Safeguarding Adults Board

Annual Report 2014/15

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

I am very pleased to introduce this Annual Report, having first taken up my appointment on 1 April 2013. I would comment that those readers who saw the 2013 Report will find much which is new in this one, including a formal input from each organisation represented at the SAB.

One of my roles has been to establish productive relationships with the organisations which are represented at the SAB and to ensure that we are working to a shared agenda with the right people around the table. That agenda has been dominated this year by our preparations for the implementation of the Care Act 2014, of which safeguarding is one small but vital part. 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!

We became a statutory body on 1 April 2015, on a par for the first time with the Children's Board and we believe that we are on track to deliver assurance to the citizens of York that everything which should be in place either is or is in the process of being implemented.

In order to progress our thinking we established a Board sub-group of key members and together we have spent the past few months clarifying and agreeing our constitution, membership, memorandum of understanding for each member and much more besides, including multi-agency procedures. We have also thought carefully about the size of the Board and have developed a clear and shared view that increasing its size and complexity in response to the Act would almost certainly be a mistake.

As a result the current Board has sixteen members drawn from twelve key organisations operating in the City of York. They can be seen in Appendix 1 and include City of York Council, Healthwatch York, the Independent Care Group, Leeds & York Partnerships NHS Foundation Trust, NHS England, NHS Vale of York Clinical Commissioning Group, North Yorkshire Police, Stockton Hall, The Retreat, York CVS, York Teaching Hospitals NHS Foundation Trust and York & North Yorkshire Partnership Commissioning Unit.

It is our intention to ensure that senior representation from the housing sector will be added imminently to the SAB, but we do not anticipate any further changes in the short to medium term. Further, and given the level of organisational turbulence which has affected NHS organisations in particular during the past three years, I am particularly grateful for the level of engagement we have achieved with them, and also with voluntary sector and private sector hospitals treating NHS patients.

I am pleased to say that York is fully engaged in the national pilot of "Making Safeguarding Personal" (MSP), the new approach which underpins the Care Act 2014 and which requires that the individual exercises as much choice and control as possible in determining and achieving the outcomes they want from safeguarding enquiries, rather than having passively to accept safeguarding being "done" to them by the Local Council and its staff. Section 3 of this Report contains two anonymised

case studies which briefly illustrate how MSP differs from more traditional approaches.

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 dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the individual. The findings of SARs must be included, as must actions taken or intended in relation to those findings. I can confirm that there have been no SARs during 2014/15. However, there have been two deaths where a lesser level of enquiry known as Lessons Learned has been initiated, and there are some details of the cases in Section 8 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 separate website which was generally recognised as not fit for purpose, as Internal Audit concluded (see Section 4) and at the time of writing it is in the process of migrating to the City of York corporate one. When that process has been completed, citizens of the city will hopefully be reassured by the information they can glean about the SAB and its work.

It may also be reassuring to know that every SAB meeting starts with reflecting in confidence on a particular case involving a real individual, to ensure that the Board never forgets that it is vulnerable people who are always the focus of its work. Our meeting minutes are always published on our website once they have been approved by the subsequent SAB meeting. There are four SAB meetings a year at West Offices, though because of the sensitive and confidential nature of much of our work they are not open to public scrutiny like Council Cabinet meetings, for example. That is not unique to York but common across the country.

I trust that you will be interested, informed and also reassured by the contents of this Report. Thank you for reading it.

Kevin McAleese CBE

Independent Chair, City of York Safeguarding Adults Board

2. The Board's Work and its Philosophy

York Safeguarding Adults Board (SAB) oversees and leads adult safeguarding across the city in order that individuals and agencies contribute effectively to the prevention of abuse and neglect. It is a multi-agency board whose role is to plan strategically and ensure the safety of vulnerable adults within the City of York Council's geographical area. 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 individuals in local health services, local care and support services and prisons and approved premises

A list of board members in attached in Annex 1.

3. Work Undertaken in 2014/2015

Making Safeguarding Personal

This year saw the second phase of York's implementation of Making Safeguarding Personal. Making Safeguarding Personal is the national approach now embedded in the Care Act 2014 which ensures that the individual exercises as much choice and control as possible in determining and achieving the outcomes they want from safeguarding enquiries.

City of York Council and its partners on the Board worked with a cohort of 30 people who did not have the mental capacity to make decisions about how they wanted to be safeguarded against abuse or neglect where there was an allegation that abuse or neglect had taken place.

By engaging with independent advocacy at an early stage, those professionals involved in helping to safeguard the adult at risk were able to understand what these individuals wanted from a safeguarding intervention. In the majority of cases the people lacking capacity were able to achieve the outcomes they wanted.

Making Safeguarding Personal (MSP) has become an embedded philosophy throughout City of York Council's safeguarding adults work. The two case studies below illustrate how this has worked:

Case Study 1- Jane

Jane has physical disabilities and lives in a nursing home .She told her social worker that a friend had taken money from her. Taking an MSP approach, the social worker talked to Jane about the options she had and what she wanted to happen. Jane wanted to be able to talk to her friend, get her money back, maintain the friendship, and have support should she find that there were difficulties in the relationship in the future.

The social worker helped Jane and her friend to have a discussion about the missing money through mediation meetings. Her friend apologised and gave Jane her money back. Jane managed to maintain the relationship in the knowledge that she would

have the support of a social worker to help resolve future issues if she needed it. Had a traditional investigation into theft from a vulnerable adult been launched, Jane may have been in a position where she was being asked to pursue an allegation against her friend which may not have given her the outcome she wanted.

Case Study 2- Brian

Brian is 85 and receives a direct payment so that he can be supported with care needs related to his physical frailty and memory problems. His family do not live locally but have supported him by finding him a carer who lives in his home. Brian was not very happy with the service he was getting, felt that the carer was prioritising other jobs and interests had neglected him. His family thought that Brian's view might be to do with his cognitive problems and felt the carer was doing a good job.

Taking an MSP approach, the social worker talked to Brian who, although thankful for his family's help, wanted to make different arrangements for his care. He was not interested in pursuing an allegation against the carer. The social worker supported him to understand what the options were and how he might go about considering them, helping him to gain the mental capacity to make choices about his care and support. The social worker also helped him to explain to the family what he wanted.

Following a short stay in a respite care home Brian has ended his contract with his previous carer and has gone on to choose a different support package.

Self-assessment

A key part of this year's work was the 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 the results were collated for the Board.

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

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

4. Care Act Implementation

The SAB established a subgroup with key members of the Board to ensure a successful transition to its statutory status. In addition, a number of specific activities were undertaken in preparation.

Policies and Procedures

In preparation for the introduction of the Care Act 2014, the City of York SAB has developed its 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 and lessons learned. These policies have ensured that the Board 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 the adult.

The multi-agency policy and procedures were updated at the start of 2014 and work continues in redrafting these to promote best practice in light of the Care Act.

Information, Advice and Guidance

This year has seen an improved offer to the public in terms of information and advice to help safeguard adults from abuse as this has become a statutory duty under the care act. The Connect to Support portal has been re-launched with improved content on 'keeping people safe.' This now also includes advice and guidance on domestic violence, bogus traders, online safety and community safety information from the police, in addition to how to report neglect and abuse.

www.connecttosupport.org

Partnership with the community

A series of workshops were run in January and March 2015 prior to the implementation of the Care Act for community groups, the voluntary sector and independent providers. Feedback from these events demonstrated that they have provided a valuable forum to help those working with adults at risk in the community understand their roles and the support they can expect from City of York Council and the SAB and signposted them to the series of resources which will help them implement the new approaches.

www.scie.org.uk/care-act-2014/safeguarding-adults

Winterbourne Concordat

City of York Council, the Partnership Commissioning Unit and the Vale of York Clinical Commissioning Group have worked together to identify vulnerable people from York who are placed out of the 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.

Over the past year, seven individuals have been helped to move back to York and plans are in place to make arrangements for accommodation and support for another fifteen people. For people who are remaining living out of York additional safeguards have been put in place to ensure that their support and treatment is reviewed and the Mental Capacity Act and its safeguards are followed.

Internal Audit

As part of the preparation for implementation of the Care Act, the internal audit service conducted an investigation into the readiness of adults safeguarding arrangements. The purpose of this audit was to provide assurance to City of York management that procedures and controls within the system had ensured that:

• The Safeguarding Board was moved onto a statutory footing
• A policy was introduced in relation to serious case reviews
• Relationships with partners and the new duties to co-operate over the supply of information were implemented
• There is a suitable system in place for processing Deprivation of Liberty cases
• There were sufficient resources to complete the increased number Deprivation of Liberty cases

The audit did not include procedures for Statutory Local Authority Deprivation of Liberty cases.

Key Findings:

Following the introduction of the Care Act 2014 considerable amounts of work have been put into ensuring that Safeguarding Adults processes in York are robust and fit for purpose. In addition the council has been suitably responsive to the significant additional demands in relation to Deprivation of Liberty cases following on from the Supreme Court judgement.

The Safeguarding Board has developed a constitution and memorandum of understanding between all members to ensure that the statutory board and its members comply with the duties placed upon them by the Care Act, and has developed an assurance framework which has been completed by all members. This enables the partnership to have an overview of how well members are undertaking their Safeguarding Adult responsibilities and respond accordingly.

The council has a policy for serious case reviews which enables a methodology of lessons learned which can be applied to cases which would not reach the threshold. This is being used to enable the partnership to gain learning from incidents which would otherwise not take place.

The council has and continues to review and adjust their Safeguarding Adults board in response to the developing guidance and information available regarding the requirements of the Care Act, and approved a policy in relation to serious case reviews. Development of the working relationships between partner organisations on the board has been undertaken. The council has participated in regional and national programmes and developed their process around Making Safeguarding Personal principles, a key part of the Care Act.

The main issue raised in the audit is that procedures for processing Deprivation of Liberty cases are heavily reliant on manual inputs, including identifying cases due for review. This is time consuming and there is a greater risk of review dates not being identified, especially given the large increase in the amount of Deprivation of Liberty cases. There is the potential for greater use of IT systems to support the staff and make the processes more robust for the increased number of cases.

The other findings of the audit related to the future development of the Safeguarding Adults board and improvement to the information available on the internet in relation to Safeguarding Adults in York.

Overall Conclusions

It was found that the arrangements for managing risk were good with few weaknesses identified. An effective control environment is in operation, but there is scope for further improvement in the areas identified. Our overall opinion of the controls within the system at the time of the audit was that they provided Substantial Assurance.

Work is already under way to address the remaining issues raised in the audit.

