Who are the partners of the Board?

Below is an overview of our partners and how they will be referenced in the report...

<table>
<thead>
<tr>
<th>The Police</th>
<th>The Hospital</th>
<th>Cheshire Fire Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgewater Community Services</td>
<td>Warrington and Halton Hospitals NHS Foundation Trust</td>
<td>Cheshire Fire &amp; Rescue Service</td>
</tr>
<tr>
<td>Bridgewater Community Healthcare NHS</td>
<td>North West Boroughs Healthcare NHS Foundation Trust</td>
<td></td>
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<tr>
<td>The CCG</td>
<td>The Third Sector</td>
<td>The Council</td>
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<tr>
<td>Warrington Clinical Commissioning Group</td>
<td>Citizens Advice Bureau</td>
<td>Warrington Council</td>
</tr>
<tr>
<td>The Community Rehabilitation Company</td>
<td>Warrington Speak Up</td>
<td>National Probation Service</td>
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<tr>
<td>NHS England</td>
<td>Prisons</td>
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<td></td>
<td>Healthwatch</td>
<td>Housing</td>
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<td>torus Golden Gates Housing Trust</td>
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<td></td>
<td></td>
<td>NHS England</td>
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</tbody>
</table>

NHS England

Healthwatch Warrington

Public Health England
“People have the right to live in safety, free from abuse and neglect”

“Organisations and people working in partnership to prevent abuse and knowing what to do when abuse does happen.”
Chair forward

This is the 6th Annual report of Warrington Safeguarding Adult Board (WSAB) and the third report I have presented since becoming Chair in 2015. I am fortunate to Chair a Board in a locality where there is clear commitment to safeguard adults at risk by all organisations. Whilst individuals have changed over the year from some partner organisations, good working relationships have been maintained, and in spite of continuing financial and demand pressures in health, social care and public safety organisations, they have continued to prioritise their safeguarding responsibilities. This is evidenced within Section 3 of the report where the scope of work of the WSAB partner organisations is set out.

This has been a year of change in terms of the Board support team who merged with their Safeguarding Children counterparts to create one Safeguarding Board support unit. This has allowed us to bring together the priorities for both WSAB and Warrington Safeguarding Children Board (WSCB) to identify areas where closer working will bring mutual benefit. In addition, we are regularly working together to raise awareness of the importance of safeguarding adults and children who may be at risk of abuse and or neglect at local community events: a recent example of this was staff attendance at the annual Disability Awareness Day.

As this year’s report shows there is little change in the profile of safeguarding adult issues in the Warrington population; we continue to see physical abuse and neglect as the most frequently reported forms of abuse with an increase in incidences in our under 65 and over 85 population. As the key information section of the report highlights we want to explore the data further to develop a greater understanding of the Warrington specific profile so that we can target our support more effectively.

We have become more aware of incidences of people being abused under conditions akin to slavery, referred to in the Care Act as Modern Slavery. Training has been provided on a multi-agency basis to raise awareness and ensure agencies know how to report their concerns so criminal activity can be identified and victims supported.

Fear of abuse can have a great impact on all our lives, but most particularly for those who due to their need for health and social care support are most at risk. I am very pleased to see the positive impact of the Anti-Stalking Clinic pilot and look forward to seeing whether this approach can be maintained and lead to reduced offending in this area over the longer term.

Preventing abuse and neglect is a key responsibility of the Board and it is good to receive assurance that Warrington is judged, through the CQC inspection process, to be one of the best places in the North West to receive good quality residential care services. I am also pleased that those who may have experienced abuse have access to a range of advocacy services that will enable their voice to be heard.

2017 has so far been a year of multiple tragedies affecting a great many of us in terms of great sadness if not direct harm. 2017-18 will be a year for WSAB to scrutinise whether partnership initiatives and single agency projects are making a positive difference to the lives of the most vulnerable in our community. I am very much looking forward to seeing this work come to fruition and supporting the partnership to identify its next steps in enabling adults at particular risk to keep safe and have a life free from fear.

Working with others to achieve that end brings me great satisfaction and as always I am very grateful to the safeguarding colleagues who support me and the Board to contribute to a safer Warrington.
The Safeguarding Principles that Shape what we do

- **PREVENTION**: It is better to take action before harm occurs.
- **PROPORTIONALITY**: The least intrusive response appropriate to the risk presented.
- **PROTECTION**: Support and representation for those in greatest need.
- **ACCOUNTABILITY**: Accountability and transparency in delivering safeguarding.
- **PARTNERSHIP**: Local solutions through the services working with their communities. Communities have a part to play in preventing neglect and abuse.
- **EMPOWERMENT**: People being supported and encouraged to make their own decisions based on informed consent.

SECTION 1: Our Vision of Adult Safeguarding
The Care Act 2014 and the role of the SAB

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

- have care and support needs 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.

What the Safeguarding Board does and how it is achieving its priorities

To Listen and Respond to adults at risk

Our priority areas covered in our Strategic Plan are:

In doing our work, the SAB works closely with other local groups and boards. The strategic plan shows how we work closely with the Safeguarding Children’s Board and Warrington Domestic Abuse Partnership to make sure that we are as effective as possible in areas of joint concern, such as transition from children to adult services and Domestic Abuse.
Delivery of the Strategic Plan

In order to achieve the goals set by the SAB there are a range of sub-groups and two reference groups that are critical in helping the Board achieve its aims. The SAB also connects to a broad range of local representatives such as GPs and other strategic boards.

Who is the SAB accountable to?

The SAB is an independent statutory body; it must ensure it delivers on its priorities and meets its legal responsibilities. The SAB Annual Report and Strategic Plan is one way we make sure there is accountability to our local community. The SAB reports to the Health & Wellbeing Board to present the annual report and to highlight its achievements and challenges in the year.

The Independent Chair has a formal appraisal and discusses the SAB’s progress every year with the three statutory partners (Warrington Borough Council (WBC), Cheshire Constabulary and Warrington Clinical Commissioning Group).

