

Calderdale Safeguarding Adults Board

ANNUAL REPORT



2017-2018



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This report explains who is involved in the work of CSAB; how the CSAB has conducted its business during the year; what has been achieved; and the CSAB's relationship with other partnerships.

This is demonstrated through:

A summary of the work of the sub groups and CSAB to achieve its objective;

- What has been done during the year to implement its strategy.
- What each member organisation has done during the year to implement the strategy.
- A summary of the findings of the completed and current Safeguarding Adults Reviews arranged by the CSAB under section 44 (Care Act 2014).
- How learning from SAR's and other sources has been implemented.

The report therefore assists analysis and evaluation of achievements, areas for further work and will form the basis for the consultation on the strategic plan for the coming year.



I am pleased to be able to present this report following my second full year as Independent Chair of Calderdale Safeguarding Adults Board, the report sets out our progress.

Our aim is for Calderdale to be a safe place to live for all its citizens, regardless of their circumstances. For citizens of Calderdale to live in a community that protects their rights and freedoms and allows them to live free from abuse and neglect or the fear of abuse and neglect.

The Board is well resourced by its statutory partners; Calderdale Clinical Commissioning Group, West Yorkshire Police and Calderdale Council Adult Social Care. Our other partners make contributions by committing staff time and resources. We are keenly aware that all agencies continue to have financial challenges and are determined to ensure that our resources are used well. Our work to collaborate in sharing resources with Calderdale Safeguarding Children Board, both in finance and a practical approach to sharing the work of sub groups is an example of this.

As the Board has become more established, some of the challenges we face have become clearer. We have made good progress, but as ever there is more to do.

Our performance framework continues to be refined and we are working closely with regional and national colleagues to find ways to develop data that can be properly compared with our peers.

Making Safeguarding Personal is a continuing theme for the Board's work and development. A key focus of our future work will be to ensure that the ethos of Making Safeguarding Personal is truly embedded across the partnerships in Calderdale. The Making Safeguarding Personal approach concentrates on the wellbeing of the person who has suffered abuse or neglect and aims to put them at the centre of the decision making.

Sadly a small group of people continue to suffer from abuse or neglect. Where this happens we are determined to use the learning to improve our practice. Our Safeguarding Adult Review Group has worked hard to put in place new procedures which will ensure that where a review is needed we are able to gain the most possible from it in terms of our learning and future development.

All the agencies in Calderdale are committed to the plan contained in this annual report and have directed resources to achieve our aspirations. I welcome the engagement and full contribution of members of the Board. We will be working hard to complement the input of our partner agencies by engaging with service users and using their views to help shape our future plans.

Calderdale Safeguarding Adult Board (CSAB) is a statutory body that works to make sure that all agencies are working together to help keep adults in Calderdale safe from harm and to protect the rights of adults to be safeguarded under the Care Act 2014, Mental Capacity Act (MCA) 2005 and the Human Rights Act (HRA) 1998.

CSAB has a strategic role which involves:

- Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Assuring itself that safeguarding practice is person-centred and outcome-focused.
- Working collaboratively to prevent abuse and neglect.
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

It does this by:

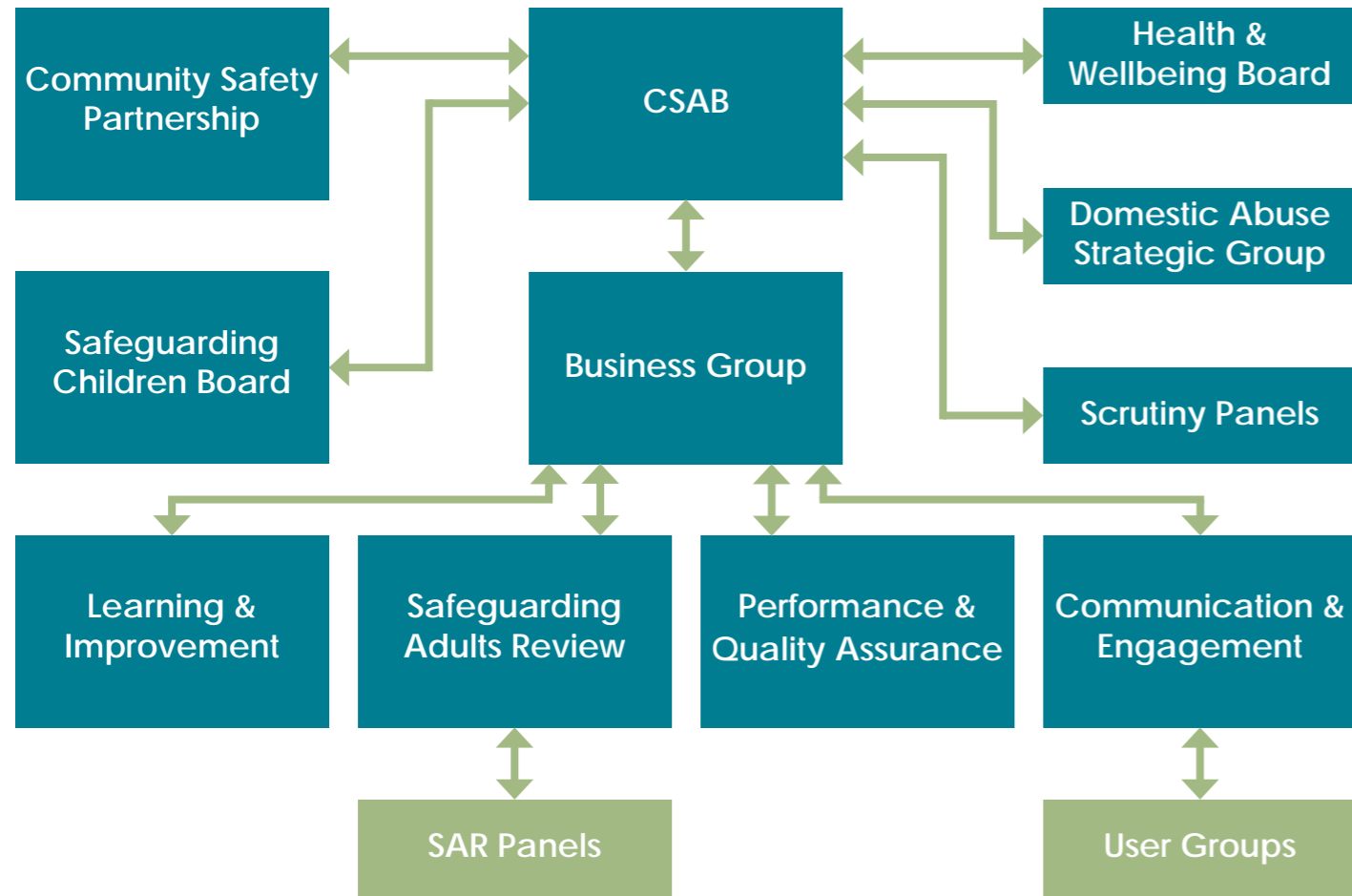
- Overseeing and coordinating the effectiveness of the safeguarding work of its member and partner agencies;
- Developing and actively promoting a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'.

