Dudley
Safeguarding
protecting adults at risk

Dudley Safeguarding Adults Board **Annual Report** 2016/17

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Executive Summary

Our Annual Report for 2016/17 covers the work the Dudley Safeguarding Adults Board has undertaken from April 2016 to March 2017.

It also outlines our future plans for 2017/18.

During 2016/17 we set ourselves three priorities on which to focus throughout the year. These were:

1. To improve service user involvement in safeguard development.
2. To make safeguarding personal for the victim of abuse, harm or neglect.
3. To develop information in order to prevent safeguard incidents occurring.

We formulated core aims and objectives for each item and these formed individual plans of action for 2016/17. We are pleased to report significant progress for these plans throughout the year.

Our action plan to improve service user involvement in the safeguard process has focused around increased working and formal links with user organisations across the borough. In addition easily understood public information about the entire safeguarding process was deemed a priority. Healthwatch Dudley has been commissioned to organise a communications and engagement sub group who are working to champion and facilitate this priority. Public information has already been updated, with additional new information also being produced.

As far as our second priority is concerned much work has been undertaken to ensure that safeguarding is made personal for the victim of harm, abuse or neglect. A framework has been developed for 'making safeguarding personal', to ensure it's fully embedded in all organisations involved in safeguarding. Data collected at the end of 2016 indicated a pleasing twenty eight percent increase in the numbers of people who felt that the outcomes they desired from the safeguarding process had been achieved - sixty-five percent in 2015 compared to ninety-three percent in 2016.

Much work has also been done around priority three - developing information to prevent safeguarding incidents occurring. Safeguarding public information has been updated and distributed across the borough to members of the public; self neglect practice guidelines were issued and a conference on this increasing problem was held; a practice learning event was also hosted to facilitate national safeguarding learning across local organisations.

There remain challenges around these priorities and the Board has formulated action plans for 2017/18. Progress is underway and monitoring will continue.

There has been a pleasing move to increased partnership working throughout the period. Organisations have been working more closely together on safeguarding related issues, to join together more effectively and ensure that any gaps are closed up.

Over 2016/2017 two safeguarding adult reviews (SARS) were conducted. These both related to individuals with care and support needs who choked, following receiving food from care staff inappropriately. The recommendations that the Board received have led to the formulation of two action plans which specific sub-groups have been created to drive forward, monitor and regularly review. It is vital that their influence continues long into the future in the area of care and support of people with complex needs.

A code of conduct to support families who have experienced such tragedies will be distributed in 2017 so that agencies do not just concentrate on the events, but also the family lives that are touched by such events.

In addition as structures and systems change in the way that partners operate, Board leaders will have responsibility to ensure that the learning from the SARs is transferred. The Board plans to undertake an assurance exercise of all Board members later in 2017 to confirm this.

The creation of the MASH (multi-agency safeguarding hub) is a massive challenge for the Board. Agreed in 2015, much progress has taken place over the period in moving forward the hub. It is anticipated that it will go live later in 2017 and the process change will create challenges to partners, a strategic and operational sub-group will however continue to work to ensure that there is a streamlined transition.

Multi-agency training has continued apace throughout the period. National directorates have influenced the focus of some of the training, for example 'preventing extremism' and mental capacity awareness. In addition partners have delivered bespoke training from their own specialist areas, including domestic abuse and financial abuse.

In 2016/17 all Board partners began to present safeguarding statistical data to the council's management information team. They collate this data and present it to the Board. This clearly demonstrates the commitment by all partners to collate reliable safeguarding statistical information. The data is also collated nationally and regionally to look at trends and assess any development work that is required.

Over the period 2809 safeguarding concerns were received, in comparison to 2091in 2015/2016. Of those concerns it was deemed that 831 required a safeguarding enquiry following information gathering exercises. This represents 29.6% of cases reported - against 35.5% on the previous year, indicating the screening process at first contact point is effectively signposting concerns.

In summary, lots of good work has gone on over the period, building upon the Board's successes. We are well placed to face the challenges of the year ahead and look forward to the launch of the MASH and the benefits that this will undoubtedly bring us all.

Message from our independent Chair

Welcome to Dudley Safeguarding Adults Board's annual report for 2016/17. I am delighted to introduce the report which covers our activities from April 2016 until March 2017. As well as reporting retrospectively, the report outlines the board's key priorities for 2017-18, along with our main areas of focus.

This annual report is aimed all agencies, organisations and individuals who work in the safeguarding arena. It also however makes useful reading for members of the public, as we continue to encourage people to understand safeguarding and be aware that they also have a role to play. We want everyone to know that it is the responsibility of us all to ensure that we are alert to signs of abuse, harm or neglect in anyone in our own local communities and that we report our concerns in a timely manner.

Much work has continued to be undertaken to support improved safeguarding arrangements and practice since I joined the Board as Independent Chair in April 2016. Significant achievements include:

- Increased reporting of safeguarding concerns about adults with care and support needs with risk removed or reduced in over 80% of cases investigated.
- Successful work completed to embed 'making safeguarding personal'. The Board developed a framework for this initiative which ensures that the victim is always placed at the very centre of any safeguarding enquiry; this includes ensuring that they state clearly the outcomes they want from the process. Performance data evidences the impact of this work with over 80% of adults reporting their desired outcomes were fully achieved.
- Improvements made in increasing local people's involvement in our safeguarding work. The Board is now directly linked to a number of organisations from across Dudley Borough which provide feedback and guidance on the Board's activities. To assist this a communications and engagement group has been established and is working to ensure improved and closer joint working.
- Increased awareness and understanding of financial abuse in the borough and an effective working relationship with the local trading standards team to tackle this form of abuse.
- Review of board structure including the establishment of an Executive group to coordinate the Board's work programme.

In addition, the past year saw two Serious Adult Reviews (SAR) published, in May and August 2016; the Board has also overseen a review that did not met the SAR criteria. There has been valuable learning from these reviews, including the need to raise awareness of dysphagia as well as engage with individuals who self-neglect. The SAR subgroup will ensure that momentum is not lost and that training and action plans are delivered to ensure that we are embedding the learning across services.

Our priorities for the coming year include an ongoing focus on preventing financial abuse and self-neglect and launching our Multi Agency Safeguarding Hub (MASH) for adults . We will further develop our work around embedding the voice of the adult victim, as well as adults with care and support needs into the entire safeguarding process and ethos and work to consolidate our performance management and quality assurance arrangements of the adult safeguarding system. This will include maintaining a robust oversight of the Transforming Care Programme. We will also work collaboratively with the Dudley Safeguarding Children Board to develop a local response to Forced Marriage and Honour Based Abuse.

I would like to thank all of the Board partners, including front line practitioners for their work in 2016-17 to safeguard adults in Dudley and I look forward to continuing to work with you in 2017-18.

Liz Murphy Independent Chair Dudley Safeguarding Adults Board July 2016

About Dudley Safeguarding Adults Board

Dudley Safeguarding Adults Board has been established since 2008 and works to ensure there is an appropriate response from a whole range of professionals to situations where there is actual or suspected abuse, harm or neglect. The Board considers how partners across Dudley Borough responsible for safeguarding work together and the quality of support provided to people who have been abused, neglected or harmed.

The Board is made up of senior representatives from Dudley Council, West Midlands police, Dudley Clinical Commissioning Group (CCG), Dudley Group NHS Foundation Trust, Dudley Fire Service, Dudley and Walsall Mental Health Trust, Black Country Partnership Foundation Trust, Healthwatch Dudley as well as voluntary sector organisations. The Care Quality Commission attend and report on their activities at one board meeting each year.

