

Annual Report 2019/20

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Section 1 Message from the Independent Chair



This is the 9th Annual report of Warrington Safeguarding Adults Board (WSAB) and the sixth report I have presented since becoming the Independent Chair in 2015. As I write this message at the end of 2020 I am very conscious of how different our lives were before the beginning of March 2020 when most of us had never heard of a virus called Corona and would never have predicted that going into 'lockdown' would signify severe restrictions on the freedom and choices of people who had done nothing wrong.

Who would have believed in early March 2020 that a hidden enemy in our midst would have taken the lives of over 75,000 people in the UK by Christmas 2020, and that the virus in its various mutations would be continuing to affect the health and wellbeing of many more. The demographics of those who die or are seriously affected by the Coronavirus have thrown into stark relief the inequalities in our society as well as the need to identify those who are most at risk, particularly older people, people with underlying health conditions, and people multiply disadvantaged by poverty, poor or no housing, including a disproportionate number of people from some minority ethnic communities.

As well as the physical risks from the virus, we have become increasingly aware at personal as well as agency level of the emotional pain and sometimes despair as a result of separation from and restricted contact with family and friends, particularly in the Care Home sector. The impact has been significant on both low paid care workers as well as family/friend carers, some of whom have taken their relatives out of care settings because of their concerns.

The aims of a Safeguarding Adults Board are to contribute to preventing abuse and neglect of adults who may be at risk, and to assure our communities that action is being taken to provide protection and that support is made available when abuse/neglect is identified. There have been many discussions at national, local and family level about whether preventing face to face contact, particularly for people in residential homes is a form of abuse and there are challenges emerging under the Human Rights Act. My experience this year is that Warrington has managed these challenges carefully, with discussions aimed at identifying and balancing risks, accompanied by a positive message of "How can we support safe contact to take place?"

To return to the financial year April 2019 to end of March 2020 we began to have a number of changes in Safeguarding Board staff, including the Board Manager In the summer of 2019. Those changes continued into 2020, but I am pleased to report that the small group of new staff have settled into their roles and brought new energy and ideas that have enabled the Board to continue to operate effectively in spite of all the Covid-19 challenges.

Whilst I may not be able to recall all the events during 2019-20, Board staff, in more than usually difficult circumstances, have pulled together in this Annual Report, the facts, figures and stories that demonstrate the extent and types of safeguarding concerns in Warrington. It also describes the work done by agencies working together in a person-centred way to prevent and mitigate risk of abuse and neglect and to learn and implement change to improve practice at individual and agency level. The Report sets out some of the plans for those improvements, which we hope can soon be celebrated without the need for masks and social distancing.

Shirley Williams
WSAB Independent Chair

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 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 the risk of, or the experiences of abuse or neglect.

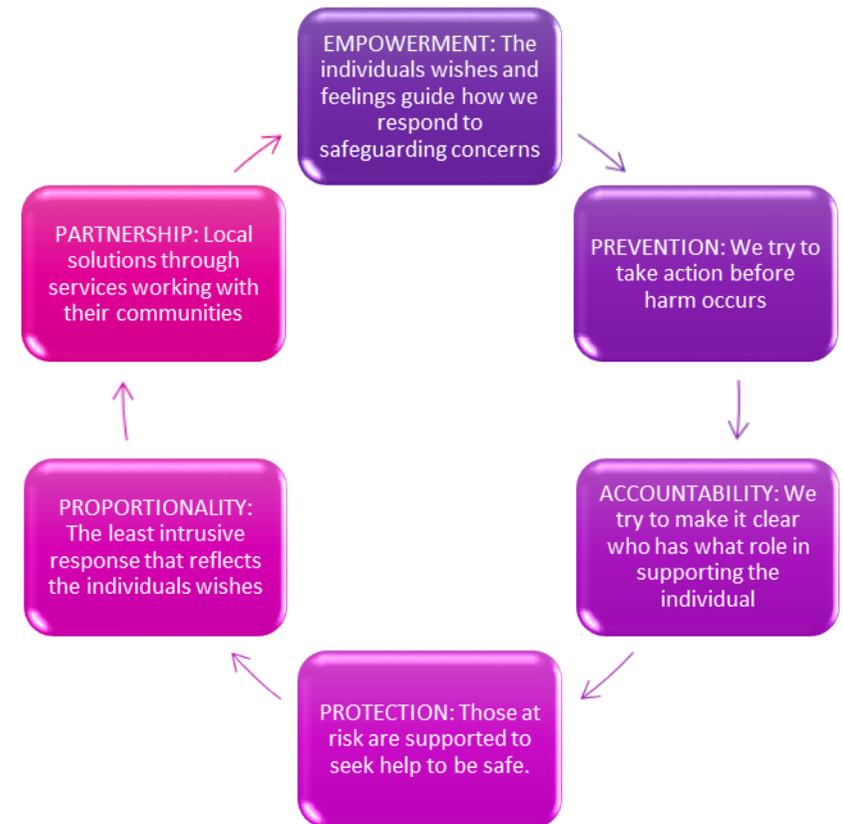
Our Vision

Warrington Safeguarding Adults Board (WSAB) believes that

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

Our principles

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



Section 2 Warrington Safeguarding Adults Board (WSAB)

