Safeguarding Adults Board (SAB)

Annual Report 2016/17

City of York Safeguarding Adults

www.safeguardingadultsyork.org.uk

CITY OF YORK COUNCIL

Contents

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

I am very pleased to introduce the SAB Annual Report for the year from April 2016 to March 2017. As you will know, the City of York SAB became a statutory body under the Care Act 2014 on 1 April 2015, and one of our legal responsibilities is to produce an annual summary of our actions and the work of both the City of York Council and all our other partners in keeping vulnerable people safe.

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

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

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

We need to be as confident as we can be that the right of every adult, including the most vulnerable, to live in safety, free from abuse and neglect, is promoted and protected as fully as possible. York is a great place to live and work, and our job as the SAB is to help ensure that organisations work together to both prevent and where possible stop the risks of abuse and neglect. At the same time we have to make sure that the wellbeing of vulnerable adults is protected, including having proper regard to their views, wishes, feelings and beliefs in deciding on any action to protect them from harm.

Unlike Children's Safeguarding Boards, Adult Boards are not held to account by OFSTED as a regulator. So this year for the first time the Council decided to invite a "Peer Review" of safeguarding adults services in York, conducted under national guidance by a team of senior staff drawn from a range of other Local Councils and services in the region. The results of the review are very pleasing overall, and there are full details in Section 5 of this Report.

As I said a year ago, whilst a City of 200,000 people can never eliminate risk entirely, we need to be satisfied as a Board that arrangements in place for safeguarding adults in York are as effective as they can be. I hope that this Annual Report will help to keep you both informed and reassured about that, and thank you for reading it. Please also feel free to visit our website at www.safeguardingadultsyork.org.uk to find out more about our work.

Kevin McAleese CBE

The Board's work and its vision

York Safeguarding Adults Board (SAB) oversees and leads adult safeguarding across the city, in order that all agencies contribute effectively to the prevention of abuse or neglect of vulnerable people. It has been in existence since November 2008 and has a strong focus on partnership working.

Our Vision, stated in our Strategic Plan (see Section 8 below) is that we seek to ensure that agencies supporting adults who are at risk or in vulnerable situations, and the wider community, can by successfully working together:

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

Work Undertaken in 2016/17

Making Safeguarding Personal (MSP)

A key part of the Care Act is the establishment of a person-centred approach to safeguarding adults across all agencies. The SAB has been encouraging the development of an MSP approach across all agencies in the city, and the matter has been reviewed at Board Development Days too. There has undoubtedly been progress on the matter, and if you look at the individual returns from Board partners in Section 9 of this Report you will see evidence of that.

MSP is challenging work, not least because not all vulnerable people have the capacity to decide what is in their best interests and may need assistance to do so. Also, many safeguarding situations are complex, often involving the actions of friends or relatives, and the problems created are seldom easy to resolve. The two real MSP case studies below illustrate how this has worked:

Case Study 1

This case involved a lady in her eighties, who had previously been diagnosed with mental health issues but who had recently refused assistance from a Mental Health social worker, about whom a concern was raised by her friend. The lady was a regular attendee at church and also at a weekly social activity, where people had become aware that she was not attending to her

personal hygiene, to the extent that people were reluctant to sit next to her and she was at risk of becoming socially isolated.

The friend began to visit her twice weekly with meals and became aware then of the extent to which the lady was also unable to manage her house. It was apparent also that she was having some problems with her legs, but continued to decline offers of assistance. The degree of self-neglect was by now putting this lady at some risk.

The safeguarding process was commenced and an initial meeting held, which included the pastor from her church and her friend. Consideration was given to the degree to which the lady had the mental capacity to make decisions about her own health and welfare and whilst it was felt that she lacked capacity to some degree, it was felt that it was important to work with her in such a way that she could be empowered to make her own decisions.

A plan was outlined and over the coming months, with support from friends, family and social care working carefully and sensitively together, the lady's trust was gained and she eventually agreed to a social care assessment, a deep clean of her house and to move closer to her son and his wife into a care home. Regular meetings were held to ensure that outcomes were being achieved and although the lady herself did not attend, her views were represented by the people who knew her best in the community.

This case illustrates the way in which safeguarding processes under the Care Act are carried out around the needs and wishes of the person at the centre and, most importantly at their pace, instead of decisions being imposed upon them.

Case Study 2

This case involved a young woman under the care of Mental Health services, whose Care Co-ordinator raised a concern that she was being physically and emotionally abused by her mother. She does not live with her mother. The concern suggested that the young woman's mother had recently assaulted her with an implement, from the injuries she had received.

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

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

Recently the young woman rang the team to say that she now felt stronger and able to manage her mother's behaviour, knew that she could contact the police and did not require the team to be involved currently. She knows that if necessary she can come back for further support.

Board sub-groups

A key part of this year's work was completion of a self-assessment framework for partners, to understand the progress their organisations are making in safeguarding adults. In addition, SAB partners contribute to Board sub-groups, of which there are now three:

Lessons Learned and Safeguarding Adults Reviews sub-group

This group is responsible for considering any lessons to be learned by partners from safeguarding cases and ensuring that cases are tracked and reported properly. The group is also responsible for recommending to the SAB Chair whether the death or serious injury of an adult as a result of abuse or neglect should become the subject of a Safeguarding Adults Review (SAR) under the Care Act 2014. SARs are full external investigations involving an independent reviewer. Under the Care Act only the SAB Chair has the statutory responsibility to make that decision.

Section 7 of the Report below gives information on Lessons Learned and any SARs in York during 2016/17.

Quality and Performance sub-group

This group is responsible for developing systems by which the SAB can assure itself of the performance of all Board partners, through the use of a Quality and Assurance Framework. The Framework was accepted by the SAB at its Mach 2017 meeting and there will be updates at every future meeting. The group has also developed a Risk Register which again will be updated at every SAB meeting.

Training and Development sub-group

This group is responsible for overseeing safeguarding training and development offered to partners within York, which is reported to the SAB on a quarterly basis. The group also oversees methods to judge the impact of training on individuals and their professional practice within their organisations, which is much harder to quantify than whether or not they attended a course. Some encouraging early work is already happening and showing some positive results.

Safeguarding policies and practices

Early in 2016 City of York decided to join the consortium of West and North Yorkshire Councils which share common safeguarding policies and practices, rather than continue to operate independently. This development was welcomed by partners like the NHS and North Yorkshire Police, which operate across a much larger geographical footprint than just York.

A major review is now under way of those policies and procedures in the light of the Care Act 2014, and senior staff from York are fully involved in developing them. It is anticipated that the work will be completed by September 2017, with a rollout to partners before the end of the year.

Safeguarding website

During 2016/17 the existing City of York Safeguarding Adults website was totally rewritten using best practice from other Councils like Hampshire. The address of www.safeguardingadultsyork.org.uk remains the same and users will find a range of new information and materials. There is also a feedback facility where users can give opinions or raise questions about safeguarding adults in general.

Performance and activity information

Adults collection

June 2017

Safeguarding concerns

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

Ratio of concerns received

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

MSP New measure for Q4

Percentage of those who were asked and expressed an opinion was **69%**

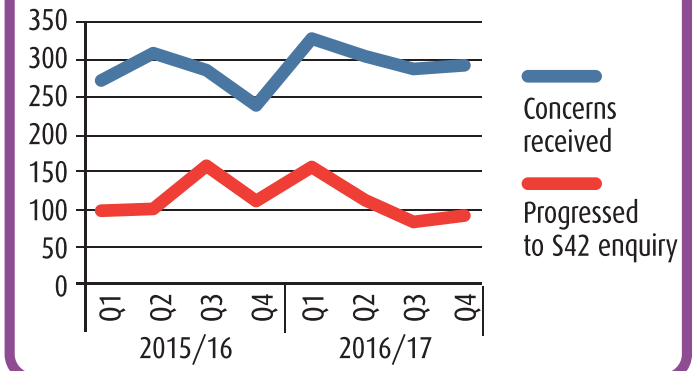
Of those:

61% - outcomes fully achieved

30% - outcomes partially achieved

9% outcomes not achieved

2 years data



Number of completed pieces of work

2015/16	2016/17
1071	**1178**

Gender of completed S42 enquiries

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

Number of completed S42 enquiries

2015/16	2016/17
391	**392**

Progress to formal S42

468 2015/16 → **454** 2016/17

Completed S42 enquiries

Location of abuse

38% in own home

9% in Nursing home

17% in Residential home

22% in hospital

7% in community setting

5% in services in the community

4% other settings

Age range of completed S42 enquiries

40% 18 - 64

33% 65 - 84

27% 85+

Source of abuse

49% Service provider

46% known to individual

5% unknown to individual

Types of abuse – completed S42 enquiries

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

Peer review of Adults Safeguarding

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

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

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

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

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

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

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

A copy of the report is available from:
https://www.york.gov.uk/downloads/file/13207/safeguarding_peer_review – 59k

Training

Introduction

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

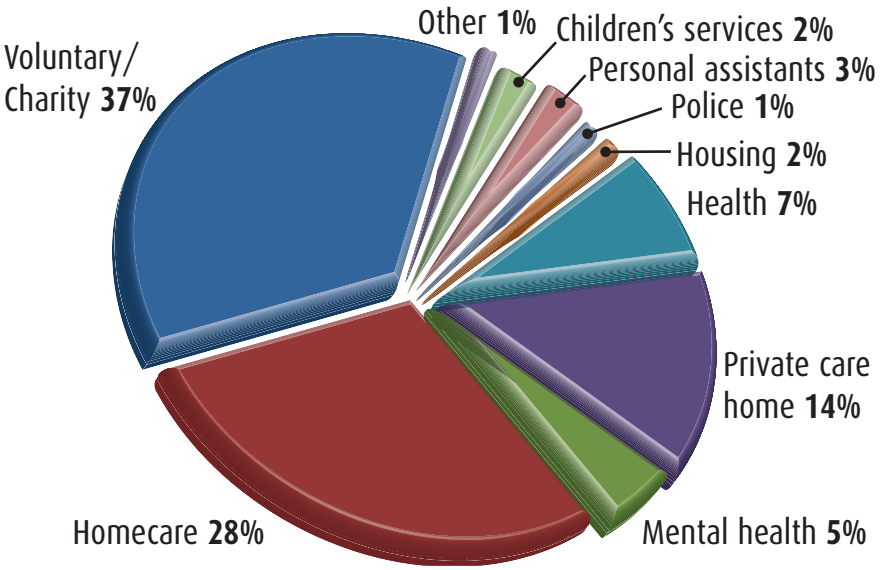
The Training Offer 2016/17

During 2016/17 our Safeguarding and Mental Capacity Act training was provided by Community Links.

