Liverpool
Safeguarding
Adults Board

Annual Report 2023/2024

Foreword from the Independent Chair

I am delighted to present Liverpool's Safeguarding Adults Board (LSAB) Annual Report for 2023-2024 on behalf of the Board. As Independent Chair, I continue to be impressed by the dedication of professionals working with adults with care and support, nursing and medical needs across the City of Liverpool, especially those who present in circumstances where a safeguarding response from services may be required. LSAB working in conjunction with statutory partners Liverpool City Council, NHS Cheshire and Merseyside, Merseyside Police, and its non-statutory partners from Housing, Health providers, Fire & Rescue Service, Probation and Advocacy services also continue to work together to strengthen safeguarding systems across the City.

One of the key elements of our work this year has been imbedding the Multi Agency Risk Assessment Management process. I can report that we are now at the stage of reviewing the implementation of this practice development.

The Board is in the process of refreshing its strategic priorities for the next three years, to achieve a shared vision with partners the board has held a development day to agree new strategic objectives. The newly agreed strategic objectives will focus on at risk adults with care and support needs at risk of experiencing abuse or neglect in relation to homelessness, transitional safeguarding, improving safeguarding systems by enhancing the voice of the local population within safeguarding processes within the city. The Board has commissioned a number of statutory Safeguarding Adults Reviews (SARs) over the past 2 years which has been a key priority for the Board and partners to progress. We are now entering a new phase for the board focussed on developing processes in relation to dissemination of key learning from SARs. We have recently held our first post Safeguarding Adults Review learning event which was delivered on behalf of the board by two partner agencies.

The event was a great success and feedback from professionals attending has been positive. The session focused on the issue of professional curiosity in cases with adults presenting with complex needs. This process will now be incorporated in to Safeguarding Adults Review procedures in Liverpool as a standard process for all completed Safeguarding Adults Reviews.

National Safeguarding adult's week was well attended, with over 300 professionals and volunteers accessing learning events across the week. The learning events included: introduction to LSAB, Introduction to Domestic Homicide Reviews, MARAM, Prevent, Adverse Childhood Experiences (ACEs) and Trauma, Financial Exploitation - Scam Awareness and Modern Slavery. The Board hopes to deliver an even more successful Safeguarding Adult Week in 2024!

I continue to be keen to hear the voice of the people of Liverpool in safeguarding processes and strengthen Making Safeguarding Personal in the work of the Board. I hope to see co-production become a feature of future annual reports.

As the Independent Chair of the Safeguarding Adults Board in Liverpool I wish to place on record my thanks to Boards statutory members and partners for their continued support in the work of the Board. I also want to thank the Board manager and her team for their support and endeavours, as without this, the work described in this report would not have been possible.

Duncan Dooley-Robinson

Chair Liverpool Safeguarding Adults Board

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Helping people live safely in Liverpool

This annual report covers the previous 12 months activity from 01 April 2023 to 31st March 2024. Over the past 12 months the board has continued to build upon learning from Safeguarding Adults Reviews, has developed new and improved multi-agency policy and guidance for practitioners, increased visibility of the board through launch events and National safeguarding adults week events, and has produced multi agency audits to scrutinise practice and provide assurance to the board.

What is Safeguarding?

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect." Care Act 2014

What is the purpose of adult safeguarding?

- Stop abuse or neglect wherever possible.
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.
- Promote an approach that concentrates on improving life for the adults concerned.
- Raise public awareness so that communities, alongside professionals, play their part in preventing, identifying, and responding to abuse and neglect.
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult.
- Address what has caused the abuse or neglect.

Adult Safeguarding Principles

- **Empowerment**
  People being supported and encouraged to make their own decisions and informed consent.
- **Prevention**
  It is better to act before harm occurs.
- **Proportionality**
  The least intrusive response appropriate to the risk presented.
- **Protection**
  Support and representation for those in greatest need.
- **Partnership**
  Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.
- **Accountability**
  Accountability and transparency in delivering safeguarding.

Our objective

The overarching objective of Liverpool SAB is to help 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 has occurred
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

Our three core duties

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect and gives the LSAB three core duties to undertake:

- Develop and publish a Strategic Plan
- Publish an Annual Report detailing the effectiveness of our work
- Commission Safeguarding Adults Reviews (SARs)

Visit our website liverpoolsab.org for more information, please visit Care Act 2014 (legislation.gov.uk)

Who are the Liverpool Safeguarding Adults Board?

As per Care Act 2014 statutory guidance, the LSAB membership must include Liverpool City Council, Merseyside Police and statutory partners.

To enhance safeguarding knowledge and expertise in Liverpool, the Board is also represented by senior representatives from the following sectors and agencies:

Strategic Priorities 2022 - 2024

1 Review safeguarding systems processes and performance

We will:

- Develop methods to monitor and evaluate the effectiveness of safeguarding arrangements in Liverpool.
- Ensure that we have intelligence led approaches to determine priorities, prevention strategies and address inequalities.
- Continue to analyse the impact of COVID 19 on society, partner agencies, and monitor it's impacts on our safeguarding adults at risk of abuse and neglect.
- Prioritise the development of effective multi-agency policy and practice guidance that is available in Liverpool to support the prevention of, and response to, abuse and neglect.
- Develop a programme of audits to help us understand how the partnership supports adults at risk in Liverpool and also to promote Making Safeguarding Personal.
- Review our Quality Assurance methods so the Board and its constituent partner agencies have effective systems, structures, process, and practice in place to effectively prevent and respond to abuse and neglect.

2 Develop city-wide approaches to safeguarding practice

We will:

- Work alongside Liverpool Children's Safeguarding Partnership to develop joint approaches to safeguarding young people with care and / or support needs who transition from children services to adults' services.
- Learn from Life and Death Reviews of people with a learning disability and autistic people. Learning Disability Mortality Review (LeDeR) will help us collaborate and develop joined up approaches to promoting healthy outcomes for adults with a learning difficulty.
- Learn from the homelessness death related panel and gain a better understanding of the challenges faced by people living street-based lives, which will help us to develop citywide approaches to self-neglect and homelessness related abuse.
- Map out and positively influence other citywide strategies that serve to protect adults with care and support needs from abuse, neglect or self-neglect.
- Seek assurance the workforce across the partnership is sufficiently skilled and equipped to effectively support adults at risk where abuse or neglect is suspected.
- Continue our commitment to raising the profile of the Liverpool Safeguarding Adults Board and its role in preventing abuse and neglect.

3 Learn from experience to im-prove how we work

We will:

- Develop a dashboard that will capture information from Safeguarding Adults Reviews, LeDe Reviews, Domestic Homicide Reviews and other reviews that will support us to identify common themes and develop action plans to implement the learning across the partnership.
- Ensure learning from Safeguarding Adults Reviews are disseminated across organisations in Liverpool.
- Use service users' experiences and feedback, to help us achieve positive safeguarding outcomes for people in Liverpool.
- Develop learning resources for practitioners that support Liverpool's approach to learning and development.
- Seek assurance from all agencies that the Board's approach to learning and development has been embedded into practice.

Our structure

Liverpool Safeguarding Adults Board governance consists of four subgroups, all of which have been established to focus on specific board related priorities to support the board to meet its statutory duties. The board has recently agreed to introduce an additional scrutiny and oversight group with the introduction of Liverpool SAB Executive Group which tracks and monitors the operational progress of each subgroup. This group is attended by Independent Chair, and Statutory representatives from Liverpool City Council- Adult Social Care, NHS Cheshire & Merseyside, and Merseyside Police. This group reports to the Liverpool Safeguarding Adults Board.

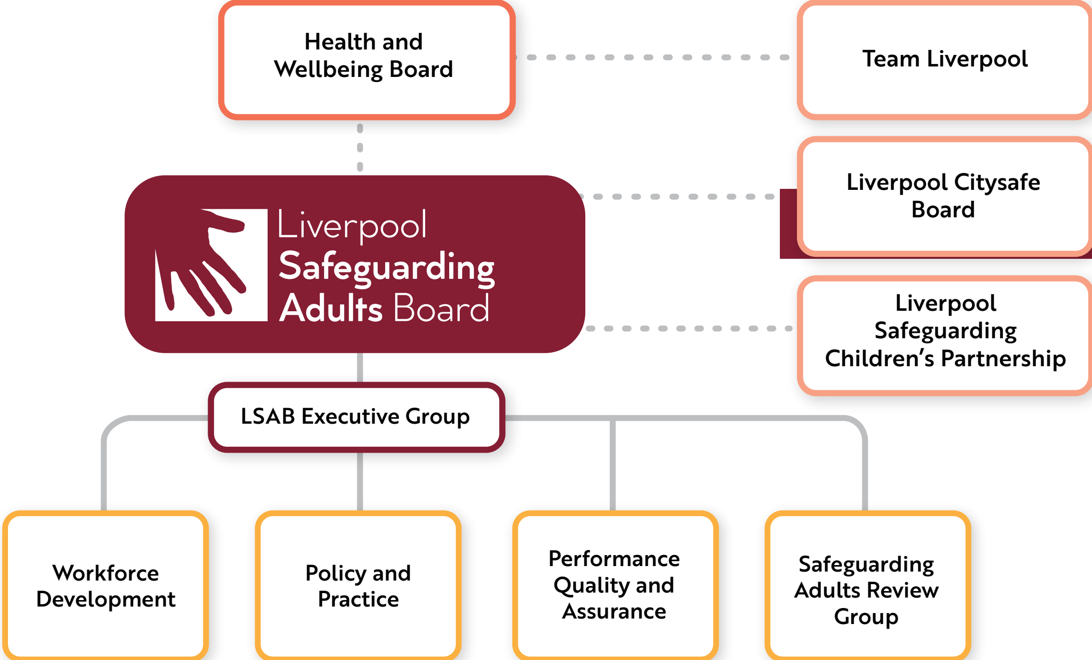
Liverpool SAB also has effective links with other Statutory Boards and Strategic partnerships including the Health and Well-being Board, Team Liverpool, Liverpool Safeguarding Children's Partnership and Liverpool Citysafe Partnership Board.

Independent Chair

This is the second consecutive year of Liverpool SAB (LSAB) having an Independent Chair to provide oversight and challenge to the board with regards to safeguarding practice. The Independent chair continues to chair LSAB meetings on a quarterly basis, and have oversight of the work activity of all four Subgroups. The Independent chair role provides scrutiny and challenge to partners around decision making in relation to Safeguarding Adults Review notification and screening recommendations.

