Annual Report 2022/23

Document Information

Sheffield Adult Safeguarding Partnership (SASP) Annual Report 2022/23

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SASP Sheffield Adult Safeguarding Partnership

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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.

For members of the public, concerns can be raised by contacting the First Contact Team on 01142734908.

Professionals are encouraged to use the referral form which can be found on our website, here.

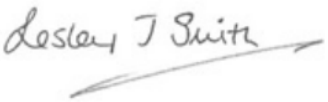
Contents

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 2022 through to March 2023, a period that continued to present unprecedented challenges for partners.

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.**

Safeguarding is very much everyone's business, and I would offer my thanks to you all for your 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 Smith

Independent Chair and Scrutineer

Sheffield Adult Safeguarding Partnership

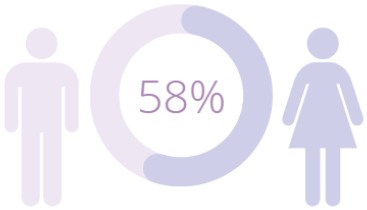
2. Key Safeguarding Facts

5660 Safeguarding Concerns Raised

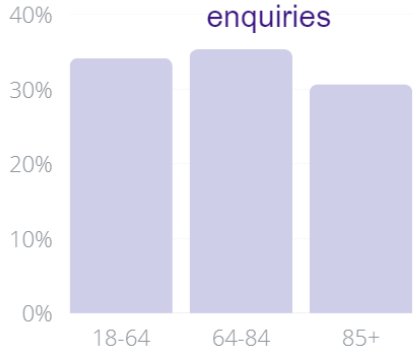
1285 Section 42 Enquiries Commenced

240 "Other" Safeguarding Enquiries Commenced

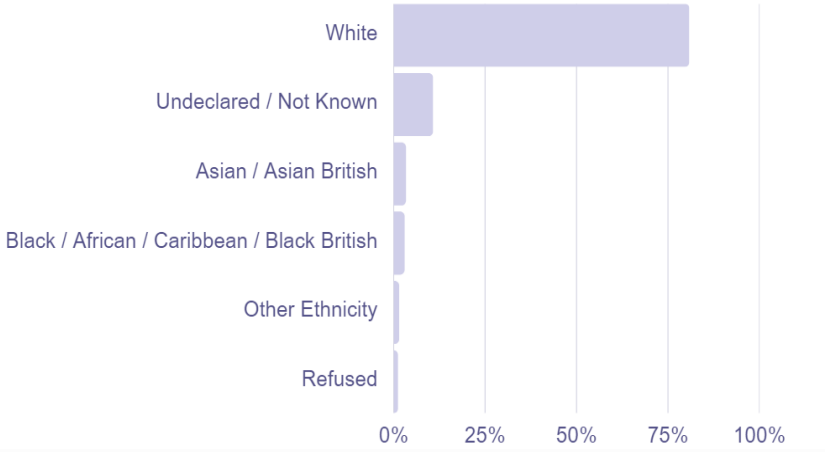
More women than men were involved in safeguarding enquiries

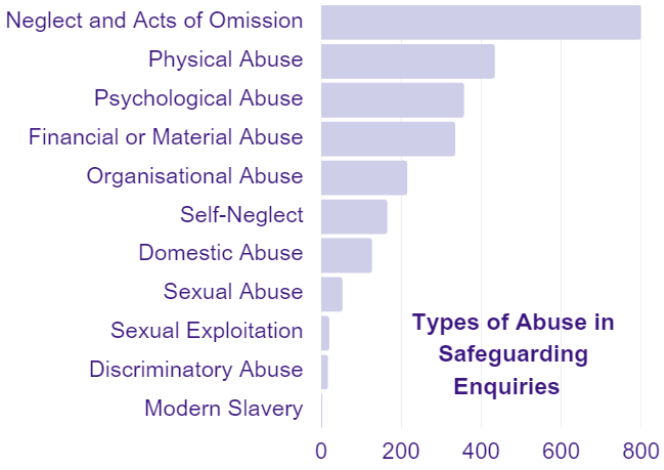


The age range of people who had safeguarding enquiries

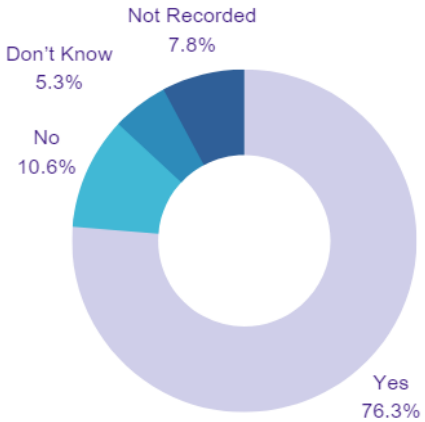


Ethnicity of Individuals Involved in Safeguarding Enquiries

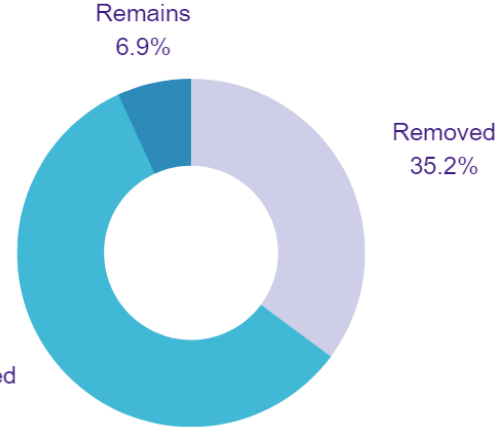




Was the Person Asked their Desired Outcomes in the Safeguarding Enquiry?



In Safeguarding Enquiries Was the Risk Removed or Reduced?



3. About Sheffield Adult Safeguarding Partnership

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 2022 to March 2023 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
NHS SY ICB (Sheffield)	NHS South Yorkshire Integrated Care Board
SYFR	South Yorkshire Fire and Rescue
AC&W	Adult Care and Wellbeing
SCC	Sheffield City Council

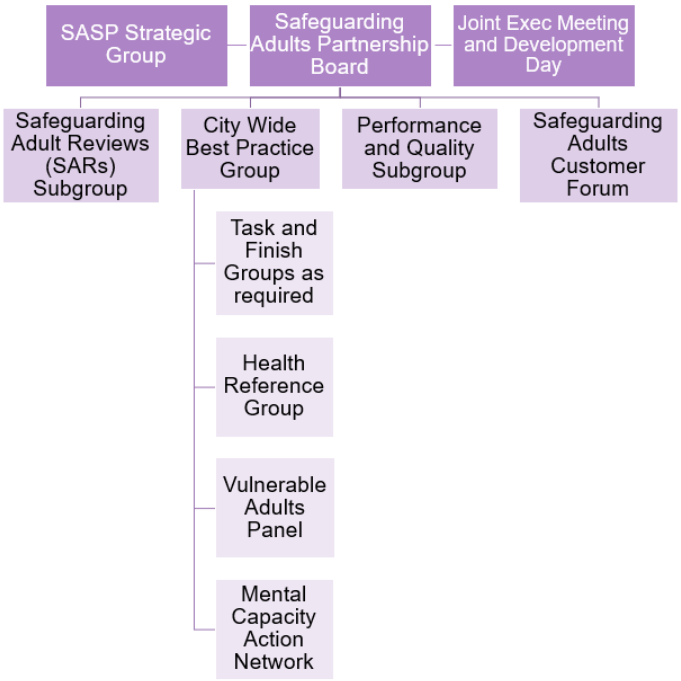
3.1 SASP Membership List

Executive Board Membership List

Member	Agency
Independent Chair	SASP
Safeguarding Board Manager	SASP
Chair of the Customer Forum	SASP
Chief Nurse	Sheffield Teaching Hospitals Foundation Trust
Exec Director of Nursing Quality and Professions	Sheffield Health and Social Care
Chief Nurse	NHS SY Integrated Care Board, Sheffield
Head of Service	Probation Service
Chief Superintendent	South Yorkshire Police
Area Manager for Prevention and Service Improvement	South Yorkshire Fire and Rescue
Head of Neighbourhood Intervention and Tenant Support – Housing Service	Sheffield City Council
Strategic Director of Adult Care and Wellbeing	Sheffield City Council
Deputy DASS (Director of Adult Social Services)	Sheffield City Council
Councillor Lead	Sheffield City Council
Chief Executive Officer	Sheffield Carers Centre (Voluntary Services Representative)

3.2 SASP Structure Chart

SASP Structure Chart



Safeguarding Adults Partnership Board: The Board works to achieve the shared aims and objectives of the partners to develop a vision of safeguarding for Sheffield which includes a strong commitment to safeguard adults at risk, including carers, and engages the active support of the public. The board ensure that as far as practicable within the resources available, each agency provides services to the interagency system which are effective in safeguarding, promote the dignity and respect of Sheffield's adults at risk, and that the Board works to maximum efficiency to achieve its purposes.

Strategic Group: Three safeguarding partners (SYP, SCC and NHS SY ICB) form the Strategic Group and set the strategic priorities, agree funding and resources, and drive forward the work of the Partnership, whilst ensuring that the vision and values are upheld. They advise and support the Executive Partnership Group to develop, implement and monitor an annual plan based on the priority actions agreed against the core business.

City Wide Best Practice Group (CWBPG): This subgroup provides a forum where improvements can be discussed, agreed and disseminated into partner organisations to staff who work with safeguarding procedures, national and local legislation, and policies/procedures.

Performance and Quality Subgroup: The SASP Performance and Quality function monitor and evaluate the effectiveness of safeguarding adults' practice across the city, using qualitative and quantitative data intelligence to identify areas of best practice and themes, trends and areas requiring action or improvement.

Safeguarding Adult Review Subgroup: The SAR subgroup of the Sheffield Adult Safeguarding Partnership is responsible for recommending the commissioning of SARs, managing the process, and assuring that all the associated recommendations and actions have been implemented by the relevant partners.

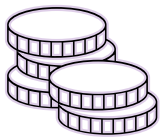
Safeguarding Adults Customer Forum: Members of the Forum share an interest in Safeguarding Adults and they can ask questions and bring information to share. The Customer Forum ensures that people have a voice and that their and opinions on safeguarding are fed back to the board and partners in order to improve services. Read more about the Forum on page 30.

3.3 Funding and Spend for 2022/23

Balance (underspend) from 2022-23	(177,410)
Adj to Reserve	

Income	**Budget**	**Outturn**
Sheffield City Council	(327,176)	(327,176)
SY Police and Crime Commissioner	(12,000)	(17,913)
SY ICB (Sheffield) (prev. CCG)	(92,700)	(92,700)
Expenditure		
Employers - Salaries	364,276	221,727
Transport - Employees Expenses	1,300	90
Supplies & Services	66,300	81,181

Net in year underspend	(134,784)
Balance to be carried forwards to 23-24	(312,193)



South Yorkshire Police and Crime Commissioner – Your Voice

NHS South Yorkshire Integrated Care Board

Sheffield City Council

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 Sheffield City Council, summarises some of the relevant issues and how they are monitored.

- The Quality and Performance Team for Adult Care and Wellbeing has continued to follow up on safeguarding concerns reported in relation to residents of care homes, looking at wider quality and safety implications. This is completed in partnership with the South Yorkshire ICB Care Homes Quality Team who explore clinical issues. Both teams jointly promote best practice within care homes.

- Both teams have supported care homes to ensure that appropriate reporting is occurring from care homes to the local authority and have promoted the training programme that is offered by Sheffield City Council.

- The Quality and Performance Team for Adult Care and Wellbeing has linked in with the Practice Development Team at the Council on specific cases relating to action that needs to be taken for People in Positions of Trust (PiPoT) and DBS referrals.

- Spoken with residents as part of quality monitoring visits to explore their wellbeing, looking at the opportunities they are offered to have a good quality of life, that they are asked for feedback in a variety of ways, that they know how to complain, and that their feedback is acted upon.

- Spot-checked how care homes manage residents' finances and how people are supported to retain access and control over their own money.

- Spoken to staff in care homes about their understanding of safeguarding, dignity and respect and how this works in day-to-day practice. Asked if staff members have attended safeguarding training and whether they are confident to raise risks with management and know about whistleblowing procedures.

- Checked that information-sharing and risk management systems in use at care homes and business continuity plans are robust.

- Discussed with care home managers their responsibilities regarding the procedures laid out in the Duty of Candour Regulation.

- Looked at recruitment practice and supervision of staff to ensure safe practice.

