Suffolk
Safeguarding Adults Board

Annual Report - 2017-2018

Index

1. Introduction - Independent Chair

I am very pleased to present the 2017/18 Annual Report of the Suffolk Safeguarding Adults Board (SAB). The report gives an overview of progress in delivering the 2017/18 priorities and sets those for 2018/19.

This has been a challenging year for the adult safeguarding system. The Board received the independent review of adult safeguarding which covered leadership, systems, policies and processes. A summary of the findings can be found on page 11. It was encouraging to see the effective work on the front line and the skills and commitment of staff across all agencies. However, the report identified many areas requiring attention in particular the need to improve the senior leadership of safeguarding and to develop stronger shared ownership of SAB multi-agency policies and procedures.

I am impressed with the open way that senior leaders in Adult Social Care, Health and the Police received the report and have worked together to develop a detailed plan and identify additional resources to deliver it. Progress is being made, with a suite of new policies in development, a safeguarding leadership development programme planned for October 2018 and a practitioners' conference for February 2019. Senior leaders are meeting monthly to progress the action plan and relationships between agencies at a senior and middle management level have improved significantly.

Part of this work is to refresh the SAB thresholds framework document which assists staff in all agencies to identify when a safeguarding referral is required. The document has been drafted and will be consulted on through the Autumn with final sign off at the Board meeting in December 2018, followed by an intensive awareness raising programme. This is important as the Multi-Agency Safeguarding Hub (MASH) is still receiving too many referrals and re-referrals that do not meet the criteria for safeguarding enquiries. The revised threshold document, the practitioners' helpline in the MASH and the feedback to referrers from MASH staff will all assist in addressing this issue.

The need to prioritise the required improvements identified in the review has meant that the SAB has not been able to deliver fully on all the priorities originally set for 2017/18.

There has been good progress in implementing the Self-Neglect and Hoarding Strategy with an improved multi-agency approach to earlier identification and intervention leading to risks being managed more effectively and either reducing or not escalating further.

The SAB continues to monitor the quality of care homes and it is reassuring to see the increasing number of homes rated good or outstanding. Feedback from service users and families shows good levels of satisfaction with the care received.

The Healthwatch survey of users of domiciliary care shows that users are highly satisfied with the quality of the care they receive but that there are concerns about timekeeping and inconsistency of carers. The SAB will be monitoring, over the coming months, progress of the recommendations made in the report to improve these areas.

The Board has developed a revised performance framework, more clearly linking data collected with the key principles of safeguarding from the Care Act. Partners need to ensure that relevant data is provided to the Board in a timely way and to improve the quality of the analysis.

The Safeguarding Adult Review Advisory Panel (SARAP) continues to operate well and partners are appropriately referring cases of concern. Over the last year, as well as commissioning formal safeguarding adult reviews (SAR) when required, the panel has developed a wider approach to reviewing cases where the threshold for a SAR is not met but there may still be opportunities for learning. The process for sharing the learning from reviews has been enhanced with the use of learning bulletins, practitioner events and case study templates.

Across the partners, recruitment and retention continues to be a challenge both in terms of actual numbers of staff and the appropriate skills mix. Senior managers need to continue to give attention to creative recruitment, retention and commissioning strategies and consider how competitive renumeration packages in neighbouring areas and other employment sectors affect retention.

Attendance across the working groups of the SAB has improved over the last year although some areas continue to be inconsistent. However, in the context of the resource constraints facing agencies I am pleased to report considerable support across the system for the work of the Board and the significant additional development work arising out of the safeguarding review.

Finally, I would like to thank Board members, members of the subgroups and the Board staff for their commitment and hard work over the last year and to thank all those practitioners, in all agencies, who give of their best every day to safeguard vulnerable adults in Suffolk.

Independent Chair

2. The Suffolk Context

2.1 Our Vision for Adult Safeguarding

Our vision remains unchanged and aims for Suffolk being a place where adults at risk of harm can live an independent life free from harm where:

- Abuse is not tolerated
- Everyone works together to prevent abuse.
- Services respond effectively when abuse is suspected or happens.

The priorities of the 2017/20 strategy are to help partner organisations to:

- Prevent abuse.
- Protect abused people.
- Make safeguarding personal.

The Board will do this by:

- Helping organisations work together.
- Mobilising community resources.
- Listening to users, carers and the public.
- Publishing what we are doing.
- Holding the Safeguarding Board and its members to account.
- Encouraging learning from when things go wrong, other areas and new developments.

Key Principles of Safeguarding

The Care Act sets out six principles which should inform and guide the ways in which professionals and other staff work with adults. We have adopted and tailored them to meet the needs of people in Suffolk and summarised how we want them to be applied locally.

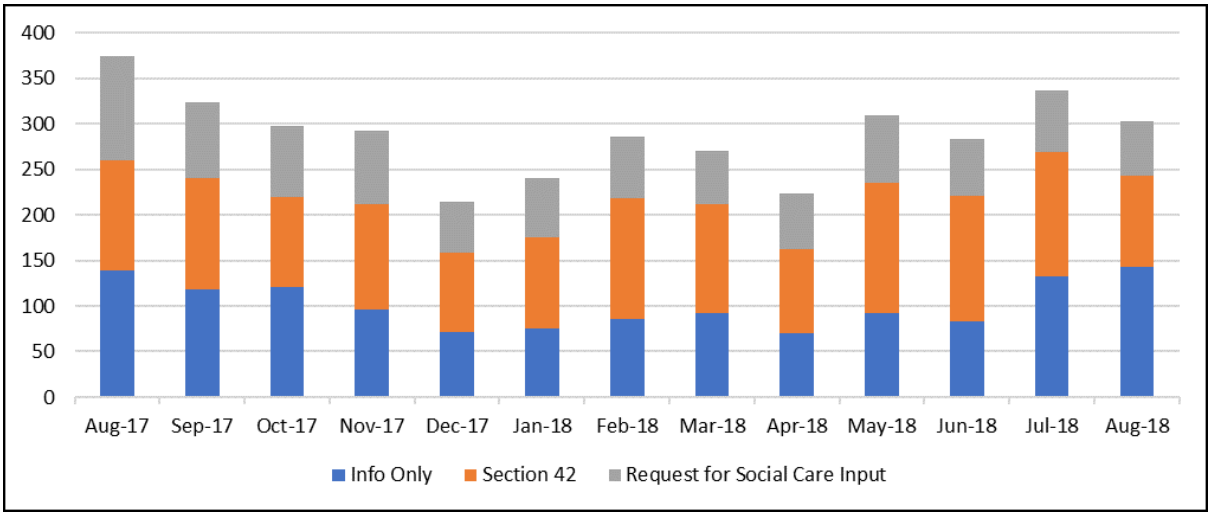
1. **Empowerment** - People being supported and encouraged to make their own decisions and informed consent.
2. **Prevention** - It is better to act before harm occurs.
3. **Proportionality** - The least intrusive response appropriate to the risk prevented.
4. **Protection** - Support and representation for those in greatest need.
5. **Partnership** - Local solutions through services working with communities. Communities have a part to play in preventing, detecting, and reporting abuse.
6. **Accountability** - Accountability and transparency in delivering safeguarding.

2.2 Summary of Adult Protection Statistics

2.2.1 Total contacts broken down by month with the outcomes of the contact

Month	Section 42 Enquiry	Request for Social Care Input	Information only given	No further action after contact	Total number of contacts rec'd in the MASH*
Aug-17	121 (25%)	115	139	110	**485**
Sep-17	123 (28%)	83	118	111	**435**
Oct-17	99 (22%)	78	121	144	**442**
Nov-17	116 (29%)	80	96	108	**400**
Dec-17	87 (26%)	56	72	119	**334**
Jan-18	101(24%)	65	75	173	**414**
Feb-18	133 (30%)	67	86	154	**440**
Mar-18	120 (28%)	59	92	162	**433**
Apr-18	92 (27%)	61	70	118	**341**
May-18	143 (37%)	74	92	69	**378**
Jun-18	138 (34%)	63	83	119	**403**
Jul-18	137 (33%)	68	132	80	**417**
Aug-18	100 (26%)	60	143	84	**387**
Average contacts per month over 12 months to August **Average conversion rate to Section 42** (last year's annual report figures in brackets)					**402 (457)** **28% (26%)**

***MASH – Multi Agency Safeguarding Hub**



The Multi-Agency Safeguarding Hub (MASH) continue to focus on 'Making Safeguarding Personal' which has an impact on the time referrals are awaiting MASH outcomes. They continue to balance timeliness with contacting customers but have richer discussions which enable effective signposting and establishing alternative solutions.

Monthly contact volume for the past 12 months is consistent with a gradual average decrease in the number of contacts which is a result of increased use of the Professional Consultation Line. However, the work is more complex, with increases in volume for Domestic Abuse, Self-Neglect, and Hoarding and Cuckooing (where someone's house is taken over against their will for the purpose of selling drugs).

The average number of contacts per month has dropped by 12% from 457 to 402 per month. This can be attributed to increased use of the Professional Consultation Line.

The volume of contacts that do not require information sharing has is gradually reducing which reflects better quality referrals and quality assurance from colleagues in Customer First. This is good news and as a result of focused work over the past 12 months.

The % of contacts resulting in Section 42 enquiries has increased by 2% from 26% to 28% on average over the past 12 months. This indicates a wider awareness of complex safeguarding issues as mentioned above.

