Calderdale Safeguarding Adults Board

Annual Report 2022 to 2023

Calderdale Safeguarding Adults Board

Contents

1. Foreword from the Independent Chair – Marianne Huison

2022/23 has been another difficult year for Safeguarding Adults across Calderdale as austerity bites as we are still recovering from the Covid Pandemic. Post Covid we have seen increasing complexity and acuity of cases which is having an impact on the resilience of a stretched workforce. However as Independent Board chair I continue to be impressed by the passion for safeguarding, the kindness and the resilience of all the frontline workers, paid or unpaid and their managers in ensuring we keep the most vulnerable to harm and exploitation safe.

When I reviewed our demographic information, I noted that our population continues to age but is becoming more diverse. However, I was delighted to see that whilst Calderdale remains in the most deprived quartile, deprivation has decreased significantly. If we continue on the same trajectory Calderdale will move out of this bottom quartile within the next year. This is significant and the result of a long-term strategy to support and encourage enterprise across the business community in both the public and private sectors. Well done, Calderdale!

The Safeguarding Adults Board is a mature board, which functions well and is well supported by Julia, the business manager and her team in the safeguarding business unit. The findings from the thematic review Burnt Bridges continue to drive both Cultural and System change across Calderdale.

Highlights for me this year have been: -

- Considerable improvements in supporting tenants in Together Housing properties where eviction is now seen as a failure!
- How data shared in our Development Day in driving change within Adult Social Care as we work towards a Multi-Agency Safeguarding Hub (MASH).
- An increased focus on using our data to identify and address inequality.
- Development of a Large-Scale Enquiry Policy and Procedures.
- Development of a PiPoT Policy.
- Introduction of new Multi-agency Safeguarding Policy and Procedures through Tri-X in partnership with North Yorkshire, York, Kirklees, Bradford and Wakefield Safeguarding Adults Boards. This new digital platform is very user friendly and ensures policy and guidance can be accessed from a laptop, desktop computer, a tablet or even a smartphone!
- Work to co-produce a new Adult Safeguarding Thresholds document.
- Changes to the CIS system within Adult Services and Wellbeing and the introduction of the Power BI tool for data sharing provides a significant step change in our ability to gather and analyse safeguarding data.
- The development of our Communication and Engagement Network to improve how we gather feedback from Service Users, ensure their voice is heard and that we work with them to co-produce new initiatives, policies, procedures and training courses.

The partner agencies, which make up the Board, continue to drive improvements within their own organisations and I would encourage you to read more about this in Appendix 2.

Learning from Safeguarding Adults Reviews (SARs) continues to focus our attention on what is working well as well as what needs to improve. You will see details of the SARs we have completed this year and what we have learned.

As I have already mentioned, we continue to reflect on the Burnt Bridges Thematic SAR. This year we took a new approach to reviewing the difference the recommendations from the SAR have made in practice. As a Board we need to ensure the findings actually result in tangible improvements to the services provided, hence this very thorough Challenge process. I hope you find reading about this interesting and we would welcome feedback on how this could be further strengthened.

Our priorities for 2022/23

I believe it was the Greek Philosopher Heraclitus who said, "*Change is the only constant*", and certainly that is very true in the field of Safeguarding and the work of the SAB.

Next year will see the introduction of the new CQC Inspection of Adult Services and a great deal of work has already been undertaken to ensure we are as 'prepared' as we can be. We look forward to the feedback from the inspection team and will use it to drive any necessary improvements to our multi agency safeguarding work.

The Right Care Right Person approach is being rolled out across the country and will be a focus of the Board next year.

The Board, in partnership with the Children Safeguarding Partnership has agreed to hold a development session to look at Transitional Safeguarding, this will lead to joint work to further strengthen this crucial area of work.

The SAB will continue to support the work of the new MASH, not least in the roll out of the new Thresholds document.

So finally, from me, I hope you enjoy reading this year's annual report, find some innovative new practice, and are reassured that the members of Calderdale Safeguarding Adults Board and both committed and proactive in their pursuit of keeping adults safe and supported to live 'a larger life, one full of hope".

M Huison

Marianne Huison

Independent Chair
Calderdale Safeguarding Adult Board

2. Calderdale Context

Calderdale is home to an estimated 206,631 residents. In the 2021 Census, it can be noted that the proportion of adults in Calderdale compared with England is different for some age groups. For example: In Calderdale 17% of residents are in the 20 to 34 age group compared with 20% in England; while 21% of Calderdale residents are in the 50 to 64 age group compared with 19% for England. In the 75 and over age group the proportion of males to females reduces.

There were increases in the proportion and the numbers of residents aged 55 and over in the last 12 years. The group aged 65 to 74 increased 25% since 2011. This compares with a 1.4% increase for the whole population. The population aged 85 and over has increased steadily by 7% from 4,294 in 2011 to over 4,600 in 2021. The fastest growing age group is projected to be those aged 75 and over.

In December 2021 21.9% (27,800) of Calderdale residents aged 16 to 64 had an Equality Act core or work-limiting disability. This compares with 22.9% in England.

The largest ethnic group in Calderdale is White British (82.7%), as recorded in the national Census 2021. The four largest minority ethnic groups are Pakistani (8.5%), Other White (2.4%), Indian (0.9%) and Irish (0.8%). The Asian ethnic category accounts for 15.6% of 0 to 4 year olds and 13.4% of 5 to 14 year olds. The pensioner population is largely white. Less than 3% of this age group is comprised of Black, Asian and Minority Ethnicity (BAME) groups.

In Calderdale, 14.9% of the population was income-deprived in 2019. Of the 316 local authorities in England (excluding the Isles of Scilly), Calderdale is ranked 75th most income deprived.

Male Life expectancy is 78.3 years compared with 79.4 for England. Female life expectancy is 82.5 years compared with 83.1 for England (3 year average: 2018-2020). The gap in life expectancy is 10.6 years for males and 9.1 years for females between the most and least deprived neighbourhoods in Calderdale. (2018-2020).

The number of Safeguarding Concerns reported in Calderdale in 2022-2023 was 4962. This is an increase of 1000 from the previous year and is the highest rate recorded. The number of concerns which met the Section 42 criteria in 2022-2023 was 2774, an increase of 300 from the previous year but disproportionally a lower %. Comparator data for Y&H shows significantly lower numbers of both (further details feature later in the report). 128 of the 2774 referrals which met the Section 42 criteria progressed to a Stage 2 Enquiry.

Over 50% of concerns raised and 75% of Section 42s were from Care Homes or Care Homes with Nursing. 40% of concerns were in the adult's own home, which was 20% of the total Section 42 numbers. Around 6% of concerns were from the community which was 3% of the total number of Section 42s. Neglect, physical and organisational are the main/highest figure of types of abuse reported with the majority of these being related to Care Home safeguarding concerns.

Calderdale is one of the largest, largely rural geographical metropolitan boroughs but is one of the smallest in terms of population. This necessitates innovative thinking about the effective delivery of services and identification of need which is commensurate with the local landscape. Halifax Town is the administrative centre and by far the largest settlement in Calderdale.

3. The Calderdale Safeguarding Adults Board Approach to Safeguarding Adults

3.1 The Purpose of a Safeguarding Adult Board

The overarching purpose of a Safeguarding Adults Board (SAB) is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- assuring itself that safeguarding practice is person-centred and outcome focused.
- working collaboratively to prevent abuse and neglect where possible.
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This requires the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- the safety of people who use services in local health settings, including mental health.
- the safety of adults with care and support needs living in social housing
- effective interventions with adults who self-neglect, for whatever reason
- the quality of local care and support services
- the effectiveness of prisons in safeguarding offenders
- making connections between adult safeguarding and domestic abuse.

3.2 Core duties

SABs have three core duties. They **must:**

- develop and publish a **strategic plan** setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an annual report detailing how effective their work has been.
- commission safeguarding adult reviews (SARs) for any cases which meet the criteria for these.

This annual report will outline how the Calderdale Safeguarding Adults Board (CSAB) has met these core and statutory duties. The CSAB is supported by the Independent Chair, Marianne Huison has no direct links to Calderdale agencies. Marianne also Chairs the Barnsley Safeguarding Adult Board and Independently Scrutinises the Sunderland Safeguarding Children Partnership. The work of the Board is supported by the Calderdale Safeguarding Business Unit, led by Julia Caldwell, Safeguarding Partnerships Manager. The business unit also supports the work of the Calderdale Safeguarding Children Partnership and Domestic Homicide Review team.

4. Safeguarding Adult Board Activity between April 2022 & March 2023

4.1 Achievements

- ✓ Involved communities and experts by experience to challenge how services have embedded trauma informed practice.
- ✓ Implemented new Safeguarding Adults multi-agency safeguarding policies and procedures across West Yorkshire, North Yorkshire and York
- ✓ Introduced Multi-Agency Professionals Meeting Guidance in September 2022
- ✓ Agreed and uploaded the Large Scale Enquiry Policy and Procedure for Calderdale
- ✓ Agreed and uploaded the Persons in Positions of Trust (PIPOT) Guidance for Calderdale
- ✓ Recognised how disadvantage, poverty and social deprivation impacts on safeguarding and what this meant for our services.
- ✓ Commenced work on agreeing safeguarding thresholds in Calderdale.
- ✓ Collected evidence that we are making safeguarding personal in Calderdale.
- ✓ Received Organisational Safeguarding Assessments from 250 partners in Calderdale providing assurance of the effectiveness of their own safeguarding arrangements.
- ✓ Delivered a two Safeguarding Week programmes to raise awareness in professionals and communities in Calderdale.

4.2 SAB Members

The Partner organisations who contribute to the Safeguarding Adult Board are as follows.

- Calderdale Metropolitan Borough Council:
  - Adult Services and Wellbeing
  - Community Safety
  - Public Health
  - Domestic Abuse
  - Housing
  - Customer Services
- Calderdale Cares Integrated Care Partnership
- West Yorkshire Police – Calderdale District
- Calderdale and Huddersfield Foundation Trust
- South West Yorkshire Partnership Foundation Trust
- Together Housing
- West Yorkshire Fire and Rescue Service
- WomensCentre Ltd
- Voluntary Sector Infrastructure Alliance
- Age UK
- Probation Service
- Department for Work and Pensions
- Healthwatch UK (Calderdale)

Further details of what each has done to support the work of the Board can be found in the Appendix.

5. Leaning and Improvement Activity

5.1 Safeguarding Adult Reviews

A Safeguarding Adults Review (SAR) is a multi-agency process which seeks to determine what relevant agencies and professionals could have done differently that could have prevented harm or a death from taking place.

The purpose of a SAR is not to hold any individual or organisation to account. Other processes exist for that purpose, including criminal proceedings, disciplinary procedures, employment law and regulation run by the Care Quality Commission (CQC) and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

Safeguarding Adults Reviews are commissioned by the CSAB when:

- There is reasonable cause for concern about how CSAB members or other agencies providing services, worked together to safeguard an adult

And

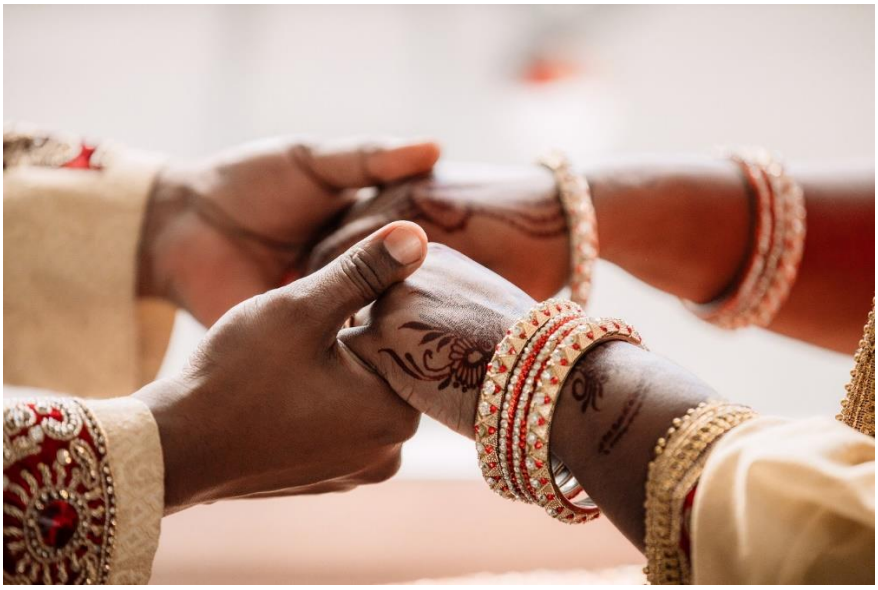
- The adult has died, and CSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

Or

- The adult is still alive, and CSAB knows or suspects that the adult has experienced serious abuse or neglect.

