Social Care and Health Overview and Scrutiny Committee | **Agenda Item No.**

DATE: 17th January 2019 | **6**

Title of the Report: Safeguarding Adult Board Annual Report (2017-18)

Ward(s) All

Portfolios: Cllr Martin – Portfolio Holder for Adult Social Care

Report:
This report provides an annual overview of the partnership performance in relation to safeguarding adults with care and support needs and of the partners delivery of the statutory safeguarding adult board arrangements.

Recommendations:

That:

1. Scrutiny notes and supports the contents of the report and the current activity to protect Walsall residents from the risk of abuse and neglect.
2. Scrutiny challenges the partnership on the outcomes for adults in Walsall in relation to preventing and protecting against abuse and neglect.

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Walsall Safeguarding Adults Board

Annual Report

2017 - 2018

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1. Introduction

Role and Function

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

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

The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This will require the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in Making Safeguarding Personal. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

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

SABs have three core duties. They must:

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

The Board was slow to develop it Strategic Plan for 2017-18, only agreeing it at the December 2017 Board meeting.

A Board Development Day was held in July 2017 where members identified 6 priorities for 2017-2019 which are outlined in section 4. These have been incorporated into a Strategic Business Plan which outlines key objectives over the next 15 months.

Board Membership

Board members are of a senior position in their organisation, able to make decisions and access resources to support WSAB's business. Board members chair WSAB sub-groups to support delivery of the Strategic Plan.

Attendance is monitored by organisation. Members unable to attend meetings are required to send an appropriate substitute from their organisation. Attendance in 2017-18 was mixed.

During 2017-18 the Board met quarterly and covered a wide range of business including progress reports from sub-groups - regarding work plans and WSAB priorities - and assurance reporting. A Development Day in February 2018 reviewed WSAB's Strategic Plan and priorities for 2018-19.

WSAB Independent Chair

The Independent Chair (Alan Critchley) – for Walsall Safeguarding Adults Board and Walsall Safeguarding Children's Board started in September 2015 with arrangements in place to meet above requirements.

Mr Critchley ceased his chairing responsibilities on 31st March 2018. A successor has been appointed for 2018-19 (Ms Liz Murphy).

2. Local Context

Walsall's overall population is predicted to increase over the next few years by 5.1% from 270,900 in 2012 to 284,700 in 2022.

Walsall has a culturally-mixed population. People of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups in Walsall. The number of Non-UK Born residents in Walsall has increased by 3.7% (or 9,859 people) between the 2001 and 2011 censuses. Walsall now has a small Eastern European population who make up about 1% of the area residents (2,681 people in total). Access and the appropriate provision of services depend upon a well-informed understanding of the specific needs of these different communities.

There were 2,073 safeguarding concerns or enquiries reported to the Local Authority (LA) in 2017-18.

Neglect or acts of omission were the highest category of concern (33%), followed by physical abuse (20%) and financial abuse (16%).

3. Evaluation of the safeguarding system

2017-18:

Evaluation of performance and effectiveness of local safeguarding services:

The number of safeguarding concerns that are being raised has increased year on year over the past three years. In 2017-18 2,183 safeguarding concerns were raised for1,620 people with the Local Authority. This was a 21% increase on the number of concerns raised in the previous year.

514 Section 42 safeguarding enquiries were held for 446 people, an increase of 35% on the previous year. The percentage of concerns that led to a Section 42 safeguarding enquiry increased by 2.5% points to 23.5%.

In 2017-18 over half of all concluded Section 42 safeguarding enquiries were for risks associated with Neglect and Acts of Omission (33%) or Physical Abuse (20%). Although only accounting for 5.4% of concluded enquiries, the proportion of risks associated with sexual abuse doubled compared with the previous year. There has also been an increase in the proportion of risks associated with psychological abuse and self-neglect. Conversely the proportion of risks associated with financial or material abuse has fallen.

This indicates a rise in more complex types of abuse, suggesting that partners and those investigating concerns are getting better at identifying more complex issues.

What works well?

- There are some examples of good, single agency, practice e.g.
- Commencement of the IRIS project (training and support in primary care) for Domestic Abuse
- 'Frequent flyers' meeting held by Walsall Healthcare Trust to address the vulnerabilities of regular A&E attenders
- Fire Service introduction of Safe and Well visits
- Walsall College – programme to raise awareness of substance misuse, Prevent, exploitation.
- Walsall Healthcare Trust awareness days including Dementia, CSE and modern slavery
- Black Country Mental Capacity Act (MCA) group produced extensive resources for use across the partnership.
- Some further alignment this year of the adult and children's agenda's (where appropriate), for example planning a combined multi agency training programme for 2018-19 and commencement of work on a transition protocol (children's disability services to adults and exploitation).
- For S42 enquires, where service users have been asked their desired outcomes, only 18 service users out of 336 did not have their outcome either fully or partially achieved

Difficulties or risks in the system

- Some agencies attend multi agency training but a lack of a clear training needs analysis and lack of robust data hampers the partnership understanding of reach and impact.
- There are issues in relation to the quality of care homes in the Borough. There are no 'Outstanding' Care Homes in Walsall.
- Safeguarding Adult Reviews and audits show a failure to recognise safeguarding concerns, or once identified, to analyse the risk.
- Making Safeguarding Personal (MSP): Ensuring service users have their voice heard or recorded in relation to safeguarding enquiries.
- There is further work to be done to raise the profile of adult safeguarding amongst both the public and professionals.
- Attendance at safeguarding board subgroups is mixed. CCG, WHT and DWMHT attend subgroups regularly, adult social care and West Midlands Fire Service are also well represented. West Midlands Police (vulnerable adults) and Probation do not attend Quality Assurance and Performance, Policies and Procedures or Learning and Development sub groups.
- As with many other areas of the region, Walsall has a high number of DoLS (Deprivation of Liberty Safeguards) applications outstanding and awaiting a decision (47%).

What do inspections tell us?

- Walsall Healthcare Trust was inspected by the CQC in May and June 2017. The trust was given an overall rating of **'requires improvement'**. The overall ratings for Walsall Manor hospital and urgent and emergency services were also judged as 'requires improvement' with maternity and gynaecology rated as 'inadequate'.
- West Midlands Police underwent a PEEL (Police Effectiveness, Efficiency and Legitimacy) assessment in 2017 by Her Majesty's Inspectorate, which determined 'The extent to which the force is effective at keeping people safe and reducing crime as **requires improvement'**.

4. Summary of WSAB activity against its priorities

Priority 1 for 2017-19:

Improve Board Effectiveness. Ensure leadership, management and governance arrangements deliver strong, strategic local leadership that measurably improves outcomes for adults at risk. - Hold partners to account and gain assurance of the effectiveness of their safeguarding arrangements.

Summary:

- Independent Review of SAB undertaken.
- Annual Assurance Statement completed by Board members.
- Constitution document revised.
- Development session held in July 2017 and February 2018.

Position:

- In the late spring of 2017 the SAB commissioned an independent review of the Board. A number of areas required attention and development. In-particular the report noted:

  'There is a general recognition among members that the Adults' Board is underdeveloped relative to that of the Children's Safeguarding Board. Until recently the funding levels for both safeguarding boards in Walsall were well below the average within the West Midlands……. In common with many local safeguarding boards' both money and time are weighted towards children's safeguarding. However, in Walsall this tendency is considerably more pronounced than most. This is most noticeable in the relative time given to children in the Joint Safeguarding Board agendas and minutes. However, this is beginning to change'.

- A SAB consultant was employed within the business unit for 4 months (Sept – Dec) in order to gain some traction on key areas of business e.g. Strategic Plan, including issues raised within the SAB review report.
- The WSAB constitution document was revised and agreed by Board members in March 2018.
- In March 2018 an Annual Assurance Statement (audit relating to Care Act 2014 compliance) was completed by statutory partners and board members (West Midlands Police / Ambulance Service and Fire Service, Walsall CCG, WHT, DWMHT, whg, Walsall College, BCPF and Adult Social Care).
- Analysis and challenge of these returns will take place during 2018-19.
- Work is planned to develop a regional Care Act compliance audit tool and Walsall SAB has been involved in this.
- An additional development session was held for WSAB members in February 2018 to consider the Strategic Business Plan and priorities.
- New business unit staffing arrangements introduced during 2017-18 have brought additional capacity, including a part time Learning and Development Officer, Part time Review Coordinator and Assistant Board Manager, as well as 2 full time administrators. All of these roles work across the adult and children's Board.
- There remains a gap in the governance arrangements for the domestic abuse agenda.

Example of Impact:

The SAB consultant enabled the Board to gain traction on a number of areas of work, including the development of a Quality Assurance Framework. This has put the Board in a stronger position moving into 2018-19 in knowing its area's for improvement and focus. The increased capacity has also started to redress the balance between the adults and children's agendas.

