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Plymouth Safeguarding Adults Board

Democratic and Members Support
Chief Executive's Department

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28 January 2015

PLYMOUTH SAFEGUARDING ADULTS BOARD

Friday 30 January 2015
1.00 pm
Windsor House

Members:
Andy Bickley, Chair

Pete Aley, Roslynn Azzam, Geoff Baines, Sue Baldwin, Carole Burgoyne, Laura Collingwood-Burke, Mandy Cox, Greg Dix, Paul Francombe, Mike French, Judith Harwood, Julian Mouland, Kelechi Nnoaham, D/Supt Paul Northcott, Dave Simpkins, Phil Smale, Tony Staunton, Jane Elliot Toncic, Councillor Tuffin and Georgia Webb.

Members are invited to attend the above meeting to consider the items of business overleaf.

Tracey Lee
Chief Executive

PLYMOUTH SAFEGUARDING ADULTS BOARD

1. WELCOME AND APOLOGIES

2. CHAIR'S INTRODUCTION

3. MINUTES AND MATTERS ARISING **(Pages 1 - 10)**

4. DECLARATIONS OF INTEREST

5. SAFEGUARDING MANAGER'S REPORT **(Pages 11 - 48)**

- Peer Challenge
- Adults who self-neglect
- Care Act update

6. PSAB PERFORMANCE INDICATORS WORK STREAM

7. DOLS UPDATE **(Pages 49 - 50)**

8. SAB BUSINESS 2015/16

9. ANY OTHER BUSINESS

10. FUTURE AGENDA ITEMS, CONFIRMATION OF FUTURE MEETINGS **(Pages 51 - 52)**

11. EXEMPT BUSINESS

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

PART II (PRIVATE MEETING)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE
that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

12. SCR UPDATE (E1) **(Pages 53 - 54)**

13. SAFEGUARDING MANAGER'S REPORT (E1) **(Pages 55 - 58)**

14. SAB AUDIT (E1) **(Pages 59 - 68)**

Plymouth Safeguarding Adults Board

Friday 3 October 2014

PRESENT:

Geoff Baines, Chair (Interim).

Lorna Collingwood-Burke, Martin Cordy, Jane Elliott Toncic, Karen Grimshaw, Julian Mouland, Kelechi Nnoaham, Charlie Pitman (for D/Supt Paul Northcott), Councillor Ian Tuffin and Tony Staunton.

Apologies for absence: Carole Burgoyne, Mandy Cox, Paul Francombe, Mike French, Dan Monck, D/Supt Paul Northcott, Stuart Palmer, Mandy Sharp, Dave Simpkins and Phil Smale.

Also in attendance: Cate Simmons and Morris Watts – Plymouth Community Healthcare, Roslynn Azzam – Deprivation of Liberty Safeguards Officer, Kat Buckley – Commissioning Officer and Amelia Boulter – Democratic Support Officer.

The meeting started at 1.00 pm and finished at 3.40 pm.

Note: At a future meeting, the Board will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

16. **MINUTES AND MATTERS ARISING**

Agreed that the minutes of the meeting held on 4 July 2014 be confirmed subject to the following amendment –

Minute 12 – Deprivation of Liberty Safeguards (DoLS). DoLS had not been extended to supported living arrangements and applications relating to this should not be forwarded to the local authority. If a person is deprived of their liberty in a supported living arrangement, the commissioner of the support would need to take legal advice and approach the court of protection for authorisation.

Matters Arising

- Minute 6 - PSAB Budget. A small working group would be looking at the different options for the budget. Research had been undertaken on the regional contributions made by other SAB and from the 5 returns received covered similar areas to what Plymouth were proposing. They were refining the budget details with financial colleagues and had in principle an agreement from the police and the NEW Devon Clinical Commissioning Group. The Assistant Director would be advised of the findings and the Board would receive an update at the next meeting.

- Minute 7 - Care Act Update. We are waiting for the latest government guidance, currently to be released on 16 October 2014. It was suggested that the Policy and Procedure Sub Group could pick up this piece of work.
- Minute 9 – Safeguarding Manager's Report. Review of the Terms of Reference and membership was also highlighted in the Devon Audit Partnership audit report. Further work on this would take place once the new PSAB Chair was in place. A meeting would also be taking place with Simon White, Safeguarding Children's Board Manager.
- Minute 11 – PSAB Performance Indicators Workstream. This item would be looked at today.
- Minute 12 – DoLS. A group had not been convened but virtual discussions were taking place. This was an on-going matter. The next MCA meeting date was in October. Karen Grimshaw is part of the Plymouth MCA group but was not involved in Devon's MCA group. Martin Cordy highlighted that in respect to the Cheshire West Supreme Court judgement, Devon and Cornwall County Councils are undertaking a piece of work to look at applications on a priority basis and how they escalate the urgent cases for immediate attention. Martin was leading on this on behalf of Devon and Kernow Clinical Commissioning Groups and would feedback into this Board.

17. DECLARATIONS OF INTEREST

In accordance with the code of conduct the following declarations were made –

Name	Reason	Interest
Martin Cordy	Member of Devon Safeguarding Board	Personal
Lorna Collingwood-Burke	Member of Devon Safeguarding Board	Personal
Geoff Baines	Vice-Chair of Plymouth Safeguarding Children Board	Personal

18. CHAIR'S URGENT BUSINESS

There were no items of Chair's Urgent Business.

19. SAB SELF ASSESSMENT PI UPDATE

Geoff Baines and Julian Mouland provided the Board with an update on the SAB Self-Assessment. They had extended the deadline to 17 October 2014 for the remaining submissions, were in the process of producing a report on the findings, and would complete the report prior to the next Board meeting in January 2015. They had used a nationally developed tool which fed into the yearly performance assessment prior to the business plan cycle.

The following comments were made -

(a) Karen Grimshaw reported that Cornwall had undertaken a self-assessment for many years and used different tools. Karen made the proposal that all SABs use the same tool. It was further highlighted that this issue has been discussed in the SW ADASS Group, and it was evident that boards and local authorities were recording things in different ways;

(b) Martin Cordy agreed that we should adopt one model across the piece to improve consistency across the peninsula;

(c) Geoff Baines reported that PCH had completed their own self-assessment which gave them clarity on how they fitted within the city and to identify the common themes for agency collaboration. It was important to collaborate wherever possible and the pending peer review would help this Board achieve a clear understanding of any gaps;

(d) Karen Grimshaw also added that Cornwall undertake their self-assessment in January which then allows them to programme the work for the SAB for the following year. Would Plymouth undertake something similar?

Agreed that –

1. as part of the PSAB Self-Assessment Performance Indicator Update to include the comments made by the Board specifically around aligning the self-assessment to take place in January followed by PSAB work planning for the year.

2. the incoming Chair to be briefed on the process to move forward

3. contact is made with Pete Murphy, ADASS lead in Gloucester on the SW assessment.

20. **SAFEGUARDING MANAGER'S REPORT**

(a) Devon Partnership Audit

Jane Elliott Toncic presented the draft Devon Audit Partnership report, with some minor amendments to be finalised later this month. The audit was completed in July 2014 followed by the development of the action plan. The report reflects that the PSAB was between Chairs and some actions would have to wait for the incoming Chair.

