Worcestershire Safeguarding Adults Board

Annual Report 2018/19

Worcestershire Safeguarding Adults Board

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Actions

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Sign Off	September 2019
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Contents

Chairs Foreword

Since the Care Act 2014 the Worcestershire Safeguarding Adults Board (WSAB) has led partnership activity to oversee and scrutinise the safeguarding of adults with care and support needs in the county.

This continues to be a high priority for a broad range of partner agencies and organisations from across the statutory and voluntary sectors, and I would like to place on record my appreciation for their commitment, diligence and determination to secure better outcomes for some of the most vulnerable people in our communities.

Safeguarding is critically important and is best approached through agencies coming together with shared ambition, shared information and joint programmes of action. 2018/19 has seen the partnership in Worcestershire continue to strengthen with engagement of not only the key partners but crucially from service users, carers and their advocates, who now all have an active place and voice on the Board. The voice of those who have care and support needs and use the services of the partner organisations is essential in understanding what is happening, what is required and how they are affected by the services provided.

This is reflected in the priorities of the Business Plan; Is 'Making Safeguarding Personal' properly understood and embedded in practice; Are the requirements of the Mental Capacity Act consistently applied; and are referrals into Social Care made at the right time, with the right information and leading to the right action and outcome? The WSAB will continue to seek assurance that arrangements in Worcestershire are appropriate and effective by working with colleagues from the Worcestershire Safeguarding Children Board, the Health and Wellbeing Board, the Community Safety Partnerships and professionals from across the partnership. The financial and resourcing issues faced by partners remain a risk to service provision and the WSAB must remain vigilant to the impact of such pressures.

I firmly believe that a collective approach is most effective in safeguarding people with care and support needs, and the WSAB will remain committed to maintaining a strong and inclusive partnership in Worcestershire.

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:

- Clearly 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 – Our work going forward

2.0 Background

2.1 Purpose of the Board

A Safeguarding Adult Board's 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 with care and support needs 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, whilst adhering to the principles of Making Safeguarding Personal.

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-led 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 Directorate of Adult Services
- 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
- National Probation Service
- Regulatory Services
- Worcestershire Voices
- Representative from Worcestershire Housing Strategic Partnership
- Representative from Care Homes Association
- Representative from Carer reference group
- Representative from Advocacy Reference Group
- Representative from People with Living Experience (PwLE) Reference Group
- Lead Councillor for Adult Social Care
- Public Health

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 Statutory Partners

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

There was an under-spend for this financial year of £37K. Alongside this there was cumulative under-spend from previous years of £49K, amounting to the Board now having reserves of £90K.

This build-up of reserves dates back to a decision made several years ago to increase the Board budget following an overspend due to the cost of completing a large number of SARs that year, alongside anticipation of increased staff cost. It took a while to recruit to some posts and the cost for SARs over subsequent years was lower than predicted.

The Board have now agreed that the future Budget will revert back to its original sum of £117,000. In addition a refund of 49K will be proportionately returned to partners contributing to this budget. The remaining surplus will be used to offset any future SAR overspend alongside supporting a number of areas of work which have been identified for additional development, including building analytical capability, training and communication. The Board will also review future contributions against planned committed expenditure to ensure that this surplus is not replicated in future years.

2.4 Delivery Model

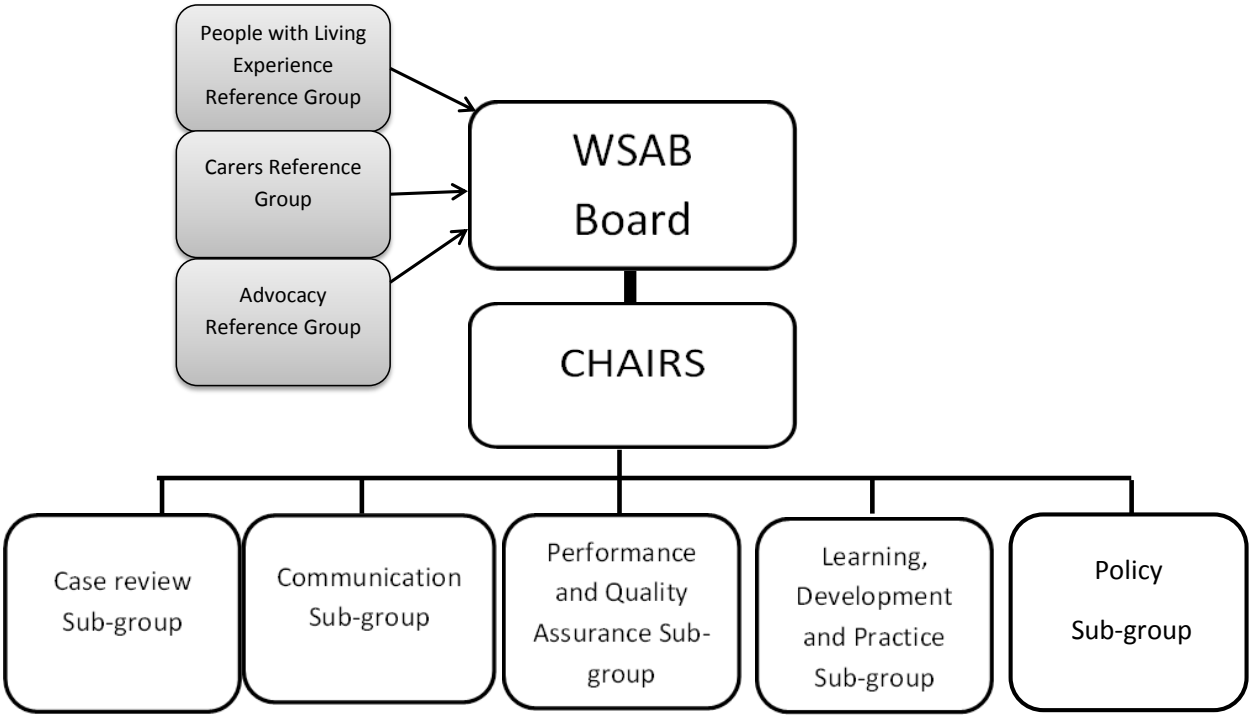
Implementation of the Business Objectives is achieved through the work of the Board and its five sub-groups (Fig 2.4). Each year annual business objectives are developed based on emerging themes from the data, findings from local and national reviews and a review of previous Board Priorities identified each year at a Board Strategy Day.

Issues are also identified and raised at the Board via three reference groups, which represent the interests of people with care and support needs, their careers and families.

There is a representative from each of these reference groups on the Board attending the Strategy Day.