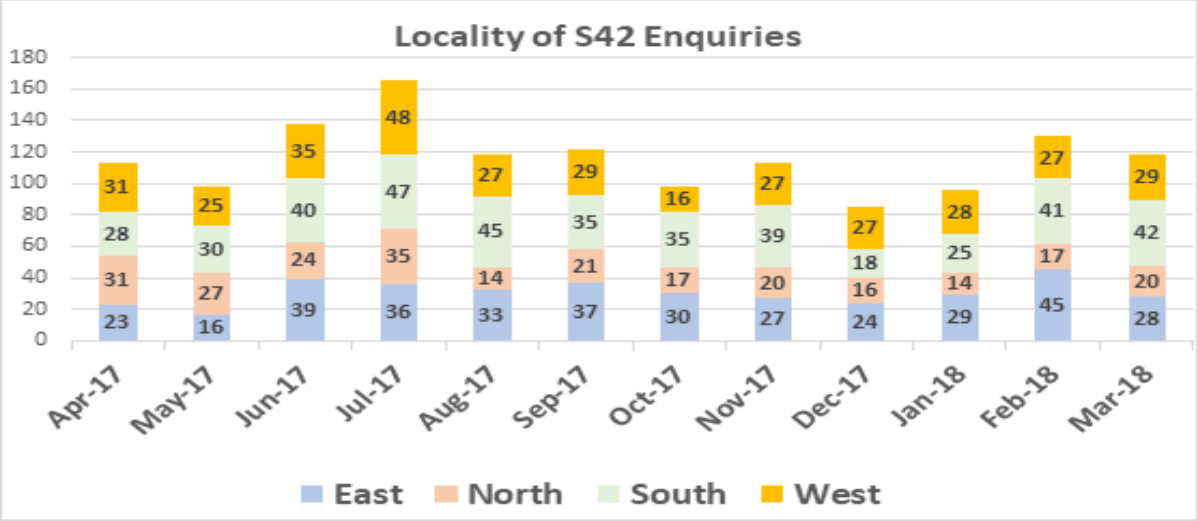
2.2.2 The number of referrals to Adult Social Care that resulted in another repeat referral within 2 years.

	Total Number of referrals	% Re Referral Rate
Apr-17	410	51%
May-17	457	51%
Jun-17	523	50%
Jul-17	558	39%
Aug-17	485	39%
Sep-17	435	42%
Oct-17	442	42%
Nov-17	400	47%
Dec-17	334	35%
Jan-18	414	41%
Feb-18	440	32%
Mar-18	433	40%
Apr-18	341	34%

Repeat referral data has only been collected since the beginning of 2017, so this is the first time the Board have a full year's data. This is an area that the Board was concerned about and led to a thematic audit of re-referrals in Autumn 2017.

This identified several areas for improvement, such as more appropriate assessment of initial risk and application of thresholds. This will improve with the implementation of the new threshold guidance in Autumn 2018. The figures for re-referrals show a gradual decrease in the number in the last 6 months which is good news.

2.2.3 Locality of Safeguarding Investigations (Sec.42 Enquires)



This table shows the number of contacts received in the Multi-Agency Safeguarding Hub (MASH) that have resulted in a Section 42 enquiry broken down by area. There continues to be a relatively even spread across the 4 areas and reflects a similar spread in the previous 12 months.

2.2.4 Risk type and where the risks took place

Type of Abuse or Risk	Care Home	Hospital	Other	Own Home	Service within the community
Discriminatory Abuse	2	1		3	4
Domestic Abuse	5		11	82	4
Financial and material	49	2	41	161	22
Modern Slavery			2		
Neglect and acts of omission	205	8	12	120	17
Organisation abuse	36	5	5	4	3
Physical	103	105	35	142	23
Psychological	22	12	24	86	9
Sexual including Sexual Exploitation	39	9	79	81	32
Other	23	2	237	41	10
Grand Total	**484**	**144**	**446**	**720**	**124**

The figures above reflect the previous 12 months data with the majority of risks being identified within the home. The Board would expect to see an increase in Modern Slavery referrals in the next 12 months with the introduction of national awareness raising materials.

2.2.5 Section 42 enquiries broken down by Age group and Gender

Age/Gender 2017/18						
Classification	**18-64**	**65-74**	**75-84**	**85-94**	**95+**	**Age Unknown**
Customers	743 (533)	116 (153)	223 (286)	271 (379)	37 (80)	39 (65)

The data in the table above shows us the proportion of Section 42 enquiries that have been undertaken by age group. There has been an increase in the number of Section 42 enquiries in the 18-64 age group, which is not a concern and it is by far the largest demographic group.

	2014/15	**2015/16**	**2016/17**	**2017/18**
Male	34%	35%	39%	36%
Female	61%	60%	58%	60%
Gender Unknown	5%	5%	4%	4%

The table above tells us that the majority of safeguarding concerns are for females. This is expected and reflects the demographic of elderly females in Suffolk.

2.2.6 Location of abuse vs conclusion and outcome

This table shows us where the abuse took place and the outcome. There is a decrease in the % of fully substantiated from last year which was 31%. This is positive as it shows us that the fully substantiated cases of abuse have fallen by 8% over the past 12 months.

Conclusion	**Care Home**	**Hospital**	**Other**	**Own Home**	**Service within the community**	**Grand Total**
1 - Substantiated - fully	25.62%	50.69%	8.97%	24.31%	22.58%	23% (31%)
2 - Substantiated - partly	17.98%	10.42%	8.97%	18.33%	6.45%	15% (15%)
3 - Inconclusive	22.31%	6.94%	32.06%	26.94%	29.84%	25% (21%)
4 - Not substantiated	29.75%	26.39%	30.94%	16.94%	28.23%	25% (24%)
5 - Investigation ceased at individuals request	4.34%	5.56%	19.06%	13.47%	12.90%	12% (9%)

2.2.7 The recorded outcomes of risks

Risk Outcomes	2015-16	2016/17	2017/18
1. Action taken - risk continues	6%	4%	0%
2. Action taken - risk reduced	48%	49%	63%
3. Action taken - risk removed	16%	15%	9%
4. No safeguarding action taken	29%	32%	28%

The above data shows us that the risk reduced in 63% of cases where outcomes are recorded, which is significant progress on the previous year's figure of 49%.

2.2.8 Making Safeguarding Personal

When dealing with Section 42 enquiries, practitioners ensure that they are Making Safeguarding Personal. Customers are asked "has the customers desired outcome been met?".

Recording showed that:

- 51 % Fully achieved
- 15% Partly achieved
- 10% ongoing
- 9% not achieved
- 15% not recorded

3. What we have achieved in the last 12 months

3.1 Progress against priorities and outcomes 2017/18

The Safeguarding Adult Board (SAB) priorities for 2017/18 were:

1. The SAB will conduct an independent review of Safeguarding Services in Suffolk acknowledging that the Board has been a statutory body for 2 years and that a review of Safeguarding priorities would give clarity to Safeguarding Services and partnership working.
2. The SAB will implement a Self-Neglect Strategy and operational procedures in Suffolk.
3. The SAB will support and seek assurance on the implementation of the Domestic Abuse Strategy.
4. The SAB will receive an annual report assessing the quality of care in care homes in Suffolk and identifying action to raise standards where required (to extend to care provided at home in 2017/18).
5. The SAB will collect feedback from service users, carers, and families to assess the impact of safeguarding enquiries.
6. The SAB will implement the Making Safeguarding Personal toolkit for the Board and its partners.

Progress against these priorities is detailed below.

3.2 Independent Review of Safeguarding Services

The Safeguarding Adults Board commissioned an Independent Review which was undertaken in 2017 to examine how effectively safeguarding services to and for vulnerable adults and older people were being provided and managed. The review focussed on how the whole system worked together. It was not a review of individual cases, specific organisations or professionals.

The focus of the review was to identify what needed to be changed to ensure that vulnerable adults and older people in Suffolk received the best possible services and outcomes when in need of, or the subject of safeguarding services. The review findings were as follows:

What is working well?

- Some outstanding pieces of casework, and some good, innovative and caring practice.
- Everyone who contributed cared strongly about the vulnerable adults and older people they were there to protect.
- No one was identified as being at risk of significant harm.
- Frontline practitioners are dedicated, hard-working and doing their best despite weaknesses in the way the system is governed, led and delivered.

What are we worried about?

- The skills of frontline staff in all agencies were recognised but were not always best utilised when considering safeguarding issues.
- Weight is not always placed equally on the frontline's understanding of how to best promote health and wellbeing for individuals and minimise the need for statutory interventions.
- The overarching "system" (the way in which key agencies work together) is not working well and the focus is not always on the right things.
- Collective system governance arrangements are unclear, roles and responsibilities are often misunderstood.

- Decisions are sometimes contested so inter-agency disputes are increasing.
- Some of the reasons for the difficulties are linked to the impact of an increasingly adversarial culture across agencies.
- Silo behaviour is the norm, the skills of respective professionals are not fully recognised or acknowledged, and relationships are in some areas, strained.
- There needs to be shared and "owned" policies, procedures, systems and frameworks for responding to concerns, that everyone uses regardless of their professional background.
- When professionals disagree there needs to be shared rules for dealing with those disagreements.

What needs to happen next?

A Transformation Manager has been appointed and is leading the delivery of a multi-agency action plan by January 2019 which aims to:

- **Develop joint communication systems and processes that ensure clear common strategic leadership messages are disseminated and received across the partnership.**

  Progress – The SAB website has been redeveloped, a newsletter and transformation plan updates widely distributed across the partnership.

- **Map out current governance and agree a system-wide multi-agency governance and partnership framework for safeguarding adults.**

  Progress – The SAB Governance framework and structure is being redeveloped alongside Children's Safeguarding as part of the Suffolk Multi-Agency Safeguarding Arrangements. This will be presented to Board in September 2018 and finalised early in 2019.

- **Develop a shared workforce development and learning programme for key personnel leading safeguarding across Suffolk from Suffolk County Council, Health and Police. A two-day training event will be held in October 2018**.

  Progress – A 2-day leadership development event will take place in October 2018 including senior leaders and managers from the strategic partners.

- **Develop and agree a local Suffolk Multi-Agency Safeguarding Adults Policy and Guidance which will set out how local agencies will work together. This will have Making Safeguarding Personal underpinning all aspects of Policy.**

  Progress – Work is underway revising the policy guidance. This will be presented to partners and consulted on in the Autumn 2018.

- **Develop a framework for identifying, assessing and responding to on-going management of safeguarding concerns alongside a serious incident framework and managing allegations against professional's policy.**

  Progress – The revised SAB thresholds document, professional disputes and safeguarding frameworks are under development and being widely consulted on.

- **Disseminate and implement the new local Suffolk Multi-Agency Safeguarding Adults Policy and Guidance and information sharing protocol.**

  Progress – Work has yet to commence and is scheduled for late 2018.

