

## MUNICIPAL YEAR 2016/2017 REPORT NO. 95

**MEETING TITLE AND DATE:**

Cabinet – 19 October  
2016

**REPORT OF: Ray James**

Director of Health,  
Housing and Adult Social  
Care

**Agenda – Part: 1****Item: 6****Subject: Safeguarding Adults Board  
Annual Report 2015-16****Wards: All  
Non Key****Cabinet Member consulted:****Cllr Alev Cazimoglu**

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### 1. EXECUTIVE SUMMARY

The Safeguarding Adults Board Annual Report 2015-2016 presents the work completed during the first year of statutory responsibility for safeguarding as defined by the Care Act 2014. This was a year in which a strong partnership embedded the legislative requirements for safeguarding, while at all times keeping the focus on how we can collectively prevent abuse from happening, while assuring when harm does occur we support recovery and resilience through the 'Making Safeguarding Personal' agenda.

The Safeguarding Adults Board is a partnership of statutory and non-statutory organisations which seeks to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area. The Safeguarding Adults Strategy 2015-2018 sets out the priorities of partners across Enfield, what we intend to achieve and the actions we will take to get there. This document was developed through consultation with local people, service users, carers and organisations.

The Annual Reports presents the key accomplishments of the Safeguarding Adults Board, both in their strategic and assurance role for safeguarding in Enfield, but also the actions across the partnership which prevent abuse and ensure a robust response when harm does occur. The annual report aims to set out a summary of Board activities and its effectiveness in assessing and driving forward safeguarding practice which keeps adults at risk safe.

### 2. RECOMMENDATIONS

To note the progress being made in protecting vulnerable adults in the Borough as set out in the annual report of the Safeguarding Adults Board.

### 3. BACKGROUND

- 3.1 The Safeguarding Adults Board meets quarterly and has a number of responsibilities as set out by the Care Act 2014 and statutory guidance. Our annual report sets out how we have met these aims and the significant accomplishments over 2015-2016. The Board is proud of their successes in **Making Safeguarding Personal**, following achievement previously to be acknowledged at gold standard level, and we have expanded on this work by all partners effecting actions which will put adults at risks central to the safeguarding process.
- 3.2 Across the partnership many organisations completed specific pieces of work which will improve the effectiveness of the safeguarding response. We set out a new multi-agency policy and procedure for responding to self-neglect and hoarding, while partners in the Clinical Commissioning Group set out a Prevent Strategy and Delivery Plan, which was adopted by NHS England as good practice. Much of the work is done through strong partnership and collaboration between partners; our **Fatal Fire Working Group** was set up to learn how we can prevent a similar occurrence in the future following death of two individuals, while our work around **dehydration** prevention continues to implement actions to reduce hospital admissions from care providers.
- 3.3 During this year we saw the operation of the Multi Agency Safeguarding Hub (MASH), a team that receives all safeguarding concerns. Through working together and sharing information, while in partnership and listening to the outcome expressed by the adult at risk, the team helps to manage risk and promote safeguarding planning. There were **3,511** reports made to the MASH, of these 1,602 were Police Merlins and 665 notifications raised by partners were about adults whom may be vulnerable but not in need of safeguarding actions. The remaining **1,244 safeguarding concerns** were considered as to whether they met Section 42 criteria for safeguarding. We know that neglect (33.9% of cases) and multiple abuse (29.2% of cases) are the most reported, and this follows previous years. Those alleged to have caused harm are often family members, which is followed by paid care workers. In 84% of cases there is a nominated advocate, often of the persons choosing where they have capacity, to support them through the process. At the time of reporting, 58.3% of cases were substantiated or partially substantiated. Our full data can be found in Section 8 of the annual report.
- 3.4 The Safeguarding Adults Board has a strong assurance role and in holding partners to account. We took part in a North Central London Challenge and Learning event following partner self-assessments. Every year adult social care has external assurance of case practice and we are establishing more diverse ways of how to include service user feedback in this process. Our **Quality Checkers** are a pivotal part of this, and have completed a number of projects including one which

focuses on establishing the quality of activities in Care Homes across the borough.

- 3.5 The Board now has a statutory duty to report on all Safeguarding Adult Reviews (previously known as Serious Case Reviews). Two of these reviews were completed during the year and have action plans monitored by the Board. There are also two further safeguarding adults reviews started, which will be completed and reported on in the next financial year.
- 3.6 Looking forward we have set ourselves some clear tasks to accomplish, which have been set out by requirements in the Care Act 2014, identified via themes and trends in our data, and through consultation feedback from service users, carers and local people:
- Produce information in a wider variety of formats, including a DVD
  - Consider how we can prevent harm from occurring within care providers
  - Increase awareness of mate crime, particularly in mental health
  - Focus our data on the extent to which a person's outcomes have been met and whether this has made them feel safer
- 3.7 Every partner on the Board has a strong commitment to safeguarding adults and activities take place within each organisation to contribute towards enabling people to keep themselves safe and respond when harm does occur. Our statement from partners, which includes their planned actions over the coming year, can be found in the final section of the annual report.

#### **4. ALTERNATIVE OPTIONS CONSIDERED**

The Care Act places a duty on Safeguarding Adults Boards to publish an annual report. Further guidance goes on to state that the SAB must publish a report on:

- what it has done during that year to achieve its objective,
- what it has done during that year to implement its strategy,
- what each member has done during that year to implement the strategy,
- the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
- the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),
- what it has done during that year to implement the findings of reviews arranged by it under that section, and
- where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

The statutory requirement for an annual report negates any alternative options.

## **5. REASONS FOR RECOMMENDATIONS**

The report is being presented to Cabinet to bring to attention the progress which has been made to support and enable adults at risk to be safe from harm, abuse and neglect.

