CITY OF WOLVERHAMPTON COUNCIL

Adult and Safer City Scrutiny Panel

31 January 2017

Time 6.00 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue

Membership

Chair Cllr Paula Brookfield (Lab)
Vice-chair Cllr Patricia Patten (Con)

Labour	**Conservative**	**UKIP**
Cllr Ian Claymore	Cllr Barry Findlay	Cllr Malcolm Gwinnett
Cllr Dr Michael Hardacre		
Cllr Rupinderjit Kaur		
Cllr Linda Leach		
Cllr Elias Mattu		
Cllr Lynne Moran		
Cllr Anwen Muston		
Cllr Rita Potter		

Quorum for this meeting is three Councillors.

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of previous meetings** (Pages 3 - 8)

4 **Matters arising**

5 **Public Space Protection Order** (Pages 9 - 22)
[To request that the Panel contribute towards the consultation on proposals to introduce a Public Space Protection Order to tackle alcohol-related anti-social behaviour in the city.

6 **Supporting a Safe and Seamless Transfer From Specialist Care or Hospital Setting** (Pages 23 - 28)
[To consider a report from Manjeet Garcha, Director of Nursing and Quality in relation to the transfer from specialist care or hospital]

7 **Safeguarding Adults Board Annual Report** (Pages 29 - 80)
[To consider the Safeguarding Adults Board Annual Report for 2015-2016]

CITY OF WOLVERHAMPTON COUNCIL

Adult and Safer City Scrutiny Panel

Agenda Item No: 3

Minutes - 6 December 2016

Attendance

Members of the Adult and Safer City Scrutiny Panel

Cllr Ian Claymore
Cllr Barry Findlay
Cllr Malcolm Gwinnett
Cllr Dr Michael Hardacre
Cllr Linda Leach
Cllr Elias Mattu
Cllr Anwen Muston
Cllr Patricia Patten (Vice-Chair)

Cllr Sandra Samuels was also in attendance.

Employees

Paul Smith	Head of Commissioning
Jas Kakkar	Lead Commissioner - Personalised Support
Alison Shannon	Finance Business Partner
Julia Cleary	Scrutiny and Systems Manager

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies were received from Cllr Brookfield, Cllr Kaur and Cllr Potter.

2 **Declarations of Interest**
There were no declarations of interest.

3 **Minutes of previous meetings**
Members and Officers drew attention to Page 9 of the agenda and requested that amendments were made in relation to paragraph 3 of the minutes in relation to the consultation and paragraph 6 in relation to the Epic Café which was thought not to be appropriate as a venue or meeting place.

It was agreed that the wording at paragraph 3 be amended to read:

Cllr Muston stated that the Council had a statutory responsibility to provide assistance to all areas of protected characteristics under the Equalities Act and that this included mental health. Cllr Muston expressed concern that the LGBT community had not been invited to participate in the consultation exercise which was

contrary to the Equalities Act 2010 and went against the Council's own Compact agreement.

Officers stated that members of the LGBT community would have been consulted as members of the public and that, Mind Out (a mental health peer support group for lesbians, gay men, bisexual and transgender people which is closely linked to and supported through LGBT) had been included within the consultation. Shen Campbell (Consultation Officer) had dropped a number of questionnaires off at Network House for Mind Out and had returned the following week to take Wellbeing Warriers some questionnaires as they also dealt with individuals with mental health.

Officers gave assurances that fuller consultation with the LGBT community and other groups such as ex-servicemen would be addressed in the future.

Resolved: (a) That the minutes of the meeting held on 11 October 2016 be agreed as a correct record.

(b) That the requested amendments be made to the minutes of the meeting held on the 25th October 2016 and that the minutes be agreed as a correct record.

4 **Matters arising**

There were no matters arising.

5 **Draft Budget and Medium Term Financial Strategy 2017/18 - 2019/20**

A report was considered requesting the Panel to provide feedback to Scrutiny Board for consolidation and onward response to Cabinet on the Draft Budget 2017/18, in particular those elements that were relevant to this Scrutiny Panel.

Older People Assessment and Care Management – Promoting Independence

Member questioned what impact an overall reduction would have on the services being provided. The Cabinet Member for Adults stated that the overall goal was to promote independence and that a risk register had been produced to manage concerns relating to any reductions in service.

Officers confirmed that the savings were a result of precious resources being spent on promoting independence and smarter, better ways of working.

Members raised concerns regarding the £13.5 million cuts that were being proposed across the Council at a time when there was a growing elderly population and that over half of the proposed cuts appeared to be coming out of budgets linked to vulnerable groups. Councillors requested assurance that the correct balance had been achieved regarding the cuts. The Cabinet Member stated that the budget linked to Adults did have the highest overspend and that an additional £2 million had been added to the budget each year to help maintain the balance and address the demographic growth and the living wage. The Cabinet member confirmed that checks and balances were in place along with the risk register.

The Panel requested that this area of work be kept under review with updates being provided to the Committee.

Members stated that it was important not to place undue pressure on officers to reduce expenditure to a level that was not appropriate for the City and sacrificed

quality and that comparing with other local authorities was not always the best was to proceed and needed to be approached with care. Officers agreed that the savings needed to be appropriate.

Officers reaffirmed that the majority of the savings proposed were as a result of enabling individuals to self-care and preventative measures that allowed individuals to remain at home rather than having to enter residential care. Officers stated that the local hospital had seen a significant fall in revenue due to more people remaining at home for longer.

Members raised some concerns that it may be the case that an individual was being encouraged to remain at home for longer when in fact they should be in residential care and that individuals were not being given an appropriate amount of time to complete the required paperwork. The Cabinet member requested that any details of incidents regarding this be passed to her as there should not be any undue pressure placed on individuals and quality assurance checks were in place. It was also stated that the Council was working with the hospitals regarding discharge policies.

Concerns were raised that there would be insufficient money to care for the increasing elderly population and in particular elderly women where an increase in dementia had been identified. The Panel agreed that a good relationship needed to be maintained with Age UK and officers confirmed that they met with representatives from the Charity on a monthly basis.

The Panel considered that there had been no additional funding for Social Services in the autumn Statement and that money from the Government was crucial to keep the services running at an appropriate level.

Age UK Contract Review

The Panel considered that this was a positive and that a good relationship needed to be maintained with the Charity. The Panel also considered whether Age UK could be used to help highlight issues and concerns raised by the Council to the Government and to other voluntary organisations.

Equipment Store Tender

The Panel had considered this at the previous meeting and were please that items of equipment were managed well in Wolverhampton and commended Officers on their hard work.

Transformation of the Emergency Duty Team

Officers stated that the Council was working with partners from Sandwell and Dudley to create a larger team. No job losses had been highlighted and at the moment agency staff were being used to cover for staff absences and sickness. The Panel requested that an update be brought back to the Committee once the new design had been established and before implementation.

There were concerns expressed by the Panel in relation to having members on the emergency team who were based far outside of the area being serviced. Officers stated that the teams would be based where they were needed and could even be

based at home. Officers also confirmed that the service was not physical but there to provide an allocation of services.

Disability and Mental Health – Promoting Independence

The Panel expressed concern that not enough funding was provided for hostels dealing with individuals with drink or drug related problems to help mitigate against any problems experienced by residents living in the vicinity of the hostels. Officers stated that often in these cases a patient had a health need and a social care need and that in most cases the health need took precedence but that if the rules were applied more robustly then there could be more opportunity for funding to come into the area.

The Panel considered that some families would be reliant on continuing healthcare and that they could be the casualties of the budget cuts and find themselves moved between different mental health commissioners and the Council. Members again expressed concerns that individuals with mental health illnesses could be expected to live independently but they really needed support that was holistic as at the moment providers would often not treat an underlying mental illness until the health problem such as alcoholism had been treated.

Members agreed that budget cuts could not be avoided but were concerned that mental health issues were not rated as highly as they should be by service providers and commissioners and that there had been little movement forward in care and treatment. The Panel considered that there needed to be one budget with one direction as at the moment there were too many departments involved.

The Panel requested that this be looked at again in detail.

Housing Related Support Services

This area had previously been known as supporting people and there was still the legacy of a budget but that spend was being reduced. Officers confirmed that people were still receiving some low level support but that this was a luxury rather than a necessity given the current budgetary context. There was some concern that there services could create a level of dependency that could in fact be detrimental to the individual rather than supportive. Officers also confirmed that this was a service that the voluntary sector could provide and members stated that there were some individuals who would need this support but could not afford it.

Omega Contract Review

Officers stated that this service was now being delivered in house with no additional resources. Members were pleased with this and there were no further comments.

Life Direct Contract Review

Officers stated that due to extremely low footfall in the drop in and welfare advice centre there had been a mutual agreement to terminate the contract early. The Panel were in agreement with this and there were no further comments.

Kaleidoscope Contract Review

This organisation provided low level mental health services and had recently been awarded lottery funding which was allowing it to continue to provide the same service but without any financial contribution from the Council.

The Panel were in agreement with this and there were no further comments.

Budget and Demographic Growth
This was noted by the Panel, there were no additional comments.

6 **Quality Assurance and Compliance Work Programme**
A report was submitted requesting the Scrutiny Panel to note the method undertaken by the Council's Quality and Compliance team to ensure all services were appropriately monitored and supported and its future work programme.

The Quality Assurance and Compliance (QA&C) team had previously consisted of three and a half full time equivalent officers, however subsequent to a commissioning restructure these posts had been increased to seven officers.

The aim of the team was to make sure that services commissioned were of an appropriate standard and quality. They did this by making sure that the terms and conditions of the Council's contracts were upheld and complied with regulations and frameworks.

Officers were currently developing a Quality Assurance Framework (QAF) which would require the service/provider to evidence their practice against a range of objectives and outcomes. This would be undertaken through an online self-assessment audit by the service/provider on an annual basis.

Officers also intended to increase the number of visits to two visits per year for each service/provider (instead of every two years as at present).

Members thanked officers for the report and considered that it contained encouraging information. Attention was drawn to item 4 which was concerned with the deaths of elderly women. Members considered that a comparison was required for this and requested information on the last five years and the previous year. Officers agreed that this information could be provided.

Members queried what a 9% increase actually meant as a population increase could mean that this number was in fact lower than previously. The Panel therefore requested that real information be provided showing the total population figures against the total number of women over the age of 65 years. Officers stated that they would go back as far as possible to provide information on deaths in each age group and the number of people who were in receipt of a service from the Council. Members also requested that information be provided to allow them to compare local information against the national average.

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Agenda Item No: 5

Adults and Safer City Scrutiny Panel

31 January 2017

Report title	Public Space Protection Order (Review of Designated Public Place Order)	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders	
Originating service	Community Safety, Public Health and Well Being	
Accountable employee(s)	Karen Samuels Tel Email	Head of Community Safety 01902 551341 Karen.samuels@wolverhampton.gov.uk
Report to be/has been considered by	Strategic Executive Board	20 Dec 2016

Recommendations for noting:

The Panel is asked to:

Contribute towards the consultation on proposals to introduce a Public Space Protection Order to tackle alcohol-related anti-social behaviour in the city.

1.0 Purpose

1.1 To present findings from a review of the existing city-wide Designated Public Place Order (DPPO), in force since April 2013.

1.2 Seek views on the introduction of a Public Space Protection Order (PSPO) to address alcohol-related anti-social behaviour (ASB) in the city.

2.0 Background

2.1 A city-wide Designated Public Place Order (DPPO) has been in place in Wolverhampton since April 2013. The order provides Police with powers to require any person to stop drinking and to surrender alcohol if they are causing or are likely to cause anti-social behaviour (ASB).

2.2 The Anti-social Behaviour, Police and Crime Act 2014 came into force in October 2014 and introduced streamlined tools and powers to replace existing orders; DPPOs have been replaced by generic Public Space Protection Orders (PSPOs) which provide the opportunity to add in more specific prohibitions to address the specific ASB concerns being experienced.

2.3 Wolverhampton has been at the forefront of trialling PSPOs in the West Midlands, with two piloted in Low Hill and Park Village since Sept 2015. These have proved to be largely successful within these locations but have required a more focused and coordinated effort across agencies to manage the logistics around application and enforcement; a multi-agency ASB Steering Group is in place to facilitate this.

2.4 The proposals for implementation of the PSPO directly support the following Corporate Plan objectives:

- Keeping the City Clean – by reducing the prevalence of alcohol-associated litter within designated locations.

- Supporting Businesses, Encouraging Enterprise and Investment – improving city image by targeting hotspot locations where street drinkers congregate.

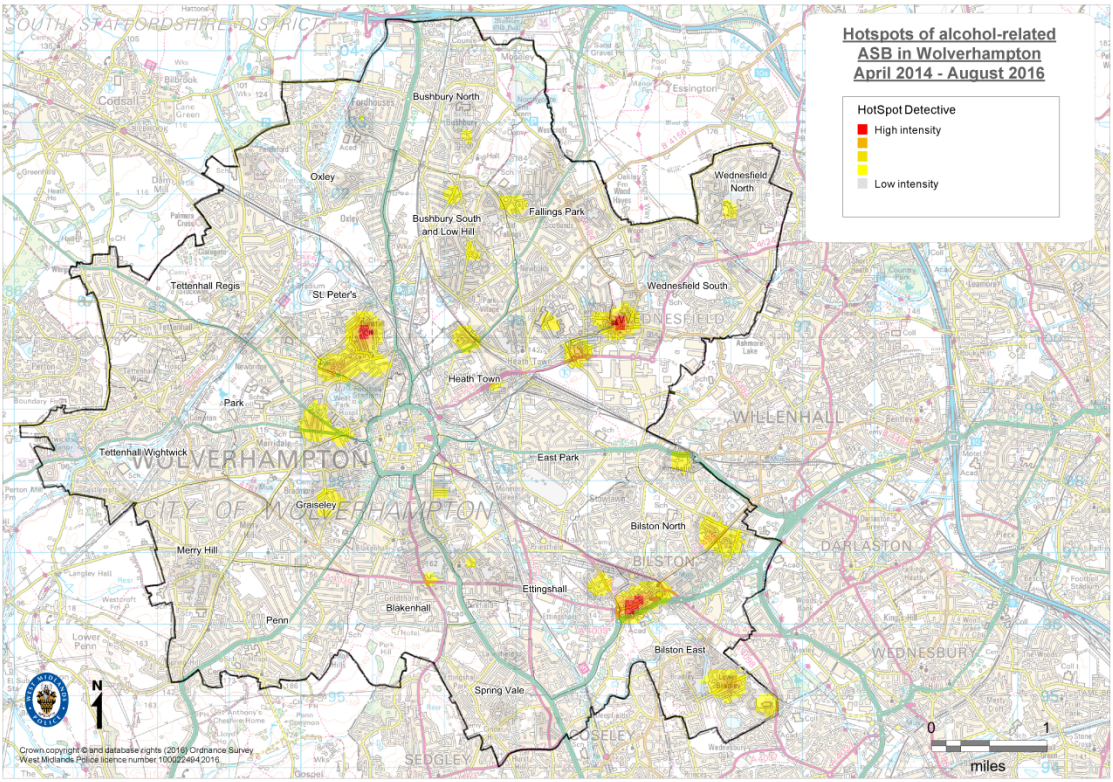
- Keeping the City Safe – creative use of new legal powers to tackle ASB.

3.0 Review of Existing DPPO Arrangements

3.1 Data highlighting use of the DPPO between April 2014 - Aug 2016 shows the power has been applied more extensively in the City Centre, St Peter's and Park areas. This is in part, attributable to Police patrolling strategies in these locations in response to local concerns raised about street drinking.

Neighbourhood	Count	% of total
Wolverhampton City Centre	248	64%
Park	90	23%
St. Peter's	31	8%
Wednesfield South	5	1%
Bilston East	3	<1%
Graiseley	3	<1%
Heath Town	3	<1%
Tettenhall Regis	2	<1%
Blakenhall	1	<1%
Bushbury South and Low Hill	1	<1%
East Park	1	<1%
Ettingshall	1	<1%
Oxley	1	<1%

3.2 In addition to use of the DPPO, the review also captured reports of alcohol-related ASB and where these are occurring across the city. There is a wide geographic spread of these reports across all areas of the city, however, the City Centre (453 reports), and the locations which include Bilston Town Centre (316 reports) and Wednesfield Town Centre (178 reports) feature as the main hotspots for alcohol-related ASB; with these areas linked directly to the night time economy.



