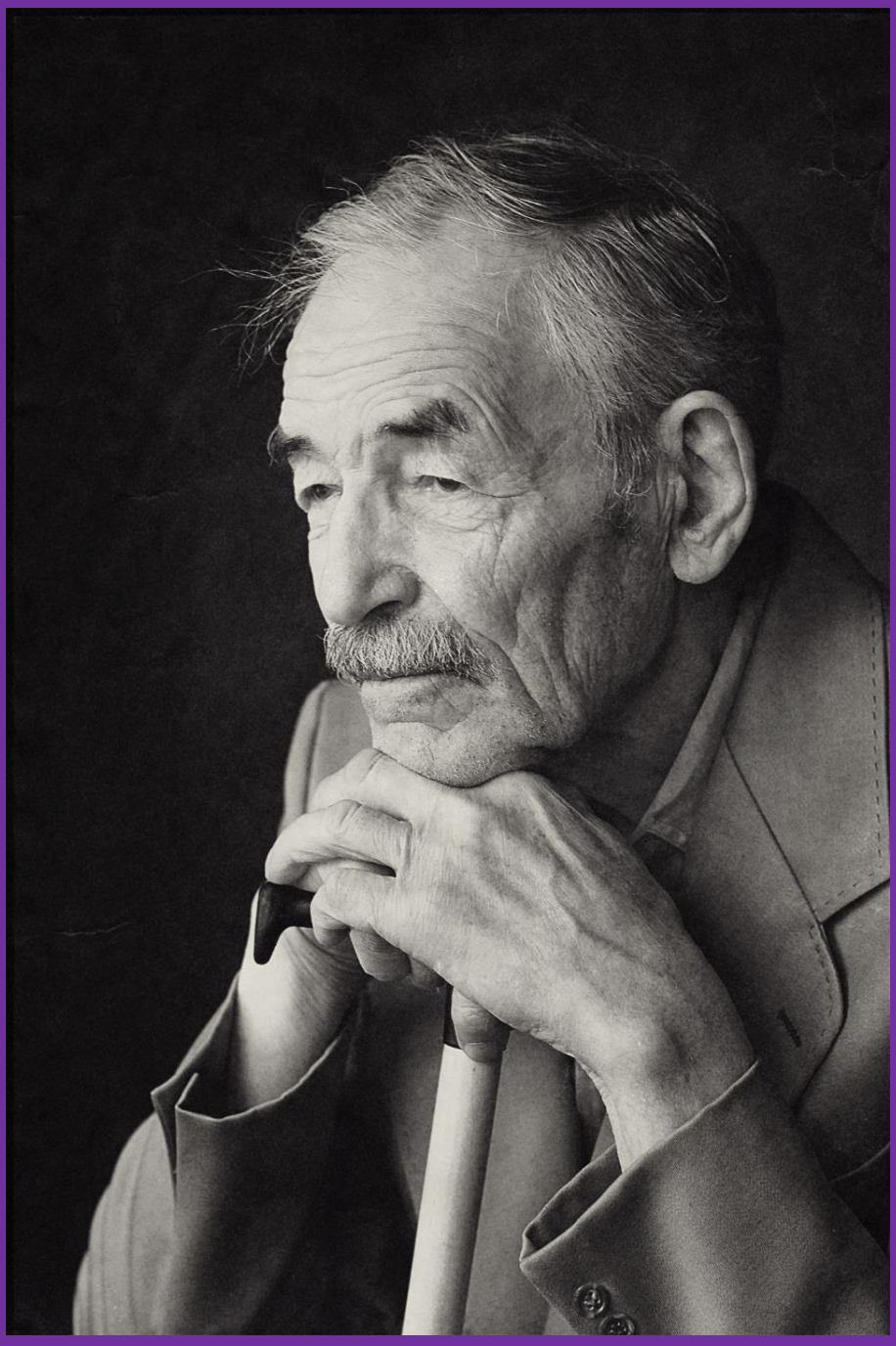
Northamptonshire Safeguarding Adults Board



Annual Report 2020-2021

Northamptonshire Safeguarding Adults Board

Contents

Foreword from Stuart Lackenby

Welcome to the Annual Report 2020-21 for Northamptonshire Safeguarding Adults Board (NSAB).

I joined West Northamptonshire Shadow Authority in December 2020 as the Executive Director for Adults, Communities and Wellbeing (DASS) and took over the chairing of NSAB in April 2021. I am writing this foreword as the new Chair of NSAB, following the departure of Tim Bishop at the end of March. Tim spent five years as the Independent Chair during that time, he had seen some significant changes, not least to Adult Social Care. With the formation of the two new unitary North and West Northamptonshire Councils from 1st April 2021, it was a good opportunity for Tim to hand over the reins. I would like to thank Tim for all his hard work during his time as Independent Chair and for the ongoing development of NSAB in those five years.

To reflect on the last year, I have to acknowledge the Covid-19 pandemic and the incredibly challenging time it's been for us all. Covid-19 has had such an enormous impact on us all, with many suffering the loss of family, friends and colleagues. On behalf of NSAB, I would like to thank all front-line staff who were there to support people through a very difficult time and to help protect lives – we are very proud of you all. On a brighter note, the success of the vaccination programme has given us all hope for a return to less restrictions and more normality.

During the year, Northamptonshire received 5,118 safeguarding concerns, and of those, 1,368 were safeguarding enquiries. These figures were on a par with the numbers seen in 2018-19 (5,390 concerns and 1,682 enquiries).

The Communications & Engagement Sub Group started the year with a focus to engaging with citizens and staff, but this was hindered greatly due to the pandemic. Instead, a social media campaign was launched in July 2020 entitled #Report It (the image on the front of this report was used in the campaign). #Report It helped to raise awareness to staff how to report safeguarding concerns, which was even more important during the lock down (see more information on page 4).

There were two ongoing Safeguarding Adult Reviews (SARs) and three new SARs during the period. Further details can be found on pages 10-14.

For many of our colleagues, the focus was on keeping people safe; for NSAB and the Business Office it was business as usual but like many, we had to embrace different ways of working such as making better use of technology including Microsoft Teams but this has enabled us to continue overseeing the effectiveness of safeguarding across the county. Moving forward, this new way of working will help us as a partnership to save valuable officer time holding meetings on 'Teams' rather than having to travel across the county, or indeed, the country.

