Plymouth
Safeguarding
Adults Board

ANNUAL REPORT

2015/16

CONTENTS

INDEPENDENT CHAIR'S Foreword

I am pleased to present the Annual Report from the Plymouth Safeguarding Adults Board (PSAB) for 2015-2016. This report sets out the work and activity undertaken as individual agencies and across partnerships to make a positive difference to adults at risk in Plymouth during the last year.

The report is required by law following the introduction of the Care Act in April 2015 and is my first as Independent Chair of the Board. The role of the PSAB and my role as its Independent Chair is to hold to account the statutory partners and others who work together to ensure adults at risk in Plymouth are safe. It's important to say that the PSAB does not deliver operational services nor is it solely responsible for all for all safeguarding arrangements for adults in Plymouth. The Board exercises oversight and assurance in respect of safeguarding arrangements, some of which may be developed and led by others.

The following pages outline how safeguarding has been promoted and developed by the Board over the last year to improve collective understanding of the key issues and the safety of adults at risk of harm. These include:

- Designing policies and procedures to address complex cases, including those involving self neglect, and a pilot for a solution-focused forum to develop bespoke care packages to better manage risk and the sharing of risk.
- Providing training for managers and front line staff on issues of Mental Capacity, ensuring people's rights under the Care Act.
- Producing a framework to deliver more meaningful and effective engagement and participation with service users and others
- Embedding the principles of Making Safeguarding Personal
- Continuing to progress and have oversight of a Serious Case Review process as a consequence of the tragic death of a young Plymouth man, identifying fundamental lessons to be learnt in relation to services and decision making.
- Producing public awareness leaflets on safeguarding and hosting a significant safeguarding conference in the city with national keynote speakers.

I recognise that there have been real challenges to organisations represented on my Board during the reporting period as reduced budget settlements, changes to staff profiles and rising demands in a number of areas of complex safeguarding social policy have impacted. Despite this, commitment to safeguarding adults remains high and focused and I'm grateful to colleagues, frontline staff and mangers across organisations for their dedicated work and skill they bring to the work of the Board.

There is no room for complacency and there is much work to do to improve the performance of the Board as set out in this report but I'm confident we can secure further progress over the next year. Continued collaboration and challenge will be the foundation of our future effectiveness.

Andrew Bickley
Independent Chair, Plymouth Safeguarding Adults Board

WHO WE ARE AND WHAT WE DO

Plymouth Safeguarding Adults Board (PSAB or 'the Board') is a statutory body set up by the local authority in line with requirements of the Care Act 2014. Our main objective is to ensure that local safeguarding arrangements and partners act to help and protect adults at risk in our area.

The Care Act 2014 requires statutory members of the Board to include; the Local Authority, the police and the Clinical Commissioning Group. In Plymouth the SAB is also supported by a range of other key partner agencies and stakeholders as associate members:

- NHS England
- Care Quality Commission (CQC)
- Office of the Police and Crime Commissioner (OPCC)
- South Western Ambulance Service NHS Foundation Trust (SWAST)
- Livewell Southwest (previously Plymouth Community Healthcare PCH)
- Plymouth Hospitals NHS Trust (PHNT)
- Plymouth, Cornwall and Isles of Scilly Local Delivery Unit, National Probation Service (NPS)
- Dorset, Devon & Cornwall Community Rehabilitation Company (CRC)
- Devon and Cornwall Housing Association (DCHA)
- City College Plymouth

The PSAB meets quarterly, with representation from a wide range of partner agencies and groups, and is supported by multi-agency subgroups.

The Board's structure ensures effective join up and robust oversight arrangements are in place to promote the safeguarding of adults at risk of abuse or neglect, and ensure accountability for performance.

The Board receives regular reports on safeguarding activity from partner agencies across the city, and seeks assurance through checks and challenges that partners are fulfilling their roles to their own internal governance arrangements and external regulators. A key role is to probe and scrutinise the effectiveness of agency arrangements.

The activity reports and feedback from partner agencies allows the Board to interrogate performance data, change policies and procedures, direct resources, commission projects and specific pieces of work. This also allows it to identify priorities and set the business plan for the forthcoming years to safeguard adults in Plymouth.

The work of the Board includes:

- Providing assurance and acting as a multi-agency partnership board of lead officers and key representatives, that takes strategic decisions aimed at safeguarding adults at risk of abuse/ neglect
- Co-ordinating the work of each partner agency to minimise the risk of abuse/neglect in community and service settings
- Promoting the safeguarding interests of adults to enable their wellbeing and safety
- Promoting inter-agency co-operation to encourage and help develop effective working relationships between different services and agencies
- Developing inter-agency safeguarding adult procedures to ensure an effective and consistent response to instances of abuse/harm
- Monitoring the effectiveness of what is done to safeguard and promote the welfare of adults, reviewing performance on safeguarding adults and making recommendations about changes within partner agencies.

WHAT DOES SAFEGUARDING MEAN?

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect, and it aims to:

- Stop abuse or neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrates on improving life for the adults concerned

- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult
- Address what has caused the abuse or neglect

WHO ARE WE RESPONSIBLE FOR?

Under the Care Act 2014, safeguarding duties apply to adults who:

- have needs for care and support, and
- are experiencing, or at risk of, abuse or neglect, and
- as a result of their care and support needs, are unable to protect themselves from either the risk, or experience of abuse or neglect.

WHAT DOES THE ANNUAL REPORT INCLUDE?

Safeguarding Adults Boards are required to produce an annual report that details what both the SAB and its members have done to carry out and deliver the objectives and other content of its strategic plan.

