# Walsall Safeguarding Adult Board

# Annual Report 2018-19

# Executive Summary

## Overview

This report provides an overview of safeguarding activity and, in particular, the nature of safeguarding adult concerns notified to the Local Authority and how these are responded to using the "Making Safeguarding Personal" (MSP) framework. Encouragingly, a greater number of adults are now asked about their desired outcomes in accordance with MSP and a high percentage of adults report their desired outcomes were either fully or partially achieved. A range of partner agencies complete adult safeguarding enquiries and this data provides evidence that MSP is understood and routinely applied in Walsall. The findings of audits conducted by the Safeguarding Adult Board support this view, albeit, the audit samples have been very small.

Neglect, physical abuse and financial abuse are the largest categories of abuse that result in adults with care and support needs being referred to the Local Authority. Just under one quarter of these referrals progress to a safeguarding enquiry. It is hard to draw meaningful comparisons in terms of the conversion rate due to inconsistencies in the way Local Authorities categorise safeguarding enquiry activity. The most recently available national data is that 38% of all safeguarding concerns were converted to an enquiry.

Self-neglect referrals have increased slightly and the need for partner agencies to respond to adults who self-neglect but fall outside of adult safeguarding has been identified.

Work to improve the quality of care in care providers gained greater momentum in the last quarter of 2018-19.

Safeguarding Adult Reviews have identified the need for greater coordination and visibility of suicide prevention awareness and the need to increase awareness of fire safety in the home.

The governance of the response to Domestic Abuse has been agreed as sitting with the Safer Walsall Partnership and the Safeguarding Adult Board, along with the Safeguarding Children Board, has advocated for the production of a Domestic Abuse Strategy to bring pace and purpose to the local response to those affected by domestic abuse. In so doing, it is recognised that there needs to be greater synergy and coordination between the Safeguarding Boards and Safer Walsall Partnership across this as well as other agendas e.g. exploitation, trafficking.

## Conclusions

### How safe are adults in Walsall?

There have been some positive practice improvements.

There is evidence of increased visibility of safeguarding adults agenda as the number of safeguarding concerns that are being raised has increased from 2017-2018.

More adults are being consulted with and asked their desired outcome of the safeguarding concern, this is also balanced with risk enablement.

The numbers of individuals with reduced levels of risk has further improved from last year and the number where risk remained has also reduced showing positive outcomes for adults in Walsall.

However, overall the adult safeguarding agenda requires further partnership accountability and ownership and a reduction in silo working, for example, better use of the Safeguarding Decision Making Tool, understanding referral conversion to Safeguarding Enquiry (appropriate referrals) rates and practice in relation to Caused Enquiries.

There also continues to be delay in making progress on key areas of work:

- Walsall still does not have a Domestic Abuse Strategy or delivery plan. This prevents a single partnership vision from been taken forward.
- The exploitation transitional protocol has been developed but this needs to be effectively embedded.
- Evidencing the impact of work undertaken continues to be a challenge for the partnership and we cannot yet demonstrate we are a learning system. Increased capacity is required to support the delivery of a robust multi agency Practice Improvement programme.
- Ensuring the views adults with care and support needs are sought and used to shape strategy, planning and service delivery needs further development.
- Development of a Quality Dashboard to further monitor quality in care providers is required.
- The Self Neglect Pathway needs to be embedded.

**Priorities for 2019-2020**

**The priorities agreed for next year are:**

<u>Shared (children and adults) Priority:</u>

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

<u>Adult Safeguarding Partnership Priorities 19/20</u>

2. To support the local and professional community to respond to **Self Neglect** in an person centred way
3. Improving the standard of care to Service Users by quality assuring safeguarding practice **in Care Homes and by Care Providers**

# Walsall Safeguarding Adult Board

# Annual Report 2018 – 2019

**Contents**

## 1. Foreword by the independent chair

Welcome to the Walsall Safeguarding Adult Board Annual Report 2018-19.

The Safeguarding Adult Board (SAB) is designed to bring together the range of organisations that deliver or commission services to support adults with care and support needs. In doing so, it aims to:

- Raise awareness of the need to safeguard adults with care and support needs and the risks they face;
- Create a culture of shared accountability for safeguarding adults with care and support needs;
- Understand how well agencies are safeguarding adults with care and support needs and
- Identify ways to improve how adults with care and support needs are safeguarded; including through the review of cases where an adult has died or been seriously abused or neglected.

This report provides an overview of safeguarding activity and, in particular, the nature of safeguarding adult concerns notified to the Local Authority and how these are responded to using the "Making Safeguarding Personal" (MSP) framework. Encouragingly, a greater number of adults are now asked about their desired outcomes in accordance with MSP and a high percentage of adults report their desired outcomes were either fully or partially achieved. A range of partner agencies complete adult safeguarding enquiries and this data provides evidence that MSP is understood and routinely applied in Walsall. The findings of audits conducted by the Safeguarding Adult Board support this view, albeit, the audit samples have been very small.

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Self-neglect referrals have increased slightly and the need for partner agencies to respond to adults who self-neglect but fall outside of adult safeguarding has been identified. Work to improve the quality of care in care providers gained greater momentum in the last quarter of 2018-19 and I welcome these developments. Safeguarding Adult Reviews have identified the need for greater coordination and visibility of suicide prevention awareness and the need to increase awareness of fire safety in the home. The governance of the response to Domestic Abuse has been agreed as sitting with the Safer Walsall Partnership and the Safeguarding Adult Board, along with the Safeguarding Children Board, has advocated for the production of a Domestic Abuse strategy to bring pace and purpose to the local response to those affected by domestic abuse. In so doing, it is recognised that there needs to be greater synergy and coordination between the Safeguarding Boards and Safer Walsall Partnership across this as well as other agendas e.g. exploitation, trafficking.

In my view, the Safeguarding Adult Board ends 2018-19 having made reasonable progress against many of its agreed priorities. However, evidence of impact and/or embedding agreed priorities is not yet apparent across the system. The Safeguarding Adult Board has an important role to play in bringing partner agencies together so they can work collaboratively to deliver their collective accountability to safeguard adults with care and support needs. This should be its focus for 2019-20, coupled with improved engagement with adults with care and support as well as an enhanced learning and development offer for the frontline workforce.

Finally, in whatever role you have played, thank you for your important contribution to the safeguarding adult agenda during 2018-19 and in 2019-20, I would ask that you champion the priorities of the Safeguarding Partnership within your agency or community. These are: self neglect, transition and quality in care homes.

Very best wishes

Liz Murphy

Independent Chair, Walsall Safeguarding Adult Board

## Introduction

During 2018-19 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. Membership of the board is drawn from the statutory safeguarding partners of Walsall Council, West Midlands Police and Walsall Clinical Commissioning Group who fund the board between them with contributions from Walsall Healthcare Trust and Probation. There are also a range of other partners committed to adult safeguarding who attend the Board meetings.

The statutory functions of the SAB are:

- To publish a strategic plan
- To publish an annual report detailing what the SAB has done to achieve it's objectives and implement it's plans
- To conduct Safeguarding Adult Reviews (SARs) in accordance with Section 44 of the Care Act.

