



National Network for Chairs of Safeguarding Adults Boards

Annual Report
2016 - 2017



National Network for Chairs of Safeguarding Adult Boards

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1. INTRODUCTION

Welcome to the National Network for Chairs of Safeguarding Adults Boards (the National Network) Annual Report 2016-17. The National Network was established in 2009 to support the new roles of Independent Chairs of Safeguarding Adults Boards (SABs). In 2016 membership was extended to all Chairs of SABs. Since it was formed the membership has expanded considerably. There are currently 112 members chairing 117 SABs. This report brings together the work of the National Network over the past year.

2. ABOUT THE NATIONAL NETWORK FOR CHAIRS OF SAFEGUARDING ADULTS BOARDS

The national network is a community of practice that aims to support and strengthen Chairs and Safeguarding Adults Board partnerships in order to improve their effectiveness in safeguarding adults and to influence and promote best practice for safeguarding adults nationally and locally through effective working. The purpose of the network is to coordinate and provide support to the Chairs of Safeguarding Adult Boards in order to:

- Support the implementation of Safeguarding Adults Boards (SABs) becoming statutory bodies under the Care Act 2014 in a coherent and consistent way;
- Share and disseminate knowledge and learning between Boards;
- Improve consistency of approaches to safeguarding and contribute to the raising of overall standards of adult safeguarding;
- Continue to develop a national voice and resource for consultations and advice on safeguarding matters; and
- Provide peer support and networking opportunities.

Attendance at National Network meetings is in excess of 30 Chairs with all regions are represented; detailed minutes are produced by a member and these contain links to documents tabled and referenced during the meeting. Feedback is arranged through regional networks and their meetings where they occur.

Network Coordinator: The network is coordinated and Chaired by Robert Templeton who is Chair of Cheshire East and Portsmouth SABs. The responsibilities of the coordinator in 2016-17 are as follows:

- Chairing National Network meetings (4 meetings)
- Establishing and maintaining the national database of SAB Chairs
- Keeping the network up to date in policy and practice
- Supporting the collation of views of members in response to national consultations
- Attending and providing regular updates to the Local Government Association (LGA)/Association of Directors of Adult Social Services (ADASS) Adult Safeguarding Network (4 meetings)
- Conducting an Audit of Safeguarding Adult Boards following the implementation of the Care Act 2014
- Drafting the National Network Annual Report

Governance: An executive group made up of members of the network supports the coordinator. The executive group gives their time on a voluntary basis, members are:

- Mike Taylor - Independent Chair Warwickshire SAB
- Julia Stephens-Row - Independent Chair of Manchester SAB
- Simon Turpitt - Independent Chair of Surrey SAB
- Deborah Klee - Independent Chair of Sutton SAB
- Paul Kingston - Independent Chair of Wigan SAB

Funding: Its members conduct the majority of the work of the National Network on a voluntary basis. Network meetings are hosted free of charge by the City of London. The network co-ordinator is funded for a specified number of days a year by the Care and Health Improvement Programme of the LGA through ADASS as part of sector led improvement work on safeguarding adults. The expenditure of the network in 2016/17 is outline below:

Item	Cost £
Coordinator Time	3,000.00
Expenses	90.40
Total	£3,090.40

3. ABOUT SAFEGUARDING ADULTS BOARDS

The overarching purpose of a SAB is to help and safeguard adults with care and support needs. It does this by:

- Assuring itself that local safeguarding arrangements are in place, as defined by the Care Act 2014 and statutory guidance;
- Assuring itself that safeguarding practice is person-centered and outcome-focused;
- Working collaboratively to prevent abuse and neglect where possible;
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred; and assuring itself that safeguarding practice is continuously improving the quality of life of adults in its area.

The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The SAB can be an important source of advice and assistance, for example in helping others improve their safeguarding mechanisms. It is important that the SAB has effective links with other key partnerships in the locality. This will require the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in ‘Making Safeguarding Personal (MSP)’ (Local Government Association MSP pages: <http://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal>). It should also concern itself with a range of issues, which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- The safety of people who use services in local health settings, including mental health;
- The safety of adults with care and support needs;
- Effective interventions for adults who self-neglect, for whatever reason
- The quality of local care and support services including how the Mental Capacity Act (MCA) 2005 affects the way services make decisions on behalf of people who do not have the capacity to make some decisions for themselves.
- The effectiveness of prisons in safeguarding offenders.
- Making connections between adult safeguarding and domestic abuse.

The Care Act (2014) gives SABs three specific duties it must:

1. Publish a strategic plan for each financial year that sets out how it will meet its main objective and what each member is to do to implement that strategy. In developing the plan it must consult the Local Healthwatch organisation and involve the community.

2. Publish an annual report detailing what the SAB has done during the year to achieve its objective and what it and each member has done to implement its strategy as well as reporting the findings of any Safeguarding Adults Reviews (SAR) including any ongoing reviews.
3. Decide when a SAR is necessary, arrange for its conduct and if it so decides, to implement the findings. Where the SAB decides not to implement an action from the findings it must state the reason for that decision in the Annual Report.

4. THE WORK OF THE NATIONAL NETWORK 2016-17

From April 2016 to April 2017 The National Network agreed the following priorities:

- Improve the effectiveness of SAB Chairs and their Boards
- Supporting policies and practice that Make Safeguarding Personal
- Provide a forum through which the views of SAB Chairs can be disseminated
- Provide a collective vision and acting as a national voice for Chairs
- Supporting the professional development of SAB Chairs
- Developing a mechanism whereby good practice and learning from Safeguarding Adults Reviews can be disseminated
- Leading on SAB matters in partnership with other safeguarding organisations
- Strengthen the identity of SABs in local, regional and national Structures

Listed below are highlights of activities the Network has undertaken to meet its priorities:

4.1 Improve the Effectiveness of SAB Chairs and Their Boards

Auditing The Impact of SABs Being Made Statutory: In the autumn of 2016 the Network conducted an audit to assess the impact of the implementation of the Care Act 2014 on SABs and to capture the effects of making SABs statutory partnerships. This was part of a sector led improvement initiative (within the Care and Health Improvement Programme at the Local Government Association) designed to inform the Department of Health and other stakeholders about the progress of SABs, the impact of the Care Act 2014, and to support further development of SABs. The final report was shared with the National Network of Safeguarding Adult Boards Chairs and sent to the LGA and Department of Health (DH). The recommendations from the Audit have also informed the priorities and work plan for the Network in 2017 - 2018. A summary of the report can be found in Appendix 4.

