Barnsley Safeguarding Adults Board Annual Report 2021 – 2022

For more information about Safeguarding - https://www.barnsley.gov.uk/services/children-families-and-education/safeguarding-families-in-barnsley/safeguarding-adults-in-barnsley/

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1. Welcome

Welcome to the annual report of the Barnsley Safeguarding Adults Board.

Take a look at our video to hear from Bob Dyson QPM, DL, Independent Chair of Barnsley Safeguarding Adults Board.

Foreword from Bob Dyson – Independent Chair of Barnsley Safeguarding Adults Board

Hello, my name is Bob Dyson and I'm the Independent Chair of Barnsley Safeguarding Adults Board. Thank you for showing an interest in the annual report of the Safeguarding Adults Board for the year of 2021 to 2022. I hope you find the time and interest to read the full report, which can be accessed on the board’s website.

If you do read the report, you’ll see that it sets out many of the achievements of that year. A number of things have improved and it's too many to list in this short video. During the last year, we did continue to operate under COVID restrictions. The board met virtually over technology, and that’s worked very well for us and enabled us to continue the work of the board without any break. The one exception to that being our customer engagement group who haven't had the technology and the training in order to keep going, but that I’m pleased to say that they are now back to meeting in person.

One of the key things we've done during the last twelve months was to try and raise public awareness of safeguarding issues. A big thrust of that was through the Safeguarding Awareness Week and last year saw Barnsley chair and host the first ever countywide launch of Safeguarding Awareness Week.

We work closely with such people as the football club and the markets to engage with the public trying to get key messages across. Recent months have seen some improvements in the number of referrals that we've seen from members of the public, where they've seen safeguarding issues and felt the need to raise them with us.

We consider that to be a real success story, something that we really want to encourage and to build on. We'll be doing more work on that in the coming year, including having a customer engagement office working with us who will go out and meet with the public in a much more structured way to try and get those messages out there so that we get to hear about the cases where our people need support.

We are always very keen to improve and there's been a couple of things that we've done over the last year that are notable on that front. One is that we met with the other partnership boards operate here in Barnsley just to make sure that between us we were covering all the issues that need to be covered and that we weren't duplicating effort and more importantly, having gaps appear where no one was doing the work as they thought someone else was doing it. An action plan come out of that and we will work smarter and better as a consequence of it.

At the back end of the year, in March, we went through a peer review where colleagues from across the region came into Barnsley and brought an outside perspective to the work that we do in safeguarding adults. That included an audit of actual cases that have been conducted here. I'm pleased to say that that peer review did not find any major failings in our approach and in fact, identified a number of strengths that we’re very proud of. It did, of course, identify some areas that we will now look to implement, and we will do that in the coming year.

As Independent Chair, one of my roles is to be satisfied that the agencies who make up the Safeguarding Board are working effectively together to ensure that they're doing what they can to keep adults at risk in Barnsley safe with the resources that they have at their disposal.

I'm pleased to say that the last twelve months has seen them continue to show a real commitment to working together and to keeping people safe. So once again, if I can encourage you, please, to look at the full report and you'll learn a lot more detail about the work of the board. Thank you.

2. About safeguarding

All adults have the right to live free from harm, abuse and fear. Ideally, safeguarding supports someone to take control and to take action to feel safer, possibly with the help of workers and volunteers.

What is safeguarding?

- Supporting someone to take action to feel safe, which might involve providing information about support services, assisting with housing issues or raising concerns about the quality of the care they, or a loved one, is receiving.
- Working with the adult, or their family and friends, if they're unable to put things right and stop the harm without support from a worker or volunteer. This might involve reviewing their care package or referring them to a specialist service like domestic abuse or the police. The adult might agree that we need to work together to safeguard them using the Care Act definitions (Section 42 enquiry).
- Improving the quality of services to make sure that people get the best possible care and support by working with the Care Quality Commission (CQC) and commissioners.
- Ensuring that workers and volunteers who have harmed adults are investigated and, if necessary, referrals are made to professional registration bodies and/or the Disclosure and Barring Service (DBS).
- Working together to support adults who are self-neglecting and/or hoarding who are refusing all support and help.

Definition of abuse

Any action, deliberate or unintentional, or a failure to take action or provide care that results in harm to the adult.

There are many different types of abuse – find out more information about abuse on our safeguarding families in Barnsley website.

How do I report concerns about the safety of an adult?