In 2016/2017 the Board formed an executive group to oversee the work of it's various sub-groups. The sub-groups structure was improved and there are now groups looking at quality, policy, safeguarding adult reviews, safeguard training and communications and engagement. The terms of reference for these groups have been made public and added to the Board's website.

The Board works to a business plan and produces an annual report which is distributed to key stakeholders as well as council cabinet members. The Board also has a protocol with the Health and Wellbeing Board and the Community Safety Partnership to ensure partnership and accountability is robust. In 2016/2017 partnership with the Children's Board was developed through joint board meetings during the year looking at the shared priorities which include supporting people who are victims of domestic abuse, modern slavery and preventing violent extremism.

The Board is funded through financial contributions from Dudley CCG, West Midlands Police and the council. Other partners provide staff and resources for meetings and training courses.

Who is an adult at risk?

The Care Act 2014 describes a person who should be protected by safeguarding work in Dudley as someone who:

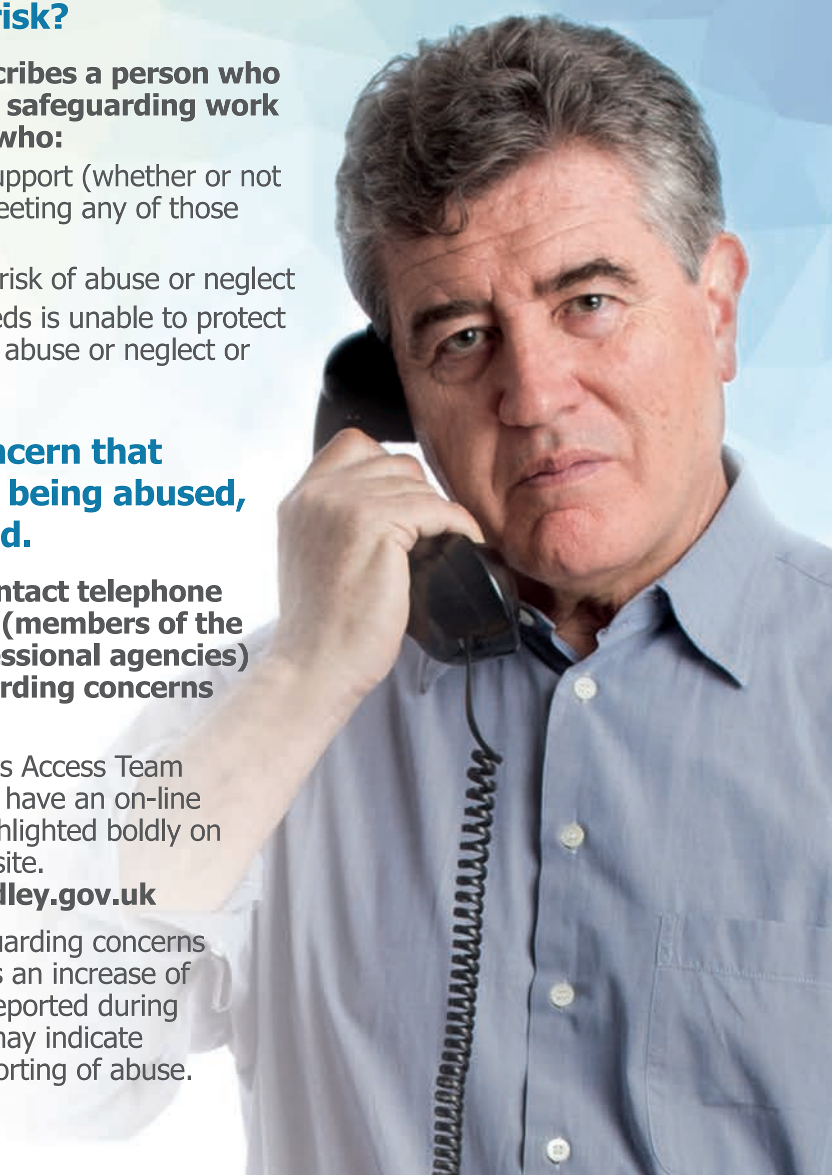
- has needs for care & support (whether or not the local authority is meeting any of those needs)
- is experiencing or is at risk of abuse or neglect
- as a result of those needs is unable to protect themselves against the abuse or neglect or risk of it.

How to report a concern that someone is, or may being abused, harmed or neglected.

There is one central contact telephone number where anyone (members of the public along with professional agencies) can report any safeguarding concerns they may have.

This number is the councils Access Team (0300 555 0055). We also have an on-line reporting tool which is highlighted boldly on Board's safeguarding website.
www.safeguarding.dudley.gov.uk

In 2016/2017 2809 safeguarding concerns were reported. This shows an increase of 34.3% against the 2091 reported during the previous year, which may indicate better knowledge and reporting of abuse.



The Safeguarding Process

During 2016/2017 there has been work and developments to improve the adult safeguarding process and improve partnership working.

When a concern is referred to the Access Team, the information is collated and where necessary the person is made immediately safe, before information is gathered to establish if the person is someone who is at risk and requires safeguarding support.

This information is then passed to the safeguarding team who devise a plan of what further enquiries are needed considering the outcomes the person wants. This work planned is known as a 'safeguarding enquiry'. The Care Act stated that local authorities could ask other agencies to make enquires and investigate a safeguard concern. This is invaluable as expertise from other professionals assists the process and ensures that all information is gathered. The safeguard team itself is made up of three managers who undertake these plans. They also chair safeguard meetings to consider outcomes once enquires are completed and undertake complex meetings, or meetings where a person in a 'position of trust' has allegations made against them which may affect their work status. The team is supported by business support colleagues who minute safeguard meetings, collate data and minute all Board and sub-group meetings

Over 2016/2017t the team has developed an information package to support staff, along with other agencies in gathering this information. This helps with the definite decision as to whether abuse has taken place and what support the victim may need. These enquires are called 'section 42' enquires. Agencies have continued to offer support in conducting these enquires and strengthening the safeguard partnership, ensuring work is carried out in a co-ordinated manner.

In 2016/2017 there has been much work around 'Making Safeguarding Personal', a national initiative which works to ensure that the victim of abuse is asked what outcomes they want from the process, ensuring it is led at the pace they are comfortable with, checking throughout that the outcomes they want have not changed and whether at the end of the process their outcomes have truly been met.

In 2016/2017 93.9% of people subject to abuse stated that their outcomes had been fully or partially achieved in comparison to 65.7% in 2015/2016.

The National and Regional Context

Throughout 2016/2017 there were many national papers produced to build upon the Care Act definitions of abuse. Information on self-neglect, safeguard adult reviews and large scale institutional abuse was produced to support staff across partnerships.

The West Midlands region worked together to update the safeguard procedures and practise guidance on positions of trust and self-neglect, were established to support the Care Act definitions.

In Dudley these were discussed at the policy sub-group at the Board and Information and training was distributed to partners throughout the year.

These papers are all available on the Board Website **www.safguarding.dudley.gov.uk**

The six safeguarding adult principles

- **Empowerment**
- **Prevention**
- **Proportionality**
- **Protection**
- **Partnership**
- **Accountability**

are daily considerations in safeguard decision making.

Our priorities for 2016/2017

We set ourselves three priorities for the period 2016/2017.

These were:

1. **To improve service user involvement in safeguard development**
2. **To make safeguarding personal for the victim of abuse, harm or neglect**
3. **To develop information in order to prevent safeguard incidents occurring**

In this section we look at the progress we have made against each of these priorites.

Priority 1

To improve service user involvement in safeguard development

What did we say we would do?

