Dudley Safeguarding

protecting children, young people and adults at risk

Dudley Safeguarding Adults Board **Annual Report** 2013/14

Contents

Message from our Independent Chair

Welcome to Dudley Safeguarding Adults Board (DSAB) Annual Report for 2013/14. This is my first annual report as Independent Chair of the Board having taken up post in April 2013. I also chair the Dudley Safeguarding Children Board (DSCB) and I consider it a privilege to contribute to the collective efforts to keep people at risk across the borough, safe and well.

I am pleased to report that the constituent agencies of the Board are both individually and collectively dedicated to the cause of adult safeguarding. I have been most impressed with the commitment and motivation of partners. This was present upon my arrival and is down to the individual motivation of board members and the excellent leadership of my predecessor, Brendan Clifford.

Developing an effective safeguarding board is not easy. There must be the right balance between working together to achieve goals and having the courage to challenge and hold an individual agency to account when necessary. Lack of challenge would render a board largely ineffective. Challenge which is overzealous or unnecessary could erode trust and damage partnership working. Again the search for that balance is embraced by board members.

The right balance had to be achieved during the past year when both safeguarding boards sought reassurance from the Dudley Group of Hospitals NHS Foundation Trust with regard to ensuring patient safety. The detail of this process can be found in the main body of the report but I am pleased to inform you that the board employed a robust style in order to hold to account the trust with openness and transparency and the partnership was strengthened as a consequence.

Another example of this strengthening of the partnership relates to the funding of board business. The Dudley Safeguarding Adults Board now receives financial contribution from both West Midlands Police and Dudley Clinical Commissioning Group having previously been solely funded by Dudley Council. Not only will this joint funding allow for increased capacity, it demonstrates a real commitment.

Safeguarding in Dudley was subject to critical external examination during a peer review exercise conducted between Dudley and Stoke during January and February 2014. This was not an inspection but was nevertheless conducted with rigour and resulted in valuable findings.

These findings showed a number of strengths and were largely favourable, with areas for improvement being identified and addressed.

Communication is an important factor in safeguarding and during the year the DSAB

and DSCB developed a new website, a single logo for both boards and a joint communications strategy.

Efforts were made during the year to capture the views of clients on their experiences of the safeguarding process. The critical importance of this makes it a continued priority for the coming year.

Sharing information effectively is key to keeping people safe. Indeed, inability or unwillingness to share information is the most common cause of failure highlighted in serious case reviews. I am pleased to report therefore that regular information sharing meetings between the Care Quality Commission and ourselves provides a clearer picture of the quality of care being delivered in care and residential establishments and improve the chances of identifying and addressing poor practice.

From a national perspective, the Care Act reaches its final stages in early 2015. It will bring the legislative support and clarity that professionals have long since advocated. Its introduction in the coming year will place specific responsibilities on safeguarding boards. Membership of key agencies will be mandated, there will be a duty to share information and reviews will need to be undertaken when someone in need of care and support dies and there is concern over how one of the agencies of the board acted. There will also be a requirement to produce an annual report and business plan. I am entirely confident that the Dudley Safeguarding Adults Board is more than ready to fulfil these requirements.

Whilst there are many positives highlighted in this report, there will always be the need for continuous improvement. The board has a strong commitment to develop further and the Strategic Plan contained in this report shows how we intend to do that.

Within the current economic climate I'm confident that we can move forward with the capabilities and commitment required to ensure that all our residents at risk are kept safe.

Roger Clayton Independent Chair Dudley Safeguarding Adults Board August 2014

About Dudley Safeguarding Adults Board

What is the Dudley Safeguarding Adults Board?

Dudley Safeguarding Adults Board works to protect adults who may be being neglected, harmed or abused, or are at risk from these things. The board also helps people to protect themselves from abuse and neglect, and ensures that people are being treated fairly, with dignity and respect.

What we do

The board works to protect people in a variety of ways. These include:

- Writing policies and procedures so that organisations work together to protect adults at risk and prevent abuse.
- Monitoring how abuse is dealt with and working to improve how this is achieved.
- Learning from situations and improving practice.
- Providing opportunities for learning and development on how to make and keep people safe.
- Raising awareness of abusive situations.
- Promoting recruitment practice to ensure that appropriate people care for vulnerable adults.

The board is well established with wide senior representation from Dudley Council, West MIdlands Police, Dudley Clinical Commissioning Group, Dudley Acute Hospital Trust, Dudley Fire Service, Dudley Probation Service, Healthwatch Dudley, Dudley and Walsall Mental Health Trust, The Black Country Partnership Trust and voluntary sector agencies and providers.

Safeguarding needs to operate on a number of levels across a range of organisations to be effective - it is recognised safeguarding really does have to be everybody's business.

Who is an adult at risk?

The board works to prevent and deal with the abuse of adults who may be at risk.

The Care Act 2014 refers to a 'person at risk' as someone who

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing or is at risk of abuse or neglect and;
- As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

How to report a concern that someone is or may be being abused

We work hard to make sure that everyone across Dudley borough is aware of our reporting procedure.

The Department Of Health ' No Secrets' document states "there can be no secrets and no hiding place when it comes to exposing the abuse of adults at risk."

To this end we have a central contact number where anyone (professional or member of the public) can report any concerns they may have. This number is based at the council's Access Team (0300 55 0055). Alternatively professionals can complete an alert form.

Additionally, the board has comnmmsiooned and launched a Safeguarding website www.safeguarding.dudley.gov.uk which has been heavily promoted. This provides information on how we work to protect adults, along with an online reporting tool, and contact numbers. The website is constantly evolving and updated as issues arise or new information is received.

The safeguarding process

When a call is made to the Access Team regarding a safeguarding concern, the information is collated and a senior social worker and manager agree together whether the alert meets the 'safeguard threshold'.

If it does a strategy meeting will be arranged to discuss the issues, gather information and to agree the investigation process.Dudley Council's adult social care team has two Safeguard Managers and an Assistant Manager who chair strategy meetings.

A social worker will then undertake the investigation and complete a report for a case conference. This will ensure that any abuse is reported to all agencies involved in the situation.

A plan to protect the person concerned will then be developed, with all actions planned to assist with this being documented. The victim of abuse and/or their carer are always invited to the case conference to receive this information.

Learning Disability and Mental Health services carry out the same process with the managers of those services leading the process.

From April 2013 to March 2014 the number of strategy meetings was 769 and the number of conferences conducted was 189. These meetings are supported by safeguard minute takers based within the safeguard team.

The National Context

Everything that we do is set against the national context of adult safeguarding, whereby we take guidance from national statutory bodies

Statement of governement policy

The Department of Health published a "Statement of Government Policy" on adult safeguarding in May 2013

This document set out six safeguard adult principles for boards to consider:

Empowerment

Prevention

Proportionality

Protection

Partnership

Accountability

These principles were intended for agencies to use to help them develop and assess the effectiveness of their own safeguarding arrangement. We have used these principals in further developing our own plans for the future.

The Care Act 2014

The Care Act comes into effect from April 2015 and will set out the first ever statutory framework for adult safeguarding which stipulates local authority's responsibilities and those with whom they work to protect adults at risk of abuse or neglect.

This Act will require that:

- Members of key agencies will be mandated
- There will be a duty to carry out enquiries into suspected cases of abuse or neglect.
- There is the establishment of the Safeguarding Adults Board on a statutory footing to develop shared strategies and report to their local communities on their progress with the production of an annual report and a business plan.
- The board must also arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs if certain laid out conditions are met).

The Mid Staffordshire NHS Foundation Trust Public Enquiry

chaired by Robert Francis Q.C. (The Francis Enquiry 2013)

This final report was published in February 2013 and recommended a common culture was instilled across the NHS of putting patients first and making sure all those who provide care are fit to provide such a service. This recommendation has been extended to safeguard boards to ensure that agencies are aware of safer recruitment practices

Disclosure and Barring Policy

The main changes to this service occurred in 2012 with the merger of the Criminal Records Bureau and the Independent Safeguarding Authority to form the Disclosure and Barring Service. A new definition of regulated activity was established and a minimum age of 16 for DBS checks agreed. In June 2013 it introduced a DBS update service. This enables an employer to carry out a free, online instant status check with the permission of the applicant.

Internal portability of a DBS certificate was accepted in 2013 for council personnel within Dudley, with the understanding that DBS checks are carried out every three years.