Below shows a breakdown of courses that took place over 2016/17

Course	Number of Sessions	Total attendees	CYC attendees	PVI attendees	No Shows	% of internal CYC delegates	% of external PVI delegates
Safeguarding General Awareness	22	263	123	140	31	47%	53%
Working Together to safeguard Adults (Level 3)	8	82	25	57	12	30%	70%
Mental Capacity Act Awareness (or Level 1)	7	72	29	43	10	40%	60%
Mental Capacity Assessment & Best Interest Decision Making for Practitioners (Level 2)	6	61	30	31	12	49%	51%
Deprivation Of Liberty(Dols) responsibilities For Managing Authorities (Care Homes/ Hospitals (Level 3)	1	5	3	2	0	60%	40%
Mental Capacity Act Complex Decision Making for Practitioners and Managers (Level 4)	1	13	6	7	1	46%	54%
Safeguarding General Awareness Train the Trainer	3	13	1	12	1	8%	92%
Total	**48**	**509**	**217**	**292**	**67**	**43%**	**57%**

Breakdown of external delegates by area:



Charging Policy

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

Full Day £40.00 **Half Day £20.00**

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

Developments

- This year the Workforce Development Unit have worked with the Safeguarding Board to revise both the Safeguarding and Mental Capacity Act training offers. We have hosted briefing events for both which have been very well attended and have resulted in feedback which has been used to shape the new offers. The Safeguarding training offer which was launched in September 2016 has been revised to embed the principles of making safeguarding personal. The new offer has received very positive feedback. The Mental Capacity Act offer will be launched in April 2017.
- The Workforce Development Unit has also developed a new course on encouraging a risk-enabling approach to underpin the approach across services to support people to take positive risks and to work in an outcome focused way, putting the individual and their wishes at the centre of decision making.
- An Impact Assessment tool for use by managers with staff attending training has been being piloted within the safeguarding courses this year. Feedback about the tool has been positive although more work needs to be done on raising awareness of the tool and how it can be used. This work is planned for 2017/18.
- The WDU have also undertaken some work with staff regarding risk enablement, which underpins an approach across the services to support people to manage risk.
- Thanks to support from the commissioning team, WDU are able to continue to offer a range of courses including safeguarding and mental capacity act, at no charge.
- The Board's Training and Development Subgroup is now meeting regularly and is providing helpful opportunities to ensure that learning and development opportunities are shared across agencies and any workforce development needs that arise through the SAR/Lessons Learned sub-group can be addressed on a multi-agency basis.

Safeguarding Adults reviews/lessons learned

It is a requirement of the Care Act 2014 that the details of any Safeguarding Adults Reviews (SARs) conducted during the year must be in the SAB Annual Report. As explained in Section 3.2 above it is the responsibility of the SAB Chair to decide whether or not a death or serious incident should be the subject of an SAR, which would involve commissioning an independent review and publishing a full report written by an author recruited for the purpose.

There were no Safeguarding Adults Reviews needing to be conducted during 2016/17, though a number of cases were considered to see if they met the threshold.

During 2016/17 the responsible Board sub-group received some briefing papers concerning serious safeguarding incidents where individuals had been in receipt of services from statutory bodies and other organisations. As Chair of the Board I decided, as I am required to do, that the facts of none of the cases warranted the establishment of an SAR. However, they 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.

Two examples of lessons Learned cases considered during 2016/17 are given below:

Case 1 - Bernice had severe learning disabilities which manifested as non-verbal communication, variable moods, frequent involuntary movements and sleep disturbances. Bernice does not express pain. It was known that her involuntary movements could sometimes result in an accidental injury to herself.

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

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

Concerns were raised about the way agencies worked together during the safeguarding process and a decision was taken to undertake a learning lessons review.

The purpose of completing a learning lessons review is not to reinvestigate the case or to apportion blame. The purpose is to:

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

A 'learning together' approach was used with representatives from each of the agencies involved in the care and treatment of Bernice coming together in a workshop to look at what the challenges were, how things could have been done differently and what needed to change. The main themes were frustrations in multi-agency working; confusion over roles and responsibilities and hearing Bernice's voice. The recommendations from the review will be reported to the Safeguarding Adults Board in June 2017 and a final summary of the review will appear in next year's Annual Report.

Case 2 - John

Concerns were raised to City of York Safeguarding Adult team about John's care at home following his death in hospital. As the City of York Council provided some of the services for John they asked the Designated Safeguarding Professional in the Partnership Commissioning Unit to look at the concerns and review his care.

Pen Picture and Summary of Concerns

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

Margaret was admitted to hospital following a short illness. The family felt that John would not manage at home alone. Although he was independent in many ways, he also had a deteriorating health condition and some short-term memory problems. An assessment of need completed by adult social care determined that John required three visits per day to help him with meals and reminding him to take his medications. However despite strenuous efforts by staff no home care agency could be found to supply the visits that John needed.

John became unwell with a chest infection and was given a course of antibiotics by his GP. Despite the efforts of several services and individuals stepping in to try to 'fill the gap', John unfortunately missed some evening doses of antibiotics. He was admitted to hospital in May 2015 and subsequently died three days later.

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

Although John was an 'adult with care and support needs' (the definition used for safeguarding under the Care Act 2014) and therefore vulnerable – this case does not easily sit with safeguarding.

John was not abused by anyone. In the wider sense his situation and the lack of available services did mean that he was at risk of neglect. City of York Adult services recognised a potential conflict of interest in them reviewing their own services, so requested an independent review from partners that provided transparency and accountability.

It is recognised that services worked hard to try to provide care for John. It is also recognised that a more joined-up service between health and social care could have provided an improved service for John and less anxiety for his family in the place where he wanted to be – at home.

Key Points:

- Good practice in consistent application of Mental Capacity Act
- Good practice in not accepting care from non-approved provider
- Highlights the difficulty in obtaining domiciliary care in some parts of the City
- Highlights the lack of 'joined up' services – John fell through gaps in service provision

New Strategic Plan for 2016 onwards

The Strategic Plan for 2016/19 is in a very accessible format and is available of the website under "Board". It follows the six guiding principles of the Care Act:

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

Prevention It is better to take action before harm occurs.

Proportionality The least intrusive response appropriate to the risk presented.

Protection Support and representation for those in greatest need.

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

Accountability Accountability and transparency in delivering safeguarding

The new Strategic Plan for 2016/19 has an Action Plan for every year and the progress report for 2016/17 is at Annex 3.

Contributions from individual member organisations

NHS England

Training & Development

Designated safeguarding professionals are jointly accountable to CCGs and NHS England and oversee the provision of safeguarding training for primary care medical services. The main source of training for other primary care independent contractors is via e-learning training packages.

NHS England Safeguarding Adults: Roles and competencies for healthcare staff - Intercollegiate Document has been awaiting final publication following review by - The Royal College of Nursing, The Royal College of Midwifery, The Royal College of General Practitioners, National Ambulance Safeguarding Group and The Allied Health Professionals Federation. The purpose of this document is to give detail to the competences and roles within adult safeguarding and the training guidance for healthcare professionals.

NHS England North hosted a safeguarding conference on 10 December 2016 which included presentations on forced marriage, honour based abuse, FGM and domestic abuse and adult safeguarding. The conference aimed to provide level 4 training for healthcare safeguarding adults and children professionals and leads in the North region. A conference was held on 11 November in York for named safeguarding GPs in Yorkshire and the Humber attended by Bradford named GPs, it was well evaluated and plans for a north region named GP conference are in place for 2017/18.

NHS England has updated and is due to circulate the Safeguarding Adults pocket book which is very popular amongst health professionals and has launched the NHS Safeguarding Guide App and a North region safeguarding repository for health professionals.

Sharing learning from safeguarding reviews

In order to continuously improve local health services, NHS England has responsibility for sharing pertinent learning from safeguarding serious incidents across Yorkshire and the Humber and more widely, ensuring that improvements are made across the local NHS, not just within the services where the incident occurred. The NHS England Yorkshire and the Humber Safeguarding Network meets on a quarterly basis throughout to facilitate this. Learning has also been shared across GP practices via quarterly Safeguarding Newsletters, a safeguarding newsletter for pharmacists has been circulation across Yorkshire and the Humber and one for optometrists and dental practices is being scheduled for March 2017.

Safeguarding Serious Incidents

All safeguarding serious incidents and domestic homicide's requiring a review are reported onto the national serious incident management system – Strategic Executive Information System (STEIS). During 2016/17 a review of current systems for recording safeguarding incidents and case reviews across the North Region was undertaken to support the identification of themes, trends and shared learning. The Yorkshire and the Humber process to jointly sign off GP IMRs, as CCGs responsibilities for commissioning of primary care

services is increasing, has been adopted across the north of England region to ensure consistency. NHS England works in collaboration with CCG designated professionals to ensure recommendations and actions from any of these reviews are implemented. Prior to publication of any child serious case reviews, serious adult reviews or domestic homicide reviews NHS England communication team liaise with the relevant local authority communications team regarding the findings and recommendations for primary care medical services.

NHS England responsibilities in relation to direct commissioned services

NHS England ensures the health commissioning system as a whole is working effectively to safeguard adults at risk of abuse or neglect, and children. NHS England is the policy lead for NHS safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Key roles are outlined in the Safeguarding Vulnerable People Accountability and Assurance Framework 2015.

Yorkshire and the Humber has an established Safeguarding Network that promotes shared learning across the safeguarding system. Representatives from this network attend the national Sub Groups, which have included priorities around Female Genital Mutilation (FGM), Mental Capacity Act (MCA), Child Sexual Exploitation (CSE) and Prevent. NHS England Yorkshire and the Humber works in collaboration with colleagues across the North region on the safeguarding agenda and during 2016/17 a Clinical Commissioning Group (CCG) peer review assurance process was undertaken covering all 44 CCGs in the North region.

Assurance of safeguarding practice

NHS England North developed a Safeguarding Assurance Tool for use with CCGs across the North Region, which was implemented in 2016/2017. NHS England North Regional Designated Nurses undertook the review which was intended to be supportive ,they reviewed all action plans to identify key themes and trends across the North Region with a view to identifying common areas requiring support. Themes from this process have influenced the commissioning of leadership training for safeguarding professionals and there are future plans for a national assurance tool for CCG's.

Learning Disabilities Mortality Review (LeDeR) Programme

Over the last 2 years a focus on improving the lives of people with a with learning disabilities and/or autism (Transforming Care) has been led jointly by NHS England, the Association of Adult Social Services, the Care Quality Commission, Local Government Association, Health Education England and the Department of Health. In November 2016 the national LeDeR Programme has been established following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD).

All NHS regions have been asked to establish the LeDeR process locally to undertake the reviews. LeDeR also complements the NHS Operational Planning and Contracting Guidance for 2017/19 which contains 2 'must-dos' for people with learning disabilities:

- "Improve access to healthcare for people with a learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making reasonable adjustments for people with a learning disability and/or autism.

LeDeR involves:

- Reviewing the deaths of all people aged 4 years.
- Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities.
- Identify variation in practice.
- Identify best practice.
- Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities.

A national database has been developed and anonymised reports will be submitted. This will allow, for the first time, a national picture of the care and treatment that people with learning disabilities receive.
The LeDeR Programme is not a formal investigation or a complaints process and will work alongside any statutory review processes that may be required.

The LeDeR Programme recognises it is important to capture the extent of personalised services, including the use of reasonable adjustments, choice and control and the well-being of people with learning disabilities. Good practice examples will be written up and shared nationally.

Prevent

Across NHS England North there are a number of priority areas which are designated by the Home Office, who fund two Regional Prevent Coordinator posts. These posts support the implementation of the Prevent Duty and ensure that Health embeds the requirements of the Contest strategy and specifically Prevent into normal safeguarding processes. Funding to support this work was secured from the North Region Safeguarding budget which has facilitated a number of projects including supporting partnership working with the North East Counter Terrorism Unit, delivering a conference in October on 'Exploitation, grooming and Radicalisation 'and an Audit of referrals to Prevent /Channel where Mental Health concerns are understood to be a contributing factor .

A research project to scope the current, attitudes, awareness and practice amongst GP colleagues has also been commissioned in the Region.
In December 2016, a North Regional Prevent conference was held to raise awareness of Prevent, delegates found this event a good opportunity to increase their knowledge and confidence in the role of the health sector in Prevent . Feedback received supported that there was an overall improvement in understanding the requirements of health organisations e.g: CCGs under the new statutory duty.

