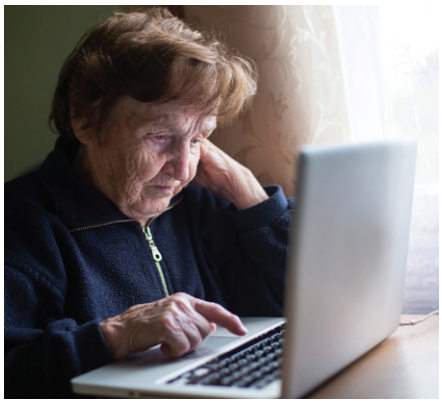
ANNEX B

Safeguarding Adults Board

Annual Report 2015/16






City of York Safeguarding Adults

CITY OF YORK COUNCIL

Contents

Introduction
by the Chair of the Safeguarding Adults Board (SAB)

Kevin McAleese CBE
Independent Chair, City of York Safeguarding Adults Board

I am very pleased to introduce the SAB Annual Report for 2015/16, having first taken up my appointment as Chair on 1 April 2013. As readers may know, the City of York SAB became a full statutory body under the Care Act 2015 on 1 April 2015, so we are just completing our first year with those new responsibilities. There are some 500 pages of statutory guidance on implementation of the Act, though the SAB has only had to concentrate on the fifty pages in Chapter 14. I am as certain as I can be as Chair that all which should be in place is, or is in the process of being finalised. The current Board members are drawn from twelve key organisations operating in the City of York. Three of them are "statutory partners" as required by the Care Act: the City Council, the "NHS" and the Police. The full list can be seen in Annex 2.

One of the requirements of the Care Act is that the SAB Annual Report must contain details of any Safeguarding Adults Reviews (SARs) which have been conducted when an adult has died 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 them. The findings of any SARs must be included, as must actions taken or intended in relation to those findings. I can confirm that, like 2014/15, there have been no SARs during 2015/16. However, there were two deaths during 2014/15 which were reported on last year in outline, where a lesser level of enquiry known as Lessons Learned had been started, and there are some details of those cases on pages 19-21 of this Report. They do illustrate the challenging nature of safeguarding work and the complexities of supporting individuals in particular circumstances.

The SAB does have a website, and I am delighted to say that it has been totally rewritten to make it more accessible for both members of the public and professional staff. The address remains www.safeguardingadultsyork.org.uk. The website can also be accessed by the safeguarding team to monitor how much usage is made of it via the internet, and we are confident that it will increase over previous years. It also contains minutes of our quarterly meetings, which are not open to public attendance because of the sensitive and confidential nature of much of our work.

I hope that you will be interested, informed and also reassured by the contents of this Report on our work for 2015/16. Thank you for taking the time to read it.

Kevin McAleese CBE
Independent Chair, City of York Safeguarding Adults Board

The Board's Work and its Vision

York Safeguarding Adults Board (SAB) oversees and leads adult safeguarding across the city in order that all agencies contribute effectively to the prevention of abuse or neglect of vulnerable people. It has been in existence since November 2008 and has a strong focus on partnership working. The work of the Board includes the safety of patients in local health services, the quality of local care and support services, and the effectiveness of prisons and approved premises in safeguarding offenders.

Our Vision, stated in our new Strategic Plan (see Section 7 below) is that we aim to ensure that agencies supporting adults who are at risk or in vulnerable situations, and the wider community, can by successfully working together:

- Establish that Safeguarding is Everybody's Business
- Develop a culture that does not tolerate abuse
- Raise awareness about abuse
- Prevent abuse from happening wherever possible
- Where abuse does unfortunately happen, support and safeguard the rights of people who are harmed to:
  - stop the abuse happening
  - access services they need, including advocacy and post-abuse support
  - have improved access to justice
  - have the outcome which is right for them and their circumstances.

Work Undertaken in 2015/16

Making Safeguarding Personal (MSP)

A key part of the Care Act is MSP and the establishment of a person-centred approach to safeguarding adults across all agencies. The City of York took part in a national MSP pilot programme which came to an end a year ago. The SAB has begun trying to encourage the development of an MSP approach across all agencies in the city.

This is challenging work, not least because not all vulnerable people have the capacity to decide what is in their best interests and need assistance to do so. The two real case studies below illustrate how this has worked:

Case Study 1

Annie has a number of physical health conditions. She has historically declined to engage with services including declining medical treatment and it has been unclear why.

Annie came to the attention of the Safeguarding Adults Team as she was being financially exploited by people she knew. Through an MSP approach, Annie was spoken with about this concern and asked how services could support her to stop this harm from continuing.

Annie identified that she would like to move to another property so that the people no longer targeted her; and with steady support from the team, identified that moving closer to family may be of benefit to her wider welfare, as it would mean that family members could support her to attend medical appointments.

Annie agreed to accepting support from an agency who were able to support her with applying for a housing transfer, and this relationship was facilitated by the team. Annie has now moved home, which has removed the risk of financial exploitation, and she continues to attend medical appointments, which has improved both her physical and mental wellbeing.

Case Study 2

Gerald has significant physical health problems, and is cared for in bed. He recently had a short break at a nursing home, and staff there were concerned about the way his informal carer interacted with him and the potential that he was suffering harm at home. Gerald's carer was known to have declined support on his behalf in the past.

Whilst Gerald was in the nursing home, a member of the safeguarding adults team visited him to discuss the staff's concerns. Gerald has limited communication so aids were used and Gerald was able to identify that he would like the team to speak with his carer, but that he would like to be present. Gerald was also very keen to return home and did not want this conversation to delay this.

As per Gerald's wishes, he was discharged home and on that day the safeguarding workers visited and outlined the concerns that had been raised. They spoke with Gerald and his carer together and separately to ensure that both had the opportunity to raise any individual concerns that they had.

As a result of this initial conversation, the carer allowed the workers to return and although she remained resistant to ongoing support from statutory services, Gerald reports that he is happy that the issue has been discussed and is out in the open.

Self-assessment

A key part of this year's work was the further development and implementation of a self-assessment framework for partners, to understand the progress their organisations are making in safeguarding adults. All partners completed this assessment and they were collated for the board.

Assurance on the ability of members to safeguard adults was good overall and areas for future work were highlighted. These areas included:

- Community engagement
- Improving delivery to minority groups
- Embedding the Mental Capacity Act
- Information sharing

A further round of self-assessment is being implemented during 2016/17, with each organisation having their own view of themselves validated and assessed by another one, beginning with City of York Council and the Vale of York Clinical Commissioning Group.

ADASS Mystery Shopping

Between October 15 and January 16 the Association of Directors of Adult Social Services (ADASS) in Yorkshire & Humberside conducted a regional "mystery shopping" exercise on behalf all the local authorities across the region focussing on access to services. The method adopted was based on the Care Quality Commission 'access to service' toolkit and a range of scenarios which have been developed through the regional Standards and Performance network. The assessment was conducted by real customers testing how easy it is to access services over the telephone, face to face, and on the internet. The feedback that was then taken from their captured observations and experience.

Face to face scenarios were used with City of York staff by calling at West Offices:

- My sister is struggling with washing and taking care of herself but has funds available. What help is on offer?
- My brother has a learning disability and I am his main carer. I a struggling to cope: what help can I get?
- Can you tell me who I need to contact to report suspected abuse, as I have concerns about a neighbour and don't know who to contact?

Telephone scenarios were used by ringing York City Council:

- My brother has a learning disability and I am his main carer. I a struggling to cope: what help can I get?
- My sister is struggling with washing and taking care of herself but has funds available. What help is on offer?
- I am not sure if this is an emergency or not but my Mum/Dad is in residential care and recently their money has been going missing. I am not sure what to do as my Mum says that staff sometimes shout at her and so doesn't want me to say anything.

Internet scenarios were asked using the City of York website:

- Is there any support for me as a carer?
- My sister is struggling with washing and taking care of herself but has funds available. What help is on offer?
- How do I report a safeguarding concern?
- How do I report suspected abuse?

Each of the scenarios was rated **Excellent** (Lots of useful information, helpful staff, very satisfied with the service received, enquiry dealt with promptly), **Good** (some information given, knowledgeable staff, satisfied with the service given, enquiry deal with in a timely manner), **Fair** (limited information given, fairly satisfied with the service, enquiry deal with in a reasonably timely manner and Unsatisfactory (no information given, poor customer experience, didn't feel valued, unhelpful staff, very dissatisfied with the service).

These are the results for City of York Council, with comparisons back to 2012:

Scenario	2015/16 Rating	2014 Rating	2013 Rating	2012 Rating
Telephone	EXCELLENT	GOOD	GOOD	FAIR
Website	EXCELLENT	GOOD	FAIR	GOOD
Face to Face	GOOD	GOOD	GOOD	FAIR
Reception	GOOD	GOOD	EXCELLENT	UNSATISFACTORY
Out of Hours	EXCELLENT	GOOD	UNSATISFACTORY	GOOD
Safeguarding Access	EXCELLENT	GOOD	GOOD	

The SAB was delighted to see such progress demonstrated over the past four years.

Care Act Implementation

Policies and Procedures

In preparation for the introduction of the Care Act 2014, the City of York SAB developed a constitution, memorandum of understanding and register of interests for its members. These documents give clarity and underpin the important statutory work of the Board. The SAB has also developed local policies for undertaking Safeguarding Adults Reviews (SARs) and Lessons Learned. These policies have helped to ensure that that the SAB has a robust process in place for carrying out a review where an adult with care and support needs has suffered serious neglect or abuse and there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard that adult.

The SAB took the decision in the Summer of 2015 to harmonise the City of York multi-agency policies and procedures for adult safeguarding with those for the whole of West and North Yorkshire, to ensure that different agencies were not using different arrangements in different parts of the same geographical region. That work is now virtually complete and the relevant information is available to staff on the SAB website. Workshops were run in February and March 2016 for community groups, the voluntary sector and independent providers, helping those working with adults at risk in the community to understand their roles and the support they can expect from City of York Council and the SAB.

Winterbourne Concordat

City of York Council and Vale of York Clinical Commissioning Group have continued to work together to identify vulnerable people from York who are placed out of the city area for whom a move back to the York area may be the best way to enable then to be safe and enjoy the highest quality of life possible. These arrangements are reported to the SAB twice yearly. During 2016/17 the SAB will also begin to receive assurance about vulnerable individuals placed in the City of York from other parts of the country.

Performance and activity information

The Safeguarding Adults Collection 2015-16

The Health and Social Care Information Centre (HSCIC) take national responsibility for compiling an annual Safeguarding Adults Collection (SAC), which records details about safeguarding activity for adults aged 18 and over in England. Each local authority (referred to by HSCIC as Councils with Adult Social Services Responsibilities-CASSRs), has a statutory obligation to contribute towards this Collection, and the data outlined in the Annex and described below represents the significant areas of the City of York's contribution.

The collection includes demographic information about the adults at risk and details of the incidents that have been alleged.

The SAC is an updated version of the Safeguarding Adults Return (SAR) which collected safeguarding data for the 2013-14 and 2014-15 reporting periods. Some of the categories collected have remained the same but there are also some significant differences and these are discussed in the following section. As a result of some of these differences, it is difficult to compare data across the collections in all areas.

Changes to the Collection between 2014-15 and 2015-16

Between December 2014 and February 2015 the HSCIC ran a public consultation about what changes needed to be made to the safeguarding return as a result of the Care Act. Key changes included changing the name of the Collection (so as not to cause confusion with the newly named Safeguarding Adults Reviews- SARs); removing words such as 'referrals' and 'completed referrals', and replacing these with 'concerns' and 'completed enquiries'; and adding in voluntary collections around 'other enquiries' (enquiries where an adult does not meet all of the section 42 criteria but the council considers it necessary and proportionate to have a safeguarding enquiry).

Certain areas of data collection were ceased, including collecting information about whether individuals were already known to the council, and importantly, collecting information regarding whether or not allegations were substantiated or not.

Certain areas remain the same, including the collections around the location of abuse or neglect, the number of SARs held; and the actions, result, and source of risk categories. The HSCIC are notably working on a different format for collection of the latter 3 areas for next year (2016-17).

Under the 'categories of abuse or neglect' four new categories were added; and two new MSP tables have been added to the SAC for voluntary collection (these are not currently within the scope of this report). NB. The consultation had asked whether it would be useful to collect a table about the type of actions taken and the HSCIC are working with stakeholders to develop this for implementation in 2016-17.

Concerns and Enquiries during the year April 2015 – March 2016:

Concerns

For data collection purposes, a Safeguarding Concern is 'a sign of suspected abuse or neglect that is reported to the council or identified by the council'.

During 2015-16, City of York Council received a total of 1108 Safeguarding Concerns (relating to 863 individuals). This figure is an increase from 1058 alerts in the previous year.

All Concerns raised with City of York Council are scrutinised to see if they meet the Care Act's conditions for a section 42 enquiry, and to consider our duties under the Wellbeing Principle (section 1 of the Care Act) to offer support, advice and information to reduce the risk for the person in question and prevent further harm.

Where the council is unable to resolve the concerns at this stage, further enquiries may take place, either under the auspices of S42 or using 'other' enquiry mechanisms as appropriate.

Section 42 and 'Other' Enquiries commenced during 2015-16

Of the 1108 Safeguarding Concerns raised with City of York Council in 2015-16, 636 were taken through an initial enquiry process which led to signposting and advice, and 4 'other enquiries'. 468 of these concerns were progressed through initial enquiry to formal S42 Enquiry (for 431 people). Please see table 1 for counts of concerns raised and referrals for further enquiries.

Table 1

Counts of Safeguarding Activity	Count
Total Number of Safeguarding Concerns	1108
Total Number of Section 42 Safeguarding Enquiries	468
Total Number of Other Safeguarding Enquiries	4

Please note this table collects counts of cases not counts of individuals

Demographic Information

Tables 2, 3 and 4 show the demographic breakdown of the Concerns raised with City of York Council – focussing on concerns raised, and enquiries undertaken, according to age, gender and ethnicity.