The Move Towards Joint Boards: In December 16 Jane Lawson and John Woodhouse presented a short report summarising the findings of a telephone survey of Chairs of Boards that have an interest in exploring the issue of joint SABs over a number of local authority areas (see Appendix 3). A number of joint Safeguarding Adults Boards have been established with various degrees of benefits. The survey found that whilst there are some positive examples of joint boards not all show the same benefits. Nevertheless the potential benefits can be considerable in terms of the effectiveness and efficiency of discharging the local authority's statutory duty of establishing a SAB. The survey suggests that where there may be potential for joint board arrangements, the process of developing a joint Board must be undertaken with careful consideration.

4.2 Supporting Policies and Practice That Make Safeguarding Personal

Making Safeguarding Personal (MSP): MSP is a standing item on networks' agenda with Network supporting regional MSP 'temperature checks' and calling for good examples of good practice. In September 2016 Lynne Turnball from Cheshire Centre Independent Living (CCIL) gave a presentation on how MSP is being supported by the Cheshire East SAB. This involved inviting people who had been affected by adult abuse to join a reference group. The reference group is chaired by Lynne who then represents them on the board however any member of the group can attend at anytime. The group has been very successful in changing social work practice and ensuing that policy and procedures are developed in a person centered way. The group has also made a powerful short video on how adult abuse has affected them. MSP continues to be a priority for the Network in 2017-18.

4.3 SAB Chairs Forum

News updates: Between meetings the network coordinator sends out regular news updates via the email database. This includes specific queries from Chairs and others asking for examples of good practice, disseminating policy documents and updating the network of opportunities relevant work assignments.

4.4 Collective Vision and National Voice for Chairs

The Wood Review: In September 2016 the Network discussed the Alan Wood's (2016) review into the role that local safeguarding children boards (LSCBs) play in protecting and safeguarding children. The discussion was informed by a paper written by Jane Lawson, which set out key areas highlighted in the Wood Report, commenting on where SABs were with these issues and examples of what is being achieved by SABs (the paper can be found in appendix 1). The Network continues to monitor this work with regional groups and will work with Local Safeguarding Children's Boards (LSCBs) to link the role of the SAB to integration work and share good practice.

Modern Slavery: Also, in September Mike Taylor presented a paper (see appendix 2) outlining the definitions of Modern Slavery in the context of safeguarding adults and seeking to ensure that all agencies were aware of the potential for abuse of adults and the action required to respond to this. The guidance to the Care Act defines Modern Slavery as one of the areas included in safeguarding. It is the SAB's responsibility to have an overview on how the local safeguarding arrangements and partners act to help adults who are in need of care and support and are at risk of abuse and neglect in this context and as a result of those care and support needs are unable to protect themselves from the experience or the risk of modern slavery. Matters for SABs to consider were:

- The level of awareness of presentation of modern slavery at key points of referral – Police, Trading Standards, A&E, Housing, social care agencies as well as schools and day nurseries
- The coverage of this aspect of the DH Guidance and response in Policy and Procedures and now in Multi-Agency Safeguarding Hub (MASH) procedures
- Referral mechanisms including the NRM and the follow up support

- Sharing of intelligence on locations and individuals in the context of potential victims of trafficking

The Network is continuing to take this work forward and it now forms part of its future priorities under the developing SAB Broadened Remit.

Influencing the National Safeguarding Adults Collection (SAC): At the March 17 meeting the Network heard a presentation from Jim Butler, Section Head Adult Social Care Statistics for NHS Digital in which the following issues were discussed:

- Chairs would find it useful to compare against local authorities and produce tables.
- SABs like to know if level of concerns can be interrogated by agency.
- Safeguarding concerns link to a reported crime.
- MSP still a voluntary return, this is unlikely to change.
- Data can be analysed locally as data comes from local authority.
- Comparator information needs to be promoted this is available.
- Are we sure that what we are collecting keeps up with practice and what we need to know?

The NNSAB will continue work with NHS digital to help address the issues above.

Quality Surveillance Groups: Also at the March meeting Lucy Ellis Strategy Lead at NHS England presented an item on reviewing the work of the Quality Surveillance Groups and their relationship with the SAB. It was agreed that this was an area that needed further work and is a priority for the Network in 2017-18.

4.5 Supporting The Professional Development of SAB Chairs

Skills for Care: In March 17 Jim Thomas, Programme Manager at Skills for Care, attended the meeting to explain the role of Skills for Care and guidance for registered managers and their workforce. It was agreed the Network would work with Skills for Care to develop similar workforce guidance for SABs and SAB Chairs.

4.6 Learning from Safeguarding Adults Reviews

Learning from Adult Safeguarding Reviews: Adi Cooper and Jane Lawson spoke in September 16 about work they were leading on behalf of the London SAB on developing SARs. The project involved a number of pieces of work including a review of SARs that have taken place in London since April 2015, and looking at how to measure the impact of the SAR in a way that is meaningful and helpful. Other regions had also done similar work.

Future work may include:

- Developing directory of methodologies
- Listing people who can do SARs
- Encouraging and supporting people with transferrable skills to develop skills in writing SARs.

Learning from Adult Safeguarding Reviews is a priority for the Network and the network will work with regional groups and Social Care Institute for Excellence (SCIE) to develop a national depository for SARs and to share learning from and good practice in this area.

Learning and Disability Mortality Review (LeDeR): In June 2016 Dr. Pauline Heslop from the University of Bristol came to the network meeting to discuss the governance of LeDeR and how it sits with current SABs and the wider safeguarding environment. The LeDeR programme is an initiative commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It aims to guide improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities.

