Safe in Sheffield

Annual Report
2021/2022

SASP
Sheffield
Adult
Safeguarding
Partnership

Document Information

Sheffield Adult Safeguarding Partnership (SASP) Annual Report 21/22

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How to Report a Safeguarding Concern

If you have any concerns that an adult is being abused or neglected, then you can share those concerns with the Local Authority. Your actions could save their lives and potentially the lives of others.

Concerns can be raised by contacting the First Contact Team on 01142734908.

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1. Message from the Independent Chair

Welcome to the annual report of the Sheffield Adult Safeguarding Partnership. I am pleased that you are taking the time to read this report, which outlines continuing progress in the multi-agency work to protect and safeguard adults at risk in Sheffield.

The report covers the period from April 2021 through to March 2022, a period that continued to present unprecedented challenges for partners as the global pandemic COVID-19 continued to impact.

I joined the partnership in April 2022 as Independent Chair and Scrutineer, a role intended to support partners by providing an independent perspective on their work to safeguard adults and to highlight challenges where appropriate. One of my duties is to be satisfied that the agencies who make up the safeguarding partnership are working effectively together to ensure that they are doing what they can to keep adults at risk in Sheffield safe, with the resources that they have available. **You will find my scrutineer's overview at the end of this report.**

I would offer my thanks to all members of the safeguarding teams for their work and persistence in sustaining effective safeguarding in Sheffield. There are many examples of practitioners going above and beyond expectations to protect some of our most vulnerable adults and families and to them I send my thanks.

Lesley J Smith

Lesley Smith

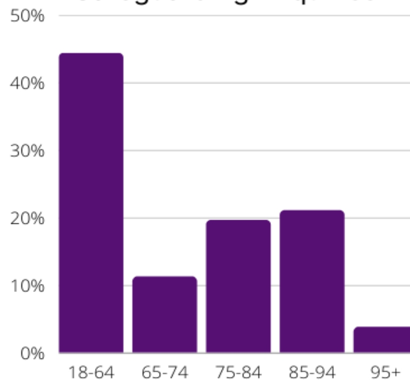
Independent Chair and Scrutineer

Sheffield Safeguarding Partnerships (Adults and Children)

2. Key Safeguarding Facts

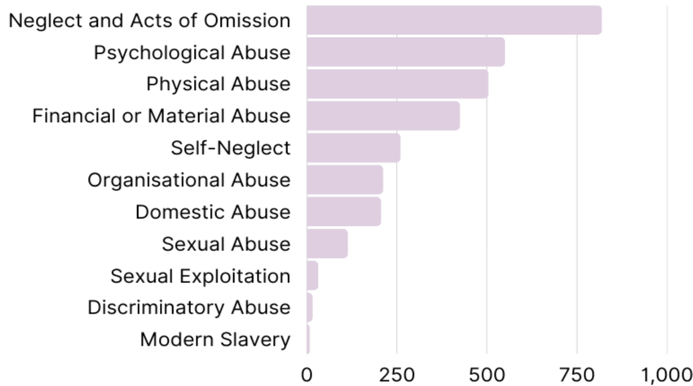
59.34% of those involved in Safeguarding Enquiries were women

Age of individuals involved in Safeguarding Enquiries



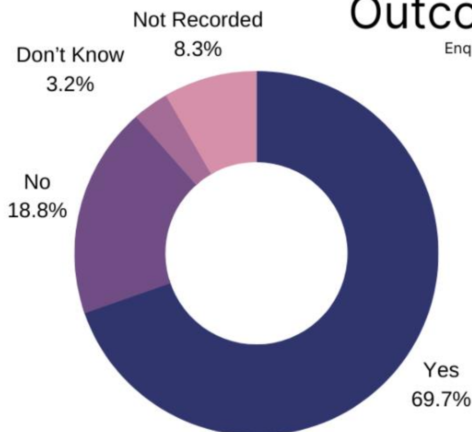
Types of Abuse

Enquiries Completed



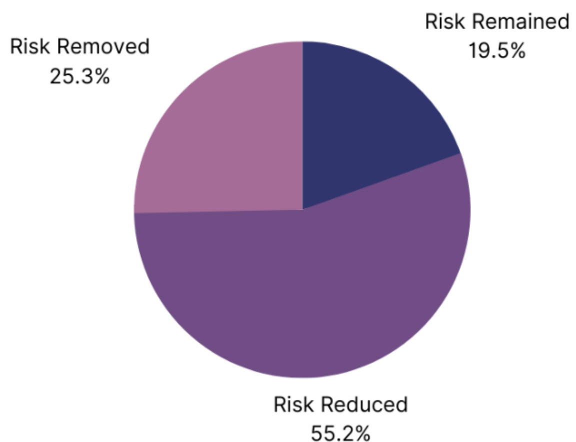
Asked About Outcomes?

Enquiries Completed



Outcome of Risk

Enquiries Completed



3. About SASP

Safeguarding aims to protect and prevent, the physical, emotional, sexual, psychological, and financial abuse of adults who have care and support needs and acts quickly when abuse is suspected. It can also include neglect, domestic violence, modern slavery, organisational or discriminatory abuse.

The Sheffield Adult Safeguarding Partnership (SASP) is a strategic, multi-agency partnership that brings together statutory and non-statutory organisations to actively promote effective working relationships between different agencies and professionals to address the issue of abuse and harm. The Safeguarding Adults Executive leads and holds individual agencies to account, to ensure adults in Sheffield are supported and protected from abuse and neglect.

The SASP's overall purpose is to make sure that people in Sheffield, particularly those with care and support needs are protected from harm, abuse, and neglect. This is a challenging task, but we are clear that by working in partnership with the community, carers, and those who receive services, we can make a difference to the well-being and safety of people across Sheffield.

SASP is required under the Care Act 2014 to produce a Safeguarding Adults Annual Report each year. The report should say what we have done during the last year to protect adults at risk of abuse and neglect in Sheffield and how the year's objectives have been achieved. The report includes an overview of the structure and membership of the partnership, data relating to safeguarding over the last financial year and examples of how partners have worked to achieve the partnerships 5 strategic priorities.

This annual report covers the 12 months from April 2021 to March 2022 and provides an update and information on significant activity and developments for Adult Safeguarding in Sheffield.

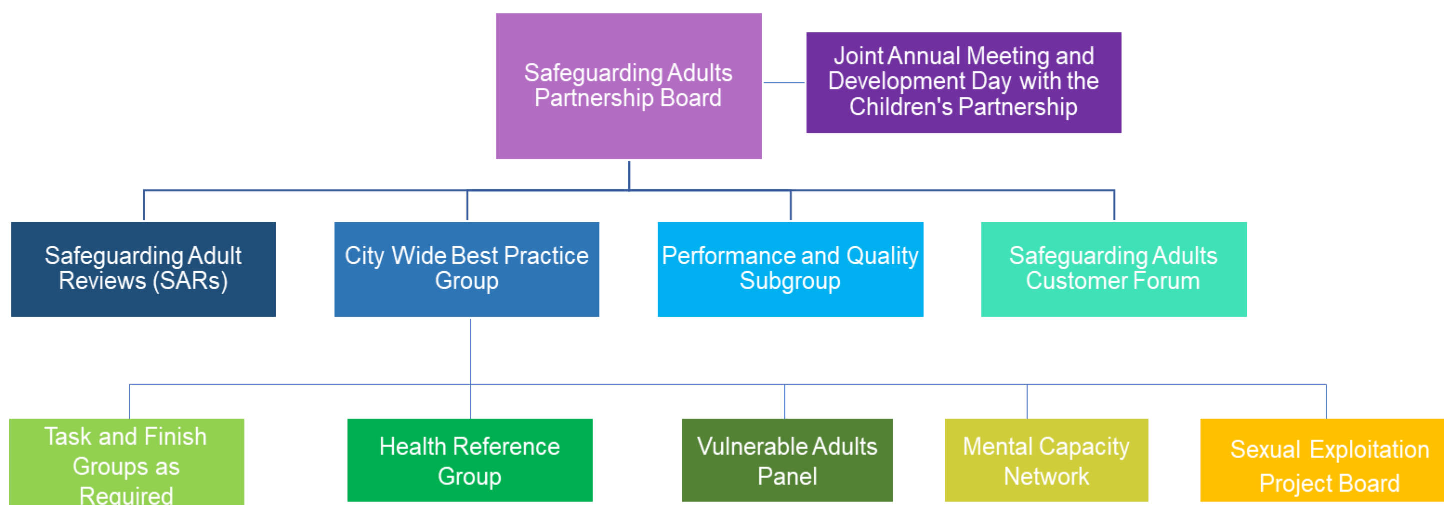
For more information about SASP please look at our website, where you can find information for professionals including Learning Briefs from Safeguarding Adult Reviews, how to report a Safeguarding Concern, policies and procedures including the newly published Multi Agency Self-Neglect Policy and Practice Guidance (Including VARM and CCM) and how to book onto multi-agency training and the courses available. The website also has information for the public, carers, and families including information on types of abuse and an Easy Read on "What is abuse and how do I tell someone?"

Throughout this report, the following acronyms may be used when referring to partners:

SYP	South Yorkshire Police
STHFT	Sheffield Teaching Hospitals NHS Foundation Trust
SHSC	Sheffield Health and Social Care NHS Foundation Trust
SY ICB (Sheffield) Previously CCG	South Yorkshire Integrated Care Board (Previously Clinical Commissioning Group)
SYFR	South Yorkshire Fire and Rescue
AHSC	Adult Health and Social Care
SCC	Sheffield City Council

A wider glossary of acronyms can be found as an appendix at the end of this report.

