Dudley Safeguarding People Partnership

ANNUAL REPORT 2022/23

Dudley Safeguarding Adults Board

Reporting Period April 2022 – March 2023

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Foreword from Independent Chair

This report was prepared by the DSPP Business Support Unit on behalf of the Board and recognises the progress the DSPP has made throughout the year and the challenges that remain and will continue in 2024/2025.

The commitment from the multi–agency partnership to work together on safeguarding people in Dudley remains unfailing. This year we have again revised our priorities and strengthened our partnership structure to reflect our joint accountability and responsibility to safeguard adults, but also to strengthen our links to all agencies with responsibility for safeguarding.

Our approach to utilising data and performance to ensure we have a good evidence base to demonstrate how the Board safeguards adults has been reinforced by extra resource. We are also working together to ensure there is a culture of high support and high challenge in our services. As a Partnership we have focussed on the challenges presented by the aftermath of the Covid pandemic. This has impacted how we delivered services in 2022/2023 and we are now able to consistently use hybrid ways of working to ensure we remain responsive to adults in Dudley.

Over the next 12 months we recognise that we need to intensify our multi – agency response to neglect. We are also developing a strategy to assist the resilience of the care sector in Dudley to support choice for individuals considering continuing care support. During the next 12 months we will also stabilise our relationship with the new Integrated Care Boards safeguarding architecture. The board have also commissioned Healthwatch to obtain local views on their experience of our safeguarding services. This research will enable us to modify or enhance our services in order to make safeguarding personal. Finally, we are also preparing for the possibility of an inspection from the CQC which will offer a helpful benchmark of progress made by the board.

I look forward to updating you on our progress and the improvements we are making in our next annual report.

Dr Paul Kingston

Independent Chair, Dudley Safeguarding Adults Board

About the DSAB

The Annual Report

Welcome to the Dudley Safeguarding Adults Board annual report. This document provides an overview of the effectiveness of services in place to safeguard adults across the Dudley Borough. The information relates to the period 1st April 2022 – 31st March 2023.

The report will be available on our website via https://dudleysafeguarding.org.uk/partnership/meetings/dsab/ and will be shared with our partners for dissemination. The report will also be shared with the Health and Wellbeing Board and Dudley Safeguarding Children's Partnership Group.

What is Safeguarding for Adults?

Safeguarding adults is about preventing and responding to allegations of abuse, harm or neglect of adults at risk across the Dudley Borough.

Section 42 of the Care Act 2014 states that safeguarding enquiries should be made where:

- a person has needs for care and support
- is experiencing, or at risk of, abuse or neglect; and
- as a result of their care and support needs, is unable to protect him or herself against the abuse or neglect, or the risk of it.

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.

What is Dudley Safeguarding Adults Board?

The core duties of the Dudley Safeguarding Adults Board (DSAB) are described in Chapter 14 of the Care Act Statutory Guidance, issued under section 78 of the Care Act 2014. This requires the DSAB to:

- Publish a strategic plan for each financial year detailing how it will meet its main objective and what individual members will do to achieve the work plan.
- Publish an annual report that details what the DSAB has done during the financial year to achieve its objectives and strategic work plan and what individual members have done to implement the strategy, with specific emphasis being given to the positive impact this has on the lives and outcomes of adult with care and support needs who have experienced, or are at risk of experiencing abuse and neglect.
- Conduct a Safeguarding Adults Review in accordance with Section 44 of the Care Act 2014.

In order to fulfil its core duties, the DSAB will develop a range of initiatives, plans, policies and procedures for safeguarding and promote the welfare of adults with care and support needs, in relation to:

- Adherence to the six declared principles of adult safeguarding
- The role, responsibility and accountability with regard to the actions each agency and professional group should take to ensure the protection of adults.
- Establish a method for analysing and interrogating data on safeguarding concerns and the outcomes of individual enquiries, which increases the DSAB's understanding of the prevalence of abuse in its area.
- Establish methods of analysing and interrogating adults' satisfaction with the outcomes that were achieved through the safeguarding process, which supports the DSPP to embed person centred approaches to safeguarding, as required by Making Safeguarding Personal.
- Establish how it will hold individual DSPP members to account and gain assurance of the effectiveness of their organisation's arrangements.
- Determine its arrangements for organisational self-assessment, DSPP self-audit and peer audits.

- Establish mechanisms for developing policies and procedures for protecting adults. The DSAB should formulate these in collaboration with all relevant agencies and will also need to consider how the views of adults with care and support needs, their families and informal carers will be represented.

- Identify types of circumstances that give grounds for concern and when they should be considered as a safeguarding concern and passed to the Local Authority for consideration of a S42 safeguarding enquiry. This should include referral pathways and guidance on thresholds for intervention.

- Embed strategies and ways of working that support staff to minimise the potential impact of issues relating to race, ethnicity, religion, gender and gender orientation, sexual orientation, beliefs, age, disadvantage and disability on abuse and neglect.

- Identify mechanisms for monitoring and reviewing the implementation and impact (on practice and culture) of policy and training.

- Develop effective mechanisms and protocols that support the effective commissioning of Safeguarding Adults Reviews, which includes local mechanisms that ensure lessons learnt are understood and embedded at all levels of staffing structures across the local safeguarding partnership. This will include identifying other processes that could be used review the effectiveness of local safeguarding responses.

- Develop mechanisms for ensuring the Annual Strategic Plan and Annual Report are conducted and published in a timely manner, so as to enhance the accountability of the DSPP to the local community.

- Evidence how individual members of DSPP have challenged one another and held other local boards to account, for example the Health and Wellbeing Board.

- Review and comment on the impact for safeguarding adults that arises from individual DSPP members organisational strategic decision making, including decisions that impact on the resources available to support the DSPP.

- The Dudley Safeguarding Adult Board will engage in any other activity that facilitates or is conducive to, the achievement of its objectives.

In all its activities the DSAB will support the equality of opportunity for all individuals and meets the diverse needs and wishes of local adults in Dudley and will advocate that the duty to safeguard and promote the welfare of all as 'everybody's responsibility'.

The Board is funded through financial contributions from Dudley MBC, Dudley Integrated Care Board (ICB) and West Midlands Police. Wider partners provide staff and resources for meetings and training courses.

Our priorities 2021-22

DSPP priorities were reviewed in April 2022 and were agreed based on feedback from quality assurance activity and emerging local and national learning. The two priorities of neglect and exploitation have remained the same. The third priority is now 'Think Family' with a specific focus on transitional safeguarding.

This third priority allows partners to be more flexible and adapt to emerging themes and trends.

1. Neglect across the life course

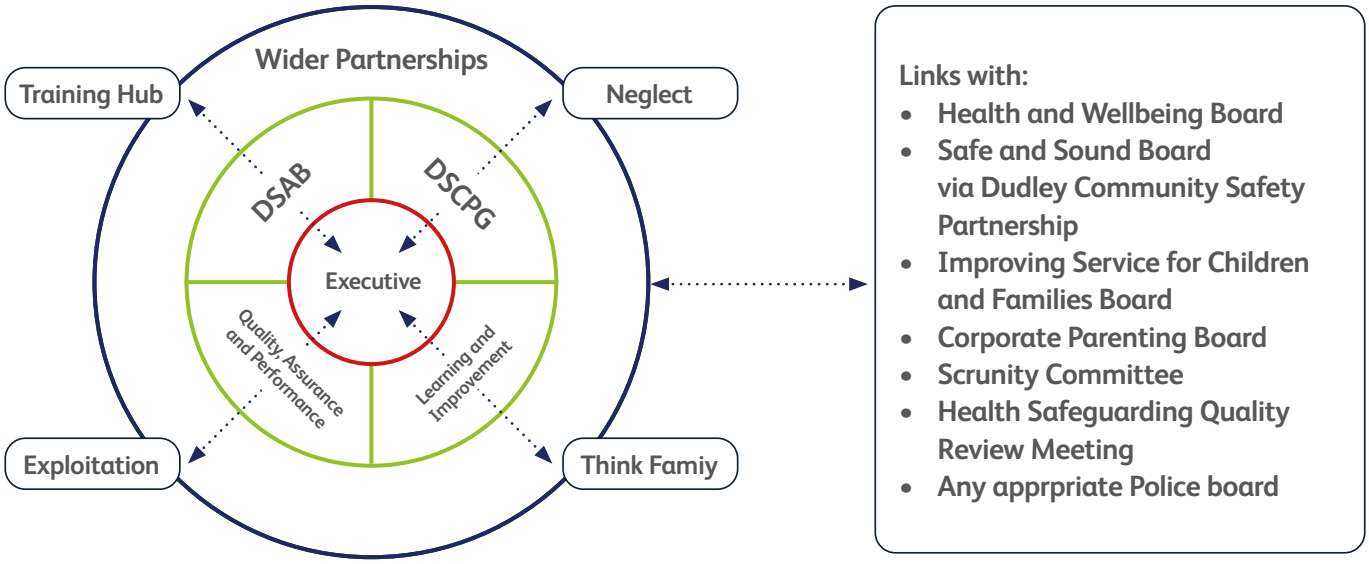
2. Exploitation across the life course

3. Adopting a Think Family approach

Our structure

We are a joint, life course Partnership which is overseen by an Executive group.