Board Unit Team

Liverpool SAB has two dedicated posts, Board Manager, and Board Support Officer. The Board Unit Team act as a dedicated resource to support the workstreams outlined in the governance arrangements in Liverpool. The purpose of the two dedicated posts is to support the Board in achieving its strategic ambitions, and to help the Board meet its statutory duties.



Workforce Development Subgroup

Chairing Arrangements:
Subgroup chaired by YMCA Together

The purpose of the Workforce Development Subgroup is to:

- Identify learning themes from Safeguarding Adults Reviews and other Reviews undertaken locally, regionally, and nationally.
- To transfer learning themes and intelligence into a robust Liverpool training strategy for professionals and volunteers in Liverpool.
- Seek assurance that all staff and volunteers working in Liverpool are equipped with the necessary skills, knowledge and understanding to prevent and respond to abuse and neglect.
- Promote multi-agency training and consider any specialist training that may be required. This would include considering whether any training could be jointly commissioned within the partnership.
- Lead on safeguarding events and awareness raising themed events throughout the calendar year, with focussed input and contribution for Safeguarding Adults Week.

Achievements in 2023/2024 Include:

1. Launch events for new and refreshed Multi-Agency Procedures
2. Developed and delivered a successful National Safeguarding Adults Week programme of events for over 300 professionals and volunteers. Group is currently in the process of planning for a strengthened National Safeguarding Adults Week for 2024 which will offer both virtual and in person learning opportunities.
3. Promoted National Safeguarding themed events throughout the year in relation to Scam Awareness, Elder Abuse, Harmful Practices, and Self Neglect.
4. Continuing to thematically review all Safeguarding Adults Reviews to understand the priority safeguarding learning. The group has reviewed learning from six SARs (Joseph, Hazel, June, Paul/James, Colin, Robert) and developed a thematic learning tracker to monitor safeguarding theme prevalence.
5. Developed a scrutiny process for the group to lead on Post Safeguarding Adults Review Learning Events, including development of a multi-agency partnership group. This Quality Assurance process has been agreed by the Board.
6. Progressed 7-minute briefings in relation to Safeguarding Adults Reviews and specific themes identified in the SAR process.
7. Identified a new booking system for training events to be more accessible with improved coordination.
8. Developed a multi-agency training survey which will be a priority in 2024/2025 to progress.

Policy and Practice Subgroup

Chairing Arrangements:
Subgroup chaired by Liverpool City Council- Adult Social Care

The purpose of the Policy and Practice sub group is to:

- Develop policies and practice guidance for The Board to endorse.
- Guide and support all agencies with adult safeguarding, in their prevention and response to abuse and neglect.
- Clarify through clear policies and practice guidance the roles and responsibilities of each agency within the partnership in relation to the prevention and response to abuse and neglect of adults with care and support needs in Liverpool.
- Regularly review policies and practice guidance to reflect national and local developments.

Subgroup Work plan

- The sub group continues to be chaired by Adult social care, with the ICB Liverpool Place committing to deputy chair the group.
- A review of the membership of the sub group has taken place ensuring a stable and core membership.
- Arrangements have been solidified regarding how members of the wider partnership contribute to the development of Board policy and procedure.
- The commitment and engagement of partners has been highly positive.

Achievements in 2023/2024 include:

1. Transferring Safeguarding Adults Review learning themes into practitioner guidance
2. Developing a Liverpool Multi-agency Self-neglect and Hoarding Policy.
3. Reviewing and updating Liverpool's Hoarding Protocol.
4. Reviewing the Board's MARAM protocol – which now includes embedded documents for practitioners to use when implementing the approach.
5. Establishing a Task and finish group with a focus on updating and refreshing the Liverpool interagency safeguarding procedures.
6. Reviewing and updating the Board's guidance on Identifying and responding to adult safeguarding concerns.
7. Work commenced on developing a risk register for the Board and an accompanying governance framework.
8. Work commenced on resolving professional difference and escalation guidance

The sub group has an ambitious workplan over the coming year 2024/ 2025, including the new Safeguarding Procedures for Liverpool and reviewing the Person in position of trust protocol.

Performance and Quality Assurance Subgroup

Chairing Arrangements:
Subgroup chaired by NHS Cheshire and Merseyside

The purpose of the Performance and Quality Assurance Subgroup is to:

- To analyse and critically evaluate multi agency performance information to assist The Board in identifying themes, trends and patterns in Liverpool.
- Develop Quality Assurance methods that seek assurance to The Board that its constituent partner agencies have effective systems, structures, processes in place to effectively prevent and respond to abuse and neglect.
- To support the embedding of Making Safeguarding Personal in Liverpool.
- Develop a programme of audits to ensure that all approaches to safeguarding across the partnership are person-centred and capture the voice and lived experience of the adult in line with Making Safeguarding Personal approaches.
- To advise The Board on best practice to gain service user feedback to ensure that the voice of the service user informs, influences, and shapes the development of services.

Achievements in 2023/2024 include:

1. Multi agency Audit cycle produced to schedule quarterly multi agency audits being undertaken.
2. Multi-agency audit completed focusing on Safeguarding concerns to consider the appropriateness of referrals. Audit will be repeated in 2024-2025.
3. Single agency audit completed by Liverpool Adult Social Care in response to multi agency dashboard which provided assurance to the board. This was a priority for 2023/2024 and will continue to be built upon in Audit cycle for 2024-2025.
4. Agreed to further strengthen the multi-agency dashboard to incorporate health specific data in relation to learning from SARs around pressure ulcer care and hospital discharge.
5. Group scrutiny and challenge of evidence provided by agencies in response to SAR Improvement Plans.

Priorities for 2024/2025 include:

1. Introduction of Quality Assurance Framework to provide governance around multi agency audit cycle, and risk management framework.
2. Group to review National SAR Analysis to consider areas of national and local themes to explore through future audit cycle.
3. Strengthened Dashboard which incorporates specific learning from Safeguarding Adults Reviews and produces twice yearly deep dives into specific safeguarding themes.
4. Scrutiny and recommendation to LSAB for completion of Safeguarding Adult Review Improvement Plans.
5. Group to ensure multi agency audit cycle sets out expectation for partner agencies to provide assurance in relation to their single agency audits and outcomes.
6. The Quality Assurance group still needs to consider how it will capture the voice of the adult within its Multi-agency Safeguarding Dashboard, communication and engagement being a key priority. This was a previous years priority however this will be remain a priority for 2024-2025

Safeguarding Adults Review Subgroup

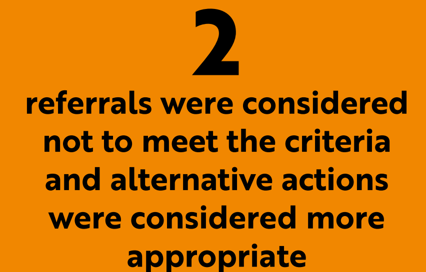
Chairing Arrangements: Subgroup has been chaired by Liverpool City Council and Merseyside Police

The purpose of the Safeguarding Adults Review Subgroup is to:

- To fulfil the statutory duty of the Board in respect of Section 44 of the Care Act 2014 and Safeguarding Adults Reviews (SARs).
- To make recommendations to the Chair of Liverpool SAB as to whether the criteria for a SAR is met along with the type of methodology and factors to be included in the terms of reference.
- To ensure SARs are completed in line with national guidance and best practice, and to continuously develop and implement local SAR processes and procedures.
- To agree and monitor the implementation of improvement plans resulting from SARs and other non-statutory reviews.
- This group meets monthly. Between April 2023 and March 2024, as well as monitoring the progress of ongoing SARs and improvement plans, the group has considered 7 Safeguarding Adults Review referrals.

Achievements in 2023/2024 include:

1. The group have thoroughly screened 7 safeguarding adults review referrals for consideration against the statutory criteria set out in Care Act 2014. Of the 7 referrals screened, 5 have been recommended to progress to a statutory Safeguarding Adults Review.
2. Created and implemented a thematic improvement plan tracker to monitor and seek assurance of single agency action completion.
3. Reviewed and updated the Safeguarding Adults Review Policy and Procedure. The newly updated document now incorporates flowcharts and user-friendly supporting guidance.
4. Scrutinised and provided assurance to Liverpool Safeguarding Adults Board to finalise and agree 5 Safeguarding Adults Review Reports.



Safeguarding Adults Reviews - Lessons learnt

The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when:

- An adult has died, and the SAB 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
- An adult has experienced serious abuse or neglect which has resulted in permanent harm, reduced capacity, or quality of life (whether or not it knew because of physical or psychological effects), or the individual would have been likely to have died but for an intervention; and
- There is concern that partner agencies could have worked more effectively to protect the adult.

Individual & Family involvement in a Safeguarding Adults Review

The aim of a SAR is to review the way agencies worked together to safeguard an individual or family. Learning from the review is shared across agencies and used by the Board to review the way services operate in order to prevent future harm.

Central to the process is the involvement of the family or the individual, if they are still alive. This ensures that we capture the experiences of people who use services and use this insight to inform any changes.

The following information shows the increase in the number of reviews commissioned by the Board in 2023 -24 compared to the previous year.

The aim of a SAR is to review the way agencies worked together to safeguard an individual or family. Learning from the review is shared across agencies and used by the Board to review the way services operate in order to prevent future harm.

Update on previous years Annual Report

2022/23	Number of case reviews	Status
Safeguarding Adults Reviews in process	6	5 of the 6 Safeguarding Adults Reviews have been completed
Safeguarding Adults Reviews on hold due to parallel process ongoing	1	SAR is currently on hold awaiting confirmation from Merseyside Police of the outcome of whether a criminal investigation will be undertaken.
Safeguarding Adults Reviews to commence	0	All SAR's from previous years annual reports have been completed.

Safeguarding Adults Reviews completed

Safeguarding Adults Review: **PAUL and JAMES**

Paul* was living in extremely poor living conditions, had poor mobility, and was alcohol dependant and a cannabis user. There were concerns Paul was self-neglecting and being financially exploited. Neighbours and a family member had alerted agencies to their concerns for Pauls mental health and wellbeing before he sadly died in April 2022.

James* had a long history of mental illness. James was living in poor living conditions which was raised by professionals undertaking a gas check at his property who referred concerns in to Adult social care following a MHAA James was detained initially under the Mental Health Act (1983). James refused medical intervention treatment for a cardiac condition in August 2022, and sadly died because of a cardiac arrest months later in October 2022.

