Herefordshire Safeguarding Adults board

Annual Report 2019/20

Contents

Foreword

Thank you for taking the time to read this annual report and your continued interest in safeguarding adults in Herefordshire.

Herefordshire's Safeguarding Adults Board comprises senior leaders from the range of commissioners and provider agencies who are the health sector, the Police, the Fire Service, the Local Authority Adult Social Care, and Public Health and representatives of the voluntary and community sector and residential care providers.

My role is independent of these organisations and my duty as Chair is to ensure that the Board is given adequate assurance that we are all delivering safe services, and that Board Members hold each other to account for this.

The report shows what the Board aimed to achieve on behalf of the residents of Herefordshire during 2019-20.

It would be remiss of me not to reflect that at the start of 2020 the nation found itself facing the worst public health crisis in modern times in the form of the Corona virus pandemic. Our early focus was on how necessary adjustments to frontline delivery might result in reduced contact with some of our most vulnerable residents, and what impact that may have on their health and well-being. As I write this foreword I reflect on the fact that we will be facing this pandemic for many months to come, and indeed are likely to see significant societal changes as a consequence. Please be assured that the board will be very focussed on the impact of this public health crisis and what it will mean for our adults who are at risk of abuse or neglect across the County.

I have no doubt that the work of adult safeguarding throughout this period will be the matter of frequent conversations with my national safeguarding board chair colleagues, and the local government association and Association of Directors of Adult Social Services, for my part I will ensure we share our local good practice as well as reflecting on other national practice which may benefit Herefordshire residents. This will be the subject of the Board's report next year.

I have also been both humbled and impressed by the willingness of people and communities across Herefordshire to come together to support families, friends and importantly people with whom they were not previously acquainted throughout the so called 'lock down' period, in particular to support those whose underlying vulnerabilities meant they had to follow the governments shielding guidance. It is this community resilience that is hugely important to ensure our most vulnerable residents, those who have needs for care and support, can live a life free from abuse and neglect.

We have also included lived experience cases in the report. Adult safeguarding is difficult work for a range of reasons not the least of which is to balance respecting an individual's right to choose how they wish to live their life against professionals concerns where this exposes the person to ongoing risk. Not all of the cases reported have successful outcomes for the person, showing the reality of how difficult a balance this can be. Where there are adverse outcomes we continue to focus on system learning and with a view to changing or improving frontline

practice to better meet a person's needs and wishes and to support them to live as they choose, but safely.

In certain circumstances when a person dies the Board has a responsibility to commission a review of the case, including that person's contact with agencies to identify where system learning exists and improvements should be made. These are called safeguarding adult reviews (SARs).

This year we commissioned two such SAR's, 'May' and 'Samuel' which we report against in detail later, however common features to both reviews were differing degrees of self-neglect and the way in which practitioners understood and applied aspects of the Mental Capacity Act. We now have an established working group focussing directly on self-neglect, which seeks to improve professionals understanding of these complex issues and improve outcomes for individuals.

Finally I would wish to place on record my thanks to those dedicated professionals, volunteers, families and communities who work daily and tirelessly to keep our most vulnerable residents free from abuse and neglect.

Ivan Powell
Chair of Herefordshire's Safeguarding Adults Board

Strategic priorities

Introduction

The strategic plan for 2019-22 was approved previously and includes a yearly business plan. This forms the foundation for the work of the sub groups to deliver the desired outcomes to safeguard the citizens of Herefordshire.

This Business Plan is developed to enable the Safeguarding Adult Board to carry out its functions as set out in legislation and guidance. This includes ensuring the safeguarding of adults in the following circumstances:

(a) Has needs for care and support (whether or not the authority is meeting any of those needs),

(b) Is experiencing, or is at risk of, abuse or neglect, and

(c) As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

The way in which a SAB must seek to achieve its objective is by coordinating and ensuring the effectiveness of what each of its members does to safeguard vulnerable adults. HSAB achieves this through scrutiny, challenge, learning and support. The key outcomes and actions in this plan are designed to help us demonstrate **Strong Partnership**, which is an essential part of ensuring strong and effective working together to safeguard vulnerable adults.

Priority One: Prevention

Prevention	
To ensure Herefordshire residents receive quality, person centred services, safeguarding responses are proportionate and people avoid reoccurrence of abuse	
Business plan 19/20	**Action**
Monitor Prevention Work plan	The HSAB to receive scheduled updates and reports on the progress of the prevention work plan
Progress This remains a key area for development within the HSAB remit. The Prevention Strategy is scheduled for update during 2020 and it is envisaged that there will be closer links with the newly appointed Assistant Director of Communities and Partnerships	
Consider the work of the multi-agency Quality and Review team	Receive regular updates from the Q and R manager
Progress The Quality Improvement Manager attends the Performance and Quality Assurance meeting of the Board and provides regular updates of the care home cohort in Herefordshire.	
Staying safe	Policy and procedures sub group to create a “Staying Safe” leaflet for those who have previously been safeguarded
Progress The Policies and Procedures sub group has been commissioned with completing this piece of work and it will be available Q1/20	