Since reviewing our priorities, we have also revised our structure for the Partnership. This is so we strengthen our links with all agencies and other Boards in the Dudley Borough. We are also keen to promote a culture of inclusivity regarding our safeguarding arrangements, utilising expertise and feedback across our Partnership. The effectiveness of this change will be discussed in this annual report. Below shows our structure for 2022-23

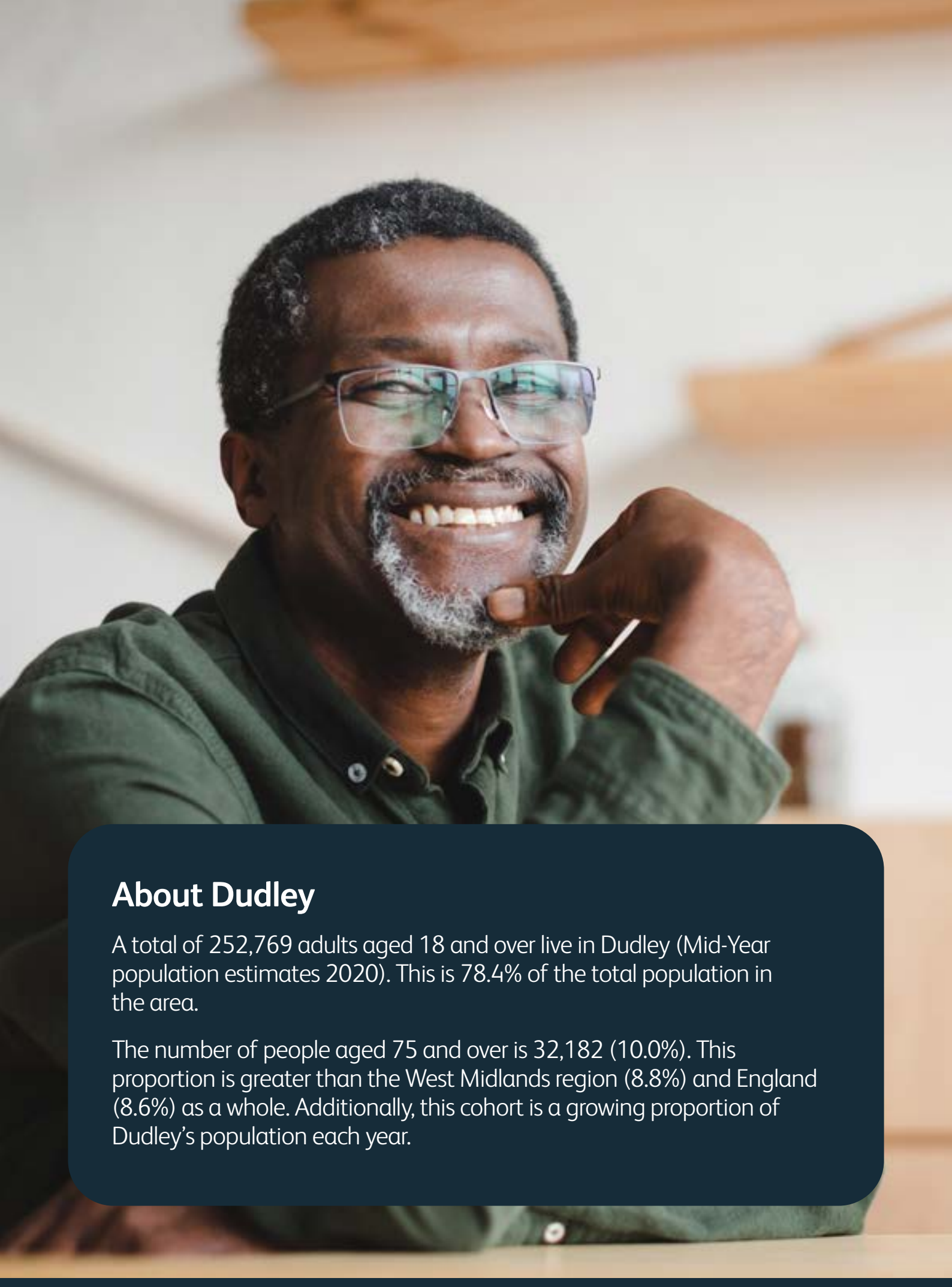


Links with other Partnerships and Boards

We are members of the West Midlands Safeguarding Adults group and West Midlands Editorial Group. This ensures we are up to date with the most recent changes as well as ensuring we work as effectively as possible with our cross-border partnerships. We recognise that many of our partners work across several local authority areas and therefore consistency in our safeguarding approach is paramount.

The DSAB also works closely with Safe and Sound, Dudley's Community Safety Partnership, as we recognise that many safeguarding themes overlap for example, exploitation and domestic abuse. We also regularly provide updates to our health colleagues via the Safeguarding and Quality Review Meeting (SQRM)

This report will also be presented to the Health and Wellbeing Board.



About Dudley

A total of 252,769 adults aged 18 and over live in Dudley (Mid-Year population estimates 2020). This is 78.4% of the total population in the area.

The number of people aged 75 and over is 32,182 (10.0%). This proportion is greater than the West Midlands region (8.8%) and England (8.6%) as a whole. Additionally, this cohort is a growing proportion of Dudley's population each year.

Homelessness

Dudley has a good track record in preventing homelessness and has low numbers of rough sleepers. Preventing or relieving homelessness is a key function that the local authority has done successfully for a number of years. In the post-covid pandemic recovery phase, however, a new set of challenges are emerging including higher housing and living costs (such as food, utilities and travel costs) and other inflationary pressures. There has been an increase in local rental market prices and house prices.

The most vulnerable in our community are often those who are on low incomes and will be more adversely impacted by rising costs as they may struggle to obtain good quality housing that meets their needs, or they may struggle to maintain their current living arrangements.

Fuel Poverty in Dudley has been increasing in absolute terms. Latest figures from 2020 showed it affected 24,248 (17.3%) of households within the Borough. Recent increases in energy costs are likely to exacerbate Fuel Poverty.

Domestic abuse-related incidents and violence rates for Dudley are derived from the West Midlands force area at 37.3 crimes per 1,000 people for 2020/21. It should be noted this measure will be influenced by other areas outside Dudley, but it is higher than the rates for both the West Midlands region (33.7) and England (30.3 per 1,000). Whilst all victims of domestic abuse are vulnerable due to the risks they face, we recognise that some victims falling under the provisions of the Care Act face an even greater risk if exposed to domestic abuse

Life Expectancy, Health Conditions and Health Inequalities

Life expectancy within Dudley is 78.8 years for men and 82.2 years for women. This is similar to the wider region (men 78.5, women 82.5); however, it is lower than England (men 79.4, women 83.1) Within Dudley, life expectancy is 9.3 years lower for men and 8.0 years lower for women in the most deprived areas of Dudley than in the least deprived areas.

The recorded prevalence of dementia in patients aged 65+, registered with a Dudley GP was 3.8%, which equates to 2,547 patients. However, the estimated dementia diagnosis rate for those aged 65+ is 56.3%, which means that the actual number is likely to be around 4,500. In patients under 65, the recorded prevalence of dementia was 2.7 per 10,000 in 2020, lower than that for the Black Country STP (3.3 per 10,000) and England (3.0 per 10,000).

The suicide rate in Dudley has increased since 2015-2017. From the latest data available for 2018-20, there were 11.3 suicides per 100,000 population (or 94 persons) which is the highest rate recorded since records began in 2001-03. This is not significantly different to the West Midlands (10.5 per 100,000) or England (10.4 per 100,000). This is a growing concern and suicide awareness, and support will need to be a focus of both our learning and development and service offer going forwards.

Our data

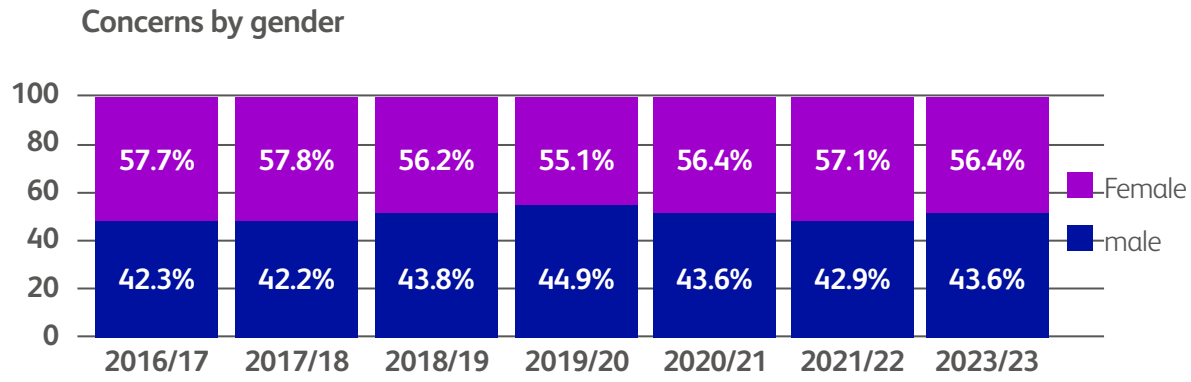
We have a multi-agency dashboard that consist of high-level partner information. We are still improving our dataset, and this is regularly reviewed. We know we have more to do with this and will ensure it is revised in line with our revised priorities.

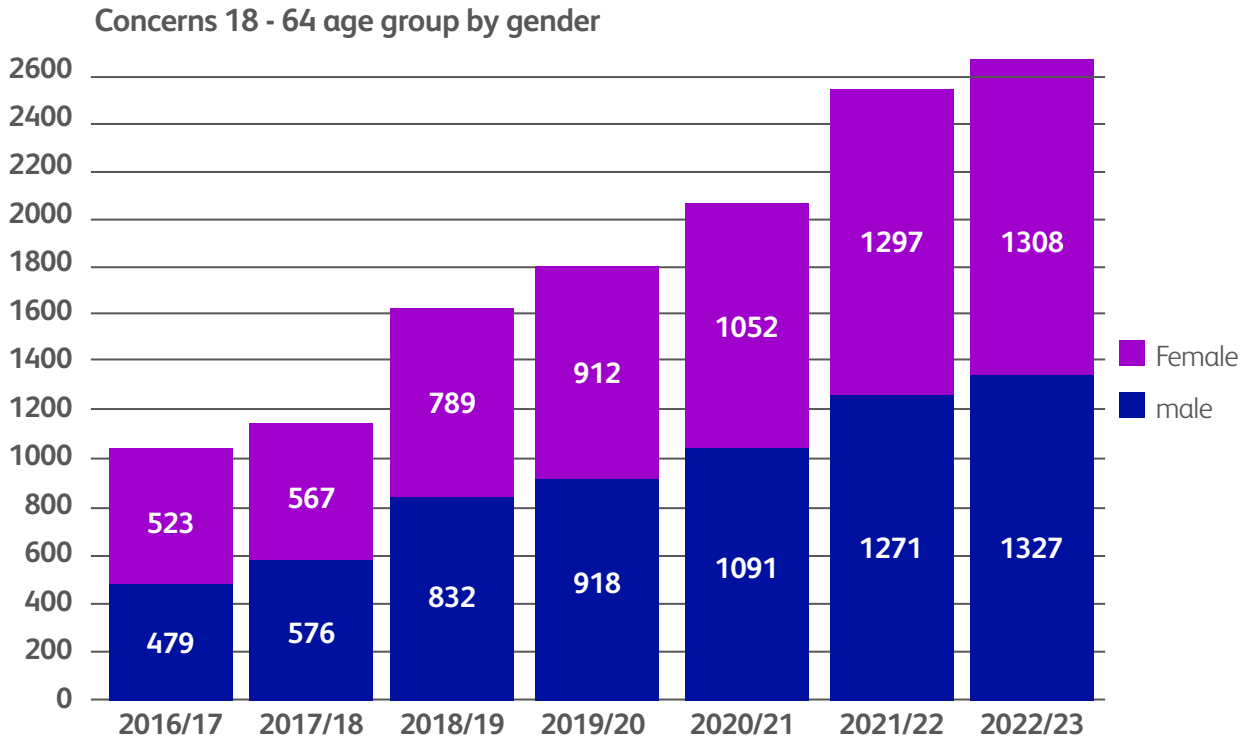
Safeguarding Concerns

Year	Concerns	% Increase From Previous Year	Enquiries	Conversion
2014/15	1713		726	42.4%
2015/16	2091	22.1%	743	35.5%
2016/17	2809	34.3%	831	29.6%
2017/18	3051	8.6%	727	23.8%
2018/19	3941	29.2%	752	19.1%
2019/20	5299	34.5%	773	14.6%
2020/21	5294	-0.1%	343	6.5%
2021/22	6156	16.3%	693	11.3%
2022/23	6434	4.5%	604	9.4%

MASH (Multi Agency Safeguarding Hub) is intended to screen and determine the appropriateness of referrals, so the lower percentage means that MASH is effective in ensuring that safeguarding enquiries only progress where relevant. However, a high proportion of concerns received into Adult MASH from professionals relate to care management concerns and are signposted to other areas of adult social car, . the Dudley Safeguarding Adult Board will respond to this by providing training in the forthcoming year to ensure that profressionals better understand when to refer to Adult Social Care and offer support & guidance for making safeguarding adult referrals, this training will be delivered by Partners.

