Dudley
Safeguarding
protecting adults at risk

Dudley Safeguarding Adults Board **Annual Report** 2017/18

Contents

What is Safeguarding for Adults?

People's wellbeing is at the heart of the Care Act 2014, and the prevention of abuse and neglect is one of the elements identified as going to make up a person's wellbeing.

In the context of section 42 of the Care Act 2014, specific adult safeguarding duties apply to any adult who:

- has care and support needs; and
- is experiencing, or is at risk of, abuse or neglect; and
- is unable to protect themselves because of their care and support needs.

In addition local authorities have safeguarding responsibilities for carers.

Safeguarding duties apply regardless of whether a person's care and support needs are being met or not. These duties also apply to people who pay for their own care and support services. Adult safeguarding duties apply in whatever setting people live, with the exception of prisons and approved premises such as bail hostels. They apply regardless of whether or not someone has the ability to make specific decisions for themselves at specific times.

If an adult at risk of being abused or neglected cannot keep themselves safe from abuse or neglect because of their care and support needs, then the local authority's safeguarding duty applies. If they are able to protect themselves, despite having care and support needs, then a safeguarding response may not be appropriate.

What is Dudley Safeguarding Adults Board (DSAB)?

Overarching purpose

The overarching purpose of an SAB is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused working collaboratively to prevent abuse and neglect where possible ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This requires the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'.

It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- the safety of people who use services in local health settings, including mental health
- the safety of adults with care and support needs living in social housing
- effective interventions with adults who self-neglect, for whatever reason
- the quality of local care and support services
- the effectiveness of prisons in safeguarding offenders
- making connections between adult safeguarding and domestic abuse.

Core duties

SABs have three core duties. They must:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an annual report detailing how effective their work has been
- commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

Section 43 of the Care Act 2014 requires the Local Authority to establish a Safeguarding Adults Board (SAB) whose main objective is to protect adults from experiencing, or being at risk of abuse and neglect. 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 and West Midlands Probation, as well as voluntary sector organisations. The Care Quality Commission attend and report on their activities at one Board meeting each year.

The Board works to a business plan and produces an annual report which is distributed to key stakeholders as well as council cabinet scutiny. 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, partnership with the Dudley Safeguarding Children 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.

Executive Summary

The last 12 months have been very exciting for DSAB. The vision of Dudley Multi-Agency Partnership promotes safety and inclusion, aiming to improve life experiences of individuals and families by ensuring that its strategic and business plans reflect the requirements of its residents.

The Board has established its priorities based on the requirements of Dudley residents. These are to:

- Make safeguarding personal
- Ensure the right intervention at the right time
- Ensure that the voice of the individual is heard

As such, the Board has identified specific areas of work which centre on reducing the risks faced by individuals. Consequently investment has been secured to develop a team within Trading Standards that will identify and support victims of financial abuse. This work continues to develop at pace.

Furthermore the Board has been active in supporting the Transforming Care Agenda. A case study has been presented to the Board highlighting the excellent outcomes secured for an individual to live safe positive life in the community with the right level of support. The Board values engaging with people and families in forums that consider how best practice can be assured.

Further the development of a Multi Agency Safeguarding Hub (MASH) has streamlined the safeguarding concerns referral process to a central point. This supports and enables immediate multi-agency responses. Information relating to this service is detailed later in this document.

Message from the independent Chair

This report covers my second year as the Independent Chairperson of DSAB. This report provides a summary of the safeguarding work carried out by local agencies.

During this year, there have been some important developments in the local safeguarding system including the launch of a Multi-Agency Safeguarding Hub (MASH) to receive and screen safeguarding concerns raised in respect of Dudley residents. Work to tackle financial abuse has also progressed through a dedicated project led by the Council's Trading Standards team.

Engagement with residents has enabled DSAB to begin to review how easy it is for members of the public to make a safeguarding referral in Dudley and to understand how family members experience the safeguarding system. Increasing our engagement with residents remains a DSAB priority and the next stage is to use the experiences of adults with care and support needs to evaluate the effectiveness of safeguarding. This will allow us to further embed the "Making Safeguarding Personal" approach. Data indicates that "Making Safeguarding Personal" is already underpinning safeguarding practice however understanding the experiences of those who receive safeguarding services will enable those services to be even more responsive to an individual's needs.

During 2017-18, the Council's internal audit team completed an audit in respect of how DSAB delivers its statutory functions. A small number of priority actions were identified; progress has been made in delivering the associated recommendations and DSAB sub groups are also progressing a number of areas of Board development, including auditing and training. The Safeguarding Adult Review referral pathway has also been revised during 2017-18.

I would like to take this opportunity to thank DSAB partner agencies for their ongoing support and commitment to safeguard adults with care and support needs in Dudley, and in particular, I would like to acknowledge the work of front line practitioners who, on a daily basis, practice with vigilance and sensitivity.

Liz Murphy Independent Chair of Dudley Safeguarding Adults Board

Adult MASH

The MASH (multi-agency safeguarding hub) includes professionals from the following organisations: Health; Police; Local Authority, Housing; Trading Standards; Probation and Substance Misuse. It receives all adult safeguarding concerns for unallocated cases and assesses whether the safeguarding threshold is reached (as defined in Section 42 of the Care Act), and directs the concerns to the appropriate team or partner agency for a safeguarding enquiry, with an appropriate plan in place for enquiry.

This provides consistency of responses to adult safeguarding within Dudley MBC. In exceptional circumstances, MASH social workers will undertake safeguarding enquiries when a very urgent response is required.

Furthermore, having identified high incident rates of self-neglect, local policies and procedures are being developed to inform practice with this group of people, Additionally a self neglect and hoarding audit tool has been developed and training from a nationally recognised trainer has been secured. This training will be open to the partnership

A real success since the start of the year has been our improved partnership working. Thanks to efforts from our colleagues, we now able to report that 97.4% of all people who have received safeguarding services state that their outcomes have either been fully or partially met. This has increased from 93.9% in 16/17 and means that Making Safeguarding Personal is central to the process.

The Adult MASH continues to evolve and improve; going forward, we will continue to develop strong links and look to colocate with the Children's MASH.

Further Partnership Working

West Midlands Fire Service

West Midlands Fire Service has a team who work with individuals with multiple and complex needs to try to reduce risk and vulnerability for people living in their own homes. This work 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 information is shared with partners to enable learning and to support future prevention work.

Dudley CCG

Dudley CCG has a statutory responsibility for ensuring that the organisations from which they commission services provide a safe system that safeguards adults at risk of or experiencing abuse or neglect. Dudley CCG have ongoing Safeguarding Quality Review Meetings with providers to ensure that robust systems and processes are in place.

