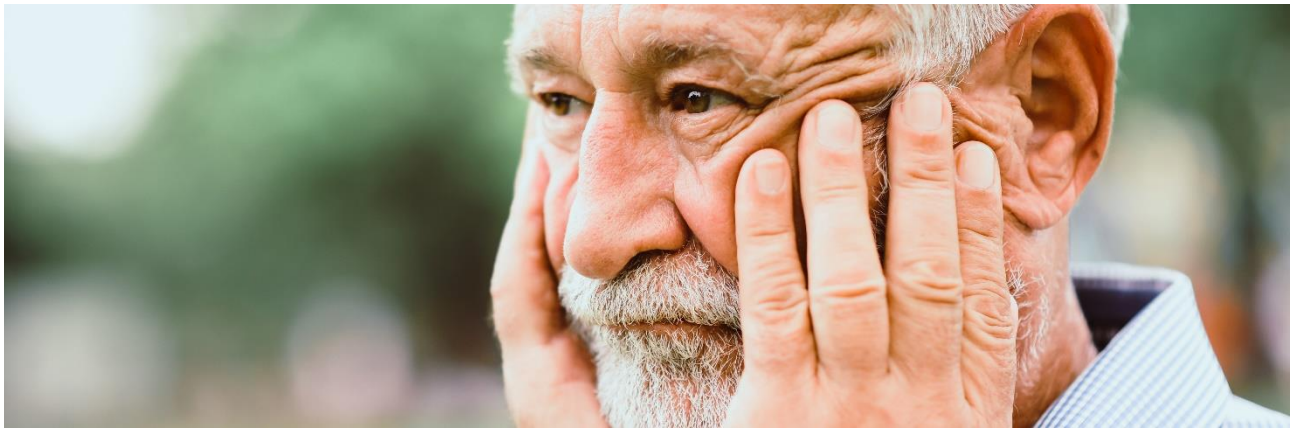
Suffolk
Safeguarding Adults Board

Annual Report 2018-19



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Introduction - Independent Chair

There have been two main areas of focus over the past twelve months, the Board's Transformation Programme following a review of the Board 18 months ago, and the development of the new Suffolk Safeguarding Arrangements which take effect from October 2019.

Developing this new model, gives us the opportunity to be more outcome focussed and to work more closely with the Safeguarding Children Board, with as much of a unified framework as possible without distracting from the specific needs and requirements of adults at risk. An example of how we will be approaching commonality is a single group covering exploitation of children and adults at risk, whatever their age using a common methodology for case reviews will be another.

Strategic leadership across the partnership strengthened considerably in the past twelve months with the development of a shared vison and values alongside a thresholds framework which gives consistency in assessments across all agencies. This framework, alongside a range of new policies and procedures, underpins the work of the Transformation Programme and is now 'business as usual'. It is important not to underestimate the hard work of everyone involved and the scale of change achieved, if this is measured as it should be, by the rate of improvement.

We continue to implement the recommendations from the Mr B Safeguarding Adults Review and build these into the self-neglect and hoarding strategy for Suffolk. There has been good use of the multi-agency partnership review model over the past 12 months which enables us to gather learning from cases and inform practice. However, some recent cases of self-neglect illustrate just how much of a problem this is in Suffolk and how difficult it is for family members and professionals to support and engage with someone who is often reluctant to accept help.

I was pleased to see a reduction in the number of referrals to the Multi-Agency Safeguarding Hub (MASH). This reflects a further increase in the use of the Professional Consultation Line and an effective triaging of referrals before they reach the MASH. This has helped the partnership to develop more consistent responses rather than to over-react or under-react to worrying situations.

Engagement with service users continues to be a priority and we have now developed a communication and engagement strategy which will be implemented over the next 12 months.

In my own role moving forward, my priorities are to spend less time requesting lengthy update reports and to move to real-time exception reporting; to involve adults at risk and their families and front line practitioners more in the work of the Board; and to strengthen our problem-solving capability on issues affecting all partners in the multi-agency system throughout Suffolk.