Further information can be found in the Care and Support Statutory Guidance, Chapter 14.

The CSAB published three Safeguarding Adult Review (SAR) during the year – Mr C, Mr D and Mr E. See the learning briefings for each below, which are also published on the SAB website here.



Mr C Safeguarding Adult Review

June 2022

1. What happened?

Mr C was a proud and independent man who maintained a strong determination to live his life as he chose. He experienced a number of health conditions including possible dementia, excessive alcohol use and poor eyesight. There were concerns around his living conditions for many years resulting in infestation and fire risks. He was served notice to leave his home against his wishes and whilst he was in a care home his property was cleaned. When he returned home his utilities were cut off and Mr C cooked using makeshift barbeques and lit the house with candles and oily rags in wine bottles. There was more than one house fire as a result and he was treated in hospital for the effects. Mr C died of ischemic heart failure during a fire at his house.

2. Learning from the review

- There was a lack of a coordinated and multi-agency response to Mr C's self-neglect
- Agencies didn't understand enough about Mr C, his previous trauma, his likes and dislikes, his lifestyle choices and how this impacted on engagement
- Practitioners assumed Mr C had the mental capacity to make decisions and the ability to execute these decisions, but this was never formally assessed
- Assessments and care planning did not mitigate the known fire risks
- Many of the issues in this review were similar to previous reviews – transforming learning into improved practice must remain a priority

3. Good practice

There was evidence of some good community engagement providing a drop in location for Mr C.

The district nurse team established and maintained a positive relationship that showed persistence in efforts to make contact.

A & E records were detailed, and Mr C had a positive relationship with the care home staff.

4. Recommendations

Gain assurance from partners about:

- Developing a trusting relationship through a trauma informed approach
- Risk assessment and planning in complex cases
- Identifying and responding to self-neglect
- Effective multi-agency safeguarding and information sharing response

5. Recommendations cont.

- Ensure that complex cases are appropriately managed through existing policies and procedures.
- Improve legal literacy including the Mental Capacity, executive functioning and inherent jurisdiction
- Seek assurance of multi-agency care planning, coordination, and communication to address self-neglect.
- Innovative ways to provide assertive outreach
- Professional curiosity, escalation and challenge processes should be understood and promoted across the partnership.
- Ensure that there is appropriate management oversight, audit and supervision processes in place for complex cases

6. Multi-agency Learning

Missed appointments particularly when there are known risks, should be appropriately followed up

Carefully consider, assess and record mental capacity for decision making when someone is self-neglecting especially when they are making high risk decisions.

Trauma informed approaches can help to engage people who face barriers to accessing support.

Take a multi-agency approach to self-neglect and hoarding concerns.

Seek safeguarding supervision oversight in cases involving complex needs.

7. Resources

New MA meeting guidance link when ready

Prof curiosity guide

CSAB-Self-Neglect-policy-2018.pdf

ma-safeguarding-adults-policy-procedures-2019

Resolving-Professional-Disputes-and-Escalation-Procedure.pdf

2. What happened?

Mr D was 59 years old and in bungalow as part of a residential care home at the time of his death. He had a complex physical and mental health history and needed access to staff support 24/7. Mr. D had a history of suicide attempts and self-harm, including cutting his neck with a knife in May 2020. He had a known history of violence, use of weapons, admission to secure settings, and arson.

At the time of his death, Mr. D was awaiting the outcome of a decision by the Crown Prosecution Service, following an incident when he had assaulted staff members from the Care Home. He was on bail with conditions which restricted his access to support and he had been served notice to vacate his property.

Mr D took his own life and in autumn 2022, an inquest determined the cause of Mr. D's death was suicide.

7. Resources

New MA meeting guidance link when ready

CSAB-Self-Neglect-policy-2018.pdf

ma-safeguarding-adults-policy-procedures-2019

Resolving-Professional-Disputes-and-Escalation-Procedure.pdf

2. Learning from the review

1. Mr D was experiencing anxiety over the uncertainty of his tenancy and the criminal investigation, particularly the impact they could have on him seeing his mother.

2. On two occasions, safeguarding alerts were raised by the staff at the home, however, their concerns appeared to be minimised with limited action and when staff requested Police assistance their response was below the minimum expected standards.

3. Mr. D repeatedly told professionals about his anxiety and worries for the future, yet decisions were being made by agencies working in isolation and without the inclusion of Mr. D

4. Whilst incidents had escalated more quickly than previously and Mr. D's condition had deteriorated, the crisis plan, and multi-agency response remained the same.

3. Good practice

Mr D was able to be provided with 24/7 supported care whilst living relatively independently in a bungalow, he was very happy there.

Communication with community staff and their continued input with the placement worked well.

Local authority case recordings were full and comprehensive.

Mr D Safeguarding Adult Review

2022

6. Learning - snapshot

Multi-agency Working

Person-Centred Decision Making

Fit for purpose and updated Care Plans

Contractual Arrangements

Terminology

Escalation

5. Multi-agency Learning

1. Missed opportunities strategically and operationally for agencies to have worked together effectively.

2. All relevant agencies should be part of multi-agency meetings

3. The sharing of information between partner agencies, is a key factor in enhancing and supporting multi-agency working.

4. The multi-agency working needs to clearly articulate how and when information was to be shared amongst agencies.

5. All staff need to understand the processes to resolve and escalate multi-agency disputes.

6. Increased understanding of the different terminology in relation to Mental Health Act assessments

7. All decisions should be centred around the person, the risks to themselves and others, and the impact of those decisions.

4. Recommendations

- to ensure that there is a multi-agency response when there have been significant events within an individual's life
- ensure staff are aware of how to escalate concerns in relation to multi-agency working.
- that decisions are being made which are centred around the individual and clearly document the individual's involvement
- provides access to a glossary, where professionals can find further information on key definitions, and processes regarding housing and accommodation
- that the contractual arrangements with residential accommodation service providers are current and up to date.

Mr E Rapid Review

September 2022

Calderdale Safeguarding Adults Board

3. What happened?

Mr E is an elderly gentleman experiencing dementia who came from out of the borough to live in a residential home in Calderdale in 2019 selected by his daughter. There was no objective assessment of Mr E's needs and risks at the point of admission.

Between June 2020 and February 2022 three reports were made to police of Mr E sexually assaulting another resident and a further 16 incidents of sexualised behaviour were recorded in his care plan.

The police concluded Mr E was unable to form the intention to commit a criminal act and the three investigations ended. The local authority safeguarding team concluded on each case that the measures in place at the home were sufficient to manage the risk posed by Mr E.

6. Resources

Section 42 Criteria ADASS

CQC guidance

Joint Multi-Agency Safeguarding Adults Policies and Procedures

Royal College Of Nursing Older People in Care Homes: Sex, Sexuality and Intimate Relationships 2022.pdf

NICE guidance Safeguarding Adults in Care Homes

2. Finding 1

There is no agreed process between agencies in Calderdale to assist identification and escalation of serious sexual safety incidents to multi-agency risk assessment where groups of vulnerable people may be at risk.

Finding 2

There is no agreed and consistently used language to describe types of sexualised behaviour in residential care homes which would more readily enable identification of high risk situations for both residents and staff.

Finding 3

Calderdale safeguarding policies and procedures recognise sexual abuse as a category however there is no local guidance about how sexual safety can be maintained specifically in residential care settings. This is despite recognition of the extreme vulnerability of residents and problematic sexualised behaviour of some residents being acknowledged as common.

Finding 4

The assessment of needs and risks undergone by a person seeking admission to residential care differs greatly depending on if they are funding their own care or not. This creates a disparity that sees full person centred assessments only conducted for people funded by the local authority, increasing the likelihood that self-funders' needs and risks are inadequately understood and shared.

4. Response

Clear guidance for multi-agency risk assessments will be developed, which will be promoted across Calderdale with the Multi-Agency Professionals Meetings Guidance Sep 2022.pdf

This will support all agencies to understand indicators that must trigger a multi-agency meeting to develop and review risk and mitigations.

All agencies need to ensure their staff are aware of escalation procedures and are confident to raise professional conflicting opinions.

5. Response

Care homes providers will be encouraged and supported to include sexual safety process in their safeguarding policies and admission assessments.

Guidance on Sexual Safety will be developed for Calderdale, based on national best practice and CQC guidance

Professional should understand the links between preventing harmful behaviours and mental capacity.

5. Multi-agency Learning

All professionals should understand the importance of describing behaviours clearly and to use correct terminology when referring to sexual criminal offences, irrespective of any concerns around capacity. Professionals should understand the need to be clear when referring to inappropriate sexual behaviour so as to ensure that relevant and sufficient risk assessment can be completed.

Building Bridges

Building on the lessons learned from the Burnt Bridges? Thematic Review which focussed on the deaths of five men who lived Street Based Lives. This Thematic Report generated significant demands on services to change, to become trauma informed and to embed flexibility of services to improve the lives of those who have multiple complex needs. This year, the SAB has recognised how remarkably individual professionals, organisations and systems responded to the thematic review and the learning implemented afterwards. Although there is more to do, the sustained transformations to services have been significant and trailblazing.

In reviewing progress against the learning from the Burnt Bridges Thematic Report, the Calderdale Safeguarding Adult Board (SAB) wanted to focus on embedding learning, changing practice and improving the experience and outcomes for service users. In light of this we took a more robust approach to challenging agencies, and to seeking assurance that the recommendations and findings had been acted on and had in fact changed practice.

The Safeguarding Adult Board not only undertook key stakeholder interviews with the statutory and voluntary agencies involved, but with business community stakeholders, experts by experience (adults with multiple complex needs) and family members in order to gain a rich insight into what, if anything, has changed since the report was published.

The CSAB Business Manager and Independent Chair visited some of the services providing support to the men as well as visiting and engaging street-based experts by experience to hear directly of their lived experiences.

On reflection, the Independent Chair, felt this approach was valuable and added another dimension to the "Progress and Challenge" methodology. The CSAB Business Manager and Report Author also felt that "walking the floor" and meeting with frontline practitioners and service users in the community was an informative exercise and that this should be built into future reviews.

What is working well.

Overwhelmingly the feedback was very positive. It was clear that Burnt Bridges has caused a cultural shift across all agencies and within the business community. Service users gave positive feedback in terms of services being brought directly to them, and of greater support being available.

Improved Multi Agency working and particularly the work of the Multi-Disciplinary Team (MDT) was highlighted by many as providing a significant step forward in managing the risks to and meeting the needs of those with multiple and complex needs.

The improvement in terms of quality, suitability and capacity of accommodation for this client group has been significant with individual pods at The Gathering Place, the addition of Craven Mount and 18 next steps properties.

The use of and availability of Naloxone, a drug which can reverse an opioid overdose was perceived to be representing a more trauma informed and non-judgemental approach, as well as literally being a life saver.

Some of the most significant cultural shifts have taken place in housing, where 'eviction' is now seen as a failure, and rent arrears seen as a safeguarding issue. It is significant that over the last 12 months, Together Housing have evicted only 2 tenants, and neither were made homeless.

What are we worried about?

Capacity is the theme. From concerns over recruitment and retention of staff within key care and support services to capacity at The Gathering Place, temporary and move on accommodation. There is a concern that as we continue to raise awareness and improve pathways for this client group, we may not be able to effectively meet demand and start to fail those who need support the most. The capacity of Mental Health Services was regularly cited as being difficult to access and often involving lengthy waiting lists which is a national picture as well as a local issue.

Culture has shifted significantly but that does not mean that everyone on the front line had made this change. Consistency in approach is key and where specific examples of when things had not gone well were given, the overarching theme was that not all the messages from Burnt Bridges had permeated down to the front line. So, whilst the 7 minute briefings and training videos particularly have been highlighted as excellent resources, there is clearly more work to do.

Cementing practice! Much of the change, for example, the establishment of the MDTs, outreach provision of wound clinics at The Gathering Place and Union Street was both organic and dynamic with individuals driving the change. There is a concern that if these positive developments are not built into operating systems and commissioning arrangements then, particularly in light of the challenging financial climate, they could fall by the wayside.