As part of their statutory responsibilities the CCG continue to play a key role in core Board business, with the Designated Nurse actively participating in the working groups of the SAB, and recently taking on a role as Chair for the Safeguarding Adult Review subgroup.

Dudley CCG team provides a safeguarding health advisory and support role for GPs and primary care colleagues, Adult Social Care, CQC and NHS provider services.

Safeguarding GP practice lead meetings are held quarterly and direct face-to-face training is delivered within the practices by the team. During 2017/18 these have particularly focused on raising awareness of adult safeguarding and to embed "making safeguarding personal" into work by recording individuals' wishes. These has directly led to an increase in GP engagement calls made to designated nurses to advise on the management of adult safeguarding concerns.

Recognition and management of domestic abuse has been a priority for 2017/18 - with the promotion and involvement of health agencies and the embedding of MARAC (Multi-Agency Risk Assessment Conference) processes and the IRIS project (Identification and Referral to Improve Safety relating to domestic abuse) into GP practices. Learning from Domestic Homicide Reviews has been incorporated into training events. This has raised awareness in this area

The CCG works collaboratively with the DMBC Commissioning Team and other teams within Social Care when safeguarding concerns have the category of neglect or acts of omission in independent provider services. The CCG have a Care Practitioners' Forum, which helps to identify concerns before they reach the threshold for safeguarding and have also undertaken joint quality assurance visits with Local Authority commissioning professionals to act on any areas of concern.

Dudley and Walsall Mental Health Partnership NHS Trust

Dudley and Walsall Mental Health Partnership NHS Trust is committed to safeguarding children and adults across the organisation. The welfare of the people who come into contact with its services either directly or indirectly is paramount and all staff have a responsibility to ensure that best practice is followed, including compliance with statutory requirements.

The Trust provides services within the borough of Dudley and is a key member of the borough's Safeguarding Board arrangements. It continues to progress a significant programme of safeguarding training for staff to ensure that all eligible staff have received the right level of training relevant to their roles and responsibilities.

As part of the Trust's commitment to the safeguarding of adults and children it has a dedicated Safeguarding Team which includes the Vulnerable Adults and Children's Safeguarding Lead, two Vulnerable Adult and Children's Specialist Practitioners, Safeguarding Report Writer, Compliance and Safety Coordinator and Safeguarding Administrator.

DWMH continues to maintain an active and robust presence within the Dudley Safeguarding Adults Arena with key personnel identified to attend the Board and subgroups.

DWMH undertakes all safeguarding enquiries in line with the Care Act for adults who use their services. This data is shared across the partnership via reporting to Dudley CCG to inform a borough wide approach. Processes are followed and information is shared with Dudley MBC via the section 75 agreement.

DWMH engages with the Adult MASH through an agreed information sharing arrangement ensuring that safeguarding responsibilities are met for service users. DWMH also engages with the SAR and DHR processes and participates in multi agency case audits as identified by DSAB

DWMH has a robust safeguarding training catalogue and accesses both internal and partnership training events for all staff. Prevent/WRAP training has now been incorporated into the training provided by the safeguarding team.

Healthwatch Dudley

Healthwatch Dudley reminds partners of the importance of listening to real life experiences of abuse and neglect to help them to continually improve local services. As an independent organisation with a passion for involving local people in decision making, Healthwatch were invited by the Board to engage partners in a Communications and Engagement subgroup. Within the Communications and Engagement subgroup, a user group has been instrumental in providing user feedback around the online "report it" function as well as a professional-led group. The key messages, themes and feedback will then be taken to construct a user-involved online "report it" mechanism which is fit for purpose, accessible and, more importantly, user friendly.

Through the group Healthwatch said it would:

- Agree key shared safeguarding messages to be promoted across the partnership
- Identify and champion ways to keep people safe
- Increase awareness of safeguarding adults in Dudley borough and how to report
- Involve adults at risk, carers and advocates in our work
- Be innovative on our approach by involving a diverse range of local people
- Ensure our messages are shared in appropriate meaningful language

A group of creative thinking communications and engagement professionals from a wide range of local organisations have been coming together every two months since first meeting in early 2017. For the first time it has been possible to capture the views of people who have been safeguarded. Lessons learnt were implemented into practice using people as "experts by experience". In addition the Board held a development day which specifically considered financial abuse. This event benefited from people sharing their experience of a relative being financially abused. The Board produced a work plan relating to preventing financial abuse as a direct result of this event. This will be implemented in 2018/19.

Furthermore Healthwatch was requested to support a group of young adults with complex learning disabilities due to safeguarding concerns. The individuals and their family members were supported to share their experience of being safeguarded. Consequently a great deal of invaluable information was gained, highlighting both areas of good practice and areas which could be improved. Despite all family members recognising the importance of the safeguarding process, it became clear that the way in which individuals and family members were communicated with, could be improved. For example when asked "What should the letter have said?" we were told that "the person writing it should have put themselves in our position and think about what they would have felt happy to receive."

Conversely, other feedback included:

"Safeguarding was something new for us, I was only allowed to attend the first part of the meeting but I definitely wanted my views to be heard. I didn't think anyone would listen to me but I was pleasantly surprised. I was listened to, actions have been set at each meeting and they have been reviewed so I know that things are happening."

The feedback received from the family members has reminded us that the way in which we relay communication is equally important as the actions we take in performing our duties.

Our work does not replace the communications and engagement activity of individual organisations, rather it complements by providing a space for networking, sharing resources and collaborative working on safeguarding campaigns, all adding value to the important work of Dudley Safeguarding Adults Board.

Dudley Trading Standards

Dudley Trading Standards continues its work to identify and protect victims of financial scamming in the Borough. In one of the worst cases encountered so far, a Dudley man in his eighties received a telephone call claiming to be from his bank. The caller said that his local branch had been compromised and that there was an investigation into a worker at the branch who was stealing money. The caller instructed the victim to go in to the branch and transfer his life savings, in excess of £50,000 to two bank accounts for which account numbers and sort codes were provided. The victim was told that on no account should they discuss the phone call with anyone in the branch, as the member of staff could be the person stealing money. On the next day the victim duly went to their local branch and transferred their entire life savings to scammers' bank accounts.

Upon discovery of the scam, within a few hours, the bank said they could do nothing about it as the money had already been transferred. The matter is now being investigated by Trading Standards, who are carrying out financial investigations to trace the scammers, and are also taking up the victim`s complaint with the bank, as there are concerns that the bank made insufficient checks before allowing the transfer.