How we make a difference

Our business plan for 2013 set out four core priorities for the board.

These were:

Priority 1

Board members to assure the board that their agencies are partners in safeguarding and understand the safeguard process and the issues it raises for its workforce and Dudley borough residents.

Priority 2

The experience of victims of abuse must influence the work of the board.

Priority 3

Promotion of the Adult Safeguard Agenda through partnership working.

Priority 4

To improve consistency and quality of inter-agency adult safeguard practice.

This Annual Report is shaped around providing evidence of the board's activities against these four core areas.

1. Information sharing, a recognition of responsibilities

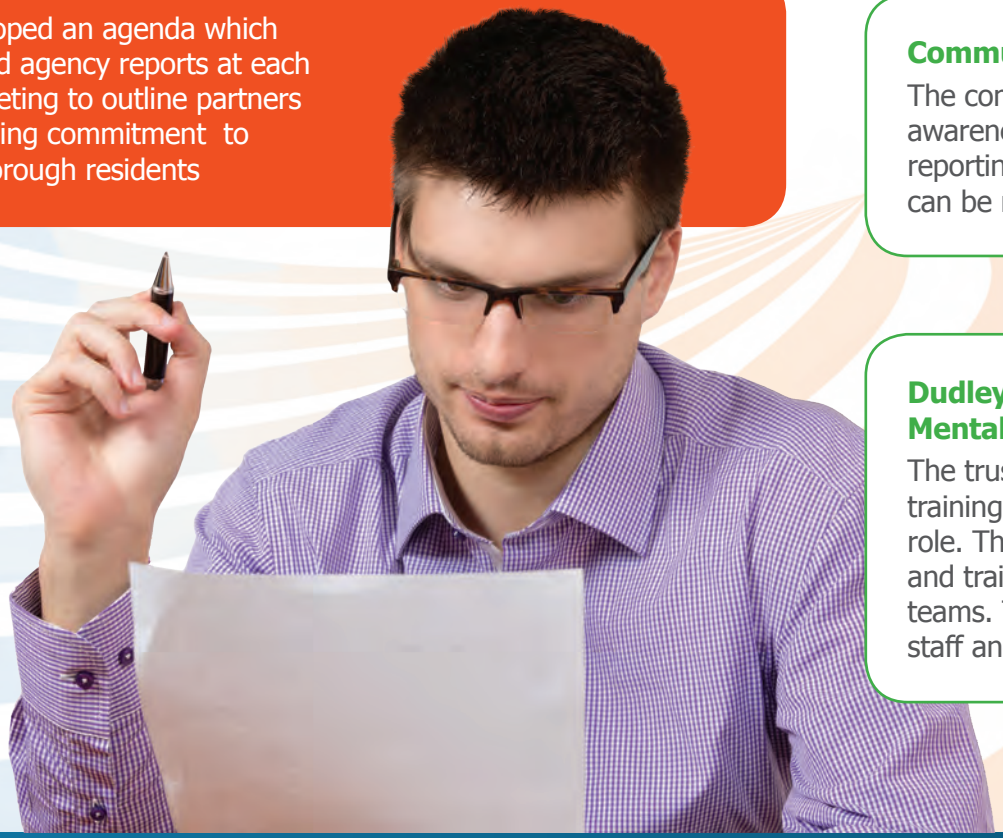
What did we say we would do?

Business plan priority 1

Agencies across Dudley borough to show their understanding of the responsibilities they have towards safeguarding vulnerable adults by bringing reports to the board about the work within their agencies

What did we do?

We developed an agenda which considered agency reports at each board meeting to outline partners safeguarding commitment to Dudley borough residents



Actions reported to the board over the period include:

SUCCESS!

West Midlands Police

The police reported that a Vulnerable Adults Hub, based in West Bromwich would take all safeguard referrals and agree safeguard investigations. The hub will collect information on referrals for each local authortty. A detective sergeant will lead with constables supporting. The hub has subsequently been deemed as best practice

SUCCESS!

Community Safety Partnership

The community safety team explained its work to promote awareness of hate crime across the borough. A third party reporting organisation has been developed where hate crmie can be reported.

SUCCESS!

Dudley and Walsall Mental Health Partnership Trust

The trust reported on their investigation and mental capacity training that has been developed to help staff in their safeguarding role. The trust has a robust approach to safeguarding awareness and training and works closely with the council's adult social care teams. They have also developed a safeguarding leaflet for their staff and victims of abuse.

Black Country Partnership NHS Foundation Trust

Have ensured that their assessment and scrutiny services have undergone scrutiny in light of the Winterbourne Report and have developed accessible support plans and meaningful ways of developing these with customers. The trust has also appointed a safeguarding lead and a lead practicioner to enhance its safeguard commitment.

Dudley Council – adult social care

Have reported on their response to the Winterbourne Report. Advocacy services work has been improved and trends for repeat referrals addressed. Commissioning services have also been strengthened to obtain the views of clients and carers. Complaints received are also now collated and compared to safeguard referrals to identify themes and trends following Winterbourne.

Healthwatch Dudley

Healthwatch Dudley is a new agency in Dudley set up to support and empower members of the public in dealing with and addressing issues in the health service. They also help people choose the right health and social care support to meet their needs and understand their rights. Safeguarding is one of the areas that Healthwatch staff and volunteers have been trained to understand, including the referral process.

Dudley Group of hospitals NHS Foundation Trust

Russells Hall hospital managers reported that they had looked at how they manage patients who lack capacity or have learning disabilities. They had invited an independent reviewer Changing our Lives to review their practice. Dudley Voices for Choices have raised awareness about learning disability issues through staff training. Mental capacity and deprivation of liberty standards training is now planned to be mandatory for all staff.

The trust also plans to launch a learning disability strategy that places the needs of patients with learning disabilities at a high priority within the trust. In addition there are plans to appoint a specialist learning disability nurse who will support the trust with specific training.

In March 2013 a Healthcare Forum was established to promote an arena where health professionals can exchange concerns including safeguarding issues.

West Midlands Fire Service

Reported how their vulnerable persons officers link with partners to support victims of abuse or neglect. They reported 36 cases over the period where they have been involved in safeguard concerns.

The Centre for Equality & Diversity

Works with black and minority ethnic groups and advice and support is provided to ensure safeguarding practice is understood and safe recruitment for paid and volunteer roles is established. They reported that support to reach eastern european and african communities would be useful to provide advice on safeguarding vulnerable adults within these communities

Dudley Clinical Commissioning Group (CCG)

Drew attention to the Francis and Keogh reports on its website in relation to the Mid Staffordshire enquiry and how the CCG plans to develop the recommendations within the processes looking at the cultural issues important to develop patient care safely and with dignity.The CCG safeguard lead continues to play an integral role in many individual safeguard concerns. The Safeguard Lead has also contributed to West Midlands hosted events to demonstrate how good care planning and recording can safeguard individuals and provide the evidence required for safeguard investigations.

Children's Services

Presented their action plan on partnership arrangements to work more effectively with families where parents with mental health issues also abuse substances.

They also told how they audit safeguard cases and explained how the elements of quality assurance were transferrable to adult safeguarding and in some cases it would be useful to look at how both adult and children's services responded to safeguarding.

The Care Quality Commission (CQC)

Informed the safeguard board about information it collates on registered services. The information currently looks at the number of inspections carried out in the borough and where organisations have not been compliant with the outcomes required. Safeguarding is one of those outcomes alongside other related outcomes such as medicines management, respecting and involving people who use services and the care and welfare of those who use the services. This information is routinely sent to the local authority and Healthwatch and is a published document.The CQC attend a liaison meeting in Dudley with partners to share specific detail behind this report.

Challenges for 2014/15

There remain a number of challenges for us to improve our performance, with regard to information sharing and recognising our shared resonsiblites. Challenges noted for 2014/15 include:

Information has been shared by partners in 2013 in board meetings. In 2014, to meet the statutory requirements outlined in The Care Act, the board will consolidate its constitution, memorandum of understanding and information shared policy.

In 2013 board members have given assurances in their reports, about their commitment to safeguarding. In 2014/2015 we will ask members to complete an Assurance Framework Document to ensure issues are addressed consistently across all agencies.

Healthwatch are to develop the Enter and View Scheme and contribute to safeguarding people using those resources.

Work with children in transition and troubled families must continue to strengthen partnerships in the wider safeguard agenda.