Two very specific concerns raised were the closure of 42 Market Street which was a valued resource, the second was a concern that a Dual Diagnosis continues to be a bar to accessing services.

What needs to happen?

Overwhelmingly the feedback was to keep doing more of what is working well, to build on the positive changes that have already taken place. Outreach services and the development of 'Navigator" roles have made a significant impact on the lives of not only theses living street based lives, but those with multiple and complex needs that so easily could become homeless.

There is a need to embed processes, for example the MDT, but also to review existing pathways, identify gaps, create new pathways and jointly commission new services to ensure a comprehensive service provision. There was a fear that we may be duplicating services, but more of a concern is that potentially people could still fall between the gaps.

We need to identify any barriers to effective treatment for those with a Dual Diagnosis and ensure theses are remedied.

An overarching Partnership Begging Strategy would ensure that all agencies and the business community are pulling in the same direction and working effectively to reduce the need for begging, rather than unintentionally exacerbating it.

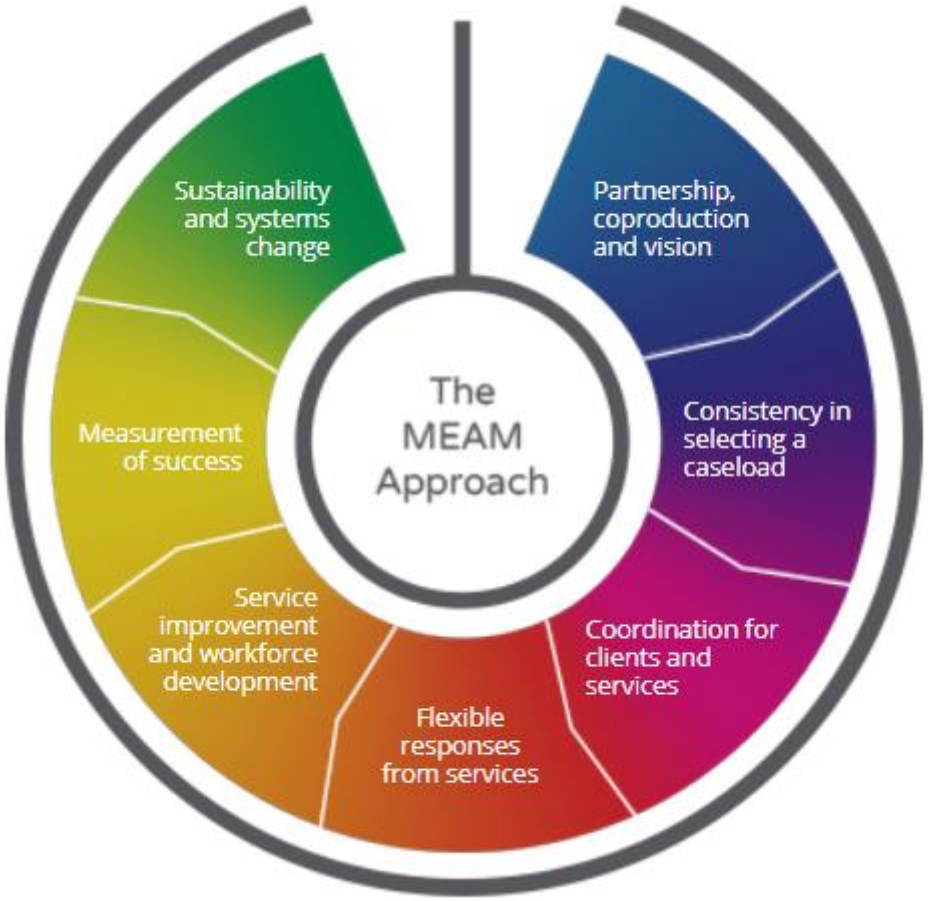
We need to continue to raise awareness, provide training for the front line and ultimately change culture. The development of a public Helpline would be a really positive step forward in meeting the needs of those people living street based lives.

Next Steps

Progress will continue to be monitored through the SAB SAR Group and detailed in the Building Bridges Action Plan. Improvement, further changes and any agreed procedures, protocols and pathways will also be evidenced in this Action Plan, and reported through to the Safeguarding Adult

Board, to Adult Scrutiny, and through individual agency chains of command, along with any obstructions to services achieving effective multi-agency responses to people who have complex needs.

The Making Every Adult Matter Group in Calderdale will lead the operational work. This MEAM multi-agency partnership approach helps to deliver better coordinated services for people experiencing multiple disadvantages.



5.2 The Impact of Learning & Improvement

e-Learning

A total of 5201 e-learning training was completed in 2022-2023 which is an increase of 826 from 2021-2022.

Face to Face Training

915 places were filled on live sessions 2019-2020
202 places were filled on live sessions 2020-21
927 places were filled on live sessions 2021-22
1030 places were filled on live sessions 2022-23
Learners are invited to complete evaluation questionnaires for all face to face or live online courses by returning to the LMS platform and updating their learning record and obtaining their certificate. Q4 saw an increase in evaluations being completed by learners from 40% to 49%.

Evaluation reports of the full years training have been shared with the providers of each session to analyse and develop the content for the 2023-24 year programme.

Feedback from participants includes:

Has this event changed your skills and knowledge of this subject?	Q1	Q2	Q3	Q4
Improved a lot	13	27	51	45
Improved quite a lot	24	29	56	53
Improved a little bit	16	8	25	18
Not Improved	0	1	1	0

Some of the 'best' parts of the training included the following quotes from attendees:

- It highlighted that coercive control isn't always male on female although the majority is, there are mixed relationships which were presented and resulted in deaths.
- how to look at the issues what the issues could be as there could be more than one and with more of the family and outside influences. how to work in partnerships with other organisations,
- The amount on information shared from the amount of people on the course.
- Highlighting that in our role we must stay curious and communicate any information to the correct agencies.
- The application of legal obligations to practice and the issues around this.
- The depth of knowledge and experience by all the speakers throughout the day. They didn't skim over any topic and showed great understanding of all the different topics which were covered.
- The wording when speaking to people. looking at words in general how people can see them differently.
- Self-reflection that came from attending. Hearing the lived experiences of the individuals from those that knew them was very emotive but important to hear. I was able to draw on my own ethics and values which are informed by the Human Rights Act 1998, respect and dignity of those I work with.
- The opportunity to hear from others in different fields about their opinions.
- The difference between low mood and depression
- Knowing that my organisation does things right.
- It was full of extra information and strategies which I was surprised about.

- Very accessible, a complex and wide- ranging area made more understandable - the presenters did well to highlight some of the key facts. Some were hard hitting but illuminating.
- The video content and the knowledge of the trainer delivering.
- I was able to identity roles within the services which I can now referred too. Also seeing how similar anxiety symptoms and the physiological function that is behind the effects is the same as trauma.
- It was informative and interesting. It helped me to realise a lot of the information I already had so gave me the confidence and reassurance. of my own knowledge and understanding.
- Understanding more from what people can endure and how it effects the way they make choices for themself.
- It not only touched on children but how adults can be very effected by online/social media overload too.
- I became more knowledgeable on certain things that never occurred to me prior to the training. I found it both interesting and insightful.

Quotes from attendees about how practice will change as a result of attending training included:

- The notion that we are sometimes colluding in hiding people who don't want to be heard, just by not being curious...or curious enough.
- how people are affected by childhood trauma
- In the past when I have previously been a little unsure on the next step, this gave me more confidence knowing where to go to seek more advice.
- I loved the point made- Every interaction is an intervention.
- That it doesn't need to be difficult or awkward to offer support.
- Understanding physically how the brain is affected by trauma.
- The impact of trauma on young people and adults and how this impacts decision making
- To identify how anxiety can affect the body, thoughts and behaviours and spotting the warning signs early.
- Not being afraid to challenge/question decisions or observations for the fear of being accused of being racist. Professional curiosity should be guided by my knowledge which is supported by evidence and sound professional practice. This curiosity should then lead me to feel confident in questioning things that do not appear right.
- I will view DA victims differently. Their world of chaos and fear will have significant impact upon their decision making.
- Prioritising supervision, and ensuring it is seen as an integral aspect of the organisations culture.
- To slow down when completing assessments, so that an honest & trusting relationship can be created to be able to gather more information.

Some quotes from attendees demonstrating different thinking prompted by the training:

- Will be more open to listening.
- To look for signs of trauma I found the hyperarousal an interesting sign that I had never thought of
- Hypothesise more in order to get answers.
- Recognising the signs more effectively

- I will be more vigilant and also pass on what I have learnt to friends, family and the people I will be working with.
- Be more open with my team, never think I am asking any silly question and always include the management.
- Professional curiosity is paramount.
- use the Day in the life Tool kit more.
- Disguised Compliance is used too loosely, and we need to re frame our thinking around this.

Secondary Evaluation

An online survey has recently been created to promote secondary evaluations. This is follow-up from training activity weeks or months after, to establish any impact or further embedding and to seek assurance that the training is having the intended and desired impact on practice, confidence and outcomes for families. The courses where responses were received were from Safeguarding Supervision, Working with Resistance and Professional Curiosity, Safeguarding Adults and Self-Neglect, Burnt Bridges Briefing.

The received evaluations provided evidence of improved operational practice as a result of the training and most people remembered some key elements. 100% would recommend the course to a colleague and 89.4% felt it had been relevant to their role.

Issues of attendance and late cancellations continued to be an issue throughout 2022-23 and so the charging policy was re-introduced in April 2023 to combat this. If applicants do not attend or cancel within 24 hours of a course, they will incur cancellation charges.

Additional Training for 2023 - 2024

Organisations have been requested to undertake and produce workforce development strategies which are ambitious, and which meet the needs and demands of Calderdale safeguarding issues, which reflect the learning from safeguarding adult reviews and are focussed on the known areas identified for improvement across services. Training on trauma informed practice and on cultural awareness and competencies will continue.

5.3 Safeguarding Week

Figure 1 Calderdale Safeguarding Week Logo

In June 2022, Calderdale held its third virtual safeguarding week following the success of the previous 2 years, but also because of continued high levels of Covid-19 at the time.

The week included a different theme each day:

- Monday: Neglect
- Tuesday: Hidden Risk
- Wednesday: Resistance and Engagement
- Thursday: Trauma
- Friday: Safe Nights

The virtual programme included a launch event which was well received, with approximately 42 participants attending the introductory messages.

As well as over 20 online learning sessions with more than 300 people attending during the week. One session was hybrid where participants could either attend the face to face venue or join online, and one session was face to face only. There was access to live chats, podcasts, research reports, academic articles, resources, useful links, and videos aimed at practitioners and managers which were available via Calderdale Safeguarding Children Partnership and Safeguarding Adult Board website. Contributions were received from across the multi-agency partnership and included a good mix of resources for practitioners who work with Children and/or Adults.

The week prior to Safeguarding Week 2022 was impacted significantly when the Councils servers were upgraded the week before launch. The consequence was severe disturbance to users outgoing emails across the network.

Analytics from the CSCP/CSAB website showed that there were 305 visits from the 'go live' date, to one week after the event. Social media impressions across twitter and Facebook showed that the number of visits across social media was down dramatically from previous years.

- Combined impressions for twitter and Facebook 18193 Impressions
- Combined engagements 181 for twitter and Facebook

The total number of Twitter impressions was 7863 and engagements was 101; the total number of Facebook impressions was 10330 impressions, and engagements was 80.

Smart Survey was used to gather evaluation from practitioners about the live sessions, videos, and resources available and the virtual method of learning, receiving 39 responses in total. Overall, the virtual week was evaluated as very positive; practitioner knowledge increased because of accessing the live sessions, and practitioners said it would enhance their practice now, and in the future.

Evaluation has shown that virtual learning works well for those with busy schedules but that you do not have personal interactions that face-to-face events offer. Suggestions of how to improve future Safeguarding Week programmes included considering spreading the events out over a longer period,

not just a week, allowing a break between sessions, and being more careful with the timing of sessions to avoid overlaps.

National Ann Craft Safeguarding Week

It was agreed by the Calderdale Safeguarding Adults Board that the members would support national Safeguarding Adults Week in November 2022 which aimed at raising awareness of safeguarding adults and provide sessions related to the recent local reviews.

All members were given the opportunity to provide resources and events which combined to offer a programme across the month of 15 events.