I hope you find the annual review of interest and that we evidence the huge amount of work that goes on to help protect those most at risk in the county.

Stuart Lackenby
Executive Director for Adults, Communities and Wellbeing (DASS) and
Chair of Northamptonshire Safeguarding Adults Board

Northamptonshire Safeguarding Adults Board

The purpose of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect the welfare of local adults who may be at risk of abuse and harm. This is in accordance with the Care Act 2014 and supporting statutory guidance.

Northamptonshire Safeguarding Adults Board (NSAB) is made up of senior officers nominated by partner agencies including statutory partners such as the local authority, police and the clinical commissioning group. Members have delegated authority to represent their organisation and to make decisions on their agency's behalf.

NSAB's vision is:

'Working together to keep people safe'

During the period 1st April 2020 to 31st March 2021, the Strategic Board continued to be supported by the operational Delivery Board and four Sub Groups; Communications & Engagement – Learning & Development – Quality & Performance and Safeguarding Adults Review.

There were no new declarations of interest received by members during the year.

Safeguarding Adults Boards have three core duties under the Care Act 2014:

- Publish a strategic plan for each financial year and its strategy for achieving its objectives;
- Publish an annual report including what has been achieved during the year, what it has done to implement the strategy, what members have achieved and findings of reviews; and
- Conduct Safeguarding Adult Reviews in accordance with Section 44 of the Care Act

Annual Report Overview

The Annual Report 2020-21 provides an overview of the Board's achievements against the NSAB Strategic Plan 2019-21 for the period 1st April 2020 to 31st March 2021.

A little later than normal and due to the outbreak of Covid-19, the Strategic Plan was reviewed virtually and agreed by the Board in May 2020.

The Strategic Plan is aligned with the six key principles as outlined in the Care Act:

Empowerment
People are supported and encouraged to make their own decision and informed consent.

Prevention
It is better to take action 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.

Accountability
Accountability and transparency in delivering safeguarding.

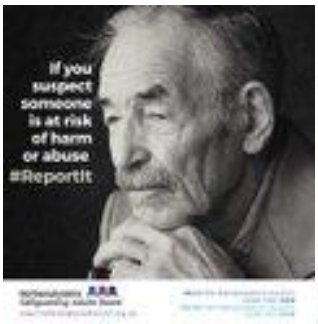
Progress and Achievements

For the period 2020-21, NSAB agreed three key priorities in line with other Adult Safeguarding Boards in the East Midlands region, namely: Prevention, Quality and Making Safeguarding Personal (MSP). These were incorporated in the Strategic Plan 2019-2021. The progress against the Plan is detailed below:

Empowerment and Prevention

Communications & Engagement Sub Group

- Plans put in place to launch a NSAB Twitter account in April 2020. For the period to 31st March 2021, NSAB gained 248 followers.
- July 2020 - Launch of a virtual poster campaign #Report It asked organisations to display posters in the workplace to raise awareness of how to report safeguarding concerns. Results of the launch highlighted 175+ new site users in July and August and 1,857 visits to the website[1]. See images below used in the campaign.



- November 2020 - A generic safeguarding survey was issued to agencies and service users to help NSAB understand if people knew how to report safeguarding concerns. 271 responses were received. The findings showed that 90% would report abuse if they saw it, but 45% said they would not know who to report a safeguarding concern to. The campaign was also well supported by agencies on Twitter, with 7,995 Tweet impressions for one Tweet[1].
- December 2020 – A leaflet for customers explaining the Adult Risk Management (ARM) process was approved and shared with members and made available on the website.
- January 2021 – The group undertook further social media coverage for the #ReportIt campaign to coincide with the national lockdown and address the findings seen in the survey results.
- The NSAB website was regularly reviewed and updated to provide a range of information to support both the public and practitioners.
- Awareness of the Adult Risk Management (ARM) process continued with a view to commencing a regular Oversight Panel to support partners with new referrals or where advice was needed for new cases.

Learning & Development Sub Group

- August 2020 - A training assurance return audit was undertaken which highlighted that partner agencies achieved a benchmark of between 87+% and 100% of staff had undertaken safeguarding adults training.
- October 2020 – Assurance was sought from partner agencies that learning opportunities were still available during the Covid-19 outbreak. The results of the exercise were reassuring.
  December 2020 – Development of a video to raise awareness of the ARM process began.
- February 2021 - 300+ e-learning courses completed by staff working in the voluntary & community sector and care home providers.
- Learning briefings for Multi Agency Case Audits (MACA) Homelessness and Mental Health were published on the NSAB Website following multi-agency case audits undertaken by the Quality & Performance Sub Group.
- Work started in partnership with University of Northampton (UoN) to develop level 4 SAR training.
- Preparations were put in place to host learning events for Safeguarding Adult Reviews (SARs) 016 'Dean' and 019 'Jonathan' following publication of the SARs.

[1] Source – Comms & Media Update Report – 9th December 2021

Quality & Performance Sub Group

- Multi-agency task and finish groups were convened to review and refresh a number of policies and procedures including: Complaints Policy; Escalation Policy; The Inter-Agency Policy & Procedures; Safeguarding Adults Review Protocol; Serious Incident and Safeguarding Protocol; Quality Assurance Framework. The ARM Toolkit was also updated.
- Composite plans for SARs 008 and 010 were reviewed for progress made throughout the year.
- The Risk Register was reviewed and updated.
- *Due to the Covid-19 pandemic, work on multi agency case audit activities was hindered.*

Safeguarding Adults Review Sub Group

- March 2021 - Safeguarding Adult Reviews 016 'Dean' and 019 'Jonathan' were published. See pages 12-14 for further details.
- Reassurance was sought from housing colleagues that light touch reviews were taking place in advance of consideration of SARs.
- Improved SAR governance was developed and put into place.
- Worked in partnership with the University of Northampton (UoN) to develop training for SAR Sub Group members.
- Following the publication of Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 full report in November 2020, an action plan was put into place to review and implement local recommendations.

