Gateshead Safeguarding Adults Board Annual Report 2024/25

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Gateshead Safeguarding Adults Board

Glossary of Terms

CGL	Change Grow Live
CNTW	Cumbria, Northumberland, Tyne and Wear, NHS Foundation Trust
DA	Domestic Abuse
GC	Gateshead Council
GHFT	Gateshead Health NHS Foundation Trust
GSAB	Gateshead Safeguarding Adults Board
GRP	Gateshead Recovery Partnership
GSCP	Gateshead Safeguarding Children's Partnership
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MSP	Making Safeguarding Personal
SAC	Safeguarding Adults Collection
SAR	Safeguarding Adult Review
S42	Section 42 Enquiry under the Care Act 2014
SPC	Serious Provider Concern
STSFT	South Tyneside and Sunderland NHS Foundation Trust
Tri-X	Platform which hosts GSAB Multi-Agency Policies and Practice Guidance
TWFRS	Tyne and Wear Fire and Rescue Service

Introduction from our Independent Chair

As Independent Chair of Gateshead's Safeguarding Adults Board (GSAB), I am pleased to present our Safeguarding Annual Report for the year 2024–2025.

Working Together to Safeguard Adults at Risk

The role of the Safeguarding Adults Board is to bring together key organisations in order to coordinate their work in safeguarding people with care and support needs from abuse, neglect and self-neglect. Safeguarding remains at the heart of everything we do. Our collective commitment is to ensure the safety and dignity of people by putting the person at the heart of what we do and that commitment to protection is unwavering.

The Safeguarding Adults Board is made up of a breadth of member organisations and the board's aim is to link in to all those organisations that provide care, support, and advice, or who may simply come into contact with someone who may need help.

The Annual Report gives an insight into the ongoing work being undertaken to help and protect adults in Gateshead. A vast amount of work is undertaken by members of the public, carers, volunteers and practitioners across Gateshead, who each and every day strive to keep people safe.

Safeguarding in Focus: Achievements and Future Priorities

This report sets out our achievements and highlights the challenges we face as a Safeguarding Adults Board. It provides updates on progress made against our key strategic priorities for this year and sets out the priorities we have set for the year ahead.

We have set out our progress and achievements linked to the key aims below within the detail of the annual report:

- Strengthening Safeguarding
- Learning and Development
- Data and Information
- Prevention of harm
- Involvement and engagement

Learning Through Review: Strengthening Safeguarding Across Gateshead

The year has presented many challenges including the need to commission an *independent thematic review. The focus of the review was to look at how effective organisational and system safeguarding processes were; it was commissioned independently after significant safeguarding issues in a care home were highlighted.

The outcomes of the thematic review, Serious Adult Reviews and other reviews provide the opportunity for learning and development. In conjunction with these reviews there is an increasing number of safeguarding enquiries across Gateshead and the differing types of issues they cover is growing significantly which system partners need to understand and respond to.

There is much learning to be done but the commitment and aspiration to continue to improve the way we work, the way we involve and include people, and their families is shared across the safeguarding partnership.

*An **independent thematic review** is a structured evaluation or analysis conducted by an external or impartial party, focusing on a specific theme, issue, or area of interest.

Safeguarding in Action: Learning, Responding, Improving

It is against this background of increasing understanding and demand for safeguarding that this report demonstrates persistence to reduce the safeguarding risk to adults, and to respond effectively when some of the most vulnerable members of our community are victims of abuse and or exploitation.

There is much learning to be done but the commitment and aspiration to continue to improve the way we work, the way we involve and include people, and their families is shared across the safeguarding partnership.

Nicola Bailey

Independent Chair

Gateshead SAB

Safeguarding in Gateshead

Welcome to the GSAB Annual Report. Within the report you will find information on the Boards strategic vision and priorities and an overview of the key outcomes from 2024/ 25.

The report outlines the board priorities/ambitions for the previous year, what we have done to achieve these in part through our subgroup work. The report outlines the governance framework of the GSAB, alongside the governance structures of its three statutory partners. It details how each partner oversees adult safeguarding within their respective organisations and highlights key achievements from the past year.

The Board has three core duties:

- to publish a strategic plan for each financial year.
- to publish an annual report detailing what the Board has done during the year.
- conduct any Safeguarding Adult Reviews (SARs).

The Definition of Safeguarding Adults

The GSAB works to protect an adult's right to live safe, free from abuse and neglect as defined in the Care Act 2014. Ensuring people and organisations work together to prevent and stop both the risks and experience of abuse or neglect. At the same time, we need to make sure that the adult's wellbeing is promoted. This includes, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action, making safeguarding personal.

The Aims of Adult Safeguarding

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

Gateshead Safeguarding Adults Board

The GSAB became a statutory body in April 2015. The Board's vision for adult safeguarding in Gateshead is:

'Everybody in Gateshead has the right to lead a fulfilling life and should be able to live safely, free from abuse and neglect – and to contribute to their own and other people's health and wellbeing'.

The Board is responsible for assuming the strategic lead and overseeing the work of Adult Safeguarding and Mental Capacity Act arrangements in Gateshead. Within Gateshead we have an Independent Chair to enhance scrutiny and challenge.

The Board has a comprehensive Memorandum of Understanding, which is updated annually, and provides a framework for identifying roles and responsibilities and demonstrating accountability. Our Safeguarding in Gateshead website provides a wealth of information about our SAB and our Gateshead Safeguarding Children's Partnership (GCSP).

Gateshead Council

Statutory Membership

In law, the statutory members of a SAB are defined as:

- the local authority (Gateshead Council)
- the local police force (Northumbria Police)
- the Integrated Care Board (ICB) (Northeast and North Cumbria)

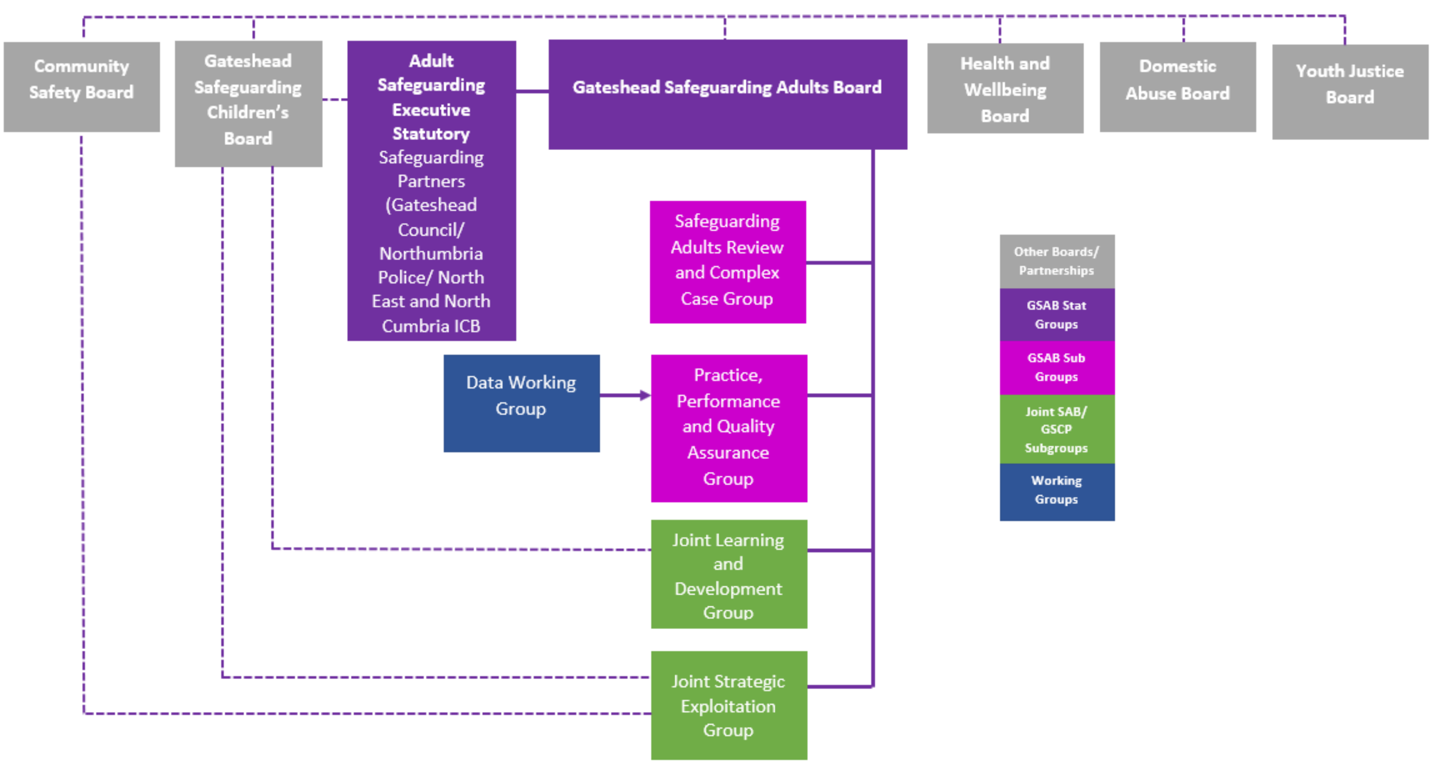
Membership

In Gateshead, we recognise the importance of the contribution made by all our partner agencies and this is reflected by the wider Board membership (correct as of June 2025):

- Northeast Ambulance Service
- Gateshead Health NHS Foundation Trust (GHFT)
- South Tyneside and Sunderland NHS Foundation Trust (STSFT)
- Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust (CNTW)
- Gateshead College
- Tyne and Wear Fire and Rescue Service (TWFRS)
- Probation Service
- Connected Voice Advocacy
- Department for Work and Pensions (DWP)
- Healthwatch Gateshead
- Your Voice Counts (Advocacy)

Gateshead Safeguarding Adults Board Structure

The GSAB sits within a clearly defined structure and has close links with other local multi-agency partnerships including the Health and Wellbeing Board, Community Safety Partnership and Gateshead Safeguarding Children's Partnership (GSCP).



Partner Governance Arrangements and Scrutiny 2024/25

Board members are responsible for ensuring that governance and scrutiny arrangements for Safeguarding Adults are incorporated within the structure of their own organisations, and that there are mechanisms for disseminating and sharing information from the GSAB. The governance and scrutiny arrangements for the three statutory partners include:

Northumbria Police

- All learning from national and local serious case reviews are scrutinised through the protecting vulnerable people board as well as highlighted on the organisational learning log to ensure compliance
- Actions from reviews are agreed , monitored and signed off by relevant DSP and governed through protecting vulnerable people governance board
- The force is launching a digital organisational learning app to record and track actions from serious case reviews.
- All safeguarding business relating to policy and procedure is governed through the protecting vulnerable people governance board

NORTHUMBRIA
POLICE

Gateshead Council

- The Health and Wellbeing Board receive an annual update from the GSAB Independent Chair upon publication of the annual report as do the Overview and Scrutiny Committee.

- The GSAB Independent Chair meets on a quarterly basis with the Portfolio holder for Adult Social Care to provide updates on the work of the board.

- The Gateshead Council Internal Audit service provide assurance that the Board and Gateshead Council are meeting their statutory duties.

- A monthly Senior Management Team meeting take place which is dedicated to performance management. The performance dashboard is used to highlight areas of good performance and areas for improvement are shared, actions are discussed and set wherever necessary through the senior management team meeting.

- A dedicated Group Management Team (GMT) focusing on finance and performance is held monthly with relevant senior leaders, where the activity from the previous steps are presented, actions and progress discussed, and further analysis and actions are agreed and taken forward.

- Safeguarding information is presented to the Gateshead SAB on a quarterly basis a dashboard has been developed which covers safeguarding data relevant to the board this is to provide assurance to the board of good practice and actions taken on areas of improvement.

Northeast and North Cumbria Integrated Care Board (NENC ICB)

- The NENC ICB Chief Nurse holds the lead for the safeguarding portfolio.
- NENC ICB internal assurance is provided via safeguarding reports to the Area Quality Sub Committee who report to the Quality Safety and Risk Committee (Quarterly).
- Reports provide local updates on the work of the safeguarding partnerships and ensure that key safeguarding risks, issues and developments are reported within the NENC ICB.
- Reports also outline activity relating to Safeguarding Adult Reviews (SARs) Domestic Homicide Reviews (DHRs) and other non-statutory reviews such as Appreciative Enquiries.
- The NENC ICB also has a Safeguarding Senior Leadership Group which coordinates and leads the development of Safeguarding arrangements across the ICB, reporting and escalating issues to the NENC ICB where appropriate and has a key role in leading on assurance and development.
- Governance and scrutiny arrangements will continue to evolve under the new Integrated Care Board arrangements.

Gateshead Safeguarding Adults Board Sub-Group Arrangements

Quality, Learning and Practice (QLP) Group

(Chaired by a senior manager from Gateshead Council)

The Quality, Learning and Practice Group is responsible for:

- Monitoring and reviewing performance data and driving forward quality via the quality assurance framework, case file audits and monitoring inspection recommendations.
- Collating and reviewing recommendations from statutory Safeguarding Adult Reviews and discretionary reviews and has oversight of multi-agency safeguarding training.
- Ensures that the Multi Agency Safeguarding Adults policy and procedures and supporting practice guidance continue to be fit for purpose.
- Keeping up to date with national policy changes that may impact upon the work of the GSAB.
- The development and implementation of the Communication and Engagement strategy.

QLP Data Working Group

(Chaired by a senior manager from Gateshead Council Performance and Systems Service)

In 2024/ 25 the QLP established a Data Working Group. The group is responsible for:

- Reviewing and analysing the GSAB data dashboard information on a quarterly basis
- Reporting findings to the QLP group on a quarterly basis.
- Making recommendations for action following data analysis including but not limited to audits, reviews and changes to reporting processes/ procedures.

Safeguarding Adult Review and Complex Case (SARCC) Group

(Chaired by a senior manager from NENC ICB)

The Safeguarding Adults Review Group (SARCC) will:

- Consider Safeguarding Adult Review (SAR) referrals, commission reviews and subsequently monitor their progress.
- Oversee discretionary reviews into cases that do not meet the criteria for a SAR, where the group feel that there are multi-agency lessons to be learned.
- Collate and review recommendations from SARs and other reviews, ensuring that achievable action plans are developed and that actions are delivered.
- Provides a forum to discuss complex Safeguarding Adult cases that require additional scrutiny and support.

Joint Strategic Exploitation Group (JSEG)

(Chaired by a senior officer from Northumbria Police)

- The Joint Strategic Exploitation Group is a sub-group of both the GSAB and the GSCP.
- The Police chair undertakes this role across the Northumbria Police Force footprint (6 LA areas) which promotes sharing of learning and best practice and connectivity across the region in identifying emerging trends or concerns.
- The remit of the group is to lead on the development of strategic work in relation to all aspects of exploitation, including but not limited to: Sexual Exploitation; Criminal Exploitation; Modern Slavery and Trafficking and Missing.

Task and Finish Groups

The GSAB, the Executive Group, and the three sub-groups regularly commission Task and Finish Groups; temporary, time-limited working groups established to examine a specific issue in depth and make recommendations, to undertake defined pieces of project work. Governance, oversight, and monitoring remain with the group that created the Task and Finish Group.

Subgroups Highlight Reports

The board receives a highlight report from each of its 3 subgroup which is presented at each board meeting. The report covers 4 main areas:

- What is working well?
- What is not working well?
- What difference are we making?
- Potential Risks

This allows each subgroup to raise the profile of its work and share good practice and outcomes, whilst also highlighting any potential risks to the board so that remedial action can be taken, by the board or by its partners.

GSAB Executive Group

During the 2024/25 reporting period, a significant structural change was implemented regarding the operation of the Gateshead Safeguarding Adults Board (GSAB) Executive Group. Previously functioning as a joint executive body with the Gateshead Safeguarding Children Partnership (GSCP), it was formally agreed that the GSAB Executive Group would now operate independently. This decision was made to strengthen the strategic focus and governance specific to adult safeguarding. As part of this transition, the Executive Group established a new bi-monthly meeting schedule to ensure consistent oversight and timely decision-making. In conjunction with this change, the Terms of Reference (ToR) were comprehensively reviewed and updated. These revisions were made to ensure full alignment with the statutory governance requirements and responsibilities of the Safeguarding Adults Board, thereby enhancing accountability, clarity of roles, and operational effectiveness.

Governance and Assurance

To support robust governance and provide assurance regarding partner engagement, the GSAB systematically monitors member attendance. This data is captured and regularly reported through the GSAB performance dashboard, enabling transparent oversight of organisational commitment and participation.

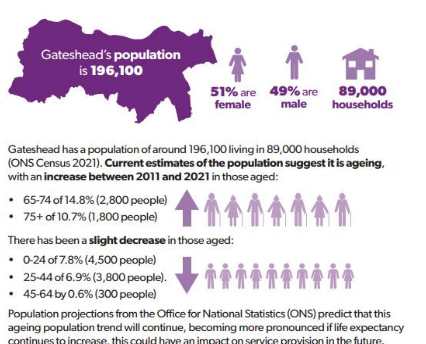
The Independent Chair of the GSAB plays a key role in maintaining accountability by reviewing attendance patterns and addressing any concerns directly with partner agencies. Where attendance is inconsistent or where representatives do not hold appropriate levels of authority or expertise, the Chair issues formal challenges to ensure that each organisation is fulfilling its statutory responsibilities and contributing effectively to the Board’s strategic objectives. This approach reinforces the importance of consistent, senior-level engagement in safeguarding adults and ensures that the GSAB remains a credible and effective multi-agency partnership.

The Local Picture

The demographics of Gateshead place additional pressures on health and social care, policing, ambulance services and the private, voluntary and independent sector who support the residents of the borough.

The GSAB plays a pivotal role in supporting its partner agencies to meet their responsibilities in relation to safeguarding alongside their statutory responsibilities and their role in service delivery.

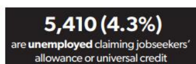
The Local Picture



47th

Gateshead is ranked 47th **most deprived** out of 317 local authorities in England.

Within Gateshead, socio-economic inequalities exist as illustrated by the 2019 Index of Multiple Deprivation (CLG). **Gateshead is ranked 47th most deprived out of 317 local authorities** in England. Within Gateshead there are **21 areas** which fall within the **10% most deprived areas in England**, equating to almost 32,700 people or 16% of the population of Gateshead. Much of this deprivation is based within the central and eastern urban areas of the borough.



Around 95,500 or 71.7% of working age (16-64) Gateshead residents are in employment which compares with an average of 75.5% for England as a whole (ONS Annual Population Survey Y/E Sep 2022), and around 5,410 or 4.3% are unemployed claiming jobseekers' allowance or universal credit which compares with an average of 3.8% for England as a whole (DWP Dec 2022).

