Sunderland Safeguarding Adults Board: Annual Report 2024 - 2025

Foreword: Vanessa Bainbridge, SSAB Independent Chair

I am pleased to present the Sunderland Safeguarding Adults Board (SSAB) Annual Report for 2024/25. I hope it proves valuable to your organisation and informs future planning.

The report outlines, through data and narrative, the work of the Board and its members over the past year. While it offers only a snapshot, it reflects the dedication and impact of our partners. I continue to be privileged to hear about the detailed work, outcomes, and shared learning that underpin our collective efforts.

This year's report also sets out our future priorities, shaped by intelligence from our member organisations and, importantly, by those who know the most - those with lived experience.

A highlight of the year was Safeguarding Learning Week in November 2024, which saw increased attendance and positive feedback. We used learning from surveys, audits, and reviews to shape the programme, ensuring it addressed key areas for improvement.

Our year-round training and briefings have aimed to build frontline staff's understanding of key issues and confidence to respond. Feedback has been instrumental in shaping next year's programme. One staff member shared:

"Interaction has been good and I have been able to take a lot from the course to support me in my work role."

Using data and audit findings, the Board has focused resources effectively - triaging and supporting individuals through formal safeguarding processes, whilst paying equal attention to the intelligence and information from those who do not meet that formal criteria whom have been supported into appropriate support, helping us identify emerging themes.

The report also shares the learning from undertaking mandatory and discretionary Safeguarding Adults Reviews (SARs). Notably, our thematic work on homelessness. The reviews brought together a wide range of partners and produced key recommendations to take forward and further strengthen our plans.

I was delighted that Care Quality Commission (CQC) recognised the Local Authority's contribution to SSAB, and that of the overall partnership's work, and awarded a rating of 'Good'. The outcome and prevention focus of the Board has been reflected in the inspection report and the Board and Local Authority's efforts to embrace wider learning and make continuous improvements, were also demonstrated to inspectors.

The Board's commitment and attention to robust processes were equally acknowledged by CQC:

"Sunderland Safeguarding Adults Board's Strategic Delivery Plan recognised that strong governance arrangements, quality assurance data from statutory partners, and well-planned and robust assurance mechanisms such as audits were the foundation for a successful Safeguarding Adults Board which achieved consistent positive progress."

I would like to take the opportunity to thank all organisations and staff who have contributed to the report, but more importantly, for their dedication and innovation throughout the year. The Board's success is only as strong as its members' efforts.

Special thanks to the Strategic Safeguarding Team, who have ensured the Board is meeting its duties and have successfully delivered reviews, training, policy oversight and have kept learning and outcomes as an integral part of the Board's work.

Finally, it is incumbent on all members and individuals to continue to be curious, prevent harm, respond effectively and embed learning, with *Making Safeguarding Personal* at the heart of all our work.

Thank you.

Sunderland Safeguarding Adults Board

Sunderland Safeguarding Adults Board (SSAB) is a statutory body which brings together partner organisations in Sunderland to safeguard and promote the welfare of adults at risk of abuse and neglect. SSAB leads and holds partners to account for safeguarding adults in the city. SSAB has a strong focus on partnership working and has representation from the following organisations across the City:

- Sunderland City Council
- Northumbria Police
- North East and North Cumbria Integrated Care Board (Sunderland)
- South Tyneside & Sunderland NHS Foundation Trust
- Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

- Healthwatch Sunderland

SSAB works closely with other statutory partnerships in Sunderland, including:

- Sunderland Health and Wellbeing Board (HWBB) - responsible for producing the Joint Strategic Needs Assessment (JSNA) and HWBB Strategy. A 'Framework of Cooperation' is in place between SSAB, HWBB and Sunderland Safeguarding Children Partnership, setting out the role and remit of each Board/Partnership and their inter-relationship with each other.
- Safer Sunderland Partnership (SSP) - SSP and SSAB work in collaboration on cross-cutting themes, including domestic abuse, violence against women and girls, sexual and criminal exploitation, migration/asylum and modern slavery. SSAB receives updates regarding Domestic Abuse Related Death Reviews (DARDRs) activity and seeks to implement learning applicable to safeguarding adults.
- Sunderland Safeguarding Children Partnership (SSCP) - SSAB and SSCP have worked jointly on a range of common workstreams, and also hold, and contribute towards, learning events and workshops, highlighting both safeguarding children and adults issues, such as exploitation, transitions and domestic abuse.

Our Vision

In order to improve the effectiveness of SSAB in accordance with its statutory responsibilities, the Board has the following vision:

People in Sunderland are able to live safely, free from neglect and abuse

SSAB's vision for safeguarding adults in Sunderland can only be delivered effectively through the support and engagement of a wide range of partner agencies and organisations across the City. SSAB continues to work toward achieving its vision through the committed local partnership working between a range of organisations that comprise the membership of SSAB, the SSAB's Partnership Group and Sub-Committees, working together with common objectives and commitments.

Strategic Delivery Plan

SSAB's Strategic Delivery Plan details key focus areas for the period of 2024 - 2029, and identifies how SSAB will ensure its statutory responsibilities are met in accordance with the Care Act 2014 and embedded in practice across the partnership. The Plan is underpinned by SSAB's Multi-Agency Memorandum of Understanding, which describes the Board's remit and governance arrangements.

SSAB's strategic priorities for 2024 - 2029:

- User engagement

- Communication
- Multi-agency training
- Measuring success

Local areas of risk:

- Homelessness and asylum seekers/refugees/immigrants
- Self-neglect
- Mental capacity
- Responding to organisational changes (understanding impacts)
- Focus on Safeguarding and Presentation of Younger Adults (up to 25 years) (linked to care experienced cases)
- Substance misuse (alcohol and drugs) - SSAB adding value to the work of Public Health & others
- Independent providers' market - changes and consequences for safeguarding: working together as a system
- Understanding the changing demographics in Sunderland and what this means for SSAB - working towards communications and activity reaching the right people

These priorities inform the Board's local actions to safeguard adults in Sunderland, and are underpinned by the Care Act Statutory Guidance's six key principles of adult safeguarding.

The strategic priorities have been progressed through the work of SSAB's Learning and Improvement in Practice, Safeguarding Adults Reviews, and Quality Assurance sub-committees.

Progress and Achievements

User Engagement

SSAB annually engages with a sample of people who have been through the safeguarding adults enquiry process (or their representative, where they lack mental capacity to engage) via Healthwatch conducting a survey on SSAB's behalf, asking people what their experience was, whether they felt listened to and whether the people they wanted to be involved in the process were involved. It also asks if they felt the process had a positive outcome or not, and what could have been done to improve it if they felt something hadn't gone quite right. The results of these surveys serve both as an assurance for SSAB that the safeguarding adults process is working well in the majority of cases and also allows improvements to be identified and made where needed.

"There were 2 social workers involved, 1 from safeguarding and 1 from the safeguarding team. They were both amazing! They asked us what the issues were and kept in touch with me".

"Me, my mam and my aunty went along to all of the meetings. The staff sat back and listened to what we had to say and the concerns we had and how we were feeling. I am very happy and so are my mam and my aunty. It was all dealt with amazingly!"

"We had meeting when the safeguarding was closed - both social workers, the manager of the home and the commissioner for home were present. We were asked if we were happy that the safeguarding was closing and were given follow-up

meetings were arranged. We saw minutes of meetings and they let me take my own notes so I could pass these onto other family members".

SSAB also commissioned Healthwatch to engage with members of the public via a short survey to ask them what they know about safeguarding; the results from this help to inform SSAB's Communications & Engagement Strategy and associated action plan. The survey included the following questions:

Do you know what safeguarding adults is/means?

Responses included: *"Safety of vulnerable adults". "Looking out for people in the community". "Protect from harm and abuse". "Being aware of any person at risk whether emotionally mentally or physically and recording and getting help". "Referral to protect".*

What types of abuse or deliberate harm do you think might come under the heading of 'safeguarding adults'?

Responses included: Physical; emotional/psychological; financial; neglect; sexual abuse; exploitation; bullying; deliberate harm; putting people in danger.

If you, or a person you know, needed support to keep themselves safe, would you know who to contact and how to contact them so that they could help you / the person?

"Police, emergency services, social welfare, emergency mental health services". "Social care, City of Sunderland".

This year, SSAB has produced animated versions of it's two posters (one for public and one for professionals) that are played on the reception screens in Sunderland City Council's offices in City Hall, the Independent Living Centre at Leechmere and GP surgeries across Sunderland. These posters offer a quick way for people to report a safeguarding adult concern, by informing them of the relevant telephone number, or using the online form via a QR code or a website link.

Communication

- In November 2024, SSAB, in partnership with Sunderland Safeguarding Children Partnership, held a successful local campaign *Safeguarding Learning Week,* in line with National Safeguarding Adults Week 2024, with the focus on Working in Partnership. The week featured a range of face-to-face and online events (webinars, briefings, training) covering a range of safeguarding topics, including: learning from Joseph Safeguarding Adults Review, Supporting Communities through Co-location and multi-agency partnership, Safeguarding and Substance Misuse, Impact of Childhood Trauma, and Professional & Organisational Safeguarding. Sessions were very well received, and feedback is being used to inform the planning of next year's event taking place in 2025.
- SSAB produces a newsletter several times a year, giving a summary of key safeguarding messages and resources. This is shared with SSAB partners & other interested parties via email, and also published on the SSAB website.
- SSAB regularly produces 7-Minute Briefings on a range of safeguarding topics and also as away of sharing key messages from Safeguarding Adult Reviews. In 2024-25, 7-Minute Briefings were produced on: learning from the

'Joseph' SAR; Prader-Willi Syndrome and Mental Capacity; Making Safeguarding Personal.

Multi-Agency Training

SSAB's Multi-Agency Training Offer comprises both trainer-led training and e-learning courses.