The figures in Table 2 initially indicate a higher proportion of Concerns raised and enquiries undertaken for individuals within the working age bracket (18-64yrs- 39% of all Enquiries undertaken). However, given that this spans a duration of 46yrs, if the remaining age brackets are combined to create a 65yrs+ category for parity, then in fact this would account for 61% of the concerns raised.

Table 2

Counts of Individuals by Age Band	18-64	65-74	75-84	85-94	95+	Not Known
Individuals Involved In Safeguarding Concerns	334	99	195	207	23	5
Individuals Involved In Section 42 Safeguarding Enquiries	170	53	101	94	9	4
Individuals Involved In Other Safeguarding Enquiries	2	0	0	1	1	0

The figures in Table 3 show a higher proportion of Concerns being raised around the possible abuse or neglect of women with care and support needs (60% of total concerns raised), which is reflective of the national picture within the Safeguarding Adults Return in 2014-15 (source: http://www.hscic.gov.uk/catalogue/PUB18869/sar-1415-rep.pdf). The progression from Concern to Enquiry does not appear to be affected by gender.

Table 3

Counts of Individuals by Gender	Male	Female	Not Known
Individuals Involved In Safeguarding Concerns	340	523	0
Individuals Involved In Section 42 Safeguarding Enquiries	172	259	0
Individuals Involved In Other Safeguarding Enquiries	1	3	0

The figures in Table 4 show that 96% of the Safeguarding Concerns raised with City of York Council related to people of White ethnic origin. This is reflective of the City's overall demographic - the main ethnicities recorded in the 2011 Census were White British (90.2%) and Chinese (1.2%).

Table 4

Counts of Individuals by Ethnicity	White	Mixed/Multiple	Asian/Asian British	Black/African/Caribbean/Black British	Other Ethnic Group	Refused	Undeclared/Not Known
Individuals Involved In Safeguarding Concerns	829	3	7	5	2	2	15
Individuals Involved In Section 42 Safeguarding Enquiries	414	0	3	4	2	1	7
Individuals Involved In Other Safeguarding Enquiries	2	0	1	0	0	0	1

Section 42 and 'Other' Enquiries completed during 2015-16

There were 391 S42 enquiries completed during 2015-16.

Type, Source and Location of Risk

Table 5 shows the type of risk cross tabulated with the Source, and Table 6 the Location where the potential harm has taken, or is taking place (again cross tabulated with the Source of risk).
NB. Because some people are at risk from multiple types of abuse in multiple locations, the figures in these tables total more than the 391 completed enquiries, as all types and location of risk are recorded.

Table 5

Counts of Enquiries by Type and Source of Risk	Concluded Section 42 Enquiries			Other Concluded Enquiries		
	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Physical Abuse	35	66	2	1	0	0
Sexual Abuse	5	9	2	0	1	0
Psychological Abuse	39	79	6	0	0	0
Financial or Material Abuse	18	68	8	0	0	0
Discriminatory Abuse	2	1	2	0	0	0
Organisational Abuse	23	4	1	0	0	0
Neglect and Acts of Omission	135	27	11	2	0	0
Domestic Abuse	0	4	0	0	0	0
Sexual Exploitation	0	0	0	0	0	0
Modern Slavery	0	0	0	0	0	0
Self-Neglect		4			0	

Type of Risk

Table 5 shows that neglect accounted for 31% of the concerns raised (78% of which was allegedly carried out by 'social care support'), followed by psychological abuse (23%) and physical abuse (19%). Financial or material abuse accounted for 17% of the concerns raised. This trend has been consistent in all quarterly reports to the Safeguarding Adults Board, and is reflective of the national picture outlined in the 2014-15 SAR.

Source and Location of Risk

The data in tables 6 and 7 indicates that the source of risk, has most frequently been people known to the adult with care and support needs (as per last year) and this has most frequently been located within their own home.

The number of concerns raised within residential and nursing care homes has increased from previous years by 46% (133 this year compared with 91 in 2014-15), but again the trends locally do appear to reflect national figures (i.e., location of own home accounts for 41% of total local concerns and 43% nationally in the 2014-15 SAR; location of care home accounts for 33% locally and 36% nationally in the 2014-15 SAR).

Notably, concerns located within hospital settings has increased locally by 50% compared to last year (41 concerns in the 2014-15 SAR , 66 concerns this year), where concerns located within community settings has decreased by 46% this year (13 in 2015-16 compared with 24 in 2014-15).

Table 6

Counts of Enquiries by Location and Source of Risk	Concluded Section 42 Enquiries			Other Concluded Enquiries		
	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Own Home	45	112	11	0	0	0
Community Service	5	5	3	0	0	0
Care Home	102	28	2	1	0	0
Hospital	37	15	11	2	1	0
Other	2	21	4	0	0	0

Actions and Results from Enquiries

Table 7 show the outcomes reached for safeguarding enquiries concluded within 2015-2016. The total numbers in these tables include Enquiries that were completed by 31st March 2016.

Action was taken to reduce or remove the risk in the majority of cases (in 8% no action was deemed to have been taken). In 59% of all completed enquiries, the risk was noted to have reduced, and in 29% to have been removed. In only 4% of cases did the risk remain.

This looks to be an improvement in the outcomes for adults with care and support needs on previous years, as in 2014-15 22% of cases resulted in no action being taken and in 67% of cases the risk remained. The number of cases where risk reduced and where risk was removed looks comparable across the collections – at 42% and 29% respectively.

Table 7

Counts of Enquiries by Action, Result and Source of Risk	Concluded Section 42 Enquiries			Other Concluded Enquiries		
	SOURCE OF RISK			SOURCE OF RISK		
	Social Care Support	Other - Known to Individual	Other - Unknown to Individual	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
No Action Taken	7	22	4	0	0	0
Action taken and risk remains	3	12	1	0	0	0
Action taken and risk reduced	118	98	17	0	0	0
Action taken and risk removed	61	43	5	3	1	0

Training

Introduction

The Workforce Development Unit (WDU) is responsible for ensuring that Safeguarding and Mental Capacity Act training is available at all levels for the workforce.

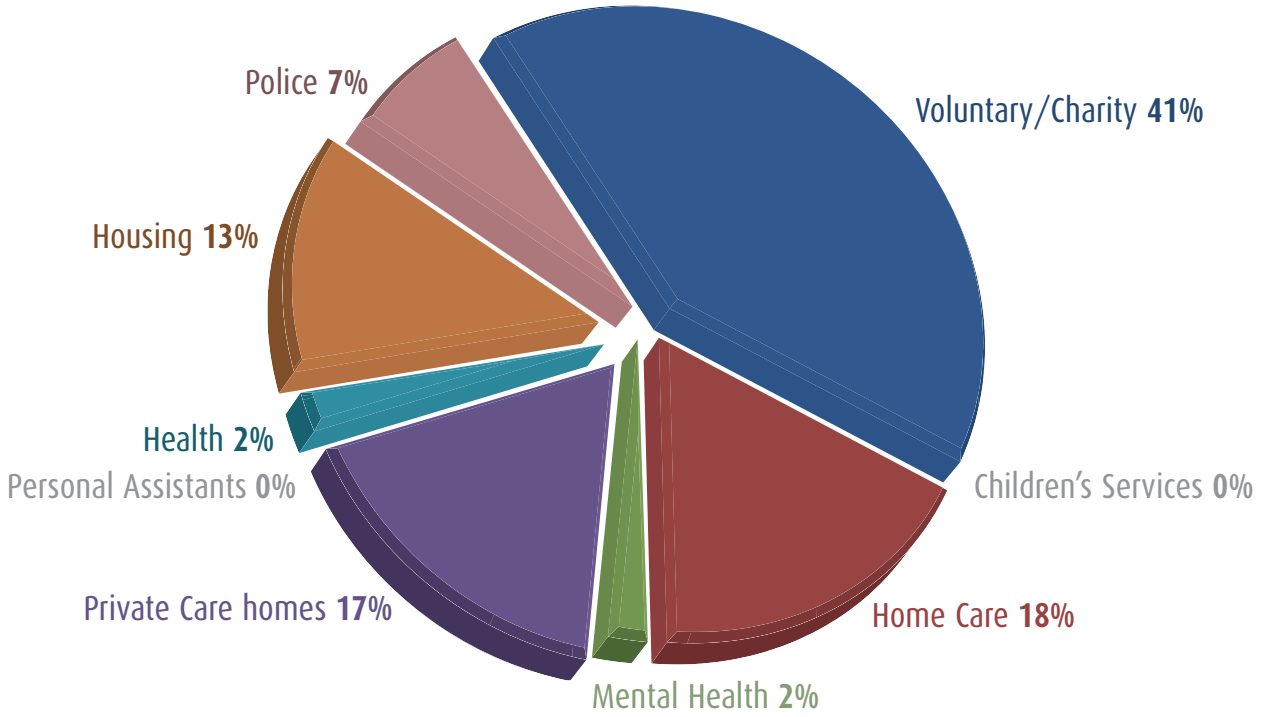
The Training Offer 2015/16

During 2015/16 our Safeguarding and Mental Capacity Act training was provided by Community Links.

Below shows a breakdown of courses that took place over 2015/16

Course	Number of Sessions	Total Cost	Total attendees	CYC attendees	PVI attendees	No Shows	% of internal CYC delegates	% of external PVI delegates
Safeguarding L1	14	£4,200	155	34	121	34	22%	78%
Safeguarding Level 2	6	£3,420	63	14	49	19	22%	78%
Safeguarding Level 3	2	£1,140	18	12	7	3	67%	33%
Safeguarding Level 4	1	£570	3	1	2	0	33%	67%
Safeguarding Train the Trainer	3	£1,950	22	2	20	1	9%	91%
MCA L1	8	£2,400	100	59	41	10	59%	41%
MCA L2	3	£1,710	20	16	4	1	80%	20%
MCA L3	2	£1,140	16	4	12	6	25%	75%
MCA L4	1	£570	7	6	1	0	86%	14%
MCA Train the Trainer	1	£650	13	1	12	0	8%	92%
Total	41	£17,750	417	149	269	74	35%	65%

Breakdown of external delegates by area:



Charging Policy

In April 2015 the pricing structure below was implemented, with the exception of Safeguarding Level 1 and Mental Capacity Act Level 1 which remain free of charge.

Full Day **£40.00**

Half Day **£20.00**

A non-attendance charge of £50.00 remained in place for all courses.

Developments

- The WDU continue to receive positive feedback from our course evaluation forms for all courses. This is monitored on a regular basis to highlight any areas for concern.
- An Impact Assessment tool for use by managers with staff attending training has been developed by WDU. This has been designed to support managers in checking on the transfer of learning from the classroom to their day to day roles. This is due to piloted on a small number of courses during May/ June 2016. If successful, we hope to roll out to all safeguarding courses during 2016/17 and would ask for the Board's support in ensuring its implementation within their own organisations.
- Following discussions with the commissioning team and feedback from providers, WDU have revised their charging policy for 2016/17. A range of courses including safeguarding and mental capacity act will be offered at no charge from April 2016 to March 2017. A non-attendance charge remains in place for all courses.
- A skills analysis of Board members was conducted in summer 2015. The responses to the needs analysis were varied and demonstrated the breadth of experience of members on the Board. In response two development sessions were held.
- The safeguarding training offer is currently being reviewed for 2016/17. The current levels 1-4 will no longer form part of the offer and a new range of courses is being developed based on making safeguarding personal principles, in conjunction with feedback from providers.

Strategic Plans

The Board agreed a Draft Strategic Plan for 2014-17 at the December 2013 meeting. Meeting of the SAB. This was completed ready for agreement at the March meeting in 2014, and placed on the Safeguarding website. The themes for action were agreed as:

A. Make sure safeguarding is embedded in corporate and service strategies across all partners
B. Ensure good partnership working
C. Focus on prevention of abuse
D. Respond to people based on the Personalisation approach, and with a clear focus on outcomes

Annex 4 shows the progress which has been made against each of the themes up to March 2016

Under the Care Act 2014 it is a legal requirement for the SAB to have a Strategic Plan and to produce an annual summary of its progress. A new Strategic Plan for 2016/19 in a very accessible format has been agreed by the SAB and is already on the website under "Board". It follows the six guiding principles of the Care Act:

1. EMPOWERMENT
2. PREVENTION
3. PROPORTIONALITY
4. PROTECTION
5. PARTNERSHIP
6. ACCOUNTABILITY

The new Strategic Plan for 2016/19 has an Action Plan for 2016/17 which will be reported on in the next Annual Report.

Safeguarding Adults Reviews/ Lessons Learned

There were no Safeguarding Adults Reviews needing to be conducted during 2015/16.

However, during 2014/15 the Board received two Lessons Learned briefing papers concerning the deaths by suicide of two individuals in York who had been in receipt of services from statutory bodies and other organisations. As Chair of the Board I had decided, as I am required to do, that the facts of neither case warranted the establishment of extended Serious Case Reviews (or Safeguarding Adults Reviews as they are known under the Care Act 2014). However, both contained issues which needed to be clarified so that the Board gained assurance both about what had been done to support the individuals concerned and also that the likelihood of any repetition had been minimised. As a result, the Lessons Learned procedure was activated in each case. Because of the timing of the two briefing papers the enquiries and actions they generated were reported to the Board during 2015/16 and so are featured in this Annual Report.

Aileen (previously 'Tracy', renamed)

The Learning Lessons review into the death of Aileen was signed off by partners at the City of York Safeguarding Adults Board meeting in December 2015. The death of Aileen and proposed review of the care she received in York services were described in the 2014/15 Annual Report. The following is a summary of the completed review and subsequent learning from it:

Aileen was born in 1978 and had a long history of mental health issues and substance misuse. She was suspected as being a victim of domestic abuse and sexual exploitation. Aileen repeatedly reported to services feeling hopeless and trapped in a cycle of relationship difficulties. She was noted as using self-harm from an early age to control her feelings and emotions. Aileen appeared to engage with services when in crisis but then disengage when the immediate crisis passed. During the time preceding the incident Aileen was not under the care of mental health services in York. She had moved repeatedly between York and London in the months before her death.