A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. In order to do this in a timely manner and to avoid duplication, reviewers need to be clear where and how the LeDeR process links with other reviews or investigation processes, which a SAB might commission, such as a Safeguarding Adult Review (SAR).

The Network will continue to monitor this work both regionally and nationally. This forms part of the work relating to the priorities of Learning from Adult Safeguarding Reviews and Developing Stronger Links with Quality Surveillance groups

4.7 Partnerships with other safeguarding organisations

Fire and Rescue: Also in June 2016 Andrea Simmonds and Dave Smithson from West Midlands Fire and Rescue outlined a review of a case of an avoidable death of a woman with significant mobility and dexterity issues who died in a house fire caused by a cigarette. The Review challenged the capacity to properly judge fire risk and build it into a risk assessment. In LB Sutton a SAR on a fire-related death resulted in referrals and risk assessments picking up potential for fire in any setting. Fire and Rescue (F&R) on the SAB should be seen as raising awareness and encourage use of F&R as a prevention service. The Network also discussed the danger of emollients in which smoking or a naked flame could cause dressings or clothing to catch fire when being treated with paraffin-based emollient that is in contact with the dressing or clothing. The Network has continued to disseminate material in this area.

The Network has continued to disseminate in this area and this forms part of the work around the priority of Learning from Adult Safeguarding Reviews.

Office of the Public Guardian (OPG): Angela Johnson joined the Network meeting in June to discuss the OPG's role in safeguarding adults at risk. The OPG had three key elements in this area:

1. **Preventative** - including promoting legal safeguards and remedies, contributing to Mental Capacity Act (2007) policy and supervising deputies.
2. **Investigative** - investigating concerns about the actions of a deputy or attorney.
3. **Remedial** - applying to the Court of Protection, Monitoring Liaison and joint working

The OPG was reviewing work in adult safeguarding and was interested in working with SABs in the following areas:

- Improve user feedback.
- Promoting Lasting Power of Attorney (LPA) as a means of planning ahead.
- Support people to select their attorneys carefully.
- Ensuring that care plans contain information about whether there is an attorney or deputy in place.
- Early detection of problems working with SABs to ensure swift and timely intervention.
- Imploring evidence when to make court applications when there has been an abuse of health and welfare powers.
- Improving information sharing and promoting good practice in deputyship service provision.

The Network will continue to work with the OPG and this will form part of it's work in the priority of supporting greater collaboration on a national level.

Financial Abuse and Scams: In December 2016 Louise Baxter from National Trading Standards (NTS) gave a presentation on the work of their Scams Team. Following on from the meeting the Network was involved in working with ADASS, NTS Scams Team and others to develop guidance for Councilors, directors, managers and social work practitioners. This guide provides valuable information on how to recognise and respond to the signs of financial abuse and gives key information on the effects of scams on the continued health and wellbeing of individuals. There is also a section to address the specific role of SABs in this area. The Network will continue to help NTS promote this work.

5. PRIORITIES 2017-18

- 1. Improving Performance and Data:** There is a varied approach to data collection, which affects the ability of SABs to consistently evaluate their own performance. In order to address this the National Network will work with NHS Digital, LGA and others to ensure adult safeguarding performance data is developed to enable SABs to evaluate and benchmark performance
- 2. Developing SAB Broadened Remit:** The Network will continue to work both nationally and regionally to ensure SABs can meet Network their broadened remit. This includes areas such as Modern Day Slavery and Human Trafficking; PREVENT; CSE; Harmful Cultural Practices; Domestic Abuse; Suicides and Self Harm; Cyber Crime – Desk Top and Door Step Crime; Self-Neglect and Hoarding; and LD Mortality Reviews.
- 3. Safeguarding Adult Reviews:** There is a need for a more consistent approach to Safeguarding Adult Reviews, taking into account the value of outcomes, cost benefit analysis and the development of other methodologies such as Reflective Learning Reviews. The National Network will work with the Department of Health and other organisations through the Adult Safeguarding Leadership Group to explore ways of ensuring a consistent approach to SARs and the development of alternative methodologies.
- 4. SAB Funding:** A nationally agreed formula for contributions for agencies in relation to funding of SABs is needed. The National Network will work with national partners to develop and recommend a formula for partner funding contributions to SABs

5. **Making Safeguarding Personal:** Greater consistency of approach and practice is needed from SABs when engaging with service users. To address this challenge, the National Network will work with ADASS and LGA to examine which methodologies are most effective in engaging with service users and ensure that SABs play a key role in implementing Making Safeguarding Personal across partnerships.
6. **Stronger Relationships with Quality Surveillance Groups:** The audit of SAB Chairs found that SABs were working well with relevant strategic partnerships but inter-relationships were sometimes unclear, particularly between SABs and QSGs in their common objective to promote safe, quality services. The National Network will work with NHS England to explore opportunities to achieve ways of strengthening relationships between SABs and QSGs.
7. **Greater Collaborations on a National Level:** The audit of SAB Chairs highlighted the developments in health and care integration and the need to develop stronger and more consistent relationships with Health and Well-being Boards together with the implications of Sustainability and Transformation Plans (STPs) for safeguarding for children and adults. In response the National and regional Networks will work with partners to link the role of the SAB to integration work and share good practice, including the learning from Safeguarding Adult Reviews.
8. **Supporting Integration:** The Network will work with regional groups and partners to link the role of the SAB to integration work and share good practice
9. **Peer Review Pilot:** The Network will follow up on the Peer Review Pilot and investigate how this can be translated into national feedback on Board effectiveness and good practice.
10. **Joint Work Across Adult and Children Safeguarding:** The network will work with The Association of Independent LSCB Chairs to identify crosscutting issues and ensure that the contribution of both the network and the association are effectively aligned in relevant areas.

Appendix 1

The Wood Report: review of the role and functions of LSCBs; what can LSABs contribute to this review/debate?

