



Warrington

**Safeguarding**

Adults Board

Annual Report

2018/19

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## Section 1: Message from the Chair

This is the 8<sup>th</sup> Annual report of Warrington Safeguarding Adult Board (WSAB) and the fifth report I have presented since becoming Chair in 2015. We have had another busy year, working in partnership with a range of organisations, including local community groups. Our aim as a Board is to contribute to preventing abuse and neglect of adults who may be at risk, and to assure our community that action will be taken, and support made available when abuse is identified. As individuals and organisations we don't always get it right but my experience in Warrington is that all partners have a strong commitment to learn and do better.

The scope of our safeguarding agendas continues to grow with increasing evidence that people with a range of issues resulting in increased vulnerability, are more likely to be exploited by those involved in Modern Slavery, Serious Organised Crime, Domestic Abuse including stalking, and aggressive targeting of gambling.

The positive news, as you will see later in this Report, is that the Anti-Stalking Unit is continuing to raise awareness, support an increasing number of people affected by stalking, and take action against those who intimidate in this way.

I am also pleased to report that Warrington's use of independent advocacy to support people who are at increased risks due to lack of mental capacity to make good decisions, continues to grow. Warrington is also clear that people with capacity ultimately have the right to make decisions that may not be in their best interests. This does mean that safeguarding processes can't reduce all risks to people, but they can ensure that people have an opportunity to support them to weigh up their decisions.

Safeguarding referrals overall have increased this last year, which means an increased workload for staff, but also may indicate that public awareness is growing. It is particularly important to note that there has been a small increase in numbers of referrals from people of diverse heritages, which we hope signifies that the awareness raising is achieving its purpose to reach out to all the residents of Warrington.

We have continued to see an increase in requests to undertake Safeguarding Adult Reviews (SARs) when there are concerns that an 'at risk' adult has died or been seriously harmed, in circumstances where partner agencies might have done more to protect them. As you will see later in the Report, the review process can take a long time. Recent cases have been more complex, involving people, not normally Warrington residents, who are in Warrington health and care facilities, commissioned by other SAB areas.

Many incidents leading to SARs necessitate inquests and we have been working with the Coroner to ensure that there is a shared understanding of a SAR's purpose of learning what might have been done differently to prevent future harm to others, as distinct from the Inquest purpose, which is to determine the cause of death.

Some of the small SAB team also work with the Children's Safeguarding Board (WCSB). Due to new legislation the Board has undergone some significant change in the last few months. SAB members have shared in some joint discussions around these new developments, though there currently appear to be no national plans to implement similar changes for SABs.

As I write this foreword, both our Board Manager and Deputy Business Manager have left their roles in Warrington to take up other challenges. They will be greatly missed but we are fortunate in that the posts have been filled and we welcome new colleagues to work with us and to challenge us to improve so that people in Warrington feel safe and are safeguarded when necessary.

**Shirley Williams**  
Independent Chair



*WEAD 2018 Winners – Residents of Summerville Nursing Home*

# Section 2: Warrington Safeguarding Adults Board (WSAB)

## What is Adult Safeguarding?

The Care Act 2014 statutory Guidance describes adult safeguarding as: *“Protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time, making sure that the adult’s wellbeing is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.”*

*This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances”.*

## Who does safeguarding apply to?

Safeguarding is everyone’s responsibility and the Board has a role to play in assuring our community that ‘adults at risk’ are safeguarded from abuse or neglect. An adult at risk can be anyone aged 18 or over who:

- Has care and support needs<sup>1</sup> and;
- Is experiencing, or at risk of, abuse or neglect; and/or
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experiences of abuse or neglect.

## Our Vision

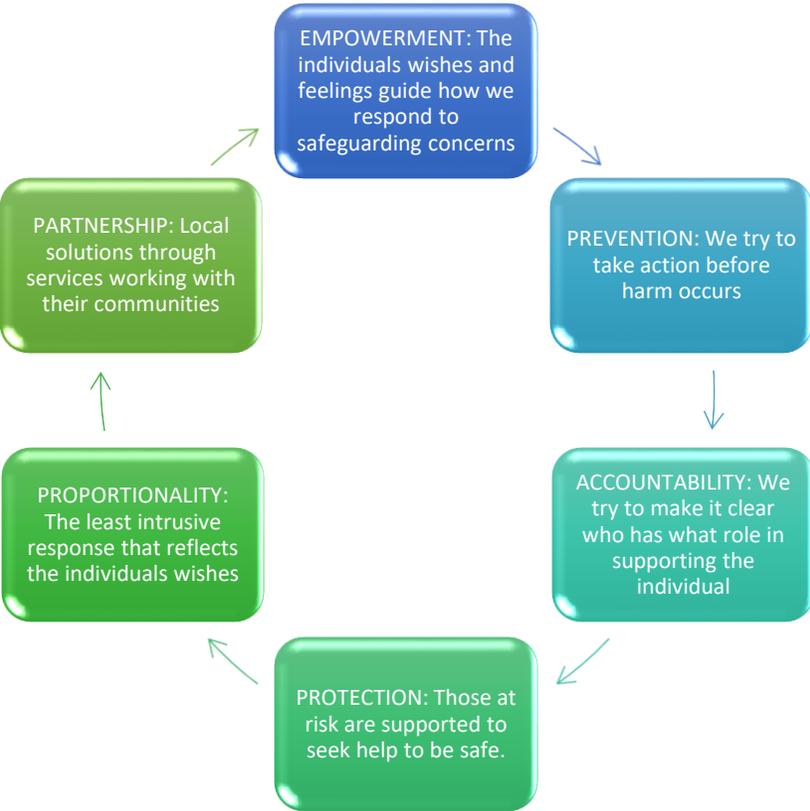
Warrington Safeguarding Adults Board (WSAB) believes that

*“ All people have the right to live in safety, free from abuse and neglect. ”*

<sup>1</sup> Even if no agency is involved in meeting those needs

It is agencies coming together to make safeguarding adults at risk a priority for local people and professionals.

We are guided by the six safeguarding principles represented in the diagram below:



**The role of the Board**

We have been here since 2010. We became a statutory body in April 2015 under the Care Act 2014.

