City of York Safeguarding Adults Board Annual Report 2015/16

Kevin McAleese CBE, Chairman

City of York Safeguarding Adults

CITY OF YORK COUNCIL

www.safeguardingadultsyork.org.uk

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SAB Board members

- City of York Council
- Healthwatch York
- Independent Care Group
- NHS England
- North Yorkshire Police
- Partnership Commissioning Unit
- Stockton Hall
- Tees, Esk & Wear Valley NHS Foundation Trust
- The Retreat
- Vale of York Clinical Commissioning Group (CCG)
- York Teaching Hospitals NHS Foundation Trust
- York CVS

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Work undertaken

Making Safeguarding Personal (MSP)

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

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

Annie agreed to accepting support from an agency who supported her with applying for a housing transfer; she 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.

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Activity I

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

Year 2015/16	Alerts/Concerns	Referrals to Enquiries
2012	690	200 (29%)
2013	912	213 (23%)
2014/15	1,058	294 (28%)
2015/16	1,108	468 (42%)

2015/16

- People over 65 and above were significantly over-represented in referrals, with 85s and over being the most over-represented
- 75% of adults reported to be at risk were already known to Social Services

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Activity II

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

2015/16: Type of abuse referred	%
Neglect	31%
Psychological/Emotional	23%
Physical	19%
Financial	17%
Organisational	4%
Sexual	2%

2015/16

Neglect and Organisational abuse are the only categories of abuse where “social care support” is the main source of risk

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Activity III

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

2015/16: Location of risk referred	%
Own home	36%
Care home	28%
Hospital	14%
Community Services	3%
Other	6%

2015/16

Care homes up by 46%, Hospitals up by 50%, Community down by 46%, compared to 2014/15 and in line with national figures

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Activity VI
Outcomes of Enquiries for 2015/16

- 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 was 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.

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Not a Safeguarding Adults Review, but Lessons Learned Case II

In November 2014 Daniel was seen walking unsteadily along a wall in the centre of York he climbed over railings and fell approximately 40 feet to the ground. His death was confirmed a short time later and 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 with a concern related to possible financial abuse. He was known to mental health services and mostly he engaged well. He had a job at a local College and was receiving counselling support there. Daniel had made several suicide attempts previously where he was found to be carrying a suicide note and had received a number of welfare checks.

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Lessons Learned findings

- 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.
- There were no obvious omissions in Daniel's care: it appears that mental health services and the police worked effectively together. *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.*

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2016/17 Planned developments include

- ✓ Adding more publicly accessible information on the website about abuse and neglect
- ✓ Developing a prevention strategy
- ✓ Using public feedback on the website to review and update safeguarding arrangements
- ✓ Monitoring and reporting on the use of advocates for people who lack mental capacity
- ✓ Developing local operational guidance on safeguarding for all SAB partners, underpinned by new training arrangements
- ✓ Planning and hosting an annual Safeguarding week, in conjunction with West and North Yorkshire Councils
- ✓ Publicising and presenting the SAB Annual Report to any community group requesting it

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Questions and comments?

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