Scheduled work 2018-19:

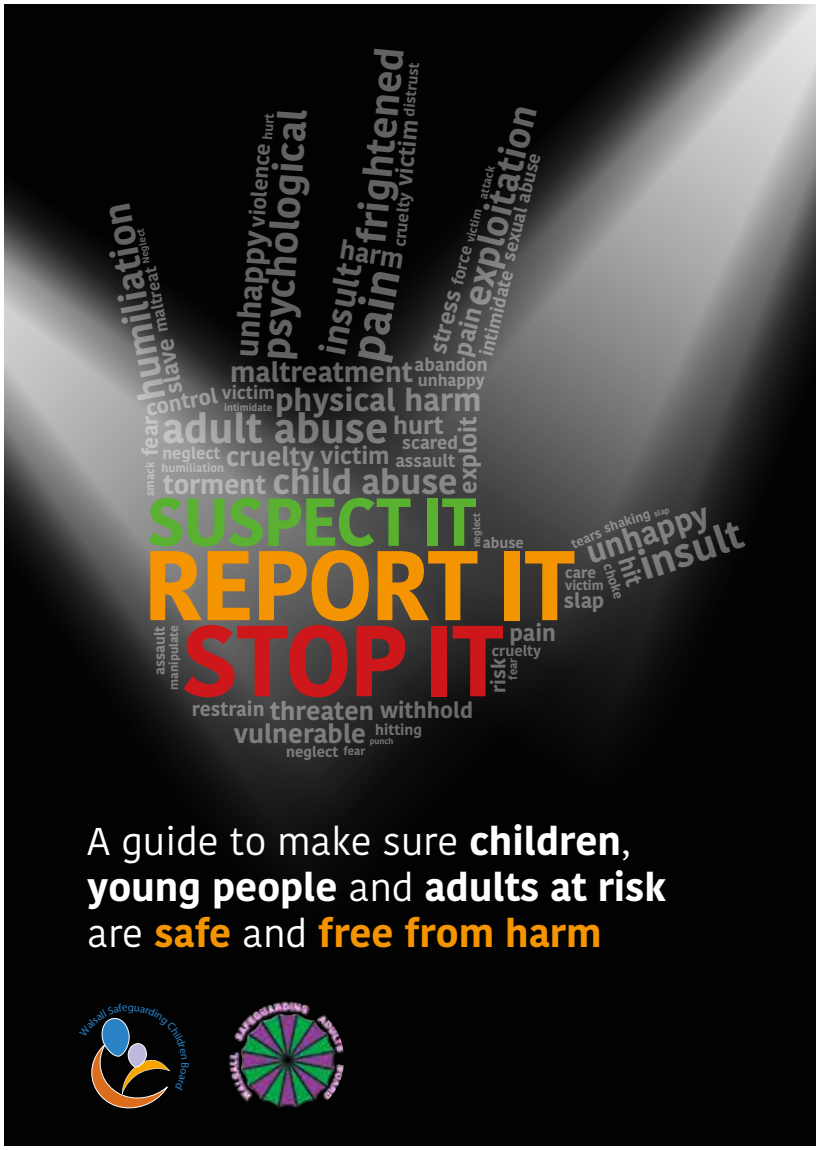
- A new chair has been appointed for 2018-2020 to drive forward the improvement agenda.
- Governance of the domestic abuse agenda requires clarification.

Priority 2 for 2017-19:

Drive forward the Walsall Plan Obsession "If it doesn't feel right, then act on it" with a focus on prevention and promoting community/public awareness

Summary:

- The Board has produced awareness raising materials for the general public, including a poster and leaflets.



Position:

- The Suspect it, Report it, Stop it! poster and leaflets have been circulated by Board member agencies including police partnership teams, GP's, Dudley and Walsall Mental Health Trust, Manor Hospital, Walsall College, Elected Members to their constituents and those not directly involved in the Board (e.g. community centres and training providers). Over 150 posters and 250 leaflets have been distributed with more being printed.

- The poster was uploaded to the Board's joint twitter page and the LSCB website http://wlscb.org.uk/suspect-it-report-it-stop-it/

- In addition to the multi-agency safeguarding training programme coordinated by the Local Authority, safeguarding awareness training has been delivered to Clean and Green staff working in parks and public spaces, as well as bar staff at the Town Hall. This included safeguarding adult and children awareness training and sexual exploitation information.

- In February 2018, Walsall Healthcare Trust held an awareness raising event for the International Day of Zero Tolerance Against Female Genital Mutilation.

Example of Impact:

Walsall Healthcare Trust held a number of awareness raising activities related to vulnerable service users throughout the year. The aim of the events were:

- to support adults with Dementia, Learning disabilities and also their carers

- promote services available to support the person, carer and agencies across the borough

- promote the fact that adults can live well with dementia

- reduce discrimination against adults with a learning disability

- empower people to keep themselves safe

Various activities took place during June's Learning Disability awareness week including demonstrations of the hospital communication toolkit - giving clinical staff the opportunity to make communication keyrings and pain / mood communication charts. On Thursday 22nd June an array of stands in the hospital atrium showcased the Community Learning Disability Service, with tea and cakes available for visitors. During the day additional entertainment and visitors included players from Walsall FC, the pet service dogs and also a flash mob dance crew from Walsall College who all helped to make the event fun and interactive.

Scheduled work 2018-19

- Work on a comprehensive Comms plan to ensure greater understanding of reach and impact.

- Further work is needed on the Safeguarding Board websites in order to monitor access and activity.

- Work with partners to develop Comms capacity in order to further progress the Walsall plan objectives regarding safeguarding awareness raising and its impact.

- Linking with Comms teams across the partnership to ensure further roll out of key messages.

Priority 3 for 2017-19:

Understand the application of 'thresholds' for vulnerable adults and those with care and support needs

Summary:

- Raising Safeguarding Adult Concerns: Decision Making Support Tool developed
- New Prevention and Early Intervention Guidance to Safeguard Adults at Risk developed
- Audits show inconsistent decision making regarding Section 42 enquiries.

Position:

- A new tool to support practitioners to make decisions about whether a case should be considered a safeguarding concern, was developed by the Policies and Procedures Subgroup (P&P) and ratified by the Board in March 2018.
- New Prevention and Early Intervention Guidance to Safeguard Adults at Risk was developed by the P&P subgroup and ratified at the Board in December 2017.
- Multi agency audits showed that decisions on whether or not to progress a safeguarding concern to Section 42 investigation were showing a developing approach to decision making.
- Further work on embedding the quality assurance framework will enable partners to fully understand this area.

Example of impact:

Level 3 Safeguarding Adults training delivered to GP's by the CCG

Date	Topics Covered	Attendance
March Day session	• Safeguarding Adult, changes since the Care Act 2 • Safeguarding Adults case scenarios and learning from SCR 3+4, SAR A1 and DHR 4+6 Case scenario used around a vulnerable adult who was a victim of Domestic Abuse from her brother. • Discussion was had around the learning • Mental Capacity Act 2005 and DoLS	11 GPs and 7 ANPs
12th July 2017	• Walsall College, delivered an interesting; thought provoking presentation describing what Walsall College have and are doing to safeguard the students and staff at the college. They covered issues such as Child Sexual Exploitation (CSE), Drugs miss use and how they use the facility of a Councillor. • DNACPR • Presentation on audit work around DNACPR. • Safeguarding Adults update. • Walsall CCG's annual report and the work we have done over the last year. • Domestic Abuse "IRIS" project • LeDeR • An introduction to the new Learning Disabilities Mortality Review programme (LeDeR), identifying what impact this may have on Practices.	40 GPs
September 2018	• Safeguarding training level 3	Pinfold, Beechdale HC and Little London 60 Practice Nurses and GPs 12 non clinical staff
Feb 2018	• Prevent WRAP 3 • This was a session with NHS England PREVENT Leads Andy Smith and Ian Grundy, who both have a vast knowledge from their background in counter termism	70 GPs 13 Practice Nurses.
March 2018	• Prevent WRAP 3 • This was a session with NHS England PREVENT Leads Andy Smith and Ian Grundy, who both have a vast knowledge from their background in counter termism	10 GPs 5 Primary care staff.

The sessions all evaluated well with feedback indicating that learning had been gained.

The table below shows the number of staff that require training with in Practices across Walsall:

Staff Group	Number
G Ps	170
Practice Nurses	122
HCAs / phlebotomy	73
Practice Managers	63

Future audits will hopefully show the impact of this on practice.

Scheduled work 2018-19

- Awareness raising of Decision Making Support Tool.
- Embedding the agreed Quality Assurance Framework.
- Auditing the application of S42 Threshold.

Priority 4 for 2017-19:

Assurance regarding transition arrangements for agreed vulnerable groups between children and adult services

Summary:

- A case review evidenced a gap in planning processes for young people who are approaching 18 and have experienced sexual exploitation.
- Adult Social Care are supporting Children's Services with the MCA/DoLS agenda.

Position:

- Work is taking place between adult service providers and children's services to develop a transition pathway for young people at risk of exploitation.
- Adult Social Care are supporting Children's Services with understanding MCA/DoLS. The DoLS Lead has provided development sessions to the transition team and responds to individual queries from the workforce. Adult Social Care workers assist in completion of Mental Capacity Assessments and identifying whether a young person may be being deprived of their liberty.
- There are no reported applications for a Community DoLS from Children's Services. Adult Social Care workers have led on identifying a DoLS for young person's supported through the transition process into Adult Social Care.
- Given parents can maintain the legal responsibility for parental consent until the age of 18, there will be fewer instances where a DoLS would be applicable for a Child. This would primarily be in such cases that were to progress through the Court of Protection as opposed to the Family Courts system. For example, case where there was no defined body for parental consent.