The following simply sets out on pages 1-3 some key areas highlighted in the Wood Report and then some comment on pages 4-6 on where LSABs are with these areas/issues and examples of what is being achieved by LSABs. There will be more issues and more examples but this is a start. This might form the basis of a more focused paper to perhaps Claire Crawley and others with the purpose of bringing LSABs experience into this debate.

Key issues from the Wood Report relevant to LSABs

The Wood Report sets out a review of the role and functions of LSCBs with recommendations in respect of: Boards; SCRs and CDOPs. It reflects a recognition in respect of limitations of LSCBs in delivering on key objectives. It sets out a proposal for fundamental reform including a greater focus on improving outcomes for children and young people. The review underlines the lack of clarity on role and expectations of LSCBs (and the extent to which Boards are effective in delivering on this) and on the issue of accountability and authority. Concern is expressed around the time and resource that the bureaucracy surrounding LSCBs demands.

Serious Case Reviews

SCRs are a focus in the Wood Report especially in respect of quality of review/reports; effectiveness of the learning (not just in the one local authority area); way in which reviews are commissioned; accountability. Proposal is for a National Learning Framework. Recs 20-29 cover this area.

What does the Wood Report highlight as in need of attention in some LSCBs?

Wellbeing; safety; protection

Para 18¹: LSCBs ... "are not in a good position to deal effectively with a remit to coordinate services and ensure their effectiveness across a spectrum encompassing child protection, safeguarding and wellbeing. They have neither the capacity nor resources to do so. These three phrases have become confused and are confusing. Some use them interchangeably; others draw a clear distinction between each. This needs to be clarified so that protecting children is the focus of multi-agency arrangements".

Governance

...Para 40 "Clear governance arrangements, mature and well developed partnership arrangements, focused priorities, conducting good section 11 audits and good challenge to partners are, according to Ofsted the characteristics of the most effective LSCBs. However, Ofsted found these to be evident in under a quarter of those reviewed".

Para 50 CAF/CASS highlighting... "*Section 11 is one ...example which has been subject to widespread 'mission-creep', morphing from being a proportionate check on arrangements into an increasingly elaborate and ineffective mechanism for evaluating practice. It absorbs huge amounts of resource to little, if any, benefit, that would be much better spent on the frontline.*"

Para 43 "many lack purpose and or leadership. A small number hold agencies to account for the delivery of services to protect children, but too often there is an absence of a presiding mind to take issues forward and ensure each agency plays its critical role in the work".

Leadership

Leadership (para 53) "Leadership of multi-agency arrangements is neither clear nor consistently effective. Despite the post of independent chair of the LSCB reporting to the

¹ Paragraph references are to The Wood Report , March 2016

local authority Chief Executive and statutory guidance on the role of the Director of Children's Services and the Lead Member, the situation is unsatisfactory and leadership expectations are focused on the local authority".

Para 108 "The relationship between a DCS and the Chair of an LSCB is not without its tensions, and while in most cases it is a strong and clear partnership, in others it is not and this is reflected also in the survey. This is sometimes made more complicated because of the important relationship between the Chair and the local authority's chief executive. The Association of Directors of Children's Services see the DCS as the leader of the system because of the statutory responsibilities they have in respect of children. Others offer a different view. They point to the fact that the system has become skewed toward the local authority with the key role of senior leaders in health and the police not recognised within the multi-agency statutory framework". The report proposes Recommendation 12 in this context: "To consider issuing new guidance on the responsibilities of a chief officer nominated by each of health, the police and local government to agree the multi-agency arrangements and processes in an area".)

Engaging with people who may need safeguarding support

Alongside this the need to develop a variety of approaches to engaging with people about their experiences and about outcomes (para 124). Need to see people as an "intrinsic and critical partner in helping to redesign and improve the services we provide..."

Collaboration and innovation

Para 24 refers to two things that must be done in respect of LSCBs

- introduce a more effective statutory framework to focus the arrangements on child protection and to ensure key agencies collaborate to deliver more effective services; and
- move away from an over prescriptive system to one that encourages and authorises local areas to determine how they organise themselves to improve outcomes for children and meet the requirements of the new framework.

...towards more effective collaboration and greater degree of innovation. (See also para 35)

There is a focus on the primary importance of coordination between LA; Police and Health with the vital role of other organisations underlined. "Without agreement and full collaboration between the police, health and local government, the necessary strategic decisions necessary to underpin effective practice will not be taken". (para 59)

The Wood report suggests in its recommendations that "NHS (England) should consider how their AAF² for safeguarding vulnerable people could be amended to place greater emphasis on how local health agencies fully participate in multi-agency practice" (rec 8).

Para 153 "The contribution made by the voluntary and community sector will continue to be a very important part of the national and local framework to protect children and we need to think harder about how we can engage them and support the valuable work they do".

Supporting "the development of highly skilled practitioners in each agency"

The wider context of protection:

(para 62) "Working Together to Safeguard Children (2015)¹³ makes clear that when the core business of child protection is secure LSCBs should go beyond it to work to a wider remit. From the evidence of Ofsted's reviews and what has been said in the consultation, I contend that only a small number of LSCBs have achieved this secure position, yet all seek to deliver against the wider remit".

² Accountability and assurance framework

The need to address the confusion across the range of partnership Boards is highlighted (LSCB; LSAB; Health and Wellbeing Board; Community Safety partnerships etc)

The effective interface between strategy and practice needs to be addressed (covered including in paras 67-70)

Para 75 “I am persuaded by the argument that ensuring effectiveness should be decoupled from the oversight of coordinating of services in local multi-agency arrangements. More should be done at local level to demonstrate the effectiveness of the arrangements we have in place to protect children and young people. Doing this will give confidence to partners within the system and to the wider community. It will be for a local area to show how effective its arrangements are for improving outcomes for children and young people, but there should be a requirement that they have such a measure in place”.

Independence

The report states that independence is important but an Independent Chair may not be the only means of achieving this.

What can the experience and development of LSABs contribute to this review/debate?