- **Ensure the board is linked to user organisations across Dudley Borough who will provide feedback and guidance on the Board's activities.**
- **Develop information about the safeguard process which is easy for the general public to understand.**
- **To agree information as board partners to ensure that we can advise community groups about safeguarding and capture community priorities.**

What did we do?

- **Healthwatch Dudley were commissioned to organise a communications and engagement sub group who will champion and facilitate this priority**
- **This sub group will utilise a focus group of local people who use care, health and support services. This group agreed to look at information provided by the various sub-groups and comment upon it. They also participated in interviews for Board lay members. In addition in response to comments from people involved in safeguarding concerns an information booklet was developed which explains in detail what people can expect when they raise a safeguarding concern. The focus group provided feedback on this to ensure that it is easy to understand and free of confusing jargon.**
- **The Board's Safeguarding information booklets were also scrutinized by other community focus groups as was the Board website and consequently all leaflets were updated in line with feedback, as was the website to ensure that they are all easy to understand and digest.**
- **More work with community groups took place in June 2017 and this will be used to plan for2017/2018 priorities.**

Priority 2

To make safeguarding personal for the victim of abuse, harm or neglect.

What did we say we would do?

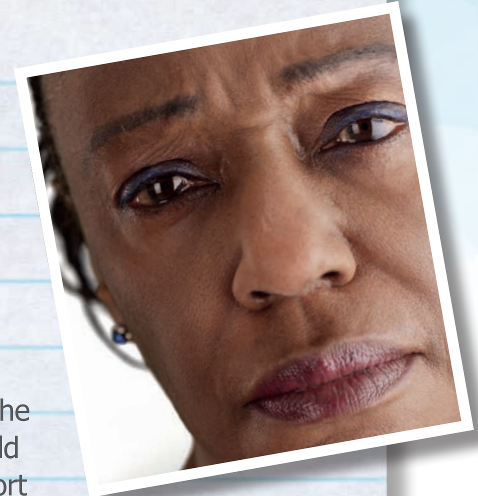
- Develop a framework for 'making safeguarding personal' so it is embedded in organisations that support the Board.
- Collect data to evidence changes in practise.
- Provide case studies which demonstrate how we have made safeguarding personal to support partner agencies training.
- Develop paperwork to record work towards 'making safeguarding personal' so all agencies can record this throughout the safeguarding process.

What did we do?

- A peer audit, an audit carried out by service managers from other authorities, was conducted in June 2016 which indicated that this priority was a key one for the Board and that further work needed to be done to embed the 'making safeguarding personal' agenda.
- The policy and implementation sub-group together with the safeguarding team and the safeguard trainer developed a power point presentation for Board members to deliver to their staff and partner agencies. This included powerful case studies as well as a quiz to help explain what making safeguard personal meant.

  Ten sessions were delivered throughout the year to council adult social care staff and other partners.
- Case studies demonstrating the 'making safeguarding personal' were presented at a Board development day in July 2016.
- Paperwork was improved to ensure the alert/concern referral form included the outcomes that the victims wanted, as well as the enquiry form, supporting partners to explore this further.
- The data set was changed to ensure that information was captured as to whether people were asked about the outcome they wanted from the safeguard process and at the end of the process whether this had been achieved.
- At the end of the year the annual data was collated. This showed a 28% increase in the number of people who felt their outcomes had been achieved over the previous year - 65% in 2015, 93% in 2016.

Case Study



Martha - lived on her own, maintained poor hygiene and refused care or support from services. She was visually impaired and required invasive treatment which she refused. The professionals involved with her queried whether she actually had capacity to make these care decisions. Advocacy servicse were involved and discussed the issues with her. It was felt that she could manage alone at present without support and on balance had the right to refuse treatment, if she chose.

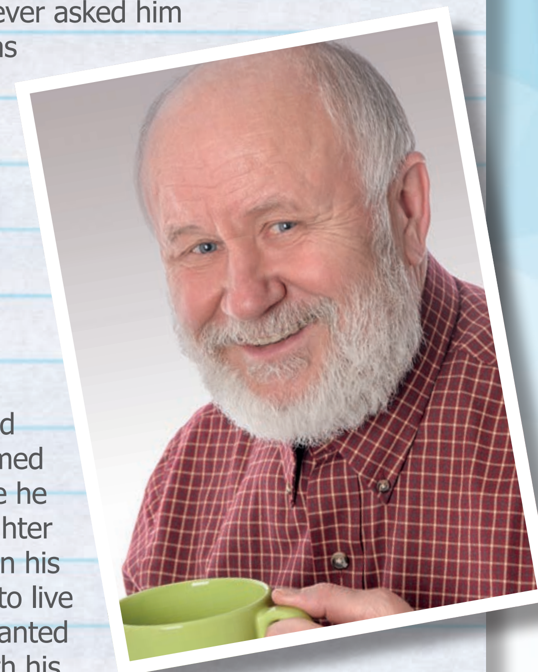
Case Study

Barbara - had advanced dementia and lacked capacity to determine how she was cared for. She lived with her husband and the family reported that it was a happy and settled marriage. Barbara certainly looked to her husband for reassurance. A carer however who was supporting Barbara at home noticed that her husband had been aggressive with his wife. To give her husband a break, relieve his stressful caring role and ensure he was able to get some much needed sleep additional day care support was provided. It was felt in a multi-agency meeting that if Barbara could express her wishes it would be that stay with her husband.

Despite this another incident occurred where Barbara was subject to further abuse from her husband. This time advocacy services were asked to support Barbara and a further safeguard meeting was held. It was agreed that Barbara should go into a nursing home but maintain regular contact with her husband and family who would continue to take her to events outside the nursing home thus enabling her to continue to enjoy family life. This also relieved her husband of his stressful caring role, whilst he contined to see his wife regularly.

Case Study

David - told a day centre that he was moving in with his son and had given him money towards the purchase of the property. His son then however asked him for further money. David was not happy and asked staff at the day centre to report this as financial abuse as he wanted it to stop.



A few weeks later David moved into a residential care home. Again this was queried as financial abuse. When David attended the case conference he indicated that the reason he had claimed financial abuse was because he had fallen out with his daughter in law. He had willingly given his son money but didn't want to live with them any longer. He wanted to retain his relationship with his son but wanted support to live elsewhere.

Staff supported him to achieve this.

Priority 3

To develop information in order to prevent safeguard incidents occurring

What did we say we would do?

- **An awareness campaign is to be rolled out in 2017 for those who live alone in their own home.**
- **Look at developing video clips on the website to raise awareness concerning neglect**
- **To look at data from other preventative initiatives to inform the prevention strategy for the Board.**

What did we do?