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:



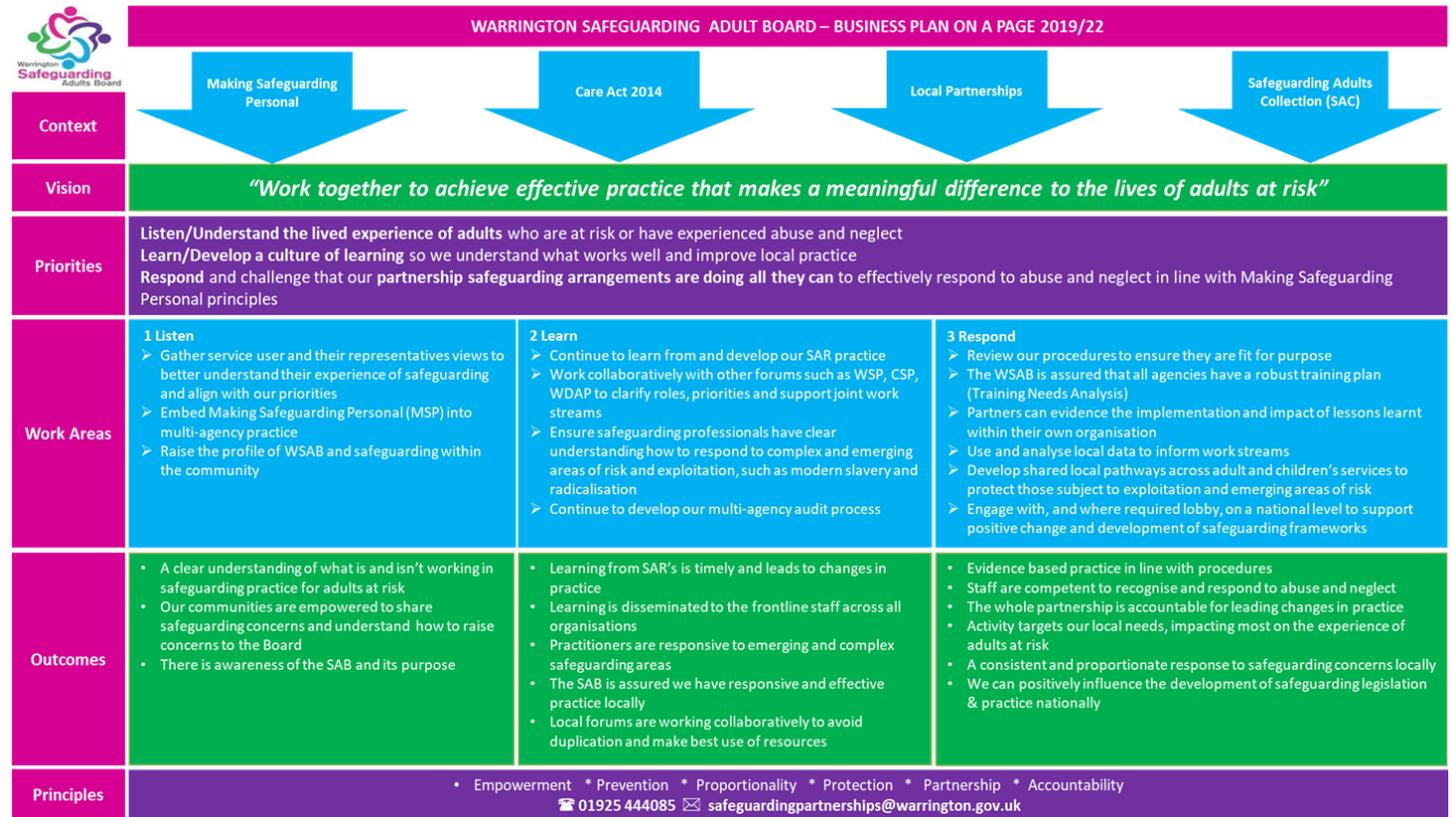
Section 2 Warrington Safeguarding Adults Board (WSAB)

What are our statutory duties?

1. To publish a Strategic Plan
 - This is a documents that stated what and how we will achieve our priorities. You can read our plan on the WSAB website (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)

1. 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 responsibilities

We try to make a difference locally by bringing agencies together to discuss how best to safeguard 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 structures 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.

Orange: Warrington Safeguarding Adults 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 2019-20

We said that we would focus on:

Listen

Listen and understand the lived experience of adults who are at risk or have experienced abuse or neglect.

