



Report of North Yorkshire Safeguarding Adults Board Chair

23rd November 2018

Presented by Dr. Sue Proctor, Independent Chair of the NYSAB

Summary:

This report introduces the Annual Report of the North Yorkshire Safeguarding Adults Board (NYSAB) for the financial year 2017/18, and outlines the future areas for development by the Board.

The Annual Report is available on the following link:-

<http://www.nypartnerships.org.uk/sabannualreports>

Which of the themes and/or enablers in the North Yorkshire Joint Health & Wellbeing Strategy are addressed in this paper?

[Please tick as appropriate]

Themes	✓
Connected Communities	✓
Start Well	
Live Well	✓
Age Well	
Dying Well	
Enablers	
A new relationship with people using services	✓
Workforce	✓
Technology	✓
Economic Prosperity	✓

How does this paper fit with other strategies and plans in place in North Yorkshire?

Safeguarding Adults Boards are a statutory requirement made upon each Local Authority area in England. They have specific duties and responsibilities to ensure that the partner agencies that meet under the auspices of the Board work together to provide safe, effective, and efficient safeguarding arrangements to those most vulnerable adults living in their areas. The Partnership is made up of a rich mix of both statutory and non-statutory bodies.

As such, the work of the Board links to other strategies and plans that address the wider wellbeing of the residents of North Yorkshire.

What do you want the Health & Wellbeing Board to do as a result of this paper?

Note the North Yorkshire Safeguarding Adult Board's Annual Report for 2017/18, and the Board's Future plans for 2019/20 and beyond; and

Consider the links between the work of the Health and Wellbeing Board and the Safeguarding Adults Board, and opportunities for closer working between the Boards

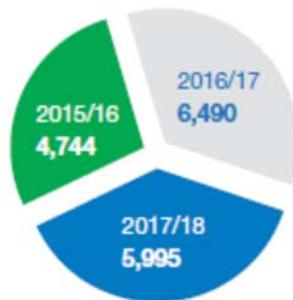
Background

1. The Care Act (2014) requires local authorities to set up a Safeguarding Adults Board (SAB). The Act identifies that the Board must
 - include the local authority, the NHS and the police, who should meet regularly to discuss and act upon local safeguarding issues;
 - develop shared strategic plans for safeguarding, working with local people to decide how to protect adults with care and support needs in vulnerable situations;
 - publish a strategic plan and report to the public annually on its progress, so that constituent Partnership organisations can ensure that they are working together in the best way.

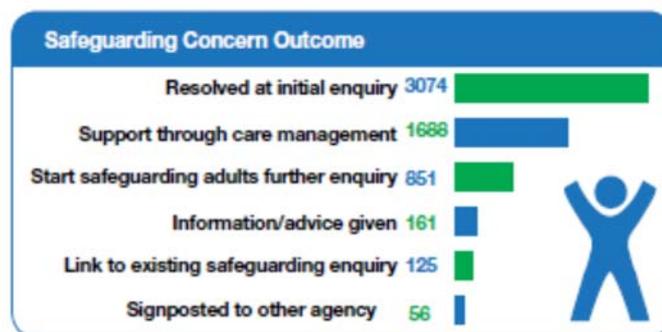
2017/18 – Key Messages

2. It has been a year of change for the Board; sadly, my predecessor, Colin Morris, passed away in January. Colin was a strong and passionate Chair of the Board, whose dedication and commitment to making safeguarding personal was the driving force behind the many improvements and new areas of work for the Boards over the last couple of years. He is greatly missed by all who worked with him.
3. In 2017 an independent consultant, Richard Burrows, was commissioned to undertake a review of adult safeguarding in North Yorkshire, working with NYSAB partners to reflect on practice and where possible improvements could be made. The report identified the following key messages and areas of learning for NYSAB:
 - A clearer vision and stronger arrangements for how we learn lessons and coordinate change.
 - Being open and transparent about our strengths and weaknesses and the challenges we face.
 - We have focused on the development of monitoring, measuring and understanding information around safeguarding to make sure our processes reflect what is important to those who use our services, our staff and partners. The report recommended that we continue to do this and use evidence to continually learn and improve.
 - Going forward NYSAB need to focus on evidence gathered from people's experience and learning from things that have happened, as well as looking at data to make sure that we make safeguarding personal for everyone.
 - NYSAB and partners were praised for the commitment to, and investment in training and activities to promote awareness of safeguarding. It was recommended that NYSAB look at how partners can work more closely together to develop their workforces.
 - It was noted in the report that being inclusive is at the heart of everything we do. Safeguarding can be a difficult process to understand, and NYSAB should continue to adopt a personalised approach to safeguarding.
 - NYSAB should get better at talking to each other and sharing information and learning.

- Although North Yorkshire County Council provides social care, the NYSAB is a partnership of organisations who all take responsibility for safeguarding in North Yorkshire. NYSAB need to improve the understanding across all partners of this joint responsibility and how it sits alongside the provision of social care services.
 - NYSAB focus on local areas to make sure that safeguarding is personal. It was recommended that SAB Partners could have a better understanding of how things work locally to give NYSAB a clear direction of priorities going forward.
4. In March 2018 NYSAB published its first Safeguarding Adults Review (SAR), a multi-agency review process that seeks to determine what the agencies involved could have done by working more closely together. The SAR looked at where there were lessons to be learned and how to promote effective learning and improvement to prevent similar situations in the future. The Board published a “7 minute briefing” on the key messages of the SAR, which is attached.
 5. There was a reduction in the number of safeguarding concerns raised during 2017/18. This was largely due to improved reporting practice by North Yorkshire Police and Yorkshire Ambulance Service.



