Contents

Foreword 4
Section 1: Introduction 6
Section 2: About Warrington 9
Section 3: Our priorities 17
Section 4: What difference have we made? 24
Learning from Case Reviews 29
What you say 31
Our resources & funding arrangements 34
The year ahead 35
Appendices:
  Appendix A - Plan on a page 36
  Appendix B - Partner statements 37
  Appendix C - Glossary of terms 48
  Appendix D - Membership 51
Foreword

Pat Wright - Lead Member for Statutory Health and Social Care

As the Lead Member for Health and Social Care, I am very proud to play my part in the Warrington’s Safeguarding Adults Board (WSAB) so that adults at risk are able to live a life that is free from abuse and neglect.

This year’s Annual Report details some of the excellent work which has been undertaken to provide challenge, promote greater openness and partnership working among our members, and embed safeguarding as ‘everybody’s business’.

We have also tried to make sure that we continue to learn from the way in which organisations and individuals have worked together, and to identify actions and examples of good practice which would reduce the risk of harm happening again in the future.

The impact of this work is reflected in some of the personal stories which are included in the report. As part of my role, I recognize the importance of engaging with local people to hear about their experiences, address their concerns and for the Safeguarding Adults Board to demonstrate that we are making a positive difference to their lives. This year events such those held on Dignity Action Day, National Care Home Day and World Elder Abuse Awareness Day were positive occasions in which to do this and to highlight dedicated work delivered every day in care services across Warrington. I have also had opportunities to talk to the people who receive our services visiting the hospital and residential and nursing homes which has helped me to understand some of our most vulnerable residents experiences of care and support.

In September 2014, the Peer Review of adult safeguarding services confirmed that we are ‘making a real difference’ in keeping people safe. The Review recognised that in Warrington there is a positive culture of openness and reflection, and that adults subject to safeguarding concerns received effective and coordinated support from well trained and knowledgeable professionals.

This was well deserved praise for every one of the people who have contributed in some way to protecting the vulnerable and the results have given us a real drive to take our plans forward in the year ahead and build on our strengths.

I have every confidence in the work of the WSAB and I will do whatever I can to continue to offer my help and support so that we are able to overcome the challenges we may face in making Warrington a safer place to live.
Foreword

Audrey Williamson - Independent Chair of the WSAB

I am pleased to present Warrington Safeguarding Adults Board (WSAB) fifth Annual Report.

The past 12 months have been eventful and we have welcomed the changes we have seen as a result of the new Care Act which are beginning to transform Warrington’s adults health and social care system. As part of these changes, safeguarding adults’ boards have been placed on a similar statutory footing to safeguarding children boards. This is long overdue and in Warrington we will continue to strengthen our arrangements to protect adults from abuse and neglect.

Our work has continued to benefit from the enthusiasm and commitment of all the main partners and in September 2014 services in Warrington were rated highly by the Local Government Association’s in their Peer Review of Adult Safeguarding and links between partners, leadership, training, staff attitude and advocacy were praised in the review.

My role as Chair has now come to an end and Shirley Williams has been recruited as my successor and I have every confidence in her ability to drive the work of the WSAB forward, making sure that we continue to challenge ourselves and each other as we evaluate the effectiveness of safeguarding adults at risk in Warrington.

I would like to take this opportunity to acknowledge the commitment of all the partners who have helped us to achieve all that we have in the last 12 months.
The Annual Report is an opportunity for us to share with the people who live and work in Warrington what has been accomplished over the past 12 months. The report sets out the progress we have made against the priorities detailed in the Business Plan for 2014/17, including our key achievements, challenges and areas for development for the upcoming year.

What is safeguarding?

Safeguarding means any activity which aims to protect people’s health, wellbeing and independence, so that they are able to live a life that is free from harm, abuse and neglect.

We have a legal responsibility to safeguard any adult who:
- Has needs for care and support (whether or not they are accessing any services);
- Is experiencing, or at risk of, abuse or neglect; and/or
- As a result of their care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

About us - Warrington Safeguarding Adults Board (WSAB)

The WSAB is a strategic board set up as a statutory body under the Care Act (2014). Our key objective is to assure ourselves that local safeguarding arrangements are strong and sustainable and that partners act together to help and protect adults at risk.
Mission statement

We will oversee local arrangements so that safeguarding adults at risk is prioritised and coordinated effectively. We are committed to:

1. Continuous improvement;
2. Learning from experience; and
3. Helping vulnerable adults at risk of neglect and abuse to have a voice and influence local arrangements.

We were established in 2009 by the council and its partners, and in December 2013 an independent chair was appointed to provide challenge, promote greater openness and partnership working among our members, and embed safeguarding as ‘everybody’s business’.

We work to the following Safeguarding Adults Principles set out in the statutory guidance:\(^1\):

- **Empowerment**: People are supported and encouraged to make their own decisions and give informed consent
- **Prevention**: It is better to take action before harm occurs
- **Proportionality**: The least intrusive response appropriate to the risk
- **Protection**: Support and representation for those in greatest need
- **Partnership**: Local solutions - services working with their communities to prevent, detect and report neglect and abuse
- **Accountability**: Transparency in delivering safeguarding

Key responsibilities

We have five key responsibilities set out in the Care Act and by April 2015 we must:

1. Write a plan of what we will do throughout the year to protect adults with care and support needs against abuse and neglect.
2. Publish a report at the end of the year to show our progress against this plan.
3. Review cases where a person dies as a result of abuse and neglect, or where it is so serious that they may have died, to make sure that lessons are learned from it so that we can try to stop it from happening again.
4. Put in place clear guidance and training on safeguarding for all people working with adults with care and support needs.
5. Agree on how to share information and respect confidentiality which will better protect adults who have been or are at risk of abuse and neglect.

\(^1\) Care and Support Statutory Guidance, Department for Health, October 2014
Business Plan

The Business Plan sets out our key priorities for the 1 April 2014 to the 31 March 2017, with the aim of keeping adults ‘at risk’ safe from abuse and neglect. These are:
1. Multi-agency policy and procedure
2. Prevention
3. Assurance and compliance. We also have identified common priorities with the Warrington Safeguarding Children Board (WSCB), which include:
4. Domestic Abuse
5. Understanding the needs of migrant and emerging communities
6. Transition (young people with disabilities).

The Plan on a Page is attached as Appendix A.

Delivery of the plan

There are five sub-groups and a Partnership Forum who are responsible for the delivery of the Business Plan.

The progress against the plan is set out in section 3.
Section 2: About Warrington

Warrington stands on the banks of the river Mersey and covers 70 square miles across the north-west of England. It is made up of small rural villages and suburbs as well as larger areas located around the town centre.

Warrington is generally considered a safe place to live and the rate of crime and anti-social behaviour has fallen over the last 12 months and is lower than the England average. However, there has been a slight increase in the rate of violence and sexual offences, as well as the number of domestic abuse incidents reported to Police since 2013/14.

Warrington’s population has risen rapidly over the last 30 years with the development of the new town and the number of residents is now estimated at 205,100. This growth is expected to continue and by 2037 it is thought that there will be around 235,600 people living in Warrington. With this in mind, the population of older people is also expected to rise and forecasts show that the number of residents aged 65 and over will double by 2033.

This will have a considerable impact on the numbers of people living with ill-health and age-related conditions such as dementia and will put a significant strain on health and social care services, as well as on communities and families. It will also create more demand for services needed to safeguard adults at the risk of abuse or neglect.
In Warrington, we know that...

• **People tend to live shorter lives and they live for less time in good health**
  The average life expectancy for both men and women is one year shorter than the England average and the number of expected healthy years is three years less for men and two years less for women.

  The likelihood of people living in Warrington with at least one long-term health problem or disability increases with age - 12% of adults of working age have a long-term health issue, compared to more than half of adults aged 65 years and over.

• **Adults suffer from low levels of emotional wellbeing**
  One quarter of all adults report suffering from low levels of emotional wellbeing and the rate is higher in areas of deprivation amongst working age adults than in the rest of Warrington.

• **The number of people with Dementia is under-reported**
  The number of older people in Warrington with dementia is expected to increase in the next five years by 300 more cases and almost double in the next 20 years. This will have a significant impact on the number of people with care and support needs, carers who will require support and preventative and intervention services to protect adults at risk of abuse.

• **There is a high number of residents providing unpaid care**
  One in ten adults provide unpaid care to family members, friends, neighbours or others because of long-term physical or mental ill-health/disability or problems related to old age. This is higher than the England average, and equates to around 21,843 people providing this type of care.

**Key facts and figures**

The council gathers intelligence around allegations of abuse and neglect involving adults in Warrington with care and support needs, which includes outcomes for individuals subject to alerts\(^2\) as well as formal safeguarding referrals\(^3\) with the purpose of understanding trends and issues so that support and help can be targeted to those most affected.