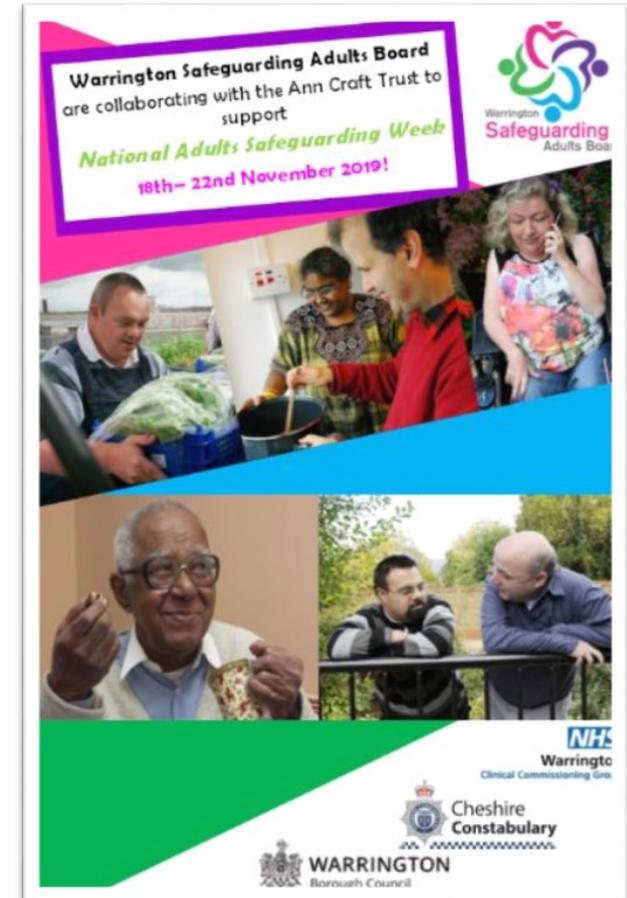
Learn

Develop a culture of learning so we understand what works well and improve local practice

Respond

Respond and challenge that our partnership safeguarding arrangements are doing all they can to effectively respond to abuse and neglect in line with Making Safeguarding Personal principles.

The following sections provide an overview of key activity undertaken in 2019-20 against our work plan.





Priority 1: Listen and understand the lived experience of adults who are at risk or have experienced abuse or neglect

During 2019 and 2020 work was undertaken to re-establish the Safeguarding Adults Forum and to ensure that the link could be made between the direction of the WSAB and the lived experience of adults at risk. Professionals invited to share feedback from the adults that they work with and case study examples.

The restrictions that were put in place due to Covid-19 have significantly affected progress towards this priority, with limiting face to face meetings of the Safeguarding Adults Forum and opportunities to gather intelligence from adults directly significantly reduced.

Gathering feedback from adults at risk, and understanding their lived experience is a key component of the quality assurance framework that was drafted in 2019 and approved by the WSAB in 2020. Further development and analysis of the information provided through the quality assurance framework will be a focus for the coming months to assure the WSAB that agencies are listening and understanding the lived experiences of the adults at risk they are working with.

Message from the Chair of the Safeguarding Adult Forum, Mandy Taviner

During 2019 the Safeguarding Adult Forum relaunched, bringing together agencies in Warrington with a new sense of purpose to champion safeguarding, focusing on the safeguarding adults agenda, and ensuring that both the practitioners voice and the voice and experience of people with a lived experience, informs the strategic work of the board to keep adults at risk safe in our communities.

The SAF provides an opportunity for local agencies to meet within an informal and supportive peer group, to receive key messages from the board, promote best practice and communication, problem solve using the expertise from colleagues, escalate concerns and emerging themes and ensure that practitioners remain current in their understanding and knowledge of safeguarding.

As our purpose must be driven and influenced by the voice and experiences of adults at risk, the forum provides an effective and supportive opportunity for practitioners to share, challenge and collaborate, in order to protect the most vulnerable.

Whilst 2020 clearly presents new challenges in the way the SAF meets and works, we remain committed to our purpose to champion safeguarding and enable local agencies and frontline practitioners to continue to have their say, influence change and make a difference in the lives of vulnerable adults.

Good Practice Highlight

Cheshire Cares victim support

Commissioned by the PCC. Cheshire cares will contact ALL victims of crime (unless opted out at point of call) and will ensure that victims are signposted and supported at the initial stage of the investigation.

If the investigation continues into the Criminal Justice stage, this will be passed to victim/witness support.

Cheshire Cares are seen as a real positive in our *we care* promise to vulnerable victims.





Priority 2: Develop a culture of learning so we understand what works well and improve local practice

In 2019/20 there were over 758 delegates attending the 39 multi-agency training safeguarding courses offered during the year.

It should be considered however that the majority of these courses have a children's safeguarding focus and therefore the focus for 2020-21 will be on developing the offer in relation to adult safeguarding and a Think Family approach.

