City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Health and Wellbeing to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on 6th September 2018

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Subject:

Safeguarding Adults at Risk of Abuse

Summary statement:

This report provides Scrutiny Committee Members with details about Bradford's Councils Health and wellbeing Departments safeguarding activities since the previous report in November 2017.

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Portfolio:

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Overview & Scrutiny Area:

Health and Social Care

1 SUMMARY

1.1 The Care Act 2014 sets out a clear legal framework for how local authorities should support and protect adults at risk of abuse or neglect. Bradford Council has a number of statutory safeguarding duties arising from the Care Act which the Council has continued to implement through changes to the structure and operating process in relation to safeguarding adults at risk of abuse including the provision of advocacy support.

1.2 The aims of the continued development of the Safeguarding Adults Team (SAT) is to provide a robust system for dealing with the increased numbers of concerns being raised whilst promoting the principles of 'Making Safeguarding Personal (MSP) to ensure that work with adults at risk remains outcome focused and person centred. Whilst ensuring key safeguarding principles of empowerment, prevention, protection, accountability, partnerships and proportionality are promoted.

2. BACKGROUND

2.1 The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should support and protect adults at risk of abuse or neglect. Bradford Council has a number of safeguarding duties arising from the Care Act including;

- Leading a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- making enquiries, or requesting other to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- establishing Safeguarding Adults Boards (SAB's), including the local authority, NHS and the Police, which will share, develop and implement a safeguarding strategy
- carry out Safeguarding Adults Reviews when someone with care and support needs dies and abuse or neglect is known or suspected, and there is a concern about how the local authority and its partners worked together to protect them, and establishing lessons learned
- arranging for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

2.2 During the periods 17/18 and 18/19 Bradford Council have continued to review and evaluate the effectiveness of the changes being implemented as part of the Care Act responsibilities.

3. REPORT ISSUES

3.1 The purpose of this report is to provide information and assurance to elected members of the continued development of the Safeguarding Adults Service in Bradford. This is to ensure that Adults at Risk in Bradford receive a high quality, safe and effective service which promotes their health and wellbeing, whilst working with them to uphold their rights to live a life as independent as possible, and supporting them to make their own decisions and choices and remain in control of their lives, safe, happy and healthy.

3.2 Development work in terms of performance data and collection continues, including a focus on achieving qualitative, subjective data. This is fundamental for the continued development for safeguarding adults in Bradford including the need to gain feedback from adults that have experienced abuse or neglect; this promotes developing a personalised response for adults affected or experiencing abuse. This work is being undertaken by the 'Voice'- user sub group of the Safeguarding Adults Board

3.3 Safeguarding Adults Concerns (SAC) data for the period 17/18 has demonstrated a significant increase on the numbers of safeguarding concerns received with an increase of 57 % from 3064 in 16/17 to 4815 in 17/18. Previously only 20% of concerns indicated further enquiries where undertaken, in comparison to regional variations of between 37% and 100%. This has increased in Bradford in the period 17/18 to a conversion of 61%. This suggests that more enquiries are being made in response to concerns raised about Adults at Risk (AAR) in Bradford.

3.4 The increase, both on amount of concerns raised and the increased enquiries undertaken has significant resource implications to meet the increased demand. A business case is being completed to consider the necessary resources for the future sustainability of the safeguarding service in Bradford.

3.5 The regional Safeguarding Multi-Agency Policy and Procedures underwent a substantial review in 2017 completed by the 7 Safeguarding Adults Boards working together; Bradford, Calderdale, Kirklees, Leeds, York, Wakefield and North Yorkshire. On April 2nd 2018 the new revised regional Joint Multi-Agency Safeguarding Adults Policy and Procedures West Yorkshire, North Yorkshire and York were launched and are being implemented over the period 17/18.

3.6 A summary of the key changes of the new procedures is the move from a 7 stage process to a 4 stage process. This was to strengthen policy and update linked agendas. To move away from process driven practice and develop a simpler person centred approach; focussing on outcomes, the 6 key principles of safeguarding further embedding making safeguarding personal throughout safeguarding adults practice.

3.7 **Multi Agency Safeguarding Hub (MASH)**

Background

3.8 Bradford MASH was set up following a research project commissioned by the Bradford Safeguarding Adults Board (SAB). The research project identified a MASH model as best practice and process for working together to safeguard Adults at Risk in Bradford District. The aim of a MASH was to increase information-sharing, enhance partnership working and provision of an effective and efficient service for adults at risk of abuse across the District.