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.

Fig 2.4 WSAB Structure



2.5 Business Objectives

There were four key objectives identified in the 2018-19 business plan. Table 2.5 gives a summary of the annual objectives and details achievements and any barriers and challenges to progress.

Table 2.5 - Achievements and Challenges

WSAB Objective	Achievements and Challenges
1. To improve awareness across all stakeholders of what safeguarding is. (Section 42 Criteria).	**Achievements:** • Reviews of a number of policies have been undertaken during the year alongside the development of professional guidelines (see section 3.2.6); • Improvement plans which were identified though the previous year's Annual Assurance Assessment, were reviewed to ensure that relevant actions were undertaken;

WSAB Objective	Achievements and Challenges
	• Learning briefings are now systematically being produced and disseminated when a SAR is completed; • The SAR protocol has been updated to reflect modifications in the SAR process, including the monitoring of action plans and evidencing the impact of learning; • Additional workshops were held on Mental Capacity Act and Section 42 criteria, for those unable to attend the oversubscribed annual SARs learning event of 2017/8; • Links were made into local Homelessness Forums to develop awareness of when Section 42 criteria could be utilised for this group of people and support the development of preventative actions; • A voluntary sector Task and Finish group was established to develop awareness of the application of Section 42 criteria and support the development of early interventions through a strength based approach to problem solving; • The Communication Sub-group is now being led by the Board Chair following a review of membership and terms of reference. **Challenges** • Whilst procurement processes meant that the joint website with Worcestershire Safeguarding Children's Board was not finalised during 2018/9, it was competed early in the next business year and is now active. • It was not possible to complete the update of the new training strategy as the publication of the revised intercollegiate document by the Royal College of Nursing supported by National Health Service England (NHSE) took place later than anticipated; This action has been carried over into the 2019/20 Business plan • The review of the Adult Safeguarding Competency framework has also not been completed due to the delay in the publication of the NHSE intercollegiate document. This action has been carried over into the 2019/20 Business plan
2. Demonstrate that we are listening to people and gathering their views.	**Achievements** • There is now representation at the Board from the three reference groups identified in the Boards Engagement Strategy, Carers, Advocacy and People with Living Experience; • Sub-groups now have wider and active representation from the voluntary sector and district councils • The People with Living Experience reference group is being developed, with the support of Onside Advocacy, to ensure that there is a wide range of representation from people who have different care and support needs; • Following the request from a Voluntary Sector task and finish

WSAB Objective	Achievements and Challenges
	group a Safeguarding Network has been established which will meet bi-annually. This network is action focused and current areas it is exploring include the development of a strength based approach in localities and joint safeguarding training approaches **Challenges** • The old website format did not allow for easy editing, once the new website is established this will enable this objective to develop further, alongside the development of the Safeguarding Network.
3. 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).	**Achievements** • Improvement plans, which were identified though the previous year's Annual Assurance Assessment, were reviewed to ensure that relevant actions were undertaken; • The dashboard, which was established to measure the WSAB progress towards meeting its measurable objectives, is presented at the quarterly Board meetings; • An audit was undertaken to review the safeguarding policies and processes in place in day care organisations which have no legal requirements to meet local or national quality standards. **Challenges** • There have been limited opportunities to review organisations' improvement plans, so these three areas (MSP, MCA and DoLs will remain a priority in the 2019/20 Business Plan.
4. To embed cross cutting work with Worcestershire Safeguarding Children's Board (WSCB) (and other relevant partnership Boards) to ensure there are improvements in professional practice, particularly in relation to professional curiosity and transition arrangements.	**Achievements** • The WSAB continued to liaise with WSCB 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; • The Chair of the Case Review Subgroup is Vice Chair of the Children's Boards SCR Subgroup and vis versa to ensure that the groups work together and learning is shared; • The SAR referral and decision template has been modified to align it with WSCB documentation; • This year's Safeguarding Adults Review (SAR) annual learning event focused on Domestic Abuse and Coercive Control in relation to people with care and support needs. The event was supported by the Domestic Abuse lead from the Health and Wellbeing Partnership, alongside an academic lead on Domestic Abuse from the University of Worcester; • A process is now in place to ensure there is better communication on reviewing cases where there is an overlap between the need for a SAR and a Learning Disability Mortality Review (LeDeR).

3.0 Review of Activities 2018/19

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 the early work undertaken by the WSAB sub-groups was to ensure partner agencies were all implementing the Care Act (2014) requirements. 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 Act, Making Safeguarding Personal and Section 42 enquiries along with specific issues identified in Safeguarding Adults Review (SARs).

Board processes are now well established and structures to engage with people who have experience of health and social care services, their carers and advocates are now in place. The work around engagement will continue to be developed and embedded over the next business year, with additional focus on developing links and early intervention approaches with the voluntary sector.

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.

Safeguarding Adult Boards are also free to arrange for a review in any other situations involving an adult in its area with needs for care and support. In this case the WSAB would only consider a review if there are clearly identified areas of learning, practice improvement or service development that have the potential to significantly improve the provision of care and support and this cannot be achieved by other review procedures. The capacity of the sub-group and agencies to manage such a review would also have to be considered.

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, procedures and professional standards;
- If these policies and procedures enabled the services required to work together to ensure the services are 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 2018/19 there were 8 referrals requesting consideration for a Safeguarding Adult Review (SAR) to be undertaken. Five of these resulted in the recommendation that a SAR should be commissioned and due to the time of referral have been carried over to be completed during 2019/20. Three of these were in relation to the death of a person living in the open, often described as as a rough sleeper. It was agreed that the review into their death should be undertaken through a thematic review, and include the findings from an independent review by Worcester City Council into a similar death two years previously.

Of the remaining referrals, one resulted in single agency actions being recommended the other two referrals required no additional actions,

Work was also completed on two SARs which were carried over from 2017/18, both of which are now published and can be found on the Board's website via the following link:

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

3.2.2 SARs: Changing Practice through Learning and Action

Action plans for each SAR are drawn up identifying where change in practice is required. The progress of the implementation of the action plans is carefully managed by agencies and monitored the WSAB. Domestic abuse and coercive control were issues identified in both of the SARs published during 2018/9. Key learning themes from these SARs include:

- Ensuring staff understand that many circumstances are both safeguarding situations and domestic abuse, with a range of legal options to work with victims;

- Ensuring safeguarding policies, protocols and procedures explain the link to domestic abuse and vice versa;

- Ensure that staff are trained to identify and deal with domestic abuse in the form of coercive and controlling behaviour, abuse in same sex relationships and domestic abuse suffered by adults at risk;

- Consider the development integrated training that covers both safeguarding and domestic abuse rather than treating them as separate issues;

There were also further recommendations on ensuring that guidance is clear on how staff and organisations need to share and review historical information, including previous assessments.