The programme consisted of:

- 4 Lunch and Learn event briefings on the recent Mr C and Mr D Safeguarding Adult Reviews, Mr E Rapid Review and the 'Jackie' Domestic Homicide Review.
- 'Burnt Bridges' learning briefing.
- Alcohol Brief Intervention training to frontline staff
- Positively Working with Adults with Mental Health Issues by The Yorkshire and Rural Teaching Partnership
- A series of 'Ask Me Anything' events were offered on various aspects of mental capacity.
- Mental Capacity Act training to frontline staff by Calderdale Council MCA Team.
- Domestic Abuse – Recognising Coercive Control delivered by Calderdale Staying Safe service.
- Working with Resistance and Professional Curiosity - delivered by Social Care facilitated.
- The Safeguarding Adults Board Annual report was presented to Scrutiny and the SAB also held its Development Day.

The events were evaluated through an online survey. 32 responses were received. 59% rated the programme as extremely good. Lunch and learn sessions were tested out during the month and were well received.

68% preferred the programme being delivered over a longer period of time. 78% of people were able to attend all the sessions they wanted with it being delivered over a longer period of time.

Further feedback included making improvements to the booking process, provide recordings of the sessions for those not able to attend and more training on executive capacity.

Recommendations for future safeguarding week programmes:

- Earlier start to planning and include comms teams.
- Keep a manageable number of sessions running in light of the feedback that practitioners couldn't get to many sessions.
- Include lunch and learn sessions throughout the year.
- Have pre-recorded sessions to enable practitioners to access when they are free.
- Launch / key messages from SAB leaders.
- Improve evaluation survey using enable.

6. Performance and Quality Assurance

6.1 Data

The intelligence and data the Bord has collated, provided comparisons for and scrutinised has not changed as much as the SAB has intended it to do. Although Adult Services & wellbeing and other partner agencies are contributing to the change to practice, thresholds and how safeguarding enquiries are raised and dealt with, things haven't improved as much as we liked because the pace of change hasn't been there. However, the SAB appreciates the complexity of the task and how new IT systems, remodelled front door, threshold document consultation and structure transformations take time to change and embed.

The number of Safeguarding Concerns reported in Calderdale in 2022-2023 was 4862. This is an increase of 1000 from the previous year and is the highest rate recorded. The number of concerns which met the Section 42 criteria in 2022-2023 was 2774, an increase of 300 from the previous year but disproportionally a lower %. Comparator data for Y&H shows significantly lower numbers of both (further details feature later in the report). 128 of the 2774 referrals which met the Section 42 criteria progressed to a Stage 2 Enquiry.

Table 1: Number of Safeguarding Concerns and S42 Assessments

	2015 /16 YE	2016 /17 YE	2017 /18 YE	2018 /19 YE	2019 /20 YE	2020 /21 YE	2021 /22 YE	2022/23				
								Q1	Q2	Q3	Q4	YE
Number of safeguarding concerns reported	1787	2734	3259	3770	4606	3458	3820	1217	1164	1290	1191	4862
Number of concerns meeting S42 criteria*	-	-	-	-	-	-	2473	769	669	736	601	2775
Number of concerns not meeting S42 criteria	-	-	-	-	-	-	915	432	481	484	378	1775
Number Blank concerns (Snapshot at 31/3/23)							432	8	13	60	181	262
Comparator data: (Per 100k population) Calderdale CIPFA Yorkshire & Humber England		1676 927 981 839	1996 974 904 902	2302 1132 1047 943	2627 1185 1094 1074	2087 1167 1066 1121	2311 1294 1227 1218					
No of concluded S42 Enquiries							1953	617	465	528	331	1941

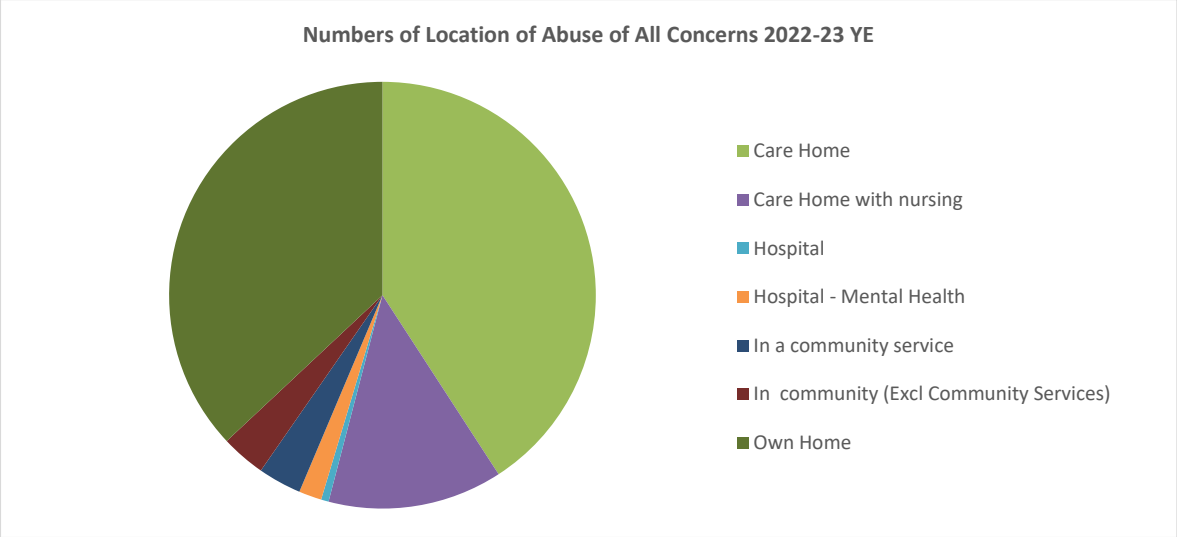
CIPFA = Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbour
Ethnicity: As used in the SAC data *Q1 data New screens 820, Old screens 123
***Q1 2021/22 doesn't include any S42 data from the old screens**
For the data from new screens there are Blank Concerns where it isn't known whether they are S42 or non S42

Throughout the years we continue to receive a high number of safeguarding concerns, many of these concerns are low level safeguarding concerns that have required a stage one enquiry.

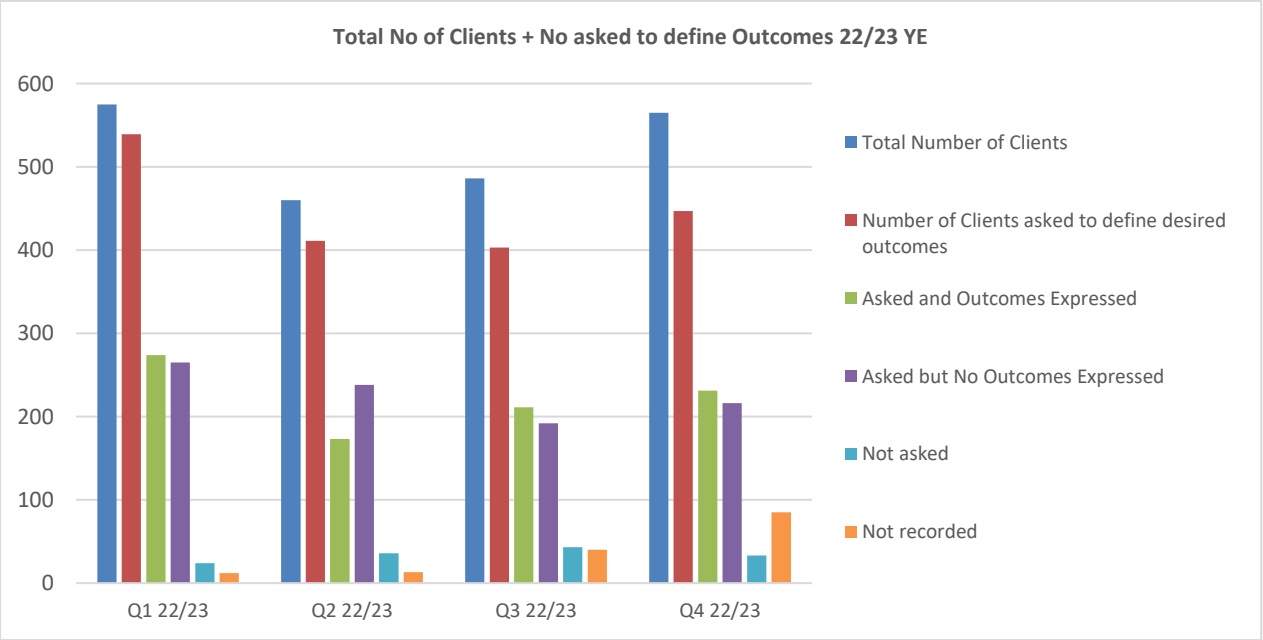
The number of safeguarding concerns reported for people living in care homes is the highest location which is usual given the structure of the Safeguarding Adults team who respond only to concerns relating to care homes and the preventative work which has encouraged low concerns over

previous years and this year. There has also been several Care Home closures in this year period, which resulted in an increase in safeguarding concerns. This year the number of concerns reported for people living in their own homes in the community has increased in comparison to previous years.

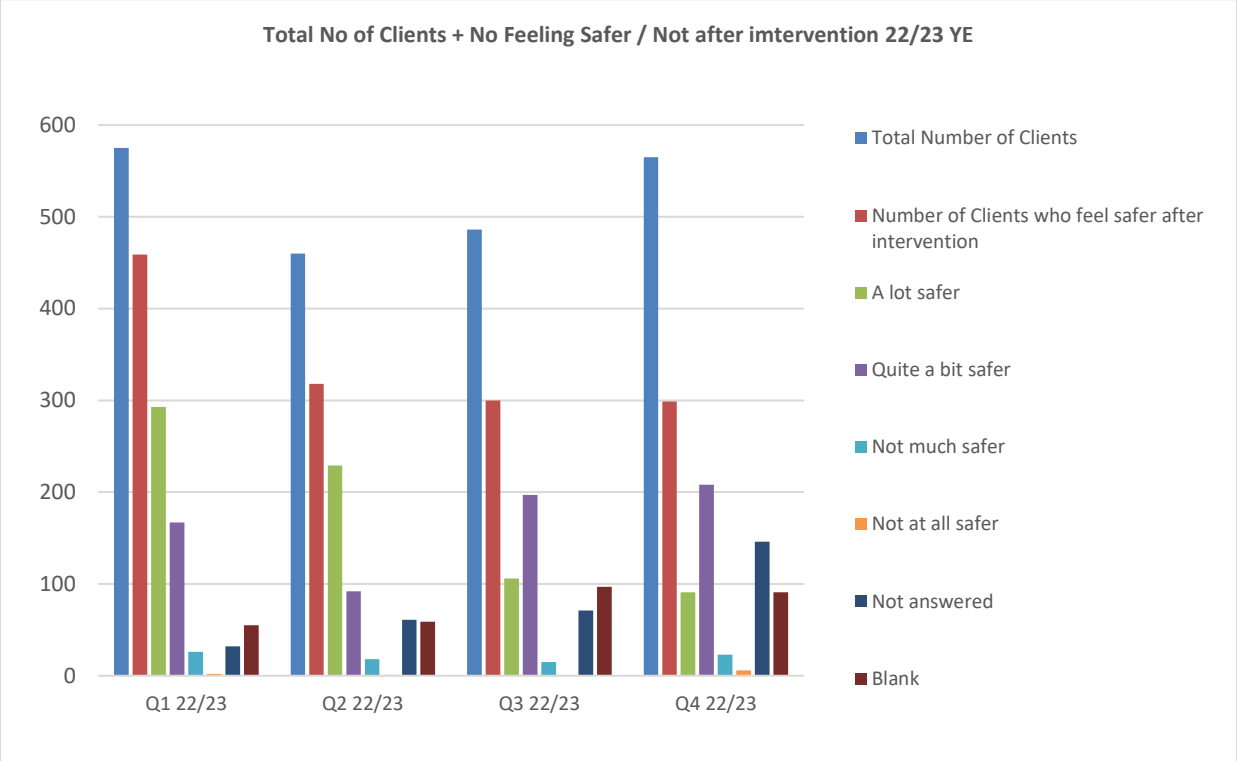
Over 50% of concerns raised and 75% of Section 42s were from Care Homes or Care Homes with Nursing. 40% of concerns were in the adult's own home, which was 20% of the total Section 42 numbers. Around 6% of concerns were from the community which was 3% of the total number of Section 42s. Neglect, physical and organisational are the main/highest figure of types of abuse reported with the majority of these being related to Care Home safeguarding concerns.