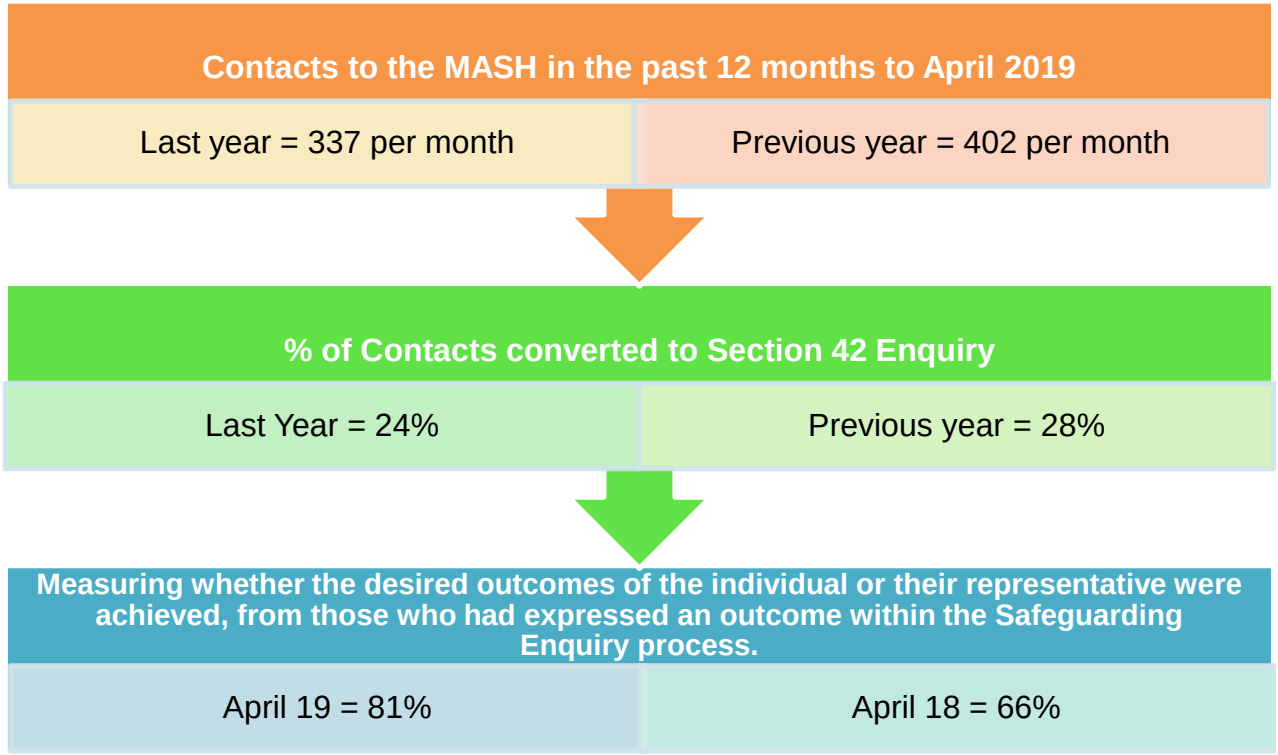
It is a pleasure to be back working in Suffolk. It is an inspirational environment in which I can try to add value to a system which is already high performing, but which is determined to do better still.

Anthony Douglas CBE
Independent Chair

1. Suffolk Safeguarding Adults Board Vision and Values

The Board's Vision and Values were launched in February 2019.

2. Adult Safeguarding in Suffolk – Headline Data



What does this data tell us?

- The decrease in the number of safeguarding contacts can be attributed to a number of factors; the first being the use of the Multi-Agency Safeguarding Hub (MASH) Professional Consultation Line providing guidance and support to callers about when a safeguarding contact is not required. The second factor is the implementation of the SAB Safeguarding Adults Framework (previously referred to as Thresholds guidance). The framework supports practitioners to be empowered to make better decisions regarding when a safeguarding referral is required.

- A decrease in the number of S42 safeguarding enquiries is likely to be the consequence of in-depth quality information gathering that occurs in the MASH. The MASH implemented the Signs of Safety (SoS) approach that is the model of engagement with customers across Adult and Community Services. The MASH aims to contact all referrers and customers when appropriate and engage with them to have a strength-based conversation about their desired outcomes for the safeguarding contact. Alongside these conversations is the strengthened partnership working in the MASH to ensure quality information is shared. These two elements have meant that there is a better quality of decision making about whether a safeguarding enquiry is required under the criteria of Section 42 of the Care Act. Consequently, it is likely that safeguarding contacts that may have previously resulted in an enquiry because information was unknown are now able to be redirected to the appropriate service or organisation.

- Within the reporting period, customers have had their desired outcomes fully or partly met in 81% of safeguarding enquires, this is an increase from last year of 66%. This is again likely to be a consequence of the Signs of Safety (SoS) model being used in safeguarding customers.

  During the conversations, customers are asked throughout the enquiry what their desired outcomes are, and these can change dependent on changing situations.

2.1 Summary of Care Home inspection data in the past twelve months

What's working well

Our new model of contract management introduced in 2016 is working well. This model is based on all providers having a nominated Service Development & Contract Manager, who is responsible for building up a relationship with the provider and being a single point of contact for commercial issues, as well as taking a lead on designing new service and contractual models. There are five service development and contacts teams, one based centrally dealing with the major contacts and procurements, and others located in areas and services, so that barriers between working with the care market and professional practice are broken down.

The teams can call on the specialist skills of the Provider Support Team, who work with providers using root cause analysis, mentoring support for care service managers and workshops for staff, such as manual handling, medicines management, care planning and record keeping.

The Care Quality Commission (CQC) is the Regulator for Health and Social Care. The CQC inspect all registered care services and provide an overall rating for each service.

The CQC ratings for the Adult Social Care (ASC) (residential and home care) in Suffolk have been consistently improving. In October 2018 74.8% of ASC locations in Suffolk were rated Good or Outstanding, in September 2019 this has risen by 13% to 87.8%, significantly higher than the national average of 75.5% (Table 1).

Looking at comparator authorities, Suffolk has the second highest percentage of ASC Locations rated Good or Outstanding (Table 2).

National data is not comparable; however, Suffolk is the 5th highest out of 153 local authority areas, with significantly more registered locations than others in the top ten (Table 3).

