

Report to: People Scrutiny Committee

Date of meeting: 1 October 2018

By: Director of Adult Social Care and Health

Title: Safeguarding Adults Board (SAB) Annual Report

Purpose: To present the SAB Annual report as required by the Care Act 2014

RECOMMENDATION:

The Committee is recommended to comment on and note the contents of the report.

1 Background

1.1 The SAB Annual Report (Appendix 1) outlines the multi-agency safeguarding activity for vulnerable adults in East Sussex between April 2017 and March 2018.

1.2 Appendix 2 outlines a breakdown of safeguarding enquiries by sector and by the agency making the referral for 2017-18, as requested by the Scrutiny Committee.

2 Supporting information

2.1 Four safeguarding adult review (SAR) referrals were made in 2017 – 18. Of these referrals, one is being taken forward as a Serious Case Review by the Local Safeguarding Children's Board (LSCB), as the majority of the concerns occurred before the person turned eighteen years of age.

2.2 The second referral is still under consideration by the SAR sub-group as, at the time of this report, the case is still subject to a section 42 safeguarding enquiry by the local authority and a serious incident process by a health provider.

2.3 The third referral was for a woman with complex support needs who was found deceased in her room in a mental health inpatient unit, with her cause of death recorded as methadone toxicity. A serious incident investigation was completed by the health provider, and the case was subject to a coroner's inquest. A SAR was not required as all the appropriate learning points had been gained from the coroner's inquest and serious incident process.

2.4 The fourth referral, regarding a woman in her nineties who was living with family members when she died and concerns have been raised over possible abuse and neglect, is being taken forward as a discretionary SAR and learning from this will be reported later in the year.

2.5 The number of safeguarding enquiries completed appears to have decreased significantly since 2016 – 17 (decreasing from 4,222 to 1,450). This is because of a change in the way safeguarding activity is recorded following lessons learned in the previous year. Previously, all safeguarding concerns were recorded as enquiries and these enquiries were managed in proportion with the degree of risk associated with each concern raised. Now concerns and enquiries are recorded separately.

2.6 In 2016 – 17, the most common form of abuse reported was neglect followed by physical and then emotional abuse. In 2017 – 18, neglect is still the most common type of abuse with 49% of all enquiries undertaken comprising, at least in part, neglect. Physical and emotional abuse remain the second and third most common forms of abuse accounting for 29% and 26% respectively.

2.7 As in previous years, the most common reported location of abuse is in the adult at risk's own home (32%). This is a drop from 37% in 2016 – 17. The second most common location continues to be residential care homes, accounting for 30%. This is an increase from 23% in 2016 – 17. Reported abuse in nursing homes has reduced from 18% to 13% whilst cases in mental health hospitals have increased from 1% to 5% of all cases.

2.8 In 2017 – 18, in 89% of enquiries there was an identified risk to the adult and action was taken. In 91% of cases the risk was either reduced or removed completely. This is a slight increase from 90% in 2016 – 17. It should be acknowledged that it is unlikely that risk will be reduced or removed in 100% of cases, as individuals may exercise choice and control over the steps taken by authorities to mitigate the risk. The proportion of cases where risk remains has dropped significantly from 10% to 5%.

2.9 Nationally, 73% of adults who lack capacity to make informed decisions about the enquiry receive support. In East Sussex, 96% receive support. This is the same proportion as reported in 2016 – 17, but a target of 100% remains in place.

ADASS Peer Review of Safeguarding

2.10 This review, undertaken in March 2018, was positive overall of adult social care and found no issues with Safeguarding Adults practice. The key message is that we should provide opportunities to take more risks and support and empower staff to do so. An action plan has been implemented to support this and key elements of it are highlighted below:

- A new threshold decision making guidance tool for partners and providers to enable improved identification of safeguarding concerns.
- A new consultation function that brings together safeguarding expertise to support and enable providers and partners to identify safeguarding concerns from non-safeguarding concerns.
- A streamlined and outcome focused LAS system for recording safeguarding concerns and enquiries.
- Options / solutions for identifying organisational abuse using LAS.
- A standardised system for providing feedback on outcomes to referrers, and seeking feedback from adults who have experienced a safeguarding intervention.

2.11 The action plan has been implemented on a phased basis over a 12 month period and is due for completion in July 2019. The majority of the plan will be completed by March 2019; the streamlined and outcome focused LAS system will be completed by July 2019 following the LAS upgrade due in February 2019.

3. Conclusion and reasons for recommendations

3.1 This report has shown the continued effort of the County Council and partner agencies to work together to safeguard adults. The SAB will ensure learning from SARs conducted under the Care Act 2014 is shared and embedded into practice appropriately in the coming year. Adult Social care is focused on developing a multi-agency strategy for Prevention in Adult Safeguarding and is looking forward to implementing this with partners from April 2019.

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LOCAL MEMBERS: All.

BACKGROUND DOCUMENTS: None