5. Performance and activity information

Alerts and Referrals during the year April 2014 – March 2015:

Alerts

The Safeguarding Adults Return is the national set of performance indicators which City of York Council use to report on their performance on safeguarding adults. **City of York Council received a total of 1058 alerts in this period**. An alert is recorded when the council is informed about a concern that a vulnerable adult may be at risk of abuse or neglect. This figure is an increase from 912 alerts in the previous year. All alerts trigger an assessment from City of York Council aimed at reducing the risk for the adult at risk and preventing further harm. Where the council is unable to resolve the concerns at this stage a referral is made for further investigation

Referrals

Following this assessment, **294 individual adults at risk were referred for further investigations** into the alleged abuse.

Tables 1, 2 and 3 below show the breakdown by age, gender and ethnicity. These figures show a far higher proportion of investigations into abuse of women at risk.

75%of adults at risk where an investigation was undertaken were previously known to the Council Social Services.

Tables 4, 5 and 6 show the nature of risk and the type of support the adult at risk needs. Because some people have more than one safeguarding investigation and are at risk from multiple types of abuse, the figures in these tables total more than the 294 adults at risk.

While the highest categorised source of risk remains people at risk in their own home from people known to them, residential and nursing care homes continue to be a

growing area where the council investigates allegations of abuse. In 2014-2015 the council investigated 91 allegations in care homes compared to 79 the previous year.

The highest support need for people is physical support. This includes older people with frailty who also have cognitive problems including dementia.

Outcomes

All the tables below are drawn from the national dataset the Council is required to submit nationally. Table 7 and 8 show the outcomes reached for safeguarding investigations concluded within 2014-2015. The total numbers in these tables include investigations that were completed by 31st March 2015

This year has seen more allegations of abuse being fully substantiated with 92 in 2014-2015 compared to 70 the previous year.

A total of 121 allegations were either partially or fully substantiated during 2014-2015

Action was taken to reduce the risk following 255 investigations and in 233 instances the risk to the individual was reduced or removed.

Adults at risk with safeguarding investigations by age:

Table 1	Number of individuals by age					
Classification	18-64	65-74	75-84	85-94	95+	Age Unknown
Already known	73	30	46	61	9	0
Previously unknown	43	4	12	9	3	4

By Gender:

Table 2	Number of Individuals by gender		
Classification	Male	Female	Gender Unknown
Already known	83	136	0
Previously unknown	21	52	2

By Ethnicity:

Table 3	Number of individuals by ethnicity					
Classification	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	No Data
Already known	212	0	1	1	0	4
Previously unknown	60	0	1	2	0	11

By Support Reason:

Table 4	Number of individuals by primary support reason						
Classification	Physical Support	Sensory Support	Support with Memory & Cognition	Learning Disability Support	Mental Health Support	Social Support	No Support Reason
Already known	159	6	2	36	37	43	15
Previously unknown	8	3	1	4	15	3	45

By Source of Risk

Table 5	Source of risk		
Type of risk	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Physical	29	44	1
Sexual	4	21	2
Psychological and Emotional	23	30	1
Financial and Material	13	49	6
Neglect and Omission	84	15	3
Discriminatory	1	1	0
Institutional	2	0	0

By Location of Risk

Table 6	Source of risk		
Location of risk	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Care Home	77	13	1
Hospital	20	19	2
Own Home	33	99	5
Community Service	17	6	1
Other	9	23	4

Actions Taken and Results

Table 7	Source of risk		
Action and Result	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
No Action Taken	33	39	2
Action taken and risk remains	1	21	0
Action taken and risk reduced	56	75	7
Action taken and risk removed	66	25	4

Outcome Reached

Table 8	Source of risk		
Conclusion	Social Care Support	Other - Known to Individual	Other - Unknown to Individual
Fully Substantiated	52	37	3
Partially Substantiat	9	20	0
Inconclusive	46	49	6
Not Substantiated	49	30	3
Investigation Ceased	0	24	1

6. Training

Developments

2014/2015 has seen significant developments by City of York Council Workforce Development Unit in the field of adult safeguarding. The prospectus including all safeguarding training can be found at www.yorkworkforcedevelopment.org.uk

- Training for care homes and hospitals to carry out their function as managing authority for deprivation of liberty safeguards has been extended from a half to a full day course in light of the increased need to use these safeguards.

- Train the trainer has been developed with six Safeguarding sessions delivered and one Mental Capacity Act session. Trainers have fed back twice yearly to monitor the success of this approach. This will increase to quarterly in 2015/2016.

- A Safeguarding learning needs analysis has been sent out to gain further detail on the learning and development needs of the Adults Safeguarding Board. This is based on the requirements of the Care Act and national competencies.

- New updated E-Learing safeguarding and MCA modules have been commissioned from Kwango.

- A new course on working with self-neglect has been commissioned and is available.

- In order to measure the impact of training workforce development unit have piloted an approach of contacting delegates 6 months after their training had taken place to ask more detailed questions about the impact the training has had on their day to day practice. This approach will be further refined in 2015/16.

- Safeguarding and the Care Act training sessions have been delivered as part of the implementation of the statutory safeguarding responsibilities that come with the Act.

The Training Offer 2014/15

During 2014/15 our Safeguarding and Mental Capacity Act training was provided by Community Links. Below shows a breakdown of courses that took place over 2014/15 and the number of course run.

Safeguarding

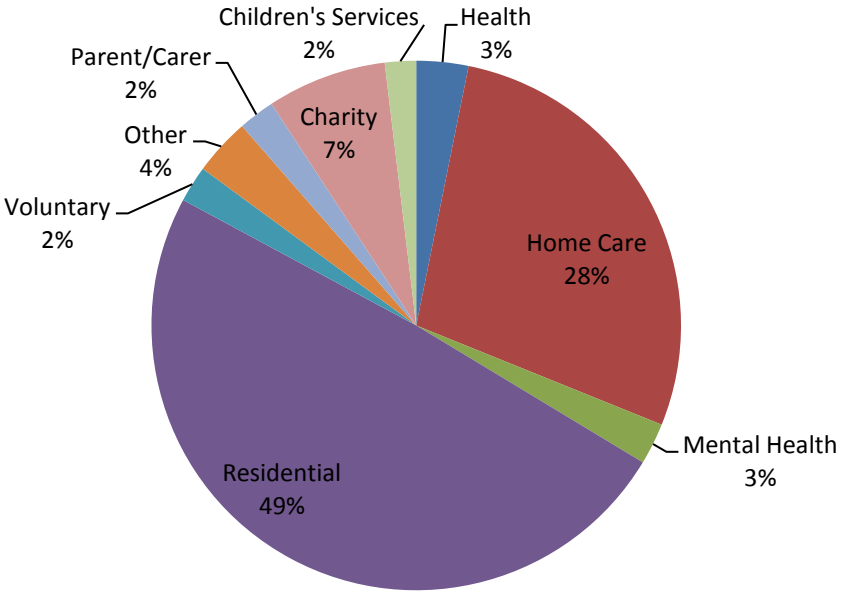
Level of Training	Number of Sessions
Safeguarding Level 1	9
Safeguarding Level 2	5

Safeguarding Level 3	2
Safeguarding Level 4	2
Safeguarding Train the Trainer	3

Mental Capacity Act

Level of Training	Number of Sessions
Mental Capacity Act Awareness Level 1	7
Mental Capacity Assessment and Best Interest Decision Making for Practitioners Level 2	3
Deprivation of Liberty (DoLS) Roles and Responsibilities for Managing Authorities (Care homes and hospitals) (Level 3)	2
Mental Capacity Act Complex Decision Making for Practitioner and Managers (Level 4)	2
Mental Capacity Act Train the Trainer	1

Analysis of CYC External Partner Attendees



Training Evaluations

The safeguarding training provided through City of York Council continues to be well regarded by those attending, with a high proportion of good and excellent ratings as shown below.

Safeguarding

Course	Feedback comments	Poor	Satisfactory	Good	Excellent
Safeguarding Level 1	529	0	0	108	421
Safeguarding Level 2	213	0	3	56	154
Safeguarding Level 3	75	0	0	25	50
Safeguarding Level 4	12	0	0	3	9
Safeguarding Train the Trainer	76	0	0	19	76

Mental Capacity Act

Course	Feedback comments	Poor	Satisfactory	Good	Excellent
MCA level 1	316	2	3	80	231
MCA level2	56	0	1	26	29
MCA level 3	23	0	0	6	17
MCA level 4	43	0	1	13	39
MCA train the trainer	53	0	1	13	39
MCA case law	20	0	0	7	13

Care Act Safeguarding

Course	Feedback comments	Poor	Satisfactory	Good	Excellent
Care Act Implications for Safeguarding	172	0	6	71	95

7. Strategic Plan for 2014/2017 and Actions Achieved

The Board considered a Draft Strategic Plan for 2014-17 at the December Board 2013 meeting. 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

Appendix 3 shows the progress which has been made against each of the themes during 2014/15.

8. Serious Case Reviews and Lessons Learned

There were no Serious Case Reviews needed to be conducted during 2014/15.

However, during 2014/15 the SAB 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. The Chair of the Board had already decided, as he was required to do, that the facts of neither case warranted the establishment of extended Serious Case Reviews (or Safeguarding Adults Reviews as they will be 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.

Briefing Paper on the case of "Tracy"

The Incident and the lead up to it:

Tracy was born in 1978 and had a long history of mental health issues complicated by substance misuse and suspected domestic abuse and sexual exploitation. Tracy didn't readily engage with services and had moved repeatedly between York and London in the months before her death.

Tracy was taken by 999 ambulance to the Emergency Department of York Hospital on 17 October 2013 following self-harm resulting in lacerations to her arms, legs and neck. She had an open wound to the neck caused by self-harm using glass, and was under the influence of alcohol and possibly other substances.

Following clinical review the patient was admitted to the High Dependency Unit overnight and then transferred to the Short Stay Ward the following morning. Because of her agitated state Tracy was admitted to a side room of the Ward with an en-suite toilet, with checks being made to ensure that there were no items in the room which might be used for self-harm purposes. Approximately two hours after transfer she was found hanging from the cistern toilet chain. CPR was commenced but was found to be futile and the patient was pronounced dead 25 minutes later.

The subsequent Coroner's Inquest recorded an Open verdict.

Briefing Paper on the case of "Daniel"

The Incident and the lead up to it:

6th November 2014 at 11:30 – the LYPFT Crisis and Access Service (CAS) contacted the North Yorkshire Police Control Room at Fulford Police Station following reports that Daniel had jumped off a high wall near the centre of York. Witnesses saw him walking unsteadily along an elevated platform in the centre of York. He was seen to climb over the railings, then lean back and let go of the railings and fall approximately 40 feet to the floor. He was taken to York District Hospital but could not be resuscitated and death was confirmed at 12:57. A note expressing his intention to take his own life was found in his pocket.

Daniel had a job and was receiving counselling support there. He was well supported by his employer throughout this period. He had a history of engaging reasonably well with mental health services and was frequently open about his suicidal thoughts and plans to act them out. 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 was the subject of a number of welfare checks.