5. Safeguarding Adult Reviews

A Safeguarding Adult Review is a multi-agency process that considers whether or not serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented and uses that consideration to develop learning that enables the partnership to improve services and prevent abuse and neglect in the future.

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.

The SAR Sub-Group of the Sheffield Adult Safeguarding Partnership is responsible for recommending the commissioning of Safeguarding Adult Reviews (SARs) in line with the Care Act 2014 Guidance (Chapter 14), managing the process, and assuring SASP that recommendations and actions arising from reviews have been addressed by the partnership and individual agencies.

REPORTS AND LEARNING BRIEFS

Links to all Safeguarding Adult Review Learning Briefs and Overview Reports can be found here on our website Sheffield Adult Safeguarding Partnership - About the Board (sheffieldasp.org.uk)

SAR DHR NEWSLETTER

Quarterly, SASP and DACT (Domestic Abuse Coordination Team) produce a SAR-DHR Newsletter, looking at themes and learning coming from reviews in the city, such a Safeguarding Adult Reviews and Domestic Homicide Reviews. We often see cross-cutting themes across these reviews. Newsletters so far have looked at:

- Carers
- Adult Family Violence
- Non-Engagement and Was Not Bought
- Trauma Informed Practice

Past editions of these newsletters are available to read on our website.

Find them here Sheffield Adult Safeguarding Partnership - (sheffieldasp.org.uk) (below the learning briefs).

5.1 Safeguarding Adult Reviews 2022/23

Number of Referrals Received

From April 1st 2022 to March 31st 2023, SASP received 8 SAR referrals.

Characteristics

Of the 8 SAR referrals, 4 were male and 4 were female. 2 were aged 40-50, 3 aged 51-60, 1 aged 61-70, 2 aged 71-80.

SARs Commissioned

1 out of the 8 referrals has met the SAR criteria. 4 are still under consideration.

SARs Ongoing

3 SARs are ongoing as of March 31st 2023, 1 of which the referral was received in 22/23, and 2 of which the referral was received prior to this financial year.

SARs Completed

There were no SARs completed in this financial year.

Of the eight SAR referrals received in 2022/23:

- One met the SAR criteria.
- Three did not meet the criteria. One did not meet the criteria as the person was not known to any agencies. Two did not meet the criteria as there were no concerns that agencies did not work together to safeguard the person.
- Four are still under consideration as more information is being gathered prior to making a decision e.g., awaiting toxicology results.

A decision was also made on two additional referrals received in the previous financial year (2021/22). One of these met the SAR criteria the other did not as there were no concerns over multi-agency failings, and instead a single agency report was presented to the SAR subgroup by Adult Care and Wellbeing.

Two SARs were therefore commissioned this year and are ongoing. Themes arising from these 2 reviews include:

1. Cuckooing, substance misuse, trauma informed practice, mental health.
2. Cross boundary working, information sharing, learning disabilities, mental health.

There is one additional SAR still ongoing that was commissioned in 21/22. Themes arising from this review includes cross boundary working, transitions, learning disability, mental health.

3 SARs are ongoing in total as of March 31st, 2023.

There were no SARs completed in 2022/23. Learning Briefs for all of our reviews can be found here.

5.2 Safeguarding Adult Reviews – Recommendations and Actions

In 2022 – 2023 SASP and partner agencies continued to implement learning and actions from Safeguarding Adults Reviews completed in Sheffield. Examples of actions completed can be found in editions of the SAR-DHR Newsletters. Actions have included:

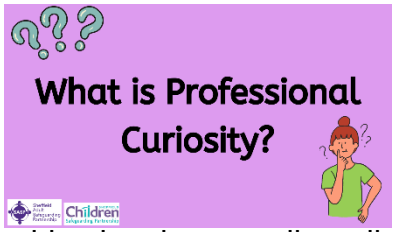
Following learning from SAR Person E, SAR Person F and SAR Harris

In July 2022, SASP published **The Multi-Agency Self Neglect Policy and Practice Guidance (including VARM and CCM).** The purpose of this policy is to outline a multi-agency approach to support those across SASP when responding to concerns relating to adults who self-neglect. It aims to ensure that those professionals involved in working with adults who may exhibit self-neglect or hoarding behaviours, have a consistent approach to responding to concerns that are up to date, easily accessible and which promote positive outcomes for those of concern.

The practice guidance that goes alongside this policy can be used to support decision making for cases involving self-neglect, and those cases of self-neglect where there are other substantial risks, such as hoarding, drug and alcohol dependency, homelessness, and sexual exploitation and will support professionals with a framework for identifying and managing those collective risks.

Following learning from SAR Person D and SAR Person Harris

A video on professional curiosity was developed by the SASP Development and Training Manager and the Sheffield Childrens Safeguarding Partnership Workforce Development Manager. **It takes you through what professional curiosity is, what skills it involves and why it's really important that we are all professionally curious.** The video has been published on the SASP website, has been shared on social media channels, shared in the e-bulletin and shared around the City-Wide Best Practice Group. The video has been really well received on social media and by partner agencies. You can watch the video here **Professional Curiosity Video - YouTube**.



Following learning from SAR Person I

Sheffield Teaching Hospitals Foundation Trust (STHFT) Continence Service updated their operational guidance to provide any young person who is transitioning to STHFT with a face-to-face appointment. The continence service is continually offering several options for clinical assessment to patients and carers including face to face. This is clearly documented throughout the Learning Disability template which is completed by all clinical staff. The Did not Attend/Was Not Bought Policy was updated and ratified.

The supply chain sends quarterly reports to the Continence Service on non-activated deliveries for patients with a learning disability. This data is monitored by the Continence Service.

Following learning from SAR Person I

The Preparation for Adult Team can now access Widgit Online (Inclusive Communication programme) to help aid communication with people who are nonverbal / prefer pictures to help communicate. The team have Makaton and BSL training arranged to help communicate and engage with the people we work with, to ensure their voice is heard.

The following recommendation was identified in SAR Harris:

"SASP should expedite continuation and finalisation of the consideration of a business model to enhance and improve interagency working and information sharing (that may or may not result in a Multi-Agency Safeguarding Hub). This work must include all relevant partners and consider how the resulting system will link in with the Children's MASH."

Over the year 2022/23 partners worked together to develop an adult multi-agency safeguarding hub (MASH) which launched in April 2023. This is a key example of partners working effectively together to ensure that they are doing what they can to keep adults at risk in Sheffield safe and fulfilling the duties and commitments made in the South Yorkshire Safeguarding Procedures. Daily huddles allow professionals to respond swiftly and effectively to safeguarding concerns, using the collective knowledge of partners and negating the risk of duplication or agencies undertaking safeguarding in isolation. Partner agencies can access their data prior or during the meeting and share relevant information, such as involvement with the individual(s). This can aid making safeguarding personal by agreeing who is best placed to take forward actions to support said individual.

For example, Adult Care and Wellbeing were contacted by the Children's Service about a group of young women who it was feared were the victims of sexual exploitation. The ages of these young women straddled the age range between adult and children, and it was clear that a joint approach was required. The MASH being in place meant that all interested parties were bought together quickly to share information.

Although still in the early stages of its launch, key to the development of the multi-agency safeguarding hub has been partnership working. Partners have welcomed the introduction of the MASH to Sheffield which continues to develop and evolve at pace as it is embedded.

6. SASP Multi-Agency Training

Over the past twelve months SASP have continued to offer training courses and workshops, virtually using Zoom and Microsoft Teams. This was to create opportunities for people to access safeguarding adults training in a safe environment and due to the flexibility that online training can offer.

Over the past 12 months 859 people have attended the courses, workshops and conferences we have offered. They have been from a wide variety of agencies across the city, and this embraces the ethos of safeguarding being everyone's business and that safeguarding is a multi-agency process.

2022/23 saw the launch of our new self-neglect training course. This course is for anyone who works with adults (at risk) due to self-neglect, hoarding or where there are concerns around multiple risks and contextual safeguarding. It may be that they are not engaging with services or that services are not working together in a coordinated way to identify the risks, support the adult and share relevant information to promote the persons safety and wellbeing or the safety and wellbeing of others.

We have also continued to work closely with Children's Safeguarding, to deliver courses and workshops which look holistically at families and family dynamics. In 2022/23 we offered five courses, which 236 people attended in total. These courses are now firmly embedded in our core programme and will continue to be offered.

Sheffield Children Safeguarding Partnership

The beginning of 2023 saw the introduction of a new training platform for SASP. This system provides information regarding our training prospectus, and it has helped to streamline the booking system, with automated provision not just for booking onto a course, but also capturing pre-evaluation, post evaluation and issuing attendance certificates. This will enable us to provide more detailed information regarding the courses and workshops which will help us review, evaluate and make the necessary changes and developments to course content.

Click here to view and book SASP multi-agency training courses

Click here to view and book SCSP multi-agency training courses

7. Strategic Priorities 2020-23

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.

The 5 key priorities in the SASP three-year strategic plan for 2020-23 are:

The following pages demonstrate examples of work ongoing by partners to achieve the priorities in the strategic plan.

7.1 Making Safeguarding Personal (MSP)

SOUTH YORKSHIRE FIRE AND RESCUE (SYFR)

SYFR continue to embed MSP into practice. The internal safeguarding concern form includes a section on MSP ensuring that safeguarding is person led and outcome focused with the aim to make people feel safer but also empowered and in control. Safeguarding concern forms are triaged by the Safeguarding Officers who regularly audit and identify learning and development opportunities within the workforce to improve practices and learning.

Safeguarding training covers MSP including case studies and learning from National and Regional Case Reviews.

IMPACT
Ensures that the adult concerned is at the centre of adult safeguarding, working with adults in order for them to identify strength-based and outcome focus solutions.

Working to empower adults by working with them in a way that enhances individual involvement, choice and control as part of improving a quality of life, wellbeing and safety.

SHEFFIELD TEACHING HOSPITALS FOUNDATION TRUST

A 7 Minute Briefing on MSP has been made available to staff via the Safeguarding Quarterly Newsletter and is accessible via the Safeguarding Patients intranet site.

MSP is promoted within the safeguarding adults mandatory training which includes discussion about person centred practice and creating opportunities to see the person on their own to obtain their wishes and feelings and to identify outcomes without the influence of family or carers.

The Safeguarding Team include MSP in discussion with staff members who contact the team for advice about an adult at risk and discuss MSP during safeguarding case supervision.

IMPACT
Staff are supported and encouraged to be more aware of the need to identify outcomes with the adult at risk when raising a safeguarding concern.

SOUTH YORKSHIRE POLICE (SYP)

SYP have continued to effectively embed training in relation to vulnerability. Domestic Abuse Matters and Child Matters training has continued throughout the year. This has been supported by continued professional development for supervisors and line managers around specific areas of identified learning.

IMPACT
One key area has been Domestic Abuse from a survivor's perspective, sudden unexpected death in infancy from the perspective of a mother and stalking and harassment training. This has ensured Sheffield district continues to embed a vulnerability focussed response across a wide and diverse workforce, to ensure that outcomes have a personal focus and that the voice of the victim is heard.

7.1 Making Safeguarding Personal (MSP)

ADULT CARE AND WELLBEING

In the last year AC&W have continued to develop a safeguarding culture. Support for staff to make a difference in their practice is offered by the Practice Development Team and the new Multi-Agency Safeguarding Hub (MASH).

AC&W continue to ensure safeguarding responses support people to improve their wellbeing and resolve circumstances that may be difficult using the principles of Making Safeguarding Personal.

IMPACT
Accountability requires collaboration and transparency between the local authority and all partner agencies. The introduction of MASH supports safeguarding responsibility for all in identifying areas of concern and improves safety measures and outcomes for the adults concerned.

Practice has focused on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'. The cultural change; staff support and development; engaging with people and across partnerships; has promoted the values and principles that are set out in Human Rights Act (1998), Care Act (2014), Mental Capacity Act (2005).

SHEFFIELD HEALTH AND SOCIAL CARE

Reviewed and adapted the MSP toolkit to make it workable for SHSC staff and service users. SHSC put together a training package based on the toolkit and delivered this to a Community Mental Health Team. In the future this potentially will be rolled out to other SHSC teams, incorporated into the Level 3 training package, and/or used within Bitesize training sessions.

IMPACT
The aim of the training is to improve current knowledge and practice around MSP, in order to improve the quality of safeguarding concerns raised, and to ultimately ensure that service users are placed at the centre of their safeguarding. Next steps will be to complete a baseline audit of the team's safeguarding concerns against the toolkit, alongside a post-training audit to measure the impact the training has had.