Black Country Partnership NHS Foundation Trust

BCPFT have:

- Maintained consistent representation at DSAB and identified key personnel to attend the Board and subgroup meetings
- Newly appointed an Associate Director of Safeguarding who has ensured consistent input from the Trust
- Refreshed internal training to bring it up to date and inclusive of local lessons learnt
- Refreshed their Training Needs Analysis in 2017/18 to best reflect the training requirements within the Trust
- Participated in multi-agency reviews in the year as identified through DSAB
- Become a virtual partner in the Adult MASH via the Community Learning Disabilities Team
- Supported Trust practitioners via the development and implementation of support and development sessions relating to safeguarding
- Incorporated Prevent training into the refreshed Safeguarding Training within BCPFT

Safe & Sound (Dudley's Community Safety Partnership)

Safe & Sound and Dudley MBC's Community Safety Team have contributed to the adult safeguarding agenda through the work of Safe & Sound sub-groups, through commissioning of services, the provision of training and other initiatives. Some examples of this include:

- Safeguarding through the "Safer Estates" meeting – a multi-agency problem-solving meeting focusing on calls for services in respect of public safety, welfare and ASB. Partners respond to underlying issues by working together to ensure individuals receive the support they need
- Victims/survivors of domestic violence and abuse have been safeguarded through MARAC. Dudley's MARAC has good outcomes for those whose cases are heard there. Support is provided through Dudley's Domestic Abuse Support Service as well as CHADD, depending on the victim's/survivor's needs
- Safe & Sound funded a number of training courses in respect of domestic violence and abuse and sexual violence in 2017/18 to raise awareness and contribute to the professional development of practitioners
- The Safe & Sound website has been updated and there are a range of help hubs to support members of the public and professionals. (This links to the Safeguarding website) https://www.dudleysafeandsound.org/

Online Safety Subgroup

Inclusion of "adults" into the Online Safety Subgroup formally happened during 2017, with the first formal report being received by the executive meeting in January 2018. Since then the following work has taken place in relation to adults and online safety:

- Adult representation on the sub group has now been confirmed from Adult Safeguarding, Adult and Community Learning, libraries, Healthwatch and the Access and Prevention Team. This is in addition to existing representation from WMP and Dudley College
- The TOR, strategy and work plans have been updated to reflect the inclusion of adults into the work stream
- Work is planned to take place with Healthwatch to look at existing documents that have been created for young people/parents and see how these can be translated to adults at risk and to include the voice of the adult in this information

- The case study template has been circulated to the subgroup to begin obtaining adults' experiences
- Information and presentations raising awareness relevant to adults have been shared with Adult and Community Learning and libraries, and a short input at Adult and Community Learning team meeting to raise awareness of the agenda to staff has taken place
- A frauds and scams sessions took place on 27th February and was well attended (despite the weather) with approximately 50 individuals attending (including members of the public). The sessions consisted of input from the illegal money lending team in respect of loan sharks, Dudley Trading Standards in respect of fraud and bogus callers, and West Midlands Police in respect of cybercrime and how to reduce the chances of becoming a victim of this. The sessions were extremely well received
- Work is taking place to ensure that an online training course is available to the Adult Social Care workforce
- The Safe and Sound website has been re-launched to include a "help hub". A specific online safety page is included in the help hub, with information and links for adults and those who work with adults included. https://www.dudleysafeandsound.org/help-hub

Modern Slavery

Three multi-agency awareness raising sessions took place on 17.01.2018. Following on from the joint Dudley Safeguarding Adults and Safeguarding Children Board meeting on 09.03.2018 it was agreed that an event in respect of Modern Slavery and Dudley's response would be held for a wider audience. This event took place on 01.05.2018.

It was clear that a local pathway needed to be developed to complement the Regional Procedures and the National Referral Mechanism. Work is underway to develop a referral pathway and agree an offer of support.

Forced Marriage and Honour Based Abuse

Following on from the Joint DSCB and DSAB Meeting in June ?? 2017 a multi-agency action plan was developed in order to take work forward in respect of Honour Based Abuse and Forced Marriage. Multi-agency training was available through the DSCB Training Calendar in 2017/18 and 3 additional multi-agency awareness raising sessions were delivered on 28.02.2018.

Large Scale Enquiries

A large scale enquiry (LSE) is normally triggered where there are significant concerns and/or a high level of safeguarding activity in relation to adults at risk or where there is a complex concern regarding a number of adults at risk.

Dudley MBC has a responsibility to coordinate the enquiry but responses are based upon multi-agency decision making. The process does not negate the need for individual safeguarding concerns to be addressed via the individual safeguarding process, and it is not a replacement for the management of individual concerns.

Examples of triggers for a large scale enquiry include:

- A number of adults at risk being allegedly abused resulting in significant harm or there being potential for significant harm (including people within a particular provider service)
- Receipt of collective concerns in relation to one service setting
- Concerns in relation to a service area of a high volume
- An individual safeguarding enquiry resulting in concerns that indicate that other individuals in the service are at risk of harm
- Receipt of a whistle blowing concern suggesting large scale concerns which suggest more than one suspected perpetrator or relate to custom and practice or a culture in a service that could result in harm to vulnerable adults
- Information received from professionals, the public, the Care Quality Commission, Clinical Commissioning Group, Police or another agency which suggests that the practices of a service are placing adults at serious risk of harm
- Where there may be multiple victims and one alleged perpetrator

A large scale enquiry planning meeting will be convened to discuss:

- Risks to adults using the service and whether immediate actions are required
- Capacity and consent issues
- Whether reviews of the adults in using the service are needed and who should undertake these
- The plan for the enquiry; to consider the level of the enquiry required, the proportionality of the response and identify the lead agency
- How the LSE will interface with any individual safeguarding enquiries that are ongoing
- The commissioning status and inform Care Quality Commission and neighbouring local authorities
- A communication strategy

A further LSE meeting will take place to draw together the strands of the enquiry. This meeting should:

- Review information gathered since the last meeting and the outcomes of enquiries
- Confirm whether any criminal prosecutions will be progressed
- Confirm an improvement plan and designate responsibilities with time scales
- Consider how improvement plans should be monitored
- Confirm the status of placements
- Confirm the status of the provider and any potential suspension of purchasing alongside commissioning
- Consider the status of the provider in respect of their CQC inspection and rating
- Confirm communication strategy with families, partners, and neighbouring authorities
- Confirm the current level of concern and whether the LSE needs to continue

Further meetings may be required depending upon the improvement plan and recommendations made.