Table 1

Good & Outstanding	Suffolk %	National %
October 2018	74.79% (n=267)	72.18%
September 2019	87.82% (n=310)	75.51%

Table 2

Comparator Sept-19	Good & Outstanding
Cumbria	89.08%
Suffolk	**87.82%**
Somerset	84.41%
Gloucestershire	83.06%
Derbyshire	78.63%
Warwickshire	78.20%
Worcestershire	77.53%
Lincolnshire	76.92%
North Yorkshire	76.42%
Leicestershire	76.39%
National Average	**75.51%**
Staffordshire	74.87%
Buckinghamshire	73.68%
Nottinghamshire	72.99%
Essex	72.84%
Norfolk	71.83%
Northamptonshire	71.62%

Table 3

Top 10 Local Authority Areas	Good & Outstanding	Total ASC Registered Locations
Isles of Scilly	100.00%	1
Darlington	90.38%	52
Wokingham	89.29%	84
Cumbria	89.08%	229
Suffolk	**87.82%**	**353**
Windsor and Maidenhead	87.50%	56
Sefton	87.29%	181
Bristol, City of	86.90%	168
South Gloucestershire	86.61%	127
Blackpool	86.32%	95

What are we worried about?

Even though the overall progress is good there are currently 2 care locations rated inadequate and 19 rated as Requires Improvement out of 353 care locations in Suffolk. SCC ACS Service Development & Contracts and Provider Support Teams continue to work with these providers to improve care quality.

The care market overall remains fragile, with difficulties in recruitment and retention being widespread, and many providers large and small operating on tight margins or covering high levels of debt. Whilst all are committed to delivering good outcomes these problems will inevitable have an impact over time and can result in falling quality or even business failure. Whilst market failures are rare, they can have a significant impact on those that need care and support, as well as creating additional work and costs to ACS.

What are we doing to reduce these concerns?

ACS is developing a Care Market Strategy co-producing this with care provider and other stakeholders. This will set out our vision for a high quality and sustainable care market, and steps we need to take to deliver this. This will form the basis of our work with the care market and will build on the work we have already done to introduce the new model of Service Development and Contract Management, and new frameworks in home care and LD services.

As part of this work we will be looking at our model of support to care providers who are rated Requires Improvement or Inadequate, with the aim of providing more targeted support to these and delivering faster improvements.

We have also been successful in securing funding from the LEP/ EU to invest in the provider workforce.

Whilst this work is going on, we will continue our routine contract management, we will seek to constantly deepen our understanding of the market using soft intelligence and a data driven risk assessment and provide the right support to those providers who need it.

2.2 Selected performance data from across the partnership

Suffolk Constabulary – Safeguarding Referrals

Reporting Period	Adult Referrals for Police only
01 April 2017 > 31 March 2018	4136
01 April 2018 > 31 March 2019	3488

There has been a significant reduction in Police referrals in the past year that have been shared with partner agencies. This is seen as a positive development indicating that officers and staff completing referrals are better considering use of the safeguarding framework and direct referral to other agencies to resolve issues rather than simple referral.

It is also recognised that the advent of the MASH helpline may have assisted in better directing enquiries regarding referral reducing the need for officers and staff to make the referral whilst still being able to provide an appropriate service.

Community Action Suffolk (CAS)

Measuring the total number of delegates who attended safeguarding courses provided by Community Action Suffolk.

Year	Introduction to Safeguarding Adults at Risk	Introduction to Safeguarding Children	Introduction to Safeguarding Vulnerable Groups	Introduction to Safeguarding for Volunteers	Equipped to Lead Safeguarding in the VCSE	Safe and Sound	Total
2018/19	50	81	122	4	22	12	291
2017/18	(n/a)	89	70	(n/a)	9	(n/a)	168

Within the reporting period, there was a 73% increase in the total number of delegates attending safeguarding training courses provided by Community Action Suffolk, compared with the number who attended within the previous year.

This increase is reflective of the increased number of courses delivered by CAS and the promotion of the course, an Introduction to Safeguarding Vulnerable Groups.

Trading Standards

Reporting Period	Prosecutions - Fraud and Consumer Protection Offences
01 April 2017 > 31 March 2018	23
01 April 2018 > 31 March 2019	29

Trading Standards have developed a robust enforcement policy for tackling rogue traders across the county. This policy is designed to ensure a level playing field for genuine Suffolk businesses by supporting their efforts to achieve legal compliance.

Locally and across the county, rogue traders continue to take advantage of Suffolk citizens. Where rogue traders attend a consumer's home and Trading Standards are notified, Officers are sent out immediately to deal with the trader and ensure the consumer is safe, supported and safeguarding concerns are addressed. This is knowns as the Doorstep Crime Rapid Response.

Within the reporting period the number of prosecutions has risen by 20% (to 29 from 23) within the corresponding period in the previous year, which is considered to be as a result of the embedding of the Enforcement Policy into practice.

3. Suffolk Safeguarding Adults Reviews (SARs) and Partnership Reviews

The Safeguarding Adults Review Panel (SARP) meets monthly and has reviewed 8 cases in the past 12 months. Here is the main learning from cases that were progressed.