This report seeks to outline how partners in Walsall have delivered these functions.

### The Walsall context

- 215,713 adults live in Walsall Council
- 50,159 are aged 65 yrs and over
- Walsall has a diverse population. The number of non-UK born residents in Walsall increased by 3.7% (or 9,900 people) between the 2001 and 2011 censuses
- Walsall's older population (> 65) is expected to increase by 12.4% by 2024 (from the 2011 census).
- The 2015 Index of Multiple Deprivation now ranks Walsall as the 33rd most deprived English local authority (out of 326).
- One in five residents have a limiting health condition: 10.4% are limited a lot, and a further 10.3% limited a little.
- 77.3% of residents say their health is good or very good – lower than the 81.2% nationally – with 7.3% experiencing bad or very bad health (5.6% nationally).

**Evaluation of performance and effectiveness of local safeguarding services**

- Across the year there was a slight increase in the number of safeguarding concerns notified to the Local Authority from 2183 (2017-18) to 2342 (2018-19). An increase of 7.3%
- This related to1,693 individuals.
- The top 3 reasons for concern were Neglect 33%, Physical abuse 18%, and Financial abuse15%.
- Black Country figures are similar to those for Walsall – Neglect (including acts of omission) 36%, Physical abuse 24% and Financial abuse 19%.
- Of the concerns raised in Walsall, 563 (24%) led to a Section 42 enquiry, this is the same as 2017-18 and the same as other Black Country authorities Nationally there are huge variations in the conversion rates of between 4 - 100%.
- This means over 75% of cases referred do not meet the criteria for a statutory enquiry. This needs further work by the partnership to understand why and address the reasons.
- Source of risk: 66% of cases are someone known to the adult, 30% relate to service providers.
  Concerns relating to Self Neglect have increased from 3% in 2017-18 to 4% in 2018-19.

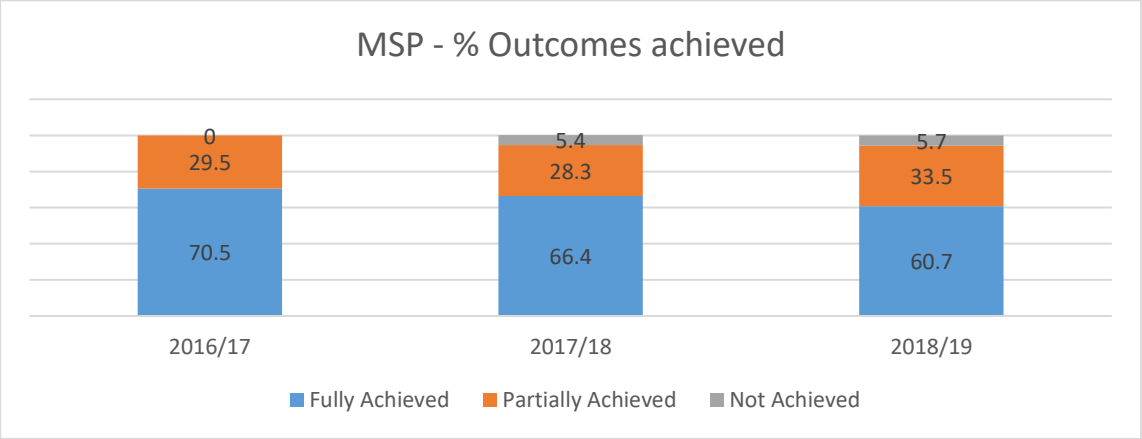
Making Safeguarding Personal[1] (MSP)

- The number of adults who were asked about their desired outcomes (working within MSP) increased from 76% in 2017/18 to 90% in 2018/19.
- However, the percentage of adults who expressed their desired outcomes were fully achieved has declined across the last 3 years

| 2016/17 | 2017/18 | 2018/19 |
|---|---|---|
| 67.62% | 64.30% | 60.7% |

- Yet, those who considered their desired outcomes were *fully* achieved and/or *partially* achieved totalled 94.2%. It should be noted that there are occasions when an adults outcomes cannot be achieved for safety reasons or are unrealistic (e.g. police prosecution or staff dismissal), therefore there will always be a small proportion of outcomes which cannot be realised.

[1] **Making Safeguarding Personal**. A personalised approach that enables **safeguarding** to be done with, not to, people. Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'.




## Safeguarding Plans

- 51 adults had safeguarding plans between Apr-18 and Mar-19.
- This is an increase, compared to 41 in 2017-18.
- 36 Section 42 enquiries led to a plan (6.4% of all enquiries).

## Deprivation of Liberty Safeguards (DoLS)

- In 2018/2019 the Council received 855 DoLS applications, of which 56% were completed by year end.
- All cases are prioritised and 'RAG' rated depending on the urgency for review.
- There were 374 (in year) applications still outstanding at end March 2019, 522 in total.

| | 17/18 | 18/19 |
|---|---|---|
| Total number of applications received in year | 1037 | 855 |
| Granted | 84 | 84 |
| Not granted | 464 | 397 |
| Assessment criteria not met | 5 | 12 |
| Change of circumstances | 289 | 282 |
| Deceased | 134 | 97 |
| Withdrawn/admin error | 36 | 6 |
| Incomplete | 489 | 374 |
| % of DoLs received during year completed by year end | 52.84% | 56.26% |

(see section 6 for more information in relation to DoLS)

## West Midlands Fire Service

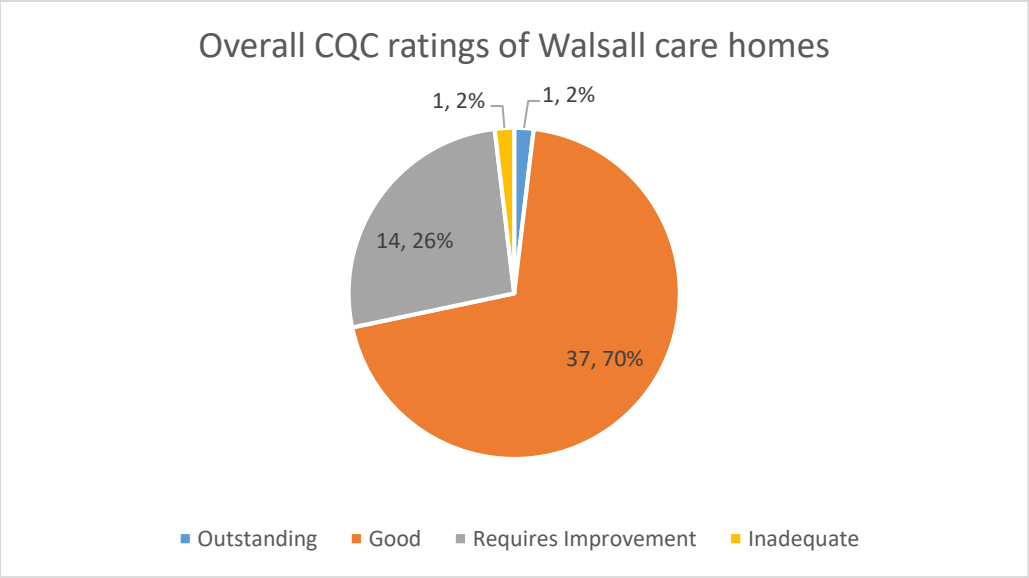
West Midlands Fire Service undertook 4,041 Safe and Well check's in Walsall in 2018-19.