The trainer-led training has 5 core courses running regularly throughout the year:

- Raising a Safeguarding Concern
- Multi-Agency Roles in the Safeguarding Adults Process
- Mental Capacity and Deprivation of Liberty Safeguards (DoLS)
- How to Assess Mental Capacity
- Self-Neglect & Hoarding

The final 2 courses were implemented as a result of learning & themes from several SARs. Courses are open to professionals working with adults at risk in Sunderland from health, social care, housing, voluntary and community sector staff and emergency services personnel. Training is free or heavily subsidised, depending on the sector of work staff come from.

Training content is regularly reviewed and refreshed in light of learning from SARs and other reviews, national, regional or local developments, and up-to-date statistics.

SSAB also offers a number of e-learning courses on a range of safeguarding topics; these are free of charge to anyone who wants to participate in them.

Both the sector participation figures and learner outcomes are monitored for the trainer-led training with feedback collected and this is communicated to the trainers so they note what works well or can make improvements as required. Sector participation figures are also collected for the e-learning. This data is used to promote the training to different sectors as & when required.

Measuring Success

Measuring success for SSAB is achieved through a range of methods; examples include:

- Safeguarding Adults Section 42 and Other Enquiries performance data (including numbers of concerns, demographic information and outcomes information) is produced on a quarterly basis and analysed by SSAB's Quality Assurance Sub Committee. A summary is the provided to SSAB's Board meetings. This data provides assurance to SSAB, and also allows for upward/downward trends to be monitored and any appropriate actions to be identified as required, e.g. themed audits of in-depth assurance exercises, revision of procedures, training updates, information resource materials to be produced.

- SSAB's partner agencies provide a summary of safeguarding adults themes and trends on a quarterly basis, which are compared against the safeguarding adults performance data to either correlate existing themes or issues or to highlight potential new areas of good practice to be shared, or issues to be investigated in more detail.
- Participants in SSAB's training offer courses are routinely asked to provide feedback on how the training has enhanced their knowledge & skills & how they have applied it in the practice; this is requested before they can receive their course certificates.

Local Areas of Risk

Homelessness

- In April 2025 SSAB published a discretionary themed Safeguarding Adults Review (SAR) featuring homelessness, intended to build upon the learning and outcomes of an earlier SAR - Alan (2021). The review highlighted the complexities of homeless issues and their impact on physical and mental health where substance misuse is also a factor and the challenges of engaging with those who experience homelessness. An action plan has being put together as a result of the review recommendations, and SSAB is making progress in implementing the actions resulting from it.
- Homelessness updates and data continue to be routinely shared with SSAB, and SSAB members continue to contribute to the work of the Strategic Housing Group, demonstrating the partnership's support of this key priority.

Self Neglect

- Self-neglect continues to be a strong theme in SSAB communications with partner agencies. A suite of regional resources, into which SSAB has inputted, have recently been updated and are regularly promoted across the partnership
- SSAB continues to provide Self-Neglect training as part of its multi-agency safeguarding training offer
- The Complex Adults Risk Management (CARM) process was developed in 2022. It was subject to an external review in 2024. From this review, recommendations included reframing the process as a stepped or staged process, and additions to partner representation on the CARM Panel - these recommendations were implemented in 2024.

Mental Capacity

- SSAB continues to include the training courses ‘How to Assess Mental Capacity’ and ‘Mental Capacity and Deprivation of Liberty Safeguards’ as part of its training offer for professionals working in Sunderland with people at risk

of abuse and/or neglect. These continue to receive good feedback from attendees, viewing them as a valuable support to their daily work and practice.

- The Learning and Improvement in Practice (LIIP) sub-committee, on behalf of SSAB, receives regular updates and assurance from partners regarding awareness raising activities in relation to mental capacity and executive function

Responding to organisational changes

- The Care Quality Commission (CQC) rated Sunderland City Council's Adult Social Care (ASC) as 'Good' in their inspection in autumn 2024. How ASC interacts with and works as a statutory partner on the SSAB along with other statutory & non-statutory partners was looked at by CQC as part of their inspection. CQC found that ASC, through their Safeguarding Adults Team and the wider ASC workforce, provide a positive impact for people going through the safeguarding process and their families. This gives SSAB assurance that one of it's key statutory partners continues to be pivotal to the successful safeguarding of adults at risk of abuse and neglect in Sunderland.
- SSAB receives regular updates and assurance from the Probation Service on the impacts of the recent reforms to prison sentencing and duration.
- SSAB receives regular updates and assurance from Northumbria Police regarding the embedding of the Right Care, Right Person approach.

Focus on safeguarding and presentation of younger adults

In February 2025 SSAB collaborated with Sunderland Safeguarding Children Partnership (SSCP) to deliver a multi-agency Transitions Workshop. The event, chaired by the SSAB Independent Chair and SSCP Independent Scrutineer focussed on transitions from childhood to adulthood, with particular consideration given to 16-25 year-olds, transitions from children to adults services and areas of specific concern identified through Child Safeguarding Practice Reviews (CSPRs) and Safeguarding Adults Reviews (SARs).

The workshop led to several actions being proposed to the Transitions Management Group (a joint group with representatives from Together for Children & Adult Social Care) and the development of a 7-minute briefing about Transitional Safeguarding, which was published on both the Sunderland Safeguarding Children Partnership & SSAB websites.

Substance Misuse

A meeting was held with Public Health representatives in 2024 to identify appropriate areas where SSAB could be linked into the work they do, including that on substance misuse (drugs and alcohol). Public Health representatives were identified to sit on

SSAB & its Sub Committees. They provide a link to the work being done on substance misuse in Sunderland, along with updates to meetings, and highlight ongoing ways in which SSAB partners can get involved in this work, such as sitting on the multi-agency Sunderland Suicide Prevention Action Group (an audit of suicide deaths in 2023-24 in Sunderland found that alcohol misuse was a feature in 41% of records and drug misuse in 43%), which leads on the local Suicide Prevention Action Plan formulated by the Public Health Team.

Independent providers' market

Market position statements giving an overview of the current circumstances in the independent providers' market (e.g. care homes, home care agencies) are received by SSAB as appropriate, when issues arise in this area. The SSAB performance data also routinely includes safeguarding data where concerns have been raised from or about these agencies. These information streams allow SSAB to gain assurance of what action has been taken when there are safeguarding concerns linked to the provider market in Sunderland.

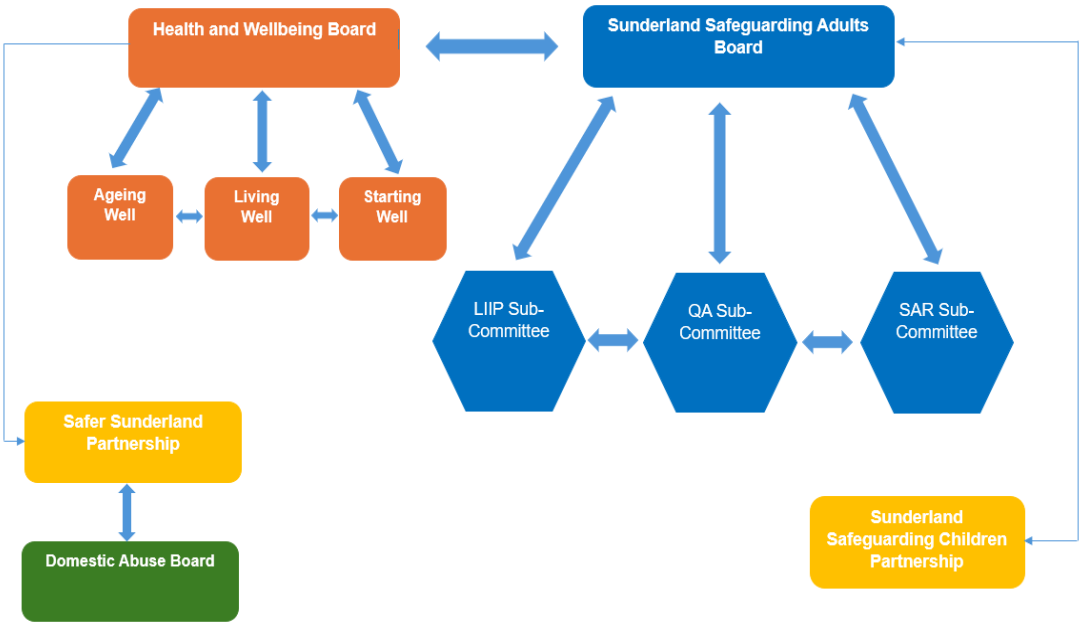
Understanding the changing demographics in Sunderland

Through the Quality Assurance Sub Committee, local data from safeguarding adult concerns cases and Safeguarding Adults Reviews (SARs) has been compared against demographics data collected as part of the CQC inspection of Adult Social Care and also against the 2nd National SARs Analysis Report. This resulted in some recommendations being formulated to improve the way in which Equality, Diversity & Inclusion (EDI) data such as gender, ethnicity and sexual orientation, are collected, particularly during the SAR process. This will allow a more detailed picture of any relevant trends or themes to be identified which may suggest further work is required by SSAB to address them.

The Work of SSAB and its Sub-Committees

Governance

- SSAB carried out a review of its governance arrangements in Summer 2024. During this interactive session, which was supported by an external facilitator, members were asked to reflect on SSAB's Strategic Plan, the Board's priorities and how they are delivered. This discussion shaped SSAB's Strategic Delivery Plan 2024 - 2029, which will be reviewed annually in line with Care Act guidance, and took into consideration relevant data regarding the population of Sunderland. Sub-committee Chairs and Vice Chairs were tasked with reviewing the draft plan and priorities, before the final version was shared across the partnership.
- As part of the review SSAB streamlined its governance structure, with what was the Partnership Group merging with the SSAB membership and meeting frequency increasing to 6 times per year, with commitment from Chief Officers to be involved on an annual basis.