DSAB audit

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

As part of the Audit Plan for 2017/18 a review of the Adult Safeguarding Board was undertaken to provide an opinion in the form of a level of assurance as to the adequacy and effectiveness of controls that are currently in place to manage the risks in relation to the objectives identified.

The objectives for the review were as follows:

- There is an effective governance and assurance framework in place which is in accordance with statutory requirements and best practice, to include: roles and responsibilities; decision making; scrutiny; subgroups; strategic plan; annual report; partnership working; communication and engagement; quality assurance; safeguarding adult reviews; financial resources
- There are adequate and effective performance management arrangements in place (including risk management).
- There are effective arrangements for data gathering and sharing which are compliant with the Data Protection Act.

Overall the audit found that there was reasonable assurance, however there were some weaknesses which could affect the Board's objectives.

The audit found the following high priority areas to address:

- An annual disclosure is not made by Board members to confirm whether they have any interests with the work undertaken by DSAB. Furthermore, Board members are not asked whether they have any interests to declare at the start of a DSAB meeting.

  This is now in place for all Board members, and declaration of interests is now a standing agenda item

- Agendas and minutes for the DSAB subgroups were not being circulated in a timely manner.

  The subgroups' terms of reference have now been updated to include timescales

- A dataset is provided to the Board on a six monthly basis but not all partners provide data and not all relevant information is included.

  The dataset has been reviewed and is submitted on a quarterly basis

- A risk register is in place but some sections were incomplete, it did not correspond with the business plan and there was no evidence that partner risk registers had been reviewed.

  The register was updated to address this and will be reviewed on a regular basis

Quality and Assurance

The Quality and Assurance subgroup undertakes multi-agency audits to provide that the residents of Dudley are benefiting from services which are safe. This work is supported by a robust quality and assurance framework.

It is acknowledged by the Board the level of multi agency audits could have been improved. A multi-agency audit tool seeking safeguarding assurance from the partnership was distributed in June 2018, this audit is designed to provide assurance to the Board that appropriate facilities and systems had been established across the partnership. However, the Board recognise that there is further work to do relating to assurances, as previously stated an annual audit calendar will be used to examine specific areas of concern or types and prevalence rate of abuse.

The subgroup will identify any themes or trends relating to types and amounts of concerns being received. The subgroup will report any areas of concern to the Board and make recommendations. The Board will consider these and where required seek assurance from the partner agency/ies. The subgroup has developed an annual calendar to ensure audits are carried out in a timely manner. Examples of this will be audits relating to improved partnership working with hard-to-reach groups to prevent violent extremism, forced marriage and domestic abuse. Training has also been secured in these and other statutory areas of safeguarding.

In addition an audit is planned to consider how the requirements of the Mental Capacity Act and advocacy are embedded in the safeguarding process. New assessment documents have been implemented which consider the Mental Capacity Act 2005 and will provide evidence for this audit. An internal safeguarding audit has been established to monitor timeframes in which concerns are dealt with. Additionally, a threshold tool has been implemented which supports consistency in the decision making process, and dip samples of referrals and activity will be undertaken regularly.

Multi-agency Learning & Development/Training

A new safeguarding learning & development strategy has been developed and there is joint work between DSAB and the Dudley Children's Safeguarding Board (DSCB).

Furthermore, in conjunction with Community Safety Partnership and the Council's Adult Safeguarding Learning and Development team, there will be online safeguarding training which will be accessible to multi-agency staff. Sessions are planned for late 2018 heading into early 2019. A robust booking and audit system will be developed to record the multi-agency staff levels of training. During 2017/18 training was commissioned and delivered in the following areas: mental capacity; financial abuse; coercion and controlling behaviours; Care Act 2014; self neglect; and level two general safeguarding training.

During 2017-18, a quality assurance exercise for single agency training was completed, the audit consisted of 23 agencies spanning both Adult and Children Safeguarding Boards.

The information was collated and fed into a report which highlighted some of the emerging key themes such as:

- A good proportion of agencies has 100% of staff trained to safeguarding basic awareness level with many others who were 90% and above.
- Almost all agencies had a current training strategy linked to local, regional and national safeguarding procedure, processes and protocols
- Evaluation methods were widespread and there was a variety of tools and techniques used within many agencies.

Recommendations

A number of agencies need to ensure clarification and confirmation around the percentage and number of staff who are and are not trained. In addition, while there is currently no centralised training in place, all agencies should be encouraging their employees to make further use of the e-learning safeguarding training packages made available through the Dudley Safeguarding Children Board. These cover legislation and guidance, different types of abuse, recognising signs and symptoms, making referrals, roles and responsibilities. This is already being employed in some sections as part of an induction and therefore could be rolled out more widely. Consideration would need to be given to evaluating this to ensure that learning outcomes have been achieved, and evaluation forms be used to achieve this.

Some agencies would also benefit from local information relating to an evaluation of the training that employees have received. It is suggested that links are forged with national learning and development departments as appropriate, to enable this information to feed back into the training at a local level. Similarly, if information relating to the qualification of trainers is held nationally, this could also be recorded locally against any training being delivered.

People who visit adults in their own homes such as health professionals, tradespeople or mobile hairdressers are often best placed to pick up on things that don't seem right. But how do these people know what to do if they are think that someone they are visiting might be at risk of abuse, harm or neglect?

Visitors to people's homes will be targeted as part a safeguarding training campaign which has started with making the reporting system more person-centred. Training and awareness-raising sessions will be offered to home visitors and, as part of these, materials will be developed with participants to help them to more easily identify and report safeguarding concerns.

These recommendations place accountability on individual agencies to be responsible for their training and its evaluation, but also offer support in terms of putting measures in place to address the concerns raised within their individual audits.

Social Media Current Developments

DSAB has developed and established a Twitter page to raise the profile of adult safeguarding and DSAB across the borough, Twitter has been a huge step forward for DSAB and, in conjunction with this, there are plans for expansion.

Consideration is being given to the introduction of podcasts. These are envisioned to be bite-sized, succinct and savvy information.

Deprivation of Liberty Safeguards (DoLS) and Deprivation of Liberty in the Community (CDoL)

SAR Sub Group

Under the Care Act 2014, local safeguarding adults Boards (SAB) have a statutory duty to carry out a Safeguarding Adults Review (SAR) when an adult with care and support in its area dies and the Board knows or suspects that the death was as a result of abuse or neglect and there is concern about how the SAB, its members or organisations worked together to safeguard the adult.

