

Annual Report 2015/16

Our vision:

To oversee local arrangements to ensure that safeguarding adults at risk is prioritised and coordinated effectively. We are committed to continuous improvement, learning from experience and enabling vulnerable adults at risk



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Foreword

Shirley Williams - Independent Chair of the WSAB



I am pleased to present Warrington's Safeguarding Adults Board (SAB) Annual Report. The publication of an Annual Report is now required under the 2014 Care Act, but this has been seen as good practice before the Act required it and this is in fact the 5th year the SAB has produced a Report.

I have been the Independent Chair of SAB since April 2015. Implementing most of the changes required by the Care Act has gone smoothly as Warrington was well prepared and partners were demonstrating good quality safeguarding practice. I have been impressed from the beginning by the commitment to improving how the voices of people who may be at risk of abuse and neglect are heard and their views taken seriously by all partners in Warrington. This has enabled Warrington to pick up the challenges of the Making Safeguarding Personal (MSP) best practice initiative even though it was not one of the early areas to adopt this approach formally. The key message of MSP is that even if the person is at risk or has been harmed, staff should try to work with the person to achieve the outcome they want, and not just concentrate on safety. This may mean that some elements of risk remain, but, provided the person has the capacity to make that decision, and no other people are put at risk, the individual's decision should be respected. This is challenging for staff, particularly when trying to work with people who self-neglect (seen as potentially meriting a safeguarding investigation under 2014 Care Act).

The Board has experienced a number of staff changes in the last few months and now has a new manager, and, more recently, an administrator. A number of long standing representatives from Partner agencies have also changed towards the end of the 2015-16 year. Changes in personnel, particularly in complex multi-agency partnerships, can bring disruption or at least a slowing down to plans being implemented. It is notable that this report into our recent activity demonstrates that improvements have continued to be made.

I have been pleased to welcome new Board members and for the first time we now have a GP directly represented on the Board. Given the key role of GPs in identifying and supporting people who are at risk of abuse or have been abused, this is an important development.

The challenges in relation to safeguarding remain the same: how can we continue to learn and act to support adults at risk, who are unable to protect themselves, to have maximum control over their lives and decision making and remain safe? The numbers who need support to keep themselves safe are increasing, but statutory and voluntary organisations have fewer and reducing resources to assist people. Avoiding and managing the consequences of this unequal resource equation for 'at risk' individuals and for the reputation of organisations, including safeguarding boards, continues to be the major challenge for us all.

Towards the end of 2015/16 year a number of discussions about safeguarding have taken place amongst the former 4 former Cheshire localities (Halton, Cheshire West and Chester, Cheshire East, and Warrington). There has been a focus, which will continue, on how we can learn together, plan together, and be more effective in how we safeguard people with reduced resources. I am indebted to staff in the Safeguarding Unit and partner Board members whose commitment, skill, and hard work enables me to carry out my work as Chair of the Board.

Shirley Williams - Independent Chair from 1 April 2015

Foreword

Councillor Pat Wright - Lead Member for Statutory Health and Social Care



As Warrington Borough Council's Executive Member for Statutory Health and Social Care, I am very proud to take my place on Warrington's Safeguarding Adults Board (SAB) and help to realise the important pledge we have made as a council to protect the most vulnerable.

The introduction of the Care Act this year has supported us in this pledge, through finally establishing a legal framework for Safeguarding Adults Boards and through a real shift in expectations for safeguarding practice that is centred on the adult who is at risk of abuse and neglect.

This year has seen a great deal of work to ensure that local practices were in line with the new legislation alongside ensuring that the SAB itself is equipped to deliver its new responsibilities.

Maintaining an effective multi-agency approach is key to ensuring that Safeguarding Adults at Risk is part of all organisations core business.

In particular there has been a greater focus on making sure that we hear and listen to the voice of the adult in the safeguarding process. This has been a key priority for the SAB and is a principle that, as an elected member I hold very dear. I particularly value the opportunity to help promote the work of the SAB and to engage with local people and staff who are delivering care and support services. Events such as World Elder Abuse Awareness Day (WEAAD) and Dignity in Care day have been opportunities to do this and hear people's stories. They provide opportunities for us to raise awareness of the signs and risks of abuse so that people and communities can help protect themselves and others.

As part of that work, the Council has delivered 2014 Care Act training to its elected members and supported the SAB with wider engagement around the principles of empowering people including promoting their rights to live as they choose within the legal parameters of safeguarding those with capacity deficits.

Within the SAB we have ensured that our meetings start with a case study of someone affected by abuse or neglect. This is one way in which the SAB can satisfy itself about the way we are working with people who have been abused or at risk of abuse and neglect and helps us all to ground our strategic discussions in the experience of our community. This will continue to be a focus over the coming years so that the Board can be confident that their work is leading to positive outcomes for adults including respecting their right to choose.

I look forward to seeing further developments and supporting the SAB to progress its strategic vision.

Pat Wright - Executive Member for Statutory Health & Adult Social Care, Warrington Borough Council

Section 1: Introduction

The Warrington Safeguarding Adult Board (SAB) is proud to present its 2015-16 annual report. This offers the SAB an opportunity to demonstrate the good practice and achievements of the previous twelve months and identify the challenges ahead. This report sets out the work against the priorities in place for 2015-16 alongside the areas that require further development in coming months.

What does safeguarding mean?

Safeguarding aims to protect the individual's "...right to live in safety, free from abuse and neglect". Its about organisations and people working together to prevent and stop abuse and neglect, making sure that the overall wellbeing of the individual is the main focus and their views and wishes are considered. It is important that in safeguarding adults at risk, organisations support individuals to understand the risks their choices may bring and do not override their right to make personal choices, (unless their lack of capacity to do so has been confirmed by formal process).

Key changes for 2015-16

• The Introduction of the Care Act

This has been an important year for adult safeguarding. New legislation – the 2014 Care Act came in force in April 2015 and brought with it important new duties for organisations involved in adult safeguarding, with Safeguarding Adults Boards becoming a legal requirement. The SAB had done a lot of the work to prepare for these changes last year, however during the year 2015-16, SAB partners have needed to review and refresh a range of materials and some of our processes to respond to the detailed guidance and further clarification issued in March 2016. An important area has been on supporting local services to understand and deliver the changes. This is reflected in the strategic plan priorities.

• A new Chair for Warrington SAB

A new independent chair Shirley Williams was appointed in April 2015. Having an independent chair is something that safeguarding organisations really value in Warrington. This helps ensure that the SAB is inclusive, fair and transparent and when it is necessary, organisations are challenged appropriately. The new chair was able to lead the SAB utilising her considerable experience of adult safeguarding and the national networks that she has engaged with for many years.

The Care Act and the role of the SAB

The Care Act introduces safeguarding duties which apply to adults who:

- Have care and support needs (whether or not those needs meet national eligibility criteria or whether or not they are accessing any services) and;
- are experiencing, or at risk of, abuse or neglect; and/or
- As a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

Under the Care Act, a SAB has 3 core duties. It must:

- publish a strategic plan for each financial year that sets out how it will meet its main objective and what each member is to do to implement that strategy. In developing the plan it must consult the Local Healthwatch organisation and involve the community;
- publish an annual report detailing what the SAB has done during the year to achieve its objective and what it and each member has done to implement its strategy as well as reporting the findings of any Safeguarding Adult Reviews (SAR) and subsequent action; and
- arrange and conduct any Safeguarding Adults Reviews that are required (these replace the former non-statutory Serious Case Reviews), where the criteria is met.

The SAB must also have in place clear policies and processes that reflect the local service processes, roles and responsibilities; provide multi agency training that promote a clear understanding and develop preventative strategies that aim to reduce instances of abuse and neglect.

Therefore an important part of our work this year has been in making sure that all of the new legal requirements have been met and the processes and systems that support organisations with safeguarding responsibilities to work effectively together reflect the changes and are understood.

Our progress against each of these statutory responsibilities is summarised on the next few pages along with the progress on the other priorities set out in our strategic plan.

Safeguarding Principles

The Safeguarding Adults Board works with partners to embed the Safeguarding Adults Principles set out in the Care Act Statutory Guidance in all the work they do:



Warrington Safeguarding Adults Board Strategic Plan

The SABs Strategic Plan sets out our priority work areas and the key actions we will take with the aim of keeping adults 'at risk' safe from abuse and neglect, for the period 1 April 2015 to the 31 March 2018.

Our priority areas are:

1. To *Listen and Respond* to adults at risk
2. To develop a *Preventative & Learning* approach to safeguarding
3. Ensuring the *right people* are in place with the *right skills*
4. To ensure we are *checking safeguarding* and *doing the SAB's business*

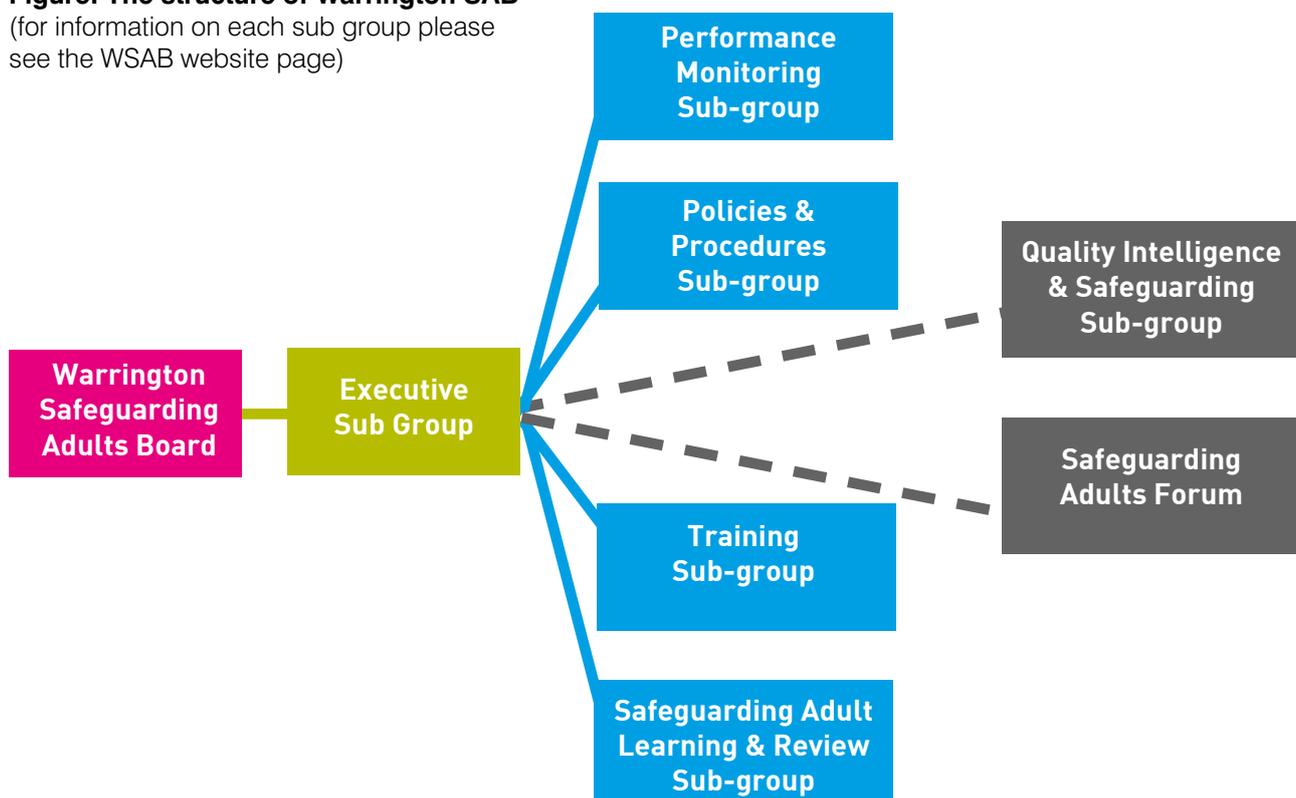
In doing our work, the SAB works closely with other local groups and boards. The plan includes how we work closely with the Safeguarding Children's Board and Warrington Domestic Abuse Partnership to make sure that we are effective as possible in areas of joint concern such as transition from children to adult services and Domestic Abuse are addressed jointly. The Plan on a Page overview of the SAB work is attached as Appendix A.

Delivery of the plan

The work we have set out to do cannot be achieved alone by members of the SAB and a range of sub groups and two reference groups are critical to helping us to achieve the aims for safeguarding in Warrington including involvement of local people and communities. The progress against the plan is set out in section 3.

Figure: The structure of Warrington SAB

(for information on each sub group please see the WSAB website page)



Who is the SAB accountable to?

Whilst the SAB is an independent statutory body, it is important that it is accountable for delivering its priorities and meeting its legal responsibilities. Publishing the SAB Annual Report and the Strategic Plan is just one way that we make sure there is accountability to our local community.

The SAB reports to the Health and Wellbeing Board twice a year initially to present the annual report and later on to showcase its achievements and challenges in the year. The independent chair also meets every three months with the chief officers from Warrington Borough Council, Cheshire Constabulary and Warrington Clinical Commissioning Group, the three statutory partners of the SAB, to discuss the SABs progress and for a formal appraisal.