The SAB also links to WBC Protecting the Most Vulnerable Committee on national and local issues that may need more scrutiny, such as care quality or issues relating to certain types of abuse such as self-neglect. The SAB also has formal links with 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 (the independent consumer champion) within the SAB also helps to bring together and represent the views of the public on the health and care services within our area.
ENQUIRIES OPENED

- 325 safeguarding enquiries received which was a reduction of 185 from 2015/16
- Increase in % of enquiries for the 18 – 64, 75 – 84 and 95+ age groups
- The majority of enquiries continue to relate to females; 2014/15: 61%, 2015/16: 62%, 2016/17: 66%
- In 2016/17, the most frequent reason for support is a result of Physical Disability (PD) (46%), followed by Mental Health Difficulties (MH) (23%) then Learning Disability (LD) (12%). (In 2015/16 PD: 45%, MH: 27% and LD: 9%)
- In 2016/17 63% of enquiries were raised by Social Care staff, 19% by Health staff and 17% by other (including friends, relatives, and other agencies including housing)

ENQUIRIES CONCLUDED

- The most frequent type of abuse reported is physical (33%), neglect (27%), financial (16%) and emotional (20%)
- The largest source of risk is from a known person source (53%) and care staff (35%).
- 51% of abuse takes place in ‘own home’, 31% in ‘care home’, 9% in ‘other’, 6% in ‘hospital’ and 3% in ‘community’
- The location of ‘own home’ has increased from 2014/15: 42%, 2015/16: 42%, 2016/17: 51%

CAPACITY & ADVOCACY

- 85 – 94 age group is the largest for lacking capacity in 2016/17, previously this was aged 75 – 84 in 2015/16
- Increase in the % of people who lack capacity that use advocacy/support – 2014/15: 65%, 2015/16: 76%, 2016/17: 81%

RISK OUTCOMES

- During 2016/17 there were 305 cases where a risk was identified and action was taken in all cases
- Where a risk was identified in 2016/17 there were 255 cases (84%) where a risk was reduced during the investigation, 10 cases (3%) that resulted in risk completely removed, 40 cases (13%) where the risk remained
Reporting concerns

Warrington has low threshold criteria for concerns of possible neglect or abuse. This is to ensure concerns are not missed and are screened by a suitably qualified person.

This year, some work was done to improve the awareness of agencies reporting concerns and the quality of information, including encouraging professionals wherever possible talking to the adult at the centre of the concern, prior to reporting. There was also some work undertaken to ensure that concerns about medication errors were managed through Health commissioners. This has resulted in a reduction in the overall concerns reported since last year and there has also been a reduction in the overall number of safeguarding S42 investigations required.

"Concerns" are screened by social work teams in the Council who carefully consider the circumstances and risks of the situation being reported. A Section 42 enquiry means that the case needs investigating as there are concerns of abuse and neglect. One of several agencies may lead on the case such as a Social Worker, A Police Officer or a Health Safeguarding Lead.

Where concerns do not require further action following screening, this can be for a number of reasons; including the situation is already resolved; initial discussions identify 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 authority’s area.

Care quality monitoring is where a care provider is supported to ensure they are providing safe and effective care.

NHS incident investigations are where a health service reviews practice following a national investigation process to identify how issues can be addressed. Sometimes these can also be Section 42 enquiries.
Sources of Enquiry

It is everyone’s responsibility to report when they believe that an adult with care and support needs may be at risk of abuse or neglect.

The main source of enquiries came from concerns raised by people working in care services.

The majority of these were in residential and nursing homes.

There was a significant increase in reports from GPs from a very low level previously. Reports from members of the community are very low.

So what does this mean?

This suggests a positive culture of reporting within residential and nursing care providers.

Many of the reports are concerns about the quality of care delivered as opposed to wilful neglect or abuse, the levels of which are comparatively low.

Research shows that people with care and support needs can be more isolated than others and that being isolated is a risk factor in terms of the likelihood of abuse or neglect occurring.

So what do we need to do next?

We will continue to encourage transparency and reporting of things that may have gone wrong and concerns about care in the care sector and also raise awareness in other settings, where people and their living arrangements are less visible.

The SAB wants to understand more about possible levels and types of hidden abuse and whether more can be done to increase reports from our communities. We will be undertaking further research as part of the Needs Assessment we are undertaking in 2017-8.

The SAB wants to continue to encourage reports from GPs and primary care professionals. We also need to explore how to increase reporting from a wider range of sources, including the general community. This will be done by be-spoke targeting campaigns and work with informal carers.
Profile of Adults at Risk

In the year 2016-17 66% of adults about whom safeguarding concerns were raised were female; up 4% from 15-16.

64% of adults were over 65 and 36% under 65 years of age, with increases from last year in the under 65 population, the 75 – 84 and over 95 years groups.

46% of adults who were subject of a safeguarding enquiry lacked capacity to make decisions relating to their safeguarding plan (this was a reduction from last year). 85 - 94 age group was the largest for lacking capacity in 2016/17; previously this was aged 75 - 84 in 2015/16.

Similarly to last year only 1.3% of adults were from ethnic minority groups which is a significant under representation of the local Warrington population (just under 7%).

**So what does this mean?**

The profile of adults at the centre of a safeguarding enquiry reflects the overall profile of adults who receive care and support services. This includes more females than males and the age profile is reflective of the ageing population and their care and support needs, particularly with the oldest age groups.

Within this, however there is potentially a low level of reporting of cases relating to males and the Black and Minority Ethnic (BAME) population. Part of the reason for this is that they are also under represented in receiving care and support services. This is partly explained for the under-represented male population by the longer life expectancy for women, but this does not offer a complete explanation.

The additional vulnerability of adults who lack capacity to make their own decisions about care and treatment may be obvious. In 2016-17 there was an increase in the proportions who received advocacy support (81% up from 76% last year). We continue to support and monitor the uptake of advocacy support for those who have substantial difficulty in contributing to their own safeguarding plan.

**So what do we need to do next?**

The SAB needs to try to understand the low level of reporting of cases involving males and BAME population and also whether there are barriers for people from certain communities both in accessing support and in raising concerns. SAB has been working to engage with people from minority ethnic groups and other “invisible” populations to encourage understanding and reporting. This needs to continue to ensure adults at risk in these groups aren’t facing unrecognised barriers. The needs analysis we are undertaking will help to better understand our local picture.
Who and What is being reported

The most frequent type of abuse reported is

- physical 33%
- neglect 27%
- financial 16%
- emotional 20%

The majority of abuse takes place in the adult’s own home (51%). However, a significant amount also takes place in care settings.

The information tells us that a significant proportion of abuse and neglect is carried out by non-professionals who are known to the individual, and are most likely to be a family member.

The next highly represented group are cases where a residential or domiciliary staff member was involved. A high number of these cases concern allegations of the impact of poor care and/or concerns of neglect.

So what does this mean?

Our data suggests the most likely people to be responsible for the alleged abuse or neglect is another family member or a residential or domiciliary care worker. However, we need to remember that the reporting of abuse and neglect may be easier when the person is living in a care home and may be more likely to be hidden when it takes place in their own home.

So what do we need to do next?

The SAB would like to better understand the profile of abuse by non-professional people and we will do that by conducting a Needs Analysis (JSNA). This will help us to better target information and support including to informal carers.

The SAB needs to ensure that the relationship between care quality issues and safeguarding is understood by all partners to ensure that local responses are proportionate and effective in keeping adults at risk safe.

The SAB needs to continue to focus on care quality in hospital and care settings to help reduce the risk of things going wrong and to ensure organisations are learning from serious incident.
Type of abuse experienced by Care and Support Need

Adults with a physical health need (42%) or mental health support need (23%) made up the biggest groups who were subject to safeguarding enquiries. Whilst the most frequently identified concerns are around physical abuse and neglect, the type of alleged abuse varies according to the support need of the adult.

Concerns about adults with a mental health need were more likely to be about financial abuse than other groups.