To date there has not been a Coroner's Inquest on this case.

Because of the timing of the two briefing papers the enquiries and actions they generated will be reported to the Board in June 2015 and so will feature in the next Annual Report.

9. New Strategic Plan for 2016 onwards

One of the consequences of the Care Act 2014 is that Safeguarding Adults Boards have to establish a Strategic Plan "*having consulted both the local Healthwatch organisation and having engaged with the local community*". Neither of these were done when the 2014/17 Plan was established, nor was there any requirement to do so.

The Board is clear that a different method needs to be employed to ensure that its new Plan is fully compliant with Care Act 2014 requirements. As a result the Board has commissioned York Healthwatch to develop an engagement strategy with the local community in York, which will feed directly into the new Strategic Plan which will be in place by April 2016.

10. Contributions from individual member organisations:

Annex 1: Members of City of York Safeguarding Adults Board, March 2015

	Name	Title	Organisation	Address
1	**Sian Balsom**	Healthwatch Manager	**Healthwatch York**	Priory Street Centre, 15, Priory Street, York YO1 6ET
2	**Lindsay Britton**	Head of Safeguarding (Adults & Children),	**Leeds & York Partnerships NHS Foundation Trust**	2150 Century Way, Thorpe Park**, Leeds**, West Yorkshire, LS15 8ZB
3	**Bruce Bradshaw**		**NHS England, NY and Humber Area Team**	Unit 3, Alpha Court, Monks Cross, York, YO32 9WN
4	**Det Supt Nigel Costello**	Police lead on Vulnerable Adults	**North Yorkshire Police**	Newby Wiske Hall, Newby Wiske, Northallerton, DL7 9HA
5	**Cllr Linsay Cunningham**	Cabinet lead for Health	**City of York Council (CYC)**	West Offices, Station Rise YORK YO1 6GA
6	**Guy Van Dichele**	Director of Adult Services	**CYC**	West Offices, Station Rise, York YO1 6GA
7	**Beverley Geary**	Chief Nurse	**York Teaching Hospital NHS Foundation Trust**	Wiggington Road, York YO31 8HE
8	**David Heywood**	Social Work Manager	**Stockton Hall**	The Village, Stockton-on-the-Forest, YORK YO32 9UN
9	**Kevin McAleese CBE**	Independent Chair, York Safeguarding Adults Board		c/o West Offices, Station Rise, York, YO1 6GA
10	**Michael Melvin**	Acting Assistant Director	**CYC**	West Offices, Station Rise, YORK YO1 6GA
11	**Melanie McQueen**	Deputy Chief Executive	**York CVS**	Priory Street Centre, 15, Priory Street, York YO1 6ET
12	**Christine Pearson**	Deputy Designated Nurse, Safeguarding Adults	**NHS Vale of York CCG**	West Offices, Station Rise, YORK YO1 6GA
13	**Janet Probert**	Director of Partnership Commissioning	**Partnership Commissioning Unit (PCU)**	Sovereign House, Kettlestring Lane, Clifton Moor, York YO30 4GQ
14	**Maggie Scott**	Director of Operations	**The Retreat**	Heslington Road, York, YO10 5BN
15	**Steve Wilcox**	Designated Professional for Adult Safeguarding	**PCU**	Sovereign House, Kettlestring Lane, Clifton Moor, York YO30 4GQ
16	**Keren Wilson**	Chief Executive	**Independent Care Group**	10 North Park Road, Harrogate, HG1 5PG

ANNEX 2: City of York Safeguarding Adults Board

Membership and Attendance 2014/15

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

Organisation	Designation	June 2014	Sep 2014	Dec 2014	March 2015	Nominated representative or substitute
	Independent Chair	Y	Y	Y	Y	100%
City of York Council	Director of Health & Well-being	Y	Y	NA	NA	100%
	Director of Adult Social Care	NA	Y	Y	A	67%
	Assistant Director , Adult Assessment and Safeguarding	Y	Y	Y	Y	100%
	Safeguarding Service Manager	Y	NA	NA	NA	100%
	Cabinet Member for Health, Housing and Adult Social Services	Y	Y	Y	A	75%
Healthwatch York	Manager	Y	Y	Y	Y	100%
Independent Care Group	Chief Executive	Y	Y	Y	Y	100%
Leeds and York Partnership NHS Foundation Trust	Lead Clinician for Safeguarding Adults	A	Y	A	Y	50%
NHS England, North Yorkshire and Humber Area Team	Director of Nursing & Quality	Y	A	A	Y	50%
North Yorkshire Police	DCI, Protecting Vulnerable People Unit	A	Y	Y	Y	75%
Partnership Commissioning Unit (PCU)	Director of Partnership Commissioning	Y	A	Y	Y	75%
	Designated Professional for Adult Safeguarding	A	Y	Y	Y	75%
The Retreat	Director of Operations	Y	Y	Y	Y	100%
Stockton Hall	Social Work Manager	Y	Y	Y	Y	100%
Vale of York CCG	Executive Nurse	Y	A	Y	Y	75%
York & North Yorkshire Probation Trust	Area Manager (Public Protection)	Y	NA	NA	NA	100%
York CVS	Partnerships Manager	NA	Y	A	Y	66%

Organisation	Designation	June 2014	Sep 2014	Dec 2014	March 2015	Nominated representative or substitute
York Teaching Hospital NHS Foundation Trust	Chief Nurse	Y	Y	Y	Y	100%
Overall Board attendance		**88%**	**82%**	**82%**	**88%**	

Chair's comments on Board attendance:

We have worked hard over the past year 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. In the ideal world the thirteen partners would each have achieved 100% attendance records. During 2014/15 a total of seven of them did just that and I hope we will increase that number significantly during 2015/16.

I am grateful to the senior representatives of each organisation listed in Appendix 1 who have given so much time, energy and commitment to the work of the Board.

Annex 3: 2014/2017 Strategic Plan and Action Plan Outcomes for 2014/15

Objective	Action		Timescale for completion	Lead	Outcomes
A	**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**	Partners to confirm this is being addressed
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	**March 2015 March 2016**	**Chair and CYC safeguarding Lead**	**Both are now members of the Board. Chairs report includes feedback. CYC lead officer met on 27 May and further guidance has**
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 Development day to consider thresholds and demand	**December 14, 15 16 December 16 March 15 March 15**	**All CYC CYC and Voluntary sector Chair**	**CYC Audit will look at care act readiness. CYC Audit is underway and includes cooperation with partners. Update will come June 2015 Development day held Nov 2014 Care Act compliant**
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	**March 15 Annual March 15 Annual review of training attendance**	**CYC Chair CYC CYC**	**Website under review March 2015**

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 Healthwatch York** **Healthwatch 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 refresh started Feb 2015**

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

Garrow House

Garrow House

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, (and that all Turning Point employees are required to undertake), 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 (and that all Turning Point employees are required to undertake) 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 89% of 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 up to level 2, including the 'train the trainer' training.

Regarding evidence of impact: I as the safeguarding lead do notice that new starting support workers, nurses and other staff seem more confident of flagging up issues and making alerts about issues for which they are unsure of or cautious about. Furthermore the training is quite good at drilling into staff the procedure, in a very clear manner, for how alerts may become referrals, which in turn may become investigations etc, and of their role as frontline staff within that process.

April to June 2014: three alerts. Two of historical sexual abuse, both referred to CYCAST and police informed, one of lending/borrowing of personal items inappropriately with peers.

July to September 2014: two alerts. First of patient borrowing of money from a peer, some suspicion of financial abuse. Referral to CYCAST made. Second of historical

sexual assault: Referral to CYCAST and police informed.

October to December 2014: two alerts. First, threat of violence from one patient towards another peer. Referral to CYCAST made. Second, visit from family member alleged to have abused patient as a child thirty years ago.

January to March 2015: two alerts. Both historical allegations of sexual abuse. Referrals to CYCAST and police informed.

Analysis: nine alerts over the course of the full year, with seven referrals to CYCAST. Averaged out this is less than one a month. Six of the nine alerts pertained to historical allegations of sexual abuse, where no ongoing substantive risk of harm was present. However, were of the opinion that generally, unless the allegations have been made before and we know that for certain, a referral should go in to CYCAST in such cases as good practice.

Two alerts pertained to inter-peer borrowing of small amounts of money; these were relatively trivial incidents that were dealt with within the service.

There was only one incident that actually encompassed some significant contemporary risk to a known individual. This was dealt with quickly by transferring the PATCH onto another unit.

New database system of recording safeguarding alerts and referrals that is clearer and stores all details of alerts/referrals (both historic and present) in one place for ease of access.

Review of safeguarding polices in light of Care Act 2014.

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

Healthwatch York

Enter & View / Community Champion volunteers trained to Level 1
13 through 3 internal training sessions
2 through CYC WDU session at Haxby Hall

Staff members
1 accessed Level 1 Train the Trainer through CYC WDU
3 received Level 1 alerter training through internal training sessions

Also attended – Safeguarding and the Care Act session provided by City of York Council, and the Care Act Legal Framework for Managers. These were very informative.

Benefits
Volunteers reported increased awareness and understanding of what to look for. They are now more confident discussing concerns below safeguarding levels with staff at provider organisations, and have stated that they would flag safeguarding issues if required.

We have not raised any safeguarding alerts this year.

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

1. Independent Care Group (ICG)

We are the representative body for independent care providers 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. It keeps members informed of DBS news.
ICG gives information on Safeguarding training and how to access it on its website.

Partner Agency Annual Safeguarding Report 2014/15

LYPFT contribution to the Effectiveness of Safeguarding arrangements in Leeds

Partner Agency: Leeds and York Partnership NHS Foundation Trust

Report Author: Lindsay Britton/Richard Hattersley- Head of Safeguarding

1.0 Executive Summary

In 2014 our Executive Lead and lead for adult safeguarding moved to new positions in new areas. This presented an opportunity for some creative thinking around the safeguarding structure in order to respond to increasing pressures, and resulted in a creation of a Head of Safeguarding for adults and children. This relieves some of the pressure on the new Executive Lead Anthony Deery and allows for greater cohesion of the safeguarding agenda in the Trust. We have strengthened our governance arrangements with the appointment of a none executive director for safeguarding and a multi agency safeguarding committee.

We have actively contributed to the emergence of the new font door safeguarding hub and are working with the multiagency team to share information around adult mental health to protect victims of domestic abuse.

LYPFT submitted its' Savile report in line with other NHS organisations for publication by the Department of Health in Feburary 2015. We are working through our internal and nationally driven recommendations.