3.9 An adult MASH would bring significant benefits to those adults experiencing abuse and the wider community, who could access adult safeguarding services via one location. The unit should deliver a holistic service, providing support where appropriate or signposting to an alternative provider when more suitable.

3.10 A team of managers from West Yorkshire Police, Bradford CCGs and the Local Authority, worked together to produce the proposals in this report. The Project was led by Senior Managers from the three organisations, which provided direction and

strategic oversight.

3.11 Research

In formulating the MASH proposals research was conducted by the team, and key stakeholders consulted wherever possible. Time was spent working with staff in the Local Authority; in the Safeguarding Adults Unit, the Access Team and Area Social Care Teams. Wider discussion was held with the Vulnerable Adults Coordinators in the Police and Safeguarding Adult teams across the health economy.

3.12 Research has also been undertaken with the College of Policing, the Social Care Institute for Excellence (SCIE) and the Police Online Knowledge Area (POLKA), alongside a general internet search for MASH's across the United Kingdom. The predominant response to this fact-finding was that there is no national guidance on Adult MASH structures/process and that local arrangements vary widely, with some examples of good practice identified.

3.13 Conversations were held with Nottingham MASH and a visit undertaken to Leeds MASH. This provided an overview of potential structures and examples of good practice.

3.14 Challenges

Through the above consultation and observations a number of challenges have become apparent in determining the best way to receive, identify and deal with concerns around the safeguarding of Adults at Risk (AARs).

- Understanding and clarity of roles and responsibilities within and across organisations, including identifying where the decision-making sits at each stage and by whom.
- What the remit of a MASH is.
- Lack of joint action at early stages of a concern being raised.
- Staffing skill mix and numbers of staff in SAU.
- Communication between agencies; who to go to, timeframes, delays, reliance on goodwill/known contacts.
- Lack of a robust, comprehensive and informative concern submitted, particularly when raised by a partner agency/professional.
- Inconsistent or lack of feedback to referrers following concerns being raised.
- Reduced number of concerns being raised.
- Decision making / risk assessment without access to full information.
- IT System Issues (systems not able to 'talk' to each other and sharing and access rights)

3.15 In considering some of the challenges above it was viewed by the team that the implementation of a MASH would enable a thorough review of roles and responsibilities in accordance with the Multi-Agency Safeguarding Adult Procedures and provide clarity for all partner agencies.

3.16 The opportunity to identify a clear remit of the MASH and realistic expectations would enable the Multi-Agency procedures to be fully implemented, adhered to and outcomes measured, particularly in relation to Making Safeguarding Personal. It is proposed that the MASH would receive concerns about the wider safeguarding issues and, in accordance with the proposed model, respond accordingly.

3.17 A more robust risk assessment process and the opportunity to discuss safeguarding adult concerns will further support practitioners to develop confidence in raising a concern and responding to a concern in a proportionate and timely manner, always considering the Adult at Risk.

3.18 An on-going issue is the lack of 'talking' between IT service user record systems. During the scoping exercise it was identified that there are a wide range of systems used by agencies, with some organisations having a number of internal IT systems in addition to SystmOne, which the LA now use. It is noted that the issue of sharing and access rights across SystmOne are currently being discussed at a senior strategic level.

3.19 Model of implementation agreed

From the original research project plan Model 1B was implemented in October 2017.3.20 This model reflects the basic role of a MASH in facilitating information-sharing and risk assessment when a concern about an Adult at Risk is raised and submitted. It envisages a basic structure of an assessment hub, through which all safeguarding concerns are properly risk-assessed using information from the Local Authority, Police and Health agencies. These are provided expeditiously and a joint decision made on the priority level of the concern.

3.20 • *Incoming Concerns*

All adult safeguarding concerns are directed into the Local Authority via the safeguarding adults Team. This is intended to cut down on barriers to reporting adult safeguarding concerns, and make it as simple as possible for members of the public and Adults at Risk themselves to report abuse.

3.21 Professionals from key partner agencies who are raising concerns would be expected to adhere to their organisation's safeguarding adult's policy and procedures, and still be encouraged to complete an online form to raise a concern, which is available via the Local Authority website and accessible by all.