3.1 SASP Structure



3.2 Executive Membership

Member	Agency
Independent Chair	SASP
Director of Adult Health & Social Care	Adult Health and Social Care Sheffield City Council
Chief Social Worker	Adult Health and Social Care Sheffield City Council
Councillor Lead	Adult Health and Social Care Sheffield City Council
Lead for Community Safety	Sheffield City Council
Detective Chief Inspector	South Yorkshire Police
Group Manager	South Yorkshire Fire and Rescue
Chief Nurse	Sheffield Teaching Hospitals NHS Foundation Trust
Executive Director of Nursing	Sheffield Health and Social Care NHS Foundation Trust
Chief Nurse	South Yorkshire Integrated Care Board - Sheffield
Head of Service	Probation Service
Head of Operations and Safeguarding Lead	Sheffield Carers Centre (Voluntary Services Representative)
Chair of Customer Forum	Sheffield Safeguarding Adults Customer Forum
Safeguarding Partnership Manager	SASP

3.3 Funding and Spend for 21/22

Balance (Underspend) from 20-21			**155,596**
Income	**Budget**	**Outturn**	
Sheffield City Council	(316,700)	(316,700)	
SY Police & Crime Commissioner	(12,000)	(16,863)	
NHS Sheffield CCG	(92,700)	(92,692)	
Expenditure			
Employers - Salaries	353,800	296,270	
Transport – Employees Expenses	1,300	266	
Supplies and Services	66,300	107,905	
Net In-Year Underspend			**(21,814) ***
Balance to be Carried Forward			**(177,410) ****

* Underspend partly due to staff vacancies

** Includes SY training fund and reserves held for Safeguarding Adult Reviews

4. Relevant Safeguarding Issues for Care Homes

Nice Guidelines include a requirement for Safeguarding Adults Boards to include information on issues relevant to safeguarding in care homes within their Annual Report. The following information provided by the Performance and Quality Team in SCC, summarises some of the relevant issues and how they are monitored.

Routine Monitoring

Through routine monitoring visits, the Quality and Performance Team (Sheffield City Council) check Care Homes are alerting the Local Authority where necessary with safeguarding concerns.

Care Homes have systems in place to record accidents and incidents appropriately, ensure an analysis of trends is done on a regular basis (usually and recommended monthly), and that follow up actions are recorded, implemented and checked.

Incidents of Falls

The Quality and Performance Team ensure Care Homes analyse falls to understand trends, implement actions and include relevant professionals to advise on preventative measures.

Resident on Resident Incidents

The Quality and Performance Team work with Care Homes to ensure residents are stimulated through a variety of activities, and that analysis of resident on resident incidents are undertaken and actions introduced to prevent any further occurrence, i.e. staff use distraction techniques and identify triggers to prevent any escalation.

Medication Errors

Care Homes advise of actions when identifying errors, including removing staff from duty, retraining, further shadow shift, observations, annual competency checks. Where there has been a number of medication errors identified, the Quality and Performance Team refer the MOCH (Medicine Optimisation in Care Homes) Team to the Care Home to advise and support them with ideas, suggestions and advice to prevent reoccurrence.

5. Update on Strategic Priorities

The SASP three-year strategic plan 2020-2023 was developed in consultation with partners but more importantly with people directly at risk of harm. The plan is a map of what the Partnership will do to make changes happen and achieve the agreed objectives. The Executive Board is responsible for overseeing the achievements of the Strategic Plan. Setting the right priorities and being clear on what outcomes we want to achieve and have achieved is essential.

Priority 1 - Making Safeguarding Personal

Making Safeguarding Personal (MSP) is an approach to safeguarding that focuses on the desired outcomes of the person being safeguarded. It is person centred and ensures the adult's wishes and views are considered as far as is possible. MSP has continued to be embedded into safeguarding practice. The number of individuals who are being asked their desired outcomes in safeguarding enquiries has increased over the last three years. 2019/20, in 54.1% of enquiries completed in the year people were asked about their desired outcomes. In 2020/21 this figure was 61.2% and in 2021/22 this figure was 69.7%.

Examples from Agencies

Adult Health and Social Care	AHSC increased the resource of vocationally trained staff to support screening in the first 24 hours to ensure First Contact can be responsive and focus attention appropriately. As an example of MSP in practice, an individual disclosed to a friend she felt her husband was struggling to support her and the concern was reported as possible neglect. Case notes clearly stated sensitivity was needed to not risk breakdown of the relationship. The individual and her husband were contacted and offered support in a sensitive way whilst considering reports of dementia progressing to further enquiries, again with sensitivity to possible carers stress.
SY ICB (Sheffield) (Previously CGG)	The six key principles of safeguarding adults at risk are included within the place based Safeguarding Policy and within safeguarding at risk training the organisation delivered. A recent 'Back to Basics' workshop covering level 3 safeguarding adults at risk training (as identified in the Roles and Competencies for Health Care Staff, 2019), emphasised how to establish with the adult what their views and wishes are and how this can be used to complete a safeguarding concern form to support better outcomes for the adult at risk. In recent recruitment processes examples of MSP in practice have been sought from interviewed candidates to ascertain that MSP is integral to safeguarding adults at risk work, and that the successful candidate would know how to apply this in practice.
Probation	The six principles of safeguarding adults at risk are part of the internal safeguarding training within the organisation. All adults subject to Probation Services have a comprehensive assessment at the start and throughout their time on Probation, part of this assessment provides the opportunity for the individual to contribute to service provision. Individual sentence plans are developed and implemented on a case-by-case basis and tailored to individual need.
SHSC	The Terms of Reference for S42 Enquiries and investigation template has standard fields to ensure service users are asked about their wishes and feelings and asked how they want to participate in the enquiry. Safeguarding Practitioners provide advice and support following review of all internal safeguarding concerns. If the wishes and feelings of the SU are not clear in the concern, they will ask staff to gather this information and their advice is person centred. All levels of training remind/introduce staff to the six principles of safeguarding and Level 3 training has specific group exercise on these principles. MSP is part of the annual audit plan, led by the Adult Safeguarding Advisor. SHSC are using the MSP toolkit to provide staff with tools and best practice guidance, with a small pilot planned to build and trial these tools.
STHFT	Mandatory safeguarding training delivered by the Safeguarding Team is based on the six key principles and has been maintained at above the 90% Trust target throughout the pandemic.
SYP	SYP have continued to effectively embed training in relation to vulnerability identification e.g., Domestic Abuse Matters, Vulnerability Assessment Framework (VAF), Child Matters and Signs of Neglect (identifying support for parents/adults in need) and embed their response by various means, across a wide and diverse workforce, to ensure that outcomes have a personal focus and that the voice of the victim is heard.

Priority 2 – Working in Partnership

SASP Subgroups have continued to meet virtually and have been well attended by all partners and agencies. The quarterly SASP Executive Board meeting continued virtually. Topics for discussion at the Executive included updates on the progress of the proposed Multi-Agency Safeguarding Hub and updates on projects funded by SASP including 'Not Born Yesterday' a Trading Standards campaign protecting vulnerable people from scams and rogue traders. Additionally, there were two joint Adult and Children Executive Board Meetings which will continue to take place twice a year going forward.

Members of the SASP team also take part in networks nationally, regionally, and locally, to ensure we can share learning from and with other areas, as well as staying well informed of any national developments and guidance. For example, the National Safeguarding Board Managers Network.

Examples from Agencies

Adult Health and Social Care	Focus has been on looking at the feasibility of setting up an Adult's Multi-Agency Safeguarding Hub (MASH). All partners have fully engaged, and meetings have had a high level of engagement. Demand and current processes have been analysed to ensure that any future model is fit for purpose. Research has been undertaken to understand what is working in other local authorities. An option has been identified and the project will now be progressed.
Carers Centre	Sheffield Carers Centre was invited to join the Executive in September 2021 and a representative from the Centre joined the Executive in March. Partners considered how they could increase carer awareness, signposting and referrals within their organisations and agreed that it would be useful to monitor the rates of new carer registrations. The Carers Centre has since been providing data on new carer registrations from partner referrals for the SASP quarterly performance reports.
SY ICB (Sheffield) (Previously CGG)	SY ICB (Sheffield) recently supported the recruitment of the new Partnership Chair. The organisation is also represented at SASP sub-groups including chairing the SAR subgroup. Actions from those meetings have been supported, for example raising the profile of the Carers Centre in ebulletins to staff internally and Primary Care externally following on from several recommendations in Safeguarding Adult and Domestic Homicide Reviews where a lack of referrals for carers assessments had a detrimental impact.
SHSC	SHSC shares S42 enquiries related to care in the Trust with SY ICB (Sheffield) as part of the quality assurance mechanisms. In addition, SHSC has co-operated fully with the Local Authority and SY ICB (Sheffield) for a S42 enquiry and worked as part of a multi-agency review group and development board to consider the future of inpatient services for individuals with Learning Disability.
SYFR	SASP members continue to sign up to and make referrals to SYFR using the Safe & Well Referral Scheme. data on referrals from partners is included in the SASP quarterly performance report and between October 21 and March 22 the number of referrals saw an upward trend.
Probation	A complex change programme in the last 12 months meant the National Probation Service and the Community Rehabilitation Companies were reunified to become one organisation again. Despite expected early transitional issues, this is a positive move for the service and has brought together all aspects of the service under one organisation. This allows for partnership working to be more efficient due to the Probation Service now having one voice and being easier to recognise. The Sheffield Probation Delivery Unit has since moved practitioners to one site in the city centre and has realigned teams with attendance at multi agency meetings. Senior and middle managers are visible and engaging with local strategic meetings and are driving quality and performance internally, particularly with a commitment to safeguarding training and development.

