



Sunderland Safeguarding Adults Board

Annual Report 2025–26

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Foreword

I am pleased to present the Sunderland Safeguarding Adults Board (SSAB) Annual Report for 2025–26. 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.

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.

Vanessa Bainbridge
SSAB Independent Chair



Executive summary

2025–26 at a glance:

During 2025–26, Sunderland Safeguarding Adults Board (SSAB) continued to drive partnership work to help ensure adults in Sunderland can live safely, free from abuse and neglect. This year we have:

- Supported 5,318 adults through safeguarding concerns, representing a 2.5% increase on the previous year
- Completed 809 section 42 safeguarding enquiries, ensuring concerns were investigated and risks addressed
- Achieved positive outcomes for people, with 96.6% of desired safeguarding outcomes fully or partially met
- Ensured 100% support for adults lacking mental capacity throughout the safeguarding process
- Delivered training to 773 professionals, strengthening knowledge, confidence and safeguarding adults practice across Sunderland. The training includes learning from Safeguarding Adult Reviews (SARs)
- Continued to provide e-learning courses that are free to both professionals and public, on a range of safeguarding topics
- Considered 11 SAR referrals, with three meeting the statutory criteria for a SAR
- Conducted and published three SARs, maintaining multi-agency involvement throughout the process of each, and shared learning from these reviews
- Produced four new seven minute briefings to increase learning and improve practice
- Engaged a wide range of practitioners during Safeguarding Learning Week 2025 through workshops, webinars and learning events
- Shared safeguarding adults messages in a range of ways across the SSAB website, emails, newsletters and briefings
- Held six Board meetings and held quarterly Sub Committee meetings for each of the three Sub Committees, with good multi-agency attendance and engagement
- Collaborated with the Sunderland Safeguarding Children Partnership (SSCP) to undertake cross-cutting safeguarding work around Transitional Safeguarding (when vulnerable children transition to adulthood). This included follow-up from a workshop held in February 2025 to gain assurance from Children's Services and Adults Services that progress was being made on areas for improvement via identified actions
- Reviewed and amended the Complex Adults Risk Management (CARM) documentation to take account of the CARM internal and external review findings, improving the clarity of the process for partner agencies who refer in to it
- Reviewed the priorities for SSAB and refreshed the SSAB Strategic Delivery Plan 2026–29 to reflect these

What we have achieved:

Working together, partners have:

- Strengthened focus on prevention, ensuring safeguarding messages reach professionals and communities before harm occurs
- Enhanced multi-agency learning and training to improve professional confidence and practice
- Published and implemented learning from local Safeguarding Adults Reviews, particularly around homelessness, self-neglect, mental capacity and transitional safeguarding
- Improved our use of data, intelligence and audit and assurance activity to identify emerging risks and trends, monitor outcomes and target improvement activity,
- Continued to develop approaches that place people's views, wishes and outcomes at the centre of safeguarding practice through Making Safeguarding Personal
- Maintained strong oversight of key local priorities, including homelessness, self-neglect, mental capacity, exploitation, domestic abuse and the safeguarding needs of younger adults

Looking ahead

While there is much to celebrate, we recognise there is still more to do.

Demand for safeguarding support remains high and the complexity of need continues to grow. We must continue to strengthen our understanding of emerging risks, improve opportunities for people with lived experience to influence our work, and ensure learning from reviews translates into sustained improvements in practice.

Through our new Strategic Delivery Plan 2026–2029, SSAB remains committed to:

- Prevention and early intervention
- Listening to and learning from people's experiences
- Improving communication and engagement
- Developing a skilled and confident workforce
- Using intelligence and evidence to drive improvement
- Working together to achieve better outcomes for adults at risk of abuse and neglect

SSAB will also continue to fulfil its statutory duties, producing an Annual Report and Strategic Delivery Plan, and scoping and conducting Safeguarding Adult Reviews to maximise learning and improvement.

Together, SSAB's ambition remains clear: to ensure that people in Sunderland are able to live safely, free from neglect and abuse.

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 and Sunderland NHS Foundation Trust
- Cumbria, Northumberland, Tyne and 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 and its sub-committees, working together with common objectives and commitments.



Strategic Delivery Plan

Following a review exercise undertaken in 2025, SSAB's Strategic Delivery Plan details key focus areas for the period of 2026–2029 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 are revisited every year, reviewed and amended if required to meet the changing local, regional and national safeguarding picture.

SSAB's strategic priorities for 2026–2029:

- Prevention
- User engagement
- Communication
- Multi-agency training
- Data and Intelligence

Local areas of focus:

- Homelessness (including asylum seekers/refugees/immigrants) - monitor and gain assurance on this work
- Self-neglect - monitor the data and ensure strategies to tackle this are aligned across partner agencies
- Mental capacity - continue to promote training, policies, guidance and briefings to frontline staff
- Responding to organisational changes (understanding impacts on SSAB)
- Focus on safeguarding and presentation of younger adults (up to 25 years) (linked to care experienced cases)
- Substance use (alcohol and drugs) - SSAB adding value to the work of Public Health and others
- Domestic Abuse/Violence Against Women and Girls (DA/VAWG) Strategy principle and priorities - SSAB adding value to the work of Public Health and others
- Independent providers' market - continue to monitor outcomes and seek assurance on the support which is provided to the market
- Changing demographics in Sunderland - respond appropriately and ensure the safeguarding policies and processes are accessible for everyone

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 Review, and Quality Assurance sub-committees.



Progress and achievements

Prevention

SSAB has a focus on prevention, and this is embedded throughout all SSAB activity. Prevention also has the principles of making safeguarding personal and professional curiosity at its core. Actions linked to prevention are woven through all areas of SSAB's work programme. Prevention-linked activities that SSAB has undertaken in 2025-26 include:

- Sharing of safeguarding adults messages in a range of ways, including SSAB website, SSAB newsletter, SSAB seven-minute briefings on a range of topics linked to prevention, information screens in public-facing reception areas, emails to partner agencies and social media
- A range of learning events during Safeguarding Learning Week (November 2025)
- Continuing to share and promote SSAB's professional curiosity guidance
- Promotion of resources and learning on the topics of closed cultures and organisational abuse

We have:

- SSAB has strengthened its focus on prevention by embedding safeguarding messages, professional curiosity and making safeguarding personal throughout all Board activity
- SSAB has increased awareness through Safeguarding Learning Week, targeted communications, guidance and learning resources on issues such as self-neglect, closed cultures and organisational abuse

We will:

- SSAB will continue to promote early intervention and prevention across all partner agencies
- SSAB will use learning from Safeguarding Adult Reviews, data analysis and engagement activities to identify emerging risks sooner and reduce the likelihood of abuse and neglect occurring

User engagement

As standard practice SSAB conducts annual engagement with a sample of people who have experienced the safeguarding adults enquiry process (or their representative, where they lack mental capacity to engage). This work is carried out on SSAB's behalf via Healthwatch using a survey to ask people a range of questions, such as; what their experience was, whether they felt listened to, and whether the people they wanted to be involved in the process had been. They are also asked whether they felt the process had a positive outcome or not, and any suggestions to improve the process.

The results of these surveys have served both as an assurance for SSAB that the safeguarding adults process is working well in the majority of cases and allows improvements to be identified and made where needed. Due to the Government's national changes to Healthwatch's role and remit, the service user survey was not conducted in 2025-26. In light of this, SSAB is actively exploring how user experience can continue to be captured.

SSAB has also previously 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 and Engagement Strategy and associated action plan. Other options to run this survey are being explored, such as the Local Authority's digital survey platform for Sunderland citizens, 'Your Sunderland'.

Examples of SSAB's partner agencies undertaking user engagement include:

- NENC ICB carried out scoping around groups within the ICB involved in lived experience feedback. They also have an Involvement Lead who facilitates and supports lived experience work
- As well as having a Making it Real Advisory Forum, which involves people who live in their supported accommodation, Sunderland Care and Support (SCAS) also have Lived Experience Training Partners. As part of Safeguarding Learning Week 2025, SCAS also delivered a session which was presented in part by people with lived experience
- Sunderland City Council's Adult Social Care engages with people with lived experience when reviewing existing services or planning new services, e.g. a wheelchair users' group

Introduced a year ago, SSAB's animated posters (one for public and one for professionals) continue to play 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 continue to 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.