A Thematic Safeguarding Adults Review has been completed to review the circumstances for both SAR Paul and SAR James, and the following outlines key learning taken forward by the partnership:

1. Agencies need to make an informed decision about the most appropriate method to risk assess an individual with known self-neglect and complex safeguarding history, and not be limited to telephone consultations.
2. Agencies need to consider support for individuals with a military background in to services available and more likely to have success advocating or supporting individual.
3. Hospital Trust need to ensure they are responding in an appropriate and timely manner when a patient is missing/ absconds from their care.
4. There were missed opportunities to share information, escalate concerns and develop action plans with other agencies when it was recognised that professionals were failing to be effective in the engagement of the person and in the management of risk. Liverpool SAB to review the Multiagency Risk assessment Management Process.
5. It is important for agencies to provide their practitioners with access to training in relation to alcohol dependency and substance addiction.
6. Practitioners need to be alert to and aware of how to respond to concerns in relation to exploitation- mate crime.
7. Agencies need to ensure practitioners understand the purpose of Best Interest Meetings, and are upskilled to be able to initiate such meetings.
8. Detailed records must be kept of all decisions relating to mental health care including capacity assessments, and best interest decisions

This review was agreed by Liverpool Safeguarding Adults Board in December 2023,

The published report along with fuller details around the learning and recommendations can be found on **liverpoolsab.org**

* All SAR’s have a psuedonym name to protect the individual and their families identity

Overview of SAR's completed in 2023/2024 - awaiting publication

Safeguarding Adults Review: WILLIAM

William*, is an older male where there were concerns around the quality of care he received in a care home. William had a diagnosis of Alzheimer's and had a long-term catheter in situ due to incontinence. Concerns were raised in relation to delayed medical attention, neglected catheter care and management, weight loss and dehydration, and deterioration in presentation from mobilising to being hoist transferred. William died in January 2021.

A Safeguarding Adults Review has been completed however this is currently on hold awaiting confirmation from Merseyside Police on any next steps they will take.

This review will be reported in next year's annual report for 2024/2025.

Safeguarding Adults Review: JUNE

June*, is an older female who was cared for at home by her family, review considered how informal carers are supported by the partnership, professionals in Liverpool can work together effectively and exhibit professional curiosity.

This SAR has been completed and LSAB are currently making publication arrangements.

This review will be reported in next year's annual report for 2024/2025

Safeguarding Adults Review: COLIN

Colin*, is a male who had a history of involvement with mental health services and experienced hidden homelessness.

Colin was of no fixed abode and had been admitted to hospital on multiple occasions in the past due to injuries occurring when under the influence of alcohol and self-harm. Colin disclosed he had been assaulted whilst staying at a property, by people he knew and presented with injuries. Colin returned to the property and was tragically murdered.

This SAR has been completed and LSAB are making publication arrangements.

This current review will be reported in next year's annual report for 2024/2025

* not their real names

All SAR's have a psuedonym name to protect the individual and their families identity

Overview of SAR's commissioned and underway in 2023/2024

Safeguarding Adults Review: ROBERT

Robert* was an older male with learning disabilities who lived independently until he had a period of illness which resulted in a hospital stay. Whilst in hospital Robert initially recovered and was discharged home, however arrangements made to plan for his return home were not robust and therefore Robert had to be returned to hospital. During the second admission to hospital Robert experienced delays in the discharge process and became ill with hospital acquired illnesses. Robert sadly died before he could be safely discharged home as was his wish.

This SAR has been completed and LSAB are currently making publication arrangements.

This review will be reported in next year's annual report for 2024/2025

Safeguarding Adults Review: A24

A24* was a female with a complex history of alcohol dependency, diagnosis of Emotionally Unstable Personality Disorder (EUPD), poor mental health which led to her being sectioned under Mental Health Act on a number of occasions. A24 was well known to agencies and had previously engaged in rehab programmes. A24 disclosed being the victim of sexual abuse. A24 sadly died following a fatal fall from height in January 2024.

This review has been commissioned and progress will be reported on in next year's annual report 2024/2025.

Safeguarding Adults Review: I23

I23* was a female with a diagnosis of mild learning disability, Emotionally Unstable Personality Disorder (EUPD), and had a history of anxiety and depression. She lived in supported accommodation since 2019. She also received intensive support from the community learning disability team, including psychiatry and named nurse. I23 had been assessed as having capacity in relation to her care and support, finances and also contact with her boyfriend. She had a history of ligaturing; risk assessments and plans were in place. Staff at her supported Living accommodation heard banging noises coming form her room, when they entered the flat to undertake a welfare check, they found I23 with a hairdryer cord around her neck. Attempts were made to resuscitate her without success, police and ambulance attended and she was sadly pronounced deceased in August 2023.

This review has been commissioned and progress will be reported on in next year's annual report 2024/2025.

* not their real names

All SAR's have a psuedonym name to protect the individual and their families identity

Overview of SAR's agreed-due to be commissioned in 2024/2025

Safeguarding Adults Review: E23

E23* was an older female, diagnosed with dementia, placed in a care home. In August 2022, E23 was sexually assaulted by another resident at the care home. E23 was able to return to the care home following the incident however the criteria for Safeguarding Adults Review was met as result of the serious abuse suffered. Both E23 and the person of interest both lack capacity. The review will explore the appropriateness of the hospital discharge and placement of the person of interest.

This review will be progressed during 2024/2025, and an update will be reported on in next year's annual report 2024/2025.

Safeguarding Adults Review: F23

F23* was a female who was visited by her GP at home and assessed as having medium sized pressure ulcers, whilst being situated in bed, with her 6-week grandchild. District Nurses attended the property the same day and were unable to convince F23 to go to hospital. The following day the District Nurses were able to convince F23 to go to hospital. Upon attendance hospital staff raised safeguarding concerns in relation to F23 physical condition. It appears she was being cared for by her family. F23 passed away in April 2023, 2 days after being admitted to hospital. F23 had not been referred and therefore was not open to social care.

This review has been commissioned and progress will be reported on in next year's annual report 2024/2025.

Safeguarding Adults Review: G23

G23 was a female who sadly died as a result of sepsis, caused by a pressure ulcer. G23 was discharged from a hospital outside of Liverpool, where concerns arose around pressure area care, leading to a further hospital admission. G23 passed away in hospital.The review will explore the appropriateness of equipment, pain management, care planning, and professionals' response in the community to concerns being highlighted by care agency and family in relation to pressure areas.

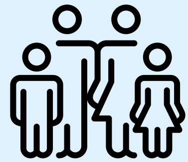
This review has been commissioned and progress will be reported on in next year's annual report 2024/2025.

* not their real names

All SAR's have a psuedonym name to protect the individual and their families identity

Liverpool - Key information about our City

This section shares key information about our City and the people who live here.



Liverpool is home to estimated **496,700** residents (Office National Statistics, 2022) and due to our student population, the average age in our city is **37.6 years**

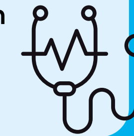
65+ Between 2011-2021, there has been an increase in Liverpool, of **13.5%** in people aged 65 years and over. For England, the increase was **20.1%** for people in the same age band

According to the 2021 Census some **23%** of our residents' class themselves as part of an ethnic minority group (non-white English, Welsh, Scottish, Northern Irish or British).

The biggest change in population in Liverpool will be the increase in those aged **60 and over**. It is estimated that the number of people in this age group will increase by **16.8%**, the equivalent of an additional **16,800** people by 2031. It is likely that the increasing numbers of older residents will impact greatly on NHS services and adult social care. However, if older people can stay healthy for longer, they can have a positive impact on the local and national economy as well as remaining engaged members of society

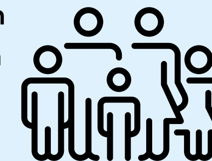
There is a strong correlation between deprivation and poor health. According to the Index of Multiple Deprivation 2019, Liverpool was the **3rd** most deprived local authority in the country and around **62%** of areas in Liverpool fall into the most deprived national quintile.

One third **(33%)** of the Liverpool population have at least one medical condition whilst **14%** have more than one and **6%** have physical and mental health condition.

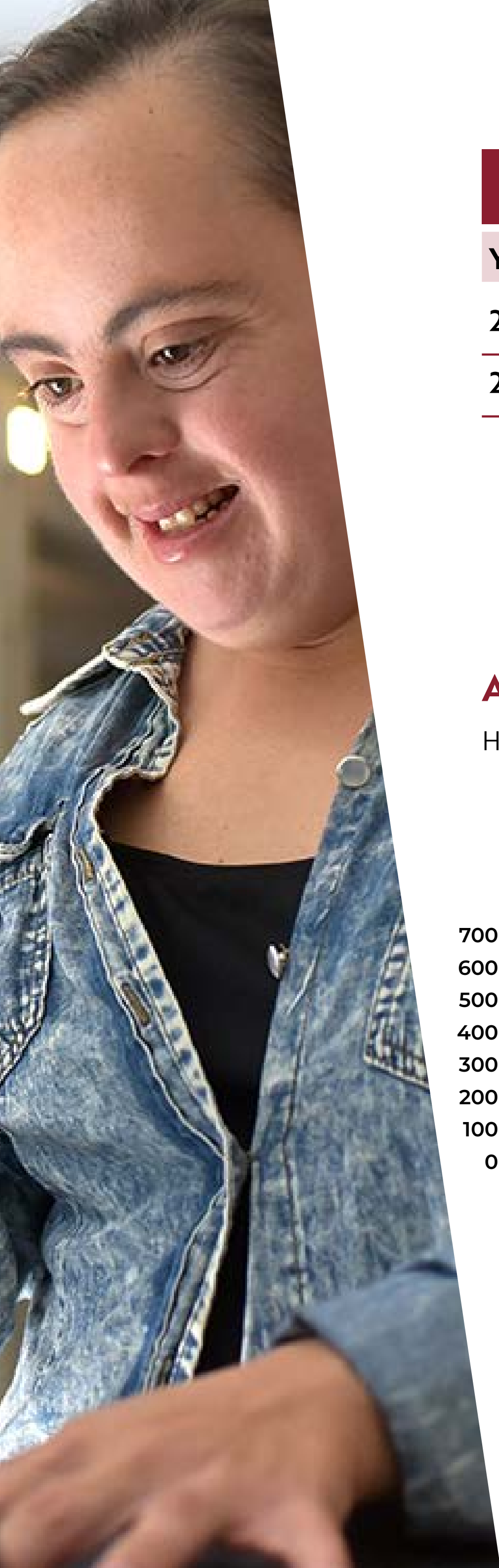


Population projections suggest there will be an increase in the coming years, with the number of local residents increasing by a further **33,400** over the next decade

Population size has increased by **4.2%** from around **466,400** in 2011, to **486,100** in 2021, based on Census data. This is lower than the overall increase for England at **6.6%**

