# Coventry Safeguarding Adults Board

## Annual Report 2023/24


Coventry City Council


WEST MIDLANDS
POLICE


NHS
Coventry and
Warwickshire Partnership
NHS Trust


NHS
Coventry and
Warwickshire


NHS
West Midlands
Ambulance Service
University NHS Foundation Trust


WEST MIDLANDS FIRE SERVICE


Probation
Service


NHS
University Hospitals
Coventry and Warwickshire
NHS Trust


healthwatch
Coventry


CARERS
TRUST
Heart of England

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# Message from the Chair

It is a privilege to work as the Independent Chair for the Coventry Adult Safeguarding Board and to welcome you our Annual Report for 2023-2024.

The primary role of a Safeguarding Adults Board (SAB) is to ensure that all public sector agencies work together to ensure that adults with care and support needs in the area are protected from abuse, harm, and neglect. The Care Act 2014 sets out that Safeguarding Adults Boards should agree a local safeguarding Business Plan and then provides an Annual Report that details how it has delivered against that plan.

The CSAB has, and will continue, to seek assurance that the those agencies tasked with a statutory responsibility to safeguard vulnerable adults do so effectively, and do so in partnership with voluntary and community services.

Our priorities place people at the heart of what we do, by emphasising the values of 'Making Safeguarding Personal', monitoring whether those with whom our safeguarding partners work are being helped to achieve the outcomes that want, that local policies and practices reflect national reforms, and we remain vigilant to the lived experiences of the people of Coventry.

I believe that the partnership in the city remains strong and effective, making a positive difference but always looking to identify opportunities to further improve. Colleagues from across the partnership continue to provide safeguarding support with dedication, commitment and hard work. It is only right that their efforts are acknowledged.

The Board will continue to work together with our partners to meet the care and support needs of the people of Coventry.

Derek Benson
Independent Chair

## What we do?

The Coventry Safeguarding Adults Board (CSAB) is a partnership of organisations that work to both prevent and end abuse of adults with care and support needs in Coventry. The Board includes a wide range of organisations that have a role in safeguarding adults with care and support needs, from abuse and neglect. This includes senior representatives from the Local Authority, Police and NHS Integrated Care Board (ICB) as well as other statutory organisations, Healthwatch and the voluntary sector. The Board commissions an Independent Chair, to provide, an independent perspective and challenge and support to the Board in achieving its ambitions. A full list of members is available at appendix 1.

The Care Act (2014) requires that each local authority must establish a Safeguarding Adults Board for its area. The objective of a Safeguarding Adults Board is to help protect adults in its area in cases where the adult:

• has care and support needs.

• is experiencing, or is at risk of, abuse or neglect and

• as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it The Safeguarding Adults Board achieves this by co-ordinating and ensuring the efficacy of what each member does. Each Safeguarding Adult Board has three core duties which are to: -

• conduct any safeguarding adults reviews in accordance with Section 44 of the Care Act 2014

• publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adult review and subsequent actions.

• publish a strategic plan for each financial year that sets out how it will meet its main objective and what members will do to achieve this

## The work of the Board is underpinned by the six safeguarding principles as defined in the Care Act 2014, which are:

Empowerment: I am asked what I want as the outcomes from the safeguarding process and this directly informs what happens.

Prevention: I receive clear and simple information about what abuse is. I know how to recognise the signs and I know what I can do to seek help.

Proportionate: I am sure that the professionals will work in my interest, and they will only get involved as much as is necessary.

Protection: I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.

Partnership: I know that staff treat personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me

Accountability: I understand the role of everyone involved in my life and what they do.

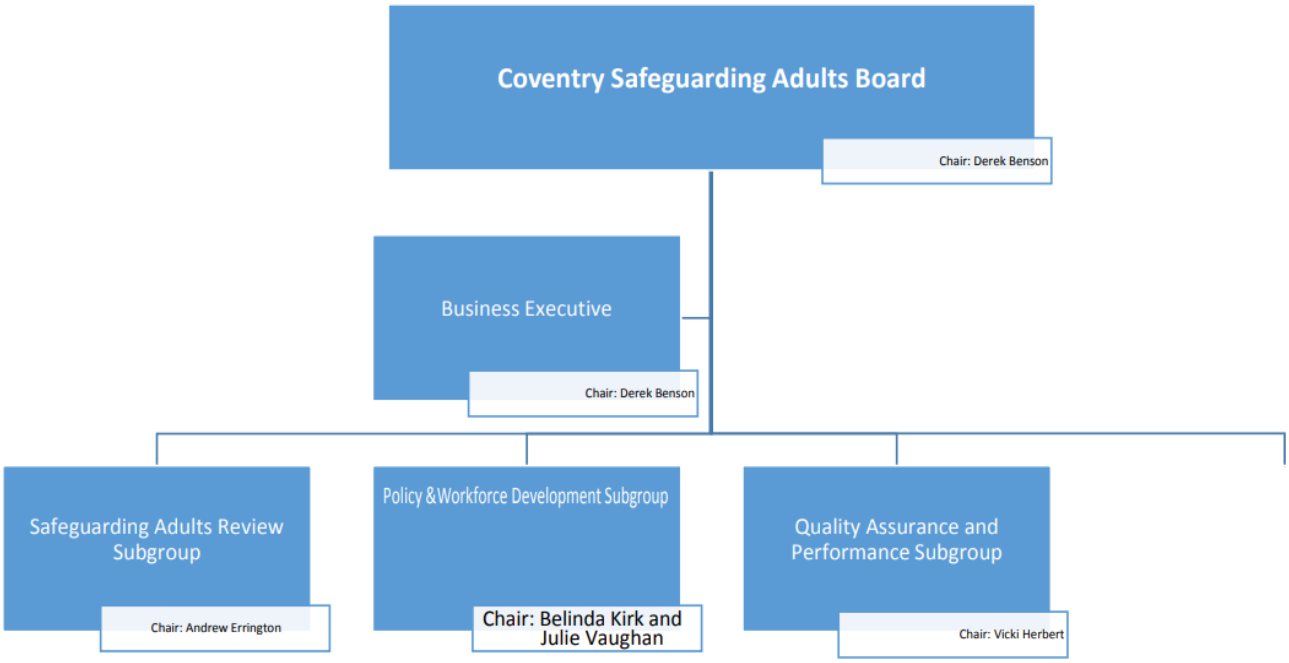
For more information on Making Safeguarding Personal please see our leaflet here: [Making Safeguarding Personal leaflet – Coventry City Council]


Coventry Safeguarding Adults Board had three priorities for 2023-2024:

| |
|---|
| To be assured that safeguarding is underpinned by the principles of Making Safeguarding Personal and that adults are supported to achieve the outcomes that they want. |
| The Safeguarding Adults Board to monitor/ respond to national and regional reforms, development and policy. |
| To have an understanding of, and response to critical emerging adult safeguarding issues and practices |

# Governance arrangements

The Board is a multi-agency statutory body which makes decisions about the strategic direction of adult safeguarding in Coventry. The work of the Board is supported through it's Business Executive Group and Subgroups. The structure of these groups is shown below:



## Coventry Population

- Coventry is home to 345,300 residents (Census, 2021), the second largest Local Authority in the West Midlands. Coventry's population has grown by 8.9% over the last 10 years
- The median age of the population has increased by one year since the 2011 Census to 35, five years lower than that of the region and England at 40.
- 13% of the population is 65+ projected to increase by 27.7% by the year 2043. 2.4% of the population are aged 85 or over.
- 65.5% of people in Coventry identified their ethnic group within the 'White' category (compared with 73.8% in 2011). 18.5% identified their ethnic group as Asian, Asian British or Asian Welsh" category (16.3% in 2011). The diversity in spoken languages is also increasing.
- Life expectancy in the city remains lower than the national and regional averages. For females this is 82 years and for males 78 years. Significant health inequalities across our neighbourhoods.
- Deprivation within the City has decreased in more recent years, the % of Coventry neighbourhoods that are amongst the 10% most deprived in England reduced from 18.5% to 14.4% between 2015 and 2019. However, over a quarter (25.6%) of neighbourhoods are amongst the most deprived 20% of areas (the most deprived 'quintile'), a particular focus for the health system for tackling inequalities (the 'Core20').

## Outcomes for Coventry Adults

During 2023/24 data was collated into a Performance Scorecard and analysed by the Quality, Assurance and Performance (QA&P) Subgroup. The Performance Scorecard indicators are aligned with CSAB priorities to ensure that the data collected can provide assurance around areas of concern; the data emanates from all partners represented at QA&P and actively provides assurance that work is protecting and improving outcomes for adults with care and support needs across the city.

**Priority 1:**

**To be assured that safeguarding is underpinned by the principles of 'Making Safeguarding Personal' and that adults are supported to achieve the outcomes that they want.**

1. The number of identified outcomes achieved for concluded safeguarding enquires:

| | Fully Achieved | Partially achieved | Not Achieved | Asked but not expressed | Person not asked | Blanks/don't know | Total |
|---|---|---|---|---|---|---|---|
| ***2022-23*** | *394* *(40%)* | *281* *(28%)* | *41* *(4%)* | *174* *(18%)* | *102* *(10%)* | *0* *(0%)* | ***992*** |
| ***Prev Q4*** | 133 (46%) | 86 (29%) | 10 (3%) | 30 (10%) | 33 (11%) | 0 (0%) | ***292*** |
| **Q1** | 178 (47%) | 96 (26%) | 10 (3%) | 33 (9%) | 58 (15%) | 1 (0%) | ***376*** |
| **Q2** | 147 (41%) | 112 (31%) | 7 (2%) | 40 (11%) | 50 (14%) | 2 (1%) | ***358*** |
| **Q3** | 83 (32%) | 81 (31%) | 15 (6%) | 47 (18%) | 30 (12%) | 2 (1%) | ***258*** |
| **Q4** | 164 (47%) | 108 (31%) | 12 (4%) | 29 (8%) | 37 (11%) | 2 (1%) | ***352*** |
| **Total** | ***572*** | ***397*** | ***44*** | ***149*** | ***175*** | ***7*** | ***1344*** |
| **% Total** | ***43%*** | ***30%*** | ***3%*** | ***11%*** | ***13%*** | ***1%*** | |

## 2. The outcomes of safeguarding enquiries:

| Concluded enquiries | *Prev Q4* | Q1 | Q2 | Q3 | Q4 | *Total* |
|---|---|---|---|---|---|---|
| Action taken, and risk remains | *27* | 11 | 12 | 8 | 9 | ***40*** |
| Action taken, and risk reduced | *236* | 140 | 126 | 79 | 97 | ***442*** |
| Action taken, and risk removed | *171* | 68 | 68 | 37 | 68 | ***241*** |
| Not recorded | *1* | 0 | 1 | 0 | 1 | ***2*** |

**3.** The percentage of adults who lack capacity with concluded safeguarding enquiries that confirm that they were supported by an advocate or family member acting as a representative:

| | Prev Q4 | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| Supported by an advocate | 95% | 96% | 94% | 86% | 97% |