This annual report includes:

- The data gathered regarding adult safeguarding in 2015/16
- How we have done in delivering the objectives of our strategy in 2015/16 and the associated work of our sub-groups during the year
- An overview of the continuing Serious Case Review and referral for a Safeguarding Adult Review
- Our priorities looking forward
- The contributions of our member organisations to adult safeguarding locally

This report will be published on the PSAB webpages for all partners and members of the public to access. As required by the Care Act, it will also be submitted to the Chief Executive and Lead Member for Health and Adult Social Care for Plymouth City Council, Chair of the Health and Wellbeing Board, the Police and Crime Commissioner for Devon and Cornwall, the Chief Constable of Devon and Cornwall Constabulary, and Healthwatch Plymouth.

It is expected that those organisations will consider the contents of the report, and how they can improve their contributions to both safeguarding in their own organisations, city-wide safeguarding networks, and in partnership with the Board.

BOARD structure

Plymouth Safeguarding Adults Board (PSAB)

Independent Chair: Andy Bickley

PSAB Executive Group

Chair:
PSAB Independent Chair

Membership:
PCC, Police, CCG, Safer Plymouth representative, Sub Group Chairs

Function:
Co-ordination of sub-groups
Governance and daily business of the Board
Embed Equality and Diversity
Oversight of SAB Strategic Action Plan

Safeguarding Adult Review (SAR) Sub-Group

Chair:
Local Authority
Independent Chair

Membership:
Adult Safeguarding Manager, Police, NHS/CCG, Lay Member
Function:
Receive SAR Referrals
Management of SAR process
Embed Equality and Diversity

Board Task and Finish Sub-Group

Chair:
Appointed by the Executive Group as appropriate

Membership:
Agreed as appropriate from LOG
Function: For example
Risk Management and Self-Neglect Plan
Policy and Procedures Review
Quality Assurance Framework
Learning and Development Strategy

Policy and Lead Officer Sub-Group (LOG)

Chair:
Local Authority
Independent Chair

Membership:
Agency/Provider Safeguarding Lead Officers
Function:
Vehicle for multi-agency communication
Review policy, practice and case studies
Provide appropriate membership for the Task and Finish Sub-Group

SAFEGUARDING in numbers

Levels of safeguarding concerns received

This year we recorded an increase in safeguarding concerns for the third consecutive year, in 2015/16 there were 1,731 concerns, representing an increase of 2 percent on the previous year. We can partly attribute this to increased awareness and the result of training increasing numbers of frontline staff across all sectors.

Safeguarding concerns meeting the criteria for further enquiry

Of the 1,731 concerns received, 1,101 were referred for further investigation, known as an enquiry. This means that the number of enquiries more than doubled in 2015/16 when compared to the previous year. When a safeguarding concern is received, we undertake a triage process to enable us to decide whether, and which type of safeguarding enquiry is required. For every safeguarding concern received this year, six were referred for further enquiry. This represents a considerable increase on the previous year when just three out of ten were investigated.

Types of abuse and those involved

The highest percentage of alleged victims subject to a safeguarding concern or enquiry have 'no support reason', this category is for those not in receipt of any social care services at the time of the alleged abuse.

41 percent of alleged victims subject to a concern were in receipt of a service, with the highest proportion of these having a primary support reason of Physical Support (19 percent of all concerns) followed by Learning disability (11 percent) and Support with memory and cognition (5 percent).

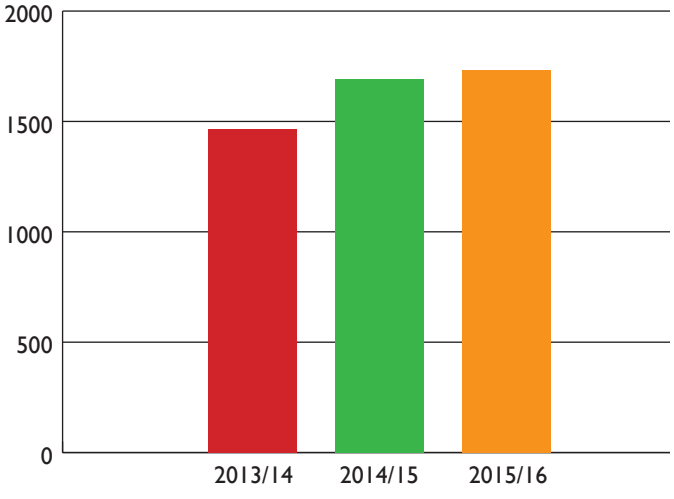
It is the same picture in relation to safeguarding enquiries with the highest percentage relating to the investigation of alleged abuse against people receiving services for Physical Support, followed by Learning Disabilities. This is illustrated in figure two below.

Location of abuse

Not surprisingly there is a big difference in the location type between those incidents where the perpetrator is a provider of social care support and when the perpetrator is another known or unknown to the victim. 61 percent of abuse involving social care support occurred within a care home setting, followed by 21 percent within the victim's own home.

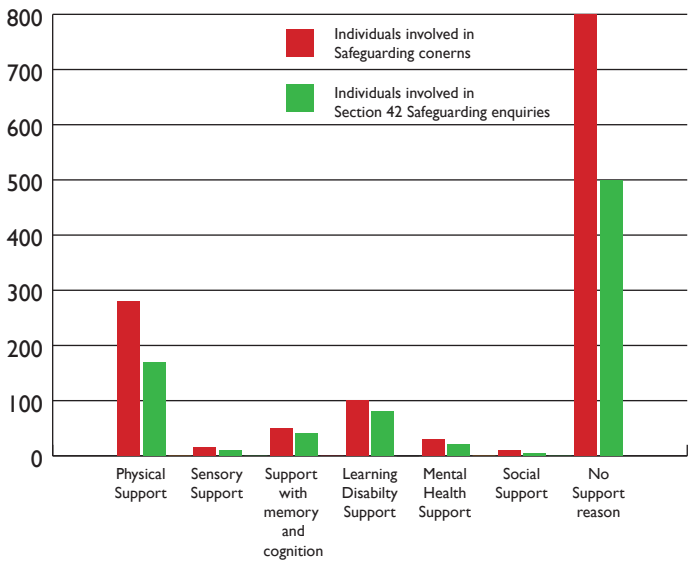
66 percent of abuse perpetrated by a person(s) known to the victim occurred within the victim's own home, with 20 percent occurring within a care home setting. Very few incidences of abuse are being reported to have occurred within a Community Service or Hospital setting (see figure four).