Impact:

The Care Act 2014 places a duty on the Local Authority to complete transition assessments for children, their carer's and young carers where there is a likely need for care and support when the child turns 18 years of age. Early planning for transition cases and working together can bring significant benefit as demonstrated in the case example below where the Local Authority Children's and Adult's services worked together to support a family where a safeguarding concern had been raised.

Case Example

Brian is an 18 year old young man who lives with his parents and younger siblings. He has severe learning disabilities, autism and complex behavioural needs.

Safeguarding concerns were raised for Brian's younger sibling in 2017 following the school witnessing father physically chastising him. He was subsequently asked to leave the family home and live elsewhere whilst risk assessment work was completed. This had a major impact on Brian as his father acted as his main carer. A care package was put in place by Children's services in order to assist mother in caring for the children and to facilitate supervised contact with father. Father continued visiting the family home (whilst care providers were present) each morning and afternoon to support Brian with getting on and off his school transport, which could be difficult for others to manage.

The adult social worker worked collaboratively with the children's social worker in completing timely assessments of Brian's care needs towards a well planned transition into adult services. They both attended and contributed to core group / CP review meetings, and the issues were eventually resolved. Both parents attended parenting courses where they learned about acceptable means of behaviour management and also the Cygnet parenting course which is targeted at parents caring for an autistic child. Following completion of further risk assessment and repatriation work, father returned to living in the family home.

A reassessment of Brian's care needs was completed after some months, as he became more settled in his behaviour after father's return. The CWD and adults social worker worked collaboratively in identifying an adult respite provision for Brian to access where he could continue on past his 18th birthday, and carers assessments were completed as part of this process to ensure sufficient support was provided to the family through adult care management processes. Brian has now completed several tea visits to the respite provision and is due to have his first overnight stay, and parents feel they have been supported well.

Scheduled work 2018-19:

- Complete the Exploitation transition pathway and monitor impact.

Priority 5 for 2017-19:

Quality assurance of safeguarding practice in **Care Homes and by Care Providers**

Summary:

A 'Quality Summit' was held in January 2018 attended by Walsall Clinical Commissioning Group (CCG), Walsall Healthcare Trust, Public Health, Providers, Carer User Support Partnership Group, Healthwatch, Adult Social Care, Procurement, Finance and Asset management

Position:

Following the Quality Summit, chaired by the Independent Chair of WSAB, there was formation of Action Planning and Data subgroups and agreement of priorities for the subgroups.

A second meeting was held in February 2018. Actions agreed included:-

- strategic oversight group to meet quarterly to provide whole system strategic view
- development of project plan to be reviewed at the quarterly meeting
- development of bids to support Quality Improvement (QI) work
- meeting with Safer Provision And Caring Excellence lead to look at how the QI work being done in the nursing homes can be replicated in the residential sector
- production of quality data dashboard
- review of the physical infrastructure of the homes
- review and develop the offer to providers

Walsall CCG has led the quality improvement approach for Walsall Nursing homes, in collaboration with Local Council colleagues and the Nursing Home sector. WCCG has commissioned and led a range of initiatives to improve quality outcomes for patients in Nursing homes, these continue to include:

- The enhanced service to provide weekly ward rounds with GPs and community matrons helps to provide improved quality of care and avoid unnecessary hospital admissions. Over the time this has been running there has been a significant reduction in carries / admissions to hospital, at times there has been a reduction of over 60% on previous years.
- Quarterly dashboards are requested from all Nursing homes to gain an understanding of their level of activity and gain assurance on the quality of services provided.
- A visit schedule has been developed for announced and unannounced visits. The aim is to review the level of care in each home, identify trends for improvement and share good practice.
- Bi-monthly Nursing Home forum meetings are organised by CCG which provides updates and support for the Homes managers.

Evidence of Impact:

Through the CQC Information Sharing meeting it was identified that there were concerns about a particular Nursing Home including several safeguarding concerns.

CQC did an unannounced visit, identified lots of concerns and rated it inadequate in all 5 areas.

With a change in management and the support from the SPACE (Safer Provision and Caring Excellence) project Quality Improvement Lead and CCG the home has made significant improvements and at the next CQC inspection were judged 'Good' in 2 areas, 'requires improvement' in the other 3 areas and judged to 'require improvement' over all.

Although there is still room for better performance, it was a big improvement in 6 months.

This has improved the care for many vulnerable adults.

Scheduled work 2018-19:

- project plan for the Quality Summit group
- design of quality data dashboard
- membership of operational working groups to be confirmed
- sign off of terms of reference for above

Priority 6 for 2017-19:

Seek assurance regarding the appropriate management of **Deprivation of Liberty Safeguards (DoLS)** which are referred to the Local Authority

Summary:

The Mental Capacity Act 2005 (MCA, 2005) provides a legal framework in relation to decision-making on behalf of people who lack capacity to consent to their care or treatment. The Act sets out five principles intended to protect those individuals who lack capacity and help them to maximise their participation in decision making. The test for capacity is specified in sections 2 and 3 of the MCA, 2005. Within the Act there are a number of specifications that enable care and treatment to be given to the incapacitated person, in their best interests. The two main provisions are under s5 of the Act and the Deprivation of Liberty Safeguards (DoLS), specified in schedule A1, which came into force in 2009 as an amendment of

the MCA and introduced by the Mental Health Act 2007. DoLS is only applicable to those aged 18 or over and should be considered when the care or treatment in a hospital or care home setting is likely to amount to a Deprivation of liberty

As with many other local authorities, Walsall has a high number of DoLS assessments pending.

On average 30 DoLS applications are received each week

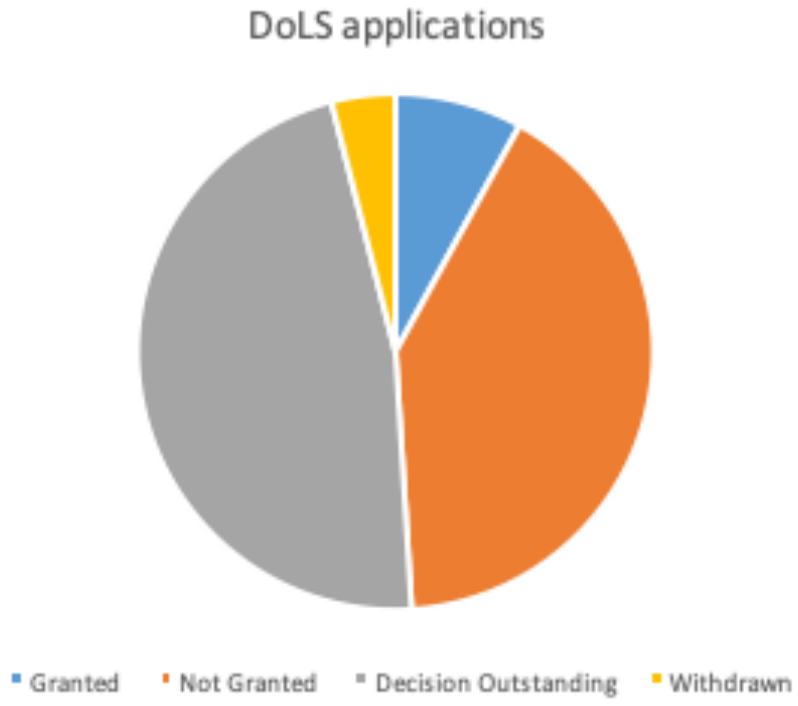
Position:

- From 1st July 2017 the New Adult Social Care (LA) structure came into force.
- The changes saw the end of the dedicated MCA/DoLS Team and dispersal of the BIA (Best Interest Assessor) activity into the locality teams.
- BIA's within locality Teams are all required to undertake at least 1 assessment per week as part of their contracted hours.
- The ASC directorate (LA) has implemented a RAG rating model for allocation of priority cases to manage the demand within available resources.
- DoLS admin screen each referral to clarify the details and assist with prioritising of cases.
- The DoLS Lead and admin are working jointly with the Manor Hospital (Safeguarding Lead) to screen patients referred for a DoLS and assist with prioritising those most in need of a DoLS authorisation.

