Herefordshire Safeguarding Adults board






Annual Report

2016-2017

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Foreword

Welcome to Herefordshire's Safeguarding Adults Board Annual Report 2016-2017. The report provides the Board members with the opportunity to reflect and report on how they have delivered progress against the Board's strategic priorities for this year.

In last year's annual report we outlined how the peer challenge of the local council and the Board had resulted in identifying both areas of strength and areas where more work was required. Earlier this year we were re-visited by the peer challenge team for them to hear how we have progressed the relevant areas of our action plan. Their feedback was very positive and the progress we've continued to deliver, demonstrates the commitment and professionalism of the Board members.

We have strengthened the content of our three year strategic plan and annual business plans to better enable the Board to understand what progress we are making, and where we need to provide additional scrutiny and challenge.

The main focus of our work is to support individuals who are at risk of harm and abuse, and to empower them to resolve the position they are in, but in a manner which is both proportionate and enables them to be more in control of their lives. This is reflected in the Making Safeguarding Personal (MSP) guidance. Helpfully during this year there has been both a national review, known as the 'MSP temperature check' and a local council co-ordinated partnership review of MSP across Herefordshire.

These two reviews formed the basis of our Board MSP action plan and were the subject of a Board development event during which agencies committed to deliver against their own particular aspects of it. Whilst this is a strong foundation from which to move forward, the Board is not complacent as to the size and complexity of the challenge, and MSP remains an area of sharp focus for the Board. In particular, different agencies are at differing levels of understanding and maturity with regard to MSP, and the challenge for the Board is to secure consistent application of MSP across the partnership.

Linked to this is the ongoing commitment to secure and learn from the experience of those who unfortunately have to seek the support of the safeguarding system. Board meetings always commence with members hearing a 'lived experience' to ensure our discussions and decision making are grounded by the day to day experience of frontline professionals and the people we serve and support.

Placing the person at the centre of the safeguarding process requires professionalism, commitment and skill from our frontline staff and leadership and support from senior and strategic managers. The Board is key to providing both challenge and seeking assurance that these dynamics work effectively.

The Board and its members are learning how complex adult safeguarding can be within specific settings and circumstances. By way of example, we are currently working jointly across Herefordshire and Shropshire with adult social care and police professionals to explore where we may need to develop and provide more flexible service responses to those who are experiencing domestic abuse.

Member agencies continue to develop their own practice but also take account of how they can impact positively across the partnership. The appointment by Wye Valley NHS Trust of a designated Mental Capacity Act lead staff member is of course important to that organisation, but additionally this has brought significant benefit to the Mental Capacity Act and Deprivation of Liberty Safeguards work of the Board. Likewise, Hereford & Worcester Fire and Rescue Service has developed its fire home safety checks to include broader discussions with potentially vulnerable individuals on a range of health and wellbeing aspects. This is a very welcome development in support of the Board's prevention work, and again is reflective of the 'coming together' of the Board members.

There is still more to do, but also much to recognise as success. I trust you will find this report open, interesting and informative, and where possible I would ask that you use it to raise the profile of the work of Herefordshire's Safeguarding Adults Board, and more importantly the profile of adult safeguarding across Herefordshire.

I am confident of the continued commitment of the Board to drive improvement forwards, and my thanks to all of you who work tirelessly to support and protect some of the most vulnerable residents in Herefordshire.

Ivan Powell
Chair of Herefordshire's Safeguarding Adults Board

Strategic priorities

The strategic priorities for 2016/17 were identified during a development meeting in November 2015. These were devolved to the relevant sub groups to the produce work plans to deliver the activity against them.

The Board priorities for the year 2016/17 were:

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

The priorities are underpinned by a set of ambitions which are detailed as bullet points in the following section. Information reporting on progress made in these areas is included, together with a number of case studies which shows how this work is making a difference to people's lives.

Priority 1 - Partnership working

- **All partners have a shared understanding of safeguarding**

A recent development has been the creation of a cross agency chairs meeting which has members from Herefordshire Council, West Mercia Police, Herefordshire Clinical Commissioning Group, Public Health, Community Safety Partnership, Independent Chair of both Adults and Children's Safeguarding Boards and Cabinet Members for both Adults and Children's Wellbeing.

The purpose of this meeting is to identify cross cutting themes and to ensure they are progressed efficiently within the partnership, avoiding duplication of effort.

- **Increased involvement from the voluntary sector**

We will increase the role and involvement of the voluntary sector regarding safeguarding.

The role of the Voluntary Community Sector (VCS) regarding safeguarding

There is an increasing expectation for 'the community' to look out and care for its own and an increasing need for communities and families to be more involved in the support and delivery of care. The Board fully recognises that within this there is potential for safeguarding risk.

In certain situations it may be inappropriate or unwelcome for a neighbour to provide care. In such circumstances, either through ignorance or malice, this could risk harm to the individual, present a risk to their dignity or result in a restriction of their choice, control and liberty. People may not have the personal resilience or understanding to challenge the action of another, to seek help or advice, or indeed raise a safeguarding concern. This is made more acute where they perceive there is no alternative to the support. Advocacy would not be sought where no risk is perceived or understood. The risk is also compounded where the most vulnerable people are isolated and do not have access to support and the right advice and information, often because they are not known to services and may be particularly hard to reach.

Herefordshire's voluntary sector is strong and vibrant and consists of organisations, large and small, engaged in a wide and diverse range of activity, in particular connecting people across the county. Its formal and informal support networks, including those facilitated by Herefordshire Voluntary Organisations Support Service (hvoss), provides opportunities to reach and engage vulnerable, isolated and sometimes difficult to reach people.

The community includes all of us who live in it, volunteers, carers (usually but not always family members, who are unpaid), support workers (paid staff), and others such as shop assistants and postal workers, all of whom play a crucial 'watchdog' role, identifying risks and raising concerns within the community.

However, something may not be recognised as a risk or as actual abuse, where they may see a change in an individual or their routine that 'niggles'. The key is to empower people to feel confident about where and how to raise a concern, and in doing so, overcome any reluctance to get involved or respond to an issue formally. The voluntary sector is a key group of organisations and individuals who greatly assist in supporting the Board's priority to improve the awareness of adult safeguarding across Herefordshire.

They are also crucial to noticing where abuse may be taking place and in supporting people to raise concerns themselves.

One of the significant challenges is the need to balance the perception of risk with a need to respect and support individuals to live in circumstances which may, in themselves, appear to be risky. The voluntary sector work hard to establish a shared understanding of risk, what constitutes safeguarding and how to identify and deal with a safeguarding matter. This is done through ongoing dialogue, engagement, training and collaborative working with the voluntary sector.

The voluntary sector has been key to raising awareness and understanding of the perception of risk and living safely on a day to day basis by providing both formal 'lived experience' studies through to anecdotal information to the Board.

Resolution of a formal safeguarding concern may not be the end of any risk or abuse in a person's life. The person may still live in the same environment and face similar risks day to day, either through their choice or circumstances. Ensuring everyone remains connected to their community in some way helps to identify, manage and respond to safeguarding risk and ensure communities and individuals living in them, including those who are most vulnerable, are safe and resilient.

Karen Hall
Aspire Chief Executive (on behalf of hvoss)

- **Active participation from all partners**

At a national level Trading Standards gather intelligence on lists of people used by unscrupulous traders and fraudsters to target those who are vulnerable to activity known as "scams". Locally, Herefordshire Council's Trading Standards work to reduce the vulnerability of those suspected of having been a potential scam victim.

Case study - How partnership working has helped a resident in Herefordshire

Mrs P was identified by this national process. In the first instance, an officer from Herefordshire Council's Trading Standards visited Mrs P's home to provide advice and determine whether or not she was a scam victim. Mrs P is a widow in her mid-80's who lives alone in rural Herefordshire and suffers from a cognitive impairment, which affects her memory.

Initially Mrs P said she hadn't been approached by anyone trying to sell her goods or services, but she did receive a small amount of unsolicited mail in the form of foreign lotteries, which she was able to identify as being a scam and said she simply put them in her recycling bin. During the home visit, the officer noticed a newly installed home security system and asked questions relating to it. Mrs P couldn't provide much detail, but gave the officer her son's phone number, as he was the best person to contact to discuss the matter.

