Worcestershire Safeguarding Adults Board

Annual Report 2017/18

Worcestershire Safeguarding Adults Board

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12/06/18	V2	Incorporation of chairs feedback and updated statistics. To be presented to Board	Bridget Brickley
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Actions

Required Actions	Date
Upload to Website	September 2018
Raised with Community Awareness & Prevention for communication	
Produce Easy Read Version	

Contents

Chairs Foreword

The Worcestershire Safeguarding Adults Board (WSAB) was established under the Care Act 2014 and this report provides an update on what has been achieved in 2017/18, whilst also outlining the scale of the challenge ahead.

Significant progress has been made since 2014 and an increasingly effective partnership has been developed in that time. Much of the credit for this rests with my predecessor, Kathy McAteer whose leadership, drive and ability to nurture an inclusive way of working between the partner agencies has built firm foundations for the oversight of adults safeguarding in Worcestershire. The contribution and continuing commitment of the partners, from the statutory and voluntary sectors should also be recognised.

I strongly believe that partnership working has never been more important, and that by working together, sharing information and promoting the importance of safeguarding, we can maintain an appropriate focus on those in our communities that are most in need of care and support. I recognise the financial and resourcing pressures faced by partners, and this underlines the necessity of working with a collaborative mindset.

Since taking on the role of Independent Chair in October 2017, I have sought to build on the work of the WSAB and deliver the objectives of the Business Plan. We will continue to seek closer engagement with the Worcestershire Safeguarding Children Board (WSCB), where I have been the Independent Chair since 2016, with the aim of identifying further efficiencies of process and procedure that improve the service provided to those who need it. We will also maintain close working relationships with the Health and Wellbeing Board and Community Safety Partnerships, focussing attention on cross-cutting issues that affect adults, children and families in the county.

It is an essential role of the Board to seek assurance as to safeguarding arrangement in Worcestershire, and this will remain a priority. Central to this will be oversight of issues around the Mental Capacity Act, Deprivation of Liberty and whether the ethos of 'Making Safeguarding Personal' is being embedded across the partnership.

Underpinning all of this is the determination to see the needs being met of the most vulnerable, and the WSAB will continue to give a voice to service users in the county.

Derek Benson
Independent Chair of Worcestershire Safeguarding Adults Board

1.0 Introduction

Annual Review 2017-18

In line with the Care Act (2014) guidance on Annual Reports the purpose of this report is to:

- Cleary state what the Worcestershire Safeguarding Adults Board (WSAB) and its members have done to carry out its objectives and strategic plan;
- Set out how the Board is monitoring progress against policies and intentions to deliver its strategic plan;
- Provide information on safeguarding adult reviews (SARs). Reporting on what has been done to act on the findings of completed reviews.

This report is set out in four parts:

- Chapter 2 Background – Why we are here, what we set out to do and how we do it
- Chapter 3 Review of Activities – What we have done
- Chapter 4 Safeguarding Activity and Performance – The difference this has made
- Chapter 5 Next Year's Priorities – Intentions to continue this

2.0 Background

2.1 Purpose of the Board

Safeguarding Adult Boards primary role is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who:

- *have needs for care and support (whether or not the local authority is meeting any of those needs) and;*
- *are experiencing, or at risk of, abuse or neglect; and*
- *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*

Worcestershire Safeguarding Adults Board's (WSAB) vision is to provide assurance that adults at risk are safeguarded from abuse or neglect. WSAB Partners work together to ensure that people who have care & support needs are empowered or kept safe from abuse or neglect and that where abuse occurs, partner organisations respond effectively and proportionately.

The work of the Board is underpinned by the six safeguarding principles as defined in the

Care Act (2014) which are:

- **Empowerment** - Personalisation and the presumption of person-led decisions and informed consent.
- **Prevention** - It is better to take action before harm occurs.
- **Proportionality** - Proportionate and least intrusive response appropriate to the risk presented.
- **Protection** - Support and representation for those in greatest need.
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding.

The application of the safeguarding principles supports a person led and outcome focused approach to safeguarding, known as Making Safeguarding Personal (MSP). The WSAB plays a key role in ensuring that an MSP approach is embedded across all agencies within Worcestershire.

2.2 Board Membership

The Board is made up of several key partner organisations in Worcestershire including:

- Worcestershire County Council
- West Mercia Police
- NHS Redditch and Bromsgrove Clinical Commissioning Group
- NHS South Worcestershire Clinical Commissioning Group
- NHS Wyre Forest Clinical Commissioning Group
- Worcestershire Health and Care NHS Trust
- Worcestershire Acute Hospitals NHS Trust
- NHS England
- National Probation Service
- Regulatory Services
- Worcestershire Voices
- Representative from Worcestershire Housing Strategic Partnership
- Representative from Care Homes Association
- Representative from Carer reference group
- Lead Councillor for Adult Social Care

Other organisations in the County providing services to adults with care and support needs continue to work in partnership with the Board to promote adult safeguarding and support the work of the Sub-groups.

2.3 Annual Budget and Financial Contribution

The 2017/18 annual budget for the Board was £133,267. Alongside staff and administration, this funds the cost of Safeguarding Adult Reviews (SAR) and supports the delivery of objectives. The annual budget is established through a financial contribution from key partner agencies. The name of the agency and their contribution; shown as a percentage of the overall cost, is set out in table 2.1 below:

Table 2.1 – Financial Contribution by Agency

Agency Name	% Contribution
Worcestershire County Council	41.94
NHS South Worcestershire Clinical Commissioning Group	22.49
NHS Redditch/Bromsgrove Clinical Commissioning Group	13.50
West Mercia Police	13.07
NHS Wyre Forest Clinical Commissioning Group	9.00

There was an under-spend for this financial year of £101,802.91. This included a cumulative under-spend from previous years, alongside the incompletion of some objectives, including the website, which have been carried over to the next business year.

The cost for SARs over the last year has been lower than predicted. These can vary in numbers each year as well as the time required by an author to complete a review due to levels of complexity. Given the unpredictability on the costs required for SARS a contingency budget is to be introduced to manage the variation across years. In addition, a number of areas of work have been identified for additional development, including building analytical capability, training and communication.

The Board therefore agreed that the cumulative underspend could be taken forward as committed expenditure for these projects and to meet outstanding objectives. However, the Board will also review future contributions against planned committed expenditure to ensure that this surplus is not replicated in future years.

2.4 Strategic Priorities 2015 to 2018

The Board agreed a three year Strategic Plan and the priorities for 2015 to 2018. There were 5 strategic objectives that the Board aimed to achieve over this three year period. These priorities were the key drivers for the work of the Board and helped to shape the annual objectives for each year. The three year priorities were:

1) To provide and seek assurance of effective leadership, partnership working and governance, holding partners and agencies to account.

2) To listen to people who have been subject to abuse or neglect, and seek assurance that people are able to be supported in the way that they want, are involved in decisions and can achieve the best outcomes.

