Annual Report 2017/18

Contents

Foreword

Thank you for taking the time to read this annual report and your interest in safeguarding adults in Herefordshire.

Herefordshire's Safeguarding Adults Board comprises senior leaders from the range of commissioners and provider agencies who are the health sector, the Police, the Fire Service, the Local Authority Adult Social Care, and Public Health and representatives of the voluntary and community sector and residential care providers.

My role is independent of these organisations and my duty as Chair is to ensure that the Board is given adequate assurance that we are all delivering safe services, and that Board Members hold each other to account for this. This is particularly important to ensure that we keep adults safe in Herefordshire as we are all working together in very challenging times. This year has seen unprecedented pressure on partners in terms of resources and capacity and I would like to thank all partners and those who have been involved in the work of the Board, for their time and effort, which continues to make a positive difference.

The report shows what the Board aimed to achieve on behalf of the residents of Herefordshire during 2017-18. We continue to reflect on how effective the Board is, and hold two development sessions each year in a structured manner to hold ourselves to account for progress and efficiency. The partnership continues to strengthen, however there is still much to do. Whilst this annual report reflects on what we have been able to achieve during this year I would have liked the report to better reflect the richness of contribution made by the broad range of partners, through their provision of information and importantly the lived experience examples. The pressures on organisational time and capacity are acknowledged but these pressures cannot be at the expense of ensuring that safeguarding adults are a key element of all agency activity across the partnership. This will be a personal focus of mine during the forthcoming year.

At the start of each Board meeting, there is a Personal (anonymised) 'Safeguarding Story' shared by a member to ensure that Making Safeguarding Personal is a focus at each Board.

I am personally committed to ensure that adults who unfortunately have to use the safeguarding system to address risks they face, find the experience as uncomplicated and supportive as possible, in effect a good personal experience. We have done much to begin to achieve this, through being clear that all staff who work on the front line delivering services have good training and support to help them. But it is not a consistent position across all agencies and we have more to do in this regard.

We also have more to do to secure the engagement and feedback from adults who have been involved in safeguarding so that we can learn from their experiences. Healthwatch are leading on this work locally and I am determined that we will build on what has been a slow start for this piece of work.

We also need to continue to raise the awareness of adult safeguarding with all of the citizens of Herefordshire, as well as our organisations, particularly if we are to support and promote the ability for people to live as independently as they can and for as long as they choose to do so.

In February 2017 the Board held a conference focusing on Mental Capacity. Delegates heard from a number of key speakers, including a very thought provoking report from a father who shared his and his sons personal experiences. Their circumstances ultimately resulted in a legal challenge to their local council which resulted in new case law in this landmark case.

We have produced a more compact version of the annual report this year and I hope therefore that you find it useful. If you would like more detailed information about the work undertaken by the board this year, may I direct you to our website https://herefordshiresafeguardingboards.org.uk or please contact Herefordshire's Safeguarding Adult Board Business Unit at admin.hscb@herefordshire.gov.uk

Ivan Powell
Chair of Herefordshire's Safeguarding Adults Board

Strategic priorities

Introduction

A review of the priorities agreed for 2016-17 took place in November 2016 and improvement opportunities were identified for the work plans for 2017/18, these align to the existing priorities:

1. Partnership working
2. Prevention and protection
3. Communications and engagement
4. Operational effectiveness

The following table shows what, as a Board, we were hoping to achieve within the year, and the progress that we have made. Further into this document you will read case studies' showing how the work the board oversees has impacted on people's lives.

PRIORITY 1. Partnership working. To develop relationships across agencies that deliver positive changes to safeguarding	
What did we want to achieve?	**What did we achieve?**
All partners have a shared and universal understanding of safeguarding	We have introduced case studies at Board which through debate aid common understanding. Awareness raising sessions are being developed.
Define and understand involvement from voluntary sector	We have been working closely with the Board representative for the voluntary sector (hvoss) and are developing a suite of resources for volunteers as well as attending events.
Active participation from all partners	Consistency of organisational representation continues to be a challenge and we endeavor to make all meetings meaningful to ensure that partners stay fully engaged with the safeguarding agenda. All partners have an opportunity at Board meetings to present a case study describing what safeguarding looks like within their organisation and the challenges that present themselves.
Multi-agency focus	We continue to engage with as many sectors as possible, including attending provider forums.
Sharing the right data	As reported last year, some partner agencies are still unable to provide meaningful data to support the safeguarding agenda, this is a national issue which is being progressed by the Chair. The local authority continues to

	be the main provider of data and analysis with additional intelligence being sought from partners where possible.
Shared understanding of other boards priorities	There continues to be regular dialogue between the chair of the adults' board with chairs from childrens board, the health and wellbeing board, the community safety partnership as well as the director of adults and childrens services, public health and representatives from the Herefordshire CCG and West Mercia Police.

PRIORITY 2. Prevention and protection. To ensure that Herefordshire residents can recognise safeguarding concerns and know what to do	
What did we want to achieve?	**What did we achieve?**
Service user involvement	We are working closely with our partner Healthwatch to engage with service users, this has been a difficult process and we are now planning on working more closely with front line professionals to try and achieve our aims in this area.
Greater focus on prevention	Our Prevention Strategy and accompanying workplan have now been published and are available to view or download from our website. We are working closely with partners and monitor the delivery of the strategy. We have also worked with Herefordshire and Worcestershire Fire and Rescue Service in developing a "Safe and Well Check" for their operatives to use when attending residents homes.

Case Study demonstrating the benefits of a safe and well check

Mrs A rang to self-refer for a visit; she said she was advised to do this however she wasn't sure who the professional who suggested this was. Mrs A gave us the following information:

- 90 (Mr A) and 88 (Mrs A)
- Poor mobility
- Memory issues
- Husband recently left egg frying
- Losing keys
- Neighbour changes the battery of existing alarms
- Home owner

A Safe and Well visit was completed on the 20.03.18 by a fire service technician. During this visit smoke alarms were tested and advice around fire safety was given. Signposting was identified. The Signposting Co-ordinator contacted Mrs A and it was agreed that referrals would be made to Age UK for a benefits check and a referral would be made to the Occupational Therapist for aids as Mr A was having difficulties from sitting to standing. Mrs A was interested in a locking cooker valve as she was concerned about her husband switching on the cooker when she went out, the contact details were given so she could ring the supplier direct to book an appointment.

On the 6th April Mrs A telephoned to say she was trying to contact someone from the memory clinic. During the phone call it was checked if Mrs A had contacted the supplier, she hadn't however and asked the Signposting Co-ordinator to do this on her behalf.

The Signposting Co-ordinator contacted the memory clinic on Mrs A's behalf and asked if the worker could contact her which they did.

Mrs A. has subsequently attended the clinic and is receiving help.

PRIORITY 3. Communications and engagement. To deliver the messages from the board and recognise the voice of those we safeguard	
What did we want to achieve?	**What did we achieve?**
Awareness raising	During the previous year we have engaged with councillors with regard to both their responsibilities to their communities and their councils with regard to safeguarding. We have developed a suite of resources for them to use and are planning a series of awareness raising sessions to be delivered over the next year.
Reach to smaller / community organisations	We will continue to develop the resources available and ensure the awareness raising sessions are suitable for these organisations
Understanding the work of the board	Many of the above achievements raise the understanding of the work of the board. Updates from the Board are an agenda item at every practitioner forum.
A greater awareness of both Mental Capacity Act and Deprivation of Liberty Safeguards	We held a MCA conference this year which was well attended and well received by front line professionals working in Herefordshire. We developed several new resources over the year, suitable for members of the public and professionals. We will ensure that this subject is included in the planned awareness raising sessions.

