APPENDIX 2

Herefordshire
Safeguarding
Adults board

Annual Report

2015-2016

Contents

Welcome

Welcome to Herefordshire's Safeguarding Adults Board Annual Report 2015-16, which provides the Board and partner agencies with the opportunity to reflect on their achievements and to consider our plans for the year ahead.

The commitment of Board members and those who work on the supporting sub groups is very positive. There is a culture of genuine inter agency working together with constructive challenge across and between the agencies, the result of which is a strong collaborative inter agency approach to safeguarding adults.

Our three year strategic plan is supported by an annual business plan, against which each sub group is tasked with delivering progress and reporting to the Board accordingly.

The Board has held two development days this year, which have given us the opportunity to reflect on the content of our strategic plan and next year's business plan to ensure they are fit for purpose

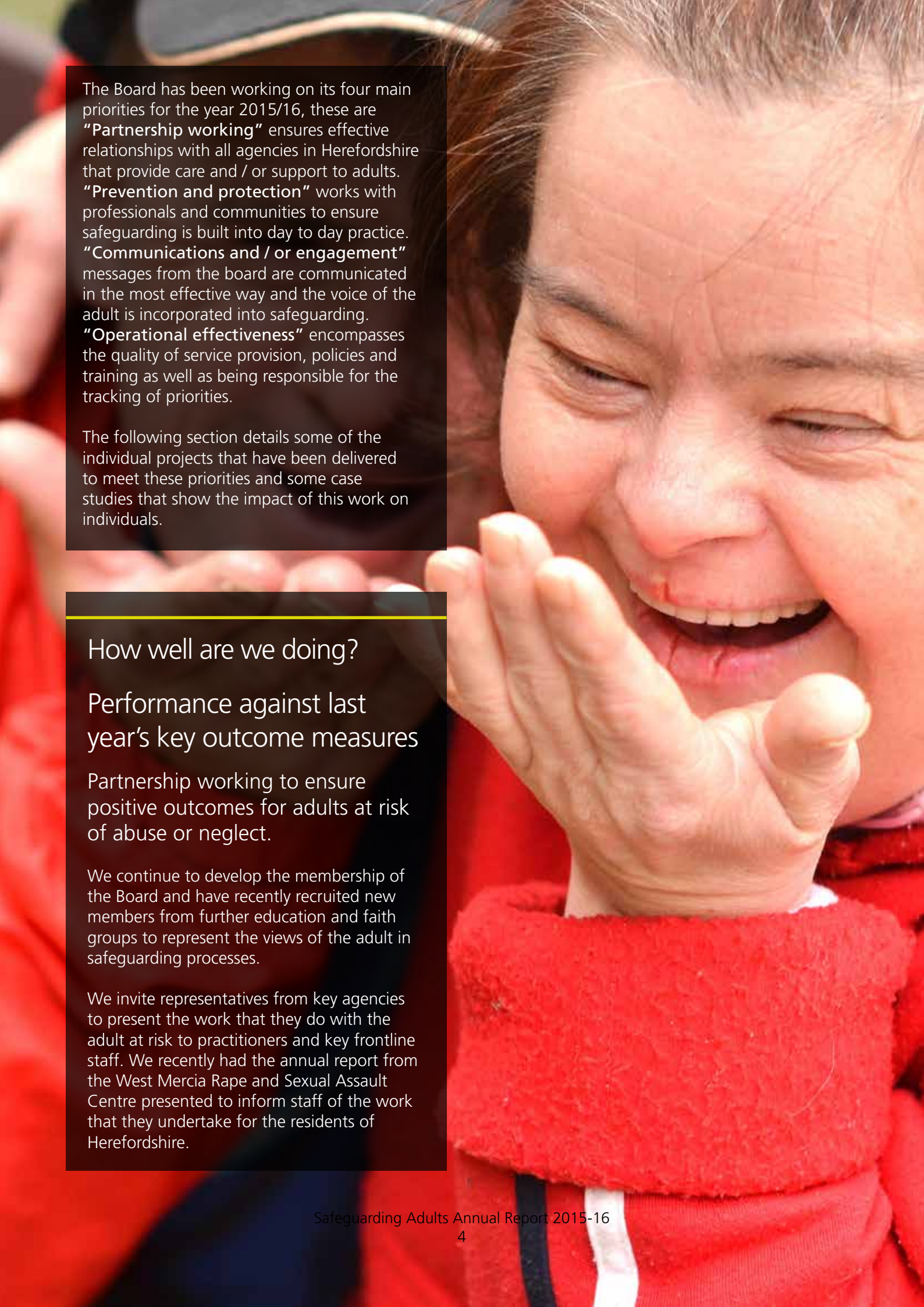
The past year for staff has been a time of change, a need to work on revised policies and procedures, and in particular to focus on making safeguarding personal, that is the process by which we put the adult at the centre of our work. Some adults do choose to live in risky situations. Some of the work the Board does is to ensure staff and the public understand that although much can be done to support adults who are at risk, we also have to respect their right to live as they wish. We cannot insist they follow what might seem sound advice, and we continue to recognise that this will remain a challenge.

We remain committed to working more closely with individuals, their families, friends and carers who have been through the safeguarding system to learn from their experience. We have made some progress in this key area, but more remains to be done during the forthcoming year.

Over the past year, we have done more to prevent neglect and abuse. Welcome, thoughtful and professional contributions have come from all Board members, notably our Faith Groups, Social Housing Providers and the Care Sector, but again there is further work to be done under the preventative agenda.

The work to raise awareness and understanding of the law regarding mental capacity and deprivation of liberty has led to a very significant increase in requests for the assessment of people who may lack capacity to make decisions and where there is a need for a decision to be made on their behalf, or indeed in some way they are being deprived of their liberty. This is not unique to Herefordshire and is reflected nationally, again this remains of significant interest moving forward for the Board.

