

## **Adult Care and Well Being Overview and Scrutiny Panel**

### **Wednesday, 12 September 2018, County Hall, Worcester - 10.00 am**

#### **Present:**

#### **Minutes**

Mrs J A Brunner (Chairman), Mr T Baker-Price, Mr A Fry, Mr P Grove, Mr P B Harrison, Mrs E B Tucker (Vice Chairman) and Ms S A Webb

#### **Also attended:**

Mr A I Hardman, Deputy Leader and Cabinet Member for Adult Social Care  
Derek Benson, Independent Chairman, Worcestershire Safeguarding Adults Board  
Bridget Brickley, Worcestershire Safeguarding Adults Board Manager

Avril Wilson (Interim Director of Adult Services),  
Samantha Morris (Scrutiny Co-ordinator) and  
Emma James (Overview and Scrutiny Officer)

#### **Available Papers**

The members had before them:

- A. The Agenda papers (previously circulated);
- B. The Minutes of the Meeting held on 18 July 2018 (previously circulated).

(Copies of document A will be attached to the signed Minutes).

#### **287 Apologies and Welcome**

The Chairman welcomed everyone to the meeting. Apologies had been received from Panel members Rob Adams and Robin Lunn.

#### **288 Declarations of Interest**

None.

#### **289 Public Participation**

None.

#### **290 Confirmation of the Minutes of the Previous Meeting**

The minutes of the meeting held on 18 July 2018 were agreed as a correct record and signed by the Chairman.

#### **291 Safeguarding**

The new Independent Chair and Board Manager of the Worcestershire Safeguarding Adults Board (WSAB) had

## Adults

been invited to discuss progress and developments in safeguarding vulnerable adults in Worcestershire. The Council's Director of Adult Services and the Cabinet Member for Adult Social Care were also present.

Derek Benson, WSAB Independent Chair, gave a brief overview of the presentation included in the agenda papers. The presentation referred to the WSAB's Annual Report 2017/18, Care Act Criteria, the Board's purpose, membership and priorities for 2017/18. It also included Safeguarding Adults Reviews (SARS), key points from data, priorities for 2018/19, key safeguarding risks and key risks for delivery of objectives (and how they would be mitigated).

As new Chair Mr Benson pointed out that the Annual Report reflected much of the previous Chair's good work (Kathy McAteer). Collaborative working by all partners of the Board enabled them to work better which in turn helped overcome some of the on-going pressures on individual agencies.

The Board's priorities included ensuring key areas were embedded in practice (making safeguarding personal, Mental Capacity Assessments and Deprivation of Liberty Safeguards), as well as closer working with the Worcestershire Safeguarding Children's Board (WSCB), of which Mr Benson was also Chair. There were opportunities to do more especially regarding transitional safeguarding, something which was not unique to Worcestershire.

During 2019/20 the Board would be reviewing budget contributions and whether they should be maintained or reduced, and the Chair assured the Panel that public money would not be wasted.

In summary, the Board's work was going well, although there was more to do in raising awareness of the Mental Capacity Act and also to improve stakeholder awareness of what safeguarding is (Section 42 Criteria), and to make safeguarding personal.

### Main discussion points

- It was suggested that there was a lack of awareness about the Adult Safeguarding Board compared to the Worcestershire Safeguarding Children's Board (WSCB), and a Panel member asked whether there were plans to learn from WSCB? The WSAB Chair agreed that the Board

could learn from the WCSB, and vice versa. He also pointed out that Adult Safeguarding Boards were younger, and that progress had been made over the past three years to set the foundations. Additionally there would be more work on communications through the Communications Sub Group and use of the website (jointly with the WCSB). The WSAB Chair appreciated there was more to be done to raise awareness.

- The importance of the Panel's continued awareness about safeguarding was flagged up and the WSAB Chair offered interim updates to assist if required.
- When asked when the external website would be progressed, the WSAB Chair explained that the delays had been frustrating but that funding was in place and a decision on procurement of the website was being discussed later that day. The website needed independence from the County Council and value for money was important when spending public money. The Panel requested an update on this decision.
- The importance of the transition period (when a child moves into adulthood) was raised. What was the Board Chair's view was on when the transition period started and how it could be improved? Mr Benson responded that as an informed lay person, rather than a professional, he believed there was no binary separation between childhood and adulthood. The focus with younger children was protection, which with older children then shifted to prevention. It was important to pick things up at the right time for the individual concerned, and studies indicated that an individual's brain was still developing at 22/23 years old. This was not to say that these dialogues were not happening, but they could be improved, which was a reason for the structure of a joined up Adults and Children's Safeguarding Board.
- The Director of Adult Services explained that, importantly, recent national focus on child sexual exploitation had resulted in lessons for the whole system that these cases had been about exploitation, and not choices. Therefore when Adult Services received a referral from Children's Services, staff would check back to ensure an individual's apparent ability to cope did not lead to them being perceived prematurely as an adult. Adult Services needed to understand that the trauma of some adverse childhood experiences

were long-lasting and required a 'watching brief'. It was vital to understand the individual's experiences rather than the legal parameters.