3.22• *Daily MASH Meeting*

On a daily basis, the MASH administrator would compile all SG Concerns received in the last 24 hours. These would be logged on SystmOne and disseminated to each agency representative in the MASH first thing in the morning. Reps would be responsible for researching all relevant information from their own organisations and bring/feed this into the daily meeting. The administrator would also contact designated Safeguarding Leads in outside agencies, particularly 3rd sector, requesting them to feed back any relevant information by a specified time.

3.23The meeting itself would be chaired by each of the representatives on a rotating basis, and all discussions and actions recorded in the minutes by the administrator. Based on the full information picture, the daily MASH meeting would identify whether the concern is a Response A, B or C in accordance with the previous Multi-Agency West and North Yorkshire and York Safeguarding Adult procedures.

3.24These options include;

- Issues resolved by initial enquiries or adult has declined further action (Response A in the previous Multi-Agency West and North Yorkshire Safeguarding Adult Procedures).

- Multi-Agency information shared with the allocated Social Worker if this is already an open case to Adult Social Care.

- Risk Management Response (currently Response B), when s42 criteria are met but the MASH is satisfied that a sufficient protection plan is already in place. In these cases, the MASH representative would still discuss if there are any additional measures that could be implemented to safeguard the AAR.

- A formal enquiry is needed to establish the facts and how to safeguard the adult (or others) and the concern will be taken through safeguarding procedures for a strategy meeting via Tier 2 of the MASH (currently Response C).

3.25 At a minimum, each verified Safeguarding Concern would be risk assessed, identify an immediate protection plan in partnership with the AAR and relevant others involved, and rationale recorded as to whether this case is being escalated to a Formal Enquiry or not. All parties who have submitted concerns, will receive feedback to inform them that the case has been discussed in a Multi-Agency setting. Any further disclosures on the outcomes of the discussion will depend on the referrer, i.e. professional or member of the public. Professionals would be provided with clarity on the actions agreed, and also the expectations on them to continue to monitor and safeguard the AAR. This both provides reassurance but also precludes any risk of confusion that professionals may feel that their responsibilities are relinquished by making the referral.

3.26 • *Domestic Abuse*
The MASH would be a daily recipient of the Daily Risk Assessment Meeting (DRAM) document, which is sent to partners each weekday before 9am. This outlines brief details of all High Risk Domestic Abuse incidents in the last 24 hours. The MASH Administrator/s would check the document for any cases relevant to Adult Safeguarding and feedback any relevant information. If there are safeguarding concerns for the adult, a MASH representative would dial into the DRAM video conference – this would form part of the Strategy Discussion outlined below.

3.27 The MASH would also obtain a Login authority for the online MARAC portal, so that similar checks can be conducted for all MARAC cases. Where Adults at Risk are discussed at MARAC, the MASH would send a representative to the MARAC, ideally a Safeguarding Coordinator from the SAU.

3.28 Conversely, when Domestic Abuse issues are identified in a safeguarding concern, the police representative would check if these matters were already known to the police. If not, they would be fed in, either through the DRAM/MARAC if deemed High Risk, or to the Domestic Abuse Unit if Medium/Standard Risk. Referrals to specialist DA support services would also be considered as part of the protection plan for the Adult at Risk. These measures would ensure far better information sharing between the worlds of adult safeguarding and domestic abuse, and allow more informed risk assessment and action-planning.

• *Advantages*
- Simplified entry route for all concerns, encouraging more concerns to be raised, particularly from members of the public and AARs themselves.
- Immediate/timely information-sharing, allowing decisions to be made with all available

information
- Formalised risk-assessment, prioritising those adults most at risk
- Accountability through recorded rationale and feedback to referrers
- Joint responsibility for decision-making between agencies
- Enhanced information packages provided to Social Work Teams, who are allocated cases for Formal Enquiries

3.29 Evaluation A recent review of this process has been undertaken by both Adult Social Care and the Police.

3.30 From an Adult Social Care perspective it has been identified that the increased volume of work has impacted significantly on the resources deployed within MASH. The effect of this is that an increased amount of work has had to be sent out to other teams for the risk assessment and response to be undertaken. This is contradictory to the principles of setting up the MASH as sufficient resource has not been available to respond as timely as anticipated in at the outset.

3.31 Also recent business process mapping has indicated a disparity between the policy and procedures and social work practice in Bradford for safeguarding adults. This is now being addressed with a service improvement plan which considers the training needs of staff within Adults Social Care, system development for effective information sharing and also roles and responsibilities across all partner agencies.