The SAB also delivers presentations to Warrington Borough Council's Protecting the Most Vulnerable Committee on national and local issues that may need more scrutiny, such as the Prevention Strategy. This group is made up of Elected Members of the Council and members of the community can also attend to watch and raise issues at the end of the meeting.

Alongside these two specific scrutiny groups the SAB also links with others to be made aware of and respond to issues raised by the community, regulators and services. One of these groups is the Quality Surveillance Group which is a forum led by NHS England that brings together different organisations within the health and care system to share information and intelligence to safeguard the quality of care patients receive.

The membership and participation of Healthwatch within the SAB (the independent consumer champion) also helps to bring together and represent the views of the public on the health and care services within our area.

Section 2: Safeguarding in Warrington



What do statistics tell us?

Warrington's population is steadily growing. With longer life expectancies, there are increasing numbers of elderly and particularly very elderly people, as well as a greater number of adults living with ill-health or disabilities within our communities. This means that we will have a greater number of adults at risk of abuse or neglect and makes it more important than ever to understand the safeguarding concerns and activity that is going on in our community. This helps us to identify changing patterns of abuse and neglect and the people who are most at risk. This should help partners to use our limited resources to intervene in ways that enable people to be safe and to feel safe.

Key facts and figures

Key Safeguarding Data 1st April 2015 – 31st March 2016

Developing trends and key performance data, enabling targeted responses to safeguard adults at risk

- Rate of concerns (160 additional Safeguarding concerns were received in 2015-6)
- Low levels of reporting from members of the public and self-referrals
- Neglect (the most reported concern relating to paid providers of care)
- Most allegations relate to care in organised care settings
- A significant proportion of the risk posed is from other vulnerable adults in care settings
- Age and frailty (66% of concerns relate to people over 65 years)
- Under representation of people from ethnic minorities in the adult at risk groups
- People without capacity (52% of adults at risk of whom 3 out of 4 had an advocate)
- People with physical support needs (subject of 42% of enquiries)
- Physical abuse allegations higher for people with mental health or memory and cognition needs
- Financial abuse (more likely with socially isolated people)
- Psychological abuse (most likely allegation against an unpaid carer, such as family or friend)
- The risk remains following interventions in 11% of cases

These patterns are consistent with previous years data and the national picture against which the SAB compares

Reporting concerns¹

Raising a concern is when a member of the public or professionals report situations where an adult with care and support needs may be at risk or experiencing neglect or abuse. In Warrington we have a low threshold for making and receiving concerns that then require further consideration by the professionals involved.

In 2015-2016, 1414 safeguarding “concerns” were received. This compared to 1,254 safeguarding “alerts” the previous year. This is part of a continuing national and local trend, probably related to greater publicity about adult abuse and neglect. The concerns average at about 120 a month, with a peak this year during the summer months (which is not an established pattern).

All concerns are screened by the social work teams in the Council. This involves gathering information so the appropriate response can be identified. After screening, there are a number of possible ways to address the concerns raised, depending on circumstances, risks and complexity of the situation.

¹Prior to 2014 Care Act referred to as ‘making an alert’

These include making referrals to:

- Care management services for the social worker to assess and address individual care and support needs; or conduct a safeguarding enquiry
- Care Quality Team to seek assurance of the safety and effectiveness of the care services provided; or
- Adult safeguarding for a full or complex multi-agency investigation that may include investigations led by other agencies such as the police

Some of the concerns are found on further examination, not to require further action. This can be for a number of reasons including; the situation is already resolved; further enquiries provide assurance that concern is not warranted; the person does not want support and the risks have been assessed as low; or the concern needs to be passed on to another authorities area.

Over the past 12 months around 34% of concerns have resulted in an adult S42² safeguarding enquiry, of which 16% were dealt with by care management services and 18% by specialist staff. 33% were referred onto contracts and commissioning.

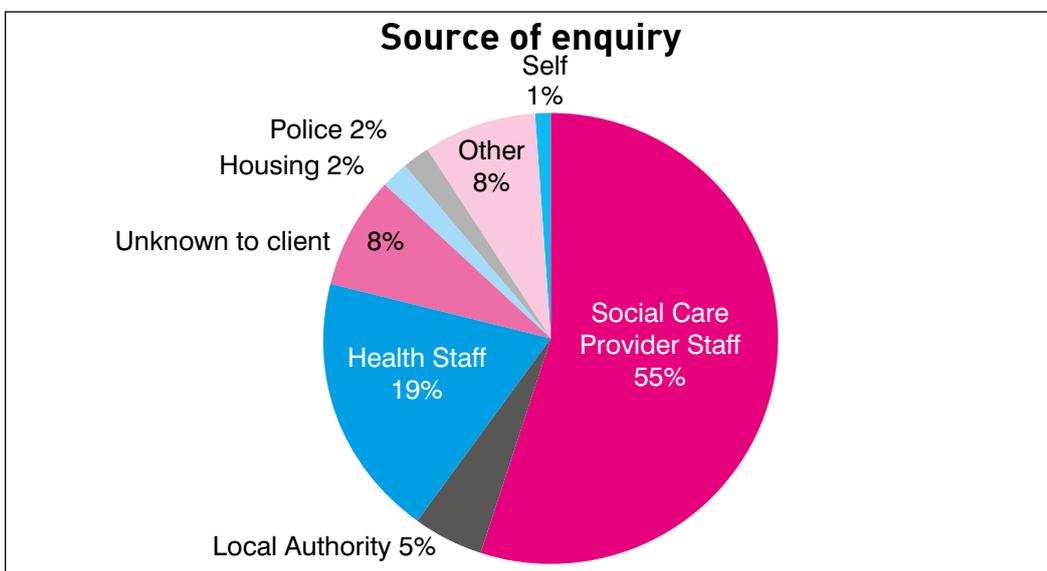


Figure 1: who reported concerns?

Everyone has a responsibility to report safeguarding concerns when they believe that an adult with support and care needs may be at risk. The majority of safeguarding enquiries result from concerns raised by people who are working in social care provider services; and the vast majority of these are working in residential and nursing homes. This is positive in the sense that ease of reporting reflects a culture of transparency, candour and a partnership approach to protecting people and addressing instances of possible neglect, abuse or poor care to prevent reoccurrences.

Enquiries resulting from information provided by members of the public are much lower and there were only 4 people who self-reported concerns. This is why the SAB will continue to raise public awareness of the signs and symptoms of abuse and neglect.

²Section 42 of the 2014 Care Act states that when the local authority has reasonable cause to suspect that an adult in its area has needs for care and support and is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Allegations about the person responsible

Analysis of the concerns that went on to Section 42 enquiries shows that social care provider staff were the largest group alleged to be responsible for the cause of the concern. In many of these cases, the issues were associated with the quality of care received; with 56% of all enquiries looking at allegations of possible neglect (23% of these enquiries were in relation to concerns about physical abuse, a significant proportion of which was related to poor handling and lifting of people).



Figure 2: Who was alleged to be the cause of the harm or risk?

Where the alleged cause for concern was a person who was someone known to the individual for reasons other than their job, the majority were other adults with care and support needs, in the same care settings and the main concern was physical abuse (see diagram below). This can reflect issues with care providers managing the care needs and challenges of people who are jointly receiving their services and sometimes that these adults are not having their needs reviewed and met appropriately, leading to risks to themselves and others. Where issues such as this are identified, there is a range of preventative actions that need to be taken. Last year the SAB helped to promote training for providers in relation to managing challenging behaviour and highlighted the need for quality care in particular for people with dementia displaying challenging behaviour.

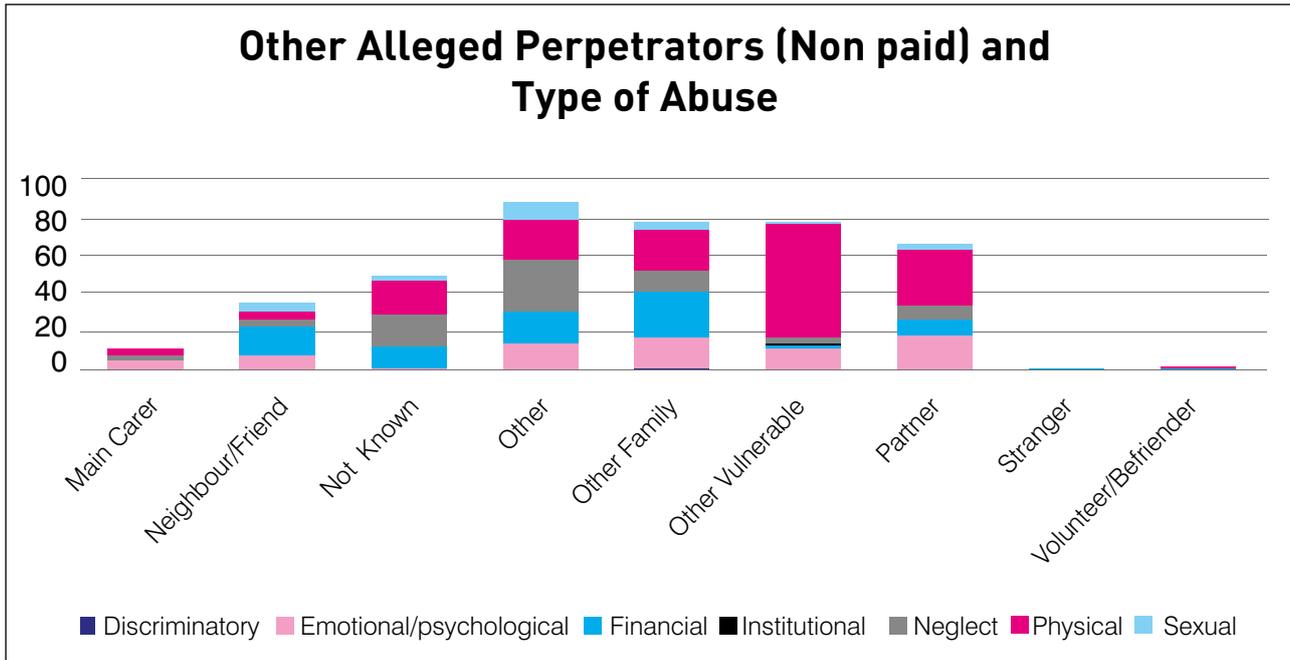


Figure 3: Allegations against other people known to the adult (non paid)

For non-professionals alleged to have caused concerns, the picture is more complex than for professional staff. Psychological and financial abuse is far more significant in these cases but the patterns vary across the different relationship types. Financial abuse is the most common concern regarding general family members followed by physical abuse, whilst physical abuse is the most common concern regarding intimate partners. Financial abuse is the most common allegation where the person of concern is a neighbour and psychological abuse is the most common concern reported about a carer. The latter reflects recent published research.

Profile of people at risk and the types of risk

In the year 2015-16, 62% of the people who were subject to safeguarding enquiries were female. This pattern varies little from year to year and reflects national trends and the population of people who access social care services. The majority of adults were over 65 years old; again this reflects the population who access social care services, with 34% under and 66% over 65. Almost 50% of all enquiries related to people in the age band 75 – 84 and 85 -94.

Only 1.9% of adults were from an ethnic minority group which is a significant under representation from our local population, but again broadly reflective of the population who access social care services. This is an area that the SAB has identified previously as an area for action and engagement with minority ethnic groups and other “invisible” populations is part of our strategic plan.

In 52% of cases, the adult was deemed to lack capacity to make some decisions. In these cases 76% had advocacy provided. This is an increase of 10% on the figure last year. The Care Act requires that people who have substantial difficulty in being involved in the safeguarding process have the support of an advocate and making sure that there are good and appropriate advocacy services to support them is something that the SAB also monitors.

