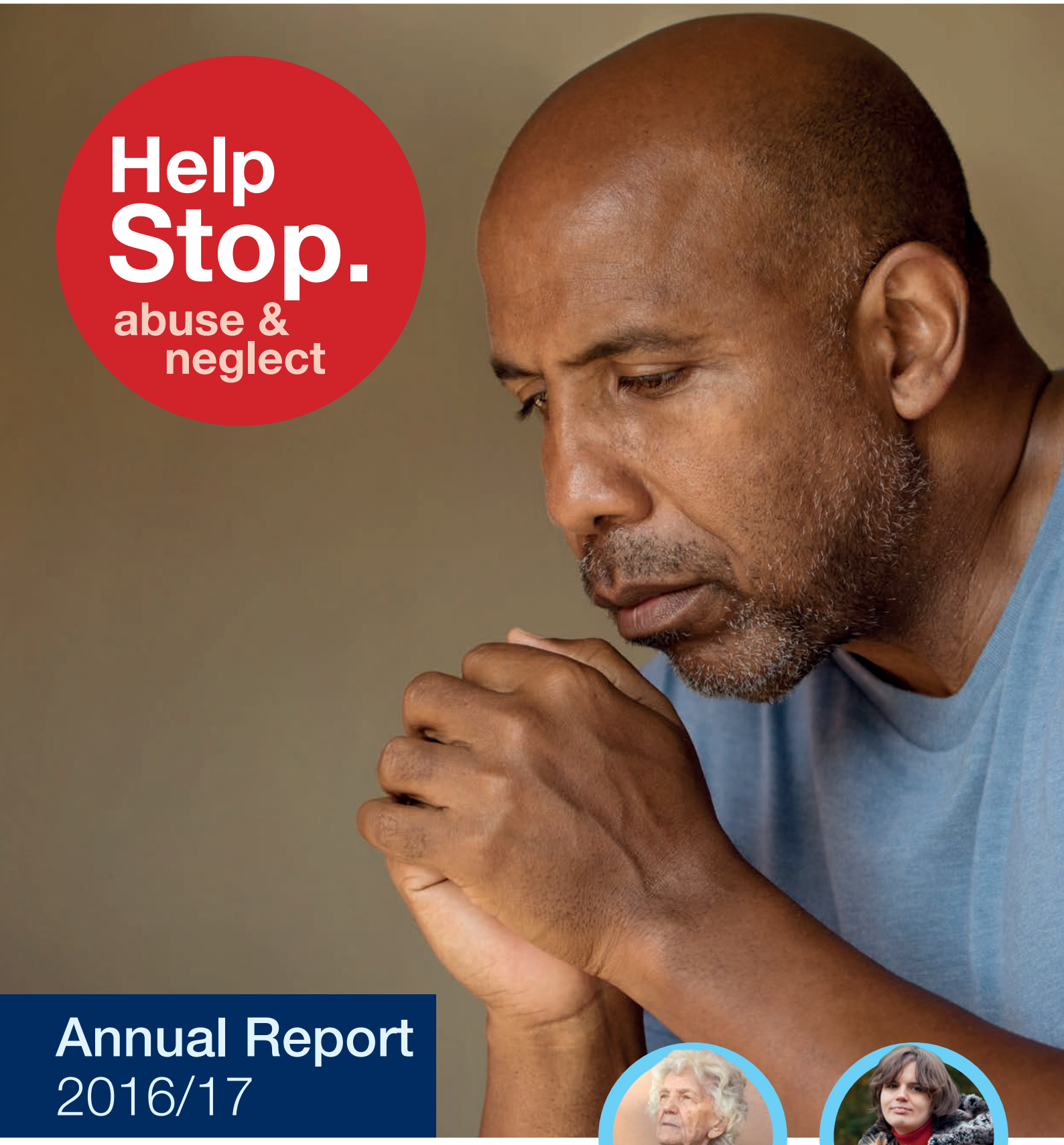
Nottinghamshire Safeguarding Adults Board



Annual Report 2016/17

Our Vision for Safeguarding Adults:
'A county where all adults can live a life free from abuse or neglect.'

