WSAB

Worcestershire Safeguarding Adults Board

Annual Report 2012-2013

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Safeguarding Adults in Worcestershire

www.worcestershire.gov.uk/safeguardingadults

Worcestershire Safeguarding Adults Board
Partner Organisations
(Please note some current partners were only formally constituted after the period of this Report)

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Introduction

This is the eighth Annual Report to be published by the Worcestershire Safeguarding Adults Board. The Board was established in 2001 as a direct response to the publication by the Department of Health in 2000 of 'No Secrets', statutory guidance on working with vulnerable adults. The Board has the strategic responsibility for the development, coordination, implementation and monitoring of multi-agency policies and procedures that safeguard and protect vulnerable adults in Worcestershire.

The Report covers the period April 2012 to March 2013. During this period the Board fully implemented the outcomes of its review of its structure and governance processes undertaken in the previous year. The Report describes the resulting changes as well as the activity of the Board and its Sub Groups in safeguarding adults in Worcestershire. It contains an analysis of performance data on the implementation of the multi-agency Worcestershire Safeguarding Adults Procedures.

The Report also contains the Board's Rolling 3 Year Business Plan for 2013 – 2015 to further improve the quality of safeguarding adult's services across the county. The implementation of this Business Plan will be monitored and reviewed by the Board in order to be annually up-dated to ensure that safeguarding adults remains a strategic priority for health, social care and criminal justice services.
During the year, the Government published the draft Care and Support Bill which is intended to consolidate a raft of different pieces of legislation underpinning the provision of adult social care services into a single Act of Parliament. As expected, this contains clauses that will put local Safeguarding Adults Boards on a statutory basis similar to Safeguarding Children Boards. The revised structure and governance processes already put in place by the Board mean it is well positioned for when the Bill is enacted. The Memorandum of Understanding that underpins the Board requires minor amendments to reflect recent changes in local organisations and structures, particularly in the NHS, and is currently being revised accordingly.

The Annual Report is presented to the internal governance systems of all member agencies and is publicly available to raise the profile of safeguarding adult responsibilities and activity, to both prevent and protect adults from abuse and neglect.

Foreword

Public and professional awareness of the abuse and neglect of adults has continued to grow over the past 12 months. Nationally, the Inquiry into the deaths and quality of care at the Mid-Staffordshire NHS Foundation Trust, and the publication of the Serious Case Review of Winterbourne View have both contributed to this. What these have both demonstrated is that the abuse and neglect suffered by patients was avoidable and should have been prevented by effective quality assurance and safeguarding adults procedures.

In this context the Worcestershire Safeguarding Adults Board (WSAB) will become all the more important. WSAB and its member agencies will continue to work to prevent abuse and neglect occurring, and to ensure that when it does, it is recognised and appropriately responded to.

The Board will provide leadership to maintain the profile of safeguarding adults across partners and raise awareness among service users, their carers and the general public. It will develop relationships and protocols with other local partnerships, such as the Health and Wellbeing Board, the Worcestershire Safeguarding Childrens Board and the Community Safety Partnership, to establish respective roles and responsibilities and enable effective sharing of information.

The Board will strengthen quality assurance of health and adult social care services and multi-agency safeguarding adults procedures. This will include monitoring and review of the performance of the Board itself, as well as holding member agencies to account. The Board will ensure that safeguarding adults policies and procedures are in place across all member agencies, that there is appropriate training for staff, and that services are co-ordinated to prevent any duplication of effort and to identify and remedy any gaps.

As the number of referrals to safeguarding adults procedures continues to rise, the Board will identify and share intelligence about specific risks. The Board will continue to lead serious case reviews to investigate allegations of abuse or neglect. And it will also ensure that learning from national incidents and local serious case reviews is embedded.

This Report is part of the Board's strategy to raise the profile of safeguarding adults and to ensure that it is transparent and accountable, not only to its member agencies, but to the citizens of Worcestershire, particularly service users and their carers.

I hope you find this Report informative and interesting. We would value your comments upon its content and our plans for the future and how we might ensure the involvement and ownership of the whole community in safeguarding adults in Worcestershire. If you have any comments or enquiries about this Report, please contact either Pete Morgan, Independent Chair of the Board, at pmorgan2@worcestershire.gov.uk, or Sarah Cox, Safeguarding Services Manager, Adult and Community Services, Worcestershire County Council, scox2@worcestershire.gov.uk

R Harling
Director Adult Social Care and Health
Worcestershire County Council

The Chair's Report

This is the third Annual Report of the Worcestershire Safeguarding Adults Board (the Board) for which I have been responsible. In both the previous Reports, I have written that the building blocks were in place to ensure adults were safeguarded in Worcestershire but that there were a number of challenges that had to be faced to make that a reality. That overall picture remains the same, though the details have changed, some for the better, some not.