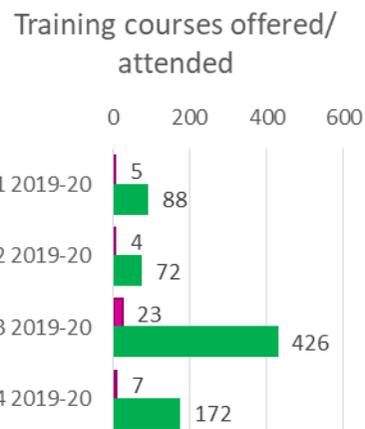
2020-21 will see the development of a Level 1 Safeguarding workbook and presentation on Safeguarding Adults, Level 2 multi agency training, other subject specific courses, a quality assurance process for training, an agreed competency framework and an updated training strategy for WSAB.

In addition to training provided over the year, learning from safeguarding adult reviews continued. There is further detail on this on page 18.

To promote learning from the Learning Disability Mortality Review (LeDeR) Programme the CCG were granted funding from NHS England to hold the LeDeR conferences in Warrington and Halton along with the supporting materials and a legacy video. The aim was to provide delegates with examples of good practice and identify the gaps through a drama company acting out local cases and then engaging the audience in discussion. The video can be accessed here: [Aftathought LeDeR Film](#)



Supporting the partnership to understand the expected impact and implications of the new Liberty Protection Safeguards, members of the WSAB Executive Group attended the briefing hosted by NWADASS and delivered by barrister Alex Ruck Keene.



Good Practice Highlight

A range of learning events were hosted by Warrington for professionals and safeguarding leads, including Coercive & Controlling Behaviour session led by Dr Emma Katz and the Mental Capacity & Best Interests Training delivered by barrister Neil Allen.



Priority 3: Respond and challenge that our partnership arrangements are doing all they can to effectively respond to abuse and neglect in line with Making Safeguarding Personal principles

With the introduction of a new Safeguarding Partnership Team supporting the work of the WSAB the arrangements have been subject to scrutiny and challenge from some fresh eyes. First steps included the re-establishment of the Safeguarding Adults Forum. Additionally, some key administrative and policy updates were undertaken to ensure that the partnership would be able to meet future needs.

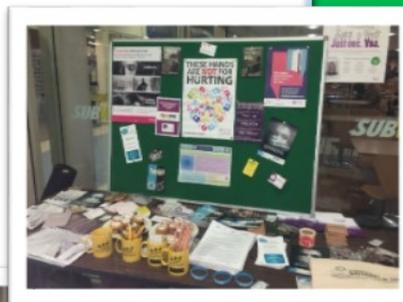
Promotion of the partnership has been undertaken at a number of events during the year, including the LeDer Conference, National Safeguarding Adults Week, White Ribbon Day, World Elder Abuse Awareness Day, the local Disability Awareness Day and the Warrington MELA.

In addition a member of the team shadowed the Warrington Hidden Harm team for the day alongside Immigration services. The operation successfully identified an individual as at risk of modern day slavery and they were taken to a place of safety.

Warrington CCG have been working to develop the Health Assessment Tool to assist clinicians to support safeguarding professionals by forming an opinion around differential diagnosis or affirming an actual condition to support the section 42 enquiry process.



During the year the SAB had a number of different presentations from local agencies to understand and seek assurance in relation to safeguarding processes. These included the Governor from HMP Thorn Cross who explained the processes in place within the prison in relation to safeguarding, a joint presentation from Warrington CCG, North West Boroughs NHS Trust and CGL in relation to Dual Diagnosis pathways and a case study presentation on



Good Practice Highlight

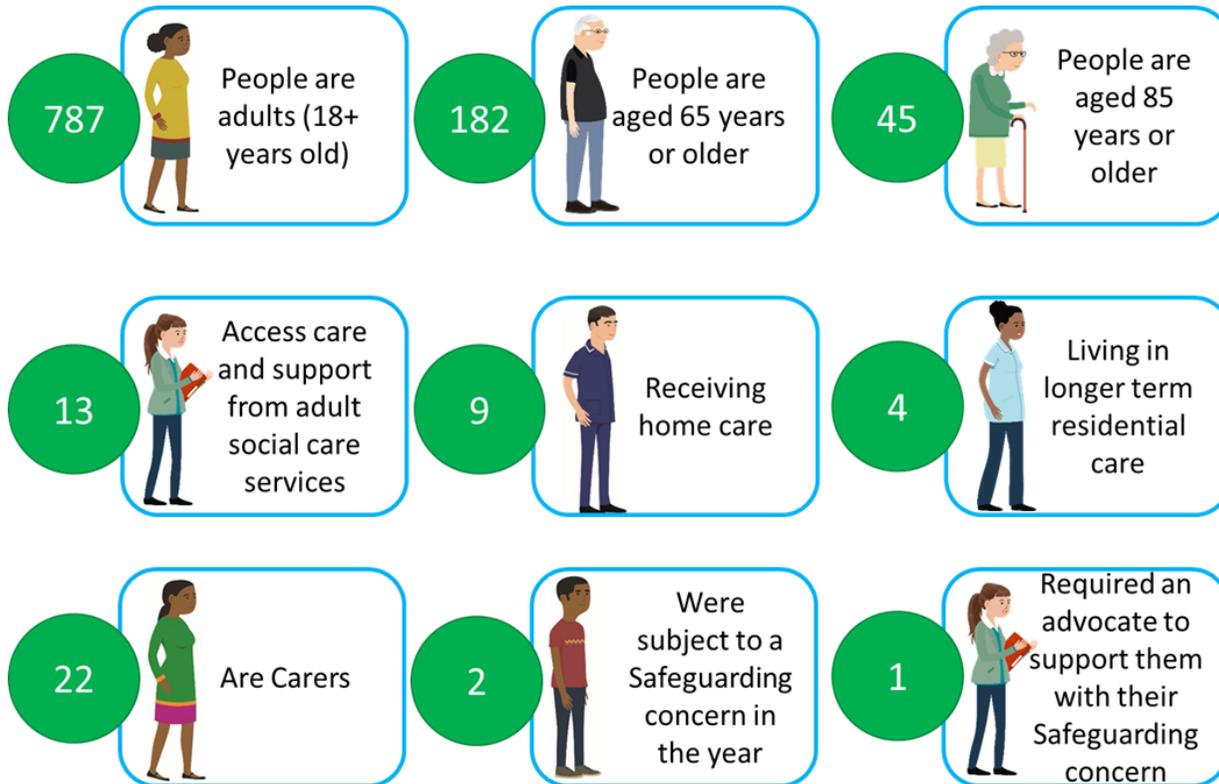
In June 2019 the Cheshire Constabulary Hidden Harm Team attended the WSAB to introduce the new Hidden Harm Team that had been set up in Warrington. The team is focussed on gathering intelligence about Warrington's Modern Slavery issues. The team work collaboratively with other agencies, businesses and the victims of Modern Slavery to support victims and uncover the organised crime.