Figure 1 Number of safeguarding concerns received



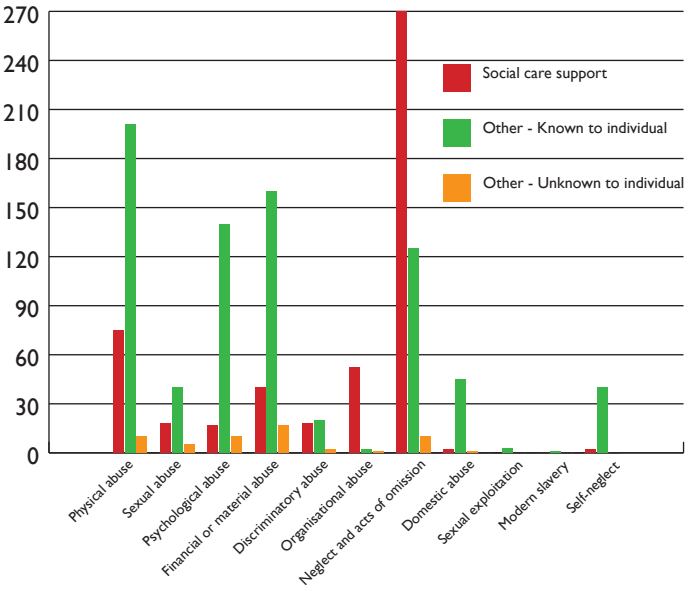
Source: National safeguarding data returns

Figure 2 Victims of abuse by primary support reason



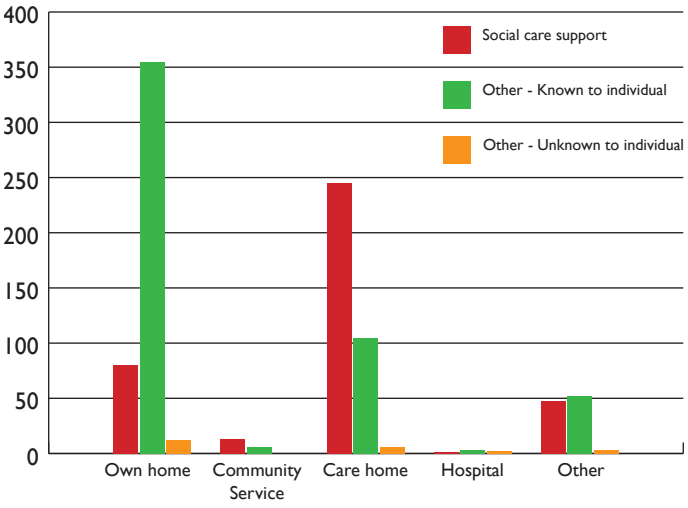
Source: National safeguarding data returns

Figure 3 Type of abuse and source of risk



Source: National safeguarding data returns

Figure 4 Location of alleged abuse



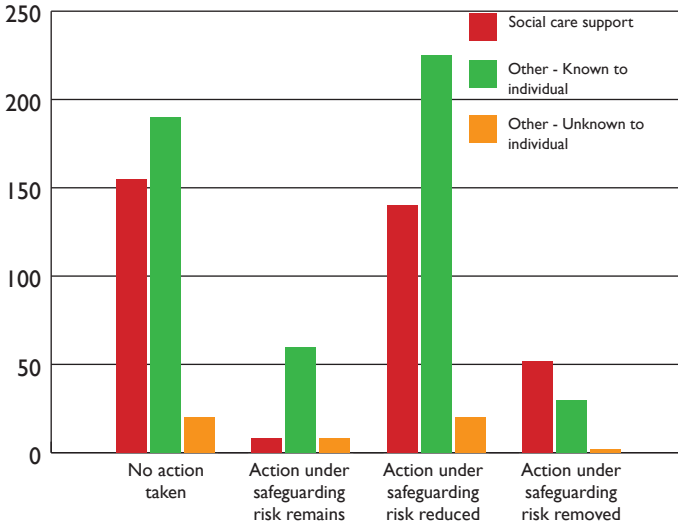
Source: National safeguarding data returns

Figure three highlights the types of abuse being alleged and the source of the victim's risk **for concluded enquiries only**. For example, if a concluded enquiry involved an allegation of financial abuse by a family member and an allegation of physical abuse from someone not known to the individual, this would be counted below as one 'Financial' with 'Other - Known to Individual' and one 'Physical' with 'Other – Unknown.

In total in 2015/16 there were 1,354 recordings related to types of abuse and source of risk identified (higher than the number of enquiries due to the rationale in the example above). Of these 58 percent were alleged to have been carried out by a person known to the victim, 38 percent by someone providing social care support and just 3 percent by someone not known to the victim. In six cases this information was not recorded.

Abuse where the perpetrator is known to the victim, but not a provider of social care was most likely to be Physical Abuse (26 percent of enquiries where the perpetrator is known to the victim, but not a provider of social care), Financial/ Material abuse (21 percent), Psychological abuse (18 percent) or Neglect (16 percent). There is a much clearer pattern in relation to alleged abuse by a person(s) who are a provider of social care support, 53 percent of these cases related to acts of Neglect, the next most common type of abuse was Physical Abuse (16 percent).

Figure 5 Completed enquiries and action taken



Source: National safeguarding data returns

Action Taken

In all safeguarding enquiries we try to help the adult at risk stay safe from harm, in line with their wishes wherever possible. This may involve taking action against the person who caused the harm or a protection plan to prevent reoccurrence of the harm. Our success in doing this can be partially measured by looking at the outcomes recorded for the victim at the conclusion of each enquiry. Figure five illustrates the outcomes for the victim in 2015/16.