Following contact with her son, it became clear that Mrs P was constantly being targeted by rogue traders and had recently signed a contract for nearly £4,000 for the installation of the home security system, which she didn't need as she already had a fully functioning system in place. The salesperson knew her current system was working and even visited her property and removed her existing alarm system in order to secure the sale.

Further investigation revealed that days after the first salesperson had coerced Mrs P into signing a contract, another completely different home security company had sent their own salesperson to her property to sell her another system. They removed the system which had only been fitted days before to secure the sale and convinced Mrs P to sign another contract for £3,000.

In only three weeks, Mrs P had been sold two home security systems she didn't need for almost £7,000 and within the previous six months, she had signed up to four worthless call blocking systems over the phone, costing her over £300.

Intervention from the council's Trading Standards and joint working with Mrs P's sons meant that almost £7,000 was recovered from the home security companies. Trading Standards represented Mrs P and also provided her with a free fully functioning call blocking system, which can be monitored remotely by her sons who don't live locally.

To date there has been no further issues due to the collaborative work between Trading Standards, Mrs P and her family.

If you think you know a scam victim, please contact Herefordshire Council's Trading Standards on 01432 261761

Herefordshire Council Trading Standards Officer

Case study - Multi-agency safeguarding in the community

West Mercia Police was working with Mrs X, who has health and care issues, which were compounded further by the anti-social behaviour issues she was reporting. Despite the best efforts of the police, they had been unable to secure sufficient evidence to pursue formal proceedings in respect of the reported behaviour. Mrs X described feeling terrorised and that the situation was extremely detrimental to her wellbeing.

This position was reviewed by both a supervising officer and senior manager and as a consequence, further measures were put in place to tackle the anti-social behaviour, but more importantly the police recognised there was a need for a more holistic approach to her daily living. As a consequence, they took a much broader review, however this was complicated due to Mrs X's reluctance to engage with agencies.

The police put in place a bespoke plan to manage the risks with Mrs X's involvement, including visible assurance from members of her local policing team, whilst also addressing concerns regarding asbestos piping and exploring the provision of sound proofing to her home.

During the time the management plan was in place, police officers came to understand that Mrs X's daughter, Miss A, lived in an upstairs room of the home, and by choice lived a very isolated lifestyle. It transpired that Miss A had her own needs but had in fact not been seen by any agency for an extended period of time. The police enquired after Miss A, but Mrs X was reluctant to allow them to talk to her as she was electively mute and moreover was genuinely concerned that seeing police officers would be further detrimental to her daughter's already fragile circumstances. A significant challenge for the police was a professional need to see Miss A to confirm she was in fact safe and well.

The police met with safeguarding practitioners from the council and agreed a joint approach to engage with Mrs X with a view to securing her support for engagement with her daughter. Ultimately, after a period of time, a plain clothes police officer and an adult social worker met with Miss A and her mother. Miss A did not wish to speak with them, but communication was established in a manner that best suited her needs and professionals were able to establish that she was safe and well.

In conclusion to this case, Mrs X continues to engage with and be supported by services and the anti-social behaviour has stopped. During the last visit by the local policing team, Mrs X said that "it has been absolutely silent and there is peace and quiet". She reported that it was the "first time they had been able to relax since living there and Miss A was a lot more relaxed".

Dean Jones
Chief Inspector, West Mercia Police

Individual agency responses to the work of safeguarding and their role within it can be found in Appendix 3. The following case studies provide real examples of how a multi-agency approach is making positive changes to peoples lives.

- **Multi-agency focus**

The table below also shows strong multi-agency commitment at the Board. Case studies are presented at every meeting, leading to discussion and debate about agencies and their roles in safeguarding both individually and collectively. Professionals are encouraged to consider the work of other organisations and invitations are issued to additional agencies or individuals to aid this and to improve knowledge and understanding.

The Care Act places a responsibility on the Independent Chair to challenge agencies which are not contributing as effectively as they should to the work of the Board. On the Chair's behalf, the Business Unit formally monitors attendance at Board meetings and when holding members to account, the Chair does not focus solely on meeting attendance, but takes a broader view of the members and their agencies contribution to the adults safeguarding agenda.

Agency	09/06/16	22/09/16	08/11/16	05/12/16	27/03/17	Total out of 5
HSAB Independent Chair	✓	✓	✓	✓	✓	5
HSAB Business Unit Manager	✓	✓	✓	✓	✓	5
HSAB Business Unit Officer	✓	✓	✓	✓	✓	5
Herefordshire Council's Adults and Wellbeing Directorate	✓	✓	✓	✓	✓	5
Herefordshire Housing	✓	AWA	AWA	✓	✓	3
2gether NHS Foundation Trust	✓	✓	✓	✓	✓	5
Herefordshire Clinical Commissioning Group	✓	✓	✓	✓	✓	5
West Mercia Police	✓	✓	✓	✓	✓	5
Community Rehabilitation Company	✓	DNR	AWA	AWA	AWA	1
Herefordshire Carers Support	DNR	✓	✓	AWA	✓	3
Healthwatch	✓	✓	✓	✓	✓	5
Public Health	✓	AWA	✓	✓	✓	4
National Probation Service	✓	AWA		AWA	✓	3
Aspire (representing the Voluntary Sector)	AWA	✓	AWA	AWA	AWA	1
Wye Valley NHS Trust	✓	✓	✓	✓	✓	5
Herefordshire Council	✓	AWA	AWA	✓	DNR	2
The Royal National College for the Blind	✓	DNR	AWA	✓	✗	2
Hereford & Worcester Fire and Rescue Service	✗	✓	✗	✓	✗	2
Trading Standards	✗	✗		✗	✓	1

KEY: AWA - absent with apologies • DNR - did not reply to invitation • ✗ - No invitation issued

- **Sharing the right data**

A key element to effective performance management is the Boards ability to collect the right multi-agency data. The local council and health partners provide timely and accurate information, however some agencies, notably the police as one of the principle partners, are still unable to provide the right information to inform Board discussion and decision making. This is a position which is reflected nationally and the Independent Chair is working with the national Police Lead on Adult Safeguarding to secure progress.

Priority 2 - Prevention and protection

- **Service user involvement**

It is important that we gather the views of those who have been through the safeguarding process, however, our ability to do so has continued to be a challenge for the Board.

We have separately tried over the year to arrange a service user group and drop in session for individuals and their families who have been safeguarded. Unfortunately, neither of these was successful and we have now engaged with Healthwatch, who are one of the Boards' statutory partners, to undertake this piece of work on our behalf. We are optimistic in this approach as the public already engage with Healthwatch.

We will include in next year's annual report how successful this has been.

- **Good mental health**

The Board recognises the importance of helping people maintain 'good mental health' and as such the principle is embedded into all of our work and discussions.

- **Greater focus on prevention**

During the past year, we have been developing our Prevention Strategy, which supports the development of initiatives to improve prevention, identification and response to abuse and neglect. It draws together work from partner agencies and includes a range of activities aimed at promoting general wellbeing and maintaining independence as a means of reducing vulnerability to exploitation, abuse or neglect.

Included in this is a work plan which will be monitored throughout the year by the task and finish group, set up to deliver this piece of work.

Next year's annual report will include the successful programmes that have been put in place to help deliver this strategy.

The Board has also been working closely with Hereford & Worcester Fire and Rescue Service to develop an improved home safety check initiative that will see fire service staff asking individuals questions about health and wellbeing as well as fire safety during home visits. This will lead to them being signposted to additional support and services that will help them maintain their independence and live more safely.

Case study - Showing understanding of mental health

Mr C is in his 40's and has long-standing mental health difficulties. He engages in therapeutic day activities provided by a Voluntary and Community Sector organisation in Herefordshire and his routine attendance provides opportunities to monitor and support his wellbeing.

Mr C's mother informed the day activities provider that she was very worried that he was at risk of abuse, including financial abuse, from people who were staying at his flat and dealing drugs. She felt he was extremely vulnerable.

Mr C did not attend the day activity for two weeks and his mother advised that he'd suffered an 'unexplained' broken ankle and she was unable to contact him. She spoke to the provider's occupational therapist, who contacted the county safeguarding team to raise a concern. She was also advised to contact the police.