CARERS CENTRE

The Carers Centre continue to provide an ongoing Carer Assessment and Advice Service. All Carer Advisors inform carers where there is a potential safeguarding concern that the safeguarding process is intended to be supportive and personalised, which follows agreed training.

IMPACT
Carers have reported being reassured by this advice.

On average one safeguarding concern per month is raised with Adult Care and Wellbeing. All safeguarding referrals or concerns are recorded on a safeguarding concern log, which is monitored by management at each monthly meeting.

HOUSING AND NEIGHBOURHOOD SERVICE

Housing has a strength-based approach that ensures parents and children are involved in case decisions and the Signs of Safety approach is used to ensures tenants are fully involved in plans.

Feedback from tenants via questionnaires/meetings is used to improve provision of services.

The annual visit form contains prompts which ensures their views are taken into account when discussing need for possible support/intervention.

IMPACT
This ensures that the right support/intervention is provided to meet individual's needs.

PROBATION SERVICE

People on Probation are fully involved with their probation practitioner, to develop their sentence plan and related support and actions.

Probation Service contribute to Adult MASH meaning that individual cases are managed more effectively and personally.

IMPACT
Improved engagement and compliance with Community Orders.

Stronger multi-agency working, and better actions taken from MASH meetings.

7.2 Working in Partnership

SOUTH YORKSHIRE FIRE AND RESCUE

The Safe and Well Referral Partnership Scheme aims to improve how the fire service and local organisations work together to effectively identify and reduce hazards for people more at risk. SASP members continue to sign up to and make referrals to SYFR using the Safer South Yorkshire Referral Scheme. Data on referrals from partners is included in the SASP quarterly performance report.

SYFR are represented on both Safeguarding Adult and Children Partnerships and attend Sub-Group meetings. SYFR were involved in the recent task and finish group to develop a new Self-Neglect and Hoarding Policy and continue to be involved in Team Around the Person (TAP) meetings.

IMPACT

SYFR became involved with a male who lived alone with no support and was a careless smoker. He lived in the kitchen/front open plan room. He was self-neglecting and heavily hoarding but refusing any help. He had initially declined visits but on one occasion when the SYFR High Risk Coordinator visited he let her in to the kitchen with the SCC Prevention Worker.

Multi-Agency meetings were held over the concerns. First Prevention Team, Adult Care and Wellbeing, Cleaning company, GP practice and SYFR all discussed their concerns during the meeting.

A short while after he had a fall and was taken into hospital. It was at this point he recognised he did need help. The property was cleaned and cleared. A Care Act Assessment was completed, and carers were put in place. He agreed to Citywide alarms and a pendant and stopped using emollient products.

SOUTH YORKSHIRE POLICE

Op Forge Kilo is a multi-agency response to identified Domestic Abuse perpetrators and their victims. An algorithm is used to identify the perpetrators and a problem-solving methodology is applied to reduce offending, reduce vulnerabilities and reduce demand, resulting in the prevention of further offences and protection of vulnerable adults.

IMPACT

One example of the impact of Op Forge Kilo is a perpetrator is being supported from an engagement perspective with a particular focus around mental health and substance misuse support. He has just been released from hospital with support.

Victims are receiving technology to enhance their safety (Ring Doorbell with cloud storage – Supplied by IDAS) and IDAS continue to support victims even where the perpetrator is remanded in custody; thus, continuing to build trust and confidence.

NHS SY ICB – SHEFFIELD

Whilst working across the SASP and Community Safety Partnership the Designated Professional noted that on occasion there were cases referred for either a SAR or DHR that could potentially be one or the other. However, the information gathering tools being used in both cases didn't go into enough detail to gather information to make robust decision. This resulted in partner agencies being asked twice to provide information. The Designated Professional worked with the Domestic Abuse Commissioning Manager to update both the DHR and SAR information gathering templates.

IMPACT

Information is provided that can lead to better decision making and establish more accurately which review process is required, hence speeding up the process, improving accuracy in decision making and resulting in learning being identified more quickly.

SHEFFIELD TEACHING HOSPITALS FOUNDATION TRUST

The STHFT Safeguarding Team participate in all SASP meetings and sub-groups including the multi-agency Vulnerable Adults Panel and the Safeguarding Adults Review Panel, undertaking Individual Management Reviews as required.

Members of the STHFT Safeguarding Team contribute to the SASP Multi-agency Training Pool, delivering safeguarding training to staff from different agencies across Sheffield.

IMPACT

This has led to a better understanding of other agencies and how collaborative working can benefit adults at risk, achieve better outcomes, and there is shared learning from working collaboratively with other agencies.

7.2 Working in Partnership

ADULT CARE AND WELLBEING

Developed with partners an Adults Multi-Agency Safeguarding Hub (MASH) which is now in operation (As of April 2023). The MASH is a local arrangement to fulfil the duties and commitments made in the South Yorkshire Safeguarding Procedures. The MASH is a hybrid team and the majority of the function sits within the First Contact Team in AC&W, however all of the Adult Social Care Teams have access to the MASH. This ensures that safeguarding activity is highly visible and well-integrated across teams.

Adult Care and Wellbeing, housing and the police are core members of the MASH, health colleagues are exploring resourcing their contribution, and currently attend as and when requested.

IMPACT

Huddles, set daily allow professionals to respond with greater effectiveness and efficiency to safeguarding concerns using the collective knowledge of partners. For example, partner agencies can access their data prior or during the meeting and share relevant information, such as involvements. This can aid making safeguarding personal by agreeing who is best placed to take forward actions to support said individual.

As all partners have the huddle in the diary and this can be called at short notice for better multi-agency response times.

SHEFFIED HEALTH AND SOCIAL CARE

SHSC has been involved in the development and implementation of the Adult MASH. SHSC has responded to requests for information from the Sheffield Adult MASH to support joint working and timely information sharing.

Continued to attend and share information at multi-agency meetings such as MARAC, MATAC and VAP.

IMPACT

The Adult MASH assists partner agencies to identify risks and make timely decisions by enabling a multi-agency view of the adult with care and support needs to be gained. SHSC's responses to requests for information contributes to reducing the risks identified within safeguarding concerns, responses being timely, and outcomes being improved for the adult at risk.

Attendance at multi-agency meetings increases partnership engagement, assists in improving victim safety and allows a multi-agency response to identified risks to be compiled, negating the risk of agencies undertaking safeguarding in isolation.

HOUSING AND NEIGHBOURHOOD SERVICE

The city's Community Safety Plan (CSP) has specific objectives to reduce criminal exploitation and safeguard vulnerable individuals.

The CSP has established 6 theme groups to address key crime concerns under specific themes, such as reducing hate crime, reducing violence against women and girls, and protecting vulnerable people. These theme groups are populated by safeguarding professionals and agencies likely to encounter vulnerable people.

IMPACT

This allows for a more joined up approach to safeguarding issues from a strategic and practice perspective and provides a multi-agency approach to issues across of number of crime types.

CARERS CENTRE

Sheffield Carers Centre is a member of the Sheffield Adult Safeguarding Partnership.

Sources of referrals to the Sheffield Carers Centre continue to be shared with the Sheffield Adult Safeguarding Partnership each quarter to ensure that carers are identified and supported.

IMPACT

Being a member of SASP allows the Carers Centre to receive up to date guidance, information and knowledge which can be shared with Carers Centre staff.

Sharing source of referral data quarterly allows the Safeguarding Partnership to identify where promotion of the carers centre could be improved to increase referrals.

PROBATION

There is now a Partnership Development Manager in place to embed the Probation Service Stakeholder Engagement Policy.

The Probation Service linked Manager contributes to Adult MASH.

IMPACT

The appointment of the Partnership Development Manager will allow for Improved partnership working across the city.

The contribution to Adult MASH leads to improved MASH meetings and actions on individual cases.

7.3 Prevention and Early Intervention

SOUTH YORKSHIRE FIRE AND RESCUE

The SYFR Safer South Yorkshire Referral Partnership Scheme aims to improve how the fire service and local organisations work together to effectively identify and reduce hazards for people most at risk. SYFR regularly train partners and their teams on fire safety awareness and secure referral pathways for partners working with people at risk. Work has been undertaken in Sheffield that has resulted in a number of referrals through the portal. The training also enhances fire and risk awareness in practice. Agencies once registered can make direct referrals to SYFR and work in partnership to either reduce or eliminate the risks.

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.

IMPACT

SYFR are active members and contributors to the annual Safeguarding Awareness Week. During 2022-2023, SYFR delivered 9 virtual training sessions covering SYFR Safer South Yorkshire Partnership scheme and Hoarding, Emollient & Airflow Products. In total, out of 167 people booked onto one of the sessions delivered that week, 110 were in attendance.

Then increase in the number of cases relating to concerns about adult abuse and neglect can be attributed to the targeted interventions by SYFR for the most vulnerable coupled with increased awareness due to learning and development training sessions.

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.

SOUTH YORKSHIRE POLICE

A GPS project, Dementia Missing People Trial was set up county wide with funding from the SYP innovation fund. This provided 50 devices for use across South Yorkshire, and these were predominantly given to dementia sufferers who are at risk of going missing.

A further example of early intervention is the use of, Domestic Violence Protection Orders (DVPO's). A civil order that provides protective measures in the immediate aftermath of a domestic incident. They are used for example where there is insufficient evidence to charge the perpetrator or provide protection via bail conditions. Prior to the application for a DVPO, a Domestic Violence Protection Notice (DVPN) is served on the perpetrator. These orders include a number of conditions, for example they can prevent the perpetrator from returning to the residence and/or from having contact from the victim for up to 28 days.

IMPACT

One successful example of the Dementia Missing People Project relates to a marathon runner who has dementia. Their illness meant they couldn't always remember how to find their way home. This has previously resulted in a missing episode where they were missing for three days before being found sleeping in someone's back garden. SYP worked with the family to devise a solution. This person now goes running with a GPS tracker, which allows the family to locate them if they are unable to find their own way home.

SHEFFIELD TEACHING HOSPITALS FOUNDATION TRUST

The STHFT Safeguarding Team has established a network of Safeguarding Champions to support ward staff to identify safeguarding concerns and take appropriate early action to safeguard vulnerable individuals.

A 7 Minute Briefing on Professional Curiosity has been developed and circulated to staff across the organisation and is available via the Trust Safeguarding Patients Intranet site. Professional Curiosity is promoted during mandatory safeguarding training to encourage staff to make further enquiries into a person's circumstances where there may be a safeguarding concern in order to identify risks and provide early intervention.

IMPACT

Safeguarding Champions receive additional training from the Safeguarding Team and are able to provide first line advice to ward staff. This is particularly helpful during shifts outside of core hours and at weekends when the Safeguarding Team is not available.

Professional Curiosity is encouraged in all interactions with staff when seeking advice about a safeguarding concern and during safeguarding supervision.

NHS SY ICB - SHEFFIELD

The Designated Professional for Safeguarding Adults and Mental Capacity Act (MCA) Lead has introduced a series of safeguarding adults and MCA key performance indicators (KPIs) for health provider organisations which will be monitored on a quarterly basis.

IMPACT

Whilst these have previously been provided, they were lacking in detail. These new KPI's have been included within provider contracts and will allow for more effective monitoring of safeguarding performances. These KPIs will provide details and early indication of good working practices or emerging concerns. This will allow for early intervention and support if required, or the suggestion of sharing good practice with other providers.

7.3 Prevention and Early Intervention

ADULT CARE AND WELLBEING

Due to pressures surrounding hospital discharge, carers are sometimes making the difficult decision to “bridge the gap” by allowing the customer to be discharged into their care while awaiting support from STIT. Where the customer is on our waiting list, we aim to offer as much support and communication as possible to them and their carers in advance of their start date with STIT.

In February 2023, following a month of high referrals to the carers’ centre, a project was initiated within STIT to offer targeted support to unpaid carers. A Provider Support Assessor was tasked with undertaking the role of Carer Support Officer. As a service STIT have always coordinated effectively with unpaid carers and wanted however to trial how effectively a designated role could benefit unpaid carers, the customers they care for and the wider service.

IMPACT

Whilst the primary aim of the project was to directly benefit and support carers (offering carers centre and other referrals, practical support and a listening ear), indirect benefits to the customer and wider service have also been identified including supporting people to sustain their support and feel like they could ‘cope’ and preventing carer breakdown and stress.