3.32 Given the significant increase in Care Act (CA) section 42 enquiries being undertaken Adult Social Care proposes an increase in staff resources to be able to complete the relevant enquiries whilst ensuring responses are person centred and outcome focused as part of 'Making Safeguarding Personal'. Staff training will also be on-going to ensure staff have sufficient knowledge and skills to respond effectively to concerns that are being raised. Quality audits will be undertaken at regular intervals to ensure a continuous learning and improvement approach is implemented.

3.33 Currently work is being undertaken to supplement the current data collection systems that are in place, following a gap analysis being undertaken. Once implemented a more robust system will allow further analysis of information coming through to safeguarding which is hoped to further inform training and development and resource allocations.

3.34West Yorkshire Police have also completed a review of the MASH model. Currently strategic meeting are being undertaken to consider the effectiveness of the model and an evaluation as to what other work is needed to improve the service delivery and customer journey.

3.**35The Safeguarding Adults Board (SAB), continued development work- Joint Partnership working with Children's and Community Safety Partnership Boards- shared resources across linked agendas.**

Joint Communications and Engagement Group.

This group now includes representatives from Children's, Adults and Community Safety partnership Boards. The group have recently developed a joint communication

strategy. It is intended to produce a user friendly version for service users and the general public. The group have also formulated a timeline and will commence work to develop a proactive, innovative and consistent approach to communications going forward.

3.36 Serious Case Reviews

Collectively there is much more collaboration between Boards in relation to the 3 groups that deal with case reviews. The Bradford Strategic Children's Board (BSCB) Case Review sub-group will be leading on a shared knowledge library. Safeguarding Adults Reviews (SAR), Serious Case Reviews (SCR) and Domestic Homicide Reviews (DHR) often produce similar learning points. This will look at previous learning and how agencies have responded and improved with a view to retaining some organisational memory. It is hoped that this library will allow the groups to access similar learning and assess if necessary changes have been implemented and to identify "what works" for spec if actions.

3.37 Joint development day

The BSCB held a development day in June, with representation from the SAB and CSP, focussing upon complex Safeguarding. The day allowed the audience to develop an understanding and awareness around such topics as criminal exploitation, Modern day Slavery and Organised Crime Groups. Discussion led to a definition of complex safeguarding and number of areas that Bradford should progress to support vulnerable people and communities. A task and finish group from all 3 Boards will progress this agenda.

3.38 **Strategic plan –Safeguarding Adults Board**

The Safeguarding Adults Board (SAB) has a statutory responsibility to complete a strategic plan. The Board is in the process of collating its three year strategic plan. The plan is a culmination of information, discussions and deliberations obtained by engaging with people, professionals and community groups within Bradford.

3.39 The SAB has only recently appointed a new chair (June 2018). Although the strategic plan has been in progress over the period February to June 2018, a recent meeting of SAB partners it has been recommended that some further priorities may need to be included. Therefore in addition to the plan attached it is suggested that other priorities are included.

3.40 The priorities that will be added to the plan include working with adults with complex needs, review of working practice as part of the transitions from children's into adults.

3.41 Consultation of public, professions and community groups were sought over a four week period in July 2018. The feedback was very positive from the consultation with an agreement on the Safeguarding Boards vision of 89% and 96% respectively of survey respondents and easy read version.

3.42 The first priority regarding making safeguarding personal was also highly rated with a response of 98% agreement to this priority. Similar responses where indicated in both surveys when asked about priority areas and how we plan to achieve the priorities. The mean response was 95%.

See draft strategic plan in Appendices

3.43 Safeguarding Adult Reviews (SAR's)

The Safeguarding Adults Board (SAB) has a statutory responsibility under section 44 of the Care Act to undertake a Safeguarding Adults Review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, where the adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died). Or in the case that the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

3.44 Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases.

3.45 During the period April 2017 to March 2018, two SAR's were complete. Of the SAR's completed, one was an independent joint SAR/Mental Health Review which identified lessons learned from 20 recommendations, these included the practice of a local provider and local and national commissioning arrangements. At this stage, the Safeguarding Adults Board continues to monitor the recommendations to be assured that lessons continue to be learned both by the provider and that commissioners are accountable for commissioning arrangements locally and nationally, especially in the circumstances that Adults at Risk are moved out of area.

