DERBYSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT

April 2022 - March 2023

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

Our Annual Report provides an overview of the progress and activity of our partnership during the year 2022-2023 in relation to adult safeguarding in Derbyshire. I believe it provides assurance that there is a collective multi-agency response to addressing the abuse and neglect of adults who have care and support needs in our County.

Over the last 12 months our Board and subgroups have focused on the three Strategic priorities of Making Safeguarding Personal, Quality Assurance and Prevention and the six principles of adult safeguarding: Empowerment, Protection, Prevention Partnership, Proportionality, and Accountability, continue to underpin everything we do as a Board. These principles remind us that every adult we support should be treated as an individual, and by providing a personalised approach to adult safeguarding, we will achieve the best possible outcomes for our citizens.

Our Board vision states that all adults should be able to live a life free from fear, harm, and abuse but our data shows that sadly over 5000 safeguarding concerns were raised to the local authority in this 12 month period. Our safeguarding work must therefore continue alongside awareness raising to ensure that our citizens know how to access support. Our website, newsletters, podcasts, leaflets, and social media platforms are some of the ways we continue to raise awareness in the community that 'there is no excuse for abuse'.

I am grateful to our Board partners and the Board office team who work incredibly hard throughout the year to safeguard adults in Derbyshire as we continue to strive to achieve our vision:

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

Andy Searle

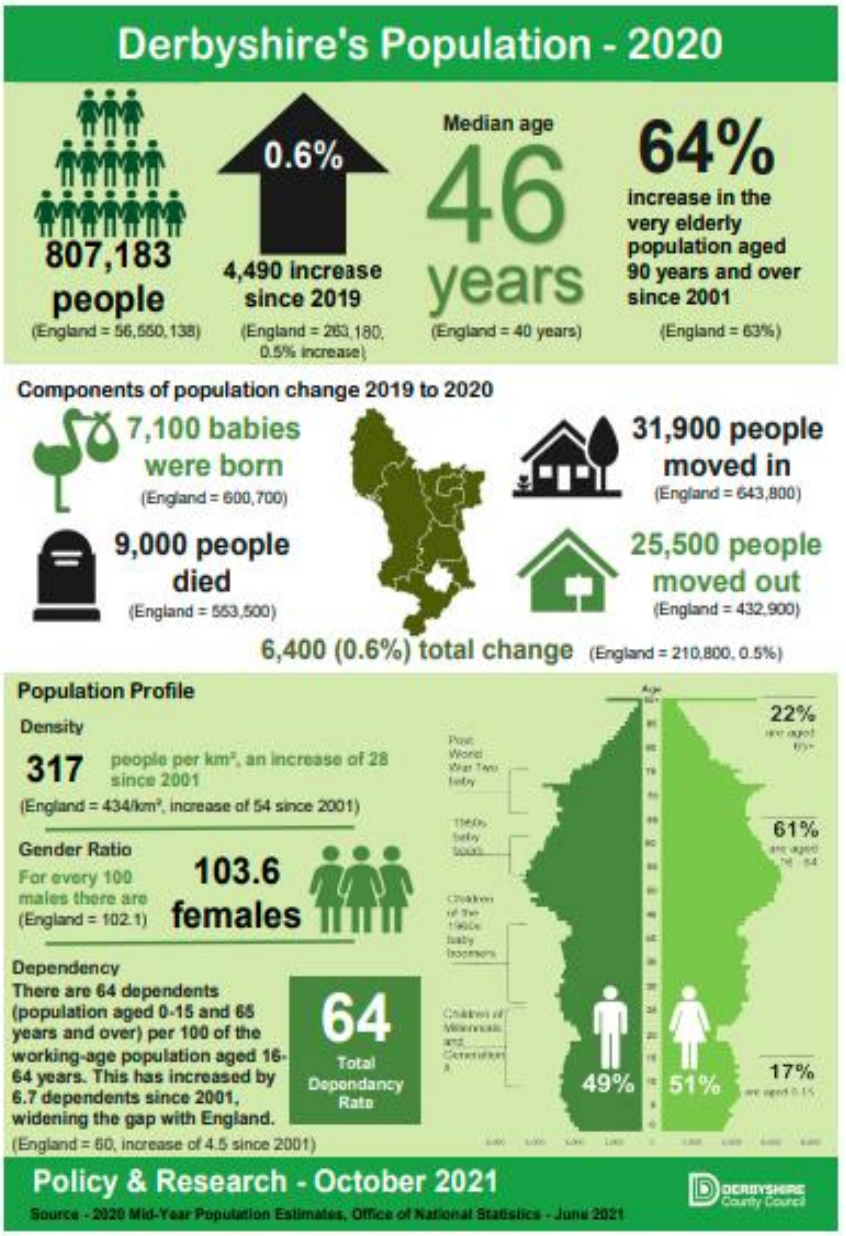
Independent Chair| Derbyshire Safeguarding Adult Board

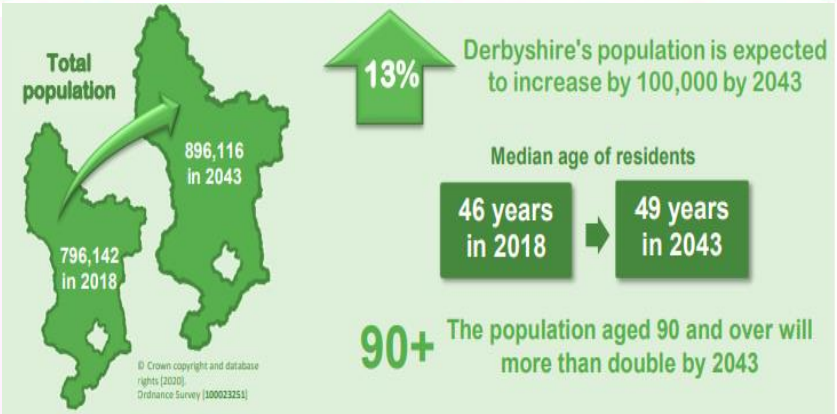
Contents

Demographic information

Derbyshire lies in the centre of England covering 630,366 acres. It is a large diverse county with several heavily built-up towns alongside large sparsely populated rural areas.

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

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, Integrated Care Board, Fire and Rescue Service, Ambulance Service and Probation Service.

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

Governance arrangements and legislative context

The Care Act 2014 made the forming of a Safeguarding Adults Board (SAB) a statutory requirement of a local authority from April 2015 onwards. The membership of the DSAB consists of senior leaders from key agencies responsible for adult safeguarding in Derbyshire. The Local Authority, Integrated Care Board (ICB) and Police are required to be statutory members of the Board, but in Derbyshire the Board membership includes other key organisations. 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 Board meets quarterly and takes a strategic lead in the protection of adults with care and support needs. The DSAB voluntarily submit themselves annually to the Improvement and Scrutiny Committee of Derbyshire County Council as an added element of oversight and the Independent Chair, on behalf of the Board has regular contact with the local authority at Executive Director Level.

The appointment of the Independent Chair is the responsibility of the local authority in consultation with statutory partners. The DSAB is independent which enables it to provide effective scrutiny of local adult safeguarding arrangements.

Statutory functions of Safeguarding Adults Boards	
Annual Report	Publication of an Annual Report detailing the activity of the Board over the previous year.
Strategic Plan	Production and publication of a plan setting out how the Board will meet its agreed strategic objectives.
Safeguarding Adult Reviews	Undertaking Safeguarding Adult Reviews (SARs) in accordance with Section 44 of the Care Act 2014.

In addition to the above statutory functions the DSAB also has a wider preventative and developmental focus on safeguarding adults including

- the development and review of multi-agency safeguarding policy, procedure, 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 where the principles of Making Safeguarding Personal (MSP) has been applied,
- raising general awareness in the community in relation to recognising and reporting abuse and neglect in Derbyshire, using accessible and easy to understand formats and a variety of different languages,
- respectfully challenging partners to provide the best quality safeguarding services,
- working with other partnership groups and Boards to improve the wellbeing of all Derbyshire citizens including Derby City Safeguarding Adults Board, Derby and Derbyshire Safeguarding Children Partnership, Derbyshire Health and Wellbeing Board, Derbyshire Safer Communities Board, East Midlands ADASS Safeguarding

Adults Community of Practice, the National Safeguarding Adults Board Managers Network and the National Independent Chairs Network.

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 act 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 DSAB 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 2022-2023

The DSAB's Strategic Plan for 2019-23 focusses on three strategic priorities: Making Safeguarding Personal, Prevention and Quality Assurance. The subgroups of the DSAB have business plans in place linked to these priorities to support the Strategy. The business plans are presented to the Board for oversight and assurance.

DSAB Strategic Priorities 2022-2023
Making Safeguarding Personal (MSP)
Prevention
Quality Assurance

DSAB Budget

The Board is funded by Derbyshire County Council Adult Social Care and Health, Derbyshire Police, and Derby and Derbyshire ICB. A separate budget, the Vulnerable Adult Risk Management (VARM) Hoarding Grant, is used to provide practical support for adults who are being supported via the VARM process. This smaller budget is funded by Derbyshire County Council Adult Social Care and Health, Derbyshire Fire and Rescue Service, and Derby and Derbyshire ICB, who each contribute £3000 to make up this £9000 per year fund. Further information about the VARM hoarding grant can be found on the DSAB website and in the separate VARM annual report 2022-2023.

DSAB Budget Contributions 2022-2023

Derbyshire County Council Adult Care	£43,000
Derby and Derbyshire ICB	£43,000
Derbyshire Police	£43,000

Total Amount Spent:	**£175,218.37** (this includes a sum of £46,218.37 carried forward from the previous year which was used to fund a 12-month temporary quality assurance post for the DSAB).

Safeguarding Adult Review (SAR) expenses are not included within the DSAB budget expenditure and are instead split three ways between the three statutory partners of the DSAB. The total expenditure for safeguarding adult reviews during 2022-2023 was **£4000.**

Key achievements and progress 2022-2023

DSAB newsletters were produced and published on the Board website. In addition to standard quarterly newsletters, special edition newsletters were produced for important events and topics such as National Safeguarding Adults Week, World Elder Abuse Awareness Day and to highlight the support available for citizens in relation to the cost of living increase. Two newsletters were also produced by the MCA subgroup to support frontline staff with understanding and applying the principles of the Mental Capacity Act.

Connect to Protect campaign

As part of World Elder Abuse Awareness Day on 15th June 2022, the DSAB office used the 'Connect to Protect Derbyshire' campaign #ConnecttoProtectDerbyshire to encourage people

to make a safeguarding referral if they are worried that an adult may be suffering from abuse or neglect.

DSAB stalls at Derbyshire Fire and Rescue Service open days

The Board office team, along with support from staff members from Derby and Derbyshire ICB, Derbyshire County Council Adult Social Care and Derbyshire County Council Trading Standards attended two Derbyshire Fire and Rescue Service open days in July 2022 in Swadlincote and Alfreton.

- Information was provided about Derbyshire Carers Association and the support available to unpaid carers, with one person registered as a carer on the day.
- Members of the public were signposted to information and services, such as hearing support in Derbyshire, GP registration and attendance allowance.
- Information and advice was given out in relation to recognising and reporting abuse.
- Advice was given in relation to financial scams, particularly scams relating to students.

Safeguarding Adult leaflet translated into Ukrainian

As Derbyshire has welcomed over 1000 Ukrainian refugees into the county the DSAB safeguarding leaflet, 'Advice if you or someone you know is being abused, neglected or exploited' has been translated into Ukrainian. The leaflet is designed to inform both the public and professionals how to recognise abuse and neglect in Derbyshire. The leaflet is now available in 5 languages - English, Polish, Romanian, Ukrainian and Urdu.

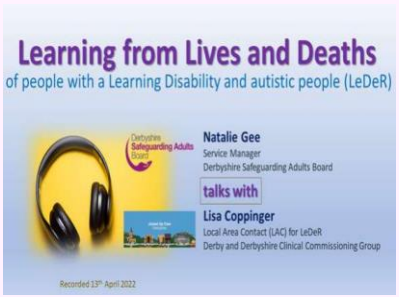
Predatory Marriage 7 minute briefing and poster

A DSAB predatory marriage leaflet and 7-minute briefing were produced to explain what predatory marriage looks like, its signs and indicators, and what can be done to report concerns.

Carers podcast

An ongoing priority area of work for the DSAB is to prevent safeguarding concerns arising in carer relationships by ensuring carers and the people they care for know how to access support and advice to keep them safe and well. The DSAB office produced a podcast where Tom Brown, Senior Practitioner for the DSAB speaks with Bev and Lisa about their experience of being carers. Tom also talks with Jude Boyle, Carers Lead at Derbyshire County Council and Helen Weston who is the Interim CEO from Derbyshire Carers Association.

Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) podcast



The DSAB office produced a podcast featuring Lisa Coppinger, the Local Area Contact for Derby and Derbyshire ICB about why the work of the LeDeR programme and LeDeR reviews are important and linked to safeguarding adults in Derbyshire.