**4.** Conversion rate from concerns to enquiries (evidencing proportionality of involvement):

| | *Prev Year Total* | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Number of new Concerns** | *6278* | 452 | 590 | 544 | 492 | 525 | 548 | 626 | 592 | 567 | 684 | 597 | 579 | ***6796*** |
| **Number of new Enquiry** | *1055* | 114 | 159 | 149 | 105 | 109 | 102 | 104 | 104 | 88 | 135 | 104 | 80 | ***1353*** |
| **% of concerns who became an Enquiry** | *17%* | 25% | 27% | 27% | 21% | 21% | 19% | 17% | 18% | 16% | 20% | 17% | 14% | ***20%*** |

### 5. Number of hits on MSP resources on the CSAB website:

| MSP Resources | Last Q4 | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| MSP Leaflet | 0 | 0 | 0 | 0 | 0 |
| MSP Learning Event YouTube Video | 4 | 28 | 0 | 0 | 0 |

### 6. % of staff currently trained in basic safeguarding awareness:

| AGENCY | End of last Q4 | Q1 | Q2 | Q3 | Q4 | CAVEAT |
|---|---|---|---|---|---|---|
| ALL Local Authority | 81 | 76 | 80 | 80 | 79 | Calculated at 3 years (employer requirement) |
| Local Authority Adult Services | 93 | 93 | 92 | 91 | 91 | |
| Local Authority Adult Social Work Teams | 92 | 91 | 90 | 88 | 89 | |
| UHCW | 96 | 95.5 | 97.1 | 96.8 | 96.7 | Calculated at 3 year (employer requirement) |
| ICB | 91.1 | 90.1 | 91.0 | 90.5 | 91 | Calculated at 3 year (employer requirement) |
| CWPT | 93.9 | 94.9 | 95.6 | 95.9 | 95.9 | Calculated annually (employer requirement) |

| | | | | | | |
|---|---|---|---|---|---|---|
| SWFT | 91 | 94 | 93 | 92 | 93 | Calculated at 3 year (employer requirement) |
| NPS | 92 | 80 | 82 | 72 | 98 | Calculated at 3 year (employer requirement) |

Making Safeguarding Personal remained a key priority for the Board this year; where possible, we want people to express their wishes and ensure that interventions are outcome-focused, and the data shows that 73% of outcomes for concluded safeguarding enquiries were either fully or partially achieved which represents a very slight increase compared to the previous year (68%). However, individuals not being asked about their preferred outcomes also increased from 10% to 13%. In 94% of all cases the risk to the individual was either reduced or completely removed by the end of their safeguarding enquiry – a consistent trend year on year.

The percentage of individuals who lacked capacity being supported by an advocate fluctuated during the year, and at times were lower than expected which did not offer much assurance that individuals who lack capacity were being supported appropriately. However, the Quality, Assurance and Performance subgroup were pleased to observe an increase to 97% by the end of the year.

The number of adults referred in as a concern increased by 8.2% overall this year compared to last year. The conversion rate from concern to Section 42 enquiry has also increased from 17% to 20% and comparative data shows a steady increase in both concerns and enquiries year on year. The Quality, Assurance and Performance subgroup understood that conversion rates can vary - both regionally and nationally (anywhere from 5% to 95%) however 15% is the expected rate locally and ASC provided assurance to the group that the conversion rate is closely monitored on a monthly basis.

There continued to be evidence of excellent safeguarding training compliance this year with all agencies maintaining their compliance at 90% or above. Unfortunately, there was minimal access to MSP resources on the CSAB website this year and the Policy & Workforce Development subgroup of Board are planning further promotional activity and awareness raising in line with the new priorities/business plan for 2024/25.

## Priority 2:

**To monitor and respond to national and regional reforms, developments and policy and adapt accordingly as a Safeguarding Adult Board.**

In April 2023 the Government made the decision to delay the implementation of the Liberty Protection Safeguards (LPS) beyond the life of this Parliament and so, Deprivation of Liberty Safeguards (DoLS) remain an important system for authorising deprivations of liberty, and it is important that health and social care providers continue to make applications in line with the Mental Capacity Act 2005 to ensure that the rights of individuals who may lack capacity are protected and looked after in a way that does not inappropriately restrict their freedom. The data outlined below was intended to provide assurances to the Quality, Assurance & Performance subgroup that DoLS applications were processed timely and to provide details of numbers of any outstanding applications:

1. **Deprivation of Liberty (DoLS) applications:**

| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Year Total | |
|---|---|---|---|---|---|---|
| Applications carried over from previous period | 458 | 569 | 548 | 470 | | |
| Number of applications received 2023 - 2024 | 593 | 500 | 591 | 559 | 2243 | |
| TOTAL Number of applications at the end of the quarter | 1051 | 1069 | 1139 | 1029 | 2701 | |
| Total number of granted | 192 | 223 | 330 | 247 | 1012 | 46% |
| Total number of not granted | 290 | 298 | 288 | 319 | 1226 | 54% |
| Total number of completed | 482 | 521 | 618 | 566 | 2238 | |
| Completed % | 46% | 49% | 54% | 55% | 83% | |
| To be completed | 569 | 548 | 521 | 463 | 463 | |
| **To be completed %** | 54% | 51% | 46% | 45% | 24% | |

| Applications **granted** timescale form being received | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0-3 months | | 3-6 months | | 6+ months | | Total |
| **Total 21-22** | **216** | **24%** | **554** | **62%** | **127** | **14%** | **897** |
| **Total 22-23** | **199** | **19%** | **750** | **71%** | **106** | **10%** | **1055** |
| **Total 23-24** | **212** | **21%** | **713** | **70%** | **87** | **9%** | **1012** |

| Reason for Not Granted DoLS | *2022-23* | | 2023-24 | |
|---|---|---|---|---|
| | ***Number*** | ***%*** | **Number** | **%** |
| **Change of circumstances** | *941* | *77%* | 689 | 79% |
| **Deceased** | *230* | *19%* | 154 | 18% |
| **Criteria not met** | *55* | *4%* | 33 | 3% |
| **Grand Total** | ***1226*** | | **876** | |

83% of all DoLS applications were completed this year – 46% were granted and 54% were not granted. The main reason for a DoLS not being granted was due to a change of circumstances for the individual - 689 (79%) out of 876, reflecting the increased use of hospital discharge processes such as D2A to support better assessment practices in the community.

The Quality, Assurance and Performance subgroup noted a slight downturn in the number of new applications compared to the same period last year, but the Local Authority DoLS Team continue to receive high numbers of applications at a rate of 980 per 100,000 adults - higher than regional and national rates.

Most applications were granted within 3 – 6 months (70%) and it was positive to see the continuing decrease of applications granted after 6 months of being received. Recent analysis suggests that whilst the Local Authority DoLS Team do receive more applications, they also complete them in a more timely way (2.4 months locally compared to 5.2 nationally).

**2. Number of SAR referrals and Active SARs per quarter:**

| | **Last Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
|---|---|---|---|---|---|
| Number of SAR referrals | 0 | 2 | 2 | 1 | 0 |
| Number of active SARs | 2 | 2 | 0 | 0 | 0 |

**3. Number of hits to resources /policy and procedures on CSAB website:**

| **Website Page** | **Last Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
|---|---|---|---|---|---|
| Safeguarding Adults Board Resources | 71 | 292 | 46 | 44 | 9 |
| Policy and Procedures | - | 230 | 241 | 235 | 165 |

Accessing resources, policies and procedures saw a downward turn in Q4; Board priorities and strategic plan for next year includes the development of the Board website to make it more user friendly and accessible.

## Priority 3:

**To have an understanding of and response to critical, emerging adult safeguarding issues and practices**

**1. Categories of safeguarding concern for concluded enquiries by abuse type by quarter (cumulative):**

| Type of abuse | *Prev Year Total 2022/23* | *Last Q4* | Q1 | Q2 | Q3 | Q4 | *Total* | *Regional (West Midlands)* | *National (England)* |
|---|---|---|---|---|---|---|---|---|---|
| Discriminatory | *2 (0%)* | 0 *(0%)* | 1 *(0%)* | *3 (1%)* | *0 (0%)* | *0 (0%)* | ***4 (0%)*** | ***0%*** | ***1%*** |
| Domestic | *43 (4%)* | 10 *(3%)* | 12 *(3%)* | *13 (4%)* | 7 (3%) | *14 (4%)* | ***46 (3%)*** | ***9%*** | ***6%*** |
| Financial | *120 (12%)* | 35 *(12%)* | 43 *(11%)* | *46 (13%)* | *44 (17%)* | *37 (10%)* | ***170 (12%)*** | ***15%*** | ***12%*** |
| Modern Slavery | *0 (0%)* | 0 *(0%)* | 0 *(0%)* | *0 (0%)* | 0 (0%) | *0 (0%)* | ***0 (0%)*** | ***0%*** | ***0%*** |
| Neglect & Acts of Omission | *500 (49%)* | 135 *(45%)* | 182 *(48%)* | *175 (49%)* | *115 (44%)* | *173 (47%)* | ***645 (47%)*** | ***30%*** | ***32%*** |
| Organisational | *18 (2%)* | 5 *(2%)* | 5 *(1%)* | *2 (1%)* | *9 (3%)* | *8 (2%)* | ***24 (2%)*** | ***4%*** | ***6%*** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Physical | *144 (14%)* | 43 *(14%)* | 57 *(15%)* | *54 (15%)* | *37 (14%)* | *56 (15%)* | ***204 (15%)*** | ***16%*** | ***19%*** |
| Psychological/Emotional | *60 (6%)* | 22 (7%) | 21 *(5%)* | *27 (8%)* | *10 (4%)* | 25 (7%) | ***83 (6%)*** | ***16%*** | ***13%*** |
| Self-neglect | *118 (12%)* | 42 *(14%)* | 57 *(15%)* | *32 (9%)* | *33 (13%)* | *50 (14%)* | ***172 (13%)*** | ***5%*** | ***7%*** |
| Sexual | *16 (2%)* | 6 *(2%)* | 4 *(1%)* | *6 (2%)* | *6 (2%)* | *5 (1%)* | ***21 (1%)*** | ***4%*** | ***4%*** |
| Sexual Exploitation | *2 (0%)* | 1 *(0%)* | 0 *(0%)* | *2 (1%)* | *0 (0%)* | *1 (0%)* | ***3 (0%)*** | ***1%*** | ***1%*** |
| **Total** | ***1023*** | **299** | **382** | **360** | **261** | **353** | **1372** | | |
| **Number of Concluded Enquiries** | ***992*** | **286** | **376** | **358** | **257** | **337** | **1345** | | |

Neglect/acts of omission, physical abuse and self-neglect were the most prevalent abuse types for concluded enquiries in Coventry this year. The Quality Assurance & Performance subgroup learnt that a recent analysis of the data within table 1 carried out by Adult Social Care identified that domestic abuse is likely to be underreported - there was a significant number of enquiries where the source of abuse was a family member or ex-partner but being recorded under other abuse types (physical, financial etc.) rather than domestic abuse. Adult Social Care recognised that there are opportunities to increase the recording of domestic abuse and continue to work on this.