This role involved contact with carers via telephone, prioritising carers of customers waiting at home to commence STIT service, and in-person visits were arranged where possible. Home visits proved effective and gave an opportunity for further observation and insight into needs of customer and carer.

Further contact with customers waiting at home has supported transition onto service in the following ways: identifying and chasing up equipment, medication etc. in advance of initial assessment, offering carers “bridging the gap” support and information, and identifying where STIT service is no longer required before the initial assessment.

SHEFFIELD HEALTH AND SOCIAL CARE

Safeguarding Adult Level 3 training and Bitesize Training has been implemented.

In addition to mandatory training, SHSC deliver a session once a month, on a variety of topics. The topics are usually identified through themes in advice calls or following investigations. SHSC have delivered sessions in house on MARAC, Prevent, Sexual Safety and have had external speakers from IDAS, Magpies (Hoarding Support), Citizens Advice and SYFR.

IMPACT

Safeguarding Adult Level 3 Training ensures staff have the necessary skills and knowledge to recognise and respond to abuse and neglect and domestic abuse. Training includes section on domestic abuse, coercive control and economic abuse and when and how to complete a DASH-RIC. It aims to increase staff confidence when responding to all forms of abuse and know where to access necessary assessments and how to complete. The additional bitesize training on local processes or services increases staff awareness of support services for their service users and increases staff confidence to respond earlier and signpost or refer to specialist agencies.

HOUSING AND NEIGHBOURHOOD SERVICE

Community Safety has introduced 10 Crime and Vulnerability Meetings to key neighbourhoods and is providing training on spotting the signs of criminal exploitation to safeguarding professionals and staff who may encounter these issues.

The Team Around the Person (TAP) service take referrals based on risk to the individual and hold regular multi agency meetings across services to help prevent escalation of risks. They also complete referrals to relevant services/agencies.

IMPACT

This work provides opportunity to prevent the exploitation of vulnerable adults by criminal gangs and provide support for those who are at risk of becoming involved. Staff will have a better understanding of the impact of organised crime and know what to do earlier to safeguard vulnerable individuals.

TAP provides support to individuals at an early stage and ensures the right support is in place to prevent escalation of risk.

CARERS CENTRE

The work of the Carers Centre allows for early identification of risk and referrals to adult care and wellbeing or other prevention services.

IMPACT

This allows risks to be addressed and mitigates escalation. Carers feel supported and are able to engage with relevant services.

PROBATION

Probation Service now have improved access to Police information on domestic abuse to inform our pre-sentence reports at Court, and in ongoing management of community sentences.

IMPACT

This has led to better risk assessments and improved advice to sentencers.

7.4 Engage and Empower

SOUTH YORKSHIRE FIRE AND RESCUE

Through our work with referral partners SYFR can offer support to those who are at risk of becoming homeless by providing Home Safety Checks in order to help keep them safe and independent. SYFR would make relevant referrals for those in need if it was found that they were struggling to maintain their tenancy. We can also provide similar interventions to recently rehoused homeless through housing associations.

While homelessness is not a protected characteristic SYFR do encourage consideration of non-legislative factors when completing Equality Impact Assessments.

IMPACT

Information has been circulated to front line staff and Fire Control Room staff in relation to referring those who are homeless when we may interact with them during incidents or while in the community. Information is also shared for the cold weather protocols for the areas SYFR cover. Previous work has been carried out with the British Red Cross to utilise fire station spaces to support the cold weather periods.

SOUTH YORKSHIRE POLICE

SYP uses a Repeat Victim Index that helps officers and staff identify victims and locations of multiple incidents.

It includes an assessment of the number of incidents, how recent the incidents are, the harm caused, the severity of incidents and the risk that is present.

IMPACT

This helps to identify any cumulative risk to victims. A weighting of the specific criteria provides a score, which is used to prioritise the response for both people and locations.

The index helps with understanding whether different teams are safeguarding or investigating the same person to focus resource and effort. It is used to inform meetings where individuals are discussed and a decision is made on which people need a plan to support them. Examples can be provided of where action has been taken that has reduced the risk to individuals and prevented more repeat incidents or reduced the seriousness of incidents occurring.

SHEFFIELD TEACHING HOSPITALS FOUNDATION TRUST

STHFT has published an Inclusion Calendar on the staff intranet site. Staff are given the opportunity to promote awareness within their own departments as appropriate. The Trust will disseminate information to promote these events via the weekly staff communication bulletin.

The Trust has developed a number of staff network groups to raise awareness of and encourage equality and diversity, respect for others. The networks promote ownership and accountability by encouraging staff to challenging racism and discrimination, negative attitudes and behaviours. Staff are encouraged to ‘Speak Up’ to raise concerns about patient or staff safety, professional misconduct or financial malpractice.

IMPACT

This highlights and promotes celebration of national and world awareness events including events to recognise people with diversity and protected characteristics and those that may be discriminated against or subject to abuse and hate crimes e.g., LGBTQ+, transgender, suicide awareness, mental health awareness, carers week, world day against trafficking in persons, plus many others.

The Trust has also published a Freedom to Speak Up Charter.

NHS SY ICB – SHEFFIELD

Sheffield ICB Safeguarding and Looked After Children Team, held a Protected Learning Initiative (PLI) event for Primary Care in October 2022. This was attended by several hundred Primary Care colleagues and focused on safeguarding adults, children and looked after and care experiences children and young people.

IMPACT

The content and guest speakers were chosen based on the current themes and issues arising within Sheffield. On the whole the feedback was positive and was a welcomed opportunity for professionals to have some time out from their day-to-day role to focus on safeguarding and looked after children.

7.4 Engage and Empower

SHEFFIELD HEALTH AND SOCIAL CARE

The safeguarding team had identified a service user who wanted to support in policy development and attend the Safeguarding Assurance Committee.

Additionally, SHSC are working on service user engagement to support service users after an allegation against staff or serious incident.

IMPACT

SHSC recognise that service user engagement is important to ensure policies and processes are person centred and have a true MSP approach. However, SHSC also recognise that safeguarding is a sensitive and complex area and the person identified was not able to progress. SHSC are now working with colleagues in our Engagement and Experience Team to identify a volunteer.

Learning from an incident following a staff allegation SHSC are working with a service user to review processes, share learning and service user experience and improve our allegations against staff policy and support that will be offered to service users.

ADULT CARE AND WELLBEING

Adult Care and Wellbeing were contacted by the Children's Service about a group of young women who it was feared were the victims of sexual exploitation. The ages of these young women straddled the age range between Adults and Childrens and it was clear that a joint approach was needed. The MASH being in place meant that we could quickly bring all interested parties together to share information.

IMPACT

A number of these young women were accommodated by a local supported housing provider who were looking to statutory services to support. We are working with the young women to help them understand their situation better, including making taxis available to take them back to their accommodation if they find themselves in a risky situation. We have also covered rent for young women at risk of eviction to keep them housed in order for us to work with them to help secure legitimate income.

PROBATION

The Annual People on Probation Survey helps the Probation Service to make improvements in services and improve service performance.

IMPACT

Some of the actions that will be taken forward following this survey include:

- Improving employment opportunities for people with lived experience of the Criminal Justice System.
- Introduce local 'you said, we did' in each office to give feedback to people on probation on the issues they have raised with us.
- Improve the involvement of people on probation in the development of their sentence plan.
- Improve links between prison releases and transfer to probation in the community through introducing Community Integration Teams (already achieved).
- Improved access to substance misuse services for people on probation.

HOUSING AND NEIGHBOURHOOD SERVICE

The Neighbourhood Services directorate safeguarding group quarterly meetings identify safeguarding practice improvements e.g., addressing safeguarding concerns with private B&Bs for temporary accommodation.

IMPACT

This has led to improved identification of safeguarding issues and support for individuals involved.

CARERS CENTRE

Carers are supported to maintain appropriate boundaries with people they support and to flag any concerns re. potentially abusive or neglectful behaviour with relevant services / practitioners.

IMPACT

Carers are supported to understand services should support them and the people they care for in a safe and respectful way (and to raise any concerns as soon as possible).

7.5 Quality Assurance

SOUTH YORKSHIRE FIRE AND RESCUE

SYFR Safeguarding Officers continue to be actively involved in the processes associated to reporting on and making referrals in relation to SARs. The impact of the reviews can be seen as influential across the organisation and all staff.

SYFR also contribute to the National Fire Chief Council (NFCC) Safeguarding work stream and Section 11 Safeguarding Audit and Assurance Meeting.

IMPACT

Lessons Learnt are embedded to improve policy, practices and processes. A number of seven-minute briefings have been created as a result of learning and communicated to staff in the internal weekly bulletin and via email to all staff.

A new Safeguarding page has been created on our internal intranet page for all staff to access. This includes policies, 7-minute briefings, safeguarding training, safeguarding flow chart and internal safeguarding form. We have also included website direct links to all South Yorkshire children and adult partnerships across South Yorkshire.

The Safeguarding Officers for SYFR attend the National Fire Chiefs Council (NFCC) and ensure that information and strategic messages from these meetings are reflected and embedded in the relevant policies and procedures and that these are cascaded down to relevant roles and responsibilities within the service.

Safeguarding Fire Standard completion of self-assessment, gap analysis and implementation toolkit has provided SYFR with an up-to-date position statement and actions required for the organisation to implement and focus on learning and improvements required.

SOUTH YORKSHIRE POLICE

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.

IMPACT

Following Sheffield SAR Person E, the forces crime recording system has now been updated so that incidents whereby self-neglect and or hoarding is a factor/concern can be recorded more effectively. The system enables the addition of 'keywords' to investigations. The system has now been updated so the keywords of 'self-neglect' and 'hoarding' can be added to any appropriate investigations. This allows for more effective reporting, allows for more effective management and investigation and these keywords will also appear on partner referrals that are automatically transferred through the system.

NHS SY ICB – SHEFFIELD

As part of the ICB commissioning functions, SY ICB Sheffield attend NHS providers Safeguarding Assurance Committees. The providers safeguarding data and performance are presented for internal understanding and scrutiny.

IMPACT

The Designated Professional attends these meeting to gain assurance that systems and process are working effectively. There is also an opportunity for the Designated Professional to make suggestions to the trusts about their performance data or to offer constructive challenge. By being involved in these meetings the ICB can work with trusts where issues may arise or take conversations to other people or teams to ensure all contractual and statutory obligations are being met to safeguard adults at risk.

SHEFFIELD TEACHING HOSPITALS FOUNDATION TRUST

Safeguarding adults mandatory training compliance at levels 1 and 2 has been maintained at above 90% which is the Trust target for mandatory training.

A Safeguarding adults level 3 training programme which reflects the requirement of the Intercollegiate Training and Competence Framework has been implemented. A Training Needs Outline has been agreed which identifies those staff members who require level 3 training.

IMPACT

There has been an 18% increase in the number of safeguarding referrals raised by STHFT staff compared to 2021-22.

Level 3 training has commenced, and compliance will be monitored via the Trust Safeguarding Assurance Group.

7.5 Quality Assurance

ADULT CARE AND WELLBEING

Until this year there was a long-standing issue with regard to care managers non-social work qualified Sheffield City Council staff, undertaking Safeguarding activity. This was due to a persistent cultural understanding dating back to pre-care Act 2014 timers, which perceived safeguarding as accusatory investigatory role performed by social work qualified social workers. This was changed over the last year by the introduction of new job descriptions for social workers and care managers making them social care professionals with Making Safeguarding Personal (MSP) as a core element of their work.

IMPACT
The impact of this has been improved throughput on safeguarding case work and an upskilled workforce.

SHEFFIELD HEALTH AND SOCIAL CARE

A member of the Safeguarding Team will attend the Daily Incident Safety Huddle where all incidents across the trust that occurred in the preceding 24hrs are reviewed.

IMPACT
The Safeguarding Team can identify incidents where safeguarding concerns have not been identified, review incidents where there may be a safeguarding issue and request further detail. This provides a safety net if a safeguarding concern is required but has not been completed and, in these huddles, the Safeguarding Team have identified incidents where an allegation has been made against a staff member but policy has not been followed. The Safeguarding Team are also able to provide a safeguarding perspective on incidents such as pressure care or use of restraint.

HOUSING AND NEIGHBOURHOOD SERVICE

Housing contributes to multi-agency audits and reviews (e.g., Safeguarding Adult Reviews and Domestic Homicide Reviews). Any learning or actions for Housing from these reviews form part of the overall review action plan.