- **Develop shared metrics and performance data and a multi-agency QA system/ improvement cycle**.

  Progress – The new SAB performance framework has been developed and implemented from September 2018. This will form part of the new performance report and evaluation for the Annual Report in 2019.

3.3 Self-Neglect Strategy and Operational Procedures

In October 2017, the Safeguarding Adults Board launched the multi-agency Self-Neglect and Hoarding policy, professional guidance and risk assessment. The policy includes key information and guidance for practitioners who are concerned about an adult who is at risk of self-neglect and hoarding and allows the opportunity to explore measures to support the customer.

The risk assessment considers all key aspects of risks associated with the individual's living environment as well as their physical health needs. Professionals report that they find the risk assessment tool enables them to effectively inform the case conference.

Here is a link to the documentation:

https://www.suffolkas.org/working-with-adults/policies-and-procedures/

What is working well?

- The referral pathway encourages a multi-disciplinary approach from the outset with the introduction of case conferencing and in cases of greatest concern, a High-Risk Panel attended by senior officers.
- The tools ensure the customer is included throughout the process and in all decision making, this is in line with Making Safeguarding Personal.
- Adult and Community Services began capturing data for self-neglect and hoarding during October 2017, therefore a full year report is not available. However, since October 2017 referrals increased steadily with a total of 48 received up to June 2018.
- Of the 48 referrals, 22 proceeded to a multi-agency case conference with the remaining 26 being supported through social work intervention. Importantly, in all 48 referrals the risk level did not increase. Of the 22 which proceeded to case conference, 9 were assessed as the risk being reduced following the multi-agency approach and 3 were referred to the High-Risk Panel due to the identification of potential 'blocker's which may be a barrier to reducing risk to the adult.
- The High-Risk Panel is in the early stages of development, but early indications show success in achieving its aim of identifying and overcoming barriers to successful interventions.

What are we worried about?

- Whilst referral numbers continue to grow, further work needs to be carried out on analysing their quality and eligibility to ensure we receive good quality information which indicates the referrer has utilised the multi-agency risk assessment.
- A focussed case audit should include cases of concern and risk of self-neglect and hoarding which will enable a full evaluation of the effectiveness of the policy and risk assessment to maximise our learning and plan responses accordingly; however, most importantly, an evaluation of customer experience will inform how we engage with adults when there are concerns of high risk.

What needs to happen next?

- A full day SAB Self-Neglect and Hoarding Conference looking at the learning from Safeguarding Adult Reviews will be held on 6th November 2018.
- This will raise awareness of the resources available to support practitioners and embed the learning from the recent safeguarding adult reviews which have come about as a result of self-neglect.

3.4 Implementation of the Domestic Abuse Strategy

The Suffolk Domestic Abuse Strategy, now called Suffolk Violence Against Woman and Girls, Men and Boys (VAWGMB) Strategy has developed significantly over the past 12 months.

Self-assessment work was undertaken in Suffolk during 2017. This matched service provision against the Home Office National Statement of Expectations and identified a number of areas for improvement. These included work with perpetrators and more proactive work with hard to reach communities. These are included in the VAWGMB action plan.

This year Suffolk Constabulary published the Domestic Abuse Delivery Plan under the four themes of:

Governance - Ensure robust senior management oversight of Domestic Abuse service delivery and explore opportunities for sustainable service improvement solutions involving partners.

Performance - Develop a comprehensive understanding of data sources relevant to Domestic Abuse and ensure that service delivery is focussed in line with detailed analysis findings and evidence-based conclusion.

Communication/Awareness - Develop effective methods of engaging with victims, the wider public, perpetrators and our staff, in relation to Domestic Abuse. Ensure focus on awareness raising, public services available, lessons learned and how to deliver effective 'Victim Focussed' policing.

Local Delivery - Ensuring that local managers have a thorough understanding of Domestic Abuse service delivery in their business area and that they are leading their teams towards excellence in relation to victim focus and investigative standards.

In the period, 9,707 domestic-related crimes and incidents were recorded in Suffolk. During that time, there were 26 Domestic Violence Protection Notice/Order (DVPN/DVPOs) applied for by officers, following which 22 DVPOs were granted by the magistrate.

Use of DVPN/DVPO has been an area of significant review and growth for the Constabulary during the last year. Further work is anticipated in the forthcoming year to further embed the use of DVPN/DVPO across the organisation aim being to increase the number of applications across the Constabulary making DVPN use a valuable additional option at the forefront of officer thinking when dealing with Domestic Abuse perpetrators.

What is working well?

- 23 specialist satellite refuge beds are now established across Suffolk. This provides sanctuary for victims fleeing domestic abuse who are not able to access refuge due to complex needs around mental health or substance dependency. In addition, funding has been secured from the Migrant Mitigation Fund, working alongside Norfolk County Council, to provide more extra refuge for victims with no recourse to public funds alongside immigration advice and support.

- Funding has been pooled by partners across Suffolk to develop a countywide process for securing the homes of high risk victims of domestic abuse. The national charity Safe Partnership are now providing a service where they conduct a crime reduction and fire risk survey, gain landlord permissions, undertake any security and arson reduction measures all in one visit and within 24 hours of referral.
- A programme of Multi-Agency Domestic Abuse training has been developed. This includes workshops on Female Genital Mutilation, Honour Based Violence and Modern Day Slavery. Over 150 practitioners across Suffolk have been trained in the dynamics of domestic abuse including risk assessing and safety planning. Domestic Abuse Matters training was rolled out across the Constabulary, focussing on best practice in 2017/18.

- Funding has been agreed to establish a Domestic Abuse 'Champions Network' which will see a long term, sustainable solution to training which goes much wider than trusted professionals who champion Domestic Abuse as part of their paid role.
- In the past year Suffolk Constabulary have revised the way in which they undertake the secondary risk assessment process for Domestic Abuse. The new process has moved towards a professional judgement-based approach using experienced officers to fully consider each case on its individual merits creating bespoke consideration. This has improved both quality and efficiency in this area and initial review and audit work has shown the change to be both accurate and positive managing risk appropriately and making sure that ongoing support is used appropriately.

What are we worried about?

- The 2017 Constabulary strategic assessment identified that Domestic Abuse (DA) is one of the highest threats as it is generally considered an under-reported area. Furthermore, there are Constabulary internal and external measures in place aiming to increase and improve DA reporting, thus driving up demand further.
- The total number of DA crime records have increased by 39.4% comparing 2017 with 2014, and the increases have only been experienced in violence against person (VAP) offences. There has been no sign of VAP levels stabilising so large percentage increases are expected to continue.
- The high number of cases referred to MARAC (Multi-Agency Risk Assessment Conferences) remains a concern across both safeguarding boards. The strategic MARAC group is reviewing the current processes. Several new MARAC chairs have been identified and trained. The MARAC case backlog has been removed and a revised risk assessment process is in place to ensure that only appropriate cases reach MARAC.

What needs to happen next?

- The Board will continue to receive updates on the VAWGMB strategy and look for assurances that the strategy is having an impact and reducing the levels of domestic abuse. We will also monitor the progress of the MARAC strategic group which is looking to improve the quality of referrals.
- Suffolk County Council and the Police and Crime Commissioner have agreed to work together to commission the Domestic Abuse Outreach Service and the Independent Domestic Violence Advisor Service which will commence following the conclusion of the current services in September 2018.

3.5 Quality and Safety of Care Homes in Suffolk

The Board received the annual report June 2017, the main points are as follows:

The chart below summarises the number of registered homes in Suffolk during 2016/17. Of these services 60 (92.3%) nursing homes and 114 (87%) care homes have had a CQC inspection.

196 CQC Registered Homes	65 Nursing	131 Residential
7079 Beds	3498 Beds	3581 Beds

The largest 10 providers operate 43% of the available beds, 78% of providers operate just 1 home in Suffolk.

Since major changes in the CQC inspection process in October 2014, CQC have based their inspection regime on risk ratings. This enables them to prioritise inspection of the locations of most concern.

What is working well?

- The process is now complete, and most homes have a published rating. As a result, Suffolk are seeing a greater number of services rated as 'Good' and 'Outstanding'. The CQC acknowledge that the new, more robust inspection regime makes it more difficult for providers to move from 'Inadequate' to 'Good'.

Of the 90% of services currently rated in Suffolk	73 % are rated as Good or Outstanding	27 % are rated as Requires Improvement (note - this figure has decreased to 18% in the 2018 report, which is good news)

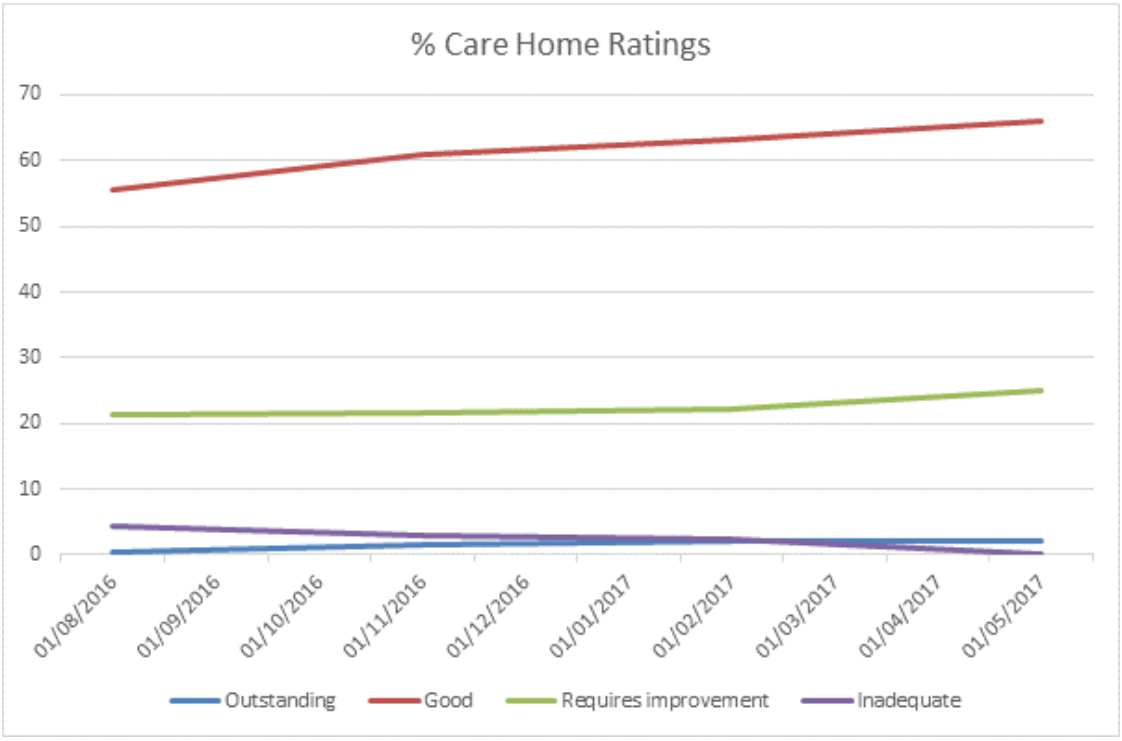
- There have been 105 CQC follow up inspections, following which 27 have improved, 22 have retained the same rating, 1 has received a lower rating (Requires Improvement to inadequate).
- The 2 services that were rated Inadequate at 2 consecutive inspections have subsequently closed due to being unable to improve.