Contents

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Allan Breeton, Independent Chair
Nottinghamshire Safeguarding Adults Board

Message from the Chair

Welcome to the 2016/17 Annual Report of the Nottinghamshire Safeguarding Adults Board (NSAB).

This annual report, written in line with Care Act requirements, details the work that NSAB has undertaken to carry out and achieve the objectives of year two (2016/17) of its three year (2015-2018) strategic plan, as well as highlighting partners' contributions.

NSAB continues to work towards the three priorities identified within its published three year strategic plan, namely:

- **Prevention** – NSAB will develop preventative strategies that aim to reduce instances of abuse and neglect within Nottinghamshire.
- **Assurance** – NSAB will assure itself that all partners have appropriate arrangements in place to safeguard those adults most at risk in Nottinghamshire.
- **Making Safeguarding Personal** – NSAB will develop and embed an approach to its work that is person-led and outcome-focused. We will engage the adult (or their representative) in a conversation about how best to respond to the safeguarding concern.

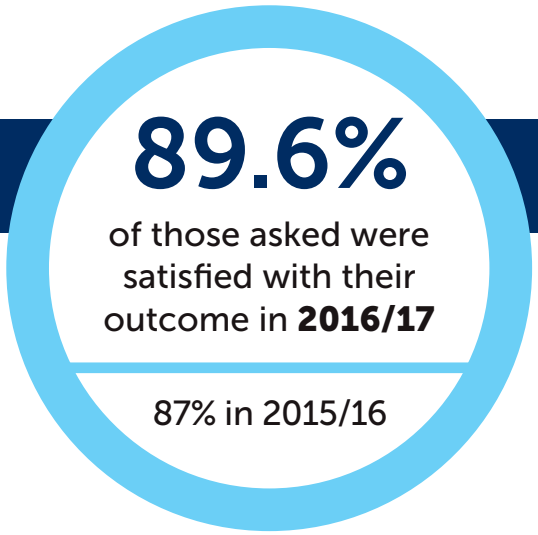
NSAB continues to meet for a full Board meeting quarterly, and holds a six-monthly Partnership event. The work undertaken by the Board is supported by the Learning and Development, Quality Assurance, Safeguarding Adults Reviews, and Communications (virtual) sub-groups. We have commissioned one Safeguarding Adults Review this year, run numerous learning events and continued to assure ourselves that partners are doing all they can to reduce and remove instances of abuse and neglect within Nottinghamshire. Further details of this work can be found in these pages, including a case study of the Safeguarding Adults Review regarding Adult H, and the work we have done as a result of the recommendations.

We continue to work in conjunction with agencies across Nottinghamshire and, as ever, our strength is in partnership working. This has been demonstrated with various presentations to the Board: the role of the Care Quality Commission within safeguarding; a presentation on the local Sustainability and Transformation Plan, and its impact upon safeguarding; and a presentation on Fatal Fire Profiling and Prevention. I would like to place on record my thanks to all of our partner agencies for their continued assistance with progressing the work of NSAB in support of delivering services that support our three year plan.

The report has taken on a slightly different look this year, presenting the information in a more concise fashion. I hope you agree that this is helpful and provides good, clear evidence of the work completed by NSAB during 2016/17. To enable us to bring you this streamlined version of the annual report, we have taken advantage of the technology available to us, so to expand on the highlights of members' contributions to our work around Safeguarding Adults in Nottinghamshire, full details of members' and partners' contributions can be found on our website at www.safeguardingadultsnotts.org

If you do not have internet access, please phone 0115 977 3911 for copies of these extra materials.

Assurance



"NSAB will assure itself that all partners have appropriate arrangements in place to safeguard those adults most at risk in Nottinghamshire."