3) To be assured that safeguarding is embedded in communities, raising, awareness, promoting well-being and preventing abuse and neglect from occurring.

4) To seek assurance that effective policies, procedures and practices are in place
that ensure the safety and well-being of anyone who has been subject to abuse or neglect, are proportionate and that action is taken against those responsible.

5) To learn lessons and make changes that prevents similar abuse or neglect happening to other people.

2.5 Delivery Model

Implementation of the Strategic Plan is achieved through the work of the Board and its five sub-groups (Fig 2.2). Each year annual business objectives are developed in line with the Strategic Objectives. The annual objectives are based on a review of priorities and progress made against the 3 year objectives.

The sub-groups develop individual implementation plans which outline the activities different stakeholders will undertake to ensure that the annual business objectives will be met. These are reviewed on a quarterly basis.

Table 2.2 WSAB Structure

<table>
<tr><td colspan="5">Worcestershire Safeguarding Adults Board</td></tr>
<tr><td colspan="5">Subgroup Chairs Subgroup</td></tr>
<tr><td>Case Review Subgroup</td><td>Communications Subgroup</td><td>Learning, Development & Practice Subgroup</td><td>Policy Subgroup</td><td>Performance & Quality Assurance Subgroup</td></tr>
<tr><td colspan="5">Virtual Network</td></tr>
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2.6 Business Objectives

There were four key objectives identified in the 2017-18 business plan. Table 2.3 gives a summary of the annual objectives and details achievements and any barriers and challenges to progress.

Table 2.3 - Achievements and Challenges

WSAB Objective	Achievements and Challenges
1. Improving awareness across stakeholders of what 'safeguarding is as well as what it isn't.	**Achievements:** • The process for Safeguarding Adults Reviews (SARs) has been modified to ensure greater clarity of purpose and improve timescales; • An approved list of SAR chairs has been established; • A new Training Strategy is underway and due to be completed in the new business year; • Reviews of a number of policies have been undertaken during the year alongside the development of professional guidelines (see section 3.2.6) • The Annual Assurance Assessment was redesigned to focus more explicitly on identifying the processes organisations have in place to ensure that staffs understand the criteria and pathways for making safeguarding referrals as set out under Section 42 of the Care act. • The annual event to disseminate learning from SARs was oversubscribed and well received. The intention is to build on this in future years. **Challenges** • Whilst the County Council still hosts an interim website implementation of an independent website held jointly with the Children's Board continues to be a challenge, due to the logistics of joint procurement. However it continues to progress and this will be carried over into next year's business plan. The County Council will continue to host the website in the interim. • Whilst communication and awareness raising amongst staff has been undertaken at an organisational level, capacity to develop coordinated campaigns has been challenging.
2. Demonstrate listening to adults and gathering their views.	**Achievements** • An Advocacy Reference group has now been established, in line with the priorities set out in the Engagement Strategy; • A chair has now been identified to work with the Board in establishing a reference group for people with safeguarding experience;

WSAB Objective	Achievements and Challenges
	Challenges • Once the website is established this will enable this objective to develop further, alongside the development of a virtual network database. • A database has been developed but its full implementation has been problematic due to resource and data collection issues
3. Continue to seek assurance from partners in relation to Making Safeguarding Personal (MSP) and the Mental Capacity Act (MCA), Deprivation of Liberty safeguards (DoLs).	**Achievements** • The Annual Assurance Assessment was redesigned to focus more explicitly on identifying the processes organisations have in place to ensure that these key WSAB priorities are being embedded in practice. • A dashboard has now been established to measure the WSAB progress towards meeting its measurable objectives and is presented at the quarterly Board meetings; **Challenges** • The Board's robust assurance processes have identified that these areas continue to remain a priority and organisations' improvement plans will be reviewed over the coming year
4. Continue with cross cutting work with Worcestershire Safeguarding Children's Board (WSCB) in relation to professional curiosity and transition.	**Achievements** • The WSAB worked closely with the Children's Board to ensure that key policies and procedures are in place and embedded in practice for young people approaching adulthood, who remain vulnerable to abuse and neglect. This year the focus was on policies and processes for addressing Child Sexual Exploitation (CSE) • A pathway has been established across children's and adults services which would include those young people where CSE has been identified;

3.0 Review of Activities 2017/18

3.1 Care Act Requirements

Care Act Guidance requires Safeguarding Adults Boards and the statutory partners to provide an account, through the Annual Report, of how they ensure that Care Act duties are both effective and meaningful so as to ensure that local safeguarding systems and processes reflect the vision, principles and requirements of the Act.

3.2 Work of the Board

A major part of work undertaken by the WSAB Sub Groups during the first year was to ensure partner agencies were all implementing the Care Act (2014) requirements. Activities over this second year built on these foundations. However, as the Board processes have evolved, a number of issues which require more in-depth focus have been identified and been taken forward as priorities. These have predominantly focussed on Mental Capacity, Making Safeguarding Personal and Section 42 enquiries along with specific issues identified in SARs.

With Board processes now well established the Board sought to build on its engagement with people who have experience of health and social care services and their carers. Over the last year representation on the Board has been established with advocates and people who have experienced safeguarding services, alongside the already active engagement of the Worcestershire Association of Carers network. The work around engagement will continue to be developed and embedded over the next business year.

3.2.1 Safeguarding Adults Reviews (SAR)

SARs are commissioned when:

- there is reasonable cause for concern about how WSAB members or other agencies providing services, worked together to safeguard an adult,

and

- The adult has died, and WSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

or

- The adult is still alive, and WSAB knows or suspects that the adult has experienced serious harm.

A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place in order to prevent future harm or death from occurring.

The purpose of a SAR is to critically review;

- The services provided and establish if these had been provided in accordance with current policies and procedures;
- If these policies and procedures enabled the services required to be delivered to the benefit of the individual;
- And importantly to identify any area where if any matter had been completed differently the outcome would have been to the advantage of the individual.

During 2017/18 there were 9 referrals requesting consideration for a Safeguarding Adult Review (SAR) to be undertaken. Two of these referrals were made towards the end of the business year are still in scoping to determine whether the criteria to commission a SAR are met. Of the remaining referrals, none met the criteria for a full SAR to be commissioned. However, three of these referrals resulted in single agency actions being recommended and one referral is awaiting the outcome of a Learning Disabilities Mortality Review (LeDeR).

Work was completed on two SARs which were carried over from 2016/17 – 'Alan' and 'Karen'. Both have now been published and are accessible via the following link;

Hold down the ctrl key and click on the link SARs Link

3.2.2 SAR Learning and Action

Action plans for each SAR are drawn up and progress of delivery of action plans is monitored. Key learning themes from the SARs published in 2017/8 include:

- Ensuring there is effective and timely record keeping;
- Embedding of the Mental Capacity Act in practice still remains a challenge;
- That body-maps are completed by a single agency prior to any hospital admission;
- Identifying the needs of carers and providing early offers of support;
- Ensuring that a Lead Professional/Key Co-ordinator role is embedded where there is multi agency involvement;
- Assurances are sought from partner agencies that there is adequate and appropriate support and information given to care and nursing facilities so they can provide emergency placements that are managed proportionately to the risk.