We have:

- SSAB has continued to value the voice of people with lived experience and sought assurance that safeguarding outcomes are person-centred and outcome-focused
- SSAB has committed to exploring alternative methods of gathering feedback during a period of national change affecting Healthwatch services

We will:

- SSAB will develop new mechanisms to capture the experiences of adults who use safeguarding services
- SSAB will strengthen opportunities for lived experience to influence Board priorities, service development and safeguarding practice

Communication

- In November 2025, SSAB, in collaboration with Sunderland Safeguarding Children Partnership, again held a successful local campaign: Safeguarding Learning Week, in line with National Safeguarding Adults Week 2025, with the focus on Prevention: Acting Against Abuse. The week featured a range of face-to-face and online events (webinars, briefings, training) covering a range of safeguarding topics, including: learning from several Safeguarding Adults Reviews (SAR James, SAR Alex, and a thematic SAR 'Human Stories featuring Homelessness', which covered four similar cases; Alcohol, Illegal Substances and Fire Risk; Prevention in Practice: Acting Against Abuse; Prevent and Channel (anti-radicalisation) learning session. As in previous years, sessions were very well received, and

feedback is being used to inform the planning of next year's event taking place in 2026. The Safeguarding Adults Board also held its Board meeting during the week and this was themed around Homelessness and Rough Sleeping, linking to the themed SAR

- SSAB continued to produce a newsletter, giving a summary of key safeguarding messages and resources. This is shared with SSAB partners and other interested parties via email and also published on the SSAB website
- SSAB periodically produces seven minute briefings on a range of safeguarding topics and also as a way of sharing key messages from Safeguarding Adult Reviews. In 2025–26, seven minute briefings were produced on: Transitional Safeguarding; learning from the 'James' SAR, the 'Alex' SAR, and the 'Human Stories featuring Homelessness' Themed SAR. Existing seven minute briefings were also reviewed and information links etc were updated where required

We have:

- SSAB has expanded opportunities for learning and awareness through Safeguarding Learning Week, newsletters, briefings and partnership communications
- SSAB has ensured learning from local Safeguarding Adults Reviews is shared widely across the workforce

We will:

- SSAB will continue to strengthen our communication channels to ensure safeguarding messages reach professionals, providers and communities
- SSAB will increase the accessibility of safeguarding information for Sunderland's changing and diverse population

Multi-agency training

SSAB's Multi-Agency Training Offer comprises both trainer-led training and e-learning courses. The trainer-led training continues to have five 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 and Hoarding

The final two courses were implemented as a result of learning and 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 continues to be free or heavily subsidised, depending on the sector of work staff come from.

Training content is regularly reviewed and refreshed considering 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 wishes to access them.

Both the sector participation figures and learner outcomes continue to be monitored for the trainer-led training with feedback collected, which is communicated to the trainers enabling them to note what works well or what can be improved or adjusted. Over the last year, this data has been enhanced with the use of a new learning management system, enabling greater analysis and more targeted response actions where more course promotion or content changes are needed. Sector participation figures continue to be collected for the e-learning. This data is used to promote the training to different sectors as and when required.

We have:

- SSAB has delivered a comprehensive multi-agency training programme which has improved professional knowledge, confidence and safeguarding practice across Sunderland
- SSAB has enhanced the learning management system to better understand the impact of training and target development activity where required

We will:

- SSAB will continue to adapt training to reflect emerging themes, legislation and learning from reviews
- SSAB will use training intelligence to ensure the workforce remains equipped to respond to increasingly complex safeguarding needs

Data and intelligence

Data and intelligence gathering forms a key part of SSAB's monitoring and assurance processes. It 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) continues to be produced on a quarterly basis and analysed by SSAB's Quality Assurance Sub Committee. A summary is then provided to SSAB's Board meetings. This data provides assurance to SSAB. It also allows for trends to be monitored so that outlying data can be analysed, and any appropriate actions identified as required. These could include themed audits, in-depth assurance exercises on specific topics, revision of procedures, training updates or information resource materials being produced, specific actions being identified and taken by SSAB partners to address the issue
- SSAB's partner agencies continue to 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, highlight potential new areas of good practice to be shared, or identify issues to be investigated in more detail
- Participants in SSAB's training offer courses continue to be routinely asked to provide feedback on how the training has enhanced their knowledge, skills and how they have applied it in the practice; this is requested before they can receive their course certificates

We have:

- SSAB has strengthened assurance through the use of safeguarding performance dashboards, partner intelligence, audits and thematic reviews
- SSAB has used evidence and data to identify trends, monitor outcomes and target improvement activity

We will:

- SSAB will further develop our use of demographic and safeguarding intelligence to better understand risk and inequality
- SSAB will continue to use evidence to drive improvement and provide assurance regarding safeguarding effectiveness across the partnership

Local areas of focus

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 use is also a factor and the challenges of engaging with those who experience homelessness. As a result of the review recommendations, an action plan has been implemented with outputs reported to the SAR subcommittee, on behalf of SSAB
- Homelessness updates and data continue to be routinely shared with SSAB, and a task and finish group has been established with SSAB membership to support the development of the homelessness service, which includes the implementation of a service development strategy - linking directly to the Supported Housing Strategy

We have:

- SSAB has published a thematic Safeguarding Adults Review on homelessness and established governance arrangements to oversee improvements
- SSAB has worked with partners to strengthen strategic oversight of homelessness and rough sleeping

We will:

- SSAB will continue to monitor implementation of recommendations and seek assurance that services effectively respond to adults experiencing homelessness
- SSAB will maintain homelessness as a priority area where safeguarding risks are significant and often complex

Self-neglect

- Self-neglect continues to be a strong theme in SSAB communications with partner agencies. A suite of regional resources, into which SSAB inputted, plus SSAB's local self-neglect guidance, 'Self-Neglect on a Page' overview sheet and a seven minute briefing are regularly promoted across the partnership
- SSAB continues to provide self-neglect training (which also includes reference to hoarding) as part of its multi-agency safeguarding training offer
- SSAB partners continue to raise awareness on the topic of self-neglect, with work including the updating of adult at risk policies to include this theme, promotion of learning materials on internal websites, and reviewing training

We have:

- SSAB has maintained a strong focus on self-neglect through guidance, communications, training and partnership learning
- SSAB has promoted consistent approaches through local and regional resources

We will:

- SSAB will continue to monitor self-neglect trends and support agencies to intervene earlier and more effectively
- SSAB will promote person-centred approaches that balance risk, autonomy and wellbeing

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, continues to receive regular updates and assurance from partners regarding awareness raising activities in relation to mental capacity and executive function, such as: thematic focus of adult safeguarding supervision, podcasts, monitoring training compliance, and the development of internal subgroups to consider 'all things MCA'
- SSAB, via the Quality Assurance Sub Committee, undertook a mental capacity themed case file audit in 2025 which looked at how mental capacity was taken account of in both the safeguarding referral information and during the safeguarding process. Recommendations for action were identified as part of this audit, and this is being progressed and monitored through the Quality Assurance Sub Committee. Recommendations included improvements to the safeguarding adults documentation/process, and recommendation to undertake further assurance exercises with partner agencies re: their mental capacity training for staff, and staff practice in relation to mental capacity

We have:

- SSAB has increased awareness of the Mental Capacity Act through training, audits and assurance activity
- SSAB has identified and begun addressing areas for improvement in safeguarding practice and documentation

We will:

- SSAB will continue to strengthen understanding of mental capacity, executive functioning and decision-making across the partnership
- SSAB will seek assurance that learning from audits leads to measurable improvements in practice

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 and non-statutory partners was considered 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 its key statutory partners continues to be pivotal to the successful safeguarding of adults at risk of abuse and neglect in Sunderland
- SSAB continues to receive regular updates and assurance from the Probation Service on the impacts of the further reforms to prison sentencing and duration which SSAB has also received have continued into the 2025–26 year
- After identifying the value of this information in the previous year, SSAB continues to receive regular updates and assurance from Northumbria Police regarding the embedding of the Right Care, Right Person approach. SSAB also received updates on the lead up to the planned implementation of the police's new data information system which went live in February 2026. Better quality data is expected to result from this new system, allowing more useful and targeted sharing with SSAB re: safeguarding adults (and other partnerships re: a range of key topics)

SSAB has received updates throughout 2025–26 from the NENC ICB regarding the planned ICB governance and personnel changes occurring locally as a result of the national legislation affecting all ICBs. Whilst the changes were implemented just after the end of the 2025–26 year, SSAB was kept aware of the ICB's plans and could undertake robust input from a wider-system perspective into what the impact might be for adults who need to be safeguarded. SSAB's 2026–27 Annual Report will reflect on the impact of these changes on local safeguarding adults activity.

We have:

- SSAB has maintained oversight of significant organisational and system changes affecting safeguarding adults and sought assurance from partner agencies regarding their impact on services and outcomes
- SSAB has provided constructive challenge and support to partners during periods of transformation, ensuring safeguarding remains a priority across the partnership

We will:

- SSAB will continue to monitor the impact of organisational change and reform on safeguarding arrangements, workforce capacity and service delivery
- SSAB will work with partners to identify emerging risks and opportunities, ensuring safeguarding remains effective, resilient and person-centred

Focus on safeguarding and presentation of younger adults

Following a successful collaboration with Sunderland Safeguarding Children Partnership (SSCP) in February 2025 to deliver a multi-agency Transitions Workshop, SSAB and SSCP came together again to plan the hosting of a further transitional safeguarding event in May 2026. The event, led by Dez Holmes (Director of Research in Practice) has a focus on transitions from childhood to adulthood, with particular consideration given to young people who are approaching 18 years old.

The event invited representatives from a range of children's and adults' organisations to consider how Sunderland can continue to strengthen its "whole-place, whole-person" approach.