Concerns about adults with a learning disability were more likely to feature physical and sexual abuse.

We continue to raise awareness of the risks for adults with a learning disability through direct work and targeted information including the use of self-advocates, supported by local advocacy services.

A significant number of the concerns relating to neglect relate to unintentional harm associated with poor care, lack of training or awareness from professionals and a significant number of alleged physical abuse concerns are linked to poor management by professionals of assaults from other adults with care and support needs in care settings.

### Type of Abuse

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Type of Person ID</th>
<th>Physical support</th>
<th>Visual, Hearing dual impairment</th>
<th>Support with Memory &amp; Cognition</th>
<th>Learning Disability support</th>
<th>Mental Health support</th>
<th>Social Isolation or other support</th>
<th>No PSR</th>
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</thead>
<tbody>
<tr>
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<td></td>
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<td>4</td>
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<td>6</td>
<td>7</td>
<td>26</td>
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<td></td>
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<td>Neglect</td>
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<td>66</td>
<td>3</td>
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<td>18</td>
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<td>12</td>
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<td>36</td>
<td>69</td>
<td>123</td>
<td>21</td>
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</tr>
</tbody>
</table>

So what does this mean?

A number of safeguarding concerns are not as a result of intentional abuse but poor delivery of care. Financial abuse of those with potential for capacity issues is an area of concern. There has been an emerging trend around financial abuse by family members holding Lasting Power of Attorney\(^1\) for relatives this year.

We have paid particular attention to certain groups of adults this year to try to ensure that the preventive messages about safeguarding are relevant to their known areas of risk.

So what do we need to do next?

The SAB needs to monitor the emerging trend of financial abuse and any learning from such cases to be able to share this with the community and empower them to protect themselves from abuse and neglect.

The SAB needs to ensure that there is evidence based proactive work to monitor and improve the quality of care services and the management of challenging behaviour in care settings to reduce unintentional harm.

The SAB needs to focus on key keep safe messages for particular groups of people, such as those with a support needs as a result of their mental health difficulties.

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1. A Lasting Power of Attorney is a legal document that allows a nominated person to make either health & welfare or financial decisions on your behalf if you become unable to make these yourself.
Domestic Abuse and Safeguarding

National research shows adults with care and support needs are more at risk of domestic abuse than other adults.

There are a number of reasons for this, including reliance on others for care and support and an increased likelihood of isolation.

48 adults safeguarded in 2016-7 were suspected as having suffered some form of domestic abuse. As nationally, the SAB anticipates this figure is an under reporting of the level of actual abuse. There are a majority of females in the data, but a higher proportion of males than is the case with general domestic abuse statistics.

Adults with care and support needs under the age of 65 are more likely to be subject to domestic abuse and in particular, those with identified mental health issues, followed by those with learning disability and physical health issues.

The Warrington Anti-Stalking Clinic Initiative has identified that 83% of stalking victims were targeted by ex-intimate partners.

So what does this mean?

More research into safeguarding enquiries is needed to establish if domestic abuse is an underlying factor.

We need to understand how the findings of the anti-stalking clinic relate to adults with care and support needs.

So what do we need to do next?

The SAB need to undertake further work to ensure that domestic abuse is recognised within situations involving people with care and support needs. Particularly when looking at forms of domestic abuse other than physical assaults which may not always be as easily identified.

The issues around stalking and harassment, alongside a local Domestic Homicide Review means the SAB needs to provide awareness raising around controlling and coercive behaviour to ensure professionals can recognise and respond appropriately.
CASE STUDY

Protecting an adult with an Acquired Brain Injury from financial abuse

Safeguarding concerns were raised regarding an adult who lacked capacity to manage their own finances as a result of an acquired brain injury. The concern was that the adult, who was living in a care home, may be being financially abused by their appointee\(^2\) who was also their relative. Staff had raised concerns about the lack of money available to the adult and there were issues regarding the care bill. They had suspicions of misuse of the adult’s finances by the relative for their own personal use.

Following the concern being raised, the Care Home, the Council Safeguarding team, the Department for Work & Pensions, and the Police all came together with the adult’s representative to immediately protect the adult from any further possible financial abuse and investigate the concerns raised. In this process the Local Authority became the new appointee who would support the adult to manage their money.

As a result of the safeguarding enquiry the police were able to work with the Crown Prosecution Service to successfully convict the adult’s relative of fraud leading to a prison sentence due to the thousands of pounds involved.

Although there are occasions where individuals may not wish to prosecute family members, in this instance the adult’s representatives were happy that the protective measures were appropriate and necessary to enable the adult to live free from abuse and able to access activities and support they required.

\(^2\) An appointee is someone who acts on another person’s behalf when they lack capacity to deal with their benefits.

Safeguarding Outcomes

During 2016/17 there were 305 cases where a risk of abuse or neglect was identified during the enquiry. In all these cases action was taken. After the safeguarding S42 enquiry, there were 255 cases (84%) where the risk of further abuse had been reduced, 10 cases (3%) where it was judged that the risk had been completely removed and 40 cases (13%) where it was felt that the risk remained.

So what does this mean?

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.

There is some evidence that professionals dealing with adults at risk are reluctant to record that all risk has been removed, as they recognise the risk factors in the lives of adults concerned and their support.

So what do we need to do next?

The SAB will continue to audit multi-agency practice to ensure that Making Safeguarding Personal Principles are evident within practice and that there is an appropriate balance between positive risk taking and safeguarding activity.
Do people who receive social care services feel safe?

There has been a 1.2% rise in people using services reporting that they feel safe. This is a continuation of the increase seen last year but at a slower rate.

At this time comparison figures are not available for reporting. This data suggests that service users continue to feel safe in Warrington.

In relation to services making adults feel safe we similarly have a 1.7% increase and overall a reassuring rate in relation to services making people feel safe (93%).

CASE STUDY

Empowering an adult with Autism to ensure his wishes and feelings direct support

There were concerns regarding a young man with Autism being vulnerable to abuse by some members of his local community. Specific concerns were around being influenced by people he thought were friends but were exposing him to criminal behaviour. This resulted in him committing a crime. His care and support needs were recognised by the criminal justice system but he remained at risk afterwards when returning to the community.

Agencies came together to help him identify options to reduce the risk from his community and make him feel safe. The Third Sector, Social Care, Police and Probation Service worked with him delivering a package of care of keep safe work and supported accommodation; and on an ongoing basis to develop general life skills such as cooking, cleaning and laundry and to become more independent.

Professionals are conscious that there have been big changes in his life and that he needs ongoing support to respond to the conflicted emotions and feelings he has around his previous situation.
Local Safeguarding survey feedback

Adults who are directly involved in a safeguarding incident are asked at the end of the safeguarding enquiry, whether they are willing to provide feedback so that the agencies involved can try to understand their experience.

This year 9 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.

- Two thirds of the adults said that they told someone straight away when they realised something was wrong (an increase from 2015 - 16).
- All reported that they were listened to and supported throughout the process.
- At the end of the process, all people who responded stated they did feel safer. This is an increase of on the previous year.