A meeting was planned with the incoming Chair to go through the report and to formulate a plan to address the actions. The overall audit opinion was 'improvement required' and discussions need to take place on the PSAB structure, management and financial support and work priorities.

The following comments were made -

- with regard to the PSCB an enormous amount of work takes place outside of the meeting and is reliant on partner agencies for support which sometimes wasn't forthcoming. As the PSAB starts to mirror the children's board it was important to map out the capacity issues clearly;

- following the audit, discussions had taken place on whether there should be a joint board manager for the PSAB and PSCB or two separate board managers.

- that clear governance links between the different agencies was required and that the PSAB annual work plan would clearly specify the relevant representation and responsibilities.

(b) Making Safeguarding Personal

Jane Elliott Tonic reported that PCC had recently signed up for the LGA and ADASS 'Making Safeguarding Personal' agenda, which was originally launched in 2012. The presentation in the board agenda pack is the recommended pack to cascade to SABs and local authorities. The suggestion is that the core values of MSP are designed for the processes to safeguard adults at risk, although the principles should permeate every area of Health and Social Care intervention, and that every effort should be made to put people and their desired outcomes at the centre of processes. The expectation is that all Local Authorities will be signed up by next year.

Under the agenda, each authority completes an assessment of where they are currently in relation to the principles, and decides on a focus for the year's work. We are developing a working group to identify our focus and how it will be operationalised.

The following comments were made –

- domestic abuse needed to be included in the focus, as it is an area that is key to the work of the SAB;

- the interface between children's and adults was very important and needed a joined-up approach on domestic abuse;

- PCH were developing relationships with other agencies and a joint meeting took place yesterday on how we can help each other on the pathways around mental health and support to families in crisis on domestic abuse. This was a clear area for development;

- domestic abuse was clearly an area of priority for this Board to pick up and to look at the linkages with safeguarding children board. It was felt that the PSAB wanted to look at this area of work before escalating to the Health and Wellbeing Board.

Agreed that –

1. the Safeguarding Adults Manager to update the Board regarding developments in the MSP work.

2. domestic abuse is identified as a piece of work for PSAB to undertake and to establish the linkages with PSCB. The Board to receive a further update in January 2015.

(c) Peer Challenge - proposed agenda

Jane Elliott Toncic shared the Peer Challenge timetable with the Board. It was reported that the incoming Chair making would make every effort to be part of the Peer Challenge, despite it being prior to the commencement of his role. This was the fourth attempt to undertake a peer review, due to previous unavailability of ADASS Challenge teams.

It was highlighted that this Peer Challenge was adult focussed and missing the interface with children, whole life approach and the transition from children's to adult services.

Agreed that –

1. the Safeguarding Adults Manager to check that all relevant officers are invited to attend the Peer Challenge taking place in December.

2. the Safeguarding Adults Manager and Tony Staunton to meet to discuss further the PSAB interface with the PSCB, the whole life approach and transition from children's to adult services.

(d) Vulnerable Adult Risk Management/Serious Self Neglect update

Jane Elliott Toncic reported that the SSN agenda is part of a national focus on people who are unwilling and/or unable to engage with services, and who inevitably had complex and often inter-dependent issues. She had completed a literature review and collated the scarce national guidance, to inform the work of the Policy and Procedures Sub Group, who are developing a set of principles from which agencies could work, although development was at an early stage.

There has been a recent Multi-Agency Partnership Review of a case involving complex issues and self neglect, and a full report would be provided in January 2015. We are looking to develop a lead officer working group and appoint a self-neglect champion/lead and would welcome expressions of interest.

For practice guidance, it needs to be noted that there are no powers of entry under the Care Act, and frontline staff needed to be legally literate around the available frameworks for intervention, whilst being able to balance these with human rights and the right to self-determination of capacitated adults. Risk sharing and risk management are crucial, and the sub group will look at continued development of guidance, to include an escalation protocol.

The following comments were made –

- The joint Chairs of the multi-agency review recommended continued revision of VARM and were looking to undertake a review;

- renaming of the process may be required due to the recent changes in acceptable terminology. The term 'vulnerable adult' has widely been replaced by 'adult at risk', the rationale for which is to change the focus from the individual to their circumstances with regard to causations of vulnerability;

It was suggested that a sub group could pick this up and bring key people together to look at the recommendations and to link up with work already underway. It was further discussed whether a 'champion' role would be of benefit and would provide an avenue of challenge for the Board.

Agreed that –

1. a Self-Neglect Champion to be identified to develop and lead an officers working group.

2. the PSAB receive the multi-agency review report on self-neglect at the next meeting in January 2015.

(e) PCC Corporate Safeguarding Improvement Plan

Jane Elliott Toncic provided an update on the planned partnership conference between PCC, PSAB and the University of Plymouth. The preferred date for the conference to take place is currently the 13 April 2015. Agreement to speak has been received from Sir James Munby President of the Family Division and the Court of Protection, Prof. Michael Preston-Shoot the leading academic on Self Neglect, recognised legal author Michael Mandelstam and Geoff Baines Director of Quality Professional Practice, Safety and Quality for PCH. A joint planning team is established and conference would take place in the Roland Levinsky Building. The University will be providing the venue and their events team will organise catering and advertising etc at cost.

(f) PAUSE Update

Jane Elliott Toncic provided the Board with an update from the PAUSE adult user group. It was reported that –

- PAUSE were pleased to have been involved in the interview process for the PSAB Independent Chair and with the appointment;

- Links have been made with PCC commissioning Quality Assurance and Improvement Team to provide support to PAUSE regarding concerns they had raised to PSAB around inconsistencies in care provided by care agencies;

- the PAUSE group have agreed to provide a focus group for the Peer Challenge;

- they highlighted that they wanted to be more involved in city-wide events to rise their profile. We have provided them contact details to relevant organisations and venues;

- they have raised concerns about the number of doorstep loans taken out by vulnerable people from large organisations. It was reported that no checks were undertaken on people taking out a loan up to the value of £1k. They have been asked to provide further information in order to identify next steps.

21. **PCH SAFEGUARDING GOVERNANCE**

Cate Simmons and Morris Watts from Plymouth Community Healthcare (PCH) reported that PCH started as a community interest company 3 years ago. Integration was vital for safeguarding and this approach ensures that childrens and adult safeguarding was integrated into both the governance and operational practice in PCH.

There were two internal meetings held monthly that were critical to the governance of adult safeguarding:

Safety, Quality and Performance Meeting (SQP)
This meeting was established to provide the PCH Board with assurances about safe practice and effective performance as well as looking at the facts and figures and to flesh out what this means, with strong areas being replicated across the organisation.

Integrated Safeguarding Committee (ISC)
This meeting provides detailed assurance to the SQP about children and adult safeguarding. At this meeting they look at the progress of Serious Incidents Requiring investigation (SIRI), and consider all aspects of safeguarding within their organisation along with implications for multi-agency working.