Where the criteria for a SAR and a Domestic Homicide Review are met, learning actions are overseen by both the Safeguarding Adults Board and the relevant Community Safety Partnership. The Board also links with the Domestic Abuse Forum which is coordinated by Public Health. Recommendations from these reviews would be discussed and implemented through these processes.

3.2.3 Learning Event

In January 2019 we held our annual learning event. This year the focus was on learning in relation to cases where Domestic Abuse or Coercive Control was a significant factor following the publication of two Joint SARs and Domestic Homicide Reviews on people with care and support needs, alongside a Safeguarding Adult Review into a person with learning difficulties who was subjected to coercive control by a family member. The author of this SAR gave a presentation into the learning from this case and a statement prepared by the subject of the report, was read by an advocate who was providing ongoing support.

The event also provided a number of learning opportunities including a presentation from a senior lecturer from the University of Worcester on the prevalence of Domestic Abuse and Coercive Control amongst people with care and support needs; Awareness raising sessions by a public health lead on identifying Coercive Control and Domestic Abuse, workshops focusing on participants identifying what they would do in relation to local case studies; Signposting advice on support available including information from a solicitor and local domestic abuse services.

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 the previous business year (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, who are members of WSAB, 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.

At the beginning of the 2018/19 business year the stakeholders provided an update on these improvement plans and progress towards meeting these three standards. All the actions identified had been activated, these included introduction and development of training; improved guidance; review of processes and awareness raising. Alongside these some organisations also undertook audits and surveys to assess how well these processes and principles were embedded in practice.

Improvements were found in a number of areas, particularly in relation to developing the understanding of safeguarding processes and incorporating the values of Making Safeguarding Personal. For example an audit undertaken within WHCT found an increase in identifying outcomes and similarly a competency assessment undertaken by Worcestershire County Council found good standards in safeguarding knowledge amongst staff. However in some areas understanding the principles and processes of the Mental Capacity Act and undertaking assessments remained a challenge.

3.2.5 WSAB – Board Governance and Development

The WSAB continued to build on the robust governance processes which were already in place. Notable work and changes for 2018/19 include:

- Ongoing development of Performance Management Framework to measure progress against Board objectives;
- Review and changes to sub-groups to reflect the development and progress of the Board work;
- Development of the People with Living Experience reference group to ensure that a diverse range of experiences are reflected in the work of the Board;

- Formation of a Voluntary Sector Task and Finish group to explore the development of early interventions and prevention actions through strength based locality work.

As part of the WSAB's commitment to improve engagement with people who have experienced safeguarding and service provision, 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, including what it means to be in receipt of services and the impact that these experience have on the recipients; as well as identifying any service issues which may need greater assurance.

3.2.6 WSAB Publications and Guidance

Policies which were required through the implementation of the Care Act are now in place. A process of reviewing these has been established, During 2018/19 the following guidance was reviewed and changes were made:

- Multi-Agency Self-Neglect Guidance

New guidance was developed to support residential and domiciliary care settings to minimise the risk of a person going missing and key actions to take if someone does go missing

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, as outlined in section 2.3, 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 To improve awareness across all stakeholders of what safeguarding is.

- Regular meetings are held between Safeguarding Leads to disseminate key messages, with a focus on key topics and learning from SARs; (WHCT, WMP, CCG/GP Practices);
- The CCGs' seek assurance from NHS commissioned services that recommendations from local and national reviews/inquiries are implemented across the health economy. In turn the CCG report to NHS England (NHSE) /NHS Improvement (NHSI) to provide assurance that they are commissioning high quality, safe, effective & sustainable care;

- The CCG Safeguarding Team undertake Quality Assurance visits in conjunction with the CCG Quality Team and Adult Social Care colleagues when safeguarding concerns have been raised;
- Continual development of training to ensure that learning around safeguarding is embedded and understood by staff within the partner organisations alongside commissioned providers; (WHCT, PH, WAHT, WCC, WMP, CCG);
- Within the WAHT levels of safeguarding training take up have improved significantly over the last year ;
- Bespoke safeguarding training in place for key front line staff, including GP's,nurses and midwives (CCG, WAHT, WHCT);
- Lunch & Learn sessions have been introduced for WCC staff these have includes sessions on Safeguarding, including question and answer sessions;
- WAHT have developed a Safeguarding Training Directory to inform staff of the levels of training required, competencies and where training can be accessed;
- WAHT undertook a full review and update of the Trust intranet pages to include WSAB SAR learning briefs;
- Closer working links have been developed between the Adult Safeguarding Team and Area Teams (WCC);
- Principles of Signs of Safety are being embedded into practice to further develop MSP (WCC);
- WCC has developed a safeguarding protocol with West Mercia Women's Aid;
- Quarterly and weekly safeguarding newsletters and briefings (WHCT, CCG).

Objective 2: Demonstrate listening to adults and gathering their views

- Work has been undertaken with service user and carer groups to ascertain their views around issues such as safeguarding (WHCT);
- Patient stories go to the WHCT Board , these can have a safeguarding element and patients have attended to share their experience;
- The Neighbourhood Teams now have experts by experience on the Alliance Boards.(WHCT);
- WHCT undertook an audit of MSP which showed an increased consultation with the adult prior to a safeguarding concern being reported;
- Discussions and awareness raising around safeguarding is delivered as part of the engagement activity with service users through a wide array of forums and networks (CCG);
- WCC have developed an outcome survey which is now sent out to people when a safeguarding enquiry is completed;
- WCC Safeguarding Team and the 3 Conversation Development Practitioners are actively supporting the development of a Safeguarding network group by the Board;
- WCC performance is above the national average in relation to MSP and MCA application;

- Guidance has been produced on MCA Frequently Answered Questions, Working with Lasting Powers of Attorney, Practice Advice and MCA (WCC);
- Patient Experience Report are shared with the WHAT, WHCT and CCG Safeguarding Committees on a quarterly basis;
- WHAT launched its Patient, Carer, and Community Engagement Plan

Objective 3: 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).