We have:

- Brought together adult and children's safeguarding partners to strengthen transitional safeguarding and improve support for young people approaching adulthood

We will:

- Continue to build joined-up approaches that recognise the changing needs of young adults and promote seamless support across services

Substance use

Public Health representatives continue to sit on SSAB and its sub-committees, providing a valued input from their perspective and a link to the work being done on substance use in Sunderland. This includes updates to meetings and highlighting ongoing ways in which SSAB partners can get involved in this work.

Domestic abuse/violence against women and girls (DA/VAWG)

Public Health representatives also link into SSAB about this topic, and over the last year, SSAB has maintained a commitment to adding value to their work through the involvement of partner agencies in the Domestic Abuse Board and its operational group, and through work updates to SSAB and its sub committees where appropriate.

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) and other relevant reports continued to be received by SSAB as appropriate, when issues arose in this area. The SSAB performance data also continues to routinely include 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.

Changing demographics in Sunderland

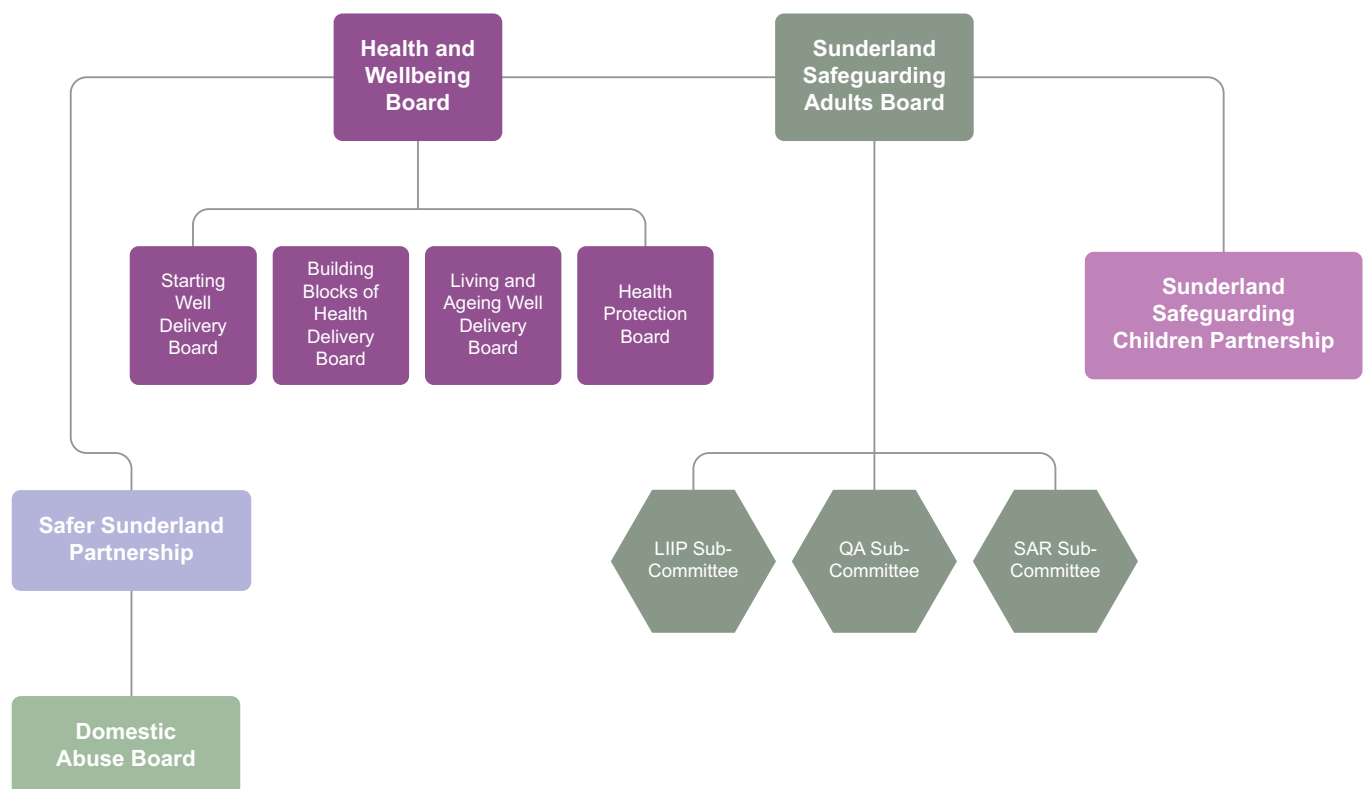
On behalf of SSAB, the Quality Assurance Sub-committee has continued to use local data from safeguarding adult concerns cases and Safeguarding Adults Reviews (SARs) as well as local demographics data to monitor trends related to Equality Act protected characteristics and Equality, Diversity and Inclusion (EDI) themes.



The work of SSAB and its sub-committees

Governance

The streamlined governance structure put in place in 2024–25 following a review has seen the Board meeting successfully continue in 2025–26 to take place six times a year, and the three sub-committees quarterly, each with good representation from a range of partner agencies. This arrangement allows for robust discussions across a range of safeguarding adults topics without overburdening partner agencies with excessive meetings at a time when the whole health, care and emergency services system is undergoing a number of challenges such as financial constraints and staff capacity considerations. Where agencies have sometimes not engaged as much as was needed throughout the year, SSAB has been able to challenge this in a constructive way to encourage and support participation.



Quality assurance

- Received quarterly safeguarding adults performance data dashboards and also partner agencies' quarterly data summaries showing their themes/trends in safeguarding adults. Since this was introduced a couple of years ago, the value of the continued discussion of these at each meeting is clear as it allows themes to be correlated across agencies and with the quarterly performance dashboard, which can confirm and assure, or support decisions about where to concentrate efforts on emerging issues
- Continued to receive quarterly training attendance data and delegates' feedback reports. This is now supplied via SSAB's new learning management system which gathers additional feedback and data about multi-agency staff's experiences of the training, providing extra detailed assurance on the continued value of SSAB's training offer to them. It also allows

targeted promotion of the training to particular sectors where required, and for the trainer-led training delivery to be changed in response to feedback from delegates if needed

- Received a number of themed data reports looking at trends identified from previous safeguarding adults data, e.g. Safeguarding Adult Concerns Thresholds audit; Duplicate Contacts and Concerns - Themes/Trends; Increase in Safeguarding Concerns - Care Homes
- Received themed case file audit reports, looking at themes identified from Safeguarding Adults Reviews and quarterly safeguarding adults data reports, e.g. Mental Capacity; Transitional Safeguarding
- Conducted some assurance exercises and received the results for discussion and agreement of either assurance or further actions, e.g. How Agencies respond to Low Level Safeguarding Adult Concerns; How Agencies share Safeguarding Adult Messages
- Received an assurance report from STSFT about their action taken on Adult Needs Assessment Referrals
- Introduced a new comprehensive Audits and Assurance Exercise Monitor to enable more robust monitoring of all the case file audit, performance data audit and assurance exercise activity that the sub-committee undertakes
- Reviewed and refreshed the SSAB Comms and Engagement Strategy, Plan and agreed the targeted activity for 2025–26
- Reviewed the sub-committee's actions against the SSAB Strategic Delivery Plan, to ensure they continue to be aligned with SSAB's objectives and priorities
- Reviewed and refreshed the Quality Assurance audit cycle, identifying the priority areas for audit in 2025–26, including consideration of completed SAR action plans for any relevant audit and assurance activity, after they were passed over from the LIIP Sub Committee
- Supported Safeguarding Learning Week 2025
- Agreed new topics for development of further SSAB seven minute briefings on a range of safeguarding adults topics, some of which were published during the year
- As in previous years, continued to receive regular updates on SARs activity, to enable identification of audit/assurance themes that may need to be taken forward

Safeguarding adults reviews

- Scoped three potential SAR case against Care Act criteria. All three cases were found to meet the Care Act 2014 criteria for a mandatory SAR. One of those SARs is due to be published in autumn 2026.
- In addition to the SARs mentioned above, the SAR subcommittee has supported the review process for the following SARs:
 - Thematic Review: Human Stories Featuring Homelessness - published April 2025
 - Alex - published July 2025
 - James - published August 2025
- Progressed learning and actions resulting from the Joseph, Alex, James, and Thematic Homelessness SARs respectively.
- Supported Safeguarding Learning Week 2025

Learning and improvement in practice

- Considered learning from local and national SARs
- Supported Safeguarding Learning Week 2025
- Received training and development updates from SSAB partners
- Reviewed and updated the SSAB Professional Curiosity Guidance
- Reviewed and updated the SSAB Training Strategy
- Received updates on Mental Health Act 2025 changes
- Identified opportunities to enhance learning from Regulation 28 (Prevention of Future Death) reports
- Reviewed and updated subcommittee Terms of Reference and membership
- Reviewed SSAB Learning and Improvement in Practice Framework