I hope you find the content of this report interesting and informative, and I ask that you use it to raise awareness within your own organisation. My thanks to all of you who continue to work to support and protect some of our most vulnerable people in Herefordshire.



The Board has been working on its four main priorities for the year 2015/16, these are **"Partnership working"** ensures effective relationships with all agencies in Herefordshire that provide care and / or support to adults. **"Prevention and protection"** works with professionals and communities to ensure safeguarding is built into day to day practice. **"Communications and / or engagement"** messages from the board are communicated in the most effective way and the voice of the adult is incorporated into safeguarding. **"Operational effectiveness"** encompasses the quality of service provision, policies and training as well as being responsible for the tracking of priorities.

The following section details some of the individual projects that have been delivered to meet these priorities and some case studies that show the impact of this work on individuals.

How well are we doing?

Performance against last year's key outcome measures

Partnership working to ensure positive outcomes for adults at risk of abuse or neglect.

We continue to develop the membership of the Board and have recently recruited new members from further education and faith groups to represent the views of the adult in safeguarding processes.

We invite representatives from key agencies to present the work that they do with the adult at risk to practitioners and key frontline staff. We recently had the annual report from the West Mercia Rape and Sexual Assault Centre presented to inform staff of the work that they undertake for the residents of Herefordshire.

How partnership working has helped a resident in Herefordshire

Mrs D came to the attention of trading standards through a neighbour and the local policing team who were concerned that she was being targeted by scammers. A home visit was made and it became clear that Mrs D was being bombarded with mail and phone calls from individuals and business trying to extort money from her. The problem was so bad that she was receiving dozens of letters each day and sometimes up to 20 scam phone calls through the day and night. Her home was filled with catalogues of medicinal products, which had been marketed at her knowing she had existing health problems as a way of preying on her vulnerability. Mrs D was spending up to £400 a month on products, thinking that the scammers were actually trying to help her, when in fact their only interest was in exploiting her.

As an incentive the fraudsters offered her free entry into a non-existent prize draw every time she ordered a product from their catalogue. Guess what happened next? They then wrote telling her she'd won a big cash prize and needed to send a £20 administration fee to process and deliver her winning cheque securely, which she thought was genuine - clearly something needed to be done.

Following long discussions with Mrs D, the biggest issue for her personally was the constant phone calls that she simply couldn't ignore or escape: even with serious mobility problems, she felt she had to answer every call in case it was somebody she knew who was in trouble. Her health was deteriorating rapidly as a result and she couldn't think straight. Trading standards were able to install a sophisticated call blocking device in her home to ensure that the scammers couldn't get through to her, and more importantly the phone wouldn't ring and wake her during the night. She started to relax in her own home again and had time to contemplate her spending. Mrs D soon realised that the amount of money she was spending on the array of worthless products was completely unnecessary and she recognised that she was being financially exploited. A 'scam mail bin' was provided as a way of empowering Mrs D to simply throw away the mail she was receiving, whilst providing trading standards with tangible examples of current scam mailings, which would help protect other consumers.

To date, Mrs D's quality of life has dramatically improved and she has stopped sending thousands of pounds a year to the fraudsters. She no longer feels a prisoner in her own home and has become quite an expert at identifying scam mail.

If you think you know a scam victim then please contact Herefordshire trading standards service on 01432 261761.

Partnership working to ensure best practice is maintained across all agencies

We have been working with other Boards across the region to develop safeguarding policies and procedures to support staff. These policies have been adopted by the Board and shared with providers and all partner agencies. Having one set of policies and procedures across the whole system helps to ensure that all staff understand their safeguarding responsibilities.

Mental Capacity Act and Deprivation of Liberty Safeguards are embedded into practice

A new policy to aid professionals to understand their responsibilities in both of these areas has been agreed and is available on our website.

New guidance has been developed for other interested parties and is available on both the HSAB website and the WISH website (the newly launched Wellbeing Information Service for Herefordshire) www.WISHerefordshire.org

How partnership working has helped a resident in Herefordshire

Miss Jones was 79 years old and lived alone in her own property. Diagnosed with Schizophrenia she was under the care of Mental Health Services. Although she was able to manage her daily needs, she also had the support of carers who visited her at home, but she was often reluctant to engage with the carers, apart from one that she got on well with. Miss Jones had no family who can support or advocate on her behalf but she did have a deputy appointed by the court of protection to manage her finances.

Although Miss Jones' day to day personal care needs were met, she had been assessed as lacking the capacity to look after and maintain her home. Carers had noted the house was in such a bad state of repair it was becoming dangerous to her and her neighbours. Pipes were leaking, part of the ceiling had collapsed, the electricity supply was unsafe and a fire risk. Miss Jones used electric convection heaters for warmth.

Miss Jones refused to allow professionals into her home to address these issues. Due to the concerns about the house the council had approached the Court of Protection which, after consideration, had made a court order giving the council the power to maintain the property on her behalf and in her best interest.

In spite of the court order, Miss Jones continued to be resistive to anyone entering the property to assess what needs to be undertaken. Mental Health Services arranged a best interest meeting with involved professionals to discuss how to progress the situation.

The meeting considered the following options: to remove Miss Jones from the property and place her in care, assess her under the Mental Health Act and detain her to a psychiatric hospital whilst her home is repaired or allow her to remain in her home and try to obtain her agreement to let contractors in.

It was felt that to place Miss Jones into care would cause her great distress and was not necessary as she was, with support, able to look after herself quite well in the community. An admission to hospital would not be appropriate as Miss Jones was mentally stable she did not meet the criteria to be detained under the Mental Health Act. It was agreed that it would be in Miss Jones best interest for the carer she got on well with to talk to her about allowing people to assess the work that needs to be done. Although this may affect the future relationship with the carer it was felt to be the only viable option.