Over the past five years the national requirements for the data collection has been subject to ongoing changes at a national level which means that that we cannot directly compare results with the England and regional averages.

---

\(^2\) Concerns reported in 2014/15 by both professionals and members of the community are known as ‘safeguarding alerts’ for the purposes of data collection

\(^3\) Safeguarding referrals follow on from when a concern is raised about a risk of abuse and this then instigates further information gathering, risk assessment and may eventually lead onto a full investigation and the development of a safeguarding/protection plan for the adult at risk.
Safeguarding Alerts

Warrington has intentionally set a low threshold for safeguarding as a way to encourage professionals and members of the public to report any concerns around potential incidents of abuse and neglect.

As a result, the council has recorded a relatively high number of safeguarding alerts, compared to the north-west and England averages and on the whole it is believed that this indicates good awareness of safeguarding across Warrington, rather than an increase in the incidence of abuse.

![Volume of Alerts](chart)

In 2014/15 the number of alerts fell for the first time by around 3% from 1,290 to 1,254. This was anticipated as more work was undertaken with partners around what types of concerns should be referred in as a safeguarding alert.

All alerts are screened by the council, until there is enough information to establish whether there is evidence to suspect whether or not the person has experienced abuse or is at risk of harm. At this point there are a number of possible ways which may be used to address the concerns raised. These include referrals to:

- Care management services for the social worker to assess and address the individual care and support needs; or
- Care Quality Team to seek assurance of the safety and effectiveness of the care services provided; or
- Adult safeguarding for a full investigation in response to the concern raised.

Over the past 12 months around 18% of all alerts received have resulted in an adult safeguarding enquiry, 16% were referred onto care management and 33% were referred onto the Care Quality Team.

Audits undertaken of safeguarding cases in 2014/15 have given assurance to the WSAB about the actions taken when concerns have been raised.
Following screening, a third of all alerts were categorised as requiring ‘No Further Action’. In 56% of alerts there was no evidence to support the likelihood of abuse whilst 13% were considered to be inappropriate referrals (a reduction from 20% in the previous year). For the other cases, the concerns were referred on or resolved at the risk assessment stage.

The WSAB commissioned an audit of these alerts to seek assurance that alerts were being screened appropriately. In 2014/15 a pilot was undertaken with the Access to Social Work Team which introduced a triage system at the front door of older people’s social care services as a way to improve responses to safeguarding alerts.
Safeguarding Referrals

It is important that multi-agency safeguarding investigations focus on cases where there is reasonable evidence to suspect that a person is at risk of, or is suffering, abuse or neglect, and that the steps taken are proportionate to the risk and harm suffered.

It was anticipated that using the most appropriate pathway for the alert would reduce the numbers of safeguarding referrals - as a result of the number of safeguarding referrals has almost halved from 414 in 2012/13 to 233 in 2014/15.

In comparison to the regional and national averages (up until the 31 March 2014), the volume of safeguarding referrals for every 100,000 adults is significantly lower than trends experienced in other local authority areas. It is believed that this is a result of the proactive arrangements undertaken at the risk assessment stage of alerts to refer concerns down the most appropriate pathway. This is in line with the Care Act guidance, including ensuring that adult safeguarding is not a substitute for the respective responsibilities of care providers, care commissioners and the regulator (Care Quality Commission) to provide effective and safe services.

Types of allegations

For referrals which concluded over the past two years, the top three most common types of allegations of abuse have remained the same. These were in relation to neglect, physical and financial abuse. The only variation in 2014/15 was that neglect became the most common type of abuse accounting for 30% of all allegations, rather than physical abuse which was the most common in 2013/14.

In terms of the people who are alleged to have committed the abuse or neglect it was found in 2014/15 that:

• The majority of institutional abuse (79%) and neglect (77%) was alleged to be caused by professionals and paid workers.
• People known to the individual were most commonly associated with 50% of all financial abuse and 47% of all sexual abuse.
• Strangers were mostly alleged to have committed discriminatory and sexual abuse.

This is broadly in line with what is found by our comparators.
Over the past two years the most common location associated with allegations of abuse was the adult’s own home (accounting for 36% in 2013/14 and 42% in 2014/15 of all allegations), followed by care homes, (accounting for 35% in 2013/14 and 36% in 2014/15 of all allegations).

In 2014/15:

- For adults in care homes and hospitals safeguarding concerns were most likely to be raised about professional abuse and neglect.
- Other people known to the individual were the most common source of risk for acts of abuse alleged to have been committed in the community.
- Concerns raised about people living in their own homes were spread more evenly across the groups, with the greatest source of risk being professionals or someone known to them.
Case conclusion

At the end of a safeguarding enquiry a decision is made about whether the allegation of abuse and neglect has been 'substantiated' and proven on the balance of probability.

During 2014/15 work was undertaken with the safeguarding strategy managers to support the quality and consistency of decision and that conclusions to safeguarding enquiries fully record the evidence on which decisions are made.

This has affected the number of allegations which were substantiated compared to the previous year.

---

*4 See Appendix C - Glossary of terms - Substantiated*
In many cases when referrals are not substantiated, the risks can still be managed. Over the past two years, of the allegations found to be substantiated we have removed the risk in over 15% of all cases and reduced the risk in over 40% of cases. In just 10% of case cases the risk remained. In 35% of ‘no further action’ was taken.

In cases in which the potential risk of abuse remained, 46% or alleged perpetrators were known to the adult and the adult did not want further action.

Criminal convictions

A number of safeguarding referrals have resulted in prosecutions which have led to criminal convictions this year. Examples include:

- A daughter convicted of defrauding her mother of £30,000 resulted in a sentence of 20 months imprisonment.
- Prosecutions against doorstep crime targeted against a woman with a diagnosis of Alzheimer’s disease and vulnerable older couple who lost £50,000, concluded in one of the culprits receiving a 32 month custodial sentence.

Deprivation of Liberty Safeguards (DoLS)

In line with the national trends relating to the Supreme Court Judgements in March 2014, the number of Deprivation of Liberty Safeguards (DoLS) applications had increased by 336% from 223 up to 817 in Warrington. This has been a great challenge and requests have needed strong prioritisation. The impact has meant that timescales have not been achieved: compliance with authorisation requests has fallen from 100% (previously maintained year on year) to 53%, though extra resources are being committed in 2015/16.

5 See Appendix C - Glossary of terms - DoLS
6 See Appendix C - Glossary of terms - DoLS
Section 3: Progress against our priorities

This section details the activity undertaken by all partners to meet the priorities in the WSAB business plan.

1. Policies and procedures

We said we would...

Review our multi-agency policies and procedures in light of the new expectations introduced as part of the Care Act so that partners and the public understand how concerns of abuse and neglect will be responded to.

Why it’s important...

Policies and procedures provide a clear framework for how we work together to protect adults with care and support needs from abuse and neglect. They define each partner’s responsibilities, what decisions they can make and what activities are appropriate. They promote openness, clarity and consistency in the way we operate as a partnership, and aim to reduce misunderstandings or debates about what to do in certain situations.
What we have achieved...

✓ Clearer guidance for professionals on self-neglect
  A policy and process on how to respond to self-neglect has been established, as well as draft self-neglect risk assessments which will be piloted in the next 12 months.

✓ Designated Adult Safeguarding Managers (DASM) in each partner organisation
  Partners have identified officers to take the role of the DASM in their organisations with the responsibility for the management and oversight of complex safeguarding cases and allegations of abuse against paid or unpaid employees so that effective action is taken.

✓ A clear approach to Safeguarding Adults Reviews (SARs)
  Clear criteria and guidance for when a Safeguarding Adult Review (SAR) should be undertaken has been put in place, as well as a methodology for the review process, with the aim of identifying learning opportunities for the partnership.

✓ Specialist safeguarding people to chair the multi-agency safeguarding meetings
  Specialist Safeguarding Chairs have been appointed to lead on multi-agency safeguarding enquiries so that more consistent decisions are made which are based on best practice and evidence of what works.

✓ Opportunities for professionals to discuss issues arising from safeguarding practice
  There is a monthly Safeguarding Chairs forum which provides training, learning and development opportunities and a forum to look at issues found in practice, including from audits. The Mental Capacity Forum also looks at safeguarding practice.

What’s next?

It has been a significant challenge to create the capacity and resources to review and improve the multi-agency procedures. There is now a clear plan in place and this is being taken forward by the Policy and Procedure sub-group so that new policies reflect the requirements of the Care Act.

There is a need to develop multi-agency advanced safeguarding and investigation training which is linked to the re-launch of the refreshed procedures.

2. Prevention

We said we would...