In addition, working alongside other partnerships in Calderdale, CSAB, is also interested in seeking assurance about the responses to a range of issues which can contribute to the wellbeing of the community and the prevention of abuse and neglect, such as:

- The safety of people who use services in local health settings, including mental health
- The safety of adults with care and support needs living in social housing
- The effectiveness of interventions with adults who self-neglect
- The quality of local care and support services
- Making connections between adult safeguarding and domestic abuse.



CSAB Structure Chart



Calderdale Context

Calderdale's topography and its pattern of settlement have implications for the location of facilities, for transport, and for how close people are to health and other care services.

Calderdale comprises of the towns of Halifax, Elland, Brighouse, Sowerby Bridge, Hebden Bridge and Todmorden as well as a number of villages. It is one of the smallest metropolitan districts in terms of population, but one of the largest in terms of area, with very strong rural elements. The district has a population density of 5.76 per hectare, the lowest of any local authority in West Yorkshire.

Over four-fifths of the Calderdale area is classed as rural (1). In contrast the local authority population is described as "Urban with major conurbations" (2). This is because over three quarters of the population live in urban areas.



Who are the people of Calderdale?

According to ONS 2016 mid-year population estimates, Calderdale has a total population of 209,069, of whom 162,972 are adults. 37,840 are aged 65 and over. This equates to 23% of the total population.

There have been large increases in the proportion and the numbers of residents aged 45 to 64 since 1991, which may have implications for the residents aged 65 and over within the next ten years;

The population aged 85 and over has increased steadily from 3,200 in 1991 to over 4,700 in 2016. The pensioner population is largely white with less than 3% of this age group comprising of Black and Minority Ethnicity (BME) groups, of which Pakistani makes up over half.

Population projections (3) assume that recent trends in migration, fertility and mortality will continue. These projections indicate a period of relatively rapid population growth over the coming years, with the total district population projected to grow by around 11,000 between 2014 and 2024 (a 5.3% increase). The largest growth is expected to occur in the older age groups, with a 29% increase in those aged 85 and over by 2024, an 11% increase in those aged 65 to 74 and a 42% increase in those aged 75 to 84.

What is Safeguarding?

Safeguarding adults means protecting a person's right to live in safety, free from abuse and neglect. It means making sure people are supported to get good access to health care and stay well. Safeguarding should make sure that people get the support they need to make the most of their lives and get their full equal rights.

Safeguarding is based on these six principles which also inform the work of the CSAB and are:

- **Empowerment:** people being supported and encouraged to make their own decisions and give informed consent.
- **Prevention:** it is better to take action before harm occurs.
- **Proportionality:** the least intrusive response appropriate to the risk presented.
- **Protection:** support and representation for those in greatest need.
- **Partnership:** local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** and transparency in safeguarding practice.



Local authorities are responsible for the establishment of Safeguarding Adult Boards. The Care Act 2014 specifies that there are three core members, namely, The Local Authority; Clinical Commissioning Groups (CCG); the Police and any other agencies it considers to be partners. During 2017-18, membership of CSAB comprised Senior Officers from the following member organisations.

- Bradford and Calderdale Probation CRC
- Calderdale Adult Social Care
- Calderdale and Huddersfield Foundation Trust
- Calderdale Clinical Commissioning Group
- Calderdale Community Safety Partnership
- Calderdale Housing Environment and Renewal
- Elected Member
- Health Watch Calderdale
- NHS England
- Pennine Housing/Together Group
- Sector Support Calderdale (now VSI Alliance)
- South West Yorkshire Partnership Foundation Trust
- West Yorkshire Police
- West Yorkshire Fire Service
- West Yorkshire National Probation Service
- WomenCentre

Members have sufficient seniority and leadership within their own agency to speak on its behalf, to commit resources and agree actions and to represent their agency should the SAB need to hold it to account.



The board is chaired by Ged McManus who is independent of all the organisations mentioned previously and is accountable to the Chief Executive of the Local Authority. The key roles of the Chair are to provide leadership, promote collaborative working, offer constructive challenges, hold member agencies to account, act as a spokesperson for the CSAB, ensure that interfaces with the other strategic boards are constructive.

CSAB met four times during 2017-18. In July 2017, the management and secretariat functions of the Safeguarding Children Board were merged with the Safeguarding Adult Board.

The merger has enabled:

1. Reduced duplication of core administrative processes and some outputs
2. Consolidation and development of expertise across common administrative/ support functions
3. Work towards a more integrated strategic approach across both boards to share priorities and functions.



Most of the work of the Board is allocated to and completed through multi-agency sub groups. Each of the sub groups is responsible for delivering an action plan that supports the board in delivering its agreed priorities and overall business plan. The sub groups provide partner agencies with the opportunities to review practice; identify and share good practice; identify and improve areas of weak practice, test progress against priorities; and challenge each other to collectively improve arrangements to prevent abuse and neglect and to safeguard adults at risk.

CSAB currently has 4 working sub groups and specific terms of reference for each.



Sub groups meet 4 times a year; the Chair of each sub group is a member of the Business Group. From July 2018, the Learning and Improvement Sub group will be joined with Calderdale Safeguarding Children Board on a trial basis. Additional meetings take place as required to consider Safeguarding Adult Review referrals.

The Business Group comprises the Chairs of the sub groups alongside the Chair of CSAB and statutory partners if not otherwise represented.

The role of this group is to ensure the objectives and priorities outlined in the Business Plan are implemented; drive the development of good practice; coordinate the work of the sub groups to reduce duplication and promote shared resources across partnerships.



What we said we would do and what happened

One of the main aims this year was to achieve and implement a robust dataset that supports and gives the Safeguarding Board oversight and assurance that assists in understanding how we are making a difference and on the effectiveness of adult safeguarding across Calderdale. In order to achieve this, we:

- Implemented a Performance Management Quality Assurance Framework
- Worked with partners to develop an agreed dataset and analysis
- Reported to the CSAB on a quarterly basis
- Reviewed and updated the work plan
- Produced a schedule of audits, completing two audits and creating action plans during the year including the engagement of some practitioners / managers from different agencies.
- Contributed to and assisted in the implementation of the combined Section 11 / Safeguarding Adults audit for Children and Adults for all partners to complete in Calderdale.

What needs to happen now?

A new format will be used 2018/19 to present data to assist Board members to understand the impact the Board has in making a difference to joint working arrangements and practice.

The Section 42 audit action plan has identified several areas of practice which should improve current joint working arrangements relating to how S42 criteria are used in decision making over the coming year. Evidence will be requested and progress against the actions will be monitored through the Performance and Quality sub group.