Case study demonstrating effective use of Deprivation of Liberty Safeguards

Mrs P is a 75 old female with a diagnosis of Dementia, Parkinson's disease and Schizophrenia. Mrs P had lived alone at home following the death of her husband some years previously and was reported to be self-neglecting and not taking her anti-psychotic and other medications. This had led to an increase in psychosis leading to a high risk of harm to herself and violence to others which resulted in her admission to hospital under the Mental Health Act. Upon discharge Mrs P moved to Care Home A.

Within the placement Mrs P appeared to have thrived on the routine and had become mostly independent with many of her activities of daily living including many personal care tasks. She was also taking her prescribed medications. Mrs P was choosing not to engage with other residents within the care home or join in with activities and was consistently stating she would like to go home.

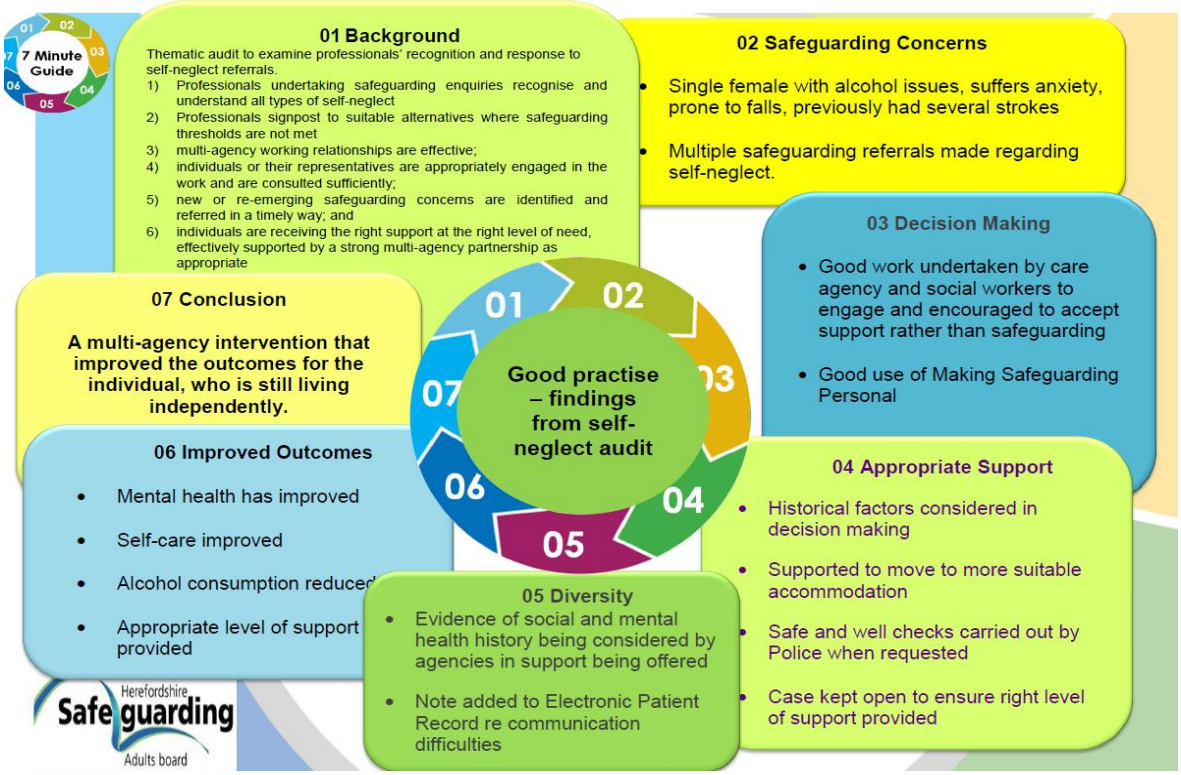
The Best Interest Assessor (BIA) for Deprivation of Liberty Safeguards undertook a mental capacity and best interest assessment following which they recommended a 6 month period of authorisation to enable an urgent re-assessment of Mrs P's needs from Adult Social Care and to support a best interest meeting. The best interest meeting would consider Mrs P's financial resources, her settled presentation and all available options to meet her on-going needs in the least restrictive way. The period was to be used to fully explore the option of her returning home and if this was not possible, if her needs could be better met in a home with others with similar needs and access to activities more in keeping with her past wishes.

The BIA also added a condition that required the care home to review the visual checks Mrs P was having as it was felt this was overly restrictive. A paid Relevant Person's Representative (RPR) was appointed to enable Mrs P to apply to the Court of Protection to appeal the authorisation and the RPR fed into the social care review, relaying Mrs P's wishes. The BIA also recommended that Mrs P be supported to record an Advanced Care Plan at a time when she was most able to contribute and express her feelings and wishes about potential future care scenarios. This was accepted as a condition of the authorisation by the Local Authority when they authorised the Deprivation of Liberty.

Mrs P is still living at the home and is settled there. She has also completed an Advanced Care Plan with the help of her representative and so can be assured that she can live as she wishes in the future.

PRIORITY 4. Operational effectiveness. To ensure safeguarding knowledge, processes, systems and structures are embedded across all agencies.	
What did we want to achieve?	**What did we achieve?**
Challenge single agency issues	Challenges have been made to agencies whose policies and / or practices do not meet current standards, also to agencies that are not fully engaged with the safeguarding agenda.

Ensure learnings from audits and reviews are shared across the partnership	A new learning tool titled "7 minute learning" has been introduced and this is disseminated across partner agencies.
Embed "Making Safeguarding Personal"	There has been a Board action plan following participation in the national "temperature check" and a local review of MSP. We have disseminated the Local Government Association toolkits to partner agencies for them to use. MSP has also been a session of a Board development day. This area continues to be a priority for the Board and more work will continue on embedding this over 18/19.
Embed competency framework	Work on embedding this across the health and social care economy continues. Information has been disseminated across partner agencies, providers and included at practitioner forums
Better tracking of outcomes against priorities	Officers within the Business Unit have taken the lead on ensuring the work of the subgroups delivers the strategic priorities and challenges Chairs where tasks are delayed or would not appear to be relevant.



Example of "7 minute learning" used to raise awareness of findings from audits, serious case reviews and other learnings

Case study demonstrating Making Safeguarding Personal in practise

This is a case relating to a safeguarding referral for Mr G who has a long term health condition that affects him on a daily basis. He lives at home with his wife who is his sole carer. Leading up to and during episodes Mr G's capacity to make decisions and behave rationally is adversely affected.

Mr G when out in the community fell and hit his head causing an injury to his brain. When he was taken to hospital he was in a confused state and was making comments to the staff stating that his wife locked him into their home and that he could not "escape".

Staff at the hospital were concerned by this. Also when the medical team suggested Mr G try new medication his wife was not in agreement. Due to their concerns staff at the hospital raised a safeguarding adults concern with Herefordshire Council's Safeguarding Adults Team. The Safeguarding Adults team appointed a Social Worker to be the enquiring officer. The Social worker spoke with Mr G and explained to him that some concerns had been raised about the care that Mr G was receiving from his wife. Mr G talked to the social worker and used words like "Locked In" and "Escape" when discussing the situation at home with his wife. However when the social worker asked him what he would like to happen when he left hospital, he told her that he wanted to return home to live with his wife, as she was his life and she supported and cared for him.

The social worker then also spoke with Mrs G who explained that she did on occasion lock both her and her husband in the house when he became confused and at risk of wandering and could fall and hurt himself. In addition to this Mrs G explained that she had not agreed to the medication that the hospital was suggesting, as he has had this medication before and it had adversely affected him to the point that it was felt that it was not in his best interests to have this medication. Discussion with Mr G's Neuro psychologist confirmed that they had previously agreed with this decision not to give Mr G this medication.

