Safeguarding Adults Annual Report 2022/23

SAFEGUARDING BARNSLEY TOGETHER

BARNSLEY SAFEGUARDING ADULTS BOARD

BARNSLEY Metropolitan Borough Council

Contents

Foreword from the Independent Chair of Barnsley Safeguarding Adults Board

It is important that the Safeguarding Adults Board reflects upon the last year's work and makes that information available to the public.

This annual report provides information showing that the Board has continued to progress in its goal to keep adults safe and free from harm. You can read more about what's happened during the last twelve months to progress the Board's strategic objectives.

Some projects that are worth mentioning are:

- the creation of the 'Preparing for Adulthood Team,' which is helping to improve the transition to adulthood for young people who need extra support.
- the creation of a customer engagement post, which is actively working with customer groups across Barnsley, increasing knowledge of safeguarding and the work of the Board. The feedback from customers will be used by the Board to inform our plans in 2023/24.
- the creation of a part-time training administrator post, freeing up the time of the trainer and the Board manager to concentrate on their core roles.

Those achievements have been made possible by the support and commitment of our statutory safeguarding partners, healthcare services, the council and the Police, who provide the funding for the Board and take a lead role in governance.

In addition to the Board, I have also chaired the Safeguarding Adults Review sub-group, which commissions and manages any case reviews that meet the criteria set out in the Care Act. Based on the review findings, the group strongly desires to learn and improve practice. In the last year, we have introduced a 'was not brought' policy for adults at risk of missing health appointments and looked at quality assurance for annual health checks for adults with learning disabilities. Both have led to improvements in working practice.

After nine years in the role, I stepped down as the Independent Chair at the end of May. I do so confident that the Board has made considerable progress, that there is a strong commitment by all partners to the aims of the Board and knowing that the Board will continue to work hard to protect adults in Barnsley.

I very much appreciate the support that I have received from partner agencies during my time as chair. I particularly want to thank the Board manager, Cath Erine, who has done so much to organise the Board and its sub-groups, to bring new ideas to fruition and to be relentless in promoting safeguarding.

Bob Dyson QPM, DL

The role of Barnsley Safeguarding Adults Board

Barnsley Safeguarding Adults Board (BSAB) is the statutory body that brings together organisations working across Barnsley to promote wellbeing and reduce the risk of harm to people with care and support needs. This includes health, including general practitioners, housing, Adult Social Care, education, the council and the Police. The Board is responsible for leading safeguarding arrangements across the borough and for overseeing, co-ordinating and challenging the effectiveness of the work of our members and partner agencies.

Our responsibility is to create and encourage a culture among our members, partners and communities that values and follows the principles of 'Making Safeguarding Personal.' Together, we have a duty to make sure that procedures are in place to promote the reporting of suspected abuse and take necessary actions to stop it.

The Board's role is to make sure that those who work to protect adults follow a coordinated and consistent approach when it comes to referring, assessing, planning, intervening and reviewing cases for people who have experienced or are at risk of abuse, keeping the adult at the centre using the principles of Making Safeguarding Personal.

Under the Care Act 2014, we must:

- Develop and publish a strategic plan, setting out how we'll meet our objectives and how our member and partner agencies will contribute.
- Publish an annual report, detailing how effective their work has been.
- Commission safeguarding adults reviews (SARs) for cases where an adult dies or is seriously harmed as a result of abuse or neglect.

Our vision is to make sure that Barnsley is a safe place for all adults.

To achieve this, we will work together to:

- Prevent abuse and harm by promoting dignity and respect, delivering high-quality services.
- Empower adults and communities to prevent abuse and be part of the solution if abuse or harm does occur.
- Protect adults by working with them to reduce the risks they face and establishing a culture that does not tolerate abuse.
- Deliver proportionate responses to abuse and harm, working with people.
- Deliver high-quality partnership working to prevent and respond to abuse and harm.
- Hold each other to account for the quality of our safeguarding work and report this to the residents of Barnsley.

The Care Act requires safeguarding boards to have an Independent Chair. Our long-standing Chair, Bob Dyson, stood down earlier this year, and a new Chair was appointed to replace him. We thank Bob for his commitment to keeping adults in Barnsley safe and all he has done to drive the Board's work forward.

Marianne Huison started in June. Marianne also chairs a safeguarding board in West Yorkshire, which will support the sharing of best practice.

Safeguarding activity during the year

The information in this report has been gathered by Barnsley Council on behalf of the partnership board. While reporting on safeguarding activities that are required by law, they found some inaccuracies in how data is collated and organised.

As a result, the council cannot guarantee the accuracy of the data. There is therefore a possibility that it might differ from other publicly available sources of safeguarding data.

To address this issue, a project has been initiated to develop locally maintained datasets for Adult Social Care. They will start by focusing on improving the accuracy and efficiency of safeguarding data.

This way, the data used to support the board's main objectives will be reliable and comparable to other safeguarding data reported at both local and national levels.

Concerns

In 2022/23, our Adult Social Care services received 3,129 safeguarding referrals, marking a significant increase when compared to the 2,231 referrals received in 2021/22.

This 33% increase was mainly due to care homes and community services submitting notifications of all falls and medication errors with safeguarding. These referrals do not meet the threshold for safeguarding and an alternative route, including the Contracts team and CQC involvement, will be explored in the coming year.