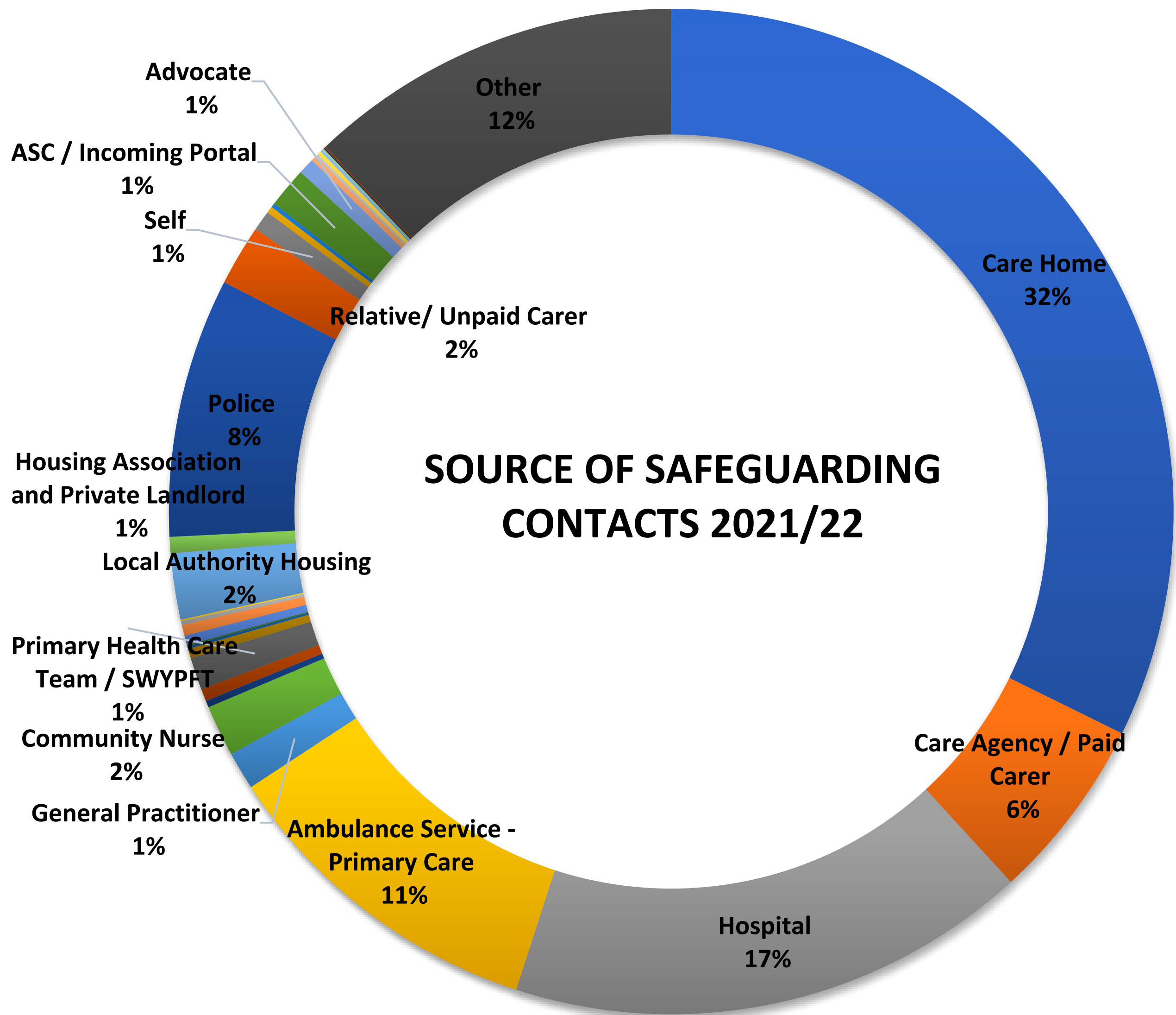
- Call Adult Social Care on (01226) 773300 or their out of hours line on (01226) 787789.
- If it’s an emergency, call the police on 999.

3 **Safeguarding activity**

Barnsley received **2,231** safeguarding concerns in 2021/2022, which is a 9% increase on the number of safeguarding concerns received in 2020/2021 (2,023 concerns)

Concerns were identified and shared by the following organisations:

- Care home - 32%
- Care agency/paid carer - 6%
- Hospital - 17%
- Ambulance service - primary care - 11%
- General practitioner - 1%
- Community nurse - 2%
- Primary healthcare team/SWYPF - 1%
- Local authority housing - 2%
- Housing association and private landlord - 1%
- Police - 8%
- Self - 1%
- Relative/unpaid carer - 2%
- Adult social care/incoming portal - 1%
- Advocate - 1%
- Other - 12%



Barnsley Hospital has committed to increase knowledge of safeguarding adults to all staff by providing training, resulting in a 6% increase in the number of adults referred in 2021/22.

A change to the screening processes at the Adult Social Care front door has reduced the number of referrals from South Yorkshire Police being incorrectly recorded as safeguarding concerns. This work has helped adults get the right support for them in a timely manner, making sure concerns are directed to the right team, whether that's safeguarding, social care assessments or other local support.

Our commitment to improving the quality of data available has reduced the percentage of concerns listed as 'other' from 14% to 12%. This year, we've seen other housing providers and advocates being identified as referrers for the first time in our annual report.

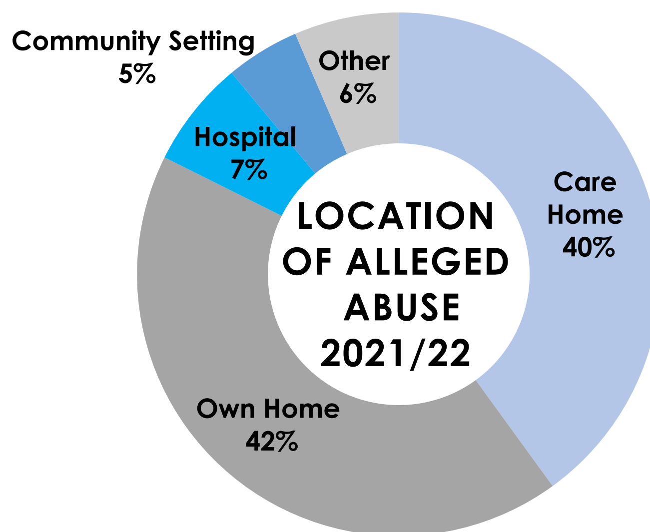
Referrals from doctors and other primary care staff remain at 3% of the total number of concerns received. However, a greater percentage have resulted in a safeguarding enquiry, demonstrating the high-quality referrals sent by GPs and practice staff. Work continues with GPs as they're well placed to identify patients at risk of harm and abuse.