Strengthen our partnership approach to prevent the abuse and neglect of adults with care and support needs.

Why it’s important...

Preventing abuse and neglect before it happens is central to maintaining the health and well-being of adults with care and support needs whose circumstances put them at greater risk of experiencing abuse or neglect.
What we have achieved...

✓ **Prevention Strategy**
   Partners have worked together with the third sector to produce a draft prevention strategy which will be consulted upon during 2015/16.

✓ **Access to advocacy**
   Issue based advocacy services have been funded by the local authority. Speak Up - a Warrington based independent organisation for adults with care and support needs - helps those who find it difficult to speak up to express their views, exercise their rights, and raise issues around keeping and feeling safe within their home, families, places of work, and local community. This includes having someone to be present at any safeguarding discussions or where the person doesn’t want or is unable to be present, so that their wishes, feelings and beliefs are heard.

✓ **Access to training**
   The Training sub-group of the WSAB was re-established in 2014 and has mapped training activity using the Learn to Care Framework and Care Act. Each organisation provides safeguarding training for staff working with adults at risk and there is access to multi-agency basic safeguarding awareness and domestic abuse training.

✓ **Sound framework for confidentiality and information sharing across agencies**
   In August 2014 all WSAB member organisations signed up to a multi-agency information sharing protocol which clarified joint processes around information sharing, consent and confidentiality. Protocols have also been established between the Crime Safety Partnership (CSP), Warrington Safeguarding Children’s Board (WSCB) and the Coroner.

✓ **Good community safety services**
   Safe Places (more information is included on Page 19) has continued to grow and there are more than 100 locations in Warrington signed up to the process and there are currently 52 adults at risk using the scheme. Safeguarding training has also been undertaken with club/bar door security staff (bouncers).

✓ **Making Safeguarding Personal**
   The WSAB and council have piloted Making Safeguarding Personal programme to improve personalisation and the involvement of adults in safeguarding investigations to make sure that their voices are heard and they take part in defining the outcomes they want from any safeguarding support and intervention to keep them safe.

✓ **Public awareness of the issues**
   The WSAB has continued to promote adult safeguarding through the media and events including public engagement work on World Elder Abuse Awareness Day (WEAAD), Warrington PRIDE and Disability Awareness Day.

What’s next?

Over the next 12 months partners will need to provide assurance to the WSAB on the impact of their work in preventing abuse and neglect and improving the wellbeing of adults at risk of abuse.
3. Assurance

We said we would...

Put in place arrangements and checks that would provide the WSAB and the local community with confidence in the quality of safeguarding adults work in Warrington.

Why it’s important...

According to the Care Act the core objective of the WSAB is to “assure itself that local safeguarding arrangements and partners act to help and protect adults in its area.” All partners are required to provide the WSAB with information about how well they are carrying out their safeguarding responsibilities. It is an important part of our Board members’ commitment to be open and transparent about how well they are protecting adults from harm and the challenges in their work. It helps us to understand about what works and what we need to improve in Warrington.

What we have achieved...

✔️ Positive peer review of adult safeguarding and the WSAB

In September 2014 the Local Government Association (LGA) undertook a Peer Review of adult safeguarding services in Warrington. The results of the review showed that there was a lot to be proud of in Warrington and found that people who may have some vulnerability receive the support that they need to improve their health and wellbeing.

The WSAB was also found to be ‘making a real difference’ in keeping people safe and confirmed that our partnership, including police, health, the council and the voluntary sector is strong and worked together to make sure that safeguarding adults was everyone’s business.

“There is a positive culture of openness and reflection and a team of committed, positive and skilled staff who are proud of what they do and have the right values and a lot of integrity.”

LGA Final Report

✔️ Greater awareness of people’s experiences of safeguarding

Case studies have been introduced at the start of each board meetings. These give an overview of the direct work undertaken with individuals so that members focus on the impact and difference made by safeguarding services.

✔️ Greater compliance with CQC standards have improved the quality of care

There has been a major re-design of Care Quality monitoring and support services and a new a care quality monitoring framework has been agreed with providers which links into the CCG’s approach, so that there is more co-working and joint inspection activity. As a result 80% of care home providers and 89 % domiciliary care providers are meeting CQC standards.

7 Care and Support Statutory Guidance, Department for Health, October 2014
✔ **Sharing of intelligence**
Warrington NHS Clinical Commissioning Group (CCG) provides intelligence to the Board on serious incidents within NHS services. Warrington and Halton Hospital trust have also been able to provide assurance to the WSAB that they have made significant progress on reducing the amount of avoidable pressure ulcers to 39.83%.

✔ **Greater collaboration with Warrington HealthWatch**
HealthWatch are now leading the Safeguarding Adults Forum and its role in engaging with adults at risk and communities of interest is now strengthened.

✔ **Collaboration with Warrington Safeguarding Children Board (WSCB)**
The WSAB and WSCB came together to scrutinise and audit professionals’ responses to incidents of domestic abuse and to identify areas for improvement, actions and learning within the Council and across agencies.

The council have also undertaken audits of 80 safeguarding cases; and an audit of alerts which had been screened out and required no further action. All audits have resulted in a number of recommendations for improvement. The audits provided a good level of assurance about safeguarding practice in the Warrington.

**What’s next?**
We will continue to embed audits of multi-agency safeguarding practice.

4. **Domestic Abuse**

**We said we would...**
Commission a joint practitioner learning event on Domestic Abuse.

**Why it’s important...**
Domestic abuse is a term used to describe violent, controlling and/or threatening behaviours between partners of family members.

The British Crime Survey found that domestic abuse is a regular occurrence in England with one incident being reported to the Police every minute. The Survey also suggested that disabled women are twice as likely to experience domestic abuse than non-disabled women, and that they were more likely to experience abuse over a longer period of time and to suffer more severe injuries as a result of the violence.8

With this in mind, it is important that Adult Safeguarding and Domestic Abuse services have a clear understanding of where their work overlaps and that they communicate with each other so to reduce both the occurrence of domestic abuse and reduce the harmful effects it has on victims.

---

8 British Crime Survey
What we have achieved...

✔ **Joint event with the WSCB**
  In December 2014 the WSCB and WSAB ran a Joint Practitioners’ Conference on the theme of Domestic Abuse. The keynote speakers were from Coordinated Action Against Domestic Abuse (CAADA), as well as the Warrington Domestic Abuse Partnership Coordinator, who provided input on the local perspective. Practitioners had the opportunity to feedback their views on working with families living with domestic abuse in Warrington. The event concentrated specifically on adults at risk and the 2014 Care Act.

What’s next?
To increase awareness of Domestic Abuse through access to training for front line staff. All organisations should promote Domestic Abuse Training and make it mandatory for certain groups of staff working with children and adults at risk.

5. **Migrant and emerging communities**

We said we would...
Understand the demographic changes in Warrington to improve public understanding of and engagement with safeguarding adults.

Why it’s important...
Warrington is changing demographically partly because of diverse and growing migration into the area. A number of challenges have been reported by different council departments and partner agencies and it is important to understand the needs of new migrants and emerging communities so that we can make sure that safeguarding services are accessible.

What we have achieved...

✔ **Better understanding of the nationalities and cultures of Warrington’s migrant communities**
The WSAB and WSCB have investigated the changes in the Warrington population over the past ten years, specifically the long and short term migration trends and locations of migrant communities in Warrington.

✔ **Representation at the Changing Warrington Project**
A member of the WSAB sits on the Changing Warrington Project working to look at the potential impact on adult safeguarding.

What’s next?
Work is ongoing to identify key cultural differences relevant to the project including issues of custom or etiquette to bear in mind when working with families; family structure and relationships; gender inequality including sexual exploitation and domestic abuse; health needs; recognition and treatment of adults at risk and community safety.
6. Transition (for people with disabilities)

We said we would...
Monitor the safeguarding arrangements for young people with disabilities as they transition from children’s to adult services.

Why it’s important...
Transition from children’s to adult social care requires good cooperation to share information and prepare the young person so that their needs continue to be met. This includes safeguarding them at a time of greater independence and throughout the changes they will encounter.

What we have achieved...
✓ Early planning in transition cases
A multi-agency Transitions team has been established to provide seamless support for young people as they, particularly those with complex needs transfer from children’s to adult social care.

The Peer Review Team was impressed by the case study examples of good practice that Warrington was able to use and the level of reflection that went into these.

What’s next?
The WSAB will continue to collaborate with the WSCB to foster joint working between children’s and adult safeguarding services so that young people have the support they need to protect them from abuse and neglect.
Section 4: What difference have we made?

Our main purpose is to help protect adults with care and support needs from abuse and neglect and keep them safe whilst still supporting them to make their own choices about how they live their lives. This section aims to show the difference we have made to safeguard adults experiencing, or at risk of, abuse and neglect and uses real examples of people with care and support needs who have accessed safeguarding services in Warrington.