- There will be promotion of the role of advocates within organisations as outlined in the Care Act to give people support throughout the safeguard process.
- We will continue to address hate crime, substance misuse and to look at promotional events to raise safeguarding awareness amongst people who may not use the internet and are not aware of the reporting mechanisms.
- We will look for additional financial contributions from partner agencies to continue to develop the work of the board. In 2013 West Midlands Police contributed to West Midlands Boards and Dudley Clinical Commissioning Group has agreed to provide funding for 2014.

These issues will be addressed within our 2014/15 Business Plan - see Appendix A.

2 Case study sharing

What did we say we would do?

Business plan priority 2
The experience of victims of abuse should influence the work of the board.

What did we do?

We developed an agenda which considered agency reports at each board meeting to outline partners safeguarding commitment to Dudley borough residents

Case study examples

Miss X

Neighbours raised concerns that an elderly lady caring for her niece Miss X who has a learning disability, was neglecting her care and that Miss X had developed ulcerated legs. Miss X was admitted to hospital and the concerns were investigated. Miss X stated that she wanted to continue to live with her aunt, as she had done since her mother had died. Professionals concluded that there was no willful neglect but that her aunt was struggling to cope and unaware of the support available. All agreed on a discharge to home with ongoing support from district nurses. They showed her aunt how to care for Miss X's legs and a social worker was appointed to monitor the situation and provide additional support as required.

Mrs Y

Mrs Y was admitted to hospital from a residential care home as she had been given the wrong medication. All other residents medications were checked to ascertain whether they were correct. Errors were subseqenly found in the home's reporting processes. Placements were stopped at the home until situation improved. An action plan was agreed and carefully monitored. Dudley and Walsall Mental Health Trust and the CQC reviewed progress and improvements were clearly noted. Mrs Y later returned to the home with no adverse effects.

Mrs Z

Mrs Z, a 40 year old lady moved to a refuge in Dudley to seek support from a violent partner. Her three children moved with her. She subsequently developed serious health problems and required a package of care to support her. Whilst receiving the care package she informed the social worker that her son had begun to physically abuse her and she felt that she was not strong enough to manage the situation. She agreed to a period of respite and housing services offered her son and his partner support to find separate accommodation.

Learning from Serious Case Reviews

In March 2013, three serious case reviews that had occurred within the West Midlands were studied by the board. It was agreed that lessons regarding professionals being professionally curious and seeking out additional information appeared to be common to all of the issues concerned. The importance of following up missed appointments where there are concerns was also noted. Support to carers to provide information which may help prevent abuse was noted. It was agreed that potential safeguard situations should be discussed with partner agencies through the safeguard route or the access route to seek general advice and guidance.

In September 2013 another serious case review was considered which led the board to consider closure arrangements for commissioned services to ensure necessary safeguards are in place to protect vulnerable adults.

Practice Learning Events

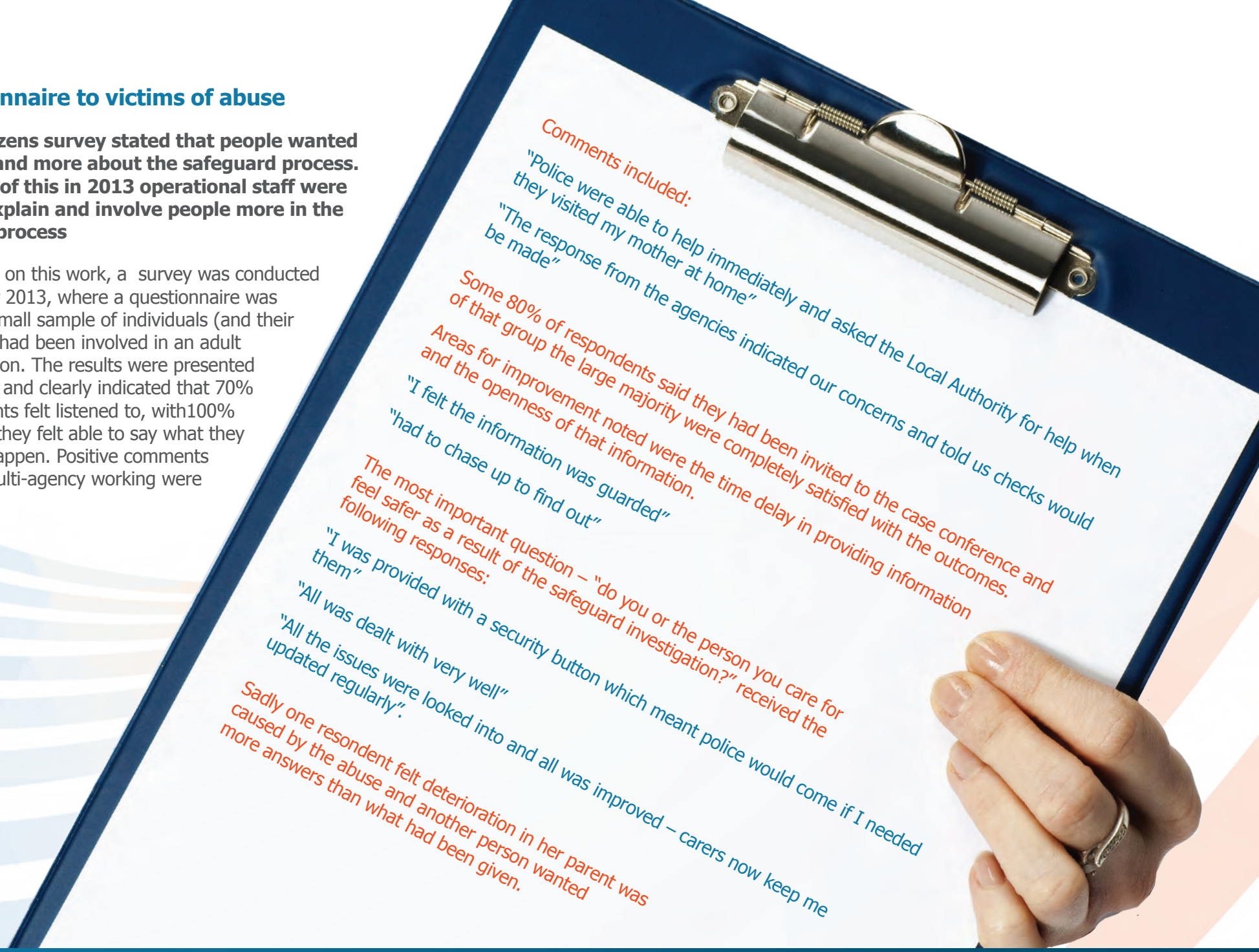
Three Practice Learning Events were held in 2013. These events explored case studies where a frail and vulnerable individual experienced coercion and fear from their son, where a person was self neglecting and a case where an individual was neglected by a care agency.

These events were attended by a wide range of professionals including social workers, police officers, housing services officers, residential and domiciliary care workers. Discussion focused upon how practice across Dudley borough can improve as a result of lessons learned from these case studies. Over 143 people have now attended such partner agency events. A self neglect proforma for staff to consider when working with people who self neglect was developed from them, as was a commitment to explore and understand the impact of mental capacity issues with safeguarding.

A questionnaire to victims of abuse

A 2012 citizens survey stated that people wanted to understand more about the safeguard process. As a result of this in 2013 operational staff were asked to explain and involve people more in the safeguard process

Following up on this work, a survey was conducted in December 2013, where a questionnaire was given to a small sample of individuals (and their carers) who had been involved in an adult abuse situation. The results were presented to the board and clearly indicated that 70% of respondents felt listened to, with100% stating that they felt able to say what they wanted to happen. Positive comments regarding multi-agency working were also noted.



Learning from Winterbourne

The Board worked throughout the year to improve Dudley's partner agency practice to ensure victims of abuse were heard and responded to appropriately.

