Herefordshire
Safeguarding
Adults board

Annual Report
2013/14 and 2014/15

Vision

"that Herefordshire's adults at risk are able to exercise choice and control in an environment in which their wellbeing needs are met and they are safe from harm".

Contents

This report covers two years 2013/14 and 2014/15 and is published on behalf of Herefordshire Safeguarding Adults Board and its partners.

We have chosen a new format which we hope makes it more accessible, reflects our achievements and identifies where we should and can do more to safeguard adults at risk.

Our story is set out in this report, and we have tried to use case studies to illustrate some of the work we have been doing and the positive impact it has had on individual lives.

The Care Act 2014 places safeguarding adults on a statutory footing, and states that local authorities must establish a Safeguarding Adults Board. Though Herefordshire already had a board, the preparations for the Care Act have helped us focus on leadership, planning and how we make sure that people who we work with feel safer as a result of our work.

A key decision was to appoint an independent chair, and in September 2014 Ivan Powell was appointed as our new Chair. Ivan has worked in the police for a number of years, many of them in the local community and has already made improvements in our partnership working.

We would both like to take the opportunity of thanking all of the individuals, families, communities and organisations that work hard to protect adults who are at risk or who are abused. Through partnerships and collective effort we can continue to make improvements and look forward to your continued support.

Ivan Powell
Independent Chair

Helen Coombes
Director of Adults Wellbeing

Some of our achievements from 2013-14

Our response to the Francis inquiry

The Francis Report was published in February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report made many recommendations, including:

- improve openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers;
- improve support for compassionate caring and committed care and stronger healthcare leadership.

Each local area Clinical Commissioning Group (CCG) was asked to look at local services and produce and deliver an action plan. The Herefordshire action plan has been presented to the board and will continue to be monitored to ensure the actions are implemented and that the failings of the Mid Staffordshire NHS Foundation Trust will are not repeated in Herefordshire.

Our response to Winterbourne View

On 31 May 2011, an undercover investigation by the BBC's Panorama programme revealed criminal abuse of patients by staff at Winterbourne View Hospital near Bristol. In response, in December 2012 The Department of Health published "Transforming Care: A national response to Winterbourne View Hospital and the Concordat: Programme of Action". This agreement and related action plan sought to address poor and inappropriate care and achieve the best outcomes for people with a learning disability, or autism, who may also have mental health needs or challenging behaviour.

Following the publication of this report, Herefordshire Council worked collaboratively with health (CCG, 2gether Foundation Trust and Wye Valley NHS Trust) colleagues to produce an action plan which was shared with the Department of Health in July 2013.

Work on the action plan continued throughout 2013 and 2014 and a revised updated action plan was submitted to the Department of Health in December 2014.

The board continues to work closely with health professionals and commissioners of care services to ensure that the changes bought about in response to this report improve the outcomes for the people using these services.

Some of our achievements from 2013-14

The dignity challenge

To support the ten dignity principles in care services across Herefordshire, the board launched a campaign, in partnership with providers, to make them more accessible to adults at risk and their care providers, both voluntary and paid.

9,000 leaflets were distributed via providers to those in receipt of services and a poster was delivered to all care providers for them to display.

Feedback from these providers has shown that it raised awareness and supported those in receipt of care services, giving them a stronger voice in planning and reviewing their care.

Partnership working

We established links into work already taking place across the council, in communities and with other organisations to keep people safe such as Safe Places Scheme.

We worked closely with trading standards and the police around door step crime, distraction burglaries and targeting of older people, raising awareness amongst staff, communities and individuals about what to do if you are a victim of crime and what support is available.

Working with the community safety partnership, we helped support victims of domestic violence, rural crime and hate crime.

8 Some of our achievements from 2013-14

Learning and improvement

Sometimes individuals are not protected well, and regulators and the public want us to review what we have done, and what we can do to improve. Where it is a very serious incident like a death caused by abuse or neglect, we undertake a Safeguarding Adult Review (SAR). Sometimes, although it is a serious incident, it does not meet the criteria for an SAR but we do still want to learn from it. During 2013-2014, in conjunction with Herefordshire's Safeguarding Children Board, we developed a locally agreed "Herefordshire Evaluation and Learning Process" (HELP). This involves reviewing cases where multi-agency failings may have contributed to someone experiencing significant harm. To date, it has been used to review two cases; the learning from these reviews has been presented to the board for action which led to a series of developmental events for professionals.