We Value Your Feedback- leaflet

The 'We Value Your Feedback' leaflet is an accessible way for making complaints, comments and compliments to the Board. This leaflet was produced with involvement from members of the Derbyshire Stakeholder Engagement Board and as an adult who was supported via a safeguarding process in Derbyshire.

Safeguarding adult referrals reference guides

Two DSAB reference guides were produced to help professionals decide when to make safeguarding adult referrals. For professionals who require more comprehensive information to support decision-making about making safeguarding adult referrals the full Adult Safeguarding Decision-Making Guidance document is available and continues to be reviewed and updated.

DSAB stall at Derby University Freshers' Fair September 2022

On 20th September 2022, the Board office team and Derbyshire Police ran a stall at Derby University Freshers' Fair. During the event, over 250 people were supported with information about personal safety, domestic violence, safeguarding adults, Vulnerable Risk Management (VARM), cybercrime and hate crime. Students with learning difficulties and mental illness who could meet the eligibility criteria for safeguarding were given practical advice and resources. Contact was also made with approximately 30 nursing and social work students who were also given information to help enhance their understanding of safeguarding, cybercrime, public safety and VARM.

National Safeguarding Adults Week Webinars 21st-27th November 2022

During National Safeguarding Week the Board office arranged four webinar sessions aimed at front-line practitioners and managers working for DSAB partner agencies. The webinars focused on the following subjects:

1. Safeguarding and the Disclosure and Barring Service
2. Technology and Domestic Abuse
3. Neurodiversity and Safeguarding Adults
4. Cuckooing and County Lines

The webinars were attended by a total of 243 professionals from organisations across Derbyshire. DSAB social media posts during the week were linked to the topics covered in the webinars to raise awareness with the public.

Campaign to raise awareness about safe money management in carer relationships

During National Safeguarding Adults Week, the DSAB Financial Abuse Working Group launched a campaign aimed at carers; 'a penny for your thoughts….' to advise carers about how to safely manage the finances of people they care for.

A top ten tips guide was produced in association with Age UK Derby and Derbyshire, Derbyshire Carers Association, and the Alzheimer's Society. The guide contains advice on;

- setting up a power of attorney
- keeping your money and the money of people you are for separate
- accessing systems designed to help you with managing finances
- making a budget and keeping a record of expenditure
- involving the person being supported in decisions about managing their money
- claiming entitlements

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. During 2022-2023 a new search box was added to make it easier for people to use the website. Two new

webpages; a Cost of Living advice and support webpage and a Trauma Informed Practice webpage were created.

For the year 2022-2023 the website had 66,489 pageviews, of which 54,395 were unique pageviews. This is an increase of 19% pageviews in comparison to the previous year.

DSAB social media @DerbyshireSAB

The DSAB Twitter and Facebook accounts were launched in September 2018 and social media posts are used to 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 and partner agencies locally and nationally via social media. The numbers of Twitter followers and Facebook fans have increased throughout 2022-2023, with 912 Twitter followers (increase of 12%) and 520 (increase of 16%) Facebook fans as of April 2023.

Vulnerable Adult Risk Management (VARM)

The vulnerable adult risk management (VARM) process was implemented in Derbyshire in 2013 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 through self-neglect, risk taking behaviour, chaotic lifestyles or refusal of services.

A separate VARM annual report for 2022-2023 has been produced and can be requested via emailing DerbyshireSAB@derbyshire.gov.uk, however a summary of key information is shown below.

The DSAB 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
- 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
- Identification of ways to improve quality and consistency of electronic recording in relation to VARM

DSAB VARM Working Group Key Achievements

- The VARM confidentiality statement was updated during 2022-2023 following a review with assistance from Derbyshire County Council legal services.
- The VARM working group promoted the use of the "VARM- What to Expect" leaflet during 2022-2023. There are now two versions of the leaflet - one that can be completed online, and one that can be printed.
- Case studies continue to be discussed at VARM working group meetings so that professionals can learn from each other. Derbyshire Constabulary presented a case to the group in April 2022, Adult social care presented a case in July 2022 and Derbyshire Fire and Rescue Service presented a case in January 2023.
- The Derbyshire County Council adult social care and health training team delivered 12 webinar VARM training briefings during 2022-2023 resulting in 240 professionals receiving the training.

- The VARM Review Working Group created a "VARM Agency Report" template which allows agencies who are unable to attend an initial VARM meeting to provide information to support the meeting in a consistent format.
- The DSAB Board office team assisted two other Safeguarding Adults Boards to launch their own VARM processes; Wigan SAB and Sandwell SAB.
- A new VARM newsletter is in the process of being launched, with the first edition to be circulated during Q1 of 2023-2024.
- The VARM Working Group drafted terms of reference for a project to be undertaken during 2022-2023 to analyse three years of VARM data. This work has been completed by the DSAB Senior Practitioner for Quality Assurance with assistance from VARM chairs, and the findings have been shared with the DSAB Board members and professionals. Work is taking place to embed the learning via an action plan.

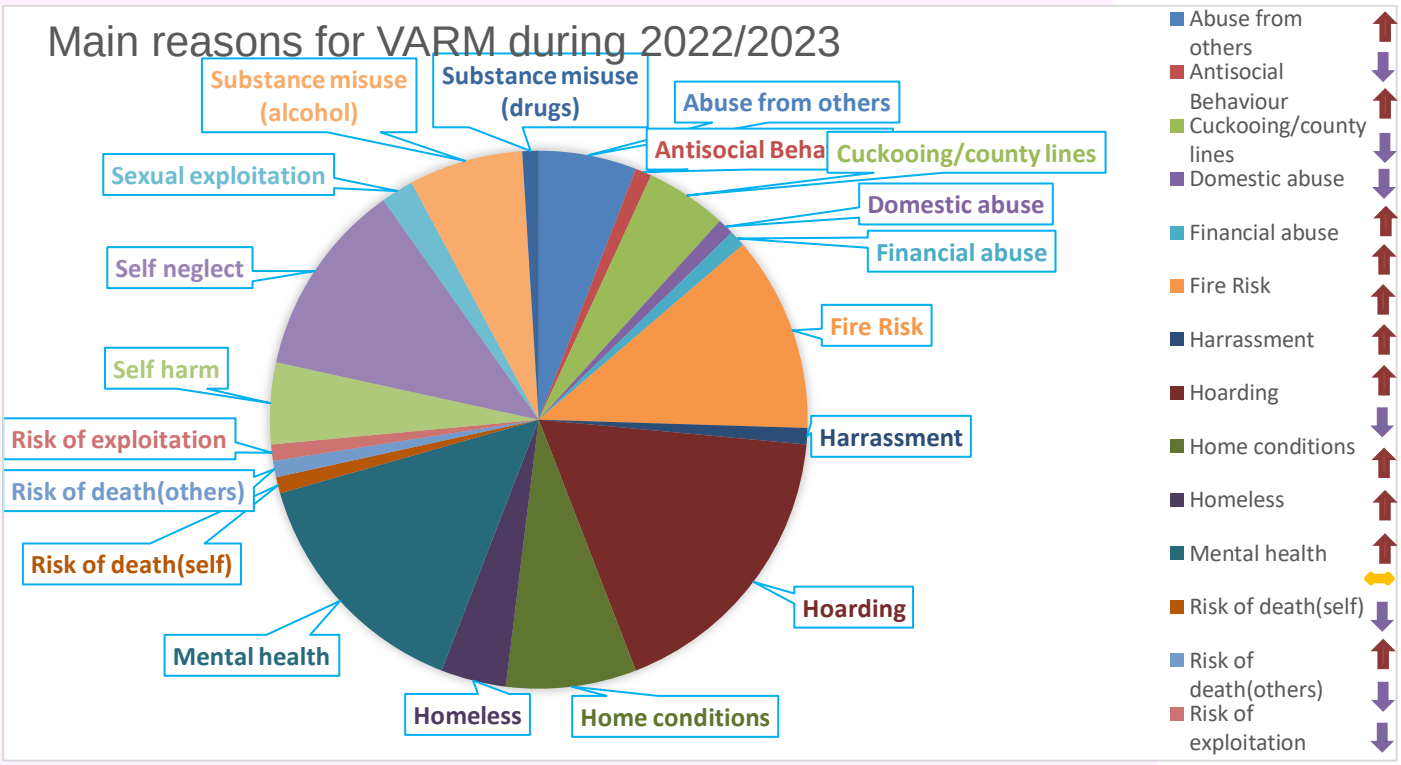
VARM Referrals data

From 1st April 2022 to 31st March 2023, 235 VARM cases were received, an increase of 23% from the previous year.

133 VARM processes were in relation to men (57%) and 101 were in relation to women (43%).

The ethnicity of adults in the VARM process during 2022-2023 was 96% White British, 1% Not stated, 1% Bosnia & Herzegovina, 1% White Irish, and 1% White 'other'.

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



DSAB Financial Abuse Working Group

The DSAB financial abuse working group met twice during 2022-2023. The group has a well-established virtual network and regular communication takes place to share information about financial scams, resources and campaigns. 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

The DSAB training course, 'Chairing multi agency meetings' is a joint course for Derbyshire and Derby City Safeguarding Adults Boards, hosted by the Derbyshire County Council electronic system, Derbyshire Learning Online. The course is available for all professionals working for partner agencies across Derbyshire and Derby City, including the voluntary sector. Two sessions took place during 2022-2023 with 44 practitioners in attendance.

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:

'The session provided a good amount of information to help make me feel more confident about chairing meetings and has given me ideas I can adopt to help improve future meetings I chair.'

'The session has made me consider the importance of ensuring that I always attend a meeting that I'm chairing prepared with an agenda to ensure that the session remains structured and focused.'

Safeguarding Adult Reviews

There were no new SARs published during 2022-23 but learning briefs for previous Derbyshire SARs can be found on the DSAB website. An update is provided within the SAR subgroup report in relation to current and ongoing Derbyshire SARs over the last 12 months.

Subgroup Activity of the Derbyshire Safeguarding Adults Board 2022/2023

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

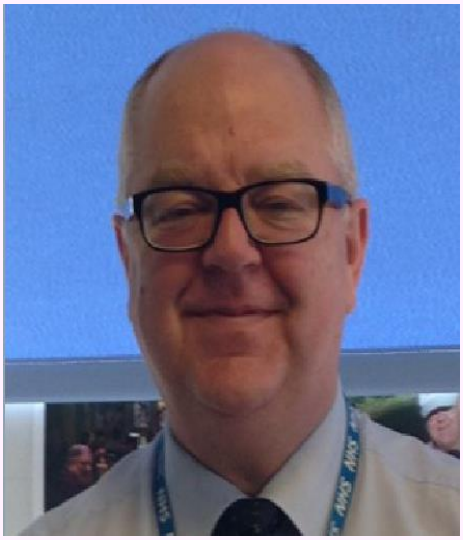
The DSAB Core Business Group is a subgroup of the Board with membership from the Independent Chair, the DSAB Board manager and the three statutory partners of the Board.

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 the DSAB.
- establish and monitor financial arrangements for the DSAB.

The group meets quarterly in between Board meetings. Key decisions remain the responsibility of the full Safeguarding Adults Board.

The Performance and Improvement Subgroup
Chair: Bill Nicol (Derby and Derbyshire Integrated Care Board)



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 via multi agency audit in order to determine any priority areas for operational improvement.
- Highlighting and sharing examples of positive safeguarding practice

It has been a positive and productive year for the group with significant progress made with

the support of a temporary DSAB Quality Assurance Senior Practitioner post. The group has been well attended and supported by partner agencies.

Areas of particular focus included Making Safeguarding Personal and case file audits, with nine audits undertaken during this 12 month period. The audits allowed for a multi-agency appraisal of case management and joint working. We were able to obtain feedback from adults who had been through the safeguarding process in order to better understand what could be done to enhance their experience and maximise feelings of safety and well-being and this feedback has helped us to enhance our audit action plans

The Local Authority have provided statistical data regarding referral types, trends, and outcomes which has enhanced our understanding of operational activity. As always there is much for us to do but I am confident that we will continue to respond to the needs of Derbyshire residents and support the Safeguarding Adult Boards strategic plan.

The Learning and Development Subgroup
Chair: Claudia Musson (Derbyshire Police)

The purpose of this subgroup is to;

- take direction from the Derby and Derbyshire SABs in relation to safeguarding adults Learning and Development
- identify, develop, and maintain and promote multi-agency safeguarding adults education and training
- promote a consistent approach to safeguarding adults practice across Derby and Derbyshire
- seek assurance that the principles of Making Safeguarding Personal and Equality, Diversity and Inclusion are embedded within safeguarding training.
- develop quality assurance tools to evaluate safeguarding training and measure its impact.

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

The Learning and Development Subgroup has been well attended and supported during 2022-2023. The 'Chairing multi-agency Meetings' course continued to be delivered by the Board with three training sessions arranged for this 12-month period. The courses have been well attended and the feedback received from attendees has been reviewed by the group on a quarterly basis. The feedback prompted discussions which resulted in a new handout being designed for attendees to provide 'top tips' on successfully chairing meetings.