There was a reduction in the number of people asked to define their desired outcome of the safeguarding intervention from 2021-22 and a very small reduction in those feeling safer as a result of intervention to 77%. 97% of people stated that their safeguarding outcomes were fully or partially met.



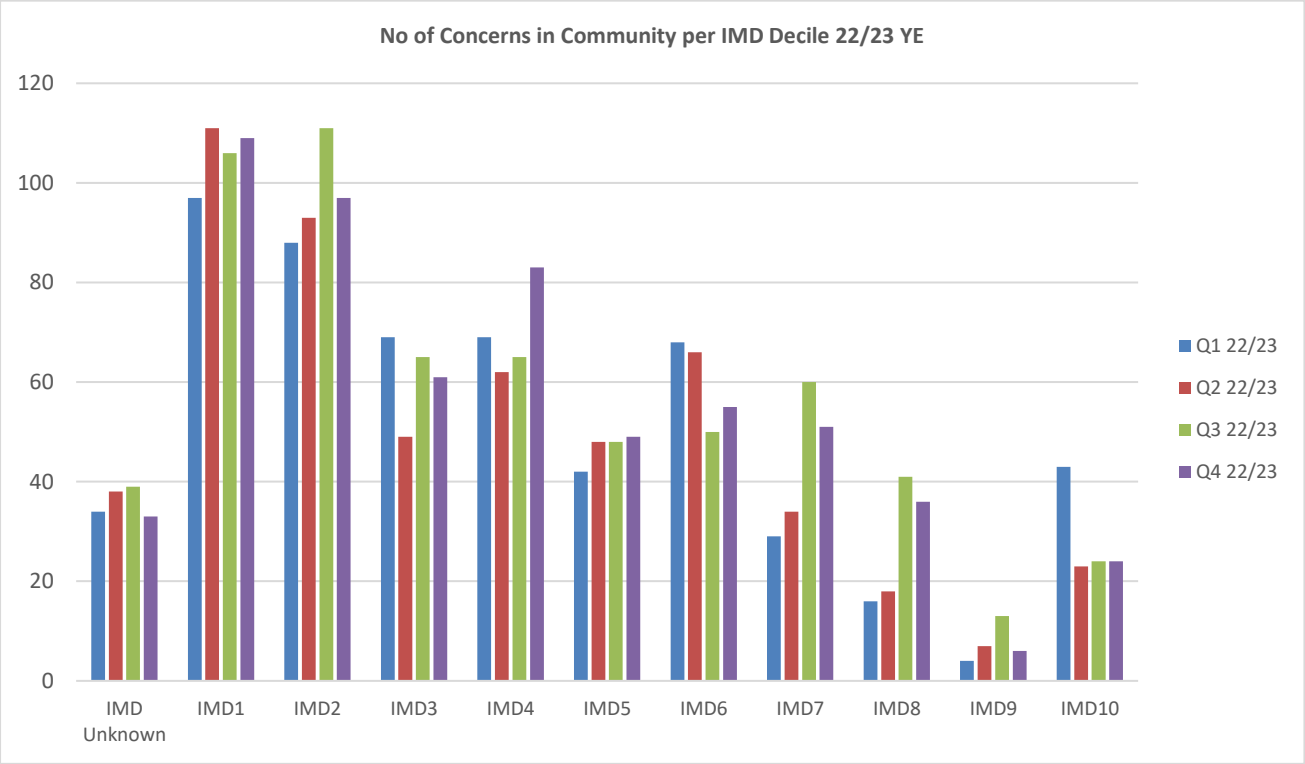
Reviews highlight that a significant number of people are satisfied with the outcome of the safeguarding enquiry, and that their outcomes have been achieved. This is recorded within an MSP questionnaire as part of safeguarding enquiry and conclusion.



There was a slight drop in the percentage of mental capacity assessments completed for safeguarding concerns to 43% in 2022-23. In over ¾ of concerns the person lacked capacity to make decisions about the safeguarding process, although this fell to 56% of those assessed as meeting the s42 criteria. Most people who lack capacity to make decisions about their safeguarding needs receive support from friends / family with only 25 individuals accessing a paid advocate with a number of people who lacked capacity and did not receive any advocacy support – this will be looked at in more detail and actions taken to address.

Data shows an increasing number of Deprivation of Liberty Safeguards (DoLS) applications made in 2022-23 and a small reduction in the number of applications completed. There has been a rise in the number and percentage of DoLS applications not granted (65.6%) and a greater number of people DoLS awaiting completion. After the recent announcement that the implementation of the Liberty Protection Safeguards has been postponed indefinitely and the DoLS process widely viewed as overly burdensome and under resourced, the Calderdale MCA Local Implementation network will consider ways to mitigate system risks of unlawful deprivations of liberty occurring.

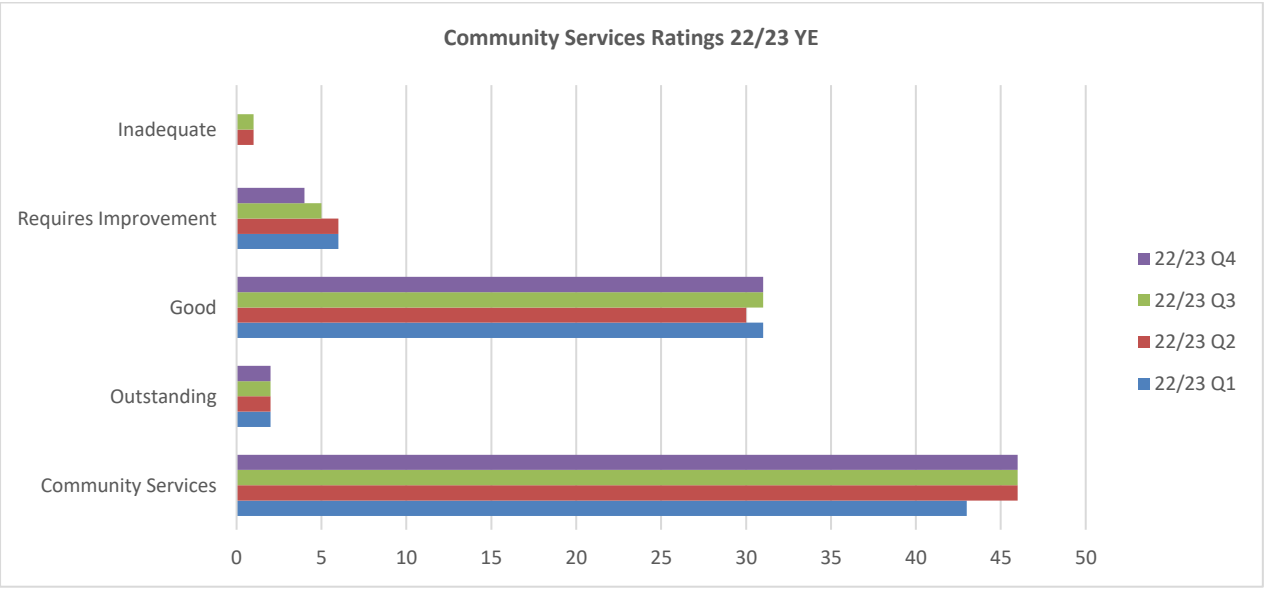
Safeguarding concerns in the community linked to the Indices of Multiple Deprivation



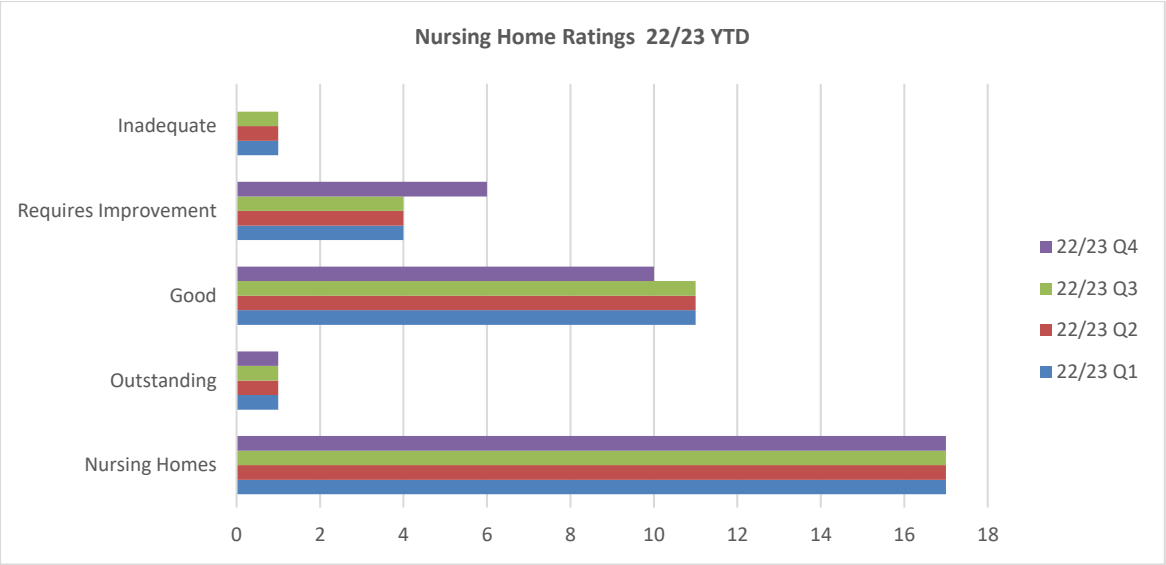
Further analysis of the number of safeguards concerns and numbers of s42s plotted against indices of multiple deprivation has taken place. Due to the number of confounding factors (e.g., location of supportive living placements, age profiles in IMD area) drawing conclusions has been tricky. Overall, the areas with the highest indices of multiple deprivation (1-5) have the highest numbers of safeguarding concerns.

CQC ratings

There has been a slight increase in the total number of CQC registered Regulated Providers over the last 12 months. The main change has been evident in community-based services. The total number of nursing homes have remained static, with a variance of +/-1 for residential homes.

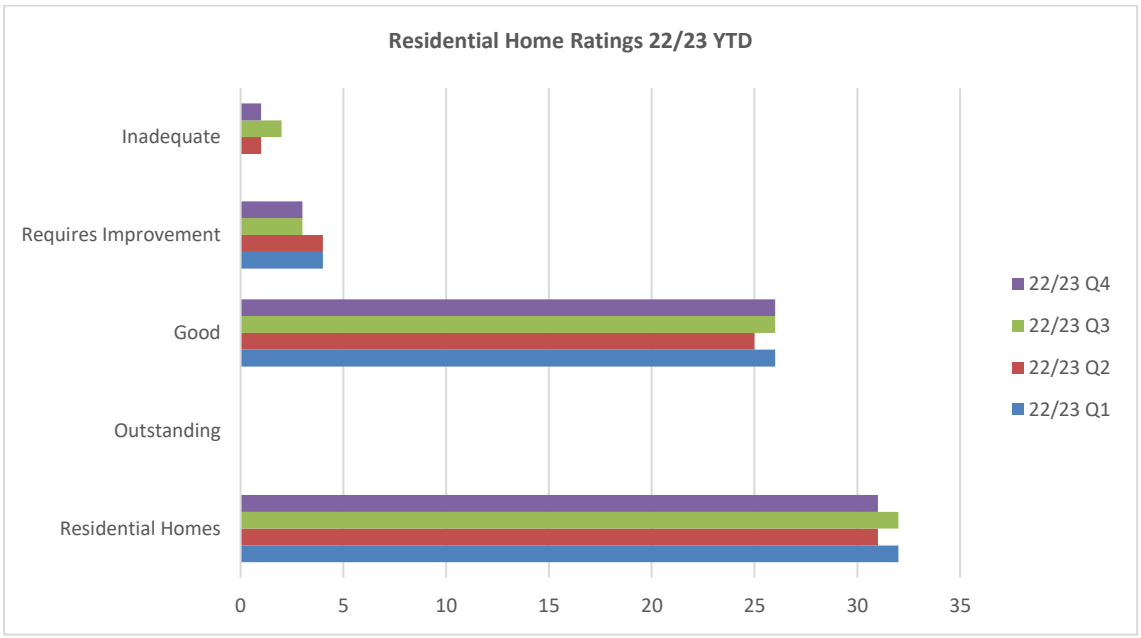


The CQC have been focusing inspections by responding to risk and improvement inspections where there is intelligence that services have improved, and the rating is no longer reflective of the service.