Following the talk with the carer contractors were able to access the property and completed an initial assessment of the work, however Miss Jones was unhappy and threatened to call the Police. A further electrical assessment was needed and this was then conducted by an electrician with the support of the police and a fire officer as Miss Jones respected the authority of the Police.

Making Safeguarding Personal (MSP) is embedded into practice

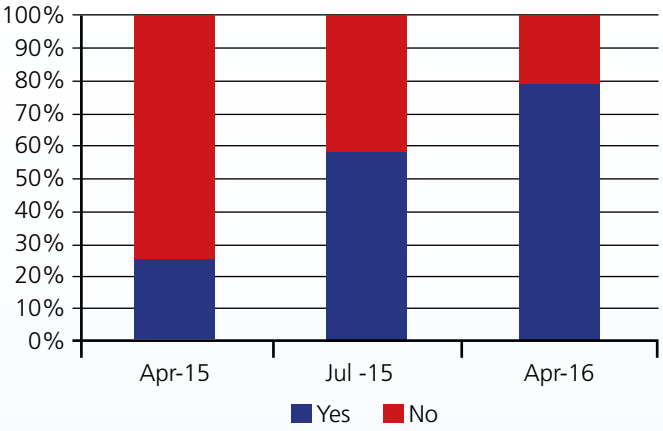
The local authority commenced the implementation of MSP in January 2015. The strategic decision to launch MSP across adult social care within the local authority rather than across the broader partnership was endorsed by the Board.

Front facing adult social care staff were provided with intensive training, and alongside this processes and paperwork were redesigned to ensure confidence with the Care Act.

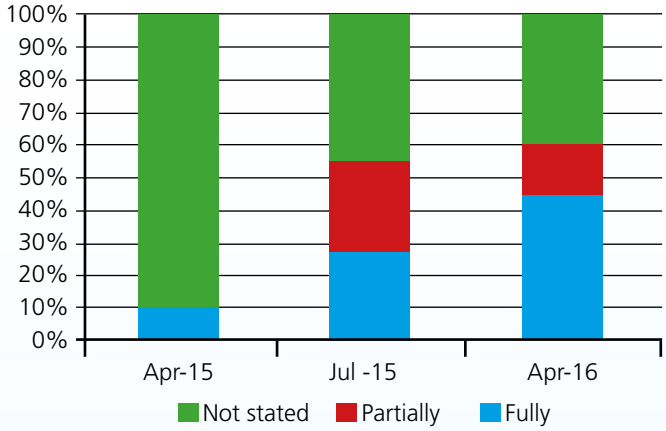
In order to measure the impact of this on those that have been subject to safeguarding investigations, we have undertaken three audits, one in April 2015 before we started the journey to get a picture of current practice, one in July 2015, and the last in April 2016 to allow us to gauge progress.

MSP Audits – results

Did the investigating officer ask the service user or their representative what outcomes they wanted to achieve from the safeguarding process?



Did the investigating officer consider/ask whether or not these outcomes had been met and whether the service user or their representative considered that the safeguarding process had been worthwhile?



The project team that were responsible for the implementation of MSP undertook a review in April 2016. When the results of this have been shared with the HSAB, an action plan will be developed, identifying areas for improvement and this will be monitored throughout the year. The results of this will be reported in next year's annual report

The voice of the adult informs decisions

We have committed to listen to people who have been subject to abuse and / or neglect, and to ensure that they are empowered to make decisions and can achieve their best outcomes and if necessary are supported to do this.

How an individual's choices are supported by professionals

Miss A is a 33 year old lady who has a supported living tenancy in a shared house. She has a learning disability and a significant mental health condition. She has capacity to make her own decisions but is extremely vulnerable.

Mr B was appointed to the staff team providing support at Miss A's home. He was observed by other staff to be behaving inappropriately towards her. Mr B was interviewed by his line management and the importance of an appropriate and professional relationship reinforced. Staff again reported concerns and Mr B's line manager arranged an investigation, but Mr B immediately resigned, before the meeting took place.

It became clear that there was a relationship between Miss A and Mr B. Support staff ascertained that Miss A's finances were being controlled; a mail order account was taken out in her name and expensive items purchased. She was observed outside a bank while Mr B withdrew money from her account. Miss A told her support team that she agreed to this because she wanted to maintain the relationship. Professionals may consider that this relationship is unwise but it is Miss A's choice and it is the role of agencies to respect her decision and to work with Miss A to minimise the risks she faces. She considers herself a more capable and confident person and feels loved and needed when in the relationship.

The support provider raised a safeguarding alert for suspected financial abuse, and the police were informed. The police added a 'flag' to Mr B's name so any application to the Disclosure and Barring Service (DBS) would indicate concerns if he applied for another caring role working with vulnerable people (Notifiable Occupation). The safeguarding alert was closed.

There have been intermittent breaks in the relationship, when Miss A can become extremely distressed and needs extensive additional support. Immediate intervention has been necessary to avoid Miss A self-neglecting and to avoid further risk to her mental health. She also needs support to maintain her tenancy. Collaborative working between all stakeholders including GP, mental health nurse, social worker and care provider ensures she has a consistent support network and manages the impact of the breaks in the relationship.

Partner agencies and providers are aware of legislation and raise appropriate referrals

As part of the implementation of MSP, a review of the structure of the council's "Advice and Referral Team", which is responsible for the receipt of all safeguarding concerns raised was carried out. Following this review, the way that staff handled concerns changed. Where a concern is found not to meet the threshold for safeguarding, a discussion is had with the person who raised the concern to help them understand when safeguarding is appropriate and when some other recourse may be used. This has led to fewer unnecessary investigations being carried out.