Priority 3 – Prevention and Early Intervention

SASP support several prevention and early intervention initiatives that are described in Chapter 6, including the Not Born Yesterday Campaign, Safe Places and the Adult Exploitation Worker. SASP contributed to Safeguarding Awareness Week which included a stall in the city centre manned by different partners each day, providing information on safeguarding and relevant issues.

Examples from Agencies

City Futures and Operational Services (Previously Place)	Housing & Neighbourhood Services are currently reviewing training pathways with the aim of ensuring safeguarding knowledge is up to date (including adding Trauma Informed Practice training as mandatory training).
STHFT	The Emergency Department established a 'Safeguarding Saturday' initiative to improve awareness and understanding of safeguarding via the dissemination to all staff of information, contact details and referral processes, relating to various topics and themes that may lead to the abuse or neglect of an adult at risk. Topics circulated included Adult Safeguarding and the Care Act Criteria for a S42 Enquiry (3 Point Test), Modern Slavery and Human Trafficking, Homeless Duty, Gun and Knife Crime and Professional Curiosity. The STHFT Safeguarding team works closely with Independent Domestic Abuse Services (IDAS) and the Drug and Alcohol/Domestic Abuse Coordination Team (DACT), attending the weekly Multi-Agency Risk Assessment Conferences (MARAC) to identify any actions required to keep victims of domestic abuse safe should they access our services e.g., placing alerts on patient records.
SYP	The Domestic Abuse Disclosure Scheme continues to be well utilised and considered when identifying risks/vulnerabilities within adults. Sheffield identified/processed 423 cases in 2021, of which 113 came in as 'right to ask', 310 were identified as 'right to know'. Of these, a disclosure was authorised and given in 65% of cases. There has been an internal focus on the use of police powers in relation to drug testing in custody for 'non trigger' offences [offences that don't routinely lead to testing], with an Inspector authority. This power has been utilised in relation to Domestic Abuse and Child Abuse investigations to allow investigators and other agencies to better understand the vulnerabilities within the wider context of the situation as well as the incident under investigation. Use of this power allows for that person (should they test positive for use of Class A drugs) to get early interventions.
Adult Health and Social Care	AHSC continue to support people with care in situations where either care has not been immediately available, or where their provider has withdrawn for some reason. Current issues around the social care workforce in terms of vacancies means that this is a more common situation than pre-pandemic. Screening at First Contact takes a preventative approach and those screened out of safeguarding will be offered advice or assistance should the formal safeguarding route not be appropriate.
SHSC	Whilst awaiting a new Electronic Patient Record, SHSC collate data on the number of referrals, types of abuse, ethnicity, and services with relatively low referral rates. The data helps to recognise where staff may need additional support, identify increases in types of abuse and emerging themes and training needs e.g., work with the DACT to facilitate delivery of training from sexual assault services to staff to enhance understanding of their services and criteria for referrals.
SYFR	SYFR provide quarterly reports to the Fire Authority and continue to see an increase in the number of cases relating to concerns about adult abuse and neglect. This can be attributed to the targeted interventions by SYFR for the most vulnerable coupled with increased awareness, because of training. SYFR also receive referrals from Independent Domestic Violence Advocacy Service (IDVAS) and SYP for Home Safety Checks where there is a threat of arson and relating to a history of Domestic Abuse (DA) within the household.

Priority 4 – Engage and Empower

The SASP website and social media continue to be updated to engage a wider cross section of Sheffield's population. The SASP Twitter page has been used to highlight and get behind different campaigns and to raise awareness of several safeguarding issues and support available, for example, mental health, homelessness, older adult abuse, and domestic abuse.

The Sheffield Safeguarding Adults Customer Forum play an active and important role in ensuring that partners hear the voice of people in the city regarding safeguarding adults at risk. The group continued to meet virtually throughout 2021 and 2022. A more detailed overview of the work that the customer forum has been engaged in over the last year can be found in Chapter 9 of this report.

Examples from Agencies

SY ICB (Sheffield) (Previously CCG)	SY ICB (Sheffield), continued to engage with users of NHS services which include minority and marginalised groups within the population when developing new specifications. The Safeguarding Team have suggested material to be included on the SASP website for example details of how the public can respond to Prevent concerns
City Futures and Operational Services (Previously Place)	Neighbourhood Officers are empowered to use professional curiosity on home visits, should they identify any areas for concern. They can work with the tenant, and if appropriate, identify the most appropriate route for referrals to support so that individuals and households can successfully sustain their tenancies and remain safe in their homes.
STHFT	STHFT uses the Friends and Family Test to obtain feedback from patients on the care they received, in order to improve services and therefore patient experience. The electronic patient record now has a section on 'What matters to me' to record any specific needs, worries or requirements, expressed by the patient. This links closely to Making Safeguarding Personal and should encourage professional curiosity to better understand what is important to the patient. All qualified nurses are required to access a mandatory training video with guidance on personalising care plans.
SYFR	Further to recommendations from an Individual Management Report (IMR), SYFR created a High Fire Risk Case Management Tool using a Problem-Solving Model and decision log. This can be used for Audit, Supervision or as a Practitioner Checklist and enables consideration of risk and contributing factors, what is working well and what are the challenges. A key thread throughout is consideration of the wishes and feelings of the person/s we are concerned about and the importance of speaking to them directly and asking them for their views. As per the risk assessment, consideration needs to be taken about whether the person is willing and able to make the changes to make themselves safe/safer and to identify the right help and support that they might need.
Probation	Practitioners have used 'blended supervision', a combination of face-to-face appointments, telephone contact and video calls when engaging with people on probation. This has showed benefits regarding increased compliance with some cohorts and therefore allowing practitioners to have greater opportunity in managing a person's risk and supporting them to make positive change.

Priority 5 – Quality Assurance

Across the Safeguarding Partnerships, it was agreed that the 2020/21 Joint Annual Safeguarding Self-Assessment and Accountability Sessions would be cancelled in recognition of the capacity issues faced by services due to the pandemic. These accountability meetings subsequently took place in May 2022.

The Performance and Quality Subgroup met virtually on a quarterly basis and had a good level of engagement and attendance from partners. A multi-agency audit was carried out on safeguarding concerns which partners engaged with. This Multi-Agency Audit included a Desk Review (looking at safeguarding data locally, best practice and multi-agency training materials), interviews with a sample of frontline staff, a multi-agency case audit and a workshop and action planning session.

Examples from Agencies

City Futures and Operational Services (Previously Place)	Two new Practice Development Co-ordinator posts have been created within the Tenancy, Enforcement and Sustainment Team to focus on ongoing learning and development for staff and providing quality assurance on all aspects of safeguarding.
ASC	Good progress has been made in relation to following up actions from the Internal Safeguarding Audit carried out last year. For example, First Contact has developed a work tray map and business flow to help support staff. A new approach to tray management has been introduced utilising priority markers on Liquid Logic and a new allocation system has also been introduced, this is alongside more vocationally qualified staff supporting in initial work. This should improve performance in the speed that referrals are reviewed. There are some outstanding actions, progress on which are being followed up at an Assistant Director level.
SY ICB (Sheffield) (Previously CCG)	The organisation shared any learning briefs internally and externally to Primary Care following reviews and audits. This information is also included in training to Continuing Health Care colleagues and Primary Care. This ensures the most recent learning is shared with colleagues to allow any recommendations to be implemented into practice.
SHSC	S42 Enquiries are reviewed through a weekly investigation panel to improve allocation of enquiries, monitor response/completion times and quality assure the reports. The safeguarding team are also producing a 'checklist' to support staff when completing and presenting their enquiries.
STHFT	Learning Briefs from reviews are disseminated via the Safeguarding Assurance Committee and are published on the Safeguarding Intranet Site. Where staff members were directly involved in the care of the subject of a review, the Learning Briefs are shared and the opportunity for supervision or discussion is offered.
SYFR	A Government White Paper: - Reforming our Fire and Rescue Services is currently out for consultation and there are recommendations for a move away from a Fire Standards Board toward the development of a College of Fire and Rescue. There is a vision to see excellence in Prevention and Protection (to match Emergency Response) using research, data and evaluation and improvement cycles. A specific example is the work undertaken by SYFR Business Fire Safety in terms of reducing the risks identified as a result of the tragic fire at Grenfell. This impacts on both private households and public buildings where adults with care and support needs may live or visit.
SYP	SYP continue to be actively involved in the processes associated to reporting on and making referrals in relation to SARs. The impact of such reviews can be seen as influential across the organisation and all staff. The SYP Force Intranet provides a forum to publish developments in areas such as lessons learned, self-assessment and accountability. These are monitored centrally within force by the Protecting Vulnerable People (PVP) Governance Unit, and this is cascaded to each local district for reference/action/implementation.

6. SASP Initiatives and Developments

SASP support and fund three initiatives within Sheffield to keep people safe, raise awareness and work in partnership to address safeguarding concerns. These are Trading Standards – Not Born Yesterday, Sheffield Safe Places and the Adult Exploitation Worker position working alongside the Sheffield Child Exploitation Service.