- A rolling programme of refresher Level 3 Safeguarding Adults training which has been commissioned by the CCG includes Making Safeguarding Personal, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS);
- MCA and DoLS training is essential for all registered professionals within the WHCT and has a compliance rate of 94.30% at the end this reporting period. This is in excess of the 90% target set by the CCGs;
- A base line assessment has been undertaken against the NICE Guidelines of the use of Decision Making and Mental Capacity. This showed 83% compliance with best practice. An action plan has been developed and will be completed during 2019/20. (WHCT);
- Considerable work has been undertaken to improve the recording of assessments of mental capacity and best interest decisions in community hospitals in relation to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions, including an e-learning tool.(WCHT);
- Bespoke sessions have been delivered to teams where audit or internal reviews indicate a need to increase understanding and implementations of the Mental Capacity Act principles. (WHCT);
- The CCG is currently piloting an MCA tool for GP practices using their electronic patient record system .
- The CCG quality assures applications to the Court of Protection where there is a deprivation of liberty in respect of domestic settings, supported living and shared lives schemes. Feedback from the applications is shared with practitioners in order to improve the quality of the information provided and therefore services to people;
- WCC has delivered presentations and reflective practice session on MCA and DoLs to their staff and a variety of forums and organisations including, Student Social workers, Homelessness Forums; GP's;
- SAR actions have included producing practical MCA guidance for staff and running reflective learning sessions;(WCC);
- Development of a staff video in relation to MCA & DoLS –this video is mandatory for all Healthcare Assistants working within the Trust and has also been uploaded to the Trust intranet training pages and incorporated into training delivered by the Trust Dementia team.(WAHT);
- Staff knowledge check audit undertaken –including MCA & DoLS (WAHT).

Objective 4: 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.

- 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. (CCG, WCC);
- A partners portal has been developed as part of the MASH process (WCC);
- WHCT and WAHT have Safeguarding champions to ensure that support and advice can be clearly provided across both children's and adult services;
- WHCT, WAHT and CCGs have Integrated Safeguarding Teams supporting work across the adult and children's safeguarding agendas;
- 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);
- WAHT held a domestic abuse and coercive control awareness raising event for staff. They now have covert items to be given to victims with contact details for West Mercia Women's Aid;
- Participation in the Domestic Abuse Triage, CSE and Missing Triage and DRIVE as part of the Safeguarding Hub (WCC, WHCT);
- WAHT promoted the Worcestershire Understanding Extremism & Radicalisation Toolkit which is available on Trust intranet as a staff resource;
- WAHT supported the Home Office Female Genital Mutilation National Campaign during October.

These are just a selection of the feedback provided by partners to evidence how they have supported the board in meeting the priorities in 2018-2019

4.0 Safeguarding Activity and Performance 2018/19

4.1 Care Act (2014)

The data in this report is based on the definitions of safeguarding criteria as set out in the Care Act (2014).

4.2 Number and Source of Concerns

Since the Care Act criteria were introduced in 2015, the number of concerns reported has seen a steady decrease (Table 4.1). Analysis suggested that the high level of reports were initially due to incorrect referrals. This was addressed through a number of measures including raising awareness on what constitutes a safeguarding concern which will meet section 42 criteria, (outlined in section 2.1 of this report), alongside reviewing the pathway for reporting care quality concerns. There was also a particular focus on services which consistently had high levels of inappropriate reporting.

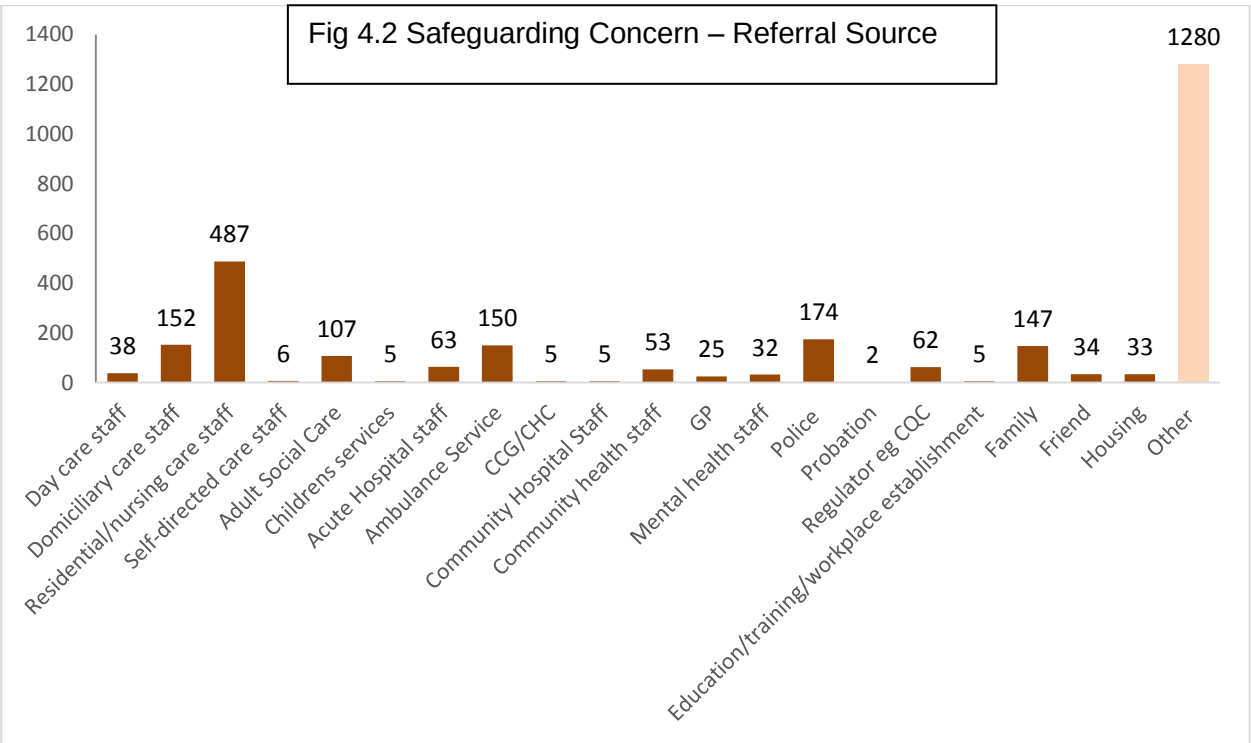
Table 4.1 – **Concerns dealt with under safeguarding 2017/18**
Source: Safeguarding Adults Collection
(compared to the previous three years)

	2015-16	2016-17	2017-18	**2018-19**
Concerns Reported	2653	2342	1942	**2202**
High Risk	99	65	79	**69**
Section 42 applies (meets criteria)	343	328	325	**318**
Percentage of concerns reported where Section 42 Applies		15%	18%	**15%**

In the previous year (2017-18) there was increase in the percentage of concerns which met Section 42 criteria last year, from 15%, to 18%. Analysis suggested that the high level of reports received prior to this year was in part due to incorrect referrals. Such referrals are likely to produce a low conversion rate. This was addressed through a number of measures, including raising awareness on section 42 safeguarding criteria. There was a particular focus on services which consistently had high levels of inappropriate reporting.