The following comments were made –

(a) that NEW Devon CCG had an open invitation to the ISC meeting, appreciated and supported the work carried out therein and found sight of the quarterly report invaluable;

(b) through the meetings and the work that goes into informing them, they recognised and identified issues and the need to bring learning back into the system.

(c) CCG were looking to set up a Chief Nursing Officer Group, it would not be a compliance group but a forum to look at the 'sticky' issues and to share the learning. This Board had a responsibility to collectively share the learning and information. The Annual SAB Report would help us to understand the patterns.

22. **SCR UPDATE**

Julian Mouland provided the Board with an update on the current serious case review.

23. **DoLS**

Roslyn Azzam reported that the task and finish group had not yet convened and attempts are being made to set a meeting in November. It was also reported that 305 DoLS applications were made to Plymouth City Council since April 2014, the majority of them were regarding people with dementia.
An update report was tabled and discussed.

The following comments were made –

(a) whether the applications are all appropriate and if not, whether training may be required. Roslynn confirmed that because the threshold of deprivation is now so low, the vast majority of applications are resulting in an authorisation. There is no indication that inappropriate applications are being made.

(b) Derriford Hospital had previously experienced some applications leading to advice that the circumstances did not amount to deprivation; however since the new guidance, this is no longer the case. There are more recently applications being made because it is not safe for the person to leave hospital until appropriate discharge arrangements and onward care are in place.

24. ANY OTHER BUSINESS

Jane Elliott Tonic had four items of any other business, it was reported that –

- there had been enquiries for adult safeguarding leaflets/posters for public awareness raising in venues such as GP surgeries and across the wider community. Previous leaflets were out of date and plans had not yet been made to replace them. The Board felt that it was important to have this information and to get this actioned quickly.

- A question was raised as to whether the Board wanted to link the conference in April to an Adult Safeguarding awareness week.

- Links had been established with the voluntary and community sector and a question raised as to whether a nomination to sit on the PSAB would be welcomed.

- Information on an event in Exeter in November, 'Safeguarding the Vulnerable from Financial Exploitation', was circulated to Board members. It was a multi-agency conference, and following on from earlier discussions would forward information to PAUSE.

Agreed that -

1. safeguarding leaflet is produced and circulated to PSAB members for review prior to the next meeting of the Board in January 2015.

2. Invite representative from the voluntary and community sector (VCS) to sit on the PSAB in January 2015.

25. **FUTURE AGENDA ITEMS AND CONFIRMATION OF FUTURE MEETINGS**

The next meeting of the Board will take place on Friday 30 January 2015 at 1 pm.

26. **EXEMPT BUSINESS**

There were no items of exempt business.

Local Government Association

Adult Social Care
Regional Peer Challenge Summary Letter

Plymouth City Council
December 2014

Report

Introduction

1. Plymouth City Council (PCC) asked the Local Government Association (LGA) to run a Regional Adult Social Care Peer Challenge as part of sector led improvement within the South West ADASS Region. The specific issue identified by PCC for the team to focus on was:

    - From November 2013, Plymouth Adult Social Care moved from an approach where all staff undertook safeguarding investigations to a dedicated adult protection pathway. How robust and effective is this model in protecting adults at risk, while ensuring that safeguarding remains everyone's business?

2. Regional Peer Challenge is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends'. It is designed to help an authority and its partners assess current achievements and areas for development, within the agreed scope of the review. It aims to help an organisation identify its current strengths, as much as what it needs to improve. But it should also provide it with a basis for further improvement in a way that is proportionate to the remit of the challenge. All information was collected on the basis that no comment or view from any individual or group is attributed to any recommendation or finding. This encourages participants to be open and honest with the team. The LGA Peer Challenge Team would like to thank Councillors, staff, people who use services and their carers, voluntary sector and other partners for their open and constructive responses during the challenge process. The team was made very welcome.

3. The members of this Regional Adult Social Care Peer Challenge Team were:

    - Alison Elliott – Director of People, Southampton City Council
    - Zoë Johnstone – Chief Officer: Adults and Joint Commissioning, Bracknell Forest Council
    - Cllr Jonathan McShane – Cabinet Member for Health and Social Care, London Borough of Hackney
    - Paul Clarke – Senior Advisor, Local Government Association
    - Jonathan Trubshaw – Challenge Manager, Local Government Association.

4. The team was on-site from 1st – 4th December 2014. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These activities included:

    - interviews and discussions with Councillors, officers and partners;
    - focus groups with managers, practitioners, front line staff and people using services and carers;
    - the reading of documents provided by the Council, including a self-assessment of progress, strengths and areas for improvement against key areas of business.

5. The recommendations in this summary letter are based on the presentation delivered to the Council on 4th December 2014 and is based on the triangulation of what the

team have read, heard and seen. This letter covers those areas most pertinent to the remit of the challenge only.

Summary

- Adult Protection Pathway provides greater assurance that safeguarding alerts are responded to consistently
- Good understanding that quality services help to prevent abuse
- There is an opportunity to build on recent improvements to drive the safeguarding agenda at a strategic and operational level through:
  - The Board
  - Performance management
  - Governance arrangements
  - Leadership, responsibility and accountability

6. The Team was well aware of the organisational context in which the Challenge was taking place. Included in the factors that the Team thought relevant to take into account was the recent Ofsted inspection and the impact that this had had on staff who had gone through this process. The Team emphasised to those participating in the Challenge that this was not an inspection and that the peers had been invited in by the Council as sector led support. The Team was also aware that the City has a challenged health and social care economy; whilst the Team was on site news was broadcast about conditions regarding treatment being placed on patients who were over-weight or who smoked. Plans are being implemented to integrate both provision and commissioning and whilst the Team was on-sight affected staff received TUPE notifications. Within this context the Team was aware that there was a high level of expectation being placed on the incoming independent chair of the Safeguarding Board to resolve key partnership issues.

7. In the Team's view the Adult Protection Pathway (APP) does provide greater assurance to the Council that safeguarding alerts are being responded to consistently.

8. There was a good understanding from across the partnership that having good quality services does help prevent abuse. There was also awareness that a high level of effort is required from all involved in safeguarding to ensure that quality standards are maintained right the way through an individual's safeguarding journey. Not only is safeguarding everybody's business, so is being aware of the processes involved and the standards that are to be attained.

9. There is an opportunity to build on the recent improvements in service delivery and to drive the safeguarding agenda at both the strategic (including the work of the Safeguarding Board) and at an operational level. This should be done through enhanced management oversight, by all members of the partnership, of their staff's work. Key areas were improvements could be driven forward include; the Board, performance management arrangements, governance structures and leadership responsibility and accountability. These areas interlink and the Team was aware that some steps were already being taken to address these.

