

**For Health & Wellbeing Board, 6 September 2017:**

# **Annual Report 2016/17 of City of York Safeguarding Adults Board**

**Kevin McAleese CBE, Chairman**

# Safeguarding Adults Board (SAB) Annual Report 2016/17



→ [www.safeguardingadultsyork.org.uk](http://www.safeguardingadultsyork.org.uk)

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## SAB Board members:

- City of York Council
- Healthwatch York
- Independent Care Group
- NHS England
- North Yorkshire Police
- Stockton Hall
- Tees, Esk & Wear Valley NHS Foundation Trust

- The Retreat
  - Vale of York Clinical Commissioning Group (CCG)
  - York Teaching Hospitals NHS Foundation Trust
  - York CVS
  - York House
- = Statutory partners and joint funders



# Work undertaken:



## ***Making Safeguarding Personal (MSP)***

This case involved a young woman under the care of Mental Health services, whose Care Co-ordinator raised a concern that she was being physically and emotionally abused by her mother. The concern suggested that the young woman's mother had recently assaulted her with an implement, from the injuries she had received.

This was a complex case because the young woman was at first reluctant to admit what had been happening, but eventually admitted that her mother had been physically abusing her. After several conversations with a worker from the team, during which the young woman was assured that she would decide what happened next, and all the possible options open to her were explored, she eventually agreed to speak to the police. Support was also given by a friend of the woman, who eventually accompanied her to the police station. At this stage, she was very clear that she wished to maintain her relationship with her mother and did not want the police to take any action. Her Mental Health worker worked alongside this intervention and gave the young woman some coping strategies.

Further long discussions took place between the young woman and the Safeguarding Team worker to explore all options and to support her, working in a person-centred way, i.e. at the pace of the young woman and without trying to impose any interventions that she did not want.



# Activity I

In line with the national picture, some 60% of both Concerns and Referrals involved female adults

Year	Alerts/Concerns	Referrals to Enquiries
2013	912	213 (23%)
2014/15	1,058	294 (28%)
2015/16	1,108	468 (42%)
2016/17	1,215	392 (32%)

## 2016/17:

- People over 65 and above continued to be significantly over-represented in referrals, with 85s and over being the most over-represented

# Activity II

These patterns of abuse have been consistent in quarterly reports to the Safeguarding Adults Board, and reflect the national picture.

<b>2016/17: Type of abuse referred</b>	<b>%</b>
<b>Neglect</b>	<b>28%</b>
<b>Physical</b>	<b>23%</b>
<b>Psychological/emotional</b>	<b>21%</b>
<b>Financial</b>	<b>15%</b>
<b>Sexual</b>	<b>6%</b>
<b>Self-neglect or Organisational</b>	<b>6%</b>



## Activity III

As last year, the source of risk has most frequently been **people known to the adult with care and support need** and this has most frequently been located **within their own home**.

<b>2016/17: Location of risk referred</b>	<b>%</b>
<b>Own home</b>	<b>38%</b>
<b>Hospital</b>	<b>22%</b>
<b>Residential home</b>	<b>17%</b>
<b>Nursing home</b>	<b>9%</b>
<b>Other (incl community)</b>	<b>14%</b>

# Activity VI: Outcomes of Enquiries for 2016/17:

1. In 61% of all completed enquiries, the planned outcomes were said by the subject of the safeguarding actions to have been fully removed.
2. In 30% the planned outcomes were said to have been partially removed and in only 9% were the outcomes not achieved.
2. This was an improvement in the outcomes for adults with care and support needs on all previous years.



## **The 2016/17 Peer Review of Adult Safeguarding found that.....**

Staff have a “can do” attitude, and a sense of collective optimism in delivering the vision.

Good evidence of personalised approaches, and “Making Safeguarding Personal” ran through York’s social care practice like a stick of rock.

York’s front line staff are ‘amazing!’ and recognised as highly committed.

The Safeguarding Board understand the importance of talking through a case, and this demonstrates a learning organisation from the bottom up and top down.

Excellent work being done to support adults with care and support needs and safeguard them from abuse.

# Safeguarding Adults Reviews (SARs)

Under the Care Act 2014, an SAR must be arranged by the Safeguarding Adults Board (SAB) when “an adult in the area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult

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SABs must also arrange a SAR if an adult in its area has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.”

## Not a Safeguarding Adults Review (SAR), but a Lessons Learned Case I

### Bernice

had severe learning disabilities with non-verbal communication, variable moods, frequent involuntary movements and sleep disturbances. Bernice could not express pain. It was known that her involuntary movements could sometimes result in an accidental injury to herself.

Bernice had lived in supported housing with twenty four hour care for over twenty years, sharing with five other people. She attends day services in the city. In July 2015 Bernice was noted to have an injury to her arm and was taken to York hospital by care staff. An x-ray showed a fracture to a bone in her arm. She was treated over a number of months and required an operation to fix the bone until it healed.