- Reviews were carried out of all learning disability placements out of borough - involving carers to ensure appropriate care plans are in place.
- External providers were used to represent the voice of the person using services
- A report from advocacy services was received by the board on the issues it sees in safeguard cases and how we can learn from them.
- A Learning Disability Specialist Nurse was appointed at Russell's Hall Hospital and a three year Learning Disability Strategy initiated
- Restraint policies were reviewed and a task and finish group established to promote good practice across agencies.
- The boards understanding of the Deprivation of Liberty Safeguards was raised and board members attended a meeting hosted by West Midlands Care Association to promote this.
- The board considered a report from Department of Health as a study about the premature death of people with a learning disability to recommend that decision around DNR and Palliative Care need to be supported by the Mental Capacity Act. The CCG and Dudley Group of Hospitals addressed this with the revision of their processes in this area as outlined previously.
- Repeat referrals - an exercise was carried out in January 2014 to look at the individuals who had repeat referrals over a period of time and assess whether this was cumulative and an indicator of wider concerns.
- The complaints service was linked to the CQC liaison meeting to look at the overlap with safeguard concerns and complaints following Winterbourne and new routine.

Challenges for 2014/15

In 2013 the board started to learn regularly from Serious Case reviews and safeguard case studies. The Care Act instructs the board to consolidate this learning. In 2014 the board plans to prepare for this by establishing a Safeguard Adult Review Panel (SAR) as a sub group of the board. This group will consider cases for a SAR within the borough and will continue to identify learning for board members from regional and national SARs.

To ensure that victims are heard more routinely concerning their experiences of abuse, Dudley borough has agreed to take part in a national pilot to promote this in 2014.The challenge is to encourage board members to develop systems within their own agencies where the voice of the victim is sought and lessons learnt and shared within the organisation and in case studies presented to the board.

The NHS Foundation Trust is to review its Learning Disability Strategy to ensure Best Interests Decisions and DNAR policies are applied consistently within the hospital to ensure the voice of the person with a learning disability is heard effectively within the hospital setting.

The coming year should also see the Task and Finish Group completing, to provide parties with a good practice document concerning the use of restraint; which will enable Dudley's wider workforce to continue to learn from the recommendations of Winterbourne.

Partners will also continue to link the complaints of people who use services with safeguard concerns to ensure themes are identified at an early stage.

Another challenge for the next year is to engage more effectively with Dudley borough councillors who play a vital role in supporting the citizens of the borough, to promote the safeguard agenda.

These challenges will be incorporated within the 2014/15 Business Plan- see Appendix A

3. True partnership working

What did we say we would do?

Business plan priority 3
Promote the adult safeguard agenda through partnership working.

What did we do?

Throughout the year there have been several effective partnerships to promote the wider safeguard agenda.

Examples of partnership working

- Children's Services organised several workshops in November 2013 to inform all partners about safe recruitment practices and new government procedures.
- Community Safety organised multi agency meetings to promote joint working on domestic abuse. They also ensured joint working between cmmsiioiners on substance misue.
- Community Safety and Housing Services organised a number of events to raise awareness of loan sharks – over 240 delegates attended these events.
- Community Safety also led on the 'Prevent' agenda – to prevent and identify violent extremism. Workshops were organised by adult social care to promote the issues this raises nationally and locally. West Midlands Police delivered this training to partners.
- Housing Services extended its network to include housing associations to widen the safeguard partnership and increase awareness.

Colleagues also work with partners at MARAC and MAPPA need names...) and with children's services to collaborate in supporting troubled families and young people vulnerable to homelessness. This work has been identified as an area of good practice on the Social Care Institute for Excellence website, recognsisng the wide range of training regarding safeguard which has been develoed.

- Black Country Housing Group is the voluntary agency representative on the board. As a commitment to the partnership and recognition of the valuable role voluntary agencies play in safeguarding they developed their own safeguard Ppanel in 2013, along with 'toolbox talks' to equip staff and residents with a knowledge of safeguarding. They have also strengthened their own recording systems and liaised with health, mental health and adult social care partners with regard to six safeguard concerns, keeping their own records to identify trends within the organisation. This commitment to improve safeguard practice is something the board has encouraged its members to develop throughout the year.
- Probation Services and Mental Health services have established a mental health referral pathway and developed protocols to ensure both victims and those that pose a risk to vulnerable adults are dealt with effectively. Probation Services also provide professional support at MARAC and MAPPA meetings to protect vulnerable people from those subject to high risk in domestic abuse situations. Their internal and external audits in 2013 demonstrated an effective approach to managing an offenders risk towards vulnerable adults

Other Partnership Initiatives

Our communication strategy - a partnership commitment

The board agreed to develop a communication strategy which would work to increase the profile of safeguarding and the role of the board, to highlight the fact that it is the responsility of all and to promote the reprorting mechanisms. Key questions that they agreed they wanted a communications campaign to address included:

- 'What does the safeguard board do?'
- 'How is it run?'
- 'How do we refer safeguard concerns?'

The Independent Chair, Roger Clayton, indicated to the board that he wanted a campaign to address these issues within six months of his taking up the chair's role.

A communications strategy and campaign to implement the actions was developed in conjunction with the council communications team. This included the development of a new safeguarding brand identity, media work, web development and public information.

Local press covered the issue with a number of pieces being run which explained the issue of safeguarding and introduced the board and chair to borough residents. A case study was also run in the press which covered the issue of financial abuse and work with trading standards.

A new safeguarding website was developed and launched. This is a joint childrens and adults website and was launched in April 2014, following a three month consultaion with children, adults and partner agencies. Pratners provided consultation opportunites to devlelop this and valuable feedback was received. The website was well promoted and has recieved positive feedback, helping to promote the issue of safeguarding and communicate key messages to the public.

Promotion of the safeguard agenda through training

The adult social care training and development team has historically taken the lead with adult safeguarding training.

There is a training subgroup, chaired by a council team manager from the support and learning team, and including representatives from Dudley and Walsall Mental Health Trust, Dudley Group of hospitals, Dudley CCG and the voluntary sector. They established a preventative training strategy and an E- Learning programme during 2013. The group consultant with the council's Adult Care team who continued to organise and deliver a significant amount of the safeguard training for 2013 with excellent co-operation from partners within the borough.

A decision was taken in 2013, to promote an annual programme of training courses, including childrens safeguarding which was then placed on the new safeguarding website

The programme aimed to continue to raise safeguard awareness but the emphasis of courses changed to encourage partners to think about the prevention of abuse.

For example, a 'Managing Safe Services' course was launched in 2013. This course involves learners producing a safeguard prevention plan for use in the services they managed.

"Who's after your money" - a course delivered by adult social care and trading standards has remained a popular course. This advises people protecting vulnerable adults to avoid involvement with rogue traders and encourages them to report anyone in the community who appears to be targeting vulnerable people with offers of work to their homes.

An e-learning generic safeguard package was launched in September 2013 both on the internet and the council's intranet sites. By the end of March 2014, 340 local authority staff and 104 partner agency staff had completed on-line training.

In addition, bespoke abuse awareness training was provided by the council's adult care team to a number of organisations including user groups at Queens Cross Network, members of Dudley's Tenants and Residents Associations, elected members and Healthwatch volunteers.

Figures produced in March 2014 showed that 92% of the council's adult social care staff had completed adult safeguard training at awareness level.

West Midlands Police supported us by delivering specialist courses on the Prevent Agenda (to promote awareness of extremism) and forced marriage awareness.

Board members themselves also received a bespoke course on safeguard legislation, together with managers from several of the partnerships, which helped highlight understanding of the range of legal powers partners have to prevent and deal with abusive situations.

A breakdown of training courses attended for the period 2013/14 can be seen below:

Course title	Number of courses	Total number of delegates	Council delegates	Health delegates	Other delegates	Total number of delegates since 2006
Full day abuse awareness	6	54	30		24	7196
Abuse awareness briefings	17	141	76		65	1030
Responding to and preventing abuse	1	9	1		8	9
Practice issues	10	143	44	49	50	1288
Managing safer services	4	20	3		17	20
Who's after your money	16	210	109		101	681
Practice learning events	2	60	37	6	17	148
Prevent	7	104	66	19	19	104
Forced marriage	3	53	50	3		53
TOTAL	**66**	**794**	**416**	**77**	**301**	**10529**

Commissioned bespoke training

Course title	Number of courses	Total number of delegates	Council delegates	Health delegates	Other delegates
Interface with the MCA	6	54	30		24
MCA & DoLS for managing authorities	17	141	76		65
Investigative skills	1	9	1		8
Legislation	10	143	44	49	50
TOTAL	**66**	**794**	**416**	**77**	**301**

Promotion of safeguarding through Partner Agency Scrutiny

In 2013 the board demonstrated its commitment to safeguarding through its willingness to ask partners to be accountable for their safeguard practice, as identified in the request for reports to the board - mentioned earlier.

