

Safeguarding Adults Board (SAB)

Annual Report 2016/17



Executive Summary

Introduction

by the Chair of the Safeguarding Adults Board (SAB)

This is my fourth annual report as Independent Chair of the City of York Safeguarding Adults Board (CoYSAB) and covers the year ending 31 March 2017.

It's vitally important that local safeguarding adults services are as good as they can possibly be, because the City of York's population of 200,000 includes some very vulnerable adults needing support to help keep them safe from harm. They include:

- Almost 9,500 older people in York with a long-term health problem. By 2020 this number is expected to rise to 10,000
- Approximately 14,000 older people who are living alone. In the next 10 years this is expected to increase to some 16,000 people
- Around 4,000 people in the City with a learning disability, over 800 of whom are already over the age of 65
- Some 12,500 working age adults in York with a moderate or serious physical disability
- Around 9,500 working age adults who have a mental health condition



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

York continues to be a great place to live and work and our job as the CoYSAB is to help ensure every adult's right to live in the City safely and free from abuse or neglect. We continually seek to ensure that agencies supporting adults who are at risk, or in vulnerable situations, are working together successfully both to stop abuse and neglect happening in the first place and to make sure that the adult's wellbeing and wishes are at the centre of any action taken.

On the basis of all the evidence available to it, the CoYSAB continues to believe that in 2016/17, the arrangements in place across the City of York for safeguarding adults are both effective and appropriate.

Kevin McAleese CBE

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Making Safeguarding Personal (MSP)

A key part of the Care Act is the establishment of a person-centred approach to safeguarding adults across all agencies. There has undoubtedly been progress on the matter, and if you look at the individual returns from Board partners in Section 9 of the full 2016/17 Report you will see evidence of that. MSP is challenging work, not least because not all vulnerable people have the capacity to decide what is in their best interests and may need assistance to do so. Also, many safeguarding situations are complex, often involving the actions of friends or relatives, and the problems created are seldom easy to resolve. The real MSP case study below illustrates how this has worked:



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

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

Further long discussions took place between the young woman and the Safeguarding Team worker to explore her options and to support her, working in a person-centred way, i.e. at the pace of the young woman and without trying to impose any interventions that she did not want. Recently the young woman rang the team to say that she now felt stronger and able to manage her mother's behaviour, knew that she could contact the police and did not require the team to be involved currently. She knows that if necessary she can come back for further support.

How are we doing?

In January 2017 York City Council invited a team from a number of local authorities to conduct a “peer review” of Adult Safeguarding under the guidance of the Local Government Association. Some nine officers and others came to the Council’s offices in the week of the 23rd and conducted interviews with a full range of staff and service users, and inspected a range of documents.

In requesting the challenge, the Council sought an external view on the robustness of safeguarding arrangements plus the direction of travel that York was undertaking in the transforming of adult social care, and how York might improve outcomes for people using services, as well as a view on how the future sustainability of the health and social care system

The report resulting from the challenge highlights many of the strengths in both the Council and across its partnerships. It also provides useful analysis as to where further work may be required to ensure that these strengths are built on and services continue to improve.

The Peer Challenge report reflected that Council has a stable and committed senior management who are driving transformation of services based on a clear vision that is recognised by the council and partners. The peer team heard from staff with a “can do” attitude, and a sense of collective optimism in delivering the vision. The peer team found good evidence of personalised approaches, commenting that “Making Safeguarding Personal” ran through York’s social care practice like a stick of rock. York’s front line staff were described as ‘amazing!’ and recognised as highly committed.

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

The peer team found that Council had strong partnerships and was both ambitious and lean. This means they need to continue to ensure that the right resources are always in place to enable the effective delivery of their ambitions

The Peer Challenge recognises the excellent work being done to support adults with care and support needs and safeguard them from abuse.



Performance and activity information

Adults collection
June 2017

Safeguarding concerns
1,215 concerns were received by the local authority - an increase of 104 from 2015



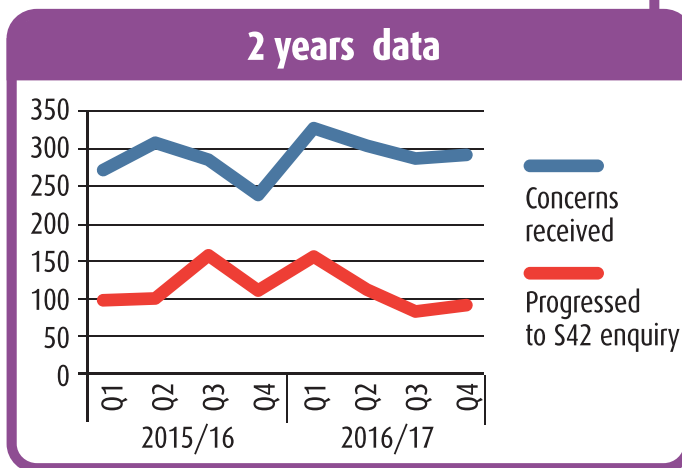
Ratio of concerns received

Female	Male
58%	42%
38% 18-64	46% 18-64
33% 65-84	37% 65-84
29% 85+	18% 85+

Number of completed pieces of work

2015/16	2016/17
1071	1178

MSP New measure for Q4
Percentage of those who were asked and expressed an opinion was **69%**
Of those:
61% - outcomes fully achieved
30% - outcomes partially achieved
9% outcomes not achieved