Case Study – West Mercia Police

This was a complicated and complex case that required a multi-agency approach if the desired outcome was to be achieved. That outcome was to ensure that all members of a household felt safe in their home and not at risk of harm from themselves or others within the family home.
Living in the household were Mr and Mrs A, a couple in their 80’s, both of whom had some vulnerabilities due to their own physical and mental health needs. The husband lived with Alzheimer’s and vascular dementia and his wife had suffered three mini strokes. Also living in the house was their grandson in his 20’s who suffered with epilepsy.
Police had been called to their address on 9 separate occasions in 5 months regarding assaults. Mr A was becoming increasingly distressed within the home, resulting in him being angry with his wife and grandson, threatening them with

violence and the threat of use of weapons with increasing frequency. Mr A himself was sometimes the victim of retaliatory violence within the home. The police had been called on nine occasions in a five month period. Clearly the increasingly escalation was a desperate situation for the whole family. In response the police Domestic Abuse Risk Officer (DARO) referred the case to the Multi-Agency Risk Assessment Conference (MARAC) process, and also worked closely in support of the family throughout the whole period. The police also worked closely with adult social care, the GP and mental health nurses to establish a safety plan.
Mr A was offered respite care in a residential care home, which only lasted for a short time as Mrs A wanted him back home. Sadly the abuse began again and it became apparent that Mr A being at home was unsustainable from the perspective of keeping all of the family members safe.
Ultimately the agencies worked with the family and secured Mrs A's support for Mr A to have a more permanent care home placements.
Three months on and currently, Mr A is still there and is happy. His wife and family visit him regularly and the pressures that were so very difficult for all to deal with, have now been removed.

Case Study – West Mercia Police

This case demonstrates how difficult balancing meeting the wishes of an individual can be with the risks they may continue to face posed by others, in particular those who seek to exploit the vulnerable.

A man in his 40's was vulnerable due to his learning difficulties, his use of illicit drugs and his exploitation by others. He was supported over a number of months through a multi-agency approach, including the use of a cuckooing notice' to support him from allowing others to use his home for drug dealing. This was compounded by the impact of drug offenders attending his property causing anti-social behaviour for neighbours. Despite use of the cuckooing notice and attempted supportive multi-agency interventions the man chose not to work with that support, ultimately resulting in him losing his tenancy. Police and partners are now supporting him as a homeless man to return to alternative accommodation.

Priority Two: Communications and Engagement

<table>
<tr><th colspan="2">Communications and engagement</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>Business plan 19/20</td><td>Action</td></tr>
<tr><td rowspan="3">Build personal and community resilience</td><td>Raise awareness of safeguarding, MCA and DoLS across councils, communities and smaller organisations</td></tr>
<tr><td>Community strategy</td></tr>
<tr><td>Summer roadshow</td></tr>
<tr><td colspan="2">Progress
Messages have been regularly shared with Councillors and Council members. Awareness raising information has been provided for parish councils. Building on the closer ties that have been established during the pandemic this will be built on in year two.

The communications log details all information that has been shared and with whom.

We will build better links into the newly launched local authority Talk Community Strategy, ensuring safeguarding is at the heart of all they do.

Plans to visit the community as part of the talk community programme, due to this being in its infancy this was not a feasible option. We will carry this over to year two

Chair and HSAB officer provide regular updates to the local registered managers' forum, also using them to gain assurance around the safeguarding system and to test new processes.</td></tr>
<tr><td rowspan="3">Service user involvement</td><td>Continue to develop the work already commenced of service user feedback through Healthwatch</td></tr>
<tr><td>Expand the work to include service user feedback via commissioned advocacy service</td></tr>
<tr><td>Promote the use of the newly introduced feedback form through social work practitioners</td></tr>
<tr><td colspan="2">Progress
Healthwatch continue to contact those service users who agree

Initial conversations have taken place with the advocacy service to assist in gaining service user feedback.

The feedback form is in the process of being rolled out to professionals for use</td></tr>
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Priority Three: Operational Effectiveness

Operational effectiveness	
To ensure safeguarding knowledge, processes, systems and structures are embedded across all agencies	
Business plan 19/20	**Action**
Single agency assurance reporting to Executive	Assurance reporting from single agency is scheduled in to the business cycle of HSAB.
Progress Added as an agenda item ongoing – outcomes from single agency audits and regulatory and inspectorate findings are presented to Board	
Ensure learnings from multi-agency audits and reviews are shared across the partnership	Develop approaches to achieve timely dissemination of messages from reviews and audits, with single agency partners taking responsibility and contributing to this.
Progress Clear action plans are developed from audits and case reviews and shared across agencies. Learnings for all front line practitioners are created and disseminated through networks. Themes form the topic for Practitioner Forums, learning events and conferences	
Embed MSP across partner organisations	Identify and promote training programme Safeguarding journey and working with risk
Progress Schedule MSP audit year 2 Externally provided MSP training delivered Working with risk has been commenced and will continue year two	
Effectiveness of the broader safeguarding system	Executive to recommend for the board how these areas should be monitored, for example for inclusion in case auditing and assurance reporting
Progress The Board take a rounded view of the whole safeguarding system, highlighting areas that require assurance A task and finish group has convened to implement a robust process around the self neglect agenda. This work will continue in year two	
Increase HSAB engagement with regional and national work and developments	The board to identify specific areas to highlight and evidence.