The police attended Mr C's flat and he was admitted to hospital for treatment to his broken ankle. Following discharge from hospital, the safeguarding concern was closed.

Mr C returned to the day activity but failed to attend follow-up treatment appointments for his ankle injury. His mother believes he is still at risk of abuse and the concern is that if she passes away, she's in her 80's and the only close family member, Mr C might disengage from services and become isolated from support, leaving him even more vulnerable.

Mr C is making his own choices about his life but his mother doesn't believe he recognises his own vulnerability, although it is not clear whether this is the case or if Mr C is aware and accepts the risks.

He enjoys the therapeutic day activity and may well recognise that it also maintains a link with a consistent support network, as well as access to services if required.

Staff will maintain a 'watching brief' to encourage and support him to continue to engage with services and ensure concerns are raised with the relevant agencies when necessary.

Karen Hall
Aspire Chief Executive (on behalf of the Voluntary and Community Sector)

Case study - Prevention of harm

Earlier this year, crews from Hereford Fire Station attended an incident in a home where a boiler was found to be leaking carbon monoxide, meaning it needed to be isolated. A lady and her 15 year old son were living in the property, which had no other source of heating, and was unable to replace the boiler.

The Crew Commander contacted the fire service's Signposting Co-ordinator whilst still at the property, as they were incredibly concerned that the home was extremely cold and the occupants had no alternative heating or accommodation. A Home Fire Safety Technician made contact with the family and delivered an oil filled heater to the property that night, with an additional heater being provided the following day.

With consent from the occupant, a referral was made to the Marches Energy Agency to see if they would be eligible for funding for a new boiler. Following the referral, a new boiler was installed, which was fully funded by Marches Energy Agency.

The occupant later commented 'I'm so happy. The attitude of all the people I've dealt with was great, people really trying to help and do positive things. The fire service was great. One chap said he had been thinking of us in the cold weather, it's lovely to hear that'.

Hereford & Worcester Fire and Rescue Service Technician

Priority 3 - Communications and engagement

- **Raising awareness of safeguarding**

During the year, we attended the Engaging Communities event in Hereford, which was hosted by Primecare. We spoke to members of the public about safeguarding, mental capacity and deprivation of liberty.

We also met the Mayor!

Our local councillors are a key group, as they help raise awareness of safeguarding across our communities.

- **Targeting smaller / community organisations**

During the year, we contacted parish magazines and asked if they could include the below article within their publication. Whilst we couldn't insist that it was included, we have had confirmation from most of them that it was.

We have also made links into the Rural Hub Network, which provide support and information to the local farming community.

Herefordshire Safeguarding Boards

Everyone has a responsibility for safeguarding children, young people and adults at risk of harm. We can help you make sure you know what to do if you think that is happening.

It might be difficult to accept, but anyone can be hurt, put at risk of harm or abused, regardless of their age, gender, religion or ethnicity by either someone they know or a stranger.

Herefordshire Safeguarding Adults board

If you are concerned about an adult ring **01432 260715** (weekdays 9-5)
OR **0330 123 9309** (at any other time)

Herefordshire Safeguarding Children Board

If you are concerned about a child ring **01432 260800**

If someone is injured or in immediate danger dial 999

If there is no emergency but you think a crime may have been committed ring West Mercia Police on 0300 333 3000 or 101

Abuse of any description is wrong and by reporting it you can help to bring it to an end

If, as a member of the public or an organisation, you want more information about the work that the Safeguarding Boards do to keep children and adults that live and work in Herefordshire safe than please contact us on **01432 260100**

- **Raising awareness of Mental Capacity Act and Deprivation of Liberty Safeguards**

In conjunction with the Herefordshire Clinical Commissioning Group (CCG), we have developed bookmarks for professionals that include a quick guide to both the Mental Capacity Act and Deprivation of Liberty Safeguards.

Case study - Best interest health decision

Mr H is 76 years old and has been seen in the hospital's outpatients department due to concerns about abnormal symptoms, which could be suggestive of cancer. A relative accompanied Mr H, as he has Alzheimer's and struggles with his short term memory and ability to focus on any particular topic.

The Doctor initially presumed Mr H had the capacity to make decisions about his own care and treatment, as the Mental Capacity Act (MCA) requires.

The Doctor discussed the problem with Mr H along with the possible causes and the need for further investigations and a medical procedure involving a general anaesthetic. Mr H had the right to be supported to make his own decisions and was given all appropriate help, including having a close relative accompany him to reassure and explain things in a way that he was familiar with. The Doctor also drew a simple diagram to help Mr H focus and understand more about the procedure. However, it became apparent that Mr H was not able to remember the information and was unable to weigh up the benefits and risks of having or not having the procedure. On the balance of probability, it was deemed that Mr H lacked the capacity to make the decision to consent to the procedure.

The MCA states that, if a person cannot make a specific decision (for Mr H it was being able to agree to a procedure to help professionals understand the cause of his physical ill health), any action carried out must be in the person's best interest. Therefore it was agreed to have a best interest meeting with Mr H, his family and medical staff with written information provided by his family GP. The meeting considered the options of either having or not having the procedure and the benefits and risks of both. After hearing the views and assessments from everyone and considering Mr H's past views and wishes about health matters, it was concluded that it was in his best interest to have the procedure.

The procedure went ahead, the cause of Mr H's health problem was diagnosed and treated appropriately and he made a good recovery.

Rhiannon Mainwaring
Lead Nurse Mental Capacity Act and Deprivation of Liberty Safeguards
Wye Valley NHS Trust

Priority 4 - Operational Effectiveness

- **Shared learning**

The Board now has a Multi-Agency Workforce Strategy to ensure that the workforce has the appropriate skills and knowledge in relation to safeguarding. A new training evaluation process has been established and this will enable the sub group to measure if the learning events have made an impact on the knowledge and skills of the attendees.

HSAB has established a series of multi-agency 'practitioner forums', for front line practitioners and managers, which aim to:

- Support practitioners to take a professional judgement-based approach to safeguarding rather than purely a process driven one
- Share good practice and experience across agencies to improve standards
- Share learning from audits, investigations and serious case reviews
- Act as a conduit for the HSAB to share key messages and information with front line practitioners and receive feedback so that the voice of the practitioner informs HSAB's work

- **Links into commissioning and public health**

A consultant of Public Health is a member of the board which ensures commissioning arrangements are informed by strategic cross agency discussions.

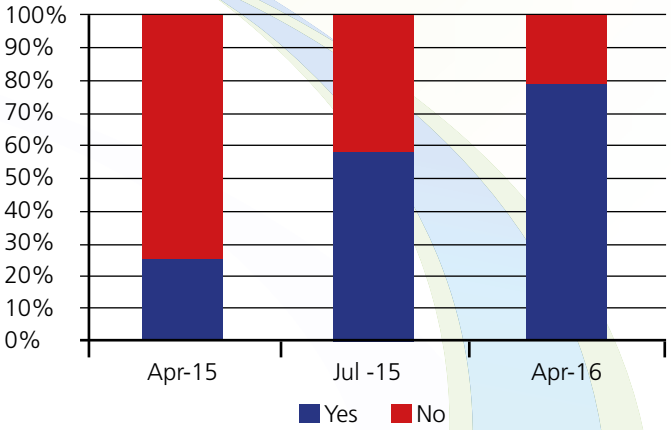
- **Embed Making Safeguarding Personal**

During the HSAB development day in December 2016, the council presented its findings from an internal review of Making Safeguarding Personal (MSP). The Board members considered the findings and recommendations and agreed an action plan, which will ensure leadership to develop and embed improvements across organisations.

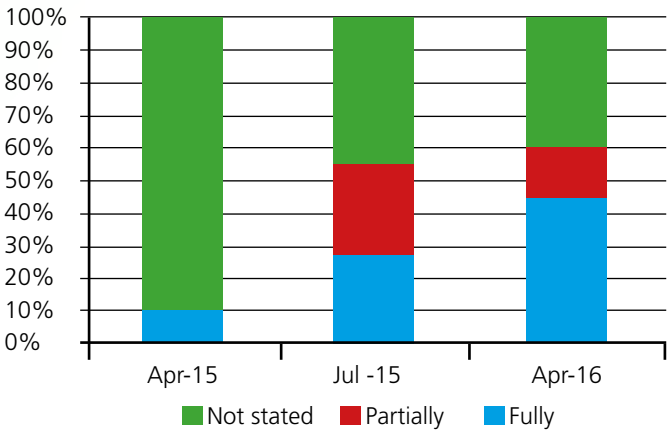
All partner agencies committed to promoting MSP and agreed to undertake one activity which would begin to underpin it as a principle within their organisation. This activity will be monitored throughout the year by the performance and quality assurance sub group.

