REPORT TO:	**Health and Social Care Scrutiny Sub Committee 21 March 2017**
AGENDA ITEM:	**12**
SUBJECT:	**Adult Social Care: Croydon Safeguarding Adults Board**
LEAD OFFICER:	**Guy Van Dichele , Director of Adult Social Care & Disabilities**
CABINET MEMBER:	**Cllr Louisa Woodley, Cabinet Member for Families, Health & Social Care**
WARDS:	**ALL**

1. Introduction

The purpose of the report is to update the Health, Social Care and Scrutiny Sub Committee in regard to the work of the Croydon Safeguarding Adults Board (CSAB). Prior to the Care Act the Croydon Safeguarding Adults Board had been in place as a non-statutory safeguarding board in line with No Secrets Guidance (2000) This Report will outline the work of the CSAB by outlining:

- The Purpose of the Board
- Recent key developments.
- Policy and Procedures
- The work of the key committees which sit under the CSAB, including, the Intelligence Committee, which supports the work with the social care market. The social care market was the focus of the previous paper to this Sub-Committee in November 2016.
- In Appendix One there is the Glossary taken from the Annual Report which might help members and in Appendix 2 a case example of a Safeguarding Adult Review

2. Purpose of the Board

As already outlined the CSAB is now a statutory board for the and has the following functions with Croydon

- Assure itself that local safeguarding arrangements are in place as defined by the Care Act
- Prevent abuse and neglect where possible
- Provide a timely and proportionate response when abuse or neglect has occurred.
- The SAB must take the lead for adult safeguarding cross its locality and oversee and co-ordinate the effectiveness of the safeguarding work of its

member and partner agencies. It must also concern itself with a range of matters which can contribute to the prevention of abuse and neglect such as the:

- Safety of patients in local health services
- Quality of local care and support services
- Effectiveness of prisons in safeguarding offenders

3. Progress of the Board

For 2015-16 The CSAB identified six priority areas. The CSAB Annual Report (http://croydonsab.co.uk/wp-content/uploads/2016/11/CSAB-Annual-Report-2015-2016-final.pdf) sets out the progress on these key areas and RAG rates them, which is summarised in the table below

Priority Area	RAG	Comment
Develop effective governance arrangements for the CSAB	Green	Governance arrangements are in place and will be reviewed as Board develops
Communication and Promotion of Safeguarding	Green	Much work has been done in this area, leaflets / promotion
Safeguarding Adult Review Committee	Green	This is a key function of the Board (see Committees section below) and Appendix 1
Personalisation(Making Safeguarding Personal)	Amber	Making Safeguarding Personal is about ensuring the individual is at the centre of the Safeguarding Enquiry. In Croydon some good work has been undertaken by the CSAB Committees to ensure that local people ae involved and the foundations have been put in place but there is room for further development.
Performance and Quality Assurance Committee	Amber	Further developments have been made – including the introduction of a multi-agency dashboard which is in development. The Dashboard will give the CSAB a cross agency view on how well adult safeguarding in being managed. It brings together a range of performance indicators across the agencies.
Learning and Development Committee	Amber	There is a range of training and development opportunities in place but there needs to be further coordination and planning for the future as learning and development is essential in ensuring good safeguarding practice.

4. Recent Developments

Outlined below are some of the key developments which are improving the Boards effectiveness.

4.1. Placing the CSAB on a statutory footing has given the Board a new impetus. *The Annual Plan* published last year set out a clear vision for the Board in a document which was far more user friendly than previous versions. This report has

previously been shared, but as a reminder a link to the Report is enclosed (http://croydonsab.co.uk/wp-content/uploads/2016/11/CSAB-Annual-Report-2015-2016-final.pdf). The report is available to the Public on the new CSAB website which has been developed this year. (www.croydonsab.co.uk)

4.2. *Independent Chair*. The recruitment of a new chair for the CSAB, who is also the chair of the Croydon Children Safeguarding Board. The reason for this is to ensure there are strong links between both Boards and that there is joint work on strategic areas such as domestic violence, modern slavery and radicalisation, which impact on both adults and children.

4.3. *Leadership Executive.* This has been established and includes wider partners beyond the statutory members on the Board. It has agreed shared funding to support these arrangements. This group plays a significant role in setting the strategic direction of the CSAB to ensure it meets it core objectives.