Race

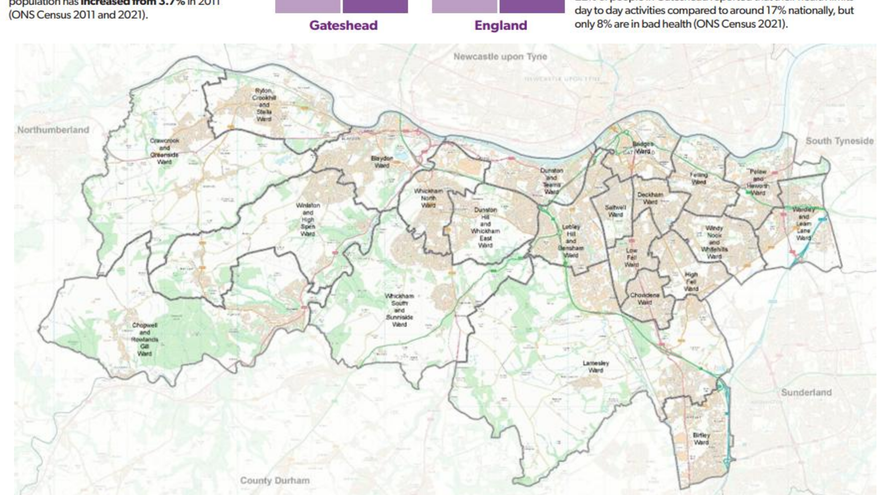
It is estimated that around **6.5% (12,660) of the population are from a non-White group** (ONS Census 2021). The non-White population has **increased from 3.7%** in 2011 (ONS Census 2011 and 2021).

Life expectancy (years)

Gateshead: Male 77.4, Female 81.6

England: Male 79.4, Female 83.1

At 77.4 for men, and 81.6 for women, life expectancy is lower than the England averages of 79.4 and 83.1 respectively. These latest life expectancy figures represent a slight decrease on the previous year (ONS 2018-20). Around 22% of people in Gateshead reported that their health limits day to day activities compared to around 17% nationally, but only 8% are in bad health (ONS Census 2021).



Please note this infographic is based on 2022 data

Strategic Priorities and Key Actions

The Strategic Plan 2024-2027 was approved by the board in June 2024 and contains five strategic priorities:

1. Strengthening Safeguarding
2. Learning and Development
3. Data and Information
4. Prevention of Harm
5. Involvement and Engagement

For further information on the key actions for each priority go to [what we achieve 2024/25](#).

What we achieved in 2024/25

The annual report must demonstrate what the GSAB and its members have done to carry out and deliver the objectives of its strategic plan. The following slides give an overview of the work of the board and its subgroups over 2024/25.

Strategic Priority 1
Strengthening Safeguarding

Strengthening Safeguarding practice across the partnerships and ensuring resources are available to support practitioners in their day-to-day safeguarding activities and that good practice is evidenced and practitioners can develop their knowledge and skills in this area.

Understanding Safeguarding Guidance

To improve consistency and confidence in safeguarding practice, the Board developed and published Understanding Safeguarding Guidance, now available on the GSAB website. This resource supports practitioners in making informed decisions regarding safeguarding concern referrals and identifying alternative, more appropriate referral pathways. The launch of this guidance was supported by multi-agency briefings, ensuring widespread awareness and understanding across the partnership.

Subgroup Highlight Reports

The Board continues to strengthen its governance arrangements. Highlight reports from Subgroups are presented at each quarterly Board meeting, ensuring transparency and accountability. A Governance Framework has been developed to formalise roles, responsibilities, and reporting structures. In addition, the implementation of an annual audit provides assurance to the Board and its members regarding the effectiveness of safeguarding arrangements and the Board's ability to meet its statutory responsibilities under the Care Act 2014.

Risk Register

A GSAB Risk Register has been established to identify and monitor risks that may impact the Board's ability to fulfil its statutory duties. This tool supports the delivery of the Strategic Plan 2024–2027, ensuring that safeguarding work across member and partner agencies remains effective and responsive to local needs. The register aligns with the Care Act's emphasis on partnership working and continuous improvement.

Safeguarding Concerns

Progress has been made in streamlining the process for submitting safeguarding concerns, particularly in relation to referrals from TWFRS (Tyne and Wear Fire and Rescue Service), GPs, and GHFT (Gateshead Health NHS Foundation Trust). These improvements aim to reduce duplication, improve clarity, and ensure timely responses to safeguarding issues.

Revision of the Decision-Making Guidance

Work is underway to revise the decision-making tool, with a focus on enhancing its usability and alignment with current practice. In collaboration with Gateshead Council's Commissioning Service, efforts are being made to implement a robust process for the reporting, monitoring, and analysis of low-level concerns, ensuring these are appropriately addressed and escalated where necessary.

Making Safeguarding Personal

The GSAB Dashboard now includes detailed data on consent and safeguarding outcomes, providing greater transparency and insight into the effectiveness of safeguarding interventions. This data is critical in understanding how individuals experience the safeguarding process and whether their desired outcomes are being achieved.

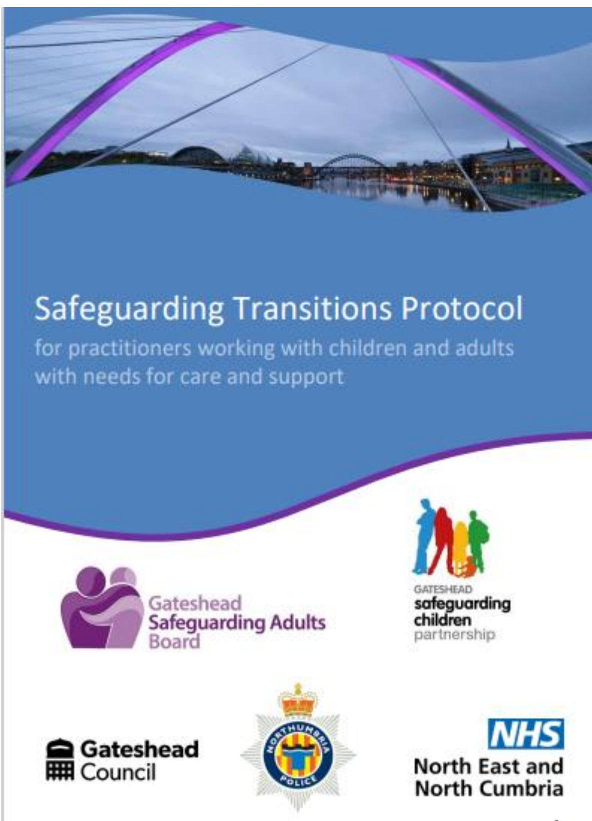
To support this, significant work has been undertaken to improve the recording and reporting mechanisms within Mosaic, the local authority's social care case management system. These improvements are designed to ensure that data captured during the Section 42 Safeguarding Enquiry process is both accurate and meaningful. This includes refining how outcomes are recorded, ensuring that practitioners are prompted to capture whether the individual's desired outcomes were identified, pursued, and ultimately achieved.

These developments contribute to a more robust evidence base for safeguarding practice, enabling the Board to monitor performance, identify areas for improvement, and ensure that safeguarding activity remains person-centred and outcome-focused. The enhanced data also supports compliance with statutory duties under the Care Act 2014, particularly in relation to making safeguarding personal.

Safeguarding Transitions Protocol

Transition to adulthood can be a particularly challenging time for some young people, who are particularly vulnerable and require additional support. Learning from Safeguarding Adult Reviews has highlighted how ineffective transition planning can contribute to young people "slipping through the net" or "facing a cliff edge" with tragic consequences. Recent Safeguarding Adult Reviews reflect this learning, with some common themes identified, including the young person being at high risk of exploitation, alcohol and substance use with no identified support needs under the Care Act.

This protocol has been developed jointly with the Gateshead Safeguarding Children's Partnership (GSCP) and aims to promote robust transitions between children and adult services. The Joint Safeguarding Transitions Protocol was finalised during 2024/25, following approval by the GSAB and GSCP it was published on the both the GSAB and GSCP Website.



Strategic Priority 2
Learning and Development

The GSAB will provide a multi-agency learning and development offer to promote a culture of continuous learning to ensure we have a workforce which is knowledgeable and confident in safeguarding adults.

SAR Learning Register

In 2024/25, we committed to developing a Safeguarding Adult Review (SAR) Learning Register to systematically capture and monitor learning from SARs and thematic reviews. The register is designed to:

- Clearly record key learning recommendations and emerging themes.
- Track progress on implementing changes in practice.
- Identify areas where sustainable improvement has not yet been achieved.

The register is updated following each SAR and incorporates feedback from partner agencies, including evidence of improvements or barriers to implementation. This approach ensures accountability and supports continuous learning across the safeguarding partnership.

	Number of Courses	Number of learners
Level 1 Safeguarding Provider Training	2	31
Level 2 Safeguarding Adults Reporting Concerns	4	51
Level 3 Undertaking Enquiries	2	44
Executive Dysfunction and the Mental Capacity Act	3	71
Voluntary Community and Social Enterprise (VCSE) Sector Safeguarding Training	3	46
Learning from SARs Henry	1	22
Learning from SARs Thomas	4	106
Mate Crime	2	38
Toxic Closed Cultures Level 1	2	37

During 2024/25 the Gateshead Council Workforce Development Adviser worked with the GSAB and GCSP and the Community Safety Partnership to produce a comprehensive training offer for 2024/25. Training courses are free of charge to practitioners and volunteers within Gateshead. Training has been delivered virtually and face to face to allow delegates to choose the most convenient method of learning to suit their job role.

Multi-Agency Training 2024/25

Voluntary, Community and Social Enterprise (VCSE) Training

This year, a dedicated safeguarding training session was developed and delivered specifically for individuals working within Gateshead's VCSE sector. This face-to-face training session compliments the on-line and e-learning offer provided by Connected Voice.

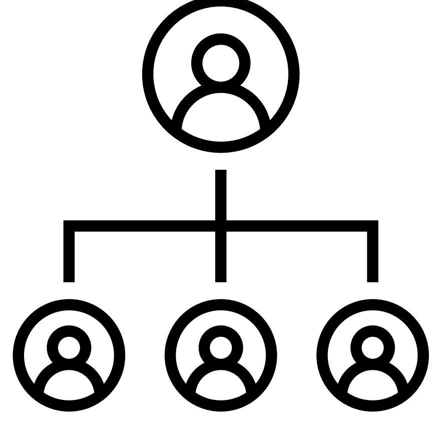
The session addresses both adult and children's safeguarding, reflecting the sector's vital role in supporting vulnerable individuals across the borough. The training was designed to be interactive and inclusive, offering participants the opportunity to share experiences and gain practical insights into safeguarding practices. It emphasises the importance of recognising and responding to safeguarding concerns, and the critical role that trustees, employees, and volunteers play in protecting those at risk.

Key areas covered include:

- Understanding roles and responsibilities in safeguarding children and adults.
- Practical advice and guidance to support organisational safeguarding.
- Clear procedures for raising safeguarding concerns and making referrals.

Attendance was strongly encouraged for all those involved in the sector, particularly in light of the requirements for organisations to demonstrate robust safeguarding practices aligned with Charity Commission guidelines. This training supports best practice implementation and strengthens the safeguarding culture within Gateshead's voluntary and community organisations.

Toxic Closed Cultures Training



In 2024/25 the GSAB supported a programme of training for practitioners and partner agencies to recognise organisational abuse within their own settings and establishments. The Toxic Closed Cultures Training was delivered by Value Based Consultancy who are an advisory and training organisation offering expertise specifically within the public sector.

This action was prompted by the Panorama TV programme aired in December 2023, which investigated a care home in Gateshead. While this did not explicitly focus on toxic closed cultures, it highlighted the importance of vigilance and robust assurance processes within the Board to identify, manage, and mitigate associated risks.

The GSAB commissioned 2 Level 1 sessions which were attended by 42 practitioners representing 13 organisations working across Gateshead. This session explored the definition of a toxic/closed culture, the relevance to adult social care and the link to vulnerability. The feedback from the session was very positive and the programme of training has continued into 2025.

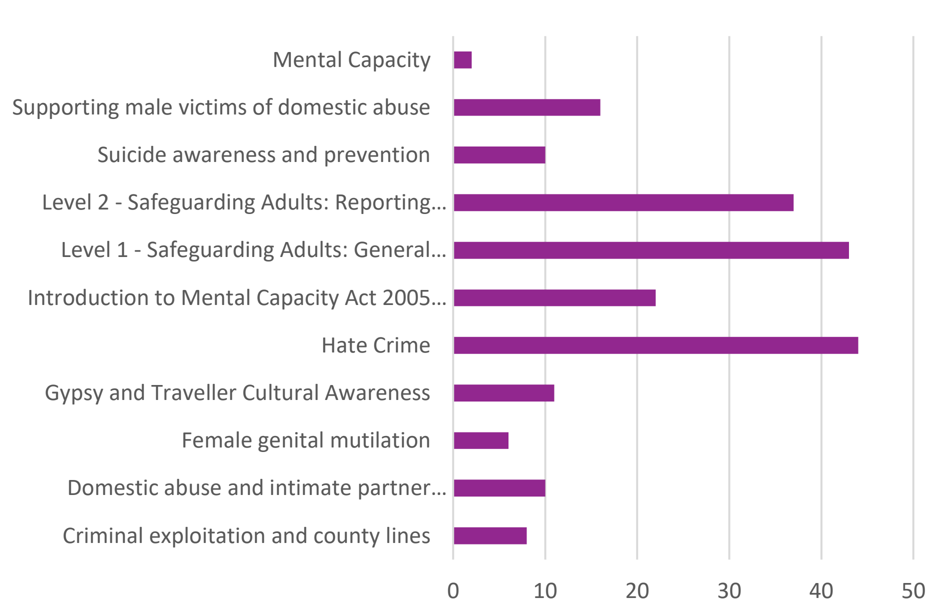
The Board Chair and the Adults Executive Group also committed to ensuring that all board members developed a strong understanding of toxic and closed cultures, how they arise, how they present, and the signs and symptoms. This shared understanding will enable the partnership to identify any gaps in current processes and take appropriate steps to address them. 17 of the GSAB board members attend the Level 2 session in January 2025 to explore the features of a toxic culture and consider guidance in addressing cultural issues in the workplace.

The GSAB commissioned 2 Level 1 sessions which were attended by 42 practitioner. Following the session the LA Commissioning Team held a development session to present ideas and proposals around a provider dashboard which can be presented to the board on a quarterly basis.

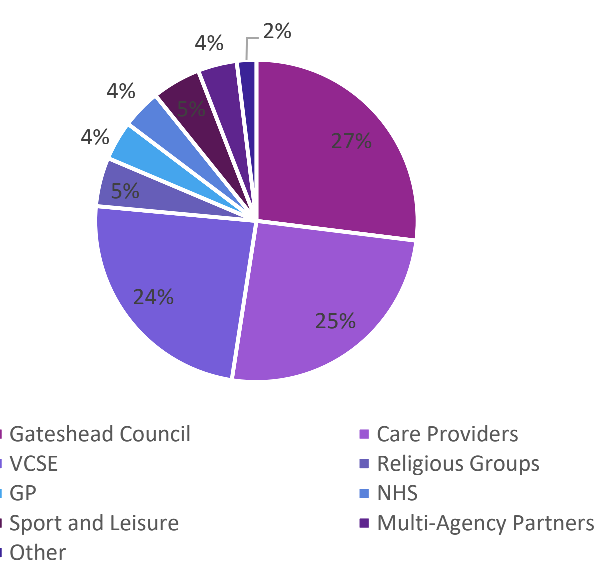
E-learning

In April 2024, the GSCP funded a new online programme of training through ME Learning. The GSAB were able to make use of this platform and host 11 courses relating to safeguarding adults, 2 specifically providing information on Gateshead policies and procedures. This was to ensure that as many people as possible have access to key safeguarding training and complements our wider offer available to our safeguarding partners. This training can be accessed here.

There was a total of 209 course completions during 2024/25



Completions by Sector



E-learning – Feedback and Evaluation

'Good content giving a good grounding in the subject.'

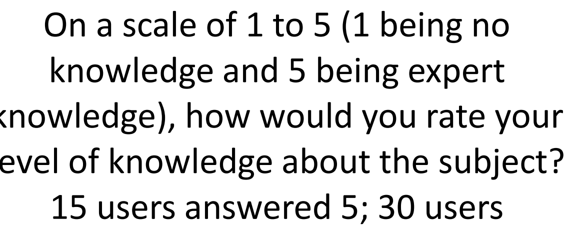
'It was valuable to be able to do this in my own time.'

'I thought the course was very good. Enjoyed doing it for my own interest.'

'Not too long and info bites are easier to follow.'

The course was engaging and interesting: 100% responded Strongly Agree or Agree

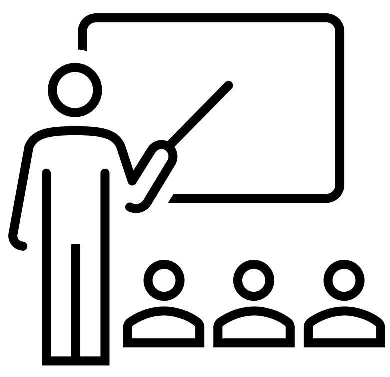
Having completed this course, I now have improved knowledge about the subject: 100% responded Strongly Agree or Agree



On a scale of 1 to 5 (1 being no knowledge and 5 being expert knowledge), how would you rate your level of knowledge about the subject? 15 users answered 5; 30 users answered 4; 5 users answered 3.

Recruitment

During 2024/25 the GSAB and the GSCP were able to secure funding for a new Safeguarding Learning and Development Officer (L & D Officer). Emily Thompson our new L & D Officer joined the Safeguarding Team in April 2025 and will be working closely with partners to ensure we have a robust multi-agency training offer to support and develop safeguarding practice across Gateshead.



Learning from SARs

Henry SAR

Following the completion of the Henry SAR a multi-agency briefing was delivered to 22 practitioners during SG week 2024. The GSAB Business Manager also delivered a briefing to Library and Leisure Services Managers based on the recommendations from the Henry SAR and also to give an overview of both Adults and Children's Safeguarding processes in Gateshead, the Private Sector Housing Manager also delivered as section on the work of their team and how they can support adults at risk and the safeguarding process.

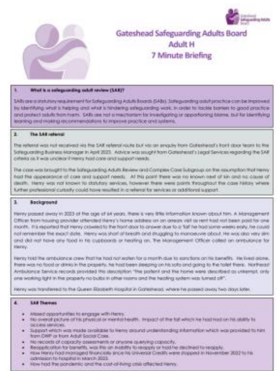
"I wanted to pass on how useful the safeguarding training was (delivered October 24) in terms of our managers understanding how to support very vulnerable residents. Since the training, library managers have been able to support at least three very vulnerable customers in requesting a care assessment and to get help in the home from private renters' team. We definitely did not understand the processes/structure of support across ASC/housing/renters prior to the training so I feel that's a big step forward"

Feedback received from the Libraries and Heritage Manager

"Session demonstrated that multi agency working is crucial"

"The session was set at a good pace and very informative, I have taken a lot from todays session"

A 7-minute briefing was also produced which provides an overview of the case and learning and recommendations. Some of the recommendations from the review have led to national changes with DWP, improving guidance and processes for handling Universal Credit (UC) phone claims and added new features to its systems to better manage these claims.



Thomas SAR

The Thomas SAR was completed in 2024, and a total of 4 multi-agency briefings were held to share the learning, recommendations and next steps from the review with 106 practitioners.