We're pleased to report that concerns reported by themselves, their family and friends increased each quarter. This indicates that the impact of our communications strategy, including promoting Safeguarding Awareness Week, is reaching Barnsley citizens and supporting them to contact us for help and support.

Location of Harm

Locations of alleged abuse in 2021/22:

- Care home - 40%
- Own home - 42%
- Hospital - 7%
- Community setting - 5%
- Other - 6%



We're planning to increase awareness of adult safeguarding in the community to increase the number of referrals relating to adults living in their own homes in 2022/23.

The percentage of cases in people's homes has dropped from 51% to 42%, as this is not directly linked to an increase in the number of adults living in care homes. The Safeguarding Board is committed to protecting people from harm and abuse in the community and encourages everyone to look out for their families, friends and neighbours.

Safeguarding starts with a conversation with the adult to explore what help they want and how we can support them to feel safer in the future.

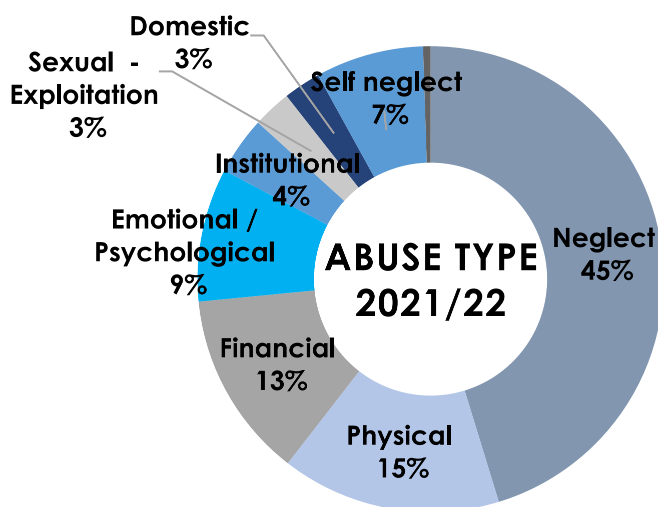
The concerns listed as hospitals include private hospitals in Barnsley, not just Barnsley Hospital.

What type of harm were reported and experienced?

Abuse type in 2021/22:

- Neglect - 45%

- Physical - 15%
- Financial - 13%
- Emotional/psychological - 9%
- Institutional - 4%
- Sexual exploitation - 3%
- Domestic - 3%
- Self-neglect - 7%



Over the past year, we've seen a rise in the number of neglect and physical abuse cases recorded in Barnsley.

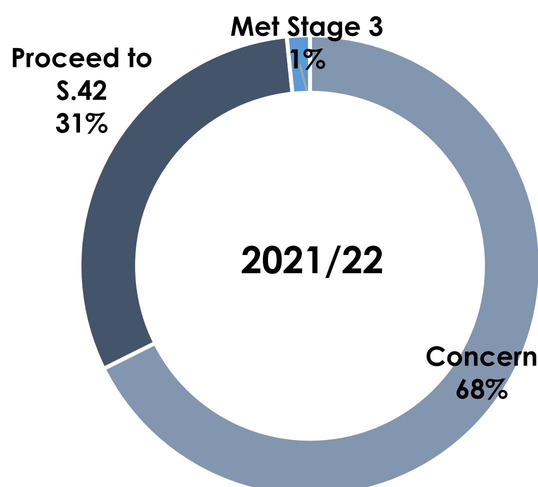
We're working to promote the support available for our borough's carers and to increase the public's ability to tell us if they're worried about their neighbours, friends or family.

We continue to work closely with our care providers, commissioners and the Care Quality Commission (CQC) to help them deliver high-quality care to adults in both care homes and their own homes.

Our work to help support adults struggling with self-neglect and hoarding has developed significantly over the past year, and we are delighted to see effective partnership working in place to help address this issue.

The board has been regularly updated on the impact of COVID-19, working together to identify solutions which minimise the risk to adults receiving care.

Safeguarding enquiries – helping adults to stop harm and to feel safer



Enquiries in 2021/22:

- Concern - 68%
- Proceed to Section 42 - 31%
- Met stage 3 - 1%

A Section 42 enquiry begins when an adult meets the three-stage test and agrees that they want help to stop or reduce the risk of harm.

Where an adult is unable to make the decision, for example, because of dementia, we'd use the Mental Capacity Act to confirm that they're unable to make this decision and decide if it's in their best interests for safeguarding to keep them safe.

Our safeguarding responses are very similar to previous years and in line with national averages, which suggest that 33% of safeguarding concerns result in safeguarding enquiries.

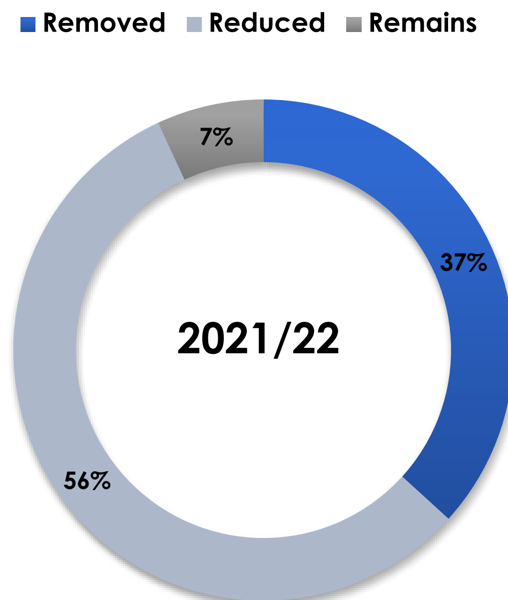
- 686 adults were supported to stop harm and abuse by a multi-agency safeguarding enquiry (Section 42). The majority were aged 65 plus.
- Demographically, the 684 adults supported by a Section 42 response are shown below; this is in line with our population demographic
    - Race
        - 80% of adults supported were white British.
        - 2.52% identified as black and minority ethnic.
    - Gender - the increase of referrals about men, noted in the 2020 – 2021 annual report, has continued to increase:
        - Women supported by safeguarding – 57%
        - Men support by safeguarding - 43%
        - Barnsley is in line with both regional and national comparators for gender.