Social care commitment

During 2013/14, local authorities along with all other sectors in the adult social care world were encouraged to sign up to the Social Care Commitment. This is a commitment to provide people who need care and support with high quality services through focusing on a core set of principles:

- work responsibly
- uphold dignity
- work co-operatively
- communicate effectively
- protect privacy
- continue to learn
- treat people fairly

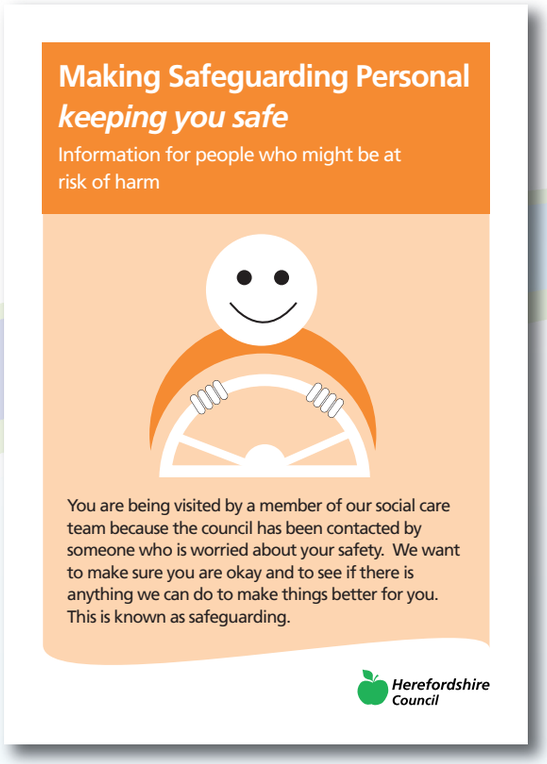
By putting these principles at the heart of our safeguarding work as a partnership, we have emphasised to our workforce, the residents of Herefordshire and other organisations that protecting the rights of vulnerable people is a key priority.

Making Safeguarding Personal

We have heard from individuals, their families and our workforce that often in the local authority when we start the safeguarding adults process we are not always very good about checking with people what they would like to happen and what a good outcome would be for the individual. As a result, in 2014-15 we started to implement Making Safeguarding Personal (MSP) in Herefordshire. MSP is a national programme aimed at listening to what people who are at risk of harm or abuse want to achieve and then at helping them achieve it by:

- talking and listening to people about what they want to happen
- recognising the person as the expert on their own life
- giving people greater choice and control
- working with the individual to attain outcomes determined by themselves
- improving the quality of life, wellbeing and safety

We began our programme of change in September 2014 with a focus on removing some of the administration from the referral process, improving our communications back to people who have referred suspected cases of abuse, and making sure that people who may be victims of abuse are clear about what we can do to support them. We have taken considerable time and effort in training our front line social work staff to think about the new approach to safeguarding adults and reduced some of the paperwork they have to complete.



Some of our achievements from 2014-15

The Care Act 2014

This new legislation, which became statutory in April 2015, heralded a change in the way the board needs to work and requires new policies and procedures to be developed. The board implemented an improvement plan to ensure full compliance with the legislation by the required date of 1st April 2015.

To support compliance we have:

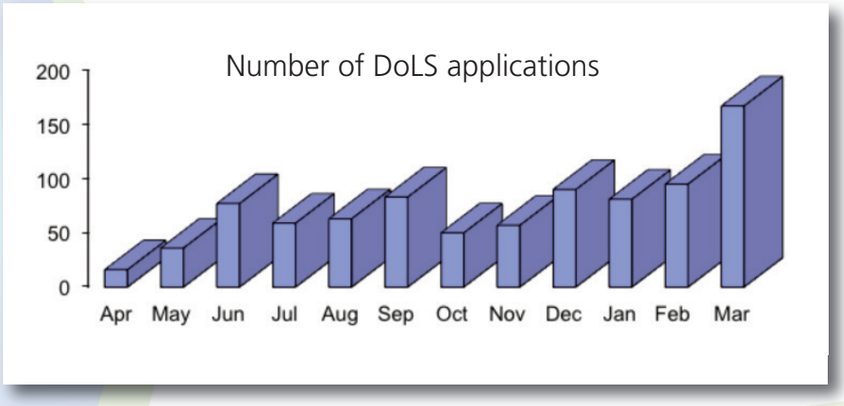
- recruited an independent chair
- rearranged the remit of the board and its sub groups
- recruited new members to the board in addition to the statutory members
- developed a constitution, members' pack and induction process, so that all members of the board are aware of their membership commitment
- developed the correct governance arrangements both within the board and its sub groups and with partner agencies
- developed the support resource available to the board through a newly established business unit
- worked with the rest of the West Midlands councils to produce a new policies and procedures

Some of our achievements from 2014-15

Deprivation of Liberty Safeguards (DoLS)

Some of our most vulnerable people are not always able to understand the consequences of decisions and therefore may place themselves at risk. The council has a responsibility for authorising appropriate care for people that will keep them safe. This applies to care homes, hospitals and some supported housing in the community. The council can only authorise restrictions on where people live or what they do after a number of independent assessments have been made.

During 2014 a court judgement on a specific case meant that all providers of care had to re-look at where they might be restricting someone's freedom in order to keep them safe. This has led to more people being referred for an assessment.