"We would 100% like to be able to attend more sessions and also possible training events, we thought the session provided was very informative and worth attending"

"We have changed the way in which we disseminate the learning from the training, after attending the session we booked in staff meetings and gave examples and also reminded carers of the importance of learning from SARs and how important it is to document everything and raise concerns to registered managers should this arise"

A 7-minute briefing was developed on the Thomas SAR which gave an overview of the background to the case, the key themes of the review, good practice and the recommendations. Following the review work commenced to implement the Blue Light Approach in Gateshead, see slide 28 for further information.

Safeguarding Adult Week 2024

GSAB proudly supported National Safeguarding Week 2024, held from Monday 18th to Friday 22nd November. The overarching theme, "Working in Partnership," inspired a collaborative approach between the GSAB and the GSCP. Together, they used the week as a valuable opportunity to deepen understanding of safeguarding across both adults and children, with all sessions reflecting this integrated focus.

Networking Event

The week started with a networking event held in the Civic Centre, welcoming over 80 people and over 24 organisations came along with stalls to promote their work, with some holding short briefing sessions. Steph Downey, Director of Adult Social Care opened the event. Stalls included:

- Age UK Gateshead
- TWFRS
- Sense Ability Matters
- Caregivers Connected
- NRASS
- Gateshead Housing
- GHNFT
- Healthwatch Gateshead
- Connected Voice
- WeAreRise
- Domestic Abuse
- Carers Federation
- Bensham Grove - Impact Wellbeing, TADA Team and Dunston Alive
- SSTNFT – Talking Therapies
- Your voice counts
- Citizens Advice

During the networking even there were presentations from:

- The Elective Home Education Officer - Raising the Profile of the work and remit of the EHE Team
- The UK Hoarding Partnership
- Gateshead Recovery Partnership - Conversation Starters
- We are Rise – Safeguarding and Welfare in Sport
- North Regional Association for Sensory Support
- Papyrus - SPARK - Suicide session

The week saw over 400 people attend 18 briefings and training sessions covering a variety of subjects from suicide prevention; mate crime; exploitation; and support for teenage fathers. Attendees were asked to complete feedback forms rating each session (1 being poor and not relevant to role and 10 being excellent and being very relevant to role)'. The average for all sessions was a score of 8.9.

The Gateshead Millennium Bridge and Tyne Bridge were lit purple as a powerful reminder that safeguarding is everyone's responsibility.

Watch the drone footage of the bridges lit in purple.

Safeguarding Week Evaluation

“I really enjoyed the training and the trainer was excellent”

Domestic Abuse Practice Short

“Trainer was very knowledgeable, friendly and able to offer questions! great session thanks”

Financial Planning, LPAs

"This was a strong and informative session with good delivery”

Recognising Exploitation

"The instructor was really informative and easy to understand“

“This was a good course providing a high-level overview”

Papyrus, Suicide Prevention Training

“One of the best training sessions I’ve ever attended. Super engaging role play with people with lived experience”

“It was a really good session; I took a lot away from it”

“I would like to say thank you to everyone involved, I'm not usually comfortable with role play situations, however the way your session was delivered was excellent and very effective”

Mate Crime, The Lawnmowers

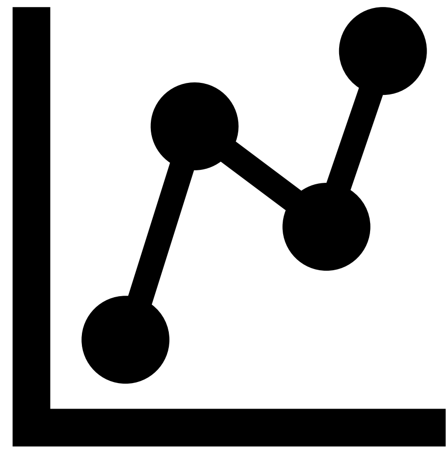
“The course was very good. The trainer shared a lot of useful information on approaches to apply in my role”

Professional Curiosity

Strategic Priority 3

Data and Information

The GSAB will ensure there is a comprehensive dataset and dashboard which includes data from partners. Themes and trends are identified through the data presented and the board will take steps to address these.



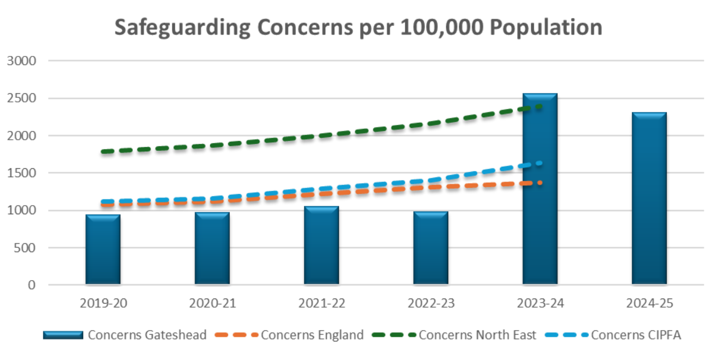
Our Performance 2024/ 25

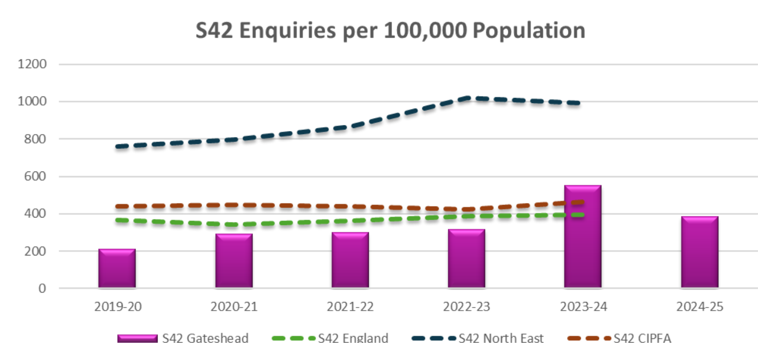
During 2024/25, the GSAB Business Unit, in collaboration with the Local Authority Performance Team, has made significant improvements in enhancing the quality and accessibility of assurance data presented to the Board on a quarterly basis.

A key development has been the migration of LA safeguarding data to Power BI, enabling more robust interrogation of data to identify emerging trends and themes.

The assurance dashboard now incorporates partner data, strengthening oversight and enabling constructive challenge. Engagement from GSAB members in data analysis has increased, supporting a more informed and collaborative approach.

Our Performance 2024/ 25





Volume of Concerns and Enquiries

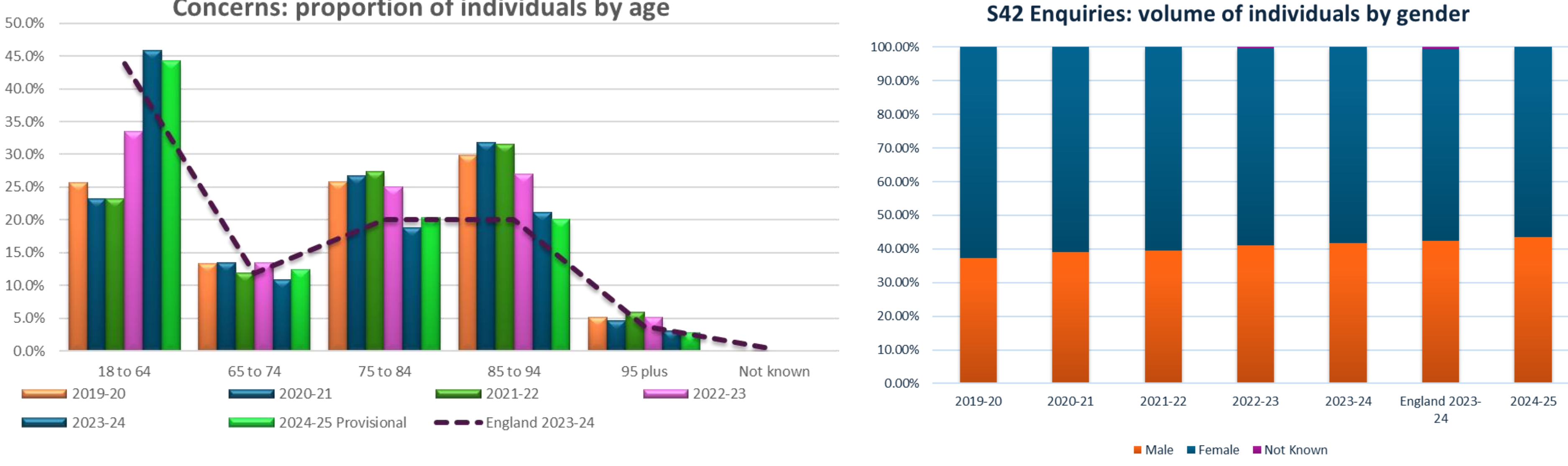
For a Concern to progress to a Section 42 Enquiry it must meet the statutory criteria. The Safeguarding duties apply to an adult who:

- Has needs for care and support (whether the local authority is meeting any of those needs).
- Is experiencing, or at risk of, abuse or neglect.
- As a result of those care and support need is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

In 2024/25 there were 2311 (per 100,000 population) Safeguarding Adult Concerns which led to 386 (per 100,000 population) Section 42 Safeguarding Enquiries.

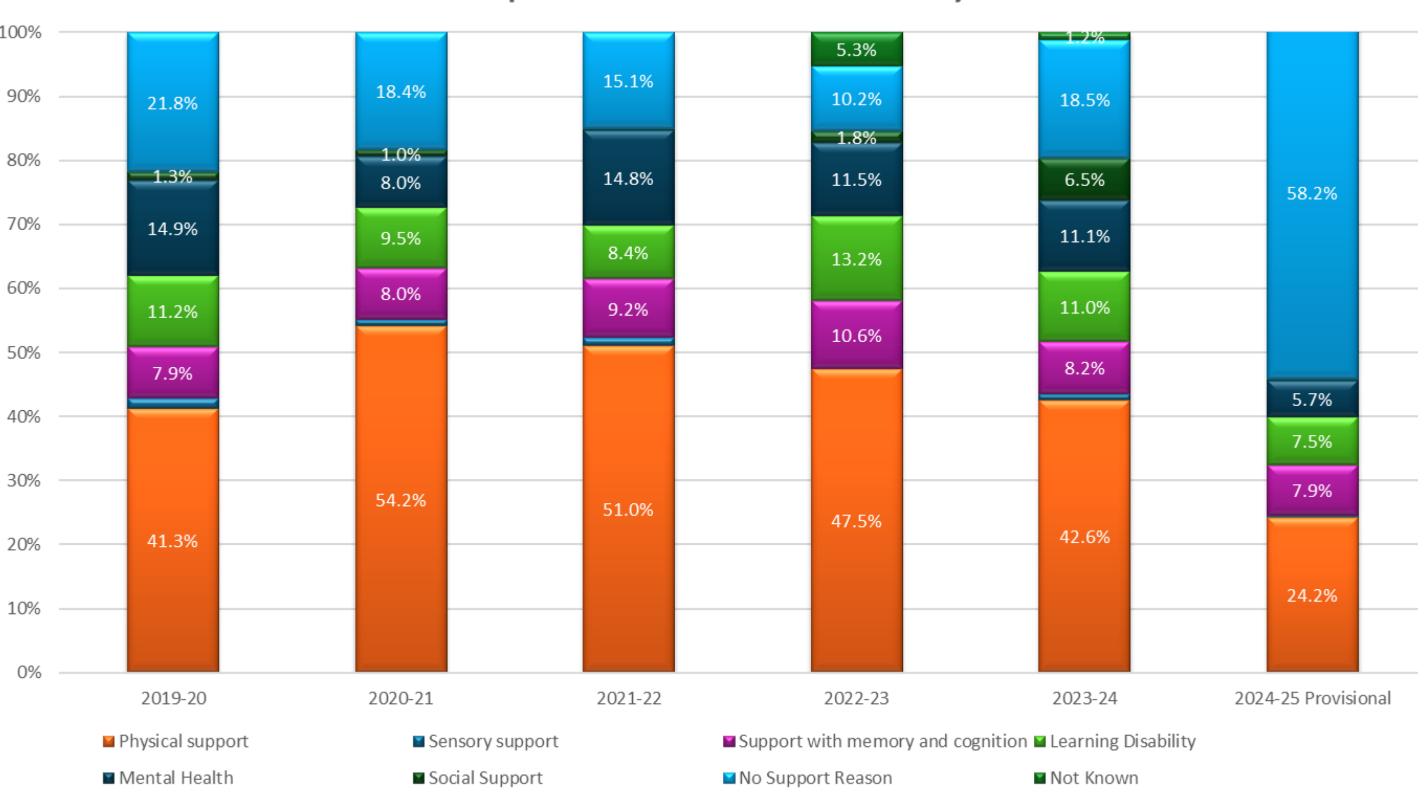
A slight fall in concerns in 24/25 are reflective of changes in some recording practice to avoid multiple concerns raised for the same incident. Gateshead S42 enquiries are in line with national and statistical neighbours' averages but are significantly lower than regional averages. This shows Gateshead have a low conversation rate for S42 enquiries and a significant volume of concerns do not meet statutory duty.

Demographics



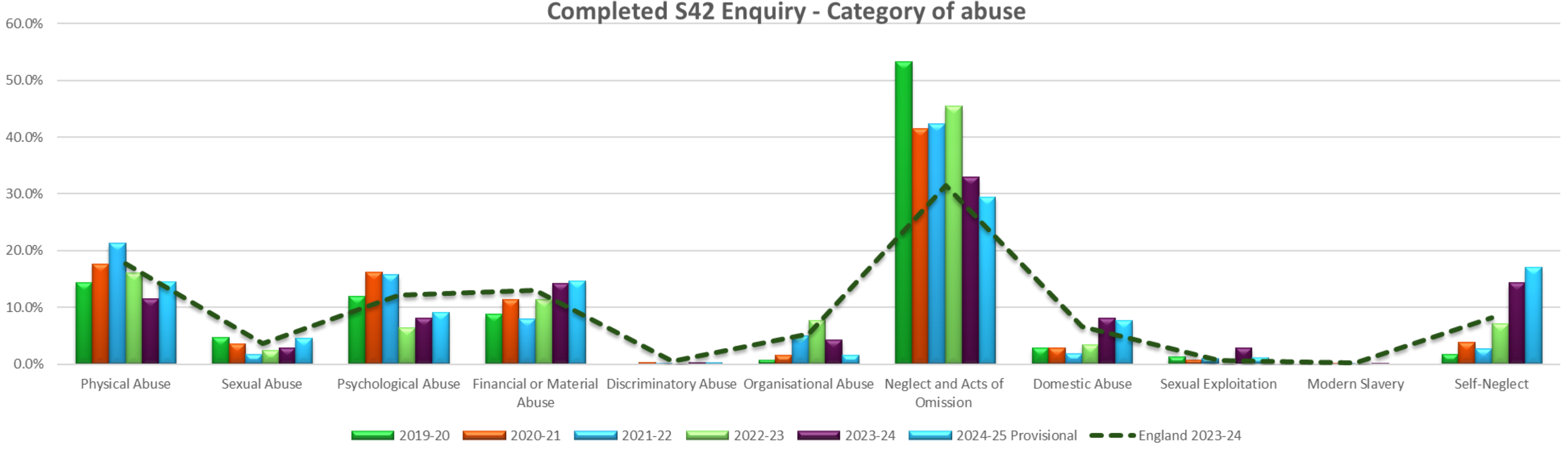
- In the past 2 years Gateshead has aligned to national averages for the proportion of concerns by age. Data shows the increase in concerns in recent years has related to working age people.
- Gateshead's gender profile is aligned to national and regional statistics showing on average 57% of S42 enquiries relate to females.
- Gateshead's data shows a small increase year on year in the number of S42 enquiries relating to males

Primary Support Reason



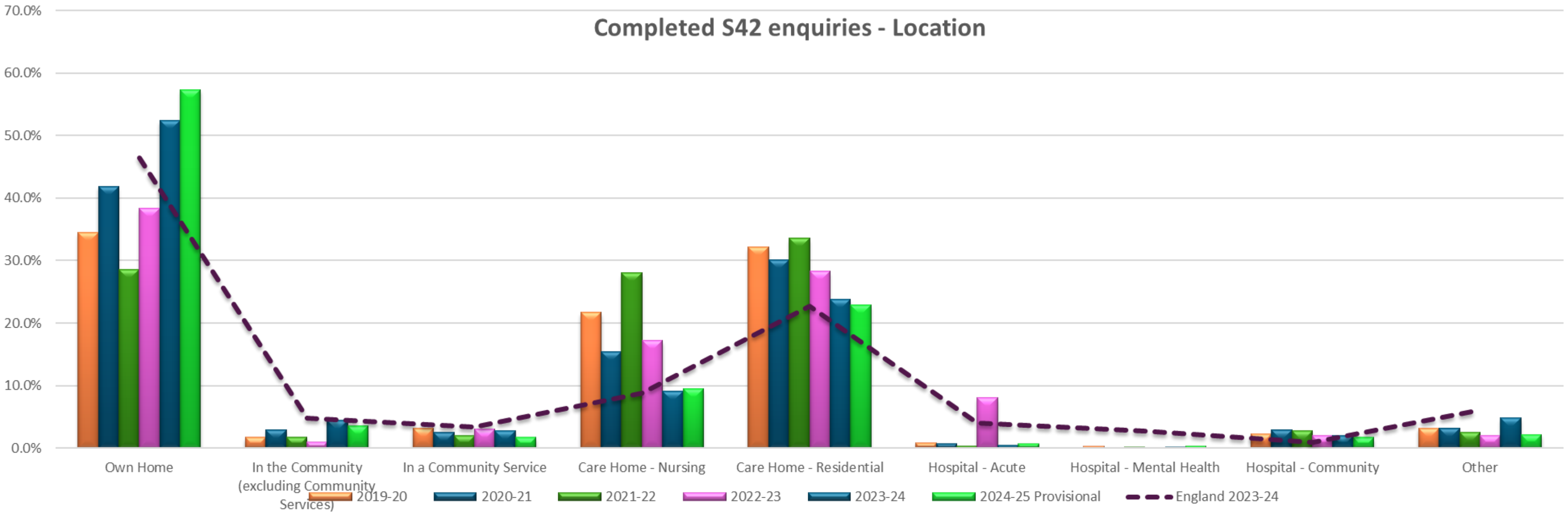
- In 23/24 we did not report Primary Support Reason as part of the Safeguarding Adults Collection (SAC) in accordance with the statutory guidance.
- This highlighted the significant change in recording of “No Support Reason” in 24/25
- Guidance states where a person is not in receipt of commissioned services then “No Support Reason” should be recorded.
- The data shows more concerns are being referred where people do not receive services.