Our purpose is to assure the people of Warrington, that local safeguarding arrangements are strong, sustainable and that people work together to prevent and respond to abuse and neglect.

This includes overseeing local activity and planning and challenging any poor practice.

We also promote information sharing between agencies and learning from cases to improve practice across the area.

**Who are we?**

WSAB is a group of organisations who work with adults at risk in Warrington.

The three statutory organisations are Warrington Borough Council (WBC), Cheshire Constabulary (Police) and Warrington Clinical Commissioning Group (CCG).

Other partners include public, commissioned, private and voluntary providers in the area.

The Organisations indicated here are currently part of the WSAB group.



## What are our statutory duties?

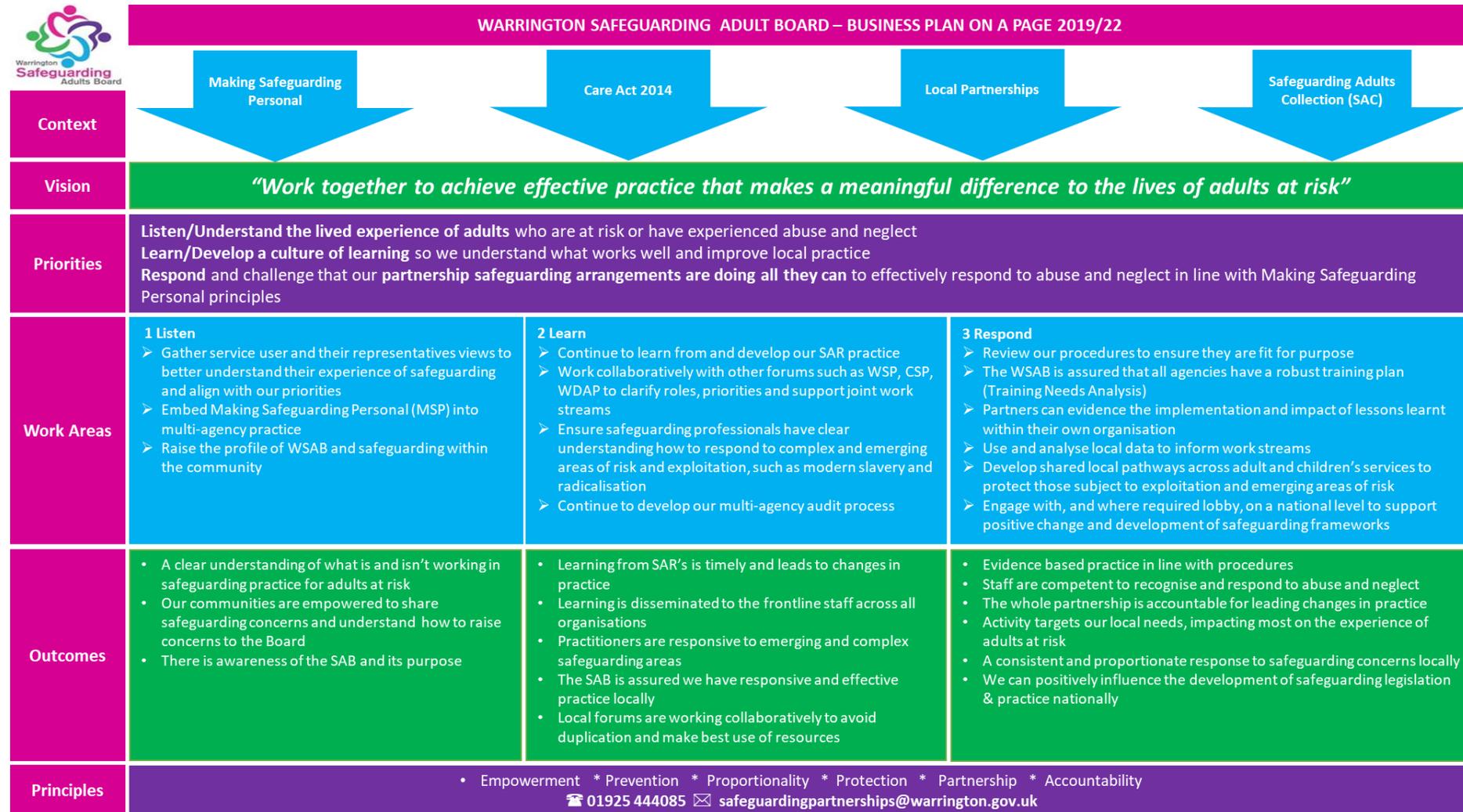
### 1. To publish a Strategic Plan

- This is a document that stated what and how we will achieve our priorities. You can read our Plan on the WSAB website ([www.warrington.gov.uk/wsab](http://www.warrington.gov.uk/wsab)) and we have a quick guide on one page to make it easier to access – look for our Plan on a Page (example on the right)

### 2. To publish an Annual Report

- This tells you what we have done each year and what has been learnt in any reviews we have done. You can view previous reports on the WSAB website ([www.warrington.gov.uk/wsab](http://www.warrington.gov.uk/wsab))

### 3. Conduct Safeguarding Adult Reviews in certain situations. See section 6 for a further explanation of when we conduct these learning events