Did we help adults feel safer?

Safeguarding aims to stop or reduce the risk of harm and to make people feel safer, if possible, by supporting them to be active partners in resolving the issues they face.

In 2021/22:

- removed - 37%
- reduced - 56%
- remains - 7%



In 2021/22 we removed or reduced the risks for 93% of the adults we supported.

Adults can choose to continue to have relationships with people who pose a risk to them, including family members and friends. Seven percent of adults valued these relationships more highly than the risks posed to their safety. In these cases, we advised them to contact us if they wanted support in the future to address the risk of harm and/or abuse.

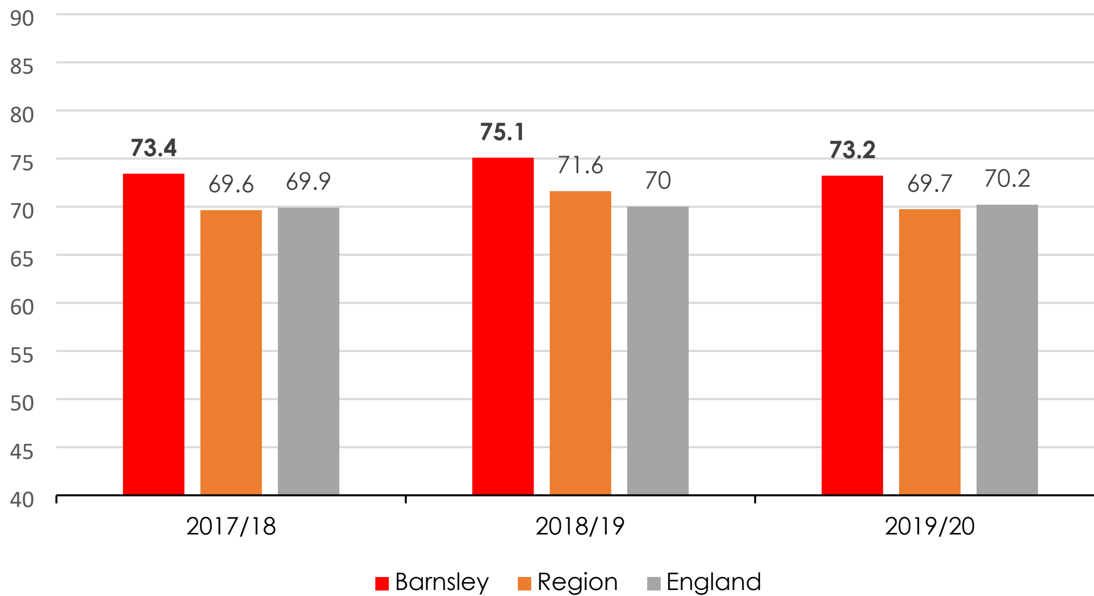
If a worker or volunteer is identified as the source of harm, a safeguarding enquiry will always take place, irrespective of the views of the adult. This is in line with our duties under the Care Act (2014) to respond to 'people in positions of trust', which includes workers or volunteers who may pose a risk to other adults.

Preventing harm and abuse

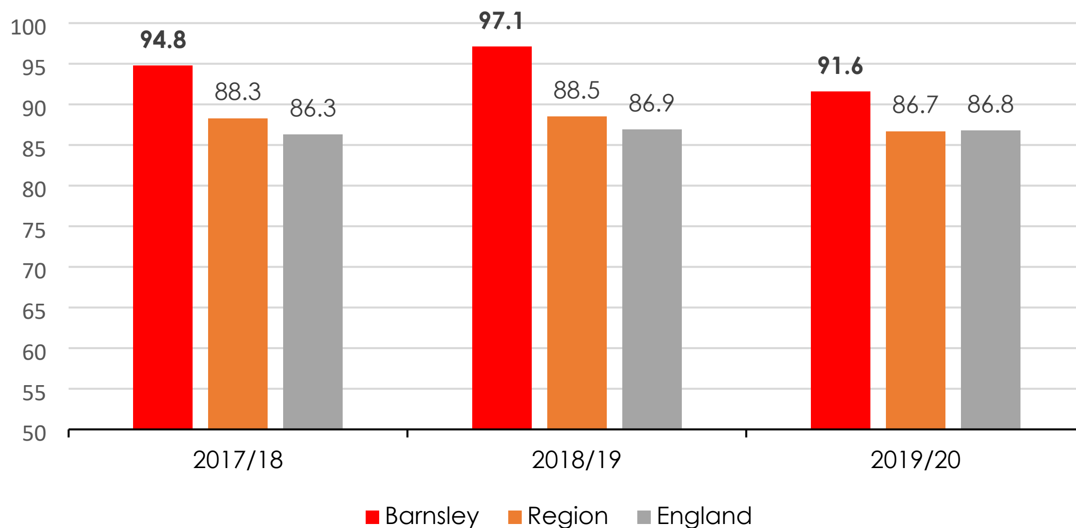
We're committed to preventing harm and abuse of adults in Barnsley. We do this by making sure that the services we provide are of a good quality and support adults to feel safe.