During early 2014, however, a specific issue arose where board members were asked to look in depth at a safeguarding situation, to assure itself that a partner was following the correct proceedures and that safe practice was in place within the organisation. In January 2014 Dudely Group of Hospitals was facing allegations of unlawful restraint of patients at Russells Hall Hospital. A piece appeared in the Sunday Telegraph reporting this and the CQC received an anonymous referral regarding an unlawful restraint in December 2013.

The safeguard board proposed that a panel be convened to examine policy and practice in respect of these issues. The panel was established and comprised of board members from children and adults, council services, West Midlands Police, Healthwatch, Age UK, lay representation along with Dudley Group of Hospitals themselves. This group met on four separate occasions between February and May 2014.

The Chief Executive Officer of Dudley Group NHS Foundations Trust authorised an independent review to clarify the facts of these allegations and the Trust's position against national safeguard standards.The police also reviewed the paperwork on the alleged restraint issues to determine if crimes had been committed.

The council's adult social care team conducted two separate safeguard processes in conjunction with the police investigating the two restraint issues. The CQC conducted a two day inspection at Russells Hall with a particular focus on the issue of unlawful restraint.

In addition, the Clinical Commissioning Group conducted a review of incident recording at Russells Hall Hospital.

Alongside these issues Dudley Group NHS Foundation Trust was advised to report on concerns raised at a Children Act Section 11 Audit and the Safeguard Peer challenge, which raised concerns about:

Evidence of hearing the voice of the child
Safer recruitment practices
Attendance at child protection case conferences
Attendance at safeguarding board meetings
Quality of hospital discharge
Care of people with challenging behaviour
Do not resuscitate (DNAR) policy

It needs to be highlighted however that areas for consideration recommended by the review panel were not limited to this agency.

The Foundation Trust was asked to provide information to the agencies looking at these concerns and throughout the process there was openness and transparency in the information provided.

The Trust provided an action plan on the changes to policy and protocol to clearly address these issues and the partnership commitments required to ensure people with challenging behaviour and those requiring support to move safely out of hospital was recognised as a multiple agency responsibility.

The process for conducting this review carried on into 2014 but at the point of writing this report there has been no evidence of unlawful restraint found in the hospital. However there have been learning opportunities identified in respect of training for both medical and security staff and policies and procedures have been strengthened to address these learning points. The breadth of the investigation, the number of agencies involved in the process together with the safeguard investigations has identified key issues regarding communication, training and information sharing with relatives of patient's Dudley Group Foundation Trust has acknowledged these issues and instigated action plans to promote the learning from these investigations.

A report to councillors within the borough will be presented to both children and adults safeguarding boards regarding the conclusion later in 2014.

Promotion of the safeguard agenda through sub-groups

The board had three sub-groups which operated in 2013. One of these groups was Policy Implementation. Members of the group included staff from Dudley and Walsall Mental Health Trust, Dudley Clinical Commissioning Group, and the council's trading standards, adult social care, housing services and training teams.

This group met throughout the year and contributed to the promotion of the safeguard agenda by responding on behalf of the board, to various documents of a local and a national significance.

These included:

- Safeguard information in Dudley Service Level Agreements with commissioned services
- A survey on self neglect conducted by the Department of Health
- A response to a consultation on safeguard powers within the Care Act led by Action on Elder Abuse
- A response to priority considerations for a NICE consultation on standards of care
- Plans to instigate support within Dudley Borough to follow up people who have experienced scams, (mass marketing scams cause £3.5 billion worth of detriment to UK consumers) which are often targeted at vulnerable or disadvantaged consumers.
- A response to West Midlands protocol on large scale investigations now adopted by the board.
- A response to the Department of Health request for information upon implementation of the Mental Health Capacity Act.

This sub-group has enabled the adult safeguard board to be outward looking in its promotion of safeguarding and ensures that we are making a solid contribution to the national safeguard arena.

Challenges for 2014/15

Although the peer review and the partnership activities indicate increasingly strong partnerships there still remain challenges for the partnership in 2014/15. These include:

- Partners to consistently improve their recording of safeguard alerts within their own organisation.
- Promotion of online safeguard training to new staff within organisations and as refresher courses.
- To review the safeguard website, including assessing its effectiveness and seeking improvements.
- Raise awareness of mental capacity issues in safeguarding so that agencies understand the complexity of safeguard concerns.
- Continue to promote the Prevention Strategy through training courses and practice learning events

4. Improved working practices

What did we say we would do?

Business plan priority 4

The board must assure itself of the safeguarding practice in place within agencies across Dudley borough.

What did we do?

In January 2014 Dudley took part in a Safeguarding Peer Challenge with Stoke City Council as part of the West Midlands approach to sector led improvement.

The principles of this review were improvement, not inspection. The Director from Stoke City Council came together with two Assistant Directors, a councillor, a carer and an 'Expert by Experience'. This group spoke to operational staff across Dudley involved in delivering services, met with carers and people who use services, together with a meeting with board members and Chief Officers from the partnership.

The peer review

The team from Stoke City Council was asked to respond to five main questions. The reponses to these are detailed below:

1. How do we know people are safe in Dudley?

   The review commented that our prevention, training, engagement of clients and surveys combined with robust systems, processes and partnership arrangements provides good assurance that residents are safe.

2. Are safeguarding partnerships robust?

   Stoke felt they were robust but there was room for improvement with both the strategic and operational involvement of the Acute Trust.

   It was also felt that the regional hub had lessened its involvement and relationships in the safeguard arena.

3. How good is the customer experience in Dudley?

   People said they felt safe, knew where to go for help and had the right intervention. People who use the services however said that in safeguarding they felt "more 'talked at' than listened to".

4. How good is the public/ political awareness of safeguarding in Dudley?

   It was felt that there was good awareness with multi-agency partners and also with corporate partners. The Stoke review felt however, that political understanding and engagement needed to be broadened.

5. Is Dudley anticipating future pressures around safeguarding?

   The Stoke review felt there is good performance monitoring data and strong work on safeguarding prevention which will support the management of demand.

   The implications of welfare reform and budget savings will need to be further addressed.

The review led to the development of an action plan which will form an integral part of the Safeguard Business Plan 2014/15.

Quality and Performance sub- group of the board.

The safeguard board has a multi-agency sub-group for quality and performance. In 2013 this group focused on improving safeguard practice by developing a referral/alert form for all parties to use online. This was agreed to improve the quality of referral/alert detail to enable adult social care staff and managers to make a decision as to whether the issue met the threshold for services. The group looked at examples of alert forms across the region, what information was required by the government together with what was felt to be accessible.

This alert form was established and three months later reviewed and adaptations made to improve its accessibility for partners. This form is now available on the safeguard website for members of the public to use. They can still alternatively however choose to call the access team.

Safeguard Audit

In March 2013 a random audit of twenty safeguard cases was undertaken by the Head of Safeguarding Service, together with operational managers within the council's adult care teams.

The audit was completed for the period January to March 2013. The outcomes of the audit indicated that vulnerability could be better established at the initial stages, but that the issues were generally followed up promptly.

Conseqeuently in September 2013 a more streamlined process was introduced which saw over 70% of meetings and discussions being held within five days.

The peer auditors felt the ranges of multi-disciplinary decisions were evidenced and the outcomes and future work planned were clear and well recorded.

Risk assessments were evidenced in more cases than in the previous year's audit but consideration of the requirements under the Mental Capacity act still needed consolidation - hence the concentration on this in the preventative training Plan.

The data set for safeguarding is presented to the board every six months. One of the improvements to the data throughout the year, due to Winterbourne recommendations, demonstrated a reduction in the number of repeat referrals. Another improvement was that safeguard managers received monthly information on the number of alerts received from commissioned services and scrutiny of this data was made in regular management meetings in adult care and in the joint liaison meetings with the CQC. A breakdown of safeguarding incidents is provided in the next section.

Challenges for 2014/15

The peer review has resulted in a number of challenges which face the board for the year ahead. These include:

- Threshold training to be organised to ensure thresholds are applied consistently across the workforce.
- Multi-agency audits are to be used to review safeguard practice.
- Agencies are to develop systems to keep records of safeguard issues and outcomes within their own organisation.
- Partners are to remain aware of implications of Winterbourne and how information collated on repeat referrals, links with complaints services and CQC to promote safer practice.