### Section 3: How do we meet our statutory duties?

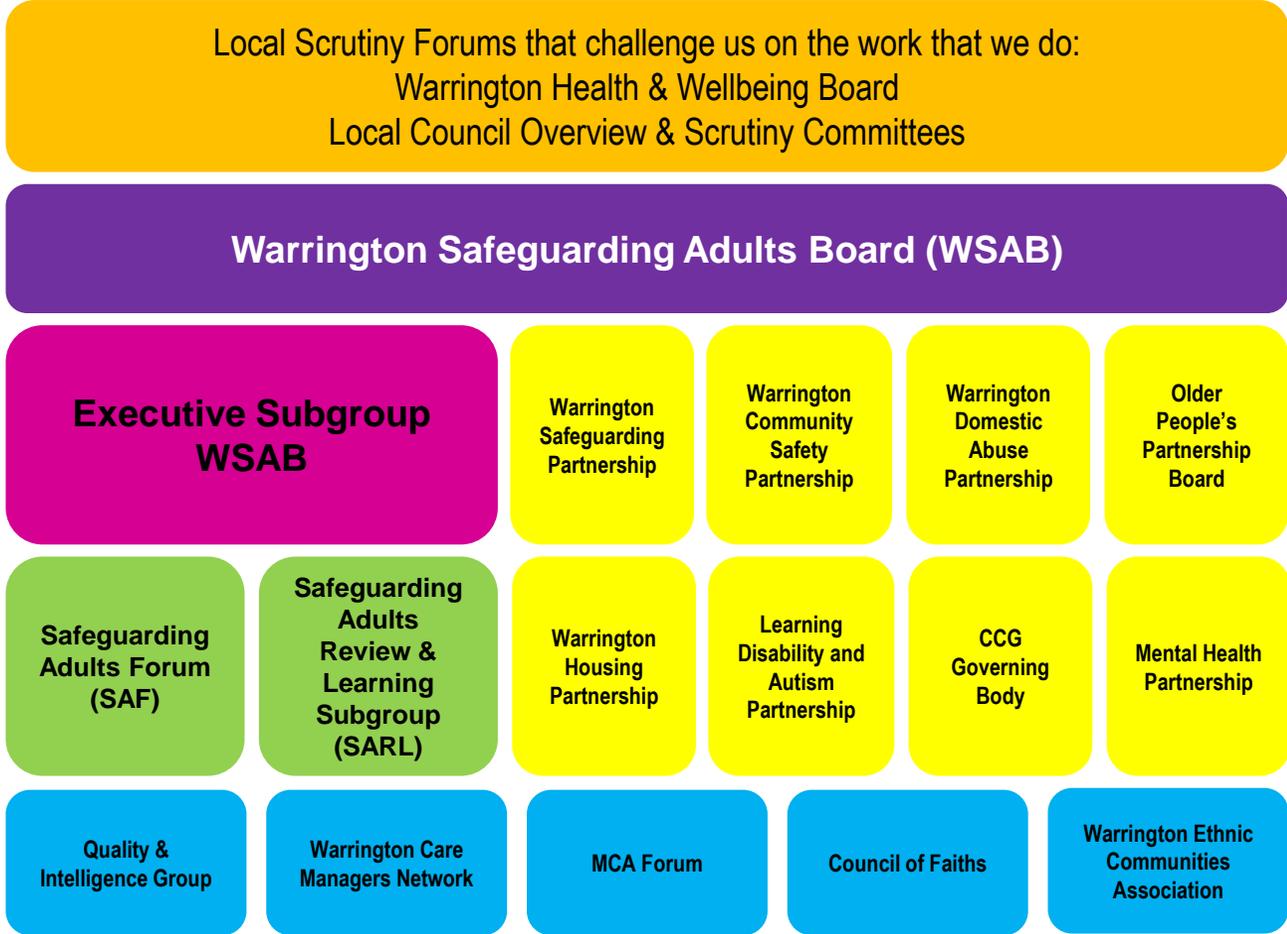
We try to make a difference locally by bringing agencies together to discuss how best to safeguarding adults at risk. We do this through setting up groups and linking in to other local partnerships. These groups inform, support and oversee the delivery of our priorities. The diagram on the right shows the current Board structure in terms of groups and local forums.

**Pink:** The Executive subgroup oversees the progress of the other subgroups to ensure the Board achieves its core functions and considers any challenges and problems.

**Green:** These subgroups are responsible for taking forward specific activity on behalf of the Board and are made up of professionals from the partner organisations.

**Blue:** Warrington also has a number of local forums and network groups who feedback concerns and challenges that they want to seek Board support to resolve. The Board facilitates the Safeguarding Adults Forum (SAF) as a way to stay engaged with smaller agencies and links in with other existing forums such as those noted in blue on the diagram.

**Yellow:** Warrington Safeguarding Board also works with a range of other local partnerships that support us to make a difference for the community.



## Section 4: Progress against our Strategic Priorities in 2018-19

We said that we would focus on:

### Listen and Do

- Listen to what adults tell us about their experiences of abuse and neglect, and the services and support they receive
- Make sure people are at the centre of safeguarding

### Learn and Prevent

- Ensure there is an embedded preventative approach
- Embedding learning/ improvements in partners practice
- Develop clear training/ education and staff competency expectations

### Doing the business and checking it

- Ensure that the WSAB is a sustainable partnership
- Prepare the partnership for developments and new ways of working

The following sections provide an overview of key activity undertaken in 2018-19 against our workplan.



## Priority 1: Listen and Do

### We wanted to make sure people are at the heart of everything we do

- Visited local community groups to discuss their sense of safety in Warrington and promote “Notice... Care... Tell...” Campaign, including a Carers event, Macintyre Friendship Group and the Knit and Natter group.
- Gathered feedback from community members to develop our understanding of their lived experience in Warrington at the MELA and Disability Awareness Day (DAD).
- The SAB has considered safeguarding issues in relation to older Carers, Appointeeship, Financial Exploitation, and areas where independent advocacy has been involved. The service users view and experience were kept in focus to make sure people are at the centre of the decisions being made.
- We have worked with North West Association of Directors of Adult Social Services (ADASS) to pilot a new approach to implementing the outcomes framework developed by Research in Practice for Adults (RIPFA). This was being done to try and ascertain the longer term impact of a Making Safeguarding Personal approach for the individual.
- We worked with Warrington Ethnic Communities Association to support the MELA and provided the opportunity to share safeguarding messages to our more diverse local groups.
- We promoted World Elder Abuse Awareness Day (WEAAD) across the partnership and once again our local care homes took up the mantle to promote the purple challenge with residents and visitors

### Good Practice Highlight

Warrington and Halton Hospital have been developing their support pathways for patients with a Learning Disability. This has included a package of awareness raising for staff alongside easy read documents to support patients to understand treatment and be able to participate more effectively in their own care and treatment. The Safeguarding leads have also been working on emergency admission pathways to support reasonable adjustments required to remove barriers for patients with a Learning Disability from accessing care.