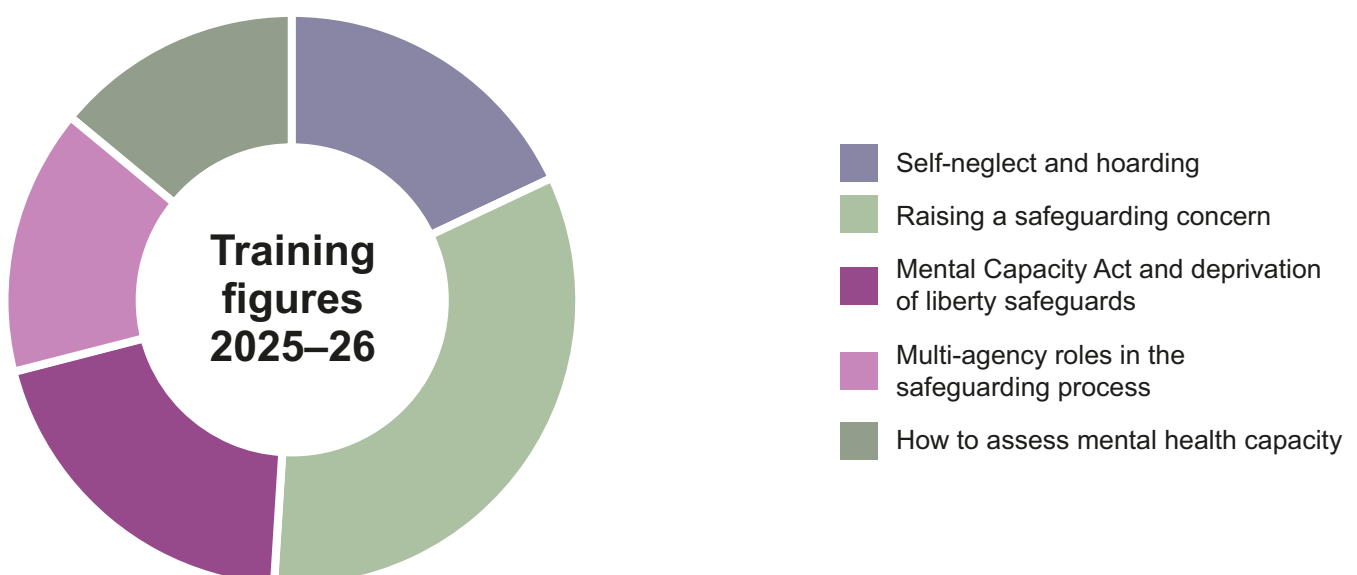
Training

SSAB provides multi-agency safeguarding adults training in trainer-led and e-learning formats. Trainer-led training is currently offered in a virtual format.

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 2025–26, 773 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



1 - SSAB safeguarding adults multi-agency training figures

Analysis of training data gathered over the period of 2025–26 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.

Feedback from participants included:

“As I have very little knowledge of safeguarding adults, I feel the session has deepened my understanding and has given me confidence to use this whilst in practice”

“The facilitator was very knowledgeable. He gave multiple examples of concepts and gave time for people in the session to share thoughts/experiences”

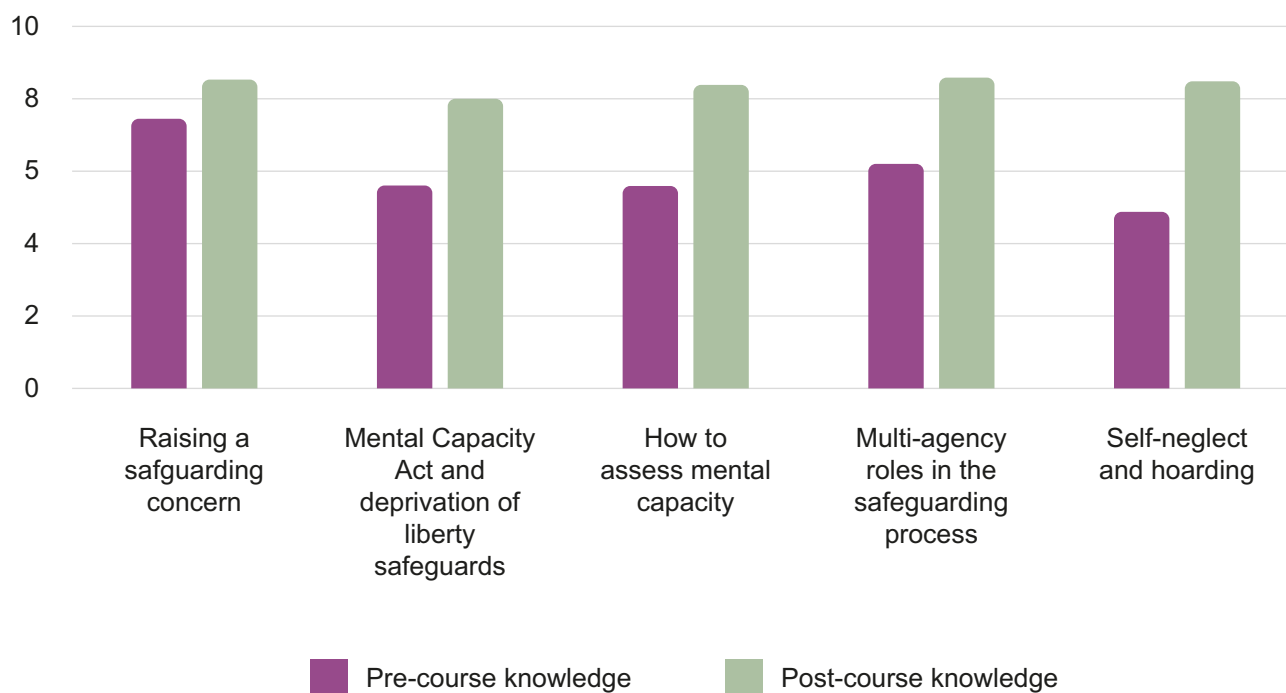
“The session was well organised and easy to follow. Information was clearly explained, and examples helped to link safeguarding principles to practice”

“Gave me a better understanding of how the MCA and DoLS will impact upon my current role”

“It flowed well and allowed for input from all those taking part. It was interesting to hear from others working in different organisations”

“The session was clear and easy to follow, with helpful real-life examples of self-neglect and hoarding. The focus on person-centred care and group discussion made it more practical and built confidence”

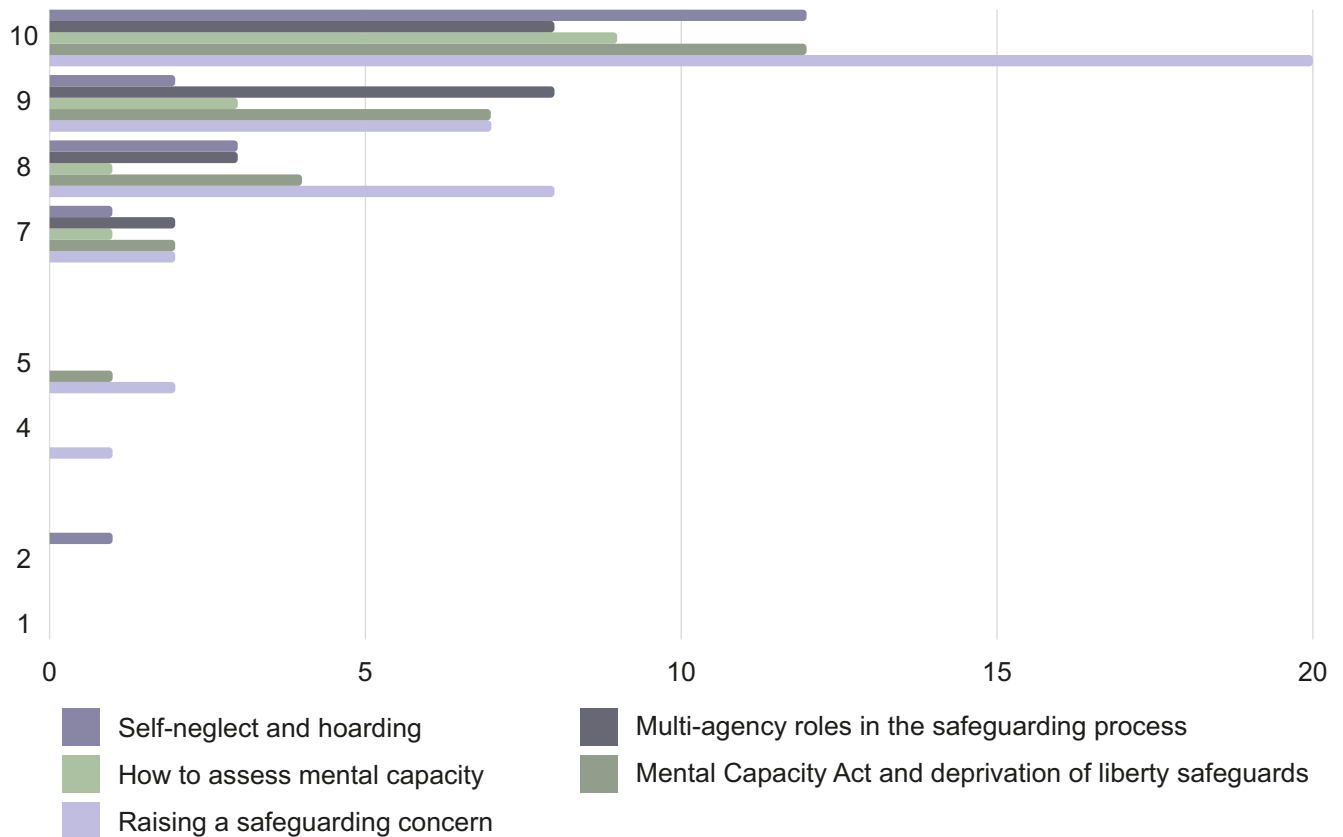
Pre versus post course knowledge and understanding scores



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

Session quality ratings

Average session quality



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



Statutory partners' contribution to safeguarding

Looking back over 2025–26: Key Achievements, Good Practice and Making Safeguarding Personal - SSAB Partners Working Together

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.