6.1 Trading Standards – Not Born Yesterday

SASP funds a position in Sheffield City Council Trading Standards to support tackling financial abuse from doorstep crime, rogue traders, and scams in the city. Trading Standards continued to promote a safeguarding agenda focused on reducing detriment from this criminality.

Despite challenges for normal service delivery, due to the pandemic, the team responded to all reported incidents of rogue trading/doorstep crime involving vulnerable persons and continued to promote the safeguarding messages associated with the 'NOT BORN YESTERDAY' campaign.

2021/22 Highlights

- **16 incidents of doorstep crime were reported.** All of which were responded to, resulting in either further investigation or intelligence gathering. **In all cases measures were put in place to protect the victims from further financial abuse.**

- **Contact was made with 280 suspected victims of mail scams** notified to Trading Standards by the National Scams Team and **two home visits were carried out.**

- **During Safeguarding Week, the team hosted an awareness raising session** in the Moor Market and delivered a presentation to safeguarding staff.

- Officers attended **9 community lunch and friendship groups and 3 Sheffield Carer's Café events** to raise awareness.

- Leaflets and door stickers were delivered to around 700 properties in S8 and S10 to **raise awareness that doorstep crime incidents** had occurred in the area.

- **7 Call Blockers were fitted in the homes of victims of telephone scams** referred to us by the Safeguarding Team.

6.2 Sheffield Safe Places

Run by Heeley City Farm, the aim of Safe Places is to support people to feel safe when they are out and about in Sheffield.

If someone needs help, for example, they are lost, ill or frightened, Safe Places can provide temporary refuge until a friend or carer comes, or the person feels able to leave again on their own.

The Safe Places are a network of businesses and organisations across the city that are committed to ensuring the safety and dignity of people who join the scheme.

2021/22 Highlights

- Chloe Wilks started as the new Safe Places coordinator in October. **63 New members joined the scheme since January** [many more use Safe Places without signing up]. Safe Places aims to be a platform to empower, advocate and encourage people who are at risk to feel safe, heard, and confident. With member volunteers, Safe Places have been working hard reinstating and updating training across all 48 Safe Places, being flexible with training needs.

- 17 co-produced creative workshops ran across the city with different day services, charities, social groups and supported living services. Promotional and accessible materials were produced to spread the word to the people who are often seldom heard. Safe Places worked closely with various community groups and charities including Transport 4 All, Sheffield Voices, Autism Partnership Network and Disability Sheffield (and many others), took part in conferences and training within the CCG and SCC, assisted with stalls at events and represented at the Festival of Debate the largest annual politics festival in the UK under the theme 'How can we create an autism friendly Sheffield'.

- Together with 20 + people around Sheffield, Safe Places created a report highlighting inequality, incidents and how law and legislation can be improved, so that drivers of taxis and public transport have a greater understanding of the importance and reliance on transport for breaking social isolation, and the wider impact of loneliness on health. The report will be circulated to all taxi drivers and included in training in the future, to ensure Sheffield transport is accessible for everyone.

6.3 Adult Exploitation Worker

The Adult Exploitation Worker is currently a 0.5 FTE post. Support is given to 18 – 25-year-olds, at risk of sexual exploitation. Many cases are transitioned from the Child Sexual Exploitation Service so if a young person is turning 18, a handover will be facilitated.

Interventions are flexible and can take place over the phone as well as in person. Sessions include work around:

- **Self-Esteem**
- **Sexual Health**
- **Exploitation**
- **Risk Management**
- **Positive and Negative Relationships**

2020/21 Highlights

- Advocated for young women and assisted them with applications to college courses.
- Identified younger girls making friendships with the older cohort and arranged multi-agency meetings with professionals to discuss this.
- Attended a wide range of professional meetings including core group and strategy and submitted third party information forms to the police where relevant.

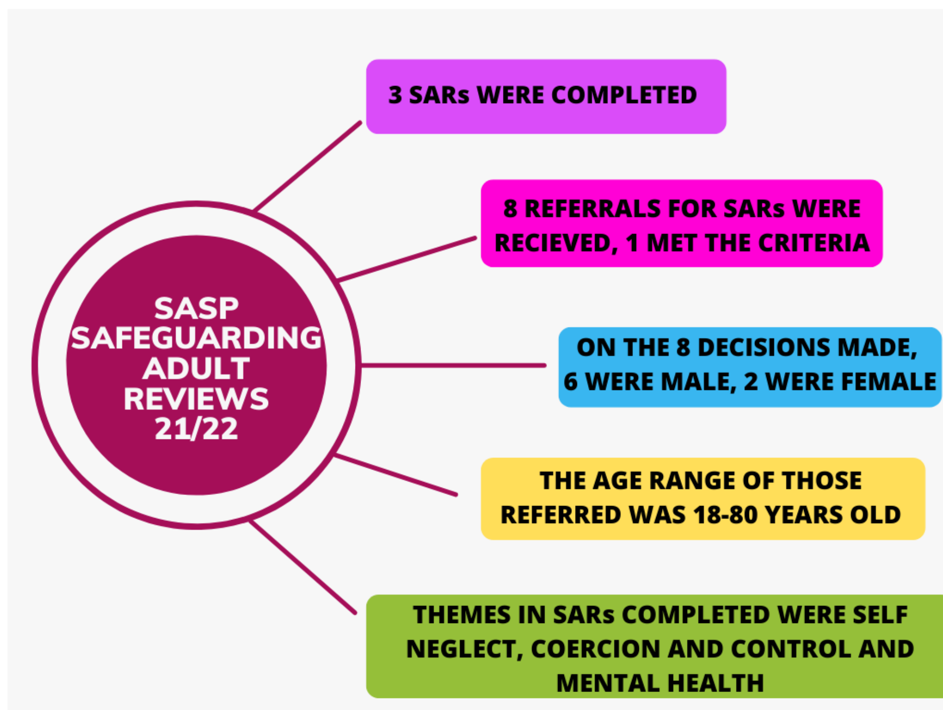
Referrals have been problematic. A gap in service provision whilst funding was agreed meant some agency's stopped referring in. This was exacerbated by Covid, lockdown and the challenges presented in awareness raising. However, there are good relationships with key partners in Supported Housing, Colleges, and Children Leaving Care Service where a lot of referrals come from.

Moving forward, the post will be working closely with the Transitions agenda and there are plans to establish a Multi-Agency Direction Panel which focuses on exploitation post 18.

7. Safeguarding Adult Reviews

Section 44 of the Care Act states that we must carry out a Safeguarding Adult Review (SAR) if certain criteria are met. This is so that we can learn lessons where an adult, with care and support needs, has died or been seriously injured, and abuse or neglect is suspected and where there are issues with how agencies worked together. The purpose is not to apportion blame to any individual or organisation.

SASP SARs and SAR Referrals in 2021/22



The SAR Subgroup has continued to meet and to manage the various stages of a review virtually with representation from key agencies. Panel meetings were held for the different SARs with involved agencies showing an openness and keenness to learn from what happened.

The reports and a one-page learning brief on published SAR's can be found on the SASP website here.

As well as recommendations, there were examples of good practice that came out of SARs including:

- Good face to face assessments by a Care Manager with clear records of needs and wishes.
- In depth handovers from Maternity Services to the Health Visiting Service including use of the Family Common Assessment Framework and frequent reference to the wider family circumstances in maternity notes demonstrating professional curiosity.
- Respite services taking time to get to know the person and tailoring care accordingly.
- Assessment of emotional health and routine domestic abuse enquiries made.

7.1 Recommendations and Actions from SARs

Several recommendations came out of the published reviews. There are several recommendations and actions that are still ongoing, however, here are a few examples of recommendations provided and actions completed to achieve those recommendations.

Recommendation ***What we've done***

Recommendation	What we've done
Review the multi-agency policy and procedures for managing Self Neglect and deliver training to support best practise.	*The policy and practice guidance has been reviewed and training is planned to commence summer 2022.*

Recommendation ***What we've done***

Recommendation	What we've done
A Multi Agency Safeguarding Hub (MASH) is to be considered to effectively review and triage referrals including how it relates to the Children's Safeguarding Hub.	*A multi-agency steering group is meeting to develop a business case for the development of a MASH.*

Recommendation ***What we've done***

Recommendation	What we've done
Agencies should provide evidence of how staff are enabled to work in a trauma informed way with those with Emotionally Unstable Personality Disorders.	*City wide work to make Sheffield a Trauma Informed City has meant over 3000 professionals within the city have attended trauma informed awareness sessions. Work to ensure agencies are set up to allow their staff to work in this way is starting. The Annual Quality Assurance Self-Assessment of Partners asked for evidence that they are working in this way.*

Recommendation ***What we've done***

Recommendation	What we've done
The need for all staff to be professionally curious in their work and supported by resources, training, and questions within self-assessments.	*Professional Curiosity is included within all training sessions but there is now a bespoke course led by the Adults and Children's Partnership. A resource has been developed to allow staff and teams to consider case studies and watch videos to extend the number of professionals who are reminded of this requirement.*

8. SASP Safeguarding Training

In the past year, we saw the easing of COVID based restrictions in relation to workspaces and meetings. However, people still had reservations about being in rooms with lots of people and the potential to catch COVID was still a concern. Therefore, we decided to maintain our virtual training programme and suite of courses, delivered via Zoom by the dedicated volunteer members of the Sheffield Adult Safeguarding Training Pool. The virtual programme has been well received and looking towards the future, we are exploring the possibility of a hybrid training programme with a mixture of face-to-face sessions and virtual ones, so attendees can choose the ones that meet their needs and circumstances.