A task and finish group has been meeting to discuss Equality, Diversity, and Inclusion. The group have worked to ensure that that Equality and Diversity runs as a 'golden thread' throughout current safeguarding adults training. An assurance template was designed and launched by the subgroup to seek assurance that current and new safeguarding course consider relevant key themes within the course content. During National Safeguarding Adults Week on 25th November 2022 a webinar was arranged by both the Derbyshire and Derby City SABs called 'Safeguarding Adults- Equality, Diversity and Bias'. The session was delivered to 69 attendees across the partnerships by an external Trainer, and a trainer from Derbyshire Healthcare NHS Foundation Trust.

Learning from Safeguarding Adult Reviews and Audits has been shared regularly with the subgroup for consideration of how key learning themes can be incorporate into existing safeguarding adults training. This has included the learning from Derbyshire SAR21A, the Derbyshire SAB Transitions, learning disability and non-white British citizens multi agency audits and the Derby City SAB multi agency Transitions audit.

Trauma Informed Practice has been another key theme being explored by the subgroup. Work took place during 2022/2023 to explore whether current safeguarding courses were covering the impact of trauma on safeguarding, and discussions are ongoing

around developing some training slides in relation to trauma informed practice for partner agencies to incorporate into their existing safeguarding training.

The subgroup has an action plan linked to the three strategic priorities which both Derbyshire and Derby City Safeguarding Adults Board have both 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.

Future work of the subgroup will include exploring how the partnership can measure the impact of safeguarding adults training on safeguarding practice.

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

The Operational and Leadership subgroup is attended by Safeguarding Leads from DSAB agencies and by adult social care managers from each locality area. We continue to work towards supporting the DSAB in its core priorities of Making Safeguarding Personal, Prevention and Quality Assurance.

The group regularly features guest speakers from a variety of organisations, and during 2022-2023 there has been a presentation by The Willow project manager, part of Rural Action Derbyshire. This presentation highlighted the work they do to raise awareness of the challenges facing people in rural communities who wish to disclose domestic abuse or protect themselves from it. To provide purposeful leadership within safeguarding, managers need to be aware of support agencies to be able to signpost and support staff in keeping people safe. 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. Subgroup members share case studies as examples of what is working well and areas which require improvement.

In the last year we discussed an issue of people referring into safeguarding procedures where a crime had potentially been committed but the referrer had not always alerted the Police. Working alongside our colleagues who attend the Policy and Procedures subgroup a solution has been agreed. Discussions have also included the safe sharing of information requests by adult social care with partner agencies. An operational issue was highlighted in early 2023 that in a small number of cases there had been a delay in a partner agency receiving S42 enquiry requests. This was specific to one locality area and a plan was put in place to address the delay which will continue to be monitored.

The subgroup is well attended, and attendees are engaged with the agenda items, however some duplication was identified between this group and other subgroups and it has been agreed to review the business plan and terms of reference for this group in 2023-2024.

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 4 occasions in 2022/2023. All key DSAB partners are represented in the sub-group, alongside representation from the Derbyshire County Council legal department, and sub-group members have worked collaboratively to deliver its workplan.

The sub-group worked according to its business plan for 2022/2023 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 across all inter-agency involvement. A substantial amount of work has also been completed in relation to quality assurance.

Members of the sub-group and Board team co-ordinated and participated in a piece of regional

SAR assurance work in February and March 2023 which was led by an independent consultant and funded via Partnerships in Care and Health (PCH). Several regional Safeguarding Adults Boards (SABs) participated in the work with a peer review approach taken with learning and recommendations developed by the consultant. The learning from this work will be shared at a Board meeting in 23/24 and acted upon by the SAR sub-group and by the East Midlands Association of Directors of Adult Social Services (ADASS) safeguarding community of practice.

There has been continued use of the SCIE quality markers to ensure the completion of quality SARs alongside the introduction of key performance targets (KPIs) for SARs from March 2023. These focus on evidence of impact following the implementation of recommendations from SARs via the development of specific, measurable, appropriate, realistic, and timed (SMART) actions and engagement with people with lived experience and practitioners to gather specific feedback.

The sub-group has taken appropriate action during the year to ensure that learning from completed SARs has been shared appropriately and proportionately across agencies and the SAR recommendations group has continued to meet and monitor the implementation of recommendations made in completed SARs and Multi-agency learning reviews (MALRs).

The sub-group has received an increased number of SAR referrals in 22/23 than in previous years. It is unclear if this is related to the awareness-raising completed in Autumn 2021 or if it is related to the Covid-19 pandemic which resulted in reduced service provision across the health and social care system. Seven new SAR referrals were received by the sub-group during 2022/2023 and considered all available information from partner agencies to determine whether these met the criteria for a SAR to be completed. As a result, four were identified as not meeting the criteria and a fifth required further supplementary information to be gathered with a decision expected in 23/24. Two new SARs were initiated: SAR22A where self-neglect is the prominent theme and SAR23A where neglect and acts of omission are the dominant themes. Independent reviewers have been contracted to lead on the completion of these with multi-agency panels established for both. One panel meeting was held for SAR22A with 2

others scheduled in 23/24.

SAR21A was completed during 22/23 which was commissioned in the previous financial year; however, engagement with the adult's family has not yet taken place due to other parallel processes. The review will not be finalised until engagement with the family has taken place. The draft report has been tabled for discussion at the DSAB meeting in April 2023 and a "learning on one page" (LOOP) summary has been drafted for practitioners to review.

Preventative work completed this year has included fire safety awareness raising across the whole of the Derbyshire homecare workforce following learning from a fatal fire review. Alongside this, the subgroup has completed awareness raising of domestic abuse of older adults across the whole of the adult social care provider market following learning from another Board with a leaflet developed and issued to all local providers.

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 a joint subgroup for both Derby and Derbyshire Safeguarding Adults Boards. It is positively 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 Strategic Action Plan which links with Derby and Derbyshire's SABs three priorities: Making Safeguarding Personal, Quality assurance and Prevention.

The following work has been undertaken by the Subgroup during 2022-23:

- Multi-agency partnership meetings to share information and undertake planning and preparation for the implementation of the Liberty Protection Safeguards.
- Circulation of two Newsletters highlighting key themes on MCA. The newsletters can be found on the DSAB website. The themes covered within the newsletter included:
  - The impact of coercive control on mental capacity to marry
  - MCA and 16/17 years old
  - Mental Capacity Act Training Slides
  - Derby & Derbyshire SAB: Practice Guidance
  - Derby SAB SAR01: Executive Summary Report
  - Information on roles of the Best Interests Assessor, Specialist Advocacy Service and Relevant Person Paid Representative
- Activities reports on Deprivation of Liberty Safeguards (DOLS) referrals and information from the Advocacy and IMCA Services are regularly discussed at the subgroup and exceptions noted for escalation to the DSABs.
- Learning and recommendations from reviews (locally and nationally) that were relevant for the Subgroup were shared and discussed, embedding any relevant learning.
- Partners continued to share good practice, tools and information and scrutinizing the application of the MCA and DOLS across partner agencies

- Feedback on internal audits on DOLS carried out by agencies was provided.

The subgroup carried out a survey for partner agencies about information and resources that they have within their organisations relating to MCA and transition from young people's services to adult's services and how agencies work and support young people and their families to understand MCA. The results will be reviewed in 2023-24.

The MCA Subgroup continues to progress and focus on the below key topics for 2023-24:

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 of the MCA 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 campaign 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 establish 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
- promote a consistent approach to safeguarding adults across Derby and Derbyshire.
- Embed the principles of Making Safeguarding Personal within safeguarding policy and practice guidance
- 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

There was a reviewing of chairing responsibilities, and both the Chair and Deputy Chair were happy to continue with the agreement of the group, 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 and the group has also completed a review of the Terms of reference and the membership.

The group are eager to bring experts speakers and support into the group and have sought support and advice from Experts by Experience, Domestic abuse services and police colleagues. The group actively seek best practice from other areas and work in partnership to both share Derby and Derbyshire practice guidance and adapt practice guidance from elsewhere.

A full review of the work plan takes 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.

All meetings have been quorate and there has been significant progress over the past four years.

	2019-2020	**2020-2021**	**2021-2022**	**2022-2023**
RED Document required and not started yet	10	6	4	2
AMBER Document being worked on or awaiting sign off	11	6	4	5
GREEN Document in place	26	42	51	56

Adult Safeguarding - Statistical information

Quarterly safeguarding adults data dashboards are reviewed by the DSAB Performance and Improvement subgroup with key headlines shared at quarterly Board meetings. Key performance indicator's (KPI's) were adopted by the Board in Quarter 1 of 2022-2023. It has been acknowledged that the data is not always accurate enough to give clear evidence of safeguarding themes and trends due to key fields not being completed within recording systems or due to recording systems not being set up in way that captures the activity taking place. To address this a number of amendments were made to the adult social care electronic safeguarding workflow in April 2023 which should enable better data quality in the future. There is also promotion with all staff around the importance of accurate recording to ensure the Board has access to meaningful and accurate data.

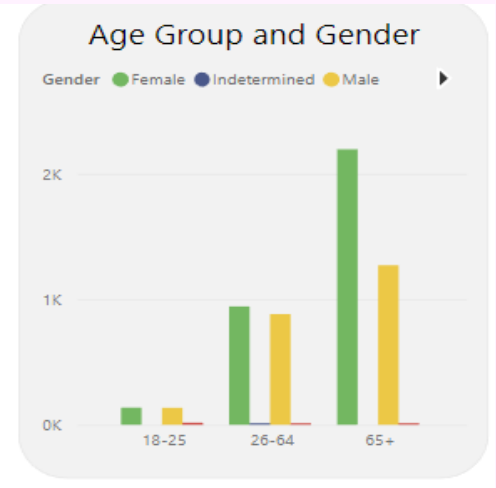
DSAB Safeguarding adults data 2022-2023

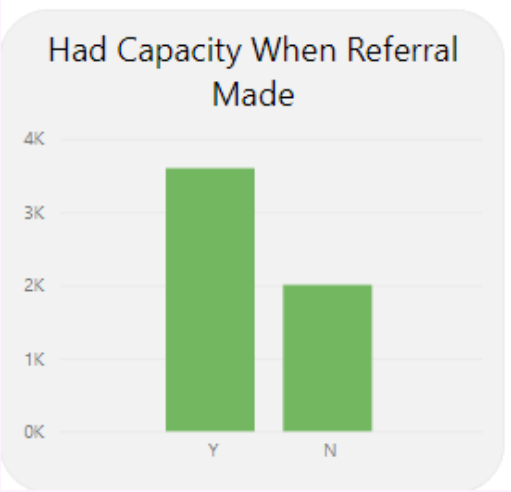
There were **5604** Safeguarding referrals/concerns raised with Derbyshire County Council Adult Social Care and Health within the year 2022-2023. This was the first time that there had been over 5000 referrals within one financial year in Derbyshire. This is an increase of **17%** from the previous year.

2423 (43%) of adults referred during this 12-month period had a safeguarding referral raised previously on at least one occasion.

2413 of referrals (43%) resulted in further enquiries being undertaken under S.42 of the Care Act 2014 during this 12-month period.

Chesterfield received **1157** safeguarding concerns during this 12 month period which was 21% of all referrals made during this period. The area receiving the second highest number of safeguarding concerns was Erewash with **850** concerns received (15%), followed by Amber Valley with **712** safeguarding concerns (13%).



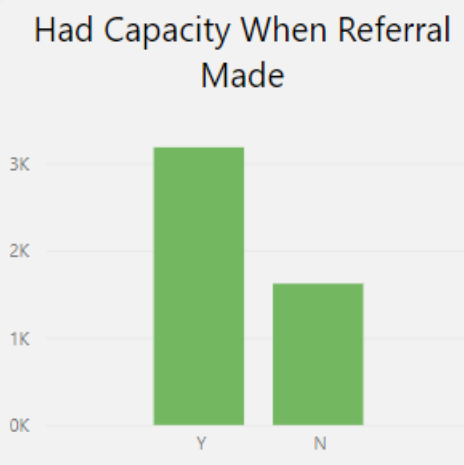


Adults aged over 65 years were the subject of **3477** (62**%)** of the referrals made during 2022-2023. **1841 (32%)** of referrals were in relation to adults aged 26-64 whilst **302 (5%)** were in relation to adults aged 18-25 during 2021/22. **58%** of referrals made during 2022-2023 were in relation to women.

89% of all of safeguarding referrals made during 2022-2023 were for adults who are White or

White British. In **8%** of referrals the ethnicity of the adults was not known or not recorded. 2.5% of referrals were for adults from BAME communities.