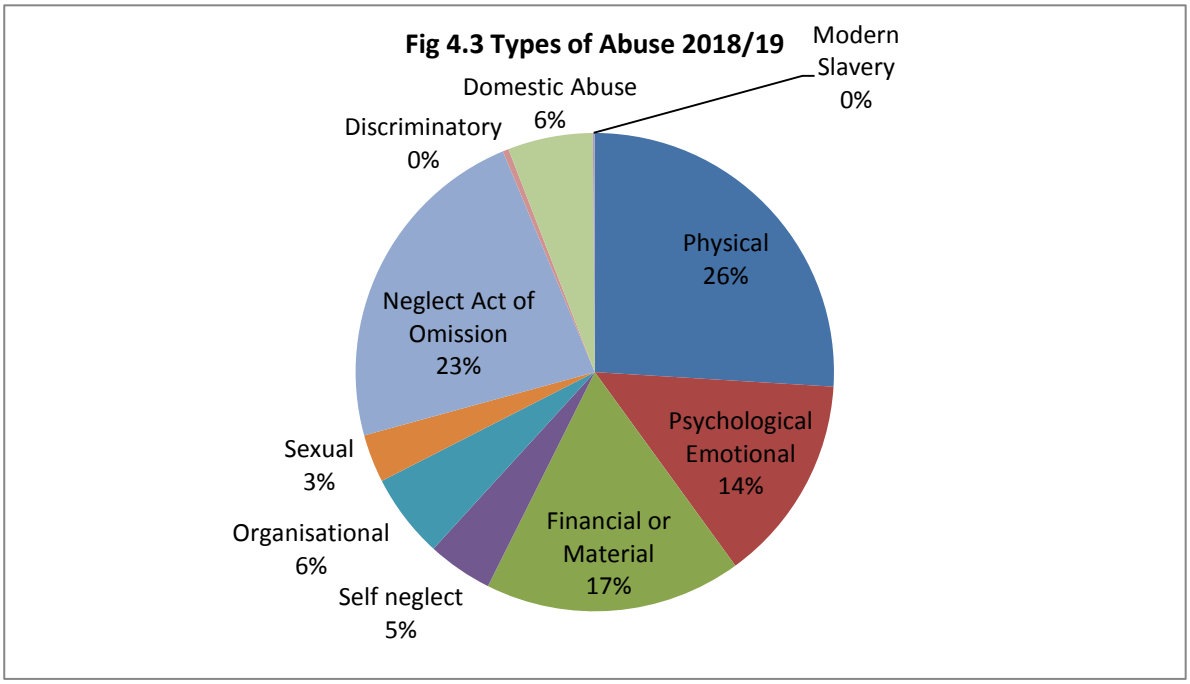
However this year it has returned to 15%, which is why awareness raising Section 42 criteria is still a key priority for the Board. It is also important to acknowledge that some of those which do not meet the criteria still require some level of support or signposting. Whilst this is often addressed through the Local Authority Safeguarding team this has an impact on their capacity. Ensuring that there is an effective pathway addressing cases which do not meet the criteria is therefore also a priority for the Board.

As with the previous year the highest numbers of concerns were raised by residential care and nursing homes followed by the police, ambulance service, domiciliary care providers and families(fig 4.2). Those recorded as 'other' include a broad spectrum of people and organisations not categorised within the current recording system.



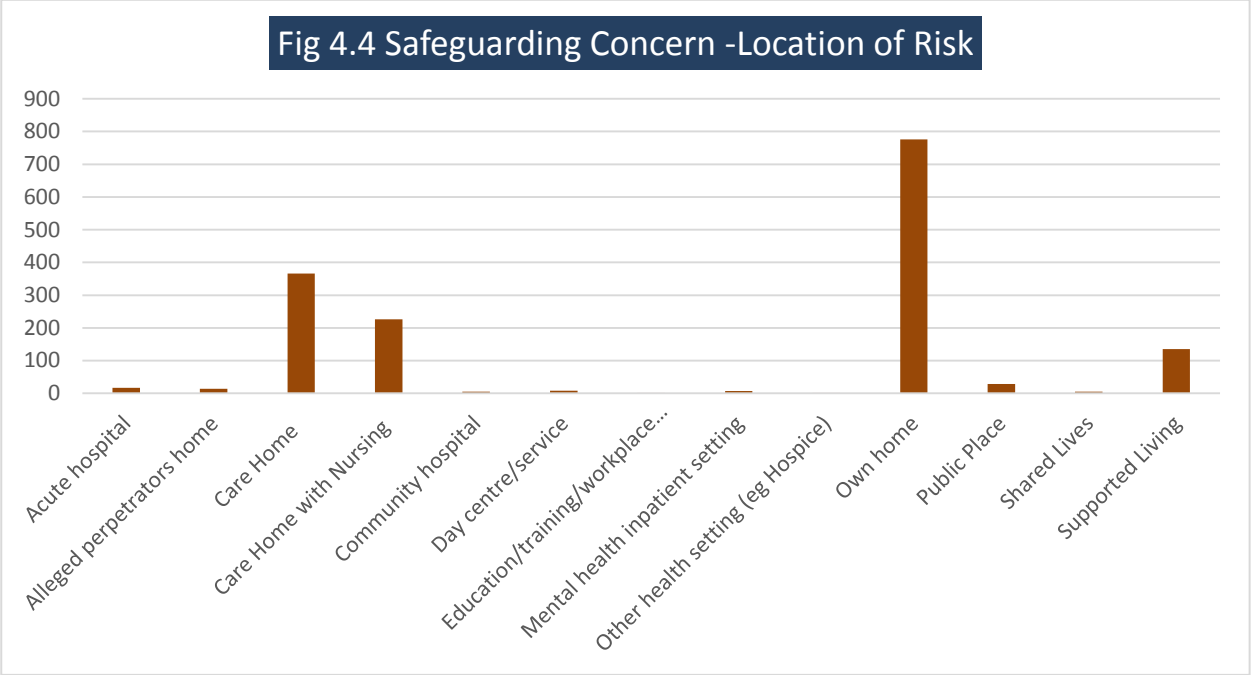
4.3 Type of Abuse

The different types of abuse recorded have remained similar levels over the last three years. (Fig 4.3) Physical abuse remains the highest type of abuse, closely followed by neglect. The next highest levels are financial and psychological abuse. These follow the national picture, so understanding and addressing the circumstances where these types of abuse could take place, alongside developing early interventions through effective pathways which prevent such cases are a priority for the WSAB.