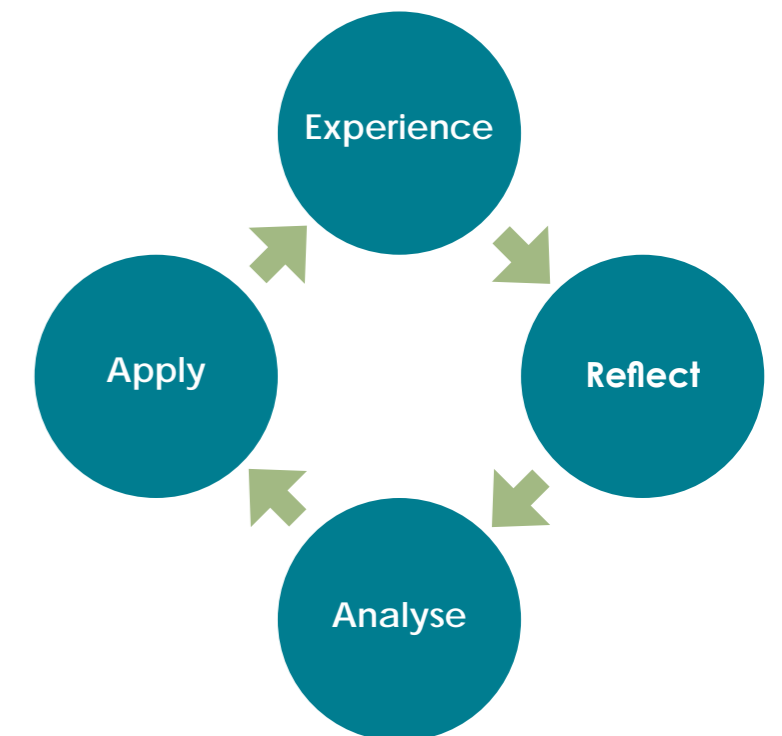
What we said we would do and what happened.

This year, this sub group has focused on a number of key issues:

- Raising awareness of the SAR process and sharing learning from SAR's (both in single and multi-agency training); ensuring that briefings on learning from SAR's were produced and disseminated.
- Quality assuring all basic awareness training to make sure the messages are accurate, the same messages are shared across the partnership and easy to understand.
- Producing a Learning & Improvement Framework in response to a requirement of the Care Act 2014 to promote a learning culture and the delivery of relevant training to develop a highly skilled and knowledgeable workforce
- Undertaking and supporting a Training Needs Analysis (TNA)
- Introducing the 'Logic Model'- to make sure courses delivered through the multi-agency training programme are developed in line with changes in legislation, policies and local priorities and to help identify ways to measure the impact of training.
- Developing a number of multi-agency Adult Safeguarding specific courses and working alongside other partnerships to organise a successful Safeguarding Week during which a greater range of Adult Safeguarding specific opportunities for learning were provided.

What needs to happen now?

- Further work is needed to improve the type of information returned by agencies to help to understand the training needs of the Adult workforce.
- As the new procedures and local guidance are implemented, CSAB needs to find ways of assessing that the changes are widely known/understood and embedded in agency's working practices.
- The 'making safeguarding personal' agenda needs to be embedded within all aspects of the multi-agency training offer.



What we said we would do and what happened

At the start of the year, this sub group aimed to make information about the safeguarding process (including pathways) easier to understand and to make it publically available. The Local Authority leaflet 'How to Report Abuse' was selected and is on Calderdale Council website.

In March 2018, a Quality Assurance officer was recruited to engage with Service Users to ensure the Making Safeguarding Personal approach is understood and the views of people who use safeguarding services are included in the work of the CSAB.

The introduction of the Care Act 2014 required development of new regional procedures, which resulted in changes to referrals forms and some changes in practice. A programme of awareness raising about the new Regional and Local procedures is taking place across the partnership. In 2017 work started on developing a Safeguarding Adults website which is shared with the Safeguarding Children Board. This is helping to develop a joint approach to Safeguarding Adults and Children in Calderdale. The sub group oversee the continued development of the website. The Communication and Engagement strategy was produced, setting out how the CSAB will promote engagement with the community and professionals.

Safeguarding Week 2018 aimed to include more public facing events and worked on the production of presentations and activities for staff to use with service users, families and carers to raise awareness about 'Safeguarding' and what could happen after a referral is made to promote prevention and protection of Adults at Risk.

What needs to happen now?

- Guidance and full implementation of new local policies and procedures is underway with a target completion date of September.
- The sub group needs to continue to oversee and support the development of the Adult Safeguarding part of the website.
- The service user engagement plan needs to be fully embedded.
- Recruit a more diverse membership for this group in order to enhance communication with the community in Calderdale.
- Work with the SAR sub group to promote the learning from Safeguarding Adult Reviews.
- Involve service users in making sure Safeguarding documents are easy to read and understand.



What we said we would do and what happened

This sub group has responsibility for coordinating and quality assuring all Safeguarding Adult Reviews (SARs) conducted in Calderdale.

The sub group has developed a process for conducting SARs and how best to learn from serious incidents (including SARs and domestic homicides) locally and nationally.

Locally, the sub group has overseen the implementation of SAR action plans, monitored progress and implementation of learning and completed lessons learned after the review.

The sub group has considered whether referrals for a SAR meets the national criteria before making recommendations to the Independent Chair of the Safeguarding Board.

The SAR toolkit has been updated as a result of experience, changes in legislation and reflective learning about the SAR process.

Training about the SAR criteria is now embedded in single and multi-agency safeguarding training. Development work has included:

- Production of a decision tool based on national guidance
- Implementation of a process to ensure that SARs undertaken in Calderdale are subject to a review after 12 months to ensure learning has been embedded. This has already been applied in one case.

During 2017/18, the sub group has overseen 2 SARs and 1 review of a SCR. Of these, one has been published, one has been completed and will be presented to CSAB in July for approval prior to publication. This SAR generated significant learning including improved understanding of self neglect and a CSAB policy on this issue has been produced. The families involved have stated that they have felt included in the SAR process and believe that lessons have been learned by services, giving them confidence that others will be safeguarded.

As a result of the recommendations from SARs several essential policies, procedures and guidance documents have been produced to aid practitioners, for example, Multi-Agency Self -neglect Policy and Multi-Agency Falls protocol.

There has been a significant rise in the number of referrals for SARs to the subgroup which indicates an increased awareness of the criteria for and benefits of conducting SARs amongst partners. Another request for a SAR has been considered.

What needs to happen now?

More work needs to be undertaken to develop an agreed process for sharing learning from SARs undertaken in other areas that have particular relevance to Calderdale.

As awareness of the SAR process has increased, together with a statutory criteria for conducting SARs (Care Act 2014) it is possible more SARs will need to be undertaken in future which have capacity implications for the CSAB and partner organisations. This has been mitigated somewhat by the development of a SAR criteria for Calderdale and awareness of proportionate methodologies for conducting reviews.