Some of our local data in relation to abuse types appears to be in line with regional and national statistics although there are a lower rate of referrals in relation to psychological abuse and domestic abuse. Both neglect/acts of omission and self-neglect rates are higher than the regional and national average however the Quality, Assurance & Performance subgroup did recognise that other local authorities have different pathways and distinct multi-agency hubs to respond to and manage self-neglect cases.

**2. Number of safeguarding enquiries broken down by location of risk:**

| Location of risk | *Prev Year 2020/21* | *Prev Year 2021/22* | *Prev Year 2022/23* | Last Q4 | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Alleged Person Causing Harm's Home | *6 (1%)* | *13 (1%)* | *8 (1%)* | *2 (1%)* | 1 *(0%)* | 2 *(1%)* | 3 (1%) | 3 (1%) | ***9 (1%)*** |
| Day Care | *4 (1%)* | *0 (0%)* | *7 (1%)* | *1 (0%)* | 0 *(0%)* | 1 *(0%)* | 0 (0%) | 2 (1%) | ***3 (0%)*** |
| Education/Training/Workplace | *0 (0%)* | *1 (0%)* | *1 (0%)* | *0 (0%)* | 0 *(0%)* | 0 *(0%)* | 0 (0%) | 0 (0%) | ***0 (0%)*** |
| Hospital | *29 (5%)* | *41 (5%)* | *29 (3%)* | *12 (4%)* | 17 *(4%)* | 14 *(4%)* | 10 (4%) | 20 (6%) | ***61 (4%)*** |
| Hospital-Mental Health | *20 (4%)* | *4 (0%)* | *3 (0%)* | *3 (1%)* | 2 *(1%)* | 3 *(1%)* | 2 (1%) | 1 (0%) | ***8 (1%)*** |
| Housing with Care | *17 (3%)* | *39 (4%)* | *23 (2%)* | *8 (3%)* | 18 *(5%)* | 10 *(3%)* | 14 (5%) | 15 (4%) | ***57 (4%)*** |
| Not Known | *10 (2%)* | *14 (2%)* | *13 (1%)* | *6 (2%)* | 0 *(0%)* | 3 *(1%)* | 4 (2%) | 5 (1%) | ***12 (1%)*** |
| Nursing Home | *68 (12%)* | *121 (13%)* | *124 (12%)* | *33 (11%)* | 45 *(12%)* | 40 *(11%)* | 36 (14%) | 42 (12%) | ***163 (12%)*** |
| Other Health Setting | *4* | *1* | *2* | *0* | 2 | 2 | 0 | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *(1%)* | *(0%)* | *(0%)* | *(0%)* | *(1%)* | *(1%)* | (0%) | 4 (1%) | ***8 (1%)*** |
| Other Location | *14 (3%)* | *14 (2%)* | *14 (1%)* | *6 (2%)* | 4 *(1%)* | 3 *(1%)* | 2 (1%) | 9 (2%) | ***18 (1%)*** |
| Own Home i.e., where adult usually lives | *270 (49%)* | *409 (45%)* | *509 (50%)* | *148 (50%)* | 163 *(43%)* | 172 *(48%)* | 148 (56%) | 178 (49%) | ***661 (49%)*** |
| Public Place | *12 (2%)* | *8 (1%)* | *19 (2%)* | *2 (1%)* | 2 *(1%)* | 7 *(2%)* | 0 (0%) | 1 (0%) | ***10 (1%)*** |
| Residential Care | *99 (18%)* | *241 (27%)* | *252 (25%)* | *75 (25%)* | 125 *(33%)* | 103 *(29%)* | 43 (16%) | 81 (22%) | ***352 (26%)*** |
| Shared Lives | *0 (0%)* | *0 (0%)* | *4 (0%)* | *0 (0%)* | 0 *(0%)* | 0 *(0%)* | 0 (0%) | 0 (0%) | ***0 (0%)*** |
| **Total** | ***553*** | ***906*** | ***1008*** | ***296*** | **379** | **360** | **262** | **361** | **1362** |

Location of harm for concluded enquires was again predominantly in the individual's own home this year with no other significant changes in trends in any other locations.

**3. Location of abuse/risk for each abuse type for concluded enquiries (cumulative year to date):**

| | Care Home Nursing | Care Home Residential | Hospital-Mental Health | Hospital Acute | In a community service | In the community | Other | Own Home | Total |
|---|---|---|---|---|---|---|---|---|---|
| Discriminatory | 1 | | | | | | | 3 | **4** |
| Domestic Abuse | | | | | | | 1 | 44 | **45** |
| Financial or material | 4 | 11 | 4 | 1 | 1 | 5 | 9 | 134 | **169** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Neglect and Acts of Omission | 115 | 233 | 1 | 44 | 5 | 2 | 6 | 224 | **630** |
| Organisational | 4 | 8 | | 1 | 1 | | | 9 | **23** |
| Physical | 31 | 71 | | 9 | 4 | 4 | 6 | 75 | **200** |
| Psychological | 4 | 11 | 3 | 3 | 1 | 4 | 1 | 56 | **83** |
| Self-Neglect | 3 | 13 | | | | 2 | 2 | 157 | **177** |
| Sexual | | 5 | 1 | 1 | | 2 | 2 | 9 | **20** |
| Sexual Exploitation | | | 2 | | | | 1 | | **3** |
| **Total** | **162** | **352** | **11** | **59** | **12** | **19** | **28** | **711** | **1354** |

Over half of all concerns relating to neglect and acts of omission (55%), physical abuse (51%) and organisational abuse (52%) were found in care homes; the other types of abuse were mainly located within the person's own home.

**4. Source of risk (i.e., perpetrator) for safeguarding enquiries**

| | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Day centre staff | 1 (0%) | 1 (0%) | 1 (0%) | 0 (0%) | ***3 (0%)*** |
| Domiciliary Care Staff (Home Support Staff) | 48 (11%) | 34 (11%) | 42 (14%) | 30 (19%) | ***154 (11%)*** |
| Family Member | 81 (19%) | 56 (18%) | 56 (19%) | 48 (15%) | ***241 (18%)*** |
| Friend/Neighbour | 14 (3%) | 13 (4%) | 8 (3%) | 14 (4%) | ***49 (4%)*** |
| GP | 3 (1%) | 0 (0%) | 1 (0%) | 0 (0%) | ***4 (0%)*** |
| Hospital Staff | 15 (4%) | 12 (4%) | 13 (4%) | 17 (5%) | ***57 (4%)*** |
| Housing with Care Worker | 9 (2%) | 4 (1%) | 4 (1%) | 3 (1%) | ***20 (1%)*** |
| Not Known | 9 (2%) | 14 (4%) | 7 (2%) | 15 (5%) | ***45 (3%)*** |
| Not Listed | 7 (2%) | 4 (1%) | 4 (1%) | 5 (2%) | ***20 (1%)*** |
| Not Recorded | 1 (0%) | 1 (0%) | 1 (0%) | 9 (3%) | ***11 (1%)*** |
| Nurse (non-hospital) | 5 (1%) | 1 (0%) | 5 (2%) | 3 (1%) | ***14 (1%)*** |
| Nursing Home Care Staff | 30 | 32 | 30 | 35 | ***127*** |

| | | | | | |
|---|---|---|---|---|---|
| | (7%) | (10%) | (10%) | (11%) | ***(9%)*** |
| Other adult with Care & Support Needs | 35 (8%) | 25 (8%) | 10 (3%) | 15 (5%) | ***85 (6%)*** |
| Other Health Care Worker | 3 (1%) | 4 (1%) | 2 (1%) | 2 (1%) | ***11 (1%)*** |
| Other Social Care Staff | 1 (0%) | 0 (0%) | 2 (1%) | 0 (0%) | ***3 (0%)*** |
| Partner/Ex-Partner | 17 (4%) | 13 (4%) | 14 (5%) | 18 (6%) | ***62 (5%)*** |
| Privately Employed Worker | 0 (0%) | 1 (0%) | 1 (0%) | 0 (0%) | ***2 (0%)*** |
| Residential Care Staff | 77 (18%) | 62 (20%) | 54 (18%) | 56 (17%) | ***249 (18%)*** |
| Self-Directed Care Staff (inc. Direct Payments PA) | 1 (0%) | 1 (0%) | 0 (0%) | 1 (0%) | ***3 (0%)*** |
| Self-Neglect | 60 (14%) | 32 (10%) | 40 (13%) | 45 (14%) | ***177 (13%)*** |
| Staff in Independent Sector | 0 (0%) | 2 (1%) | 2 (1%) | 2 (1%) | ***7 (1%)*** |
| Stranger | 6 (1%) | 4 (1%) | 0 (0%) | 4 (1%) | ***14 (1%)*** |
| **Total** | **422** | **317** | **297** | **322** | ***1358*** |

Residential care staff and family members were the predominant source of risk this this year (both at 18%) however risks from family members is not reflected in the domestic abuse data. Adult Social Care continue to remind practitioners to ensure the abuse type selected is domestic abuse when the perpetrator of abuse is a family member.