- In response to a question about whether there was any retrospective understanding of cases, the Director advised that there were regular audits of Section 42 cases, with over 80% rated as good or better, but there hadn't been any root cause analysis of safeguarding adults reviews (SARs). Training or supervision was introduced where the need was identified.
- A Panel member asked whether the WSAB's capacity issues had now been addressed, and the Board Manager advised that she now had more support – the Team was tight but able to operate as well as it could. There was a capacity issue with the Board's sub groups, for example when an individual staff member moved on, and it could be a challenge to get people to see the value of working in partnership.
- A Panel member was aware of the growing number of multi-agency safeguarding hubs (MASH) and asked whether this was something for Worcestershire? The Director of Adult Services was aware that where they worked well, MASH could be very good, and bring together different perspectives, however they could be expensive and she was unaware of any discussions about plans for Worcestershire. Both she and the WSAB Chair agreed that there could be an opportunity to look at the different models in other areas over the long term, it would be important to understand the benefits for systems in Worcestershire and more work was needed at the moment.
- A member asked about the Multi-Agency Risk Assessment Conference (MARAC) system ie a meeting where agencies talk about the risk of future harm to people experiencing domestic abuse. The Board Manager explained that the majority of safeguarding concerns took place in the adult's own home, as highlighted in the Annual Report and the Board Manager referred to overall work underway, to get better information on what was being reported – for example something reported as physical abuse, upon further investigation may reveal domestic abuse. Colleagues in Public Health were assisting with this work, which may reveal a staff training need.
- It was noted that domestic abuse training was now mandatory for all staff at Worcestershire Health and Care Trust (WHCT) and the Panel Chairman

asked whether this also applied to Worcestershire Acute Hospitals Trust? The WSAB Chair would verify this fact, but explained that information in the report had been offered by individual organisations, and a learning point for future reports would be to be clear where good practice was being applied.

- The WSAB Chair also undertook to verify to which organisations Mental Capacity Act crib cards were being rolled out.
- When asked about work to reach black and minority ethnic (BME) communities, the WSAB Chair agreed that more awareness raising was needed and the Board Manager explained that the safeguarding data mirrored figures using social care, which was something to pick up jointly with the Council's Adult Services. Little progress had been achieved and the Board Manager offered to attend any appropriate groups which the Panel may be aware of.
- Referring to those in residential care homes, particularly with dementia, a member asked whether safeguarding extended to ensuring people were enabled through their care, rather than merely looked after (fed, clothed etc), especially in the face of budget pressures? The WSAB Chair referred to Deprivation of Liberty (DoL) Safeguards which provided protection for such individuals but acknowledged that such people were not free to leave as they lacked capacity to direct this – however from going out to care homes, he had seen some very good practice, which did not reflect the member's concern at all, although this could not be assumed for all care homes. The WSAB included a representative from the care home sector, who was a strong contributor. The Director said that DoL standards were very well regulated. She was also clear that the type of care described by the member should absolutely not be accepted, since social interaction should be encouraged for everyone - she asked members to alert her if they were aware of any such instances. The Director confirmed that everyone placed by the Council had an individual care plan.
- Referring to the expansion of supported living, a member asked what was being done to work with providers on safeguarding, since although there was good practice, some providers may need support. The WSAB Chair and Board Manager clarified that there was a difference between

safeguarding and quality issues, however issues were raised at Board meetings, for example a family had recently spoken to the Board about Day Centres, which had resulted in outcomes. An annual assurance of all statutory partners took place each year, looking at appropriate safeguarding standards, which included visits and identifying gaps. The WSAB Chair pointed out that although the WSAB was not a regulatory body, he felt it important to know more about what was going on and service users' experiences.

- The Director spoke about the importance of keeping abreast with technology and work to consider changes to the way in which services were delivered, including communications and availability of information.
- It was confirmed that attendance at WSAB meetings was monitored, and that any issues were addressed quickly. The message was that safeguarding was a part of the representatives' day job and it helped that meetings were action focused.
- The Panel Chairman asked for more detail about the recommendation in relation to SARs, to ensure that there was clear communication with the family from the onset of a case being referred for a SAR, so that families and carers understood the purpose, process, criteria and how decisions are made. The WSAB Chair advised that this issue was also an issue nationally and that when determining who needed to be spoken with, and what they could be told, each case needed to be considered on its own merits. Family members may not always accept or like what they were told, however the Board's terms of reference would feature in conversations with the family.
- A Panel member asked how prepared the Council was to deal with the growing prevalence of dementia. The Director advised that things had changed greatly over the past 5 years, to one where dementia services were simply what the Council did; the new norm. However it was important to stress that vascular dementia was absolutely avoidable, through lifestyle changes, as promoted by public health colleagues.
- The WSAB Chair assured that the Panel that, while not a regulatory body, he could be awkward in asking about any issues which were not being addressed, although the best way forward was to educate and raise awareness. A member asked how the Panel would know about any such issues

and it was agreed that more dialogue between the Panel and WSAB would be helpful.

The Chairman thanked everyone for their contribution and the Panel agreed the following actions:

Agreed actions

In order to build on the dialogue between the Scrutiny Panel and the Safeguarding Board, it would be beneficial to share agendas and minutes of meetings and the Panel extended a welcome to the WSAB Chair to attend meetings where relevant. The Scrutiny Officers would circulate the relevant information.

The Panel was interested to promote conversation about multi-agency safeguarding hubs and whether they may be a 'spend to save' opportunity, and the Director of Adult Services agreed to pick this up with the Director of Children's Services.

It was agreed that there was still more work to do around transitional safeguarding, and also that awareness raising around safeguarding within black and minority ethnic communities was to be encouraged.

The Panel asked to be updated on:

- completion of an external website for the WSAB
- which organisations MCA crib cards were being rolled out to
- whether domestic abuse training was mandatory for staff at Worcestershire Acute Hospitals Trust.

The meeting ended at 11.15 am

Chairman .....