In the incidences where the perpetrator is a provider of social care support, the outcome is primarily either 'no action taken' (44 percent) or 'risk reduced' (40 per cent). The category 'no action taken' should only be used where no safeguarding action has taken place at all during the case and no further action is planned, therefore that 44 per cent of enquiries concluded with this outcome raised concern and we undertook audit which found that the practitioners had been wrongly interpreting the category, and therefore that the recording was not representative. We have improved the related recording guidance and amended the recording forms by adding mandatory rationale fields. These actions have improved recording practice, and have seen the percentage of 'no action taken' recorded drop in 2015/16 compared to 2014/15 when this percentage was 57 per cent. The percentage of concluded enquiries which led to the risk being reduced increased in 2015/16. Across all concluded enquiries the percentage of outcomes that are 'risk remains' and 'risk removed' is low.

REVIEW OF PROGRESS and achievements

For its Strategic Plan for 2015-16, the Board identified and separated its priorities into those for Service and Board development, in order to differentiate between the areas it wanted to focus on across the safeguarding network, and those for its own development in line with the requirements of the Care Act 2014. Dedicated task and finish groups were established from the Policy and Lead Officer sub group (LOG) to take them forward in the following ways.

Self-Neglect

- To develop strategies for responding to risk management, self-neglect and people with complex needs who do not engage with services:

The multi-agency policy and procedures were reviewed and the related chapter revised in line with the principles of the Care Act 2014, incorporating national guidance. A risk assessment tool was identified and agreed along with related practice guidance, and was circulated to partner agencies through LOG.

It was identified that when care management and care co-ordination are unable to resolve concerns about some individuals, a different more creative approach involving multiple agencies, and often commissioning responses, is required. Accordingly the group proposed a Creative Solutions Forum, agreed a terms of reference and carried out a scoping exercise for referrals. Ongoing work involves launching a pilot of the forum, practitioners' guidance and an awareness raising event.

Mental Capacity

- To increase awareness of Advance Decisions and Lasting Powers of Attorney within services to ensure compliance with people's rights:

We designed and commissioned delivery of 21 sessions of training to nearly 300 staff across the city, to which feedback was very positive. Further sessions are planned in 2016-17. In addition a public awareness leaflet was designed, commissioned and circulated to a variety of agencies, including care homes, GP surgeries, hospitals, and community providers (see Appendix 2).

Engagement and Participation

- To undertake a review and make recommendations to increase engagement and participation with citizens and stakeholders, and develop further awareness of the Making Safeguarding Personal (MSP) agenda. This agenda was introduced to promote the inclusion of the person concerned in safeguarding investigations, ensuring that the process is person centred and focused on their desired outcomes.

Links were established with Healthwatch Plymouth and a proposal for an engagement strategy was drawn up. Unfortunately it was not possible to progress the strategy and this work will continue as a priority for 2016-17. We continued links with the Plymouth Adult User Safeguarding Executive (PAUSE), regularly consulting with members and establishing communication channels in & out of the Board. The SAB Independent Chair attended some of their meetings and the work to promote the voice of user groups will continue into the Board work for 2016-17.

We have embedded the principles of MSP in the values of the multi-agency policy and procedures manual, and multi-agency safeguarding training has been updated accordingly. Documents on the safeguarding recording system have been updated with mandatory fields to ensure that MSP is integral to any safeguarding enquiry, enabling auditing and providing assurance that the approach is being implemented. We are continuing to link with the national agenda, and to share evaluation and guidance through the Policy and Lead Officer sub group.

BOARD DEVELOPMENT PRIORITIES

Care Act Compliance

- To comply with duties under the Care Act and its statutory guidance related to Safeguarding :

We reviewed the multi-agency policy and procedures, along with practice guidance, training and public information materials in line with statutory guidance. In addition, in line with the requirements for SABs, the Board terms of reference have been revised and agreed, and the membership reviewed. We published our Strategic Pan 2015-16 and a sub group was established to manage referrals for and progress of Safeguarding Adult Reviews. We designed and commissioned a revised adult safeguarding public awareness leaflet, which was distributed to all Council

public-facing offices and reception points, care homes, GP surgeries and public advisory agencies (See Appendix 2).

Quality and Performance Framework

- To agree a performance framework to provide Board assurance and inform future priorities:

Research was carried out on a number of models and the agreed model was adapted for local purposes and data (See Appendix 3).

Annual Report Framework

- To develop and agree an annual report framework:

Through multi-agency consultation via the relevant sub groups, a model was developed and agreed. This is the Board's first report following the Care Act implementation and in its current format, and its principal purpose is to show publically the work of the board and it's future focus.

Learning and Development Strategy

- To review current learning and development activity, making recommendations to the Board:

A review was completed and subsequent strategy developed to include a safeguarding competency framework covering agencies' responsibilities, evidencing and recording requirements, core values and timescales for refresher training, which will continue in 2016-17. We have continued to train a significant number of frontline staff (almost 2000) across the sectors, and deliver safeguarding courses at a number of levels. Audits have identified improved referral quality as one indication of the impact of the training schedule.

Recognising the need to strengthen networks across the area, we continue to improve how we link with other parts of the system, for example children's safeguarding, domestic abuse and community safety partnerships. However, we acknowledge that there is further work required and this will be represented in the priorities for the year ahead. Agency co-operation and engagement with the Board and its sub groups is reassuring and has resulted in some significant partnership agreements, for example a multi-agency operational pathway protocol which aids practice and defines roles and responsibilities.