The type of alleged abuse investigated also varies by age group and the type of support and care needs. The table below shows that the most common allegations for adults of working age were physical and psychological abuse, although levels of financial and sexual abuse were significant proportions of the total allegations. For older adults, physical abuse and neglect concerns form three quarters of all enquiries

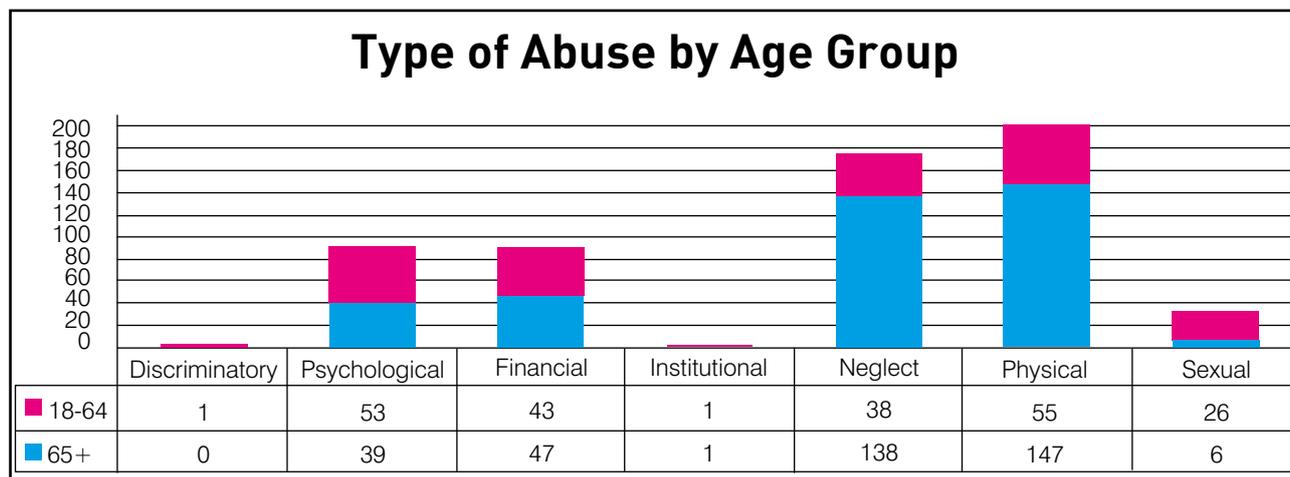


Figure 4: Type of Abuse by age group

The kind of alleged abuse also varies with the primary support need of the adult. Physical abuse and neglect are the most common concern overall at 34% and 30% respectively, with physical abuse being significantly the highest category for allegations involving adults requiring support with memory and cognition as well as those requiring mental health support. Neglect concerns are slightly higher for those requiring support with their physical needs or a learning disability. Adults with a need for physical support (42 %) or mental health support (30%) were by far the most likely to be the subject of an enquiry into alleged abuse or neglect.

| Type of Abuse | Physical Support | Support for Visual / Hearing / Dual Impairment | Support with Memory & Cognition | Learning Disability Support | Mental Health Support | Support for Social Isolation or Other Support | No PSR | Grand Total | % |
|---------------------------|------------------|--|---------------------------------|-----------------------------|-----------------------|---|-----------|-------------|----------------|
| Physical | 83 | 1 | 21 | 11 | 70 | 3 | 13 | 202 | 33.95% |
| Neglect | 90 | 1 | 17 | 13 | 34 | 4 | 17 | 176 | 29.58% |
| Emotional / psychological | 28 | 1 | 5 | 9 | 34 | 5 | 10 | 92 | 15.46% |
| Financial | 41 | 0 | 6 | 4 | 28 | 6 | 5 | 90 | 15.13% |
| Sexual | 6 | 0 | 0 | 6 | 12 | 3 | 5 | 32 | 5.38% |
| Institutional | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | 0.34% |
| Discriminatory | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0.17% |
| Grand Total | 248 | 3 | 49 | 43 | 179 | 21 | 52 | 595 | 100.00% |

Table 1: Type of abuse broken down by Primary Support Reason (PSR)

The highest category for those who require support for social isolation or other needs is financial abuse and then emotional/psychological abuse which is a very different pattern. Adults with mental health support needs are more likely to be identified as at risk of sexual abuse, however this rate of abuse form a larger proportion of the enquiries undertaken with people with learning disability, social isolation needs or other (at 14%), because overall the levels of safeguarding enquiries are lower in respect of people with those needs compared to those with mental health needs.

Domestic abuse and safeguarding

There were 42 safeguarding concerns which were also recorded as domestic abuse. In terms of age range, the largest group were working age adults in the age range 18-64. Whilst the majority of adults were female, there were more males than is the case in universal domestic abuse statistics. Almost half of women who were felt to be at risk had physical support needs, whilst the most common support need for men was mental health.

| Age Group | Physical Support | Support for Visual/Hearing/ Dual Impairment | Support with Memory & Cognition | Learning Disability Support | Mental Health Support | Support for Social Isolation or Other Support | No PSR | Grand Total |
|--------------------|-------------------|---|---------------------------------|-----------------------------|-----------------------|---|----------------|-------------|
| 18-64 | 3 | 0 | 0 | 1 | 11 | 1 | 8 | 24 |
| 65-74 | 5 | 0 | 0 | 0 | 1 | 0 | 0 | 6 |
| 75-84 | 4 | 0 | 0 | 0 | 2 | 1 | 0 | 7 |
| 85-94 | 4 | 0 | 0 | 0 | 1 | 0 | 0 | 5 |
| Grand Total | 16 (81.1%) | 0% | 0% | 1 (2.4%) | 15 (35.7%) | 2 (4.8%) | 8 (19%) | 42 |

Table 2: Domestic Abuse Safeguarding Cases by Age Group and Primary Support Need (PSR)

| Gender | Physical Support | Support for Visual/Hearing/ Dual Impairment | Support with Memory & Cognition | Learning Disability Support | Mental Health Support | Support for Social Isolation or Other Support | No PSR | Grand Total |
|--------------------|-------------------|---|---------------------------------|-----------------------------|-----------------------|---|----------------|-------------|
| Female | 14 | | | | 10 | 1 | 5 | 30 (71.4%) |
| Male | 2 | | | 1 | 5 | 1 | 3 | 12 (28.6%) |
| Grand Total | 16 (38.1%) | 0 | 0 | 1 (2.4%) | 15 (35.7%) | 2 (4.8%) | 8 (19%) | 42 |

Table 3: Domestic Abuse Safeguarding Case by Gender and Primary Support Need (PSR)

People with care and support needs can be particularly vulnerable to this form of abuse and less able to protect themselves. The SAB and WDAP each share a series of actions in their strategies to help ensure close and effective work between safeguarding and domestic abuse services.

Safeguarding Outcomes

In terms of completed enquiries no further action was required in 26% of cases and the risk was reduced or removed in 63% of cases. In approximately 11% of cases, the risk was judged to remain. This is very little different from the previous year when the risk remained in 12% of cases.

| SG2c Risk Management | Source of Risk | | | Total | % |
|-------------------------|----------------|------------|------------|------------|----------------|
| | 1 Social Care | 2 Known | 3 Unknown | | |
| No further action | 37 | 50 | 31 | 118 | 26.18% |
| Risk reduced | 73 | 90 | 48 | 212 | 47.12% |
| Risk remains | 4 | 32 | 18 | 49 | 10.99% |
| Risk removed | 34 | 20 | 13 | 71 | 15.71% |
| Grand Total | 148 | 192 | 110 | 450 | 100.00% |

Table 4: Impact on risk reduction after S42 Enquiry

The reasons why a risk would be judged to remain can vary and include an adult exercising choice in declining support offered. For example, by continuing to engage in a relationship or lifestyle choice which presents risks but which they do not wish to discontinue. This reflects the principles of Making Safeguarding Personal.

What do Adults at Risk tell us?

Each year the Local Authority is required to undertake a statutory Adult Social Care Survey which is a national canvass of people's views and opinions that are in receipt of care and support services. 994 requests were sent this year and led to 417 returns – a 42% response rate. This represents an almost 4% increase on previous year's levels.

Do people who receive social care services feel safe?

This year's national survey results show that again Warrington has a higher proportion of people receiving social care services who say they feel safe than is generally the case across the North West and England. This year there has been a small improvement from last year with rates locally rising almost 3%.

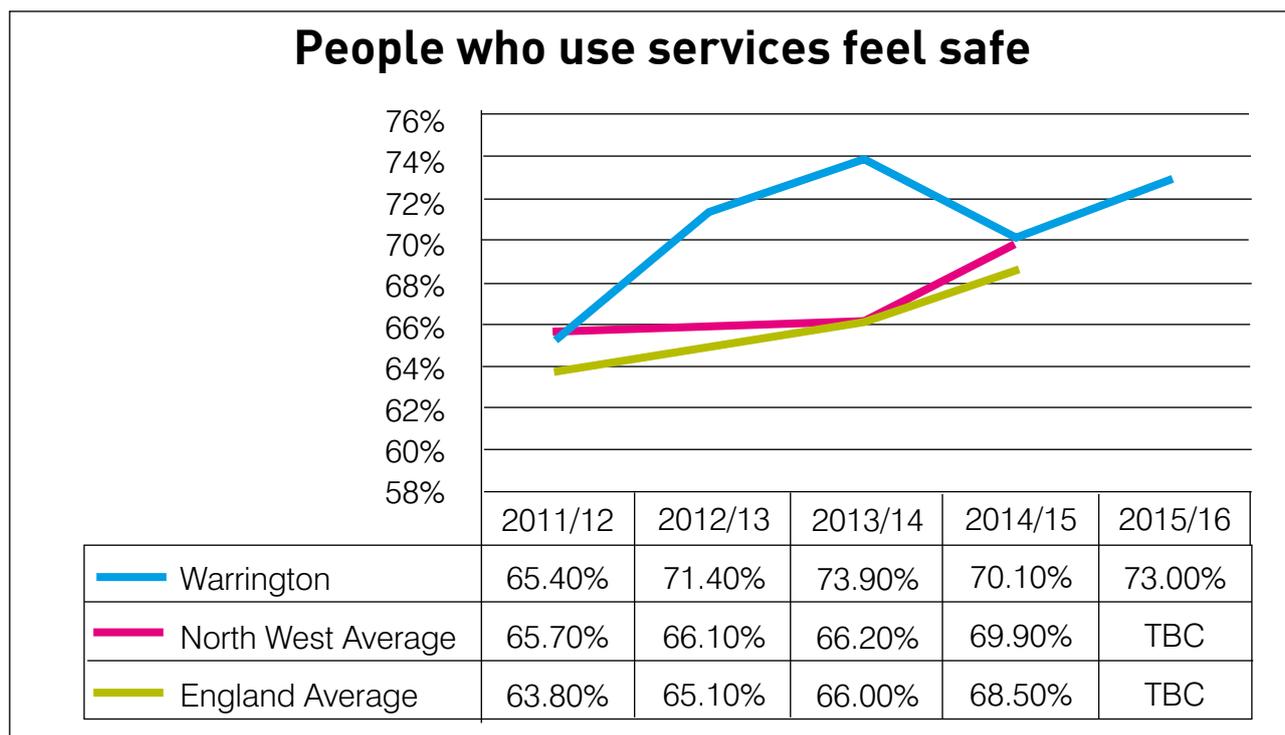


Figure 5: Adult Social Care Outcome Framework (ASCOF - Measure 4a, HSCIC).

Services help to keep people safe

In Warrington the survey also indicated that a high percentage of those asked said services have helped them to feel safe.

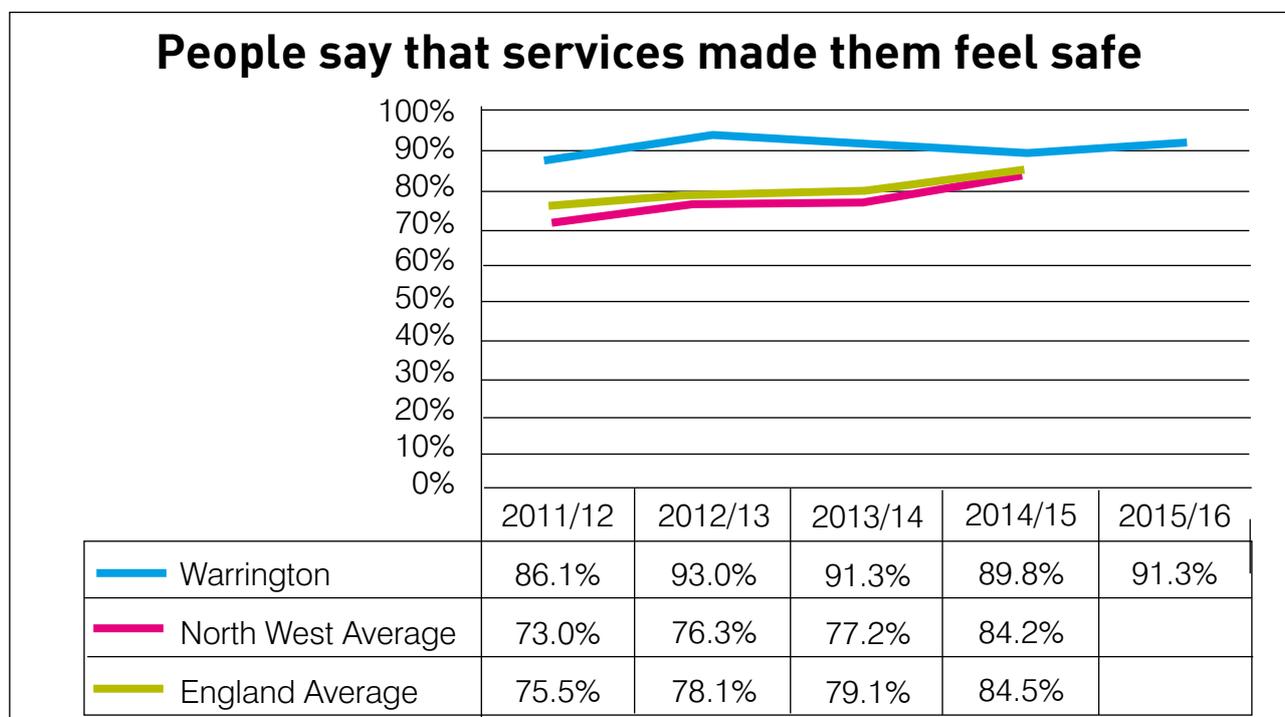


Figure 6: Adult Social Care Outcome Framework (ASCOF - Measure 4b, HSCIC).