The social worker concluded that Mrs G did not pose any risk of harm to Mr G and that she was acting in his best interests.

The Social worker involved Mr and Mrs G regarding applying to the Court of protection for an authorisation of any times when Mr G was considered as being deprived of his liberty, in his best interests. It was agreed an application to the Court of Protection would be made so that the deprivation of liberty could be authorised by the Court. They also discussed the possibility of Mrs G applying to the court to become her husband's deputy for health and welfare decisions. The social worker also explained to Mrs G how Adult Social Care might be able to provide her support as a Carer.

Mr G was able to return home to live with his wife which had been his desired outcome and his wife was also happy as she felt it was good that she and her husband were now being supported and provided with advice and support from Adult Social Care

What does safeguarding look like in Herefordshire?

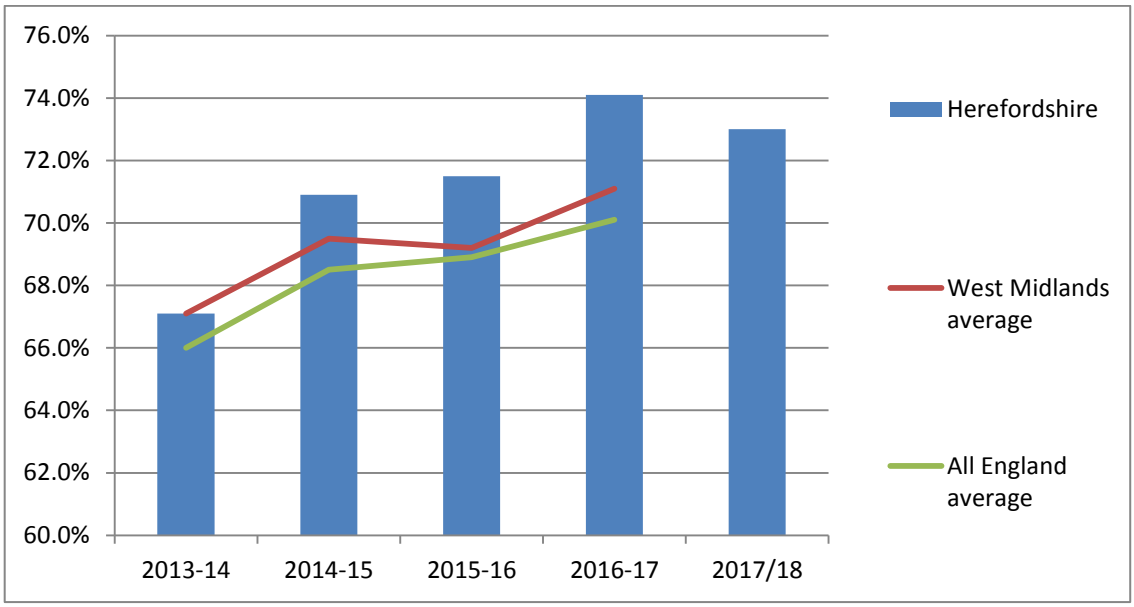
Every year the local council takes part in a survey, commissioned by the government, collecting multi-agency performance data and asking individuals about their experience of care.

Some key highlights are:

Proportion of people who use services who feel safe

Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of service users' experience and their care and support.

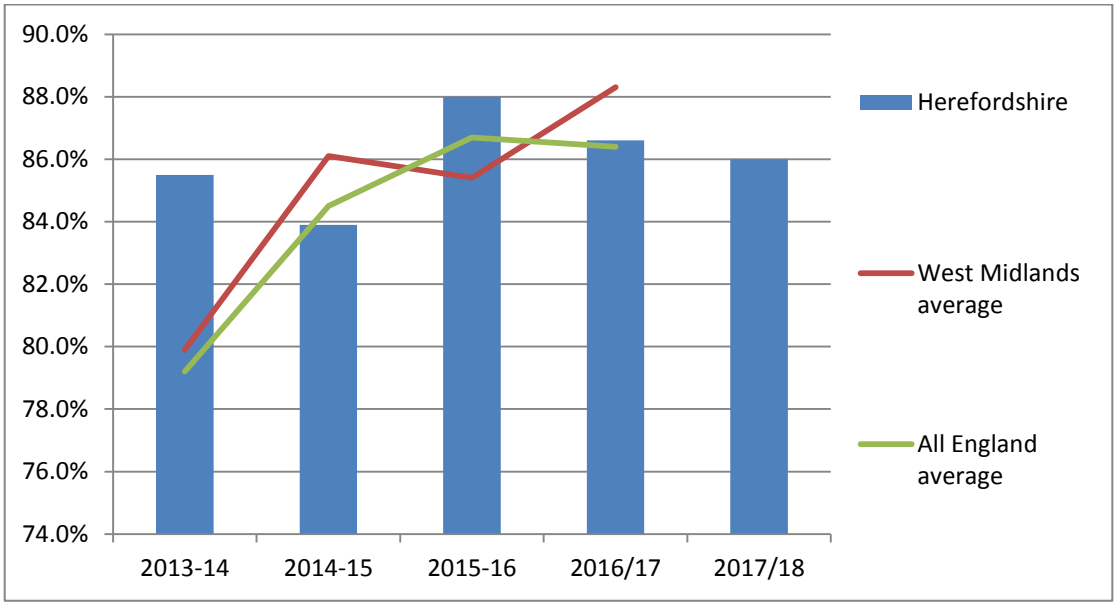
	2013/14	2014/15	2015/16	2016/17	2017/18
Herefordshire	67.1%	70.9%	71.5%	74.1%	73.3%
West Midlands average	67.1%	69.5%	69.2%	71.1%	71.3%
All England average	66.0%	68.5%	68.9%	70.1%	69.9%



Proportion of people who use services who say that those services have made them feel safe and secure

The measure below reflects the extent to which users of care services feel that their care and support has contributed to making them feel safe and secure.

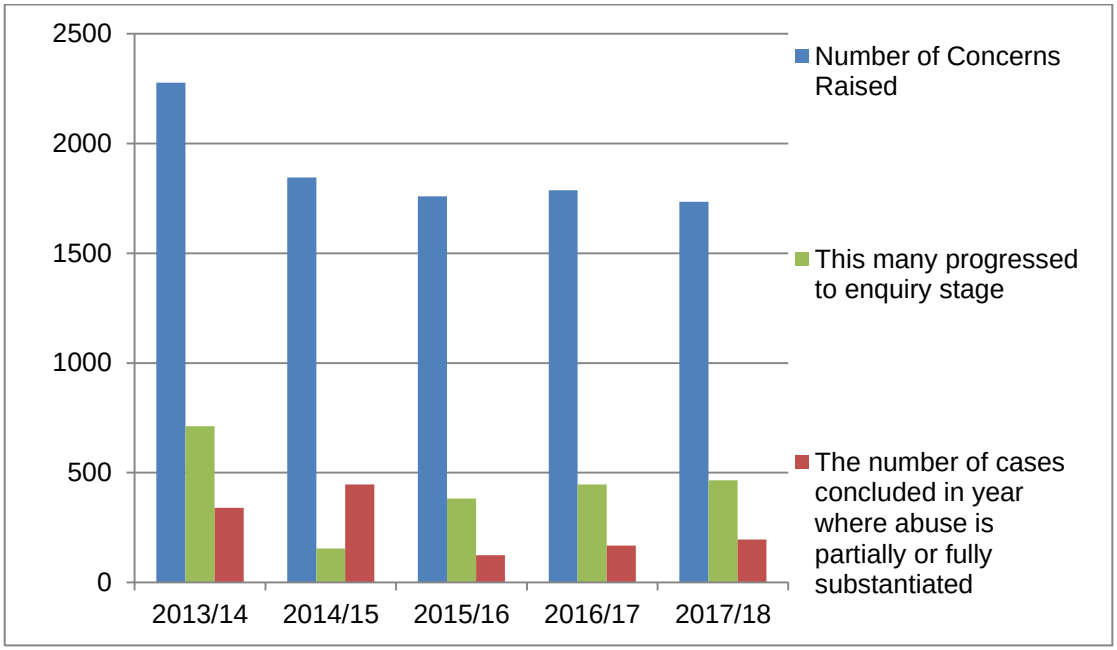
	2013/14	2014/15	2015/16	2016/17	2017/18
Herefordshire	85.5%	83.9%	88.0%	86.6%	85.9%
West Midlands average	79.9%	86.1%	85.4%	88.3%	88.4%
All England average	79.2%	84.5%	86.7%	86.4%	86.3%