MSP audit 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?



Case study - Making Safeguarding Personal in hospital

Mr Q is 64 years old and was admitted to hospital with medical problems. He had capacity to make decisions in relation to his care and treatment and where he wanted to live.

Mr Q's wife had died six months prior to his admission to hospital and he had no other family or friends to support him at home. Mr Q and his wife had been inseparable and after her death he had become depressed and lost interest in taking care of himself and his home.

The hospital safeguarding nurses met with Mr Q whilst he was in hospital, and whilst he recognised that he was struggling, he was initially reticent to discuss some of the difficulties he was having at home. The nurses explained to him that no one would be making decisions for him and this reassured him enough to speak about his problems.

Over a two week period, the safeguarding nurses met with Mr Q on several occasions and developed a good rapport with him, ensuring he had choice and control over any decisions made. Mr Q thought it was a good idea to start taking medication for his depression and agreed to attend bereavement counselling. He also agreed to be referred to the council's adult social care and when he left hospital a daily package of care was put in place to help support him to keep on top of things at home.

By engaging Mr Q in conversation on how best to support him at home, he remained firmly at the centre of all decisions and this has ultimately improved his quality of life, wellbeing and safety.

Cath Holberry
Lead Nurse Adult Safeguarding
Wye Valley NHS Trust

- **Embed competency framework**

Following on from the 2015 launch of the HSAB Workforce Development Strategy, which included the competency framework, work on a joint children's and adults safeguarding (HSCB and HSAB) strategy has been completed. It now includes the ability for organisations to have their training validated.

The validation scheme requires organisations to show how their training is making a difference to the people who use their services and how the competency framework is used within the organisation to ensure a competent workforce.

- **Multi-agency training**

The Board does not commission training, but through its competency framework, it holds partner agencies and commissioned service providers to account for the quality of training for its staff.

The practitioner forums, which are held at regular intervals throughout the year, are an opportunity for professionals from all agencies to meet and exchange ideas and share learning.

- **Better priority tracking**

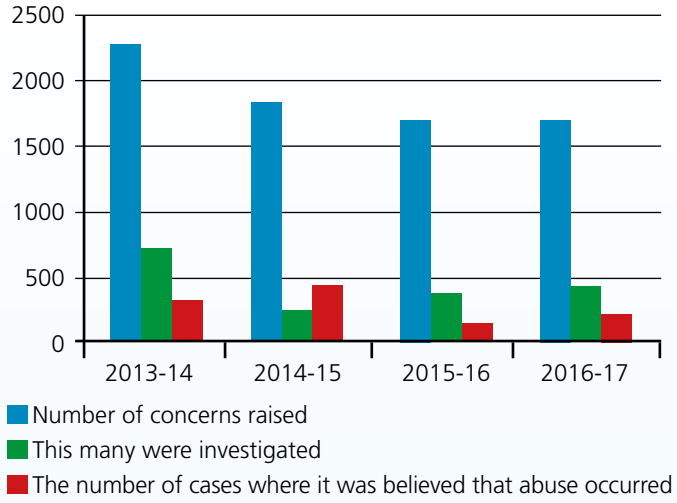
The Business Unit, which supports the work of the Board, the Children's Safeguarding Board and the Community Safety Partnership, has oversight of all work streams. Where there are cross cutting themes, such as domestic violence, it identifies a lead Board to progress actions and provide assurance across the partnership. This oversight ensures that duplication of effort is avoided and that all partner agencies are aware of developments.

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

The council receives all safeguarding concerns from partner agencies and members of the public. Where agencies are consistently raising concerns that do not meet the threshold for safeguarding, council practitioners will work with them so they better understand when a safeguarding referral is appropriate and when some other course of action may be used.

The following graphic shows that over the four year period the proportion of concerns being raised which are investigated is increasing. This shows we are making progress but there is still more to do.

About the concerns regarding abuse that have been raised



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

The Board continues to raise awareness of safeguarding across Herefordshire in a variety of ways and will continue to do so. Several campaigns have been supported by the Board and new materials have been developed and distributed across agencies. We plan to deliver awareness raising sessions for councillors and parish councils, the outcome of which will be recorded in next year's report.

- **Service providers deliver quality care**

Within Herefordshire, there are 79 homes which deliver residential and nursing care and 53 community care service providers, which are regulated by the Care Quality Commission (CQC).

Herefordshire Council and Herefordshire Clinical Commissioning Group complement the CQC's work through the Quality Assurance Framework. This was introduced in 2016 and is now fully embedded into practise and dictates that services showing heightened risk are visited by the council's quality and review team.

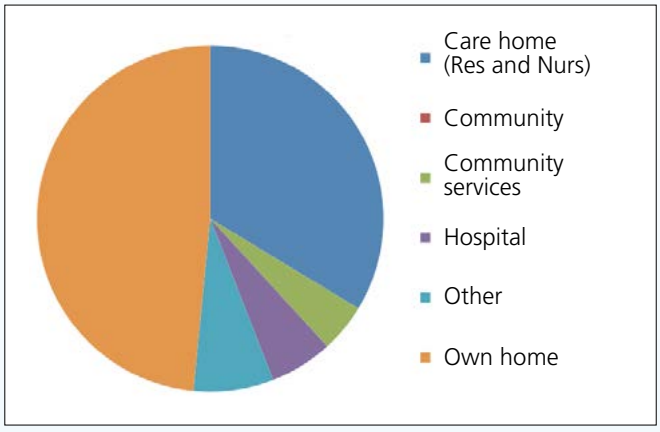
In the 12 month period from April 2016 to March 2017, the team has undertaken interventions with 18 care homes and 8 community services. Services are visited on numerous occasions, in line with agreed processes to review and monitor.

There have been approximately 190 quality and review site visits to monitor services in the 12 month period from April 2016 to March 2017. These visits may have involved more than one council officer and also include visits undertaken out of office hours, such as evenings, weekends and bank holidays. The visits continue until the quality of the service has improved.

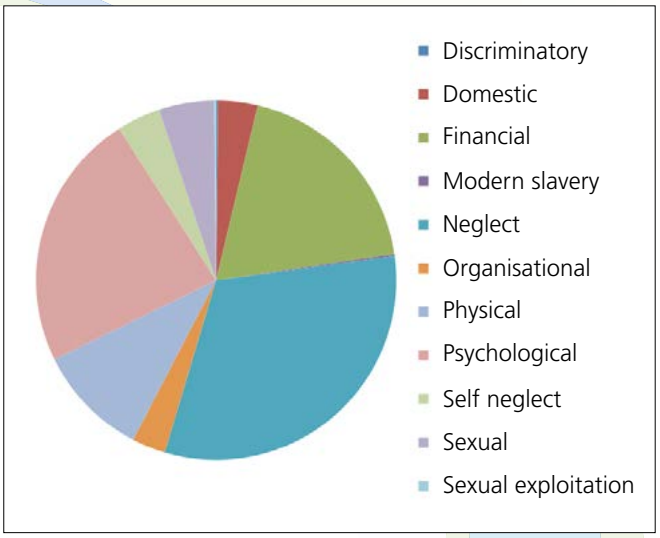
This new way of working is designed to ensure the delivery of high quality care and support services in Herefordshire.

What does safeguarding look like in Herefordshire?

This shows where abuse has been reported



This shows what type of abuse has been reported?