Overall Warrington has remained significantly above the national and regional averages over the last four years on this indicator.

Local Safeguarding survey feedback

Adults who are directly involved in a safeguarding incident are asked at the end of the process, whether they are willing to provide feedback so that the agencies involved can try to understand the experience from their perspective. This year 13 service users took the time to give their feedback. Despite small numbers the comments provided give valuable insight into the experience of the safeguarding process and what the SAB should focus on to help improve it.

Returns this year show only 58% of the adults who responded to the survey said that they told someone straight away when they realised something was wrong; and this is a reduction from last year. Comments from the surveys reflect this is partly because some people are unaware of the possible abuse or neglect before others identify it. However there can be other barriers to reporting.

Every person who completed the survey reported that they felt listened to and supported (up by 9%) and all said that this was what happened all the way through the process (up by 19%). As last year all the adults felt able to tell people how they were feeling. This is very positive and indicates that once people come forward they are receiving the response we would expect and in line with Making Safeguarding Personal (MSP). This is further supported by the words people circled to describe their experience...



Listened to...
involved

There was also an increase in the use of the term “in control” however this was only from 23% of adults.

It is clear that whilst most professionals may be able to engage, support and listen to adults who are at risk, enabling them to feel in control of their situation is challenging and hard to achieve. Being person centred means whenever possible supporting adults to make the choices that they feel are right for them and that their overall wellbeing is central to this. At the end of the process, 23% of people stated they did not feel safer. In some cases the enquiry may show that the initial concern to be unjustified, in others the adult may not accept that they are unsafe when others have concerns and some adults at risk may not want to choose the safest option if in their view this would have a detrimental impact on things that they value more, for example continuing with a relationship in which there are risks. Although the majority of people told us that there was nothing more that could have been done differently the SAB would like to understand more about the reasons behind some individuals not feeling safer and also where the lack of satisfaction relates to the safeguarding process itself.

The comments below illustrate a range of outcomes reported by adults at risk following the safeguarding process.



17% of people who responded to the survey said they would have preferred some independent support. Whilst there has been a significant increase in the use of advocacy within safeguarding and social care assessments, the emphasis is often on people who do not have capacity to make decisions. This supports the need to further promote advocacy support for people, who may have capacity, but need independent support during safeguarding investigations.

Advocacy

Independent advocacy is a statutory requirement and is key to upholding the rights of some of the most vulnerable members of our society - adults who lack capacity for serious significant decisions, but who are also without the support of family or friends. Every quarter the SAB receives statistical and outcome information from the local Independent Mental Capacity Advocacy (IMCA) provider, Together for Wellbeing. This shows that Warrington uses a higher level of IMCA advocacy than neighbouring councils. This is increasing every year and the as the table below shows.

| Mid-2012 Census Population Estimate | HALTON 125,722 = 19% | KNOWSLEY 145,903 = 23% | ST HELENS 175,405 = 27% | WARRINGTON 202,709 = 31% | Totals 649,739 |
|-------------------------------------|-------------------------|---------------------------|----------------------------|-----------------------------|-------------------|
| Serious Medical Treatment | 10 (13) | 14 (16) | 8 (8) | 38 (25) | 70 (62) |
| Change of Residence | 5 (3) | 16 (16) | 10 (12) | 32 (28) | 63 (59) |
| Adult Safeguarding | 6 (7) | 8 (31) | 2 (2) | 7 (5) | 23 (45) |
| Care Review | 1 (1) | 0 (0) | 1 (2) | 5 (6) | 7 (9) |
| Inappropriate | 4 (16) | 10 (18) | 4 (7) | 19 (15) | 37 (56) |
| DOLS | 5 (4) | 10 (7) | 55 (21) | 25 (22) | 95 (54) |
| Paid RPR | 12 (3) | 16 (2) | 42 (12) | 86 (12) | 156 (29) |
| Totals | 43 (47) | 74 (90) | 122 (64) | 212 (113) | 451(314) |

Table 5: Advocacy Service use across areas and type

Whilst the IMCA service was only used in 7 safeguarding cases, our safeguarding statistics show that 176 people who needed advocacy support received it – this was often a family member or friend but Speak Up, a local advocacy provider has been commissioned when an independent advocate is required.

| People involved in concluded safeguarding enquiries | 18-64 | 65-74 | 75-84 | 85-94 | 95+ | Total |
|---|-------|-------|-------|-------|-----|-------|
| S42 Enquiries 2015-16 | 151 | 65 | 117 | 107 | 10 | 450 |
| Numbers of people who had substantial difficulty in engaging in decisions | 45 | 30 | 80 | 70 | 7 | 232 |
| Numbers of people where an Advocate/Support Provided | 51 | 17 | 66 | 32 | 10 | 176 |

Table 6: Rates of Advocacy support in Safeguarding enquiries

Care quality

The SAB is keen to ensure that there are high standards in care across Warrington to reduce the possibility of poor care escalating into safeguarding concerns. This is managed by the SAB through regular reports and assurances from the Quality Intelligence and Safeguarding Group which provides an overview of care issues across homes and health providers in the area. This is further supported by the membership of the CCG and key local NHS Trusts as the SAB requests feedback about the findings of CQC inspections and any action plans that they put in place to address areas of concern. The SAB will also regularly request additional information about issues that are of particular national or local interest such as the Transforming Care agenda or mental health service provision. Below represents some summary data and overviews of care quality management within Warrington in 2015-16.

Warrington Hospitals Current CQC ratings

In 2015-16 Warrington Hospital presented its inspection results to the SAB along with its action plan to address areas of concern. This has led to a further piece of research by the SAB around members of the community coming into acute services with pressure ulcers and no visible service input to identify actions that can be taken to reduce this issue.

| Provider | Rating | Date |
|--|---|----------------------|
| Warrington Hospital (Warrington and Halton Hospitals NHS Foundation Trust) | Requires improvement | July 2015 |
| Hollins Park Hospital & Fairhaven Young Peoples Unit (5 Boroughs Partnership NHS Foundation Trust) | Requires improvement | February 2016 |
| Spire Cheshire Hospital (Spire Healthcare Ltd) | Not required to take any further action | September 2013 |
| St Mary's Hospital (St George Care UK Limited) | Good | May 2016 |
| Lea Court & Abbey Court (Alternative Futures Group Limited) | Good & Requires improvement | June 2016 & May 2016 |
| Arbury Court (Partnerships in Care Limited) | Outstanding | June 2016 |

Table 7: Local Hospital CQC ratings

Warrington Care providers

In 2015/16 86% and 84% of care homes and domiciliary care services, respectively, were considered to be compliant (rated good or outstanding) against the Care Quality Commission's (CQC) standards. This figure comes from a combined analysis of services against the new and previous CQC approach to inspection.

At the end of 2015/16, there were 16 services in total that were assessed as red or amber against the Warrington Borough Council (WBC) care quality monitoring framework. Being 'amber' means that the service is on an improvement plan. In many instances this simply means that some quality concerns have been identified and the service would benefit from close monitoring and support to improve standards. Monitoring involves regular visits by a Care Quality Monitoring Officer to see progress against the agreed improvement areas. They will also offer advice, share good practice and signpost to other guidance and resources available. This continues until the CQC standards, and the terms and conditions of the contract with the council are met.

Where there are serious and/or ongoing concerns about the safety of service users which cannot be addressed by any other means the Council may need to take contractual action, such as suspending purchasing arrangements. In certain circumstances where providers are failing to meet regulatory standards CQC may also place restrictions on the service. Restrictions on purchasing are only considered as a last resort where there are serious and ongoing concerns about the safety of service users which cannot be addressed by any other means. In 2015-16, 2 services were rated as 'red' and were subject to contractual action where suspension of purchasing arrangements and increased monitoring was in place.

Prison Services

The Care Act 2014³ is clear that safeguarding processes within prisons are managed by prison governors rather than the Local Authority. This does not mean that these processes work in isolation as there is an expectation that prison governors ensure information around processes and lessons learnt are shared with local SABs. The SAB has identified prisons as associate members to the Board who will in 2016 attend on an annual basis to provide assurance to the Board of their internal processes and that lessons are being learnt from any incidents. Alongside this safer custody representatives from both HMP Thorn Cross and Risley attend the Safeguarding Adult Forum to ensure they are connected to practice discussions and activity.

Alongside the safeguarding processes there is also a need to ensure that prisons link effectively with social care services so that the care and support needs of prisoners are met. In 2015 Warrington Borough Council implemented the prisoner care service at HMP Risley and Thorn Cross to ensure that social workers and occupational therapists are providing support to prisoners. This scheme at HMP Risley was visited by Lyn Romeo, Chief Social Worker for Adults at the Department of Health, in 2015 as an example of innovative practice.

³Care Act 2014 paragraph 14.6 acknowledges that within prisons and approved premises it is the prison governor and National Offender Management Service (NOMS) respectively that have the responsibility to meet the statutory safeguarding adult duty and not the local authority.

“I was impressed to see how successful the service is proving to be in enabling prisoners with care needs, some quite complex, to be accommodated satisfactorily in a prison while serving their sentence. I am keen to promote the learning from the implementation of this model and their collaborative approach to other areas in England.”

Learning from complaints

The WSAB receives very few complaints directly in relation to safeguarding activity and in 2015-16 none were made directly. The WSAB has committed to gathering further intelligence around complaints across partners to enable monitoring of trends and themes cross the partnership in 2016-17.

In this period one complaint was made into the Local Authority complaints team in relation to satisfaction with the outcome of a safeguarding investigation which occurred in 2014. This case was identified as the Safeguarding Managers work closely with the complaints team to ensure that any complaints with safeguarding issues are responded to and addressed. The complainant's issues with a delayed investigation process were acknowledged and it was confirmed that since 2014 Safeguarding Managers were in place to lead investigations to ensure that safeguarding investigations were timely, person-centred and robust. Thus, this incident has not highlighted any new learning for 2015-16 as processes have significantly changed since the case occurred to ensure no further similar incidents.

Section 3: Progress against our priorities



The following sections summarise some of the key areas of progress that the SAB has made in each of our priority areas with future areas for focus for 2016-17. community with confidence in the quality of safeguarding adults work in Warrington.

In 2015-16 we focussed on:

1. Listening and Responding to Adults at Risk

Why it's important...

It is important that the SAB understand the realities of adults at risk in Warrington and their experiences; so that services can respond appropriately to their needs and the SAB can ensure that its priorities are the right ones. We need to gain assurance that the adult is at the centre of what all partners do. We also want to ensure professionals in Warrington are sharing information appropriately to help protect individuals and their best interests.

What we have achieved...

✓ Refreshed the Information Sharing Protocol

SAB agencies agreed to a revised information sharing agreement that will support us to better share information appropriately in safeguarding.

✓ Included an Adult's story at every Safeguarding Adults Board

At every SAB meeting we hear a story about the experience of an adult at risk Warrington. This ensures we remain focussed on the real life experiences of people to keep partners focused on achieving improvements on their behalf.

✓ Implemented making Safeguarding personal audits

We made sure that in the safeguarding audits, people's wishes and feelings were being properly taken into account and that their feedback and satisfaction with the outcome of the investigation was sought and recorded.

✓ Reviewed the findings of the Making Safeguarding Personal Pilot and sought assurance that this was being embedded in local practice

We identified the next steps from the Local Authority Making Safeguarding Personal Pilot to explore how to embed this into all partners' safeguarding activity. Our experiences mirror the national picture in that there are some barriers to implementing a truly genuine personalised approach such as the need for a wide cultural shift across all organisations to achieve real change. Further details of these issues will be available in more detail in the Making Safeguarding Personal Temperature Check Report from ADASS in 2016/17.

✓ We monitored the use of advocacy for people who lack capacity to make major decisions and reviewed the impact advocacy had on the outcomes for the person.

In addition to receiving quarterly reports from the IMCA service, we heard some individual stories from advocacy services at the SAB and valued both the support given and on occasions the challenges made to services, so that they were supported to access their rights.

✓ We reviewed and promoted the feedback survey that tells us about the experience of adults who have experienced safeguarding.

The survey was reviewed with local advocacy services and people with care and support needs and we have tried to encourage and promote its completion. The results are monitored by the SAB every quarter.

✓ Recognised our diverse and 'invisible' communities

We started the process of exploring what is known about our emerging communities (referred to as 'invisible' communities) and where the gaps are. We learnt that our agencies may lack awareness, and members of those communities may lack awareness of what agencies can offer them. We will do more work with local agencies to identify activities that can be undertaken to ensure all residents are included within our awareness raising and preventative activity.

What's next?

- Make sure that all agencies adopt a Making Safeguarding Personal approach, not just within safeguarding enquiries
- Develop approaches to identifying and working with our invisible communities
- Work with our local groups to re-design our awareness raising materials
- Develop and monitor new outcome measures from the safeguarding process to see if peoples desired outcomes have been achieved
- Evaluate the impact of advocacy

2. Developing a preventative and learning approach to safeguarding

Why it's important...