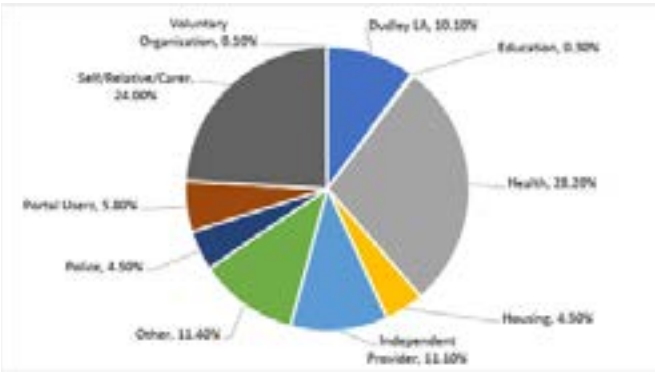
351 concerns were not recorded correctly/fully therefore were excluded from the submission. This was due mainly to the implementation of LAS and a change in recording processes whereby the decision was made to record an episode for each concern which has resulted in many concerns with no episode recorded, an episode but with no 'type' recorded etc. This practice was adopted during the early stages of recording adult safeguarding in 2009/10 but that decision was reversed quickly due to a similar experience of missing data. However, this data quality is slightly improved compared with last year when 382 concerns were excluded for the same reasons. The % conversion has decreased slightly compared with last year. The overall proportion of concerns within the 18-64 age group remains the highest proportion by age group overall (41%) with males forming 50.3% of the concerns in this age group. However, overall, and consistently over the past 7 years, females continue to form the highest proportion of all concerns.

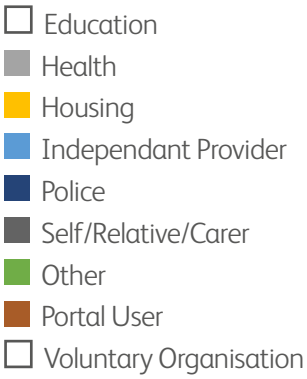




Concerns by source

The proportion of concerns received from a Health source forms the highest proportion of all concerns at 28.2% with concerns from Self/Relative/Carer at 24%.





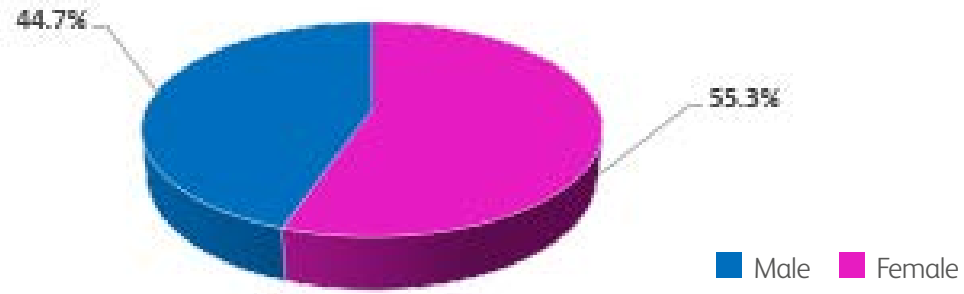
2022/23 Enquiries

The detail of the enquiry, eg abuse category, location of abuse etc, is not submitted in the SAC until the actual enquiry is completed. Therefore, the following is an analysis of 2022/23 enquiry data only.

Enquiry Type	Number	%
S42	477	79.0%
Other	127	21.0%
Total	604	100.0%

In line with concerns, females formed the highest proportion of enquiries at 55.3%

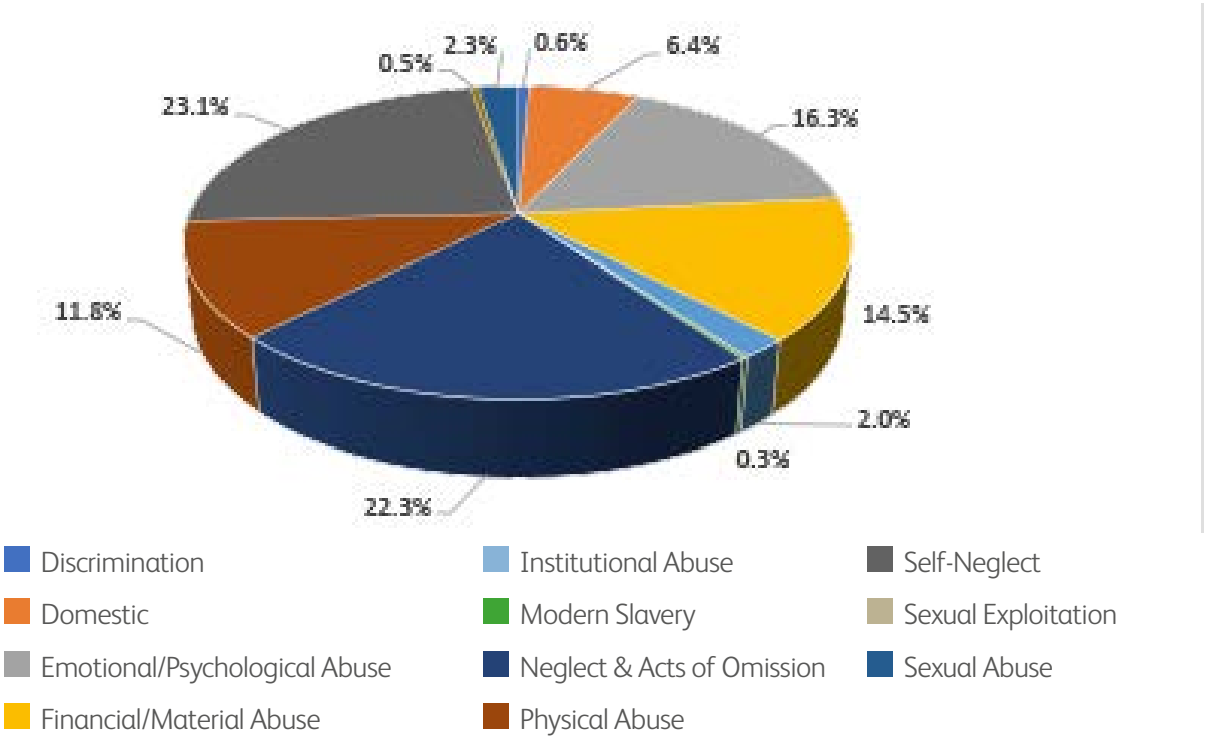
Enquiries By Gender



Gender	18-64	65-74	75-84	85-94	95+	Total
Female	135	53	61	75	10	334
Male	159	37	46	27	1	270
Total	294	90	107	102	11	604

Males form the highest proportion within the younger 18-64 age group (54%) and in general, females within the older age groups, however, this could have a direct correlation with the general population overall in Dudley, where females form the highest proportion of older adults.

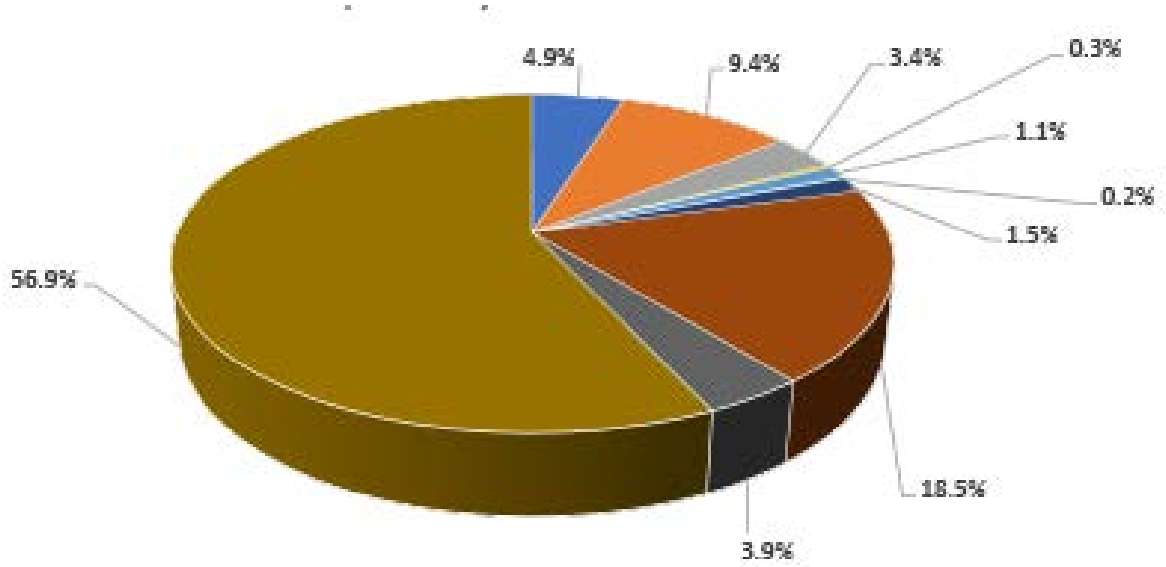
Enquiries By Catergory of Abuse



In a change to previous reporting, the category of Self Neglect forms the highest proportion of all enquiries at 23.1% followed by Neglect & Acts of Omission at 22.3%

Abuse Category	Female	Male
Discrimination	4	3
Domestic	51	19
Emotional/Psychological Abuse	99	81
Financial/Material Abuse	76	84
Institutional Abuse	15	7
Modern Slavery	2	1
Neglect & Acts of Omission	146	99
Physical Abuse	90	40
Self-Neglect	110	144
Sexual Exploitation	3	2
Sexual Abuse	19	6
Total	615	486