As we continued to run sessions via Zoom, attendance numbers are slightly lower but **426 people attended our courses over the year**. These were from partner agencies and other organisations across the city. Some courses are new and were only introduced February/March this year so these should be fully reflected in next year's figures.

Collaboration with the Sheffield Children's Safeguarding Partnership

Adult Safeguarding continues to work collaboratively with Children's Safeguarding. In February 2022 we ran a joint 'Training for Trainers' course for people interested in joining either the Adults Safeguarding training pool or the Children's Safeguarding training pool or both. The course was well attended and well received, so this will continue to be one of the four joint courses we currently offer. We have also worked closely on a joint 'seminar' programme of shorter, targeted sessions which have included Modern Slavery, Scams and Rogue Traders and more recently Predatory Marriage.

Introduction of New Courses and CPD Accreditation

The core programme is constantly being reviewed and updated. This year has seen the introduction of two new courses to the core programme, following pilot courses which were extremely well received. The new courses are 'Designated Safeguarding Adults Lead' and 'Safeguarding Adults Reviews - Lessons we can Learn'.

The last year has also seen many of our courses receive CPD Accreditation, recognising the value of the courses in addition to the quality of the content, structure, materials, and relevance to attendees needs and working practice.

9. SASP Customer Forum

Message from the chair of the SASP Customer Forum

Being Chair of the Sheffield Adult Safeguarding Customer Forum provides great insight into safeguarding and how associated partner organisations work well to endeavour to ensure good quality outcomes are achieved.

In addition to being Chair, I am also a carer rep on the LD Partnership Board, Carers & Young Carers Partnership Board, Carers Voice, Sheffield Carers Centre Expert Panel, Trustee of 2 local Charities Sheffield Mencap & Gateway and Nomad Opening Doors.

The forum is, currently, a small team of individuals who work well together and wish for safeguarding to be achieved for everyone, however, greater diversity is one of our priorities to provide greater depth and more insight to how safeguarding is in Sheffield, so new individuals will be very welcomed.

Chris Sterry,
Chair of the Customer Forum

COVID-19 continued to have an impact, limiting some of the work planned by the customer forum. Quarterly meetings continued virtually, with efforts made to make these as accessible as possible e.g., having phone ins. However, COVID-19 has further highlighted the impact of digital exclusion on many people. Here are some of the ongoing projects which the customer forum has been involved in the last year:

Seldom Heard

The forum discussed the importance of language and challenged the use of the term "hard to reach". The forum reflected on how this language discriminates, recognising that often people are not "hard to reach" but they are instead **seldom heard**. COVID-19 has exacerbated this, with people not being heard due to a lack of access to technology e.g., to book vaccinations. The City-Wide Best Practice Group and Board were challenged on this, and the language is now used by various other groups and partners.

Loneliness Project

The forum was approached by Sheffield Hallam University to be involved with a research project looking into loneliness. The forum will be involved in calling people to talk about loneliness and collect data. The project is currently going through ethics with work to begin over the coming year.

Taxi Service

A long-term project that started in 2019, the aim is to train new and current drivers to recognise different disabilities and vulnerabilities. The customer forum had input into the training materials and going forward will be involved in creating videos to create more engaging content e.g., to show the difficulties of getting a taxi as a wheelchair user.

10. Case Studies

Adult S – Domestic Abuse and Safe Accommodation

Background

Adult S suffered trauma and neglect as a child which continued into adulthood. Adult S has been subjected to extensive and persistent abuse in extremely violent relationships including, Emotional, Psychological, Financial, Physical, and Sexual abuse. Adult S has been heavily misusing substances and consequently, Adult S lost her home and was presenting as homeless and experienced Cuckooing in most of her temporary accommodations.

Adult S suffers from PTSD, Psychosis, Delayed Trauma and Emotional Unstable Personality Disorder. Adult S is well-known to the associates of her perpetrators and associates from her past who have previously caused her harm, Adult S can often bump into these in chance meetings making her extremely vulnerable.

Actions Taken and Support Provided

- There has been significant focus on safety planning work to look at the specifics of people continuing to pose a risk to Adult S, attend her home or known regular appointments.
- Adult S was given 3 personal alarms to keep on her/in her property.
- Alternative routes to collect prescriptions were discussed and agreed and were walked to identify any issues prior.
- As part of Adult S's support, there was liaison with staff at the Ben's Centre (who provide support for the sufferers of addiction and street life), on a regular basis to ensure she was safe and that all those working with her were sighted of the safety plan and able to advise Adult S with any queries.

Impact

Since being in the service, Adult S has not used substances and has been able to achieve the milestones within her safety plan she set for herself. Adult S has started to consider reducing her methadone script as she feels much better able to cope with not using and taking positive steps forward. This is worked into the support plan with timescales of when she would like to achieve this and what support she feels she may need.

Adult S is now receiving psychological support to help her at her own pace to unpack her trauma and move forward positively and more confidently. Adult S has started to eat healthily and identified that she would like to join a gym which she has now done with our support.

The ability to work intensively and at Adult S's pace, prioritising what was important to her, led to building a trusting relationship.

In Adult S's own words

"I've managed to stay clean…there's no-one bothering me at my house…no harassment, nobody controlling me (which is all I've ever known). This house has made me feel human again, made me feel at ease, more secure and safe. My neighbours mind their own business and get on with their own lives. I've always lived on council estates where people know everyone's business, but these are polite, they say hello and then move on and get on with their own lives, I like it. This house is a good place to heal you know and find who I am again. I've started to know what I like, what music I like…I've always had to listen to everyone else, now it's about me. I sit back and just listen…there's no noise and I feel at peace".

Adult F – Adult Social Care

Background

Adult F was living in the community with progressing dementia and was identified to be at risk of financial exploitation and self-neglect with lack of insight into her situation. Adult F was fiercely independent, went out every day using public transport, and within her extremely clear routine was managing well day to day. This routine enabled Adult F to function whilst her cognition became quite impaired. Adult F knew the times of her care calls, accepted support and recognised her carers, she was able to shop and manage routine tasks such as cleaning. Informal and formal support meant any changes were always identified. However, Adult F could not respond to emergencies (e.g., boiler breaking) nor handle her money safely as she could not recall how much she had withdrawn, so it accumulated.

There were reports of concern from professionals including the GP surgery, police (Adult F went into the front desk looking for directions) neighbours and family. Concerns from neighbours included knocking on doors, however when speaking to Adult F she was firmly orientated in the past where these relationships with neighbours were commonplace. She had her own safety plan, to ask her neighbours, which worked for her as they were very responsive.

There was a strong sense in safeguarding concerns of the risk to her, and that she was not safe at home. The assessment and subsequent plan did not shy away from what might happen, however the impact of the loss of independence seemed very clear and whilst Adult F lacked capacity to make a decision about care and support or finances, the decisions made in her best interest were the least restrictive possible, which was not the least risky. The decision was made to close the safeguarding and continue to manage the case through case management.

Actions Taken and Support Provided

- Application made to SCC executive services and Court of Protection to manage Adult F's finances, to enable her to have access to sufficient funds to do the 'daily shop' without accumulating large amounts from multiple withdrawals. The daily shop and having a purpose to her day was identified by Adult F as the most important part of her life and she did not want this taken off her.
- The agency monitored the levels of food in the house and identified when Adult F was struggling to shop (which was the start of the changes in her physical health). Contingency was used on the days when she was not able to shop and the familiarity with regular carers made her more accepting of this additional support, although she was very reluctant.
- A referral was made to the falls team and a specialist dementia Occupational Therapist helped identify safety strategies to supplement Adult F's own strategies e.g., list of important numbers. There was involvement with district nurses and GP surgery. A referral was made to SYFR and there was a joint visit.
- Worked with an advocate to ensure her views were clear and decisions were made in her best interest.

Impact

Adult F was able to stay in her own home for as long as possible. She was able to retain the independence that was so important to her. The risk could not be fully mitigated but, regarding financial risk, the actions to safeguard her would have been effective if completed. Sadly, Adult F's physical health deteriorated which sadly resulted in hospital admission and she subsequently passed away.

Adult H – Hospital First Contact Team

Background

Adult H was admitted to hospital following a joint visit from social services and the Adult Mental Health Team which had been an outcome from a MARAC meeting due to concerns raised regarding serious domestic violence allegations. On arrival at the property Adult H was found in a very poor state, severely malnourished and weak. He was taken to hospital and the police were informed.

When admitted to hospital, Adult H was confused, severely malnourished and with reduced mobility. A decision was made by the Police/STHFT safeguarding team to prevent visiting from Adult H's partner. He had lost significant weight disclosing to professionals that he had not eaten food for several months and had been surviving on Fortisips. Allegations were made by Adult H that his partner had not been allowing him food, not allowing him to attend medical appointments, displayed physical aggression towards him, isolated him from anyone he knew and demonstrated coercive and controlling behaviour.

Actions Taken and Support Provided

- After several visits to Adult H and building a relationship with him, he stated that he did not wish to continue in the relationship. Adult H opened up to his social worker and disclosed more information regarding the abuse he has sustained. Joint visits were carried out with the investigating police officer.
- The ward medical team and therapy team worked with Adult H to a point where he was independently mobile and had put more weight on. Adult H was discharged to stay in temporary accommodation as his property required a deep clean. He also needed a phone line installing, assistive technology, a lock change, and a care package to support with medication and prompting/encouraging with meals.
- Supported Adult H to go through his post and bills. Adult H had significant debts as no bills had been paid for a considerable amount of time. He was supported to set up repayment plans for all outstanding debts.

