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**2023-2024 Annual Report**

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**1****. FOREWORD**

1.1 I am pleased to introduce the South Tyneside Safeguarding Adults Annual Report which covers the period April 2023 to March 2024. The Care Act requires us to set out our strategic aims which were revised and updated during the year. This annual report celebrates our achievements, highlights our challenges, and provides updates on progress made against these aims and supporting priorities.

1.2 This report provides evidence that good progress has been made, delivered through a planned programme of work ensuring that we continue to meet our statutory duties. We have strengthened our approach to communication and engagement, supporting partners in offering training, multi-agency safeguarding resources and opportunities for learning and reflection through Safeguarding Adults Reviews. We are also developing new approaches to seek feedback on the lived experience of individuals that have been through the safeguarding process and will continue to build on this work over the next twelve months e.g. strengthened links with the voluntary sector, an improved advocacy offer, and use of audits to understand the current position.

1.3 Services across South Tyneside continue to operate under significant pressure; the challenges brought about by the cost-of-living crisis, continued demographic changes and other external factors all contribute to this sustained demand and the increased number of referrals (identified in this report). Going forward the Board will seek to understand these increases in terms of data quality and gaps in commissioning. The work ongoing to introduce a Multi-Agency Safeguarding Hub (MASH) and Complex Adult Risk Management (CARM) process for adults will also seek to reduce referrals through early intervention and problem solving.  Our partners continue to deliver personalised and person-centred services to the residents of South Tyneside despite the pressures brought about by external influences. I would like to take this opportunity to thank them for their commitment to working together to keep people safe during these difficult times.

1.4 There have been changes to key personnel within partner agencies during the year; despite these changes’ commitment to adult safeguarding within partner agencies remains a high priority. This report also identifies some partners who need to be more visible at partnership arrangements going forward, and as Independent Chair I will improve attendance over the next twelve months. We continue to build on our approach to seeking assurance from partner agencies on their safeguarding arrangements and I am grateful to them for sharing their successes and challenges with the board. This has helped to ensure that we learn from one another; build on good practice as well as understanding any risks along with mitigating actions.

1.5 Partners continue to support the process of learning and improvement obtained through the Safeguarding Adult Review (SAR) process. This report highlights information on the three safeguarding adult referrals which met the threshold for review, the subsequent thematic review which took place and how the learning and development from this review was delivered across our partnership. An excellent piece of work!

1.6 Looking ahead for 2024/2025 this report clearly outlines our intentions as a board for the coming twelve months. The programme of work is both challenging and achievable and will improve the services delivered to vulnerable adults across South Tyneside. I look forward to working with the South Tyneside Safeguarding Adults Business Manager, the wider team and board members to continue to deliver on our aims, priorities while driving improvement and ensuring safeguarding arrangements are effective across South Tyneside. If you have any suggestions about how we can improve this report, please contact the Business Unit:

**Telephone No:** 0191 424 6512

**Email:** [STSCAP@southtyneside.gov.uk](mailto:STSCAP@southtyneside.gov.uk)

**Stephen Chapman – Independent Chair**

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**2. INTRODUCTION**

2.1 In September 2023 partners agreed to have a separate Safeguarding Adults Board. The recruitment of the Independent Chair Mr Stephen Chapman was made in November 2023. The rationale for separate arrangements was because from a national and local perspective it was becoming more evident that there was a need to have a more aligned approach to the safeguarding adult’s agenda with a particular focus on the following;

* The introduction of the Adults Assurance Framework. TheCQC will undertake reviews and assess how local authorities are delivering their Care Act functions.
* The impact on safeguarding adults with the police initiative of introducing Right Care Right Person. This will ensure people who call the police get the best support and service as the police are being asked to attend situations where people are in a mental health crisis but there is no crime which is detracting the Police from their key role.
* The evaluation and recommendations for the Local Government Association, LGA peer review which examined the safeguarding arrangements through an adult safeguarding lens.

2.2 Prior to September 2023 there was a collaborative safeguarding partnership with adults and children. The collective Partnership arrangements aimed to strengthen the Think Family model across South Tyneside. At the time the Partnership had agreed three strategic priorities:

2.3 The impact on these priorities both as a joint partnership and a SAB are outlined in this report.

**3. THE SAFEGUARDING ADULTS BOARD PURPOSE & STRUCTURE**

3.1 The Care Act 2014 requires a local authority to establish a Safeguarding Adults Board (SAB), which aims to help and protect individuals who it believes to have care and support needs and who are at risk of neglect and abuse and are unable to protect themselves, and to promote their wellbeing.

3.2 The SAB is a multi-agency partnership which has statutory functions under the Care Act 2014. The main focus of the Board is to ensure that safeguarding arrangements work effectively in South Tyneside so that adults at risk are able to live their lives free from abuse or neglect.

3.3 SABs have three core duties – they **MUST:**

3.4 The work of the SAB is underpinned by the Care Act’s six key principles of safeguarding:

**4. WHAT IS SAFEGUARDING?**

4.1 Safeguarding means protecting a person’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent both the risks and experience of abuse or neglect, while at the same time making sure that the individual’s wellbeing is promoted and supporting people in making informed decisions.

4.2 Section 42 of the [Care Act 2014](http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted) requires that each local authority must make enquiries (or cause others to do so) if it believes an adult is experiencing, or is at risk of, abuse or neglect.

4.3 Safeguarding adult duties apply to an adult who:

Has care and support needs (whether the Local Authority is meeting any of those needs)

As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Is experiencing, or at risk of experiencing abuse or neglect.

**5. WHO CAN RAISE A SAFEGUARDING CONCERN?**

5.1 Anyone can raise a concern about an adult with care and support needs who is at risk of abuse or neglect.This may be family or friend, a carer, a professional working with adults with care and support needs or somebody who thinks they have been abused. It may even be a tradesperson or a member of the public seeing something in a health/care setting or home.Alternatively, if a person has contacted other professionals (such as the police, health services or voluntary organisations) and there is concern that abuse is taking place, those agencies can also raise a concern.

5.2 Information on how to raise a concern is a key feature on the SAB website pages, safeguarding adults’ literature, features within all the multi-agency safeguarding training and is outlined on the online safeguarding adults’ policies and procedures site.