What we said we would do	What NSAB did to achieve it	Complete
We will ensure that the Board's working arrangements are efficient and effective.	During 2016-17, NSAB implemented the sub-group structures which were reviewed and agreed during 2015/16. The Independent Chair met with the individual Statutory Board Members and the Police and Crime Commissioner, and attended meetings of the individual sub-groups. Briefings for elected Council Members were held in order to provide them with support in understanding the safeguarding agenda in Nottinghamshire.	✔
We will implement the three year communication strategy, benchmarking against relevant success measures.	Publicity materials were updated, using a co-production approach. The Safeguarding Awareness Survey was repeated. Messages were promoted using launch events, and there was television coverage of a service user's experience of the safeguarding process. A safeguarding e-bulletin has been developed, which will provide information items such as relevant safeguarding news, updates in legislation, and learning from Safeguarding Adults Reviews.	✔
We will continue to analyse and develop management information, agreed in year one (2015/16) to enable us to further identify those most at risk of abuse and neglect.	Sources of information for the Board's suite of data have been identified using a scoping exercise. Data is analysed on a quarterly basis to identify those most at risk.	✔
We will use the analysis to target support to staff across partner agencies, where required, to improve performance.	Information is shared each quarter with partner agencies and measured against the Board's performance measures. Agencies are provided with additional support where improvements in performance are required.	✔

What we said we would do	What NSAB did to achieve it	Complete
We will implement the learning pathway, agreed in year one (2015/16), across partner organisations and care providers.	The learning pathway was launched, and work has been undertaken to identify gaps in possible learning and development opportunities. Agencies have been supported to determine their priorities in implementing and embedding the pathway. The Trainers' Forum has been established and now meets approximately every four months.	✔
We will create a method to evaluate the impact of the pathway.	The review focused on Making Safeguarding Personal and outcomes, and agency assurance regarding staff competence is sought as part of the "Self-Assessment and Assurance Framework" completed every two years by agencies. A training quality assurance scheme has been developed to ensure that internal training is at the required level and has MSP embedded within.	✔
We will ensure that learning opportunities focus on a Making Safeguarding Personal approach.	The multi-agency Trainers' Forum aids those facilitating learning events to become "champions" in the subject and support best practice.	✔

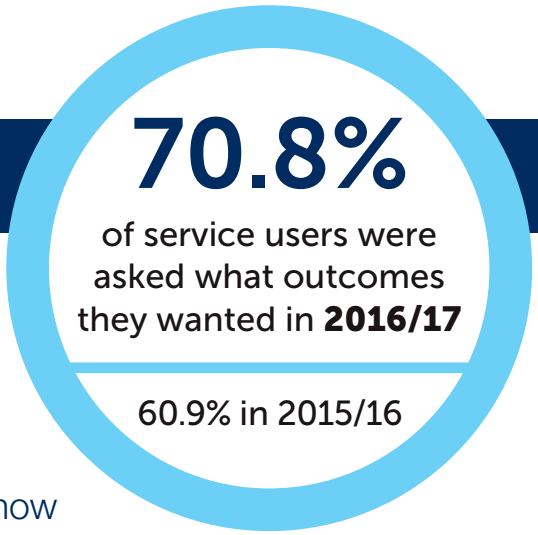
In 2016/17, NSAB partners completed the safeguarding adults Self-Assessment and Assurance Framework, and by March 2017, all partner agencies had reported as either effective, or excelling in those areas which they were required to assure us of.

67.8%

of people had risk reduced or removed in **2016/17**

61.4% in 2015/16

Making Safeguarding Personal



"NSAB will develop and embed an approach to its work that is person-led and outcome-focused. We will engage the adult (or their representative) in a conversation about how best to respond to the safeguarding concern."