PSAB CONFERENCE 2015

'Adult Safeguarding – Changes, Challenges and Opportunities'

In partnership with Plymouth City Council and the University of Plymouth, we hosted a conference in June 2015. Nearly 300 delegates came from across the country to attend a programme which included presentations by nationally recognised speakers:

- The Right Hon. Sir James Munby, President of the Court of Protection and President of the Family Division - 'The nature and limits of intervening in adults' lives.'
- Michael Mandelstam, legal author – 'Protecting adults from abuse and neglect – practice under the Care Act'
- Dr David Orr, lecturer and author – 'Self neglect: evidence base and implications for practice'
- Geoff Baines, Director for Professional Practice Quality and Safety, PCH (CIC) – 'Adult safeguarding in health settings'

Feedback was very positive:

"The speakers were excellent; I have learnt a lot and some of the points were very thought provoking"

"Provided good insight into the complex landscape of safeguarding"

"Very well planned, great range of speakers who are well known in their fields. A range of experience that enabled us to see the subject from several angles"

"Good venue, well organised and attended, with and interesting range of speakers – thank you."

PSAB Development Day November 2015

In November 2015 the Board held its first Development Day. The agenda included discussions around roles and responsibilities, the SAB's role in prevention, a gap analysis against the SCIE guidance for SABs, Board structure and governance arrangements, communication with and links to other partnership and scrutiny boards, and quality assurance mechanisms. Members submitted pledges detailing their commitment and ideas going forward, and agreed for this to be an annual event.

SERIOUS CASE REVIEW

The Care Act 2014 specifies the circumstances under which a Safeguarding Adults Board (SAB) must arrange a Safeguarding Adult Review (SAR), previously known as a Serious Case Review or (SCR). It should primarily be concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Serious Case Review (SCR) 'V'

In the last year work has continued to progress this complex Serious Case Review, originally commissioned in 2013. Following the Coroner's Inquest in February 2015, the report has been progressed with the release of key information from the Inquest, the Independent Police Complaints Commission (IPCC) and the Police.

A Serious Case Review Panel, led by an independent chair, continue to meet regularly, coordinating the work of the agencies involved and supporting the review author to deliver a draft report to the SAB Executive Group and subsequently the full Board. The work of the panel has been overseen by the Serious Case Review/Safeguarding Adult Review Sub-group of the SAB. At each sub-group meeting there is an update and discussion on progress. Subsequently reports to the Executive Group and full Board are provided quarterly.

The Independent author has maintained contact with the family and their solicitors throughout the period, acting as a point of contact for queries and communicating updates from the Panel. In April 2016 the SCR Author and independent Equalities Advisor met with family members to provide feedback on their draft report findings and recommendations. This provided greater context around the circumstances prior to the death of V. During the meeting the family introduced some significant information and raised a number of questions which have required further consideration by the Police and the Ambulance Service.

Currently there are three areas of work outstanding prior to publication. Firstly, receiving and communicating responses from the Police and the Ambulance Service to the additional questions posed by the family. Secondly, to finalise the SCR report recommendations in conjunction with the SAB and other stakeholders. Thirdly, the SAB is to receive, agree and share a plan for publication of the report. It is envisaged this will be achieved by October 2016.

Safeguarding Adult Review (SAR) Referral

In the past year the SAB SAR sub-group received a referral from a family, having followed the Coroner's Inquest into V in the local press. The family wrote to the SAB chair to request an SAR be considered in regard to the death of their daughter.

The referral was received by the SAR Sub-group and the SAB updated. Subsequently further information was requested in the form of chronologies from a number of agencies and organisations involved. This information was presented and considered at a further SAR sub-group meeting, and based on the information provided it was confirmed that the referral meet the criteria for a SAR as set out in the relevant guidance.

As a result of this decision, this year the following actions have been taken. Firstly, ongoing communication with the family; providing information on the Safeguarding Adult Review sub-group process and terms of reference, report options and define aims.

Secondly, a meeting with family members to assist with the explanation of the SAR process, understand their expectations of the process, and request their consideration of and feedback from the meeting to allow for outcomes to be further discussed and agreed. Thirdly, an independent lead reviewer has been identified and engaged with their background and curriculum vitae details shared with the family.

The next steps will include the lead reviewer receiving detailed case records and other relevant information. Also, to plan a meeting between the family and lead reviewer and, in conjunction with the SAR sub-group, confirm the specific terms of reference, model of learning, timescales and outcomes agreed. Quarterly briefings from the SAR sub-group will be provided to the Executive Group and full Board, where questions can be taken and SAB members updated.

MEMBERS REPORTS

We have welcomed new members to PSAB this year and maintained established links with others. All members have reported on their engagement with the Board priorities and emphasised their areas of focus, some of which are highlighted here:

Plymouth City Council

As the lead agency for safeguarding we have ensured that our policies and processes are Care Act compliant, and have provided management support to the Board, including chairing and co-ordination of sub groups.

We included adult safeguarding questions in our 2015 Staff Survey and developed a subsequent action plan which included

- Circulating the revised web based adult safeguarding leaflet to all public facing offices, and publishing it on web pages
- Publishing adult safeguarding information on the staff web pages and providing posters for teams without access to IT
- We audited customer facing teams and developed a city wide plan to ensure all relevant Council staff have appropriate adult safeguarding and child protection information and training
- We developed a joint child protection and adult safeguarding training scheme for taxi drivers in the city. Over 200 have been trained so far and this will continue and be included in the requirements for future licensing.

We have participated in the Home Office pilot in response to their review of the National Referral Mechanism for modern slavery, and been significantly involved with the development of both the Devon and Cornwall wide and local Plymouth Anti-Slavery Partnerships. Accordingly, we have been involved with a number of live operations and the resulting requirements.

NEW Devon Clinical Commissioning Group

The CCG have had regular representation on the SAB sub groups, in particular providing expertise and research in developing a risk assessment tool which will assist professionals in the care and risk management of those with complex needs. We contributed funding for multi-agency safeguarding adults and Mental Capacity Act training and MCA resource packs have been made available to all GP practices in the City.

The CCG Safeguarding Team work closely across the local safeguarding pathways to ensure where possible, that individual's wishes are known. Enquiries undertaken by providers are reviewed to ensure those wishes have been met.