Progress

1. Since 2016 direct involvement with the national police lead for adults at risk to develop national police safeguarding procedure. West Mercia Police have produced a local toolkit for frontline officers June 2019 and this is to be the basis of national policy and the subject of ongoing work between national police lead and College of Policing.
2. HSAB were actively engaged in supporting and informing the HWFRS safe and well check scheme
3. Chair on behalf of HSAB engaged in the LGA/ADASS Making Safeguarding Personal workshops and developed practice locally using resultant guidance documents.
4. Chair on behalf of HSAB attended the 'working with risk' workshops –work ongoing to produce local practice guidance
5. Chair on behalf of HSAB engaged in national chairs network following the publication of 'A Patchwork of Practice'
6. HSAB attended national working conference to inform thinking on section 42 decision making resulting from the above
7. Chair on behalf of HSAB pursuing West Midlands regional workshop regarding section 42 decision making guidance
8. Chair on behalf of HSAB engaged in national work with DWP to inform safeguarding procedures
9. Chair on behalf of HSAB engaged with HMICFRS to inform their thematic inspection 'crimes against the elderly' and was a critical reader for the final report
10. Chair on behalf of HSAB engaged with HMICFRS to inform future thematic adult safeguarding inspection
11. Chair is a member of the West Midlands Regional CPS Hate Crime Scrutiny panel
12. Chair and business manager on behalf of HSAB lead on regional engagement with West Midlands Ambulance service
13. Chair and performance lead took an active part in the development of a West Midlands Performance Framework through workshops.
14. HSAB and NHSE SANN "Victims of crime as a health recovery issue"

Issues arising from the term vulnerable adult	Define referral pathways
Progress HSAB explored this and agreed the introduction of a vulnerable adult process that will be delivered in year two	
All relevant partners are aware of their responsibilities under the new LPS legislation	Multi-agency task and finish group to be convened
Progress Implementation of this and its associated guidance has been postponed. Action will be carried forward to year two	

'Miss P' Case Study – Self Neglect and Hoarding

Miss P is a 47 year old white British woman who lived with her four cats in housing association accommodation. She was first assessed by MH services in 2015 by the Primary Care Mental Health Team (PCMHT) based at the GP's surgery. She reported experiencing stress – alleging housing were putting pressure on her to declutter her home. She described herself as a hoarder, but also that she was

sorting things out with a friend. She declined any support e.g. MIND. There was some evidence that she was mildly self-neglecting. She was prescribed medication and discharged back to the care of her GP as were her wishes.

In 2019 Miss P was again referred -to the Recovery Team, by her GP, with symptoms of anxiety, in the context of delusional thinking.
She was assessed and accepted intervention from the team.
During a home visit, the community mental health nurse (CMHN) identified self-neglect and evidence of hoarding, and sought advice on safeguarding from the Trusts safeguarding team. A Safeguarding referral was made to the Local Authority, which led to a Section 42 Enquiry, under the Care Act 2014.

What worked well?
The CMHN identified self-neglect, including hoarding and sought advice.
There was a prompt response from Adult Social Care - a joint visit by adult social care and mental health was conducted. A joint strategy meeting was held which included housing and fire officers.
A risk assessment was completed on the mental health database as per trust guidance - Risks of hoarding, fire, falls and accidents were identified.
Adult Social Care completed a mental capacity assessment and reported that Miss P had the capacity in relation to how she keeps her house and is fully aware of the risks associated with her hoarding.
Evidence of 'Making Safeguarding Personal' by the CMHN, who spent time talking to Miss P about risks associated with hoarding such as accident, falls and fire risks. She agreed for the CMHN to make a referral to Safeguarding and hoped she would get help with slowly clearing her home.

What are we still worried about?
The Safeguarding process was followed with a positive outcome for Miss P it was identified that she wanted help with clearing her home and support was arranged via friends at her church. She did not meet the eligibility criteria for further support under the Care Act 2014, and nor did she want it.
This was not a one off incident, the improvement needed to be maintained if Miss P wanted to continue to live independently (and safely). It is noted that she continues to have a hoarding issue and is refusing to further engage e.g. have a smoke alarm or a visit from a CMHN.
A multi-agency approach was needed – the CMHN contacted adult social care to discuss the housing officers' report that the hoarding had increased.
Miss P remains open to the mental health team, who will continue to monitor her health and wellbeing, under the Care Management process; ensuring communication channels with partner agencies remain open and that Miss Ps views and wishes are at the forefront.

What does safeguarding look like in Herefordshire?

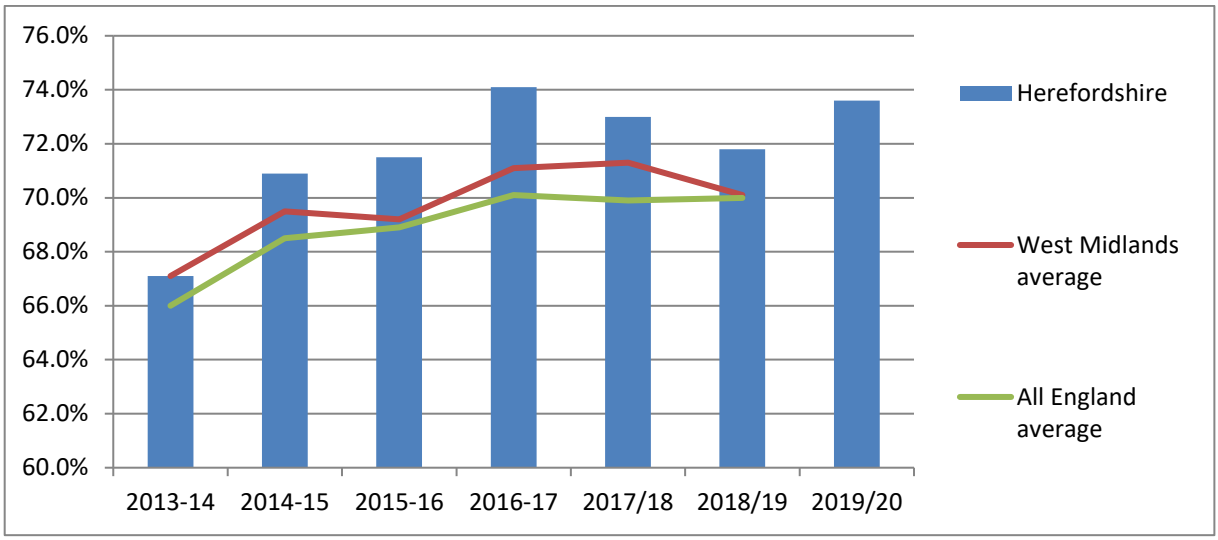
Every year the local council takes part in a survey, commissioned by the government, collecting multi-agency performance data and asking individuals about their experience of care.