In addition to supporting a number of victims through the National Referral Mechanism, a number of prosecutions have been made, modern slavery operations disrupted and significant intelligence gathered about the Warrington Modern Slavery landscape.

The team update the WSAB through the multi-agency Warrington Anti-Slavery Network which has a focus on the victims of Modern Slavery and ensuring that the pathways to support are working well.

Section 5 Our area

If Warrington were a village of 1000 people ...



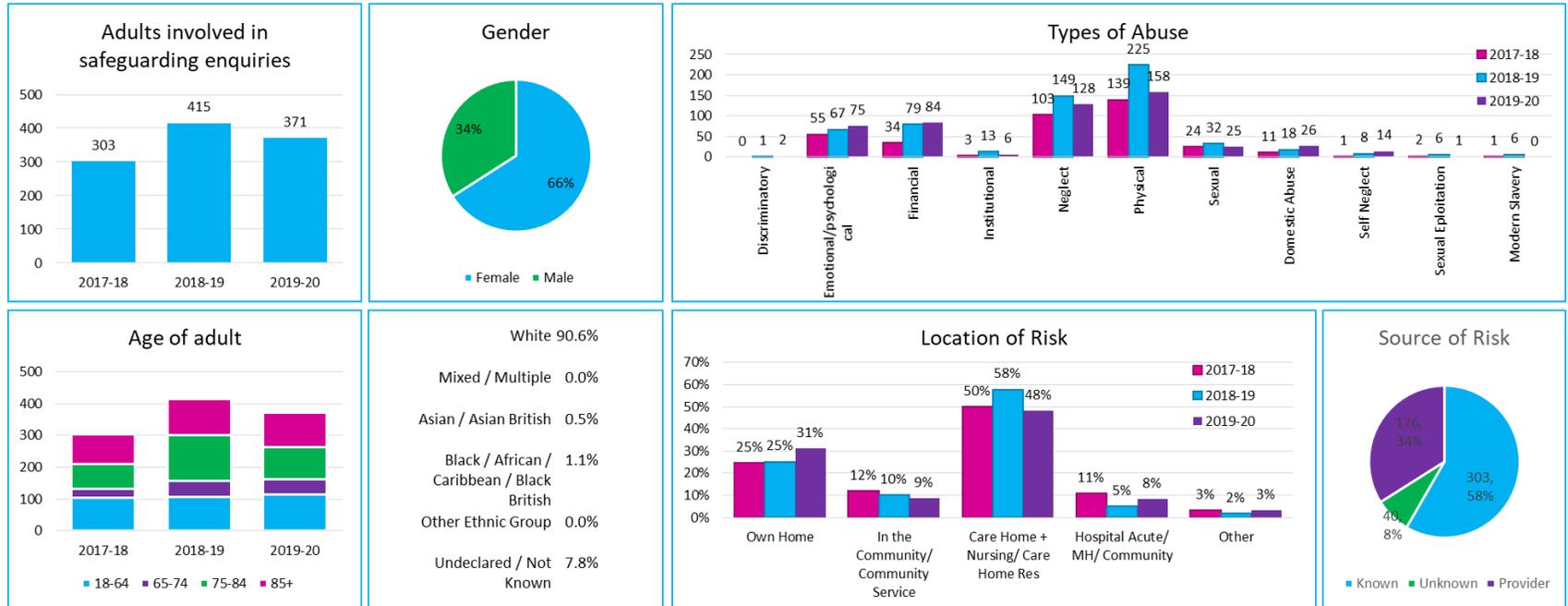
Key Safeguarding data for 2019-20

Number of adults who access care and support from adult social care services	3409
Number of adults receiving home care	2282
Number of adults living in long-term residential care	1123
Number of adults subject to safeguarding concerns completed in the year	371
Number of adults with safeguarding concerns where they were assessed to lack capacity	220
Number of adults who had an advocate support them with their safeguarding concern	203
Number of adults who had a DoLS assessment completed	1215
Number of LeDeR reviews completed	14 <i>(1 awaiting closure with Coroner)</i>
Number of SAR referrals received by the WSAB	2