We are committed to providing relevant data for the performance framework and have taken a lead role led the development of the learning and development framework. The CCG actively reviews its compliance with statutory guidance through regular reports to the Governing Body Executive.

PLYMOUTH CITY COUNCIL

Dorset Devon & Cornwall Community Rehabilitation Company PROBATION

Operated by Working Links

HEALTHY PEOPLE living healthy lives in healthy communities

NHS Northern, Eastern and Western Devon Clinical Commissioning Group

Dorset, Devon and Cornwall Community Rehabilitation Company (DDC CRC)

The CRC contributes to the work of the board and its sub groups. We have reviewed and audited cases related to the all of the Board Service Development Priorities, and developed training and development activities accordingly. We have raised awareness internally and externally of the changes to safeguarding under the Care Act, and have audited policy and training packages to inform practice. We are committed to continuing to share learning and themes of case reviews to inform and support the work of the Board.

Plymouth Hospitals NHS Trust

PHNT has contributed to, and continues to support the tasked working groups of the Board through their engagement with the Policy and Lead Officers Group. Related information on, for example, self neglect, MSP and the MCA has been embedded in internal policy and training packages. We have active involvement with the safeguarding partners' network to ensure compliance with duties under the Care Act 2014, contribution to S42 enquires, and regular attendance at information sharing and networking meetings. In addition, we continue to monitor data and contribute to the performance framework for Board assurance. PHNT continues to raise the safeguarding adult's agenda throughout the organisation, including through bespoke workshops and training programmes.

Plymouth Hospitals NHS
NHS Trust

Devon & Cornwall Police
Building safer communities together

National Probation Service

Livewell Southwest

Livewell Southwest

Livewell Southwest work closely within the multi-agency safeguarding network, make an active contribution to the sub groups of the Board, and have championed the area of risk management and self neglect at Board level. We were a significant contributor to the Adult Safeguarding conference held in June 2015, when the Executive Lead for Safeguarding Adults presented and was a member of the plenary panel. The conference was also attended by 22 Livewell staff who have taken back the learning to their work bases for the benefit of local people and families.

We have identified the board priorities at executive and operational level within the organisation. Specialised and advanced training on a number of related topics has been provided by the organisational leads to clinical and medical staff. The principles of MSP are embedded in practice, and all safeguarding enquiries requested to be undertaken by the organisation ensure that due consideration is given on an individual basis to involving the views of the individual at risk.

Devon and Cornwall Constabulary

We have rolled out across the force area, including Plymouth, a new safeguarding process, initially piloted in Torbay. This new process brings together all of the risk identification and assessment working practices into a single safeguarding process. Officers who identify safeguarding concerns around individuals or groups will submit a Vulnerability Screening Tool form. This is coordinated and researched by the Central Safeguarding Team, who collate any concerns around vulnerability, risk assess them, and either action immediate safeguarding action or signpost to other agencies. This new approach brings consistency, more timely interventions and improved signposting to the right agency.

We have undertaken a number of safeguarding training programmes throughout the year. This training has included general safeguarding, domestic abuse and modern slavery. Over the last year domestic abuse officers and staff have been collocated with their colleagues in the Sexual Offences and Domestic Abuse Investigation Teams (SODAITs). This has allowed better partnership working from identification of risk, investigation and support for victims.

Devon and Cornwall Police were heavily involved in a national modern slavery operation targeting car washes and nail bars, and were the Force responsible for coordinating the south west regional response. It is known that a number of vulnerable people are being exploited and this operation is an excellent example of the Force working in partnership with other agencies to safeguard communities.

Local Delivery Unit, National Probation Service

We held a safeguarding awareness week , core features of which included self neglect, MCA and MSP via a tailored approach. Links to the management of offenders on case load are built into sentence and risk management planning, and connections have been made to staff's familiarity with the practice of tailoring plans to meet the presenting needs of individuals with whom we work. We have ensured that staff are aware of their responsibilities under the Care Act., and we will be carrying out a review of safeguarding practice assessed against the guidance. Adult safeguarding training has been identified as a priority for NPS staff, and we have introduced it as a mandatory package with management monitoring built in.

PRIORITIES AND PLANS FOR 2016-19

These priorities will be reviewed and reported on annually:

Risk Management and Self Neglect

- To continue to develop the 'Creative Solutions Forum' for the City, finalise policy and plan multi-agency awareness events

Mental Health

- To gain assurance from commissioners and providers that safeguarding principles are embedded and actively promoted throughout the mental health system.
- To ensure that learning from Serious Case Reviews and Safeguarding Adult Reviews are embedded in operational practice

Engagement and Participation

To further develop a strategy with two main priorities:

- ensuring local people with care and support needs are involved in the safeguarding agenda and the SAB strategic plan
- increasing understanding of adult safeguarding across the city

Quality assurance

- To develop a multi-agency Quality Assurance and Performance sub group to analyse information from the Performance Framework, and evaluate trends and patterns for which the SAB will seek assurance and /or action plans from relevant agencies

Learning and Development Strategy

- To continue work to produce and monitor an agreed competency framework for Board partners and related agencies and organisations

SAB management arrangements

- To establish an annual review process covering SAB membership, board meetings, terms of reference, sub-groups, governance, budget and resources.
- To develop a SAB communication strategy, including revised web pages and use of social media
- To agree protocols for interaction with partnership and scrutiny boards.
- To develop links to gain assurance that safeguarding is acknowledged and embedded in other partnership boards' strategies and priorities