LSABs were set on a statutory footing with implementation of the Care Act, 2014. The statutory guidance (March 2016) sets out the aim of the LSAB as to “assure itself that ...safeguarding arrangements and partners act to help and protect adults in its area...”

The Guidance is clear as to the remit of the Board in overseeing and leading, including taking an interest in matters that contribute to prevention of abuse and neglect.

The Guidance underlines the need for Boards to be a source of advice and assistance and to do this alongside other partnerships, coordinating effort.

The Guidance underlines the need to have strategic discussions that impact on practice.

“The SAB is a multi-agency group that is the appropriate forum where strategic discussions can take place on dealing with what are often complex and challenging situations for practitioners and managers as well as communities more broadly” (para 14.141) This is said in the context of self-neglect. It is an areas that demonstrates that there are examples of SABs supporting development of practice and of practitioner skills.

Wellbeing, safety and protection

Safeguarding adults is set firmly in the context of the broader care agenda and specifically the core principle of the Care Act, the ‘wellbeing principle’. There is not the same history as in safeguarding children of an emphasis on protection.

Paragraph 1.5 of the statutory guidance refers to this as follows: ‘Wellbeing’ is a broad concept, and it is described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation

- the individual's contribution to society

Paragraph 1.6 states: "The individual aspects of wellbeing or outcomes above are those which are set out in the Care Act, and are most relevant to people with care and support needs and carers. There is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round".

So for safeguarding adults the starting point must be to set safeguarding support and enquiry in the context of what makes for wellbeing in an individual's life. Any support/enquiry must begin by asking about the outcomes the individual(s) want(s). This is well established in many SABs and there is evidence, particularly from the MSP (Making Safeguarding Personal) Programme reports that practice and strategy is really beginning to understand and engage with the balancing of these roles. The Mental Capacity Act underpins the requirement to balance these aspects of safeguarding adults and supports the development of practice in this context.

Governance and leadership

There is evidence that SABs have learned a great deal from the experience of LSCBs in this respect. For example there are a growing number of Adults' Boards implementing a proportionate section 11 type approach rather than an unwieldy process. These Boards are using these audits to promote challenge and leadership and to inform strategic plans for improvement across the whole partnership. In London the audit has been a collaboration between Boards and NHSE (London Region). This kind of joint leadership is increasing. The national Chairs network and the London Chairs group both facilitate the sharing of best practice in this respect. For example, a section 11 type audit tool was developed in Solihull and in Essex and then developed further in London.

Furthermore there are examples of Boards developing proportionate integrated scorecards in order to be in a position to gain assurance on safeguarding arrangements and including taking an interest in issues of prevention of abuse and neglect.

SABs are beginning to develop approaches to strategic planning that take account of the outcomes of section 11 type audits; data from the LA; learning from SCRs/SARs locally and nationally and are beginning to engage with their communities to identify priorities.

Collaboration

I think we need to acknowledge here that SABs are experiencing some issues in common with LSCBs around the potential for an unequal relationship with the Chair across the 3 statutory partners. However some Boards have addressed this through establishing an executive body or similar. Some such bodies have included the voluntary sector, recognising the point made in the Wood Report as to the vital role of this sector in safeguarding.

Innovation

The Wood Report refers to a

'move away from an over prescriptive system to one that encourages and authorises local areas to determine how they organise themselves to improve outcomes for children and meet the requirements of the new framework'.

The engagement in the national Making Safeguarding Personal programme has provided a broad range of evidence that SABs and practitioners are developing innovative responses to the recognition of a need for an outcomes approach. They are developing ways of evidencing the extent to which outcomes are met so that Boards can receive assurance on this. Boards are supporting this.

SARs/SCRs

There is work underway across regions (for example in the West Midlands and in London) to address the issues in respect of SARs outlined in the Wood Report. There is scope for sharing this development and learning across LSCBs and LSABs

Engaging with people who may need safeguarding support

There is evidence that a minority of LSABs have in place arrangements for meaningful engagement that will mean that those who may be in need of safeguarding support will inform strategy and practice. There is further evidence in a recent Making Safeguarding Personal temperature check (July 2016) that there is an appetite across LSABs to learn from those who have already made significant progress.

Independence

Perhaps highlight the number of SABs which have an independent chair despite this not being a requirement and examples of benefits derived that have brought this about??

APENDIX 2

MODERN SLAVERY

SUMMARY

This presentation paper outlines the definitions of Modern Slavery in the context of safeguarding adults and seeks to ensure that all agencies are aware of the potential for abuse of adults and the action required of them to respond to this.

1.0 INTRODUCTION

The Guidance to the Care Act defines Modern Slavery as one of the areas which constitutes abuse or neglect. It is the Board's responsibility to have an overview on how the local safeguarding arrangements and partners act to help adults who are in need of care and support and are at risk of abuse and neglect in this context and as a result of those care and support needs are unable to protect themselves from the experience or the risk of modern slavery

2.0 COMMENTARY

Human Trafficking – A crime against a person (Humanity)

Human trafficking is the acquisition of people by improper means such as force, fraud or deception, with the aim of exploiting them.

Human Smuggling – A crime against the State

Smuggling migrants is the procurement of illegal entry of a person into a State, of which that person is not a national or resident, for financial or other material benefit.

Modern Slavery Bill – enacted 31/07/15 – relevant sections:-

- **S1 -Slavery** = Holding someone as a slave or servant or for compulsory or forced labour – Life Imprisonment
- **S2 Human Trafficking** – Offence of Arranging and facilitating the travel of a person with a view to them being exploited - Life Imprisonment
- **S3 The Meaning of Exploitation** – consolidates all the different definitions from the existing legislation by putting exploitation under one meaning and at the centre of slavery offences. – sexual, labour, forced criminality, organ harvesting
- **S4 Committing offence with intent to commit offence under section 2 (Trafficking)** commits **any** offence with the intention of committing an offence under section 2 (including an offence committed by aiding, abetting, counselling or procuring an offence under that section).