In order to address this in Herefordshire we have recruited a new DoLS lead and support staff. They are responsible for monitoring the process and also informing and training our partner agencies and providers.

We continue to recruit and train best interest assessors. These professionals help to inform decisions about care and support, when the person concerned is no longer able to do so. It is based on a person's likes and dislikes and is an integral part of the DoLS application.

Joined up working across adults' and children's safeguarding

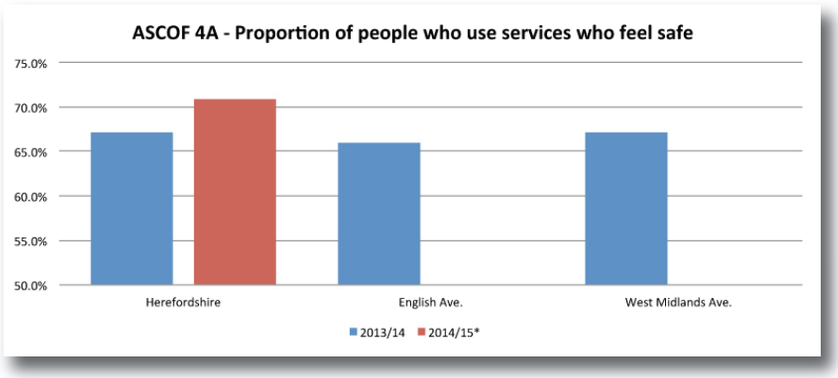
We undertook a review of both the children's and adults' boards, looking specifically at the governance and support arrangements and taking into account the new statutory responsibilities for both areas. We recognised that there is learning to be gained across children's and adults' safeguarding, and that we have common areas of interest such as sharing information, working with families and workforce development. We are developing plans to consolidate this joint work.

Our performance - Feeling Safe

Herefordshire has a total population of 186,100 which includes approximately 157,400 adults. During 2013/14, adult social care worked with 4,200 people aged 18 years and over. This is 2.27% of the population. Each year we take part in surveys, collect data and ask the people we work with about our performance. Some key highlights are:

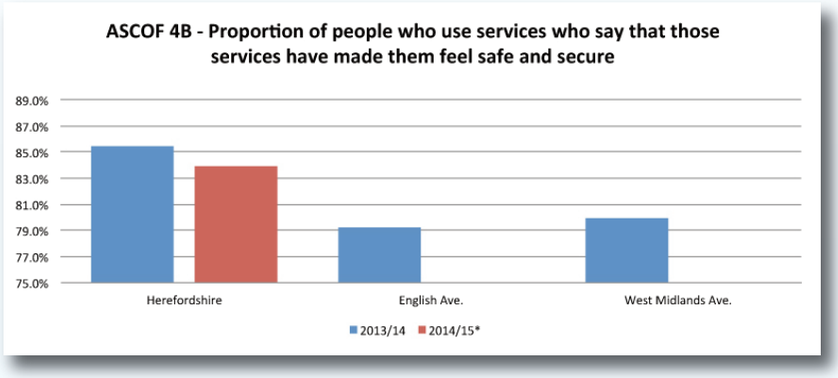
Proportion of people who use services who feel safe
* 2014/15 figure is current draft and subject to change as part of the PI validation process

	2013/14	2014/15*
Herefordshire	67.1%	70.9%
English Average	66.0%	Not yet available
West Midlands Average	67.1%	

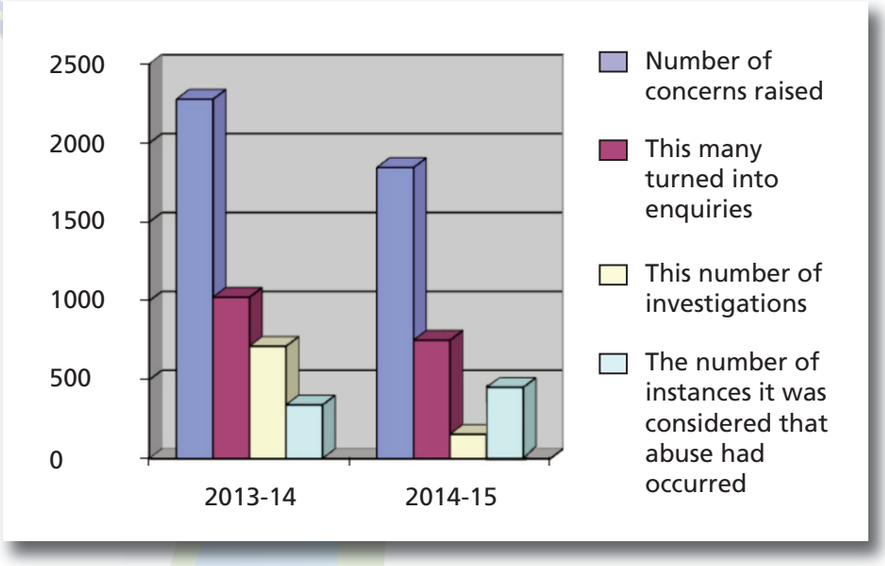


Proportion of people who use services who say that those services have made them feel safe and secure
* 2014/15 figure is current draft and subject to change as part of the PI validation process