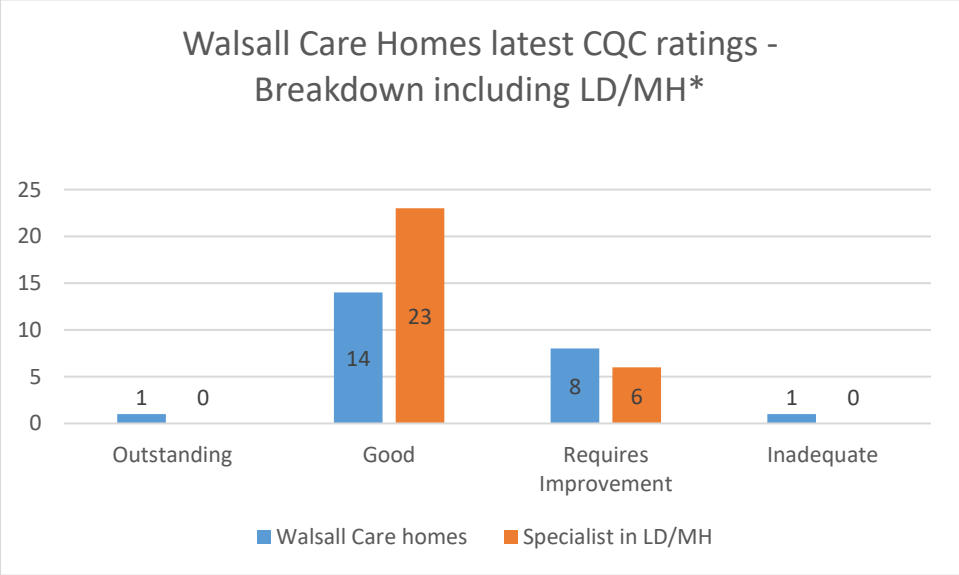
Throughout the West Midlands the Fire Service responded to 25 incidents which it considered 'significant or serious'. These involved serious injury or were fatal.

64% of the individuals lived alone and 76% were over the age of 65.

44% were in receipt of care packages and 52% were known to social care or mental health services.

## Walsall Care Homes




*Learning Disabilities / Mental Health

**Large Scale Enquiries (LSE's)**

- There were 2x LSE's in 2018/9. 1 from previous year (2017-18) that concluded in 2018/19 and 1 LSE that both commenced & concluded in 2018/9. The outcome from both enquiries found concerns with quality issues and both providers were supported to make improvements and therefore remained open.

# Our Priorities

**Priority 1:** 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

**Intention:**

- Ensure there is a quality assurance programme in place which offers the Board robust information about multi-agency safeguarding practice.
- More robust scrutiny and challenge at Sub Group level with exception reporting to the Board
- Clarify the governance of the domestic abuse agenda
- The voice of the service user informing the work of the board

**Implementation:**

- A new independent Chair was appointed and took up the role in April 2018, this has influenced improvements in safeguarding arrangements.
- The WSAB quality assurance process was further developed to ensure partners were reviewing and scrutinising their safeguarding practices, including a revised Multi Agency Audit process and new performance report framework.
- During 2018/2019 there was 1 audit on Self Neglect and two themed audits that took place under the new audit framework, these related to Financial Abuse and Safeguarding Practice in Care Homes. A small sample of 5 cases were audited per theme / quarter.
- Of the latter two themed audits 1 case was graded as outstanding, 4 were good and 5 require improvement.

- Key findings from these audits included:

Good Practice

  - Good multi-agency work and clear risk assessments was identified in some cases
  - Practitioners engaged with the adults at the centre of the safeguarding concerns and achieved meaningful outcomes that reduced the identified financial abuse and neglect.
  - Mental capacity was assessed in all cases but evidenced predominately by Adult Social Care
  - There was evidence of appropriate use of advocates by staff

Area's for Improvement

- A need to improve the understanding of self–neglect across the partnership
- Inconsistent application of the multi-agency decision making support tool by some partners
- Improvements required to sharing outcomes of Police Investigations and Safeguarding Enquiries across the partnership

- Uncertainty in some partners knowing the process and the expectation in relation to Caused Enquiries

- An Annual Assurance Statement (self evaluation by partners of the statutory safeguarding responsibilities) was completed, with analysis and feedback provided at WSAB.
- West Midlands Fire Service (WMFS) have worked with regional SAB's in developing a Care Act Compliance audit tool which will be implemented in June 2019 and will replace the Annual Assurance Statement.
- The SAB effectively challenged the governance of the domestic abuse agenda and sought agreement from the Community Safety Partnership that they would take this forward. The SAB have been advised that Walsall Community Safety Partnership are now leading on a re-write of the Domestic Abuse Strategy.
- Walsall Clinical Commissioning Group (WCCG) continue to run the IRIS (Identification and Referral to Improve Safety) project which provides training to GPs to recognise and report if there are concerns about Domestic Abuse with a patient.
- To represent the voice of the service users, case studies have been presented to WSAB by member agencies. This also creates an opportunity to share good practice.

**Impact:**

- The annual assurance statement audit highlighted a strong sense of partnership engagement at board, however attendance at safeguarding board subgroups is mixed. Senior leader representation at Board is varied. However, there is now agreement for the Chief Nurse for Walsall Healthcare Trust and Public Health to attend Board meetings and a Named GP for Safeguarding has been appointed by the CCG.
  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.
- The quality assurance framework has developed, which is evidenced by the safeguarding board routinely receiving assurance from performance reports and learning from audits.
- 146 adults were referred to the IRIS project during the 2018-19 financial year.
- There continues to be slow progress in the leadership and vision for the domestic abuse agenda as there was no agreed strategy in place by the end of March 2019.

- Although case studies are presented to some board meetings, this has not been embedded as routine practice and requires further development.
- A gap in relation to a Learning Disability Forum and inclusion of LD in service user forums has been identified.

- Further work is now required to ‘close the loop’ on audit findings and use performance data in challenging multi agency front line practice.

**Case Study**

Miss X has a learning disability and was being targeted by unknown persons, who began to live with her, demanding money and refusing to pay it back. Police officers attended the property, and found she was vulnerable and needed some support.

The risk was initially responded to by Police and a subsequent referral made to Adult Social Care.

A safeguarding risk assessment was completed by ASC and a safe and well visit was made within 48 hours. During which Miss X’s desired outcomes were identified in line with Making Safeguarding Personal. Miss X’s capacity was considered in respect of choices/risks (risk enablement) and at her request the safeguarding concern was closed.

Although the safeguarding concern was ‘closed’, wider community networks were utilised to support Miss X and manage ongoing issues. Through multi-agency involvement Miss X appears to be doing well and is refusing contact from the adults alleged to have previously caused harm.

Agencies continue to support Miss X with accessing social networks.