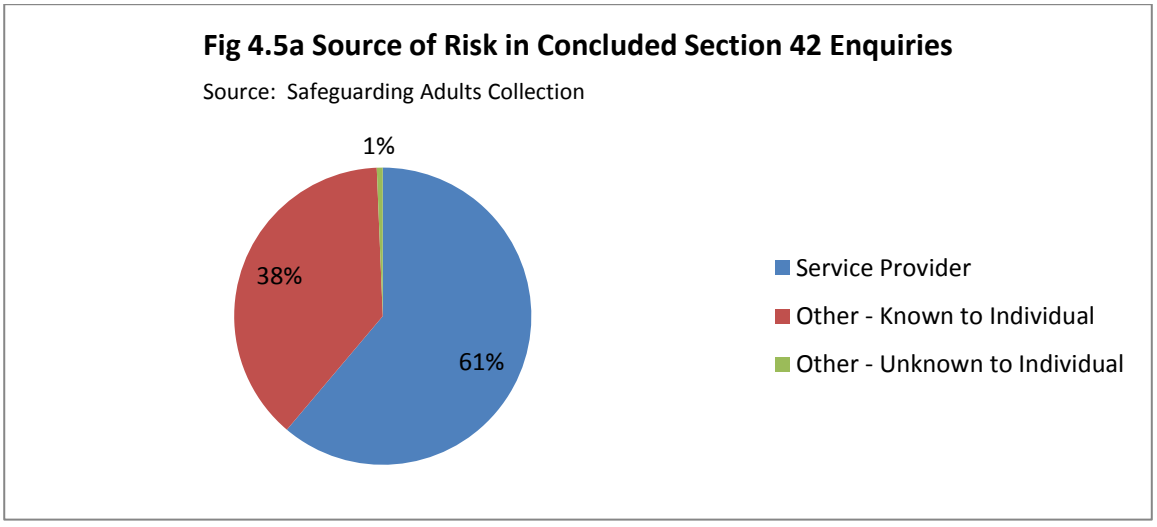
4.4 Location of Risk

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 4.4) As with the previous year, Care and Nursing Homes continue to be the next highest location.



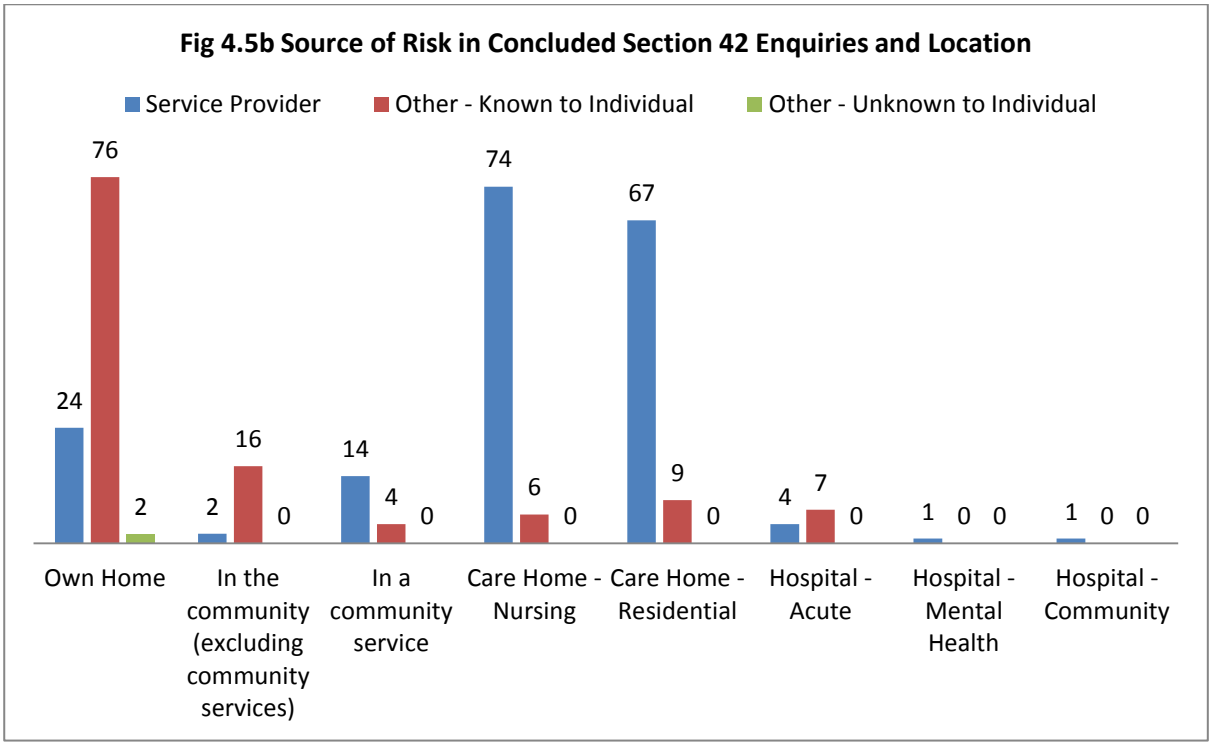
4.5 Source of Risk

In those cases which met the Section 42 criteria and the enquiry had been completed well over half (61%) of the person who presented the risk, was someone who worked for a service being received by the person with care and support needs. The remainder were people who were known to the individual, such as a family member, friend or neighbour (Fig 4.5a).



In terms of the location of the abuse in concluded enquiries, the combination of residential and nursing homes were the location where more incidents occurred, and the source of the risk was predominantly someone working within that services. This is because within these settings there is a culture of reporting safeguarding conerns. Also there are more staff present who are likely to witness incidents,