There have been some difficulties in 2025–26 due to several partners experiencing challenges in relation to resources, staffing and legislative or regulatory changes; however, SSAB has been able to address these with proactive discussions and different solutions that have still enabled the Board's work to be taken forward.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

STSFT highlights - key achievements:

- STSFT safeguarding services 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. 25/26 continued to focus upon embedding the learning from local and regional SAR's, DARDR's and DHR's and so key themes were re-visited, for example professional curiosity, trauma informed practice, MSP, self-neglect, mental capacity and executive function. The team continue to share key messages through the safeguarding link forums, safeguarding newsletter, seven minute briefings, attendance at governance meetings, face to face at conference stalls, and via delivery of a "Learning from CSPR's, SAR's, DHR's and DARDR's" session at the patient safety and safeguarding conference
- The safeguarding team continue to deliver safeguarding adult and children supervision, adopting a "Think family" approach. To improve compliance and further upskill the workforce to support supervision, further CPD funding was secured in 2025 to facilitate externally sourced supervision skills training for Trust nurses, midwives and Allied Health Professionals, for trained staff to become supervisors in their own clinical area, supporting real time supervision. These supervisors are buddied with a member of the Trust safeguarding team. Positive feedback has been received post training delivery, including "Discovered lots of information regarding models and learning styles to enable me to deliver safeguarding supervision in the future"
- 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 25/26, STSFT staff submitted 1,948 safeguarding referrals, an increase of 8% from previous year reporting. The adult safeguarding team also received 2,269 internal telephone calls to their SPOC, an increase of 3%
- The safeguarding Intranet page and external site has been updated to ensure staff are provided with up to date and relevant information and support 24/7
- 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, DHR's and DARDR's. Safeguarding Adults Level 1 and Level 2 continue to be delivered by the National e-Learning package. 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. STSFT staff remain compliant in all four levels of safeguarding adults training. Slido continues to be used to ensure sessions remain interactive. Slido also enables evaluations of sessions in "real time" and measures impact by capturing how staff are going to embed training into their practice. Feedback includes:

- "I feel more confident in recognising signs of abuse and being able to do the right thing if I am concerned about a patient I am seeing"
- "I feel more confident in when a safeguarding referral is appropriate"
- MCA level 1 and Induction packages are well embedded with good achievement rates. A new mandatory training MCA refresher module created for all staff who have completed the HEE e-LfH Mental Capacity Act (MCA) e-learning programme has been updated and so far, it has been well received by staff, supporting them further at improving skill levels, building on the baseline set in the HEE modules with a level two training package created to improve knowledge and application of DoLS legislation
- CPD packages are available to support STSFT staff 24 hours per day via the STSFT dedicated Intranet Repository. These packages include themed PowerPoints and podcasts with commentary. Packages created are based on areas of complexity identified via internal complex cases or external recommendations from SARs, CSPR's, DHR's and DARDR's. Additional 25/26 topics include:
 - A video commissioned through CPD funding by the theatre company 'Twisting Ducks' covering MCA and Learning Disabilities [link here](#)
 - An update to the Executive Dysfunction and Prader Willi and Mental Capacity identified via local SARs
 - Assessing Capacity and Executive Dysfunction
 - Diabetes and Mental Capacity
 - MCA and how it applies in Maternity Settings
 - Surgery and Mental Capacity Assessment
 - Adult AX C-Section Case: Mental Capacity Assessment in Maternity
 - Parkinson's Disease and Mental Capacity Assessment
 - Intensive Care and Mental Capacity Assessment/Deprivation of Liberty
 - Dental Care and Mental Capacity Assessment
- The DoLS Team continue to monitor MCA and DoLS 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 continue to provide visibility and support on wards and via bespoke training sessions to further support compliance with the legal process. Training presentations are available to staff to support them on how to complete the forms on the electronic patient record system
- The Mental Capacity Good Practice Forum continues with extended membership. 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

forums and continues to take a key role in the established national support group for health sector MCA leads, enabling sharing of good practice and training materials, as well as peer supervision and support from across the country

- 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
- The team continue to see audit work as essential in monitoring and improving performance. Internally, audits have been completed pertaining to the quality of mental capacity assessments, and best interest decision making on our electronic patient record system. Audit results led to further improvements being made to MCA assessment forms to capture richer detail and improved quality. The STSFT Executive MCA Lead continues to audit cases where patients are admitted, and clinical assessment indicates there is ‘no reason to doubt mental capacity’ to ensure any missed opportunities are minimised. The STSFT MCA/DoLS Lead has also supported partner agencies by participating in a multi- agency audit reviewing mental capacity assessment
- Work continues to support MCA compliance in Paediatric services working with young people aged 16 and 17 years old. This includes completion of a further audit in 2025 which resulted in improvements to electronic patient record system to prompt paediatric staff to assess mental capacity
- 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. 25/26 has seen a further 65.4% increase in DAHA referral activity, explained by their visibility and accessibility across the Trust
- The DAHA team are instrumental in supporting STSFT’s White Ribbon accreditation. The DAHA team contributed to the White Ribbon Campaign (We Speak Up) in November 2025, encouraging Trust staff to sign up as either a domestic abuse ambassador or champion. Staff were asked to make a pledge and attach it to a tree
- On 19th November 2025, the DAHA team worked alongside the Young People’s Group (YPG) to deliver a session that raised awareness of white ribbon, linking it to the influence of social media
- Recent DAHA and adult safeguarding team feedback include:
 - “You really listen to me”
 - “I feel really listened to”
 - “She spoke to me calmly, reassured me, and talked me through everything step by step”
 - “It has been a complex journey, but your involvement, compassion, and patience have made a meaningful difference”
 - “The level of information you add into the referrals is very comprehensive and helps us as a service gain vital information in the first instance from you as a referrer”
 - “I would like to thank you for your exceptional vigilance, professionalism and collaborative working in a recent case, which resulted in timely safeguarding action being taken and appropriate support services being put into place. I feel this case is an excellent example of professional curiosity, effective information sharing and true partnership working”

STSFT highlights - good practice:

- STSFT DAHA Service have been shortlisted in the Trust 2026 “Recognition Awards”. This follows the safeguarding team winning in the Corporate Team of the Year category last year
- STSFT continue with White Ribbon accreditation. There are several new White Ribbon Ambassadors, including our Chief Executive and Deputy Chief Executive, and White Ribbon Champions in the organisation
- The STSFT Young Peoples Group (YPG) worked alongside the DAHA team to make an individual pledge to white ribbon and developed their own white ribbon posters. The YPG shared key highlights from the session and their posters and pledges within their newsletter
- 2025–26 also saw the launch of domestic abuse comfort bags for homeless victim-survivors of DA who attend STSFT Emergency Departments (ED)
- The STSFT safeguarding 25/26 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 and selective enquiry and identification of missed opportunities), procedural self-neglect guidance and threshold tool compliance and chaperone policy compliance. STSFT Named Nurse participated in a multi-agency audit relating to transitional safeguarding
- The safeguarding visibility model continues, ensuring 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 ED huddles
- The safeguarding team continue to complete a daily audit of 10 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 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 seven minute briefings following the publication of SAR’s, CSPR’s, DHR’s and DARDR’s. In 25/26, a Mental capacity and reasonable adjustments video was also developed and shared via the safeguarding newsletter and Safeguarding links forum. A seven minute briefing has also been shared with safeguarding links to highlight the importance of adopting MSP from the perspective of a patient with lived experience. Trust communications shared the seven minute briefings containing links to the Safeguarding Intranet page inclusive of the Executive summary for SAR “Alex” and SAR “James”, DARDR “Catherine”, the “thematic homeless review”, GSAB “Thematic review”, and the SAR “Tom” video re conviction under the Modern Slavery Act. Mandatory training was updated to reflect learning from SAR “Alex”, “James” and “Joseph”. The Named Nurse Safeguarding Adults and Named Nurse Safeguarding Children delivered a session at the “Patient Safety and Safeguarding conference 04/09/25 with the focus on learning from CSPR’s/SAR’s/ DHR’s and DARDR’s. “Patient Safety and Safeguarding” conference held 04/09/25 had a trauma informed care/practice focus. A “How modern slavery hides in plain sight” video was shared with safeguarding links. Men’s Role in Gender Equality training was shared via safeguarding link networks. A Brighter Futures representative presented in May 2025’s safeguarding forum. Knife crime awareness details were shared with safeguarding links. A County lines and exploitation information video shared

with safeguarding links. Emollient focus week of action was shared with safeguarding links. Positive feedback has been received from staff in relation to content and information within the safeguarding newsletter and following link forums