So what does this mean?

Overall the feedback is largely positive and suggest that once people come forward they are receiving the response we would expect and in line with Making Safeguarding Personal (MSP).

Some people are unaware of the possible abuse or neglect before others identify it. However there can be other barriers to reporting.

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 more challenging and can be 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.

So what do we need to do next?

The SAB needs to improve the level of responses to the survey – this year it will also be sent to advocates for adults who have required their support to feedback on their behalf.
Advocacy

Advocacy is all about helping people to speak up and get involved when decisions are being made about their life.

Advocacy seeks to ensure that the most vulnerable people in our communities:
• have their voice heard on the things that are most important to them
• defend and safeguard their rights
• have their views and wishes genuinely considered when decisions are being made about their lives

In December 2016, a new advocacy hub was launched in Warrington. Jointly commissioned by the Council and Clinical Commissioning Group, the new advocacy hub is a collaboration between Warrington Speak Up and Together for Mental Wellbeing based in the town centre. It brings together different advocacy services in one place to make it easier for people to access the right kind of advocacy at the time they need it and with continuity of support.

In the first 4 months of its operation:
• 126 adults were supported with advocacy
• In total 1,613 hours of advocacy were delivered

This has resulted in a wide range of outcomes:
• adults having their rights upheld
• being supported to access services
• having their wishes and views heard
• being supported to make a life changing decision such as where to live or whether to have medical treatment
• Positive feedback from a range of agencies

Benchmarking suggests that in terms of compliance with statutory duties, there is a high level of advocacy being used in Warrington compared to similar areas.

So what does this mean?

The SAB has gained assurance that good quality advocacy is available and being accessed in Warrington.
Whilst there is a high level of demand to be monitored there is evidence that the new hub model provides the flexibility between types of advocacy to meet the changing local demand.

So what do we need to do next?

The SAB is aware that there is increasing demand for professional advocacy support and there is particular pressure in certain areas including supporting assessments under the Care Act and for people who are subject of the Deprivation of Liberty Safeguards who do not have another relevant person to help them achieve their legal rights.

The SAB will continue to promote the use of advocacy and monitor the levels and quality of provision. The service has a very important role in representing the experience of adults in Warrington to the Safeguarding Adults Board.
Assurance around Health and Social Care in Warrington

Throughout the year the SAB receives regular information to keep it assured about the quality and safety of health and social care provision. In Warrington there are 3 main NHS Trusts, several independent hospitals, and approximately 80 registered care providers (care homes, domiciliary care and supported living providers).

On a quarterly basis the SAB via sub groups receives updates on CQC inspections, trends and themes across the health and social care economy and will ask for progress reports in areas where there are concerns.

Care Homes & Domiciliary Care Providers

In 2016/17 86% of care homes 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. This figure is much higher than the national average of 72%.

Warrington was the highest rated for care homes without nursing beds in the North West currently rated outstanding or good and fourth placed in the region for Care homes with nursing provision. 1 care home in Warrington has been rated as outstanding.

There were 12 services (care homes, domiciliary care and supported living providers) at the end of 2016/17 that were assessed amber (requiring improvement) against the Council & CCG care quality monitoring framework receiving monitoring - No services were rated Red (inadequate). Monitoring involves regular visits by specialist staff to see progress against the agreed improvement areas.

At the end of the year 82% of Domiciliary care providers were considered to be compliant against the Care Quality Commission’s (CQC) standards.

Healthwatch conducted a survey with home care users in 2016-17 “Opening the door: Exploring the quality & safety of Care delivered at Home”. This document revealed:

- 85% of service users describe themselves as ‘very satisfied’ or ‘satisfied’ with their home care, only 4% are not satisfied
- Overall, 90% said they do not have any concerns with their care
- 96% feel carers communicated with them well
- 97% feel that carers treat them with dignity and respect

This provided some assurance around satisfaction levels. However, we need to continue to monitor performance in this area as we know there are pressures in the market that could impact on quality and safety.
NHS Providers and Independent Hospitals

There are 3 main NHS Trusts in Warrington which are regulated by CQC using the categories outlined below:

- **Outstanding**
  - The service is performing exceptionally well.

- **Good**
  - The service is performing well and meeting our expectations.

- **Requires improvement**
  - The service isn’t performing as well as it should and we have told the service it must improve.

- **Inadequate**
  - The service is performing badly and we’ve taken action against the person or organisation that runs it.

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<tbody>
<tr>
<td>Overall Good</td>
<td>Overall requires improvement</td>
<td>Overall requires improvement</td>
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There are also a number of independent hospitals and the number and type can change from year to year. Often patients in these settings will not be local residents as the places will be commissioned by other areas.

In 2016-17 one of these hospitals was rated as inadequate by CQC and placed in special measures. The SAB, Council and CCG have worked with NHS England to support the delivery of an improvement plan with the provider.
How Healthwatch worked in partnership with an adult and their family to improve standards of care

Healthwatch became aware of a concern via community members regarding the quality of care being experienced by an elderly woman in a local care home who had suffered a fall. This resulted in a hospital admission due to a head injury.

Healthwatch contacted and met with the adult’s relative to discuss their experiences. They described how she had experienced low staff numbers, difficulty in managing toileting needs and poor communications of care plans during staff handover periods.

Healthwatch recognised that this was an unheard voice that needed to be brought to the attention of the Council’s Safeguarding Team for advice and guidance. As a result of this a full review of the woman’s care also took place and the Care Quality Monitoring Team worked with the provider to address the concerns identified.

The outcome for the adult involved was that via their advocates they were able to challenge unacceptable standards of care.
Deprivation of Liberty Safeguards (DOLS)

The Deprivation of Liberty Safeguards (DoLS) are safeguards that provide a legal framework to protect adults who lack capacity to decide for themselves about their care and treatment and that where deprivation of liberty is unavoidable, decisions are made in their best interests. The Council is the organisation responsible for authorising the DOLS assessments which apply to adults in care homes and hospitals. Following a decision made by the Supreme Court in 2014, the Council as nationally, has received a spike in the volume of authorisations and has implemented a nationally approved risk management system to prioritise them. Progress is formally monitored, reported and reviewed on a monthly basis.

In 2016-17 there were:
- 1,260 requests for an assessment, an increase of 50 from the previous year
- 1,050 requests were completed compared with 760 the previous year
- At the end of the year 615 assessments were outstanding, which was a reduction of 8% at the end of the previous year

The DoLS process can help to give assurance about the care that the most vulnerable adults are receiving. It can also result in changes, that may be significant or small but that make such an important difference to everyday life, such as ensuring the person takes part in particular activities or has contact with people who are important to them.

