Report to Hackney Health and Wellbeing Board

Item No:		**Date:**	**1st November 2017**
Subject:	City and Hackney Safeguarding Adults Board Annual Report 2016/17		
Report From:	Dr Adi Cooper, Independent Chair City & Hackney Safeguarding Adults Board		
Summary:	This report provides an assessment of the key developments in local multi-agency adult safeguarding activities in 2016/2017 in the City of London and London Borough of Hackney. This is presented as a partnership document. It is representative of the work carried out by statutory and other agencies to realise the vision of the City and Hackney Safeguarding Adults Board, to assist people to live free from harm in communities that are intolerant of abuse, working together to prevent abuse and know what to do when it happens.		
Recommendations:	That the Hackney Health and Wellbeing Board: Is aware of the accomplishments of the City and Hackney Safeguarding Adults Board (CHSAB) during 2016/17.		
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1. Introduction

1.1 The London Borough of Hackney and the City of London have diverse, vibrant communities, with many organisations and individuals not only providing effective adult safeguarding, but also committed to the Safeguarding Adults Board and the partnership it represents. The City and Hackney Safeguarding Adults Board is a multi-agency partnership of statutory and non-statutory stakeholders, including the City and Hackney Clinical Commissioning Group, Metropolitan Police, East London Foundation Trust, London Fire Brigade, the Homerton NHS Foundation Trust, Housing, Providers and the Hackney Council for Voluntary Services. This report sets out an appraisal of safeguarding adults activity of those agencies across the City of London and Hackney boroughs in 2016/2017.

1.2 The Care Act sets out a clear statutory framework for how local authorities and other key partners, such as care providers, health services, housing providers and criminal justice agencies, should work together to protect an adult's right to live in safety, free from abuse and neglect. It introduces new safeguarding duties for local authorities including: leading a multi-agency local adult safeguarding system; making or causing enquiries to be made where there is a safeguarding concern; carrying out Safeguarding Adults Reviews; arranging for the provision of independent advocates; and hosting Safeguarding Adults Boards.

1.3 In setting out a statutory requirement for Safeguarding Adults Boards for the first time, the Care Act establishes three core duties for those Boards: The Board must:

a) Publish a strategic plan for each financial year that sets out how it will meet its main objectives and what the members will do to achieve this.

b) Conduct any Safeguarding Adults Reviews as may be required.

c) Publish an annual report detailing what the SAB has done during the year to achieve our main objectives and implement its strategic plan.

This annual report is provided in line with this requirement.

2. Key Achievements

2.1. In line with its strategy, key achievements for the Board in 2016/2017 include:

2.2. Following the presentation by Detective Inspector Phil Brewer on Modern Slavery in the previous year, each partner identified a lead for Modern Slavery. A policy was adopted which provided guidance on how to work with child and adult victims

2.3. The Board has maintained an interest in the Children's and Community Safety Partnership agenda.

2.4. Arising from findings from a SAR, the ‘self-neglect policy’ was reviewed and improved. Included in this review was the review of the Community MARAC, which included recommendations to redefine it as a ‘High risk panel’ to avoid confusion with domestic abuse, and to lower the threshold for referral, in line with the principle of prevention of abuse and neglect. A multi-agency file audit was instigated, which focused on the theme of self-neglect, and priorities for improvement identified by SARs.

2.5. In response to the findings of a SAR, the CHSAB commissioned a report and best practice guide for supported housing service providers on sexuality, consent and sexual relations when working with older people.

2.6. An escalation protocol was produced to provide a process for partner agencies to resolve, or escalate for resolution, professional disagreements regarding the actions, inactions or decisions of another partner agency in exercising its responsibilities.

2.7. To prevent cases that would be appropriate for consideration under the SAR protocol from slipping through the net and improve understanding, a referral process was agreed, circulated in all agencies and disseminated to staff.

2.8. The CHSAB funded an assurance tool for grant giving services to ensure that the organisations that they fund have suitable adult safeguarding policies and procedures, and a toolkit to support voluntary organisations to develop safeguarding policies. Safeguarding awareness training was made available to the voluntary sector. The Board has recognised the need to identify and support safeguarding champions in the voluntary sector.

2.9. The CHSAB funded training to build staff competence and to increase knowledge in particular areas of practice to prevent recurrence of issues identified in the SARs.

2.10. The collection and presentation of appropriate data on safeguarding activity and trends were reviewed and revised to inform the CHSAB works.

2.11. In line with good practice stipulated in the Care Act 2014 and further amplified in the Multi Agency Pan London Policy and Procedures, a representative of local Housing organisations was .invited to join the CHSAB.