3.46 The second SAR considered the circumstances where an adult at risk experienced neglect whilst he was being cared for in a local care home. The lessons learned in this case focused on professional learning and development regarding the Mental Capacity Act 2005,

3.47 A further SAR has commenced in the period 2017-2018. This SAR is being undertaken by an Independent author and is in its final review stage, professional feedback/scrutiny. This should be concluded in October 2018.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 The Department continues to significantly invest in the safeguarding service within Bradford, which has been under resourced in previous years.

4.2 A business plan to fully staff the department to safe levels is currently being proposed

and is proposing that there will be an additional cost of £906k. This will be the subject of a report which will go to the Executive in the very near future.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The safeguarding service needs to be resourced sufficiently to ensure appropriate responses are made when allegations of abuse are raised. Without sufficient resource there remains a risk that adults at risk in Bradford will not receive the support, advice or guidance as needed, to safeguard them from harm and abuse and that the local authority will breach its Care Act statutory responsibilities towards AAR in Bradford.

5.2 Within the safeguarding team there was previously a backlog of 1000 cases for the period 2014-2017, concerns raised where not addressed sufficiently by the then under resourced service. The backlog was addressed by using additional resources; unfortunately the impact of this was a further overspend in the Department. Extensive work has been undertaken to mitigate the risk of this reoccurrence and the future resourcing of the Safeguarding service is paramount to mitigating this risk. Additional resources allowed for further scrutiny of concerns raised over a 5 year period, to ensure no adults at risk were left in unsafe situations as a result of the backlog.

5.3 The resourcing of the safeguarding adult's team is now to a maximum, this allows for the effective screen and triage of all concerns coming through to Adult Care. Development continues

6. LEGAL APPRAISAL

The Council's legal obligations relating to safeguarding are set out in Sections 42-47 of the Care Act 2014. It must make enquiries and then decide whether any action should be taken when it has reasonable cause to suspect that an adult in its area:

i. needs care and support, or
ii. is experiencing, or is at risk of, abuse or neglect, and is unable to protect himself or herself

In this context "abuse" includes having money or other property stolen, being put under pressure in relation to money or other property, and having money or other property misused.

It must also establish a Safeguarding Adults Board (an "SAB") for its area to help and protect adults in its area. The SAB must achieve this objective is by coordinating and ensuring the effectiveness of what each of its members does.

The SAB must arrange for a Safeguarding Adult Review of any case involving an adult in its area with needs for care and support where there is reasonable cause for concern about how the safeguarding authorities worked together to safeguard the adult.

Schedule 2 of the Care Act also requires the SAB to provide an annual report and submit it to the Chair of the Health and wellbeing Board. The report must set out:

(a) what it has done during that year to achieve its objective,

(b) what it has done during that year to implement its strategy,

(c) what each member has done during that year to implement the strategy,

(d) the findings of the SAR's arranged by it which have concluded in that year (whether or not they began in that year),

(e) the SAR's arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),

(f) what it has done during that year to implement the findings of reviews arranged by it under that section, and

(g) where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

Legal appraisal of this report was sought on 22nd August 2018.

The safeguarding role of the Council is complex, multi-faceted, and potentially applies during all of its interactions with the public. It is required to make arrangements to be kept informed about the safety of any adult's at risk within its area, to investigate and then make any necessary assessments of actual or potential risk or harm to such individuals; and to arrange any necessary protection. Legal advice has been sought in relation to al aspects of the role. The backlog of safeguarding cases referred to earlier in this report has also been the subject of frequent review, and legal advice has been sought as and when required.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.2 SUSTAINABILITY IMPLICATIONS

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.4 COMMUNITY SAFETY IMPLICATIONS

7.5 HUMAN RIGHTS ACT

Consideration to the impact of any service changes will always take into account the local authority's legal obligation in regards to the relevant articles within the Human Right Act 1998.

7.6 TRADE UNION

7.7 WARD IMPLICATIONS

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

7.9 IMPLICATIONS FOR CORPORATE PARENTING

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

8. NOT FOR PUBLICATION DOCUMENTS

9. OPTIONS

10. RECOMMENDATIONS

- That the contents within the report are noted.
- Request for any further comments or considerations from elected members.

11 APPENDICES

- Draft Strategic plan 2018-2021

12. BACKGROUND DOCUMENTS