Category of Abuse



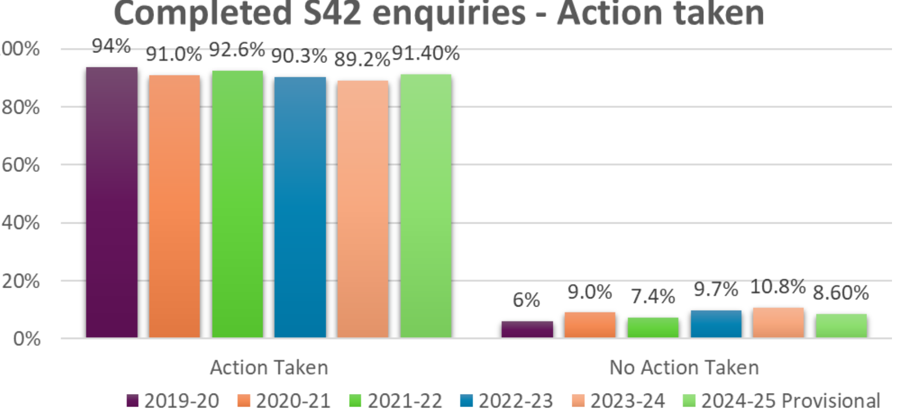
- Gateshead data is consistent with national data for categories of abuse
- In the past 2 years Gateshead has seen rises in Financial or Material Abuse, Domestic Abuse and Self-Neglect

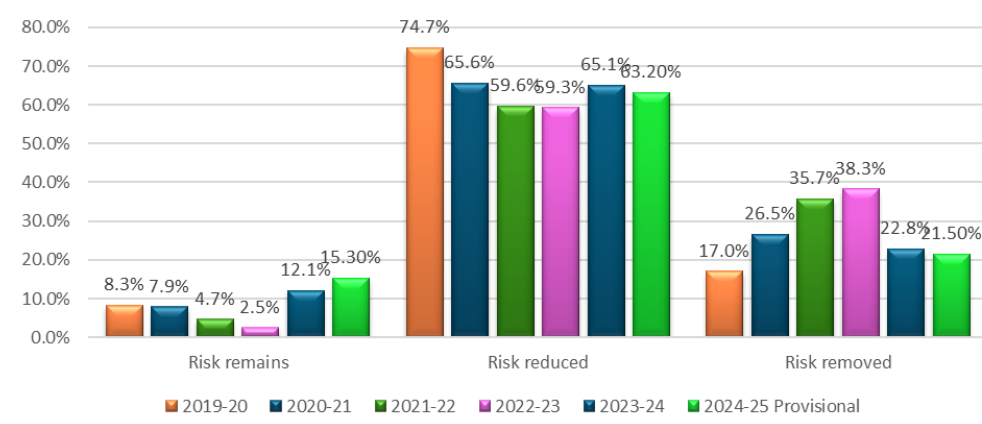
Location of Abuse



- In the past 2 years the proportion of S42 enquiries in care homes has fallen but aligns to national averages
- Gateshead has higher-than-average rates of abuse occurring in people's own homes. This reflects earlier data showing a rise in cases among working-age adults, particularly where individuals are not receiving support services
- Gateshead are below national averages for abuse in some hospital locations

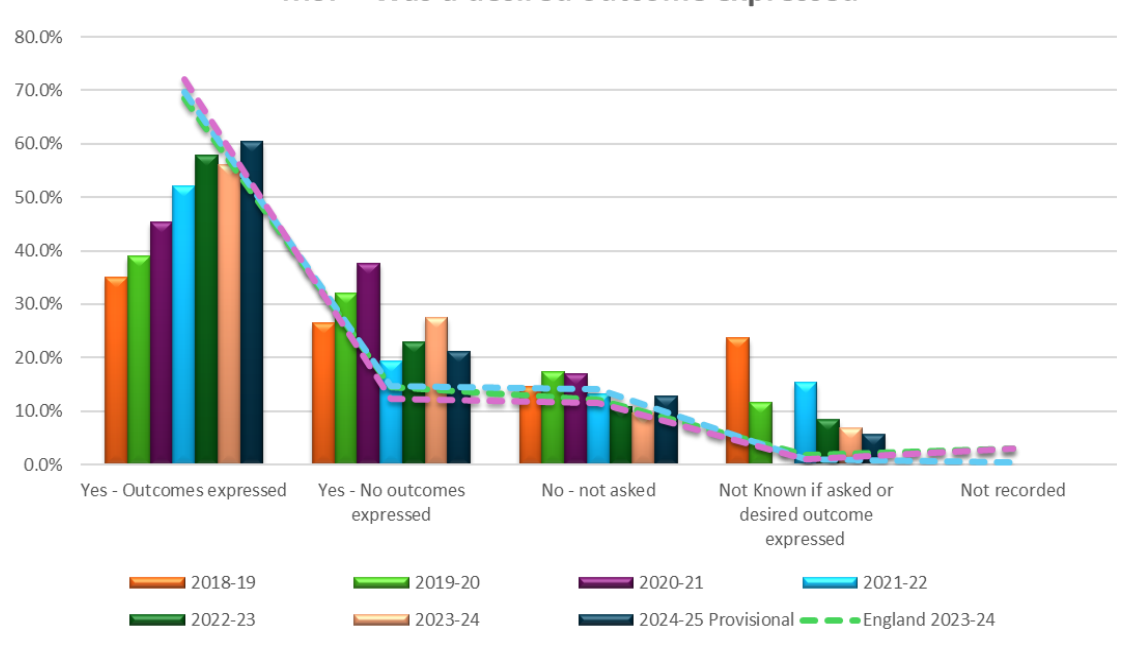
S42 Enquiry Outcomes





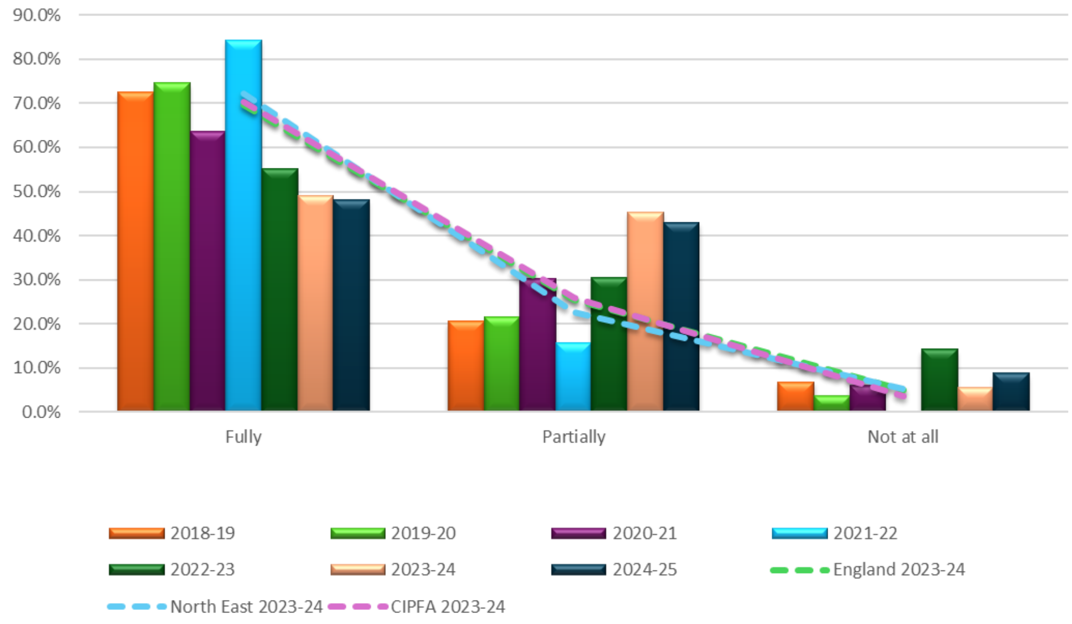
- Gateshead has consistently performed better than regional and national averages for action taken in S42 enquiries. National and regional averages are around 85% for action taken but Gateshead is usually over 90%
- The past 2 years Gateshead has seen a higher proportion of S42 enquiries where risk remained which puts our performance below national and regional averages by around 8-10%

S42 Enquiry Outcomes



- National, regional and statistical neighbour averages are similar:
  - Yes - outcomes expressed – 70%
  - Yes – No outcomes expressed – 15%
  - No – not asked – 13%
  - Not known – 1%
  - Not recorded – 1%
- Gateshead has improved each year with asking and recording an outcome expressed but are still about 10% short of averages
- Gateshead has a higher percentage of completed S42 enquiries where no outcomes expressed
- Gateshead are in line with averages for recording where desired outcomes are not asked
- Gateshead have a higher percentage than average where it is not known if asked or desired outcome expressed but this percentage is improving in Gateshead against recent years.

S42 Enquiry Outcomes



- National, regional and statistical neighbour averages are similar:
  - Outcome Fully Achieved – 70%
  - Outcome Partially Achieved – 25%
  - Outcome not achieved – 5%
- In the past 3 years Gateshead has saw a fall in outcomes fully achieved and an increase in partially achieved outcomes.
- The past 2 years Gateshead just under 50% of completed S42 enquiries have fully achieved outcomes and 40-45% of S42 enquiries where outcomes are partially achieved
- Except for 2022/23 Gateshead has had less than 10% of completed enquiries where outcomes were not achieved at all and is close to national, regional and statistical neighbour's averages.

Deprivation of Liberty Safeguards (DoLS)

For the period April 2024 to March 2025 Gateshead Council received 2841 Deprivation of Liberty Safeguard applications. This remains consistent with activity from the previous financial year (2840). The demands placed on local authorities in meeting statutory obligations remains high. Gateshead are compliant with care home DoLS, and do not have a waiting list,

The highest rate for DoLS applications remains with those over the age of 65. Within Gateshead this represents 2475 applications (87% of all applications) and for those aged under 65, 366 (13%) for those under 65.

925 applications were signed off with the status "Not Granted", this could be due to no ongoing requirement to complete an authorisation:

- 72 Assessment Criteria not met
- 778 Change of Circumstances (usually in a short-term setting ie hospital and there is no ongoing requirement for an assessment/ authorisation)
- 75 Death of Person

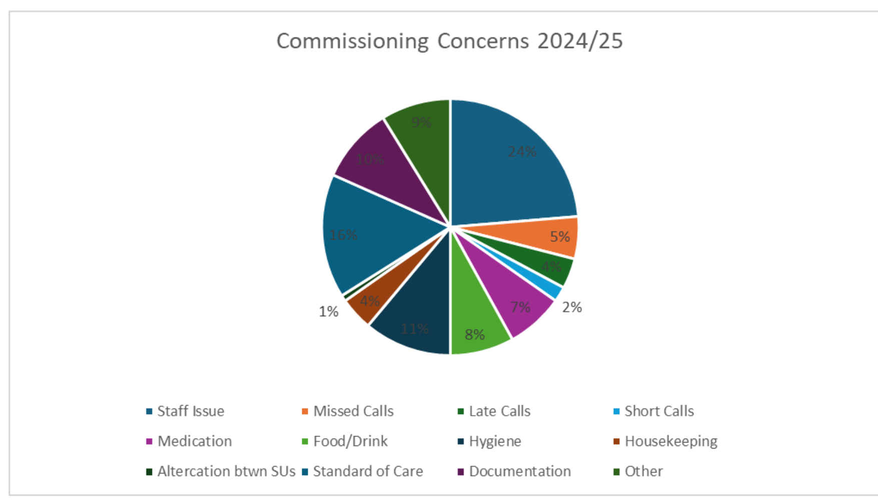
Commissioning Concerns

The number of provider concerns reduced from 262 in 2023/24 to 168 in 2024/25 with 367 types of abuse raised within those concerns. Staff issues was the highest category at 30% rising from 23.7% in 2023/24, this demonstrates the continued difficulty in recruiting staff in the health and social care sector.

Older Person Residential & Nursing establishments received the highest number of concerns at 72% of all concerns received, this is an increase from 55% in 2023/24. This is followed by Generalist Homecare with 17% of the concerns and Working Age (18-64 providers) with a total of 11% of all concerns.

The health and social care system continues to face significant challenges, particularly due to high staff turnover, which adversely affects service delivery and continuity. Furthermore, there remains a lack of clarity around the appropriate channels for reporting safeguarding issues, commissioning concerns, and quality of care matters. This has hindered the commissioning function's ability to respond effectively to emerging issues.

To address these concerns, a comprehensive review of the decision-making framework is underway. In parallel, more robust processes are being introduced to enhance the triangulation of information across adult social care, health services, and commissioning teams, ensuring a more coordinated and responsive approach.



Type of concern		2023/24		2024/25	
Staff Issue	↑	62	24%	109	30%
Missed Calls	↓	14	5%	4	1%
Late Calls	↓	10	4%	11	3%
Short Calls	↑	5	2%	14	4%
Medication	↑	19	7%	31	8%
Food/Drink	↑	21	8%	24	7%
Hygiene	↓	29	11%	26	7%
Housekeeping	→	11	4%	16	4%
Altercation between SUs	→	2	1%	1	0%
Standard of Care	↑	41	16%	66	18%
Documentation	↓	25	10%	26	7%
Other	↓	23	9%	39	11%
Total		**262**		**367**	

Multi-agency Task and Finish Group

Following an action agreed by the Board in February 2024, a multi-agency Task and Finish Group was established to strengthen safeguarding referral pathways and ensure all partners have a clear understanding of the new triage process. The group convened in April 2024, with representation from Gateshead Council (LA), Gateshead Health NHS Foundation Trust (GHFT), North East and North Cumbria Integrated Care Board (NENC ICB), Tyne and Wear Fire and Rescue Service (TWFRS), Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), and North East Ambulance Service (NEAS).

An action plan was developed and agreed upon during the meeting, focusing on the following key areas:

- **Referral Pathways:** Updating the Adult Social Care Practitioner Enquiry link to enable NEAS, GHFT, TWFRS, and GPs to upload safeguarding referrals and provide relevant information to practitioners.
- **Information Access:** Facilitating GHFT's access to case file information via the Local Authority's Mosaic platform or the Great North Care Record.
- **GP Referral Process**: Transitioning GPs to use a dedicated safeguarding concern referral form uploaded via a secure website link, replacing the previous portal-based system.
- **Quality Assurance**: Implementing regular quality audits of safeguarding concerns received from partner agencies to support continuous improvement and inform internal learning and development.
- **Form Enhancement**: Updating the Mosaic portal safeguarding concern form to ensure it effectively captures the necessary information for assessment under Section 42 enquiries and aligns with Safeguarding Adults Board (SAB) data requirements.

This collaborative approach aimed to enhance safeguarding practices across the partnership and ensure a consistent, high-quality response to concerns. This group was a precursor to the formation of the Data Working Group has provided a structured forum for ongoing data development and scrutiny.

Strategic Priority 4
Prevention of Harm

The GSAB recognises the need to prevent harm from occurring rather than responding once the harm has occurred.

Blue Light Project

One of the recommendations from the Thomas SAR was for the GSAB should consider the development of assertive outreach capacity for people with multiple complex needs. In light of this recommendation the LA agreed to fund the implementation of the Blue Light Approach in Gateshead.

The Blue Light Approach implementation project launched in Gateshead during 2024/25, with full endorsement from the GSAB. Its success relies on strong collaboration across partner organisations and a well-equipped workforce, ensuring staff have the skills and knowledge needed to provide effective support to individuals facing complex and multiple needs.

Blue Light is a national initiative used throughout the country and has been implemented in several LA areas including Northumberland with great success. The focus of Blue Light is on supporting change resistant dependent drinkers who are difficult to engage, (NB the title of the project will be changed as there are concerns regarding the use of Blue Light in the title). In Gateshead the brief is being expanded to also cover drug users, an approach which has been successful in other areas of the country.

The outline model for the projects covers the following key areas:

- Development of a strategic statement
- Frontline staff are trained to identify and respond to clients
- A multi-agency operational group is in place. This might be a standalone group or tied into other existing groups.
- Outreach is organised to serve this group
- Specialist services have a prioritised responsibility for this group; they don’t turn them away because they are not engaging.
- Staff training in using legal powers with this client group.
- Evaluation is built into the system.

The LA are leading on the co-ordination of a task and finish group with representation from a variety of agencies including police, recovery services, NENC ICB, GHNFT, CNTW and people with lived experience. The role of this group is to consider the model, agree that the model meets the Gateshead brief and decide how to progress with the programme. The task and finish group will maintain oversight of the programme and ensure that updates are provided to all interested parties. The implementation of Blue Light takes approximately 6 months however this is flexible to ensure local factors are taken into consideration.

It was recognised that the focus of the Blue Light Project is wider than the role of the Safeguarding Adults Board, and that representatives from wider teams within organisations (e.g. the Place delivery team in the NENC ICB) will be crucial to the successful delivery of the programme. The Health and Wellbeing Board and Gateshead Council's elected members have shown a keen interest in the programme, particularly in relation to the provision of an outreach approach, the potential positive impact on individuals and on local communities. Arrangements will be made to ensure appropriate and timely updates are provided to these two groups as well as the Gateshead Community Safety Partnership and the Domestic Abuse Board, both of which have links into the programme.

Communications Plan

A comprehensive communications plan has been developed to enhance engagement and visibility of safeguarding initiatives. The plan outlines key awareness days throughout the year and provides a framework for themed content to be shared via GSAB's website and social media channels, including X (formerly Twitter). This approach ensures timely and relevant messaging that supports public awareness, professional development, and community involvement in safeguarding adults. The plan is designed to be flexible and responsive, allowing for the inclusion of emerging issues and priorities as they arise.

Safeguarding Adults Week 2024

Safeguarding Adults Week 2024 see slide 36.

VCSE Training Offer

See Slide 29 for further information.

Strategic Priority 5

Involvement and Engagement

The GSAB recognises the importance of working with statutory and non-statutory partners to ensure we have robust systems in place to adequately represent the people who are involved in operational and statutory safeguarding

Annual Development Day and Quality Assurance Challenge Event

The GSAB held its Development Day in January 2025; which included it challenge event. All statutory partners were represented at the event along with wide representation from other agencies. The purpose of the day was to decide collectively how best to achieve our strategic vision to:

- Strengthen safeguarding practice across the partnership
- Provide multi-agency learning that promotes a culture of continuous learning
- Ensure we have a comprehensive dataset which demonstrates the impact of all partner's activities
- Demonstrate the effect of our preventative offer
- Engage assertively with experts by experience, statutory and non-statutory partners and provides confidence to residents

In preparation for the day a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis was undertaken, see Appendix 2 for the feedback.

Following the event the board refreshed the strategic plan identifying the actions which have been completed and adding further actions identified by board members. The refreshed strategic plan was approved by the board in March 2025 and will be implemented during 2025-26. The refreshed strategic plan can be found here.

Findings from the day

The findings from the development day have been used to update the strategic plan for 2025/26.

Learning, Data and Organisational Impact

- The partnership continues to explore how learning from Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) can be embedded across organisations to prevent future harm.
- There is a need to better use local learning to inform internal training and guidance, though challenges remain in evidencing the impact of this work.
- Baseline measures are lacking, making it difficult to track improvements and success. While data is available—including from advocacy and third sector partners—its use in shaping Board-level decisions needs strengthening. The newly formed Data Group presents an opportunity to improve understanding of how trends influence practice.
- There are limited mechanisms to demonstrate how SARs and DHRs are impacting individual organisations. Agencies operating across multiple areas face challenges in embedding learning locally, but this also offers opportunities to share lessons regionally and nationally.

