Leeds Safeguarding Adults Board

Minutes – 14th October 2015

Board Membership		
Name	**Organisation**	**Attended**
Ellie Monkhouse	Interim Chair – Leeds Safeguarding Adults Board & Leeds North and Leeds South and East CCG	✓
Cath Roff (Member)	Director of Adult Social Services	
Shona McFarlane (Member)	Adult Social Care	✓
Superintendent Sam Millar (Member)	West Yorkshire Police	✓
DCI Mark Griffin (Member)	West Yorkshire Police	
Jo Harding (Member)	Leeds West CCG	
Maureen Kelly (Member)	Leeds CCG	✓
Suzanne Hinchliffe CBE (Member)	Leeds Teaching Hospitals NHS Trust	
Clare Linley (Deputy)	Leeds Teaching Hospitals NHS Trust	✓
Anthony Deery (Member)	Leeds and York Partnerships NHS Foundation Trust	✓
Marcia Perry (Member)	Leeds Community Healthcare NHS Trust	
Tanya Matilainen (Member)	Healthwatch Leeds	✓
Lisa Toner (Member)	West Yorkshire Fire and Rescue Service	✓
Diane Pellew (Member)	HMP Wealstun	
Andrew Chandler (Member)	National Probation Service	
Rachel Garry (Deputy)	National Probation Service	
Sandra Chatter (Member)	Community Rehabilitation Company	
Peter Turner (Member)	Community Rehabilitation Company	✓
Emma Stewart (Member)	Alliance of Service Experts	✓
John Statham (Member)	Leeds City Council: Environments and Housing	
Philip Bransom (Member)	Advonet	
Bridget Emery (Member)	Leeds City Council: Public Health	✓
Hilary Paxton (Ex Officio)	LSAPSU	✓
Emma Mortimer (Ex Officio)	LSAPSU	✓
Kieron Smith (Ex Officio)	LSAPSU	✓
Loraine Danby (Ex Officio)	LSAPSU	✓
Gerry Gillen (In attendance)	Leeds City Council: Legal Services	✓
Ben Eckles (Observer)	Student, Leeds CCG, Observer	✓

Item No.	Item	Action, Timescale and Person responsible
1.	**Welcome**	
	Ellie Monkhouse, Interim Chair welcomed members to the Leeds Safeguarding Adults Board meeting.	
i.	**Introductions and Apologies**	
	Members of the Board introduced themselves. Ellie Monkhouse noted apologies.	
2.	**Minutes of 18 June 2015**	
2i.	These were accepted as an accurate record. **Matters Arising/Action list from June 2015** Actions from previous meeting: Draft Information Sharing Agreement to be circulated to Board Information Governance Officers and Board Members. This action was complete and forms Item 8 of the Agenda. Item 4: Kieron Smith confirmed that members wishing to provide an amended contribution for the Board Annual Report had done so. Item 7.1: Hilary Paxton confirmed that the Adult Social Care/NHS Trust Enquiry Protocol has been updated with the requested amendment. Item 7.2: Hilary reported that the Department of Health is advising that the impending revised Statutory Guidance will remove the role of the Designated Adults Safeguarding Manager. The responsibility to have operational safeguarding leadership and a procedure for responding to concerns about a 'person in a position of trust' will however remain. Additional matters arising: Shona MacFarlane advised that Richard Jones has been appointed as the new Independent Chair. He is a former Director of Social Services, ADASS Chair and a Chief Operating Officer an NHS England area team, bringing a wealth of experience to the role. Richard will join the Board from its next meeting on the 10th December. In advance of this, an induction programme is being developed, and the Partnership Support Unit will email members seeking their availability to meet Richard.	**Action:** Partnership Support Unit to present the revised Statutory Guidance to the Board when published

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	Shona MacFarlane confirmed that Hilary Paxton, Head of Safeguarding had commenced a secondment with ADASS working on the Transforming Care project 3 days per week until the end of March. Arrangements are in place to ensure work is progressed in Leeds during this period. Shona MacFarlane, on behalf the Board, acknowledged that Ellie Monkhouse was moving onto a new role and thanked Ellie for her valuable contributions to the Board as a member, and more recently as the Interim Chair. Board members wished Ellie well in her new role.	
3.	**LSAB Strategy and Annual Plan:** **Sub-group activity – Chairs' updates**	
	Emma Mortimer explained that the Annual Plan was agreed at the last Board meeting. The intention is that the Annual Plan will be updated at each meeting, and that each sub-group may be asked to provide a written summary of their work so as to keep the Board informed of progress, issues and challenges. **Safeguarding Adults Review sub-group:** Emma Mortimer explained that the current priority for the sub-group is a scoping exercise in relation to a SAR referral, the findings of which will be assessed by the group to consider if a SAR should be undertaken. In addition the SAR policy is being reviewed to ensure it meets the requirements of the Care Act 2014. **Quality Assurance and Performance sub-group:** The revised sub-group's first meeting has taken place. Work has commenced on developing the Quality Assurance Framework and a multi-agency audit tool. The Member Annual Self-assessment has been circulated, the findings of which will be collated and presented to the Board. The sub-group also has an action around safeguarding standards, but there is corporative approach within Leeds City Council to explore the potential for standards across Domestic Violence, Children Services and Safeguarding Adults, the sub-group will look at how it can link into this work. **Citizens Engagement sub-group** Tanya Matilainen advised that the sub-group had met once, and has been refreshing its membership. The intention is to have a smaller core group and a wider set of links, such as	

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	with police, probation and fire service and other Board members organisations that can be involved in projects as required. The sub-group will approach Board members for support in the first instance, unless otherwise represented on the sub-group. The sub-group has a broad plan for how to take forward its actions in the Annual Plan. **Learning and Improvement sub-group** Maureen Kelly explained the Board had a formal update report on the sub-group's work and progress in August, and there were no additional updates at this time.	
4.	**Board member updates**	
	Hilary Paxton spoke to the National Probation Service: National Partnership Framework, Safeguarding Adults Boards that was tabled for the Board's awareness. Ellie Monkhouse queried if there were any implications for the Board. Kieron Smith said he felt it was a statement of commitment to the Board and its work. Peter Turner said that it helped to clarify that National Probation Service and Crime Reduction Companies are separate in their membership of Safeguarding Boards.	
5.	**Discussion items:** **i. Savile – Lessions for adult safeguarding** **ii. 'Justice for LB' – Reflecting on the lessons from Connor Sparrowhawke's death**	
	Emma Mortimer spoke to a power point presentation regarding: i. The nature and thematic learning from the Savile Inquiries ii. The context of LB's tragic death, before showing a short film about LB on the My Life My Choice website: http://mylifemychoice.org.uk/campaigns/justice-for-lb/ The presentation slides are attached to the minutes. Emma explained that learning was relevant to all organisations that provided services to people with care and support needs. Considering both of these items, Board members were asked in groups to consider the implications for the Board and for wider organisations in Leeds.	

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	Table 1: Feedback: • Need for individuals to be at the centre of decision making, with the support of advocacy when needed • Need to consider how the Board assures itself that organisations are listening to individuals and their family/advocate • Need to consider auditing a sample of concerns that have been raised, but have not taken through safeguarding to assure us that appropriate actions have been undertaken. • Need to explore joint work with LSCB regarding Transitions and Safeguarding, not just for those with care and support needs. **Table 2: Feedback** • Need to consider our self-assessment process – does it include learning from Savile, as well as complaints, whistleblowing and safer recruitment. • Need to know about support services and their responsiveness in Leeds, particularly for people in transitions. • Need to ensure we are listening to families, and being person centred focused • Need to embed this culture in organisations • Need to promote the 6 C's, Care, Compassion, Competence, Communication, Courage and Commitment. **Table 3: Feedback** • Need to consider how we evaluate services by outcomes achieved and not just processes followed. • Need to consider how commissioning arrangements evaluate the demonstration of values • Need to promote skills and resources to fully engage with adults and their families. • Need for cultural change, not necessarily new laws, and this requires vision and leadership within organisations. **Table 4: Feedback** **<u>Savile</u>** • Need to understand different role of celebrities • Need to ensure people have a voice • Need a shared understanding of safeguarding terms	