In December 2013 Aileen was taken to the Emergency Department at York hospital by ambulance following a self-harm incident. She had injuries to her arms, legs and neck. Aileen was under the influence of alcohol and possibly other substances. Following clinical review Aileen received care overnight on the High Dependency Unit and then was transferred the following day to a short stay acute ward. Approximately two hours following transfer Aileen was found unresponsive following a further significant episode of self-harm in an area away from the view of staff. Attempts made to resuscitate Aileen were unsuccessful and her death was confirmed a short time later.

The review highlights where the partners of the Safeguarding Adults Board could have worked better together to safeguard Aileen, with a focus on three main areas:

- The patient pathway between the Emergency Department; the Acute Ward Services and Mental Health Services
- The broader health context
- The window of opportunity and potential missed opportunities between Aileen's admission and subsequent death

The findings relate to systems failures rather than the actions of any individuals. Key Learning and Actions taken following the findings of the review were:

1) Focused work on the development of a multi-agency Mental Health Crisis Concordat in York, involving mental health services, acute hospital services, ambulance services, police services and the local authority.
2) Opening of a Section 136 'place of safety' suite where individuals in mental health crisis can be safely assessed and cared for.
3) Development of a 24 hour Mental Health Intervention Team based in the acute hospital so individuals attending the Emergency Department with mental health issues receive assessment, support and appropriate referral in a timely way.
4) Mental Health first aid training for key identified hospital staff to support them in managing people with mental health problems in acute medical settings.
5) Commitment to a Multi-Agency Safeguarding Adults Information Sharing Agreement to facilitate appropriate sharing of information to protect individuals at risk who are unable to protect themselves.

The City of York Safeguarding Adults Board wishes to extend their sincere condolences to Aileen's family and friends.

Daniel

The Learning Lessons review into the death of Daniel was signed off by partners at the City of York Safeguarding Adults Board meeting in June 2015. The death of Daniel and proposed review of the care he received in York services was described in the 2014/15 Annual Report. The following is a summary of the completed review and subsequent learning from it:

In November 2014 Daniel was seen walking unsteadily along an elevated platform in the centre of York. He was seen to climb over railings and fall approximately 40 feet to the ground. Daniel was taken to York District Hospital but his injuries were such that he could not be resuscitated and his death was confirmed a short time later. A note expressing his intention to take his own life was found in his pocket.

Daniel had been referred to Adult Safeguarding in the months prior to his death by a Housing Support Worker with a concern related to possible financial abuse. Daniel had been interviewed under caution and released on police bail following the death of a male at his address from a suspected drug overdose. Daniel was known to mental health services and mostly he engaged well with support services. He had a job at a local college and was receiving counselling support there. Daniel was frequently open about suicidal thoughts and plans. In the period leading up to his death Daniel had made several suicide attempts where he was found to be carrying a suicide note and he had received a number of welfare checks.

The review sought to ascertain if services could have worked better together to safeguard Daniel.

Key findings from the review:

- In general all involved services engaged well with Daniel, they shared their level of concern equally and exchanged information appropriately.
- The management and human resources team at the college deserve particular mention for going the extra mile in trying to keep Daniel safe and well.
- Daniel's suicidal ideas were regularly addressed by his Community Psychiatric Nurse (CPN) and these concerns fed into the safeguarding process.
- It was less clear to identify a proportionate response to the potential escalation of risk as a result of the death at his accommodation and the subsequent police investigation.
- There were however found to be no obvious omissions in Daniel's care: it appears that mental health services and the police worked effectively together to do what was reasonably possible to try to keep Daniel safe.

In order for North Yorkshire and York services to gain a better understanding of suicide and responses to it, a senior suicide prevention co-ordinator has been recruited to undertake a review of all deaths from suicide during the past five years. The York Safeguarding Adult Board will receive the report for York when it is completed and will continue to work with partners to address any themes or issues arising from it, in particular in relation to adults with care and support needs.

The City of York Safeguarding Adults Board wishes to extend their sincere condolences to Daniel's family and friends.

New Strategic Plan for 2016 onwards

Under the Care Act 2014 it is a legal requirement for the SAB to have a Strategic Plan and to produce an annual summary of its progress. The SAB was clear during 2015/16 that a new method needs to be employed to ensure that its new Plan was based on the views of local residents and staff. As a result the SAB commissioned York Healthwatch to develop an engagement strategy with the local community in York, which fed directly into the new Strategic Plan to be in place by April 2016.

The Strategic Plan for 2016/19 in a very accessible format has now been agreed by the SAB and is already on the website under "Board". It follows the six guiding principles of the Care Act:

Empowerment
People being supported and encouraged to make their own decisions and informed consent.

Prevention
It is better to take action before harm occurs.

Proportionality
The least intrusive response appropriate to the risk presented.

Protection
Support and representation for those in greatest need.

Partnership
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability
Accountability and transparency in delivering safeguarding

The new Strategic Plan for 2016/19 has an Action Plan for 2016/17 which will be reported on in the next Annual Report.

Annex 1:
Contributions from individual member organisations:

Garrow House Yearly Safeguarding Report (2015/2016)

Training:
All staff employed at Garrow House, clinical or otherwise, undertake e-learning on safeguarding upon induction, which is provided from head office via the Turning Point e-learning resources, which is then refreshed each year. This training is focused upon recognizing the signs of abuse, the law, human rights issues, and similar 'awareness' issues. At the time of writing all staff at Garrow House have undertaken this training within the last year.

Further to the e-learning, all staff at Garrow House, clinical or otherwise, undertake face-to-face internal training using materials provided from head office that is facilitated either by the unit's safeguarding lead, or by members of Turning Point's 'risk and assurance' team. This training builds upon the e-learning training, re-capping the 'awareness' issues already touched upon, and adding a focus on the mechanics of the safeguarding policy, namely alerts and referrals. This training takes place as part of the induction process, and is then refreshed yearly. At the time of writing all but two (27 out of 29) staff have completed this training within the last year.

Regarding the external training on safeguarding provided by City of York council's Workforce Development Unit: Garrow House's operations manager and safeguarding lead do up to level 4, and the senior nurses doing on call duties up to level 2.

Safeguarding Concerns and Completed Enquiries:
the unit raised internally seven concerns in total in the year April 2015 – April 28th 2016.

Five of these pertained to allegations/concerns of sexual assault by third parties unknown to the service while patients were on leave, AWOL, or historical allegations.

Garrow House continues to experience a relatively low number of concerns this year. Generally we have about eight or nine a year, and most of these often pertain to historical claims of abuse from long before their stay at Garrow. This continues to broadly be the case.

Achievements/developments relating to safeguarding:

Regarding making safeguarding personal, patients are always asked their views before referrals are made. These are respected unless issues around capacity, coercion or overriding public interest are present. Training and policy has been adapted to reflect this.

The safeguarding lead produced a safeguarding file in the staff office for staff when they are on nights or weekend and no management are physically around (we have on call managers at all times however!). It contains flow charts regarding the need for putting in a concern; how to put in concerns; what to do in an emergency; how to document concerns etc. This was in response to staff saying that they wanted some more guidance re the process to enhance their confidence in safeguarding situations, in addition to the posters we have up and the policy document itself The flow charts were adapted and lifted from the local multi-agency policy to ensure quality and compliance.

Independent Care Group

Independent Care Group (ICG)

ICG is the representative body for independent care providers (care homes, homecare and supported living services) in York and North Yorkshire.

ICG keeps its members informed on all matters connected to Safeguarding including Safeguarding training and Mental Capacity Act which is offered at no charge from CYC. This includes that changes to Safeguarding Adults brought in by the Care Act. ICG keeps members informed of DBS news.

ICG gives information on Safeguarding training and how to access it on its website.

Leeds and York Partnership NHS
NHS Foundation Trust

Leeds and York Partnerships NHS Foundation Trust

The LYPFT have a high compliance rate for mandatory safeguarding training, the LYPFT provides mandatory training in three levels with the first being online, the second 2 hour face to face and a full day level three for senior clinicians. A number of senior clinicians from York forensic services have now completed this training. The York Forensic service have on site level two training which is aimed at where possible full team training to support the development of whole team approach to safeguarding.

The Safeguarding team attend all Health Action Group development sessions and have individual training priorities such as PREVENT health wrap training, Modern Slavery, DV and FGM.

A training plan has been developed and will be implemented for 2015/16, this builds on a rate of 80% uptake of safeguarding training with an aim of attempting to raise this compliance to 85-90% where possible.

We have safer recruitment in our 2015 audit plan to give more insight into staff awareness and compliance with safer recruitment.

The Safeguarding team contribute to all HR disciplinary enquiries and have provided a number of safeguarding reports for panel.

Training Evaluation

Questions are rated on a scale of 1 to 5. York Training – Nov 14 to March 15

Overall rating are as follows:
5 = 79.5%
4 = 17.7%
3 = 2.8%
2 = 0%
1 = 0%

The evaluation was based on a number of measures from suitability of venue to content The evaluation process was begun in November 2014.

The LYPFT strategy for 2015-16 has been to embed Safeguarding within practice across the Trust. The actions listed have gone some way to continue to raise the profile of Safeguarding across all LYPFT sites and empower staff to recognize and respond to risk where it occurs.

The LYPFT have successfully worked through a transition to transfer care provision in the York region to TEWV. This was complete on the 01/09/15.The aim was to transfer all care whist ensuring no patient care was affected or any patients harmed. A LYPFT Safeguarding advisor was allocated for this period to ensure all cases remaining open were handed over on completion to ASC safeguarding.

As part of this process the remaining LYPFT services within York have been offered an enhanced safeguarding package. To avoid any issues that may arise from providing services some distance from the mainstream, and to acknowledge the complexities that can arise within inpatient forensic services (provided in York); a package of safeguarding support has been offered to the unit in York. This includes attending MDT meetings, offering individual and team supervision and providing Safeguarding training on site at agreed regular intervals.

An external audit of Care Act 2014 compliance was completed in early 2016. This was carried out by the West Yorkshire Audit Consortium.

The audit found that the LYPFT Safeguarding team provided 'Significant' evidence that it was compliant with the Care Act and had successfully put in place changes to policy and practice to meet the demands of the new legislations.

An audit of PREVENT referrals has been completed and is awaiting a draft report.

Work was carried out to introduce a number of new work streams into the Safeguarding training packs. The team has had training in modern slavery, FGM and Think Family.

The Domestic Violence agenda is now well embedded within the Safeguarding team; the LYPFT clinical recording system has been updated to include the DASH DV risk assessment form. This now enables LYPFT staff to make risk assessments and direct referrals within the clinical record with the aim of embedding good practice around DV and mental health.

The LYPFT team are in the process of developing a Domestic Violence training pack to be offered across the Trust.

In 2015 the Safeguarding team was allocated a designated section in the electronic recording system (PARIS), this is a step forward in embedding safeguarding advice within the patient record. It is hoped this will develop and enable a strong auditing trail for safeguarding advice and risk. The aims to support staff with accessing safeguarding advice out of hours where advice and plans are in place.

The LYPFT Safeguarding Adult training plan has been updated and amended. Safeguarding Adult training was defined into three levels with a level 3 being introduced. This is aimed at senior clinical staff who have responsibility for supervising and leading staff. The long term aim is to have all clinical staff at NHS band 7 to be level three compliant, in the short term to have one or two senior clinicians to take on the role of safeguarding Adult link for their clinical area.

York Teaching Hospital NHS
NHS Foundation Trust

York Teaching Hospital

Safeguarding Training undertaken

Training is fully embedded in Trust induction sessions and in the Trust statutory and mandatory training programmes at Level 1 and 2. This is a bespoke complete Safeguarding Adults, Mental Capacity Act and Deprivations of Liberty Safeguards package. Key individuals in high risk areas receive Level 2 training (how to respond to a safeguarding concern) and the Trust has a training plan for the delivery of Level 1 and further Level 2 training on a 3 year rolling programme.

The Safeguarding Adults Team are all trained to Level 3 (conducting multi agency investigations), and Level 4 (chairing multi agency case conferences) having accessed external training to achieve the necessary competencies.

As there were concerns regarding Level 1 & 2 uptake figures in 2014-15, significant changes have been made to delivery in 2015:

- To ensure increased accessibility the Level 2 training, previous a full day, was transferred to an e-learning package to good effect from April 2015.

- A bespoke Prevent e-learning training package was also developed and became part of the Statutory Mandatory Programme from October 2015.

The introduction of the Trust Learning Hub has also increased compliance of Statutory and Mandatory training uptake.

To further support staff, the staff intranet site now includes Safeguarding Adults resource pages which includes the Trust policy, guidance and paperwork necessary to safeguard a patient whether that is related to general Safeguarding, Mental Capacity or Deprivation of Liberty concerns.

Safeguarding Adults Training Figures 2015/2016

Level 1: 78%

Level 2: 81%

Prevent: 60%

Accessed externally

Level 3: 0

Level 4: 0

See above – all Safeguarding Adults Team staff are currently up-to-date with this level of training, thus there was no requirement to attend such training in 2015-16

Safeguarding Adult Referral/alerts analysis

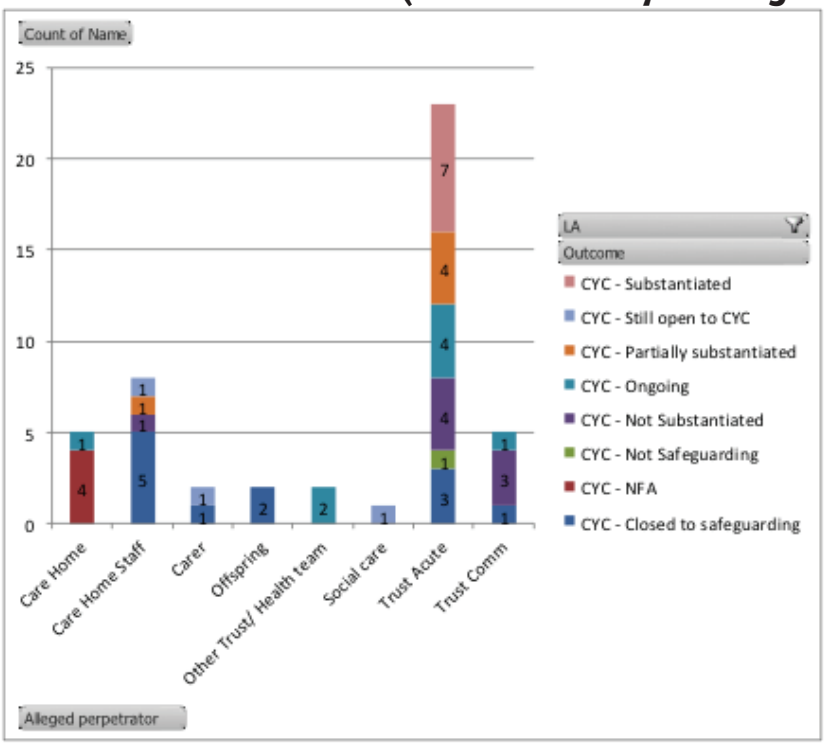
There were 87 Safeguarding Adults alerts received through the Trust Safeguarding Adults Team in 2015/16. This figure relates to all alerts referred through the Safeguarding Adults Team raised either against or by the Trust.