Deprivation of Liberty Safeguards were introduced in conjunction with the Mental Capacity Act 2005. However, in 2014 the threshold for a deprivation was significantly lowered by the Cheshire West judgement and the Supreme Court developed the "acid test" to see whether a person is being deprived of their liberty, which consisted of two questions:

- **Is the person subject to continuous supervision and control?**

  and

- **Is the person free to leave?** - with the focus, the Law Society advises us, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

This resulted in a large increase in referrals both locally and nationally. For example in Dudley there were 142 DoLS referrals in 2013-14; this increased to 940 in 2017-18. Further developments include Deprivation of Liberty in the Community (CDoL). This is a protection for people over 16 who are in supported living, extra care housing and in their own homes.

Safeguarding Adult Reviews

SAR Sub Group

Under the Care Act 2014, local safeguarding adults Boards (SAB) have a statutory duty to carry out a Safeguarding Adults Review (SAR) when an adult with care and support in its area dies and the Board knows or suspects that the death was as a result of abuse or neglect and there is concern about how the SAB, its members or organisations worked together to safeguard the adult.

What were the person's wishes?

↓

What was supposed to happen?

↓

What actually happened?

↓

Why was there a difference?

↓

What can we learn from this?

These questions are supported by reflection on the six safeguarding adults principles that were published in 2011 and embedded within the Care and Support Statutory Guidance 2016. The SAR process is designed to establish whether there are any lessons to be learnt from the circumstances of a particular case, about the way in which local professionals and agencies worked together to safeguard the adult at risk. The SAR brings together and analyses findings from investigations carried out by individual agencies involved in the case, in order to make recommendations for improving future practice where this is necessary.

It is felt that the voice of the adult at risk is explicit in the centre of the review. This includes seeking consent for the review, including their views and that of their family wherever possible, and asking agencies how they have considered the adult's wishes and views throughout their involvement. From feedback from families who felt that they were not heard, a Victim's Code has been developed to ensure that families/carers are kept fully informed when a serious incident has occurred.

Prior to January 2018 Dudley's Safeguarding Adult Review (SAR) pathway was not clearly defined and consequently not embedded into practice. This deficit did not support referrals being made to Dudley Adult Safeguarding Board, from either members of the multi-agency partnership and or single agencies and individuals. However, this position has significantly improved. A clear and robust procedure has now been developed and agreed by the multi-agency partners who make up the SAR Subgroup. This pathway is now published on the Adult Safeguarding Board webpage; additionally seven minute briefs have been developed to raise the profile of SARs and training.

The Board accepts that the recommendations and learning from the two completed SARs have been delayed. This was partly due to a lack of a multi-agency strategic training programme. This has now been addressed and the learning from these reviews will be appropriately shared. Additionally, difficulties were experienced in delivering some of the recommendations due to securing funding for a specialist allied health care professional, this has now been completed. Furthermore, there have been challenges in implementing changes to the social care assessment tool to include any disclosed issues with eating and drinking. Work continues in this area.

Case Studies

Case Study - Adult MASH

Beryl - is 88 years old and lives in a residential home. She has a diagnosis of vascular dementia.

A safeguarding contact was received from CQC; a whistle-blower had reported that Beryl had been shouted at by staff and was often forced to go to bed at 5pm without food. It was also reported that she was often tearful.

The concern was considered in the Adult MASH team and forwarded to the social work Reviews team for an enquiry. An enquiry was completed by a social worker who examined care home records and spoke with Beryl. Beryl was assessed as lacking mental capacity to contribute to the safeguarding process and therefore contact was made with her daughter as her representative. The daughter was told about the safeguarding and asked about her desired outcomes under "Making Safeguarding Personal". The daughter was very happy with the care at the residential home and had no concerns.

The social worker examined the care records; care plans, risk assessments and daily recording.

No evidence to support the allegation was found and the safeguarding was closed at the end of the enquiry and no further action was taken in accordance with Beryl's daughter's wishes. Assurance had been gained as to the quality of care and Beryl's care had been reviewed. Her daughter was satisfied with these outcomes.

Case Study - Adult MASH

Kevin - is a 45 year old man who is sleeping rough.

He has issues with substance and alcohol misuse.

A relative who was worried about him raised concerns, stating that he was neglecting his own health, not eating or attending health appointments and that his mental health was suffering.

The MASH team were able to share information effectively and quickly with partners; including mental health, primary care GP, homelessness team and substance misuse services. It was quickly established that Kevin was well known to many of these services. A safeguarding meeting was held to discuss our approach. The meeting allocated tasks, coordinated our approach and appointed a lead worker to make contact with Kevin to establish his feelings and his desired outcomes from the safeguarding process.

Through the process we were able to establish that Kevin was in fact in quite good health. Although he still had issues with alcohol and substance misuse these were reasonably well controlled. He did not wish to be "safeguarded", but did agree that he would like to work towards accommodation if he were in control of the decision making process. In accordance with his wishes; safeguarding processes did not continue but he continues to have positive engagement with the Homelessness team who are working towards accommodation. Kevin has also been encouraged to have medical checks with his GP and his health is now monitored. All of this is with his consent and because of the relationship building work undertaken by the homelessness team.

Case Studies

Case Study - Dudley Disability Service

Jade - is 20 years old and has a moderate learning difficulty. She initially attended mainstream school,

but subsequently moved to a special school to meet her educational needs. The safeguarding alert came from Housing and the Police following an investigation of antisocial behaviour and criminal activity, including the use of illegal drugs taking place at a property within the Dudley locality.

The safeguarding alert was made in relation to Jade, in view of her perceived particular vulnerabilities and concerns of her inability to protect herself from harm. It was also established that Jade was homeless, sofa surfing across Dudley and pregnant, expecting her first child. The initial risks and concerns were immense. Jade was in a relationship with a young man who had a long criminal history, including violence that posed significant risks for Jade and her unborn child. Initially it was viewed that Jade had a moderate learning disability as opposed to learning difficulties.

The safeguarding alert alleged concerns of Jade being physically abused, sexually abused, risk of emotional/psychological abuse, financial abuse and potential control and coercion.

As result of multi-agency working across the Police, Housing, Health, Probation Services, Adult and Children's Social Care services under the Inter agency Adult Safeguarding Policy and Procedures we were able to establish a firm diagnosis, undertake mental capacity assessments in relation to specific decisions, agree actions and complete a multi agency risk assessment to manage risks for the protection of Jade and her unborn child. As part of this process and in line with Making Safeguarding Personal we engaged Jade in the whole process and were able to offer her access to lot of support, advice and information.

