Dudley Safeguarding

protecting children, young people and adults at risk

Dudley Safeguarding Adults Board **Annual Report** 2014/15

Executive Summary










Executive Summary

Each year the Dudley Safeguarding Adults Board publishes an Annual Report which reports and reflects upon the board's activities over the past year. This is the executive summary of the Annual Report for 2014/15

Dudley Safeguarding Adults Board works to protect adults aged eighteen and over from neglect, harm or abuse. The board is made up of representatives from Dudley Council's adult social care team, West Midlands Police, Dudley Clinical Commissioning Group (CCG), Dudley Acute Hospital Trust, Dudley Fire Service, Healthwatch Dudley, Dudley & Walsall Mental Health Trust, as well as voluntary sector organisations.

These partners work together in a joined up way to ensure that they are protecting adults from across Dudley borough, as effectively as possible.

Dudley Council is the lead agency on the board and is responsible for investigating and decision making in all safeguarding cases, where there are concerns about any abuse, neglect or harm of adults. It is a complex and sensitive area of work, requiring close partnership working to ensure that no one slips through the net and that all people are protected from harm - particularly vulnerable adults.

The board ensures that all agencies work together to protect adults from abuse and indeed from the risk of abuse. It monitors the number of safeguarding referrals and information about the safeguarding assessments.

The board also provides information to organisations and agencies on national safeguarding situations and experiences - to improve local practice. As well as working to promote awareness of adult safeguarding and abuse, to prevent it from happening and to ensure that people know how to report issues or concerns.

The Care Act 2015

Over the year 2014/15 an important piece of new legislation was about to be introduced which has made safeguarding a far more visible and high profile issue. The Care Act 2014 was introduced by the government in April 2015 and much work went on in the year prior to this by the Dudley Safeguarding Adults Board to ensure that the board and its partners were fully Care Act compliant.

The Care Act provides clarity on the responsibilities of a Safeguarding Board, as well as making it a statutory requirement. It also defines exactly who the duty to safeguard applies to. This is defined in the Act as an adult who:

- Has needs for care and support (irrespective of whether the council is meeting these needs) and,
- Is experiencing, or is at risk of abuse or neglect and,
- As a result of their care and support needs is not able to protect themselves from either the risk of, or the experience of abuse or neglect.

Abuse as defined in The Care Act can include:

- Physical abuse
- Emotional/psychological abuse
- Domestic violence
- Sexual abuse
- Financial abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self neglect

The Safeguard 'threshold'

- In 2014 a new pathway for safeguard referrals was introduced which incorporated a 'safeguard threshold'. This means that there is now a formal agreed criteria for whether or not a reported issue or concern needs to be investigated any further. This decision is made by a senior social worker. If an issue does meet the new threshold then it follows a new 'pathway' which fully involves the victim and/or their carer - if they have one.
- The council's adult social care team also during 2014, developed a team specifically to support people who are 'at risk.' This is in recognition that not everyone meets the safeguard threshold but still requires support to live a life free from abuse and neglect.

Key focuses 2014/15

Throughout the year the board worked hard to implement their 2014/15 business plan which focused around six key principles - empowerment, prevention, proportionality, protection, partnership, accountability. Each of these six areas has been the key areas which have been focused upon.

Empowerment

The board have worked hard to ensure that victims of abuse and carers are providing information on what they want to achieve from their own safeguarding investigations. They are providing information on their own experiences and this is being taken on board. The board signed up to the 'Making Safeguard Personal' project which aims to ensure that views of victims are captured throughout safeguarding episodes.

The role of advocates is also being promoted to make sure that people are being supported throughout the safeguarding process. Advocacy services are now asked to help at a much earlier stage in the safeguard process and are now fully involved in the decision making process.

Work has also gone on to promote the issue of adult safeguarding and to ensure that people are clear as to what abuse is and how to report it. A new safeguarding website was launched in April 2014. This contains lots of information on both adults and children's safeguarding, along with a 'Report it' button. Throughout 2014 1050 alerts were received via the website.