Some recommendations were also made in relation to the SAR process itself these included ensuring that there is clear communication with the family from the onset of a case being referred for a SAR so that families and carers understand the purpose, process, criteria and how decisions are made.

3.2.3 Learning Event

In January 2018 a multi-agency learning event was held and attended by over one hundred social care and health staff, alongside the voluntary and independent sector. At the event there was an in-depth presentation from a SARs Chair/Author on the findings the review into the death of RN.

Areas identified as needing further development through this review were:

- the role of the lead professional
- and issues around how self-neglect is defined and addressed.

Participants attended three workshops where they considered the findings of this review, within the context of the application of section 42, Mental Capacity Assessments and developing a person centred approach though MSP. They were encouraged to explore how they could overcome barriers and improve future practice.

Further information on the event can be accessed via the link below;

Learning Event link

3.2.4 Annual Assurance Statement

Member organisations of Safeguarding Adults Boards are required to undertake an annual assurance review of how they have worked to meet the Care Act requirements and deliver the Boards priorities. Partner organisations assess themselves against a set of standards and provide evidence to support these statements. The WSAB then challenge organisations to provide additional evidence, where appropriate.

In 2017/18 the assessment framework was revised to take a more in-depth focus on areas which were identified as reoccurring themes through SARs and performance measures. The framework was redesigned to elicit evidence of effective practice and processes that are in place to embed the following in each organisation, alongside any plans to develop and improve future practice:

- Appropriate use of Mental Capacity Assessments;
- Safeguarding process leading to a Section 42 inquiry;
- Incorporation of the values of Making Safeguarding Personal as a key element of all Safeguarding discussions and recordings.

Overall most organisations were found to be addressing and working well towards meeting the requirements of these areas. However some gaps or challenges were identified and actions were being put in place to address these. These included:

- Auditing cases to better understand where the difficulties were so appropriate actions could be taken;
- Undertaking a staff survey to establish how well the safeguarding competencies were understood and embedded;
- Reviewing the provision of current services and pathways;
- Analysing data to target service areas where practice is not meeting the required standards and developing the appropriate actions;
- Targeting awareness of the processes and standards to those services where a weakness has been identified.

The outcome of the actions each organisation identified will be reviewed at the beginning of the new business year.

3.2.5 WSAB – Board Governance and Development

The WSAB continued to build on the robust governance processes which were already in place. Alongside the development of the Annual Assurance Framework notable work for 2017/18 includes:

- Ongoing development of Performance Management Framework to measure progress against Board objectives;
- Review and changes to Chairs and Sponsors to reflect the diversity of the Board membership;
- Formal representation from Worcestershire Housing Strategic Partnership;
- Representation from the County's Advocacy services on the Board;
- Appointment of a person with experience on the Board and to work with the WSAB in developing a reference group.

As part of the WSAB's commitment to improve engagement with people experience of safeguarding and service provision, an active approach has continued to evolve. The Board receives regular presentations from people with experience of adult health and social care services. This provides an opportunity for WSAB members to widen their understanding and identify any service issues which may need greater assurance.

3.2.6 WSAB Publications and Guidance

The following documents were reviewed or formally adopted and published by the WSAB during 2017/18m in order to promote evidenced based practice and support improvements in safeguarding practice across the partnership;

- Best interest decision meeting guidance;
- Mental Capacity Act Policy;
- Position of trust guidance;
- Safeguarding Judgments Guidance;
- Toolkit to support organisations in the self-assessment for benchmarking of Mental Capacity Act Policies.

The following documents were revised during the year:

- Assisted Suicide Policy;
- Self-Neglect Guidance;

- Toolkit to support organisations in the self-assessment of Safeguarding Adults Policies.

All documents can be found on the WSAB website

Hold down the ctrl key and click on the link WSAB website

3.3 Organisational Contributions

Statutory Partners have continued to ensure that they build on their Safeguarding work and responsibilities. Organisational activities and achievements which have supported the delivery and development of the four WSAB objectives include:

Objective 1: Improving awareness across stakeholders of what 'safeguarding is as well as what it isn't

- Regular meetings with Safeguarding Leads to disseminate key messages, with a focus on key topics and learning from SARs; (WHCT, WMP, CCG/GP Practices);
- Continual development of training to ensure that learning around safeguarding is embedded and understood; (WHCT, PH, WHAT, WCC, WMP, CCG);
- Bespoke training for key front line staff, including GP's and Nurses (CCG), drug and alcohol service providers (PH), and midwives (WAHT);
- Embedding the WSAB competency framework across the Adult Social Care directorate and undertaking a workforce review to test how well training has been embedded (WCC);
- Development of a reference chart to clarify what constitutes a safeguarding concern around tissue viability (WAHT and WCC);
- Linking Safeguarding Team members into locality teams (WCC);
- Quarterly and weekly safeguarding newsletters and briefings (WHCT, CCG);
- Providing information to patients and people who use services (CCG; WHCT, WAHT);
- Ensuring commissioned services include the expectation that there is mandatory safeguarding training for staff – (CCG);
- Strengthening assurance processes with a detailed safeguarding template which includes reporting requirements and training details for NHS providers. This includes providing evidence that learning from SARs has been implemented. (CCG);
- Ensuring that learning and actions from SARs are implemented across providers
    - through regular review of actions and strengthening the assurance process to reflect recommendations (CCG);

- Targeted awareness raising on domestic abuse with organisations who provide support to people with learning disabilities following a joint Domestic Homicide Review (DHR) and SAR (PH, CCG);
- Disseminating published SARs to internal and external tutors who deliver safeguarding courses (WCC);

Objective 2: Demonstrate listening to adults and gathering their views

- A number of partner organisations regularly present patient and service user stories to their Boards and utilise patient feedback to shape the work they do and services which are commissioned (WHCT, CCG);
- Work has been undertaken with service user and carer groups to ascertain their views around issues such as safeguarding;
- Working closely with an active learning disability group 'Speakeasy NOW' with one of the main areas of focus during the year being on staying safe, which includes safeguarding issues. (CCG, WCC and WSAB)
- Monthly analysis and reviews are undertaken on whether the outcomes that adults who go through safeguarding services are achieved (WCC)
- A local outcome survey is being developed to gather views of adults on their experience through the safeguarding process (WCC);
- Undertake customer satisfaction surveys, targeting vulnerable adults (WMP)

Objective 3: Continue to seek assurance from partners in relation to Making Safeguarding Personal (MSP) and the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS).