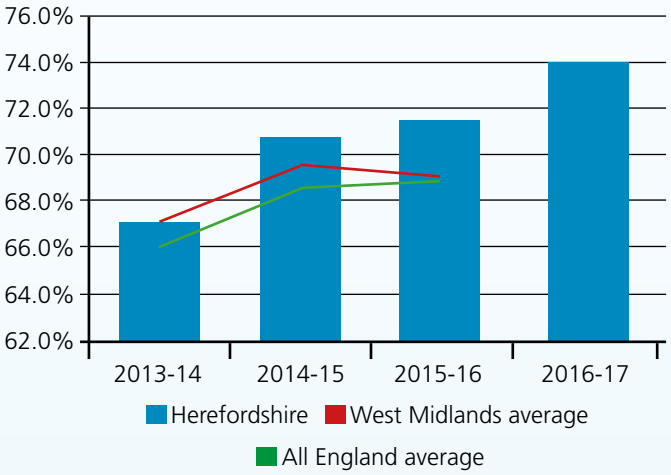


Every year the local council takes part in a survey, commissioned by the government, collecting multi-agency performance data and asking individuals about their experience of care.

Some key highlights are:

Proportion of people who use services who feel safe

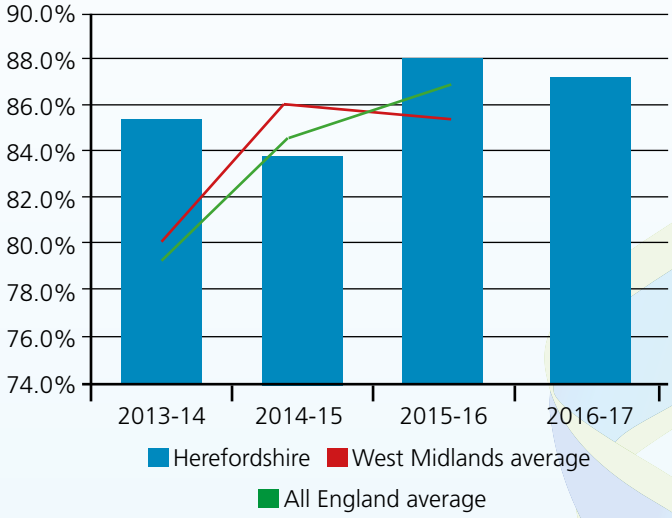
	2013-14	2014-15	2015-16	2016-17
Herefordshire	67.1%	70.9%	71.5%	74.0%
West Midlands average	67.1%	69.5%	69.2%	Not yet available
All England average	66.0%	68.5%	68.9%	Not yet available



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

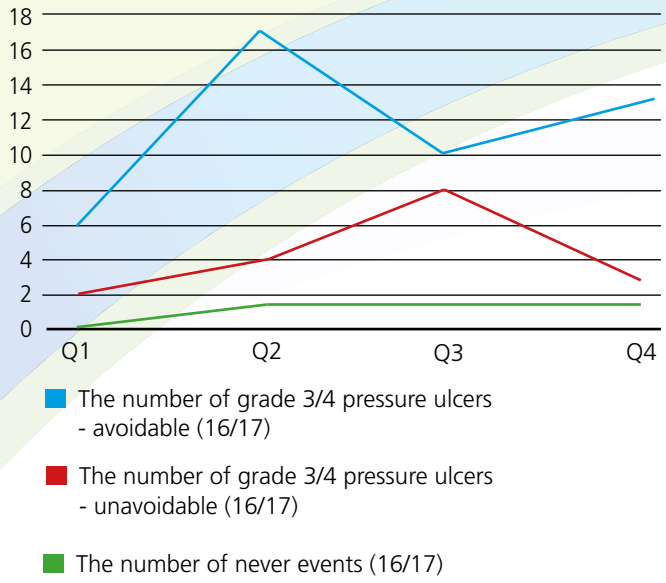
Proportion of people who use services who say that those services have made them feel safe and secure

	2013-14	2014-15	2015-16	2016-17
Herefordshire	85.5%	83.9%	88.0%	87.0%
West Midlands average	79.9%	86.1%	85.4%	Not yet available
All England average	79.2%	84.5%	86.7%	Not yet available



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

Wye Valley NHS Trust



For each reported incident, a root cause analysis review is carried out and learnings from this are shared with hospital staff, with a view to improving clinical practise and knowledge across the trust.

In January 2017, the trust set up a Pressure Ulcer Panel where all pressure damage is reviewed, themes identified and training and support targeted to the appropriate clinical area.

Peer challenge

Following on from the original peer challenge which took place in September 2015 and was detailed in last year's report, a second visit has taken place to review our progress against the original action plan. The peer challenge team recognised that we have made some real changes to the way we work, including that HSAB is no longer dominated by the council and is much more engaged with all partners. They complimented the independent chair on his strong leadership, as well as the political leadership from the Cabinet member. They did make some additional recommendations, which we are adding to the action plan and will continue to work towards completing through 2017/18. You can view the full suite of documents on our website.

How the Board works to deliver results

The Board brings together representatives from:

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

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

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

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

The executive sub group of the board is the group which ensures delivery against priorities is on track. Where progress is not being made the executive group make recommendations to the Board on what needs to change for progress to then be made.

What the sub groups have delivered this year:

Performance and Quality Assurance

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

Chairs update

Lynne Renton
Director of Nursing, Herefordshire CCG

During the year, the sub group has carried out, in conjunction with the council's Children's Wellbeing directorate, an audit of young people transitioning between children's and adults services. This showed that for most of the individuals, support continued effectively over this period, however some of the agency processes were not adhered to and communication between agencies was not always as robust as it might have been. Measures have been put in place to improve this.

An MCA audit was issued to all Herefordshire care home providers, which resulted in a poor response rate of only 18%. The reason for the low response rate is now understood by the Board and this will be taken into consideration when other audits are undertaken. Despite the low response rate, the audit did highlight some consistent themes, which were shared with the MCA / DoLS sub group which incorporated them into their work plan to progress.

Findings from audits and round table reviews are shared with the joint workforce development sub group to inform training and the practitioner forum, where appropriate. Training has also been delivered to nursing homes, focussing on accountability, responsibility and challenge.

An annual assurance buddying exercise was completed and demonstrated good compliance with safeguarding processes across statutory agencies.

The work plan for 2017/18 includes a re-issue of the annual assurance proforma for completion by Board partners.

Wye Valley NHS Trust's "Do not attempt Cardio Pulmonary Resuscitation" (DNACPR) policy was agreed through their governance process. Previous discussions elicited support from statutory partners to adopt this policy throughout Herefordshire and training was commissioned through January and February from the CCG's legal advisors to support this.

Messages from the performance and quality assurance sub group are shared with the communications sub group, where appropriate, for dissemination across the partnership.

Policies and procedures

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

Chairs update

Alison Feher
Safeguarding Lead, 2gether NHS Foundation Trust

The latest version of the West Midlands Multi-Agency Safeguarding Adult Policy and Procedures was published in September 2016.

This document is the main procedural multi-agency adult safeguarding point of reference for practitioners and was ratified by the HSAB policies and procedures (P&P) group in 2016. We will continue to contribute to the regional group, which develop and update this key document.

The regional policy and procedures sub group also devised the West Midlands Position of Trust Framework during 2016/17. This document was agreed by the P&P group and was published in Herefordshire in January 2017.

Locally, various other policies and guidance have been developed by the P&P group to assist professionals. This includes the Self Neglect Policy (published 2016), the HSAB Resolving Professional Disagreements Policy (published 2017) and the HSAB Professionals Guidance (published 2016).

Activity that has moved into 2017/18 includes the implementation of phase two of Making Safeguarding Personal (MSP) and development of the Child Sexual Exploitation (CSE) Transition Policy with the Herefordshire Safeguarding Children Board CSE and missing children sub group. The P&P sub group will also be involved in implementing the MSP phase two documentation.

The Female Genital Mutilation (FGM) and Modern Slavery and Human Trafficking policies sit with the Herefordshire Community Safety Partnership, but the P&P group will be actively contributing to them.

The P&P sub group was previously required to disseminate key messages and learning to agencies and professionals. This role now sits with the newly formed cross partnership communications sub group. The P&P group will work with this sub group in 2017/18 to promote policy changes and new guidelines. During 2016 /17, effective dissemination of P&P news and policy changes came about through the practitioners forum, which is held quarterly.

Over the past 12 months the P&P sub group has formally met on four occasions: 14 June 2016 (4 attended), 13 September 2016 (6 attended), 15 November 2016 (8 attended) and 7 March 2017 (5 attended). Additional meetings have been arranged to move business along outside the formal P&P forum and whilst attendance has been inconsistent, work has been completed and the annual work plan achieved.