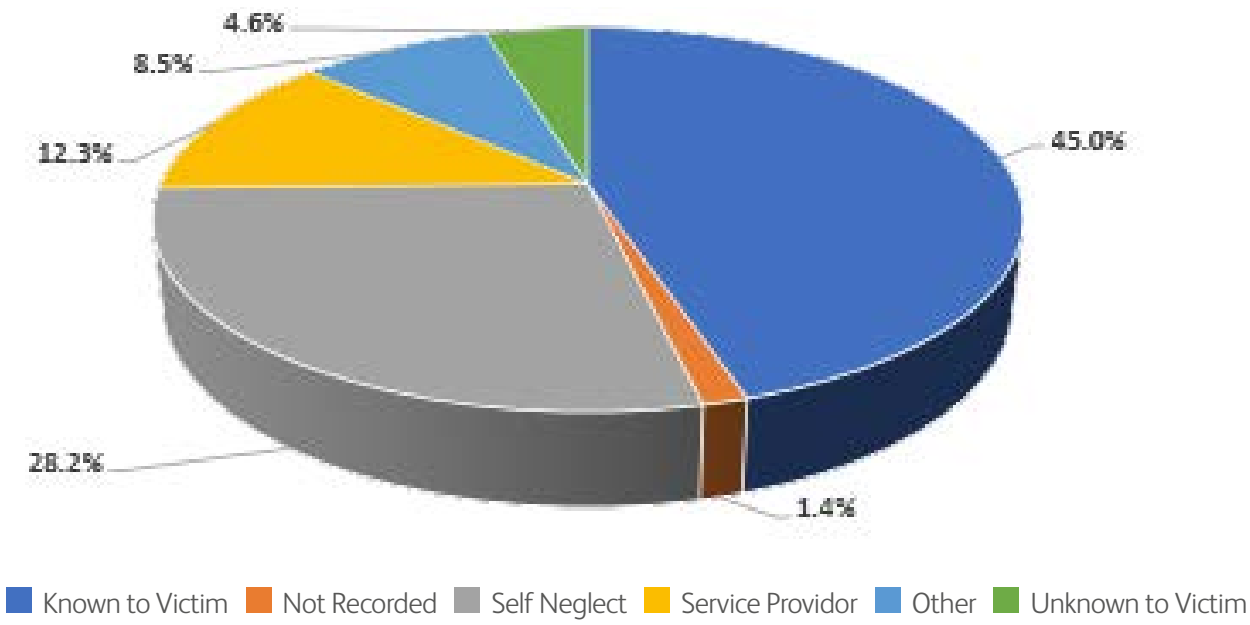
Enquiries By Location of Incident



As in previous reporting, the highest proportion of incidents occurred at the victims own home 56.9% with 50% of these recorded with an alleged perpetrator known to the victim.

Overall, 45% of incidents were recorded with an alleged perpetrator known to the victim.

Enquiries By Alleged Perpetrator



Concluded Enquiries

Year	Concerns	% Increase/Decrease From Previous Year
2014/15	567	
2015/16	529	-6.7%
2016/17	625	18.1%
2017/18	589	-5.8%
2018/19	542	-8.0%
2019/20	564	4.1%
2020/21	448	-20.6%
2021/22	549	22.5%
2022/23	511	-6.9%

The number of concluded enquiries that we were able to submit in the SAC has decreased during 22-23 by 6.9%. There were 126 concluded enquiries not being submittable due to having missing risk data (table validation within the SAC doesn't allow an option in tables 2c and 2e of 'Not Recorded' and therefore these records had to be excluded). 94 concluded cases had no Location of episode recorded however, these have been included as 'Other' and 9 episodes had no perpetrator recorded but were included as Unknown/ Stranger.

419 (82%) were S42 enquiries with 92 (18%) being 'Other' enquiries.

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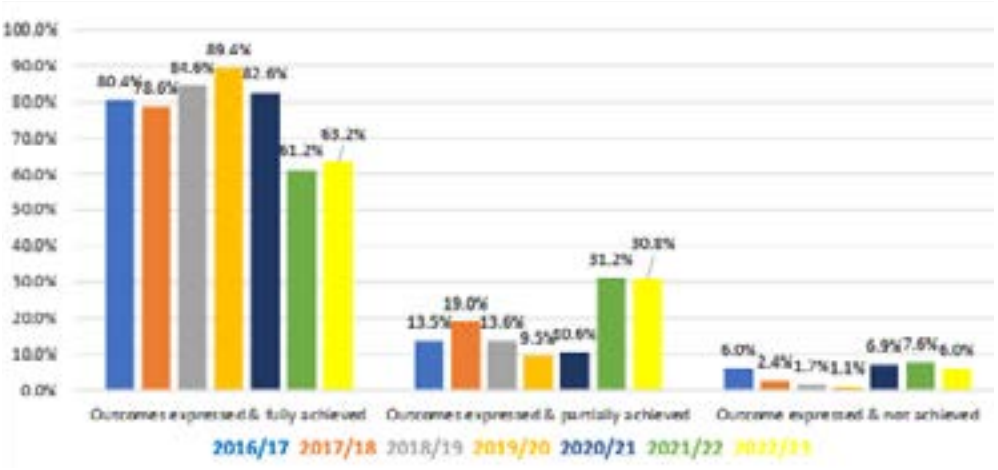
Performance regarding concluded enquiries where an outcome was expressed and that outcome was fully or partially achieved has slightly increased compared with last year, with a combined fully and partially achieved figure of 94% compared with 92.4% during 2021-22.



An element of risk was identified for 382 concluded enquiries.

Concluded enquiries where risk was identified

The table below shows where a risk was identified and if it was reduced, removed or remained. A case audit would be required to ascertain why cases fall into the cohort where action was taken but the risk remained.

	Risk reduced	Risk remains	Risk removed
Risk identified and action taken	195	32	93
Risk identified and no action taken	26	14	22
Total	221	46	115

Progress against our priorities

During 2022 – 2023 Dudley Safeguarding People Partnership has fully embedded the new subgroup structure which has proved beneficial in progressing our priorities. To support this DSPP held its first Annual Conference on 5th July 2022 where the partnership priorities were formally launched.

Joining us were keynote speakers Dez Holmes, Director at Research in Practice and Professor Michael Preston-Shoot, Emeritus Professor of Social Work at the University of Bedfordshire. Dez spoke about developing a transitional safeguarding approach and Michael spoke about learning from self-neglect SARs, research and people with lived experiences.

Facilitating the day were AFTA Thought, an organisation who use drama to bring learning from recent CSPRs and SARs to life.

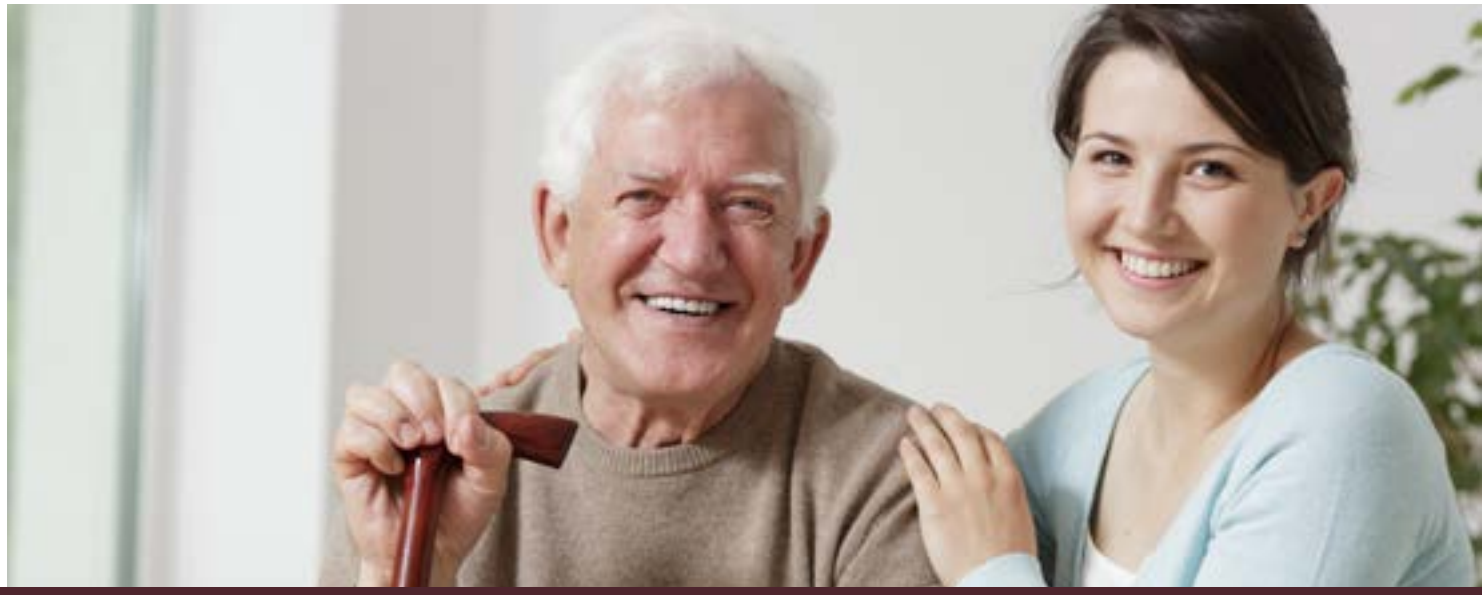
5.1. Priority 1 – Neglect across the Life course:

In Dudley, Self-Neglect forms the highest proportion of all enquiries at 23.1% followed by Neglect & Acts of Omission at 22.3%.

The Neglect subgroup is the group with responsibility for progressing this priority, it has strong partnership leadership with the ICB Designated Nurses chairing the subgroup and overseeing the Neglect work plan for the Partnership.

What we did:

- A Self-neglect thematic review was completed towards the end of the reporting period into five self-neglect cases. The report highlighted some crucial learning around Trauma informed practice and alcohol misuse and dependency, this learning has resulted in the DSAB having a clear focus on Alcohol Misuse and subsequent training will be commissioned by Blue Light in the forthcoming year.
- Dudley Group has implemented a Pressure Ulcer Standard Operating Procedure. This enables areas of learning to be shared in relation to avoidable Scrutiny meeting pressure ulcers to improve practice and prevent further harm.
- There continues to be an upward trend in staff recognition and referral for self-neglect for Dudley Group. There was a significant increase in referrals following a 2-week intensive safeguarding training period which focused on a local Safeguarding Adult Review (SAR) where self-neglect was a focus and there was learning and recommendations for the Trust around our recognition and referral of self-neglect
- We developed a cost-of-living resource web page in response to the National challenges around the rising cost of living, the resources were requested of the subgroup who all helped to populate ways to support children and adults in the Dudley borough.
- Work is underway to implement Neglect strategy for adults. It is recognised that acts of omission and neglect are not necessarily focussed on and the need to have a dedicated resource has been agreed by the Neglect sub-group. This will be launched during 2023-24.
- A position statement was developed for 'Was Not Brought' and 'Did Not Attend' to ensure we have a consistent approach to children and adults not attending for their appointments this will support professional curiosity where neglect could be a feature in a child or adults life.
- Work has commenced on the development of the Hoarding Toolkit; this is as a result of learning from reviews which evidenced that many professionals were utilising various tools to assess clutter/hoarding. Dudley needs professionals to use the same tools so that there is consistency in assessing risk to adults and children, the development of this work will be reported in the next annual report.
- Self-Neglect promotional materials were developed and shared as part of National Safeguarding Adults Week; the topic alone saw 745 impressions on twitter with a further 40 retweets/likes.