Current themes, trends, and challenges:

- Workforce shortages i.e., staff vacancies and the retention and recruitment of more care workers. Sickness, vacancy, and turnover rates are having an impact.
- Some homecare providers are handing care packages back to local authorities and a reduction in hours of homecare due to severe staff shortages.
- Services for people with learning disability and who are autistic– areas where our inspections have found issues with culture, leadership, and engagement with people who use services.
- Financial viability is an issue for some providers.



6.2 Data, Performance Assurance and Intelligence

Objectives at the start of the year

- Address new and emerging vulnerabilities / safeguarding issues.
- Strengthen Multi-Agency Safeguarding Work: MASH, Thresholds, Common language.
- Work with the Calderdale Safeguarding Children Partnership to review Transitional Safeguarding Arrangements in Calderdale
- Assurance of the effectiveness of PIPOT procedures
- Complete the Organisational Safeguarding Assessment for 2023

What the group did and what went well

- The group have continued to collate and analyse partnership safeguarding adult data. The data set has expanded and includes trends data. Findings, risks, and mitigation are reported to the CSAB.
- The changes to the CIS system at the beginning of 2022/23 has meant that the data shows much more detail about the journeys of the adults at risk, through the assessment of concerns and the speed of how interventions are carried out. This allowed more analysis to be undertaken to ensure operational teams understood the impact of their processes.
- Comprehensive comparative data was presented at a CSAB Development Day which highlighted areas of good performance and where Calderdale was an outlier. This along with the continued collation and analysis of partnership data influenced a decision to:
  - expand the CMBC safeguarding team,
  - join together community and care home safeguarding teams,
  - agree to produce thresholds guidance for safeguarding and the interface with quality / contract monitoring.
  - agree to work towards a multi-agency safeguarding hub.
- Data on safeguarding concerns raised, and those accepted as s42, have been overlaid with deprivation data and have been analysed to better understand any inequalities and to better inform service response.
- The annual Organisational Safeguarding Assessment (OSA) has been completed for 2022: assurance and areas for development received from all agencies. An OSA will be carried out for 2023. The OSA will be revisited to assess if improvements have been made.
- The Large Scale Enquiry Policy to address institutional abuse has been developed and agreed by the CSAB.
- The introduction of the Making Safeguarding Personal data capture has shown a good overview of how that process is carried out by the Adult Services and Wellbeing teams.
- The introduction of Power BI allows a more accurate and more easily accessible picture of the data to be presented at each quarter.

Any barriers or what you didn't manage to achieve and why

- Operational pressures from all agencies have meant that some multi-agency audits have not been completed as planned.
- It was decided that the Children's Safeguarding Partnership would initially lead on assurance of transitional safeguarding arrangements. A joint development day has been agreed to further explore the role of CSAB in this.

- Agency commentary on their safeguarding data and plans to address issues has been inconsistent due to agency capacity pressures which could be directly related to post-covid impact and the cost of living crisis. A review of the dataset has been undertaken to ensure what the CSAB is asking for is relevant and meaningful to further streamline the requests for data.

Any impact on practice, services, joint working arrangements or directly on adults, families or communities

- Greater multi-agency understanding of thresholds for safeguarding and the interface with quality and contracting.
- Data shows that a high percentage of people who receive a safeguarding response have their outcomes met, feel safer following intervention, and receive advocacy support throughout the safeguarding process.
- Agency awareness of self-neglect has led to increased safeguarding concerns in this area.
- Unsafe discharges from hospital have reduced significantly.

Present or Future Risks / Anticipated Future Direction:

- The cost-of-living crisis and increasing poverty and inequalities are likely to result in increased incidents of abuse and neglect, with financial abuse and self-neglect being key areas to track during 2023-24.
- The government decision not to implement the Liberty Protection Safeguards means that the "overly complex" Deprivation of Liberty Safeguards remain in place with insufficient resources to ensure that people are not unlawfully detained.
- Agency's' operational capacity pressures sometimes mean that audit Action Plans are not actioned as quickly as we would like, meaning that the implementation of learning is delayed.
- Continued work on analysing safeguarding concerns related to poverty and indices of multiple deprivation.

6.2 Engagement with Service Users, Families and Communities

A new Safeguarding Engagement sub-group has been set up to capturing the voice, view and experiences of service users, their families and the front line staff who support them. The group will continue to build on gathering voice, and tyring to ensure this influences and contributes to the coproduction of safeguarding interventions in Calderdale.

The group includes representation from a wide breadth of agencies including statutory and voluntary sector:

- Adults Services and Well-being
- Advocacy services within the Council
- CVAC – a local charity supporting voluntary and community sector groups
- Happy Days a charity supporting people who are homeless or in crisis
- Health Watch
- Integrated Care Board, NHS
- Independent Reviewing Service, CMBC
- Independent Visitor & Volunteer, CMBC

- West Yorkshire Police
- Public Health
- Together Housing
- Youth Voice Service

Each member is expected to contribute to the subgroup with the voice of children, young people, families, adults at risk, carers and the wider community. The focus of the group is on safeguarding identification, intervention and on the impact of services on lives.

Standing agenda items include:

- Personalised Safeguarding Stories from agencies featuring positive practice, barriers, and stories which need to be studied to gain learning.
- Themed complaints or compliments.
- What's keeping people awake at night – members will seek views.
- Communication / information sharing.

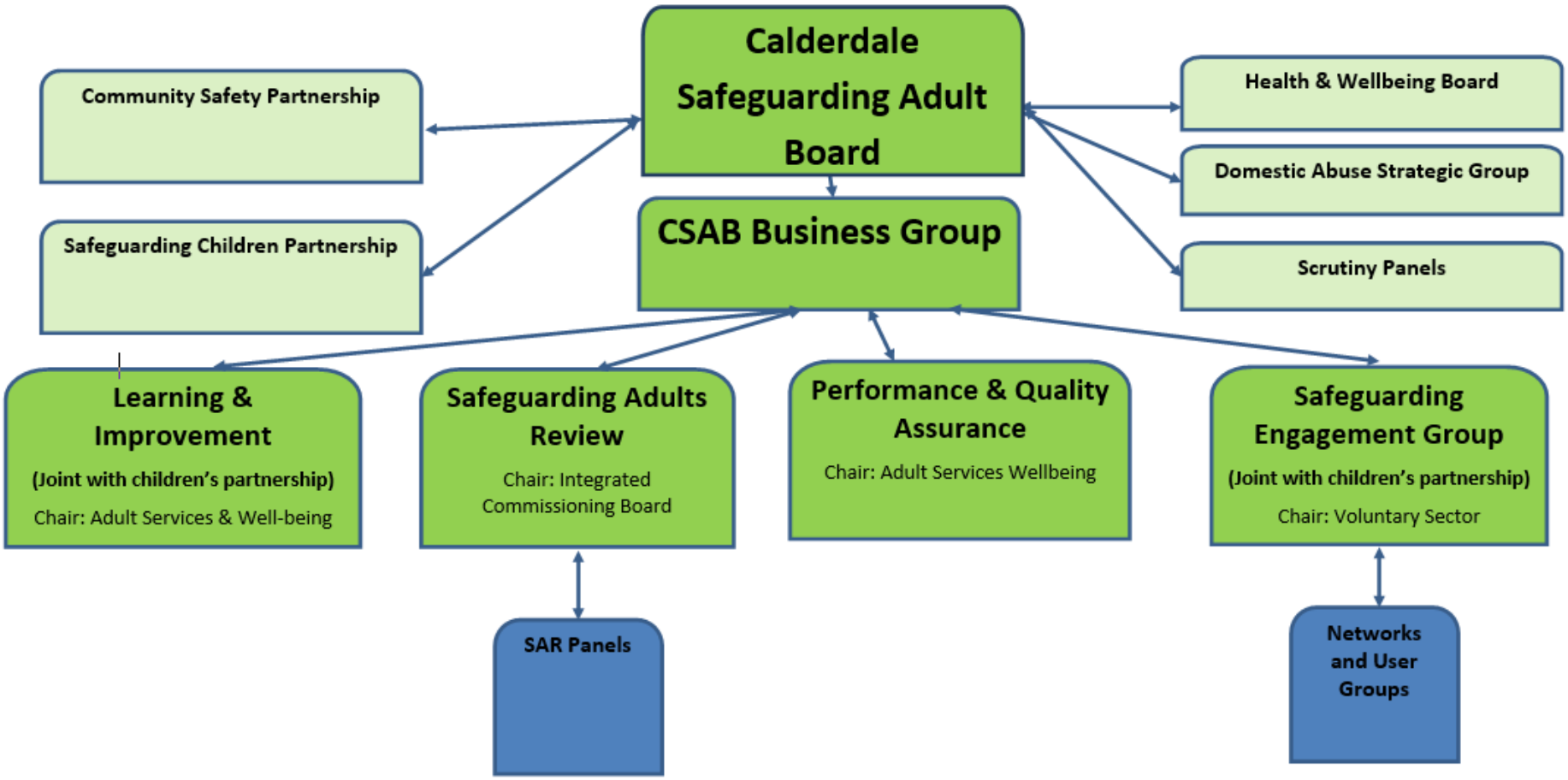
The chair of the group is from the CVAC, a charity championing, supporting and strengthening the positive impact of the voluntary and community sector on local lives and communities.

7. Areas identified for increased focus during 2023 and beyond.

The Calderdale Safeguarding Adults Board, through the work done to review, quality assure, data collation and analysis, intelligence and from feedback from service users has identified that the following areas will be scrutinised and supported through CSAB activity in 2023 and beyond.

- Strengthening multi-agency working through the development of a multi-agency safeguarding hub (MASH), agreeing safeguarding thresholds and clear pathways of support for adults at risk of abuse or neglect.
- Focussing activity on how we seek assurance about the outcomes of people who have had safeguarding interventions. Including through data, audit, review and feedback from service users, carers, families and communities.
- Encouraging ambitious Workforce Development Strategies which are reflective of the local areas for improvement identified in review, audit activity and through self-assessment.
- Organisational awareness and competence in the different cultural values and beliefs in Calderdale, and a recognition of any work needed to be done to address any inequalities. A respectful and culturally sensitive approach which is responsive to the beliefs, practices and cultural and linguistic needs of the diverse communities in Calderdale.
- More regional policies and procedures which are more aligned with neighbouring authorities aiding how organisations with wider footprints are able to respond to more seamlessly and effectively to safeguarding concerns.
- Continued exploration on the impact of covid, the cost of living crisis, and the risks associated nationally recruitment, retention and expertise across care health & care settings.
- Transitions – joint work with the Calderdale Safeguarding Children Partnership who are leading the strategy around 'Risk and Vulnerability in Adolescence' in Calderdale.

Appendix 1: Safeguarding Adult Board Structure Chart



Appendix 2: CSAB Members

a) Adult Services and Wellbeing

The Local Authority Adult Services and Wellbeing Directorate has divisions – Social Care Operations and Commissioning. Social Care Operations has three broad functions:

- Prevention. For example, Gateway to Care, Safeguarding and Hospital Social Work.
- Long Term Support. For example, Social Work Practice and Locality Teams.
- Direct Service Provision.

As we all continue to face challenges following and within the impact of unprecedented times including the Covid pandemic and current cost of living challenges; we continue to work together to try to build healthier and happier futures for people living in Calderdale and especially for those with or facing vulnerabilities. Whilst there is an increasing demand, we strive to ensure that people contacting Adult Services and Wellbeing feel that they have been listened to and are shown kindness and are supported in the way that benefits them to help reach positive outcomes together.

We have had access to more and improved data by having fully embedded and reviewed our newer safeguarding information systems. This enables us to monitor the types of safeguarding concerns, enquiries and measure outcomes and professional practice across our services. There has been and is further opportunity to use this information to review the standard of safeguarding work and most importantly people's experiences to identify areas for development and improvement.

Adult Services and Wellbeing are embedding new local policy and procedures including a large-scale enquiry protocol and Person in position of trust protocol. Both of these provide a clearer guide for practitioners with access to tools to ensure that any large-scale safeguarding or employer related concern is responded to effectively.

Adult services and well-being focus on the safeguarding principles and ensuring these are applied within our safeguarding work with people. Now that the Safeguarding Adults team is structured within the Prevention and Early Help service; we are continuing to build the team by increasing the staffing size and redesigning the functions so that the response to safeguarding concerns are the most efficient and effective. This will help with consistency, timeliness and prevention which is key to reducing future risks.