**5. Source of referral / concern:**

| Referral source | ***Prev Year 2020/21*** | ***Prev Year 2021/22*** | ***Prev Year 2022/23*** | ***Last Q4*** | **Q1** | **Q2** | **Q3** | **Q4** | **Total** |
|---|---|---|---|---|---|---|---|---|---|
| Adult Social Care (CCC) | *75 (2%)* | *114 (2%)* | *193 (3%)* | *40 (3%)* | 48 (3%) | 38 (2%) | 34 (2%) | 36 (2%) | ***156 (2%)*** |
| Ambulance Service | *1001 (23%)* | *2007 (34%)* | *2280 (36%)* | *563 (36%)* | 494 (31%) | 504 (32%) | 535 (30%) | 627 (34%) | ***2160 (32%)*** |
| Anonymous/Neighbour/Member of Public | *59 (1%)* | *56 (1%)* | *59 (1%)* | *22 (1%)* | 18 (1%) | 20 (1%) | 18 (1%) | 10 (1%) | ***66 (1%)*** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Care Quality Commission | *57 (1%)* | *58 (1%)* | *42 (1%)* | *8 (1%)* | 10 (1%) | 5 (0%) | 13 (1%) | 3 (0%) | ***31 (0%)*** |
| Community Health Staff/Setting | *192 (4%)* | *221 (4%)* | *357 (6%)* | *93 (6%)* | 114 (7%) | 107 (7%) | 111 (6%) | 130 (7%) | ***463 (7%)*** |
| Coventry & Warwickshire ICB | *9 (9%)* | *5 (0%)* | *12 (0%)* | *2 (0%)* | 0 (0%) | 2 (0%) | 2 (0%) | 2 (0%) | ***6 (0%)*** |
| Fire Service | *14 (0%)* | *18 (0%)* | *21 (0%)* | *6 (0%)* | 5 (0%) | 12 (1%) | 4 (0%) | 0 (0%) | ***21 (0%)*** |
| Friend/Family/Partner (Ex) | *321 (7%)* | *318 (5%)* | *369 (6%)* | *103 (7%)* | 103 (6%) | 97 (6%) | 116 (6%) | 100 (5%) | ***416 (6%)*** |
| NHS Hospital Trust | *482 (11%)* | *514 (9%)* | *474 (8%)* | *120 (8%)* | 154 (10%) | 140 (9%) | 202 (11%) | 208 (11%) | ***704 (10%)*** |
| Not Recorded | *6 (0%)* | *5 (0%)* | *7 (0%)* | *2 (0%)* | 0 (0%) | 0 (0%) | 1 (0%) | 1 (0%) | ***1 (0%)*** |
| Other | *462 (11%)* | *390 (7%)* | *529 (8%)* | *132 (8%)* | 131 (8%) | 129 (8%) | 171 (10%) | 195 (10%) | ***626 (9%)*** |
| Other Local Authority | *45 (1%)* | *32 (1%)* | *33 (1%)* | *12 (1%)* | 11 (1%) | 12 (1%) | 14 (1%) | 9 (0%) | ***46 (1%)*** |
| Other Service User (or their family) | *14 (0%)* | *26 (0%)* | *13 (0%)* | *4 (0%)* | 3 (0%) | 6 (0%) | 8 (0%) | 4 (0%) | ***21 (0%)*** |
| Police | *213 (5%)* | *215 (4%)* | *213 (3%)* | *47 (3%)* | 43 (3%) | 29 (2%) | 47 (3%) | 48 (3%) | ***167 (2%)*** |
| Self | *86 (2%)* | *113 (2%)* | *101 (2%)* | *29 (2%)* | 30 (2%) | 53 (3%) | 39 (2%) | 32 (2%) | ***154 (2%)*** |
| Social Care Provider/Setting | *1285 (30%)* | *1766 (30%)* | *1577 (25%)* | *373 (24%)* | 422 (27%) | 411 (26%) | 470 (26%) | 455 (24%) | ***1758 (26%)*** |
| **Total** | ***4321*** | ***5858*** | ***6278*** | ***1556*** | **1586** | **1565** | **1785** | **1860** | ***6796*** |

Concerns into Adult Social Care are received from a variety of sources and the table above shows the agencies who submitted referrals/concerns across 2023/24.

There were no significant change in trends in relation to source of referral; the main referrer this year was WMAS. A small Task & Finish group reviewed and update the classifications that sit underneath the source of risk and source of referral datasets. These updates will be reflected in the revised scorecard for Q1 onwards and will help to inform any targeted work that might be required next year.

**6. Number of concerns broken down by age of individual:**

| Age range | *Prev Year 2022/23* | Last Q4 | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|---|---|
| 18-64 | *2016 (31%)* | 487 | 514 | 513 | 562 | 634 | ***2223 (33%)*** |
| 65-74 | *898 (14%)* | 236 | 233 | 218 | 268 | 240 | ***959 (14%)*** |
| 75-84 | *1546 (25%)* | 406 | 379 | 389 | 472 | 491 | ***1731 (25%)*** |
| 85-94 | *1560 (25%)* | 361 | 395 | 377 | 407 | 423 | ***1602 (23%)*** |
| 95+ | *246 (4%)* | 61 | 63 | 65 | 71 | 66 | ***265 (4%)*** |
| Unknown | *12 (0%)* | 5 | 2 | 3 | 5 | 6 | ***16 (0%)*** |
| **Total** | ***5862*** | **1556** | **1586** | **1565** | **1785** | **1860** | **6796** |

***7.*** **Number of referrals/concerns and enquiries broken down by gender of individual**

| Gender | 2022/23 | | 2023/24 (YTD)* | |
|---|---|---|---|---|
| | Concern | Enquiry | Concern | Enquiry |
| Female | 2184 | 539 | 2284 | 614 |
| Male | 1834 | 334 | 1841 | 430 |
| Indeterminate | 4 | 0 | 8 | 0 |
| **Total** | **4022** | **873** | **4133** | **1044** |

**yearly total based on individuals as per the SAC, e.g., when a person has had more than one concern started in the year you only count them once)*

### *8.* Number of referrals/concerns and enquiries broken down by ethnicity of individual

| Ethnicity | 2022/23 | | 2023/24 (YTD)* | |
|---|---|---|---|---|
| | Concern | Enquiry | Concern | Enquiry |
| Asian/Asian British | 240 | 46 | 278 | 70 |
| Black/African/Caribbean/Black British | 118 | 22 | 129 | 29 |
| Mixed/Multiple | 31 | 5 | 35 | 10 |
| Other Ethnic Group | 36 | 4 | 30 | 6 |
| Refused | 60 | 10 | 68 | 21 |
| Undeclared/Not Known | 489 | 70 | 521 | 74 |
| White | 3048 | 716 | 3072 | 834 |
| **Total** | **4022** | **873** | **4133** | **1044** |

**yearly total based on individuals as per the SAC, e.g. when a person has had more than one concern started in the year you only count them once)*

67% of all concerns this year were in relation to individuals aged 65+. The Quality, Assurance and Performance subgroup have expanded the demographic data within the scorecard and included ethnicity and gender profiles but in order to draw any conclusions regarding proportionality, demographic data of the local population is required, and this will be explored in more detail next year.

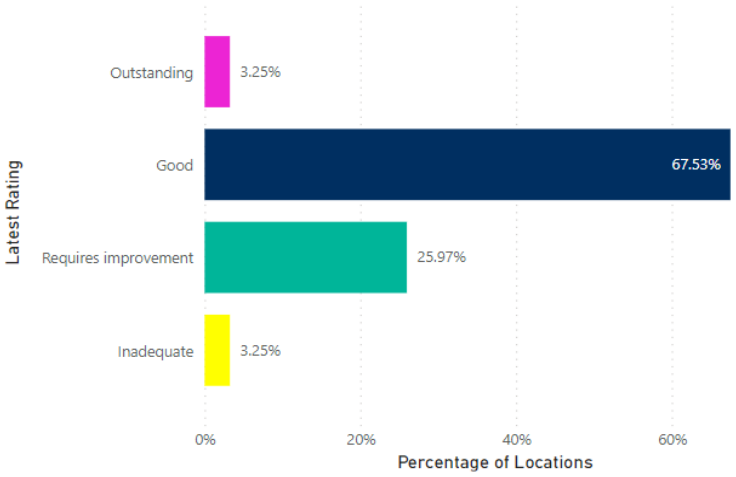
### 9. Number of providers attending the Provider Forum:

| Service Area | Number of Providers | Average number of attendees at forum | | | | |
|---|---|---|---|---|---|---|
| | | Prev Q4 | Q1 | Q2 | Q3 | Q4 |
| Older People – Care Homes (Residential/Nursing) | 45 | *0 – Provider forum cancelled due to other priorities* | 16 *(hybrid)* | 20 *(face to face)* | 20 *(face to face)* | 29 *(face to face)* |

| | | | | | | |
|---|---|---|---|---|---|---|
| Housing with Care | *TBC* | - | 8<br>*(face to face)* | 2 Providers however representing 2 organisations with a total of 8 Coventry schemes<br>*(face to face)* | *No provider forum in Q3* | *Next face to face provider forum arrange for 14.05.24* |
| Home Support | *TBC* | *0 – No Provider forum in Q4* | *0 – No Provider forum in Q1* | 8<br>*(face to face)* | *No provider forum in Q3* | *June 2024 – Long-Term Improving Lives Engagement Event*<br>*15.05.24 – Short Term Event* |
| Mental Health | 34 | 19<br>*(virtual)* | 10<br>*(virtual)* | - | *No provider forum in Q3* | - |
| Learning Disability | *TBC* | 5<br>*(face to face)* | *0 – No Provider forum in Q1* | - | *No provider forum in Q3* | *No provider forum in Q4* |
| Mental Health & Learning Disability Joint Provider Forum | *TBC* | - | - | *17*<br>*(face to face)* | *No provider forum in Q3* | - |

**CQC rating of Coventry care homes:**

The Care Quality Commission (CQC) is the independent regulator of Health and Social Care in
England. Each quarter a representative from the Commissioning Team brought a report
to the subgroup to provide assurance around the internal and external audit and inspection
systems in care homes in Coventry, how they are rated by CQC and any plans for improvement.




This table shows all Coventry CQC registered provision (154 registered locations), including internal providers and providers the Council did not contract with but are registered in Coventry. In Q4, there were 5 providers rated overall "Inadequate". This includes 3 Community Providers the Council did not contract with, and 2 older people care homes rated as "Inadequate".

At the end of the year, the Council contracted “in City” with 26 providers CQC rated as “Requires Improvement” and 2 providers CQC rated as “Inadequate”. The Joint Quality Assurance Team continued to focus assurance activity on commissioned providers with these ratings; providers were supported in improving their practice, key actions were undertaken and information and intelligence was shared with the CQC to inform their inspections. The Quality Peer Support Group (QPSG) and Provider Escalation Panel (PEP) continued to monitor and manage providers that had quality concerns and presented levels of risk to both the users of the service and/or risks to the market. These multi-agency groups have a shared responsibility for managing local quality assurance.

**Covid-19 Position Statement**

The Safeguarding Executive Group (the Director of Adult Services, the ICB Head of Safeguarding and the Coventry Police Commander) of the CSAB continued to update the city’s Position Statement every 6 months to seek assurances from partner agencies about their current methods of operation and how it impacted on their ability to identify safeguarding issues, and to ensure there was a collective understanding of the services available for adults with care and support needs.

We requested succinct information from services across the city with a focus on any positives and challenges in the system including (but not limited to) safeguarding concerns (identification and response), prevalence of abuse types, multi-agency working, communication/information sharing, operational/workforce issues, training, engagement with service users, cost of living crisis etc and how agencies were responding to these and proposed recommendations to strengthen the safeguarding system. This afforded the Executive Group with strategic oversight of safeguarding activity and any safeguarding adults’ issues in the system to ensure they were able to respond appropriately.