The recently announced Spending Review continues the cuts in funding for local authorities in particular, although the Police are also affected and despite health spending being ring-fenced and protected, the recent figures for increased demand for A&E services, inflation and demographic factors mean that the NHS is also having to face difficult decisions about service provision. Perhaps more importantly, the overall impact of the coalition government's financial policy is magnified by the gaps that will appear in services that make the most vulnerable in our society feel safe and enhance their quality of life and by the possible reduction in joint working that may result. All local authorities, and the County Council is no exception, are having to cut or reduce services that support people to live in the community, from library services to leisure services to transport services. It is not the role of the Board to take a party political view or to be in any way partisan in its approach to these issues. Elected members have to manage within the current financial climate, as do managers in other organisations and across all sectors, the statutory, the independent and the voluntary. Where the Board does have a role is in coordinating the activity of its member agencies to minimise the negative impacts of the current situation and to ensure that all members exercise their Duty of Candour. It is essential that the Board, along with its member agencies and organisations, is honest, open and transparent about what we can and cannot do, individually and collectively, to safeguard the citizens of Worcestershire.

However, the Board has taken considerable strides towards realising its ambitions to make Worcestershire a safer place for all, particularly the most vulnerable. This is despite the challenges I mention above, which may have helped focus on the need to ensure practice, policy and procedure are as effective and efficient as possible. There have also been significant developments nationally to support the work of the Board, and I will deal with these first of all, before returning to what has been achieved and what is in process locally to continue that progress.

The coalition government has published and extensively consulted upon the draft Care and Support Bill, now the Care Bill. This has recently completed a period of pre-legislative scrutiny and has now returned to Parliament for debate. The relevant clauses of the Bill, from the Board's perspective, are those relating to Safeguarding Adults and Schedule 2, which relates to Safeguarding Adults Boards (SABs). Sadly, the words 'and Support' have been dropped from the Bill's title, a seemingly minor change, but one with great symbolic importance. 'Care' tends to something 'done to' people, 'Support' something that is 'done with' people. Safeguarding adults, being grounded in the human rights of adults at risk, has to be something 'done with' people whenever and as far as possible. It is also often seen as the prerogative of social care and health services, when in fact housing, advocacy and other support services are key to the prevention, identification and amelioration of abuse and neglect. These services are still referred to in the Bill, but more implicitly rather than explicitly, compared to the first draft. For example, there is no requirement to include housing services,

service users or carers in the membership of SABs. The Board has established subgroups for the latter two constituencies and is working to develop formal links with the former.

The Bill, if passed in its current form, will place a duty on local authorities to make or cause to be made enquiries into the circumstances of adults it thinks or knows are or might be at risk of abuse or neglect. After a consultation process, the government has decided not to introduce powers, similar to those in Scotland and which the Welsh Assembly is likely to introduce, that would enable the local authority to have access to the adult about who they have concerns, in order to carry out that enquiry effectively and to assess their circumstances, arguing that relevant legal powers already exist. This was not the view expressed by those working with adults at risk, including those agencies, such as the Police, who were said to have those existing powers, but does reflect the view of the majority of service users who responded to the consultation. It will be interesting to see the findings of the recently conducted research into the use of the powers in Scotland, and how they are now viewed by service users, carers and practitioners. These should be published later this year.

Hopefully, the steps it has taken over the past year will enable the Board to fulfil the functions and duties that the Bill, once enacted, will lay upon SABs nationally. The Service User Subgroup is now meeting regularly and contributing to and influencing the work of the Board and the Carers Subgroup has drafted its Terms of Reference and should be operative in the immediate future. All the other subgroups now have chairs from agencies other than the County Council, an important development in the Board establishing its own identity and not being seen as an adjunct of the local authority.

The Memorandum of Understanding which underpins the Board's governance and structure is being reviewed and revised to reflect the organisations and partnerships that have been established over the past year and a protocol is being developed to coordinate the activity of the Board with the Worcestershire Safeguarding Children Board and the Worcestershire Health and Wellbeing Board. It is important for its future development that the Board establishes formal links to the other community partnerships to coordinate their activities, thereby avoiding duplication or the gaps in service provision and to enable them to hold each other to account for the areas of overlap in their responsibilities.

For example, the Board is monitoring the implementation of the joint Health/County Council Action Plan developed as a result of the abuse at Winterbourne View Independent Hospital. Much of that Action Plan is designed to prevent abuse or neglect occurring in the first place by the commissioning and reviewing of appropriate and safe services. This is rightly the responsibility of the Health and Wellbeing Board to monitor. It is the Board's responsibility to hold the Health and Wellbeing Board to account for so doing and ensuring good practice is embedded across and between partner agencies. Likewise for the recommendations from the Mid Staffordshire NHS Foundation Trust Inquiry; the Board will be monitoring the implementation of the relevant safeguarding recommendations across Worcestershire rather than establish parallel work streams alongside partner agencies. Key to the above is working closely with Worcestershire Healthwatch, who will be joining the Executive Board during the coming year and linking into the Board and its subgroups as appropriate and practical.