4.0 Multi-agency response to tackling alcohol-related ASB

4.1 The DPPO has been used as part of a suite of measures to respond and manage alcohol-related ASB which includes active Police patrols, ASB team civil enforcement against known perpetrators, licensing restrictions and advice to off-licenses and targeted outreach by Recovery Near You, the city's drug and alcohol treatment provider. The multi-agency steering group coordinates delivery responses to ASB across the various enforcement agencies which is underpinned by a commitment to joint and shared enforcement.

5.0 PSPO Proposals

5.1 The volume and geographic spread of alcohol-related ASB reports over the period would suggest there is a need to retain the existing powers held by Police under the current DPPO.

5.1.1 **Recommended Proposal:**
A continuation of existing DPPO powers on a city-wide basis authorising Police to require a person to stop drinking and surrender alcohol where ASB is occurring or is likely to occur.

5.2 The level of DPPO use within St Peter's, Park and City Centre neighbourhoods, however, is a reflection of the ongoing nuisance caused by street drinking within these locations. This is supported by ongoing reports through PACT and Tasking meetings and via businesses that street drinking remains a priority for these areas.

5.2.1 **Recommended Proposal**: Inclusion of a street drinking ban for St Peter's and Park wards, which includes the City Centre (as designated on **Appendix A** attached) within the PSPO. This prohibition would not apply to premises which are licensed for the supply of alcohol so would not impede these legitimate business functions; this includes any curtilage (e.g. a beer garden or pavement seating area).

5.2.2 The prohibition would also include a waivering option to allow for public drinking at organised events within these locations (e.g. Christmas market) via applications made for temporary event notices through the Council's Licensing Team.

6.0 Consultation

6.1 Police are in full support of the proposed prohibitions on public street drinking within the designated locations; it will support enforcement efforts to tackle pockets of street drinkers congregating in hotspot locations reported by residents and businesses which can have a negative impact on trade and city image. Police are confident, however, that the discretionary confiscation powers currently in place, if continued, would be sufficient to respond to alcohol-related ASB covering the night time economy within Wednesfield and Bilston town centres.

6.2 A six week consultation was launched on the proposals on 5 January and will run until 16 February 2017; this will include briefings with ward Councillors from St Peter's and Park, the business sector including the City Centre BID, voluntary and community sector,

Communities of Interest, designated service leads within the City Council, Councillors, community networks/forums and external partners such as Police and Wolverhampton Homes. A Frequently Asked Questions sheet has been produced to provide clarification on aspects of the proposal (**Appendix B** attached)**.** The consultation can be accessed electronically via the following link: https://www.surveymonkey.co.uk/r/CH7LGTG

6.3 The views of Adults and Safer City Scrutiny Panel are invited on these proposals by responding to the following questions:

The PSPO would provide a continuation of existing city-wide discretionary powers held by the Police to request the surrender of alcohol where anti-social behaviour is occurring or is likely to occur as a result of alcohol consumption.

a) Would you be in support of Police retaining this discretionary power?

There is an opportunity for the PSPO to include an outright street drinking ban in St Peter's and Park wards. The selection of these locations has been informed by data on the existing use of DPPO powers and reports of alcohol related anti-social behaviour in these locations. This would not affect the activity of legitimate licenced premises or organised events within these areas.

b) What are your views on the introduction of a street drinking ban within these locations?

6.4 The Council's Communications team is leading all communications relating to these proposals and is actively promoting opportunities to feed in via City People and social media.

6.5 Responses to the consultation will be captured and inform the Cabinet report and any subsequent decision by Cabinet on how to proceed.

7.0 Implementation

7.1 Subject to Cabinet authorisation of the PSPO on 22 February 2017, the proposals must then be formally publicised and will be subject to a six week stand still period during which an appeal against the proposals can be made to the High Court before coming into force. Proposals will be advertised through partner and community networks, social media, the Council and SWP websites and an advertisement in the local press.

7.2 Subject to Cabinet approval, and assuming no appeal against the proposals is lodged with the High Court, the PSPO would come into force on 6 April 2017.

7.3 The conditions of the PSPO would be in place for a period of three years; revisions to the prohibitions contained within the PSPO are not proposed within this period, however, the impact of the order will be closely monitored to allow for any operational variations across partners to be built in as required. The PSPO will be subject to review before its expiry in April 2020.

8.0 Financial implications

8.1 The cost of the statutory notice, consultation and signage will be met from existing budgets within the Community Safety Team.

8.2 Breach of PSPO prohibitions can result in fixed penalty notices being issued by authorised Council Officers or other persons designated by the Council. A penalty charge of £80 will be applicable in these circumstances, though it is not expected that the PSPO will generate any notable income as the main focus is to deter ASB or follow through with enforcement against perpetrators of ASB. [GS/20012017/W]

9.0 Legal implications

9.1 The Anti-social Behaviour, Crime and Policing Act 2014 ("the Act") came into effect on 20 October 2014.

9.2 Section 59 of The Act gives local authorities the power to make PSPOs which are intended to deal with ASB and nuisance in a particular area that is detrimental to the local community's quality of life by imposing conditions on the use of that area.

9.3 The Act places limitations on how a PSPO can be used to restrict the consumption of alcohol in a public space where the test has been met. A PSPO cannot be used to restrict the consumption of alcohol where the premises or its curtilage (a beer garden or pavement seating area) is licensed for the supply of alcohol. There are also limitations where either Part 5 of the Licensing Act 2003 or section 115E of the Highways Act 1980 applies, as these already provide safeguards against ASB.

9.4 Before making a PSPO, councils must consult with the local police (section 72(3) and 72(4) of the Act). Formal consultation was held with with West Midlands Police on this matter on 8 November 2016 where support for these proposals was recorded.

9.5 The Act also stipulates that councils must consult with the local community on any proposed PSPO. Consultation opportunities have been widely publicised across the city within communities, councillors, business sector and partner agencies.

9.6 Anyone who lives in or regularly works or visits the area can appeal a PSPO in the High Court within six weeks of issue. The PSPO will be publicised locally. Signage will not be erected until after the six week period or, if an appeal is lodged, after any High Court ruling. [AS/23012017/S]

10.0 Equalities implications

10.1 An equalities screening has been carried out and there is no evidence to suggest that the proposal would be directly or indirectly discriminatory. Data relating to use of the existing DPPO and the proposed PSPO is reliant on Police recording systems which do not capture data concerning individuals where alcohol has been confiscated unless a crime

has been committed. Views from the city's voluntary and community sector and Communities of Interest have been actively sought as part of the consultation.

11.0 Environmental implications

11.1 The proposals would have a positive environmental impact by reducing the litter associated with street drinking within St Peter's and Park wards.

12.0 Human resources implications

12.1 There are no human resource implications associated with this proposal.

13.0 Corporate landlord implications

13.1 There are no corporate landlord implications associated with this proposal.

14.0 Schedule of background papers

14.1 There are no background papers.

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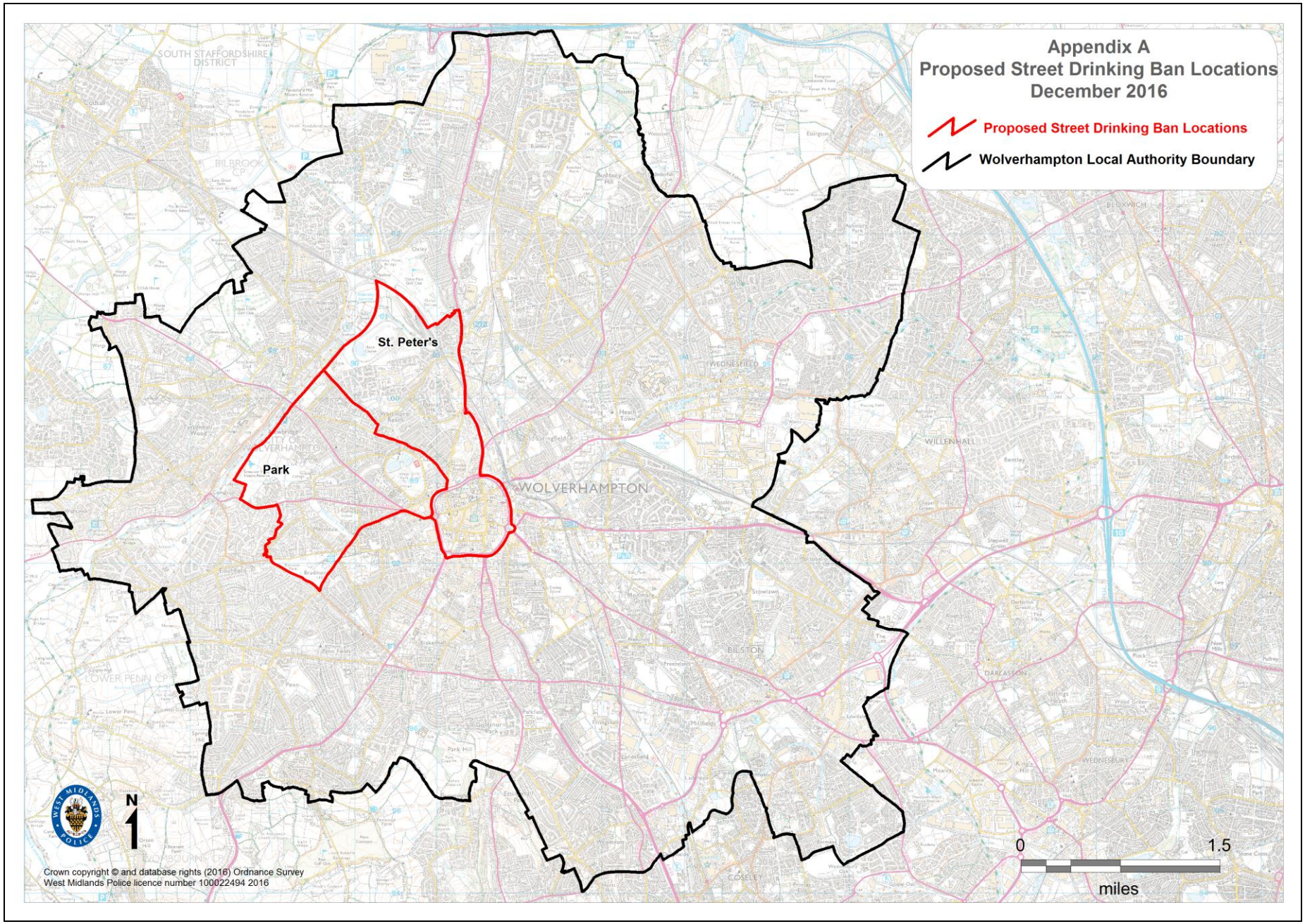
Appendix A – Proposed Street Drinking Ban Locations



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CITY OF WOLVERHAMPTON COUNCIL

Public Space Protection Orders

Frequently Asked Questions

What is a Public Space Protection Order?

Public Place Protection Orders (PSPO) are orders made by the local authority under powers which were given to them under the Anti-social Behaviour, Crime and Policing Act 2014.

These powers make it possible for Local Authorities to deal with a particular nuisance or problem which is detrimental to the local community's quality of life by imposing conditions on the use of that area which apply to everyone. They are designed to ensure the law abiding majority can use and enjoy public spaces, safe from anti-social behaviour (ASB).

The Council is consulting on proposals to implement a PSPO which will provide a continuation of city-wide discretionary powers held by the Police to request the surrender of alcohol where ASB is occurring or is likely to occur as a result of alcohol consumption. There is also an opportunity to include additional prohibitions on street drinking within designated locations.

Is this a ban on drinking alcohol in public areas?

Proposals could include introducing a street drinking ban for St Peter's and Park wards, to include the city centre. For these localities, consuming alcohol in a public place would not be permitted.

These prohibitions would not affect legitimate trading activity of licenced premises. Consequently, land within the curtilage of licenced premises certified to serve alcohol. E.g. a pub beer garden or paved seating area would not be affected.

There are also options to waiver these prohibitions to support organised events, so the order would not apply to events covered by a temporary event notice. This could be an outdoor Christmas Fete where mulled wine is sold for example.

For designated areas which have an outright street drinking ban imposed, drinking alcohol in a public place would not be permitted. As explained above, this would not apply to drinking within the curtilage of licenced premises or in circumstances which have been covered by a temporary event notice.

Why have these area been selected?

Police already have discretionary powers to require that a person ceases drinking and surrenders alcohol where ASB is occurring or it likely to occur as a result of their alcohol consumption. This has been in place since the introduction of a city wide Designated Public Place order (DPPO) in April 2013.

Data collected since April 2014 and ASB reports by residents and businesses within St Peters and Park wards and in the city centre indicate that more robust measures are needed to respond to concerns highlighted in these areas.

How will Police use their discretion on applying this power?

The PSPO gives Police the authority to request that a person ceases drinking and surrenders alcohol upon request where they are causing ASB or are likely to cause ASB as a consequence of their alcohol consumption. This discretionary power would apply to all areas within the Wolverhampton Local Authority boundary.

For areas which have an imposed outright street drinking ban, alcohol consumption would not be permitted in any public place unless within the curtilage of a licenced premises or in circumstances covered by a temporary event notice.

What can the Police do?

The Police would have the power to request that a person drinking alcohol anywhere within the Wolverhampton Local Authority boundary stops drinking, or ask the person to surrender all alcohol, sealed or not within their possession if they reasonably believe the individual or group are causing or likely to cause ASB or disorder.

In areas where there is an outright street drinking ban, the Police have the power to confiscate all alcohol when street drinking is occurring. Where these prohibitions are breached officers authorised by the council can issue a fixed penalty notice of £80.00.

Am I breaking the law if I drink in a designated area?

If prohibitions are introduced to impose a street drinking ban in St Peter's and Park wards including the city centre it would be an offence to drink alcohol in a public area within these localities. Drinking alcohol in a public place in other areas of the city would be permitted as long as this does not cause, or is likely to cause anti-social behaviour.

What can I do if I witness someone drinking in a designated area or causing alcohol related anti-social behaviour?

Do not call 999 unless a person's behaviour poses a threat to life, where there is on-going violence or if a crime has been committed and the offenders are still at or near the scene.

If you witness and are concerned about anti-social drinking you can report it by emailing your local Neighbourhood Policing Team or by calling the non-emergency telephone number 101. Alternatively, you could keep a diary of the incidents and speak to your local neighbourhood Police Officer.

When will this be implemented in Wolverhampton?

If the terms of this proposed PSPO are approved, the order would come into effect in April 2017.

To complete the survey please follow the link below:

https://www.surveymonkey.co.uk/r/CH7LGTG

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CITY OF WOLVERHAMPTON COUNCIL

Adult and Safer Scrutiny Panel

31st January 2017

Report title	**Supporting a Safe and Seamless Transfer From Specialist Care or Hospital Setting.**
Cabinet member with lead responsibility	Councillor Peter Bilson Economic Regeneration and Prosperity
Wards affected	All
Accountable director	Manjeet Garcha, Director of Nursing and Quality
Originating service	Wolverhampton Clinical Commissioning Group
Accountable employee(s)	Manjeet Garcha — Director of Nursing and Quality Tel — 01902 442476 Email — Manjeet.garcha@nhs.net
Report to be/has been considered by	

Recommendation(s) for action or decision:

The Health Scrutiny Panel is requested to:

1. **Receive** and **Discuss** the Report
2. **Note** the current systems and processes in place to assist a safe and seamless transfer out of specialised care
3. **Note** the joint working arrangements in place to facilitate the above
4. **Note** the actions taken to continually improve the commissioning arrangement to meet the needs to vulnerable adults and children to facilitate the above.

1.0 Purpose

The purpose of this report is to give an outline of the systems and processes in place to support a safe, timely and seamless transfer of patients from a specialist care or hospital setting to their usual or new place of abode.

2.0 Background

According the NHS England (NHSE), a 'delayed transfer of care' occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care but is prevented from doing so. Sometimes referred to in the media as 'bed blocking', delayed transfers of care are a problem for the NHS as they reduce the numbers of beds available to other patients who need them, as well as unnecessary long stays in hospital for patients. Over the last few years there have been many reviews and publications on the statistics and effects of delayed transfers of care. The majority of patients that are admitted to hospital for an acute episode of care or planned surgery will return to their usual place of residence with either very little or no required support. However, there are a growing number of a patients, in the main frail elderly but also patients with complex physical and mental health needs that do require discharge to be planned and executed in a safe and seamless manner for the best adjustment to their condition and surroundings.