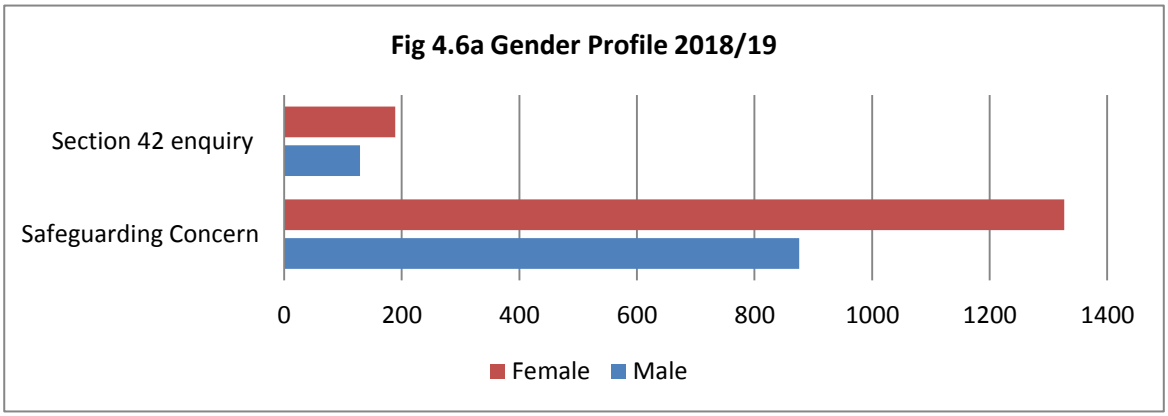
The next most prevalent location was the persons own home, however the biggest risk here was someone known to the individual for example a family member, friend or neighbour. (fig 4.5b)



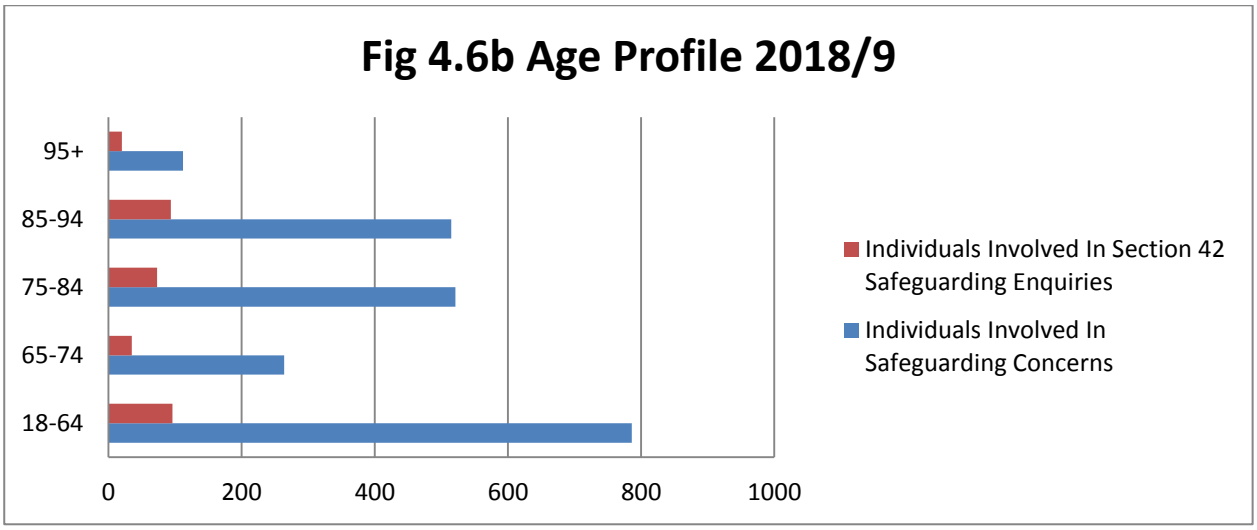
4.6 Demographic Profiles

Gender and Age

As with the previous year, the number of cases which are raised as a safeguarding concern and those which subsequently meet the safeguarding section 42 criteria is higher for women than for men (fig 4.6a).

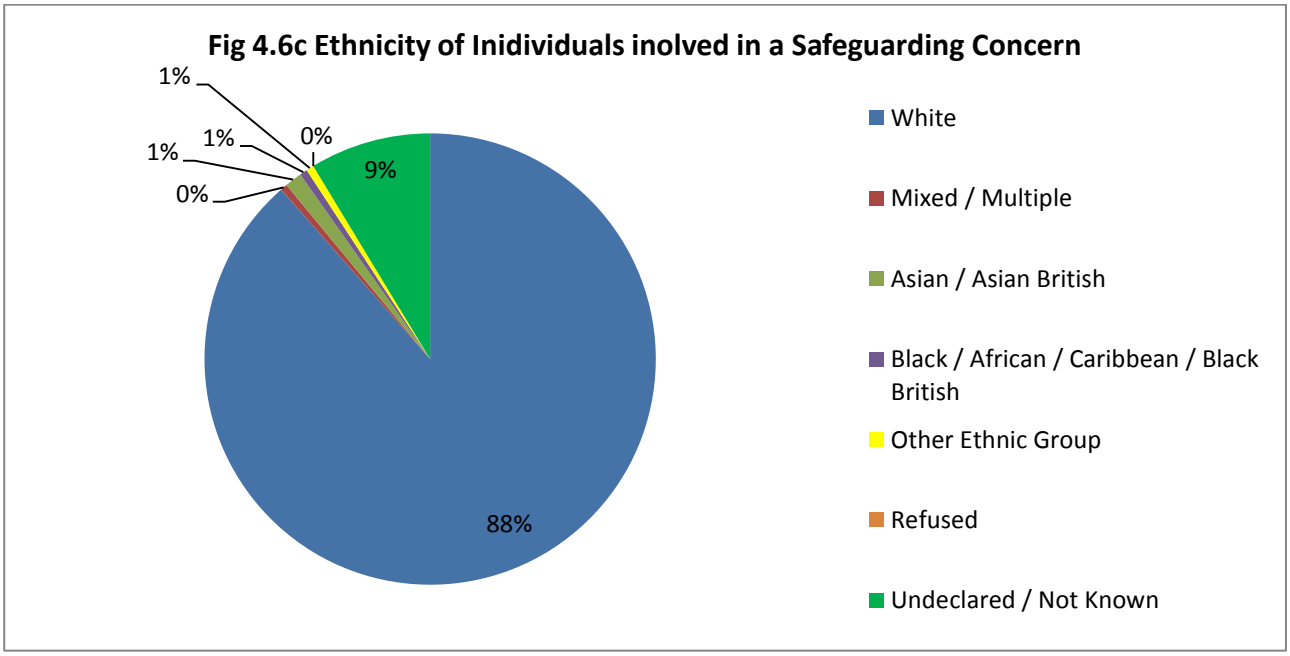


The age profile of concerns raised (fig 4.6b) shows that there are more concerns raised amongst the 28 to 64 age group. However those which meet the Section 42 criteria in this age group reduces significantly and is at a similar level to some of the older groups (85-94).