Communities and individuals are aware of what safeguarding means and who to contact and when

To raise awareness of safeguarding and provide information that is easy for individuals to access, we redesigned our leaflets. Copies were then issued to GP surgeries, dental surgeries and community areas.

A new website has been commissioned and is in the process of being populated as we go to press. This will have more information for individuals and communities on the work that we do throughout the year.
Take a look here:
www.herefordshiresafeguardingboards.org.uk

Service providers deliver quality care

Herefordshire Council, in conjunction with the CCG, Police, Healthwatch and CQC, has introduced a new approach to the quality assurance of care and support services offered in the county. The new Quality Assurance Framework has been designed to ensure that local care and support services provide the appropriate care and support that individual adults need. It is a set of processes which are put in place with one goal; to deliver high quality care and support services in Herefordshire.
Building positive relationships between the range of agencies, care providers and adults in Herefordshire is fundamental to achieving this. It is through supportive partnership based working that continued improvement in quality can be delivered with better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

As part of the framework, new quality standards, reflecting what good practice looks like, which includes reference to the newly developed West Midlands Adult Safeguarding Procedures, that has been communicated to all stakeholders. These will be required to work collaboratively to make sure that good quality care and support is delivered.

Staff are well trained and learning from audits and Safeguarding Adults Reviews are embedded into practice

We have introduced a competency framework relevant to all areas of service delivery, including providers, practitioners and other professionals. This framework outlines the levels of training required for each role and provides monitoring information which can be fed into the Quality Assurance Framework.

Practitioner forums continue to be run on a regular basis and are available to all agencies, recent subjects have included domestic abuse and information sharing.

These learning events are targeted across adults' and childrens' services where possible to encourage cross agency knowledge and working and to make the best use of resources.

This year we have undertaken four reviews of practice

The Joint Case Review sub group received four adult's referrals in 2015/16. These are referrals that are made by professionals when they feel that multi-agency practice has not been as effective as it should have been. Two of these cases were deemed to meet the threshold for a full Safeguarding Adults Review (SAR). Of the remaining two, one was passed to our public health team as they have a statutory requirement to investigate drug related deaths and one was managed through a practice learning review.

A Herefordshire Evaluation Learning Process (HELP) was commissioned for the first case, which involved an elderly gentleman in a care home who had a history of repeated falls. This review was the first that the Board had commissioned using this process and, subsequently, the JCR sub group felt that the report needed further detail. Although this meant that more time was required before the report could be finalised, the group felt this was absolutely necessary in order to consolidate the learnings and the recommendations from the review. The process in itself was a learning for the JCR subgroup. As a result, the commissioning process is now being more robustly considered at the beginning of the process. This will improve how adult reviews are undertaken in the future.

The second SAR involved an elderly gentleman in his own home. As the learnings from this review mainly focussed on Health and Adult Social Care, a root cause analysis and a chronology from Adult Social Care were commissioned and reported to the sub group.

The learnings from both of these reviews will be built into our work with practitioners once finalised.

A Practice Learning Review (PLR) was identified as being the most appropriate review process for one referral, with a multi-agency review meeting taking place with 6 agencies present. A report has been written by a member of the JCR sub group, independent of the case. The report has been considered at JCR Sub Group meeting, where recommendations and an action plan were agreed.
The following actions and learnings were identified as a consequence of the four reviews undertaken:-

1) The Community Safety Partnership reviewed the domestic abuse care pathway to capture adult facing services and ensures the pathway is underpinned by a training strategy.
2) The HSAB set multi-agency standards for safeguarding supervision in statutory agencies.
3) Wye Valley NHS Trust reviewed their processes regarding Mental Capacity Act and Depravation of Liberty Safeguards (MCA/DoLS) and the support offered to front line staff.
4) The Clinical Commissioning Group and Adults Wellbeing Directorate reviewed the pathway for people suffering from an acquired brain injury to ensure that the pathway is fit for purpose.
5) The HSAB ensured that Best Interest Decision making is included in the MCA/DoLS suite of procedures.

JCR will continue to regularly monitor the recommendations and actions arising from reviews for implementation and improvement to practice.

Other achievements for 2015/16

Making safeguarding personal

MSP was successfully launched across the council/adults social care in January 2015. This followed the training of social work teams to the level assessed as being needed for their role. A review was recently carried out by the council to evaluate how successful the implementation has been, and to make recommendations to aid in embedding this way of working. It will also make recommendations to inform the embedding of MSP across partner agencies. The next steps are for the board to receive the report and for board members to develop an action plan to embed MSP across the partnership.

The Care Act 2014

This legislation, which was implemented in April 2015, heralded a change in the Board's way of working, as it places the Board on a statutory footing for the first time.

During this year, we have reviewed our meeting structures, streamlining membership in consideration of members' other commitments, and also reduced our meeting frequency to allow for more meaningful work to take place between meetings.

We continue to develop the work of the Board in line with the requirements of the Care Act and have recently introduced an engagement group to improve the methods of gaining the views of the general public in matters of safeguarding.

Peer Challenge

A peer challenge is designed to help the local authority assess its current position and to advise on areas for improvement. It is carried out by professionals external to the authority.

The challenge, which took place in September 2015, was commissioned by the council and included a review of the Safeguarding Adults Board.

Whilst they found many encouraging things to report on, such as positive partnerships across agencies, good political leadership and the implementation of the cross cutting business unit, they also identified some areas for improvement. Some of these, such as the Independent Chair becoming a member of the Executive Group were implemented immediately. Others will take longer to achieve and there is an action plan which is regularly monitored and updated to show progress.

If you would like to see the full report and corresponding action plan you can visit https://herefordshiresafeguardingboards.org.uk/herefordshire-safeguarding-adults-board/for-professionals/learning-and-improvement/ and review the documents in the external reviews of our effectiveness and self-evaluation section.