5.3 **HOW TO REPORT ABUSE OF AN ADULT IN SOUTH TYNESIDE**

Call 999 if you are reporting a crime that is in progress or if someone is in immediate danger. If you think someone is at risk or is being abused, you should report it to South Tyneside Council;

0191 4246000

Mondy to Thursday 8.30am to 5pm

Friday 8.30am to 4.30pm

0191 456 2093 Outside of the above office hours

If you are a professional, you can report concerns using the [Safeguarding Adults Referral Form](https://www.southtynesidesafeguardingappp.co.uk/resources/forms-leaflets-and-posters/#forms)

**6. MAKING SAFEGUARDING PERSONAL (MSP)**

6.1 Making Safeguarding Personal (MSP) remains a core objective for the SAB as it was for the collaborative Safeguarding Partnership. MSP is incorporated within the strategic plan and all subgroup activity. As a SAB there is a continued commitment to achieve person-led and strengths based frontline practice, across all agencies. Fundamental to its role, the SAB continues to promote the principles of MSP through its communications, quality assurance measures, and learning and development. From a workforce development perspective, the principles of MSP continue to be embedded in all learning packages. The emphasis being on the importance of person led interventions to achieve desired outcomes.MSP will continue to be a focus across the work of the SAB.

6.2 One indicator of the improvement in MSP is highlighted within the Performance data for 2023 -24. The percentage of people being asked what their desired outcome would be for MSP outcome increased to 92%, in 2023-24 compared to 87% in the previous year. Likewise of the people who provided a response to the MSP question, 97% believed their outcome was either fully or partly achieved. 3% believed their outcome was ‘Not Achieved’, this fell from 6% the previous year.

**7. PARTNERSHIP STRUCTURE**

7.1 The SAB is supported by an Independent Chair who oversees the work of the Board, provides leadership, offers constructive challenge, and ensures independence. The day-to-day work of the Board is undertaken by the subgroups and the Safeguarding Business Unit.

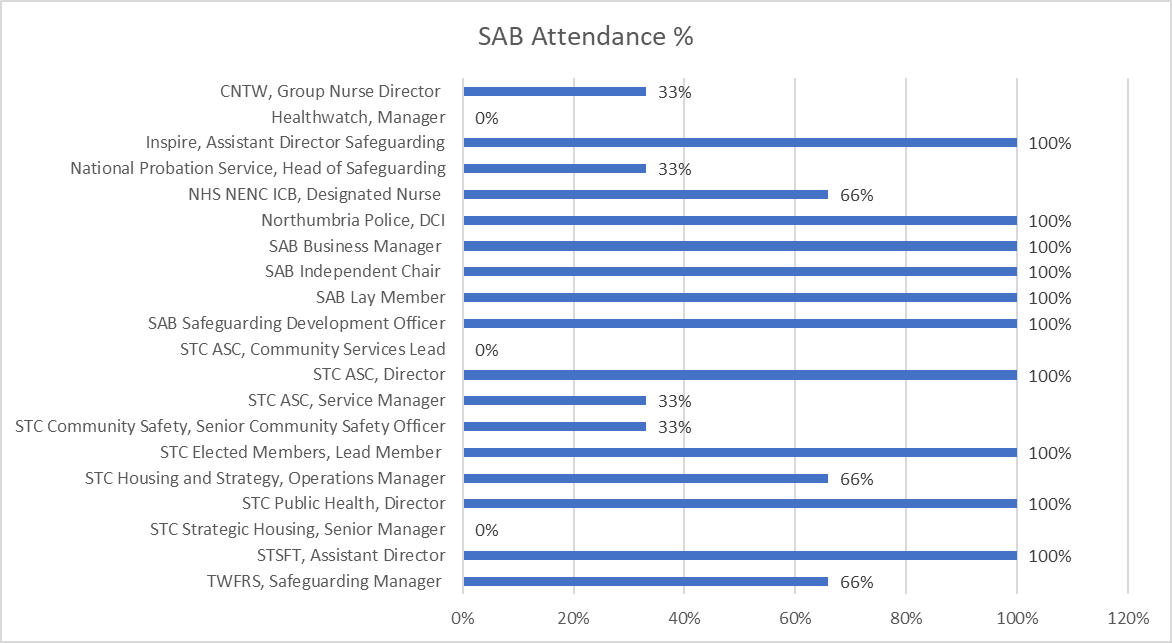
7.2 The Safeguarding Business Unit supports the operational running of the SAB and manages the Board on behalf of the multi-agency partners. The Board facilitates joint multi-agency working to ensure effective safeguarding work across South Tyneside.

**8. MEMBERSHIP**

8.1 Membership

|  |  |
| --- | --- |
| **Agency** | **Designation** |
| Healthwatch | Operations Manager |
| Independent | Lay Member |
| National Probation Service | Head of South Tyneside and Gateshead |
| NHS North East and North Cumbria Integrated Care Board | Designated Nurse Safeguarding Adults |
| Designated Doctor |
| Northumbria Police | Detective Chief Inspector Safeguarding |
| South Tyneside and Sunderland NHS Foundation Trust | Assistant Director for Safeguarding |
| South Tyneside Council, Adult Social Care | Director of Adults Social Services |
| Practice and Safeguarding Service Manager |
| South Tyneside Council, Community Safety Partnership | Senior Community Safety Officer |
| South Tyneside Council, Elected Member | Lead Member Adults, Health and Independence |
| South Tyneside Council, Housing and Area Management | Head of Housing and Area Management |
| South Tyneside Council, Public Health | Director of Public Health |
| South Tyneside Council, Strategic Housing | Senior Manager |
| South Tyneside Joint Commissioning Unit | Head of Commissioning |
| Tyne and Wear Fire and Rescue Service | Safeguarding Manager |

8.2 Attendance



\*% includes where a deputy was provided

See [Appendix A](#AppA) for full attendance details

8.3 The governance structures were refreshed in September 2023 when the joint partnership arrangements were disestablished.

8.4 The current structure of the SAB is illustrated below:

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8.5 As illustrated on the structure chart the SAB reports by exception to the recently established South Tyneside Safeguarding Executive Board (ST-SEB) This Board provides strategic leadership, governance and ensures local accountability for Safeguarding services in South Tyneside. It is chaired by the Chief Executive of South Tyneside Council. The core Membership includes the Integrated Care Board , ICB and Northumbria Police with additional attendees from the following:

8.6 Attendees

* Director of Adult Social Care
* Independent Chair of South Tyneside SAB
* Chair of South Tyneside SCP
* Independent Scrutineer – SCP
* Place Director - ICB
* South Tyneside SCP/SAB Business Manager

8.7 In addition, the ST-SEB will provide scrutiny; to scrutinise the work of safeguarding services; to identify successes and areas for improvement, and in doing so learn from experience; to monitor trends; to examine comparisons and take appropriate action.