Service Delivery and Effective Practice

Strengths

- Partners and staff are positive about the Pathway – they feel it is more timely and more responsive, they feel it is a better arrangement than was previously in place
- Committed, capable and enthusiastic staff
- Police have clarity on thresholds and process
- PCC staff feel processes are applied more consistently
- Training for elected members is good and well regarded
- Commitment to Making Safeguarding Personal

Areas for consideration

- Inconsistent feedback from across the system about the safeguarding process and thresholds
- Do you need to apply a risk assessment tool consistently across the agencies?
- Lack of rigorous and consistent approach to performance management
- People are unclear as to why time scales are not being met
- Partners report out-of-hours response is poor and high risk
- Whose responsibility is it to lead on safeguarding and are there risks if based on commissioning arrangements?
- Where is the multi-agency decision making?
- A sense that each organisation deals with safeguarding separately – not in a multi-agency way
- Alerters report a lack of feedback
- Service users want a dedicated safeguarding number

10. The staff and partners that the Team met with were committed, capable and enthusiastic. They were positive about the changes that had been made to put the Pathway in place and stated that it was an improvement on what was there before. They said that alerts were dealt with in a more timely and responsive manner.

11. The Police were clear on their understanding of the thresholds and how these were being applied and PCC staff felt that processes were being applied more consistently.

However, there was feedback from across the partnership on the inconsistent application of thresholds and it may be useful to build on the Police's clarity with other organisations so that there is greater understanding and consistency across the partnership as a whole.

12. There is a commitment at all levels to making safeguarding personal. One way that this is demonstrated at a senior level is through the training offered to elected members, which is of good quality and is well regarded.

13. The team found some inconsistencies in the way in which safeguarding alerts were being prioritised. It may therefore be useful to implement a multi-agency risk assessment tool that would direct organisations, right the way across the partnership, to operate in a more consistent way

14. There appeared to be a lack of a rigorous and consistent approach to performance management. Information was collected but there was little evidence that this was routinely and systematically interrogated so that issues, once identified, were monitored to establish trends and the impact of interventions to address these.

15. Some participants were unclear on timescales, even though it was acknowledged that these were written down. There was also a lack of clarity on when delays occurred as to why these had happened. It is important that reasons for delays are understood and can be explained, e.g. due to an on-going police investigation.

16. The out-of-hours service was criticised by some participants, with them saying they had been asked if they could wait until the morning to resolve their issues.

17. In the Team's view there appeared to be a focus on safeguarding those individuals receiving commissioned services (Domiciliary Care and those in Care Homes) but not those funding their own support or not receiving support at all. There also appeared to be a lack of clarity on who was leading on the safeguarding. This needs to be resolved at a multi-agency level so that all partners understand who is responsible. At present there is a sense that each agency deals with safeguarding separately, with clear reporting lines within their organisation.

18. Alerters feel they receive too little feedback once their concern has entered the system. A routine mechanism needs to be put in place to keep people informed of what is happening, including where no further action is required.

Commissioning

Strengths

- Clear shared vision of Making Safeguarding Personal
- Dignity in Care Forum reported as working well
- Good alignment between QAIT and the Adult Protection Pathway
- Increase in provider alerts as a result of increased uptake of training by providers
- QAIT aware of trends in registered care homes, have programme of work and are able to respond to concerns raised
- Weekly multi-agency 'Overview' meeting
- Plans are in place to take learning from the current Serious Case Review

Areas for consideration

- Lack of understanding of where the Safeguarding Unit and the Adult Protection Pathway integrate
- Are there risks of creating further hand-offs?
- Commissioning need to respond to quality concerns
- How do you ensure learning from complaints, SCRs and investigations improves commissioning, services and practices?
- Is alignment of Adult Protection Pathway and QAIT due to personalities or governance?

19. In the Team's view there was a clear and shared vision for Making Safeguarding Personal with a good alignment between the Quality Assurance and Improvement Team (QAIT) and the APP. However, there was some concern expressed that good working relationships might be reliant on the personalities involved and not sufficiently based on embedded practice and procedures. It was reported that the Dignity in Care Forum (led by the QAIT) works well, although this is a large meeting and it may be worth considering if this could be refreshed.

20. There has been an increase in alerts from providers following training. It was recognised that the previous Safeguarding Lead was from a Commissioning background and that there may therefore have been a focus on commissioned services. It may now be necessary to consider how to broaden where alerts are raised from and how people not in receipt of commissioned services receive an equitable response.

21. The Team considered that there was a lack of clarity as to where the Safeguarding Unit and the APP integrate, both now and in the future. It needs to be made clear whether the integration will be at a commissioning and/or provider level. However this is done care needs to be taken about additional 'hand-offs' being built into the system, creating the potential for duplications, delays or gaps in the process.

22. Commissioning needs to respond to quality concerns, particularly where issues are identified from service user feedback. Some service users that the Team spoke with reported inconsistency in their care, with a high number of care workers being used within a short period of time. Commissioning could take a more proactive role in researching and facilitating solutions with service users.

23. The Team acknowledged that there was a plan in place to take the learning from the current Serious Case Review. However, more could be done to link the learning from other feedback, including from; complaints, practice reviews, investigations, etc. This learning needs to be embedded in a systematic way so that it informs future commissioning.

Performance and Resource Management

Strengths

- Trend information provided to QAIT
- QAIT undertake quality reviews of care homes with a view to improvement
- Beginning to conduct consistent, structured practice audits
- Beginning to look at outcome focussed reporting
- Quantitative information captured on dashboard
- Weekly safeguarding overview meeting considers health and adult social care alerts

Areas for consideration

- How do you use the dashboard as a management tool to drive performance improvement?
- Implement a systematic approach to performance management and governance
- No evidence that performance information is systematically interrogated throughout the organisation
- In addition to the annual return what other performance information should the Board require e.g. practice audits?

24. The Team recognised that performance information was being collected by the QAIT, including that obtained from the quality reviews of care homes. It was also recognised that you are beginning to conduct structured practice audits and to look at outcome focussed reporting. The challenge is how the information that is captured and presented (including on the Dashboard) is used to inform practice improvements and how these improvements are then monitored.

25. There is a need for management information to be systematically interrogated throughout the organisation. You need to be clear as to why information is being collected and then what needs to be presented at different levels. What does the Board need to see and how do other levels within the organisation provide and interrogate their contributions so that this is made meaningful and relevant?

Working Together

Strengths

- People reported good relationships between partners, especially at operational level
- People reported that partners were able to challenge and there is an openness at the Board
- Multi-agency commitment to the Board
- Some multi-agency participation in training
- New Independent Chair is highly thought of – people are keen for him to start and have high expectations of the difference he can make
- Agencies have undertaken self-assessment – report on findings January 2015
- Developed an information sharing protocol – waiting for sign off

Areas for consideration

- People reported a lack of commitment, drive and leadership from PCC within the Board
- Board does not drive the multi-agency vision for safeguarding across the city
- There is a sense of limited challenge, pace and grip in driving forward improvements
- How does the Board assure itself that it is making a difference?
- Need to review sub-committee structure to ensure clarity of purpose
- Consider combining with LSCB on sub-committees
- Does the Board hold agencies sufficiently to account?
- Governance arrangements – clarify links with Health and Wellbeing Board, scrutiny and other partnership arrangements
- Lack of participation in multi-agency training
- Lack of regional working across the three Boards – meeting has been arranged for January 2015
- Lack of service user and carer voice into the Board

26. People that the Team spoke with reported good working relationships, both operationally and at the Board. Board members were able to challenge one another and there was a commitment to making the Board work. However, some of the participants that the Team spoke with expressed a desire for PCC to take a stronger lead within the Board. The Team acknowledges that the Care Act does not give clear guidance on this but recognises that other authorities have taken a clear lead and PCC could be clear about its leadership role.