SAR – JT

This SAR commenced in March 2017 and concluded in December 2017. It focused on how the principles of Making Safeguarding Personal were demonstrated in practice in relation to JT. JT is 70 years old and a resident at a Care Home. She has a diagnosis of Alzheimer's Dementia and requires support 24 hours a day. JT experienced an unwitnessed incident at the care home which was believed to have been a fall. The care home did not inform the family of the event. The family discovered extensive bruising to JT's body and were upset and concerned. The family were advised by a Local Authority representative to report the incident to the police.

Key Findings

- The principle of person centred care was not explicitly or consistently applied during the investigation into the incident. Seeing and speaking to the person at risk is critical.
- Record keeping did not meet expected standards, there were a number of examples where meetings were not recorded, rationale and relevant evidence for decisions was not consistently recorded, information was not circulated, and in general the quality of information could be improved.
- There was delay in assessing JT's ability to contribute to the enquiry, due to a belief that she lacked capacity. This indicates a need for a better understanding of the Mental Capacity Act and Lasting Power of Attorney - understanding the documentation, interpretation and application of legislation and promoting the use of advocates in addition to family members if there is a risk of compromising Best Interest decisions.
- There is a need for more consistent understanding of when to raise safeguarding concerns and arrangements for 'out of hours'. Safeguarding processes should ensure people raising safeguarding concerns are informed of decisions made and understand how to challenge.
- The right people were not consistently invited to statutory safeguarding multi-agency meetings.
- There was a lack of understanding of the roles and responsibilities of agencies and individuals during a police and safeguarding investigation.

CSAB Response

- Through the revision of the Joint Multi-Agency Safeguarding Adults Policies and Procedures (April 2018), there has been clarification of agency roles and responsibilities and expectations of processes during a safeguarding investigation.
- Assurance has been sought that care home providers in Calderdale are aware of their responsibility in relation to maintaining records
- The SAR Toolkit has been rewritten to promote clarity on methodology, criteria for reviews, to ensure timeliness and avoid drift.
- Relationships between the CSAB and care homes have strengthened
- A Multi-Agency Falls Protocol has been produced, agreed and disseminated to the partnership.
- Learning from this SAR has been shared via a 7 minute briefing; Multi-Agency Safeguarding Training; production and dissemination of guidance on the 'Procedure for Resolving Multi-Agency Professional Disputes and Escalation'; and recently in a guide to Recording.

A challenge event to test the implementation of actions and learning from this SAR will be arranged for early 2019.

SAR – Mr A

This SAR commenced in December 2017 and concluded in July 2018, as such, it has not yet been possible to determine the extent to which the learning and actions from this review have been implemented across the partnership. The key themes and learning from this review will be presented in greater detail in the Annual Report 2018/2019

In summary, this review concerned Mr A, aged 70 years, who, despite a comprehensive response by the Police in attempting to find him safe and well, was found dead in a river in Calderdale in August 2017. His cause of death was confirmed as drowning combined with a pre-existing heart condition.

Mr A. had been reported as a missing person to West Yorkshire Police by a family member the previous day. CCTV had showed him struggling to walk on a street near the river on the day prior to that.

When his body was recovered he was found not to be wearing the Buddi monitoring system which had been provided by Adult Social Care (ASC), a measure utilised to manage the known risk factors in relation to Mr A. wandering and getting lost.

Key Themes

- Communication between agencies to share safeguarding related information was inconsistent and lacked coordination. This was also reflected in communications with family members.
- The application of Multi-Agency policies and procedures was inconsistent, especially in relation to raising safeguarding concerns, risk assessment, planning and management.
- Practitioners/Managers struggled to manage the complexities of working with Mr A who presented with indicators of self-neglect and who, at times, was resistant to intervention and offers of support. In this respect there was a lack of application of the Mental Capacity Act and understanding and management of risk.

CSAB Response

- There has been a delay in fully implementing Joint Multi-Agency Safeguarding Adults Policies and Procedures (April 2018), however, a comprehensive implementation plan has been followed with partners to raise awareness about the new procedures and changes to practice.
- A Self-Neglect Policy and Toolkit which incorporates consideration of mental health and alcohol misuse has been produced and disseminated via the CSAB.
- Promotion of use of the updated Herbert Protocol forms part of the CSAB Business Plan 2018/2021.
- An extensive audit is being undertaken to provide a baseline of MCA implementation in Calderdale and to inform an action plan to improve this area of practice.
- Single agencies will be required to provide assurance that areas of practice that were identified as inadequate in this review have been addressed.
- The learning from this review is being disseminated via a briefing paper; in single and multi-agency training, and the production of the Self-Neglect toolkit.



Empowerment

Safeguarding is embedded in Calderdale District: Some officers have received specialised training in Domestic Abuse and Vulnerable Adults; the adult and any appropriate adult/carers are informed of an adult at risk referral; Police access intermediaries to aid communication with adults at risk;

West Yorkshire Police run the Herbert Protocol (advertised on the West Yorkshire Police and CSAB website) which assists in locating individuals when they go missing. Referrals are made to the police and families and adults are encouraged to participate in the scheme. Events are held monthly at drop in Dementia cafes throughout Calderdale; The Police work with partners and attend professional meetings to ensure adults with care and support needs can access the support and that their voice is heard.

Prevention

Within the Police there is a culture of care and ensuring the needs of individuals are met. Incidents are risk assessed and referrals made to the Vulnerable Adults Coordinators.

Police engage with local authorities and attend multi-agency meetings to ensure that early intervention prevents care homes from closing. A recent example has been the Retreat where all agencies have worked together to safeguard individuals and prevent harm. Police actively participate in Safeguarding Adult reviews and multi-agency learning events, disseminating learning within the service.

The Police were involved in writing and implementing new multi-agency policies with the CSAB such as the Multi-Agency Falls policy.

The force has joined with UK Finance, a number of high street banks, building societies and the Post Office to catch offenders who attempt to swindle vulnerable people out of their savings and to provide a more rapid response to financial fraud. Counter staff are trained to spot suspicious activity and act as "critical friends" to anyone they believe to be at risk and therefore to intervene as soon as the crime is identified. At the end of June the Banking Protocol had accumulated £27,861,581 in prevented fraud and amounted 227 arrests. 3,923 emergency calls have now been placed and responded to, with the average prevention per call equating to £7,102. There are several ongoing investigations in Calderdale where offenders have been charged and are awaiting trial.

Proportionality

When a safeguarding concern is raised, the police computer system "Niche" is checked for any previous incidents and whether the person has a marker/flag for an adult at risk. The police call handling system "Storm" is also checked for any markers.

Police use the National Decision Model to ensure a proportionate response when a concern is identified.

There is consistency on thresholds throughout the partnership an example of this is within the Domestic Abuse Hub daily MARAC meeting where generally the same individuals from all agencies attend, risk is discussed and responses are proportionate to the risk, this gives consistency in decision making and an awareness of different agencies thresholds and the outcome is focused on the victim.

The police participate in S44 audits and reviews of safeguarding thresholds.

The police participate in Domestic Abuse audit thresholds for Standard, Medium and High DASH to ensure consistency and proportionality.