2.12. In response to the absence of representation from the Care and Support services on the Board, as identified by this group themselves, members of the adult social care Provider Forum elected a representative to join the CHSAB.

2.13. Partners of the CHSAB and the Chair have visited community groups to engage with the wider community on safeguarding issues. It has agreed a SAR communication strategy and is working on a model for user engagement.

2.14. Members of Board have audited themselves to identify where they need to make improvements in adult safeguarding and have created action plans to address the deficits

3. Safeguarding Adult Reviews

3.1. During this year 4 Safeguarding Adult Reviews were completed. While each SAR has identified specific issues for learning, there are some shared themes for learning i.e. the need for:

a) Effective working together arrangements across agencies
b) Coordinated working together on a case with one agency taking the lead, including effective communication between all parties
c) Thorough risk assessment and risk management
d) Shared ownership of risk
e) Understanding of the Mental Capacity Act and its application

All four SARs from previous years were completed during 2016/17. The Board noted that these have taken some time to complete. Various processes were used to complete the SARs and it is becoming clearer about the way forward to ensure timely completion of SARs to improve learning and impact. The Board has agreed a series of events during 2017/18 to promote learning from the SARs.

4. Highlights form 2016-17 Data

4.1. The number of safeguarding adult concerns raised almost doubled this year, compared to the previous year, 2015/16. 508 of the 1261 concerns were progressed as Section 42 enquiries[1]. This increase in Section 42 enquiries relates to a consistent application of safeguarding guidance.
The biggest category of abuse remains neglect and acts of omission, followed closely by financial and material abuse, then by physical abuse.
Neglect and omission was the largest category of abuse in people's own home, while physical abuse was the highest category in hosptals and care homes. Financial and material abuse was the main category in other settings.

4.2. Asian/Asian British is under represented in safeguarding where cases progressed to Section 42 enquiries. As per the Office of National Statistics Asian/Asian British Population makes up 11% of the population of Hackney and have had 5% of cases taken forward to Section 42 Enquiries. In relation to all other ethnic groups, Section 42 enquiries have been in line or above the average as per the population profile of Hackney residents.

People of Islamic faith are under represented i.e. whereas 14% of the population of Hackney are people of this faith, only 5% of people involved in the Section 42 enquiries were people of Islamic faith. Taking into account that Asian/Asian British have low representation (as stated earlier), it is worth noting that there

[1] A section 42 enquiry is undertaken according to Chapter 14 of the Care and Support Statutory Guidance (Department of Health, updated February 2016), sometimes referred to as 'a formal safeguarding enquiry'. 'section 42' or a 's.42'.

were very low level of Section 42 enquiries involving people of Sikh, Buddhist and Hindu faith.

4.3. The data showed that 1 person was subject to 4 Section 42 enquiries, 13 were subject to 3 such enquiries and 45 people had had 2 Section 42 enquiries during 2016/17. This data where more than two Section 42 enquiries were pursued warrants further investigation to understand the reasons for repeat enquiries in order to refine practice and this will be undertaken.

4.4. During 2016/17, 69% of people whose safeguarding concerns were progressed as Section 42 safeguarding enquiries were asked and expressed their desired outcomes. 92% had their outcomes fully or partially achieved.

4.5. In 2016/17 there were 804 applications for DoLS, an increase from 682 applications in 2015/16, and 344 in 2014/15. This continues the pattern of a radically increased DoLS workload each year since the Supreme Court's judgment in the "Cheshire West" case in March 2014. By comparison, there were only 23 applications for DoLS 2013/14, of which 13 were approved

5. Priorities for 2017/18

1. We will continue to raise awareness
2. We want to engage with service users to get feedback
3. We aim to make services personal
4. We will meet our duties to commission safeguarding adult reviews and improve services in line with learning gained including through commissioning relevant training
5. We evaluate improvements through multi-agency case file audits and self-audits
6. We will promote advocacy to support people
7. We are aiming to devise a prevention and early intervention protocol
8. We will gather appropriate data to provide reassurance and improve service

6. Financial Contributions

6.1. The partnership funds the Board

7. Legal Considerations

7.1. The Care Act establishes three core duties for Safeguarding Boards: The Board must:

1) Publish a strategic plan for each financial year that sets out how it will meet its main objectives and what the members will do to achieve this. The plan needs to be developed with local community involvement and in consultation with local Healthwatch organisations.

2) Conduct any Safeguarding Adults Reviews as may be required.

3) Publish an annual report detailing what the SAB has done during the year to achieve our main objectives and implement its strategic plan.

8. Equality Impact Assessment

8.1. The Report highlights equality considerations in terms of the ethnicity, age, and gender and disability status of people about whom a safeguarding concern has been reported to the statutory agencies.