27. There was some multi-agency training, although it was also reported that individual organisations, most notably Health and the Police, were still focussed on their own training. There are benefits in multi-agency training above raising skills and the Board has a role in ensuring that all organisations understand this and engage more fully.

28. There was a high level of expectation from all those that the Team spoke with about the new Independent Chair. He was seen as a credible choice and someone who could stimulate change and further challenge.

29. In the view of the Team it was positive that the partnership had undertaken a self-assessment of how they were working together and that this was being taken to the January 2015 Board. It will therefore be important how the findings from this self-assessment are used to influence the development of the partnership, so that it is viewed as a positive and useful undertaking by all the organisations.

30. It is the Team's opinion that the Board needs to drive the multi-agency vision for safeguarding across the City. There needs to be clear and simple guidance that sets out what the vision is so that it can be followed by all the agencies involved. The Board then needs to hold members to account in a transparent and accessible way. To do this effectively there needs to be greater challenge, pace and grip so that improvements are driven forwards.

31. There is an opportunity with the Board moving to a statutory basis and the commencement of a new Independent Chair for the Board to consider the culture in which it operates. Each Safeguarding Board is developing its own style and at its own pace. It is now time for the Plymouth Safeguarding Adults Board to become more challenging of its members and more responsive to the needs of its residents in the ways in which services are commissioned and provided.

32. The Board needs to put in place sufficient measures and information gathering systems so that it can demonstrate the difference it is making for the residents of Plymouth. The Board needs to become more outcome focussed.

33. There is an opportunity to review the Board's sub-group structure and consider where there are possibilities for combining with the Safeguarding Children's sub-groups, e.g. training. A significant number of organisations send the same people to represent them at both the Adults' and Children's Boards. The people attending the Board's current sub-groups value being there. However, you need to be assured that the right people attend the sub-groups and that the work of the groups drives forward the work of the Board. The Lead Officers' group is highly valued because it allows the participants to share operational experiences and issues. It may be practically beneficial for this group to continue but does this need to be a sub-group of the Board?

34. Greater clarity is needed on the relationship and governance arrangements between the Safeguarding Adults Board and the Health and Wellbeing Board, scrutiny and other partnership arrangements.

35. Regional agencies, including the Police and Ambulance services, would welcome greater linkages between the three sub-regional boards (Plymouth, Torbay and Devon). The Team understood that a meeting has been arranged for January 2015 and believe this will be helpful in aligning policies and practices.

36. Service users and carers reported to the Team that they felt they did not have a voice into the Board. They did not necessarily want to be represented on the Board but a mechanism needs to be found so that views are recognised and acknowledged.

What you might like to do

- Review the language used across the system to ensure everyone understands what is meant
- Be clear about your processes and tell staff, partners and the public what they are
- Clearly communicate what is meant by integration and confirm that people understand
- Consider whether the Adult Protection Pathway should respond to all alerts rather than to those receiving commissioned services
- Consider whether the Public Protection Unit should respond consistently with above
- Implement a performance management framework using the “dashboard”
- Review SAB sub-groups
- Review out-of-hours response to adult protection alerts
- Develop a feedback process for alerters
- Review integration arrangements so that hand-offs are not increased
- Put in governance arrangements for the SAB
- Consider strengthening the Board support and whether this could be shared with the LSCB
- Publish Board minutes earlier and make them easier to find on the website

37. The Team felt that some of the language used in describing services and processes could be confusing and interpreted in different ways within different organisations. .An example is the use of the term ‘APP’; which in practice is a team of people but could be viewed as a process by other partners. There is therefore a need to review the language used by all partners so that it is understood by staff in the different organisations and service users.

38. Be clear on which organisation leads on which process. In the Team’s view there is an argument to be made that it should be the Local Authority that leads on all Safeguarding. Whatever is decided staff, partners and the public need to understand and be clear on where the accountability lies.

39. It is important to continue to communicate what is meant by and what is happening with integration. The Team recognised that a considerable amount of information has already been made available to staff and partners but there still remains some uncertainty and this is having a negative impact on effective delivery.

40. Consider whether all alerts should be dealt with by the APP. At present some alerts are dealt with by Health and others managed by another Pathway. You will need to

assure yourselves that alerts are being dealt with consistently and in a way that minimises hand-offs and unilateral closures (this is of particular importance in regard to the integration arrangements), thereby making responsibility and accountability clear to all. You will need to be clear as to what the APP is required to deal with and that it is adequately resourced to meet these requirements. The remit of the APP needs to be clearly communicated to all staff so that any perceptions that it only deals with commissioned services are addressed. Any review of arrangements should include the Public Protection Unit so that risks are fully assessed and not on the basis of where people live or the services they receive.

41. Review the existing Dashboard measures to assure yourselves that you are able to track and respond to performance issues. This needs to form the basis of a robust performance management framework that draws in data from all levels of the organisation and is able to provided targeted feedback and requirements for change. You should also consider how the dashboard might aid scrutiny, both within PCC and through the Board.

42. A quick win would be to develop a system for feeding back actions taken (including where no further action is required) to alerters. This can be a useful demonstration that you have listened to people and have responded. This could subsequently be linked in to any review of the alerts process.

43. Review out-of-hours arrangements to ensure there is sufficient capacity to deal with alerters concerns so that there is a consistent response.

44. The commencement of a new Independent Chair provides you with the opportunity to review operating arrangements within the Board including; strengthening and clarifying the governance arrangements, reviewing and where necessary revising the sub-group structure, increasing Board support and consider sharing staff with the Children's Board so as to maximise resources and enable sufficient capacity to publish Board reports swiftly. There is also an opportunity to develop the culture within the Board so that partners are more confident to engage in even more robust challenge and meaningfully hold each other to account; particularly on issues on capacity and clarity of process. The Board's website should be refreshed so that it easier for staff, partners and residents to find information and be clear on what they need to do and when. This would also help meet the expectations of service users, who ask for information to be published, so that they are kept informed and feel that they are being responded to.

Next Steps

45. After due consideration of the issues and recommendations in this summary report the Peer Challenge Team assume you will take forward aspects of this report in your future plans. We suggest you disseminate the key messages to staff and partners and seek to publish the report.

46. In due course LGA and South West Regional ADASS will evaluate the progress of this work in line with the wider regional sector led improvement work.

Contact details

For more information about the Regional Adult Social Care Peer Challenge of Plymouth City Council please contact:

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For more information on peer challenge and the work of the Local Government Association please see our website: http://www.local.gov.uk/peer-challenges

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Adults who self-neglect

Learning from serious case reviews

Self-Neglect Definition

- lack of self-care – neglect of personal hygiene, nutrition, hydration, and health, thereby endangering safety and well-being, and/or
- lack of care of one's environment – squalor and hoarding, and/or
- refusal of services that would mitigate risk of harm.

Research Focus

- What is the nature of the self-neglect cases reviewed through SCR processes?
- What themes emerge from the SCRs and how do these add to understanding about professional intervention in cases of self-neglect?
- How many and what kind of recommendations are made by SCRs and to which agencies are they addressed?