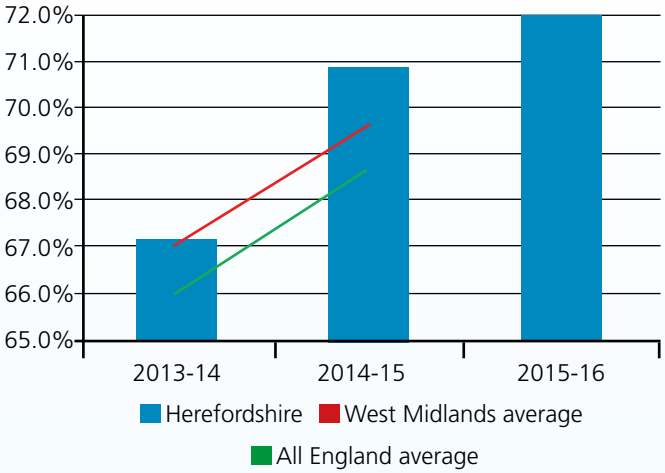
What does safeguarding look like in Herefordshire?

Every year the local authority takes part in a survey, commissioned by the government, collecting multi-agency performance data and asking individuals that they have worked with about how the safeguarding experience has been for them.

Some key highlights are:

Proportion of people who use services who feel safe

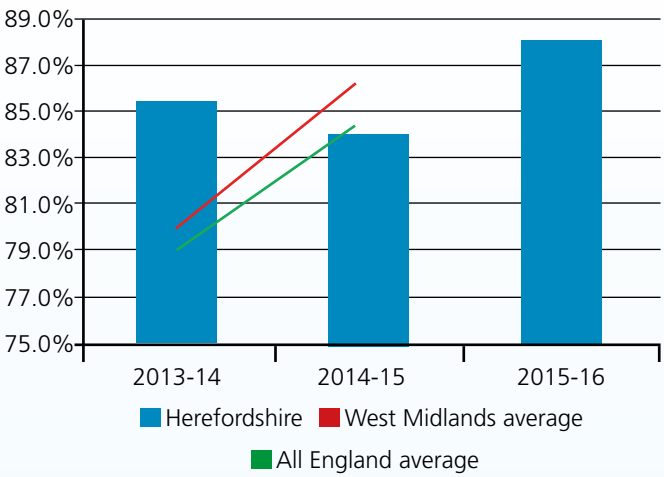
	2013-14	2014-15	2015-16*
Herefordshire	67.10%	70.90%	72.00%
West Midlands average	67.10%	69.50%	Not yet available
All England average	66.00%	68.50%	Not yet available



*Figures for 2015/16 are not yet finialised and may be subject to change

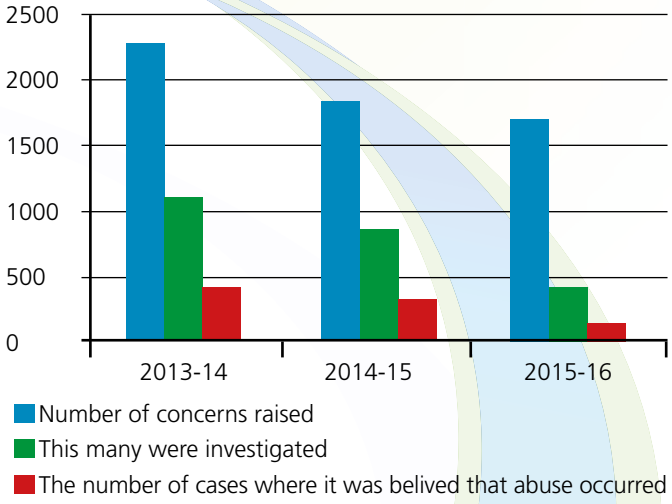
Proportion of people who use services who say that those services have made them feel safe and secure

	2013-14	2014-15	2015-16*
Herefordshire	85.50%	83.90%	88.00%
West Midlands average	79.90%	86.10%	Not yet available
All England average	79.20%	84.50%	Not yet available



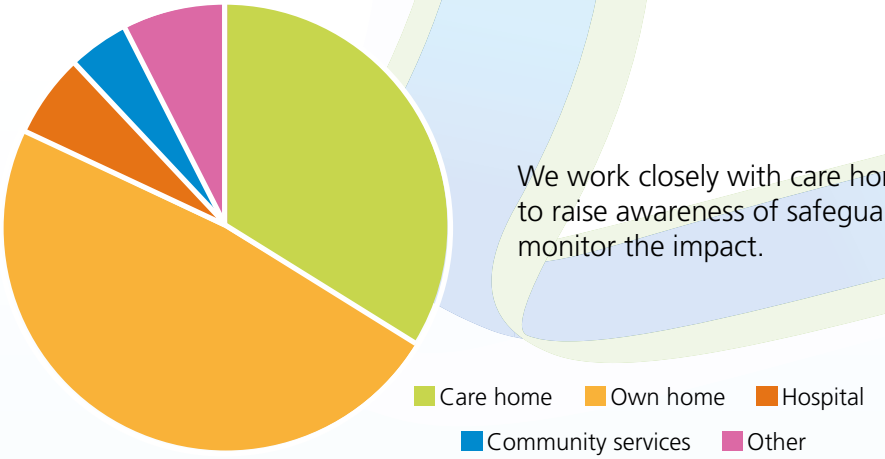
*Figures for 2015/16 are not yet finialised and may be subject to change

About the concerns regarding abuse that have been raised



Although the number of concerns raised has not differed much over the last two periods the reduction in the number of investigations is as a result of the introduction of MSP as, generally, concerns are no longer investigated unless there is agreement from the individual involved.