- **Updated the safeguard leaflets and distributed them across the borough. These leaflets noted the feedback from user groups led by Healthwatch.**
- **Partners attended a conference on self-neglect with other colleagues from across the Black Country to raise awareness of the concerns this issue raised for people who are isolated and living alone.**
- **Practise guidelines were issued to staff across the borough to help them support people who are self-neglecting**
- **A practice learning event was planned for June 17 to look at three Dudley Borough case studies and relate these to national learning. This was led by Dudley CCG and the council's adult social care staff.**
- **In 2015/2016 Dudley conducted two Safeguard Adult Reviews and the Board's key focus throughout the year was the action plan arising from these reviews to prevent similar situations reoccurring.**

Examples of this work include:

- Work with the council's adult social care staff, Dudley CCG and the Black Country Partnership Foundation Trust to offer specialist support to people with complex needs.
- Work with Dudley Group Foundation Trust to educate staff on the many and varied care settings which people can live in, to better inform hospital discharge planning.
- The development of work on a family support code. This was the result of the comments of a family member of a safeguarding victim. They felt that agencies should respond better to safeguarding traumas. West Midlands Police praised their work and they provided information to support this, leading a workshop to promote understanding.
- Work on dysphagia – a practice learning event for one hundred partners was held in February 2017. A representative from Dudley Group Foundation Trust trained partners on how to prevent swallowing problems which can arise in people who have care and support needs. This led to a focus group developing documentation to support this training which is to be developed in 2017.
- In September 2016 and March 2017 the Board was recognised for its regional and national lead on work in partnership with Trading Standards. Members of the Board were asked to speak at national and regional conferences to explain how partners in Dudley had worked closely together on a groundbreaking case to prevent a case of financial abuse.
- In February 2017 Trading Standards also presented a paper to the Board outlining the huge problem that national scams are creating locally, particularly for older people as well as vulnerable residents. Over 2016/2017 Dudley's Trading Standards received 369 rogue trader complaints and 465 other referrals from the national trading standards scams. In 2017 there are plans to address this issue with the formation of a dedicated team.
- West Midlands Fire Service provided data to the Board in 2016/2017 on the issues found when Fire Service staff undertook safety checks. This data contributed to the preventative work planned for 2017 with people who self-neglect.

Challenges for 2017-18

Financial abuse/scams

The Board's 2017/18 business plan highlights the requirement for information to be provided from many other agencies in the bid to prevent abuse. Trading standards indicate that only 5% of victims report being scammed. The average age of a scam victim is 74. They lose an average of £4,500 and a scam victim is 2.4 times more likely to require support over the two year period after a scam. This is a huge challenge and following a Trading Standards presentation to the Board, the council has accepted a proposal to create a small unit in 2017/18, within Trading Standards to work specifically on this issue, in conjunction with the Board.

Self-neglect

Dudley has the highest incidence of self neglect within the region. Board members have received both local and regional training to address the issues associated with self neglect. They are working to review a raft of self neglect case studies and are looking to develop a plan to address the problem. This issue continues to present a challenge into 2017/2018.

Case Study

Jackie - lives in a residential care home because her own home is currently unsafe to live in. This is a result of the vast amount of possessions she has. As a consequence the floors are unsafe and there is simply no room to move around the property. Her cat is being cared for by a neighbour. She wants to return to live in her home and has agreed it needs cleaning but insists that she wants to keep her possessions. She goes home for visits and is now working with an advocate, as well as support services who will work with her to help resolve the situation.

Case Study

Anne - lives with her husband. She has multiple sclerosis and although her husband cares for her, professionals were worried about the state of the home, as well as their volatile relationship. Anne attended a case conference and stated she wanted to continue to live with her husband, regardless of these issues. She stated that she was aware of the risks and didn't feel they were that significant. She did however agree to recieve additional support from an allocated social worker who will continue to monitor the situation at home. Occupational therapists have also supported her with equipment which enabled her to cope better at home.

Further Partnership Work

- Every two months the council's adult social care and commissioning team (the team that monitors the quality of services delivered on behalf of the local authority), the CQC, Healthwatch Dudley and the CCG have been meeting to discuss commissioned services which have had safeguarding concerns raised against them. They work together to agree how to improve practice and drive up standards. As a result there have been subsequent meetings to discuss individuals, as well as organisitaions and the expectation has been that action plans will be developed to demonstrate how standards will then be raised.
- Partners have worked with many agencies to improve practice standards, resulting in a number of services that had been suspended from supporting people regaining their status and demonstrated much improved practice. In addition West Midlands Police Adults at Risk Team has continued to provide support to victims of crime together with local police units improving support for Dudley Borough residents
- To endeavour to ensure that individual's are supported personally Dudley & Walsall Mental Health Trust, Dudley CCG and Dudey Group Foundation Trust have worked together to establish meetings to discuss highly complex cases and ensure that appropriate measures are put in place to support the individual victims. This may sometimes include escalation to senior managers.
- Dudley CCG has established safeguarding quality review meetings as a forum to provide reassurance that safeguarding is embedded into health organisations and to identify areas where improvements may be required.
- Dudley Group Foundation Trust continues to monitor and support people with learning disabilities when they are admitted to hospital and ensures that communication plans and advocacy support is available when required to safeguard the person, working closely with partners along the way.
- West Midlands Fire Service has a team of staff who work with individuals with multiple and complex needs to reduce risks for people living in their own homes. This work often involves multi agency meetings to agree who is best placed to support each person. The service also undertakes serious incident review processes where there is a serious or fatal fire and the information is always now shared with partners.
- In 2016 a new project was rolled out where Dudley Telecare Service working closely in partnership with West Midlands Fire Service began responding to people who had fallen to prevent hospital admission, self-neglect and promote well-being. This ensures that Fire Service resources are protected and that people are responded to quickly and efficiently. As an example some seventry - six incidents were attended in a four week period. This quick reponse prevents any further deterioration and ensures that any specialist equipment required is swiftly provided.
- Healthwatch Dudley established a communications and engagement group with partners to consult with local residents and share important messages about safeguarding. They have also ensured that Dudley Council for Voluntary Services ran a striking piece in their monthly bulletin which explained the work of the Board as well as a quick guide to safeguarding. In addition Healthwatch's focus group - The People's Network have worked with the Board to promote safeguarding appropriately.
- The council's housing team has trained tenants and residents in safeguarding and in particular the awareness of violent extremism. They have also worked with people fleeing domestic abuse within the borough and those sleeping rough to prevent self-neglect and potential vulnerability.
- There has been a clear recognition within the council that children in transition to adulthood are particularly vulnerable and staff across services are working collaboratively to address these concerns

- Community safety and the community safety partnership have taken the lead for the board on domestic abuse, modern slavery, Prevent, forced marriages and human trafficking in 2016-2017. This has been invaluable to the partnership. A domestic abuse conference was held in March 2017, regular Prevent training was delivered throughout the year to partners and development work on modern slavery has also begun which will be consolidated 2017/2018.
- The community safety team have also led on a domestic homicide review which is still awaiting Home Office approval and will be reported on in our 2017- 2018 Annual report. These reviews are carried out when it is felt that lessons can be learnt from the review of circumstances in which the death of a person aged 16 or over resulted from violence by a person to whom the victim was related to, lived in the same household or was in an intimate relationship with.
- Still on domestic abuse, a proactive partnership exercise was conducted during the summer of 2016 to learn lessons across partnerships about serious incidents of domestic abuse. The learning from this event was fed into the Strategic Domestic Abuse Network to encourage partners to disseminate information to staff working operationally. The Probation Service, West Midlands Police, Dudley Group Foundation Trust , the council's adult social care team and children's services team and Dudley CCG all took part in this exercise. Individual cases were carefully scrutinized to look at how people had worked together prior to the incident, to protect the victim.

Challenges for 2017-18

Challenges to partnerships

Partnerships' capacity to carry out joint investigations or lead on enquiries as requestedby the local authority.

Partnerships who support several local authorities in the West Midlands value the regional approach to safeguarding.

Soundbite: *"We think it is valuable that our group can give different viewpoints. People assume we would know the language that agencies use but we don't. It is good the Board members are checking this out".*

Case Study

Joan - lived independently at home with support from her daughter, district nurses and care agency staff. Her daughter asked for some respite provision to enable her to take a break from her caring role. Whilst staying in a residential care home for a respite stay staff reported pressure sores and a safeguard alert was made as there were concerns about how agencies in the community had cared for Joan.

An enquiry took place and staff's actions were considered under disciplinary procedures. Joan lacks capacity to make a decision about where she lives but her daughter felt that she would want to return home to live. This is the outcome she would have chosen if she could, however it was agreed that initially priority should be given to her pressure sores getting better and the need for 24 hour care.