### What's next?

- We will work with other local forums, such as the Community Safety Partnership and Licensing Forum to address some of our communities safety concerns.
- Continue to connect with our local community groups to raise awareness of the Board and develop our understanding of their concerns and experiences.
- Explore with partners what difference the Making Safeguarding Personal approach is making for the individual and the impact on carers, and what we should be considering for practice across other agencies.



WEAAD 2018 Warrington Council Senior Managers wearing Purple with Pride

## Priority 2: Learn & Prevent

### Ensure that there is a preventative approach

- We have delivered a learning event on working with Personality Disorder to develop understanding of local services and awareness of appropriate practice .
- In response to new Housing legislation we worked with the housing partnership to understand the risks and challenges for local services. This included supporting local organisations to review their practise in supporting homeless people.
- We have monitored how people are supported through advocacy services locally and how this is promoted by frontline staff .
- A Response Service Pilot has been implemented to explore opportunities to avoid unnecessary admissions to hospital in the best interests of the individual through bringing support to them at home.
- We have looked at data from housing and Cheshire Fire and Rescue partners to inform our understanding of the support needs of our more isolated community members.

### Embedding learning/ improving partners practice

- We worked with NHS England to develop a national framework of oversight for private sector hospitals after concerns regarding robust oversight were identified.
- We have ensured we kept abreast of emerging challenge areas through raising awareness of the Counter Corruption Unit focus on Abuse of People in Position of Trust (PiPoT) concerns and the development of Serious Organised Crime Units.

### Embedding developing areas of practice

- We provided feedback on a revised Intercollegiate document for Adult Safeguarding.
- We continued to develop our audit process by trialling a Section 42 panel and a Think Family Parental Mental Health audit with children's services.
- We developed a Modern Slavery training matrix and package for agencies.

### Embedding developing areas of practice

- We have worked closely with the Coroner to train officers on the purpose and functions of Safeguarding Adult Reviews (SARs).
- We have raised awareness of the Banking Protocol to respond to financial abuse of adults at risk
- We have supported the Warrington Domestic Abuse Partnership to establish its priorities with a focus on adults at risk experiencing Domestic Abuse.

### What's next?

- We will re-develop our Safeguarding Adult Review process to ensure our learning model is effective and reflect our learning from this year.
- We will continue to work with local forums to tackle complex safeguarding such as Modern Slavery.
- Continue to develop our training offer around complex areas of practice.
- Embed audit processes further across the partnership.

#### Good Practice Highlight

Warrington Anti-Slavery Network has reflected on any Modern Slavery cases identified in Warrington to develop and formalise a joint protocol between police, housing, social care and local housing providers.

Learning from three cases has helped develop our support to women subject to sexual exploitation including support from sexual health services, information and advice, and personalised aftercare.

The increased awareness of Modern Slavery has led to police increasing capacity within their teams to respond to this in Warrington.

## Priority 3: Doing the business and checking

### Ensure WSAB is a sustainable partnership

- We have been exploring a core partners' agreement to ensure necessary resources are in place to be able to undertake Safeguarding Adult Reviews
- We have sought assurances from the Clinical Commissioning Group (CCG), the Local Authority, North West Boroughs (Mental Health services) and Prisons about how safeguarding responsibilities are made clear when commissioning services and how organisations are held accountable
- Focused on Appointeeship processes after concerns were raised that the system may be disadvantaging those needing its protections
- We worked with the Community Safety Partnership to participate in a Domestic Homicide Review (DHR) that included Adults with possible Care and Support needs to ensure adult safeguarding learning was included in the process
- We have been leading on 2 Safeguarding Adult Reviews (SARs) involving people with complex needs placed in Warrington hospitals by health/social care agencies outside our locality

### Prepare the Partnership for change

- Promoted the WSAB training programme and developed our packages including in relation to Modern Slavery so that partners can deliver awareness raising in their own agencies to improve staff recognition and response to Modern Slavery and Trafficking.
- We have participated in developing the understanding of “Contextual Safeguarding” so that we can identify where adult and children’s services and systems need to work together to respond more effectively.
- As a result of the Housing audit tool completion we have worked on intelligence with a key housing partner to promote this approach across the housing sector.
- We have continued to Support the Council of Faiths and Warrington Ethnic Communities Association (WECA) by linking to their forums and sharing our safeguarding skills and products.

### Good Practice Highlight

Following a SAR in which concerns were raised about a person’s care in a private hospital, WSAB wrote to NHS England and Care Quality Commission (CQC) to request a review of the arrangements that may have contributed to a fatal incident.