Pressure Ulcers – "React to Red"

React to Red was launched on 01 February 2016 at the Pressure Ulcer Summit in Leeds. It is a bespoke training package for pressure ulcer prevention which is competency based and designed specifically for care home staff and care providers. Since its launch in February 2016, there has been significant interest in this resource from CCGs: private organisations; secondary care; hospices; domiciliary care providers; tissue viability nurses and care homes. During 2017/18 this work will continue to be a priority across NHS England North and will focus on embedding the programme as a quality improvement initiative using a focused approach co-ordinated by CCG's and robust evaluation by NHS England North.

Independent Care Group (ICG)

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

1. ICG keeps its members informed on all matters connected to Safeguarding including Safeguarding training and Mental Capacity Act training which is offered by CYC at no charge. It keeps members informed of DBS news.

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

Tees, Esk and Wear Valleys NHS Trust

Training

The information on training below is for York and Selby. At present the Selby data is unable to be removed.

Safeguarding adult's level 1 is mandatory for all staff in the organisation (fig 1). Safeguarding level 2 is mandatory for all clinical staff band 5 and above and contains prevent WRAP 3 (fig 2).

Fig 1

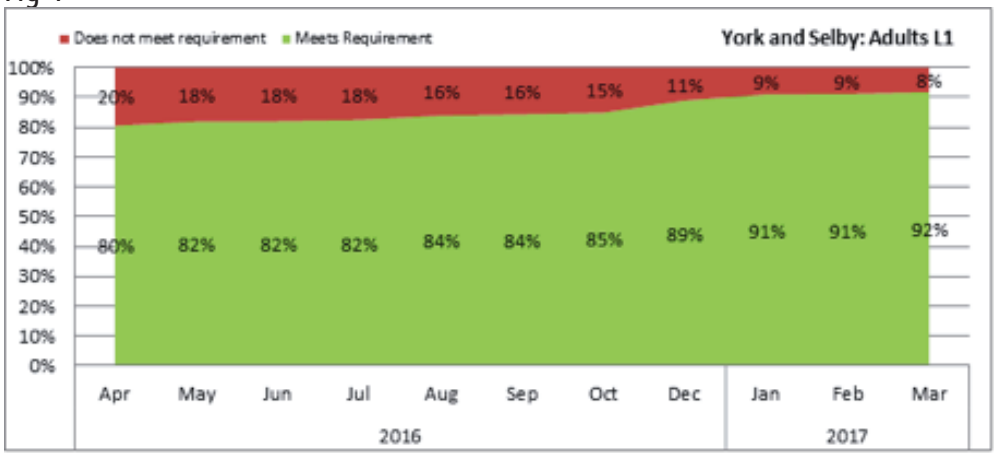
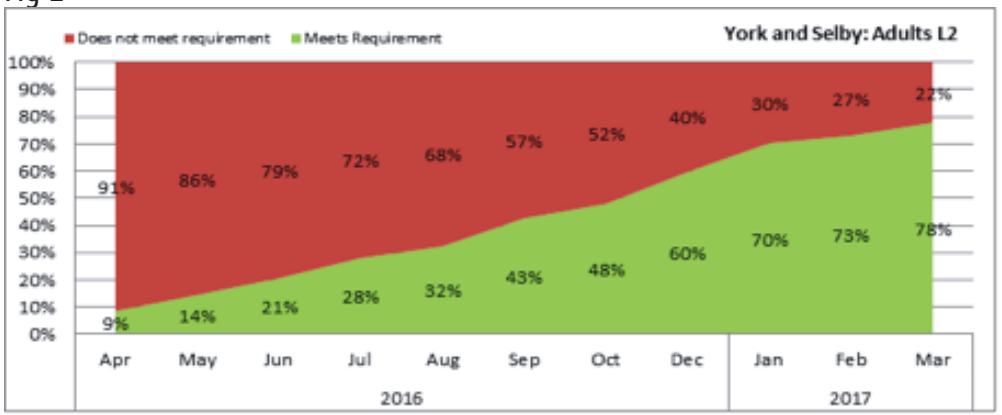
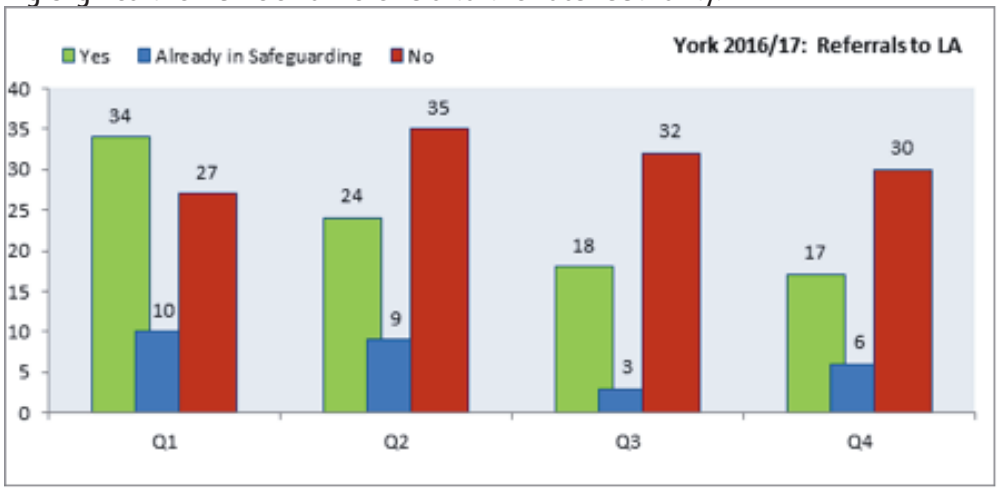


Fig 2



Referral/contact information

Fig 3 gives the number of referrals to the local authority.

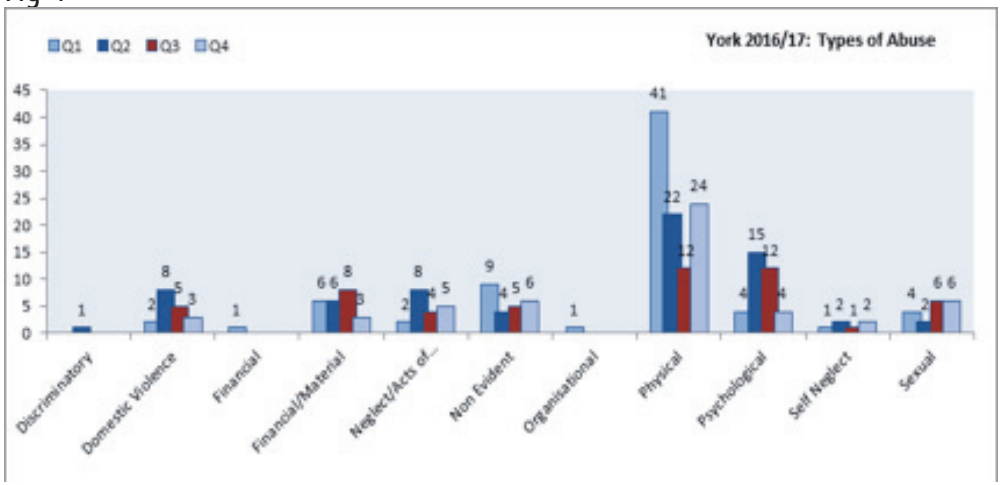


The numbers together give the total for the calls received by TEWV Trust safeguarding adults team. Identified in figure 3 is the number that progress to the local authority, those that were already in safeguarding and those that required no further action.

Types of abuse

Types of possible abuse that were discussed in the calls to the TEWV trust safeguarding adult's team (Fig 4). This is mostly physical abuse, with these being patient on patient. It is important to note that the Trust will review these to ensure that hot spots are identified. None were identified through this period.

Fig 4



TEWV completes an annual audit of compliance with the safeguarding protocol to ensure that staff are acting in a manner that is in line with the principles of making safeguarding personal, this looks at the empowerment and choice people were given prior to a concern was raised and the outcomes expected.

The Trust Safeguarding Adults team participates and engages in the SAB and SAB subgroups; the team actively participated in the safeguarding week in 2017 and is actively participating in preparation with the plans for the next safeguarding week.

The Trust Safeguarding Adults team has committed to attend the local safeguarding adults groups and work with other agencies to ensure the best outcomes for individuals who are at risk of abuse of neglect.

York Teaching Hospital NHS
NHS Foundation Trust

York Teaching Hospital

Training

Training is now fully embedded in Trust induction and statutory and mandatory training for York Sites – Level 1 and 2 which is a complete Safeguarding Adults, Mental Capacity Act and Deprivations of Liberty Safeguards package. This programme has been available for all sites since April 2013. Key individuals in high risk areas have received 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.

It is understood that NHS England will shortly publish "Safeguarding Adults Roles/Competences/ Intercollegiate" document and as a result the current training will be reviewed to ensure all aspects of the competences are addressed.

Safeguarding Adults Training Statistics for 2016

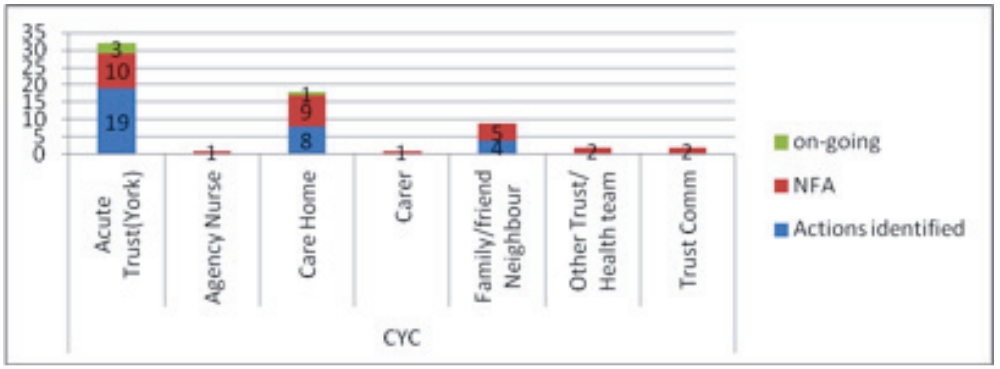
Training	Compliance 2016	Eligible staff
Awareness	90%	All Staff
Level 1	82%	All clinical staff B4 and below.
Level 2	83%	All clinical staff Band 5 and above, excluding doctors and consultants (who should complete Level 1) All doctors and consultants All managers of staff who complete L1 or Awareness
Learning Disabilities	87%	All patient contact staff
PREVENT	83%	All patient contact staff

Safeguarding Adults Activity 2016

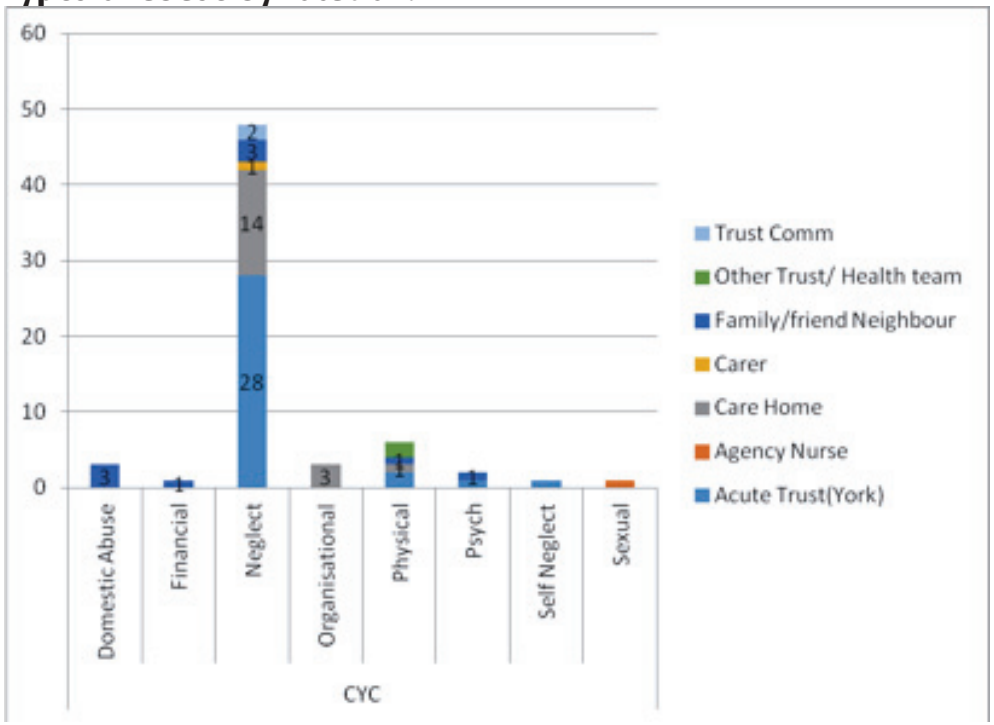
There were 118 Safeguarding Adults alerts received in 2016. This figure relates to all alerts referred through the Safeguarding Adults Team raised either against or by the Trust.