CQC look at 5 Key Lines of Enquiry (KLOE) when inspecting services. The table below shows how services have performed at re-inspection against each of the KLOEs.

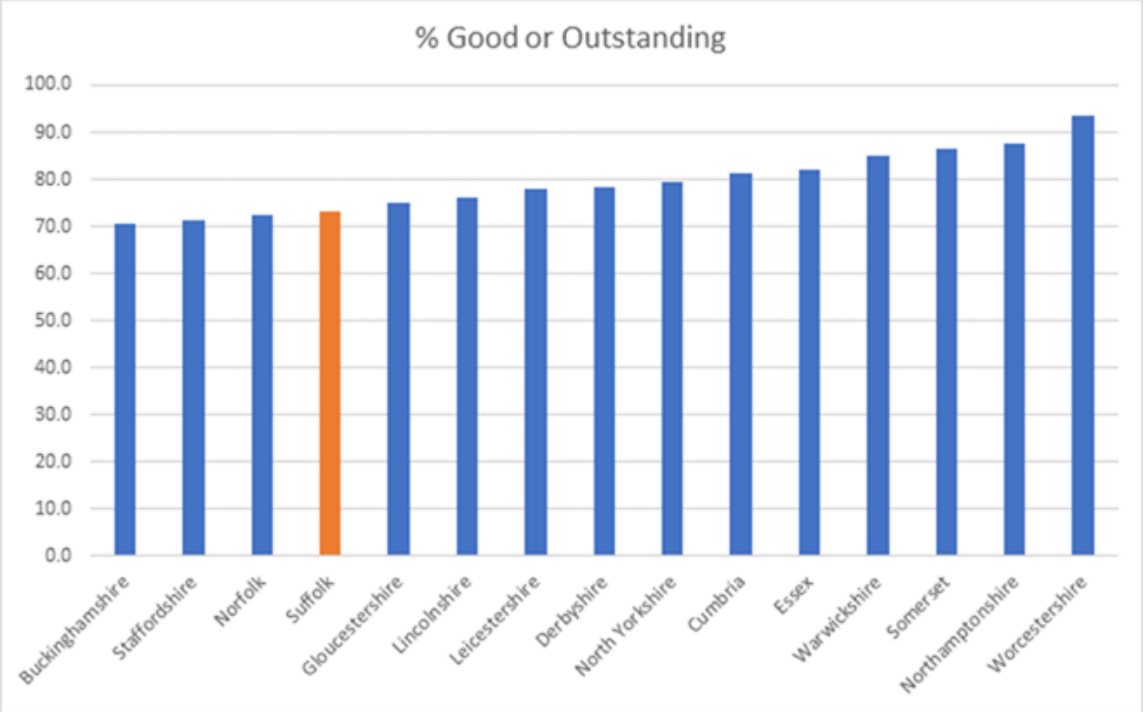
	Overall	**Safe**	**Effective**	**Responsive**	**Caring**	**Well led**
No change	6	22	33	27	32	21
Improved	27	24	16	20	13	26
Lower rating	1	4	1	3	5	3

The table below show a breakdown of the CQC rating.

Rating Before / After	Nursing homes	Residential homes	Grand Total
Good to Good		3	3
Good to No Published Rating		4	4
Good to Outstanding		1	1
Inadequate to Inadequate	2		2
Inadequate to Requires improvement	4	6	10
No Published Rating to Good	6	23	29
No Published Rating to Inadequate	1		1
No Published Rating to No Published Rating		1	1
No Published Rating to Outstanding		2	2
No Published Rating to Requires improvement	2	12	14
Requires Improvement to Good	10	6	16
Requires Improvement to Inadequate	1		1
Requires improvement to No Published Rating		4	4
Requires improvement to Requires improvement	7	10	17
Grand Total	**33**	**72**	**105**



- National benchmarking is difficult due to geographic and demographic differences and the diverse nature of regional care markets, for example some Local Authorities exclusively contract with a small number of large national providers, enabling them to closely manage contract compliance.
- Suffolk County Council has contracts with a wide variety of care providers, ranging from large national providers through to small to medium enterprises. This diverse market has many benefits and offers real choice to the people of Suffolk. However, each section of the market experiences different challenges, requiring different models of contract management and/or support from the Local Authority.



Suffolk currently has a much higher than average number of providers with no published ratings, lowering the position of Suffolk in national benchmarking.

What are we worried about?

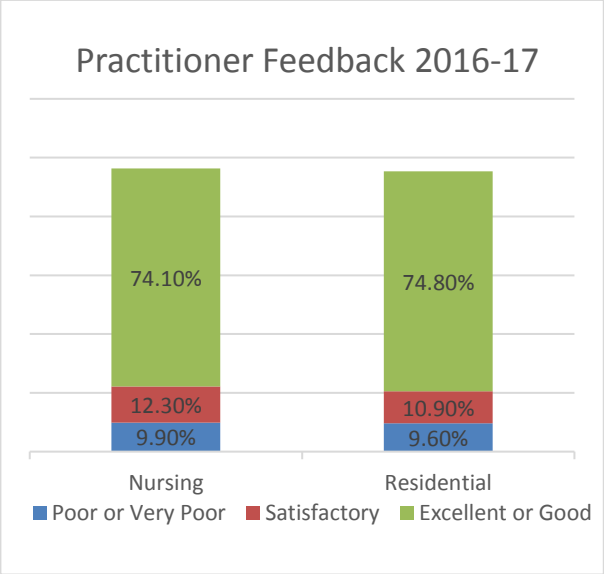
- There is tentative evidence locally and nationally of a correlation between bed price in homes and quality as represented by CQC ratings, a concern echoed by Suffolk Association of Independent Care Providers (SAICP). However, it is not possible to demonstrate a causal link. Whilst higher prices may support the delivery of better quality care, it does not follow that increasing prices will automatically influence the quality of care. Pricing, along with factors such as good management and high calibre workforce, all play complex and inter-linked roles in influencing the quality of care received by service users and failing homes can often be turned around by effective leadership rather than extra funding.
- 10% of services do not currently have a rating, either because they are new services, have changed owners, or have changed their legal entity – causing re-registration.

What needs to happen next?

The Board will monitor progress in the 2018 report against the figures above. We will be looking for improvements in CQC ratings and identifying areas which are of concern.

3.6 Feedback from service users, carers, and families

At their annual review, people living in residential and nursing homes are asked to give feedback on the care they receive. When people report concerns about the service they are receiving, this is raised at the time with the provider. Practitioners can also complete a Professional's Experience Report to give their feedback on a service. This feedback is collated and shared at Provider Performance Panel meetings and form part of the process of identifying themes and trends at individual homes, with actions agreed as appropriate.



'My Care at Home' research, carried out by Healthwatch Suffolk (HWS) and commissioned by Suffolk County Council (SCC), provided an overview of service user and family carer experience of home care services in Suffolk. The project was designed in two phases and started in November 2017.

Healthwatch Suffolk recognises that conducting such a survey during a winter period, and in particular a winter that had a distinct impact on rural health and care systems nationally, could be reflected in some of the survey and interview responses. Service users and their family members were initially contacted through a scoping survey, which was mainly distributed by SCC to a random selection of [2,164] service users of council funded care. Surveys were received from 517 service users, family members and friends, involving 76 different care providers, including both private providers and council funded care services.

Phase two of the research consisted of 50 in-depth qualitative semi-structured interviews involving 72 service users and/or their family members. These explored service user's experience of care in more detail. Every effort was made to interview service users from different localities and involving a wide range of care providers.

What is working well?

- There was generally high satisfaction with the care received.
- This research into home care was wide-ranging and the results and recommendations highlight the strengths and weaknesses in the home care system as experienced by the service user. Where consistent care is provided, and service users know their carers well and are treated with dignity and respect, they feel real benefit.

What are we worried about?

- Lateness, non-arrival and having too many different carers can cause distress and confusion. Good communication and co-operation between service user and care provider gives confidence and stability to the service user and their families.
- Consistent training in all areas of care also benefits the service user. In a rural county like Suffolk, the difficulties in providing care to all communities are self-evident.

What needs to happen next?

- Healthwatch gave 15 recommendations that build on the aspects of home care which are already satisfactory and address shortcomings for the benefit of all those concerned.
- User involvement and feedback is an area for development for the Board in 2018-19 and has been identified as a priority. The Safeguarding Adult Board will be considering a User Involvement Strategy developed by Healthwatch colleagues in September 2018.

3.7 Making Safeguarding Personal

A focus of a SAB Board meeting in September 2017 was Making Safeguarding Personal (MSP). Each partner agency identified specific actions to ensure MSP was embedded in practice. Some of these include:

- De-formalise safeguarding processes where appropriate.
- Empower and help individuals to manage risks.
- Start to encompass six principals in practice and recording.
- Use of effective and considered advocacy.
- To ensure safeguarding training reflects Making Safeguarding Personal Principles.
- To ensure that Adult Safeguarding Policy incorporates Making Safeguarding Personal.
- Organisational assurance to ensure that Making Safeguarding Personal is incorporated in strategic polices.
- Adult and Community Services (ACS) ensure Making Safeguarding Personal is “golden thread” in new care management system.