Findings from the day - Strengthening Safeguarding

- Partners reaffirmed their commitment to strengthening safeguarding across the region and nationally, wherever possible.
- A key priority identified was the development and alignment of safeguarding guidelines and policies. It was agreed that safeguarding leads within organisations must take ownership of ensuring their internal policies reflect learning from both national and local SARs, as well as policies adopted by the GSAB.
- A significant barrier to proactive safeguarding was identified in the over-reliance on Section 42 referral pathways, which are sometimes used as a default mechanism to mitigate organisational risk. In contrast, the Team Around the Person (TAP) approach, though more resource-intensive and reliant on senior leadership buy-in, was recognised as a more effective model for prevention and long-term outcomes. This approach aligns with recommendations from recent thematic SARs and offers opportunities for improved collaboration, particularly with emergency response agencies, through structured liaison with safeguarding teams.
- Another challenge highlighted was the reliance on individual relationships across agencies, rather than a shared understanding of each other's safeguarding processes. This relational working, while valuable, is vulnerable to staff turnover and can undermine consistent multi-agency practice. To address this, there will be a renewed focus on embedding knowledge of roles, responsibilities, and operational procedures across partner organisations.
- Looking ahead, there are significant opportunities to strengthen safeguarding practices. A more strategic and careful use of the Shared Care Record could become a vital tool in enabling timely and informed decision-making.
- By reframing safeguarding language and promoting a culture of shared accountability, we can remove perceived barriers and ensure that safeguarding remains central to our collective practice.

Findings from the day - Prevention

- In terms of prevention, partners agreed to consider adopting a more proactive stance by initiating Section 42 enquiries when three or more concerns are raised within a six-month period. Staff will also be supported with scenario-based guidance to help them identify alternative pathways when concerns do not yet meet the threshold for statutory intervention but may escalate if welfare needs are not addressed.
- To support cultural change, we will promote the principle that "safeguarding remains everyone's responsibility." This includes encouraging staff to voice concerns rather than viewing safeguarding as a handoff to specialist teams. Practical tools such as shared care records and a 'little black book' of safeguarding contacts will be developed and incorporated into staff induction programmes to support this shift.
- Safeguarding continues to be a shared responsibility across all services. However, staff have voiced concerns that GDPR is often perceived as a barrier to effective safeguarding, leading some to rely on Section 42 enquiries as a workaround. This highlights the need for clearer guidance and a shift in language and culture.
- We recognise that staff sometimes hesitate to make referrals because they feel a need to remain involved in the case. This underscores the importance of fostering a culture where raising concerns is seen as a proactive and collaborative step, not a relinquishment of responsibility.

Findings from the day - Involvement and Engagement

- The GSAB continues to strengthen its approach to involvement and engagement by embedding existing pathways, such as young people's groups and mandatory NHS feedback questions, into its strategic planning. These channels provide valuable insights that inform our priorities and ensure our work reflects lived experience.
- A key focus has been identifying under-represented groups to ensure service delivery meets diverse and evolving needs. This includes exploring how questions like "How safe do you feel?" can be used meaningfully and sensitively to gather qualitative data that reflects real-world experiences.
- We have adopted a multi-method approach to data collection, enabling us to analyse what has changed, what has worked, and how successful practices can be shared and scaled. This includes capturing intent, evidencing impact, and ensuring that feedback loops are closed with visible outcomes.
- Importantly, we are working to embed aftercare planning as a standard part of safeguarding responses, ensuring that individuals have clear, supportive pathways once a crisis ends, reducing the risk of re-escalation and promoting long-term wellbeing.

Gateshead Safeguarding Adults Boards Involvement in the CQC Assurance Visit

The GSAB was pleased to support the Local Authority during its Care Quality Commission (CQC) assurance visit in October 2024.

As part of the process, the Independent Chair of the GSAB was interviewed and provided a comprehensive overview of the Board's work and its key interactions with Adult Social Care.

The Chair emphasised that Equality, Diversity, and Inclusion (EDI) remains a central focus for the Board. However, there was a candid recognition that the Board could have been more rigorous in its scrutiny.

Important questions were raised regarding statutory responsibilities, how they are understood, evidenced, and how partners are held to account.

The discussion also highlighted the critical importance of learning from Safeguarding Adult Reviews (SARs), particularly how organisations embed this learning and how they are constructively challenged when they do not.

The structure and governance of the GSAB were reviewed, including strategic priorities, implementation planning, and responses to complex cases and thematic reviews.

Initiatives such as the Blue Light Project were also referenced as examples of innovative practice.

Additional areas of focus included:

- The role of Healthwatch and its “Enter and View” powers.
- The use of data dashboards to support informed decision-making.
- Local Authority leadership in delivering statutory duties.
- Partnership working, triage processes, and the “Front Door” model.
- Subgroup contributions and their integration into the wider GSAB framework

There was a clear acknowledgment that further work is needed to strengthen EDI from a GSAB perspective. A recent SAR involving a member of the Polish community highlighted the need for greater cultural awareness and engagement. Similarly, discussions around the Jewish community revealed gaps in community knowledge that need to be addressed.

The Chair reflected positively on the collaborative spirit of the partnership, noting that all parties were “stepping up to the plate” with openness, constructive challenge, and a shared commitment to safeguarding.

Website Relaunch

In January 2025, the GSAB proudly relaunched its newly updated and refreshed website, following a comprehensive redesign led by the LA Digital Team. The update was driven by a commitment to improving user experience, with a focus on enhanced navigation, accessibility, and visual appeal. The refreshed site now offers a more engaging platform for showcasing the work of the Board and provides the Business Unit with a modern way to share key safeguarding information, resources, and updates. Ongoing development is focused on expanding the range of materials available, ensuring the website continues to support practitioners across Gateshead and individuals seeking guidance or assistance related to adult safeguarding.

- The GSAB website includes:
    - Information on the work of GSAB, including its strategic plan, annual reports, and Safeguarding Adults Reviews.
    - Multi-Agency Safeguarding Policy and Procedures, outlining how local authorities and partner agencies work together to protect adults at risk.
    - Resources and guidance for professionals, carers, and individuals using adult services.
    - Links to other agencies and their work, such as: The Making Safeguarding Personal Toolkit from the Local Government Association.
    - Guidance on Information Sharing, Whistleblowing, Positions of Trust, and Deprivation of Liberty Safeguards (DoLS).
    - Contact details for local safeguarding teams and reporting pathways for concerns.
    - Safeguarding Adults Review Protocols and Organisational Abuse Procedures.

Weekly E-mail Circulation

At the beginning of 2024/25, the GSAB introduced newsletters covering key themes including adult and children's safeguarding and community safety. These newsletters were developed and shared to enhance awareness and engagement across the partnership. Building on this, the Board has now transitioned to weekly email updates, enabling real-time information sharing and allowing partners to disseminate important safeguarding messages and updates to a wide network across Gateshead. This shift supports a more agile and responsive approach to communication, ensuring that practitioners and stakeholders remain informed and connected.

Tri-x Online Platform

In April and May 2024, GSAB relaunched Tri-X, its online platform for hosting procedures. Prior to the relaunch, all procedures, protocols, and resources were reviewed and updated. To showcase the platform's new features, Signis, the Tri-x Provider, delivered three briefing sessions. Since the relaunch, usage data has been incorporated into the GSAB Data Dashboard and is reviewed on a quarterly basis. During 2025/26, the SG Business Unit will carry out a comprehensive evaluation of the platform's usage and present recommendations to the board regarding its long-term viability. continued usage of the platform.

Social Media

We continue to actively use X (formerly Twitter) to raise awareness of safeguarding and highlight the vital work of both local and national organisations. With a growing audience of over 900 followers, our platform serves as an effective tool for sharing key messages, promoting events, and strengthening engagement across the safeguarding community.

Safeguarding Adult Reviews

The GSAB devolves responsibility for the undertaking of undertaking of safeguarding adult reviews to the SARCC group. In 2024/25 five safeguarding adult review referrals were received. All cases were discussed by the group using the rapid review process with 1 progressing to a mandatory SAR and 1 progressing to a discretionary appreciative inquiry. In addition to this the GSAB also commissioned a thematic review following the airing of a Panorama programme in December 2023, see slide 75 for more information.

Recruitment

During 2024/25, the Gateshead Safeguarding Adults Board (GSAB) and the Gateshead Safeguarding Children Partnership (GSCP) successfully secured funding for a new Safeguarding Partnership Officer role. Claire Stewart was appointed to the position and joined the team in December 2024. The role is primarily focused on supporting the Safeguarding Adults Review (SAR) process, ensuring that learning and recommendations arising from SARs and final reports are systematically recorded, monitored, and actioned. This includes oversight of both single-agency and multi-agency responses to ensure improvements in safeguarding practice.

Learning Register

Throughout 2024/25, the group continued to support the development of a Learning Register designed to capture key learning from Safeguarding Adults Reviews (SARs). This register serves as a vital tool for the Quality, Learning and Practice (QLP) group, enabling effective monitoring of actions and progress updates. Ongoing work is focused on enhancing the register to ensure that assurance information from partner agencies is consistently gathered, recorded, and used to inform safeguarding improvements.

Cross Boundary Working

During the year, two Safeguarding Adult Review (SAR) referrals involved individuals who were engaged with services across Durham and Gateshead. These cases a lack of multi-agency and cross-boundary collaboration. Agencies had not worked together to gather relevant information from all involved local authority areas, shared this information effectively, or facilitated joint meetings to ensure inclusive decision-making.

Following a learning event where cross boundary working was discussed specific actions were taken away to consider how meaningful discussion across two Safeguarding Adults Board (SAB) areas can be undertaken, fostering shared learning and demonstrating a strong commitment from all partners to engage in the process. Notably, there was a clear willingness from representatives to participate in cross-boundary discussions, enhancing the quality and consistency of safeguarding practice.

The GSAB Business Manager will contribute to the development of a regional Cross-Boundary SAR protocol to further strengthen collaborative efforts across the region.

Engagement of Care Home Managers in the SAR Process

Following discussions within the SARCC, it was recognised that care home managers play a vital role throughout the SAR process—from the provision of initial scoping information and attendance at rapid reviews to active involvement in full Safeguarding Adults Reviews.

To support this, it was agreed that the GSAB Business Manager would deliver a targeted briefs within the Commissioning Provider Forums. This initiative aimed to enhance understanding among care home managers of the purpose of a SAR and clarify their role within the process, promoting more effective engagement and collaboration.

Learning from SARs

There are key actions undertaken following the completion of a SAR In order to ensure the Safeguarding Adults Board takes forward the learning and recommendations:

- A multi-agency action plan is developed; this is agreed by the partners and regular updates are requested by the SG Business Unit. The action plans are monitored and reviewed by the QLP subgroup and any issues with the completion of actions are escalated via the Safeguarding Adults Board Executive.
- Single agency actions are monitored via the QLP Subgroup, a monitoring tool is used to ensure all actions are responded to by agencies and any issues are escalated via the Safeguarding Adults Board Executive and senior representatives of the agencies involved.
- Multi-agency briefings are designed and delivered to all partners, sharing the case information and the recommendations and actions with frontline practitioners.
- Resources and guides are developed and published on the Safeguarding Adults Board website which provides a useful resource library for practitioners.

Feedback

Following a SAR Rapid Review where a Team Manager came along to present information, they provided the following feedback:

"No need to thank us for attending it is important learning for us all and part of our role, the learning we gain from these pieces of work is invaluable so thank for inviting us to take part"

Referral 1

In April 2024, a woman aged 44 sadly passed away. A coroner's inquest concluded that her death was the result of misadventure. She had relocated to the Gateshead area in October 2023, having previously engaged with services in the Durham area. Her family, including her children, reside in Yorkshire. She had a diagnosis of Emotionally Unstable Personality Disorder and had previously disclosed suicidal intentions to professionals.

In March 2024, a Safeguarding Concern was raised by the Northeast Ambulance Service (NEAS), highlighting issues including self-harm, alcohol dependency, self-neglect, and home invasion. The case progressed to a Section 42 enquiry in April 2024, and initial information gathering had commenced. Unfortunately, she passed away before her views and wishes could be obtained, and prior to the enquiry reaching the planning stage.

The case was reviewed by the SARCC Group to determine whether she had identified care and support needs under the Care Act in relation to her mental health and substance misuse. The group also considered the effectiveness of multi-agency safeguarding efforts, including cross-boundary working between Gateshead and Durham services, and whether information sharing practices impacted the ability of services to engage with and support her effectively.

While the case did not meet the threshold for a mandatory Safeguarding Adults Review (SAR), the group recommended its inclusion in a thematic analysis. This analysis will focus on cases involving alcohol misuse and mental health concerns where individuals did not present with care and support needs.

Referral 2 Adult K

Adult K was discharged from hospital in Durham and subsequently admitted to a care home in Gateshead. In July 2024, following concerns about significant harm experienced during his placement, a Safeguarding Adults Review (SAR) referral was submitted to the Gateshead Safeguarding Adults Board (GSAB) by the Safeguarding Co-ordinator who had overseen the Section 42 enquiries into the neglect and harm Adult K suffered.

According to Mosaic, Gateshead Council's social care management system, Adult K had eligible needs for care and support under the Care Act 2014. He was unable to meet these needs independently and required ongoing assistance. He was admitted to a care home in Birtley at the end of February 2024.

Adult K was also eligible for NHS podiatry services, and although a referral was made by the Community Nurse Practitioner and later escalated by the GP, no podiatry input was provided. There is evidence of poor communication between professionals, with no multi-disciplinary team (MDT) meetings held until the day Adult K was admitted to hospital.

Adult K was a known diabetic and had previously received podiatry care in Durham. This critical aspect of his health management was not picked up following his move to Gateshead. In April 2024, Adult K was admitted to hospital with an open wound and pressure damage to his foot, which progressed to a bone infection, ultimately resulting in the amputation of several toes.

Concerns were raised about the standard of care provided in the residential home. Adult K was described as being in a state of extreme poor hygiene and not receiving appropriate levels of care. It is likely that delays in making referrals and securing appropriate support contributed to the severity of his injury.

The SARCC group was asked to consider whether the injuries sustained by Adult K were the result of abuse and neglect, and whether agencies in Durham and Gateshead worked effectively together to safeguard him.

Referral 2 Adult K continued

Based on the information provided in the SAR referral, there is reasonable cause for concern regarding the effectiveness of multi-agency working. This includes the care home, GP, podiatry services (Durham and Gateshead), and mental health services (Durham and Gateshead). The case met the criteria for a mandatory SAR.

An independent author was appointed to lead the review, and a practitioner workshop was held in March 2025. The final report and recommendations are scheduled for submission to the SARCC in June 2025, with a view to presenting them to the GSAB for final approval.

Referral 3 (Adult L)

Adult L passed away in April 2024 at the age of 38 from acute alcohol intoxication. GSAB received a referral for a SAR from the Safeguarding Coordinator then led the safeguarding investigations (under Section 42 of the Care Act) concerning time over the last 18 months before Adult L died.

In July 2024 the SARCC discussed the case and concluded that the case did not meet the criteria to progress to a statutory SAR as Adult L did not have identified care and support needs under the Care Act and there was no evidence that agencies had not worked together to safeguarding her. There was evidence of self-neglect relating to alcohol use and due to the number of services and difficulties in working with Adult L it was agreed that a discretionary review should be undertaken to consider how agencies can work to support people with complex presentation and multiple risk factors.

After agreeing to move forward, representatives from the Gateshead GSAB, the Local Authority Safeguarding Team, Public Health, and Community Safety (Domestic Abuse) met to decide whether a joint review should be carried out. They discussed doing a broader review to learn more from Adult L's case. It was suggested that using an Appreciative Inquiry approach would help explore Adult L's entire life journey, including childhood trauma and how it affected her later in life. This approach could highlight missed chances for support, gaps in services, ways to work with trauma without causing more harm, and examples of good practice.

An independent author was appointed by the GSAB to undertake the appreciative inquiry with practitioner workshops planned for June 2025 and the draft report due for presentation in October 2025.

Referral 4

This individual was 80 years old at the time of her passing at Queen Elizabeth Hospital in June 2024. She had a diagnosis of mild learning disability and schizophrenia, requiring support with all aspects of personal care. She was able to access respite care when needed.

There were longstanding safeguarding concerns related to her relationship with her husband, with previous discussions held at *Multi Agency Risk Assessment Conference (MARAC). In September 2023, a Community Psychiatric Nurse raised concerns regarding potential neglect by third-party agencies involved in her care. These concerns prompted the submission of incident reports and a review by CNTW's Safeguarding Adults and Public Protection (SAPP) team. Multiple safeguarding referrals were subsequently made to Adult Social Care by CNTW.

Weekly multi-agency meetings commenced in April 2024; however, it is understood that the care provider did not attend these meetings. It remains unclear how concerns were escalated in relation to professional challenge, lack of improvement in care delivery, and the effectiveness of inter-agency communication.

She was admitted to Queen Elizabeth Hospital on 14th June 2024 with suspected urinary tract infection and dehydration. Hospital staff were advised that it was unsafe to discharge her home until a further multidisciplinary team (MDT) meeting could be convened.

Partner agencies are requested to provide any relevant information from September 2023 to June 2024 to support the SARCC group in reviewing the following:

- Whether the response to safeguarding referrals was appropriate.
- Whether the management of her discharge from acute care was safe and appropriate.
- Whether delays in arranging a new care provider contributed to ongoing concerns about her care and safety.
- Whether the concerns raised led to improvements in the quality of care, and how repeated concerns were challenged or escalated.

* A meeting where professionals from multiple agencies share information about **high-risk domestic abuse cases** to develop a **coordinated safety plan** for the victim and their children

Referral 4 continued

The SARCC group agreed that the referral did not meet the criteria for a mandatory SAR as there was no evidence upon review that partner agencies had not worked together to safeguard this lady. However single agency actions were identified for GHFT in relation to discharge protocols in particularly in relation to supply of medication to the patient. These are being monitored via the QLP group.

Referral 5

The GSAB received a SAR referral in November 2024 from GHFT for a lady who passed away in the QE hospital. She was admitted to the QE on 7th November after being found on the floor at home by her partner, it isn't clear how long she had laid on the floor but possibly around 4 hours. Upon admission she was lethargic and hypoxic (not known diabetic), with significant bilateral ulceration on both legs. Main diagnosis was sepsis multi organ failure, community acquired pneumonia, PVD (vascular disease), ischaemic leg. Despite treatment she passed away the same day.

From information contained on Mosaic, Gateshead Council's social care management system she did have identified needs for care and support under the Care Act 2014 following an assessment undertaken in 2015, although she was not receiving any services through the LA.

Although an inquest was not conducted the coroner commented:

"her GP info showed she was actually under GHFT Podiatry and District Nursing wound team having her leg ulcers checked and dressed regularly".

She did DNA / cancel a few appointments, but they always re-arranged them for her.

She was last seen a couple of weeks ago and wound was stable and not infected.

Coroner felt not strong enough link to cause of death and is happy with cause of death proposed by the GHFT Medical Examiner of streptococcus pneumonia, sepsis and multiple organ failure. The family are in agreement.