STSFT highlights - working with partners:

- 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 in both South Tyneside and Sunderland
- 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

STSFT highlights – making safeguarding personal

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

- Successful roll out of events to celebrate Safeguarding Adults/Learners Week (21st – 21st November 2025). The Trust supported the Ann Craft Trust and local Safeguarding Adults Boards and Partnerships. The 2025 overall theme was “Prevention, Act Before Abuse” with each day of the week focusing upon a specific theme. Guest speakers included Counter Terrorism Policing North East raising awareness of Prevent, Dr Rachel Bissett discussing “Breaking the Cycle: Implementation of Trauma Informed Care across a Hospital Trust setting” and the Named Nurses and Named Midwife offering a session on “Learning from CSPA’s, SAR’s, DHR’s and DARDR’s”
- On White Ribbon Day (25th November 2025), the DAHA team were visible in the hospital to raise awareness of domestic abuse with front line staff and visitors. The DAHA team also encouraged Trust staff to sign up as either a domestic abuse ambassador or champion
- STSFT leaders are encouraged to champion a culture of dignity, respect and inclusivity in line with the organisations strategic intent, executed by its mission statement, vision and values. Safeguarding training packages have been amended to ensure that MSP is clearly understood by staff, advocating the importance of empowering the individual at all stages of the process, using advocates appropriately, and embedding a personalised culture
- STSFT Staff have MSP resources available to support their practice (policy, MSP toolkit, seven minute briefing, lived experience video). The importance of adopting MSP has been reinforced at a recent safeguarding link forum (26.2.26), via sharing a video to listen to the voice of the person with lived experience and what MSP means to them and what staff can do to support MSP in practice. MSP continues to be included in the annual audit cycle

Northumbria Police

Northumbria Police continues its drive and focus on domestic abuse, working closely with partners on a number of strategic areas, the adoption of the VAWG 25 framework (focusing on the top VAWG offenders) has enhanced our ability to take a more targeted and proactive approach to offender management and pursuit.

We have recently introduced a new police records management system to overhaul an older legacy system. In the short term whilst officers become proficient in the new system, data quality has been an area of focus, however it is envisaged in the longer term the system will pay significant dividends in improving data quality, enabling us to provide more accurate insight into safeguarding demand, risk, and outcomes.

Work is progressing to develop our performance dashboards to strengthen our oversight. We are also undertaking a review of the Safeguarding Department to review our operating models with a view to identifying efficiencies, enhance our oversight, improve consistency in practice, and drive improved performance and outcomes across safeguarding.

Early intervention and a strong problem-solving approach are proving particularly effective within adult triage, enabling timely and appropriate responses to vulnerability. We have also established clear pathways into key partner services, including Homelessness and Housing, Wear Recovery (adult drug and alcohol services), Age Concern, Sunderland University, Cumbria, Northumberland, Tyne and Wear NHS Trust (CNTW), GP services, and the CARM process.

Sunderland City Council

Safeguarding demand in 2025–26 has increased slightly, with more concerns and individuals coming to attention. At the same time, there has been a reduction in formal safeguarding enquiries. Despite this, quality of practice and outcomes for residents remain strong.

- 5,318 Adult Social Care safeguarding concerns received (+2.5% from last year)
- Fewer formal enquiries undertaken:
 - Section 42 enquiries down 24%
 - Other enquiries down 63%
- Outcomes remain high quality:
 - Safeguarding starts with what matters to the person. 96.7% of people advised had their outcomes fully or partially achieved
- More Safeguarding Adult Reviews (SARs): 3 completed (up from one in previous 12 months)

This has meant:

Rising demand, fewer formal interventions

- More people are being reported, but fewer cases are progressing to formal safeguarding enquiries. This is impacted for example by referrals from Northeast Ambulance Service where concerns are investigated to ensure resident is safe, e.g. admitted to hospital but then not progressing to a S.42 enquiry or domestic abuse incidents (3.2% increase) which are alternatively managed via Multi Agency Risk Assessment Conference (MARAC). Finally, we continue to receive a significant number of Police Notifications into our Multi Agency Safeguarding Hub (MASH) which do not progress beyond that referral and partnership triage process

- Sunderland also manage our most complex safeguarding concerns via our Complex Adult Risk Management (CARM) Panel rather than a S.42 enquiry to ensure those that pose a high risk of harm to themselves or others are managed in a multi-agency environment
- Generally, this reflects a change in how concerns are assessed and managed, rather than reduced need
- We have also asked 'Other Enquiry' not to be used and be more specific regarding the type of abuse that is being reported, hence the reduction in that enquiry type

Strengthening thresholds and decision-making

A review and refresh of the safeguarding threshold tool was completed with key stakeholders including care home providers earlier this year. This ensures the document is co-produced with all partners share a clear understanding of what constitutes a safeguarding concern and improve consistency in decision-making.

Strong focus on people's outcomes

- 92% of people were asked about their desired outcomes
- Nearly all saw these achieved or partly achieved (96.7%)

This shows safeguarding remains person-centred and effective

Supporting vulnerable residents

- 344 people who lacked mental capacity were identified
- All were appropriately supported

This demonstrates continued strong practice and statutory compliance.

In summary, Safeguarding services are managing slightly increasing demand, with a notable shift away from formal enquiries. While this may reflect improved triage and more proportionate responses, it is important to ensure consistency, appropriate thresholds, and robust risk management across the system.

Encouragingly, outcomes for residents remain very strong, and safeguarding practice continues to be person-centred and effective.

Learning from SAR's: Following the BBCC Review/Action plan and a themed audit regarding Transitional Safeguarding, ASC have identified a Senior Social Worker from the Assertive Outreach Team to work with our Children's services (TFC) to promote early identification and management of people going through transitions, irrespective of where they are located.

Assertive Outreach Team: A previous recommendation from the Alan SAR was for an "investment in assertive outreach capacity" to "ensure that the specific needs and impacts of chronic, change resistant and dependent drinkers are identified in needs assessments and addressed in any future commissioning plans". Adult Social Care has now established and recruited into this standalone Assertive Outreach Team who are working with those customers who have traditionally been most difficult to engage with.

Transitional safeguarding: ASC and TFC are working together to develop and embed transitional safeguarding in our local area. We contribute towards the action plan following the multi-agency transitions workshop in 2025 with plan overseen by both Sunderland Safeguarding Children Partnership (SSCP) Board, and Sunderland Safeguarding Adults Board (SSAB). Working in the partnership, we know that many young people in Sunderland experience needs

and risks that do not neatly align with the statutory divide at age 18. Supporting them safely requires a coordinated approach across children's and adults' services, rooted in shared responsibility, whole system thinking, and collaborative leadership.

Partnership Reduction of Exploited and Missing (PREM): Adult Care now mirror TFC with regular PREM meeting which is a multi-agency framework/panel which have replaced MSET in TFC. Missing, Slavery, Exploited, Trafficked (MSET) have operated since 2012/8 across the six LA's children's services in the Northumbria Police.

PREM takes a deliberately broader, all age approach, so adult exploitation is handled in much the same structured way as children - but with alignment to Care Act safeguarding duties and adult specific thresholds.

Governance for PREM is through the newly formed **Joint Strategic Exploitation Group (JSEG)**. JSEG is the strategic, multi agency oversight group for exploitation and missing across the Northumbria Police force area. It sits above operational forums (like PREM) providing governance, oversight and performance management, ensuring agencies are working together effectively to tackle child exploitation (CSE/CCE), adult exploitation, missing persons linked to exploitation

Changing Futures (CF): CF is a Cross-government programme, with MHCLG, DHSC, HO, MoJ, DWP and (for phase one) National Lottery.

- Phase 1: supported 15 cross-sector partnerships across England - running July 2021 to March 2026
- Phase 2: £55.8m announced for 2026-2029, will work with 18 of the most deprived areas and Sunderland has been identified as one of these

Adult Social Care are working with Public Health who are taking the lead in Sunderland in working with customers with multiple needs - including three or more of homelessness, substance use, mental ill health, domestic abuse, and criminal justice contact. We are currently scoping those individuals who have repeat crisis contacts across public services - including accident and emergency departments, Police, Safeguarding etc.

Quality Assurance: We have refreshed our Safeguarding Audit Tool to afford a greater focus on outcomes and ensure the customer involvement and voice is visible and captured throughout all interactions, in keeping with a person-centred and Making Safeguarding Personal approach.

We have also developed a clear set of practice standards to support consistency in practice.

Case study

Karen* was referred into CARM as professionals identified a number of risks including:

- Homelessness
- Domestic abuse
- Exploitation
- Victim of thefts and assaults
- Long standing history of alcohol dependency
- Substance use

- Number of physical health conditions including diabetes which wasn't being managed

Karen's case was accepted into CARM and several meetings followed to address the presenting risks. At the time of the initial meeting, Karen was an inpatient at SRH and was supported by STSFT staff to join the meeting via Teams.

All professionals worked together to secure supported accommodation out of area. At the final meeting it was reported that Karen had settled into new accommodation in another local authority and all appropriate referrals had been made into local services to ensure a smooth transition of support services.

