directors of adass
adult social services
West Midlands

Report to West Midlands Fire & Rescue Authority Scrutiny Committee 27th March 2019

Review of Safeguarding Arrangements

Author of report: Alan Lotinga, Associate Consultant, West Midlands Association of Directors of Adult Social Services (WMADASS)

1. Introduction and Purpose of Report

1.1 The purpose of this report to review the West Midlands Fire Service's current arrangements for the safeguarding of children and adults in the West Midlands metropolitan area, and to make recommendations for action to improve those arrangements.

1.2 This report follows a presentation and discussion of interim findings at the last meeting of this Committee on 27th February.

2. Background

2.1 At its September 2018 meeting this Committee confirmed its agreement to commission and independent review of the Service's safeguarding arrangements, four main objectives or key lines of enquiry for the review, intended outcomes, and the Chair and three other Members agreed to contribute specifically and provide oversight to the review.

2.2 I would like to thank those Members and the Officer Stakeholder Group, and in particular Andrea Simmonds, Pete Wilson, Carol Morgan and Helen Sherlock for their help, support and openness with this review.

2.3 The agreed four main lines of enquiry were as follows:-

- **Leadership** – including whether the policy is owned by the most appropriate Senior Executive Team member so that safeguarding is seen as everyone's responsibility

- The WMFS **policy and procedures** (in particular Standing Order 1712) are compliant with the legislation, statutory guidance and addresses the learning from the Metro Court multi-agency review
- The whole **workforce** has the necessary skills and knowledge to identify safeguarding concerns within the context of their role and apply the policy and processes consistently and competently
- **Quality standards and monitoring processes** in place to ensure safeguarding concerns are identified and managed in accordance with WMFS Policy.

2.4 The outcomes or deliverables being sought from the review were:-

- Analysis of the current safeguarding arrangements within WMFS
- Produce a report providing analysis into the extent to which is WMFS compliant with the four elements of the key lines of enquiry within the scoping
- Make recommendations for action to address gaps and shortfalls and for improvement where required
- Present the analysis and recommendations to WMFRA Scrutiny Committee on 27th February 2019
- Finalise report and recommendations following WMFRA Scrutiny Committee by end March 2019

2.5 The Service approached WMADASS for an objective, independent reviewer and I was invited to submit a bid for this piece of work. I have a wide range of experience and knowledge in relation to the safeguarding of adults and children, both strategically and operationally, including as Director of Adult Social Care and Housing Options and Chair of the Birmingham Safeguarding Adults Board (SAB) up until December 2016. I am currently national Policy Co-Lead on Safeguarding Adults for ADASS.

2.6 My intended approach to this review was as follows:-

- A clear understanding of where we (West Midlands Fire Service) need to get to with regard to safeguarding arrangements
- An informed, objective assessment of where we are at now – in a format making it relatively easy to compare to where we need to get to

- A SWOT-type (strengths, weaknesses, opportunities and threat) analysis to identify gaps and shortfalls/threats between where we are and where we need to get to, but also key things to keep and strengthen, potential opportunities and relationships to develop further, and some thoughts/suggestions on what other partners etc might be able to do to help us. Mindful here that the scope of the review and, therefore, the format of the analysis and implementation plan needs to cover policy, training and development, roles and responsibilities, recruitment/selection/induction, governance/assurance/monitoring, and specific suggestions in relation to the future role of the WMFS Lead for Safeguarding.
- Converting this into a suggested implementation or action plan framework – to be developed into who needs to do what by when to get to where – and how progress can be monitored and reviewed.

2.7 In undertaking this review, I have been particularly mindful of the scale and breadth of the population served (a total population served of some 2.57 million people across seven metropolitan local authority areas, with a wide range of needs and population diversity), and the fact that you have to work with 14 different Safeguarding Boards or equivalent, with some quite different approaches and expectations. This is at time of austerity and increasing public expectations of public services. Also, the issues having to be faced by the Service are in the context that the most recent main legislation and statutory guidance governing/driving safeguarding – the Care Act 2014 and the Children and Social Work Act 2017 – make no mention of any specific statutory safeguarding responsibilities placed on the Fire Service. The primary safeguarding partners statutorily are Local Authorities, the NHS and Police. Having said this, of course, the Fire Service is expected to comply with or be mindful of an extensive list of other, related legal duties in the delivery of its services, including from:-

- Fire and Rescue Services Act 2004
- Human Rights Act 1988
- Mental Health Act 2007
- Mental Capacity Act 2005
- Children Acts 1989 and 2004
- Safeguarding Vulnerable Groups Act 2006 and the Protection of Freedoms Act 2012
- Public Interest Disclosure Act 1998
- Modern Slavery Act 2015
- Counter Terrorism and Security Act 2015
- Data Protection Act 1998

- General Data Protection Regulations 2018
- Police and Crime Act 2017

2.8 Reflecting this scale and breadth of these responsibilities and pressures, I have also been mindful of the necessary scale and complexity of the Service's staffing structure. As at January 2019 you employed, along with volunteers, 1889 people – 1395 of whom were uniformed, 63 in Fire Control and 431 non-uninformed – across five Service divisions or categories (Riders, Technical Rescue, Non-rider Service Delivery, Fire Safety, Support). Within these, I understand you now have some 26 Complex Needs Officers – a particularly important role supporting the Service's response to safeguarding issues.