	2013/14	2014/15*
Herefordshire	85.5%	83.9%
English Average	79.2%	Not yet available
West Midlands Average	79.9%	



How many people contacted us about suspected abuse

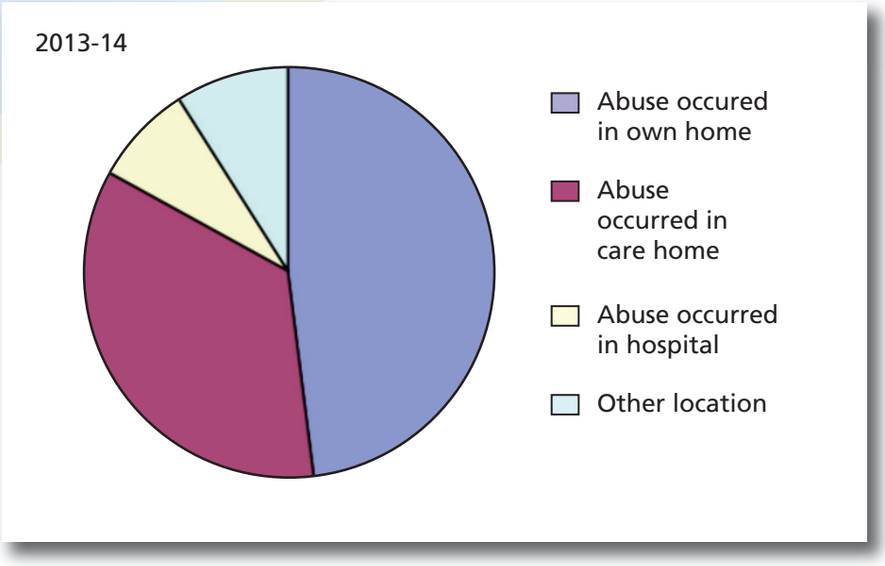


*figures for 2014/15 are not yet finalised and may change

- Concern is the initial contact made raising concerns. It can be made by anyone; police, health, social care professionals, any other professional or members of the public
- Once the information contained in the concern has been verified, an enquiry is sent to social care staff and they begin an investigation
- Once an investigation is completed the social care staff, taking into account all of the information will make a decision about whether the allegation of abuse can be substainiated and how we can work with an individual to protect them in the future

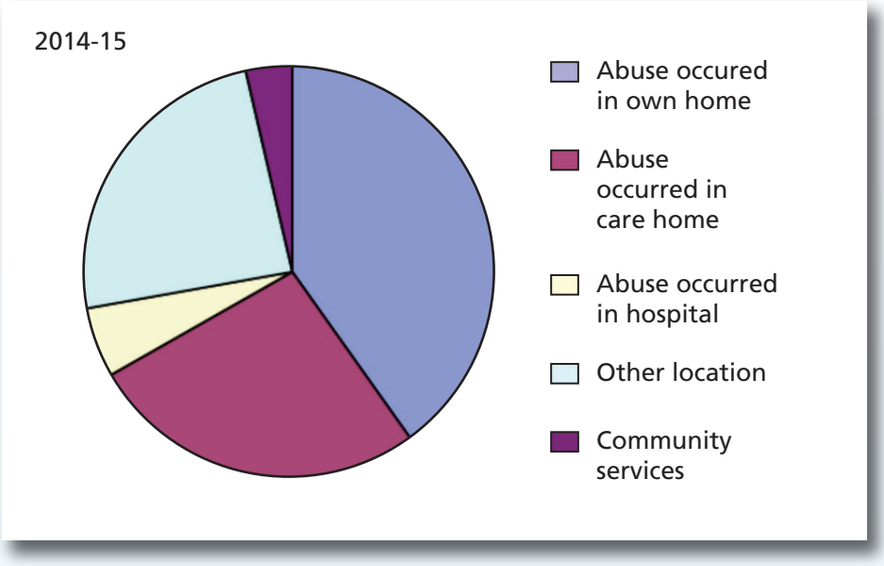
How well are we doing?

Where abuse occured



Some of the information we collect allows us to make decisions about what work we should undertake as a board.

Because abuse in care homes is a large percentage in the overall figure we are working very closely with care providers to help reduce this number.



How the local authority works to help keep people safe

The local authority has a quality and review team (Q&RTeam) responsible for monitoring safeguarding and quality concerns. They will support social workers and other professionals who have concerns with regard to specific services.