**9. LEARNING FROM STATUTORY REVIEWS**

9.1 In accordance with the Care Act 2014 Safeguarding Adult Boards have a statutory duty to carry out Safeguarding Adult Reviews. There is a requirement to undertake reviews when an adult in a SAB’s area has died as a result of abuse or neglect, and there is a concern about how the partner agencies have worked together to safeguard the adult.

9.2 **Adults**

In 2023-24 there were 5 cases referred for consideration of a SAR. Of these, 3 cases met the SAR threshold and were part of an agreed thematic learning review. The themes included self-neglect, mental capacity, complexities in the lives of people, engagement and overcoming challenges.

There were over 80 multi-agency partners attend the thematic learning event held in November 2024.

**What did we learn?**

9.3 **Advocacy**

All the cases featured in the thematic learning review, presented missed opportunities for effective advocacy which may have helped to build those trusting relationships with both the adult and their families.

9.4 **Missing Adults**

The Missing Adults Across Northumbria Protocol which was introduced in November 2020 had not been implemented nor were the staff involved aware of it.

9.5 **Mental Capacity Assessments and Executive Functioning**

There needs to be further multi-agency work around mental capacity assessments with a specific focus on self-neglect and executive functioning. The learning identified highlighted that multi-agency partners were unclear as to how to mitigate a decline in an individual by the appropriate understanding and application of a mental capacity assessment in a person presenting with self-neglect.

9.6 **Wellbeing**

The learning highlighted the need for multi-agency partners to be cognisant of the impact of chronic illness, loss of a sense of individuality and inappropriate accommodation on an individual’s mental health / general wellbeing.

9.7 **The importance of a Trauma Informed Approach**

The learning highlighted the need for professionals to consider a trauma informed approach where past trauma has played a significant part in a person’s life. This would help inform professionals to consider the reasons for a person’s lack of engagement and how to work more effectively with them.

9.8 **Malignant Alienation**

This was a key area of learning for most multi-agency professionals, especially when reflecting on some of the challenging situations and outcomes that were highlighted in the thematic learning review. Malignant Alienation refers to the progressive deterioration in relationship when a practitioner effectively starts to dislike the individual they are supporting. It is often accompanied by a reduction in sympathy and level of support provided under the cover of rationalisation.

9.9 **What did we do as a result?**

A multi-agency consultation event and production of a multi-agency Self-Neglect Guidance and Toolkit. The impact of the use of the guidance and toolkit has been included in the 2024-2025 SAB Audit Cycle.

Set up multi-agency working group that is progressing with the development of a Transitional Safeguarding model.

An immediate response was to offer the Missing Adults Protocol Briefing Sessions to ensure that all care settings had an overview and insight of the actions required. Future work for the SAB will include an oversight of missing adults’ data, the subsequent multi-agency response and completion of Return Home Interviews where appropriate.

A multi-agency audit of self-neglect cases to be undertaken to determine if mental capacity assessments, where necessary, are being recorded at an acceptable and appropriate standard.

The SAB requested assurance and update reports regarding the Care Act Advocacy Service offer in South Tyneside. There is now a commissioned provider and regular assurance, and an update report will be a standard agenda item at SAB meetings.

All the learning from the Thematic Review is reflected within the multi-agency safeguarding training offer, particularly with reference to malignant alienation, trauma informed approach and the wellbeing principles.

**10. STRATEGIC DELIVERY PLAN 2024-2027**

10.1 The new Strategic Delivery Plan and revised aims and priorities include;

Effective Safeguarding

Making Safeguarding Personal

Learning and Delivering

10.2The priorities under the previous arrangements included Effective Safeguarding; Prevention and Early Intervention; Focus on Practice.An additional priority was added to reflect the implementation of the new safeguarding arrangements and re-establishment of the SAB.

| **ADDITIONAL PRIORITY: Ensure the governance and structure of the SAB are Care Act Compliant** | | |
| --- | --- | --- |
| **What we said we would do** | **What we did** | **Outcome** |
| **Progress with the recommendations from the LGA Peer Review** | * Shared the LGA Report with partners to seek a consensus of the suggested recommendations and agree a plan of action. * Re-established the SAB in September 2023 * Appointed an Independent Chair November 2023 * Held a multi-agency development session in December 2023 to agree the SAB Strategic Plan and future priorities. * Increase participation & engagement of all in the work of the SAB. * Disseminated the learning from the Thematic Review undertaken on the SARS. * Revised the multi-agency threshold tool and guidance. * Started the development of an adult Multi-agency Safeguarding Hub, MASH and a Complex Adult Abuse Management process, CARM | * Independent Chair seeks assurance on a range of issues as outlined in SAB minutes. * SAB meets bi-monthly; newly formed Safeguarding ExecutiveAssurance Board meets quarterly |