5.2. Priority 2 – Exploitation across the life course:

From 1st January 2022 there have been 90 National Referral Mechanism referrals in total, 66 relate to children and 24 to adults. 69 of the 90 referrals were made by Dudley MBC (other referrers include other LA's, Home Office and WMP)

The most common exploitation types for adults were: 13 criminal (majority drug related), 5 labour, 2 modern slavery,1 sexual, 1 multiple, 1 unknown and 1 cuckooing.

The Adults exploitation subgroup is group responsible for delivering this priority and has strong partnership leadership led by the Police who also chairs the Dudley Safe and Sound Board (Community Safety Partnership), this ensures consistency and avoids duplication between the two partnerships.

What we did:

- The subgroup continues to implement the Exploitation Strategy following its launch in November 2021 via a partnership led action plan for the group. This will strengthen the pathway for referrals around exploitation meaning a robust approach can be taken to concerns of exploitation.
- WRAP Training is available to all partners ensuring that practitioner knowledge around PREVENT is current and embedded in practice.
- Dudley's Safe and Sound Board (Dudley's Community Safety Partnership) have drafted a needs assessment and strategy in response to the new Serious Violence Duty. Mapping has been completed of support services, whilst a system wide commissioning group has been established to oversee procurement and contract management of local services
- Exploitation and County lines promotional materials were developed and shared as part of National Safeguarding Adults Week; the topic alone saw 653 impressions on twitter with a further 44 retweets/likes.
- Safe & Sound Board, through its website, campaigns and meetings has raised awareness, sign posting to support and advice and reporting issues of how to report safeguarding concerns, Hate Crime, Modern Slavery, Prevent, Domestic Abuse, Sexual Assault and Abuse, VAWG, On-Line Harms, Fraud and Scams, personal safety and violence prevention
- Dudley Trading Standards' Scams Unit have adopted a preventative and proactive approach to raising awareness, through the establishment of a Dudley Financial Abuse Alliance with financial institutions, 'friends against scams' training for any person, group or organisation, distribution of the annual fix-a-trade brochure, instalment of call blockers and visits to community groups to provide scams prevention information and advice.
- In addition, the Trading Standards team have been involved in the multi-agency safeguarding hub (MASH), receiving referrals for alleged financial abuse cases and working in a coordinated way to respond to referrals, investigate concerns and support people.

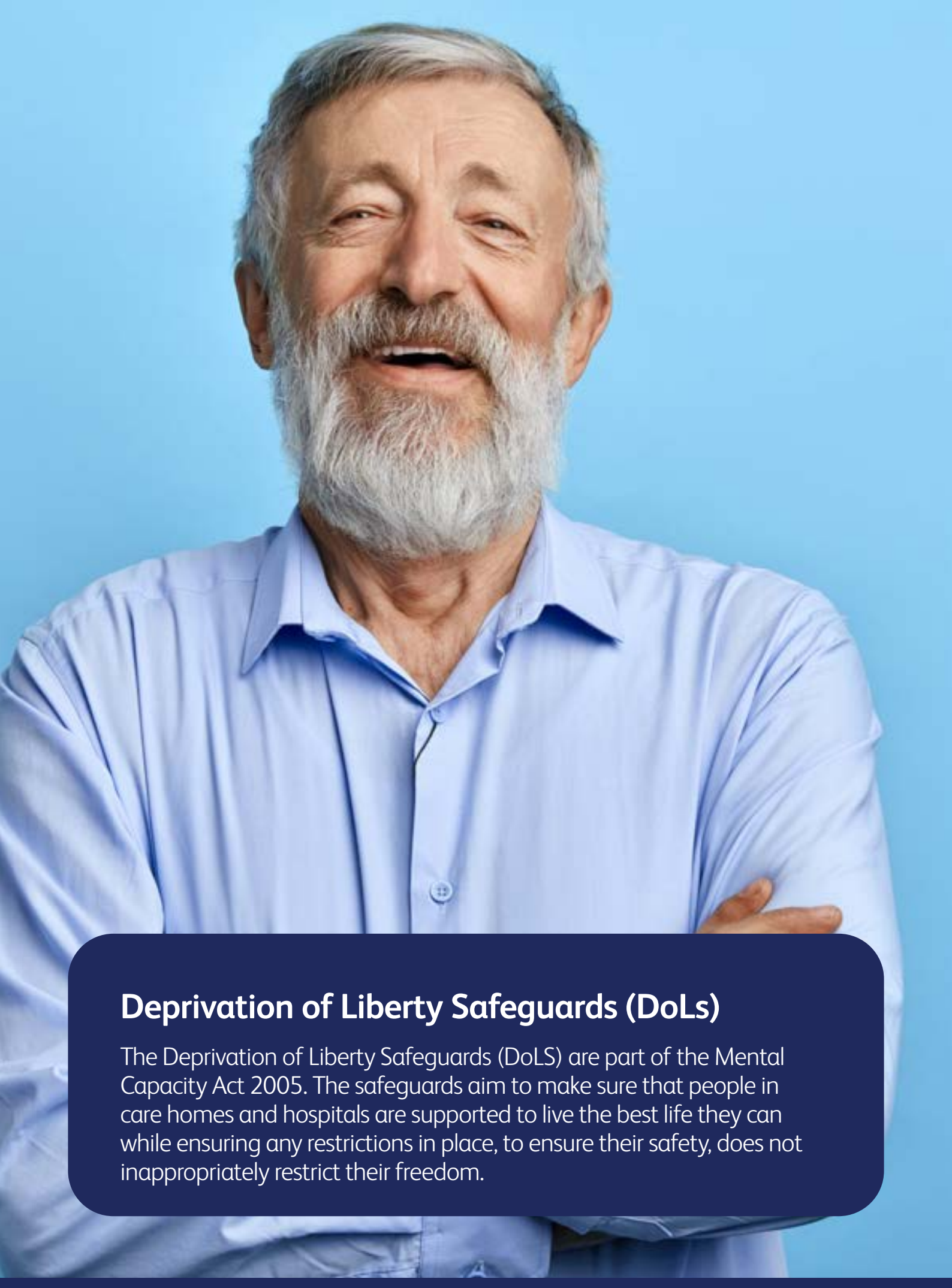
5.3. Priority 3 – Adopting a Think Family Approach

Although there is no specific subgroup for this priority, the partnership has progressed this area in the following ways.

- The restructure of our priority groups for Neglect spans across the life course which addresses any cross-cutting issues.
- The chairs of both Exploitation Groups regularly meeting to discuss such issues of transition between children's and adults.
- Following on from the success of the DSPP conference held in July 2022, partners felt it would be beneficial to have more opportunities to enable more discussion on and progress the priorities of DSPP. In response to this DSPP and its partners organised and held a development workshop on 27 March 2023 with a theme of Think Family which incorporated both Exploitation and Neglect priorities, which was well attended across the partnership.
- By the end of the workshop members had contributed to the work of the subgroups by recognising achievements to date against the respective strategies, highlighting the areas that require development and identifying ways forward in terms of next steps for the groups and partners. The general feedback from each of the sessions was fed into the Exploitation and Neglect Sub
- Over the past 12 months DIHC and Dudley Group have continued its work to develop a safeguarding infrastructure across the life course and in doing so embed a Think Family approach. This has included the successful launch of a suite of safeguarding policies and procedures. The organisation has an overarching Safeguarding Children and Adults policy.
- The DIHC safeguarding team have delivered a short training package on Think Family within safeguarding supervision sessions, service, and team meetings, and a 7-minute briefing has been disseminated within the Trust.
- The ICB Designated Team work across both adults and children, there is adult and children expertise in the team and utilise this to share learning from reviews, incidents and themes. This learning is shared via GP safeguarding forums and the Safeguarding Quality Review Meeting.

5.4. Additional work in support of the DSPP:

- We have strengthened the quality assurance arrangements from our Neglect and Exploitation subgroups to the Quality Assurance Subgroup by implementing 6 monthly assurance activity reports into the group.
- A complex vulnerabilities delayed discharged pathway has been developed for those patients where there is a risk of delays to discharge due to the complexities of a patient's health and care needs AND there has been a breakdown in their care package. Analysis of the effectiveness of the pathway will be shared in the next report.
- Public Health have funded a voluntary sector organisation - Just Straight Talk to deliver a project to improve the digital skills of local residents. Overall, 180 people have accessed support from Digi Dudley (July 21 -June 23). Of which, 122 received 1-to-1 sessions (of up to 8 sessions each) and 58 people who received support in group settings. The project has so far delivered 1,208 digital skills sessions, of which 80% were 1-1 sessions provided face to face with the vast majority taking place in people's own home.
- The Public Health Protection Team have been involved in Adult Safeguarding investigations and Large Scale Enquiries (LSE). These are multi-agency led response to supporting providers requiring improvements in standards of care which has resulted in protecting the most vulnerable people in our community. The team have also joined the Care Homes Practitioner Forum led by the Black Country Integrated Care Board's Designated Nurse for Safeguarding Adults, where concerns are raised for discussion and appropriate actions put in place to safeguard care setting residents. This demonstrates joined up working and collaboration across the system.
- Delegated portals in Adult Social Care continue to provide a safer, quick and more robust process of information gathering between partners using the previous system. This ensures all information pertaining to a safeguarding concern is recorded together transparently and securely, creating greater clarity in decision making and reducing room for error when storing sensitive data.