Barnsley remains well ahead of both regional and national comparators in the data provided to the Department of Health. The data is recorded in the Adult Social Care Outcomes Frameworks (ASCOF).

People who use services in Barnsley who say they feel safer – comparison of local/regional and national data



People who use services who tell us they help them feel safe and secure, showing local, regional, and national performance



The data for 2020/21 is not published until October 2022.

4 Case Studies

Emma (please note these are not the real names of the individuals involved)

Emma's Story - Safeguarding Adults Board

Emma (age – 59) has struggled with mental ill health and alcohol problems for many years. Her problems escalated following the death of her son by suicide, 5 years ago. Emma has no contact with her daughter or other family members and has no social networks

Emma has a long history of ringing for help from ambulance, police, and other services, which resulted in a referral to the High Intensity User Group, a multi-agency group, who attempt to reduce unnecessary calls to "blue light" services. Emma was often transported to Barnsley Hospital where she developed a strong and positive relationship with staff.

Emma was convicted of arson in her flat in 2020 and sent to prison who identified memory concerns and referred her for a social care assessment. On release she was monitored by probation and subject to monitoring via MAPPA (Multi Agency Public Protection Arrangements) because of the risks posed by her offending

In 2021 she returned to Barnsley and was placed in residential care, however her verbal aggression resulted in eviction. A short hold tenancy with support from two workers lasted less than a week and resulted in a period of very chaotic behaviour and drinking. Information from the MAPPA meeting indicated that Emma had been diagnosed with an "Emotionally Unstable Personality Disorder" and was best supported by a "strong structure of care and support"

A multi-agency meeting attended by organisations who knew Emma well was held and as a result she was placed in a residential unit with support from two workers, at the start of 2022. A capacity assessment was completed which evidenced that Emma was unable to understand the risks linked to her behaviour and the necessary restrictions in her care plan to keep her safe were authorised by a Deprivation of Liberty Safeguard's standard Her relationship with staff at Barnsley hospital enabled an assessment of her physical health to confirm if her claim that she needed crutches and/or wheelchair were factual. Emma and the hospital agreed that she did not need these walking aids.

Emma reports being "happy "in the unit and her drinking is rarely an issue and the unit have not reported any concerns that would put the placement in jeopardy.

Helen (please note these are not the real names of the individuals involved)

Helen's Story - Safeguarding Adults Board

Helen (49) was referred to Adult Social Care, by her daughter who was concerned that Helen was hoarding and not looking after herself. Adult Social Care picked up the case in February 2021 and started to build up a relationship with her. Helen has a history of mental ill-health, substance misuse and has lived with domestic abuse for many years.

Initially Helen was reluctant to engage with professionals and would not let anyone into her home, so conversations with Helen took place at her mum's house, who she felt safe with.

Helen lives in a three-bed house, managed by Berneslai Homes, who had been unsuccessful in completing the required checks on her boiler, despite many attempts and this forced them to "cut off "her gas supply.

Helen's partner, who frequently took high value items to sell, which contributed to Helen's desire to have "spares" in the property. His death in 2021, ended the domestic abuse, he subjected her too, however this loss added to Helen's hoarding behaviours.

Due to the concerns about fire safety, her physical and mental health the case was escalated into the Self-Neglect and Hoarding process, part of Adult Safeguarding. As a result, three agencies began working closely with Helen and each other to share the responsibility of building relationships and addressing the risks. (Adult Social Care, Berneslai Homes (Mental Health Tenancy Support) and Safer Neighbourhoods.) As a result of the persistent and empowering approach taken, Helen felt able to let workers into her home and this allowed Berneslai Homes to service the boiler and complete other improvements to her home. South Yorkshire Fire and Rescue were able assess fire risks and put in place the necessary alarms etc.

Helen was invited to all the meetings but chose not to attend but has continued to engage with the workers, sadly Helen's mum died unexpectedly, and it was feared that Helen would disengage, fortunately this did not happen.

Helen is no longer being managed under the self-neglect and hoarding processes as the risks have reduced, however she still receives regular support, it is hoped that she may be able to move to a smaller property and consider accessing other support in the coming months

The workers have benefited from the mutual support from working together to support Helen over many months and Ellen has regained her faith in contact with workers.

James (please note these are not the real names of the individuals involved)

[James' Story - Safeguarding Adults Board]

James (37) was referred into Neighbourhood nursing services in October 2020 following a hospital admission for abdominal pain, vomiting and loose stools. Diagnosed with a diabetic Ketoacidosis. James has a history of Type 1 Diabetes, Severe left ventricular Dysfunction (heart Failure), anaemia, severe kidney disease and hepatomegaly (enlarged liver). It was noted on his discharge letter that he had been referred to learning disability team for support although learning disability had not been confirmed. He was initially treated with intravenous fluid and a fix rate insulin in accident and emergency department however transferred to intensive care due to poor access and a central line was inserted. He was very unwell whilst in hospital. On discharge James had voiced that he was struggling to manage at home particularly remembering his insulin. James had had numerous admissions to hospital in the past with diabetic related problems. James had not particularly engaged with health professionals in the past and had managed his condition himself.

James lived with his mum initially however prior to admission had moved to a Berneslai homes flat and was living independently with ongoing adhoc support from his mum.

Following the initial assessment visit and subsequent visits to provide education and support to James regarding his condition and management there were concerns regarding his capacity around his Diabetes care, treatment, and management. He was very frail in appearance and due to his admissions to hospital very vulnerable with the possibility of a fatality in his poor management of his condition. As a result, discussions were held with the trust safeguarding team for advice and a decision to arrange a professionals meeting to discuss his case was made. This took place involving all professionals from health and social care that had been involved with him to discuss concerns along with adult safeguarding team for support and trust legal team.