**Priority 2; 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**

**Intention:**

- Work on a comprehensive communication plan to ensure greater understanding of reach and impact
- Further work on the safeguarding board website in order to monitor access and activity
- Work with partners to develop communications capacity in order to further progress the Walsall Plan objective regarding safeguarding awareness raising and its impact

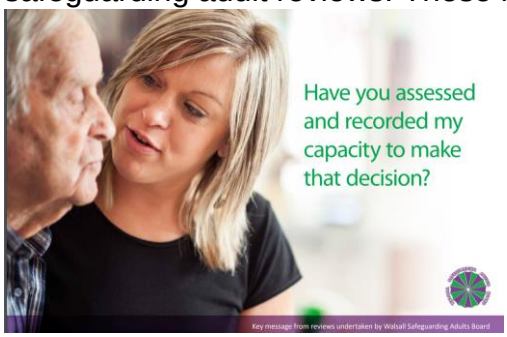
**Implementation**

Community and the public

- The board supported Ann Craft Trust's National Safeguarding Adults Week by sharing its safeguarding posters via Twitter and encouraging the public to speak out if something doesn't feel right.
- In November 2018 the suspect it, report it, stop it, awareness raising image was featured in Walsall's Health and Community Guide. 40,000 copies of the guide were distributed to GP surgeries, health centres and clinics.
- To further increase the visibility of the Safeguarding Adults board, the website was refreshed and updated by the safeguarding business unit with policies, information and key learning from reviews and audits**.**

Professionals

- A joint adult's and children's Communications Plan was developed to monitor all board campaign work. A key focus was to raise the profile of safeguarding adults.
  To support this, campaign posters were developed using key messages from safeguarding adult reviews. These have been distributed widely across the partnership.





- A multi-agency Safeguarding Adult Review (SAR) event was held which enabled the outcomes and learning from previous SAR's to be shared with all attendees.
- Following a recent SAR, staff briefing sessions were delivered jointly by ASC and West Midlands Fire Service (WMFS) to ASC staff to raise awareness in respect of fire safety awareness and what services WMFS can offer. WMFS attended 5 briefing sessions and delivered their presentation to over 170 ASC staff.
- Quarterly board Newsletters were launched across the partnership to raise the profile of safeguarding adults, disseminate key messages from audits and provide updates and news for safeguarding partners.

- The multi-agency training programme included new and modified courses being delivered in response to the learning from Safeguarding Adult reviews/significant incidents, outcomes of audits, feedback from practitioners and review of the regional training offer:

| | | |
|---|---|---|
| Introduction to Stalking and Harassment Training | New | **66 trained** |
| Domestic Abuse Awareness | Modified to cover children and adult | **39 trained** |
| Domestic Abuse Advanced | Modified to children and adult | **51 trained** |
| Deprivation of Liberty Safeguards (DoLS) & Mental Capacity Act (MCA) Awareness | New | **34 Trained** |
| An Understanding of Harmful Practices: Managing the Risk and Reporting – FGM/HBV/Forced Marriage | New | **22 Trained** |
| Safeguarding Children/Young People & Adults at Risk (Part A) | New | **31 Trained** |
| Safeguarding people with Learning Disabilities; Dementia & Mental Health Problems | New | **17 Trained** |

Attendee's included practitioners from Care Homes, Adult Social Care, Economy and Environment (LA) and GP practices.

Partners continue to raise awareness in their respective agencies:

- Adult Social Care (ASC) facilitated 3 development sessions with the Palliative Care Services. This covered safeguarding adults practice, application of MCA and DoLS.
- ASC commissioned training to staff to support the understanding and application of the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) checklist and to also raise awareness regarding domestic abuse
- ASC have also developed and rolled out Safeguarding Practice Guidance to support robust decision making, risk enablement and MSP, alongside an update of their website to ensure practitioners can access all relevant information.

- WMFS have adapted their training following recommendations from Serious incident reviews, staff have delivered 'reducing future deaths' awareness sessions.
- Dudley and Walsall Mental Health Trust continues to build upon the information it provides to its staff, service users and carers on key themes and concerns around safeguarding.
- NHS England have raised the profile of the safeguarding adult's agenda at their National Safeguarding Conference and through their annual report.
- Walsall Healthcare Trust have undertaken activities that have promoted the obsession: Dementia Action Week, Learning disabilities awareness week and National Safeguarding Adults day.

**Impact**

- Further works needs to be undertaken to understand the impact and visibility of the suite of posters which were produced and distributed.
- Feedback from some of the training included:
    - practitioners reporting a great understanding of how the MCA can be used with the Making Safeguarding Personal principles.
    - an understanding of how to access capacity.
    - a better knowledge of referral pathways for support.
    - being more confident in the legal aspects of domestic abuse, stalking and harassment.
- Practitioners advised they would use this in their daily practice, share their new knowledge with colleagues in team meetings, provide information to service users and develop internal (single agency) learning and development resources.

- In 2018/19 the total number of safeguarding concerns was 2,342 in relation to 1,693 individuals, an increase of 6% from last year, which evidences an increase in safeguarding awareness across the partnership. However there still remains a high percentage of referrals that do not progress to a S42.

- In order to be able to analyse referral data more accurately the QA&P subgroup asked for changes to Mosaic (ASC electronic recording system) to capture the source of referrals. This was completed and data is now available.

- The board increased awareness in the community of safeguarding by supporting National Safeguarding week through twitter, this led directly to a member of the public coming forward to raise a concern about an adult they knew.

- It is recognised that more work needs to be done to further promote the citizen and service user voice in service review and planning. Looking forward to 2019/20, on behalf of the partnership Walsall CCG are leading on an engagement strategy for Adults ( including those with care and support needs) to assist in improving this dialogue and partnership.

- Whilst it was a positive development that some multi agency training was delivered across the partnership, the numbers remain low in comparison to the size of the workforce. Developing this involvement and the programme itself is a priority for the Learning and Development Subgroup.

- Although the courses have been modified to incorporate a ‘Think Family’ approach, further work is required in respect of delivering a robust and impactful multi agency practice improvement programme linked to locally agreed priorities.