Deprivation of Liberty Safeguards (DoLs)

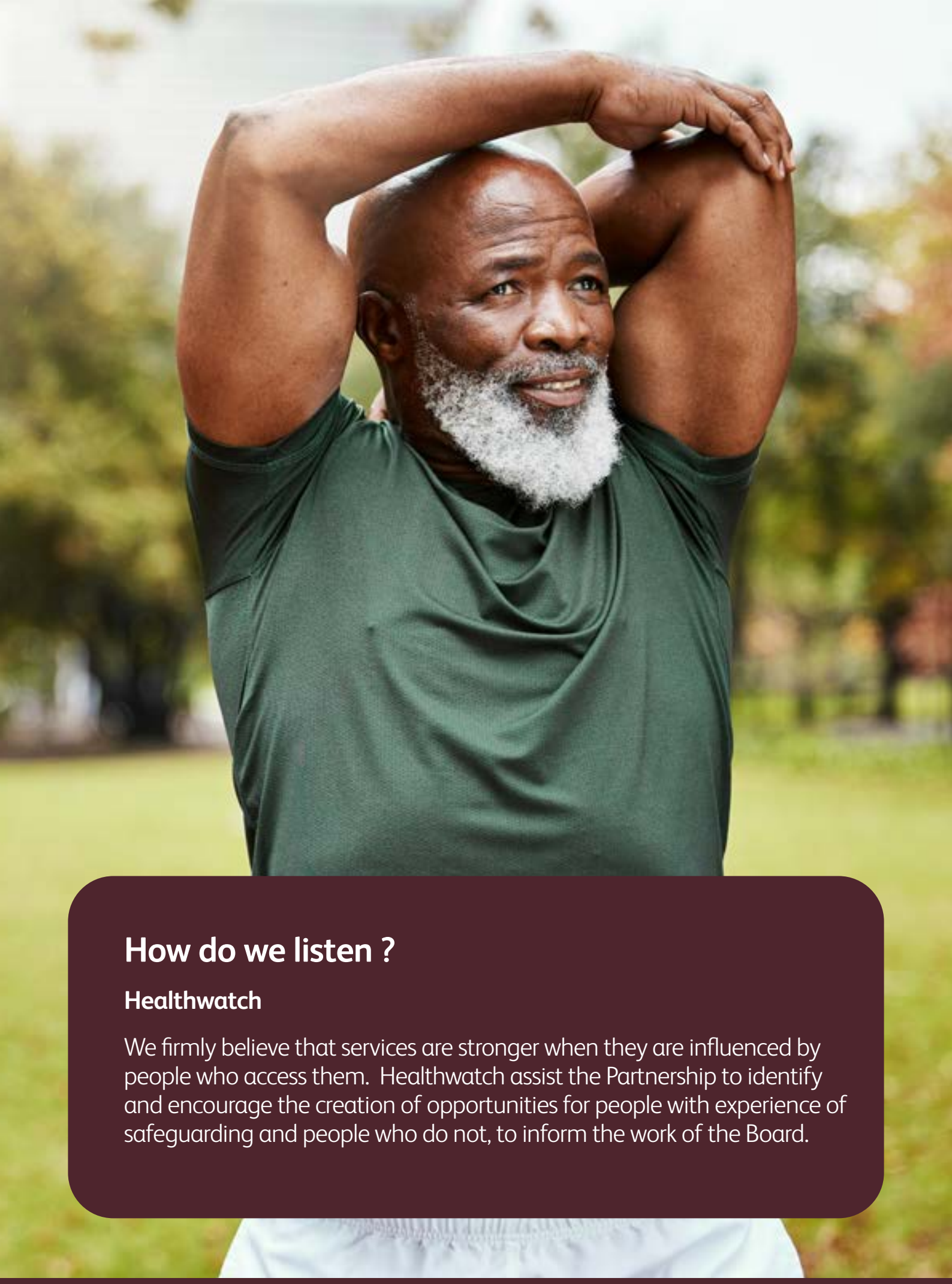
The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are supported to live the best life they can while ensuring any restrictions in place, to ensure their safety, does not inappropriately restrict their freedom.

The safeguards set out a process that hospitals and care homes must follow if they believe it is in the person's best interests to deprive a person of their liberty, in order to provide a particular care plan. The care home or hospital send a referral to the Local Authority who commission a Mental Health Assessment and Best Interest Assessment and if agreed an authorisation of the DoLS can be granted for a maximum of 12 months. The safeguards provide a number of legal protections including a right to request a review by the person (Relevant person) and the Relevant person's Representative who can be a friend, relative or Advocate.

Deprivation of Liberty in the Community (CDoL) is a protection for people over 16 who are in supported living, extra care housing or in their own homes. A designated worker from the funding organisation completes an application to the Court of Protection and the court decides if they will grant an authorisation of the deprivation of liberty for up to 12 months.

Liberty Protection Safeguards (LPS) were due to be implemented to replace DoLS and CDol and place mental capacity assessments, best interest decisions and decisions around restrictions that might amount to a deprivation of peoples liberty at the centre of all care planning and assessment. However the government has advised they will be delayed indefinitely and the DoLs and CDoL schemes remain. Support has been provided to practitioners' families, ICB and Care Homes around the legal aspects of DoLS and the process.

Dudley MBC Adult Social Care continue to triage, assess and manage all DoLS referrals. In 2022-23 there have been 547 applications received, with 440 assessments completed.



How do we listen ?

Healthwatch

We firmly believe that services are stronger when they are influenced by people who access them. Healthwatch assist the Partnership to identify and encourage the creation of opportunities for people with experience of safeguarding and people who do not, to inform the work of the Board.

Healthwatch Dudley provide a signposting service to help people make more informed choices and to access additional services for help and support. They work with the Partnership to ensure their views and opinions are taken into consideration for learning going forward.

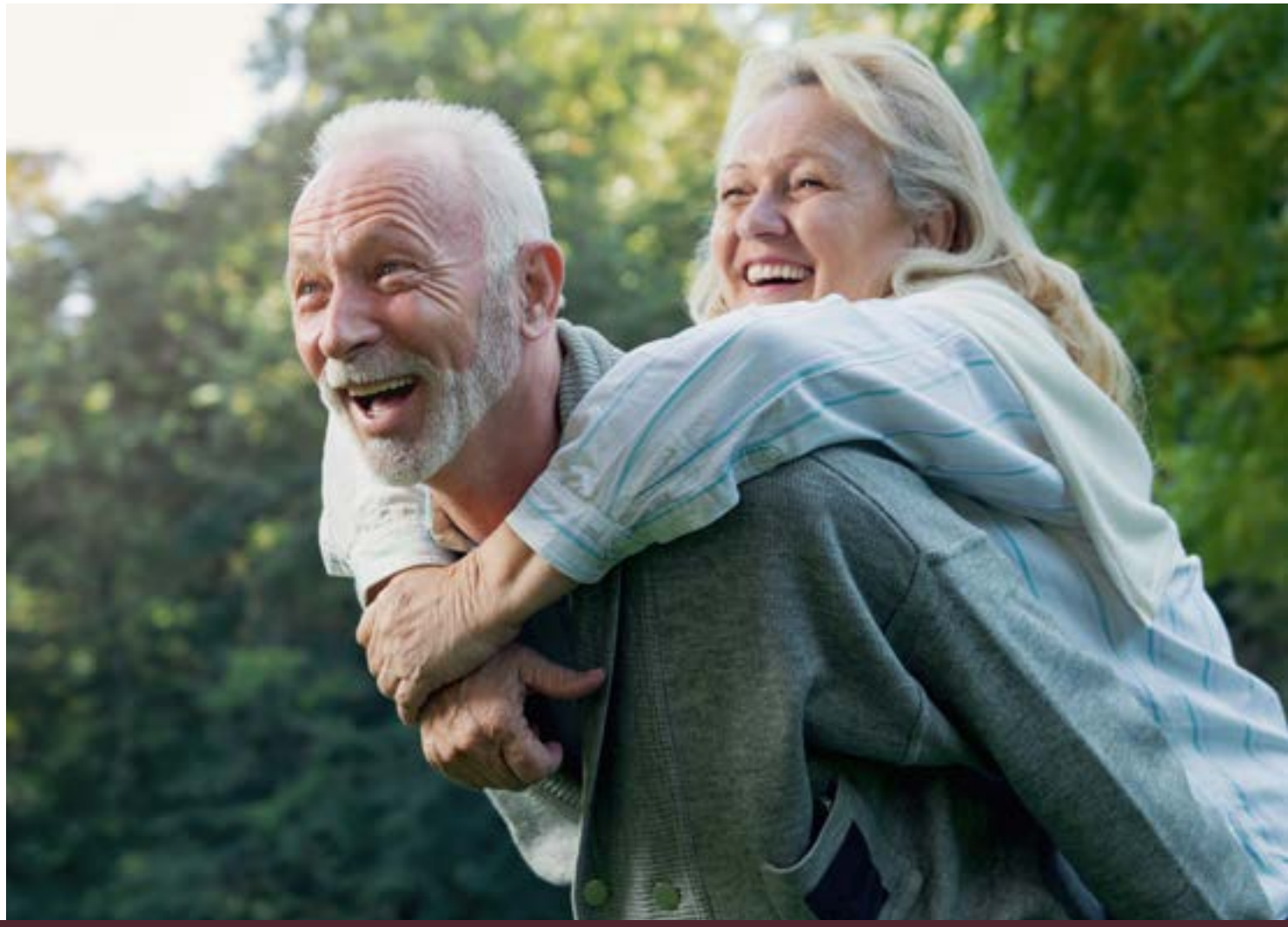
During the forthcoming year Healthwatch will be supporting DSPP to obtain local people's views on their experiences of self-neglect and safeguarding in general. The research question will be: 'What are local people's experiences of self-neglect and the safeguarding process?'

The aim is to improve understanding of people's circumstances and how they feel about the safeguarding process.

Case Study 1 • Peter's story

Healthwatch Dudley have been working with Peter for the last 12 months, his complaint and concerns have been through the internal channels and completed the ombudsmen process. The case was complicated and Peter felt that the response was not adequate but the deadline had passed for him to raise further concerns with the Ombudsmen. DSPP were made aware and were able to arrange a three-way meeting. Healthwatch Dudley were particularly interested from the perspective of someone going through the safeguarding process and how it felt to them. They were able to reflect and address any areas where provision can be considered.

This evidences the strong collaborative approach and the open lines of communication we have with Healthwatch.



Learning from Reviews

The purpose of a Safeguarding Adult Review is not to re-investigate or apportion blame but to establish whether lessons can be learnt from the circumstances of a case that may improve practice or the way in which agencies and professionals work together to safeguard vulnerable adults.

Legislation requires Dudley Safeguarding Adult Board (DSAB) to arrange a safeguarding adult review when:

- An adult in the area dies as a result of abuse or neglect, whether known or suspected and,
- There is concern that partner agencies could have worked more effectively to protect the person at risk.
- The DSAB must also arrange a safeguarding adult review when an adult in its area has not died, but the DSAB knows or suspects that the adult has experienced serious abuse or neglect.

The focus of Safeguarding Adult Reviews, in line with both multi-agency policy and national guidance is to:

- Learn from past experiences and the specific event examined.
- Improve future practice and outcomes by acting on learning identified by the review.
- Improve multi-agency working and compliance with any other multi-agency or single agency procedures, including regulated care services.

Not all incidents that are reviewed will meet the definition of a SAR but may still raise issues of importance. This might include cases where there has been good practice, poor practice or where there have been 'near misses'. In these circumstances the Partnership will decide whether to conduct a Practice Learning Review or case audit to ensure that learning is captured and shared with the workforce.