As a result, a capacity assessment was carried by the Diabetes Specialist nurse around his Diabetes care and treatment. Initially there was concern that James had some understanding however due to his concrete thinking around his disease was unable to manage his condition effectively. James was involved in the meetings to be able to voice his wishes around his care and support. Several services were involved in supporting James (Social Worker, District Nurses, Diabetes Specialist Nurses, Community Matron, Continuing Health Care and GP). Community Matron visited on a regular basis to build up a relationship with James and ensure he was involved in all decisions being discussed regarding his care whilst ensuring his wishes were taken into consideration as he was reluctant to engage with nurses visiting daily to support with his insulin management. During the time that meetings were being held James developed bilateral retinal detachment (retinas of the eye had become detached resulting in loss of sight) which required surgery to maintain a level of eyesight. This was a complication of his poor management of his condition. Throughout the episode of care, the multi-agency self-neglect pathway has been used to support the process.

As a result of continual support and empowering James with his care, working with him to achieve his outcomes, he agreed to accept support. He now has a care package for support with meals three times per day, shopping weekly, District Nurses visiting twice daily to support and encourage James with his insulin administration, regular review from Diabetes Nurse specialist and ongoing monitoring from Matron. He is attending his appointments at renal unit on regular basis for review of his poor kidney function as he may, at later date require kidney transplant.

Previously James was being admitted to hospital on a very frequent basis and in quite a poor condition. Since referral to the service and the support that has been provided to James his admissions have reduced greatly and he is remaining well, for the severity of his condition. Professionals involved in his care have greatly appreciated the discussions and teamwork that took place to provide support plans and support to proactively maintain and level of health for James.

5 Key achievements

Achievements	Impact
Safeguarding adults education programme A high-quality programme has been established, offering workers and volunteers free education and training virtually via Teams or face-to-face. As a result of this training post, Barnsley is now	The Safeguarding Adults Board can monitor which organisations are accessing training and how this impacts the quality of the safeguarding support we offer. We can influence the content of regional conferences to meet the needs of Barnsley workers and volunteers.

actively involved in shaping the South Yorkshire education programme.	
South Yorkshire safeguarding adults launch event In 2021, we held the first South Yorkshire-wide launch event at Northern College, where colleagues from across the region benefitted from specialist inputs and sharing their experiences of: • Preparing young people for adulthood • Supporting adults who are self-neglecting and/or hoarding	The format was so successful that the event will be repeated in 2022, hosted by another regional local authority. Locally, a task and finish group has been created to improve the support we offer young people who may struggle to be safe adults or effective parents.
Safeguarding Awareness Week Radio advertising brought safeguarding messages into people's homes and cars, with the aim of supporting people in Barnsley to share concerns about themselves, their families, or neighbours. A joint leaflet explaining adults' and children's safeguarding was produced and kindly shared by market stall holders during the week. The leaflet was also shared at several public-facing events. We saw a strong social media presence by all Safeguarding Adults Board partners during the week and supplemented by ongoing campaigns during the year.	The leaflet is available in care homes, pharmacies and support organisations across Barnsley. We'll continue to extend its availability across the borough. The SAFE customer group have agreed to deliver local public information events throughout the year. The Safeguarding Adults Board have agreed to fund a customer engagement post to improve the safeguarding knowledge of community groups and their ability to prevent and respond to safeguarding concerns.
Partnership boards working together A development event bringing together six boards took place to support us in working effectively on topics impacting us. These include domestic abuse, homelessness, modern slavery, and neglect.	We'll develop our ability to work together on shared issues by changing our meetings, creating shared data resources and building feedback mechanisms to reduce duplication and improve our ability to keep people in Barnsley safe.
Safeguarding adults peer review The Barnsley Safeguarding Adults Board invited the Local Government Association to review how well we safeguard adults and help us develop an action plan for any improvements needed. We'd like to thank all our colleagues who took part in this and shared their views.	Initial feedback says we're doing well and confirmed areas we'd previously identified for improvement. When the full report is produced, it'll be used to inform our strategy and work plan for the coming year.

<table>
<tr><th>Achievements</th><th>Impact</th></tr>
<tr><td>New guidance and policies developed

Our guidance and policies are regularly reviewed and updated to support workers and volunteers to keep adults safe in line with best practice.</td><td>Workers and volunteers always have access to current policies and guidance.</td></tr>
<tr><td>Increase in the number of self-neglect and hoarding positively resolved

Learning from recent cases, new policies and a commitment to partnership working has led to an increase in the number of adults supported to resolve the risks linked to their self-neglect and/or hoarding.

The customer-led hoarding support groups have been positively received.</td><td>Adults and workers are reporting that self-neglect and hoarding issues are being resolved.

Only one safeguarding adults review request, following the death of an adult linked to their self-neglect, was received in the year.</td></tr>
<tr><td>Research

The Safeguarding Adults Board has agreed to be part of three national research projects:
1. Self-neglect and hoarding, led by the University of Sussex
2. Transitions, led by the University of Sussex
3. Medication safety in care homes, a PhD project with support from the South Yorkshire Integrated Cared System.

Some of these will run to 2024 but will support ongoing improvements.</td><td>We'll benefit from the learning and resources produced because of the research, and this will improve local practice.

Care homes will be supported to manage medication in line with best practice.</td></tr>
<tr><td>Subgroups development event

The subgroup members met to evaluate their performance and explore if changes could be made to membership, developing new relationships and priorities to improve their ability to deliver to keep adults in Barnsley safe.</td><td>The workplans for each subgroup have been amended and are regularly reviewed to help keep adults in Barnsley safe from abuse.</td></tr>
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6 Safeguarding Adults Reviews (SAR) and lessons learnt

The Care Act (2014) requires safeguarding boards to "consider all deaths or 'near misses' of adults we know or suspect were being abused or at risk of abuse, and partners may not have worked together to prevent the harm."