"In 2016/17, Nottinghamshire County Council, as the lead agency for Safeguarding in Nottinghamshire, implemented its Capability Framework, designed to measure staff capability against a number of factors, and launched a rolling programme of multi-level safeguarding adults training for all staff within Adult Social Care and Health. This has helped to embed Making Safeguarding Personal into practice across the department."

Nottinghamshire County Council

"MSP is an integral part of safeguarding processes at the Trust. As well as seeking consent for safeguarding input, staff ask the individual what support they would like and the outcome of the enquiry."

Nottingham University Hospitals NHS Trust

Throughout 2016/17, NSAB has continued to promote the Making Safeguarding Personal agenda, encouraging partners and care providers to focus on the person, or their representative, and to work using a person-led, outcome-focused approach.

NSAB launched its Referral Pathways document in 2016, which provides guidance to both services and individual staff responsible for making safeguarding referrals into Nottinghamshire County Council on the correct actions to take in response to safeguarding concerns. This document supports the principles of proportionality and empowerment in response to safeguarding concerns.

Building upon this, NSAB has commenced a rolling programme of referrer training, aimed at those responsible for making adult safeguarding referrals within their organisation. This training has been well-received, and covers the journey to making safeguarding personal, highlighting the importance of the adult's views, as well as how to make an effective adult safeguarding referral, what to do when a safeguarding referral is not required, and how to use the multi-agency procedures and pathways in Nottinghamshire.

NSAB launched its Trainers' Forum in September 2016, aimed at those responsible for delivering safeguarding adults training within their organisation. The Forum provides professionals with a place to share best practice, network with peers from other organisations, and to gain information on subjects relevant to adult safeguarding that may support them in their training delivery. All the information discussed at the Forum has a Making Safeguarding Personal focus.

Prevention

5679
referrals received in **2016/17**

2713 (47.8%) went on to enquiry

"NSAB will develop preventative strategies that aim to reduce instances of abuse and neglect within Nottinghamshire."

Throughout 2016/17, NSAB has continued to develop preventative strategies in line with its three year priorities.

Work was finalised on the Transitions Pathway across Social Care and Health, and this was published and implemented across services during 2016/17. This pathway aims to improve transition arrangements for young adults with care and support needs across Nottinghamshire moving from Children's to Adult Services.

We have also written factsheets explaining what the different types of abuse are and what happens following a safeguarding referral being made, to give to service users, their families, and carers, to support those going through the process. These are also available in Easy Read format at www.nottinghamshire.gov.uk/abusetypes

One of the identified actions from the Communications virtual sub-group action plan was to update and distribute materials to raise awareness of adult abuse across Nottinghamshire, and how to report it. These materials (posters, leaflets, digital screens) were co-produced with various service user groups, and are displayed in GP surgeries, libraries, and day services, as well as distributed to NSAB members and partners.

NSAB has hosted presentations from Nottinghamshire Fire & Rescue Service on their 'Safe and Well' visits, and from Nottinghamshire County Council Trading Standards on 'Financial Abuse through the Letter Box', both of which aim to prevent abuse and neglect.

NSAB has also launched an e-bulletin, which is aimed at disseminating information on various national and local issues within Adult Safeguarding. We feel that it is important we assist Nottinghamshire's busy practitioners in keeping up to date with issues by providing relevant and clear updates on subjects that matter, with the aim of increasing awareness and preventing further instances of abuse or neglect.

We have used performance data to enable us to work in a targeted fashion with providers to prevent abuse occurring. NSAB also identified a service user who had been through the safeguarding process and was willing to share his experience. His case study was featured by Central TV and other Nottinghamshire media.

"Broxtowe has worked in partnership with Gedling and Rushcliffe Borough Councils to fund a social worker post [which] spans mental health and social care and provides advice ... and 1:2:1 support to individuals who do not meet the threshold for MASH or other services or who are difficult to engage."

Broxtowe Borough Council

Peter – a case study of self-neglect

Peter and his brother were born with the same rare medical condition; Myotonic Dystrophy, which affects the muscles causing weakness and wasting. It can also cause cataracts, excessive tiredness and difficulties swallowing.