An example of this is that a number of safeguarding alerts and concerns regarding the quality of care had been raised about a particular care home. The team collected further feedback from residents, their families and professionals. A report was generated which contained all of the information which was then shared with the provider in question.

The provider reviewed all of this information and agreed with the concerns identified and began to work with the Q&RTeam to address the concerns in order to improve the quality of care being given to their residents.

Together they produced and implemented an action plan that identified areas for improvements to be made. Progress was reviewed during regular monitoring visits until all the actions had been completed. In addition, a training provider became involved to provide some additional support and promote and build excellence with staff in the home.

This improvement process is made possible by good collaborative working relationships between the local authority, its partners and providers to improve the experience of residents in care homes.

Some of the ways we work to keep people safe

Best interest decisions

Mr Adams is a gentleman in his seventies, he was admitted to hospital after having had a stroke. Prior to being admitted to hospital he had been living at home caring for himself with some support from a family member who lived close by. In addition to having a stroke Mr Adams also had a diagnosis of vascular dementia. After having the stroke Mr Adams experienced some difficulties in his abilities to express himself and he was assessed as not having capacity to make decisions about where to live and what care and treatment he needed. However he was still mobile and able to wash and dress himself. It had been suggested to Mr Adams' family that he might need to go into residential care and because of this they had started to look at possible homes for him to live in when he was discharged from hospital. However Mr Adams had repeatedly said that he wanted to return to live at home.

In order to work out what was in Mr Adams' best interests, a best interest assessor (bia) was appointed to help to decide if Mr Adams could return home or if he needed to go into residential care.

The bia met with Mr Adams to talk to him about his needs and what his wishes were and what his understanding of the options was. She also spoke with other professionals involved in Mr Adams' care and his family. The family initially felt that Mr Adams' should be placed in residential care, as this is what another professional they had spoken with had suggested. However the bia considered Mr Adams' needs, his abilities to care for himself, his wish to return home and options of support that could be available to him, and felt that he could be supported to return home. The bia asked the care team to identify support services that could be offered to support Mr Adams at home. The care team then held a best interest meeting and invited Mr Adams, his family and the professionals involved in his care to look at what options would be available to Mr Adams when he was ready to be discharged. They explained to the family what support could be offered to Mr Adams and the family to support Mr Adams to return to live at home. It was agreed at the best interests meeting that it was in Mr Adams' best interest that he should be discharged back home with a package of care to support him.

Mr Adams did return home and his family were pleasantly surprised at how well he managed to cope with the support from the package of care that had been provided.

Living idependently safely

A social worker raised a safeguarding concern relating to John, a service user with a learning disability. John has support from a care agency and also his extended family. The care agency were concerned that some members of the family were not looking after John properly and were expecting the care agency to do things which were not in John's care plan. There were also concerns that John's mother who lived with John was not being looked after properly.

A meeting was held following concerns regarding John's appearance, lack of food in the house, attitude of some family members to the carers and concerns about medication. It was also agreed that the social worker would complete a mental capacity assessment (mca) (this is an assessment of a persons ability to make decisions).

A planning meeting was held a week later at John's house with his sister, his main carer, his sister Helen and her husband Graeme to look at the issues. A plan was put in place to ensure that John was getting appropriate support. There were other members of the family who seemed to be visiting and staying in John's house.

It was decided at the meeting that John would benefit from the support of an Independent Mental Capacity Advocate (IMCA) to make sure he was happy with all the decisions made and also that his voice would be heard.

The IMCA worked with John and other people who were important to him, his sister and brother-in-law, the carers, a support worker at a horticultural project to improve his life. Helen and Graeme agreed to look into the actions of the other family members who were monopolising the washing machine and causing issues for the carers. The other family members were eating all John and his mother's food and not replacing it. Helen also agreed to provide some meals for John and his mother and monitor what they were eating on other days as well.

John was supported to have his own bank account so he could keep his money separate from his mothers and it would be 'protected'.

Following the safeguarding meetings the carers from the care agency reported that there had been an improvement in the support John received from his extended family. There is always food in the house and John and his mother are having well-balanced meals. The laundry is being managed and John goes to his day centre dressed appropriately in clean and tidy clothing. The care agency monitors the situation closely and liaises with John's sister and social worker if required.

John had a positive outcome from the safeguarding concern. Although he lacked capacity, he was able to make his views known through his advocate. By working closely with the care agency and family, the social worker was able to effect a change in the behaviours of some family members. John was able to remain at home with his mother which was his wish.

Some of the ways we work to keep people safe

How trading standards works to help keep people safe

Henry lives with his wife at their address near the centre of Hereford. Over a 5-10 year period Henry was targeted by scammers who sold him financial investments which didn't exist, conned him into sending money to bogus prize draws and entering fake foreign lotteries. The scammers were so convincing Henry gave over £50,000 of the couple's life savings to them. He was told by scammers that the details were completely confidential and not to discuss the matters with anybody. Therefore Henry hid everything from his wife (who is a dementia sufferer) family members and all other agencies, nobody was aware of the problem.