2017-18

No. of DoLS applications received = 488 (per 100,000 population 18+)

Of the DoLS application received the % granted:



No. of DoLS applications open at the end of the year: 86 (per 100,000 population 18+)

5. Audit and Performance

Multi Agency Audits and Performance Data 2017-18:

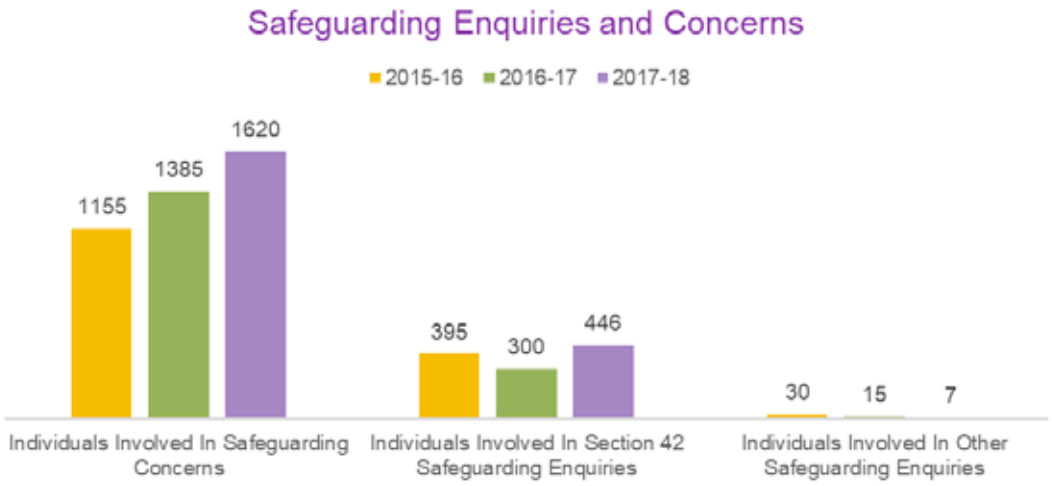
Summary:

The QAP sub group has worked towards collecting and collating single agency data in order to give assurance to Walsall Safeguarding Adults Board around safeguarding practices and activity across Walsall. There is still more work be completed to enable individual agency data streams to be collated into one overarching report to enable there to be a multiagency view of safeguarding across the Borough.

Position:

- The group has found it challenging to identify and gather information
- An agreed Quality Assurance Framework has been developed that the QA&P subgroup will be working through over the coming year.
- Other challenges have included the attendance / engagement of agencies at the sub group and the submission of individual agency data and reports and therefore it hasn't been possible for the group to give assurance that safeguarding Adults procedures and activity are adequate within Walsall.

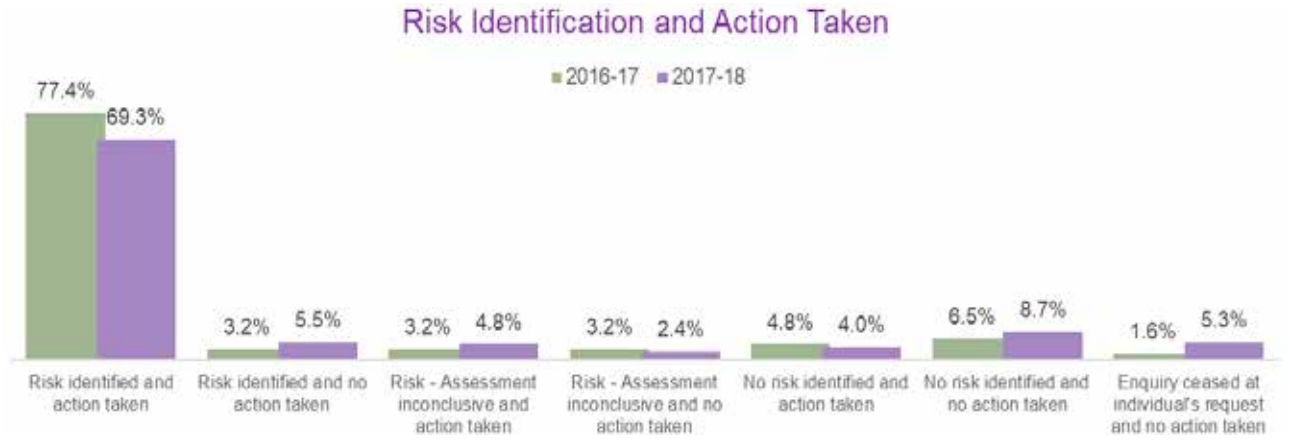
Data



The source of risks was identified as a service provider in 27% of enquiries with over 50% of them being due to acts of Neglect and Acts of Ommission. In 63% of enquiries, the source of risk was the individual known to the person at risk, however, in these cases, the types of risk were more varied with 22% being due to Neglect and Acts of Ommission, 22% being due to Physical Abuse and 19% due to Financial or Material Abuse. In the remaining 10% of enquiries the source of risk was someone unknown to the individual. The proportions in relation to the source of risk have remained broadly similar each year.

The majority section 42 enquiries were in relation to risks that took place in people's own homes, followed by risks that took place in residential care homes – this pattern was the same across all three sources of risk. However, between 2016-17 and 2017-18 there has been a fall in the proportion of risks that have taken place in people's homes by 10 percentage points from 58% to 48%. The proportion of risks that occur in residential care homes has also decreased, however, the proportion that take place in nursing care homes has increased, meaning overall, the proportion of risks taking place in a care home setting has remained at 34%. The proportion of all other risks has increased by between 1.2 and 2.4 percentage points.

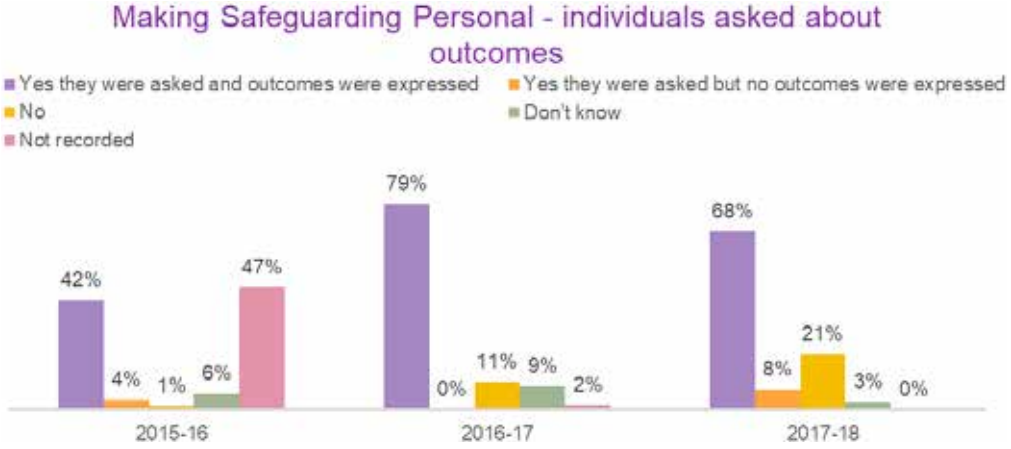
Overall there was a 7.3% reduction in the number of enquiries that resulted in action being taken in 2017-18 compared with the previous year. There was a significant increase in the proportion of enquiries which ceased at the individual request with the proportion of enquiries which ended this way more than trebling. There was also a 2.3 percentage point increase in the number of enquiries where a risk was identified but no action was taken.



Positively, the risk identified was reduced or removed in 86.3% of cases where action was taken, with the proportion of cases where the risk was removed entirely increasing by 4.3% percentage points. However, there was also an increase in the proportion of cases where the risk remained.

Making Safeguarding Personal

In 2017-18 there was a reduction in both the proportion of people who were asked what their desired outcomes were and in the proportion that expressed an outcome when asked. There was a 10 percentage point increase in the proportion of people that were not asked what their desired outcomes were.



Where people did express a desired outcome, the outcome was achieved or partially achieved in almost 95% of cases. Although a slight reduction on the previous year, this is still a positive result.

Multi Agency Audits

A Multi Agency Audit Group aims to meet bi-monthly (members include Adult Social Care, CCG, DWMHT, Walsall Healthcare Trust). During 2017-18, 12 cases were audited. Findings included:

- There was some cases with good evidence of MSP, however this was not sufficiently robust in all cases reviewed .
- Mental Capacity was not fully considered/documented in some cases
- Recording in some cases required improvement
- A developing robust approach for decisions to progress to a section 42 investigation was evidenced
- Some evidence of good, timely screening for safeguarding concerns and engagement with the service user and agencies where appropriate.

Good practice identified:

- Use of interpreters for non-English speaking service users
- Use of case meetings to address other issues in addition to safeguarding concerns
- Liaison between agencies e.g. Welfare Rights, housing

Multi agency action plans were not developed in response to these audits, but this will be an area of development for 2018-19.

Scheduled work 2018-19:

- A new Quality Assurance Framework adopted by the subgroup and Board will be implemented in 2018-19. This will see a quarterly audit programme which will audit safeguarding cases but also undertake thematic 'deep dives'.
- Dedicated Quality Assurance Officer post within the WSAB business unit will help to drive forward the work of the QA&P subgroup.

6. Reviews

Safeguarding Adult Reviews (SAR) and Learning Reviews 2017-18:

Summary:

The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

The overall purpose of a Safeguarding Adult Review is to promote learning and improve practice, not to re-investigate or to apportion blame. The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice issues
- how to improve local inter-agency practice
- service improvement or development needs for one or more service or agency.

Lessons learnt are shared to maximise the opportunity to better safeguard adults with care and support needs, who are or may be at risk of abuse or neglect. The Care Act 2014 requires that lessons learnt are published in the Annual Report following the conclusion of the review.

The WSAB exercises it duties above through a SAR Subgroup (see structure chart – appendix 1).

Position:

- 1 SAR (SAR1) a final draft of the report was agreed by the SAR subgroup during the reporting period.
- 1 SAR (SAR2) was agreed and commenced in March 2018.
- There were 2 referrals which were considered by the subgroup and WSAB Chair not to meet the criteria for a SAR.
- 1 Learning review was revisited to ensure that all the learning had been sufficiently drawn from the incident and to support the family in answering questions regarding the death of their relative.
- A briefing session was held in January 2018 to share lessons learnt with practitioners.
  40 practitioners attended from adult social care, the hospital trust and a GP's surgery.