Mental Capacity Act and Deprivation of Liberty Safeguards

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

Chairs update

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

The HSAB MCA/DoLS sub group has engaged in a number of activities to raise awareness and improve practice in relation to the MCA and DoLS, including:

- Undertaking an audit of care providers and organisations in relation to their awareness and implementation of the MCA
- Updating the new HSAB website with a range of information, tools and resources regarding MCA and DoLS for members of the public and practitioners
- The creation of leaflets providing a quick guide to the MCA and DoLS
- The creation of legal case law newsletters for professionals
- Attendance at an event in High Town, Hereford to promote the work of the HSAB and raise awareness of the MCA and DoLS
- Production of bookmarks, available for practitioners for use a quick guide

The sub group is also in the process of organising an MCA conference.

Herefordshire DoLS Service continues to experience high referral rates, however the service has been working hard to start to stabilise and reduce the number of referrals awaiting assessment. All referrals are triaged to ensure that people who are most at risk, as a result of being deprived of their liberty, are assessed quickly. The DoLs team is working closely with the quality and review team to ensure that cases where there are concerns about the quality of care being received are prioritised.

The DoLs team continues to work closely with a pool of independent assessors to complement the team's in house assessors and is proactive in expanding its pool of workers to help maintain assessment capacity.

Joint training and workforce development

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

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

Chairs update

Alison Chambers
Project Officer, Training and Development, Hoople Ltd

The Multi-Agency Workforce Strategy, which determines the workforce development plans for all who work with and support adults at risk to ensure that they are skilled and competent, has been refreshed. It has been updated to include learning from reviews and changes to legislation. The updated strategy includes a process whereby provider services / training providers apply to have their training programmes validated as meeting the requirements of the strategy and competency framework.

This new strategy and validation process ensures HSAB meets the requirement of the Care Act 2014, which states:

"In order to respond appropriately where abuse or neglect may be taking place, anyone in contact with the adult, whether in a volunteer or paid role, must understand their own role and responsibility and have access to practical and legal guidance, advice and support. This will include understanding local interagency policies and procedures" (14.43 Care Act 2014).

The new evaluation process has been established and used with learning events delivered on behalf of the HSAB. This will enable the sub group to measure if the learning events have made an impact on the knowledge and skills of the workforce and those who access services.

The improving numbers attending the practitioner forums is encouraging with the last two forums being booked to capacity. We have had 330 bookings and 236 practitioners attend over seven sessions this year from 48 agencies. This forum programme included dissemination of learning from Safeguarding Adults Reviews (SAR's), informing practitioners about the work of the Board, Care Act and Making Safeguarding Personal.

From each forum, a Voice of the Practitioner report is developed and presented to the executive group.

A specialist 'Silent Victim' conference was held this year at The Kindle Centre, Hereford on 19 October and was attended by 122 practitioners drawn from over 30 agencies based in Herefordshire. Evaluations from the event were positive, particularly for two presenters, who were talking from their own personal experience, and the session highlighted the barriers faced by people from minority communities.

Joint Case Review (JCR)

The Board has a legal duty to undertake a review 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.

Chairs update

Mandy Appleby
Principal Social Worker, Herefordshire Council

The chairing arrangements of this sub group have been reviewed this year and a new chair, with greater knowledge of adult safeguarding, has been appointed. This will lead to better management of the process, which has caused drift in previous cases, with learnings not getting to front line practitioners in a timely way.

One referral was received within this period, which did not meet the threshold for a Safeguarding Adults Review (SAR).

One SAR report, commissioned in 2015, has been received by the sub group. The independent chair felt that not all learnings had been identified and requested some additional work to take place. This has not been completed within the reporting period, so will be included in next year's report.

One SAR report has been approved by the sub group and chair and this led to a learning event attended by practitioners. It has also led to changes in recording on the council's case management system, changes in cross border commissioning arrangements and resources for practitioners being readily made available in respect of MCA and DoLS.

One Practice Learning Review (PLR) has been completed and the recommendations from this have been overseen and monitored by the sub group.

The availability of suitable independent authors to write these reviews continues to be a concern for the Board and they are considering ways of managing this, should future SARs be commissioned.

Communications

To ensure that the key messages identified from any of the Boards' strategic priorities are appropriately communicated via the most effective conduit, consistent with the statutory requirements of the boards.

Chairs update

Steve Eccleston
Business Manager, Safeguarding Business Unit

The Board shares a joint communications sub group with the Safeguarding Children Board and Community Safety Partnership. The purpose of this sub group is to ensure that all safeguarding communications across the partnerships are as co-ordinated and effective as possible.

The sub group is aware of the Boards priority areas and looks to ensure these are captured in communications. Importantly the group also share what each agency is doing on communications about particular topics, so it can be more informed and co-ordinated about messages given to partners and the community. To develop this co-ordination further, the sub group is now working closely with the One Herefordshire Strategic Communication and Engagement Group, which is a forum led by Herefordshire Clinical Commissioning Group.

What the sub groups will deliver next year:

Introduction
A review of the priorities agreed for 2016/17 took place in November 2016 and future improvement opportunities were identified for populating the work plans for 2017/18.

These align to the existing priorities:
- Partnership working
- Prevention and protection
- Communications and engagement
- Operational effectiveness

Strategic priorities	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Aim	To develop relationships across agencies that deliver positive changes to safeguarding	To ensure that Herefordshire residents can recognise safeguarding concerns and know what to do	To deliver the messages from the Board and recognise the voice of those we safeguard	To ensure safeguarding knowledge, processes, systems and structures are embedded across all agencies

The document at appendix 1 shows the 2017 - 18 strategic priorities and the sub group work plans to deliver this.

Appendix 1

Strategic priorities	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Strategic Board work plan	Single agency contributions to annual report Develop and monitor action plans arising from Making Safeguarding Personal (MSP) review Promote MSP across all partner agencies	Review prevention strategy Monitor prevention work plan	Ensure the messages from the Board are communicated in a timely and consistent manner Ensure the voice of those who have been safeguarded are considered in the work of the Board HSAB partners to ensure MSP messages and awareness are cascaded to staff	Publish annual report on the effectiveness of local safeguarding arrangements Ensure the needs of adults at risk are addressed in the JSNA and HWB strategies

Sub group work plans

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Executive group	Monitor relevant sub group work plans Oversee delivery of action plan arising from peer review Learning from other areas, including Domestic Homicide Reviews, Safeguarding Adults Reviews and Serious Case Reviews Monitor risk register	Monitor relevant sub group work plans Monitor risk register	Monitor relevant sub group work plans Monitor risk register	Monitor relevant sub group work plans Monitor risk register

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
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 Mental Capacity Act (MCA) protocols into practice	Embed self-neglect policy into practice	Launch of new policies	Report to executive group Embed new policies Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
MCA and DoLS	Develop suitable tools for all professionals to aid understanding Multi-agency audit	Gather evidence of the voice of those without capacity	Raise awareness of MCA and Deprivation of Liberty Safeguards (DoLS), via: • Website • Roadshow • Newsletter Increase awareness of the Court of Protection Increase the understanding of consent	Report to executive group Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Performance and quality audit	Monitor multi-agency and single agency scorecards Programme of multi-agency audits Introduce multi-agency MSP audit	Monitor results of the activity undertaken by the Community Safety Partnership (annual) Audits to include the voice of those without capacity Adapt council audit format to include the voice of the carer Monitor support provided to carers and young carers	Introduce seven minute learnings for findings from audit and SARs Six monthly reports from MIR evaluating their work with vulnerable groups	Report to executive group Monitor the effectiveness of services provided to adults at risk via a six monthly report from the quality and review team Continue to review performance measures and reporting Contribution to the annual report Monitoring of single agency actions relating to MSP

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Workforce development	Practitioner forum Engage with front line staff and use their experiences to inform HSAB activity Ensure learning from MSP review is aligned to competency framework Develop familiarisation workshops for MSP	Empower staff to deliver person centered care Empower staff to professionally challenge	Ensure competency framework is embedded across all partners	Report to executive group Develop safeguarding supervision standards and guidance Develop guidance to support partner agencies to evaluate training Contribution to the annual report

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Safe voice			Obtain views of safeguarding and services Develop independent arrangements to verify service user feedback of the safeguarding experience (MSP)	Review of user facing material