* Figures for 2017/18 are not yet finalised and may be subject to change
(Source NHS digital)

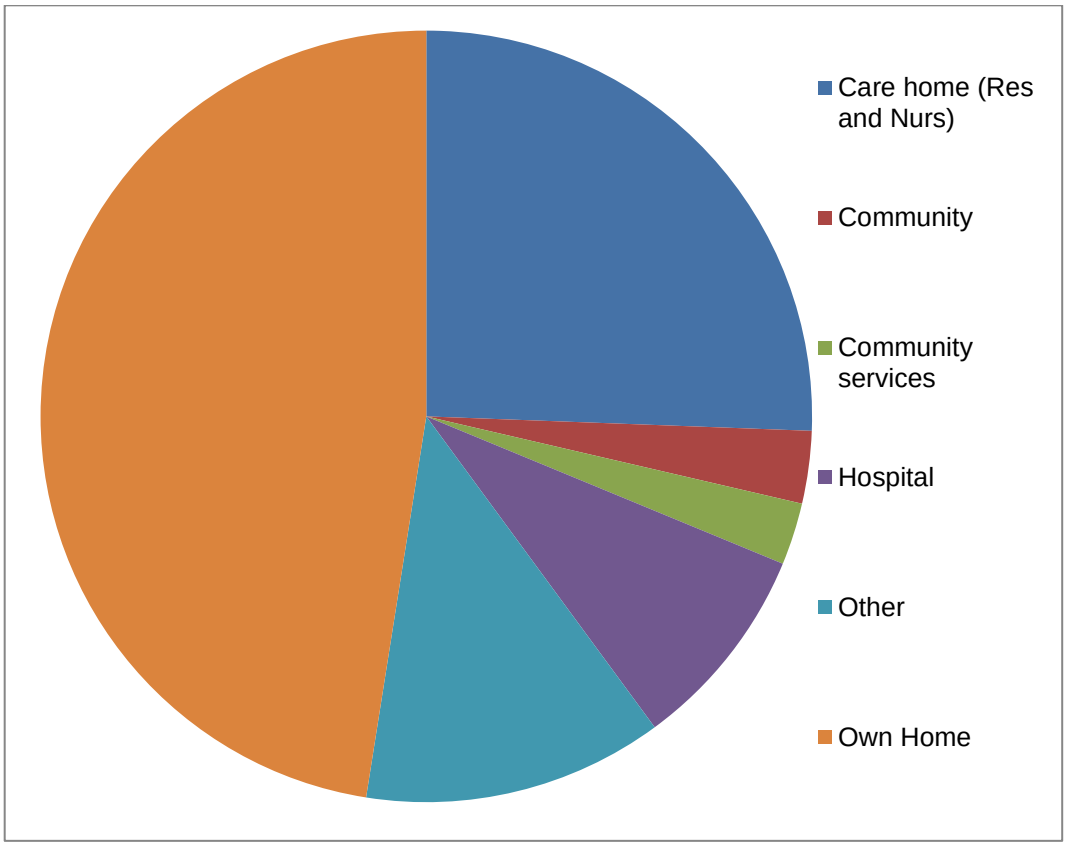
The following graphics relate to circumstances where safeguarding concerns were raised. All of this data is from the Local Authority information systems as, has been previously reported, limited information is available from partner agencies to support the safeguarding agenda.

About the concerns regarding abuse that have been raised



The decrease in the number of safeguarding concerns raised is largely contributed to the ongoing education of partner agencies in what contributes to a safeguarding concern. This is evidenced by the largely consistent number of concerns being transferred to the enquiry stage.

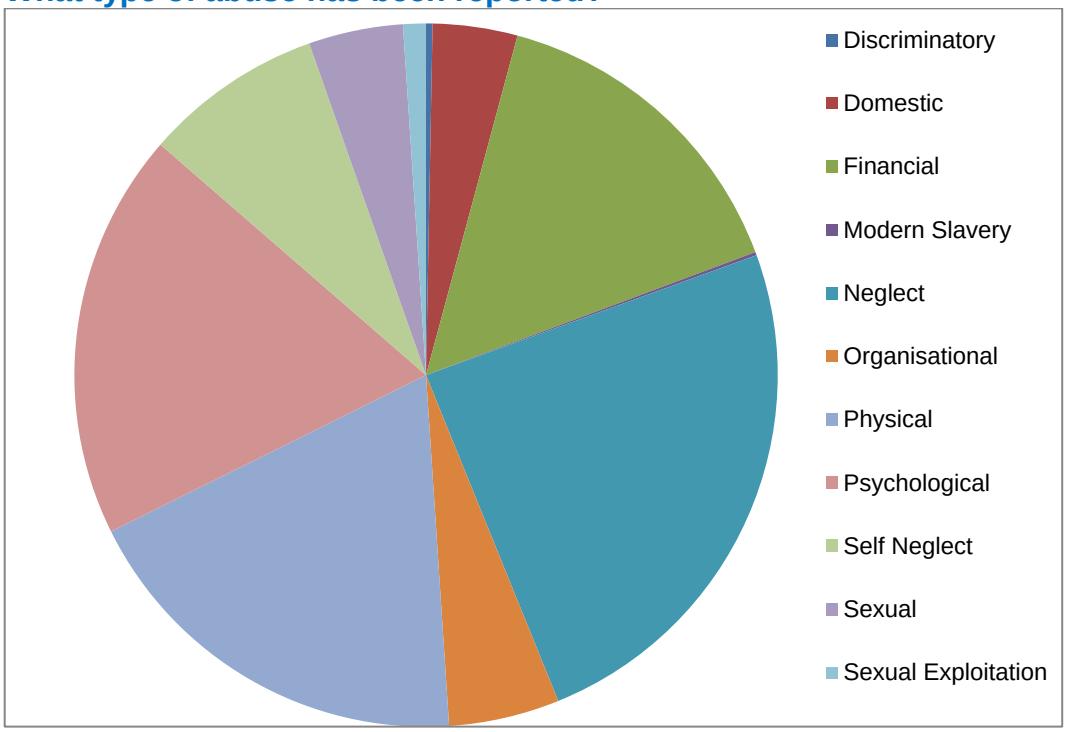
Where abuse has occurred



The instances of abuse in individuals own home and in the community as a percentage of all abuse remain fairly static, there has been a decrease this year in reports from care homes and an increase in reports from hospital.

*Community services include provisions such as day care.

What type of abuse has been reported?



The largest increase in type of abuse reported has been in physical and in self neglect with a decrease in the reports of neglect.

How the Board works to deliver results

The Board brings together representatives from:

- Herefordshire Council social care and public health teams
- Herefordshire Clinical Commissioning Group (responsible for the purchase of health care)
- Wye Valley NHS Trust and 2Gether NHS Foundation Trust (health care providers)
- Healthwatch
- West Mercia Police
- National Probation Service
- Community Rehabilitation Company
- Herefordshire Housing
- West Midlands Ambulance Service NHS Foundation Trust
- Hereford & Worcester Fire and Rescue Service
- Members from provider and voluntary services

This multi-agency approach ensures that all partner organisations work cohesively, using the same information and communicate consistent messages to provide the strategic direction for the work undertaken on their behalf.