Impact

There had been several safeguarding episodes raised regarding suspected domestic violence. However, on each occasion Adult H had stated that the concerns were not founded.

Adult H's admission to hospital allowed him time away from his partner and time to reflect and understand that what had been happening was not ok and had resulted in a significant deterioration in his physical health. The interventions from the hospital social work team had a very positive impact on Adult H, he regained his independence and was excited about doing things on his own.

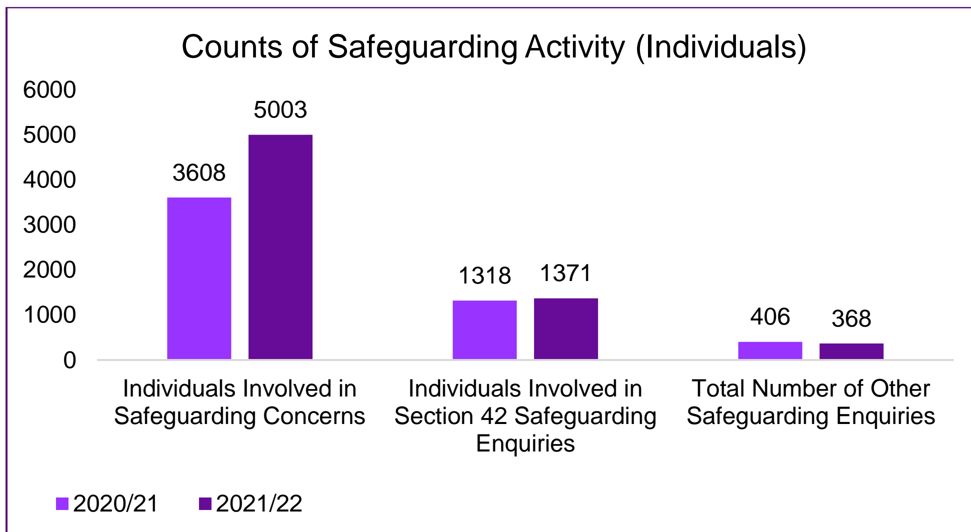
Adult H returned home and was very happy to be back home. Adult H gained weight and confidence and looked forward to getting back into a routine. There was a great deal of liaison with mental health services who supported Adult H's partner and there was positive joint working to ensure that the risks of Adult H's partner returning were minimised.

11. What do the Numbers Tell us?

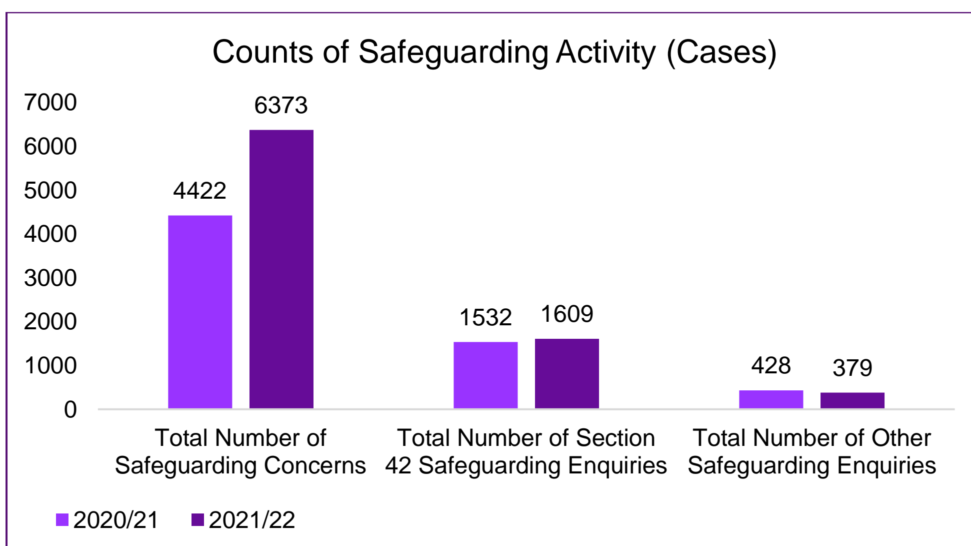
Safeguarding Concerns and Section 42 Enquiries

There has been an increase in safeguarding concerns raised and safeguarding enquiries commenced in 2021/22 when compared with 2020/21. 5003 individuals were involved in a safeguarding concern raised, an increase of 38.7% on 2020/21. **However, In December 21 there was a change in processes where First Contact started recording more of the Safeguarding Concerns that previously went direct to SHSC for screening. This was a sharp increase in work for First Contact, which explains the increase on last year.**

1739 individuals were involved in a safeguarding enquiry commenced in 2021/22.

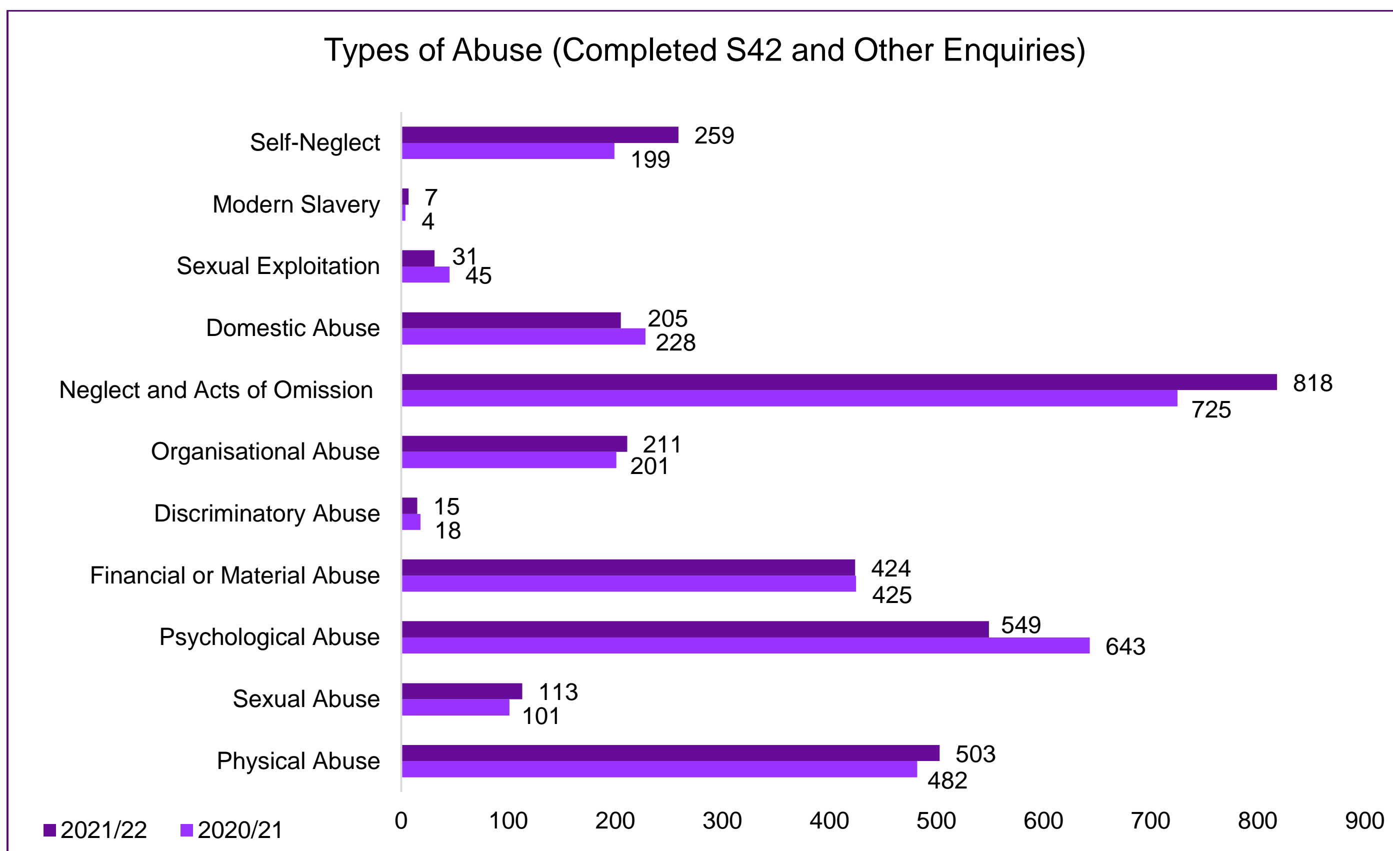


However, there are a proportion of individuals who were involved in safeguarding concerns raised/ enquiries commenced, multiple times across the year. The total number of safeguarding concerns in 2021/22 was 6373, a 44.1% increase on last year. However, again, this is likely a reflection on the explanation above whereby in December 21 there was a change in processes in First Contact.