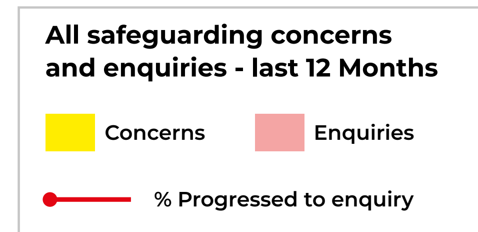


There are **58,600** more people living in the city than in 2001, which is a **13.3% increase**



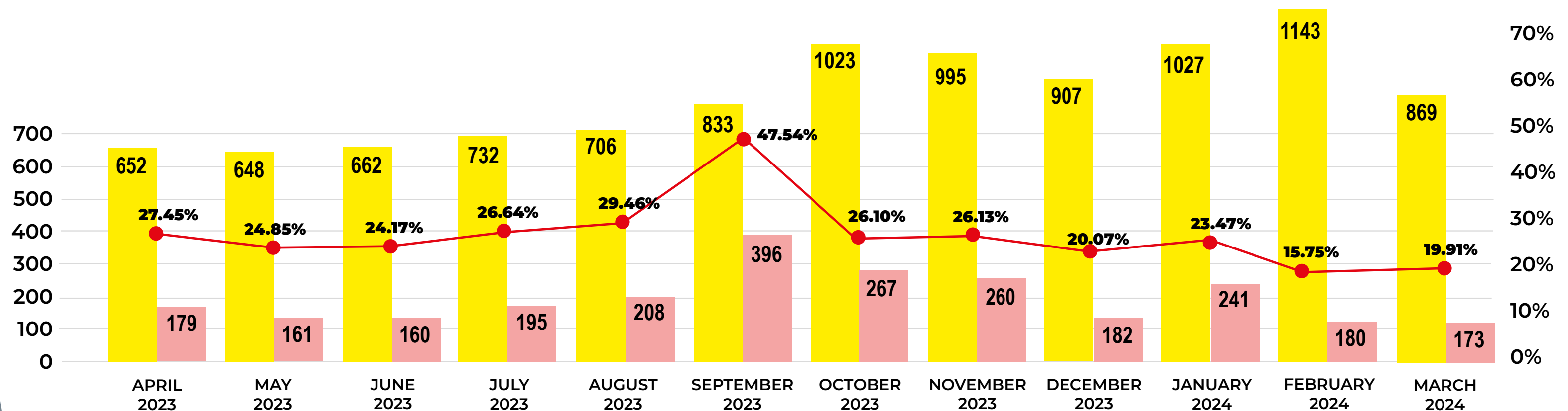
LIVERPOOL'S POPULATION

YEAR	All Ages	Aged 0-14		Aged 15-24		Aged 25-64		Aged 65+	
2022	495,849	79,515	16.04%	88,351	17.82%	252,139	50.85%	75,844	15.30%
2023	503,740	80,513	15.98%	93,142	18.49%	253,223	50.27%	76,862	15.26%



Adult safeguarding data:

Here we provide some details of the adult safeguarding data over the last year:



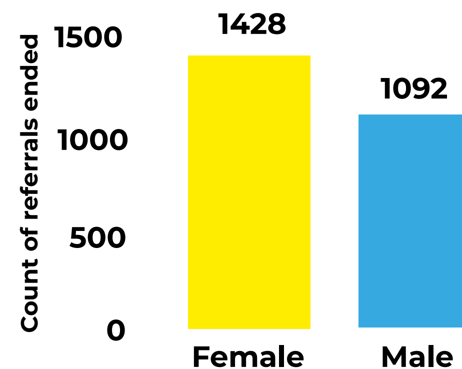
Safeguarding concerns and enquiries

MONTH (2023)	Concerns	Enquiries	% progressed to enquiry
April 2023	652	179	27.45%
May 2023	648	161	24.85%
June 2023	662	160	24.17%
July 2023	732	195	26.64%
August 2023	706	208	29.46%
September 2023	833	396	47.54%
October 2023	1023	267	26.10%
November 2023	995	260	26.13%
December 2023	907	182	20.07%
January 2024	1027	180	23.47%
February 2024	1143	180	15.75%
March 2024	869	173	19.91%

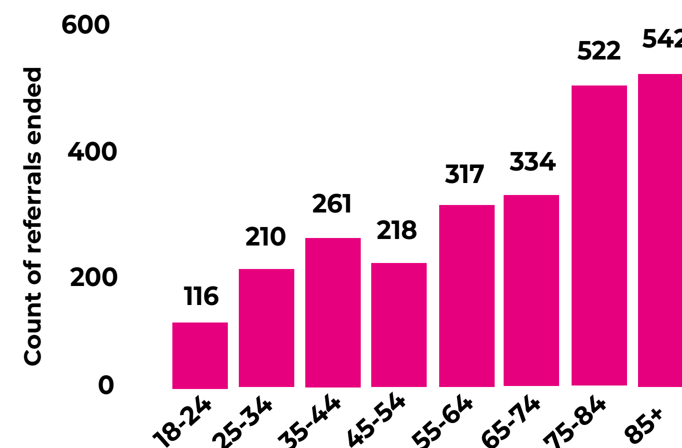
Source: Safeguarding dashboard

AGE BAND	Enquiries	%
18-24	116	4.6%
25-34	210	8.3%
35-44	261	10.4%
45-54	218	8.7%
55-64	317	12.6%
65-74	334	13.3%
75-84	522	20.7%
85+	9542	21.5%

Safeguarding enquiries by gender of the adult at risk



Safeguarding enquiries by age of the adult at risk



Safeguarding concluded enquiries

ABUSE TYPE	Enquiries	%
Neglect and acts of omission	935	38.6%
Financial or material abuse	508	21.0%
Physical abuse	437	18.0%
Domestic abuse	163	6.7%
Self-neglect	143	5.9%
Sexual abuse	118	4.9%
Organisational abuse	53	2.2%
Discriminatory abuse	26	1.1%
Sexual exploitation	20	0.8%
Modern slavery	19	0.8%

GENDER	Enquiries	%
Female	1428	56.7%
May 2023	1092	43.3%

LOCATION	Enquiries	%
Own home	755	35.1%
In the community (Excluding community services)	175	8.1%
In a community service	145	6.8%
Care home-Nursing	158	7.4%
Care home-Residential	401	18.7%
Hospital - Acute	221	10.3%
Hospital - Mental Health	25	1.2%
Hospital - Community	70	3.3%
Other	198	9.2%

SOURCE OF RISK	Enquiries	%
Service provider	808	37.6%
Other - Known to individual	837	39.0%
Other - Unknown to individual	503	23.4%

RISK OUTCOME	Enquiries	%
Risk remained	80	9.0%
Risk reduced	594	66.8%
Risk removed	215	24.2%

Safeguarding - What does good look like?

This is a snapshot example of good practice, and commitment to safeguarding adults in Liverpool

Learner: X
Background: Domestic Violence

Learner disclosed to tutor that she was suffering domestic abuse and was fearing for her safety and did not feel safe leaving the building after class. The Safeguarding Lead team met with the learner and discussed what has happened. The Learner disclosed what has been happening to her at home.

Safeguarding Officer phoned the Police due to the outcomes of the discussion. Police arranged for an interpreter to support with further questioning. Learner disclosed more information about the severity of the abuse. The Police agreed it was not safe for her to go home. The learner was immediately placed in a safe house outside Liverpool. Her partner was arrested. The service supported the learner during this period with regular welfare checks.

Service Actions:

- Contacted Police
- Contacted Savera for advice
- Signposted to Mental Health Support.

Outcomes

Learner has since returned to the home she shared with her partner as the lease is in her name. The matter is still under criminal investigation. The learner has returned to class and her Tutor has noticed a significant improvement in her wellbeing. The learner also thanked the Safeguarding Officers for keeping her safe.

Feedback from tutor

Since the intervention of our ALS Safeguarding Team X has been a different person.

She is cheerful, positive, enthusiastic for learning.

I can see the impact of the intervention in her attitude and behaviours – she enjoys dressing up, putting on her make up and trying different hairstyles. It is clear to see she feels safe at home thanks to your help.

Partner Contributions:

Liverpool City Council Adult Social Care

Who we are

Adult Social Care in Liverpool keeps people, families, and communities at the heart of what we do. We are committed to providing our residents with the right level of support when they need it. As part of our approach to prevent, reduce, and delay the need for care, we build upon people's strengths and assets; to support their independence and enable them to live a better life; in the neighbourhoods and communities they call home.

Our role in Safeguarding?

We have a critical role in delivering the Safeguarding Adults agenda in Liverpool by providing strategic and operational leadership within adult social care, the wider council and partner agencies.

As the lead agency for statutory safeguarding work, our duty is to make, or cause to be made, safeguarding enquiries when we suspect an adult with care and support needs is at risk of abuse or neglect. Our front door team triages adult safeguarding concerns determining whether any other actions are required to support someone. If safeguarding enquiries are needed these are made by staff in our locality teams.

Within Adult Social Care we promote that safeguarding is everyone's business recognising that staff at every level have a role to play and should know their responsibilities around adult safeguarding. We understand this is how we achieve the best outcomes for people.

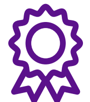
The Liverpool Safeguarding Adults Board is hosted within our Adult Social Care directorate. We are a statutory partner of the Board and during 2023 / 2024 we chaired the Policy and Practice sub group and the Safeguarding Adults Review (SAR) Sub group. We are members of SAR panels and our practitioners attend the associated events. We are key members of the Performance and Quality Assurance sub group and Workforce Development sub group.

We have supported the Board to achieve its current priorities though leading on the development of the Board performance dashboard, leading on multi-agency audits such as the safeguarding concern audit. We have also led on the development and review of key

Safeguarding Adults Board policy and guidance. We have been central to the development of the new SAR process for Liverpool and have continued to embed the Board's approach to SARs via chairing the SAR sub group and providing leadership and support to partner agencies around SAR referrals and criteria.

Safeguarding Themes in 2023-2024

- Complex lives - Substance Misuse, Homelessness.
- Domestic Abuse.
- Informal carers – identification and support offered to carers.
- Professional curiosity.
- Supporting the Independent Provider Market.



Safeguarding achievements in 2023-2024

We have worked hard to implement new ways of working and pathways resulting from Phase 1 of our transformation programme. Phase 1 of our new structure went live in March 2024. This has included a new Adult Access service at the front door, an Emergency Duty Response Team, a new locality structure with reduced layers and vastly improved IT systems that support strength-based practice.

Learning from our reviews has helped shape our transformation journey. We have reviewed our Safeguarding Pathway to ensure that we undertake enquiries where our duties are triggered and that we take a more preventative and co-ordinated, strategic approach to our safeguarding activity.