It is the task of the Strategic Board to agree the priorities for the year, in consultation with Healthwatch and the community and to inform the executive group of these.

Sub groups develop work plans which contain the activity required to deliver the priorities. Each sub group chair is responsible for reporting successes, developments and any barriers to progress to the executive.

What the sub groups have delivered this year

Performance and quality assurance

Terms of reference:
This group is responsible for data quality, audit and effective information systems to meet current and future expected national and local data reporting requirements and enable performance to be managed and reasonable assurance secured on the quality of local safeguarding.

Chairs update
Performance data continues to be scrutinised at meetings, we continue to have problems with accessing meaningful narrative from some agencies but work is ongoing to address this.

During the year the group has carried an audit into self-neglect (neglecting to care for one's personal hygiene, health or surroundings) which showed that although staff were not aware of the policy that had been approved by board, professionals were competent in recognising and responding to signs of self-neglect.

The group continues to receive regular updates regarding the quality of care in residential and nursing homes and as a result of the significant concerns in one home carried out a round table review, involving many of the professionals who had supported the individuals in the home. The findings from this round table review were in the main for the care home to action. The home was monitored for some time to ensure that the actions were put into practise.

We once again issued our bi-ennial self-assessment to all partners of the Board. This has been updated to incorporate areas were additional assurance was sought following audits and reviews including safeguarding supervision, female genital mutilation, modern slavery.

Policies and procedures

Terms of reference:
This group aims to ensure there is a comprehensive catalogue of policies which underpin the multi-agency safeguarding procedures. Its goal is that staff across the partnership have access to the necessary range of multi-agency safeguarding and adult protection policies and procedures and that these are embedded into practice. It also includes the review and maintenance of existing policies.

Chairs update
Adrian Turton on behalf of **Alison Feher**
Safeguarding Lead, 2gether NHS Foundation Trust

Between April 2017 and the end of March 2018 the HSAB Policies and Procedures Sub group (HSAB P&P) met on four occasions. HSAB is part of the West Midlands Multi-Agency Safeguarding Adults Policy consortium, developing and driving forward regional safeguarding policies. The overarching West Midland's Safeguarding Adults Policy was updated in September 2016 with amendments due in 2018.

Notable developments for the HSAB P&P group over the 17/18 financial year include; amendments to the West Midlands Position of Trust (POT) Toolkit which was localised for Herefordshire in 2018. The HSAB Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DOLS) policies were developed in conjunction with the MCA/DoLS subgroup and published in January 2018. The HSAB Professional Disagreements Policy, Organisational Failure and Abuse Policy, and the Out of Contact Guidance were all developed, agreed and implemented by the HSAB P&P group in 2017/18.

The HSAB P&P sub group has matured and will drive policy development into 2018/19. The key to success will be consistent agency representation on the HSAB P&P group and a strong relationship with the West Midlands policies and procedures consortium. Key items on the work plan for 18/19 include the development and agreement of the Regional Self Neglect policy and the Herefordshire Making Safeguarding Personal (MSP) guidance. All organisations will need to be made aware of their responsibilities regarding complaints concerning people in positions of trust. HSAB P&P will work alongside the Joint Training and Workforce Development Subgroup to achieve a universal understanding of the Positions of Trust guidance approved for Herefordshire

During 2018 the sub group will strengthen the governance of HSAB policies and procedures. There will be enhanced version control of the documents, and agreed pathways for policy development and adoption.

Mental Capacity Act and Deprivation of Liberty Safeguards

Terms of reference:
This group provides clear leadership on the promotion of the application of the Human Rights Act, Mental Capacity Act and the Deprivation of Liberty Safeguards in everyday clinical practice and ensures that a framework is in place to support staff in relation to their responsibilities and monitor compliance with this legislation.

Chairs update
Jane Higgins
Mental Capacity Act and Mental Health Manager, Herefordshire Council

The group continued to meet over the year to share information with regard to changes from case law.

The Chair met with GP's to help raise the understanding of their responsibilities with regard to the legislation.

Several new leaflets were published including information regarding the Court of Protection and Lasting Power of Attorney. All resources are available on the website.

The highlight of our year was the conference held in February. We had some well renowned speakers including Mark Neary whose case against Hillingdon Council changed case law and Rachel Griffiths who advised CQC in respect of their inspection regime with regard to Mental Capacity. It was attended by 78 delegates. Feedback was really positive and comments include

- I am looking forward to further conferences arranged by Herefordshire. I felt privileged to have attended this day and shared with others such strong messages.
- A good day with some good networking too, thank you to all who organised it.
- This was a very enjoyable event, hosted by very informative experts coming from very different perspectives. It was also an excellent opportunity to hear the points of view of delegates from many different areas of health and social care.
- It was a very well put together event which ran smoothly and on time. Thank you

This sub group of the Board has now been dissolved as the strategic objectives have been met. The ongoing embedding of Mental Capacity Act and Deprivation of Liberty Safeguards in policies and professional practise will continue through the remaining sub groups.

Joint training and workforce development

Terms of reference:
This group is responsible for developing and maintaining Herefordshire's competency framework and provides evidenced assurance that partner agencies are meeting the requirements of the framework.

The group has particular responsibility to ensure that multi-agency development opportunities exist for all practitioners. By undertaking such activities, the group will ensure people working with or engaging with adults at risk in Herefordshire understand their responsibilities.

Chairs update
Alison Chambers
Project Officer, Training and Development, Hoople Ltd (On behalf of AWB)

The Multi-Agency Workforce Strategy determines the workforce development plans for all who work with adults at risk to ensure that they are skilled and competent. It includes learning from safeguarding adults reviews, practice learning reviews and changes to legislation.

Care Act Guidance requires all commissioners and providers to ensure that staff have the necessary competencies and training in place to ensure that their staff are able to deliver the service in relation to the safeguarding of individuals. To support this, a Validation Process has been put in place so that agencies and providers can be assured that they are meeting the requirements to ensure staff are trained and competent.

The Joint Safeguarding Practitioner Forums continue to have good attendance with professionals drawn form a wide range of agencies / sectors. 90 practitioners have attended over the 4 sessions this year representing 31 agencies. This forum programme included dissemination of learning from reviews, informing practitioners about the work of the board, as well as presenters who covered the following subjects:

- Learning disability & dementia project

- CAHMS Service
- Adult Community Disability Service Overview supporting Adults at risk
- Impact of sexual exploitation on families
- Prevent & disrupt
- CSE Services – What is available in Herefordshire
- Work of the LADO
- Update on Position of Trust policy
- Embedding the Competency framework into practice and training
- See Past the Obvious – Police vulnerability strategy

Specialist conferences were supported this year; a Domestic Violence Conference in Nov 2017 which 88 people attended and the MCA Conference in February 2018 which 78 people attended.

Joint Case Review (JCR)

The Board has a legal duty under the Care Act 2014 to undertake a review of cases where an adult at risk has died or suffered serious harm. The reviews involve all agencies which were, or should have been, working with the adult and are used to identify learning outcomes for policy, procedure and practice.

Chairs update
Mandy Appleby
Principal Social Worker, Herefordshire Council

Activity for the joint case review during 2017/18 was divided between completing actions from the previous year and processing four new referrals. The JCR directed and oversaw the following:

- 1 Practice Learning Review (PLR)
- 1 Single Agency Review
- 1 Deep Dive Review
- 1 Referral to Public Health

There have been no Safeguarding Adults Reviews commissioned during the year 17/18.