Themes and Learning:

- The need for the LA to have clear processes and procedures for whole home (nursing / residential / learning disability) investigations.
- The need for a single recording system / repository to collate concerns regarding homes.
- Improved record keeping required by practitioners in Adult Social Care.
- The need for local quality monitoring processes (in addition to CQC inspections) for Learning Disability homes.
- The need for timely and thorough responses to safeguarding referrals.

Good Practice included:

- proactive information sharing between the police, CQC and funding authorities,
- escalation of concerns to senior managers.
- Information sharing meetings are now being held bi monthly between Walsall MBC and the CQC

Scheduled work 2018-19:

- Complete SAR 2 and publish.
- Disseminate lessons learnt (event booked October 2018).
- Amalgamate the SAR and Children's Serious Case Review subgroups.
- Develop a single operating process for the combined subgroup.

7. Key Messages: West Midlands Fire Service/ Walsall Council / Quality and Adult Safeguarding Lead (CCG)/ West Midlands Ambulance Service

West Midlands Fire Service activity 2017-18:

West Midlands Fire Service Data return to Safeguarding Boards

The data submission is part of the Regional Emergency Services Adult meeting agreement. This data covers the whole of the West Midlands region.

WMFS Serious Incident Review Information

	Gender		Result of Incident		Age					Tenure			Occupancy
	M	F	Injury	Fatal	4-24	25-44	45-64	65-80	80+	Owner	Rented	Not known	Living alone
Qtr 1	2	1	1	2	0	0	1	1	0	2	0	1	3
Qtr 2	2	0	0	2	0	0	2	0	0	1	1	0	2
½ year Total	4	1	1	4	0	0	3	1	1	3	1	1	5
Qtr 3	3	4	4	2	0	2	2	0	2	3	3	0	5
Qtr 4	1	3	3	2	3	0	1	0	1	1	3	1	3
Year to date Total	8	8	8	8	3	2	6	1	4	7	7	2	13

	Suspected Cause						Circumstances							Smoke Alarm		
	Smoking	Electrical	Too close to heat source	Deliberate	Cooking	Naked Flame	Care Package in place	Alcohol factor	Known to mental health	Known to social care teams	Known dementia diagnosis	Mobility /disability issue	Faulty appliance	Y	N	Not known
Qtr 1	1	1	0	0	1	0	2	1	0	0	0	0	0	2	1	0
Qtr 2	1	1	0	0	0	0	0	1	1	0	0	0	0	1	1	0
½ year Total	2	2	0	0	1	0	2	2	1	0	0	0	0	3	2	0
Qtr 3	1	1	1	0	2	1	0	3	1	0	0	1	1	4	2	0
Qtr 4	2	0	1	1	1	0	2	0	1	1	1	0	0	2	2	1
Year to date Total	5	3	2	1	4	1	4	5	3	1	1	1	1	9	6	1

The above tables shows the summary data available from WMFS Accidental incidents that have resulted in a Serious Incident Review as at the end of Quarter 4 2017/18.

In Brief

Since the beginning of the financial year to the end of Quarter 4 there have been a total of 16 injuries or fatalities, of which 8 were male and 8 were female with 13 living alone. There was no difference between owner occupied or rented accommodation with 7 people in each category.

The age demographic indicates that they are still predominantly within the 45- 64-year age range with Alcohol being the single highest circumstances of the injury or fatality. The age range is lower than the norm – which is usually in the older age ranges of 65+, but this is dependent on other factors ie. disabilities, mobility and lifestyle choices.

Of the 16 people involved 8 were fatalities (an increase of 2 from Quarter 3) and 8 were injuries (an increase of 3 in the quarter).

The suspected causes of the fires involved were smoking at 5 people, and cooking at 4 and in 50% of the people involved the Smoke Alarm was activated during the incident.

Any learning outcomes, including trends, from a Serious Incident Review will be fed back directly to the partner concerned and to the respective Safeguarding Adult Review (SAR) group.

In the financial year 2017/18 there was a marked decrease of both fatalities (56%) and injuries (38%). The number of incidents where the person lived alone increased from 68% to 81% whilst the accommodation tenure was the same for both rented and owner occupier at 43% which was an increase for rented accommodation from 29% in 2016/17 – which was noted as being against the norm – and a slight decrease for owner occupier from 54% in 2016/17.

WMFS Safe and Well Checks Competed as at end of Quarter 4 2017/18

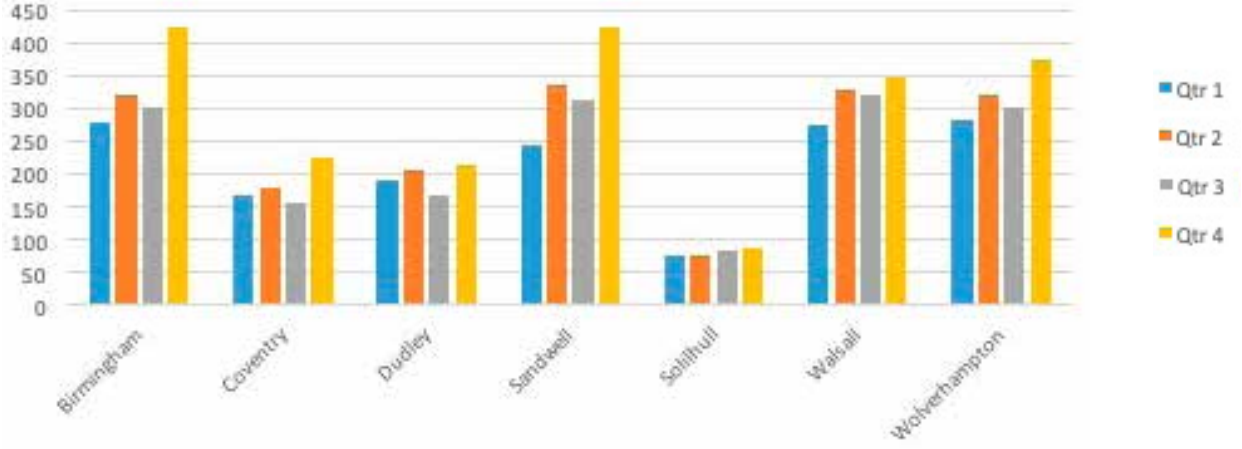
WMFS free 'Safe and Well' visits are carried out by firefighters and have helped to protect thousands of people in the West Midlands from the risk of fire in their home.

The visits have built on what used to be called Home Safety Checks, and include advice to help people improve their health and wellbeing – with the ultimate goal of reducing their risk from fire.

They assess the physical risks of fire in a home, but now also look at health, social and lifestyle factors. There can be clear links between these and a person's vulnerability to fire.

Local Authority Area	Qtr 1	Qtr 1 per 100,000 population	Qtr 2	Qtr 2 per 100,000 population	Qtr 3	Qtr 3 per 100,000 population	Qtr 4	Qtr 4 per 100,000 population
Birmingham	3137	279	3594	320	3392	302	4765	424
Coventry	596	169	633	179	544	154	788	223
Dudley	607	191	648	204	537	169	680	214
Sandwell	789	244	1080	335	1007	312	1368	424
Solihull	159	75	159	75	179	85	180	85
Walsall	763	274	919	330	897	322	962	345
Wolverhampton	720	281	819	319	775	302	961	375

Safe and Well Checks per 100,000 population by quarter



The table above gives the actual number of Safe and Well Checks that have been completed, by Local Authority Area, Apr to Mar 2017. A figure has also been calculated to give the number per 100,000 of the population to enable a direct comparison to be made, this figure has also be put into chart form. (Population figures were taken from Office of National Statistics data 2016).

The number of checks completed will depend upon the number of requests, referrals received and the demographic profile of the area.

The Brigade completed a total of 31,576 Safe and Wells in 2017/18 of which 17,539 were over 65+ (56%) and 19,761 had a form of disability (63%)

Referrals from Partner agencies resulted in a total of 15,882 Safe and Wells of which 9,253 (61%) were for over 65s and 10,455 (66%) had a form of disability.

Using the information obtained at the Safe and Well check the table specifically indicates the number of times Mental Health issues have been indicated. The table also shows the number per 100,000 of the population and the percentage of the total number of Safe and Well Checks completed.

Mental Health issues indicated from the Safe and Well Visit

Local Authority Area	Number indicated	Number per 100,000 population	% of S & W visits
Birmingham	440	39	13.0
Coventry	79	22	14.5
Dudley	49	15	9.1
Sandwell	54	17	5.4
Solihull	14	7	7.8
Walsall	97	35	10.8
Wolverhampton	101	39	13.0

Quality and Adult Safeguarding Lead (CCG) activity 2017-18:

Summary:
Performance and Assurance

The effectiveness of the safeguarding system is assured and regulated by a number of bodies and mechanisms. These include:

- Provider internal assurance processes and Board accountability
- The Adult Safeguarding Board
- External regulation and inspection - CQC
- Effective commissioning, procurement and contract monitoring arrangements.