Quality Assurance

- Received the Complex Adults Risk Management (CARM) external review report and a presentation on the recommendations, which were endorsed on behalf of SSAB.
- Received quarterly safeguarding adults performance data dashboards and also partner agencies' quarterly data summaries showing their themes/trends in safeguarding adults. Discussion of these at each meeting allows themes to be correlated across agencies & with the quarterly performance dashboard, which can confirm and assure, or support decisions about where to concentrate efforts on emerging issues.
- Received quarterly training attendance data and delegates' feedback reports, providing assurance on the continued value of SSAB's training offer to multi-agency staff who attend.
- Received a number of themed data reports looking at trends identified from previous safeguarding adults data, e.g. 18-24 year olds where a safeguarding concern had been raised and they had also been Looked After/Cared For as a child; Timeliness of the Section 42 Safeguarding Adults Enquiry Process; relevant Equality, Diversity & Inclusion & Demographics data.
- Conducted a number of assurance exercises and received the results for discussion & agreement of either assurance or further actions, e.g. Agencies' responses to a Healthwatch Hospital Discharge Survey; Safeguarding Messages shared by Partner Agencies.

- Commissioned quarterly surveys from Healthwatch re: the public's understanding of safeguarding, which were used to support decisions about SSAB's Communications & Engagement activity.
- Commissioned a survey from Healthwatch re: service user experiences (or their representative, where they lacked mental capacity) of the safeguarding adults process. The resulting report gave assurance that the overall process embodies good practice and also identified some areas for improvement. This survey is undertaken on an annual basis.
- Reviewed the Sub Committee's actions against the SSAB Strategic Delivery Plan, to ensure they continue to be aligned with SSAB's objectives & priorities.
- Reviewed & refreshed the Quality Assurance audit cycle, identifying the priority areas for audit in 2024-25.
- Supported Safeguarding Learning Week 2024.
- Reviewed SSAB's Communications & Engagement Targeted Activity Plan.
- Agreed new topics for development of further SSAB 7-Minute Briefings on a range of safeguarding adults topics, some of which were published during the year.
- Received updates on SARs activity, to enable identification of audit/assurance themes that may need to be taken forward.

Safeguarding Adults Reviews

- Scoped 1 potential SAR case against Care Act criteria. The case was not found to meet the criteria for a SAR, however there was single-agency learning identified for two SSAB partners. An action plan was developed and completed and has since been shared with the Quality Assurance sub-committee for further assurance work.
- Supported the review process for the following SARs:
    - Joseph - published Summer 2024
    - Thematic Review: Human Stories Featuring Homelessness - published April 2025
    - Alex - due for publication in Summer 2025
    - James - due for publication in Summer 2025
- Progressed learning and actions resulting from the Joseph SAR
- Reviewed and amended SAR Protocol and SSAB SAR Referral form in response to the 2nd National SAR Analysis report

- Reviewed and endorsed the Interface between SARs and Coronial Processes Best Practice Guidance, produced by the National Safeguarding Adults Board Manager Network, and shared this with HM Coroner for Sunderland
- Reviewed and endorsed the Cross-Boundary SAR Guidance for Safeguarding Adults Board Business Units
- Received a presentation regarding the role of the District Nurse in response to learning identified from a case scoped against Care Act criteria
- Following guidance from DLUHC (Department for Levelling up, Housing and Communities - now Ministry for Housing, Communities and Local Government) the Housing Options Team Manager is now part of the sub-committee membership to enhance discussions regarding potential SAR cases
- Supported Safeguarding Learning Week 2024

Learning and Improvement in Practice

- Considered learning from local and national SARs
- Supported Safeguarding Learning Week 2024
- Received training and development updates from SSAB partners
- Undertook a multi-agency review of SSAB's classroom-based safeguarding adults training
- Reviewed and endorsed the North East ADASS Organisational Abuse: Good Practice Guide
- Received a presentation from RISE (a charity) regarding sport welfare and safeguarding

Training

SSAB provides multi-agency safeguarding adults training in trainer-led and e-learning formats. Trainer-led training continues to be offered in a hybrid format, with both classroom-based and virtual trainer-led training on offer.

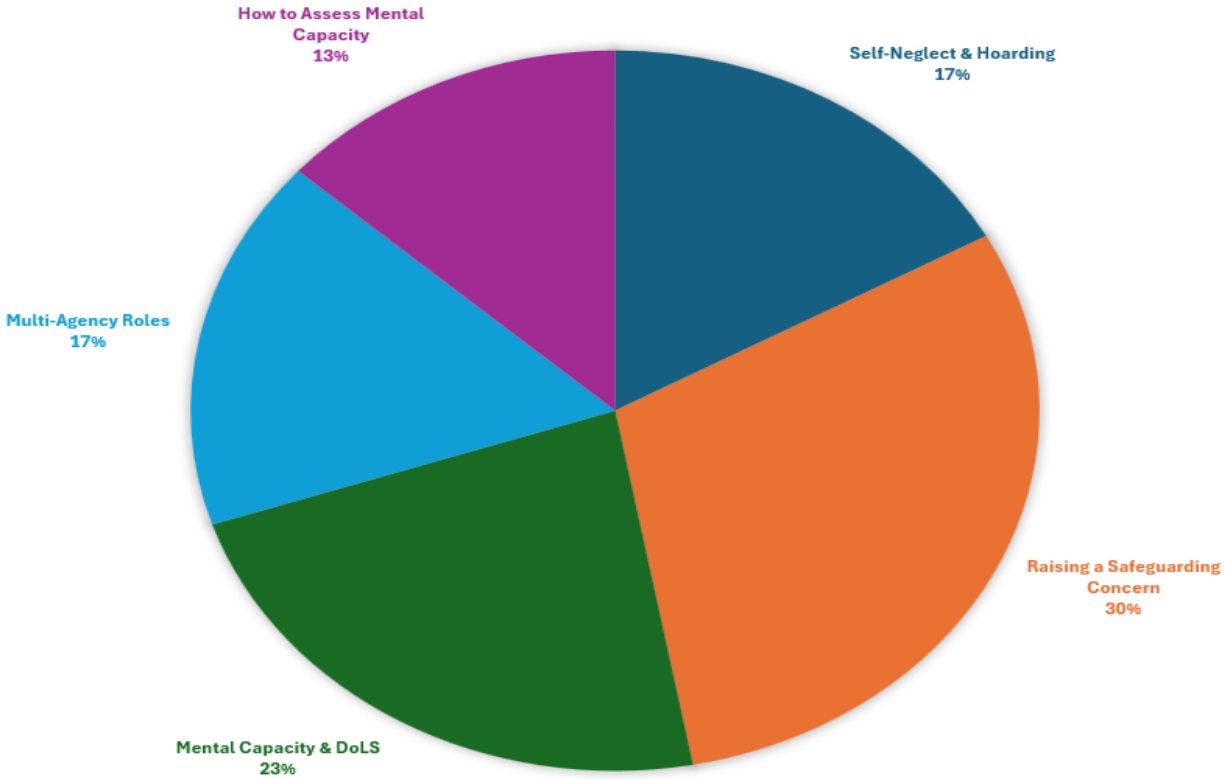
Training content is regularly reviewed and refreshed to ensure that it reflects current themes and trends of adult safeguarding in Sunderland. Over the course of 2024-25, **866** delegates received trainer-led training provided by SSAB.

In partnership with Sunderland Safeguarding Children Partnership (SSCP), SSAB continues to provide a range of safeguarding e-learning courses to organisations working with adults and children in Sunderland, including the following which are aligned with SSAB's strategic priorities:

- Self-neglect

- Supporting teenagers and young people
- Understanding the importance of the mental capacity act and liberty protection safeguards

In Autumn 2024 SSAB collaborated with SSCP to implement a new Learning Management System, which allows for enhanced data collection and analysis. It has also provided a much more streamlined way for people to sign up for training courses and to manage their learning around safeguarding topics, with online resources and certificates.



1 - SSAB Safeguarding Adults Multi-Agency Training Figures

Analysis of training data gathered over the period of 2024-25 shows that across the five trainer-led courses, there has been a consistent improvement in understanding, skills and confidence, with trainers rated highly for their knowledge and engagement. Sessions were noted to be interactive and well-structured, with a preference for face-to-face delivery.

Feedback from participants included:

"Interaction has been good and have been able to take a lot from the course to support me in my work role".

"I gained a great deal of knowledge surrounding the legislation that can be used in these situations. The course gave me a deeper understanding of the significance of mental capacity assessments when it comes to self neglect and hoarding. The

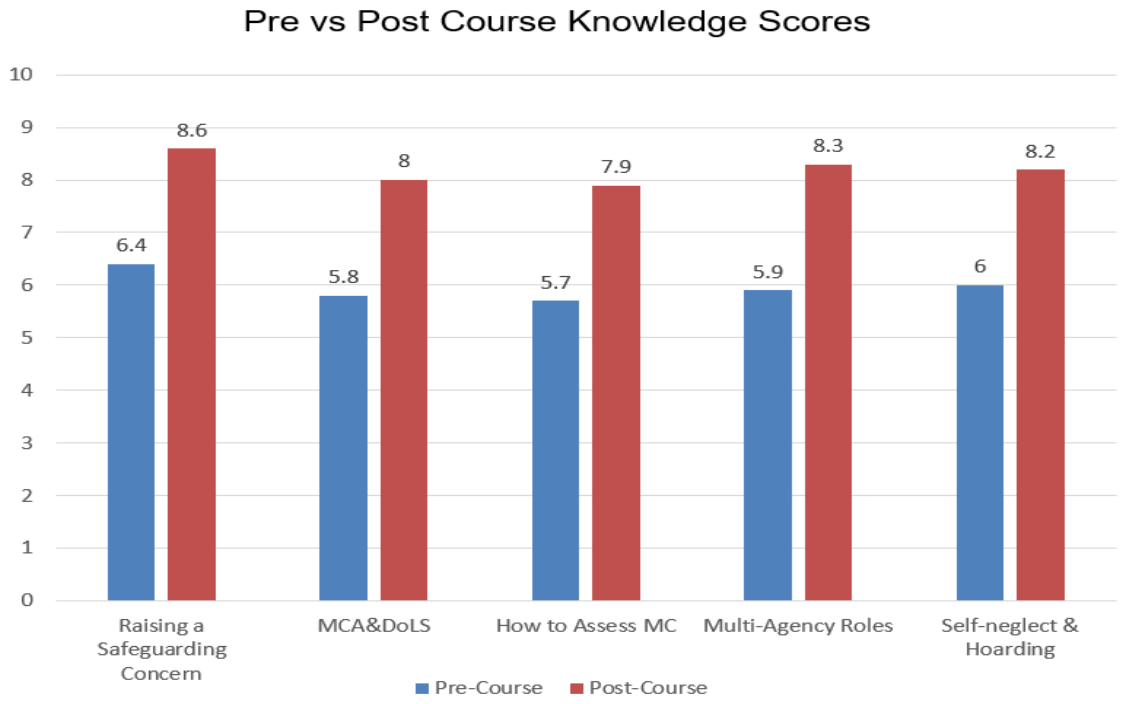
session was structured well and it was good that time was given for people to share knowledge they had around the subject. As a student it is always valuable to hear from diverse perspectives and experiences".