Mr. B

Safeguarding Adults Review

- Improved service response to self-neglect.
- Identification of coercive and controlling relationships and engagement with family members.
- How an individual's life history, bereavements and health conditions may impact on their decision-making.
- Effective capacity asessments undertaken.
- **Case Study in Appendix Three.**

Ms. W

Partnership Review

- The effects of coercive and controlling relationships.
- How a person's status can affect their eligibility for services.
- Ensuring that communications are in an appropriate language.
- Assumptions are taken as fact by professionals.
- Ensuring that there is a co-ordinated multi-agency rather than single agency response.

Mr. B

Partnership Review

- Ensuring that the pathways to support for clients with autism is understood.
- Early intervention and notification to housing for people at risk of homelessness.
- Working with people who are reluctant to engage.

Mrs J and Mrs D

Domestic Homicide Reviews

- The learning was shared with the SARP and will be cross referenced to future similar cases.

Mrs X

Ongoing Safeguarding Adults Review

- This review is underway as at September 2019 and will focus on the neglect of someone in a care home.

System Learning from Cases

Shared learning with DHRs

The SARP invited the Community Safety Partnership to present learning from a Suffolk Domestic Homicide Review (DHR) and facilitated a Partnership Review using Signs of Safety on another DHR to share learning. It is important that the learning from DHRs and SAB Partnership Reviews is shared and informs practice.

Links to Learning Disabilities Mortality Reviews (LeDer)

Each month the SARP discusses salient learning from local LeDeR reviews on approaches to amalgamate learning systems to better support the work of SARP and ensure best outcomes for adults at risk of abuse.

Easy read case studies to inform training

Five 'Easy read' case studies have been developed and are available as training aids across the partnership – see Appendix Three for an example.

Joint working with Norfolk

Representatives agreed to align policies to avoid where possible, any disparity in process for partners who work across both counties

4. What we have achieved in the last 12 months

Our Board Priorities for 2018-19 were:

1. **Ensure that the identified improvements for the Safeguarding service review are fully considered and implemented including revised thresholds and risk assessments.**
2. **The SAB will increase public awareness of adult abuse and where to get help.**
3. **Ensure that the effect of Domestic Abuse on adults at risk of abuse or neglect is appropriately identified and addressed through the Domestic Abuse Strategy.**
4. **The SAB further develop and implement the Learning and Improvement Strategy and ensure that cross partnership performance data identifies thematic audits and informs learning and risks.**
5. **Ensure that the views of adults at risk of abuse or neglect, their carers and families influence safeguarding provision across Suffolk.**

1. Ensure that the identified improvements for the Safeguarding service review are fully considered and implemented including revised thresholds and risk assessments

There was significant progress in 2018/19 and this was the focus of the Board over the past 12 months.

Strategic Leadership

Leadership across the partnership strengthened considerably in 2018/19. The Strategic Leads for each statutory agency met with the Safeguarding Adults Board Independent Chair on a monthly basis to take strategic oversight of safeguarding adults' transformation. Strategic Leads led senior leader events promoting multi-agency safeguarding adults working.

These aimed to build stronger working relationships between the statutory agencies (Care, Health and Police), two separate leadership events focussing on developing high performing multi-agency teams, and solution-orientated outcomes.

Feedback on what had changed in the past twelve months was as follows:

- "*seismic change in interagency working"*
- "*I don't feel on my own anymore, I feel part of a bigger, wider team"*
- *"there is more energy in the system"*
- *"before we spent our time thinking about how different we were, now we see how similar we are but that we think differently"*.

Suffolk Safeguarding Adults Board Senior Leaders worked alongside the Safeguarding Children Board Leads to develop the Suffolk Safeguarding Partnership Arrangements which will come into place in September 2019 providing governance and more opportunity to 'Think Family' across both Boards.

Cultural, Behavioural and Language

A key element to address the cultural, behavioural and linguistic concerns highlighted in the independent review was the development of a new Suffolk Safeguarding Adults Board Vision, Mission, Values and Pledges.

Launched in February 2019, the new SAB Vision, developed over 12 months, provides all Board partners with a common purpose around safeguarding adults. It aims to ensure that all partners collectively focus on multi-agency working that puts the adult at the centre of all discussions and decisions.

Policies and Procedures

During 2018 and 2019 a considerable amount of time was spent developing new policies and guidance to support all local organisations and frontline staff around safeguarding adults. These are:

- **Multi-Agency Safeguarding Policy**

  The focus of the policy is that each adult with care and support needs in Suffolk has their chosen outcomes at the heart of the safeguarding process. This policy provides overarching guidance on how Suffolk manages safeguarding concerns. It references both the Safeguarding Adults Framework and the Safeguarding Journey, details roles and responsibilities of organisations and has a glossary of terms.

- **Safeguarding Adults Framework (previously referred to as Thresholds)**

  A key area that the independent report focused upon was a lack of clear definitions around safeguarding that all agencies agreed and a threshold tool for agreeing system wide responses to safeguarding concerns. The finalised Safeguarding Adults Framework was published in February 2019 and helps front-line practitioners understand and identify the abuse types and what, if any, interventions are required. It provides a consistent approach across the partnership and has reduced the number of referrals to the MASH.