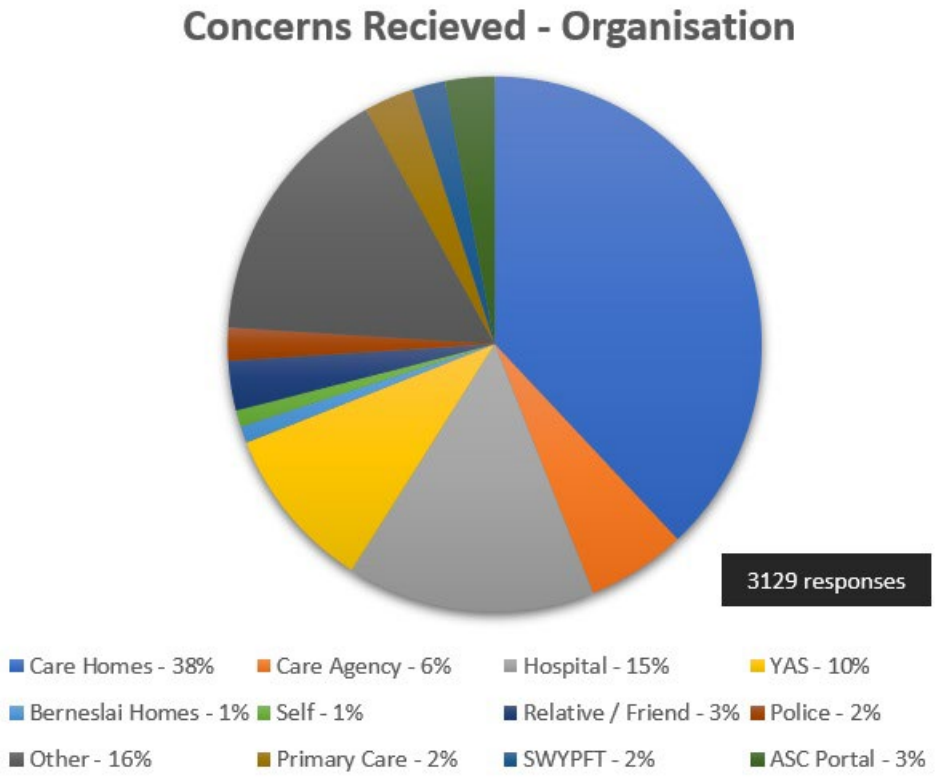
29% of concerns received required a safeguarding enquiry (Section 42) in 2022/23, down from 31% of the concerns received in 2021/22. 71% of concerns did not require a safeguarding response. Work has begun to reduce the number of inappropriate referrals as this is time-consuming for safeguarding and Adult Social Care, who triage all referrals.

The Safeguarding Adults Board aims to make sure that adults are aware when workers and volunteers have concerns about their safety. To achieve this, they are encouraged to directly communicate with the adult, supporting them to share their worries and explaining what actions will be taken to help keep them safe if they share their concerns with Adult Social Care.

We are ambitious and want to see 90% of all concerns shared by workers and volunteers to seek the adult’s consent if they are able. During the year, 77% of concerns received either had consent or were related to adults who could not give permission.

We are completing an audit in 2023/24 to clarify which organisations are not seeking permission and why. This will allow us to support them as part of our commitment to person-centred practice.

Which organisations sent in concerns?



The 6% increase in referrals from care homes is linked to quality concerns which do not require a safeguarding response. Work is underway to provide an alternative method of sharing quality concerns with us. We anticipate that as new reporting processes go live in 2023/24, the numbers of referrals will reduce, and the percentage that requires a safeguarding response will increase in line with other referrers.

The 6% decrease in the number of referrals from the Police is positive, resulting from:

- The introduction of a new safeguarding adults app on mobile equipment, which helps police colleagues to provide better quality data to support screening by Adult Social Care.
- Co-location of a police officer in our Front Door team, who triage concerns. The officer provides feedback to police colleagues to deliver continuous improvement.

Barnsley Hospital has an established safeguarding team who are actively working with all departments to identify and report safeguarding concerns. The 4% increase from 2021/22 to 2022/23 is a testament to the impact of this work.

We aim to support the public to share concerns about themselves, their family, friends or neighbours. We have a target of 10% of referrals coming from this area.

While the increase to 4% is positive, we need to continue working with customer groups and our communications colleagues to empower the public to feel confident in sharing their concerns. Most referrals received from the public do result in a safeguarding enquiry.

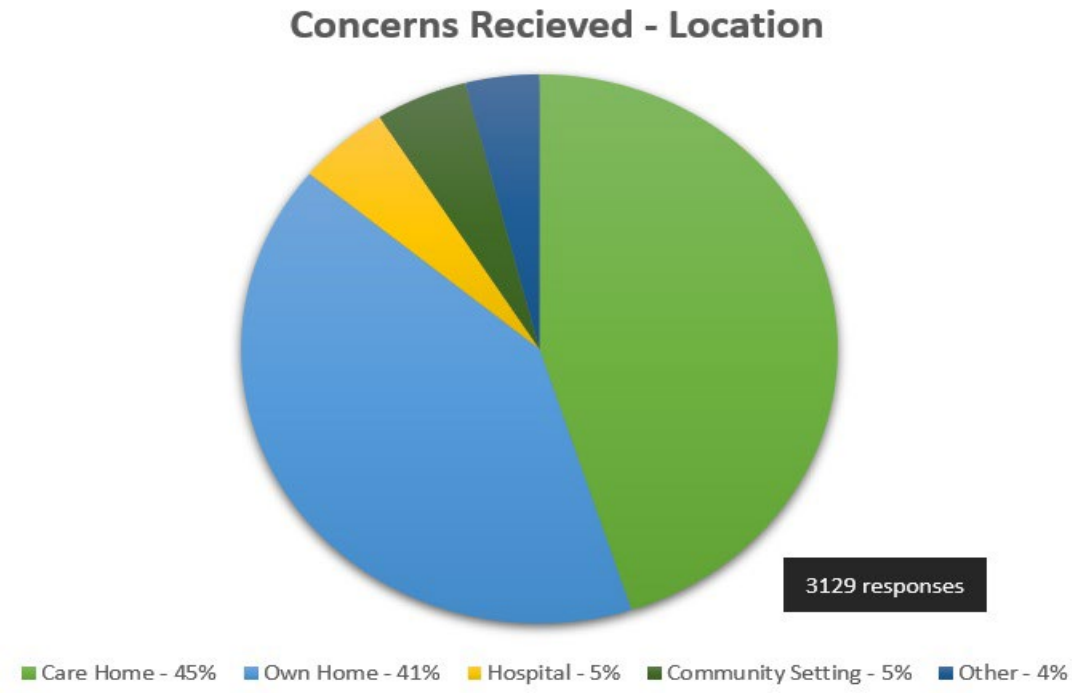
The appointment of a Safeguarding Customer Engagement post within Healthwatch will increase the number of referrals in 2023/24. More details of the role of the Safeguarding Engagement Worker are included later in this report.

