Nottingham City Safeguarding Adults Board

Annual Report 2016/17

Foreword by the Independent Chair

Welcome to Nottingham City's Safeguarding Adults Board Annual Report for 2016-2017. I hope you will find it an interesting read.

Last year's report described implementation of the Care Act as it came in to force, staff learning to work to new adult safeguarding policies and procedures, and new arrangements for the Board. So, to some extent, 2016-7 has been more about consolidation, and all the better for that. But as this report will show you, it has also been a year with plenty of review, learning and development – for safeguarding practice across Nottingham, for the agencies which form the Board and the Board itself.

This report is shaped in line with the Board's strategic plan. It describes both what the Board has undertaken, learnt and achieved – much of it through our excellent subgroups – and what the agencies who lead on safeguarding adults in Nottingham have each done. Within those sections there is a wealth of detail: about staff working closely in support of citizens who have needed help with safeguarding, about creative initiatives, and about assisting and ensuring good practice and improvement across our local services. For all of us involved in adult safeguarding in Nottingham, it provides information and stimulation to continue developing our practice.

The independent reviewer who wrote the Safeguarding Adults Review concerning Autumn Grange found evidence 'that there is a heightened awareness of the safeguarding adults agenda throughout…organisations and therefore the quote 'safeguarding is everybody's business' is a reality – evidenced by the way professionals operate and interact with one another'. The Board's continuing work reinforces that; citizens need to have confidence in our organisations and staff; staff need to know their adult safeguarding responsibilities and how to work well.

Financial stringency in the public sector of course continues to impact. The Board is lucky to have an effective Board Manager and part time administrator – but the budget no longer allows for training officer time as well. Agencies in Nottingham clearly treat safeguarding as a priority but service and staff change and reductions all create risks to good and safe practice that our agencies and the Board need to continue to address.

The following is a summary of what the Board did to achieve the objectives of its strategic plan in 2016-7:

Prevention

- The risk register was established, agreed by the Board and kept under review through the Business Management Group
- The Board received a report on Early Intervention covering various initiatives

Assurance

- A Quality Assurance Framework was established
- Three Safeguarding Adult Reviews (SARs) have been completed; learning identified and executive summaries have been published on the Board's webpages.
- An internal review of SAR processes based on learning from our SARs was completed, and will link to a cross authority review in 2017/18
- The learning and improvement strategy was reviewed with a new strategy developed for 2017/18

Making Safeguarding Personal (MSP)

- A refreshed communication and engagement strategy was developed and agreed by the Board
- An MSP awareness raising session was delivered as part of Every Colleague Matters

Safeguarding Performance and Capacity

- The Budget for 2017/18 was agreed
- The board's office function was reviewed and a new Board Manager post was successfully recruited to, and a fixed term, part time training officer was recruited.
- The Board's Constitution was reviewed
- There was on-going co-ordination with other strategic partnerships.

Malcolm Dillon

Independent Chair

Nottingham City Safeguarding Adults Board

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1 Introduction

1.1.1 The Care Act 2014 stipulates that the Safeguarding Adults Board (SAB) 'must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action'.[1]

1.1.2 This report therefore provides an overview of what Nottingham City Safeguarding Adults Board has done during 2016/17 to achieve its main objective to assure itself regarding the adult safeguarding arrangements in Nottingham City.

1.1.3 The report begins by setting the scene with a brief overview of the local demographic context in Nottingham. The next section describes the function of the Safeguarding Board, the membership and the governance structure. The main body of the report takes each of the Board's four strategic priorities in its annual plan for 2016/17 (which can be found here) and reports on progress against these. Partner agencies' descriptions of the contributions they have made towards the Board's strategic priorities are included at the end of each section, including some illustrative case examples. The report concludes by looking forward to the work planned for 2017/18.

1.2 Local Context[2]

1.2.1 Nottingham has an estimated population of **318,900** people, having risen by 4,600 since 2014 (Office for National Statistics, mid-year estimate 2015).

1.2.2 The 2011 Census shows 35% of the Nottingham population as being from BME groups; an increase from 19% in 2001.

1.2.3 Looking at the detailed ethnic groups, in those Census figures, those showing the biggest increases were Other White (2.5% to 5.1%), Mixed - White and Black Caribbean (2% to 4%), Black African (0.5% to 3.2%), and Pakistani (3.6% to 5.5%). The largest groups other than White British are now Other White (5.1%) – which will include large numbers of people from Poland - and Pakistani (5.5%)

1.2.4 Nottingham is the eighth most deprived district of 326 districts in the country (Indices of Deprivation – Office for National Statistics): 34% of children and 25% of people aged 60 and over live in areas described as affected by income deprivation. Out of the seven separate 'domains' that make up the Index of Multiple Deprivation, Health and Disability is the domain in which Nottingham performs worst.

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[2] This section is taken from the demographic chapter at http://www.nottinghaminsight.org.uk/

1.2.5 Despite its relatively young age-structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability.

1.2.6 7.9% of the population aged 16-64 were claiming Incapacity Benefit, Severe Disablement Allowance or Employment and Support Allowance in August 2015, compared with 6.0% nationally.

1.3 The Board Structure

1.3.1 What is the Safeguarding Adults Board?

1.3.2 The Care Act (2014) made it a statutory requirement for each local authority to set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria, also defined in the Care Act.

1.3.3 The criteria are that safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

1.3.4 The adult's care and support needs should arise from, or be related to a physical or mental impairment or illness; however, they do not need to meet the minimum eligibility criteria as set out in chapter 14 of the Care and Support Guidance, issued under the Care Act 2014[3]. Abuse and neglect includes: Physical abuse, Domestic violence, Sexual abuse, Psychological abuse, Financial or material abuse, Modern Slavery, Discriminatory abuse, Organisational abuse, Neglect and acts of omission, Self-neglect

1.3.5 Who sits on the Board?

The Board has representation from the following organisations:

- Nottingham City Council (including Adult Social Care & Public Health)
- Nottinghamshire Police
- NHS Nottingham City Clinical Commissioning Group
- National Probation Service, Nottinghamshire
- DLNR Community Rehabilitation Company
- Nottinghamshire Fire and Rescue Service

[3] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

- East Midlands Ambulance Service
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham CityCare Partnership
- Nottingham University Hospitals NHS Trust
- Vulnerable Adults Provider Network
- HMP Nottingham

In addition, Nottingham City Council's Lead Member for safeguarding adults is a participating observer on the Board. In practice, this means routinely attending meetings and receiving all written reports.

All Board papers are sent to the Crime and Drugs partnership, and a representative is invited to attend meetings where cross cutting issues are on the agenda.

The Board has an Independent Chair, Malcolm Dillon. The Board is supported by a full time Board Manager, and 0.5 FTE Business Support Officer. The Board meets quarterly.

1.3.6 How is the work of the Board delivered?

1.3.7 The Board has a Business Management Group (BMG), which drives the main business of the Board. The BMG is responsible for co-ordinating the business of the NCSAB to enable the Board to focus on strategic decision-making, and is responsible for managing the implementation of Board decisions, ensuring work is appropriately delegated to subgroups.

1.3.8 The Board has three subgroups.

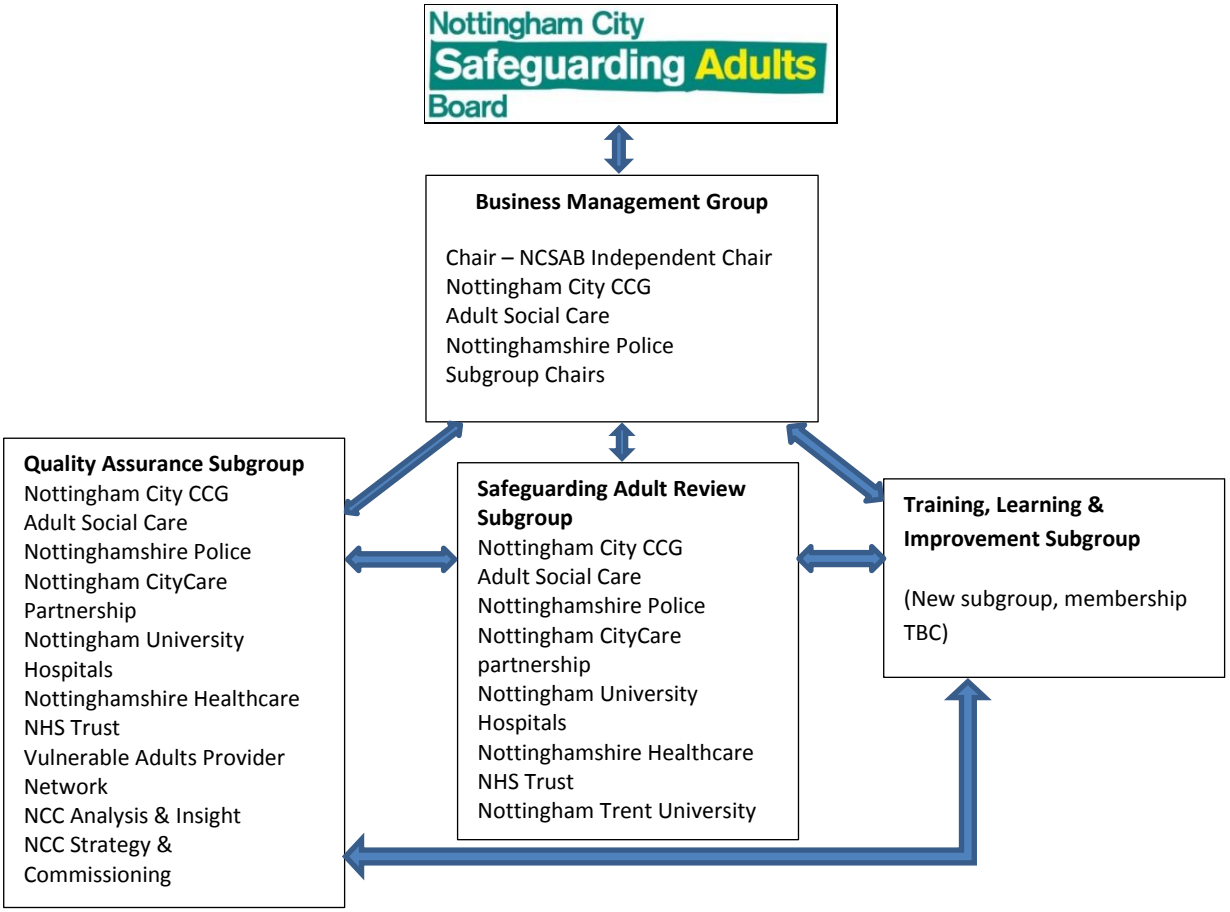
1.3.9 **The Quality Assurance Subgroup** is responsible for supporting the NCSAB in its assurance responsibilities by collecting evidence on behalf of the Board in regard to the quality of local Safeguarding Adults interventions and the performance of agencies in carrying out their safeguarding responsibilities. This includes a focus on the principles of Making Safeguarding Personal.

1.3.10 **The Safeguarding Adults Review Subgroup** is responsible for ensuring that agencies and individuals learn lessons to improve the way in which they work, both individually and collectively, to safeguard and promote the welfare of vulnerable adults. The SAR subgroup will seek to regularly develop SAR processes in line with The Care Act 2014, local and national best practice.

1.3.11 **The Training, Learning & Improvement Subgroup** aims are: to be assured that the organisations working with adults at risk understand what their workforce need to know in terms of their safeguarding responsibilities, and that the workforce is competent in carrying out these responsibilities; to promote learning and improvement opportunities that respond to Safeguarding Adults Reviews (SARs), audits and other work of the Board and their partner agencies and that this leads to improved practice and better outcomes for adults at risk; to act as a vehicle for disseminating safeguarding messages into the workforce and to review the effectiveness of multi-agency learning and improvement

activities, including training, in order to safeguard and promote the welfare of adults at risk.

1.3.12 The Governance Structure is represented by the diagram on the following page



1.3.13 The Quality Assurance Subgroup was re-launched in April 2016 and has a new chair, the Director of Nursing and Allied Health Professionals at Nottingham CityCare Partnership. The QA subgroup has also gained representation from the Vulnerable Adults Provider Network, creating a valuable link to the voluntary sector.

1.3.14 The Training, Learning and Improvement subgroup was chaired by the Safeguarding Partnerships Service Manager (NCC Children's Services). This was a joint subgroup of both the NCSAB and the NCSCB, but a decision was taken that subgroup should split and a new subgroup for the Safeguarding Adults Board will be established in 2017/18.

1.3.15 The chair of the SAR subgroup changed part way through 2016/17 and the subgroup is now chaired by the Safeguarding Practitioner at the NHS Nottingham City Clinical Commissioning Group. The subgroup was joined by a representative from Nottingham Trent University during 2016/17.

1.3.16 The Early Intervention Subgroup was still in place for a short while at the start of 2016/17; however, the work of this subgroup was reported on in last year's report and is not included here.

Performance Against the NCSAB Annual Plan

2 Strategic Priority 1: Prevention

2.1 Establish a coherent approach to ensure Board risks are identified and mitigation is in place

2.1.1 The Board has established a risk register, which is overseen by the Business Management Group.

2.1.2 During the year, the subgroups have been asked to ensure that risks are considered through their work and these are reported to the Business Management Group.

2.1.3 The risk register will be reviewed during 2017/18 to ensure it is effective as an active document.

2.1.4 Mental Health Beds - Risk Management, Challenge & Impact

Concerns were raised at the Board of a risk to a small number of adults where mental health beds were not made available at the point of need following assessments in the community. The Board facilitated a meeting with key partner agencies, chaired by the Board's Independent Chair, and reviewed the matter at Board meetings throughout the year. This led to a number of actions to reduce this risk. A joint report written by the Local Authority and Nottinghamshire Healthcare Trust was presented to the Board in December, which provided sufficient assurance to the Board that actions had been taken, and the risks to Nottingham citizens reduced.

2.2 Identify & agree priority actions in regard to preventative and early intervention strategies

2.2.1 The early intervention subgroup reported to the Board in June 2016. As the majority of the work had been completed in 2015/16 this was reported on in last year's annual report, which can be found here.

2.3 Partner Descriptions of their Contributions to Strategic Priority 1

2.3.1 **East Midlands Ambulance Service (EMAS)** continue to work towards ensuring that there are supportive mechanisms in place for patients to help support them and prevent abuse from occurring. **EMAS** have pathways set up with Nottinghamshire Fire and Rescue Service to enable fire safety checks to be carried out on those most vulnerable. **EMAS** have also set up a domestic violence and abuse pathway to enable frontline staff to refer directly to supportive services via the **EMAS** safeguarding referral line.

2.3.2 **HMP Nottingham** sends a representative to the NCSAB. Any SARs are shared with the health provider. Good information sharing systems are in place between the establishment, healthcare and partners. Prison staff are trained in self-harm and suicide prevention and both the prison and health induction process support the identification of potential vulnerabilities and safeguarding issues. Health providers have good information sharing with external agencies.

2.3.3 **NHS Nottingham City Clinical Commissioning Group (CCG):** In order to support the prevention agenda the **CCG** has continued to fund the two Early Intervention Practitioners that work across both health and the local authority to help identify and support care homes that are not reaching or maintaining adequate care and wellbeing standards for their residents. These practitioners are also responsible for organising and coordinating the multi-agency Quality Information Sharing Forum, which is attended by all key stakeholders involved in the care sector. This forum facilitates appropriate and timely information sharing about regulated providers that are commissioned by the **CCG**, Nottingham City Council and regulated by the Care Quality Commission (CQC).

2.3.4 The **CCG** have also funded a Court of Protection application officer whose role is to identify patients who are living in their own home and may be subject to a Deprivation of Liberty, due to the restrictions and restraints resulting from their condition and the care package that is funded by the **CCG**. They have then worked with case managers, families and any other relevant person to ensure that the care package is the least restrictive and in the best interests of the patient. It is at this point that the **CCG** would apply to the Court of Protection to have this deprivation authorised by the Court of Protection. The aim has not only been to get the cases authorised but also to educate workers in the health sector and to engage and support families and carers to review their loved one's care to ensure it is the least restrictive and in that person's best interest.

2.3.5 The **CCG** and Nottingham City Council (NCC) have also worked closely with the NCC DOLs team on Court of Protection cases where the **CCG** fund the package but an objection has been raised with the court in relation to conditions imposed in the standard authorisation.

2.3.6 **Nottingham City Council Adult Social Care (ASC)** Effective multi-agency working is the cornerstone of good Safeguarding practice, and **Adult Social Care** have strong and effective relationships with partners involved in Safeguarding.

2.3.7 Multi-agency working and Early Intervention: In terms of Safeguarding investigations into regulated services such as Care Homes and homecare providers, we know from the regular Lessons Learned events facilitated by **Adult Social Care** that early indicators of deteriorating standards in service delivery, if acted upon, can prevent a service from entering formal Safeguarding procedures. A monthly multi-agency quality information sharing meeting (QUIF) is led by our Early Intervention Officers and collectively action is decided upon for how to support Providers who require assistance, support and training. Developed in November 2015 as a joint venture between the **Local Authority** and Nottingham City CCG, the Early Intervention Service is now running into its third year. The Officers in the service support homes by identifying and agreeing what areas for improvements exist with a care setting, identifying strategies and skills needed to make improvements in the service, and setting out a plan to achieve those improvements. The

impact of this project has been significant and there has been strong evidence of success. The Officers have now worked with many care homes and improved standards and care delivery.

Early Intervention:

- A case example of the positive outcomes achieved was in relation to a care home demonstrating evidence of a decline in performance in areas such as medicine management, infection control and safeguarding. Further investigation highlighted a large turnover of managers, with an inability to retain a consistent cohort of nurses to deliver care. At the QUIF, stakeholders voiced their concerns, through data and information about the decline in standards and the potential risk to residents.
- Further to this, it was decided to offer the support of the Early Intervention Practitioners, who, with the care home, established a focused action plan to improve standards in areas like care plans, mental capacity, facilitating basic needs whilst giving support to the manager to enable them to lead the home more effectively. This involved daily visits, particularly observing handover and medicine rounds; establishing training programmes and linking the home with specialists, like Tissue Viability and Falls Prevention.
- As signs of improvement, (like a reduction in whistle blowing) were evidenced, support was shaped accordingly until the care home was assessed as achieving sustainable improvements.
- Staff at care homes where there is a decline in standards often feel jaded, exhausted and unsupported, leading to a lack of trust and confidence in the authorities that are working to improve their standards. The model used by the Early Intervention practitioners involves positive communication, making everything relevant, meaningful and two-way.