2.9 The Care Act and Children Acts, and supporting statutory guidance provide extensive definitions and examples of what constitutes safeguarding but, in short, safeguarding describes all the work carried out to help people of all ages at risk to stay safe from abuse, harm or neglect, including self-neglect. Within this, clearly, such help and how it is provided varies considerably in safeguarding children as opposed to adults and for adults in particular the matter of their mental capacity/ability to make their own decisions and life-choices (and how that impacts on other people) is crucial.

3. Strengths

LEADERSHIP

3.1 You have a very clear and strong 2018-21 Community Safety Strategy: Safer, Stronger and Healthier with its Prevention, Protection and Response headings. You are here to protect people and keep them safe but, just as importantly, to contribute in all sorts of ways to prevent things going wrong and to help people, particularly vulnerable people, to lead the lives they wish to lead, and as independently as possible.

3.2 There is a clear determination, from the front-line, in support services, and right through to senior management to "add value" to local communities, in all sorts of ways, and to "do the right thing".

3.3 There is also a strong commitment to learn from major local and national reviews, and to feed into delivering better services and support. Linked to this and picking up from learning and actions from recent national and local multi-agency reviews I was asked to look at specifically, I feel the Service can share with other Forces some of its own learning from the Metro Court review (June 2018 report). I would suggest, in particular, a strong reinforcement of the connections between significant fire risk and the safeguarding of children and frail adults, and the need to take a proportionate, risk-based approach to the re-inspection and the enforcement measures following an instruction to vacate high-risk premises.

3.4 The Service has an excellent reputation with key partners and, for various reasons, your front-line officers are trusted by citizens probably more than any other professionals.

3.5 With regard to safeguarding specifically, hopefully this report will help, but the Service's approach and who needs to what in what circumstances is already being transformed and driven by a wider change and modernisation programme – Vulnerability to Fire. Important recent changes include the move from Vulnerable Persons Officer to the new Complex Needs Officer posts. It is early days, and such changes and the programme as a whole will be reviewed as it progresses and evaluated in due course.

3.6 Linked to major national and local developments over recent years, and as already mentioned, there is a strong emphasis, backed up by significant expertise and skills, on prevention, and some excellent innovations operating successfully in the Service eg the Safeside sites and services.

3.7 Significant practical progress and mutual benefit has been achieved in relation to adult safeguarding over the last year or two working with West Midlands Police, the Ambulance Service and the seven metropolitan local authority areas across the region, in the Adult Safeguarding Emergency Services Group. For example, agreeing a common Care Act Audit template.

POLICIES AND PROCEDURES

3.8 There are a number of very good, relevant and up to date policies operating. This includes your 1712 Safeguarding Policy, covering the safeguarding of children and adults, which is easily accessible via your MESH intranet system. There are also good cross-references to other relevant policies. For example, the Safeguarding Policy cross-references to the Service's policies on Equality and Diversity, Management of Information, Code of Conduct, Disciplinary Procedure and Criminal Records Information.

3.9 There are also some good support materials available to help staff and volunteers know what they need to do, and who to refer things to and how and when in relation to safeguarding issues – for example, simple flow-charts, pocket inserts.

3.10 There is an enthusiasm to focus more on supporting vulnerable people to achieve the outcomes they are looking for in a harm or risk of harm situation. For children' services and safeguarding this is known as focussing more on the "Voice of the Child"; for adults, the main approach is known as "Making Safeguarding Personal".

WORKFORCE ISSUES

3.11 As already stated above, I see (and have in the past in my previous role in Birmingham) consistently a genuine commitment and desire to "do the right thing" for vulnerable or potentially vulnerable people and their communities, and some excellent practice to celebrate and learn from.

3.12 I also see, just as importantly, a genuine concern to support your staff and volunteers in their safeguarding and wider welfare work and activities, and to promote and support their own health and wellbeing.

3.13 Recruitment and selection procedures, including the approach to seeking Enhanced DBS (Disclosure and Barring Service) check for key groups of staff, and the adult safeguarding competency framework appear to be sound and effective.

3.14 There is an impressive structure and range of safeguarding training and how it is delivered (for example, e-learning) available, with particular strong and effective links with Birmingham City Council's training and development service.