Focusing on prevention in safeguarding and learning from things that go wrong are key priorities in the implementation of the Care Act and are vital if we are to reduce experiences of abuse and neglect. We can also share and learn from best practice.

What we have achieved...

✓ Further developed our Prevention Strategy

We undertook a significant consultation with local organisations and groups to help inform our Strategic Plan priorities and to identify the priorities for local people in terms of preventing instances of abuse and neglect.

✓ Implemented a Safeguarding Adult Review Process

We developed a process for considering and conducting Safeguarding Adult Reviews and making sure that the SAB could learn from cases, particularly where organisations could have worked better together to prevent abuse and neglect. We commissioned an independent person to carry out a Learning Together model review of the death of a resident to explore any lessons that could be learnt for our practice. This is discussed in more detail in Section 5.

✓ Sharing lessons learnt nationally

It is important that the SAB also learns from national enquiries and findings and we have systems in place to do that through the SARL sub group. This year this included learning from the nationally reported death of Connor Sparrowhawk and the *“Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015”* which followed it. This has led to assurances being sought around our local NHS death review processes.

✓ Ensuring awareness of Regulation 28⁴ Notices issued by the Coroner

The SAB has discussed a number of national cases where coroners have identified the need for organisations to learn from incidents to prevent future deaths, for example those caused by fire. This has led to us taking action to raise awareness within our local community. We have also agreed a process for all relevant Regulation 28 notices issued in Warrington to be notified to the safeguarding team so that the SAB is assured appropriate action is being taken.

✓ Raising awareness around Self-Neglect

Self-Neglect can be a very challenging area for people and organisations who work with local communities; and it requires a sensitive and respectful response to people's life choices, whilst focusing on assisting them to reduce the risk of harm to themselves and others. A workshop for over 70 frontline professionals was held to explore appropriate responses to people who self-neglect. We also consulted practitioners on requirements for a local policy, guidance, and other resources to assist them in their practice.

✓ Auditing safeguarding practice

The SAB commissioned two themed audits during the year; one around safeguarding concerns screened out after a risk assessment and the other exploring low to medium risk concerns overseen by social workers, rather than the specialist safeguarding team. This provided assurance around decisions that had been made.

What's next?

- We want to focus more with the Community Safety Partnership on local incidents of hate crime, particularly those that are disability motivated and receive assurance that activity and resources are appropriately targeted
- We will work to raise awareness of modern slavery across the area
- We want to further develop processes to share learning and raise awareness of the work of the SAB, including lessons learnt from SARs
- We want to develop a repository of resources around Self-Neglect Policy statement to support frontline professionals to respond to such cases robustly
- We want to develop more systematic multi agency audits of safeguarding practice

3. Ensuring the right people are in place with the right skills

Why it's important...

It is vital in safeguarding work to ensure that people who work with adults at risk are clear about their roles and responsibilities and have the skills and knowledge to prevent and respond to abuse and neglect.

⁴The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013.

What we have achieved...

✓ **Launched revised Procedures and Practice Guidance**

We updated and amended our procedures and practice guidance to ensure it reflected the new Care Act requirements. These were promoted on a dedicated website page. We also amended our training sessions to ensure they reflect the local procedures and changes to practice in light of the Care Act.

✓ **Collaboration with Warrington Safeguarding Children Board (WSCB)**

We commissioned a SAR in association with the Children's Board and staff from across children and adults services worked together on the review and practitioner teams to identify the learning. Joint training was also arranged for practitioners around the Sexual Assault Referral Centres (SARC) and Multi-Agency Public Protection Arrangements (MAPPA). We also collaborated with the WSCB to raise awareness with schools about the impact of bullying and hate crime.

✓ **Reviewed Multi-agency training needs**

We wanted to make sure that local training was in line with best practice, and to do this we used the Bournemouth Framework for 2015 and also considered the draft NHS Intercollegiate document to review and develop our training plans. We have also promoted a range of other local training to SAB members and organisations such as Prevent training –the government programme to prevent.

✓ **Developed training**

Care Act Training was designed and delivered to frontline social workers to make sure they understand the new Care Act expectations and also to help them carry out robust investigations.

✓ **Supporting Education providers to develop masters level CPD**

We have worked with John Moore's university to help develop a master level course for safeguarding aimed at developing advanced practitioners.

✓ **Promoted closer working with Warrington Domestic Abuse Partnership**

We have worked closely with the WDAP to promote Domestic Abuse training and encourage referrals into Domestic Abuse services. We also ensured that the data on Domestic Abuse highlighted those adults with care and support needs and reported to the Safeguarding Adults Board each quarter. We also worked together at Disability Awareness Day to jointly promote the work of both partnerships.

✓ **Provided additional alternative learning opportunities to a range of organisations**

The local Safeguarding Adult Forum provides a good opportunity to share new information on a broad range of safeguarding issues. This year this included a presentation on a modern slavery from the author of a regional Serious Case Review (SCR) on the exploitation of a young person with disabilities in domestic servitude.

What's next?

- We want to continue to improve local understanding of the Mental Capacity Act and how it should be helping to protect rights and improve wellbeing of adults with care and support needs
- Further development of multi-agency safeguarding training including the Care Act training
- Further development of the data and best practise on domestic abuse and adults with support needs and older people.

4. Ensure we are checking and doing SAB's business

Why it's important...

The SAB is the strategic partnership that has been established to hold agencies to account and provide assurance that local safeguarding arrangements and partners are helping and protecting adults in Warrington. This requires us to have a number of key business arrangements in place to provide the structure and processes to do this work.

What we have achieved...

✓ Created an Escalation Policy

It is important in safeguarding work that professionals are able to raise concerns both about their own and other organisations and that where necessary these can be escalated up to the SAB.

✓ Development of a multi-agency safeguarding investigation pathway

The SAB asked for further work to be undertaken about how individual agency investigation processes fitted in with the Care Act requirements. The aim was to develop a clearer pathway for cases so that single agencies were clear when they could lead investigations themselves and when they must be referred for independent investigation.

✓ Development of SAB Governance

A constitution was drawn up for the SAB in 2015 to ensure that partners were clear regarding expectations and that the SAB was transparent about how it would make decisions, resolve disputes and monitor membership. This was implemented in April 2015 as the SAB was established as an independent body. Alongside this, Memorandums of Understanding were also reviewed and developed to give clarity to agencies and their nominated SAB representatives as to the expectations of their role as a SAB member. The SAB also reviewed its Performance Framework which describes the arrangements it has in place to scrutinise safeguarding performance and activity within the area.

✓ Held partners to account

The SAB has implemented processes that require partners to report on their inspections or serious incidents to allow the partnership to scrutinise the action being taken. This year we have had presentations from Warrington and Halton Hospital Foundation Trust

regarding their action plan as a result of their inspection. We have also reviewed a regulation 28 Notice for 5 Boroughs Partnership to seek assurance about how the agency was planning to address the issues the coroner raised. The SAB also received a report from the Care Quality team and the CCG regarding the quality framework and the way in which they assure that people who receive care services receive quality care. Links have also been developed with the local NHS Quality Surveillance Group to ensure the SAB is aware when there are concerns or action being taken around health and care providers.

✓ **Built links with specialist services**

The SAB often invites specialists from other fields to discuss their area and explore developments with adult safeguarding. One example for this year was the attendance of the Local Coroner to discuss safeguarding experiences and identify any barriers to effective working.

✓ **Monitored case reviews**

The SAB has received regular updates from its learning and review sub group regarding progress against actions from case reviews undertaken in this period.

✓ **Established an Executive Sub Group**

The SAB has trialled an executive sub group within this period to support the mainboard group to focus time where it was most needed. The Executive sub group now sets the agendas to ensure the SAB focuses on key priorities as agreed by the wider membership. It also identifies key issues to be escalated to the SAB mainboard for wider discussion.

What's next?

- Revising our performance framework and data set to ensure activity is driven by intelligence.
- We want to develop our links to prisons and education services in the local area to receive assurances about safeguarding activity.
- Securing a sustainable Safeguarding budget moving forward.
- Developing and implementing a multi-agency case audit process to provide greater assurance of effective safeguarding practice.

Section 4: What difference have we made?



It is critical that in doing our strategic work, the SAB is making a difference to the real life experience of adults who we seek to help empower and protect. As part of this work, the SAB looks for evidence that agencies are following the MSP approach and focussing their work on the adult at the centre of a safeguarding concern. We have chosen to bring together several case studies to demonstrate how the six principles of adult safeguarding are reflected in practice in Warrington. These case studies demonstrate how across agencies we are working with “Adults at Risk” to safeguard them from abuse and neglect.

Empowerment

Paul⁵ lived alone in a bungalow after his wife passed away which led to a significant increase in his alcohol intake. In 2011, concerns were raised around possible financial abuse of Paul by young people he was allowing in his property. After the police raised concerns Paul agreed to move temporarily into a sheltered accommodation placement. Sadly, Paul had developed alcohol related Dementia and this had left him without the capacity to decide on where he should live afterwards. As a result a Best Interests Assessor was allocated as required by the Mental Capacity Act 2005⁶ who agreed that a residential placement in Warrington would be in his Best Interests.

⁵This case study has been anonymised to protect the person's identity

⁶The Mental Capacity Act 2005 sets the legal framework for professionals to assess an individual's capacity to make a specific decision at a specific point in time. Where someone lacks capacity to choose where to reside and is unable to agree to the placement and is likely to be supervised and unable to leave that setting it triggers the Deprivation of Liberty Safeguards. This includes an independent person assessing what is in the persons Best Interests to make sure placements are suitable and the best option for the individual.

At the 6 month review of the placement the Best Interest Assessor was concerned that Paul was not settled and was asking leave. The assessor authorised the placement for a further 6 months but set conditions for the Manager to explore alternative less restrictive environments and for Occupational Therapists (OT) to assess if Paul could go on trips out. The OT and Paul's social worker completed a joint risk assessment looking at aspects like road sense and made a best interest decision for Paul to be able to go on his own to the local paper shop. This was made possible by involving the Council's Telecare team who were able to provide a piece of equipment called a BUDDI system. This is a GPS tracker that would send an alert to his care home if Paul went beyond the designated distance. As a result of using this technology Paul was able to extend his trips out alone until he was able to leave the home in the morning and return at the end of the day. Paul demonstrated during this time that he would not drink alcohol, go beyond the agreed areas, return on time for his required medication and could safely manage on his own. This provided the evidence needed to safely return Paul, with support, to the community.

Thanks to the Best Interest Assessor recognising Paul's wishes and feelings and setting conditions to explore alternatives Paul has been supported to safely live with a level of self-management he valued. The Key learning point here is the importance of professionals considering the wishes and feelings of the individual and looking for alternative measures that empower individuals to make their own choices.

Prevention

Recognising and supporting a person who self neglects to a level that affects their health and wellbeing has always been a challenging area of practice for professionals. They are charged with respecting the individual's rights and wishes to live in conditions or circumstances that contain elements of risk, as well as demonstrating that they have done all they can to check out that the person, has capacity to make those choices, and is not in immediate danger.

Bill⁷ came to professional attention when a concerned member of the public rang the police after noticing a large number of flies in his front living room window. Police officers inspected his property to try and locate the source of the flies, and discovered the property was in a poor state, that suggested self-neglect.

“ This address was the worst case of hoarding I have ever seen and the fire crews who attended described it as one of the worst hazards they had encountered”

Professionals from a number of agencies had significant concerns about Bill living this way but he made it clear he did not want services. He was angry that the police had gained entry into his home. In himself Bill appeared clean and to have the capacity to make his own decision on the state of his living environment. His neighbours did not have any concerns about Bill or any environmental concerns about his way of living. After checking that there were no concerns around health to suggest his living choices were causing him harm the remaining concerns were around his own safety from fire in the property.

⁷The person's name has been changed to protect their identity.

The fire service was able to establish a rapport with Bill and he agreed to have smoke alarms fitted and a fire escape plan was developed with him. The fire service also supported his neighbours and discussed safety advice with them. Professionals understood Bill's right to make his own decision and that the steps available had been taken. Whilst agencies such as his GP, the fire service and social services would continue to regularly check on Bill and attempt to establish rapport with him, this was as much as could be done at this stage. One of the key learning points from this case is that, whilst it is very difficult for agency staff to change entrenched behaviours, it is possible if they work together and respect the person's choices they can support the person to reduce the risks their way of living may pose to themselves and others.

Proportionality

Ivy⁸ lives in a supported tenancy with twenty four hour staff support: she has learning disabilities and a long term mental health diagnosis. A safeguarding alert was made by the care provider after Ivy disclosed that an unknown male had offered her money following a brief meeting in his car. Concerns were raised by both the social worker and care provider regarding her vulnerability.