Recently Trading Standards acquired a "victims list" full of names and addresses that the scammers trade amongst themselves on the black market so they know who to target and exploit. On the list were the details of Henry and his wife. Trading Standards were able to contact Henry and his family to highlight the extent of the problem. Henry's family and Trading Standards are now in regular contact and have put various measures in place to protect him from falling victim to scams and giving away his entire life savings to fraudsters. The intervention has saved them around £1,500 per month.

Many victims like Henry are persuaded into thinking they are due to win huge sums of money and are told by the scammers not to tell anyone until the money is released. Victims therefore continually hide the problem which makes detection extremely hard. Even when family members or friends become aware of the problem and try to advise the victim they still refuse to accept they are being scammed. It's only when intervention from Trading Standards occurs that the victim starts to understand they are being scammed and successful measures can be put in place to combat the problem. If anyone suspects a scam victim they should be report the information to Trading Standards directly.

How Women's Aid works to help keep people safe

Kay was being physically abused by her ex-partner in the home they had previously shared. Kay fled to stay with her mother, although this was still in the same area, as she was too frightened to stay alone.

On speaking to the agency concerned she stated that she wanted to leave the area to escape the ongoing abuse, which had left her feeling suicidal.

The agency then worked with Kay to understand fully the issues she was dealing with which as well as the abuse included mental health issues, a diagnosis of COPD and social isolation.

Once all of the information has been gathered a suitable refuge was identified which, as well as providing a place of safety, would also be able to enable Kay to address her mental and physical health issues.

Kay is now residing in a refuge and planning on applying for permanent accommodation. Her needs are being met and she is looking forward to a safer and more productive life.

Some of the ways we work to keep people safe

How the police work to help keep people safe

Alice lives alone in a bungalow in a street in Kington populated with similar residents. During 2013 a number of men cold called at her address offering to do 'essential' building work. Alice has a large supportive family although they are not local, so with a view to not bothering them, she agreed for the men to do the work.

The men charged an initial price of £2000 to do the work and once paid they took this as an opportunity to obtain more money from her. Over seven months and after bombarding her with phone calls and requests for money Alice parted with £34,000. There was no work completed on the property.

Alice has since explained that at the time she felt sorry for them. The men repeatedly told her that their business was struggling and that they had families to support. She felt that she was doing her bit to support them. She almost found the routine of going to the bank to withdraw money and meeting with them to hand over the money, a comfort in her lonely everyday life.

Alice has not had any interaction with local services or adult social care: she has only had support from the local policing team. The use of an intermediary for the Court process is being considered but due to her good communication and lack of 'needs' it is unlikely that they can assist.

The case is awaiting trial at Crown Court.

Our board priorities

A multi-agency safeguarding adults board is responsible for coordinating and overseeing work of all of the partners in Herefordshire that helps keep adults safe. The board held a development day during March 2015 with key partners and agencies as part of our preparation for the Care Act. From this six strategic priorities were identified:

- To ensure that process, systems and structures are in place to safeguard and promote the welfare of adults who may be at risk of being abused and/or neglected
- HSAB is a truly effective agent for change that has a real impact for adults at risk
- To improve the recognition and response to those in need of safeguarding including those who lack capacity to make decisions and drive a person-centred approach to safeguarding adults at risk
- To support increased resilience in individuals, families and communities with a focus on raising awareness and empowering people to better protect themselves
- To raise the awareness of safeguarding in the workforce, service providers and communities to ensure the safety of adults at risk
- To promote the work of the board and the difference our strategic priorities has made to the safeguarding of adults at risk and the provision of quality services delivered by a well-informed workforce

Specific projects have been identified to meet these strategic objectives which include the quality of care delivered by local providers, training, performance data and the issue of self neglect. (Full details of the work plans are available as Appendix 1).

We have commissioned a safeguarding peer challenge to take place during this year. A peer challenge is when a team of experts from another area comes and spends time with the board and the council to review our work, identify good practice but also advise where further improvements could be made.

In addition the board willl continue to embed the making safeguarding personal ethos into practice and decision-making and undertake regular audits.