Protection

When adults at risk are identified the police refer to the most appropriate agency and ensure that markers and flags are placed on the computer systems. Police attend professional meetings to provide any information that assists in best interest decisions being made; and assess and provide crime prevention advice and any target hardening measures that are necessary.

The police actively take part in Safeguarding Adults Reviews (SAR) and learn the lessons of such reviews, implementing the recommendations at a local level to officers and managers to prevent any reoccurrence by providing training and supporting attendance at learning events.

The police also protect adults suffering all types of domestic abuse by referring to support agencies and applying for and enforcing Domestic Violence Protection Orders for which Calderdale is joint best in the force.

Partnership

The police actively participate in multi-agency learning events associated with SARs and DHRs. The force contributes to the planning and delivery of Safeguarding week across West Yorkshire, highlighting the support available from all agencies and the importance of partnership work to safeguard both children and adults. This continues at community events such as the Brighouse Carnival, Police Open day, and Todmorden festival by being visible, engaging with the public, offering support, information and leaflets.

Officers contribute to the CSCB/CSAB multi-agency training programme, delivering awareness on Human Trafficking, Modern Day Slavery, FGM and adult safeguarding.

The Police is a statutory partner and represented at strategic boards and attend all relevant sub-groups.

The strapline "Safeguarding is everyone's business" is embedded within the police.

Accountability

There are good information sharing practices between all agencies to prevent and protect adults from harm. An example of this is within the DA Hub MARAC meeting daily where all agencies share their relevant information to protect and safeguard the victim.

The police take part in the CSAB/CSCB section 11/self-assessment process and challenge events, providing evidence which demonstrates policies and procedures are in place to protect vulnerable adults.



Local Authority Adult Social Care

Calderdale Adult Social Care work alongside a regional group to monitor and review the Safeguarding Adults Policy and Procedure. Following the latest review, work is being carried out to fully implement the new policy and procedure which includes raising awareness, system development and training for Social workers undertaking Safeguarding Adults work. All of this will further develop and embed Making Safeguarding Personal. Audit work has been developed so that outcomes and performance can be monitored and necessary actions taken forward.

Along with the police and CHFT, Social Care have organised and started to deliver full day sessions on Achieving Good Outcomes for Adults at Risk, this offer is open to all agencies. The community social work practice team based at 42 Market Street took part in Safeguarding week and opened their door to members of the public throughout the week to encourage people to talk about Safeguarding and what it means to them. This was a successful event where over 50 people engaged in discussions and took away Safeguarding knowledge.

During Safeguarding Week, the Safeguarding adult's team visited a number of care home settings and successfully raised awareness of both residents at the home and staff members on how to recognise a Safeguarding concern and what to do in those situations. This event empowered residents to be in control and seek support when necessary.

There are a number of functions in place to ensure any immediate risks identified within any Safeguarding concern are reduced and removed at an early stage. The recorded current average time taken to make a decision on a Safeguarding concern is 2.65 days this figure has been static or lower throughout 2017/18.

The Safeguarding adult's team continue to respond to a high level of concerns which are received from care home settings. Providers increasingly report their own concerns which is a positive move forward and highlights the partnership work between the safeguarding team and providers. All the data received from concerns are analysed to identify any themes and trends which guides early intervention work and prevents a number of high level and whole service Safeguarding issues.





Calderdale

Clinical Commissioning Group

Calderdale Clinical Commissioning Group (CCCG) is the commissioning arm of the NHS in Calderdale and commissions most hospital and community health provision, including GP services. CCCG has arrangements in place to ensure that the organisations from which we commission services have effective safeguarding arrangements in place. This includes attending provider safeguarding forums, inspections, care reviews and safeguarding standards which all providers are expected to adhere to.

The CCCG safeguarding team provides expert advice and support to all health services in Calderdale through regular meetings and telephone advice. The Safeguarding Health Alliance is led and facilitated by the CCCG and brings together safeguarding leads in health services to share best practice and discuss complex cases. The team quality assures serious incidents that have a safeguarding element to ensure improvements to practice are embedded in services.

All GP practices in Calderdale have GP safeguarding leads who are provided updates on the latest safeguarding developments. This year safeguarding standards for GP practices have been developed further and 100% have responded to a safeguarding self-assessment. This process has provided the CCCG with baseline information in order to further develop safeguarding practice in GP surgeries.

In 2018 a Named GP for Adult Safeguarding was recruited to provide specialist medical input as well as strategic advice to the Safeguarding Adults Board.

The CCG safeguarding team has worked with CCCG Continuing Healthcare (CHC) Team, providing: support and advice; regular training; and ensured new safeguarding policies are implemented. The CHC team are responsible for ensuring that individual packages of care provide people with safe and effective care and treatment and a specialist worker has been employed to scrutinise any particularly restrictive care arrangements to ensure they are necessary, proportionate, in the best interests of the individual and legally compliant.

The team has responsibilities for safeguarding adults in its broadest sense including related areas such as the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), Prevent (part of the government's counter terrorism strategy), Domestic Abuse and Modern Day Slavery and Human Trafficking. Through membership of various regional and national safeguarding forums, the Safeguarding team are able to influence and contribute to national safeguarding and MCA policy.

The CCCG has been able to demonstrate a high level of compliance with its safeguarding responsibilities through the CSAB self-assessment submission, independent audit and providing quarterly and safeguarding annual reports to provide assurance to the CCCG governing body.

The CCCG has made significant contributions to the CSAB in 2017-18 including:

- A financial contribution to the Board.
- Chair of the Safeguarding Adults Review subgroup.
- Deputy Chair of the Performance and Quality sub group;
- Attendance and input to all other CSAB subgroups;
- Providing health expertise to the CSAB;
- Providing safeguarding and Mental Capacity Act training for CCG and primary care staff;
- Active involvement in safeguarding week including involvement in a public engagement exercise;
- Developing template safeguarding policies to GP practices which provide staff with information about how to manage safeguarding issues and signposting for further information and advice;
- Commissioning of health support to the Domestic Abuse Hub
- Providing training to GPs with a particular focus on empowering patients to stay in control of their safeguarding needs.
- Led on the development of several multi-agency safeguarding policies
- The CCCG policies on Prevent and the Mental Capacity Act have been updated and reviewed.

Case Study

The Designated Nurse for Adult Safeguarding who chairs the Safeguarding Adults Review subgroup has led a review of a previous serious case review in order to check the extent to which learning from the case has been implemented across all services in Calderdale. Service Managers and practitioners were asked to demonstrate how the learning from the serious case review has changed practice. The results of this review showed much improved multi-agency arrangements to ensure care homes are monitored and supported to ensure that any concerns are identified early and acted on. When care homes are closed the process for ensuring residents are safeguarded is much improved.

It is the first time that the CSAB have reviewed how learning has been embedded following a serious safeguarding incident and the Board have decided to repeat this process for any future Safeguarding Adult Reviews.