Of the 118 alerts 34 were raised against acute staff and 4 against community staff in the City of York Area.

Concerns raised and outcomes



Types of abuse by location.



Summary

The Safeguarding Adults Team continue to be a useful expert resource to staff for raising safeguarding concerns, management of enquiries, MCA/DoLS and Learning Disability Liaison Support.

Activity within the Safeguarding Adults team continues to become more complex.

The safeguarding Adults team is now fully resourced with the valuable addition of Admin support.

During 2016 Discharge remained the common theme emerging for which actions have been identified as a Trust-wide initiative and encouraging progress.

Making Safeguarding Personal

Making Safeguarding Personal is our largest challenge due to the nature of the care we deliver. However we are confident that by working with our multi-agency links, we can fulfil this aspect of the Care Act to provide on-going protection for vulnerable adults once they have left our care. However Making Safeguarding Personal underpins the following:

- Trust policy
- Trust training
- User leaflets for patients and their families involved in the safeguarding Process
- Multi-Agency Working and commitment
- Open visiting

Additionally the Trust Safeguarding Adult Strategy 2017 – 2017 focuses on the 6 key principles of the Care Act and as such the work plan from this strategy focuses on Making Safeguarding Personal.

Achievements

DoLS – Cheshire West Progress

In September 2016 Safeguarding Adults recruited administration support whose role was primarily to establish a robust data collection and ward/local authority system to manage applications made by the Trust for patients in our care.

Clear data collection is required externally by Local Authority Safeguarding Adult Boards, Clinical Commissioning Groups and CQC and internally through the Trust Safeguarding Adults Governance Group. This acts as assurance of both an embedded understanding and process for DoLS.

The DoLs process has been impeded by the backlog of referrals requiring assessment once they reach the Local Authority. Both NYCC and CYC DoLS team have recently reported delayed responses to applications and are implementing a priority system which does not include patients in an acute hospital setting.

This impacts of the Trust notifying the CQC of approvals/cancellations of applications as the patient is no longer in our care. The Trust CQC representative was informed of this challenge and has reported that is a well-recognised national issue and noted to be beyond the Trust's control.

In the meantime the Safeguarding Adults Team continues to support staff with this as follows:

- Monthly Ward visits to increase support awareness and identify potential Deprivations of Liberty
- Specialist Training to high risk areas
- High Risk Wards subsequently managing own applications with the Support of the Safeguarding Adults Team.
- Information Packs delivered to each ward
- Pocket guidance for Consultants/Medical staff
- Intranet Resource page with links to required paperwork and guidance
- Data analysis base developed to monitor applications and chase up outcomes.

It should be noted that there is now a substantial commitment from wards that now on the whole, make their own applications and follow process to good effect. However from recent data analysis there is a need to target wards where there would be an expectation of higher DoLS application and data suggests otherwise.

Leder Programme

The LeDeR Programme has been established as a result of one of the key recommendations of the Confidential Enquiry into the premature deaths of people with learning disabilities (CIPOLD). Commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England the LeDeR Programme supports local reviews of deaths of people with learning disabilities aged 4 to 74 across England.

The Trust Named Nurse for safeguarding adults has been nominated as organisational contact and is now also trained as a reviewer
Trust policies and procedures include the following:

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

Learning from Safeguarding Adults Investigations

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

- Task and Finish group to develop policies, training and risk management tools to support staff care for patients with Mental ill-health.
- Assistant Director of Nursing and Matron involvement in delivering actions arising from Safeguarding Adults Investigations
- Discharge Improvement Working Group, revised discharge tools
- Improved body marking systems and observation charts
- Development of communication tools for carers/family
- Care Planning for patients who decline care

North Yorkshire Police

North Yorkshire Police Officers, The Special Constabulary and Staff are trained on Safeguarding in a number of ways.

Student Police Officers & Special Constables & Police Community Support Officers

2016/17 New Starters
- Student Officer Initial Course 48 delegates.
- PCSO Initial Course 38 delegates
- Initial Learning 4 Special Constables Foundation Course 32 delegates.

Safeguarding Adults Training is included in new starter initial training. The Student officers, Special Constabulary and PCSO's complete a Vulnerability Training Package . Within the Vulnerability Training package new staff will learn about adult vulnerability, the Vulnerable Risk Assessment (VRA) which explores actions and solutions in dealing with people affected by alcohol, drugs and mental health issues and how to make referrals.
Students and Special Constabulary receive module base Domestic abuse training including Honour Based Abuse (HBA) and Forced Marriage (FM) / Sexual offences including Female Genital Mutilation (FGM) followed by two further inputs from the training department (Safeguarding Portfolio Trainer) and the Domestic Abuse Coordinator which will focus on operational , case study , administrative responsibilities, dynamics and legislation both criminal and Civil law remedies.

North Yorkshire Police use an e-learning programme called NCALT provided by the College of Policing where safeguarding packages/ updates, refreshers, changes in law and new legislation can be found.

Packages which are covered by e-learning include the following:-
- Mental Health and vulnerability - explores Section 136 of the Mental Health Act
- Stalking and Harassment
- Human Trafficking and Modern Day Slavery
- Dealing with people with Autistic Spectrum Disorder.
- Coercive and Controlling behavior in Domestic Abuse
- Cyber Crime
- DASH – Domestic Abuse Stalking and Harassment

All officers, staff and supervision have received Safeguarding training on their allocated training days .Training days provide an opportunity to cascade important changes operationally and legally .This is delivered by an Inspector. Supervisors & Specialist officers also have the opportunity to attend external training, which include regional Police training, College of Police training, subject specific conferences to ensure best practice is shared in relation to Investigative standards.

North Yorkshire Police continue to invest in Safeguarding. Investment into the MAST (Multi Agency Screening teams) In North Yorkshire and City of York providing experienced officers and Police staff to be co-located with key partners.

North Yorkshire Police submit referrals of a safeguarding nature to the relevant authority. North Yorkshire Police will also complete Vulnerable Risk Assessments which the local Community Safety Hubs manage. It is not possible to differentiate Adult and Children referrals due to the way North Yorkshire Police store and record.

North Yorkshire Police can provide the following data:

In 2016/17 North Yorkshire Police responded to 2389 PSW Collapse/Injury/ Illness/ Trapped within this category there are 30 subtypes.

In 2016/17 North Yorkshire Police Responded to 20,901 PSW concern for Safety type incidents within this category there are 49 subtypes.

These particular incidents were closed as a PSW Concern for Safety. This would prompt further action of varying types, some of which are highlighted below:

- A referral for Safeguarding (without consent)
- A referral for care and support needs assessment (with consent)
- Completion of a Herbert protocol
- Completion of a Vulnerable Risk Assessment
- Completion of a Domestic Incident form
- Strategy meeting
- Trigger plan
- Referral to MAPPA
- Referral to MARAC
- MAPPA

The list is not exhaustive.

North Yorkshire Police support the local authority-led initiative "Making Safeguarding Personal"

North Yorkshire Police take into account a victim's views in relation to prosecutions and will respect the decision made by victims who decide not to support the criminal justice process. (This is done with a review of risk) We will only pursue a victimless prosecution if we feel the risk is high or the victim is being controlled or intimidated in some way. This still involves the victim being informed throughout.

For those victims supporting a criminal complaint North Yorkshire Police involve victims by taking Victim Personal Statements or Impact statements this records and communicates what impact the incident has had on their day to day life and can assist in providing victims with the correct ongoing support once the legal process has ended.

North Yorkshire Police often attend incidents where engagement and decision making with the victim or alleged offender is not always possible. North Yorkshire Police deal with those where engagement hasn't been possible with dignity and respect and will share information with our partners to ensure the ongoing support is provided or addressed.

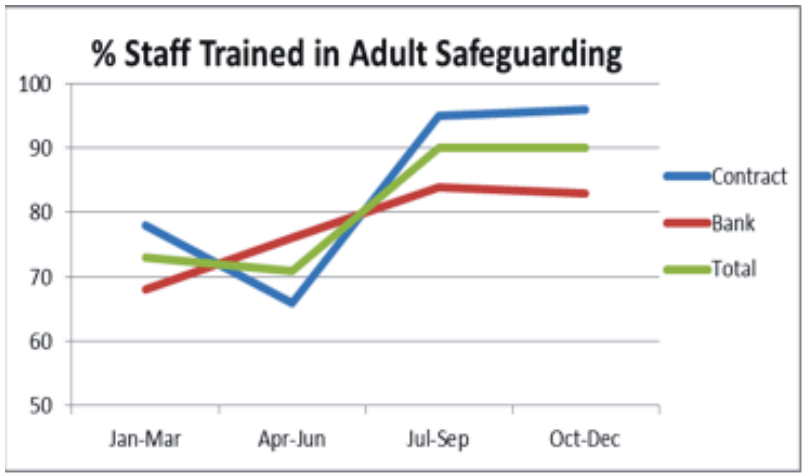
- 2016/17 Two new Safeguarding Managers were introduced following a peer review, the role is to provide the consistency and engagement with Partners.
- MAST (Multi Agency Screening Team) development for City of York
- Adult services and Police daily screening implemented.
- Domestic Abuse teams have Increased full time equivalent (FTE) to cope with recent new Law (Domestic Violence Protection Notices) , Domestic Violence Disclosure Scheme (DVDS also referred to as Claire's Law) and an overall increase in demand.

York House

Training

As you can see from the below graph there have been significant improvements in the amount of staff who are up to date with safeguarding training. This is delivered face-to-face in-house as part of the induction, with an e-learning package available for refreshing training. Following a review of the training procedures, the target for training was set at 85% which we are now achieving for contract staff and are on target to achieve by February 2017 for all staff (contract and bank).