| **Priority 1: Continue to effectively safeguard and prevent abuse and neglect of adults** | | |
| --- | --- | --- |
| **What we said we would do** | **What we did** | **Outcome** |
| **We will be aware of the key local safeguarding areas of concern and implement the appropriate action** | * Awareness raising and preventative work around safeguarding. * A robust multi-agency safeguarding training offer 2023-24. * Ensured the annual MSET Roadshow was inclusive of adults especially around missing adults. * Ensured that the SAB have more insight around the data for missing adults. | * Increase in the uptake of face-to-face training of 63% in 2023-24 (1910 compared to 1166 in 2022-23) * Safeguarding Adults - multi-agency responsibility remains the most popular course with 250 attendees in 2023 -24. * E-Learning increased by **43%in 2023-24.** * There were 2,783 completions in 2023-24 of E-Learning compared to 1,956 in the previous year. * Level 2 Safeguarding Adults featured in the top five E-learning courses with 344 applications in 2023-24. * The MSET Roadshow featured ‘Missing Adults’ to raise the awareness of the Missing Adults Protocol and actions to be taken by multi-agency partners. * 142 delegates attended across the four sessions and 91 returned evaluations, which is a return rate of 64%. * 87% or attendees rated the roadshow as excellent or very good. * 100% stated their understanding of the subjects covered wasexcellent or good after attending the roadshow. * ‘All About Us’ was the thematic learning review based on the SAR cases. In total over 88 multi-agency practitioners attended the event * Developed and delivered Self-Neglect Flyers across the business communities in South Tyneside to raise the awareness of self-neglect and how to report a concern. * Delivered a regional webinar around Diabetes and the Link to SARs. 117 attended.   In 23/24 762 abuse types were recorded against 450 enquiries (more than one type of abuse can be recorded against an enquiry). Neglect and Acts of Omission and organisational both recording the highest number.  Whilst there were increases in every abuse type the most notable were Domestic (78%) Self-Neglect (36%) and Domestic and Sexual (20%). With this awareness the training offer will reflect this local data. |
| **Put in place an effective multi-agency performance monitoring/quality assurance and scrutiny arrangements** | * Evidence of greater scrutiny and challenge around the multi-agency performance data and audit cycle * Developed a robust multi-agency quality assurance and performance framework. * Reintroduce the Risk Register | * Robust multi-agency performance framework, supported by Power BI, which continues to evolve. * There is now a completed and evidenced 2023-24 multi and single agency audit cycle. The findings of which are shared with the Workforce Development Subgroup and Learning Development Advisor * Risk Register is a standard agenda item at the SAB |

| **Priority 2: Prevention and Early Intervention** | | |
| --- | --- | --- |
| **What we said we would do** | **What we did** | **Outcome** |
| **Continue to promote an effective engagement and co-production approach with people in order that they recognise and report abuse or neglect** | * Feature a safeguarding article in the resident’s quarterly newsletter. * Share information and raise awareness across local communities/groups. * Predatory Marriage Session delivered by Daphne Franks on 4/10/2024 as Part of the South Tyneside Older People’s festival – attended by 38 older people. * In Partnership with Community Safety, delivered The South Tyneside Hate Crime Conference on 10/10/2024 including input around Discriminatory Abuse | * In 2023-24 have had 3 articles in the resident’s newsletter – June 2023 Elder Abuse / November 2023 Domestic Abuse / March 2024 Self-Neglect * Shared ‘self-neglect’ awareness raising flier across the local business communities in South Tyneside      * Worked alongside Your Voice Counts to update the visual safeguarding awareness leaflet.     There has been a 300% increase in referrals for self-neglect however it is not possible to ascertain how much of this is due to awareness raising.  Attended by 80 people.  Evaluation highlighted an increased understanding around Hate Crime and the link to safeguarding. |
| **Develop a Multi-Agency Safeguarding Hub (MASH) and a Complex Adult Risk Management (CARM) pathway for South Tyneside** | * This remains ‘work in progress’ but has achieved many milestones and has overcome some of the challenges. * Two working groups have been established to take forward the development and proposed implementations. These groups have been led by the SAB and have met monthly since November 2023. The working models for each have been agreed however the MASH is currently unable to be launched until one of two options are in place: * The appointment of a mental health/health navigator, or; * Read only access to RIO which is the operating database for CNTW. * The CARM – all key documentation agreed. A communications plan for the launch on August 19th has been developed and shared with multi-agency partners. | **The MASH**   * Agreement from all partners to the establishment of the MASH, it is proposed that the new model is brought back to Board once all resourcing issues are resolved. * Key partners agreed as minimum quorate for the MASH identified as Adult Social Care, Police, South Tyneside Homes, and a Mental Health/Health navigator. * Outward lines of referrals established with South Tyneside Alcohol and Recovery service, South Tyneside RESTART service (Domestic Abuse), Probation, South Tyneside College, Tyne and Wear Fire and Rescue Service, Primary Care Networks, Adult Social Care teams, including prevention services, Age Concern. These will develop as the work continues.     **The CARM**   * The CARM will be formally launched on August 19th, 2024**.** * Like all new models the South Tyneside CARM will evolve and be reviewed at the 3-, 6-, 9- and 12-month stages. It is proposed that the 12-month review will be undertaken by an Independent Reviewer. |

| **Priority 3: Focus on Practice** | | |
| --- | --- | --- |
| **What we said we would do** | **What we did** | **Outcome** |
| **Actively participate in Safeguarding Adults Week 2023** | * South Tyneside actively promoted the learning from the thematic SARs as highlighted earlier. * Missing Adult Protocol reviewed and updated because of the Thematic Learning Event * Further briefing sessions delivered to Care Home Managers and staff. * In addition, South Tyneside hosted the ‘Diabetes the Thematic Trend Across the North East’ session | 79 Attendees  36 attendees  117 attendees (recorded session)  <https://youtu.be/52BpYM8Bx1E>  38 attendees attended the event |
| **Ensure multi-agency online safeguarding policies and procedures for children and adults are up to date and relevant to front line practice** | * Complied with safeguarding policies and procedures updates with the input from the relevant multi-agency partners. * Promoted online policies and procedure links throughout all multi-agency training. * Briefing sessions offered to support familiarity with the online safeguarding adults’ policies and procedures website. * In addition, the Person in a Position of Trust (PiPoT) policy and procedure has been developed and shared with multi-agency partners via awareness raising sessions | Adults: in 2023-24 there were 1700 users and 21,000 events (link to another page, opening a form etc). See attached breakdown.    Take up of briefing sessions has been minimal this year but queries have been addressed on a more informal basis and through promotion of the multi-agency safeguarding training programme. |

**11. MULTI-AGENCY DATA AND INFORMATION – THE HIGHLIGHTS**

11.1 The past twelve months have offered little respite from the significant and sustained pressures placed upon the range of services across the SAB, and the heightened risk of these to safeguarding adults from abuse or neglect. Most partners continued to be faced with ongoing recruitment and retention challenges alongside high demand, placing extreme pressure on services. This has been reflected in the notable increase in referrals in terms of complexity where cases are not referred until at crisis point.

11.2 **Safeguarding Activity 2023-2024**

There are key areas identified from the PME Annual Report that warrant additional assurance. Many of the areas will be reported on via the developing Multiagency Safeguarding Score Card and assurance from other appropriate sources e.g. single and multi-agency safeguarding audits.