- Quality assurance processes of commissioned services and NHS provider organisations regularly assess whether MCA and DoLS applications are being effectively undertaken and meet the needs of service users;
- MCA and DoLS training for staff is continually being developed and tested to ensure that it is embedded in practice;
- MCA and DoLS are viewed as key components of training which should be undertaken by services commissioned by the WSAB individual partners;
- An MCA crib card has been provided to all clinical staff. (WAHT):
- Following a report by the Coroner Court in relation to a DoLS /MCA case a number of actions have taken place, including the dissemination of wider learning within training for the Senior Nursing team to raise awareness (WAHT);
- A focus on supporting the development of GP's knowledge and awareness of safeguarding and in particular MCA and DoLS (CCG);

- Appointing Mental Health strategic and tactical leads (WMP)

Continue with cross cutting work with Worcestershire Safeguarding Children's Board (WSCB) in relation to professional curiosity and transition.

- Operating procedures for safeguarding alerts are being developed so that they are more standardised, and thus clearer, across both children's and adults services (WAHT);
- Ensuring the MARAC system which flags up domestic abuse works closely across both Adults and Children's services ;
- Safeguarding champions are integrated to ensure that support and advice can be clearly provided across both children's and adult services (WHCT);
- The Young Adults Team (YAT) has introduced a protocol of joint working arrangements with the Children's Disability Team (WCC);
- A monthly meeting of the Integrated Safeguarding Committee takes place to ensure that senior leadership have oversight over work streams and safeguarding matters (CCG, WAHT and WHCT).
- Weekly CCG and GP Briefings includes safeguarding issues for information;
- Domestic abuse training is now delivered jointly across children's and adults services to ensure that it addresses the issue from a holistic perspective';
- Domestic abuse training is now mandatory for all staff (WHCT)
- Representation at both the WSAB and Worcestershire Safeguarding Children's Board is undertaken by the same person in many partner organisations to ensure greater joined up work and continuity.

4.0 Safeguarding Activity and Performance 2017/18

4.1 Care Act (2014)

When the Care Act (2014) was introduced in April 2015 there were some changes to the definition around the safeguarding criteria. These changes mean it is only possible to make direct comparisons for the last three business years.

4.2 Number and Source of Concerns

Over the last three years the number of concerns reported has decreased (Table 4.1). Ongoing analysis suggested that the high level of reports in the past was due to incorrect referrals. This has been addressed through a number of measures including raising awareness on what constitutes a safeguarding concern which will meet section 42 criteria, alongside reviewing the pathway for reporting care quality concerns. There has been a particular focus on services which consistently had high levels of inappropriate reporting.

The effectiveness of this effort can be demonstrated through the level of concerns reported which meet the section 42 criteria which, as outlined in the Care Act, are adults who;

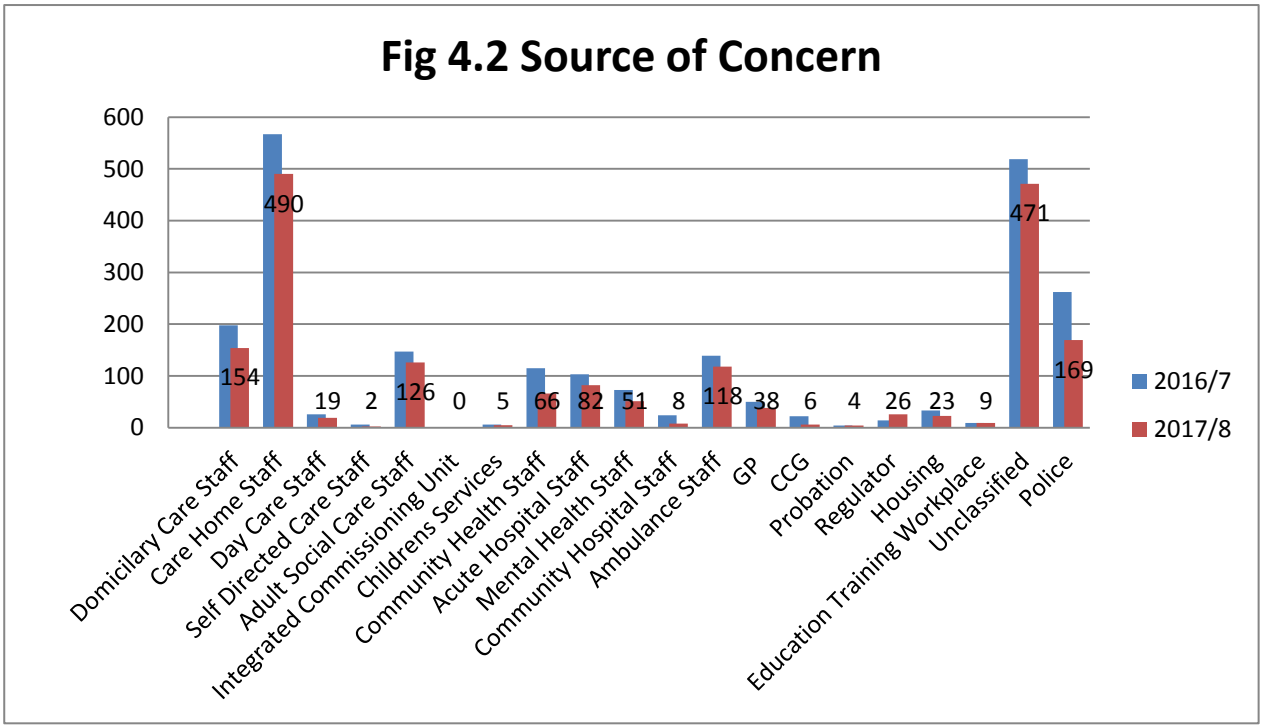
- *have needs for care and support (whether or not the local authority is meeting any of those needs) and;*
- *are experiencing, or at risk of, abuse or neglect; and*
- *as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect*

Numerically this has remained relatively constant over the three years meaning the percentage of appropriate reports has increased.

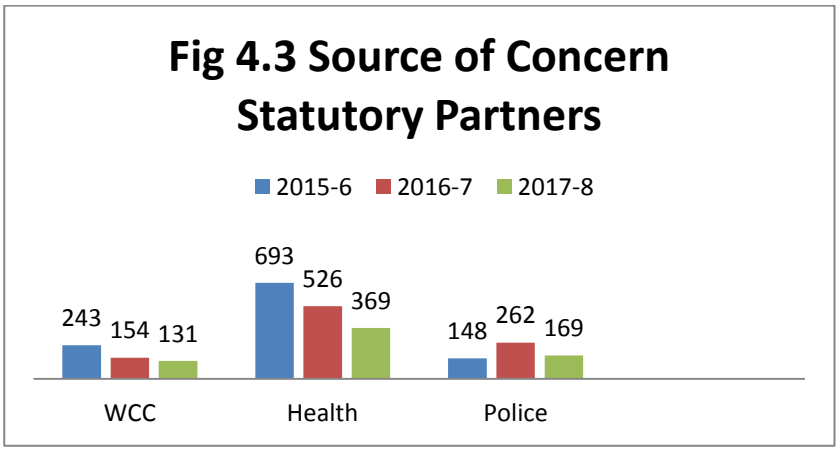
Table 4.1 – Concerns dealt with under safeguarding 2017/18 (compared to 2015/16 and 2016/17)

	2015-16	2016-17	**2017-18**
Concerns Reported	2653	2342	**1942**
Decisions Made	2492	2244	**1799**
High Risk	99	65	**79**
Section 42 applies (meets criteria)	343	328	**325**
Percentage of concerns reported where Section 42 Applies		15%	**18%**

As with the previous year the highest number of concerns were raised by Care homes, followed by the police, then domiciliary care providers (fig 4.2). Those recorded as unclassified include a broad spectrum of people and organisations, a large number of which are family and friends, currently not categorised for recording purposes. The categories are being reviewed and are likely to be extended.