APPENDIX 1
2015-16 SAB budget

PLYMOUTH SAFEGUARDING ADULTS BOARD					
SUMMARY EXPENDITURE 2015/16					
			Proj. Expenditure		Actual
			£	£	Exp
SAB Employee Costs (includes on-costs)					
Safeguarding Administrator (D Grade - 50% FTE)			11,485		
Safeguarding Training Administrator (D Grade - 100% FTE)			22,970		
Safeguarding Independent Chair (J Grade - 100% FTE)			53,696		
				88,151	88,151
Engagement of Independent Chair of the PSAB					
Fees for Independent Chair			10,000		
				10,000	9,353
Learning and Development					
Core training plan			35,000		
Safeguarding Training					
Safeguarding Enquiry Training					
Safeguarding Managers Training					
MCA/DoLS Training					
MCA Awareness Training					
				35,000	35,000
Safeguarding Adults Review (SAR)					
SCR Independent Overview Report Author			10,000		
				10,000	7,572
Supplies and Services					
Printing (leaflets and banners)			1,200		1,200
Office Expenditure			200		200
Bi-Annual SAB conference			7,000		5,367
Tri-X On line Safeguarding Procedures			6,000		5,000
				14,400	11,767
Total Projected SAB Expenditure				157,551	
Total Actual SAB Expenditure					151,843
Variance					-5,708
Income Source	Contribution				
	£				
NEW Devon CCG	20.75%	37,873			
Devon and Cornwall Police	8.50%	15,514			
Probation	1.75%	3,194			
Community Rehabitation Company	1.75%	0			
	33%	56,581			
NB The SAB budget is part of the wider PCC Safeguarding budget expenditure which totalled £252,119 in 2015-16 There is additional expenditure funded by PCC not included in the SAB expenditure above, for example:					
Adult Safeguarding Manager (100% FTE)		59,816			
Adult Safeguarding Administrator (50% FTE)		11,485			
		71,301			

APPENDIX 2
publications

APPENDIX 3
performance framework

SAFEGUARDING ADULTS IS EVERYONE'S BUSINESS WITHIN A LEARNING CULTURE

PLYMOUTH ADULT SAFEGUARDING BOARD PERFORMANCE FRAMEWORK

QUESTION	Q1 does our safeguarding system protect people in a timely way and in keeping with their desired outcomes?	Q2 Is the workforce fit for purpose?	Q3 Are we satisfied with the quality of care for any adult at risk?
METHOD	Quarterly Adult safeguarding statistics Improvement activity – case conferences/case recording Multi-agency audits MSP audits/surveys Annual police report	Complaints & compliments etc. Safeguarding Training information Multi agency audits Implementation of safer recruitment standards Safeguarding Adult Review	QAIT reports/QRs HIghlight report from commissioners: Quality assurance and improvement activity / management of risk CQC reports and joint meeting intelligence Multi agency meetings Categories of concerns Contract monitoring National reporting and learning systems (SIRI analysis) Quality Surveillance Group
INDICATORS	Performance indicators Number of safeguarding concerns Number of safeguarding concerns by source organisation Number of safeguarding enquires Enquiry outcomes Percentage of enquiries where the individual or individual's representative asked what their desired outcomes were? Of the enquiries recorded what percentage of enquiries were the desired outcomes achieved? Improvement activity – case conferences/case recording Timeliness of information gathering Percentage of investigations concluded in the time agreed Percentage of enquiries resulting in a criminal investigation Number of criminal investigations resulting in charges being brought Qualitative monitoring Analysis of Making Safeguarding Personal audits/surveys Multi-agency audits (frequency and format to be agreed) Sample of enquiries	Performance indicators Number of Complaints received Number of Compliments received Agency attendance at PSAB Number of professionals trained in safeguarding awareness Outcome of training (feedback method to be agreed) Agency training uptake/ delivery Number of Domestic Homicide Reviews Number of cases where a person in a position of trust is investigated Qualitative monitoring Qualitative indicators from SCR/SARs (Number and outcomes of enquiries and outcomes) Regional learning MH reviews	Performance indicators Number of registered Providers with a CQC rating of outstanding Number of registered providers with a CQC rating of good Number of registered providers with a CQC rating of require improvement Number of registered providers with a CQC rating of inadequate ASCOF 4A The proportion of people who use services who feel safe ASCOF 4B The proportion of people who use services who say that those services make them feel safe and secure Numbers and types of SIRI's Qualitative monitoring Annual/biannual audits Sample of enquiries Over-viiew of risks and issues across the whole system