**Empowerment**

Sally⁹ was having breakfast at the care home where she was staying when she realised that £70 was missing from her purse. She then remembered a blonde lady kneeling next to her bed where her handbag was the previous night.

A safeguarding alert was made to adult social care and Sally was visited the following day by a social worker to find out her views and wishes. Sally asked the Police to be involved and said that she was happy to give a statement and for the incident to be monitored by the safeguarding team.

⁹ The name has been changed to protect the identity of the individual.
Sally’s main aim was for the alleged perpetrator not to be able to do this again and she felt that reporting this as a crime was a way of achieving this.

Sally was worried about her trust in caring services being undermined by the incident, but special measures were requested by the social worker so that Sally felt safe and supported in court and screens were used when Sally gave her testimony.

The thief was found guilty.

**Prevention**

Safe Places helps potentially vulnerable people feel safer when out and about in Warrington. More than 100 shops, cafes and other businesses across the town have signed up to the scheme and display a Safe Places sticker in their windows. This means they are a safe place to go to and staff will know what to do if someone is worried or distressed and needs some help.

Premises are visited to make sure they are still supporting the scheme and to update new members of staff.

The scheme is run by people who may have/had vulnerabilities themselves, supported by the local advocacy charity, Warrington Speak Up, which facilitates the self-advocacy group Advocacy in Action. A self-advocate project worker (an individual who has learning disabilities) locates new premises/organisations as well as recruiting individual members.

> “Working on the Safe Places scheme is one of the best parts of my job. I honestly believe it can be the difference between people staying at home, lonely and afraid or getting out and about and being a part of the community where they live.”

Self-advocate project worker.

The project benefits from the active support of Cheshire Police. For example, during a recent drive to enlist new premises in the village of Stockton Heath, the worker was accompanied by local Police Community Support Officers, giving extra credibility and boosting sign up.

Although the initial focus has been on people with learning disabilities, the scheme is open to any vulnerable person. Promotion of the scheme to older people is taking advantage of the well-developed network of older people’s groups in the town under the umbrella of the recently opened Life Time centre for over 50s. Here, individuals can register for the scheme, and suggest locations that would make good Safe Places.

Feedback from people who use the scheme has been extremely positive:

> “It makes me feel safer - it’s just in case”
> “It helps everyone to know that it’s safe out and about, that people do care how you feel, that’s the difference”
> “My family feel more relaxed about me going out on my own”
Proportionality

Anne\(^{10}\) had a history of low moods and struggled to find positive ways of coping with stress. Her husband acted as her main carer, but she confided in her mental health support worker that she felt that he wasn’t always able to take care of her properly because of his own needs.

On a routine visit, the worker found Anne in a distressed state following an argument with her husband. Anne said that she had struck out at her husband in a temper and that he had walked out, without taking medication, money or suitable clothing for the weather. Anne confessed that this had happened on other occasions but he had always returned home safe some hours later.

The local authority became involved and a request was made to the Police to undertake a welfare check later that day. As the assault was a potential criminal offence, the police led on the safeguarding investigation and interviewed both Anne and her husband in line with the multi-agency safeguarding procedures.

A carer’s assessment also found that the husband had competing support needs and that he required care as well. A review of his role as a carer resulted in home care being set up for both Anne and her husband and the home situation did become more stable.

A plan was established to give Anne more counselling and support from mental health services.

Even though it was decided to take no further action, the Police warned that any further incidents may result in formal action being taken.

Protection

Ivy\(^{11}\) was befriended by a cleaner working at her care home. The cleaner had previously been a neighbour of Ivy’s and so she placed her trust in her. The cleaner had arranged for a solicitor to visit Ivy in her care home and draw up a Lasting Power of Attorney (LPA) naming the cleaner as the sole attorney.

The solicitor certified that Ivy had the capacity to agree to the LPA, however this raised alarms with professionals at the care home and a safeguarding alert was made. Assessments completed by other professionals including a psychiatrist found that Ivy did not have capacity to make such an important decision and it was believed that this had been the case for some time.

The safeguarding enquiry also revealed that substantial amounts of money and goods had been stolen from Ivy and the cleaner was arrested, prosecuted and convicted of theft, and received a custodial sentence.

Steps were taken by the council to object to the cleaner being granted a LPA by the Court of Protection; the application was eventually refused by the Court. However, this raised

\(^{10}\) The name has been changed to protect the identity of the individual.

\(^{11}\) The person’s name has been changed to protect their identity.
concerns about the rigour that legal representatives apply when undertaking LPA applications and assurance was sought from the Law Society that legal representatives completed capacity assessments when drawing up and certifying LPA applications.

“The Law Society does publish guidance for solicitors through a Practice Note on Lasting Powers of Attorney. We will be issuing a new Practice note later this year on the broader theme of meeting the needs of vulnerable clients, including clients who lack capacity.”

**Partnership**

Charles\(^{12}\) described himself as having lived a ‘colourful life’ spending much of his time socialising in pubs and clubs and betting on the horses, and following a diagnosis of alcohol related dementia was placed in a care home because of concerns that he was harming himself as a result of self-neglect. He was reluctant to wash, dress, needed prompts to maintain a nutritional diet and would often drink to excess, which had already a serious impact on his physical health and resulted in regular nursing intervention and if he continued was sure to lead to his death. The social worker (Best Interest Assessor) who had the task of looking at his best interests as he had issues of mental capacity in some areas of decision making spoke with Charles who described the environment at the home as ‘stifling’ as there was no one he could interact with. Charles was miserable and it appeared that any expression of frustration on his part was interpreted by staff as ‘challenging behaviour’ which demonstrated the need for him to remain in this specialist placement.

Charles had two brothers, who agreed that although he needed 24 hour care, the current care home wasn’t the appropriate placement to meet his emotional and social needs. The care team were of the opinion that the placement was appropriate given his challenging behaviour and the risk to his safety. After an in-depth assessment, the Best Interest Assessor agreed with Charles and his brothers that the care home placement and care plan were not suitable or in his best interests. The Best Interest Assessor recommended that Charles be moved to another home which was an all-male environment with many residents with similar backgrounds and interests. Charles and his brothers were pleased with the outcome and thanked the Best Interest Assessor saying that they were impressed with the Deprivation of Liberty Safeguards process which had put so much emphasis on their brother accessing appropriate care and treatment instead of just being housed in a “place of safety”.

**Accountability**

Barry\(^{13}\) had been diagnosed with Autism as a child and had lived the majority of his adult life in a residential care home for people with learning disabilities.

Barry had a very good relationship with his support staff at the home and social work staff were impressed with the way in which the home were able to manage his care and support needs.

\(^{12}\) The person’s name has been changed to protect their identity.

\(^{13}\) This person’s name has been changed to protect their identity.
In late 2014 Barry was admitted into hospital for an emergency operation on his hip which had become seriously infected and had to be replaced. Whilst in hospital, nursed in intensive care, a Deprivation of Liberty Safeguard (DoLS) authorisation was granted.

On discharge back to the care home, another DoLS request was received relating to the new care plan for Barry.

However the Best Interest Assessor was concerned that the discharge planning arrangements had not taken into consideration Barry’s change in circumstances and his physical needs. There appeared to have been an assumption that because Barry lived in a 24 hour care setting that his care and support needs could still be met there without further assessment.

On further investigation it was revealed that Barry now required the support of two carers to weight bear with a Zimmer frame and a wheelchair for transfers. No equipment had been provided by the hospital and the home was using equipment provided for another resident who had since died.

Given that Barry had lived in the home for 14 years it was felt that a move to a different placement would be very distressing and would not be in his best interest. However, the care plan met the ‘acid test’ and Barry was found to be deprived of his liberty.

It was agreed that a short 14 day period would be authorised on the basis that the home met the recommendations for further occupational therapy and physio intervention, training for staff and the provision of equipment.

The conditions were fully met and staff were able to take Barry outside again something that he had previously enjoyed on a daily basis.

“Thank you so much. I feel a lot better that my son’s care plan is overseen by an independent person who has is best interests at heart.”
The WSAB carries out reviews of cases to make sure that lessons are learned from the way agencies and individuals have worked together, and to identify actions which would reduce the risk of harm happening again in the future.

Serious Case Reviews\textsuperscript{14} take place if an ‘adult at risk’ has died and:
\begin{itemize}
  \item abuse and neglect was suspected to be a contributing factor to their death; or
  \item where there were grave concerns about the way in which agencies had worked together to safeguard the individual concerned.
\end{itemize}

In 2014/15 two cases were referred as potential Serious Case Reviews, but none met the criteria for review. However, it was agreed to undertake a detailed discussion around the situation of one person and a multi-agency review of the other.