The major challenge for the LYPFT safeguarding adults team is to respond to the Care Act 2014. We aim to actively respond to the Leeds, York and North Yorkshire safeguarding board's recommendations on the implementation of the Care Act. But also to work proactively to ensure the Care Act is fully understood and implemented by staff in the Trust, to better safeguard adults who may be at risk whilst in our care.

The Trust has aimed to maintain a low threshold for raising safeguarding concerns and actively works to develop a robust understanding amongst its staff base for safeguarding intervention. This has been reflected in a strong partnership with Adult Social care partners over the years.

Work is underway to embed an understanding of 'Making Safeguarding Personal' within the Trust, to put the service user at the centre of the safeguarding process.

2.0 Introduction

The Trust Safeguarding team have dealt with significant numbers of advice calls from staff over the year, this is evidenced in a detailed data base from which a qualitative and quantitative report is presented to the Trust Wide Safeguarding Committee. Documentation around this has been refined as a result of an audit earlier this year.

The Trustwide Safeguarding Committee is now well developed and has representation from partner agencies thus ensuring transparency of practice.

We work closely with our partner agencies across the locality to ensure we fulfil our child protection, adult protection and domestic abuse responsibilities. Our Head of Safeguarding is the lead for PREVENT.

LYPFT have a safeguarding structure comprising strategic oversight by the Director of Nursing, a Head of Safeguarding for adults and children, Named Doctors for safeguarding adults and children and 2 Deputy Named Nurses/trainers and 2 safeguarding adult practitioners. We are looking to recruit a trainer,a deputy Head of Safeguarding and another adult safeguarding specialist, a business case has been approved.

3.0 Effectiveness of Safeguarding Arrangements

- Safeguarding Performance
  - Summary and analysis of quantitative data
  - Summary and analysis of qualitative data

- Quality of safeguarding practice
- Attendance and engagement in the Safeguarding Health Action Group including shared lessons learned and audit findings.
- Active engagement in the LSAB performance and quality sub group.
- Active engagement in the YSAB Sub group.

- Safeguarding is represented at Trust Incident Review Group.

- Findings from Internal Reviews

- Findings from External Inspections and Reviews

- Summary analysis of the effectiveness of safeguarding arrangements
  - Strengths
  - Areas for improvement

- Summary of lessons learnt, actions taken and impact on practice / multi-agency working / outcomes for C&YP.

Work throughout 2014/15

- The need to improve on the consistency of staff recording has been identified in an audit of paris (clinical electronic notes) in relation to the LYPFT safeguarding data base.
- A designated safeguarding section has been embedded into the clinical recording system and guidance has been broadly circulated to staff with guidance as to how to use.
- Improved incident reporting via implementation of a DATIX risk management system. The safeguarding adult practitioners have an overview of this system where safeguarding has been noted as a need on the risk form.
- Development of a robust recording system dealing with safeguarding queries to LYPFT safeguarding staff which will mean the service user records are updated with the relevant information and recommendations.
- Better monitoring of compliance for mandatory safeguarding training via the Oracle Learning Management data system.
- A non executive director allocated to safeguarding.
- A new Executive Lead as member of the SAB.
- New performance reporting for Trust Safeguarding Committee.
- We included a mandatory mental capacity act element to our safeguarding training following a CQC inspection recommendation from November 2014.
- A data report is shared with ASC at the end of the financial year detailing cases investigated and coordinated for 2014-15.

Audit

- We have complied with the actions from an internal audit by an external company and shared via our safeguarding committee.
- We audited against how our staff act on safeguarding adults advice and are progressing these actions

Projected work through 2015

- April 2015 brought the formal introduction of the Care Act. For the LYPFT this has brought a change to how cases at a defined level of

risk previously investigated within the Trust, are now to be sent directly to ASC as lead agency. Work is underway to ensure all staff have updated clear guidelines for raising a concern, and partner agencies (ASC) have strong lines of communication with the (LYPFT) Safeguarding Adults advisors with which to make enquiries within the Trust as directed by Adult Social Care.

- Adopt and link in all policy and practice in line with the Care Act 2014. Including making Safeguarding training compliant with the Care Act.
- To work with the Health Community via health Action groups and time limited project groups to better understand and implement the Care Act. For example to better understand the concept of self neglect as it is described in the Act and its implications for mental health services.
- Improve the links between the DATIX incident reporting system and the identification of safeguarding issues via a central safeguarding team email address.
- Embed 'Making Safeguarding Personal' into the work of the Safeguarding Adult team, ensuring all cases subject to enquiry are based on the outcomes wanted by the adult at risk and that those wishes inform what interventions are taken.
- Implement the Savile recommendations relevant to our organisation.
- Ratify a prevent policy.
- The LYPFT safeguarding team have contributed full IMR reports to 8 Domestic Violence Reviews since 2014. A number of such reports will be completed and published during 2015, the team will be ensure full engagement with this process and implement any lessons leant fully.
- Widen our training offer to include specialist sessions on supervision and domestic violence.
- Health Wrap PREVENT training is being rolled across the Trust, dates are now available for booking to December 15. Basic PREVENT awareness is covered in the Safeguarding Level 2 training.
- There is a need to Train more Health Wrap PREVENT trainers and ensure all areas of the Trust are covered giving good access to staff for this training.
- To develop a bespoke training pack (level 3) for senior clinical staff across the Trust to better enable senior clinical staff to provide safeguarding supervision and guidance within their clinical teams and settings.
- Safeguarding Adult training and mental Capacity training were delivered together during 2014. However it has now been agreed that Mental Capacity Act training will be delivered in a stand alone module to avoid any confusion to staff and to give enough time to be able to better deliver this training.
- Work with Safer Leeds to provide ongoing support and strengthen the Front door safeguarding hub.
- To ensure representation at the Domestic Violence safeguarding Hub (Leeds) on a daily basis where resource allows.

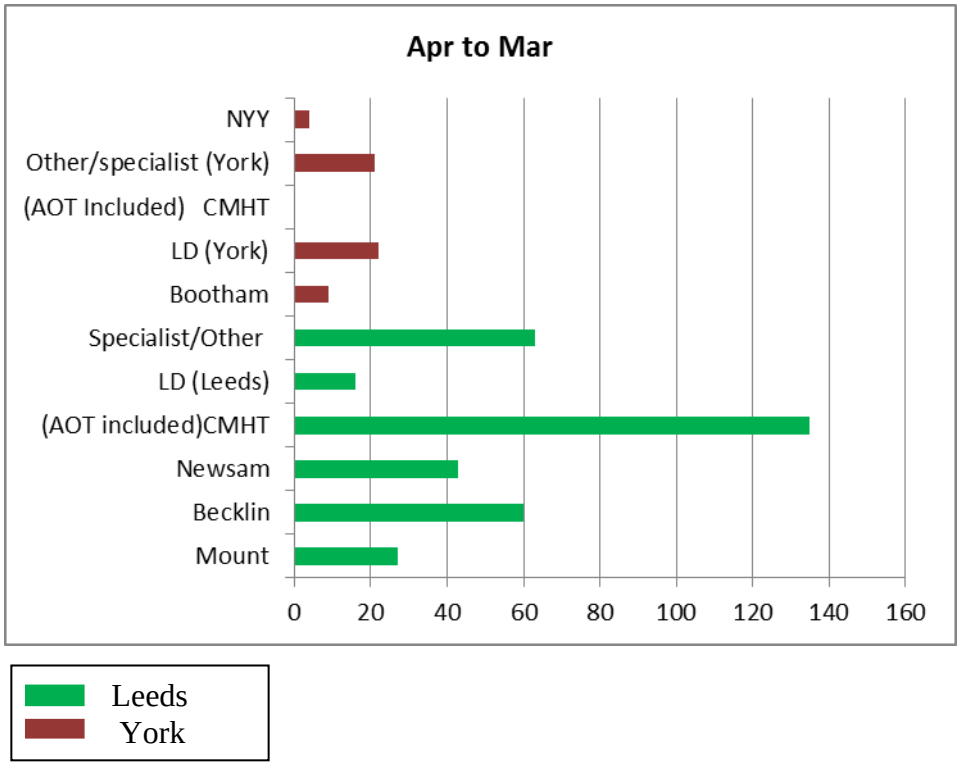
Audit

- HR audit against staff compliance with safer recruitment
- MCA/Dols- how do we know staff practice in accordance with procedures?
- Prevent- staff awareness.

Review areas for audit within safeguarding Adult practice consider a repeat of the 2014 case note audit.

- Safeguarding Performance

Safeguarding Adults Referrals and Advice
April 2014 – Mar 2015 (cumulative annual)



- Learning from complaints and compliments

We have a PALS (Patient advice and liaison service) which deals with our enquiries and a complaint lead. Any safeguarding issues would be drawn to the attention of the safeguarding team.

We evaluate training, take comments on board and make changes accordingly.

We have an internal incident reporting system which aims to pick up serious issues or incidents. These are shared with the team and progressed with relevant actions. This has been transferred to a new more effective DATIX system.

We have begun to bring good practice cases to our safeguarding committee to look at the quality of learning from these as well as addressing failings and concerns.

4.0 Responding to emerging issues

- The LYPFT safeguarding team aim to be fully compliant with the Care Act in 2015. Training has been updated and work is underway with partners within ASC to agree a clear pathway for staff to raise concerns via Social Services contact centre. This involves a change in pathway for staff within Leeds clinical services a plan is in place to provide information and support to staff in reporting concerns.

- The challenge for the LYPFT for 2015 is to ensure a continued low threshold for safeguarding advice being rung through to the team for advice (currently evidenced by the safeguarding data base) whist ensuring that the Trust is fully compliant with the Care Act. The Trust Safeguarding team will retain a strong presence within the Trust, it is envisaged that significant numbers of advice calls will be taken by the team, though all Safeguarding concerns raised to an enquiry will be reported to ASC as lead agency.

- A CQC issue raised in a recent review was that York clinical areas had some confusion regarding how to refer or raise an alert (cause an enquiry to be made). A Trust Wide website 'banner' has advertised City of York safeguarding team number. This will be further reviewed at the point where commissioning arrangements are clear for the York and North Yorkshire region.

- A Safeguarding Adult training Plan has been developed to include a stepped approach to training from level 1 (on line) 2 face to face and 3 face to face enhanced training for senior clinicians who may be involved in supporting the safeguarding process.

- A Communication on the Trust website has been sent to all staff regarding PREVENT training. This is now being booked onto and will be monitored as to numbers of staff having completed this training. In the event of numbers not reaching a reasonable and agreed threshold of staff having completed the training by October 2015 then a plan will be formulated to increase take up.

- The Safeguarding Adults practitioners attend CHANNEL meetings and include PREVENT enquiries on the safeguarding data base.

- Bespoke Safeguarding Adult training is currently being planned for

Dementia services in York if successful this can be offered to other clinical services.