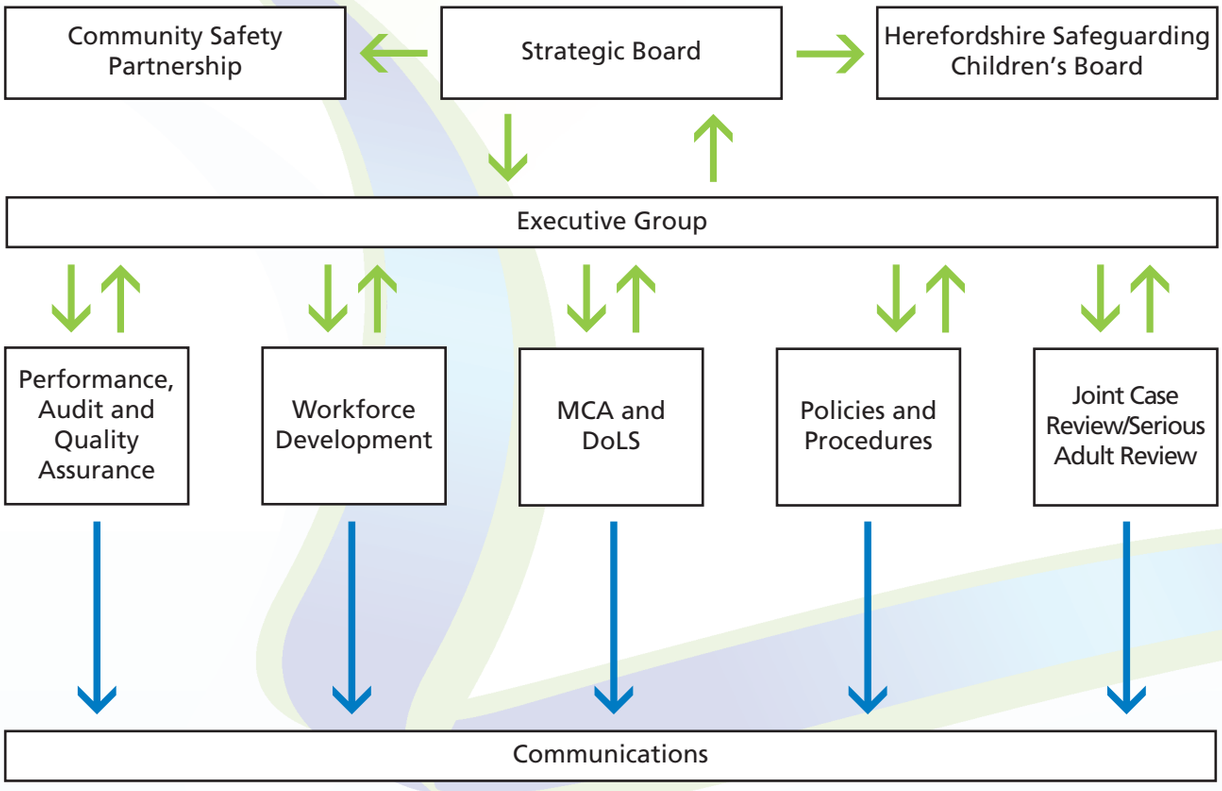
Our plans and priorities for 2015-16

Our workforce training is key to the board having confidence that abuse is identified and then steps are taken to protect vulnerable people. We have prioritised investing in the workforce and will be providing professional development opportunities to all partner agencies by hosting practitioner forums on a quarterly basis. All of the agencies are also planning their own programmes and development.

The care act continues to demand changes in our systems and processes and a project team within the local authority makes regular representation to the board with updates.
We also plan to increase the level of communication and engagement that we have with people who use services, their families/carers, voluntary sector providers and other organisations that provide care and support.

Our board has developed working sub groups to ensure priorities are agreed and delivered. These are set out below:

HSAB Structure and Governance Chart



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

For each identified priority there will be a workplan which will be owned by the chair of each sub group. The workplan will contain the activity required to deliver the priorities, which will be carried out by the members of that group. The chair will report developments or barriers preventing progress back to the Executive Group.

The sub groups will also be measuring the impact of the changes that are put in place so that the board can evidence it is making a difference to the lives of people in Herefordshire.

The sub groups

Performance and Quality Assurance

This group is responsible for data quality, audit and effective information systems. It has to make sure we meet current and future expected national and local data reporting requirements. Importantly it enables performance to be managed and seeks assurance on the quality of local safeguarding.

Policies and Procedures (commissioned January 2015)

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

Mental Capacity Act and Deprivation of Liberty Safeguards

This group provides clear leadership in 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.

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 adults at risk, or people who may engage with adults at risk as part of their work, in Herefordshire understand their responsibilities.

Joint Case Reviews

The board has a legal duty to undertake reviews of cases where an adult at risk has died or suffered serious harm, the criteria for such reviews is set out in the Care Act 2014. The reviews involve all agencies who were working with the adult and are used as a learning platform for both good and bad practise.

Arrangements for co-ordinating work

Our board is made up from representatives from the local authority (social care provider), the clinical commissioning group (responsible for the purchase of health care) Wye Valley Trust (health care provider) 2Gether NHS Trust, West Mercia Police, National Probation Service, Community Rehabilitation Company, West Midland Ambulance Service, Healthwatch, Herefordshire Carers Support, Herefordshire Housing and members from the provider and voluntary sectors.

This multiagency approach ensures that all partner organisations receive the same information and messages and work together cohesively to provide the strategic direction for work undertaken on their behalf.

