Bristol Clinical Commissioning Group

# Bristol Health & Wellbeing Board

| Bristol Safeguarding Adults Board Annual Report | |
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| Date of meeting | 21st February 2018 |
| Report for Information/Discussion/ Decision [delete as appropriate] | |

## 1. Purpose of this Paper

Fulfil the statutory requirement for the Health and Wellbeing Board to receive a copy of the Bristol Safeguarding Adult Board Annual Report.

## 2. Executive Summary

The full Annual Report is provided with this paper as required under legislation.

Key areas for discussion are:

- Mental health delivery in Bristol
- Safety and provider quality
- Role of commissioners in out of area placements
- Profile of Safeguarding within Health and Wellbeing

## 3. Context

Local Safeguarding Adults Boards (LSABs) are required in every Local Authority are under the Care Act (2014). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area The LSAB is independent and is not subordinate to, nor subsumed within, other local structures. One function of the LSAB is the production of an Annual Report which sets out transparently the performance and effectiveness of local services in safeguarding adults with care and support needs. This must be submitted to the Health and Wellbeing Board Chair and other key decision makers as set out in the Care Act Guidance. The guidance outlines that it is expected that the Health and Wellbeing Board will fully consider the contents of the report and how they can improve their contributions to both safeguarding as a result of it. This paper is being submitted along with the 2016-2017 Bristol Safeguarding Adults Board (BSAB) Annual Report. This report was sent to the Chairs of the Health and Wellbeing Board when it was completed last summer however due

to the changes to the Health and Wellbeing Board it has only now been possible to bring it to the Board.

## 4. Main body of the report

Safeguarding Arrangements in Bristol:

When the 2015-2016 BSAB Annual Report to the HWB last year we highlighted significant concerns about the safety of mental health services in the city. One of the pieces of work HWB agreed to pursue was the support of care and supported accommodation providers through a consultation service. There has been no response from HWB on this issue. It remains a concern of the BSAB that this is a significant gap with many complex adults being managed in community settings with limited support to the housing and/care providers who are managing the immediate risk much of the time. This was reinforced again to the BSAB in the Melissa Safeguarding Adult Review (SAR) and murder of Kamil Ahmad in 2016 which is currently subject to a SAR. We are also concerned that there are not sufficient Section 2 doctors always available to respond to people in mental health crisis out of hours. This has been escalated to the Clinical Commissioning Group and Bristol City Council but should be an area of risk that the HWB is cited on.

Furthermore, we are aware that there is a review of the mental health pathway. This process has been ongoing for a significant period of time and the BSAB has requested regular updates due to the concerns about the response of mental health services raised in three Serious Case Review Mr C, RC and Simon Reynolds. Both the BSAB and HWB require assurance that this process is improving services and we would recommend that a joint dashboard is developed to support oversight of this area of work.

Our Annual Report 2016-17 found that 38% of safeguarding incidents in 2016-17 were reported by care providers, an increase on the 29% reported in 2015-16. While we are reassured that in part this is due to the increased understanding of responsibility under the Care Act (2014) since its implementation in 2015, HWB and BSAB should be concerned about the level of abuse and harm adults in Bristol are exposed to within care settings and through Home Care providers. Neglect and Acts of Omission remain our highest reported form of abuse. We therefore intend to have a strategic focus on improving the quality of care in the city in 2018-2021.Commissioners should have comprehensive plans as to how they are improving the quality of care provided by their commissioned services and how we improve the safety of adults in these settings. The HWB should consider the impact of poor care on health inequality and outcomes for this vulnerable population.

From a wide range of sources, we are aware that there remains a lack of understanding across professionals in the city as to how to apply the Mental Capacity Act. This is an issue regionally and we need to continue to support professionals in improving their practice in this area.

Safeguarding Adults Review (SARs):

The BSAB published two reviews in 2016-2017 – Mr C who died in a fire in his flat which was exacerbated by hoarding and self-neglect; and Simon Reynolds who died at a Place of Safety. Both of these reviews highlighted concerns with the mental health provision in the city as indicated above.

In 2017-2018 the BSAB has published one review 'Melissa' following the murder of a young woman in a care home by another resident. Both residents had learning disabilities. This review highlighted the significant risk of adults placed in the city from out of area as both Melissa and the young man were. This meant there was no local knowledge of the risk posed by the young man who had a significant history of concern. There is currently no notification system for adults being placed out of area. This is a significant risk to other adults in those environments and the services locally they access. Furthermore we need commissioners to assure us that Bristol adults placed in provision out of Bristol have sufficient safety and risk management plans in place given the lack of local oversight.

Community Engagement:

As partnerships in the city it is important that we continue to raise the profile of safeguarding within strategic delivery and public and professional understanding. In order to increase safety and early intervention we need to better equip the public to understanding how to report concerns both about themselves and about their family, friends and community members.

## 5. Key risks and Opportunities

The BSAB have identified multiple areas of ongoing risk in Bristol's mental health provision which remain unaddressed over a significant period of time.

There is an opportunity in 2018 for HWB to work more effectively with BSAB. We would welcome steps taken to improve BSAB's oversight and assurance role of the other city partnerships. We would welcome the development of some key measure or indicators, and the development of a shared mental health dashboard that minimises duplication but supports the functions of the BSCB, BSAB and HWB.

There are ongoing significant risks in our care and home care provision due to the high level of abuse and neglect reported in these settings.

The BSAB have identified concerns that the current financial pressures across the partnerships in the city bring significant risk that adults with care and support needs could be exposed to higher risk or not able to access support to reduce risk at the earliest opportunity. We are concerned that as multiple agencies cut and restructure services at the same time, this may have unintended consequences if decisions are not made in partnership.

## 6. Implications (Financial and Legal if appropriate)

## 7. Evidence informing this report.

**What evidence have you used to inform:**

- Evidence of need and the case for change (eg. **JSNA,** activity data, patient feedback, national directive etc)

- Evidence of effectiveness of proposed solution/initiative/new service

The BSAB Annual Report includes evidence from multi agency data sets, audits, Safeguarding Adults Reviews, practitioner events, national research and consultation with children.

## 8. Conclusions

The BSAB welcomes the refreshed and reframed structure of the HWB as an opportunity to highlight the need for a core focus on safeguarding within all partnerships' work. We would ask that a safeguarding lens is applied to decision making within the HWB so that commissioning and delivery decisions are understood in this context. There are significant risks for our adult population with care and support needs. This is an ageing population whose care needs are becoming increasingly complex. We would appreciate strengthening the governance arrangements between the two boards to enable quicker escalation of concerns.

## 9. Recommendations

1. .HWB responds to issues raised by the BSAB Chair following the 2015-2016 Annual Report that mental health consultation support for accommodation and care providers should be commissioned as this is yet to be resolved

2. HWB establishes a shared data dashboard with BSAB about the effectiveness of provision of mental health services to improve scrutiny, consistency and shared drive

3. HWB reports to the BSAB on their plans to improve safeguarding within mental health services in the city

4. HWB JSNA to include scrutiny of the impact of neglect and acts of omission for adults with care and support needs

5. HWB to work with the other city partnerships through the partnership chairs group to develop clearer escalation and governance processes at this time of change

## 10. Appendices

Bristol Safeguarding Adults Board Annual Report 2016-2017