2.3.8 The Early Intervention Project was referenced as an example of Good Practice in the "Making Safeguarding Personal Temperature Check" published by the Local Government Association in July 2016.

2.3.9 Despite our confidence in the effectiveness of our partnership approach to Safeguarding, we are never complacent and in the past year, **Adult Social Care** has continued to lead Lessons Learned events after significant incidents in order to inform future practice and procedures. **Adult Social Care** has undertaken a multiagency review of the QUIF, the outcome of which was full support of this approach in relation to information sharing, and embarked upon a review of our Provider Investigation Procedure, which was launched with a multi-agency workshop with the Care Quality Commission as a key contributor. It is reassuring to note that the Autumn Grange Safeguarding Adults Review published in 2017 commented that *'the author is confident of coordination and high priority given to Care Homes'* and' *'the strong emphasis on partnership working between the CCG and **Adult Social Care**'.*

2.3.10 Prevention – Financial Abuse remains one of our highest categories of abuse referred to **Adult Social Care**. In 2016, we were pleased to be approached by Outreach Solutions, a social enterprise commissioned by the Credit Industry Fraud Avoidance System (CIFAS) who are the UK's independent fraud protection service. CIFAS wanted to increase their engagement with local authorities generally and consequently be able to protect more of the most vulnerable people via the "Protecting the Vulnerable" scheme. **Adult Social Care** are now participating in a pilot project with them. Two focus groups have been held with

NCC colleagues and Outreach Solutions on behalf of CIFAS. These groups both felt that there would be significant value in trialling a protective registration scheme with citizens who may be at risk of financial exploitation. The protective registration scheme ensures that any applications for financial products are automatically declined; this is a free service to citizens. A training programme is about to commence around how to register citizens and thus help protect them from fraud and identity theft.

2.3.11 Prevention & Early Intervention – Domestic Abuse became a statutory category of abuse in the Care Act 2014. **Adult Social Care** practitioners participate in the regular training provided by Equation, our local Domestic Abuse charitable service. In 2016 **Adult Social Care** were approached by Women's Aid England and invited to participate in the 'Change that Lasts' Trusted Professionals pilot, one of only four in the country. The Trusted Professional role is an integral component of the Change that Lasts approach; it enables earlier intervention and increases opportunities for survivors to get the help they need. Survivors have paid testament to the importance of a trusted relationship with an individual professional in facilitating change for them. The aims of the role include:

- removing or reducing barriers on the journey to safety and independence;
- meeting the particular and individual needs of survivors;
- empowering survivors to draw and build upon their individual strengths and resources.

2.3.12 The approach taken by Women's Aid aligns strongly with Making Safeguarding Personal, which advocates that best practice ensures that the person at risk is at the centre of safeguarding enquiries. The role involves looking beyond the immediate issues that women may be presenting to identify domestic abuse, ultimately helping survivors to access help earlier. **Adult Social Care** are very much looking forward to the training programme in the summer of 2017.

2.3.13 **Nottingham CityCare Partnership: Preventative and early intervention strategies at CityCare**

2.3.14 Factsheets have been developed on key safeguarding and MCA topics: person centred practice in safeguarding, record keeping and talking to adults about concerns. **CityCare** Safeguarding Champions assist in promoting key safeguarding messages throughout **CityCare**. Champions promote a framework of actions for staff to ensure that they have taken prior to seeking specialist safeguarding adults advice, such as asking the adult their views and wishes relating to the safeguarding concern.

Case Example

A CityCare Allied Health Professional sought advice from the NCCP Safeguarding Team's Duty Service. The practitioner was working with a frail elderly citizen living with dementia. The citizen was requiring increased levels of care and support from their family due to their deteriorating health. The Local Authority carers, who were supporting the citizen, were concerned that the family could not meet the citizen's needs. The citizen was having numerous falls and was felt to be at risk and experiencing distress at home. The citizen's family were experiencing serious

anguish in attempting to meet the citizen's needs and struggling to come to terms with the fact the citizen could access respite care. The practitioner joined the MCA paperwork pilot and utilised the new assessment framework to assess the adult's ability to maintain safety at home. The citizen was assessed as unable to maintain safety at home due to dementia impairing her decision-making. The Safeguarding Practitioner chaired a Best Interests meeting. The MCA was explained to family members. This facilitated a Best Interests decision for the citizen to transfer into respite care with the support of family.

2.3.15 Examples of successful agency co-operation: **CityCare's** internal Quality Information Sharing Forum (QUIF) meets monthly to discuss good practice and concerns in care homes. **CityCare** QUIF provides information for and receives information from the Local Authority multi-agency QUIF to ensure **CityCare** staff are well placed to support our care home colleagues in partnership with the Local Authority and CCG. Regular attendees are the Early Intervention practitioners who provide feedback, advice and share information between the **CityCare** QUIF and Local Authority multi-agency QUIF.

2.3.16 **CityCare** Lead Practitioner for Safeguarding Adults and MCA is a qualified Best Interests Assessor and provides assessments for the Local Authority as part of their Best Interests Assessor rota. This has enabled joint learning and training between **CityCare** and staff across Adult Social Care.

2.3.17 **CityCare's** Prevent training package was shared with partner agencies to assist them in the development of their Prevent training.

2.3.18 **CityCare** has responded to the Local Authority safeguarding adult enquiries by developing an Enquiry Pathway so all **CityCare** staff are aware of how to provide a timely and accurate response to a Local Authority safeguarding enquiry.

2.3.19 **CityCare** Safeguarding policies have been converted to Standard Operating Procedures (SOP); Safeguarding Adults, Mental Capacity Act and Prevent to reflect local and national safeguarding best practice and policy. Nottingham City and Nottinghamshire County Safeguarding Policy and Procedures have been adopted as CityCare's overarching SGA guidance.

Case Example

A Community Nurse sought advice from the NCCP Safeguarding Duty Service in relation to a concern about a citizen with a terminal illness. The citizen had disclosed domestic abuse to the Community Nurse. The citizen was assessed as lacking capacity to protect herself from domestic abuse. The advice sought by the nurse ensured all actions were taken to ensure the citizen's safety and wellbeing. There is on-going multi-agency co-operation between CityCare and other local partners with this citizen. The actions taken by the Community Nurse have ensured the citizen is safe.

2.3.20 **Nottinghamshire Fire and Rescue Service (NFRS)** have a proven track record in pursuing a prevention agenda and this forms one of the priorities in the service's Integrated Risk Management Plan. Fire fighters engage with people at one of the most distressing events in their lives when they attend a fire or other incident; they provide an emergency service and respond professionally and quickly. Fire fighters also enter people's homes to do a Home Safety Visit and again may have concerns about adults at risk and need to register this with someone who can act upon this. Understanding safeguarding in these situations is paramount to our staff. For the last ten years, **NFRS** have pursued a successful Prevention strategy, which encompasses Safeguarding as a key element.

2.3.21 Building on the success of **NFRS's** Home Safety Visit (which primarily assesses fire risk), the Service's Prevention team have been busy working with our partners putting together the new Safe and Well programme. This visit harnesses the 'making every contact count' principle as well as early intervention and aims to do as much as we can for the individual during one visit. With this in mind, we have been working with Falls Services, Smoking Cessation, Warmer Homes, Alcohol support services as well as the Bowel Cancer Screening programme to expand our current prevention agenda and train our staff. Through this new programme, the Service aims to improve outcomes for the individual, keep them living at home safely for longer, reduce hospital admissions as well as pursue the Making Safeguarding Personal agenda and ensure that the outcome is what the individual wants.

2.3.22 Following the success of seconding a Fire Officer into the County's Multi Agency Safeguarding Hub, **NFRS** will be meeting with the City's Safeguarding Manager to establish if replicating this agreement in the City would be viable.

2.3.23 **Nottinghamshire Healthcare Trust** safeguarding team has completed the second year of our five-year plan to effect quality improvements in safeguarding across the Trust. We have three key priorities:

1. To demonstrate Nottinghamshire Healthcare has a strong integrated and sustainable culture of both safeguarding leadership and strategic and operational working across the Trust.
2. To demonstrate that we are assured that safeguarding is everyone's responsibility and are able to evidence that we are making a difference.
3. To demonstrate that we are assured that learning and improvement is raising awareness and quality of safeguarding practice and ensure that training, procedures and guidance support improvements in safeguarding children and adults.

2.3.24 All three of these priorities link to the NCSAB priorities to ensure that our work is in line with that of the Board. The Trust has seen significant change over the last 12 months with the merger of two divisions to form the Local Partnerships Division with the aim to: "Through partnerships improve lives and the quality of care."

The service model to achieve this vision has three core components:

- self-care and prevention,
- community and integrated care
- highly specialist and inpatient care.

2.3.25 The integration of these services strengthens and supports the Trust's Think Family Safeguarding Strategy, which has been a key focus during the last 18 months. The strategy aims to improve outcomes for children and adults by the provision of timely, well-co-ordinated services and forms the basis for all our safeguarding training. Thus, staff are encouraged to work in partnership with other agencies. This has been further strengthened by the hosting of two multi-agency Think Family conferences during the last year, which looked at diverse topics such as modern slavery, confirmatory bias, information sharing and multi-agency working. Both events provided staff with a real opportunity to reflect on current issues with staff from partner organisations. Within our Think Family agenda, we are now starting to focus on domestic violence and abuse across the Trust and how this impacts upon our safeguarding practice.

2.3.26 Another key area of work has been round the Independent Inquiry into Child Sexual Abuse (IICSA). The Associate Director for Safeguarding and Social Work is a member of the multi-agency Operation Equinox strategic management group whose work has included the setting up of a survivors group and the drafting of a multi-agency leaflet to assist survivors in accessing support.

2.3.27 Once again, the Trust facilitated multi-agency Individual Management Review (IMR) author training for potential authors of IMRs and other internal reports for Serious Case Reviews and SARs. The event was supported by the local safeguarding boards and was well attended.

2.3.28 Finally, we have developed an exciting programme of workshops to meet the needs of Adult Social Care staff around the impact of human factors (e.g confirmatory bias) on practice. The workshops will be rolled out in 2017/18 and will be formally evaluated to assess their impact to inform future planning.

2.3.29 **Nottinghamshire Police:** Adult Vulnerability remains 'core business' for Nottinghamshire Police and this is reflected in the Force Strategic Intelligence Assessment and Operational Control Strategy for 2017. The assessments set out the force's operational priorities and intelligence requirements for the coming year. Vulnerability drives tasking and resource allocation through a daily force Demand Management Meeting chaired by the Operational Superintendent.

2.3.30 Adoption of the new (National) College of Policing definition of vulnerability and how we define a person as vulnerable - 'if as a result of their situation or circumstances, they are unable to take care of or protect themselves, or others, from harm or exploitation.'

2.3.31 An accompanying **Nottinghamshire Police** force strategy, delivery plan and communications strategy have been created and will be updated regularly. The key message communicated across the organisation in all of this is: Know it. Spot it. Stop it.

2.3.32 Improving the quality of information transfer through the introduction of the PPN (Public

Protection Notice) - an improved referral template for all safeguarding referrals. Now implemented (March 2017), NICHE an integrated system supporting core policing – now enables crime, intelligence, custody and case file preparation to all be held in one place. **Nottinghamshire Police** went live with NICHE in March 2016 and in March 2017 with the PPN. In terms of fulfilling the Board's strategic objectives regarding the prevention of adult abuse and neglect, NICHE will become invaluable as it will enable real-time sharing of information and reduce risks by saving on time and multiple system search.

2.3.33 **Nottingham University Hospitals (NUH):** Clinical staff within the organisation receive safeguarding adults training on induction and annually. This is delivered by the adult safeguarding team and in line with training levels expected from the board and continually updated as a result of learning from SARs and Domestic Homicide Reviews (DHRs). Although learning from SARs and DHRs is as a result of abuse that has already occurred, it allows the trust to redesign pathways, policies and training to reduce the risk of future occurrence.

2.3.34 In 2016-17, the **NUH** adult safeguarding team introduced an electronic referral form for staff to complete in order to make a referral. The majority of non-urgent safeguarding referrals are made via this route. The referral is initially received and acted upon by the safeguarding team. This has allowed the **NUH** team the opportunity to initiate necessary interventions and preventative measures prior to involvement of the local authority.

2.3.35 The trust maintains partnership working with key agencies, specifically leading on cases of on-going domestic abuse where the survivor has complex health and social care needs.

2.3.36 As **NUH** is predominantly a referring agency, staff knowledge of identifying and acting on abuse is a key element of the safeguarding team workload. Training tailored to the specific needs of individual clinical departments is delivered as required.

2.3.37 **Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company (DLNR CRC)** works with a significant number of adults with vulnerabilities, and has specific interventions to address alcohol misuse, substance misuse, gambling addiction, homelessness and employment and training opportunities. A substance misuse 'brief' intervention aims to address the early stages of drug misuse prior to dependence developing.

2.3.38 In all the **CRC's** structured work with Domestic Abuse perpetrators, a Women's Safety Worker remains in contact with current and previous partners to help manage any risk to them. This work is done in close co-operation with Domestic Abuse support organisations.

2.3.39 The **CRC** has worked with the Police and the Police & Crime Commissioner to provide Independent Domestic Violence Advocate support to partners of serial domestic abusers who are managed within the Integrated Offender Management Scheme.

2.3.40 **Nottinghamshire National Probation Service**

Case Example:

A recent example is an adult who is currently located in a prison hospital unit. The adult is assessed as posing a risk of harm to partners after committing a serious violent offence on a previous partner. Despite the risks, the adult was considered to be vulnerable on the grounds of his on-going health needs.

This service user has reached the stage in his sentence where release needs to be considered by the Parole board. As such, a Care Act assessment was completed by the local region. It was established after the Care Act assessment and Nottingham City Adult Safeguarding assessments that the adult would require fully supervised residential care. It is evident from case notes and discussions with the offender manager that there has been extensive and successful agency co-operation and communication. In terms of preparing for the adult's release Nottingham City Adult Safeguarding team have sourced what is considered an appropriate residential unit. Further to this and what incorporates making safeguarding personal, the adult was granted an escorted leave from the prison to the residential unit. This was completed to establish how the service user would initially cope and if it was deemed that there was a likelihood that he would be settled and his needs well managed. After the visit, it was agreed with agencies and the consent from the adult that the residential unit would be put forward as a suitable address within the parole recommendations. It is noteworthy that this process has been on going for approximately 12 months. Therefore highlighting the detailed assessments and planning that have taken place in achieving a valuable positive outcome for the adult and maintaining safeguarding and public protection.

Throughout the process, agencies maintained contact with both the adult to ensure his views were taken into consideration, and that there was a continued communication with his mother who is identified as a supportive and protective family member.

2.3.41 **Vulnerable Adults Provider Network (VAPN):** In November 2016, we committed to ensuring that network members received safeguarding training and that we would work with them to ensure that they had suitable safeguarding policies in place, which reflect the guidance and local procedures. Feedback from all participants has been positive.

2.3.42 In 2016 - 2017 the **VAPN** undertook the following actions to ensure that organisations were aware of their responsibilities for safeguarding adults:

1. Delivered introduction to safeguarding adults training to 72 individuals representing 23 organisations
2. Featured 39 safeguarding updates in the **VAPN** newsletter
3. Delivered a multi-agency workshop on Making Safeguarding Personal as part of the Every Colleague Matters event alongside colleagues from adult social care, CityCare partnership, the Local Authority and other Safeguarding Board members
4. Shared guidance on best interest and developed a pro-forma to help organisations

2.3.43 In 2016 - 2017, the **VAPN** undertook a survey to enable us to include safeguarding training delivered by other VCS organisations. We found that:

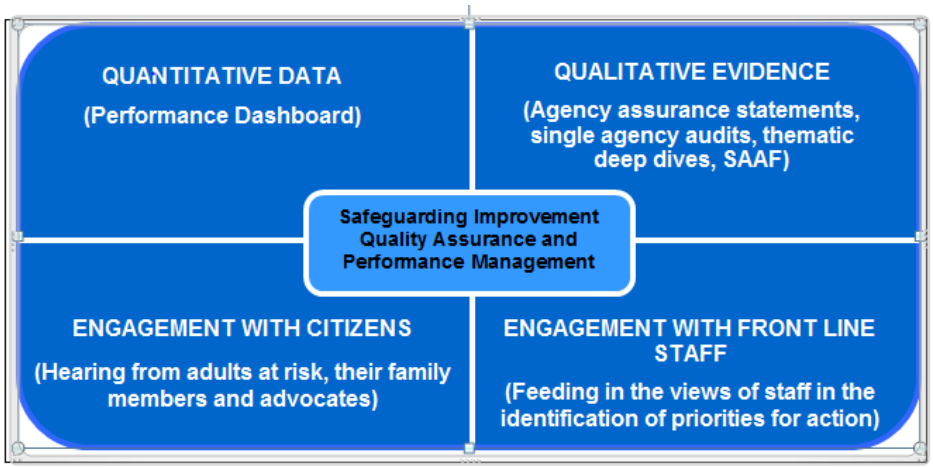
- Seven organisations were providing designated safeguarding lead training and four were providing additional in house training.
- Of the four organisations providing in house training, they trained 80+ members of the VCS workforce.

2.3.44 The **VAPN** will continue to ensure that organisations receive regular safeguarding updates and that the network is used as vehicle to ensure that learning is disseminated. We have 10 training sessions planned and expect to train over 120 members of the VCS workforce.

3 Strategic Priority 2) Assurance

3.1 Develop a robust and targeted Quality Assurance framework that informs the work of the Board and provides assurance that the City's arrangements for safeguarding adults are robust and person centred. To evidence the impact of safeguarding work in the City and promote an outcome focus. This will be used to promote effective challenge by the SAB to bring about improved outcomes for adults at risk.