Proportionality, Protection, Partnership and Accountability

- Four strategic board meetings were held during the year with 100% attendance from members representing statutory partners. Due to the Covid-19 pandemic these meetings were held virtually via Teams.
- From April 2020, all NSAB, Delivery Board and Sub Group meetings were held virtually via Microsoft Teams (Teams) due to the Covid-19 pandemic.
- There was also good attendance and participation from members at NSAB, Delivery Board and all Sub Group meetings. Again, meetings were held via Teams.
- The Delivery Board focused on members' operational activities made against the priorities and five themes in the Strategic Plan 2019-21; domestic abuse, suicide prevention, street homelessness, serious organised crime and adults that don't meet the need for statutory services. Updates were received at Delivery Board meetings throughout the year to highlight programme, key issues and to provide assurance to members.
- The Chair of the Delivery Board provided updates to the Strategic Board on a quarterly basis and highlighted good practice and key issues.
- The NSAB Annual Report for 2019-20 was published and received by the Health & Wellbeing Board and Northamptonshire County Council Full Council.
- Membership of the Boards and Sub Groups were reviewed and appropriate challenge was made where necessary.
- At the outset of the Covid-19 emergency, the Independent Chair advised statutory partners that the Business Office would maintain a Business Continuity and Safeguarding Framework to provide assurance that safeguarding adults at risk continued in the county, and that we would use details from Local Resilience Forums, and details from Gold and Silver meetings to populate the framework – in line with Annex D: Safeguarding Guidance of the Care Act easements: guidance for local authorities Updated 1 April 2020.
- Northamptonshire County Council's Adult Social Care took strategic ownership of the Adult Risk Management (ARM) process.
- NSAB received quarterly updates from Northamptonshire County Council's Adult Social Care on Safeguarding, the Target Operating Model, and the transition to the unitary councils.
- Adult Social Care also provided quarterly updates on the Deprivation of Liberty Safeguards (DoLS) assessments and progress on the transition to Liberty Protection Safeguards (LPS).
- Representatives from St. Andrew's Healthcare attended NSAB to update the Board on their Care Quality Commission action plans.
- An annual update on the Learning Disabilities Mortality Review (LeDeR) was provided to Board in August 2020.
- The Business Manager continued to be an active member of the Modern Slavery & Human Trafficking working group and Northamptonshire Against Domestic Abuse and Sexual Abuse (NADASA).

Working in Partnership with our Key Statutory Partners

NSAB worked closely with its statutory partners; NHS Northamptonshire Clinical Commissioning Group (CCG), Northamptonshire County Council (NCC) and Northamptonshire Police. All statutory partners are represented on the Strategic Board, the Delivery Board and Sub Groups.

NHS Northamptonshire Clinical Commissioning Group

Achievements in 2020-2021

- NHS Nene CCG and NHS Corby CCG merged in April 2020 and became NHS Northamptonshire CCG. Safeguarding is of the upmost importance for the CCG and our quality and safeguarding teams work across the system to support and discharge our statutory responsibilities.
- We collaborated with provider trusts and NHS England (NHSE) and NHS Improvement (NHSI) on a joint child and adult safeguarding commissioning assurance framework (SCAT). This has been rolled out and assurance returns completed.
- We worked with NHSE/I and local partners to understand and act on the impact of Covid-19 in relation to safeguarding adults.
- We continued to hold regular forums and training events for general practice safeguarding leads covering adult themes, for example, care homes, Safeguarding Adult Review (SARs) and domestic abuse.
- We promoted the assessment and use of risk-based pathways in primary care for victims of domestic abuse.
- We revised and added to a suite of PowerPoint presentations which deal with all aspects of adult safeguarding aimed at clinicians within primary care requiring level 3 adult safeguarding training.
- We collaborated with the police to develop a form to request medical information from general practitioners when required for the purpose of a police investigation.
- We continued to improve the content and layout of the safeguarding section of the CCG's primary care safeguarding website portal.
- We continued to support providers in relation to training about gangs, emphasising the "violence and vulnerability" programme. This has included the delivery of online training sessions.
- We promoted the use of "Microsoft Teams" to enhance the sharing of information when discussing vulnerable adults in general practice safeguarding Multi-Disciplinary Teams (MDTs).
- We continued to support NSAB by maintaining a presence at Board meetings and actively supporting Sub Groups to ensure NSAB is able to meet its annual strategic plan, and we worked closely with Northamptonshire Community Safety Partnership.

Areas for development in 2021-22

- We will continue to work closely with primary care in promoting the safeguarding assurance self-assessment framework.
- We will continue to work with health providers and key partners in improving practice in relation to the Adult Risk Management Process (ARM).
- We will work with colleagues across health and social care to support the implementation and delivery of the Liberty Protection Safeguards.
- We are progressing work at pace to support the transition towards an integrated care system.
- We will work with health and other partners to implement actions relating to recent SARs and Domestic Homicide Reviews (DHRs) – areas of focus include safeguarding legal literacy, strengthening and fully embedding the ARM process in practice, increased awareness and recognition of potential domestic abuse - DHRs have identified inconsistent responses to concerns and disclosure of domestic abuse.
- We will add voiceovers to our suite of adult safeguarding PowerPoint presentations and produce podcasts for key primary care safeguarding topics.

Northamptonshire County Council – Adult Social Care

- A new target operating model was introduced across adult social care in October 2020.
- Safeguarding processes were reviewed and changed in light of the new target operating model. This included safeguarding processes at the front door so that they are triaged in the team, and changes to how enquiries and safeguarding functions are completed.
- The Safeguarding Team was increased in size and reflects the two new unitary footprints.
- Northamptonshire Adult Social Care (NASS) continued to work closely with Northamptonshire Police and East Midlands Ambulance Service (EMAS) to improve the triaging process for appropriate referrals to safeguarding.
- NASS worked alongside partners on the implementation of the multi-agency Adult Risk Management (ARM) guidance.
- Northamptonshire County Council Chairs the Channel Panel.
- A number of cases have been reviewed as part of the Person in Position of Trust (PIPOT) process.
- The Lead Principal Social Worker (PSW) worked with the Complaints Officer to ensure that learning from complaints was embedded across NASS.
- Learning from Safeguarding Adult Reviews was disseminated across Adult Social Care.
- The new adult social care case management system (Eclipse) was implemented and reflects the new safeguarding processes.