Countries of Origin:-

- In the UK these are the top countries that identified victims come from: Albania, Vietnam, Nigeria, Romania, UK and Poland.
- Predominantly, Eastern European males will be found in labour industries.

- Romanians are predominantly used for street begging and forced crime, women for sexual exploitation/forced marriage.
- Nigerian females - sexual exploitation and domestic servitude.
- China – forced labour (Morecombe Bay & cockle pickers) and sexual exploitation
- Vietnam – predominantly men and children forced in the farming of cannabis cultivation and nail bars etc.

Identifying Victims of Human Trafficking

- Living and or working at a location where intelligence suggests potential victims of trafficking are held;
- Others speaking for the person with whom you are trying to talk;
- Others attempting to influence you or the people with whom you are trying to talk;
- Others trying to distract you from your enquiries;
- Living in 'degraded', unsanitary or overcrowded conditions;
- Poor health and hygiene (including poor dental hygiene and malnutrition);
- Injuries old and new, apparently a result of assault or restraint;
- Injuries or impairments typical of certain jobs possibly due to lack of appropriate clothing or equipment;
- Any evidence of control over movement either as an individual or a group including segregation.
- Passport or documents held by someone else, No days off or holiday time;
- Limited contact with family, Lack of access to earnings;
- Lack of access to medical care.
- Very limited social contact;
- Threat to be handed over to the authorities
- Perception of being bonded by a debt.
- Threats against the person / family members;
- Being in a situation of dependency (food, shelter, clothing, 'substances' transport
- Imposed working conditions and lack of ability to negotiate;
- Lack of ability to quit work environment;
- Transport / accommodation is 'provided' by the employer, as a condition of employment, at inflated/unrealistic cost which is deducted from wages

The National Referral Mechanism (NRM)

Members of Safeguarding Adults Boards are deemed to be first responders and make referral to the NRM

- The NRM was set up to implement the Council of Europe Convention on Action against Trafficking in Human Beings. Came into being on 1st April 2009.
- The requirements of the Convention are to protect and assist victims of human trafficking It is a victim identification and support process.

- The NRM encourages cooperation between agencies involved in human trafficking cases.

The NRM is the framework adopted by the UK to:-

- Identify victims of human trafficking – adults have to consent to referral
- Provide a reflection and recovery period
- Provide victims with the care and support
- Victim is rescued and in a place of safety – free from coercion
- Interview process including use of reception centres in different parts of UK
- Reasonable Grounds decision – 5 days
- Conclusive Grounds decision – 45 days – funded by Home Office

Post 45 days – remain in UK, leave UK or perhaps homelessness and re exploitation.
The West Midlands Regional Crime Unit has a Modern Slavery threat group which receives intelligence on modern slavery.

3.0 MATTERS FOR CONSIDERATION

- i. The level of awareness of presentation of modern slavery at key points of referral – Police, Trading Standards, A&E, Housing, social care agencies as well as schools and day nurseries
- ii. The coverage of this aspect of the DH Guidance and response in Policy and Procedures and now in MASH procedures
- iii. Referral mechanisms including the NRM and the follow up support
- iv. Sharing of intelligence on locations and individuals in the context of potential victims of trafficking

With acknowledgement to Robin Brierley West Midlands Anti-Slavery Network for use of his presentation material.

APENDIX 3

Establishing Joint Safeguarding Boards – Success Factors, Benefits and Risks A Paper for Discussion

Purpose

To inform discussion at national meeting of Safeguarding Adults Board Chairs in March 2017 with a view to informing wider debate. The methodology is set out below and in an appendix.

Introduction and description of some of the key benefits that underlie moves towards joint Boards

A number of joint Safeguarding Adults Boards have been established with various degrees of benefits. This approach is often seen as a solution to a number of common issues facing SABs. These include:

- the need to ensure that policies and procedures of neighbouring areas are consistent so that the public and professionals are not confused about how to access and use services
- the problem for some partners (in particular the Police and the NHS) of having to attend multiple Boards
- optimising the use of scarce board support and leadership skills
- optimising the efficiency and resources of partnership arrangements
- optimising opportunities for shared learning and development (sharing skills, knowledge and expertise across geographies as well as organisations)

It is noted by some that these benefits may be developed in a range of different ways, it doesn't have to be alternative Board arrangement.

Methodology

This short report summarises the findings of a telephone survey of Chairs of Boards that have an interest in exploring the issue and most of whom have managed this process both successfully and unsuccessfully. It is not intended as an exhaustive exploration of the issues and does not include all joint Boards and views but is a starting point to guide decision making. (See methodology appendix 1). It is anticipated that those chairs of joint boards whose views are not yet reflected in this paper will want to add these so that this can inform national debate on this issue.

Success Factors

The experience of those areas that have established joint Boards, both successfully and unsuccessfully (and who have so far contributed to discussion) indicate that there are a number of measures that can support positive development and functioning of joint Boards. These include:

- a joint *multiagency* (including all the statutory partners) commitment to make a single statutory Board and subgroups work effectively
- a champion - a senior person committed to making the arrangements work
- joint commitment from local politicians particularly where across existing single Boards there are significant political differences/different ways of working.