CASE STUDY

How the DOLS process promoted proportionality when balancing risks against quality of life

One man was supported through the DoLS process to move to a community placement from a secure care home where he had been unhappy. This was a long process and there were a number of risks that needed to be considered and carefully managed. The DoLS assessor came across him out shopping sometime after the move, observing: “He looked great: he’d put on weight and was dressed really smartly. He said how much he was enjoying his new place and that he felt ‘free as a bird’. The nice thing was that he was just like everybody else in the Supermarket: going about his business, moaning about the price of plastic bags [probably]. It’s hard to believe that this time last year, he could not go out on the porch for a fag without supervision”.

22. Warrington Safeguarding Adults Board Annual Report 2016/17
In 2016-17 we focussed on:
1. Listening and Responding to Adults at Risk

Why it’s important…
We need to gain assurance that the adult is at the centre of what all partners do.

What we have achieved…

The Board has monitored the national reviews of Making Safeguarding Personal and how this can be embedded across all agency practice as a result:

- The Council has conducted audits to look at where the outcomes of safeguarding activity meet the wishes of the adult
- The hospital has empowered their patients by asking their views on what changes need to be made to support them to engage with safeguarding
- The Third sector in Warrington provides advocacy and advice to support individuals to voice their experiences of abuse and neglect
- Bridgewater Community services have made changes to their reporting to ensure the voice of the Adult is heard in all cases
- Healthwatch collected the experiences of local people in relation to Health and Social Care services to ensure these shape safeguarding practice and services
- Northwest Boroughs, a mental health service provider, developed policies and learning processes with its service users and their Carers alongside offering training for service users/Carers to improve the quality and safety of services
- Warrington Ethnic Communities Association (WECA) and the Council of Faiths have worked with us to ensure they are involved in “Invisible Communities” safeguarding activity – WECA now have a Modern Slavery awareness focus for 2017-18

WECA have been working with Council wellbeing services staff to support the integration of refugee families into the area. WECA are vital to the process as they often can help liaise with the formal services to encourage ethnic minority communities to feel empowered to engage.

WECA have taken on a range of informal support roles from finding volunteer interpreters, arranging Halal groceries, transportation to and from the mosque and introductions to key community members and services. They have raised up £1000 from the community to support new arrivals since January 2017. They also have dedicated befriender volunteers who continue to support these new families in day to day activities, accessing English as a second language and practical advice on the local area.
• Public Health have requested that their commissioned services review their processes to ensure adults’ voices and wishes are central to practice

• The CCG engagement team chair a Health Forum where patient experiences of health services can be discussed

• With our local advocacy groups we’ve redesigned the Feel Safe, Keep Safe booklet to ensure that information on recognising & reporting abuse is accessible

• Self-advocacy groups have, supported by the Third Sector, explored any safeguarding issues/experiences on a regular basis, with input from the Council’s safeguarding team

• Reviewed the purpose of Safeguarding Adult Forum to ensure the service users voice is central to its purpose

What’s next?

• We want to enable everyone in Warrington to be alert to abuse and know how to report it – we will update our methods & target awareness raising to help the community to engage in safeguarding activity

• We want to ensure service users and Carers are effectively represented at Safeguarding Adult Forum so the voice of the adult is heard by WSAB

• We want Making Safeguarding Personal to be embedded across the partnership – we will continue to audit practice against national initiatives

• We want to improve the take up of our safeguarding feedback survey
2. Developing a Preventative & Learning approach to safeguarding

Why it’s important…
Focusing on prevention in safeguarding and learning from things that go wrong are vital if we are to reduce experiences of abuse and neglect.

What we have achieved…

- The Police have explored how they can more effectively identify disability hate crime whilst the Third sector continues to facilitate the reporting of hate crime and to support vulnerable victims.
- The Police and Northwest Boroughs completed a 12 month pilot of an Anti-Stalking Clinic Initiative (ASC-I). This forum has been supporting stalking victims through developing a risk management plan designed to protect them.
- Further developed our approach to sharing information & learning from experience:
  - Development of 7 minute briefings to cascade lessons from SARs
  - Dissemination of safeguarding adults pocket guides by NHS England to frontline health staff such as GPs and Dentists
  - Development of an audit process for multi-agency case practice, service user feedback and S42 decisions

Supporting the Cheshire Anti-Slavery network to raise awareness of Modern Slavery leading to:

- The Council publishing a Transparency Statement
- Developed training materials and delivered a day for frontline professionals
- Distribution of modern slavery and trafficking information to NHS England providers and frontline health staff
- Northwest Boroughs running a conference on Modern Slavery
- Sexual Health Services providing testing, support, advice and treatment to women trafficked as sex workers
What’s next?

- Pilot our new audit tools and processes to ensure they are fit for purpose
- Undertake joint audits with the Warrington Safeguarding Children Board (WSCB) and Warrington Domestic Abuse Partnership (WDAP)

Ensure we are supporting partners to promote good practice initiatives.

- Support the NHS England App for health staff with access to LSAB websites
- Support NHS England priority of raising awareness of FGM, Prevent and MCA
- Support Third Sector leads to monitor the Safe Places scheme and explore how we can recognise the impact of Hate Crime on adults at risk
- Access updates on the stalking clinic outcomes and the bid for an Independent Stalking Advocacy Case Worker
- Monitor the role out of Safe and Well visits around loneliness and social isolation in late 2017 by Cheshire Fire Service

Continuously refined our SAR process after each use to improve the process for all involved. Created a Self-Neglect policy statement with practice guidance including legal frameworks and risk assessment:

- The Hospital, Bridgewater and Northwest Boroughs trialled the risk tool
- Citizens Advice Bureau continued to promote safeguarding risks where eviction from properties was being considered
- Healthwatch trained their Enter and View volunteers to ensure safeguarding and care quality issues are identified
- Northwest Boroughs had a Collaborative Quality Visit to drive up standards to improve service user experiences of care
- The Probation Service in collaboration with other agencies has focused on increasing accessibility for particular groups of service users
- Public Health working with Sexual Health service providers have created a database of adults at risk so concerns and repeat issues can be identified and responded to
- Cheshire Fire Service completed over 40,000 Home Safety Assessments to over 65’s and people at risk from fire, to introduce the new ‘Safe and Well’ visits. These aim to identify those with unmet support needs and ensure they are flagged to partners
3. Ensuring the right people are in place with the right skills

Why it’s important…

It is vital in safeguarding work that people who work with adults at risk have the skills and knowledge to prevent and respond to abuse and neglect.