All provider services, now including every General Practice, are required to comply with the Care Quality Commission Essential Standards for Quality and Safety which include safeguarding standards (Standard 7).

Walsall CCG performance manages each provider organisation via formal contract review meetings led at senior level. In addition the following arrangements have been developed to further strengthen the CCG's assurance processes:

- Strengthening of the Safeguarding Assurance Framework for large providers within contracts.
- Introduction of Safeguarding Frameworks for smaller providers within contracts.
- A programme of unannounced and announced assurance visits for providers and Nursing Homes.

Systematic reviews of serious untoward incidents have been strengthened and reviews taken place where required.

Evidence of Impact:
Domestic Abuse – IRIS project

Walsall CCG are currently work on rolling out the IRIS (Identification and Referral to Improve Safety) Project with Primary Care GP practices and we are looking to join with our other partners to develop it on an STP footprint and updates will be available over the year to come.

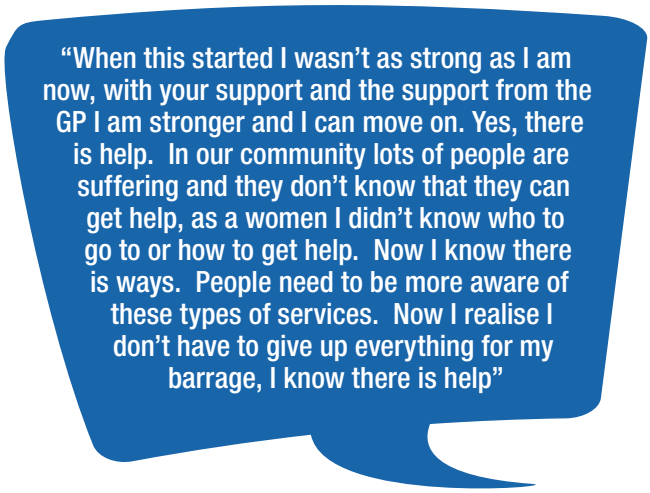
http://www.irisdomesticviolence.org.uk/iris/

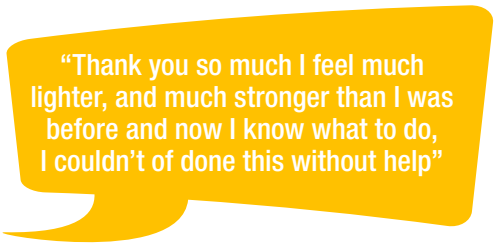
The project has been running since August 2017 with one advocate covering 25 practices and in that time the number of safeguarding referrals made by GP practices has risen from only 4 in 2016 to 50 in the first 7 months of the project starting. The CCG has secured funding to double the number of Advocates for the IRIS project (to two) and to run for an extended time until end March 2019 which will cover most practices and the walk in centre in Walsall.

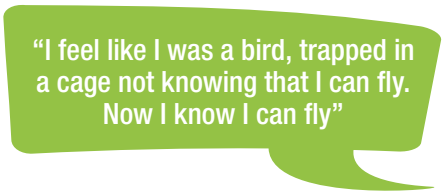
In total, 35 D/A referrals were made by GP's following roll out of the IRIS project, compared to 4 the previous year.

Feedback from clients who accessed Black Country Women's Aid as a result of the IRIS project:

Outcome	Improvement recorded
How do you feel about your overall situation?	83.33% improved
How frightened do you now feel?	60% improved
How is your safety at home and / work?	83.33% improved
How is your emotional and physical wellbeing?	33.33% improved
How is your safety at child contact visits / school?	50% improved
How is your confidence and self-esteem?	33%% improved
How is your ability to cope?	66.66% improved
How is your access to social networks / support?	50% improved
How is your relationship with your children?	50% improved
How is your children's wellbeing?	50% improved
How is your children's safety?	75% improved
Do you know what to do if another incident occurred?	100% would know how to respond if another incident occurred







Mental Capacity

Walsall CCG was lead commissioner for the Black Country MCA project has now come to an end but aimed to improve compliance with the Act. It was originally commissioned for a 12 months, funded by Dudley, Walsall and Wolverhampton CCGs, however the project was able to run for another 6 months with the original funding and each CCG found more funding to continue it into 2017-18.

The project supported health teams with the embedding the Mental Capacity Act across the boroughs, raised public awareness of the Act and how it can benefit them. Resources have been developed in order to inform staff about the Act and guide practice. Information factsheets have been developed which include:

- An overview of the MCA
- Guiding principles
- Assessing capacity
- Decision making under MCA
- LPAs
- ADRTs
- Deputies
- Advocacy
- Preparing for assessments
- Blood tests and the MCA
- Carers role under the Mental Capacity Act
- Public awareness leaflet
- Staff fact toolkits
- Posters
- Resources on MHA/MCA interface
- Guide/factsheet for acute/general hospitals on DoLS
- Training tool/DVD- a DVD on the application of the MCA in action in various clinical settings
- A GP resource pack

Link to resources and DVD:

http://www.dudleyccg.nhs.uk/mental-capacity-act-project/

In the last 12 months is has supported new areas that weren't accessed before, such as Residential homes with dementia registration, Dentists and Pharmacists

Walsall CCG will continue to work closely with providers to support them with complying with the Act and to gain assurance that MCA is embedded in the day to day care provided to all patients.

LeDeR Programme (The Learning Disabilities Mortality Review)

The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. It is being implemented at the time of considerable spotlight on the deaths of patients in the NHS, and the introduction of the national Learning from Deaths framework in England in 2017.

The programme has developed a review process for the deaths of people with learning disabilities. All deaths receive an initial review; those where there are any areas of concern in relation to the care of the person who has died, or if it is felt that further learning could be gained, receive a full multi-agency review of the death. Deaths subject to the current priority review themes (aged 18-24years or from a Black or minority ethnic background) receive multiagency review and expert panel scrutiny. At the completion of the review, an action planning process identifies any service improvements that may be indicated.

There are 2 key priorities for the LeDeR programme across the Black Country:

1. Improving the rate at which reviews are assigned to reviewers and completed
2. Ensuring action is taken to address the recommendations emerging from completed reviews

NHS England expects a significant improvement in the following by December 2018:

- An increase in performance with a target of 90% of reviews completed
- The CCG is prioritising the reduction of the premature mortality of people with a learning disability.
- Monitoring and assurance processes are being introduced to ensure local areas are implementing the LeDeR programme.
- CCG is making satisfactory progress towards the 2 key priorities as above in line with the Key Lines of Enquiry (KLOE).

Walsall CCG has a LeDeR programme recovery action plan in place to address the above. The WSAB will seek assurance that this is progressing.

West Midlands Ambulance Service activity 2017-18:

Summary:

- During 17/18 21,130 adult safeguarding referrals/welfare concerns were completed by WMAS staff. This is a 1.9% decrease from 21,386 in 2016 / 2017. [Across the whole of the West Midlands area]
- During 17/18 23 Prevent referrals were completed by WMAS staff.

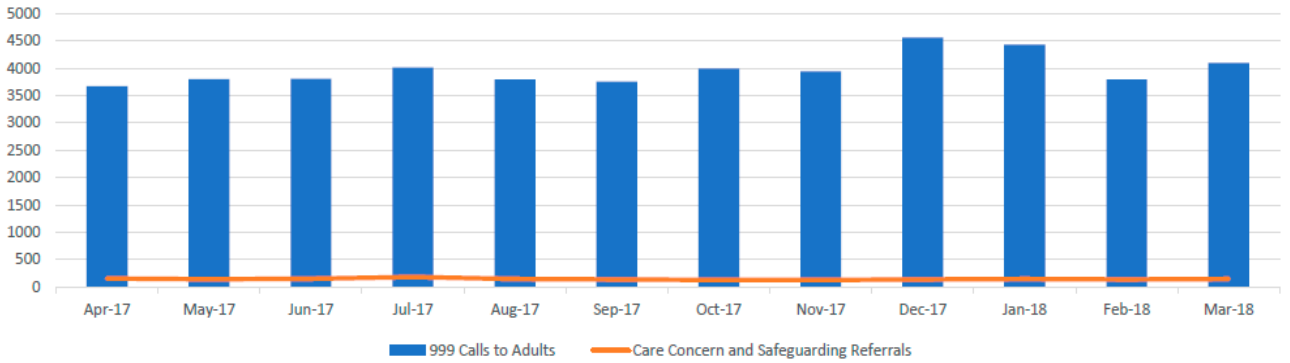
Position:

Adult Safeguarding Referral Activity
2016-2017 and 2017-2018 Comparison

	April	May	June	July	August	September	October	November	December	January	February	March	YTD
2016-2017	1694	1832	1726	1769	1829	1592	1749	1663	1897	2083	1734	1818	21386
2017-2018	1819	1764	1799	1869	1827	1600	1620	1700	1889	1866	1606	1771	21130
%Variance	7%	-4%	4%	6%	0%	1%	-7%	2%	0%	-10%	-7%	-3%	-1.9%

Walsall Data:

	999 Calls to Adults	Care Concern and Safeguarding referrals	% of 999 Calls resulting in a care concern/ safeguarding referral
Apr – 17	3671	149	4.05
May – 17	3802	137	3.60
Jun – 17	3808	147	3.86
Jul – 17	4015	178	4.43
Aug – 17	3795	142	3.74
Sep -17	3753	132	3.51
Oct – 17	3998	126	3.15
Nov – 17	3947	124	3.14
Dec – 17	4563	132	2.89
Jan – 18	4437	140	3.15
Feb – 18	3793	134	3.53
Mar – 18	4097	141	3.44
YTD	46679	1713	3.66%



Evidence of Impact:

A patient transport crew were tasked with collecting a 93-year-old male from his home address and conveying to hospital appointments three times a week. During ongoing conversations, the patient disclosed his grandson was traveling to Syria for some months. He also identified other behaviours that alerted the crew he may be vulnerable and in the process of being radicalised. A prevent referral was made via our safeguarding HUB by the attending staff.