Each agency took a very proactive approach towards supporting Jade to deliver the best outcome for her and her unborn baby. Jade did not always engage so this proved a challenge at times in both supporting her and managing risks. The Children's Safeguarding Investigations ran parallel to this process for the protection of the unborn child.

Jade moved back home to be supported by her family, her baby was delivered safely and placed into care. The outcome is not what Jade wanted but the case study is an example of the some of the complex situations that we are dealing with within the Dudley Disability Service and how working within a multidisciplinary approach, with good communication, sharing knowledge, skills and resources support the management of risks we aim to achieve the best outcome for the vulnerable adult , young person and children, whilst also fulfilling our statutory responsibilities to safeguard vulnerable adults and children.

Case Study - Primary Care

Concerns raised by ambulance service when they attended a lady who was caring for her partner who had a palliative diagnosis. They overheard him say that he was going to kill her before he died. Police were contacted and she refused to speak to them as she was frightened of the repercussions and that "it would only make matters worse". A safeguarding concern was raised to MASH and checks were completed with various agencies to gain further details:

- Talking to family who shared that there had been domestic abuse within the household for over 50 yrs and the woman had left five years previously due to her husband's controlling and coercive behaviour
- Palliative care team who visited regularly that the lady had a very strict regime on times when she would go to bed and when she could go out and shared that the lady had told them of one incident where her husband had knocked her teeth out
- It was identified that she was allowed to attend GP appointments on her own
- GP surgery had an appointment booked for a medicines review and it was agreed that this would be an opportunity for the DA officers to speak to the lady on her own
- Referral into MARAC to ensure that safety measures were put in place

With support from IDVA, her family, and several meetings set up at the GP practice, the woman made the decision to move in to a shelter until it was safe to return home.

Case Study - Trading Standards

Dudley Trading Standards are dealing with multiple complaints regarding financial scamming of adults within the borough. In the most extreme cases tens of thousands of pounds have been lost by victims. In one case, an elderly resident was telephoned by scammers claiming to be from his bank. They persuaded him to transfer his life savings to another bank account for "safety". The money was then removed and disappeared. On realisation that they had been scammed, the victim was devastated. Trading Standards are now investigating the criminal accounts with a view to criminal proceedings if the operators can be located and identified. They are also representing the victim in a complaint against their bank, who it is argued should have made greater checks before allowing the transfer of an elderly customer`s life savings.

In March 2017 Dudley Trading Standards successfully completed a ground breaking investigation into a carer who had financially abused a 93 year old man. Over less than two years, the carer took at least £230,000 from the man, including using his money to purchase a detached house for herself in Halesowen. The carer was convicted of Fraud by Abuse of Position and Perverting the Course of Justice, and sentenced to five and a half years in prison. However, the carer appealed both the conviction and the sentence. In July 2018 both appeals were dismissed by the Court of Appeal.

Case Study - Dudley and Walsall Mental Health Trust

Concerns were raised by the community older adults service with DWMH safeguarding team about a 76 year old woman with advanced dementia. She was in receipt of carers four times a day for all aspects of care, however still lived with her son in the family home. The son had been posing difficulties with care agencies, blocking access to his mother, becoming aggressive with care staff where they felt too vulnerable to provide the care. This led to there being no availability of any care agencies willing to attend the property to provide the care due to the risk.

A safeguarding meeting was held due to the escalating concerns and no services being available to provide the care that she needed to function and maintain her basic needs and dignity. The outcome of the meeting was that it was unsafe to leave this woman in the home over the weekend without the appropriate care and support going into the home. The legal department was contacted and an urgent court of protection application was made. That same night, with the aid of multi-agency working and with emergency services, the woman was removed to a place of safety where a full assessment of her needs could be carried out and care and support provided appropriately.

This lady has not returned to the family home despite interventions being offered to support the son, however his behaviour and the home environment was not conducive and deemed unsafe for the return of an extremely vulnerable lady who has no insight or capacity. She is now placed in a nursing home and thriving, with support she now eats and feeds herself. In the family home she was not weight bearing at all and now stands for short periods supported by staff.