16% of the concerns made progressed into safeguarding or are linked to existing safeguarding enquiries.



6. We built on our existing joint working with safeguarding and community safety colleagues in North Yorkshire County Council and City of York Council through delivery of Safeguarding Week, with a conference for over 300 staff.

The annual week provides an opportunity to raise awareness of different aspects of safeguarding with staff, managers and the public.

Future Plans

7. Members of NYSAB came together for a Development Session on 1st November, during which we considered the priorities for the Board going forward and the value the Board can bring over and above the work of its individual agencies. Taking into account what we have been told through the Burrows Review, a survey by Healthwatch, and Countywide engagement around the Mental Capacity Act, the key themes that came out of the discussion are below:
 - Given the demographics of North Yorkshire, we should involve representatives from the Military, Trading Standards, and the Farming Community in the work of the Board. We should also consider how we can develop community resilience and build on existing social capital.
 - A range of issues around Communication:
 - We need to have a stronger focus on Communication with partners, staff and the public about safeguarding generally, and about the business of the Board.
 - We should improve our links with the media, and look for opportunities to work across Safeguarding Boards and Community Safety Partnerships (CSPs) around public campaigns and messages
 - The language we use needs to be easily understood by people so that they understand what we mean
 - We need to think about how we can communicate better with people about what happens when a concern is raised, and how we keep in touch with people during Safeguarding and keep them updated
 - We should build on the joint work that already exists with other Safeguarding Boards and CSPs to improve our joint responses strategically, and at a local level, to areas of common interest eg Modern Slavery, Domestic Abuse, County Lines.
 - We need to strengthen how we capture people's views and experiences of safeguarding so that we can learn from these and improve how we carry out safeguarding
 - We have an evolving and improving approach to learning eg SARs and Lessons Learned, that provides us with a good foundation to continue to develop and strengthen our approach to Continuous Learning, so that the Board can be assured that immediate and longer term learning is understood and implemented.
 - Safeguarding needs to be supported by confident and competent practice that makes use of multi-agency discussions in complex cases to ensure joint working wherever possible; the Board needs to be assured of the competency and capacity of staff across the partnership.
 - We should think about how we can link most effectively with national and regional colleagues to identify best practice and share learning.
 - We need to have a better understanding of the range of risks to the work of the Board and its partners, particularly those that could have system-

wide implications eg the impact of Brexit on the workforce, and the financial sustainability of the care sector.

Further work is being carried out to translate these into strategic objectives for the Board in 2019/20, and which will then be discussed at its meeting in December.

8. A key aspect of the Board's work going forward is the implementation of new Multi-agency Safeguarding Policies and Procedures from April 2019. A range of work in the following areas is taking place prior to implementation:
- Communication of, and engagement about, changes with partners;
 - Work across all partners on cultural and practice change;
 - Development by each agency of Operational Guidance that will underpin the Policy and Procedures;
 - Review and redesign of HAS's IT system to reflect the new safeguarding procedures; and
 - Training of workforce

Progress on this is monitored through a Project Board and reported to the Board and, due to the complexity, dependencies and far reaching nature of the work required, a shared post has been created to Project Manage this work on behalf of the NYSAB. Whilst the policies and procedures will be implemented in April 2019, work to personalise and streamline our approach to safeguarding will continue beyond this.

Dr Sue Proctor
Independent Chair, North Yorkshire SAB

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What is a Safeguarding Adults Review (SAR)?

A SAR is a multi-agency review process, which seeks to determine what relevant agencies and individuals involved could have done to have prevented harm or death from taking place. It will establish whether there are lessons to be learned and promote effective learning and improvement to prevent future deaths or serious harm happening again. A SAR should reflect the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability.

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Background

Mrs A was an 88 year old lady who died in June 2015 of septicaemia. She had received care at home four times a day since 2010 and despite some physical frailty, socialised regularly with friends and was described as having an 'iron constitution, sharp views and a strong mind' by her family. In March 2015 she broke her femur while being assisted with personal care. Due to a breakdown in communication between professionals they weren't aware of this. Complications lead to septicaemia and Mrs A refused treatment. Following two hospital admissions she died in June 2015.

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Key Learning: Person Centred Working

"Making Safeguarding Personal" guidance should be embedded in all practice, including Social Work Practice – we need to ensure that the person is at the 'heart' of the process.

We must promote a holistic approach to patient assessment and care planning to ensure it is personalised to the individual.

Care plans should be personalised to reflect decisions of the patient – even if contrary to medical advice.

Key learning: Training

All practitioners across all SAB Partners should undergo a rolling programme of Safeguarding Training that is relevant and appropriate to their job role and function.

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Key Learning: Support and Guidance

All agencies should provide support and guidance to staff around safeguarding, the role of their organisation and make any support offered to staff easily accessible.

Consideration should be given to the level of support offered to smaller agencies to enable them to engage more effectively with future SAR's.

03

Key Learning: Information Sharing and Communication

A review of systems and processes is required to facilitate multi-disciplinary working. This includes a system which enables agencies to 'talk to each other' with a system for checking that urgent tasks have been received and there is confirmation of actions taken so each agency knows who has done what and if they have any outstanding actions so that things don't get missed.

Each organisation must have an appropriate mechanism for escalating concerns.

Key Learning: Mental Capacity and Unwise Decisions

Everyone has the right to make unwise decisions. Mental Capacity Assessments must be time and decision specific. Any capacity decision must be recorded accurately: it is not enough to record that a person has, or may have previously 'had capacity'.

A person's right to decline assessments under the Care Act must be weighed sufficiently, fully and carefully against professional standards in Health and Social Care.

The full SAR report is available [here](#)

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