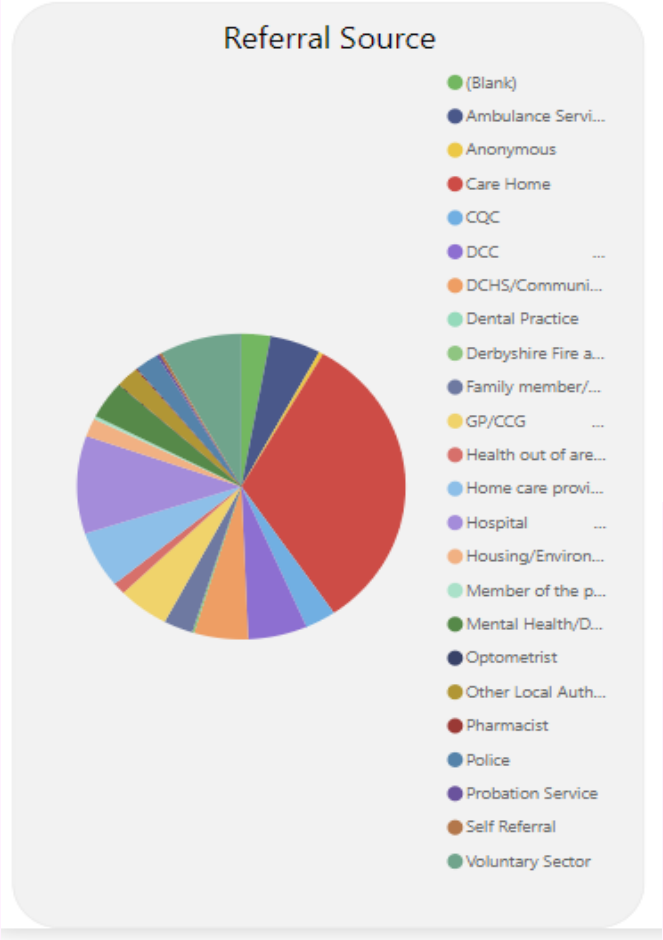
In relation to referrals that resulted in further enquiries under S.42 of the Care Act, 90% of adults were White British. In 7% of cases the ethnicity of the adults was not known or not recorded and in 2% of cases the adult was from a BAME background.

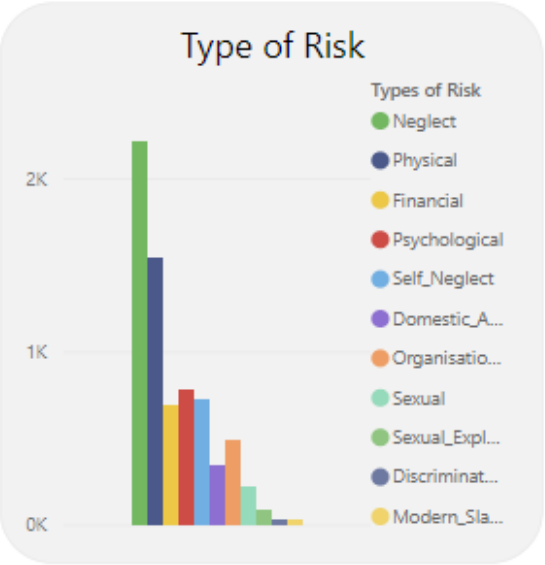


In 3**6**% of safeguarding adult referrals made the adult was recorded as lacking capacity to consent to the referral at the point the safeguarding adult referral was made.

Care homes (a combination of residential and nursing) made 32% of the safeguarding adult referrals during 2022/23 making them the largest referral source. Hospitals were the second highest referrer at 10% The voluntary sector is third highest referrer with 8% of all referrals made.

Self-referrals, referrals from family and friends, referrals from members of the public, and anonymous referrals made up 1% during the 12-month period up to the end of Q2. 16 Safeguarding referrals over the last year were self-referrals.





Type of Risk

Neglect	2215	31.03%
Physical	1542	21.60%
Financial	692	9.69%
Psychological	776	10.87%
Unanswered_Abuse	386	5.41%
Self_Neglect	720	10.09%
Domestic_Abuse	347	4.86%
Organisational	483	6.77%
Sexual	219	3.07%
Sexual_Exploitation	87	1.22%
Discriminatory	32	0.45%
Modern_Slavery	25	0.35%

Neglect is the most common reason for referral with safeguarding adult referrals relating to neglect featuring in 31% of all referrals made between 01/04/2022-31/03/2023.

Physical abuse was the second most common reason for referral featuring in 22% of cases.

Psychological abuse has been listed as the reason for referral in 11% of cases

Both self-neglect and financial abuse were the reason for referral in 10% of cases.

Concluded referrals and S42 enquiries

There were **4957** safeguarding referrals concluded during 2022-2023. In **1644** of these cases (33%), further enquiries were undertaken under S.42 of the Care Act. In relation to S42 enquiries concluded over this 12-month period, **767 (47%)** of adults were recorded as lacking capacity at some point during the safeguarding enquiries undertaken.

Advocate

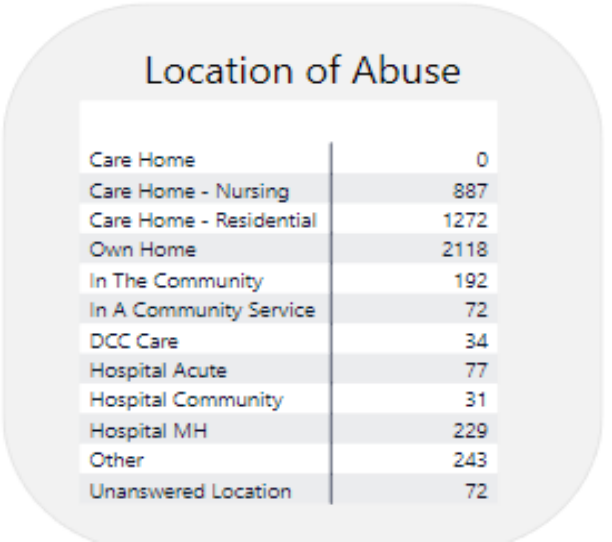
Advocate	Count of Pins
1_No	655
2_Informal	2
3_Mind	22
4_Specialist Advocacy	16
5_Other_Agency	72
Total	**767**

Derbyshire Mind is 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.

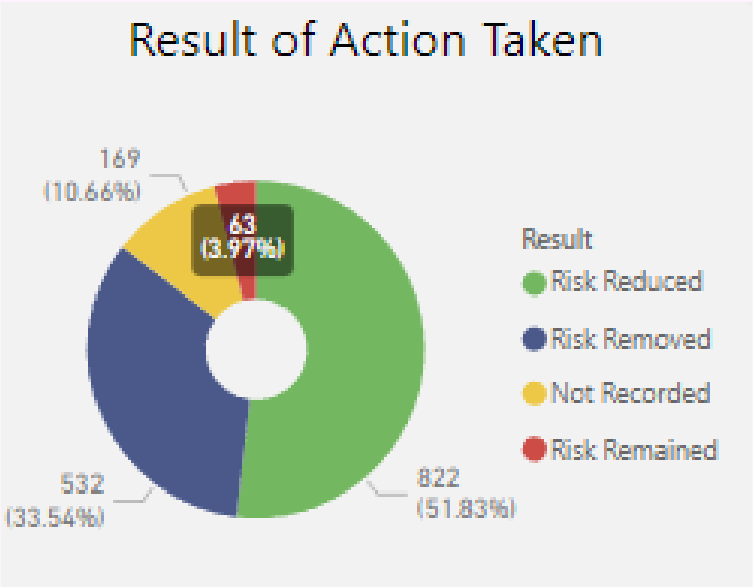
In 655 out of the 767 cases where an adult was recorded as lacking capacity during safeguarding enquiries concluded between 01/04/2022-31/03/20223 (85%), nothing was recorded in the advocacy section of the adult social care safeguarding workflow and it has therefore has to be assumed in the data that an advocate was not in place for these adults. In order to improve the quality of data captured in relation to advocacy provision, an update will be made to the advocacy section of the MOSAIC workflow in April 2023.

Location of abuse



The majority of abuse took place in the adult's own home (2118 cases). Residential and nursing care homes were the second and third most common locations of abuse taking place. It should be noted that more than one location of abuse can be selected for each adult.

Safeguarding Outcomes for adults in Derbyshire



This information is taken from S42 enquiries that were concluded during 2022-2023.

In **87%** of cases, it was recorded that the risk of harm to the adult was completely removed or was reduced.

In **4%** of cases, it was recorded that there remained a risk to the adult at the conclusion of the Safeguarding enquiries.

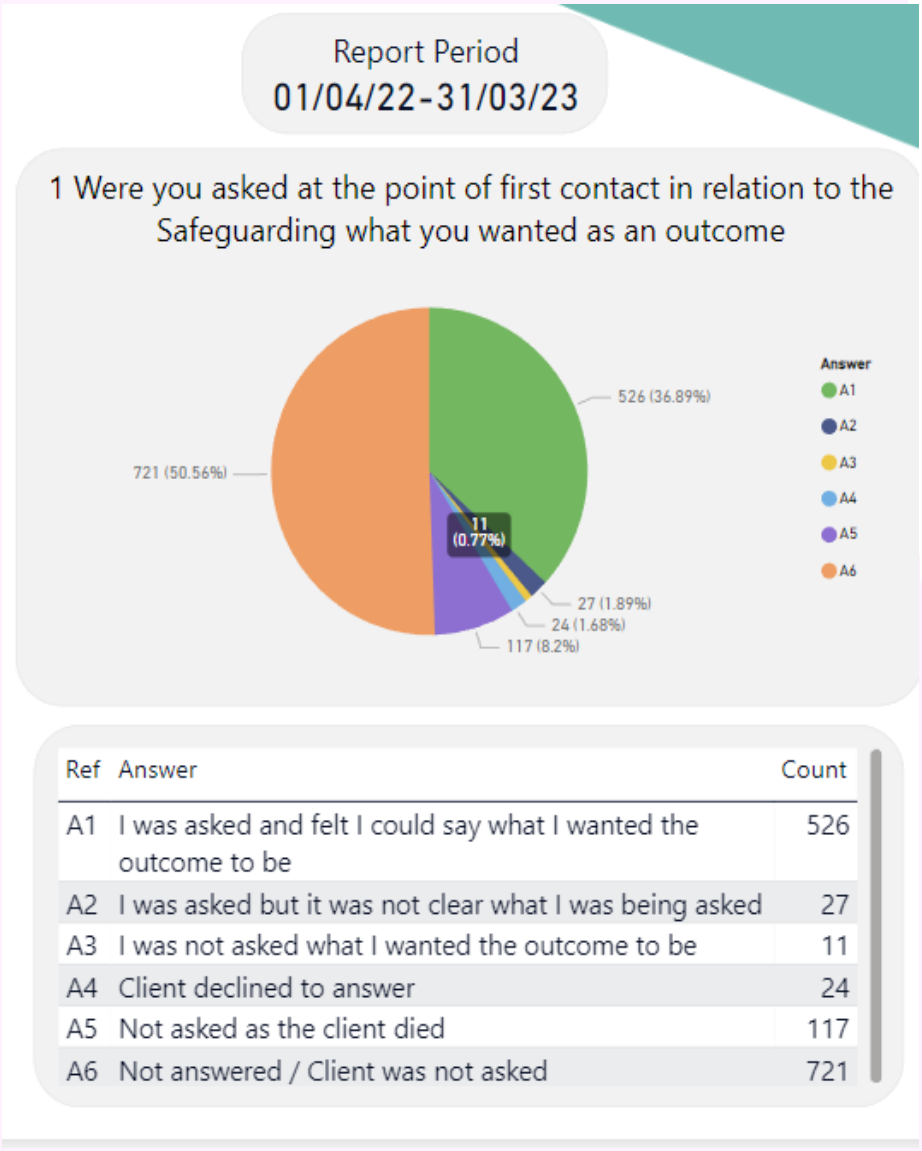
In the remaining 9% of cases there was nothing recorded within this section of the record.

Making Safeguarding Personal

The Care Act 2014 promotes an approach to adult safeguarding that is led by the individual, not by the process. Adult safeguarding support 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.

During 2022-2023 there were **1426** Closure summaries completed for **1193** adults where all or some of the multiple-choice questions were answered. From April 2023 onwards a 'mandatory field' has been added to ensure the completion of the multiple-choice questions for every adult.

