidance
- Quality assurance of VARM processes and practice
- Sharing examples of good practice and 'cases studies' in relation to VARM to evidence and demonstrate the impact of VARM and measure outcomes
- Identification of training gaps and assisting with the production of training in relation to VARM
- Monitoring the use and effectiveness of the VARM Hoarding Grant using statistical data
- Sharing information in relation to VARM with operational staff and colleagues – all representatives taking responsibility to feed back to their teams
- Identification of ways to improve quality and consistency of electronic recording in relation to VARM

A separate VARM annual report for 2021/22 has been produced and can be requested via email DerbyshireSAB@derbyshire.gov.uk, however some statistical data and highlights of progress made during 2020/21 in relation to VARM are listed below.

VARM Referrals

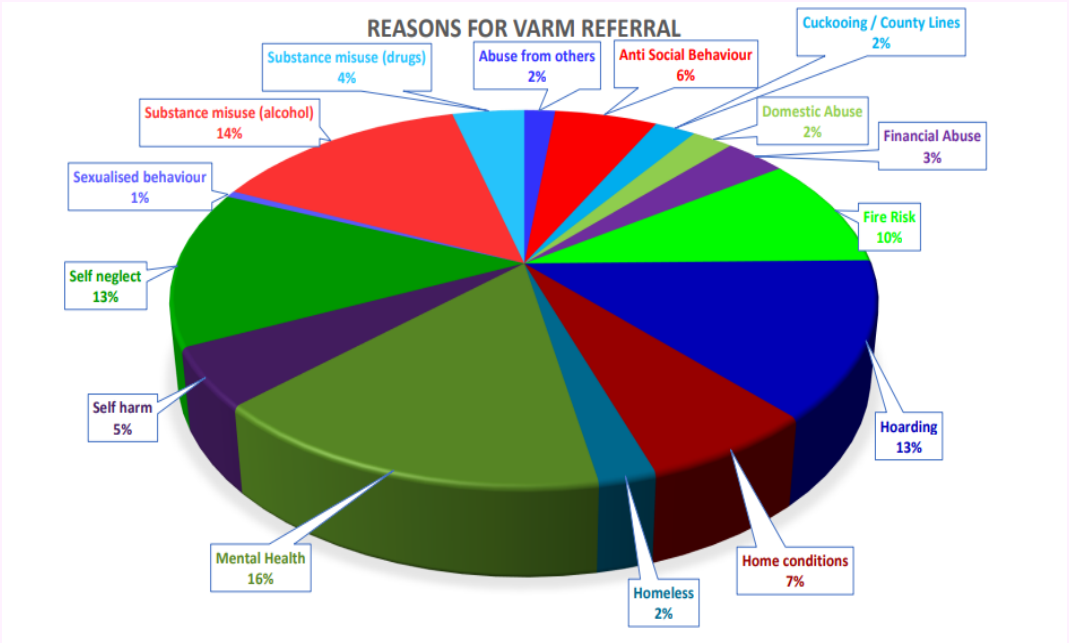
192 VARM referrals resulted in initial VARM meeting being undertaken, 120 cases were in relation to males (62 %) and 72 in relation to females (38%).

The ethnicity of adults in the VARM process during 2021-2022 was: 90% White British, 5% not stated and the other 4% were either Black British, Asian British, Mixed Race or recorded as 'other'.

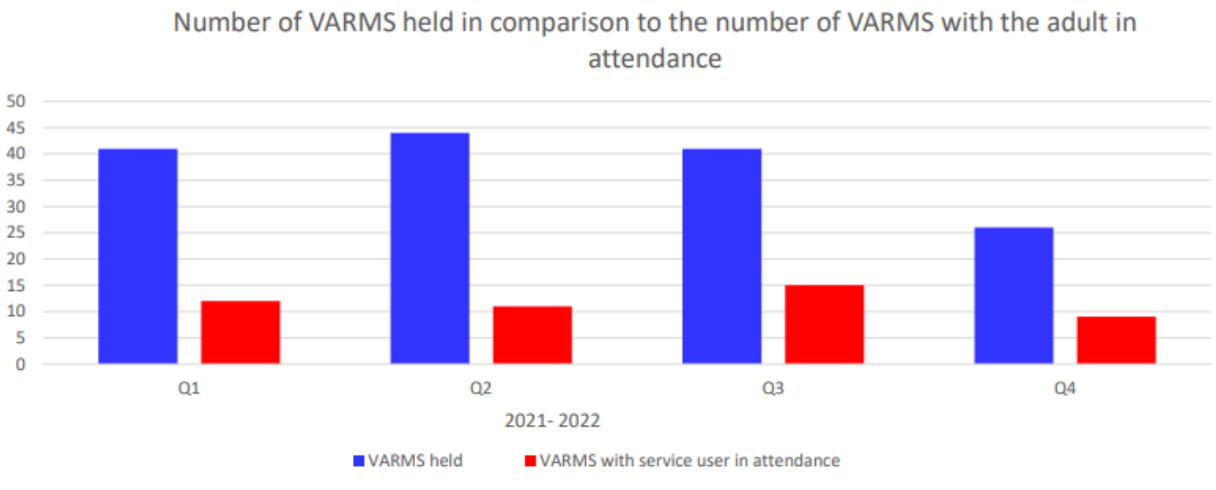


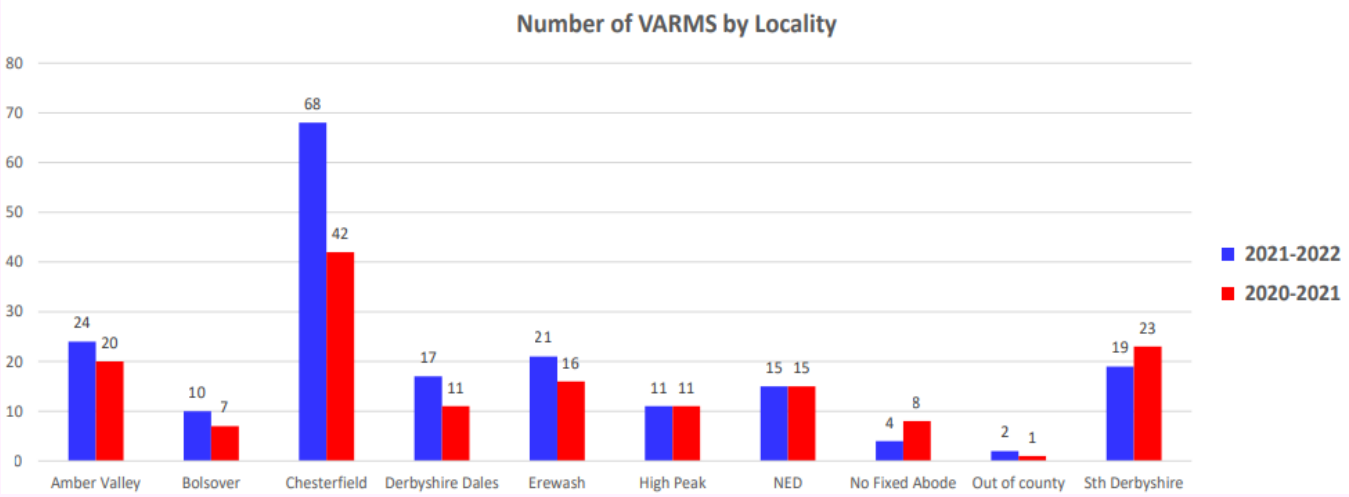
The VARM is a multi- agency process, and 30 different services took the role of lead in VARMs during 2021/2022

For many adults in the VARM process, multiple risk factors are identified as shown below.



The Board is monitoring the involvement and attendance of adults in the VARM process and ongoing work is taking place to seek assurance that the adult is at the centre of every VARM meeting.





DSAB VARM Working Group Key Achievements 2021-22

- The confidentiality statement continues to be shared with all meeting attendees prior to the initial VARM meeting. It was slightly updated during 2021/22 following a review with assistance from legal services in Derbyshire County Council.
- In order to encourage as many adults as possible to utilise the VARM-What to Expect leaflet, there are now two versions of the leaflet; one that can be completed online and one that can be printed and handwritten completed.
- 'Good news' stories of where the VARM process has been successful continue to be shared.

- Complex cases continue to be discussed at VARM working group meetings, so that professionals can learn from each other and provide peer support.
- The VARM Review Working Group created a VARM Agency Report template which will allow agencies who are unable to attend an initial VARM meeting to provide information to support the meeting in a clear and consistent way.
- The DSAB has assisted another Safeguarding Adults Board to launch their VARM policy. The DSAB Service Manager and VARM Administrator both worked with Sandwell Safeguarding Adults Board to advise and guide them about the implementation of their own local VARM procedure, which was launched as part of National Safeguarding Adults Week 2021 (15th - 21st November 2021).
- The VARM Working Group drafted terms of reference for a project to be undertaken in 2022/2023 to analyse the VARM data and the impact of COVID-19 on self-neglect in Derbyshire. This work will be undertaken by the DSAB Senior Practitioner for Quality Assurance.

VARM multi-agency training

The Derbyshire County Council adult social care and health training team delivered eight VARM training webinars during 2021/22.

The training was open to all partner agencies across Derbyshire and was attended by 174 practitioners.

DSAB Financial Abuse Working Group

The DSAB financial abuse working group met twice during 2021/22. The group has a well-established virtual network and regular communications take place to share information about financial scams. The group has been highlighted at regional forums as an example of good practice. A suite of information is available on the DSAB website which can be used by the public and professionals to learn about the risks and how to access support.

Multi-Agency Training

Two DSAB training courses, 'Chairing Meetings' and 'Making enquiries under S.42 of the Care Act (2014)' are hosted by the Derbyshire County Council electronic system, Derbyshire Learning Online. These courses are multi agency delivered and are available for all professionals working for partner agencies across Derbyshire and Derby City, including the voluntary sector. Six sessions of Making enquiries under S.42 of the Care Act 2014 were delivered during 2021-22.

Key learning outcomes for Making enquiries under S.42 of the Care Act 2014 are listed below:

- Demonstrate how the adult is at the heart of everything we do, while carrying out a S42 enquiry by understanding Making Safeguarding Personal (MSP)
- Describe the process for recording information in an Adult Safeguarding Enquiry
- Clarify the role and responsibilities of safeguarding adults' partners in making S42 enquiries, and the possible consequences

Below are some quotes from professionals who have attended the training:

"I now have the confidence and knowledge to make enquiries if I believe an adult is at risk of abuse or neglect".

"I have been able to reflect on what constitutes professional curiosity and also what constitutes disguised compliance. Both of these will help me when dealing with Safeguarding concerns as a practitioner."

" It will enable me to be more confident about making enquiries, liaising with other professionals and sharing awareness with colleagues in relation to breaking a case down, gaining all perspectives, but remaining the person concerned remains central throughout the process."

The 'Chairing multi-agency meetings' course was launched in November 2018 to help professionals explore the skills needed to chair multi agency meetings with a focus on Making Safeguarding Personal and handling conflict. Four sessions took place during

2021-22.

Key learning outcomes for this course are listed below:

- Explore how to plan and chair multi-agency meetings where someone is at risk, whilst maintaining the values that underpin Making Safeguarding Personal.
- Consider how to chair meetings to best practice standards, applying relevant legislation and guidance, including information sharing protocols.
- Discuss how to prepare for a meeting, ensuring that participants are clear about their roles and what outcomes are to be achieved.
- Recognise and practice a range of interpersonal skills to manage the meeting and achieve specified outcomes for individuals.
- Identify some of the things that may go wrong in meetings and consider what actions can be taken to ensure the meeting remains focussed.

Below is some feedback from professionals who attended the training:

'I feel that I would be more confident in chairing larger meetings and that the success lies with having a clear agenda and agreed outcomes which can be introduced as part of the planning."

"Really useful to have some dedicated time to think about this aspect of practice"

"This session has definitely given me the confidence to chair a meeting and to not worry about setting boundaries and helping the meeting adhere to an agenda."

Safeguarding Adult Reviews

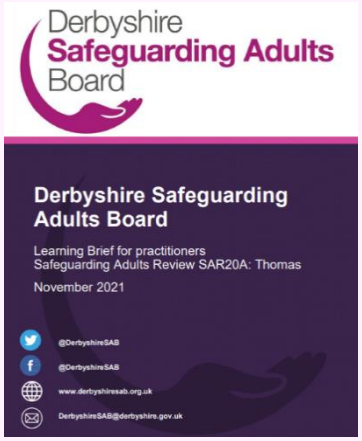
Section 44 of the Care Act 2014 requires Local Safeguarding Adults Boards to arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk. A SAR may also be conducted when a person has not died but it is known or suspected that they have experienced serious abuse/neglect, sustained a potentially life-threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

The SAR process is not about apportioning blame, or investigating the actual circumstances of an incident, it is about learning what we are doing well and where improvements can be

made to systems, processes, and practice, to make a difference to the way agencies work together to support adults in Derbyshire. During 2021/22 the DSAB completed and published one review, SAR20A.

A Learning from Safeguarding Adult Reviews, Multi-Agency Learning Reviews and Domestic Homicide Reviews' conference took place on 29th April 2021. Over 150 practitioners and managers attended, where guest speakers included SAR reviewers and the assistant coroner. Reviewers shared learning and good practice in relation to the review they had undertaken, as well as local, regional, and national thematic learning themes being shared.