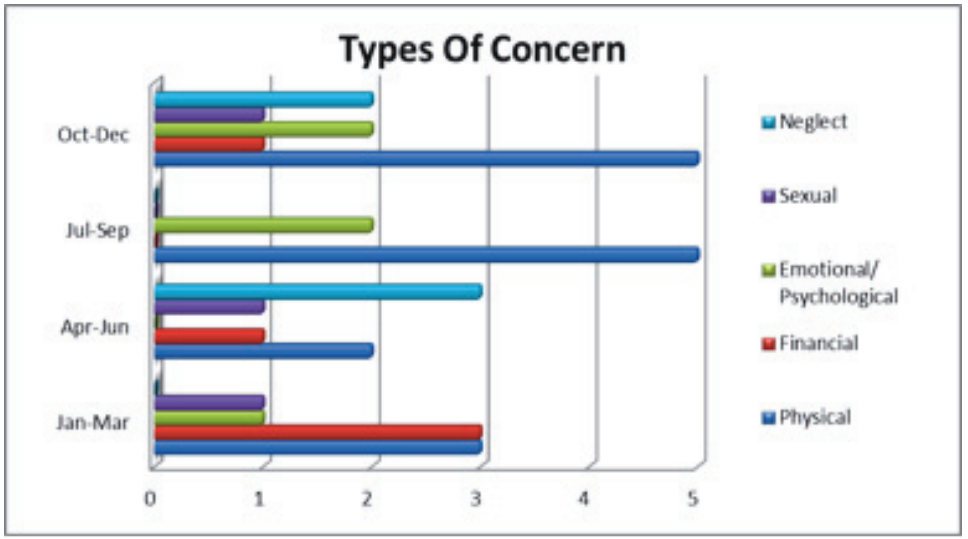
All members of the safeguarding team at York House have carried out the level 3 training provided by CYC and we aim to put senior clinicians and management through the training as it becomes available. We are also looking at sourcing this for the Trust, to be run by the learning and development department.



Types of Concerns

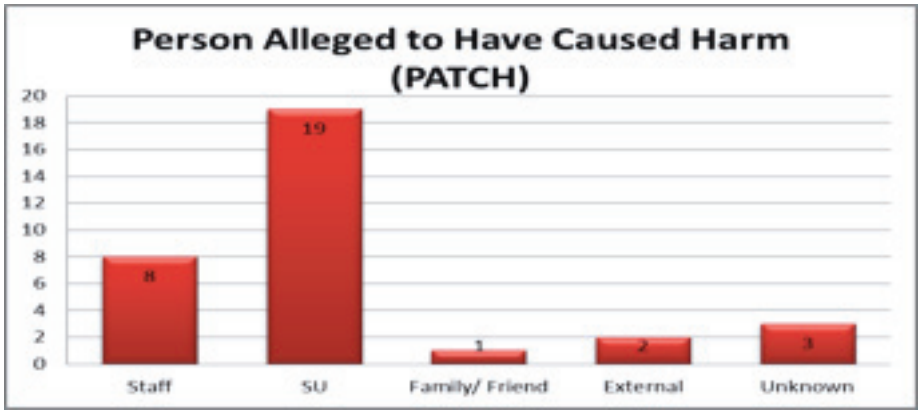
There were 33 concerns raised over the year at York House with 46% of these being physical abuse. From analysis we can see that they were all service user on service user altercations. This pattern was also evident in the previous year's annual report. We feel this is unlikely to change due to the nature of our service and the disinhibited behaviors displayed by those service users with an acquired brain injury.

Around the time this increased (June), we had a number of admissions in close succession and this disrupted the dynamics on the Dales unit. One individual service user is very verbally perseverative and this led to him being targeted by other service users through frustration.



PATCH

All incidents in relation to staff were fully investigated and disciplinary action taken where appropriate, however some of these were unfounded.



39% of incidents raised to the safeguarding team were either dealt with in-house and managed proportionately, or a verbal conversation was had with the City of York Council and not felt necessary to refer due to the actions already taken.

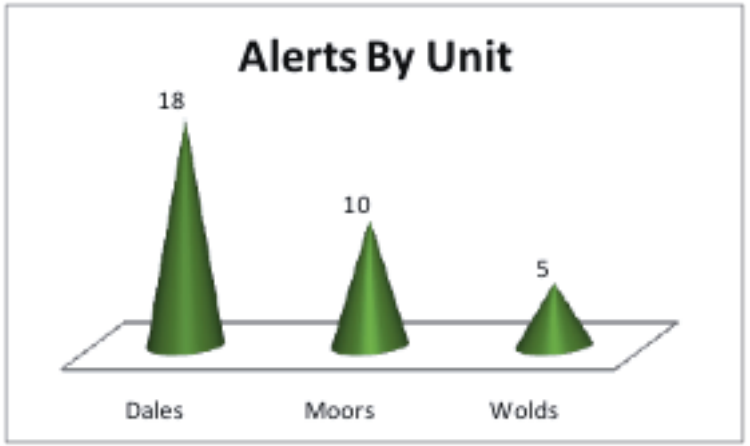
The number of alerts by unit accurately reflects the service user needs and the nature of the work carried out across the different units at York House. The staffing levels across the unit therefore reflect the need to manage the risk with a higher staff to service user ratio on The Dales unit.

There have been two s42 investigations carried out in 2016 by York House as directed by CYC. Following the level 3 training attended by the social worker at York House the s42 enquiry which was submitted received good feedback on the standard of this report.

Making Safeguarding Personal

York House are currently involved in a task and finish group along with other members of the multi-agency sub-group looking at improving the way we report, record and evidence MSP in a meaningful way. This will run for a period of 6 months with monthly meetings scheduled. We currently ensure that service users are involved wherever possible in the safeguarding process with their views, wishes and where possible specific outcomes recorded. A Speech and language therapist is currently involved where appropriate in the safeguarding process to ensure that communication is accessible and appropriate to the individual's needs.

York House service users have good advocacy uptake which is often a crucial element where service users lack capacity in relation to safeguarding.



Garrow House

All clinical and non-clinical staff members employed within the service have received safeguarding awareness face to face training. Same for safeguarding awareness e-learning course.

We had seven concerns raised internally by frontline staff within the service this reporting year. Of these seven, three were subsequently after review passed onto the relevant local authority adult safeguarding team. Of these three, one resulted in a section 42 enquiry.

We have continued to seek and respect the wishes of patients involved in safeguarding concerns throughout the process where possible. The safeguarding adults policy within the unit states clearly how this should be done.

Nothing new this year.

This is a joint response from

Healthwatch York and York CVS

Siân Balsom has refreshed the level 1 safeguarding adults training (she has previously completed the Train the Trainer Course). This refresh is in advance of delivering Level 1 Safeguarding sessions in 2017. The first is for all our staff and volunteer team within Healthwatch York. However, to maximize the benefit Siân will also cascade this learning to York CVS reception team as a priority.

There were no completed enquiries in the year.

In the year, we have begun working on a coproduction strategy in partnership with City of York Council in preparation for the 'national coproduction week' taking place in July 2017.

We attended the 'making safeguarding personal' event in Bradford in the summer to explore how this approach can be more widely understood and embedded. Following this, we explored this with the sector through the forums we run, explaining this approach and inviting the sector to share their thoughts and views in relation to their own work. Safeguarding continued to be an active topic within the forums of which there were 21 during the year, with over 300 participants in total attending.

In addition, and following the event in Bradford, we reviewed our safeguarding adults policy with three aims; to ensure the approach of 'making safeguarding personal' was included and embedded, to make it more accessible and easy to use, and to be able to offer this to the third sector once completed. This work is in progress and will be completed later in the spring.

We continued to support the sub group structure and attend the board development days during the year. We were also engaged in the peer support process, and supported and attended National Safeguarding Week. We have begun work on supporting the National Safeguarding Week (due to take place in October 2017).

We continued to feature items in the Healthwatch magazine to raise awareness of issues of importance to the Safeguarding Adults Board. For example, there was a feature on suicide prevention in the Winter 2016/17 edition.

In summary, we continued to find ways to engage the third sector and the public in raising their awareness of 'making safeguarding personal' over the year.

NHS Vale of York Clinical Commissioning Group (CCG)

The PCU hosts adult safeguarding on behalf of the four North Yorkshire CCGs. The Deputy Designated Nurse from the Vale of York CCG moved into an interim designated role with the PCU to lead the safeguarding team in April 2016 and became permanent in the role of Designated Professional in October 2016. As such the following is a summary from both of the above organisations and also includes the work of the Nurse Consultant Safeguarding for Primary Care.

In 2016/17 training delivered to CCG staff and GP and primary care practitioners has included WRAP (workshop raising awareness of prevent)/ prevent awareness; domestic abuse; human trafficking and modern slavery. Embedding of changes made through the Care Act has also continued. A total of 671 staff have received training.

The Named GPs North Yorkshire and York CCGs, Nurse Consultant Safeguarding Primary Care and Designated Professionals Children and Adult hosted the first Northern Region Safeguarding Named GP Conference on the 11th November 2016 in York. The aim of the conference was to deliver safeguarding level 4 training for Named GPs, showcase and share local innovations in practice and to develop peer support networks for Named GPs within the Northern Region. The event was extremely successful and will as such be expanded across the Northern region in 2017.

The PCU safeguarding officers have completed the new 'Working together to Safeguard Adults' training, evaluating it as excellent. Three team members attended the Making Safeguarding Personal (MSP) full-day workshop hosted by ADASS in Bradford in May 2016. The workshop examined the different elements of MSP and provided a theoretical example using a theatre performance group and a real example from practice hearing the experience of a service user.

The Designated Professional has attended regional conferences and training:

- Prevent - Making The Link – June 2016 – (1 day)
- ADASS – delivering an effective safeguarding adults review November 2016 (2 days)
- Mental Capacity Act – held regionally each quarter (1day)
- NHS England - Managing Risk and Leading Change in Safeguarding – December 2016 – (1 day)

Following the introduction of the Care Act and the changes in safeguarding enquiry work the safeguarding officers have taken a joint role with City of York Safeguarding team on a smaller number of enquiries than in previous years. These mainly involve Independent Provider services and are predominantly in the category of neglect or omission of care. We have continued to embed 'making safeguarding personal' into enquiry work recording service user wishes. The intention for 2016/17 is to audit this practice.

In addition to enquiry work the safeguarding officers have also undertaken joint quality assurance visits picking up areas of concern before they reach the threshold for safeguarding. The team has provided a safeguarding health advisory and support role for GP and primary care colleagues; Adult Social Care; CQC and NHS provider services.

Safeguarding GP practice leads meetings are held quarterly in the CCG area. During 2016/17 these meetings have particularly focused on raising awareness of adult safeguarding policy and processes. This has directly led to a three-fold increase in GP engagement calls made to specialist nurses to advise on the management of adult safeguarding concerns.

Recognition and management of domestic abuse has been a priority for 2016/17 – with the promotion and involvement of health agencies in safeguarding week and the embedding of MARAC (multi-agency risk assessment conferences) processes into GP practices. Learning from Domestic Homicide Reviews has been incorporated into training events. Following learning from a national serious case review the team has begun to develop pathways and processes for managing MAPPA (multi-agency public protection arrangements) cases across the health economy.

The CCG provides safeguarding assurance to NHS England and in July 2016 an assessment of the CCG assurance framework was completed. This was followed with an assurance visit over two days to examine evidence of compliance. The CCG developed an action plan to address a small number of gaps noted namely in a training needs analysis and in guidance for staff.

In 2017/18 the PCU function will be re-aligned into CCGs. The safeguarding function for NHS Vale of York CCG will be hosted by NHS Scarborough and Ryedale CCG. The team will also undergo some re-modelling of function in line with the changing environment of the health economy. This will serve to appropriately strengthen the resource within the team and provide a re-energised commitment to safeguarding adults.

Leeds and York Partnership NHS
NHS Foundation Trust

Clifton House - Leeds and York Partnership

Safeguarding Adult Concerns raised with the LYPFT Safeguarding team from April 2016 to March 2017.