Peter lived with his parents and his brother until 2009 when his parents died and he became the main carer for his brother, balancing working at an electronics factory with his caring responsibilities. Around this time, an anonymous referral was received by the Physical Disability Team expressing concern that Peter and his brother were living in squalor. They were offered a community care assessment, but they declined assistance with their care and support needs and the case was closed.

A further referral, received in September 2015 from East Midlands Ambulance Service when Peter had a fall and refused to go into hospital, raised concerns regarding the state of the property, described as dirty with food, take-away wrappers, cobwebs, and dust. The house smelt strongly of damp and the carpet squelched underfoot. Peter appeared malnourished and dirty.

Peter didn't respond to initial visits and phone calls, however a social worker eventually visited Peter, corroborating the concerns raised by East Midlands Ambulance Service. In addition, the electrics didn't work, water leaked, and the ceiling was collapsing in the front room. Letters piled up at the door made access difficult, causing a fire hazard, and indicated Peter wasn't reading essential mail. Peter agreed to a referral to Meals at Home, and to having essential electrical repairs undertaken. A referral was also made for a Promoting Independence Worker to engage with Peter and his GP was contacted regarding his mental health and capacity. Peter engaged with Meals at Home and on the few occasions they were unable to gain access to the property, they contacted Adult Social Care, providing a valuable monitoring service. Often this was because Peter had fallen asleep due to his condition.

Peter kept agreeing to certain visits and then refusing to answer the door. To gain trust and allay any fears Peter had, assurances were made that the aim was to support him in his own home, and the priority was to keep him safe. Meals at Home would read letters out to Peter to ensure he had received information. During a visit in January 2016, there were concerns about how cold it was. Peter appeared more unkempt, dirty and frail with each visit and the smell from the house was getting stronger.

A referral was made to the Multi-Agency Safeguarding Hub and an Adult Safeguarding strategy meeting was convened with Housing, Fire Service, Meals at Home, and a Care Act Advocate. The plan of action included sending letters from Housing via Meals at Home to offer Peter support. The plan was to seek Peter's permission to undertake essential repairs rather than enforce them on him.

A joint Social Care and Fire Service visit took place and smoke alarms were fitted in Peter's property. Peter also agreed for the bin men to come and put his bin out as this was now overflowing with rubbish. Little by little, Peter was allowing small gestures of support to be provided.

Peter was admitted to hospital having sustained a fall on 27th September 2016, and agreed to a Care and Support Assessment. He also agreed to go into residential care for a period until his property could be cleaned up and essential repairs undertaken. This proved to be a major turning point in Peter's engagement with services.

A working relationship developed with Peter, with at least one weekly trip to see him at the care home to support him with any tasks. Peter's boiler was repaired, the downstairs radiators were upgraded, his old bed was disposed of, a stair lift was fitted, a stair carpet was laid, and the kitchen lino and hallway tiles were replaced. Over time, Peter began to trust the involved workers as they ensured Peter was included in the whole process, taking him home to see completed works or meeting the contractors if he felt the need to.

Since moving back to his property, Peter has continued to engage well, especially with one of the care agency staff. Since moving back home, Peter has begun to replace some household items, concentrating on the kitchen first, buying himself a new cooker, microwave and saucepans. Peter has also been known to go out in the community with the support of the two main carers he trusts.

The lessons learned from this case study into self-neglect are that persistence, small steps, and a long-term strategy are key. Peter stated that the workers respected him and didn't make him feel bad for how he lived. The involved workers stated that they worked on Peter's level, at a pace dictated by Peter, and didn't apply their own values or judgements on his situation, nor force him into any actions he wasn't ready for.

Safeguarding Adults Review – Adult H

This is a summary of the Safeguarding Adults Review (SAR) regarding Adult H, which also details what NSAB has done as a result of the recommendations within this SAR.