Areas for development in 2021-22 - West Northamptonshire Council[2]

- Development of the ARM Oversight Panel under the Chair of the local authority.
- Development and the further embedding of the target operating model (phase 2).
- Development of an assurance framework that underpins internal practice and external market management. This includes the joint Quality Board with CCG and CQC, and the internal joint working of commissioning & quality and safeguarding, and the care home review team via a weekly forum to proactively manage quality in the market.
- Change of the PSW role to focus on practice development and assurance and include proposals for roles to be created to support this.
- PSW to Chair the NSAB Learning and Development Sub Group.
- WNC will continue to disseminate learning from Safeguarding Adult Reviews once published.
- Preparation for the introduction of Liberty Protection Safeguards (LPS) is ongoing. A proactive working group across both councils is in place and will start to formalise the plan for LPS in Northants once the code of conduct is released for consultation.
- Work in conjunction with the NSAB Independent Scrutineer in relation to assurance activity on behalf of the NSAB.

Areas for development in 2021-22 - North Northamptonshire Council

- Continue to work on embedding the Target Operating Model within North Northants.
- Safeguarding processes across North ASC will be reviewed. This will include safeguarding processes at the front door, how they are dealt with and how enquiries and other safeguarding functions are completed within the service.
- The current Adult Social Care IT system was replaced in November 2020. 'Eclipse' has replaced CareFirst and work is underway to ensure processes are reviewed.
- Work continues to take place with providers looking at what training, information and advice they require.
- The provider Quality Board will be reviewed in order to monitor its effectiveness and ensure that robust governance arrangements are in place moving forward.
- North Northants will continue to disseminate learning from Safeguarding Adult Reviews once published.
- Preparation for the introduction of Liberty Protection Safeguards (LPS) is ongoing.

[2] Northamptonshire County Council ceased to exist from the 1st April 2021 and two unitary councils were formed; North and West Northamptonshire Councils.

Northamptonshire Police

Domestic Abuse

- Domestic Abuse (DA) is one of four 'Matters of Priority' for Northamptonshire Police.
- A working group has been set up to ensure that there is a force wide response aimed at delivering an outstanding service to victims of DA.
- A specialist team has been set up to investigate all "high risk" cases of DA. The team has doubled in size, with officers based at both Northampton and Kettering.
- 'DA Matters' training is being rolled out to all officers. Evaluation of earlier training showed that 81% of first responders said that the training had improved the way in which they support victims.
- Senior Detectives now regularly review DA crimes with a view to highlighting learning and best practice.
- A serial perpetrator scheme aimed at preventing further offences being committed by offenders identified as posing the biggest risk continued. A number of perpetrators agreed to take part in support programmes to change their behaviour.
- Northants Police were one of six forces who took part in a Telephone Resolution Scheme. This continued to deliver positive outcomes relating to crime recording, disclosure of abuse and Criminal Justice System outcomes for victims who had a telephone first response as opposed to a low priority deployment.
- The force continued making effective use of Conditional Cautions having launched Project PIPA (Preventing Intimate Partner Abuse) referrals, where offenders were encouraged to take part in a course to prevent further offences.
- Guidance was issued to staff to help them to identify and investigate stalking and harassment cases and make best use of the Stalking Protection Act.
- The Northamptonshire Against Domestic and Sexual Abuse (NADASA) partnership co-ordinated the response of statutory and voluntary agencies for Covid-19 and agreed a communications strategy to support victims.
- A partnership meeting has been set up to improve the identification of and response to incidents of so called honour based abuse.
- Accredited training has been provided to Multi Agency Risk Assessment Conference (MARAC) Chairs.

Mental Health

- The force reviewed and refreshed mechanisms for recording mental health (MH) incidents to help understand hidden demand. This led to a better understanding of the demands on staff to enable the provision of tools to deliver a quality service to those living with MH. Data shows that 23% of all front line police officer time was spent dealing with MH related incidents (over 5,100 officer hours in March alone).
- Bespoke 'Time to Listen' training was provided to front line officers to support service users. 'Time to Listen' training is based on a consultation with service users conducted by the Office of the Police, Fire and Crime Commissioner (OPFCC). The training helps to recognise MH conditions and vulnerabilities, with input from service users and discussion with service providers to understand pathways and options.
- Op Alloy (street triage) was refreshed during the period with an expectation to launch a new model in the near future. This will include two MH nurses on duty between the hours of 1100hrs and 0300hrs, with a trained police officer who is a 'MH tactical advisor' working alongside the nurses to improve the crisis response to those in need. One nurse will be based in the Force Control Room and the other on patrol with an officer, proactively addressing incidents that involve mental health.

Serious Organised Crime

- Heroin and Crack Action Area 'CITADEL' continues in Kettering and supports those susceptible to MSHT type offences.
- Organised immigration strategy is in place for the force and work has been undertaken with partners to improve the response and support to those who are trafficked into or within the UK illegally.
- A review group and monitoring is in place for MSHT with a particular focus on National Referral Mechanism (NRM) referrals.
- Work is ongoing to secure and improve obtaining Modern Slavery Risk and Prevention Orders for longer term disruption to criminals who exploit the vulnerable, as is work with partners around sham marriages.

Working in Partnership with our Key Statutory Partners - continued

Partnership working

- A Multi-Agency Daily Risk Assessment (MADRA) Conference for Domestic Abuse has been funded by the Office of the Police, Fire and Crime Commissioner (OPFCC). The MADRA now reviews all domestic abuse incidents reports at the earliest opportunity (normally within 24 hours) to ensure that safeguarding measures are put in place for early intervention with families and children.
- The force continues to work with partners to audit our outcomes and ensure that service users receive the best and most appropriate experience from our staff by providing them with the tools and training to support those living with mental health issues. Understanding our demand and positive partner relationships has been key to this process.

Areas for development in 2021-22

- Voice have been successful in bidding for Ministry of Justice funding to recruit additional Independent Domestic Violence Advocates (IDVAs), who provide support to victims with complex needs, and are deployed to victims after an arrest is made to provide support at the earliest opportunity.
- Serious and Organised Crime is a new 'Matter of Priority' for 2021-2022. Modern Slavery & Human Trafficking (MSHT) forms part of the analysis and work to ensure the force supports victims/reduce repeat victimisation.
- MSHT will also feature as part of the new Community One partnership meeting, and a 'SOC community profile' will be presented at the first Community One meeting for onward support.
- Victim Navigators who support MSHT victims will be bid for regionally in support of our ongoing safeguarding and response to victims of MSHT.
- Audits will be undertaken in respect of MSHT/SOC offences in May 2021 for feedback and learning to improve our response to victims.
- Following Covid-19, focus will be on improving relations in communities and identification of businesses which may exploit vulnerable persons.