Where abuse has occurred



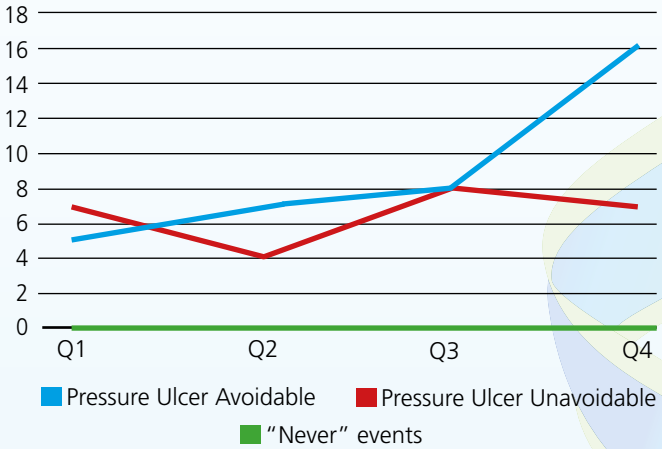
We work closely with care homes and providers in the community to raise awareness of safeguarding and we will continue to monitor the impact.

Wye Valley NHS Trust

During the course of the year Wye Valley NHS Trust, a Board partner, which provides health services in Herefordshire, report key figures with regard to patient safety.

We are pleased to report that they have had no "never" events during the year. These are, as the name suggests, events that should never happen, such as instruments being left in situ after an operation.

Pressure areas, both categories 3 and 4, are also reported. For each reported incident a root cause analysis is carried out and learnings from this are shared with hospital staff, with a view of increasing awareness and knowledge across the Trust.



How the Board works to deliver results

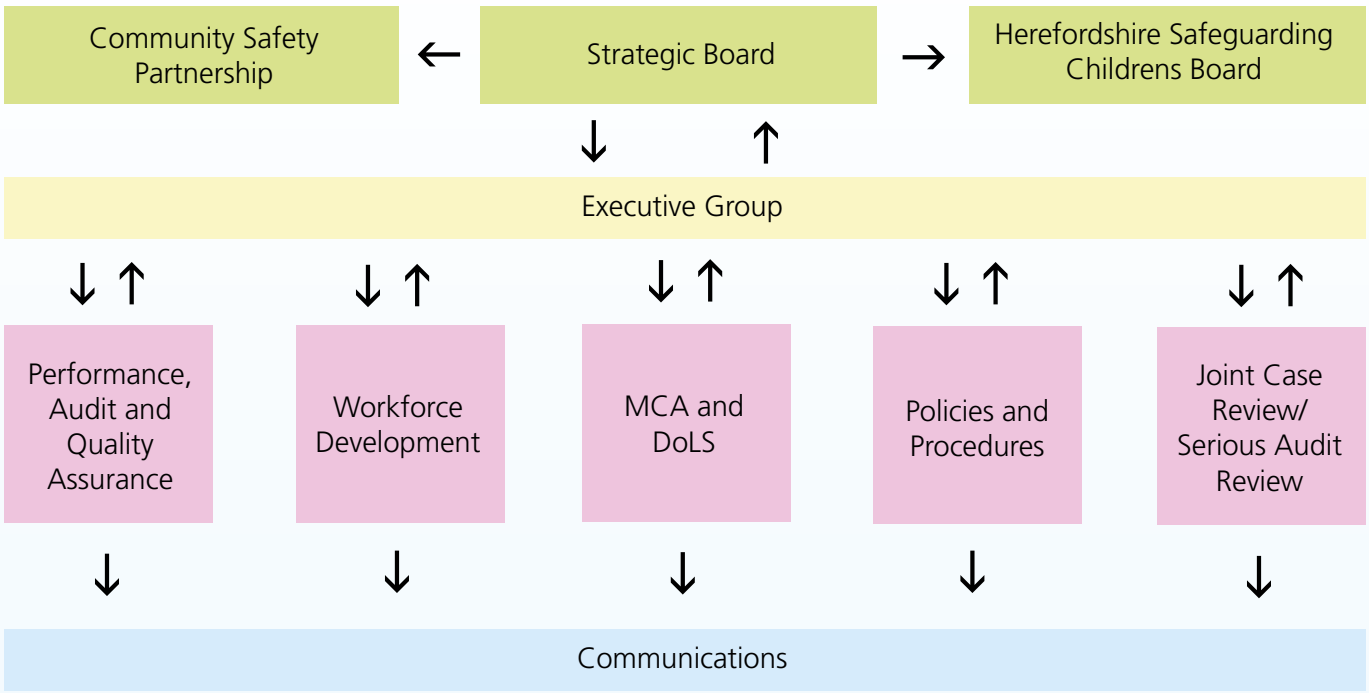
The Board brings together representatives from

- local authority (social care)
- the clinical commissioning group (responsible for the purchase of health care)
- Wye Valley Trust and 2Gether NHS Trust (health care providers)
- Healthwatch
- West Mercia Police
- National Probation Service and Community Rehabilitation Company
- Herefordshire Housing
- West Midlands Ambulance Service
- Herefordshire and Worcestershire Fire and Rescue
- Members from provider and voluntary services.

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

It is the task of the Strategic Board to agree the priorities for the year and to inform the Executive group of these.

Sub groups then develop work plans aligned to each priority. These contain the activity required to deliver the priorities. Each sub group chair has the responsibility of reporting back to the executive the successes, developments and any barriers to progress.



What the sub groups have delivered this year:

Performance and Quality Assurance

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

CHAIR'S UPDATE (Lynne Renton, Deputy Chief Nurse, CCG).

The group has developed a performance scorecard; this allows us to consider multi-agency information that has an impact on safeguarding.

We have carried out multi-agency case audits which have highlighted learning needs across agencies which are being delivered via the workforce training sub group.