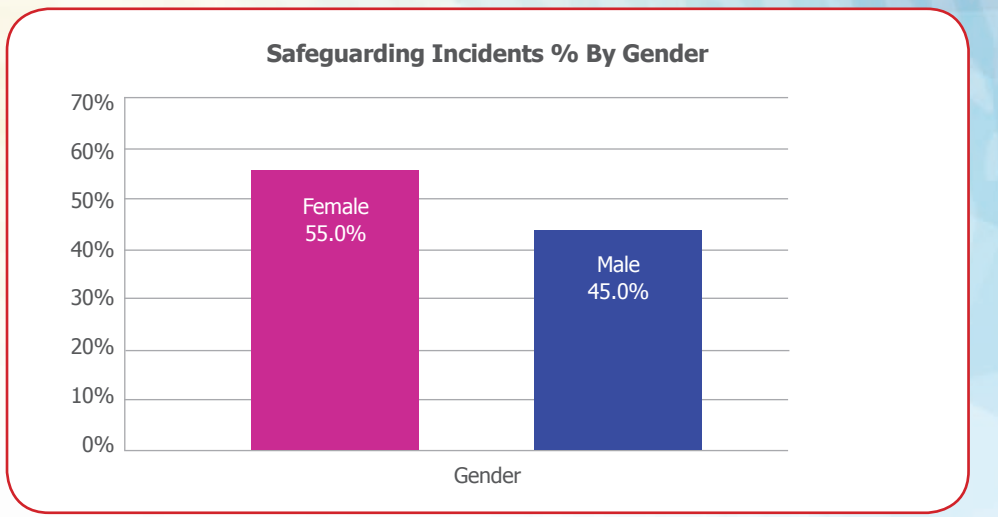
Performance data

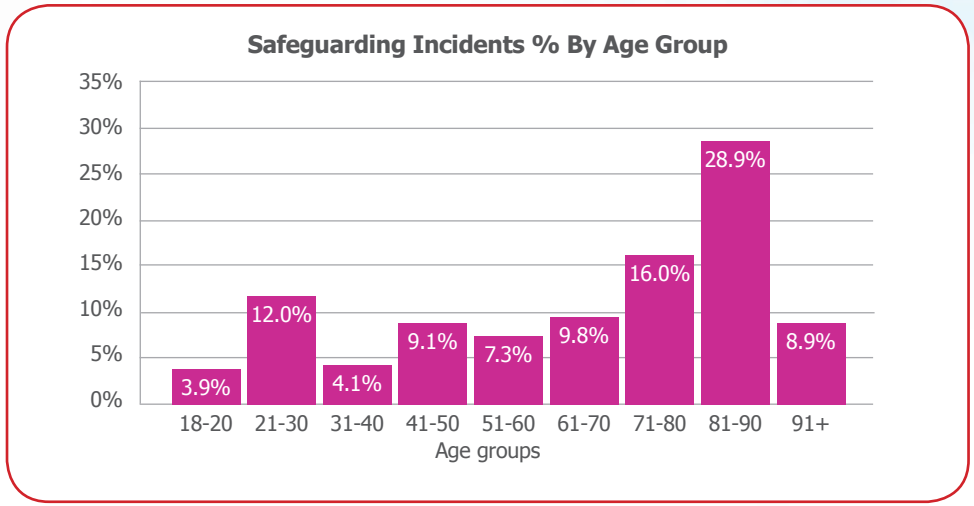
1st April 2017 - 31st March 2018

The number of adult safeguarding concerns reported between 1st April 2017 and 31st March 2018 was 3051, continuing the upward trend; 2016-17 at 2809, 2015-16 at 2091 and 2014-15 at 1713. During 2017-18, 727 (23.8%) were progressed through the safeguarding process as enquiries, however during 2016-17, 831 (29.6%), 2015-16, 743 (35.5%) and 2014-15, 726 (42.4%) were progressed, suggesting that the screening process at first contact is continuing to effectively signpost and the MASH implementation is having a positive affect.

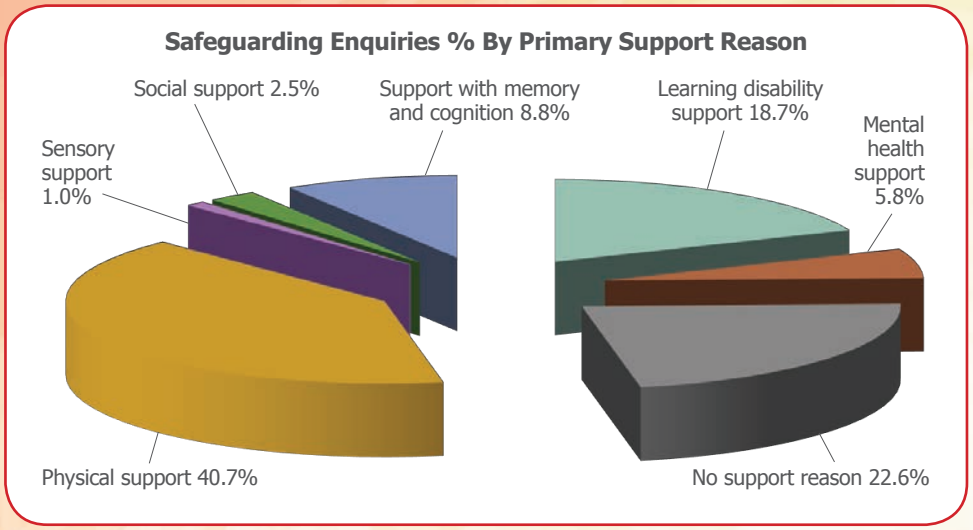
The following graphs analyse this enquiry data for 2017-2018.

Overall, the majority of enquiries were for females at 55%, with 33.8% of females falling into the 81-90 age group.

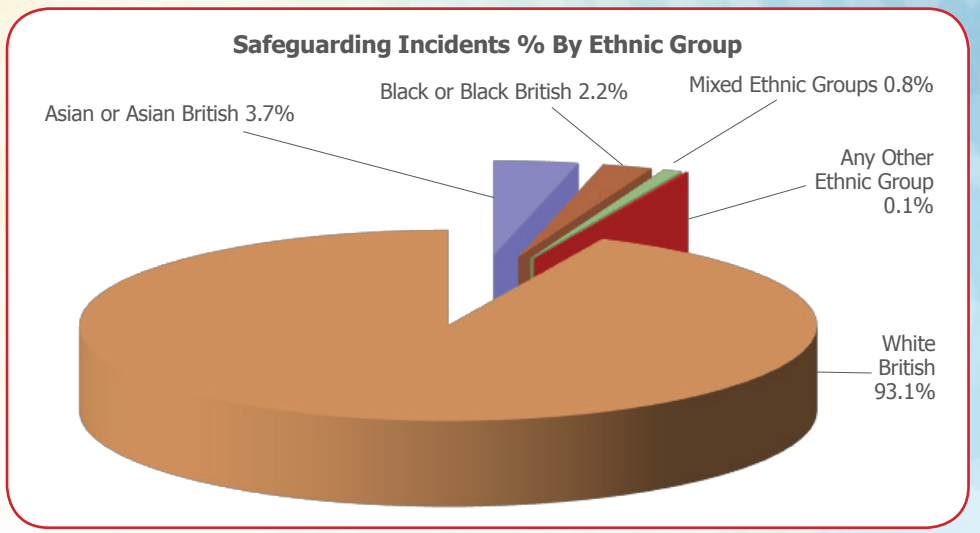




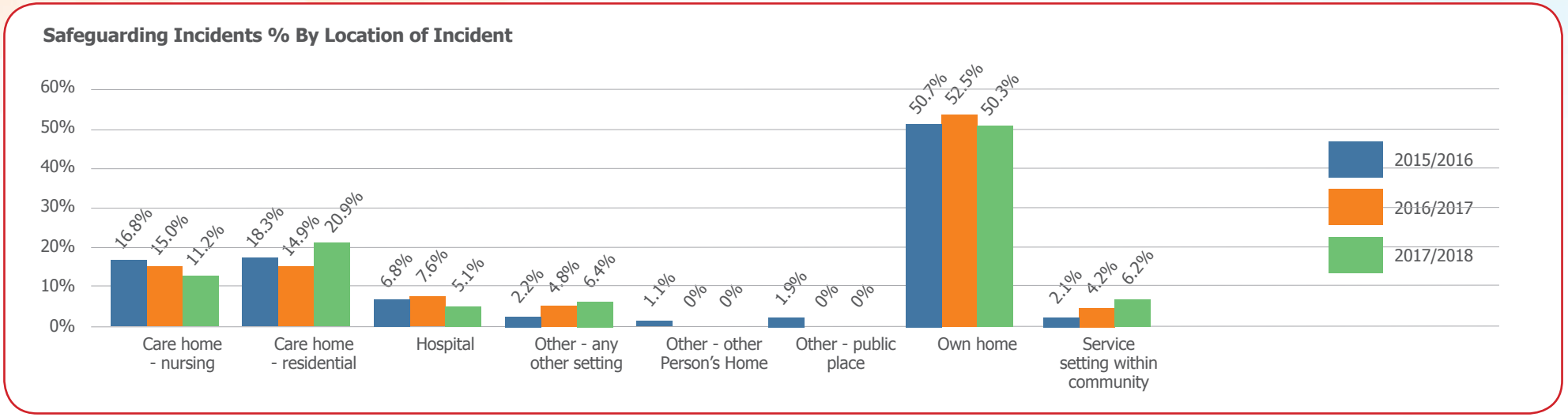
As in 16-17, the majority of enquiries were recorded for people in the physical support primary support reason at 40.7%.