\textsuperscript{14}SCRs were not legally required until April 2015 (Care Act enactment) but were regarded as good safeguarding practice
Multi-agency review

Case summary
In 2014 a serious incident report was made to the council because of concerns around the circumstances of the death of an older woman.

During the last four weeks of her life, visiting professionals raised concerns about her physical environment, deterioration of health and consistent refusal to accept support. However, she was assessed to have the necessary mental capacity to make decisions about her own care and treatment.

The case review found that a common approach to self-neglect was required in Warrington, including a clear pathway for progressing issues.

As a result of the review, the WSAB have developed a multi-agency self-neglect policy with guidance for professionals on how to spot and respond to concerns more effectively. This includes recommendations on how to achieve improved recording of an individual’s care and support needs as part of the professional’s assessment.

All agencies have reviewed their policies and procedures to ensure they include guidance for staff when there is a concern about an adult that staff do not have direct involvement with.

They have also reviewed their training provision to identify gaps around mental capacity which have been shared with the Training Sub-group to follow up.

Work is ongoing with:

• The patient’s GP to understand whether they were able to provide other learning points from this case.

Safeguarding Adult Review (SAR)

In 2015 the WSAB commissioned a Safeguarding Adult Review under the new legislation on the unexpected death of a young adult. An Independent Reviewer has been appointed to facilitate a multi-agency review using the ‘Learning Together’ approach.

The full report is expected to be published in the Autumn of 2015.
The Adult Social Care Survey is a national canvass of people’s views and opinions that are in receipt of care and support services. Between January and March 2015 the local authority sent questionnaires to 970 service users aged 18 years or above to learn more about how effectively services are helping them to live safely and independently in their own homes, as well as improve the quality of their life.

365 people returned a completed survey and the response rate of almost 38% was similar to the previous year, although in terms of numbers 9 fewer people participated in 2015 compared to 2014.

Services help to keep people safe

This measure helps partners to understand how services work to protect adults from abuse and neglect and help keep them safe.

“I feel happy that the person has been removed from the flats where I live, I am now able to get on with my life without fear.”
People have reported that services in Warrington help to make them feel safe and secure. Over the past three years the proportion of people reporting has fallen by three point two percentage point, our performance is much higher than the regional and national average and seems to demonstrate that safeguarding works in Warrington. Whilst this is a small drop, the variations may not be statistically significant and we will continue to monitor this key indicator.

<table>
<thead>
<tr>
<th>People say that services help to keep them safe</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="graph.png" alt="Graph showing percentage of people feeling safe" /></td>
</tr>
<tr>
<td>2011/12</td>
</tr>
<tr>
<td>Warrington</td>
</tr>
<tr>
<td>England Average</td>
</tr>
<tr>
<td>North West Average</td>
</tr>
</tbody>
</table>

People who use services feel safe

“The social worker was lovely to talk to - she listened and helped me.”

The results of the survey suggest that people feel relatively safe in Warrington. Over the past four years a higher percentage of people living in Warrington are reporting that they ‘feel safe’ compared to the national and regional averages.

<table>
<thead>
<tr>
<th>People who use services feel safe</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="graph.png" alt="Graph showing percentage of people feeling safe" /></td>
</tr>
<tr>
<td>2011/12</td>
</tr>
<tr>
<td>Warrington</td>
</tr>
<tr>
<td>England Average</td>
</tr>
<tr>
<td>North West Average</td>
</tr>
</tbody>
</table>

Adult Social Care Outcomes Framework (ASCOF - Measures 4a, HSCIC)
However, between 2014 and 2015 the rate of people using services who report that they ‘feel safe’ has fallen from almost 74% to around 70%, but we are still above our comparators and the England average.

Local Safeguarding Survey

The council’s service user survey reinforces the findings of the national ASCOF measures set out above.

Feedback is collected after a safeguarding enquiry has been completed and in 2014/15 a total of 11 people responded. Participation in the survey has always been poor, and returns from 2014/15 were down 35% from 2013/14.

Whilst responses were low, they do show, in the main, a favourable response to the process and intervention.

“I feel safe and happy that my complaint was investigated.”

The majority of people surveyed said that they didn’t think we could have done anything differently, however three people requested “more communication”.

“Give me more information on what was going on.”

Learning from Complaints

In 2014/15, the WSAB received two complaints from an individual who was subject to a safeguarding investigation.

The complainant was offered advocacy to support him engaging in the safeguarding and complaints process, however this was declined.

Even though the safeguarding allegation was found to be inconclusive in relation to the complaint the council have now established staff cover to acknowledge and respond to complaints when there is absence. Going forward it was suggested that complaints procedures for adult social care should be publicised alongside the council corporate guidelines for handling and responding to complaints.
In 2014/15 the budget for the WSAB was £83,423 with a total spend of £83,422.99. This was used in the main to fund salaries and expenses for the Independent Chair, Safeguarding Adults Board Manager and Administration Officer who lead and support the business functions of the WSAB.

The budget is mostly funded through the council and Cheshire Constabulary also makes an annual contribution of £5,000.

Member organisations also provide resources to lead on the work plans of the sub-groups, attend meetings, deliver and attend training and events, as well as providing venues to host our meetings.

Going forward it is a priority for the WSAB to gain agreement that all member organisations will make a contribution to resourcing the Board activities and that the three statutory members - the local authority, the police and NHS - will make a proportionate financial contribution.
The year ahead

WSAB priorities from the 1 April 2015 to 31 March 2016

Our aim is to:

Have evidence which gives us assurance that all adults at risk of abuse or neglect across Warrington are able to live safely, free from the fear of abuse, neglect or victimisation.

Our priorities are to:

- Listen and respond to what adults tell us about their experiences of abuse and neglect, and the services and support they receive
- Develop a preventative approach to support, safeguard and protect adults at risk of abuse and neglect
- Make sure and evidence that there is a good range of multi-agency safeguarding training for all professionals who come into contact with adults at risk so that they have the right skills to protect adults from abuse and neglect.
- Develop our scrutiny of partnership arrangements for adult safeguarding so that we can be confident that all is being done to prevent abuse from occurring and that interventions are proportionate and in the best interests of the adult.

What’s next?

These priorities are set out in the Business Plan available at www.warrington.gov.uk/wsab which describes what the WSAB will do over the next 12 months to assure itself that adults with care and support needs are safe from abuse and neglect.

The success measures in the action plan will be used to inform the review and evaluation process to ensure that progress is being made and to identify the difference we have made to people’s lives.

Monitoring and review

Progress against the action plan will be monitored four times a year by the WSAB and overseen by the Health and Wellbeing Board.
### Context
- Changing national agenda
- Care Act 2014

### Vision
- Effective leadership
- Legislation implementation
- Multi-agency policy and procedure revision to reflect the Care Act

### Priorities
- Multi-agency policy and procedure revision to reflect the Care Act
- Serious Case Reviews
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

### Work Areas
#### WSCB
- Safeguarding operational improvement
- Multi-agency policy and procedure revision to reflect the Care Act
- Warrington Safeguarding Adults Board (WSAB)
- Care Act/Peer Review Implementation
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

#### Warrington SAB
- Chair: Shirley Williams
- Contacts: Mike Padfield (WSAB Administrator) & Shirley Williams
- Email: m.padfield@warrington.gov.uk & Shirley.Williams@warrington.gov.uk

### Outcomes
- Multi-agency policy and procedure revision to reflect the Care Act
- Serious Case Reviews
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

### Cross Cutting Themes
- Service user & community involvement
- Quality & Safeguarding
- Prevention
- Partnership working
- Governance & Assurance

---

**Warrington Safeguarding Adults Board**

Warrington’s Safeguarding Adults Board will oversee local arrangements to ensure that safeguarding vulnerable adults at risk is prioritised and coordinated effectively. We are committed to continuous improvement, learning from experience and ensuring vulnerable adults at risk are safeguarded appropriately.

**Changing national agenda**

<table>
<thead>
<tr>
<th>Work Areas</th>
<th>P2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>WSCB</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Operational Improvement</td>
<td></td>
</tr>
<tr>
<td>SAB Multi-agency groups and Task &amp; Finish Groups</td>
<td></td>
</tr>
<tr>
<td>WSAB</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Forum</td>
<td></td>
</tr>
<tr>
<td>Links to other boards</td>
<td></td>
</tr>
</tbody>
</table>

---

**Warrington SAB**

Chair: Shirley Williams

Contacts: Mike Padfield (WSAB Administrator) & Shirley Williams

Email: m.padfield@warrington.gov.uk & Shirley.Williams@warrington.gov.uk

---

**Warrington’s Safeguarding Adults Board** will oversee local arrangements to ensure that safeguarding vulnerable adults at risk is prioritised and coordinated effectively. We are committed to continuous improvement, learning from experience and ensuring vulnerable adults at risk are safeguarded appropriately.