There are no concerns around self-neglect as she was actively attending appointments / receiving visits for this wound care. The cause of death is streptococcus pneumonia.

After reviewing the information provided by partners the SARCC group agreed the case did not meet the criteria for a mandatory SAR.

Thematic Review

The full report, GSAB Chair statement and Executive Summary is available to view on the *GSAB Website.

Following a BBC Panorama programme which aired in December 2023 featuring a care home in Gateshead, the Safeguarding Adults Board commissioned an independent Safeguarding Adult Review.

The focus of the programme was around the employment of overseas workers; however, it also highlighted quality of care issues and safeguarding concerns, relating to former and current residents of the home.

The focus of the review was to consider the robustness of multi-agency enquiries undertaken in relation to the care home, and the purpose was to identify any learning which could improve local multi-agency safeguarding processes.

Following completion of the review in February 2025 the GSAB approved the report recommendations in March 2025 and agreed that a multi-agency panel should be established to lead on the implementation of these recommendations.

This panel is chaired by Nicola Bailey, the GSAB Independent Chair, and includes representatives from:

- Northeast and North Cumbria ICB
- Gateshead Health NHS Foundation Trust
- Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust
- Northumbria Police
- Gateshead Integrated Adults and Social Care (Adult Social Care and Commissioning, Performance and Quality Assurance)
- Northeast Ambulance Service (NEAS)
- Care Quality Commission (CQC)
- Advocacy Providers (Connected Voice and Your Voice Counts)
- South Tyneside and Sunderland NHS Foundation Trust
- Health Watch

* https://www.gatesheadsafeguarding.org.uk/article/31994/Thematic-Review

Thematic Review continued

Regular progress updates on the work of the panel are provided to both the GSAB and its Executive Group on a quarterly and bi-monthly basis respectively.

The first panel meeting took place in April 2025, where the draft action plan was discussed and updated, with lead professionals identified for each of the recommendations/actions. The panel also identified practitioners/agencies who would support the completion of these actions, to ensure responsibility and accountability was shared appropriately across multi-agency partners.

The panel agreed to meet monthly to monitor and track the progress of the recommendations. Leads will be required to complete and submit a highlight report to the panel meetings to update on progress, key risks, issues and barriers, and any benefits or impact. Where risks are identified which impact on the GSABs ability to meet its statutory obligations, these will be added to the GSAB Risk Register, as will any recommendations which leads, or the panel view are unachievable.

The Safeguarding Learning and Development Officer is working on a programme of learning events and resources for practitioners to raise awareness of the review, its purpose, the recommendations, and the work of the panel. The events will be hosted both online via Teams and face to face and will take the form of short briefings and workshop events to undertake consultation. Lead practitioners will also be asked to provide updates on progress at these events. Resources will be available in a variety of formats including podcasts, videos, briefing documents, and social media posts.

How the Board Links with Other Parts of the System

Monthly Cross Partnership Meetings

To promote effective collaboration across the GSAB, GSCP, Community Safety Partnership, and the Domestic Abuse Partnership Board, managers from each partnership convene monthly. These meetings follow a structured agenda and provide a forum for sharing updates on reviews, projects, and legislative developments. They also serve to identify opportunities for joint working to support shared priorities and areas of need.

Updates

To support transparency and shared understanding across Gateshead's partnership boards, business managers contribute updates to one another's information reports. These reports are presented at board meetings, ensuring each board remains informed of the ongoing work and priorities of other partnerships. This process supports a consistent and timely flow of information between boards and partnerships, strengthening communication and collaborative working.

Drug and Alcohol Strategy Development Group

The GSAB BM plays an active role in the Drug and Alcohol Strategy Development Group. The aim of the group is to produce and deliver a strategy to address drug and alcohol related issues within Gateshead. The multi-agency group aims to ensure effective partnership working to deliver a borough wide evidence-based Drug and Alcohol Strategy and Action Plan on behalf of both the Community Safety and Health and Wellbeing Boards.

Emerging Trends – Suicide

The GSAB supported a meeting hosted by Public Health in September 2024, following a rise in the number of female suicides reported in Gateshead since November 2023. The meeting was attended by representatives from:

- Adult Social Care
- Children Services
- Northumbria Police
- Gateshead Health NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear Foundation Trust
- North East and North Cumbria ICB
- Change Grow Live (CGL - recovery services)

The group reviewed 7 cases to identify suicide contagion or clusters and to identify any similarities in risk factors. The main risk factors identified were, mental health issues, domestic abuse and substance misuse (drug and alcohol). There were additional factors identified around contact with children's services in relation to the care of their own children, having had children removed from their care, and individuals being diagnosed or on the pathway for diagnosis of Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactive Disorder (ADHD).

Two of the individuals lived in close proximity to each other one area of Gateshead. The individuals died within 6 months of each other; however, the group was unable to establish if the individuals were known to each other.

Gateshead Recovery Partnership (GRP) are now providing additional services in this area to ensure there is adequate provision for individuals with substance misuse issues and CNTW are working with the local GP practice to develop mental health service provision. Further work is to be undertaken by Public Health to consider actions in relation to the findings.

Review of Gateshead Council's Domestic Abuse Services

The Gateshead Domestic Abuse Partnership Board instigated a strategic review of domestic abuse, with the aim of ensuring we are delivering an effective and sustainable model across the Council. They have also agreed a new Domestic Abuse Strategy 2025/28 and agreed a number of strategic objectives with a supporting action plan. The four pillars of the strategy are each being supported by a working group:

- Prioritising Prevention
- Supporting Victim/Survivors
- Tackling Perpetrators
- Creating a Stronger System

The report has been published and is available to view here.

GATESHEAD DOMESTIC ABUSE STRATEGY

2025 | 2028

Domestic Abuse Task and Finish Group - Domestic abuse and over 55's

The GSAB Business Manager takes an active role in the Domestic Abuse Task and Finish Group which was set up to consider how to effective support older people experiencing domestic abuse'. The group aims to:

- Identify the specific needs of this client group (over 55)
- Undertake a scoping exercise to identify appropriate effective signposting to partner agencies
- Understand agency referral routes/ criteria
- Decide on most appropriate methodology to demonstrate a route to support

Consultation has been undertaken with partner representatives and with people who have been the victim of domestic abuse. The key themes from this consultation were:

Lack of training, practitioners do not have the skills or knowledge to ask the questions at the right time. Need to upskill frontline workers from health, libraries, leisure, pharmacies etc to instigate conversations and signpost to appropriate services. Scoping exercise identify domestic abuse training resources, who is delivering training, how can training be accessed (particularly for people working outside of the LA).

Publicity, awareness raising, older people need to recognise when they are in a domestically abusive relationship. Changing their perception of domestic abuse, consider coercive control and psychological abuse. The co-production group have made several suggestions on publicity material and where they should be made available. Consideration needs to be given to male and ethnic minority victims.

Recognising that older people have different needs to younger people in relation to domestic abuse, and may need differing advice on finances, housing and benefits.

National Referral Mechanism (NRM)

The NRM is a framework for identifying victims of human trafficking or modern slavery and ensuring they receive appropriate support. The local authority is working to develop a corporate process to ensure all employees are aware of the authority's responsibilities as a first responder under the framework and to develop a process for effective reporting and recording. A group including representatives from Public Health, Community Safety, Adult Social Care, Housing, Economy Innovation and Growth and Housing, Environments and Health Communities met in February 2025. The group discussed Community Safety Partnership owning and overseeing the process, they will act as a single point of contact. The authorities Modern Slavery, Trafficking and Exploitation [MTSE] Concept of Operations which was developed in September 2017, to be reviewed to include guidance on the NRM process and ensure it is embedded in practice.

The group agreed key actions:

- Process to be developed using the No Recourse to Public Funds process/ framework as a template.
- Pathway on reporting, can anyone within the authority report or are all referrals via Community Safety - who reports and how do they report
- Process for recording referrals/ cases
- Who is responsible for the NRM in each service area

Updates on progress are provided to the Joint Strategic Exploitation Group.

Regional and National Work

Regional Organisational Abuse Good Practice Toolkit

During 2024/25 the final draft of the Organisational Abuse Good Practice toolkit was approved by the Northeast Association of Directors for Adult Social Services (ADASS) Safeguarding Network. The toolkit was developed by the Regional SAR Champions group. The document is not mandated nor a policy but moreover a means of sharing practice and tools available across adult social care colleagues and commissioners (including health) in the Northeast. It can be drawn upon to inform local practice and/or shape any changes to practice or policy. It's hoped that the guide will support a level of consistency across the region. The tool will be used by the GSAB Thematic Review panel as the basis on which to draft the Gateshead Organisational Abuse Framework.

Cross Boundary SAR Protocol

The SAR Champions Group are working on guidance for safeguarding business unit on Cross Boundary SARs. The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult with care and support needs in its area dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. There is growing recognition nationally that where a SAR involves more than one SAB (a cross-boundary SAR), the 'Host SAB' (where the adult has been seriously harmed or died), may not always be best placed to coordinate the SAR as the adult may not be known or have minimal involvement with services in its area. Therefore, the Host SAB may identify learning that is not wholly relevant or applicable to its partners and would be seeking assurance from agencies that are not within its partnership.

The final version of the protocol has now been approved by all regional SABs and will be used by Safeguarding Business Units to provide a consistent approach across the regional when undertaking cross boundary SARs.

National SAB Guidance on the Interface Between SARs and Coronial Processes

The final version of the National SAB Guidance on the Interface between SARs and the Coronial Process was shared at the SAB Business Managers Network meeting in September 2024. The guidance was developed by business managers, led by the Nottingham City SAB Business Manager, there were over 28 SABs involved in the development of the document and coroners were consulted throughout. The aim of the document was to provide guidance for areas that had no guidance, to adopt in full or to adapt for their needs and for those SABs that have protocols to strengthen and refresh them. The document includes sections on what are SARs, the current legal guidance, best practice guidance, the GSAB will agree how to adopt the protocol, and reference the guidance in its own protocols.

Second National SAR Analysis

The final reports and the executive summary from the second national analysis of Safeguarding Adult Reviews (SARs) in England have now been published and are available on the LGA Website as well as the GSAB Website. The analysis was undertaken in 2023 covering SARs completed between April 2019 and March 2023, which also covered the period of the Covid 19 pandemic.

The purpose of the analysis was to identify priorities for sector-led improvement as a result of learning from SARs, there are a total of 31 recommendations and the GSAB will be considering how it responds to these recommendations and gathers and monitors assurance that actions have been taken to address the recommendations.

The National SAB Managers Network have created a task and finish group to consider how to take forward the recommendations from the analysis, this will minimise duplication and maximise shared learning. The group have identified the recommendations, and the issues raised within the analysis which should be approached from a national perspective, and which should remain local.

North East SAR Champions Network – Achievements

Throughout 2024/25, the North East SAR Champions Network maintained its commitment to quarterly meetings, fostering collaboration and shared learning. During this period, champions actively contributed to a range of initiatives and addressed actions arising from both regional and national Safeguarding Adult Reviews (SARs), driving improvements in practice and outcomes.

- Cross Boundary SAR Guidance.
- Effectiveness of SAR Escalation Protocol raised nationally.
- National Survey to Business Managers regarding key questions around SARs, such as how timescales are captured.
- Discussed National SAR Analysis, interface between SARs/ Coronial Process and Ministerial Letter re Rough Sleeping.
- Regional offer to practitioners for some webinars during National Safeguarding Adults Week 2024.
- Speakers invited from RISE (Safeguarding in Sport) and North East Procurement Framework for Independent Reviewers.

Appendix 1 – Partner Updates

Local Authority Housing

We continue to play an active role in multi-agency safeguarding groups, including the Gateshead Safeguarding Adults Board (GSAB), where we chair the Quality, Learning and Practice sub-group. We also contribute to the Joint Strategic Exploitation Group, the SAR & Complex Cases Group, and attend operational forums such as PIT Stop and multi-disciplinary team (MDT) meetings.

Strengthening Safeguarding

Our involvement ensures we stay informed of legislative and practice developments while benefiting from peer collaboration. The Partnership & Inclusion Coordinator supports daily PIT Stop meetings, offering housing advice and facilitating swift case allocation. This approach has strengthened links between housing and safeguarding, ensuring concerns with housing needs are addressed appropriately—even when they fall below safeguarding thresholds.

Adult Social Care introduced changes to the ASSET team structure, altering how concerns are triaged and reducing the number of complex case meetings. However, stronger partnerships have developed between ASSET workers and Neighbourhood Housing Officers, enabling joint working where needed. Housing representatives continue to attend complex case meetings when a housing need is identified, with the Partnership & Inclusion Coordinator allocating actions where necessary.

In 2024/25, Housing received 190 domestic abuse reports. Of these, 103 were investigated as anti-social behaviour (ASB) cases, with support provided to both victims and perpetrators. The remaining 110 cases involved re-housing support from Domestic Abuse Housing Outreach Workers.

Strengthening Safeguarding continued

Housing was represented at all 52 MARAC meetings, where 416 victims were discussed. Of these, 170 (41%) were council tenants, and 66 (16%) of perpetrators were either council tenants or living with one. The Neighbourhood Relations Team conducted detailed research to support each case, including tenancy history, ASB involvement, and security measures.

Changes to the ASSET team have reshaped how concerns are triaged, reducing complex case meetings but improving joint working between ASSET staff and Neighbourhood Housing Officers. Housing representatives attend meetings where a housing need is identified, with the Partnership & Inclusion Coordinator stepping in when needed.

In 2024/25, Housing received 190 domestic abuse reports. Of these, 103 were investigated as ASB cases, while 110 victims were supported with re-housing by Domestic Abuse Housing Outreach Workers.

Housing was represented at all 52 MARAC meetings, where 416 victims were discussed. Of these, 170 (41%) were council tenants, and 66 (16%) of perpetrators were either council tenants or living with one. The Neighbourhood Relations Team provided detailed case research to support multi-agency decision-making.

In 2024/25, 16 actions were agreed through MATAC to address perpetrator behaviour, including joint visits with police, ASB case management, tenancy monitoring, and victim support.

A total of 64 sanctuary/security measures were installed in council properties, benefiting 46 households—primarily through lock changes and security lighting. Additionally, 41 measures were provided to 26 victims in privately owned or rented homes.

We are working with the Council's Domestic Abuse team to develop a tailored support pathway for older victims. Our Housing-related Domestic Abuse Policy is currently being refreshed to align with Housing Regulator consumer standards, incorporating good practice and lived experience. Refresher training will follow once the policy is finalised.

Strengthening Safeguarding continued

A benchmarking review was carried out to explore why domestic abuse remains the leading cause of homelessness in Gateshead. This included comparing local practices with other authorities and reporting findings to the Board. Further analysis is underway to identify best practice.

In 2024/25, there were 12 new hoarding cases, 8 closures, and 7 active cases. These often require long-term support, with an average resolution time of 355 working days due to the need to build trust and provide tailored help.

The ‘Less is More’ peer support group, developed with Northumbria University, continues to meet monthly at Bensham Grove Community Centre. Open to anyone with lived experience of hoarding, the group shares insights and hosts guest speakers offering advice and support. A dedicated Facebook page also provides resources and links.

Following ministerial guidance issued in May 2024, Gateshead has strengthened its approach to safeguarding rough sleepers. Key recommendations included improved governance, a named board member, inclusion in strategies and reports, and commissioning SARs for deaths involving rough sleeping.

Our Rough Sleeper Coordinator and Neighbourhood Relations Team attend partnership meetings to share intelligence and support engagement. Work is ongoing to improve referral quality across housing teams, with updates managed via the Safeguarding Lead. Housing safeguarding guidance is being refreshed, with staff briefings planned.

Learning and Development

The Partnership & Inclusion Coordinator co-delivered two multi-agency safeguarding training sessions and contributed to revised content, including “Making Safeguarding Personal.” They also joined team briefings to promote safeguarding referrals across housing services.

Adult Social Care

Adult Social Care continues to play an active role in local safeguarding arrangements and strengthening partnership working, in alignment with the priorities set out in the GSAB strategic plan.

CQC assessment – ‘Good’ rating

In March 2025, the Care Quality Commission (CQC) rated Gateshead’s Integrated Adult Social Care teams as ‘Good’, recognising their commitment to helping people lead fulfilling lives in the community. The report highlighted that safety was a shared priority for everyone, with risks across care journeys being clearly identified, well understood, proactively managed, and consistently monitored. The voices of people who use services, as well as those of partners and staff, were actively listened to and considered.

The CQC particularly commended the local authority’s collaborative work with the Safeguarding Adults Board (SAB) and other partners, recognising a coordinated and effective approach to adult safeguarding.

Local safeguarding arrangements were highlighted, with the report noting: “There were effective systems, processes, and practices in place to ensure people were protected from abuse and neglect. The local authority had a clear pathway for receiving and responding to safeguarding concerns.”

During the reporting year, Adult Social Care successfully recruited permanent staff to its Safeguarding Triage Team and enhanced its operational safeguarding arrangements. The CQC report specifically referenced these developments, highlighting their positive impact on consistency and understanding of safeguarding practices. Staff and partners spoke positively about the new safeguarding team and model. “They told us there was clear understanding of who was accountable, with improved collaboration between colleagues.”

Strengthening Safeguarding

During this year we have continued to strengthen our safeguarding arrangements and make improvements to guidance about what constitutes a safeguarding concern. Work has been undertaken to ensure our front facing Mosaic/GOSS portal streamlines and captures appropriate information, places the individual at the centre of the process, and provides clear guidance to support the identification of the correct pathway selection from the outset.

Partners have been offered shadowing opportunities to gain direct, experiential insight into operational practices related to Section 42 enquiries. This initiative aims to strengthen multi-agency understanding of when a safeguarding concern is appropriate, through direct learning.

We have also developed and introduced a new hub model at our front door to facilitate the timely triaging of safeguarding concerns and ensure the right pathway is followed from the point of referral. The new Safeguarding Interface hub launched in April 2025 and supports timely decision-making and improved outcomes for those who require a safeguarding response.

Safeguarding pathways continue to be enhanced across the service through close collaboration with Commissioning colleagues. This has positioned us strongly within the safeguarding system to effectively respond to and implement the actions and recommendations arising from the Thematic Safeguarding Adults Review (SAR).

Data and Information

During this reporting year, substantial progress has been made to align the GSAB and Operational Safeguarding dashboards, ensuring they are equipped to identify emerging trends and patterns that inform strategic planning and service development. This work has placed a strong emphasis on preventative approaches and has enhanced learning and development through the intelligent use of data and insights.

Improvements to the case management system have strengthened the quality and consistency of recorded data, supporting more robust reporting and better-informed decision-making. Additionally, the appointment of a Safeguarding Hub Partnership Officer will play a key role in advancing thematic analysis, enabling earlier identification of trends and pressure points across the system.

Learning and Development

A Multi-Agency Learning from Deaths process has been established to review cases where individuals have died during safeguarding enquiries. This ensures that any learning opportunities or alternative pathways are identified and acted upon promptly. Although still in its early stages, the process has already received positive feedback from partners and aligns with recommendations from the Thematic Safeguarding Adults Review (SAR).