The absence of referrals from housing associations and private landlords is a concern and will form part of our communications strategy in 2023/24.

Reporting accurately on referrals from primary care and the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), which provides a range of community, therapy, and mental health services, is challenging due to the fields provided by the Department of Health and Social Care. However, we know that Adult Social Care has received more referrals from primary care.

This increase is a direct result of the work of the Integrated Care Board's safeguarding team and multiple inputs from the Board's multi-agency trainer.

Where did harm take place?



The 5% increase in reported abuse cases in care homes is evidence that more cases of alleged harm have been reported in line with the new advice to report everything.

This includes:

- Witnessing falls of adults with a fall risk management plan.

- Medication errors that do not result in harm.
- Tissue viability concerns managed by both robust care plans and the active involvement of nursing and other health colleagues.

The percentage of concerns from this sector requiring a safeguarding response is less than 15%. The Safeguarding Adults Board is committed to supporting all staff and volunteers to raise appropriate, high-quality concerns, as shown by our offer of free training for everyone.

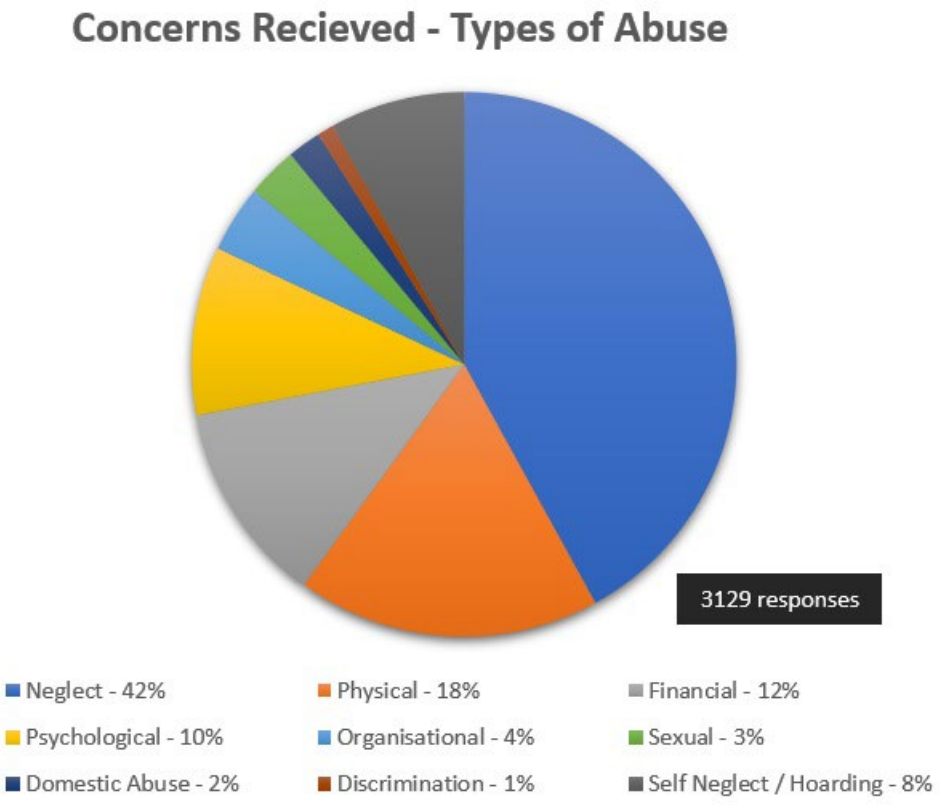
Who needed help?

62% of adults who needed support to stay safe were aged 65 and over.

86% identified as White British and 2% as Black or from other ethnic minorities, which aligns with our demographic data for Barnsley. 10% of adults did not provide ethnicity data.

The gender of adults needing help to stop harm remained the same as last year, with women at 57% and men at 43%.

Types of abuse reported.



The types of abuse reported in the year are like those reported in the previous year.

Neglect is the most reported abuse in both care settings and in an adult's home. Most financial abuse occurs in someone's home, with family and friends being the most likely to be causing the harm.

The number of self-neglect and hoarding cases has risen slightly, evidencing the work we are doing locally. Research indicates that between 4% and 6% of the population are likely to

struggle with hoarding and/or self-neglect, showing we need to continue our efforts to equip workers, volunteers and the public to identify and report their concerns.

Rosie's case study, included later in this report, demonstrates the positive impact joint work with the people we support can bring.

How did we support adults to feel safe?

We are committed to working with adults to identify solutions. In line with 'Making Safeguarding Personal,' this means working to the below principles:

- Talk to me; hear my voice.
- Work with me to support me to be safe.
- Work together with me.
- Work with me to resolve my concerns and let me move on with my life.
- Support me to be safe now and in the future.
- Work with me, knowing you have done all you should.

To do this, we may

- Agree on a set of outcomes with the adult and work with them and other organisations to reduce the risk of further abuse or harm and help them feel safer. This allows us to support them in choosing what they would like to happen when they can do so. During the year, we worked with 907 adults.
- Offer a Care Act assessment to identify the support they need, including a care package via Adult Social Care.
- Refer them to other organisations for support, including specialist domestic abuse services and teams who can help with drug or alcohol dependence.
- Agree that we will offer adults advice and support to help them to resolve issues or risks for themselves.

The Care Act requires us to act without consent from the adult if:

- The person alleged to have caused the harm may pose a risk to other adults in their role as a worker or volunteer, defined as a person in a position of trust (PIPOT). Our data is incomplete in this area, and work is underway to resolve this in the coming months. Appropriate dismissals and referrals to the Disclosure and Barring Service and other professional registration bodies have been made.

If the adult is unable to consent to work with us because of dementia or a learning disability, we will make sure that a decision is made with them, their family, friends or advocates. We will agree on how best to keep them safe in line with the Mental Capacity Act 2005.

Did we keep people safe?