Safeguarding Adult Review (SAR20A)



The DSAB commissioned a Safeguarding Adult Review (SAR20A) in 2020 in accordance with the Care Act in relation to the death of an adult we refer to as, 'Thomas'. On 22nd November 2021 the DSAB published the learning brief for SAR20A outlining the background, findings, good practice, and next steps required. The learning brief for this SAR is available to read on our website.

The DSAB's Independent Chair, Andy Searle, would like to thank all those involved in the SAR process, especially the Independent Author and Thomas' Mum, whose contributions to the review were much appreciated.

The Board encourages all front-line staff and managers to read and discuss the learning points and the good practice highlighted. The learning brief can be used as a tool to understand cases of a similar nature and promote professional curiosity and self-reflection.

Work is ongoing to ensure that the learning from this review and reviews undertaken previously are embedded across the partnership, with action plans in place which are monitored closely via the SAR subgroup.

Subgroup Activity of the Derbyshire Safeguarding Adults Board 2021/2022

The DSAB currently has seven sub-groups supporting the work of the Board. Each subgroup reports quarterly to the DSAB on activity, progress, and challenges.

- Core Business Group
- Performance and Improvement (PISG)
- Operational and Leadership
- Safeguarding Adults Review (SAR)
- Learning and Development* (L&D)
- Mental Capacity Act (MCA)*
- Policy and Procedures (P&P) *

* Indicates a joint Derbyshire and Derby City SAB Subgroup

The Core Business Subgroup
Chair - Andy Searle

The DSAB Core Business Group is a subgroup of the Board with membership from the DSAB Service Manager, Independent Chair and the three statutory partners of the Board.

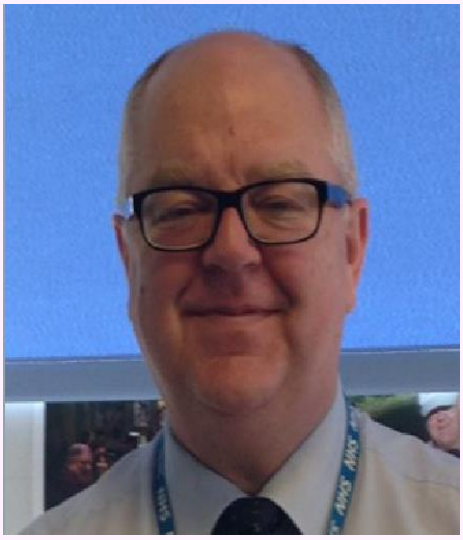
The purpose of the Core Business Group is to:

- Inform and agree the agenda for each DSAB Board meeting.
- Discuss and follow up on DSAB Business in between Board meetings.
- Co-ordinate the production and implementation of the DSAB Business Plan.
- Monitor the effectiveness of the DSAB and subgroups in relation to safeguarding adults in Derbyshire, bringing good practice/areas for further scrutiny to main Board.
- Monitor the effectiveness of processes and areas that are routinely reported to DSAB.
- Provide oversight of the relationship between other forums, for example, Health & Wellbeing Board, Safer Communities Board and the Derby and Derbyshire Safeguarding Children Partnership.
- Establish and monitor financial arrangements for the DSAB.

Key decisions remain the responsibility of the full Safeguarding Adults Board.

The Performance and Improvement Subgroup
Chair: Bill Nicol (Derby and Derbyshire CCG)

The Performance and Improvement subgroup is responsible for:



- analysing the safeguarding adult performance data
- identifying areas of risk and thematic areas of practice and performance in order to determine any priority areas for operational improvement.
- identifying areas of work that are required to improve multi agency practice and to monitor progress.
- Highlighting and sharing positive safeguarding practice.

It has been another productive and positive year for the sub-group. The COVID-19 pandemic had a major impact upon our priorities and focus. Much of the work was to monitor the impact that COVID restrictions had placed upon adults at risk. Scrutiny of statistical information was therefore crucial in helping to identify operational themes and trends. Our case file audit work also concentrated upon referrals made during the COVID period. We found strong evidence that partner agencies and providers had worked well, and in partnership, to assist those adults deemed to be at risk of abusive behaviours.

The subgroup also maintained a close regard to the three strategic priorities of the DSAB (Quality Assurance, Prevention, and Making Safeguarding Personal). These three areas were key elements within our audit activity. Topics covered included Domestic Abuse, Self-Neglect, and the abuse of older people.

Another very positive development was the agreement of the Board to funding of Quality Assurance Officer post for 12 months. This will have a positive impact on the scope and the range of activity undertaken in identifying areas for closer attention and further development.

The Learning and Development Subgroup
Chair: Kerry Pope (Derbyshire Police)

The purpose of this subgroup is to:

• take direction from Derby and Derbyshire SABs in relation to Learning and Development and agree priorities which meet the strategic objectives of both Boards

• support both SABs in meeting the requirements of national guidance/legislation and standards in service provision to safeguard adults who are in need of care and support

• identify, develop, and maintain and promote a multi-agency safeguarding adults training programme

• promote a consistent approach to safeguarding adults across Derby and Derbyshire

• seek assurance that the principles of Making Safeguarding Personal are embedded within safeguarding training.

• develop quality assurance tools to evaluate safeguarding training.

• analyse learning identified in multi-agency reviews and audits in relation to existing safeguarding adults training and identify gaps and areas for development.

The Learning and Development Subgroup has had another productive year. We have adapted well to the online learning world and continued to arrange and facilitate two multi-agency training courses, 'Making Enquiries under s42 of the Care Act (2014)' and 'Chairing Meetings' during 2021/22. The courses have been well attended and the feedback received from those that attended was good.

In order for the group to move on to other areas of training we will no longer provide training from the board in respect of Making Enquiries under s42, this training package is now available for individual agency training.

A task and finish group has been meeting throughout 2021/22 to discuss Equality and Diversity. The subgroups aim is to ensure that that Equality and Diversity has consistent messages within training and the work that is carried out as a partnership. The work of this group has continued into 2022 and a training course has now been developed. The roll out of the training is pending sign off from the board, but it is anticipated delivery will commence in the last quarter of 2022.

The National Safeguarding Adults week took place in November 2021 and the partnership put on a number of training events. All courses were well attended and feedback from the events was positive.

The group have developed a course planning and development checklist for agencies to consider when putting courses together. The checklists include, 'golden threads' of safeguarding that need to be included, ensuring that the relevant audience is specified and at what level the course is pitched at. This will drive consistency within the partnership.

The subgroup has an action plan linked to the three strategic priorities which both Derbyshire and Derby City Safeguarding Adults Board have adopted; these are Making Safeguarding Personal, Quality Assurance and Prevention. This action plan is reviewed at each meeting and shared with both Boards to monitor progress.

The Operational and Leadership Subgroup
Chair: Michelle Grant (Derby and Derbyshire CCG)

The Operational and Leadership subgroup is attended by Safeguarding Leads from DSAB agencies and by adult social care managers from each locality area. The group regularly features guest speakers from a variety of organisations, including a recent presentation by Derbyshire Autism Services and the Changes Programme Manager who gave us a presentation on the work they do with perpetrators of domestic abuse these continue to be a valuable way of increasing our knowledge and of sharing information across all our partners about the wide range of services available in Derbyshire to assist us with our safeguarding responsibilities.

The meetings allow an opportunity for all partners to discuss how to improve operational systems and safeguarding processes and to review our action plan to ensure progress is being made against the actions agreed. Discussions during 2021/22 have included the ongoing challenge of responding to referrers, Making Safeguarding Personal and how partners are able to evidence increased compliance with this, the use of Derbyshire Mind who provide our advocacy service for those who have nobody to support them in safeguarding procedures, inappropriate/non safeguarding referrals and the promotion of the updated Herbert Protocol to protect adults who are at risk of going missing due to dementia or other illnesses.

Subgroup members have also been encouraged to share case studies as examples of what is working well and areas which require improvement. The new additions to the Practice Guidance document have been promoted widely following the recommendations from Safeguarding Adult Reviews (SARs).

Safeguarding Adults Review (SAR) Subgroup
Chair: Gemma Poulter (Derbyshire County Council, Adult Social Care and Health)

The Safeguarding Adult Review (SAR) sub-group has met on four occasions in 2021/2022. All key DSAB partners are represented in the subgroup and subgroup members have worked collaboratively to deliver its workplan.

The sub-group worked according to its business plan for 2021/2022 which centres on activity to deliver the strategic priorities of Making Safeguarding Personal (MSP), Quality Assurance and Prevention. Activity included ensuring a person-centred approach in the completion of all Safeguarding Adult Reviews and seeking assurance that Making Safeguarding Personal (MSP) is embedded within all inter-agency involvement.

The SCIE quality markers have been used to ensure quality SARs. A SAR publication checklist was written and adopted to cover all eventualities, and the subgroup has taken appropriate action to ensure that learning from SARs has been shared appropriately and proportionately across agencies.

The panel has received one new SAR referral during 2021/2022 and considered all available information from partner agencies to determine whether the referral met the criteria for a SAR to be completed. As a result, SAR21A was commissioned on 13/12/2021.

SAR20A, which was commissioned on 15/5/2021, was concluded in relation to “Thomas”. A learning brief was published on 22/11/2021 and can be found on the DSAB website. Learning events have been held within organisations for all relevant colleagues. In addition, a learning briefing was given at the Joined-Up Care Derbyshire Mental Health, Learning Disability and Autism and Children and Young People System Delivery Board meeting held on the 11/11/2021 to ensure that joint strategic and operational plans reflected appropriate priorities and actions

relevant to the learning. Information about this review can be found in an earlier section of this annual report.

Agencies have provided reports at the SAR sub-group on progress made in respect of the recommendations for SAR20A and these have provided evidence of appropriate progress in respect of the recommendations of that review.

The SAR recommendations group has continued to monitor implementation of recommendations made in completed SARs and Multi-agency learning reviews (MALRs).

The Mental Capacity Act (MCA) Subgroup

Chair: Emily Freeman, Head of Service for Safeguarding Adults and Professional Standards, Derby City Council

The Mental Capacity Act (MCA) Subgroup is chaired by Emily Freeman, Head of Service for Safeguarding Adults and Professional Standards at Derby City Council. This is a joint subgroup for both Derby and Derbyshire Safeguarding Adults Boards. It is well supported with representation from key statutory and non-statutory partners and is well attended.

The purpose of the MCA is to promote and safeguard decision making within a legal framework. The MCA empowers people to make decisions for themselves wherever possible and protects those who are unable to make decisions for themselves.

The MCA Subgroup sits under the Derby and Derbyshire Safeguarding Adults Boards and the aim of these Boards is to work with partners to:

- stop abuse or neglect
- prevent harm
- reduce the risk of abuse or neglect to adults with care and support needs
- safeguard adults in Derby and Derbyshire in a way that supports them in making choices and having control about how they want to live.

The MCA Subgroup meets quarterly, reviewing the action plan which links with Derby and Derbyshire's SABs three priorities: Making Safeguarding Personal, Quality assurance and Prevention.

Progress during 2021-22:

The following work has been undertaken by the Subgroup:

- Implementation of newsletters highlighting key themes on MCA. The newsletters have been circulated to SAB members and have also been published on the SAB websites. This newsletter will continue to be published twice a year in 2022-23.
- Activity reports are regularly discussed at the subgroup. Reports are received from partners such as health and from the advocacy and IMCA Services
- Successfully published guidance around information available to young people, their carers and families about MCA to assist transition to adult services when the young person turns 18. The guidance was signed off by the Policy and Procedures Subgroup in January 2022
- Received recommendations from reviews (locally and nationally) that were relevant for the subgroup, embedding any learning for example implementation of the MCA slides
- The Deprivation of Liberty Safeguards were due to be replaced with the Liberty Protection Safeguards in October 2020, however this was delayed due to Coronavirus. The MCA subgroup formed a Partnership Implementation Project Group to work collaboratively to develop as much joint policy, procedure and guidance as possible to ensure consistency across the city and county. This work will be progressed throughout 2022-23 in preparation for the implementation of LPS.
- The terms of reference for the MCA Subgroup were reviewed to include the core values of Equality and Diversity
- Partners continued to share good practice, tools and information and scrutinizing the application of the MCA and DOLS across partner agencies

The following work is in progress and focus for the MCA Subgroup for 2022-23:

- Making safeguarding personal:
    - To look at how to obtain feedback from customers or their representatives

- To develop a forward plan of items for the MCA newsletter, and explore expansion of audience from staff and professionals to include citizens

- Quality assurance:
  - Receiving assurance from agencies that they are implementing the legal framework within their organisations
  - To consider and develop Key Performance Indicators that demonstrate appropriate application of MCA within partner agencies
- Prevention:
  - To develop up to date information and awareness campaigns on the preventative safeguards within the MCA, such as Lasting Power of Attorney and Advance Decisions to Refuse Treatment.

The Policy and Procedures Subgroup

Chair: Zoe Rodger-Fox, Head of Safeguarding, Chesterfield Royal Hospital NHS Foundation Trust.

The purpose of the Joint Policies and Procedures Subgroup is to develop and review multi-agency policies and procedures and practice guidance in relation to safeguarding adults to ensure that staff are equipped to respond to safeguarding adults concerns and promote the welfare of adults with care and support needs with the aim to:

- support both SABs in meeting the requirements of national guidance/legislation and standards in service provision to safeguard adults who are in need of care and support
- identify, develop, review and promote multi-agency safeguarding adults policy,procedures and practice guidance.
- Existing guidance will not be reviewed unless there is a requirement due to:
  - A change in legislation or statutory guidance
  - The review date has arrived
  - A formal request is made via the Board or a SAB subgroup that an amendment is
  - required due to a factual inaccuracy.