- Mental capacity Training is being led by the Mental Health Legislation Team. The Safeguarding Adults practitioners are working closely with the MHLT to ensure all staff are aware of and compliant with the 'Cheshire West' ruling. In 2014-15 a Mental Capacity module was added to the level 2 safeguarding adult training though this is to be split in July 15 to ensure clarity of message and ensure all clinical staff have access to such training.

- The Safeguarding team have begum to develop a protocol for making safeguarding personal, agreeing to use the Adult Social care form given to service users to identify what the individual wants as an outcome in the process. This will be monitored in 2015 to ensure compliance with the MSP model.

- Domestic violence support remains a priority in 2015, with the start of the DV Hub the team are committed to a daily input and will continue to work with staff to consider DV as an issue to consider in assessment an treatment for our service users.

- The team will continue to engage with 'Claire's Law' panel through 2015.

5.0 Partnership Working

Our Executive Lead, Director of Nursing is now the LSCB board member and Head of Safeguarding is deputy. We have consistent representatives for the learning and developments, policies and procedures, performance management and CSE sub committees.

We are beginning to collate our compliance with board attendance within our performance reporting.

We have agreed a shared process for a member of the team to represent at the front door safeguarding hub for 2 hours on a daily basis. It is envisaged this will be a significant role for 2015 and should be seen as a good practice example of how the LYPFT is committed to partnership working in line with the Care Act 2014. Strong links are in place across LYPFT and ASC safeguarding teams this has been enhanced by the employment of a second safeguarding practitioner in 2014.

6.0 Workforce Development

A training plan has been developed and will be implemented for 2015, 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.

Leeds Training – Nov 14 to March 15

Overall rating are as follows:
5= 75.1%
4= 18.8%
3= 6.1%
2= 0%
1= 0%

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.

7.0 Summary of achievements in 2014/15 and emerging themes

Partnership working with Social Service colleagues to implement the Care Act 2014.

Updated training plan for safeguarding Adults level 1/2/3 training model. Contribution to front door safeguarding hub.

Significant resource contribution to safeguarding DV Hub and MARAC. Governance arrangements.

Audit completion.

Performance reporting, the Safeguarding Team provide a comprehensive report to the Trust Wide Safeguarding Committee.

Joined up working with front door and data collection and analysis on our multiagency contribution.

Full representation at SAB meetings.

Strengthen the Trust Wide safeguarding Committee to increase the quality of reporting and continue to maintain the open nature of the group with representation from key partner agencies and Senior clinical staff representing Trust wide services.

A move to unify and build on the strengths of the Safeguarding Adult and Child teams into a strong Safeguarding Unit for the Trust.

8.0 Challenges for 2015/16

Effective recruitment to address shortfalls in training provision and the growth of safeguarding role in Domestic Violence reviews, HR processes and advice calls.

To continue to be responsive to the increasing safeguarding agenda.

To continue to raise awareness of safeguarding within the Trust and health Community in Leeds and York.

Improve outcome measuring and performance reporting to reflect trends.

To ensure safeguarding strengthen links with risk reporting and has clear pathways for reporting to include clear guidelines for reporting to LYPFT risk/CQC/ASC and CCG partners.

Notes
There will be a maximum word count in the document of 3,000 words.

Please can signed off Partner Reports be sent to LSCB BU by ***Thursday 4 June 2015***

Lindsay Britton, Head of Safeguarding

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.

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

NHS Partnership Commissioning Unit

Commissioning services on behalf of:
NHS Hambleton Richmondshire and Whitby CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Vale of York CCG

The PCU is a relatively small unit and all staff place a high priority on keeping up to date their mandatory training. Adult Safeguarding is also central to the work of the PCU and its focus on monitoring and maintaining the quality and performance of NHS providers so that apart from 100% compliance on level 1 training we can report a healthy engagement with safeguarding from our colleagues in other functions in our day-to-day work.

The PCU Safeguarding Adults Team provides advice and guidance to all NHS and private sector providers in the VoY CCG catchment area and work collaboratively with the City of York Safeguarding Team. These are the figures for York cases in 2014-15 where the PCU have been the lead investigative agency:

- Number of new alerts received – **17**
- Number of investigations required for the above alerts – **14**
- Number of new low level concerns opened – **4**
- Number of cases opened pre 1st April 2014 but closed during the period 1st April 14 – 31st March 15 – **5**
- Number of cases (opened and) closed during the period – **15**

Safeguarding Adults PCU
In August 2014 the Designated Professional for Adult Safeguarding took up post at the PCU. The workload and outputs of the partially newly recruited team was reviewed and a programme of development was initiated. The main focus of this was to focus the work of the team onto a specific safeguarding function rather than quality and performance and safeguarding. Of course quality and performance are still integral to ensuring services are safe but the team needed to change emphasis in order to properly respond to serious safeguarding concerns and fulfil their role as main partners in multi-agency safeguarding.

Whilst the performance of providers will always be a central focus, along with the services funded by Continuing Health Care (CHC), the team's central focus is to ensure the CCGs and the services they commission and monitor are properly connected to the prevention and response initiatives that address the whole safeguarding agenda; ie the types of abuse that occur in the homes and communities of the populations the CCGs serve as well as the hospitals and care homes. Team developments in these areas and on-going improvements to information sharing and support and liaison with partner agencies has led to the team and its safeguarding work gaining a higher profile across the health economy.

The Vale of York CCG now has a Link Safeguarding Officer at the PCU and in January appointed its own Deputy Designated Nurse Safeguarding Adults. This ensures good knowledge of the localities and their services and allows for effective relationships to develop with key CCG staff. If a major safeguarding issue arises the team can also act flexibly to ensure resources are focused on the area of need. Effective team building and team working is key to this and two development days took place in late 2014 culminating in a new strategic approach and revised operating procedure.

In response to a spate of recent reports on investigations into institutional failures to protect the vulnerable in society; Operation Yew Tree, Winterbourne, Mid-Staffs and Rotherham. The PCU Safeguarding Team have ensured that their on-going service development is in accordance with national drivers influencing clinical and safeguarding practice. The Care Act (2014) which becomes statute on 1st April 2015 has also influenced team development and their new operating procedures reflect the language and frameworks within the Act.

There is now a joint action plan on Winterbourne between the different agencies, in place to address key objectives, this is monitored via a multi-agency approach with representation from the lead stakeholders in this area, and covers both the Local Authorities. The action plan is currently monitored via the two SABs.

Suicide Prevention

North Yorkshire County Council, City of York Council and Partners have produced this suicide prevention implementation plan in response to the government's Preventing suicide in England a cross-government outcomes strategy to save lives (2012) and the subsequent Preventing suicide in England: one year on first annual report on the cross-government outcomes strategy to save lives (2014). Suicide prevention has also been identified through the Safeguarding Adults Board and the Safeguarding Children's Board.

We are at the point of appointing to the above post which will be funded on a multi-agency basis between North Yorkshire County Council, Public Health and the Police, the post will be hosted by the Partnership Commissioning Unit (PCU). The post holder will be accountable to and line managed by the Designated Professional for Adult Safeguarding at the PCU although operationally they will be part of the Public Health senior team working with the Director of Public Health to deliver the Local Authority's vision, goals and core values in relation to suicide prevention. The post holder will be instrumental on delivering on actions within the North Yorkshire Suicide Prevention

Implementation Plan.

MCA/DoLS
The PCU Safeguarding Team bid successfully for NHSEngland funding to develop the awareness of the legal framework around the Mental Capacity Act (2005) The Year 1 programme (2013-14)raised the profile of MCA/DoLS with CCG leads and managers engaging key staff with the complexities, risks and legal requirements of the legislation. Year 2 of the project will provide front line staff with tools, materials and training in order to understand how to operate safely within the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) legal framework.

The 'Cheshire West' Supreme Court Judgement has brought MCA/DoLS into focus with the interpretation of what constitutes continuous supervision. This has placed the Local Authority and Court of Protection under some pressure as hospitals and care homes have a legal responsibility to apply for a DoL if someone is subject to 'continuous supervision' what, when and how to do this remains very challenging for front line staff.

The PCU Safeguarding Lead issued guidance to GPs and care homes on the special considerations when issuing death certificates when someone has died whilst subject to a deprivation of liberty.

Contributions to CoY SAB
The Designated Professional for Adult Safeguarding for City of York CCG at the PCU is the Chair of the Safeguarding Adults Review Group (formerly known as the Serious Case Review Group) Two cases have been submitted and subject to the Lessons Learned Review process.

Individual Board Member organisation's contribution to 2014/2015 SAB Annual Report.

North Yorkshire Police

Training regarding Safeguarding Adults is built into all of NYP's initial training programmes in a number of different ways for new PC'S , SC'S and PCSO's. All Police Constables and all new recruits (PC, PCSO, SC) complete a Vulnerability Training Package. The aim of the training is to ensure that Police Officers and PCSOs understand their responsibilities and duty of care to vulnerable people and the actions that must be taken to reduce identified risk. The package looks at vulnerability in relation to adults with factors such as alcohol and drugs and age.

Vulnerable Risk Assessment Training focuses on identifying those individuals that are Vulnerable and at risk in local communities, how to complete the Vulnerable Risk Assessment and what referrals need to be made and to whom.

WRAP (Workshop to Raise Awareness of Prevent) has been rolled out to all existing PCSO's and is to be rolled out to Police Officers and Special Constables this year. This assists officers to identify those that may be at risk of radicalisation because of vulnerability.

All new staff are required to complete the online learning package pertaining to Mental Health and Vulnerability and PC and SC courses follow this up by scenario based lessons and discussion on recognising and responding appropriately to adults as risk.

NYP's SC's have all had training on Human Trafficking and responding to people who have Autistic Spectrum Disorder.

North Yorkshire Police has changed the Control Strategy to have more of a focus upon cross-cutting themes such as victim vulnerability. As part of this intelligence structure a number of problem profiles have been reviewed including Missing and Absent, Prostitution and Modern Slavery / Human Trafficking.

NYP has undertaken a review and re-published its Safeguarding Adults procedure in light of changes to legislation within the Care Act.

The force has produced a Domestic Abuse Action Plan. This is available via the NYP website and has been developed using ACPO guidance and incorporating recommendations from HMIC. NYP is also leading on the alignment of performance data relating to domestic abuse across a number of partner agencies.

The Domestic Violence Disclosure Scheme (DVDS), also referred to as "Clare's Law", started in York and North Yorkshire in March 2014 as part of the national rollout**.** This was followed by the successful implementation of Domestic Violence Protection Notices (DVPN) / Domestic Violence Protection Orders (DVPO) at the end of June 2014.

Following research into victim needs, the Police and Crime Commissioner has commissioned and implemented a Victim Services Unit to help the most at risk and vulnerable people. Through the new services, more victims of domestic and sexual abuse, as well as those who have suffered as a result of serious crime, receive help from an independent adviser. The advisers provide the emotional and practical support that victims need to cope with what has happened and get back to normal as soon as possible.