**Priority 3 Understand the application of 'thresholds' for vulnerable adults and those with care and support needs**

**Intention**:

- Awareness raising of the Decision Making Support Tool
- Auditing the application of S42 threshold
- Develop a pathway for vulnerable adults who do not meet the threshold for a safeguarding response and may be self-neglecting

**Implementation:**

- In March 2018 Adult Social Care (ASC) revised the Safeguarding Adults Decision Making Support Tool which was also adopted by the Safeguarding Board for partners to use.
- In 2018-19 Walsall CCG commenced rolling out the multi-agency guidance tool out to Nursing Homes and Primary Care.
- Multi-agency Audits were undertaken during 2018-2019, routinely measuring the application and understanding of S42 and the use of the tool.
- A large scale case audit was completed by ASC, which showed only 48% of cases audited evidenced a clear use of eligibility criteria. A number of initiatives have since been completed during 2018/19 which have evidenced improvements in understanding and application eg. ASC Practice Guidance, L4 safeguarding training delivered to all safeguarding managers, new supervision policy to ensure safeguarding cases are discussed, audits and feedback.
- Development and roll out of the Adult Safeguarding Practice Guidance by ASC provides guidance in respect of legal responsibilities for safeguarding within the Care Act 2014. Improvements in practice are being noted, as described in the point above.
- West Midlands Fire Service safeguarding process includes notifying specified people when safeguarding concerns are raised. Their role is to support the decision-making process for action which may include a referral or internal escalation to a complex needs officer.
- Walsall Healthcare Trust training covered the board's priorities including the Safeguarding Decision Making document which is a key element within Safeguarding Adult's face to face training.
- Multi-agency audit activity highlighted that more work needs to be done across the partnership in supporting adults who are self-neglecting. A key recommendation from this audit included; consideration of developing a self-neglect a pathway to follow with self-neglect cases
- A multi-agency self – neglect pathway was developed to help practitioners identify and respond to adults who may be self-neglecting this was shared at a Multi-agency event on 2nd April 2019, however the required infrastructure

was not in place at this time to support the roll out across the partnership and therefore further work will take place in 2019-20 to embed this.

**Impact:**

- The conversion rate for concerns (referrals) in to a safeguarding enquiry remains fairly static with only a 0.38% increase from 2017/18. Therefore ensuring appropriate safeguarding referrals are made to ASC will be an area that will need to monitored and further understood by the Quality Assurance group and the Learning and Development Subgroup.
- The risk identified was reduced or removed in 90% of cases and enquiries where action was taken increased by 3.7% compared with last year. In addition, there were fewer cases where the risk remained. Risk management / enablement is factored against MSP and for some adults they do not want any risk management.
- A multi-agency audit demonstrated that using the decision making support tool supported a good understanding and application of S42 criteria ~~by ASC staff~~, however it was only evidenced in 2 of 5 cases audited. It is perhaps a sign that there is a lack of partnership ownership for documents such as the Decision Making tool, that it was not used more widely by agencies.
- The multi-agency training does not yet have a course that includes the use and implementation of the Decision Making Tool, alongside other best practice principles such as Making Safeguarding Personal.
- Audit activity and performance data during the year evidenced that the recording of Caused Enquiries[2] was not consistent.
- The self-neglect pathway will be officially launched during 2019-2020 and this work will be overseen by the board communications work.

**Case Study**

Mrs X is an 79 year old woman, who lives independently. She has a number of health and mobility issues. She cannot use her hands and struggles to walk. Initially, her family were staying with her, however during the families stay with Mrs X, they would often ask her for money, be verbally abusive and had pushed her over on occasions. The grandchildren would also be physically abusive towards Mrs X.

A holistic, partnership approach was taken, where meetings took place between Adult services, Children's Services and Police to explore the risks. Working within Making Safeguarding Personal and the Mental Capacity Act (2015), Mrs X had the

[2] Local authorities must make enquiries, or **cause another agency to do so**, whenever abuse or neglect are suspected in relation to an adult and the local authority thinks it necessary to enable it to decide what (if any) action is needed to help and protect the adult.

capacity to decide to take no further action, however all agencies continued to work in partnership to support Mrs X with her desired outcomes to remain at home and not press any charges.  Through effective information sharing and joint working Mrs X recognised that there were concerns in respect of her family and consequently asked them to leave the house, but continued to remain in contact with her, this lowered the risk to Mrs X but enabled her to maintain her family contact in line with her desired outcomes.

**Priority 4 –** Assurance regarding transition arrangements for agreed vulnerable groups between children and adult services.

**Intention:**

- Develop strategic and operational links between adults and children's services in relation to sexual exploitation
- Inclusion of 'See the Adult, See the Child – 'Think Family Approach' and robust transition planning for all partner agencies

**Implementation**

- A transitional exploitation protocol was developed to support Children's and Adult services to ensure there is a robust transition for young people into adult services who are at risk of or are experiencing exploitation and have care and support needs and was to be audited 6 months after approval.
- Street Teams have been commissioned to run a project to support and enable vulnerable young people approaching/experiencing transition into adulthood who have experienced Child Sexual Exploitation (CSE) and are at risk of abuse to understand the risks that they face and how to make changes to improve their lives.
- Adult services now attend CSE and Missing Operational Group (CMOG) which discusses young people who are transitioning into adult services.
- Children's and adults practice with regard to transition cases is continuing to develop with closer working with the children's teams for those children subject to a plan (Child Protection[3] / Child in Need [4]/ Education, Health & Care Plan)[5].
- Direct work and reviews take place before the children's worker ceases their involvement, to support a smooth transition for the young adult and identify any issues at an early point.
- Walsall Healthcare Trust hold initial discussions regarding care and transition of children with a learning disability and Acute Learning Disability liaison nurses attend the transition meetings.
- Walsall CCG have Learning Disabilities and Mental Health teams for both children and adults. The LD adult team has made great progress with managing care for these vulnerable groups. For example supporting a young man where safeguarding concerns identified his mother was preventing him from accessing the care and support he required to move into residential care where he is now recovering and making good progress. And supporting a gentleman whose elderly parents were struggling to continue meeting his

[3] A child protection plan is a multi-agency drawn up by the local authority. It sets out how the child can be kept safe, how things can be made better for the family and what support they will need.

4 A Child in Need plan (CIN) can be produced for a child who has need of extra support for his safety, health and/or development, such as a child who has disabilities.

5 An EHCP plan is a single plan, which covers the education, health and social care needs of a child or young person with special educational needs and/or a disability (SEND).

complex needs The team assisted him to identify and move into supported accommodation, becoming more independent and relieving the day to day worries of his parents who had previously always resisted him moving out of the family home.

- West Midlands Fire Service have a dedicated Children & Young People's Team who provide targeted interventions and education for children, young people and their families. The Junior Fire Safety Tutoring Officers and Complex Needs Officers work with young adults to help them navigate their way into appropriate adult services.
- Dudley and Walsall Mental Health Trust implements and delivers a Trust wide 'Think Family Approach', this helps to ensure that the voices of children, young people and adults are heard and that they have the freedom to be involved in decision making relating to their care and the way in which they move between the services provided.

**Impact**

- Street Teams provided support to 19 service users in transition
- A Multi-Agency Risk and Vulnerability Panel has been established to support those children who are being criminally exploited.
- Although the board have developed an exploitation transitional protocol, further work is required to fully embed this and assess the impact of it.
- There is a gap around the transitions data received by the Board as currently this is not reported or discussed at the Quality Assurance and Performance Group.
- Transitional arrangements for vulnerable groups of young people into adults will be a key priority for the Safeguarding Partnership in 2019-2020
- Auditing transitions cases will be to be an area of focus going forward for the Multi Agency Audit group.
- ASC are supporting Children's Services with understanding MCA/DoIs, with training delivered by the MCA lead to the multi-agency partnership, including Children's Services
- Joint reviews are undertaken between ASC and Children's Services for transition cases before the children's worker is deallocated to support smooth transition arrangements.

