Agenda Item No: 7

SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2016/17

To: **Health and Wellbeing Board**

Date: **6th July 2017**

From: **Russell Wate, Independent Chair**

Recommendation: **The Health and Wellbeing Board is invited to:**

1. **Comment on the content of the covering report and the Cambridgeshire Safeguarding Adults Board Annual Report 2016/17;**

2. **Ask the Independent Chair to present the next Annual Report (for 2017/18) at a Health and Wellbeing Board meeting in 2018.**

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1.0 PURPOSE

1.1 To present the Cambridgeshire Safeguarding Adults Board Annual Report for 2016/17.

2.0 BACKGROUND

2.1 The Care Act 2014 (enacted in April 2015) introduced the statutory duty on Local Authorities, Clinical Commissioning Groups and the Constabulary to operate a Safeguarding Adults Board (SAB) to promote and oversee the protection of adults with care and support needs from abuse and/or neglect.
Cambridgeshire has a well-established SAB with strong commitment from the Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG) and police and other key partners and we have continued to build on this collaborative approach during 2016/17.

2.2 The Draft Annual Report (Appendix A) provides a background to adult safeguarding work in Cambridgeshire and a summary of the work undertaken by the Safeguarding Adults Board (SAB), Adult Safeguarding Team and partners. N.B. The Draft Annual Report will be presented to the SAB for approval on 27 June 2017. Confirmation of that approval will be provided verbally at the Health and Wellbeing Board (HWB) Board meeting on 6 July 2016.

3.0 PROGRESS ON PRIORITIES IN 2016/17

3.1 The report to the Health and Wellbeing Board in September 2016 identified a number of priority areas of work for the SAB in 2016/17. An update on each of these priorities is provided below.

3.2 *Embedding the practice of Making Safeguarding Personal (MSP) across all organisations involved in safeguarding. Use feedback from a "Temperature Check" commissioned by Association of Directors of Adult Social Services (ADASS) and due out in the Autumn 2016 to focus further development of MSP practice.*

3.2.1 For information, MSP is an initiative developed by ADASS and the Local Government Association prior to the Care Act 2014 to promote a person centred approach to safeguarding. MSP is referred to in the Department of Health guidance for the Care Act 2014 (link below). The guidance recognises that safeguarding arrangements are there to protect individuals and that people "…..all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised." The guidance goes on to say that "Making Safeguarding Personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in

a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety." https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

3.3 Building on experience since the implementation of the Care Act in April 2015, all safeguarding courses delivered by the Cambridgeshire County Council Safeguarding Adults Team were updated in 2016/17 to strengthen compliance with the Care Act 2014, and in particular, the focus on MSP. This work informed a new Training Programme that was launched on March 2017, with MSP Training being the prerequisite to all other safeguarding training courses.

3.4 Following the feedback from the national "Temperature Check", the Eastern Region of ADASS agreed to commission a regional report to provide more detailed feedback and recommendations for action. This report and the recommendations will be considered fully at the SAB meeting in June 2017 and will inform the work required to continue to embed the practice of MSP across Cambridgeshire.

3.5 *Embedding the Multi-agency Safeguarding Hub (MASH) arrangements and understanding the impact on numbers of safeguarding referrals being passed to locality teams. Explore why cases that are not safeguarding are passed to the MASH and provide guidance as necessary to other organisations.*

3.6 The adults' team in the MASH has been operating since April 2016, providing a consistent approach to all safeguarding adult concerns, liaising with the Police and other agencies as necessary, and advising the next steps in responding to the concerns.

3.7 Data collected from April 2016 to January 2017 showed that 30% of cases were referred to long-term care teams for general case work and a further 12% of cases being passed to teams to carry out a Section 42 enquiry, as required under the Care Act 2014. Approximately 60% of the concerns coming into the Adults MASH were being handled by the MASH team rather than being dealt with within the long-term care teams freeing up capacity in these teams to focus on the more complex safeguarding cases and assessment and review work for people who require support from the long-term care teams.

