PAPER H

Purpose: For Discussion

Committee report

Committee	**POLICY AND SCRUTINY COMMITTEE FOR ADULT SOCIAL CARE AND HEALTH**
Date	**19 MARCH 2018**
Title	**ADULT SAFEGUARDING PROGRESS REPORT**
Report of	**DR CAROL TOZER – DIRECTOR OF ADULT SOCIAL CARE AND COUNCILLOR CLARE MOSDELL – CABINET MEMBER FOR ADULT SOCIAL CARE & PUBLIC HEALTH**

1. EXECUTIVE SUMMARY

This report outlines the progress made within Adult Social Care (ASC) to develop robust operational services to support vulnerable adults: in partnership with both statutory and none statutory agencies. The report further identifies some of the key challenges remaining and how these are being progressed through a process of programme management.

2. BACKGROUND

The Care Act 2014 established the statutory duties for Local Authorities and statutory partners in relation to safeguarding adults.
They must:

- Lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- Make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- Arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.
- Establish Safeguarding Adults Boards, including the local authority, CCG and police.

Safeguarding Adults Boards have three core duties. They **must:**

- develop and publish a **strategic plan** setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an **annual report** detailing how effective their work has been

- commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

In the summer of 2017 the Director of Adult Social Services (DASS) commissioned an Independent Review of the progress being made within Adult Social Care to provide against the above duties. However, the review did not have the remit to consider the functions of the Local Safeguarding Adults Board (LSAB). The report made a number of recommendations, which can be viewed within the attached action plan of this report. A key recommendation was that the Isle of Wight council develop a local Threshold / Criteria guidance that is accessible and offers a clear understanding of what constitutes a safeguarding concern. Progress against this particular recommendation will be addressed further in the report. Beyond this, the service has continued to review best practices from a national research to continually drive for service improvements and partnership working. ASC has recently become a member of a national organisation - Research in Practice for Adults, (RipFa) an organisation geared towards improving practice from empirical evidence based research.

The overarching principles of keeping people safe; providing protective interventions and Making Safeguarding Personal (MSP) remain central values to the work undertaken in ACS.

PERFORMANCE REPORTING

ASC has developed a comprehensive performance reporting system to capture the work being undertaken, provide analysis of such information and develop services accordingly. There are regular performance meetings of operational managers and the Business Information Team (BIT) to ensure that constant methods of capturing and reporting of data is undertaken. Work is presently underway, utilising Critical Pathway Analysis, to investigate how to subtract all valuable data from the PARIS electronic recording system.

Two key performance indicators are:

Safeguarding Strategy meetings held within 7 working days of receiving the referral

This indicator is reflective of the response to concerns raised and measures a proactive approach to making initial enquiries into Safeguarding referrals. This has improved steadily as a result of improved communications with partners and the development of a Multi-Agency Adults Safeguarding Hub (MAASH) and full implementation of Making Safeguarding Personal (MSP). Currently ASC is achieving a 95.7% rate against a target of 100%.

Number of S42 Enquiries referred per month, and their 28-day timeliness

This indicator refers to the conclusion of those safeguarding referrals that have progressed to formal Section (42) enquiries. This target date refers to the conclusion of the enquiry - 28 days from the receiving of a referral. Performance against this target presently stands at 53% with a target of 100%. The indicator presents challenge as the safeguarding process is dependent on receiving timely engagement and information from partner agencies. Receiving information in particular from our Health partners (NHS Trust) is noted in our performance reports as a lead reason for delays. As noted, there are established meetings, wherein progress against this indicator is investigated.

Conversation Rates

This indicator remains a concern as it reflects the amount of referrals that are not appropriate to the service as they do not meet the threshold criteria to constitute a safeguarding enquiry. The attached appendix offers a breakdown as to the source of referrals. There a number of reasons for this and a variety of workshops with Clinical Commission Groups (CCG) and the NHS Trust are in place to identify the reasons for this and action solutions. The most apparent area leading to a poor conversation rate is the reporting of medication errors (particularly in permanent care providers) that do not constitute safeguarding breaches. Progress against this indicator will be presented to future Scrutiny Committee for Adult Social Care and Health.