In terms of the statutory partners (Health, County Council and Police), comparisons with the previous two years data shows a drop in the number of concerns being raised (Fig 4.3). Following the introduction of the care act there has been a concerted effort to target training and awareness raising across these sectors. This now needs to be built upon across the wider stakeholders.



4.3 Type of Abuse

Reporting on the different types of abuse, as defined in the Care Act, is voluntary at a national level. Worcestershire County Council does not currently report Sexual Exploitation as it is considered to be a sub set of Sexual Abuse. However it has now been agreed that this will be introduced.

Physical abuse remains the highest type of abuse, fig (4.4), closely followed by neglect. The next highest levels are financial and psychological abuse

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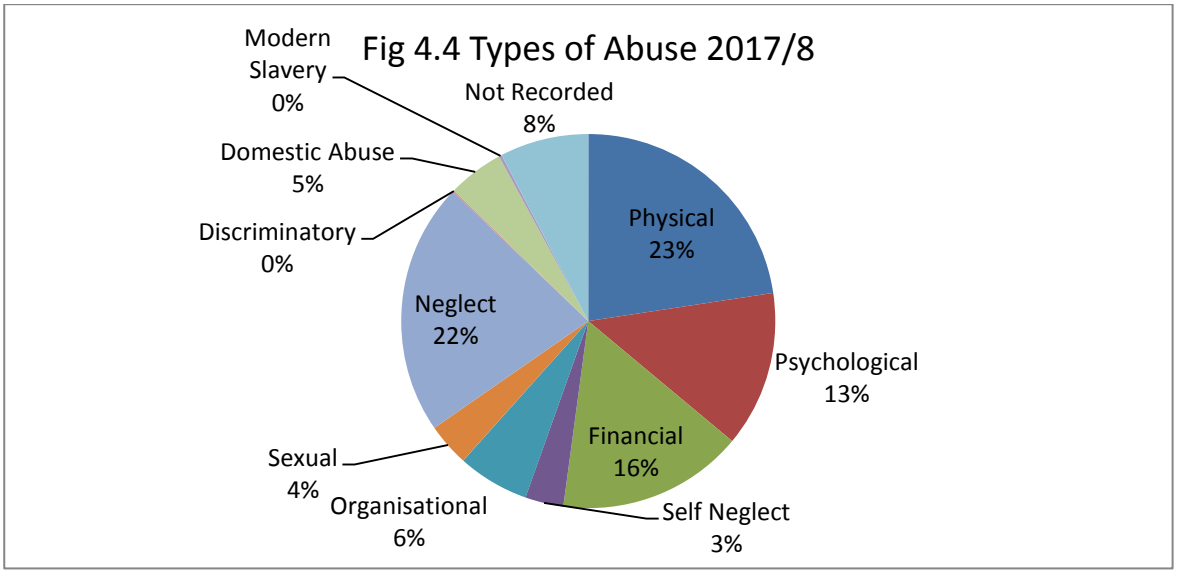
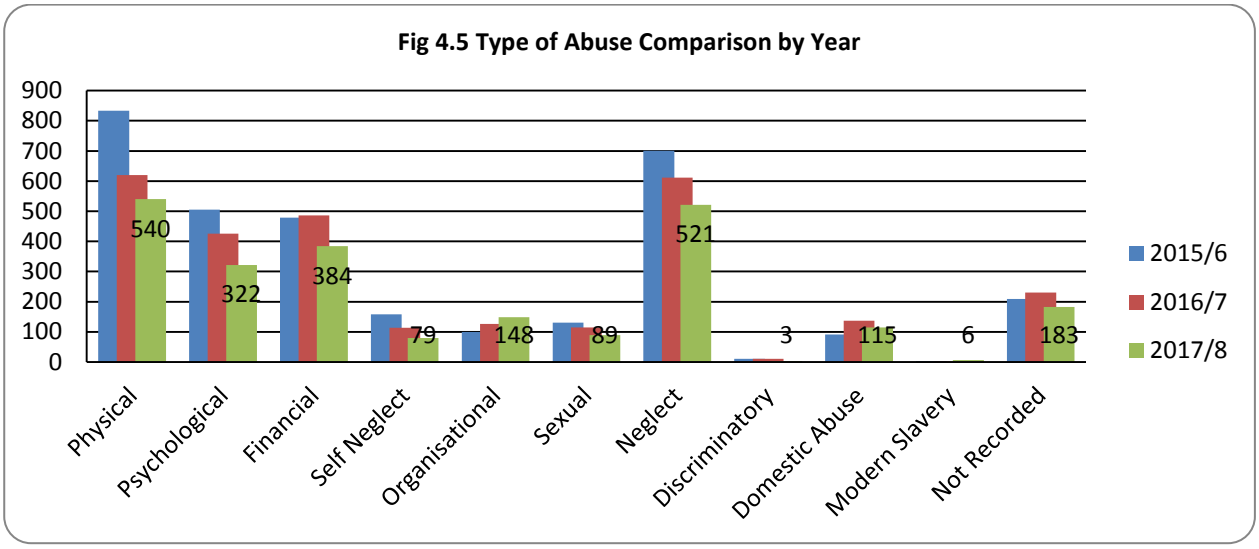