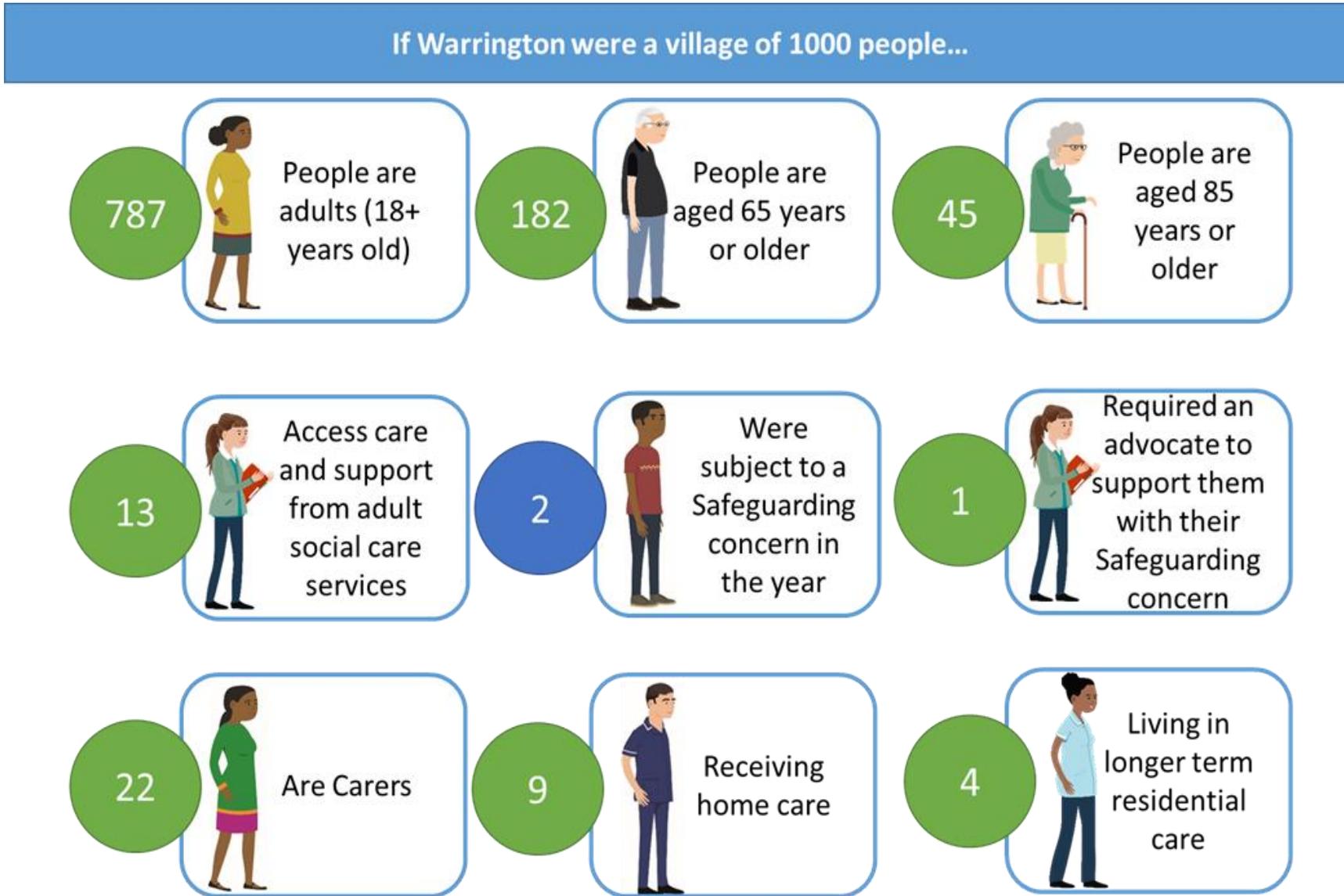
Following this NHS England have reviewed their processes and made changes nationally which have clarified responsibilities for monitoring independent hospitals and CQC have introduced some changes to strengthen their registration processes.

These changes will increase the oversight on particularly vulnerable people who are often placed far from home.

### What’s next?

- We will consider our local structures and procedures based on our developing practice and implement any required changes and updates.
- We will carry out our Training Needs Analysis to identify skills gaps.
- We will develop a process to seek assurance that lessons are being learnt across the Partnership.
- We will continue to build our local intelligence picture to inform our priority work.
- We will maintain our links to local forums and continue to support their engagement with safeguarding responsibilities by offering support and guidance where needed.

Section 5:  
Our Area



### People involved in safeguarding enquiries and the nature of concerns

The People	Type of Concern	Who was the source of risk	What does this mean?	What will we do?
<p>415 adults were involved in safeguarding enquiries, compared with 303 last year (63% female; 37% male). The greatest number were older people (74% over 65, up from 66% last year). Over a quarter were over 85 years old. Almost half had physical care needs.</p> <p>Compared with last year, 103 more people were in the age group 65 to 94 and were mainly those with physical support needs.</p> <p>There was an increase in the proportions of people from a minority ethnic group from 2% last year (6 individuals) to 4.3% this year (18 individuals).</p>	<p>Physical abuse and then Neglect were the most common concerns. This year there was a rise in number of concerns across most types of abuse, but the rise in physical abuse and financial abuse, now the third most common concern, was significant.</p> <p>Though small numbers, there was a significant increase in identifying, recording and investigating concerns about Modern Slavery and Neglect.</p> <p>There were also 13 institutional safeguarding enquiries, which was a significant increase from last year.</p> <p>Over half (59%) of safeguarding enquiries focussed on risks that were identified in care home settings with 36% arising in the adults own home or community. 26 of the enquiries considered risks identified in hospital setting, the majority in Mental Health settings.</p>	<p>The source of the risk was most often someone known to the individual (57%) followed by the care provider (31%).</p> <p>Emotional abuse, financial abuse, sexual abuse and physical abuse were areas where the source of the risk was another adult known to the person at risk.</p> <p>In a significant number of cases, particularly in care settings, this was another adult with care and support needs. Primarily this is the case in settings for people with dementia and Learning Disabilities, as well as those in specialist hospitals.</p>	<p>As the population ages, more adults have care and support needs and therefore are more vulnerable and at increased risk of neglect, poor care or potential abuse.</p> <p>For younger adults with care and support needs, resulting from a severe physical or learning disability, there can be similar risks and vulnerabilities, particularly when they may lack capacity to make decisions about their care and welfare.</p> <p>The patterns and types of risk vary with the kind of support needs and whether the adult is living in a care setting of their own home.</p> <p>WSAB partners work together to monitor and support improved quality in care settings and to help professionals to understand and deal effectively with areas of increased risks, such as self-neglect, homelessness, criminal exploitation and Modern Slavery.</p>	<p>WSAB has done a lot of work to support professionals who work with adults who have risky lifestyles, including drug and alcohol dependencies and self-neglect. We will continue to help support them with guidance and best practice.</p> <p>We will continue to develop approaches to promoting good care in care settings and to hearing the voice of adults.</p> <p>We will continue to support local work on exploitation and Modern Slavery.</p> <p>We will continue to promote public awareness and to reach target communities.</p> <p>WSAB has undertaken some focused work on minimising the impact of adults in shared care settings posing risks to each other. This work will be further developed and assurances sought regarding the type and suitability of support available.</p> <p>WSAB has worked to raise awareness in the community, and with community and voluntary groups, including minority ethnic and religious groups, with our “Notice... Care... Tell...” Campaign.</p>

## Results of Safeguarding Enquiries

## Findings

In 15% of enquiries, no risks were identified.

In 9% of enquiries, the evidence of risk was inconclusive.

In 3% of enquiries, the enquiry was ceased at the request of the individual and no action was taken.

In 73% of enquiries, risks were identified.

The majority of people who were involved in safeguarding concerns (61%) of people lacked the capacity to make decisions about the risks identified. This was an increase from 47% last year.