3.1.1 In 2016/17 the Quality Assurance (QA) Subgroup has reviewed the performance dashboard and developed a Quality Assurance Framework based on the four quadrant model:



3.1.2 This Framework will underpin the work of the QA subgroup and provide the means of evidencing the effectiveness of the safeguarding arrangements in Nottingham, and will provide the Board with the assurance required, or identify where there are gaps in assurance. It is intended to draw on assurance processes already in place with partner agencies, and to minimise duplication, for example, where providers already provide assurance to commissioners. The framework was approved at the Board in March 2017 subject to some minor amendments.

3.1.3 As part of this review, the subgroup has reviewed the metrics collected on the performance dashboard since April 2016. This had resulted in active discussion of the key metrics and the key themes identified. In April 2016, there was a limited data set available and concerns were raised over the accuracy and interpretation of the data from the partnership. This position has improved significantly over the past twelve months and areas prompting active discussion have included:

- A review of the large increase in the number of enquiries,
- Age range of referrals,
- Types of abuse and location of abuse,
- Referrals by ethnic group
- Deprivation of Liberty Safeguards

Safeguarding Referrals: Reviewing the data has shown us that the Care Act led to a spike in referrals but this has now settled. Approximately two thirds of safeguarding referrals made to Adult Social Care Safeguarding do not require further multi agency Safeguarding intervention or a Safeguarding plan. This indicates there is far greater potential for early intervention across the partnership. The QA sub group asked the data analyst to undertake a comparison of the data at a national level so we can identify further outlier areas, and this will be reviewed in 2017/18. The sub group have discussed those referrals that were deemed not to be safeguarding, where alternative pathways could have been considered. A dedicated piece of work will be taken forward in 2017/18 with all partner agencies to agree actions that can be taken.

Deprivation of Liberty Safeguards (DoLS): The subgroup has considered how assurance should be sought about the DoLS arrangements in Nottingham. Key partner agencies have been asked to provide an assurance statement outlining how they identify and prioritise referrals for DoLS. This will be reviewed in the first quarter of 2017/18.

3.1.4 In February 2017, the subgroup received a presentation from the NCC Analytical Insight team about referrals over time. This included an overview of how to best understand data including separating out signals (when something has changed) from noise (random changes in data). This was very well received. The subgroup agreed that they will review the core data set on a six monthly basis, the performance analyst will report by exception if the data shows any significant changes, and a full data set will be produced annually.

3.1.5 The following report has been prepared by the Senior Performance Analyst, who is a member of the Quality Assurance Subgroup.

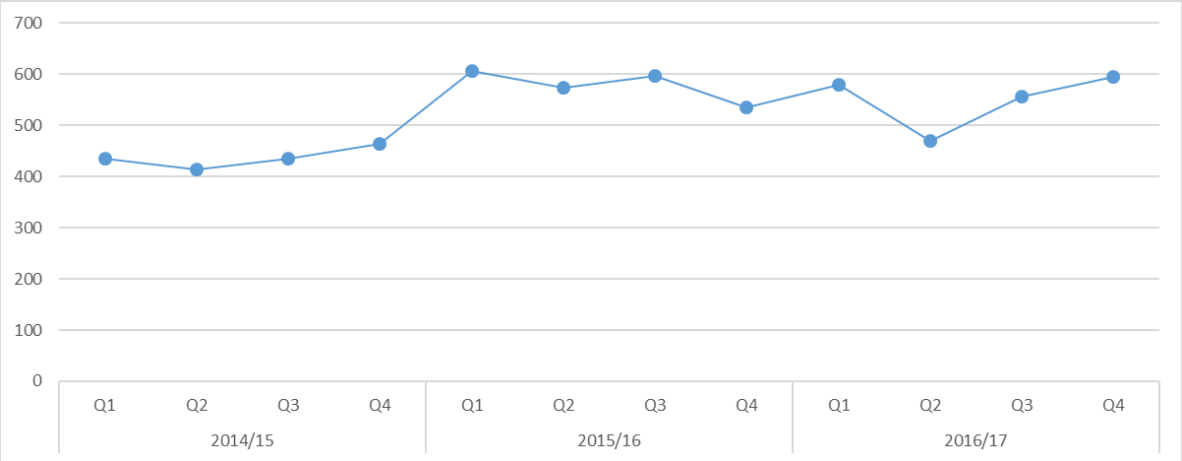
Analysis of Safeguarding Data

3.1.6 It is worth noting that there have been some significant changes in safeguarding over the past two years that have affected the figures below and the possible trends outlined. At the beginning of April 2015, the way in which Nottingham City Council recorded safeguarding changed significantly, and, coupled with changes as a result of the Care Act, this led to a significant increase in the number of safeguarding referrals received by Adult

Social Care. Nottingham City Council also changed the IT system that they used to record Adult Social Care data, this new system went live in August 2016. A consequence of this was that data in both July 2016 and August 2016 is not fully complete due to issues with data migration onto the new system. This does not mean that citizens are not safe because of this data issue; however, some data for these months is not available to be included in this report.

3.1.7 The number of referrals received by Adult Social Care rose in quarter one of 2015/16 (see chart 1), however this was not a significant increase, and since this time the number of referrals received on a quarterly basis has remained reasonably static. The only deviation from this pattern is quarter 2 of 2016/17, this is when the new IT system was introduced into Adult Social Care and this has had an effect on the data within this quarter.

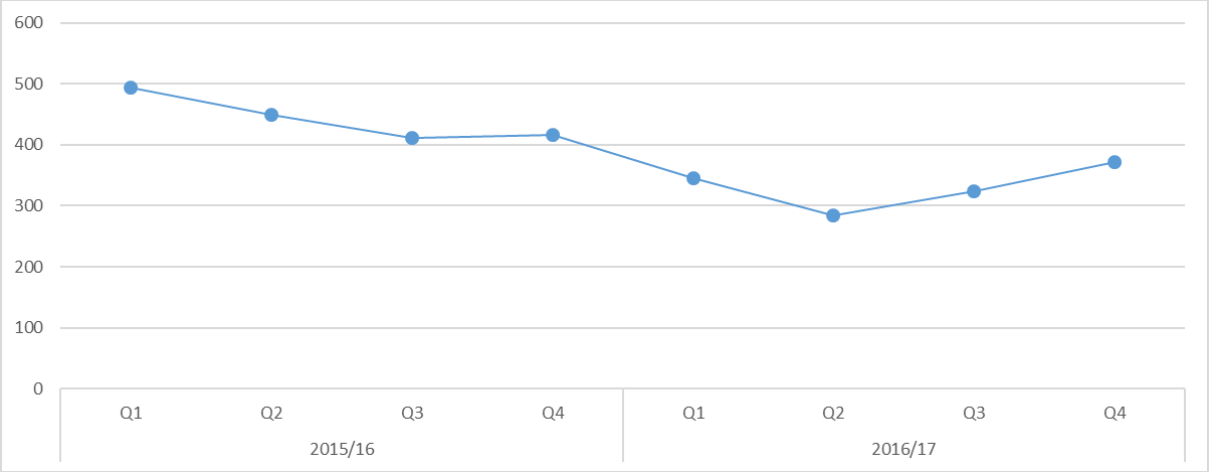
Chart 1 – Number of Referrals Received



3.1.8 The number of Section 42 referrals received (see chart 2), as defined by the Care Act, has seen a slight downward trend over the past two years (the only period that this data is available for). This trend is not evident in the overall number of referrals received and the most likely reason for this is due to the large amount of work undertaken to ensure that all staff are provided with the correct training in order to identify when a safeguarding referral needs to be progressed to a section 42 referral. A consequence of this is that even though the number of referrals received hasn't really changed the number that are progressed to an enquiry or intervention has reduced between 2015/16 and 2016/17.

3.1.9 Once again, there is evidence of quarter 2 in 2016-17 displaying a pronounced drop in volume when compared to other quarters, however the reason for this is the same as for the total number of referrals received and will be a common element in all 'over time' charts shown in this report.

Chart 2 – Number of Section 42 Referrals Received



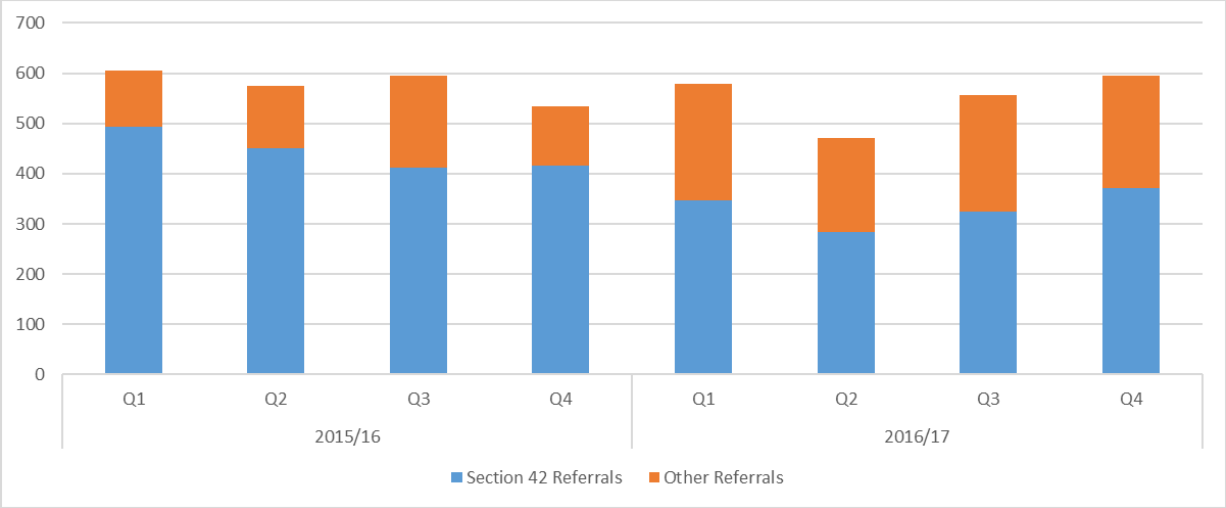
3.1.10 As has been seen the number of Section 42 referrals has gradually reduced in 2016-17 when compared to the previous year despite the number of overall referrals received staying roughly the same. This would therefore lead to the assumption that the number of referrals made that did not require further intervention has increased, however this is not necessarily the case.

3.1.11 Chart 3 shows the number of overall referrals received broken down by those that were a section 42 and those that were not. Although there is evidence here to suggest that the number of referrals that did not require further intervention has increased in 2016/17, a number of factors need to be considered.

3.1.12 Firstly, the additional training provided to social care staff has led to a better understanding of exactly what constitutes a section 42 referral. This means that in some cases a referral may have been recorded as a section 42 in 2015-16, but that same referral was not recorded as one in 2016/17, purely down to an increase in understanding.

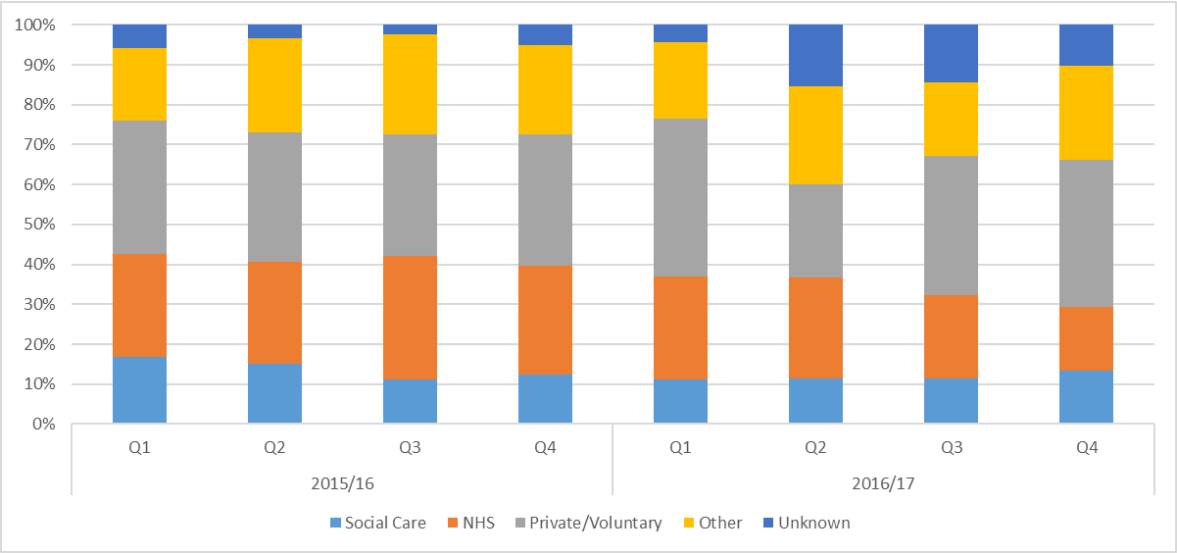
3.1.13 Secondly, referrals that are made to Social Care may still need to be made even though they do not constitute a section 42 referral. Some detailed analysis undertaken for the Quality and Assurance sub-group found that even though a number of referrals were assessed to not be a section 42 referral, there were still reasons for passing this referral to Adult Social Care. This work is still on going at present and further results will be provided to the subgroup mid 2017/18.

Chart 3 – Section 42 Referrals & Non Section 42 Referrals



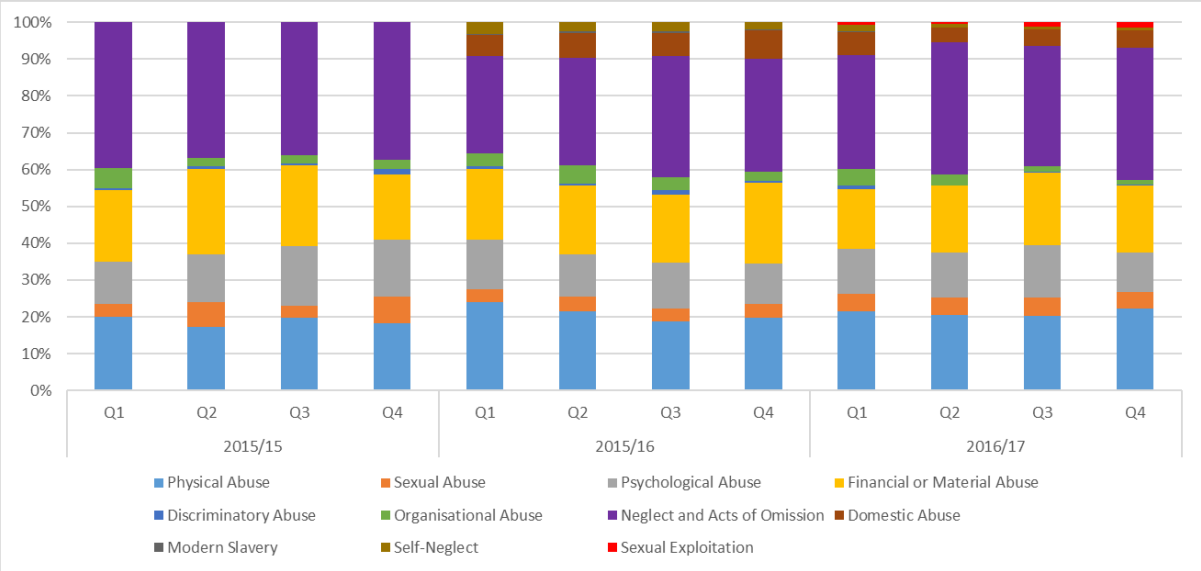
3.1.14 Examining the source of the safeguarding referral (see chart 4) reveals that the trend over the last two years has not changed significantly. Quarter 1 of 2016/17 shows a slight change in the source of a referral, with a private sector or voluntary sector source contributing a higher percentage in this quarter than in any other. The reason for this is due to the change in system mentioned earlier in this report having an effect within this month, specifically July 2016. Quarter 2 of 2016/17 also shows a slight change in profile, with 'other' sources contributing a higher percentage than in other quarters; analysis of this data does not reveal any specific sources contained within 'other' that can account for this difference, with a large variety of different people or organisations accounting for this. In general, the majority of referrals come from either the NHS or the private/voluntary sector, with a key reason for this being strong partnership links, coupled with robust sector management within the private and voluntary sector. These two sources are also more likely to be made aware of safeguarding issues and because of strong links and robust management are also likely to report these issues.

Chart 4 – Volume of Referrals by Source of Referral



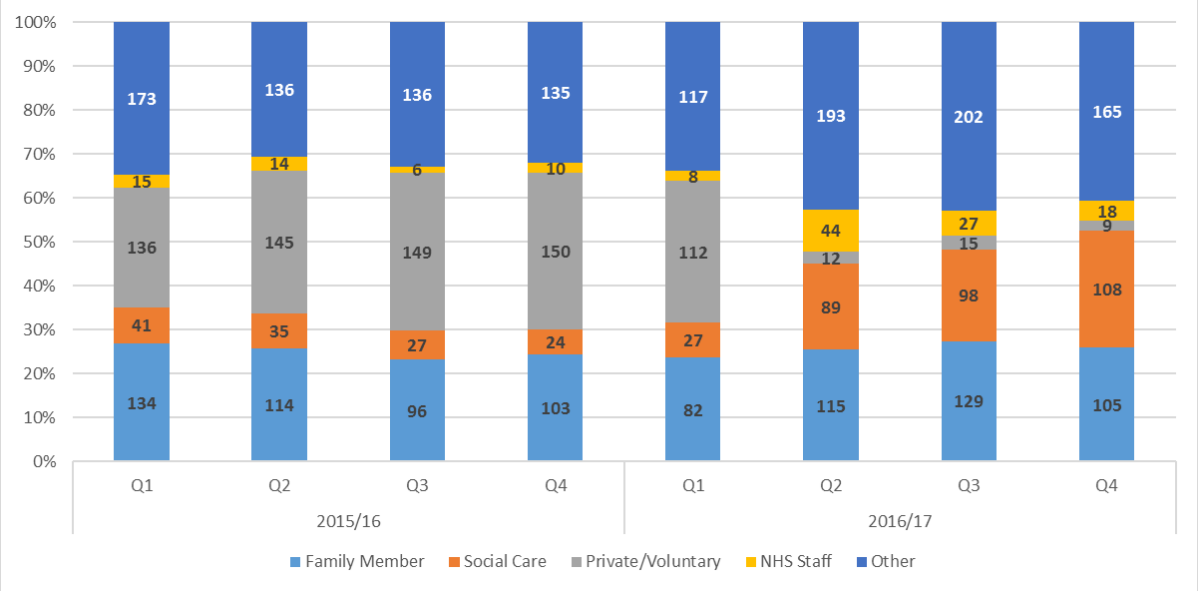
3.1.15 The different types of alleged abuse have slightly changed over the course of the last three years with Domestic Abuse, Modern Slavery, Self-Neglect, and Sexual Exploitation all now recorded as separate types of abuse. This change came into effect with the implementation of the Care Act since quarter 1 of 2015/16 and chart 5 shows that the main effect of this is that domestic abuse can now be broken out from the various abuse types that it used to be recorded under. The profile of abuse type over time hasn't changed significantly over the three year period covered but the last three quarters of 2016/17 show a slight reduction in the number of domestic abuse cases recorded. There has been some work around recording standards for alleged abuse types and this could have had an effect on this particular area; however, more depth analysis may be warranted in this area over the coming year if this trend continues. There were no other significant patterns highlighted in the data, with the majority of alleged abuse being either neglect, financial or physical abuse.