**Vision**

- Effective leadership
- Legislation implementation
- Multi-agency policy and procedure revision to reflect the Care Act

**Priorities**

- Multi-agency policy and procedure revision to reflect the Care Act
- Serious Case Reviews
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

**Work Areas**

#### WSCB

- Safeguarding operational improvement
- Multi-agency policy and procedure revision to reflect the Care Act
- Warrington Safeguarding Adults Board (WSAB)
- Care Act/Peer Review Implementation
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

#### Warrington SAB

- Chair: Shirley Williams
- Contacts: Mike Padfield (WSAB Administrator) & Shirley Williams
- Email: m.padfield@warrington.gov.uk & Shirley.Williams@warrington.gov.uk

**Outcomes**

- Multi-agency policy and procedure revision to reflect the Care Act
- Serious Case Reviews
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

**Cross Cutting Themes**

- Service user & community involvement
- Quality & Safeguarding
- Prevention
- Partnership working
- Governance & Assurance

---

**Changing national agenda**

<table>
<thead>
<tr>
<th>Work Areas</th>
<th>P2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>WSCB</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Operational Improvement</td>
<td></td>
</tr>
<tr>
<td>SAB Multi-agency groups and Task &amp; Finish Groups</td>
<td></td>
</tr>
<tr>
<td>WSAB</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Forum</td>
<td></td>
</tr>
<tr>
<td>Links to other boards</td>
<td></td>
</tr>
</tbody>
</table>

---

**Warrington’s Safeguarding Adults Board** will oversee local arrangements to ensure that safeguarding vulnerable adults at risk is prioritised and coordinated effectively. We are committed to continuous improvement, learning from experience and ensuring vulnerable adults at risk are safeguarded appropriately.

**Vision**

- Effective leadership
- Legislation implementation
- Multi-agency policy and procedure revision to reflect the Care Act

**Priorities**

- Multi-agency policy and procedure revision to reflect the Care Act
- Serious Case Reviews
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

**Work Areas**

#### WSCB

- Safeguarding operational improvement
- Multi-agency policy and procedure revision to reflect the Care Act
- Warrington Safeguarding Adults Board (WSAB)
- Care Act/Peer Review Implementation
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

#### Warrington SAB

- Chair: Shirley Williams
- Contacts: Mike Padfield (WSAB Administrator) & Shirley Williams
- Email: m.padfield@warrington.gov.uk & Shirley.Williams@warrington.gov.uk

**Outcomes**

- Multi-agency policy and procedure revision to reflect the Care Act
- Serious Case Reviews
- Assurance including the voice of the service user, outcomes, WSAB effectiveness, quality assurance and accountability.

**Cross Cutting Themes**

- Service user & community involvement
- Quality & Safeguarding
- Prevention
- Partnership working
- Governance & Assurance

---

**Changing national agenda**

<table>
<thead>
<tr>
<th>Work Areas</th>
<th>P2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>WSCB</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Operational Improvement</td>
<td></td>
</tr>
<tr>
<td>SAB Multi-agency groups and Task &amp; Finish Groups</td>
<td></td>
</tr>
<tr>
<td>WSAB</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults Forum</td>
<td></td>
</tr>
<tr>
<td>Links to other boards</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

Partner Statement
Warrington Borough Council

In 2014/15 we have:

• Addressed the local authority requirements for safeguarding brought in by the Care Act, including establishing the WSAB as a statutory board.

• Commissioned a LGA Peer Review of safeguarding which found services to be good and that people were supported to ‘stay safe’

• Invested in training and support for safeguarding chairs and operational staff to increase legal literacy and to apply consistent thresholds in the safeguarding process.

• Signed up to the LGA ‘Making Safeguarding Personal’ pilot and launched it to support safeguarding approaches centred on adults at risk and the outcomes they want.

• Reviewed and amended our feedback survey to understand the impact of our services

• Re-commissioned residential and domiciliary care services so that they reflect our core principles to protect people from abuse and neglect and give value for money.

Our challenges in 2014/15 were:

The steep rise in DoLS applications affected the number we were able to complete in timescale. A new model was developed and more staff recruited to support the process.

Raising awareness of domestic abuse and hate crime in safeguarding was not progressed due to staffing changes and this will be a focus in 2015/16.

Links with MAPPA and work to prevent various forms of exploitation of adults such as human trafficking, modern slavery and sexual exploitation.

Key priorities for 2015/16 are to:

• Embed Making Safeguarding Personal in our day to day practice.

• Support practice and manage demands around the Mental Capacity Act, DoLS and Court of Protection.

• Roll out the new framework and tools which support integration with the CCG around Care Quality Monitoring.

• Develop a more effective and joined up complaints service.

• Redesign the Deputyship and Appointee service.
Partner Statement

Cheshire Constabulary

In 2014/15 we have:

• Delivered training to all staff about the Care Act, adults at risk, and roles and responsibilities of staff, which has been supported by partner agencies.

• Supported multi-agency training events about Capacity and Deprivation of Liberty particularly to health and social workers.

• Given presentations at Practitioners Workshops to improve understanding of the police role in respect of Adults at Risk and our processes for professional referral.

• Revised our Force Policy to reflect the changes from the new Care Act.

Our challenges in 2014/15 were:

The change to the referral process from social care to the police.

We are responsible for public protection and aim for the people of Cheshire to be and feel safe. In Warrington we have a dedicated Public Protection Unit supported by a referral unit and resourced by specialist officers who manage the day to day safeguarding activity.

The restructuring process and an additional dedicated Adult at Risk officer has been introduced aligned to each Local Authority area.

Key priorities for 2015/16 are to:

• Cheshire Constabulary is committed to safeguarding the most vulnerable members of our community and working with partners to achieve this. Safeguarding has been identified as a training priority for the Constabulary.
Partner Statement

National Probation Services, Cheshire & Greater Manchester Community Rehabilitation Company

In 2014/15 we have:

• Made Domestic Violence perpetrator programmes part of an order or licence condition to try and change attitudes and behaviour and promote healthy relationships.

• Used police intelligence to inform risk management plans and impose external controls on perpetrators to further protect the adults at risk of abuse.

• Established links with adult social care and residential providers across the Cheshire footprint to meet the demand for placements for older sexual offenders with care and support needs when they transition from prison to the community.

• Taken an active role in MAPPA and MARAC, establishing effective links with Community Safety Partnerships, adult social care, the IDVA service and the learning disability Service.

• Audited our high risk cases on a monthly basis including contact and assessment records. As part of MAPPA, we have also audited meetings and minutes with regards to the Risk Management Plans on community orders and prison licences.

Our challenges in 2014/15 were:

• We manage offenders who may abuse others in a less powerful position than themselves, and the Victim Liaison Team information and advice to victims of domestic abuse. Exclusion zones and no contact clauses have been imposed on perpetrators coming out of prison to safeguard children and adults in danger of being re-victimised.

Key priorities for 2015/16 are to:

• Find appropriate facilities for vulnerable high risk offenders as they transition from custody to the community.

• Developing policies and procedures around adult safeguarding and the Care Act.
We have the legal responsibility for leading and overseeing safeguarding arrangements across the health community. We work with Warrington Clinical Commissioning Group, GPs, dentists, pharmacists and opticians to make sure that services protect adults from abuse and neglect and that their services also meet the expected safeguarding standards.

Partner Statement

NHS England North (Cheshire and Merseyside)

In 2014/15 we have:

- Provided support to GP practices around safeguarding people from abuse who use services.
- Made funding available to increase awareness and deliver training around the Mental Capacity Act and Deprivation of Liberty Safeguards. Additional capacity was also resourced so that more applications from hospitals and care homes are completed in a timely manner.
- Overseen Care and Treatment reviews as part of our response to the Winterbourne View Concordat to find the best placements for patients with learning disabilities which best meet their care and support needs.
- Had successful validation and peer review of the Joint Learning Disabilities Self-Assessment Framework (LDSAF) which has supported the Cheshire & Merseyside Health and Social Care economy to share examples of good practice, as well as highlighted potential areas of concern that are escalated to NHS England Quality Surveillance groups and relevant Safeguarding Boards.
- Made significant progress so that primary care services achieve the best outcomes for adults. Policy documents on adult safeguarding, standards for practice, assessment tools, and guidelines to assist practitioners have been developed. Also, a clear framework has been put in place which sets out the competences required for health care staff.
- Adopted safeguarding assurance tool for NHS England primary care commissioned services and put in place in GP practices in Warrington CCG with support from the designated nurses.