"Really good trainer who promoted the use of case studies to explain complex and difficult topics".

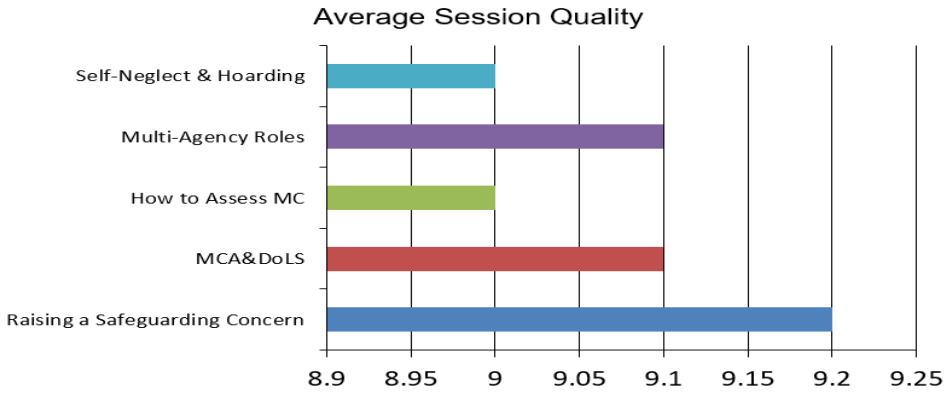
"Trainer had very good knowledge, polite and professional, gave everyone the chance to have an input".

"Very informative & knowledgeable, and a good refresher".

"Good resources used and a good explanation on how to use threshold guidance".

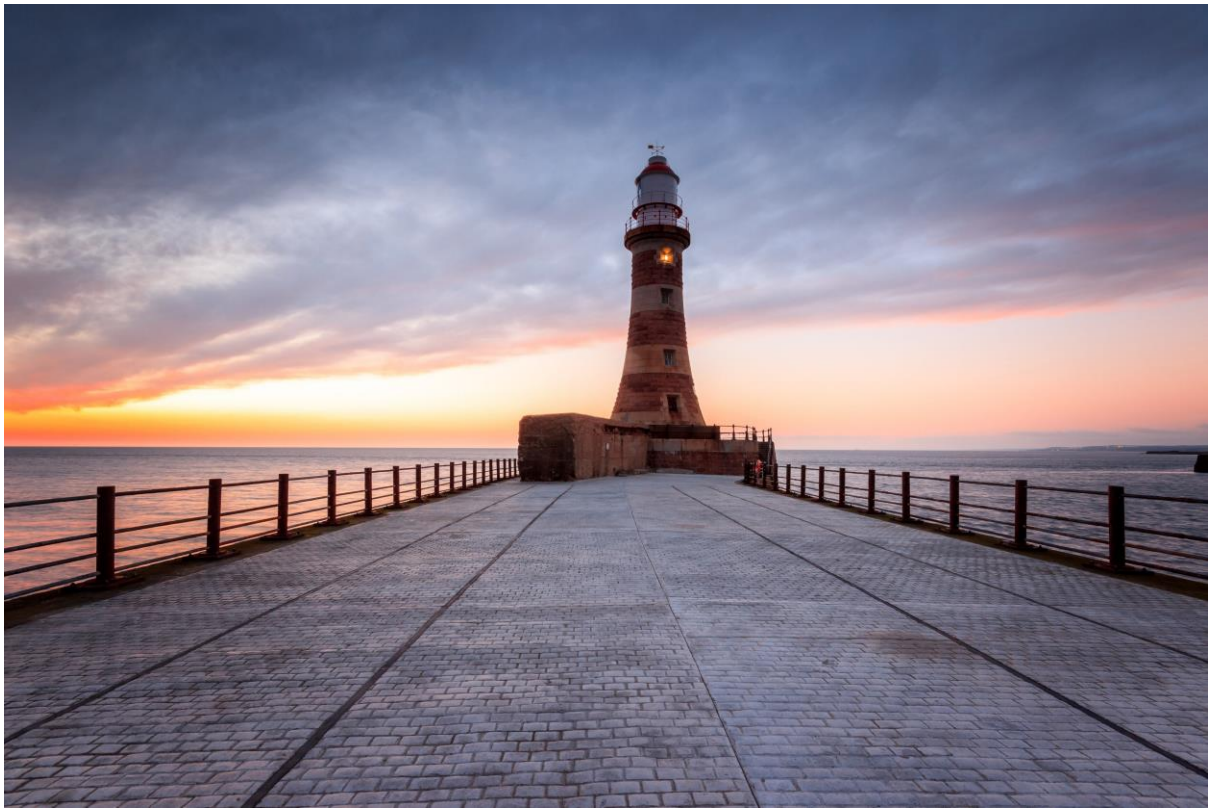


2 - Comparison of pre and post course knowledge (on a scale of 0 - 10, where 0 is low and 10 is high).



3 - Session quality ratings (on a scale of 0 - 10, where 0 is low and 10 is high).

Statutory Partners' Contribution to Safeguarding



Key Achievements

SSAB partners continue to support the safeguarding adults' agenda, meeting key statutory responsibilities and contributing to the work of the sub-committees and Board. Partners have proactively engaged in local and national campaigns, and continue to share good practice and learning. Partners also undertake regular governance and assurance activities.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

- The safeguarding team continue to work in collaboration with multi-agency partners to ensure safeguarding measures are in place and learning is shared to support and protect adults at risk and their families. 2024-25 focused upon learning from local and regional SAR's, DARDR's (Domestic Abuse Related Death Reviews) and DHR's (Domestic Homicide Reviews) and included professional curiosity, trauma informed practice, Making Safeguarding Personal, self-neglect, mental capacity and executive capacity. The team shared key messages through the safeguarding link forums, safeguarding newsletter, 7-minute briefings and attendance at governance meetings.
- Safeguarding adult and children supervision delivery has been reviewed to ensure that supervision delivery adopts a "Think family" approach and that staff are clear on their individual supervision requirements and the support the safeguarding team can offer.

- The safeguarding team have maintained core business in relation to providing staff advice, support, supervision, and training. This includes hosting a single point of contact and ensuring enhanced visibility upon wards and departments to increase face to face presence in areas. This is to further support staff in their safeguarding practice and offer safeguarding supervision in action. Throughout 2024-25, STSFT staff submitted **1,801** safeguarding referrals.
- Safeguarding Adult training has been reviewed to ensure that it is aligned to the adult intercollegiate document, NHS Sexual Safety Charter and learning from local and regional SAR's. In 2024, STSFT adopted the National E-Learning package for Safeguarding Adults Level 1 and 2 training. Level 3 face to face "Think family" training continues to be delivered via a hybrid model of face to face classroom sessions and E-learning. Slido continues to be used to ensure sessions remain interactive. Slido enables evaluations of sessions in "real time". STSFT staff are compliant in all 4 levels of safeguarding adults training.
- MCA level 1 and Induction packages are well embedded with good achievement rates. There is a bespoke MCA refresher module for front line staff aimed at improving practical skills around applying the MCA and DoLS (Deprivation of Liberty Safeguards).
- Additional efforts have gone into adding to the list of Continuous Professional Development (CPD) packages available to staff 24 hours per day via our dedicated Internet Repository. These packages included themed PowerPoints with commentary. Packages created are based on areas of complexity identified via internal complex cases or external recommendations from SARs and DHRs. Topics include packages such as:
    - Executive Dysfunction and Prader Willi and Mental Capacity identified via local SARs and shared with SAB partners.
    - Domestic Abuse and Mental Capacity package was created in response to recommendations from DHRs.
    - Other packages include LPA and ADRT, Court of Protection, Dental Care and Mental Capacity, Human Rights Act and Diabetes and Mental Capacity. The latter package was presented to NHS England's Safeguarding Community of Practice as an example of good practice and is now available nationally via the NHS Futures platform.
- The DoLS Team continue to monitor compliance via a daily launchpad monitoring tool that allows the team to support colleagues working in acute hospital services to complete the necessary MCA and DoLS forms in a timely fashion. The team have provided greater visibility on wards and via bespoke training sessions to further support compliance with the legal process.

Training presentations have been created to demonstrate how to complete the forms on our Electronic Patient Record System.

- Further support is available to acute and community staff via a Mental Capacity Good Practice Forum. This forum facilitates learning from case law, identifies training needs and shares good practice across STSFT. The MCA Lead also represents STSFT at a range of local, regional and national MCA fora. Indeed, our MCA Lead has established a national support group for health sector MCA leads which allows for a richer sharing of good practice and training materials, as well as peer supervision and support from across the country.
- The team assessed STSFT's performance against a national NHS England Self-assessment tool and have used the outcomes to help plan where improvements can be made. An example of the areas we identified as requiring improvement included how we actively involve staff, families and those with lived experience in shaping our services.
    - To that end, the team have worked with Twisting Ducks Theatre company to produce a training video looking at assessing mental capacity and making reasonable adjustments when working with adults with learning disabilities in a maternity scenario. The safeguarding service now includes direct management and oversight of our learning disability and autism liaison service.
    - We have commenced a service evaluation with former patients who were admitted with a delirium but later regained mental capacity to learn from their experiences of having their mental capacity assessed and of having a DoLS Standard Authorisation. We are including the views of families in this work.
    - With staff, we have continued to add to our library of podcast interviews with internal staff and external advocacy services to further promote MCA in daily practice. The most recent podcast included an interview with one of our senior nurses who was born and trained overseas to talk about the challenge faced by our new internationally recruited nurses in understanding and applying the current legal framework.
- We have continued to promote MCA practice via giving presentations at a variety of conferences and seminars, including the Discharge Planning conference. We regularly attend Clinical Governance meetings and create bespoke training events for staff in their area of practice. For example, themed sessions in renal, ophthalmology, surgery and anaesthetics, as well as many more.
- The team continue to work closely with CNTW Psychiatric Liaison Team to help improve understanding of mental health and the interface between

mental capacity and mental health legislation, including speaking at their bi-annual Mental Health Symposium.