**Case Study**

Miss Y is a young woman who had experienced Child Sexual Exploitation (CSE) often going missing and being found with older men. She had been raped by a man who she identified as her 'boyfriend', although he was much older than her. She was referred to the Street Teams Transition Project, aged 17, and was supported through the court process by their qualified Independent Sexual Violence Advocate (ISVA). Alongside supporting Miss Y through the Court process which resulted in a non-molestation order, Miss Y worked with Street Teams to further understand how she had been groomed and abused.

Due to the abuse she had suffered Miss Y had poor mental health, a chaotic lifestyle and was smoking cannabis. Because of this Miss Y's parents were looking after her child but often refused to comply with the contact arrangements in place for Miss Y to see her daughter.

With a lot of support from Street Teams, Mental Health Services, Substance Misuse Services and Housing and liaison with Children's Social Care, over a period of 2 years, Miss Y's determination and hard work means she has now regained full custody of her child. Her self-esteem and confidence has improved dramatically and she has worked with Impact to explore career options and is looking forward to starting work with the elderly.

**Priority 5 Quality Assurance of safeguarding practice in Care Homes and by Care Providers**

**Intention:**

- Develop a Project Plan for the Quality in Care Board
- Design of a quality data dashboard

**Implementation:**

- In 2017-18 a quality summit took place to take a proactive approach to ensuring quality services are commissioned and delivered within the borough. This was a priority for the Safeguarding Board due to a number of Large Scale Enquiries (LSE) being initiated during this time and one home closure.
- Between December 2017 and December 2018 the removal of CQC registration and subsequent closure of a second care home, combined with 3 other homes being under suspension and several homes in the borough having restrictions applied, prompted action to look at improving the quality and capacity of the Care Home market in the borough.
- In 2018-19 this led to the formation of the Quality in Care Board to take a whole system approach to quality in care provision and providing strategic oversight. Learning Disability Care Homes are now included in this Boards agenda following challenge from the WSAB.
- A Large Scale Enquiry guidance document has been developed by ASC.
- Walsall CCG hosted the SPACE (Safer Provision and Caring Excellence) project to increase quality in care Homes.
- Walsall CCG have provided Nursing Homes with tools and training to facilitate quality improvement and leave them in a position to continue the measure after the SPACE project had finished.
- Bi monthly CQC Information sharing meetings continue to be held which are attended by partners. This enables there to be proactive information sharing regarding commissioned services within Walsall.
- A multi-agency audit in quarter 4 considered the safeguarding practice in Care Homes and found that there were some delays in notifying the local authority of safeguarding concerns and also highlighted some issues in practice with caused enquiries (e.g. recording and information sharing).

Key recommendations included:

- Care Homes to improve reporting of safeguarding concerns in a timely manner
- WMP to improve sharing the outcomes of their investigations
- Encourage the use of the ‘Caused Enquiries’ templates when undertaking the safeguarding enquiry.

**Impact**

- A Safeguarding tracker is now in place that enables themes and patterns of concerns to be identified across care homes and supports a preventative/early intervention approach in relation to wider work with providers where needed or escalation to a concerns meeting or LSE. This has enabled there to be a more consistent approach.
- In the time the SPACE Project ran there were two Nursing Homes that were rated Inadequate that are now graded 'Good' and 'Requires Improvement'.
- The development of a Quality in Care dashboard remains underdevelopment to support an evidence based approach to risk stratification, quality improvement activities, and drive quality improvement.
- Further work is taking place across the LA and CCG to create increased capacity in the quality monitoring of commissioned services. 2019-20 will see the introduction of dedicated posts to support this work.

2018-19 CQC ratings

| Latest CQC rating | Walsall Care homes | Specialist in LD/MH | Total |
|---|---|---|---|
| Outstanding | 1 | 0 | 1 |
| Good | 14 | 23 | 37 |
| Requires Improvement | 8 | 6 | 14 |
| Inadequate | 1 | 0 | 1 |
| | 24 | 29 | 53 |

## Priority 6: Seek assurance regarding the appropriate management of Deprivation of Liberty Safeguards (DoLS) which are referred to the Local Authority

**Intention:**

- Ensure sufficient training and education opportunities and resource is available across the partnership to support MCA & DoLS.
- The Board to be kept informed of any upcoming changes to legislation and implications for practice

**Implementation**

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 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 2005 and introduced by the Mental Health Act 2007.

- In 2018/2019 the Council received 855 DoLS applications, of which 56% were completed by year end.
- All cases are prioritised and 'RAG' rated depending on the urgency for review.
- There were 375 (in year) applications still outstanding at end March 2019, 522 in total.
- A small project to reduce the amount of outstanding urgent referrals was undertaken in 2018 and achieved a 30% reduction in the overall amount of un-reviewed referrals.
- It is hard to know how this compares regionally or nationally as there is no comparator data available. For Walsall there was a slight improvement on last years completion rate e.g. 56% DoLS completed in year, compared to 53% the previous year (17-18). However there was also a reduction in referrals in 18-19, therefore the volume of cases to review was less.
- All nursing providers have MCA / DoLS training within the Safeguarding performance framework which is monitored through the monthly CCG Clinical Quality Review meetings.
- A DoLS register has been developed to enable Walsall Healthcare Trust safeguarding team to record applications centrally and monitor timescales of the applications.
- A review tool has been developed and is in place to monitor the welfare of WHT patients whose application exceeds 14 days.
- DoLS administrators (in the LA) screen each referral to clarify the details and assist with prioritising of cases. There is close working between the Local Authority and the acute hospitals.
- Workshops and training continue to be delivered across Adult Social Care, including training for students, newly qualified workers for both children's and adult's directorate, the safeguarding boards and health colleagues at the Clinical Commissioning Group.

- Guidance, toolkits, resources (intranet pages) and training sessions are delivered by Adult Social Care and being reviewed or developed, including a pre-assessment tool for mental capacity decision making to aid front line staff identify when a capacity assessment should take place.
- The Law Commission put forward a proposal for the overhaul of the current regime and in July 2018 Parliament launched the Mental Capacity (Amendment) Bill 2018 to replace DoLS with Liberty Protection Safeguards. It is expected that this amendment to the Act will be introduced into practice no later than October 2020.

**Impact**

- 854 DoLS applications received in year, of those 56% were completed by year end. Of those received, percentage granted was 10% and those incomplete was 44%, compared with 1037 received in 2017/2018 of those 53%% were completed by year end. Of those completed in 2017/2018 the percentage granted was 8%
- A proposal has been developed by ASC to address the back log and manage the demand for incoming referrals and renewals. A further 5 BIA's are undertaking the assessment qualification and are due to graduate in October 2019. Current BIA's are supported via forums, specialist legal updates and training and peer supervision
- Work is underway to look at what the new Liberty Protection Safeguards arrangements will look like and what changes need to be made. Support will be given to the partnership with updates regarding case law and developments that affect frontline practitioners across partner agencies with regard to the proposed changes.