- **Managing Challenge and Professional Disputes**

  The independent report highlighted that inter-agency professional disputes were increasing and the process for managing these was not clear. In October 2018, the Board published its Managing Challenge and Professional Disputes policy. This policy provides clear guidance on managing professional disputes and the escalation process.

- **Training Strategy**

  A Training Strategy was developed in line with national guidance and details new competency standards for safeguarding adults in Suffolk that are also in line with national guidance.

Safeguarding Adults Conference 2019

On 13 February 2019 the Suffolk Safeguarding Adults Board held a conference to launch the Vision and policies developed as part of the Transformation Programme - (See section 5 of this report).

Evaluation of Transformation Work

To summarise, in 2018/19 the following work has been undertaken:

- The Suffolk Safeguarding Adults Board has a clear vision in place for the future that was jointly developed with Board members and front-line safeguarding managers
- Governance arrangements have been strengthened and will continue to evolve with the new joint arrangements with safeguarding children going forward.
- Leadership for safeguarding adults has also been strengthened and there is greater oversight and visibility of the statutory agency safeguarding leads.
- The Suffolk Safeguarding Adults Board now has a suite of jointly owned system wide policies and procedures to support staff at all levels around safeguarding adults.
- The Suffolk Safeguarding Adults Framework provides frontline staff with clear guidance on identifying abuse types and the interventions required (if any).
- A jointly owned common language around safeguarding adults has been developed across all agencies with both the Framework and Multi-Agency Policy providing definitions to support staff.

2. The SAB will increase public awareness of adult abuse and where to get help.

The SAB website has been further developed to help the public and professionals access policies, procedures and easy read guides. We saw a significant increase in website 'hits' in the past 12 months.

Our website makes it easy to make a referral and to find guides and policies.

SAB Website data	2017/2018	2018/2019
Total Number of Website Sessions/Hits	7,201	8,990
Total Number of Visitors	5,437	5,602
Returning Visitors	1,764	3,418
Page Views	21,134	27,028
Pages Viewed per Session	2.93	3.01

Newsletter and Twitter

The redesigned SAB newsletter goes to around 150 people each quarter and we have over 200 Twitter followers.

Easy Read documents and audio guides

We have invested significant time and resource in producing easy read guides for the public to help understand safeguarding and share learning from case studies.

3. Ensure that the effect of Domestic Abuse on adults at risk of abuse or neglect is appropriately identified and addressed through the Domestic Abuse Strategy.

The Board continues to monitor the Violence Against Women and Girls, Men and Boys (VAWGMB) Strategy and is pleased to note positive impacts over the past 12 months e.g.

- Suffolk County Council provides £263k per year to fund the Domestic Abuse Outreach Service. Delivered by Anglia Care Trust, the service provides support for victims of Domestic Abuse across Suffolk.
- Suffolk County Council provides £348k per year to fund three Women's Refuges across Suffolk to ensure that the highest risk victims and their children are safe and supported.
- Working with colleagues in Norfolk to support victims with no recourse to public funds. to provide emergency accommodation along with safety planning and immigration advice.
- 21 bed spaces are available across the county for arguably our most vulnerable domestic abuse victims. In 2018 SCC were successful with an additional bid for £270,000 to further develop this support and provide sanctuary measures to keep victims and their families safe in their own homes.
- Suffolk are working with the national charity Safe Partnership to support victims of Domestic Abuse to remain safe in their homes. The scheme commenced in April 2018 and the 10 months to the end of January 2019 saw 90 high risk victims of Domestic Abuse supported with measures to secure their homes.
- Suffolk Public Sector Leaders have agreed funding to develop a Domestic Abuse Champions Network to ensure a consistent approach to training and a collective response to Domestic Abuse rooted in communities.
- Suffolk County Council have appointed two part time Domestic Abuse Champions Coordinators to train 'Champions' in a wide range of organisations to encourage opportunities for early disclosure and support.
- Suffolk Public Sector Leaders have also provided funds to help develop a Coordination Centre for Domestic Abuse providing a single point of contact for victims, friends, family and professionals to seek support.
- Working with University of Suffolk to develop a Regional Domestic Abuse Network which will coordinate research and act as a knowledge exchange for academics and professionals. Launched in June 2019.
- Suffolk Constabulary is rolling out the DA Matters training programme to all frontline staff. This training equips officers with the knowledge and confidence to spot and deal with matters of abuse and vulnerability.
- MARAC (Multi-Agency Risk Assessment Conference) - The past year has seen the development of 12 new MARAC chairs across the county from many of the partner agencies that deal with high risk abuse. This change has led to an improved understanding and buy-in from all partners when dealing with adult victims suffering high risk Domestic Abuse.

4. The SAB further develop and implement the Learning and Improvement strategy and ensure that cross partnership performance data identifies thematic audits and informs learning and risks.

The Learning and Improvement Strategy was redeveloped in 2019 and can be found on the SAB website:

https://www.suffolkas.org/assets/Working-with-Adults/Policies-and-Procedures/2018-11-19-Learning-and-Improvement-Framework.pdf

It gives the Board a framework for continuous improvement through its audit schedules and led to the development of a new performance framework, gathering data from across the partnership.