The Board made submissions to the Worcestershire Carer's Awareness Challenge, the Worcestershire Health and Wellbeing Consultation and the County Council's Consultation on its Proposed Maximum Expenditure Policy. It also made a submission to the consultation on Police and Crime Commissioner's Plan for the West Mercia Police Area and has assisted in the redrafting of the section on safeguarding adults. We look forward to working with the Commissioner and his Deputy to ensure that adults at risk in Worcestershire have appropriate and effective access to and support from the Police and the Criminal Justice System.

As well as locally, the Board has contributed to the national debate around safeguarding adults: we made submissions to the consultations on the draft Care and Support Bill and the New Safeguarding Power mentioned earlier, to the Joint Committee of the House of Commons on the Draft Care and Support Bill and to the Care Quality Commission's consultation on its Safeguarding Protocol. In addition we made a submission to the Delivering Dignity Consultation, the Action on Elder Abuse Consultation on the need for Adult Safeguarding Powers of Intervention and a Consultation on the Involvement of Safeguarding Adult Boards in Domestic Violence Services. The drafting of such submissions not only helps inform a multi-agency perspective, but also enables service users, service providers and carers to be part of the debate and inform member agencies of the perspectives, views, remits and limitations of partner agencies that is not possible by other means.

Much has been achieved in the past 12 months, most of it by the hard work of the subgroups described later in this Report. The support and commitment of the Executive Board has been key to this, both in terms of providing a strategic direction to the Board's Work Plan and in agreeing to releasing staff as members of the subgroups. However, if these achievements are to be built upon and strengthened, the Board needs to have the resources necessary to do so. At present, the Board has a minimal budget and little formal infrastructure to support its activity. At a time when financial constraint and cuts are impacting on all members, it will be difficult to identify and release those resources. However, times of financial constraint are also, I would suggest, the times when adults at risk are even more likely to experience abuse and neglect, as services are reduced and pressure on carers, formal and informal, are increased.

It is therefore important that the Board and its member agencies exercise their Duty of Candour and are honest and open with service users, carers, the public, their staff and their internal governance structures, including elected members, as to what they can do, what they would like to do and what it is not possible to do with the resources available. The coming years will be challenging for the Board and its members, but financial resources are not everything. What we, as a Board, will strive to do is ensure that the resources that are available are used as effectively and as efficiently as possible to safeguard the citizens of Worcestershire.

I would like to take this opportunity to express my appreciation of the hard work and commitment shown by members of the Board, its subgroups and the Executive Board over the past year, supported by staff and volunteers across health and social care services and the police. The administrative support that I and the Board have received has been essential to its smooth running. I look forward to working with them in the future to continue and develop the Board's work. It is only appropriate to acknowledge the contribution made three

people in particular over the past two and a half years I've been in post, as they have either recently left or are about to leave the Board. Sue Pidduck, the Safeguarding Service Manager with Adults and Community Services in the County Council, moved to Hampshire before Christmas; Michelle Norton, the Deputy Chief Nurse with the Worcestershire Acute Hospitals NHS Trust was seconded to a regional post at the end of the financial year, Detective Inspector Phil Shakesheff will shortly be retiring from the West Mercia Police and Cllr Philip Gretton resigned as the Cabinet Member with responsibility for Adult Social Care just before the last Council elections. All will be missed for the contribution they made in their particular areas of responsibility and the work of the Board in general, and we wish them well for the future. Sue proved particularly hard to replace – the Council employed two Interim Safeguarding Service Managers, Ruth Ingram and Adrienne Stathakis, before Sarah Cox was appointed. I'd like to thank Ruth and Adrienne for their input to the Board and look forward to working with Sarah who will take up post in August 2013.

Pete Morgan
Independent Chair

Subgroups Report

The Board now has six subgroups with active participation from a cross-section of staff representatives from the Board's partner agencies and also from service users. The subgroups have been instrumental this year in moving safeguarding arrangements forward in the County, for instance drafting the Board's Prevention of Abuse and Neglect Strategy, contributing to the new West Midlands Safeguarding Adults Policy and Procedure, overseeing the Serious Case Review process, the safeguarding training arrangements and many other areas. The contribution of individual staff and service users to the subgroups is invaluable for the Board.

The Service Users Subgroup was only set up during the year of this Report and the Carers Subgroup is still in the process of being established, though carers are represented on the Board.

Each of the subgroups' activities during the year are described in more detail below.