The number individuals involved in Section 42 (S42) enquiries has decreased from the previous year (caution should be used with comparator data due to differing recording methods used in 2017-18).

A higher proportion of females are likely to be involved in S42 enquiries than males, with the proportion of males decreasing in 2019-20 from the previous year.

People involved in safeguarding enquiries and the nature of concerns 2019-20

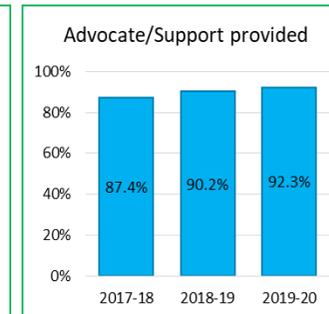
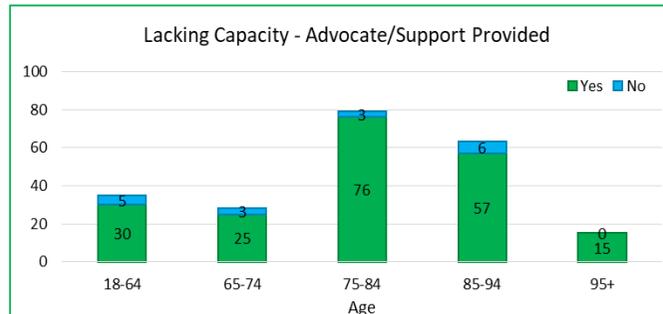
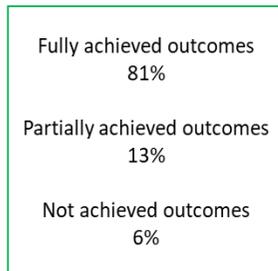
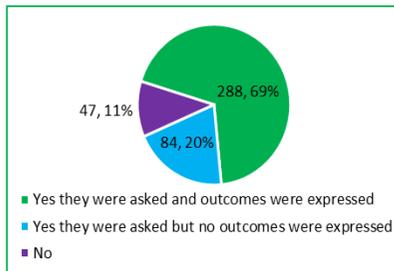
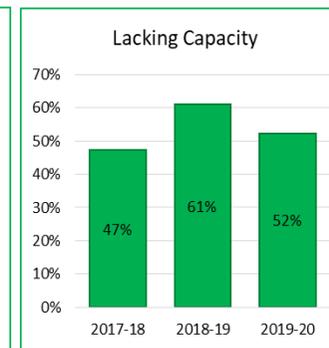
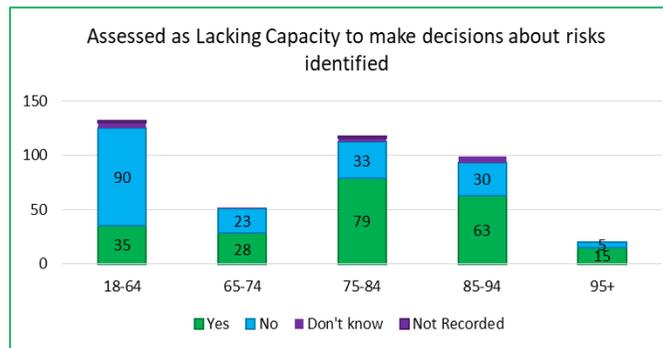
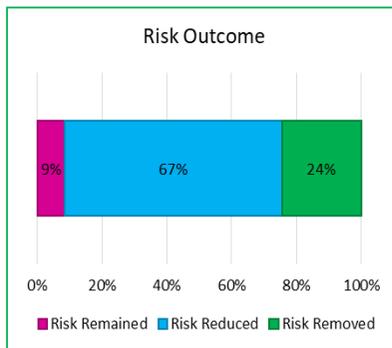
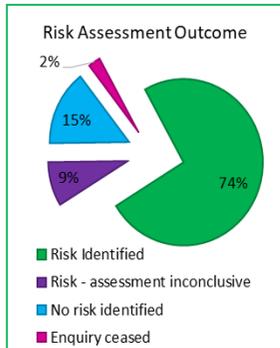


In line with the number of individuals decreasing there was a corresponding decrease in the number of enquiries.

The profile of the types of abuse also changed with an increase in those recorded as Emotional/ Psychological abuse, Financial abuse, self-Neglect and Domestic Abuse.