In the past 12 months, 'deep dive' case audits have been completed on:

- Self-Neglect and Hoarding.
- Re-referrals.
- Application of the threshold's framework.

The findings of these audits are reported via the Learning and Improvement Group and action plans developed to inform practice.

The performance and audit data, as well as other mechanisms, has helped the Board identify risks and build a Risk Register which is regularly reported to Board and the Learning and Improvement Group. An example of an ongoing risk being monitored by the Board would be the Norfolk and Suffolk Foundation Trust (NSFT) inspection reports, which have resulted in high level intervention and seeking of assurances from the Independent Chair.

5. Ensure that the views of adults at risk of abuse or neglect, their carers and families, influence safeguarding provision across Suffolk.

The views of service users are gathered when a service is offered to ensure they are happy with the provision. The MASH aims to contact all referrers and customers when appropriate and engage with them to have a strength-based conversation about their desired outcomes for the safeguarding contact.

Adult Protection Teams measure whether the desired outcomes of the individual or their representative were achieved, from those who had expressed an outcome within the safeguarding enquiry process – see table below.

Desired outcomes	**Age Range**						
	18-64	65-74	75-84	85-94	95+	Not Known	Total
Fully achieved	266	51	81	91	21	1	511 (59%)
Not achieved	92	15	25	28	5	0	165 (19%)
Partially achieved	115	21	25	27	3	0	191 (22%)
Total	473	87	131	146	29	1	**867**

The Suffolk SAB User Engagement Strategy will give a framework for further engagement with user from September 2019. The three main strands of work are:

Strand One (Communications)	Strand Two (Co-Production)	Strand Three (User experience)
Sharing of Board information across the partnership	**The Co-production of information produced by the Board.**	**The experience of service users who have experienced an intervention**
What will this look like? Locality events where we share information, leaflets, guidance and gather feedback from users. 'Plugging into' existing user groups such as community engagement groups, disability forums, Voluntary groups, Social prescribing. Working closely with Healthwatch, District and Borough Council colleagues with local knowledge and experience. Ensuring our website and newsletters are fit for purpose and reach the right places. Develop teams in each locality, to suit local need, not a 'one size fits all' approach.	**What will this look like?** Working will partners such as Ace Anglia to produce easy read leaflets, videos etc. Partners' pages on the SAB website to share relevant information from a wide variety of sources. 'You said we did' – taking individuals views seriously and involving them in co-producing information. Ensuring the information, we produce is accessible to all. Adopt common access standards around information.	**What will this look like?** Working with Healthwatch and other colleagues to gather feedback from the users of our services. To listen to service users and ensure their experiences shape future work. Be open to feedback and inform future practice. Ensure that users are made aware of any changes we make 'you said we did' approach. Develop outcome focused, 'person-centered' intervention. 'What was the experience like for you?' to inform the development of services.

5. Other work in 2018/19 worthy of mention

Self-Neglect and Hoarding Conference

06 November 2018 – A Summary

On 06 November 2018 the Suffolk Safeguarding Adults Board facilitated a Self-Neglect & Hoarding conference at Trinity Park, Ipswich.

The aim of the day was to highlight best practice across the Partnership.

150 delegates representing the many agencies that make up the Partnership heard presentations from national experts and local practitioners.

Key Note Speakers included;

Suzy Braye – Professor of Social Work at the University of Sussex
Highlighted the learning arising from Safeguarding Adult Reviews

Mark Hardingham – Chief Fire Officer; Suffolk County Council
Explored Hoarding and Fire Risks

Dr. David Orr – Senior Lecturer in Social Work at the University of Sussex
Provided insight into Understanding Hoarding

Other Talks and Workshops were facilitated by;

Amanda Takavarasha – Adult Safeguarding Manager Suffolk County Council
Introduced Suffolk's Self-Neglect and Hoarding Policy and Risk Assessment

Carole Balding – West Suffolk Councils Senior Public Health and Housing Officer
Explained Environmental Health and Housing Legislation

Superintendent Simon Osbourne - RSPCA
Clarified situations regarding Hoarding and Animals

Olive Quinton – Lofty Heights
Discussed Decluttering to Support Families & Individuals

Sam Hall and Fiona Green – Suffolk Community Health
Described the Impact of Hoarding on the Whole Family – including Children

Slides used by the Key Note Speakers can be accessed below;

Learning from SARs

Hoarding and Fire Risks

Understanding Hoarding

Self-Neglect & Hoarding Policy

Environment Health & Housing Legislation

The Conference reinforced the need for a partnership approach across agencies when working to support individuals and families in situations of Self-Neglect and Hoarding.

Making Safeguarding Adults Your Business - Conference 13 February 2019

The Conference promoted the recently produced Vision of the Suffolk Safeguarding Adults Board.

At the Conference, the Safeguarding Adults Framework and the Safeguarding Journey were also launched, and several other documents were also highlighted that were being developed to support all staff working with adults at risk. These included the Multi-Agency Policy, SAB Training Strategy and the Positions of Trust Policy.