This took longer than expected and professionals met once again and agreed that she should now move home. Specialist equipment was provided to monitor her health care needs at home.

Safeguarding Adult Reviews

Over 2016/2017 two safeguarding adult reviews (known as SARS) were conducted. These reviews take place where a person with care and support needs had died and it is felt that an independent review of the issues around the death should be conducted. Two SARS were completed over the period - in May and August 2016.

SAR 1

This case was considered in May 2016 and involved a gentleman with Multiple Sclerosis. He lived in an extra-care housing scheme in his own flat, receiving care and support from the scheme provider. In December 2013 the gentleman sadly choked on his lunch and subsequently passed away. The Board had to wait for a lengthy coroner's enquiry and police investigation before it could proceed with the SAR.

The author of the SAR made a list of recommendations to the Board partners. In response the Board established a sub-group to consider these recommendations, develop an action plan and regularly review it. This was made public on the Board's safeguarding website.

What did the report recommend?

- Dudley CCG, Dudley Group of Foundation Trust and Dudley Council to build greater awareness of dysphagia across their organisations.
- Agencies are to look at how they work together when people are moving services to ensure that information is passed between professionals and care is well co-ordinated.
- New systems planned for development within healthcare settings should recognise that acute hospitals need to consider the very specific requirment of people with complex needs.
- Assessments for people requiring services should include a specific question about dysphagia, plus advice from a healthcare professional when a specialist resource is sought.
- Hospital staff should be made aware of different types of care settings so that when discharging a person back to that setting, they are aware of the level of support they will need.
- The CQC were asked to review dysphagia training in services that provide care to people diagnosed with the condition. Dysphagia is a condition where people have problems swallowing.

What did we do?

- A task and finish group developed a document for staff working in the community to support adults with eating and drinking difficulties. This has been completed and is being consulted on prior to training and distribution later in 2017.
- A practice learning event was held in February 2017 for one hundred practitioners working across Dudley. They looked at these recommendations and the importance of multi-disciplinary meetings to ensure information is shared between partners especially when a person is moving accommodation.
- A document was developed which outlines the many different types of care provision across the borough. This has been distributed to all hospital wards so that staff are now aware of the support provided post discharge.
- People with most complex needs now have the involvement of a health professional to lead on issues surrounding the person's welfare and care planning.

- The council's adult social care management team informed its operational staff about referencing dysphagia in care plans for people. In 2017 it is planned to change paperwork to ensure this is a specific question that is always asked.
- West Midlands Care Association held several events across the year for providers of services - both domiciliary and residential. Dysphagia training was recommended.

Challenges for 2017-18

This action plan has been consistently worked upon following this tragic death. The SAR sub-group will review its progress and ensure that momentum is not lost in embedding the lessons learnt. There is still work to be done on training and raising staff awareness, which will be maintained throughout the coming year.

SAR 2

In 2016/2017 the same independent author conducted a further SAR on a gentleman who had also choked whilst travelling in a car with his support workers to a holiday in Cornwall. He had severe learning disabilities and lived in a supported living scheme with his own home and staff support. Again the review was delayed due to police investigations and the prosecution of the staff involved. Once the author had completed the work she made recommendations to the partners of the Board. The SAR sub-group developed an action plan on the basis of these recommendations too .

What did the report recommend?

- Ensure that care plans for people clearly note their risk assessments and that care needs should be agreed with the relevant healthcare professionals. Staff should receive regular supervision to review and discuss these.
- Consideration should be given to appoint a named lead healthcare professional for each person with complex needs and a learning disability.
- Job descriptions and person specifications for support workers should include competence in menu planning, food preparation and healthy eating.
- People with dysphagia must have support from staff who have recieved dysphagia training, safer swallowing and nutrition awareness.
- A local strategy should be developed to reduce people's risk of choking.
- Multi-agency reviews should be regularly arranged to support person centred care. Families and advocates should have access to these and feel free to request then. A change in a person's need should then prompt a review.
- Commissioners should be explicit in their contracts about what is expected from services that support people with complex needs.
- Health plans should be linked to the GP's annual review.

What did we do?

- Work within partnerships has developed to ensure that people who have complex learning disabilities, health and care needs are guided by relevant healthcare professionals and that a named health colleague is assigned to each person.
- Commissioned services have included demonstrating competence in menu planning, healthy eating and good preparation in job descriptions and specifications for support workers. This was also reiterated in a training session for providers, led by West Midlands Care Association in the last year. The practice learning event held in February 2017 shared this requirement too so that staff visiting homes could ensure this was being followed.

- This SAR too recommended training for support staff in dysphagia, safer swallowing and nutrition awareness.
- As in the first SAR a task and finish group developed a document for staff working in the community to manage adults with eating and drinking difficulties.
- The care planning process will be reviewed in 2017 with the reviewing process ensuring that reviews can be held when an individual with specifc needs requires consideration.
- The practice learning event held in February 2017 addressed the recommendations of this SAR too. The sister of the victim attended this event to share her experiences in a group exercise.

Challenges for 2017-18

- Following on from the SARS it is vital that their influence continues long into the future in the area of care and support of people with complex needs.
- The SAR sub-group will continue to monitor this and ensure that the learning is consolidated.
- The code of conduct to support for families who have experienced such tragedies will be distributed in 2017 so that agencies do not just concentrate on the events, but also the family lives that are touched by such events.
- As structures and systems change in the way that partners operate, Board leaders will have responsibility to ensure that this learning is transferred. The Board plans to undertake an assurance exercise of all Board members later in 2017 to confirm this.

Soundbite:

"It was heart warming to see so many people who can influence and help to prevent these types of death in the future" were her comments after the event.

Case Study

Arthur - had passed away and whilst his daughter knew that his death had not been caused by his respite stay in a residential care home, she felt that while staying there he had not been cared for well. Her concerns focused around the fact that there didn't ever seem to be enough staff on duty and records of how much fluid he had taken seemed to be poor. She raised her concerns and asked that standards be checked in the home.

The investigating social worker confirmed that valid issues had indeed been raised. A new manager was appointed at the home and changes were made in how things were recorded and numbers of staff on duty. Arthur's daughter was invited to the home to see the improvements for herself. As a result she felt that she had been listened to and was pleased to hear that care had improved for other residents as a result of her reporting the neglect that her father had experienced.

Data Collection

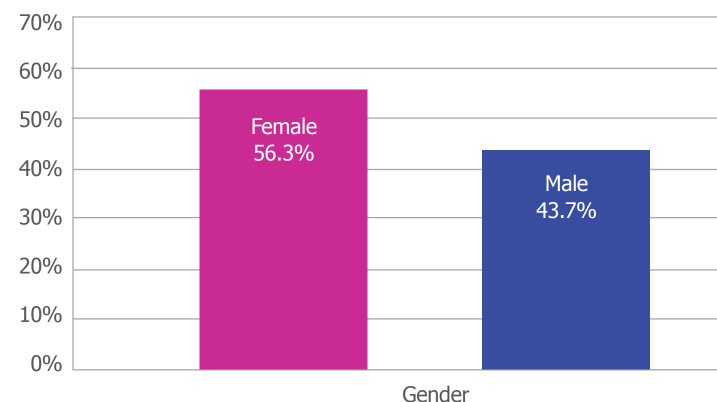
In 2016/17 all Board partners began to present safeguarding statistical data to the council's management information team. They collate this data and present it to the Board. This clearly demonstrates the commitment by all partners to collate reliable safeguarding statistical information. The data is also collated nationally and regionally to look at trends and assess any development work that is required.