The majority of enquiries were recorded for people in the white British ethnic origin group at 93.1%% which is almost exactly the same as for 16-17 (92.5%).



The majority of enquiries were recorded as taking place within the victim's own home at 50.3%.
Of these 364 referrals taking place in their own home 54.4% were for females.

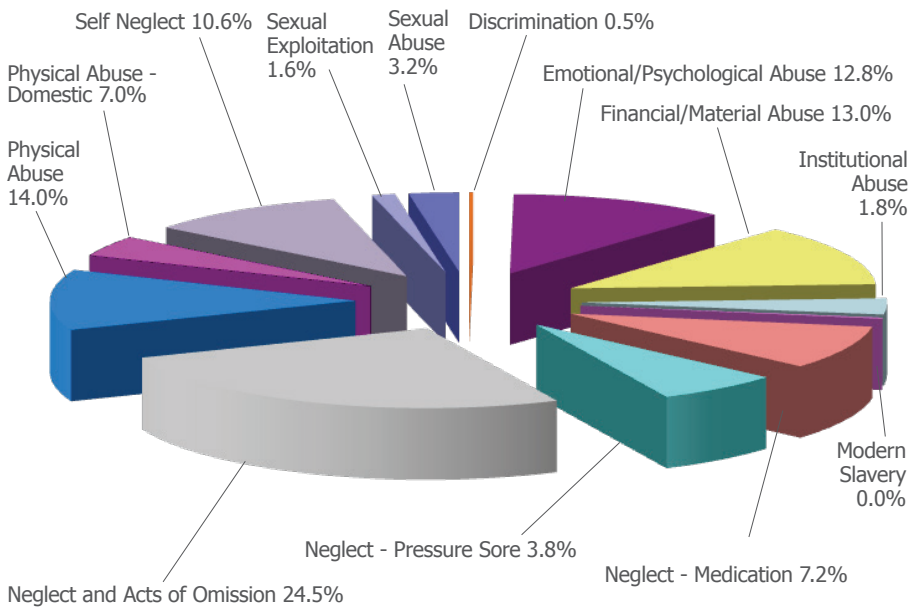


The abuse category of neglect and acts of omission was recorded as the highest proportion of all enquiries at 24.5% and similar to 2016-2017 (27.76%), however, if all neglect categories are combined this figure increases to 35.5% and clearly forms the majority of abuse categories overall.

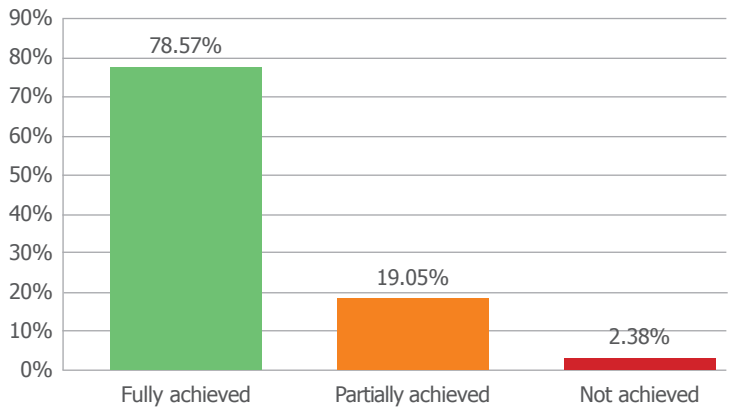
The number of completed enquiries during the same time period, i.e. where all investigations have been completed and an outcome agreed, was 589 compared with 625 during 2016-2017.

The fact that an enquiry was substantiated or not is no longer collected. In line with the Care Act, Making Safeguarding Personal is recorded to replace this. Of the 420 people that expressed an outcome of their safeguarding experience, 78.57% had that outcome fully achieved.

Safeguarding Referrals % By Category of Abuse



Completed safeguarding enquiries where an outcome was expressed



The Adult MASH has identified the need to improve timeliness of completing contacts. The most recent data suggests that one in three contacts is completed within three days, and three out of four contacts are completed within fifteen days.

In 2016/17 staff recorded that 86.5% of risks to people were reduced or removed as a result of safeguarding actions. This trend has continued into 2017/18 with 86.75% of risks being reduced or removed.

Risk Outcome	2016/2017		2017/2018	
	No. of risks	%	No. of risks	%
Risk Remained	53	13.35%	53	13.28%
Risk Reduced	180	45.34%	190	47.62%
Risk Removed	164	41.31%	156	39.10%
Total	397	100%	399	100%

Making safeguarding personal

MSP Outcomes	2015/2016		2016/2017		2017/2018	
	No. of risks	%	No. of risks	%	No. of risks	%
Asked & outcomes expressed	236	44.60%	465	74.40%	420	71.31%
Asked & no outcomes expressed	13	2.50%	34	5.40%	50	8.49%
Not asked	73	13.80%	74	11.80%	86	14.60%
Don't know if asked	21	4.00%	46	7.40%	33	5.60%
Not recorded	186	35.20%	6	1.00%	0	0.00%
Total	529	100.00%	625	100.00%	589	100.00%

MSP Outcomes	2015/2016		2016/2017		2017/2018	
	No. of risks	%	No. of risks	%	No. of risks	%
Fully Achieved	135	57.20%	374	80.40%	330	78.57%
Partially Achieved	20	8.50%	63	13.50%	80	19.05%
Not Achieved	81	34.30%	28	6.00%	10	2.38%
Total	236	100.00%	465	100.00%	420	100.00%

The percentage of people who have had their personal outcomes either partly or fully achieved has risen from 65.7% in 2015-16, to 93.9% in 2016/17 and again to 97.6% in 2017-18. 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.

Notes

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 17-18 is still operational and the Board will review this in August 2018 to ensure it is updated and pertinent to the year ahead

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