Some key highlights are:

Proportion of people who use services who feel safe

Safety is fundamental to the wellbeing and independence of people using social care, and the wider population. Feeling safe is a vital part of service users' experience and their care and support.

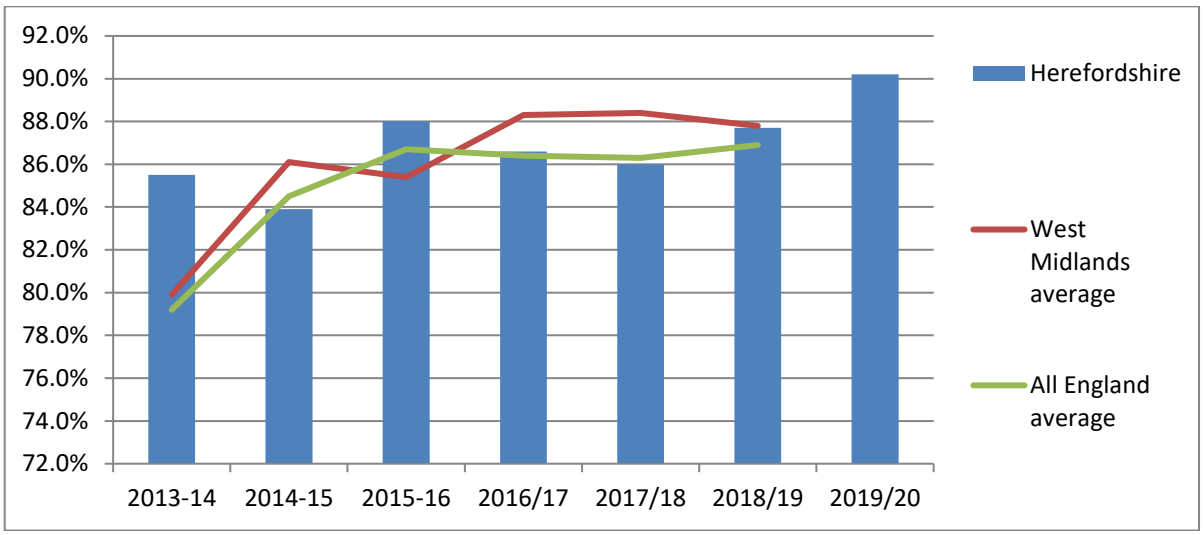
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Herefordshire	67.1%	70.9%	71.5%	74.1%	73.3%	71.8%	73.6%
West Midlands average	67.1%	69.5%	69.2%	71.1%	71.3%	70.1%	Not yet available
All England average	66.0%	68.5%	68.9%	70.1%	69.9%	70.0%	Not yet available



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

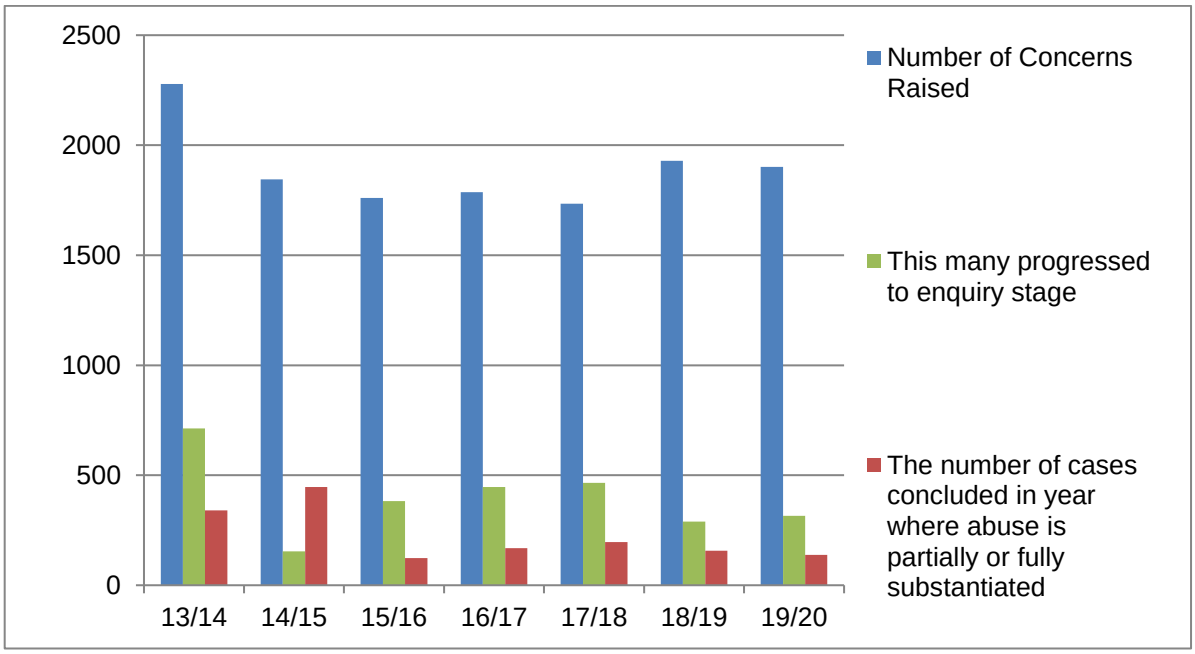
The measure below reflects the extent to which users of care services feel that their care and support has contributed to making them feel safe and secure.