92% of adults supported through a safeguarding enquiry (Section 42) reported that safeguarding support had delivered their outcomes or safeguarding needs.

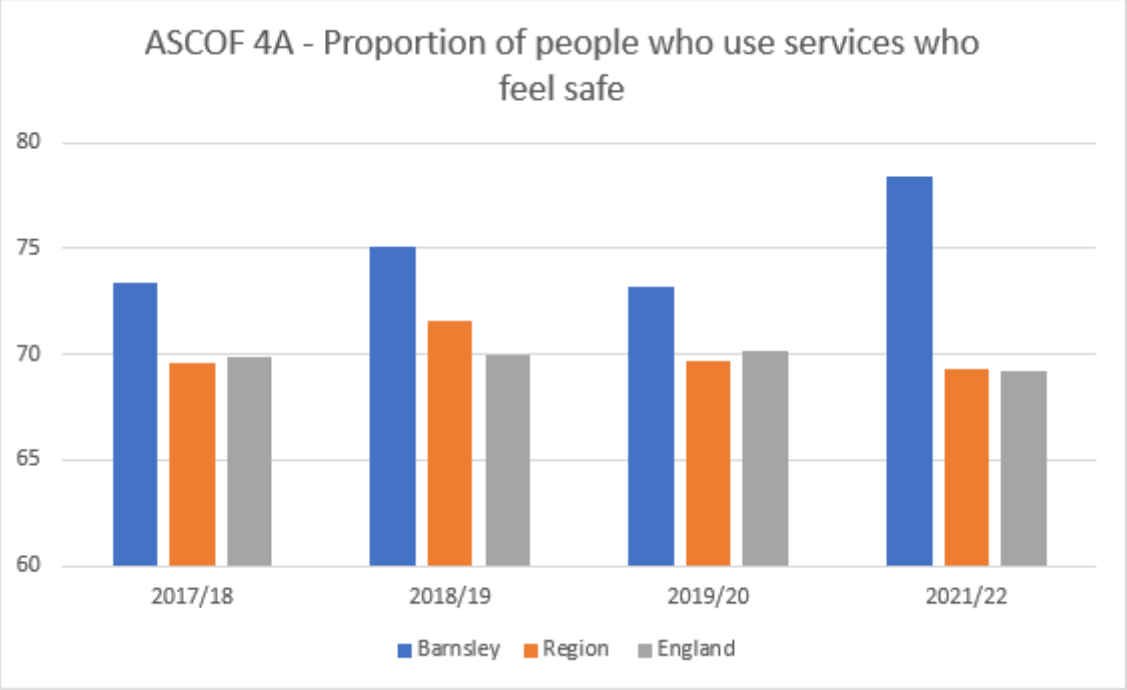
Did we help remove the risk of further harm?

- 37% reported that safeguarding support had removed all the risks of further harm.
- 56% reported that safeguarding support had reduced the risk of harm.
- 7% reported that risks of further harm remain.

Removing all the risks may result in the adult not seeing family members or friends or having to move home, and some adults are not prepared to make these choices.

Comparisons with regional and national data.

It is notable that Barnsley continues to provide safer services than our regional and national neighbours. It should be noted that no data is available for 2020/21 due to Covid-19.



Partner data

Partner organisations, such as the hospital and Police, provide data about the number of workers who have received training, the number of people in positions of trust enquiries completed outside of a Section 42. A new data set will be agreed within the first quarter of 2023 to increase our ability to assure the quality of safeguarding within partner organisations.

Case studies

Case study 1 – Rosie (name chosen as a pseudonym by the adult)

Rosie, a forces veteran, lives in an owner-occupied home. She needed support with hoarding, which affected all the rooms in her home. Rosie lives with bipolar disorder and struggles with agoraphobia.

Sadly, over the last four years, Rosie has lost her husband, a fellow veteran, and twin brother. Her son lives overseas and is not aware of her struggles.

Adult Social Care and private housing officers visited Rosie's house, but they were denied access. Rosie finally allowed the workers in and agreed to attend a multi-agency meeting with all relevant organisations to make a plan to reduce the risks linked to her hoarding.

Weekly social or community safety worker visits helped build a strong relationship with her and supported Rosie in addressing the issues. Rosie has been provided support to sell on many of the goods to recoup the cost of new items that have yet to be worn or used.

Rosie has become a regular attendee at the people-led D' Clutter group and enjoys these events. Rosie told us:

"It has dragged me from a very bad place, and I have had endless support from housing and social care to move on slowly. I have moved on from that place and wouldn't be where I am now without their support. I wasn't aware of the support available from the council. It has changed my life."

This case reinforces the need to:

- Work with people in a way and pace that helps them to be in control.
- Be persistent and persuasive.
- Be creative and persistent when the adult refuses suggested actions and approaches.
- Be committed to a long-term approach.

Case Study 2 – Simon (pseudonym)

Simon lives in a supported living project with 24-hour one-to-one support to enable him to manage his cerebral palsy and other health issues. Simon uses both a motorised and manual wheelchair to get around and provide him with some independence.

Simon had requested support to use the toilet, which was refused by the allocated worker. Another worker, who was working from his home, offered to assist him but was told by the allocated worker that she could not do this as "Simon was not on her hours."

The worker was overheard saying, "If he wets himself, we can move him into his manual wheelchair."

Two hours after the initial request, the male worker aggressively started removing Simon's clothing in the hallway in front of other workers. Simon was very distressed, and the worker eventually took him into his bedroom to allow him to use the toilet.

The worker, who was refused permission to assist Simon, reported this to managers, who suspended and completed an internal investigation, including reporting it to safeguarding.

The worker was dismissed and referred to the Disclosure and Barring Service and Adult Social Care recorded that harm had taken place by a person in a position of trust.

Simon confirmed he was happy to continue living at the service now that the worker would not be supporting him.

"I am happy with the end result and feel relieved that it is over and I won't have to deal with that worker again."