The force has produced a number of safeguarding bulletins which are circulated forcewide. Topics which have been included within these publications have included safe use of the internet, grooming and sextortion.

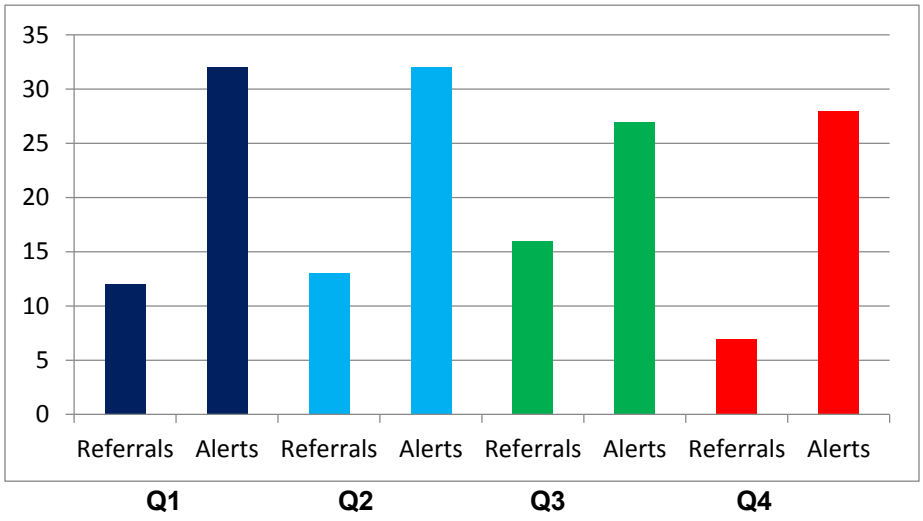
NYP has an established Hate Crime Working Group and have recently held a multi-agency workshop." We Stand Together" is a police-led campaign to show that we (and others) stand united against hate crime.

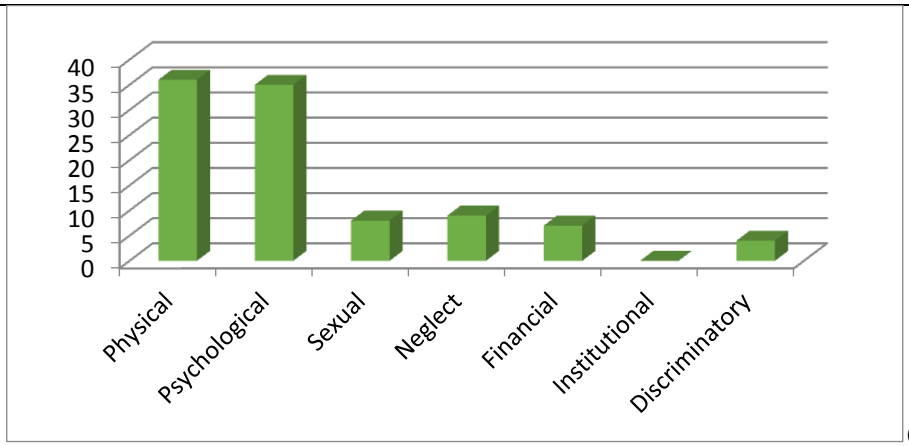
Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

Stockton Hall Hospital

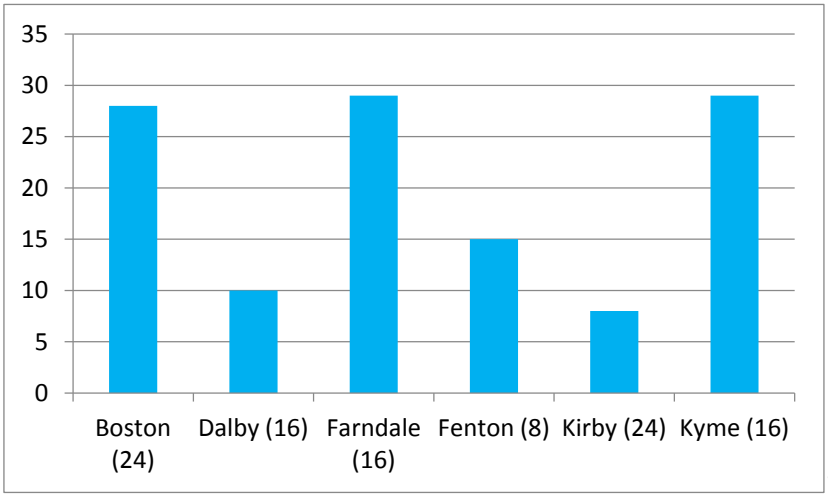
Partnerships in care

All newly recruited members of staff receive level 1 safeguarding adults' awareness training during the induction course. Furthermore, there is a standard for clinical and non-clinical staff to attend annual statutory/mandatory safeguarding training. The compliance for the year was 83.4%. Non-clinical staff members are provided with safeguarding training to address their specific needs; these sessions are delivered on a quarterly basis in order to ensure full compliance. Senior managers and clinicians have had the opportunity to attend Level 3 safeguarding investigator training which is delivered by Community Links on behalf of City of York Council. Two internal Level 3 safeguarding investigator training sessions, provided by an external facilitator, were attended by 20 senior clinical and management staff, bringing the total number of staff trained to 41. The expectation is that all senior staff will participate in Level 3 training every three years.





Categories



Ward

The hospital's Safeguarding Lead provides regular verbal feedback from the Board to the monthly Senior Management Team meetings. Written reports are provided, as required. A quarterly report, including data and analysis, is completed for the organisation.

The organisation and the hospital policies have been amended to incorporate changes from the Care Act 2014. This has included the development of a revised Safeguarding Adults presentation for Statutory/Induction training purposes. A presentation has also been developed to summarise the key points of the Care Act regarding safeguarding practices to be used at clinical governance meetings.

The government's PREVENT strategy is being supported through a training programme to ensure that all qualified clinical staff are trained within 12 months.

The agenda for Patient Safety Meetings has been reviewed to include a requirement to allocate link workers for the alleged victim and the person alleged to have caused harm in order to elicit their views in making safeguarding personal.

An audit of the incident recording systems identified a lack of synergy with safeguarding. An action plan has been developed in order to improve safeguarding documentation across the hospital. The Referrals and Clinical Governance Meetings have been utilised to address the key issues regarding recording safeguarding activities. The Out of Hours Safeguarding Protocol is being amended accordingly.

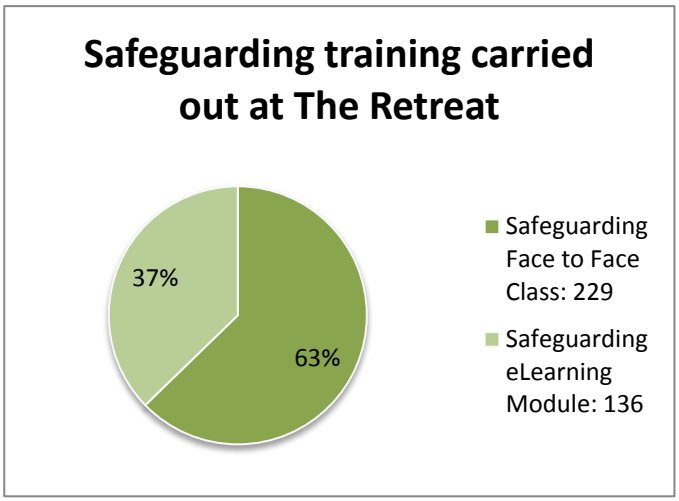
Ongoing participation in the Safeguarding Implementation Group, with the other independent hospitals, has included a review of the changes being implemented for the Disclosure and Barring Service. Referrals have been actively considered following safeguarding investigations into alleged staff misconduct. The organisation's Legal Department has issued guidance in that regard.

Safeguarding Adults alerts are now being discussed daily at SMT briefings and weekly at Referrals Meetings, thus improving organisational responses following the raising of a concern.

The Retreat Yearly Safeguarding Report (2014/2015)

1. Safeguarding training

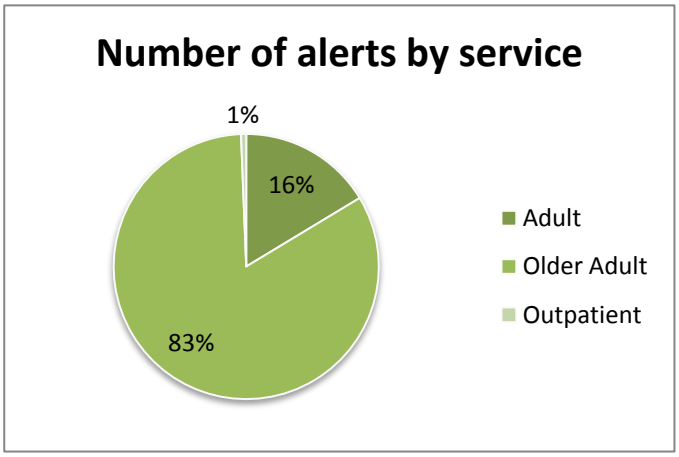
Adult Safeguarding Level 1 (Alerter) Training Compliance for the hospital (inc. Bank) was 100%, the refresher training compliance is: 272 compliant (79%), 71 non-compliant (21%). The safeguarding training level 1 is delivered face to face and as an eLearning module.
Adult Safeguarding Level 2 (Responder) and Level 3 (Investigator) Training Compliance for the hospital was 100%. Adult Safeguarding Level 4 (Chair) Training Compliance for Hospital was 75%, due to problems with accessing the training at WDU.



The impact of the new safeguarding training (revised at the beginning of 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.

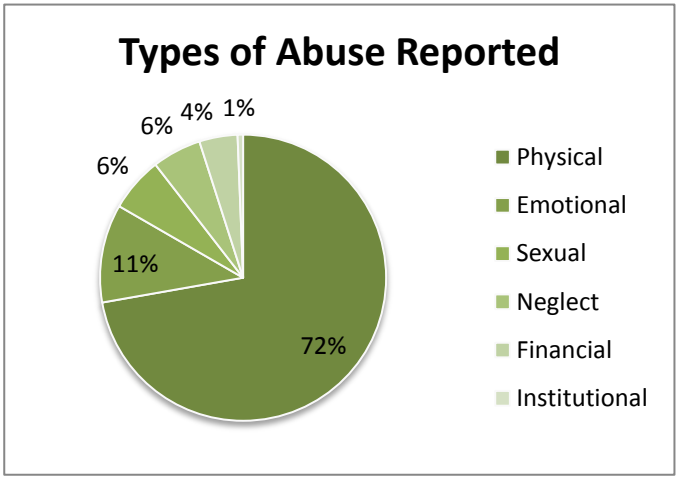
2. Safeguarding alerts and responses

The number of reported safeguarding alerts has been on the rise over the last 3 years: 62 in 2012, 85 in 2013 and 159 in 2014. The number of alerts received is much higher than the previous year (increase of 87%) and as mentioned before this can be associated with an improvement in reporting.