## **6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS**

### **6.1 Financial Implications**

The Care and Support Statutory Guidance sets out guidance for members on the assistance they may provide to support the Board in its work. As a result of this for 2015-2016 the Board established an allocated budget for the administration and implementation of the Boards work plan. This took into account the expected increase in Safeguarding Adults Reviews, which was due to their statutory nature. The total budget allocated for the Board was £63,500 and was made up of all partner contributions. The contribution from the Local Authority was made up of £43,000 from the Better Care Fund.

The Boards budget was managed by the London Borough of Enfield Strategic Safeguarding Adults Service.

### **6.2 Legal Implications**

Section 43 of the Care Act 2014 imposes a duty on each local authority to establish a Safeguarding Adults Board (SAB) for its area. Schedule 2 of the Care Act 2014 sets out various requirements for SABs, including at paragraph 4 the duty to publish an annual report. Paragraph 4 prescribes the subjects which must be covered in an annual report and the people and bodies to whom the SAB must send copies.

The parts of the Care Act 2014 concerning SABs have been in force since 1 April 2015.

The proposals set out in this report comply with the above legislation.

### **6.3 Property Implications**

None identified.

## **7. KEY RISKS**

- 7.1 Mitigation of risks in relation to vulnerable adults is demonstrated in the Board's annual report. The Board is required to work effectively within

partner resources while ensuring it can meet the changing needs and trends emerging in relation to the harm and abuse of adults in its area. Taking into account changes by the Care Act, the Board seeks assurances from partners through quality assurance mechanisms that they are able to keep people safe and manage risks. This is evidenced, by one example, via partner self-assessments and the North Central London Challenge and Learning event.

- 7.2 The Board is continually looking at options to enhance efficiency and joint working that minimises duplication while provide quality and safe services to adults at risk. Needing to deliver in times of austerity, the Board will work in partnership with its statutory partners, namely the Police and Clinical Commissioning Group, alongside existing partnership Boards, to maximise its impact. The Board will continue to work closely with the Safeguarding Children Board and other partnerships to effectively keep people safe.
- 7.3 The community and those whom use services have inputted strongly into the development of the Board strategy action plan, which sets out the work program on an annual basis. The Boards action plan is reviewed at each quarterly meetings and highlights progress against each action.
- 7.4 Co-production and challenge on safeguarding adults is crucial and a clear requirement in the Care Act. This risk has been mitigated by the Service User, Carer and Patient sub group of the Safeguarding Adults Board. In addition, London Borough of Enfield are working on alternative digital and face to face options for adults or their representatives to provide feedback.

## **8. IMPACT ON COUNCIL PRIORITIES**

### **8.1 Fairness for All**

The Board is strongly committed to tackling inequalities, with an emphasis in improving the wellbeing of those at risk of abuse or whom have experienced harm. The Board undertakes this through a range of activities with communities on improving the identification and reporting of abuse, as well as preventative activities as set out the Boards Prevention Framework 2015-2018.

Accessibility is a key part of ensuring service users, carers and local people understand what abuse is and how to report concerns. The Board has undertaken significant work on addressing these alongside the Service User, Carer and Patient sub-group of the Board, with robust plans during the coming year on diversifying communication methods. This has been set out in the Boards Communication Plan for 2015-2016.

## **8.2 Growth and Sustainability**

The Board's work has not directly impacted on the Council's priority of growth and sustainability.

## **8.3 Strong Communities**

The Safeguarding Adults Board has strong leadership through an independent chair. In addition, partners on the Board are of appropriate seniority and commitment to promote the vision that 'safeguarding is everyone's business.' The work of the Boards is responsive to the needs of local people and those who use services; this is achieved through a range of activities, including consultations, events, sub-groups of the Board and quality assurance activities.

Above all, the Boards work in partnership to improve safety of people in Enfield, linking to issues such as hate crime, domestic abuse, and female genital mutilation in partnership with other Boards, such as Safeguarding Children's Board and Safer and Stronger Communities Board.

## **9. EQUALITIES IMPACT IMPLICATIONS**

- 9.1 Corporate advice has been sought in regard to equalities and an agreement has been reached that an equalities impact assessment is neither relevant nor proportionate for the approval of the Safeguarding Adults Board Annual Report. Safeguarding forms part of the Council's programme of retrospective equalities impact assessments (EQIA) and this was completed in June 2016. The retrospective EQIA collates equalities monitoring of service users, and consider how the service impacts on disadvantaged, vulnerable and protected characteristic groups in the community.
- 9.2 Equalities in relation to the performance data for safeguarding are considered at each Safeguarding Adults Board meeting and as part of the Quality, Safety and Performance sub-group. The themes and trends emerging from data help direct the actions of the Board. Equalities Impact assessments will be completed for each of the project streams as appropriate.

## **10. PERFORMANCE MANAGEMENT IMPLICATIONS**

- 10.1 The Safeguarding Adults Board Strategy Action Plan 2015-2018 was developed through strong consultation, including with those whom use services, carers and via Enfield Healthwatch. The performance of the Board is assessed against this action plan and the annual report reflects the achievements and areas which require further work.

## **11. PUBLIC HEALTH IMPLICATIONS**

- 11.1 Safeguarding of adults at risk is recognised as a significant public health issue; preventing abuse and promoting choice will increase wellbeing within these populations. Safeguarding interventions are focused on recovery and resilience from abuse, which has the potential to further improve wellbeing of adults at risk.
- 11.2 Prevention of abuse has focused not solely on individuals, but also on working with services and organisations to provide assurances that care is safe and of significant quality.
- 11.3 The Board is also reviewing the data we collect so that outcomes for service users from safeguarding link to the wellbeing principles, allowing the Board to address the areas of wellbeing most important to adults whom may be at risk of abuse.

### **Background Papers**

None