This report will cover the steps taken by Wolverhampton Clinical Commissioning Group as the lead commissioner of health care services in Wolverhampton to ensure that there are systems and processes in place to support a safe and timely transfer from an acute episode of care into the community.

3.0 Current Arrangements for planning discharge for adults

3.1 At present we have a wide variety of discharge options from a specialist care or acute hospital setting:

- Home without the need for support
- Home with low level support from 3rd Sector provision
- Home with support from HARP
- Home with support from CICT
- Home with support from a social care package
- Discharge to a resource centre bed
- Discharge to West Park Rehabilitation Hospital
- Step down into a block purchased bed at Probert Court
- Step down into a spot purchased bed in a residential or nursing home
- Discharge back into a residential/nursing home if previously resident there
- Discharge arrangements for young people and adults from secure units of care

3.1.2 Discharge planning has been reviewed extensively in Wolverhampton over the last few years; this has been as result of local need and national recommendation i.e.

Winterbourne View. Locally a number of review and small scale projects as The West Midlands Quality Review Service, Emergency Care Intensive Support Team and most recently The PriceWaterhouse Cooper (PWC) review commissioned jointly by the CCG, City of Wolverhampton Council and The Royal Hospitals NHS Trust have identified the need to improve patient flow through the hospital by improving pro-active discharge planning, having clearly defined discharge pathways, having access to timely and effective support on discharge, moving away from keeping people in hospital whilst they wait for assessments to be completed and for the identified care to be procured.

3.1.3 In Wolverhampton a multi-agency 'Discharge to Assess' programme of work has commenced and it is anticipated this will further improve the discharge arrangements for individuals from acute care settings.

There is also increasing evidence base supporting the move to an integrated Discharge to Assess approach, this was the main recommendation from the PWc Review and the benefits include:

- Improved health outcomes
- Decreased length of stay in hospital
- Reduced length of stay in an acute hospital reduces decompensating; chances of acute physical and mental deterioration, particularly in older people
- It improves patient flow through the system maximising safe discharges, minimising delayed transfers of care and ensuring the availability of beds in the acute care setting for people requiring admission
- Assessments for on-going care are done at the right time and in the right place; maximising peoples' capacity for independent living
- Many people will be able to remain living at home for longer if discharges to assess services adopt a 'home first' approach.
- Reduces duplication of work by ensuring people are discharged to the most appropriate setting and are assessed using a process that is accepted by all agencies
- It makes better use of existing resources by pooling the resource and provision; providing the right care at the right time, prevents wastage
- It builds on existing understanding and enhances working relationships between all staff
- It ensures that people access the right care and support at the right time and in the right place removing the need for any delay associated with the health or social care need debate (seamless for the patient and carer).

3.2 Current arrangements for planning discharge for children and young people across the health economy.

3.2.1 Children and young people from Wolverhampton can be in patients in hospitals both in city and out of city, depending on their medical or mental health needs. When children are in patients at New Cross Hospital, and there is a need for on-going community input following the discharge, it is usually a smooth transition between acute and community services as they are both provided by Royal Wolverhampton Trust.

3.2.2 Birmingham Children's NHS Foundation Trust, where a number of children with Wolverhampton CCG commissioned care patients are admitted over the year have well developed links with local services to ensure a smooth process for children and their families when they return to Wolverhampton, especially if there are actions outstanding which requires links with the individual's school. Occasionally there are times when links are not so robust. A case study has been used below to highlight the complexities that can exist with some cases.

3.2.3 Case Study

There has been a case recently where a young girl who was involved in a road traffic accident. Due to the complexity of the injuries, she still requires significant assistance with activities of daily living i.e. assisted breathing with a tracheostomy and multiple complex handling and lifting aids to move in and out of bed.

This patient had been on an acute unit in a regional specialist hospital for a significant period of time. This was due to the family's property not being adaptable and the time it took for the council to identify an appropriate property which was appropriately adaptable. Whilst this was happening, the adult acute unit where she was an inpatient, started to pursue discharging the young lady from the specialist ward. This was appropriate as an acute ward is not the most appropriate place for someone who is ready for discharge.

It was unclear if the family were going to be able to manage this young lady when she returned home due to her complex medical needs which now included tracheostomy care and frequent suctioning as well as full support with personal care including continence issues. There were many meetings to support the transition of her from the acute unit and whilst there was willingness from the family to care for her at home, their home was not suitable and they did not own their own home to agree the adaptations required.

Several alternative options were considered and multi-agency meetings held with the social, health and family representatives. As an immediate safe, appropriate and interim solution a children's hospice was considered. The hospice could meet her complex needs. Also a full assessment of the family's ability to care for the young person could be undertaken and specialist skills i.e. suctioning could be taught. When she is discharged home, once her home is adapted, there will be carers available who can support her care at home. She was admitted to the hospice in June 2016 and the adaptations have not started yet. There is a complex care team supporting this young person's care at night time and learning the care package so that she will be discharged home with a care package planned and the family will be supported.

The Case Study highlights the complexity of some cases where there is a requirement for multi-agency collaboration.

3.2.4 Discharge planning for Mental Health/CAMHS and Learning Disability support.

For children and young people with mental health conditions that lead to in- patient admissions, the nearest unit is in Birmingham or in Stafford but most of our children and young people have been admitted recently to units much further afield. Currently we have young people in Sheffield and Woking. The CAMHS team who have been involved with the young person tend to keep in touch with the inpatient unit to ensure they are fully aware of the child's condition on a weekly basis and participate as fully as they can and if notice allows, in Care and Treatment Reviews as well as Care Programme Approach meetings. These discharges can be the most problematic as the child is usually located a distance from Wolverhampton which makes it difficult to ensure there is a comprehensive approach to the child's discharge. Furthermore, these placements are commissioned by NHSE and not the CCG. Local processes have been strengthened as a result of recent national inquiries highlighting issues i.e. Winterbourne View. For those young people who are Looked After and have existing placements funded via External Placement Panel, or where there has been a previous Care and Treatment Review undertaken prior to admission, the CCG has employed a Children's Commissioner who is responsible to ensure that commissioning issues do not result in the delay of discharges.

4.0 Financial implications

4.1 Not assessed for this report

5.0 Legal implications

5.1 Not assessed for this report

6.0 Equalities implications

6.1 No equality analysis undertaken.

7.0 Environmental implications

7.1 Not assessed.

8.0 Human resources implications

8.1 Not assessed.

9.0 Corporate landlord implications

9.1 Not assessed.

10.0 Schedule of background papers

10.1 NA

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Agenda Item No: 7

CITY OF WOLVERHAMPTON COUNCIL

Adult and Safer Scrutiny Panel

31 January 2017

Report title	Safeguarding Adults' Board Report 2015-16
Cabinet member with lead responsibility	Councillor Sandra Samuels Adults
Wards affected	All
Accountable director	Linda Sanders , Community
Originating service	Adults' Safeguarding
Accountable employee(s)	Dawn Williams — Head of Service - Safeguarding & Quality , Adults & Children Tel — 01902 550477 Email — Dawn.williams@wolverhampton.gov.uk
Report to be/has been considered by	Wolverhampton Safeguarding Adults Board — 15 September 2016

Recommendation(s) for action or decision:

The Scrutiny Panel is recommended to:

1. Consider and provide comments on the Safeguarding Adults' Board Report 2015-16
2. To support the delivery of the key challenges for 2016-17.

1.0 Purpose

1.1 The purpose of this report is to provide the Panel with a copy of the Wolverhampton Safeguarding Adult Board's (SAB) Annual Report to inform the Panel of safeguarding activity 2015/2016 and to present the Panel with progress made against the priorities for 2014-15.

1.2 Since April 2015 all Safeguarding Adults' Boards are statutorily required to produce an annual report. It is published on the Wolverhampton Safeguarding Website and is a copy must be shared with the Chief officer and leader of each Council, the Police and Crime Commissioner and is presented to the Chair of the local Health and Wellbeing Board.

2.0 Background

2.1 The Chair of the Safeguarding Adults Board through the Safeguarding Manager - Adults is responsible for ensuring there is an annual report on behalf of the Wolverhampton Safeguarding Adults Board. The annual report contains contributions from the partner agencies who are members of the Safeguarding Board.

2.2 The report provides information regarding local safeguarding initiatives, the work and structure of the Safeguarding Board, progress against previous year priorities, partner achievements, and safeguarding data performance. The executive summary summarises the key headlines from the full report and has been developed in recognition of the needs of the potential audience.

2.3 The annual report and executive summary was presented as a final draft at the September Safeguarding Adults Board. It was endorsed by Board members and is now available on the Joint Safeguarding Board website

2.4 The annual report reflects the complex and wide ranging agenda that the Board, its working groups and partner organisations have been addressing throughout the year. In line with statutory guidance we now have a strategic plan that identifies our priorities. This plan is included as **Appendix 1.**

3 Progress against Priorities

3.1 The annual report outlines our progress. The report provides individual assurance statements from the organisations represented at the Safeguarding Adults Board. More detail on both progress and future priorities can be found in the body of the annual report. In line with my report to this Board last year we have succeeded in obtaining greater quality and consistency of those reports which in turn provides greater comparability when summarising the progress we have made.

3.2 For each of the Board's priorities there is a lead responsible for driving the priority forward. The leads are all Board members and they report regularly to the Board on both the progress made and challenges faced. The priority leads make up the Board's Executive Group.

3.3 Over the past 12 months I want to highlight six issues that you will find in the report. They are:

3.3.1 To improve both communication and engagement we have created a new shared safeguarding website with social media presence for the public, staff and organisations in conjunction with the Wolverhampton Safeguarding Children's Board. This ensures there is more accurate and up to date information to help professionals and members of the public better protect adults;

3.3.2 Page 42 of Wolverhampton Safeguarding Adults' Board Report highlights a 29% increase in safeguarding concerns which reflects higher levels of public awareness and concern. The parallel reduction in the numbers that translated into safeguarding enquiries was in part attributable to a different interpretation of what an enquiry is under the new Care Act 2015 guidance;

3.3.3 The introduction of a range of case studies into the report will help readers understand the reality of how agencies work together to safeguard people;

3.3.4 We have improved our assurance on the quality and consistency of practice through the introduction of case file audits;

3.3.5 We commenced our first Safeguarding Adult Review under new guidance that helps us understand the reasons why, despite our best efforts, adults have not been protected effectively and what we need to do to learn from such situations; and

3.3.6 We started gathering greater information about people's individual experience of intervention designed to safeguard them and what the public understand about how we try to protect and safeguard people at risk of abuse.

3.4 This year our annual report has some shared content with the Children's Safeguarding Board Annual Report. Issues such as domestic abuse, trafficking or forced marriage do not fit into neat age-related compartments and our response has to demonstrate that we do not think that way.

3.5 There is more to do and the report outlines our priorities over the next 12 months and beyond. In particular, I wish to highlight the following:

3.5.1 We are looking for all partner agencies to demonstrate how they are reflecting the new Department of Health guidance in supporting individuals exercise choice and control over their situation and how they wish to be safeguarded.

3.5.2 We need to have a greater understanding of the levels and consistency of safeguarding training offered within partner agencies and be assured that in all circumstances it is sufficient and fit for purpose.

3.5.3 We want to produce improved performance information which will increase our ability to identify some safeguarding concerns earlier and secure more robust qualitative information on the experience of safeguarding and how this should shape future priorities in terms of awareness raising and multi-agency practice

4 Equalities implications

4.1 How and in what ways we safeguard children must reflect the differing cultural values and norms within communities. Although the legal framework is universal how we ensure children and parents understand recognise and respond to potential safeguarding issues varies and is reflected for example in our work to reach out to faith communities and through our links with the Refugee and Migrant Centre.

5.0 Environmental implications

5.1 There are no direct environmental implications arising from this report.

6.0 Schedule of background papers

6.1 Report to Wolverhampton Safeguarding Adults' Board 15.09.2016.

Wolverhampton Safeguarding Adults Board

Annual Report 2015 – 2016

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Wolverhampton Safeguarding Children Board

Annual Report 2015 – 2016

Contents

A word from the Independent Chair, Alan Coe

Welcome to the Annual Report of Wolverhampton Safeguarding Adults Board (WSAB) for 2015/16.

This report gives information about how all agencies work together to support adults in Wolverhampton and help keep them safe.

It identifies what we have all done over the past 12 months to make improvements both in terms of better practice and more effective systems. Most importantly it gives examples of how adults have felt safer and more secure as a result of the assistance they have received.

The report highlights the importance of close partnership working that promotes safety and wellbeing. It is the contribution of police officers, nurses, doctors, teachers, social workers and the host of voluntary and organised groups working together that makes the difference.

We have worked hard to make this year's report easier to read and to use as a way to help us all think more carefully about the personal contribution we can make to the safety and wellbeing of adults. More detail about the performance of individual agencies can be found on our website www.wolverhamptonsafeguarding.org.uk.

I want to highlight three things in particular that you will find in the report. They are:

- The progress made against our strategic priorities.
- Multi Agency Case Studies demonstrating how we keep people safe in the city.
- Reports from individual agencies represented on the Board which demonstrate what each agency has done to implement the Board's safeguarding strategy.

This year our annual report has some shared content with the Children's Safeguarding Board Annual Report. Issues such as domestic abuse, trafficking or forced marriage do not fit into neat age-related compartments and our response has to demonstrate we do not think that way.

Keeping people safe is an inter-generational issue. We must and do 'think family'. For example, we need to be alive to the fact that if there are concerns about children in a family there may also be issues for adults living in the same family.

I hope you find this report thought-provoking, challenging but also reassuring you that professionals working in Wolverhampton and the wider community are committed to making a positive difference to the lives of adults. I welcome your feedback. You can do this by offering comments either by e mail to WSAB@wolverhampton.gov.uk or on our website www.wolverhamptonsafeguarding.org.uk.

Alan Coe, Independent Chair, Wolverhampton Safeguarding Adults Board

Our mission

In Wolverhampton our mission is to provide assurance that adults with care and support needs are safeguarded from abuse or neglect.

We recognise that safeguarding adults is not just about reacting when abuse has been identified, but is also developing a culture that promotes good practice within services, raises public awareness, responds effectively and swiftly when abuse or neglect has been alleged or occurs, is sensitive to the issues of cultural diversity and puts the person at the centre of planning to ensure they are safe in their homes and communities.

All partners to the Wolverhampton Safeguarding Adults Board work together to embed a way of working that assure themselves that people who have care and support needs are empowered. This is known as Making Safeguarding Personal.

Service Developments

The Care Act came into force in April 2015 and the statutory duties under the Care Act duties include:

- the development of a multi-agency Safeguarding Adult Board.
- the need to publish a three to five year strategic plan addressing the short and long term actions for protecting people in its area.
- the need to publish an annual report detailing the SAB's activity during the year including what it and each member has done to contribute to achieving the objectives and to conduct Safeguarding Adults Reviews (SARs) .

In January 2016 the Children's Multi-Agency Safeguarding Hub (MASH) was launched in Wolverhampton.

The Multi-Agency Safeguarding Hub consists of the police, social care, Early Help, Wolverhampton Homes, Recovery Near You, health professionals and probation.

It is already enabling agencies to improve the timeliness and effectiveness of responses to safeguarding referrals by providing access to real time partnership information and facilitating speedier understanding of levels of risk. This has been achieved through a significant piece of joint partnership working.

Further work is in progress to extend the MASH to include adults with care and support needs by the end of August 2016.

Throughout 2015-16 the Wolverhampton Board manager chaired a West Midlands group to ensure policies and procedures reflected the changes in Government guidance on safeguarding. Regional guidance in the areas of Self Neglect, Safeguarding Adult Reviews and Position of Trust has also been updated following the Department of Health's publication of the revised Care Act Statutory Guidance.

Strategic arrangements

Partnerships in Wolverhampton to include WSAB, Wolverhampton Safeguarding Children's Board, Children's Trust Board, Health and Well Being Board and Safer Wolverhampton Partnership all produce detailed strategic plans setting out the key outcomes to be achieved within a timescale.