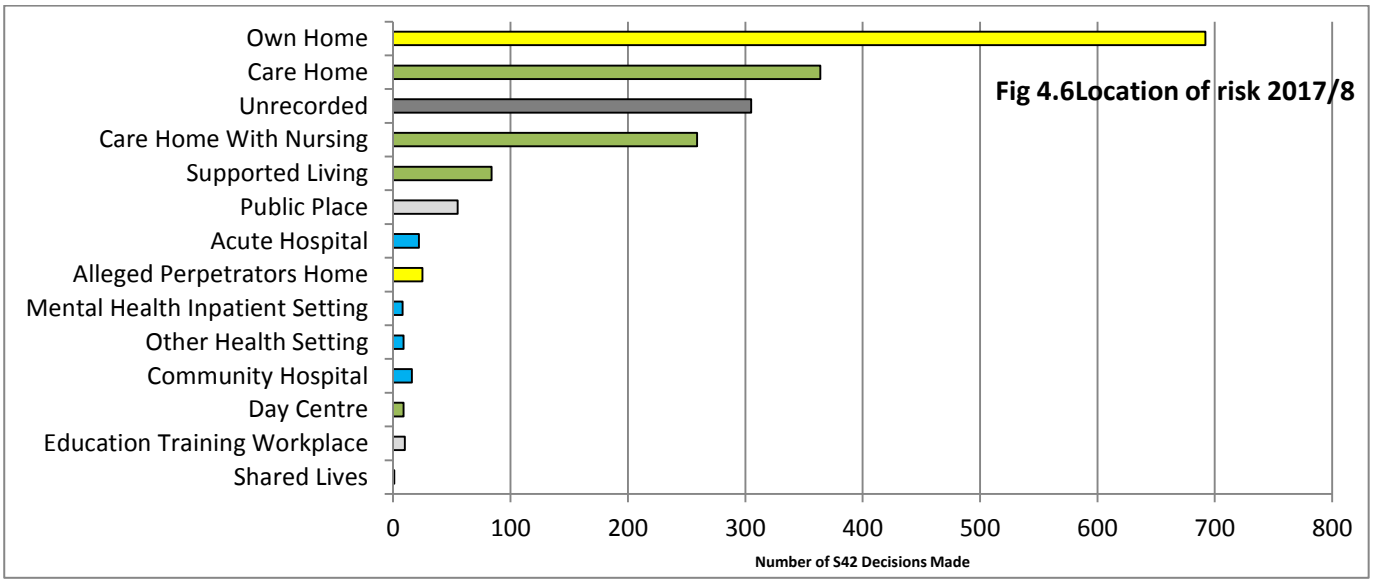
These mirror the highest types of reported abuse in the previous two years (Fig 4.5). A reduction is shown in all types of abuse this year, the exception being modern slavery,

although the numbers for this are relatively low. Types of abuse shown as 'not recorded' reflect the situation that in some cases when an incident is initially reported it is not possible to define the type of abuse.



4.4 Location of Risk

Data on the location again shows a similar pattern to previous years. The majority of safeguarding concerns, where a decision has been made that they meet the section 42 criteria, have taken place in the adult's own home. (Fig 4.6) As with the previous year, Care and Nursing homes continue to be the next highest locations.

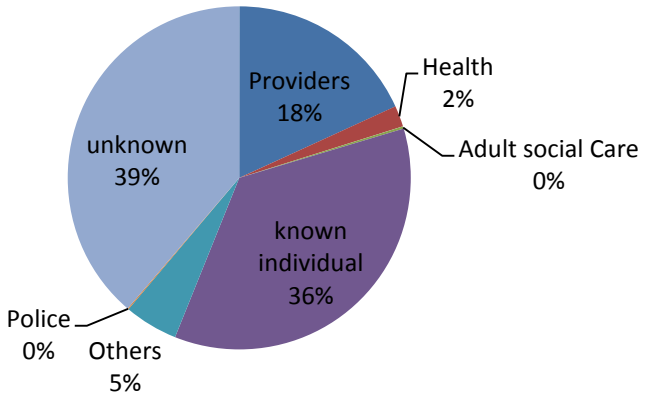


4.5 Source of Risk

One third of those people identified as the source of risk were known to the individual (Fig 4.7), (i.e. their partner, another family member, a friend or neighbour or, for those in a

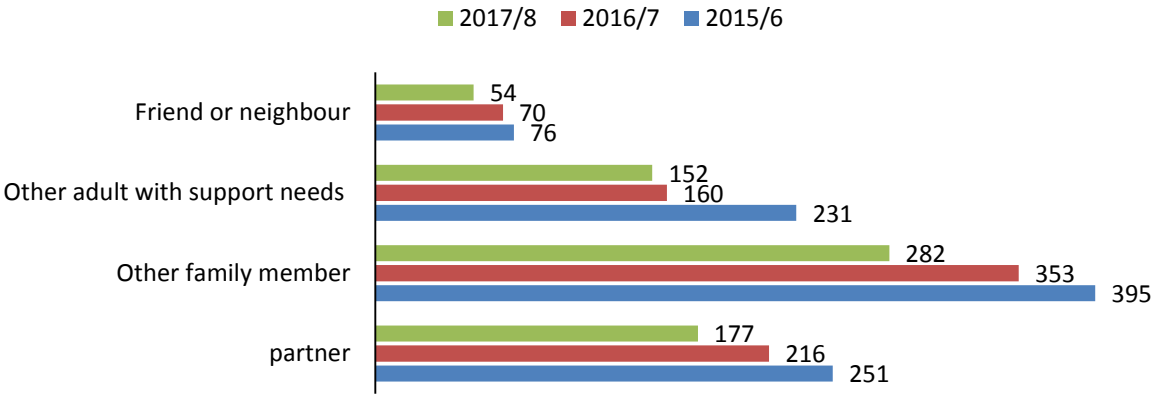
support setting, another adult with support needs). The next largest category was a service provider member of staff (i.e. Care homes and nursing homes). A large proportion were recorded as 'unknown'. This is because the data is extrapolated from the point the incident is first reported and some of these may be disclosed further down the investigation. It is also important to note that whilst Adult Social Care and the Police show up as 0% this is because the numbers are low. There were 4 incidents recorded where Adult Social Care staff were the source of risk and 6 where the Police were the sources of risk.