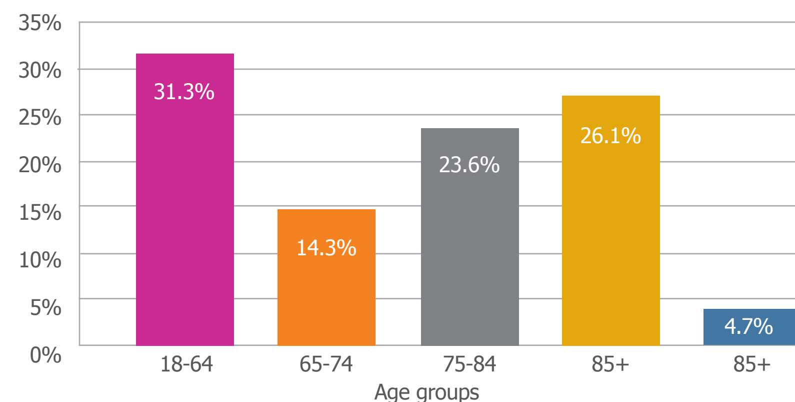
In 2016/2017 2809 safeguarding concerns were received within Dudley Borough, in comparison to 2091in 2015/2016. Of those concerns it was deemed that 831 required a safeguarding enquiry following information gathering exercises.

Commissioning services dealt with many of the issues that were not progressed, with quality checks made on a number of services. In addition services which provide additional low level support to people, such as telecare, financial management, safety schemes, health care advice and support, along with staff training were also felt to be more appropriate for many of the cases which were not progressed to an enquiry. This demonstrates clear proportionality and empowerment for people who need additional help to feel safe and secure.

Overall the majority of safeguarding enquires conducted over the reporting period were for females at 56.3%, with the majority of females falling into the 85+ age group (31.2% of all female enquiries).

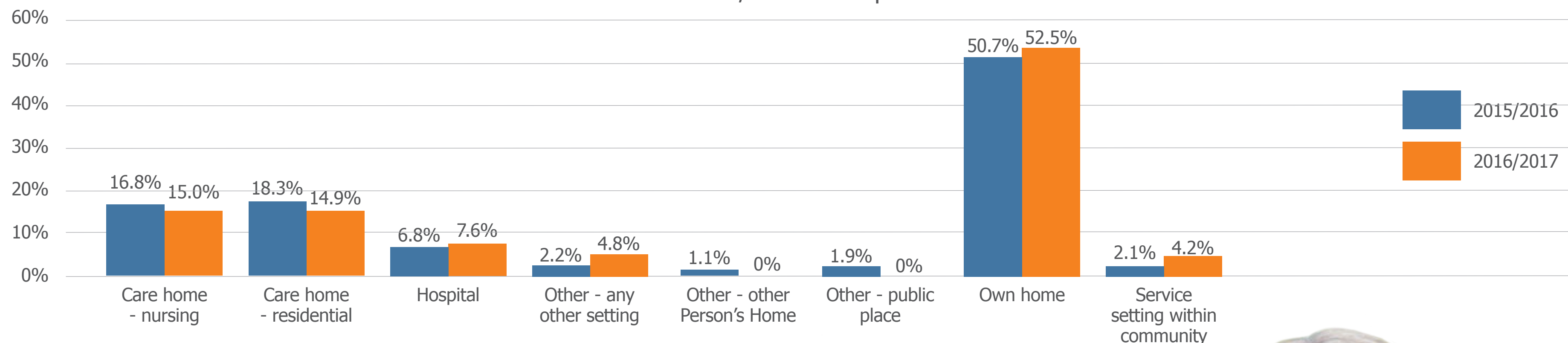
The majority of all enquires were in 18-64 age group- this is the first time in ten years that this has been higher that the older age group catergory. This may be the result of more younger people living independently with care and support needs and reporting abusive situations, as the awareness of safeguarding is raised across the borough.



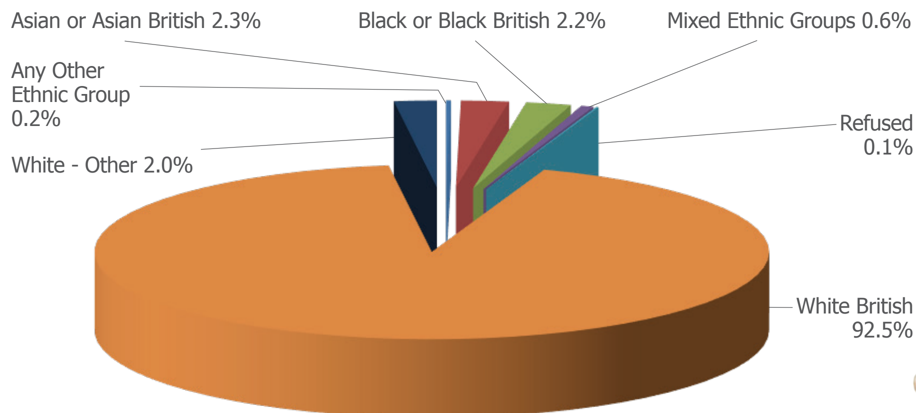


As in the previous ten years the majority of enquires were recorded as taking place within the victim's own home at 52.5%, only a slight increase compared with 2015/2016 which stood at 50.7%. Of these 436 referrals recorded as taking place in the persons own home, 54% were females. This continues to support the prevention strategy adapted by the Board.

The board recognises the high percentage of incidents within people's homes and focusses upon this in it's 16/17 business plan

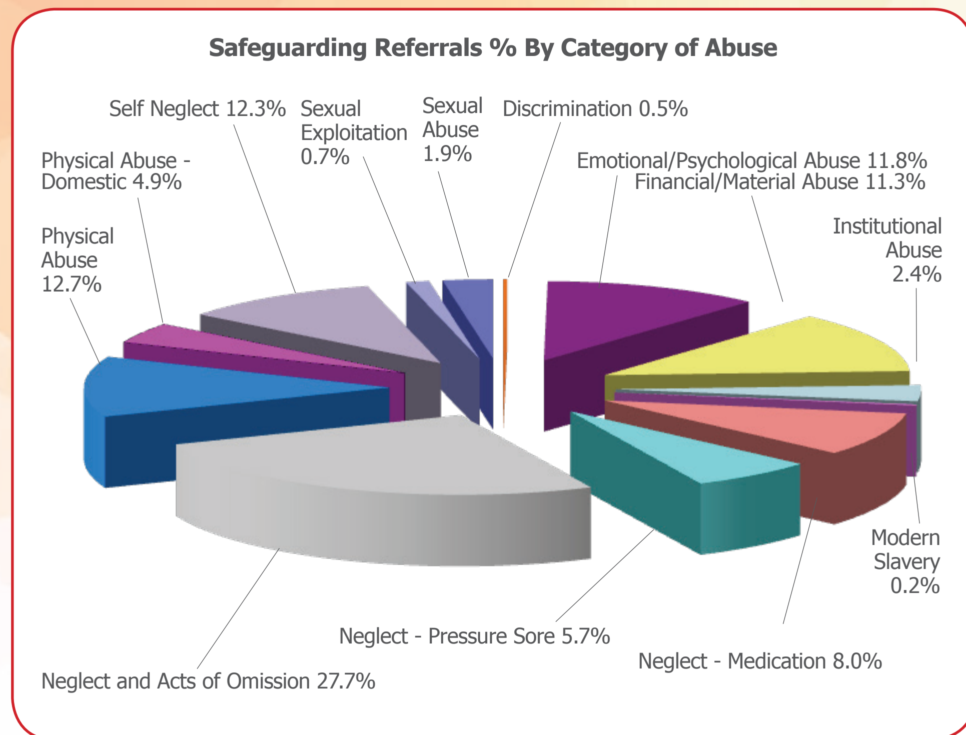


The majority of enquires were recorded for people in the white british ethnic group at 92.5% which is almost exactly the same as for 2015/2016 at 91%.