* The increasing number of referrals and the subsequent pressures on all partner agencies.
* The reduction of the age range of people involved in safeguarding enquiries – Average age of victims was 49 and is now 41
* The impact in relation to the revised self-neglect guidance and toolkit launched in November 2023.
* Additional assurance around the impact of the work undertaken to reduce the number of falls, assaults and medication errors within residential settings.
* Assurance from South Tyneside Homes in terms of the impact of the safeguarding training on the number of in-house referrals received and as a result the referrals into partner organisations.
* The average time to complete a S42-2.
* Assurances around the multi-agency activity around awareness rising and prevention related to the increase in the following abuse types; Domestic (78%) Self-Neglect (36%) and Domestic and Sexual (20%).
* Due to the most likely location of abuse continues to be ‘Own Home’, assurance around the multi-agency activity and data around safeguarding awareness raising and action to be taken by people living in their own homes and impact on referrals.
* Consideration of an additional audit area based on seeking an understanding of the low level of referrals from ethnic minority groups given the demographics of South Tyneside.

11.3 **Safeguarding Contacts** - the number of contacts has increased significantly in recent years. 2023/24 saw a 22% increase on the previous year and a 44% increase on 21/22.

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Whilst there is still a significant increase of contacts in 23/24 this has slowed down in recent months and may be a direct result of the introduction of ‘Right Care, Right Person’ whereby Police are reviewing welfare calls from professionals or members of the public and determining if Police attendance is necessary, based on no harm, threat and risk.

11.4 **The four main sources of Safeguarding Concerns** all increased. Residential Care increased by 146 (27%), Police by 280 (79%), Domiciliary Care by 268 (86%) and NEAS by 94 (35%).

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11.5 **The gender split** - saw a change in 23/24 with the percentage of males increasing from 37% to a more even split of 45%.

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11.6 **Age Range** - almost all age ranges recorded and increased however the most significant increase was 18-30 rising from 26 to 59. An increase of 127%.

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11.7 **Ethnicity** - the majority (86%) of those involved in S42 enquiries were recorded as White: British with less than 2% recorded being of different ethnicity. ***‘Information Not Yet Obtained’*** represents 12%.

11.8 **Abuse Types** **and Location**- whilst there were increases in every abuse type the most notable were Domestic (78%) Self-Neglect (36%) and Domestic and Sexual (20%). The most likely location of abuse continues to be ‘Own Home.’

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**12.** **STRATEGIC PARTNERSHIPS**

**South Tyneside Safeguarding Executive Board (ST-SEB)**

12.1 This Board was set up in January 2024. Its purpose is to provide leadership, governance and ensure local accountability for Safeguarding services in South Tyneside. It is chaired by the Chief Executive of South Tyneside Council. The core Membership includes the NHS North East and North Cumbria Integrated Care Board, ICB, and Northumbria Police with additional attendees. The Board has met twice to consider a strategic approach to the following;

* The governance and accountability arrangements for safeguarding in South Tyneside, across children and adults, and the actions that need to be taken.
* The required funding and resourcing required to meet the statutory duties and effective co-ordination and management of the SAB / Childrens Partnership
* Consideration of local and national safeguarding directives applicable to adult and children safeguarding.

**South Tyneside Safeguarding Adults Board**

12.2 With the re-introduction of the SAB in September 2023 the Board has met on 3 occasions during 2023 -24. Highlights from the SAB related to adult safeguarding included:

* Revised governance arrangements for the SAB
* Recruitment of an Independent Chair
* Sign off the Annual report for 2022 -23.
* Sign off the Independent Scrutineers report 2022-23.
* Agreed the Escalation and Challenge Protocol
* Review of the local authority operating model for adult safeguarding
* Right Care / Right person and the implications for partners
* Development session in December 2023 facilitated by the Independent Chair to scope out the vision, strategic aims and priorities for 2024-25.
* Continued the conversation around the SAB Budget
* SAB Risk Register
* Sign off the strategy and Business Plan.
* Continue with the conversation around future budgets and contributions.

**South Tyneside Safeguarding Children and Adults Partnership**

12.3 **PLEASE NOTE THE PARTERSHIP MET ONCE IN JUNE 2023 as the decision was taken to have separate Safeguarding arrangements for adults and children in September 2023.**

12.4 The aim of the Practice Partnership was to strengthen the focus on practice ensuring a direct link with practitioners to influence and fully understand frontline practice from both a practitioner, adult and child perspective. Members of the Partnership were expected to consider solutions and disseminate learning from shared good practice across the partnership and community and identify, agree, and support with the development and dissemination of the learning. All partners were expected to raise safeguarding issues that their organisation was experiencing as well as share examples of good practice. As part of the development of the Partnership members views were sought in terms of the structure and proportionality of the agenda across adults and children to ensure fairness and transparency. Key highlights related to adult safeguarding included:

* The introduction of the Police Right Care Right Time initiative and the implications on the multi-agency safeguarding response and understanding of risk thresholds
* Independent Scrutineers response to the Whorlton Hall Review
* Local Government Association, LGA, Peer Review Update and the understanding of the CQC Inspection Framework and expectations

**13. SUBGROUP HIGHLIGHTS**

**Practice Evaluation and Learning Subgroup (PEL)**

13.1 The PEL subgroup is a joint subgroup with children although this report will focus on adult related information only. The aim of the subgroup is to:

* Make recommendations to the SAB Independent Chair to undertake Safeguarding Adult Reviews.
* Initiate Safeguarding Adult Reviews in line with the Care Act 2014 and monitor their progress.
* Oversee and ensure action plans and learning from Safeguarding Adult Reviews are embedded and evaluated for impact on multi-agency practice.

13.2 In addition, the subgroup has the authority to determine and recommend to the Independent Chair the possibility of alternative multi-agency learning reviews should any case not meet the statutory criteria but clearly highlights learning for multi-agency partners.

13.3 To support PEL members awareness raising sessions were built into subgroup meetings. These highlighted the purpose, criteria and required compliance with the statutory processes.

**Safeguarding Adult Reviews (SARs)**

13.4 In 2023-24 there were 5 cases referred for consideration of a SAR. Of these 3 cases met the SAR threshold and were part of an agreed thematic learning review. The themes included self-neglect, mental capacity, complexities in the lives of these people, engagement and overcoming challenges.