In addition, we have developed and co-delivered tailored Mental Capacity Act training to the multi-agency partnership, with a specific focus on executive capacity and functioning. To support this, a concise 7-minute briefing is being produced to provide accessible guidance for staff. This work will also support the Blue Light Project Operational Group and reinforce learning from SARs.

Adult Social Care’s strong commitment to continuous learning and development was also recognised in the CQC report, which stated: “Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice.”

Engagement

Work continues across the service to ensure that Making Safeguarding Personal (MSP) remains embedded and central to all safeguarding activity. Multi-agency practice guidance is being developed to enhance understanding and application of MSP principles. In parallel, efforts are underway to strengthen and embed advocacy responsibilities within audits, performance reporting, and contract monitoring and this will form the basis of a future project plan.

Our commitment to MSP was also recognised in the CQC report, which noted: “People were put at the centre of safeguarding decisions, and we heard examples of people being kept safe in ways that aligned with their wishes.”

Northumbria Police

Gateshead Area Command is in the early stages of implementing the HIVE model, which will see police co-located with a range of statutory partners to enhance the collective response to exploitation, vulnerability, and domestic abuse. By harnessing the expertise of a broad spectrum of professionals through daily tasking and information sharing, the model aims to deliver a more tailored and dynamic response to community needs.

The first phase involves the Neighbourhood Policing Team relocating to the Civic Centre in late November

Key developments include:

- **Exploitation SPOC Trial**: A three-month pilot has commenced, with a PC acting as the Single Point of Contact for exploitation who will be the conduit between the MASH, Local Authority, and Neighbourhood Policing Team, attending safeguarding and missing meetings, facilitating information sharing, and standardising risk assessments and harm plans.
- **Mental Health Problem-Solving Team**: The Prevention Department has launched a dedicated team with new terms of reference, focused on managing small cohorts of individuals who pose high harm or demand within local areas.
- **Suicide Prevention Working Group**: A newly formed multi-agency group, attended by Public Health and Domestic Abuse leads across the region, is now in place. A regional suicide prevention conference is scheduled for January 2026.
- **Serious and Organised Exploitation Team**: Northumbria Police has introduced a new team working alongside partners to ensure a coordinated multi-agency approach to safeguarding victims of exploitation.

- **Reduction in Missing Adult Incidents**: Gateshead has seen a 16% decrease in missing adult incidents compared to the previous 12-month period. The introduction of the Missing from Home team within the Prevention Department has contributed to a reduction in repeat incidents through a problem-solving approach.
- **Reviews Team Restructure**: The Reviews Team has undergone a structural change and staffing uplift, ensuring that learning and actions from reviews are embedded, implemented, and evaluated for impact at the earliest opportunity.

Partnership Reduction of Exploitation and Missing (PREM)

Partners in Gateshead were key to a multi-agency task and finish group to consider improvements to the system so that the process was standardised across all six LAs in the Northumbria Police area to:

- Include adults in the process
- To be outcome focussed
- To not only focus on the victim, but also on the offender to remove/resolve the issue and also the location.

As a result, a new process was agreed – Partnership Reduction of Exploitation and Missing (PREM) which will put the onus on each local authority to gatekeep cases, which will give back a number of hours back to partners and ensure a multi-agency problem solving meeting to work together to reduce risk, tackle perpetrators and disrupt hot spot locations. The PREM meeting will be chaired by a Detective Inspector from the Prevention Department, Northumbria Police to ensure a corporate and consistent approach. Following agreement to proceed on this basis in June 2024, a roadshow, training and raising awareness with partners will be undertaken in summer 2024 before the new process is launched in the autumn of 2024. The impact of this new process will be monitored at a strategic level.

The new process will be monitored at a strategic level.

Northeast and North Cumbria ICB (NENC ICB)

Following a Government announcement on March 13th NENC ICB are undergoing a further restructure to reduce running costs and make efficiency savings. The previous restructure completed in April 2024 saw the introduction to the Safeguarding Adults Team of a Deputy Designated nurse role and a change to the Safeguarding nurses to become all age Safeguarding Specialist Practitioners to promote skill mix and succession planning.

Newcastle Gateshead Local Delivery Team is managed under the umbrella of the larger organisation. Delivery Teams and the Safeguarding Teams in each local delivery area report to the NENC ICB's Safeguarding Executive meeting which is chaired by the Executive Chief Nurse, facilitating an assurance and escalation process for safeguarding issues across the NENC ICB.

During this current restructure the Team will continue to support the delivery of the NENC ICB strategic priorities of:

- Longer and healthier lives
- Fairer outcomes for all
- Better health and care services
- Giving Children and Young People the best start in life

The Key Areas of Learning for Safeguarding, Domestic Abuse, Self-Neglect, Transitional Safeguarding and Children in Care, align us to delivery of the strategic plan of Gateshead Safeguarding Adults Board working with multiagency partners.

Strengthening Safeguarding

The NENC ICB remain committed to supporting multiagency training and education, participating in the Learning and Development Group and dissemination of learning from Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs), seeking assurance from commissioned services regarding recommendations and outcomes. More recently the multi-agency partnership working has extended to Public Health colleagues with appreciative enquiry to highlight areas of good practice and further develop services to meet the needs of the increasing vulnerable population and Making Safeguarding Personal.

Recent case reviews have highlighted the importance of working with multi- agency partners including Tyne & Wear Fire and Rescue Service (TWFRS) and Department for Work and Pensions (DWP) where information has been disseminated and changes made to improve services following recommendations from reviews.

There has been significant work carried out to improve cross border working particularly where health (including mental health) and social care providers are from different areas, which makes communication more challenging, but essential to provide better health care services and improve outcomes.

Following the Independent Thematic Review commissioned by GSAB into a care provider, the NENC ICB have been a key partner in contributing to the report, recommendations and actions. Information has been disseminated to General Practice (GP), Quality and Continuing Health Care Teams. GP training has been delivered by the Named GP for Safeguarding and Designated Nurse to ensure safeguarding concerns are raised and escalated appropriately; particularly where organisational issues are highlighted. The NENC ICB are supporting with development of tools and processes to ensure that agencies have clear guidance.

The NENC ICB Safeguarding Team support the Named GPs with online and face to face training for Primary Care staff to promote good practice from case review recommendations, sharing learning and developing easily accessible resources. Further support for individual practices is provided on a case-by-case basis where there are complex needs and/ or multiagency working. One of the Named GPs has been involved with the 'Make a Change' programme, which is a community-wide, early response approach to people who are concerned that they are using harmful behaviours in their intimate, or previously intimate, relationships. Training has been delivered, and primary care have been supported by the Named GP in identifying and referring patients to this programme.

The NENC ICB safeguarding team support the Local Authority safeguarding team with complex cases involving health issues and have been an integral part in the development of a Section 42 Closure process following death, where consideration is given to an individual's health concerns being considered as part of a wider safeguarding enquiry.

Learning and Development

NENC ICB Exploitation Nurse raises awareness of exploitation and modern slavery, delivers training sessions and facilitates health support into modern slavery operations led by the Police.

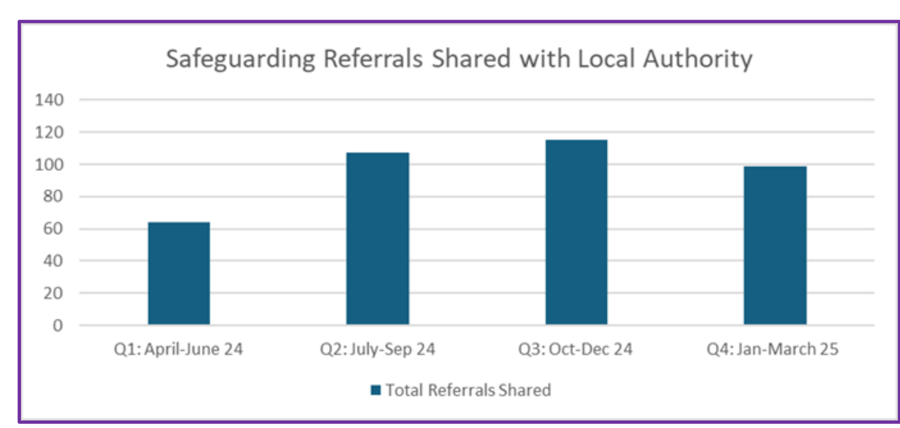
The NENC ICB safeguarding team discharges its duty to collaborate supporting and contributing to multiagency working including supporting asylum seekers, hate crime prevention, Prevent, Community Safety Partnerships and the Local Domestic Abuse Partnership Board. Safeguarding Adults Week 2024 was promoted across the NENC ICB highlighting themes and raising awareness.

Gateshead Health NHS Foundation Trust (GHNFT)

Gateshead Health NHS Foundation Trust (GHNFT) is committed to ensuring safeguarding is part of its core business and recognises that safeguarding young people and adults at risk is a shared responsibility with the need for effective joint working between partner agencies and professionals.

We recognise that safeguarding can be complex and challenging, and we strive to ensure our service reflects the trusts ICORE values by being Innovative, caring, open and honest, respectful, and engaging with our patients, families, partners and staff. We continue to respond and support staff in ensuring a high-quality safeguarding service for the Trust.

As a Trust we continue to see a significant increase in complex safeguarding activity in both acute and community settings. A total of 1170 safeguarding concerns have been raised between April 2024-March 2025, mainly in relation to neglect, self-neglect, domestic abuse, physical and financial abuse.



Working in partnership and strengthening relationships with our partners remains an important part of the teams work with complex safeguarding cases including self-neglect, hoarding, capacity, substance misuse and complex health needs. The team continue to play an active role and contribute to various multi-agency meetings, Safeguarding Adult Reviews, MARAC, MAPPA and Domestic Abuse related Death Reviews. Focusing on Sharing any learning and implementing any recommendations made, which is vital in continuing to improve safeguarding practice within the Trust.

The Trust continues to raise awareness of the application of the Mental Capacity Act. The Trust has continued to recognise the challenges in the use of the Mental Capacity Act.

The Mental health Legislation service within the Safeguarding Adults team works to ensure that professionals are working in accordance with legislation and ensuring patient safeguards are met by educating staff on the legal frameworks of the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), and the Mental Health Act (MHA). The team supports practice with the provision of training, advice, support, and policies, to ensure the rights of our patients are supported and upheld.

As a Trust we are continuing to see a significant increase in the number of Deprivation of Liberty Safeguards. A total of 1084 DoLS applications were received between April 2024-March 2025.

The Trust have continued to focus on increasing the safeguarding compliance and ensuring that all staff are assigned to the appropriate level of training. Focusing on level 3 safeguarding, prevent, MCA, and domestic abuse training. Additionally, looking at face to face training sessions working in partnership with the children's safeguarding team. The team also deliver safeguarding training as part of the multi-agency training programme.

GHFT Case Study

This case study is in relation to a 71-year-old female victim of domestic abuse (Adult X), the perpetrator being her 71-year-old husband (Adult Y).

Background

Safeguarding (SG) office received a call from ward asking for advice re: domestic abuse disclosure. Adult X had been a patient for 3 weeks with:

- Leg/hip pain and reduced mobility
- A fall at home 5 weeks earlier had resulted in a wrist injury, a further fall whilst in hospital resulted in an injury to her other wrist which required treatment

Adult X unexpectedly disclosed domestic abuse to an OT during an assessment and stated she wanted to leave her home and her husband. She stated she would like to be re-housed by the Local Authority (LA), she disclosed abuse as:

- Emotional – isolated from friends/family by Adult Y's behaviour towards them
- Controlling – Adult Y refused carers for either of them 'wife can look after me'
- Physical attacks – pushing (historic)
- Verbally aggressive

SG Plan

SG staff visited Adult X and carried out a DASH risk assessment, with a medium risk score of 11 with no red flags to escalate to high risk. Staff contacted LA Housing, Domestic Abuse Housing Officer who carried out an assessment with Adult X. The Housing Officer discovered Adult X was sole named tenant of her current property. The Housing Officer explained that Adult X could have Adult Y removed and he would be eligible to be re-housed.

During LA Housing assessment with Adult X, Adult Y was admitted to ward for 'alcohol dependence/gastro problems/peg feed/stoma'. Both were now in hospital on different wards. Adult Y was not due to be discharged but when enquires made it was discovered he would have been made homeless on discharge as Adult X would have enacted her plan to have him removed with support from LA Housing from their current home. Adult X was aware that Adult Y had been admitted to hospital and confirmed she still wanted him removed from the property of which she was the sole tenant.

Next steps

SG staff and LA Housing Officer agreed it would be appropriate to have separate housing officers for both adults to avoid any conflict of interest. The following steps were taken:

- Adult Y was told that his Adult X did not want him to return to their home. The Ward Matron supported with this potential difficult situation. Adult Y accepted the situation, and he was assigned a LA Housing Officer, an initial appointment was arranged to explore the options available to him.
- All ward staff were updated during every stage of the decision making process. With consent from both Adult X and Adult Y ward staff were able to update family, who were calling regarding ongoing treatment and discharge plans, of the decisions made by Adult X and Adult Y and the next steps.

Outcome

Adult Y cancelled his appointment with LA Housing Officer as the couple had reconciled. A Safeguarding referral made to the LA to support both Adults on discharge and to ensure appropriate discharge plans were implemented.

Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust (CNTW)

Key achievements

Recruitment to Named Professional roles has been successful, with 2 Named Professionals and 1 Named Nurse now in post. allowing for improved safeguarding oversight and support to CNTW services but also creating capacity for greater involvement and interfacing with locality SAB/CSP subgroups, task and finish groups and joint initiatives.

A dedicated Safeguarding Dashboard has been developed and is in the final stages of review prior to going live. This will allow the organisation to monitor and review safeguarding information, to identify trends and learning, to better support safeguarding practice at a strategic and operational level.

CNTW Trust Quality and Safety priorities for 2025 – 2026 have a focus on; reducing incidents of Violence and Aggression, reducing Restrictive Practice, reducing incidents of Self Harm and suicide and improving Physical Health care. Safeguarding leads have membership of the working groups to ensure action plans and service/practice developments are considered through a Safeguarding lens.

Good practice

The Patient Safety Incident Response Framework (PSIRF) continues to embed across the organisation, fostering a culture of learning and continuous improvement. Internally, this has led to more compassionate responses to incidents, improved staff engagement, and greater transparency in learning processes. Externally, partners benefit from enhanced collaboration, increased trust, and assurance that the organisation is committed to delivering safer, more responsive care. In line with this framework incident reporting and review systems ensure that the classification of incidents retains relevant safeguarding information, to enable incidents to be reviewed, clinicians supported, and patients safeguarded.

Domestic Abuse awareness sessions have been provided to teams Trustwide. Training is reflective of local DHR/DARDR learning.

A Trustwide weekly question was developed to assess and improve domestic abuse awareness. This was an automatic pop up on accessing the trust intranet and included links to further information, briefings and policy. 84.45% of the Trust workforce demonstrated a robust understanding of Domestic Abuse and the appropriate actions to take to safeguard victims, with a further 7.92% identifying that they would seek appropriate advice and guidance from the SAPP team.

Working with Partners

The internal MARAC admin process has been reviewed and increased admin support is in place for SAPP practitioners, to ensure a robust and timely response to MARAC concerns and referrals.

The CNTW Clinical Police Liaison Lead has worked collaboratively with the Northumbria Police Mental Health Lead to improve multi agency awareness and processes in the context of criminal investigations and mental health. They will be presenting this valuable work at the National Police Chief and College of Policing Mental health and Policing Conference on 26th June 2025.

The CNTW Safeguarding and Public Protection PREVENT lead, Nigel Atkinson, has been recognised with a Head of Department Commendation by the Head of Prevent. This award has been presented in recognition of his valuable support to Counter Terrorism Policing in the Northeast, his participation in Channel and Police Led Panels and the vital support he has offered to vulnerable suspects whilst in custody.

Making Safeguarding Personal (MSP)

MSP information, including a 7-minute briefing, guidance and good practice examples have been circulated via the Trustwide Bulletin. The information is readily available on the Trust intranet and is referred to during Safeguarding supervisions where appropriate. A “My Personal Safeguarding” framework is consistently utilised by clinical staff when responding to and exploring safeguarding incidents or concerns, to support referrals to Local Authority Safeguarding services.

Safeguarding Adults and Children Level 3 training is mandatory for all qualified clinical staff. The training package is reviewed and updated regularly. It includes information and guidance relating to Making Safeguarding Personal.

In 2024 CNTW launched a new service user and carer experience survey: "The ultimate aim is that people have a voice, and we hear that voice". The survey was co-developed with almost 300 people, half of who were service users. The survey questions reflect what the group told us were the most important themes. The survey is now more accessible and can be received in by email, text, letter, printed copy, and on-demand online. Speech and Language Therapy and other colleagues worked with the group to make the questions as accessible as possible.

Safeguarding priorities or developments for the coming year

There are sustained increases in Safeguard reporting within the organisation. Focused work will review the triage functions capacity to review all safeguarding incidents and the quality and consistency of the triage advice offered.

Further work is to be undertaken to support accurate safeguarding reporting and data capture, to better inform CNTW and external partners of our Safeguarding activity and allow targeted improvement work to take place.

CNTW continue to be committed to working collaboratively with partnership boards to identify and dynamically respond to learning and areas of development, highlighted through DHR/DARDR/CSPR/case reviews. Work is ongoing to review representation at Boards and Partnerships to support greater consistency and improve attendance.

The Trust Wide SAPP group attendance and structure is being reviewed and will in future include the Nominated Representative from the NENC ICB, which will improve strategic alignment, enhance multi-agency collaboration, and strengthen the consistency and quality of safeguarding practices across the system.

Claire Andre receives Commendation from Northumbria Police

Claire Andre, the Trust’s Clinical Police Liaison Lead, has been presented with a commendation from Northumbria Police for her dedication, hard work and support on the rollout of the new “Right Care, Right Person” approach.

Claire has been instrumental in the Trust’s preparation for the roll-out of this new approach by the Police, working closely with local forces and CNTW teams affected by the changes. Claire has prepared guidance and documentation attended regular incident reviews meetings, provided valuable advice and support to staff and ran regular training webinars.

The certificate was presented by Assistant Chief Constable Alderson from Northumbria Police.

South Tyneside and Sunderland NHS Foundation Trust (STSFT)

Key Achievements

The safeguarding team continues to work closely with multi-agency partners to protect adults at risk and share learning. In 2024/25, the focus was on insights from SARs, DARDRs, and DHRs, covering topics such as professional curiosity, trauma-informed practice, MSP, self-neglect, and mental capacity. Key messages were shared via forums, newsletters, briefings, and governance meetings.

Safeguarding supervision has been reviewed to adopt a "Think Family" approach, clarifying staff responsibilities and available support. The team maintained core functions including advice, supervision, training, and a visible presence across wards and departments. In total, STSFT staff submitted 1,801 safeguarding referrals during the year.

Learning and Development

Safeguarding Adult training has been reviewed to align with national guidance and learning from SARs. STSFT adopted the national e-learning package for Levels 1 and 2, while Level 3 "Think Family" training continues via hybrid delivery. Interactive tools like Slido support real-time feedback, and staff remain compliant across all training levels.