These plans are based on a detailed analysis of the needs, the aspirations of the local residents and the resources available to organisations to meet these needs and aspirations. WSAB has arrangements in place to share its annual report with these key strategic groups and join up the business planning processes so priorities can be shared and reflected accordingly.

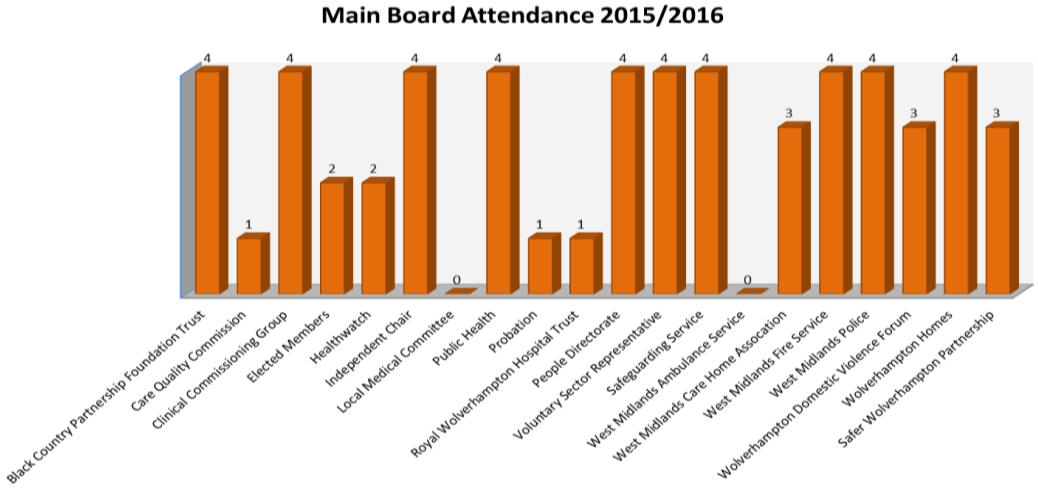
The Wolverhampton Safeguarding Adults Board is well established and provides strategic leadership for adult safeguarding work and seeks to ensure there is a consistently high standard of professional response to situations where there is actual or suspected abuse.

We do not have responsibility for day-to-day practice. Our job is to ensure agencies work together well and are consistent in supporting adults at risk of abuse. We get assurance from all agencies about how they protect people including how they train and support their staff to recognise and respond to any concerns. We also help keep all agencies up to date with policy and procedures and we establish joint plans to promote the safety of adults.

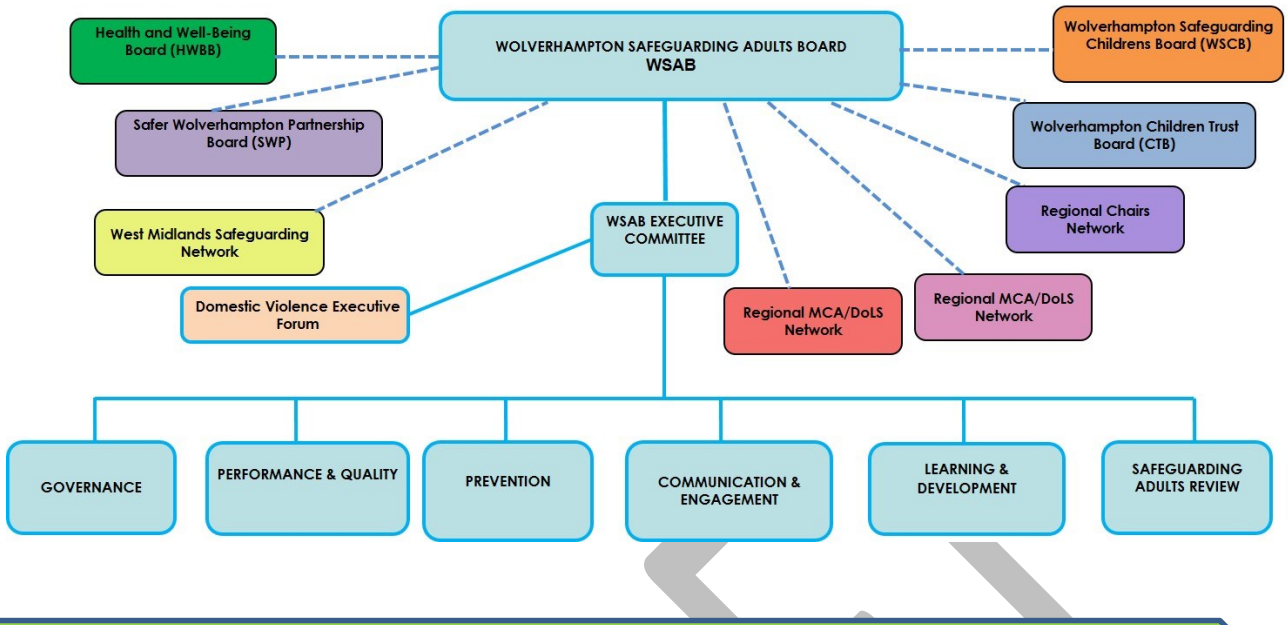
Currently, 15 agencies are represented on the Board .You can find a list of who they are in Appendix 3 to this Report. Also it is agreed that the Care Quality Commission attend and report on their activity at one Board meeting each year. During 2015/16 the Board also had the support of an elected Council Member who attended meetings whenever he was able to do so and participated in various adult safeguarding events including an event on World Elder Abuse Awareness Day.

The Board has four meetings per year; it also has one development event which usually takes place in March. The development event this year focussed on Making Safeguarding Personal and Challenge across the Partnership.

The minutes of all the open part of the meetings can be found on the Board's new Safeguarding website [www.wolverhamptonsafeguarding.org.uk.](http://www.wolverhamptonsafeguarding.org.uk)



Wolverhampton Safeguarding Adults Board structure



Case Study #1

West Midlands Police identified a care home within Wolverhampton which was reporting adult safeguarding concerns on a regular basis. It was identified that these calls were in relation to service users at the home coming into conflict with each other.

It was apparent that there was a need for a multi-agency approach to addressing this safeguarding concern, with the need to share information, and agree how best to intervene.

West Midlands Police's Safeguarding Adult team hosted a series of meetings attended by key partners including Adult Safeguarding, the Mental Health Assessment Team, Commissioning, Care Quality Commission and the service managers at the home.

This resulted in a multi-agency discussion and the implementation of a number of safeguarding interventions, addressing both immediate and longer term concerns. This has seen a significant reduction in incidents being reported at the home.

Regular meetings continue to be held to monitor the progress of the implementation of these interventions and to address any new safeguarding concerns in a multi-agency environment. These meetings have embedded good working relationships and will assist in tackling similar incidents in future.

Business Priorities 2015-18

The Board's priorities are reviewed each year and are included in the table below. Each of the Board's committees has its own work plans which set out how the objectives will be delivered throughout the reporting period.

Effective Governance	**We will develop the capacity of WSAB and its infrastructure to effectively deliver the core functions of the Board to help keep adults with care and support needs in Wolverhampton safe.**
Performance & Quality	**We will ensure that there are effective multi-agency quality assurance and performance management processes in place which will promote the welfare of adults with care and support needs and will hold partners to account.**
Prevention	**We will ensure there is a coherent inclusive approach by both Safeguarding Boards to reduce risk of harm to children, young people and adults.**
Communication & Engagement	**We will ensure there is a consistent and co-ordinated approach to how the safeguarding message for adults, young people and children is disseminated to all groups and communities in Wolverhampton, and we will ensure that we engage children, young people, families, adults and communities of all backgrounds and make up in the work of WSAB.**
Workforce Development	**We will ensure a Safeguarding and Adult Protection training Programme is available to contribute to the learning, development and education of the multi-agency workforce.**

For more information about the Safeguarding Adults Board, please visit our new website, at www.wolverhamptonsafeguarding.org.uk

Summary of Progress against Board Priorities

Priority One: Effective Governance

"We will develop the capacity of WSAB and its infrastructure to effectively deliver the core functions of the Board to help keep adults with care and support needs in Wolverhampton safe"

What did we want to achieve?	What did we achieve?
• Review the level of resource available to the Board and ensure that all partners make an equitable and proportionate contribution. • Ensure the Board budget is managed effectively. • Establish an Induction Programme at the appropriate level for new Board and Committee members to ensure they are briefed in relation to the area of business. • Develop improved mechanisms to gather feedback and furthering the commitment to 'making safeguarding personal'.	• Funding contributions from partners has increased. The Clinical Commissioning Group (CCG) contribution has doubled and funding has also been secured from the National Probation Service. • An up to date Budget Report is produced and discussed at each Board Executive Committee, ensuring the budget is managed appropriately. • A Board Constitution including Board member job role induction programme has been developed in conjunction with Safeguarding Children Board. • The WSAB commissioned Healthwatch to undertake a project to gather feedback from people who had experienced a safeguarding enquiry, the findings are due to be reported to the Sept 2016 Board. Early feedback is that the term safeguarding is not clearly understood but there is a better understanding of terms such as abuse and neglect.

Priorities for 2016/2017

- Following feedback from the Healthwatch project, we are going to establish a user reference group to gain the voice of local people which in turn will influence the work of the Board.
- There are many areas of work such as human trafficking or forced marriage which are rightly concerns of the Safeguarding board. They are also of interest to other Wolverhampton multi agency groups. We are working with them all to have a joint agreement on who will lead on what. This agreement is between the different partnership boards in the City e.g. WSAB, WSCB, the Health and Well-Being Board, and Safer Wolverhampton Partnership by developing a Joint Protocol.

Priority Two: Quality Assurance

"Ensure there are effective Multi-Agency Quality Assurance and Performance Management processes in place"

What did we want to achieve?	What did we achieve?
• Board Partners to complete annual assurance framework focusing on Board priorities. • Develop multi-agency dashboard. • Develop multi-agency audit tool in partnership with Children's.	• Each agency reports to the Board on how it safeguards the people they serve. This is contained in something called an Assurance Document. • We need to understand how well we are doing. Information is now collected and reported on a dashboard. Green for those things that are working well, amber if there are some concerns and red if we identify a service that is not safeguarding people effectively. We then work hard on the most serious areas of concern. • We developed a multi-agency audit framework, the first joint WSAB/WSCB audit has taken place, and a schedule for further audits has been agreed.

Priorities for 2016/2017

- Service user experiences contribute to the Board priorities and work plan.
- Collate and analyse feedback from Service User Feedback project to ensure that safeguarding processes are robust , person centred and make people feel safer.

Case Study #2

West Midlands Fire Service has emphasised the need to ensure robust referral mechanisms are in place to reduce the risk of fire fatalities. The development of the adult MASH will support prompt and appropriate information sharing.

A referral was raised via a family member of an older person to Adult Social Care stating the person was at risk of 'dying in a house fire'. A social worker was allocated but unfortunately 24 hours later the person sadly died in a house fire. These tragic circumstances lead to the development of a robust procedure for identifying fire risk hazards and referring people who are known to be at risk from fire immediately and directly into West Midlands Fire Service.

Priority Three: Prevention

"We will ensure there is a coherent inclusive approach by both Safeguarding Boards to reduce risk of harm to children, young people and adults"

What did we want to achieve?	What did we achieve?
• Partners, service users and communities are aware of available prevention and early intervention support and how to access it. • We will ensure there is a coherent inclusive approach by both Safeguarding Boards to reduce risk of harm to children, young people and adults. • Prompt multi-agency dissemination of learning from Serious Case Reviews/Domestic Homicide Reviews (SCR/DHR) for managers and front-line staff. • SCR/DHR overview forums to undertake sample auditing to ensure revised practice from is fully embedded.	• Improved access and awareness of specialist services across the City. • Wolverhampton safeguarding website launched March 2016 which provides information on both safeguarding adult and children. • Wolverhampton Information Network (WIN) launched and accessed by public. • Communication & Engagement Committee awareness raising campaigns held during 15/16 and scheduled for 16/17. • Adoption of city's Overarching Domestic Violence Protocol. • We now have Safeguarding Adult Review Committee which ensures that if there is a serious incident where an adult (or adults) with care and support needs were harmed and it might have been prevented we investigate this. • Multi agency event held hosted by WSAB,WSCB, Wolverhampton Safer Partnership and Wolverhampton Domestic Violence Forum to share learning from Domestic Homicide Reviews, Serious Case Reviews and Safeguarding Adult Reviews. • Practitioner toolkit developed for frontline staff.

Priorities for 2016/2017

- Progress 'trigger thresholds' work across agencies to identify adults at risk before safeguarding adults risk threshold is met.

Case Study #3

Over the last year, Wolverhampton's Trading Standards has continued its on-going partnership with the national Trading Standards Scam Team, which has worked closely with Royal Mail to identify Wolverhampton residents who have become scam victims.

This involves home visits to determine the extent of their vulnerability to the plethora of scams including the opportunities to win a holiday, cash prize draws, receive good luck from clairvoyants and more. It is also an opportunity to discuss the ease with which personal details can be comprised, often via the internet or phone calls. The success of this project has relied heavily on partnership working and in particular background checks carried out by Adult Social Care along with referrals/feedback following visits. They visits can also be conducted with the Safer Wolverhampton Partnership's Crime and Vulnerability Officer and have resulted in safeguarding referrals due to a possible financial abuse element.

Over the year vulnerable service users have been targeted not just via mass marketing postal scams but also via face to face scams in the guise as legitimate traders cold calling offering 'competitively priced' home improvements, often pressurising a customer into making a decision there and then.

On one occasion the victim had been caught up in a spiral where the trader had exploited his position of trust and carried out building works to such a poor standard that the victim had been left with no central heating, a new cloak room with sanitary equipment unconnected, an unsafe staircase, and roof/guttering work that required a new roof. The constant on-going issues with the builder had such a negative impact on the mental health of their victim that it culminated in a safeguarding referral.

Trading Standards engaged the services of a chartered building surveyor to determine the extent of the works carried out and a video recorded interview was also conducted to capture the effect of the poor building works on the victim. The investigation is on-going.

On another occasion, building works were been carried out by a tradesman without authorisation by the non-resident extended family. This resulted in additional works being necessary to ensure the occupants could safely use their home. A safeguarding referral was generated on behalf of both elderly vulnerable residents and Trading Standards again engaged the services of a chartered building surveyor to determine the standard of workmanship. The investigation is still on-going.

In cases where vulnerable service users have been the victim of any doorstep crime, bogus traders or scams there is the opportunity for the short term loan of call blocking devices. Here all calls can be screened and therefore enable the victim to make their own decision as to whether they wish to speak to the caller, or to block the call along with any future attempts at reaching them on that specific number.

There has also been a continued increase in raising the awareness of how scams work with 15 talks being given so far this year to a wide range of groups including luncheon clubs, tenants and residents meetings, sheltered housing residents, the Alzheimer's Society and various voluntary sector groups.

Priority Four: Communication and Engagement

"There is a consistent and co-ordinated approach to how the safeguarding message for both adults, young people and children is disseminated to all groups and communities"

What did we want to achieve?	What did we achieve?
• Develop and maintain a shared public-facing safeguarding website and social media presence in conjunction with Wolverhampton Safeguarding Children Board for the public, staff and organisations. • Develop and run specific safeguarding campaigns in 2015-16.	• A joint children and adult Board safeguarding website was commissioned and launched March 2016. The website includes information sections for children, adults with care and support needs, carers and professionals. Funding was secured to enable the website to be maintained and regularly updated with information. The website is at www.wolverhamptonsafeguarding.org.uk. • Safeguarding Awareness sessions held in various locations, Bilston, Wednesfield and City Centre during October 2015

Priorities for 2016/2017

- Produce and disseminate a monthly safeguarding update covering children and adults with care and support needs.
- Improve understanding of and links with faith groups to improve organisational practice and awareness of safeguarding responsibilities.
- Raise awareness of safeguarding with new arrival communities in the city.

Case Study #4

Healthwatch Wolverhampton received a number of safeguarding concerns in respect of a care service in the city.

As a result of the information an unannounced visit was undertaken by Healthwatch authorised representatives through the Enter and View programme and information was shared appropriately with the council.