Ethnicity

Ethnicity also follows the same pattern as previous years. Of those individuals who were referred as a safeguarding concern during 2018/9 88% were white (fig 4.6c). Representation in the other groups was as low as 1%. The percentage of safeguarding concerns for all BME groups combined is 3% which is lower than the 7.6% of BME groups identified as living across the county in the last census. 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 (9%). 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.
Of the completed enquiries this year, 61% of the people being supported identified an outcome. Whilst this is a decline compared to previous years this is because an issue was identified in the process of recording the outcomes during the previous year (2016/7). The information management system had previously allowed outcomes to be added later as the enquiry progresses. This meant that the outcome may not always have been identified by the person being supported at the beginning of the process.

This has now been rectified and table 4.7 shows the type of outcomes which people wanted to achieve through the enquiry process and whether these were felt to be met.

Table 4.7 Making Safeguarding Personal – Desired outcomes achieved

Desired Outcome	Achieved %	Set	Achieved
To be and feel safe	87%	133	116
To know that disciplinary action has been taken	79%	81	64
To have exercised choice	52%	31	16
To get new friends	0%	0	0
To maintain a key relationship	58%	38	22
To maintain control of the situation	22%	60	13
To be involved in making decisions	73%	51	37
To know where to get help	43%	14	6
To know that this won't happen to anyone else	75%	102	64
To have help to recover	70%	27	19
To have access to justice or an apology	53%	32	17
To achieve any other outcome	78%	9	7

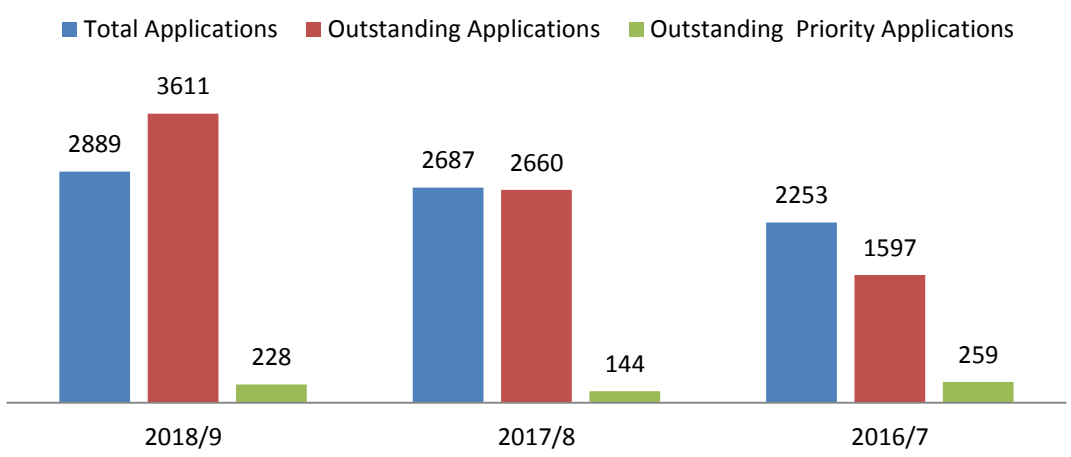
4.8 Deprivation of Liberty Safeguards (DoLS)

The ruling in the Cheshire West case in 2014 significantly increased the level of applications locally and nationally. As a consequence, alongside applications made during each financial year, there was also a significant carry over of outstanding cases from the year before this decision. 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.

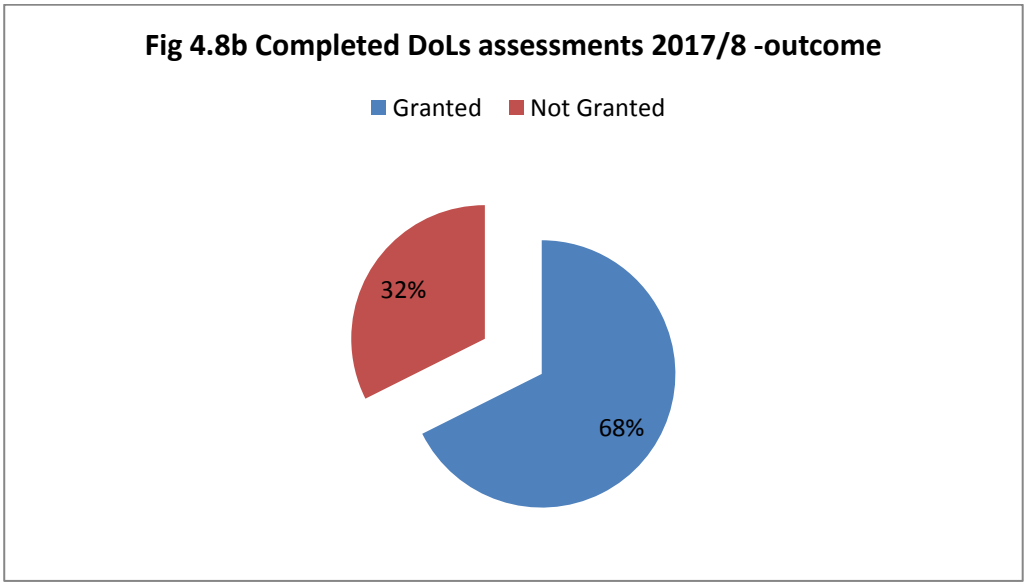
The total number of Deprivation of Liberty Safeguards applications made during 2018/9 was 2889 (Fig 4.8a), a slight increase compared to the previous year. Whilst this had some bearing on the increase in outstanding applications, including the priority applications, other factors also had an impact. There was a short period when there was an unexplained increase in applications. Whilst these have now returned to the expected level, this combined with reduced capacity in the team on a few occasions, had an impact on the level of applications which could be assessed.

Fig 4.13 Number of DoLs referrals and outstanding applications (comparison by year)



During the year a total of 1701 assessments were completed during the year , of which 68% of the applications were granted, compared to 79% the previous year (Fig 4.8b). Those which were not granted will include people who died before an assessment was made or those which did not meet the requirements.

Fig 4.8b Completed DoLs assessments 2017/8 -outcome



5.0 Priorities for 2019/20

In January 2019 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 and consultations, alongside information from organisational audits and surveys were reviewed.

Based on this information the following priorities were identified for the forthcoming year:

1. Ensure that there is an effective pathway for addressing and preventing safeguarding concerns (particularly in relation to Making Safeguarding Personal, Mental Capacity Act and application of Section 42 Criteria);
2. The development of Joint working with the Children's Board;
3. Addressing the risks of exploitation amongst adults with care and support needs.

These have been used to complete the Annual Business Plan for 2019/20 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
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
GP	General Practitioner (Doctor)
LeDeR	Learning Disability Mortality Review
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
PH	Public Health
SAR	Safeguarding Adults Review
WCC	Worcestershire County Council
WAHT	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