140 delegates representing the agencies that make up the SAB Partnership heard presentations from facilitators from a range of organisations and witnessed an inspirational production from the Red Rose Chain Theatre Company.

Feedback from our partners:

- *'The new Adult Safeguarding Framework, Journey and Mission are excellent – well delivered and really helpful to support me in my practice'.*
- *'It was a good update on the direction of safeguarding across the county and nationally including useful skills and models for practical working'.*
- *'The day was well organised and very well presented and the case studies gave helpful examples of what has worked well'.*
- *'Very challenging and thought provoking. The Market Place was a good opportunity to learn more about the work being undertaken by other partners.*

6. Our Specific Priorities for 2019-20

Our Board Priorities for 2019-20 are:

1. **Monitor the impact of the SAB Transformation Plan.**
2. **Ensure that the views of adults at risk of abuse or neglect, influence safeguarding provision across Suffolk, through the development of an effective User Involvement Strategy.**
3. **Raise public awareness using the Public Health approach around the risks to adults from issues such as exploitation, modern slavery and rough sleeping.**
4. **Reduce the safeguarding risk to adults with mental health issues from the lack of effective mental health services by taking positive action ourselves, including holding those in authority to a stronger and clearer account.**
5. **Implementation of the recommendations from recent reviews focussing on the risks of self-neglect and hoarding.**
6. **Continue to implement the domestic abuse strategy to ensure that adult victims are better supported.**

7. Appendix One: SAB Budget and Expenditure

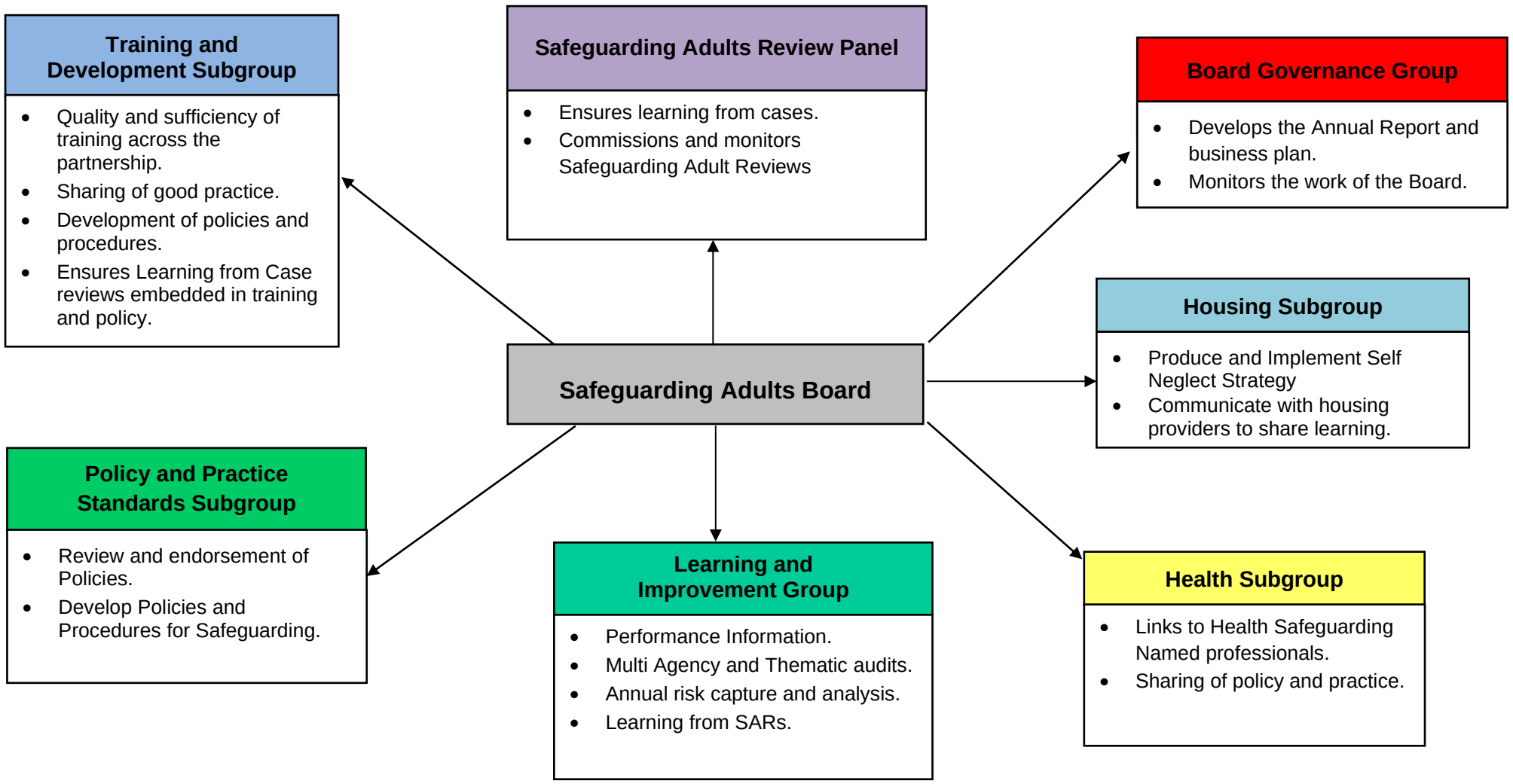
It was agreed at the April 2018 Governance meeting that the reserves would be used to support SAB transformation work over the next 12-18 months.