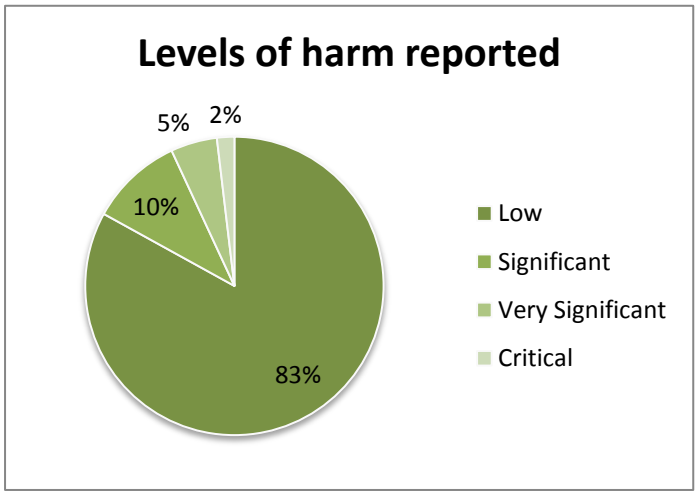


The number of alerts which were later referred to the City of York Council Safeguarding Team and Care Quality Commission did not change much over the last few years: 39 in 2012, 39 in 2013 and 32 in 2014. The number of the referred alerts did not go up with the increase of the alerts.

The new average for the quarter is 38 alerts, in comparison with 21 in the previous year (increase of 85%). The average number of referred alerts per quarter was 8 (9 in previous year), which has been a stable number for the last two years.



The significant majority of alerts: 132 (83%) were submitted within older adult services in comparison to 26 (16%) reported on adult units and 1 (1%) in outpatient service. However when it comes to the referred alerts the figures present a different picture: 72% of cases were from older adult, 28% were from adult services. Further analysis shows that 17% of all alerts submitted within older adults are referred, while in adult services this figure is higher (33%).



The cases of physical abuse account for the majority of all of the alerts: 117; emotional abuse was reported in 18 cases, sexual in 10, neglect in 9, financial in 7 and institutional in 1 case. There were no incidents of exploitation.

The incidents of physical abuse (primarily patient on patient assaults) have more than doubled in comparison to the previous year; however the sexual abuse cases have reduced by almost half. A notable increase of neglect allegations has been noted in comparison to 2013.

Person alleged to cause harm (PATCH) was in 118 cases a current patient of The Retreat, in 22 cases allegations were made against staff, and in 19 cases the PATCH was identified as external which includes family members, friends and ex-patients.

The level of harm in 132 cases was described as low, 16 were described as significant, 8 were very significant and 3 were critical.

Out of 159 alerts 156 met the safeguarding criteria and were either investigated or reviewed by the social work department; 3 alerts (2%) did not meet the criteria, but were still recorded within The Retreat's internal safeguarding database. It is justified to say that the alerts are being made appropriately.

In 119 cases the allegations were proved, in 24 cases they were disproved and in 13 cases the social workers were not able to determine the outcome; 3 investigations (all external) are still pending.

The social work department has improved its own system of monitoring data, which has helped to analyse the safeguarding within the organisation and determine current trends.

The regular safeguarding review meetings which involved practitioners from across the hospital helped to identify other factors e.g. environment, which have had an effect on safeguarding.

3. Achievements in relation to safeguarding

The Retreat's aim in 2014 was to enhance people's involvement, choice and control in the safeguarding process. We have worked with people who use services to ascertain what outcome they want when a safeguarding alert is raised. Our procedure includes the implementation of a safeguarding link role. The safeguarding link role ensures that the adult at risk and PATCH, (where they are also an adult at risk), are fully involved in the safeguarding process. We have developed leaflets for the adult at risk and the PATCH to explain the safeguarding process and the other areas of support that are available to them for example advocacy.

We have rolled out a training programme for people who use our services, to educate them about the safeguarding process. Our aim is to make safeguarding personal, a process that is done with and not to the people who use our services. We have found that the process has become more empowering and that the individual service users are at the centre of the process.

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

York CVS

Two York CVS's Independent Living Scheme staff members attended Safeguarding level one alerter training as a refresher.

One Adult Safeguarding Alert made by York CVS's Independent Living Scheme.

- We reviewed our organisational Safeguarding Vulnerable Adults Policy In December 2014 and presented this at our internal managers meeting.
- We are actively promoting safeguarding best practice and learning through our Voluntary Sector Forums (older people & long term conditions, learning disabilities, mental health and children, young people and families).
- The Safeguarding Adults Board Chair is presenting the Annual SAB return to the Voluntary Sector Forums.
- We attended the Safeguarding Adults and Children's Board Development Days and completed the annual self assessment documentation.
- York CVS maintained attendance at the Safeguarding Adults and Children's Boards.

Individual Board Member organisation's contribution to the 2014/2015 SAB Annual Report.

YORK HOUSE

A neurobehavioural service for acquired brain injury

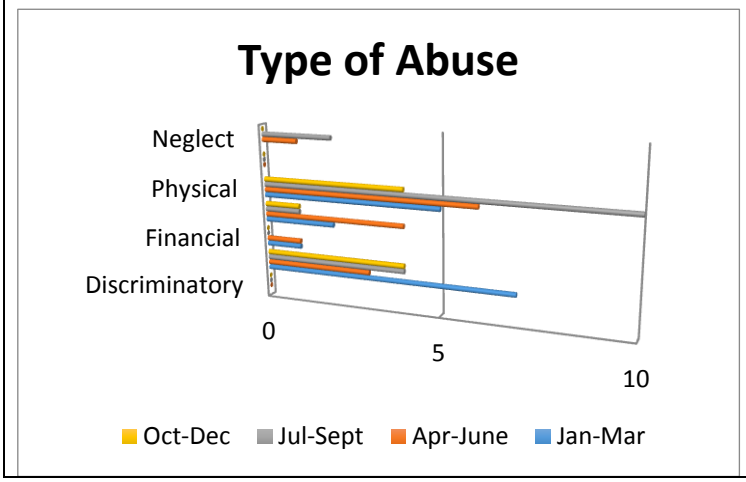
1. The following information shows the number of staff who have completed the SOVA training at York House between April 2014 and March 2015:

Total Staff - 201

Training	Contract (136)	Bank (65)
SOVA	110	17
Training	Contract (%)	Bank (%)
SOVA	81	26

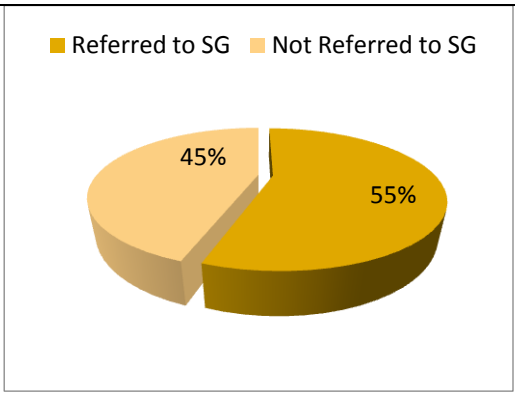
All staff are required to complete a week long comprehensive induction training prior to any shifts being completed, this includes Safeguarding training. All staff must then repeat this training yearly in the 3 day mandatory training program.

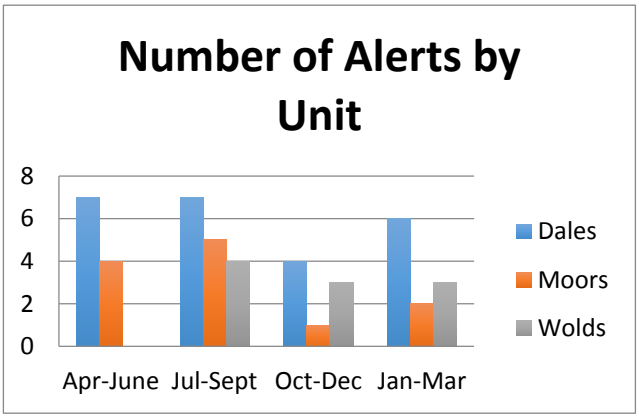
Those staff responsible for overall safeguarding at York House have also completed further training on Level 2,3 and 4 run by City of York Council. Training on the care act implications for safeguarding has also been attended by a member of the governance team at York House and the safeguarding lead which will impact on the induction and mandatory training following April 2015.



The types of abuse reported and dealt with at York House from April 2014-March 2015 are shown in the graph opposite. There have been no incidents of institutional or discriminatory abuse in this period. The most common type of abuse identified in this time frame was physical abuse.

There was 45% of safeguarding cases that were not sent to City of York Council (CYC) for further safeguarding intervention due to it being dealt with in-house through management of risks, protection plans or support measures being implemented. Some of these cases may have been discussed with the safeguarding team to reach the decision not to refer and all are discussed between the York House safeguarding sub-committee. 55% of the cases were referred to CYC, these have now all been closed with all internal and/or external investigations completed.





The alerts by unit tend to follow the same trend throughout the year, with the majority of alerts being from the Dales unit at York House.
This is the assessment unit were all new admissions (excluding females) are generally admitted. The population as a whole is as a result often more challenging and behaviours more unpredictable. As a result staffing levels are higher to ensure adequate support and management. The Moors unit of York House is a slower stream rehabilitation unit and so care plans are more established and service user's behaviors more stable in comparison.
The Wolds unit of York House is intensive long term care needs with a focus on quality of life, however the long term effects of brain injury from this client group and mix of service users can lead to safeguarding issues following conflict.

York House are using the new Disclosure and Barring service, with all new recruits and renewals of CRB's due being dealt with under the new system. This is significantly reducing the time taken to complete checks.

Safeguarding information specifically developed in conjunction with Speech and Language therapists has been produced for our service users including posters for all 3 units. We are now looking at updating this in line the introduction of the Care Act.

Those staff with overall safeguarding responsibilities at York House are continuing to seek out external training and attend the level 2 upwards training delivered by CYC.

Training and awareness raising

Training is fully embedded in Trust induction and statutory and mandatory training– Level 1 and 2 which is a 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.

There were concerns regarding take –up figures and as a result and with the help of the learning hub these figures are on the increase. To ensure more accessibility the Level 2 training, previous a full day has been transferred to an e-learning package. This will be in place from April 2015.