Protection

The board has worked hard to make sure that Mental Capacity, Best interest and the Deprivation of Liberty are central to the safeguarding process.

A Supreme Court Judgement in March 2014 had a big impact on the number of people in hospitals and care homes who may be deprived of their liberty in their best interests and need a 'Deprivation of Liberty' order. The board has held meetings with care homes who have reviewed their care plans of residents to make sure they are using the least restrictive practices and have requested Deprivation of Liberty Safeguard orders for people who they felt met the new criteria.

Mental Capacity Act training has been delivered to two hundred members of staff and an action plan to raise the awareness of 'Best Interest' has been formulated.

The board has been identifying repeat safeguarding concerns and emergency themes from safeguarding issues in line with the Winterbourne View recommendations (Winterbourne View was a private hospital where people with learning disabilities were widely physically and psychologically abused by staff up to 2011. A serious case review took place as a result and was published by the Department of Health which cited many recommendations to avoid any repeats of this type of abuse in any organisation).

Prevention

The focus here through 2014/15 has been on the promotion of safeguard training to a much broader audience, to raise awareness on how abuse can be prevented. Along with these efforts has been work to promote safer recruitment of people in 'positions of trust'. The board has been keen to learn lessons from case studies and nationwide serious case reviews.

A whole range of tailored safeguarding awareness training courses have been provided over the past year to all sorts of groups and organisations across Dudley borough. The board was even asked to provide training to a local building society and to the Diocese of Worcester.

Three multi-agency practice learning events were held in 2014 where serious case reviews were considered and assessed. These were learned from and communicated through each agency.

Proportionality

Threshold training was provided to operational staff to make sure that there is an understanding of what actually constitutes a safeguarding issue. This will mean that people will be confident about reporting a safeguard issue and will eliminate unnecessary reporting.

It was also agreed that all of the board partners will immediately contribute staff and information to assist a safeguarding investigation. This will then be able to be conducted in a timely and proportionate manner.

Methods of restraint have also been identified and recorded to protect adults at risk and shared with local services and organisations. A Department of Health report called 'Positive and safe' was produced in response to the Winterbourne review where the incorrect use of restrictive practices was identified. Research showed that organisations are often unsure about the correct use of restrictive practices, with some services relying too heavily on the use of restraint. Guidelines have been produced for services which were shared with all borough wide organisations.

Partnerships

To meet the now statutory requirements of The Care Act the board consolidated its footing amongst partners.

The board also extended its wider partnership working with children's services, community safety, health and wellbeing services, health workers and councillors.

Board members were also asked over the period to commit additional financial and manpower resources to the board itself. This is to support the increased efforts in training, promotion and prevention work that the board has committed to deliver.

It is recognised that the financial pressures facing Dudley Council will impact considerably on the availability of resources and manpower and the board members have been regularly advised about this throughout the year especially when it has impacted upon the ability to deal with safeguard concerns within the borough.

Accountability

The board has asked for real assurances from all organisations across Dudley borough to recognise their responsibilities for safeguarding - as now laid down in the new Care Act. This has meant sometimes scrutinising incidents which have occurred in partner's settings.

The board also established a serious adult review panel which has begun to collect information and performance data to analyse information relating to specific serious incidents. Learning is shared and lessons are learned to ensure that people subject to abuse receive timely support from organisations.

Further training has been identified to meet competence levels required to properly and fully address safeguard concerns.

Performance Data

A full breakdown of safeguarding incidents can be found in the complete annual report.

- In summary, 1,713 adult safeguarding incidents were reported between 1 April 2014 and 31 March 2015. Of these 726 (42.4%) were carried forward through the safeguarding process as referrals.
- The majority of these were for females (59.8%), the majority being in the 85 plus age group (35.7%).
- The majority of these incidents took place in the victims own home (46.1%).
- The abuse category neglect and acts of omission was recorded as the highest proportion of all incidents at 29.5%. If all neglect categories are combined this increases to 43.7%.
- The number of completed referrals (where all investigations have been completed and an outcome agreed) was 567. The majority of these were either fully or partially substantiated.