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Herefordshire	85.5%	83.9%	88.0%	86.6%	85.9%	87.7%	90.2%
West Midlands average	79.9%	86.1%	85.4%	88.3%	88.4%	87.8%	Not yet available
All England average	79.2%	84.5%	86.7%	86.4%	86.3%	86.9%	Not yet available



The following graphics relate to circumstances where safeguarding concerns were raised. All of this data is from the Local Authority information systems as, has been previously reported, limited information is available from partner agencies to support the safeguarding agenda.

About the concerns regarding abuse that have been raised



The number of concerns has once again levelled off after a 10% increase reported last year.

A review of how the data is recorded was commissioned and that has identified some anomalies, changes will be made to some of the processes to ensure the data more accurately reflect safeguarding activity.

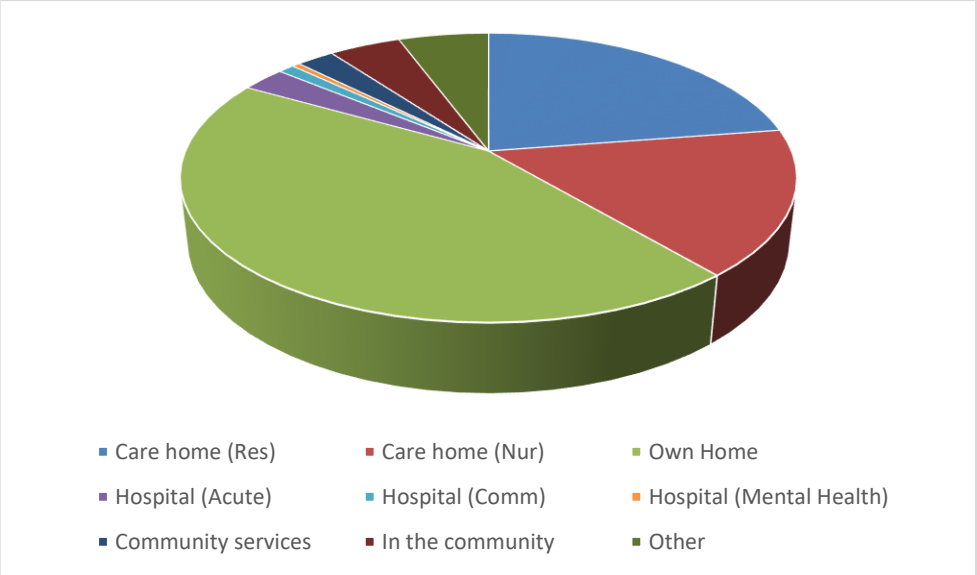
56% of the individuals involved in safeguarding enquiries were over the age of 65

47% of individuals involved in safeguarding concerns were male

53% of individuals involved in safeguarding concerns were female

44% of the individuals involved in safeguarding enquiries were aged between 18 and 64

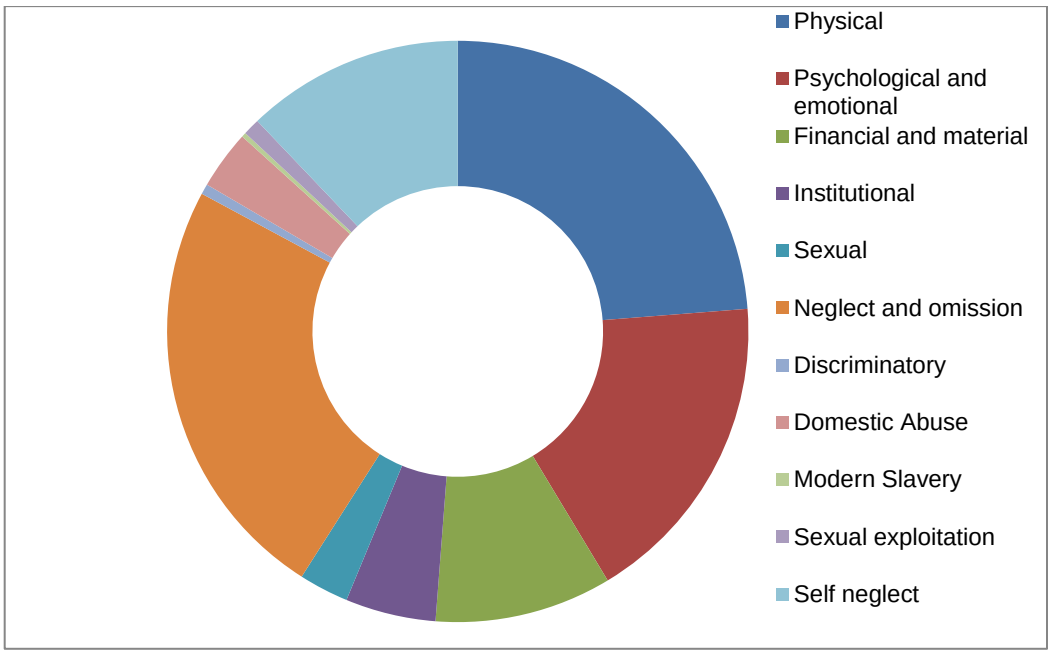
Where abuse has occurred



The diagram above depicts the location of the concern at the time of this being raised with the local authority.

Once again the largest number involve those in their own home (44%).

What type of abuse has been reported?



Physical abuse and Neglect and Omission remain the most commonly reported types of abuse. There is little change in percentage terms in any of the types of abuse on last year.