## How have we made a difference?

| |
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| To be assured that safeguarding is underpinned by the principles of Making Safeguarding Personal and that adults are supported to achieve the outcomes that they want. |
| **Contract and service design**<br>Coventry City Council Adults Strategic Commissioning In designing and awarding contracts, specific consideration is given to both safeguarding and ensuring contracts are worded in a manner that promotes independence, enablement / reablement and personalisation of care. As part of the tender and contract award process, providers are specifically assessed on their understanding of and processes in respect of safeguarding individuals, including alignment to the West Midlands Safeguarding Adults policies and procedures. Responses in respect of safeguarding are specifically weighted above other criteria. Contract specifications provide further stipulations to providers in respect of safeguarding and quality requirements.<br>As part of the design of new contracts and services, engagement with individuals in receipt of services and carers is undertaken to ensure services are delivered in line with user requirements. Examples of this can be noted within the recent re-commissioning of Short Term Home Support and development of the Carers Action Plan 2024/26. |
| The Integrated Care Board fund and deliver training for the Safeguarding Adults Co-ordinators programme within Primary Care where Making Safeguarding Personal is a common thread.<br>This role is open to all GP practices and is designed to assist the practices Safeguarding GPs on delivering their Safeguarding Adults responsibilities. This is to improve Primary Care's engagement in Adult Safeguarding but also to support their roles in the partnership.<br>This includes reporting and responding to external enquiries, requests for information and audits, and to co-ordinate all Safeguarding activity within the practice. |
| **Commissioning quality assurance and contract management**<br><br>Coventry City Council Adults Strategic Commissioning aim to undertake an annual quality assurance visit of at least one visit per annum to all commissioned provision to monitor safety, quality of care, care planning and recording, and outcomes achieved. Additional visits are undertaken where risk is identified in line with our Quality Assurance Framework. |
| At CWPT MSP is a core component of our ethos in the Trust underpinned by policy, training discussion and recording. Since the restoration of Carenotes our Section 75 data has been regularly scrutinised to consider and record patient wishes and wants. Further work is being considered. |

The principles of Making Safeguarding Personal are explored and discussed within our level 1 safeguarding training – a mandatory course for all WMFS staff. This training is 2 yearly.

CWPT have worked in partnership with the safeguarding partnership boards to contribute to a multi-agency casefile audit in order to seek assurance that safeguarding is underpinned by the principles of 'Making Safeguarding Personal' and that adults are supported to achieve the outcomes they want (CSAB). This included providing a case study example of when MSP has improved outcomes and how CWPT embodies and promotes MSP principles within the organisation and day to day work.

Coventry and Warwickshire Integrated Care Board host a GP safeguarding leads forum to offer support, learning and an opportunity to assist the safeguarding team to understanding any developing challenges or themes practices are experiencing.

While Registered Providers of Housing such as Citizen do not have primary responsibility for safeguarding subject to the Childrens Act 2004, they are expected to mirror organisations. Citizen does this by:

- Having a designated safeguarding lead
- Sharing information with professionals
- Having safe recruitment practices and whistleblowing procedures
- Training their staff in safeguarding
- Having a clear safeguarding policy; and
- Having a procedure on how to respond – We call these Standard Operating Procedures (SOP).

Customers can report safeguarding concerns in confidence either through our dedicated safeguarding phone line or email address. Of course, they can report this during face-to-face visits.
This year we revised & updated our Child Safeguarding policy.

The Council's Modern Slavery Lead circulates changes in policy, guidance, and practice to relevant stakeholders as and when released. These are circulated to department and organisation leaders and are sometimes discussed within the Modern Slavery Protocol Task and Finish Group.
One example of this was the changes in immigration policy relating the Skilled Care Worker Visa and the subsequent affects this had on Adult Social Care's commissioning of social care services. The Modern Slavery lead has worked with Adult Social Care to produce local guidance based on national recommendations and implement new practice to respond to increases in exploitation concerns.

'Safeguarding Adults Practice Guidance and Making Safeguarding Personal Toolkit' has been shared with all probation staff at Coventry PDU, alongside the one-minute guide on MSP. Senior Probation Officers have been asked to share and discuss MSP in team meetings.

A recent WMFS audit of Complex Needs highlighted a need for Mental Capacity awareness to be increased across specialist roles. Following a review of the Prevention department at WMFS, 'Specialist Roles' within this department may receive this training as part of their development.

The Council's Modern Slavery Lead keeps a database of all modern slavery concerns so that trends can be monitored and responded to as appropriate.
During 2023/2024, trends included a high number of cases involving cuckooing, labour exploitation in the care sector and county lines involving young adults previously open to Childrens Services. To address these themes, work is being undertaken to embed a cuckooing toolkit into practice, Adult Social Care Commissioning have been recognised as national best practice for the work they have done to support care workers affected by issues with their employment, and a new transitions panel pilot has been launched in partnership with the Horizon (Child Exploitation) Team to improve outcomes for exploited young people transitioning to adulthood.
The Council Is currently developing a pathway for staff to follow when a case of modern slavery is identified in addition to a protocol which ascribes roles and responsibilities to organisations in the city to tackle and prevent modern slavery. There are several challenges to this such as housing, no recourse to public funds, the role of Adult Social Care and referral into the National Referral Mechanism which are being worked through with partners in the Task and Finish Group.

Coventry and Warwickshire Integrated Care Board have an internal Safeguarding website which provides Safeguarding information, safeguarding pathways, processes, and links to other services. Making Safeguarding Personal is included, with direct links to both CSABs resources but also external resources such as SCIE. This is designed to give practitioners an overview and easy access to further information on specific safeguarding areas

**Coproduction and Engagement**
Coventry City Council Adult Social Care continued to work to grow its commitment to developing a culture of 'Coproduction and Engagement'. This included producing a commitment to the way the way the service would engage and involve people.

**https://www.coventry.gov.uk/downloads/file/39258/adult-social-care-engagement-involvement-and-co-production-it-s-our-approach**

A real time experience survey continues to be used to seek feedback from people who have recently experienced support from Adult Social Care. The results so far are showing a broadly very positive experience of those people who access support or the people who care for them having a positive experience. Feedback has included being complimentary about support and how Adult Social Care have worked to build a rapport and connection with people and a great proportion of people have wanted to get involved in some way in the work of Adult Social Care (over 1300 people now signed up to the Adult Social Care bulletin as of April 2024). Links for the survey are now on Adult Social Care's assessment, support plan and review forms.
https://myaccount.coventry.gov.uk/service/Adult_Social_Care___Experience_survey

UHCW have a Trust strategy which puts the patient at the pinnacle of the strategy, and this is continued in our approach to safeguarding. Patient's preferences and wishes are at the centre of Safeguarding and all decisions are made in an inclusive way. Capturing the patient's wishes and feelings is a mandated field within a UHCW Safeguarding Adult referral to ensure the persons views are heard and respected.

**Safeguarding Experience**

Coventry City Council Adult Services have been reviewing way they engage with the experience of those accessing safeguarding support. For a number of years this has included a user feedback form which can be completed at the beginning of the Safeguarding process: My Safeguarding Experience Part 1 and a further user feedback form which is used at the end of the process: My Safeguarding Experience Part 2. However, very few responses have been received over the years. A new online survey has been designed and trialled to be given to people after the recent conclusion of the s42 enquiry (with the option to provide details for direct contact if required by the person).
The following questions formed part of the survey, with an additional free text box for any further comments;

- Did you feel you were fully involved and included during the safeguarding, and did you feel your views and wishes were listened to?
- During your safeguarding experience, were the most important things that you wanted to see happen, achieved?
- Is there anything that we could have done differently that would have improved your experience?

Subject to a successful trial this will be rolled out in 2024/5.

CWPT active Champions group spread the safeguarding message throughout our services.

CWPT have completed internal briefings for staff and reviewed our Trust intranet site to reflect documentation including the MSP safeguarding tool kit being available to all.

In the 2023/2024 financial year, there have been 130 cases of modern slavery reported to the Council's Modern Slavery Lead, involving victims, perpetrators, and locations of concern. In all cases regarding victims of modern slavery, the Modern Slavery Lead has provided signposting and advice on cases to ensure that adults have been safeguarded and supported. In all these cases the concept of informed consent has been crucial for adults with capacity, ensuring that the adult's aspirations and opinions are at the heart of the safeguarding response.

**Practice Quality Assurance**

Coventry City Council Adult Services commenced a new routine monthly audit activity across the whole end to end safeguarding process in 2023/24, to support identification of good practice and areas for practice development. This included undertaking dip sample audits at 3 key stages of the safeguarding process;

Concerns open to Intakes and allocated workers
Enquiries allocated and open 0 to 6 months
Enquiries allocated and open 6 months +

Audits are undertaken each month and are undertaken by the Head of Safeguarding, Adults Safeguarding Coordinator and Practice Development Social

Worker. These audits aim to ensure our practice is in keeping with Making Safeguarding Personal

Safeguarding training is planned for all executive ICB staff members which was written in partnership with NHSE.

At Citizen year ending March 2024 97.1% of housing and care staff (253 out 0f 260 staff colleagues) compliance with attendance at mandatory Safeguarding training.
Year ending March 2024 99.23% of housing and care staff (258 out 0f 260 staff colleagues) compliance with attendance at mandatory equality and inclusion training.

UHCW encourage all staff to adapt the ethos of "Think family" in relation to safeguarding practice and families, friends and advocates are an integral part of all care and discharge decisions.
UHCW endeavours to hear the patients voice, and this is done in many ways including using person centred documentation such as Advanced Decision Making, Hospital Passports for patients with Learning Disability and / or Autism and Getting to Know You booklets for people with Dementia. Over 80% of staff have completed the level 1 Oliver McGowan training which again supports the need to be person centred. This was also a key message delivered during the Learning Disability Awareness Week which the Safeguarding Team promoted.

**Accessible Safeguarding Information**
Coventry Council Adult Services have developed a live demographic dashboard to identify the different characteristics of people accessing support. This has led to the development of information materials in different languages. We have updated all our public information which identifies that they can be made available in 6 main languages used in Coventry – Polish, Punjabi, Urdu, Arabic, Romanian and Tigrinya. We have also produced our safeguarding information leaflet in Arabic as this is one of the most requested languages for translation.
https://www.coventry.gov.uk/ASCpublicinformation

The ICB leads a strategic health group as part of the inequalities work to ensure the physical and emotional needs of asylum seekers and migrants are met.

The approach to be adopted throughout The Probation Service is called 'Skills for Effective Engagement, Development and Supervision' (SEEDS). With person-centred, relational approaches at its core, SEEDS reflects the role Probation can play in reducing reoffending and protecting the public, through effective, holistic engagement with people on probation, helping us to see and work with individuals, as a whole (holistically). This approach is in line with the principles of 'Making Safeguarding Personal'. SEEDS training has been rolled out across Coventry staff. Probation Practitioners are well versed in completing appropriate safeguarding enquires/referrals when there are safeguarding concerns. People on probation are included (where appropriate) in conversations about their risk assessment, risk management and sentence planning, supporting their voice to be included within probation work. People on probations feedback is promoted through 'Your voice matters' survey that takes place annually, from which a regional/PDU plan is created.

Conclusion

Coventry Safeguarding Adult's Board is assured that Making Safeguarding Personal continues to be embedded in all safeguarding activity across the city. 73% of all safeguarding enquiries were either fully or partially met. Coventry Safeguarding Adult's Board recognises that Making Safeguarding Personal underpins all safeguarding activity. It is vital that we strive for continuous improvement in this area and challenge ourselves to ensure that the needs and wishes of adults with care and support needs are understood and acted upon. Making Safeguarding Personal will therefore continue to be a priority for Coventry Safeguarding Adult Board in 2024- 2025.

The Safeguarding Adults Board to monitor/ respond to national and regional reforms, development and policy.

**West Midlands Safeguarding Leads Network**

Coventry City Council Adult Social Care, are members of the West Midlands Regional Safeguarding Adults Leads Network.