13.5 In addition, the SAB organised a regional webinar around Diabetes and the Link to North East SAR’s. There were 117 attendees.

13.6 The SAB continues to be proactive in the regional SAR Champions network.

13.7 The regional SAR Library and Quality Marker Checklist continues to attract national interest and has been shared with the National Safeguarding Adults Board Managers Network.

**Policies and Procedures**

13.8 The aim of the Policy and Procedures subgroup is to develop and maintain up to date multiagency policies and procedures for safeguarding and promoting the welfare of adults in South Tyneside.

13.9 The offer and uptake of multi-agency virtual sessions to raise the awareness of the online safeguarding adults’ policies and procedures has been minimal this year but queries have been addressed on a more informal basis and through promotion of the multi-agency safeguarding training programme.

13.10 There has been an increased uptake with the online safeguarding policies and procedures, particularly from single agencies.

13.11 A link to the online [Safeguarding Policies and Procedures](https://www.southtynesidesafeguardingappp.co.uk/) is included at all multiagency training sessions.

**Performance Management and Evaluation (PME)**

13.12 This group receives, monitors, and analyses multiagency performance data on a quarterly basis in line with statutory returns which help inform the Practice Evaluation and Learning Group (PEL), the multi-agency safeguarding training offer as well as highlight strategic issues and provide the SAB with additional information for further consideration. To date key pieces of work have included:

* The development and implementation of the 2023 -24 Quality Assurance Framework.
* The development and implementation of the Single and multi—agency audit cycle 2023-24.
* Agreement and sign off of the Multi-agency Threshold document.
* Throughout 2023-24 the sub group has continued to develop and contribute to a multiagency safeguarding score card. This remains work in progress to ensure the score card aligns with the agreed SAB priorities for 2024-25.

13.13 There has been a delay of the ICB-wide Safeguarding Dashboard to provide consistency to reporting due to the ICB restructure. This remains a risk that the subgroup needs to monitor.

**Workforce Development and Training (WD&T)**

13.14 The aim of the subgroup is to develop a multi-agency safeguarding training programme across adults and children as well as to implement a robust quality assurance process across all the training.

13.15 A robust quality assurance process was established to evaluate internal multi-agency adult and children safeguarding training courses to ensure that all courses aligned with current safeguarding trends and effectively reflect emerging themes to provide participants with timely knowledge and skills.

13.16 The ‘Kirkpatrick’ training evaluation model was implemented to measure impact on behaviour and to assess how practitioners applied the knowledge and skills gained from the training into their practice.

13.17 The annual training report highlighted a significant increase in requests and attendance on multi-agency safeguarding training courses with 99% of attendees rating their understanding after training as ‘Good’ or ‘Excellent’.

13.18 The 2023/24 training programme was reviewed and updated for 2024/25 to ensure that the training offer remained current and relevant in addressing emerging safeguarding themes and challenges.

**Strategic Exploitation Group (Adults and Children)**

13.19 This group ensures that both the SAB and Childrens Safeguarding Partnership have a strategic oversight and assurance that appropriate actions have been taken in response to the exploitation of adults, children and young people, at risk in South Tyneside. The group seeks assurance from the operational progress of the South Tyneside Missing, Slavery, Exploited and Trafficked (MSET) subgroup. Through a ‘live’ multiagency action plan the group have been able to contribute and measure the impact of partners actions against the key elements of the plan. These have included:

* Prevention - by creating an increased awareness and understanding of the exploitation of vulnerable adults, the indicators and actions to be taken. This was a key focus of the sessions offered to the local ‘Welcoming Spaces.’
* South Tyneside Licensing Service mandate exploitation awareness sessions as part of the application process for taxi drivers
* Raising the profile of PREVENT as a standard agenda item.
* Highlighting the Missing Adults protocol considering the learning from a local SAR
* Multi-Agency working around Transitional Safeguarding continues to make significant progress. There have been three multiagency events held with a focus on the expectations of both adult and children’s service areas and their roles within transitional safeguarding, the legal parameters and a focus on the role of multiagency partners in transitional safeguarding. Work is in progress to develop a South Tyneside Transitional Safeguarding model.

**Pre-Missing, Slavery, Exploited and Trafficked (Pre MSET)**

13.20 The pre-MSET was set up to ensure that robust and appropriate screening is undertaken on cases put forward for consideration at MSET.

13.21 Adult Social Care is a key representative at the pre-MSET meeting to offer the appropriate support, advice, and guidance to those young people aged 17+ who remain vulnerable and at risk of exploitation. In addition, work is currently progressing around the process to address missing adults.

13.22 In 2023 -24 1 young adult, aged 18, was considered. The main concern was around missing episodes and concerning associates but there was no evidence of exploitation.

**Missing, Slavery, Exploited and Trafficked (MSET)**

13.23 MSET is responsible for ensuring the effectiveness of multiagency working to safeguard and promote the welfare of those adults’ children and young people who have been identified as medium/high risk on the Exploitation Framework for Screening, Assessment, Safeguarding and Disruption, and Review. In addition, the group provides advice, learning, and signposting to additional support to those frontline workers responsible for medium/high risk adults / young people. A representative from Adult Social Care supports the MSET process with advice and intervention, where appropriate with young people aged 17+.

13.24 During 2023 -2024 there have been a total of 5 full MSET meetings. Of these 2 young people aged 17+ were discussed. Key areas of concern identified:

* Missing episodes increasing vulnerability to exploitation.
* Exploitative online activity including the sharing of explicit images and unsafe relationships.
* Alcohol and substance misuse

13.25 The appropriate disruption and multi-agency actions were put in place to reduce the risks.

**Multi-Agency Cost of Living Group**

13.26 In addition to the standard joint and single SAB subgroups the Safeguarding Business Unit organised and facilitated the Multi-Agency Cost of Living group. This group was set up to gain assurance from multi-agency partners and community groups that safeguarding remained a focus during the ‘cost of living crises. Safeguarding awareness sessions around exploitation, indicators and actions required were offered to all involved with the ‘Welcoming Spaces.’

13.27 In November 2023, this group was stood down and merged with the local authority Poverty Group to avoid duplication.

**Designated Safeguarding Leads (DSL) Forum**

13.28 The Designated Safeguarding Leads (DSL) network facilitates and promotes a culture of safeguarding as everybody’s business. It provides a networking opportunity for DSLs in education settings, including post 16 provision to keep abreast of the latest safeguarding updates and guidance nationally and locally. A key agenda item is for all educational providers to highlight safeguarding issues that they are facing.