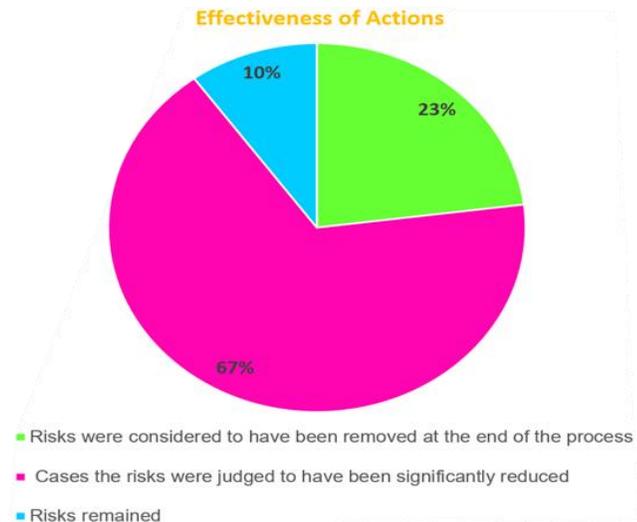
Over 90% of people who were assessed as lacking capacity were represented in safeguarding process. This was an increase of 35 from last year.

## Outcomes

Records show that 87.5% of people were asked or supported to consider what outcomes they would like to achieve from the safeguarding process and the vast majority responded. Those not asked were more likely to be younger adults with severe impairments or older adults with dementia.

Of those who said what outcomes they would want, the vast majority felt they were achieved (81%) or partly achieved (8%). In 10% of cases however they were not achieved which was an increase from last year (6%).

In feedback surveys 100% of individuals or their advocates, told us that they felt listened to and supported. 87.5% said that they felt safer. Where risks were identified in the enquiry, in 363 of the 381 cases actions were taken.



## What does this mean?

Making Safeguarding Personal is all about working with the adult to look at risks that are impacting them and supporting them to have a safeguarding plan that reduces risk and helps them to achieve the lifestyle and the outcomes they want.

The high proportion of people involved in safeguarding concerns who lack capacity to make decisions about the safeguarding risk, shows their level of vulnerability. It is important that they have support through the process and their wishes and feelings are represented, with decisions taken in their best interests.

The data shows that in Warrington, services are working directly with adults and that they are being supported well through advocacy and feel they are being listened to in the safeguarding process.

It is not always possible to remove a risk. This can be because the adult may value a relationship that may include risk, for example with a member of the family which they want to still see, or a lifestyle that is seen as risky. Sometimes the evidence of risk may be difficult to establish.

## What will we do?

WSAB will seek assurance that where risks are judged to remain at the end of safeguarding process, appropriate support has been offered, there has been appropriate consideration of mental capacity, and that the adults views and wishes have been central.

WSAB will also consider the reasons for not achieving the outcomes people said they wanted in a minority of cases.

The above will help give assurance that Making Safeguarding Personal is working.

## We Said ... We Did ... in 2018-19

### Gender balance in Enquiries

We said we would explore why there are more females than males in Section 42 Enquiries particularly as our data included more females than in the national picture. We were concerned that this could reflect a gender bias in practice. We worked with Public Health analysts and also conducted a case audit. We confirmed that our population gender breakdown changes with age and that there are more women than men in the oldest age group. The case audit also showed that safeguarding decision making had been appropriately based on risk and need. Therefore, we have assured ourselves that the higher number of females is not due to a gender bias. This year the safeguarding data more closely reflects national gender ratios. We will continue to monitor gender breakdown in safeguarding concerns.

### Mental Health Support Needs

We said we wanted to explore specific risks for adults with Mental Health Support needs. This showed us that we need to support and encourage staff to promote positive approaches in risk management when adults want to have outcomes or lifestyles that can present risks. We are developing local guidance to support professionals to practice with confidence and within the legal framework for safeguarding. WSAB will also be seeking assurance from mental health services and the Mental Health Partnership about access to Mental Health services and the progress with local plans to improve this.

### Community Awareness

We said we wanted to continue to promote reporting of safeguarding by the local Community. This was to encourage wider reporting of safeguarding and care concerns less visible to professionals, such as care in people's own homes or instances of self-neglect or exploitation. We did this through the promotion of the "Notice... Care... Tell..." campaign at events like the MELA and Disability Awareness Day (DAD) and by producing advice information and engaging directly with residents.





### Anti-Stalking Unit

The two year pilot of an integrated Anti-Stalking Unit, which co-locates professionals from three police forces, three NHS Trusts and the Suzy Lamplugh Trust continues in Warrington. Cheshire Police and North West Boroughs NHS Trust contribute to developing this service that will provide greater protection to victims and increase public safety. Over 1500 professionals have received training from the IASU including professionals from Warrington.

Across Cheshire, compared to the previous 12 months, there has been a 129% increase in reported stalking crimes. For the same period, there has been a 69% increase in the number of stalking cases resulting in a charge for stalking. Referrals from Warrington have increased, peaking in July 2019 following a period of awareness raising.

Since the operational “go-live” date for the Integrated Anti-Stalking Unit on 1st September 2018, there have been 435 referrals into the service; 305 of these have been for Warrington cases. 127 of the Warrington cases were heard at the case management meetings where each case, identified as stalking, received a bespoke risk profile and risk management plan.

### Engaging with Advocates

Advocates are an important voice of adults who are at risk. Our data shows that in Warrington, adults who need support in the safeguarding process have access to that support and that where it is appropriate, there is access to a professional and independent advocate. We said we wanted to hear more from advocates about the experience of adults who lack capacity involved in safeguarding processes. The feedback survey was extended to include their views. Speak Up, the local advocacy hub, who have representation on WSAB also presented a case study that demonstrated some of the barriers that exist and how they are addressing these to ensure people’s rights. This gave assurance about how advocacy services are supporting people to achieve positive outcomes. It also showed that services may need to do more to address barriers and ensure advocacy support is involved at the earliest point.

## Modern Slavery

Warrington Anti-Slavery group has focused on exploring a consistent response to victims in the last 12 months. Through operational experience the network has been able to update the local protocol based on our learning. For example ensuring that we have named agency contacts to provide guidance and support when cases are identified.