Together with the MCA sub group the PAQA group has conducted a multi-agency MCA awareness/ governance audit to ascertain each agency's compliance with MCA legislation. As a result of the findings the Board has designed MCA leaflets, enhanced the content of the MCA information on the web site and started a system wide review of the MCA/Do Not Attempt Cardiac Pulmonary Resuscitation processes.

We have carried out a review of the multi-agency self-assessment audit to ensure that agencies actions which were agreed in 2014/15 have been progressed.

Policies and Procedures

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

CHAIR'S UPDATE (Mandy Appleby, Principal Social Worker, Herefordshire Council)

HSAB Policies and Procedures sub group are contributing to the development of the multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands which has now reached editorial stage.

During this year we have worked with colleagues to promote making safeguarding personal (MSP) in Herefordshire, to develop the self-neglect policy for Herefordshire and to develop and disseminate the revised information sharing protocol.

We have also contributed to the development of the prevent strategy for Herefordshire, and the implementation of the channel process, input into the domestic abuse referral pathway and made representation on both the multi-agency child sexual exploitation strategic group and the Herefordshire female genital mutilation strategic group to develop safe pathways for those adults at risk.

The sub group has met on four occasions since April 2015. With attendance at meetings becoming challenging as we moved into 2016 most of the work has been developed virtually.

The sub group develops and adopts policy, but works closely with the Joint Workforce Development and Training sub group and the Joint Communications sub group to ensure dissemination and training concerning the policies and procedures is delivered in a co-ordinated manner.

Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

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

CHAIR'S UPDATE (Jane Higgins, DoLS Lead, Herefordshire Council).

Following on from a supreme court judgement in 2014 which stated that "Incapacitated people subject by state decision to continuous supervision and control without option to leave setting are deprived of their liberty" care providers have had to review where they might be restricting someone's freedom in order to keep them safe. As a direct consequence the number of people being referred to the Herefordshire DoLS service for assessment has continued at a high level.

In response to this demand, Herefordshire has created a dedicated DoLS service. We now have a full time permanent senior best interest assessor, a number of permanent full time best interest assessors and in addition to this have increased our pool of independent assessors who can help meet demand.
(If you want to read the full report it can be found here: https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf)

Over the last 12 months we have sought to raise awareness of the MCA and DoLS and increase effective practice in a number of ways: we have created multi-agency policies for the MCA and DoLS, have put information regarding MCA and DoLS on the HSAB Web site and on the Local Authorities Wellbeing Information and Signposting (WISH) web pages,

We have also developed information leaflets regarding MCA and DoLS and have started to undertake engagement work within the wider community.

Training in relation to MCA and DoLS continues to be provided to partner agencies and providers of care.

Joint Training and Workforce Development

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

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

CHAIR'S UPDATE (Ali Chambers, Senior Manager Workplace Learning Support Services, Hoople)

At the beginning of the year a focused working group developed the new multi-agency workforce strategy which determined the workforce development plans for those who work with and support adults at risk to ensure that they are skilled and competent.

The HSAB multi-agency workforce development strategy also contains the new HSAB competency framework. The competency framework aims to;

- Raise standards and ensure consistent and proportionate response to safeguarding issues for adults at risk of abuse and neglect
- Improve partnership working and consistency to secure better outcomes for adults at risk of abuse and neglect
- Support work based evidence of learning and competence in practice
- Provide managers with a framework to evaluate performance, and identify workforce development needs
- Clarify expectations of the role of all relevant members of the workforce in safeguarding
- Provide a quality assurance tool for commissioners of services and for contract monitoring.

A set of recording forms have also been developed to compliment the Framework for agencies to use.

Work is continuing by the sub group through the training needs analysis (TNA) to establish training needs for the workforce in the coming year. There has been low numbers of completed TNA forms coming back to the sub group. This will make it more difficult to determine what learning resources will be required for the coming year to meet the needs of the workforce.

A new evaluation process has also been established and all training delivered on behalf of the HSAB will be subject to this new process. This will enable the sub group to measure if training has made an impact on the knowledge and skills of the workforce and in turn improved the experience of those who access services.

Safeguarding Practitioner Forums are now well established. During the year 166 practitioners representing 20 agencies have attended the 5 sessions held.

This forum includes dissemination of learning from SARs, informing practitioners about the work of the Board and sharing knowledge and best practice across agencies.

As the Care Act is not prescriptive over the methodology used, the joint case review sub group will use their discretion to decide on the most appropriate methodology on a case-by-case basis in order to optimise the learnings.

HSAB have also been actively involved in the consultation process to establish a regional learning repository for the outcomes from SARs.

Joint Case Review

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

CHAIR'S UPDATE (Adam Scott, Assistant Director Safeguarding and Early Help, Childrens Wellbeing, Herefordshire Council).

Since the Care Act 2014 made Safeguarding Adults Reviews (SAR) statutory, a Case Review Toolkit has been developed which overarches both adults and children's reviews.

The Toolkit details the processes to be followed from receipt of a SAR referral, through to publication. It sets out the thresholds and procedures for safeguarding adult reviews and also for reviews which do not meet the threshold.

Communications

This is a joint group across the Safeguarding Adult and Children Boards and the Community Safety Partnership. It was fully established in February 2016, and works to ensure a more coordinated and effective approach across the three partnerships.

CHAIR'S UPDATE (Bill Joyce, Business Manager, Safeguarding Boards Business Unit)

Immediate benefits were realised by the group in terms of sharing communication activity.

There was a very effective campaign in March 2016 promoting awareness of child sexual exploitation around CSE awareness day 17 March 2016. Messages from children's services, health and police were well coordinated for maximum impact.

We will continue to work together to co-ordinate the communication of safeguarding messages to maximise impact.