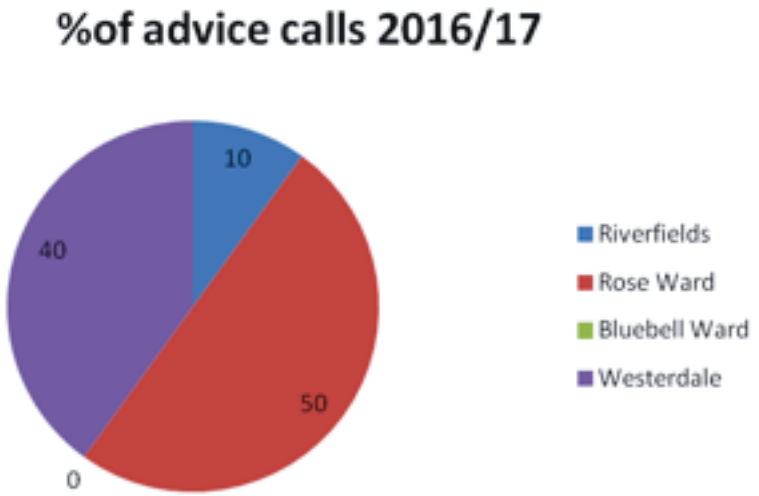
The following tables indicate safeguarding patterns of referrals (City of York alert/ referral form sent to the ASC safeguarding unit) and advice calls to the LYPFT team.

Westerdale Ward (temporarily closed from 2.12.16), Riverfield Ward, Bluebell Ward, Rose Ward.

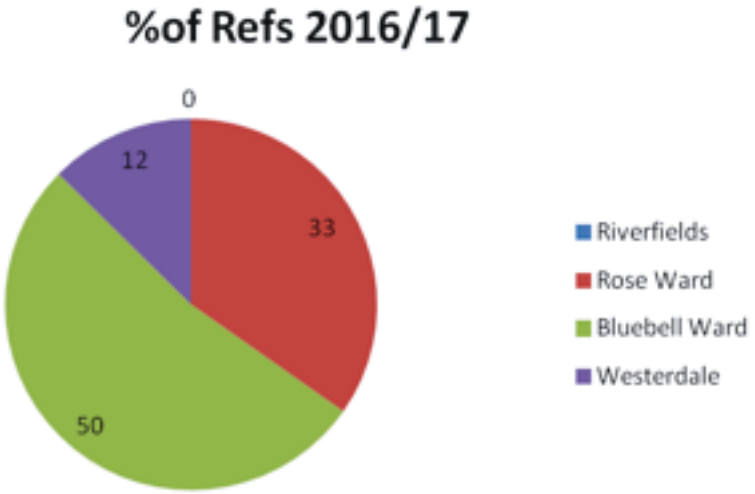
For the purposes of this overview we have defined 'advice' as calls to the LYPFT team for advice which may not reach the threshold for safeguarding but involve advice being given regarding care plans and protection plans. Much of this work aims to be preventative and encourage staff to report incidents at an early stage.

'Referrals' relate to incidents requiring further enquiry led by ASC and completion of the City of York alert/ referral form.

	No of advice calls 2015/16	No of advice calls 2016/17	%of advice calls 2016/17
Riverfields	2	1	10
Rose Ward	3	5	50
Bluebell Ward	1	0	0
Westerdale	0	4	40
Total	**6**	**10**	**100**



	No of refs 2015/16	No of refs 2016/17	%of refs 2016/17
Riverfields	1	0	0
Rose Ward	7	2	33
Bluebell Ward	3	3	50
Westerdale	0	1	12
Total	**11**	**6**	**100**



Due to the small numbers involved it is difficult to interpret the year to year data with confidence and with Westerdale being temporarily closed and overall bed reduction the data is skewed downwards. However, it appears that safeguarding concerns raised by the Clifton Ward practitioners remains fairly consistent with a downturn in referrals but an increase in advice.

The following chart shows advice/referral by type of abuse/ allegation for 2016/17

Type of abuse/allegation	Emotional	Financial	Physical	Psychological	Self-neglect	Sexual
	1	4	3	4	1	2

Training

Over 2016/2017 the LYPFT safeguarding team have delivered four Level 2 taught safeguarding training sessions at Clifton House in addition to the planned Trust-wide rolling programme of training. Drop-in safeguarding sessions are offered alongside safeguarding attendance at MDT meetings as required.

Current compliance for compulsory adult safeguarding training is at 94% for the specialist care group.

Level 3 taught safeguarding adult training has started to be implemented and 5 representatives from Clifton House have attended. This is aimed at senior clinical staff who have responsibility for supervising and leading staff. The long term aim is to have all clinical staff at NHS band 7 to be level three compliant the end of 2018.

Alongside e-learning, the LYPFT team have developed a Domestic Violence training pack and a rolling programme of taught sessions is being developed and offered across the Trust.

A new safeguarding supervision policy is also being disseminated with associated training and support. Staff will be required to access this 4 times a year.

Audit

The Trust has accepted the NICE guidelines for Domestic Abuse and the internal audit team is undertaking a series of benchmarking audits to inform the development of forthcoming work in the four guidance areas.

The Trust has participated in a LSAB review of service user records to determine if care act principles are being followed including Making Safeguarding Personal - this was completed in January 2017. We are still awaiting formal feedback and actions, but the interim feedback has been generally positive.

The Trust is also currently running a staff survey eliciting feedback in regards staff experiences of internal safeguarding processes and which areas of knowledge they believe they require extra support with from the safeguarding team.

Stockton Hall - Priory Healthcare

Information about Safeguarding training undertaken internally and externally during the year byrelevant staff plus any evidence of impact

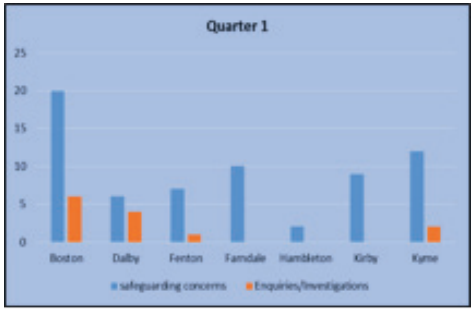
There has continued to be 100% compliance with safeguarding adults training for induction staff. This has involved attendance at a 1½ hour face to face training session. Safeguarding adults training for contracted clinical staff has also been facilitated on monthly basis, alongside induction training, with 83% compliance. There were 8 training sessions for non-clinical staff with attendance of 72, giving 94% compliance.

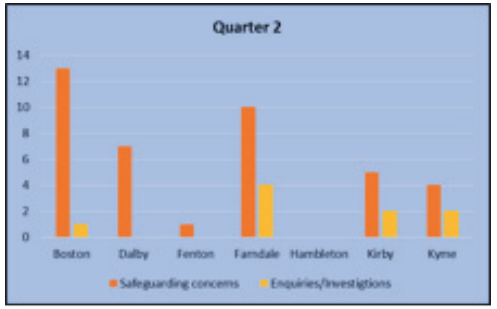
Three sessions of Safeguarding Enquiry and Investigation training were provided by an independent trainer in April and November 2016. A one day session was attended by 15 senior clinicians and managers at Stockton Hall Hospital, including doctors, charge nurses, and heads of departments. Two ½ day sessions were also facilitated by an independent trainer to 14 senior clinicians and 10 non-clinical managers from the hospital, regional Partnerships in Care units and the local independent hospitals. The feedback was very positive (70% excellent, 30% Good) and certificates were provided.

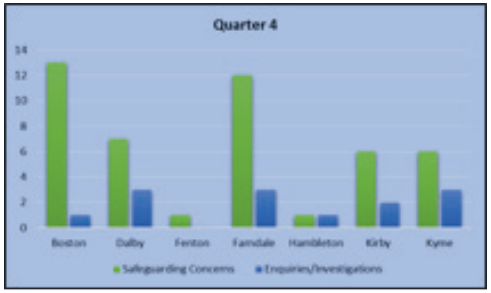
247 members of staff who have contact with adults and children attended the Workshop to Raise Awareness of Prevent training sessions during the year, which is a mandatory requirement in accordance with the NHS Contract. Feedback questionnaires are completed and forwarded to the Regional Prevent Lead, indicating that attendance at WRAP training significantly enhances knowledge and understanding of the Government's Counter Terrorism Strategy.

Information about any Safeguarding Concerns and Completed Enquiries during the year including analysis by location and type

Stockton Hall Hospital is a 112 bed medium secure psychiatric unit comprising seven wards, inclusive of women's services, mental illness, learning disabilities and personality disorders. The majority of patients have been admitted due to offending behavior, they are commissioned through NHS England and are all detained under the Mental Health Act 1983. Admissions are from across the country, with approximately 50% originating from the Yorkshire and Humber region.







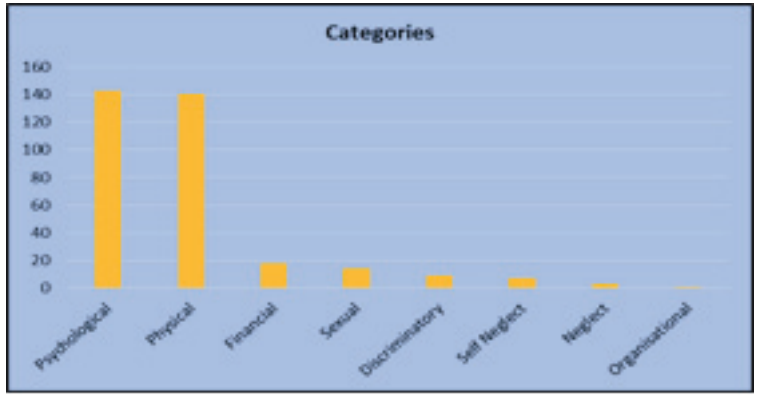
There were 221 safeguarding concerns during the year of which 57 were reported to City of York Council, requiring Section 42 Enquiries under the auspices of the Care Act 2014 or internal investigations completed by the hospital. This represented an increase of 77% compared with the number of safeguarding concerns the previous year and an increase of 14% of reported cases respectively. The increase in safeguarding concerns is likely to be due to the improvement in collating data from the wards following the introduction of the ward based safeguarding leads who provide monthly reports which are discussed at the Safeguarding Practice Meetings and form the basis of the monthly and quarterly safeguarding reports provided by the hospital's Safeguarding Lead to the Clinical Governance Meeting.

The numbers of persons alleged to have caused harm were as follows: Service Users 187 (85%), Staff 22 (10%), Relatives 4 (2%) and Not/Disclosed 8 (4%). This is broadly similar to previous years.

An analysis of safeguarding concerns on the wards indicates a variable level of activities. Boston, a 24 bed ward for men with a primary diagnosis of mental illness had 64 safeguarding concerns (29% of the total) of which 9 (14%) were reported to City of York Council, requiring further enquiry or investigation. Kirby, an equivalent sized ward with a similar client group had 33 safeguarding concerns (15% of the total) of which 12 (36%) were reported. Farndale, a 16 bed ward for females with a wide range of mental health problems, had 38 safeguarding concerns (17% of the total) of which 11 (29%) were reported.

Most of the wards demonstrated increased safeguarding concerns at different times of the year, reflecting a number of dynamics including the following. Adults at risk on Boston ward experienced specific difficulties during the period after the introduction of smoking cessation, with cigarettes reportedly being sold to patients on the ward leading to illicit smoking in

bedrooms and concerns about financial exploitation. This was ameliorated following an internal disciplinary investigation and staff changes. Kirby ward reported heightened anxiety among adults at risk due to the serious physical aggression presented by a patient on the ward towards staff and service users. Fenton, an 8 bed learning disability ward for patients presenting with symptoms associated with Autism Spectrum Disorders had relatively small numbers except for the third quarter when 18 safeguarding concerns were raised of which 5 were reported. A common factor on this ward, particularly with regard to cases reported to City of York Council was allegations of financial abuse. This was reported to the police and an internal investigation was requested, resulting in more effective methods of financial management at ward level. All the wards have reported an increase in trading between patients as a significant cause of safeguarding concerns being raised, including items of property and medication which may have been exacerbated due to the increase in disposable income.