**Case Study**

A DoLS referral was received with a request to undertake a Standard Authorisation for a 72 year old gentleman who came to be resident in a care home following a breakdown in his care arrangements at home as a result of him having a stroke and developing associated cognitive impairment, later diagnosed as having vascular dementia. His wife had developed her own health issues and was unable to continue in her caring role. He was admitted to the care home and it was found by the referrer (the Managing Authority) that the gentleman lacked capacity and was subject to continuous supervision and control within the care home. The wife was consulted with as part of this assessment and also the care records kept at the home were viewed and the care home's representative consulted with to gain their views. The wife found the process very supportive in ensuring that her husband's care and treatment were independently scrutinised and was reassured that he had the legal safeguards in place to ensure he would be supported to stay in the care home.

## Safeguarding Adult Reviews

### What is a safeguarding adult review (SAR)?

The Care Act 2014 introduced statutory safeguarding adults reviews, and mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

The overall purpose of a SAR is to promote learning and improve practice, not to re-investigate or apportion blame.

The objectives include establishing;

- Lessons that can be learnt from how professional and their agencies worked 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

Within the period of this annual report we:

- have completed and published 1 review (SAR 2)
- are currently progressing one review (SAR 3)
- have started to scope a further one review (SAR 4)
- have disseminated the lessons learnt from SAR 1 & SAR 2 during an event in October
- amalgamated the SAR and Children's Serious case review sub group into a 'Practice Review Group'
- Are developing a single operating process for this group

Learning from SAR 2 included:

- Agencies understanding over the appropriate use of a Section 136
- Processes for patients presenting to A&E with mental health issues need to be more robust
- A review of arrangements for out of hours' mental health support including the Triage car availability for people threatening suicide and requiring mental health assessments

To respond to this, a meeting was held with Senior Managers from agencies involved in the review at which Andrew's (SAR 2) mother was in attendance. Key actions were for agencies to review the Mental Health out of hours support and for Public Health to develop a suicide prevention strategy. There remains a lack of clarity regarding pathways to services, in particular crisis services however progress has been made in relation to the development of a Suicide Prevention 'Hub' which will go 'live' in 2019-20. This online

resource is designed to be easily accessible for professionals and the community to source accurate, relevant information on mental health

Including addressing issues such as:

- Crisis Support
- Supporting someone in a crisis
- Coping with Suicidal thoughts
- Medications and
- Carers information and support.

In 2019-20 there will be a focus on clarifying crisis intervention pathways and raising awareness across the professional and local community.

**All SARs are published on our Safeguarding Adult Board webpage and learning for all reviews is shared through the quarterly newsletters**

## Learning Disabilities Mortality Reviews

The Learning Disabilities Mortality Review (LeDeR) programme supports 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.

The persistence of health inequalities between different population groups has been well documented, including the inequalities faced by people with learning disabilities. Today, people with learning disabilities die, on average, 15-20 years sooner than people in the general population.

At the end of this reporting period there have been:

- 6 Reviews Completed
- 12 Allocated
- 8 that require allocating

The most commonly reported learning and recommendations were made in relation to the need for:

- Inter-agency collaboration and communication
- Awareness of the needs of people with learning disabilities
- The understanding and the application of the Mental Capacity Act (MCA).

The most significant challenge to programme delivery has been the timeliness with which mortality reviews have been completed, largely driven by four key factors:

- Large numbers of deaths being notified before full capacity was in place locally to review them
- The low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review
- Trained reviewers having sufficient time away from their other duties to be able to complete a mortality review
- The process not being formally mandated.

- In order to help progress this the SAB has requested that the number of reviewers are monitored via the SAB dataset.

## Conclusions

### How safe are adults in Walsall?

There have been some positive practice improvements.

There is evidence of increased visibility of safeguarding adults agenda as the number of safeguarding concerns that are being raised has increased from 2017-2018.

More adults are being consulted with and asked their desired outcome of the safeguarding concern, this is also balanced with risk enablement.

The numbers of individuals with reduced levels of risk has further improved from last year and the number where risk remained has also reduced showing positive outcomes for adults in Walsall.

However, overall the adult safeguarding agenda requires further partnership accountability and ownership and a reduction in silo working, for example, better use of the Decision Making Support Tool, understanding referral conversion to Safeguarding Enquiry (appropriate referrals) rates and practice in relation to Caused Enquiries.

There also continues to be delay in making progress on key areas of work:

- Walsall still does not have a Domestic Abuse Strategy or delivery plan. This prevents a single partnership vision from been taken forward.
- The exploitation transitional protocol has been developed but this needs to be effectively embedded.
- Evidencing the impact of work undertaken continues to be a challenge for the partnership and we cannot yet demonstrate we are a learning system. Increased capacity is required to support the delivery of a robust multi agency Practice Improvement programme.
- Ensuring the views adults with care and support needs are sought and used to shape strategy, planning and service delivery needs further development.
- Development of a Quality Dashboard to further monitor quality in care providers is required.
- The Self Neglect Pathway needs to be embedded.

**Priorities for 2019-2020**

**The priorities agreed for next year are:**

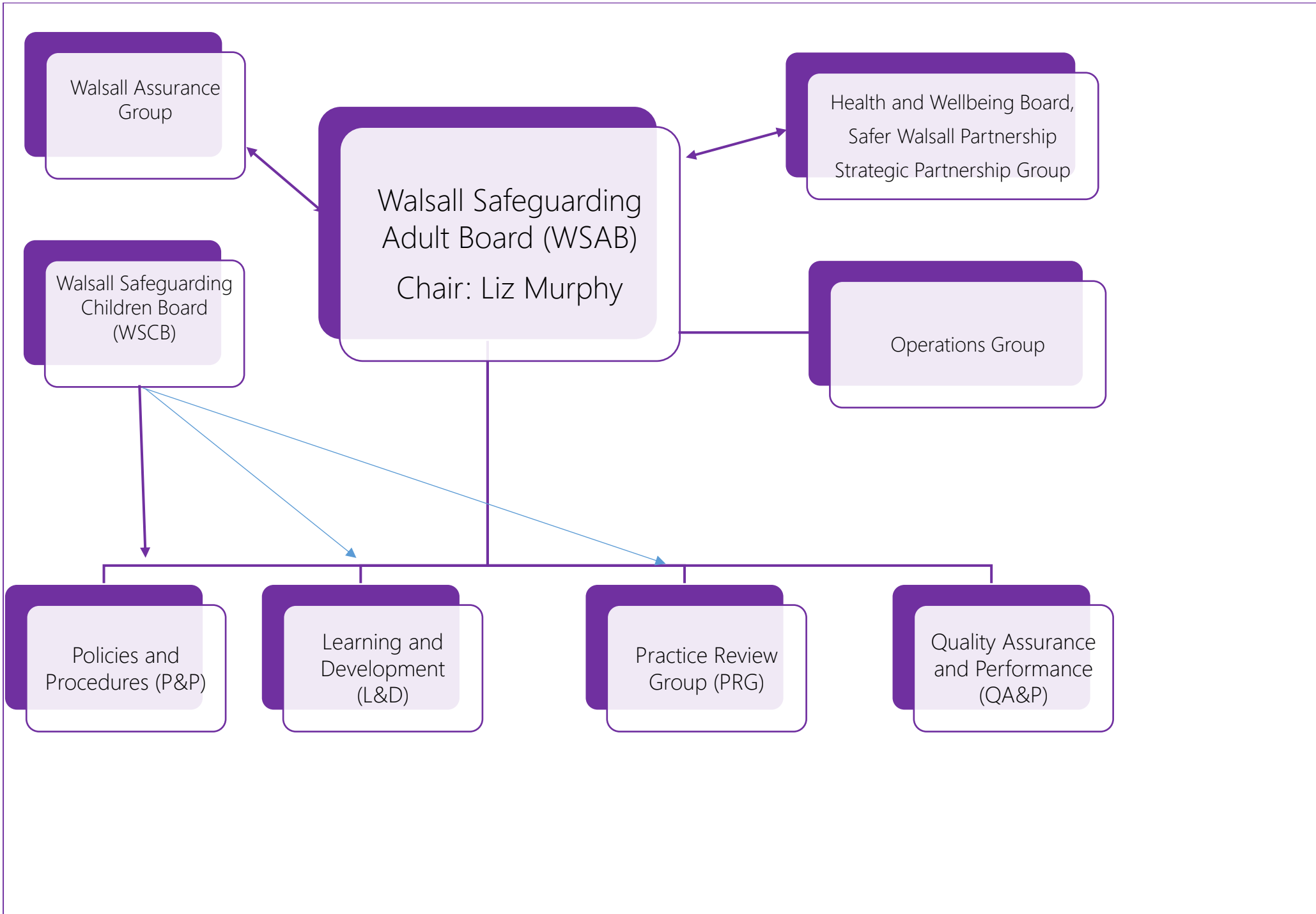
Shared (children and adults) Priority:

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

Adult Safeguarding Partnership Priorities 19/20

2. To support the local and professional community to respond to **Self Neglect** in an person centred way
3. Improving the standard of care to Service Users by quality assuring safeguarding practice **in Care Homes and by Care Providers**

## Appendices


Walsall Assurance Group
Walsall Safeguarding Adult Board (WSAB)
Chair: Liz Murphy
Health and Wellbeing Board, Safer Walsall Partnership Strategic Partnership Group
Walsall Safeguarding Children Board (WSCB)
Operations Group
Policies and Procedures (P&P)
Learning and Development (L&D)
Practice Review Group (PRG)
Quality Assurance and Performance (QA&P)

## Appendices

Appendix 2 - Walsall Safeguarding Adults Board - Meeting attendance April 2018 – March 2019

| Organisation / Member | June 18 | Sept 18 | Dec 18 | Mar 19 | Total (%) |
|---|---|---|---|---|---|
| **Independent Chair** | ✓ | ✓ | ✓ | ✓ | **100%** |
| **Lead Member/Councillor** | ✓ | **Apologies** | ✓ | ✓ | **75%** |
| **WSAB Business Unit** | ✓ | ✓ | ✓ | ✓ | **100%** |
| **Adult Social Care, Walsall Council** | ✓ | ✓ | ✓ | ✓ | **100%** |
| **Clinical Commissioning Group** | ✓ | ✓ | ✓ | ✓ | **100%** |
| **Walsall Healthcare NHS Trust** | ✓ | ✓ | ✓ | ✓ | **100%** |
| **Walsall College** | ✓ | ✓ | **X** | ✓ | **75%** |
| **West Midlands Police** | ✓ | ✓ | ✓ | ✓ | **100%** |
| **National Probation Service** | **x** | **X** | ✓ | ✓ | **50%** |
| **West Midlands Fire Service** | ✓ | **X** | ✓ | ✓ | **75%** |
| **Lay Member** | ✓ | ✓ | ✓ | ✓ | **100%** |
| **Health Watch** | **X** | ✓ | ✓ | ✓ | **75%** |
| **Public Health, Walsall Council** | **X** | **X** | ✓ | **X** | **25%** |
| **Dudley & Walsall Mental Health Partnership Trust** | ✓ | ✓ | **X** | ✓ | **75%** |
| **Black Country Partnership Foundation Trust** | **X** | **X** | ✓ | **X** | **25%** |
| **Housing-whg** | ✓ | ✓ | **X** | ✓ | **75%** |
| **One Walsall** | ✓ | **X** | **X** | **X** | **25%** |

# Appendices

**Budget**

| | BUDGET 2018/19 | | OUTTURN 2018/19 | |
|---|---|---|---|---|
| | Childrens & Adults | Total | Total | Variation |
| **Funding** | | £ | £ | £ |
| Walsall Council Contribution | | (55,633) | (55,633) | 0 |
| Walsall Council Additional Investment | | (200,000) | (200,000) | 0 |
| NHS Walsall | | | (10,000) | 0 |
| Probation Services (NPS & CRC) | | (4,500) | (1,500) | 3,000 |
| West Midlands Police | | (30,594) | (30,594) | 0 |
| CAFCASS | | (550) | (550) | 0 |
| CCG | | (40,000) | (40,000) | 0 |
| CCG Additional (One off) | | 0 | (15,000) | (15,000) |
| Other Training | | (7,146) | (1,080) | 6,066 |
| Other CDOP | | 0 | 0 | 0 |
| | | **(348,423)** | **(354,357)** | **(5,934)** |
| **Costs** | | | | |
| Salary Costs | | 196,565 | 194,129 | (2,436) |
| Chair Costs | | 43,200 | 43,742 | 542 |
| Agency | | 0 | 5,942 | 5,942 |
| Consultants Costs | | 2,750 | 4,000 | 1,250 |
| Workforce Development SLA | | 20,000 | 15,000 | (5,000) |
| Section 11/157/175 Tool | | 3,000 | 0 | (3,000) |
| Chronolator Tool | | 1,580 | 850 | (730) |
| SCR / SAR | | 32,000 | 32,655 | 655 |
| Development Day / Conference | | 16,000 | 0 | (16,000) |
| Development Activities | | 60,000 | 15,316 | (44,684) |
| PHEW - Online Child Protection Procedures | | 686 | 0 | (686) |
| Other Costs - Catering, IT, Room Hire, Membership Fees etc. | | 3,487 | 8,962 | 5,475 |
| | | **379,268** | **320,596** | **(58,672)** |
| Carry forward to 2019-20 | | | **50,000** | 50,000 |
| **Forecast Outturn Over / (Under)** | | **30,845** | **16,239** | **(14,606)** |

## Appendices

New Arrangements:

In September 2019 the Safeguarding Children Board, in partnership with the Safeguarding Adult Board, will launch their new arrangements in line with Working Together to Safeguard Children.

Transitional arrangements will commence in summer 2019 with a view to the new arrangements being ‘live’ in early September.

The partnership arrangements can be found here

The Walsall Safeguarding Partnership has agreed that its shared ambitions for 2019-22 are:

1. Improving our visibility amongst local communities and across the partnership;
2. Developing a stronger culture of working together to keep children, young people and adults at risk safe;
3. Increasing the involvement of children, young people and adults in our work;
4. Developing a confident, knowledgeable and curious workforce who are supported to work together and deliver their safeguarding responsibilities
5. Acting on learning and data to improve the quality of the safeguarding response to children, young people and adults at risk