The Audit and Good Practice Subgroup

The Subgroup met seven times during the year but had to manage the loss of its chair in October. The Subgroup focused on five areas of work: the development of a multi-agency case audit tool for safeguarding cases, the development of the Prevention Strategy, a review of the implementation of the recommendations from Serious Case Review 01, an audit of the outcomes of all the previous Serious Case Reviews and the establishing of a data collection process including a scorecard to monitor the implementation of the multi-agency safeguarding adults procedures.

The multi-agency audit tool has been completed and successfully trialled. The Prevention Strategy has been completed and formally launched. The review of the recommendations from Serious Case Review 01 has been completed and reported back to the Board. The audit of the outcomes of all the previous Serious Case Reviews is being completed and should be ready for feeding back to the Board before the end of 2013. The establishment of a data collection process has proved more difficult to complete: quantitative data is available for the implementation of the multi-agency procedures and can, to a degree, be compared with that from other Boards. There are problems in ensuring consistency in the comparative data and work continues to identify qualitative data not only for the implementation of the multi-agency procedures but also for member agencies' internal safeguarding activity.

Membership of the Audit and Good Practice Subgroup has not been consistent across the year but included the following:

WCC Adults Social Care and Health	Quality and Governance manger
WCC Adults Social Care and Health	Safeguarding Adults Team Manager
WCC Adults Social Care and Health	Safeguarding Services Manager
NHS Worcestershire	Countywide Continuing Health Care Manager
West Mercia Police	Detective Inspector

Hereford & Worcester Fire & Rescue	Vulnerable Persons Officer
Worcestershire Health and Care Trust	Audit, Research & Clinical Effectiveness Manager Quality & Safety Team
Worcestershire Forum Against Sexual Abuse and Violence	Strategic Co-ordinator
NHS Worcestershire	Safeguarding Vulnerable Adults Lead

The Communications Subgroup

During the past year the Communications Subgroup has run two successful awareness raising campaigns, highlighting specific issues around adult safeguarding, principally aimed at professionals in the health and social care sector market. These campaigns focused on financial abuse and Internet abuse through spam. We also supported two external campaigns on domestic abuse and hate crime.

The campaigns were delivered through the statutory and VCS organisations on the Board. We measured our success by the increase in traffic on the campaign linked website page, anecdotal feedback through Twitter and the number of column centimetres exposure in the press. Internally we set a Terms of Reference for the group and a strategy and programme plan for the group.

During the forthcoming year we plan to re-vamp our generic literature and undertake up to three more campaigns either directly or supporting other programmes. This is likely to extend our reach to the general public although funding for such campaigns has yet to be established.

It has been difficult to get a settled group together over the past year because of the significant changes in statutory sector however, it is hoped that now most of these changes have taken place we will be able to function more effectively.

Membership of the Communications Subgroup included the following:

Age UK Herefordshire & Worcestershire	Chief Executive
WCC Department Adult Social Care and Health	Safeguarding Services Manager
Worcs. H&SC Access Services	Sue Hope (SH)
WCC Department Adult Social Care and Health	Communications Officer
Worcestershire Health & Care NHS Trust	Marketing & Communications Manager
Worcestershire Clinical Commissioning Groups	Communications Officer
Worcestershire Acute Hospital NHS Trust	Communications Officer
WCC Department Adult Social Care and Health	Adult Protection Manager
WCC Department Adult Social Care and Health	Community Safety Partnership

Philip Talbot, AgeUK Worcestershire

The Policies and Procedures Subgroup

The inaugural meeting of the Policy and Procedures Sub Group was on 7th February 2012; thereby being a new group at the time of the last Annual Report. This has meant that 2012/13 has been the first full year of the group and, as such, has seen much activity in finalising membership and terms of reference. The year also saw the chairing of the group move away from the local authority into a partner agency with the new chair being the Integrated Safeguarding Team Manager from Worcestershire Health and Care Trust and the Vice chair being the WSAB representative from the Independent Care Homes Sector.

The group meets bi monthly with membership drawn from

Worcestershire NHS Health and Care Trust	Integrated Safeguarding Team Manager
Worcestershire NHS Health and Care Trust	Inpatient Pathway Manager
Worcestershire Acute Hospital Trust	Clinical Educator,
Worcestershire NHS Clinical Commissioning Groups	Designated Nurse Safeguarding
Independent Care Homes Sector	Provider forum representative
West Mercia Police	
WCC Adults Social Care and Health	Safeguarding Services Manager

As required

WCC Adults Social Care and Health

The group has also been working hard on determining priorities and developing its business plan. Key work streams have been:

- Development of MOPAR Pathway (More than One Person at Risk).
- Continued work to publicise West Midlands Policies and Procedures
- Commencing work on Multi Agency Self Neglect Guidance

Work for the next year will focus on:

- Review and Update of Thresholds Guidance
- Establish a mechanism for review of multi-agency policies
- Development of toolkit to support agencies in the development of safeguarding adults policies
- Review of Assisted Suicide Policy
- Finalisation and launch of Self-Neglect Guidance

Karen Rees Integrated Safeguarding Team Manager, Worcestershire NHS Health and Care Trust

The Serious Case Review Subgroup

The report period from April 2012 to March 2013 was countenanced by a period of organisational change amongst many agencies which form the Safeguarding Board. The work of the Serious Case Review Subgroup has continued successfully throughout this period by the personal commitment of those individuals involved.