- The team continue to see audit work as essential in monitoring and improving performance. Internally, we have carried out audits around the quality of mental capacity assessments and another on best interest decision making on our Electronic Patient Record System. This has led to making improvements to our assessment form to capture richer detail and the creation of face-to-face masterclass training session aimed at improving quality. We continue to audit cases admitted with 'no reason to doubt' mental capacity to ensure any missed opportunities are minimised. STSFT have also worked closely with external auditors, Audit One, who have carried out two audits, one of our DoLS process and one for our mental capacity assessments. Both received good ratings and clear action plans for improvement. We have also supported local authority partners in carrying out an audit of their mental capacity assessments in safeguarding cases around hoarding and self-neglect.
- In the last year, a key priority was to support improvement in MCA compliance in Paediatric services working with young people aged 16 and 17 years old. This work included an audit of current practice, improvements in policies and procedures and the creation of bespoke face-to-face sessions and CPD PowerPoint presentations made available via the repository. We made changes to our Electronic Patient Record System to prompt paediatric staff to assess mental capacity. We have also been asked to present this work at internal and external conference events. We plan a follow up audit in the coming year to monitor progress which is included in our annual audit plan.
- The Domestic Abuse Health Advocates (DAHA's) in conjunction with the safeguarding team, support staff in the identification and response to any disclosure of Domestic Abuse. DAHA's are specialists working with victims of domestic abuse, targeting ward areas, ED, maternity, and community in supporting staff to recognise and respond to domestic abuse. 2024-25 has seen a further increase in DAHA referral activity, explained by their visibility and accessibility across the Trust. In 2024, the Trust was successful in White Ribbon accreditation (a charity scheme in England and Wales engaging men and boys to prevent men's violence against women and girls).
- The safeguarding Intranet page is continually updated to ensure staff are provided with up to date and relevant information and support 24/7. There is now a stand-alone Sexual Violence section.
- Recent DAHA feedback from patients include:

“You supported me throughout my first days here and also my very worst days at rock bottom when I was in so much pain. I'll never know how to thank you. Your work has made me safe again - something I thought was unimaginable”.

“It's rare to experience a professional who listens to you and who empathises. You considered every thought and feeling I had - even if the next was the opposite of the last”.

"Please never ever lose the passion and drive you have for your job and simply to help people like me! (Although never simple!)"

“You are part of the reason I have been protected and I don’t know how to ever thank you for that. Your job makes a difference to people in so many ways, I’m sure you already knew that! Thank you so much for your hard work and support this week”.

“Thank you for fighting for me and keeping me safe”.

4 - STSFT Safeguarding Team staff and their information stall

North East and North Cumbria Integrated Care Board (NENC ICB) - Sunderland

- Established and developed safeguarding enabler and workforce workstreams aligned to statutory safeguarding responsibilities across the NENC ICB footprint.
- Safeguarding assurance perspective: across the NENC ICB, have reviewed our contracting and commissioning arrangements with health providers and improved links - now have an allocated safeguarding lead for each health organisation.
- Facilitation of the primary care safeguarding leads meeting by the Named GP and safeguarding team to provide updates, offer peer support and facilitate training.

- A learning and development safeguarding programme has been developed for safeguarding staff within the NENC ICB.
- The workforce enabler group within the NENC ICB has developed a competency framework and induction pack for newly established specialist practitioner roles which are 'all age' across the safeguarding life span.
- Established a process around MAPPA (Multi-Agency Public Protection Arrangements) to safeguard members of staff within the primary care setting.
- A training programme within the NENC ICB for safeguarding staff has been developed and is in place.

Northumbria Police

Northumbria Police have continued their focus on Domestic Abuse (DA) this year, Sunderland has seen a 6.2% reduction in Domestic Abuse related incidents.

The Prevention department have implemented a mental health problem solving team with a new terms of reference, who are now managing small cohorts of individuals, those who are high harm or place high demand on local areas.

The Safeguarding and Prevention department have newly formed a suicide prevention working group attended by Local Authority Public Health leads and DA leads across the region. A Northumbria area, multi-agency suicide prevention conference is planned for Jan 2026.

Sunderland City Council

- Compared to 2023-24, Adult Social Care (ASC) Safeguarding concerns have remained consistent with only a 0.6% increase.
- There has been a 15% increase in S42 enquiries started in the period
- Continuing to review existing processes and systems to create increased efficiencies in terms of ASC Safeguarding
- A successful CQC Inspection where Safeguarding was rated as Good. Examples of comments made by CQC in their report include:

"The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area. The Safeguarding Adult Board undertook an independent review which resulted in condensing to 1 board and 3 sub-groups and a more streamlined system".

"A wider focus on learning and improvement was gained through feedback and audits. Audits were reviewed and fed into the safeguarding board as evidence of how the local authority were meeting its duties under the Care Act 2014".

"There was a strong multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear. Information

sharing arrangements were in place so that concerns were raised quickly and investigated without delay. There was an embedded person-centred approach to safeguarding investigations".

"There was a focus on making safeguarding personal and involving service users but also on prevention and early intervention. The local authority worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring".

"Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice".

"Staff told us they had received 7-minute briefing information on the learning from Safeguarding Adults Reviews".

"Staff and leaders had clarity on what constitutes a Section 42 safeguarding concern and when section 42 safeguarding enquiries were required, and this was applied consistently. There was a clear rationale and outcome from initial enquiries, including those which did not progress to a Section 42 enquiry".

"People had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they did not feel safe, or they had concerns about the safety of other people. People could participate in the safeguarding process as much as they wanted to, and people could get support from an advocate if they wished to do so".

"People were supported to understand their rights, including their human rights, rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices that balanced risks with positive choice and control in their lives".

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

There has been successful recruitment into Named Professional positions. There are now 2 Named Professionals and 1 Named Nurse in post allowing for improved safeguarding oversight and support to CNTW services but also creating capacity for greater involvement and interfacing with locality Safeguarding Adult Board/Safeguarding Children Partnership subgroups, task and finish groups and joint initiatives.

A dedicated Safeguarding Dashboard has been developed and is in the final stages of review prior to going live. This will allow the organisation to monitor and review safeguarding information, to identify trends and learning, to better support safeguarding practice at a strategic and operational level.

CNTW Trust Quality and Safety priorities for 2025 – 2026 have a focus on; reducing incidents of Violence and Aggression, reducing Restrictive Practice, reducing incidents of Self Harm and suicide and improving Physical Health care. Safeguarding

leads have membership of the working groups to ensure action plans and service/practice developments are considered through a Safeguarding lens.

Good Practice

Examples of good practice across the partnership include partner agencies' dedicated participation in Safeguarding Adult Reviews and dissemination of the learning afterwards; participation in Safeguarding Adults Week activities; being part of SSAB's case file audit process and sharing knowledge to aid learning & improvement activity.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

- STSFT safeguarding team were successful in the Trust “Recognition Awards” ceremony, winning in the Corporate Team of the Year category.
- STSFT were awarded White Ribbon accreditation in 2024. There are now several White Ribbon Ambassadors, including our Chief Executive and Deputy Chief Executive, and White Ribbon Champions in the organisation.
- STSFT launched the NHS England Sexual Safety Charter in 2024, which aims to take a systematic zero-tolerance approach to sexual misconduct and violence, keeping patients and colleague’s safe, recognising that sexual misconduct can happen to anyone anywhere. A separate sexual violence section on the Trust intranet page has been devised to further support staff in their safeguarding practice.
- The STSFT safeguarding 2024-25 annual audit cycle has been completed to provide assurance alongside the recognition of any actions to be taken to further improve safeguarding practice within the organisation. Audit activity included ED attendance and asking of safeguarding questions, safeguarding policy compliance (inclusive of routine & selective enquiry and identification of missed opportunities), procedural self-neglect guidance and threshold tool compliance and chaperone policy compliance.
- The safeguarding visibility model has been further reviewed to ensure that staff have access to and support from, a member of the safeguarding team due to increased face to face presence on wards and departments. This includes daily attendance at Emergency Department (ED) huddles and Paediatric ED (Monday-Friday).
- The safeguarding team continue to complete a daily audit of ED attendances to ascertain if there are any missed opportunities and to gain assurance that safeguarding questions are being asked at each individual attendance. Any learning to arise from missed opportunities are Incident reported. The Named Nurse continues to attend ED Clinical Governance meetings to discuss any reported missed opportunities. The annual audit of ED attendance activity continues to be part of the safeguarding annual audit cycle.