Delivery group	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Communications	Promote RIPFA as a resource	Promote community resilience for town and parish councils Raise understanding and awareness of the advocacy offer	Raise awareness of adults at risk Sharing of best practice and case studies Dissemination of shared learnings	Report to executive group Contribution to the annual report Raise awareness of partner agencies

	Partnership working	Prevention and protection	Communications and engagement	Operational effectiveness
Key outcome measures: **How will we know how successful we have been**	• Partner agencies are committed and attendance at meetings is at least 80% • The Board is aware of voluntary and community organisations and the work undertaken to support the safeguarding agenda • Other Boards are aware of the work of the HSAB Board and engage effectively when required • Partner agencies are showing progress in MSP • Multi-agency attendance at practitioner forums and learning events • Bi-annual assurance statements received from all partners	• Production and publication of a prevention strategy and work plan • Partner agencies and providers are aware of legislation and raise appropriate referrals • MCA, DoLS and MSP are embedded into practice • Adult safeguarding information is incorporated into the Joint Strategic Needs analysis • Workforce is supported to exercise professional judgement / challenge • Hereford & Worcester Fire and Rescue Service safety checks are carried out for 2,000 households	• Messages from the Board are effectively disseminated • Communities and individuals are aware of what safeguarding is • Communities and individuals are aware of the Mental Capacity Act • Communities and individuals are aware of Deprivation of Liberty Safeguards • Communities and individuals are aware of Lasting Power of Attorney • Seven minute learnings are recognised as a learning tool • All relevant national campaigns are promoted by the Board	• Service providers deliver quality care • Workforce is well trained / supervised • Learnings from SARs are embedded into practice • Priorities are tracked effectively • A truly multi-agency scorecard is available

Appendix 2

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

Contributions from statutory partner agencies for 2016/17 remained the same as in 2015/16 at a total of **£383,964**.

Note: This total contribution is for the support of the Herefordshire Safeguarding Adults Board, 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 Unit, is as follows:

Business Unit Manager: Full time
Learning Development Officer: Full time x 3
Training Officer: Part time x 0.41
Business Support: Full time x 3

Basic pay and on costs	**£292,738**
Independent HSAB and HSCB chairs	**£ 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 for 2016/17

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 funds designated to the Training Officer Post (contained within the above staffing costs)	**£ 10,034**

Note: The Business Unit is developing a multi-agency training pool for partners to deliver training together (contributions in kind), wherever possible and using free venues, where refreshments can be easily purchased by course participants (such as the council's Plough Lane office).

The Business unit is 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 residual balance is what remains to cover any Serious Case Reviews, Serious Adult Reviews, annual conference / promotions and any sundry costs.

Appendix 3

Herefordshire Council

Position Statements for HSAB Annual Report

With the implementation of the Care Act 2014 and the new statutory duties placed upon local councils, Herefordshire Council has placed even greater emphasis on working with its partners, communities and residents to encourage, support and facilitate the safety and wellbeing of those who are exposed to or are vulnerable to abuse, exploitation and discrimination in all its forms.

In 2016/17, the council completed a review of Making Safeguarding Personal (MSP) which it had introduced in readiness for the Care Act in January 2015. The vision in 2015 was to develop a safeguarding culture that focused on personalised outcomes, desired by people who may have been abused, as a key operational and strategic goal.

The purpose of the MSP review was to establish the success so far in delivering the initial vision for a more personal approach and to inform further improvements required of the established MSP safeguarding processes, which are led by the council's operational social care services. Additionally, the review sought to ensure that all partners participated in evaluating the effectiveness of shared responsibilities to safeguarding and making safeguarding personal. As part of this review, the Head of Safeguarding participated in the National MSP evaluation. This has assisted us to develop our safeguarding approach alongside progress made nationally. The MSP review, including the action plan of recommendations, was received positively by the West Midlands Peer Challenge team, whose remit was to review progress made since their earlier review of safeguarding in 2015.

Herefordshire Council has continued to forge strong links regionally and nationally to assist in developing safeguarding services that are personal, responsive and effective. There are established professional roles to facilitate the safeguarding agenda, including the roles of Principal Social Worker and Head of Safeguarding, Operational Safeguarding Lead and Mental Capacity and Deprivation of Liberty Lead. All the council's adults and wellbeing professional leads work closely with the Herefordshire Safeguarding Boards and / or sub groups and with all agencies, such as the NHS, police, probation and local service providers, to prevent or reduce factors that can lead to abuse and ensure there is confidence in how to support a person who is in need of a safeguarding approach. More recently, the council's Assistant Director of adults and wellbeing operational services has been appointed as the Chair of the Association of Directors of Adult Social Services (ADASS) West Midlands Safeguarding Network.

Herefordshire Council has provided a representative on the West Midlands multi-agency safeguarding editorial group to re-write the multi-agency procedures. These procedures are now published on the HSAB website. The council has also led the development of the Mental Capacity and Deprivation of Liberty guidance and has provided bespoke training across a range of provider agencies. The framework and process for 'allegations about a person in a position of trust' as set out in the statutory guidance and the West Midlands multi-agency guidance, has been developed by the council, agreed by HSAB and is now implemented.

We have implemented a three step process to safeguarding to support practitioners in promoting a responsive and personal service, with an aim of promoting less time on process and more time for face to face contact with the individuals involved. This is an example of responding to feedback from professionals during the review as well as to the recommendations of the Safeguarding Peer Challenge Review influencing improvements.

The council has now completed phase one of the operational 'whole systems' pathway design, which realigned internal resources so it could meet increases in demand and reflect the focus of the Care Act towards personalised approaches (such as Making Safeguarding Personal) and strengths based approaches to assessment and support planning. Plans are now in place to train operational and commissioning staff in the principles of strengths based practice and commissioning. This encompasses the principles of safeguarding and making safeguarding personal and will support the sustainability and resilience of our communities

Mandy Appleby
Head of Safeguarding and Principal Social Worker, Herefordshire Council

Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013, they are membership organisations that bring together general practices to commission services for their registered populations and for unregistered patients who live in their area. CCGs are responsible for commissioning most hospital and community healthcare services as well as primary care services.

In July 2015, NHS England published a document entitled 'Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework', which sets out the responsibilities of each part of the NHS system. Herefordshire CCG conforms to all the requirements set out in this document.

All staff receive yearly safeguarding training and those who have patient contact, receive regular safeguarding supervision.

As a commissioning organisation, the CCG ensures that all its commissioned services have robust safeguarding processes and policies in place. We frequently assure ourselves that these processes are robustly adhered to by holding regular Contract Quality Review Forums with all our major contractors and also conducting quality assurance visits to provider's clinical areas.

The CCG has good working relationships with partner agencies and supports the Herefordshire Safeguarding Boards, both financially and by a commitment to the functioning of the Boards, including the chairing of several sub groups.

The CCG regularly reviews its safeguarding duties by reporting performance and safeguarding developments to the CCGs Quality and Patient Safety Committee (a sub group of the Governing Body) and the Governing Body.

The CCG Governing Body receive an annual NHS system wide safeguarding report, which analyses safeguarding across all NHS services, and provides assurance that the NHS is delivering services which protect the residents of Herefordshire.

Lynne Renton
Deputy Director of Nursing, Herefordshire CCG

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

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

As part of the trust's commitment to safeguarding adults throughout all its services, we have a dedicated Adult Safeguarding Lead Nurse and in September 2016 appointed a Lead Nurse for Mental Capacity (MCA) and Deprivation of Liberty Safeguards (DoLS). The Director of Nursing is the Executive Lead for safeguarding and has clear oversight of safeguarding activity.

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

We have a safeguarding training programme in place to ensure staff are aware of their roles and responsibilities and act appropriately and proportionately to any concerns raised. WVT was inspected by the Care Quality Commission (CQC) in June 2016, with their final report being published in November 2016. The report showed that staff were aware of their responsibilities regarding safeguarding procedures, MCA and DOLS, knew how to raise concerns and who to go to for advice and support.

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

WVT remains committed to making safeguarding personal, ensuring vulnerable individuals are central to the safeguarding process with their wishes and feelings being paramount.