PLR

Subject: A young male adult who was known to MAPPA (Multi-Agency Public Protection Arrangements) for criminal damage and possession of a firearm. A referral was made due to transitional shortcomings from Children's Social Care to Adult Social Care, as he was formerly supported by the Children with Disabilities Team. It was agreed that this met the criteria for a PLR and the CCG would chair this. The report is currently being considered and any learning will be included in next years annual report

Single Agency Review

Resident of residential home deliberately set fire to papers in bedroom and later died in hospital.
It was agreed that this met the criteria for a single agency review only and this has been carried out by the local authority.
A number of recommendations were made and completed.

Review of involvement (Multi-agency input)
Adult male released from prison with no fixed abode and no accommodation plan. The individual was arrested in relation to theft and criminal damage later released and later found in the area of Hereford County Hospital. The referral focused on the level of multi-agency coordination and planning prior to release from prison. The referral was discussed in depth at JCR where it was agreed that this case did not meet the threshold criteria for SAR, however, there were enough concerns regarding HMP's duty of care upon his release to require a review of input from agencies involved. This has now been completed and the recommendations from key agencies involved are being put forward for the executive board.

Referral to Public Health
Father found deceased in River Wye. It was agreed that this case did not meet the threshold for SAR and a request was made to Public Health to investigate the circumstances under their regulatory powers.

Domestic Homicide Review (DHR)
The JCR subgroup also receives referrals for Domestic Homicide Reviews. One was received in 2017/18.

Female found murdered at home by Police responding to a previous incident requiring them to locate next of kin. It was agreed that this met the criteria for DHR and this is in progress. Findings from DHRs are published on the Herefordshire Council website.

Agencies have been referring in with appropriate cases and there have been healthy discussions regarding the threshold.

Action Plans for all reviews have been have been monitored at every meeting. The learnings have been the subject of a joint HSAB/HSCB Practitioner Forum.

We will also review how each agency feeds back the multi-agency learnings from all reviews commissioned. A new "Learning Lessons" feedback sheet to confirm dissemination is being developed by the Business Unit, and will be added to the Case Review Toolkit.

What the sub groups will deliver next year

2015-18 BUSINESS PLAN – year 3

Introduction

A review of the 17/18 Business Plan has been undertaken and additional recommendations have been included, arising from the board development day. This document now forms the basis for the 18/19 Business Plan.

The Business Plan is an addendum to the Strategic Plan 2015-18 and forms the foundation for the work of the sub groups to deliver the outcomes. The Strategic Plan will require a refresh.

This Business Plan is developed to enable the Safeguarding adult board to carry out its functions as set out in legislation and guidance. This includes ensuring the protection of adults in the following circumstances:

(a) Has needs for care and support (whether or not the authority is meeting any of those needs),

(b) Is experiencing, or is at risk of, abuse or neglect, and

(c) As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

The way in which a SAB must seek to achieve its objective is by coordinating and ensuring the effectiveness of what each of its members does to safeguard vulnerable adults. HSAB achieves this through scrutiny, challenge, learning and support. The key outcomes and actions in this plan are designed to help us demonstrate **Strong Partnership**, which is an essential part of ensuring strong and effective working together to safeguard vulnerable adults.

Partnership working	
To develop relationships across agencies that deliver positive changes to safeguarding	
Define and understand involvement from voluntary sector	Clarify representation of voluntary sector through the membership and work of the HSAB.
Develop a more qualitative approach to performance monitoring (Outcome from board development day March 17)	Establishment of multi-agency case audit process against boards priority areas. For the board to be clear about what we need to know to be able to be assured about progress in priority areas and develop multi-agency performance information against these priorities .

Prevention and protection	
To ensure that Herefordshire residents can recognise safeguarding concerns and know what to do	
Service user involvement	Continue to develop the work already commended of service user feedback through Healthwatch.
Monitor Prevention Work plan	The HSAB to receive scheduled updates and reports on the progress of the prevention work plan.

Communications and engagement	
To deliver the messages from the board and recognise the voice of those we safeguard	
Raise awareness of safeguarding, MCA and DoLS across councils, communities and smaller organisations	To be included in sub group work plans and reported to the executive on work and actions taken and a view on impact. Business unit to retain a log of communications, and link in to One Herefordshire.
Develop effective arrangements for delivering messages to and from the board	Review terms of reference of practitioner forums to maximise this process as an approach to messages from front line practice.

Operational effectiveness	
To ensure safeguarding knowledge, processes, systems and structures are embedded across all agencies	
Single agency assurance reporting to Exec" Suggested themes: ❖ Assurance of right referral for right reason ❖ Activity against prevention agenda ❖ Board and sub group contributions ❖ Compliance with care act / MCA / DoLS / competency framework	Assurance reporting from single agency to be scheduled in to the business cycle of HSAB.
Messages from the board are disseminated	Partners need to provide evidence, including through assurance reporting, that the relevant messages identified through the board are being disseminated in their agencies.
Ensure learnings from audits and reviews are shared across the partnership	Develop approaches to achieve timely dissemination of messages from reviews and audits, with single agency partners taking responsibility and contributing to this. Details to be included in sub group work plans.

Operational effectiveness	
To ensure safeguarding knowledge, processes, systems and structures are embedded across all agencies	
Consideration of ADASS "Making safeguarding personal for safeguarding adult's boards" report. Consideration of ADASS Making Safeguarding Personal resources for individual agencies report. Monitoring of Board MSP action plan	The Board is using this report to gain assurance that it is indeed making safeguarding personal. The Board is using these resources to lead and guide single agencies development of MSP within their organisations MSP action plan to be scheduled in to business cycle of HSAB executive for regular update on progress and any risks.
Develop self-assessment for partner agencies based on Competency Framework	
Examine effectiveness of sub groups	The sub groups to report to the executive group on the commitment of partners to the working of the sub groups, progress on core business and priorities of the HSAB. The Executive will lead on recommendations for improvements of the effectiveness of the sub groups.
Effectiveness of the broader safeguarding system Suggested themes: ❖ Provision of advocacy and access to it ❖ Addaction (identified from development day)	Executive to recommend for the board how these areas should be monitored, for example for inclusion in case auditing and assurance reporting
Increase HSAB engagement with regional and national work and developments (identified from development day)	The board to identify specific areas to highlight and evidence.

Appendix 1

% Meeting attendance

Meeting	Board	Exec	PAQA	MCA	TWD	PandP	JCR
Meeting	4/12	4/12	8/12	4/12	6/12	9/12	9/12
Agency							
2gether NHS Foundation Trust	100	75	83	100	57	Chair 66	100
Adult and Wellbeing	75	Chair 100	100	Chair 100	Chair 86	33	Chair 100
Community Rehabilitation Company	DNA				DNA		AR
Healthwatch	50		50				
Hereford and Worcester Fire and Rescue Service	50						
Herefordshire Carers Support	25						
Herefordshire CCG	75	25	Chair 67	25	28	DNA	64
Hvoss	75	75			14		
LA Governance	As required						
Lead Member	50						
Legal services rep	As required						
National Probation Service	DNA				DNA		18 AR
Public Health	25						
West Mercia Police	100	100	83			100	91
Wye Valley NHS Trust	100		83	100	57		100

DNA – Member invited, but does not attend

AR - As required

Appendix 2

To deliver the above, the Business Unit is used, which is a multi-agency funded team overseeing the work of the Board and its sub groups. The unit is funded as follows:

Contributions from statutory partner agencies for 2017/18 remained the same as in previous years at a total of **£383,964**.