A key focus over the past year has been promoting 'Making Safeguarding Personal' to support outcomes focus and person led approach to Safeguarding Adults. Recognising the importance of safeguarding and also the challenges people face; we aim to ensure that the person and their families and carers feel that the response has been managed in the best possible way to engage people and promote choice and control whilst improving quality of life, wellbeing and safety.

Whilst moving towards a closer Multi-Agency Safeguarding Arrangement the safeguarding operational and strategic leads within Adult Services and Wellbeing are committed to working closer with our partner agencies within the Safeguarding Adults Board. We will plan and embed future partnership working and demonstrate the effectiveness of this including improved information sharing, robust risk assessment, joint decision making and coordinated action which ultimately leads to improved safeguarding practices offering people more effective support.

b) Calderdale Clinical Commissioning Group – (CCG). (West Yorkshire Integrated Care Board – Calderdale Care Partnership as from 1st July 2002)

An Integrated Care Board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

The NHS West Yorkshire Integrated Care Board (WYICB) became a statutory organisation on the 1 July 2022 as part of the Government's new Health and Care Act.

The WYICB has 4 aims:

- To reduce health inequalities
- Manage unwarranted variations in care.
- Secure the sider benefits of investing in health and care.
- Use our collective resources wisely.

The WYICB has a legal responsibility to ensure that the principles and duties of safeguarding children and adults at risk are fulfilled for both the WYICB and the providers through which it commissions services. The WYICB is one of three statutory partners on the Calderdale Safeguarding Adult Board (CSAB).

The WYICB is made up of 5 placed base partnerships: Calderdale, Kirklees, Bradford, Wakefield and Leeds. The placed based partnership in Calderdale is called the Calderdale Cares Partnership (CCP) and has a shared safeguarding team with Kirklees Health and Care Partnership. We come together with other safeguarding teams in the WYICB to deliver of aspects of work that make sense to do at scale. Formal governance arrangements are established at both Calderdale and West Yorkshire level.

The West Yorkshire Integrated Care Board safeguarding team's work encompasses a range of workstreams including Child and Adult Protection, Mental Capacity Act, Deprivation of Liberty Safeguards, Domestic Abuse, Modern Day Slavery and Human Trafficking and Prevent.

Key achievements of the WYICB and Calderdale safeguarding work for 2022- 23 include:

- Established formal safeguarding governance and assurance mechanisms as part of the transition from Clinical Commissioning Groups to the West Yorkshire Integrated Care Board.
- Calderdale Cares Partnership, in partnership with other safeguarding teams across the WYICB, has developed Safeguarding and Mental Capacity Act standards to seek assurance that commissioned providers across Calderdale and the rest of West Yorkshire continue to prioritise and deliver safe and effective systems for safeguarding. The returns from commissioned providers have provided a good level of assurance and have identified key areas for future development.
- Provided safeguarding assurance to NHS England and received feedback that the safeguarding arrangements in West Yorkshire are robust.
- Continued representation at regional and national forums including such as the National Designated Professionals Network and Safeguarding Adults National Network to support the dissemination of key information locally and within the West Yorkshire Partnership.

- Active involvement and leadership in safeguarding related partnerships including the Domestic Abuse Strategic Board, Community Safety Partnership, Governance and Assurance Board, Suicide Prevention Group.
- Provided expert health input into Safeguarding Adults Reviews and Domestic Homicide Reviews: ensuring that any learning is shared quickly to protect children or adults who may be at risk. The WYICB Safeguarding Team have continued to support the work on these cases throughout the year.
- Ensured that WYICB staff receive the appropriate level of safeguarding training.
- Facilitated training sessions on the CSAB Multi-agency training programme.
- Supported primary care and other partners with pertinent safeguarding information: including 7 minute briefings (quick reference guides) on priority and emerging areas of safeguarding practice.
- Delivered a series of Mental Capacity Act (MCA) expert level training sessions for Senior Managers, MCA leads and supervisors.
- The CCG has established and led a Liberty Protection Safeguards (LPS) Local Implementation Network that brings together Responsible Bodies across Calderdale. This group aims to ensure that the health and care system across Calderdale can successfully implement the proposed replacement for the Deprivation of Liberty Safeguards.
- Continued to run the Health Alliance network which brings together specialist safeguarding practitioners from Calderdale, Wakefield and Kirklees to share learning.
- Facilitated a region wide Prevent Conference for health leaders.
- Continued to develop and deliver quarterly GP safeguarding leads meetings.
- Delivered a half day training session on a variety of safeguarding topics all GP practice staff.
- Supportive safeguarding advice: The WYICB Safeguarding team offered advice to support professionals in the Calderdale Cares Partnership, primary care, staff in commissioned health providers and wider safeguarding partnership.
- Produced guidance for Calderdale Council on when and how to access expert health support into complex safeguarding enquiries.
- Leadership and involvement in all CSAB subgroups and Business Group. The WYICB Designated Nurse chaired the Performance and Quality Subgroup.
- Leadership and involvement in the development of an adult safeguarding threshold tool as we work towards a Multi-agency Safeguarding Hub.
- Re-written with Calderdale Council the CSAB Large Scale Safeguarding process to manage allegations of institutional abuse.
- The close association between inequalities and abuse and neglect means that the safeguarding team have a strong focus on reducing health inequalities. In addition to its core safeguarding work the team work closely with other WYICB teams and partners in Calderdale and across West Yorkshire to use commissioning and service development levers to reduce health inequalities, with a particular attention on those who face multiple disadvantages.
- Commissioned trauma informed training for all GP practice staff in Calderdale.

c) West Yorkshire Police

West Yorkshire Police remain committed to delivering the best possible service to the public of Calderdale and to protecting those most vulnerable within society.

Safeguarding the vulnerable remains a key priority for West Yorkshire Police, Calderdale District, and myself personally as District Commander.

We look forward to continuing the fine work undertaken with our partners to ensure Calderdale has a collegiate, effective, and compassionate multi-agency response to safeguarding adults.

Our key achievements include:

Calderdale District's response and performance to emergency and priority calls remains impressive, we respond to calls swifter than all other Districts within West Yorkshire. This ensures we are in the best position to address immediate safeguarding concerns, maximise evidential and investigative opportunities.

Calderdale District continue to have strong criminal justice outcomes, in addition we have the lowest repeat victim and suspect rates for domestic abuse offences, testament to strong partnership working and robust investigation progression.

The Police at Calderdale continue to make best use of innovative civil orders that place restrictions upon those who perpetrate abuse to allow for effective engagement opportunities to address offending behaviour whilst ensuring vulnerable victims are appropriately safeguarded. We have built upon our previous success with dedicated offender managers who now solely focus on domestic abuse cases.

Calderdale District Police have worked with partners to create safe spaces for Women and Girls throughout the District and our approach to Policing and safeguarding of the night-time economy has been such a success it has been adopted through West Yorkshire.

Calderdale continue to provide a fresh and innovative approach to hate crime, delivering a compassionate and supportive approach through our neighbourhood Policing teams supported by professional investigations which has seen success resulting in our approach again being adopted as best practice throughout West Yorkshire.

Our next steps include embarking on a challenging and exciting journey to reshape the district approach to Adult Safeguarding investigations, we have invested additional staff into a newly formed specialist department, consisting of highly trained Detectives who will focus on adult sexual offences. This team will work closely with partners across the criminal justice system to ensure victims are supported, investigations are relentlessly pursued, and offenders brought to justice.

d) Calderdale & Huddersfield Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust actively support our most vulnerable patients and are committed to protecting their safety and welfare, whilst supporting individuals to be free to make their own decisions. We strive to ensure our staff are empowered to speak up and act when they identify actual/ potential safeguarding concerns and continue to support the work of the Calderdale Adults Safeguarding Board.

Here are some of our key achievements:

We continue to consistently achieve above 90% compliance in levels of safeguarding Adults/Prevent/ MCA/DoLS training.

In relation to receipt and scrutiny of MHA papers CHFT have worked with SWYFT to develop receipt and scrutiny training. This training has been available for staff from January 2023, and we are seeing a positive response to this with our training compliance steadily increasing. Our Nurse Consultant for mental health supports learning in relation to the MHA and provides bespoke training to supplement the online training.

Our Deputy Head of Safeguarding/Named Professional Adult Safeguarding commenced in post in November 2022. Appointment to this post has enabled CHFT to review our internal safeguarding training and MCA programme is now compliant with the Intercollegiate Documents for Adults and supports an increased training offer tailored to staff need. Face to face training has been reintroduced. Bespoke packages have been designed to provide staff in key areas with more specific safeguarding knowledge. These have been developed in response to multiple complex cases and these are initially being directed towards the community division, the acute sector and the Emergency Department. Face to face training is evaluating positively.

We have also extended our training offer to our Internationally Educated Nurses, providing face to face Safeguarding Training at their induction. Safeguarding and MCA is now also one of their competency requirements for sign off.

Safeguarding Supervision has seen a 45% increase in compliance since November 2022, with the team working hard to support staff to attend supervision when able with ‘drop in sessions’ and

'safeguarding surgeries'. This approach has been well received by the Trust and has prompted staff particularly in the community to reach out for support on cases within these sessions.

Emergency Department bespoke training has been reviewed and a new format established and implemented. Joint working between BLOSM (Trauma Informed Navigation which aims to support people who come to A&E with complex social issues), an external provider and the Named Professional Adult Safeguarding is ongoing to implement bespoke trauma informed practice training with our Emergency Departments. It is anticipated these sessions will start in May 2023 and will increase CHFT's response in meeting identified learning from recent safeguarding reviews.

The number of Urgent Applications DOLS has risen by 20% in the reporting period and reflects CHFT staffs ongoing commitment to protecting the Human Rights of their patients. We continue to make applications for Deprivation of Liberty Safeguards, in line with the Mental Capacity Act 2005 and work to ensure that the rights of those who may lack the relevant capacity are protected.

Work is underway to refresh and embed the safeguarding champions role across the CHFT footprint. A review of the safeguarding champions network was completed in December 2022. Safeguarding champions will now be identifiable by a badge and there is a communication launch due in 2023 to promote this role.

The Specialist Midwifery Panel continues to meet weekly to review families where increased vulnerabilities may require extra support. In response to national findings information in relation to fathers/ significant others is now forms part of the assessment process in identifying risk factors.

CHFT have now appointed a Transition Clinical Nurse Specialist to support transition between children's and adult services.

We have been planning for Safeguarding week in June 2023, with daily campaigns taking the spotlight and concentrating on key Safeguarding issues. During this week the Safeguarding team will be visible within wards and departments, providing supervision, support, and education to our staff members. On the Friday of Safeguarding week, our Safeguarding team will be sharing a video entitled 'what safeguarding means to us'. This will be promoted Trust wide and featured on our Chief Executives weekly brief. The team will be asking staff during face-to-face training what safeguarding means to them in their role, to strengthen our key message that safeguarding is 'everyday business'.

e) South West Yorkshire Partnership Foundation Trust

Achievements

The South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) safeguarding team, continue to provide leadership, advice, and support throughout the organisation to ensure that the footprint of safeguarding is embedded in practice. There has been changes in the Nursing Quality and Professions Directorate and service portfolio changes, including the safeguarding team, these changes are positive and the aim to better support the wider workforce.

Within the safeguarding team there have been personnel changes however, there has been the recent appointment and commencement of the named nurse and nurse advisor for safeguarding children. During these times of changes the team have continued to deliver on their commitment to safeguarding agendas and have continued to deliver training for, both safeguarding children and safeguarding adults ensuring the compliance rate remains above the mandatory requirements set by

the Trust. The team, also deliver the safeguarding element of the Care Certificate training and training for the new international nurse programme.

The sharing of learning is important to the Trust and the team. The Safeguarding team facilitated a safeguarding conference in September 2022, the topics were: Professional Boundaries and Persons on Position of Trust concerns, Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children RCPCH guidance update for Practitioners, Myth of Invisible Men, The Burnt Bridges Report, Speaker from the National Centre for Domestic Violence, Trauma Informed Practice, which was co-presented by a person with lived experience. Additionally, a Domestic Abuse conference was hosted in February 2023 to share the learning from a Mental Health Homicide Review and to raise the awareness around Domestic Abuse. Each conference was well received, and the feedback was positive.