4.4. *Joint Adults and Children's Safeguarding Committee*. This is a new Committee which will focus on joint policies between the Children and Adult Safeguarding Boards and will focus on strategic cross cutting issues. It is chaired by the Independent Chair, Sarah Baker

4.5. *Development Day of the CSAB.* Recently CSAB met to review the progress that CSAB had made since the Care Act was implemented and to begin developing the strategic plan for next year. This was a lively and productive event, which showed, without being complacent, that the CSAB had made significant progress since the implementation of the Care Act. There was much discussion about the priorities for the next year. It was recognised that the CSAB was now working very closely with other Multi- Agency Boards and that priorities need to compliment rather than duplicate. For example Domestic Violence is a key priority for all but this is led by Safer Croydon Partnership and the CSAB support this priority through tits joint work .

4.6 Strategic Plan. Following a steer from the working day the CSAB Chair has been working to develop a draft of the next Strategic Plan. The Care Act (Schedule 2) has given Safeguarding Adults Boards the statutory duty of publishing a Strategic Plan. The previous Strategic Plan had identified a number of priorities which the Annual Plan reported on progress. The unanimous view was there needed to be fewer priorities which complimented rather than duplicated the work of other Boards. The draft priorities that were identified were:

- **Seek out the voice of the adult.** Although there has been an area of focus through such initiatives as Making Safeguarding Personal the view of CSAB members that this is an area priority which continues to need more focus.
- **To ensure that learning and development reflects local need and is responsive to change.** Learning and Development of people involved in safeguarding work is key to good safe practice.
- **Improve awareness and application of the Mental Capacity Act (MCA)**. MCA should be an integral part of practice, when working with people with significant care and support needs.

These priorities have still to be agreed through CSAB governance process but one in place will underpin the work of the CSAB Committees discussed later in the report.

5. Policies and Procedures

5.1. The Care and Support Statutory Guidance (14.137) stipulates that there is collaboration between partners to create a 'framework of inter-agency arrangements' to protect adults. The Policy and Procedures are the responsibility of the CSAB and are vital to give a framework for safe safeguarding practice. Croydon have supported the development and use the Pan London Procedures administered by Association of Adult Social Services (ADASS). This ensures there are consistent procedures across London. Enclosed is a link to these for information.

(https://londonadass.org.uk/safeguarding/review-of-the-pan-london-policy-and-procedures)

5.2. These Policies and Procedures are updated at regular intervals, the last update being August. Croydon are fully represented on the groups responsible for this work. CSAB also have developed local procedures to meet local situations, such as Self Neglect and managing concerns in respect of providers.

6. Safeguarding Activity

6.1. Pages 10-12 of the Annual Report highlights the safeguarding activity, in Croydon. The report highlights that there were 1638 safeguarding concerns reported last year, over 65% went on to further enquires under S42 of the Care Act. This was a significant increase from the previous year and current estimates strongly suggest there will be a further increase this year. Not all cases raised as safeguarding concerns transpire to be safeguarding matters requiring a full s42 Safeguarding Enquiry. In fact sometimes this can be unhelpful to the person at the centre of the Enquiry, Therefore, Croydon Council have now developed a function within the People's Directorate Central Duty Team whereby all Safeguarding Concerns are triaged before S42 Enquiries start. This has proved to be successful. Although the numbers of concerns are increasing a smaller percentage are going on to enquiries with others being managed with a more appropriate response.

7. Croydon Safeguarding Adults Board Committees.

As briefly noted CSAB have several Committees which focus on key areas of activity and drive forward the day to day work which supports the CSAB priorities.

7.1. *Joint Chairs Committee*, This Committee brings together the chairs of those committees below to ensure that there is synergy between all of their work plans.

7.2. *The Health Committee.* This Committee brings together the NHS organisations / Public Health in Croydon to focus on safeguarding adults and enables Health to bring concerns and recommendations to the CSAB. It is a key group in driving the CSAB priorities within the NHS.

7.4. *Performance and Quality Assurance Committee*. This Committee focuses on the multi- agency performance in safeguarding. The Groups has developed a multi-agency dashboard which is currently being updated. Focusing on Safeguarding performance is a key function of the CSAB in support of its key objective. A key area of work has been the development of a multi-agency

7.5. *Safeguarding Adults Review Committee*. The Care Act (S42) requires that a Safeguarding Adults Review is undertaken, where someone may have died as a result of serious abuse / neglect or that someone experienced serious abuse / neglect that resulted in a major impact on their lives. The role of the committee is to decide whether a case should be subject of a SAR and how this would be conducted as there are several ways of doing this proportionate to the circumstances of a case.