Chart 5 – Volume of Referrals by Alleged Abuse Type



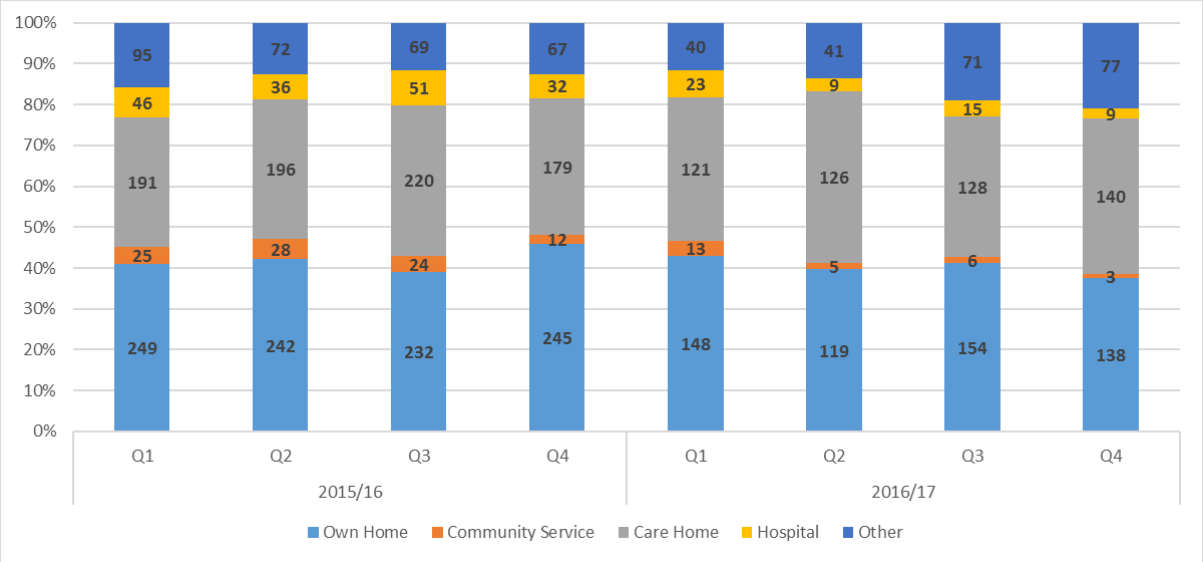
3.1.16 The relationship of the alleged perpetrator is also another area that has seen a change in recording between years. Chart 6 shows a significant change between a relationship with someone in a private/voluntary setting compared to that in a social care or other setting, however analysis of this change has revealed that is purely due to change in how this data is recorded. The relationship options available in the new IT system within adult social care are different to those available in the old IT and there is not direct or logical comparison between the two figures. If these two time periods (2015/16 and quarter 1 of 2016/17 vs quarters 2 – 4 of 2016/17) are taken as separate entities then there is no evidence of a change in pattern, further evidencing that the change that is there is purely down to a change in system rather than a change in behaviour of alleged perpetrators. The higher number of NHS staff recorded as being alleged perpetrators in quarter 2 of 2016/17 is also a consequence of data recording in the new IT system. This is evidenced by the sudden drop in volume in quarters 3 and 4 which are more in-keeping with previous totals and it is expected that this trend continues over the coming quarters. It is worth noting that this data is taken from the referral, so allegations, which may not have been substantiated.

Chart 6 – Volume of Referrals by Alleged Perpetrator Relationship



3.1.17 Please note that the location of alleged abuse only refers to where the citizen was when the alleged abuse took place and does not necessarily link to whom the alleged perpetrator of the abuse is. For example, alleged abuse that took place within a hospital does not mean that hospital staff were responsible for the alleged abuse; it could have been a family member visiting the citizen or another patient in the setting. There appears to be a slight increase in the location of alleged abuse being recorded as other in the second half of 2016/17 (see chart 7), although this is not enough to be classed as significant. This area may require further monitoring over the next few quarters and if this pattern continues then further analysis should be undertaken to discover the reasoning behind this increase. Aside from this, there is no real change over the last two years of data, with the majority of referrals taking place either in the citizen's own home or a care home, both places where one would expect the majority of referrals are most likely to take place.

Chart 7 – Volume of Referrals by Location of Alleged Abuse



3.1.18 As with adult social care in general there is an under representation of citizens of an Asian ethnicity, particularly within the Chinese and Other Asian ethnic groups, when examining the amount of referrals received compared to the latest census data (2011). Charts 8 and 9 show this picture more clearly and this data has been presented to the Q&A sub-group earlier in the year. As already mentioned this is not a pattern solely relating to safeguarding, but the wider adult social care context also, and further work with communities in this context may also boost safeguarding referrals for this ethnic group. It is worth noting however that the Asian ethnic group has a much higher percentage of younger citizens than other ethnic groups, with 25.0% of citizens within this ethnic group aged between 18-30 years old (see Chart 10). This could therefore be a key reason for a lower safeguarding rate, and lower rate of social care contact in general, as this age group is less likely to need to make contact with social services, as opposed to older citizens.

Chart 8 – Percentage of Referrals by Ethnicity & Year

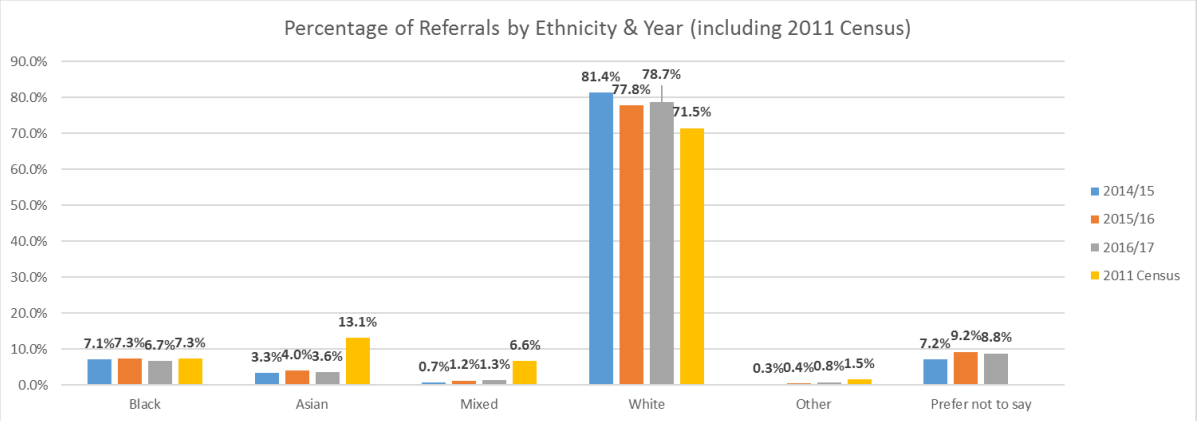


Chart 9 – Percentage of Referrals by Asian Ethnicity

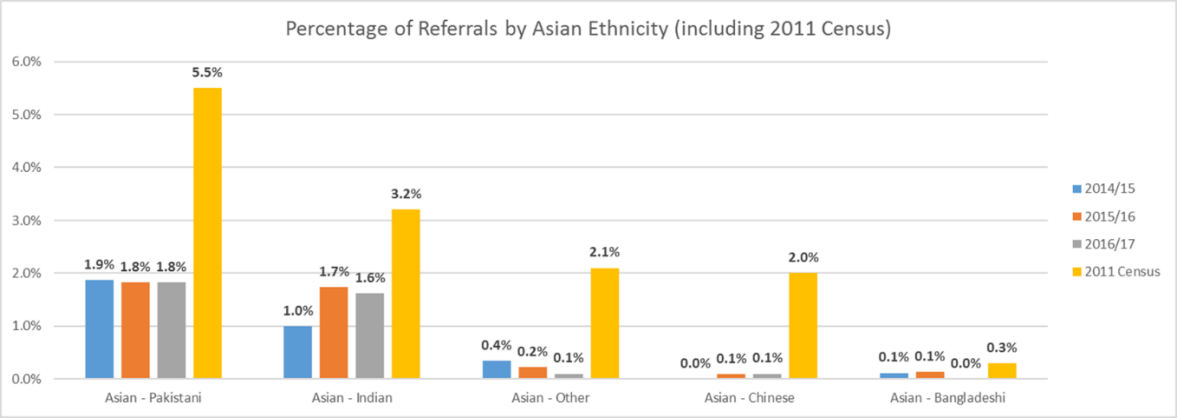
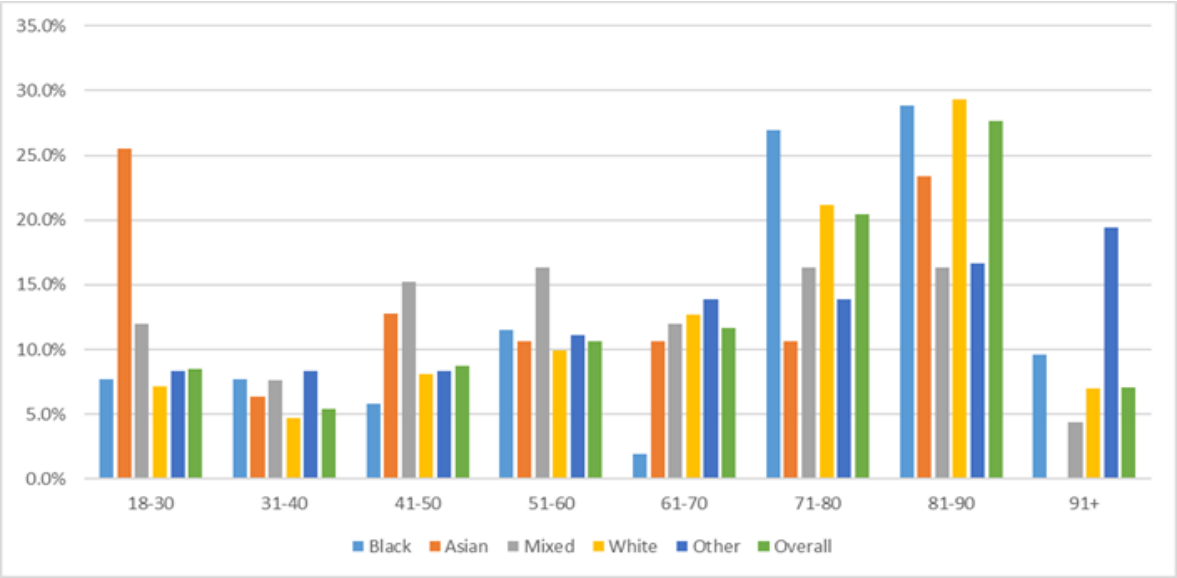


Chart 10 – Percentage of Referrals by Ethnicity & Age 2016/17



3.1.19 Moving on from ethnicity and more closely examining age and gender of citizens of referrals shows that aside from the second quarter of 2016/17, when once again the changed IT system played a large role, the age profile of vulnerable citizens is very similar, with the majority of citizens aged 65+, and within this cohort those aged 75-94 most likely to have a safeguarding referral. The gender of citizens is also very similar across the same time period with female citizens more likely to have a safeguarding referral made than their male counterparts (see charts 10 and 11).

3.1.20 Linking the above into the type of alleged abuse that took place shows that for female citizens, physical abuse is more prevalent in the younger age groups, with neglect the key abuse type for citizens aged over 71 years of age. Financial abuse is more prevalent in the 51-90 age range and the picture over time shows no significant change (see chart 12). Chart 13 shows the very same patterns can be seen when examining the male citizens who have had a safeguarding referral, with the additional caveat that male citizens are more likely to suffer financial abuse than their female counterparts (in terms of proportion of alleged abuse committed against both genders).