- Learning from a SAR/learning review/DHR/CSPR requires a change to be made to existing guidance
- promote a consistent approach to safeguarding adults across Derby and Derbyshire.
- Embed the principles of Making Safeguarding Personal within safeguarding policy and practice guidance

This group has completed a review of the terms of reference and the membership. The Chair and Deputy Chair were happy to continue; they are both from Health services and they are accompanied by a wide range of agencies as partner members. Engagement with the meeting has remained high throughout the year, with contribution to the work plan being shared across the partnership. The group are eager to bring experts speakers and support into the group and have sought support and advice from Her majesty's coroner, domestic abuse services and police colleagues.

There is a full review of the work plan taking place at each meeting and reassignment of actions to support the group in moving forward with creations of new documents. There is a standing agenda item where policy and procedure change requests can be reviewed to ensure timely change in line with new legislation and learning.

` The group continue to risk assess the outstanding work and ensure new policies, procedures and guidance are produced to meet the needs of the public and the partners.

The table below highlights the progress the group have made during the year.

	2021-2022
AMBER **Document being worked on or awaiting sign off**	4
GREEN **Document produced and published**	51

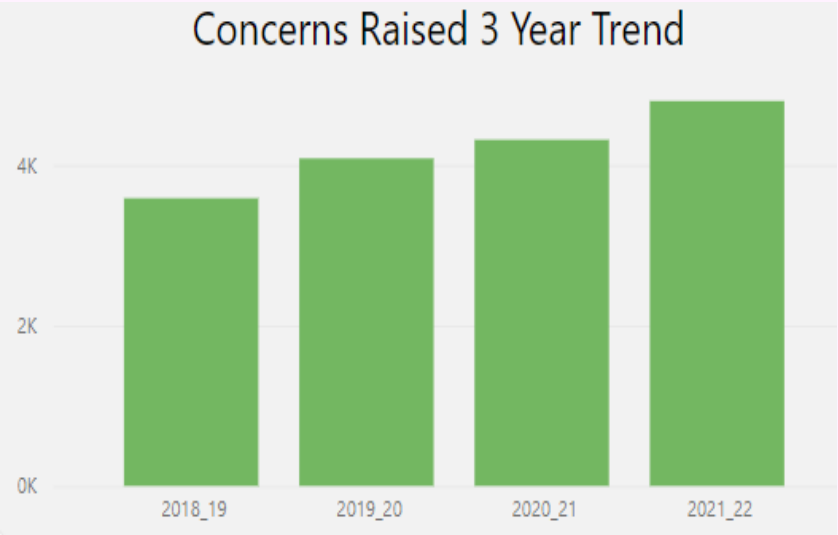
Adult Safeguarding - Statistical information

The DSAB has access to quarterly data dashboards in relation to safeguarding adults referrals, safeguarding enquiries and outcomes, which are presented at Performance and Improvement subgroup meetings with key headlines shared at Board meetings. This information helps to improve the Board's understanding of the main areas of risk to adults in Derbyshire, what is working well in relation to safeguarding and where improvements are needed. There is ongoing work to improve the data with a key focus on promoting the importance of accurate recording to all professionals to ensure the Board has access to meaningful data. DCC Adult Social Care and Health and the DSAB are working together to improve data capture.

It has been agreed that from quarter 1 of 2022/2023, key performance indicator's (KPI) will be adopted and reported into the Board on a quarterly basis.

The Board has begun to get more qualitative data from adults who have been through the safeguarding process. This is being used to inform action plans and to feedback to agencies.

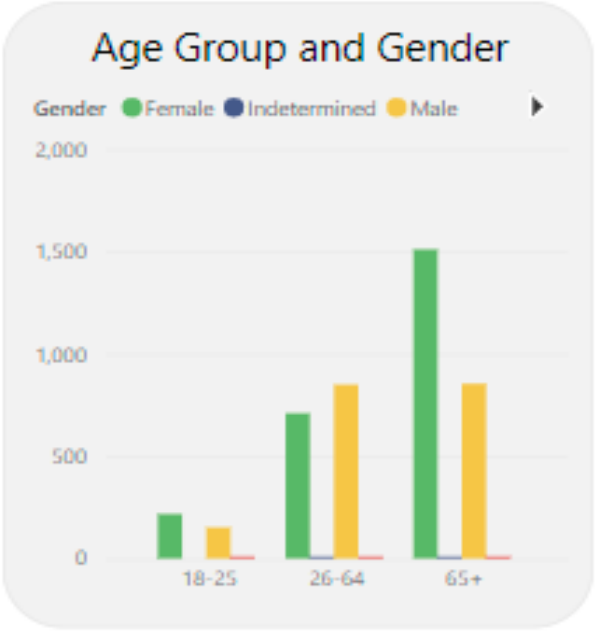
Safeguarding adult referrals and safeguarding enquiries data 2021/2022



There were **4799** Safeguarding referrals/concerns raised with Derbyshire County Council Adult Social Care and Health within the year 2021-2022. This is an increase of **10%** from the previous year, a smaller annual increase than in the years prior to the COVID-19 pandemic.

1946 of these referrals **(40.5%)** resulted in further enquiries being undertaken under S.42 of the Care Act 2014 during this 12-month period. A slight increase on the previous year.

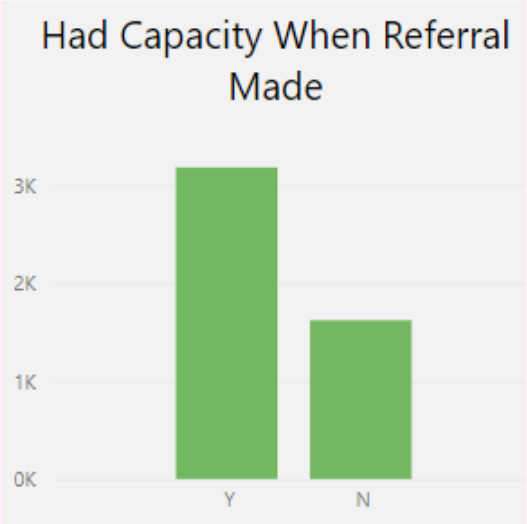
Chesterfield received the most safeguarding referrals during 2021/22 (18.7%) followed by Erewash (16.2%) and Amber Valley (13.9%). This is the same as the previous year.



Adults aged over 65 years were the subject of **2638** (55**%)** of the referrals made during 2021/22. This is exactly the same percentage as last year.

1785 (37%) of referrals were in relation to adults aged 26-64 whilst only **334 (8%)** were in relation to adults aged 18-25 during 2021/22. In 2020/21 8.5% of referrals were made for adults aged 18-25.

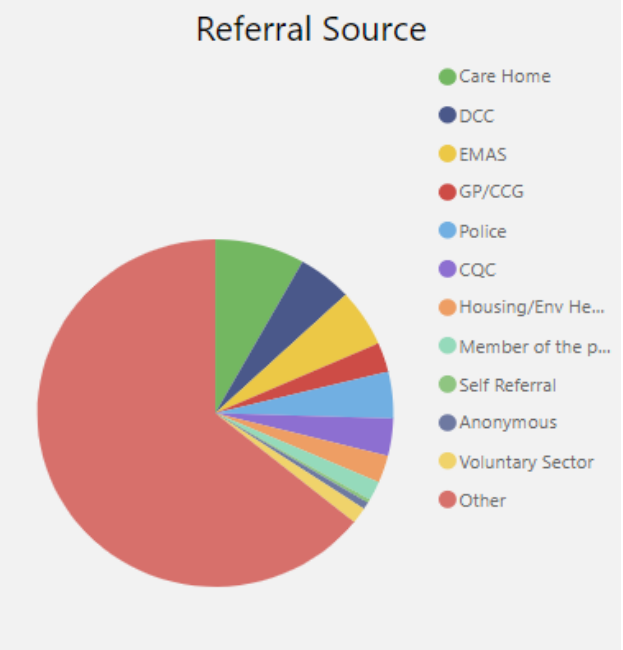
55% of referrals made during 2021/22 were in relation to women. In 2020/21 this was 56% and in 2019/20 61% of referrals were in relation to women so this majority has reduced by 6% over 2 years.



In **1619** (34%) of safeguarding adult referrals made 01/04/2021 - 31/03/2022, the adult was recorded as lacking capacity at the point the safeguarding adult referral was made.

The percentage of adults recorded as lacking capacity during 2021/22 has stayed the same as the previous year.

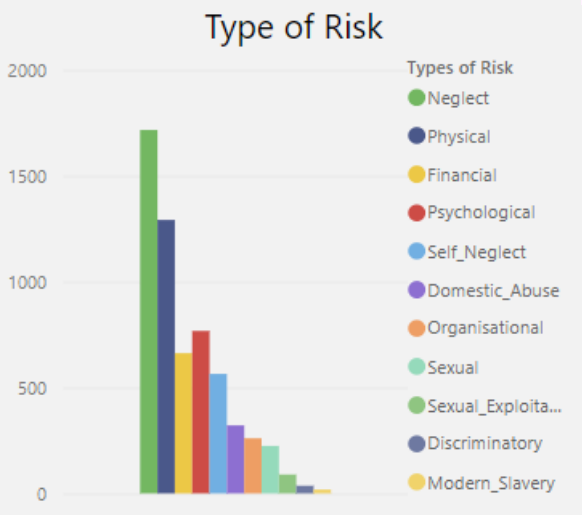
There was a high amount (64%) of referrals recorded with the referral source, 'other' which was linked to issues with recording and data capture. This has now been resolved and the data for next year's report will be improved.



Care homes made 8.5% of all safeguarding adult referrals during 2021/22. Case audits indicate that some care home referrals have been classified as 'other', so the percentage is likely to be higher than this.

Hospitals were the 3rd highest referrer with 5.4% of the referrals made during 2021/22.

Self-referrals, referrals from members of the public, and anonymous referrals made up just under 3.6% of referrals made during 2021/22.



Type of Risk

Neglect	1716	28.85%
Physical	1291	21.70%
Financial	662	11.13%
Psychological	767	12.90%
Unanswered_Abuse	429	7.21%
Self_Neglect	564	9.48%
Domestic_Abuse	321	5.40%
Organisational	260	4.37%
Sexual	224	3.77%
Sexual_Exploitation	89	1.50%
Discriminatory	36	0.61%
Modern_Slavery	18	0.30%

Safeguarding adult referrals relating to **neglect** were a feature of **29%** of all referrals made during 2021/22. **Physical abuse** was the second most common reason for referral averaging **22%** for the year 2021/22. There was a 3% decrease in referrals in relation to physical abuse during 2020/21 in comparison to the previous year. **Psychological abuse** has been listed as the reason for referral in **13%** of cases with **financial abuse** featuring in **11%** of referrals.

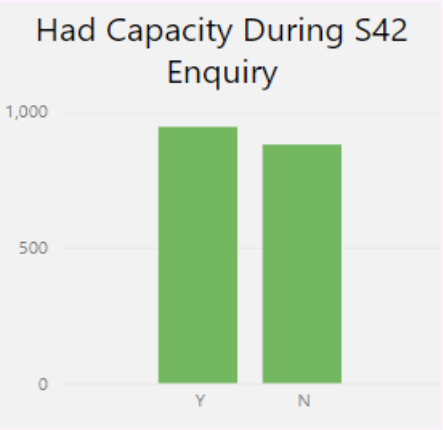
Self-neglect referrals are the fifth most common reason for referral at 9%. This is broadly similar to 2020/21 and a 3% increase in self-neglect referrals in comparison to 2019/20.

The percentage of referrals received in relation to domestic abuse has remained at the same level for the past three years (5%).

Concluded referrals and S42 enquiries

There were **5011** safeguarding referrals concluded during 2021/22 (01/04/2021 to 31/03/2022).

In **1823** of these cases (36%), further enquiries were undertaken under S.42 of the Care Act.



In relation to S42 enquiries over this 12-month period, **879 (48%)** of adults were recorded as lacking capacity at some point during the safeguarding enquiries undertaken.

During the previous year, 2020/21 it was reported that 48% of adults lacked capacity during the S42 enquiries.

Advocacy

Advocate

Advocate	Count of Pins
1_No	779
2_Informal	23
3_Mind	31
4_Specialist Advocacy	16
5_Other_Agency	30
Total	**879**

During 2021/22 Derbyshire Mind was the service commissioned to provide advocacy support for adults in Derbyshire.

'Informal' advocate refers to adults who had a family member/friend as their advocate during the safeguarding enquiry.

Of the 879 cases where an adult was recorded as lacking capacity to make decisions during concluded safeguarding enquiries over the 12 months period 01/04/2020 - 31/03/2021, 557 (89%) of adults were recorded as not having an advocate in place as nothing had been recorded about advocacy on their case record.

The data in relation to advocacy has been discussed at recent Derbyshire Safeguarding Adults Board meetings and some work is underway to better capture the data in relation to advocacy.

Ethnicity

The majority (88.7%) of referrals made in Derbyshire are for adults who are white British. There is a small percentage (7.7%) where the ethnicity is not known/recorded. White Other/White Irish adults make up 1.7% of referrals and the remaining 2.2% are adults from BAME communities. The percentages are very small for each BAME group.

The proportion of all DCC Adult Care service users from BAME communities is 2.2%. According to the 2011 census, there were 32,652 individuals from BAME groups living within Derbyshire, comprising 4.2% of the population.