Our challenges in 2014/15 were:

Key priorities for 2015/16 are to:

- Develop the skills and knowledge of frontline staff and work with Coroner on GP knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Set up mandatory reporting across GP Practices in Warrington of Female Genital Mutilation.
- Work with partner agencies on radicalisation and the PREVENT agenda.
Partner Statement

Warrington Clinical Commissioning Group

In 2014/15 we have:

• Taken on the role of leading the Policies and Procedures sub-group and have worked to clarify thresholds so that the differences between allegations, complaints and care quality issues as well as responsibilities were clearly defined.

• Hosted a joint information event in February which clarified guidance to 14 home managers around policies, procedures and reporting on safeguarding issues, and promoted an integrated approach to safeguarding.

• Hosted an event which provided awareness raising in relation to mental capacity and assessments, across partner organisations in Warrington.

• Appointed a Quality Improvement Manager for Care Homes to work in collaboration with the homes and other providers and commissioners, to provide support and intelligence in relation to quality and information sharing.

Our challenges in 2014/15 were:

We are responsible for the NHS care provided to the local residents of Warrington and commission the three large NHS health providers, a large private hospital and a number of other smaller organisations. We work with these providers so that services deliver high quality care that serves the needs of the local population.

Key priorities for 2015/16 are to:

• Work with primary care providers (GP’s) around improving information sharing and attendance at MARAC.

• Continue to monitor provider adherence towards legislation to effectively prevent abuse, drive up quality and protect adults with care and support needs from harm.

• Continually work to improve and strengthen partnership working, in order to reduce any risk associated with safeguarding adults.

• Embed the NHS Serious Incident Framework 2015 into the Warrington Multi-agency Safeguarding Policies and Procedures.

Changes to the WSAB structure and recruitment of a new Independent Chair.

Anticipation around the Care Act and its impact on local safeguarding responses would be made.

Developing an infrastructure to support effective scrutiny of care quality and safeguarding which offers assurance to the WSAB.
Partner Statement

Warrington & Halton Hospital
NHS Foundation Trust

In 2014/15 we have:

• Appointed an Executive lead for Prevent, the Director of Nursing, produced a Trust policy for all staff and volunteers and started basic awareness training as part of all clinical safeguarding updates.

• Contributed to the development of multi-agency Safeguarding and self-neglect policies for front line staff.

• Updated our local safeguarding policy and included sections on Human Trafficking and Modern slavery, Exploitation by radicalisers who promote violence (The Prevent Strategy), Celebrities and VIP visits to hospital (Savile enquiry), the Care Act 2014 and Mental Capacity Act and DOLS update following ‘Cheshire West’ ruling.

• Undertaken audits of mental capacity assessments which have shown that although there is increased awareness, staff do not always record the communication and input of family members.

• Audited clinical records for patients who were restrained and made improvements to case recording which now contain an outcome and changes to care plans.

Our challenges in 2014/15 were:

Balancing the demands of the partnership (meetings and reports) alongside the day to day business (clinical referrals and investigations) with limited resources.

Implementing the findings of the Cheshire West ruling in relation to DoLS, which has created an ongoing service pressure to update and educate all clinical staff.

Key priorities for 2015/16 are to:

• Implement the WASB Partnership Safeguarding Guidance and Procedure Policy.

• Implement level 3 Prevent training (WRAP).

• Review and update the Trust Restraint Policy and the Mental Capacity Act Policy so that they are Care Act compliant.

• Monitor and manage the capacity and workload of the safeguarding team so that continuous improvement in achieving the ‘Cheshire West Judgements’.
Partner Statement

Bridgewater NHS Trust

In 2014/15 we have:

• Been an active member of Warrington SAB and its sub-groups, contributing to the improvement of care and protection of adults at risk through the assessment and identification of risks, escalation of concerns and multi-agency care planning.

• Provided basic awareness training for all staff and for those working directly with adults at risk specific training on the Mental Capacity Act and Deprivation of Liberty Safeguards so that they are able to identify issues and report concerns.

• Provided assurance to commissioners on our safeguarding arrangements. An Audit undertaken by Mersey Internal Audit in 2014/15 showed that the systems and processes in place provided significant assurance that people are safe in our care.

• Identified Safeguarding Adult Champions across the organisation and act as a resource for information, support and supervision for the teams.

• Established the serious untoward incident group which reviews investigation reports to identify trends and contributes to improving practice.

• Established the Mental Capacity Act steering group to review the implementation of the Mental Capacity Act and identify further training issues.

• Participated in local case reviews for adults and domestic homicide reviews to support on-going learning from and to inform best practice in the organisation and in partnership working.

Key priorities for 2015/16 are to:

• Review and strengthen partnership working in the adult safeguarding arena.

• Continue to develop and improve systems to promote effective reporting and lessons learnt from safeguarding incidents.

• Review training need analysis to evaluate the needs of our staffing line with national competencies.
Partner Statement

5 Borough Partnership
NHS Trust

In 2014/15 we have:

• Worked alongside our WSAB partners to review the local policies and procedures in preparation for the Care Act, including the review of the thresholds criteria.

• Raised awareness of Domestic Abuse, using the expertise of our local domestic abuse services.

• Completed an internal programme of quality review visits to assess compliance with the Care Quality Commission’s Outcome 7 (Regulation 13) and developed action plans to address non-compliance.

• Supported clinical managers to confidently ‘self-declare’ compliance with Outcome 7 to promote the profile of quality within the safeguarding agenda, increase insights in terms of manager’s accountability and assist them to sustain the initiative.

• Provided the CCG’s with assurance on our contractual performance, quality, safety and safeguarding arrangements.

Our challenges in 2014/15 were:

Changes with some staff retiring or leaving employment to take up new opportunities.

The review of Corporate Services and Safeguarding Team restructure was following consultation with operational services within the Trust and with external stakeholders and partners.

Key priorities for 2015/16 are to:

• Embed the Making Safeguarding Personal Agenda into safeguarding activity across the Trust.

• Implement the National Competency Framework (Bournemouth) into our training strategy.

• Implement the Care Act, including how “making an enquiry” so that staff have the skills and knowledge to do this in a safe way.

• Review of the Domestic Abuse agenda, raising awareness and review of training needs across the Trust.
Partner Statement

Cheshire Fire and Rescue Service

In 2014/15 we have:

• Provided front-line staff with safeguarding refresher training.
• Raised awareness amongst agencies and professionals offering services to those who may be at heightened risk from fire.
• Highlighted some of the more vulnerable members of the community who may have fallen under the radar we have identified by attending emergency incidents.
• We have made four alerts to make sure people receive the relevant care, assistance and support to improve the quality of life and independence.
• Commissioned an external training provider to deliver Adult Safeguarding Train the Trainer which has created additional capacity as well as front-line awareness on recognising and reporting adult abuse and neglect.

Key priorities for 2015/16 are to:

• Review of our organisation’s safeguarding adults at risk policy.

• Scope mental capacity training for those staff involved in case managing adults at risk who are at heightened risk from fire.
Partner Statement

Golden Gates Housing

In 2014/15 we have:

• Provided safeguarding training to our staff working in the Neighbourhoods Teams.

• Restructured our Neighbourhood Teams so that officers are now able to spend more time identifying vulnerabilities and working with other agencies to improve tenants’ circumstances.

• Participated in the Delivering Wellbeing in Bewsey and Dallam initiative to improve the lives of adults, young people and children by increasing employment, skills levels, school attendance, health and community participation.

• Provided help to tenants to get into work, improve their financial circumstances, reduce anti-social behaviour, reduce fuel poverty and improve the condition of their homes.

Our challenges in 2014/15 were:

Welfare Reform and support for those affected by the benefits cap, bedroom tax and roll out of Universal Credit.

Self-neglect, in particular engagement with other agencies to resolve tenant issues such as hoarding.

The multi-agency Self Neglect Policy will further improve the partnership response.

Key priorities for 2015/16 are to:

• Roll out training to the wider workforce and embed our new safeguarding policies and procedures.

• Invite an independent safeguarding expert to review our approach to safeguarding.
Partner Statement

HealthWatch

Everything we say and do is informed by our connections to local people and our expertise is grounded in their experience. As a statutory watchdog our role is to ensure that local health and social care services and local decision makers, put the experiences of people at the heart of their care. We work to harness the views and engagement of local people and this includes the experiences of those who are vulnerable and fall under the remit of WASB.

In 2014/15 we have:

• Included personal safeguarding and general safeguarding adults training into our staff and volunteer training programme.

• Identified a Designated Adults Safeguarding Manager for our organisation.

• Updated our Enter and View training to include specific safeguarding awareness-raising.

Our challenges in 2014/15 were:

- Identifying the correct pathway for referral and sometimes front line referral has not been as smooth as it could be.