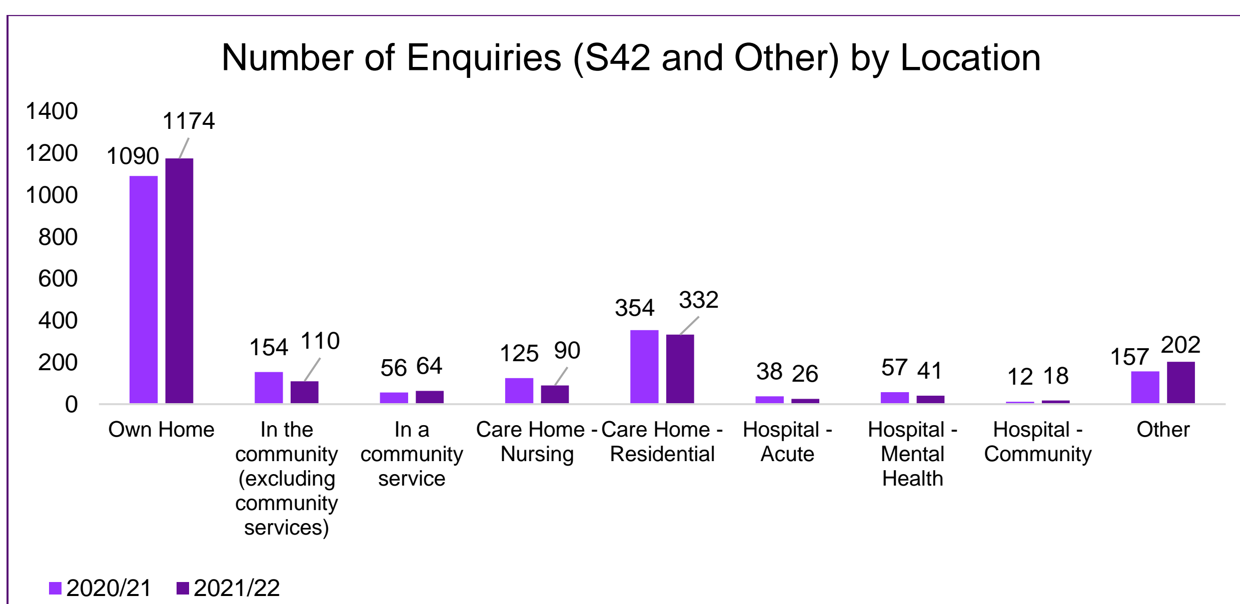
Type of Abuse Experienced

Of the enquiries completed in the year 2021/22, the types of abuse that were most prominent were Neglect and Acts of Omission, Psychological Abuse and Physical Abuse. When compared with last year the biggest increases in abuse type were Neglect and Acts of Omission (+93) and Self-Neglect (+60). The biggest decrease was in Psychological Abuse (-94).



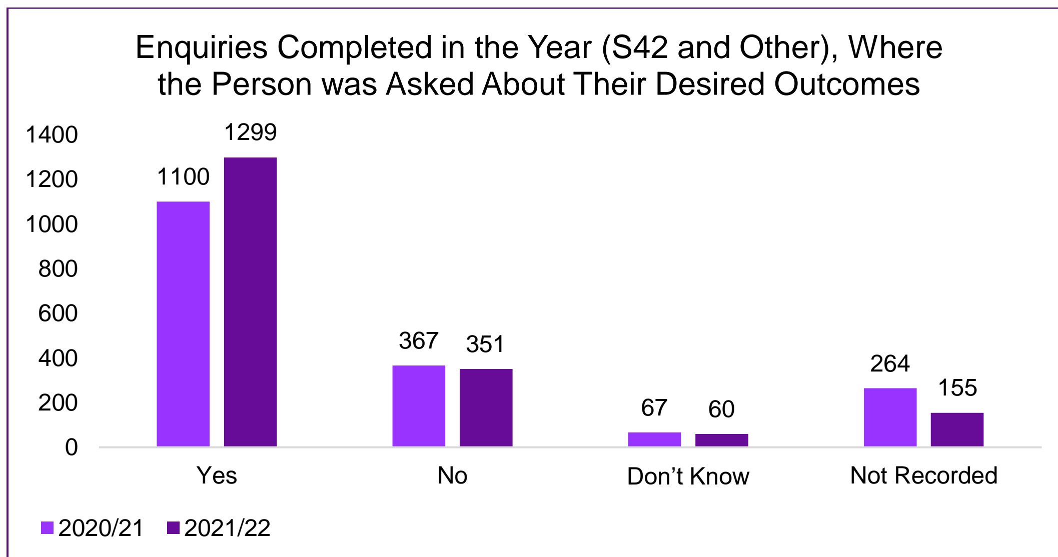
Location of Abuse

Own home continued to be the most prominent location of abuse in enquiries completed; this figure was slightly higher than last year, 1090 in 20/21 vs 1174 in 21/22. This was followed by residential care homes.



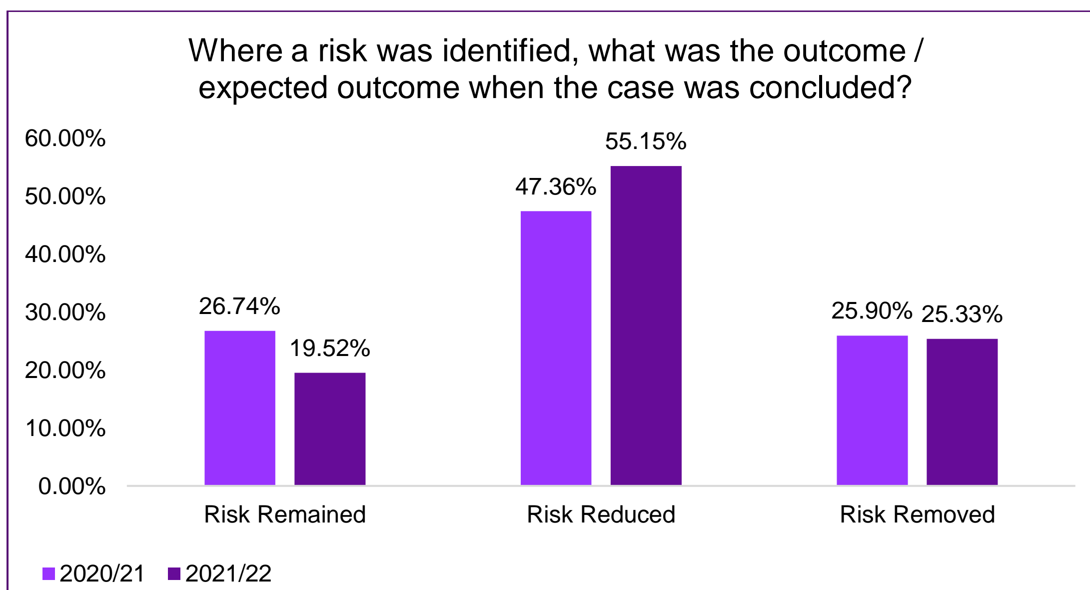
Making Safeguarding Personal (ASC data)

The number of individuals who were asked their desired outcomes in safeguarding enquiries concluded, increased in the year 2021/22 compared with the previous year. In 2020/21 the proportion of people asked was 61.2% and in 2021/22 this figure was 69.7%. Both years were an increase on 2019/20 where in 54.1% of enquiries completed in the year people were asked about their desired outcomes.



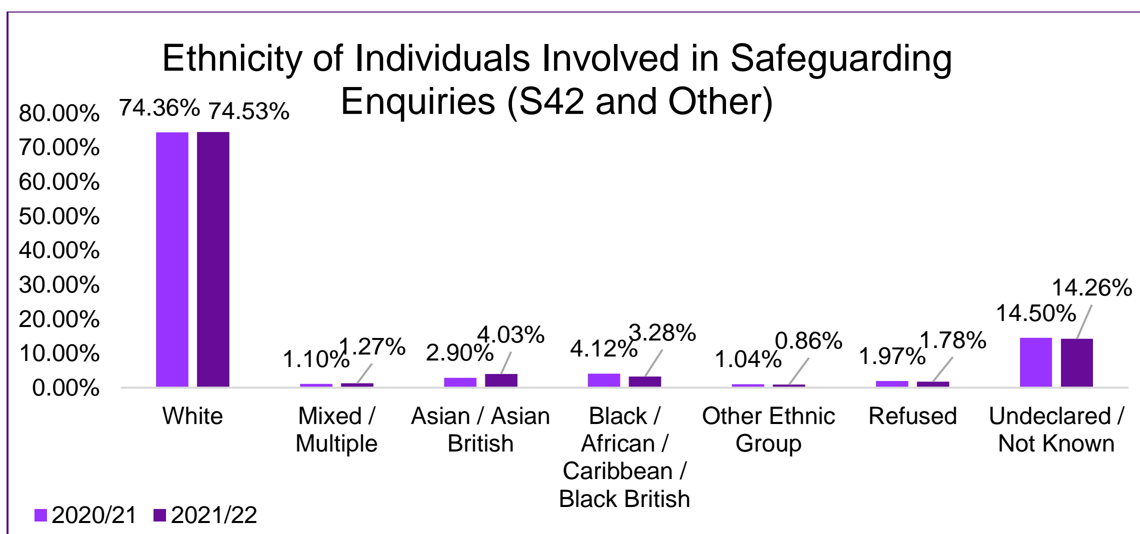
Impact on Risk

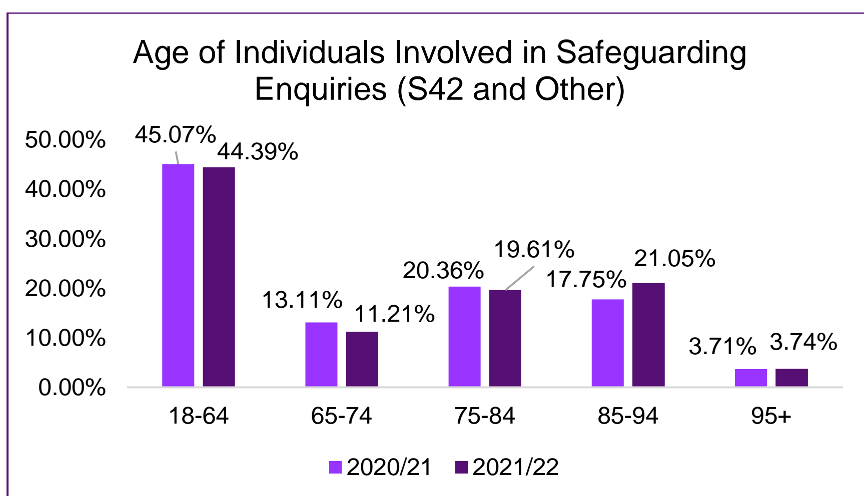
Where risk was identified, the risk remained in 19.52% of enquiries completed (S42 and Other) this is an improvement on last year, where risk remained in 26.74% of enquires completed in the year. Risk was reduced in 55.15% of enquiries completed this year, compared with 47.36% the year before, and the proportion of enquiries where risk removed was at a similar rate to 20/21.