What the sub groups will deliver next year:

The review of progress against the priorities for 2015-16 took place in November 2015. Additionally future improvement opportunities were identified:

- Partnership working (including annual review of Board membership and effectiveness and build inter-relationships between Boards / partnerships)
- Prevention and protection (including care homes, carers and young carers, self-neglect)
- Communications and engagement
- Operational effectiveness (including workforce development, statutory functions and performance)

The document at appendix 1 shows the proposed 2016-17 strategic priorities and the sub groups work plans to deliver against them. The Board will now be consulting with Healthwatch and the local community to seek feedback on these priorities.

Budget 2016/17

Contributions from statutory partner agencies for 2016/17 remained the same as in 2015/16.

Total £383,964

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

Projected costs 2016/17:

Staffing costs:

The staffing complement as identified in the establishment of the Business Support Unit is as follows:
Business Unit Manager: F/T
Learning Development Officer: F/T X 3
Training Officer: P/T 0.41
Business Support F/T X 3

Basic pay and on costs	**£292,738**
Independent Chairs HSCB & HSAB:	**£38,520**
Council recharge costs:	**£32,000**
Total expenditure	**£363,258**
Balance:	**£20,706**
Potential income from training based on 2015/16 figures:	**£14,000**
Final balance (assuming same income from training):	**£34,706**

Proposed use of partnership budget 2016/17:

Workforce Development (WFD) training offer:

Administration of training programmes (face to face, bookings; evaluation; reporting; training needs analysis etc.) **£15,900**

Cost of Face to face training: HSCB; joint HSAB/HSCB practitioner forums:
To be covered by the £10,034 designated to Training Officer Post (staffing costs above).

Note: The Business Unit are developing a multi-agency training pool, for partners to deliver training together (contributions in kind), wherever possible to use free venues where refreshments can be easily purchased by course participants (e.g. Local Authority Plough Lane Offices).
The Business unit are also collating and making available any free to access E-Learning courses, which will be made available on the HSAB/HSCB joint website.

Total cost of training offer:	**£25,934**
Residual balance:	**£18,806**

The remaining balance is what remains to cover any Serious Case Reviews, Serious Adult Reviews, Domestic Homicide Reviews, annual conference/ promotions and any sundry costs.

Appendix 1

2015-18 Business Plan

Strategic Priorities	Partnership working	Prevention and protection	Communications and/or engagement	Operational effectiveness
Focus for 2016/17	All partners have a shared and universal understanding of safeguarding Increased involvement from voluntary sector Active participation from all partners Multi-agency focus Sharing the right data Connectedness with other boards	Service user involvement Good mental health Greater focus on prevention	Awareness raising Understanding the work of the Board Reach to smaller / community organisations MCA and DoLS	Challenge single agency issues Shared learning Links into commissioning and public health Embed MSP Embed competency framework Multi-agency training Better tracking of priorities

Sub group work plans

Delivery group	Partnership working	Prevention and protection	Communications and/or engagement	Operational effectiveness
Executive Board	Monitor actions arising from peer review Learning from other areas including DHR's, SAR's and SCR's Risk register Ensure the needs of adults at risk are addressed in the Joint Strategic Need Analysis and Health and Wellbeing strategies	Monitor relevant sub group work plans Risk register	Monitor relevant sub group work plans Risk register	Monitor relevant sub group work plans Risk register Publish annual report on the effectiveness of local safeguarding arrangements Better tracking of priorities
Policy and Procedures	Maintain up to date HSAB procedures that align with sub regional arrangements and address cross border issues. Embed MSP protocols into practice Embed MCA protocols into practice	Embed self-neglect policy into practice Develop arrangements to gather service users feedback of the safeguarding experience (MSP)	Launch of new policies	Embed new policies Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and/or engagement	Operational effectiveness
Communications	Consider the experiences of adults at risk at each Board meeting via case study Introduce "Chairs Message"	Increase awareness of DoLS and MCA Promote community resilience for town and parish councils.	Raise awareness of adults at risk	Pilot a safeguarding initiative with existing community champions Contribution to annual report
MCA and DoLS	Develop shared learning tool Multi-agency audit	Gather from Best Interest Assessors evidence of the voice of those without capacity	Raise awareness of MCA and DoLS • Website • Roadshow • Newsletter	Contribution to annual report
Performance and Quality Audit	Monitor multi-agency and single agency scorecards 6 monthly reports from Making It Real evaluating their work with vulnerable groups	Monitor results of the support provided via the Domestic Violence, Substance Misuse and Reducing Reoffending work plans held by the Community Safety Partnership (annual)	Monitor support provided to carers and young carers Adapt LA audit format to include the voice of the carer	Monitor the effectiveness of services provided to adults at risk via 6 monthly report from Quality and Review team Contribution to the annual report
Workforce Development	Practitioner forum Engage with front line staff and use their experiences to inform HSAB activity.			Develop guidance to support partner agencies to evaluate training Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and/or engagement	Operational effectiveness
Key Outcome Measures	• Partner agencies are committed and attendance at meeting is at least nn% • More voluntary organisations are aware of the work of the Board and engage effectively when required • Other Boards are aware of the work of the Board and engage effectively when required	• Production and publication of a prevention strategy • Partner agencies and providers are aware of legislation and raise appropriate referrals • MCA and DoLS are embedded into practice • MSP is embedded into practice	• Messages from the Board are effectively disseminated • Communities are aware of what safeguarding is • Individuals are aware of what safeguarding is • Communities are aware of Mental Capacity Act • Individuals are aware of Mental Capacity Act • Communities are aware of Deprivation of Liberty Safeguards • Individuals Communities are aware of Deprivation of Liberty Safeguards • Communities are aware of Lasting Power of Attorney • Individuals are aware of Lasting Power of Attorney	• Service providers deliver quality care • Staff are well trained • Learnings from SARs are embedded into practice • Priorities are tracked effectively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