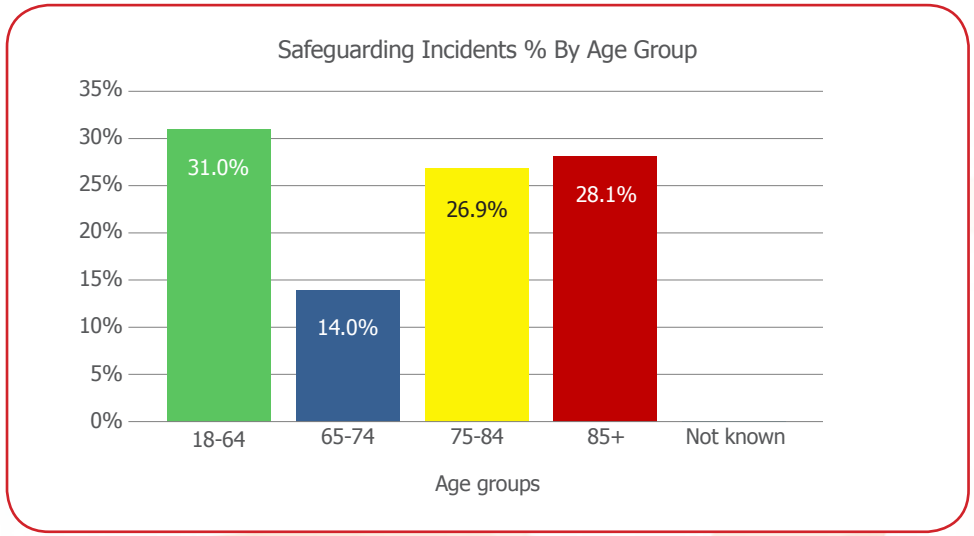
In 2014/15 the duty of The Care Act for agencies to make enquiries about safeguard concerns will necessitate robust recording systems across partnerships. The Assurance Framework document planned for 2014/15 will provide the tools for organisations to collate this information ensuring robust systems exist across the partnerships.

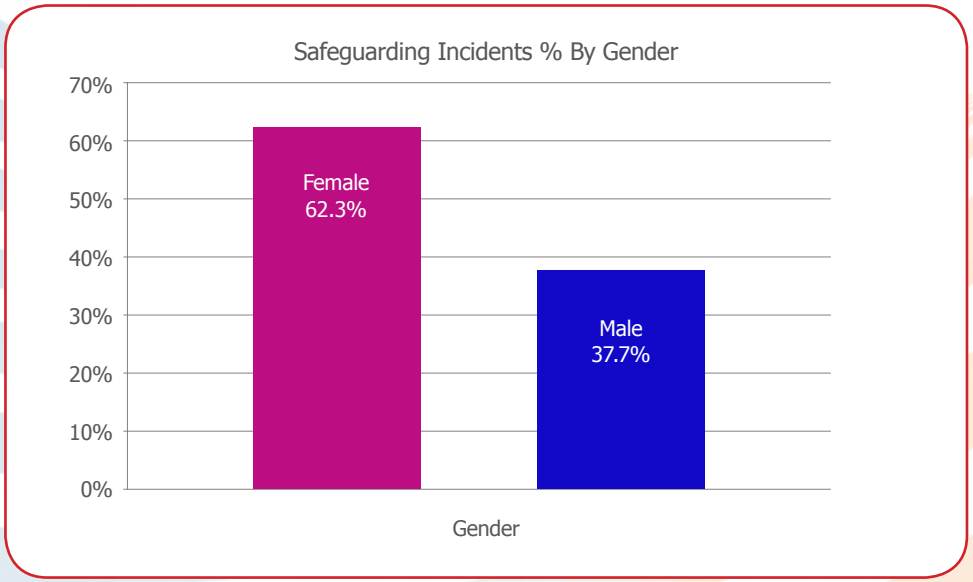
Incidence 2013/14

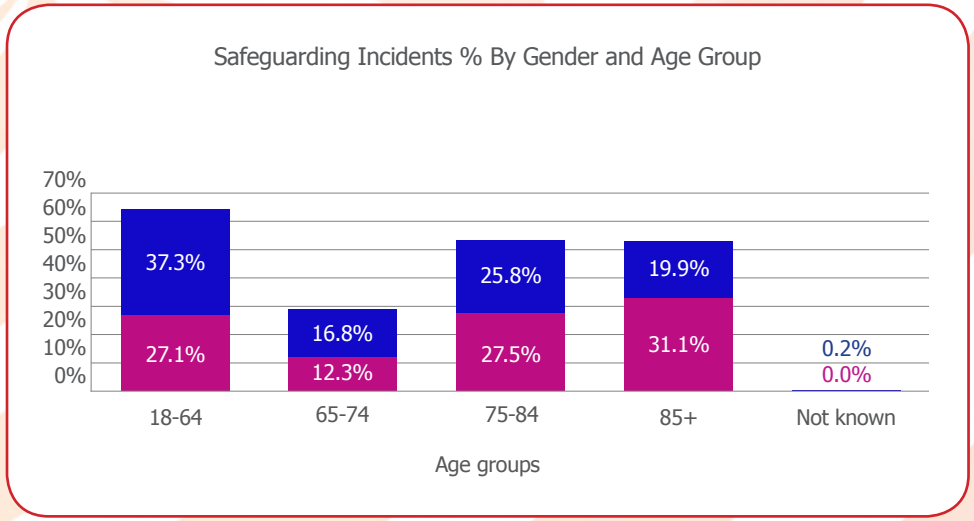
A breakdown of significant incidents

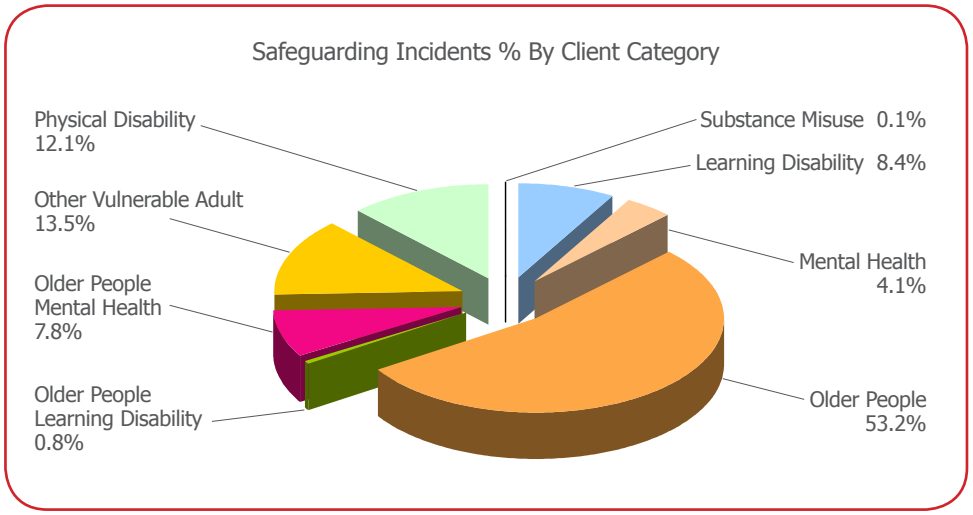
Provided below is an analysis of reported safeguarding incidents during the 2013/14 period concerned.

- The number of adult safeguarding incidents reported between 1st April 2013 and 31st March 2014 was 1266.
- Overall, the majority of these were for females (62%), with the majority of females being in the 85 plus age group - representing 33% of all female incidents.
- Overall, the majority of incidents recorded were in the 18-64 age group - representing some 31%. As were the incidents reported for males - 37%.