During the report period one serious case review has been commissioned. The final report will be considered at the September 2013 meeting of the Safeguarding Board.

Furthermore, the Subgroup dealt with general issues relevant to its work. As an outcome there is a unanimous understanding of the Subgroup's members of the role of serious case reviews. This can briefly be summarised as critically evaluating statutory services provided to an individual where the individual's life expectancy was threatened or affected through no fault of their own. The analysis will primarily reveal the effectiveness of those agencies providing services to the individual and as a priority it will explore extensively how well the agencies worked together for the benefit of the individual.

The most challenging aspect of the Subgroup's work is identifying areas where the successful interaction of the agencies concerned by an individual case can be shared widely as best practice. Of critical importance is the identification of how agencies can improve their methods of working together successfully to the advantage of the individual.

The Subgroup looked at other published serious case reviews from outside Worcestershire. These reviews together with Worcestershire's own experiences are providing a valuable source of transferrable knowledge leading to improved practices across all member agencies of the Safeguarding Board.

Membership of the Serious Case Review Subgroup is as follows:

Worcestershire NHS Health and Care Trust	Integrated Safeguarding Team Manager Inpatient Pathway Manager
Worcestershire Acute Hospital Trust	Head of Nursing & Quality
Worcestershire NHS Clinical Commissioning Groups	Designated Nurse Safeguarding
Worcestershire Forums Against Domestic Abuse and Sexual Violence, WCC Adults Social Care and Health	Strategic Co-ordinator
Independent Care Homes Sector	Provider Forum representative
West Mercia Police	Detective Inspector
WCC Adults Social Care and Health	Safeguarding Services Manager

Richard White, Independent Chair

The Service User Subgroup

The Service User Subgroup was established during the year, involving a number of meetings with service users to explain the purpose and role of the subgroup. As a result, Terms of Reference have been agreed by the Subgroup and ratified by the Board, the Subgroup has elected a Chair and Vice Chair, both of whom are service users, and meetings have been arranged for the coming year. The Subgroup will both comment upon proposals from the

Board and its activities and provide a conduit from service users to the Board on issues that concern them. The Board has committed to nominate one of its members to attend the Subgroup.

The Training and Staff Development Subgroup

The Training Subgroup has met regularly throughout the year.

Worcestershire County Council's Learning and Development Centre continued to provide Safeguarding Adults training at level 1, 2, 3 and 4. The Level 1 course is designed for those staff (paid or volunteers) whose role brings them into regular contact with potentially vulnerable adults and who have a duty to report under Worcestershire's Adult Protection Procedures (2010). Other courses are designed for staff who have a designated responsibility under Worcestershire's Adult Protection Procedures (2010) to receive and respond (Level 2), investigate (Level 3) or manage staff undertaking these roles (Level 4) re adult protection referrals within social, health or integrated care teams.
The courses at level 2 and above have predominantly been accessed by social workers. In the year 2012 – 13, 962 individuals accessed this training. The statutory agencies also deliver basic awareness sessions and level 1 training through a mixture of e-learning and face-to-face delivery.

In addition to the on-going training a conference was delivered on the learning from the Winterbourne View Enquiry. This event was well attended with 160 participants from statutory, private and voluntary agencies.

Membership of the Training and Staff Development Subgroup is as follows:

Worcestershire Acute Hospital Trust	Clinical Educator - Chair
WCC Adults Social Care and Health	Service Manager Safeguarding
	Learning & Development Advisor
	Provider Services Manager
	Social Work Practitioner
	Strategic Domestic Abuse & Sexual Violence Coordinator
West Mercia Police	Training Advisor
Worcestershire Health & Care Trust	Training & Development Manager Adult Services
Worcestershire Community Commissioning Groups (CCG)	Safeguarding Lead
West Mercia Probation Trust	Snr. Probation Officer (Public Protection)
Voluntary Sector Representative	Age UK

Suzanne Hardy, Clinical Educator, Worcestershire Acute Hospital NHS Trust

Key Patterns in Safeguarding Adults in Worcestershire 2012-2013

1. Introduction – Safeguarding Trends

The number of safeguarding 'Alerts' received into the multi-agency Safeguarding Adult Procedures in 2012/13 was up by 3% to 1501 compared to 1454 last year. This is a very much smaller increase in both absolute terms and as a percentage than last year - 291 and 24% respectively - and is further evidence of a possible levelling off of the increase year-on-year that has been seen since data was first collected in 2005/6. It is not yet possible to know whether or not this is in line with a national trend as the national data is not yet available. It is also the case that there has been an increase in the number of Alerts relating to financial abuse, possibly linked to a campaign to raise awareness of this type of abuse during the year. It would be presumptuous to assume that this levelling off is indicative of having identified all the instances of abuse and neglect across Worcestershire. A Care Home is still the most common location of alleged abuse and neglect, namely 45% of all Alerts, despite the majority of adults at risk of abuse living in their own homes in the community but providing only 27% of all Alerts.