On 27 March 2018, the **‘21st Century Adult Care in Suffolk: an integrated approach’** conference took place at University of Suffolk, Waterfront Building, Ipswich. This event was organised in partnership by Adult and Community Services, Suffolk Safeguarding Adult Board and the University of Suffolk, who have been very supportive from the beginning of this idea. This proved to be an informative and interactive day that included:

- 21st century social work and social care perspectives.
- Making Safeguarding Personal.
- An integrated approach to better outcomes.
- Supporting Lives, Connecting Communities – a strengths-based approach that promotes good practice.
- Self-neglect and hoarding.
- The role of the Mental Capacity Act in making safeguarding personal.
- Learning Disability Mortality Reviews and our local steps.
- How we can involve more people accessing our services to achieve outstanding outcomes for them and improve practice/services.

The conference was well attended by various professionals from Adult and Community Services, Police, Norfolk & Suffolk Foundation Trust, Health partners that included Clinical Commissioning Groups in Suffolk, housing professionals, care providers, commissioners and many more, who all demonstrated our commitment to working in partnership in a safe, effective, caring, responsible, well-led way.

Delegates shared and recognised more than ever that Making Safeguarding Personal (MSP) requires partnership working and clear commitment to engage with people who may be in need of safeguarding as well as with staff in our organisations. The event, although first for the partners involved, demonstrated that we are committed, in 2018, to working together in Suffolk to support and deliver best outcomes to people in Suffolk, by using an integrated approach that builds on the idea that 21st century requires development of adult social care models of work that meet people's complex needs.

More interactive workshops took place during the afternoon and the participants, across all organisations, explored our current understanding and how our practice looks in MSP alongside 'self-neglect and hoarding workshop that attracted the biggest interest from the participants; the need for better use of Mental Capacity Act 2005 in achieving person-centred approach, as well as how can we best achieve best practice and outstanding outcomes for people in Suffolk by involving them.

Making Safeguarding Personal principles are embedded in the SAB transformation work and form an integral part of the new Thresholds guidance.

4. What we plan to do – Priorities for 2018-19

The SAB will continue its **core business** which is:

- Continue to evaluate the effectiveness of safeguarding provision across the SAB partnership through a range of performance reports and audits.
- Ensure that learning from Safeguarding Adult Reviews and Case Management Reviews is effectively shared, monitored and embedded in practice.
- Effective working across the key strategic Boards, the Safeguarding Children Board, Health and Wellbeing Board, Alliance Boards and Strong and Safe Communities Group.
- Develop a core set of policies and procedures which support front line practice across the partnership.
- Undertake Safeguarding Adult Reviews as required and ensure the learning is shared and informs practice.

Our **specific priorities** are:

- Ensure that the identified improvements for the Safeguarding service review are fully considered and implemented including revised thresholds and risk assessments.
- Ensure that the views of adults at risk of abuse or neglect, their carers and families, influence safeguarding provision across Suffolk.
- Ensure that the effect of Domestic Abuse on adults at risk of abuse or neglect is appropriately identified and addressed through the Domestic Abuse Strategy.
- The SAB will increase public awareness of adult abuse and where to get help.
- The SAB will further develop and implement the Learning and Improvement Strategy and ensure that cross partnership performance data identifies thematic audits and informs learning and risks.

5. Other key agenda items discussed at the Safeguarding Adults Board over the past 12 months

5.1 Mental Capacity and Deprivation of Liberty Safeguards (DoLS) - 2017 / 2018

The DoLS continue to provide statutory safeguards for those customers who are assessed under the scheme. Due to the large number of referrals that continue to be received, it is recognised there is a significant shortfall which exists nationally between those who are protected and those who continue to wait for an assessment to which Suffolk is no exception.

The Mental Capacity Act (MCA) Amendment Bill was introduced to the House of Lords on Tuesday 3 July and seeks to replace the current DoLS system; in doing so the government has now developed a new system, known as 'Liberty Protection Safeguards', which will become law through the Bill.

Further work is planned on reviewing the current response to DoLS referrals with an action plan due to be produced during Autumn 2018. This will address further opportunities in the current system to best meet the service need whilst modernising the system in accordance with the anticipated requirements of the new arrangements.

During 2017/2018 the Suffolk MCA DoLS Team has continued to receive and prioritise DoLS referrals, to assess and to authorise the arrangements on behalf of the local authority, in accordance with these statutory safeguards.

Within the financial year the following number of referrals have been received and assessments undertaken as can be seen within the two tables below;

Table One – DoLS Referrals

	Total Number of DoLS Referrals	Priority 1	Priority 2	Priority 3	Priority 4
01 April 2016 > 31 March 2017	2,510	1,532	345	608	25*
01 April 2017 > 31 March 2018	2,440	1,024	337	517	565

Table Two – Assessments Undertaken and Waiting List

	Total Number of DoLS Assessments Undertaken	Customers Waiting for Assessment	Waiting Time for Priority 1 Referral
01 April 2016 > 31 March 2017	735	1,489	6 months
01 April 2017 > 31 March 2018	635	2,330	4 > 5 Months

Referrals on average, have been received in the region of 200 per month of varying levels of complexity, within the threshold of the understanding of what constitutes a deprivation of liberty.

This has been consistent with the numbers received within previous reporting years and the numbers of customers waiting and the time frame for being assessed are consistence with regional and national comparators.

What is working well?

- Continual Professional Development Sessions including County meetings for Best Interests Assessors (BIAs) and Section 12 doctors.
- Facilitating workshops and development sessions for Adult & Community Service staff to support on-going understanding and compliance of both MCA and DoLS.
- The maintenance of the Suffolk MCA website as a helpful and informative resource for staff, providers, customers and carers - www.suffolk.gov.uk/mca.
- Mental Capacity Audits - throughout the reporting year, the DoLS Team have audited the quality of the Mental Capacity Audits undertaken; the findings informed training sessions and workshops for practitioners.
- Review of the DoLS Prioritisation Tool - to enable a targeted response to be delivered to those customers with the greatest need.

What are we worried about?

- The SAB challenged the time that assessments are taking and the length of the waiting lists and were reassured that the prioritisation tool is appropriately identifying the priority cases.
- The increasing number of referrals received exceeds the number of assessments that can be undertaken month-on-month and continues to cause concern – both in Suffolk and nationally.
- The review of the DoLS Prioritisation Tool has helped target responses to customers of greatest need and has, in turn, reduced the waiting time for assessment, for those customers within the Priority 1 Category.
- Concern exists about the length of time that it will take for the government's replacement scheme to be ready for implementation and the increasing numbers of customers who will, as a result, be waiting to be assessed during this time frame.

What needs to happen next?

Discussions have recently taken place with both the SAB and the Adult & Community Service Directorate Management Team (DMT) to explore the options that are available for:

- Managing the number of DoLS referrals received by the local authority prior to the implementation of the replacement scheme and the increasing numbers of customers who will be waiting as a result.
- Preparing for the implementation of the replacement scheme - to ensure knowledge and processes (including staffing numbers with appropriate training) are in place to enable the local authority and its key partners to be ready for the new government arrangements.

5.2 MASH Annual Report

The SAB received the annual MASH report, which was predominantly children focussed but identified a number of strengths in adult safeguarding. The Board were pleased to note the feedback from Ofsted in 2017 which reported that:

- Thresholds are applied consistently.
- Information is shared appropriately.
- Decision-making is timely.

The volume of contacts that do not require information sharing has reduced by 26% from 2016/17 which reflects better quality referrals and quality assurance from our colleagues in Customer First. However, the number of contacts with the outcome “information only” has increased by 13%; this increase reflects the work undertaken with customers to establish consent and alternative solutions, which also accounts for the increase in social work assessments by 21%.

The number of section 42 (s.42 of the care act) enquiries initiated has reduced by 16% with a conversion rate of 27%. This reflects the continued multi-agency approach to applying thresholds and proportionate responses

5.3 Direct Payments Report

People who are eligible to receive services from Adult & Community Services (ACS) have the option to choose to receive some or all of their services in the form of a Direct Payment. They must sign up to a legal agreement and confirm that they will only use the money in line with what has been agreed with ACS in their care & support plan. The Care Act (2014) requires the Local Authority to carry out a review of Direct Payments within six months of it starting and then at least annually thereafter.

The report from the Customer Rights Team, identified areas for improvement in both the care and financial aspects of Direct Payments in Suffolk and how some have not been carried out in line with the requirements of The Care Act (2014).

It was acknowledged that recent work by the ACS management team sought to address these issues and an implementation plan was put in place to meet the recommendations in the report. The plan includes:

1. New agreed process is to combine financial and care reviews. This includes a ‘risk matrix’ to identify cases which will require more frequent reviews. However, there are concerns about the capacity of the Social Work teams to be able to manage this.
2. Process of panel approval for Direct Payments for people who want to employ a close family member as their carer.
3. New booklets are now routinely given to people interested in Direct Payments, covering both the general aspects of Direct Payments and one specifically aimed at people who want to use their Direct Payment to employ staff.
4. Pre-payment cards for Direct Payments were introduced from January 2018. These will enable ACS to have ‘real-time’ access to how Direct Payments monies are being used.

5.4 Redevelopment of the SAB Website and Newsletter

The SAB website launched in April 2018 makes it more accessible to non-professionals and easier to navigate. It was positively received across the partnership. All the policies and procedures on the website have been reviewed and updated.

The July 2018 website statistics show there were 5000 visits to the SAB website in total during the year April 2017 to March 2018. This is a significant increase on previous year’s figures.

The SAB newsletter was redeveloped and is now distributed electronically. It is more partner focussed and is distributed to over 500 multi-agency partners.

5.5 The Prevent Duty and People Vulnerable to Radicalisation in Suffolk

Suffolk partners work to safeguard and provide support to individuals who have been identified as being at risk of radicalisation through a multi-agency panel called 'Channel'.