IMPACT
Examples of recent actions that have been completed are:

- Updating the ASB policy to recognise that noise nuisance could be in relation to Domestic Abuse.
- Ensuring staff in Housing attend Trauma Informed Practice training, to help staff recognise trauma and improve responses to vulnerable tenants. The training pathway for Neighbourhood Officers was updated to make this mandatory.

PROBATION

R-Cat & C-Cat rolled out and will be embedded in Sheffield during next 12 months. (These are quality assurance processes for sentence management and Court reports).

EQuaL rolled out and will be embedded in Sheffield during the next 12 months. This is the process for ensuring quality of casework is maintained and improved.

IMPACT
Improved management of individual cases, improving safeguarding processes.

CARERS CENTRE

All safeguarding referrals or concerns are recorded on a safeguarding concern log, which is monitored by management at each monthly meeting.

IMPACT
This allows concerns to be reviewed and ability to give feedback to Carer Advisors re. individual practice and provides continual oversight and review of internal safeguarding procedures to ensure these remain fit for purpose.

8. SASP Initiatives Sheffield Safe Places and Not Born Yesterday

SASP support and fund two initiatives within Sheffield to keep people safe, raise awareness and work in partnership to address safeguarding concerns. These are Trading Standards – Not Born Yesterday and Sheffield Safe Places.

Run by Heeley City Farm, the aim of Safe Place's is to support people to feel safe when they are out and about in Sheffield. For example, if someone needs help, if they are lost, ill or frightened, Safe Places can provide a temporary refuge until a friend or carer comes, or the person feels able to leave again on their own. They are a network of organisations across the city that are committed to ensuring the safety and dignity of people who join the scheme.

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. The Not Born Yesterday (NBY) campaign, helps protect vulnerable people from scams and rogue traders.

8.1 Safe Places – Heeley City Farm

HIGHLIGHTS AND ACHIEVEMENTS 2022/23

- 4 new safe places joined the scheme and trained up.
- 40 safe places packs handed out.
- 42 community meeting / conferences attended.
- 12 community workshops / presentations.
- 17 co-produced advocacy meetings ran with member volunteers and over 5 organisations across the city.
- 10 known people recorded using a Safe Place when in need.
- Helping the development and launch of 'Synergy' Sheffield mental health alliance.
- 1 Exposed magazine award won.
- 7 Hate Crime awareness events ran / attended. One being a flash mob on The Moor handing out over 75 leaflets and working with Sheffield Voices and SY Police.
- New safeguarding and disability training developed, designed, and coproduced with our volunteers and over 50 people's experiences, with an adjoining animation made by our volunteers and FlyCheese Animation studio, concentrating on raising awareness of the equality act and social isolation.

THE IMPACT

As part of feedback from the Autism partnership board, Safe Places have been focusing on marketing and community engagement, to ensure more people know about the scheme. Engaging more with communities that are under the radar this year has brought a lot of inspiration and momentum for the upcoming year. Especially with transition ages (young people), refugees and asylum seekers, Hate Crime / Mate Crime and developing stronger more cohesive disability awareness across the city.

All of this hard work reaching out to new grass route organisations will hopefully help Safe Places to support new people and signpost them to other amazing support groups, advice centres, charities, and events across the city. Working more with new people and organisations has given Safe Places a lot of feedback and things to improve for the upcoming year.

Read more about Safe Places on their website www.sheffieldsafeplaces.co.uk

8.2 Trading Standards - Not Born Yesterday

HIGHLIGHTS AND ACHIEVEMENTS 2022/23

Crime in The Home (doorstep crime and rogue trading)

- The team has responded to **52** reports of Crime in the Home.
- The victims have paid the criminals a total of **£183,000.00.** Through interventions, Trading Standards have stopped the victims from paying a further **£53,000.00.** All interventions have resulted in either further investigation or intelligence gathering. In all cases, measures were put in place to protect these victims from further financial abuse.

Awareness Raising

- Delivered awareness raising sessions to members of the public and organisations including Age UK, SASP, National Power Grid Care Team, South Yorkshire Fire and South Yorkshire Police.
- Distributed NBY material including no cold calling door stickers to housing officers, PCSO's and Neighbourhood Watch.
- Established contacts within the voluntary sector including Lunch Clubs, Dementia Cafes and Carers Cafes and have provided NBY material for distribution.
- Worked with Neighbourhood Watch schemes to distribute NBY material to libraries, doctors' surgeries, post offices and various community events.

Events

- Participated in Safeguarding Awareness week to deliver NBY bitesize training sessions and participated in Regional Crime in The Home week including hosting a NBY event in Morrisons supermarket.

Scams

- Carried out home visits to 11 victims of postal scams.
- 3 Trucall Call Blocker units have been installed to help protect victims of telephone scams.

Prosecutions

- 1 successful prosecution resulting in an immediate custodial sentence and 5 cases proceeding through the court process.

THE IMPACT

- In recognition of the success of the Not Born Yesterday (NBY) campaign, it was used by the Yorkshire and The Humber Region during Crime in the Home week in January 2023.
- Further recognition has come from Rotherham Trading Standards who have adopted the NBY campaign to raise awareness in their area.

THE NUMBERS*

- ❖ Local Authority Trading Standards Interventions:
  - Total Financial Savings = £484,724.
- ❖ Through home visits to suspected scam victims, local trading standards officials realise:
  - Estimated future financial savings = £10,010.
  - Estimated healthcare savings and health related quality of life saving = £5,405.
- ❖ Through doorstep crime education to suspected scam victims, Local Trading Standards officials realise:
  - Estimated future financial savings = £254,600.
  - Estimated healthcare savings and health related quality of life saving = £137,484.
- ❖ Call Blockers administered; local Trading Standards Officials realised:
  - Financial savings from Call Blockers Programme = £49,622.
  - Estimated healthcare savings and health related quality of life saving = £26,796.

* Calculated using The National Trading Standards Scams Team calculator and is based on 'average' savings data collated by the Sheffield Team.

9. Sheffield Adults Safeguarding Customer Forum

The Customer Forum is a group of individuals who have lived experiences of adult social care and health and in some cases, safeguarding. They bring their knowledge and experience to the group meetings and combined with their passion to promote adult safeguarding, they work in partnership with other agencies and organisations.

In 2022/23

This year the group have been brought back together for face-to-face meetings. In 2022, the group were approached by Hallam University and asked if they would be involved in the co-production of a research funding bid and potential research project in relation to Loneliness, Isolation and Wellbeing. The research funding bid has now been submitted and this is a perfect example of co production. The Customer Forum have been involved from the initial idea and have played an active part in consultation sessions and the drafting of the bid application. If the bid is successful, then the co-production will continue as part of the research plan.

The Chair and Vice Chair of the Customer Forum have been involved in the Mental Capacity Act Action Network (MCAAN) working with colleagues to ensure the Mental Capacity Act (MCA) is understood and applied by all staff and how it will reflect potential amendments and changes.

The MCAAN was formed due to the probable introduction of Liberty Protection Safeguards (LPS) in place of Deprivation of Liberty Safeguards (DoLS) and now LPS has been indefinitely delayed the group agreed to continue to ensure there is a better understanding of MCA, that it is consistent in its use throughout all involved areas and to improve all aspects relating to MCA.

The Customer Forum also continue to be active members of the City-Wide Best Practice Group, contributing to ensuring best practice in relation to adult safeguarding in Sheffield.

To learn more about the forum, the work they do, how to get involved, and future meeting dates, take a look at our website Sheffield Adult Safeguarding Partnership - (sheffieldasp.org.uk)

10. Case Study 1 - Housing and Neighbourhood Service

BACKGROUND

Following reports of Cuckooing, the Housing and Neighbourhood Service became aware of a tenant, Jack*. Upon engagement, officers established that not only was Jack the victim of Cuckooing, but the overall condition of his property was hoarded and unsanitary. This was further coupled with the fact that since signing for the property, a flat located on the third floor, Jack's health had deteriorated to a point where he was unable to safely self-evacuate (in the event of an emergency) from the property.

Cuckooing is a practice where people take over a person's home and use the property for some form of exploitation. They may use the property for drug-dealing and other criminal activities.

Due to the Cuckooing and other practices within the property (smoking / alcohol use), the flat was deemed a fire risk to both Jack and other residents within the block of flats.

ACTIONS TAKEN AND SUPPORT PROVIDED

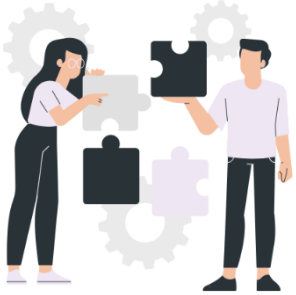
Officers took immediate action and raised an adult safeguarding concern, with Jack being placed into temporary accommodation to remove them from harm. A Vulnerable Adults Risk Management (VARM) was arranged with representatives from South Yorkshire Police, South Yorkshire Fire and Rescue, Adult Care and Wellbeing and the Housing Service.

South Yorkshire Police oversaw any criminal related matters in relation to the cuckooing. South Yorkshire Fire and Rescue conducted fire risk assessments of the property, along with providing fire safety advice / guidance to neighbouring properties. Adult Care and Wellbeing explored care packages to support Jack being independent and Housing looked for more suitable accommodation.

IMPACT

A ground floor property was sourced which had a built in 'misting system' (this would activate upon detection of fire reducing risk for the tenant and neighbouring properties). This property considered any mobility issues Jack had, accounted for any fire risk posed and removed the risk of cuckooing as it was based in a new geographical area.

Adult Care and Wellbeing also implemented a care package to allow Jack to maintain a high level of independence upon moving to the new property. This allowed for future safeguarding moving forward.



*For all case studies included in this report, a pseudonym has been used.

10.1 Case Study 2 – Hospital First Contact Team

BACKGROUND

Luke is a 65-year-old gentleman with a history of self-neglect and alcohol dependency. He previously had care packages to support with meals, medication and personal care but cancelled them and deteriorated in physical and mental health over a period of time. He was admitted to hospital following a fall in his property resulting in a fractured leg requiring surgery. This injury resulted in a significant reduction in his mobility and significant increase in his care and support needs. His housing was now unsuitable as he lived in a 2nd floor flat and could no longer manage stairs. He was at increased risk of harm in case of a housefire as he was not able to safely self-evacuate. He was also at increased risk of social isolation being housebound, along with continued risk of self-neglect and poor home environment as he found this difficult to manage on his own. Luke now had an increased risk of falls along with other health needs that needed meeting.

ACTIONS TAKEN AND SUPPORT PROVIDED

Hospital and community-based professionals including nursing staff, physiotherapists and occupational therapists worked to assess Luke's needs to ensure he could return home to his flat with the necessary level of care and reassessed his needs for his new level access accommodation. He was registered with Sheffield City Council Property Shop and provided with relevant information about different accommodation options e.g., extra care housing so that he could make an informed choice about what type of accommodation he wanted to live in the future. The Hospital First Contact team worked collaboratively with other colleagues in Adult Care and Wellbeing such as the Home First Team to ensure Luke was suitably rehoused and supported with all aspects of this including organising removal service, sourcing extra furniture and furnishings, support with setting up bills, registering with new GP practice and ensuring medications were delivered.

IMPACT

Luke was supported to temporarily return home safely to his 2nd floor flat with all necessary equipment and care provider in place to meet his needs whilst waiting to be rehoused. He was supported to bid on suitable properties and was suitably rehoused in a 1 bed council bungalow with ramp access and wet room. Luke is extremely happy with the accommodation and feels it has improved his quality of life and feels hopeful in the future about accessing the community as he continues to improve with his mobility.

Luke engaged well with the care provider and therapy staff and is improving his confidence, strength and mobility. He is at significantly lower risk of self-neglect as his home environment is now well maintained and his personal hygiene and mental wellbeing is improved, and he is starting to do more for himself as he settles into the property. He has been visited by South Yorkshire Fire Service who installed the assistive technology required to ensure that in the case of a fire, the fire service is alerted and can support Luke in a timely manner. Luke has City Wide Care Alarm and key safe in place to ensure he can access help and assistance in an emergency.

Central to the positive impact of this case was effective relationship-based and person-centred practice. Luke's case was reallocated to the same social worker on each hospital admission over a period of 2.5 years. Over this time the social worker built a good rapport and trust with Luke and his brother, and this helped with supporting Luke to accept care and support and have informed choice about his future accommodation options.

10.2 Case Study 3 - IDAS

BACKGROUND

Margaret is 75 years old. She was referred to IDAS following a disclosure of harm towards her by her husband, Alfred. He was unpredictable, and the physical harm towards Margaret was increasing in severity, including non-fatal strangulation. The couple had little support in the family home and Margaret was worried for her safety. A high-risk DASH was completed, and Margaret was referred to MARAC.