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	and assessment work • Volunteers are better screened and supervised; the risk is lower but not eliminated. • Horizon scanning, need for the Board to regularly consider if there are actions needed or key lessons to be learned from such incidents. **LB** • Need to promote learning and good practice across Board members • Need a greater focus on assurance around transitions • Need to consider the Board's role in assurance in contrast to that of commissioner and regulators. Does the Board want to have more active role than self-assessment, such as 'challenge visits'? Ellie Monkhouse advised NHS organisations have all undertaken evaluation of the learning from Savile in the context of their organisations. However, it is important that we also consider how other organisations across the city can benefit from this learning. Claire Linley welcomed this approach and felt that it is important that the Board routinely reflected on these national incidents and identified as a Board its learning and its required actions. There was a discussion about the level of assurance that the Board should be seeking from member organisations, and a query as to whether the member self-assessment would achieve this learning. Hilary Paxton said that the Board's assurances were at a strategic level. The self-assessment was developed by independent chairs in the region, and if it does not focus on the right issues, we can provide feedback for its development. Shona MacFarlane felt that although the Board's responses were at a strategic level, it is important that it be informed by individual stories. There is much in these reports about how we could listen better to adults and their families. Emma Stewart said whilst the focus of the Board is less on individual cases, when many people are effected in the same way, it illustrates strategic failings in services, and this should be the concern of the Board. Bridget Emery reflected that members of the public would be staggered that such events occur, and there was a role in developing general awareness of how people should expect	

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	to be treated by services, and how they can challenge services if they are not treated appropriately. Ellie Monkhouse asked for these reflections to be collated, and for the Board to consider at a subsequent meeting, how it could work to achieve improvements for people in Leeds.	**Actions:** Partnership Support Unit to collate key issues the Board to consider at the December meeting.
6.	**Outcomes of Formal Enquiries: Case Conclusions**	
	Shona MacFarlane presented a paper proposing changes to the decision making options available to practitioners when, following a Formal Enquiry, they are deciding whether abuse has occurred. The proposal is to remove the 'inconclusive' option, and therefore allegations would be substantiated or not substantiated. It was proposed that this would provide clearer outcomes for all concerned. Hilary Paxton explained the context that this decision no longer needs to be reported as part of the national data collection. However, next year, it will be necessary to report whether the risk has been reduced and whether actions are taken. Maureen Kelly suggested we need to focus more on these new requirements in relation to risk, rather than about whether abuse is substantiated or not substantiated. Maureen queried how much difference these outcomes made to the safety of the individual. Shona MacFarlane advised that sometimes the risk is the person alleged to have caused harm, and that the enquiry provides an evidence base for actions. Clear outcomes support this. Sam Millar felt it was important to look at any issues behind such a change. Is there a concern that good decisions are not been made? or is there a concern that risk is not being well managed? These issues might need to be understood better in the first instance. Sam felt that it is sometimes reasonable for an outcome to be 'inconclusive', given the complexities of the issues involved. Hilary confirmed that regardless of this decision, there was always a need to assess risk and consider the need for a safeguarding plan.	**Action:** Quality Assurance and Performance sub-group to undertake an audit in relation to case conclusion decision making. Findings will be used to inform the decision to bring this item to the Board for further discussion.

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	Ellie Monkhouse felt this was an issue for the Board to reflect on and revisit at a later date. Shona MacFarlane agreed that an audit regarding decision making would support a later discussion on this issue.	
7.	**Local Government Ombudsman: Safeguarding Adults Board Casework Guidance Statement**	
	Hilary Paxton presented the Local Government Ombudsman Case work statement. This clarifies the role of the Local Government Ombudsman to investigate complaints in relation to the Safeguarding Adults Board and Formal Enquiries undertaken on behalf of Adult Social Care. Hilary confirmed that references in the Local Government Association in the covering report, were errors, and should read Local Government Ombudsman in all cases.	
8.	**Leeds Safeguarding Adults Board: Information Sharing Agreement**	
	Hilary Paxton presented the updated Information Sharing Agreement. This has been shared with partners, and now finalised will form part of the new Board Constitution.	**Action**: Hilary Paxton to include the Information Sharing Agreement within the new Board Constitution.
9	**Key messages to/from other strategic partnerships in Leeds**	
	None noted on this occasion.	
10.	**Any other Business**	
	Ellie Monkhouse confirmed this was her last Safeguarding Adults Board in Leeds and thanked everyone for their support. With Richard Jones now appointed, Ellie was pleased to be leaving the Chair role in safe hands, and wished the Board and its members well for the future.	
11.	**Dates of future meetings:**	
	10th December 2015 All meetings scheduled at 2.00 pm – 4.30 pm at the Rose Bowl, Leeds Beckett University, Portland Crescent, Leeds, LS1 3HB	