Source of risk

The “source of risk” was personally known to the individual in 30% of concluded safeguarding enquiries.

The “source of risk” was providing a service to the person in 36% of concluded safeguarding enquiries.

Mental Capacity

In safeguarding enquiries that were completed more people lacked mental capacity (119) than had mental capacity (99).

Advocacy

Where the person was assessed as not having capacity 68% were provided with either formal or informal advocacy. This is a considerable increase on last years reported figure of 36%

Making Safeguarding Personal

68% of people or their representatives were asked what they wanted to outcome of their safeguarding enquiry to be. This is a slight decrease on last years reported figure and some analysis will be undertaken to understand why this should be as MSP should be considered at all times.

Outcomes were partially or fully achieved in 38% of concluded safeguarding enquiries. This is a significant decrease in the figure reported last year (63%) and some analysis will be undertaken to understand why this should be the case.

The number of enquiries concluded were it was assessed that the risk of abuse or neglect for the person was

Removed 80 (26%)

Reduced 198 (64%)

Remained 34 (11%)

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
- 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 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.

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.

Update from the Chair: Christine Price, Chief Officer, Healthwatch
The sub group has met 6 times this year, unfortunately due to staff shortages within one key agency, these meetings were not always quorate and this, along with requested reports not being provided, hindered some of the planned work of the group.

We did carry out an audit of referrals into the Safeguarding Team, this was undertaken due to the large percentage not being converted into safeguarding enquiries (83.5). The findings included that although the referrals were identified as No Further Action in fact many were passed for case management and others had been subject to safety planning by the Safeguarding Team during the Section 42.1 process. We will be working with colleagues in both the Safeguarding Team and also the Business Systems Team to ensure that all activity is correctly recorded.

A planned second audit into the transitioning of young people into adult Mental Health Teams unfortunately did not take place, as a group we were unable to finalise the details of this and this will be considered for the 20/21 workplan.

The Boards Independent Chair along with the Local Authority Performance Lead took part in a regional review of safeguarding performance datasets. This has resulted in a new product being created for use by this sub group that will allow for better data analysis and debate and also allow for better comparison between us and our statistical neighbours and across the region.

The group continues to explore ways to seek the voice of those who have been safeguarded and their families, following a review and a relaunch of the documentation we are hoping for better results during 20/21.

Policies and procedures

Terms of reference:
This group aims to ensure there is a comprehensive catalogue of policies which underpin multi-agency safeguarding practices. Its objective is to ensure that staff across the partnership have access to a 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
Adrian Turton on behalf of Alison Feher, Safeguarding Lead, 2gether NHS Foundation Trust

Between April 2019 and the end of March 2020 the HSAB Policies and Procedures Sub group (HSAB P&P) met on four occasions. HSAB is part of the

West Midlands Multi-Agency Safeguarding Adults Policy consortium, developing and driving forward regional safeguarding policies.

The most significant piece of work this year was the revision of the West Midlands Safeguarding Adults Policy and Guidance document; updated and adopted by the HSAB in November 2020. The revision was a key piece of work and thanks go to the Herefordshire representatives that sit on the regional editorial group. This document is the core procedure and guidance manual for professionals and volunteers working in the safeguarding adult environment. All practitioners in Herefordshire were made aware of the updated guidance.

Looking forward to 20/21, the HSAB P&P group is eagerly awaiting the delayed Liberty Protection Safeguards legislation that was deferred by Parliament in 19/20 and will continue to be delayed in 2020. This will be a significant piece of work for the Policies and Procedures sub group to roll out its implementation in Herefordshire. It is not expected to be legislation until late 2020 at the earliest.

Future policy development will also align with the Herefordshire Community Safety Partnership, in that it is becoming increasingly clear that protection of vulnerable adults from exploitation and abuse is an issue where adult safeguarding policy guidance is required.

Finally, Alison Feher, has chaired the HSAB policies and Procedures sub group for 3 years and thanks go to Alison for her work in this role.

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.

Anne Bonney on behalf of the Chair.

The Adults Board made a decision at its formal inception not to provide regular multi-agency training but to support the Competency Framework, which all members are signed up to, which provides the level of training required for each role.

However, during 19/20 it became obvious that there were some areas where some training would be required in order to meet the outcomes of the Business Plan in areas such as raising awareness and making safeguarding personal, which are golden threads through all of the work that the Board undertakes. The lead Learning and Development Officer together with the designated Training Officer developed a short awareness raising course, suitable for members of voluntary and community sector agencies, members of the public, parish councillors etc.

In addition a Making Safeguarding Personal course was scoped with the Social Care Institute of Excellence and this was delivered, cost neutral, over several sessions.

Practitioner Forums continue to go from strength to strength with over a 100% increase in attendance over this year, these forums focus on areas that front line professionals have expressed an interest in and have covered subject such as Housing and Homelessness, Adverse Childhood Experiences and Trauma Informed Practice, Harmful Sexual Behaviour and have included some very popular sessions provided by the Office of the Police and Crime Commissioner covering the Exploitation of Vulnerable People.

Taxi driver training was developed in conjunction with the licensing team, with drivers potentially being used to ferry vulnerable children and adults for the purpose of exploitation it is important to give them the knowledge to identify the potential indicators of this. It is now a condition of their licence that they undertake this training.

Domestic Abuse training continues to be provided at a cost, by West Mercia Womens Aid.

Course	**No. of delegates**
Domestic Abuse	109
Practitioners Forums	359
Making Safeguarding Personal	43
Taxi Driver Training	138
Basic Awareness	15
Total	**664**

Joint Case Review (JCR)

Terms of reference

The Joint Case Review Sub Group (JCR) is accountable to the Herefordshire Safeguarding Partners, Herefordshire Safeguarding Adults Board and Herefordshire Community Safety Partnership.