Activity during this Period

During the reporting period ten referrals were received for consideration. On review six were returned to the referrer as they did not meet threshold for consideration based on the information provided. A further three were returned to the partner agency for completion of S42 or other enquiry. One was progressed to a rapid review scoping exercise and subsequently progress to a SAR

Characteristics of the referral subjects:

- Five of the referrals relate to males and five relate to females
- Eight of the referrals were submitted following the death of the subject adult.
- Ethnicity was not stated on two referrals, with one being Asian-Pakistani, one being White Polish and the other six being White British.
- The youngest was 28 and the oldest was 96 at the time of the incident.

18-24: 0	25-34: 2	35-44: 0
45-54: 1	55-64: 0	65 and over: 7

DSPP published 2 reviews during the reporting period:

Thematic SAR – review of self-neglect

Dudley Safeguarding People Partnership (DSPP) reviewed five cases of individuals who were regarded to be self-neglecting prior to their death. All five people were considered difficult for agencies to engage with and either declined or cancelled support from services.

The review recognised that self-neglect is not a lifestyle choice, but often the outcome of a traumatic significant life event such as (but not limited to) the death of a close relative, abuse or neglect. Substance misuse, self-harm, suicidal ideation and hoarding. These are often coping mechanisms people suffering from trauma use, whilst practitioners may see these as part of the problem to be rectified, they are in fact survival strategies used by the person.

The effects of trauma and associated survival strategies, impacts upon a person's physical, emotional and mental wellbeing. By addressing trauma, it creates resilience for the future. Less homelessness, less mental ill health, and reduction in physical ill health, less hoarding, less criminal activity and a solution lies in practitioners understanding a person's experiences.

Overview of learning outcomes:

1. A Persons Own Story. It is important to get the person's story; connections, life events, how they have coped and what they want to stay safe and well.
2. Safeguarding and Wellbeing Principles. The safeguarding and wellbeing principles might serve as checklists for all agencies to use in relation to people who self-neglect.
3. Eligibility Pathways & Criteria. Eligibility criteria for statutory assessment needs to be better understood by all agencies. Pathways mapped in relation to people considered to be self-neglecting need to include consideration of critical risks when practitioners are concerned.
4. Safeguarding Risk Assessment and Decision Making. Consistent safeguarding risk assessment and consideration of the safeguarding and wellbeing principles should be embedded into frontline practice. Where required, multi-agency safeguarding enquiry and support process should be undertaken in a timely manner.
5. Mental Capacity and Executive Functioning. Agencies need to be aware of the importance of determining whether executive brain function is affected by a person's adverse experiences.
6. Think Family. A whole family approach to assessment and co-caring responsibilities should be developed if a person is identified as meeting a need and safeguarding concerns have been raised.
7. Trauma Informed Practice. Consider whether the impact of trauma is affecting a person's responses and preventing them from being able to self-care. Agencies should work to support trauma intervention at an earlier stage.

SAR - Stanley

Stanley was an elderly gentleman of White British heritage who lived alone. Stanley was the youngest of six children, brought up by his parents in the Dudley area where he continued to live.

A diagnosis of paranoid schizophrenia from early adulthood, necessitated involvement with secondary mental health services at that time and support continued throughout his life.

Stanley had been admitted into hospital with a swollen abdomen and leg and he sadly died at the age 82. There had been a series of five 999 responses over the previous weeks regarding one fall and four related to issues with his catheter.

Key Learning Centred around:

- Understanding the person's journey
- Mental Capacity
- Multi-Agency Working and Communication
- Supervision and Management Oversight
- Mate Crime
- Record Keeping

Full details of the review and learning resources are now available on the DSPP website. An action plan is in place in respect of this review and progress is being made.

Learning Shared

Learning highlighted from these reviews led to the Partnership undertaking work around self-neglect including developing a self-neglect webpage with resources for practitioners.

Promotional work and activity undertaken for Safeguarding Adults in November 2022 further highlighted learning from these reviews along with national safeguarding themes including self-neglect, creating safer organisational cultures, elder abuse and safeguarding in everyday life.

Looking Forward

A thematic learning dissemination plan is planned from 1st April 2023, giving an opportunity for staff and partner organisations in Dudley to be made aware of the key learning from our quality assurance activity and case reviews along with offering information in relation to this learning.

April's joint Children's and Adults theme will be Alcohol Misuse and Dependency which is a key theme in the Thematic SAR – review of self-neglect. The thematic learning plan will be measured through the DSPP Quality Assurance Framework by way of a 6 monthly staff survey.

In addition to this a new training course is in development, delivered by partners, which focuses on professional curiosity and brings in case review examples, SAR – Stanley is a case that will be used in this training along with previous SARs .

Learning from Audits

During 2022/23 DSAV have looked to introduce a multi-agency audit process. The Multi-Agency Audit of Practice (MAAP) process will look at and scrutinise multi-agency practice from a random selection of cases to assess the quality of practice and lessons to be learned in terms of both multi-agency and multi-disciplinary practice. The following will underpin the MAAP Audit process:

- Focus on multi-agency and multi-disciplinary interventions and have a clear focus and clearly defined terms of reference
- An expectation that all agencies commit to the MAAP procedures
- Focus on current practice, considering interventions that have occurred within the last 12 months
- Consider interventions that are within the remit and work of local agencies
- Include a focus on the welfare of the adult, timeliness, communication and engagement with families or other significant adults.

Multi-Agency Training

During the year we changed our approach of our offer of Learning and Development, the programme was amended to better reflect learning from our reviews and responded to local and national emerging themes. The learning offer was adapted to a blended approach of online learning events and the return of face-to-face training.

Key Developments

- **The Learning and Development Strategy was refreshed for 2022-2024, this was streamlined to make it more focused on what we are trying to achieve and how.**
- **The first DSPP competency framework for safeguarding training in Dudley was developed in line with statutory guidance and national competency frameworks.**
- **The training plan was revised to ensure all training directly linked to DSPP priorities or local learning identified through case reviews and audit activity.**
- **A full training needs analysis was completed which will inform the 2023-24 programme.**

Training Data:

68 total training events (both adults and children courses) were delivered through the DSPP between 1st April 2022 and 31st March 2023.

We offered a total of 2068 places, of which 1106 were used, and out of that 849 delegates attended the courses.

We found that 344 delegates cancelled their place prior to the course, mainly due to capacity, and 257 did not attend on the day, and again this was mainly due to operational service delivery issues.

100% of our training was half day or less.

21 events for both adults and life course training were delivered through the financial year.

Delegates representing 48 different services or organisations have been able to network and build relationships on multi-agency training.

Attendance at our training in relation specifically to our key priorities is as follows:

Introduction to Domestic Abuse	Introduction to Modern Slavery	Adults Safeguarding Awareness	MCA Awareness	introduction to Hate Crime
1030	285	239	124	119

Attendees reported improved knowledge following courses which will improve their practice.

"I was impressed about the deaf safe and well visits and also the young people service as I was unaware that these were available and will definitely bear in mind in the future. I also did not know about the QR codes being up in the offices which was useful."

Fire Prevention in the Home and How you can help prevent residents of Dudley dying or getting injured in a house fire

"This course taught me the importance of language in shaping a person's story (e.g. referrals) and then in turn how others perceive them."

Trauma Informed Practice

Training Evaluations

What we can see from our data embedded in our Learning Management System is that (at this time of writing this report):

- 75.2% of people complete pre-evaluation
- only 58.3% of people complete post course evaluation
- only 11.7% of people complete post event stage 2

This suggests there is more work to do in measuring how our training is making a difference to practice in Dudley.

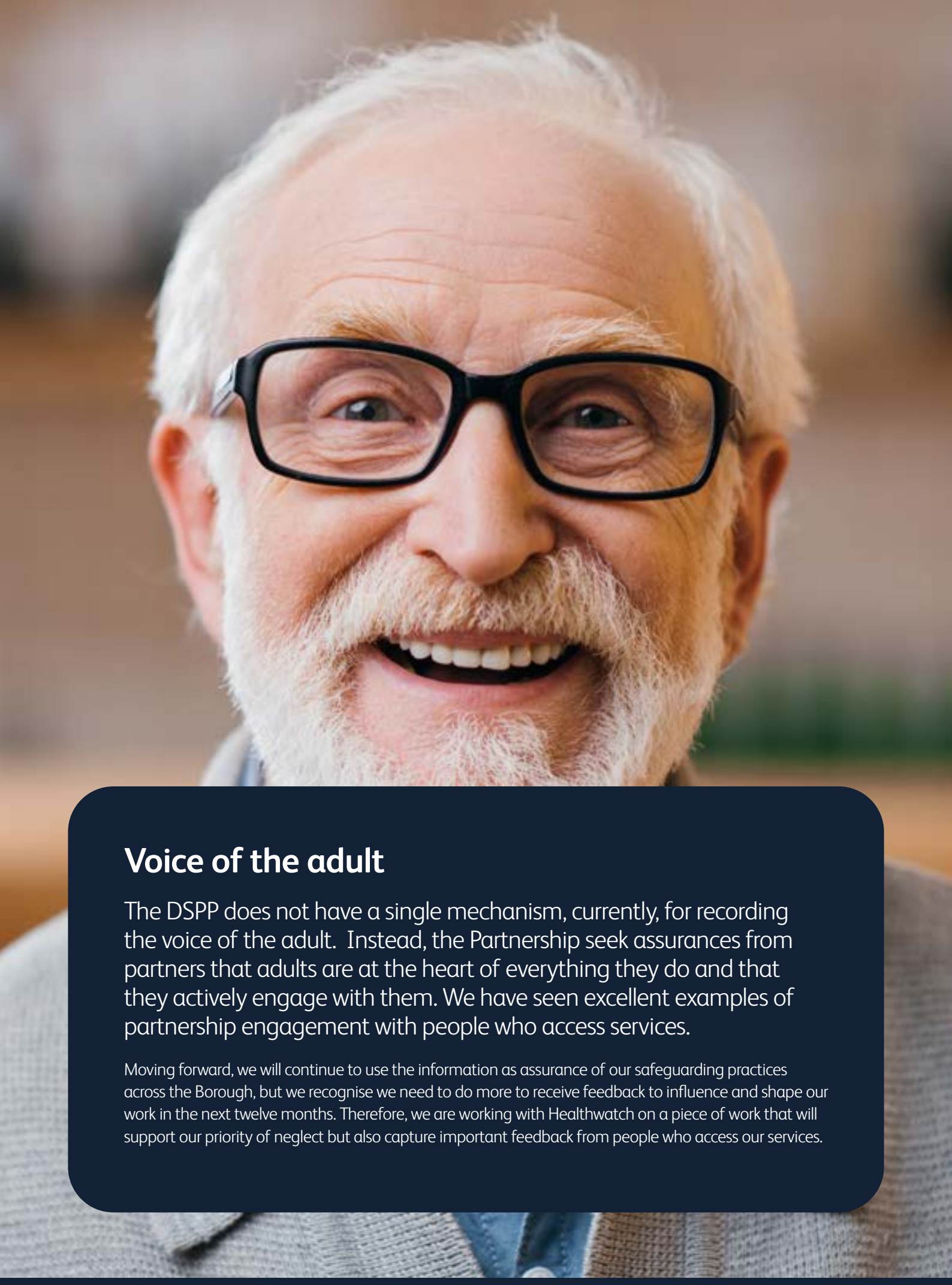
Learning Gain

Pre-booked average	Post Event Average	Learning Gain
3.01	4.30	1.29
Data collected from 01.04.2022 – 31.03.2023		

Our learning gain figures show that our training is improving professional knowledge which will in turn improve safeguarding practice. We regularly ask for feedback on our courses to ensure we are delivering the right material to the right audience. We are part of a regional learning and development group which enables us to share best practice.