Key achievements and impact

Progress linked to our strategic plan for 2022/23:

Ambitions		
Ambition 1: To ensure that collectively we all work hard to prevent harm and abuse across Barnsley		
Achievements	Impact	Completed or ongoing
Safeguarding training - From April 2022 to March 2023, 732 people attended workshops and/or completed e-learning. It is a dynamic programme, and key achievements include: • A series of workshops highlighting the support available to people impacted by the cost-of-living challenges. Thanks to Yorkshire Water, the Citizens Advice Bureau and the Department of Work and Pensions. • Safer recruitment sessions aimed to equip managers to support them to recruit high-quality workers into the care sector. The Police outlined how to share concerns about Police Officers abusing their position for sexual purposes, demonstrating their commitment to high-quality policing. • Strategies and approaches to help workers and volunteers provide support to adults who are "challenging to work with." Thanks to South Yorkshire Police, SWYPFT and DBS. • Co-delivering joint Safeguarding Adults and Safeguarding Children workshops with the	Evaluations show that courses are meeting needs. Limited uptake from the independent care sector remains a concern. Most of these courses were oversubscribed, and workers reported how they supported their practice. Reduced duplication and support, sharing best practice across Adult and Children's Services.	A priority area for 2023/24 will be the engagement of the independent and voluntary sectors to improve knowledge of adult safeguarding. Additional sessions will feature in the 2023/24 training programme.

Safeguarding Children's Partnership for workers with limited contact with adults or children. • Reviewing our courses and updating the format and timings based on feedback gathered from delegates. • Launching a new e-learning course on the Mental Capacity Act and the Deprivation of Liberty Safeguards. • Gathering and analysing information about the impact of the training on practice. This is to make sure that the training we deliver leads to improvements in the way we work as agencies.	Courses reflect the needs of workers and volunteers. Learning from local and national Safeguarding Adult Reviews (SARs) indicates that competing Mental Capacity Assessments remains challenging. The course includes a knowledge check to demonstrate the impact on learning.	Active review will continue to deliver a high-quality, responsive programme. Work is ongoing to test the impact on practice. Planned changes to the council's learning platform (POD) will require a reflective learning piece to be completed before receiving certificates.
Funding was identified to create a training administration post to support the Board's work.	Additional data is available to evidence uptake and impact of training.	Completed.
The existing bi-monthly newsletter for workers and volunteers will increase to a monthly format. This is based on research that suggests the average read time is less than five minutes.	New software will allow us to track engagement with the newsletter. We will use this to inform future content and length. More people have subscribed to the newsletter since we switched software.	Pathways and Partnerships will receive this data at future meetings from May 2023.
Review of the BSAB webpages commenced, helping workers find resources and access learning opportunities more efficiently.	Early data indicates that creating a new training 'tile' is helping access in addition to a QR code.	Plans are in place to complete the website review before September 2023.
Regular reflective sessions feature at the Pathways and Partnerships sub-group meetings to cascade best practice and identify areas for improvement.	New or revised guidance tools and policies have resulted from these sessions. Partnership working and professional relationships have improved.	Quarterly.
Performance Management and Quality Assurance sub-group collaborates with all safeguarding partners to develop a data dashboard. This will improve oversight of trends and data relating to safeguarding and making safeguarding personal.	Due to pressures on key partners, the improved dashboard needs to be implemented. To provide robust analysis, we may need to examine individual cases thoroughly.	Quarterly. The importance of data is on the board's risk register.

A consultant assisted our Care Quality Commission (CQC) preparations, funded by the Local Government Association. Their report identified the need to improve our ability to track "people in positions of trust" via Adult Social Care records. Communication between Adult Social Care and South Yorkshire Police on 'shared' cases also required improvement.	Work commenced to resolve both these issues in advance of the CQC inspection, with a projected completion date of September 2023. The co-location of a police colleague in the Adult Social Care Front Door has positively impacted both triaging and active case management.	January 2024.
Implementation of the Integrated Care System. In July 2022, the Integrated Care Board (ICB) came into being and replaced the previous Clinical Commissioning Group. At the same time, the Integrated Care Partnership (ICP) was created. An ICB is a statutory NHS organisation responsible for developing a plan to meet the local population's health needs, managing the NHS budget and arranging health services. The ICP is a statutory committee jointly formed between the ICB and local authorities that fall within the Integrated Care System (ICS)'s area. It brings together a broad alliance of partners concerned with improving the population's care, health and wellbeing. The ICP is responsible for producing an Integrated Care Strategy to meet the health and wellbeing needs of the local population.	There has been a clear commitment, as part of the reorganisation, that safeguarding remains a priority. Whilst working collectively on a bigger footprint provides an opportunity to do some things collectively at a regional level, the commitment to safeguarding locally (at Barnsley place) remains strong. This means that locally, personnel and support have remained the same. The Executive Partner from Health remains unchanged, as does the representation of the partnership sub-groups, which remains a priority.	Quarterly updates.
Creation and active use of a public-facing hoarding postcard. Delivered to homes in Barnsley by Community Safety colleagues. This has increased awareness of hoarding and self-neglect	Early evidence indicates that using the postcard has resulted in adults struggling with hoarding and their neighbours' contacting services. The postcard has been identified as a best practice example and adopted by other Safeguarding Adults Boards nationally.	November 2023, as we have not identified the four to six per cent of the population that research indicates are likely to be struggling with hoarding and/or self-neglect.
Our annual Safeguarding Awareness Week (SAW) took place in November 2022, including a 'take over' of Barnsley	Adults accepted referrals to services and took advice on how to self-refer.	The markets have agreed to host stalls for this year's Safeguarding Awareness Week.