Margaret and Alfred have been married for over 50 years and she describes him as a loving, caring and supportive husband. There is no history of abuse in their relationship. Alfred has dementia and was becoming increasingly confused as his condition deteriorated. His harmful behaviour towards Margaret during the previous few months was entirely due to his condition.

ACTIONS TAKEN AND SUPPORT PROVIDED

IDAS spoke to Margaret about whether she would like any support, which she declined. She was shocked to learn that she had been referred to a domestic abuse service as she did not consider her situation in those terms. She spoke about how devastated she was about what had happened to Alfred and how cruel dementia is. She did not want Alfred referred to as a perpetrator of domestic abuse as their situation was entirely due to the effects of dementia.

IDAS advocated for Margaret at MARAC and requested that Alfred be referred to by his name or as PATCH (Person Alleged To have Caused Harm). We included details of the couple's history to help understanding that although harm had been caused, Margaret and Alfred were both suffering the effects of dementia, and not domestic abuse.

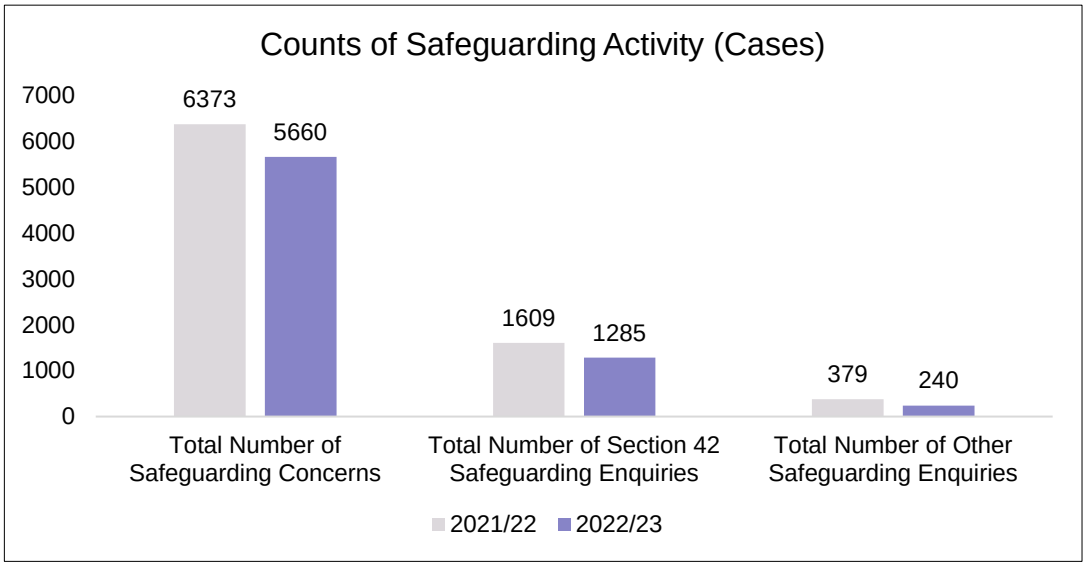
IMPACT

Alfred's condition is now too severe for him to remain at home with Margaret and he now lives in a care home. While this means that Margaret is safe from further harm, she is now living apart from her husband and she finds this difficult. She was grateful that IDAS had advocated for her and Alfred. After Margaret's case was shared at MARAC, IDAS received positive feedback relating to the advocacy and about the language used to describe people causing harm in situations like Margaret and Alfreds.

11. What Do the Numbers Tell Us?

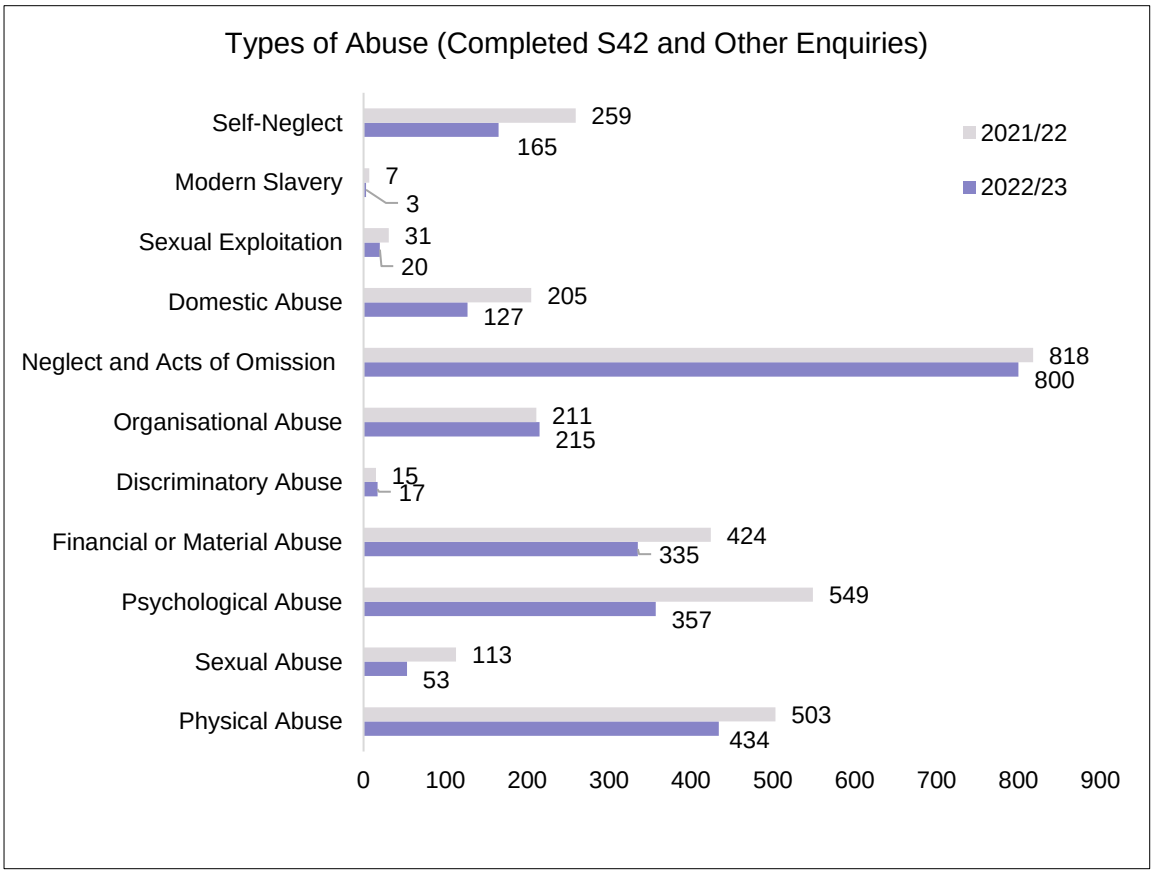
Safeguarding Concerns and Section 42 and Other Enquiries

The total number of safeguarding concerns in 2022/23 was 5660, this is a decrease on the previous year. Safeguarding Concerns make up the biggest proportion of safeguarding activity. There were 1285 Section 42 Safeguarding Enquiries (324 less than last year) and 240 “Other” enquiries. This data relates to Safeguarding Activity that commenced in the year 2022/23.



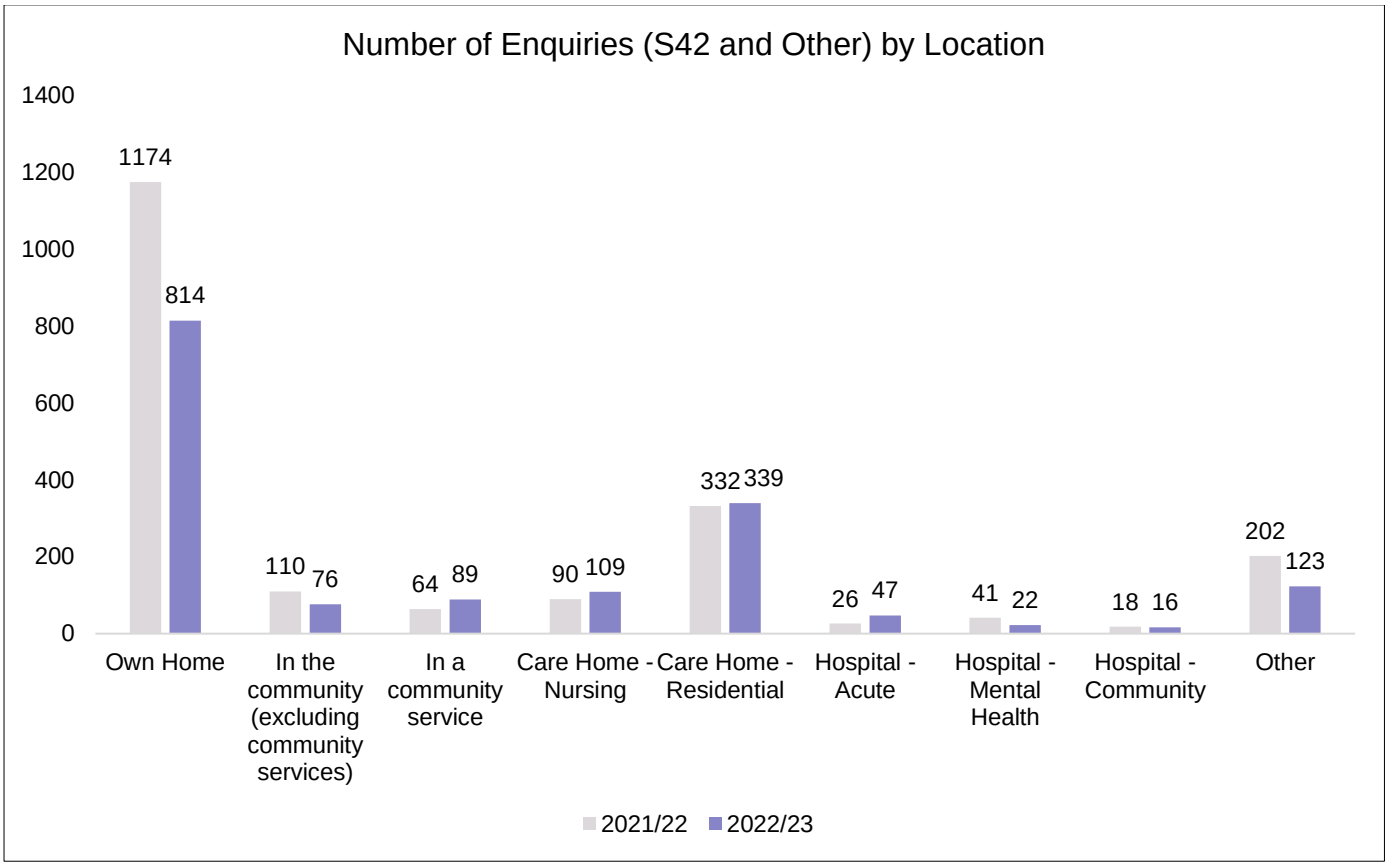
Type of Abuse Experienced

Of the enquiries completed in the year 2022/23, the types of abuse that were most prominent were Neglect and Acts of Omission, Psychological Abuse and Physical Abuse.