The abuse category of neglect and acts of omission was recorded as the highest proportion of all enquires at 27.7% and this is similar to 2015/2016 at 26%, however if all neglect categories are combined this figure increases to 41.4% and clearly forms the majority of abuse categories overall.

The statistics show that financial abuse is a key concern as outlined in our business plan, along with self-neglect - hence the Board's emphasis on training partners throughout the year.



Research clearly indicates that people experiencing abuse are at risk from further abuse. In 2016/2017 data collected examined how effective our safeguard practise deals with risk.

In 2014 a peer review had told us that they felt too many cases had been investigated by staff where there were no positive outcomes. It is encouraging therefore to see that in 2016/2017 staff have recorded over 80% of risk to people had been removed or reduced as a result of safeguard actions.

Risk Outcome	2016/2017
Risk Remained	13.4%
Risk Reduced	45.3%
Risk Removed	41.3%

This work to address risk typically will involve:

- Staff providing inappropriate care and support undergoing disciplinary procedures or being removed from their roles.
- People choosing to recive support from someone else.
- Helping people to manage their money differently.
- Providing regular support to monitor a person more effectively.
- Alternative accommodation being found for people
- Simply empowering people to make changes to their life which makes them feel safer.

These actions will typically involve many of the Board partners working together in a coordinated way to remove the risk factors.

The national initiative "making safeguarding personal" asked local authorities to ensure that they are asking the victim exactly what outcomes they wanted from their safeguarding experience. This is then recorded as fully or partially achieved. Partner agencies who made enquires on behalf of the local authority were also asked to record this so that their information could be collated within the local authority data.

Making safeguarding personal outcomes 2015/2016 - 2016/2017

Asked and outcomes expressed

Outcomes	15-16	%	16-17	%
Asked & outcomes expressed	236	44.6%	465	74.4%
Asked & no outcomes expressed	13	2.5%	34	5.4%
Not asked	73	13.8%	74	11.8%
Don't know if asked	21	4.0%	46	7.4%
Not recorded	186	35.2%	6	1.0%
Total	529	100.0%	625	100.0%

Outcomes achieved

Outcomes achieved	15-16	%	16-17	%
Fully achieved	135	57.2%	374	80.4%
Partially achieved	20	8.5%	63	13.5%
Not achieved	81	34.3%	28	6.0%
Total	236	100.0%	465	100.0%

In June 2015 the board was told by a local authority peer audit that they needed to embed this working across all practice. The data for the period concerned indicates that this has now been achieved. It is important to be challenged in safeguard practice, challenge can often lead to important practice development.

Clearly Board partners rose to this challenge and recorded their findings. Members of the Board's policy and workforce development sub-group developed and agreed Power Point presentations, quizzes and case studies which are used for training staff and partners.

Dudley is now in a strong regional position as far as 'making safeguarding personal' is concerned. The voice of the victim is clearly embedded in practice and so is heard so much more loudly.

Where someone lacks the mental capacity to express their safeguard outcomes, family and friends are asked to comment basing their views on past wishes and beliefs. Dudley Advocacy Service also supports people who do not have this family support, or where the family member is in conflict with the victim. Thirty two people were supported in this way with their safeguard concerns, with many more supported regarding Mental Capacity issues.

Advocacy Service are in regular contact with Board partners, they represent people's views when they attend hospital, where they are in residential and nursing homes and in community settings. Information on the support they offer is presented to the Board twice yearly.

Case Study

Nancy - had a fall and was admitted to hospital. She had fluctuating capacity and prior to her admission there had been a query as to whether she was being financially abused. Whilst in hospital it was felt that she needed to move into residential care. The safeguard team however, felt that Nancy had clearly wanted to be at home previously despite the risks and so advocacy services were asked to support her with this decision making.

Advocacy Service felt that she did lack capacity to make decisions about her care and support arrangements and to manage her finances, but a return home was clearly what she would have chosen. They recommended that she be supported to do so with a care package in place and with financial management support. Her family agreed that this is what Nancy would have wanted and were pleased that Advocacy Services had explored this option on her behalf.

The Board has also received data as previously recorded in this report from West Midlands Fire Service to demonstrate safeguard prevention, along with information concerning crime involving vulnerable people from West Midlands Police. This is reported twice annually to the Board. Domestic abuse data is also collated for the Board as indicated in the previous tables.

The Community Safety Partnership also leads on domestic abuse and oversees the MARAC process- which is a Multi-Agency Risk Assessment Conference - to share information on high risk cases of domestic violence and abuse and put in place a risk management plan for the person concerned.

MARAC Aims to...

- Share information to increase the safety, health and well-being of victims, their families and their children.
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and reduces the risk of harm and repeat victimisation.
- Improve agency accountability and provides data to the Board twice a year to raise awareness on where partners may not be flagging up referrals to the service and looks at the numbers of people involved in the process.

Over the period 408 people were referred to MARAC. The police are one of the most significant partners in the MARAC process, having referred over 300 of these people to the multi-agency process. West Midlands Police work with partners to ensure victims of domestic abuse have the appropriate support to avoid repeat victimisation.

Several members of the Board also receive regular bi-monthly data from childrens service on the Multi-Agency Safeguard Hub (MASH). This information covers a wide range of data which is scrutinized through the Children Safeguarding Process but is shared with members of the Adult Board for transparency.

Dudley & Walsall Mental Health Trust undertakes all safeguarding enquires on people who use their services. Their data is included in all of the data tables evidenced earlier and this information is consistent and robustly shared within across the partnership.

Case Study

Eloise - lives alone and has sadly experienced several traumas. She had a male partner who is younger than her but the relationship has become volatile and he abused her and her property.

With support from a social worker, West Midlands Police and an independent domestic abuse advocate she was re-housed well away from the man and has requested support for the other personal issues she experienced.

Her self- esteem and wellbeing has improved through this support When she first asked for support she really did think that she was beyond help.

Challenges for 2017

Dudley CCG is considering what information could be provided twice annually for the Board. It collates information on wider areas of concern for Dudley & Walsall Mental Health Trust, Black Country Partnership Foundation Trust and Dudley Group Foundation Trust. The quality and performance sub-group of the Board plans to address this in 2017.

Safeguard Scrutiny 2016/2017

Board members recognise that data collected only shows a very small part of the complete picture. Regular case studies are now also presented to the Board, along with SARS cases. Board partners discuss and explore these individual cases, learning from them and implementing this learning across their partnerships and organisations.

The Board's quality and performance sub-group has the audit of safeguard cases within it's remit to add to this assurance process. Dudley & Walsall Mental Health Trust has developed a desk top audit template which was adapted by the sub-group and two exercises were held in April 2016 and February 2017 to consider specific cases. Files from various agencies were scrutinized and information was collated about the standard of the recording. Learning from those reviews were shared with the Board at its meetings.

In October 2016 the quality and performance sub-group met with partners to examine a sample of safeguarding cases to look at whether the cases were felt to meet the threshold for support and whether the right agencies had been involved in information gathering. Twenty cases were looked at. The sub-group was reassured by this process that threshold decisions were being appropriately applied in the main but expressed concern about three cases where issues should have been explored in more depth. With regards to the partnership, the breadth of liaison was noted. Over twelve partners had contributed to these discussions on these cases. Auditors felt that domestic abuse cases required further partnership involvement. It was agreed that an audit planned in June 2017 should concentrate specifically on this.