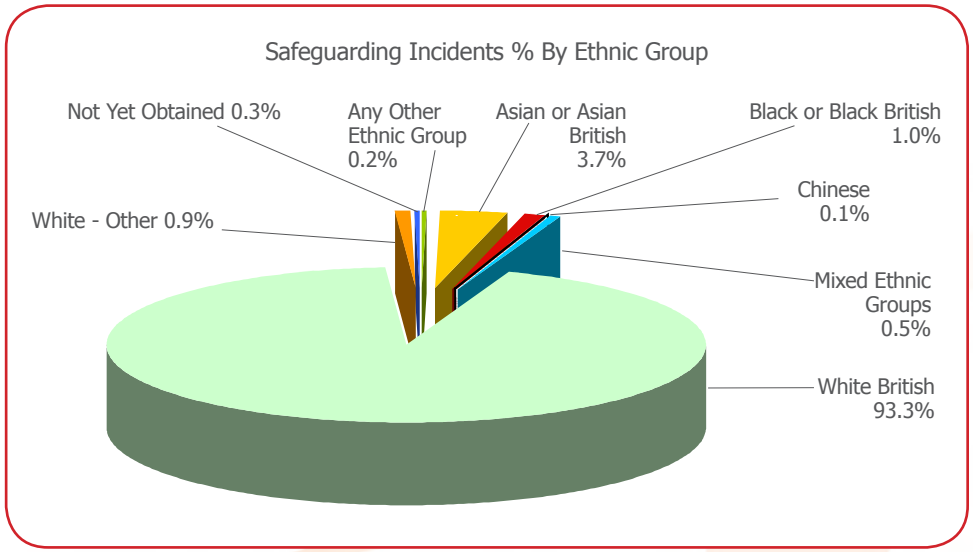




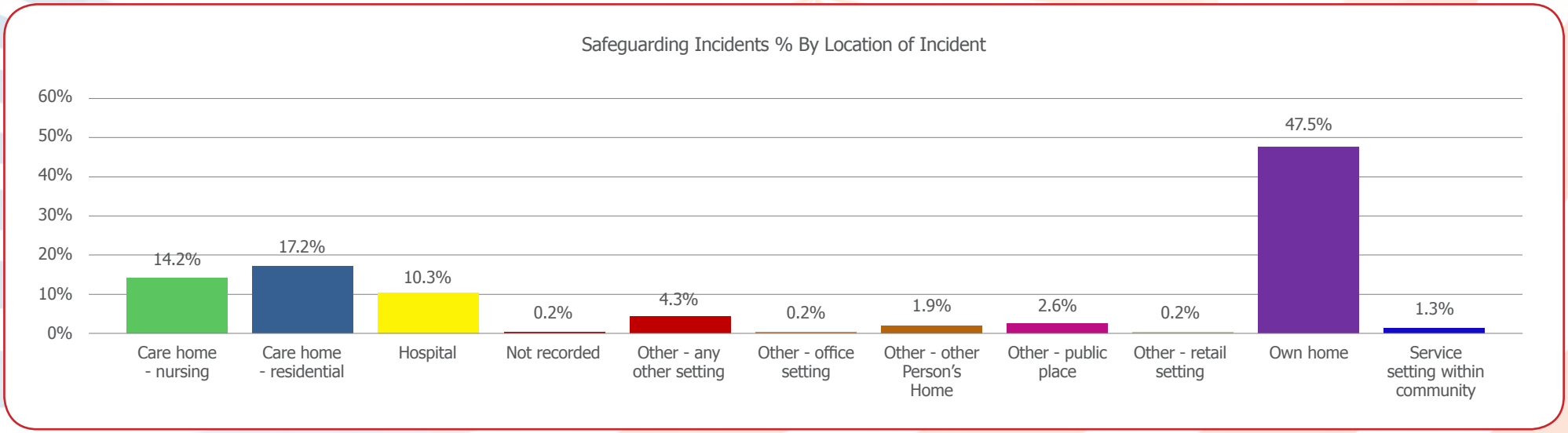




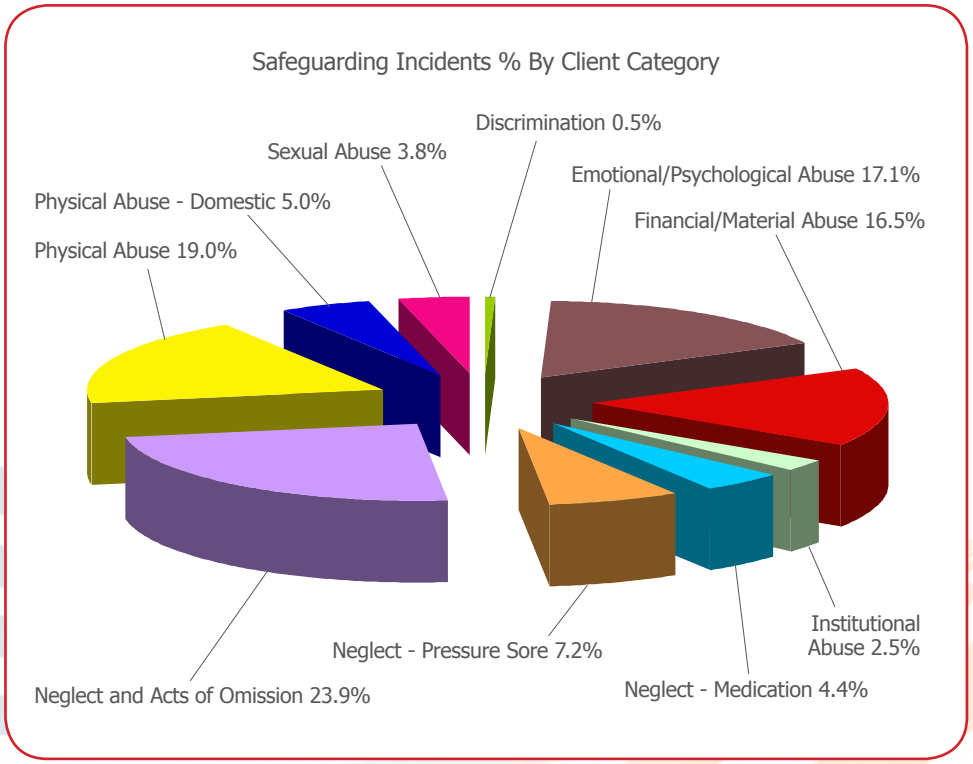
The majority of incidents were recorded for people in the White British ethnic origin group at 93%



The majority of incidents were recorded as taking place within the victims own home (47.5%). Of these 602 incidents taking place in their own home 63.5% were for females.

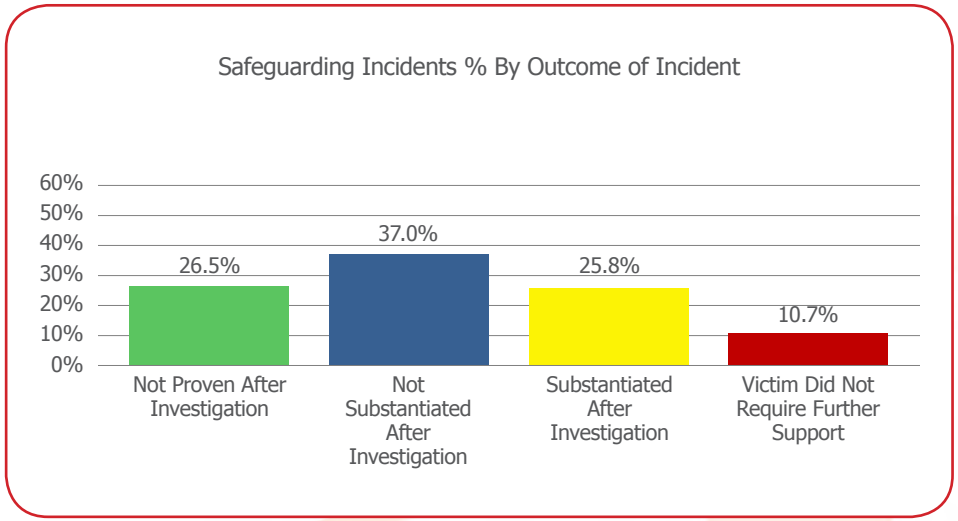


The abuse category of Neglect and Acts of Omission was recorded as the highest proportion of all incidents at 24%, however, if all neglect categories are combined this figure increases to 35.5% and clearly forms the majority of abuse categories overall



The number of completed incidents during the same time period, i.e. where all investigations have been completed and an outcome agreed, was 1102

The majority of incidents investigated resulted in the abuse not being substantiated at 37% with 26% being substantiated.



The Director of adult social care and the Assistant Director and the Chief Executive of the council met regularly throughout the year with the Chair of the Board and the Head of Safeguarding to gain assurances of the practice of the board partners; to review data information; to look at situations of specific concern and projects planned to promote the safeguard agenda across the borough.