Chart 11 – Volume of Referrals by Age

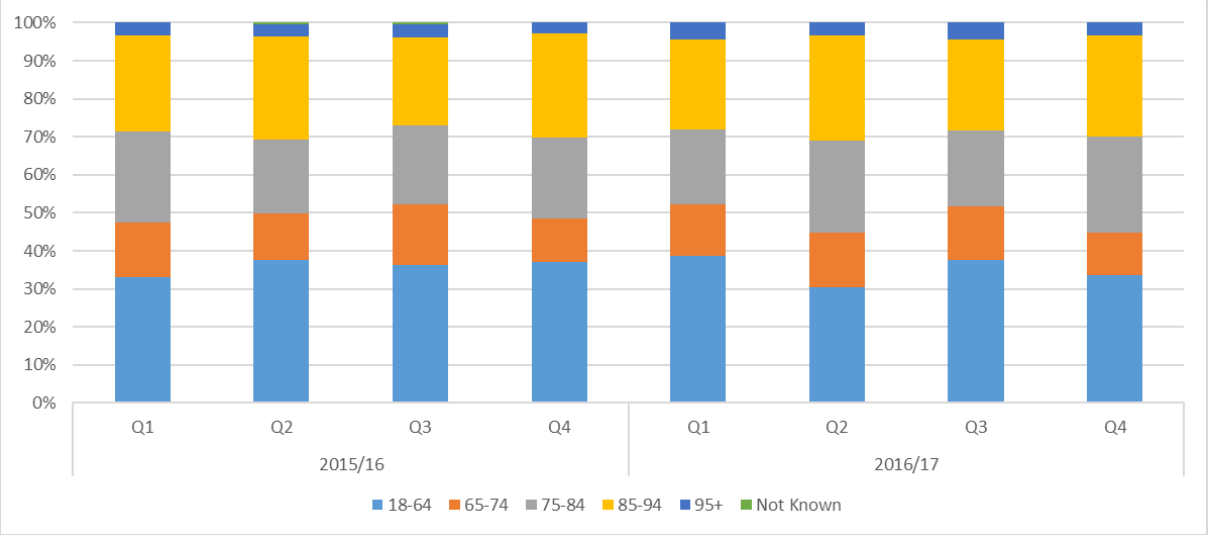


Chart 12 – Volume of Referrals by Gender

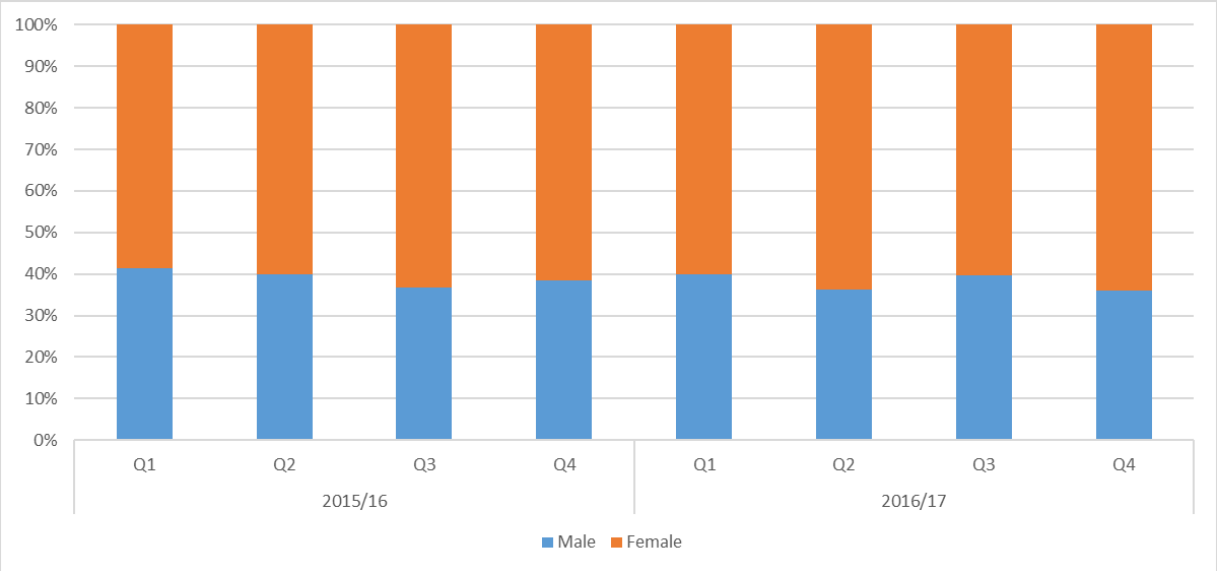


Chart 13 – Female Abuse Type by Age Group

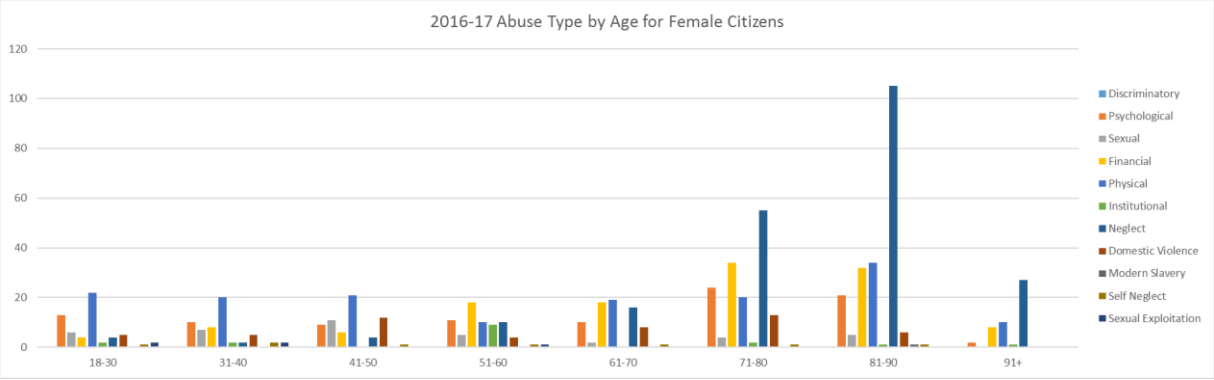
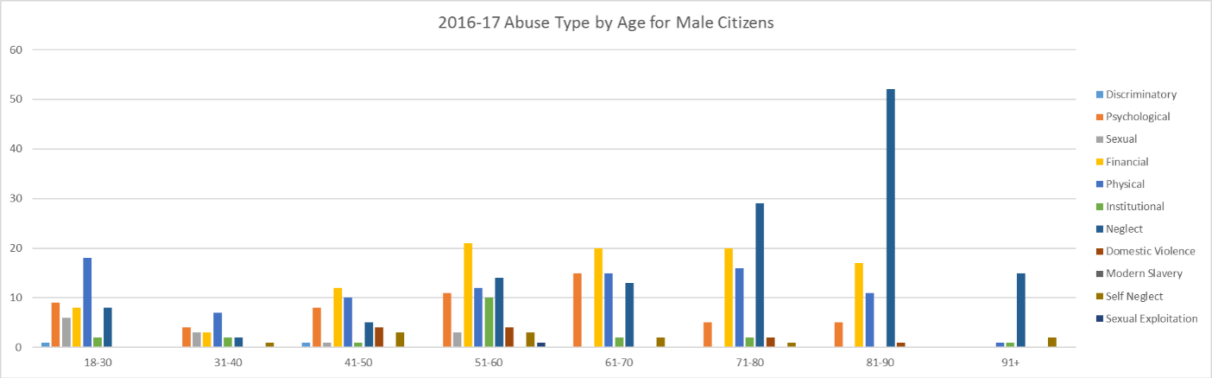
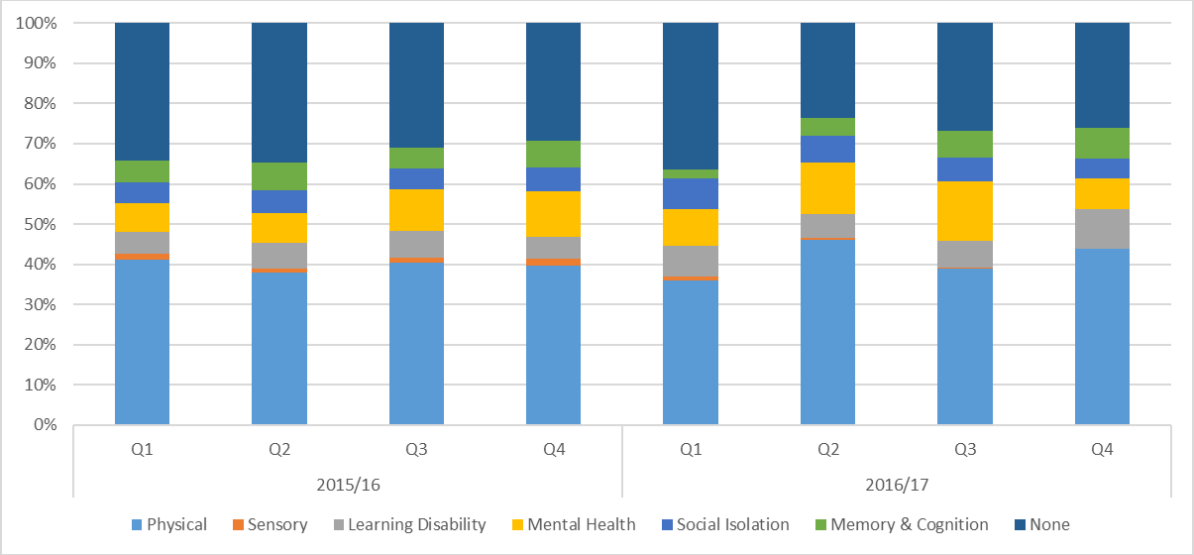


Chart 14 – Male Abuse Type by Age Group



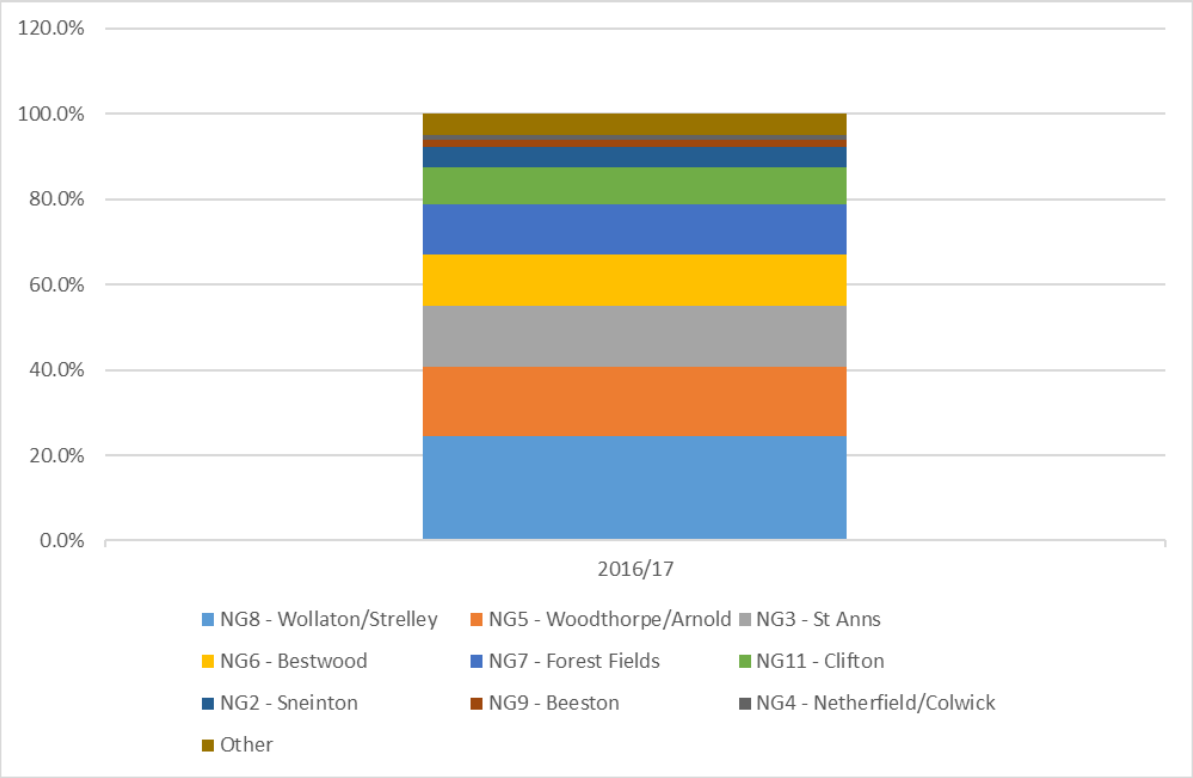
3.1.21 Examining the primary support reason (PSR) of citizens shows that there has been change in quarter 2 of 2016/17 with an increase in the proportion of citizens with a physical disability or mental health disability and a decrease in the number of citizens with an unknown PSR. There will always be a number of citizens who have no PSR, and a PSR is only given to citizens that receive adult social care services, and not all citizens with a referral do. However, one advantage of the new IT system implemented in quarter 3 of 2016/17 is that it is much more robust than the previous one and requires more information to be input in the majority of referrals, this has therefore decreased the number of referrals with an unknown PSR. Because of this the increase in physical and mental health PSRs is not thought to be an actual increase, more an increase in accuracy in terms of information on citizen demographics (see chart 14).

Chart 15 – Volume of Referrals by Primary Support Reason



3.1.22 Analysing the number of referrals received by postcode shows that the areas of NG8 and NG5 make up over 40.0% of the referrals received (see chart 15), although in part is expected as a large number of Nottingham City Council's adult social care population also reside in these areas. Examining these postcodes by type of alleged abuse does not show any substantial deviation from the overall picture seen in alleged abuse types; however, NG5 postcode shows a slightly lower volume of alleged neglect abuse.

3.1.23 Chart 16 – Volume of referrals by postcode



3.1.24 With the implementation of the Care Act a focus on citizen outcomes is now at the forefront for all partners within safeguarding. In 2015/16, 82.0% of citizens had their specified outcomes either fully or partially met, and this figure has increased to around 94.0% in 2016/17. This is obviously a large increase in performance and for this reason, as well as to try to identify themes within those specified outcomes that were not met; some detailed analysis of this area is to be taken to the Q&A sub-group in June 2017.

3.1.25 During 2017/18, the Quality Assurance Subgroup will continue to develop, review and implement the Quality Assurance Framework.

3.1.26 Lack of capacity in the Board Office during the first half of 2016/17, and the impact of the Safeguarding Adults Reviews (see 2.2 below) meant that the Safeguarding Adults Self-Assessment Assurance Framework (SAAF) was not completed as planned during 2016/17. This has not been carried forward to 2017/18; instead, the Board Manager will review the mechanisms for partners to provide assurance to the Board on their safeguarding arrangements and will develop an alternative to the SAAF, in collaboration with Nottinghamshire SAB.

Learning From Safeguarding Adults Reviews

3.2 A robust process of learning from SARs ensuring that learning leads to embedded improvements in local arrangements where actions have been identified.

3.2.1 The SAR subgroup has overseen three Safeguarding Adults Reviews (SARs) during 2016/17.

3.2.2 The summaries of the SARs below are all taken from the published executive summaries. Links to the full executive summaries are included below.

Adult B

Adult B died in October 2014 in circumstances where there were indications of possible neglect. He was 75 years old when he died. His death was described at the time as resulting from sepsis following infection of his laryngeal stoma. Adult B had been living with his wife, who was then aged 74 and had been diagnosed with dementia, although in the last days of his life, Adult B was no longer living with her. It was agreed, with the consent of their daughter, that the needs and care of both Adult B and his wife should be considered in this review. The decision to conduct a review into how agencies worked together to respond to the health and social care needs of Adult B & his wife was taken in February 2015, before the Care Act come in to force, so this was a Serious Case Review.

The Serious Case Review Overview report was accepted by the Board in August 2015. An inquest concerning the circumstances of Adult B's death took place from the 30th September to October 2nd 2015 and concluded that the cause of Adult B's death was an infection at his elbow and that any problems which may have existed in relation to his health and social care needs did not contribute to his death.

The review found that as Adult B's & his wife's health deteriorated and their ability to care for one another diminished, information sharing and coordination between agencies should have been more effective. The agencies involved in our review have recognised the learning identified in the report and taken action to address the recommendations.

The independent author made 9 recommendations covering a range of safeguarding practice including the implementation of the Care Act, promoting awareness of carers' needs, understanding and application of the Mental Capacity Act, promoting good practice, information sharing, arrangements to manage frequent admissions to hospital, the effectiveness of training, particularly for the third sector, and stoma care. The Board has taken action in relation to each of the recommendations.

The SAR subgroup has sought and gained assurance from all partner agencies in relation to the implementation of the Care Act, identification of carers' needs, application of the Mental Capacity Act (and in particular how agencies support work with adults who have capacity who make unwise decisions which put them at risk) and how they promote good practice. The subgroup's findings will be presented to the first Board meeting in 2017/18, and the subgroup will be following this up in September 2017.

The development of the Carer's hub (commissioned by the CCG) and the new online service directory LION will strengthen arrangements for supporting carers.

The CCG has reviewed the effectiveness of Hospital Avoidance care plans, which identified some gaps in assurance. The CCG and Adult Social Care are continuing to work together to develop how the multi-disciplinary teams operate.

The Safeguarding Training checklist has been updated to include learning from this SAR.

Further details can be found in the executive summary, which can be found here (for at least 12 months after publication.)

Autumn Grange

This review was prompted by issues linked to the inadequate and unacceptable standard of care in Autumn Grange, a residential care home. In immediate response to events at Autumn Grange in 2012, agencies reviewed their involvement with the home to ensure any lessons that could be learned about the monitoring and regulation at this care home were immediately implemented.

Following the subsequent conviction of the home owners in 2016 for corporate manslaughter, when further information became available from the evidence provided through the criminal investigation, the Board undertook a thorough independent review of that information, using it to provide further assurance that partner agencies are working effectively to safeguard adults in Nottingham's care homes who may be at risk of abuse or neglect.

By undertaking this new independent review the SAR has evidenced that since the closure of Autumn Grange in 2012 agencies have given assurance and been able to evidence to the SAB that significant improvements have been made in individual organisations as well as with partnership working. This has led to a strong level of assurance being given by the independent reviewer. The Safeguarding Adults Board is assured that Nottingham agencies work effectively to deliver a joined-up service with an improved grip on monitoring performance, quality assurance and reporting mechanisms - all with a strong safeguarding focus. The Action Plan has now been developed and agreed by the Sub Group to ensure that the learning from this review can continue to be built upon and shared throughout the partnership.

An Inquest concerning Resident A, who had lived at Autumn Grange care home, was held in October 2016 in Nottingham. The Coroner concluded that Resident A died as a result of Unlawful Killing, as concluded by the earlier criminal proceedings, where it had been established by a Home Office Forensic Pathologist that there were clear and direct causal links between lack of appropriate care for her at Autumn Grange and her death.

The Coroner stated that care, support and welfare were the responsibility of Autumn Grange, and everyone else had a secondary role. The Coroner, in her concluding remarks, determined that none of the identified failings in agency practice were causative or made a material contribution to Resident A's death. In her concluding remarks, she said the case showed that experienced and well-meaning professionals can sometimes be misled.

The Coroner made a Regulation 28 Notice to Prevent Future Deaths report to the CQC, Department of Health and Secretary of State for Justice, as she was concerned that there is no systematic mechanism and/or statutory provision to check whether the Nominated Individual for a care home is of good character, such as through a DBS check. At Autumn Grange, the Nominated Individual had previous convictions but CQC does not routinely or systematically request a DBS check for the Nominated Individual.

The independent reviewer made 10 Recommendations to the NCSAB. Nottingham City Safeguarding Adults Board accepted the recommendations of the independent reviewer at an extra-ordinary Board meeting in September 2016. In accepting the recommendations, the Board decided that it should take into account some information that the independent reviewer had not had the opportunity to consider and to develop the recommendations accordingly. The Board also took into account themes that had emerged during the subsequent Inquest into the death of Resident A, which indicated the need for further assurance in some areas.

The developed recommendations covered a range of aspects relating to safeguarding adults in Care homes and included:

- The availability of information for residents and their families about how to make complaints, escalate concerns and access to advocacy
- Raising awareness in the workforce of how to work with deception, avoid confirmatory bias and use professional curiosity
- Information sharing in respect of adults in care homes; effective co-ordination of enforcement action, including with the regulatory body, including assurance regarding concerns about registered managers and nominated individuals
- Assurance regarding GP local enhanced contracts
- Assurance regarding how the Local Authority will work with partners to review citizens' care and support plans in the context of reduced capacity.

An action plan has been developed to address these recommendations and will be overseen by the SAR subgroup during 2017/18. Actions to be completed include:

- An assurance report to the Board on the arrangements for monitoring the provision of complaints and advocacy information in care homes
- Promotion of advocacy and complaints processes within care homes
- An assurance report to the Board from the CQC regarding monitoring care home compliance around complaints and advocacy, information sharing with partners, and their response to the regulation 28 notice
- Scoping tools and resources for practitioners to support improved practice to avoid confirmatory bias and promote professional curiosity
- A review of the Provider Investigation Procedure
- An assurance report to the Board from the CCG regarding GP contracts and learning from this SAR
- An assurance report from Adult Social Care regarding arrangements for reviewing residents in care homes and mitigating risks around reduced capacity
- An annual report from the Local Authority and CCG regarding on-going partnership approaches to safeguarding care home residents.

Full details can be found in the executive summary, which can be found here (for at least 12 months after publication).

Adult C & Adult D

This review was jointly commissioned with the Nottinghamshire Safeguarding Adults Board (NSAB), with Nottingham City Safeguarding Adults Board as the lead SAB. The review concerned two adults who had been kept in domestic servitude. There was a criminal trial, which resulted in prosecution in respect of the abuse of Adult D. Both adults are still alive, and in order to protect their identity the details of the case will not be reported here in any detail.

This was a difficult case where various agencies had different involvement with someone who accessed services at times of crisis but did not appear to want further support when it was offered. Adult C provided plausible explanations for injuries because, it is clear now, he wanted to divert attention away from his abusers.

Greater professional curiosity could have led to Adult C being viewed as an adult at risk of harm and different actions being taken. This case also raised an area of learning around dealing with deception, although it was not typical of how modern slavery might usually present itself. There is now greater knowledge and understanding of modern slavery and this case reiterates the need for professionals to be aware of and equipped to respond to it. However, both safeguarding boards will continue to seek assurance from the agencies involved that they are raising awareness about modern slavery with their workforces.

In the case of Adult D, it is evident that she moved from one area to another and went missing without any professionals being aware, as there was no active involvement from agencies. Her bravery ensured that the abuse ended and that the perpetrators were brought to justice.

The learning from the Adult C SAR concerned:

- A lack of professional curiosity and a reliance upon self-reporting
- Recognition of and response to safeguarding concerns and indicators of abuse
- Professional assumptions made as a result of diagnostic labels and gender bias.
- Working with adults who are perceived as hard to engage
- Interagency communication and silo working

The independent author made three recommendations to the NCSAB (& NSAB). These included:

- Assurance that awareness has been raised with the workforce regarding modern slavery and coercive control, and that training reinforces the need for professional curiosity and that learning from this SAR is shared.
- The case to be referred to the strategic leads for modern slavery in the City and County to inform the development of the modern slavery strategy.