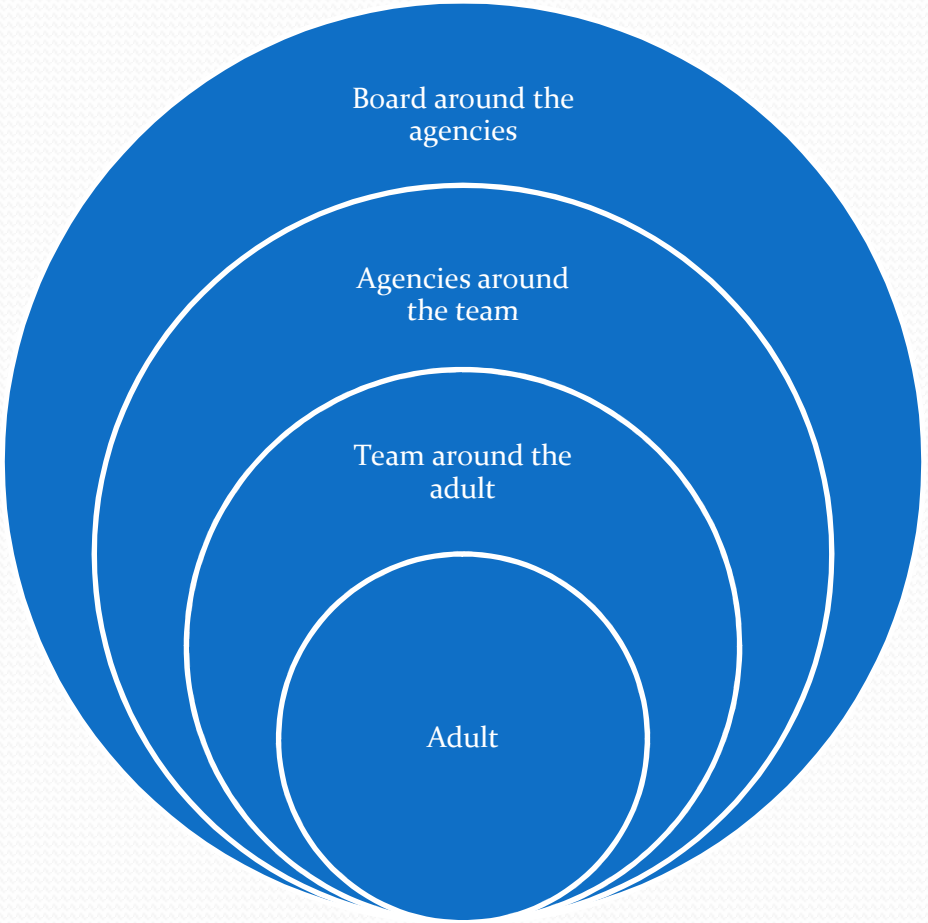
Numbers

- 153 Local Authority and Local Safeguarding Adult Board web pages reviewed.
- 21 SCRs identified in the public domain.
- Personal contacts with Independent Chairs & Board Managers.
- 11 additional SCRs obtained, not all published.
- Total of 38 SCRs known to have been commissioned; some yet to be completed.

Analysis Methodology

- Key characteristics of each case (n=38): gender, ethnicity, age, domestic living status, disability, details of agency involvement;
- Key characteristics of the SCRs (n=38): publication, length, whether self-neglect comprised a central dynamic, number of recommendations, availability of action plans;
- Frequency of recommendations in the SCRs (n=31) for individual agencies and for LSABs;
- Themes extracted from the recommendations in the SCRs (n=31).

Thematic Analysis of SCRs



Case Characteristics

- Published reports do not always give exact details of how the individuals concerned died.
- Where known (n = 36), 56% of the sample are male and 44% female.
- Where age was known (n = 27), the largest group were over 76 (41%); 19% of the sample were aged between 21 and 39, 30% between 40 and 59 and 10% between 60 and 75.
- Ethnicity was not routinely recorded in the reports.
- 21 lived alone, 10 with family or friends, 3 in sheltered accommodation or care homes, 4 not known

SCR Characteristics

- In available reports, self-neglect a central focus in 14, implicit in 12 & peripheral in 5.
- Considerable variation in length: 5 – 63 pages.
- Similar variation (between 4 and 30) in the number and detail of the recommendations.
- Different approaches towards naming SCR author & independent oversight of process.
- Mixed attitudes towards publication.