Ivy's family had previously expressed concerns about Ivy's contact with a man she viewed as a partner. Ivy had had an assessment under the Mental Capacity Act, which indicated that she had the capacity to decide for herself about having sexual relationships. However, given the recent incident, and the concerns of her family, a referral for advocacy was made by the social worker. The advocate was to enable Ivy to participate in and understand the safeguarding process and to ensure her wishes and views were heard. The advocate met with Ivy and was able to represent Ivy's wish that restrictions would not be placed on her relationship with her partner. Ivy was very positive about the advocacy support...

“it has helped improve my understanding and awareness of the process and confidence that my voice would be heard within it”

As a result of advocacy involvement Ivy was able to ensure that the care provider continued to support her to work within an agreed plan to promote her personal safety and reduce risks. The advocate also requested that the provider helped Ivy to revisit the benefits of the Safe Places⁹ scheme in terms of providing a place of safety when accessing the community. In addition they recommended that information about relevant community groups was provided to improve self-confidence and develop community links and friendships.

By enabling adult to access advocacy support, professionals can ensure that individual's views are strongly represented within safeguarding processes to ensure the correct balance between risk and quality of life is attained. In this case a reduction in risk was attained whilst still leaving Ivy feeling that she had control over how she lived her life.

⁸The person's name has been changed to protect their identity.

⁹Safe Places is a way of helping vulnerable people enjoy their communities and access the town. They carry a Safe Places card with their name, emergency contact details and relevant health information. Public premises such as shops, cafes, pubs, libraries and other places of interest display a Safe Places sticker in the window. If a vulnerable person then needs help when they are out they can show their card to a member of staff in a business displaying the Safe Places sticker. Someone will then call their emergency contact or the police, depending on what the problem is. A short film explaining the scheme can be accessed here <http://www.warringtonspeakup.org.uk/safe-places/>

Protection

Working in partnership is an essential aspect of how partners of the WSAB try to protect people particularly when it comes to ensuring that they are in a safe environment and are receiving good quality care. There are a number of ways that the council and local health commissioners work closely with health and care providers to make sure that the services they arrange for people have clear standards and that the quality of care is monitored. This includes seeking feedback and intelligence from a range of professionals, the people who use services and their families.

“We are very happy with the new placement and feel in hindsight that the move was a positive one for Dad”

Serious concerns were identified at a residential and nursing home in the Warrington area, including the Care Quality Commission (CQC) publishing a report stating the home was ‘Inadequate’. The Safeguarding Unit wanted to understand the experience that residents were having so tried to achieve this by speaking to social workers, advocacy services, residents and their families about the care being provided. After clarifying there were no specific individuals harmed but that improvements were needed around person centred care plans, consistent application of the MCA, adherence to hygiene plans, poor record keeping, and staffing levels an action plan was put in place to drive improvements for the residents.

“It is early yet, but we can see changes being made”

Ultimately when limited progress was made by the service we had to take contractual action. The Council and Clinical Commissioning Group (CCG) worked closely with the local GP practice and CQC to ensure the residents wellbeing. At the same time, discussions took place with the care provider regarding the future of the care home. The Home Owner informed the Council and Warrington CCG that another care provider was interested in taking over the delivery of the service. The Council, the CCG, CQC and the potential new service provider then worked closely to agree transfer of the service safely and in the best interests of the residents.

“We were anxious about our mother’s move, but it could not have gone better... she appears to be much happier...”

Additional monitoring and support was provided during the transitional period to the new service provider and individual support to residents, some of whom needed to move to alternative provision as the new home would no longer provide nursing care. As a result, 9 residents were supported to move to nursing home accommodation whilst the other residents remained with the new care providers improved service.

“I am happy at the new home. It is different as there are a number of people that I can talk to in the lounge area”

Partnership

Dot¹⁰ was suffering from an acute phase with her mental health issue which had led to a stay at an inpatient hospital locally. This was sadly at the time she was due to give birth so plans needed to be made to place her baby with the extended family to allow Dot to recover. In order to achieve this, a range of professionals came together to plan the arrangements around the birth, including meeting the needs of the baby and managing the likely impact on Dot's mental health. During this process Dot often was not able to participate fully in the planning and decision making due to her lack of mental capacity. This meant that staff had to work together to ensure decisions were made in her Best Interests and that additional meetings were held when Dot was able to participate so that her anxiety and concerns were addressed at all times.

The local Hospital Maternity staff worked closely with both local authority safeguarding adult and children's teams, alongside the psychiatric team. These plans involved Dot's family to help identify how to create an admission for labour that would support Dot. This included multiple case conferences to discuss suitable labour areas, explain the plans to Dot, alter plans around her improving mental state, and creating opportunities for Dot to share her concerns and opinions about how she wanted to be cared for. Professionals worked hard to ensure that Dot had the plans explained regularly to her and in doing so that she could contribute to them as she was able. Staff also sought to ask Dot how she wanted to dress the baby when it was born.

“Logistically, everything went really well. The staff ...are a credit to your unit, and the care and compassion shown to her by them, was second to none... helped us to facilitate her spending time with her baby... We were able to work together as a team to manage her condition and to get her through what I can only imagine has been an incredibly difficult personal experience.”

After the birth staff supported Dot to celebrate the birth by having photographs taken, and celebrating with gifts for the baby and a cake. This was all aimed to make the occasion as positive as possible under the circumstances. Whilst Dot was not able to comment on this experience at this time other professionals involved have...

“...how wonderful you and your colleagues have been, and how much kindness and compassion you have shown... we cannot thank you enough for everything that you did. We will certainly be in touch if ever we have another pregnant patient referred to us.”

This case study highlights how in safeguarding working together is crucial to achieve the best outcomes for the individual. Due to Dot's needs no one professional could be expected to recognise how best to provide care and support. Instead professionals recognised the need to work in partnership and draw on each other's expertise for the best outcome for the individual. As a result of these experiences professionals feel their knowledge has increased and feel confident to work together in the future.

¹⁰The person's name has been changed to protect their identity.

Accountability

Matt¹¹ was living with chronic back pain and struggling with his mental health when he decided to try and kill himself. He was fortunately intercepted by the police and prevented from carrying this through. However, due to being high on drugs and carrying what was classed as an offensive weapon he was sentenced to a 12 month Community Order. This required him to meet with a Probation Service Officer (PSO) and attend the Criminal Justice Liaison Service Support4Change partnership. This organisation works with offenders with low level mental health needs or a learning disability.

Matt recognised that he had reached the end and at the time couldn't see a way out for himself as he was unemployed, homeless and felt his medication wasn't working. But coming into the Community Rehabilitation Company service he was able to meet others with similar issues and not feel so alone with his issues. His PSO worked with him to establish a rapport so that they could work together to address his needs and set some goals.

Alongside this Matt's Support4Change worker arranged for him to see a psychologist, accommodation providers and participate in groups to improve health and wellbeing. This helped Matt to get to a point where he could arrange a tenancy and start to re-establish a relationship with his daughter.

Whilst Matt's circumstances might not be seen to reach some of the thresholds for a standard adult social care intervention response as he was assessed as having low level mental health issues, it is important that individuals can access support when they are going into crisis and experiencing significant harm. This case study highlights why the SAB links into the National Probation Service and Community Rehabilitation Company are important to have an effective oversight of safeguarding activity in the area.

“I am getting a tenancy and, even more importantly, I'm back in touch with my daughter. That's all thanks to probation and Support4Change.”

¹¹Matt is the individual's real name as he has given permission to CRC to use his case study in public documents.

Section 5: Learning from Case Reviews

Under the Care Act the SAB is required to identify whether or not cases where someone has died or suffered significant harm require a Safeguarding Adult Review¹² (SAR) to ensure lessons are learned that would reduce the risk of harm happening again in the future.

Locally this happens by agencies referring a case into our Safeguarding Adult Learning and Review subgroup. They then review the case to see if it meets the SAR criteria:

- an 'adult at risk' has died and;
- abuse and neglect was suspected to be a contributing factor to their death; or
- where there were grave concerns about the way in which agencies had worked together to safeguard the individual concerned.

In 2015/16 one case was referred as potential SAR, but did not meet the criteria for review. Details of the case and decisions made can be found below. Alongside this a SAR identified in 2014/15 was conducted and concluded.

¹²SARs are now a statutory requirement for SAB whereas previously the Board would conduct serious case reviews as best practice guidance.

Safeguarding Adult Review (SAR)

Case summary

In October 2015 a referral for a SAR was received regarding the death of a young woman. She had died in January 2015 whilst an inpatient at the local Mental Health Trust after hanging herself.

Concerns were expressed around how as an inpatient she had been able to secure a means to hang herself and be unsupervised.

The Panel review could find no evidence of multi-agency working issues. However, they requested that oversight of the single agency action plan be shared by the commissioner with the Safeguarding Adult Learning and Review subgroup to assure the SAB of appropriate preventative action being put in place.

This case was also reviewed at a later date by the Coroner who issued a regulation 28 notice to the agency in March 2016. This notice requires the agency to report back to the Coroner on the action they have taken to address concerns raised.

Whilst this case did not move forward for a Safeguarding Adult Review it did provide an opportunity to scrutinise multi-agency activity around individuals with mental health support needs which in this instance appeared to be effective and appropriate. It also helped inform the content of a Safeguarding Adult's Board Workshop on suicide and self-harm.

Case summary

In March 2015 a SAR referral was received for the case of a woman who had completed suicide in her own home. This followed a range of difficulties in her life, including her children being placed in care following concerns over their welfare.

Although the case did not clearly meet the criteria for a statutory Safeguarding Adult Review (SAR) it was felt that there was some learning to be gained from reviewing the case so a discretionary SAR was agreed. Given the involvement of children's services, the WSCB (Warrington Safeguarding Children's Board) worked together with the SAB to review this case.

An independent reviewer was commissioned to conduct a SAR using the SCIE Learning Together methodology¹³. This required practitioners and managers to participate in workshops to scrutinise practice and identify areas for improvement. This learning was combined with feedback from family members to ensure a wide range of perspectives were considered.

The findings of the case were:

1. **Long term work:** Consideration of the support given to vulnerable men and women who have children removed through child protection processes

¹³<http://www.scie.org.uk/children/learningtogether/>

2. **Professionals Interactions with service users:** Professionals need to be able to recognise past abuse histories and respond to them when working with individuals
3. **Long term work:** Exploration of multi-agency working practices to share case information below safeguarding thresholds to coordinate interventions

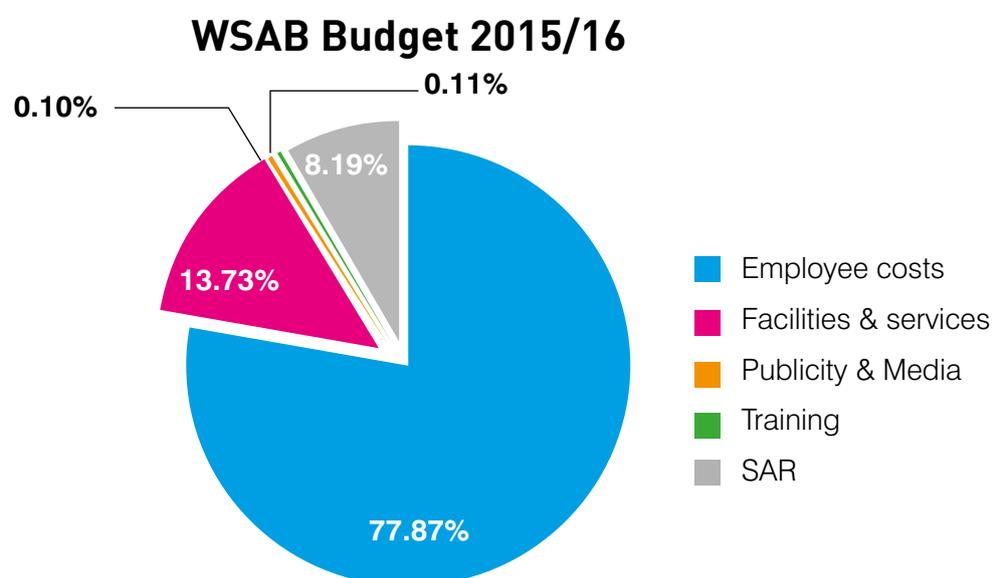
As a result of the SAR we held a workshop with professionals to develop an action plan to support frontline practitioners to develop their practice as identified. The Safeguarding Children and Adult Board will also be exploring longer term work that may be required from this investigation.

This investigation highlighted some good practice locally in terms of agencies trying to engage a service user and has provided some insight into how we can change practice to better engage individuals in the future. The SAB will be monitoring the progress of the action plan in 2016/17 and identifying any further work to be undertaken.

Section 6: Our resources and funding arrangements

In 2015/16 the budget for the SAB was £113,000, which was comprised of £88,000 core funding from Warrington Borough Council, £5,000 from Cheshire Constabulary and £20,000 contribution from the Better Care Fund¹⁴. The total spend was £78,800.

The main costs of the SAB are salaries for the Independent Chair, SAB Manager and Administration Officer who all ensure the business functions of the SAB are carried out. There was a significant underspend in staffing costs during the year as a result of staffing changes which included recruiting a full time SAB manager.