Safeguarding Adult Reviews

The Safeguarding Adults Board (SAB) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The SAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse.

Criteria for a Safeguarding Adult Review (SAR)

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.
4. A SAB may arrange for there to be a review of any other 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).
5. Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:
   (a) Identifying the lessons to be learnt from the adult's case; and
   (b) Applying those lessons to future cases.

The Safeguarding Adult Review (SAR) Sub Group has responsibility for considering SAR referrals, and for managing the SAR process. The group has strong links with the other NSAB Sub Groups to ensure that the monitoring and communication of SARs and other type of reviews are undertaken, and that learning is embedded. The Chair of the Sub Group has responsibility for keeping NSAB updated on the progress of SARs.

For the period 1st April 2020 to 31st March 2021, three referrals were made for consideration of a SAR. The recommendation actions for two previous SARs, 008 and 010 were also monitored with a view to completing during the period. SARs were approved by the NSAB Independent Chair and Statutory Partners for referrals 020 and 021. Referral 018 was considered but the SAR Sub Group subsequently referred the case to Corby Community Safety Partnership for consideration of a Domestic Homicide Review (DHR) which was subsequently approved in June 2020.

Safeguarding Adult Reviews approved/published during the period

Reference	Reason for Referral - Summary	Approved by Statutory Partners	Published
016	Male murdered whilst living in supported accommodation[3]	December 2019	March 2021
018	*Female in relationship with coercive control* – ***met criteria for DHR***	June 2020	Ongoing
019	Male found dead in hotel room following hospital discharge	February 2020	March 2021
020	Male committed suicide out of county	August 2020	July 2021
021	Serious neglect reported at a care home	June 2020	Ongoing

[3] Some delay caused by the Covid-19 pandemic and agency resources to fully support the SAR during early 2020.

Safeguarding Adult Review Findings, Recommendations and Outcomes

Safeguarding Adult Reviews commenced in previous years with outstanding recommendation actions as at 31st March 2021

SAR 008 'Mrs Webster'

The review evaluated multi-agency responses concerning the sad death of 'Mrs Webster' who died in November 2017, aged 86. Prior to her death and whilst living in a residential care home, Mrs Webster experienced a number of falls, including one that resulted in a puncture wound to her back. The cause of Mrs Webster's death was bronchopneumonia which was likely to have been exacerbated by her lack of mobility due to a neck collar following an earlier fall. The SAR was published in October 2019 with 13 recommendations. At the 31st March 2021, there was one outstanding action remaining.

An example of some of the recommendations that were actioned and implemented during the period:

Recommendation 1 – NCC[4] senior managers should provide assurance to NSAB that their current actions to manage the identified shortages in assessment and review teams are having a positive impact in reducing waiting times for people as delayed reviews of care and support can have significant negative consequences for individuals whose needs and risks are likely to be change over time. ***Dedicated staff and teams were put in place to address pending lists.***
Recommendation 2 - NCC Quality Team should provide assurance to NSAB that the quality of all contracted residential homes is being monitored and that action plans are in place to ensure people are receiving appropriate person centred support. ***A new Learning Disability Quality Board was put in place and the Older People's Quality Board was reviewed. Monitoring was put in place and the frequency increased throughout Covid. Action plans are also in place.***
Recommendation 4 - KGH[5] should provide assurance to NSAB that it has implemented and is monitoring an action plan to prevent similar errors identified in this SAR. ***Action Plans to be reviewed at the Safeguarding Steering Group until complete. Evidence available via meeting minutes.***
Recommendation 6 - All NSAB partner organisations should review their training (access to learning opportunities as well as formal training) and practice in relation to MCA assessments and Best Interest decision making. ***Agencies confirmed that this has been addressed, evidence includes: 100% training compliance, master class registers being kept, simulation training being included, and external training provider commissioned.***
Single Agency Action - A Northamptonshire National Health Service Falls Risk/Action Plan support service to be contacted after 2 falls and the Falls Risk Assessment Action Plan to be completed alongside Shaw Healthcare's policies on Falls/Risk Assessment. ***Monthly monitoring of record keeping ensuring policy and procedure is followed and all records are updated relating to the adverse incident. CQC inspection of 15 October 2019 corroborates this (overall GOOD and all five KLOE[6] questions are deemed GOOD).***

SAR 010 'Andrea'

The review evaluated multi-agency responses concerning the sad death of Andrea who died in December 2017 following a period of self-neglect. A redacted summary SAR report was also published in October 2019. The report had 20 recommendations. As at 31st March 2021, two outstanding actions remained.

An example of some of the recommendations that were actioned and implemented during the period:

Recommendation 1 - That partner agencies and the services they commission should assure the Board that their policies and procedures have been reviewed and revised as appropriate to ensure that the Mental Capacity Act 2005 and its supporting code of Practice are implemented properly, with particular regard to unwise decisions and situations of self-neglect. ***Agencies confirmed that relevant policies and procedures were reviewed and refreshed, and training was updated where appropriate.***
Recommendation 6 - That partner agencies should assure the Board that they are implementing and monitoring the use of the Self-Neglect Guidance. ***Agencies confirmed that self-neglect guidance is in place and is embedded in training.***

[4] NCC - Northamptonshire County Council
[5] KGH – Kettering General Hospital
[6] KLOE – Key Lines of Enquiry