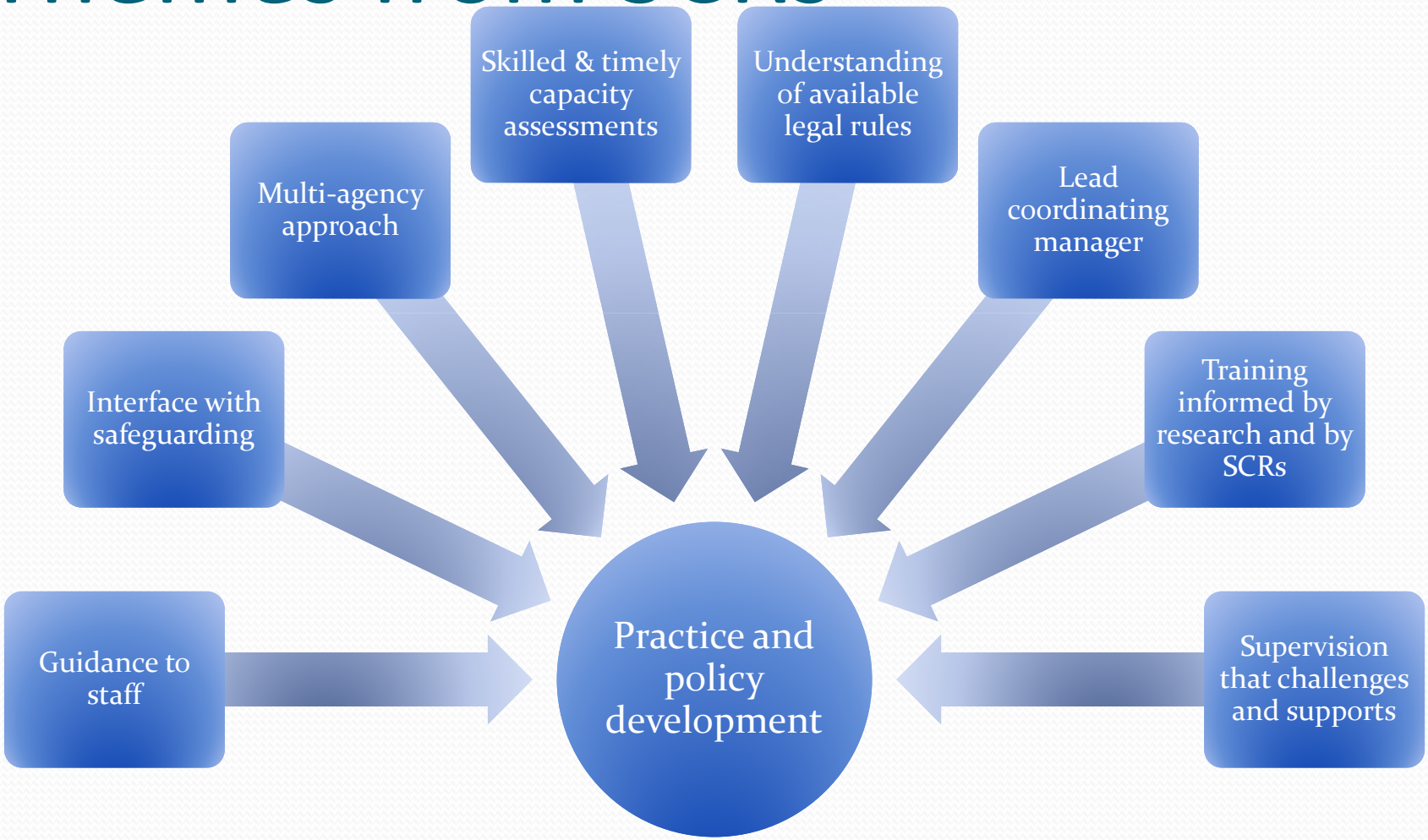
Recommendations to Agencies

- 81% contained recommendations for the SAB itself, with adult social care also targeted (71%).
- NHS commissioners (42%), Housing (29%), Mental health and acute care sectors (23%), Police (19%), GPs (16%)
- Some recommendations where it was not possible to identify the healthcare organisation (5 reports) or other agency (21 reports – 68%) charged with taking forward particular actions.
- Recommendations often directed simultaneously at a number of agencies and/or professionals, making audit of progress difficult.
- Only 14 SCRs (45%) contained action plans.

Types of Recommendations

- Broad categories relating to procedures, best practice, SCR process, and staff training and support.
- Support – training (84%), supervision (48%)
- Procedures – develop guidance (77%), referral & assessment (71%), case management (65%), recording (58%), working together (45%), information sharing (39%)
- Best practice – relationship-centred (48%), engaging hard to reach (48%), mental capacity (48%), carer involvement, (42%) legal knowledge (19%)
- SCR process – action plan (48%), managing process (45%), using SCR (45%)

Themes from SCRs



Thematic Analysis – Adult

- History – explore questions why; curiosity
- Person-centred approach – be proactive
- Hard to reach – try different approaches, use advocates and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure
- Mental capacity – ongoing assessment & review, guidance for staff regarding people with capacity who refuse services and are at risk
- Carers – offer assessments, concerned curiosity & challenge, explore family dynamics, engage neighbours

Thematic Analysis – Team around the Adult

- Recording – clarity & thoroughness of work done, agreed plans, outcomes achieved, discussions held
- Legal literacy – know and consider available law
- Safeguarding literacy – awareness of guidance & procedures, of risks and vulnerabilities, of safeguarding systems; adequate exploration of apparent choices
- Working together – silo working, threshold bouncing, shared assessments & plans, liaison & challenge, follow-through
- Information sharing
- Advocacy – consider use with hard to engage people
- Use of procedures – DNAs, safeguarding alerts, risk assessments
- Standards of good practice – thoroughness of assessments, challenge professional optimism, lack of assertiveness & curiosity, authoritative practice

Thematic Analysis – Organisations around the Team

- Support – cases are complex, high risk, stressful & demanding, so support systems essential; review scope and adequacy of policies
- Culture – encourage challenge & escalation of concerns; balance personalisation with duty of care; review case management approach
- Supervision & managerial oversight – senior managers should take responsibility for overseeing complex cases; effective supervision; use risk panels; audit cases
- Staffing – practitioners must have appropriate experience & resilience; review allocation of work; mindful of health & safety

Thematic Analysis – LSAB around the Organisations

- Conducting SCRs – involve family & carers, avoid delay
- Monitoring & action planning – robust action plans and audits of impact needed
- Procedures & guidance – develop protocols on risk & capacity assessments, follow up of service refusal, cases where adults have capacity but at risk of harm
- Use of SCR – across LSABs, in training, with government departments, for procedural development
- Training – on mental capacity, law, procedures, writing IMRs, on person-centred approach & strategies to engage people; evidence outcomes

Final Observations

- Difficulty of obtaining SCRs limits learning.
- Emphasis on procedural development but guidance often ignored or not embedded.
- Emphasis on training but outcomes, if captured, variable.
- Does publication make a difference? Publication of executive summaries or full reports?
- Legal, ethical and organisational contexts important to explore in SCRs.
- Descriptive but do we know why things mapped out the way they did?
- To what degree will the Care Bill help with these cases – statutory LSABs, duty to cooperate, duty to review cases; likely absence of power of entry & protection orders

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dealing with situations involving abuse and neglect can be stressful and distressing for staff and workplace support should be available.

14.173. Managers need to develop good working relationships with their counterparts in other agencies to improve cooperation locally and swiftly address any differences or difficulties that arise between front line staff or managers.

14.174. They should have access to legal advice on when proposed interventions, such as the proposed stopping of contact between family members, require applications to the Court of Protection.

Designated Adult Safeguarding Manager

14.175. Each SAB should establish and agree a framework and process for any organisation under the umbrella of the SAB to respond to allegations and issues of concern that are raised about a person who may have harmed or who may pose a risk to adults. The framework should have clear recording and information-sharing guidance and explicit timescales for action and be mindful of the need to preserve evidence. This will be whether the allegation or concern is current or historical.

14.176. Each member of the SAB should have a Designated Adult Safeguarding Manager (DASM) responsible for the management and oversight of individual complex cases and coordination where allegations are made or concerns raised about a person, whether an employee, volunteer or student, paid or unpaid. DASMs should keep in regular contact with their counterparts in partner organisations. They should also have a role in highlighting the extent to which their own organisation prevents abuse and neglect taking place.

14.177. The DASM should provide advice and guidance within their organisation, liaising with other agencies as necessary. The DASM should monitor the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

14.178. The DASMs will work with care and support providers and other service providers e.g. housing and NHS trusts to ensure that referral of individual employees to the DBS and, or, Regulatory Bodies (e.g. CQC, HCPC, GMC, NMC) are made promptly and appropriately and that any supporting evidence required is made available.

14.179. The DASMs will ensure that systems are in place to provide the employee with support and regular updates in respect of the adult safeguarding investigation. Particular care must be taken to not breach the right to a fair trial in Article Six of the European Convention on Human Rights as incorporated by the Human Rights Act 1998.

14.180. DASMs should ensure that appropriate recording systems are in place that provide clear audit trails about decision-making and recommendations in all processes relating to the management of adult safeguarding allegations against the person alleged to have caused the harm or risk of harm and ensure the control of information in respect of individual cases is in accordance with accepted Data Protection and Confidentiality requirements.

14.181. The local authority DASM will need to work closely with the children's services Local Authority Designated Officer (LADO) and other DASMs and LADOs for both adults and children in the region or nationally to ensure sharing of information and development of best practice.

14.182. There may be times when a person is working with adults and their behaviour towards a child or children may impact on their suitability to work with or continue to work with adults at risk. This may be referred to the DASM from a LADO, if it is not, then information should be shared with the LADO. Each situation will be risk assessed individually.