The Safeguarding Adults Review Panel meets monthly to consider all referrals, and Barnsley is committed to reviewing cases that don't meet the SAR criteria where we feel that we can improve practice by completing a lessons learnt review.

Safeguarding Adults Reviews

1) **Lola (please note these are not the real names of the individuals involved)**

Lola, an adult with learning disabilities, was admitted to the hospital emaciated and dehydrated from her family home, who had been her carers. Lola required an intensive care bed and remained in hospital for many weeks. South Yorkshire Police interviewed the family about possible wilful neglect of Lola, and Adult Social Care offered support to two elderly relatives living in the household who were reliant on Lola's parents for care and support.

Several opportunities were missed to seek Lola's views in previous contacts with the family, as the professional was too accepting of the families' views that neither Lola, nor they, required any support. Most professionals didn't have a conversation with Lola on her own to establish her views and wishes. Failure to support or bring Lola to her appointments did not generate the expected level of professional curiosity about her circumstances. Work has been commenced, in collaboration with GPs and the Health and Wellbeing Board, to improve our ability to track and respond to adults with learning disabilities who are not brought to health appointments.

Lola has made good progress and is living in supported accommodation, where she's developing skills in cooking and budgeting. Her social network has grown, and she reports that 'I'm alright now to be here. Listening to music and having a nice chillin' time in my bed.'

You can read the full report regarding Lola or the seven-minute briefing about Lola.

2) **Mr J (please note these are not the real names of the individuals involved)**

Mr J died in hospital because of his non-engagement with health services, also known as self-neglect. He had a long history of mental ill-health and struggled with relationships, in part because of his inability to manage his emotions or money. Mr J was a probation client, and they referred his case to the Safeguarding Adults Review Panel.

A review has commenced and a report will be published in autumn 2022.

Learning review: Adult F (please note these are not the real names of the individuals involved)

Adult F, aged 18, died at home following a fall in the bathroom.

F lived with his mother, and his father was a regular feature in his life. Historical social care referrals began when F was six, reporting verbal and physical abuse by his mother and father. Later, when he was a teenager, there became counter allegations of fights and F returning his mother's abuse.

He was in 'child in need planning' at the age of nine and 13 to 15 years. He was known to Children's Services when he was 16 and 17. There were additional concerns about his health, parents not attending appointments and a lack of engagement with professionals.

He suffered broken bones through playing on two occasions, but wasn't taken to hospital for over a week after the injuries occurred. F was referred to CAMHS and for Prada Willi tests in 2015. He had

moderate learning disabilities and was isolated at school with few friends, relating to the staff better than the other children.

He raised concerns over his weight and self-harming (picking skin) with the school nurse. His parents did not follow up on medical tests or follow health advice for F, and failed to engage with CAMHS after his first appointment. F was morbidly obese at the time of his death.

As adult services held no information on the case, Barnsley Safeguarding Children's Partnership was asked to complete the review into his death. Key learning included:

1. Support or plans for cases with insufficient movement to be peer reviewed to help ensure progress to effective outcomes.
2. Share best practice strategies to address barriers and encourage family engagement.
3. Outline of the deep dive to be used as case study in neglect awareness and family engagement skills training.
4. Recording systems and professional curiosity to support information sharing between services.
5. Audit findings to inform the Neglect Strategy.

You can read a seven-minute briefing on Adult F's case.

Learning review: Gillian (please note these are not the real names of the individuals involved)

We commenced a learning review into the circumstances of Gillian, an adult with learning disabilities, who was found in her family home with her deceased mother, who had died of natural causes. Her mother had been dead for several days before the police were contacted by a concerned neighbour and broke into the property.

The police found Gillian distressed, unable to provide her name or other information about other family members. As a result, they took Gillian to a mental health hospital for an assessment.

The review identified concerns about highly sexualised behaviour going back to childhood and an ongoing refusal to wear clothes. Gillian had very poor physical and oral health and had not been seen by medical services for several years. Gillian had a learning disability diagnosis as a child, but this did not result in transition into adult services.

The review identified several areas for development:

- Assessments, including mental capacity assessments, must be completed on adults who are thought to lack capacity to make these decisions, irrespective of the views of family members. Where possible, an advocate should be appointed to support the adult in expressing their views if possible.
- Non-attendance of health appointments, especially annual learning disability health checks, must be escalated and, if necessary, result in a safeguarding concern being shared with Adult Social Care. A 'was not brought' policy is being worked on, and this will support the escalation of concerns linked to non-attendance of all health appointments.
- Family assertions must be 'tested' to check their validity when an adult with learning disabilities is involved. Gillian's mother claimed that she attended college and was a volunteer with a local charity. However, there was no evidence supporting either of these claims.

- The creation of training and guidance to support workers to demonstrate persistence and professional curiosity when working with difficult to engage family members is being considered.

You can read a seven-minute briefing on Gillian's case.

Learning review: Provider case

The Care Quality Commission identified concerns about the safety of services provided by a private organisation in Barnsley. Neither Barnsley Council nor the South Yorkshire Integrated Care System had a contract with them to place young people in their unit.

The provider offered support to people aged 16 and over, but it was not registered with Ofsted as the care extended until at least the age of 25.