As was said in the last Annual Report, one difficulty with drawing conclusions on the prevalence of abuse and neglect is the absence of any credible base line figures from which to start. There has only been one national data study of the prevalence of adult abuse and neglect in the UK. This study was undertaken by the National Centre for Social Research and King's College London in 2006. Details of this study are available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076197

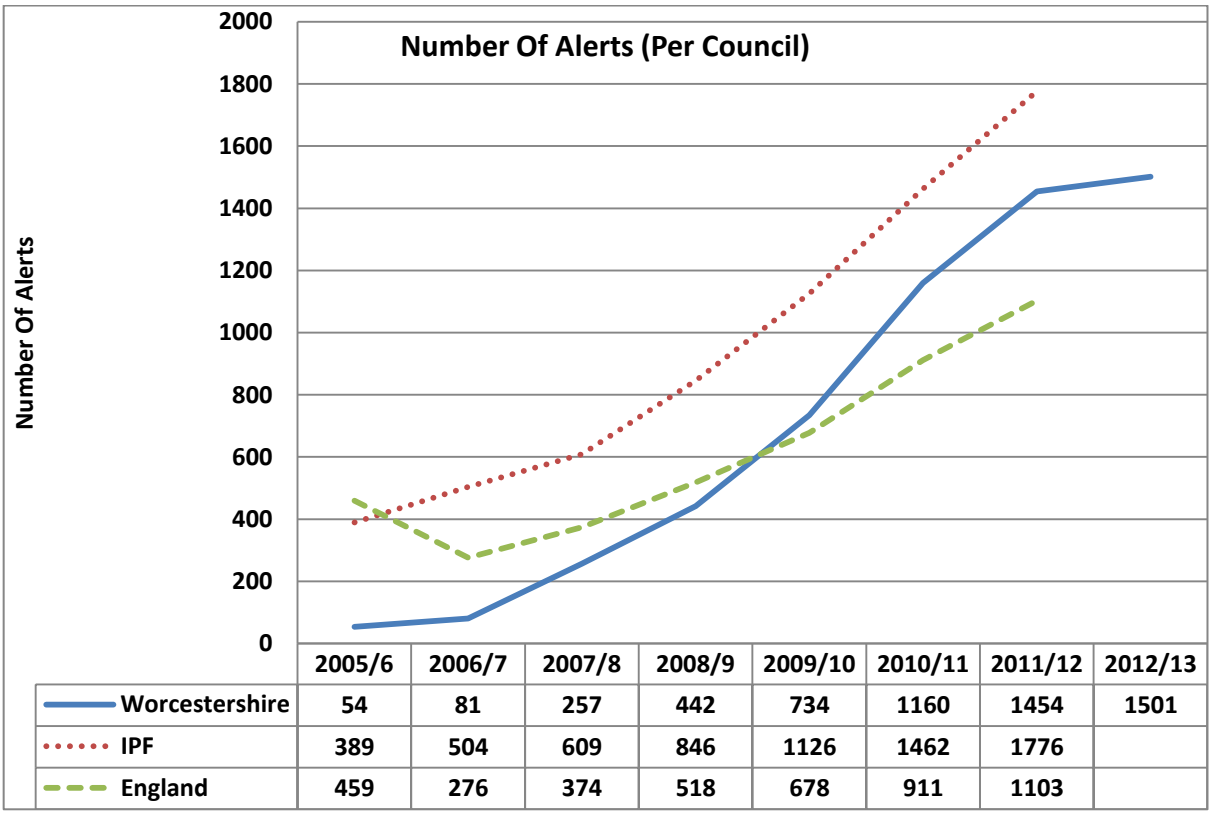
Over 2,100 people in England, Scotland, Wales and Northern Ireland took part in the study between March and September 2006. The data produced related only to adults aged over 66, living in the community and with no diagnosed cognitive impairment. However the study continues to show a higher prevalence of abuse nationally than has been demonstrated by the Worcestershire figures since that time.

Despite pressure from a number of sources for the establishment of a standard data set, the 'Abuse of Vulnerable Adults' data that is collated nationally continues to suffer from a lack of consistent definitions and procedures. This means that it is very difficult to draw meaningful comparisons between the performances of the Board and its member agencies in safeguarding adults with other Safeguarding Adults Boards. However, this is being succeeded by Safeguarding Adults return from 2013-14 which combined with the development and adoption of a series of regional multi-agency safeguarding adults including that for the West Midlands that the Board adopted, based on the Pan London Safeguarding Adults Policy and Procedures will help to address this issue. Hopefully the guidance and regulations that will support the Care Bill when it is enacted will provide further consistency of definitions and data.