The proportion recorded as Neglect and Physical abuse decreased significantly. There was a 6% increase in the number of enquiries where the individual was living in their own home, whilst the proportion living in a Care Home/Residential setting decreased by 10%. The source of risk of most often someone known to the individual (58%) followed by the Provider (34%).

Results of Safeguarding Enquiries 2019-20



Where risks were identified (74% of enquiries) actions were taken in all except 7 cases. This represents an increase in both the proportion of cases where risks identified, and where action was taken.

For 24% of the enquiries, risks were considered to have been removed at the end of the process, and in a further 67% of the cases the risk was judged to have been reduced. In 28

cases the risks remained.

The majority of people who were involved in safeguarding concerns (52%) lacked the capacity to make decisions about the risks identified. This is a decrease on the proportion assessed to be lacking capacity in the previous year (61%), but above the proportion in 2017-18 (47%).

Over 92% of the people who were assessed to be lacking capacity were represented by an advocate/support in the safeguarding process. This is an increase from the previous two years.

Homelessness

Homeless deaths panel

Prior to COVID lockdown a panel was set up to consider learning from people who died on the streets or in our accommodation across the town.

Organisations invited to participate included:

- WBC Public Health
- WBC Contracts and Commissioning
- WBC Adult Social Care (Mental Health)
- WBC Housing Plus service
- WBC Adult Social Care (Adult Safeguarding Team)
- Cheshire Police
- CGL – Pathways to Recovery
- Your Housing Group (VTSS and the Verve)
- Salvation Army – James Lee House
- Room at the Inn
- Forum Housing – Haven House

A process has been developed and was approved on the 19th March, at the very beginning of COVID lockdown. This had been put on hold, primarily as during lockdown all people who presented as homeless had been placed in some form of accommodation in the town. The process will be relaunched once more from 1st October.

An added bonus is that WBC Public Health now have Liverpool John Moores University reviewing the Drug Related Deaths in service, so any additional information can be used as part of the wider learning, as appropriate. A designated email inbox has now been set up to receive notification forms from partners. This process will certainly enable all partners to learn from any homeless deaths across the town and ensure that any actions or considerations are taken to strengthen any learning that can be made.

Domestic Abuse

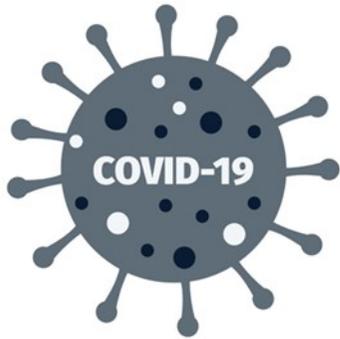
Domestic Abuse was recorded in 26 of the Section 42 safeguarding enquiries undertaken during the year. An audit undertaken by Warrington Borough Council however found that although not recorded as the type of abuse, Domestic Abuse could be included on a number of other cases where other abuse types were recorded. This prevalence is the reason that the WSAB has been keen to support work undertaken in relation to domestic abuse, with a particular focus for the WSAB on those with care and support needs.

Cheshire Constabulary use the website [Cheshire – Open the Door](#) which has a number of helplines and support agencies which are based both nationally and locally.

In November WSAB supported colleagues at Warrington Hospital promoting support for victims of Domestic Abuse on White Ribbon Day.

At the start of the Covid-19 restrictions leaflets and posters as part of the ‘Alone at last ‘ campaign were distributed locally to supermarkets and food banks to ensure that information was available to victims on how to access support. Cheshire Police, in collaboration with a number of agencies including Children's Social Care and Health colleagues, hosted weekly Domestic Abuse Q and A sessions. The sessions attracted between 10-14,000 viewers weekly with 15-20 questions, 10% of these coming from the Warrington area.





Covid-19 – Impact and assurance work – March to July 2020

The Warrington Safeguarding Adults Board responded to the Covid-19 pandemic with a range of different assurance exercises to ensure that adults with care and support needs are safeguarded.

The first few weeks of the lockdown staff from the Safeguarding Partnership Team were redeployed to support WBC Adult Social Care to support a number of work streams including the distribution of PPE, the set up of the adult social care response hub and the training and support for professionals and volunteers.

During the period March to July all face to face meetings were suspended. In their place a number of virtual meetings were set up to ensure continued communication between agencies and to assure WSAB that safeguarding activity was still being undertaken.

- Safeguarding strategic group, bringing together the core partner leads across both the WSAB and WSP met weekly.
- Operational adult safeguarding assurance meeting (covering Warrington and Halton) brought together the safeguarding leads for the providers across the health sector, with the local authority, police, probation and advocacy.

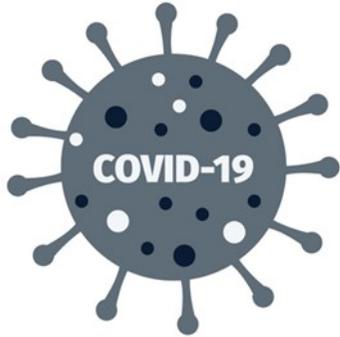
Additional meetings were set up with care home and independent hospitals which fed into these key assurance meetings.