Allegations of psychological and physical abuse continued to be predominant safeguarding categories. There were 7 recent safeguarding concerns under the category of self-neglect. Although this is a relatively small number it is a significant development. The primary cause of suspected self-neglect involved adults at risk failing to adhere to their physical health needs, including managing chronic conditions such as diabetes. Mental capacity issues were identified in several cases requiring capacity assessments to be undertaken, occasionally necessitating best interest meetings.

Information relating to Making Safeguarding Personal or other safeguarding outcome measures implemented during the year

A Service User Involvement Safeguarding Group was established towards the end of 2016. The purpose of the group was to ascertain the views and feelings of adults at risk within the hospital's safeguarding procedures and ensure the application of the principles of Making Safeguarding Personal are adhered to. The agenda has included discussions about how to enhance the active participation of service users, with the support of the Independent Advocacy Service. The intention is for adults at risk to feel that they are at the Centre of their safeguarding needs and to promote empowerment at all stages of the process.

Service users identified the following requirements to improve their involvement in safeguarding; a) The link worker role for the adult at risk and the person alleged to have caused harm needs to be clarified in order to improve communication and empowerment, b) The adult at risk and the link worker should sign the Safeguarding Plan with an agreed review date, c) Advocacy involvement will be consistently promoted at all stages of the safeguarding process, d) An outcomes meeting will take place at the next scheduled ward round or individual care review in order for the adult at risk can evaluate the effectiveness of the Safeguarding Plan and other agreed actions.

An outcomes based questionnaire to review safeguarding actions will initially be piloted on one of the wards and feedback discussed at the hospital's Clinical Governance Meeting. Thereafter the plan is for safeguarding outcomes to be a regular agenda item at all clinical team meetings. This will

enable the views and feelings of adults at risk and persons alleged to have caused harm to be elicited and for this information to be integrated into care planning to identify themes and avoid further safeguarding concerns from arising. Auditing this data should create a method of accurately evaluating the effectiveness of Making Safeguarding Personal within the hospital. Furthermore, Service Users and Rethink Advocates have begun to attend the monthly Safeguarding Practice Meetings, along with the ward based safeguarding leads and the clinical heads of departments, providing them with a direct voice in discussing changes to practices and procedures.

Any other achievements/developments relating to Safeguarding during the year

Following two meetings between Stockton Hall Hospital North Yorkshire Police and York City Council Safeguarding Adults Team and further liaison between these agencies a Memorandum of Agreement was agreed, providing minimum quality standards for patients who have reported criminal offences. This document was quality assured at the December Safeguarding Adults Board. The Memorandum of Agreement was formatted with the logos of the three organisations and has been forwarded to partner agencies for circulation to their staff, as required. This document will be reviewed within two years.

Stockton Hall Hospital has been actively involved in changing the terms of reference for the Safeguarding Implementation Group that is attended by the local independent mental health hospitals. It is now called the Multi Agency Safeguarding Group and its membership is expanding to include Clifton House Low Secure Unit. The meetings are also attended by representatives of the Clinical Commissioning Group and the City of York Council Safeguarding Adults Team and incorporate a safeguarding story/scenario discussion in order to share good practice and learn lessons from colleagues' experiences.

The Retreat

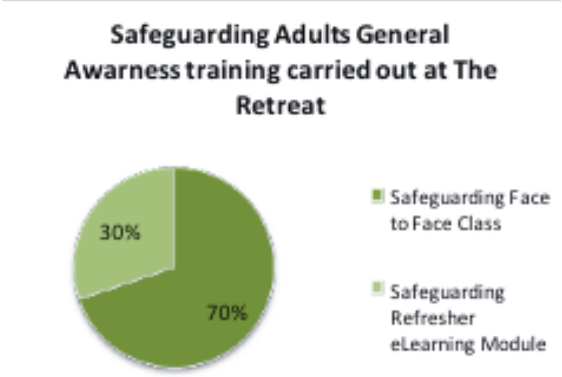
Safeguarding training

Safeguarding Adults General Awarness Training compliance for the hospital was 98% (335 people out of 343 required to complete); a 4% improvement compared to the previous year.

The safeguarding training level 1 is delivered face to face to all new starters (109) and as an eLearning refresher module (47). The refresher frequency is 3 years.

Compliance for external training: Working Together to Safeguard Adults was 100%.

The Retreat has revised its Level 1 Safeguarding Training in line with City Of York Council's revised training package and in line with the Care Act 2014.

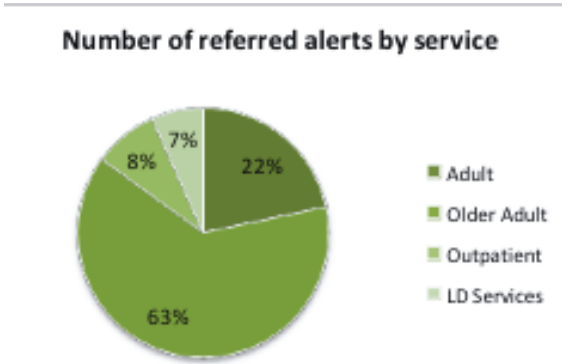


Safeguarding Concerns and Completed Enquiries

The number of reported safeguarding alerts (220) has been lower in comparison to the previous year: 236 in 2015/2016, a 7% reduction. The number of alerts which were later referred to the City of York Council Safeguarding Team and Care Quality Commission was higher in comparison with the previous years and for the 2016/2017 was 60 (previous year: 42).

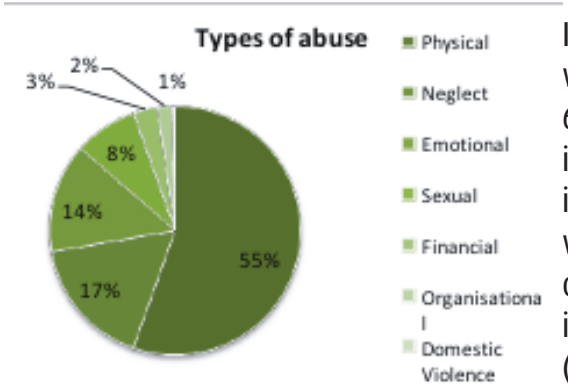
The new average for the quarter is 55 alerts, in comparison with 59 in the previous year. The average number of referred alerts per quarter is 15 (10 in the previous year).

The significant majority of alerts, 164 (75%), were submitted within older adult services in comparison with 38 (17%) reported on adult units, 11 reported within the Learning Disability (LD) services (5%) and 7 reported in outpatient services (3%). However when it comes to the referred alerts the figures present a different picture: 63% of cases were from older adult (38), 22% were from adult services (13), 8% from outpatient (5) and 7% from LD services (4).



Person alleged to cause harm (PATCH) was a current patient of The Retreat in 128 cases (58%). In 56 cases (26%) allegations were made against staff, and in 36 cases (16%) the PATCH was identified as external which includes family members, friends, ex-patients, agency staff and other agencies.

Cases of physical abuse account for the majority of all of the alerts: 122 (55%). Neglect was reported in 37 cases (17%), emotional abuse in 31 (14%), sexual in 18 (8%), financial in 7 (3%), organisational in 4 (2%) and domestic violence in 1 (1%).



In 92 cases the allegations were substantiated (42%), in 6 partially substantiated (3%), in 70 unsubstantiated (32%), in 27 cases the social workers were not able to determine the outcome (12%). The investigation is currently pending in 25 cases (11%).

Information relating to Making Safeguarding Personal or other safeguarding outcome measures implemented during the year

The Retreat has made significant progress with regards to Making Safeguarding Personal (MSP). Service users' views (or their carers/advocates where they lack capacity to engage in the safeguarding process) are sought on all occasions that a safeguarding concern is raised.

A sub group, of the Multi Agency Safeguarding Group which is attended, amongst others, by the Independent Hospitals in York has been set up to determine how we both measure and capture MSP in line with MSP guidance and in a way that is meaningful for our service users. The group is chaired by The Retreat's Involvement Lead.

The Retreat attend the Quality and Performance sub group of the Safeguarding Adults Board and will be providing data gathered re MPS as requested by this group.

Any other achievements/developments relating to Safeguarding during the year

The Retreat has one full time position (across two posts) that receive and process all safeguarding concerns raised. This has been further developed to allocate each of the safeguarding social workers to specific unit areas, thus allowing for a consistent approach with regards to proactive safety planning.

The Retreat is in the process of writing a safeguarding strategy; this will be done in conjunction with our service user and carers.

The Retreat continues to hold a strong relationship with City of York Council Safeguarding Team. We have an open and transparent approach to safeguarding, allowing us to act with advice in the best interest of our service users. A significant number of s.42 enquiries are entrusted to us by City of York Safeguarding Team.

The Retreat was fortunate to have been asked to be interviewed as part of City of York Councils Peer review to provide feedback on our experience of working with the local authority in relation to safeguarding. We consider this to be a positive reflection of our partnership working.

Annex 1:
Members of City of York Safeguarding Adults Board, March 2017

	Name	Title	Organisation	Address
1	Karen Agar	Associate Director of Nursing (Safeguarding)	Tees, Esk & Wear Valley (TEWV) NHS Foundation Trust	Flatts Lane Centre, Flatts Lane, Normanby, Middlesbrough, TS6 0SZ
2	Sarah Armstrong	CEO	York CVS	Priory Street Centre 15, Priory Street, York YO1 6ET
3	Kyra Ayre	Head of Service Safeguarding, MCA & DoLs	City of York Council	West Offices, Station Rise, York YO1 6GA
4	Sian Balsom	Healthwatch Manager	Healthwatch York	Priory Street Centre 15, Priory Street, York YO1 6ET
5	Michelle Carrington	Chief Nurse	NHS Vale of York CCG	West Offices, Station Rise, YORK YO1 6GA
6	Martin Farran	Corporate Director of Health, Housing and Adult Social Care	CYC	West Offices, Station Rise, York YO1 6GA
7	Beverley Geary	Chief Nurse	York Teaching Hospital NHS Foundation Trust	Wigginton Road, York YO31 8HE
8	David Heywood	Social Work Manager	Stockton Hall	The Village, Stockton-on-the-Forest, York YO32 9UN
9	Kim Bevan	Director of Business Development	The Retreat	Heslington Road, York, YO10 5BN
10	Kevin McAleese CBE	Independent Chair	York Safeguarding Adults Board	c/o West Offices, Station Rise, YORK , YO1 6GA
11	Michael Melvin	Assistant Director	CYC	West Offices, Station Rise, York YO1 6GA
12	John Pattinson	Deputy Director of Nursing & Quality	NHS England	Unit 3, Alpha Court, Monks Cross Drive, York, YO32 9WN

13	Christine Pearson	Deputy Designated Nurse, Safeguarding Adults	NHS Vale of York CCG	West Offices, Station Rise, York YO1 6GA
14	Cllr Carol Runciman	Cabinet Lead	City of York Council (CYC)	West Offices, Station Rise, York YO1 6GA
15	Sharon Stoltz	Director of Public Health	CYC	West Offices, Station Rise, York YO1 6GA
16	Keren Wilson	Chief Executive	Independent Care Group	10 North Park Road, Harrogate, HG1 5PG
17	Lisa Winward	Assistant Chief Constable	North Yorkshire Police	Newby Wiske Hall, Newby Wiske, Northallerton DL7 9HA

ANNEX 2:

City of York Safeguarding Adults Board Membership and Attendance 2016/17

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

Organisation	Designation	June 2016	Sep 2016	Dec 2016	March 2017	Nominated representative or substitute
	Independent Chair	N	Y	Y	Y	75%
City of York Council	Director of Adult Social Care	Y	N	Y	Y	75%
	Assistant Director , Adult Assessment and Safeguarding	Y	Y	Y	Y	100%
	Safeguarding Service Manager	NA	NA	Y	Y	100%
	Director of Public Health	NA	NA	Y	Y	100%
	Cabinet Member for Health, Housing and Adult Social Services	Y	Y	Y	Y	100%
Healthwatch York	Manager	Y	Y	Y	N	75%
Independent Care Group	Chief Executive	Y	Y	Y	Y	100%
NHS England	Assistant Director	Y	N	N	Y	50%
North Yorkshire Police	Deputy Chief Constable	Y	Y	N	Y	75%
Partnership Commissioning Unit (PCU)	Director of Partnership Commissioning	Y	N	Y	NA	66%
	Designated Professional for Adult Safeguarding	N	N	Y	Y	50%
The Retreat	Director of Operations	Y	Y	Y	Y	100%
Stockton Hall	Social Work Manager	Y	Y	Y	Y	100%
Tees, Esk & Wear Valley NHS FT	Associate Director of Nursing (Safeguarding)	Y	Y	Y	Y	100%
Vale of York CCG	Chief Nurse	Y	N	Y	Y	75%
	Designated Nurse, Safeguarding	N	Y	Y	Y	75%
York CVS	Representative	Y	N	Y	N	50%
York Teaching Hospital NHS Foundation Trust	Chief Nurse	Y	Y	Y	N	75%
Overall Board attendance		**88%**	**69%**	**94%**	**82%**	

Independent Chair's comments on Board attendance

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

However, there are inevitably operational pressures on individuals and organisations as well as annual leaves to be allowed for, given that the SAB only meets four times a year. There are also personal crises in the best managed of diaries, as well as reorganisations and role changes. In the ideal world the twelve partners would each have achieved 100% attendance records. During 2016/17, six of them managed to, one down from 2015/16 but the same as 2014/15. Well done to them for that!