14.183. There may also be times when a person's conduct towards an adult may impact on their suitability to work with or continue to work with children. All these situations must be referred to the LADO.

14.184. Unless it puts the adult at risk or child in danger, the individual should be informed that the information regarding the allegation against them will be shared. Responsibility lies with the person receiving the information to obtain the consent of the individual to share information. The person with the allegation against them should be offered a right to reply, wherever possible seek their consent to share, and be informed what information will be shared, how and who with. Each case must be assessed individually as there may be rare cases where informing the person about details of the allegations may increase the risks to the adult or child.

14.185. Decisions on sharing information must be justifiable and proportionate, based on the potential or actual harm to adults or children at risk and the rationale for decision-making should always be recorded.

14.186. When sharing information about adults, children and young people at risk between agencies it should only be shared:

- where relevant and necessary, not simply all the information held;
- with the relevant people who need all or some of the information; and
- when there is a specific need for the information to be shared at that time.

Senior managers

14.187.

Safeguarding

Adult safeguarding means **protecting** a person's right to live in safety, free from abuse and neglect. This section of the guidance sets out a series of principles to inform **all adult safeguarding** work focusing on:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership

Local Authorities Must:

- Make enquiries, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect – such enquiries should establish whether any action needs to be taken to stop prevent abuse or neglect, and if so, by whom
- Set up a Safeguarding Adults Board
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult review where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them
- Co-operate with each of its relevant partners (as set out in section 6 of the Act) in order to protect adults experiencing or at risk of abuse or neglect.

All Staff Must:

- Keep accurate records, clearly stating what the facts are and what are the known opinions of professionals and others.

Safeguarding Adults Board (SAB) must:

- Publish a strategic plan for each financial year that sets how it will meet its main objectives and what the members will do to achieve these objectives.
  - The plan ***must*** be developed with local community involvement, and the SAB ***must*** consult the Local Healthwatch organisation
- Publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy, as well as detailing the findings of any Safeguarding Adults Reviews or any on-going reviews
- Conduct any necessary safeguarding Adults Reviews.

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DEPRIVATION OF LIBERTY SAFEGUARDS

Update report for Safeguarding Adults Board January 2015

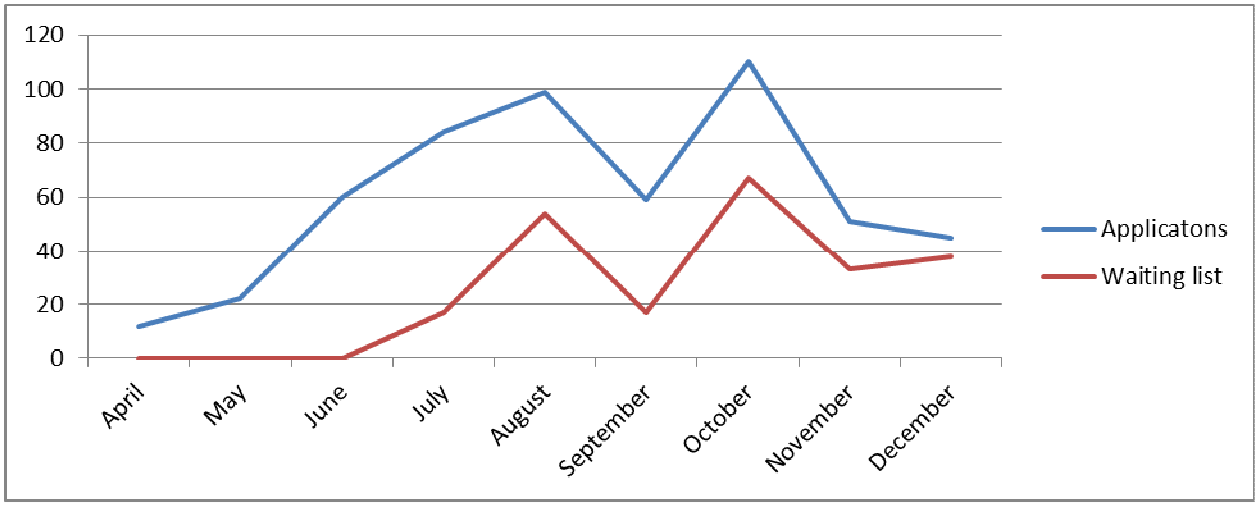
PLYMOUTH CITY COUNCIL

DoLS applications made to Plymouth City Council Supervisory Body

67	Applications in 2013-14

550	Applications in 2014-15 (April to December)		
of which Care Homes		**of which Hospitals**	
261	Dementia	51	Edgcumbe unit
90	learning disability	39	Derriford
86	Other (not DE or LD)	23	Other hospitals/wards (including out of area)

Number of Applications received from Care homes and hospitals per month



311	Total number of people awaiting assessments
18	High priority applications awaiting assessment
30%	of applications assessed not leading to authorisations (½ of which person had capacity)
117	People currently subject to authorisations (all will require a re-assessment this year)

Safeguarding Adults Board DOLS Supreme Court task and finish group

The Supervisory body, Plymouth Community Healthcare and Derriford Hospital attended the first meeting of the DoLS task and finish group 24 November. Apologies: ASC and CCG
The task and finish group plans to meet again in May 2015.

Deprivation of Liberty Safeguards -

PCH has an action plan monitored by the PCH MCA sub-group. There is an MCA/DoLS policy going out for consultation.

Derriford – Restraining therapy guidelines are being updated to take into account Cheshire West Judgment. Karen Grimshaw is working toward having a named medical lead for mental capacity.

DoL in other community settings – Court of Protection

PCH – All teams have been spoken to and asked to put forward individuals they are aware of including people living on their own. 28 people were identified, 24 of which have learning disabilities.

Actions

Roslynn to arrange a DoLS communication to care homes	
Roslynn to explore inclusion of consideration of DoL in whole institution safeguarding/review closure processes.	
Roslynn to explore inclusion of consideration of DoL in transition planning from age 16 where a person lacks capacity to consent to care.	
Roslynn to circulate date of 6 month review meeting in May/June.	
Ian/Amanda to consider including consideration of DoL in discharge planning from mental health units.	
Karen to notify Roslynn if an MCA medical lead is appointed for Derriford	
Karen to consider consideration of DoLS in discharge planning to care homes where this is against the patient's stated wishes	
Karen to consider coroner notification process for people subject to DoLS authorisations	
Roslynn to seek view of CCG	
Roslynn to circulate safeguarding policy on unauthorised DoL and alerts	
Roslynn to forward minutes to Safeguarding Adults Board.	
Ian to consider introducing a specific 3rd party DoLS application process	
Ian to feed back to Roslynn plans for court applications in circumstances where an urgent authorisation has expired while awaiting a best interest assessor	
Karen to notify Roslynn when central DoLS mailbox is in use.	

Proposed future dates:

The PSAB is asked to note the dates of future meetings for 2015-16 –

- 24.04.15 10am-1pm
- 16.07.15 10am-1pm
- 08.10.15 10am-1pm
- 21.01.16 10am-1pm

Venues to be discussed

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