The business unit

We recognised that we have a shared agenda with some elements of the Community Safety Partnership work so we have increased our investment in the business unit that supports the board.

A plan to provide tripartite resource across Herefordshire Safeguarding Children's Board, Herefordshire Safeguarding Adults Board and the Community Safety Partnership was agreed by all chairs.

The new business unit which provides support to sub groups, the strategic board and the chairs went live on 1st April 2015 and consists of one business unit manager, three learning and development officers and three business support co-ordinators.

We are the first area in the West Midlands to do this; it illustrates our commitment to keep improving how we work.

This document sets out the strategic objectives for Herefordshire HSAB for 2015-16 and the high level measures of success. Delivery group work plans provide the details of how the priorities will be achieved. The HSAB's multi-agency performance dataset, audit programme and other associated learning and improvement activity will enable the HSAB to evaluate the impact of this plan on improving practice and outcomes for adults at risk in Herefordshire. The impact of the plan will be reported in the HSAB Annual Report 2015-16 and any further areas of improvement will also be identified.

The previously agreed strategic priorities of "Operational effectiveness" "Partnership working" "Prevention and protection" and "Communications and engagement" have been aligned to the HSCB priorities where possible. The projects that were agreed under these headings have been assigned to the new headings.

Strategic Priorities	HSAB is a truly effective agent for change that has a real impact for adults at risk.	To improve the recognition and response to those in need of safeguarding including those who lack capacity to make decisions and drive a person centred approach to safeguarding adults at risk.	To support increased resilience in individuals, families and communities with a focus on raising awareness and empowering people to better protect themselves.	To ensure that process, systems and structures are in place to safeguard and promote the welfare of adults who may be at risk of being abused and/or neglected.
Aligns to	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness

Key Outcome Measures	Partnership working to ensure positive outcomes for adults at risk of abuse or neglect. Partnership working to ensure best practice is maintained across all agencies.	MCA and DoLS are embedded into practice. MSP is embedded into practice. The voice of the adult informs decisions. Partner agencies and providers are aware of legislation and raise appropriate referrals.	Communities and individuals are aware of what safeguarding means and who to contact and when.	Service providers deliver quality care. Staff are well trained and learnings from audits and SARs are embedded into practice.

What will we do to deliver the four strategic priorities?

Executive Board	Develop protocols HSCB / CSP. Peer review. Learning from other areas. Risk register. Develop SAR process and notification arrangements for serious cases for discussion at JCR. Ensure the needs of adults at risk are addressed in the JSNA and HWB 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.

Policy and Procedures	Maintain up to date HSAB procedures that align with sub regional arrangements and address cross border issues. Disseminate information sharing protocol.	Embed MSP protocols into practice. Incorporate learnings from DV pathway into practice.	Launch safeguarding toolkit for town and parish councils.	Work regionally to develop self neglect pathway.

Communications and engagement (including the voice of the adult)	Engage with front line staff and use their experiences to inform HSAB activity. Engage and learn from front line staff at each board meeting – methodology to be agreed. Consider the experiences of adults at risk at each board meeting via case study. Promote HSAB membership and purpose. Introduce "Chairs Blog". Introduce Roadshow.	Increase awareness of DoLS and MCA. Gather from BIAs evidence of the voice of those without capacity. Develop arrangements to gather SU feedback of the safeguarding experience.	Raise awareness of adults at risk. Work collaboratively with DVA Workstream to raise awareness of domestic violence in relation to dementia. 6 monthly reports from MIR evaluating their work with vulnerable groups. Raise member and community awareness.	Pilot a safeguarding initiative with existing community champions. Ensure the issue of self neglect is addressed in JSNA. Develop HSAB website.

MCA and DoLS		Develop multi-agency MCA and DoLS policies.	Raise awareness of MCA and DoLS.	Develop multi agency training strategy. Implement MCA / DoLS audit process.
Performance and Quality Audit	Develop and monitor multi-agency scorecard and understand measures on single agency scorecards. 6 monthly report from HCC compliance team. Develop audit arrangements to measure quality and impact of organisational safeguarding arrangements.	Monitor application of DoLS process. Carry out routine audits of MSP.	Monitor support provided to carers and young carers. Adapt LA audit format to include the voice of the carer. Monitor results of the support provided via the Domestic Violence, Substance Misuse and Reducing Reoffending work plans held by the Community Safety Partnership.	Monitor the effectiveness of services provided to adults at risk. Interrogate findings from audits to inform practitioner learning. Annual report on the implementation of the competency framework.

Workforce Training and Development	Launch competency framework. Use local and national learning including SCR / DHR / SAR to shape service delivery and improvement. Implement significant incident learning process.	Develop guidance to support partner agencies to evaluate training.	Promote dementia friendly initiative.	Develop guidance to support partner agencies to evaluate training.

Notes

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www.herefordshire.gov.uk/hsab