We have made significant progress on working with partners to develop and facilitate our courses which will be running from 2023-24.

We have started discussions on a regional level to enable Dudley to gain improved learning on practice improvement as a result of our training and awareness raising. The implementation and subsequent analysis of the thematic learning plan will also significantly address closing the loop in learning and improvement cycle.



Voice of the adult

The DSPP does not have a single mechanism, currently, for recording the voice of the adult. Instead, the Partnership seek assurances from partners that adults are at the heart of everything they do and that they actively engage with them. We have seen excellent examples of partnership engagement with people who access services.

Moving forward, we will continue to use the information as assurance of our safeguarding practices across the Borough, but we recognise we need to do more to receive feedback to influence and shape our work in the next twelve months. Therefore, we are working with Healthwatch on a piece of work that will support our priority of neglect but also capture important feedback from people who access our services.

Our priorities for 2022-2024

The priorities for the forthcoming year reflect 2022-23 priorities and we will continue to further progress the identified work plans. In the next twelve months we will also focus on the following:

1. Develop robust transitional arrangements for 16-18 years who are at risk of exploitation.
2. Develop a more robust hoarding/ squalor/ clutter tool which reflects a think family approach. Learning from reviews highlighted that professionals are using a number of different tools to assess the conditions in a home.
3. Revise the exploitation screening tool and appropriate risk levels to ensure its effective use across the partnership.
4. We will introduce a Multi-Agency Audit of Practice process, ensuring we focus on the quality of practice and the difference we make and analyse the findings and embed learning in our practice ensuring we have a shared understanding of what good looks like
5. Implement a Thematic Learning Plan to enable staff and partner organisations in Dudley to be made aware of the key learning from our quality assurance activity and case reviews and how they can implement changes in their everyday practice.
6. Develop the learning offer based on the findings of a Training Needs Exercise. This exercise will demonstrate the training needs across the partnership and strengthen the adults learning offer.
7. Partners to assist in the co-delivery of Multi-Agency Courses: Health and Social Care Partners to jointly deliver a brand-new course on Professional Curiosity and Effective Challenge (key finding from both adults and children's reviews). Health, Police and Social Care Partners will develop and deliver a course on making safeguarding concerns due to an emerging data trend.
8. Hold an Annual Conference directly linking to case reviews; The theme of the conference will focus on Developing a Trauma Informed Partnership and will take place during Autumn of 2023
9. Review the Training Impact Process to better inform the Partnership of the impact of its multi-agency training on practice.

Summary

During 2022/23, the Dudley Safeguarding Adults Board has embedded the new strategic priorities and the work within of the subgroups. We aim to have a robust process where our work is influenced regularly by people who access our safeguarding services, therefore the newly commissioned work by Healthwatch will provide valuable insights into the effectiveness of our work.

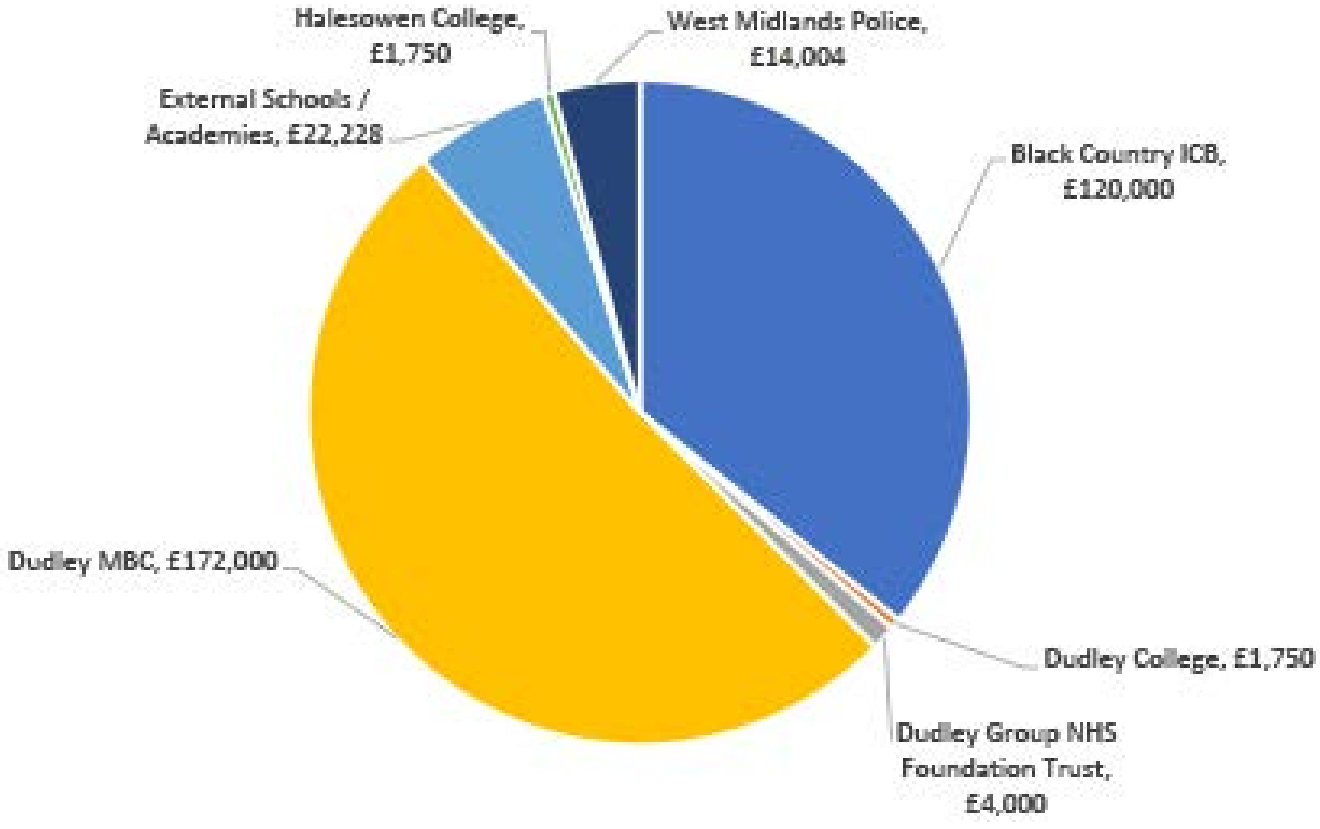
Through our work in the Neglect Subgroup, we are now seeing a new and equally concerning problem in the rise of Self-Neglect and Disorganised living. We know this issue affects both children's and adults in Dudley therefore the development of new Hoarding/Squalor toolkit working across services for Children's and Adults will commence in the coming months. This remains a specific strand to the work of the subgroup who will be leading on the implementation for this piece of work.

A significant focus for the partnership is our approach to Think Family, in particular reviewing our Transitional Arrangements for Safeguarding, a clear strength in progressing this work is the unity of the two Exploitation Subgroup Chairs. This is proving beneficial in making progress on the development of robust exploitation transitional arrangements between Children and Adults.

We will continue to learn from our safeguarding adult reviews, ensuring timely and appropriate dissemination of themes and trends and to use this information to underpin our training and influence our strategic direction. Our Learning offer for adults will be strengthened over the next 12 months and we are excited to implement our schedule of thematic learning that will evidence how learning from reviews has been implemented and making a difference to practice.

Appendix 1

DSPP funding arrangements 2022-23



Appendix 2

Case study 1

Patient B was an 86-year-old patient, admitted to the hospital following a fall in her care home. Patient B had a multitude of health problems and was deteriorating quickly.

All reversible causes had been ruled out and she was considered close to end of life. B was receiving IV fluids with limited benefit and at times appeared to be causing her distress, she would often try to remove the cannula.

When B was more alert, staff would support her to receive fluids orally. B did not have any relatives or friends to support her with decision-making. Medics had two options available: to withdraw IV fluids and discharge her back to the care home to live out the time she had left in comfort and in an environment, she was familiar with, or remain in hospital to continue IV fluids, putting her at risk of hospital acquired infections and the possibility of dying in hospital.

Following the first principle of the MCA, B was not assumed to lack capacity to make this decision herself. Support, the second principle of the MCA, was given to B to help her understand this decision. Staff approached her at different times of the day, at times she appeared more alert, they gave her the information using simplified language and shorter sentences, explaining only the salient points in relation to the choices available. During this support, staff established a reason to doubt B's mental capacity in relation to this decision, so an MCA assessment was carried out. The assessment determined B lacked capacity to make this decision herself.

As part of the MCA process, B was entitled to support from an Independent Mental Capacity Advocate (IMCA).

The decision-maker, the consultant in charge of B's care, was identified and a best interest meeting was held involving the IMCA and professionals relevant to this decision.

Considering principles 4 and 5 of the MCA, everything must be done in the patient's best interest and least restrictive practice. The benefits and risks of each decision were weighed up while considering the least restrictive option. The decision was made to withdraw active treatment and discharge B back to the care home.

The MCA supported the decision-making process in a timely way. A few days later B was discharged to a Nursing Home for end-of-life care.

Case study 2

P was referred to safeguarding after being admitted to hospital following extensive domestic abuse resulting in physical injury.

They were found to be homeless and addicted to alcohol, which was impacting on their ability to self-protect and engage with professionals. P was heard at MARAC due to the high-risk domestic abuse they were experiencing and their case progressed to section 42 enquiry in the Safeguarding Adults at Risk team. The team supports adults under the age of 65 who's primary needs relate to alcohol and substance misuse.

P was allocated to a worker has used a person centred and trauma informed approach to understand their desired outcomes. They have worked together with P to form a network of professionals [including Change Grow Live, Housing support, IDVA, Probation and Police] to ensure they have the right support at the right time to minimise risk and empower P with skills to deal with their trauma and increase their independence. As a result of this support P has felt able to end their relationship with their abuser, access alcohol detox and has obtained independent accommodation.

Dudley Safeguarding
People Partnership