We have shared our local protocol across Cheshire with colleagues to support other areas to develop the same local pathways.

We have also worked with our colleagues in other Local Authority areas to explore a 'victim pathway' that offers support whilst national support services make decisions on eligibility for their intervention. Many of the victims have basic needs to be met such as appropriate accommodation, food, clothing and toiletries. We are proud of the dedication our practitioners have shown to support victims.



Throughout this work we have remained linked to Cheshire Anti-Slavery Network (CASN), the multi-agency partnership of organisations across Cheshire aiming to raise awareness of modern slavery and human trafficking. We have worked with the Networks independent chair, Robin Brierley.

During 2018-19 the WSAB has supported CASN to;

- Deliver a train the trainer Modern Slavery package suitable for a multi-agency workforce,
- Develop a network newsletter to raise awareness,
- Deliver against its strategic action plan in relation to engaging communities.

Within Warrington we have delivered awareness raising sessions to our local Soroptomists to support them to raise wider public awareness.

## Assurance from Commissioned Services

WSAB has sought assurance from Commissioners within the health and social care sector and acknowledge that there are areas of good practice:

- A joint Local Authority and NHS Clinical Commissioning Group (CCG) monitoring programme, with the CCG adding a health element to the monitoring visits relating to infection control, falls, medication management, pressure area care and the management of long term conditions.
- Intelligence sharing with the Care Quality Commission (CQC) to inform future inspections and co-ordinate responses to support improvement in homes in Warrington
- Development of joint improvement plans with care home managers to develop services and ensure responsibilities are clear
- Agreement of a joint provider 'failure policy' which is utilised with the aim of preventing failure or facilitating resulting closure safely should that be necessary.
- A focus on effectiveness and any specific areas for improvement that includes supporting an individual provider or wider access to targeted training where themes and trends are apparent
- The CCG quality improvement manager works closely with the community enhanced care home support service and clinical skills hub educator to identify and address concerns and provide a standardised, evidence based approach to knowledge and practice
- Continued support through the Registered Care Home Providers network

## Section 6: Learning from Safeguarding Adult Reviews (SARs)

Consideration of a SAR is a legal requirement under the Care Act 2014. The Care Act Statutory Guidance requires that:

*“Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.*

*SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.”*

When a case meets the criteria above, the SAB must undertake a SAR and make sure that there is appropriate engagement with the agencies who were involved as well as with the adult or family affected. This is a complex and sensitive process that often involves bereaved families. The WSAB has a clear SAR Protocol that outlines the referral, screening and review process. The approach to each case is dependent on the circumstances. The SAR looks at what agencies might have done differently that may have prevented harm or death. The purpose is to learn lessons from the situation to try and prevent a similar situation happening again.

In 2018/19, 5 new cases were referred for review, of which 1 was taken forward for a Domestic Homicide Review, 1 was reviewed as a Practice Brief for learning and 3 were deemed not to have met the criteria for a Safeguarding Adult Review or SAB involvement. In addition to these new cases, activity continued against 2 ongoing SARs from 2017-18.

### Overview of ongoing Safeguarding Adult Review (SAR) activity for cases referred in 2017

Case	Referral Date	Activity Update
F	December 2017	As reported last year a review was taken forward in 2018-19 on this case after a death in a private Mental Health Hospital occurred. This case is still ongoing and we are awaiting the conclusion of the Coroner’s inquest. This review is expected to conclude in the Autumn of 2019.
H	June 2017	Having reviewed the SAR findings, the SAB requested further work on the review the report to meet quality and accessibility markers. The SAR is expected to be ratified in Autumn 2019. At this stage the recommendations will be taken forward.

## Safeguarding Adult Review (SAR) cases referred in 2018-19

### Case L: April 2018 – Potential Self-Neglect Concerns

WSAB reviewed a case where an adult with complex health conditions had died from Chronic Obstructive Pulmonary Disease. In this situation there were a number of complicating issues including self-neglect and intervention by a partner, which made it more difficult for care staff to support the adult to manage their health. There had been significant challenges for staff in gaining access to the home and supporting the adult and their partner to accept services and follow the care plan. The review identified good practice where professionals had invested time in building relationships to encourage and continue the offer of support and appropriate escalation of safeguarding concerns.

The case did not meet the SAR criteria, however some learning was identified and shared through a brief which is published on the WSAB website. The key learning related to:

- Ensuring professionals consider the impact of deteriorating physical health on mental health and decision making and clearly record the persons views (reasons for declining)
- Understanding the relationships within the home to identify opportunities and risks that family members may provide in cases of self-neglect and refusal of services
- The value of multi-agency professional meetings to build a clear picture of the person, identify opportunities and existing relationships and support staff and share decision making in complex cases

### Case M/DHR: July 2018 – Potential Mental Health and Domestic Abuse concerns

This case met the criteria for a Domestic Homicide Review (DHR). To avoid duplication, WSAB worked with the Community Safety Partnership (CSP) to ensure that any learning relevant to Safeguarding was discussed and captured within the DHR report.

The case involved an individual who was murdered by their ex-partner following release from prison. Both individuals were known to homelessness, alcohol and social care services. No safeguarding concerns were identified however the panel identified a missed opportunity to assess and therefore respond to any care and support needs.

WSAB will work with CSP in 2019-20 to respond to the DHR recommendation to explore *“the feasibility of developing a coordinated case management/information sharing approach to the care of high intensity service users, who for whatever reason engage in risky behaviours that are not captured by other safeguarding processes.”*

### Case N: October 2018 – Potential concerns regarding care and restraint in MH settings

A referral was made for an individual who died in a Mental Health setting after being placed there by another authority. The family had concerns how his care needs were supported and about whether the death was related to incidents of service user on service user abuse. It was not considered that on the evidence available that the SAR criteria was met, however a number of other relevant processes were being followed including under the Coroner, NHS Serious Incident Framework and local Safeguarding Team. It was considered that these appeared to be the appropriate processes to respond to the families concerns in this case.