West midlands ambulance service NHS Foundation trust (WMAS) received a 999 call from an elderly female, who reported that she had fallen and was unable to get up from the floor. On arrival, the crew were initially unable to gain access however; when they did manage to gain entry via a key safe, the female disclosed she was unable to exit the property as the doors were locked and she had no means of unlocking them from the inside. It was identified that this patient had care and support needs and was struggling to cope at home and she had had minimal assistance from her son, although he was controlling her finances and she had no means of accessing money. This patient was conveyed to the emergency department due to her injuries with a full handover and documentation of safeguarding concerns. A referral was also made to the local authority.

Walsall Council (LA) activity 2017-18:

Summary: The data return for the Local Authority can be found within the Annual Data report, which should be read in conjunction with the Annual Report.

The Local Authority has restructured its safeguarding response and specifically incorporated responsibility and accountability into the workforce, through revision of Job roles and changes to job descriptions. The directorate is also launching detailed practice guidance for all staff in relation to the Local Authorities safeguarding responsibilities. Furthermore, the Adult Social Care directorate has developed and is implementing a large-scale internal audit process which quality assures safeguarding practice. This is supported by the appointment of a Principal Social Worker - Adults (statutory role), who oversees a small workforce practice development team which includes the Safeguarding Lead Officer, Deprivation of Liberty Safeguards Lead Officer and an Advanced Social Work Practitioner. Together the team have begun to focus on quality assurance and practice development and training for all staff within Adult Social Care.

Senior Management have scheduled regular performance meetings with all managers to review safeguarding practice. This is far wider than practice relating to Section 42 enquiries. Lessons learnt from the audit process, staff supervision, performance meetings and a quality assurance panel that considers all Case reviews, and assessments, has helped inform the directorate's workforce training plan for the coming months. This combination of activities will continue.

Every safeguarding concern that progresses to the enquiry stage, now has an allocated manager overseeing practice to provide both quality assurance and practice development.

Training has also been delivered to the workforce in a number of areas, including the Mental Capacity Act, Managing Safeguarding Enquiries and a regional event was delivered for Sexual Exploitation.

Position

Please see additional Adult Social Care Safeguarding Data Report for further details on safeguarding data and analysis

Evidence of Impact:

Hannah and Joe case study

Background

Hannah and Joe are a married couple who live in a housing association property. Hannah is 72, an insulin dependent Diabetic, has Obsessive Compulsive Disorder but has previously disengaged from Community Mental Health Services. She leaves the property each day and visits local charity shops; bringing a large amount of items into the property. Hannah is also reluctant to dispose of any items and the property has not been cleaned in a significant period of time.

Joe is 84. He is able to mobilise with the aid of a walking frame, although he is at high risk of experiencing falls and also has a hearing impairment. Joe has care and support needs. Following completion of a care and support assessment and support plan, Joe is accessing a personal budget which is used to purchase daily domiciliary support within his own home.

Concerns raised

Representatives from the Housing Association contacted Adult Social Care to express concerns that Hannah is self-neglecting and that the conditions within the property are having a negative impact upon Hannah, Joe and other tenants.

Outcomes

- Hannah and Joe received support from the Fire Service, who provided a home fire safety check and equipment to enable them to remain safer at home. A Vulnerable Persons Officer (VPO) was appointed who completed an assessment and supported Hannah and Joe to ensure that risk within the property was managed appropriately, whilst ensuring that Hannah and Joe retained control over actions taken

- Hannah was re-referred to the Community Mental Health Team and received support from her CPN and Mental Health Support Worker to address concerns relating to her mental health. Her medications were changed, she accessed counselling, had weekly visits from her Support Worker and attended social groups to bolster her support network. Her CPN and Support Worker also supported her to manage the amount of items brought into the property to ensure that an appropriate balance was reached between respecting her right to self-determination with ensuring that the safety and well-being of both parties were maintained.

- Care and support assessments were completed for both Hannah and Joe. A combined support plan was devised to ensure that the individual needs of each person was met, as well as ensuring that Hannah and Joe's right to private and family life were respected and maintained.

- Housing Association appointed a Tenancy Support Officer to assist Hannah and Joe, to ensure that they were supported to maintain their tenancy and also that the safety and well-being of other tenants was maintained

- Hannah and Joe were empowered to take positive actions to improve their own situation

8. Voice of Service Users and Making Safeguarding Personal:

Voice of Service Users 2017-18:

Summary:

Position:

Making Safeguarding Personal

MSP Table for Concluded Section 42 Safeguarding Enquiries	Age Group						
For each enquiry, was the individual or individual's representative asked what their desired outcomes were?	**18-64**	**65-74**	**75-84**	**85-94**	**95+**	**Not Known**	**Total**
Yes they were asked and outcomes were expressed	101	51	70	106	8	0	**336**
Yes they were asked but no outcomes were expressed	18	5	5	9	1	0	**38**
No	33	15	28	26	3	0	**105**
Don't know	7	5	1	2	0	0	**15**
Not recorded	1	0	0	0	0	0	**1**
Of the enquiries recorded as 'Yes', in how many of these cases were the desired outcomes achieved?	**18-64**	**65-74**	**75-84**	**85-94**	**95+**	**Not Known**	**Total**
Fully Achieved	69	34	46	68	6	0	**223**
Partially Achieved	27	15	21	31	1	0	**95**
Not Achieved	5	2	3	7	1	0	**18**

MSP Table for Other Concluded Safeguarding Enquiries	Age Group						
For each enquiry, was the individual or individual's representative asked what their desired outcomes were?	**18-64**	**65-74**	**75-84**	**85-94**	**95+**	**Not Known**	**Total**
Yes they were asked and outcomes were expressed	2	2	1	3	0	0	**8**
Yes they were asked but no outcomes were expressed	0	0	0	1	0	0	**1**
No	1	0	0	1	0	0	**2**
Don't know	0	0	0	0	0	0	**0**
Not recorded	0	0	0	0	0	0	**0**
Of the enquiries recorded as Yes in row 1 of this table, in how many of these cases were the desired outcomes achieved?	**18-64**	**65-74**	**75-84**	**85-94**	**95+**	**Not Known**	**Total**
Fully Achieved	0	2	0	2	0	0	**4**
Partially Achieved	2	0	0	1	0	0	**3**
Not Achieved	0	0	1	0	0	0	**1**

West Midlands Ambulance Service Case Study:

West Midlands ambulance service NHS Foundation trust attended a 79-year-old female with breathing difficulties, she had care and support needs and lived alone with her husband. Due to a medical condition, she was unable to communicate and she had swallowing difficulties. It was disclosed to the crew at the scene that the husband refused to thicken fluids as directed by medical professionals and as a result, she had been admitted into hospital due to aspiration on several occasions. Carers were also concerned that the husband was having sexual intercourse with the patient however she was unable to consent. It was reported that when carers attended, the patient's husband often smelt strongly of intoxicants. All safeguarding concerns were documented and shared with relevant agencies. The patient was convey to the local emergency department and concerns handed over to staff. An enquiry was launched which resulted in the patient being relocated to residential care.

'Voice of the Service User' is an area of development for the Board and will continue to be a priority in 2018-19.

Scheduled work 2018-19:

- Further develop the engagement of service users and mechanisms for their voice to be reflected in Board business.

Healthwatch Walsall

Case Study: Hospital Discharge procedure for patients with Dementia

Healthwatch Walsall contacted PALS (Patient Advice and Liaison Service) at Walsall Manor Hospital, raising concerns about the discharge and lack of communication to relatives of a vulnerable patient. PALS investigated the concerns and found there had been an error in a particular patients discharge process. Not only was an apology made to the relative directly, but it highlighted the importance of better communication between staff at the hospital and that there were opportunities to improve patient safety.

Outcome and impact

A new communication style to highlight vulnerable patients has been developed called "Blue Ribbon Process". All Blue Ribbon patients will have a poster placed above their bed and this will be documented in their notes and updated by the Matron.

Patients are also now escorted to a discharge lounge by staff (either lounge or ward) to ensure patient safety in transfer.

This will mean that vulnerable patients are monitored and placed in a safe environment to be discharged and that relatives, carers or friends are informed of their discharge details.

Comment from relative of patient:

"I am exceedingly happy with the way that Healthwatch Walsall dealt with my concern. They listened to me and kept me informed throughout. I would recommend talking to them when any one else has a concern. I hope that other patients will be safer when being discharged from hospital and their relatives don't have the worry it caused me."