Leeds Safeguarding Adults Board

Actions list from 14th October 2015

Item No.	Action	Person / organisation responsible	Deadline
Item 2i	**Action:** Revised Statutory Guidance to be presented to the Board for consideration when published	Partnership Support Unit	
Item 5:	**Actions:** Key learning discussed in relation to Savile Inquiry and LB, to be collated for the Board to consider further at the December meeting.	Partnership Support Unit	December Board Meeting
Item 6:	**Action:** Quality Assurance and Performance sub-group and undertake an audit in relation to case conclusion decision making. Findings will be used to inform the decision to bring this item to the Board for further discussion.	Shona MacFarlane	
Item 8	**Action**: Information Sharing Agreement to be included within the Board Constitution.	Hilary Paxton	

Leeds Safeguarding Adults Board

Continuing Actions From Previous Boards Meetings

Board Date	Agenda Item	Action	Lead Person/ Agency	Agreed Date	Comments
February 2015	Item 1 ii	Domestic Homicide Reviews A thematic analysis of Domestic Homicide Reviews in Leeds to be provided to the LSAB	Supt Sam Millar		Timescale to be agreed
June 2015	Item 7	Leeds Safeguarding Adults Board Strategic Plan Consultation event to be held considering the priorities for the 2016/17 Strategic Plan	Partnership Support Unit & Leeds Healthwatch		To be considered as part of Strategic Planning for 2016/17 Action relates to the new Care Act duty to consult with the Local Healthwatch and involve the community in devising the Board's Strategic Plan.

Item 2) Appendix.
Presentation slides from October Board 2015

Leeds Safeguarding Adults Board

Learning from National Concerns

LSAB Strategic Learning

- Opportunity to consider how two national concerns impact on the Board's strategic plans
- Overview of Savile Inquiries and Investigations' Findings
- Film: Connor Sparrowhawk
- Reflection

Savile Inquiries

- Savile was, '*hiding in plain sight and using his celebrity status and fundraising activity to gain uncontrolled access to vulnerable people across six decades… He only picked the most vulnerable, the ones least likely to speak out against him.*'

Superintendent David Gray, Operation Yewtree

Savile Inquiries and Investigations

- BBC
- Operation Yewtree
- Operation Outreach
- Her Majesty's Inspectorate of Constabulary
- Three NHS Investigations:
  - Leeds
  - Broadmoor
  - Stoke Mandeville

  } Independent Oversight
- Thirty-eight further hospital investigations
- A children's home, an ambulance service and a hospice

Overview

- James Wilson Savile: Born in Leeds in 1926, died aged 84 in 2001

- October 2012: ITV '*Exposure*'

- Operation Yewtree – Savile was a, '*prolific sexual predator, paedophile and rapist, with 214 criminal offences recorded across the UK*'.

Themes and learning for organisations

- Need for clarity about organisational values and attitudes
- Good governance systems in place
- A culture of openness and transparency - internally and externally
- Need for safe recruitment approaches
- Accessible, valued and robust complaints procedures, with a demonstrably clear culture of wanting to hear people's views
- A policy of non-acceptance of any form of abuse and communication of this at all levels of the organisation
- A culture of valuing safeguarding adults and children and placing this at the heart of their work

Connor Sparrowhawk aka LB Laughing Boy

'*LB is Connor Sparrowhawk. LB was a fit and healthy young man, who loved buses, London, Eddie Stobart and speaking his mind. He lived in Oxford and was in the sixth form of a local special school. LB was diagnosed with autism, learning disabilities and epilepsy*'. Dr Sara Ryan, his mum

Connor died on 4th July, at the age of 18, having drowned in a bath. He was an informal patient in the Short Term Assessment and Treatment Team inpatient unit run by Southern Health NHS Foundation Trust.

The Tale of Laughing Boy (LB)

- A 15 minute film, to find out more about LB, what happened to him and the family's subsequent campaign for justice, can be seen here:

https://vimeo.com/130521001

Connor Sparrowhawk: Reviews and Inquiries

Verita – Independent Investigation, published February 2014

- Preventable death
- Poor risk assessment
- Poor care planning
- Lack of consultation with CS or his family about his care planning and needs
- Antipathy towards parents for 'speaking up'
- Lack of reference to the Mental Capacity Act 2005
- Lack of transparency
- Failure to respond to complaints and concerns from CS's family

Connor Sparrowhawk: Reviews and Inquiries

Care Quality Commission Inspection:

- Requires improvement
- Unsafe
- Training required for all staff
- Lack of leadership

Healthwatch Oxford:

- Families shut out of care decisions when their child reached 18
- Not being helped until person hit crisis point
- Adults with LD and Autism moved miles away
- Over-use of physical and chemical restraint

Strategic Learning for LSAB

Please consider and note:

- The implications for this Board
- Implications for organisations in Leeds working with adults with care and support needs