Calderdale and Huddersfield NHS Foundation Trust

Empowerment

- Updated Adult Safeguarding Policy in line with the new West and North Yorkshire and York Multi-agency Safeguarding Adults Policies and Procedures.
- Revised MCA, DoLS Policy and Procedures Significantly increased safeguarding adults, MCA DoLS and Prevent training at all levels.
- Hosted a Trust wide event on the interface between the MCA and DoLS and the MHA in the Acute Trust.
- Safeguarding Committee oversees compliance of the Trusts 3 year mandatory safeguarding training through the electronic staff record. Making Safeguarding Personal is embedded within this training.
- Introduced and developed monthly Trust Wide Virtual Notice Board which disseminates key information to all Trust staff, including key messages from SAB.
- Developed new intranet webpages to provide a resource for staff relating to Safeguarding Adults, Prevent, MCA and DoLS, Domestic Abuse etc.

Prevention

- Implemented a new electronic patient record Trust wide in order to flag records and categorise any vulnerability.
- Set up a new Safeguarding Committee Meeting sub-Group that has oversight of all action plans. This Subgroup works closely with the Learning and Audit Subgroup.
- Updated Safeguarding Adults Policy with links to the West, North Yorkshire and York Multi-agency Policies and Procedures.

Proportionality

- Safeguarding team works closely with multi-agency partners to ensure that information is shared and that responses are in line with 'Making Safeguarding Personal' approach.
- Implemented and reviewed new guidance from the DOH 'Pressure Ulcers and the Interface with a Safeguarding Enquiry' : when to raise a safeguarding concern (DOH 2018).

Protection

- Safeguarding Committee has oversight of the Safeguarding Dashboard which is aligned to the safeguarding strategy.
- Delivered awareness around 'See Me and Care' Campaign at CHFT's Compassionate Care in Practice Nursing and Midwifery Conference – delivered as part ongoing safeguarding training.
- Developed and built a network of Safeguarding Champions and hold regular meetings and training with them.
- Developed and implemented a robust safeguarding audit plan overseen by the Learning and Audit Subgroup of the Safeguarding Committee Any learning is disseminated from the group to Trust Divisions.

Partnership

- Participated in Safeguarding Week.
- Met 85% training compliance set by NHSE for Prevent Health Wrap training and introduced new eLearning package for staff.
- Significantly improved suite of Safeguarding training compliance. Reviewed level 3 safeguarding training and updated in line with Multi-agency Policy and Procedures.

Accountability

- CHFT Safeguarding Adults Policy reviewed and updated to include statutory functions relating to the Care Act and the West, North Yorkshire and York Multi-agency Safeguarding Adults Policies and Procedures and clearly defines its role within the procedures.
- Safeguarding Annual Report for 2017-18 was produced and presented at CHFT Board.

**National
Probation
Service**



The NPS's role is to protect the public, support victims and reduce reoffending. In carrying out these roles the NPS is committed to protecting adults' rights to live free from abuse or neglect. NPS staff work within the Safeguarding Adults at Risk Practice Guidance (May 2017).

This supports NPS staff working with offenders in the community who:

- Pose a risk of harm to known adults and or pose a risk of harm to adults in general.
- Are adults at risk themselves.
- Have care and support needs
- Are carers in need of support

The NPS works with partners to Safeguard adults according to the NPS National Partnership Framework June 2015.

The following information comments on how the NPS has contributed to the CSAB Strategy 2017/18.

Empowerment

The NPS North East Delivery Plan 2018/19 has a strong focus on service user engagement. In Calderdale a team manager and the team of Probation Service Officers have launched Service Users forums. A front-line Probation Officer practitioner has a designated lead role in relation to Adult Safeguarding. Links have been made with the SAB with a view to support engaging with Service Users in the future. A manager in Calderdale sits on the Performance and Quality Sub Group.

Prevention

The NPS has assessed itself and submitted the Section 11 audit which grades the NPS as 'fully met' in relation to the Safer Recruitment Policy.

Protection

Learning from SCR's is disseminated at the NPS.

Proportionality

The lead practitioner in this area and the team manager are devising a briefing for staff in relation to the Joint Multi Agency Safeguarding Adults Policy and Procedures. This will raise awareness amongst staff about when and how to raise Safeguarding concerns. The NPS also runs mandatory Adult Safeguarding training for all staff.

Partnership

NPS comply with the request for a completed Training Needs Analysis every year. The Service contributes to Safeguarding Week, running a different event for the past 3 years. This year the focus was on Domestic Abuse and the event was attended by a range of partner agencies.

Accountability

The Bradford and Calderdale NPS Delivery Plan 2018/19 has a focus in relation to Adult Safeguarding. The lead team manager is responsible for providing the Local Leadership Team and practitioners with updates in relation to this area. There is regular NPS engagement with the Adult Safeguarding Board.



Yorkshire and the Humber

NHS England is the policy lead for NHS safeguarding, working across health and social care and leading and defining improvement in safeguarding practice and outcomes. It is the responsibility of NHS England to ensure that the health commissioning system as a whole is working effectively to safeguard children and adults.

NHS England Yorkshire and the Humber has an established Safeguarding Network that promotes shared learning across the safeguarding system. Representatives from this network attend the national Sub Groups, which have included priorities around Female Genital Mutilation (FGM), Child Sexual Exploitation, Children Looked After, Mental Capacity Act (MCA), Modern Slavery and Trafficking and Prevent.

A North region newsletter is now circulated weekly to safeguarding professionals to share learning from safeguarding serious incidents. Learning is also shared with GP practices (quarterly Safeguarding Newsletters), pharmacists, optometrists and dental practices (annual safeguarding newsletters). An annual North region safeguarding conference is hosted for all health safeguarding professionals and due to the success of last years named GP conference, NHS England North also held a conference for named GPs to share good practice and learning; topics included homelessness, domestic violence, travelling families and safeguarding.

NHS England works in collaboration with CCG designated professionals to ensure a robust oversight of all incidents, recommendations and actions from reviews. Designated safeguarding professionals are jointly accountable to CCGs and NHS England who oversee the provision of safeguarding training for primary care medical services. In addition, NHS England, in 2017/18, updated and circulated the Safeguarding Adults pocket book and has launched the NHS Safeguarding Guide App and a North region safeguarding repository for health professionals. A Safeguarding Assurance Tool for use with CCGs across the North Region was implemented in 2016/2017 and an online version has been piloted in 2017/18 in order to develop a national assurance tool for CCG's.

NHS England Yorkshire and the Humber have appointed an Independent Care Sector (ICS) Lead to support organisations in the delivery of the Enhanced Health in Care Homes framework. The key work streams in this programme for the ICS leads are the delivery of the red bag scheme and the roll out of an electronic bed state tool.

In response to safeguarding elements of complaints, priorities in 2017/18 were:

- Review and agree a standard process for the management of safeguarding concerns within complaints.
- Deliver safeguarding training to the required standard and level to all complaints staff in accordance with relevant national guidance.

NHS England North have two Regional Prevent coordinators who work across the North region to support Prevent implementation, they are part of the National and regional safeguarding and Quality team. This year has seen an increased focus and scrutiny on Prevent implementation within health and safeguarding.