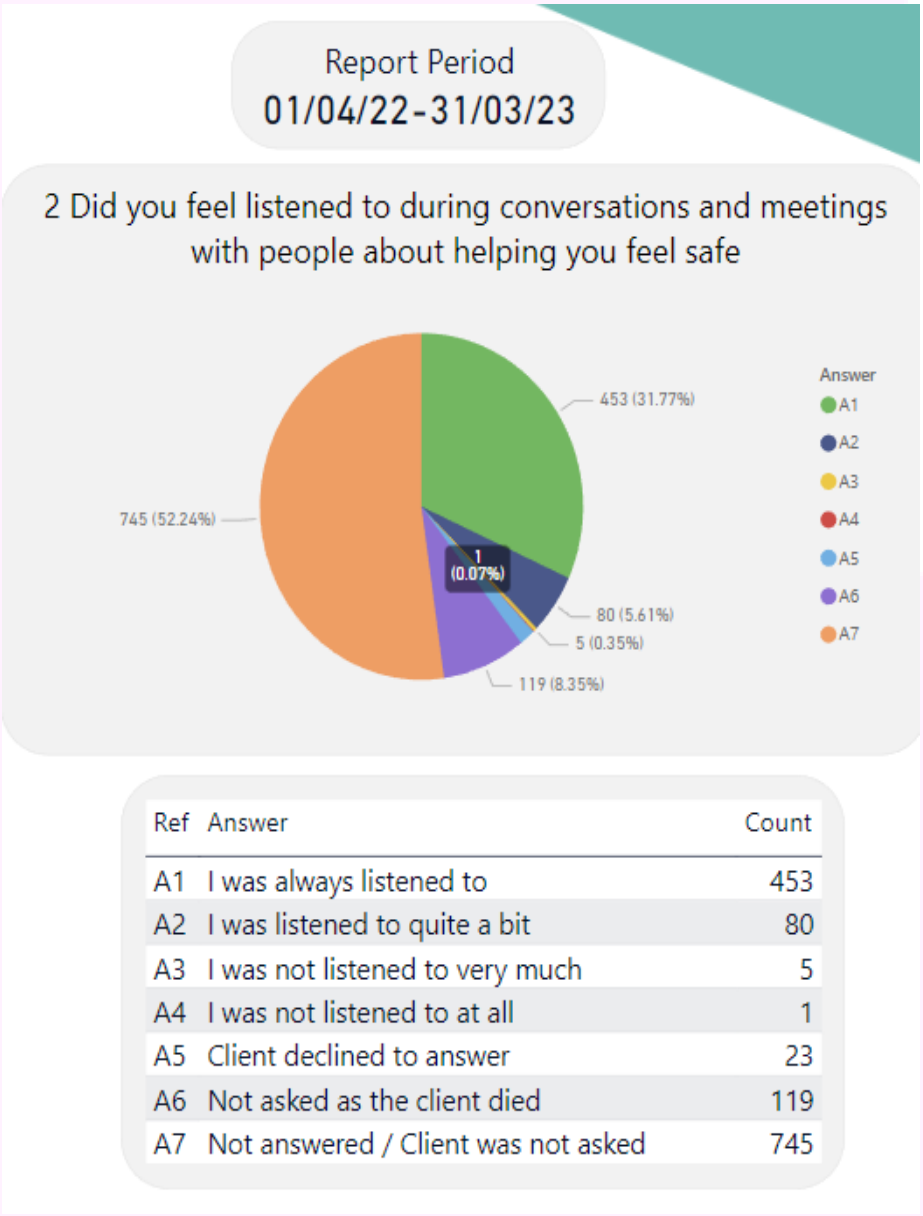


Ref	Answer	Count
A1	I was asked and felt I could say what I wanted the outcome to be	526
A2	I was asked but it was not clear what I was being asked	27
A3	I was not asked what I wanted the outcome to be	11
A4	Client declined to answer	24
A5	Not asked as the client died	117
A6	Not answered / Client was not asked	721

In **60%** of cases an answer to this question was not recorded because the adult had sadly died, declined to answer, or this question was not asked/completed on the Mosaic system. This is the same as last quarter.

Where the adult was asked this question, **93%** said that they were asked about their desired outcomes and felt able to discuss their desired outcomes during the safeguarding process.

11 adults said that they were not asked about what they wanted their outcome to be.



Ref	Answer	Count
A1	I was always listened to	453
A2	I was listened to quite a bit	80
A3	I was not listened to very much	5
A4	I was not listened to at all	1
A5	Client declined to answer	23
A6	Not asked as the client died	119
A7	Not answered / Client was not asked	745

In **62%** of cases there was no answer recorded against this question, the client declined to answer or the question was not asked because the adult had sadly died.

84% of adults who were asked this question and felt able to answer said that they were always listened to or were listened to quite a bit.

5 adults said that they were not listened to very much

1 adult said that they were not listened to at all

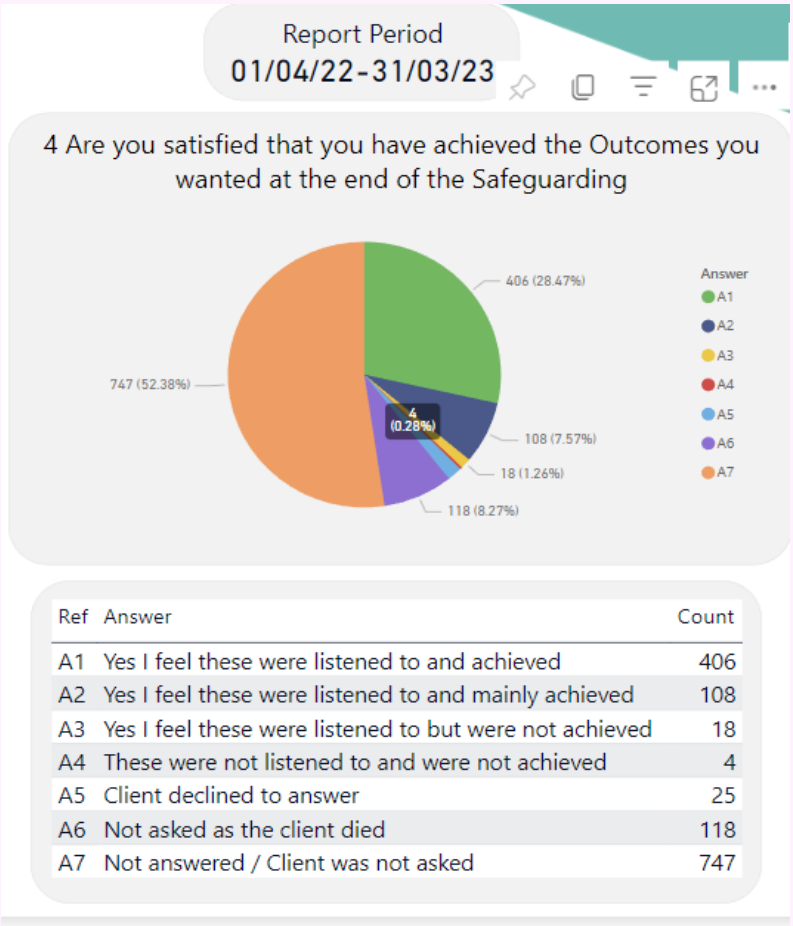
Ref	Answer	Count
A1	I am very happy with the end result	383
A2	I am quite happy with the end result	141
A3	I am not very happy with the end result	13
A4	I am not at all happy with the end result	7
A5	Client declined to answer	27
A6	Not asked as the client died	119
A7	Not answered / Client was not asked	736

In **62%** of cases the adult was not asked this question, declined to answer, or the question could not be asked as the adult had sadly died.

For the adults who were asked this question, **96%** said that they were very happy or quite happy with the end result of what people did to help them keep safe.

13 adults said that they were not very happy with the end result

7 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	406
A2	Yes I feel these were listened to and mainly achieved	108
A3	Yes I feel these were listened to but were not achieved	18
A4	These were not listened to and were not achieved	4
A5	Client declined to answer	25
A6	Not asked as the client died	118
A7	Not answered / Client was not asked	747

In **62%** of cases nothing was recorded against this question, client declined to answer, or this question was not completed because the adult had sadly died.

96% of the adults who were asked this question said that their desired outcomes were listened to and achieved, or mainly achieved.

18 adults said that their desired outcomes were listened to but not achieved

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

Feedback from Adults

The Board has access to qualitative data in a variety of forms including case studies provided by Board partners and direct feedback from adults who have been through the safeguarding process which is sought during DSAB agency audits. This information is being used to inform action plans and to feedback to agencies on positive practice and areas of learning. An example of feedback provided to the Board during 2022-2023 is shown below.

‘James’

Tom Brown, Quality Assurance Senior Practitioner with the Derbyshire Safeguarding Adults Board, visited ‘James’ (not his real name) who had been abused by a family member and received safeguarding support from services in Derbyshire. James gave us permission to share his story.

James is in his 60’s and lives alone. He has a severe mental illness. He was referred to adult social care by his GP due to concerns about family members financially abusing him and using coercion and control. Threats had been made to James and he was scared that the threats would be carried out if he did not give money to his family. James gave away over £10,000 due to these threats.

James explained that the outcome he wanted from the safeguarding process was ‘to feel protected’. James felt that the safeguarding process had been a turning point in his life as he had realised that there were people who cared about him. James attended the initial safeguarding meeting with his advocate. Also in attendance were James’ Social Worker, their Manager, a representative from the Court of Protection, and the police. James decided to set up a Power of Attorney through a Solicitor which helped to stop financial abuse taking place.

James said his relatives still contact him, but he now feels able to say no to their requests for money. He said he has told them how he feels about being badly treated by them. James said his advocate has been particularly helpful in giving him a voice in the safeguarding process. James said, ‘The (safeguarding) process made me feel more secure. I have numbers to contact services if I feel threatened and know they will respond quickly’.

Reports from DSAB Partner Agencies of the 2022-2023

Derbyshire County Council Adult Social Care and Health

2022-2023 has been a busy year for Adult Social Care. There has been a continuation of increased referral rates and complexity of need coupled with challenges to workforce sufficiency both internally, in frontline practitioner roles and our directly delivered services, and in the wider market. To address this, a series of actions and initiatives have been developed and implemented.

A prioritisation tool has been developed and implemented in frontline assessment and review teams to enable consistent prioritisation and improved understanding of the variation in demand and capacity across the county. This has improved risk assessment and management and has informed decision making by the extended leadership team and directorate management team (DMT).

A change project has been implemented to improve the business processes associated with our care hub and brokerage team to improve efficiency, to enable best use of the capacity in our internal short-term reablement service and to enable more efficient transfer to external homecare agencies as required. This has resulted in increased speed at which support at home can be provided by our short-term reablement service and has also resulted in a significant reduction in the number of people waiting for their support to be transferred to external homecare agencies. A redesign of our short-term reablement service is planned for 2023-2024 to ensure sufficient capacity and resilience to meet increasing demand and to enable people with care and support needs to have the support needed to regain, increase and retain their independence. This, along with other preventative services, will enable the council to deliver its Care Act duties to prevent, reduce and delay the development of social care needs.

Adult social care's commissioning and contracts and compliance teams have continued to work hard to maintain the capacity in our adult social care market in 2022-2023. A refreshed market position statement was published this year to signal the need for increased support at home provision across the county with a corresponding reduction in need for residential care. This reflects changing attitudes and wishes of our population which may have been accelerated by the Covid-19 pandemic. This work has included the completion of the market sustainability and improvement work as required by the Department of Health and Social Care (DHSC) which included the fair cost of care exercise. Learning from this indicated that the fees paid by the council for care and support are reflective of the delivery costs. The teams have worked collaboratively with local providers to enable best practice for recruitment and retention to be shared at an event hosted by the Council but delivered collaboratively with providers. Alongside this, investment into the direct payments team has enabled a continuous increase in the number of new people accessing direct payments to purchase the services they require to meet their assessed needs. Short-term direct payments have been an area of innovation in Adult Social Care in this year and have been established and used to good effect to support people to remain well at home with a reduced risk of potential avoidable hospital admission and to enable prompt and safe hospital discharge.

The contracts and compliance team has continued to work collaboratively with the Integrated Care Board (ICB) and Care Quality Commission (CQC) alongside other partners to support continuous improvement in the quality of care delivered in the adult social care market. This includes effective sharing of intelligence and joint decision-making regarding appropriate early intervention and action to support providers. The team 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, and to ensure appropriate action to support people's ongoing safety.

Adult social care has continued to receive a significant volume of inappropriate referrals and partnership action has been taken to reduce these and to improve the quality of referrals, including safeguarding referrals, received. A successful initiative with the police safeguarding

hub has resulted in improved understanding of adult social care's duties and safeguarding thresholds and has improved officers' awareness of and connection with other services within the health and social care system. This has resulted in a substantial reduction in the number of referrals received from the police where no action was indicated for adult social care. This initiative has also increased the percentage of safeguarding referrals made by the police which progress to section 42 enquiries from 20% to 40%. This has been enabled via delivery of joint workshops, co-located working, and review of data with learning shared and acted upon. Refresher workshops are planned and joint working continues.

There was a significant amount of activity completed this year to improve quality in safeguarding practice across adult social care. New safeguarding practice standards were developed and implemented by the principal social worker (PSW) and safeguarding quality assurance team to support best practice. A safeguarding audit programme has also been implemented which provides assurance about the quality of practice and which highlights individual and thematic learning. This enables effective action to be taken to improve quality where indicated. Alongside this, Making Safeguarding Personal (MSP) training has been reviewed and strengthened to support practitioners to deliver MSP and the new training module will be available for practitioners in 2023-2024.