An action plan has been developed and will be overseen by the SAR subgroup during 2017/18. Actions for the NCSAB include:

- The new Training, Learning and Improvement Subgroup scope resources, tools and good practice available to partner agencies to support awareness of modern slavery and coercion and control and for partner agencies to benchmark themselves against this.
- The actions from Autumn Grange SAR in relation to working with deception & understanding confirmatory bias will also be applicable to this SAR
- The SAR has been shared with the strategic lead for Modern Slavery in Nottingham City

In addition, assurance was sought regarding non-urgent referrals to Adult Safeguarding for adult at risk presenting to Emergency Departments out of hours. Assurance was provided to the Board that a system is now in place to address this.

Learning from the review was included in a presentation on Modern Slavery as part of the Every Colleague Matters event in February 2017. 52 People attended the session, comprised of Nottingham City Council (22); Health (1); Nottingham City Homes (1); Police (7); Education (2) and 19 people from 9 Private, voluntary or independent organisations. 61% rated it excellent, 36% rated it good.

Since meeting with the independent author as part of the review, Adult C has been referred to and accepted appropriate support services.

Further details can be found in the executive summary, which can be found here (for at least 12 months after publication.)

3.2.3 In undertaking these SARs learning also emerged about the SAR processes and how best to conduct these reviews. Following consultation with partners, recommendations were taken to the Board in March 2017. Work to refine these processes will continue into 2017/18, and will be completed in conjunction with Nottinghamshire SAB.

3.2.4 There have been three new referrals made into the SAR Subgroup over the past 12 months. Each of the referrals was scoped by individual agencies and reviewed by the group. The Subgroup has not made any recommendations to the SAB to carry out a SAR on these referrals.

3.2.5 Self-Neglect and non-engagement with services for those that have capacity has been a theme in a number of the reviews including Domestic Homicide Reviews (DHRs) in the city. A subgroup of the Crime and Drugs Partnership will lead on this work to develop guidance with adults who do not engage with services, and it will be shared with the SAR subgroup. Following learning from a SAR in their area, Nottinghamshire SAB will also be reviewing the cross-authority policies and procedures for working with self-neglect.

3.2.6 The SAR subgroup has reviewed SAR reports from other areas. No specific actions or areas for assurance were identified, but findings from these SARs has reinforced the challenges that arise in working with adults who have capacity (and/or where MCA does not apply) but who self-neglect or make unwise decisions which put them at risk of harm.

3.2.7 Following a SAR referral in March 2016 which did not progress to a full review, the subgroup has overseen an action in relation to equipment in care homes, and has sought and received assurance in relation to the concerns raised.

3.2.8 The East Midlands Safeguarding Adults Network (EMSAN) (which is currently chaired by the Director of Adult Social Care (DASS) in Nottingham City) is developing a regional SAR database, which the NCSAB will refer to when considering new SAR referrals.

3.2.9 Sharing good practice has been added as a standard agenda item to the SAR Subgroup and members are encouraged to share case examples from their agencies with a view to disseminating learning and positive practice across partner agencies.

3.3 The Board to be assured that training is effective in supporting the delivery of high quality practice in regard to safeguarding adults in need of care and support.

3.3.1 During 2016/17, the NCSAB underwent a review of its training, learning and improvement arrangements to determine a position on what it would provide given increasing budget pressures. With the budget available for the Board from the funding partners (Nottingham City Council, NHS Nottingham City CCG and Nottinghamshire Police) for 2017-8, it was not possible to continue to fund a part-time Training Officer role beyond March 2017. As a result, a new strategy has been developed which reflects the new model where partners are central in supporting the learning and improvement activities of the Board.

3.3.2 Members of the former joint Learning & Improvement subgroup have raised concerns about the Training Officer for safeguarding adults post not being funded and the impact this will have on how safeguarding messages are disseminated to the wider workforce. The NCSAB members decided to form a separate Training, Learning and Improvement subgroup to give sole focus on the learning and improvement arrangements of the NCSAB. The subgroup will also have a communication and engagement role as this is a central part of ensuring that the workforce is competent to carry out its safeguarding responsibilities and that learning from reviews is disseminated. To define the structure and purpose of the new subgroup, new Terms of Reference have been written.

3.3.3 The successful implementation and delivery of the Training, Learning and Improvement Strategy through the new subgroup will be dependent on 'in-kind' contributions from key partner agencies, including representation on the subgroup and sharing training and learning resources. The subgroup will be supported by the Board Manager but there will be less Board office capacity than has previously been available through the part time Training Officer.

3.3.4 The learning and improvement strategy was based on a gap analysis against the requirements outlined in the Care Act. The new subgroup will have a broad range of tasks including implementing learning from reviews and seeking assurance around training across the partnership. The subgroup will need to ensure that the strategy considers how risks arising from not having a Training Officer coordinating and delivering training to the Private, Voluntary and Independent (PVI) sector can be mitigated. However, the NCSAB has not directly delivered any training since 2016. There had previously been a pool of trainers from partner agencies to deliver training, but it was not operating efficiently, and was reliant on trainers from the Local Authority. There continues to be evidence of need in the PVI sector for multi-agency adult safeguarding training. The Vulnerable Adults Provider Network are ascertaining the level of need.

3.3.5 The former Sub-Group supported the review of the cross-authority safeguarding training quality assurance scheme. This is a process where partner agencies complete a checklist to confirm that the training they are delivering includes all relevant content required by the Boards (NCSAB & NSAB). The training officers in both Boards then review checklists and issue certificates to partner agencies who can then use the Board logos. The process has been streamlined to ensure on-going engagement from partner agencies with the scheme. The new subgroup and the Board Manager (in liaison with the NSAB) will review how to effectively and proportionately quality assure partner agency safeguarding training in the context of reduced Board office capacity.

3.3.6 During 2016/17 work was progressed in collaboration with Nottinghamshire SAB to develop a Safeguarding Adults competency framework, based on the framework devised by Bournemouth University. This was presented to the Business Management Group in July 2016, where a decision was taken that the competency framework would not be adopted in Nottingham City as key agencies already had their own standards and programmes in place. There remains an outstanding action to adapt the framework for use by the Voluntary Sector. The Vulnerable Adults Provider Network will work with the City Council's Integrated Workforce Development to progress this and this will be followed up in 2017/18.

3.4 Partner Descriptions of their Contributions to Strategic Priority 2

3.4.1 **Crime & Drugs Partnership:** Commissioned services are reviewed quarterly. The Domestic and Sexual Violence and Abuse (DSVA) performance framework requires data coming from providers and service users and captures information about referrals to safeguarding. Officers meet to share learning from SARs, Serious Case Reviews and Domestic Homicide Reviews (DHRs). There are requirements that actions arising from DHRs are audited. This is overseen by the DHR Assurance and Learning Implementation Group, which reports into the DSVA Strategy Group.

3.4.2 **East Midlands Ambulance Service (EMAS):** The safeguarding agenda is embedded in **EMAS** from board to frontline. Safeguarding is included within the quality assurance framework and is assessed on all individual performance reviews. The safeguarding team carry out specialist audits to audit staff knowledge of safeguarding and also the quality of the referral being raised, compliance levels are high across all areas. A level 2 education book has been provided to all frontline staff during 2016-2017 and will be assured during the next financial year using an eLearning education and training needs analysis platform.

3.4.3 **HMP Nottingham's** internal Safeguarding Board documents discussions and actions made in relation to the identification and safeguarding of vulnerable men.

3.4.4 **Nottingham City Council Adult Social Care:**

3.4.5 Quality Assurance framework: **Adult Social Care (ASC)** has a robust framework in relation to Adult Safeguarding. In terms of quantitative data, reports relating to safeguarding are produced on a monthly basis and analysed at both an operational and strategic level to identify performance issues, themes and trends. However, further qualitative assurance measures are embedded in our Safeguarding and Quality assurance processes and on average 20 cases are audited on a monthly basis across the Adult Assessment and Safeguarding services. Key indicators in **Adult Social Care's** audit tool are the six principles of adult safeguarding work as specified in the Care Act statutory guidance. Audit results are fed back to practitioners and managers for individual learning, but in addition to this, the **ASC** Safeguarding Training & Development Officer undertakes a three monthly thematic analysis, which informs changes required in both procedure, and future training. Thus far, the footprint/consistency of management decisions and recording information are the two main areas that have been highlighted as requiring action, and as a result, we have introduced record keeping training and are developing a bespoke Safeguarding Manager training programme. Good practice is also highlighted and good partnership working has been identified as a strong theme.

3.4.6 Learning from SARs has highlighted learning and training needs. As a result of the recent SARs undertaken by the Board, **Adult Social Care** have already commissioned Modern Slavery briefings and the City Safeguarding Team will undertake specialist Modern Slavery training in June 2017 to be delivered by 'Hope for Justice', the global non-profit organisation which aims to end human trafficking and modern-day slavery. The issue of confirmatory bias has also been highlighted as a theme emerging in both Children's SCRs

and Adult SARs. Training has now been organised for ASC colleagues to educate them on the subject and up skill them so as to avoid some of the negative consequences of this approach to assessing risk and safeguarding.

3.4.7 Safeguarding Training: Assurance of a well-trained workforce is a priority. **Adult Social Care** benefit from a dedicated Training & Development Officer and a robust training plan of both mandatory and bespoke sessions is delivered annually. All sessions are evaluated, and regular observations from training officer peers take place to provide assurance of competence standards. Besides an annual plan **Adult Social Care** commission bespoke sessions that arise from learning and promote partnership working; briefings this year have covered a broad range of topics such as Infection Control, CityCare Care Homes team, Tissue Viability and Dementia Outreach.

3.4.8 We are also committed to sharing our expert knowledge of safeguarding and supporting the partnership. The **Adult Social Care** City Safeguarding team and Quality Assurance team have developed strong experience and expertise and a key achievement this year has been sharing this rich knowledge base. **Adult Social Care** co-led with the Clinical Commissioning Group a workshop as part of the multi-agency 'Every Colleague Matters' programme in relation to Making Safeguarding Personal; we have delivered lectures to trainee social workers at Nottingham Trent University and at a regional level at the Principal Social Workers conference: **Adult Social Care** delivered a workshop in relation to Inherent Jurisdiction and Legal Literacy.

3.4.9 The case below demonstrates the expertise applied in safeguarding interventions - which makes the work satisfying in achieving positive outcomes for citizens - and how essential training in risk management and legal interventions is to ensure safe, effective practice.

Nottingham City Council was involved with Citizen X a frail older person who lived in an owner occupied property in Nottingham. She was immobile and required a wheel chair. X needed the support of two carers to assist with transfers and the use of a hoist.

Citizen X employed an agency to support her care needs and her finances were managed by one of her relatives. A referral came through to the department to investigate financial abuse by a concerned professional as it was noticed by them that her savings had dropped significantly in a short period of time.

It transpired Citizen X had "no idea" why her savings had dwindled and she had very little oversight of her finances.

The outcome of a complex Safeguarding Investigation concluded that although Citizen X had the mental capacity to understand her financial position she had been financially abused as she had been coerced into agreeing to signing away almost all her savings.

An application was made to the High Court for Inherent Jurisdiction, to prevent the person responsible for the financial abuse having any further involvement with care and finances. The order was granted and a police investigation was initiated.

X now has her finances managed safely and has appropriate professional support. The social worker remained involved to co-ordinate a multi - agency protection plan in supporting X.

3.4.10 **Nottingham CityCare Partnership:** The Serious Incident Review Group uses a standardised framework to implement, monitor and review learning from serious incidents. SARS learning is embedded through training, Safeguarding Bitesize (quarterly updates), **CityCare** Safeguarding pages on the intranet, **CityCare** Champions and the **CityCare** Safeguarding Facebook Group. **CityCare** Safeguarding Champions review and feed back learning to their team using the appropriate communication method for their team. There is on-going thematic audit of Safeguarding Adults Duty to monitor staff themes to enable prompt and responsive information to be provided to staff.

3.4.11 Safeguarding Adults processes are quality assured through the **CityCare** Quality and Safety Group, which reports to the **CityCare** Board. All **CityCare** policy and processes relating to adults at risk are informed by national policy and guidance such as Making Safeguarding Personal, The Care Act 2014 and Mental Capacity Act (2005).

3.4.12 **CityCare** staff feedback following training demonstrates that staff would like to explore a case study around self-neglect and unwise decisions. In response to this, a Safeguarding Adults/ Mental Capacity Act training day was developed to enable staff to work on some cases from practice that incorporate MSP and MCA. Champions' sessions reflect discussions around the complex cases derived from Safeguarding Adult Duty. Speakers who attend the group are chosen in response to staff feedback. In June 2017, the Fire Service will come to discuss hoarding and Safe and Well Checks.

3.4.13 **Nottinghamshire Fire and Rescue Service (NFRS)** recognise the challenges to working with individuals who self-neglect. Following the implementation of the Care Act (and introduction of self-neglect as a category of abuse), there was a period of initial confusion within **NFRS** around this issue and how to progress referrals of this nature. With guidance from Safeguarding leads and support from Board colleagues and their organisations, **NFRS** held a number of workshops with the Persons at Risk Team and others with the responsibility of making Safeguarding referrals to ensure they were being made to the appropriate team. Analysis of the data **NFRS** collect on Safeguarding demonstrates this has led to a drop in Safeguarding referrals but an increase in referrals for a Care and Support Assessment.

3.4.14 **NFRS** recognise the value of learning from SARs both locally and nationally. Following a recent SAR outside Nottinghamshire, **NFRS** has instigated a piece of work with our Fire Protection Team, who conduct inspections within Care Homes, around emollient creams and their use. This information will be highlighted to managers as well as sent as a mail shot to every care home on our database system. We hope to highlight the potential dangers of emollient creams and smoking and prevent any fire of this nature happening locally.

3.4.15 Through national SARs and partnership working with other fire services **NFRS** have done a lot of work in profiling our most at risk groups. This has led to the development of CHARLIE, which is an acronym for all of the issues that we believe put individuals at an increased risk of dying in a fire. These stand for;

Care and Support Needs

Hoarding
Alcohol issues,
Reduced mobility,
Lives Alone,
Inappropriate use of electrics and
Elderly.

The profile of CHARLIE features in many of **NFRS's** prevention campaigns, raising awareness both internally and externally. In addition to this work, **NFRS** have standardised our Community Reassurance and Engagement programme in order to offer appropriate levels of reassurance post incident to our most vulnerable members of the community.

3.4.18 **NFRS** has a robust system to collate and enable auditing of our Safeguarding referrals and cases. The Safeguarding Team meet six-monthly to review cases, identify learning and plan preventative action against any emerging or topical themes e.g. inappropriate referrals, modern slavery, hoarding.

3.4.19 A Serious Incident Group meets to discuss appropriate cases whereby Safeguarding might be involved following a fire death or incident causing life-changing injury. The Safeguarding lead has recently put a report out for endorsement by the Senior Management Team to have a Chief Officer chair this panel as well as include delegates from partner agencies to allow for peer scrutiny. It is envisaged this will maximise the effectiveness of this group and ensure **NFRS** is fulfilling their Safeguarding commitments.

3.4.20 **NFRS** Service's Safeguarding e-learning package will be ready for staff to access on 3rd July '17. This is a compulsory e-learning package for all NFRS 'frontline' employees. The impact of the previous training and trials of the e-learning package have been successful and resulted in the adoption of additional 'coffee break' learning sessions for staff. This is the result of feedback from staff who have requested face-to-face informal sessions to brief them on changes within Safeguarding and also scrutinise their referrals to provide updates and ensure appropriate referrals. The Service utilises every opportunity to train and ensure partners are equipped to identify and respond to the risk of fire in the homes of vulnerable adults before the Service has to respond in either its emergency service capacity or as a preventative service. By working closely with other agencies and in particular being involved in the development of policy and training, the Service is more likely to influence the way in which its partners work and help them spot the risks of fire before we have to respond to the consequences.

3.4.21 **Nottinghamshire Healthcare Foundation Trust (NHFT):** The learning from all SARs is communicated across the organisation in the form of case specific briefings (entitled 'Safeguarding Matters') which are disseminated by the safeguarding team and are tweeted and highlighted on our internal website which has been redesigned during the last year to be more accessible and user friendly. This year we also took the lessons from multi-agency reviews out to staff via seminars across the Trust. These workshops provided staff with a reflective session in which they were able to learn more about multi-agency reviews and focus on how the learning identified could have a positive impact on

their practice. The seminars were well received and we continue to develop ways in which to share learning with colleagues. The actions from all reviews are monitored for implementation and impact by the internal SCR subgroup, although evidencing impact remains an area for further development.

3.4.22 In terms of quality assurance, **NHFT** continues to develop a quality performance quarterly report, which is reviewed internally by the Trustwide Safeguarding Strategic Group. There remain a number of challenges to ensuring the data collected is robust but we continue to strive to put the necessary systems in place.

3.4.23 **NHFT's** Quality assurance practice has been greatly enhanced by the introduction of a Safeguarding Compliance Framework, which has been trialled during the last quarter of 2016/17 and has recently been formally launched. The aim of the framework is to assist teams in self-assessing their safeguarding practice and also to facilitate both planned and unplanned audits of practice by members of the safeguarding team. The trial audits have gone well and we look forward to being able to report on a full schedule of safeguarding visits next year.

3.4.24 Finally, **NHFT** have also revised our Safeguarding Supervision Framework during the last quarter and this has also just been launched. The aim is to ensure that safeguarding supervision is more readily accessible to staff in order to continue to strengthen safeguarding across the Trust.

3.4.25 This year has also been busy in terms of the provision of safeguarding training. A new safeguarding training team has been established who are now delivering safeguarding training across the Trust to ensure consistent training provision to all staff. The training requirements have been revised so that all non-clinical staff now complete level 1 training and all clinical staff complete level 3 training or above, dependent upon role. Both training packages have been fully revised and updated and new packages are also being developed, in particular around domestic violence and self-neglect. The establishing of a specialised team means that we are able to keep our training more up to date and the learning from reviews is fed into training in a far more timely fashion. In addition, the safeguarding team have hosted two emerging themes events for staff looking at current key issues around safeguarding.