Gender of completed S42 enquiries

Female 60%	18-64 36%	65-84 31%	85+ 32%
Male 40%	18-64 46%	65-84 36%	85+ 18%

Number of completed S42 enquiries

2015/16	2016/17
391	392

Progress to formal S42

468 → 454
2015/16 → 2016/17

Completed S42 enquiries

Location of abuse

- 38%** in own home
- 9%** in Nursing home
- 17%** in Residential home
- 22%** in hospital
- 7%** in community setting
- 5%** in services in the community
- 4%** other settings

Age range of completed S42 enquiries

- 40%** 18 - 64
- 33%** 65 - 84
- 27%** 85+

Source of abuse

- 49%** Service provider
- 46%** known to individual
- 5%** unknown to individual

Types of abuse - completed S42 enquiries

6% sexual abuse	3% organisational
23% physical abuse	28% neglect
21% psychological/emotional	2% domestic abuse
15% financial	3% self neglect

Training and development

The full Annual Report for 2016/17 shows that the Council's Workforce Development Unit (WDU) has continued to offer an extensive range of safeguarding training courses for staff from partner agencies. A total of 509 staff attended such training, of whom 57% were from organisations other than City of York Council. Level 1 courses continue to be offered free of charge, with £20 for other half-days and £40 for full-days. A charge of £50 continues to be made for non-attendance. Feedback from course attendees has continued to be highly positive.

During 2016/17 the WDU has worked with the Safeguarding Adults Board to revise both the Safeguarding and Mental Capacity Act training offers. Briefing events for both have been very well attended and have resulted in feedback which has been used to shape the new offers. The Safeguarding training offer which was launched in September 2016 has been revised to embed the principles of Making Safeguarding Personal. The new offer has received very positive feedback. The Mental Capacity Act offer will be launched in April 2017.

The WDU has also developed a new course on encouraging a risk-enabling approach to underpin the approach across services, to support people to take positive risks and to work in an outcome focused way, putting the individual and their wishes at the centre of decision making.

An Impact Assessment tool for use by managers with staff attending training has also been being piloted within the safeguarding courses this year. Feedback about the tool has been positive although more work needs to be done on raising awareness of the tool and how it can be used. This work is planned for 2017/18.

The CoYSAB's Training and Development sub-group is now meeting regularly and is providing helpful opportunities to ensure that learning and development opportunities are shared across agencies and any workforce development needs that arise through the SAR/Lessons Learned sub-group can be addressed on a multi-agency basis.



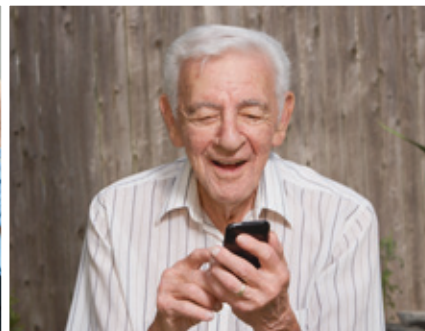
Safeguarding Adults reviews and lessons learned

It is a requirement of the Care Act 2014 that the details of any Safeguarding Adults Reviews (SARs) conducted during the year must be in the SAB Annual Report. There were no Safeguarding Adults Reviews needing to be conducted during 2016/17, though a number of cases were considered to see if they met the threshold and became Lessons Learned instead. Below is an example of a Lessons Learned case considered during 2016/17:

John had a career in the Navy until his retirement following which he then worked until he was seventy years old. He was married to Margaret for thirty-five years, a second marriage for both of them and between them they had four children. John was in his eighties and Margaret was in her nineties, both had long-term illnesses but supported each other and managed well at home with some family help.

Margaret was admitted to hospital following a short illness. The family felt that John would not manage at home alone. Although he was independent in many ways, he also had a deteriorating health condition and some short-term memory problems. An assessment by Adult Social Care determined that John required three visits per day to help him with meals and reminding him to take his medications. However, despite strenuous efforts by staff no home care agency could be found to supply the visits that John needed. He became unwell with a chest infection and was given a course of antibiotics by his GP. Despite the efforts of several services and individuals stepping in to try to 'fill the gap', John unfortunately missed some evening doses of antibiotics. He was admitted to hospital in May 2015 and subsequently died three days later.

Following his death concern was raised by a family member to City of York Council in relation to care provided. John's family acknowledged that services tried to help him. They were concerned that despite recognising that he needed help that help was not always available in the community. Family members stated they did not want a big enquiry and weren't trying to find someone to blame but just didn't want this to happen to anyone else. A chronology of events from the agencies involved was compiled. A visit to John's step-daughter and his sister was made to better understand the situation from their and John's point of view. John's family agreed that this summary could be shared as an example for those commissioning and providing services.



Contacts

City of York Council, West Offices, Station Rise, York YO1 6GA

To report a safeguarding concern:

- Contact adult social care, tel: 01904 555111 (office hours) or fax 01904 554055
- Hearing impaired customers can use the text facility 07534 437804
- Out of hours, tel: 01609 780780

To report a crime:

- In an emergency, tel: 999
- If the person is not in immediate danger, tel: 101

If you would like this information in an accessible format (for example in large print, in Braille, on CD or by email) please call **(01904) 551550**

This information can be provided in your own language.

Informacje te mogą być przekazywane w języku ojczystym.

Polish

Bu bilgi kendi dilinizde almanız mümkündür.

Turkish

此信息可以在您自己的语言。

Chinese (Simplified)

此資訊可以提供您自己的語言。

Chinese (Traditional)

 **01904 551550**