We have established a safeguarding triage team with updated practices to reflect national guidance on concern decision making. We have invested in our social work team structures to ensure support for staff to manage risks and safeguarding enquiries safely and efficiently.

Our recording system has been updated and within it we have provided guidance to staff on how to undertake enquiries keeping the person central to the process. We have included questions from the Making Safeguarding Personal outcomes framework within our documents to support staff to keep this approach central to their work.

We have established a safeguarding assurance service. This service is key in providing professional leadership and strategic direction on Adult Safeguarding to all of those within the directorate and wider council. The service has clear oversight of departmental activity, performance, and quality with regards to adult safeguarding and it co-ordinates our response when serious incidents that lead to SARs occur.

Our priorities for 2024-2025

- Further improve multi-agency working with our safeguarding partners, considering best use of resources whilst keeping the adult central to our work.
- Finalise our Safeguarding Quality Assurance Framework
- Continue to support the work of the Liverpool Safeguarding Adults Board including supporting the workforce development offer via delivering learning sessions and developing learning materials such as 7-minute briefings.
- Continue with Phase 2 of our Adult social care Transformation which includes consideration of our reablement, occupational therapy and brokerage offer as well as other departments such as mental health.
- Embed learning from Safeguarding Adults Reviews to prevent further harm.

Safeguarding challenges in 2024-2025

Supporting our staff to respond to increasingly complex lives and situations including people with multiple vulnerabilities such as domestic abuse, homelessness, substance use and mental health.

- Further embed the Multiagency risk assessment and management (MARAM) process within adult social care.
- Continue with our renewed focus on the DoLS arrangements ensuring sustained improvements within the DoLS pathway in Liverpool.

Partner Contributions:

Cheshire & Merseyside Integrated Care Board - Liverpool Place

Who we are

NHS Cheshire and Merseyside Integrated Care Board (C&M ICB) is a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS.

C&M ICB Chief Executive is the Accountable Officer with the responsibility for ensuring that the health contribution to safeguarding and children in care is delivered effectively across the local health economy through the Integrated Care Board commissioning and monitoring arrangements.

The Integrated Care Board has an identified Non-Executive Board Member with responsibility for safeguarding scrutiny. This role is supported through the Director of Nursing and Care who holds delegated responsibility and is the Executive Lead for Safeguarding and Children in Care. The Director of Nursing and Care discharges those duties through the Associate Directors of Quality and Safety Improvement and with Designated Safeguarding Professionals/ Nurses across nine place areas.

Designated Safeguarding Adults Nurse has strategic oversight of safeguarding arrangements within commissioned health services in Liverpool, maintains oversight of statutory adult reviews and domestic homicide reviews (DHRs). Represents C&M ICB Liverpool Place on the Domestic Abuse Partnership Board and LSAB and LSAB subgroup, maintaining close working relationships with children's safeguarding colleagues to embed a think family approach to safeguarding.

Our role in Safeguarding?

C&M ICB Liverpool Place Associate Director of Quality & Safety Improvement and the Designated Safeguarding Adults Nurse are members of the LSAB and represent one of the three key statutory partners. They are also engaged in the Community Safety (CSP) Executive meetings and associated sub-groups; Liverpool Domestic Abuse Partnership Board (LDAPB), Domestic Abuse MARAC Steering Group and Domestic Homicide Steering Group.

Designated Safeguarding Adult Nurse is a member of the aligned sub-groups of the LSAB & LDAPB, Safeguarding Adults Review Group (SARG), Policies & Procedures (P&P), Performance & Quality

Assurance (PQA) and Domestic Homicide Steering Group. During 2023-24 has been involved with multi-agency audits, SAR panels and SAR learning events, DHR panels and DHR learning events.

C&M ICB additionally lead on the Learning from Life and Deaths (LeDeR) programme, which is a national programme established by NHS England in 2015 to support local areas to review the deaths of people with learning disabilities and autism, identify learning from those deaths, and take forward the learning into service improvement initiatives. The LeDeR programme sits centrally within the ICB, this model enables partnership working across a larger footprint and allows for larger data collection for enhanced learning across the whole of Cheshire and Merseyside. LeDeR Local Area contact attended the LSAB meeting held 11 April 2024 providing an overview of the LeDer criteria, the key findings of the C&M LeDeR Annual report (March 22/23), National Annual Report (22) key findings and the focus review priorities for 2024/25.

C&M ICB have developed a learning section on FutureNHS where a range of tools such as podcasts, presentations, recordings, and documents are available for staff to access.

Safeguarding Themes in 2023-2024

- Neglect
- Domestic Abuse
- Complex lives
- Hospital discharges with a non-criterion to reside.

Safeguarding achievements in 2023-2024

Liverpool NHS commissioned hospital and community health providers have:

- Submitted performance against C&M ICB Safeguarding key performance indicators (KPI's) quarterly covering 2023-24 contractual year.
- Comprehensive safeguarding arrangements in place in accordance with legislative requirements monitored using the NHS C&M Commissioning Standards 2023-25. Evidence is from data received and a follow up Quality Assurance Hospital visit with hospital safeguarding teams during Q4 2023-24.
- Signed up to the Sexual Safety Charter.

C&M ICB have:

- Developed learning sections on FutureNHS (where a range of tools such as podcasts, presentations, recordings, and documents are available for staff to access.
- Established partnership working with Primary Care Networks (PCNs) GP Clinical Leads to deliver the Enhanced Health in Care Home (EHiCH) model.
- Developed and piloted Care Home multidisciplinary team (MDT) Communication tool to promote the use of IMMEDICARE service and the Restore2 model in care homes. These support staff to identify when one of their residents is clinically deteriorating. They also support effective communication with GP Practices and support learning from Safeguarding Adult Reviews.

How we have embedded learning from Safe-guarding Adults Reviews:

- C&M ICB Named GP's Safeguarding Monthly Newsletter disseminated to the NHS Hospitals and primary care used to update and inform Primary Care colleagues.
- Using the Designated Safeguarding Professionals and Named GP networks to share learning from statutory reviews / inspections (taking a Think Family Approach) across Cheshire and Merseyside footprint.
- C&M ICB Named Safeguarding GPs deliver bi-weekly 'think family' safeguarding lunch and learn sessions to Primary care and health colleagues.
- Bi-monthly C&M MCA forum established to share best practice, learning from cases, and used for peer support by the C&M ICB NHS commissioned hospital and community health providers MCA leads.
- FutureNHS online platform has been established and is used by the NHS to share learning and use as a peer networking tool.
- C&M ICB developed Safeguarding learning sections on FutureNHS where a range of tools such as podcasts, presentations, recordings, and documents are available for staff to access.

Our priorities for 2024-2025

- Develop a new Safeguarding Governance and Accountability Framework.
- Review and update any current corporate safeguarding risks.
- Develop a Safeguarding Training Strategy and updated Training Needs Analysis.
- Undertake a Safeguarding workforce review.
- Standardisation of C&M ICB MAPPA, MARAC, Channel processes across C&M to reduce variation and duplication.
- Standardisation of the Safeguarding Commissioning Standards for 2025/2026 for NHS Provider Trusts and small NHS contract holders.
- Develop and implement Domestic abuse champions across the workforce.

Safeguarding challenges in 2024-2025

- Ensuring safety and quality is maintained as C&M ICB drives work to improve the urgent and emergency care (UEC) system across North Mersey, focusing on three key areas:
  - Admissions Avoidance
  - Reducing length of stay in Hospital
  - Safe and timely discharge
- Strengthen the links between the Statutory Safeguarding Boards and Partnerships in relation to learning from statutory reviews.:

C&M ICB have introduced two sub-groups to support the governance of the existing Designated Safeguarding Nurses/Professionals and Named GP Group.

Both sub-groups will support the continued reduction of duplication and variation across the Cheshire and Merseyside footprint as we continue to mature as an organisation working together to ensure think family safeguarding is done once and well across Cheshire & Merseyside.

- The Policy and Procedure Group will focus on development of ICB wide safeguarding protocols.
- Learning and Development Group will focus on continuous improvement and learning from both safeguarding training and embedding learning from statutory reviews.
- The volume of Liverpool Domestic Homicide Reviews (DHR's), Safeguarding Adult Reviews (SARs) and Child Practice Safeguarding Reviews (CPSR's) thirty plus embedding the learning by making sure recommendations are meaningful and fully embraced.
- Strengthening partnerships to respond to the whole system, think family, transition SEND young carer's, care leavers and All Aged Continuing Health Care (AACHC) broader agendum is and implement effective operating models.

To support safeguarding across the partnership in 2024-25 C&M ICB will:

- Establish High Intensity User (HIU) task and finish group to oversee the recovery actions needed to reduce HIU of emergency and acute services by key groups (complex lives including Homelessness, young people, and people experiencing mental health or life crisis).

Maintain oversight of C&M ICB Safeguarding key performance indicators (KPI's) and Safeguarding Commissioning Standards 2023-25 in all Liverpool Place NHS commissioned Hospitals covering 2023-24 contractual year.

Work with C &M ICB Business Intelligence Team to develop a centralised data system, a single data repository for all statutory safeguarding reviews to share emerging themes and learning in relation to local, regional, and national CSPR's, SARs, DHR's and LeDeR reviews providing peer support opportunities to share best practices across all Providers.

- Embed the Multiagency risk assessment and management (MARAM) process and support all Liverpool Statutory Reviews
- Establish Liverpool Place Strategic Care Home Quality Oversight Group using an initiative-taking approach to supporting care homes using available data intelligence of the key risks impacting on the delivery of clinical care and quality improvement within care homes and aligning the commissioning of the Enhanced Health in Care Homes (EHiCH) operating model.

Partner Contributions:

Merseyside Police

Who we are

Recently, Detective Superintendent Paul Lamb (Merseyside Police) took over as force Lead for Adult Safeguarding.

Merseyside Police remain a key statutory partner to Liverpool Safeguarding Adults Partnership and are proud to have such strong ties to the board, in which we sit on.

In addition he has become the chair of both the Liverpool Safeguarding Adults Review Group and also the Merseyside Safeguarding Adult Review Group, working across the partnership with Knowsley, St Helens, Sefton and Wirral SAB members to provide a standardised approach to the consideration and management of Safeguarding Adult Reviews as defined under the Care Act (2014).

Merseyside Police have also began to support the LSAB Performance, Quality Assurance and Audit sub-group with representation through the Detective Chief Inspector/ Detective Inspector from Liverpool PVP team.

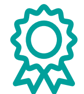
Our role in Safeguarding?