Learning from safeguarding audits, local and national data highlights that DCC has a continued need to improve MSP and to improve practitioner recording of this. The workflow for practitioners has been reviewed and strengthened to enable better recording and, to complement this, recording training has been commissioned for all frontline practitioners and managers. The revised workflow will be live from April 2023 and the recording training will start in May 2023 and will run until October 2023. Similarly, local and national data sets also highlight the need for adult social care to improve recording of advocacy in relation to safeguarding activity. Briefing sessions and a revision to the safeguarding workflow have been designed and facilitated to improve recording. Performance will continue to be closely monitored by senior officers at a departmental level to assess whether these actions have resulted in performance

improvement.

The Adult Social Care Quality Assurance Board has continued to meet regularly to monitor quality and performance and the delivery and impact of quality improvement work being completed across the department. Alongside this, adult social care has commenced preparation for CQC assurance with the expected commencement in April 2023 of inspections of councils' delivery of their duties under part one of the Care Act 2014. The council's self-assessment has confirmed the directorate's existing priorities which, for the "Safe Services" theme, include improved performance in delivery of making safeguarding personal, increased use and recording of advocacy, action to reduce caseloads, effective management of waiting lists, and action to reduce the waiting list for Deprivation of Liberty Safeguards (DOLS).

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. The department is also a member of the regional ADASS Safeguarding Community of Practice and contributes to, and benefits from, regional shared learning ensuring that learning is brought back and acted upon to improve the quality of our safeguarding practice. A focused piece of assurance work on Safeguarding Adult Reviews (SARs) was completed in 2022-2023 by community of practice members. A report summarising the learning from this work, and the associated recommendations is tabled for discussion regionally and at a local level within a future DSAB meeting.

Derbyshire Constabulary

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

Performance in this area is governed at the highest levels within the organization, through the Vulnerability Governance and Performance Assurance Boards both chaired by members of the Police Executive Team. These meetings are supported by local performance and tasking groups and scrutiny panels, which focus on quantitative and qualitative data.

Derbyshire has made significant improvements to its operating model in 2023 to achieve its mission of protecting the vulnerable. The Safeguarding and Coordination Hub (SCH), established in 2022 has brought expertise from across the organisation to a combination of centralized and locally based teams within MASH and starting Point partnership arrangements. To dedicated Rape and Serious Sexual Violence, High Risk Domestic abuse and Adult and Child exploitation teams.

In January 2023 Derbyshire Constabulary aligned Integrated Offender Management (IOM) with Management of Sexual & Violent Offenders (MOSOVO) and Multi Agency Public Protection Arrangements (MAPPA) arrangements and saw the launch of the new Serial and Repeat Offender and Civil Orders Teams, to improve how we manage offenders and safeguard the public. These teams will focus on prevention rather than 'picking up the pieces' when things have gone wrong.

The Constabulary commenced its force wide Vulnerability Training Program in November 2022, delivering 8 individual modules concluding March 2024. This training is being delivered to all front-line staff giving them the skills to spot the early signs of vulnerability, Capture the Victim's

Voice and how to effectively safeguard vulnerable people.

The Constabulary has recently adopted 'Quality Assurance Thematic Testing' (QATT) to improve how we deal with Victims, Protect the vulnerable, manage offenders and improve the quality of our investigations. Already data being received has highlighted good practice, but also areas the force wants to focus on within the coming months.

The investment made during 2022 will continue for 2023 – 2024, in a concerted effort to reduce harm and protect vulnerable people.

Derby and Derbyshire Integrated Care Board (DDICB)

NHS
Derby and Derbyshire
Integrated Care Board

The Derby & Derbyshire Integrated Care Board has fulfilled their statutory safeguarding adults duty by working closely with key partner agencies to enhance the safety of adults at risk from abusive behaviour and practice.

The ICB have continued to support the work of the Derbyshire Safeguarding Adult Board through active membership of Board meetings and their supporting networks. The work of the ICBs safeguarding adult team has positive support from the Chief Nurse as the Executive lead and the Deputy Chief Nurse.

The ICB enjoy close working relationships across the wider NHS community. Regular meetings with care providers in conjunction with the implementation of the Safeguarding Adult Assurance Framework (SAAF) demonstrated that a great deal of work had been undertaken to reduce the risk of harm and promote awareness of safeguarding initiatives. Particular emphasis was placed upon Making Safeguarding Personal with efforts being made to include patients throughout the safeguarding process. The case file audit programme continued to good effect

and provided insight into operational challenges and outcomes. Case management was of a good standard.

The team also participated in a number of Safeguarding Adult and Domestic Homicide Reviews with learning points from these incorporated into the content of our training offer.

Due to Covid our staff training programme was facilitated online via the use of Teams. Attendance rates were once again positive and the events were well received.

The ICB also contribute to a wide range of activities relating to patient safety. These include the prevention of radicalisation to support terrorism, domestic abuse, public protection, the Mental Capacity Act, Human Trafficking, and serious violence duty.

Looking forward the ICB will continue to be vigilant in light of the cost of living crisis and also the pressures upon public sector finances. Both these national challenges are almost guaranteed to impact negatively upon adult at risk. Self-neglect and hoarding concerns have risen sharply as community services try to meet demand.

A positive and productive year. There is strong evidence of progress with much done although there remains much to do.

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 strategic threat and risk process 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 eight thematic boards which in turn will direct community safety activity over the coming years.

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

Derbyshire County Council's CSU delivers a comprehensive programme of training for both Derbyshire County Council staff and multi-agency partners working within Derbyshire. During 2022 to 2023, 8,279 delegates completed awareness raising webinars and eLearning modules on domestic and sexual abuse, honour-based violence, modern slavery, hate crime, cybercrime and online harms, criminal exploitation, anti-social behaviour, substance misuse and counter-terrorism (Prevent).

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

The Domestic Abuse Act 2021 created a duty to provide support in safe accommodation for victims of domestic abuse and their children. Within Derbyshire we have commissioned emergency accommodation for many years, but the funding provided to meet the new duty has enabled us to increase our provision.

Derbyshire County Council's Community Safety Unit Chair the Derby and Derbyshire Hate Crime Network, a quarterly forum where multi-agency partners can co-ordinate a joint approach to raise awareness of and tackle hate crime. In December 2022, the Network became a formal sub-group of the Neighbourhood Crime and Anti-Social Behaviour Thematic Board. The Network helps to promote hate crime training and awareness raising events, including National Hate Crime Awareness Week held in October 2022 and also comes together develop countywide processes and share best practice in tackling hate crime and supporting

victims. Using the skills and knowledge of the practitioners in Derbyshire we also collaborate to support communities impacted by hate crime. Commissioned by Derbyshire County Council, Derby City Council and Derbyshire Police, Stop Hate UK is a national anti-hate organisation which provides a 24-hour third-party hate crime reporting service across Derby and Derbyshire. The service is designed to offer support for victims, witnesses and third parties relating to all types of hate crime including alternative subculture and gender / misogyny. During 2022 to 23, 43% of contacts were received outside of regular office hours and the average duration of a call was 19 minutes. The types of incident most commonly reported were 'threatening behaviour' and 'verbal abuse' and the most commonly reported hate motivations were related to 'disability' and 'race'.

Derbyshire County Council along with Derby City Council jointly commissioned the Hope for Justice charity to provide Pre-NRM support and care for potential victims of modern slavery. The service provides up to three working days support, accommodation and advice to assist potential adult victims of exploitation to make an informed decision about their future and whether they wish to enter the National Referral Mechanism service which is managed by the Salvation Army under their Victims Care Contract for victims of human trafficking and modern slavery

The Council is hosting a pan-Derbyshire post funded by NHS England to lead work on Sexual Abuse and Assault. The post will work with partners to further develop prevention activity and specialist provision to support survivors to cope and recover.

The Resettlement Team work jointly with the District and Borough councils to deliver refugee resettlement schemes such as the UK Resettlement scheme (formerly the Vulnerable Persons Resettlement scheme), the Afghan Relocations and Assistance Program and the Afghan Citizens Resettlement Scheme. These schemes provide a safe passage to the UK for those fleeing conflict in countries such as Syria, Afghanistan and Iraq. To date the County has welcomed 173 people through these schemes. The team works with partner organisations to ensure refugees have access to housing, health, employment, training and education as well as other mainstream support. A specialist keyworker service ensures that refugees have the right support to re-build their lives in their new communities. Since 2022, the remit of the

team has expanded to include the Homes for Ukraine scheme. To date Derbyshire has welcomed over 1300 Ukrainian guests under the Homes for Ukraine scheme.

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 2022/2023 Derbyshire Mind received and supported 68 Safeguarding referrals.

DHU Healthcare

DHU Health Care is an active member of both the Derbyshire and Derby Safeguarding Adult Boards and has continued to contribute to the Board's Strategic key strategic objectives. Throughout 2022/23 DHU has proactively contributed to the boards supporting subgroups including the subgroups for Quality Assurance, Operational and Leadership, Multi-agency case

file audits & Performance and Improvement.

To support the delivery of the safeguarding agenda within DHU there is a clear governance and accountability framework in place. The framework provides assurance to our commissioners that Safeguarding is a priority throughout the organisation.

The DHU Safeguarding Team advocates making safeguarding personal. This can be demonstrated through the provision of advice, support and supervision for staff and the bespoke 'think family' training provided by the team. The bespoke training has been developed to reflect our service provision whilst meeting guidance outlined within the intercollegiate documents. The training is enhanced by a suite of easy read factsheets on our internal intranet, this is inclusive of information regarding MSP.

DHU Health Care demonstrates safeguarding compliance with completion of the Safeguarding Adult Assurance Framework (SAAF) and Section 11 Audit. These quality assurance assessments provide opportunity to demonstrate good practice and ensures DHU are compliant in all aspects of safeguarding against specific key standards of Safeguarding, inclusive of the SAB's key strategic objectives.

Safeguarding sits within the portfolio of Director of Nursing & Quality and forms part of the Quality Strategy. There are established links from the frontline to Board of Directors with clear reporting mechanisms in place via structured internal governance committees.

The DHU safeguarding leads are active members of the DHU Health Care Patient & Public Involvement Committee & the Clinical Quality and Patient Safety Committee ensuring Safeguarding is a consideration with all agenda items.

DHU have a robust referral system in place to refer safeguarding and low-level care concerns for adults with care and support requirements. These early help referrals provide opportunity

to ensure that an individual receives the right support, thus reducing risk by enabling access to appropriate support. This demonstrates DHU commitment to interagency working to enable people in Derby & Derbyshire to live a life free from fear, harm and abuse.

DHU contributes to Domestic homicide reviews and Safeguarding adult reviews. Any learning identified within these statutory reviews are disseminated throughout the organization to promote and aide understanding and consequently improvements to service provision.

DHU Healthcare provides numerous contracts consisting of Urgent Care and Out of Hours services across Derbyshire Leicester, Leicestershire and Rutland and Northamptonshire with the recent addition of Bassetlaw Urgent Care from May 1st 2023.

The NHS111 contract for East Midlands has recently seen the addition of the West Midlands from 1 March 2023. Providing services across such a large geographical area provides opportunities to share best practice and disseminate lessons learnt across regional borders.

Diocese of Derby- Church of England

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

Our safeguarding service has continued to be busy with churches resuming their full range of

activities for all ages. We continue to support our 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 continued to be strengthened with a particular focus on the delivery of domestic abuse awareness training. We have embedded our support for our volunteer Parish Safeguarding Officers who support our work in individual parishes.

Our work continues to be overseen by our multi-agency Diocesan Safeguarding Advisory Panel. An executive summary of our Past Cases review has been published and we have made good progress in addressing the recommendations made.

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. We have also been working with partners in mental health services to ensure that appropriate signposting is provided to those who need it.

Derbyshire Fire and Rescue Service

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

children.

The Service has a Strategic Manager who has overall responsibility for safeguarding supported by three safeguarding officers who manage the day to day running of the safeguarding function.

This year DFRS have referred 11 adults to the safeguarding process and 7 children. Alongside this we have supported 2,012 vulnerable adult referrals and 262 vulnerable children's referrals. All of these have been managed via a multi-agency setting including the VARM process and Initial Enquiry meetings. We also continue to support the MARAC, Domestic Homicide Reviews and Serious Case Reviews.

Over the past year DFRS has worked towards the National Fire Standards for Safeguarding and will shortly be sharing these with the Derby and Derbyshire Safeguarding Adults and Children's board for scrutiny. We have also embarked on an ambitious program to deliver Safeguarding Refresher training to our 800 employees ensuring that our Response, Protection and Protection Teams are up to date with legislation, continue to recognise signs of abuse and to ensure all referrals are personal to the person at risk.