Suffolk Channel Panel meeting continues to be held every 4 weeks. They discuss new referrals and manage existing cases for both children and adults. The Panel is recognised by the Home Office in the Eastern Region as being well established and is used as a good practice model.

Common themes from the Channel Panel in the past 12 months:

- Most referrals in Suffolk involve right wing extremism and racism.
- Fear of terrorism and the perceived threat to personal safety is a motivating factor for incidents leading to referral.
- Most referrals are for males aged under 18.
- A disproportionate number of referrals related to people with learning disabilities.

What is working well?

- Established Channel meeting – good multi-agency attendance.
- Good take up of training across the partnership.
- There is engagement with local mosques and faith institutions.
- Intervention providers continue to achieve positive outcomes with those referred to them.

What are we worried about?

- A more efficient process to identify who has undertaken training.
- NHS advice on gaining consent for Prevent referrals is contrary to the advice issued by the Home Office. This has been highlighted to the Home Office and they have agreed to address this nationally.
- Referrals may not be made as referrers are concerned that the threshold is not met.

What needs to happen next?

- The Channel Panel will continue to build on its strengths and further develop its multi-agency partnerships. The SAB will receive annual reports from the Panel.

5.6 HMIC Inspection of Probation Service and Community Rehabilitation Company

The Board received quarterly updates from both organisations on their action plans following their inspections the previous year.

The Board will continue to monitor the progress, particularly with resourcing issues identified to Board in the most recent action plan update.

5.7 Care Quality Commission Inspection report of Norfolk and Suffolk Foundation Trust (NSFT)

The Board received quarterly updates from NSFT Senior Managers. The Board were pleased to note some progress being made but also acknowledged that there are still areas for improvement which are included in the current action plan, including backlogs in care planning and risk assessment.

The Board will continue to monitor progress as this is highlighted on the SAB Risk Register.

5.8 Working with the Voluntary Sector - The first Community Action Suffolk (CAS) Safeguarding Leads Conference 2018

The Safeguarding Adults Board and Safeguarding Children Board were the keynote speakers at the conference and led a multi-agency workshop focussing on self-neglect and hoarding.

Over 30 organisations were represented, and the feedback received was excellent.

Some feedback from participants:

- Very informative quick over view of referrals, more insight into specific areas to gain further knowledge. Excellent presentations and speakers who are professionals in their field.
- Self-neglect and hoarding workshop was invaluable.
- Worthwhile way to spend an afternoon, to network, be updated and informed of current issues.
- Invaluable in terms of knowledge gained and opportunities to network with other agencies, professionals.

5.9 Parish and Town Councillors Safeguarding Conference

The Safeguarding Adults Board and Safeguarding Children Board, in conjunction with Suffolk Association of Local Councils (SALC), Mid Suffolk and Babergh District Council and West Suffolk Borough Council delivered a successful safeguarding conference attended by 21 Parish and Town Councillors.

The Councillors received a comprehensive introduction to safeguarding and presentations on the role of the Multi-Agency Safeguarding Hub (MASH), self-neglect and hoarding and the importance of having a safeguarding lead and a safeguarding policy. 85% of participants rated the quality and content of the conference as 'Excellent' or 'Good'. Evaluation forms show that participants were much clearer about their role, the signs and symptoms of abuse and neglect, and how to make a referral.

5.10 The Learning Disability Mortality Review (LeDer) Programme in Suffolk

Learning Disability Mortality Reviews are part of a national programme whereby Suffolk can identify any barriers or inequalities in health and/or social care provision which may have contributed to the premature deaths of local people who have a learning disability. The reviews will identify learning that can be taken forward and utilised to improve multi-agency local services.

The implementation of the LeDeR programme across Suffolk was reviewed in December 2017. This followed low numbers of referrals to the programme and difficulties in improving LeDeR learning across the health and social care economy 2017/18.

- Two new Local Area Coordinators were trained in January 2018; the Designated Nurse for Safeguarding Adults to lead and facilitate the programme in Suffolk and the Deputy Chief Nurse to have oversight of the LeDeR Programme and its development.
- A Communications programme was implemented in March/April 2018 and has been successful in engaging professionals across health and social care in the programme work streams and/or referring learning disability deaths to the programme.
- A multi-agency LeDeR Steering Group was set up and continues to meet monthly. A learning action plan has been developed and the Steering Group is working hard to implement and take forward national learning which is relevant to Suffolk services.
- The Steering Group is accountable to the LSCB, SAB, Transforming Care Board and the Learning Disability (LD) Partnership Board

- A Reviewer recruitment programme commenced early 2018 resulting in the training of 8 reviewers in Suffolk, with a further 10 to 12 reviewers to be trained later this year. The Clinical Commissioning Groups (CCGs) additionally recruited a Named Nurse to lead on setting up and monitoring the review process and supporting services in implementing the learning from local/national LeDeR Reviews. Reviewers meetings take place monthly.
- A LeDeR Engagement Group will be set up Autumn 2018. This meeting will be an opportunity for local families, people with learning disabilities and the LD Partnership Board to be involved in the LeDeR work streams across Suffolk. It is yet to be decided how frequently this group will meet.

The number of reviews for Suffolk continues to grow. Work is underway to recruit even more reviewers following the LeDeR programme's research. Expectation is that Suffolk will expect 50 + learning disability deaths within the next year. NHS England have indicated an expectation area will achieve completion of 90% of local reviews by end of December 2018 and will continue to maintain this level of achievement during 2019. To date Suffolk have received 26 reviews. 11 of these reviews are in progress or completed and 15 waiting to be allocated.

Learning currently in progress includes:

- Developing a tool to audit effectiveness of the bowel passports across NHS Provider Services, Primary Care and Social Care. The review of this document will support good and consistent bowel monitoring care across all services.
- Progressing "Understanding Learning Disabilities (LD)" to be part of all Suffolk organisation's mandatory training and developing a local multi-agency e-learning package.
- Working with the Safeguarding Adults Board in progressing multi-agency services completion of regular internal MCA audits.

6.Subgroup Highlights

6.1 Safeguarding Adult Review Advisory Panel (SARAP)

Key activity during 2017 -18	• 7 new cases were reviewed by the panel in the 12 months to April 2018. • Two cases (M and A) resulted in a Serious Adult Review (SAR). • The M review was completed in November and the action plan is being monitored with particular focus on agencies awareness on environmental fire risk assessments. • A is ongoing and due to be published in October 2018. This case focusses on self-neglect and hoarding. • The T case resulted in a multi-agency partnership review focussing on Executive Decision making and unwise choices. The learning has been shared across the partnership. • Two cases are awaiting further information before a decision can be made. • One case resulted in a serious incident review by NSFT and the seeking of further assurances from the group. • One case resulted in no further action. • The J Action Plan continues to be monitored with particular focus on agencies awareness of unwise decision making and awareness in reporting concerns of self-neglect. • The individual agency action plans from the published SARs in relation to J and A were reviewed.
Reviews and learning events	• A multi-agency practitioner learning event was held to discuss the learning from concerns relating to an adult at risk of self-neglect which has formed a strong case study to inform future training programmes. • Signs of safety methodology has been used to good effect on cases. • The SARAP worked with the Domestic Homicide Review Panel to undertake a joint learning review to explore learning opportunities in the case of an adult who died. • A multi-agency conference focussing on self-neglect and hoarding will be held for 150 practitioners in November 2018.

Additional activity	• Pertinent national SAR's have been discussed including SAR's from neighbouring authorities where shared learning is evident. •Learning from relevant Serious Incident Reviews have been discussed where it is felt the SARAP may contribute to the activities within the action plan or where learning may be reflected across the partnership. •The referral process, Terms of Reference and SARAP Policy have been reviewed. •The LeDeR Programme continues to be discussed at the SARAP including learning from the LeDeR enquiries and relevant actions taken. •Joint work is scheduled with Norfolk colleagues to share good practice, policies and protocols.
Outcomes learning from reviews over the past 12 months.	•Greater understanding of the need for effective fire risk assessment, particularly for non-mobile people. •The impact of executive capacity and its effect on decision making following the T case review. •The importance of effective care assessments and planning on hospital discharge following the M review. •The signs of safety partnership review model has been further developed to gather multi-agency learning from cases within a short timescale with minimal cost. •Easy read case study templates have been developed to inform learning across the partnership - See example on the next page.

‘T’ Case Study – Self-Neglect and Hoarding

T’s Story.

T lived alone with his dog, in a Council owned property for over 40 years.

He had a serious long-term health condition which was gradually worsening and severely affected his health and mobility. The condition of T’s property gradually deteriorated as his health diminished, to a point where it was described as unfit for human habitation.

T had close family locally who helped when they could, but the magnitude of the situation was beyond what they were able to resolve. T’s sister lived thousands of miles away but phoned weekly, and a neighbour helped as much as she could. T was not receiving Social Care Services until 3 years before his death, although he first came to their attention nearly 20 years ago.

T’s dog caused issues because he fouled inside the property. Social Workers felt that the environment was beyond cleaning, so the focus was on rehousing, but this was taking time as no suitable properties accepting T and his dog could be found. Other options were being explored to rehome the dog towards the end of T’s life.

Housing officers worked closely with T over a lengthy period and often felt frustrated about not being able to improve outcomes for him. They were aware that he had mental capacity and was entitled to make his own decisions and live how he chose.

They expressed concerns that the winter months were approaching, and T had no heating or hot water. T was a proud independent man who often overstated what he could do, including saying he would go to the shops to buy a heater during the winter, but he was physically unable to achieve this. He was banned from many shops in the local town due to his unkempt condition.

T died of natural causes at home, contributed to by self-neglect and poor housing aged in his mid-60s.

The coroner stated that T made lifestyle choices; he was reclusive but independent and had mental capacity, so his decisions could not be legally overridden.

The coroner also stated that there was a balance between what made T happy and what made him safe. He felt that those intervening did all they could to help him.

What went well?

- Generally, there was good communications between Adult Services, Housing and Environmental Health colleagues.
- His neighbour was very supportive. She acted as an unofficial advocate.
- There was extensive support and engagement from Housing colleagues who did all they could to help and support T.