Merseyside Police's ability to manage and respond to safeguarding needs, in particular through criminal investigation and safeguarding pathways, has been greatly improved through the restructure of teams such as the forces Vulnerability Hub which works collaboratively with partners to deal with safeguarding in terms of assessment and pathways for referrals, Initial Child Protection conferences, MASH, MARAC, and assessment and disclosure of DVDS.

As well as a whole force response working as one team to respond to vulnerability, from identification and referrals to appropriate agencies, to the most appropriate investigation in the circumstances, for example, investigation of elder financial abuse by the Economic Crime Team, or Investigations PVP for neglect cases. Police continue to work with each of the Local Authority Safeguarding partners on events such as Safeguarding week and Financial Abuse initiatives.

Safeguarding Themes in 2023-2024

Key themes/ trends for the police in respect of Safeguarding Adults and bringing offenders to justice, include areas such as Domestic Abuse, Hate Crime, Financial Abuse as well as those who are considered most vulnerable under the Care Act, in that they are in need of care and support. We continue to build on the learning from Safeguarding Adults Reviews and training to better educate the workforce on early intervention, trauma informed understanding and prevention.



Safeguarding achievements in 2023-2024

Over the last twelve months Merseyside Police have undergone some key positive operational changes that impact on how it responds to and approaches the protection of vulnerable people through Investigation and Safeguarding, with specialist departments for those disciplines.

Through the changes the force now has a dedicated Chief Superintendent who leads the PVP teams with the support of two Detective Superintendents, all of whom are actively engaged with partners in key strategic discussions across all strands of Vulnerability.

Through these changes the force has also been able to improve key departments that have improved how we safeguard such as the PVP Policy & Strategy Unit and the Vulnerability Hub- responsible for vulnerable persons and onward referrals, management of Domestic Violence Disclosures (DVDS- Claires Law), Multi Agency Risk Assessment Conference, Multi Agency Safeguarding Hubs (MASH's) and Child Protection Conferences.

How we have embedded learning from Safe-guarding Adults Reviews:

Through the restructure of the force, we have now introduced a new Protecting Vulnerable Persons Policy and Strategy unit. Through this until the force is now able to collate and co-ordinate all recommendations from not only SAR learning, but across Children and Domestic Homicide Reviews.

Through the unit the force is able to ensure all polices and procedures are maintained in line with force wide learning. As well being central to the dissemination of learning across the force through the forces IForce pages and also through the support of the Academy were appropriate.

Our priorities for 2024-2025

- Professional Curiosity in the risk posed to vulnerable adults- this continues to be for one of the biggest issues across all SAB member organisation across Merseyside.
- Trust and Confidence in adults to engage with Police- both in respect of crime and safeguarding reports.
- Focusing on the implementation of Right Care, Right Person approach. This involves the Police working with partner agencies to identify the most appropriate agency to give vulnerable people the care and support they need.

Safeguarding challenges in 2024-2025

- In relation to Adults, Children and Domestic Abuse the force will be developing more effective approach to sharing learning across the organisation from partners/ reviews.
- Increase its capacity & capability to adequately investigate 'Adults at Risk' incidents.

Tackle the HMICFRS areas for improvement around VPRF and DVDS backlogs and improve the effectiveness of the Vulnerability Hub.

Non-statutory partners:

Mersey Care

Who we are

Mersey Care is one of the largest NHS trusts, offering specialist inpatient and community services to support physical and mental health, learning disabilities, addiction, and brain injury services. They provide Mental Health Urgent Care Services and short-term assessments within Liverpool, Sefton, Knowsley, Halton, St Helens, and Warrington. Our role in safeguarding includes:

- Creating and updating safeguarding policies and integrating them into daily practices.
- Providing mandatory safeguarding training for all staff to recognize and respond to abuse and neglect.
- Establishing clear processes for identifying and reporting safeguarding concerns.
- Collaborating with local authorities, police, and other agencies to share information and coordinate responses.
- Engaging with the workforce to raise safeguarding awareness and ensure their concerns are addressed.
- Auditing safeguarding practices to ensure compliance and identify areas for improvement.

Our role in safeguarding

Meetings we participate in:

- Policy and Practice Subgroup
- SAR Subgroup
- Workforce Development Subgroup (Assistant Director of Safeguarding is Deputy Chair)
- PQA Subgroup
- Four working groups under the Workforce Development Subgroup
- SAR Panels
- Multiagency Audit
- Actively participated in the Policy and Practice Subgroup to develop and update safeguarding policies such as the MARAM.
- Contributed to the SAR Subgroup.
- Engaged in SAR Panels, offering to review cases and implement lessons learned.
- The Assistant Director of Safeguarding is the Deputy Chair of the Workforce Development Subgroup, leading initiatives to enhance staff training and development.
- Supported and participated in four working groups within the Workforce Development Subgroup.
- Lead of the MARAM roll out within Liverpool
- Participated in the PQA Subgroup to monitor and improve the quality of safeguarding practices.
- Took part in multiagency audits to assess and enhance the effectiveness of safeguarding procedures across agencies.
- Engaged in multiagency efforts to promote safeguarding awareness and ensure comprehensive support for adults at risk.

Safeguarding themes in 2023-24

This information has been taken from the Safeguarding Duty Hub data for adults. During 2023 the key adult safeguarding themes are:

- Neglect / Acts of Omission
- Self-Neglect
- Domestic Abuse

Safeguarding achievements in 2023-2024

- The Safeguarding Adults Duty Hub has been well-utilized by the Trust workforce, leading to the development of new

processes such as guidance on non-recent sexual abuse and subsequent themed training sessions.

- A quarterly programme of thematic supervision is delivered to the workforce, focusing on current topics, trends, and themes. This programme is well-attended, and the workforce report has significantly benefited practice.
- The Trust's safeguarding team regularly attends the weekly Complex Lives MDT meetings, addressing a recurring theme identified in several SARs and DHRs.
- We have strengthened partnership working with other agencies, enhancing our collaborative efforts in safeguarding.
- We continue to strengthen our internal PiPoT (Persons in Position of Trust) process internally and have relaunched a new PIPoT policy bringing safeguarding, Human Resources and Senior Clinical Leadership teams together to collectively apply policy to practice.

How we have embedded learning from Safe-guarding Adults Reviews:

- Themes such as substance misuse, homelessness, and domestic abuse have emerged from recent DHRs and SARs completed over the past year. In response, the safeguarding adults team now attends the weekly Complex Lives MDT to support practitioners caring for patients with complex lives, addressing often intricate safeguarding issues. This participation has enhanced collaborative working between agencies and led to early preventative measures, such as utilizing the MARAM process.

Our priorities for 2024-2025?

- Increase awareness of trauma-informed care among the Trust workforce by adding it as a module in the 2024/2025 safeguarding training brochure.
- Maintain active involvement in the Complex Lives MDT, providing holistic support for individuals dealing with substance misuse, homelessness, and domestic abuse.
- Promote the MARAM process within the workforce to facilitate early identification and mitigation of risks.
- Continued development of our data sets to identify vulnerabilities and "hot spots" across our communities so we can target specific areas of work to improve practice and support our frontline practitioners who work with our complex families/individuals.

Safeguarding challenges in 2024-2025

- Dealing with increasingly complex cases involving multiple vulnerabilities and intersecting issues such as mental health, substance misuse, and domestic abuse it can be difficult for agencies to come together.
- Supporting the workforce in current challenges of capacity/demand – working with partners to look at where we can collaborate to improve the experience of our service users and/or families will provide opportunities to offer safe and effective services.

Non-statutory partners:

Liverpool Probation

Who we are

Probation manage men and women in the community who are on community Court orders or on licence. Many of the people we supervise are both victims and perpetrators of violence, sexual harm, financial and/or emotional harm. Our role is to reduce re-offending, protect the public and this is achieved through rehabilitation as well as monitoring and controlling. Key to our success is partnership arrangements and information sharing.

Probation attend the LSAB, SARs, DHRs and DA Board.

Our role in Safeguarding?

Probation ensure referrals are completed when there are ASG concerns and that information sharing is in place for all vulnerable adults.

Safeguarding Themes in 2023-2024

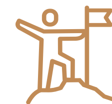
- Cuckooing
- DA victims and perps
- Criminal exploitation of vulnerable adults

Safeguarding achievements in 2023-2024

- Automated Domestic Abuse call outs info provided on all Merseyside cases and alerts for any new call outs
- Domestic Abuse and professional curiosity learning event
- Completion rate of the accredited Building Better Relationships programme
- Introduction of polygraph testing for DA perps
- Safeguarding Adults Review learning is shared in team meetings and on monthly learning days

Our priorities for 2024-2025?

- Domestic abuse – keeping people safe
- Criminal exploitation – organised criminal activity



Safeguarding challenges in 2024-2025

- Staff knowledge due to the number of new starters – robust training plan in place and management oversight
- Resourcing challenges – ongoing recruitment campaigns, change in national policy with people in the last 2/3rd of their sentence having supervision suspended (exceptions high risk, MAPPA and child protection cases)

Non-statutory partners:

Healthwatch

Who we are

Healthwatch Liverpool is a voice for the public on health and adult social care issues. Our vision is "We want a health and social care system that is fair and works for everyone. We want to make a difference by influencing positive change". We are a 'critical friend' of the NHS and social care, outside of the system and helping to ensure that services keep people at the heart of their work Our interest in safeguarding is partly preventative (helping services to keep people's care and support safe), partly escalating concerns we hear from staff or public and finally, as with all services ensuring that our own staff are trained and supported to keep our own services safe.

Our role in Safeguarding?

As part of LSAB - Attending meetings, contributing to discussions and providing an external, public perspective. More broadly - As part of our enter and view activities we visit registered nursing and care homes across the city. We speak to staff and residents and make observations on behaviours and environment. We are able to feed this back directly to the Safeguarding teams at Liverpool City Council and also to further organisations at the Liverpool Quality Assurance Group meetings. This allows us to help feed into the overall knowledge of these environments providing both "softer" intelligence such as staff behaviours and reports, environmental adjustments and resident satisfaction which helps builds a picture of the environment. We have also been part of joint safeguarding reports as part of these visits and fed back to the team. As our visits also involves the provision of questionnaires to friends and family and the publication of reports we are an avenue for feedback about concerns even when we are not on site at a care homes.

Safeguarding Themes in 2023-2024

- People's lives are more pressured and complex
- Financial challenges limiting people's options and ability to make wise decisions
- Services are under more pressure making it harder for people to access the support they need when they need it

Safeguarding achievements in 2023-2024

We continue to work with the public, partners and services to improve people's experiences of health and social care. This is rarely focused on safeguarding but on services which when working well can reduce the risk of someone coming to harm.