An individual management report was also presented to the Board which was felt by the SARS group not to meet their criteria for an independent review. Dudley's CCG Safeguard lead undertook this and the findings were managed by the SARS sub-group so that its impact on practice was not lost. A practice learning event planned for 2017 to disseminate learning about this issue was organised and will be reported upon in the 2017/2018 annual report

One organisation in the borough, as a result of one of the SARS, was asked to present updates to the Board of their action plans to improve their practice on two occasions within the year. This monitoring continues into 2017 as Board members want to keep informed of progress. Dudley Integrated Commissioning Service supported this process and provided reports to the Board in 2016/2017 on the issues raised within the organisation concerned.

Challenges for 2017

There is an opportunity to scrutinize safeguard practice in a variety of ways. The Board has endeavoured to do this throughout 2016/2017 The challenge for the coming year is to maintain this, with Board members feeling empowered to ask for information and data that is relevant to the Board and also relevant to themselves as active partners. The quality and performance sub-group of the Board will continue to monitor this.

An assurance audit for all Board members is planned for 2017 and the appropriate framework to agree this will be developed by the Executive group of the Board in 2017/2018.

Managing operational and strategic risk is also critical and a risk register will be developed in2017/2018 to collate risk from partners and strategic risk which the Board manages.

Multi-Agency Safeguard Hub

In 2015 it was agreed that Dudley would develop a Multi-Agency Safeguard Hub (MASH). The purpose of MASH is to bring key professionals together to provide better quality information sharing across agencies and joint Safeguarding decision making.

The peer review mentioned previously in the report indicated that inconsistent approaches to planning adult Safeguard intervention were occurring due to different access systems for referrals to parts of the service. In 2016/2017 partner agencies and operational staff met together to develop an Adult MASH.

The council's single point of access (SPA) for adult social care is based at Brierley Hill Health and Social Care Centre and deals with all safeguarding referrals except for those allocated to other teams and those meeting the criteria for complex and inclusion services. It is planned that this will change in September 2017 so that this SPA becomes the access point for all unallocated cases with a group of dedicated staff receiving all safeguard concerns directly from the SPA. This team will be the initial development phase of the Adult MASH and will apply safeguard thresholds, undertake lateral checks with partners and ask the victim what outcomes they want from the process. The manager of the MASH will then authorise, co-ordinate and record planning decisions and undertake any urgent planning meetings which may be required.

This team will then identify which safeguard enquiry will be needed and whether these are to be undertaken by partner agencies or the local authority. The cases will then be passed to the appropriate teams for the work to be undertaken. The local authority will retain responsibility for collating those enquiries carried out by partners which will return to MASH managers for conclusion

Challenges for 2017/2018

It is recognised that partnerships within the Board are strong, however this process change will provide challenge to partnerships and there is a resource issue - these issues need to be addressed for the MASH to be successful.

The Board has been advised of the changes planned and it has been discussed at Board meetings and the Executive Board throughout the year. In 2016/2017 a strategic and operational sub-group was held for a period of time to discuss MASH proposals and this will be developed in 2017/2018 as the operational process for the Adult MASH development is agreed.

Multi-Agency Training - Safeguard 2016/2017

There has been continued support once again throughout the year for multi-agency training. The policy and workforce development group (renamed in 2016) continued to monitor training across the partnership.

National directives have influenced the focus of training in 2016/7. For example 'Preventing Extremism' where every local authority:

- Supports people who are at risk of being drawn into terrorism.
- Works with community groups that provide services to vulnerable people.
- Supports local schools and partners agencies through engagement, advice and training. This strategy is maintained by the Home Office and in 2016/2017 a prevent co-ordinator supported training and projects across the borough.

This initiative led to extensive training programmes within all organisations across the borough.

Agencies have also delivered training on safeguard awareness, Mental Capacity Act awareness and have shared bespoke courses that they have delivered to their staff group. For example:

- Making Safeguarding Personal was delivered across the partnerships with a toolkit developed for the training.
- A practice learning event in February 2017 shared learning from the SARS with over one hundred participants. The presentations from that learning event were widely distributed afterwards and many partners took part.
- The Community Safety Partnership held a multi-agency conference in March 2017 about domestic abuse to which operational staff from across the borough were invited. The concil's children's services offered multi-agency courses throughout the year too concerning domestic abuse. Within the conference information on coercive behaviour was distributed to partners and individual training sessions on this were also developed and delivered in December 20 16 and 2017
- In 2016/2017 joint multi-agency training was also offered about financial abuse from local authorities in conjunction with trading standards.
- Black Country Partnership Foundation Trust and the council's adult social care team also delivered training on practice issues for staff managing safeguard enquires.
- A key development in 2016/2017 was a project which ran across health organisations in Dudley, Wolverhampton and Walsall to raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards. This project produced excellent training resources to support best practise and aimed to develop and deliver a training plan to meet the requirements of the Mental Capacity Act and DoLs process to Healthcare professionals and primary care. Throughout 2016/2017 regular multi-agency meetings were held to progress this project which continued into 2017. Training videos and fact sheets were developed for partners and the project was discussed at the Board and supported by Board members. They tools are available on www.dudleyccg.nhs.uk/mental-capacity-act-project and remain a valuable resource not just for practitioners but for Dudley Borough residents too.

Challenges for 2017

The learning and workforce development sub-group recognises a continual commitment to adult safeguarding. The sub group recognised excellent practice for example from the council's housing teams..

The challenge for 2017/2018 is to collate information which evidences the staff requirements for training across organisations. Dudley Group Foundation Trust and Dudley & Walsall Mental Health Trust evidenced their collation of this information based on competency requirements of their staff. This is required across the partnership and is a challenge for 2017/2018.

Deprivation of Liberty Safeguards (DoLS)

These safeguards exist to provide a proper legal process and suitable protection for people in residential, nursing or hospital settings where deprivation of liberty appears to be unavoidable and in a person's own best interest.

In 2014 different thresholds were applied which has resulted in a significant court backlog of cases in every local authority. The Department of Health provided councils with a grant towards this to provide additional training for staff and to provide support for the complex administrative process.

The number of DoLS applicants received in Dudley over the past four years is detailed below:

Year	Total
2013 - 2014	142
2014 - 2015	615
2015 - 2016	856
2016 - 2017	812

As a result of the additional resources provided in 2016 the number of assessments completed in 2016/2017 totalled 363, as against 234 over 2015/16.

Community DoLS were also introduced in 2014, where a person is deprived of their liberty in the community such as in a supported living arrangement, an adult placement or in domestic settings.

In these situations the council has to request a Deprivation of Liberty application through the Court of Protection. As this is a different process to DoLS - staff have been trained and were supported by a dedicated member of staff to prepare papers for the Court of Protection.

A new scheme for Deprivation of Liberty safeguards is being consulted upon for implementation in 2017 to address the issues the current scheme.

Case Study

A ground breaking prosecution was concluded in 2016/2017. This involved a lady who posed as a cleaner and carer financially abusing a 93 year old gentleman. He had dementia and care and support needs but continued to live independently.

The alleged 'carer' took £250,000 from the gentleman, including £188,000 which was used to purchase a house for herself. Both safeguarding and Trading Standards were alerted to this case which subsequently led to criminal proceedings at Crown Court and civil proceedings in the Court of Protection. The lady was subsequently jailed for five and a half years.

Thanks are extended from the Board to the Communication and Public Affairs team who have supported the preparation of this report; updated the website throughout the year as required and supported communications work to deliver the business plan. The team have also provided a communication strategy to support the work of the Communication and Engagement sub-group in its work throughout the year.

The Business plan for 16-17 is still operational and the Board will review this in August 2017 to ensure it is updated and pertinent to the year ahead

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