The named nurse and specialist advisor delivered a presentation in May 2022 on clinical risk, safeguarding, protecting children and vulnerable adults. The aims were to 'critically analyse the links between vulnerability, capacity, consent and safeguarding and how risk-taking can contribute to the achievement of positive outcomes for individuals' and 'critically evaluate own practice in leading a person-centred approach to risk taking, clinical risk management and restrictive practices while safeguarding children and vulnerable adults. This was well received, and feedback was positive.

The Trust team have also delivered training to the Care Groups on the following subjects: Domestic Abuse, Parental Mental illness and the impact on children, Boundary Training, Self-Neglect, Hoarding, Cuckooing and Homelessness. Boundary Training was also delivered during Safeguarding Awareness Week.

The learning from safeguarding incidents is shared across the Trust, senior management have an overview of any safeguarding incidents via the incident reporting system Datix and through the governance of the risk panel. To support and embed learning, the safeguarding team has presented learning from Safeguarding Adult Reviews and Domestic Homicide Reviews at the Trust wide learning forum and through the matron and quality lead forum.

The safeguarding team also presented a virtual update to the Joint Academic Psychiatric Seminar (JAPS), this is the forum for medical colleagues, doctors, and Psychiatric Consultants, and was attended by over one hundred participants, this was positively received. The information centred on the updates from the Domestic Abuse Act (2021), Use of Force Act (2018) and safeguarding and case studies / learning from Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews have resulted in additional training around key lines of enquire, for example, parental mental illness and the impact on children training is being delivered Trust wide and has been well received.

The safeguarding team continue to support the Trust Quality Monitoring Visits (QMV). These visits provide quality assurance and identify areas for improvement in preparation for subsequent CQC visits. Service users, family, carers, and practitioners are interviewed as part of the process. Documentation and Datix incident reports are reviewed by the safeguarding team as part of the QMV. Following these visits, the themes and trends from these visits are fed back to the service areas and wider Trust.

The safeguarding team also provide resources to support practitioners deliver on their safeguarding duties, through the safeguarding team newsletter and the production of briefing papers.

The safeguarding team are committed to the multi-agency partnership working and attend the Safer Adult Board (SAB) and subgroups and are active members at the hoarding panel.

In addition to supporting the collation and analysis for Safeguarding Adults Reviews, Domestic Homicide Reviews, and Child Safeguarding Practice Reviews, the Safeguarding Team support on wider Trust wide agendas, including the pregnant person's protocol.

Challenges
The safeguarding team within South West Yorkshire Partnership NHS Foundation Trust have continued to support the frontline practitioners to deliver on their duties to safeguard those who may be a risk of abuse or neglect. The acuity of work and the pressure on the clinical workforce continues to be a challenge. The safeguarding team support through the advice line, supervision and attendance at multi-disciplinary team meetings and professional meetings. The request for advice has increased each year since the pandemic. The impact of COVID-19 and the current impact of the recession and state of economy, poverty and trauma are yet to be realised.

Future Plans
The safeguarding team have a leadership role, and are significantly involved, in the Sexual Safety Collaborative work and the quality improvement initiative attached to this work. There have been further developments undertaken on this initiative and an update was provided to the Joint Strategic Safeguarding Meeting including the production of sexual safety charters, refresh of the leaflets and promotion of the work. These resources have been shared with partner agencies.

Also there has been developments around the Person in Positions of Trust agenda with the associate director nursing quality and professions collaborating closely with the Peoples Directorate to move this agenda forward. There has been progression and involvement of the learning and development team to develop two levels of training that are to be considered, 'essential to job role' training courses.

Another of the key areas that the safeguarding team will be focusing on over the next year will be the Domestic Abuse agenda and the introduction of routine enquiry. Following Domestic Homicide reviews where the recommendation has been centred on the use of 'routine enquiry,' a task and finish group has been established led by the associate director of nursing. The safeguarding team have updated their workplans to include these areas of work.

f) Together Housing

Together Housing continues to be privileged to be part of the Calderdale Safeguarding Adults Board which we consider is an exemplary example of multiagency partnership. Albeit we are not a statutory agency, we are very much part of the multiagency framework and committed to playing our part to keeping victims safe from abuse or harm. Our commitment includes embedding the culture that safeguarding is everyone's responsibility, both as an organisation and for every member of staff. To spot the signs, be professionally curious and always raise concerns. We believe that our colleagues have the understanding that safeguarding is a core part of what we do every day.

Responding to and dealing with safeguarding concerns can be complex. It takes effort, commitment and persistence including navigating pathways and thresholds and requires the absolute resilience of our staff. Even more so over recent years, with the pandemic and now the cost-of-living crisis, impacting greatly on so many of our customer's lives. However, by working together more effectively as one Together team, as well as with external partners, we believe we are playing our part in helping to protect victims of abuse. We have put considerable effort into strengthening our internal arrangements to support front line staff and operational managers and ensure that no one

ever carries the worries and burden alone. As well as working with our external partners to help join the dots and to have the confidence to query and escalate when needs be as part of keeping customers at the heart of all that we do.

We continue to play our part in Safeguarding Adult Reviews, reflecting on positive practice and areas of learning, with our partners of Calderdale Safeguarding Adults Board. Continuous improvement and learning is very much part of what we do at Together, with the focus on what we can do differently or even better to protect those that are vulnerable and experiencing abuse or harm and together with our partners, help victims recover and have hope in their lives.

Key achievements over the last year include:

- Training –this continues to be delivered by our in-house safeguarding team, both mandatory and bespoke training, tailored to reflect the diversity of our workforce, and significant improvement in attendance rates.
- Roll out programme of the Burnt Bridges review - to strengthen understanding of trauma-informed practice, complemented by training via the WY Housing partnership and incorporated into our core training pack.
- Strengthening our internal dataset – data relating to wellbeing concerns ("cause for concerns") has been separated from safeguarding concerns to give a clearer picture.
- Procedures and practice – updated to reflect changes in legalisation, practice and ongoing alignment with multiagency updates, and reformatted to be more interactive and easier to use.
- Safeguarding toolkit for customers – updated with input from tenants and residents.
- Operational management group – established to support our Strategic group and to strengthen ownership of operational performance.
- One team approach – strengthening practice through internal case management meetings, supported by our safeguarding team.
- Learning from formal reviews – developed our approach to the roll-out of learning through themed sessions.

g) Age UK

We have implemented many improvements within our safeguarding procedures. We have appointed a Safeguarding Representative at each site; they are trained to NVQ Level 2 and have had additional training. We display a poster displaying a picture of the site rep and ways they can be contacted.

We have a monthly safeguarding meeting with all the reps to discuss any safeguarding matters and ways we can improve systems and procedures.

We have just implemented the function to enter any safeguarding issues on our management system. This will give the safeguarding lead better reporting facilities that can show any patterns or peaks in services etc.

We have a section in our weekly bulletin dedicated to safeguarding; it gives examples of safeguarding breaches and asks how you would handle this situation.

We have just carried out an organisation questionnaire on Safeguarding. This covers feedback about training, inductions and covers questions on safeguarding, would you report etc. This tests that our staff and volunteers understand Safeguarding policies and procedures and they know what and how to report.

h) VSI Alliance

Voluntary Sector Infrastructure Alliance is a partnership of 6 organisations, four delivery partners (Voluntary and Community, Forum CIO, West Yorkshire Community Accounting Service, Locality) and 2 Commissioning partners, Calderdale ICB and Calderdale MBC.

Dedicated Team Managers sit at each the Children Safeguarding Partnership and the Safeguarding Adults Board.

We offer continuous and tailored safeguarding support to any of our 500+ community voluntary and social enterprise groups across the district. This support is offered to Trustees, Volunteers, and paid staff and in this last year has included:

- Policy & Procedure development and advice, including support to improve safeguarding practice.
- 1-2-1 support in completing Organisational Safeguarding Assessments
- Tailored training across a range of safeguarding matters including Safeguarding for Volunteers, Safeguarding for Trustees, Safeguarding for DSLs in the Voluntary Sector and Safer Recruitment in the Voluntary Sector.

In the last year, twenty-four groups received specific support around safeguarding matters and ten training sessions were delivered with approximately 80 attendees.

During 2020, a Due Diligence partnership was established (with the VSI Alliance, CMCB commissioners and Community Foundation for Calderdale) to monitor and review specific concerns that were raised through whistleblowing or complaints. Despite receiving no referrals in this year, this group still met quarterly to explore expansion of the diligence work to include wider issues of safeguarding and good practice. This work is ongoing.

i) Women's Centre

WomenCentre's focus as part of CSAB has been to continue to contribute to the wider work through our involvement in strategic agendas including Domestic Abuse, MEAM, Suicide Prevention and wider Community Safety work.

Participation in the CSAB away day in November 2022 and a Thresholds Workshop enabled us to contribute to the much-needed development of this work in Calderdale alongside the wider partnership.

Our expertise in Domestic Abuse work has contributed to the review of both the MARAC and the DRAMM processes in Calderdale in 2022-2023 and we envisage this will provide wider safeguards for adults in Calderdale.

j) Healthwatch

Healthwatch Calderdale has been a member of Calderdale Safeguarding Adults Board since 2016, Healthwatch is the local health and social care champion; the team in Calderdale gather feedback on any publicly funded health and care services, such as GP's, hospitals, dentists, day services and care homes, trying to understand what is working well and where things could be improved. When issues are identified, Healthwatch ensures that peoples voices are heard in the right forum to make change happen. For Healthwatch, one of those forums is the Safeguarding Adults Board.

Throughout our involvement with Calderdale Safeguarding Adults Board, we have reflected back whether the concerns, issues and complaints we hear from people are having an impact on adults at risk in Calderdale and we'll continue to do so. Championing the voice of those who find it most difficult to be heard is always one of our top priorities.

k) Probation Service

The Probation Service consists of 12 regions across England and Wales. The probation service is a department of His Majesty's Prison and Probation Service (HMPPS) - an executive agency of the Ministry of Justice. As a statutory body, the probation service is responsible for providing recommendations to sentencing courts and supervising individuals who are in custody and in the community.

Each region has its own Director and comprises several Probation Delivery Units (PDUs). The Bradford and Calderdale (BAC) PDU sits in the Yorkshire and the Humber (YaH) region and is led by a Head of Service (HoS) who is responsible for the delivery of local probation services. As Bradford and Calderdale is not one homogeneous area the two Deputy Heads have been assigned to predominantly cover each vicinity supporting the HoS alongside other areas of responsibility.

The commissioning and co-commissioning of rehabilitation and resettlement services plays a key role in addressing the needs, and managing the risks presented by people on probation. In BAC there is a commitment to working with partners to protect the public and help people lead healthy, satisfying and law-abiding lives. A probation commissioned personal wellbeing service operates alongside other Adult Safeguarding interventions in Calderdale. This is a holistic service which addresses frequently occurring rehabilitative needs including emotional wellbeing, family and significant others, lifestyle and associates and social inclusion.

Services are available for adult males on probation on a community/suspended sentence order with a RAR or on licence/post-sentence supervision. The social inclusion 'mentoring' service is delivered pre-release for those who will be released on licence. A new neurodiversity service in being commissioned to provide bespoke services. Calderdale Probation staff work closely with the Forensic Outreach Liaison Service.

In addition, probation staff are collaborating with the data manager of the Adult Safeguarding to share information and improve joint working for those people on probation referred into Adult Social Care. The Probation Service utilises a range of approaches including direct delivery of interventions, support and advocacy, and advice and guidance. Interventions are tailored to reflect the complexity of an individual needs. Joint work with partner agencies in Calderdale is integral to probation work.

This report will be published on the Calderdale SAB website.

As required by the Care Act 2014, it will also be shared with the Chief Executive and Lead Member of the Local Authority, the Police and Crime Commissioner (now the West Yorkshire Mayoral Authority) and the Chief Constable, the local Healthwatch organisation, and the Chair of the Health and Wellbeing Board. A copy will also be shared with the Chief Officer of the Clinical Commissioning Group.

For further information about this report contact Julia Caldwell,
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www.calderdale-safeguarding.co.uk

If you need safeguarding guidance or advice, call Gateway to Care on 01422 393000

To report adult abuse or neglect, call Gateway to Care on 01422 393000

To contact out of office hours, call the Emergency Duty Team on 01422 288000

Guidance on making a referral can be accessed from the Safeguarding Board Website