Examples of our work in 2024-2025

- A report on barriers to GP access especially or those with the biggest barriers.
- Research into the experiences of people who have experienced sexual trauma and how this impacts on their ability to access NHS care.
- We share findings and learning from Safeguarding Adults Reviews with our team.

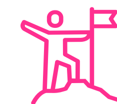
Our priorities for 2024-2025?

We are visiting more care homes in this year (a focus of our new contract) and are working to make our care home survey more widely seen so that family members can share any concerns (or praise) about care homes at any time, giving an early alert to potential problems.

We have limited staffing so are looking to involve volunteers/students as additional participants on visits so we can speak to more people in each home

Our continued listening events in Hospital Trusts can also spot issues around NHS care.

Our work with the Learning Disability and Neurodiversity partnerships aims to improve people's quality of live and experiences of services – hopefully helping keep people safe, well, thriving and connected and so at less risk of harm and becoming the subject of a safeguarding incident in future.



Safeguarding challenges in 2024-2025

We are rarely involved in safeguarding issues ourselves so our challenge is more about how to hear people's experiences and ensure these are heard and learned from and how people can be supported earlier to prevent issues reaching a safeguarding stage.

Non-statutory partners:

YMCA Together

Who we are

YMCA Together is a charity working across the Northwest of England to support people who are experiencing challenging times in their lives. We provide support and accommodation to people experiencing homelessness, and have specialist services in Recovery, Addiction, Harm Reduction, Domestic Abuse, Care and Mental Health.

We have been representing the voluntary, community and homeless services on the Liverpool Safeguarding Adults Board since it was established.

Our role in Safeguarding?

We are committed to safeguarding and protecting the people we work alongside, and protecting their rights to ensure everyone lives safely and free from abuse and neglect. Our approach to safeguarding is to embed robust training, reporting, recording, and monitoring processes. We work in partnership with local agencies and providers to ensure that together we can deliver the best possible care and support for those who are in need. We continue to have representation at LSAB meetings and task groups and to have input into safeguarding across the city to ensure our priorities align with the board and our local area.

Safeguarding Themes in 2023-2024

- Self-Neglect is our largest reported safeguarding concern across services
- We are seeing an increase in Domestic Abuse referrals and domestic abuse safeguarding cases across temporary accommodation services
- We are continuing to see increased health and social care needs within homeless services and are working hard with partners to look at how we can effectively meet those needs.

Safeguarding achievements in 2023-2024

- In December 2023 we opened a specialist residential care home with a bespoke support model, aimed at providing care for people who have experienced homelessness and have additional health and social care needs. The care home was developed from identifying a gap in service provision, we wanted to create a specialist service that could meet a higher level of need that temporary accommodation and other care homes were unable to support. In June 2024 we were shortlisted by Homeless link excellence awards for this work.
- We have inducted over 200 new staff over the last 12 months all of which have completed a half day introduction to Safeguarding and the Care Act, delivered by our organisational safeguarding lead. Alongside this we have organised advanced safeguarding training for Safeguarding Champions and Service leads and have introduced Domestic abuse training to our induction for new staff.
- In November 2023 we organised a very successful Safeguarding week and held a number of training sessions for our services including Domestic Abuse, Care Act Assessments and Trauma & the Brain.
- In January 2024 we asked external auditors to complete an audit on our safeguarding processes for assurance. The audit results showed that there was a good system of internal control designed to meet safeguarding objectives.

How we have embedded learning from Safeguarding Adults Reviews:

We continue to include relevant themes in our safeguarding training and meetings and most recently this has included Neuro awareness and Think Family. We are a learning organisation and are pleased to be involved and to be able to share any learning from LSAB and board partners. Our organisation recently had input into SAR Colin and has volunteered

to deliver a learning event in partnership with the police around the learning from this SAR.

Our priorities for 2024-2025?

Training - To ensure we continue to identify training gaps, improve our Safeguarding training monitoring and E learning offer for staff.

Assurance and compliance - To complete Service Level Audits with managers around safeguarding processes and involve Safeguarding Champions.

Learning - To ensure learning and prevention measures regarding safeguarding concerns and incidents are circulated and changes embedded includer wider learning from LSAB and SARs.

Empowerment and Advocacy - We will plan that our Service user involvement across services includes safeguarding information and tools to support to make informed decisions about their own safety and wellbeing, including updating our Safeguarding Easy read policy with their input.

Safeguarding challenges in 2024-2025

Our main challenges for 2024/25 include;

- Preparing for increased health and social care needs presenting to our services
- Navigating ongoing barriers for the people we support to access services

We will approach these challenges by

- Ongoing staff training to equip our staff to understand and support people using trauma-informed approaches and therapeutic working. We have also been rolling this training out to partners and other boroughs across Liverpool City Region.
- We continue to increase our support offer and bring services directly to those in need, including drop-in services and in-reach with partner agencies and statutory services.
- We continue to strengthen partnerships to develop joint initiatives with healthcare providers, drug services and social care to work towards integrated and improved care for the people we support.

Non-statutory partners:

Merseyside Fire & Rescue Service

Who we are

Merseyside Fire and Rescue Service (MFRS) is an emergency service that covers the Merseyside region which also covers:

- Response (attending incidents)
- Prevention (preventing fires and working with vulnerable people)
- Protection (Fire safety in commercial premise)
- Preparedness (Training)

Our role in Safeguarding?

The Safeguarding Lead Officer is a member of the LSAB and the Liverpool Safeguarding Adults Review Sub group

Safeguarding Themes in 2023-2024

- Hoarding/Self-Neglect
- Neglect
- Safer Recruitment/Culture

Safeguarding achievements in 2023-2024

- The creation of a CPD accredited National Fire Chiefs Council (NFCC) Safer Recruitment Train the Trainer package which is being delivered to all United Kingdom Fire and Rescue Service sector.
- MFRS Safeguarding Lead Officer in the National Chair of the NFCC Safeguarding Practitioner Group.
- MFRS have embedded a Student Social Worker within our Princes Trust Teams (16-25 years) who supports the pastoral care of our young people.
- The introduction of a robust national guidance for Managing Allegation and Risk Assessments for Positive DBS checks.

How we have embedded learning from Safeguarding Adults Reviews:

MFRS are using Safeguarding Briefing notes (which are sent to all MFRS staff) to highlight safeguarding issues, which includes learning from SAR's and 7-minute briefings as appropriate.

Our priorities for 2024-2025?

To look at national SAR's that have involved neglect and fire (approximately 350) and identify common themes and learning for the sector.

Safeguarding challenges in 2024-2025

- Capacity issues when attending 5 x seperate Merseyside Safeguarding Adults Boards.This is being reviewed internally.
- Managing self-neglect and hoarding, which is an increasing issue in Merseyside, however, is a very complex matter to manage. This requires a multi-agency approach with regards to the support around mental wellbeing and addressing the underlying issues.

Non-statutory partners:

Torus Housing

Who we are

Torus is a registered social landlord operating in 11 different local authority areas with 40, 000 homes, with the majority being in Liverpool, Warrington, and St Helens.

Torus represents Housing at the Safeguarding Adults Board in Liverpool, Warrington, and St Helens and contributes to a wide range of safeguarding forums at both strategic and operational levels.

As a housing and support provider, Torus's role in safeguarding is to ensure that all staff have the skills and competencies to be able to identify and escalate safeguarding concerns. Torus works in partnership with a wide range of agencies to offer specialist housing related advice and works with partners to agree actions to support the safety and welfare of our tenants and their household members.

As a housing provider, Torus employees often gain access to homes where other agencies cannot therefore, we see our role in safeguarding is not only as an alerters of incidents of abuse or neglect but to also identify concerns for the welfare of our tenants before they escalate to crisis point.

Our role in Safeguarding?

Torus is proud to represent Housing at Liverpool's Safeguarding Adults Board updating the board of changes to practice and legislation within the housing sector, providing assurance of Torus' safeguarding arrangements and contributing to a number of board subgroups.

Torus has invested in safeguarding and domestic abuse training programme for colleagues: providing all staff with the skills and competencies to be able to identify safeguarding concerns, utilise appropriate risk assessments and follow referral pathways into local authority and/or specialist services.

Where required, Torus has contributed to safeguarding adults review processes. We are keen to learn from experience and understand how we can continually develop and improve how we can work with others to safeguard adults at risk.

In December 2021, Torus started its journey towards achieving accreditation with Domestic Abuse Housing Alliance (DAHA) who have created a set of standards for housing providers to achieve which will strengthen the sectors response to domestic abuse.

Over the last 12 months Torus' Domestic Abuse Steering Group have work collaboratively with internal and external colleagues including specialist support services and DAHA to work towards the standards set within each of the following priority areas:

1 Policy and Procedure

2 Staff development and Support

3 Partnerships and Collaboration

4 Case Management

5 Survivor Led Support

6 Perpetrator Accountability

7 Intersectionality and Anti-Racist Practice

8 Publicity and Awareness Raising

Torus aim to achieve accreditation during financial year 2024/25

Safeguarding Themes in 2023-2024

- Need for increased professional curiosity.
- Self-Neglect
- Domestic Abuse
- Launched domestic abuse training programme for all frontline staff.
- Extended safeguarding training for external contractors.

- Invested in additional resources in the form of a new Domestic Abuse team within housing, who respond to the needs of tenants experiencing domestic abuse: providing practical housing support.
- Launched a DA Champion Network of 23 members of staff from across the group who are all trained to support their colleagues both in their day-to-day practice with tenants and service users and provide support to colleagues who may be experiencing DA themselves.
- Learning from safeguarding adults review identified a need for Torus to improve communication and collaboration with health care professionals in relation to the safe discharge of adults from hospital into our sheltered housing schemes. Joint training was arranged between Torus and Adults Social Care. This has resulted in improved relationships between all agencies and strengthened the links between hospital discharge teams, our Customer Service Centre, and our Neighbourhood Housing teams.

Our priorities for 2024-2025?

- Launch and embed our new Safeguarding Strategy 'Playing Our Role: Think Family' 2024-2027
- Achieve accreditation with the Domestic Abuse Housing Alliance (DAHA)
- Roll out safeguarding refresher training for all staff (October 2024)
- Launch a new module of training on Management of Allegations Against Staff

Safeguarding challenges in 2024-2025

For Torus to continue to improve our housing and case management systems to ensure improved consistency around internal reporting on safeguarding concerns.

To continue to work with partners to ensure that the quality of our safeguarding referrals meets the expected standards; ensuring that local authority processes are embedded into our training and staff guidance.

Following a restructure of our Housing Teams, we aim increase awareness of the roles, function and referral pathways into the range of housing services available, enhancing communication and improving the customer experience.