Lucy Flanagan
Director of Nursing, Wye Valley NHS Trust

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

Achievements 2016/17
2g has continued to improve the take up of training for safeguarding adults with a 'Think Family' approach. This involved Making Safeguarding Personal (MSP) and incorporated safeguarding children within the adult's social network. 2g has also hosted two events to raise awareness of the new criminal offence of coercive and controlling behaviour.

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

In line with the Board's objectives, 2g has specifically shared learning from Safeguarding Adults Reviews, Serious Case Reviews and other learning models, shared learning from multi-agency and single agency (internal) audits. Other staff training has focussed on domestic abuse and sexual violence, perinatal mental health, substance misuse, female genital mutilation and prevent.

2g has actively participated in Board and sub group activity, ranging from chairing sub groups, facilitating learning events (Practice Learning Reviews) and front line staff keenly partake in learning events / audits.

Priorities for 2017/18
2g will continue to work in partnership to improve overall safeguarding activity, in particular to increase the recording in all aspects of safeguarding within the trust's electronic patient record. This includes participation in all sub groups, while specifically focusing on learning from multi-agency and internal single agency audits, learning from Domestic Homicide Reviews, Safeguarding Adult Reviews, Serious Care Reviews and other learning models (e.g. Practice Learning Reviews and Significant Incident Learning Process).

2g will continue to increase the provision of safeguarding supervision to teams working with adults, concentrating on MSP while ensuring the safety of children within the service user's social network.

It will also continue to update the 'Think Family' training approach (level 2), Health WRAP (Workshop to Raise Awareness of Prevent), improve statutory and mandatory training compliance, offer training in FGM and build on the training from 2016/17 in coercive control.

2g looks forward to continually improving practice with partner agencies to ensure an adult's right to live in safety, free from abuse and neglect, is protected. Acknowledging the pressures presented by the current economic climate, safeguarding adults and children remain a priority in the delivery of mental health services.

Quality Assurance
2g will continue to provide assurance to the Board that safeguarding priorities are in line with best practice and evidence a positive outcome for families.

Alison Curson
Deputy Director of Nursing, 2gether NHS Foundation Trust

Our vision continues to be protecting people from harm, and one of our core values includes working in partnership to provide the best service we can. This is further supported by our forces ambition 'looking to 2020' to be great at protecting the most vulnerable.

West Mercia police has recently received a 'Good' grading in the HMIC inspection, relating to legitimacy, effectiveness and leadership and was praised for our work relating to vulnerability.

It is now almost 12 months since we restructured and streamlined our investigative framework in Herefordshire to bring about one investigative criminal investigation department to incorporate the traditional CID and Protecting Vulnerable People (PVP) functions. A key driver for bringing about this change was the need to reinforce the fact that protecting vulnerable people is everyone's business and not the sole responsibility of a specific department, which had largely evolved to be the case. This has brought resources together operating deployment principles, which ensure that the most appropriate resource is allocated to deal with incidents dependent upon the threat, harm and risk of the situation and potential vulnerability of those involved. The force has invested in ensuring that more officers and staff are trained with specialist skills to investigate complex crimes, along with additional staff working in roles specially focused on protecting the most vulnerable.

West Mercia Police has launched a vulnerability strategy under the corporate branding of 'see past the obvious' and is a leading force on the national platform to promote the effective recognition and response to all forms of vulnerability, by taking a professionally curious approach to every engagement. This means understanding each situation and circumstances of every person that we come into contact with and respond appropriately to their needs, in partnership with other agencies. It is recognised that in order to achieve this, there needs to be a structured learning model and associated tools and in that regard the following has been developed and is being rolled out to officers and staff:

- Each policing area has been allocated a specific vulnerability lead at Chief Inspector level
- Recruitment of three additional staff to the learning and development department specific to the vulnerability agenda
- Development of bespoke vulnerability training
- Training of 36 Sergeants to deliver 'see past the obvious' briefing sessions
- The force has also developed innovative electronic reference guides and a training video (with others under development)

The force has invested significantly in appropriately equipping our workforce with the tools to do the job more effectively and thus protect people from harm. The introduction of laptops and smart phones, with innovative applications, enable our officers to work remotely, whilst being able to access relevant information and guidance, as well as being more visible and accessible to our communities. The provision of body worn video for officers enables them to capture evidence effectively and brings transparency to our operational work.

The force is also investing in a new investigation management system and a new command and control room, which will further improve the efficiency of our response to the most vulnerable people in our community.

So what does all this mean to adults with care and support needs? Our approach seeks to identify all forms of vulnerability and we expect officers and staff, from our very first public contact, to be professionally curious in their assessment of an individual's needs and to consider the most appropriate response to support them. This will very often be small measures, such as providing general advice through to signposting and for relevant cases referral to other agencies for either single agency or multi-agency intervention. Our approaches and training materials help our staff to specifically identify those who may have care and support needs and to respond appropriately. We do put people at the centre of our investigative processes, as required by the Victim's Code, however we do recognise that we have further work to do to fully embed the principles of Making Safeguarding Personal' in everyday policing activity. In that regard, we are developing bespoke materials relevant to this and engaging with partners to share our approach to vulnerability.

Dean Jones
Chief Inspector, West Mercia Police

Safe and well visit form
Hereford and Worcester Fire & Rescue Service (HWFRS) has amended its Home Fire Safety Check (HFSC) form to include questions that support the work of other agencies; improving the referral process of vulnerable adults to relevant support organisations. The original HFSC form supported the fire prevention strategy for HWFRS, which incidentally provided information that resulted in a referral to other support services for vulnerable adults. The inclusion of additional new specific questions has assisted in the identification of other issues or concerns, which has enabled HWFRS to refer vulnerable adults to the correct services, improving their safety and wellbeing.

Shared premises: HWFRS and West Mercia Police (WMP)
The HWFRS Community Risk Department in Herefordshire has moved into Hereford Police Station. This department is responsible for delivering preventative support (fire, road and water safety and arson reduction) across the county, including to vulnerable adults. This work is closely linked to the work of the WMP Harm Hub. The move has enabled closer working relationships to be established, leading to improved sharing of information between these organisations and will provide improved preventative services and support for vulnerable adults in Herefordshire.

Mark Preece (MSc MIFireE)
Area Commander, Hereford and Worcester Fire & Rescue Service

The Care Act 2014 created a clear legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect. West Midlands Ambulance Service Foundation Trust (WMAS), as a partner member of the adult safeguarding arrangements outlined in the act, discharge its responsibilities through a range of interconnected strategic, tactical and operational activities.

WMAS worked with representatives of the adults board to ensure our referral process is aligned to that of the Care Act and appropriately addresses some historic issues of inappropriate referrals.

The guidance was agreed by all Boards and is now current within WMAS.

Partnership
WMAS regionally covers 28 adults and children's safeguarding boards and as a consequence the service does not have the resilience to send a representative to all Board meetings. WMAS has an agreement to attend at least one Board meeting a year and by invitation to address a specific matter. WMAS receive all minutes and papers and submit reports when required.

WMAS also provides information for Individual Management Reviews, short reports, briefs, Domestic Homicide Reviews and Safeguarding Adults Reviews both at scoping panel meetings and via written reports. WMAS is also a member in the new Emergency Services Group, which is scoping new ways of working and we are also on the prevent agenda.

Local council arrangements
WMAS operates across the whole of the West Midlands, where all localities require information and participation, but each locality has different operating approaches, referral pathways and partnership arrangements from the other local councils.

Quality assurance
West Midlands Ambulance Service is monitored and audited externally by the Care Quality Commission (CQC), which in its recent review deemed the service as 'Outstanding'. Lead commissioners regularly review our processes and peer reviews are undertaken by other ambulance services. These are supplemented by internal audit reports and regular monitoring referrals.

Training
WMAS has a dedicated education and training department, which is responsible for the delivering and auditing of training. All WMAS staff members receive safeguarding training, however the method and level of training varies dependant on individual job roles. Training is delivered via mandatory workbooks, face to face and e-learning packages. WMAS, as an organisation, collates and disseminates learning from SAR / DHRs and use that to feed into policies and procedures.

WMAS safeguarding team members attend multi-agency training at a variety of levels and the trust set a target of 85% and achieved an overall average of 91%.

Lauren Hadley
Safeguarding Team, West Midlands Ambulance Service Foundation Trust


Herefordshire
Safeguarding
Adults board