'Alerts' are expressions of concern that an adult may be at risk of or experiencing abuse or neglect, not all of which need investigating as Safeguarding Adult Referrals. Once they have been screened by a social worker or other professional, they may be dealt with in other ways, for instance through agencies' complaints procedures or the provision of

support services to remedy the situation. One measure of an effective safeguarding procedure would be the number of Alerts that progress to become Safeguarding Adult Referrals. In Worcestershire in 2009/10, 17% of Alerts did not become Referrals under the multi-agency Safeguarding Adults Procedures; in 2010/11 the figure was 24%, in 2011/12 this figure had fallen to 20% and in 2012/13 the figure had fallen again to 16%. The above fall continues despite the overall number of Alerts continuing to rise. This increase in appropriate Alerts would suggest that there is an increased awareness of the multi-agency Safeguarding Adults Policy and Procedures and of the need to report any concerns about possible abuse of an adult. The Board will continue to monitor the ratio of Alerts to Referrals to ensure the procedures are working effectively.

Figure 1: Worcestershire Safeguarding Adults Alerts 2012 -13



	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Worcestershire	54	81	257	442	734	1160	1454	1501
IPF	389	504	609	846	1126	1462	1776	
England	459	276	374	518	678	911	1103	

IPF = Family of comparable authorities including Worcestershire

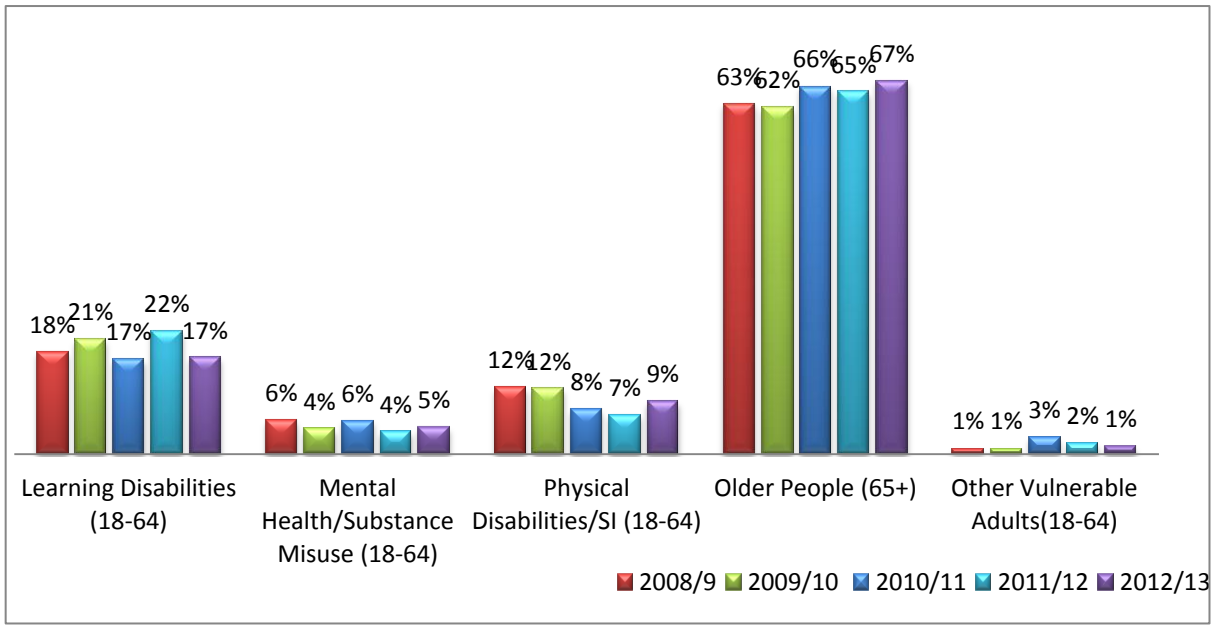
NB: The figures in this table are table are based on absolute numbers and are not modified by population size for each authority. This table therefore only identifies overall trends.

2. Service User Group trends

The table below shows that the increase in Alerts did not apply to all service user groups in terms of numbers, but the percentage split between the groups showed some differences. Alerts relating to adults with a Learning Disability accounted for 17% of all Alerts a fall of 5% compared to last year. Alerts relating to adults with mental health and substance misuse issues rose slightly numerically but their percentage of the total remained constant at 5%. Alerts relating to adults with a physical or sensory disability rose by 2% to 9%. Alerts relating to Older People rose by 3% to 67%. While some variations between years is understandable and possibly predictable given events such

as the abuse at Winterbourne View highlighting the risks for particular service user groups, the preponderance of Alerts relating to older adults may reflect both societal attitudes to other service user groups or, more likely, the fact that abuse and neglect are more easily identified and responded to in regulated services such as care homes than in people's own homes.