Non-statutory partners:

Liverpool Prison

Who we are

HMP Liverpool; are responsible for overseeing the management of violence, self harm, debt, segregation and death in custody. Our role within this function is to safeguard prisoners and their families who visit.

Our role in Safeguarding?

HMP Liverpool are a non-statutory member of LSAB for the purpose of sharing safeguarding lessons learnt within the prison environment.

Safeguarding Themes in 2023-2024

Majority of our safeguarding themes that rise are in relation to those suffering with mental health concerns who are unmedicated and those who are classed as vulnerable within the custodial setting as a result of learning disability and difficulties.

Safeguarding achievements in 2023-2024

- The Primary Healthcare provider conduct a health screening and make relevant referrals in the prison reception.
- The Integrated Mental Health Team conduct a mental health screening on every prisoner admitted into the prison.
- Mental Capacity assessments are carried out where there are concerns of Mental Capacity to make specific decisions.
- MDT Risk Assessments are conducted.
- MDT meetings ensuring information -sharing, coordination of care, guidance, knowledge of national legal requirements and policies and systemic factors for the escalation of concerns.

Our priorities for 2024-2025?

- The Integrated Mental Health Team to continue to conduct a mental health screening on every prisoner admitted into the prison.
- To conduct Mental Capacity Assessments as required.
- MDT risk assessments.

Safeguarding challenges in 2024-2025

- Acute mentally unwell adults refusing treatment within the prison setting.
- Ensuring the safety of adults with Learning Disabilities and an Autism diagnosis.

Non-statutory partners:

Altcourse Prison

Who we are

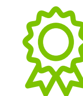
HMP Altcourse, a contracted-out prison, run by Sodexo Justice Services. We have an operational capacity of 1194 prisoners and take remand and sentenced prisoners from local courts and also from the wider North of England region. As part of the Safer Custody department, Safeguarding in Altcourse ensures all new receptions are treated decently and that on arrival they are provided with all the necessary information to help them settle into the early days in custody. As part of the Induction process, any new receptions can raise any safeguarding concerns they have, both in the community, and those that they feel they may experience in custody. This can range from having been the sole carer for a relative in the community to informing the induction staff of any gang-related or Modern Slavery issues that they may experience in custody. To ensure that we are providing support for those in our care, we liaise with agencies such as Merseyside Police, Home Office Immigration Enforcement Team, Probation, Merseycare Mental Health Team, located within the prison and Practice Plus Group, who run the healthcare provision in HMP Altcourse. As a partner of the LSAB, we are required to attend Board meetings, development days and have when requested, provided information for Safeguarding Adults Reviews.

Our role in Safeguarding?

We regularly review Safeguarding practices and procedures by completing quality assurance checks of Assessment Care in Custody Teamwork (ACCT) documentation, thereby satisfying ourselves that we are appropriately monitoring those prisoners at risk of suicide and self-harm. This also extends to using welfare officers to offer support to prisoners identified through the Induction process and through the Alert, Intervene and Monitor (AIM) system as prolific self-harmers, isolators and potential victims of intimidation and violence. This work also links closely with the Challenge, Support, Intervention Plan (CSIP), which is used to identify those most likely to commit violence, who are then allocated a Case Coordinator to both challenge their behaviour and to work on individualised plans to address anti-social behaviour. Our weekly Safety Intervention Meeting (SIM) brings together departments across the prison to discuss the previous seven days and to see what has worked for those in our care and to agree on actions, going forward, for the prisoners who have come to our attention, either through vulnerability issues, mental health concerns or for being perpetrators of violence.

Safeguarding Themes in 2023-2024

- Support for victims of Modern Slavery
- Community based gang related issues and how they link to custody
- Targeted approaches to vulnerability and isolation such as AIM



Safeguarding achievements in 2023-2024

- Roll-out of AIM, which is hoped to be a 'gamechanger' in how we target support for individuals
- Recognition from the National Safety Team of high-quality assessments being completed for individuals in crisis.
- Prison regularly at maximum occupancy levels. Despite this challenge, self-harm and violence levels have remained at a similar level to the previous year.

Our priorities for 2024-2025?

- Encouraging supportive relationships, built by trust and integrity.
- Encouraging the maintenance of family ties.
- Encouraging and supporting links within the community.
- The management of a robust Violence Reduction Strategy with a zero-tolerance attitude towards anti-social behavior and bullying.
- Promoting good health and well-being.

Safeguarding challenges in 2024-2025

2024/2025 will continue to be challenging in terms of an expected upturn in the prisoner population. This will inevitably present more complex situations that are likely to test our existing processes and support systems that we have in place. By working with partner agencies and internal support services, we stand the best chance of ensuring that those in our care are treated with decency and respect and that we are helping those in our care to rehabilitate and leave prison with the skills to lead productive lives, gain employment and thus, help reduce reoffending rates. We are confident that through maintaining and discovering new links within the Liverpool region, that we can deal with the unexpected situations that we face and that this will also lead to improved outcomes for those in our care.

Liverpool Safeguarding Adults Board Resources

Currently our Board is resourced by contributions from the three statutory safeguarding partners

Liverpool City Council	£115,533
NHS Cheshire & Merseyside	£40,000
Merseyside Police	£10,000

The contribution from Liverpool City council covers the staffing costs associated with running The Board and the costs of the Independent Chair.

This leaves £50,000 which has been spent on the following:

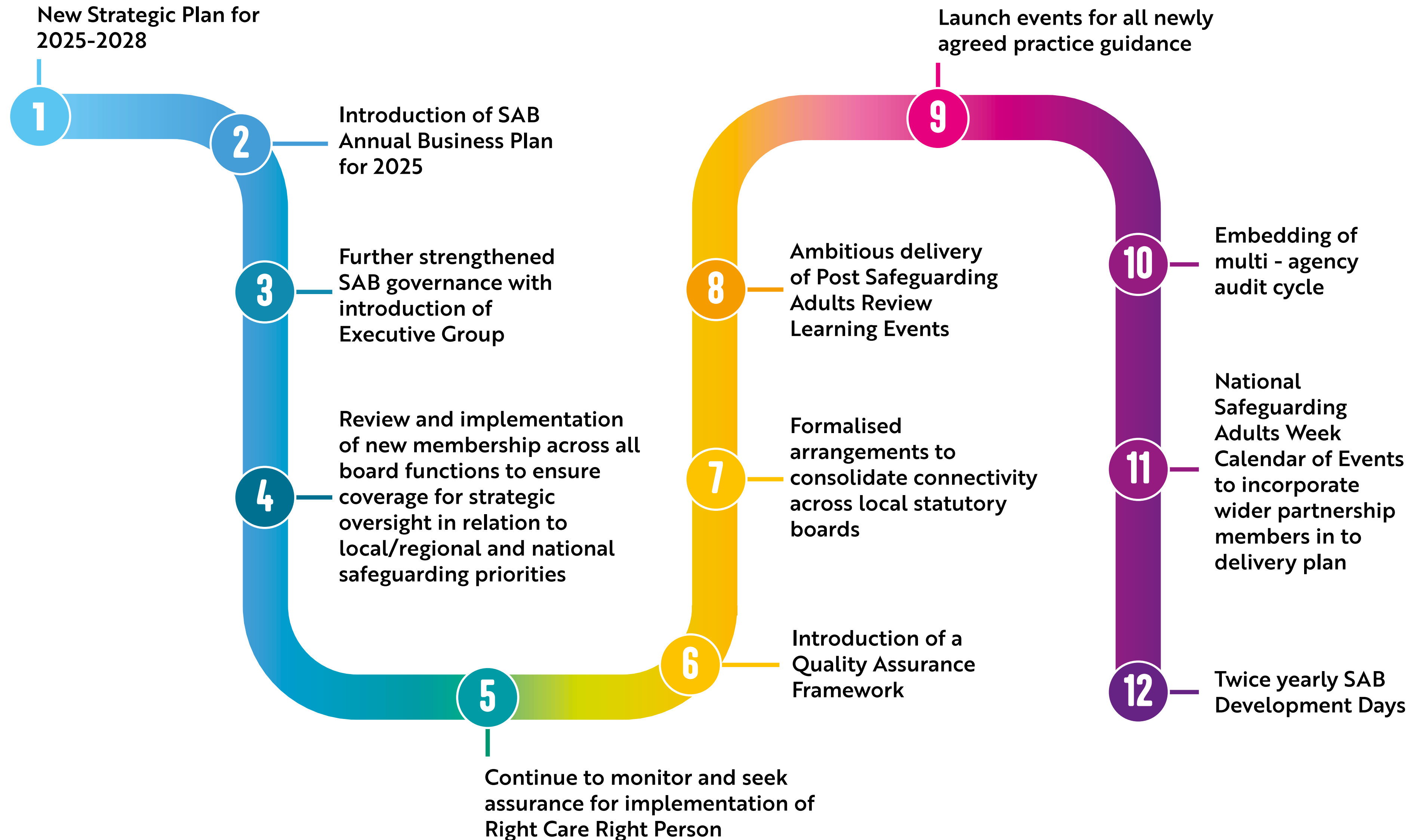
Safeguarding Adults Reviews	£36,235

Previous year carry forward for 22/23	£110,541
Leaving a total carry forward of	£105,849

Future financial planning

Discussions are ongoing with statutory partners regarding ongoing funding for our Board as our current budget doesn't reflect the need for financial growth as a result of staff inflation costs. There is also no contribution towards our communication and engagement strategy, costs associated with training nor contribution towards independent chair costs. There will be an increase in the number of commissioned Safeguarding adults Reviews in 2024/2025. The Board are also exploring increasing staffing of the board unit team to support the increased demands. This would directly impact on the Boards financial position at the end of financial year 2024/2025.

Plans for 2024/25 - Liverpool Strategic Plan on a page



Useful Contacts

Abuse and neglect can happen anywhere and be carried out by anyone. If you are experiencing abuse, or you think someone you know is experiencing or is at risk of being abused or neglected, and they are not able to protect themselves then please report it.

If the person is at immediate risk of harm and an urgent response is required please contact the police on 0151 709 6010. **Dial 999 in an emergency** or where there is any indication a criminal act has occurred.

Adult Access can offer support if you want to report a safeguarding concern.

Concerns can be raised by completing **https://liverpool.gov.uk/adult-social-care/worried-about-someone/report-an-adult-at-risk/**

Stay in touch Board Unit Team

The work of the Liverpool Safeguarding Adults Board is supported by the Board Unit Team who help support the Board to carry out its statutory duties and signpost residents and professionals to information, advice, and training resources. If you would like to keep in touch and find out more about our work, please contact us at: LSAB@liverpool.gov.uk or follow our updates on our website **https://liverpoolsab.org/**