As can be seen the provision for a Safeguarding Adult Review (SAR) in this period has impacted on the use of the allocated budget. These are somewhat unpredictable costs in that the SAB cannot predict when or how many SARs may be required in their area each year. Therefore, these can create financial pressures. This year the costs have successfully been managed.

¹⁴The Better Care Fund is Central Government funding to support integrated health and social care services to improve people's wellbeing and health and care services. For more information please use this link.

Section 7: The Year Ahead - WSAB priorities from 1 April 2015 to March 2016



Our Vision is to:

Oversee local arrangements to ensure that safeguarding adults at risk is prioritised and coordinated effectively. We are committed to continuous improvement, learning from experience and enabling vulnerable adults at risk.

We aim to develop evidence that provides 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 do** when adults tell us about their experiences of abuse and neglect, and the services and support they receive
- Develop a **preventative and learning** approach to support, safeguard and protect adults at risk of abuse and neglect and ensure that when things do go wrong, we learn and improve.
- 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 people with the right skills** to protect adults from abuse and neglect.
- Develop our **doing the business and checking** of 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?

The Warrington Safeguarding Adult Board (SAB) Strategic Plan outlines the work we plan to undertake over the next three years to achieve our aim and can be accessed at www.warrington.gov.uk/wsab under "The Board" section.

Monitoring and review

The work plan for the Strategic Plan is a living document which will develop each year as activity is commenced and completed. The SAB will monitor progress against currently identified activity and outcomes via its Executive sub group quarterly. The sub group will ensure activity is timely, identify when additional activity needs to be agreed and report any exceptions to the SAB.

The SAB will also seek external scrutiny through half yearly updates to the Health and Wellbeing Board.

Appendix A

| | | |
|--|---|-------------------------------------|
| <p>warrington [safeguarding] adults board</p> | | <p>Making Safeguarding Personal</p> |
| <p>WARRINGTON SAFEGUARDING ADULT BOARD – BUSINESS PLAN ON A PAGE 2015/18</p> | | |
| <p>JSNA Care Act 2014 Engagement</p> | | |
| Context | | |
| Vision | <p>"Warrington's Safeguarding Adults Board will oversee local arrangements to ensure that safeguarding adults at risk is prioritised and coordinated effectively. We are committed to continuous improvement, learning from experience and enabling vulnerable adults at risk"</p> | |
| Priorities | <p>Listen and respond to what adults tell us about their experiences of abuse and neglect, and the services and support they received.</p> <p>Develop a preventative and learning approach to support, safeguard and protect adults at risk of abuse and neglect and ensure that <i>when things do go wrong, we learn and improve.</i></p> | |
| Work Areas | <p>1 Listen and Do</p> <ul style="list-style-type: none"> ➤ Share information (ongoing) ➤ Making sure adults and carers have a voice (including SU reps groups) ➤ Embedding MSP into multi-agency practice (front door) ➤ Better understanding of emerging communities and communities who traditionally may not engage ➤ Develop safeguarding materials with the local community <p>2 Learn and Prevent</p> <ul style="list-style-type: none"> ➤ Produce a prevention strategy and monitor its delivery ➤ Ensuring efficient SAR practice and learning ➤ Multi agency audits ➤ Implement a multi agency approach to Self Neglect ➤ Works effectively with Csp and other organisations to address issues such as Hate Crime and Modern Slavery ➤ Increase awareness <p>3 Right People, Right Skills</p> <ul style="list-style-type: none"> ➤ Ensure improved understanding of young adults and the MCA and consistent practice through transition to adulthood ➤ Revise multi agency Policy & Procedures ➤ Review and launch the Care Act compliant procedures ➤ Develop multi agency safeguarding understanding ➤ Ensuring an integrated informed approach between safeguarding and DA ➤ Themed and topical joint events with WSCB <p>4 Doing the Business & Checking</p> <ul style="list-style-type: none"> ➤ Review and publish the plan ➤ The WSAB regularly reviews its purpose and progress ➤ Publish the Annual Report ➤ Secure a dedicated budget performance data ➤ Receiving assurances about serious cases ➤ Making sure the SAB has its say with other local boards ➤ Review JSNA | |
| Outcomes 2015/18 | <p>✓ Information Sharing is effective across agencies</p> <p>✓ Feedback shows people feel safe</p> <p>✓ Making Safeguarding Personal is evident within practice</p> <p>✓ Safeguarding activity responds to Adults at Risk wishes and feelings</p> <p>✓ Emerging communities are being engaged in safeguarding work</p> <p>✓ Safeguarding materials reflect service user & community needs</p> <p>✓ Preventative action is being taken by organisations</p> <p>✓ Learning from SAR's effects changes in practice</p> <p>✓ Audits and reviews support improvements to practice</p> <p>✓ A clear & effective process is in place to share learning around adult safeguarding</p> <p>✓ There is a clear response to self-neglect across the partnership</p> <p>✓ Safeguarding Training is monitored & provided by WSAB</p> <p>✓ There are clear WSCB, WSAB & WDAP joint working plans</p> <p>✓ There are regular joint events from WSCB & WSAB</p> <p>✓ There is clear understanding of procedures & awareness of lessons learnt</p> <p>✓ Annual reviews priorities & progress are in place</p> <p>✓ The Strategic Plan is driving activity of the WSAB and sub groups</p> <p>✓ There is awareness of the WSAB across local forums and Boards</p> <p>✓ The WSAB is financially resourced</p> <p>✓ There is awareness of local serious incidents & associated learning</p> <p>✓ The JSNA reflects Safeguarding Priorities</p> | |
| Principles | <p>* Empowerment * Prevention * Proportionality * Protection * Partnership * Accountability</p> <p>Warrington SAB Chair: Shirley Williams Manager: Rosie Lyden ☎ 01925 442334 📧 sab@warrington.gov.uk www.warrington.gov.uk/sab www.warrington.gov.uk/sab Link to WSAB web page: www.warrington.gov.uk/sab</p> | |

Appendix B

Warrington Borough Council

Our key learning and challenges in 2015/16 were:

We are the lead agency for coordinating adult safeguarding arrangements under the Care Act with responsibility for establishing a SAB and ensuring that its members have the collective skills and experience necessary to safeguard adults in Warrington.

Feedback from the Court of Protection and case reviews highlighted the need to increase awareness and develop practice in relation to the Mental Capacity Act and the importance of balancing safeguarding with empowerment and the right to family life. This led to a programme of training and the introduction of a Legal Gateway. This has resulted in a noticeable shift in practice.

Learning from the experience of families affected by poor quality care which has been the subject of a criminal investigation has led to a new protocol between the police and the council that helps support a more personalised, proportionate and effective response that takes better account of the impact on the family.

We identified a lower use of advocacy in social care and safeguarding cases than had been anticipated. This was promoted and advocacy services were engaged in training of social workers in relation to the care Act. This has resulted in a large increase in uptake from 27 hours in April 2015 to 123 hours in March 2016

Key priorities for 2016/17 are to:

- Review all our public leaflets and feedback survey with the local advocacy group working with people with care and support needs
- Extend the use of the feedback survey to all adults and advocates including those who lack capacity
- Further implement MSP and develop new forms and a database to support practice and evidence outcomes
- Commission a local advocacy hub to be in operation from December 2016
- Further develop access to advice and information through a web based resource
- Utilise the care provider forum and newsletters to help promote best practice
- Continue to develop links between adult care services and the MASH, including clarifying the role for adult safeguarding
- Conduct a training gap analysis across the Council & ensure that all social workers have been trained in safeguarding and the Care Act with access to new course such as Modern Slavery & self-neglect
- We will provide a duty system for advice & support enhanced screening & triaging at ASC
- We will improve our analysis of safeguarding cases to better identify themes and trends

Cheshire Constabulary

Our key learning and challenges in 2015/16 were:

Cheshire Constabulary services a population of over 1 million people. They provide an emergency service 24 hours a day to respond to crime and its victims. We link to Safeguarding through all that we do as we are integral to the prosecution of safeguarding cases and all that we do aims to prevent harm to communities.

The introduction of the Domestic Abuse controlling and coercive behaviour statutory guidance

Responding to the issues of Honour Based Abuse, Female Genital Mutilation and Forced Marriage and Modern Day Slavery

HMIC vulnerability inspection

Key priorities for 2016/17 are to:

- Prioritising the policing of vulnerability as a key objective
- Prioritising the investigation of Public Protection issues such as Domestic Abuse, Missing from Home, Modern day Slavery, Honour Based Abuse, Female Genital Mutilation, Forced Marriage and Financial Abuse
- Contribution and implementation of learning from reviews such as SCR, DHR and SAR
- Review all referrals of adults at risk via the Referral Unit

National Probation Service Cheshire

Our challenges in 2015/16 were:

National Probation Service Cheshire (NPS) is part of the national statutory criminal justice service that supervises high risk offenders released into the community. Their work ensures that risks are managed to prevent further victims of crime including adults at risk.

Meeting the needs for those prisoners being released - We have found that the prison environment when everything is done for them often disguises their needs if they were to live independently and the necessary assessments have not been undertaken sufficiently to determine the best outcome.

Staff are encouraged to attend local events from SABS but have had a great deal of mandatory training over the last 12 months meaning that linking into this additional training has been difficult.

Some people on the autistic spectrum and some with Asperger's display very risky sexual offending behaviour when under stress. We worked alongside the police and psychologists to find appropriate support and ways of reducing their risks while empowering them to live safely in the community. Whilst this provides insight into case management this remains a challenging practice area that will be a continuing priority and theme.

Key priorities for 2016/17 are:

- We will continue to roll out more effective communication tools and ensure that "offender engagement" determines the direction our work. This has become more of a positive theme in the NPS...the notion of 'desistance' (going straight) and meeting needs rather than concentrating primarily on "risks" in an exclusive way
- To ensure that POs are clearer as to the role of adult social care and the safeguarding team and to ensure that they invoke the escalation process if required.
- To ensure that staff complete the E learning and the face to face training and embed this into practice evaluated by managers in audit of cases and supervision and that some attend any locally appropriate based SAB training and cascade to staff
- To work closely with prisons and in reach medical and mental health teams and disability teams to ensure that the offenders have had their needs comprehensively assessed to better assure a safe entry back into the community
- The service has flags and registrations on our system to alert new workers to the case of those areas they need to be alert to. A regular check in teams that they are in order will take place and the "adult at risk" section of our HR form where most of our offenders are discussed each month or three monthly has now been inserted and will form part of the discussion to reduce risk to self and others.

Cheshire & Greater Manchester Community Rehabilitation Company (CRC)

Our challenges in 2015/16 were:

Gaps in knowledge and skills in relation to responding to Domestic Abuse. To support staff manage the increase of these cases we have ensured additional training and support in this area, more frequent supervision and professional discussions and quality assurance checks.

Monthly Risk Management Review meetings now take place with Case Manager and Interchange Manager to review cases of concern, which may include those cases where adults at risk are involved, either as a perpetrator or victim.

We work with adult offenders subject to community sentences, licence and post-sentence supervision to reduce reoffending and promote rehabilitation and community integration. Our service users can be vulnerable themselves, as can their victims. We work to reduce reoffending and to rehabilitate our service users to hopefully see a reduction in additional victims and an improvement for adults at risk.

Following a Serious Further Offence committed by a male perpetrator of domestic violence during the course of his current community sentence in 2015, a full review was undertaken which identified several learning points and an Action Plan has been developed which has been put into place to act on the learning from that case including, creating reporting processes for programme tutors to escalate concerns about engagement.

Key priorities for 2016/17 are:

- Continue to provide a high level of service and support to our service users, and to refer adults, who are identified as at risk, to appropriate services whilst liaising with relevant partner agencies to work together to safeguard adults at risk.
- Reflect on our practice and develop improvements to any areas of concern.
- We will scrutinise any serious case reviews in order to develop our own practice and learn from experience. We aim to do this collaboratively with other partner agencies to take a joint action approach to safeguard adults.
- We will continue to train our staff and aim to work collaboratively with other agencies to jointly train and develop skills across our organisations. We will ensure attendance to and involvement in any joint agency safeguarding audits, and listen and respond to the feedback from such audits.
- We will commit to engaging with the SAB Annual Business Plan to ensure our agency continues to promote and contribute towards the safeguarding of adults in Warrington.
- CRC Transformation – once complete will enhance significantly the way in which we work with our service users and therefore improve our ability to link in with other agencies to manage those risk within the communities.

NHS England North (Cheshire and Merseyside)

Our challenges in 2015/16 were:

NHS England, as the commissioner of primary care (GPs, Dentists, Pharmacists and Opticians) and specialised services, is responsible for ensuring these services meet all required safeguarding standards. These standards include essential safeguarding training for all staff, including how staff must listen to adults to improve the services they deliver.

Due to The Autism Act 2009 there has been a steady increase in the numbers of individuals identified as being on the 'spectrum' who require care and treatment within both local and specialised mental health services. There is an acknowledged lack of expertise and capacity within statutory services across the North of England in both provision and commissioning.

Ensuring health organisations were able to release staff to benefit from the training and learning opportunities being made available.