13.29 The Forum is the key educational link into the Safeguarding Adults Board. The DSL Forum currently meets six times a year. To date the following key areas have been included within the forum:

* Vaping and the links to exploitation
* ICT Updates – including awareness of online sexually coerced extortion on line /Tik Tok trends and the latest Apps that potentially increase a person’s vulnerability.
* Prevent Duty and how to make a referral
* Consultation around the Northumbria Weapon and Knife Crime Protocol

**14. PARTNER CONTRIBUTIONS REGARDING THEIR ACHIEVEMENTS AND SAFEGUARDING PRIORITIES FOR 2023-24**

**Full details can be found at** [**Appendix B**](#AppB)

**South Tyneside Council, Adult social Care**

14.1 **Introduced new safeguarding adults s42 (1) and (2) safeguarding audit tools and introduced monthly Safeguarding Performance clinics which focus on interactive data/intelligence on Safeguarding activity.**

It has resulted in more effective evaluation of safeguarding patterns, trends and themes. It seeks to identify areas of strength and development. We have seen significant improvements in the timeframes for initial safeguarding decisions being made and completing s42(1) enquiries. This data is part of the Safeguarding Adults Board Safeguarding score card that informs the need for any additional analysis; assists with comparison across other partners data / findings and informs future audits / assurance reports.

14.2 **New safeguarding operating model developed and approved at the Adult Social Care Living Better Lives. The model will interface with the implementation of the wider partnership approaches to safeguarding including a Multi-agency Safeguarding Hub, (MASH), and the Complex Adult Risk Management, CARM, process.**

It is anticipated that the new ways of working with strengthen multi agency decision making on safeguarding concerns received the impact of which will be evaluated throughout the new financial year with review points at 3, 6, 9 and 12 months.

14.3 **Contributed to a revised Association of Directors of Adult Social Services, (ADASS), threshold tool for making safeguarding decisions.**

Audit analysis indicates good use of the new tool in the local authority by the adult safeguarding team since implementation. Audit activity indicates the appropriate application of the thresholds to inform decision making in respect of safeguarding concerns.

14.4 **Core safeguarding practice is effective in keeping adults safe.**

A new training and development plan for Adult Social Care staff which offers three core practice modules including safeguarding have been approved by the Adult Social Care Leadership. The safeguarding module comprises 4 sessions in respect of core adult safeguarding training. The training content is moderated and approved by the Safeguarding Adult Board Partners.

14.5 **Safeguarding referral pathways are understood and used appropriately.**

The threshold tool is being used within the service and audits undertaken on s42(1) decision making indicate safeguarding decisions made are appropriate and clear. Recent Audit activity has highlighted good uptake and use of the tool.

14.6 **Risk management within prevention and early intervention work is robust.**

Risk Management approaches within adult social care have been reviewed to ensure there is sufficient oversight where there may be high risk indicators to inform practice and commissioning decisions and lead partnership conversations around new approaches undertaken. Further enhanced with the introduction of the CARM model.

**NHS North East and North Cumbria Integrated Care Board, ICB.**

14.7 **The partnership training has been shared with primary care to encourage and support practices with safeguarding training compliance and to improve knowledge and skillset for those practitioners that attend.** In addition, the Designated Nurse for Safeguarding Adults has delivered training on self-neglect and mental capacity following the recent SAR recommendations.

14.8 **Improved process and ways of working around safeguarding adult concerns, the ICB and Primary Care.**

This has resulted in ashared understanding and improvement with interface in Primary Care, safeguarding adults in the local authority and the ICB.

14.9 **Core safeguarding practice is effective in keeping adults safe**.

This has been implemented via quarterly assurance from health providers, including primary care, that organisations are fulfilling their statutory safeguarding functions and patients are safeguarded effectively. This is supported with the relevant data.

14.10 **Safeguarding referral pathways are understood and used appropriately.**

Assurance provided by Health providers via the quarterly assurance dashboard and meetings.

**Northumbria Police**

14.11 **Northumbria Police introduced the prevention department which includes the addition of a missing person investigation team. This team works alongside the existing missing from home coordinators and oversee missing person investigations, other than those of immediate high-risk concern. They have taken oversight of the MSET process which now has a dedicated MSET Inspector. The prevention team has additionally seen the introduction of a mental health and problem-solving Inspector to oversee the street triage team.**

Early indications show a reduction in average time missing, a reduction in average missing episodes and evidence of rapport building between the investigation team and those vulnerable repeat missing persons. Strong multi agency working in this area has seen the introduction of a missing adults tracker to ensure a problem-solving partnership approach to vulnerable missing adults. The addition of the dedicated Inspector for MSET has allowed a real focus on working with partners to improve and adapt the process to better meet the demands and needs of the region, this includes a review and refresh of the process.

14.12 **Right care Right person, RCRP, has been expanded to ensure those calls for service by the most vulnerable are dealt with by the most appropriate resource, police or partners in the most effective manner.**

Northumbria Police have seen a reduction in the calls they attend with the introduction of RCRP, meaning that resources are available to deal with our most vulnerable in a timelier manner, ensuring that safeguarding is addressed at the earliest opportunity. This has contributed to a 5.2% reduction across South Tyneside in adult concern notifications.

14.13 **We have used the expertise of Safe Lives to deliver Domestic Abuse matters training to over 1500 of our front-line practitioners to ensure a greater awareness and focus on Domestic abuse. Particularly on recognising the signs of coercive and controlling behaviour and emotional abuse.**

Early indicators show positive improvements in our responses to Domestic abuse, through response times, investigations and use of protective orders.

14.14 **At a strategic level Northumbria police has returned to a six-area command locality model as opposed to three. For South Tyneside this means that it is a standalone area command, no longer joined with Sunderland with one dedicated Chief Superintendent and a dedicated South Tyneside Senior leadership team. The responsibility for Statutory partnership requirements will be facilitated by Area Command, with the Executive group representative now being the Area Command Chief Superintendent with responsibility for South Tyneside**.

The new model means that there will be better partnership join up for multi-agency working with the area command sole focus on South Tyneside. The move away from the Chief Superintendent safeguarding attending the executive boards allows the area commander and the partnerships to have a better oversight and understanding of the local issues.