9. Learning and Development

Multi Agency Training 2017-18:

During 2017-2018 the multi-agency training programme was commissioned and funded by the LA.

This was due to a historical lack of capacity within the WSAB business unit. This will be addressed in 2018-19 by additional resources and capacity and a bringing together of the multi agency programmes for children and adults.

Course title 17/18 programme	No. of courses that took place	Delegates attended: LA	Delegates attended : other partners
Safeguarding Adults Awareness training	11	60	81
Safeguarding Adults Risk Management	8	50	42
Safeguarding Adults Refresher training	2	15	9
Safeguarding Adults Key stages of the Safeguarding Response for Local Authority	1	10	4
Safeguarding Adults Key Stages for Responding to a Safeguarding Caused Enquiry	1	6	5
Safeguarding Adults Managing the Safeguarding Response	2	16	8
Mental Capacity Act and Best Interest Decision Making	2	13	8

E-learning course title	Delegates completed: LA	Delegates completed: other partners
Making Safeguarding Personal	11	1
Safeguarding Awareness: children and vulnerable adults	237	71
Sexual Exploitation	43	7

Evaluation of training:

There is no evaluation data available for the multi-agency courses due to capacity within the LA workforce development team.

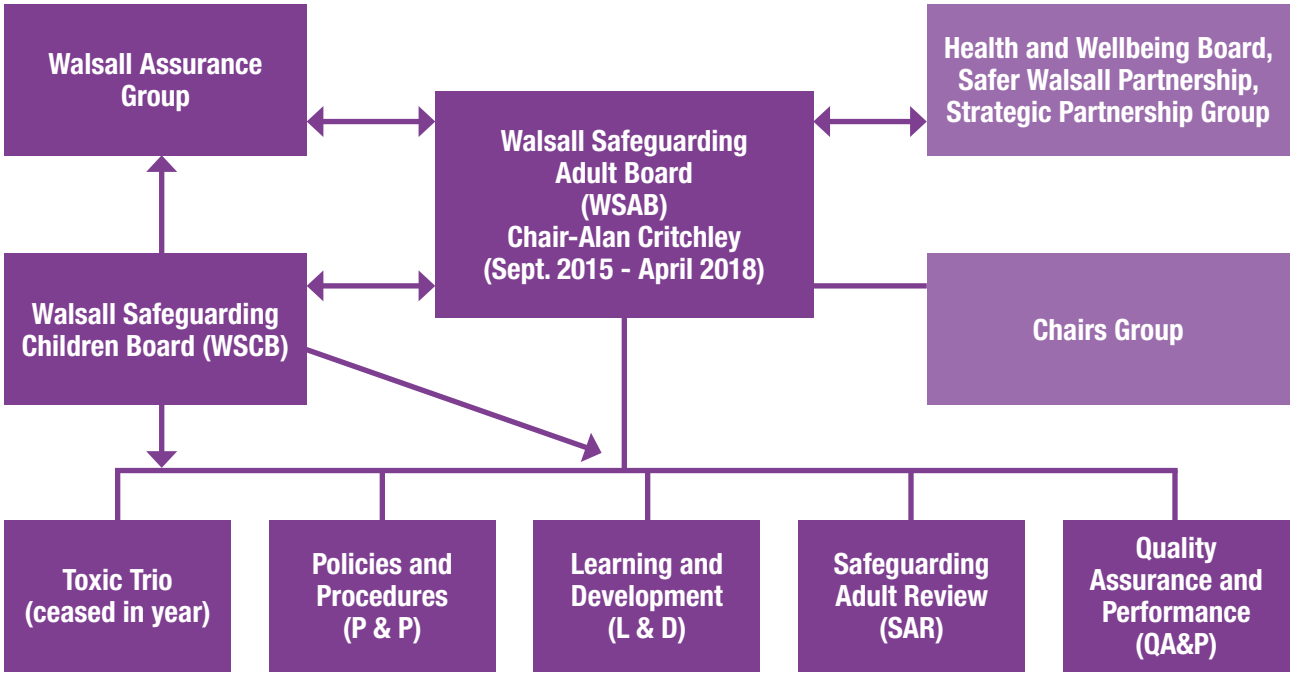
Domestic Abuse Training (IRIS project) for Primary Care:

42 Training sessions have been completed

- 21 practises have received Clinical 1 sessions this quarter
- 11 practises have received Clinical 2 sessions this quarter
- 10 practises have received the None Clinical sessions this quarter

Therefore a total of 74 hours of direct training have been delivered to Walsall GP's, Practices Nurses, Health Care Assistants, Community Midwives, Phlebotomists, and student practitioners such as student doctors and student midwives.

Appendix 1: Board Structure



Sub Group Chairs:

Toxic Trio – (when subgroup in operation) David Haley, Director of Children's Services

Policies and Procedures – Diane Rhoden, Corporate Senior Nurse, Quality and Safeguarding, Walsall Healthcare Hospital Trust

Learning and Development – Jayne Holt, Assistant Principal, Walsall College

Safeguarding Adult Review – Martin Thom, Assistant Director, Children's Services Social Care / Alan Critchley, Independent Chair

Quality Assurance and Performance – Andrew Colson, Quality, Adult Safeguarding Lead, CCG

Appendix 2: Walsall Safeguarding Adult Board

Meeting Attendance April 2017-March 2018

ORGANISATION	Apr 17	June 17	Sept 17	Dec 17	Mar 18	Total (%)
Independent Chair	✓	✓	✓	✓	✓	100%
Lead Member/Councillor	×	×	×	×	✓	20%
WSAB Business Unit	✓	✓	✓	✓	✓	100%
Clinical Commissioning Group	✓	✓	✓	✓	✓	100%
Walsall Healthcare NHS Trust	✓	✓	✓	✓	✓	100%
Walsall College	×	✓	✓	✓	✓	80%
West Midlands Police	✓	✓	✓	✓	×	80%
National Probation Service	✓	✓	✓	✓	×	80%
West Midlands Fire Service	✓	×	✓	✓	×	60%
Lay Member	✓	✓	✓	✓	✓	100%
Walsall Council, Public Health	✓	×	✓	✓	×	60%
Dudley & Walsall Mental Health Partnership Trust	✓	✓	✓	×	✓	80%
Walsall Council, Adult Social Care	✓	✓	✓	✓	✓	100%
Housing-whg	✓	×	✓	✓	✓	80%
NHS England	×	×	×	×	×	0%

Appendix 3: Finance

Budget 2017-18:

Funding 17/18	Children's	Adult's	Total
	£	£	£
Walsall Council Contribution	79,457	15,000	94,457
Walsall Council Additional Investment	200,000	0	200,000
NHS Walsall	5,000	5,000	10,000
Probation Services (NPS & CRC)	3,000	1,500	4,500
West Midlands Police	15,322	15,272	30,594
CAFCASS	550	0	550
CCG	25,000	15,000	40,000
CCG Additional (One off)	30,000	0	30,000
Other	319	0	319
	358,648	**51,772**	**410,420**

Costs	£	£	£
Salary Costs	101,150	5,569	106,718
Chair Costs	24,470	24,469	48,939
Agency	67,170		67,170
Consultants Costs	119,950	32,500	152,450
Workforce Development SLA	15,003		15,003
Section 11/157/175 Tool	0		0
Chronolator Tool	790	790	1,580
SCR / SAR	2,275	6,000	8,275
Development Day / Conference	3,968		3,968
Online Child Protection Procedures	7,141		7,141
Other Costs - Catering, IT, Room Hire, Membership Fees etc.	4,139	1,000	5,139
Shortfall in contributions	0	0	0
Additional Income	-7,461	0	-7,461
	346,056	**70,328**	**408,923**

Forecast Outturn Over / (Under)	**-1,497**

- The Safeguarding Board Business Unit services the Children and Adult Safeguarding Boards, therefore the financial resources are managed across both.

- Work has taken place to employ permanent staff to the Board Business Unit. All roles are now recruited too except the QA Officer and Vulnerabilities / CSE Coordinator.

    - Following advertising on WM Jobs for the QA Officer post, which elicited 22 applications and no one who was short-listable, the role was advertised as a secondment and opened up to all board partner agencies. Unfortunately, this also proved unsuccessful. Therefore, the Board Manager is going to explore the possibility of utilising agency staff / consultant whilst another round of advertising take place.

    - The roles which were proposed in the original draft of the business unit structure were graded higher than expected when they were accessed by the LA Pay and Grading team. This has meant there will not be enough resource within the budget to recruit to the vulnerabilities / CSE coordinator role.

- The Workforce Development SLA outlines the costs of multi-agency training (in addition to the Training Officer salary costs). This will increase in 2018-19 due to the merger of the Children and Adults programme.

- 2018-19 will see a significant reduction in the costs for the Online Child Protection Procedures due to a new regional contract.

- Increased funding has been set aside in 18-19 for the high costs expected with the increased number of Children's SCR's already being undertaken.

- 'Additional income' is generated through non-attendance charges for training.

- Additional resources have been allocated in 2018-19 for both Boards for a Conference, Development Day and further development activities to progress Board effectiveness.

- Overall, across both Boards, at the year end, there was an underspend of just under £1500.

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