7.6. *Mental Capacity Act and Deprivation of Liberty Safeguarding Committee*. The role of the Committee is to support and ensure the principles of the Mental Capacity Act are embedded in Safeguarding work.

7.7. *Learning and Reflection Committee*. This Committee is essential to ensure improvements in safeguarding practice. It oversees the programme for learning and development across the Agencies.

7.8. *Public Awareness and Information Dissemination Committee (PAID)*. This is a key group in developing the interface with the public, particularly those who use services. A key focus recently is developing initiatives to ensure that unrepresented groups are given a stronger voice. It also has a major role in ensuring Making Safeguarding Personal is the foundation of safeguarding practice.

7.9. *Intelligence Committee.* The work of this CSAB Committee was discussed in depth at the last Health and Social Care Scrutiny Sub Committee. The Intelligence Committee brings together relevant colleagues from safeguarding, operational services, commissioning, contracting and health teams to share information that is of concern in respect of Providers. It also shares, examples of good practice and general information – for example information from contract management visits. The Committee is responsible for the Provider Concerns process and it has developed good links with CQC. Currently there are no Providers in Croydon rated as Inadequate. The table below gives a current summary of CQC ratings. There is one Provider rated as Outstanding – Croydon Shared Lives Service. Over 80% of Providers are rated as Good in Croydon.

Outstanding	1
Good	169
Requires Improvement	40
Inadequate	0

8. Conclusion

The report has set out the work that the Croydon Safeguarding Adults Board has undertaken since the implementation of the Care Act. The CSAB has good inter-agency support and has set out a structure to support future development. A key achievement is having in place a someone with experience and knowledge to chair both the Children and Adult Safeguarding Board. This is leading to stronger links between both Boards and will help to develop consistent safeguarding services across all ages.

9. Recommendation

The Committee are asked to support the work of the Croydon Safeguarding Adults Board as outlined in the report.

REPORT AUTHOR: Guy Van Dichele, Director of Adult Social Care & Disabilities

BACKGROUND DOCUMENTS: None

Appendix 1

Safeguarding Adult Review Example

Mr. A1 – Safeguarding Adult Review

The purpose of a Safeguarding Adults Review (SAR) is neither to investigate nor to apportion blame with the aim for professionals and agencies to learn lessons and adjust practice in the light of lessons learnt.

The CSAB commissioned a SAR into the death of Mr A1 during 2014. The Executive summary of the SAR is due to be published on the CSAB website.

Background and History:

Mr. A1 was a gentleman with a severe learning disability and epilepsy who died on 14th July 2013 in Croydon University Hospital.

Mr. A1 experienced an institutional lifestyle after spending many years living in a long stay hospital, St Lawrence's, and then moving with some of the same staff to a care home, The Gables, in 1990.

The Gables was run and managed by the NHS Trust that eventually became Surrey and Borders Partnership NHS Trust. It was set up as part of the national movement to care for people with a learning disability in smaller community based homes rather than big institutions.

The Gables was taken over by The Brandon Trust before a decision was taken a few years later for it to close. As part of the closure plan Mr. A1 was transferred to the Tree Tops, a residential home run by Totem Care on the 13th July 2013.

During the period of transition from The Gables to Tree Tops, Mr. A1 became unwell and was seen by a GP at Birdhurst Medical Practice and then again by the out of hours GP service at The Gables. As a result of the out of hour's assessment, Mr. A1 was taken to Croydon University Hospital where he was given an abdominal x-ray, blood tests and catheterised, before being discharged.

The lack of a personalised approach to care meant that Mr. A1's needs, wishes and preferences were not always 'listened' to or perceived. It was, for example, not until a visiting optician diagnosed Mr. A1 as blind in his left eye and partially sighted in his right that staff were aware he had an impairment.

Appendix 2

Glossary

This glossary is not an exhaustive list, but explains some of the key words or terms that are used in Safeguarding Adults work and in the Annual Report

Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.

ACPO (Association of Chief Police Officers), an organisation that leads the development of police policy in England, Wales and Northern Ire-land.

ADASS (Association of Directors of Adult Social Services) is the national leadership association for directors of local authority adult social care services.

Adult Services arrange social care and support for adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers. Adult social care services include the provision by local authorities and others of care homes, day centres, equipment and adaptations, meals and home care Adult social care also includes services that are provided to carers.