14.15 **Safeguarding referral pathways are understood and used appropriately.**

Refresher CPD training given to staff at regular intervals to ensure understanding. Currently all front-line officers are undertaking training in relation to thresholds and consent using examples of best practice.

**South Tyneside and Sunderland NHS Foundation Trust (STSFT)**

14.16 **The STSFT safeguarding annual audit cycle has been completed. This provides assurance and the actions to be taken to further improve safeguarding practice at a local level. Audit activity included Emergency Department , ED, attendance, Mental Capacity Act, (MCA)/Deprivation of Liberty Safeguards, (DOL’s) procedures adherence, inclusive of when a medic has felt there were no concerns about capacity, safeguarding policy compliance (inclusive of routine & selective enquiry), procedural self-neglect guidance and threshold tool compliance and chaperone policy compliance.**

Audit results have provided assurance of staff compliance with policy, alongside areas of good practice and areas for action.

14.17 **Safeguarding link forums and “Hot Topic” sessions are held regularly. A bi-monthly safeguarding newsletter is disseminated across STSFT and held on the Intranet. The key aim of the newsletter and link forums is to share any safeguarding learning, training courses and 7-minute briefings following Safeguarding Adult Review’s, (SAR’s) and Child Safeguarding Practice Reviews, (CSPR’s). During 23/24 there was shared learning in relation to MCA assessment, executive dysfunction, professional curiosity, self-neglect awareness (inclusive of the use of the self-neglect toolkit), trauma informed practice, Making Safeguarding Personal, (MSP), ICON Safe sleep,(Infant crying is normal/ Comforting methods can help, its OK to walk away, Never, ever shake a baby), Caring for Migrant women, The Find-a-way project, unaccompanied asylum seekers, transitional safeguarding and preventing fire deaths.**

Positive feedback received from staff in relation to content and information within the safeguarding newsletter and following link forums, particularly in respect of the 7-minute briefings.

14.18 **MCA and Safeguarding podcast produced raising awareness of MCA and DOLS issues and learning from Safeguarding Adult Reviews.**

Staff raised awareness on the relevance of the Mental Capacity Act to safeguarding adults at risk of harm and abuse, in particular how mental capacity, and in particular, executive dysfunction are often key areas for improvement highlighted via the Safeguarding Adults Review or Domestic Homicide review process. Staff are also supported to understand the significance of DoLS from a variety of perspectives.

14.19 **Core safeguarding practice is effective in keeping children, young people and adults safe.**

All STSFT staff attend safeguarding mandatory training and safeguarding supervision sessions (as per intercollegiate document). Audit results have provided assurance of staff compliance with policy, alongside areas of good practice and areas for action.

14.20 **Safeguarding referral pathways are understood and used appropriately.**

The Trust use a system called Datix to generate all safeguarding children and adult referrals. Datix allows the safeguarding team to have oversight of all referrals. The safeguarding team are then able to quality assure the referrals and provide feedback to staff where necessary on the threshold applied.

**South Tyneside College**

14.21 **The college has several safeguarding initiatives which include the following.**

* **Hot topics- introduction in to the curriculum of hot topics where we present common, local national concerns/trends etc.**
* **Mandatory safeguarding training for all staff every quarter on a concern/trend.**
* **Additional qualifications, level 4 for front line Safeguarding Officers and level 5 for Safeguarding Leads.**
* **Staff development day, presenting quarterly statistics related to safeguarding and concerns, trends coming through.**
* **Informing parents via text of any concerns/trends of a safeguarding nature**

14.22 General vigilance and awareness amongst staff has increased, although referrals have maintained the trajectory, the standard of referrals has improved, which demonstrates better knowledge from staff of what a safeguarding concern is.

**Healthwatch South Tyneside**

14.23 **Everyone working or volunteering for Healthwatch South Tyneside has a responsibility to familiarise themselves with the safeguarding policy and the local authority procedures. They must maintain a focus on the safety and welfare of vulnerable adults in all aspects of their work**.

Staff and volunteers have taken part in the latest safeguarding training sessions for adults. Staff and volunteers are confident in identifying a safeguarding issue and know the appropriate referral pathway to raise a safeguarding concern.

**15. LOOKING AHEAD TO 2024-25**

15.1 This annual report references the progress made of the SAB from September 2023 - March 2024 and the collaborative working model that was in place from 1st April to 1st September 2023. The SAB has agreed the following priorities for 2024 -25.

Delivering Effective Safeguarding

Learning and Delivering

Making Safeguarding Personal

15.2 Within the SAB Strategy and Business Plan the following ambitions for 2024-25 are identified;

* Finalise the SAB Safeguarding scorecard and multi-agency audit cycle which aligns with the Strategic Plan. This will enable the Board to understand safeguarding trends, themes, risks and seek the appropriate assurance from relevant partners.
* The SAB will continue to coordinate the development and implementation of the multi-agency adult safeguarding hub (MASH). In addition, regular updates and assurance around impact on people will be shared at SAB meetings.
* The SAB will continue to coordinate and facilitate the implementation and evaluation of the Complex Adult Risk Management (CARM) model which is due to be launched in August 2024
* Working with our partners the SAB will collectively gather the views of those with lived experience of being supported through a safeguarding issue to highlight and share best practice and improvements
* Develop a multi-agency assurance audit to scrutinise the effectiveness of MSP across the SAB to be able to share best practice and improvements
* Ensure an effective multi-agency safeguarding training programme is in place for 2024-25
* Recruit additional Lay Members to the SAB
* The SAB will continue to coordinate and facilitate local and national safeguarding initiatives throughout the year, e.g. multi-agency learning events post SARs/Learning Reviews/Elder Abuse Day/Safeguarding Adults Week.

15.3 In addition the SAB will monitor its progress against the recommendations made in the Ministerial letter aimed at helping SABs support vulnerable individuals rough sleeping.

**APPENDIX A – REPRESENTATION AT PARTNERSHIP / SAB MEETINGS 2023-2024**

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**APPENDIX B – PARTNER CONTRIBUTION TO SAFEGUARDING**

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**APPENDIX C – CONTRIBUTIONS AND SUMMARY OF 2023-2024 BUDGET**

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**APPENDIX D – GLOSSARY OF ABBREVIATIONS**

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**APPENDIX E – CONTACTS**

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