Market to share messages with the public.		
We have updated our public-facing leaflet in partnership with the Safeguarding Adults Forum by Experience (SAFE) customer group.	The temporary Safeguarding Engagement post reports that the leaflet is popular with customer groups.	Ongoing – we will continue to evaluate impact and change as required.
Bi-monthly public-facing minutes summarising the Board's work and its sub-groups are available on our webpages and shared directly with customer groups.	Impact data is not yet available.	December 2023. The 2023/34 annual report will include this data.
Communications colleagues have produced animations of safeguarding cases, which are available on the website and social media.	Positive feedback from both the public and workers. Requests from other Safeguarding Adults Boards to use them.	Support to produce further resources from all communications teams is required.
Building on best practice in other parts of the region, we secured funding to appoint a Safeguarding Customer Engagement post. The position is based within Healthwatch and actively links with existing customer and voluntary groups to increase knowledge of staying safe and well.	A local mosque has taken up the offer of a health check session from health colleagues at Friday prayers. An insecurely housed young man was offered support from Children's Social Care and returned to his family in Portsmouth. A local foodbank has accepted safeguarding training. A jointly produced resource pack supports customer groups to make appropriate referrals to a wide range of organisations.	Funding is in place until 2024. Funding to extend the post will be explored to build on its positive impact.

Ambition 2 - To develop citizen-led approaches to safeguarding		
Achievements	Impact	Ongoing or completed
The Safeguarding Adults Board supported the SAFE group in producing a patient-held Universal Health Passport, which covers support needed across all health settings.	The pilot evidenced that the passport was popular with adults and young people and accepted by all health workers. The Safeguarding Adults Board approved the document, with training for adults and their families, workers and volunteers now underway.	Completed, pending further evaluation.
Barnsley Safeguarding Adults Board is keen to work towards active co-	Not available at this stage.	Ongoing.

production but recognises that requests for people's time are duplicated across boards. The joint-board strategy will attempt to reduce duplication and improve communication between boards on shared issues.		

Ambition 3: To continue to develop safe transition experiences for young people		
Achievement	Impact	Ongoing or completed
Adult Social Care has established a Preparing for Adulthood team. The ambition is to expand it to include Children's Social Care, mental health and other colleagues.	The service is still in its infancy, and its impact is not yet known. Regular updates will be provided to the Safeguarding Adults Board.	Updates bi-annually. First update is due in December 2023.
Workers supporting young people in preparing for adulthood will have increased access to jointly run courses and resources.	There is limited data on the impact of this change at this point. Further evaluation is ongoing.	January 2024.
Learning events to cascade the messages from SARs involving young adults have been delivered to staff in Barnsley.	Positive evaluations.	Completed.

Ambition 4 - Learning together and continually improving		
Achievement	Impact	Ongoing or completed
Barnsley completed more learning lesson reviews than comparators. A thematic review of all SARs and lessons learnt reviews completed in the previous eight years showed that practice has improved. This included increased professional collaboration in managing self-neglect and hoarding, our commitment to work with the adult or their advocate and developing ASIST meetings to involve family and friends in resolving hoarding and/or self-neglect concerns.	The learning from the thematic audit will inform our training programme moving forwards and our priorities for the work plans of the Board and its sub-groups. Use of the Mental Capacity Act, professional curiosity and persistence were all identified as areas requiring additional scrutiny. National reviews of SARs identify the same challenges.	Ongoing.
Learning from Lola, a Safeguarding Adults Review, and Gillian, a non-statutory lesson learnt, identified	Primary care now has a specific code to record adults who were not brought to health appointments.	The number of patients not brought to

the need for a 'was not brought' policy for adults with learning disabilities or other cognitive impairments. The Safeguarding Adults Board has approved the new policy, with training underway for health and social care staff.	Repeated non-attendance will generate a referral to adult safeguarding.	appointments or referred to safeguarding adults will be part of the performance data shared with the Safeguarding Adults Board.
The Safeguarding Adults Board has committed to being involved in two pieces of research. One exploring responses to self-neglect and/or hoarding, led by Professor David Orr. Malcolm Irons led another to improve medication safety in care settings. Both are in the early stages.	Limited impact at this stage. The self-neglect research is a three-year programme.	Ongoing.
The appointment of a part-time training administrator on a three-year, fixed-term contract will enable us to evidence the impact of training on practice.	The postholder started in early 2023, so limited data on the impact of training is available at this point.	September 2023.
We are actively involved in partnerships with South Yorkshire and wider regional colleagues across health and social care to share learning and best practice. This includes regional safeguarding forums in health and social care and specific meetings for Independent Chairs and Board Managers.	Barnsley has shared and obtained best practice examples for use locally.	Ongoing.

Learning from Safeguarding Adults Reviews (SARs) and lessons learnt

The Care Act 2014 requires Safeguarding Adults Boards to consider a Safeguarding Adults Review (SAR) when:

- An adult at risk dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has sustained a potentially life-threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect.

And one of the following has taken place:

- Where procedures may have failed, and the case raises serious concerns about how local professionals or services worked together to safeguard adults at risk.

- Serious or systematic abuse occurs in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time.
- Where circumstances give rise to serious public concern or adverse media interest about at-risk adults.

During 2022/23, the Safeguarding Adults Review Panel, chaired by the Independent Chair of the Safeguarding Adults Board, considered eight cases:

Case number	Cause for concern	Outcome
1	Choking in hospital	Single agency enquiry with report and action plan shared with SAR panel.
2	Choking in hospital	As above.
3	Neglect by an adult child where the individual did not die	Did not progress. Adult child cannot care for their parent and did not know how to access support.
4	Suicide	No failure in partnership working. Referred to suicide panel.
5	Self-neglect/hoarding by adult child. The adult did not die	Did not progress to review. The adult was placed in a care setting, was unable to make decisions for herself and support to address mental ill health was provided to her adult child.
6	Self-neglect. Concerns about lack of access to services	Learning review completed, with strong evidence of effective working by all organisations involved with this adult.
7	Self-neglect. Concerns about the quality of communications between agencies	The joint review between relevant organisations was shared with the SAR panel.
8	Suicide	Referred to suicide panel.

In 2022/23, Barnsley's Safeguarding Adults Board signed off two SARs into the deaths of Harry and Richard, both of which started in the previous year. Summaries of these reviews are included below:

Harry

What happened?
Harry died when he was 34 years old. He died because of sepsis, cellulitis and non-alcohol-related liver cirrhosis. Harry was known as someone who could be challenging to work with. He was often threatening and abusive to workers and his parents. He would sometimes refuse to engage with assessments and the support offered.