What we have achieved…

- Encouraged greater understanding and awareness of the implications of the Mental Capacity Act:
  - The Council and Clinical Commissioning Group developed & distributed a public leaflet for GP practices and delivered training to improve awareness
  - The Council, CCG and Advocacy service provided a workshop for a range of local providers to improve understanding

- Launched lunchtime workshops to offer bitesize opportunities to develop and refresh safeguarding skills & knowledge

- The Council undertook a project exploring Domestic Abuse in the adult with care and support needs population

- A review of training identified compliance of agencies around safeguarding training:
  - The Hospital have increased training compliance to 91% at level 1 and 87% at level 2 and are going to implement a level 3 training package
  - Healthwatch are working to train and inform wider groups i.e. local elected councillors, in partnership with the Council
  - The Probation Service has ensured safeguarding adult issues now feature in MAPPA referral paperwork
  - The Police have developed training in the Mental Capacity Act and Safeguarding alongside a programme of domestic abuse training which focuses on Coercive Control and vulnerability in Domestic Abuse
  - The CCG have included safeguarding adults sections within GP training to ensure they can recognise and respond
• Developed a WSAB training programme promoted and delivered by partners:
  » Care Act training is delivered by the Council with support from Speak Up, Health and Police
  » Warrington Voluntary Action promote the programme to help attract smaller faith & community groups
  » A range of partners have ensured links are made from their safeguarding webpages to the WSAB site
  » Delivery of a North West area Coercion and Control Train the Trainer Masterclass with Research in Practice for Adults

• Ensured training focuses for Safeguarding Adults reflect emerging issues and changes coming from the Care Act 2014 legislation:
  » NHS England delivered executive masterclasses to raise awareness of Prevent, Slavery and Human Trafficking within health organisations
  » Bridgewater Services Level 3 training now includes Self Neglect and Domestic Abuse
  » The Hospital have attended modern slavery, domestic abuse and MCA training to enable information to be shared across the trust alongside links to WSAB resources

What’s next?

• Roll out workshops around Coercion and Control in relation to Adults with care and support needs
• Develop Group B Safeguarding training to support professionals to participate in and contribute to safeguarding processes
• Review the Domestic Abuse data project and ensure robust recording processes are in place moving forward
• Ensure there is widespread awareness of the Herbert Protocol initiative across Warrington
• Deliver events for the third sector and smaller voluntary groups to continue to encourage their involvement in safeguarding activity, ensure access to quality training and information
• Monitor how partners are effectively cascading learning from SARs within their own organisations

3 This is a Cheshire Police initiative to effectively respond to missing episodes of adults with dementia.
4. Ensure we are checking and doing the SAB’s business

Why it’s important…

WSAB is the strategic partnership established to hold agencies to account and provide assurance that local safeguarding arrangements are helping and protecting adults in Warrington.

What we have achieved…

• Designed a new performance dashboard so we can see what the data is telling us needs to happen locally
• Worked with local prisons to ensure they have robust safer custody processes including; attendance at the Safeguarding Adult Forum, training sessions to custody staff and presentations to Board on safer custody processes
• Worked with further education colleges to develop an audit tool for safeguarding to ensure they are responding effectively to adults with care and support needs
• We have encouraged partners to share their challenges and success at board.  This discussion of individual activity is helping lead to a multi-agency perspective on safeguarding

Working with other partners, Third Sector representatives have fulfilled a key role in a Community Safety Partnership led Domestic Homicide Review and WSCB Serious Case Review – Third Sector leads scrutinise partner’s processes acting as a “Critical friend”.  They offer a perspective from outside of the usual case management system.  They are key to ensuring that interventions are necessary, proportionate and in the best interests of the adult.

• The Council and CCG have worked with Care Providers to develop a self-assessment tool which helps them manage and provide assurances about the quality of local care provision
• We have worked with Bridgewater, Northwest Boroughs, CCG, the Council and Care providers in the area to develop a guidance document around safeguarding concern pathways to enable agencies to better understand the responses available locally and the integration with Health Care investigation processes
• We have run several Safeguarding Adult Review (SAR) multi-agency screening panels during this period.
• We have developed protocol for members that highlights their roles in sharing the WSAB priorities within other forums and reporting back on the activities of these into WSAB:
  » Northwest Boroughs have joined the Channel Panel to ensure they are linked into the local partnership arrangements
  » To ensure the voices of the service users are heard within safeguarding forums, Healthwatch are represented within SAF.
  » Bridgewater Community Services Named Nurse sits on the Warrington Safeguarding Health Provider Leads Forum to share safeguarding issues and information in order that health providers work together to ensure that adults at risk are safe and achieve their full potential
  » The Council and CCG are members of the North West Quality Surveillance Group and regularly update regional trends and themes to the Executive sub group
What’s next?

- Finalise the safeguarding audit tool & launch it more widely as an aid to agencies wanting to self-assess their safeguarding infrastructure
- Monitor the development of the adult focused contribution to the Multi Agency Safeguarding Hub (MASH) arrangements
- Ensure that issues of capacity either within the market or individual partner organisations remain on the WSAB risk register for scrutiny and support
- Ensure progress on the development of a national Domestic Abuse Audit tool for the National Probation Service is monitored by WSAB
- Receive the findings from the Public Health review of commissioned services in relation to adult safeguarding processes in late Autumn 2017
- Receive assurances from the Hospital in relation to the impact of their MCA/DOLS improvements on the effectiveness of the organisations response to this area
- Receive assurances regarding Cheshire Police in relation to HMIC Effectiveness Inspection and HMIC PEEL Vulnerability Inspections

- Delivered a joint development half day for WSAB with WSCB so that both Boards could review priorities and act as critical friend to each other in relation to work plan development
- Following a safeguarding investigation into the care provided to Dialysis patients at a local hospital the Council, CCG and NHS England identified concerns to the Dialysis Service provider which led to an independent review at a national level. This has resulted in the delivery of a monitored improvement plan to ensure the dignity and safety of patients is maintained
- The SAB shared concerns in relation to a local nursing home with other areas via the Quality Surveillance Group. This identified that other areas had similar concerns with the organisation which is a national care provider. This resulted in NHS England working with the provider to address safety and quality standards for their residents
The SAB is required to identify whether or not cases where someone has died or suffered significant harm require a Safeguarding Adult Review (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; and
- where there were grave concerns about the way in which agencies had worked together to safeguard the individual concerned.

In 2016/17 we received 5 SAR referral forms. Within this 2 were made in error as professionals were attempting to report safeguarding concerns. In both cases they were redirected and encouraged to re-refer once the safeguarding processes had progressed if they felt they had identified potential SAR cases. For the 3 valid referrals one case was reported to another areas SAB as the safeguarding enquiry established that the potential concerns around multi-agency practice related to agencies in the other area that had placed the adult in Warrington. The other two were taken forward to a screening panel and in both cases, further review was required. One case required a SAR under the statutory criteria. In the other case a discretionary review has been triggered.

We also work on other forms of review as a partner to the process as required. For example, partners participated with Halton on a SAR exploring mental health service support to a young person transitioning from children’s to adult services. We have also supported a local Domestic Homicide Review that has been managed by the Community Safety Partnership. However, details will only be included in the annual report when there are specific elements agreed for the SAB to monitor.
Case D Summary: Referred January 2017 – Adult D

Concerned a choking incident of an adult male in an independent hospital, who sadly later died. Adult D had very specific care plan that recognised a significant risk of choking and there were concerns that this plan was not adhered to as required.

The screening panel reviewed the case through chronology submissions and interviews with some of the practitioners involved. The panel concluded that the issues were primarily single agency and on this basis this case did not meet the statutory criteria for a SAR as the concerns were not about how partners had worked together.