These alerts are either investigated by the Local Authority, or in cases where the concern regard care delivered by the Trust these alerts are investigated by the Trust Safeguarding Adults Team.

Of the 87, 48 were where City of York Council (CYC) was the lead Local Authority.

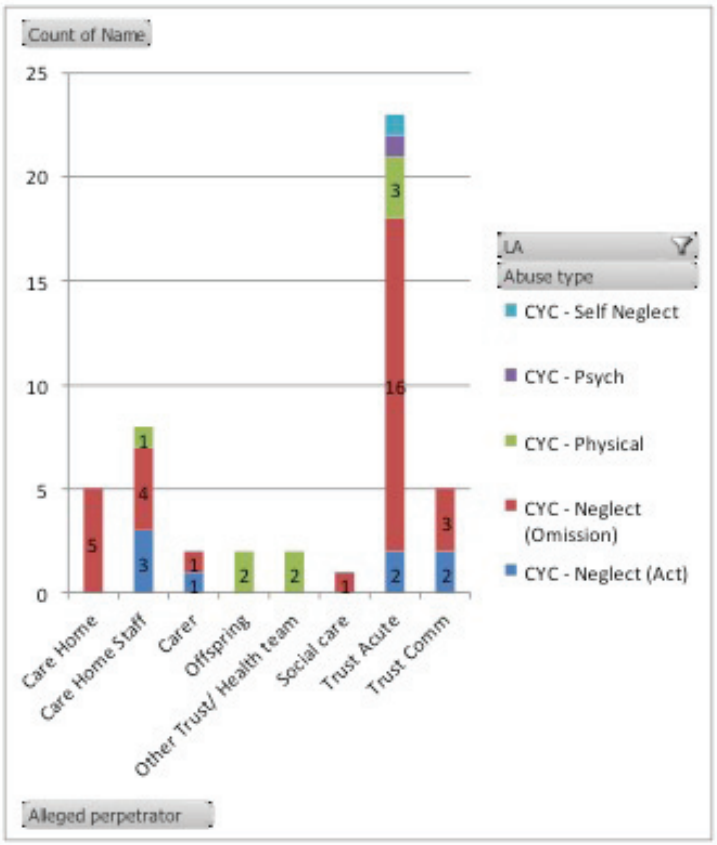
The following data relates only to alerts involving CYC Safeguarding Adults Team. Data is available for other local authorities the Trust serves.

Outcomes for all alerts (both raised by and against the Trust)

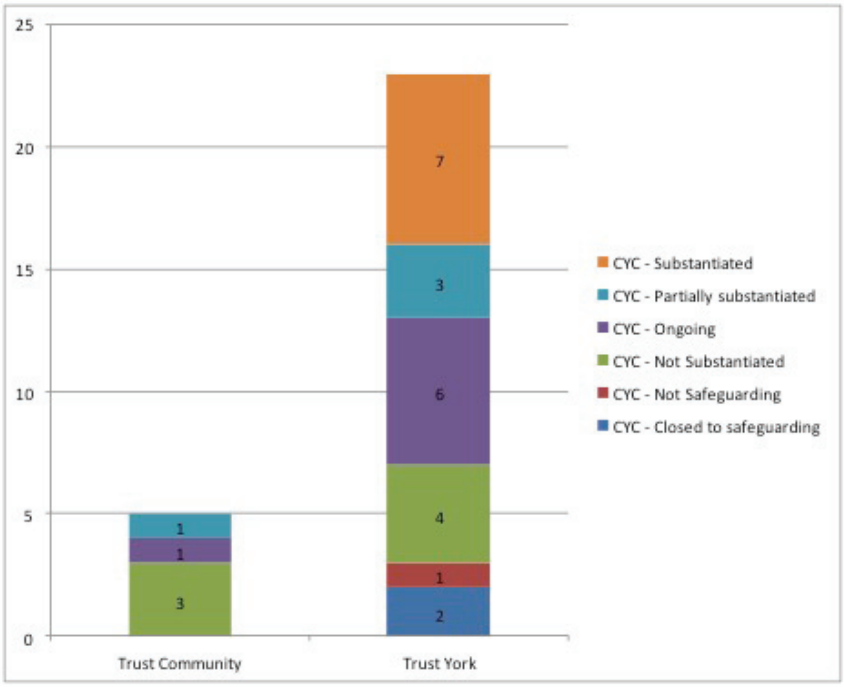


Where the outcome is shown as not known, this is as a result of the Trust raising an alert against another source and there has been no update received from the LA. The Trust Safeguarding Adults team are liaising with CYC for updates.

Type of abuse (all concerns raised against or by the Trust)



Outcome for Alerts raised against the Trust analysis (for CYC only)



Any achievements/developments relating to Safeguarding during the year

Activity within the Safeguarding Adults team continues to be at a high level of demand & complexity.

Under the Care Act (2015) there is a specified approach for the contribution the Trust is required to make in safeguarding adult concerns.

The work of the team has intensified due to fulfilling the scope of enquiries directed by the local authority. There is much more involvement with the patient and/or their representative to focus on their desired outcomes of any investigation and their views. All enquiries begin and end with consultation with the patient and/or their representative. There are also strict time scales enforced to the process which increases pressure on the Team.

The Safeguarding Adults Agenda profile has greatly risen and as a result, so has assurance expectations required from health providers.

Cheshire West ruling continues to dominate, with an ever-changing landscape to enable providers to manage the legislation. The Safeguarding Adults Team represents the Trust at relevant local forums to be in a position to provide regular up-dates of progression/developments.

The implementation of Prevent has been a large project and not without its challenges. However with training and guidance in place, the risk of non-compliance has been reduced to such an extent that it has been removed from the Trust Risk Register.

Trust policies and procedures include the following:

- Safeguarding Adults Policy and Procedures (based on Multi- Agency Policy and Procedures). This has been amended in light of the Care Act 2015.
- Therapeutic Restrictions Guidance
- Mental Capacity Act (NEEDS DATE) Guidance
- Deprivation of Liberty Safeguards (DoLS) Guidance
- Learning Disability Liaison Service Specification
- Prevent Policy

Learning from Safeguarding Adults Investigations

Learning from Safeguarding Adults Investigations have led to the following Trust initiatives:

- Task and Finish group to develop policies, training and risk management tools to support staff care for patients with Mental ill-health.
- Close liaison, training and policy development with the Head of Security in respect of vulnerable adults requiring the support of security
- Matron involvement in delivering actions arising from Safeguarding Adults Investigations.
- Review of Exclusion Policy
- Discharge Improvement Working Group
- Improved pre-operative body marking systems

Training

Significantly improved Safeguarding Adults mandatory Training uptake and compliance has been a major achievement in 2015. Concerning statistics in 2-014-15 meant that a fresh approach to delivery was required. As a result, previous face-to-face training was substituted by e-learning, and compliance was also increased by the introduction of the Trust Learning Hub, which facilitates all Trust staff, in a user friendly intranet site, to ascertain what training is available to them & whether they are currently compliant with their mandatory training requirements.

NHS England have recently published "Safeguarding Adults: Roles and Competences For Health Care Staff, Intercollegiate document" (2016) and as a result the current Trust training delivery is being reviewed to ensure all aspects of the competences are addressed at appropriate levels.

Nicola Cowley - Lead Nurse for Safeguarding Adults
April 2016

NHS England Yorkshire & the Humber

Contribution to Local Safeguarding Adult and Children Boards Annual Report 2014-15

The overall responsibilities of NHS England in relation to safeguarding

NHS England was established on 1 April 2013 and has an assurance role for local health systems and directly commissions some services. NHS England has worked with Clinical Commissioning Groups to ensure their commissioned providers take all reasonable steps to reduce serious incidents. NHS England provides assurance that the local health system, including Clinical Commissioning Groups (CCGs) and designated professionals, are working effectively to safeguard and promote the welfare of children and adults at risk (Safeguarding Vulnerable People Accountability and Assurance Framework, NHS England 2013). This role includes ensuring that CCGs are working with their directly commissioned providers to improve services as a result of learning from safeguarding incidents. These services include acute, community, mental health and ambulance care.

NHS England responsibilities in relation to direct commissioned services

NHS England is responsible for driving up the quality of safeguarding in its directly commissioned services and for holding these providers to account for their responses to serious safeguarding incidents, ensuring that safeguarding practice and processes are optimal within these services. In Yorkshire and Humber, this includes all GP practices, dental practices, pharmacies, optometrists, health and justice services and the following public health services:-

- National immunisation programmes
- National screening programmes
- Public health services for offenders in custody
- Sexual assault referral centres
- Public health services for children aged 0-5 years (including health visiting, family nurse partnerships and much of the healthy child programme)
- Child health information systems

From April 2015 onwards, NHS England will commence a programme of transferring responsibility for GP practices (and eventually all other primary care providers) to CCG's with delegated powers of co-commissioning.

NHS England has worked in partnership with local Safeguarding Boards to ensure that the NHS contribution is fit for purpose and that there is no un-necessary duplication of requests for safeguarding reviews to be undertaken. NHS England also has its own assurance processes in place concerning NHS safeguarding reviews, learning and improvements.

Sharing learning from safeguarding reports

In order to continuously improve local health services, NHS England has responsibility for sharing learning from safeguarding serious incidents across Yorkshire and the Humber and more widely, making sure that improvements are made across the local NHS, not just within the services where the incident occurred. The NHS England North Yorkshire and Humber Safeguarding Forum has met on a quarterly basis throughout 2014-15 to facilitate this along with sharing learning.

Training programme for general practice

Designated safeguarding professionals are jointly accountable to Clinical Commissioning Groups and NHS England. They have overseen the provision of level 3 training for primary care medical services. Training sessions have been provided on a locality basis rather than to individual practices. The main source of training for other primary care independent contractors has been via e-learning training packages.

Assurance of safeguarding practice

NHS England North Yorkshire and the Humber have provided templates for CCGs to feedback on the assurance of safeguarding practice as well as developing safeguarding standards and aspirations for GP practices to benchmark themselves against. These standards will be reviewed and updated annually and incorporate learning from recent serious case reviews within Yorkshire and the Humber.

Standard Operating Procedure: Safeguarding Incidents

In order to establish a strong governance framework surrounding safeguarding incidents NHS England Yorkshire and the Humber have developed a Standard Operating Procedure: Safeguarding Incidents. This describes communication processes regarding these incidents and sets out NHS England's role and responsibilities in quality assuring review reports, signing off reports and ensuring improvement actions are implemented. It clarifies the interface between NHS England Yorkshire and the Humber and the North Yorkshire and Humber designated safeguarding professionals who are hosted by CCGs yet have a dotted line of accountability to us and work closely with us to enable us to deliver our statutory duties in relation to safeguarding incidents.

North Yorkshire Police

North Yorkshire Police is committed to protecting vulnerable people and taking positive action against those who commit crimes against them. This is achieved by:

- Investigating possible crimes, either as a single agency but more importantly by conducting joint investigations with our partners
- Gathering the best possible evidence to maximize the prospects for prosecuting offenders
- Achieving, with partners, the best protection and support for the person suffering abuse or neglect
- Enhanced access to counselling, where appropriate, for any victim

North Yorkshire Police have enhanced the MASH Unit – which is now called the Vulnerable Assessment Team. This enhancement has seen the setting up of meetings where those at risk of CSE are discussed in a multi-agency forum to ensure that all information is known by all agencies and a plan put into place, This is not only to protect the victim but also to gather evidence to identify offenders. This ensures that all those who are vulnerable and at serious risk of crime being committed against them, or already victims receive the best possible service and that all areas of Safeguarding are addressed.

This enhancement also ensures that there is a close working liaison with City of York Adult Safeguarding Team.

Staff within the Force Control Room has received enhanced training and awareness. They work to the THRIVE principle, which is - threat, harm, risk, investigation, vulnerability and engagement. This approach ensures that those with vulnerabilities re identified at the earliest opportunity and that the right response is given at the right time according to need, vulnerability and risk.

Training in relation to Safeguarding Adults is built into all of NYP's initial training programs in a variety of ways. All Police constables and all new PCSO and SC complete a Vulnerability Training Package. The aim of this training is for staff to understand their responsibilities and duty of care to vulnerable people and the actions that must be taken to reduce any identified risk.

Vulnerable Risk Assessments Training focuses on identifying t hose individuals that are at most risk in local communities, how to complete a VRA and what referrals need to be made to whom and when.

WRAP – Workshop to Raise Awareness of Prevent has also been rolled out to staff, assisting officers to identify those that maybe at risk of radicalisation because of vulnerability.

Training will be delivered this year to staff to include areas such as EDHR, Modern Slavery and Hate Crime.