- it helps significantly if the local authorities involved have some history of successful joint working (e.g. Teeswide and Tri Borough, London which is also joint across ASC functions with one DASS)
- existing joint governance relationships - for example for economic development (for example Teeswide and Tri- Borough, London as above)
- clear governance and accountability arrangements (an agreed accountability framework including between the SAB and all of the local Scrutiny Committees and Health and Wellbeing Boards. This can be challenging, for example in one Board the Independent Chair reports to 3 OSCs, 3 HWBs, 3 Chief Executives and compiles 3 different versions of the annual report. This additional work has been recognised with an increase in allocated days.
- meaningful geographical footprint - perhaps that of the Police service
- a degree of consistency in respect of demographic characteristics. Examples cited include: 'difference in terms of urban/rural mix...urban issues can soak up attention/resource to detriment of rural areas or vice versa' and 'sometimes there is little but physical proximity that unites us'. Also size of population may be a factor (It was suggested a population of between 500,000 and 1, 000, 000 might be a pre requisite)
- adequate resourcing of the Board support unit both in terms of financial support and skills (see note*) as well as costs associated with meeting statutory duties. For example one respondent expressed a view that 'without a business unit you can't make it work. A single Board manager cannot do everything...' 'The key to success is to appoint good staff at the right level.' A joint Board may be in a better financial position to appoint dedicated Business Unit staff at a higher level than a single Board may be able to achieve,
- A joint Board may be better resourced and placed to raise the profile of adult safeguarding by a broader communication strategy, e.g., radio/TV/posters/ Annual Conference
- effective arrangements for the engagement of partners at a local level (typically that of a single local authority)
- clear and effective arrangements for Board members to communicate with all their constituency of interest (e.g. Police with all Divisional commanders and HQ)
- two Chairs felt that a clear, fully resourced and well executed project plan to establish a joint Board is important with clarity about the aim of establishing a joint Board; clear plans and adequate time given for transition and testing out aspects of the plan. Two others, on the other hand, felt that whilst this may help, a joint Board can 'evolve in a more fluid manner' :

** The costs of running a joint Board include all those required to effectively manage a single Board plus the need for additional capacity to ensure effective engagement at a local level, undertake the additional work that is needed to engage and work with several local authority social care, finance and policy teams and additional time for the chair to service all the support functions that she has to manage. As one example, the Teeswide Board is a successful joint Board. It has a business unit with a Board Manager; three fte posts and two part time posts. There are additional costs of statutory duties such as information including website construction/ management; community engagement; annual reports; SARs.*

There is a significant degree of agreement that there are a number of additional factors (alongside the absence of the above) that can undermine the establishment of a joint Board. These include:

- where adequate support from partners and political leaders for the new arrangements is not developed before they are established
- where there has been insufficient focus on the need for local communication and networks in support of Board objectives. Problems have emerged for some Boards where adequate arrangements for the assimilation and dissemination of views and information between 'local' partners and the joint Board are not in place before the joint Board is established (The experience of several Boards is that local groups have been established to get round the issue of lack of a locality focus. These can undermine the objective of a joint Board. One Board said that 'To deliver what is needed a complicated network of subgroups can be needed. Some LAs will invent a partnership group locally...and this undermines the Board and is something that needs to be resolved'. Another offered 'Local meetings will be needed to communicate with local people/issues')
- the experience of some is that to deliver what is needed, a complicated network of subgroups can be needed
- where the challenges presented in terms of engagement with voluntary sector, independent providers, Healthwatch are inadequately addressed. Here the development and support function of the Board needs to be focused and this is challenging with a joint Board.
- where there is inadequate funding for the chair (more work e.g. attendance at Scrutiny Committees and Health and Wellbeing Boards for each of the local authorities involved). (See the example of governance arrangements above)
- where issues about efficient representation of partner organisations are not adequately addressed. This can manifest itself either in a Board that is too large or if for example one police representative attends on behalf of two or three colleagues the Board must be able to rely upon her/ him briefing their colleagues. This has been problematic in some situations. One Board has found this particularly relevant in the context of health providers- the Board has 2 acute health providers, 2 mental health trusts, specialist health providers, community health providers all providing similar services across Council boundaries.

Risks

The risk that concerns many established SABs is the loss of hard won local partnerships, engagement and local service integration. This has not been a significant issue for the Teeswide Board, which has had a significant degree of success in joining Boards. It is less clear that retaining and building on local strengths has been achieved elsewhere. One Chair offered: 'The Board is much more than a structure and a process; it is about making a real difference. Engagement is key to being what we want to be in terms of effectiveness and development ... Engagement is difficult with the range of partners with just one Chair.'

A common concern is that joint Board arrangements will lead to a loss of focus on local arrangements and needs, particularly the engagement of the voluntary and community sectors.

There are concerns about ‘levelling up’ or ‘levelling down when one area is less advanced than another. ‘All [two; three...Boards] can become subsumed under one set of issues. There is a real danger of spending a disproportionate resource in one area’

There are clearly risks associated with not having clarity around governance and accountability arrangements at all levels (political and managerial). In the worst-case scenario the governance of joint Board arrangements must be able to stand up to scrutiny in a court or public enquiry.

Alternative Models and/ or first steps to joint working across Boards

The benefits of joint Board arrangements can be achieved through other means and/or these approaches can be a first step in the direction of a joint Board. These include:

- shared policy, performance and SAR commissioning arrangements across several Boards whilst maintaining local Board arrangements (the issues about adequate resourcing of the system overall remain, but different functions can be discharged by individual Board support teams, or a shared support team can be established).
- establishing shared Board arrangements, where individual Boards share functions through the use of shared subgroups and expertise (for example SAR arrangements; QA subgroup; communications subgroup; task & finish groups). This could for example form the basis of a stepwise process toward the formation of a joint Board. Alternatively it could constitute a stand-alone methodology for sharing resources, knowledge and expertise across Board areas.
- Establishing /strengthening trust and necessary behaviours across Boards by starting with consideration of the above areas of common interest, including SARs; joint interests in subgroup activity.

Summary

Whilst there are some positive examples of joint Boards not all yet show the same benefits. In at least one case (Hull and East Riding) the arrangements failed and separate Boards were re-established.

Nevertheless the potential benefits can be considerable in terms of the effectiveness and efficiency of discharging the local authority’s statutory duty of establishing a SAB.

This survey of Board Chairs suggest that where there may be potential for joint Board arrangements, the process of developing a joint Board must be undertaken with careful consideration of the above factors.

Jane Lawson, John Woodhouse
Independent Chairs
February 2017

Appendix 4

SAFEGUARDING ADULT BOARDS AUDITING THE IMPACT OF BEING MADE STATUTORY

In the autumn of 2016 the Network conducted an audit to assess the impact of the implementation of the Care Act 2014 on SABs and to capture the effects of making SABs statutory partnerships. This was part of a sector led improvement initiative (within the Care and Health Improvement Programme at the Local Government Association) designed to inform the Department of Health and other stakeholders about the progress of SABs, the impact of the Care Act 2014, and to support further development of SABs. The final report was shared with the National Network of Safeguarding Adult Boards Chairs and sent to the Local Government Association and Department of Health (DH). The recommendations from the Audit have also informed the priorities and work plan for the Network in 2017 - 2018.

Methodology: The survey took the form of a questionnaire, which was agreed at the National Network of SAB Chairs' meeting in September 2016 and emailed to individual SAB Chairs in October 2016. The survey was designed to collect background information about SABs and the various aspects of their work. Respondents returned the completed the survey via email at the end of January 2017. While ethical permissions were not required the data collected was made anonymous on the request of the participants. The questionnaire was discussed at regional group meetings (where these happen) and local decisions made about how to complete them.

Summary of Findings: The survey offers a useful set of data, across a range of areas. The summary of findings is as follows:

Membership: Representations of the three statutory agencies (local authority, health and police) attending SAB meetings were at a high level. The commitment from local authorities was highest. There was also strong representation from elected members with the majority (83%) of SABs having an elected member sitting on the Board.

Engagement: There was broad engagement with service users with SABs trying out different methodologies to achieve this; although 3% of SABs reported they were not there yet. However, it remains to be seen which methodology works most effectively, and there is further analysis underway through the Association of Directors of Adult Social Services (ADASS). Boards also used a variety of ways of working with Healthwatch in facilitating service user engagement. The other commonly used methods were the use of Service User Forums (22%) and sub-groups (18%).

Governance: Over half (63%) of SABs reported they had wider governance arrangements above the SAB. This was most commonly an executive made up of the statutory partners and the Chairs of the SABs sub-groups. These executive groups often conducted tasks such as agreeing the agenda of the Boards, checking on progress of the sub-groups and ensuring that statutory partners were happy with the direction the Board was taking.

Wider Partnerships: Other arrangements were wider partnerships with relevant bodies such as Safer Communities Partnerships and the Local Safeguarding Children's Boards, regular meetings with the CEO and the Lead Member within the Local Authority. Boards also reported governance links with the Health and Wellbeing Board and one Board reported

links with the Police and Crime Commissioner.

Terms of Reference: The majority (97%) of Boards had a Memorandum of Agreement or Terms of Reference in place. 86% of the respondents had a Board Manager. For those who didn't, this was due to resource or recruitment issues or this role being either part time or part of a wider remit. Although thirteen respondents reported they shared the SAB support function with children's services, this was still relatively unusual.

Strategic Plans: Predominantly SABs have published their strategic plan on their own dedicated website (69%) and where this wasn't available, the strategic plan was often included in the annual report. Other examples of where the report was published were in the minutes of the Health and Wellbeing Board and other public meetings. Two Boards reported they had developed an easy read version of the strategic plan. 30% developed their strategic plan over 3 years, 28% over two and 42% over one.

Annual Reports: Most SABs had published their annual report on their website or the councils website. In addition the annual report was often presented to the Health and Wellbeing Board or the Overview and Scrutiny Committee (43%). SABs also reported sending their reports to Healthwatch, service user groups, chief officers of the statutory partners or simply stating that they complied with the statutory requirements within the Care Act 2014. No one reported issues around transparency and for those SABs who had not published their annual report (6%), some were planning to publish in the near future but were delayed due to resources, absence of SAB Manager or competing claims with the Local Safeguarding Children's Board (LSCB).

Board Finances: Only 62% of respondents had or were going to publish the SAB annual budget. It seems likely this is due to the difficulties Chairs were experiencing in agreeing budgetary contributions with the statutory partners.

Measuring Effectiveness: Boards reported a variety of activities to measure their effectiveness. The majority described having development days, challenge events and local audits as well as monitoring of their strategic plan or a mixture of activities. Eight Boards used Peer Review to measure how effective they were and to inform their strategic plan.

Links with Other Significant Partnerships: All of the Boards reported they had strong links with other partners, predominantly with LSBCs, Health and Wellbeing Boards and Community Safety Partnerships. Some Boards described having a mechanism for joining up partnerships concerned with keeping all children and adults safe across a local authority area. 94% of respondents also reported strong links with wider partners. Most commonly this was housing, prisons, probation services and NHS providers. The weakest links were with Quality Surveillance Groups (QSGs) with nine Boards specifically mentioning poor or no links.

Increase in Concerns as a Result of the Care Act: Although just over half of respondents reported an increase in safeguarding concerns, a surprisingly high number of SABs said they had not seen an increase.

Changes in the Pattern of Section 42 Enquiries: 52% of respondents reported a change in the pattern of Section 42 enquiries. Some Boards reported needing to further audit in order to understand what these changes were.

Safeguarding Adult Review (SAR) Protocols: Most SABs (94%) reported they had a SAR protocol in place. None of the other respondents offered an explanation of why there was a lack of protocol. A large number of Boards (58%) had either not commissioned or commissioned just one SAR since April 2015 with the highest number being between 6 and 7 SARs. Some Boards reported they had been using an alternative to SARs, including shared learning and one day challenge events.

Impact on Safeguarding Practice: Nearly all SABs (91%) reported that the Care Act had an impact on safeguarding practice, particularly the impact of Making Safeguarding Personal. The audit found SABs were using a variety of ways to support more personalised ways of working and to ensure partners' on-going commitment.

Overall Impact of the Care Act: 61% of respondents reported that there had been an impact of the Care Act 2014. Of those who added additional comments, one respondent reported that SABs being made statutory had enabled the Chair to raise the profile of the SAB and its work.

Particular Issues: The predominant issue, which reflects a theme throughout the audit is funding, followed by commitment of both statutory and non-statutory partners on the SAB to the Partnership. Other issues raised were: ensuring consistency of methodology in both collecting data and conducting safeguarding adult reviews. A number of respondents called for more collaboration between the statutory partners on a national level.

Robert Templeton