Safeguarding Children and Young People in Herefordshire have a legal duty to undertake reviews of serious child safeguarding cases (Local Child Safeguarding Practice Reviews LCSPR's) where children have died or suffered serious harm, the criteria for such reviews is set out in Working Together 2018

Herefordshire Safeguarding Adults Board. The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. The criteria for such reviews is set out in the Care Act 2014 (See Care Act Guidance 2016)The Chair of HSAB has the responsibility for decision making about whether to conduct a review in individual cases.

Herefordshire Community Safety Partnership. Overall responsibility for establishing a review rests with the local Community Safety Partnership (CSP) Statutory Guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)1.

Update from Chair: Ellen Footman, Head of Safeguarding, Herefordshire CCG.

The sub group this year published two Safeguarding Adults Reviews and commissioned a third which will be reported on in next years annual report. The first, “May” who lived alone in a housing association flat. She had no known care and support needs and was a lady who lived a reclusive lifestyle. The review found that the quality of May’s life was affected by the way in which her needs and decisions were interpreted by a range of agencies and the lack of interagency discussion about her predicament although there was no connection between May’s death and the failure of a multi-agency response to her circumstances.

To see the full report follow this link: Serious Adult Review - May

The second, “Samuel” also lived alone in the house he inherited from his parents. He too was reclusive and indeed some of his neighbours did not realise that anyone lived in the house. He had blocked up the letterbox and only ventured out at night. Samuel did have mental health issues and was supported with these for many years.
The review found that agencies did not work holistically to support Samuel. The effect of changes in service or policy were not considered to the detriment of the care provided for Samuel.
To see the full report follow this link: Serious Adult Review - Samuel

The learnings from these reviews are encapsulated on the following 7 minute learnings.

In addition to carrying out reviews the sub group has produced a professionals’ leaflet explaining the SAR process was disseminated to all front line practitioners.

The sub group continues to have oversight of the two Domestic Homicide Reviews that are currently being undertaken by the Community Safety Partnership, both of these have suffered significant delay, however HDHR05 has been submitted to the Home Office for scheduled scrutiny in November 2020 and HDHR06 has been forwarded onto the deceased’s family for comment before final presentation to the HCSP Board, HSAB and JCR members. Deadline for feedback from family is 07 September 2020.

The group has also sought additional membership to bring broader perspective to the meetings and to provide better opportunities for partnership working.

Learnings from Safeguarding Adults Review "May"

01 Background

May had lived in a House of Multiple Occupancy (HMO) for many years. She spoke fondly about aspects of her furnished room in the house. She did not have to worry about bills as the rent was all inclusive, she had a bed and a warm fire.

May received a Notice to Quit from her HMO. Her housing needs were assessed as being eligible for a one bedroomed property. May was unhappy in her new sheltered housing flat and told her new social housing provider that she felt "forced" into the tenancy and the flat did not suit her lifestyle.

02 Safeguarding Concerns

A Safeguarding Adults Review (SAR) was commissioned by the Herefordshire Safeguarding Adults Board in response to the circumstances surrounding the death of 'May' in February 2019. At the time of her death May lived alone in a one bedroomed flat with no bed, little furniture or food. She did not use heating or cooking facilities and had no TV or phone. She slept on the living room floor.

May spent most of the day outside, in cafés and betting shops to keep warm and told various professionals that she often walked six to eight miles per day.

03 Case details

May's neighbours, and staff in shops and cafés where she used to frequent were concerned for her but May declined support and was reported to be angry that support from social care was offered just because she "chose to live differently".

04 case details cont..

Adult Social Care received 3 referrals in March 2018, 2 from Police and 1 from the Ambulance Service

May was taken to hospital having developed hypothermia during the night in her flat.

The acute trust documented that there was a high likelihood of readmission and injury if sent home. She was also having chest pains.

The social housing provider was not made aware of the concerns about May, the police or ambulance referrals or the visit from Adult Social Care Staff. They did not know that May had had hypothermia. May continued her lifestyle after she was discharged from hospital.

05 Themes

- **Mental Capacity – V-Capability**
- **Self-Neglect**
- **Think "Well-Being Principle"**

06 Overall Finding

It was not found that there was any connection between May's death and any failure of multi-agency response to her circumstances.

However the quality of May's life was affected by the way in which her needs and decisions were interpreted by a range of agencies and the lack of interagency discussion about her predicament.

07 What we have learned

A person may have capacity to make a decision but struggle with the capability to act upon it.

A whole systems approach to "wellbeing" can be preventative of crises as well as supporting good quality of life for people we work with.

There was a really strong element of community concern which should be actively encouraged.

Learnings from Samuel

01 Background

Samuel was isolated, he was unemployed and had no contact with family or friends. He loved the radio and reading books, he was an intelligent man who took an interest in world affairs. Samuel had the support of mental health services for many years his mental health issues were described in a number of ways, as a 'major' depressive illness, severe anxiety, obsessive compulsive disorder, social phobia, or agoraphobia.