Concerns identified

- All adults in the unit were placed by local authorities outside the borough, which meant social workers or families didn't regularly see them.
- Inappropriate and excessive use of restraint were regularly used by staff.
- High levels of violence between residents.
- High levels of self-harm and absconding.
- Staff were not skilled to work with these young people, and some had not received the required Disclosure and Barring Service (DBS) and pre-employment checks.
- Safeguarding children's concerns about the young people under the age of 18 were not shared with Adult Social Care. However, they were shared with the placing social worker and local authority.
- None of the young people were registered with a local GP.

Learning identified includes:

- The CQC and commissioning colleagues must share details of providers in Barnsley who do not have an existing commissioning relationship.
- Records are created in the adult social care system to track low-level and safeguarding concerns so we can share them with the placing agencies.
- Exploring the role of GPs in working with providers who have no commissioned relationship with Barnsley Council or the South Yorkshire Integrated Care System.
- The risks of out-of-area placements in non-commissioned services are shared at all relevant forums, including adult and children's commissioning and the Yorkshire and Humber ADASS.
- Barnsley will adopt an out-of-area checklist to protect adults placed outside of the borough.

A learning brief will be published by mid-August 2022.

7. Ambitions for 2022/23

- Develop our ability to work with all boards and partnerships in Barnsley to keep adults safe.
- Improve the knowledge and confidence of members of the public to recognise and report safeguarding concerns, to be our eyes and ears.
- Use early learning from the research to inform practice.

- Gather evidence that training is making a difference in practice.
- Use learning from the peer review to inform the development of our 2022/23 work plan.
- Deliver a community-based Safeguarding Awareness Week in November 2022.
- Be ambitious in our desire to learn from practice, not just when cases meet the criteria for a Safeguarding Adults Review.

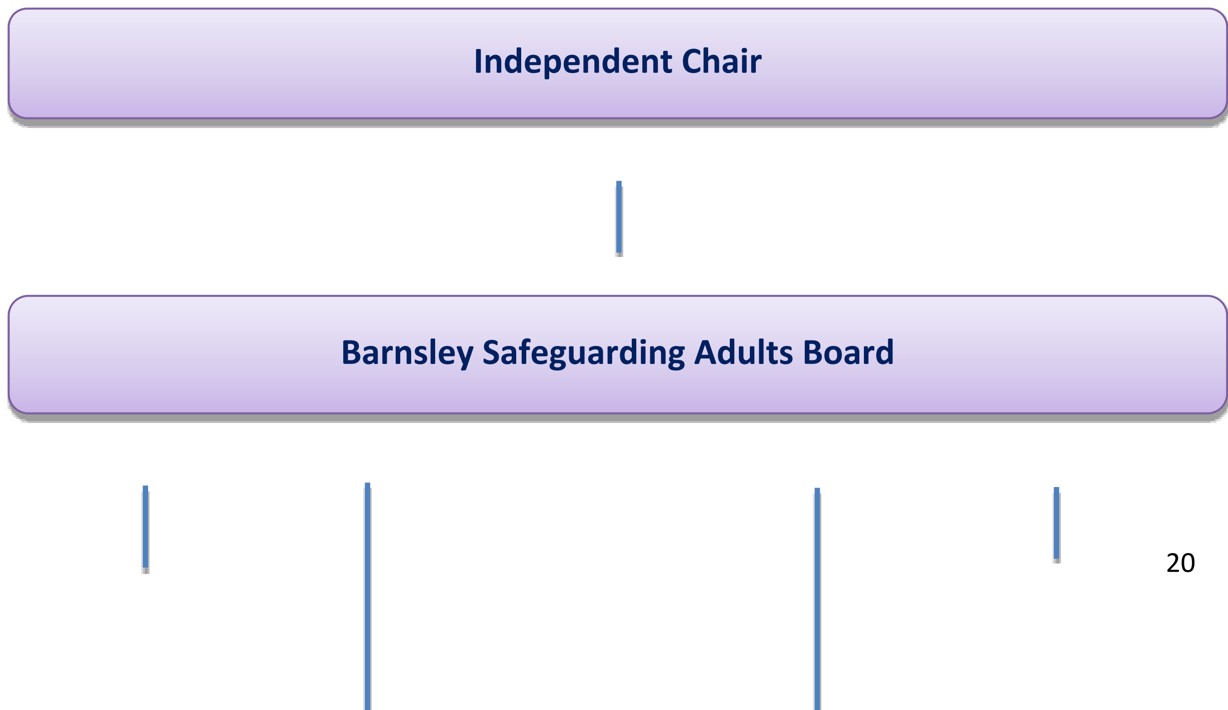
8 – Board Budget

The table below shows the financial position of the Adult Safeguarding Board for the 2021/22 financial year:

	Expenditure
Employee Costs	93,066
Supplies & Services	24,217
Business Support	21,784
Total expenditure	**139,067**
NHS Barnsley CCG	-26,642
Police & Crime Commissioner	-20,429
Uncommitted resources from 20/21	-35,750
BMBC budget contribution	-97,240
Total funding / income	**-180,061**
budget underspend 21/22	**-40,994**

The underspend of £40,994 has been carried over to 2022/23, with the agreement of the Barnsley Safeguarding Adults Board. This underspend is due to the late recruitment of a new part-time multi-agency trainer and the temporary reduction in hours for another employee.

9 – Board structure



Performance Management and Quality Assurance Subgroup

Chair: Healthwatch

Safeguarding Adults Forum by Experience

Chair: Member of SAFE

Pathways and Partnership Subgroup

Chair: Adult Social Care

Learning and Development Subgroup

Chair: Barnsley Council

SAR and DHR Sub Committee

Chair: Independent Chair of BSAB

11 – Board Partne

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