It is estimated that incidents involving people with a mental vulnerability account for around 40% of policing time. For example, research suggests that:

- around 80% of people going missing from home are experiencing a mental health crisis
- people with a mental vulnerability are ten times more likely to be a victim of crime than the general population
- 69% of women and 49% of men with severe mental illness reported adulthood domestic violence
- 40% of women with severe mental illness had been the victims of rape or attempted rape
- Suicide is the leading cause of male mortality for those under 50yrs of age

NYP and University of York were successful in a £1.1M bid to the Police Knowledge Fund to undertake research into policing and mental health. The project also includes the development of a training package for frontline staff to improve our effectiveness in identifying, recording, responding to, referring and reviewing incidents involving a mental health component. To enhance capability in this area, NYP and OPCC have contracted with the NHS to employ Registered Mental Nurses (RMNs) to work alongside police in Mental Health Triage schemes in:

- Force Control Room
- Scarborough, Whitby and Ryedale
- Vale of York

NYP has also revisited the domestic abuse problem profile and written a Human Trafficking and Modern Slavery Problem Profile.

A draft Problem Profile on those who are 70+ in years has recently been completed with observations and recommendations. Further analysis is required before being presented to NYP's internal Operational Delivery board for governance and acceptance for action.

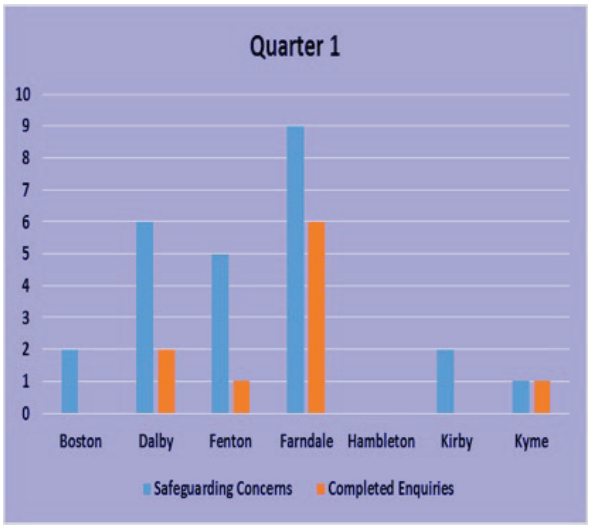
Partnerships in care

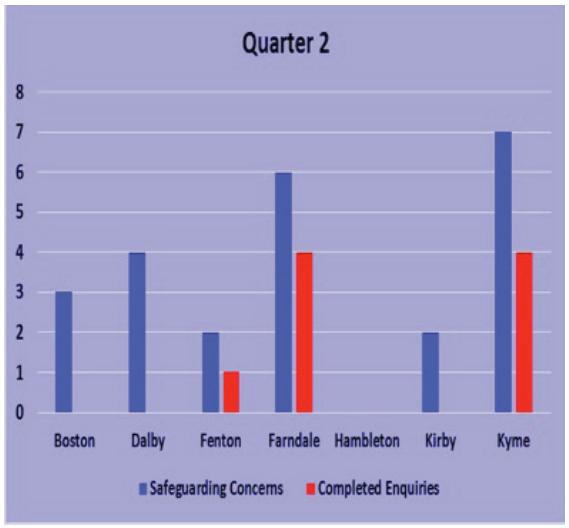
Stockton Hall Hospital, Partnerships in Care

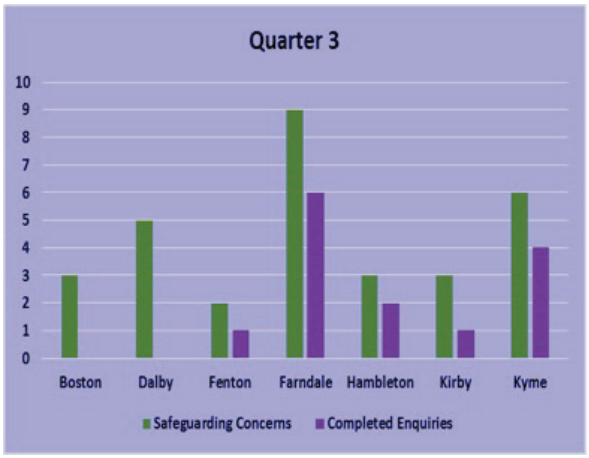
Information about safeguarding training undertaken internally and externally during the year by relevant staff plus any evidence of impact.

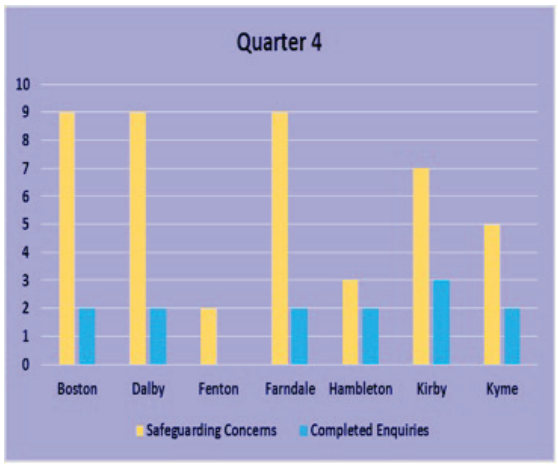
Newly recruited members of staff continue to receive level 1 safeguarding adults' awareness training during the induction course, 100% compliance. There is also a requirement for clinical and non-clinical staff to attend annual statutory/mandatory safeguarding training, 85% compliance. Additionally, Level 3 Safeguarding Investigator training has been provided to senior managers and clinicians by Community Links on behalf of City of York Council.

Workshop to Raise the Awareness of Prevent (WRAP) sessions, under the auspices of the Government's Counter Terrorism Strategy, have been provided to qualified clinical staff in accordance with NHS contractual requirements. During the year 95 members of staff have attended, 93% compliance. Members of staff employed to work in PIC regional units have also attended WRAP training whilst on induction at Stockton Hall Hospital. Feedback has been for the most part positive. The Safeguarding and Security Leads have completed the WRAP Train the Trainer session. WRAP sessions are being integrated into statutory/mandatory training for all members of staff who have contact with adults and children from April 2016.







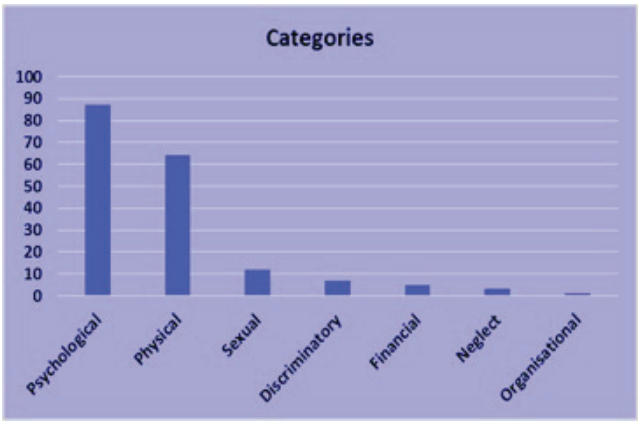


There were 124 safeguarding concerns during the year, of which there were 50 investigations/ enquiries (40%) following being reported to the CoY Safeguarding. This data demonstrated small increases compared with the previous year. Farndale, a 16 bed female ward had the largest number of safeguarding concerns (33) and investigations/enquiries (18), equating to 54.5% of concerns. Kyme, a 16 bed male learning disability ward had 19 safeguarding concerns and 11 Section 42 investigations/ enquiries (58%). It is noted that of the 17 safeguarding concerns on Dalby, a 16 bed male personality disorder ward, 2 (12%) resulted in investigations/enquiries and of the 17 safeguarding concerns on Boston, a 24 bed male mental illness ward, 4 (24%) resulted in investigations/enquiries. There were 10 outstanding investigations/enquires at the end of the year.

Patient Safety Meetings and safeguarding investigations/enquiries have become increasingly service user focused, thereby applying the principles of Making Safeguarding Personal. Of the 40 completed investigations/enquires 28 (70%) concluded that the safeguarding plan had led the adult at risk to feel significantly safer or there was no evidence that they had experienced harm or potential harm. Adults at risk now regularly attend patient safety meetings and documentation, including clinical notes and minutes from meetings, include direct quotes about the nature of the alleged neglect or abuse and the feelings of the individuals involved. However, it is acknowledged that further information is required to accurately reflect the longer term views of adults at risk regarding their involvement in the safeguarding process.

Twelve of the safeguarding concerns regarding members of staff, including a historical allegation from a previous care setting and inappropriate comments by four ex-members of staff on social media involving the disclosure of abusive and confidential information about a current service user and an ex-service user. Of the remaining nine safeguarding investigations/enquiries into alleged staff misconduct two resulted in investigations upholding the complaints and subsequent disciplinary action being undertaken.

An ethnicity audit was completed following the Safeguarding Adults Self-Assessment. Distribution of the patient population by ethnicity in the year 2015/16 indicates that just over 80% reported their ethnicity as British (White) this was followed by Pakistani (Asian or Asian British) at just over 5%, next was the African (African or Black British) at just above 3%. All other ethnic groups were at less than 2% each. Attention was given towards safeguarding concerns for all the ethnic groups. The most significant finding was that the Irish (White) ethnic group had a higher occurrence of safeguarding concerns proportionately in relation to population size. However, it is noted that this data was influenced by 7 safeguarding concerns being reported by one Irish (White) adult at risk.



The most significant change from the previous year has been the relative increase in safeguarding concerns under the category of psychological abuse, which is often a duel category with other forms of abuse. There was also a proportionate reduction in reported physical abuse allegations. It is noted that there have been no safeguarding concerns under the additional categories introduced by the Care Act 2014 which is being addressed through training.

Any achievements/developments relating to Safeguarding during the year.

A Safeguarding Practice Group has been established. The group meets monthly and includes the charge nurses as the ward based safeguarding leads and senior managers. The purpose of the group is to discuss practice issues arising from the safeguarding process, including lessons learnt and to discuss information from the SAB. It is an expectation that charge nurses will submit written reports in preparation for the meetings, including a review of actions taken to prevent concerns from arising, methods of addressing safeguarding concerns, reporting arrangements and a summary of open/closed safeguarding investigations/enquiries. It is planned for representatives of the PIC regional units to be invited to attend future meetings.

Liaison between the NHS England Specialist Commissioning Team and the Clinical Commissioning Group was facilitated following the request from the SAB regarding learning disability service users placed at the hospital from other regions of the country in order to be compliant with the Winterbourne Concordat.

A meeting, attended by the senior managers of the hospital, North Yorkshire Police and the City of York Safeguarding Adults Team took place to discuss reporting arrangements. The meeting reviewed the draft amendments to hospital policy to clarify lines of responsibility for the reporting of alleged crimes, ongoing liaison with North Yorkshire Police, communication between the hospital and the police including the establishment of a single point of contact and the coordination of criminal investigations and safeguarding investigations/enquiries. A revised protocol is being developed which the SAB will be requested to authorise.

There has been liaison with Rethink about ensuring that the Independent Mental Health Act Advocates (IMHAs) receive relevant training about the Care Act 2014 in order to represent the needs of adults at risk who lack capacity following safeguarding concerns being raised.

Partnership Commissioning Unit
Hambleton, Richmondshire and Whitby CCG
Harrogate and Rural District CCG
Scarborough and Ryedale CCG
Vale of York CCG

The Partnership Commissioning Unit (PCU)

The Partnership Commissioning Unit (PCU) is contracted to host the role of Designated Lead Professional for Safeguarding Adults on behalf of the NHS Vale of York Clinical Commissioning Group (CCG) and as such works closely with City of York Council, North Yorkshire Police and other health and independent sector partners to safeguard adults in York. The role and function of the Designated Professional covers the whole health economy across the City. In addition to the Designated Professional within the PCU there is a team of four safeguarding officers. The safeguarding officer function undertakes delegated enquiry work on behalf of the City of York Council where health concerns feature as a predominant factor.

The team of safeguarding officers have had a busy and challenging year. Their role has included attendance at enquiry planning meetings, undertaking investigations and writing reports for outcomes meetings. The safeguarding officers have also responded to requests from health and social care professionals for health and safeguarding advice and provided scrutiny and overview of safeguarding cases. The bulk of the enquiry work completed by the safeguarding officers has been in relation to care homes and as such they have worked closely with the Care Quality Commission and the Local Authority contracting team to undertake assurance visits to independent providers of care. They have maintained ongoing support to providers across the City where standards of care have required improvement, continuing that contact and overview until care standards have returned to an acceptable level.

The majority of safeguarding cases which the PCU safeguarding team have been involved in during 2015/16 have been in the categories of physical abuse and neglect or omission of care. The current database system for recording the work of the team has not easily supported providing data on the numbers of cases that the team has been involved in within York. This is an area that we would like to make improvements to in 2016/17. Also for 2016/17 the team will be further developing and embedding 'making safeguarding personal'. Whilst the principles are already in place – the practice requires further work and alongside our partners this will be an exciting challenge for 2016/17.

In addition to fulfilling their statutory and mandatory safeguarding training requirement in 2015/16 the safeguarding officers have attended specialist training in Safeguarding Concerns & Alerts (1 day); Root Cause Analysis (2 days); Mental Capacity Act and Advanced Decisions (1 day), Prevent WRAP (Workshop Raising Awareness of Prevent) and Fundamental Standards of Care (1/2 day).

The PCU has provided an additional role seconding the Deputy Designated Nurse Safeguarding Adults for NHS Vale of York CCG to undertake work related to the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS). This work has comprised developing assurance and embedding of MCA/DoLS in health care practice through: engagement, support, supervision, training and resource development.

The training below has been completed for GPs and primary care staff – jointly facilitated as part of Safeguarding Adults and Children 'Hot Topic' events with the Safeguarding Nurse Lead for primary care and for the Continuing Healthcare Team (CHC) – jointly facilitated with City of York Council DoLS team staff.

Date	Venue	Number attended
For CHC nurses & team leaders		
22.09.15	Sovereign House	15
20.10.15	Sovereign House	12

For GPs & Primary Care		
07.10.15	New Earswick Folkhall, York	21
10.11.15	Galtres Centre Easingwold	10
02.12.15	Maple Court York (Out of Hours GPs)	10

The PCU MCA/DoLS lead and the City of York DoLS Lead jointly facilitated a public engagement event 'No decision about me without me' on National Mental Capacity Act Day 15th March 2016 providing information and advice to members of the public around the principles of the Mental Capacity Act 2005 with particular focus on making advanced decision and Lasting Powers of Attorney.

