Role and duties of the City of York Safeguarding Adults Board (SAB)

Overarching purpose

The overarching purpose of the SAB is to help and safeguard vulnerable adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The SAB is not an executive Board responsible for the *delivery* of services (like a hospital Trust Board) but an independent body *assuring itself* as far as possible that safeguarding services in the City of York for vulnerable adults are robust and collectively meeting statutory guidance. It has very senior representation from three statutory partners (City of York Council, North Yorkshire Police and the Vale of York Clinical Commissioning Group) plus ten other providers, including Tees, Esk & Wear Valley NHS Trust, York Teaching Hospitals NHS Foundation Trust, Healthwatch York, York CVS and a number of independent providers of care to NHS patients. It is chaired by an experienced independent person who is not an employee of City of York Council.

The SAB *oversees* adult safeguarding arrangements across its locality and *oversees* and *coordinates* the effectiveness of the safeguarding work of its member and partner agencies, though it does not deliver any services itself. This requires the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in **'Making Safeguarding Personal'**. It will also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- the safety of people who use services in local health settings, including mental health
- the safety of adults with care and support needs living in social housing
- effective interventions with adults who self-neglect, for whatever reason
- the quality of local care and support services
- the effectiveness of prisons in safeguarding offenders
- making connections between adult safeguarding and domestic abuse.

Core duties

SABs have three core duties. They **must:**

1. develop and publish a **Strategic Plan** setting out how they will meet their objectives and how their member and partner agencies will contribute

2. publish an **Annual Report** detailing how effective their work has been

3. commission a **Safeguarding Adults Review (SAR**) for any cases which meet the threshold for these as set out in the Care Act 2014 and statutory guidance.

Safeguarding Adults Reviews (SARs)

The SAB must authorise an SAR if a case meets the legal criteria of a death arising from abuse or neglect, whether known or suspected, and where there is concern that partner agencies could have worked more effectively, or where someone has not died but serious abuse or neglect is suspected.

SABs never hear safeguarding cases themselves because their role is assurance rather than executive action. The SAB has three Board sub-groups, one of which is the SAR/Lessons Learned sub-group. It is for this group, on the basis of all the evidence available, to recommend to the Chair of the SAB in writing that an SAR should be commissioned. The Chair of the SAB must put their reasons in writing if they do not accept the recommendation, and must establish an SAR if they believe it is appropriate in all the circumstances. An SAR involves the recruitment of an independent author who will write a report for the SAB and other affected parties to consider after a detailed investigation of all the evidence available. SARs take several months to complete.

To give some indication of scale, in any year there will be some 1,200 or so safeguarding concerns raised with City of York Council from a population of some 200,000 citizens. That figure rises each year as publicity about being safe is distributed more widely. Of those 1,200 cases, a quarter of them will result in some kind of investigation known as a Section 42 Enquiry by the Council's safeguarding team and the remaining 900 will be appropriately resolved by the team without the need for a Section 42 enquiry. A very small number of cases, usually less than 10 a year, may be referred to the SAR/Lessons Learned sub-group for further consideration, the outcome of which is that a number may be dealt with as Lessons Learned cases, involving staff training across all relevant providers. The action plan from a Lessons Learned case must be approved by the SAB, but it will have no further involvement in the matter. Very exceptionally, an SAR may be recommended by the relevant SAB sub-group as outlined in the previous paragraph. There has been no SAR in York since the SAB was created in 2008.