We continue to promote our CHARLIE and FRANCES schemes with our partner agencies and have worked closely with Derbyshire Constabulary this year on a briefing sheet to enable our Community Safety Officers to spot signs of abuse and criminal activity that could give the Police vital intelligence around safeguarding. Similarly, we have improved our referral process into the Risk and Referral Unit, so we have up to date safeguarding information prior to conducting any visits.

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

Derbyshire Fire and Rescue Service continue to have a long standing Service Priority to making Derbyshire safer together with our partners and other agencies. This commitment legislatively 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 eventualities appropriately.

Derbyshire Community Health Services NHS Foundation Trust (DCHSFT)

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.
DCHS is a proactive member of both the Derby SAB and the Derbyshire SAB with attendance at the Board Meetings and sub-groups. The DCHS Named Nurse Safeguarding Adults, chairs the Derbyshire SAB Multi-agency Audit Group.

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 Integrated Care Board regarding safeguarding data and activity which includes 'making safeguarding personal', quality assurance, Board/sub-group

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.

The audit schedule for 2022-2023 included the quality of referrals to adult social care, including making safeguarding personal and repeat audits for safeguarding supervision and Deprivation of Liberty Safeguards.

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 radicalization, as part of information sharing across agencies and includes contributing to safety plans; to reduce risk and enable access to appropriate support.

Learning from Safeguarding Adult Reviews, Domestic Homicide Reviews, Fatal Fires and Child Safeguarding Practice Reviews is actioned and disseminated throughout DCHS, to support minimizing harm and abuse.

Derbyshire Health Care NHS Foundation Trust

Making Safeguarding Personal

We continue to work with our clinical teams to ensure that safeguarding is the 'golden thread' running through our Organisation.

We continue to apply person-centered safeguarding responses. We do this by our attendance at Trust complex case discussions which helps us respond with an approach that enables safeguarding to be done with and not to, people. We help our staff focus on meaningful improvement to people's circumstances that enables practitioners to ensure service users feel they are the focus of the safeguarding and are empowered within the process.
We support all staff to safeguarding themselves and the people they work with.

Prevention

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

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 fully involved in the VARM process and continue to encourage staff to consider VARM within complex cases.

Sexual safety is a Trust priority, and we are currently working with our acute inpatient wards and community to continue their reporting of incidents. A policy/protocol will be produced to support this. Training has been implemented within the trust through the Icare programme to support greater understanding around sexual safety and relationship boundaries.

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. The Safeguarding Unit prepare a monthly report that is issued to all Clinical Operational Assurance Team (COAT) meetings for the Trust which includes Specialist, Children's, Neighborhood, Forensic and Campus Divisions. The leads provide organisational scrutiny, guidance and learning and includes points for action for the Divisions representatives as well as points for information. Both Safeguarding Operational Groups can escalate matters that require executive or committee consideration / inclusion in the Trust Risk Register but, equally, can escalate good news stories, lessons learned to share across the Organisation.
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. The Safeguarding of all our patients, both adults and children remains a high priority for DHCFT. Safeguarding and 'Think Family' is the 'Golden Thread' throughout the care standards and practice reviews and analysis provided.

DHCFT are active and visible members of Safeguarding Adult Boards and the associated subgroups, as well as other interagency public protection meetings including MAPPA and Channel. Effective safeguarding relies on strong partnerships within the Trust and with other

agencies and the Safeguarding Boards in a culture of consistent, respectful cooperation. The Trust has continued to be an active partner in Domestic Homicide Reviews and Safeguarding Adult Reviews when appropriate.

University Hospitals of Derby and Burton

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

The UHDB Safeguarding Adult Team provides advice and support for a wide range of safeguarding issues relating to adults who may be at risk of abuse or neglect either deliberately or by acts of omission. They aim to attend the wards when a referral is received, meet the patient, and discuss the referral with them – including the issue of desired outcome – advise staff, liaise with social care and other relevant agencies / professionals, attending professionals' meetings where safeguarding issues are a factor and ensuring effective multi-agency working and discharge planning takes place. The team also responds to Initial Enquiries (IEs) from several Local Authorities.

UHDB staff made 791 referrals to adult social care across Derby, Derbyshire, and Staffordshire in 2022-23, a decrease of approximately 5.5% from 2021-22. We have responded to 82, section 42 enquiries in the last year. This is the highest number ever received in a year by the Trust. Themes commonly include information sharing concerns across agencies regarding medication or mobility aids for example and discharge issues.

The Team recognizes that there is further work to be done on Domestic and Sexual Violence across the Trust in terms of staff training and support to HR. Policy development in the light of the 2022 Statutory Guidance has taken place and a dedicated post is being developed.

We undertake a number of audits;

- Audit of Initial Enquiries identified a significantly disproportionate number of IEs received from a LA with 574 requests received in contrast to 8 from 2 other LAs. We raised concerns in the MASH strategic group, and this has resulted in significantly fewer, and more appropriate s42s being received thereafter.
- An External Assurance Audit of MCA performance was completed in 2022. Limited assurance was identified and required actions relating to issues already known at the time and having an implementation plan in place. All actions are complete. Mental Capacity Act quarterly audits have been reinstated with the implementation of MCA Educators – a team of 3.6 wte educators working on the wards with clinical teams in "real time." The audit demonstrates improvements in practice.

The Trust participated in 8 Domestic Homicide Review scoping requests and 6 Safeguarding Adult review scoping requests. UHDB was not required to undertake an individual management review in the light of these.

Training is a significant issue for the Trust with high numbers of clinical staff facing significant post-pandemic pressures. Training compliance across the Trust is as follows; Level 1 89%, Level 2 80%, and level 3 (which includes level 1 & 2 competences) is 80% and MCA compliance is 83%.

Chesterfield Royal Hospital NHS Foundation Trust

Chesterfield Royal hospital continues to prioritise the delivery of the safeguarding agenda as part of everyday business. The agenda continues to grow year on year with engagement from board to frontline. Executive leadership for the agenda sits under the Chief Nurse with strategic and operational leadership provided by the Deputy Chief Nurse and the Head of Safeguarding.

There has been a full review of the safeguarding suite of policies ensuring that they are updated and in line with the Care Act and the Derbyshire and Derby Multi Agency policies and Procedures. The Prevent processes sits within the adult safeguarding policy 61recognizing the close links between the agendas and prevention, and the Trust continues to maintain compliance with the government guidance Building Partnerships, Staying Safe.

The Trust have continued to deliver the three year rolling education strategy in line with the Safeguarding Adult Roles and Competencies for Healthcare Staff Intercollegiate document (2019), compliance percentages can be seen below and these are monitored through Trust governance procedures.

	2020-2021	2021-2022	2022-2023
Level 1/2	88.6%	76.5%	90%
Level 3	82%	78%	69%
Level 4	100%	100%	100%
Prevent	87.5%	83%	91%
MCA education	91%	71%	89%

The work within the adult safeguarding team remains consistent and has returned to pre-pandemic levels, trust submitted 279 adult referrals to the local authority however the team carried out work on 1069 active cases over the last financial year as a combined workload of CRHFT referrals, requests to contribute to other Section 42 investigations, Section 42 referrals against the Trust and MCA and DoLS with over 1933 contacts.

During 2022-2023 there have been 38 Section 42 safeguarding referrals raised against the Trust of which 5 were challenged and not accepted by the Trust as not meeting threshold, this was agreed by the local authority. All others were processed through the Section 42 arrangements the Trust have in place, learning is shared with social care, families and disseminated through the organisation.

During 2022-2023 there have been a number of key achievements in relation to the safeguarding and complex needs service including

- ✓ Active involvement in the Local Safeguarding Adult Boards (LSAB), Local Safeguarding Children Partnership, Channel Panel and Multi-Agency Risk Assessment Conference (MARAC)
- ✓ Structure review of the team
- ✓ Expansion of the team to include alcohol and substance misuse midwifery services
- ✓ Review and creation of safeguarding and complex needs policies
- ✓ Ensuring the Trust maintain statutory and legislative requirements
- ✓ Delivery of MCA master classes
- ✓ Developed a placement for medical students

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. The referral rates have started to plateau post pandemic levels, with an increase in the complexity in the management of the safeguarding cases. There has been an increase in support required for patients with complex needs and a requirement to source specialist services for patient with behaviours that challenge. The team have adapted to the change in presentation of the patients that are being seen by the service remaining resilient throughout the year, ensuring that the most vulnerable in our society were protected by the Trust maintaining 62ongoing services and developing new areas of service delivery.

Probation Service, Derbyshire

Since unification there has been a renewed emphasis with our operational staff on the importance of safeguarding and this is reflected within the unification mandatory training schedule. Safeguarding discussions are also an integral feature of supervision sessions between the probation practitioner and the senior probation officer. Alongside, this our MAPPA protocols mandate consideration of Adult safeguarding issues within all formal meetings and our assessment tool OASys also gives specific consideration to adult safeguarding issues.

There has been work undertaken centrally to support the adaption of licence conditions to support people with learning difficulties to understand the terms of their supervision. We also 63have the Personality Disorder Project which supports us with a plan of best practice to support the individual to engage and to manage any barriers which may be problematic in this process based on the individuals personal circumstances/needs/vulnerabilities.

All of the Assurance and QA tools used in the Probation Service include guidance and require reference and assessment of Adult Safeguarding issues. All high risk of serious harm assessments are quality assured and counter signed by a Senior Probation Officer, all assessments identifying an individual as posing a very high risk of harm are countersigned by the Head of service. Management oversight of cases of interest/safeguarding concerns/MAPPA are discussed in supervision sessions with staff and we promote the Touchpoints Model which is guidance for managers on where case discussion is required.

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. 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. The pandemic has impacted on our ability to complete case file audits as standard. Now we are returning to offices these have resumed.

Attendance at Board Level – Head/Deputy Head
Attendance at Safeguarding Adult Reviews – Deputy Head
Attendance at sub-groups – Deputy Head/Senior Probation Officer (Safeguarding Lead)
We have a local lead and a specialist divisional team working with TACT and Prevent cases.

Safeguarding is a feature of all of our assessments on PoPs. Our organisation 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 organisational 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 completes 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 organisational 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 NPS 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.

HMP/YOI Foston Hall

HMP Foston Hall remains committed to making women safer within our community. We encourage and promote a holistic approach to safeguarding, ensuring all women have a voice and their individual needs are addressed. Our 'whole prison approach' towards safeguarding acts as an effective means that best supports safety and non-violent attitudes and behaviours.

Our Safeguarding Committee continues to realise our 'whole-prison approach, by ensuring accountability and ownership by all front line and support staff who work and visit HMP/YOI Foston Hall to conduct their day-to-day duties. We continue to ensure that all staff are given the necessary skills to identify and support vulnerable women wherever they are in their custodial journey. Along, with ensuring through a robust assurance process that our women and their needs are at the heart of everything we do.

In order to ensure we maintain a proactive approach to safeguarding we will

- Continue to identify and provide up to date and relevant training for all who work with the women at HMP/YOI Foston Hall.
- Continue to use effective evidence-based practice that puts our women at its heart.
- Ensure legitimate use of all available tools, such as the Incentives Policy Framework (IPF) & the Challenge, Support & Intervention Process (CSIP) to encouraging pro-social behaviour whilst challenging negative responses.
- Ensure effective partnership working with all agencies including Social Care, Primary & Secondary Health Care Services, Mental Health, and Mother & Baby Services.
- Continue to maintain a decent, and respectful environment that promotes and supports a culture of safety and continued moral legitimacy.

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 2022/2023, EMAS responded to 955,203 incidents emergency and urgent calls (compared to 990,825 in 2021/222). EMAS staff recognised and responded to safeguarding and or care concerns in 4.1% of these responses. This equates to 39,592 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 2022, 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. Workbook,
3. eLearning package,
4. Reflective supervision annually through the appraisal process to meet level three requirements.

All frontline staff receive face to face education on clinical induction and all EOC staff receive face to face training during AMPDS training. Staff in support services receive Level 1 education on induction and a copy of the EMAS education booklet electronically. The Safeguarding Team continue to support education colleagues to deliver face to face safeguarding training to direct entry technicians, ECA to technician training, ASC training and to new EMDS. During 2022-2023 the team delivered over 250 hours face to face training. Due to the small size of the team and increase in demand on our team as well as increase in recruitment it is not sustainable for the leads to deliver all new starter safeguarding training. Support has been requested from the Clinical Education Team. During Quarter 4, 2022-2023 the leads have provided Train the Trainer session to the CET with a view to them delivering the safeguarding training to new starters during 2023-2024. During 2022-2023, due to the ongoing implications of unprecedented demand on the service, engagement with training during 2022-2023 has been impacted. The Safeguarding brochure which was due to be issued to all staff this has been deferred until 2023-2024.

In addition, the following bespoke training packages have also been delivered face to face:

- Women's Aid was commissioned to ensure all operational senior managers and Human Resource Business Partners (HRPB) can offer support to staff experiencing Domestic Abuse. Providing guidance on what senior managers need to know to support survivors in their remit as employers.

• Level 3 safeguarding training to all Specialist Paramedics.
• Level 3 Safeguarding training to all Clinical Assessment Team members.