AGREED BUDGET FOR 2017-18	
Children's Wellbeing	133,569
Adults Wellbeing	103,000
CCG	80,190
Police	53,510
Probation/CRC	6,136
CAFCASS	550
YOS	1,144
TOTAL GROSS BUDGET	**378,099**

Note: This total contribution is for the support of the Herefordshire Safeguarding Adults Board, Safeguarding Children Board and the Community Safety Partnership

Budgeted costs 2017/18

Category	Budget
Salary Costs	275,899
Agency costs	0
Transport costs	750
Independent chair costs	38,520
Serious Case Review costs	10,000
Training expenses	22,000
Office expenses (includes local authority recharge)	37,930
Training income	-7,000
Total	**378,099**

Appendix 3

Partners Position Statements for HSAB Annual Report

With the implementation of the Care Act 2014 and the new statutory duties placed upon Local Authorities, Herefordshire Council continues to place greater emphasis on working with our partners, communities and citizens to encourage, support and facilitate the safety and wellbeing of those who are exposed to or vulnerable to abuse, exploitation and discrimination in all its forms. In 17/18 the safeguarding board reaffirmed the commitment to Making Safeguarding Personal (MSP) which had been introduced by Herefordshire Council in readiness for the Care Act in January 2015.

In the 2016/17 annual account Herefordshire Council reported its participation in the National MSP evaluation. This has assisted us to develop our safeguarding approach alongside progress made nationally with one of our key priorities being to capture the opinions and experiences of individuals and their families who have required safeguarding to improve our services. The council has consequently changed its client record systems so that expectations of individuals and how effective the Council is in safeguarding can be better evidenced. The council is also supporting initiatives of Herefordshire Safeguarding board to encourage independent feedback from our customers. This approach we think will support greater transparency and continuing improvement.

In the 2016/17 annual report the council informed of our plans to train all operational and commissioning staff in the principles of strengths based practice and commissioning. This training has successfully been concluded and we have been able to evidence that customer experience of our services has improved. We think that our commitment to working with and supporting communities lays the best foundation for supporting our most vulnerable citizens, now and in the future. Within adults and well-being new posts have been developed to connect our local community resources to our customers who are vulnerable, isolated and whom always have something positive to offer in return.

The nature of safeguarding challenges continues to evolve and in 17/18 we have been working with our partners on developing knowledge and skills to respond to emerging issues in Herefordshire of adult sexual exploitation, human trafficking and modern slavery to name just some of the many facets of modern society that we along with our partners are required to respond to.

Our work continues nationally, regionally and locally to lead and develop personal and responsive safeguarding services. Stephen Vickers who until his recent appointment as the interim Director of Herefordshire Adults and Wellbeing, continued as the appointed Chair of the Association of Directors of Adult Social Services (ADASS) West Midlands Safeguarding Network in leading the West Midlands approach. Stephen due to his new responsibilities has stepped down although senior officers continue to be involved sharing best practice and ideas. A new Principal Social worker, Jane Higgins has also been

appointed and other key professionals remain in post who provide specialist leadership, training and advice that is available to the HSAB partnership and our own workforce.

Introduction

Safeguarding for children and adults means protecting a child or children's; as well as adult's right to live in safety, free from abuse and neglect.
It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the child or adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action ('VOICE of the CHILD' and 'Making Safeguarding Personal' for adults).
Therefore, the purpose of the Safeguarding Annual Report for 2017-18 is to provide assurance to the Governing Body on how HCCG is meeting its statutory requirements for Safeguarding Children and Adults at Risk of abuse and neglect;
Provides an overview of the progress made during the year 2017-18, and the key challenges to be addressed to ensure the CCG and it's commissioned health providers are compliant with National and local requirements including those set by NHS England.
The report illustrates how HCCG has continued to improve outcomes for Children and Adults at Risk through governance and assurance processes; with an overview and summary of safeguarding activities across NHS Commissioned Health Services and within the CCG during 2017-18 and reduces the following;

- The risk in relation to safeguarding children is that failure to meet statutory responsibilities including NHS England safeguarding monitoring tool (SATs) will lead to poor quality of care.
- The risk in relation to adults is that failure to sustain compliance with the Care Act 2014 implemented 2015; and NHS England Assurance Framework across all the services that we commission.
- The risk Mental Capacity Assessments (MCA) and Deprivation of Liberty Safeguards (DOLs) not being applied or implemented in clinical practice; impact being treatment interventions not in the patient's 'Best Interests'.

Background

Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (NHS Commissioning Board 2013 and NHSE June 2015).
The framework describes the Safeguarding roles, duties and responsibilities of NHS England, Clinical Commissioning Groups, NHS providers and various other bodies in the health economy.
Therefore, this report aims to provide assurance in regards to the framework; and highlight areas of improvement and or risks and how these will be mitigated for.

Key Achievements (2017-18);

1) Partnerships and multi-agency working

During 2017/18 Herefordshire CCG have further strengthened its governance and assurance arrangements regarding safeguarding across Herefordshire;

through further developing our relationship working with commissioned providers, NHS England, Local Authority, CQC and NHS Improvement colleagues and wider health economy organisations. Partnership approaches with Local Authorities, other Arm's Length Bodies and emerging STPs/ICSs have continued, and do so as we move into next year's schedule of work.

2) Leadership and Accountability

The CCG has strengthened its structure with clear leadership e.g. Chief Nursing Officer as the Executive lead for safeguarding; Head of Safeguarding/Designated Nurse for Safeguarding and supporting safeguarding specialist nurses and leads. The CCG also has a presence in the MASH which strengthens information sharing and support for the commissioned services i.e. Wye Valley Trust and 2Gether Trust.

The HCCG over the reporting year have successfully completed section 11 for safeguarding children compliance; the adults safeguarding self-assessment using 6 principles; and the NHS England Safeguarding Assurance Tool and have action plans where there are identified ambers as reflected below in the key objectives for 2018-19.

3) Governance

The CGG has internal safeguarding integrated meetings weekly with the Quality team which enables sharing information; discussing key themes and concerns and how these are being supported. This meeting then reports to the Quality and Safety Committee which then reports to the CCG Governing Body.

Externally CCG leads on a BI-monthly health Leads meeting where information is shared including lessons learnt from e.g. SCRS/DHRs and or SARs. This meeting enhances learning and communication between CCG and providers of services including discussions around new legislation and guidance.

The CCG effectively engages with the local HSAB/HSCBs and their sub-groups. However, there is further work to be done to ensure the CCG engage with sub-groups where they add value working with the whole health economy to ensure effective resource management.

4) Enablers

HCCG supports commissioned service providers Named Nurses and Safeguarding Leads including LAC with safeguarding supervision and training for GPs as well as Continuing Health Care staff (CHC). This has been impacted on slightly over the reporting year due to resource implications.

Key Objectives for 2018-19

1. To develop a safeguarding training strategy for CCG and ensure training compliance is monitored.
2. For providers Wye Valley and 2Gether to produce a Training Needs Analysis that supports training compliance including Prevent
3. Review safeguarding structure to ensure effective support for commissioned services; and engagement with safeguarding Boards and their sub-groups
4. Implement safeguarding supervision structures for commissioned Named professionals
5. Support the implementation of CP-IS in WVT
6. Develop effective pathways for LAC especially out of area placements
7. Develop pathways for Nursing Homes safeguarding referral processes

8. Review NHS England SATs action plan and complete

Conclusion

Safeguarding is everybody's business driven by effective Leadership; Accountability; Governance and clear enablers.

Wye Valley NHS Trust (WVT) was established in April 2011 and is the provider of healthcare services at Hereford County Hospital, along with a number of community services for Herefordshire and its borders. We also provide healthcare services at community hospitals in the market towns of Ross-on-Wye, Leominster and Bromyard.

Safeguarding vulnerable adults is everyone's business and WVT is committed to safeguarding adults across the organisation. The welfare of people who come into contact with our services either directly or indirectly is paramount and all our staff have a responsibility to ensure best practice is followed and integral to everyday practice.