Outcomes per Ethnic Group

Total Figures Per 100,000

Ethnic Groups	S42 Count	2021_22 Q1	2021_22 Q2	2021_22 Q3	2021_22 Q4	Total
Black	31	196.77	78.71	118.06	118.06	**511.61**
White Other	86	58.23	34.94	93.17	128.12	**314.47**
White British	4430	67.66	60.29	70.07	63.33	**261.35**
Mixed	36	19.51	156.07	19.51	58.53	**253.61**
Asian	42	13.09	26.18	52.37	13.09	**104.74**
Unknown	369					

The table above shows a breakdown of ethnicity for concluded S42 enquiries during 2021/22. The breakdown is shown per 100,000 of the population.

Due to the low numbers of referrals, it is difficult to draw any conclusions about under or over representation. The data is monitored closely to see if any trends and patterns can be identified.

Location of abuse

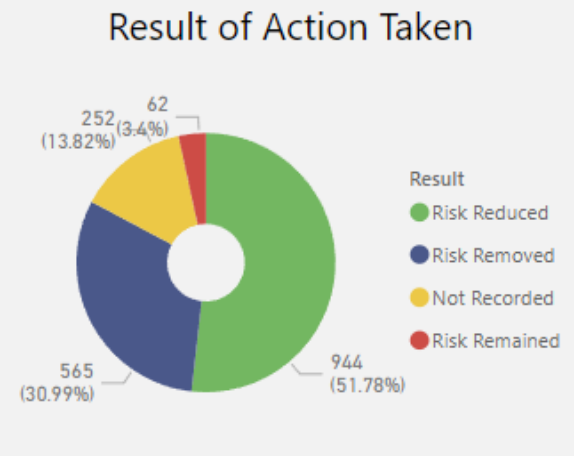
Location of Abuse

Care Home	3
Care Home - Nursing	660
Care Home - Residential	1133
Own Home	2223
In The Community	183
In A Community Service	82
DCC Care	25
Hospital Acute	55
Hospital Community	19
Hospital MH	169
Other	142
Unanswered Location	498

It should be noted that more than one location of abuse can be selected for each adult.

The majority of abuse took place in the adult's own home (2223 cases). Residential and nursing care homes were the second and third most common locations of abuse taking place.

Safeguarding Outcomes for adults in Derbyshire



The information is taken from concluded S42 enquiries over the 12-month period 01/04/2021 – 31/03/2022.

The outcomes are recorded by the social worker as part of the closure of the safeguarding enquiries.

In **83%** of cases, it was recorded that the risk of harm to the adult was completely removed or was reduced during 2020/21.

In **3%** of cases, it was recorded that there remained a risk to the adult at the conclusion of the Safeguarding enquiries.

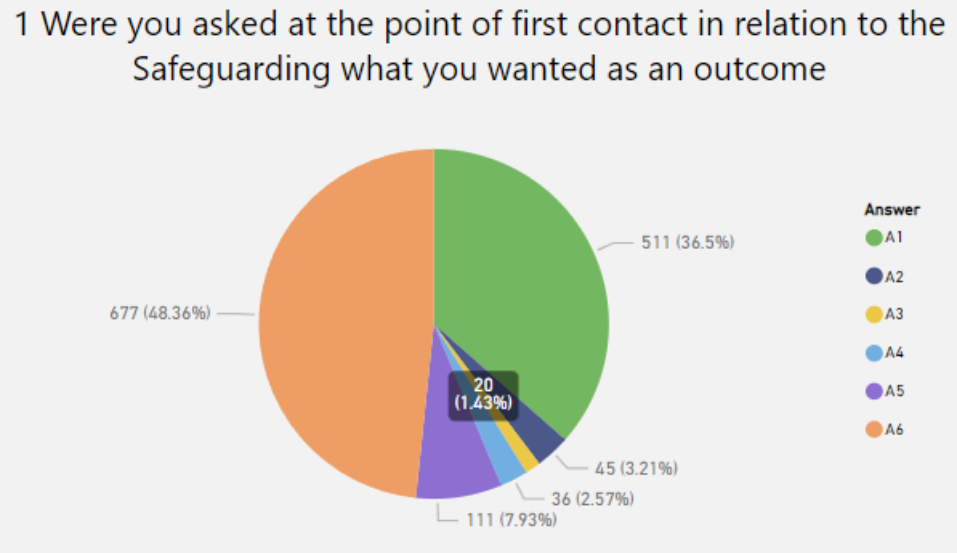
During the previous year, 2019/20, **81%** of cases were recorded as the risk of harm to the adult being completely removed or being reduced. In **4%** of cases there remained a risk to the adult.

Making Safeguarding Personal

The Care Act 2014 emphasises a personalised approach to adult safeguarding that is led by the individual, not by the process. The approach of agencies and services to adult safeguarding should be person-led and outcome-focused.

Four multiple choice questions are included in the local authority electronic safeguarding record, to ensure that the views of the adult are captured.

Between 01/04/2021 and 31/03/2022, there were **1400** Closure summaries completed for **1209** adults where all or some of the multiple-choice questions were answered.

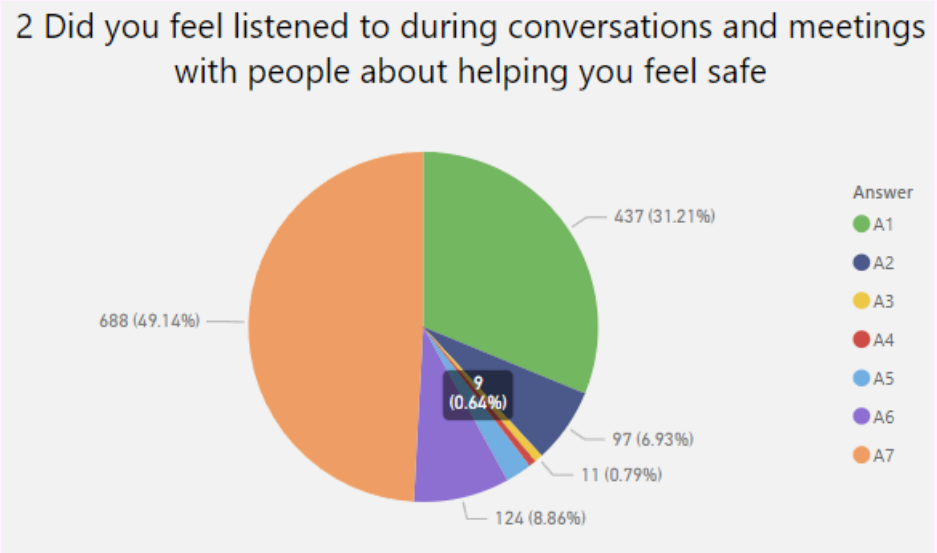


Ref	Answer	Count
A1	I was asked and felt I could say what I wanted the outcome to be	511
A2	I was asked but it was not clear what I was being asked	45
A3	I was not asked what I wanted the outcome to be	20
A4	Client declined to answer	36
A5	Not asked as the client died	111
A6	Not answered / Client was not asked	677

In **56%** of cases during 2021/22 an answer to this question was not recorded because the adult had sadly died, or the adult was not asked what they wanted their outcome to be.

It is recorded that in the cases where the adult was asked this question, **82%** said that they were asked about their outcomes and felt able to discuss their desired outcomes during the safeguarding process.

In **20** cases the adult said that they were not asked what they wanted their outcome to be.

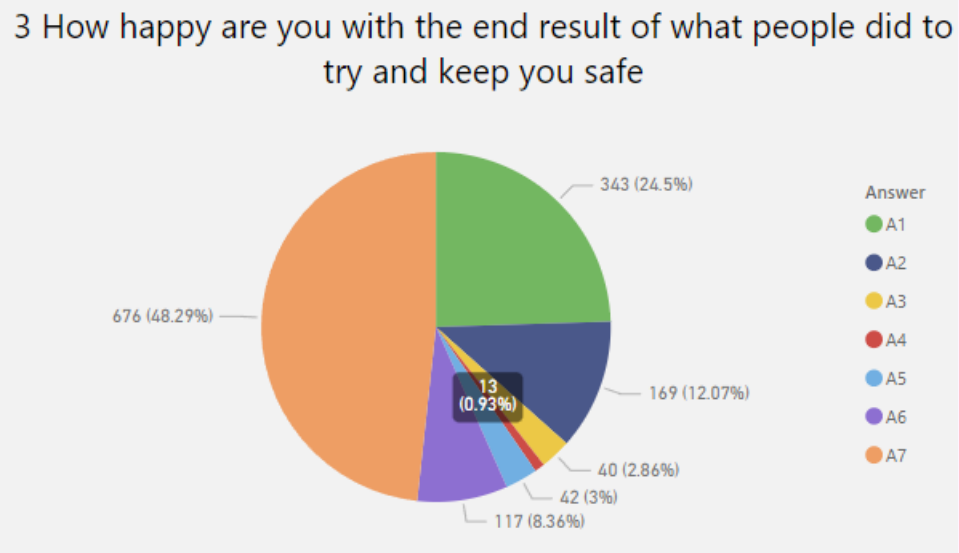


Ref	Answer	Count
A1	I was always listened to	437
A2	I was listened to quite a bit	97
A3	I was not listened to very much	11
A4	I was not listened to at all	9
A5	Client declined to answer	34
A6	Not asked as the client died	124
A7	Not answered / Client was not asked	688

In **58%** of cases this question was not answered/the adult was not asked because they had sadly died.

93% of adults who were asked this question said that they were always listened to or were listened to quite a bit.

11 adults said that they were not listened to very much and **9** adults said that they were not listened to at all



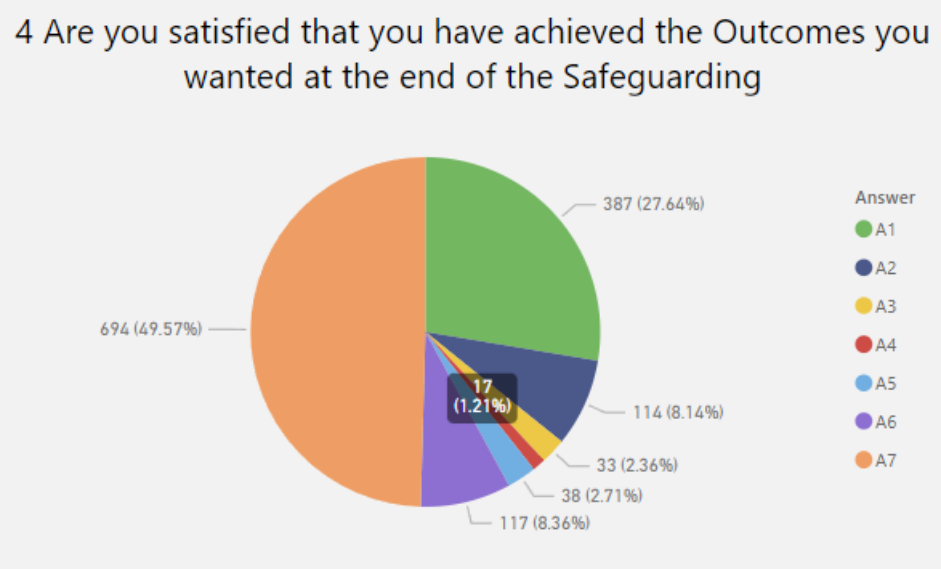
Ref	Answer	Count
A1	I am very happy with the end result	343
A2	I am quite happy with the end result	169
A3	I am not very happy with the end result	40
A4	I am not at all happy with the end result	13
A5	Client declined to answer	42
A6	Not asked as the client died	117
A7	Not answered / Client was not asked	676

In **57%** of cases the adult was not asked/this question was not answered because the adult

had sadly died.

For the adults who were asked this question, **84%** said that they were very happy or quite happy with the end result of what people did to help them keep safe.

40 adults said that they were not very happy with the end result, and **13** adults said that they were not happy at all with the end result of what was done to help them keep safe.



Ref	Answer	Count
A1	Yes I feel these were listened to and achieved	387
A2	Yes I feel these were listened to and mainly achieved	114
A3	Yes I feel these were listened to but were not achieved	33
A4	These were not listened to and were not achieved	17
A5	Client declined to answer	38
A6	Not asked as the client died	117
A7	Not answered / Client was not asked	694

In **58%** of cases the adult was not asked, or this question was not answered because the adult had sadly died.

87% of adults who were asked this question said that their desired outcomes were listened to and achieved, or mainly achieved.

17 adults said that their desired outcomes were not listened to and were not achieved.

Reports from DSAB Partner Agencies of the 2021/2022

Derbyshire County Council Adult Social Care and Health

2021/2022 has been a challenging year for Adult Social Care in the context of the continuation of the COVID-19 pandemic and the rise of the Omicron variant which posed considerable challenges to the resilience of our services. This impacted negatively on workforce capacity across our whole Health & Social Care System and resulted in temporary outbreak-related closures across our residential care home sector.

Alongside the increase in COVID-19 related absence from work, the impact of the planned introduction of mandatory vaccinations for people working in care and health settings, resulted in a loss of workers who did not want to be vaccinated. This contributed to a reduction in workforce capacity in our Private, Voluntary, and independent sector with a reduction in homecare workers experienced between August 2021 and January 2022 resulting in a reduced number of available homecare hours and a reduction in residential care workers in the same period across Derbyshire. It also exacerbated the acute difficulties experienced by nursing homes in recruiting and retaining qualified nurses.