In the final 18 months of his life, Harry was suspended from accessing services from the South West Yorkshire Partnership NHS Foundation Trust. However, crisis services remained

open to him through Accident and Emergency. Harry had spent time in prison. In his final days, Harry was arrested again and detained under the Mental Health Act.

Terms of reference
The review focused on the period from 1 June 2018 until Harry's death on 21 September 2021. The review period was chosen to understand the impact that the Safeguarding Adult Board's Self-Neglect and Hoarding Policy and procedures may have had on practice with Harry. In particular, the review was to understand how effectively agencies worked together. The review also reflected on the experience of Harry's parents, when they adopted him and missed opportunities for support throughout Harry's childhood.

Key learning when working with adults
There was good evidence of joint visits between practitioners, but there needed to be strategic joint working between agencies. There were no joint risk assessments or joint risk management plans. No single agency had all the information.

Each agency struggled to support its workers experiencing abuse, but opportunities for joint responses were missed. There was evidence of agencies being 'played off' against each other as there was no joint plan. Workers did not recognise that Harry was neglecting himself. Harry had likely never really cared for himself and depended on others for his cleaning, managing his money and support to access his community. Opportunities to offer his parents support as his main carers for many years were missed.

It is possible that Harry's mental and executive capacity to make and carry through decisions was "overestimated", as he could articulate himself well and appeared to understand information. However, there was much evidence about his impulsive behaviour and its negative impacts, which raises the question of how well he could weigh up information when making decisions.

Learning from Children's Services
Understanding Harry's childhood and the challenges faced by his birth mother could have assisted the practitioners involved with managing his behaviour. Harry's behaviours may have resulted from Foetal Alcohol Syndrome Disorder (FASD).

Early diagnosis and support for the child and their families are essential to limit the impact of the condition. Harry's parents were offered limited support when he was excluded from several schools under the age of ten. During the last 20 years, there have been changes in practice that may address some of these challenges. However, do people have access to services that can support the diagnosis of FASD?

Good practice
There was collaboration between workers when conducting joint visits. Some agencies' workers identified Harry's inability to meet his needs and attempted referrals to statutory services. Some workers developed clear boundaries with Harry, enabling them to continue working with him despite his challenging and aggressive behaviour. There was recognition from managers that some of Harry's behaviours toward workers was unacceptable, and they sought to protect them from these.

Richard

What happened

Richard died, aged 69, in Sheffield Teaching Hospital from sepsis. Richard's family reported that he was impulsive and very gregarious. He liked cars, holidays and houses. Richard "disappeared" in 2004, and despite his son reporting him missing, he did not know where he was until 2021, when he discovered him in a care home in Barnsley.

Richard's family was able to talk to him on the phone. However, visits angered Richard, who did not recognise them as his family.

Richard had developed Korsakoff Syndrome (alcohol-related dementia), and while he had stopped drinking, he was a very heavy smoker. As a result, Richard had significant issues with ischaemia and leg ulcers but was resistant to treatment in care settings and in the hospital. Richard was under the care of specialist vascular services at Sheffield Teaching Hospitals, who advised a lower leg amputation which Richard refused.

This decision was not challenged, despite his diagnosis of Korsakoff and the Deprivation of Liberty Safeguards order in place at the care home where he lived. Later that year, Richard informed Barnsley Hospital that he would consider the amputation as he had not appreciated that he might die without it.

They shared this information via a telephone call, but this was sadly not recorded, and Richard's decision was not reviewed by the medical staff.

Terms of reference

- How did your agency 'access' Richard's voice to make sure his wishes and views were obtained and considered? This includes any past or present wishes and feelings as well as 'beliefs and values'.
- How did organisations share information to support holistic risk assessments and treatment plans?
- How did organisations use the legal frameworks to safeguard Richard, including the Care Act, and was this in line with internal policies and best practice?
- How did organisations use advocates and family members to support Richard and any decision making?
- How did the use of health services in different local authority areas impact his care?
- What support was provided to front-line practitioners working with Richard?
- What learning will your organisation take from this review, and how will any changes be implemented?

Key learning

- Assessments into Richard's capacity were not completed, despite his diagnosis of Korsakoff Syndrome and his history of self-neglect in care settings and in hospitals.
- Deprivation of Liberty Safeguards, which should have been put in place, were absent.

- The care home did not actively monitor his self-neglect and complete assessments to establish his ability to make decisions or escalate concerns to Adult Social Care.
- Health and social care organisations failed to tell family members about his many hospital admissions or health status. Richard had not stated he did not want them involved, nor was it based on a best-interest decision.
- Whilst he benefitted from a strong relationship with an advocate in Barnsley, Sheffield did not secure this support for him whilst in hospital.
- The absence of a shared healthcare record between Barnsley and Sheffield hospitals increased the risk of information being "lost" and impacted the ability to complete risk and capacity assessments.

Good practice

- Richard had a strong relationship with his advocate and social worker, who supported each other despite a Section 21A appeal against his Deprivation of Liberty.
- The district nurse's persistence in meeting his needs in the care home, despite his resistance.
- The well-recorded capacity assessment and decision about his willingness to consider an assessment completed by Barnsley Hospital.
- The advocate's support of Richard whilst in Sheffield Hospital, as he had no other advocacy support.

Recommendations

- Recommendations aiming to embed the use of the Mental Capacity Act in practice for health and care settings.
- Recommendations aiming to improve communication between agencies, especially between Barnsley and Sheffield hospitals.
- Recommendations to clarify family members' role and access to information when adults are accessing health or social care settings. The Mental Capacity Act is to be used if the adult is unable to make decisions about contact with family or friends.
- Recommendations to reinforce a multi-agency approach to the care of people with complex needs, including the use of the new Universal Health Passport.
- Recommendations addressing points raised by the family to make sure their voices and views are considered when working with an adult who may be unable to make decisions about contact with family.

Putting the learning into practice

- Make sure that organisations involved in the care of adults with complex needs or with a history of self-neglect have robust information-sharing processes in place.
- Escalation routes are in place when messages are not received and recorded, including to legal services.
- Clear processes are in place to keep family and friends informed of key events, unless they are excluded from contact with the adult.