3.4.26 **Nottinghamshire Police:** Development of the Organisational Risk and Learning Board. There is now a quarterly organisational risk and learning board, chaired by the Deputy Chief Constable, to respond and provide reassurance that recommendations from SARs, Significant Incident Learning Processes (SILPs), SCRs and DHRs, including publications of reports are actioned, disseminated and form part of operational best practice. The board will be integral to providing organisational reassurance to safeguarding Boards through scrutiny of action plan delivery. Action plan assurances following senior officer scrutiny are delivered by the organisational representative at the relevant board. The force is presently undertaking a departmental assessment to match resource with the increasing demand in this area of vulnerability.

3.4.25 A comprehensive Safeguarding Adults at Risk Procedure. These inter-agency procedures are accessible to all officers and staff throughout the police service via the Police Intranet. Policy is continually reviewed and updated. For example, in May 2017 Nottinghamshire Police will adopt the College of Policing definition surrounding Vulnerability and adopt a communication strategy:

- Know It – know the definition of vulnerability and understand how it relates to your day to day role (a person is vulnerable "if as a result of their situation or circumstances, they are unable to take care of or protect themselves or others, from harm or exploitation").
- Spot it – spot the signs of vulnerability. Use your professional curiosity and try to think outside the box
- Stop it – stop the potential harm before it escalates. Take action to put safeguarding measures in place.

3.4.26 A re-organisation of police structure to simplify its interaction both internally and externally with partners: From June 2017, Public Protection will have two main areas of business. Namely, an adults branch and a children's branch, providing clarity for referrals and to ensure correct and appropriately trained officers deal with the relevant enquiry.

3.4.27 Effective training. All new Police recruits are provided with a Safeguarding input. Staff receive additional 'adults at risk' and safeguarding inputs when they reach 1 ½ year service. This input specifically covers MSP in the presentation (see later). Detectives also receive a week-long training input dedicated to safeguarding, vulnerability and associated investigations.

3.4.28 Protecting the public is a core role for the police and in order to achieve safer communities, the force continues to work in partnership with other agencies. **Nottinghamshire Police** have provided contributions, training and also various presentations to the Safeguarding Adults Board, sub committees and partner agencies including the statutory obligations now placed upon public authorities under the 2015 Modern Slavery Act.

3.4.29 **Nottinghamshire Police** has a dedicated Public Protection website that is accessible to everyone within the force. The Adults at Risk webpage has been refreshed in line with the Care Act 2014. This tool acts as a reference point for officers/staff and has links to the relevant external web-pages

Case Study: Modern Day Slavery

Nottinghamshire Police continues to be praised for its work tackling modern slavery. Two Polish brothers Erwin & Krystian Markowski were each sentenced to six years in prison for conspiracy to arrange travel with a view to exploitation and fraud by false representation.

In a letter to the force, the commissioner Kevin Hyland OBE congratulated the force on the way it deals with this type of criminality.

"I am writing to thank you and your force's recent efforts that has been recently reported against the fight on Human Slavery and Trafficking."

The trial judge HHJ Coupland said that the defendants were involved in a 'planned and systematic' scheme of human trafficking. Both defendants received six years imprisonment, for slavery with a concurrent sentence for fraud. Nottinghamshire Police continues to engage with agencies to assist agency staff with training and awareness in this increasing area of business.

3.4.30 **Nottingham University Hospitals (NUH):** The trust completes an annual audit of safeguarding knowledge and practice across the organisation (Essence of Care Benchmark). This audit is completed in all clinical areas between November and December. Results of this are used to guide safeguarding training for the following financial year. It also provides detail to the safeguarding team about potential knowledge gaps in specific clinical areas who then focus additional resources and training accordingly.

3.4.31 Safeguarding adults processes are reviewed on a bi-monthly basis at the **NUH** safeguarding adults committee. This is chaired by the trust lead doctor for adult safeguarding. The **NUH** safeguarding adults team provide a 6 monthly and annual report of safeguarding process. The annual report is scrutinised by the trust board, 6 monthly by the Quality Assurance Committee. The safeguarding team present a quarterly report to the external Quality Scrutiny Panel.

3.4.32 Learning from SARs and DHRs is disseminated to clinical teams as required and changes to policies, procedures and care pathways are undertaken accordingly. The **NUH** safeguarding team are fully engaged in the review process.

3.4.33 The **NUH** adult safeguarding team have membership on the Safeguarding Adult Review, Quality Assurance and Training, Learning and Improvement Subgroups of the NCSAB.

3.4.34 **DLNR CRC** All team managers attend 'Quality Days' on a monthly basis during which case records are sampled and quality assured. Such Quality Assurance days, whatever the specific theme, will always include scrutiny of case management with regard to safeguarding practice. Individual findings are fed back to case managers, and general themes are fed into the work of the organisation's Quality Improvement Group (QUIG).

3.4.35 The QUIG collate the findings from these Quality Assurance days, and combines them with any relevant findings from internal and external audits, HMIP Reports, Serious Further Offence Reviews, Serious Case Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews. A centrally managed Organisational Improvement Plan then assigns actions to specific working groups for senior managers to implement.

3.4.36 **Nottinghamshire National Probation Service** has embedded awareness of adult safeguarding and The Care Act into practitioners' practice. **NPS** have had adults released

from custody with Care Act assessments where the approved premises staff have aided the support of care workers to meet the individual's needs.

3.4.37 The **National Probation Service** does not currently collect statistical data specifically in relation to safeguarding adults. Sources for this data are being developed and will be fed into partnership reports accordingly. The data is to be included within the portfolio once resources have been developed and established.

3.4.38 The **National Probation Service** carries out regular quality assurance audits on practitioner assessments. An area of the audit specifically requires the auditor to assess if and how the practitioner recognised and took into account a vulnerable adult's safeguarding needs but also the adult's personal opinion of how they felt their needs should to be met.

3.4.39 It is recognised within the criminal justice system that we have an increasingly ageing population who are subject to licence and community supervision. The **National Probation Service** continues to provide structured and mandatory training for all grades of staff nationally. This includes e-learning and classroom based events. Mandatory staff training is reviewed every three years, which includes Adult Safeguarding. This is independent of local boards and meets the national expectations of the **National Probation Service**.

3.4.40 **The Vulnerable Adults Provider Network (VAPN):** is a forum for voluntary and community organisations. The network meets every 8 weeks and produces a two weekly newsletter. There are 279 individuals involved in the network representing 184 Voluntary organisations working with vulnerable adults in Nottingham City. All members sign up to the **VAPN** framework and the **VAPN** safeguarding pledge, which outlines our commitment to safeguarding adults.

Strategic Priority 3: Making Safeguarding Personal

4.1 Ensure our engagement strategy maximises opportunities for promoting key messages about how adults at risk can be safeguarded and ensures their feedback informs the work of the Board

4.1.1 The Board's Communication and Engagement Strategy was presented to the Board in September 2016, and was developed collaboratively with input from communications leads across partner agencies. This is a joint strategy with the Children's Safeguarding Board. The aims and outcomes are summarised in the diagram below.

Key Principles

This strategy will enable the Safeguarding Boards to:

Connect	Highlight	Assure	Add value	Learn
To reach a diverse range of audiences and establish effective mechanisms for engagement	To promote and engage audiences with the tools, resources and learning which will reduce risk	To seek assurance that agencies are communicating and engaging effectively with audiences	To support agencies to communicate and engage effectively through collaboration and shared learning	To continuously review and learn from the best methods of communication and engagement

Deliverables

The main outputs will deliver:

Output: An insight map which clarifies the existing communications and engagement mechanisms for children and adults	Output: A fit-for-purpose website which makes tools, resources and learning accessible A communications and engagement toolkit based on the insight map.	Output: A shared system for agencies and partners to assess the effectiveness of their safeguarding communications and engagement activity	Output: An annual calendar of campaign priorities which will be delivered using a multi-agency approach	Output: A review and reporting process to collate the learning from communications and engagement activity

4.1.2 Capacity in the board office has impacted on the ability of the Board to implement this strategy. Work has commenced on improving the Board's online presence, and identifying potential routes for engagement. This will continue in 2017/18, however in previous years communication and engagement work was overseen by the Board's training officer post, which will not continue in 2017/18.

4.1.3 Work has begun developing new awareness raising materials that will be made available during 2017/18.

4.2 The Board ensures strong multi-agency commitment to Making Safeguarding Personal. The Principles of Making Safeguarding Personal are embedded in local safeguarding practice and make safeguarding person centred and outcomes focussed.

4.2.1 The new Quality Assurance Framework (see para. 3.1.1 above), emphasises the need for the Board to receive intelligence about what people who experience safeguarding services have to say about the process.

4.2.2 The QA subgroup has explored various ways in which to engage with citizens and capture their experiences of safeguarding, and the Making Safeguarding Personal approach. There was a proposal to carry out a questionnaire, but it was felt that knowledge of Making Safeguarding Personal (MSP) was not yet clearly established across the partnership.

4.2.3 In order to address this, members of the QA subgroup facilitated a briefing session on MSP as part of the Every Colleague Matters event. This was attended by 51 people from the City Council (13) Health (1), Police (1), Education (2) and 34 people from 16 Private,

Voluntary and Independent sector organisations. Feedback collated by the Every Colleagues Matters team was good with 23% rating the session as excellent and 60% rating it as good. The presentation has been circulated to the members of the QA subgroup for use in internal agency safeguarding training.

4.2.4 The Quality Assurance subgroup will continue to develop work around MSP in 2017/18, particularly to agree methods of collecting quantitative and qualitative data with a view to improve the range and quality of information which the Board receives regarding people's experience of safeguarding. (Please see also 3.1.24 for details of the outcomes recorded by Adult Social Care).

4.2.5 Work has commenced locally (and regionally through EMSAN) to develop benchmarking measures to demonstrate the effectiveness of Making Safeguarding Personal.

4.3 Partner Descriptions of their Contributions to Strategic Priority 3

4.3.1 The **Crime and Drugs Partnership** commissions Domestic and Sexual Violence and Abuse (DSVA) services & substance misuse services. All service specifications require DSVA service providers and substance misuse providers to have a robust safeguarding policy in place and adhere to local procedures. Individual care plans for substance misuse services and support plans for DVSA services will address this to some extent. Safeguarding is addressed as part of the service review process and MSP can be taken forward for inclusion in future commissioning activity.

4.3.2 **EMAS** policy and procedures highlight the importance of MSP and person centred care, and the safeguarding referral form has a mandatory field regarding the wishes of the patient.

4.3.3 **HMP Nottingham** holds a weekly safeguarding board comprising attendees from across prison functions. Any individual working in the establishment can make a referral. This allows for the implementation of support plans for individuals with specific safeguarding needs, the sharing of useful information about how to support individuals with operational staff and the coordination of actions to safeguard the individual and reduce vulnerability.

4.3.4 **NHS Nottingham City Clinical Commissioning Group:**

4.3.5 As the CCG is not a patient facing organisation, we do not hold any data in relation to Making Safeguarding Personal. Through attendance at the Quality Assurance subgroup, CCG representatives have supported the board with the development of a Multi-Agency Training session on the principles of MSP and supported colleagues with the presentation at an Every Colleagues Matters event.

4.3.6 **Nottingham City Council Adult Social Care:**

4.3.7 Achieving Desired Outcomes for Citizens**: Adult Social Care** has embedded Outcome Measurements in its Electronic Social Care record system, 'Liquid Logic', and uses the measures as recommended in the 'MSP toolkit' (Local Government Association 2015). As

Liquid Logic was implemented in August 2016, a full year's data is not at this stage possible, however the results are positive and indicate;

- **863** citizens were asked to define their outcomes, this is **83.4%** of all citizens referred for Safeguarding Enquiries
- **751** citizens had their outcomes fully or partially met, this is **95.9%** of all citizens who expressed an outcome

4.3.8 In 2016, the **Adult Social Care** City Adult Safeguarding Team commenced on-going participation in the East Midlands Regional Safeguarding Network project through conducting a short MSP focussed questionnaire with citizens who had participated in a Safeguarding Enquiry. The Safeguarding Training and Development Officer makes direct telephone contact with the citizen or their advocate where consent has been given to undertake a questionnaire asking for direct feedback on the person's experience The benefit of this approach is that such qualitative feedback can be used in future training. Case examples are always used within training that emphasise the principles of MSP and provide guidance on effective approaches.

4.3.9 There is a growing recognition of how tackling social isolation can help to increase resilience. Through practice we are learning that for instance in scenarios where domestic violence is an issue, this can be tackled through ensuring that social links of the victim are developed and maximised as a protective factor in the safeguarding plan. With the victim's consent to share information about their situation with their support network this extra awareness can enhance support of the victim and ensure authorities are notified should further concerns arise.

4.3.10 Nottingham CityCare Partnership:

4.3.11 All CityCare staff are directed to ask the citizen what outcomes they would like to see in relation to safeguarding concerns and the principles of Making Safeguarding Personal are promoted in our delivery of care.

Case Example: An Adult reported to a CityCare Registered Mental Nurse that a female friend took a "large" amount of money from him. There were no doubts about the adult's mental capacity to manage finances, relationships and overall wellbeing. The adult did not want to take further action (i.e. contacting the police). The RMN discussed this with the adult several times explaining what would happen and how he would be supported. He was offered assistance and support to inform the police. The adult accessed support from the RMN around safe relationships and maintaining financial security and personal safety.

4.3.12 Information for patients and carers is accessible on **CityCare's** website relating to Safeguarding adults, children and MCA. A DoLS leaflet for service users and carers (including an easy read version), is currently being piloted in Continuing Care. This will be evaluated by citizens to ensure it provides them with accessible information. There is MCA and Safeguarding consultation with the **CityCare** Service User Group (Patient Engagement Group) to share work around development of MCA and Safeguarding Adults

policy and process. **CityCare** Safeguarding Adults Referral template asks staff to elicit adults' views and desired outcomes from the Local Authority.

4.3.13 **CityCare** Level 1 and Level 2 Safeguarding Adults Training is underpinned by Making Safeguarding Personal. Training includes support for staff on how to clearly communicate safeguarding concerns to adults in order to promote the adult's ability to discuss and make decisions relating to safeguarding. Safeguarding Adults training evaluation has been carried out for 2016/2017. 100% of staff evaluated post training stated that they knew how to seek advice about a safeguarding adults concern or how to raise a concern with the Local Authority (based on MSP safeguarding training). MSP information is provided in a Level 2 Workbook. An engagement event is held with staff to review the MCA and Safeguarding Adults Policy and process. There is on-going engagement with staff around the implementation of new **CityCare** MCA templates. Following the templates' implementation, in June 2017 staff will be able to respond to a Survey Monkey questionnaire around ease of use/ any challenges and what further information they would like to see.

4.3.14 Making Safeguarding Personal (MSP) is embedded within all safeguarding standard operating procedures and training. A template has been developed to promote MSP compliant Safeguarding Adult referrals to the Local Authority from **CityCare**. This includes questions around the views of the adult and the adult's desired outcomes. Making Safeguarding Personal underpins all standard operating procedures and safeguarding adult documentation; staff advice sheet, staff supervision record, safeguarding adults incident debrief. This socialises **CityCare** to the safeguarding language and terminology used by the Local Authority with regards to safeguarding adults. There is a Master Class on Making Safeguarding Personal available to all **CityCare** staff following a Local Authority Making Safeguarding Personal training event. MCA training focuses on the rights of the adult. There is a factsheet on MCA to support staff when working with adults who may make an unwise decision in relation to their health, social care or other personal choices. The MCA template requires staff to record practicable steps taken to communicate with the adult around their decisions as well as how to include the adult in any best interests decisions (Best Interests Checklist).

4.3.15 **Nottinghamshire Fire and Rescue Service:** As an emergency service, reacting to situations at crisis point it is not always possible to involve the adult in safeguarding decisions and 'best interest' action is taken. However, where possible as a Service we are learning more about the MSP principles and putting the individual at the heart of our interventions

4.3.16 The Safe and Well Check signals a major change in practice for **NFRS** – a move away from the process-led, tick box culture. We have learnt this method of engagement does not promote the best outcome for the individual so we have made every effort to phrase our questions in a way that prompts a conversation in order to talk to the individual about how they live and how they wish to continue living. We hope this will help to achieve an outcome that individuals want and are happy with. The Service is also utilising the use of tablets and a paperless system for this programme in order to further safeguard the individuals' information and ensure referrals are made there and then. In support of this culture change, the Service has embraced training from Nottinghamshire Healthcare

Trust Occupational Therapists regarding sensible risk appraisal, not risk avoidance, which takes into account individuals' preferences and life-styles to achieve a proportionate tolerance of acceptable risk. Training during Continuing Professional Development days include the MSP principles and how we can apply them during our home visits and follow-up work from incidents.

4.3.17 Citizen feedback of Home Safety Checks is measured via 400 telephone interviews and 'After the Incident' is measured via postal questionnaires. Response rates for the postal questionnaires can be variable. Results of the surveys were generally in keeping with **NFRS** expectations and confirmed many of the Service's assumptions about the standards of service **NFRS** delivers. However, following the feedback, there are some areas the Service are considering for improvement and recommendations have been made to the Senior Management Team for endorsement.

4.3.18 **Nottinghamshire Healthcare NHS Trust:** Making Safeguarding Personal has continued to be a focus across the Trust. This has included a detailed article in last year's annual report, looking at what it means and tying it in with our Think Family agenda. We have developed an MSP poster for display across the Trust, which links, to our poster on the key aspects of the Care Act. We are now in the process of designing a poster around self-referrals to assist our patients/clients.

4.3.19 MSP continues to be a focus in all our safeguarding training and our revised clinical package delivers clear messages on this area. As we develop new adult safeguarding training, MSP will continue to feature heavily so that staff strengthen their knowledge and skills for future practice.

4.3.20 Work has also begun on developing a leaflet for use by a number of health agencies to provide consistent safeguarding information to our patients.