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

Alert is a concern that a person at risk is or may be a victim of abuse, neglect or exploitation. An alert may be a result of a disclosure, an inci-dent, or other signs or indicators.

Central Referral Unit is where all adult safeguarding referrals to the police are received, risk assessed, graded and allocated for action by the most appropriate police team and/or partner agency.

CCGs (Clinical Commissioning Groups) were formally established on 1 April 2013 to replace Primary Care Trusts and are responsible for the planning and commissioning of local health services for the local population.

Clinical Governance is the framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care.

Community Safety Partnerships bring agencies and communities together to tackle crime within their communities. Community Safety Partner-ships (CSPs) are made up of representatives from the responsible authorities, these are Police, police authorities, local authorities, Fire and Rescue authorities, Clinical Commissioning Groups and Probation

CPS (Crown Prosecution Service) is the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

CQC (Care Quality Commission) is responsible for the registration and regulation of health and social care in England.

DASH (Domestic Abuse, Stalking and Harassment and 'Honour'- Based Violence) risk identification checklist (RIC) is a tool used to help front-line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.

Disclosure and Barring Service (DBS) was established in 2012 through the Protection of Freedoms Act and merges two former organisations, the Criminal Records Bureau and the Independent Safeguarding Authority. The DBS is designed to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults. The DBS search police records and barring lists of prospective employees and issue DBS certificates. They also manage central barred lists of people who are known to have caused harm to vulnerable adults.

DOLS (Deprivation of Liberty Safeguards) are measures to protect people who lack the mental capacity to make certain decisions for them-selves. They came into effect in April 2009 using the principles of the *Mental Capacity Act 2005*, and apply to people in care homes or hospitals where they may be deprived of their liberty.

Domestic Homicide Reviews are commissioned by local Safer Communities Partnerships in response to deaths caused through domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the *Domestic Violence Crime and Victims Act 2004*. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Family Group Conferences (FGC) are used to try and empower people to work out solutions to their own problems. A trained FGC coordinator can support the person at risk and their family or wider support network to reach an agreement about why the harm occurred, what needs to be done to repair the harm and what needs to be put into place to prevent it from happening again.

HealthWatch is the new independent consumer champion created to gather and represent the views of the public. It exists in two distinct forms - local Healthwatch and Healthwatch England at a national level. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch has taken on the work of the Local Involvement Networks (LINks).

Health and Well-being Board a statutory, multi-organisation committee of NHS and local authority commissioners, co-ordinated by the local authority which gives strategic leadership across Hampshire regarding the commissioning of health and social care services.

MAPPA (Multi-agency Public Protection Arrangements) are statutory arrangements for managing sexual and violent offenders.

MARAC (Multi-agency Risk Assessment Conference) is the multi-agency forum of organisations that manage high risk cases of domestic abuse, stalk-ing and 'honour'-based violence.

MASH (Multi Agency Safeguarding Hub) is a joint service made up of Police, Adult Services and the NHS. Information from different agencies is collated and used to decide what action to take. This means the agencies will be able to act quickly in a co-ordinated and consistent way, ensuring that the person at risk is kept safe.

Mate Crime occurs when a person is harmed or taken advantage of by someone they thought was their friend. There is limited information on the prevalence of Mate Crime nationally; however there has been an increase in the number of safeguarding alerts that involve Mate Crime across Hampshire in recent years.

Mental Capacity refers to whether someone has the mental capacity to make a decision or not. The Mental Capacity Act 2005 and the code of practice outlines how agencies should support someone who lacks the capacity to make a decision

NHS (National Health Service) is the publicly funded health care system in the UK.
OPG (Office of the Public Guardian), established in October 2007, supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.

PALS (Patient Advice and Liaison Service) is an NHS service created to provide advice and support to NHS patients and their relatives and carers.

Safer Neighbourhood Teams are local police working with local people and partner agencies to identify and tackle issues of concern in their area to make neighbourhoods safer.

SAR (Safeguarding Adult Review) undertaken by a Safeguarding Adults Board when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SI (Serious Incident) is a term used for serious incidents in the NHS. It is defined as an incident that occurred in relation to NHS-funded ser-vices resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

Wilful Neglect or Ill Treatment is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a per-son who lacks capacity to care for them. *Section 44* of the *Mental Capacity Act 2005* makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.