The overarching purpose of the West Midlands Safeguarding Leads Network is to work together as a group of Safeguarding Adult Board Managers and operational local authority Adult Safeguarding leads to ensure safeguarding adults practice is based on a person's strengths and promotes independence and supports people in achieving better lives.

One of the aims of the Network is to share learning and develop good practice across region, by promoting/reporting on local initiatives, research, Safeguarding Adults Reviews and national developments.

It also ensures regional procedures are developed, reviewed, updated and reflect best practice through the process of an Editorial Group. Over the last year, the adult safeguarding coordinator has been involved in the work to review and revise the West Midlands Adult Safeguarding Policy & Procedures.

Link to document:

https://www.coventry.gov.uk/downloads/file/31335/west-midlands-adult-safeguarding-policy-and-procedures

The Probation Service Sentence Management in the Community Policy Framework, Safeguarding Adults at Risk in the Community with Care and Support Needs – Practice Guidance, and Safeguarding Adults at Risk Policy Statement all outline the Probation Services responsibility under the Care Act 2014 for safeguarding and promoting the welfare of adults with care and support needs to keep them safe from abuse or neglect. Any change to Probation policy in relation to adult safeguarding would be completed nationally, and cascaded to Probation Delivery Units, including Coventry.

The Coventry and Warwickshire Integrated Care Board continue to commission IRIS. Some practices are now receiving refresher training due to the programme nearing six years. IRIS in addition to their usual programme, deliver additional bi-monthly training sessions to allow for focused or thematic learning such as changes to legislation.

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| WMFS respond to all national and regional reforms, development and policy in relation to safeguarding. This is assured through regional and national safeguarding meetings (NFCC) where support is sought and given on a range of safeguarding related themes. This is then assured through the WMFS Safeguarding Oversight and Assurance Group that meet on a monthly basis. |
| CWICB are involved with the Offensive Weapons Homicide Reviews pilot in Coventry as a Review Partner as required in the guidance. |
| Since the abandoning of LPS CWPT have continued to monitor their Deprivation of Liberty Safeguards through the Mental Health legislation department. |
| CWICB are currently introducing a Domestic Abuse in Health Community of Practice which will focus on health response to Domestic Abuse, Sexual Assault, NFS, MARAC and Suicide. Similarly, a Community of Practice for Health response to MCA and Prevent is also being organised. |
| UHCW Trust Board are kept regularly updated in relation to all safeguarding activity. This includes any national and regional reforms, developments and policies. Topics shared over this year have included the cessation of Liberty Protection Safeguards and Right Care Right Person.<br><br>Other key adaptions UHCW have made in relation to national and regional reforms include the introduction of a Homelessness Lead and Clinical Nurse Specialist for Drug Misuse. |
| CWICB both locally and regionally has been involved in the planning and implementation of the Serious Violence Duty with other partners. |
| Poor housing conditions have surfaced as a safeguarding issue because of damp and mould. We are connecting with contextual safeguarding risks that can face households – not due to neglect, abuse, or exploitation but due to harms such as damp, mould and poor insulation.<br>Citizen has reviewed its approach to disrepair including damp and mould. Our proactive approach to damp and mould has increased visibility of properties prone to damp and mould. This proactive approach to data analysis is helping us to target homes that are more likely to suffer from disrepair. The initiatives include setting up specialist teams to respond, improving ventilation and the installation of environmental monitors to help us understand the performance of these homes.<br>The Combined Authority asked local authorities to seek bids for funding targeted at category 1 and 2 hazards, this includes damp and mould growth and while the timescales were extremely tight Citizen was able to respond and secured £2.1m from Coventry City Council. |
| CWPT have reviewed policy, processes and training in light of the Domestic Abuse Act 2021. |
| CWPT have considered the national response in Health to Domestic Abuse with the Head of Safeguarding being the representative on that group. |

Overlapping the issue of poor housing conditions is austerity Inflation and while prices may be falling the prospects for households on low incomes remain bleak. As pressures on household finances increase, we're likely to see a commensurate rise in safeguarding issues, for example, domestic abuse, financial abuse, neglect and self-neglect.

Our response as a social landlord has to go beyond an appropriate reactive response to an increase in cases. It has embraced a positive proactive set of preventative activities. These include money and advice and employment services, providing grants via hardship fund, as well as (and most significantly) good quality homes.

Last year (year ending March 2024) the team were able to obtain £4,030,286 of additional cashable income for our residents and when we include the other activities with their added social value of £3,064,006 they generated over £7 million of annual investment in for our customers and communities.

Conclusion
The Safeguarding Adult Board and it's member agencies continually horizon scan for national and regional reforms, development and policy. Members of the Board work collaboratively across the West Midlands areas to identify best practice and to standardise practice for staff who may work across border where possible. The Board receives regular updates from agencies and the Business Manager about emerging policy and best practice and considers how these can be be implemented locally. This will continue across 2024/2025.

To have an understanding of and response to critical emerging adult safeguarding issues and practices

CWPT have been active to respond to critical emerging adult safeguarding issues such as responses to the economic crisis through briefings and speakers at their Safeguarding Champions group.

**Market awareness and development**
In December 2023 Coventry City Council Adults Strategic Commissioning undertook a survey of the market to better understand how we can improve our overall support offer and specifically the level of provider understanding of Coventry Adult Social Care safeguarding processes and any potential training needs. From this survey, all 63 responders confirmed they were clear on their roles and responsibilities in respect of the safeguarding process, however 70% of responders advised additional safeguarding training would be beneficial. An online safeguarding training was delivered by the Safeguarding Adults Co-ordinator to the market in Spring 2024, with updates to policy, practice or resources circulated to providers via email communications and the monthly Provider Bulletin. Further, the 'Provider Zone' on the Coventry City Council's website is updated to reflect latest updates and information. In response to suggested improvements from providers within the survey, a dedicated inbox for escalation of safeguarding concerns is now available to all providers to chase of escalate safeguarding concerns.

The Safeguarding Team remain fully staffed and accessible to all staff. There are good governance structures within the Trust allowing regular formal updates to brief key senior officers in relation to emerging issues but also good informal relationships enabling timely escalation outside of formalised channels as and when required.

Citizen has reviewed its Domestic Abuse policy and procedures –to reflect the new Regulator for Social Housing's consumer standards. Registered Providers (housing associations) are now required to be able to identify and respond appropriately to reports of domestic abuse, including an appreciation of the different specific needs of tenants who experience it and also sets out requirements to work cooperatively with other agencies and enable tenants to access appropriate support and advice.

The regulatory expectation is supported by customers, with 90% of respondents in the Domestic Abuse review stating that they felt Citizen had a role to play in responding to cases of abuse. Introducing this role, and formalising roles that already exist in the organisation, will ensure we are in a good position to deliver a consistent service to all customers no matter where they live.

New guidance to frontline staff has been written and is included in new face to face training for all Housing & CASH staff.
We have created two dedicated DA Advisor posts to provide specialist support to colleagues and manage complex cases.

**Ongoing skills development in assessment of mental capacity**
Coventry City Council Adult Services continues to host and develop an external resources web page for adults, carers and providers of health and social care services living and working in Coventry https://www.umccoventry.co.uk/.
Training for front line staff has been complemented by the provision of Mental Capacity Masterclasses in 2023/24. Including

Acquired Brain Injury, Sexual relations, hoarding and self-neglect, Discharge to assess and tenancy agreements. Further events are being planned for 2024/25.

WMFS have employed a permanent safeguarding manager that attends regional Safeguarding meetings where critical emerging adult safeguarding issues and practises are discussed. This coupled with the national safeguarding (NFCC) meetings ensure any emerging issues and practices are better understood and then shared with WMFS through the WMFS Safeguarding Oversight and Assurance Group that meet on a monthly basis.

CWPT have reviewed the Section 75 arrangements in our Mental Health services.

The Coventry and Warwickshire Integrated Care Board Safeguarding Team host a Safeguarding and Looked after Children's assurance group for health professionals working with both adults and children. These forums provide the opportunity to identify safeguarding themes and/or gaps from across the health system which can then be shared/escalated across the Partnership.

**One-Page guides on key aspects of safeguarding practice**

Coventry City Council Safeguarding Adults Team developed a number of one-page guides for frontline staff on key aspects of the safeguarding process. The guides were developed using content taken, from the West Midlands Adult Safeguarding Policy & Procedures, and made more accessible for staff.

The guides were developed with the aim to achieve more consistency and standardisation within safeguarding practice. For example, one of the guides focuses on the use of safeguarding plans, providing clear guidance about when a plan should be in place, e.g. when there is on-going risk to an adult. The afeguarding adult's coordinator continues to deliver monthly staff briefings about the one page guides across the teams to both frontline practitioners and managers.

CWICB deliver Safeguarding supervision to practitioners internally but also across our health partners.

Monthly safeguarding training is offered face to face alongside bespoke safeguarding training for the Emergency Department, which is well evaluated and has supported an increase in safeguarding training compliance.

Internally CWPT has considered transitions from Childrens services to Adult Mental health services and Learning Disability and Autism services.

CWICB are involved in the now titled ICS Newly arrived community. This has previously been focused on the quadrant, the four hotels commissioned to support migrants placed into the city. CWICB are part of the Coventry and Warwickshire Suicide prevention network.

There are monthly safeguarding champions sessions and quarterly newsletters which ensure all emerging issues can be shared in a timely manner to all. There is also an internal intranet which can be updated by the Team meaning key messages can be made available in the matter of minutes. This is useful for incidents where Severe Weather Emergency Protocol (SWEP) is activated.

Conclusion

Coventry Safeguarding Adults Board regularly receives positions statements from partners which asks them to outline what is going well in their agency, what they are worried about and what they feel the Board needs to do or support with moving forwards. These position statements allow the Board to have a good understanding of emerging issues and look at possible responses.

## Policies and Procedures

West Midlands Adult Safeguarding policies and procedures have been developed jointly by the fourteen West Midland Adult Boards/ Local Authority areas working together to introduce a consistent approach and practice within adult safeguarding.

Please access the regional documents here: [WM Adult Docs (safeguardingwarwickshire.co.uk)]

## Audits

Across the year the Quality, Assurance and Performance subgroup (QA&P) undertook 3 audits.

**Forced Marriage Statutory Guidance**

Forced marriage is a crime in the UK but remains a hidden practice, with many cases going unreported. Adults with care and support needs are particularly vulnerable to forced marriage and, in the cases of vulnerable adults who lack the capacity to consent to marriage, coercion is not required for a marriage to be forced. The Board, via its Quality, Assurance and Performance (QA&P) Subgroup wanted to explore how well partner agencies have embedded the multi-agency statutory guidance for dealing with forced marriage and seek assurance that effective processes are in place, that any good practice is identified, and to identify areas where improvement may be needed to ensure adherence and compliance with the statutory guidance across the partnership, and ensure frontline practitioners are equipped and supported to deal with cases of forced marriage effectively.