- Tracing where referrals are up to due to staff handover or absence.

- Making people aware of HealthWatch and our purpose.

Key priorities for 2015/16 are to:

- Be more proactive in seeking out issues and letting people know about the referral routes that are open to them.
## Appendix C

### Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>Advocacy is a process of supporting and helping people to express their views and concerns; access information and services; and defend and promote their rights and responsibilities. This may include providing encouragement or representing their views.</td>
</tr>
<tr>
<td>Community Safety Partnerships</td>
<td>Community Safety Partnerships are local statutory bodies made up of Councillors and independent people from each local authority area. They work together to make a community safer by focusing on issues which matter most in your area.</td>
</tr>
<tr>
<td>Coordinated Action Against Domestic Abuse</td>
<td>Coordinated Action Against Domestic Abuse (CAADA) are a national charity who build professional advocacy services in the domestic violence sector and provide training, education and support for advocates, as well as tools for setting up Multi-Agency Risk Assessment Conferences (MARACs).</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>The Deprivation of Liberty Safeguards (DoLS) provide additional protection for the most vulnerable people living in residential homes, nursing homes or hospital environments (and more recently some housing with care environment) through the use of a rigorous, standardised assessment and authorisation process. They help to make sure that a person’s liberty is restricted legally, and that this is done when there is no other way to take care of that person safely. Following a Supreme Court judgement on cases in Cheshire West and Surrey, there has been a broadening of the circumstances of care that might now constitute a deprivation of liberty. As a result the number of applications for DoLS has increased significantly across the country.</td>
</tr>
<tr>
<td>Designated Adult Safeguarding Managers</td>
<td>Designated Adult Safeguarding Managers (DASMs) are responsible for the management and oversight of individual complex cases and coordination where allegations are made or concerns raised about a person, whether an employee, volunteer or student, paid or unpaid. They are expected to keep in touch with their counterparts in partner organisations, and highlight the extent to which their own organisation prevents abuse and neglect taking place.</td>
</tr>
<tr>
<td>Disability Awareness Day</td>
<td>Disability Awareness Day (DAD) is the biggest non-profit disability exhibition led by volunteers in the UK. It is held by Warrington Disability Partnership and attracts more than 25,000 people every year. The day aims to raise awareness to the voluntary, statutory and private services available to people with disabilities.</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>Violent, controlling and/or threatening behaviours between partners of family members.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Domestic Homicide Review</td>
<td>Domestic Homicide Review refers to a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by a person whom he/she was related or had been in an intimate personal relationship, or a member of the same household. They aim to establish what lessons can be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.</td>
</tr>
<tr>
<td>Health and Wellbeing Board</td>
<td>Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children’s services, including elected representatives and Local HealthWatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.</td>
</tr>
<tr>
<td>HealthWatch</td>
<td>HealthWatch are the local consumer champion in health and social care. They have significant statutory powers to make sure that the voice of the consumer is strengthened and heard by those who commission, deliver and regulate services.</td>
</tr>
</tbody>
</table>
| Learning Together            | Learning Together supports learning and improvement in safeguarding adults and children. They help local safeguarding children boards, safeguarding adults boards, and their equivalent organisations to:  
• use systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture  
• build internal capacity by having staff trained and accredited in the Learning Together approach to reviewing  
• undertake rigorous case reviews and audits using a core set of principles and analytic tools  
• access a pool of accredited independent reviewers as required by statutory requirements  
• build on the experience and findings of previous reviews as part of the Learning Together community. |
<p>| Local Government Association | The LGA are a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. They aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems. |
| Making Safeguarding Personal | The Making Safeguarding Personal programme was established by the LGA to develop person-centred, outcome focused responses to safeguarding adults. |
| Mental Capacity Act          | The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themselves. This could be due to a learning disability, or a mental health problem or condition such as dementia. The act applies to people aged 16 and over in England and Wales. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migration</td>
<td>Migration is the movement of people from one place to another. The reasons for migration can be economic, social, political or environmental.</td>
</tr>
<tr>
<td>Multi-Agency Public Protection Arrangements</td>
<td>Multi Agency Public Protection Arrangements (MAPPA) is the framework which joins up the agencies who manage offenders. The fundamental purpose of MAPPA is public safety and the reduction of serious harm.</td>
</tr>
<tr>
<td>National Health Service</td>
<td>The National Health Service (NHS) is the publicly funded healthcare system for England. It is the largest and the oldest single-payer healthcare system in the world.</td>
</tr>
<tr>
<td>Peer Review</td>
<td>A peer review is an evaluation of adult safeguarding work by specialists working in the same field to make sure that it meets the required standards. The Review aims to help the council and its partners to assess and identify current strengths; areas for development; and capacity for change.</td>
</tr>
<tr>
<td>Public Protection Unit</td>
<td>The Public Protection Unit (PPU) is a dedicated team that deal with crimes of Domestic Abuse, Honour Based Violence and Hate Crime.</td>
</tr>
<tr>
<td>Safeguarding Adults Board</td>
<td>Safeguarding Adults Boards are the statutory body responsible for overseeing and leading on adult safeguarding in the local authority area. It is responsible for making sure that local safeguarding arrangements help to protect adults with care and support needs in its area.</td>
</tr>
<tr>
<td>Safeguarding Adults Reviews</td>
<td>Safeguarding Adults Reviews are reviews of cases where a person has died as a result of abuse and neglect, or where the incident was so serious that they may have died, to make sure that lessons are learned across the partnership and to prevent it from happening again. Safeguarding Adults Boards are legally responsible for completing the reviews.</td>
</tr>
<tr>
<td>Safeguarding Alert</td>
<td>A safeguarding alert is a concern raised with the local authority by either a member of the public or professional about an adult who is or might be experiencing abuse or neglect.</td>
</tr>
<tr>
<td>Safeguarding Referral</td>
<td>A safeguarding referral is where a concern is raised about a risk of abuse and this instigates further information gathering, risk assessment and may lead onto a full investigation and the development and implementation of a safeguarding/protection plan for the adult at risk.</td>
</tr>
<tr>
<td>Serious Case Review</td>
<td>Serious case reviews are undertaken by local safeguarding boards for every case where abuse or neglect is known - or suspected - and either: a person has died or a person is seriously harmed and there are concerns about how organisations or professionals worked together to protect the individual from abuse.</td>
</tr>
</tbody>
</table>
### Appendix D

**Membership 2014/15**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audrey Williamson</td>
<td>Independent</td>
<td>Independent Chair</td>
</tr>
<tr>
<td>Michaela Beeston</td>
<td>Warrington Borough Council</td>
<td>Coordinator</td>
</tr>
<tr>
<td>Steven Reddy</td>
<td>Warrington Borough Council</td>
<td>Board Member</td>
</tr>
<tr>
<td>Steve Peddie</td>
<td>Warrington Borough Council</td>
<td>Board Member</td>
</tr>
<tr>
<td>Ann McCormack</td>
<td>Warrington Borough Council</td>
<td>Board Member</td>
</tr>
<tr>
<td>Margaret Macklin</td>
<td>Warrington Borough Council</td>
<td>Board Advisor</td>
</tr>
<tr>
<td>Rebecca Knight</td>
<td>Warrington Clinical Commissioning Group</td>
<td>Board Member</td>
</tr>
<tr>
<td>Julie Ryder</td>
<td>Warrington Clinical Commissioning Group</td>
<td>Board Advisor</td>
</tr>
<tr>
<td>Alison Lynch</td>
<td>Warrington &amp; Halton Hospital Foundation Trust</td>
<td>Board Member</td>
</tr>
<tr>
<td>Lisa Cooper</td>
<td>Cheshire, Warrington and Wirral Area Team-NHS</td>
<td>Board Member</td>
</tr>
<tr>
<td>Mike Anderson</td>
<td>Cheshire Fire &amp; Rescue Service</td>
<td>Board Member</td>
</tr>
<tr>
<td>Lorriane Page from Jan 15 Steve Cullen</td>
<td>Citizens Advice Bureau</td>
<td>Board Member</td>
</tr>
<tr>
<td>Steve Hull</td>
<td>5 Borough Partnership</td>
<td>Board Member</td>
</tr>
<tr>
<td>Paul Beauchamp</td>
<td>Cheshire Police</td>
<td>Board Member</td>
</tr>
<tr>
<td>Donna Meade</td>
<td>Cheshire Probation</td>
<td>Board Member</td>
</tr>
<tr>
<td>Ged Timson</td>
<td>Bridgewater Community Healthcare NHS Trust</td>
<td>Board Member</td>
</tr>
<tr>
<td>Helen Speed</td>
<td>Health Watch</td>
<td>Board Member</td>
</tr>
</tbody>
</table>