Each SAB meeting ends with a meeting review in which all members comment on what went well during the two and three quarter hours and what would have been even better if it had happened. This feedback is included in the SAB minutes which are available on the SAB public website. Those reviews continue to confirm a broadly consistent picture, which is that SAB members find meeting together four times a year to be challenging, constructive and rewarding.

I am very grateful to the senior representatives of each organisation listed in Annex 1 who have given so much time, interest and commitment to the work of the Board during 2016/17.

ANNEX 3:

April 2016 to March 2019 action plan - March 2017 update

Priority Area 1 Empowerment: People know what abuse and neglect is and what they can do to keep safe and seek help				
Action	What we will achieve	How we will evidence this	Lead officer	Date
1a. The Safeguarding Adults Board will produce an information leaflet and develop a Board website about Adult Safeguarding. This will contain information about keeping safe, advice that explains types of abuse and neglect, and contact information to be used by anyone with a safeguarding concern.	People in the community will have increased knowledge about how to stay safe and what to do when they are concerned about their own safety; or the safety of another adult with care and support needs.	We will develop and roll out a communication/engagement strategy and launch it in the community	SAB Board Manager	31.03.17
		The website will include accessible information about abuse and neglect and a section for the wider public to access	SAB Board Manager	31.03.17
		We will agree a quality assurance framework that includes case files audits, single agency and multi agency audits.	SAB Quality & Performance Sub Group	31.03.17

Audit:

- Media and Comms strategy agreed by Board June 2016
- Keep safe guide to personal safety on website – further work required
- Audit tool has been to Quality & Performance group
- Audit tool designed and tested on 8 cases in CYC- partners to test
- Leaflet published
- New quality assurance framework almost complete

Priority area 2 Prevention We will need to demonstrate how we are working to prevent adults experiencing, or being at risk of experiencing avoidable abuse and neglect				
Action	What we will achieve	How we will evidence this	Lead officer	Date
2a. All Safeguarding Adults Board partners will be required to assure the Board on a regular basis about the actions they are talking locally to prevent people experiencing abuse or neglect. SAR policy at September Board for ratification	People in the community will be able to see how partners work together to commission safe and high quality services and how organisations hold themselves to account when concerns are raised about the quality and safety of their services.	We will commission Healthwatch to undertake a consultation with the community on adult safeguarding	SAB Board Manager	31.03.17
		We will publish a preventative strategy on the website that helps explain how we ensure we commission services that are safe and high quality.	SAB Quality & Performance Sub Group	31.03.17
		We will ensure there is a transparent process in place that demonstrates how we learn lessons when things go wrong and the SAB can provide proportionate responses under S44 of the Care Act 2014	Lessons Learned Sub Group	31.03.17
2b. The Safeguarding Adults Board will update and maintain the public section of its website using the accessible information standards, with a section on staying safe.	People in the community will have more access to information which will increase their knowledge about how to stay safe and what to do when they are concerned about their own safety or the safety of another person.	We will include information about how to keep safe on the public section of the SAB website. This will include information about door step crime, general home safety etc.	SAB Board Manager	31.03.17

Audit
- SAR policy has been ratified
- Lessons Learned sub group is processing cases and has case 'tracker' to actively monitor
- Referral form is on website plus video on reporting abuse

Priority area 3: Proportionality: People are asked what they want to happen as a result of a safeguarding concern being raised and their views directly inform what action follows				
Action	What we will achieve	How we will evidence this	Lead officer	Date
3. The Safeguarding Adults Board will ensure that when partners undertake an enquiry into safeguarding concerns, any actions taken are informed by the expressed wishes and feelings of the person at the centre of the concern, in accordance with The Care Act 2014 and Making Safeguarding Personal requirements.	People in the community will gain in confidence that any safeguarding adult plans are informed by people's wishes and feelings, balancing concerns for someone's personal safety with an understanding of how they see their own quality of life & wellbeing	We will have a clearly defined and transparent governance, performance management and quality assurance framework in place, which will comprise a series of single agency and multi-agency audits and quality assurance processes.	Quality & Performance Sub Group	31.03.17
		Healthwatch will lead on customer focused surveys to ensure people have the opportunity to feedback their experiences of adult safeguarding.	Healthwatch	31.03.17
		We will ensure that we use customer feedback to review and update our local adult safeguarding responses.	Quality & Performance Sub Group	31.03.17

Audit:

- Quality & Performance group developing the performance management framework
- Risk register has been developed and is monitored via Q and P group
- Healthwatch and CYC exploring possible options for ongoing feedback on people's experiences and consultation over regional review proposed changes to the Safeguarding Policy

Priority area 4: Protection: We will support people to manage the risks they experience as a result of abuse, or neglect and the help they receive makes their situation better				
Action	What we will achieve	How we will evidence this	Lead officer	Date
4a. The Safeguarding Adults Board will require all partners to ensure that there is an up to date assessment of mental capacity and any best interest decision on file, and will ensure the person is supported where required by an advocate or a independent mental capacity advocate	People in the community will gain confidence that that all adults who are assessed as lacking the mental capacity to decide how a safeguarding concern should be progressed are offered the appropriate support which ensures all decision are made in their best interests.	We will monitor and report on the use of advocates & IMCA's for individuals who are assessed as lacking mental capacity.	Quality & Performance Sub Group	31.03.17
		We will undertake case file audits to ensure best practice is followed in MCA and Safeguarding.	Quality & Performance Sub Group	31.03.17
4b. The Safeguarding Adults Board partners will ensure that when abuse or neglect has occurred, safeguarding adults plans are developed in a way which shows a balance between quality of life and concerns about peoples' safety.	People in the community will be able to see more clearly that work is undertaken in response to current and ongoing risks, supporting the person to recover from the abuse or neglect and keeping them more safe.	We will develop local operational guidance to support front line staff and managers, which will be supported by a new safeguarding adults training offer.	SAB Board Manager	31.03.17
		We will agree governance and quality assurance arrangements for partners to feedback themes and trends identified through case file audits.	SAB Quality & Performance Sub Group	31.03.17

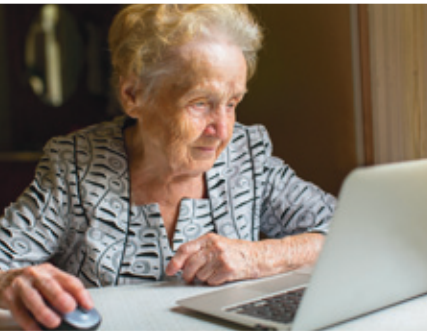
Audit:
- Use of advocacy is part of the performance reporting to the SAB
- Local Operational Guidance is on the website
- Audit tool is being piloted and Performance & assurance framework is almost complete

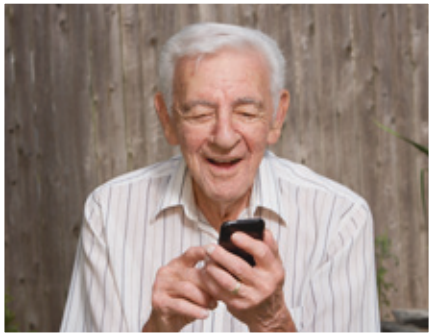
Priority area 5: Partnership: We will work together to ensure adults receive help and support from the people best placed to help them feel safer.				
Action	What we will achieve	How we will evidence this	Lead officer	Date
5a. Each Safeguarding Adults Board partner will ensure their organisation upholds their collective responsibilities to safeguard adults in accordance with the requirements of the Care Act 2014.	People in the community will gain in confidence that Care Act 2014 requirements are well established across every partner organisation in the City of York.	Each Board partner will report to SAB on an annual basis about the work their organisation has undertaken as required by the memorandum of understanding.	Quality & Performance Sub Group	31.03.17
5b. The Safeguarding Adults Board will work with the Children's Safeguarding Board and other local partners to host an annual Safeguarding week across the City of York.	We will help to raise the profile of whole life safeguarding and enhance people's understanding of all the work undertaken locally to help keep people safe.	The Safeguarding Boards will work with other partners (including local media) to plan and host an annual event. The information and feedback from events will be held on the respective Board websites.	SAB Board Manager	31.03.17

Audit:
- 5a. Annual SAB report been to Health & Wellbeing Board and Health & Social Care Policy and Scrutiny Committee
- 5b. Safeguarding week to be held including children and adult safeguarding in October 2017

Priority area 6: Accountability: The roles and responsibilities of individuals and organisations who have a responsibility for safeguarding adults is clearly understood and people know what action they can take if individuals or organisations do not fulfil their responsibilities.				
Action	What we will achieve	How we will evidence this	Lead officer	Date
6a. The Safeguarding Adults Board will agree and maintain common safeguarding adults policies and procedures for all partners to use.	People in the community will be able to understand how local partners work together to tackle any abuse of vulnerable adults.	SAB will officially adopt the West Yorkshire / North Yorkshire multi agency policy and procedures	SAB Board Manager	31.03.17
		SAB will agree a series of good practice guides/working protocols that embed Statutory safeguarding duties.	Quality & Performance Sub Group	31.03.17
6b. The Safeguarding Adults Board will produce an Annual Report explaining what it has done and how its partners have helped keep people safe in the City of York.	People in the community will be able to read the report, see how safeguarding adults operates and be helped to hold local organisations to account if they fail to work in accordance with policies and procedures.	The Safeguarding Adults Board Independent Chairman will present the Board's Annual Report to Health and Scrutiny panel, the Council's Health & Well Being Board, to standing community forums organised by York CVS, to Healthwatch York and to any other community groups which request a presentation.	Independent chair / Director of Adult Social Care.	31.03.17
		The SAB will develop and maintain a risk register to ensure that all identified risks are effectively identified and addressed.	SAB Board Manager	31.03.17

Audit:
- Local Operational guidance is on the website
- CYSAB participating of review of WYNYY procedures and in discussion with NYSAB
- Quality & Performance group have a risk register and monitor updates at each meeting
- Annual report complete with Easy Read summary on website





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City of York Safeguarding Adults

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