02 Safeguarding Concerns

Samuel neglected many aspects of his own wellbeing, he only ventured out at night, had blocked up his own letter box and had not been seen by any agency since December 2018, fourteen months before his body was found

03 Themes

- Mental Capacity – V- Capability
- Self-Neglect
- Multi-agency working

04 Learnings

1. Mental health services cannot work with people with complex needs in isolation.
2. It is vital that opportunities for mental health services and GPs to work together are identified
3. Mental Health services must also focus on the person's physical health
4. If a person with previously known self-neglecting behaviour is being discharged from the Mental Health services their wellbeing at the point of discharge should be ascertained
5. The discharge from services of people who are at risk of harm or self- neglect and who are isolated must be carefully considered and planned
6. When working with people who self-neglect agencies must consider seeking consent them to register them as a vulnerable customer with utility companies

05 Learnings

7. Organisations who regularly visit locations in communities are indeed the vital 'ears and eyes' as to the welfare of adults and children.
8. All agencies in Herefordshire must be confident and capable in using the provisions of the MCA 2005, where appropriate, in everyday practice.
9. All agencies need to be familiar with pathways that can be used to support and promote financial resilience.

06 Recommendations

- SAB partners to audit and report back to HSAB how the agreed Adult Self Neglect best practice guidance is understood and implemented by staff in all agencies, whether statutory or non-statutory
- Address identified gaps or concerns regarding staff competence and confidence in using the Adult Self Neglect best practice guidance in Herefordshire.
- Promote the positive benefits to adults of using the provisions of the Mental Capacity Act, including the need to support both decisional and executive capacity.

07 Implementing change

A multi-agency action plan to implement the recommendation has been developed and is regularly monitored by the Joint Case Review sub group until all actions are completed.

What the sub groups will deliver next year

Prevention	
To ensure Herefordshire residents receive quality, person centred services, safeguarding responses are proportionate and people avoid reoccurrence of abuse	
Business plan 20/21	**Action**
Talk Community (TC) programme provides appropriate safeguarding signposting for the community	The TC programme needs to demonstrate that safeguarding is one of the golden threads running through its work.
Assurance of quality of care and safeguarding in care homes	Consider the work of the Care Home Support network
Those who have previously been safeguarded are empowered to resist abuse in the future or to seek support quickly	Policy and procedures sub group to create a “Staying Safe” leaflet for those who have previously been safeguarded
Transitional safeguarding: criminal and sexual exploitation	CSC to provide quarterly report to Board in respect of statutory duties care leavers (18-25 yrs old).
Tackling rough sleeping and homelessness Statutory agencies to be held to account by The Board	HSAB to lead on MHCLG rough sleeping and homelessness next phase and implement the principles of ADASS / LGA Adult Safeguarding and Homelessness – A Briefing on Positive Practice. The street based link worker model will report activity into the PAQA sub group of the Board.

Communications and engagement	
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**	
Business plan 20/21	**Action**
Build personal and community resilience	Raise awareness of safeguarding, MCA and DoLS across councils, communities and smaller organisations
	Build strong links with the local authority Talk Community programme
Service user involvement	Continue to develop the work already commenced of service user feedback through Healthwatch

	Expand the work to include service user feedback via commissioned advocacy service
	Promote the use of the newly introduced feedback form through social work practitioners

Operational effectiveness	
To ensure safeguarding knowledge, processes, systems and structures are embedded across all agencies	
Business plan 20/21	**Action**
Single agency assurance reporting to Exec	Assurance reporting from single agency is scheduled in to the business cycle of HSAB.
Ensure learnings from multi-agency audits and reviews are shared across the partnership	Develop approaches to achieve timely dissemination of messages from reviews and audits, with single agency partners taking responsibility and contributing to this. Details to be included in sub group work plans
Continue to embed MSP across partner organisations	Safeguarding journey and working with risk
Increase HSAB engagement with regional and national work and developments	The board to identify specific areas to highlight and evidence.
Issues arising from the term vulnerable adult	Define referral pathways for those that do not need Safeguarding Develop and implement VARM process
All relevant partners are aware of their responsibilities under the new LPS legislation	Multi-agency task and finish group to be convened
Ensure Mosaic records accurately reflect both safeguarding referrals and activity	Improve understanding of Section 42.1 and 42.2 activity
Enabling a skilled workforce	Ensure conferences where relevant deliver an element of adults Consider the S42 Framework paper for DASSs and Chairs Staff are aware of and adhere to the Self Neglect and Hoarding Policy

Appendix 1

% Meeting attendance

Meeting and Frequency	Board 4	Exec 4	PAQA 6	TWD 1	PandP 5	JCR 8
Agency						
2gether NHS Foundation Trust	4	2	5	1	4	7
Adult and Communities	4	4	3	1	4	6
Community Rehabilitation Company	2					A/R
Healthwatch	3	1	6			
Hereford & Worcester Fire & Rescue Service	1					A/R
Herefordshire Carers Support	3					
Herefordshire CCG	4	4	6		4	8
Hvoss	1	3		1		
Lead Member	3					
LA Governance and Legal services rep	Attendance as required					
National Probation Service	0					A/R
Public Health	2					A/R
West Mercia Police	4	4	6		5	8
Wye Valley NHS Trust	4		2	1		8

DNA – Member invited, but does not attend

A/R - Attendance as required

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:

AGREED BUDGET FOR 2019-20	
Children's Wellbeing	133,569
Adults Wellbeing	103,000
CCG	80,190
Police	53,510
Probation/CRC	6,136
CAFCASS	550
YOS	1,144
TOTAL GROSS BUDGET	**378,099**

Contributions from statutory partner agencies for 2019-20 remained the same as in previous years at a total of **£378,099**.

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

BUDGETED COSTS FOR 2019-20	
Salary costs	278,814
Transport costs	1,300
Independent chair costs	38,520
Consultancy costs	34,200
Training expenses	28,000
Office expenses	65,781
Training income	-13,000
Total	433,615

The £55,516 overspend is largely down to the unprecedented number of safeguarding reviews that were commissioned during the year across the childrens and adults safeguarding arenas and was drawn down from reserves.

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