What were we worried about?

- T regularly overstated what he could do, leading to concerns around executive capacity e.g. offering to buy a heater when he had limited physical capacity and was banned from many shops. He said he used the toilet, but it was blocked by his mobility scooter.
- T's refusal to rehome his dog limited his housing options. However, the housing officer had engaged with an external organisation and T was considering letting them take care of his dog. Sadly, he died before this happened.
- The Housing Officer sometimes felt isolated in dealing with this case, particularly in the early involvement. They were unaware of the Professional Consultation Line in the MASH which can be used for advice.
- Despite his medical condition there was no evidence that T had been seen by his GP since 2009.

What is the learning from this case?

- An earlier referral to the MASH and a self-neglect and hoarding referral could have resulted in an earlier multi-agency strategy discussion.
- Partners should be aware that there is now a Self-Neglect and Hoarding (SNH) risk assessment tool. This assesses health, environment, self-care, nutrition etc. within the SNH policy.
- The referral form and risk assessment can be found here: https://www.suffolkas.org/working-with-adults/policies-and-procedures/
- Multi-agency case conferences are now held for customers who are self-neglecting and hoarding where appropriate. The case conferences will provide the opportunity to review mental capacity assessment and executive decision making.
- Resources are available to adults who struggle to heat their homes through schemes such as Warm Homes Healthy People: https://www.suffolk.gov.uk/community-and-safety/warm-homes-healthy-people/

6.2 Learning and Improvement Subgroup

Key Activity during 2017-18	•Performance dashboard with basic data developed to report at Board meetings; this is being further developed. •Work with Safeguarding Children Board colleagues to develop a joint annual safeguarding self assessment for statutory partners. •Multi-Agency Risk Register monitored at Learning and Improvement Group and Board. •Safeguarding Service monthly audits within the MASH and ACS, the learning has included: •Ensuring customers are central to process and adhering to the Mental Capacity Act 2005. •Ensuring customers have appropriate advocacy support. •Strengthening partnership working both within MASH and the Adult Protection Team. •Application of Thresholds and appropriate responses. •A repeat referrals audit.
Work under develpment by the group	• Further development of a cross partnership outcome focussed performance framework using signs of safety commentary. •Improved data sharing from partners to inform the Board Performance Framework. •A schedule of thematic audits based on areas identified in the Performance Report and Risk Register. •Learning cae and partnership reviews results in action plans identifying changes to frontline practice. • Continue to work with Regional partners to share good practice and ideas. •Further development of the Learning and Improvement Framework.

Audit findings from the past 12 months

- **Whats working well**
- Practitioners working well with adults at risk of abuse and applying principles of Making Safeguarding Personal in high risk situations. The audits also show strong examples of partnership working.
- During Section 42 enquires there is strong evidence to support that advocacy is being considered and when needed referred to the advocacy services. Other forms of advocacy are also explored such as identifying a family member or friend who the adult feels would be a good supporter.
- High risk and urgent cases show some excellent examples of partnership decision making and partnership working, especially where the adult had both health and social care needs.
- Strong management oversight of all cases.
- The Signs of Safety approach has demonstrated how a strengths-based approach in working with adults at risk can not only prevent further harm, but empower them to make positive choices and find ways to protect themselves without the need for professional services.

- **What are we worried about?**
- In cases where concerns do not proceed to a Section 42 enquiry the need to refer to advocacy services is not always given immediate consideration.
- When a concern is assessed as being low risk, opportunities for partnership working are not always fully utilised.

- **What needs to happen next?**
- Work with our partners to improve skills in identifying the risk criteria and decision making for intervention and escalation for Section 42 enquiries to ensure a consistent approach to our multi-agency working.
- The new Care Management IT System has been implemented to allow a greater management scrutiny of cases, including a separate section to record management oversight.
- Support the outcomes from the Safeguarding Review and the associated work programme in which we are fully involved.

6.3 Health Subgroup

Key Activity during 2017-18	•Implementation of the Safeguarding Supervision framework. •The disseminating and embedding of health learning from the J and M SARs across Health. •The completion of an Adult Safeguarding Supervision Framework and Health organisations taking this forward to embed into frontline health practices. •Keeping up to date on the continually changing proposed Liberty Protection Safeguards and seeking assurances on local DoLS work across Health. •Keeping up to date with safeguarding work streams in Suffolk, inclusive of the Domestic Abuse Strategy and the Prevent Strategy. •Embedding new national and local safeguarding policies, protocols into healthcare practice.
Work under develpment by the group	•Named Nurse for Safeguarding Primary Care will work closely with the Designated Nurse in utilising funds secured from NHS England to commission a GP event on Best Interests and Executive Capacity Decision Making. •Priorities for the Suffolk LeDeR Steering Group Action Plan 2018/2019. •Identify locally relevant learning from the national LeDeR programme. •Identify service learning from local LeDeR reviews. •Facilitate multi-agency commitment and approach to learning.

6.4 Training and Development Subgroup

Key Activity during 2017-18

- 21st Century Safeguarding conference focussing on Making Safeguarding Personal attended by over 100 practitioners.
- Development of a Quality Assurance framework from endorsing safeguarding training across the Board. This ensures consistency and quality.
- Standard slides for adult safeguarding across the partnership to ensure quality and consistency.
- Case studies from Serious Adult Reviews using signs of safety format developed to inform learning across the partnership.
- Work with the Voluntary Sector running workshops of Self-Neglect and Hoarding at the Voluntary Sector conference.
- Training for Suffolk Association of Local Councils at learning event in June to raise awareness of support available to Councils.
- Faith Groups Conference in partnership with Norfolk Colleagues. This raised awareness of the issues for faith groups and safeguarding.
- Membership and Terms of Reference reviewed under the guidance of a new chair of the group.

Work under develpment by the group

- Further Endorsement of partner safeguarding training across the partnership.
- Build on the learning from the Self-Neglect and Hoarding Conference in November 2018.
- Cross regional training and partnership working to share good practice e.g. work with Trading Standards.
- Further development of case studies using Signs of Safety to inform training.
- Improving awareness in relationship to Making Safeguarding Personal, scams, self-neglect and modern slavery.
- Partnership work between Trading Standards and UCS around hoarding, self-neglect and scamming. Two dissertations are currently being developed with a view to publication later in the year.

6.5 Housing Subgroup

Key Activity during 2017-18	•Review of membership of the group and the Terms of Reference. •Widening of the membership following the recommendations from the T Partnership Review. •Further work with colleagues to raise awareness of the Self-Neglect and Hoarding referral and risk assessment. •Development of an easy read Tenancy Guide now on the Safeguarding Adults Board website alongside various resources to support housing colleagues. •Development of a Housing web page with useful resources for partners and families.
Work under develpment by the group	•Partnership work with Housing colleagues to develop workshops for the November Self-Neglect and Hoarding Conference. •Further development of the Housing web page on the Safeguarding Adult Board website to give improved pathways to guidance and legislation for housing colleagues. •Work on how to support homeless people and provide pathways to support. •Work with Rough Sleeping teams to develop pathways to support. •Involve Safeguarding Children Board colleagues in the group to give a 'Think Family' approach.

6.6 Policy and Practice Standards Group

Key Activity during 2017-18	•Redevelopment of SAB website and refresh of all policies. •Development of SAB Newsletter to 500 partners. •Working with Transfomation Manager to develop Thresholds and Professional Disputes policies. •Review of group and its membership to ensure it is effective.
Work under develpment by the group	•Support the ACS Transformation Programme and develop new policies where required. •Refresh the Adult Safeguarding Practice guidance following the recommendations from the AM Safeguarding Adult Review. •Continue to work with Regional colleagues, especially Norfolk, to develop joint policies and procedures where appropriate.

6.7 Safeguarding Locality Forums

Key Activity during 2017-18	•Review of Locality Forums and their membership to ensure effectiveness. •Revised standard agendas across all localities to ensure consistency of message from the Board. •Sharing of learning from case reviews across all localities. •Regular updates on new policies and procedures and sharing of the new SAB newsletter. •Greater sharing of partners priorities and challenges as part of the standard agenda.
Work under develpment by the group	•Raise the profile and benefits of the meetings in target areas. •Improved reporting of locality issues back to Board. •Improved attendance by frontline practitioners, especially in the North. •Greater sharing of relevant information e.g. housing, self-neglect and hoarding across children and adults locality meetings.

7. The Work of our Partners on the Safeguarding Adults Board

In addition to the work of the Board, Partners have undertaken a range of individual activities to support the development of safeguarding in Suffolk.

Some highlights of the work across the partnership are:

Trading Standards

- Have undertaken **62 criminal cases** regarding the activities of rogue traders.
- Supported consumers by our ongoing financial abuse prevention (scams and doorstep crime) home visits. Completed **approximately 99 home visits**
- Completed **51 partnership/training events**.
- Created and manage **14 No Cold Calling Zones** – where doorstep traders are not permitted to call on residents – bringing the total number in the County to 118.
- **751 Friends Against Scams / Scam Champions**.
- **641 Consumer Champions** – empowering citizens and spreading awareness and information on rogue traders, alerts and product recalls.
- Developing our future work on the SCC loneliness provision agenda and work with University of Suffolk, dissertation completed on scamming, further work planned on faith groups.

Public Health

- Have implemented the Suffolk Suicide prevention strategy.
- Provides resources and pathways to support.
- Identified the most vulnerable groups.
- Encourages people to become support partners to help those most at risk.

Suffolk Constabulary

- Implemented the Modern Slavery toolkit providing resources for practitioners.
- Pathways to support and national guidance.
- Aims to increase the number of Modern Slavery referrals.

District and Borough Councils

- Safeguarding Training for Councillors.
- Raising awareness of Exploitation with taxi drivers.
- Annual safeguarding audit across adult and children.

East of England Ambulance Service

- Safeguarding awareness month March 2018, embedding partnership working.
- Rollout of Prevent training.
- Safeguarding masterclasses for Ambulance Trust Educators.

Community Action Suffolk

- Voluntary sector partners conferences for over 30 agencies.
- Focus on self-neglect and hoarding and effective referrals.
- Policy and practice standards ensure quality and consistency .