Key priorities for 2016/17 are to:

- There is a requirement that NHS England Cheshire and Merseyside supports the delivery of the NHS England National Adult Safeguarding priorities for 2016/17 in relation to Female Genital Mutilation; Prevent; MCA, however confirmation is still required regarding these priorities and deliverables and will include commissioning of health services to support those experiencing:
- Child Sexual Abuse/Exploitation (including historic and routine inquiry)
- Female Genital Mutilation
- Trafficking and Modern Slavery
- Unaccompanied children and adults from abroad
- React to red pressure ulcer initiative within Care Homes

Warrington Clinical Commissioning Group

Our challenges in 2015/16 were:

We are statutorily responsible for ensuring we and the organisations from which we commission services, provides a safe system that safeguards children and adults at risk of abuse or neglect. We need to be assured that the organisations from which we commissions services have effective safeguarding arrangements in place. This assurance is sought through contract management and audits.

Multi -agency agreements around self -neglect prior to the Care Act. Care quality/clinical concerns versus safeguarding

Key priorities for 2016/17 are:

- The CCG plan to ascertain the views of homeless people in respect of their health services and the CCG will also need to consider how patient views are ascertained around their care and treatment where a section 42 enquiry has been made
- The CCG is keen to see safeguarding thresholds be introduced to Warrington through the current task and finish group, which should support those involved in care delivery to understand what poor care is and what is alleged abuse and neglect.
- The CCG is also aiming to deliver a future MCA conference in conjunction with WBC through its task and finish group
- Sharing the NHS England (NHSE) (March 2016) Intercollegiate Competency Framework for adult safeguarding for NHS staff with the training sub group to share with other partners
- The Quality Team within the CCG have commenced quality team meetings and a timetable to carry out provider assurance visits using a monitoring tool with relevant standards which are checked relating to concerns at the time

Warrington & Halton Hospital NHS Foundation Trust

We are an acute trust covering 3 hospitals on two sites. Warrington being the acute site, with the Cheshire and Merseyside Treatment Centre (CMTC) and Halton Hospital on the Halton site where we provide elective surgical and orthopaedic care and treatment.

Our challenges in 2015/16 were:

Our compliance rates did not meet our expectations so a key area for development over the coming year will focus on DoLS education, prevent and WRAP training, and the development of clinical supervision.

Key priorities for 2016/17 are:

- We will be conducting a yearly audit about our patient's experience of safeguarding and the service that they have received.
- There will be a focus on working with the Lead Nurses within the new Clinical Business Units and the education teams to improve training compliance. A number of E learning modules are in development to support this.
- We are currently revising local safeguarding adults' investigation procedures to support the investigations conducted around concerns raised into and out of the Trust.
- There will be a review of policies and we will update and review our audits in a timely manner. We will continue to share learning from incident investigations. There will be feedback from patient questionnaires to the Clinical Business Units (CBU's) to support and continue to improve upon learning.
- We aim to improve our response to themes and trends from safeguarding complaints. A new complaints and concerns policy and Standard Operating Procedures (SOPs) are in place to improve response times to complaints.
- Liaison with the new CBU managers to help embed good safeguarding practice in our trust.

Bridgewater NHS Trust

Our challenges in 2015/16 were:

Cheshire Constabulary services a population of over 1 million people. They provide an emergency service 24 hours a day to respond to crime and its victims. We link to Safeguarding through all that we do as we are integral to the prosecution of safeguarding cases and all that we do aims to prevent harm to communities.

To appoint a Named Nurse for adults.

To review and develop our adult training in line with national guidance

Key priorities for 2016/17 are:

- To consolidate our training offer across the trust in line with Trust Training Strategy
- Increase staff awareness of MCA and DoLS
- Further develop our Adult champion network

5 Borough Partnership NHS Trust

Our challenges in 2015/16 were:

During the past past year the Trust has significantly developed the Lessons Learned Forum which enables systematic analysis of a range of patient quality and safety information including the outcomes of internal and external reviews following incidents in order to identify and improve the quality of services. A series of lessons learned events have taken place across the Trust during the past year involving practitioners aimed at the sharing of information and to improve clinical practice.

We provide treatment, support and guidance for a wide range of health issues. These include physical and mental ill-health issues and Learning disabilities. We're here for people of all ages, living in the boroughs of Halton, Knowsley, St Helens, Warrington and Wigan. We offer services in community clinics, day care centres and in-patient care for people with mental ill-health.

Key priorities for 2016/17 are to:

- Involvement and development of the multi-agency Channel Prevent to roll out our duties under the governments Prevent strategy.
- Implementation of safeguarding training reflective of the National Competency Model (Bournemouth) across the Trust.
- Implementation of the Trust's new clinical recording system, RiO, and working to ensure that this is safeguarding compliant and enables safeguarding activity undertaken by staff to be recorded appropriately.

Cheshire Fire and Rescue Service

We provide prevention, protection and emergency response services and work to provide assistance and support to adults at risk. We contribute to safeguarding adults through attendance at emergency incidents, community safety activity such as Home Fire Safety Assessment and in its enforcement of activity in residential care premises.

Our challenges in 2015/16 were:

To continue to reduce the number of Accidental dwelling fires and fire fatalities within Cheshire.

Complete over 25,000 Home Safety Assessments to over 65's and people at risk from fire.

Key priorities for 2016/17 are:

- The Fire Service will continue to focus on the most at risk from fire and will work with health and other partnership agencies to identify those householders which also face additional risk from health and fire.
- Cheshire fire rescue service will relaunch the Home Safety Assessment programme under the name "Safe and Well" visits to over 65's. Phase 1 will be implemented as of 1st October 2016.
- Cheshire Fire and Rescue service delivery target for 2016/17 is to engage with over 40,000 homes within Cheshire.

Golden Gates Housing Trust

Golden Gates Housing Trust became part of the Torus Group in April 2015. Since then the Torus Group has appointed a Safeguarding Operations Group to carry out a full review of its activity with regard to Adult Safeguarding.

Our challenges in 2015/16 were:

Across the Torus Group we have now established a Safeguarding Operations Group. This is a cross functional / cross organisations group formed to consider operational issues, ensure the sharing of good practice, overseeing training requirements, developing operating procedures and reviewing near misses. This group will act as a vehicle for ensuring we embed safeguarding principles within all of our core activities. Following any Serious Adult or Child Review cases the group will review practice in line with learning outcomes.

Key priorities for 2016/17 are to:

- We will roll out ABC respond to all maintenance officers within GGHT. This procedure currently supports Helena's Safeguarding Policy which requires employees of Helena Partnerships to identify and report an issue which could indicate that a tenant –who may be adult, or child, or an employee- could be at risk. The '**ABC RESPOND**' Procedure is one of the mechanisms by which we can protect vulnerable members of the community we serve. This process enables employees to identify concerns and allow the Safeguarding Officer (Tenancy Sustainment Team) to effectively respond to circumstances where concerns have been highlighted and ensures reporting via adult safeguarding is done in a proper and timely manner.
- We have profiled all staff into 4 levels to reflect the level of training required into adult safeguarding. This is based on a general awareness of all staff up to a detailed awareness of certain staff involved in front line support services, Mandatory training will be rolled out during 2016/17.
- A full restructure has been carried out as part of the formation of the Torus Group. As a consequence a full review of DBS checks is being carried out cross all employees within the Torus Group to ensure that all posts requiring a DBS check is completed.
- A full website review is being carried out. Full links and awareness raising of Adult Safeguarding will be built into our information on this site.
- Develop a suit of performance indicators to track performance and show commitment to this area of work.
- Complete external audit of systems at the end to give overall assurance.

HealthWatch

**Healthwatch
is your independent
consumer champion created
to gather and represent the views
of the public in health and
social care.**

Our challenges in 2015/16 were:

We have become much more aware of the tight parameters in Safeguarding referrals and now direct these and intelligence much more effectively. Wherever relevant we also channel issues through the quality management and systemic review route.

We have also been proactive in gleaning possible safeguarding issues when undertaking survey and consultation activity, for example our recent investigation into domiciliary care highlighted specific issues relevant for the safeguarding team.

Key priorities for 2016/17 are:

- We will continue to attend the SAF (Safeguarding Adults Forum) and SAB and keep abreast of current thinking and developments through attending local events and workshop sessions.

Citizens Advice Bureau

Our challenges in 2015/16 were:

The sector has learned that in some cases signposting is not sufficient. That all partners need to firm up on appropriate referrals and follow up procedures for clients that do not attend appointments or disengage. We continue to encourage multi agency referral arrangements and holistic partnership work.

Warrington District Citizens Advice represents the third sector on the Safeguarding Adults Board. This appointment is ratified by Warrington Third Sector Hub which represents over twenty sub sectors and over 1300 voluntary, community and faith organisations

Key priorities for 2016/17 are:

- The Third Sector will continue to make safeguarding personal and will encourage adults at risk to utilise multi agency support. We look forward to the delivery of the prevention strategy and the provision of statutory advocacy services.
- Safeguarding training will be embedded in relevant organisations and we continue to work with the Statutory commissioning sub group to ensure that training and qualifications form part of all relevant contracts and that we can work together to deliver training in a more effective manner, looking at e-learning in particular to obtain economies of scale.

Appendix C

Glossary of Terms

| Term | Definition |
|-----------------------------------|--|
| Advocacy | 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. |
| Allegation | An allegation is when someone claims that an individual has done something illegal or wrong. At the allegation stage there is often no specific evidence available to ascertain the truth of the claims. |
| Care Act 2014 | This is a key piece of legislation which sets out how the local authority should respond to individuals with care and support needs. Alongside this it sets out how Safeguarding Adult Boards should be established within each Local Authority area and the expectations on their activity. For more information see: https://www.gov.uk/government/publications/care-act-2014-part-1-fact-sheets/care-act-factsheets |
| Care Quality Commission (CQC) | The independent regulator of health and social care in England. They ensure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. They do this through monitoring, inspecting and regulating services to make sure they meet fundamental standards of quality and safety and publish what they find, including performance ratings to help people choose care. For more information see: http://www.cqc.org.uk/content/who-we-are |
| Community Safety Partnerships | 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. |
| Deprivation of Liberty Safeguards | 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. |

| Term | Definition |
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| Disability Awareness Day | 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. |
| Domestic Abuse | Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. |
| Domestic Homicide Review | 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. |
| Health and Wellbeing Board | 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 |
| HealthWatch | local inequalities in health. 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. |
| Independent Mental Capacity Advocate (IMCA) | IMCAs are a safeguard for people who lack the capacity to make important decisions: including making decisions about where they live and serious medical treatment options. IMCAs advocate by representing people where there is no one independent of services, such as a family member or friend, who is able to represent them. |
| 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: <ul style="list-style-type: none"> • 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. |

| Term | Definition |
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| 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. |
| Migration | Migration is the movement of people from one place to another. The reasons for migration can be economic, social, political or environmental. |
| Multi-Agency Public Protection Arrangements | 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. |
| National Health Service | 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. |
| Peer Review | 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. |
| Public Protection Unit | The Public Protection Unit (PPU) is a dedicated team that deal with crimes of Domestic Abuse, Honour Based Violence and Hate Crime. |
| Regulation 28 | Regulation 28 Notices are issued to organisations in circumstances where a coroner believes that action taken could prevent future deaths. |
| Safeguarding Adults Board | 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. |
| Safeguarding Adults Reviews | 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. |

| Term | Definition |
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| Safeguarding Concerns | A safeguarding concern is an issue 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. |
| Safeguarding Enquiry | A safeguarding enquiry 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. |
| Serious Case Review | 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. |

Appendix D

Membership 2014/15

| Name | Organisation | Role |
|--------------------------------|--|-----------------------------|
| Shirley Williams | Independent | Independent Chair |
| Steve Cullen | 3rd Sector Hub | Board Member and Vice Chair |
| Michaela Beeston & Rosie Lyden | Warrington Safeguarding Adult Board | Board Manager |
| Councillor Pat Wright | Lead Member for Statutory Health and Social Care | Board Member |
| Steven Reddy | Warrington Borough Council | Board Member |
| Steve Peddie | Warrington Borough Council | Board Member |
| Ann McCormack | Warrington Borough Council | Board Member |
| Kevin Bennett | Cheshire Police | Board Member |
| Rebecca Knight | Warrington Clinical Commissioning Group | Board Member |
| Alison Lynch | Warrington & Halton Hospital Foundation Trust | Board Member |
| Jackie Rooney | NHS England North (Cheshire & Merseyside) | Board Member |
| Lorraine Page | Cheshire Fire & Rescue Service | Board Member |
| Steve Hull | 5 Borough Partnership | Board Member |
| Donna Meade | Cheshire Probation | Board Member |
| Chris Gwenlan | Probation | Board Member |
| Dr Neil Fisher | Bridgewater Community Healthcare NHS Trust | Board Member |
| Debbie Dalby | Health Watch | Board Member |
| Margaret Macklin | Warrington Borough Council | Board Advisor |
| Penny Owen | Warrington Borough Council | Board Advisor |
| James Bacon | Golden Gates Housing Trust | Board Advisor |
| Julie Ryder | Warrington Clinical Commissioning Group | Board Advisor |