- Safeguarding link forums and “Hot Topic” sessions are held regularly. A bi-monthly safeguarding newsletter continues to be disseminated across STSFT staff and is held centrally on the Intranet. The key aim of the newsletter and link forums is to share any safeguarding learning, training courses and 7-minute briefings following the publication of SAR’s, CSPR’s (Child Safeguarding Practice Reviews), DHR’s and DARDR’s. In 2024-25, learning has been shared pertaining to CSPR Child S, CSPR Child C & D, SAR Joseph, South Tyneside Thematic Review “All About Us”, SAR Adult “AX”, SAR “Thomas”, DHR 6, DHR 9 and DHR 15. Other learning was shared in relation to mental capacity assessment, executive dysfunction, trauma informed practice and self-neglect, the implementation of CARM and how to make a referral, the findings from the 2nd National SAR Analysis review, professional curiosity, professional challenge and escalation, learning from inquests, preventing future deaths, contextual safeguarding - transitioning to adult care, PREM (Partnership Reduction Exploitation & Missing), Prevent and the new definition of extremism and HOT principles, knife crime (via a Hot Topic session), raising awareness of the White Ribbon campaign, the Herbert and Winnie Protocol, (Right Care Right Person), Northumbria Police Violence Reduction Unit – Violence Prevention Ambassadors Programme awareness, opiate awareness dependency, Counterfeit alcohol - Glen’s vodka, Youth Drug and Alcohol Project (YDAP), Prader Willi Syndrome and MCA, executive dysfunction and MCA, LPA/Deputyship, Role of Court of Protection, Children, Capacity and DoLS, Barnardo’s Helplines Asylum Seekers and Refuge Family helpline. Positive feedback has been received from staff in relation to content and information within the safeguarding newsletter and following link forums.

5 - STSFT Safeguarding Team winning Corporate Team of the Year in the Trust Recognition Awards ceremony

North East and North Cumbria Integrated Care Board (NENC ICB) - Sunderland

- The NENC ICB (South Tyneside and Sunderland) safeguarding team worked alongside STSFT safeguarding team with the domestic abuse health advocate (DAHA) within South Tyneside to deliver domestic abuse specialist training to primary care networks (PCNs), this included various members of staff such as: clinical pharmacists, some GP's, and other non-clinical staff.
- Internally within the NENC ICB (South Tyneside and Sunderland), there are positive links within the South Tyneside and Sunderland Local Delivery Team and safeguarding.
- The promotion of 'boost' as a training platform – this needs further exploration as to how this can be used more widely and whether a safeguarding module would be beneficial.

Northumbria Police

Northumbria Police Sunderland Area Command continue to provide a locality based, multi-agency approach to problem solving and safeguarding through the three established hubs; SARA (Southwick Altogether Raising Aspirations) HALO (Hetton Aspirations Linking Opportunities) and SAIL (Sunderland Altogether Improving Lives.)

The established multi-agency hubs are all multi-agency partnerships involving public and third sector services working at the strategic and community levels with the aim of improving issues impacting the community. The hubs have priority areas of work:

- Improving health and wellbeing.
- Reducing crime and anti-social behaviour.
- Improving environmental and housing standards.

This model allows improved information sharing, more efficient working and has been shown to have a from different organisations to tackle problem solving collaboratively. The hubs have improved partnerships, improved the overall service provided to the community by Police and partners whilst providing a social return on investment. Overall, the projects have shown reductions in crime and anti-social behaviour across Sunderland. In light of their success, the local authority and Northumbria Police are working on plans to establish three additional multi-agency hubs in Sunderland West, Sunderland East and Washington. The hubs are planned to be launched end of Summer/early Autumn.

Sunderland City Council

- As part of the quality assurance work in Adult Services, an audit programme is in place that covers the Safeguarding Adults Team, Adult Social Care and the Therapy service. Actions and learning from these are discussed in the Quality

Assurance Group that includes representatives from across the Adult Services Directorate.

- In June 2024, Adult Services held one of their Whole Service Events to keep staff up to date on a range of important issues. 200+ staff attended this event and were given a presentation on 'Learning from SARs and DHRs'. Highlights include attendees being informed about the themes, key learning points and actions/outcomes from the 'Alan' and 'Joseph' SARs; information on mental capacity, self-neglect, the importance of professional curiosity, multi-agency working and taking up the SSAB and other relevant training offers.
- In 2024, CQC assessed Adult Services, and the report was published in May 2025. The Directorate has been rated as Good across the 9 quality statements and Good overall. Positive feedback was received in relation to both operational and strategic aspects of safeguarding and CQC recognised that there were effective systems, processes and practices in place to make sure people were protected from abuse and neglect.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

The Patient Safety Incident Response Framework (PSIRF) continues to embed across the organisation, fostering a culture of learning and continuous improvement. Internally, this has led to more compassionate responses to incidents, improved staff engagement, and greater transparency in learning processes. Externally, partners benefit from enhanced collaboration, increased trust, and assurance that the organisation is committed to delivering safer, more responsive care. In line with this framework incident reporting and review systems ensure that the classification of incidents retains relevant safeguarding information, to enable incidents to be reviewed, clinicians supported, and patients safeguarded.

Learning from local Child Safeguarding Practice Reviews indicated that we needed to improve our assessment of the impact of parental mental health to children. In response to this the Keeping Children Safe Assessment within the electronic recording system has been reviewed and updated, it’s use is monitored via regular Healthcare Record audit.

Domestic Abuse awareness sessions have been provided to teams Trust-wide. Training is reflective of local DHR/DARDR learning.

A Trust-wide weekly question was developed to assess and improve domestic abuse awareness. This was an automatic pop up on accessing the trust intranet and included links to further information, briefings and policy. 84.45% of the Trust workforce demonstrated a robust understanding of Domestic Abuse and the appropriate actions to take to safeguard victims, with a further 7.92% identifying that they would seek appropriate advice and guidance from the Safeguarding and Public Protection (SAPP) team.

Case Study

The NENC ICB (South Tyneside and Sunderland) Designated Nurse escalated concerns around a high-risk individual that had been raised through discussions with the hospital trust. They had raised concerns and initiated various safeguarding adult concern (SAC) to the Local Authority. The ICB Designated Nurse and STSFT Named Nurse initiated discussions with other multi-agency professionals to understand the plan around the individual. Through understanding and discussion, it was ascertained that there were regular Multi-Disciplinary Team (MDT) meetings around the individual, however, the trust had not been invited to these although they were a significant link within the individual's care. Whilst the risks have not improved around the individual, the key people and multi-agency members of staff are now present within the MDT to assess risk and establish management plans.

Working with Partners

Partners continue to contribute to multi-agency working, in particular by representation at a wide range of multi-agency safeguarding fora, which includes Safeguarding Enquiry meetings, CARM*, MAPPA (now MOSOVO), MATAC, MARAC, CONTEST Board and Channel Panel.*

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

- STSFT Senior staff continue to represent the Trust at Safeguarding Adult Boards. The Associate Director for Safeguarding continues to attend Community Safety Partnerships and Domestic Abuse Partnerships.
- STSFT Safeguarding Team continue to be active members of local partnerships ensuring representation and contribution across all sub-group meetings.
- The Safeguarding Team are active participants within the Complex Adult Risk Management (CARM) meetings within the Sunderland and South Tyneside locality and are a central point of contact for the Sunderland MASH Health Navigator.

6 - STSFT's Domestic Abuse Health Advocate team raising awareness of domestic abuse with front line staff and patients on White Ribbon Day (25th November 2024)

North East and North Cumbria Integrated Care Board (NENC ICB) - Sunderland

- Deputy Designated Nurse for Safeguarding adults represents the NENC ICB (South Tyneside and Sunderland) at provider collaborative in respect of safeguarding and care homes.
- The NENC ICB (South Tyneside and Sunderland) took part in the ASC audit of cases, prompted by the 'BBCC' (a young adult) case review.
- The NENC ICB (South Tyneside and Sunderland) supported with the development of the strategic priorities of the SSAB.
- As an organisation, we continue to ensure presence within the multi-agency arena, ensuring health are represented accordingly.
- NENC ICB (South Tyneside and Sunderland) Deputy Designated Nurse for Safeguarding adults chairs the SSAB Learning & Improvement in Practice meeting.
- NENC ICB (South Tyneside and Sunderland) Deputy Designated Nurse for Safeguarding adults co-chairs the CARM meetings and is involved in promotion of the CARM, and in reviewing the process.

Northumbria Police

Key areas of work within the City include:

- The SAIL team continues to focus activity with Police and Partners to reduce adult crime and ASB within Sunderland City Centre. The team support a cohort of adults and young people to reduce and prevent their involvement on crime and ASB. In 2024, the team saw a reduction of 33% reduction in ASB,

62% reduction in Youth ASB, 6% reduction in all crime and 52% reduction in Serious Youth Violence.

- In April 2025, the Home Office granted further funding for Project Shield. Sunderland ‘hot spot areas’ for Anti-Social behaviour and Serious Violence have been agreed to concentrate activity within Sunderland City Centre, Concord (Washington) and Pallion (Sunderland West). This project focusses problem solving activity around high harm offenders and locations, preventing harm to our most vulnerable victims.
- In 2024-25, Project Shield funded XL Health within the Night Time Economy (NTE), providing health care support to adults within the NTE setting, in support of the Police and response plan. This plan was supported by local authority and Safe Haven partners
- Police and partners are pursuing the ‘Purple Flag’ award to achieve a safer, more diverse NTE
- Safer Streets funding (Office of the Police & Crime Commissioner) 2024-2025 funded Operations Salus: NTE focussed operation to prevent sexual assaults for our females within the NTE
- SARA team continue to work closely with partners from Gentoo Housing and the local authority to utilise ASB legislation, tackling crime and ASB within the community. The team continue to work with partners to support victims and offenders through referrals into local services including Wear recovery and Wearside Women In Need (WWIN)
- Operation Aegis continues within Sunderland Neighbourhood Policing Teams to support repeat victims and offenders of domestic abuse to ensure a whole system approach to problem solving is considered to prevent further harm
- SARA host a bimonthly surgery with WWIN to enable victims within the Southwick Community to attend a local and safe environment for advice and support. Future plans are underway with “Findaway” service to offer families of victims the opportunity to receive support and guidance

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"Northumbria police commits to working in collaboration with partners to ensure that adults at risk are identified early and supported effectively. The work of the SSAB is vital to delivering effective multi agency safeguarding arrangements and to keep all those living in our community safe."

Mark Hall, Chief Superintendent, Northumbria Police

Sunderland City Council

- Ongoing full participation in multi-agency working both with individual cases and at a strategic and sub-committee level
- Partners have been involved in a review of CARM
- Partners have been involved in a review of SAR Guidance and Referral documentation
- Contributed to SAR's and DARDR's for neighbouring authorities
- CQC in their inspection advised "There was a strong multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear."