### Case O: November 2018

The WSAB was asked by a family to consider an alleged misuse of a Lasting Power of Attorney and potential coercion and control of a family member who has since died. The case was not felt to meet SAR criteria, however the relevant partner agency was asked to undertake a single agency review of responses to the concern raised whilst the individual was alive. WSAB will seek assurances about the appropriateness of the response and how lessons have been shared with frontline staff.

### Case P: January 2019

The WSAB received a SAR referral related to an emergency placement of a vulnerable adult in Warrington by another authority area. There was an active safeguarding concern about the young adult who was diagnosed with a Personality Disorder. The referrer had concerns about the current risks and, potentially unmet needs due to limited placement options. It was agreed that the appropriate route for this concern was through the WSAB Escalation Policy rather than a SAR referral. As a result the WSAB supported the local safeguarding team to engage with colleagues from other localities to ensure a move to a more appropriate setting where her needs could be more effectively met and this happened. The referring agency was asked to ensure that the escalation process was used for any future cases where an urgent response was needed.

## Section 7: Feedback

### Local Safeguarding Survey Feedback

We ask adults involved in safeguarding enquiries to complete a Safeguarding Survey at the end of the process to capture their opinions and support partners to improve how they work with adults.

### Adult Social Care Outcomes Framework (ASCOF) Survey

The Adult Social Care Outcomes Framework (ASCOF) is a national survey that measures how well care and support services achieve the outcomes that matter most to people.

Data from 2018-19 shows that the proportion of services users that feel safe has reduced from three quarters last year to two thirds this year. However, the proportion of people who use services who say that those services have made them feel safe and secure has increased by 1.5% to a rate of 87.5%.

This is assuring to know that despite general feelings of being safe in Warrington is reducing, those who are receiving services are feeling more secure as a result.

### What do we need to do next?

We need to ensure that we are regularly hearing from service users and professionals. Whilst we have regular focuses on service user views and case studies we have not identified a regular mechanism to support professionals to tell us what they think.

This is an area for focus in 2019-20 alongside continuing to develop our service user feedback.



## Section 8: Funding Arrangements

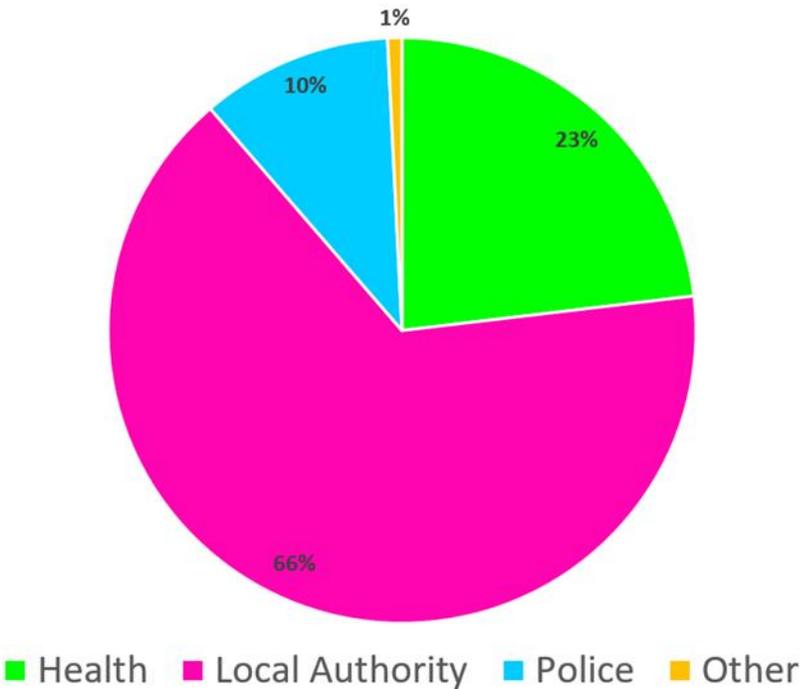
In 2018 the WSAB and Warrington Safeguarding Children's Board (WSCB) continued to operate with a shared team and budget. This was to ensure an efficient use of resources and opportunities to collaborate were identified. The budget comes from partner agencies contributions which are indicated below:

The budget for 2018-19 was £402,287 (combined contributions and carried forward budget).

Running Costs	2018/19 £000
Staffing costs	229
Corporate charges	34
Partnership costs	4
<b>Total</b>	<b>267</b>

Whilst this supports the partnerships to continue to discharge their statutory functions the realised additional cost of SARs and SCRs is going to effect the budget moving into 2020-2021. Partners are in the process of agreeing how to ensure that the SAB can achieve its aspiration of a learning focus within its current funding arrangements. This has created the opportunity to explore different ways of delivering SARs that supports learning as an embedded part of the review process.

### Contributions Breakdown 2017-18



## Section 9: The Year Ahead 01 April 2019 to 31 March 2020

### Our Vision for 2019-20

Make sure that our learning influences practice so that we see improvements in the experience of adults at risk, and wider awareness of the WSAB and safeguarding responsibilities.

### Our priorities

Our revised priorities for 2019 - 22 have been published as a plan on a page. As a Partnership Board we will continue to review our priorities, make up and arrangements to ensure we achieve our and our communities' priorities.

### Monitoring and review

WSAB will monitor progress against currently identified activity and outcomes quarterly via its Executive Sub-group. The Board will also seek external scrutiny through half yearly updates to local scrutiny forums such as the local Health and Wellbeing Being Board.

## Section 10: References and further information

Care Act Statutory Guidance

[www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance](http://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance)

Warrington Safeguarding Adult's Board (WSAB)

[www.warrington.gov.uk/wsab](http://www.warrington.gov.uk/wsab)

Care Act 2014

[www.legislation.gov.uk/ukpga/2014/23/contents/enact-ed](http://www.legislation.gov.uk/ukpga/2014/23/contents/enact-ed)

World Elder Abuse Awareness Day (WEAAD)

[www.elderabuse.org.uk/Pages/Category/weaad](http://www.elderabuse.org.uk/Pages/Category/weaad)

Disability Awareness Day (DAD)

[www.disabilityawarenessday.org.uk](http://www.disabilityawarenessday.org.uk)

Warrington Safeguarding Partnership

[www.warrington.gov.uk/wsp](http://www.warrington.gov.uk/wsp)