The Senior Suicide Prevention Officer successfully recruited in 2015 and hosted by the PCU has been part of a team with Public Health and North Yorkshire Police working to complete an audit of all suicide deaths in York covering a five year period. The report will be completed later in 2016 and will add a valuable source of knowledge to inform the prevention and protection work of the York Safeguarding Adults Board.

The Designated Professional, in addition to undertaking the function of assurance work for the CCG and NHS England, has worked with partners in North Yorkshire Police, City of York Council and North Yorkshire County Council to develop and launch the joint protocol for 'Adults at Risk - missing and absent from home or care' which incorporates the Herbert protocol. Use of the protocol enables family members, carers and providers in care settings to share vital information when adults with significant vulnerabilities go missing from either their own home or a care setting so that they may be found, protected and hopefully returned safely within the quickest possible timeframe.

The Designated Professional has been an active member of the City of York Safeguarding Adults Board and has completed the two Learning Lesson Reviews on behalf of the Board.

(Christine Pearson, Acting Designated Professional for Safeguarding Adults)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees Esk and Wear Valleys NHS Foundation Trust

Training

Level 1 training – raising a concern – is aimed at all staff within the Trust. This training is available to staff to access via e-learning. Face to face sessions will be organised within the York area in due course.

Level 2 training – responding to concerns – is aimed at all clinical staff, Band 5 and above within the Trust. This training is delivered face to face and sessions are arranged to commence April 2016 in the York area. However, staff can also access other venues across the Trust and bespoke sessions. To date there have been 12 staff trained in this time period.

Safeguarding Concerns

During Q3 & Q4, there were 58 concerns raised with the Safeguarding Adults team (see Fig 1). 29 of these concerns were referred on to the City of York Council. From these 58 concerns, 29 of them were regarding inpatients.

Fig 2. shows a breakdown of the concerns raised by speciality with the majority of concerns being raised within adult mental health and Mental Health for Older People services.

Fig 3. Highlights the categories of abuse that have been raised during Q3 & Q4. The predominant category of abuse raised is physical abuse (25) with 20 of these concerns related to inpatients (which are predominantly patient on patient assaults).

Figure 1

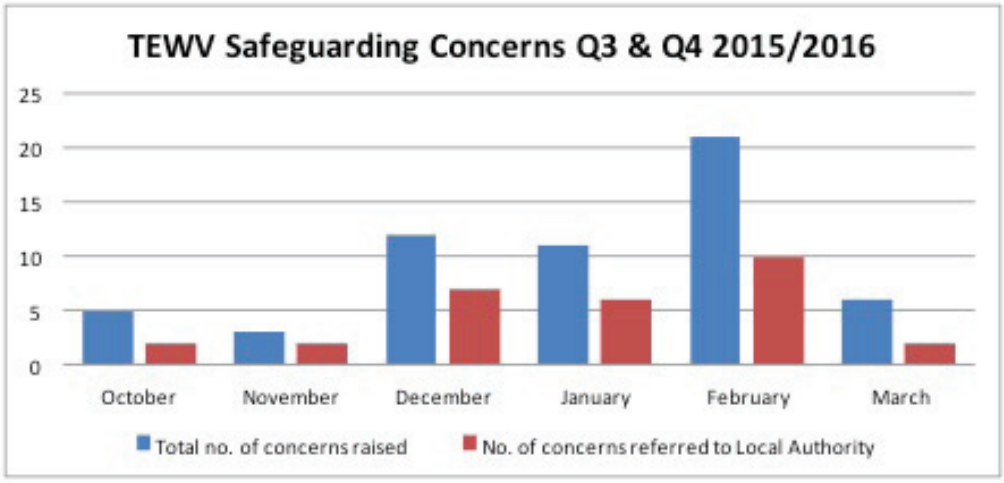


Figure 2

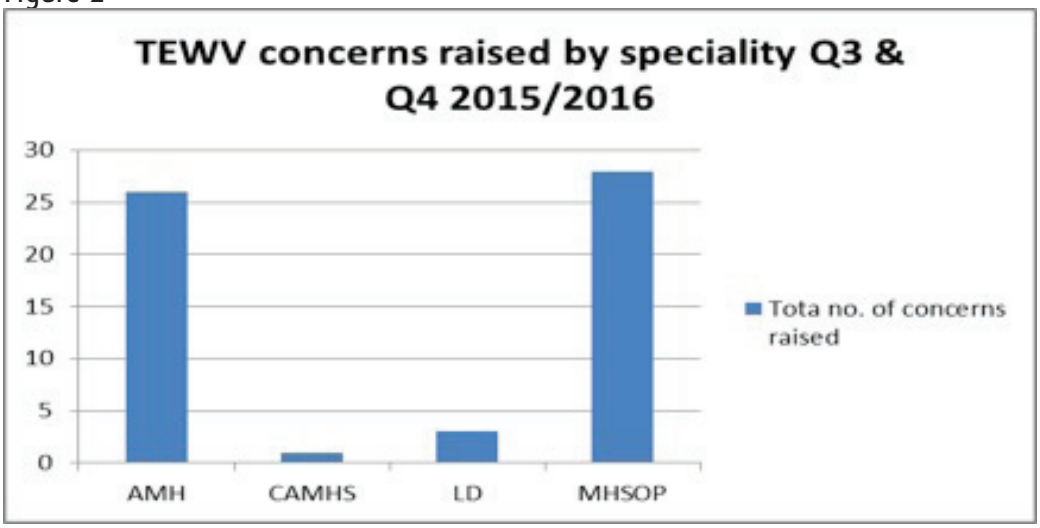
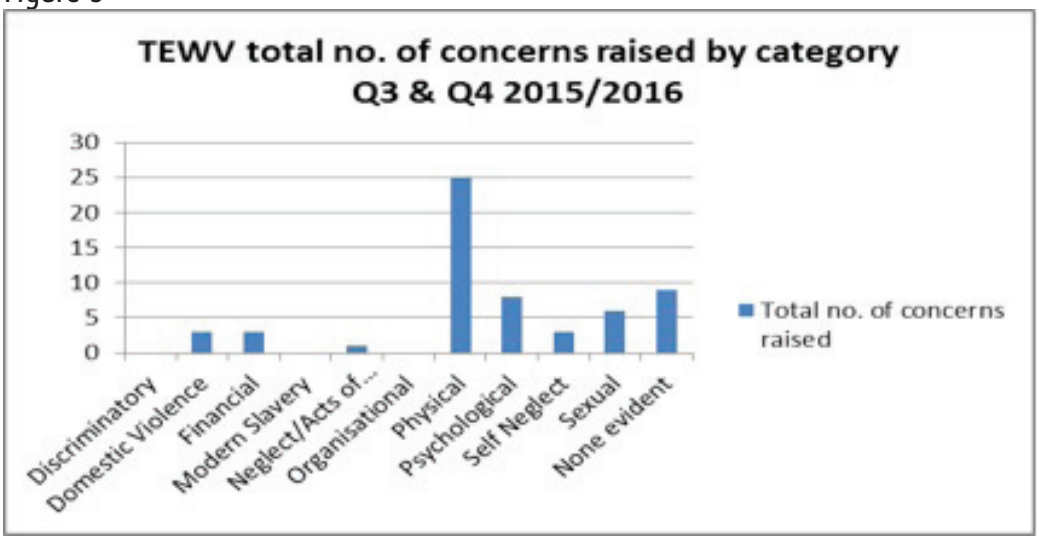


Figure 3



Any achievements/developments relating to Safeguarding during the year

Development of a York based TEWV Safeguarding resource including safeguarding adults, safeguarding children and MARAC, to provide advice and support to York staff, facilitate multi agency collaboration and provide staff training.

York staff are now aware how to access TEWV Safeguarding Adults team for advice and support in relation to any safeguarding concerns raised. Verbal feedback from staff is they feel this assists them to feel more confident around raising a safeguarding concern.

Bespoke Level 2 training sessions have been offered to York staff during Q3 & Q4. Training in York, for both Level 1 and Level 2, is planned for 2016/2017.

Safe transfer of patients from Bootham Park in December 2015 following CQC closure notice.

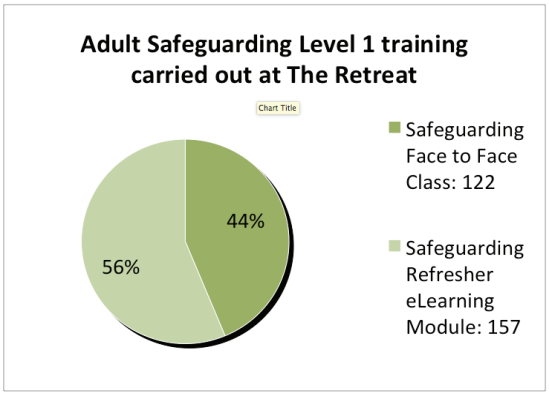
Attendance at York MARACs to facilitate information sharing and risk assessment and management.

The Retreat Yearly Safeguarding Report (2015/2016)

Safeguarding training

Adult Safeguarding Level 1 (Alerter) Training compliance for the hospital was 94% (279 people out of 296 required to complete). The safeguarding training level 1 is delivered face to face to all new starters (122) and as an eLearning refresher module (157).

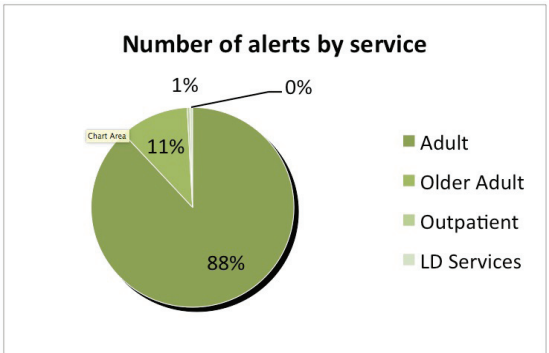
Compliance for external training: Adult Safeguarding Level 2 (Responder) was 85%, Level 3 (Investigator) was 100% and Level 4 (Chair) was 50%. Training compliance for hospital varied due to problems with accessing the training at WDU.



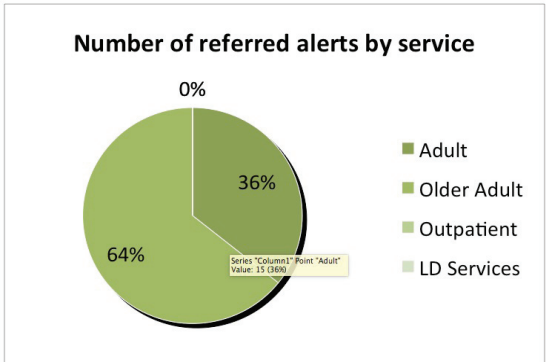
The impact of the new safeguarding training (revised at the beginning of 2014 and again in 2015 following the changes brought by the Care Act 2014) has been positive. The rate of reporting low level incidents has improved; also the levels of understanding and confidence have increased among the frontline staff.

Safeguarding alerts and responses

The number of reported safeguarding alerts has been on the rise over the last 4 years: 62 in 2012, 85 in 2013, 159 in 2014 and 236 in 2015. The number of alerts received is much higher than the previous year (increase of 48%) and as mentioned before this can be associated with an improvement in reporting.
The number of alerts which were later referred to the City of York Council Safeguarding Team and Care Quality Commission did not change much over the last few years: 39 in 2012, 39 in 2013, 32 in 2014 and 42 in 2015. The number of the referred alerts did not go up with the increase of the alerts.

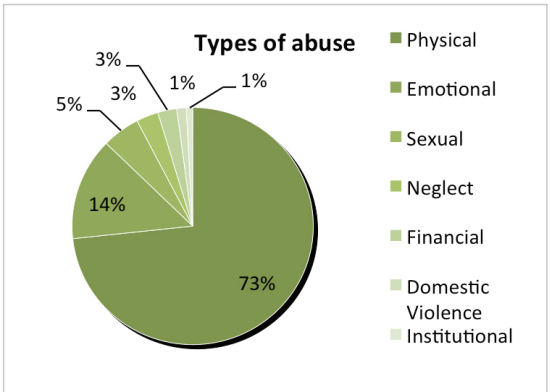


The new average for the quarter is 59 alerts, in comparison with 55 in the previous year (increase of 7%). The average number of referred alerts per quarter was 10 (8 in previous year), which has been a fairly stable number for the last three years.



The significant majority of alerts: 208 (88%) were submitted within older adult services in comparison to 26 (11%) reported on adult units and 1 each reported in Outpatient and Learning Disability (LD) services (0.5% each). However when it comes to the referred alerts the figures present a different picture: 64% of cases were from older adult, 36% were from adult services (none from Outpatient and LD services). Further analysis shows that only 12% of all alerts submitted within older adults are referred, while in adult services this figure is significantly higher (58%).

The cases of physical abuse account for the majority of all of the alerts: 173; emotional abuse was reported in 33 cases, sexual in 12, neglect in 7, financial in 6, domestic violence in 3 and institutional in 2 cases.



The cases of 3 major types of abuse recorded an increase: physical abuse have increased by 50%, emotional abuse by over 80% and sexual abuse by 30% in comparison to the previous year. The neglect cases have fallen by 20%.

Person alleged to cause harm (PATCH) was in 185 cases a current patient of The Retreat, in 28 cases allegations were made against staff, and in 23 cases the PATCH was identified as external which includes family members, friends, ex-patients, agency staff and other agencies.

In 158 cases the allegations were proved, in 67 cases they were disproved and in 11 cases the social workers were not able to determine the outcome.

Achievements in relation to safeguarding

The Retreat have made significant improvements both in 'Making Safeguarding Personal' and the overall involvement of people who use our services, or where they lack capacity to involve their families. Each time a safeguarding concern is raised the view / outcome a person wants from the safeguarding process is sought by the safeguarding link worker. The Retreat now monitors if the outcome identified has been met.