James Paget Hospital

- Focus on Domestic Abuse and self-neglect and hoarding in 2017-18.
- 35 members of staff trained as champions.

8. Appendices

8.1 Statutory and Legislative Context for Safeguarding Adult's Boards

The Safeguarding Adults Board (SAB) is a statutory body required by the Care Act 2014. The main function of the SAB is to ensure that local safeguarding arrangements and partners protect adults at risk of abuse and neglect in Suffolk.

The safeguarding duties apply to an adult who:

- Has needs for care and support (whether the local authority is meeting any of those needs) and;
- is experiencing, or at risk of abuse or neglect; and
- as result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

The Safeguarding Adults Board has three primary duties:

- It must produce an annual report setting out how we have met our duties and progressed in delivering our priorities.
- It must publish a strategic plan for each year that sets out how it will meet its main objective and implement its strategic plan.
- It must conduct any Safeguarding Adult Reviews in accordance with section 44 of the Care Act.

8.2. The SAB Budget and Expenditure for the past 12 months

Partners contributions for 2017-18 were as follows:

2017/18 Partner contributions to SAB Budget:	Actual Income
Babergh District Council	1,000
Forest Heath District Council	1,000
Ipswich Borough Council	1,000
Mid Suffolk District Council	1,000
Suffolk Coastal District Council	1,000
St Edmundsbury Borough Council	1,000
Waveney District Council	1,000
SCC, ACS Budget	40,000
Suffolk Constabulary	30,000
CCGs - Health	40,000
Total Income 2017-18:	**117,000**

The expenditure for 2017-18 was as follows:

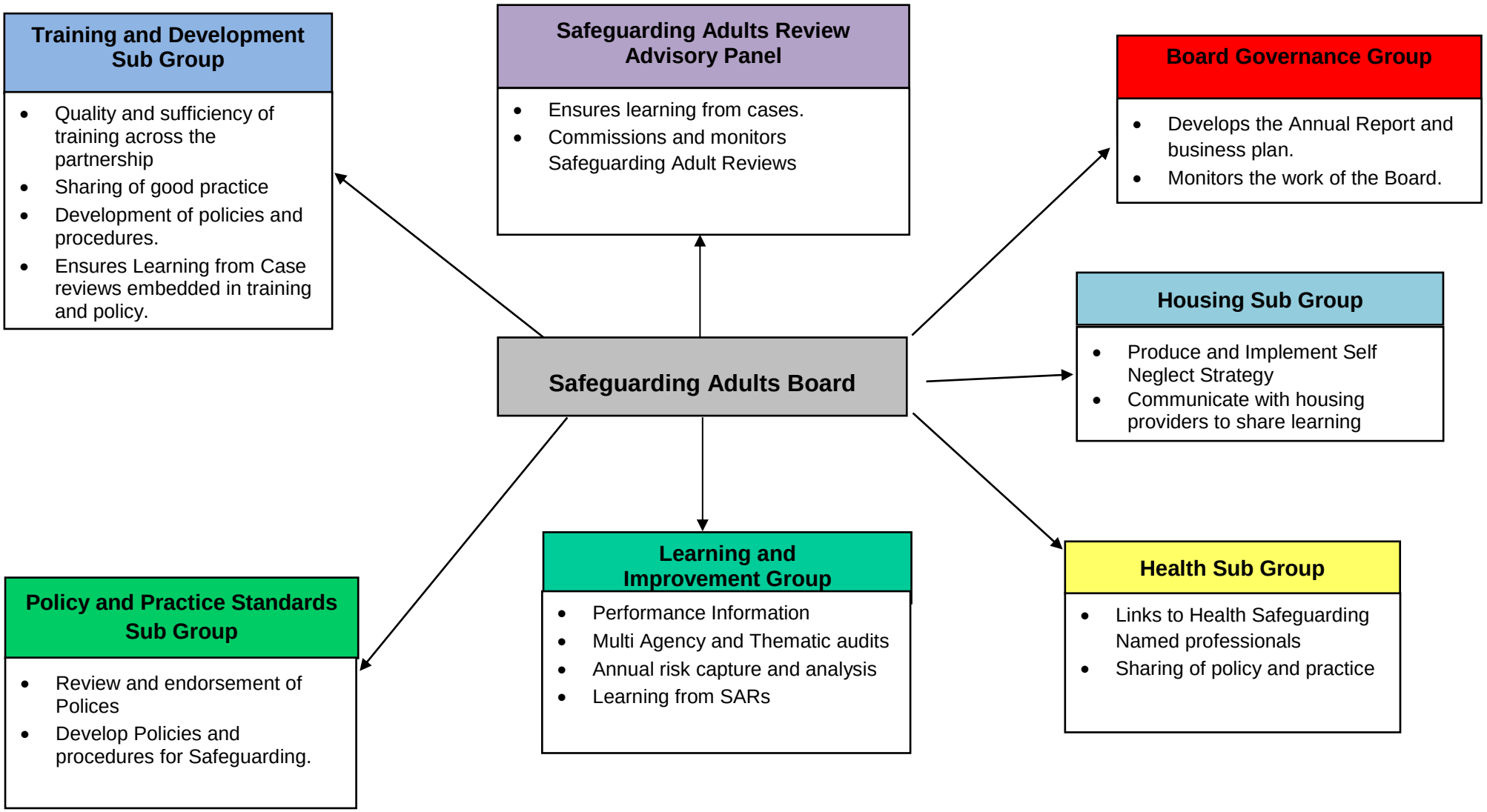
Expenditure 2017-18	Actual Expenditure
Salaries	74,853
Supplies and Services:	
Consultant Services (Chair +Jane Held)	28,627
Room Hire	410
Subsistence + photocopying	320
Website development	2,000
Professional Fees Coroners Court re RH	1,020
MCA Training payment to NHS	1,000
Payment to NHS for Contribution to Safeguarding Adults review	395
Transport Related Expenses	550
Total spend: Underspend	**109,175** **(£7,825)**
Existing reserves **Current reserves**	£77,017 **£84,842**

The budget for 2018-19 is as follows:

Estimated Budget 2018-19	Estimated Expenditure	Income
Partner contributions		117,000
Salaries		
Advisor	55,004	
Admin Support	18,555	
50% Board Manager	25,800	
Transport Related Expenses	1,000	
Supplies and Services:		
Professional Services Chair +	25,000	
External consultant (Jane Held)	5,000	
Funding for Serious Adult Reviews	25,000	
Room Hire	1,000	
Subsistence	500	
Further website development	2,000	
Contributions to Learning events and Projects	5,000	
Leaflets, publications and comms.	5,000	
Transformation programme training event – behaviours	5,000	
Safeguarding Conference Feb 2019	5,000	
Estimated spend:	**178,859**	**117,000**

Agreed potential draw on reserves = **£61,859**
Estimated reserves at April 2019 = £22,983

8.3 Safeguarding Adults Board – Subgroup Structure and Governance



8.4 Attendance and Membership of the Board 2017/18

Organisation	Job Role	Mar-17	Jun-17	Sep-17	Nov-17	Dec-17	Mar-18
Suffolk County Council	Corporate Director of Adult and Community Services	No	No	No	Yes	Yes	No
Independent Chair	Chairperson	Yes	Yes	Yes	No	No	Yes
James Paget Hospital	Named Lead for Safeguarding Adults	No	No	No	No	No	No
Church of England	Diocesan Safeguarding Advisor	No	No	No	No	Yes	No
Suffolk Family Carers	Chief Executive	No	Yes	No	Yes	No	No
Ipswich Hospital	Director of Nursing	Yes	Yes	Yes	Yes	Yes	No
Suffolk County Council Fire Service	Area Commander	Yes	Yes	Yes	No	Yes	Yes
South East Region National Probation Service	Assistant Director	No	No	No	No	Yes	Yes
Norfolk and Suffolk Community Rehabilitation Company Limited	Senior Probation Officer	Yes	No	No	Yes	Yes	Yes
Ipswich, East & West Suffolk Clinical Commissioning Group	Designated Nurse for Safeguarding Adults	Yes	Yes	Yes	Yes	No	Yes
Suffolk Constabulary	Detective Superintendent	Yes	Yes	No	No	No	Yes
Suffolk County Council, Adult and Community Services	Assistant Director	Yes	Yes	Yes	No	Yes	Yes
East of England Ambulance Trust	Assistant General Manager (Safeguarding)	No	No	No	Yes	No	No
East of England Faith Agency & Ipswich Faith & Community Forum	Trustee	Yes	Yes	Yes	No	Yes	Yes
Borough/District Council Representative	Corporate Director	Yes	Yes	Yes	Yes	Yes	Yes
Suffolk County Council - Public Health	Clinical Governance Manager	Yes	No	No	No	Yes	Yes
Healthwatch	Operational Manager	Yes	No	Yes	No	No	Yes

Organisation	Job Role	Mar-17	Jun-17	Sep-17	Nov-17	Dec-17	Mar-18
Suffolk Association of Independent Care Providers	Vice Chair	No	Yes	No	Yes	No	No
SAB Board Manager	Safeguarding Adults Board	Yes	Yes	Yes	Yes	Yes	Yes
Adult and Community Services, Suffolk County Council	Head of Adult Safeguarding	Yes	Yes	Yes	Yes	Yes	Yes
Norfolk and Suffolk Foundation Trust	Assistant Director for Nursing	No	Yes	Yes	Yes	Yes	No
West Suffolk Hospital	Head of Nursing	Yes	Yes	Yes	Yes	Yes	No
Trading Standards	Assistant County Trading Standards Officer	Yes	Yes	No	No	Yes	Yes
Suffolk Prison Service	Head of Residence	Yes	No	Yes	Yes	No	Yes
Suffolk County Council Legal Service	Solicitor	Yes	Yes	Yes	Yes	No	No
Great Yarmouth and Waveney Clinical Commissioning Group	Deputy Chief Executive	No	Yes	Yes	Yes	No	No
Suffolk County Council	Head of Performance and Intelligence	No	Yes	Yes	Yes	Yes	No
Care Quality Commission	Inspection Manager	No	No	No	Yes	No	No