Budget 2018-19	**Planned spend for the year**	**Spend @ 31 March**	**Income from Partners**
Partner contributions			117,000
Salaries • Professional Advisor • Admin Support • 50% Board Manager **Total**	**100,971**	**92,867**	
Transport Related Expenses	**1,000**	**802**	
Supplies and Services:			
Professional Services Chair	25,000	27,743	
External consultant (Jane Held review)	5,000	4,461	
Funding for Serious Adult Reviews (AM)	20,000	10,400	
Room Hire	1,000	1,346	
Subsistence	500	126	
SAB new website dev + maintenance.	2,500	2,400	
Learning events - SNH Conf – 6 Nov	6,000	5,630	
Leaflets, publications, printing	5,000	2,688	
Transformation programme training events – SYCOL 10/11 Oct	5,000	4,100	
– SYCOL 6 March		1,800	
Safeguarding Conference – 13 Feb 2019	4,000	2,950	
Estimated spend:	**175,971 (-58,971)**	**157,317 (-40,317)**	**117,000**

The reserves carried forward from April 2018 were **£88,143.**

Reserves at April 2019 = £88,143 - £40,317 = **£47,826**

8. Appendix Two: SAB Subgroup Structure and Governance



9. Appendix Three: 'Mr. B' Case Study – Self-Neglect and Hoarding

Mr. B's Story

Mr. B lived a sheltered life in the property in which he was raised by his parents. On the death of his parents in 1992, he received support from an aunt and uncle and Adult and Community Services (ACS).

Mr. B was befriended by C who moved into his property and acted as his "carer".

Mr. B's property deteriorated to a soiled and cluttered state and he was reported to be neglected regarding his personal hygiene. The pets in the house were removed by the RSPCA.

ACS along with other agencies including Environmental Health, Police, Fire, attempted to assist Mr. B & C but they were reluctant to engage with services.

Mr. B suffered a stroke which affected his mobility, communication skills and ability to process and retain information, Concerns were raised about C's treatment of Mr. B which now reached the threshold for the involvement of adult safeguarding.

Mr. B was found to be in a severely neglected state and the property was filthy throughout, cluttered with household waste and hoarded objects. The property was also without heating, hot water and was identified as a fire risk.

Mr. B agreed, albeit reluctantly, to attend community facilities where he could be assisted to have a shower and for his clothes to be washed. Several visits were undertaken to the property by the Fire Service, but they were unable to carry out a fire safety visit.

Until relatively recently, the professional view was that Mr. B had mental capacity to make choices about his care, treatment and living conditions. However, in 2017, following assessments under the Mental Capacity Act 2005, he was found to lack capacity to manage his financial affairs and to make decisions about his personal care and living conditions.

A multi-agency approach was adopted through safeguarding meetings working with Mr. B, to assist him to adopt changes at a pace at which he was able to accept.

Sadly, in Summer 2017 a fire broke out at Mr. B's property. Both Mr. B and C died at the scene.

The coroner's inquest report confirmed the cause of Mr. B's death as smoke inhalation due to a house fire with the background of serious social self-neglect and coronary artery atheroma. The likely cause of the fire was an electric toaster found in the kitchen. There was no suggestion that the fire was deliberate.

What went well?

- There was good communication between agencies and a commitment by partners to work together, through safeguarding case conferences to attempt to implement identified changes.
- There was extensive engagement between agencies to support and work with Mr. B at a pace that he was able to adopt over a sustained period of time.

What were we worried about?

- Early missed opportunities to conduct care & support needs assessment.
- Reliance on assumption of capacity rather than formal process of assessment.
- Mental health needs recognised too late in the process.
- AM's assurances taken at face value - absence of professional curiosity.
- Loss of momentum in response to continued refusal to deal with the state of the property.
- Coercion and control of Mr. B recognized but not addressed.
- Some evidence of a lack of multi-agency communication and collaboration.
- More proactive communications with Mr B's family could have resulted in a stronger presence for them in his life.

What is the learning from this case?

- The appropriate application of the Mental Capacity Act, especially regarding the presumption of capacity, best interests and executive capacity is vital is such cases.
- The needs for mental health assessments needs to be recognised early in the engagement process.
- Partners need to recognise the impact of coercive and controlling relationships on the risk assessment process.
- Consideration should be given to the need for a mental capacity assessment for carers where doubt exist about their ability to make specific decisions.
- Comprehensive multiagency strategies are needed during the relationship-building work, notably to ensure that key agencies such as the Fire Service and Police were able to input to discussion and decision-making.
- There needs to be collective ownership of self-neglect cases, core membership of multi-agency meetings, and nomination of a case coordinator.

A range of resources to support practitioners including the **Self-Neglect and Hoarding Policy and risk assessment** are available on the SAB website:

https://www.suffolkas.org/safeguarding-topics/self-neglect-and-hoarding/