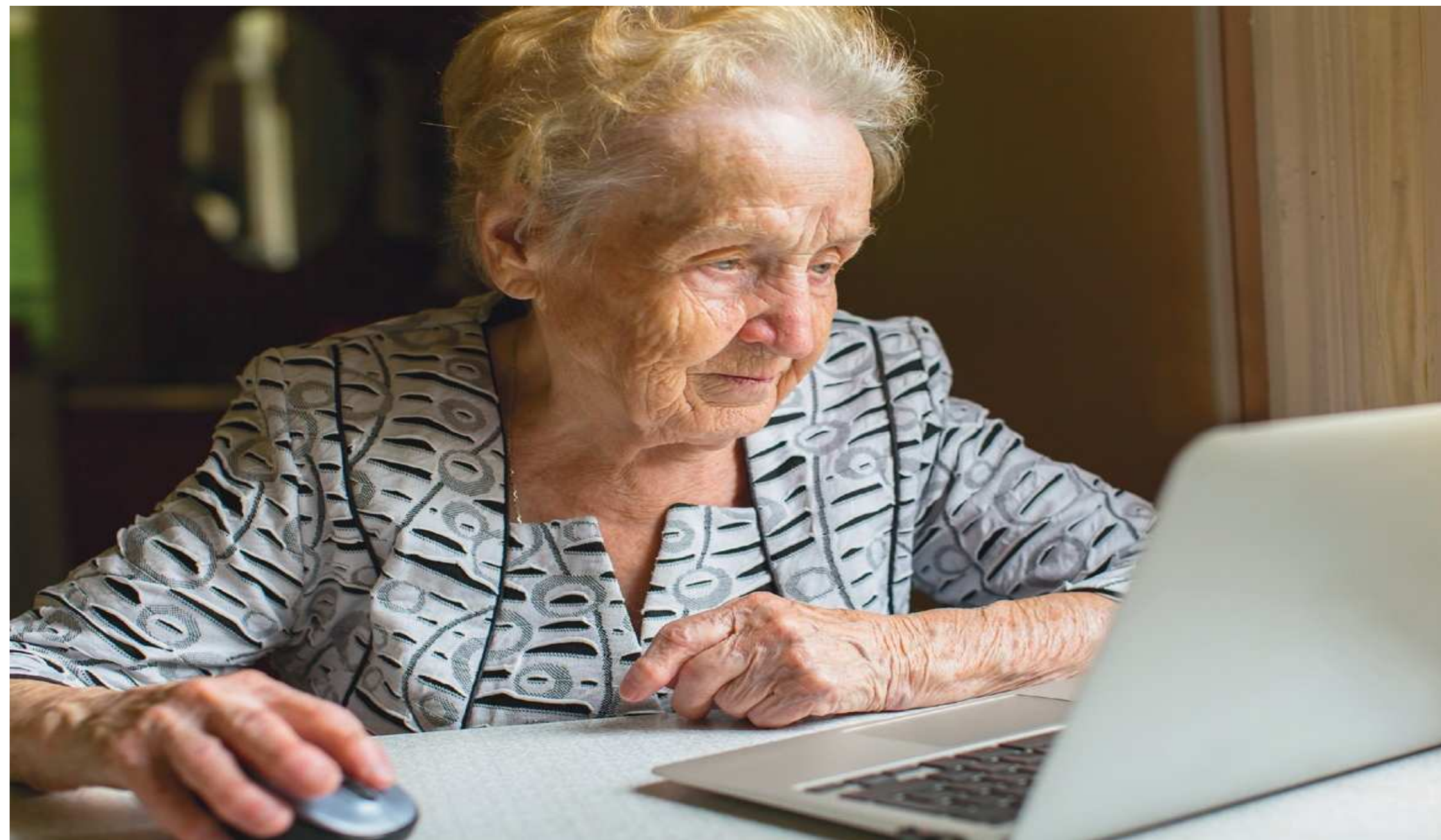
As the cause of the injury was unknown a safeguarding alert was made to the City of York Safeguarding Adult team. The subsequent investigation took six months to conclude, with a consensus that 'on the balance of probabilities temporary bed/bedrail entrapment had occurred which led to the injury.

## Lessons Learned findings:

Concerns were raised about the way agencies worked together during the safeguarding process and a decision was taken to undertake a Learning Lessons review, whose purpose is not to reinvestigate the case or to apportion blame but to:

- Identify any lessons that can be learned about the way in which local professionals and agencies worked together to safeguard adults
- Inform and improve multi-agency practice
- Improve practice by acting on learning

A 'learning together' approach was used with representatives from all of the agencies involved in the care and treatment of Bernice coming together in a workshop to look at what the challenges were, how things could have been done differently and what needed to change. The recommendations from the review were reported to and agreed at the Safeguarding Adults Board in June 2017 and a final summary of the review will appear in next year's Annual Report.





## **2016/17 Planned SAB developments included:**

Agree a Media and Communications strategy

Develop an audit tool for use in case reviews

Publish an information leaflet on Adult Safeguarding

Establish a new Quality Assurance Framework

Revise the Safeguarding Referral Form

Establish a Board Risk Register

Agree revisions in local Operational Guidance across West and North Yorkshire and City of York and conduct briefing sessions for staff and service users

Publicise and present the SAB Annual Report to any community group requesting it

# Questions and comments?

**Kevin McAleese CBE, Chairman**