TRAINING

Extensive work has been undertaken with the training department to develop a training programme that promotes the skills required to deliver a high quality safeguarding service. ASC is working closely with partners to extend the training offer for a collaborative approach and reporting the LASB as to the value added to all agencies. New initiatives have been developed such as the introduction of Cognitive Behavioural Therapy as recommend by the Chief Social Worker for England. A further range of training programmes are being investigated: such initiatives have received recognition from across the region regarding the progressive approach taken by the Isle of Wight council to safeguarding.

Recognition of this work has been noted by the Local Government Association (LGA) who has requested representatives from the Safeguarding unit attend a national conference to present how success in this area was achieved (Lessons Learnt). This relates, in particular, to the use of the Multi-Agency Risk Framework, (MARM) which has been embedded in practice on the Isle of Wight to a higher level than many Local Authorities.

SAFEGUARDING ADULTS REVIEW GROUP (SARG)

Current and Recent Reviews
The Safeguarding Adults Review Group (SARG) is a sub-group to the LSAB.

One statutory SAR (Mr R) and one non-statutory SAR (Mrs P) were concluded in 2017 and one non-statutory SAR is currently underway and due to complete in April 2018. The statutory SAR into the death of (Mr R) has not yet been published as whilst the process is complete - the case is due in the Coroner's Court shortly, and the LSAB has been advised that publication must wait until after the inquest is concluded.

The concluded non-statutory SAR into the case of (Mrs P) can be found on the LSAB webpage.
The current non-statutory review has been commissioned into the death of a gentleman with care and support needs. This review was commissioned despite the statutory criteria not being met, as it was felt there were sufficient concerns about how agencies worked together to safeguard the individual to merit a multi-agency review of practice.

Concerns to be addressed through this review include how agencies have communicated with each other and exchanged information, and how agencies worked together to support a person with multiple complex needs - including homelessness, use of alcohol, fluctuating capacity and physical health issues. This review is being led by Professor Michael Preston-Shoot (University of Sussex) and is due to conclude in April 2018, whereupon the recommendations from the review will be converted into a multi-agency action plan, which will be monitored by the LSAB.

Concluded SARs and Discretionary Reviews

Previous SARs undertaken by the LSAB can be found on the Board's webpage: https://www.iwight.com/Residents/Care-and-Support/Adults-Services/Safeguarding-Adults-Board/Safeguarding-Adults-Reviews

SAFEGUARDING THRESHOLDS /CRITERIA

In December 2017 ASC commissioned Making Connections (a local training provider), to undertake a programme of work to develop a local Criteria for all partner agencies. Central to this work was the full engagement of as many partners as possible, so as to ensure the criteria were fully understood and agreed. The completed work will be presented to the March LSAB for sign-off and this will be followed by awareness raising exercises and a comprehensive training programme.

MULTI-AGENCY ADULTS SAFEGUARDING HUB (MAASH)

On 1 December 2017 a MAASH became operational on the Island. Meetings take place daily to review all safeguarding referrals. At present, attendance at the meetings is by ASC and the Police Vulnerable Adults Unit. Unfortunately, Health as a statutory body has not been able to provide support directly due to available resources. This is an area of concern as a MAASH to be able to fully operational and to provide timely and skills based decisions to its full potential needs the contribution of Health. Consideration to recruitment a Specialist Nurse to sit within the MAASH has been shared by the DASS with the LSAB. Progress against this work will be provided to a future Scrutiny Committee.

3. APPENDICES ATTACHED

- Appendix 1 – Analysis of sources of Safeguarding referrals
- Appendix 2 - Safeguarding Action Plan

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