Karen said: "Moving into a safe and stable home has given me the peace and space I needed to focus on my recovery and wellbeing. Being away from negative influences has helped me concentrate on improving my physical and mental health and rebuilding my life. While I know the journey ahead will be challenging, I am committed to making positive changes and surrounding myself with supportive people. For the first time in a long time, I feel hopeful about the future and grateful for the support that has helped me reach this point".

Case study

Ellen* referred to safeguarding due to concerns related to substance use and exploitation. Partners have worked together including commissioned substance use services and domestic violence service. She is currently doing well, accessing adult education, and has distanced herself from previous risky situations. Ellen is maintaining positive engagement with services and is no longer considered at risk.

Case study

Bella* was referred to Safeguarding due to self-neglect and history of hoarding. Initial temporary accommodation was provided but she has returned to her home and social worker has arranged for small package of care to work with her to continue decluttering her belongings which has reduced the risk of losing her accommodation with her landlord.

Case study

Daniel* A Section 42 enquiry was completed, involving multi-agency information sharing and coordination due to the high level of risk associated with ongoing alcohol misuse and repeated hospital admissions.

Daniel's stated goals include: Maintaining abstinence and improving health; Managing triggers linked to low self-worth and relapse; Securing safe and stable housing; Engaging consistently with support services; Reducing debt and improving financial wellbeing

Daniel is reportedly progressing well in rehabilitation, with plans to remain in the area. No further concerns have been raised, and family feedback is positive.

Case study

Margaret* was referred to Safeguarding by the Police following concerns of financial abuse and fraud. Working with Social Care Financial Assessment Team, Advocate, Police and family appropriate arrangements are now in place including the ladies daughter being appointee which has removed the risk.

The Adult Social Care Senior Management Team said: “Safeguarding is not a standalone function or the responsibility of a single team - it is a collective duty that must be embedded in every decision, interaction, and service we deliver. From frontline practice to strategic leadership, safeguarding underpins how we design services, allocate resources, manage risk, and uphold the dignity, rights, and wellbeing of adults at risk. It is everyone’s business because harm can emerge anywhere, and prevention depends on a shared culture of vigilance, accountability, and professional curiosity that permeates all aspects of our work.”

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

CNTW’s strategic plan and direction has seen them launch their ‘Delivering tomorrow, With You in Mind’, service change plan in 2025–26. This sets out the changes we want to make over the next three years, with a particular focus on delivery in 2026/2027.

CNTW is undertaking a series of service developments across community, inpatient, crisis, learning disability, neurodevelopmental and specialist pathways. Although each scheme focuses on different services, they are driven by the same challenges: rising demand, increasing complexity, workforce pressures. Addressing these issues together, rather than in isolation, will create a more joined up and sustainable approach to the services we provide across the North East and North Cumbria.

Across the Trust, several core areas are being taken forward including but not limited to:

- Improving access to community mental health care, with neighbourhood mental health centres, better triage, and more personalised support
- Strengthening urgent care, including mental health emergency departments, access to crisis assessment and treatment services
- Improving ADHD and Autism pathways, including a region wide re triage to reduce waits
- Reviewing children and young people’s inpatient capacity, aligning beds to need and strengthening community alternatives

Viewing these developments together allows us to coordinate decisions, avoid duplication, share resources, and ensure each change supports the wider system. People will experience more coordinated care, more support closer to home, fewer unnecessary hospital stays, and clearer, more consistent pathways across the region. Changes will be phased, with full engagement and support. Some teams may work differently or in new locations, but the focus is on building sustainable, safer and more resilient services.

CNTW highlights – key achievements:

Hope Haven - Hope Haven is one of six ‘neighbourhood mental health centres’, part of a national pilot of this new approach funded by NHS England in collaboration with CNTW, Cumbria Health, Everyturn Mental Health, Home Group and others. Hope Haven has been

delivering support to people across the Copeland area for around a year and can now welcome people into its new specially designed home in the centre of Whitehaven. Hope Haven offers people support on a wide range of things they may be dealing with, from practical physical and mental health support to tackling drug or alcohol addiction, or advice on housing, work, or money difficulties. Since December 2025, Hope Haven has been providing walk-in support from its temporary home at the Senhouse Centre in Whitehaven. More than 150 local people have been able to get the help they needed

Embedding learning from internal and external reviews - CNTW continue to embed learning from statutory learning reviews such as DARDRs, SARs and CSPRs. Learning is shared via organisational meetings such as care group safety meetings, Trust Safety Group. Additionally, our Safeguarding Level 3 and Domestic Abuse training contains contemporary learning from statutory reviews, ensuring that learning is embedded to improve practice.

Learning from audits - Further learning from internal and external audits remains a significant part of improving quality practice within CNTW. We have recently completed an internal audit of our response to Domestic Abuse; within these areas of good practice were identified and the need for some improvements were recognised. A robust action plan has been formulated to address the areas of improvement with the aim of all actions being completed by summer 2026.

Learning from inspections - our children's services in the North had a recent CQC inspection where the service obtained a Requires Improvement rating. Despite the Requires Improvement rating, positive feedback from service users and carers was noted within the report including that the nursing team is kind and caring, staff are responsive, helpful and patients felt included in their care. The Trust is actively working on relevant learning and improvement points to improve practice, patient experience, patient safety and increase statutory compliance.

Involvement Bank; The Service User and Carer Reference Group (SUCRG) - The Involvement Bank is a way for service users and carers, who are not paid employees of CNTW. The group meets six times per year with approximately 200 people in attendance. The group meets face to face, with membership consisting of service users, carers, staff, and third sector organisations, providing an opportunity for service users and carers in the North-East and North Cumbria to use their own lived experience to influence change within the Trust. The continual success of the SUCRG is something to celebrate, however this success also brings with it several challenges. Finding a suitable venue for the group has become increasingly challenging, and ensuring every voice is heard within such a sizeable group brings additional considerations. To address these challenges, and after careful consideration, the SUCRG is to be restructured into smaller 'Lived Experience Networks' (LEN's). Each Care Group; Inpatients, Community, and Specialist, will have its own Lived Experience Network. The LEN's will enable smaller groups of people to come together to influence change, ensuring everyone is meaningfully involved and that every voice is heard. By focussing the LEN's on Care Group issues, each LEN will be able to explore in greater depth the issues that are of importance to them and, together, explore how we can make CNTW the best it can be.

Embedding new guidance (Working Together to Safeguarding Children 2026) - CNTW remain committed to embedding learning and new guidance across all services provided by the Trust. The new Working together to Safeguarding Children guidance has been published and, we will ensure that our policies, procedures and training offer reflect these new changes, ensuring that practice is contemporary and robust.

CNTW highlights - safeguarding activity and making safeguarding personal:

One of the key functions within CNTW is the Safeguarding and Public Protection (SAPP) Team. The team is responsible for providing advice, support and supervision relating to SAPP matters to all Trust staff with one of the key functions of the team being that of reviewing Safeguarding Triage incident reports. To date (excluding Q4 data), the SAPP team has reviewed almost 3400 incidents, providing advice and support to staff. For a small team, this is a significant amount of work. SAPP remain key members of MARAC, MAPPA and PREVENT.

CNTW highlights - working with partners:

A recent letter has been sent to the ICB and Boards by Sarah Glacken, Executive Director of Nursing, Therapies and Quality Assurance, Nursing and Therapies. The letter noted that CNTW will continue to attend all Board and Partnership meetings and attend and contribute to subgroup/panel meetings and practitioner events related to statutory review activity (SAR's, CSPR's and DARDR's). We will no longer attend other subgroups due to limited capacity to meet all demands from the nine local authorities within our footprint. CNTW remain committed to working in partnership to improve outcomes, promote safety and learn from incidents and reviews.

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

During 2025–26, the NENC ICB experienced a period of significant organisational change and restructuring. Despite these challenges, safeguarding remained a priority, with statutory responsibilities maintained throughout the transition period. The safeguarding team continued to provide strategic leadership and assurance across the health system, ensuring safeguarding concerns were appropriately managed and escalated where necessary. Representation at the Safeguarding Adults Board and its sub-committees was maintained, alongside contributions to Safeguarding Adult Reviews and Domestic Abuse Related Death Reviews. While restructuring has presented challenges, as a strategic commissioning organisation, it provides an opportunity to review current safeguarding arrangements locally and ICB wide, strengthen collaborative relationships, and consider how safeguarding leadership can be delivered effectively within a changing health and care landscape.

Supervision

The ICB safeguarding team continues to provide supervision to our CHC nursing team, who work into Sunderland providers. This is to ensure that our practitioners feel confident in safeguarding and MCA and are also up to date with safeguarding reviews and outcomes. In these sessions any relevant materials published on the SSAB website are presented and highlighted.

The GP Leads meetings, which encompass South Tyneside and Sunderland primary care, are used to provide support to safeguarding leads across the area and can be used to provide training and updates from SSAB.

Learning and Improvement

As a result of SARs and DARDRs - we continue to embed learning and improvement into primary care safeguarding leads meetings. As part of our changes as an ICB to strategic commissioner, South Tyneside and Sunderland safeguarding team have worked hard to align a process whereby GPs are more embedded in terms of writing their own IMR's, considering their own learning and outcomes as well as understanding whether there is wider learning for primary care.