Adult Social Care's Contracts and Compliance team continued to work collaboratively with providers and partners during the year to enable delivery of effective business continuity plans to minimise the impact on people who use services; however, an increased number of people received care and support in a residential setting on a short-term basis due to delays experienced with sourcing their necessary support package at home. Similarly, an increased number of people's support from commissioned services at home was supplemented by care and support provided by family members due to homecare capacity difficulties.

Demand for Adult Social Care has remained high and Safeguarding referrals continued to

increase in this year alongside an increase in the complexity of the investigations required. Effective prioritisation and workload management systems were used throughout the year to manage demand and risk.

As the risk of infection and related covid guidance prevented the return to pre-pandemic ways of conducting quality monitoring work in the Private, Voluntary and Independent sector, the Contracts and Compliance Team has continued to use the covid-safe quality monitoring processes developed in 2020/2021 and has worked with the Primary Care Networks (PCNs) to promote timely information sharing to strengthen assurance. The team has continued to work collaboratively with the Clinical Commissioning Group and Care Quality Commission to share intelligence and make joint decisions regarding appropriate early intervention and action and has maintained weekly meetings with frontline Adult Social Care teams to share intelligence regarding the quality of care provision and safeguarding referrals where these are related.

Work has continued in Adult Social Care throughout 2021/2022 to improve prevention by ensuring that effective advice, information and signposting is available to Derbyshire residents regarding available services and to increase awareness of abuse and how to raise concerns. Appropriate and proportionate training is also provided to all colleagues in every role in Adult Social Care to ensure that colleagues are able to recognise abuse and deliver their duties in respect of adult safeguarding.

There was a significant amount of activity completed to deliver Making Safeguarding Personal during 2021/2022 and included work by the Safeguarding Quality Assurance Team to ensure that the individual's wishes were central to safeguarding practice. This included a focus on the need to use advocates, both informal and formal, where individuals lack capacity, to deliver Making Safeguarding Personal. Audits completed by the team indicated good performance in respect of Making Safeguarding Personal but highlighted a recording issue resulting in a mismatch between the quality of practice reviewed and related performance data. Quality improvement work is underway to improve recording accuracy.

The Adult Social Care Quality Assurance Board was established in 2021 and meets on a regular basis to monitor performance and the delivery and impact of quality improvement work being completed across the department. Within this work, there is focused assurance activity on adult safeguarding, with the strategic priorities of the DSAB reflected in this and monitored and reported to the Quality Assurance Board. This includes work to: improve recording; to ensure that all colleagues receive training appropriate to their role; that practice guidance is issued according to role; that policy and procedures are reviewed to ensure they reflect best practice; that regular safeguarding audits are completed to monitor the standard of practice and to inform appropriate action where required; to ensure that Making Safeguarding Personal is central to safeguarding practice and to ensure that colleagues are appropriately supported to continue to complete safeguarding work in the context of increasing referrals and complexity of investigations required. Partnership work is also underway to improve the quality of safeguarding referrals received and to ensure that there is a shared understanding of appropriate thresholds.

Adult Social Care colleagues, including frontline practitioners, Safeguarding Quality Assurance managers and the Principal Social Worker, have all continued to contribute to the work of the DSAB both in their contribution to different sub-groups and in the completion of multi-agency audits. Derbyshire County Council's Adult Social Care department is also a member of the regional ADASS Safeguarding Community of Practice and contributes to, and benefits from, that shared learning opportunity ensuring that learning is brought back and acted upon to improve the quality of our safeguarding practice.

Derbyshire Constabulary

Protecting the vulnerable is central to our policing mission and is a continual thread through the Chief Constable Priorities. Protecting the vulnerable is also a key feature within the PCC's Priorities.

Derbyshire Constabulary continues to invest in several dedicated units which work in partnership to achieve this. From a centralised Safeguarding Coordination Hub (SCH) which has improved the previous Risk and Referral Unit by adding an additional three supervisors and twelve staff dedicated to the management of all cases involving vulnerable adults, to Public Protection hubs, within in Buxton, Chesterfield and Derby.

During the last year we have restructured these hubs to allow for many officers to focus on safeguarding adults. A dedicated team for the investigation of adult exploitation has been created, along with the introduction of a central Missing persons unit, all focused on safeguarding adults and vulnerable people.

In May 2021 we commenced in partnership a DRIVE programme to tackle the highest harm domestic abuse perpetrators identified through established MARAC processes. To support this further a Domestic Abuse Review Team (DART) was established in November 2021 enhancing domestic abuse risk assessment further. By considering accumulative risk, they are identifying those at most need of safeguarding and specialist support.

Two new teams have also been created and are due to start within 2022, focusing on the management of civil orders and repeat and serial offenders. Again, demonstrating Derbyshire's Constabularies' commitment to this important agenda.

Safeguarding adults is a core responsibility for all officers and staff. To ensure our people are skilled all operational officers now have access to the Vulnerability Hub accessed through their

mobile data terminals, to assist them identify vulnerability on patrol and ensure early support. A learning and development team have been recruited and are due to deliver a continuous cycle of vulnerability training to new recruits and the wider organisation. This is to ensure every police contact makes a difference to change someone's life.

Domestic Abuse Matters training continues to be rolled out across the force. All incidents and reports to police are subject to a risk assessment process called THRI'V'E. This allows us to prioritise and reprioritise against not only threat, harm and risk but also known vulnerabilities. 'V' is central to our decision making at all levels.

Performance in this area is governed by the Vulnerability Governance and Performance Assurance Boards both chaired by the Deputy Chief Constable. These meetings are supported by local performance and tasking groups and scrutiny panels, which focus on quantitative and qualitative data.

Demand continues to increase. In Spring 2020 we would typically deal with around 30 vulnerable adult cases across the county each day. 2021 this saw rise to an average of 50 cases a day and in 2022 we are seeing this trend continue.

In the year ahead we will continue our 24/7/365 service to support and protect vulnerable adults across Derbyshire. We continue to strive for further improvement by adopting a crime directorate model, realigning all detective resources under one command function, allowing resources to be realigned to areas of greater harm, risk and threat, in an agile and timely manner. Whole force training and a robust performance framework demonstrates Derbyshire Constabularies' commitment to protecting the people of Derbyshire.

Derby and Derbyshire Clinical Commissioning Group (DDCCG)

DDCCG has continued to play a significant role in implementing the Board's key strategic objectives. Throughout 2021/22 the Safeguarding adults team contributed to each of the boards supporting sub-groups and workstreams including chairing the Quality Assurance sub-group, Operational & Leadership sub-group and Case file audit group meetings.

The Safeguarding team seek continuous quality and reassurance from all providers in Derby and Derbyshire, via communication streams such as on-going dialogue, site visits, assurance frameworks and self-assessments. This quality assurance work is used to demonstrate good practice but also analytically assess providers against key standards of Safeguarding, including the boards key strategic objectives.

The Safeguarding team continue to contribute to Domestic Homicide Reviews, Safeguarding Adult Reviews and Fatal Fire Reviews. Furthermore, learning from such reviews is disseminated to relevant partners, and 'key themes' are incorporated into wider training delivery.

DDCCG provide staff development opportunities in respect of Safeguarding with events such as Level 3 Safeguarding Adults Training, attended by over 380 of staff throughout 21/22, in addition to more specific and specialised guest sessions such 'Mental Capacity Act & the Role of the GP' which had over 40 attendees, delivered by Capsticks Solicitors.

During the Level 3 Safeguarding Adults training, the statistical data regarding Making Safeguarding Personal (MSP) is a key focus point for improvement using the data gathered from partner agencies (e.g., 50.75% outcomes not asked/recorded at referral point), in effort to increase the quality of MSP authenticated referrals from health providers.

Safeguarding adults has remained a priority across the NHS and staff should be proud of their commitment during these on-going unique circumstances. The extraordinary challenges presented by COVID have necessitated robust inter-agency partnership working arrangements.

Throughout quality assurance measures, all partner agencies of the CCG have demonstrated evidence of robust inter-agency collaboration, with both prevention and partnership working being critical components in any safeguarding care planning. The audits were well supported by key partner agencies and their commitment to learning and improvement should be commended.

Finally, DDCCG has maintained its presence at all safeguarding related activity and fulfilled its statutory functions, in addition to increasing the number of staff that have attended Safeguarding training during the past 12 months.

Tameside & Glossop CCG

NHS
Tameside and Glossop
Clinical Commissioning Group

Tameside & Glossop Strategic Commissioning Group has a statutory responsibility to ensure that all providers, from whom they commission services (both public and independent sector), have comprehensive safeguarding arrangements in place in accordance with legislative requirements. These arrangements should ensure that providers are engaged with their Local Safeguarding Boards.

Our Corporate Plan 'Our People Our Place Our Plan' outlines the Strategic Commission's aims and aspirations and outlines how we will commit to working with people every day as they progress through the course of their lives. Safeguarding threads throughout all life courses and the Safeguarding Team ensures it is firmly embedded in all commissioning intentions from procurement through to service delivery.

Tameside & Glossop CCG has continued with Safeguarding Business throughout 2021/22 focusing on key areas of our core business

- Statutory Duties
- Safeguarding Assurance
- Training

- Learning from Statutory Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.

The Care Act 2014 is a legal framework which sets out statutory responsibility for integration of care and support between health and social care.

CCG's are a Statutory Core Partner of the Safeguarding Adult Board alongside the Police and Local Authority. Tameside and Glossop CCG have continued to support with Board Business and represent at Board meetings.

Safeguarding scrutiny and oversight continues through our revised and strengthened Safeguarding Assurance Framework. This is an ongoing assurance cycle and audit mechanism that enables CCG to seek assurance about the safeguarding arrangements that commissioned organisations have in place.

We have strengthened and improved our Safeguarding Assurance processes in 2021/22 with a refreshed Primary Care Safeguarding Audit Tool, this has resulted in an improved compliance with an 86% return.

We have strengthened our communication strategy with improved and smarter ways of communicating including the use of social media and CCG Intranet.

We continue to lead on safeguarding training/briefings sessions for Primary Care and have expanded this to include monthly 30-minute Primary Care Safeguarding Snippet sessions.

Designated Safeguarding Professionals at the CCG support Statutory Safeguarding Adult Reviews and Domestic Homicide Reviews, ensuring that the learning is shared with health colleagues. In the reporting period 2021/22 there have been no statutory reviews in the Glossop area, learning and best practice from external reviews however has been shared and has informed training and briefing sessions.

Designated Safeguarding Professionals continued to support the Learning from the lives and deaths of people with a learning disability and autistic people (LeDer) programme.

In February 2021 the Department of Health and Social Care published its White Paper *"Integration and Innovation: working together to improve health and Social Care for all."*

Following a short delay in procedures, Royal Assent to the Health and Social Care Bill was given on 28th April 2022. Integrated Care Systems (ICS) will replace CCG's on a statutory footing from 1st July 2022. All CCG statutory duties will therefore transfer to the NHS body (ICB) of the ICS. Responsibilities for the Glossop/High Peak population will transfer to Derbyshire/Derby ICB and Tameside will no longer be a partner of the safeguarding arrangements.

CCG Safeguarding Leads have been working closely with partners across the sector to ensure a smooth handover and identification of any risks are included in risk management plans and closely monitored.

Derbyshire County Council - Community Safety Unit – Corporate Services and Transformation Department

The Council's Community Safety Unit (CSU) works to ensure that local residents and visitors are safe at home, work and when travelling around the county. This is achieved through partnership working with other agencies, initiatives aimed at reducing crime and vulnerability, as well as, through the commissioning of support services for victims of crime. Many of the CSU's priorities relate to either adult or children safeguarding issues.

The work undertaken by the Community Safety Unit is directed through a joint strategic threat and risk process with the Police which identifies the key crime and community safety priorities for the County. These priorities are reflected in the Derbyshire Community Safety Agreement. A review of strategic and operational structures for community safety has taken place with the aspiration to better integrate community safety structures across the City, County, District and Boroughs. The reconfiguration of community safety workstreams has resulted in the establishment of nine thematic boards which in turn will direct community safety activity over the coming years.

Our key contribution to the Boards priorities relate to Prevention, and work has been undertaken in relation to a range of vulnerabilities relating to crime and community safety.

The Unit delivers a comprehensive programme of training, the numbers of delegates accessing training during 2021/22 has increased significantly, with 11,369 staff and partners completing courses.

The CSU also has a role in the commissioning and co-commissioning of a number of specialist services relating to domestic abuse, sexual violence, modern slavery, hate crime and reducing reoffending.

The introduction of the new legislation such as the Domestic Abuse Act (2021) will help transform the response to domestic abuse. The Act created a duty to provide support in safe accommodation for victims of domestic abuse and their children. To meet the needs of the legislation, the Unit has been instrumental in reconstituting existing governance structures to establish a Domestic Abuse and Sexual Violence Partnership Board. As required by the Act, the Unit also collaborated with Derby City Council in carrying out a Needs Assessment and writing and publishing the Derby and Derbyshire Support in Accommodation Strategy 2021-24 and in accordance with the findings of the needs assessment will undertake commissioning to fill the gaps in support identified. The Partnership Board has determined that the priority areas of work identified in the needs assessment that it will oversee are Accommodation, Communication, Perpetrators and Sexual Abuse and has established sub-groups for each of these with the view to prevent offending, protect victims and ensure they have the support they need and raise awareness of domestic abuse and the services available.

The last twelve months have brought with them unprecedented challenges for our communities and all the organisations which serve them. Responding to the pandemic, and more recently the setting up of the Homes for Ukraine scheme has placed extraordinary pressures on our public services and our ability to undertake development work has been significantly impacted. Despite this, we have managed to maintain services, and this has been possible due to the unwavering commitment of all partners and stakeholders to work together to meet the demands the last year has brought.