We are working closely with providers, commissioners and regulators to support and monitor the work being undertaken to ensure that all health care organisations can meet their statutory duty for Prevent.

Following 'The Transforming Care' national programme in 2015 which announced a radical transformation of the delivery of Learning Disability and Autism services, the 6 Transforming Care Partnerships across Y&H continue to work collaboratively to achieve Building the Right Support for patients with Learning Disabilities and/or Autism in our area.

In November 2016 the national LeDeR Programme was introduced in to the Transforming Care Programme following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD). This resulted in implementation of the LeDeR programme to undertake reviews. LeDeR also complements the NHS Operational Planning and Contracting Guidance for 2017/19 which identifies the need to:

- "Improve access to healthcare for people with a learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making reasonable adjustments for people with a learning disability and/or autism.

The LeDeR process recognises it is important to capture the extent of personalised services, including the use of reasonable adjustments, choice and control and the well-being of people with learning disabilities. Early findings of the reviews already completed have started to be shared across the area.



West Yorkshire
Fire & Rescue Service

A Safe & Well Journey

In October 2015 based on success around prevention, the need to reduce expenditure, find ways of improving coordination and making every contact count, the Fire and Rescue Service, along with key partners, set out their intention to work more closely together. Six key strands were agreed for the roll out of the safe and well programme across West Yorkshire, closely linked to risk factors identified for increased vulnerability and health. These include:

- Fire Prevention
- Falls and frailty
- Social isolation
- Smoking
- Cold homes
- Crime prevention

Our Vision: Making West Yorkshire Safer

Our Objectives

Support individuals to be safer within their homes
Identify and improve the safety, health and well-being of the most vulnerable
Provide a range of community safety activities including targeted home visits, sessions in school, social media campaigns, awareness sessions within local communities, specialised individual support and group activities for children and young people and targeted campaigns aimed at high risk groups.

Since the introduction in April 2017, Calderdale crews and teams have been trained on five out of the six modules. Further training is currently underway. Where possible partners have co-delivered the training to front line staff, which has added weight to delivery and enabled operational and prevention staff to seek advice and query any issues.

Safeguarding

The introduction of the Safe & Well programme into our daily service has seen an escalation in Safeguarding referrals and in turn has generated more communication with the Partners involved. Calderdale Prevention and Crews have been spending longer in people's homes, communicating better and have gained confidence in recognising more vulnerability through the training received to conduct this service. A large number of cases generated as Safeguarding have come under the title of Self neglect and often relating to some form of Hoarding. A new Hoarding Framework in Calderdale is in development to address this growth incorporating other concerns relating to Environmental Health, Mental Health & Housing. West Yorkshire Fire Service is keen to play a vital part in this multi-agency approach and to also help to develop an after care package to support vulnerable people experiencing this lifestyle within their homes.



WY CRC supervises around 550 offenders from Calderdale, of whom almost 20% are in prison. Around 14% are women.

Domestic Abuse Initiatives - The Domestic Abuse Policy was updated in February 2018. Extensive and detailed training is undertaken, in groups and on-line. Domestic Abuse Programmes are co-delivered by experienced tutors, with quality assurance observations built in. Partner Link Workers work with victims of the male perpetrators who attend one of the programmes. The workers undertake home visits, offer support, information and practical steps to stay safe. Individual focused work with domestic abusers takes place through Creating Safer Relationships service. Other interventions are also delivered, including South East Asian Mentoring Support.

Tackling Substance and Alcohol Misuse – 2 brief case examples

A man in Halifax is in his 30s, he has been in the criminal justice system since aged 18. He has, with help of his Probation Officer, secured his CSCC Card (required for working in the construction and building sector); attended Rail Track training course and secured a fulltime position working on the railways. This person has stopped drinking and he is supporting his children. 25 appointments kept since release from prison in May, a 100% attendance rate. This man is maturing and growing out of crime.

Once a week, the WY CRC Case Manager facilitates the Halifax Drug Rehabilitation Requirement Group at The Basement Recovery Project bringing together: the Basement Project, Calderdale Recovery Steps and WYCRC. This enables service users with substance misuse issues to have easy access to all 3 services at once and for staff to keep up to date with local developments.

Integrated Through The Gate is an initiative that involves additional CRC staff being seconded to work in local prisons, helping to prepare offenders for the best possible release back into Calderdale.

Delivering on the 6 Principles of the CSAB

Empowerment: each service user has a personalised Sentence Plan that includes the user's self assessment details. Our partner agency User Voice enables offenders under our supervision to speak out, including regular meetings with staff and our Executive Director. We have our own accredited volunteers, current and former service users, who are now crime free and giving something positive back. Our Right Direction Volunteers are making a difference! In Halifax a volunteer supports a case manager with running a regular Victim Awareness group.

Prevention: each assessment for each service user includes specific details as to how harm, abuse, neglect and offending can be prevented, this translates into the Sentence Plan and a Risk Management Plan pulls all the issues together. A brief case example:

In September 2017 we were informed of a suicide of a group member. He was a Halifax service user. Since then tutors highlight and discuss the issue of male suicide in particular sessions, and the importance of support networks, strategies to lift negative emotions and also the value of recognising and responding to depression and potential suicidal thoughts in friends. We have issued 'Is Your Mate Off His Game?' wallet cards developed by the Men's Health Forum to group members. We also direct them to CALM (Campaign Against Living Miserably) aimed at reducing suicide.

Proportionality: the allocation of offenders to CRC staff is based on a Banding and Allocation Tool; this ensures the greater the risks the greater the resources are deployed. We have Case Managers and Senior Case Managers/Probation Officers to ensure our interventions are proportionate. Additionally, we "risk escalate" any high risk of harm offenders over to the National Probation Service. Regular supervision of practitioners helps to ensure we have the right amount of intervention focused on the highest risk of harm.

Protection: the Risk Management Plan is central to this work and we enforce court orders, including Non Molestation Orders, by breaching offenders back to court. We recall prisoners on licence supervision back to prison where there has been further offending, or a breach of any licence condition. Our Partner Link Workers provide support and guidance, helping victims of domestic abuse stay safe. We are committed to MARAC, contributing on a daily basis to the WY Police Domestic Abuse Hub through information sharing.

Partnership: this is key to our effective working and we are in contractual arrangements with a range of stakeholders including: The National Probation Service; West Yorkshire Police; HM Prison Service. We have staff from P3, Shafa and PACT working directly with a range of our service users.

Accountability: we work to Ministry of Justice/HM Prisons and Probation Service standards, are monitored regularly and have a rigorous performance management culture that all our staff buy into. The findings from a recent external audit highlighted the need for further work to improve risk assessment and management, with our leadership and Unpaid Work/Community service rated as good.

Going forward we are about to re-structure our CRC Teams to make the most effective use of the resources we have. We are looking to improve opportunities for offenders in a number of areas including: access to mental health services; reasonable accommodation on release from prison; integrated and bespoke services for women we supervise; access to education, training and employment with local providers.