The panel felt that some clear lessons had been learnt from the screening process that would be beneficial to be shared with the wider partnership, these included:

- Awareness of gaps in CQCs registration process. This was a newly registered hospital and agencies had assumed assurance through CQCs registration process. However, no inspection or detailed review had been undertaken and when this did occur failings were found. Practitioners consequently need to understand the limitations of the CQC registration process with new providers.
- There is a national challenge around safe “spot purchasing” of beds in private hospitals by CCGs – NHS England are exploring establishing a framework to support a consistent approach to assessing quality and risk monitoring. This is an area the WSAB need to engage with regionally and monitor and report on locally.
- The process of Speech and Language Therapy (SALT) input to those adults at risk of choking in private hospitals was not consistent – this hospital did not have a clear access pathway.
- It is very important that people delivering care to those at risk of choking have access to best practice guidance.

Subsequently, it was agreed the Board would support the following activity:

1. Write to CQC to identify what they had learnt about gaps in their current registration process
2. Monitor NHS England’s progress in establishing a framework for quality assuring and risk monitoring on spot purchased beds
3. Produce a concise overview of this case with practice guidance in relation to adults identified at risk of choking.

Case E Summary: Referred February 2017

This case concerned an elderly woman who was residing in a care home in Warrington and suffered a knife attack from a visitor. Fortunately she did not suffer life-threatening injuries. The alleged attacker was detained under section 2 of the Mental Health Act and was arrested for attempted murder.

The safeguarding enquiry established that the alleged attacker had a long-standing history of mental health issues and that there were potential gaps in her care and treatment in another area had made this incident possible. There were no identified measures that the care home could have been expected to take that could of prevented the attack.

The Independent Chair determined that the SAR criteria was not met, in terms of issues with our local agencies joint working to safeguard an adult with care and support needs. It was decided that information would be shared with the other area’s SAB in order that they could convene a local review into multi-agency practice around the management of the alleged attacker. We have requested to be informed of their findings so these can be shared locally.
**Case G Summary: Referred March 2017**

This case involved an attempted murder. The case appeared to occur in the context of increasing care and support needs for both parties with concerns about each of their mental wellbeing.

The panel recognised reviewing the chronology leading up to the incident a pattern of crisis points in relation to carer breakdown followed by a pattern of declining agency support which was not unique to the case. Whilst the panel did not believe that the outcome of this case could have been predicted it was felt that a review would be beneficial to understand if there was any learning.

In conjunction with the Independent Chair it has been agreed that a concise SAR will be taken forward using the Individual Management Review process. An independent author is to be sought to construct a final SAR overview report.

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**Update on SAR Adult A activity within 2016-17**

An Executive summary for SAR adult A was published on the WSAB website in October 2016 once the family had been given the opportunity to review the findings. This can be found at www.warrington.gov.uk/WSAB under the Professionals’ section.

A data review has been undertaken to scope the number of adults turning to local mental health services when children are being formally removed from their care. Once completed this is to be reviewed by WSAB to discuss next steps.

In line with the family’s wishes we have held multi-agency workshops to raise awareness of the case and lessons learnt utilising a 7 minute briefing. Alongside this we have asked several groups, such as Transition, Complex Families and the Missing Child Sexual Exploitation and Trafficking group, to review the case and identify if any of Adult A’s earlier life experiences indicate the need for changes to their current processes.

The Local Authority was asked to review its current support services around families moving towards formal court proceedings in light of the SAR. There have been additional processes put in place to support families to avoid reaching court proceedings by offering early support and interventions. Alongside this a bid was made to pilot the PAUSE model locally.

We will continue to progress the action plan for this case in the coming months and where scoping activity was identified we will take the new actions identified from this into the WSAB’s annual work plan to ensure the learning process continues to inform our work.

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4 PAUSE is a model aimed at breaking the cycle of repeat child removal by intervening when women have no children in their care to address the issues involved.
In 2016/17 the SAB support team and budget was merged with the team for Warrington Safeguarding Children Board (WSCB). This was to create a more efficient shared resource across safeguarding. The total budget available for the Safeguarding Board team was £400,363 which was comprised from £136,076 carry forward and £264,287 from partner contributions. The breakdown of contributions is shown below.

The total spends for 2016/17 was approximately £328,824.87. The main costs of the SAB stem from Independent Chair and Employee costs who ensure the functions of the SAB are discharged. The next highest costs accrued are those associated with housing a team. The increase in staff costs is as a result of the revised team structure and the employee changes for the SAB that took place in quarter 4 of 2015-16.

The joint budget will be carrying forward £71,538.13 which will ensure the viability of the team for 2017-18 to undertake the proposed WSAB activity.

*SAB Consultancy costs relate to SAR A and only those incurred in 2016/17 so do not reflect total costs of the Review
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 programme 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
### Glossary of Terms