As part of the Trusts commitment to safeguarding adults throughout all its services, we have a dedicated adult safeguarding Lead Nurse and in February 2018 appointed a Lead Nurse for Mental Capacity (MCA) and Deprivation of Liberty Safeguards (DOLS) on a permanent basis. The Director of Nursing is the Executive Lead for safeguarding and has clear oversight of safeguarding activity.

In line with the Care Act 2014, WVT has continued, over the last twelve months, to work closely with partner agencies and is a key member of the Herefordshire Safeguarding Adults Board (HSAB) and associated sub groups. We are committed to working collaboratively with other agencies, sharing information in a safe and appropriate manner. WVT produces an adult safeguarding annual report which is also shared with partner agencies.

We have a safeguarding training programme in place to ensure staff are aware of their roles and responsibilities and act appropriately and proportionately to any safeguarding concerns raised. The WVT adult safeguarding team see it as a priority to support staff in clinical practice with the aim to achieve an appropriate outcome for the individual at risk.

WVT has signed up to the HSAB safeguarding policies and procedures which are available to all staff and there are local flowcharts in all clinical areas as an immediate guide to support staff in their decision making.

During 2017-18 Making Safeguarding Personal (MSP) has remained a high priority for the Trust in ensuring the adult, their wishes and desired outcomes are at the centre of the safeguarding process; additional information about MSP has been added to the Trust adult safeguarding intranet page and has been incorporated into the adult safeguarding flowcharts. MSP has been a shift in culture and practice and we have recognised the importance of a patient centred approach to safeguarding and have made progress in promoting and embedding the principles of MSP.

Cath Holberry
Lead Nurse Adult Safeguarding

2g continues to play an active part and is fully committed to multi-agency working, with all partners at the Herefordshire Safeguarding Adult and Children Board, in order to safeguard children and adults at risk of abuse or neglect.

Achievements 2017/18

2g has continued to improve the take up of training for safeguarding adults and children within a 'Think Family' approach. This involved Making Safeguarding Personal (*MSP*) and incorporated safeguarding children within the adult's social network.

2g has contributed to the Safeguarding Boards' training pool; jointly delivering training on recognising neglect in families, and has included level 3 Prevent e-learning as statutory training requirement.

Staff working within Adult Teams, have received improved access to internal safeguarding supervision via the Trust's Safeguarding Team. This is modelled on reflective practice as advocated within children's safeguarding and includes formal group and one to one sessions.

In line with the Boards' objectives, 2g has specifically shared learning from Safeguarding Adults Reviews, Serious Case Reviews and other learning models, and shared learning from multi-agency and single agency (internal) audits. 2g particularly focussed on Modern Day Slavery, improving documentation of safeguarding activity, Self-neglect, MAPPA and the Prevent agenda.

2g has actively participated in Board and sub group activity, ranging from chairing sub groups to front line staff keenly partake in learning events / audits.

Priorities for 2018/19

2g plans to continue working in partnership to improve overall safeguarding activity. This will involve participation in all sub groups, focusing on learning from multi-agency and internal single agency audits; learning from Domestic Homicide Reviews, Safeguarding Adult Reviews, Serious Case Reviews and other learning models (e.g. Practice Learning Reviews). 2g will also concentrate on increasing the provision of safeguarding supervision to teams working with children and adults; improving the quality of safeguarding referrals for adults by evidencing 'MSP' and children (evidencing Levels of Need guidance); increase awareness around Domestic Abuse and Sexual Violence; Prevent, MAPPA - and to include early help for children and families.

In order for us to ensure we have the capacity to deliver all requirements we have recruited substantively for another Specialist Safeguarding Practitioner within the Safeguarding team.

Safeguarding Children and Adults remain a priority in the delivery of Mental Health services, irrespective of financial demands and constraints in the current economic climate.

Quality Assurance

2g will continue to provide assurance to the Board that Safeguarding Priorities are in line with best practice and evidences positive outcome for families. Through our own internal Safeguarding Subcommittee we will monitor our objectives to ensure they are delivered in line with the Safeguarding Board strategic agenda.

West Mercia Police are committed to their vision to protect people from harm. To achieve this, our focus and priorities puts the public at the centre of everything that we do. A key element within the delivery plan locally is to be able to identify the most vulnerable and to work with our partners to achieve the best outcomes for the public. This will include aligning strategies, intelligence and resources to optimise the public pound.

A vulnerability strategy under the corporate branding of 'see past the obvious', encourages Officers and Staff to be professionally curious in situations where adults may appear vulnerable for a whole range of reasons. It further raises awareness that we need to understand the situation and circumstances of every person that we come into contact with. A range of training opportunities has given staff the confidence to be able to respond appropriately to individual needs and to work in partnership with other agencies. An innovative mobile phone application is available to staff to have ready access to legislation, information and tools to assist them in their daily work including how to signpost to other agencies who may be able to offer support.

Whilst we have dedicated staff who work closely with other agencies especially in terms of referrals and joint decision making, we have moved further to ensuring that protecting vulnerable adults is everyone's responsibility. A model known as THRIVE (Threat, Harm, Risk, Investigation, Vulnerability, Engagement) is embraced by all staff to identify the most appropriate response and ongoing ownership which is overseen, with daily scrutiny, by Senior Management Team. A new policing model was implemented earlier this year which has introduced staff working within an Integrated Victim Management team who focus on the most vulnerable and those who have been unfortunate to be repeat victims

The six statutory safeguarding principles are defined as core to Making Safeguarding Personal and there is an emphasis on wellbeing alongside safety. These principles are made clear to all police officers. Alongside our Code of Ethics and Values, the six safeguarding principles of empowerment, prevention, proportionality, protection, partnership and accountability are at the heart of what Officers do in their day to day business.

We have a range of policies and procedures which promote and support the development of MSP. From the Police and Crime Commissioner's (PCC) plan to the local delivery plan, there is emphasis on the victim’s code which summarises our responsibilities to support victims and their rights and to manage their expectations. In Herefordshire, we have made good use of restorative justice to address and meet victim’s wishes.

We work hard with our intelligence to ensure that those deemed most vulnerable from serious and organised crime are protected. For example, we have issued a number of "Cuckoo" notices to protect those deemed most vulnerable to abuse from County Lines drugs activity. We lead on key elements of the Community Safety Plan for Human Trafficking and Modern Day slavery and give an enhanced service to victims of hate crime.

Hereford & Worcester Fire and Rescue Service have this year reviewed their Safeguarding Policies and Safeguarding

Training and have introduced a quarterly safeguarding meeting to monitor that the service is meeting its obligation in regards to Safeguarding.

Hereford & Worcester Fire and Rescue Service have completed their pilot Safe and Well visit project and this is currently being evaluated. Early signs are that the project has been well received by staff and those they visit. The Safe and Well visits not only focus on fire safety but on the wellbeing of the occupier which means the service can signpost to other services if additional needs are identified.

The Safeguarding Team provides expert, evidence based clinical leadership on all aspects of the safeguarding agenda. The team have a responsibility for the development and implementation of systems and processes, working with partner agencies in line with local and national standards and legislation.

The team ensures the implementation of appropriate Care Quality Commission core standards, and other relevant external targets and standards, contributing to national and local inspections and assessments of safeguarding arrangements. The safeguarding team works with the Local Safeguarding Children Boards (LSCB's), and Adult Safeguarding Boards (LSAB's).

The team also provides information and support to partner agencies for example safeguarding investigations, Serious Case Reviews (SCR's) for both children and adults, Safeguarding Adult Reviews (SAR's), Court Orders, Child Death Overview Panels (CDOP's), Section 42 enquiries and Domestic Homicide Reviews (DHR's) - this list is not exhaustive.

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