Fig 4.7 Categories of People as Source of Risk 2017/8

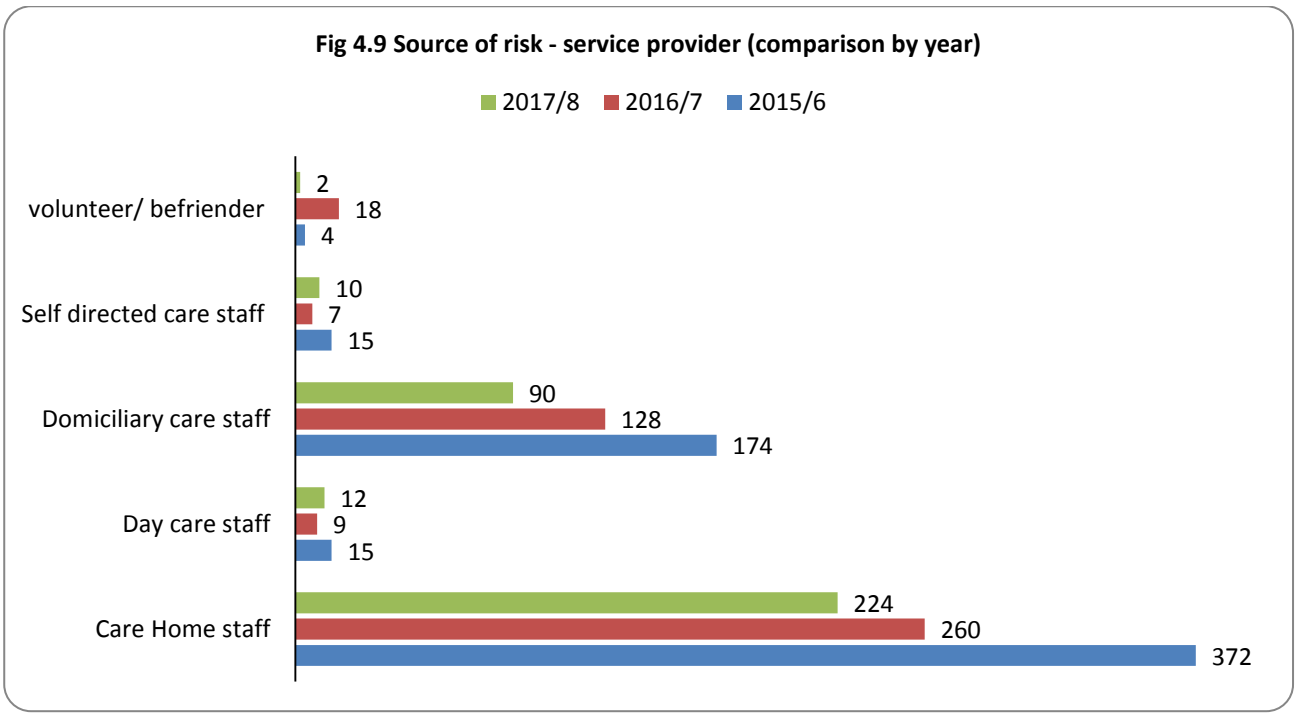


When looking more closely at the two greatest risk areas family members continue to be the largest group (fig 4.8) in the category of known individuals.

Fig 4.8 Source of risk - Known individuals (Comparison by year)



In the second highest category of 'Providers' (fig 4.9), Care Home Staff continue to be the highest source of risk. However this has shown a notable decline over the last three years, as has the number of Domiciliary care staff.

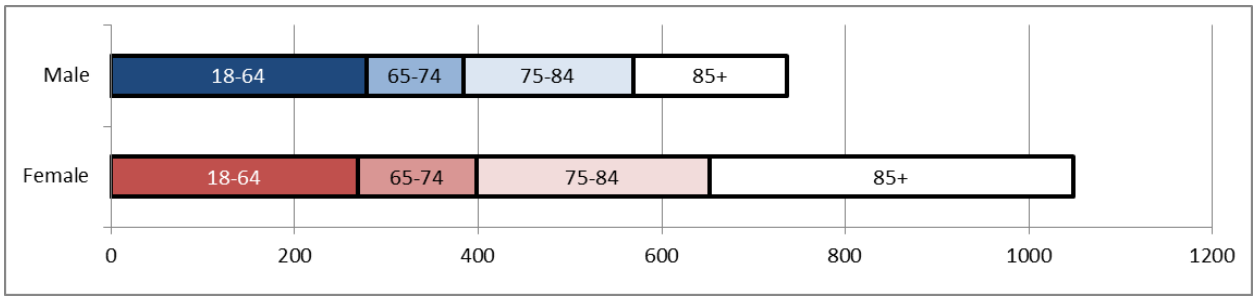


4.6 Demographic Profiles

Gender and Age

As with the previous year, the number of cases which meet the safeguarding section 42 criteria is higher for women than for men (Fig 4.10). This is particularly pertinent in age groups over 75 and is reflective of the gender demographic of the County.

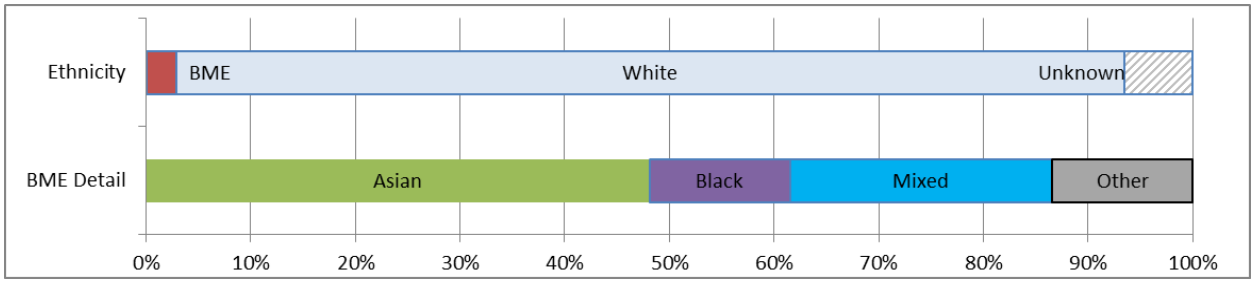
Fig 4.10 Gender/Age Profile of Concerns – Decisions Made (2017/18)



Ethnicity

In terms of ethnicity the level of cases again mirrors previous years, with the vast majority of those cases where the enquiry had been completed identified as being white (Fig 4.11).

Fig 4.11 Number of completed enquiries - Ethnicity



Within the BME groups Asian adults continue to represent the largest group, followed those adults identified as having a mixed ethnic background, then Black or Black British.

The percentage of safeguarding decisions made for all BME groups combined is 3 %, which is significantly lower than the 7.6% of BME groups living across the County. This could be due to underreporting within these communities. However, there is also a relatively significant number where the ethnicity is either not recorded or not stated. So there could be some inaccuracies in recording amongst this group.

4.7 Making Safeguarding Personal

Embedding this person centred approach is an ongoing priority for the WSAB and over the last year it was a primary focus of the Board, being a central element of the Annual Assurance Process and the annual learning event. .

Types of Outcomes

Of the 364 completed enquiries this year, 78% of the people being supported identified an outcome. Table 4.12 shows the type of outcomes which people wanted to achieve through the enquiry process and whether these were felt to be met. This year data shows that almost all outcomes were met. Whilst there has been a concerted effort to ensure outcomes are being achieved there has been a problem with the information management system which has led to some outcomes being added later as the enquiry progresses. This means that the outcome may not always have been identified by the person being supported at the beginning of the process. This could explain the exceptionally high success rate and is being addressed.

