Suffolk
Safeguarding Adults Board

Annual report 2017-19 – Summary

Our Independent Chair

Sue Hadley

Our vision for Adult Safeguarding in Suffolk

Our vision is for Suffolk to be 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 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

"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…It was encouraging to see the effective work on the front line and the skills and commitment of staff across all agencies…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 of outstanding. Feedback from service users and families shows good levels of satisfaction with the care received.

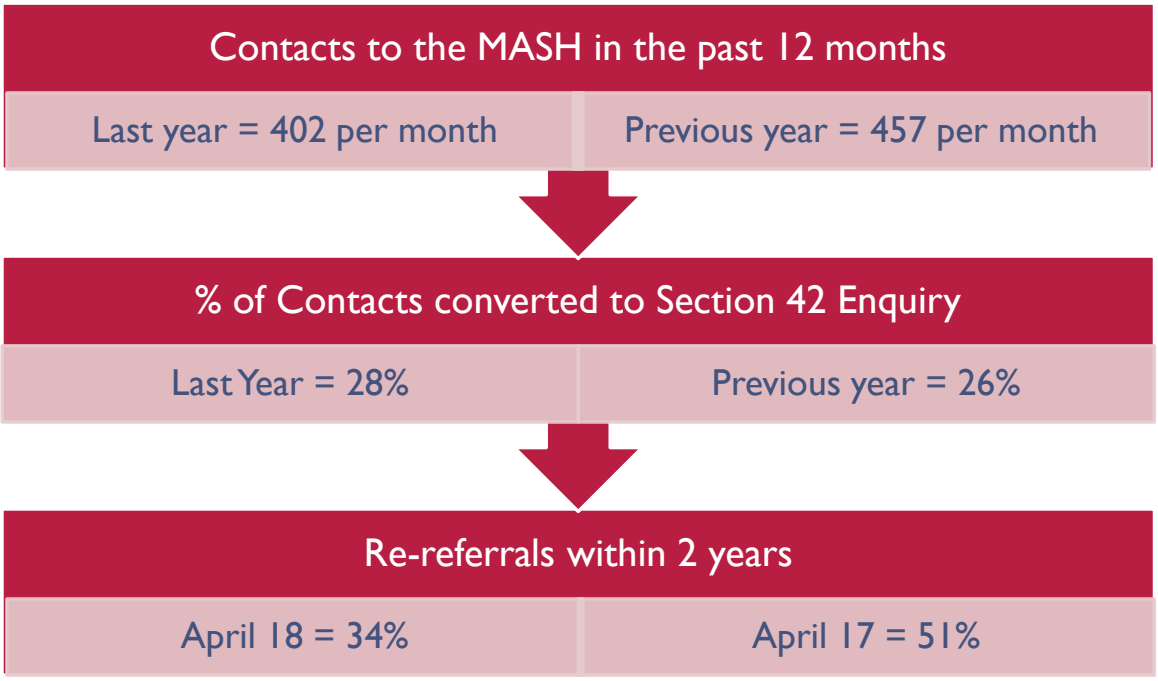
(Taken from the Independent Chairs summary in the Annual report 2017-18)

Our Board priorities for 2018-19

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

The number of contacts we dealt with last year and what happened to them.

- The Average number of contacts to the MASH has dropped form 457 per month last year, to 402 per month this year.
- The % of contacts that became Section 42 enquiries dropped from 28% last year to 26% this year



What does this data tell us?

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.

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 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.

What have we achieved in the past 12 months?

- An increasing number of care homes rated good or outstanding.
- Feedback from service users and families shows increased levels of satisfaction with the care they received.
- Senior leaders in Adult Social Care, Health and the Police working together to successfully deliver the Safeguarding Transformation Plan and its recommendations.
- A suite of new policies in development including revised Threshold Framework and Safeguarding and Professional Disputes policies, these will be officially launched at the February 2019 conference.
- A safeguarding leadership development programme in October 2018 to identify the Boards vision and values.
- A revised and improved Self Neglect and Hoarding Strategy with a multi-agency toolkit and approach to earlier identification and intervention.
- The Safeguarding Adult Review Advisory Panel (SARAP) continues to operate well review the most serious cases and put in place the appropriate measures to capture the learning and inform training.
- A new range of easy read documents leaflets and case studies.
- Increased use of the Professional Consultation line has led to a decrease in the number of contacts to the MASH.
- Communications across the partnership have improved through a quartely newsletter, revamped website, twitter and locality meetings.
- A quality assurance framework that ensures high quality consistnet training across the partnership.

What we need to do in the next 12 months

- Further embed the Threshold Framework to ensure consistent levels of assessment and referral across the partnership.
- Work our Performance and Audit data so we understand what we are doing well and where we need to focus our attentions.
- Implement an effective User Engagement Strategy that tells us how we are doing , what our customers think of us and how we can improve.
- Continue to learn from Case Reviews and embed the Self neglect and hoarding strategy into front line practice across the partnership.

What have we learned from Safeguarding adult reviews in the past 12 months?

Fire risks for non-mobile patients

- There needs to be better sharing of information between commissioners and independent care providers regarding the potential fire risks of non-mobile patients who smoke.
- Person centred fire risk environmental assessments need to be an integral part of care planning.
- There is an increased fire risk for patients being treated with a paraffin-based emollient products such a pads.
- Smoking cessation programmes shoudl be considered in person centered support plans.

Fluctuating capacity and self-neglect

- The relevant guidance needs to be clear where fluctuating capacity results in unwise decision making.
- Hospitals need to have an effective multi-agency discharge process which results in an appropriate care package in place, particularly where the patient is at high risk due to self-neglect.

Self Neglect and Hoarding and Executive decision making

- Partners should be aware that there is now a Self-Neglect and Hoarding risk assessment tool.
- This assesses health, environment, self-care, nutrition etc. within the policy.
- The referral form and risk assessment can be found here*
- We need to be aware when clients overstate what they can do e.g. offering to buy things to help them when they limited physical capacity to do so.

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

The anonymised case studies with learning from Suffolk adult reviews can be found here -

https://www.suffolkas.org/working-with-adults/safeguarding-adults-review-case-studies-other-local-authorities/