OVERSIGHT AND ASSURANCE

3.15 The Service holds a significant amount of safeguarding and related data and intelligence in various parts of the organisation.

4. Areas for Improvement

LEADERSHIP

4.1 The leadership of the Service's safeguarding work rests currently with the Strategic Enabler (Prevention), supported by the Prevention and Partnerships Team. I would suggest consideration of re-locating that with more of a "cross-cutting" senior management role, as long as that role is supported properly with dedicated capacity and expertise to be able to carry out that leadership. The key point I make here is about the **location** of that leadership, not the capability of or support for the current post-holder. Safeguarding needs to be seen as everyone's concern not just the Prevention Team's.

4.2 Whilst excellent, the 2018-21 Community Safety Strategy could be more explicit about the Service's commitment to safeguard and protect vulnerable people, and not just under the Prevention heading. I would suggest this be considered as the Strategy comes up for review.

4.3 Whilst mutual progress has been made across the seven metropolitan areas of the West Midlands, I would suggest the Service presses for this progress on adult safeguarding to be extended and into children's safeguarding work. For example, I would suggest aiming for just two sets (on each for children and adults) of annual self-assessment templates and safeguarding concern referral forms, not 14. More generally, I would also recommend the Service makes top-level requests to the 14 Safeguarding Boards or equivalent, and with the seven local authorities directly, seeking confirmation of who, if at all, from the Service needs to cover the existing multitude of groups and meetings relating to safeguarding activities.

POLICIES AND PROCEDURES

4.4 I would suggest some relatively minor amendments/updates to the 1712 Safeguarding Policy, for example bringing things up to date on children's safeguarding following the Children and Social Work Act 2017 and with reference to the latest NFCC (National Fire Chiefs Council) guidance. I will share these suggested changes directly with your Officers.

4.5 I believe a key missing piece of policy guidance is in relation to "People in a Position of Trust" (or often abbreviated to PiPoT). This is a term that has tended in the past to be more familiar and applicable to children's services, i.e. 'People in a Position of Trust' are defined as those who work with children or young people, whether in a paid or a voluntary basis. How allegations of child abuse against people who work in a position of trust should be managed has been a key feature of children's safeguarding legislation, regulations and guidance for a number of years. Since the Care Act 2014, more emphasis has been placed on filling an important gap here in relation to the management of allegations of adult abuse against staff employed to work with adults at risk and more specifically:-

- What responsibilities public sector bodies have with regard to information in relation to a person alleged to have caused harm
- How they should exercise their duty of care towards adults at risk who may be at risk from the person alleged to have caused harm
- How to respect the human rights of the person alleged to have caused harm and to operate within the Data Protection Act.

It might help to illustrate this by example to clarify why I feel there is a gap in policies to fill. Fire Service Officers, having been invited to visit a particular home or setting, come across concerns about abuse (where the abused person might also be another member of Service staff) where the alleged abuser works for another agency – in the same area or another – in a position of trust e.g. they might be a teacher or a social worker or a care assistant. Officers need to be clearer what to do in such, hopefully, exceptional circumstances.

Again, I will share with your Officers a suggested framework for a Service PiPoT Policy to assist with this, to link directly to and from your Safeguarding Policy. The alternative is to continue to rely solely on the Service's Disciplinary Policy, which I would suggest is not intended or tailored to help on these important matters.

4.6 Whilst of course I would support the Service's wish to focus more on Voice of the Child/Making Safeguarding Personal, I would suggest strongly that you keep the approach here as simple as possible and relevant to the Fire Service and its "core business". I would also be wary here that this is about supporting vulnerable children and adults and their families/carers to get the outcomes or results they wish for, not about telling people what we think they need to do – no matter how well-intended this may be. Again, I will provide some suggestions on this for your Officers.

WORKFORCE ISSUES

4.7 I would recommend this report and recommendations be shared with the Service's Unions/Federations with a request that they help to jointly support the consideration and application of the workforce-related recommendations especially.

4.8 The widespread commitment to care for and support people as well as protect them is to evident across the Service and is, of course, to the credit of your workforce. However, I sense that a number of staff at the front-line may often feel the need to go "above and beyond" to help and support families and vulnerable individuals, particularly over the past few years of austerity. This, I would suggest, needs close monitoring as there is a danger of the Fire Service in effect being diverted from its core business and filling the gaps in services and support left by other agencies, and/or of this having a detrimental effect on the welfare of your staff. I would suggest a limited staff survey aimed at:-

- Highlighting particular areas of activity/care and support where there are service provision gaps or access to those services are unclear
- Using this to bring issues to the partnership forums or directly with those agencies who are obviously responsible
- Asking staff if they would find helpful any other support and actions, with their own welfare in mind eg simple reminders of their core responsibilities and the safeguarding essentials, where to go to and how for the more common instances
- where they feel they have to step in, re-assurance that "all of isn't your responsibility"

4.9 As I say above, the range and type of training is good, as is the adult safeguarding competency framework. However, with help from the seven metropolitan area Children's Safeguarding Board Managers/Leads, I would aim to extend the

competency framework to cover children's safeguarding, and I would also suggest the Service reviews quickly the list of training to identify those courses etc that should be mandatory and those where certain staff need to have periodic refreshes of that training/guidance (I understand currently only the modern slavery training is mandatory and most training is one-off).