During 2022- 2023, Learning from Events (LFE) sessions have continued to be delivered, the sessions are 45 minutes long and are facilitated by an expert in the topic area. The sessions provide rapid learning from things that go well as well as things that didn't go as well. The LFE sessions are a collaboration between all directorates within the Trust and are accessible to every staff member. The format of the event is on a virtual platform.

During 2022-2023 the Adult Safeguarding Lead delivered a session on Adult Safeguarding. The session was co-delivered by an external speaker from Derbyshire Adult Social Care. The focus of the session was Making Safeguarding Personal, Consent and referral quality. The Child and Young Person Safeguarding Lead has also developed a session on child safeguarding with a particular focus on unexpected child death which is due to be delivered during 2023-2024. The team intend to continue to use this platform to promote the safeguarding agenda. The Child and Young Person Lead has continued to support multi-agency CDOP training in Nottinghamshire and Leicestershire which is recognised as good multi-agency working. During 2023-2024, the team will be issuing all staff with an Educational Brochure that covers three hours training. The content of the brochure incorporates Training Needs identified in both intercollegiate documents, Key Skills for health as well as learning from reviews and local audits.

One area that is of focus across the safeguarding agenda is exercising professional curiosity and documenting concerns appropriately. These issues will feature in the audit plan for 2023-2024 as well as incorporating audit of knowledge around the recently introduced pathways for illicit drug and alcohol support services and the Soldiers', Sailors', and Airmen's Families Association (SSAFA) veteran's pathway.

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 (SAAF) 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 last SAAF 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.

Demands on capacity across EMAS and within the Safeguarding Team unfortunately dictated that audits were not fully completed in 2022-2023. Audits were carried out in Nottingham, Derby, Northamptonshire and with the Clinical Assessment Team, (CAT).
The audit plan had identified key areas for review taken from learning found from the statutory reviews completed, issues raised via external partners, and from referrals raised with the

Safeguarding Leads for quality assurance via PALS or the SIAs. These included:

1. Unwell capacitous adult with care and support needs refusing transfer to hospital,
2. Process for raising immediate referrals,
3. Under 18 intoxicated in a public space
4. Domestic abuse concerns, specifically around information required in referral,
5. Homeless adult – threshold for referral,
6. Child with poor prognosis,
7. Adult living in poor conditions with fire risks,
8. Unresponsive adult following illicit drug use,
9. Mental Health and intentional overdose of an under 18,
10. Disclosure of rape by an adult with capacity and no care or support needs.

Across the frontline crews, 41 audits were carried out. Overall, the results were positive, with no staff members receiving a 'fail' resulting in escalation to division and 78.8% passing and the remaining 21.2% passing following prompting by the Safeguarding Leads completing the audit. Crews were most confident in their response to the question regarding an intentional overdose taken by an under 18 with 100% passing this question, the question receiving the lowest pass rate was for the adult disclosing rape with no care and support needs, with 44% of respondents requiring prompting to pass.

A key area of identified learning for EMAS is around taking full details when Domestic Abuse is disclosed, 73% of respondents passed this question, with the remaining 27% requiring some prompting. Audits were carried out with 12 clinicians from the CAT, the questions asked were adapted to consider learning identified throughout the previous year from referrals raised by the CAT identified via PALS or the SIAs and from external reviews.

Again, there was a high majority of positive responses with 98% of respondents passing without prompting. The question that required the most prompting was around the health care professional allegedly acting outside of their scope of practice, with 33% requiring support with this question. The questions that related to mental health concerns for the under 18 and adult, domestic abuse, bruising in non-mobile babies, adult with alcohol dependency and Termination of Pregnancy all had 100% pass rate.

While the numbers of audits completed are low, these positive audit results reflect the significant amount of training and communications facilitated by the Safeguarding Team across frontline crews and the CAT. Due to the limited numbers carried out, it is likely that audit questions for 2023-2024 will be modified slightly, but themes by and large will remain the same. One area that is of focus across the safeguarding agenda is exercising professional curiosity and documenting concerns appropriately. These issues will feature in the audit plan for 2023-2024 as well as incorporating audit of knowledge around the recently introduced pathways for illicit drug and alcohol support services and the Soldiers', Sailors', and Airmen's Families Association (SSAFA) veteran's pathway.

The 2023-2024 face to face audit programme will recommence once the Adult Safeguarding Lead is recruited and confident in post which is likely to be Autumn 2023. The importance of auditing safeguarding knowledge is recognised by the Safeguarding Team, and due to two consecutive years where audits have not been completed in full due to constraints from Covid-19 and demands on organisational and team capacity this will be a priority on the workplan for 2023-2024 and it is anticipated that the divisional management teams will continue to support this.

All EMAS staff remain engaged with the agenda and the Safeguarding Team are looking forward to the new financial year. It is a priority that the Safeguarding Team to continue to develop and maintain the engagement of staff, rise to the challenge of continued service improvement and ensuring that safeguarding remains an integral part of all service delivery. There is ongoing work required to ensure that the learning regarding the safeguarding agenda and quality of referrals is embedded. The aim for the 2023-2024 work plan (see appendix three) continues to strengthen the current agenda, adapting to the ever-changing landscape of health and social care alongside the needs of EMAS as an organisation. The safeguarding work plan is fluid and there is recognition that due to unprecedented demand some planned work for 2022-2023 has been carried over. Additional work may also be added to the plan in line with national learning. The work plan will be adapted should the needs of the service require the Safeguarding Team to support in additional agendas.

Concluding Statement: DSAB Service Manager

Thank you for taking the time to read our annual report for 2022-2023. The achievements highlighted in this report are a joint effort from our Board partners and our DSAB Board business team.

During 2022-2023 we benefited from a having a senior practitioner post for the Board. This was a 12 month temporary post to enable the Board to enhance its quality assurance processes and activity. I would like to thank the postholder, Tom Brown, as his work has given the Board a better understanding of themes and trends in relation to adult safeguarding in Derbyshire. It has also enabled us to improve our understanding of safeguarding outcomes from the perspective of adults who have been supported via our services and we will continue to benefit from this feedback in future years.

At our recent Board development session, we agreed to explore ways for the Derbyshire and Derby City Safeguarding Adults Boards to become more closely aligned. With that in mind it was decided that both Boards would continue to work to the same three strategic priorities of Making Safeguarding Personal, Quality Assurance and Prevention for 2023-2024 and further discussions are underway around how the two Boards can work together in the future.

As Andy Searle said in his introduction, we received over 5000 safeguarding adult referrals during 2022-2023. That is over 5000 opportunities for services to work together to improve the lives of people in our County. This annual report shows that a lot of positive work is taking place but we must take every opportunity to learn from each interaction so that we can continue to improve the way we work together to safeguard adults in Derbyshire.

Natalie Gee
Service Manager| Derbyshire Safeguarding Adult Board

Photograph of DSAB Board business team 2022-2023 (Left to Right: Paul Joyce, Adele Crapper, Tom Brown and Natalie Gee)

"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"

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 or format, please contact ***DerbyshireSAB@derbyshire.gov.uk***

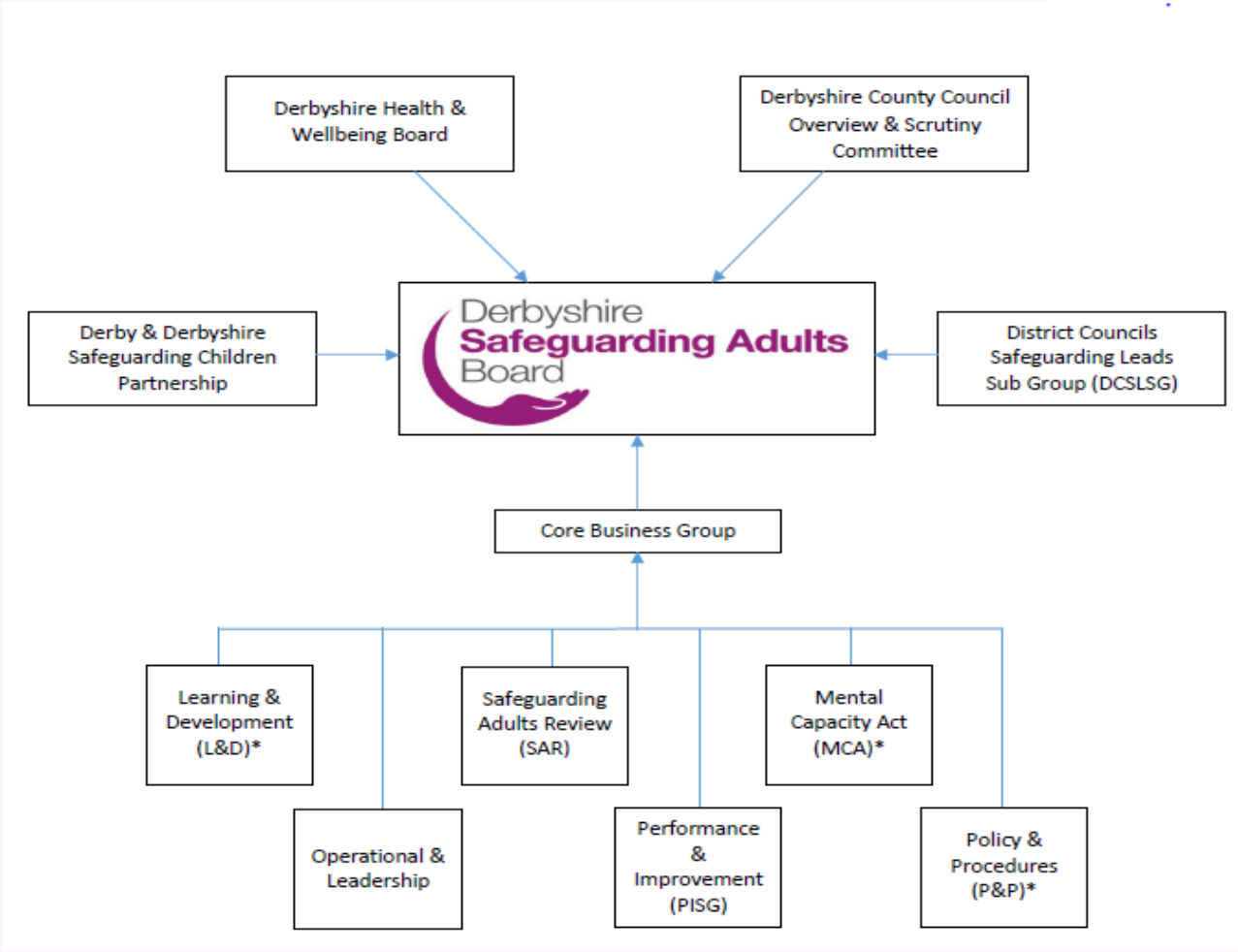
We will all work together to enable people in Derbyshire
to live a life free from fear, harm and abuse

www.derbyshiresab.org.uk @DerbyshireSAB

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 2022/2023

Key	
	Attended
A	Apologies received
	Did Not Attend

DSAB Meeting Attendance 2022-2023

Date	Age UK Derby & Derbyshire	Chesterfield Royal Hospital NHS Foundation Trust (CRHFT)	Derby and Derbyshire Integrated Care Board (DDICB) [previously known as Derby & Derbyshire NHS Clinical Commisioning Group (DDCCG) prior to 1st July 2022]	Derbyshire Community Health Services Foundation Trust (DCHSFT)	Derbyshire Constabulary	Derbyshire County Council Adult Social Care & Health (DCC ASCH)	Derbyshire County Council Community Safety	Derbyshire Fire and Rescue (DFRS)	Derbyshire Healthcare NHS Foundation Trust (DHCFT)	Derbyshire Mind	Derbyshire Voluntary Action (DVA)	Diocese of Derby
14/06/2022											A	
13/09/2022	A									A		A
13/12/2022											A	
17/01/2023 Joint Derby and Derbyshire Development Session		A					A			A	A	

DHU Health Care CIC	East Midlands Ambulance Service NHS Trust (EMAS)	Healthwatch Derbyshire	Housing/ Environmental Health	Office of the Police & Crime Commissioner (OPCC)	Prison Service	Probation Service	Tameside & Glossop Clinical Commissioning Group (TGCCG) [No longer Board members after 1st July 2022 due to the introduction of the Derby and Derbyshire Integrated Care Board]	University Hospitals of Derby & Burton NHS Foundation Trust (UHDBT)
				Vacant post at time of meeting		A		
				Vacant post at time of meeting	HMP & YOI Foston Hall		Not applicable	
	A	A		Vacant post at time of meeting	HMP & YOI Foston Hall	A	Not applicable	
	A			A	HMP & YOI Foston Hall		Not applicable	

Appendix 3: Abbreviation index

A
ADASS: Association of Directors of Adult Social Services
B
BSL: British Sign Language
C
COP: Community of Practice
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
K
KPI: Key Performance Indicator
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