This audit was undertaken in the form of an Enquiry Panel and Board representatives were asked to create a response to a number questions and present these to the panel. The questions were designed to elicit specific responses related to some of the key areas of the guidance and actions that need to be taken by agencies. The panel consisted of: CSAB Quality Assurance Manager (Chair), CSAB Business Manager, Local Authority Head of Safeguarding & Practice Development and Public Health Programme Manager who were able to ask additional questions to the presenters.

The evidence submitted and presented by most agencies demonstrated that there is good compliance with the multi-agency statutory guidance; the panel were reassured by the responses to the questions, particularly in relation to development of local policies and procedures, training, guidance and resources. All agencies recognised the importance of having a designated lead within their organisations who act as a point of liaison for expert advice and support, and applying the principles of MSP to ensure all interventions are victim-centred. There were four case studies received in total (two via written submissions) but the two agencies who presented at the panel were able to provide a case study that evidenced compliance with the statutory guidance and good safeguarding practice when dealing with a case of forced marriage and improved outcomes for those adults involved.

In terms of areas for development, a theme emerging from the Enquiry Panel was the challenges faced by partners in relation to data collection and monitoring and evaluating agency practice with regards to the management of forced marriage cases. The panel were also concerned that Probation did not provide enough assurance as to their compliance with the statutory guidance and how this is embedded within their organisation.

## *RECOMMENDATIONS*

- The Board should aim to increase knowledge and capability of practitioners across the Adults and Children's safeguarding partnerships, to ensure they are empowered and well-equipped to be able to identify and respond to cases of forced marriage, by facilitating a multi-agency learning event to raise awareness of the specific issues surrounding forced marriage and honour-based abuse. The event should have a focus on vulnerable adults who lack capacity to consent, the nuances between forced and arranged marriages, promotion of the one chance rule, victim-centred approach, the Forced Marriage Unit and the importance of supervision and reflection.

- The Board, via the Policy & Workforce Development subgroup, should undertake a mapping exercise and collate all forced marriage and honour-based abuse resources, guides and best practice tools into a central location that can be shared across the Adult and Children's safeguarding partnerships and made accessible to all practitioners working with children and adults with care and support needs.

- The Board may wish to seek further assurance from the Probation Service about their compliance with the statutory guidance.

**Making Safeguarding Personal (MSP)**

Making Safeguarding Personal remains a key priority for the Coventry Safeguarding Adults Board (CSAB) and previous multi-agency audits were carried out by the Board in 2019 and 2021 identified many areas of strength in relation to MSP and the positive direction of travel was evident, however there were some areas that required further development. As part of the Board's Quality Assurance and Continuous Improvement Framework, the QA&P subgroup decided that repeating the case file audit again, with a similar methodology, will ensure that a picture of current safeguarding practice in relation to the application of MSP principles is evident and assurance that practitioners understand the principles of MSP, apply these when dealing with safeguarding cases and are fully informed and supported to work in a person-centred, outcome-focused way resulting in a positive impact on people's lives.

All relevant partners were asked to examine their agencies involvement with the individuals in the cohort within the last 6 months and complete a case file audit using an agreed audit template. Auditors were asked questions specifically formulated to capture the information the Board can use to gain assurance. Members of the Quality, Assurance & Performance subgroup were asked to complete 10 questionnaires with frontline practitioners from their organisation with the aim of gaining an insight into how practitioners understand and utilise the principles of Making Safeguarding Personal.

For this audit, where possible to do so, the service user's main practitioner was asked to go through a series of short questions with them to hear their thoughts about Making Safeguarding Personal and whether they feel work with them has embraced the principles of adult safeguarding.

Following completion of the case a multi-agency audit panel was held to consider the initial analysis of results of the case file audit from across the partnership and then as a panel, collectively drew out the key findings, themes and recommendations to ensure improvements are made.

### *FINDINGS*

The panel were in agreement that, based on evidence in the case files, the principles of MSP are well-embedded within safeguarding practice across the partnership; good application of MCA, safeguarding is tailored to the individuals' needs, they're kept at the heart of decision-making, outcomes are met and their lives improve as a result. The majority of case files evidenced effective information sharing, multidisciplinary team working, collaboration and a co-ordinated response between partner agencies; relevant information was shared appropriately in a secure and timely way ensuring the individual and their family were kept updated at all stages

The audit also revealed a plethora of guidance materials within organisations to help colleagues practice MSP and in most organisations this is featured in their safeguarding policies and delivered as part of their safeguarding training at all levels. Other resources identified included MSP toolkits, dedicated intranet pages and links to the CSAB's website and MSP resources as well as local safeguarding adult reviews.

In terms of improvement areas, the audit did highlight the need for practitioners to be assured about the suitability of any family advocate to represent the service user at the earliest opportunity, evidence how this has been obtained and ensure the rationale for this is clearly documented in the records. There also appeared to be a lack of understanding of the dynamics of domestic abuse and in particular the difficulties faced by older people.

In conclusion, the positive direction of travel of was evident and is a direct reflection of the journey the Board and partners have been on - travelling towards a more person-centred, outcome-focused and relational model of safeguarding when working with vulnerable individuals. This conclusion is also supported by the response to practitioner questionnaires and feedback from service users.

The audit made two recommendations to help support partners in their application of MSP and work with service users and these are summarised below:

***RECOMMENDATIONS***

- The Policy & Workforce Development Subgroup should continue to support and develop practitioners understanding around the application of MSP, MCA, the use of appropriate advocates, and responding to abuse types (i.e. domestic abuse and older people) across all services. This should include a review of all information, resources and publications, development of the Board website to make it more user friendly and accessible and disseminating materials across the partnership.

- The Quality Assurance & Performance Subgroup should continue to implement their QA Framework and consider appropriate methods to seek assurance that MSP is at the heart of adult safeguarding for all agencies, and is embedded in safeguarding practice across the partnership, in line with the Board's priorities for 2024/25.

**Care Act 2014 Compliance**

The Coventry Safeguarding Adults Board completes this piece of multi-agency assurance work every 2 years to understand agencies' general compliance with the Care Act 2014. This self-assessment reviews the effectiveness of the arrangements for safeguarding adults at a strategic level. The audit assesses each organisation against standards based on the requirements of the Care Act 2014, and throughout the process consideration must be given to evidencing improved outcomes for adults as a result of the arrangements.

This self-assessment consistently provides assurance and evidence of good quality safeguarding practice by agencies working with adults with care and support needs in Coventry which has continued again this year, with agencies reporting a high level of compliance with all standards and no obvious areas of development for the Board.

There were many areas of strength within this audit to evidence that agencies are meeting the requirements of the Care Act 2014; senior leadership, robust governance and commissioning arrangements and organisational strategy that promotes a safeguarding culture scored highly, and the positive direction of travel in relation to embedding Making Safeguarding Personal within organisations across the partnership was evident, having previously been identified as an area requiring improvement during self-assessments in 2019 and 2021. Partners were able to evidence their responses and rationale for their grading judgements with clarity and by providing examples and documents, therefore clearly providing assurance around their practice.

There were few areas overall in which agencies judged themselves as 'requires improvement', and only one 'inadequate' rating was given. However, the main area of concern was in relation to staff supervision; three agencies said that

their staff and volunteers do not have access to regular supervision. Additionally, a trend that continued this year was in relation to quality assurance frameworks, two agencies did not have a quality assurance framework in place, meaning they have little internal assurance that their practice meets the safeguarding needs of their service users. This was identified as an area for improvement in last year's audit; limited progress appears to have been made and it would benefit from continued focus and further development. Positively, agencies which identified a development need have provided plans and assurances that this is being, or will be, implemented and provided set timescales as to when this will be completed by.

**Next Steps**

SMART Action Plans are produced following all audit activity and the progress of this is monitored by the Quality, Assurance & Performance Subgroup to ensure all recommendations are fully implemented. Overall performance is also monitored via data incorporated into the quarterly CSAB Performance Scorecard.

## Safeguarding Adult Reviews

The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) of a case in its area where there is reasonable concern about the way the Board, members of it or relevant agencies worked together and an adult in its area has died as a result of abuse or neglect, whether known or suspected, or the adult is still alive and the Board knows or suspects that the adult has experienced serious abuse or neglect. This is a statutory responsibility.

The overall purpose of a Safeguarding Adult Review is to promote learning and improve practice, not to re-investigate or to apportion blame. The objectives include establishing:

• lessons that can be learnt from how professionals and their agencies work together.

• how effective the safeguarding procedures are.

• learning and good practice issues.

• how to improve local inter-agency practice.

• service improvement or development needs for one or more service or agency.

• lessons learned are shared to maximise the opportunity to better safeguard adults with care and support needs, who are or maybe at risk of abuse or neglect.

The Care Act 2014 requires that lessons learned are published in the Annual Report following the conclusion of the review. The Safeguarding Adult Board has published two Safeguarding Adults Reviews across 2023-2024. A learning

event has taken place in relation to these Safeguarding and Adult Reviews and this can be found here: Safeguarding Adult Reviews – Coventry City Council

## Carol

Carol was 64-year-old women with a complex medical history including drug resistant epilepsy. She had a mild to moderate learning disability and some physical health challenges. These included long-standing lymphoedema and a misaligned left ankle fracture which was unable to be surgically corrected. She was cared for by her family and was then moved to a nursing home during the Covid-19 pandemic.

Carol's physical and mental health was reported to have deteriorated during her stay at the care home, and in October 2020 she was admitted to University Hospital Coventry and Warwickshire following episodes of her lymphoedema worsening.

Carol then died at the hospital, and the coroner noted her cause of death as sepsis and multiple organ failure. The executive summary can be found here: safeguarding-adult-review-carol-executive-summary (coventry.gov.uk)

| Recommendation | Implementation Assurance |
|---|---|
| The Adult Safeguarding Board should ensure that placing authorities can demonstrate that their teams proactively ensure the welfare of service users through regular checks and liaison with care providers and family members. | Adult Social Care have included this is their internal guidance – Out of City Placements and review process.<br><br>The number of individuals who are supported out of City is now included in the Safeguarding Adult Board scorecard and monitored by Quality, Audit and Performance.<br><br>An enquiry panel has taken place with all relevant agencies where agencies have provided assurance about their process for placing residents out of City. |
| Agencies making referrals for Nursing Home placements for service users with complex health needs should consult with the relevant community health services before placement to ensure that adequate provision is available. | All relevant agencies have provided assurance to the Safeguarding Adult Board about their processes for identifying relevant services through the enquiry panel process. |
| Care plans should specify the services which are needed to | All relevant agencies have provided assurance to the Safeguarding Adult |

| | |
|---|---|
| deliver adequate treatment and care, and ensure they are in place before a placement is made. | Board about their processes for identifying relevant services through the enquiry panel process |
| The Adult Safeguarding Board should seek assurance from constituent agencies about the standards of the quality and content of training on the Mental Capacity Act 2005 for providers of services to adults.[1] | The Safeguarding Adult Board has reviewed the Workforce Development Framework to incorporate this.<br><br>The Business Manager has attended the Provider forum to raise awareness of the importance of Mental Capacity Act 2005 training and share resources.<br><br>Mental Capacity Act 2005 resources have been shared across the partnership to support this area of learning. |
| The Adult Safeguarding Board should seek assurance that workers in all agencies have the professional support and supervision available to challenge decisions if the needs of the service user are not being met. | The Policy/ Workforce Sub-Group has undertaken scoping in relation to supervision processes. The scoping exercise provided assurance that agencies have clear processes in place and no further support is needed from the Safeguarding Adult Board. |
| Agencies should ensure that their workers are aware of escalation procedures when they are dissatisfied with the response from other agencies. | The Safeguarding Adult Board has promoted the escalation policy in the newsletter, at events and within relevant forums. |

### David

David was 55 years of age at the time of his death. David was admitted to hospital in mid-July 2021. David lived in a one-bedroom rented flat and had done so for some time. David was a drug user and was very open about the use of heroin and other controlled drugs.