4.10 Linked to this, I would recommend a more formal, regular review and evaluation of the impact of safeguarding and related training, and the various methods of delivery (eg e-learning, classroom, workshop etc), to ensure you are getting best value from the expenditure and the necessary time taken away from the front-line/workplace.

4.11 I would also recommend more co-ordinated and focussed sharing and learning from real-life local and, where helpful, national case studies – perhaps using your Tactical Decision Exercises and "one-minute briefings".

4.12 I would suggest in particular that the Service considers places more emphasis on Mental Health Act/mental capacity awareness training, as this is a growing concern generally and where the consequences of not knowing what to do and/or where to ask for help in necessarily urgent and potentially stressful situations could be especially damaging.

4.13 I would recommend the Service considers working with the Sandwell Council's DBS checking service to discuss the feasibility of all staff, other than those approximately 70-80 currently having enhanced checks, undertaking a basic DBS check. If feasible, I would suggest this be staggered over a 3-year period as this would relate to some 1,800 people, and then they could be re-checked every 3 years. The annual extra cost to the Service would be approximately £15,600 plus any additional administrative costs charged by Sandwell Council.

OVERSIGHT AND ASSURANCE

4.14 There are some very clear and relevant policies, procedures, work-flow summaries, training and information helpful to promote and support good, consistent safeguarding practice, but these could be brought together better into a co-ordinated safeguarding section of the MESH intranet system, for quick and easy reference.

4.15 I would recommend a quick, focussed process review of the logging and recording of safeguarding concerns and alerts throughout the Service i.e. an "as is" compared to where you want "to be" process review, and the primary aim being to get to a "one record" approach – rather than continuing to risk omitting or duplicating these concerns by not picking them up or having parallel recording arrangements. If I can put this into some context, I understand Fire Control is currently logging about 110,000 total incidents of all types in a full year, and there are also some 30,000 safe and well checks each year. Fire Control are recording some 210 or so safeguarding concerns in the current year and emails to the Prevention Team suggest total safeguarding concerns of between 300-400 over the course of year. This suggests that safeguarding concerns, in terms of pure numbers not potential gravity/risk of course, represent up to only 0.3% of total West Midlands Fire Service activity. But is this about right? Which figures are the correct ones? How do you know if your policies, procedures and training are having the right effects?

4.16 To support this, I feel the Service should consider having a clearer, central 24/7 safeguarding "duty" process to triage, advise on concerns and thresholds, and to get more consistency i.e. where front-line and support staff and volunteers are not sure if they have a safeguarding concern/alert they can get advice quickly and the Service can limit what they call "near misses".

5. Conclusions

5.1 In putting forward the above strengths and suggested areas for improvement across the four main lines of enquiry I was asked to cover, I have been particularly mindful of the increasing capacity and other resource constraints faced by the West Midlands Fire Service. Indeed, this and understandable rising expectations from members of the public are, of course, major challenges for most public sector bodies, and certainly the main partners of the Fire Service. I have, therefore, tried to be balanced and realistic in framing my recommendations and how to take them forward. For example, suggesting ways that other partners might be able to help more and/or where the Service might scale down or re-focus what it is currently doing. Nonetheless, some largely one-off additional expenditures or re-direction of capacity will be needed to action my recommendations, but I hope the Scrutiny Committee will agree that this is necessary for the Service to better meet its safeguarding responsibilities in the future.

5.2 I am also conscious, although this was not in my brief of course, that the Fire Service and its governance – including the future of this Committee - are approaching some major changes with regarding to the West Midlands Combined Authority and its responsibilities. I also hope, therefore, that in some small measure this review and report have been timely as well as useful.

6. Recommendations and Action Plan

6.1 I submit this report to the West Midlands Fire and Rescue Authority with the recommendations that it requests the West Midlands Fire Service to:-

a) maintain and celebrate its safeguarding strengths, as summarised in section 3 above, and
b) develop and deliver the Action Plan framework outlined in the attached Appendix, based in particular on the safeguarding areas for improvement summarised in section 4 above.

6.2 The Scrutiny Committee may also wish to consider asking the Service to report back on progress with these actions in the future – I would suggest initially after six months i.e. the end of September 2019.

Alan Lotinga

WMADASS Associate Consultant

March 2019.