The Retreat has reviewed its safeguarding enquiry process to good effect and now ensures that people who use our service are involved throughout; also by involving different clinical disciplines safeguarding is now everybody's business and as such safeguarding enquiries are now carried out by members across a multi-disciplinary team.

The Retreat has allocated a full time post to manage the safeguarding process; this has ensured consistency for the people who use our service and the development of multi-agency process and policy. The Retreat's social work department has further improved its own system of monitoring data, which has helped to analyse the safeguarding within the organisation and determine current trends.

The Retreat continues to hold a strong relationship with the local authority safeguarding team and is working currently to complement our reviewed processes in line with the Care Act 2014.The Retreat continues to co-chair the safeguarding implementation group to share and develop good practice.

NHS Vale of York Clinical Commissioning Group

The best health and wellbeing for everyone.

NHS Vale of York Clinical Commissioning Group (CCG)

NHS Vale of York Clinical Commissioning Group (CCG) is responsible for commissioning hospital and community healthcare services for the Vale of York which includes the City of York population and has a range of statutory duties which includes Safeguarding Adults. The Chief Nurse is the Executive Lead for Safeguarding in the CCG and as such works closely with the Partnership Commissioning Unit (PCU) Safeguarding team, NHS England, the City of York Council, North Yorkshire Police and other partners on the City of York Safeguarding Adults Board.

To strengthen the commitment to safeguarding the CCG also employs a Deputy Designated Nurse for Safeguarding Adults with a particular focus on supporting quality in the independent care home sector. As part of this commitment the CCG has continued to develop a care home meeting forum 'Partners in Care' where care home managers can connect with CCG staff and get involved in training events and project work with a focus on innovation and improvement of patient care.

During 2015/16 the deputy designated nurse has worked together with the PCU on a number of safeguarding enquires and investigations, in addition to spending time with the City of York Council contracts team shadowing assurance visits to care home providers. As part of a secondment role the deputy designated nurse has worked with the Partnership Commissioning Unit as Lead for Mental Capacity Act and Deprivation of Liberty Safeguards – more about this role is in the Partnership Commissioning Unit section of the report.

The CCG has developed a soft intelligence tool to capture information from General Practitioners, Primary Care staff and Care Home Managers in relation to concerns that they have with the care and treatment of vulnerable people. The CCG meets with colleagues in City of York Safeguarding team and the Care Quality Commission to share 'early warning' signs which may indicate that services are struggling to maintain safe services. This has been developing work in 2015/16 and the challenge for 2016/17 along with partners will be to structure the support that is offered to struggling services at a point before it impacts on the care of those most vulnerable.

In 2015/16 the CCG secured the roles of Nurse Consultant and Named Doctor for Safeguarding in Primary Care Services. Each GP practice in York also identified a lead for safeguarding in their primary care team. This structure has enabled a clear pathway for information sharing, specialist advice and support and improved visibility of the primary care commitment to safeguarding. A number of safeguarding 'hot topics' training events have been completed in venues across York to support GPs and primary care staff in their safeguarding roles. The training events have been successful and following feedback gathered from attendees the programme of training for 2016/17 has been developed. The Nurse Consultant has also standardised the safeguarding adults' policy and procedure for primary care – with the completion of a generic policy which practice managers can adapt for their particular surgeries.

NHS Vale of York Clinical Commissioning Group (CCG) announced Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) as the provider of mental health and learning disability services in the Vale of York for the next five years, commencing on 1 October 2015. The contract was developed with partners after a series of in-depth discussions with local service users, members of the community and clinicians through DISCOVER. This was an extensive engagement programme to listen to and collate the views of people from across the Vale of York to help develop high quality mental health and learning disability services. The CQC did not re-register Bootham Park Hospital as it did not meet the standards and this occurred at very short notice. This was an unforeseen consequence which had the potential to compromise the care of people with a high level of vulnerabilities. The CCG worked jointly with NHS England and other key partners to learn lessons from the closure and is continuing to work closely with partners in TEWV to provide in-patient acute services back in York by summer 2016 and a new permanent base for mental health services in York with facilities that are fit for the 21st century.

The financial picture for 2016/17 is a challenging one across the health economy in York and the CCG is working in conjunction with its partners to transform services and create sustainability of safe services for the population. The CCG will continue to uphold the six principles of safeguarding adults in all its work and will continue to meet its statutory obligations as a partner of the City of York Safeguarding Adults Board.

yorkcvs

York CVS

The ILS (Independent Living Service) team have undertaken safeguarding training in relation to the adults they support. We have begun to review our safeguarding policy so we can use this to provide staff training in 2016/17.

We continued to provide forums (8 in total) across the year so organisations who support older adults, and adults with learning disabilities, can come together and share concerns and good practice. Safeguarding was a standing item on the agenda for these forums.

Information (ie graphs, numbers) about any Safeguarding Concerns and Completed Enquiries during the year including analysis by location and type

We logged two safeguarding incidents with City of York Council during the year.
Any achievements/developments relating to Safeguarding during the year

We have attended the Safeguarding Adults and Children's Board Development Days and attended both the Safeguarding Adults and Children's Boards.

YORK HOUSE
A neurobehavioural service for acquired brain injury

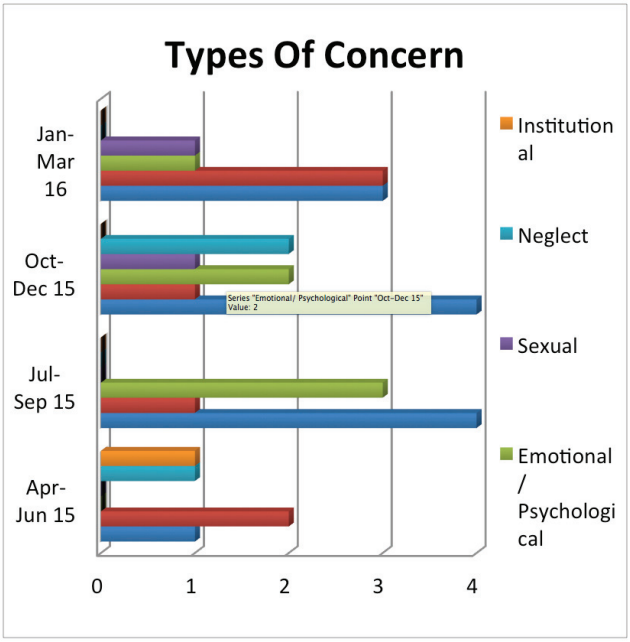
York House

Training

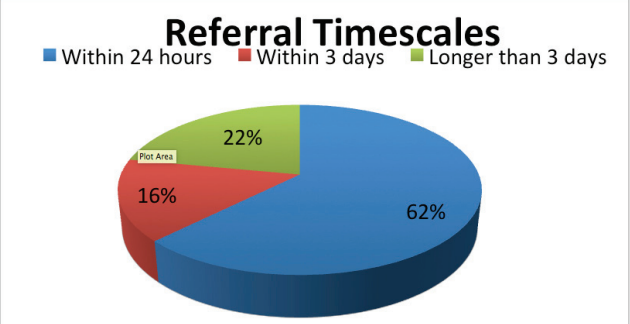
All new staff must complete the in-house Safeguarding training within their initial induction week before they start working with Service Users and they complete two shadow sessions. After this induction period the aim is for all staff to attend training yearly to ensure they are kept up to date with any changes and refresh their knowledge. The table below shows the percentage of staff who have completed Safeguarding training between 31st March 2015 and 1st April 1016:

	Contract	Bank	Total
% Completed Training	72	68	71

York House aims to realistically have 95-100% of staff completing yearly training in safeguarding. The current low percentage is down to down to a higher staff turnover this year and staffing numbers falling below our ideal staffing establishment levels and so facilitating training has been more difficult. All staff have completed the initial training, however the numbers reflect the completion of the yearly mandatory refresher. We have reintroduced e-learning safeguarding training, however the preference will always be for staff to complete face-to-face training delivered by our Legislation and Safeguarding Manager.
100% of the safeguarding sub-committee have completed level 2 external training and we are in the process of sourcing levels 3 and 4 from Work Development Unit.



The training package has been updated to incorporate the new legislation brought in by the Care Act in April 2015.



Types of Abuse

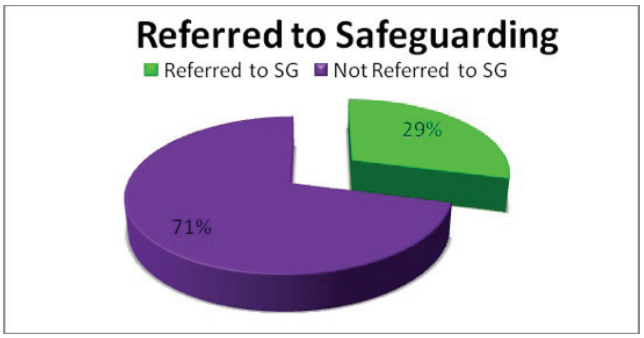
There were 31 concerns raised in total between April 2015 and April 2016. The graph shows the types of concerns raised in each quarter. The majority of the cases were physical abuse accounting for 12 incidents all of which were service user on service user incidents. Financial abuse accounted for 7 of the cases, emotional/psychological in 6 of the cases and sexual, neglect and institutional jointly making up the other 6.

Timescales

62% of concerns raised in the last 12 months have been referred to the safeguarding subcommittee within York House and then to City of York Council id necessary within 24 hours of the concern being raised.

Referrals

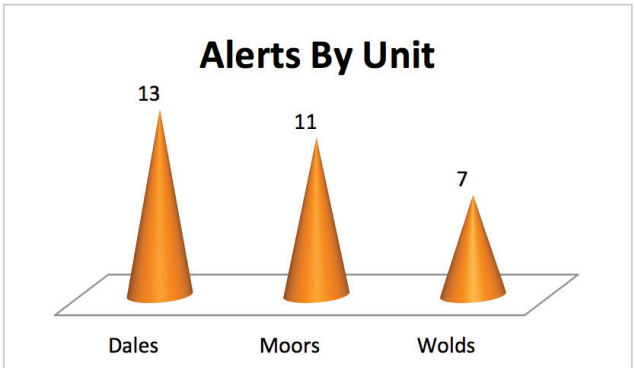
71% of all concerns were not formally referred on to the City of York Council Safeguarding and were managed in-house following discussion with the safeguarding subcommittee and/or members of the MDT were it is assessed that the risk and management is sufficiently in place. Those that were dealt with in-house were all closed based on the effective management of risks and protection plans and/or support measures being implemented.



Some of those handled in-house were discussed with City of York Council but it was agreed with them that it was more appropriate that they were dealt with in-house. 29% of concerns were referred to CYC Safeguarding; there are still two that remain open (both from December 2015 and in relation to York District Hospital). These have been regularly followed up in the aim to bring them to a close, however due to the investigating hospital not completing the investigation we are unable to.

Alerts by Unit

As you can see from the graph shown the majority of alerts are from the Dales unit followed by the Moors. The Dales is the main assessment unit (males only), however any females whether or not under assessment reside on the Moors as the only mixed gender ward. Due to the Dales being the main assessment unit the behaviours are often more challenging and unpredictable with care plans and management of challenging behaviors still being formulated. This can lead to difficult dynamics between service users. The Moors is a slightly slower stream assessment unit where as expected behaviours are often more stable, however there has been an increase in the number of female admissions to the Moors and so there may be an increase in the number of incidents due to the challenging behaviours displayed, however we do not believe there to be a safeguarding concern at this time. The Wolds unit is focused on long term care needs with a focus on quality of life as opposed to rehabilitation. However the mix of Service Users are complex, variable and long standing challenging behaviours can still contribute to safeguarding issues raised.



Summary

Due to various staff members leaving York House, the safeguarding sub-committee has been re-established in the past 6 months. It now includes a cross section of clinicians, led by the legislation and safeguarding lead. Training plans are in place to increase education and awareness of new staff nurses to York House, in addition to the induction training. One of the main challenges faced in "making safeguarding personal" continues to be in relation to communication, memory and cognitive processing difficulties experienced by those service users with Acquired Brain Injuries. However the involvement of speech and language therapist to aid communication and advocacy and family where capacity is lacking is heavily incorporated into the safeguarding process when establishing outcomes. Links with a new police liaison officer have aided communication and working with North Yorkshire Police as concerted efforts have been made to understand the challenges faced in the environment of York House, but more importantly for those living with Acquired Brain Injuries.

As a hospital we continue to struggle without an integrated computer system to log, maintain and monitor safeguarding risks and outcomes, rather relying on manual interpretation and collation of data.

York House continues to attend the Safeguarding Implementation Group to share and develop good practice with other independent Hospitals in the local area and receives feedback from the Safeguarding Adults Board both via email and through this group.

City of York Council Housing department

Training

Housing staff are expected to complete online safeguarding training for adults and children's services. The department has also purchased online training from the Housing Quality Network (HQN) and this includes safeguarding training. Safeguarding is included in new starters induction training.

Any achievements/developments relating to Safeguarding during the year

Employing mental health workers at hostels, Annual severe weather and NSNO, Provision of shower facilities at Peasholme for rough sleeper drop in, the older persons housing options worker and the research that we have done into housing hazards and the opportunity to target interventions to reduce falls and excess cold, Creation of respite beds in sheltered schemes, the housing first scheme for difficult to place adults.