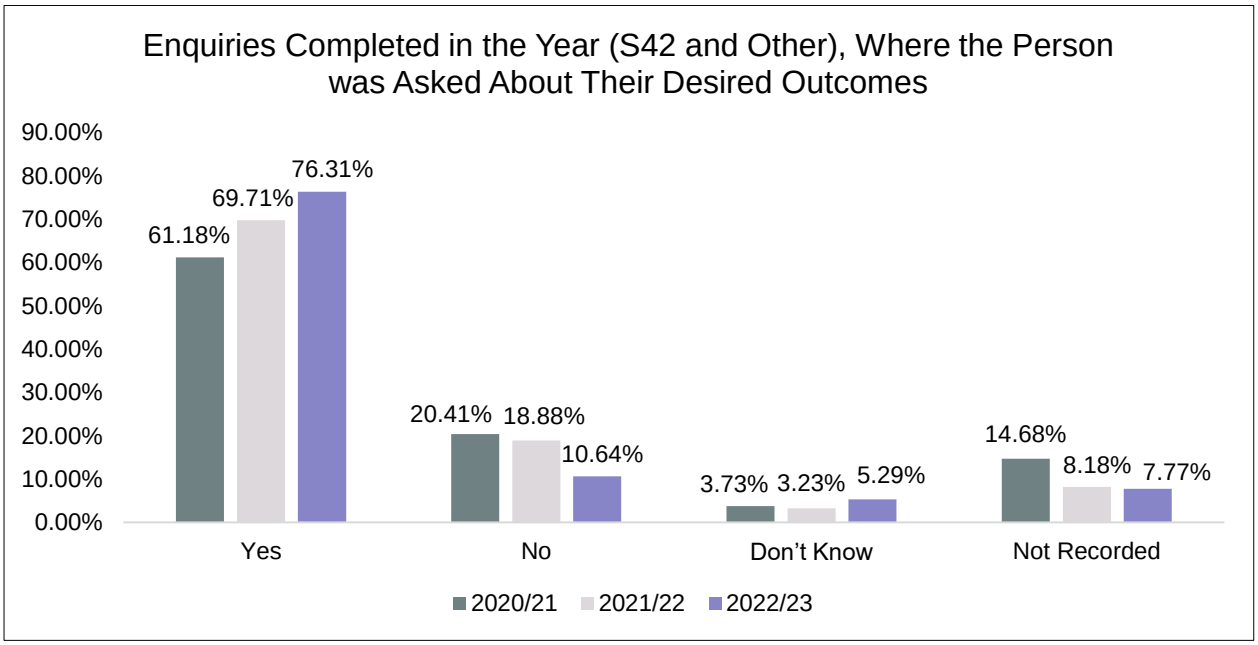
Location of Abuse

Own home continued to be the most prominent location of abuse in enquiries completed, this was followed by residential care homes.



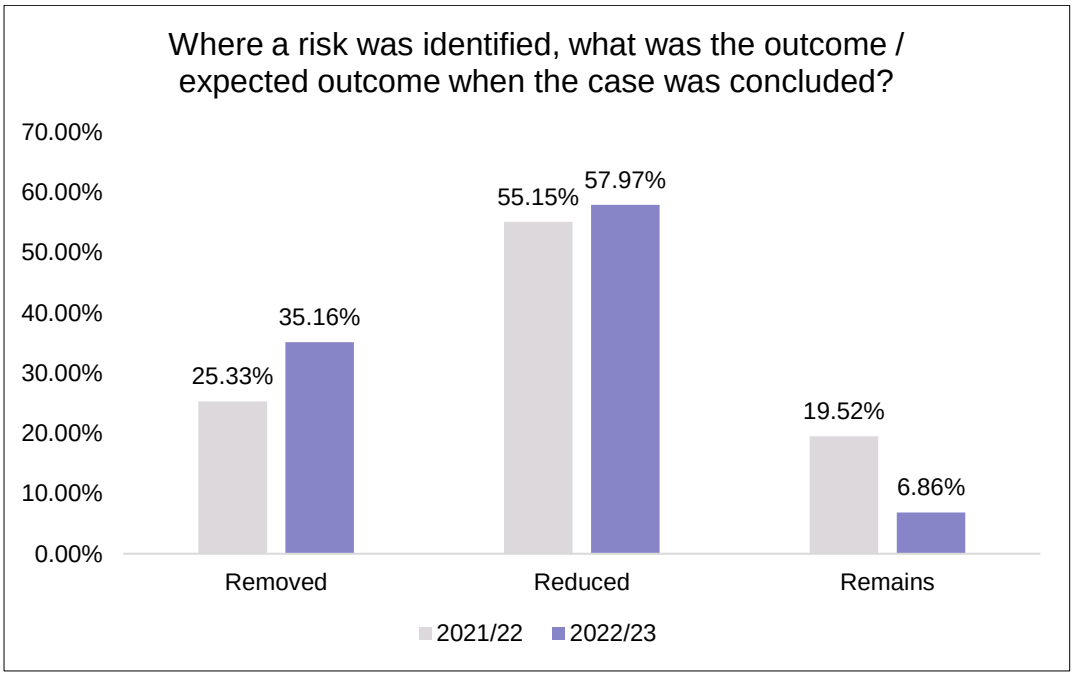
Making Safeguarding Personal (AC&W Data Only)

The number of individuals who were asked their desired outcomes in safeguarding enquiries concluded, increased in the year 2022/23 compared with the previous year. In 2021/22 the proportion of people asked was 69.71% and in 2022/23 this figure was 76.31%. Both years were an increase on 2020/21 where in 61.18% of enquiries completed in the year people were asked about their desired outcomes.



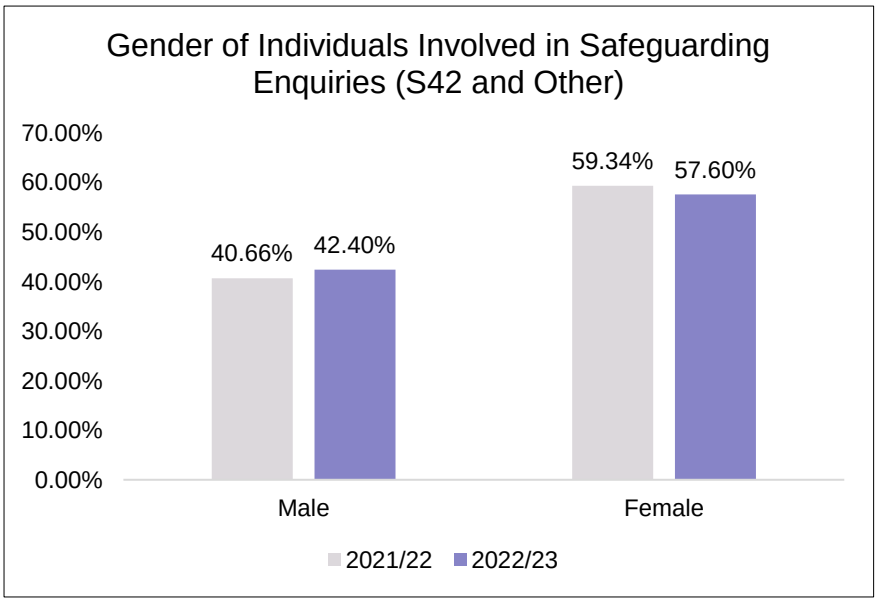
Impact on Risk (AC&W Data Only)

Where risk was identified, the risk remained in 6.86% of enquiries completed (S42 and Other) this is an improvement on last year, where risk remained in 19.52% of enquires completed in the year. Risk was reduced in 57.97% of enquiries completed this year, compared with 55.15% the year before, and the proportion of enquiries where risk removed increased by around 10%.



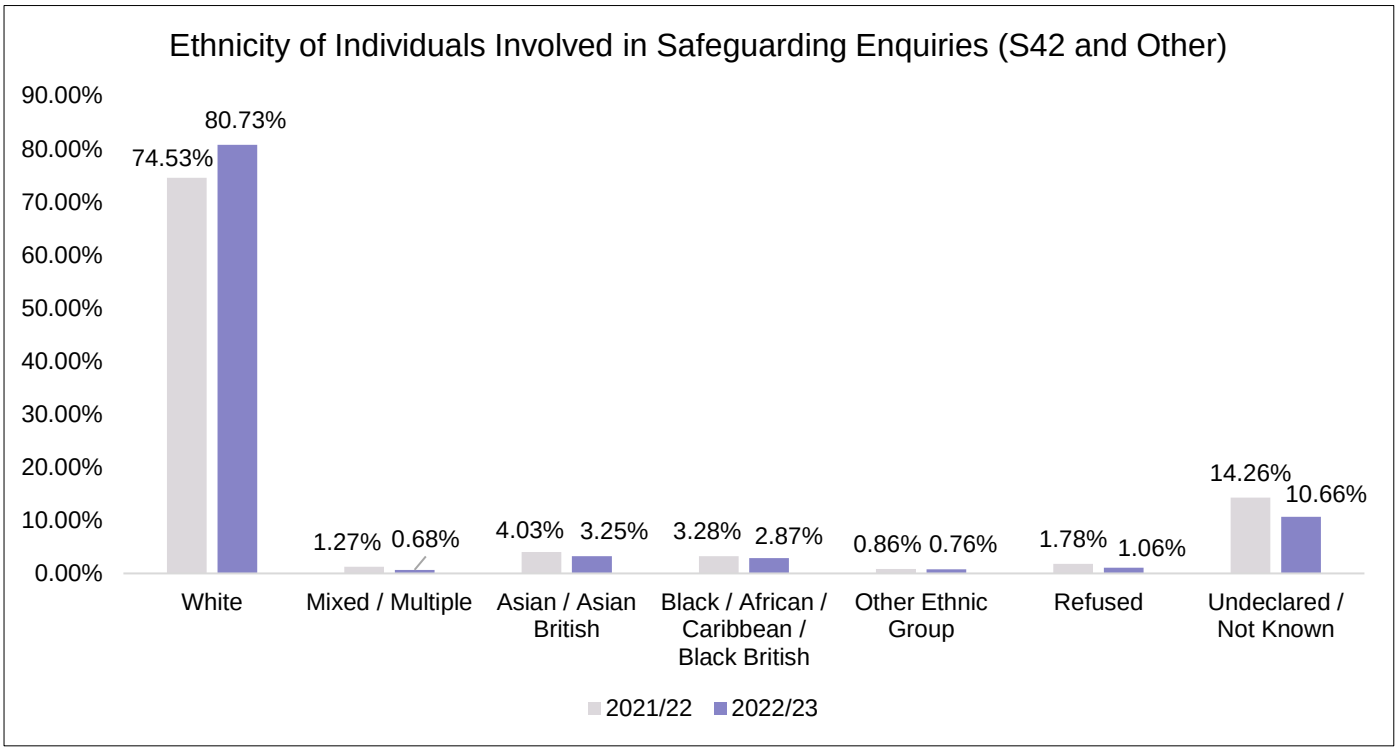
Demographics of Individuals Safeguarded (Safeguarding Enquiries)

More women than men were involved in a safeguarding enquiry that commenced in the year (57.60% vs 42.40%) a slightly higher % of men and slightly lower % of women were involved in safeguarding enquiries compared with last year.

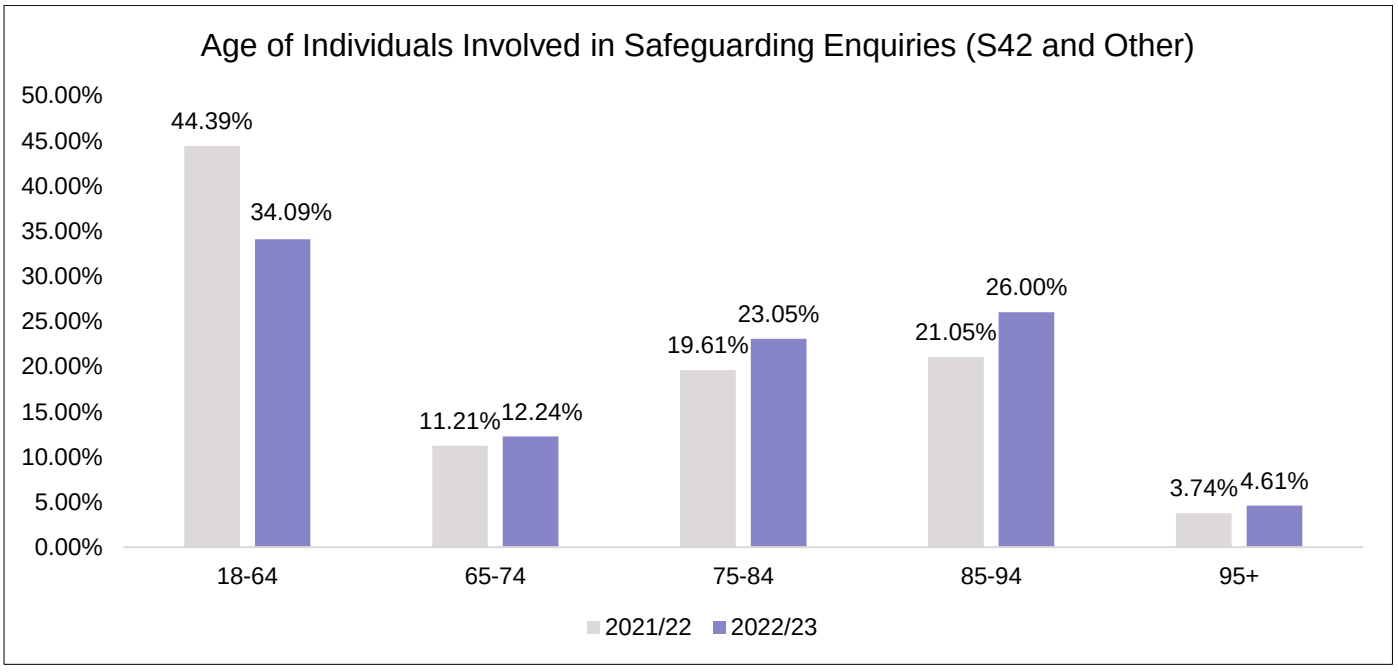


Adults who identified as White continue to be the highest represented group in safeguarding enquiries that commenced in the year, and this figure increased on last year (74.53% vs 80.73%).