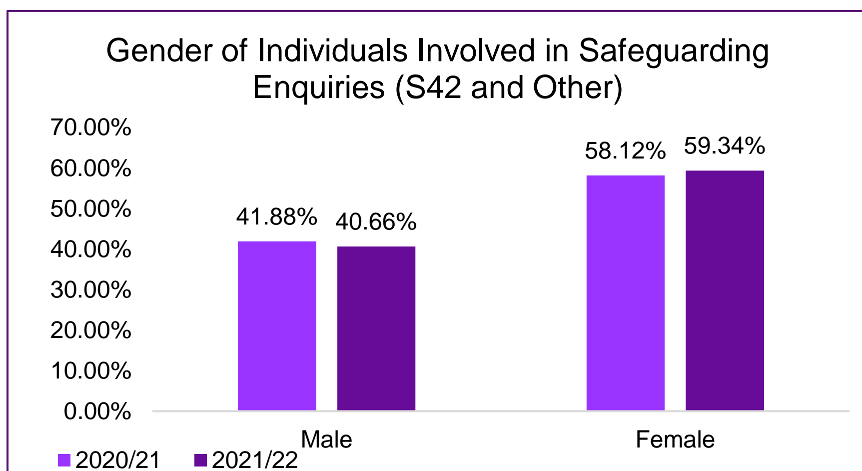


Demographics of Individuals Safeguarded (Safeguarding Enquiries)

Adults who identified as White were the highest represented group in safeguarding enquiries that commenced in the year. Except for instances where ethnicity was not known or undeclared, Asian/Asian British were the second highest represented. Gender and age remained similar to 20/21. More women than men were involved in a safeguarding enquiry that commenced in the year (59.34% vs 40.66%). 44.39% of enquiries commenced in the year involved individuals in the 18-64 category, 55.61% of individuals involved in enquiries were 65+.







12. Overview from the Independent Scrutineer

Thank you for taking the time to read this report outlining continuing progress in the multi-agency work to protect and safeguard adults at risk in Sheffield.

The report covers the period from April 2021 through to March 2022, a period that continued to present unprecedented challenges for partners as the global pandemic COVID-19 continued to impact. We have seen increasing referrals to services in both volume and complexity, workforce shortages, ever increasing pressures on public sector funding and a worsening economic and cost of living crisis, which is impacting differentially on the most vulnerable in our society.

The report details Safeguarding Adults Reviews (SARs) undertaken in the year, together with an overview of the dissemination of learning briefs, capturing of key themes and the updating of policies, procedures and training offers as a result. My reflection would be that some themes such as information sharing, and professional curiosity continue to be repeated in new SARs. Adult Health and Social Care are commissioning a review to identify any barriers to embedding learning and changing practice with suggestions of what we could do differently. I would support that approach.

The impact of the COVID-19 outbreak on Mental Health Crisis Services in Sheffield has been significant, resulting in an increase in demand of unprecedented expectations, with more people than ever in mental health crisis. A specific request was made to NHS Yorkshire and the Humber Mental Health Clinical Network, to undertake a review of the adult crisis pathway, complementing improvement work on going in the Children and Young People's crisis pathway. The review was conducted in the interest of providing high quality services, and the duty to safeguard adults in Sheffield in crisis. Engagement was positive, and it was reported that all stakeholders were extremely passionate about making an improvement. The report which has been shared with SASP, outlined immediate, essential, and desirable recommendations. SASP welcomed the report and will monitor improvements in outcomes for adults in Sheffield experiencing mental health crisis.

CQC is the independent regulator of health and adult social care in England charged with ensuring that health and social care services provide people with safe, effective, compassionate, and high-quality care. Their inspections and reports provide an important source of assurance that agencies in Sheffield are working to keep people safe. CQC undertook several inspections in Sheffield in 2021/22, some of which are important to highlight in this report.

In August 2021 CQC reported on their visit to Sheffield Health and Social Care NHS Foundation Trust. Whilst the Trust's overall rating had improved, recommendations particularly relevant to the work of the partnership included that the trust: must ensure that the statutory and delegated safeguarding functions are carried out effectively; that there are robust reporting, governance processes and oversight in place; that incidents and safeguarding are reported and investigated in line with the trust's processes and in line with national guidance; that complaints are responded to in a timely manner via a process accessible to patients and staff and that they are used for processes of feedback and learning; that care is provided in estates and accommodation which are suitable, safe, clean, private and dignified.

CQC identified significant patient safety concerns at the focussed inspection of maternity services in Sheffield in March 2021. The inspection saw the rating of the service deteriorate to inadequate.

A remedial action plan is in place with most actions already completed or due for completion over the summer of 2022.

CQC visited Sheffield Teaching Hospitals Trust in October 2021 focusing on medical care including older peoples' care, surgery, and urgent and emergency services. Whilst the review identified that staff knew how to protect patients from abuse, it found that there was not enough staff to care for patients and keep them safe.

I am pleased to note that actions plans have been developed to address all the findings from each of the CQC inspections with robust reporting, governance and oversight in place. However, the SASP must monitor progress with the action plans and develop mechanisms for partners to hold each other to account to ensure that the risks to vulnerable people have been mitigated and they are protected from harm. This must be a priority for 2022/23 and should build upon, rather than duplicate, the updated NHS Safeguarding Assurance and Accountability Framework.

The Sheffield City Council Delivery Plan recognises that Adult Health and Care Services are under a significant amount of pressure across key areas of business (including home care, residential care, discharge and reablement and safeguarding) with rising demands, costs and lack of capacity in the system. To establish the foundations for a sustainable Adult Health and Social Care system which improves the outcomes and wellbeing of adults and carers across Sheffield, a new long-term Strategy for Adult Health and Social Care, underpinned by a Delivery Plan, Care Governance Framework and Homecare Transformation Programme have been approved by the Council. Delivery plans focused on preventing abuse and neglect, preventing unnecessary admission to hospital, supporting safe discharge from hospital and co-production with service users are also scheduled for approval by the Council this year, so that the focus remains on risk mitigation and improving outcomes for vulnerable people.

Children's and Adults' Care Services represent the council's two largest areas of expenditure, and the two most significant areas of risk in terms of poor outcomes for vulnerable people. There is also an ongoing risk of market failure in both the adults' and children's care sectors. Adult Health and Social Care is CQC-regulated, and inspection is possible at some point over the course of 2022/23. Plans are in place and being implemented to ensure that they are well-prepared for this.

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) are currently undertaking a PEEL inspection (police efficiency, effectiveness, and legitimacy) at South Yorkshire Police, which includes safeguarding and vulnerability. The report is expected early in 2023.

The annual report demonstrates that partners have faced significant challenges during the year. However, there has also been significant innovation, and safeguarding has been maintained as a priority. What I have seen since my arrival is real commitment to working together, and the willingness to address the need for change. I have seen great examples of innovation, with Sheffield at the leading edge locally and contributing nationally to emerging policy on interventions that support adults and their families and prevent escalation of need. Many examples are set out in detail in this report together with the impact they have made.

I again, extend my thanks to all members of the safeguarding teams for their work and persistence in sustaining effective safeguarding in Sheffield.

Lesley Smith,
Independent Chair and Scrutineer, Sheffield Adult Safeguarding Partnership

13. Appendix

Appendix A - Acronyms

Acronym	Definition
DASH	Domestic Abuse, Stalking and Harassment
IDVAS	Independent Domestic Violence Advocacy Service:
IRO	Independent Reviewing Officer
IRS	Independent Reviewing Service
JTAI	Joint Targeted Area Inspection
LADO	Local Authority Designated Officer
LLR	Learning Lessons Review
LPIG	Learning and Practice Improvement Group
MACF	Multi-Agency Confirmation Form
MAPLAG	Multi-Agency Pregnancy Liaison and Assessment Group
MARAC	Multi-Agency Risk Assessment Conference
MAST	Multi-Agency Support Teams
NPS	National Probation Service
SCC	Sheffield City Council
SCCG	Sheffield Clinical Commissioning Group
SCH	Sheffield Children's Hospital
SCIRS	Safeguarding Children & Independent Review Service
SCSP	Sheffield Children's Safeguarding Partnership
SHSC	Sheffield Health and Social Care
SoS	Signs of Safety
SSES	Sheffield Sexual Exploitation Service
SSH	Sheffield Safeguarding Hub
STH	Sheffield Teaching Hospitals
SYP	South Yorkshire Police
YAS	Yorkshire Ambulance Service
YJS	Youth Justice Service