In addition in light of Cheshire West specific areas of high risk have been targeted for one-off training sessions and a bespoke Prevent training package has been developed and subject to Corporate Learning and Development Director approval will become part of the Statutory Mandatory Programme from April 2015.

In addition the Trust Safeguarding Adults team began in January a monthly “Ward Wander” programme which involves our team visiting departments/wards/units to offer support, tutorials and on the spot review of patient issues.

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

Safeguarding Adults Training Figures 2014/2015
Level 1 1714
Level 2 309
Level 3 1
Level 4 1

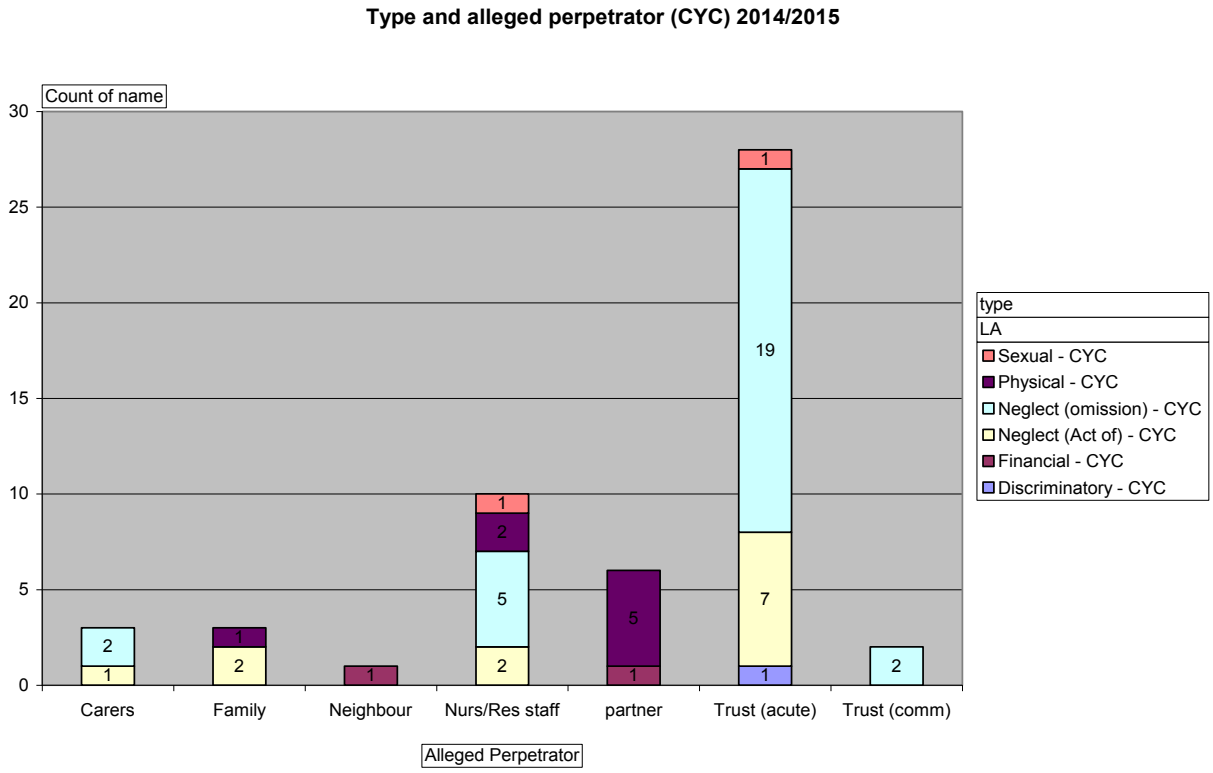
Safeguarding Adult Referral/alerts analysis

There were 146 Safeguarding Adults alerts received in 2014/2015. This figure relates to **all** alerts referred through the Safeguarding Adults Team raised either **against** or **by** the Trust.

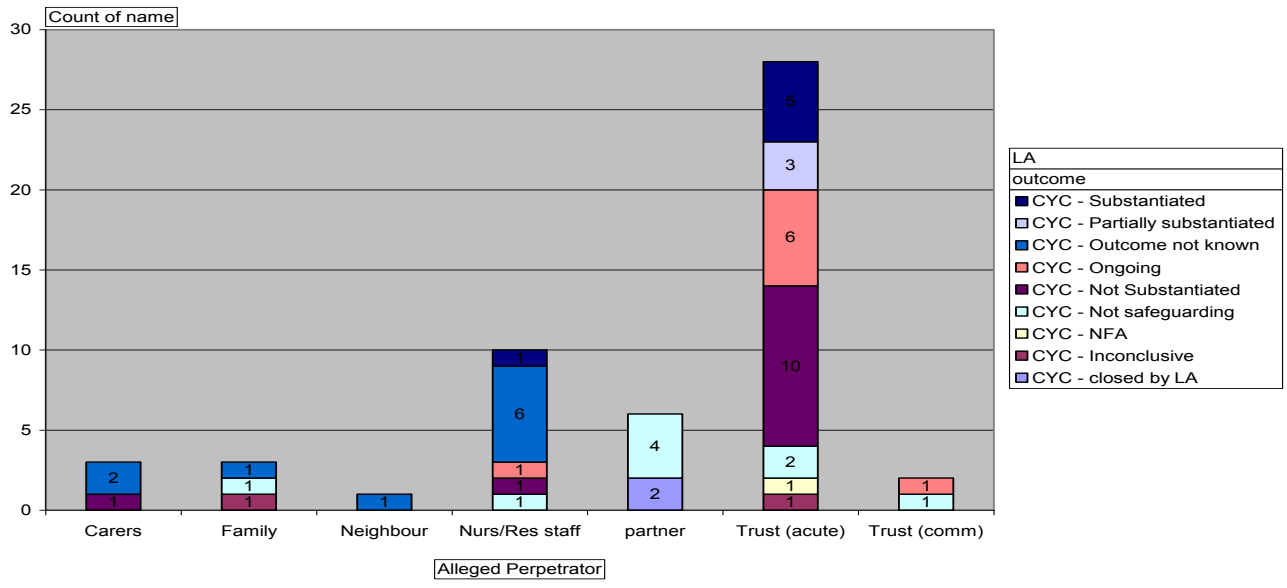
These alerts are either investigated by the Local Authority or in cases where the concern regarded care delivered by the Trust investigated by the Trust Safeguarding Adults Team.

Of the 146, 53 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.

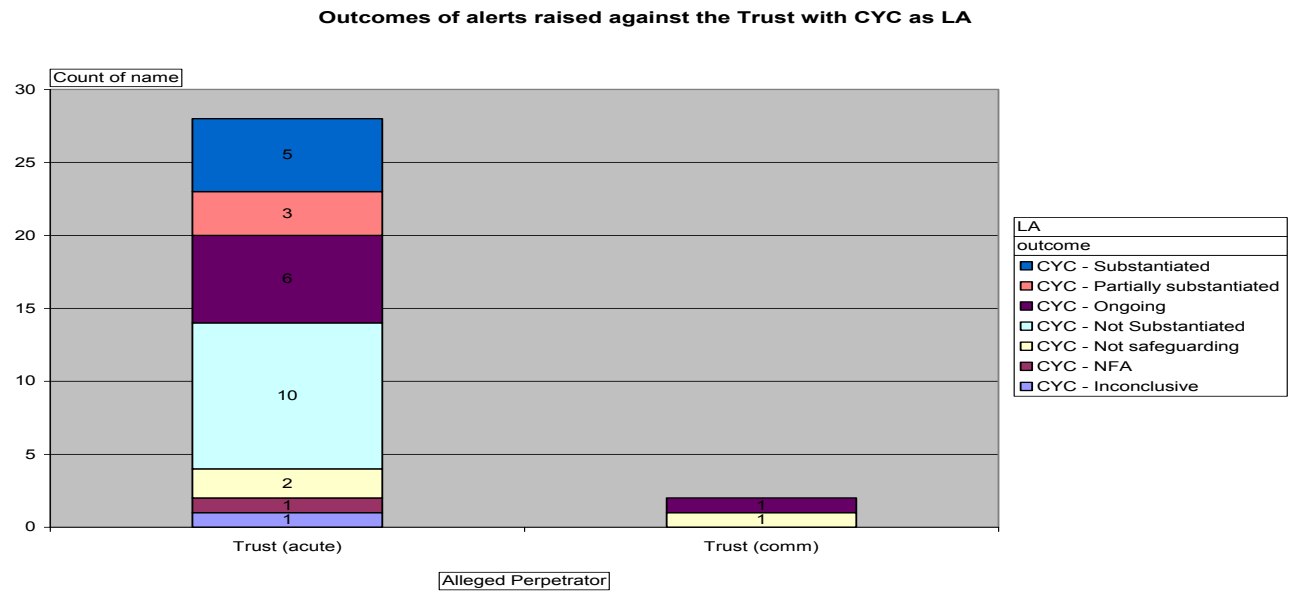


Outcomes for all alerts (both raised by and against the Trust)



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.

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



Achievements during 2014

1) Resources

The Safeguarding Adults Team consist of:

- ☐ Head of Safeguarding
- ☐ Lead Nurse for Safeguarding Adults
- ☐ 2 x specialist nurse to support staff with the Safeguarding Adults agenda which includes Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)
- ☐ 1 x Learning Disability Liaison Nurse
- ☐ 1 x Learning Disability assistant (Scarborough acute only)

This robust structure, established in 2014, further indicates the commitment the Trust is making towards Safeguarding Adults in our care.

2) Policies and Procedure

Trust policies and procedures include the following:

- ☐ Safeguarding Adults Policy and Procedures (based on Multi- Agency Policy and Procedures) This has been amended provisionally in light of the Care Act but is awaiting final multi agency guidance before complete review.
- ☐ Therapeutic Restrictions Guidance
- ☐ Mental Capacity Act Guidance
- ☐ Deprivation of Liberty Safeguards (DoLS) Guidance
- ☐ Learning Disability Specification

Where appropriate these have been reviewed to include changes from National legislation. A Draft Prevent Policy has been circulated for approval and will be published from April 2015.

3) Learning from Safeguarding Adults Investigations

Thanks to Senior Management support and commitment, the profile of the Safeguarding Adults Team within the Trust has raised considerably. Reports are requested at Board level for progress and concerns raised through the team are reported weekly to the Trust Quality and Safety meeting to ensure high level awareness of concerns.

These measures have greatly improved the commitment to learning from Safeguarding Adults Investigations and as a result Safeguarding Adult Action plans have been the basis for work streams to improve the care delivered. For example:

- ☐ Awareness of need for robust documentation following documentation audit
- ☐ 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
- ☐ Specific Awareness raising Tutorials for staff involved in Safeguarding Adults Investigation.

Nicola Cowley - Lead Nurse for Safeguarding Adults

Approved by Beverley Geary - Chief Nurse

April 2015