Annex 2

Members of City of York Safeguarding Adults Board, March 2016

	Name	Title	Organisation	Address
1	Karen Agar	Associate Director of Nursing (Safeguarding)	Tees, Esk & Wear Valley (TEWV) NHS Foundation Trust	Flatts Lane Centre, Flatts Lane, Normanby, Middlesbrough, TS6 0SZ
2	Sarah Armstrong	Chief Executive	York CVS	Priory Street Centre, 15, Priory Street, York YO1 6ET
3	Sian Balsom	Healthwatch Manager	Healthwatch York	Priory Street Centre, 15, Priory Street, York YO1 6ET
4	Tom Brittain	Head of Housing	CYC	West Offices, Station Rise, YO1 6GA
5	Michelle Carrington	Chief Nurse	NHS Vale of York CCG	West Offices, Station Rise, York YO1 6GA
6	Martin Farran	Director Adult Social Care	CYC	West Offices, Station Rise, York YO1 6GA
7	Beverley Geary	Chief Nurse	York Teaching Hospital NHS Foundation Trust	Wigginton Road, York YO31 8HE
8	David Heywood	Safeguarding Lead	Stockton Hall	The Village, Stockton-on-the-Forest, York YO32 9UN
9	Caroline Johnson	Director of Operations	The Retreat	Heslington Road, York, YO10 5BN
10	Tim Madgwick	Deputy Chief Constable	North Yorkshire Police	Newby Wiske Hall, Newby Wiske, Northallerton DL7 9HA
11	Kevin McAleese CBE	Independent Chair,	York Safeguarding Adults Board	c/o West Offices, Station Rise, York YO1 6GA
12	Michael Melvin	Assistant Director	CYC	West Offices, Station Rise, York YO1 6GA
13	Christine Pearson	Deputy Designated Nurse, Safeguarding Adults	NHS Vale of York CCG	West Offices, Station Rise, York YO1 6GA
14	Victoria Pilkington	Head of Partnership Commissioning	Partnership Commissioning Unit (PCU)	Sovereign House, Kettlestring Lane, Clifton Moor, York YO30 4GQ
15	Cllr Carol Runciman	Cabinet Lead	City of York Council (CYC)	West Offices, Station Rise, York YO1 6GA
16	Amanda Robson	Senior Nurse	NHS England, NY and Humber Area Team	Unit 3, Alpha Court, Monks Cross, York, YO32 9WN
17	Steve Wilcox	Designated Professional for Adult Safeguarding	Partnership Commissioning Unit (PCU)	Sovereign House, Kettlestring Lane, Clifton Moor, York YO30 4GQ
18	Keren Wilson	Chief Executive	Independent Care Group	10 North Park Road, Harrogate, HG1 5PG

Annex 3

City of York Safeguarding Adults Board Membership & Attendance 2015/16

(Key: Y = present or substituted; A = Apologies sent; NA = Not yet a member/replaced as a member)

Organisation	Designation	June 2015	Sep 2015	Dec 2015	March 2016	Nominated representative or substitute
	Independent Chair	Y	Y	Y	Y	100%
City of York Council	Director of Adult Social Care	Y	N	Y	Y	75%
	Assistant Director, Adult Assessment and Safeguarding	Y	Y	Y	Y	100%
	Safeguarding Service Manager	NA	NA	Y	Y	100%
	Cabinet Member for Health, Housing and Adult Social Services	Y	Y	N	Y	75%
	Head of Housing	NA	NA	NA	Y	100%
Healthwatch York	Manager	Y	Y	Y	Y	100%
Independent Care Group	Chief Executive	Y	N	Y	Y	75%
1.4.15-30.9.15, Leeds & York Partnerships NHS FT	Head of Safeguarding	Y	N	NA	NA	50%
NHS England,	Assistant Director	Y	N	Y	Y	75%
North Yorkshire Police	Deputy Chief Constable	Y	Y	Y	Y	100%
Partnership Commissioning Unit (PCU)	Director of Partnership Commissioning	Y	Y	Y	Y	100%
	Designated Professional for Adult Safeguarding	Y	Y	Y	N	75%
The Retreat	Director of Operations	Y	Y	Y	Y	100%
Stockton Hall	Social Work Manager	Y	Y	Y	Y	100%
1.10.15-30.3.16, Tees, Esk & Wear Valley NHS FT	Associate Director of Nursing (Safeguarding)	NA	NA	Y	Y	100%
Vale of York CCG	Chief Nurse	Y	Y	Y	Y	100%
	Designated Nurse, Safeguarding	Y	N	Y	Y	75%
York CVS	Representative	Y	N	N	Y	50%
York Teaching Hospital NHS Foundation Trust	Chief Nurse	Y	Y	Y	N	75%
Overall Board attendance		**100%**	**65%**	**88%**	**90%**	

Independent Chair's comments on Board attendance:

We have worked hard once again to ensure that all partner organisations on the Safeguarding Adults Board are represented by a post holder of sufficient seniority and expertise and that ideally the same person should attend each meeting.

However, there are inevitably operational pressures on individuals as well as annual leaves to be allowed for, given that the SAB only meets four times a year. There are also personal crises in the best managed of diaries, and even unexpected weather problems as in March 2016. In the ideal world the thirteen partners would each have achieved 100% attendance records. During 2015/16 a total of eight of them did just that, an increase of one from 2014/15.

Each SAB meeting ends with a meeting review, which is then published in the SAB minutes which are available on the SAB website. Those reviews confirm a broadly consistent picture that SAB members find meeting together four times a year to be appropriately challenging and rewarding. I am very grateful to the senior representatives of each organisation listed in Annex 1 who have given so much time, interest and commitment to the work of the Board during 2015/16.

Annex 4

2014/2017 Strategic Plan and Action Plan Outcomes for 2015/16

	Objective	Action	Timescale for completion	Lead	March 2016 update
A	**Make sure safeguarding is embedded in corporate and service strategies across all partners.**				
A1	Ensure key strategic plans evidence that adult safeguarding is a priority and is being addressed.	Partners to identify key strategies and include in annual reports to Boards	March 2015	All	Annual Reports Submitted
A2	Ensure a robust interface with Community Safety Plans	Engage with Domestic Violence strategy Board. Improve information sharing on Domestic Abuse. Engage with Community Safety Board regarding Hate Crime, safe Places etc	March 2015 March 2016	Chair and CYC safeguarding Lead	Both are now members of the Board. May 2015 saw work coordinated by North Yorkshire Police together the information held by all agencies about domestic violence to improve our strategic response. North Yorkshire and York SAB and partners held Joint Domestic Abuse Working Conference Oct 2015 Safeguarding Systems Leadership Group in place February 2016
A3	Influence Joint Strategic Needs Analysis and Health and Well Being strategy	Feed messages from this strategy to JSNA refresh. Annual review of performance indicators for key strategic messages on need.	March 2015 March 2016	CYC safeguarding Lead	Refreshed JSNA contains information on referral rates of vulnerable population groups.
A4	Ensure a robust interface with the Health and Wellbeing Board.	Standing item on Safeguarding Board agenda – items from and to HWB	From March 14	Chair	See Chair's reports

	Objective	Action	Timescale for completion	Lead	March 2016 update
A5	Ensure that Adult Safeguarding Board members, and non – Executives, Board Members and Councillors of partner organisations understand their role in safeguarding and have attended basic awareness training.	Members of Partner Boards to monitor through annual assurance reports to Board Each partner agency to consider in their competency framework Introduce Adult Safeguarding Board Development Days – minimum 1 per year Training needs review for Board members Induction training for new Board members .	March 2015 March 2015 March 2015	All All Chair	Partners to confirm Safeguarding Training Needs survey developed and put to Board members by CYC WDU Needs Survey sent out to board members and proposal for development submitted to Dec 15 SAB Safeguarding Board Development Day completed, January 2016 (second day on 4 April 2016)
A6	Assurance that all partners present an Annual Safeguarding Report to their relevant governing body.	Partners to advise Board when Annual report received by their Board. Summary of reports in Annual Adult Safeguarding Board report.	Annual Annual	All Chair	Completed Completed

	Objective	Action	Timescale for completion	Lead	March 2016 update
B	**Ensure good partnership working**				
B1	Ensure that all partners are signed up to, and working in line with Multi agency procedures and practice. Procedures' to be reviewed for Care Act readiness.	Annual check for changes and updates. Full review every 3 years. Seminar/event for voluntary sector groups.	December 14, 15 16 March 15 March 15	CYC CYC and Voluntary sector	CYC Safeguarding Adults Audit including Care Act Readiness shows substantial assurance. Regional and local policy and procedure for discussion at June 2015 Board. Development day held Nov 2014. Care Act stock take reports good progress on safeguarding adults. Care Act subgroup work completed and stepped down Sept 2015. West Yorkshire, North Yorkshire and York Multi-Agency Procedures adopted. Work ongoing to develop local operational guidance consistently across the North Yorkshire Locality. Dec 2015. Local Guidance drafted and circulated February 2016.
B2	Share learning from practice, Lessons Learned and Serious Case Reviews.	Review of serious case review protocol. Develop a lessons learned protocol. Continue with regular agenda item on each Safeguarding Adult Board meeting to share case studies.	March 15 March 15 ongoing	Board sub Group Board sub Group Chair	Protocols at December 2014 Board agreed. In place. Subgroup in place and to be formalised through proposal to the board Sept 2015 Sub group Structure in place Dec 2015.
B3	Senior level, regular, attendance at Board from all partners.	Attendance reported in Annual Safeguarding Board report.	Annual	All/CYC	In place.

	Objective	Action	Timescale for completion	Lead	March 2016 update
B4	Ensure a shared approach to understanding and managing risk of abuse in safeguarding.	MCA/DoIS training – monitor uptake and feedback.	Quarterly reports to Board	CYC	Reports to SAB on impact of training.
B5	ure best use of resources to meet growing demand and shared priorities.	Development of the multi agency safeguarding hub with police and children's safeguarding Develop virtual network for safeguarding advisors in partner agencies Review of thresholds for referrals	Sept 14 March 15	CYC Police All	Agency DASMs in place, network to be developed. DASM meeting established August 2015, role then abolished nationally.

	Objective	Action	Timescale for completion	Lead	March 2016 update
C	**Focus on prevention of abuse**				
C1	Raise awareness and empower community to keep people safe.	Review of Adult Safeguarding Adults website. Annual radio or Press interview/article on Adult Safeguarding. Develop information for the community. Ensure housing and support providers, drug and alcohol service, A&E can access alerter training.	March 15 Annual March 15 Annual review of training attend-ance.	CYC Chair CYC CYC	CYC Website with updated Safeguarding Adults taken from current website to be launched end May 2015. SAB website launch set for Jan 2016. Alerter training advertised to all providers through WDU Dec 2015 SAB Website structure and content developed on track for Jan 2016 launch.
C2	Reduce risk of harm through effective and intelligent commissioning.	Winterbourne concordat assurance. Sponsor work between health and social care commissioners and contract managers on sharing intelligence on quality of providers, Ensure that Contract monitoring has a focus on safeguarding and dignity and any shortfalls in standards are addressed Commissioning and contracting with regulated providers includes Care Quality Commission (CQC) registration guidance in relation to safeguarding. Ensure commissioners review their training needs regarding safeguarding and quality assurance. Ensure arrangements for commissioning of advocacy services.	6 Monthly updates June 15 March 15 Annual assurance Annual assurance June	Partnership Commis-sioning Unit (PCU) and CYC CYC/PCU/ CCG CYC/PCU/ CCG/NHS England CYC/PCU/ CCG/NHS England CYC/PCU/ CCG/NHS England	Regular Soft intelligence meetings are now established. Advocacy service commissioned by CYC April 2015 includes advocacy for people with safeguarding needs.

	Objective	Action	Timescale for completion	Lead	March 2016 update
C3	Workforce development plans to develop quality provision.	Work with city wide Workforce Strategy Group to ensure training delivered on: Managing challenging behaviour and reducing incidents between residents. Medication management. Reduce risks of pressure sores. Dignity agenda. Review themes and areas of risk emerging from performance data to continue to inform training plans.	June 2015	CYC	CYC have developed and delivered training in Administration of medication in domiciliary and residential care settings Managing Challenging behaviour. Pressure Sore Training and Dignity agenda require further work. Commitment in WDU report to develop MSP approach April 2016-Dec 2016, Updated training planned underpinned by new operational guidance.

	Objective	Action	Timescale for completion	Lead	March 2016 update
D	**Respond to people based on the Personalisation approach, and with a clear focus on outcomes**				
D1	Commit to an outcome focus for safeguarding activity.	Engagement in Making Safeguarding Personal Programme.	March 15	CYC	MSP report at March 2015 Board.
D2	Enhance and improve user 'voice' in all the Board does.	Improve links with Healthwatch York and Safeguarding Board. Develop proposals for greater user involvement.	March 15 March 15	Chair and Health-watch York Health-watch York	Healthwatch agreement to public involvement in strategic plan refresh to be compete April 2016.
D3	Ensure people with personal budgets in health and social care are supported to manage safety and risk at the same time as preserving the right to choice and control.	Consider evidence from the Research underway with York University on Safeguarding and personalisation.	March 15	CYC	Research complete and circulated to care managers Feb 2015.
D4	Empower people to be able to make good choices about quality care and support.	Continue to develop information for public on care and support choices.	March 15	CYC	Connect to Support information and advice major refresh completed April 2015.

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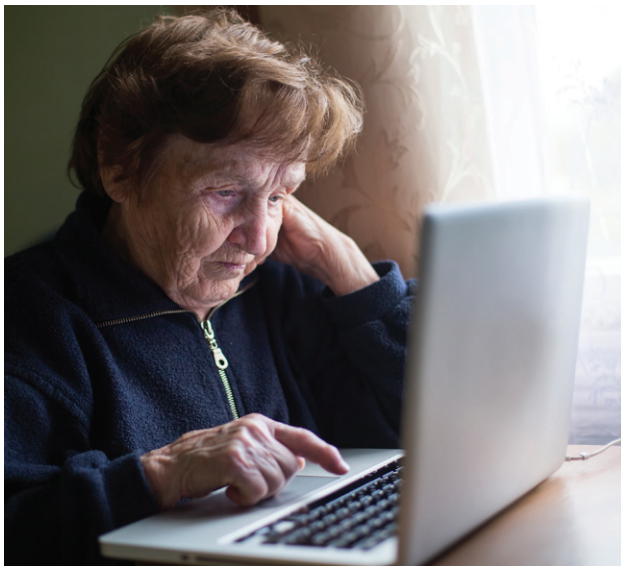

City of York Safeguarding Adults

CITY OF YORK COUNCIL