David had for some months lived in one room in his flat and had not moved from the sofa. When David was admitted to hospital his home conditions were very poor and it was apparent that he had neglected his health and personal care for some time. David was in receipt of low-level package of support, to maximise his independence, but also to ensure that his basic care needs were met.

Three weeks after being admitted to hospital David died. HM Coroner held an inquest in January 2022. HM Coroner recorded a narrative verdict stating that David died 'due to multifactorial causes which included the deceased drug addiction and self-neglect, agencies involved in his care not escalating issues regarding his living conditions.' The executive summary can be found here: safeguarding-adult-review-david-executive-summary (coventry.gov.uk)

| Recommendation | Implementation Assurance |
|---|---|
| The Coventry Safeguarding Adults' Board should promote the use of the West Midlands self-neglect guidance by all agencies. | A webinar has been developed incorporating key messages from the self-neglect guidance. This has been shared across the partnership. |
| The Coventry Safeguarding Adults' Board should promote the positive use of the stages of the Escalation and resolution of professional differences policy. | The Safeguarding Adult Board has promoted the escalation policy in the newsletter, at events and within relevant forums. |
| Coventry Adult Social Care needs to ensure that where domiciliary care providers are engaged in a complex case that there is suitable oversight and support. | This is now part of the contract monitoring arrangements.<br><br>Adult Social Care have promoted the Risk Enablement Panel at the Provider forum to assist in situations where there is high complexity and risk. |
| Consideration should be given by commissioners of domiciliary care to refreshing and re-enforcing the information given on self-neglect and escalation of concerns | The Self- neglect guidance and escalation policy have been shared in the Provider bulletin. |
| Coventry and Warwickshire Partnership Trust should review the internal process for withdrawing services to ensure that all relevant agencies involved in the case are fully aware, that the withdrawal is risk assessed and there is a clear route for requests for the service to be re-engaged if appropriate. | The withdrawal of service policy has been reviewed and shared with key stakeholders. |

| | |
|---|---|
| The Coventry Safeguarding Adults' Board should seek assurance from all the agencies identified in the s42 enquiry as having actions that they have completed them. | Adult Social Care have confirmed that all of the actions are now complete. |
| Coventry Adult Social Care should review the method of prioritising cases for assessment and be confident that cases where there is risk are expedited. | Adult Social Care Organisational Guidance has been produced and implemented. |
| Coventry and Warwickshire Integrated Care Board should request GP practices ensure that their processes to review requests for their intervention are viewed by the practice clinician where appropriate and are effective. | This learning was shared to the GP's Annual Safeguarding Protected Learning Time and the Safeguarding Co-ordinators bi-annual training conference. |

## Engagement

Engagement is important to Coventry Safeguarding Adults Board. Across 2023-2024 we have developed our approach to engagement to make it clear to the people that require our help that their views are respected and listened to and influence and effectively contribute to our work. We have been engaging with people in relation to two key questions:

If you knew someone was suffering abuse or neglect, where would you go for support?

Have you ever accessed support for someone suffering abuse or neglect, if so, how was your experience?

Members of the Board have been encouraging individuals to complete the questions both a public facing events and online. ON a bi-annual basis the Board receives a report outlining the responses that we have received so that individuals' views can be heard and acted upon.

If you would like to take part in this engagement please scan the QR code below.


## Learning events

## Sexual Relations and Mental Capacity Act Seminar

Coventry Safeguarding Adults Board hosted a learning event on the 27th of July 2023 focusing on sexual relations and mental capacity. The Board commissioned Edge Training to deliver this theme and seminar.

Edge Training and Consultancy are leading experts in delivering legal training on health and social care law and have established training contacts and programmes within NHS Trusts and Integrated Care Boards.

The course delivered by Edge Training examined issues surrounding the issue of mental capacity to sexual relations, the course included understanding the legal hierarchy, consent and the Mental Capacity Act, case law principles, the use of the Sexual Offences Act 2003 and safeguarding adults and mental capacity to sexual relations. The session allowed delegates to understand basic principles and points to be aware of when working with adults in safeguarding roles. Delegates also had the opportunity for questioned and received a comprehensive training pack with additional details and resources.

The training acquired 39 participants from different organisations and specialisms including practitioners from University Hospital Coventry & Warwickshire, GP's, Disability Team, Dementia Team, and Community Social Care.

### *Participant Feedback:*

→ "I'm new to adult services, so this training has been very useful in terms of the Mental Capacity Act 2005. I'm currently working in transitions and I'll more than likely come across cases where these concerns are highlighted".
→ "Fantastic training – really useful. Trainer clearly very well versed on the subject matter – very informative!"
→ "Really interesting event!"
→ "This is such a useful session to my role. Thank you"

## Safeguarding Adult Review Learning Event

On November 20th, 2023, Coventry Safeguarding Adults Board hosted a learning event focusing on Safeguarding Adult Reviews and improving practice. The event received 79 attendees in total from multi-agency backgrounds.

The event comprised of looking at and learning from 2 local SARS, understanding the self-neglect and hoarding framework, which was discussed alongside a webinar, and also how to use and access CSAB resources that were highlighted throughout the SAR Learning.

A number of guest speakers entertained the learning event including, Coventry Safeguarding Adult Board Business Manager; Head of Adult Safeguarding & Practice Development and Lead Professional for Safeguarding from UHCW.

***Participant Feedback:***

→ “Interesting to hear practitioners' perspectives on the issues and learning points that had been identified”
→ “Will recommend the webinar to colleagues and share my learning with them”
→ “Very knowledgeable and experienced presenters!”
→ “It was clear and well planned!”

# Looking forwards


Coventry Safeguarding Adults Board
Strategic Plan 2024-2027
Coventry Safeguarding Adults Board

**Safeguarding is everybodys business**

**Coventry Safeguarding Adults Board Strategic Plan 2024-27**

| Our responsibilities are: | Our role is to help and safeguard adults with care and support needs by: | Our structure: |
|---|---|---|
| Publish Strategic Plan: our year ambition.<br><br>Publish an Annual Report which includes what we have achieved.<br><br>Complete Safeguarding Adults Reviews when adults die or are seriously injured as a result of abuse/neglect. | ▶ Seeking assurance that local safeguarding arrangements are in place as defined in the Care Act 2014.<br><br>▶ Assuring that safeguarding practice is person centred and outcome focused.<br><br>▶ Work collaboratively to prevent abuse and neglect where possible.<br><br>▶ Ensuring that agencies and individuals work in a timely and proportionate manner where abuse or neglect has occurred.<br><br>▶ Seeking assurance that safeguarding practice is continually improving.<br><br>▶ Concern ourselves with a range of issues which may impact on people with care and support needs. | Board with an Independent Chair<br><br>Business Executive Subgroup<br><br>Policy and Workforce Development Sub-Group.<br><br>Safeguarding Adult Review Sub-Group.<br><br>Quality, Audit and Performance Sub-Group. |

## Our Strategic Plan 2024-2027: What we will do?

### Strategic Priority 1

### Making Safeguarding Personal (MSP)

**Ambition - To be assured that safeguarding is underpinned by the principles of MSP and that adults are supported to achieve the outcomes that they want, we will:**

- continue to seek assurance that MSP is at the heart of adult safeguarding for all agencies and ensure that as a Board we actively support a culture of MSP.
- continue to support and develop practitioners understanding and application of the Mental Capacity Act 2005.
- undertake audit activity to seek assurance that MSP is embedded in safeguarding practice.
- monitor the implementation of Right Care, Right Person model.
- seek assurance in relation to the effectiveness of adult safeguarding, and Deprivation of Liberty Safeguards (DoLS).
- continue to develop and disseminate materials to support understanding of Making Safeguarding Personal and Mental Capacity Act 2005.

### Strategic Priority 2

### Prevention and Early Intervention

**Ambition - To reduce the risk that adults with care and support needs will experience harm from abuse or neglect, we will:**

- develop a Prevention and Early Intervention Strategy and ensures that we continue to work closely with other statutory Boards.
- continue to review and implement our Workforce Development Strategy to include and reach a wider range of partners and agencies.
- continue to develop and promote practice in supporting people who self-neglect.
- seek to further understand those accessing adult safeguarding taking into account their protected characteristics.
- continue to promote and raise awareness of a range of preventative initiatives and services to support people within the community.
- continue to explore sources of support for individuals affected by the cost-of-living crisis and promote these.

## Our Strategic Plan 2024-2027: What we will do?

### Strategic Priority 3

### Engagement and Communication

**Ambition - To ensure that safeguarding processes and approaches are accessible for all within our communities, we will:**

- continue to develop our Board website to make it more user friendly and accessible.
- continue to produce regular newsletters, Board resources and deliver Learning Events across the partnership.
- seek to engage individuals or their representatives in the work of the Board and its subgroups.
- continue to engage with partner agencies by the development of a stakeholder and provider engagement forum.
- review our information and publications to make sure they are accessible, reach marginalised groups and are available in the main languages spoken in Coventry.
- engage with those directly accessing adult safeguarding to understand their experience.

### Strategic Priority 4

### Development and Assurance

**Ambition - To ensure that the Board continuously improves delivery of its key responsibilities, we will:**

- develop a Board assurance framework that includes Peer review of the work of the Board.
- continue to implement the CSAB Quality Assurance Framework ensuring that we respond to emerging safeguarding issues.
- work closely with LeDeR reviews to seek assurance that actions are implemented and learning is shared.
- continue to promote and improve our SAR process and ensure that we are learning from SAR's locally, regionally and nationally.
- continue to develop and promote the West Midlands Adult Safeguarding Policy and Procedures and seek assurance of the effectiveness of causing others to make enquiries processes.
- seek to understand the profile of people receiving services outside of the city and assurance as to how they are safeguarded and supported.

If you think an adult is at risk of abuse call Adult Social Care Direct

**024 7683 3003**

or e-mail

**ascdirect@coventry.gov.uk**

Adult Social Care Direct is based at Broadgate House, Coventry, CV1 1FS

## 10 categories of abuse:

**Physical**
**Domestic violence**
**Sexual**
**Psychological**
**Modern slavery**
**Financial or material**
**Neglect & Acts of Omission**
**Discriminatory**
**Organisational**
**Self-neglect**

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