LUTON BOROUGH COUNCIL

SCRUTINY: HEALTH AND SOCIAL CARE REVIEW GROUP	AGENDA ITEM 6

DATE OF MEETING: 17th November 2011

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SUBJECT: Safeguarding Adults Annual Report 2010-11 and Update

PURPOSE:

1. To present the 1 April 2010 – 31 March 2011 Annual Report of Luton's Safeguarding Adults Board to the Health and Social Care Review Group, and update on significant developments that have taken place since then. The latter includes the Independent Review of Safeguarding Adults and proposed changes to the way safeguarding adults are managed in Luton.

RECOMMENDATIONS:

2. Members are asked to note this report and the annual report and are encouraged to ask questions about safeguarding adults in Luton.

REPORT:

3. An extract from the Safeguarding Adults Annual Report, providing an introduction and overview of the report by Professor Michael Preston-Shoot, Chair of Luton Safeguarding Adults Board is attached as Appendix A. Due to the large size of the actual report, it is available to view on request from Democratic Services.

4. Key developments that have taken place include:

- The decision by the multi-agency Board (taken in April) to follow the recommendations made by the Law Commission (endorsed by the Association of Directors of Adult Social Services ADASS) and replace the word '*vulnerable adult'* with '*adult at risk of significant harm';*

- Related to this and the Independent Review the decision was made to work more closely with colleagues in the two Bedfordshire Councils (who share a joint Safeguarding Board) and adopt their policy and procedures (in principle);

  Bedfordshire has also agreed a change in wording, so their policy covers: adults at risk who are 18 and over who may be eligible for community care services, whose independence and well being would be at risk, permanently or periodically, if they did not receive appropriate support and who may be at risk of abuse, maltreatment or neglect. This includes adults with physical, sensory and mental impairments and learning disabilities however those impairments have arisen e.g. whether present from birth or due to advancing age, chronic illness or injury, and those who may or may not be eligible for community care services whose needs in relation to Safeguarding is for access to mainstream services and the police. Their policy also covers carers and self-funders;

- The decision, as a result of the Review, to increase strategic capacity by creating a post of Strategic Safeguarding Manager and establishing a larger central team to make the decision on safeguarding alerts (following Bedfordshire) and deal with all investigations involving paid staff (from all agencies) and volunteers. These changes which propose forming a team that also includes three safeguarding managers and three social workers are currently at the formal consultation phase with staff;

- A review of governance arrangements for the multi-agency agency safeguarding board, with new arrangements being introduced from November 2010. Under the new arrangements, there is a Safeguarding Adults Board (LSAB) attended by very senior officers from partner agencies and the Portfolio Holder for Adult Social Care. This Board sets strategy and monitors the effectiveness of safeguarding arrangements, and there is an Executive Board under this with wider membership that deals with systems process and receives more detailed reports. Both Boards are chaired by the Independent Chair Michael Preston Shoot, from the University of Bedfordshire;

5. The Annual Report also covers:

- Information on the number of safeguarding adults' alerts and investigations. 672 alerts were received, of which 412 led to further investigations. Although there was only a minor increase in the number of alerts since the previous year, significantly more cases 123 (42.5%) required investigation which has placed a strain on staffing resources, not only for Adult Social Care Assessment and Care Management teams but also for partner agencies especially NHS colleagues;

  The LSAB has linked this increase to poor quality standards in care providers (8% of alerts related to one provider that has now closed) as well as increased awareness and understanding of front line practitioners resulting in a higher level of appropriate alerts. As a result of concerns about care providers and the need to use the serious establishment concerns procedure on 11 occasions, revisions to pathways and contract specifications have been made for some services and an escalation procedure to tackle serious concerns has been drafted. (This is currently being considered by Bedfordshire and will be consulted on with independent providers before being finalised);

- Information on serious case reviews including the high profile Michael Gilbert case;

- The work of partner agencies including: NHS Luton (the PCT), the Luton and Dunstable hospital, SEPT (MH Trust), CCS (previously NHS Luton Community Services) and Bedfordshire Police Vulnerable Adults Investigation Unit;

- Training, covering Safeguarding Adults, Mental Capacity Act and DOLS Training and the Staff Competency Framework for Safeguarding Adults developed in partnership with Bedfordshire;

- Case examples of how we are applying the Care Quality Commission's (CQC) Essential standards for safeguarding in Luton;

- Work undertaken to deliver the Council's and the NHS's responsibilities under the Mental Capacity Act and DOLS. This includes raising awareness of and meeting the statutory timescales for DOLS assessment which came into force in April 2009;

- The Safeguarding Boards Business Plan for 2011 /12.

6. The Independent Review considered:

- Recent developments in safeguarding nationally including changes in the role of the regulator, and policy developments including the work of the Law Commission;

- The views of stakeholders, including a staff and care home survey;

- The way safeguarding is managed in other authorities, including benchmarking information from 25 councils. This work identified seven models in use;

- How well safeguarding adults is operating in Luton using various frameworks for analysing information and performance.

7. The independent consultant presented the report and made several recommendations to the Safeguarding Board at the meeting in April 2011. The key recommendations included:

- Increasing strategic capacity, working more closely with the Bedfordshire Safeguarding Board and adopting their policy and procedures;

- Establishing a larger central team which will make the decision on alerts and oversee the investigations in all cases involving employees and volunteers;

- Co-locating staff with partner agencies and that partner agencies should contribute towards core costs including the cost of the strategic post, the independent chair, serious case reviews.