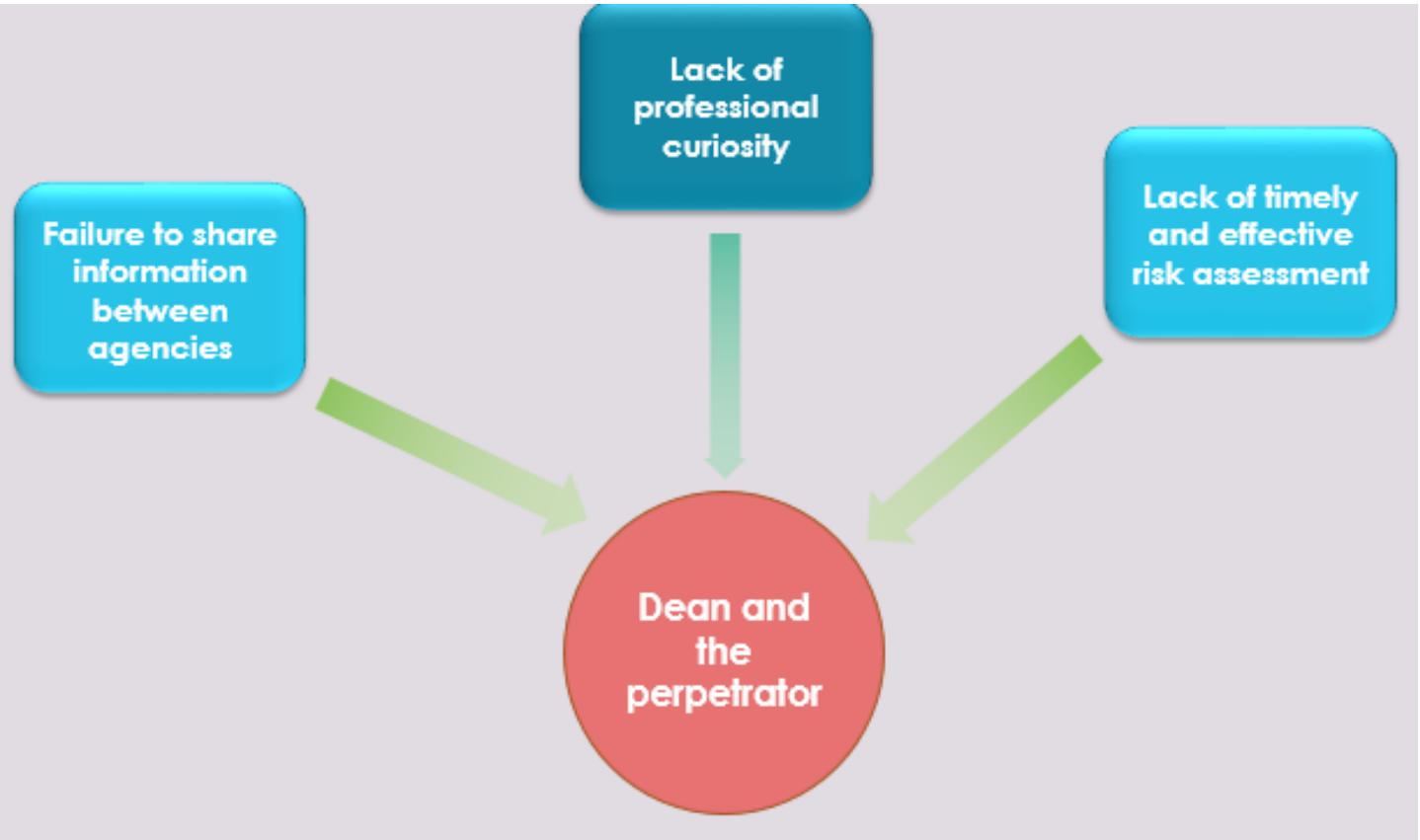
Recommendation 7 - That partner agencies should assure the Board that they are implementing and monitoring the appropriate use of the Adult Risk Management (ARM) Guidance. ***Responses include: Use monitored via Safeguarding steering group reporting, ARM audit undertaken quarterly and shared with NSAB; Reviewed as part of the Target Operating Model; ARM process is within the safeguarding policy and discussed at safeguarding training. In addition, in 2021, Northamptonshire County Council, Adult Social Services confirmed the strategic ownership of the ARM process and will convene a regular Strategic ARM Oversight Panel meeting to improve the process.***
Recommendation 14 - That the Board review and revise as appropriate the Inter-Agency Procedures in place to receive, triage and respond to safeguarding concerns re adults and the recording systems to support them. ***The Inter-Agency Policy & Procedures were reviewed by a multi-agency task & finish group and ratified at Strategic Board on 13.05.2020.***
Single Agency Action - Accuracy of recording - Team Managers to disseminate Recording with Care policy to team members, reminding practitioners of their responsibilities. ***Supervisors within the teams' complete audits and checks as part of their supervisions. This is also addressed in weekly meetings and included in audits.***
Single Agency Action – Concept of professional curiosity - Proposal for professional curiosity to be a topic at upcoming Good Practice forum for Principals of NASS[7], with a view that this information is disseminated throughout Directorate. ***Professional curiosity was included in the training that all teams received. It is also included in our training plan moving forward and lead principal social worker undertakes sessions that cover it.***

Safeguarding Adult Reviews Started in 2020-21

SAR 016 'Dean'

SAR 016 evaluated multi-agency responses concerning the death of 'Dean' who died in June 2018. Dean had known alcohol issues and was placed in supported housing accommodation with a man with a long history of violence, alcohol and drug abuse (and had been subject to MAPPA). There was no risk assessment made as to the men's suitability to reside together in the same house. Dean's housemate was subsequently convicted of Dean's murder.

Key themes:



[7] Northamptonshire Adult Social Services

Safeguarding Adult Reviews Started in 2020-21 continued

Key points of learning:

Number of missed opportunities for multi-disciplinary meetings to discuss concerns regarding the perpetrator's risk to others, particularly when the formal arrangements for public protection or MAPPA, with incidents the perpetrator was involved dealt with in isolation.
The Police Public Protection Notice (PPN) process should be used to share information and assess whether a professionals' meeting is required.
When the criteria for MAPPA is not met and there are concerns, a professionals' meeting should be considered in order to share information. Information should be shared with agencies as per the Northamptonshire Safeguarding Adults Board Information Sharing Protocol.
When considering placing adults in shared accommodation, thorough risk assessment should be given to the individual's history and suitability for sharing a dwelling.