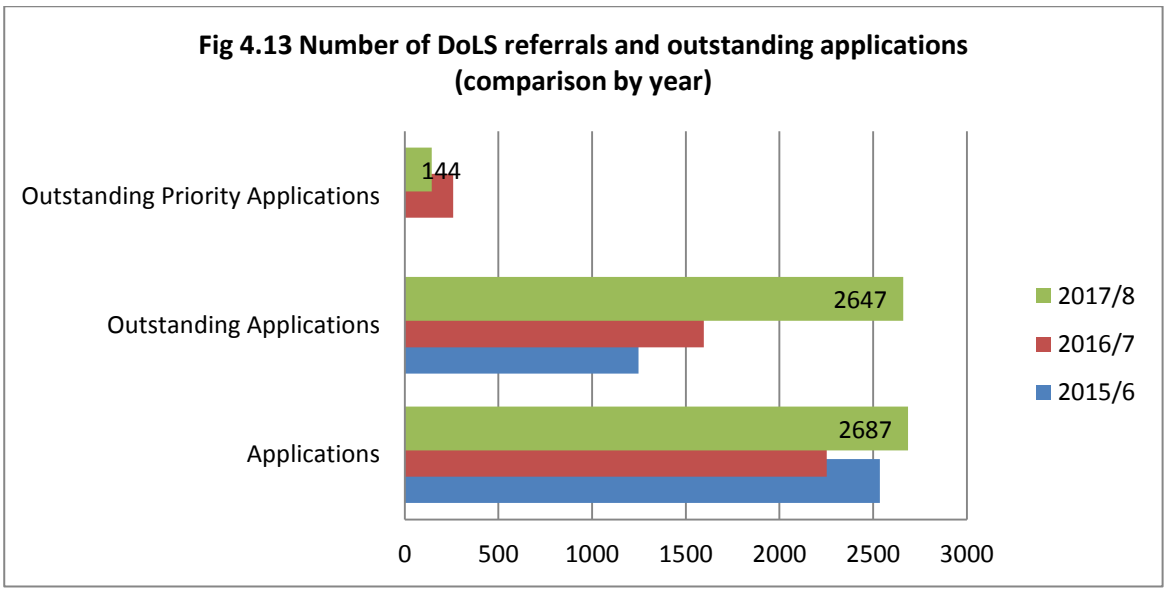
Table 4.12 Making Safeguarding Personal – Desired Outcomes –comparison by year			
Desired Outcome	**2017/18**	2016/17	2015/16
To Be And To Feel Safe	**100.0%**	100.00%	83%
To Know That Disciplinary Or Other Action Has Been Taken	**100.0%**	100.00%	100%
To Have Exercised Choice	**100.0%**	100.00%	100%
To Get New Friends	**100.0%**	100.00%	100%
To Maintain A Key Relationship	**100.0%**	100.00%	100%
To Maintain Control Over The Situation	**100.0%**	100.00%	90%
To Be Involved In Making Decisions	**100.0%**	98.20%	98%
To Know Where To Get Help	**100.0%**	92.10%	100%
To Know That This Won't Happen To Anyone Else	**98.0%**	93.10%	71%
To Have Help To Recover	**100.0%**	74.50%	100%
To Have Access To Justice Or An Apology	**100.0%**	85.40%	64%
Other Outcome	**100.0%**	71.40%	83%

4.8 Deprivation of Liberty Safeguards (DoLS)

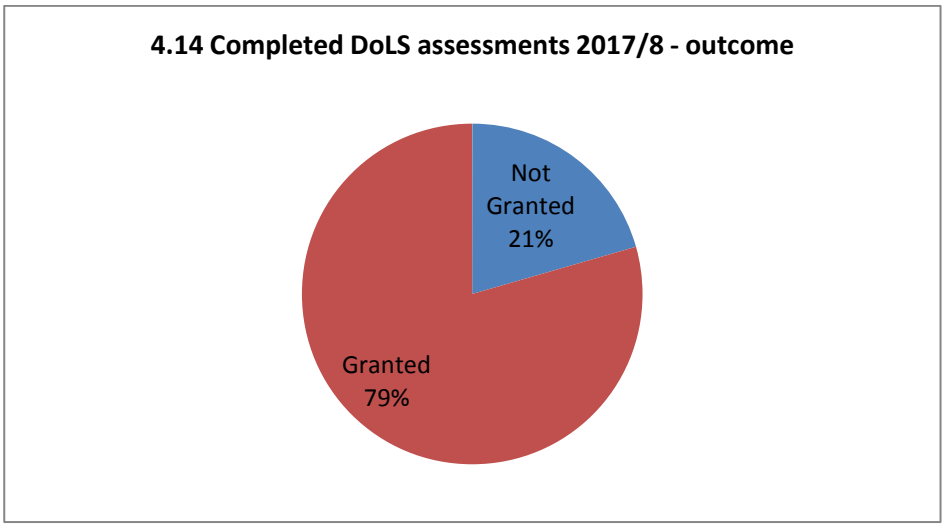
DoLS has continued to be a challenge, both locally and nationally, since the ruling in the Cheshire West case in 2014 which significantly increased the level of applications locally and nationally. As a consequence, alongside applications made during each financial year, there has also been a significant carry over of outstanding cases from the previous year. This accounts for the combined higher level of assessments undertaken or started compared to the number of applications made during the year.

In order to manage this situation, alongside the increased workload which has resulted, Worcestershire has streamlined areas of the administration process and reviewed how cases are prioritised to ensure that resources are targeted at those who are most in need or vulnerable.

The total number of Deprivation of Liberty Safeguards applications made during 2017/8 was 2687 (Fig 4.13). This is an increase of 19% compared to the previous year. Of these referrals 20% (524) were identified as a high priority.



During the year a total of 2660 assessments were completed during the year (Fig 4.14), of which 79% of the applications were granted (Fig 4.14):



The assessments completed during the DoLS process continue to be vital in order to ensure that the rights of vulnerable people are protected and that no one is deprived of their liberty unlawfully.

5.0 Priorities for 2017/18

In January 2018 the Board held its annual Strategy Day to evaluate the impact of activities over the last year and identify business objectives for the forthcoming year. The activity required to deliver Care Act (2014) duties and requirements, alongside exploring performance data was analysed and key themes, which emerged through engagement events and consultations, were reviewed.

The Board agreed to move away from a three year strategy and focus on the Annual Business Plan in order to address emerging priorities identified through SARs and performance data. Priorities for the forthcoming year are:

- To improve awareness across all stakeholders of what safeguarding is. (Section 42 Criteria).
- Demonstrate that we are listening to service user and gathering their views.
- To seek assurance that stakeholders are continuously improving knowledge and practice in relation to Making Safeguarding Personal (MSP), the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- To embed cross cutting work with Worcestershire Safeguarding Children's Board (and other relevant partnership Boards) to ensure there are improvements in professional practice, particularly in relation to professional curiosity and transition arrangements.

These have been used to complete the Annual Business Plan for 2018/19 and aligned to the relevant sub groups to ensure that objectives are achieved.

KEY to Acronyms

CCG	Clinical Commissioning Group
CSE	Child Sexual Exploitation
DoLS	Deprivation of Liberty Safeguards
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHS	National Health Service
PH	Public Health
SAR	Safeguarding Adults Review
WCC	Worcestershire County Council
WHAT	Worcestershire Acute Hospital Trust
WHCT	Worcestershire Health and Care Trust
WMP	West Mercia Police
WSAB	Worcestershire Safeguarding Adults Board
WSCB	Worcestershire Safeguarding Children’s Board