Priority Five: Workforce Development

"We will ensure a Safeguarding and Adult Protection training Programme is available to contribute to the learning, development and education of the multi-agency workforce"

What did we want to achieve?	What did we achieve?
• Develop a training reporting mechanism to the board on an annual basis for:	• A reporting template was developed and agreed by the Board, and included in the Boards Annual Assurance statement completed by Board members this details the safeguarding training that has been delivered and how many employees or volunteers have undertaken the training.

Priorities for 2016/2017

- We will develop a Safeguarding and Adult Training Programme that:
  - Meets the needs of the local workforce.
  - Is informed by current research.
  - Includes lessons learnt from local and national SARs and local and national developments.
  - Represents the needs of the local community and encompasses issues of equality and diversity.
- The Workforce Development Committee of WSAB and the Learning and Development Committee of WSCB to integrate their work streams.

Safeguarding Adult Reviews (SARs)

The Care Act 2014 introduced Safeguarding Adults Reviews (SARs). These are commissioned by the WSAB when:

- there is reasonable cause for concern about how WSAB members or other agencies providing services, worked together to safeguard an adult, and
- the adult has died, and WSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died), or
- the adult is still alive, and WSAB knows or suspects that the adult has experienced serious abuse or neglect.

The Safeguarding Adults Review (SAR) is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that may have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again, and for agencies to work together to aim towards positive outcomes for the adult and/or family involved.

During the period 2015-2016 the Board's newly formed SAR Committee received two formal referrals, it was decided that the criteria for a SAR was met for one of the referrals and an independent Chair and Author was commissioned to undertake a full review into the case. The outcome of review will be published later in 2016. In the case where the criteria for a SAR was not met a single agency review is being undertaken and lessons learnt will be shared with the Board.

Case Study #5

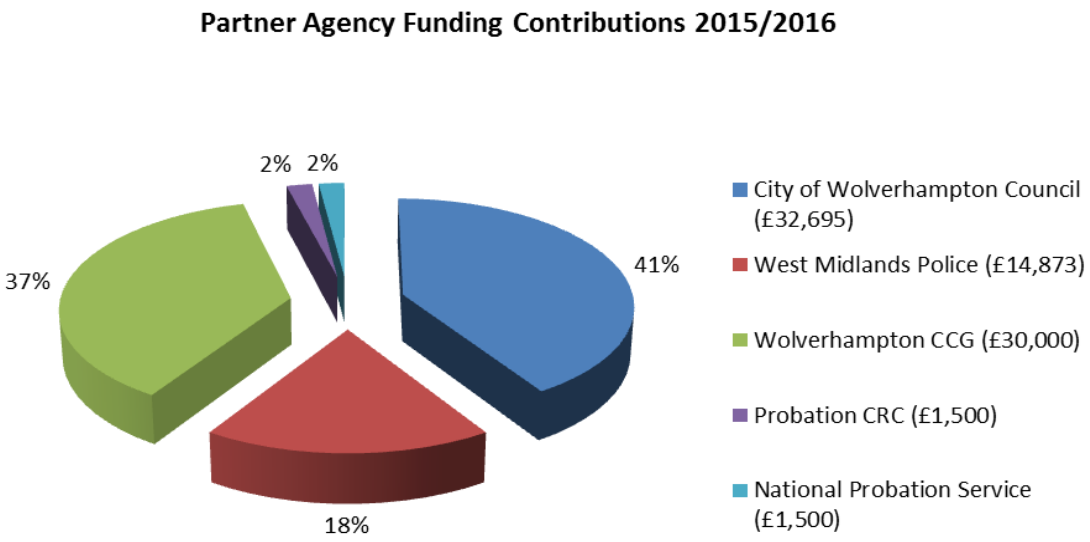
Wolverhampton Homes shows the importance of the "Think Family" approach and safeguarding both adults and children. In a recent case involved a safeguarding referral made due to reports of parents and their children, both under the age of 11, shouting, swearing and screaming at each other.

A housing officer noted concern around the state of the house which was dirty with hoarding evident. There was also d no sign of home schooling, as had been suggested, with the children still in their night clothes late in the morning.

As a result of the referral, the social worker visited and confirmed the concerns about the property, helping the family to take steps to improve the state of the house, providing a skip and working with the family regarding parenting skills. Investigations are on-going into the issue of schooling. The level of anti-social behaviour has reduced and the Estate Manager has re-visited to assess property once again. Improvements have been noted.

Wolverhampton Safeguarding Adult Budget

This year the Board has secured an increase in funding from partner agencies. The budget is monitored and overseen by the Board's Executive Committee.



The contributions made by the above agencies have covered:

- the general expenses of Board business
- the work of the Independent Chair of the Board
- 9.25 hours per week for the Board Manager
- 18.5 hours for the Board Administrator
- the costs of multi- agency safeguarding training during 2015/16
- the commissioning of a project undertaken by Healthwatch
- the costs of an independent chair and author for a Safeguarding Adult Review.

Feedback

We would love to hear what you think of the contents of this report. If you have any feedback, please contact the Safeguarding Adult Board Manager on 01902 550477 with your comments.

Referral process

If you have any concerns about the health and wellbeing of a vulnerable adult, referrals should be made by calling Adult Social Care Services on 01902 551199. In an emergency, always ring 999.

Case Study #6

The Black Country Partnership Foundation Trust evidences the benefits of multi-agency working, and the need for robust information sharing and communication processes.

A Community Mental Health Nurse, who was the care co-ordinator for an individual, had already raised a number of safeguarding concerns. The concerns related to suspected physical abuse from a daughter to her father, who was known to the Community Mental Health Team. Previous Safeguarding concerns had been closed with no further actions required as the individual was deemed to have capacity and chose not to report his daughter to the authorities.

The Community Mental Health Nurse attended the house with a Social Worker and a Community Mental Health Team colleague. They asked the daughter for permission to see her father which she initially declined, stating that her father was sleeping. However the Community Mental Health Nurse persisted and advised the daughter that as a nurse she had a duty of care to see her father to check on his well-being.

Reluctantly, the daughter agreed but was unhappy that too much time was spent looking at her father. The Social Worker had more success in seeing the individual and seeking his involvement in the review and ascertained that he felt unwell and had pains all over his body. When the Community Mental Health Nurse asked for the chance to talk more with the individual about how he was feeling, the daughter became extremely irate and threatening towards the staff. As a result of her behaviour, staff left the house.

A Safeguarding Section 42 Enquiry was undertaken and an allocated Social Worker (separate to the Safeguarding Enquiry Social worker, as good practice suggests) was identified to undertake a needs assessment for the individual and arrange the necessary care. Whilst awaiting the care package, assessment and provider agencies for example NHS Mental Health, Recovery House, Police and Social Care, continued to work collaboratively and offered care and support to the individual to ensure regular monitoring of his well-being occurred.

When access to the home address was not possible, the police were enlisted for their support to undertake safe and well checks, where the individual was assessed face to face and asked if he had any concerns regarding the care and support offered to him by his daughter. The daughter was offered a carer's assessment in her own right and the psychiatrist assigned to the individual's case informed the General Practitioner of his concerns regarding the daughter's mental health status with a request that the general Practitioner undertook an assessment in this regard.

The daughter is now more willing to engage with services when they arrive to visit her father. There are still noted incidents where she struggles with the requests professionals make in their effort to safeguard her father, but she is clear about the support plans available and the reasons services are involved. She is now more amenable to seek out support from agencies in order to arrange the care her father requires, for example ringing the District Nurses for them to help with post-surgery wound management.

Appendix 1

Member Agencies Contribution to the Annual Report 2015-2016

Wolverhampton Clinical Commissioning Group

Overview of 2015-2016

- NHS England has provided a sum of money to support the learning and development of the health workforce. A number of events have been organised for health practitioners – including a number of places made available to health colleagues across the Black Country, including Female Genital Mutilation, Sexual Violence.
- Planned training for Wolverhampton Practice Nurses: including Safeguarding Adults , Principles of MCA/DoLs, Domestic Violence and PREVENT.
- CCG engagement with SCR/SAR/DHR Learning event at Goodyear in March – very well attended event.
- Further training planned in Domestic Violence for Primary Care staff.

Governance Arrangements

- Joint Safeguarding Vulnerable Adults, Children and Young People self- assessment to monitor CCGs compliance against the refreshed NHSE Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2015). An action plan has been developed to strengthen areas that require improvement. Reviewed, updated and reported ¼ to Quality & Safety Committee.
- Working to ensure robust monitoring is in place to ensure services commissioned by WCCG have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children. Development of a joint (adult and children inc LAC & PREVENT) dashboard and a reporting framework to provide on-going additional assurances.
- WCCG Safeguarding Strategy.
- Internal Audit – Safeguarding Children and Adults – rated 'substantial'.

Key Achievements

- Collaborative working – with stakeholders and the Local Authority – Safeguarding Adult Review Committee, Domestic Homicide Standing Panel, Adult MASH Operational and Sub Groups.
- Collaborative working with Children and Adults Safeguarding within CCG teams – development of joint assurance documentation.
- Positive internal audit.
- Contribution towards the WCC Local Practice Guidance and West Midlands Multi Agency Policy and Procedure.
- Collaborative working with WSAB/WSCB Workforce Development Committee to

develop the strategy and join the Committees in to one.
- Approval of the WCCG Safeguarding Strategy.

Key Challenges

- Ensuring that Providers report in a timely manner.
- Development of an effective WCCG Safeguarding Adults Policy – difficult with changing local practice guidance and development of Adult MASH.

Future Plans for 2016-2017

- Implementation of the NHSE Intercollegiate Guidance for Safeguarding Adults.
- Greater scrutiny of Provider performance using Dashboard and Reporting Framework.
- Introduction of Adult Safeguarding Lead role within WCCG.
- Development of public facing WCCG Safeguarding Internet page with appropriate links to WSAB/WSCB and Wolverhampton Safeguarding websites.
- Development of specific WCCG Safeguarding Adults with Care and Support Needs Policy – to reflect Local Practice Guidance and Adult MASH Process and Procedures.

How do we report safeguarding concerns within our organisation

- Directly to the Local Authority – link available to LA website on CCG intranet page.
- Care Home concerns – Datix reporting system used by Quality Nurse Advisor Team.

West Midlands Police

Overview of 2015-2016

- Wolverhampton Local Authority area is supported by a Local Policing Unit (LPU), headed by Chief Superintendent Simon Hyde. CSU Hyde is responsible for the overall policing and management of the area. The LPU resourcing model consists of police officers, police community support officers and special constables. The policing of Wolverhampton is supported by a number of centrally managed specialist departments.
- One of these departments is the Public Protection Unit, which has officers locally based, to ensure that there is collaborative working with local policing teams. Public Protection is one of the biggest commands in the Force, responsible for managing the most dangerous offenders and protecting and safeguarding those who are the most vulnerable. The department has specialist teams, which manage both criminal investigations and safeguarding concerns in relation to victims of domestic abuse, sexual offences and offences against vulnerable adults. The Force is also working

within a multi-agency arena to understand hidden crimes, such as offences related to modern day slavery. This is in the forms of forced labour, sexual exploitation, forced criminality and domestic servitude and how best to identify and safeguard adults that are exposed to such offending.

- WMP continue to invest heavily in the learning and development of their staff. Safeguarding inputs form part of initial police training which are regularly updated on designated training days. In May 2015 there was a Continuous Professional Development event for local Crime and Vulnerability Officers which provided a toolkit of consideration and lines of enquiry to be followed in respect to the initial police response, identification, assessment and risk management of safeguarding incidents involving an adult at risk.
- "Sentinel" is a Force wide initiative that has seen officers and staff from LPUs and departments focusing on key vulnerable crime types, including domestic abuse, modern day slavery and vulnerable adult abuse. This has resulted in all front line officers being trained about vulnerability issues, closer integration with partners and the coordination of a number of operations and initiatives to raise awareness and reduce offending. This has resulted in the Force delivering multi-agency conferences in relation to these key themes; in October 2016 the Force will deliver a multi-agency event in relation to vulnerable adults.
- West Midlands Policing on-going response to the national concern of Adults at Risk of abuse was to establish a dedicated team of officers to cover the seven Local Authority areas across the West Midlands; the team continue to deliver tailored training events to adult safeguard managers within Wolverhampton to provide an overview of "Criminal Threshold" The training includes an understanding of the Police procedures when pursuing prosecutions.
- During the last reporting period WMP implemented a new process in how the Force received partnership referrals in relation to vulnerable adults. This was to enable a 24/7 response to concerns, and ensure that any safeguarding interventions could be implemented in a timelier manner. This was as a result of direct testimony and identification of vulnerabilities that the organisation experienced with the previous system (email referral into a standalone account). This resulted in WMP simplifying the process, by ensuring that where crimes or concerns were identified by partners, referrals were conducted via conventional routes utilising 101 or 999 systems. Workshops and learning events were held within Wolverhampton to embed this new process to partners.
- WMP continue to be represented at Wolverhampton's Local Safeguarding Adult Boards, with Chief Superintendent Simon Hyde being the Police representative. This is in support of the recommendations with the Care Act, which states that attendees must be someone who can speak with authority, can commit resources and agree actions on behalf of their organisation.
- WMP also provide quarterly data returns to the board, enabling the sharing of police information to enhance multi-agency discussion in relation to: Vulnerable Adult total recorded crime; Vulnerable Adult total recorded non crime; Offences where there is a disability marker in relation to an Adult; Missing Adult data; Police attendance at both Nursing and Care homes within the local authority area.
- WMP continue to be actively engaged in the development and implementation of the Adult Multi-Agency Safeguarding Hub at both strategic and tactical levels. This is to ensure that there is a collaborative approach to inform this process and enhance safeguarding interventions for adults within Wolverhampton.

Governance Arrangements

- Over the last reporting period WMP were subject to an independent inspection by HMIC in July 2015. The HMIC PEEL vulnerability inspection was in relation to the Force's effectiveness, efficiency and legitimacy to keep people safe and reduce harm.
- The report was published in December 2015 and made a number of recommendations which were accepted by the force. An improvement plan was drawn up to address the issues highlighted within the recommendations and this is being progressed under the governance of ACC Foulkes and Detective Chief Superintendent Claire Bell.
- As a member of the Quality and Assurance sub groups, WMP participate in multi-agency audits across the Force area. We have consistent membership across the seven local authorities with Detective Inspector Mark Burnell being the Police representative. This is to look at a variety of case samples and review the quality of practice and lessons to be learned in both multi-agency and multi-disciplinary working to enable improvements in service delivery for vulnerable adults within Wolverhampton.
- WMP conduct a number of single agency audits. These are completed in relation to a wide range of Policing functions. Examples of such audits are as follows:

    - Quality of investigation and safeguarding strategies in domestic abuse incidents. This is to review how the Force supports the victim from the time of report to the conclusion of the investigation. A quarterly report is completed to identify inefficiencies in service delivery as well as identifying and sharing good practice.
    - Victim satisfaction surveys to assess the service that both victims of crime and members of the public have had when in contact with the Force and compliance to the "victim's code", which is a Home Office directive to ensure that all victims receive tailored support to cope, recover and be protected from re victimisation.

- The results of such audits are fed back to the Local Policing Units to identify opportunities to improve the victim's experience.
- WMP recognise the importance of learning attributed to SARs, DHRs, and SCRs, and as such have invested in a dedicated Force Review Team. The team are responsible for all aspects of work related to statutory reviews. Learning from SARs, DHRs, and SCRs is now routinely embedded across all themes of Force wide training delivered to all WMP staff regardless of role or rank, and is a theme that continues in future Sentinel and supervisor training. Learning that results in recommendations for WMP are tracked by way of a recommendation tracker governed by Crime Governance Board, chaired by ACC Foulkes. Progress on the completion of recommendations is accountable to Crime and Governance and features as an agenda item on a quarterly basis.
- Over the last reporting year WMP has seen an increase in the volume of cases (crime and non-crime investigations) that have been reported in relation to vulnerable adult abuse. The Force recorded 734 crimes which had a vulnerable adult offence type marker between April 2015 and March 2016, which was 12% higher than the previous year's 656 reports. Of those recorded 85 offences occurred within Wolverhampton local authority area, where the police were identified as the lead agency. During the same period there were 117 non crime numbers obtained in relation to vulnerable adults within Wolverhampton. WMP received 1998 calls for service from Nursing and Care homes within the Force area, of which 350 calls were made from Nursing and Care homes within Wolverhampton.