Adult Social Care Case Study

Mr C lives in a care home and a referral was received from them following a fall. All partners worked together including community and district nursing services, hospital occupational therapy and safeguarding team. Family and care home commented on how grateful for the support and gave positive feedback regarding the safeguarding response and outcome of ensuring Mr. C's ongoing safety.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

The internal MARAC admin process has been reviewed and increased admin support is in place for SAPP practitioners, to ensure a robust and timely response to MARAC concerns and referrals.

The CNTW Clinical Police Liaison Lead has worked collaboratively with the Northumbria Police Mental Health Lead to improve multi agency awareness and processes in the context of criminal investigations and mental health. They will be presenting this valuable work at the National Police Chief and College of Policing Mental Health and Policing Conference on 26th June 2025.

The CNTW Safeguarding and Public Protection PREVENT lead, Nigel Atkinson, has been recognised with a Head of Department Commendation by the Head of Prevent. This award has been presented in recognition of his valuable support to Counter Terrorism Policing in the North East, his participation in Channel and Police Led Panels and the vital support he has offered to vulnerable suspects whilst in custody.

7 - ***Claire Andre receives commendation from Northumbria Police***

Claire Andre, CNTW's Clinical Police Liaison Lead, has been presented with a commendation by Northumbria Police for her dedication, hard work and support on the rollout of the new Right Care, Right Person approach.

Claire has been instrumental to the Trust's preparation for the roll-out of this new approach by the Police, working closely with local forces and CNW teams affected by the changes. Claire has prepared guidance and documentation, attended regular incident review meetings, provided valuable advice and support to staff, and run regular training webinars.

The certificate was presented by Assistant Chief Constable Alderson from Northumbria Police.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) has been embedded across the partnership. Partners incorporate the principles of MSP into their policies and procedures, staff ways of working, staff communications and single-agency training opportunities.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

STSFT safeguarding team continue to contribute to both National and local safeguarding campaigns. These include:

- Successful roll out of events to celebrate Safeguarding Adults / Learning Week 18th – 22nd November 2024 where the key theme was ‘Working in Partnership” A robust programme of activity and training sessions were shared with STSFT staff and partners. Safeguarding stalls were set up in acute trust sites to raise safeguarding awareness with staff and patients.
- As part of “Think family” the team participated in knife crime awareness week 20th – 26th May 2024. This week-long initiative aims to shed light on the detrimental effects of knife crime while providing educational resources about its risks and consequences. A hot topic session was organised which was delivered by the Education Liaison Officer at Northumbria Violence Reduction Unit (VRU).

8 - On White Ribbon Day (25th November 2024), STSFT's DAHA team were visible in the hospital to raise awareness of domestic abuse with front line staff and patients.

North East and North Cumbria Integrated Care Board (NENC ICB) - Sunderland

- Although the NENC ICB (South Tyneside and Sunderland) does not work directly with adults we do have frontline staff engaging with adults, e.g. Continuing Health Care (CHC) nurses, and MSP is covered in CHC nursing supervision sessions, which are delivered by the Deputy Designated Nurse for Safeguarding adults.
- MCA training was delivered to NENC ICB staff, which included an emphasis on MSP and was recorded, with slides, for future reference.

Northumbria Police

Northumbria Police actively promote Making Safeguarding Personal, and this is reflected in our Policy and Procedures, along with the Victims' Code of Practice, whereby the views of our victims are recognised and considered when decisions are made regarding safeguarding and any investigation. Vulnerability Matters training continues to be mandatory for new joiners to the service and safeguarding continuous professional development (CPD) highlights the voice of the victim.

Sunderland City Council

With regard to CQC they advised “Safeguarding enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre”.

In terms of performance MSP 79% were asked and expressed outcome in 2024-25, compared to 71% in 2023-24. Of these 96.7% were fully/partially achieved in both years.

The ASC Safeguarding Team work hard at ensuring we are putting the individual at the heart of safeguarding decisions - focusing on what matters most to them, not just

what professionals think is best. We continue to work with Healthwatch to undertake independent reviews of the safeguarding experience. Healthwatch is a local independent consumer organisation who work with local people, patients, service users, carers, community groups, organisations, service providers and commissioners to get the best out of local health and social care services.

Adult Social Care Case Study

Mr. M is a 37-year-old man who has lived in a supported living environment since 2022, after expressing a wish to live more independently. Prior to his move, Mr M lived with his family. Safeguarding concerns were raised by Health and Police relating to reported abuse from family which included Financial Abuse, coercion & control and emotional and psychological abuse. A safeguarding investigation was undertaken and numerous meetings held with an action plan agreed. There have been significant positive outcomes for Mr. M and he is currently described as "flourishing" and thriving with the support of staff. He is managing his own finances with support from his care team and he has been able to purchase new clothing and treat his partner to a meal out, which he is very proud of.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

Making Safeguarding Personal information, including a 7 minute briefing, guidance and good practice examples have been circulated via the Trustwide Bulletin. The information is readily available on the Trust intranet and is referred to during Safeguarding supervisions where appropriate. A My Personal Safeguarding framework is consistently utilised by clinical staff when responding to and exploring safeguarding incidents or concerns, to support referrals to Local Authority Safeguarding services.

Safeguarding Adults and Children Level 3 training is mandatory for all qualified clinical staff. The training package is reviewed and updated regularly. It includes information and guidance relating to Making Safeguarding Personal.

In 2024 CNTW launched a new service user and carer experience survey: "The ultimate aim is that people have a voice, and we hear that voice". The survey was co-developed with almost 300 people, half of who were service users. The survey questions reflect what the group told us were the most important themes. The survey is now more accessible and can be received in by email, text, letter, printed copy, and on-demand online. Speech and Language Therapy and other colleagues worked with the group to make the questions as accessible as possible.

2024 - 25 In Figures

5187 Concerns were received; this is a 0.5% decrease compared to 5159 concerns received in 2023-24.

Of these concerns, (927) 17.9% were progressed to Section 42 Enquiries, (125) 2.4% progressed to 'Other Safeguarding Enquiry', and (3381) 65.2% did not progress to a Safeguarding Enquiry. 754 concerns were linked to already open episodes (which could be a Section 42 Enquiry or an Other Enquiry), these were concerns that were considered to be so similar to the cases to which they were linked that they should be part of the same episode e.g. generally the same location and categories of abuse.

There were 843 completed Section 42 Enquiries in 2024-25, a 6.2% decrease on 899 completed in 2023-24.

Of the 3381 concerns raised that did not progress to a Safeguarding Adult Enquiry, 3042 had an agreed threshold level of low/not applicable, 319 were significant,19 were very significant and 1 was recorded as critical. The following outcomes for these concerns were recorded:

- Information & advice provided = 3
- Signposted to other agencies = 121 (84% of these were signposted to Adult Services)
- Progress to episode (safeguarding concern only) = 2
- No further action = 3255 (these cases were all 'triaged' by the Safeguarding Adults Team. This means that a check was done of the case circumstances and a decision taken that no further action by the Safeguarding Adults Team was needed, often because other agencies had already done all they could to safeguard the person and this was sufficient, or because the issue was not a safeguarding concern).

Desired Outcomes

Of those customers with a completed Section 42 Enquiry or Other Enquiry, 90.8% of these individuals, or their representatives, were asked what their desired outcomes were. Of those asked what their desired outcomes were, 88.3% expressed a desired outcome, 96.1% of which were either fully or partially achieved.

Primary Support Reason

Individuals with physical support needs represented 37.2% of all concerns received, followed by mental health needs (17.8%), and learning disabilities (11%).

Mental Capacity

In 36% of completed cases, the customer was identified to lack mental capacity. 100% of these individuals were supported.

Main Location of Abuse

Individuals' own homes: 56.7%

Residential/nursing home: 25.5%

Health setting 13.3% (acute hospital 11.3% and mental health inpatient setting 2.1%)

Alleged perpetrator's home: 1.0%

Main Categories of Abuse

Neglect: 28.7%

Physical abuse: 21.4%

Self-neglect: 26.1%

Psychological: 15.6%

Financial: 15.8%

Compared to 2023-24, neglect and acts of omission continues to be the highest category followed by self neglect. The main changes are a decrease in the percentage where physical abuse was alleged (from 24.3%) and an increase in financial or material (from 13.5%).

Age/Gender

Females account for 54.1% of all concerns raised, with 44.2% of these being aged 75+.

Males account for 45.9% of all concerns raised, with 54.6% of these being aged 18 – 64.

Learning Lessons

In the previous 2023-24 annual report, SSAB reported that it had commenced two discretionary Safeguarding Adults Reviews (SARs) (where a case does not fully meet the Care Act criteria but the Safeguarding Adults Board feels there is still sufficient grounds to progress as a SAR as there is significant multi-agency learning that can be taken from the case). These SARs are referred to locally as 'Alex' and 'James', and both concern individuals who were placed in Sunderland residential placements from a neighbouring local authority. Both reviews have involved a number of partner agencies across Sunderland and the Teesside area and were due for publication in Summer 2025.

Key Themes from 'Alex' SAR:

- Transition
- Cross-boundary working
- Deprivation of Liberty Safeguards (DoLS)
- Advocacy
- Multi-agency working
- Communication and information sharing
- Organisational factors
- Covid 19

Key Themes from 'James' SAR:

- Transition
- Communication and information sharing
- Professional curiosity
- Cross-boundary working

The 'Alex' SAR Executive Summary and 'James' SAR Executive Summary are now published on the SSAB website.

In July 2024, the Safeguarding Adults Review (SAR) sub-committee undertook a scoping exercise regarding one case, which did not meet the criteria to undertake a SAR, but did result in an action plan and learning for three of SSAB's partners. This action plan was monitored by the SAR sub-committee and upon its completion was shared with the Quality Assurance sub-committee for further assurance on the learning gained from this case.

July 2024 also saw the publication of the 'Joseph' SAR, which concerned a 20-year-old man who resided in Stockton-upon-Tees, but upon breakdown of his residential placement was moved to a care home in Sunderland. The review covers the period 21st September 2020, the date Joseph moved into the care home in Sunderland, to his death in May 2022 and involved a number of partner agencies who operate in Sunderland as well as involvement from agencies operating in Stockton-on-Tees and Teeswide Safeguarding Adults Board.