- Do you know how and when to appoint advocates for people in Barnsley and when they are out of the area?

We extend thanks to the families of Harry and Richard, whose involvement provided a picture of the person. This information helps us embed learning more effectively.

Full copies of the report can be found on our safeguarding webpages.

Action plans are produced for all SARs and lessons learnt. These are monitored monthly by the relevant sub-group to prove that learning has been embedded in practice.

The combined action plan for four adults who died of self-neglect and hoarding in previous years was signed off as completed in 2023. A challenge event aimed at checking that the required changes have been made will take place before the end of this summer.

Ambitions for 2023/24

Our core ambitions will remain the same, with a development event being held later this year to inform our strategic plan for 2024 to 2027.

Core ambitions

- To ensure that collectively, we all work hard to prevent harm and abuse across Barnsley.
- To develop citizen-led approaches to safeguarding.
- To continue to develop safe transition experiences for young people.
- Learning together and continually improving.

Specifically, we will work to

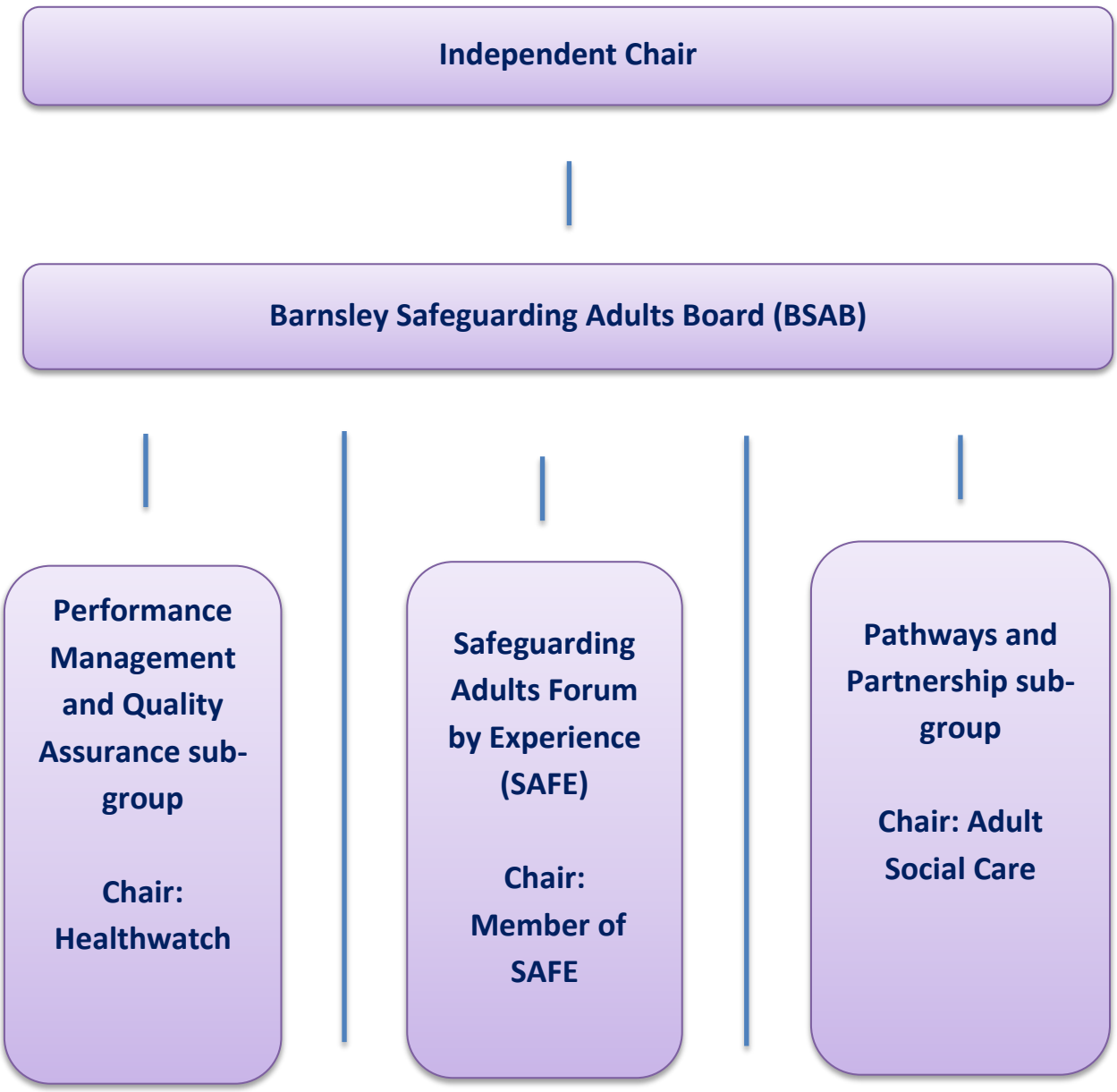
- Review and update our strategic plan.
- Improve the quality of data available to the Board to provide the necessary assurance about how well we are keeping people safe.
- Improve our knowledge of the quality of training provided within the independent care and voluntary sectors.
- Use the learning and impact of the temporary customer engagement post to inform our ambition to increase public knowledge of and confidence to share concerns about themselves, their families or neighbours.
- Support the new Chair in her role to benefit from her experience in West Yorkshire.
- Complete audits and challenge events to test the impact of our work in practice.

Board's budget

	£
Employee costs	142,230

Supplies and services	21,165
Total expenditure	**163,394**
NHS Barnsley CCG (Clinical Commissioning Group)	26,642
Police and crime commissioner	20,429
Uncommitted resources from 21/22	40,994
Barnsley Council budget contribution	113,850
Total funding / income	**201,915**
Budget underspend 22/23	**-38,521**

Barnsley Safeguarding Adults Board structure



Learning and Development sub-group

Chair: Barnsley Council

Safeguarding Adults Review and Domestic Homicide Review sub-committee

Chair: Independent Chair of BSAB

Thanks to all our partners who have worked with us to demonstrate what they are doing to prevent harm and abuse every day.