Over the last twelve months we have focused on further strengthening our operational arrangements, helped by our Safeguarding Coordinator who came into post in April 2017. Our Coordinator has developed and delivered safeguarding training, now much more tailored to housing as well as meeting the diverse needs of our workforce. The Coordinator provides specialist advice to Managers and staff on dealing with safeguarding concerns which in turn improves oversight of overall performance. This has increased confidence in dealing with concerns and embedding the culture of speaking out and raising concerns.

New starters receive appropriate training, all staff undertake mandatory e-learning and refresher training for existing staff. More specialist training is being developed e.g. Prevent (Radicalisation and extremism) and awareness around financial scams.

Internal policies, procedures and guidance have been refreshed to ensure alignment with local multiagency procedures and sector best practice. We have also rolled out specialist guidance on hoarding, mental capacity and tenancy agreements and dealing with customers expressing suicidal thoughts and guidance for our Finance and HR teams who have a key role to play to ensure the links are made with other associated policies and procedures ie recruitment and disciplinary, whistle blowing, antifraud etc. We have developed a very successful partnership with WY Fire Service as part of prevention to identify and assist vulnerable tenants, which often identifies concerns around hoarding and self-neglect.

We have also been much more involved in Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. This has brought a great deal of learning, both in terms of specific cases as well as developing our in-house skills in undertaking reviews and reflection. We have also recently established our own Safeguarding Learning Group, comprising senior management representatives from across the Organisation to ensure structured time and attention is given to learning as well as capturing and cascading the learning across the Organisation through formal and informal training. This is also part of strengthening our governance and assurance framework which includes reporting serious cases (including significant near misses) to our Risk and Audit committee (sub group of our Board) together with an annual performance report.

We are reviewing our safeguarding processes around recording and performance data to improve the ease of reporting concerns, consistency, timeliness, capturing outcomes, recording of mental capacity and to be more aligned with our Anti-social behaviour recording system, given safeguarding is a key element of many ASB cases.

The following case study helps to illustrate the positive work that has been done around training of our staff and meeting the diverse needs of our workforce.

This example from practice relates to a piece of work involving 3 members of staff who are hearing impaired (and refer to themselves as the Deaf Team). They all work in the Estate Services team, the majority of their work is in the community and in customers' homes and they are therefore well-placed to spot signs of abuse as well as general concerns about the welfare of customers. Traditionally, the team have undertaken safeguarding training via e-learning. However, we were aware from their feedback that this was difficult as they struggled with the large amount of information to take in all at once, with very limited relevant examples of how safeguarding applies to their role. So we looked at how we could do it better.

Working with the team and the Deaf Team Communicator, we formulated a tailored training package. Using in-depth knowledge and understanding of the team's learning needs, alternative communication methods were proposed. One key example was that the team explained that the word "safeguarding" had no meaning to them and that they needed literal examples to be able to relate to what safeguarding from abuse is all about, together with a lot more visual aids. The training was a huge success. The team achieved their learning outcomes and one member summed it up in his feedback, stating that "this was the best training we have ever had. It would be great if all of our training was like this".

Our staff are our greatest asset in prevention and we are proud that our deaf colleagues now feel properly included and can play their part in making 'safeguarding everyone's responsibility'.



South West Yorkshire Partnership NHS Foundation Trust

South West Yorkshire Partnership Foundation Trust remain committed to safeguarding both adults and children, this remains a high priority for the organisation.

SWYPFT have been accredited with the West Yorkshire Quality Mark in relation to our training package for domestic abuse and our policies to support both service users and staff. Our work around this agenda empowers service users and staff to make decisions about how to live their lives and stay free from abuse.

The Safeguarding Team developed a safeguarding risk assessment document for use by practitioners, its promotion and use has supported practitioners to capture the outcomes of service users and triangulate the relevant information.

The Safeguarding Team have produced and delivered 'Parental Mental Health' training focussing on the impact that mental illness can have on adults with parenting responsibilities and protective factors. This promotes interagency collaboration, assessment and intervention.

In March 2018 SWYPFT hosted a Safeguarding Conference and invited a number of partners to attend. This which focussed on Human Trafficking, Child Sexual Exploitation, raising awareness of people with Learning Disabilities around the potential for exploitation and issues of consent, Radicalisation and Honour Based Violence. A core theme which ran throughout the various presentations was that of missed opportunities, the importance of listening and acting, making every contact count.

The safeguarding adults and children Specialist Advisers and Named Nurse have merged to form one team in line with the 'Think Family' approach. The link professional forums have also merged both adult and children professionals and opened these forums up to partner organisations, thus promoting a rich and diverse body of experience and expertise. External speakers are invited to attend to promote understanding around a range of subjects such as Female Genital Mutilation and Human Trafficking, learning from Safeguarding Adult Reviews is also shared at this forum, this promotes prevention, partnership working, accountability and protection.

The Safeguarding Team developed a self-neglect/hoarding presentation following a serious incident in which this was a theme, to enable staff to learn from the incident and support them with future decision making.

SWYPFT supported West Yorkshire Safeguarding Week; delivering a presentation on "Perinatal mental health and Safeguarding".

The Safeguarding Team have produced and disseminated a number of briefings around a number of subject areas, including harmful sexual behaviour, parenting as an abuse survivor and the sexual exploitation of boys and young men. A weekly safeguarding newsletter is disseminated across the organisation which may contain information from the Safeguarding Boards, national, regional or local learning.

The Trust exceeded the new 85% training target for PREVENT as set by NHS England and achieved 93%. A case study was developed for NHS England to utilise in training.

Case study

A service user, who is an older person, disclosed unwelcome visits from their son who is known to have difficulties with substances and who was asking for money and requesting to stay at the property. The service user had the capacity to make the decision to tell him not to visit anymore and also decide whether to involve the police. Initially the service user had been reluctant to discuss the matter, as the source of harm was their son, however, this was impacting on the service user's mental health and the risks were increasing. The options available to the service user were shared and discussed by their Care Co-ordinator. As a result, the service user made the decision that the Care Co-ordinator could raise a safeguarding concern. Information was shared across the multidisciplinary team to ensure colleagues were aware of the risks and the case was referred to both Local Authority Safeguarding and the police. An appropriate plan of care was developed and appropriate support provided to the Care Co-ordinator via the Trust's Safeguarding Team. This case demonstrates protection, proportionality and empowerment.

1. The Government Statistical Service in its 2011 Rural-Urban Classification for Local Authority Districts in England
2. The national Census 2011 (ONS, 2011).
3. Office for National Statistics 2014 population projections published in May 2016

If you need guidance or advice, call **Gateway to Care** on **01422 393000**

To report adult abuse or neglect, call **Gateway to Care** on **01422 393000**

To contact out of office hours, call the **Emergency Duty Team** on **01422 288000**

Guidance on making a referral can be accessed from the Safeguarding Board Website
<http://calderdale-safeguarding.co.uk/>