The purpose of the review was to identify multi-agency learning, exploring information under the broad themes of mental capacity (including deprivation of liberty safeguards), advocacy, multi-agency working, communication and information sharing, risk assessment and care planning, organisational factors, the impact of the Covid-19 pandemic and cross-boundary working. As part of the review, frontline staff who worked with Joseph participated in a practitioner event which provided valuable insight & supported the SAR process.

Key Outputs:

- **Increased** awareness of Prader-Willi Syndrome, including the production of a 7-minute briefing
- **Assurance** that the learning from the Joseph SAR is incorporated into partners' internal training
- **Strengthened** links with Teeswide SAB
- **Reinforced** safeguarding role and responsibilities across partner agencies
- **Development** of standard model of response, enabling Learning Disability Liaison Nurse to see an in-patient within 24 hours of admission to hospital

- **Implementation** of revised reasonable adjustments assessment documents
- **Assurance** that partners have robust mental capacity assessment policies in place, applied consistently by staff
- **Clarity** of multi-disciplinary team (MDT) responsibility, care quality and leadership

SSAB published a thematic Safeguarding Adult Review regarding Human Stories Featuring Homelessness. SSAB commissioned this discretionary SAR to learn from how agencies worked with four homeless people in Sunderland who sadly died. This themed review is in line with the action recommended in the joint ministerial letter to Safeguarding Adults Boards dated May 2024, that consideration should be given to conducting safeguarding adults reviews where a person experiencing homelessness has died. The review is intended to build on the learning and outcomes of an earlier SSAB SAR, Alan (2021), and to provide an opportunity to review how services work together and with individuals who experience homelessness alongside having physical and/or mental health concerns, and/or care and support needs.

Key Themes:

- Homelessness
- Substance misuse
- Mental health
- Physical health
- Engagement
- Organisational factors

Each of the reviews mentioned above have resulted in detailed multi-agency action plans, which will be monitored by the SAR sub-committee to completion before being shared with the Quality Assurance sub-committee for any further assurance activity.

What Does 2025 - 26 Hold?

SSAB will continue to take forward it's work programme of actions to meet the identified priorities in the SSAB Strategic Delivery Plan 2024-29. Particularly important to this work will be:

- The changing demographics of Sunderland, which will continue to be monitored to keep track of any trends which might be relevant for safeguarding adults
- The themes and learning from national work such as SARs from other areas, the work of the National SAB Chairs Network and National SAB Managers Network and any relevant research such as the 2nd National SARs Analysis, which continues to provide valuable insights that can be used to inform local work
- Sharing the learning from recent local SARs: Alex, James and the Human Stories Featuring Homelessness Themed SAR.
- Reviewing progress made in the first year of the refreshed Strategic Delivery Plan to ensure the originally set priorities are being addressed and objectives and actions continue to be relevant and achievable.

Glossary

Abuse

Abuse is a violation of a person's human and civil rights by any other person or persons and is a crime.

Adult at Risk

Who is an "Adult at risk"? All adults who are over 18 years of age who have care and support needs, and who are experiencing, or are at risk of, abuse or neglect, and are unable to protect themselves.

An adult with care and support needs may be:

- An older person,
- A person with a physical or learning disability or a sensory impairment,
- Someone with mental health needs, including dementia or a personality disorder,
- A person with a long-term health condition,
- Someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living,
- A carer, providing unpaid care to a family member or friend.
- Adult safeguarding applies whatever setting people live in, and regardless of whether they have mental capacity to make specific decisions at specific times.
- An adult at risk could also include someone who does not receive community care services but because they have been abused or are at risk of being abused, they could become vulnerable. The adult may not be able to protect themselves against harm or abuse.

Care Act (2014)

The Care Act 2014 sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.

Care Quality Commission (CQC)

CQC is the independent regulator of health and adult social care in England.

Channel Panel

Channel is an early intervention multi agency panel designed to safeguard vulnerable individuals from being drawn into extremist or terrorist behaviour.

Child Safeguarding Practice Reviews (CSPRs)

CSPRs are systematic evaluations aimed at improving child welfare practices by learning from serious safeguarding incidents. The primary goal is to learn lessons from serious child safeguarding cases to enhance the effectiveness of safeguarding practices.

Complex Adults Risk Management (CARM)

CARM is a multi-agency approach to manage risks that may arise for adults who can make decisions for themselves, but who are at risk of serious harm or death from:

- Self-Neglect
- Risk taking behaviour, chaotic lifestyles or
- Refusal of services.

CONTEST Board

CONTEST is the UK's strategy for countering terrorism. The OCNTEST Board is a senior officials board that monitors the implementation of CONTEST and ensures that collective decision-making and effective co-ordination is maintained.

Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards (DoLS) apply to people who have a mental disorder or mental impairments and who do not have the mental capacity to decide whether or not they should be accommodated in the relevant care home or hospital to be given care or treatment. This can also apply to those living in Independent Supported Living, Shared Lives scheme or in their own homes (authorised by the Court of Protection).

Domestic Abuse Related Death Reviews (DARDRs)

A DARDR is a multi-agency review which seeks to identify and implement lessons learnt from deaths which have, or appear to have, resulted from domestic abuse, including suicide cases, in line with the legal definition of domestic abuse as introduced in the Domestic Abuse Act 2021. As well as physical domestic abuse, this includes controlling or coercive behaviour and emotional and economic abuse.

Executive Dysfunction

Executive dysfunction is a cognitive condition that affects a person's ability to manage thoughts, emotions, and behaviours, often leading to difficulties in planning, organising, and completing tasks.

Hoarding

Hoarding is considered a standalone mental disorder, it is not simply a lifestyle choice. Hoarding can can be a symptom of other mental disorders and is distinct

from the act of collecting. It is also different from people whose property is generally cluttered or messy, the main difference being that hoarders have a strong emotional attachment to their objects, which is well in excess of their real value. There are three types of hoarding: inanimate objects, animal hoarding, data hoarding.

Making Safeguarding Personal

Making safeguarding personal means that safeguarding should be person-led and outcome-focused, engaging people in determining how best to respond to their safeguarding situation. Workers involved with an adult at risk should engage them in a conversation about how best to respond to their safeguarding situation, in a way that enhances their involvement, choice and control seeking to improve their quality of life, wellbeing and safety.

Professional Curiosity

Professional curiosity is the capacity and communication skill to explore and understand what is happening with an individual and/or within a family. It is about:

- enquiring deeper and using proactive questioning and appropriate challenge
- understanding one's own responsibility and knowing when to act, rather than making assumptions or taking things at 'face value'
- thinking 'outside the box', beyond a practitioners' usual professional role, considering all of the family's circumstances holistically – "Think Family".
- Being curious, engaging with individuals and families through visits, conversations, asking relevant questions – gathering historical and current information.

Multi-Agency Public Protection Arrangements (MAPPA) (also known as MOSOVO)

MAPPA provides a national framework in England & Wales for the assessment and management of risks posed by serious and violent offenders and other individuals who are considered to pose a risk or potential harm to children. The arrangements are made in accordance with statutory requirements on the police and probation services to make these arrangements and the statutory requirements imposed on other agencies to cooperate.

Multi-Agency Risk Assessment Conference (MARAC)

This forum is to assess and manage the risk of adult perpetrators of domestic abuse.

Multi-Agency Tasking & Coordination (MATAC)

MATAC is a collaborative process where police & partner organisations work together to tackle domestic abuse by identifying an engaging with serial

perpetrators. The core objective of MATAC is to ensure that agencies coordinate their efforts to protect vulnerable victims and take enforcement actions against offenders.

Mental Capacity Act (MCA)

The MCA (2005) applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- By empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
- By allowing people to plan ahead for a time in the future when they might lack the capacity.

Mental Capacity

Mental capacity refers to an individual's ability to make decisions at a specific time. It involves the ability to understand, retain, and weigh up relevant information to make an informed choice, as well as the ability to communicate that choice. Essentially, mental capacity is about being able to make decisions for oneself.

PREVENT Programme

The core mission of Prevent is stopping people from becoming terrorists or supporting terrorism. The early intervention support provided by Prevent addresses the personal, ideological, and social factors which make people more susceptible to radicalisation.

Right Care, Right Person

Right Care, Right Person (RCRP) is a partnership approach which aims to ensure that individuals in mental health crisis are seen by the right professional, to improve outcomes and the experience for people who need mental health support. It also applies to calls to Police regarding concerns about welfare.

Safeguarding

Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop the experience of abuse or neglect.

Safeguarding Adult Review (SAR)

SARs are systematic evaluations aimed at improving adult safeguarding practices by learning from serious safeguarding incidents. The primary goal is to learn lessons from serious adult safeguarding cases to enhance the effectiveness of safeguarding

practices. They are mandatory in the Care Act (2014) where an adult has been harmed or died, or suspected to have been harmed or died as a result of neglect or abuse.

Section 42 Safeguarding Adult Enquiry

Section 42 of the Care Act 2014 mandates local authorities to conduct safeguarding inquiries when there is reasonable cause to suspect that an adult is at risk of abuse or neglect.

Self-Neglect

Self-neglect is the inability or unwillingness to care for one's essential needs, leading to serious consequences for health and well-being. The Care Act describes self-neglect as covering “a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings, and includes behaviour such as hoarding”.

Slido

Slido is an interactive engagement platform primarily focused on enhancing audience participation in meetings, events, and conferences. It is used to do live polls & surveys.

Statutory

Decided or controlled by law (statute).

Transitional Safeguarding

Transitional safeguarding aims to bridge the gap between child and adult safeguarding services. When young people move from being minors to adults, their needs and the risks they face change. Transitional safeguarding seeks to ensure their safety during this important period.

Trauma Informed Practice

Trauma-informed practice is an approach that recognises the widespread impact of trauma and integrates this understanding into all aspects of service delivery, aiming to avoid re-traumatisation and promote healing.