3.8 *Confirm the appointment of an independent chair for the SAB. Review the operation of the SAB with the new chair.*

3.9 Russell Wate was confirmed as the Independent Chair for the Cambridgeshire SAB in September 2016. Russell's appointment has brought together the chairmanship of the SABs for Cambridgeshire and

Peterborough and the Local Safeguarding Children's Boards for both local authority areas. This arrangement supports closer collaboration across the Cambridgeshire and Peterborough locality which mirrors the area covered by key partners including the Constabulary and Cambridgeshire and Peterborough Clinical Commissioning Group. A joint business unit is being established to support Russell in the work of all four boards.

3.10 *Develop the joint working arrangements across SAB subgroups with Peterborough colleagues, including agreement on joint procedures.*

3.11 Joint arrangements were established across SAB subgroups with Peterborough colleagues during 2016/17 and work has progressed on developing joint procedures. The development of the joint business unit will support the collaborative work of subgroups going forward.

3.12 *Review dataset of information that allows effective monitoring of safeguarding activity and outcomes, doing in depth data and trend analysis.*

3.13 This work was been postponed until 2017/18 to allow the data from the MASH and the new recording requirements introduced by the Care Act around the person's desired outcomes to be fully considered in this work.

4.0 Safeguarding Activity in 2016/17

4.1 The Annual Report provides information and commentary on the safeguarding activity relating to 21016/17. The headlines are provided below.

4.2 The number of incidents referred to the Council has reduced this year from 1499 in 2015/6 to 1272 in 2016/17.

4.3 The most commonly reported type of abuse continues to be physical abuse (33%) although this has reduced from 42% of referrals in 2015/16.

4.4 Neglect, which has been given greater prominence through the Care Act 2014 has increased from 24% in 2015/16 to 30%.

4.5 New reporting has been introduced regarding alleged perpetrator that shows that most abuse/neglect occurs by people known to the adult, followed by service provider. The category of "known to individual" would include situations between residents in care homes that cater for people who present behaviours that can challenge, specifically people with

dementia, mental health issues and learning disabilities. This group was the most prevalent in the way that information was collected in previous years.

4.6 The Care Act 2014 changed the reporting regarding the outcome of safeguarding enquiries, so rather than collect whether a safeguarding allegation has been substantiated or not, we record whether the actions taken in response to the allegation has led to the following:

- Risk reduced
- Risk remains
- Risk removed
- No action taken under safeguarding

In the majority of cases (58%), the risk was reduced, with a smaller numbers where the risk was removed (17%) or where the risk still remains (10%). This emphasises the importance of working with the person to agree the personal outcome that they want from the safeguarding intervention and the follow up that will be required to minimise the impact of remaining or reduced risks.

5.0 Priorities for 2017/18

5.1 The following priorities have been identified for 2017/18.

5.1.1 *Domestic Abuse [including Sexual Violence (SV), Female Genital Mutilation (FGM), Honour based violence (HBV), Forced Marriage (M), across all genders] – To ensure that adults at risk of abuse and neglect are protected from all types of Domestic Abuse; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.*

5.1.2 *Neglect (including self-neglect and hoarding) – To ensure that adults, at risk of abuse and neglect, in all settings, are protected from neglect; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.*

5.1.3 *Adults living with mental illness - To ensure that adults at risk of abuse and neglect are protected, and that practitioners are skilled and trained appropriately to recognise changes in symptoms and behaviours that may indicate a deterioration in their mental health and that a change in care management/planning is required; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.*

5.2 In support of these priorities, work on embedding the practice of MSP across all organisations involved in safeguarding, will need to be informed by the report and recommendations from the “Temperature Check” commissioned by Eastern Region ADASS.

6.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

6.1 The work on safeguarding adults from abuse and neglect supports the implementation of the following priorities in the Cambridgeshire Health and Wellbeing Strategy:
Priority 2: Support older people to be independent, safe and well.
Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
Priority 6: Work together effectively

7.0 Sources

Source Documents	Location
The Care Act 2014	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted