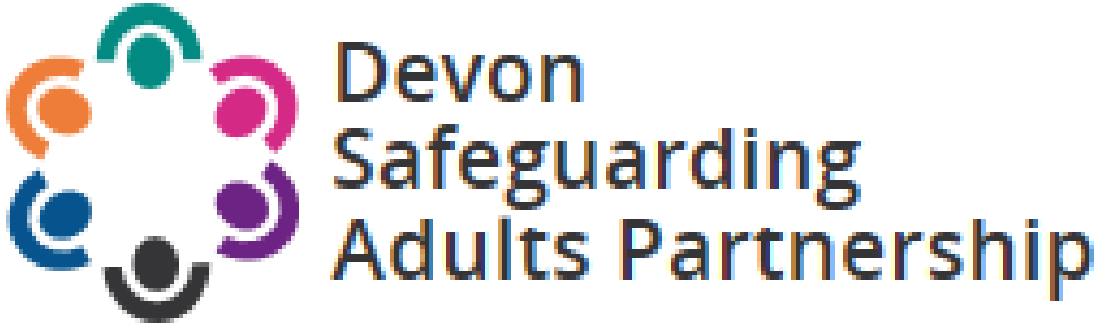
Devon Safeguarding Adults Board Annual Report 2018/19



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1. Introduction from Independent Chair

Welcome to my third Annual Report – a different style adopted because, in the spirit of continuing to improve how we communicate the activities of the Devon Safeguarding Adults Board (DSAB); we wanted to add in some more information about how we delivered against our strategic priorities for 2018/ 2019. We also wanted to add in some data and facts, which are helpful to people in determining how successful we are as a partnership. Last year we listened to feedback from Devon's elected Councillors at Health & Adult Care Scrutiny Committee, who asked for this information and I hope this annual report is more informative.

I continue to believe in the power of personal stories which help us all to understand the impact of what we do, supporting those with care and support needs who suffer abuse, neglect and harm. At every DSAB meeting, we listen to a personal story, often presented by the person with lived experience. This gives us many learning opportunities which are cascaded by partners through into their organisations. A Safeguarding Adults Board has a duty to act to prevent people experiencing abuse, neglect and harm and these powerful stories show us that it is often the simple things we need to do which make the difference. These experiences add to the learning from Safeguarding Adult Reviews and all this plays its part in continuously improving services – Greg's and Tom's stories are included in this Annual Report.

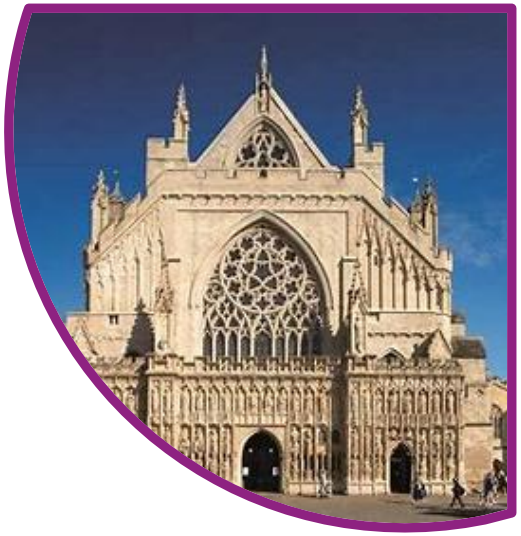
The DSAB has a duty to publish findings from Safeguarding Adult Reviews which have been delivered in the year. Section 14 of this Report outlines three SARs delivered in the year. Our position is to usually publish these unless there is a compelling reason, e.g. to protect and ensure the safety of others, why we should not to so. SAR Adrian Munday is published in full on the DSAB website and a summary is included in this Annual Report. SAR Sally is still awaiting publication as there is more work being completed with her family and this SAR will be published in full on the DSAB website in the coming months. SAR Rita was also completed in this year and the Board is currently working with the family prior to full publication planned for October 2019.

I commend to you the work of the Board's sub-groups, where a wide number of people work hard to ensure that the Board's strategy and work plan is delivered. In particular I would like to highlight the work of the Community Reference Group which has matured this year and now comprises a proactive group of people with lived experience of safeguarding and those who are supporting people who have been safeguarded; working with the DSAB on projects such as the development of the Board's website and with plans to support us on our continuing safeguarding awareness campaign. This group is led by 'Living Options', whose Chief Officer is also now a member of the Board.

Finally I would like to thank the Board team who work incredibly hard to deliver an effective partnership and support me to bring this together. I hope you find this report readable and informative and I look forward to continuing to work with you in 2019/ 2020.

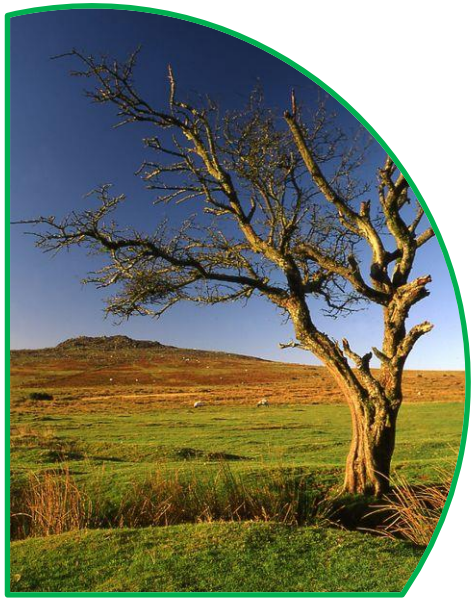
Siân Walker

2. Introduction to Devon



Devon is the third largest county in England, covering 2,534 square miles. It is also one of the most sparsely populated counties, its 780,000 residents distributed between the city of Exeter, twenty or so coastal and market towns, and several hundred rural communities, some of which are isolated.

In Devon there is a higher proportion of older people than the national average due to a high migration into the county at retirement age, and a migration out of the county of younger adults. The county enjoys high levels of employment, but lower than average wages and productivity, and higher than average housing costs. There are areas of deprivation, but they are dispersed rather than concentrated.



There are eight district councils in the Devon County Council administrative area and two unitary authorities in Devon, Plymouth City Council and Torbay Council. From 1st April 2019 two Clinical Commissioning Groups (CCGs) merged to form NHS Devon Clinical Commissioning Group covering the geographic area of the Devon Sustainability and Transformation Partnership. Four Acute Hospital Trusts serve the area: Northern Devon Healthcare NHS Trust, Royal Devon and Exeter NHS Foundation Trust, South Devon Healthcare NHS Foundation Trust, and University Hospitals Plymouth NHS Trust, with mental health services and specialist learning disability services provided by the Devon Partnership NHS Trust on a county-wide basis. Police services are the responsibility of Devon and Cornwall Police.

3. What is Safeguarding Adults?

Safeguarding adults' means protecting an adult's right to live in safety, free from abuse and neglect. It is something that everyone needs to know about.

The legal framework for safeguarding adults work is set out by the Care Act 2014. Safeguarding involves:

- People and organisations working together;
- Preventing abuse or neglect from happening in the first place;
- Stopping abuse and neglect where it is taking place;
- Protecting an adult in line with their views, wishes, feelings and beliefs;
- Empowering adults to keep themselves safe in the future; and,
- Everyone taking responsibility for reporting suspected abuse or neglect.

Who is an adult at risk?

An adult at risk of abuse or neglect is someone who has care and support needs and is therefore unable to protect themselves from either the risk of, or the experience of, abuse or neglect. Their care and support needs may be due to a mental, sensory or physical disability; age, frailty or illness; a learning disability; substance misuse; or an unpaid role as a formal/ informal carer for a family member or friend. More information is available on the Board's website at: https://www.devonsafeguardingadultspartnership.org.uk/

6 Safeguarding Principles

Empowerment: people being supported and encouraged to make their own decisions and give informed consent

Prevention: It is better to act before harm occurs

Proportionality: the least intrusive response appropriate to the risk presented

Protection: support and representation for those in greatest need

Partnership: local solutions through services working with their communities- communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability: accountability and transparency in safeguarding practice

4. What do we mean by abuse?

Abuse is an intentional or unintentional act that harms, hurts or exploits another individual/s. Abuse can take many forms, but no type of abuse is acceptable.

Abuse can happen just once or many times; it can be done on purpose or by someone who may not realise they are doing it.

It can happen anywhere including at home, in care homes or in day care centres or hospitals.

The different types

What happens when a Safeguarding Adults Concern is raised?

① Wherever possible, the adult will be contacted by the professional who has received the concern, to ask them about their situation and to find out what they would like to see done about it.

② Actions are then identified to achieve this wherever possible.

Sometimes, concerns are raised due to confusion over what is happening in a certain situation. Sometimes, concerns are raised because a family member is struggling to care for an adult with needs and requires support. Sometimes concerns are raised because someone really is being abused or neglected.

③ The *Safeguarding Adults Enquiry* establishes the facts and works with the adult and those most close to them, to ensure their safety and to resolve the issues putting the adult at risk.

5. Personal stories presented to the Board

Greg's Story

Greg's support was funded by the NHS because of his health needs; he received one to one support during the day and shared support with other people during the night.

In March 2018 concerns were raised about Greg's support in respect of emotional and physical neglect. A Social Worker met with Greg, listened to his story and asked him what he wanted to happen and what outcomes he wished for.

The safeguarding enquiry found that there were some key themes including a lack of communication with him and his family; an absence of consideration that Greg's support was being delivered in his own home; a need to ensure that Greg received continuity of care which was uninterrupted and overall that there needed to be consideration of what Greg would like to achieve.

The enquiry found that that the support service needed to reorganise its staff, so they worked with individuals at specific times and not share a number of hours of support across a number of people who lived as neighbours to Greg. The way Greg's support had been organised meant that sometimes Greg did not receive the necessary support and his support hours were sometimes used for other people. A change of culture and attitude was needed by the Support Provider.

Greg was given the option to move into other accommodation whilst the investigation was underway. Greg stated that he was happy to stay where he was and he gave the Social Worker permission to inform his parents of any issues he had, as they knew what the problems were and could give their side of the story. At first Greg wanted to keep the investigation private and did not want the staff to know.

With the support of his parents, the Social Worker and his Mental Health worker, Greg felt confident to speak openly and honestly in the first formal safeguarding meeting. This period of time was described as tough and on occasions Greg was still asked if his staff could be used for other people. Greg reported this, and his Social Worker was made aware and it was investigated. The Manager for the service which worked with Greg, his keyworker and Social Worker agreed to bring about the changes to the service that were required. The Manager knew the new model could work but a change in staff attitude was needed to assist this.

Greg was allocated his own full-time key worker which offered him more stability and control. It was agreed that Greg and his staff would be open and honest about their day during the hand over period to ensure that any issues were dealt with. Initially Greg found it difficult to be more assertive, but he is growing in confidence with support. Greg now choses his own support team and he raises any issues straight away.

Greg spoke to the board about his experience:
Greg described himself as being in a bad way during the review period saying that at times he felt like he wanted to die. He questioned the point of the safeguarding investigation as at one point (on the morning of the safeguarding meeting) his staff were still being used elsewhere. He felt that things were continuing and indeed getting worse and Greg began to self-harm. However, his relationship with the Social Worker and Mental Health worker gave him hope. He found it empowering that they were working with him and believed in him.

The outcome of the enquiry is that Greg is now 'the boss' and feels in control. He is leading a busy life which requires extensive diary management. The activities Greg wants to do are matched by the support from staff. Greg reported that the service he receives now is better than it ever was. Greg's self-esteem and feelings of self-worth have increased, and he feels confident to make decisions. He is now the Service Representative for the service where he lives although he is rarely at home. Greg related that he has found his voice, knows what he wants and what he needs and will not take any rubbish!

Greg and his family believe they would not have reached this point without the help of the Social Worker and the safeguarding process. The safeguarding enquiry acted as a catalyst for improvements to the service for everyone.

Tom's Story

Tom is a 37-year-old man who is diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), bipolar affective disorder, alcohol and substance dependence, and psychosis. He has children from a previous relationship and his parents have custody of the children. Tom has contact with his children on a regular basis, supervised by his parents who provide support to Tom where-ever possible. Tom's father is a retired health professional and has acted as guarantor for Tom's current accommodation. Tom has been given notice on this property by the private landlord due to non-payment of rent.

Safeguarding Concerns were originally raised in August 2018 by Tom's care coordinator who was concerned about Tom's chaotic life style, drug and alcohol intake and his blood-letting.

During the Safeguarding Enquiry, Tom described being involved in the distribution of drugs (know as 'county lines' activity; Where he was being targeted on his journey to obtain methadone from the Pharmacy. He alluded to owing people money and was open about selling his body sexually for money to pay his rent. Tom also described other people staying at his property. This is sometimes referred to as 'cuckooing'. He was clear that he could not say no to these people as they were violent – he described them as 'weaponed-up' and he described the gang of people as coming from Manchester.

A safety plan was agreed with Tom, that he would continue to work with together re his drug use, consider rehab/detox outside of his current location, that he would have a sexual health screen to support his physical health and his GP (present at the meeting) would monitor Tom's blood to ensure his blood-letting was not impacting on him physically. Tom did say this practice was very infrequent at the time of the meeting. Tom agreed that the threats of violence from the Manchester gang would be discreetly escalated to the police. Local Policing Team have opened a criminal inquiry in response to Tom's disclosures. Tom assured the professionals at the meeting that he was able to and happy to call the police should he feel in danger and is regularly meeting with the local beat manager and his care coordinator who are supporting his safety in the community. Tom has been supported to address his accommodation and has set up a payment plan with the council who have paid his rent arrears to enable him time to source alternative accommodation. Tom was clear that he did not wish for his family to be informed of anything at this point. Staff involved in supporting Tom advised that him that they will reassess lone working and update care records.

The staff supporting Tom used an approach often described as 'Making Safeguarding Personal'. The Devon Partnership Trust (DPT) worked quickly with Tom in a way that meant that Tom hasn't been over whelmed by the increase in professionals scrutinising his life style. He was supported to participate in the investigation and all the meetings to express his views, wishes and anxieties at this time. Tom wanted and received support in liaising with the police, about his concerns about being targeted; he also requested that police only attend his address in plain clothes. Tom received the support he wanted in attending appointments, managing paperwork and forms. Tom's wishes changed throughout the time of the 1st and 2nd S42 Enquiry Meetings. He wanted to at one point leave his area for rehab/detox and then decided against this. He wanted to have his daily method prescription changed. However, the GP explained his rationale for not doing this and Tom was happy with this explanation. It was important for Tom to received support with reading the minutes and making sense of them.

6. How to report abuse

If you report a safeguarding concern you will be listened to, supported and involved in any decisions.

If you think that you, or someone you know, is being abused or neglected you can:

OR

Call Care Direct on 0345 1551 007

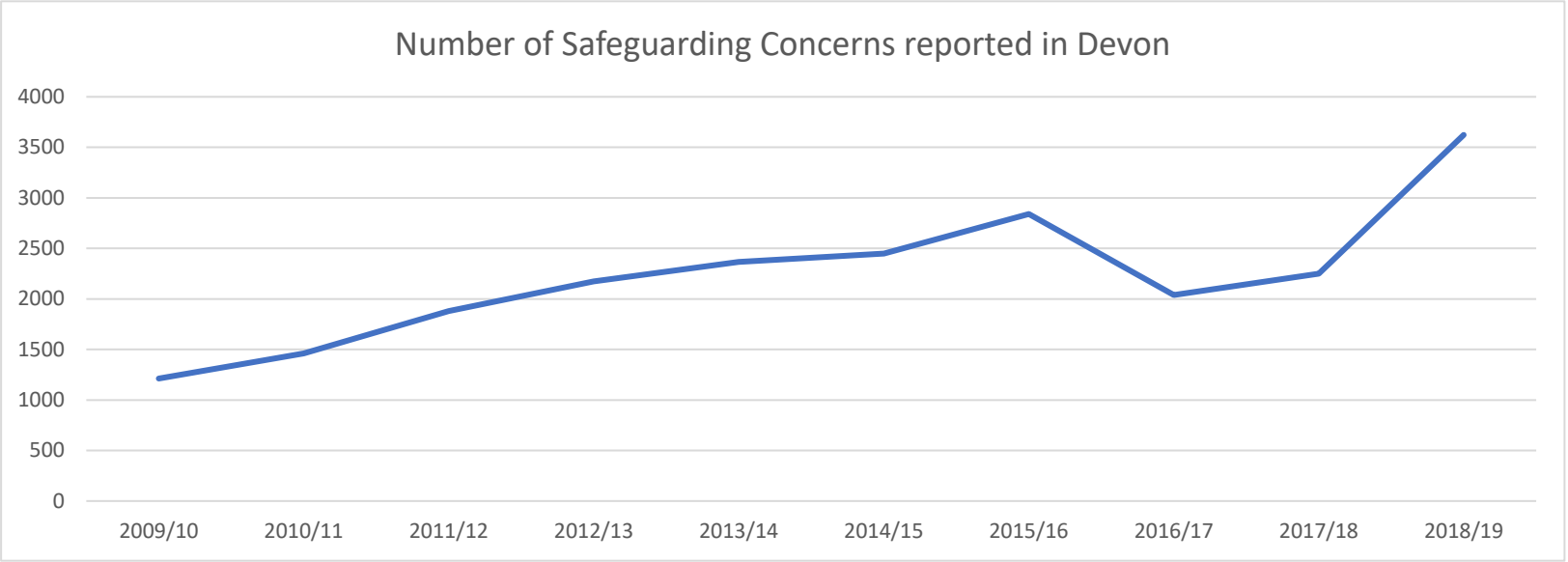
Email csc.caredirect@devon.gov.uk

(Monday-Friday 8am-8pm and Saturday 9am-1pm – outside of these hours or on bank holidays call 0845 6000 388 or email the address above)

Alternatively a safeguarding adult concern referral can be made to Care Direct using the referral form on the DSAB website: https://www.devonsafeguardingadultspartnership.org.uk/reporting-a-concern/

If it's an emergency, call 999

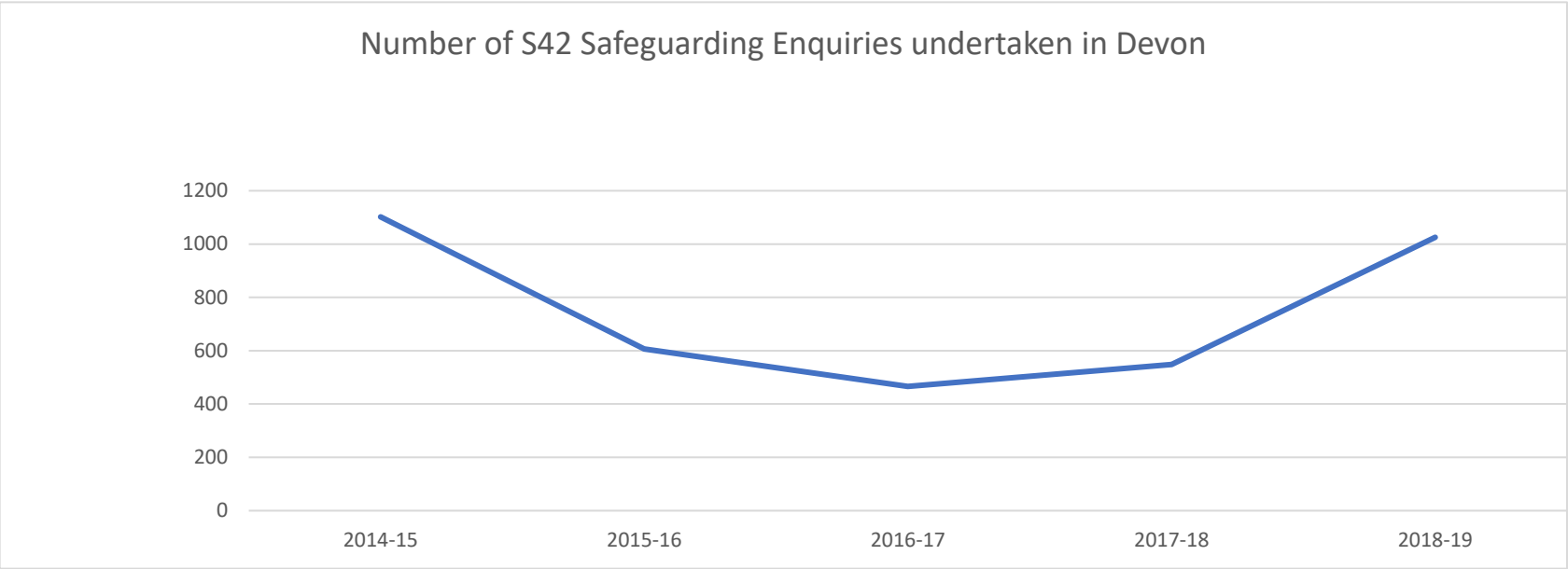
7. Safeguarding activity in Devon



Since the Care Act came into force in April 2015, the number of adult safeguarding concerns reported began to increase and then dipped in 2016-17 to 2017/18.

Devon Safeguarding Adults Board (DSAB) undertook a Deep Dive Audit to provide further analysis. It was identified that a proportion of safeguarding issues were being managed without reporting the incident formally to Devon County Council (DCC) as a safeguarding concern. This did not mean that the concerns were not being responded to, but the findings indicated that they were being directed to more appropriate pathways e.g. to receive an assessment of needs.

Since the Deep Dive Audit our trend has changed. In 2018/19 the number of concerns reported has significantly increased. Over the last 12 months Devon has seen a **61% increase** in Concerns raised bringing us closer to the local authority comparator group average in 2017-18. However, we still experienced a lower rate of concerns relative to the population in 2018-19 when compared to our comparator group local authorities and England rate in 2017-18 (2018-19 benchmarking not yet available).



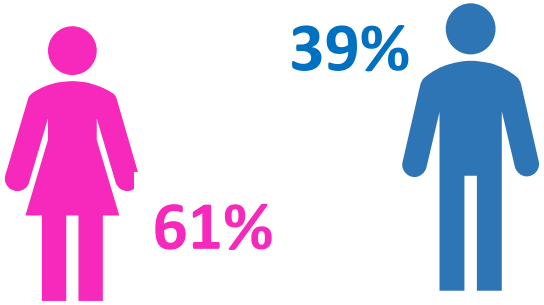
Since the Care Act came into force, the number of section 42 safeguarding enquiries (concerns that meet the threshold for further investigation) decreased but has now significantly increased again in 2018/19.

However, we still experienced a lower rate of s42 enquiries relative to the population in 2018-19 when compared to the comparator group local authorities and England rate in 2017-18 (2018-19 benchmarking not yet available).

Devon County Council (DCC) understanding of increased numbers of concerns and enquiries.

DCC are undertaking work to better understand demand and their activity in this area. DCC have been proactively working with Community Health and Care Teams to ensure that safeguarding concerns are raised as appropriate, promoting the safeguarding process as a positive way of understanding and responding in partnership for better outcomes for people at risk of harm.

There is some anecdotal evidence (that this increasing trend would support) that historically, teams 'deal' with issues within their local system as business as usual without raising a concern and working through any subsequent S42 enquiry.



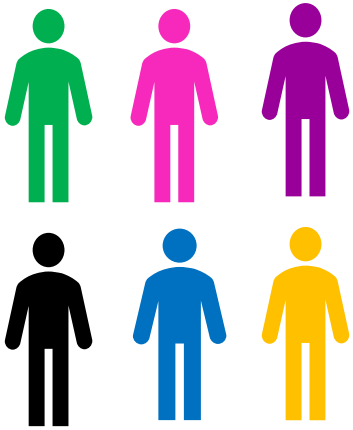
61% of individuals involved in safeguarding concerns in 2018-19 were female. This is consistent with previous years and remains slightly above the national trend. This is disproportionate to the overall, although not necessarily the elderly population in Devon, which the majority of our safeguarding activity relates to.

Approaches to safeguarding should be person-led and outcome-focused. In Devon, people were asked about their desired outcomes in 68% of safeguarding enquiries in 2018-19. This is an increase on the previous year.

53% of enquiries of abuse or neglect pursued in 2018-19 took place within the person's own home. This is consistent with previous years but a higher proportion than the national picture (46% in 2017-18).

A lower proportion of enquiries were recorded in care homes in 2018-19 than the previous year and significantly below the national picture in 2017-18.

A higher proportion of enquiries were recorded in hospital settings in 2018-19 than the previous year and bringing us in line with the national picture in 2017-18.



87% of individuals involved in safeguarding concerns in 2018-19 recorded their ethnicity as white. The proportion of people in Devon who describe themselves as white British increases with each age group and safeguarding data on ethnicity should therefore be considered in conjunction with data on age. This data shows that the majority of Safeguarding concerns in Devon relate to individual's aged 65+.

8. Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (2005).

The safeguards apply to people over the age of 18 who lack capacity to consent to their care and treatment arrangements in a hospital or care in a care home.

Sometimes a person may need high levels of support and supervision to maintain their wellbeing. The level of care and support provided may amount to a deprivation of their liberty. The DoLS are designed to ensure that in those circumstances the person's rights are protected. The person will have the right to representation and any authorisation should be monitored, can be reviewed and the person has the right to appeal.

People can also be deprived of their liberty in other settings such as supported living or their own home. However, in such cases the deprivation can only be approved by the Court of Protection and applications for authorisations be made to the Court.

The DoLS scheme has been criticised for many things including being overly bureaucratic and costly. These criticisms have been exacerbated by the increase in demand for authorisations since the Supreme Court judgment of 2014 in the case now popularly known as 'Cheshire West', which effectively lowered the threshold for eligibility and significantly increased the volume of requests. The workload demands in relation to the DoLS remains a challenge, nationally and locally.

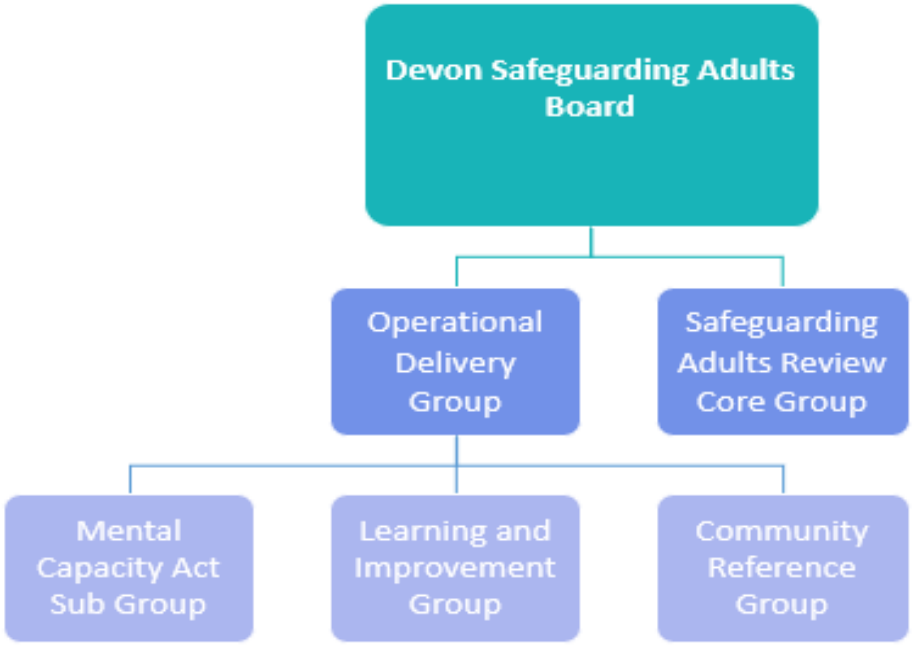
In March 2014, a House of Lords Select Committee published a detailed report concluding that the DoLS arrangements were "not fit for purpose" and recommended that they be replaced. The Mental Capacity (Amendment) Act 2019 received Royal Assent on 16 May 2019. The Deprivation of Liberty Safeguards legal framework will be replaced by the Liberty Protection Safeguards which are expected to come into force on the 1st October 2020.

9. Introduction to the Board and its subgroups

The Devon Safeguarding Adults Board (DSAB) is a statutory board set up in accordance with the S44 of the Care Act 2014.

Its main objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults at risk and those most vulnerable, in its area. To help the DSAB achieve this objective, there a number of focused subgroups in place.

Devon Safeguarding Adults Partnership



10. The work of the Safeguarding Adults partnership subgroups

The Mental Capacity Act (MCA) Subgroup

The Mental Capacity Act (2005) is a legal framework designed to empower and protect the rights of people who may lack the mental capacity to make some of their own decisions.

Over the last year the MCA Subgroup, (a joint sub-group with Torbay Safeguarding Adults Board), focused on advocacy, learning from Safeguarding Adult Reviews and Liberty Protection Safeguards. A programme of joint work was initiated to ensure increased awareness of eligibility in relation to the legal requirements to provide advocacy including Independent Mental Capacity Advocates (IMCA), Care Act and Independent Mental Health Advocates (IMHA).

Partner agencies have used legal frameworks within formal supervision, clinical supervision, peer oversight and line management relationships to help put legal literacy into practice.

Safeguarding Adults Review Core Group (SARCG)

This group has a key role in organising and delivering the Reviews and then ensures that they are presented to the Board for discussion, dissemination of key learning and review amongst all partner organisations. In 2018/19, this group commissioned 6 Safeguarding Adults Reviews which aim to improve the quality of lives of people with care and support needs in Devon. Details of the Reviews published in 2018/2019 are set out later in this report

Learning and Improvement (L&I) Subgroup

The joint Devon and Torbay Learning and Improvement sub group has continued to focus on five work streams to support the Board in ensuring staff in all organisations are undertaking safeguarding training and that processes are in place to support improvements in practice. These work streams include Multi-Agency Case Audit; a Training and Competency framework review; DSAB commissioned training; Embedding Learning into Practice and the interface between Domestic Abuse and Sexual Violence with Safeguarding Adults.

Operational Delivery Subgroup (Ops Group)

The Operational Delivery Group is responsible for delivering the objectives set out in the DSAB Business Plan. The ODG considers multi-agency processes across Devon to ensure that there is effective communication and working practices in place that contribute to protecting members of the public from potential abuse.

The group works closely with the other sub-groups of the Board and will ensure that any potential duplication is minimised. This will be achieved through close communication between the DSAB, this group and the Chairs of the individual sub-groups

Community Reference Group (CRG)

The Community Reference Group includes people recruited from local Voluntary, Community and Social Enterprise (VCSE) and people with lived experience of safeguarding investigations across Devon

The CRG focus group supported the development of the new Safeguarding Website, and gave suggestions resulting in improved accessibility of the website. The CRG also helped Identify key priorities for future work, raise awareness of safeguarding and develop clear and understandable leaflets so that people who are going through safeguarding investigations can better understand what to expect.

11. What have we done in the last year?

The Devon Safeguarding Adults Board's Strategic Plan for 2018/2019 focuses on three key priorities. These priorities have guided our focus through the last year and helped to shape our practice.

Our 2018/19 priorities were:

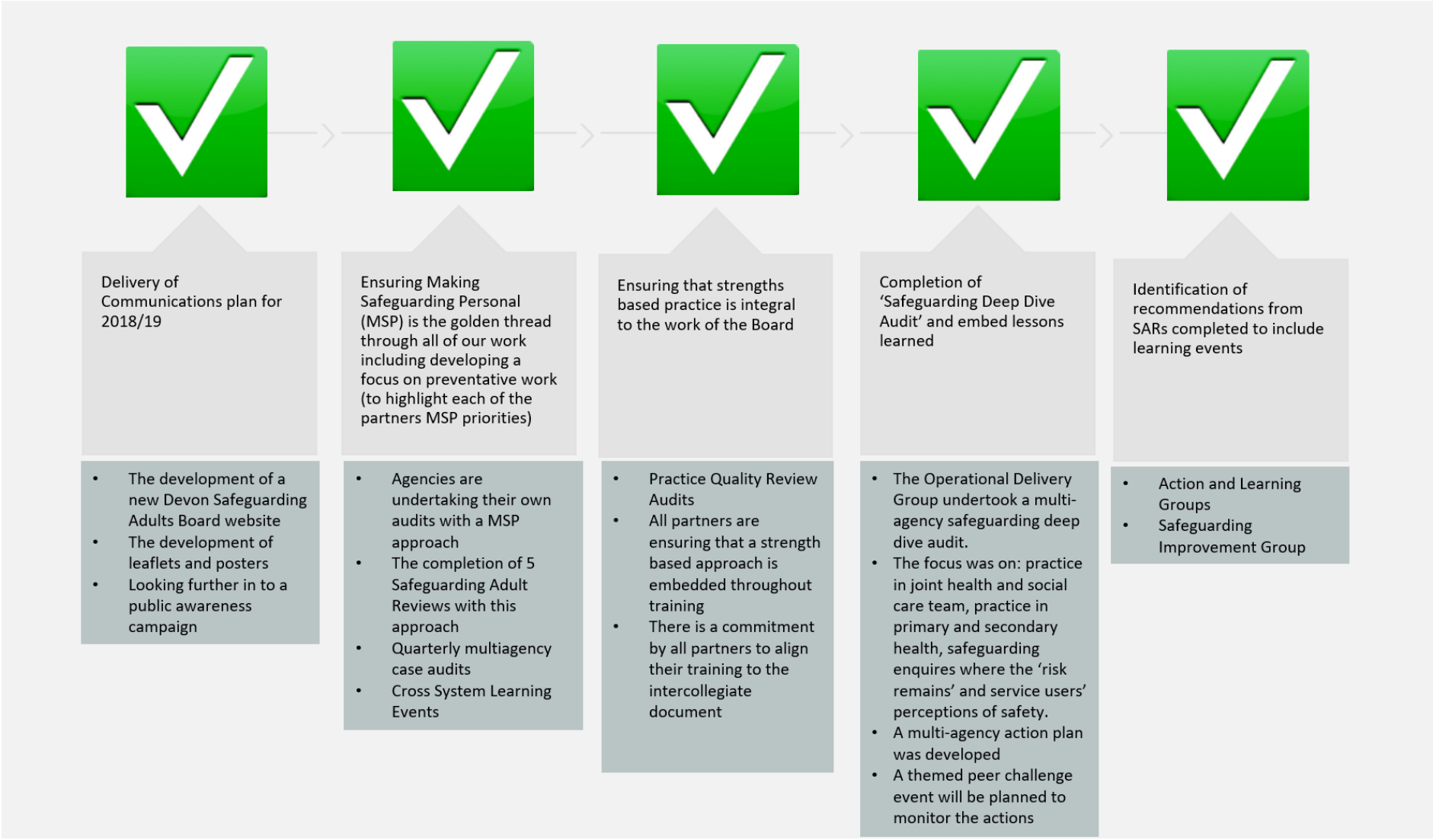
1. Ensuring that people in Devon feel safer

2. Protecting people from harm by proactively identifying people at risk, whilst promoting independence

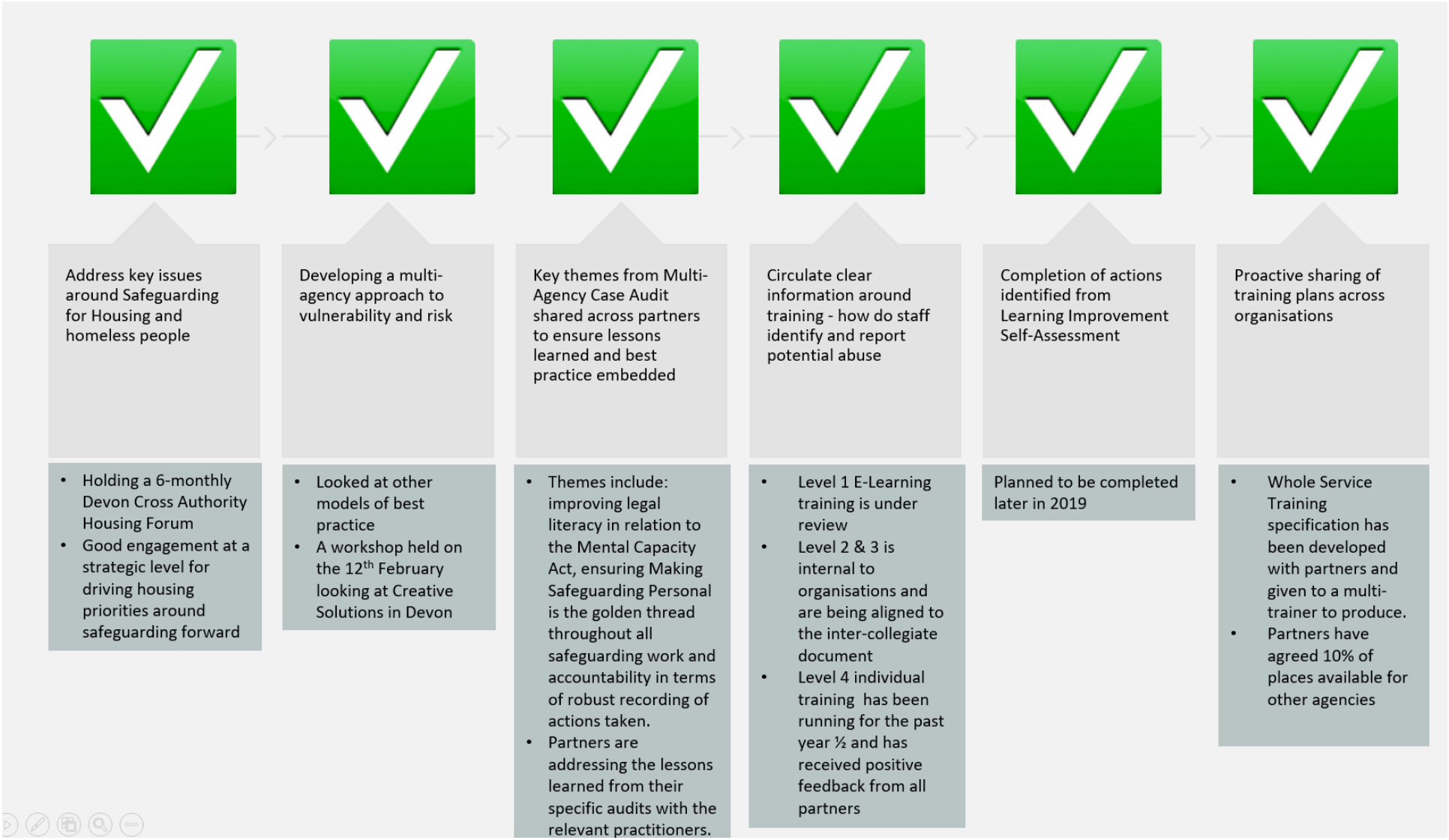
3. Increase legal literacy of practitioners in respect of the Mental Capacity Act

How have we addressed these?

Priority 1



Priority 2


Address key issues around Safeguarding for Housing and homeless people
Developing a multi-agency approach to vulnerability and risk
Key themes from Multi-Agency Case Audit shared across partners to ensure lessons learned and best practice embedded
Circulate clear information around training - how do staff identify and report potential abuse
Completion of actions identified from Learning Improvement Self-Assessment
Proactive sharing of training plans across organisations
• Holding a 6-monthly Devon Cross Authority Housing Forum
• Good engagement at a strategic level for driving housing priorities around safeguarding forward
• Looked at other models of best practice
• A workshop held on the 12th February looking at Creative Solutions in Devon
• Themes include: improving legal literacy in relation to the Mental Capacity Act, ensuring Making Safeguarding Personal is the golden thread throughout all safeguarding work and accountability in terms of robust recording of actions taken.
• Partners are addressing the lessons learned from their specific audits with the relevant practitioners.
• Level 1 E-Learning training is under review
• Level 2 & 3 is internal to organisations and are being aligned to the inter-collegiate document
• Level 4 individual training has been running for the past year ½ and has received positive feedback from all partners
Planned to be completed later in 2019
• Whole Service Training specification has been developed with partners and given to a multi-trainer to produce.
• Partners have agreed 10% of places available for other agencies

Priority 3

Identify actions from completed Safeguarding Adult Reviews (SARs) to capture the Mental Capacity Act themes

- Currently reviewing South West SARs

Improving overall understanding of legal literacy and practice

- A short paper is in development that raises awareness of the mental capacity act for staff and the public

Increase overall awareness of advocacy services across all partners

- A combination of increased contract capacity, the creation of easy-read flow charts for Independent Mental Capacity Advocacy (IMCA) and Independent Mental Health Advocacy (IMHA) and a revision of the referral form to clarify eligibility of IMCA has aided a reduction in the waiting list for IMCA's

12. Learning Events

In 2018/19 Devon Safeguarding Adults Board contacted the whole of the Operations Sub Group to ask about any learning events taking place within our partner agencies, these were some of the responses:

Livewell Southwest & Quality Assurance Improvement Team (QAIT) led some reflective learning following the closure of a care home last year

DSAB ran multiple learning events in relation to Safeguarding Adult Reviews (SARs) to better understand the barriers to effective multi agency working and as a means of sharing learning across the partnership

Devon County Council (DCC) led multi-agency reflective learning events following whole service safeguarding processes. These explored strategic and systemic issues arising from recent whole service enquiries processes

DCC Adult Social Care ran an action learning event following a South Gloucestershire Safeguarding Adults Review as DCC had placed one person within the care home investigated.

Devon Partnership NHS Trust have and continue to run events to feedback findings from Domestic Homicide Reviews and Safeguarding Adults Reviews to staff

The Clinical Commissioning Groups (CCG) delivered a safeguarding conference for Practice Nurses working in Primary Care

13. Partners' Key achievements 2018/19

Devon and Cornwall Police

- We continue to develop safeguarding processes to protect vulnerable adults from being exploited from drug dealers.
- We have commissioned an independent peer review from the College of Policing, examining its response to vulnerability, and the recommendations from that review have been incorporated into the force safeguarding processes
- We are a key member of a multi-agency process to better identify vulnerability amongst adults, encouraging 'professional curiosity' and better signposting
- We have strengthened our processes to ensure recommendations from Safeguarding Adult Reviews and will be taking these forward, primarily through the Force Safeguarding Business Board.

HMP Exeter

- HMP Exeter was subject to an Urgent Notification protocol following the HMIP (Her Majesty's Chief Inspector of Prisons) visit in 2018 and has worked with support to move out of this process. A follow up visit from HMIP (the Independent Review of Progress) identified improvements in safety for men residing in HMP Exeter. This was achieved through a reduction in violence and assaults.
- HMP Exeter has improved systems for people coming into custody to identify risk factors and to take the appropriate action once identified, by offering support through the 'Challenge Support and Intervention Plan' (CSIP) and the 'Assessment, Care in Custody and Teamwork' processes.
- Prison staff are supported by the Mental Health Team when any concerns around mental capacity are raised and individuals can be discussed at multi-professional case conference clinics to ensure support from healthcare, social care and prison staff is linked together and appropriate information sharing which ensures that support takes place.

Devon County Council Adult Social Care

- Devon County Council (DCC) have a risk profile tool used by the Quality Assurance and Improvement Team to identify services that might benefit from support. There are regular 'quality huddles' which feed in to this strategic county wide meeting.

- Level 2 & 3 internal safeguarding adult training has been revamped in line with the intercollegiate document, as agreed by all partners at the DSAB. In addition, DCC has proactively worked with Children's Services to ensure the co-delivery of new Domestic Abuse training to all social work staff within care management services. Further work is planned with Children's Services around joint protocols for working with parents with disabilities and whole service safeguarding across children's and adult services.

- DCC is developing a practice model based on promoting independence and has developed a significant workforce plan to support workforce organisational change. This forms part of a disability transformation initiative which centres on our aspirations for how we work with people who experience an intellectual disability, mental health issues and/ or autism. This focuses on strengths-based approaches, risk and decision making, the provision of solution focussed approaches training, seminar-based workshops on specialist areas of practice e.g. working with those with intellectual disability and autism and stronger links with advocacy.

- DCC has worked with the Safer Devon, Partnership, Devon Safeguarding Adults Board and Devon Children & Families Partnership to develop an 'Exploitation Toolkit'. This toolkit is for anyone who, through their paid or voluntary work, may encounter people who are vulnerable to exploitation. It will support people to understand, identify and report signs of exploitation, and access guidance and support. In addition, DCC has developed a risk assessment tool for professionals to use for assessing risk and impact.

- DCC is in the process of reviewing its Mental Capacity Act training offer to its staff to ensure that it is fit for purpose and supports people to understand decision making; particularly where there are issues around undue influence or unwise decision making. DCC is recruiting a Mental Capacity Act Practice Lead Practitioner responsible for supporting the development of best practice guidance and learning and development by end of 2019.

Northern, Eastern and Western (NEW) Devon and South Devon & Torbay Clinical Commissioning Groups (CCGs)

- During 2018/2019, NEW Devon CCG and South Devon & Torbay CCG safeguarding teams worked as an integrated team. As a commissioning organisation we ensure that safeguarding is a key requirement of any tender process and is embedded within all contracts.

- The CCG developed and implemented a Safeguarding Training Strategy ensuring that all staff completed safeguarding training appropriate to their role. Training supports staff to identify and respond to safeguarding concerns whilst acknowledging the need to promote the independence. Training compliance is monitored and regularly reported to the CCG Quality Assurance Committee.

- The CCG's Mental Capacity Act (MCA) Lead has developed a support network among the MCA leads of NHS providers to discuss case law and learning relating to the Mental Capacity Act. Additionally, a key element of their role is to support CCG staff in meeting their legal requirements.

National Probation Service (NPS)

- The National Probation Service and Devon & Cornwall Police are the lead agencies for managing dangerous individuals under Multi Agency Public Protection Arrangements (MAPPA). The NPS also contribute to other partnerships, such as Multi Agency Safeguarding Hubs (MASH), Multi Agency Risk Assessment Conferences (MARAC), Integrated Offender Management (IOM) meetings which support the management of the safety and welfare of people of Devon.

- In all cases, for people supervised by the NPS, the risk of harm posed is assessed and a Risk Management Plan is identified. This can include referrals to adult safeguarding where appropriate.

- All NPS Practitioners are required to attend safeguarding training every 2 years, including relevant guidance on safeguarding legislation. In addition, the NPS uses MAPPA to seek advice, support and guidance from safeguarding professionals when required to manage cases safely.

RD&E Hospital

- We have built on the work undertaken in the Trust last year to raise awareness of domestic violence and continue to train more staff. Since April 2019 we have a full time Independent Domestic Violence Advisor funded by Pathfinder Project to support staff and patients.

- We have developed information leaflets for patients about the safeguarding adult process. This information gives patients and their families the key messages and opens a route for further discussion. The leaflets have also been useful for junior staff members to understand the safeguarding process and to give them confidence to talk to patients and their families about safeguarding

- Awareness of County Lines, Modern Slavery & Human Trafficking has become embedded within the Trust, with more staff considering this as an issue when talking to the people they meet and considering their personal circumstances. This has resulted in safeguarding referrals being made.

Devon Partnership Trust (DPT)

- By ensuring that patients in DPT are routinely offered information about safeguarding and that bespoke posters and leaflets about safeguarding are displayed in all clinical areas and waiting rooms.

- Over 85% of our registered clinicians have now completed their Level 3 Safeguarding Training (in both adults and children) ensuring they can proactively identify those who may be at risk. Integration of the risk management system with safeguarding ensures robust oversight of all incidents reported to identify any patterns

- Training on the Mental Capacity Act is mandatory for all clinical staff working for Devon Partnership Trust and audit of completed assessments is reported through the Mental Health Act Scrutiny Committee and ultimately to the Trust Executive Committee. This ensures robust oversight of the implementation of the legislation. Lessons from enquiries and incidents relating to legal literacy are implemented across the Trust and shared with all clinicians through a variety of means including bi-monthly internal Safeguarding Bulletin.

Public Health Devon

- The Safer Devon Partnership has worked on several initiatives with the Safeguarding Adults Board to prevent and tackle the exploitation of vulnerable adults such as the development of the Preventing Exploitation Toolkit for frontline professionals and continuing the work of the following Working Groups: the Dangerous Drugs Network (County Lines) Partnership and the Anti-Slavery Partnership

- The Safer Devon Partnership (SDP) and Public Health Devon have worked with the Safeguarding Adults Board on establishing a 'Creative Solutions' Forum and SDP has continued to work collaboratively with the Safeguarding Adults Board on Domestic Homicide Reviews/Safeguarding Adults Reviews. It has recently published a briefing note for frontline professionals which summarises the learning from three Domestic Homicide Reviews which involved older couples

- Public Health is leading on the work in relation to drug-related Deaths. The whole ethos of Drug & Alcohol Service interventions is about keeping individuals, families and communities safe. The commissioned Sexual Violence & Domestic Violence & Abuse service works with people at highest risk of severe harm from domestic violence and abuse. Over the past two years we have developed clinical enquiry in primary care that has successfully identified people who have experienced or are experiencing serious domestic violence and abuse and work with perpetrators has continued to progress.

University Hospitals Plymouth NHS Trust

- Refined systems and processes for referral to safeguarding teams within the trust and to multi-agency partners.
- UHP response - Increased the frequency of publicity publishing improving the profile of the team and ensuring up to date information is available to staff.
- Trained 700+ staff to ensure a deeper understanding of the use of the Mental Capacity Act and correct use of DoLS.

South Western Ambulance Service NHS Foundation Trust

- The safeguarding service has begun to liaise more closely with some Local Community Safety Partnerships (LCSPs). These statutory partnerships have responsibility overview of local delivery of strategies for domestic abuse prevention and other safeguarding issues. In some regions within the area of operation of the Trust, some Lost Adult and Child Safeguarding Boards and Partnerships and LCSPs have announced their intention to merge into single partnerships within the next couple of years.

- The service manages allegations by: setting up a weekly confidential peer-review meeting for case discussion to improve the consistency of decision-making within the safeguarding team; provided training, assisting managers and HR to make decisions about making disclosure and barring (DBS) referrals; and the Safeguarding Service works collaboratively with the Trust's Learning and Development Team to develop and plan safeguarding training for staff. This enables key themes emerging from safeguarding activity and analysis to be embedded in the training

Torbay and South Devon NHS Foundation Trust (TSDFT)

- The safeguarding 'Golden Thread' theme is embedded in mandatory safeguarding adult training for all staff, linking to the Human Rights Act principles, NHS Constitution and Trust core values. Making Safeguarding Personal is embedded as baseline principle of safeguarding adult practice at all levels of safeguarding adult training. Safeguarding Adult Review (SAR) learning posters have been developed for dissemination for all staff, covering key themes from a regional thematic review which directly links to how staff say they want to be kept informed of SAR learning feedback.

- The Trust is a core member of the Torbay Safeguarding Adults Board / Devon Safeguarding Adults Board Learning and Improvement sub group with membership extended to include The Trust's Head of Education and Workforce development. All staff receive notice of safeguarding training required for their role and when an update is required. Compliance has been consistently within Trust targets of 90% or above for level 1, 80% for all other levels. 'Prevent' training data is compliant with local Clinical Commissioning Groups (CCG) targets. The Learning & Improvement sub group safeguarding adult

self-assessment tool has been updated and presented to the TSDFT safeguarding governance committee.

- The trust is a core member of Mental Capacity Act (MCA) Sub Group and also the regional MCA Network. MCA training feedback is collated regarding knowledge impact and the MCA training framework identifies what level of training is recommended to all staff

Northern Devon Healthcare NHS Trust

- The Trust focussed internally on systems and process including enhanced access and support from independent Domestic Violence Advisors and running of information campaigns around Hate crime and PREVENT.

- We have worked with our community teams and wider social care to identify risk with some key projects to enhance support at home including work with Devon and Somerset Fire and Rescue Service, equally ensuring standard questions around risk of harm are asked at ED attendances.

- Significant work has been undertaken with clinical teams both at a work based level and enhanced training to increase confidence and assurance around MCA.

Dorset, Devon and Cornwall Community Rehabilitation Company (CRC)

- We have developed a benchmark for practice for safeguarding adults which has been shared with all teams across Devon. The standard sets out expected practice when working with vulnerable adults and sits alongside the Safeguarding Policy for the organisation.

- We have worked to increase understanding in relation to 'mate crime' and share learning across the region as to effective approaches in assessing and managing risk presented to and by our service users in relation to others.

- We have promoted and encouraged our practitioners to access the Devon Exploitation Toolkit to help improve skills and knowledge in identification and interventions. We have also promoted the Plymouth Exploitation Screening Tool across the teams

Health Watch Devon

- Healthwatch Devon is a consumer champion organisation for Health and Social Care across Devon. Over an annual period, we might receive in excess of 400 Speak Out Forms from members of the public bringing to our attention matters that concern them most about Health and Social Care. In 2018-19, seven cases warranted reporting to the authorities responsible for personal safety and safeguarding. Healthwatch Devon partner, Citizens Advice Devon, provide a team of Healthwatch Champions who follow the national Citizens Advice Safeguarding policy and procedures. The principles are used to guide safeguarding activities. Fundamental to this policy is our aim to involve the client in decisions about what should happen wherever possible
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- Healthwatch Devon undertakes Enter and View visits to Health and Social Care services. We have worked with the Devon County Council Quality Assurance Improvement Team in order to extend our Good Care Matters programme. Reports are generated detailing findings from our visits, any concerns and any subsequent recommendations.
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- Our Citizens Advice HWD Champions have worked closely with the England Illegal Money Lending Team to raise awareness of loan sharks and the incidence of illegal money lending in Devon. Citizens Advice local offices are introducing a new approach to gender violence and abuse, training all volunteers and staff so they can approach the issues as a routine enquiry during face to face interview

14. Learning from Safeguarding Adults Reviews (SARs)

The Care Act 2014 specified that it is the duty of a Safeguarding Adults Board (SAB) to commission SARs under the following circumstances:

(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) condition 1 or 2 is met.

(2) Condition 1 is met if –

a) the adult has died, and
b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)

(3) Condition 2 is met if –

a) the adult is still alive, and
b) the SAB knows or suspects that the adult has experienced serious abuse or neglect

SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.

We set out below the summaries of SARs which were completed and approved by the Board in 2018/ 2019. For those SARs published, the full details are on the DSAB website. Full publication is not mandatory, and decision are made on a case by case basis.

Summary of SAR Sally (approved by the Board in September 2018, awaiting publication)

Sally was 26 years old when she died on 14th October 2015. The Coroner gave a verdict of natural causes contributed to by neglect. The pathologist gave a cause of death of Bronchopneumonia with side effects of opiates (prescribed) in a female with physical, psychological and nutritional compromise.

Sally had 2 young children who had been placed in the care of their paternal grandmother and a husband who, although not always living with her, was described as her main family carer. She had been known to mental health services since the birth of her second child in 2011. She had a history of drug misuse and self-harm. Sally had been diagnosed in October 2013 with peripheral sensory neuropathy and having rejected the physiotherapy offered, the illness left her with very little mobility. She eventually spent long periods in bed sleeping and was unable to attend to any of her personal care needs without help. Sally was in receipt of care and support from various services including personal care in her home.

In the 6 months prior to her death Sally made a number of allegations against her husband namely that he left her without care for several days, stole money from her and ultimately that she did not feel safe in the house with him. However, she went on to withdraw these statements and did not want any action taken.

Summary of SAR Adrian Munday (published in December 2018)

Adrian Munday (51) died on 6th October 2015. Police were called to Adrian's home where they discovered his body, following a fire which had occurred in his accommodation. A forensic post mortem held on 15th October established that Adrian had suffered significant trauma injuries not consistent with a fire, and a murder enquiry was instigated.

On 17th October 2015 SH was arrested on suspicion of Adrian's murder. He was later charged with the murder of Adrian between 2nd and 6th October 2015. SH was found guilty of murder on 14th June 2016. The court heard that SH had met Adrian on 18th September 2015, had moved into Adrian's accommodation, and had exploited him for money and his possessions. Adrian had received significant injuries all over his body, his death was caused by head and brain injuries. SH had set fire to his body. SH was given a life sentence. He was diagnosed with cancer whilst serving this sentence [while on remand] and died in prison on April 2nd 2017.

At the time of his death Adrian was being supported by a care agency and was seen regularly by a Recovery Coordinator and a Psychiatrist according to his Care Programme Approach plan.

Summary of SAR Rita (approved by the Board in March 2019, awaiting publication)

Rita was a woman in her late 40's, who had been admitted to hospital on 14th October 2017 following a 111 call by her partner as he was concerned about her apparent breathing difficulties. She did not recover consciousness. The initial Safeguarding referral from the hospital outlined significant concern about her physical condition, a significant number of what appeared to be burn marks on her body and known IV drug use. The medical cause of death was Infected Endocarditis and Intravenous Drug Use. Rita had a history of illicit drug abuse and was known to inject intravenously. This led her to develop infected endocarditis, from which she died on 20th October 2017 at Hospital. The Coroner concluded that Rita's death was drug-related. Rita had a diagnosed mild learning disability and was known to a number of agencies. There was concern in relation to self-neglect and that Rita had withdrawn herself from services in the year prior to her death.

Review findings/themes from these examples:

- The importance of **involving the person** when working with them and ensuring **continuity of care** across organisations
- The importance of **engagement with families** in support planning, risk assessment and management of the work
- **Inter-agency working -** the need for a clear process for **identifying a lead agency** in complex cases where there are many agencies involved in supporting an individual or family.
- Staff need to be clear when they can and must **share information** appropriately to understand and respond to risk
- Staff knowledge of the **Mental Capacity Act** must improve
- The importance of **professional curiosity and challenge** at all times when working with individuals at risk
- The need for professionals to have access to robust safeguarding training to promote their understanding of and ability to work within an **intimidatory atmosphere** and ban understanding of its **impact on professional practice.**
- There was a missed opportunity to work in a collaborative way under **safeguarding** in relation to **self-neglect.** This would have provided a multi-agency framework. The framework does not give any additional powers to act, however would have brought recognition that management of the risks required **multi-agency collaboration**; clarity on seeking consent to **share information**, or to justify sharing it without consent; **assessment of the level of risk** based on more informed input; and a **shared record** of what had been agreed.
- The need for professionals (practitioners and commissioners) to ensure effective **communication and coordination** in high risk, highly complex cases.
- Staff need to have effective **awareness of services available** alongside a thorough understanding of the Care Act (section 42) which describes the requirements to respond to safeguarding concerns, investigate and proceed to Enquiries.

15. What are our plans moving forward?

As highlighted in this report, the DSAB has made a number of achievements this year, however there continues to be a number of areas requiring further work and focus. Our Strategic Plans for 2019/20 aim to measure our progress in achieving our targets

Strategic Priorities 2019/20

1. **Finding the right solution at the right time for the most at-risk people.**

   Key goals:

   - Promote multi-agency communication, ensuring cooperation as the underlying principle of frontline social care work.
   - Equip all agencies with the tools to promote collaboration and integration, making sure agency frameworks allow for the sharing of information.
   - Support the development of a unanimous understanding of what vulnerability and exploitation is.
   - Ensure the Making Safeguarding Personal (MSP) framework is embedded in staff practice

2. **Increasing the public awareness of Safeguarding**

   Key goals:

   - Increase public knowledge regarding the recognition of abuse and/or exploitation.
   - Promote the reporting of abuse from the public.
   - Encourage a sense of community responsibility for safeguarding within all communities.
   - Improve the understanding of safeguarding amongst Black, Asian and other minority ethnic groups through effective engagement and increased awareness

3. **Improving the experience of children transitioning (moving) to adult services, working together to ensure they remain safe.**

Key goals:

- Ensure early intervention systems are in place
- Increase awareness on trauma and adverse childhood experiences to inform and shape future practice.
- Ensure commissioning arrangements for transitional periods are in place and effective.

4. **Increasing our staff understanding of the law in relation to Safeguarding Adults.**

Key goals:

- Increase legal literacy regarding the Mental Capacity Act and Liberty Protection Safeguards.
- Increase awareness and understanding of Restrictive Intervention and Seclusion
- Ensure professionals have a current, working understanding of legislation and are competent at putting it into practice.