Deprivation of liberties

Deprivation of liberties standards

The Head of Safeguarding has responsibility for managing the Deprivation of Liberty process within the borough in partnership with Dudley and Walsall Mental Health Trust who provide the administration of the process. These safeguards provide legal protection for those vulnerable people who are, or may become deprived, of their liberty in a care home or hospital, whether placed there under public or private arrangements.

From 2009 to 2013 the responsibility for overseeing the Deprivation of Liberty Safeguards lay with the Primary Care Trust and the council. From April 2013 local authorities were given the sole responsibility to make assessments of Deprivation of Liberty Safeguards (DoLS) in hospital and care settings. The council became the sole Supervisory Body with governance arrangements established with Dudley CCG to provide clinical advice and guidance and to monitor the number of DoLS in hospital settings.

Numbers of Dols in comparison to other local authorities April 13 - March 14

Local Authority	Care home	Hospital
Dudley	97	49
Sandwell	49	30
Walsall	23	21
Wolverhampton	63	12
Worcestershire	89	25

This demonstrates the recognition of the importance of these safeguards within the borough and the role that social workers and WMCA have played in encouraging commissioned service to consider this safeguard for their residents.

Every DoLs assessment requires a specifically trained doctor to undertake a mental capacity and mental health assessment together with a Best Interest Assessor. There are currently five employed by the council and two by external agencies.

The important role advocacy plays in this process has also been strengthened in 2013 by ensuring the advocate (IMCA ???) meets regularly to discuss processes and cases with the Best Interest Assessors.

On 19 March 2014 the Supreme Court published a judgment on two specific Deprivation of Liberty cases which revised the test of deprivation of liberty into the so-called "acid test" by the Supreme Court - the person is under continuous supervision and control and is not free to leave.

Challenges for 2014/15

This Supreme Court Judgement has had a huge impact on the level of Deprivation of Liberty referrals as care homes and hospitals will now need to apply different thresholds to decide on whether they are depriving a person of their liberty. An action plan has been developed for 2014/15 to address this together with increased levels of administration and Best Interest resources agreed.

Business Plan 2014 – 2015- Appendix A

Prepared by:

Anne Harris

Head of Adult Safeguarding

On behalf of Dudley Safeguard Adult Board

PRIORITY ONE - Empowerment						
	What are we going to do	**Lead person**	**By when**	**How are we going to do it**	**What will the outcomes be**	**Progress**
1.	Victims of abuse or their carers to provide information on the outcomes they want from safeguarding and feedback on their experiences	A Harris Head of Safeguarding	March 15	Put systems in place to routinely check peoples experience	Outcomes will analyse customer satisfaction and improvements required.	
2.	The promotion of the role of Advocates as outlined in the Care Act to provide people with support throughout the safeguard process	Advocacy Services	Jan 15	Collate number of referrals to advocacy services Raise Board members awareness of Advocacy services and its use within their agencies	Issues arising from use of Advocacy Services analysed to inform practice	
3.	To ensure vulnerable adults are clear about what is abuse and how to report it	Board Members	Dec 14	Promotional events to raise awareness of abuse and how to report it Analyse use of safeguard website Monitor number of alerts raised on the website	To develop information for wider groups of vulnerable adults To analyse effectiveness of website and develop its usage	

PRIORITY TWO - Protection						
	What are we going to do	**Lead person**	**By when**	**How are we going to do it**	**What will the outcomes be**	**Progress**
1.	Demonstrate that Mental Capacity, Best Interest and the Deprivation of Liberty is central to the safeguard process	A Harris Head of Safeguarding	Dec 14	To ensure systems in place to record MCA & DOLS assessments within agencies	MCA principles demonstrated in safeguard practice	
2.	Ensure agencies are applying the safeguard procedures within their workface	Quality & Performance sub-group	March 15	Multi-agency audits to review specific cases	To assure Board members that proceses are robust and where improvements should be focused	
3.	To identify repeat safeguard concerns, emerging themes from safeguard issues in line with Winterbourne recommendations	Quality & Performance sub-group	Dec 14	Regular liaison meetings with agencies and CQC to identify concerns Collate information about repeat referrals and emerging themes	Safeguard meetings held to protect people where there are repeat referrals/ emerging themes	

PRIORITY three - Prevention						
	What are we going to do	**Lead person**	**By when**	**How are we going to do it**	**What will the outcomes be**	**Progress**
1.	Promote broader uptake of safeguard training to raise awareness of how abuse can be prevented	Training sub-group	March 15	Increase use of E-Learning Target personal assistants and voluntary sector for training	Numbers of people trained will increase to prevent abuse occurring	
2.	Promote safe recruitment in workforce group and procedures that deal with people in Positions of Trust	Safer recruitment sub-group	Nov 14	Information to board members re safe recruitment provided Develop regional protocol for people in Positions of Trust	Consistent approach in recruitment and dealing with workforce issues to prevent unsuitable people working with adults at risk	
3.	Learn lessons from case studies and National Serious Case Reviews	Safeguard Adult Review panel	Jan 15	Use multi agency practice learning events to learn from SCRs Consolidate sub-group to look at Safeguard Adult Reviews as a requirement of the Care Act. Examine case studies in Board meetings	Dudley partners apply lessons learnt nationally to their work with adults at risk	

PRIORITY four - Proportionality						
	What are we going to do	**Lead person**	**By when**	**How are we going to do it**	**What will the outcomes be**	**Progress**
1.	Individuals will be confident that professionals will work for their best interests and will only get involved as much as is needed	Operational safeguard managers	March 15	Provide threshold training for operational staff and decision makers to ensure a consistent response for dealing with safeguard alerts.	Each safeguard matter will be dealt with consistently	
2.	As recommended in the Care Act partners will contribute personnel and information to assist a safeguard investigation to be conducted in a timely, proportionate way	Operational safeguard managers	Nov 14	Personnel from relevant agencies to agree a strategy for investigating abuse in a timely manner Feedback from victims and their carers to inform this practice	People at risk or experiencing abuse will be dealt with in a timely manner - data collated to record this	
3.	In line with Winterbourne recommendations ensure that local services identify and record methods of restraint used to protect adults at risk	Multi Agency Task and Finish group Board Members	Jan 15	Establish good practice guidelines for use by local services following national recommendations	Restraint recorded correctly in services following national guidelines Monitored by CQC & Commissioning	

PRIORITY five - Partnership						
	What are we going to do	**Lead person**	**By when**	**How are we going to do it**	**What will the outcomes be**	**Progress**
1.	To meet the statutory requirements outlined in the Care Act the Board will consolidate its constitution, memorandum of understanding and information sharing protocol with its partners	Independent Chair of the Board	Oct 15	Board members asked to sign agreements about their role and commitment to the work of Board	The partnerships that exist will be strengthened and placed on a statutory basis	
2.	In line with the Care Act recommendations Board members will ensure that the wider partnership with Children Services, Community Safety, Health & Wellbeing boards, Health Watch and Councillors remains priority for its members	All Board members	Mar 15	Board members take responsibility to ensure that information is shared with other Boards they work with and that developments address the aims of the wider agenda.	In a time of limited resources opportunities for training and for planning services to protect adults at risk will be shared.	
3.	In line with Care Act agencies to consider their financial contribution to support the work of the Board in its training, promotion and preventative work	All Board members	Mar 15	Board members to consider their financial contribution to the Board from within their own resources	The work of the Board can continue to prompt the welfare of adults at risk of or experiencing abuse	

PRIORITY six - Accountability						
	What are we going to do	**Lead person**	**By when**	**How are we going to do it**	**What will the outcomes be**	**Progress**
1.	The Board to have assurance that agencies within Dudley recognise their collective responsibility for safeguard arrangements as indicated in the Care Acts	Independent Chair of the Board	Oct 15	Board members to complete a Quality Assurance document to evidence their accountability	The Board will gain assurance about its agencies safeguard practice	
2.	Performance Data will be looked at to ensure that individuals subject to abuse receive timely support from agencies	Quality & Performance sub-group of the Board	Mar 15	The Sub-Group to look at data from Board agencies to analyse trends and report and act on issues raised	Areas of concern will be highlighted to inform targeted support to individuals at risk	
3.	Training within Board agencies meets the levels of specialism and competence required to address safeguard concerns	Anne Harris Training sub-group	Mar 15	Board members to ensure that national competences outline for safeguard training are established and reported through assurance document	Board to gain assurance that the staff within their organisation are trained to address safeguard issues to their appropriate level	