Derbyshire Mind

Derbyshire Mind are committed to safeguarding being an organisational focus and that all staff understand safeguarding from harm and abuse is everyone's business.

Derbyshire Mind aims to ensure that a person's voice is being heard and considered in any decisions or actions that may be being discussed. Derbyshire Mind work in partnership with an individual and will ensure a person-centered approach is being adopted by all involved in the safeguarding.

All new staff attend mandatory safeguarding training (Adult & Children) and training records allow the organisation to track when refreshers are due. Organisational policies, procedures and forms are in place and regularly reviewed. Derbyshire Mind has a senior Safeguarding lead alongside a named Safeguarding member on the Board of Trustees.

During 2021/2022 Derbyshire Mind received and supported 33 Safeguarding referrals.

DHU Healthcare

DHU Healthcare's core values revolve around putting patients' interests at the heart of everything we do, respecting individual rights to respect and dignity, demonstrating excellence in everything we do and placing patients and colleagues at the heart of the organisation. These four core values underpin the safeguarding criteria within the internal structures of DHU Healthcare.

To support the delivery of the safeguarding agenda within DHU Healthcare, there is a clear governance and accountability framework in place. The framework provides assurance to our commissioners that whilst the ultimate responsibility and accountability for adult safeguarding lies firmly with the Board of Directors, every member of staff is accountable and is responsible for safeguarding adults at risk.

DHU Healthcare has a robust referral pathway and strong communication and information sharing links with other organisations. This is coupled with representation at The Safeguarding Board meeting and associated subgroups.

Current and future work

The DHU Healthcare Safeguarding team will continue to provide support to all DHU Healthcare staff regarding safeguarding concerns and will develop new and innovative means of ensuring quality assurance within the safeguarding agenda.

The DHU Healthcare Safeguarding training has been further developed utilising various mediums and platforms to enhance the learning experience.

The DHU Healthcare Safeguarding Childrens and Safeguarding Adult procedures have been redeveloped into one overarching safeguarding procedure, in line with the 'Think Family' approach. This was coupled with area specific guidance documents keeping abreast of important safeguarding initiatives both local and national and easily available to all staff across DHU Healthcare.

Going forward DHU Healthcare will continue to be vigilant about the expanding range of initiatives and disciplines that come under the 'safeguarding' umbrella. DHU Healthcare will continue to focus upon safeguarding practice, and as a partner agency within the Safeguarding network we will continue to work collaboratively, supporting the development and implementation of agreed safeguarding strategies and policies.

It is recognised that the impact of COVID-19 has affected many people's daily lives, in different ways. Financially, socially, family relationships and support networks, and children's education to name a few. These changes increased the risk for some of the most vulnerable who were unable to protect themselves from abuse and neglect.

During this past year the Safeguarding Team at DHU Healthcare were involved in both National and Local campaigns and initiatives to safeguard Children and Adults at risk.

Regular updates and information were distributed to clinical staff to assist them in recognising the risks associated with the pandemic and the ongoing areas of concern.

Diocese of Derby- Church of England

The Diocese of Derby has over 300 churches across most of Derbyshire. We work in communities, schools, prisons and hospitals as well other aspects of city and county life. Our churches have continued to deliver services such a food banks and to provide pastoral support to seek to ensure the most vulnerable in our communities remain safe from harm.

We have maintained our safeguarding service throughout the year with increasing numbers of referrals as churches reopened and began worshipping in person once again. We have supported a number of churches in working with elderly parishioners who may be at risk of abuse and have ensured that arrangements are in place in relation to those who may pose a risk when returning to worship in church.

The Diocese continues to work towards embedding a culture of safeguarding in all we do. Our practice around safer recruitment and training has been strengthened with the implementation of new national guidance. We have continued to develop our support for and communication with our Parish Safeguarding Officers who support our work in individual parishes.

Our work continues to be overseen by our multi-agency Diocesan Safeguarding Advisory Panel. We have now completed our internal past cases review and this will be published

during the forthcoming year. A number of recommendations have been identified and work is commencing on taking these forward.

We continue to develop our partnership working not only via our advisory panel but also by representation on the safeguarding board and various subgroups and our work with others in relation to faith and safeguarding.

Derbyshire Fire and Rescue Service

Derbyshire Fire and Rescue Service (DFRS) remain committed to the safeguarding adults and children.

Area Manager Clive Stanbrook who is the strategic manager for Safeguarding within Derbyshire Fire and Rescue Service (DFRS) states:

'*DFRS have an unwavering commitment to making Derbyshire safer together with our partners and other agencies. This commitment includes all situations where the lives, health and wellbeing of the public of Derbyshire are placed at any way at risk, including safeguarding of the most vulnerable.*

Because of this pledge we will endeavor to do everything in our power to work with the Adults and Children's Safeguarding Boards to increase the safety of the most vulnerable in Derbyshire and to ensure that our staff are trained and aware to deal with all safeguarding concerns appropriately.

This year DFRS have referred 17 adults to the safeguarding process and 2 children. Alongside this we have supported 1181 vulnerable adult referrals and 180 vulnerable children's referrals. All of these have been managed in a multi-agency setting and the VARM process. We are pleased to be able to continue to support the VARM hoarding grant again this year and believe this funding is integral to getting the right outcome for those adults that live in poor housing conditions.

In January this year the Fire Standards Board, who set the Standards for the Fire and Rescue Sector, introduced a set of Safeguarding Standards for all services to implement to ensure compliance and the best outcomes for adults and children at risk. It is Derbyshire Fire and Rescue Services' aspirations to implement these by April 2023 with agreement by the Board.

The Safeguarding Team have also introduced an Easy Read Guide for all operational staff on how to spot signs of abuse and what to do. This includes how to make safeguarding personal to the victim, how to discuss concerns with empathy and understanding consent. This has been welcomed by the Response, Protection and Prevention teams.

We have also introduced our new referral process for Children workers this year called 'FRANCES'. It is hoped that this process will support and encourage all professionals who work with children to refer into us for safe and well visits.

DFRS continue to make significant commitments to safeguarding continuing to ensure all new employees undertake safeguarding models for adults and children and understanding the categories of abuse. This training is now mandatory and is part of our Induction toolkit for new employees.

Lastly, DFRS safeguarding officers have continued to support attendance at all sub-groups and boards this year.

Derbyshire Community Health Services NHS Foundation Trust (DCHSFT)

DCHS has continued throughout 2021/22 to ensure that the Trust has a local service delivery response based on clinical prioritisation that is in keeping with the latest guidance from NHSE/I, in response to the pandemic.

DCHS is a proactive member of the Board and sub-groups; contributing to the Board work streams and working with partner agencies to enable people in Derbyshire to live a life free from fear, harm and abuse.

Making Safeguarding Personal (MSP)

The Safeguarding Team advocates making safeguarding personal through the provision of advice/support, training and supervision. Staff are advised and encouraged to have conversations with the patients/service users that they are providing care for and/or where there is a safeguarding referral; to give the person the opportunity to voice their needs and what they want, reflecting the safeguarding personal agenda.

Safeguarding supervision enables the Named Nurses and Specialist Practitioners for both adults and children to explore and reflect with staff what daily life is like for the patient/service user, their current level of need/support and how to make a safeguarding journey personal.

Prevention

The Safeguarding Team provides advice/support to staff: this includes discussions regarding care and support/safety plans to prevent harm when either someone makes an unwise decision and/or they don't have capacity and how to make a safeguarding referral to Social Care to enable the people that DCHS staff have contact with to be safeguarded and protected from

harm.

Safeguarding supervision is recognised by DCHS as an important element of the safety culture. It provides professional advice and support to practitioners who are involved in the day-to-day work with adults and their families including promoting good standards of practice and contributes to improving outcomes for adults at risk and their families. DCHS has identified which staff groups require safeguarding adult supervision.

DCHS attends meetings where there are concerns regarding abuse, harm, domestic abuse and radicalisation, as part of information sharing across agencies. This includes contributing to safety plans; to reduce risk and enable access to appropriate support.

Quality Assurance

DCHS has demonstrated compliance with the Safeguarding Adult Assurance Framework (SAAF), Section 11 Audit and the Markers of Good Practice, Looked After Children Audit. DCHS submitted the SAAF in October 2021 and had a follow up site visit on 13th June 2022. DCHS is required to provide quarterly information to the Clinical Commissioning Group regarding safeguarding data and activity which includes 'making safeguarding personal', quality assurance, Board/subgroup activity and learning.

The DCHS Safeguarding Governance Group (SGG) provides assurance to the Quality Services Committee (QSC) and the DCHS Board. The Group meets bi-monthly and provides assurance to QSC that DCHS is meeting its statutory safeguarding duty and is compliant with the Care Act 2014 and Section 11 of the Children Act 2004.

Covid working arrangements continued to have an impact on the planned safeguarding audit for 2021/22. The audit schedule in place for 2022-2023 includes the quality of referrals to adult social care, including making safeguarding personal and repeat audits for safeguarding supervision and Deprivation of Liberty Safeguards.

Derbyshire Health Care NHS Foundation Trust

There has been a change in personnel within the Assistant Director Safeguarding Adults role in May 2022; A transition with cross over was enacted to ensure partnership working has continued with a smooth transition. The Assistant Director and Named Doctor work closely within the Trust and for the multi-agencies.

DHCFT are active members of Safeguarding Adult Boards and the associated subgroups, as well as other interagency meetings including MAPPA and Channel.

The Trust has continued to be an active partner in Domestic Homicide Reviews and Safeguarding Adult Reviews when appropriate.

There is a move to restore further face-to-face work within DHCFT and we remain very proud of our services and the way they have responded to the COVID-19 pandemic, and their hard work to continue to prioritize the safeguarding of our most vulnerable. This allowed the 'business' of adult safeguarding to continue.

Prevention

We continue to work with our clinical teams to ensure that safeguarding is the 'golden thread' running through our organization. Our Safeguarding Named Nurses have continued to meet with teams throughout the pandemic.

We continue to be involved in complex case discussions which are held fortnightly with our teams and inpatient services.

Our Trust teams continue to support Prevent with attendance at monthly Channel Panel meetings and referral related activity daily.

We are core panel members at monthly MAPPA and MARAC meetings.

As a Trust we fully work with the accountability of the NHS, the Police, and Local Authorities. This relationship is absolutely crucial in ensuring the safeguarding of our vulnerable adults and children.

Quality Assurance

Accountability and transparency in the Trust remain key to the delivery of safeguarding procedures. We continue to publish our Safeguarding Annual Reports, committee papers and our learning.

We have members of the Local Authority attend our safeguarding operational meetings adding the extra layer of transparency and to offer their specialist knowledge to our safeguarding champions.

We review actions from SAR/DHR and ensure learning is cascaded throughout the Organization

Making Safeguarding Personal

We continue to apply person-centered safeguarding responses. We do this by our attendance

at Trust complex case discussions which helps us respond to person-centered safeguarding responses and safety plans.

We support all staff in safeguarding themselves and the people they work with.
An example of this is contact from our Estate's Office regarding concerns about a member of staff. We were able to support further enquiries and ensure they were safe and out of a potentially abusive situation.

We work closely with our Safeguarding Trainers to ensure the learning from DHRs, and SARs are shared within the safeguarding training.

Equality, diversity and inclusion work remains a priority and is given consideration in all our work within the Trust and our multi-agency involvement.
We remain involved in the VARM process and attend the Steering Group and the Task and Finish Group.

Sexual safety is a Trust priority and we are currently working with our acute inpatient wards to continue their reporting of incidents. A policy/protocol will be produced to support this.

Throughout COVID we have continued to run our services. We are working to restore all services; however, we are mindful, from a wellbeing point of view that this is time of change. We remain supportive and compassionate towards our staff during this time.

<u>LPS</u>

We are actively engaging with the agencies and developing internal plans primarily about on-going assurance of the MCA/LPS. We will continue to provide feedback and consultation during this draft stage of the process. We have a nominated lead within DHCFT to take this forward.

University Hospitals of Derby and Burton

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

The UHDB Safeguarding & Vulnerable People Team is made up of a diverse and multi-professional team who provide specialist and expert safeguarding training, specialist advice, case coordination and supervision to Trust Executives and employees. We provide training, coordinate multi-agency and multi-disciplinary work in safeguarding and vulnerable people activity across the Trust to ensure UHDB fulfils its safeguarding obligations and duties in a wide range of issues and cases - ensuring the loop is closed effectively and sufficiently on any safeguarding enquiries and concerns.

The Trust has well established governance arrangements and safeguarding is regularly reported to the Board. The Trust is also subject to the Safeguarding Adult Assurance Framework and a Tier 2 individual audit for Staffordshire.

Given the impact and challenges faced over the last 2 years due to the pandemic Covid-19 we are assured that focus on safeguarding has been maintained within front line services with broadly consistent numbers of referrals made. The Trust Safeguarding Team have remained present in clinical areas to support staff with the management of safeguarding concerns.

UHDB continues to prioritise the safeguarding agenda and adopts a THINK family approach across the organisation. This is embedded across training and supervision sessions.

Domestic abuse management remains a high priority for the organisation and training and guidance has been developed to support staff within this area. Learning and audit work across children and adult safeguarding services has influenced this provision.

As part of UHDB's commitment to supporting our colleagues, Special Leave guidance has been implemented. This has been developed in conjunction with the Trust's inclusion networks and champion roles and explores broader support we can offer to our colleagues when they need it most, this includes safe leave for victims of domestic abuse.