4.3.21 **Nottinghamshire Police:** The messages around MSP have been reinforced in a series of individual bite-size revision videos. These have been sent to every employee from the Chief Constable down within the organisation. They are also available for review on the force intranet. The vulnerability training input provided in May 2017 included a short video on the new Public Protection Notice (PPN) and reiterated to all staff to specifically seek the views and wishes of the person and document them accordingly. The data set questions now developed within the PPN for an adult at risk, specifically now includes the question of what the adult concerned wants as an effective outcome, so it has become more victim rather than organisationally focussed.

4.3.22 Changes to National Crime Recording Rules have seen changes to the way the police record information received by external professionals and the introduction of new disposal types; the emphasis is again now on achieving successful outcomes rather than simply detecting crimes. This highly significant change has led to a cultural shift within the police and the need in some cases to acknowledge that safeguarding and investigative aims are not forced to run in tandem. For example, where an individual is not wishing at that precise moment in time to support a police prosecution, the realisation that in many cases pursuance of a criminal investigation in the form of a charge would not be the desired or required outcome for the victim.

4.3.23 A vulnerability flag is now used by the **Nottinghamshire Police** force control room for incidents where vulnerability has been identified as a potential factor with callers. To assist, contact cards and system prompts for all call handlers within the force control room have been developed within the general incident (GI) working practice guide which are APP (authorised professional practice) compliant. These assist and assess triage of calls, identify vulnerability and need, utilising an NDM (national decision-making model) approach.

4.3.24 **Nottingham University Hospitals:** 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 what outcome of the enquiry. Safeguarding training has focused on the individual who does not engage in processes, specifically due to coercion and control. The trust has a number of safeguarding practitioners specifically trained in domestic abuse. As domestic abuse survivors often experience coercion and control, team members are able to provide support and training to the wider trust. This process has involvement of the individual at its core, but balancing this with the risks involved. The adult safeguarding referral form at **NUH** has been adjusted in line with MSP, specifically requiring practitioners to enquire about expected outcomes of the individual prior to safeguarding processes being initiated.

4.3.25 As **NUH** is predominantly a referrer within safeguarding processes, outcome focused information is gained by the local authority. As a core member of the Quality Assurance sub-group, **NUH** endorses and participates in the good work currently being undertaken to measure the outcome of adult safeguarding processes.

4.3.26 **DLNR CRC** Safeguarding is a key statutory function of **DLNR CRC.** Risk assessment and risk management is one of its key activities, driving all its activities with service users. Safeguarding considerations are key areas for all assessment and risk management plans at all stages. All operational staff are trained in safeguarding.

4.3.27 **DLNR CRC has** recently refreshed and updated all its Public Protection policies, including Adult Safeguarding.

4.3.28 **Nottinghamshire National Probation Service:** Currently within The **National Probation Service,** one to one engagement to all service users via supervision with an Offender Manager is offered. This allows the Service User a forum to discuss their needs and/or raise safeguarding concerns.

4.3.29 All staff have the ability and understanding to complete a safeguarding referral when a vulnerable adult has been identified.

Case Example

A member of staff liaised closely with a service user, the social worker and care providers who visited the adult within one of our Probation Approved Premises upon his release from custody. Due the nature of risk that the service user presented he was unable to be initially accommodated within his own residency. This caused the service user distress, but the offender manager and social worker worked closely to assist his understanding. Despite a high level of support from all

agencies involved, the service user's behaviour deteriorated, resulting in him being returned to custody. Upon his return to custody, both social care and **Probation** liaised with Prison staff to ensure his needs continued to be met.

4.3.30 The **Vulnerable Adults Provider Network** contributed to the development of the Making Safeguarding Personal Training delivered at the Every Colleague Matters Event. Guidance on Best Interests has been produced.

4.3.31 There is a Safeguarding Model Policy for organisations who have attended the **VAPN** Safeguarding Training.

Strategic Priority 4: Board Performance and Capacity

5.1 <u>There will be a shared view about the Board's financial requirements</u>

5.1.1 Funding partners met in the third quarter of 2016/17 and reached agreement regarding the funding arrangements for both the NCSAB and the NCSCB for 2017/18.

5.1.2 The agreed budget for 2017/18 will include funding for an Independent Chair (three days per month), a full time Board Manager, and 0.5 full time equivalent (FTE) Business Support Officer, with a small amount for running costs related to communication and engagement activity.

5.1.3 The 0.5 FTE training officer post will no longer be funded by the NCSAB in 2017/18. Managing the impact of this is addressed in the Board's Learning and Improvement Strategy (see section 3.3. for further details).

5.1.4 The budget for 2017/18 does not include any funding for Safeguarding Adults Reviews (SARs). Should any be commissioned, funding partners will need to agree how these will be funded, and this could be from an 'in kind' contribution from partners not directly involved in the SAR, or by working with the East Midlands Safeguarding Adults Network to facilitate swapping authors with Boards in other areas in the region. The risk associated with the lack of funding for SARs will be added to the Board's risk register in 2017/18. The risk will be mitigated by revising the SAR processes to strengthen decision making around SARs and to ensure that the review process is proportional to the learning achieved.

5.2 <u>Ensure the Board has required back office staff to support the delivery of its functions.</u>

5.2.1 The Board Officer post was filled on an interim basis during the first half of 2016/17.

5.2.2 During this time, the board office support was reviewed, and a new post of Board Manager was created. This post was recruited to on a permanent basis from October 2016. The Board Manager works closely with the Independent Chair and now reports to the Director of Adult Social Care (DASS), whilst remaining in the team with NCSCB officers. The Board Manager is responsible for managing all aspects of NCSAB business. This new structure has enabled a greater focus on the Safeguarding Adults agenda than had been possible

under the previous arrangements in which the Board Officer was more closely aligned with the Children's Board.

5.2.3 The Training Officer (shared with the NCSCB) was recruited to in May 2016 on a fixed term basis for one year pending a review of the Learning and Improvement Strategy. As outlined in section 3.3 above, the 0.5 FTE post working with the Adult's Board will not continue into 2017/18.

5.2.4 The 0.5 Business Support Officer post remained the same as in previous years.

5.3 <u>Ensure the Board operating model is fit for purpose to enable it to respond to national and local strategic drivers and priorities. Ensure the Board has clear protocols.</u>

5.3.1 The Board constitution was reviewed during the second half of 2016/17 and will be presented to the Board for approval at the first meeting in 2017/18.

5.3.2 The review included the development of a complaints policy following guidance issued nationally by the Local Government Ombudsman. This will be finalised in 2017/18.

5.3.3 The subgroup terms of reference have all been reviewed during 2016/17.

5.3.4 A development session was held in October 2016 to review the purpose of the board, and identify priorities. The focus of the discussion was around financial pressures on all partner agencies, the likely impact on safeguarding arrangements in the City and how this should inform the work of the Board. Particular attention was given to the reduction in preventative services, and the need for caution around any Board expenditure. This discussion was followed up at the BMG meeting in November, and the themes informed the development of the 2017/18 plan. The BMG concluded that the Board should aim to have small and achievable objectives in its 2017/18 plan.

5.4 <u>Ensure the Board's work is aligned with work of other strategic Boards across the City.</u>

5.4.1 Work led by the Corporate Director for Children and Adults was progressed during 2016/17 to co-ordinate the work of various strategic boards across Nottingham City.

5.4.2 The Board Office has collated information from Board members to identify the range and breadth of other Boards and partnerships, which Board members attend. Board members are asked to act as champions of the work of the NCSAB in their roles on other Boards. This includes the Head of Service for Crime & Drugs being sent papers and invited to attend Board Meetings and along with a policy officer providing a key link to co-ordinate the work of the SAB with that of the Crime and Drugs Partnership.

5.4.3 The Board Meeting has a standard agenda item in which any significant safeguarding feedback is requested from other Boards and partnerships, and items which may need sharing with or escalating to other Boards are identified. For example, the Board has considered the Sustainability and Transformation Plans (STP) and the impact of proposals on safeguarding. The DASS provides the main link between the Safeguarding Board and the STP. In addition, the Independent Chair responded to the Consultation in a personal capacity in his chair's role requesting that implications for Safeguarding should be included in local plans.

5.4.4 The Independent Chair meets regularly with the Independent Chairs of the NCSCB and the Nottinghamshire SAB. He attends the regional chairs network, and Nottinghamshire Strategic Chairs network (chaired by the Police & Crime Commissioner).

5.4.5 The Board Manager works closely with the Children's Board Officer and Safeguarding Partnerships Service Manager; meets regularly with the Nottinghamshire County Safeguarding Adults Board Manager and also attends the regional East Midlands Safeguarding Adults Network.

5.4.6 The Board Manager (and Children's Board Officer) met with the Domestic and Sexual Violence Policy Officer to co-ordinate the sharing of learning from SARs, DHRs and SCRs. This will be on going and continue into 2017/18.

5.4.7 Closer alignment with the Nottinghamshire SAB has been discussed throughout 2016/17. The development session in October 2016 considered whether the purpose of the board should be to focus on broad themes such as MSP and Prevention, and whether this would be better achieved by closer working arrangements with Nottinghamshire SAB. This was considered in detail at the BMG meeting in January. Benefits of working more closely with Nottinghamshire SAB included greater efficiencies around publicity, engagement and training, and simpler arrangements for Board partner agencies who work across both areas. However, the respective populations in the City and County are very different; operational safeguarding arrangements in the Local Authorities are different, CCGs do not operate in the same way, and the Boards have different resources and structures. It was felt that the Board's limited capacity would be better spent understanding the particular needs of adults at risk in Nottingham City and improving the work of the Board, rather than diverting resources to joining the Boards. However, NSCAB will continue to work closely with NSAB to co-ordinate and avoid duplication wherever possible, and closer alignment of the Boards will be kept under regular review.

5.4.8 The Board receives regular reports regarding Operation Equinox, the overarching investigation into allegations of historical child abuse in care settings in Nottingham and Nottinghamshire. The Strategic Management Group have developed a Victim/Survivor Support Strategy on behalf of both Councils. This was promoted to Board partners, who were asked to consider what arrangements they had for supporting Victims and Survivors.

5.4.9 The Board has representation from a Consultant in Public Health. The Board has considered how it will seek assurance on areas of work such as the suicide reduction strategy, and Female Genital Mutilation. These arrangements remain under review and will be considered further in 2017/18.

5.4.10 Co-ordination with other strategic partnerships remains an area for development for the Board and work will continue on this into 2017/18.

5.5 Partner Descriptions of their Contributions Toward Strategic Priority 4

5.5.1 The Board has been well attended by Partner agencies. The table below shows the cumulative attendance record of partner agencies.

Organisation/Role	Possible	Actual	Sent Rep	Agency Total		Organisation/Role	Possible	Actual	Sent Rep	Agency Total
Independent Chair	6	6		6:6		DLNR Community Rehab Company – Regional Manager	4	1		1:4
Nottingham City Council Director for Adult Social Services (DASS)	6	5	1	6:6		Nottingham University Hospitals – Chief Nurse	6	0	6	6:6
NCC - Head of Safeguarding & Quality Assurance (Adults)	6	5		5:6		East Midlands Ambulance Service - Locality Quality Manager	6	2	2	4:6
CCG - Director of Quality & Personalisation	6	5		5:6		Nottinghamshire Healthcare Trust – Associate Director Safeguarding & Social Care	6	5		5:6
CCG - Corporate Medical Director	6	4		4:6		NCC – Consultant in Public Health	6	4		4:6
Police – Head of Public Protection	6	5		5:6		Vulnerable Adults Provider Network representative	6	5		5:6
CityCare – Director of Nursing & Allied Health Professionals	6	3	3	6:6		NCC – Safeguarding Partnerships Service Manager (until October)	4	1		1:4
HMP Nottingham - Head of Residence & Safety (until Dec)	4	2		2:4		Interim Board Manager (until October)	3	3		3:3
HMP Nottingham – Head of Residence (from Dec)	2	2		4:6		NCC Corporate Director for Children & Families	2	0		0:2
Notts Fire & Rescue - Crew Manager (until Oct)	3	1		1:3		NCC Safeguarding Partnerships Manger	4	4		4:4
Notts Fire & Rescue – Engagement & Partnerships Officer (from October)	3	1		2:6		NCC Head of Safeguarding and Quality Assurance (Children) (until October)	4	1		1:4
National Probation Service - Head of Nottinghamshire	6	3	1	4:6		Board Manager (from October)	5	5		5:5

5.5.2 The City Council's Lead Member with responsibility for safeguarding adults is a participating observer of the Board. He receives all Board papers, and attended some meetings in 2016/17.

5.5.3 The Head of Service for **The Crime and Drugs Partnership** receives all Board papers and sent a representative to the Board meetings where there are relevant cross cutting issues. This supports co-ordination between the two boards.

5.5.4 The **East Midlands Ambulance Service** supports the on-going work of the board with 80% compliance on attendance at meetings set as a minimum by the organisation. Feedback from the board is fed into the **EMAS** safeguarding Forum to support moving the work of the board forward.

5.5.5 **EMAS** contribute to Safeguarding Adults Reviews providing Individual Management Reviews (IMRs) and panel membership. Learning from the reviews is shared across **EMAS** and best practice is adopted.

5.5.6 **HMP Nottingham** contributes to the work of the Board through attendance at Board meetings

5.5.7 **NHS Nottingham City Clinical Commissioning Group** is represented throughout the board subgroups and continues to support chairing the SAR subgroup. We are well represented at board level and make a financial contribution to the board as one of the statutory agencies.

5.5.8 Nottingham City Council

5.5.9 Contributing specialist Expertise: We are very pleased that the nomination of our Training and Development Team Manager has been accepted to chair the new Training, Learning and Improvement subgroup with the purpose of maximising the resources across the partnership to develop and share Safeguarding good practice, learning from SARs and supporting the PVI sector.

5.5.10 The **Adult Social Care** Head of Adult Safeguarding and Quality Assurance sits on the SAR subgroup, the Business Management Group and Board. The Team Manager for Adult Safeguarding and Quality Assurance sits on the Quality Assurance subgroup and is participating in a priority area for this group - assuring that citizens are fully consulted regarding referrals to Adult Safeguarding where possible and asked what outcomes they wish to achieve at a point prior to a referral being made.

5.5.11 The Director for **Adult Social Care** is also the DASS co-chair for the national Association of Directors of Adult Social Services (ADASS) and the chair of the East Midlands Safeguarding Adult Network (EMSAN), which brings the benefits to the Board of both escalating issues to a regional and national level and sharing developments and expertise gleaned from these positions.

5.5.12 The **local authority** contributes financially as a statutory partner of the board.

5.5.13 **Nottingham CityCare Partnership:** the **CityCare** Director of Quality & Safety/Executive Nurse attends Board Meetings and cascades information to **CityCare** colleagues, and also chairs the Quality Assurance Subgroup.

5.5.14 **CityCare** has membership of the Safeguarding Adult Review Sub-Group and the Quality Assurance Sub-Group. **CityCare** has responded appropriately to requests for information in relation to referrals to the SAR subgroup.

5.5.15 As part of the Quality Assurance Sub-Group **CityCare** assisted in the development and implementation of a multi-agency training session on Making Safeguarding Personal as part of the "Every Colleague Matters" Events.

5.5.16 **Nottinghamshire Healthcare NHS Trust** continues to support the work of the Board in all areas. The Associate Director for Safeguarding and Social Work remains a Board member and the Named Nurse for Safeguarding sits on the SAR subgroup, whilst the corporate Interim Safeguarding Lead attends the newly reconstituted Quality Assurance subgroup. The Trust fully supports all SAR processes where we have had involvement and has supported the process in the wider partnership by providing the IMR author training.

5.5.17 The **Nottinghamshire Healthcare NHS Trust** has also worked on a research project with the Institute of Mental Health to create a toolkit for staff to work with older women survivors of domestic abuse and this is available across the partnership.

5.5.18 **Nottinghamshire Police** are a core member and funding partner of the Safeguarding Adults Board, with regular attendance and contributions to meetings. **Nottinghamshire Police** provide agency training and lectures where relevant, for example a Modern Day Slavery session for the Every Colleague Matters event.

5.5.19 **Nottinghamshire Police** chair several subgroups across other partnerships with relevance to safeguarding including MARAC, the DHR Assurance, Learning Implementation Group and the Nottinghamshire Sexual and Domestic Violence Criminal Justice Group.

5.5.20 **Nottingham University Hospitals:** appropriate representation at the board is provided by the trust. As safeguarding adults is a core value for the organisation, the trust is an active partner at the board and all appropriate sub-groups. The SAR subgroup was chaired by the Trust's Interim Head of Safeguarding during the first half of 2016/17.

5.5.21 **DLNR CRC** supports the work of the Board by receiving Board papers and attending where possible and will attend particular Board meetings where specifically requested to by the Independent Chair.

5.5.22 **Nottinghamshire National Probation Service** has contributed to the performance of the board through regular attendance at meetings and events developed from Safeguarding Adults Review findings. This information has been shared with Heads of Service to discuss how we as a National and Divisional service could implement recommended changes in working with safeguarding.

5.5.23 **Vulnerable Adults Provider Network** have a representative who regularly attends the Safeguarding Adults Board. The rep gives an update at all **VAPN** meetings - we held 7 meetings throughout the period. She also used the forum to fact find about issues that may need to be escalated further. We were active in the joint boards' learning sub group and other task and finish groups. We hold a place on many other strategic boards and

regularly talk about the work of the safeguarding board. We are unable to commit financially to the board but support reps on the board.

6 Looking forward into 2017/18

6.1 The areas of work to be carried forward into 2017/18 are:

- Ensuring that recommendations from the SARs are acted upon, and the learning is disseminated across the safeguarding workforce.
- Reviewing the cross authority SAR processes to ensure that they are up to date and fit for purpose.
- Establishing the new Training, Learning and Improvement Subgroup, and implementing the strategy to ensure that learning is disseminated across the partnership
- Progressing the communication and engagement strategy, developing the Board's on-line presence, devising awareness raising materials and establishing routes for engagement.
- Seeking further assurance that Making Safeguarding Personal is embedded across the partnership and identifying actions for all partners to promote person centred adult safeguarding practice with a focus on outcomes.
- Reviewing the Self-assessment audit and assurance processes to improve the level of assurance to the Board.
- Further developing preventative strategies.

6.2 The NCSAB is looking forward to working on these and more, and its plan for 2017/18 can be found here.