Establishing the new normal in July, WSAB meetings started to be reinitiated with the intention of returning to usual meeting frequency for each of the subgroups to be in place by the end of September, albeit all meetings to remain virtual for the near future.

Work on open SAR's continued throughout the period of the Covid-19 restrictions (more detail included on page 18) alongside any policy or background administrative work.

Training delivery was postponed, and part of the recovery work to be undertaken from September onwards includes how to reinitiate training in a Covid-19 secure way.

The impact of Covid-19 on safeguarding enquiries reaching the local authority for the period March to July was monitored through the weekly and fortnightly assurance meetings.



Covid-19 – Impact and assurance work – March to July 2020

Homelessness

One of the key areas that has had renewed focus has been homelessness. During lockdown, every local authority had to ensure its homeless community had their own single room, for self isolation as part of the “Everyone In” Campaign. For Warrington, outside of the offers at James Lee House, Haven House, the Verve and the Refuge, the Council was able to access the Travelodge on Legh Street.

From the beginning of April until end of June, 84 people were offered accommodation at Travelodge. Of the offer – 9 refused the accommodation and 75 people accepted. During that time, people had access to 3 meals a day, in reach services from Vulnerable Tenants Support Services (VTSS) and in reach support from CGL/Pathways for drug and alcohol support and the service was managed by RATI.

One notable issue was that the Gov.uk page for support for homeless went down on 26th March and was finally revised on 3rd August, which realistically meant that Local Authorities had to devise their own ways of working with homeless people during COVID as national guidance was very limited. Locally some good practice and learning was held – all providers across the town had a bi-weekly call in chaired by Public Health, to share concerns, updates on guidance and any key issues.

It has been agreed that this will carry on at least weekly. After the Travelodge closed a new offer on Museum Street has opened with 22 en-suite rooms – this is again being managed by RATI, with support once more from VTSS and CGL. Ongoing conversation between Public Health with colleagues in the CCG and NHS England is also looking at a more robust health offer for this group.

Next steps for the WSAB for 2020-21 is to continue to monitor the impact of Covid-19 on those with care and support needs to ensure that there are not additional safeguarding needs as a result of the pandemic.

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.

During the period April 2019 to March 2020 there were two referrals to WSAB for a SAR. One of these was then retracted as it was referred in error (Case Q), and the other was not deemed to meet the criteria for a SAR (Case R).

In December 2019 Case H report was finalised and agreed by WSAB. An executive summary is being produced to publish on the WSAB website and submit to the SCIE National Library.

At the end of March 2020 one SAR Report (Case F) report was awaiting finalisation. This will be presented to the WSAB Main Board in August 2020.

A number of the SAR's and alternative reviews undertaken in previous years require final learning briefs completing and the action plans completed. This is a priority piece of work for 2020/21 for WSAB to ensure that all learning has been appropriately disseminated and to look at the impact of the learning on practice in Warrington.

Section 7 Feedback

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 2019-20 showed an increase in the proportion of people who use services who feel safe (69.6% in 2019/20, increased from 66.2% in 2018/19). Additionally there was an increase in the proportion who say that the services they received made them feel safe and secure (93.3% in 2019/20, increased from 87.5% in 2018/19).



Section 8 The year ahead

Our Vision for 2020-21

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 priorities for 2020 - 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 six weekly via its Executive Sub-group. The Board will also seek external scrutiny through updates to local scrutiny forums such as the local Health and Wellbeing Being Board.

Training & Development: Forward Planning

2020-21 will see the development of further learning opportunities, supported by a Training Plan. There will be a redesign of the WSAB website which will offer resources and community advice. A working group to regularly review policy, procedures and practice guidance will be established. A comprehensive quality assurance process for training will be written, along with an agreed competency framework and updated training strategy.

Impact of Covid-19

As we went to print with this year's annual report, Covid-19 movement restriction and all of the measures required to stem transmission of the disease were fully in place. Next year's annual report will detail how Warrington dealt with the safeguarding aspects of the pandemic, and will begin to look at the long-term impact upon service users.

MARAM

As part of the actions arising from a DHR in 2019, the board was tasked with identifying a means by which to gather together professionals to consider high-risk/high-complexity cases with poor engagement, as this was considered a key risk factor in the DHR. The board has resolved to deal with this action by instituting a MARAM process (Multi-agency Risk Assessment and Management). Next year it will be trialled and piloted, rolling out as soon as possible afterwards into business as usual. We will report progress on this in the next annual report.

SARS in Rapid Time

Warrington SAB is aware that SCIE is considering a new approach to undertaking SARs in 2020. A goal is reduce the time taken from resolution to carry out a SAR to realisation of the key learning emerging from the case. This will be undergoing initial pilot during the next 12 month period, and potentially trialled more widely in 2021. We will continue to review practice in Warrington in concert with this and other national learning.