Except for instances where ethnicity was not known or undeclared, Asian/Asian British were the second highest represented at 3.25%. There was a decrease in the % where ethnicity was not declared or not known.



34.09% of enquiries commenced in the year involved individuals in the 18-64 category, 65.91% of individuals involved in enquiries were 65+. A higher proportion of individuals who were 64+ were involved in safeguarding enquiries in 2022/23 (an increase of around 10%) and the proportion of those aged 18-64 decreased by around 10%.



12. Overview from the Independent Scrutineer

Thank you for 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 2022 through to March 2023, a period during which the partnership has continued to be tested in the aftermath of the Covid 19 pandemic. We have continued to see 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.

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.

Developing Our Approach to Assurance

In December 2022 I introduced a quarterly scrutineer's report to SASP which takes account of the findings from all local and national reviews and considers how identified improvements should be implemented locally. To do this I draw upon the ongoing work of regulators such as the Care Quality Commission (CQC), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services, as well as reports from the National Network of Chairs of Safeguarding Adult Boards and reviews undertaken by NHS England and Improvement.

Assurance is also informed by partners responses to the annual Section 11 Safeguarding Audit and Assurance Meetings which are held in May each year, by the quarterly performance report and the Performance and Quality Subgroup, which monitors and evaluates the effectiveness of safeguarding adults' practice across the city, using qualitative and quantitative data and intelligence.

In addition, SASP partners commissioned an independent review to test our approach to compliance with legislation, quality assurance and continuous improvement, as well as our process for and evidence of system wide learning, with a particular focus on our governance and decision making around Safeguarding Adult Reviews (SARs).

Importantly the review found:

- Overwhelming willingness and desire of all staff to support and ensure that safeguarding. practice is continuously improving and enhancing the quality of life of adults in Sheffield.
- A progressive and developmental approach to safeguarding across Sheffield.
- Outward facing partners, looking for and sharing new opportunities for partnership working.
- Making safeguarding personal embedded in practice.

Recommendations from the review covered; safeguarding referrals and feedback, partnerships and working relationships and embedding learning and governance. Recommendations are relevant both to individual partners and to the partnership, as a whole. SASP officers have developed an action plan in response to the recommendations in the review and assurance will be provided to SASP on an ongoing basis.

Safeguarding Adult Reviews

This annual report details SAR activity 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. Partners feared that harm and neglect with their roots in the pandemic would emerge. Sadly, we have seen some examples where this is the case and Section 5 of this report outlines how the partnership has responded and tried to learn from these situations. A programme of joint SAR/DHR workshops has been arranged for this autumn. It is clear that there is an overlap between the two and both have similar emerging themes that we need to explore in relation to the best way to learn from these reviews and embed changes in our practice.

Over 70% of cases in the National Analysis of SARs – involved mental health, highlighting the importance of safeguarding in mental health. Safeguarding and mental health will form a key area in the work plan of the National Network of SAB (Safeguarding Adult Board) Chairs for 2023-24.

The Sheffield City Council Delivery Plan recognises that Adult Care and Wellbeing Services are under a significant amount of pressure across key areas of business with rising demands, costs and lack of capacity in the system. To establish the foundations for a sustainable Adult Care and Wellbeing system which improves the outcomes and wellbeing of adults and carers across Sheffield, a new long-term Strategy for Adult Care and Wellbeing, underpinned by a Delivery Plan, and an Adult Safeguarding Delivery Plan have been approved by the Council's Adult Health and Social Care Policy Committee. The Committee monitors the implementation of the plans which in turn provides an important source of public accountability and assurance.

A key example of partners working effectively together to keep adults at risk in Sheffield safe, was the development of an adult multi-agency safeguarding hub (MASH) which launched in April 2023, more information about the MASH can be found on page 14.

Sources of External Assurance Inspection

During the year SASP received assurance from several external sources.

The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England, ensuring health and social care services provide people with safe, effective, compassionate, high-quality care and encouraging care services to improve. They monitor, inspect and regulate services. CQC reports are an important source of assurance to SASP.

The CQC's 'State of Care' report for 2021-2022 was published on 21 October 2022. The report says that the health and care system is in a gridlocked situation and unable to operate effectively. It is particularly concerning that capacity in adult social care has reduced and that unmet need has increased. We need to be cognisant in Sheffield about how this situation affects people, their carers and families. SASP has recently received a presentation on the Hospital Discharge Programme and investment in home care support in Sheffield. Sheffield has established new integrated partnerships arrangements across health and social care for transformation and oversight. These will provide an important source of assurance for the partnership that Sheffield is able to harness and scale up the potential for innovation to improve outcomes for our most vulnerable populations.

The CQC has also published its Monitoring the Mental Health Act (MHA) report 2021/22. The review found that mental health services and staff are at breaking point, with staffing shortages affecting people's care and putting safety at risk. In some cases, the lack of staff to deliver therapeutic interventions is increasing the risk of violence and aggression on inpatient wards, threatening the safety of patients and staff. While providers are attempting to put in place measures to mitigate staffing issues, the shortage of qualified mental health nurses is a systemic issue which requires longer-term national workforce planning.

CQC also highlighted inequalities in the care people receive, with people from Black and some ethnic minority groups subject to disproportionate use of sectioning and restrictive community treatment orders and suggest providers should be asking themselves what they are doing to actively challenge this. Sheffield Health and Care NHS FT provided assurance that there are robust arrangements in place around the use of restrictive practices and work is being carried out on inequalities and improving access to services.

CQC inspectors have found improvements at Sheffield Teaching Hospitals NHS Foundation Trust following an inspection in September 2022. CQC reported that when they returned to Sheffield; "it was promising to see that several improvements had been made and we hope the trust continues to make progress across services to ensure people receive safe and appropriate care." Following the inspection, the trust's overall rating remains as requires improvement. However, SASP can take assurance in relation to safeguarding, as the inspectors reported that in the areas they visited staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could describe how to complete a safeguarding referral and could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The service has a team of midwifery staff specialised in managing vulnerabilities. The team are responsible for overseeing women who are identified as having a safeguarding concern and ensuring that the appropriate support and authorities are involved in women's care. The service followed the Family Common Assessment Framework (FCAF) (incorporating threshold of need guidance) and referral to the local safeguarding hub. Safeguarding adult and children's policies were in place, in date and in line with intercollegiate guidance.

CQC did have concerns re understanding of, training and application of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) and I am pleased to report that SASP has since received assurance in the form of a report on the Trust's Mental Health Improvement Programme together with a report on how Sheffield City Council is investing in the DoLS service.

Adult Health and Social Care is also CQC-regulated, and inspection is possible at some point over the course of 2023/24. Plans are in place and being implemented to ensure that they are well-prepared for this.

NHS England: Review of Safeguarding in NHS Mental Health Trusts

On Wednesday 28 September Panorama aired an undercover documentary into Edenfield, a secure unit run by Greater Manchester Mental Health Trust. Monday 10th October Channel Four aired "Hospital Undercover: Are our Mental Health wards safe".

The programmes highlighted a culture that had grown and pervaded across teams and wards. The behaviours of staff towards some of the most vulnerable people in society, admitted for care and treatment was unacceptable.

The NHS National Director of Mental Health, Clare Murdoch ordered a national review of safety across all the NHS. She also wrote to all NHS Mental Health Trusts urging them to urgently review safeguarding of care in their organisations and identify any immediate issues requiring action.

An interim report was brought to the joint SASP/SCSP Executive on 21 October, focussed on the response in Sheffield from SHSC and partners were asked to consider how we will bring assurance to SASP going forward.

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services, conduct police effectiveness, efficiency, and legitimacy (PEEL) inspections, which assess the performance of all police forces in England and Wales. HM Inspectorate's inspection of South Yorkshire Police found the force's focus on vulnerable people to be strong in every area inspected. During 2022/23 SYP launched the Right Care, Right Person approach, with Phase 1 focused on Concern for Welfare. A multi-agency strategical and tactical governance structure has been established which enables partners to raise any safeguarding concerns. South Yorkshire Police has also been selected by the National Police Chief's Council to be the national case study demonstrating the effective use of Right Care, Right Person for our partnership working and focus on ensuring that vulnerable people are protected.

HM Inspectorate of Probation

HM Inspectorate of Probation is the independent inspector of youth offending and probation services in England and Wales and reports on the effectiveness of probation and youth offending service work with adults and children. The inspectorate reported on their inspection of Sheffield Probation Delivery Unit (PDU) in April 2023. The inspectors noted that Sheffield had high vacancy rates across probation practitioner and administrative grades. The impact of that was being shouldered by frontline staff, almost all of whom were dealing with unmanageable caseloads. Sickness levels were well above the Civil Service average and there had been a steady flow of staff leaving the PDU for careers elsewhere. Those problems underpinned its findings in relation to casework. Work to keep the public safe was the weakest area of practice across all standards. There were a worrying number of cases where essential information had not been gathered from the police or social services, which weakened attempts to keep people (women and children in particular) safe from abusive behaviour. In response, the PDU now has a quality improvement plan in place and there is on-going recruitment of staff at all grades.

Regulatory inspection remains a key source of assurance to the SASP and over 2022/23 review systems have continued to develop. The national network of SAB chairs has recognised the need for discussions with the Home Office, Department for Education and NHS England to explore how the requirements of different review systems might be more closely aligned to ensure that the potential for learning is maximised. Discussions have taken place with the Home Office and with NHS England to ensure that nationally, the interface between SARs, DHRs and patient safety incident reporting is acknowledged. Contact will be made with the Department for Education to open discussion regarding the links between SARs and Safeguarding Child Practice Reviews. This work continues in 2023/24.

In Conclusion

The annual report demonstrates that partners have faced significant challenges during the year and there is still much to address. However, there has also been significant innovation, and safeguarding has been maintained as a priority. Notwithstanding all the current challenges, 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 some great examples of innovation, with Sheffield at the leading edge locally and contributing nationally to emerging policy on interventions that support vulnerable adults and families. Many examples are set out in detail in this report together with the impact they have made.

Safeguarding is very much everyone's business, and I would extend my appreciation to you all for your work and persistence in sustaining effective safeguarding in Sheffield. Thank you to everyone who supports the work of Sheffield Safeguarding Adults Partnership as a member, an adviser, or in running our business day-to-day. 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 Smith

Independent Chair and Scrutineer

Sheffield Adult Safeguarding Partnership

13. Acronyms

Acronym	Full Name
AC&W	Adult Care and Wellbeing
BSL	British Sign Language
C Cat	Court Case Assessment Tool (Used by Managers and Quality Development Officers to assess the reports and work done by probation court staff).
CCG	Clinical Commissioning Group
CCM	Complex Care Management
CWBPG	City Wide Best Practice Group
DACT	Domestic Abuse Co-ordination Team
DASH	Domestic Abuse, Stalking and 'Honour'-based violence.
DBS	Disclosure and Barring Service
DHR	Domestic Homicide Review
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Orders
EQuaL	Embedding Quality and Learning (Probation)
IDAS	Independent Domestic Abuse Services
IDVAS	Independent Domestic Violence Adviser
MARAC	Multi-Agency Risk Assessment Conference
MATAC	Multi-Agency Tasking and Coordination
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
PiPoT	Person in Position of Trust
R Cat	Regional Case Audit Tool (Probation)
SAR	Safeguarding Adult Review
SASP	Sheffield Adult Safeguarding Partnership
SCC	Sheffield City Council
SHSC	Sheffield Health and Social Care
STHFT	Sheffield Teaching Hospital Foundation Trust
STIT	Short Term Intervention Team
SYFR	South Yorkshire Fire and Rescue
SY ICB	South Yorkshire Integrated Care Board
SYP	South Yorkshire Police
TAP	Team Around the Person
VAP	Vulnerable Adult Panel
VARM	Vulnerable Adult Risk Management

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