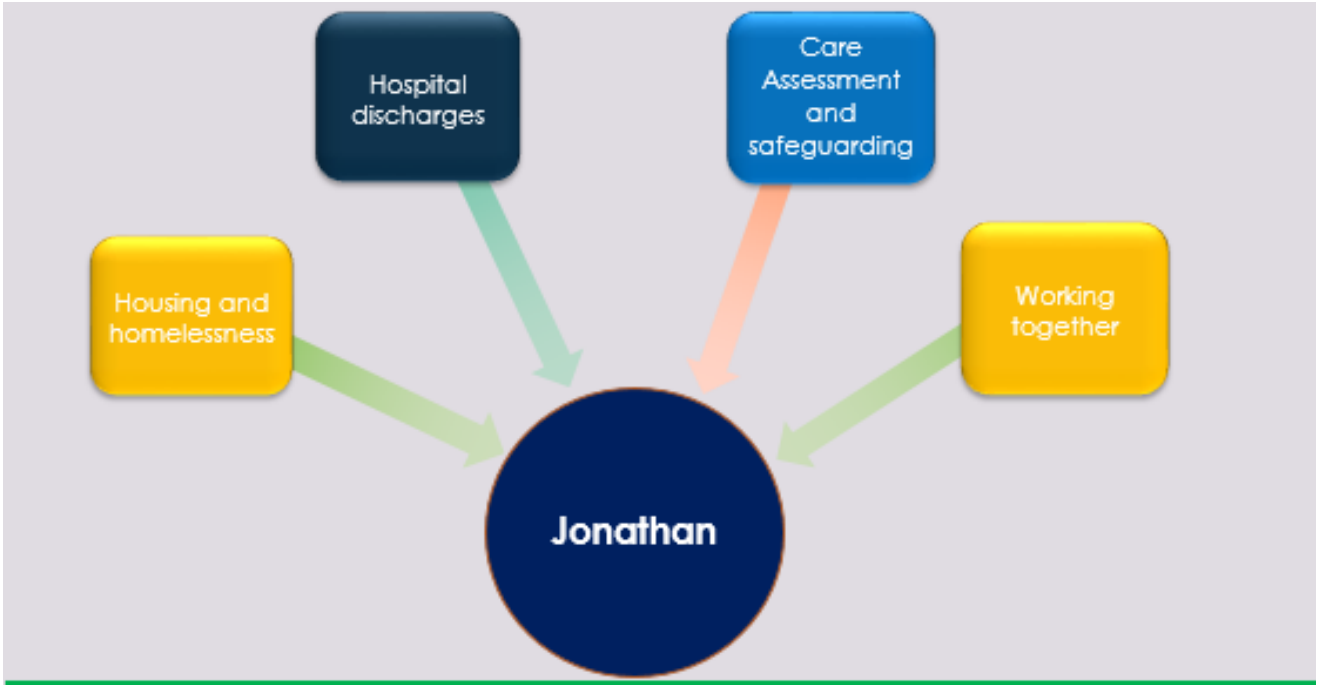
7 recommendations were highlighted in the report.

The SAR was published in March 2021, and a redacted summary was published – this was to protect the victim's school aged children.

SAR 019 'Jonathan'

SAR 019 evaluated multi-agency responses concerning the death of 'Jonathan' who sadly died in December 2019. Jonathan was living in a hotel at the time of his death, aged 46 on 31st December 2019. Jonathan was found deceased in the hotel room by a Social Worker carrying out a welfare check. Jonathan was considered to have multiple vulnerabilities and risks which were further complicated by homelessness; in particular, rough sleeping. Jonathan had frequent visits to emergency departments and a history of offending and imprisonment. Despite regularly coming to the attention of a number of statutory services as an adult experiencing street homelessness and significant physical and mental health conditions, his housing, health and care and support needs, including risks, were not readily acknowledged.

Key themes:



Safeguarding Adult Review Findings, Recommendations and Outcomes - continued

Key points of learning:

Learning for all agencies in relation to addressing safeguarding concerns to prevent the escalation of health and social care needs and harm through timely, coordinated assessments and protection planning for people experiencing high levels of risks like Jonathan.
Learning for all agencies to establish regular meetings where information can be shared, and decisions made for people experiencing Multiple Exclusion Homelessness. A comprehensive approach to risk assessment is an essential component of practice and proportionate risk assessment.
Practitioners should pay close attention to a person's mental capacity, carrying out capacity assessments where indicated, particularly where an individual consistently disregards high levels of risk to themselves or others. The potential impact of impaired executive brain function on decision-making may also need to be considered.
Learning for all agencies in relation to transitions between services and institutions, such as from prison and admissions to and discharge from hospital. This should include understanding when the duty to refer under the Homelessness Reduction Act 2017 is triggered.
Practitioners should learn the lessons from SARs, both in their own locality and elsewhere, and draw on this developing evidence base to inform their own practice.

The SAR was published in March 2021 and 11 recommendations were documented.

SAR 020 'William'

The SAR relates to the sad circumstances of a man 'William' who died through suicide in 2018. SAR Sub Group members and the NSAB Independent Chair initially agreed that the criteria for a SAR was met. However, from the information gathered by agencies in Northamptonshire and out of county, it became apparent that the case did not in fact meet the criteria for a SAR, but nonetheless, there was important learning that could be disseminated and a table top exercise was undertaken by the Independent Author.

Key points of learning for Northamptonshire:

Referrals to Primary Care Liaison should be responded to within the standard two working days.
Primary Care Liaison should not expect an IAPT worker to risk assess patients.
Assumptions should not be made by Primary Care Liaison that assessments have already been made without being verified.

Key points of learning for Bournemouth, Christchurch and Poole:

Poole Emergency Department (ED) staff should ensure that key information regarding suicidal thinking is communicated to police when the Criminal Justice Liaison Service (CJLS) are expected to undertake a clinical assessment.
CJLS practice at that time was not to interrogate Systm1 electronic records. Had Systm1 been viewed and information gathered from the family, this is likely to have provided a very different picture of the risk.
Pressure on resources resulted in Mental Health Liaison not carrying out an assessment within the ED – this may have elicited information about the risk of suicide and communication to the police.

Published Reports and learning briefings

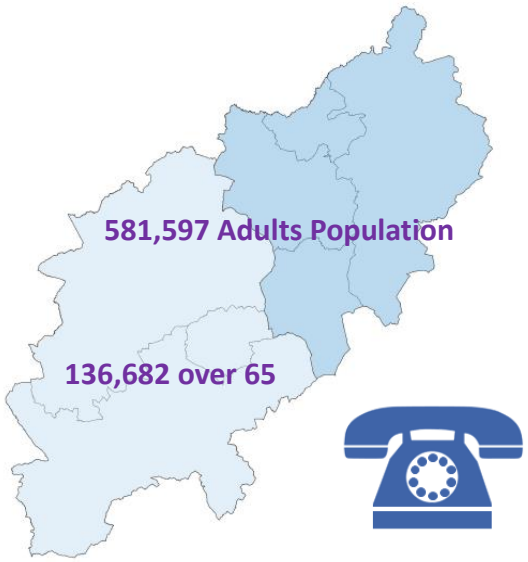
Published reports and learning briefings for all Safeguarding Adult Reviews mentioned above can be found on the NSAB website.