MCA training is well embedded, with a refresher module focused on practical application. Additional CPD packages are available 24/7 via the internal repository, covering complex topics such as executive dysfunction, domestic abuse and mental capacity, and diabetes. The diabetes package was recognised nationally and is now hosted on the NHS Futures platform.

The DoLS Team continues to support compliance through daily monitoring tools and ward-based training. Bespoke presentations help staff complete MCA and DoLS forms accurately using the Electronic Patient Record System.

Staff are further supported through the Mental Capacity Good Practice Forum, which promotes learning from case law and shares best practice. The MCA Lead represents STSFT nationally and has established a support group for health sector MCA leads.

Using the NHS England self-assessment tool, the team identified areas for improvement, including involving people with lived experience. In response, a training video was developed with Twisting Ducks Theatre to support staff working with adults with learning disabilities in maternity care.

A service evaluation is underway with former patients who experienced delirium, alongside input from families. Staff engagement continues through podcast interviews, including one highlighting the challenges faced by internationally recruited nurses in applying MCA legislation.

Working with Partners

Senior staff continue to represent the Trust at Safeguarding Adult Boards. Safeguarding Team continue to be active members of local partnerships ensuring representation and contribution across all sub-group meetings. The Safeguarding Team are active participants within the Complex Adult Risk Management (CARM) meetings within the Sunderland and South Tyneside locality and are a central point of contact for the Sunderland MASH Health Navigator.

The team continues to promote MCA practice through presentations at conferences and bespoke training across clinical areas. Collaboration with CNTW’s Psychiatric Liaison Team supports understanding of the interface between mental health and capacity legislation.

Audit remains central to improving practice. Internal audits have led to enhancements in assessment forms and the introduction of masterclass sessions. External audits by Audit One rated our DoLS and MCA processes positively, with clear action plans.

Work to improve MCA compliance in paediatric services for 16–17-year-olds included audits, policy updates, and tailored training. Changes to the Electronic Patient Record System now prompt assessments, and this work has been shared at conferences.

We’ve also developed podcasts to promote MCA in practice, including one featuring an internationally trained nurse discussing legal framework challenges.

Domestic Abuse Health Advocates (DAHAs), in partnership with the safeguarding team, continue to support staff in recognising and responding to disclosures of domestic abuse across wards, ED, maternity, and community settings. Increased visibility has led to a rise in referrals. In 2024, the Trust achieved White Ribbon accreditation.

The safeguarding intranet page is regularly updated, now featuring a dedicated section on sexual violence to ensure staff have 24/7 access to relevant guidance and support.

Recent DAHA feedback from patients include:

"You supported me throughout my first days here and also my very worst days at rock bottom when I was in so much pain. I'll never know how to thank you. Your work has made me safe again - something I thought was unimaginable".

"It's rare to experience a professional who listens to you and who empathises. You considered every thought and feeling I had - even if the next was the opposite of the last".

"Please never ever lose the passion and drive you have for your job and simply to help people like me! (Although never simple!)'"

"You are part of the reason I have been protected and I don't know how to ever thank you for that. Your job makes a difference to people in so many ways, I'm sure you already knew that! Thank you so much for your hard work and support this week".

"Thank you for fighting for me and keeping me safe".

Good Practice

The STSFT Safeguarding Team won the Trust's Corporate Team of the Year award and achieved White Ribbon accreditation in 2024, with several ambassadors and champions across the organisation.

The Trust launched the NHS Sexual Safety Charter, reinforcing a zero-tolerance approach to sexual misconduct. A dedicated sexual violence section has been added to the safeguarding intranet for staff support.

The 2024/25 safeguarding audit cycle included reviews of Emergency Department (ED) attendance, policy compliance, self-neglect guidance, and chaperone policy. Daily ED audits continue to identify missed safeguarding opportunities, with findings discussed at Clinical Governance meetings.

Staff access to safeguarding support has increased through enhanced ward presence, including daily attendance at ED huddles and Paediatric ED.

Safeguarding link forums and bi-monthly newsletters continue to share key learning, training opportunities, and briefings from SARs, CSPRs, DHRs, and DARDRs. In 2024/25, learning was shared from cases including Child S, Child C & D, SAR Joseph, and others.

Topics covered included trauma-informed practice, mental capacity, self-neglect, professional curiosity, extremism, knife crime, and substance misuse. The safeguarding intranet page remains a central resource, with positive feedback received from staff on the usefulness of the content.

Making Safeguarding Personal

STSFT safeguarding team continue to contribute to both National and local safeguarding campaigns. These include:

Successful roll out of events to celebrate Safeguarding Adults/ Learners Week 2024, the key theme was ‘Working in Partnership” A robust programme of activity and training sessions shared with staff and partners. Safeguarding stalls were set up in acute trust sites to raise safeguarding awareness with staff and patients.

As part of “Think family” the team participated in knife crime awareness 2024. This week-long initiative aims to shed light on the detrimental effects of knife crime while providing educational resources about its risks and consequences. A hot topic session was organised which was delivered by the Education Liaison Officer at Northumbria VRU.

On White Ribbon Day 2024, the DAHA team were visible in the hospital to raise awareness of domestic abuse with front line staff and patients.

Tyne and Wear Fire and Rescue Service (TWFRS)

Strengthening Safeguarding and Learning and Development

In 2024, TWFRS changed its safeguarding reporting system to improve the quality, administration, and speed of referrals to LAs across our region, including Gateshead. This work was done in collaboration with our software partner, CIVICA, over nine months, and recent internal evaluation has been overwhelmingly positive, with other Fire and Rescue Services across the country, looking to learn from the system we have created.

To ensure that the quality of referrals improve, and to embrace Making Safeguarding Personal, we worked closely with local safeguarding business managers, especially Catherine Hardman, GSAB Business Manager.

This change in procedure gave us the opportunity to deliver safeguarding training around thresholds and “Safeguarding v safeguarding” to all operational firefighters, and other frontline staff, in a concentrated period during the summer.

Alongside this technical change, we have created a Safeguarding Adults information leaflet, for frontline staff to offer the individuals they are concerned about, demystifying the process, and give frontline staff the support to engage in conversations about safeguarding, inline with MSP.

Case Study - Best Practice in Multi-Agency Support for Self-Neglect and Hoarding
District: West P&E
Date: August–December 2024

In August 2024, Tyne and Wear Fire and Rescue Service (TWFRS) responded to a referral from Community Nursing about significant self-neglect and hoarding concerns. Within three days, a Safe & Well visit was conducted, and a safeguarding concern was raised.

The case quickly progressed to a multi-agency meeting, involving Adult Social Care, Environmental Health, and NHS partners. Collaborative site visits and safeguarding meetings led to swift actions, including a proposed prohibition order, essential repairs, and urgent care planning.

Challenges included financial barriers to clearing the property, the adult's reluctance to be open with family members about the difficulties he faced following family trauma, and a lack of immediate temporary accommodation.

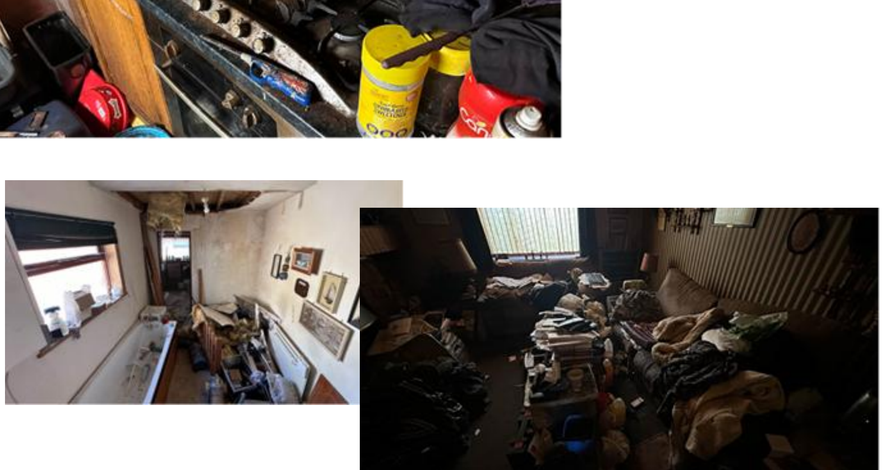
Solutions included placing a legal charge on the property to recover costs, referring to Citizens Advice for benefit maximisation, and temporary arrangements with family before the individual moved into respite care for further assessment.

Outcome:

The individual was back home before Christmas 2024, following substantial repairs and a deep clean. Family relationships were re-established, and the person received appropriate care throughout.

Key Learning:

- Early and coordinated intervention leads to effective outcomes.
- Understanding partner roles strengthens future joint responses.
- This case exemplifies the value of proactive, respectful, and holistic multi-agency collaboration in supporting vulnerable adults.
- Sometimes pushing the button on radical action is the best option.



South Tyneside & Gateshead Probation Service

Learning and Development

Within Probation we continue to ensure all staff complete regular safeguarding training with the expectation this is refreshed every three years. In addition, staff are encouraged to engaged in wider multi agency training to improve both knowledge and networking with other agencies. In 2024-25 we have been focusing on Professional Registration for Probation Officers which includes attendance at face-to-face adult and child safeguarding events to ensure a culture of continuous professional learning is promoted and staff are aware of current practice and process. We also use learning from Safeguarding Adult Reviews to improve our service delivery.

Strengthening Safeguarding

Our staff are improving their knowledge of trauma informed practise and using this to support the individuals they work with. This year has also seen an improved focus on supporting those with increased levels of self-harm and suicidal ideation through the development of an individual safety plan to be completed with those at risk to ensure we are keeping people safe.

Prevention

We continue to work closely and collaboratively with partnership agencies to address issues around domestic abuse and deliver interventions in both a group and one to one format with the aim of reducing further offending.

Involvement and Engagement

Within Probation we use peoples lived experience to support our service delivery and promote new ideas and change. We currently have an established Engaging People on Probation Forum which runs quarterly.

Preventing victims by changing lives

Connected Voice

Connected Voice has continued to provide advocacy to people in vulnerable situations to prevent formal safeguarding procedures. We track data on the number of people supported, the types of problems they have. We have delivered training to people to help keep themselves safe through Self Advocacy skills. We have engaged people in research. We have continued to deliver specialist advocacy to people targeted for their characteristics and refuges and asylum seekers.

We have contributed to the annual plan by:

Learning and Development

Delivered training to VCSE on:

- Role of advocacy in safeguarding
- Introduction to Safeguarding
- Adult Safeguarding Essentials
- Intro to children and young people safeguarding
- Hate Crime and Anti-social behaviour strategies for frontline workers
- SAFE research project

Prevention

- Advocacy to avoid Section 42 referrals from people in vulnerable situations to empower and support them.
- Stall to raise awareness of non-statutory advocacy offer in Safeguarding Adults Week in Gateshead
- Social media campaign for Safeguarding Adults week
- Direct support to victims of hate crime (up to 120 per year)
- Attendance at Gateshead Hate Crime and Community Tension Group to share local intelligence and strategies to reduce impact of hate on community
- Attendance at joint Engagement Groups in summer 2024 following civil unrest and racial tensions

Involvement in Hate Crime awareness films by students at Sunderland University and Police and Crime Commissioner

- Hate Crime Advocacy | Connected Voice
- Development of HATE ID app with Northumbria and Durham universities as a result of long-term research on Hate Relationships:
- Researchers collaborate on new app to improve support for hate incident victims - Durham University
- Read the first research report, Exploring 'hate relationships' through Connected Voice's Hate Crime Advocacy Service
- Read the second research report, Improving responses to Hate Relationships or read a short summary of the report here.

Your Voice Counts

During 2024/2025 Your Voice Counts (YVC) provided independent advocacy services to over 900 people in Gateshead, supporting 938 referrals for IMCA, Care Act, RPR and NHS complaints advocacy. We've worked to make these services as accessible and welcoming as possible, helping people to understand and speak up for their rights and supporting effective Safeguarding Adults procedures.

Promoting Advocacy and Raising Standards Through Training and Awareness Raising

We've continued to raise awareness of advocacy in very practical ways - through conversations, training, and support to professionals who need to make referrals. This includes 1:1 support and tailored briefings to help people feel confident about when and how to involve an advocate, particularly in safeguarding situations.

We've also spent time making sure our wider messages land well - through regular blogs and social media to support national and local campaigns and events including Safeguarding Adults Week, Hoarding Awareness Week and Advocacy Awareness Week. We believe that raising awareness helps people speak up and knowing where to go for help is key to getting the right support early.

We've built up a library of plain-language tools and guides that are accessible to everyone, from carers and families to frontline professionals. These cover a range of topics such as 'Understanding safeguarding' and 'How advocates support you in safeguarding meetings' as well as a new set of self-neglect resources which we developed to respond to local need and in partnership with wider safeguarding awareness work.

Our focus remains on helping people see advocacy not just as a service of last resort, but as something that can make a big difference early on - supporting people's rights, preventing harm, and making sure their voice is heard when it matters most.

Using Data to Drive Action

We've built safeguarding into our everyday monitoring - not just tracking referrals but looking at patterns and trends. We now produce a quarterly safeguarding summary that helps us notice repeat concerns, and where needed, share this insight with the Safeguarding Adults Board or commissioners.

We've also built better ways to show how advocates are protecting the person's voice, including where we've raised concerns ourselves. This means our safeguarding data isn't just stored - it's used. It's become part of how we reflect on quality and make improvements in real time.

Working in Partnership and Strategic Engagement

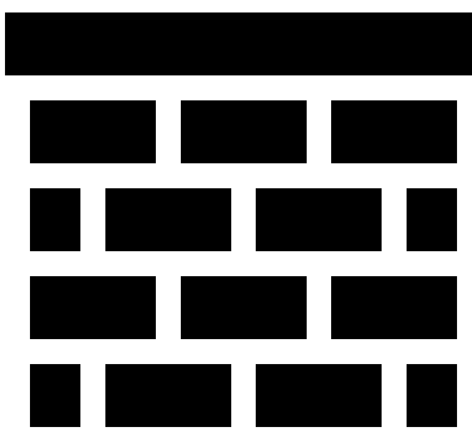
We remain active members of the Safeguarding Adults Boards in Gateshead, Newcastle, and South Tyneside. Our team takes part in working groups and development sessions, feeding in what we learn from advocacy practice and hearing directly from people who use services.

We've also continued to contribute nationally through the Leaders in Advocacy group and other forums - sharing what we're learning locally and helping shape conversations about access to advocacy and good safeguarding practice.

We're proud to play a part in the wider safeguarding landscape. Our focus this year has been on embedding advocacy into everyday safeguarding work - so that people aren't just protected, but involved, empowered, and supported to make choices that work for them

Visit www.yvc.org.uk/advocacy for more information about Your Voice Counts or to make a referral.

Appendix 2 – SWOT Analysis

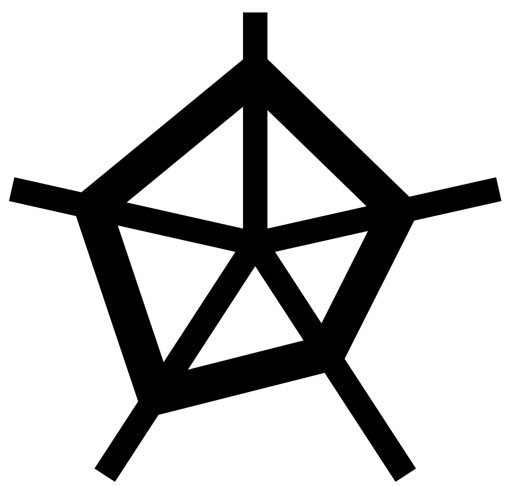


Strengths:

- Continued strength in governance and collaboration across the partnership.
- Board meetings were well attended with active and meaningful participation from all members.
- Clear and sustained commitment to improving safeguarding practices.
- Enhanced website now offers accessible resources and training opportunities.
- The partnership is guided by a robust and clearly defined strategic plan.
- Progress is underway toward developing a multi-agency dashboard to monitor performance.
- Strategic-level communication remains excellent, enabling strong coordination and shared understanding across agencies.
- Partners and the independent chair have provided constructive challenge, ensuring accountability and continuous improvement.
- Members are respected, their voices heard, and their contributions valued.
- Overall, the partnership reflects strength, cohesion, and a culture of continuous improvement.

Weaknesses:

- Progress has been made, but several areas still need attention to strengthen the Board's impact and effectiveness.
- Analysis of demand and need remains fragmented:
  - Power BI data requires better integration and interpretation.
- Public awareness of the Board's role and function needs to be improved.
- Assurance mechanisms must be strengthened to:
  - Evidence learning from Safeguarding Adult Reviews (SARs).
  - Show how learning is disseminated and its impact on practice and systems.
- Better gap analysis is needed between partners, especially for:
  - Complex issues such as hoarding and self-neglect.
  - Evaluating initiatives like "Right Care, Right Person" in Gateshead.
- Service user engagement should be more effectively used to inform learning outcomes and training development.
- Ongoing concerns around provider assurance:
  - The Decision-Making Tool needs revision.
  - Wider adoption is required across commissioning, regulatory, and provider bodies.
- There is no formal induction process for new Board members.
- Representation of large organisations across multiple areas needs to be addressed to ensure:



Opportunities

- Training resources are being reshaped to focus on:
    - Practical, practitioner-led learning.
    - 7-minute briefings.
    - Multi-agency training using pooled partner resources.
- Data collection and analysis improvements are underway, and a newly formed Data Group supports partners in understanding how trends influence practice and service delivery.
- Increased emphasis on promoting good practice more visibly and making the SAB Annual Report more accessible to the public, including a shortened summary version.
- Ongoing work includes:
    - Developing a fully embedded Multi-Agency Safeguarding Hub (MASH).
    - Advancing proposals around the Multi-Agency Risk Management (MARM) framework.
    - Encouraging joint working and partnership approaches, such as the Blue Light project.
- Assurance processes are under review to focus on learning from SAR recommendations and identifying and addressing barriers to implementation.
- Provider assurance improvements needed to revise and promote the Decision-Making Tool and ensuring adoption across commissioning, regulatory, and provider networks.
- Additional areas being addressed the lack of an induction for new Board members. Representation from large organisations across multiple areas to strengthen engagement and feedback mechanisms.

Threats

- The partnership continues to face rising volumes of safeguarding concerns, placing pressure on services and increasing the risk of missed issues.
- There remains a misconception that Section 42 enquiries can resolve complex, multi-need cases, highlighting the need for broader, integrated responses.
- Preventative approaches lack mechanisms for reporting outcomes, and safeguarding prevention activity risks being deprioritized due to competing demands on staff.
- The nature of safeguarding is evolving, with increasing complexity and intersectionality involving mental health, substance misuse, exploitation, and criminal justice.
- Attendance at Board and sub-group meetings has been affected by service pressures, and partnership funding arrangements are impacting the Board's ability to deliver on priorities.
- Dissemination of information within GSAB partner organisations is inconsistent, and limited investment in training and sharing good practice may lead to misinformation and inappropriate referrals.
- There is also a need to adapt to changes in government focus, funding, and statutory responsibilities.
- Multiple reporting systems exist, but low-level concerns often lack sufficient attention.
- A shared understanding of how to review culture in care settings is essential to drive improvement and assurance.