Adult H is a confident young person who has a diagnosis of Spina Bifida and Hydrocephalus. She lives with, and has close relationships with, her mother and sister, who have provided support to her to remain within the family home over the years, although this support is now provided by professionals at Adult H's request.

Safeguarding adult referrals were made by the Ambulance Service and Hospital after Adult H had been found by her family with severe burns indicative of urine burns. A strategy meeting was held during which Adult H was described as having 14% skin loss and chronic wounds. After an extended period in hospital, Adult H returned home with a significant package of care.

Adult H's consistent desire to return home and be as independent as possible has been respected. There is no evidence she lacks capacity. The Police had no legal grounds to pursue an investigation and the Council similarly had no legal power to prevent her from returning home.

The review found that there were elements of good practice which made a difference, including persistence shown by some professionals despite high levels of non-engagement from Adult H and the response provided when Adult H was in hospital.

The review also highlighted that improvements had been made to some systems since this incident occurred:

- the creation of a new transitions team which provides a pathway between children's and adults services for people with care and support needs;
- establishment of non-attendance policies in respect of missed medical appointments;
- Think Family appointments in the GP surgery;
- regular meetings held by occupational therapists.

Although the review did not identify any major areas of concern about practice or systems, some recommendations were identified for NSAB to consider. These included:

- reviewing the measures that are in place to ensure families of young people transferring to adult services are offered a carers assessment where appropriate;
- developing a self-neglect policy;
- developing an escalation policy;
- developing advice, guidance and support for staff who work with people with capacity but who do not or are unable to engage with services.

As a result of this Safeguarding Adults Review, NSAB has acted on the recommendations made in the review, details of which can be found here: http://www.nottinghamshire.gov.uk/media/117266/adulthexecutivesummaryfinal20170130.pdf

1. Links for carer support are now included in the transitions pathway, which has been implemented across Nottinghamshire.
2. The review of the Multi-Agency Safeguarding Procedures is due to start in January 2018 and be completed by the end of March 2018.
3. Gaps (of which "service refusal" is one) were identified in the Competency Framework and it has been updated accordingly. A number of SAR Learning Events are now scheduled to take place in the Autumn of 2017, and these will include the topic of "service refusal".
4. A report has been produced and presented to the Nottinghamshire Safeguarding Children's Board (NSCB). Details of the SAR Learning Events to be held in the Autumn of 2017 have been shared with the NSCB for escalation to relevant staff.

How can I report abuse?

If you have been abused, or know someone who has, please report this to Nottinghamshire County Council on 0300 500 80 80.

You could also report this to someone you trust e.g. police, doctor, family member, social worker.

In an emergency, you should contact the relevant emergency service (police, ambulance, and fire and rescue service) by dialling 999.

What will happen next?

We may need to inform other people or organisations, such as the person's doctor, but we will ask permission before we do this.

We will work with the person affected to find out what they want to happen following a report of abuse and keep the person involved throughout the process. People have the right to change their minds about what they want to happen during the process.

Report in confidence:
Online at Nottinghamshire.gov.uk/abuse
or call 0300 500 8080

Our partners

NHS Bassetlaw Clinical Commissioning Group

NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS East Midlands Ambulance Service NHS Trust

Nottinghamshire Healthcare NHS Foundation Trust

Nottingham University Hospitals NHS Trust

Sherwood Forest Hospitals NHS Foundation Trust

Ashfield District Council

Bassetlaw District Council — North Nottinghamshire —

Broxtowe Borough Council

Gedling Borough Council

Mansfield District Council

Newark & Sherwood District Council

Rushcliffe Borough Council

Nottinghamshire Police Proud to Serve

National Probation Service

Nottinghamshire County Council

Nottinghamshire Fire & Rescue Service Creating Safer Communities

Nottinghamshire Safeguarding Adults Board

www.safeguardingadultsnotts.org

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