UHDB has an effective model to support High Volume Service Users. This multiagency forum has been efficient in identifying those who frequently attend our services. Representatives at the group include medical and nursing staff, safeguarding professional, Social Care and Mental Health Liaison. Robust care planning is undertaken and a multiagency response to the action plans. This includes liaison with external partners. The model is now being developed at our Queens Hospital Burton site.

An internal audit on the quality of safeguarding adult referrals demonstrated the added value that UHDB Safeguarding Team brings to the referral process in ensuring that thresholds are met, and appropriate information is included to support safeguarding enquiries. It also identified a benchmark of the Trust's position in making safeguarding personal and actions plans implemented to ensure improvements in this area.

Our Trust priorities as set out in our Safeguarding Framework

- Embed respect for human rights and personhood of patients who lack capacity
- Ensure that the views and wishes of children, young people and adults are sought and heard within safeguarding processes as appropriate
- Ensure that the Trust is a responsible and effective agent in working with multi-agency partnerships
- Ensure that awareness of safeguarding and vulnerability issues is maintained and improved by regular communications and promotion
- Maintaining effective recruitment processes and response to allegations against staff

Chesterfield Royal Hospital NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation TRUST (CRHFT) continues to prioritise safeguarding as an essential part of providing high quality patient care. The team has expanded during 2021-2022 to not only provide a safeguarding service but also to meet the needs of some of our most vulnerable patients who have complex needs contributing to safeguarding early intervention/preventative work with the creation of a new High impact user role as well as the dementia matron and enhanced support team merging with the team.

This year has again shown an unprecedented demand on health and social care professionals to adapt and respond to the changing needs to our patients as the nation navigated its way out of the COVID-19 pandemic. During the pandemic CRHFT recognised the importance of the protection of adults and children and ensured that the safeguarding team members maintained their roles throughout the pandemic response. The referral rates have increased further than post pandemic levels, with an increase in the complexity of the patients that are being seen due to the impact of lockdown as we witness the outcome of individuals not accessing services, and victims being hidden from view.

This has included:

- Increase in Domestic Abuse across adults and older adults
- Balancing between case holding for wards and supporting them through the processes when there have been challenges with staffing and increased acuity of patients
- Increase in patient with challenging behaviours and complex needs
- Increase in support of reasonable adjustments
- Increase in DoLS and Lasting Power of Attorney (LPA) requests

The Trust "Think Family" committee ensure that the Trust are working in-line with all required legal frameworks as well as CQC requirements and contract arrangements ensuring the wellbeing and safeguarding at children and adults at risk whilst in the care of the organisation. Partners from the CCG and adult social care sit on this group. The group monitor education, audit, allegations, DBS and multi-agency working through this process.

Following a full review during 2020-2021, the Trust adopted a three-year rolling programme of education using a blended approach for delivery, written by the Trust specialists in safeguarding. During 2021-2022 face to face education was delivered whilst the online education booklets were produced. Three booklets were produced that were available electronically and in paper with an online assessment.

Feedback for the level three education has been positive, please see below.

Understanding of safeguarding and differences between adults and children safeguarding.	3.3/4
Understanding of Domestic Abuse and MARAC process	3.1/4
Understanding Prevent, and how to refer	3.2/4
Understanding of Management of Staff Allegations	3.1/4
Are the booklets a helpful resource to support moving forward?	95% staff stated yes

The Trust have a standardised process for risk assessing a DBS with a positive disclosure and a clear governance framework through which this is reported. The process supports the Rehabilitation of Offenders Act but also ensures equity to all applicants and provides the Trust

with assurance that patients are safe. This process is now well established following its creation within 2020-2021 with a total of 34 DBS having been reviewed since its establishment contributing towards safer recruitment and keeping patient safe.

Multi-agency work is the foundation of effective safeguarding practice, sharing information to safeguard patients and learning when mistakes have been made. The Safeguarding team in CRHFT recognise the importance of multi-agency working and attend forums and groups to benchmark, share best practice and lessons learned. The Trust continues to engage with colleagues such as:

- ✓ Derbyshire safeguarding Adult Board
- ✓ Channel Panel
- ✓ Partnership and board sub-groups
- ✓ DRIVE Panel
- ✓ MARAC
- ✓ Regional LeDeR forum

The Head of safeguarding also chairs the Adults Safeguarding Board joint policy and procedures sub-group.

Whilst the Trust completed 204 adult referrals and 177 domestic abuse referrals, the team carried out work on 1061 active cases over the last financial year as a combined workload of CRHFT referrals which included requests to contribute to other Section 42 investigations, Section 42 referrals against the Trust, Domestic Abuse, supporting patients with complex needs, MCA and DoLS. There has been an increase in requests for the Trust to attend Vulnerable Adults Risk Management (VARM) processes for patient who are inpatients but also to contribute to ongoing work on discharge as a preventative measure.

The team remained resilient throughout the year, ensuring that the most vulnerable in our society were protected by the Trust maintaining its ongoing services and developing new areas of service delivery.

During 2021-2022 there have been a number of key achievements in relation to safeguarding:

- ✓ Active involvement in the Local Safeguarding Adult Boards (LSAB), Local Safeguarding
- ✓ Children Partnership and Multi-Agency Risk Assessment Conference (MARAC), has helped our organisation's capacity to protect vulnerable people from abuse, including participation in Board sub-groups and partnership led multi-agency audits
- ✓ Expansion of the team to include High Impact User and administrator
- ✓ Integration of the Dementia matron, older person team and Enhanced support team into the wider safeguarding team
- ✓ Development of a three-module safeguarding booklet
- ✓ Review of safeguarding policies including Domestic Abuse policy
- ✓ Joint working guidance for Ash green and CRHFT staff
- ✓ Fifty staff trained in DoLS
- ✓ 5 staff educated as best interest assessors

Probation Service, Derbyshire

- Making Safeguarding Personal (MSP)

Although People on Probation (PoPs) are supported by their probation practitioners and there is a requirement for PoP's to inform their sentence plans, we do recognize a need to improve the visibility of the 'Making Safeguarding Personal' agenda into our adult safeguarding practices. We also have gaps in providing information and advice about adult safeguarding in an accessible format to those adults at risk being supported.

We involve and seek feedback from those adults at risk in the safeguarding activity being undertaken through regular supervision meetings where their views and wishes will be canvassed and embedded into their supervision for support and signposting.

- Prevention

We are a member of SAB and have staff members who are formally recognized as the organization's 'safeguarding adults lead. We also have a local lead and a specialist divisional team working with TACT and Prevent cases. Our organization is a member of and sighted on the activities of the local Safeguarding Adults Board.

Safeguarding is a feature of all of our assessments on our PoPs. Our organization is aware of and compliant with s.42 to s.46 of the 2014 Care Act, as well as chapter 14 of the Statutory Guidance, both of which detail organizational responsibilities regarding adult safeguarding. We also have a formal process of our responsibility for identifying and referring incidents of potentially concerning practice which may meet Safeguarding Adult Review (SAR) criteria to your local Safeguarding Adults Board.

We have national policies and procedures with regards to the following:

- Safeguarding adults and making a referral
- Whistleblowing & management of allegations against staff
- Complaints
- Staff supervision
- Information sharing
- MCA/DoLS including 'best Interest' and consent
- Prevent
- Risk assessment & management
- Domestic abuse.

In addition, our offender personality disorder project does complete case formulations prepared for offender managers to assist them in working in the best way with people who may be more difficult to engage. Policies and procedures for the National Probation Service are reviewed at a national level.

Our organizational recruitment policy and procedure includes a requirement to obtain at least two references; undertake DBS checks and confirm professional registration is still current. Staff are expected to adhere to a code of conduct for any professional body they might be a member of. The PS ensures that all staff are aware of their personal responsibility to report safeguarding concerns as well as ensuring that poor practice is identified and improved. Our ' new starter' induction programme ensures that staff and volunteers are made aware of their adult safeguarding responsibilities. All staff are required to undertaken mandatory training which is in e-learning and face to face classroom events. Reflective practice sessions are offered to all staff with service user roles.

Equalities are promoted both in terms of our staff group and in relation to our work with our service users. This includes mandatory training events.

- Quality Assurance

Although we do not have a 'Quality Assurance Framework' specifically for adult safeguarding, it is included in all QA frameworks we use. All high risk of serious harm assessments are quality assured, and counter signed by a Senior Probation Officer. Management oversight of cases of interest/safeguarding concerns/MAPPA are discussed in supervision. Internal assurance is provided by our Operational and Systems Assurance Group, external audits are undertaken by HMIP and we have ad hoc audits completed by our performance team.

Similarly, whilst we do not have performance measures and / or indicators regarding adult safeguarding there are expectations in relation to safeguarding and risk management planning which would be picked up by the quality assurance process described in the above paragraph.

We monitor attendance of staff at training events by recording all training on the “My learning” system. This can be viewed by their line manager. Feedback is required after all training offered and followed up in discussions within their supervision with their line managers. A spreadsheet monitoring completion of mandatory training is sent to all line managers with the expectation that all staff complete this.

Learning from local and national SARs and Domestic Homicide Reviews (DHRs) is implemented via attendance by senior managers and learning is devolved to staff via the middle manager group and through feedback to individual practitioners via the DHR process and our own Serious Further Offence process.

We have arrangements in place to regularly undertake case file audits or 'dip tests' areas of practice. There are themed audits which take place. In addition, our Quality and Development workers focus on areas specifically identified as requiring learning input.

Although some backlogs remain in respect of the delivery of Accredited Programmes and Community Payback the Probation Service is otherwise fully recovered in respect of the impact that the pandemic had on operational delivery. The Probation Service is no longer delivering under the Extraordinary Delivery Model that was implemented to adjust operational delivery to ensure staff and People on Probation safety throughout that period.

The re-unification of Probation Services was completed in June 2021. The main challenge 12 months on remains the lack of qualified Probation Officers in the system. Although officers are being training in high numbers this process takes between 15 and 21 months to complete, it also requires support from the small pool of qualified/experiences officers to support the process which adds a further pressure to operational delivery.

NHS
East Midlands Ambulance Service
NHS Trust

East Midlands Ambulance Service

East Midlands Ambulance Service NHS Trust (EMAS) provides emergency 999 and urgent care services for a population of approximately 4.81 million people within the East Midlands region. This region, which covers approximately 6,425 square miles, includes the counties of Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire, Northamptonshire and Rutland. EMAS also provides Patient Transport Services for people who

have a routine (non-urgent) clinical appointment across Derbyshire and Northamptonshire.

During 2021/2022, EMAS received 1,267,624 emergency and urgent calls (compared to 994,144 in 2020/221). Accident and emergency crews responded to 711,414 of these calls, which equates to 1,949 responses every day. EMAS staff recognised and responded to safeguarding and or care concerns in 5.8% of these responses. This equates to 41,460 referrals. EMAS continues to work in partnership to safeguard patients, their families and members of the public as well as EMAS staff members. EMAS is assured that they have processes in place to protect those who are being abused or are at risk of abuse.

Since September 2021, referral numbers have stabilised. Although it is not possible to provide a definitive cause for this, it is likely to be multifactorial and due to:

- Education around quality of referrals provided by the Safeguarding Leads
- Feedback to crews via the referrals returns tracker
- Enews, and Learning from Events sessions
- Creation of new pathways available to crews, including Drug and Alcohol and the Soldiers', Sailors, and Airmen's' Families Association (SSAFA) pathway
- More consistent recognition of safeguarding and care concerns by crews on Scene

EMAS continues to promote "Think Family" with a safeguarding team that is dedicated to ensuring that all vulnerable individuals are a priority and that policy and procedure reflects everyone's needs. There is strong leadership of the safeguarding agenda and an acknowledgement that safeguarding is "everybody's business" with engagement from Board to frontline demonstrating a commitment to the protection of children and adults at risk in our society.

Safeguarding education is delivered in a variety of ways within EMAS promoting a blended approach in a rolling program over a period of three years incorporating:

1. Face to Face,
2. Work Book,
3. eLearning package,
4. Reflective supervision annually through the appraisal process to meet level three requirements.

During 2021-2022, face to face training was developed which consisted of scenario-based learning in which safeguarding is featured. Alongside this, a supplementary eLearning package was developed using the referral form to guide staff through legislation and explain how to raise a high-quality referral. The e-learning package included a section on making safeguarding personal, including the 6 key principles of adult safeguarding and the importance of gaining consent for referrals. The training also included case studies with questions for self-neglect and modern day slavery.

A learning from events session (a live teaching session via Teams which is recorded for staff to access later if they are working) was held on Mental Health and Mental Capacity. This included making safeguarding referrals, MSP and consent. The session was co-delivered by an external speaker from Derbyshire Adult Social Care and reviewed two patient stories, looking at good practice and areas for learning. The session was recorded and is now available for all staff to access on Totora (web-based learning platform) There has been a full review of EMAS Safeguarding Adult Policy, this includes a section on MSP and also flow charts which promote MSP principles and aid practitioners with decision making around social care thresholds and consideration of when to make referrals to other partner agencies.

Prevention

EMAS employees can now make referrals to SSAFA (solider sailors air force families association), a pilot for EMAS to refer to substance misuse services in Lincoln (it is hoped Derby

will be included in 2022) and referrals Domestic Abuse services continues. There is regular communication with EMAS employees on the safeguarding agenda. Promoting how employees can signpost and refer patients to agencies that can provide advice and support.

Development of a Domestic Abuse awareness sticker. This sticker is on equipment taken into the patient's home.