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<th>Term</th>
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<tr>
<td>Advocacy</td>
<td>Advocacy is a process of supporting and helping people to express their views and concerns; access information and services; and defend and promote their rights and responsibilities. This may include providing encouragement or representing their views.</td>
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<td>Allegation</td>
<td>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.</td>
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<td>Care Act 2014</td>
<td>This is a key piece of legislation which sets out how the Warrington Borough Council should respond to individuals with care and support needs. Alongside this it as set out how Safeguarding Adult Boards should be established within each Local Authority area and the expectations on their activity. For more information see: <a href="https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets">https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets</a></td>
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<td>Care Quality Commission (CQC)</td>
<td>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: <a href="http://www.cqc.org.uk/content/who-we-are">http://www.cqc.org.uk/content/who-we-are</a></td>
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<td>Community Safety Partnerships</td>
<td>Community Safety Partnerships are local statutory bodies made up of Councillors and independent people from each local authority area. They work together to make a community safer by focusing on issues which matter most in your area.</td>
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<td>Deprivation of Liberty Safeguards</td>
<td>The Deprivation of Liberty Safeguards (DoLS) provide additional protection for the most vulnerable people living in residential homes, nursing homes or hospital environments (and more recently some housing with care environment) through the use of a rigorous, standardised assessment and authorisation process. They help to make sure that a person’s liberty is restricted legally, and that this is done when there is no other way to take care of that person safely. Following a Supreme Court judgement on cases in Cheshire West and Surrey, there has been a broadening of the circumstances of care that might now constitute a deprivation of liberty. As a result the number of applications for DoLS has increased significantly across the country.</td>
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<td>Disability Awareness Day</td>
<td>Disability Awareness Day (DAD) is the biggest non-profit disability exhibition led by volunteers in the UK. It is held by Warrington Disability Partnership and attracts more than 25,000 people every year. The day aims to raise awareness to the voluntary, statutory and private services available to people with disabilities.</td>
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<td>Term</td>
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<td>Domestic Abuse</td>
<td>Violent, controlling and/or threatening behaviours between partners of family members.</td>
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<td>Domestic Homicide Review</td>
<td>Domestic Homicide Review refers to a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by a person whom he/she was related or had been in an intimate personal relationship, or a member of the same household. They aim to establish what lessons can be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.</td>
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<td>Health and Wellbeing Board</td>
<td>Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children’s services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.</td>
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<td>Healthwatch</td>
<td>Healthwatch are the local consumer champion in health and social care. They have significant statutory powers to make sure that the voice of the consumer is strengthened and heard by those who commission, deliver and regulate services.</td>
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<td>Independent Mental Capacity Advocate (IMCA)</td>
<td>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.</td>
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<td>Learning Together</td>
<td>Learning Together supports learning and improvement in safeguarding adults and children. They help local safeguarding children boards, safeguarding adults boards, and their equivalent organisations to: • use systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture • build internal capacity by having staff trained and accredited in the Learning Together approach to reviewing • undertake rigorous case reviews and audits using a core set of principles and analytic tools • access a pool of accredited independent reviewers as required by statutory requirements • build on the experience and findings of previous reviews as part of the Learning Together community.</td>
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<td>Local Government Association</td>
<td>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.</td>
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<tr>
<td>Making Safeguarding Personal</td>
<td>The Making Safeguarding Personal programme was established by the LGA to develop person-centred, outcome focused responses to safeguarding adults.</td>
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<tr>
<td>Mental Capacity Act</td>
<td>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.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Migration</td>
<td>Migration is the movement of people from one place to another. The reasons for migration can be economic, social, political or environmental.</td>
</tr>
<tr>
<td>Multi-Agency Public Protection Arrangements</td>
<td>Multi Agency Public Protection Arrangements (MAPPA) is the framework which joins up the agencies who manage offenders. The fundamental purpose of MAPPA is public safety and the reduction of serious harm.</td>
</tr>
<tr>
<td>National Health Service</td>
<td>The National Health Service (NHS) is the publicly funded healthcare system for England. It is the largest and the oldest single-payer healthcare system in the world.</td>
</tr>
<tr>
<td>Peer Review</td>
<td>A peer review is an evaluation of adult safeguarding work by specialists working in the same field to make sure that it meets the required standards. The Review aims to help the council and its partners to assess and identify current strengths; areas for development; and capacity for change.</td>
</tr>
<tr>
<td>Public Protection Unit</td>
<td>The Public Protection Unit (PPU) is a dedicated team that deal with crimes of Domestic Abuse, Honour Based Violence and Hate Crime.</td>
</tr>
<tr>
<td>Regulation 28</td>
<td>Regulation 28 Notices are issued to organisations in circumstances where a coroner believes that action taken could prevent future deaths.</td>
</tr>
<tr>
<td>Safeguarding Adults Board</td>
<td>Safeguarding Adults Boards are the statutory body responsible for overseeing and leading on adult safeguarding in the local authority area. It is responsible for making sure that local safeguarding arrangements help to protect adults with care and support needs in its area.</td>
</tr>
<tr>
<td>Safeguarding Adults Reviews</td>
<td>Safeguarding Adults Reviews are reviews of cases where a person has died as a result of abuse and neglect, or where the incident was so serious that they may have died, to make sure that lessons are learned across the partnership and to prevent it from happening again. Safeguarding Adults Boards are legally responsible for completing the reviews.</td>
</tr>
<tr>
<td>Safeguarding Concerns</td>
<td>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.</td>
</tr>
<tr>
<td>Safeguarding Enquiry</td>
<td>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.</td>
</tr>
<tr>
<td>Serious Case Review</td>
<td>Serious case reviews are undertaken by local safeguarding boards for every case where abuse or neglect is known - or suspected - and either: a person has died or a person is seriously harmed and there are concerns about how organisations or professionals worked together to protect the individual from abuse.</td>
</tr>
</tbody>
</table>
### Appendix B

#### Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shirley Williams</td>
<td>Independent</td>
<td>Independent Chair</td>
</tr>
<tr>
<td>Steve Cullen</td>
<td>3rd Sector Hub</td>
<td>Board Member and Vice Chair</td>
</tr>
<tr>
<td>Rosie Lyden</td>
<td>Warrington Safeguarding Adult Board</td>
<td>Board Manager</td>
</tr>
<tr>
<td>Pat Wright Councillor</td>
<td>Lead Member for Statutory Health and Social Care</td>
<td>Board Member</td>
</tr>
<tr>
<td>Steven Reddy</td>
<td>Warrington Borough Council</td>
<td>Board Member</td>
</tr>
<tr>
<td>Steve Peddie</td>
<td>Warrington Borough Council</td>
<td>Board Member</td>
</tr>
<tr>
<td>Gareth Lee</td>
<td>Cheshire Police</td>
<td>Board Member</td>
</tr>
<tr>
<td>Dawn Chalmers</td>
<td>Warrington Clinical Commissioning Group</td>
<td>Board Member</td>
</tr>
<tr>
<td>Angela Madigan</td>
<td>Warrington &amp; Halton Hospital Foundation Trust</td>
<td>Board Member</td>
</tr>
<tr>
<td>Jackie Rooney (April-Sept) Joe Allen (Sept-Dec) Lisa Cooper (Dec-March)</td>
<td>NHS England North (Cheshire &amp; Merseyside)</td>
<td>Board Member</td>
</tr>
<tr>
<td>Lorraine Page</td>
<td>Cheshire Fire &amp; Rescue Service</td>
<td>Board Member</td>
</tr>
<tr>
<td>Steve Hull</td>
<td>5 Borough Partnership</td>
<td>Board Member</td>
</tr>
<tr>
<td>Donna Yates</td>
<td>Cheshire &amp; Greater Manchester CRC</td>
<td>Board Member</td>
</tr>
<tr>
<td>Rebecca Lane</td>
<td>National Probation Service</td>
<td>Board Member</td>
</tr>
<tr>
<td>Dot Keates (April-Sept)   Bernadette Connell (Sept-March)</td>
<td>Bridgewater Community Healthcare NHS Trust</td>
<td>Board Member</td>
</tr>
<tr>
<td>Debbie Dalby (April – Dec) Lydia Thompson (Jan-Mar)</td>
<td>Health Watch</td>
<td>Board Member</td>
</tr>
<tr>
<td>James Woolgar</td>
<td>Public Health Improvement Services</td>
<td>Board Member</td>
</tr>
<tr>
<td>Gill Healey</td>
<td>Golden Gates Housing Trust (Torus)</td>
<td>Board Member</td>
</tr>
<tr>
<td>Margaret Macklin</td>
<td>Warrington Borough Council</td>
<td>Board Advisor</td>
</tr>
<tr>
<td>Julie Ryder</td>
<td>Warrington Clinical Commissioning Group</td>
<td>Board Advisor</td>
</tr>
</tbody>
</table>
Get in touch

Email: wsabAdministrator@warrington.gov.uk
Call: 01925 444085
Visit our website: www.warrington.gov.uk/wsab

Or write to us at:
Warrington Safeguarding Adult Board, New Town House, Buttermarket Street, WA1 2NH