- Wolverhampton has also seen an increase in the volume of cases (crime and non-crime investigations) that have been reported in relation to domestic abuse. Wolverhampton recorded 2373 crimes which had a domestic abuse offence type marker between April 2015 and March 2016, which was 17 % higher than the previous year's 2029 reports. During the same period there were 3330 non crime numbers obtained in relation to domestic abuse over this same time period, which was 2% higher than the previous year's 3268 reports.
- The increase in recording of incidents within the adult safeguarding arena supports the investment WMP has made into the vulnerability portfolio, both in relation to resource and training. This investment has resulted in officers and staff recognising these types of crime and ensuring that incidents are recorded and investigated appropriately. It also reflects that the public have greater confidence in the police response when reporting such incidents.

Key Achievements

Effective Governance

- An internal cross discipline 'Improvement Board' (held bi-monthly, chaired by Assistant Chief Constable Foulkes) has been implemented to oversee the progression of the Forces' improvement plan. This brings together HMIC recommendations as well as issues identified through internal auditing, which requires additional focus.
- The Plan is set out under the following headers:

  - Prepare - Providing strong leadership, effective systems whist working with partners to reduce vulnerability, the prevalence of hidden crimes and the harmful impact of missing episodes.
  - Prevent - Raising awareness of all aspects of hidden crime and vulnerability amongst our work force, partners, young people, parents, carers and potential perpetrators in order to identify risk quicker and prevent incidents/repeat incidents of harm including missing episodes.
  - Protect –Safeguarding vulnerable people and support victims and those professionals who seek to reduce instances concerning all forms of abuse including missing episodes.
  - Pursue - Disrupting, arresting and prosecuting offenders, ensuring a victim/child-centred approach at all times.

Performance and Quality

- As a member of the Quality and Assurance sub groups, WMP participate in multi-agency audits across the Force area. We have consistent membership across the seven local authorities with Detective Inspector Mark Burnell being the Police representative. This is to look at a variety of case samples and review the quality of practice and lessons to be learned in both multi-agency and multi-disciplinary working to enable improvements in service delivery for vulnerable adults. This can be evidenced in WMP participation with a number of multi-agency audits in relation to the evolvement of the Wolverhampton Adult MASH.
- This is enhanced by a variety of internal audits that has been previously reported on in the report, which identifies area to improve our service to victims of crime.

Prevention

- WMP recognises that it is imperative that we support the transforming care agenda. The Adult at Risk team work closely with both internal and external partners to ensure that there is a cohesive approach to safeguarding concerns and the identification of high demand locations. This enables a multi-agency review of the concerns and safeguarding plans can be implemented in relation to identified victims or institutions. The team have a close working relationship with the partnership team based within Wolverhampton Local Policing Unit to ensure that opportunities for early intervention in relation to adults within the community who potentially require additional support are signposted to the most appropriate organisations.
- WMP continue to work in partnership including CQC to investigate all referrals where there is information to support that service providers have failed to meet fundamental standards, and these failures have led to avoidable harm or the significant risk of such harm. These investigations have been in relation to both individual and organisational concerns.

Communication and Engagement

- WMP have a comprehensive internal and external communications strategy which incorporates the WMP website (www.west-midlands.police.uk) that not only provides the public with general information regarding organisational communication and information, but includes hyperlinks to local geographic areas, including Wolverhampton so that localised, specific safeguarding information and police contacts that can be accessed 24 hours a day.

Workforce development

- WMP invest heavily in the learning and development of their staff. Training has been delivered to all staff posted to the Adult at Risk hub to ensure that they are cognisant with the Care act and Legislation.
- Detective Inspector Mark Burnell in conjunction with learning and development have developed an e learning package that is in the process of being delivered across the Force to ensure that all front line staff are aware of their safeguarding obligations in relation to the Care Act.
- In May 2015 there was a Continuous Professional Development event for local Crime and Vulnerability Officers. This was to provide a toolkit of consideration and lines of enquiry to follow with respect to the initial police response, identification, assessment and risk management of safeguarding incidents involving a vulnerable adult.
- Bespoke training has been delivered to contact centre staff to understand the Act and what options are available as concerns are raised as a result of new referral processes being implemented.
- Tailored training events have been delivered to Adult Safeguard Managers across the Boroughs to provide an overview of “Criminal Threshold “. The training includes an understanding of the Police procedures when pursuing prosecutions.

Key Challenges

- Reporting levels in relation Adult safeguarding concerns within Wolverhampton

continue to rise. This puts increased pressure on the policing teams, which tackle such issues. WMP continue to face financial challenges over the forthcoming years and the need to identify a sustainable resourcing model is clear; this supports the on-going need to work closely with partners to improve the early identification of risk and to encourage the prevent strand of multi-agency working. WMP will continue to look at ways to transform our services and drive efficiencies through the WMP2020 programme; this will form a vital element of the force's medium term financial strategy.

- The Force continues to work in partnership to understand the emergence of offences related to modern day slavery. This is in the forms of forced labour, sexual exploitation, forced criminality and domestic servitude and how best to identify and safeguard adults that are exposed to such offending.
- As MASH evolves in Wolverhampton, it is imperative that there is an on-going review of the Force's investment in resource to this process to ensure that any potential increase in demand is appropriately serviced.

Future Plans for 2016-2017

- West Midlands Police published its Strategic Assessment for 2016/17 in January 2016, full details of which can be found at https://www.west-midlands.police.uk/docs/keeping-you-safe/about-us/public-facing-strategic-assessment.pdfcomes. This year's assessment emphasises the need for us to maintain our current priorities of reducing violence and investing in intervention strategies. However, it also highlights the need for us to change the way we work with our partners.
- We recognise that it is no longer enough for the police to simply lock up criminals. We must find ways to work collaboratively with partners to understand and provide interventions to prevent young people especially from becoming victims and the people who commit crime.
- There is growing awareness that there is a big overlap in the effect of serious issues such as homelessness, drug and alcohol misuse, poor mental health and offending behaviours for people experiencing them.
- Serious issues such as these rarely happen in isolation and the focus of our future plans for 2016/2017 is to prevent people from becoming victims or offenders of crime and identify and work with partners to provide appropriate interventions at the right time to reduce the harm caused to our community.

How do we report safeguarding concerns within our organisation

- WMP has a daily management process where performance information is shared and critical incidents are raised. This allows the Force to respond effectively and efficiently, deploying appropriate resources to match calls for service. This has resulted in times of high demand for additional resource to be flexed across the Force to support the variety of teams, which service the community within Wolverhampton.
- The Public Protection unit also has a dedicated Service Improvement Team, which collates data that sits within Force systems in relation to reported crime/non-crime and outstanding offenders. This data is presented to managers and senior leaders within a monthly document to ensure that the risk around reported incidents are monitored and appropriate resource is allocated to match demand.

City of Wolverhampton Council

Overview of 2015-2016

- Safeguarding is the business of every agency however the Local Authority has lead responsibility for both children and adult safeguarding in the City. During 2015-16 the Local Authority has co-ordinated the development of a Children's Multi-Agency Safeguarding Hub (MASH) which became operational in January 2016. Work is now well on the way to launch an Adult MASH in August 2016.
- The Local Authority has worked to embed the principles of the Care Act within Adult Social Care and has ensured that Safeguarding Awareness is extended beyond the People Directorate by establishing a thriving Place, Partnership Safeguarding Forum, representation is from Licensing, Environmental Health, Trading Standards, Wolverhampton Homes, Regulatory Services, Adult Education , Private Sector Housing, Operational Services and the Safeguarding Service.
- Safeguarding People in Vulnerable situations is a key objective in the Council's Corporate Business Plan.

Governance Arrangements

- The Local Authority is signed up to the West Midlands safeguarding Adults Policy & Procedures; specific Local Practice guidance has also been developed for social work practitioners and also for service providers in the city.
- Mandatory e-Learning has been developed in the areas of Adult Safeguarding, Child Abuse, Child Sexual Exploitation. Safeguarding also features in the new corporate induction for all new council employees.
- Safeguarding Training has been delivered to Elected Members and a Councillor Safeguarding Induction pack has been produced and updated to reflect the Care Act. The Lead Councillor for Adult Social Care also attends the Wolverhampton Safeguarding Adult Board. A monthly safeguarding update detailing national, regional and local safeguarding developments is produced for the Council Leader and managing Director, this is circulated across the People Directorate.
- An adult safeguarding case file audit tool was developed and piloted across adult social care to measure effectiveness and compliance with safeguarding policies and procedures. The Council is also a key player in multi-agency safeguarding audits undertaken on behalf of the Wolverhampton Safeguarding Adult Board. The Strategic Director is an active member of the WSAB and Executive Committee. The Independent Chair of the report reports to the Council's Managing Director who has ultimate oversight of the Chair's annual work plan.
- Bi-monthly information sharing meetings continue to take place between the Council, Wolverhampton Clinical Commissioning Group (CCG) and the Care Quality Commission (CQC) identifying services of concern and leading to joint action planning.

Key Achievements

- The launch of the Children's Safeguarding MASH in Jan 2016 and preparation for the Adult MASH in August 2016 demonstrates the Council's commitment to strengthening multi-agency arrangements within the city.
- Safeguarding and Mental Capacity Act update training was delivered to all social workers and managers.
- Wolverhampton Safeguarding Adult Manager has continued to chair the West Midlands Safeguarding Policy Editorial Group driving the revisions to the Policy and Procedures.
- Revision of the Policy & Procedures post Care Act and revised Statutory Guidance.
- The appointment of a Principal Social Worker with responsibility for children and adult social care workforce strengthens the Councils commitment to "Think Family" approach.
- The development and growth of the Place Partnership Safeguarding Forum has led to improved safeguarding awareness and recognition of potential abuse in the community.
- The development of a dedicated Deprivation of Liberty safeguards Team has strengthened and improved our timeliness of Best Interest Assessments for individuals deprived of their liberty in care homes and hospitals.

Key Challenges

- Increasing demand for DoLS Assessments remains a challenge for the Council in its capacity as the Supervisory Body, measures are in place to reduce the number of referrals awaiting assessment.
- The Adult Social Care Transformation and workforce development is identified as a challenge going forward into 2016-2017.
- Extending Making Safeguarding Personal beyond social workers into the wider council and with partner agencies.
- The Council's prevention and early help offer for adults needs to be clearly understood and communicated across agencies.

Future Plans for 2016-2017

- Strengthen the transition arrangements for young people moving into adulthood particularly for those at risk of sexual exploitation.
- Launch the Adult MASH in August 2016 and evaluate the outcomes and effectiveness of the MASH.
- Rollout and embed the final version of the West Midlands Safeguarding Policy & Procedures including care provider contractual compliance.

How do we report safeguarding concerns within our organisation

- All safeguarding referrals are raised on the SA1 form and forwarded to the Councils City Direct Team, all referrals are then loaded onto the electronic CareFirst system and processed according to the Wolverhampton Local Practice Guidance. From August 2016 the safeguarding referrals will be triaged in the Adult Multi-Agency Safeguarding

Hub (MASH).
- The Council's Business and Intelligence Team provides regular reports on the number and status of referrals.

Safer Wolverhampton Partnership

Overview of 2015-2016

- A joint event was held in March 2016 to share learning amongst frontline practitioners from serious case reviews (SCRs), domestic homicide reviews (DHRs) and safeguarding adult reviews (SARs). The event was attended by 200 practitioners, and a safeguarding toolkit was widely disseminated across agencies for practitioner use as a prompt to implement day to day safeguarding practice. The new Prevent duty has been successfully introduced with a programme of work, including a training plan is being rolled out across partners to raise awareness and better identify individuals at risk from extremism. A new Violence Against Women and Girls (VAWG) Strategy and Gangs and Youth Violence Strategy were launched in March 2016 to drive tackle these crimes and reduce exploitation to better coordinate the partnership approach, encourage reporting of 'hidden' crimes and improve support for victims.

Governance Arrangements

- A joint event was held in March 2016 to share learning amongst frontline practitioners from serious case reviews (SCRs), domestic homicide reviews (DHRs) and safeguarding adult reviews (SARs). The event was attended by 200 practitioners, and a safeguarding toolkit was widely disseminated across agencies for practitioner use as a prompt to implement day to day safeguarding practice. The new Prevent duty has been successfully introduced with a programme of work, including a training plan is being rolled out across partners to raise awareness and better identify individuals at risk from extremism. A new Violence Against Women and Girls (VAWG) Strategy and Gangs and Youth Violence Strategy were launched in March 2016 to drive tackle these crimes and reduce exploitation to better coordinate the partnership approach, encourage reporting of 'hidden' crimes and improve support for victims.

Key Achievements

- Delivery of joint DHR/SCR/SAR learning event for frontline practitioners and dissemination of safeguarding toolkit.
- Strengthened response to Prevent and Channel Panel case management to safeguarding individuals at risk from extremism.

- Strengthened response to identifying victims of gang and youth violence and violence against women and girls.
- Resourced training provision for VAWG and Prevent as part of the safeguarding training offer.

Future Plans for 2016-2017

- Formalise the working relationship between SWP, WSCB and WSAB through development of an operational protocol.
- Input into coordination of the city's safeguarding training offer.
- Ensure the safeguarding website is kept updated with relevant information on SWP's delivery responsibilities.
- Raise awareness and encourage reporting of 'hidden crimes' such as FGM, HBV and FM and improve outcomes for families affected by domestic violence.

How do we report safeguarding concerns within our organisation

- SWP is not an organisation but a Board made up of statutory, third sector, resident and business sector representatives. Each organisation will have their own arrangements for reporting safeguarding concerns; however, members of the Board are reaffirming/reviewing their own organisational safeguarding practice through discussions held at SWP to enhance delivery.

Wolverhampton Public Health

Overview of 2015-2016

- Public Health hosted a public stakeholder event on behalf of Infant Mortality Scrutiny Group for the launch of Safer Sleep week in March 2016. The aim of this was to reduce the rate of sudden infant deaths across Wolverhampton.
- PH have attended various stakeholder events to support reducing deaths including a Public Health England hosted event for reducing Drug Related Deaths. Learning from this event is currently being explored for review of Local Enquiry Processes.
- PH commissioned a review of Falls and Bone Health within Wolverhampton to review the needs, services available and accessible and also inform improvement actions across the city to prevent primary (first) falls. This work is being supported by CCG and LA health and social care partners.
- In March 2016, a letter from the council to Liam Byrne MP, as chair of the All-Party Parliamentary Group on Children of Alcohols, highlighted some of the work being undertaken in Wolverhampton that seeks to support children living in a home environment where alcohol misuse has the potential to cause harm. Some of the developments over the last year include the development of a joint working protocol between Children and Young People and Substance Misuse Services to support

children, young people and families.

- The Children & Young People's Health Improvement Team (within Healthier Place) has supported educational settings across themes within Personal, Social, Health and Economic (PSHE) education. PSHE education covers many areas which relate to protecting young people, including sex and relationships education (SRE), drug education and emotional wellbeing. Pertinent activity carried out this year with schools includes:

    - Workforce training – self-harm, FGM, body image, SRE, basic substance awareness.
    - Curriculum resources and support – local programmes for SRE & Drug Education
    - Policy support – anti-bullying, SRE, substance misuse.
    - Health Related Behaviour Survey 2016 – an on-line health & lifestyle consultation survey for pupils from KS1 – KS4 which provides data for schools and services to base future support and interventions upon. Data is currently being collated ahead of a results event later this year.

Governance Arrangements

- Safeguarding have submitted a separate report which may include mandatory training figures across the organisation.
- PH Mandatory training compliance, including safeguarding,is monitored via Staff Appraisals and oversight is via PH SMT.
- PH have assurance roles at various boards / scrutiny panels across the city including

    - WSAB – Partnership membership – independently chaired.
    - WSCB– Partnership membership – independently chaired.
    - MORAG – Mortality Review Assurance Group - RWT lead.
    - Infant Mortality Scrutiny Group – Leader of the Council.
    - Infant Mortality Working Group – LA lead.
    - CDOP – Child Death Overview Panel – Independent Chair of Walsall and Wolverhampton Safeguarding Children's Board.
    - SISG – Serious Incident Scrutiny Group (CCG lead).
    - Neonatal Mortality Review Group – RWT Lead.
    - Commissioner Mortality Oversight Group – CCG lead.
    - Serious Case review - Chair nominated by WSCB.