Internal communications with employees on- - Modern Day Slavery - SSAFA - Sexual Assault Referral Centres (SARC)- processes and contact details - Clutter rating tool and Fire referrals.

Quality Assurance

The Safeguarding Adults Assurance Framework

Across the EMAS region both LSABs and commissioners seek assurance from EMAS that they meet safeguarding adults' responsibilities and improve outcomes for their patients. EMAS completes one Safeguarding Adult Assurance Framework (SAFA) and provide this to our commissioners. The tool is reviewed and followed up by an assurance visit after which a letter is received with feedback. EMAS then shares this information with its safeguarding boards to provide assurance across the Region. The SSAFA was submitted in November 2021.

The SAAF looked at:

- partnership and Collaborative working
- Policies and Governance
- Training and Development
- Implementation of the Mental Capacity Act
- Deprivation of Liberty Safeguards
- Making Safeguarding Personal/Patient Experience
- PREVENT
- Associated Workstreams (including the Covid Pandemic)

An assurance visit was completed in June 2022. EMAS were found to be compliant in all areas.

Safeguarding sits within the Director of Quality Improvement and Patient Safety portfolio and forms part of the Quality Strategy. There are clear links from the frontline to Board and the reporting mechanisms are via the EMAS Integrated Quality Forum, Clinical Governance Group and Quality and Governance Committee. The Safeguarding Team are also members of the Incident Review Group (IRG) and Confidential IRG Group (CIRG). The Head of Safeguarding is the Chair for CIRG.

Referral rates, participation in statutory reviews and staff allegations are presented to the Clinical Governance Group (CGG) and the Quality and Governance Committee (QGC) via the monthly Quality Metrics Report. This ensures safeguarding remains a focus for discussion, safeguarding activity is monitored, safeguarding quality is reviewed and learning is embedded.

Audit

Due to circumstances beyond the control of EMAS, it has been challenging to complete the face-to-face audit during 2021-2022. There were still significant restrictions on face to face contact for much of the year due to the legislation and guidance in relation to Covid-19; and a long period where demands on the service were so high that it had reached REAP level four. Ultimately this has meant that face to face audits could not recommence until January 2022. Given demands on the Safeguarding Team Leads' time in terms of fulfilling daily responsibilities and statutory reporting for the region's Adult and Children's Safeguarding Boards, this meant there has been a limited timeframe for audit completion. Unfortunately, this has meant that the team were unable to fully complete the audit, therefore it must be noted that the audit results are only indicative of a small sample size and exclude Leicestershire as time restrictions for completion meant that the leads were not able to get there to complete face to face audits.

Safeguarding knowledge across the areas that were audited was good, although in some safeguarding issues crews were more confident on than others. No EMAS colleague failed the audit and had to have an escalation process to line management for further training.

This was the first year that an online tool 'Forms' was used to complete the audit. Learning was taken around having standardised assessment criteria in order to have consistent results in order to robustly analyse results on completion of the next phase of face-to-face audits.

The sample size for the audit completed in 2021-2022 was limited, it is hoped that there will be no further restrictions preventing a full sample size of EMAS colleagues being audited in 2022-2023; and Leicestershire/PTS will be audited in the first phase of this year's audit.

In the absence of further restrictions, it should also be possible for the audits to be completed throughout the year enabling the team to complete all audits across all areas.

As you can see from the figures supplied in section 1 the demand for ambulances continues to increase year on year. EMAS has continued to operate a full emergency service during Covid.

Going forward EMAS as a Trust must continue to be vigilant about the evolving safeguarding agenda. Early identification and effective information sharing is key to ensuring EMAS remains compliant and reacts appropriately to safeguarding and protecting our most vulnerable patients. Alongside education delivery, the Trust has an active communication plan, governance framework and strong leadership to ensure the safeguarding agenda continues to be integral to patient safety and high-quality care at EMAS.

HMP/YOI Foston Hall

HMP Foston Hall remains committed to making women safer within our prison. We encourage and promote a 'whole prison approach' culture as an effective means that best supports safety and non-violent attitudes and behaviours. Creating a decent, well-maintained and respectful environment promotes and supports a culture of safety and moral legitimacy within our prison.

This will be achieved by delivering.

- An effective training package for both new & existing staff.
- A trauma informed Safety Strategy that puts our women at its heart.
- Effective use of the establishments Incentive & Earned Privilege Scheme that takes a holistic approach to encouraging pro-social behaviour whilst challenging negative responses and actions.
- Effective partnership working with all agencies including Social Care, Primary & Secondary Health Care Services, Mental Health, and Mother & Baby Services.
- An effective Equalities & Inclusion policy that promotes positive working relationships between staff and prisoners.

Vulnerability amongst the women at HMP Foston Hall will vary, there will be occasions when it may be necessary to offer support, assistance and protection for vulnerable adults that may be at risk of, or subject to abuse, neglect, bullying or threatening behaviour.

On all occasions we will encourage vulnerable adults to remain within their chosen community rather than move to alternative locations which may engender feelings of isolation, or the belief they are being ignored.

We also recognize that our population is made up of a significant number of young adults along with mothers and their unborn babies, and we are committed to ensuring the safety and wellbeing of this small but important part of our diverse community.

Looking to the future, we will continue to prioritise our safeguarding agenda by expanding our safeguarding meeting attendance to ensure we capture all available partners with a vested interest in supporting our vulnerable population. We will ensure that all staff are given the necessary skills to identify and support vulnerable women wherever they are in their custodial journey. Assurance will be achieved via monthly meetings and outcome from actions, that are responsive to the individuals needs and involves them having a voice in the outcome.

Concluding Statement from DSAB Service Manager

I hope you have enjoyed reading our annual report for 2021-22. The achievements highlighted in this report would not have been possible without the support of our Board partners and our DSAB Board business team, who have built and maintained strong working relationships and shown an unwavering commitment to safeguarding adults in Derbyshire.

Our Board development session was held on 8th March 2022, which was an opportunity for our partnership to reflect on achievements, challenges, and future objectives. Board members agreed to extend our strategic plan for another twelve months until the end of March 2023, with the same three strategic priorities of Making Safeguarding Personal, Quality Assurance and Prevention. Our development session generated useful discussion about how our Board can make progress in all three areas and our sub-groups business plans are being updated to reflect these discussions.

I am pleased that our small Board team will be growing in 2022 with the recruitment of a temporary 12-month Senior Practitioner post to support our DSAB quality assurance work. This will give us more scope to undertake valuable audit work and increase our understanding of safeguarding from the perspective of adults who have been supported via our services. We want to continue to learn and improve the way we work together to safeguard adults in Derbyshire, but also share the examples of positive and innovative practice that make a difference to the lives of Derbyshire citizens on a daily basis.

Natalie Gee

Service Manager| Derbyshire Safeguarding Adult Board

If you have any comments or feedback, or if you would like a copy of this report in large print, or in an alternative language, please contact ***DerbyshireSAB@derbyshire.gov.uk***

We will all work together to enable people in Derbyshire
to live a life free from fear, harm and abuse

www.derbyshiresab.org.uk

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Derbyshire Safeguarding Adults Board

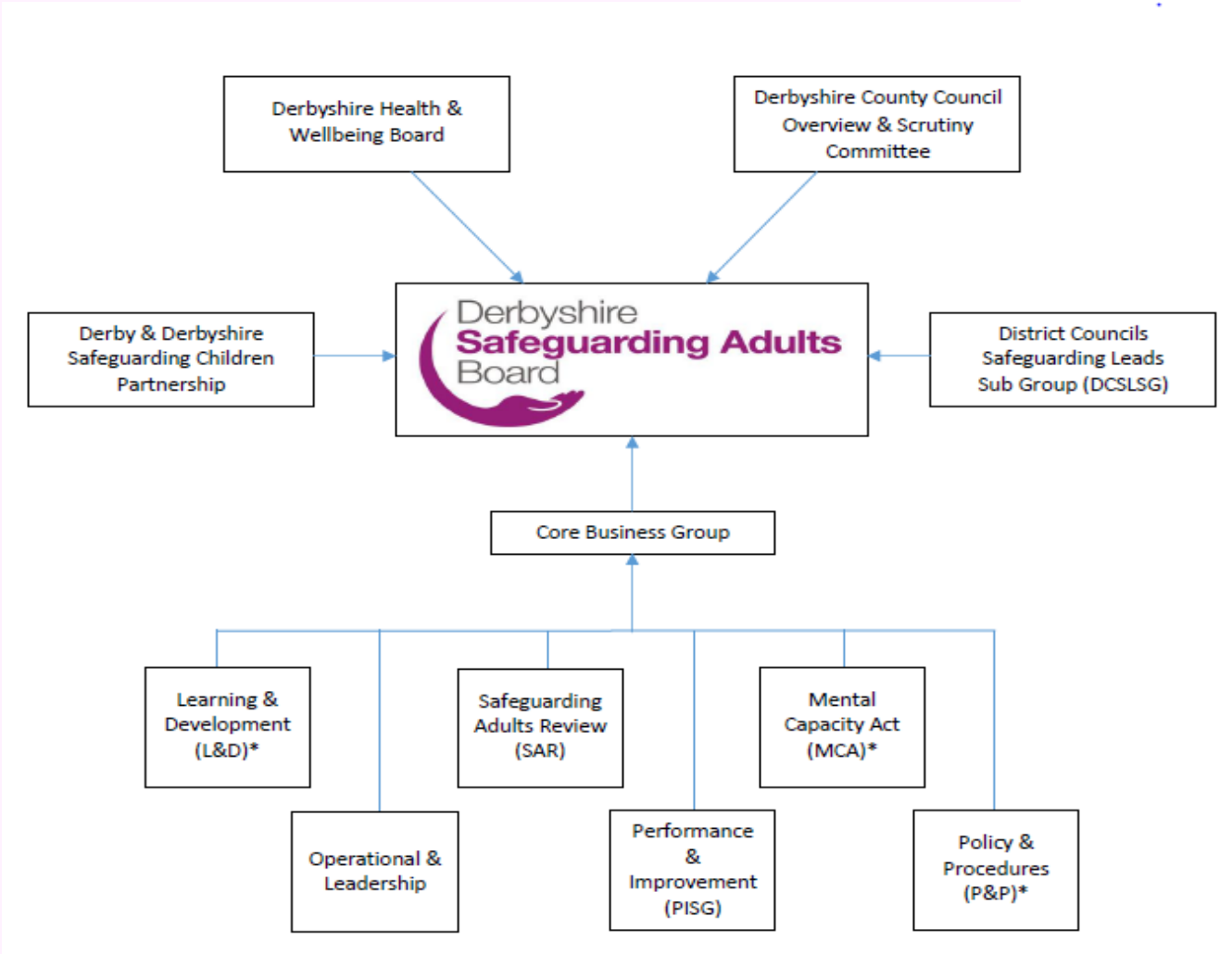
DERBYSHIRE County Council

NHS Derby and Derbyshire Clinical Commissioning Group

DERBYSHIRE CONSTABULARY

Appendix 1 DSAB Structure Chart

* Indicates a joint sub-group with Derby City



Appendix 2: DSAB meeting attendance monitoring form 2021/2022

Key	
	Attended
A	Apologies received
	Did Not Attend

From 25th June 2021, the National Probation Service and the Derbyshire, Leicestershire, Nottinghamshire, and Rutland Community Rehabilitation Service (DLNR CRC) merged to form the National Probation Service.

Date	Age UK Derby & Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust (CRHFT)	Derby & Derbyshire NHS Clinical Commisiong Group (DDCCG)	Derbyshire Community Health Services Foundation Trust (DCHSFT)	Derbyshire Constabulary	Derbyshire County Council Adult Social Care & Health (DCC ASCH)	Derbyshire County Council Community Safety	Derbyshire District Councils Safeguarding Leads Sub-Group	Derbyshire Fire and Rescue (DFRS)	Derbyshire Healthcare NHS Foundation Trust (DHCFT)	Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabiliation Company (DLNR CRC)*	Derbyshire Mind
01/06/2021										A	A	
14/09/2021	A						A	A			Not applicable	
14/12/2021											Not applicable	
08/03/2022									A		Not applicable	A

Derbyshire Voluntary Action (DVA)	Diocese of Derby	DHU HealthCare Commnity Interest Company (DHU CIC)	East Midlands Ambulance Service NHS Trust (EMAS)	Healthwatch Derbyshire	Housing/ Environmental Health	National Probation Service Derbysire (NPSD)*	Office of the Police & Crime Commissioner (OPCC)	Prison Service	Probation Service*	Tameside and Glossop Clinical Commissioning Group (TGCCG)	University Hospitals of Derby & Burton NHS Foundation Trust (UHDBT)
A		A	A						Not applicable		
						Not applicable	A			A	
						Not applicable	A				
						Not applicable	No notification of new member		A	A	

Appendix 3: Abbreviation index

A
ADASS: Association of Directors of Adult Social Services
B
BSL: British Sign Language
C
CCG: Clinical Commissioning Group
D
DDCSLSG: Derbyshire District Councils Safeguarding Leads Subgroup
DDSCP: Derby and Derbyshire Safeguarding Children Partnership
DoLS: Deprivation of Liberty Safeguards
DSAB: Derbyshire Safeguarding Adults Board
E
EMAS: East Midlands Ambulance Service
I

ICB: Integrated Care Board
M
MCA: Mental Capacity Act
MSP: Making Safeguarding Personal
P
PiPoT: Persons in a Position of Trust
S
SAR: Safeguarding Adult Review
V
VARM: Vulnerable Adult Risk Management