Monitoring agency actions

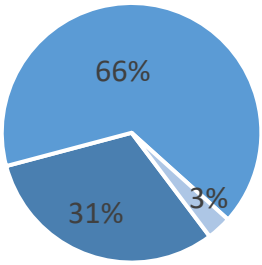
Agency recommendations for the three reviews were collated into composite action plans. All actions will be monitored closely by the Quality & Assurance Sub Group and reviewed by the SAR Sub Group. NSAB will evaluate changes to policy and practice and the embedding of the learning within agencies moving forward.

Northamptonshire Safeguarding Return Statistics

Northamptonshire covers an area of 913 square miles, has 57 electoral wards and a total population of 753,278[8] of which 581,597 are adults.



66% (902) of enquiries included someone known to the person at risk



Other options included service provider 31% and unknown 3%

5,118 concerns raised

3,750 remained Alerts

1,368 became Enquiries

46% Male

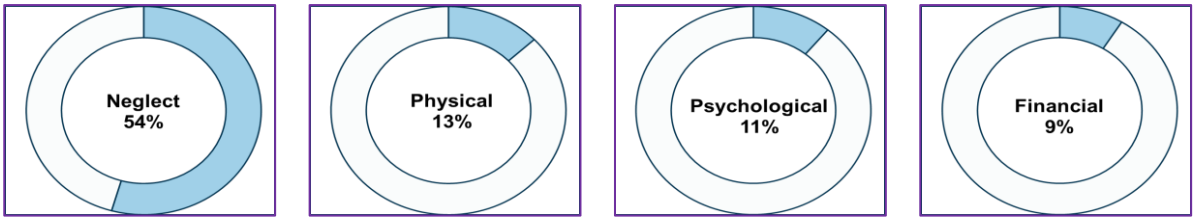
54% Female

The enquiry subject was frequently of the female gender

Subject age band of the enquiry

18-64	65-74	75-84	85-94	95+
42%	13%	19%	21%	5%

54% of completed enquiries involved Neglect



Risk Remains 7%

Risk Reduced 74%

Risk Removed 19%

Following investigation, 93% identified with risk had their risk removed or reduced

[8] JSNA Insight Pack June 2020

Strategic Plan 2019-21 – Progress

The Strategic Plan 2019-21 was built on the previous plan 2018-20 and is structured according to NSAB's vision, the six key principles (as set out by the government in the Care Act 2014 statutory guidance), local and national priorities.

Board priorities for 2019-21:

1. **Making Safeguarding Personal**
2. **Prevention**
3. **Quality**

NSAB themes for 2019-21:

1. **Suicide**
2. **Domestic Abuse**
3. **Street Homelessness**
4. **Serious Organised Crime**
5. **Adults that don't meet the need for statutory services (Adult Risk Management process)**

Further progress was made on the previous year's achievements, with just two areas that were not fully met – these will remain a priority for the year ahead.

Priority 1 - Making Safeguarding Personal

a. Work together as a Board to provide local leadership on safeguarding adults to ensure people are safe; particularly during the period of transition from the County Council to the new Unitary Authorities. ✓**Achieved**

b. Continuously learn and develop as the NSAB to ensure the Board's key priorities and objectives are delivered by the partnership. ✓ **Achieved**

c. Ensure appropriate membership is at the right level for Board and Sub Groups and engagement is appropriate to drive business. ✓ **Achieved**

d. Ensure users and carers are supported in their role in keeping people safe, and they help to evaluate the effectiveness of safeguarding adults within Northamptonshire. **X Partially achieved**

Priority 2 - Prevention

a. Enable and support local communities to play their role in keeping people safe by improving communication to raise awareness of key safeguarding messages. ✓ **Achieved**

b. Ensure learning from national and local multi-agency reviews and reports are shared and implemented locally. ✓ **Achieved**

c. Ensure learning and development opportunities are available to the voluntary sector. ✓ **Achieved**

Priority 3 - Quality

a. Ensure statutory responsibilities for a safe and legal transfer to the new Unitary Authorities is in place, and that customers are not adversely affected by the change. ✓ **Achieved**

b. Mitigate risks flagged on the NSAB Risk Register. ✓ **Achieved**

c. Ensure effective analysis and response to partnership data. **X Partially achieved**

d. Ensure Board have oversight of partners' use of resources to meet the demands to meet quality standards. ✓ **Achieved**

e. Ensure NSAB multi-agency policies and procedures are reviewed in a timely manner. ✓ **Achieved**

Income and Expenditure for 2020-21

Statutory partners contribute financially to NSAB's operating expenditure as well as providing 'in kind' resources such as meeting venues and their officers' valuable time and expertise.

Partnership Income

Income	2020-21 £
Northamptonshire County Council	30,624
NHS Corby and NHS Nene Clinical Commissioning Groups	38,974
Northamptonshire Police	38,974
Carry forward from 2019-20	28,418
Total Income	**136,990**

NSAB has historically been funded by three partners; Northamptonshire County Council (NCC), Northamptonshire Police and NHS Corby & NHS Nene Clinical Commissioning Groups (CCG). The contribution should be equally funded, but in 2020-21 NCC did not put in an equal amount, so the unspent balance at the end of the year could not be carried forward in equal amounts.

The base budget was set at £30,624 (the amount NCC held the budget for), which gave a total contribution from all three parties of £91,872. There was a carry forward from 2019-20 of £9,473 each, which gave an overall base budget of £120,291. Towards the end of the financial year, an additional contribution was requested from each partner, but NCC did not adjust their base budget. If each party had contributed equally to the amount requested of £4,155, they would each have to put in an additional £1,385 contribution for 2020-21. At year end, this took the form of an overspend of £1,385 for NCC and an underspend for CCG and Police of £6,965.

Partnership Expenditure

Expenditure	2020-21 £
Staffing	80,732
Independent Chair	18,400
Safeguarding Adult Reviews (SAR)	18,928
Marketing and print - #Report It campaign	1,921
Office costs	28
SAR Sub Group training & SAR Level 4 training	1,122
SAR legal fees	3,315
Total Expenditure	**124,446**

Northamptonshire Safeguarding Adults Board

NHS Corby Clinical Commissioning Group

NHS Nene Clinical Commissioning Group

Northamptonshire County Council

Northamptonshire Police