- PH is a core member of a Domestic Homicide Review Panel.
- PH provide assurance regarding Safeguarding via the Annual Controls Assurance statement and also the Annual Governance Statement - currently compliant for the safeguarding element within the statement (2015/16).
- PH have not had any regulatory inspections within the last financial year 2015/16.

Key Achievements

- Involvement in shaping children's and adults MASH provision in the city.
- Joint learning event held March 2016 for 200 frontline practitioners and toolkit widely

disseminated.
- Development of a multi-agency Violence Against Women and Girls Strategy and a Preventing Gang Involvement Strategy both of which includes a key focus on prevention and earlier identification of individuals at risk for targeted support.

Key Challenges

- Areas of lead responsibility between the various strategic forums in the city are sometimes unclear; there are proposals to develop a joint Protocol between Partnership Boards in Wolverhampton to clarify these responsibilities and promote joint working.
- Whilst there have been recognised improvements in early help provision within children's services and adults services, the early help offer for adults needs to be clearly understood and communicated across agencies.

Future Plans for 2016-2017

- Child Death Overview Panel – CDOP.
- Infant mortality.
- Contract assurance –quality safety (Please note public health commission the majority of services).

How do we report safeguarding concerns within our organisation

- PH would follow the respective Wolverhampton Safeguarding Boards Policies and Procedures to raise any safeguarding concerns for adults or children.

Wolverhampton Homes

Wolverhampton Homes

Overview of 2015-2016

- WH's adult and children's safeguarding procedures have been reviewed and, where necessary, amended to reflect the provisions of the Care Act 2014.
- IT system has been amended to make recording and monitoring of safeguarding referrals more robust with training provided to staff where needed.
- All managers and supervisors have attended an adult safeguarding awareness raising session in light of the Care Act, with each then cascading the content of the session to staff within their teams.
- WH has an officer located in the Multi Agency Safeguarding Hub, with the same officer attending the Barnardo's weekly screening sessions.

- Introduction of the Supporting People in Need process which aims to ensure WH identifies and supports any person in need of a tailored approach to help them sustain their tenancy.
- WH took part in the Safeguarding Adult week in October 2015.
- WH attends weekly MARAC meetings.
- WH hosts an IDVA employed by WDVF.
- Mental Health Support and Advice Officer continues in post.
- Young Person Advisor supports, where necessary, young people (16-24) who take their first tenancy with WH, focusing specifically on those who are care leavers, leaving prison or any other institution/facility.
- Updated information relating to safeguarding on the website.
- Contribute to the Workforce Development Meetings.

The activity noted above has contributed to an increased awareness of safeguarding thresholds and safeguarding procedures across all sections of the company. There has been an increase in the number of MARAC referrals being made by WH and an improvement in the sharing of information at MARAC as there is consistency in who now attends the meetings for WH. The role of the IDVA and the hosting of this post by WH allows for the victims voice to be heard, thereby increasing the chance of a more positive outcome.

The presence of a WH officer in MASH allows for better information sharing and building of positive relationships with partner agencies. Relevant information that comes out of the MASH can be shared with housing staff, allowing for a more tailored approach to cases.

Governance Arrangements

- Attendance at safeguarding awareness sessions is monitored.
- Business Improvement Team conducts audits following the sessions to ensure that the briefings required have been given by managers/supervisors and to make sure the key messages were understood.
- Copy of all safeguarding referrals made to both children's and adult's social care are seen by operational lead for safeguarding to ensure quality and to make sure procedures are complied with.
- MASH officer alerts operational lead for safeguarding of any non-compliance in recording referrals on IT system should this occur (will be replicated when adults goes into the MASH).
- Equality Impact Assessment has been done on WH's response to the Care Act.

Key Achievements

- Improved front line delivery.
- Presence in the MASH.
- Safeguarding/early help much more common topic of discussion among teams and will inform decision making much more now.

Key Challenges

- Demand placed on WH to do training and awareness raising on a regular basis.
- Ensuring early identification/referral.
- Ensuring partners work together to achieve best possible outcome – thresholds make it difficult to refer/get assistance from other agencies.
- Issue of capacity particularly challenging – where it exists housing staff often feel there are few places to go and may have to resort to taking tenancy action.
- Continuation of MASH Officer post.

Future Plans for 2016-2017

- Further training planned – Modern Slavery May 2016 to all managers and supervisors and contractor event where partners will hear a presentation on safeguarding and modern slavery.
- Introduction of adults into the MASH – ensure procedures are appropriate and consider workload of MASH Officer.
- Continue monitoring safeguarding referrals in terms of quality, meeting thresholds and outcomes (where possible).

How do we report safeguarding concerns within our organisation

- Report to Equalities Circle on safeguarding referrals.
- With enhanced IT processes, will now be able to report to DMT/SMT on quarterly basis.

Royal Wolverhampton NHS Trust

Overview of 2015-2016

- During 2015, RWT has completed the Self-Assessment Assurance Framework and Markers of Good Practice guidance to provide confidence that the organisation is meeting its statutory responsibility to safeguard and promote the welfare of children, young people and adults. The outcome of this process informs the Trust Board, NHS Wolverhampton Clinical Commissioning Group (CCG) and the Wolverhampton Safeguarding Children/Adult Board (WSCB/WSAB) of the progress being made to safeguard local children, young people and families.
- From March 2016, Serious Case Reviews/Domestic Homicide Reviews and Safeguarding Adult Reviews are received, monitored and updated via the RWT Safeguarding SCR/DHR/SAR sub group.
- Safeguarding Children Training is delivered to RWT staff, as per RCN Intercollegiate Guidance 2014. PREVENT training (Health WRAP 3) is being cascaded to all clinical staff during 2016. The compliance regarding attendance is reported to the Wolverhampton Safeguarding Children Board and Wolverhampton CCG. All staff will

receive face to face training on Induction.

- Safeguarding Adult Training is delivered to RWT staff (Level 1 & 2). All staff will receive face to face training on Induction.
- The Safeguarding Children Policy for RWT was updated in 2015 to reflect national changes. This will be reviewed annually.
- RWT have participated in 1 SCR and 1 Safeguarding Adult Review.

Key Achievements

- Member of WSAB/WSCB.
- Member of all subgroups.
- Contribute to Wolverhampton Domestic Violence partnership working arrangements.
- Recruitment of health representative to participate in MASH (children post).
- Provision of robust safeguarding supervision to front line staff.
- Engage with children, young people and families in the community to get feedback on services provided by the Organisation via family and friends test, questionnaires, safeguarding meetings, case conferences.

Key Challenges

- Identify increase of activity in light of new services and staff joining RWT.
- Review of current service delivery to teams that have been identified as requiring additional support.
- Review and development of safeguarding training programme for 2016 in line with the new requirements of RCN Intercollegiate
  Doc for Safeguarding Adults (2016)
- Review of Domestic Violence Pathway and organisation role and responsibility.
- IT solutions support for MASH (children and adult).

Future Plans for 2016-2017

- Development of RWT Safeguarding Training Programme for 2016 – 2019
- Review of RWT safeguarding team structure
- Update Safeguarding children and adult policy in 2016//17
- Development of RWT PREVENTS Policy.
- Development of monthly safeguarding briefing.
- Contribution to the organisation audit process.

How we report safeguarding concerns within our organisation

RWT reports safeguarding matters via:

- Weekly brief/communication process.
- RWT Trust Safeguarding Operations Group
- RWT Trust Safeguarding Committee which reports to Board.

Black Country Partnership NHS Foundation Trust

Black Country Partnership NHS
NHS Foundation Trust

Overview of 2015-2016

- This year saw significant changes to the Black Country Partnership NHS Foundation Trust (BCPFT) adult safeguarding team that covers the 4 Black Country areas, in that its membership was almost entirely replaced from September 2015 onwards, due to job moves and retirements.
- The team took advantage of this to review team activity, capacity & demand with fresh eyes, take stock and propose some new ways of working for the future.
- This along with the implementation of the Care Act 2014 and the incremental changes to practice that are now emerging from it, have ensured the adult safeguarding team continues to develop and improve.

Governance Arrangements

- The trust has a monthly Safeguarding Children & Adults Forum where the organisations safeguarding professionals and senior managers & clinicians meet with the following agenda items:
  - **Effectiveness** Including: Safeguarding Training, Policies and Procedures/Legislation, Audit and the results and responses to any inspections from regulators including CQC & Ofsted
  - **Safety** Including: DOLs /MCA,Prevent, MASH, Serious Case Reviews and Safeguarding Adult Reviews, Domestic Homicide Reviews, Serious Incidents Actions & Learning, National Inquiries & Reports
  - **Experience** Including: Making safeguarding personal
- In addition, adult safeguarding staff attend Divisional Quality & Safety meetings to feedback learning from SARs, DHRs, audits and hear how safeguarding is conducted in clinical operational services.

Key Achievements

- Development of a one page service description to better to identify team core business in terms of: Primary Purpose, Values, Core Activities and Services Provided.
- Improved reporting monitoring of safeguarding concerns within the organisation. This more accurate reporting method may account for the 11% increase in reporting

concerns in the second six months of the year.

- Audit of advice calls received: outlined the importance of the role of the named nurses for adult safeguarding and the unpredictable nature of the demands of their work. The audit also highlighted the degree to which trust staff are aware of, recognise and respond to concerns of abuse – only one call required no further action.
- Appointment of a Mental Capacity Act & Deprivation of Liberty Safeguards (MCA & DoLS) Practitioner: undertook a scoping of the current situation regarding existing MCA & DoLS arrangements and practice within the Trust resulting in an improvement plan and new policies.
- Safeguarding training compliance: the trust has improved the level 2 adult safeguarding compliance to 87% and significantly improved the level 3 position, although more work is required here and additional training resources have been allocated.

Key Challenges

- The demands of a small team and it's senior officers to maintain regular attendance and contribution to 4 adult safeguarding boards and their subgroups remains a challenge but one that has in this year been met.
- The trust continues to struggle with the response from local authority safeguarding teams to concerns/alerts raised with them. There is frequently a lack of acknowledgment of receipt, little or no feedback on intentions, results or when concerns/alerts are closed as requiring no further action or are resolved. With partners we are currently undertaking a "housekeeping" exercise to update all outcomes for existing SA1s and will work together to improve processes this year. This issue remains on the trust risk register.
- When local authorities "cause an enquiry to be made" the trust has a legal duty to cooperate and conduct such enquiries. Processes could be improved in this area that clearly sets out the expectations of trust staff.

Future Plans for 2016-2017

- Work with local authorities to improve the response to concerns/alerts raised with them, including proposing a DATIX based electronic submission that results in a delivery receipt.
- Undertake a "housekeeping" exercise to clarify the position with alerts on DATIX that remain open and unresolved, enabling them to be closed/updated.
- Clarify with local authorities the process for "causing an enquiry to be made" when trust staff are asked to undertake a Section 42 enquiry.
- Conduct routine audits of advice calls at points throughout the year and include this measure for comparison and demand management in future annual reports.

National Probation Service

Governance Arrangements

- Safeguarding Policies and Procedures are produced by the National Offender Management Service (NOMS) Policy Unit within the Ministry of Justice (MoJ). National Instructions are issued detailing professional obligations and minimum statutory responsibilities.
- Training is provided by the National training Team for all practitioners, with an expectation that all Senior Probation Officers, Probation Officers and Probation Service Officers, refresh their Safeguarding training every 2 years.
- Locally, all operational staff are directed ot attend Threshold Training Events, all the relevant LSCB training such as CSE, Neglect etc.
- Within the Cluster, learning lessons from Serious Case Reviews and Serious Further Offence Reviews are disseminated in a variety of ways including briefing notes, team development sessions and multi-team briefings.
- Quality Assurance Audits are undertaken on Risk Assessments at a minimum of twice per year and assess response to safeguarding concerns. All Audits for 2015/16 achieved a rating of 'Good'.

Key Challenges

- The separation of the Probation Service into two distinct Public and Private Organisations. This created a brand new organisation in the NPS, and became part of the Civil Service requiring time for the operation to stabilise and to adapt to a change of culture. In respect to managing the risk of harm posed via Safeguarding matters, this mean that large number so f cases were transferred to different Officers, taking time for staff to become familiar with new cases and families.
- The introduction of the E3 Programme (Efficiency, Effectiveness & Excellence) aims to bring consistency of practice to the new national service and to implement a standardised operating model. This will bring further changes of the personnel arrangements and will impact on the management structures.
- Senior Managers now have wider spans of control and have less availability to participate in wider Board activities.

Third Sector Representative

Governance Arrangements

- I am designated safeguarding officer in my organisation I am responsible for Safeguarding Policies, I aligned THW policy with the Wolverhampton Adults at Risk Policy. I am the named lead for any DHR's and restricted high risk cases of DV. I ensure that staff induction on safeguarding are fully up to date. As TS Rep I ensure that this information is shared at any voluntary sector meeting I attend. During service level agreements, partnership arrangements with other voluntary sector organisation I ensure that safeguarding arrangements are compliant and agreed by all partners. I oversee staff training in relation to safeguarding reporting adults at risk.

Key Achievements

- The Third Sector has been represented at every WSAB meeting during 2015-16.

Key Challenges

As a Third Sector rep the challenges have been:

- The first year on the board, getting used to all the groups and levels of safeguarding responsibilities around the table.
- Establishing Third sector rep position in terms of expectation of the role in line with board priorities.

Future Plans for 2016-2017

- To ensure inclusion of the Third Sector in WASB.
- To support implementation and review of monitoring and evaluation of safeguarding practices in own organisation and through Third sector where possible.
- Drive safeguarding practices to improve practice and outcomes through TSP. Report good practice to WASB.
- Promote importance of engagement.
- Continue to support the strategies priorities of the WASB.

How we report safeguarding concerns within our organisation

- Follow Safeguarding Adults at risk policy.

West Midlands Fire Service

Overview of 2015-2016

- Firefighters receive ongoing safeguarding training. VPOs are trained to a higher level and receive extra training and support to carry out their duties. Training around gangs, CSE, honour based violence, FGM, exploitation will be offered in the coming 12 months. An e-learn safeguarding training package has been developed and is mandatory for all staff. All staff are adequately trained to identify vulnerable people and those at risk. The policy and procedures are being updated currently. The process for making a safeguarding referral is embedded in day to day work practices.

Governance Arrangements

- WMFS has an embedded Standing Order Safeguarding Policy 17/12 which lays out the responsibilities of staff in relation to the protection of children, young people or adults with whom they come into contact through their work and details the reporting mechanism and procedures. When a safeguarding concern is raised this is internally reviewed to ensure it has been acted upon.

Key Achievements

- Training for all staff, additional supportive training is made available for all staff, safeguarding e-learn package is now available, safeguarding support in the form of the local Partnerships Team and the Brigade Community Safety Team is available, knowledge of local partner agency services.

Key Challenges

- Identifying and engaging with the most vulnerable members of our communities to keep them safer and healthier.

Future Plans for 2016-2017

- West Midlands Fire Service's priorities and objectives are laid out in The Plan 2016 – 2019 and can be found by following this link https://www.wmfs.net/your-fire-service/our-plan/
- Supporting communities and partners to promote and advise on safer and healthier lifestyles in their homes.

How we report safeguarding concerns within our organisation

- Safeguarding alerts are reported as per Standing Order Safeguarding Policy 17/12

which is embedded in 'Governance Arrangements' (above). The Group Commander and local Partnerships Officer are informed when a safeguarding alert is raised and is followed up internally to ensure resolution.

Healthwatch Wolverhampton

Overview of 2015-2016

- We have sought to gather safeguarding concerns from service users and the public in general, as well as supporting the collating of information from other agencies about their methods of seeking feedback from service users in relation to vulnerable adults and the safeguarding process.
- Staff attended MASH event.
- Healthwatch safeguarding lead attended and contributed to a Regional Safeguarding Workshop in Birmingham on service involvement in the work of Safeguarding Boards.