Plymouth Safeguarding Adult's Board - Data Set Quarter four 2015/16

Ref	Data Set	Data frequency	2015/16 Outturn	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4.	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Target (TBC)	Trend	RAG	Performance Comment
Q1 does our safeguarding system protect people in a timely way and in keeping with their desired outcomes?															
Ref 1	Number of safeguarding concerns	Quarterly	1,833	474	422	433	419	460	509	449	415	TBC			Ref 4 - In 2015/16. Of the concerns received, 1,101 were referred for further investigation, known as an enquiry. This means that the number of enquiries more than doubled in 2015/16 when compared to the previous year. For every 10 concerns received, 6 were referred for investigation. This represents a considerable increase on the previous year when just three out of 10 were investigated. **In quarter four the percentage rose to 75%.** Ref 6 - Enquiry outcome to victim - Between August 2015 and March 2016 the percentage of outcomes recorded as 'no action taken' has dropped, reducing to a low of 13% for those closed in March 2016. For the whole year the percentage of outcomes recorded as 'no action taken' was 40%. This is an improvement on 2014/15 when 63% of enquiries were closed as 'no action taken' - performance that was queried by the Information Centre. **In quarter four the percentage fell to 23%.** Ref 8 and 9 - The percentage of enquiries resulting in 'risk reduced' has increased to 58% for quarter four, while 'risk removed' has increased to 13%. Ref 14 - The percentage of enquiries that have been ceased at the request of the victim is on an increasing trend. In 2015/16 the percentage ceased for this reason was 14%, compared to 8% in 2014/15.
Ref 2	of which Individual	Quarterly	1,747	Information not captured				423	492	433	399	TBC			
Ref 3	of which care home	Quarterly	86	Information not captured				37	17	16	16	TBC			
Ref 17	% of concerns from Care Home	Quarterly	36%	34%	41%	40%	42%	33%	34%	39%	37%	TBC			
Ref 18	% of concerns from Community Service	Quarterly	4%	4%	2%	5%	1%	5%	5%	4%	3%	TBC			
Ref 19	% of concerns from Hospital	Quarterly	3%	3%	2%	3%	3%	2%	3%	4%	3%	TBC			
Ref 20	% of concerns from own home	Quarterly	52%	43%	45%	42%	47%	50%	54%	51%	54%	TBC			
Ref 21	% of concerns from other	Quarterly	11%	7%	11%	12%	11%	13%	10%	12%	10%	TBC			
Ref 4	Number of safeguarding enquires	Quarterly	1,167	138	137	136	148	238	297	310	322	TBC			
Ref 5	% of concerns progressing to enquiry	Quarterly	66%	29%	35%	30%	37%	56%	65%	66%	75%	TBC			
Ref 6	% of completed enquiries where 'no action taken under safeguarding'	Quarterly	41%	71%	61%	58%	61%	58%	55%	29%	23%	TBC			
Ref 7	% of completed enquiries where Risk remains	Quarterly	7%	3%	6%	9%	11%	7%	7%	8%	6%	TBC			
Ref 8	% of completed enquiries where Risk reduced	Quarterly	43%	20%	24%	27%	22%	27%	33%	52%	58%	TBC			
Ref 9	% of completed enquiries where Risk removed	Quarterly	10%	6%	8%	6%	6%	8%	6%	12%	13%	TBC			
Ref 10	% of allegations fully substantiated	Quarterly	35%	20%	21%	24%	23%	31%	43%	33%	31%	TBC			
Ref 11	% of allegations partly substantiated	Quarterly	9%	9%	13%	11%	14%	6%	7%	14%	10%	TBC			
Ref 12	% of allegations found to be inconclusive	Quarterly	17%	18%	29%	25%	21%	19%	11%	18%	20%	TBC			
Ref 13	% of allegations found to be non-substantiated	Quarterly	26%	48%	33%	29%	31%	30%	26%	23%	25%	TBC			
Ref 14	% of allegations ceased at individual's request	Quarterly	14%	5%	4%	11%	10%	15%	13%	13%	14%	TBC			
Ref 15	% of enquiries where the individual or individual's representative areasked what their desired outcomes were?	Quarterly	60%	Information not captured						51%	69%	TBC			
Ref 16	For each enquiry, where the individual or individual's representative asked what their desired outcomes were, were these outcomes;	Quarterly		Information not captured											
	Fully Achieved	Quarterly	70%	Information not captured						70%	70%	TBC			
	Partially Achieved	Quarterly	23%	Information not captured						22%	23%	TBC			
	Not Achieved	Quarterly	8%	Information not captured						8%	7%	TBC			
Ref 32	Safeguarding concerns completed within 7 working days	Quarterly	79%	66%	78%	86%	64%	66%	78%	86%	87%	TBC			
Q2 Is the workforce fit for purpose?															
Ref 22	Number of Complaints received	Quarterly	0									TBC			Ref 24 - The numbers of professionals attending safeguarding training fluctuates on a quarterly basis, although the longer term trend is steady. In 2015/16 there were 2,220 attendees, down from 2,548 in 2014/15. 2015/16 saw numbers of attendendances affected by increased non-attenders and increased sickness.
Ref 23	Number of Compliments received	Quarterly	0									TBC			
Ref 24	Number of professionals trained in safeguarding awareness	Quarterly	2220	545	584	748	671	482	568	631	539	TBC			
Ref 25	Percentage of professionals who find safeguarding training useful	Quarterly		Information not captured								TBC			
Ref 26	Number of Domestic Homicide Reviews	Quarterly	2	0	0	0	0	0	0	2	2	TBC			
Ref 28	Number of CQC providers with a CQC rating of outstanding	Quarterly	1%	Information not captured							1%	TBC			CQC Ratings - Performance updated in June - latest performance showing improvement with 3% now 'outstanding', 81% 'good', 15% 'requires improvement' and 1% 'inadequate'. ASCOF 4A - For the second year running the percentage of people who state that they feel safe has fallen, result is based on the responses of people surveyed who are in receipt of long term social care packages. Provisional results show that 63% of respondents feel safe, down from 68% in 2014/15 and below national and comparator averages. ASCOF 4B - The percentage of respondents who state that services make them feel has fallen in the 2015/16 survey (from 93% to 88%). However performance is still above
Ref 29	Number of CQC providers with a CQC rating of good	Quarterly	81%	Information not captured							81%	TBC			
Ref 30	Number of CQC providers with a CQC rating of require improvement	Quarterly	17%	Information not captured							17%	TBC			
Ref 31	Number of CQC providers with a CQC rating of inadequate	Quarterly	1%	Information not captured							1%	TBC			
ASCOF 4A	ASCOF 4A The proportion of people who use services who feel safe	Annual	70%	68%				70%				TBC			
ASCOF 4B	ASCOF 4B The proportion of people who use services who say that those services make them feel safe and secure	Annual	94%	93%				94%				TBC			
Ref 27	Number of SIRIS initiated by Adult Safeguarding	Quarterly										TBC			

Plymouth Safeguarding Adults Board

Plymouth Hospitals NHS
NHS Trust

South Western Ambulance Service NHS
NHS Foundation Trust

PLYMOUTH
CITY COUNCIL

HEALTHY PEOPLE
living healthy lives in healthy communities

NHS
Northern, Eastern and Western Devon Clinical Commissioning Group

city college plymouth

NHS England

dch

Devon & Cornwall Police
Building safer communities together

PCC
Office of the Police and Crime Commissioner
Devon and Cornwall

National Probation Service

Livewell Southwest

Dorset Devon & Cornwall
Community Rehabilitation Company
PROBATION
Operated by Working Links