The ICB underwent an audit last year which highlighted limited electronic staff recording capabilities of training compliance for levels 4 and 5, as set out in the intercollegiate adult safeguarding framework. As lead for workforce and learning workstream across the ICB, the designate nurse for adult safeguarding has worked with the ICB OD department to resolve this issue enabling the demonstration of evidence of full training compliance.

The deputy designate safeguarding nurse continues to chair the LIIP, ensuring multi agency coordination of learning from SARs and DARDR's as well as providing a forum to discuss any issues and highlight any new ways of working around training and improvement.

Links to quality assurance

The ICB designate nurse for adult safeguarding has participated in a piece of work to streamline and centralise concerns across the NENC. This enables the ICB to collate various levels of concern in order to produce assurance around provider concerns. The safeguarding team continue to support the quality team with assurance visits where required and sharing information around provider concerns.

Tyne and Wear Fire and Rescue Service (TWFRS)

During 2025/26, Tyne and Wear Fire and Rescue Service (TWFRS) supported safeguarding in Sunderland through early identification of vulnerability, effective information sharing and coordinated multi agency responses. Safeguarding is embedded within operational response and Safe and Well activity, enabling identification of adults at risk, particularly those experiencing self neglect and complex needs.

This has contributed to reduced environmental and fire risk, improved engagement with support services and more timely intervention by partner agencies. TWFRS works closely with Sunderland Adult Social Care, health services and other partners to support coordinated and proportionate safeguarding responses.

A 2025/26 internal audit, in collaboration with Sunderland City Council, provided a substantial level of assurance, confirming that safeguarding governance, referral processes and partnership working are effective. Learning from this has informed improvements in training oversight, performance monitoring and data quality.

Safeguarding activity reflects increasing complexity of need, with self neglect a key theme. Workforce capability has been strengthened through initiatives including new Modern Day Slavery awareness training.

TWFRS remains an active partner in safeguarding arrangements and was recognised as a finalist for the Safeguarding Award at the NFCC Prevention Conference, reflecting its commitment to continuous improvement and protecting vulnerable individuals.



2025–26 in figures

5,318 concerns were received; this is a 2.5% increase compared to 5,187 concerns received in 2024–25.

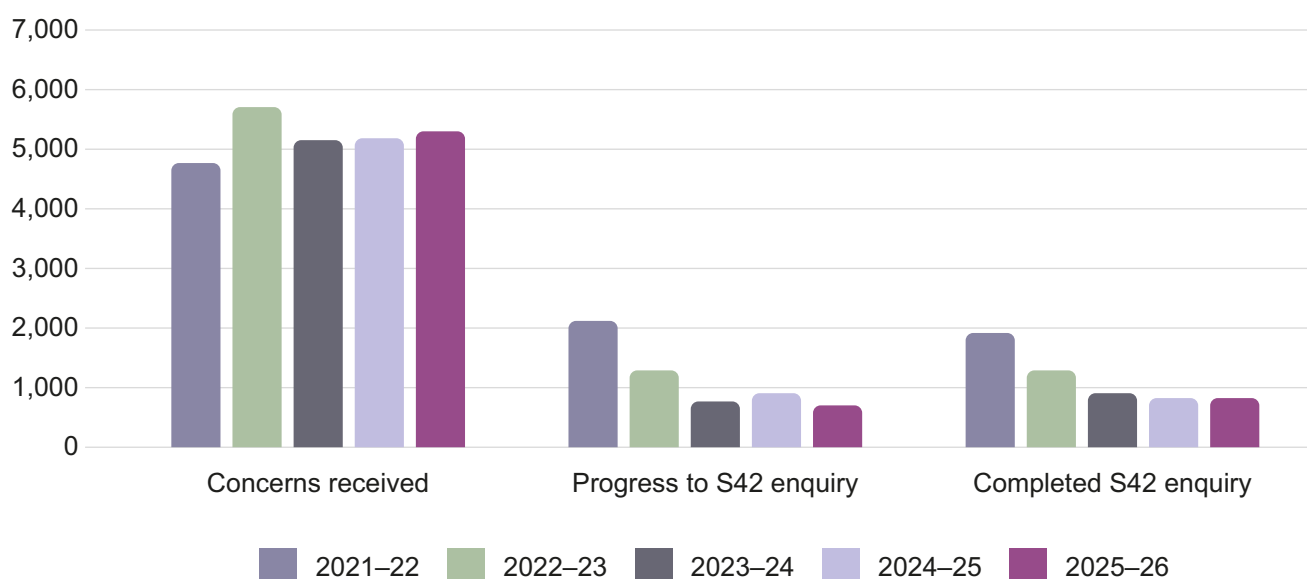
Of these concerns, (707) 13.3% were progressed to Section 42 Enquiries, (45) 0.8% progressed to 'Other Safeguarding Enquiry', and (3,855) 72.5% did not progress to a Safeguarding Enquiry. 705 concerns were linked to already open episodes (which could be a Section 42 Enquiry or an Other Enquiry), these 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 809 completed Section 42 Enquiries in 2025–26, a 4% decrease on 843 completed in 2024–25.

Of the 3,858 concerns raised that did not progress to a Safeguarding Adult Enquiry, 3,524 had an agreed threshold level of low/not applicable, 315 were significant, 17 were very significant and two were recorded as critical. The following outcomes for these concerns were recorded:

- Linked to existing Adult Services Referral = 3
- Signposted to other agencies = 105
- No further action = 3,750 (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)

Safeguarding activity comparisons



Desired outcomes

Of those customers with a completed Section 42 Enquiry or Other Enquiry, 92.2% of these individuals, or their representatives, were asked what their desired outcomes were. Of those asked what their desired outcomes were, 89.1% expressed a desired outcome, 96.6% of which were either fully or partially achieved.

Primary support reason

Individuals with physical support needs represented 37.9% of all concerns received, followed by mental health needs (16%), and learning disabilities (10.8%).

Mental capacity

In 40.4% of completed cases, the customer was identified to lack mental capacity. 100% of these individuals were supported.

Main location of abuse

Individuals' own homes: 58.5%

Residential/nursing home: 25.3%

Health setting 11.1% (acute hospital 8.9% and mental health inpatient setting 2.2%)

Alleged perpetrator's home: 2.1%

Main categories of abuse

Neglect: 28.4%

Self-Neglect 26.4%

Physical abuse: 22%

Financial 14.6%

Psychological: 13.9%

Compared to 2024-25, 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 psychological abuse was alleged (from 15.6%) and an increase in financial or material (from 15.8%).

Age/gender

Females account for 54% of all concerns raised, with 45.9% of these being aged 75+.

Males account for 46% of all concerns raised, with 54.6% of these being aged 18–64.

Learning lessons

In 2025–26 SSAB partners participated in a review of a case led by the Sunderland Safeguarding Children Partnership (SSCP), where the individual sadly died just after their 18th birthday. Whilst the review was not able to be published for various reasons, the learning from the case was shared across partner agencies and has resulted in an action plan which is being monitored across both SSCP and SSAB.

In 2025–26 SSAB received 11 Safeguarding Adult Review referrals. Of these, eight were classed as inappropriate referrals and were either redirected to other more appropriate processes or were already being managed through an active safeguarding adult case process. Referrers were informed about the outcome for each of these cases, and where required were given links to redirect them to appropriate processes/resources, therefore using it as a learning opportunity for referrers. Of the remaining three SAR referrals, all met the SAR criteria. Two are being progressed, and the third has been temporarily paused to allow for police investigations and related work to take place.

Each of the reviews mentioned above, once completed, will result 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 2026–27 hold?

SSAB will continue to take forward its work programme of actions to meet the identified priorities in the SSAB Strategic Delivery Plan 2026–29. Particularly important to this work will be:

- Developments in the capturing of local demographic data, particularly any client level data and area-level data that can support identification of themes and trends, alongside the safeguarding adults data that is also available. This data will be used to support SSAB's work
- The themes and learning from national work such as SARs from other areas, the work of the National SAB Independent Chairs Network and National SAB Managers Network and any relevant research. In particular, national documentation has been published to support all Boards to conduct Safeguarding Adult Reviews as effectively and robustly as possible, and SSAB will be looking to consider and adopt this guidance, whilst considering how best to do this alongside the existing local processes
- Sharing the learning from the local SARs which are currently being progressed and will be concluded within the 2026–27 year
- Continuing to review progress made against the Strategic Delivery Plan to ensure the priorities are being addressed and objectives and actions continue to be relevant and achievable.

We have:

- SSAB has reviewed their priorities and developed a new Strategic Delivery Plan for 2026–29 that reflects local need, emerging risks and statutory responsibilities

We will:

- SSAB will continue to focus on prevention, user engagement, communication, training and intelligence-led assurance
- SSAB will use learning, evidence and partnership working to ensure adults in Sunderland can live safely, free from abuse and neglect
- SSAB will remain ambitious, accountable and focused on improving outcomes for the people of Sunderland



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 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 and 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 and Coordination (MATAC)

MATAC is a collaborative process where police and partner organisations work together to tackle domestic abuse by identifying and 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 and 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.