Governance Arrangements

- Healthwatch Wolverhampton (HWW) is committed to ensuring that vulnerable people and children are not abused and that working practices minimise the risk of such abuse. The Directors, staff and volunteers have a duty to identify abuse and report it accordingly. A policy is in place with the overarching aim to maintain a safe working and service delivery environment, which is free from abuse, where directors, staff, service users, volunteers and visitors feel confident to report concerns. A designated member from the Board had lead responsibility for safeguarding. The attached flowchart shows how any allegation of abuse would be managed by the organisation.
- In addition, the Healthwatch representative on Safeguarding Board has played an active role in contributing to the work of the Safeguarding Executive Committee in delivery of the priorities identified in the Safeguarding Boards Strategic Plan.

Key Achievements

- We have clarified what needs to be done to get better information from people who have been at risk and who can tell us whether our intervention has made them feel safer, whether they feel they have been given choice and control and whether people have confidence that they are listened to. We are well on the way to getting that and we can make improvements based on the feedback we receive.
- We have also ensured our staff understands sharing information with other agencies when adults may be at risk of harm.
- Also during the year, we were commissioned by the WSAB to develop a consultation

and engagement programme in order to gather views and feedback of safeguarding matters with specific reference to adult social care. The outcome of the project is aimed at ensuring service user experience and involvement in safeguarding enquiries are used to direct improvements to the safeguarding process and the evaluation of the safeguarding service. The project has involved:

- Organising and delivering focus groups
- Surveying individuals with a safeguarding concern
- Interviewing advocates
- Review good practice of advocacy services.

- A full report will be made available in 2016/17 with the findings and recommendations.

Key Challenges

- Gathering experiences from individuals receiving care in their own home.
- Linking Enter and View programme with CQC inspections and safeguarding concerns received by providers and commissioners.
- Improving engagement with young people around safeguarding.
- Recruiting awareness amongst volunteers.

Future Plans for 2016-2017

- Continue to be represented on the WSAB to support the development of the Board.
- Continue to generate feedback and experiences in respect to safeguarding concerns.
- Through our enter and view programme will seek to monitor services and identify safeguarding concerns.
- Provide training to staff and volunteers in respect to safeguarding.
- Through communication activity raise awareness of safeguarding, especially around care being received in individual situations.

West Midlands Ambulance Service

Overview of 2015-2016

- In July 2009 the Safeguarding Single Point Of Contact (SPOC) was created. It was designed so that crews can make safeguarding referrals quickly and efficiently to a single point without the need for unnecessary paper trails and complex processes. All staff working within the SPOC have received training in safeguarding adults and children and Prevent.
- There is a dedicated telephone number which is staffed 24 hours a day, seven days per week; the SPOC is currently based within the Commercial Call Centre in Tollgate Staffordshire.
- The SPOC staff ask a pre-determined set of questions. The system used, the referral forms, questions asked were updated in October 2015 following a consultation with key stakeholders across the region. These are continually reviewed to ensure the questions meet the needs of our partner agencies throughout the region. The referral process is aimed at providing accurate and succinct information in a timely fashion that does not delay operational crews from attending life threatening emergencies, but at the same time elicits the correct information required to ensure a robust referral is made when there is a need to protect a member, or members, of the public.
- The SPOC staff will refer onwards the alert to the appropriate services in line with a robust referral process.
- WMASFT hosted the 4th National Ambulance Clinical and Patient Safety Conference which the safeguarding team contributed to and hosted the National Ambulance Safeguarding Group. This event was in Partnership with WMAS, the College of Paramedics and AACE (Association of Ambulance Chief Executives). The safeguarding team lead a series of workshops and the event was very positively received. The National Ambulance Safeguarding Group delivered 3 safeguarding sessions.

Governance Arrangements

- The safeguarding team provide quality assurance to the board via the Deputy Director of Nursing Quality/Medical Director. The Safeguarding team also produce section 11 audits as well as completing Safeguarding Adults Self-Assessment and Assurance framework for the Strategic Health authority along with a Learning Disability and Mental Health Self-Assessment. No areas were highlighted as less effective, the majority were rated as effective and some were rated as excelling.
- In 2015/2016 WMAS had a Safeguarding Commissioning for Quality and Innovation (CQUIN) which required WMASFT to identify 10 safeguarding concerns per quarter, 5 adults and 5 children's. By 2015-2016 Q4, 40 cases had been identified and Q4 data was submitted in April 2016. No learning was identified during this process but feedback on referrals was highlighted as an area which required development.

Key Achievements

- Across the West Midlands there are 28 Safeguarding Boards. Made up of 14 Adult Safeguarding Boards and 14 Children Safeguarding Boards. Considerable engagement and relationships have continued to be made in 2015/2016 with Safeguarding Boards and their Chair and Managers. WMASFT welcomes communication with all Boards and enhanced attendance is provided when and where necessary.
- There has been an increase in the number of Safeguarding Board meetings due to Board Development days and sub groups etc. Several of the Boards have had change of Chairs as a move towards Independent Chairs across the region continued. The Safeguarding team have over the last year met and engaged with a considerable amount of board Chairs and Managers and presented at a number of boards.
- Safeguarding Boards are reviewing the way members are represented to increase the efficiency of the boards. WMASFT have also attended health forum meetings which ensure that the views of health are fed into the boards and any specific health issues are addressed on behalf of the board.

Key Challenges

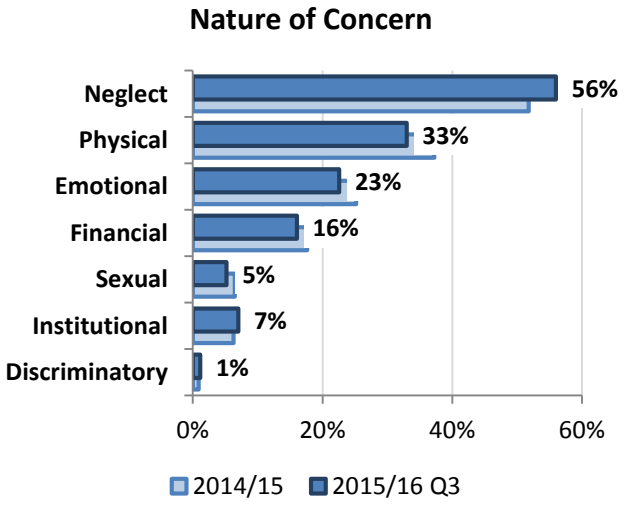
- Due to the demand placed upon a regional organisation with limited safeguarding resource attendance is limited at board meetings.

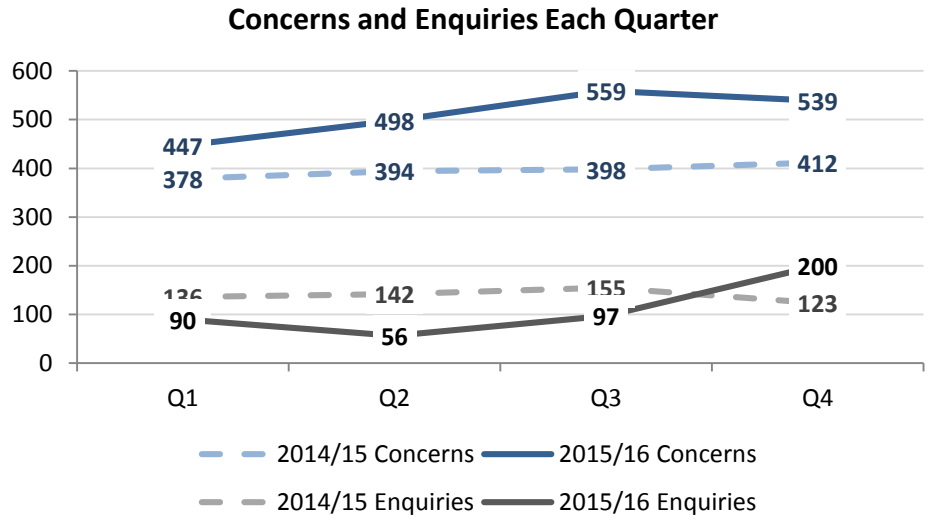
Future Plans for 2016-2017

- Currently the recording system at the moment is not able to differentiate the categories of referral but it is planned to be able to do this in the year 2016.
- WMASFT developed priority safeguarding work-streams for 2015/16 to ensure a consistent and high level approach to Safeguarding continues within the Trust.
- Working in partnership with Education and Training team to ensure that all safeguarding training is relevant and up to date and reflects new initiatives and themes.

Safeguarding Performance Data 2015/2016

Measure		Period	Q1	Q2	Q3	Q4
Number of Safeguarding Concerns	LA	2014/15	378	772	1170	1582
	YTD	**2015/16**	447	945	1504	**2043**
The number of safeguarding concerns remains significantly increased at 2043 compared with 1582 in the previous year, a 29% increase. This increase can be partly attributed to increased awareness.						
Number of Safeguarding Enquiries	LA	2014/15	136	278	433	556
	YTD	**2015/16**	90	146	243	**443**
The number of safeguarding enquiries remains lower than last year due to the implementation of the Care Act and the definition of a 'Section 42' enquiry that this entails. Also in the earlier quarters there were a number of incorrectly recorded enquiries. The recording issues have now been addressed through training.						
Conversion from Concern to Enquiry	LA	2014/15	36%	36%	37%	35.1%
	YTD	**2015/16**	20.1%	15.4%	16.2%	**21.7%**
Conversion from concern to enquiry remains significantly lower than last year. Bespoke training has taken place throughout November and December which is shown in the increase in conversion in Q4. The Q4 conversion rate taken in isolation was 37%.						





The nature of concern shown above shows that Neglect is present in 56% of concerns followed by physical abuse in 33% of cases and emotional abuse in 23% of concerns. There has been little change from the concerns raised in the previous year.

% of completed Safeguarding enquiries where the person at risk or their advocate say that the desired outcomes were achieved or partly achieved (where answered)	LAYTD	2014/15	95.0%	94.2%	94.3%	93.2%
		2015/16	95.4%	97.5%	95.5%	95.9%
Safeguarding outcome remains high at 95.9% of people saying that their outcomes were achieved (83%) or partly achieved (12%).						
% of completed Safeguarding enquiries where an advocate or an Independent Mental Capacity Advocate was involved	LA YTD	2014/15	16.7%	15.3%	15.0%	15.0%
		2015/16	20.6%	16.2%	22.0%	**20.9%**
The use of an advocate has fallen slightly in the full year to 20.9% from 22% at the end of Q3. However the result remains significantly higher than in 2014/15 where an advocate was used in 15% of cases. The value of the indicator has been questioned at the performance sub group and will be further interrogated to identify a more meaningful indicator if possible as not all adults require an advocate.						
Proportion of people who use services who feel safe	LA Annual	2014/15	73.2%			
		2015/16	**74.8%**			
Annual indicator. The proportion of users who feel safe is a good result as Wolverhampton falls into the top quartile. The regional average is **69.5%**. Discussion was raised around the possibility of comparison to a similar question in a Health Watch commissioned survey.						
Proportion of people who use services who say that those services have made them feel safe and secure	LA Annual	2014/15	82.5%			
		2015/16	**84.4%**			
Annual indicator. The proportion of has improved but remains in the lower-mid quartile. Regional average is **86.1%**.						
Number of providers with purchase suspension or partial suspension	LA SS	2014/15	5	5	8	8
		2015/16	7	8	6	**5**
The number of service users with a suspension has fallen to 5 which suggests an improvement.						
% of Safeguarding concerns that require the gathering of supplementary information	LA YTD	2014/15	40.2%	44.2%	43.3%	43.4%
		2015/16	47.4%	46.1%	48.3%	**45.1%**

The proportion of cases that requires supplementary information has fallen in Q4 to 45% from 48% in Q3. This decrease can be attributed to training that was carried out by the Safeguarding team to ensure correct use of the supplementary forms which were previously being used incorrectly.						
% of concerns where the person who raised the concern has had feedback	WMFSYTD	2014/15	84.7%	87.8%	87.7%	88.7%
		2015/16	94.3%	91.1%	91.1%	**90.6%**
Please note that this relates to enquiries not concerns. Feedback remains high at 90.9% of enquiries fed back to in the case of safeguarding enquiries. Data is not available for safeguarding concerns that do not meet enquiry threshold.						
Number of Home Safety Checks carried out in the Wolverhampton area (WMFS)	LA YTD	2014/15	531	1277	1963	2564
		2015/16	596	1512	2046	**2580**
The number of home safety checks carried out is slightly higher than last year at 2580 against 2564. The value of this indicator has been questioned by the sub group. Can a more meaningful indicator be identified.						
Number of Vulnerable Persons Officer visits carried out in the Wolverhampton area (WMFS)	WMFS YTD	2014/15	11	32	61	88
		2015/16	24	45	79	**113**
There have been more Vulnerable Persons Officer visits carried out every quarter throughout 2015/16 compared with the previous year.						
Vulnerable adult crimes	POLICE YTD	% West Midlands	12%	13%	12%	12%
		2015/16	23	48	63	**85**
Number of disability crime incidents (Police)	POLICE YTD	% West Midlands			15%	12%
		2015/16			4 (Q3 only)	**35**
Incident Logs to Nursing and Care Homes (Police)	POLICE YTD	% West Midlands			15%	18%
		2015/16			78 (Q3 only)	**350**

The data is new however comparing all three police indicators shows that Wolverhampton reports 12% of West Midlands vulnerable adult and disability crime incidents but 18% of all incident logs to Nursing and Care Homes.						
Number (and proportion) of Safeguarding Concerns where Domestic Violence is present	LAYTD	2014/15	59 (15%)	129 (17%)	194 (16%)	250 (16%)
		2015/16	10 (14%)	25 (12%)	45 (11%)	**87 (11%)**
% Not Applicable		**2014/15**	10%	8%	8%	8%
		2015/16	15%	13%	16%	**24%**
The proportion of cases where domestic violence is being identified as present continues to fall in Q3 from 12% to 11%.						
% of Safeguarding concerns for people from BME communities	LA YTD	2014/15	20.9%	20.8%	19.9%	19.7%
		2015/16	21.8%	20.5%	19.7% 30% 18-64 13% 65+	**18.8%** **30% 18-64** **15% 65+**
The proportion of concerns relating to adults at risk from BME communities has fallen slightly overall but is not significantly different from the previous year. The data split by 18-64 and 65+ referrals show that both age groups show a slight under representation in BME safeguarding enquiries when compared to the population BME figures below.						
% of BME adults in Wolverhampton	Annual	**18-64**	**33.1%**			
		65+	**14.4%**			

This data from all agencies demonstrates safeguarding activity in Wolverhampton. The data is collected by the City of Wolverhampton Council as the lead agency for safeguarding adults; all data is scrutinised and used to inform prevention work and reviews of guidance and policy. Wolverhampton's data collection meets the requirements of the annual Health and Social Care Information Centre (HSCIC) Safeguarding Adults Return.

Wolverhampton Safeguarding Adult Boards Members & Representatives 2015/16

Alan Coe	Independent Chair
Chief Supt Simon Hyde/DI Julie Woods	West Midlands Police
Tabetha Damon	Black Country Partnership NHS Foundation Trust
Manjeet Garcha	Wolverhampton Clinical Commissioning Group
Dawn Williams	City of Wolverhampton Council, Head of Service Safeguarding & Quality
Sandra Ashton-Jones	City of Wolverhampton Council, Adult Safeguarding and Quality Service
Cheryl EtcheS	Royal Wolverhampton NHS Trust
Karen Samuels	City of Wolverhampton Council, Safer Wolverhampton Partnership
Kirsty Baker	National Probation Service
Mark Henderson/ Sue Kunynec	Wolverhampton Homes
Kathy Cole-Evans	Wolverhampton Domestic Violence Forum
Linda Sanders	City of Wolverhampton Council, Strategic Director
Brian Pearce/Kate Houghton	West Midlands Fire Service
Andy Proctor	West Midlands Ambulance Service
Fiona Davis	City of Wolverhampton Council, Legal Services
Trisha Haywood	Wolverhampton Branch, West Midlands Care Association
Anthony Ivko	City of Wolverhampton Council, Service Director Older People
Vacancy	Local Medical Council
Emma Wynne	Care Quality Commission
Ros Jervis	City of Wolverhampton Council Public Health
Sandra Jones	Healthwatch Wolverhampton
Stephen Dodd	YOW (Youth Organisations Wolverhampton)
Councillor Elias Mattu	City of Wolverhampton Council


WOLVERHAMPTON SAFEGUARDING
Working together to keep you safe from abuse and neglect, and promote your well-being