Figure 2: Worcestershire Safeguarding Adults Alerts by Service User Group 2008 - 2013



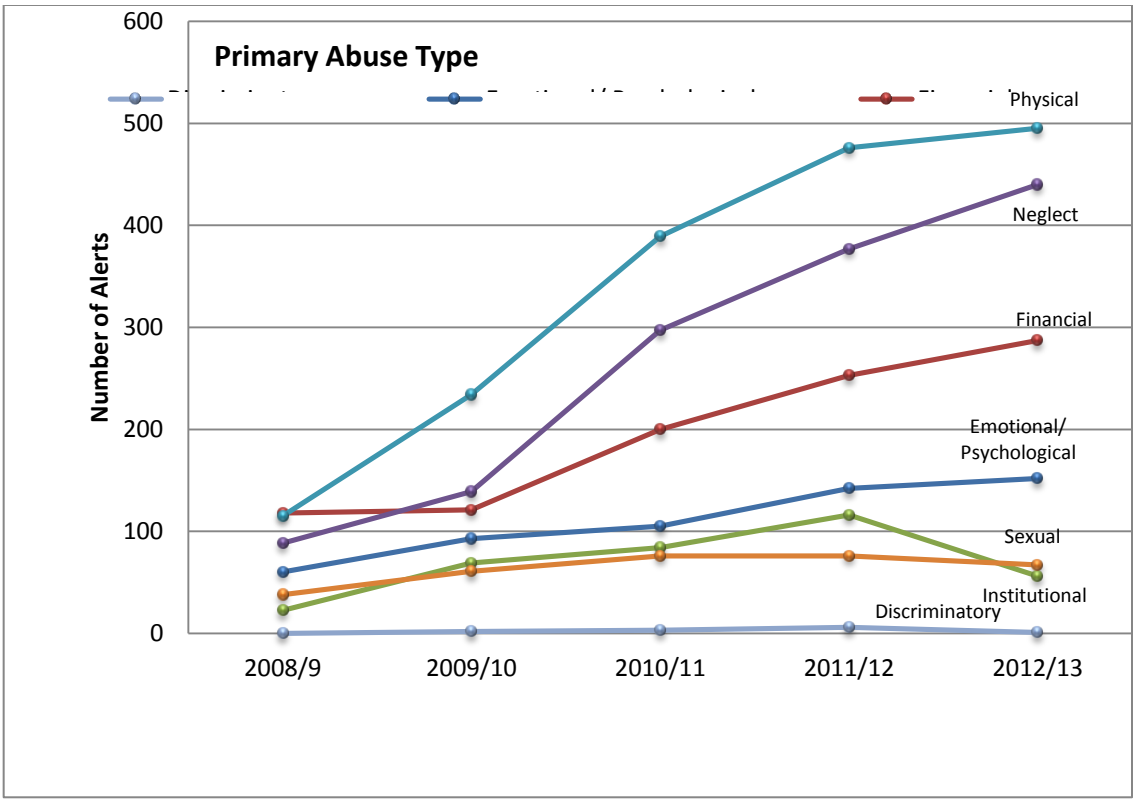
3. Types of abuse reported

Most abusive situations can be identified as exhibiting more than one form of abuse; it is also the case that the form of abuse that is identified in the Alert can turn out to be hiding a more serious form of abuse. This of course raises the issue of whose definition of which is the most serious form of abuse is recorded – the worker's or the service user's? There is also some evidence of inconsistency nationally over the definitions of the different types of abuse. For example, mal-administration of medication may be recorded as either physical or institutional abuse or neglect. It is therefore important not to put too much emphasis on the prevalence rates of the different types of abuse but they can highlight areas where there is increased need for vigilance and preventative action such as awareness-raising campaigns.

The next table shows that the most reported primary form of abuse is physical abuse, followed by neglect and financial abuse. This continues the pattern in 2011/12. There has been an increase of 6% in the proportion of Alerts for physical abuse and one of 3% for those of neglect. There has also been an increase of almost 2% in Alerts for financial abuse, but a 4% fall in Alerts for institutional abuse while Alerts for emotional, sexual and discriminatory abuse were within 1% of last year's figures. Institutional abuse is a generic term covering abuse which is experienced by people who live in a formal care setting such as a residential care home or hospital, where the abuse is a result of the way in which people are cared for by that organisation. In fact the figures for location of abuse, (Figures 9a and b, pages 23-23), shows an increase from last year of abuse in these

settings. This disparity is due to the fact that some abuse in these settings is as a result of the actions by individual staff and will be counted under the other categories, such as physical abuse or neglect

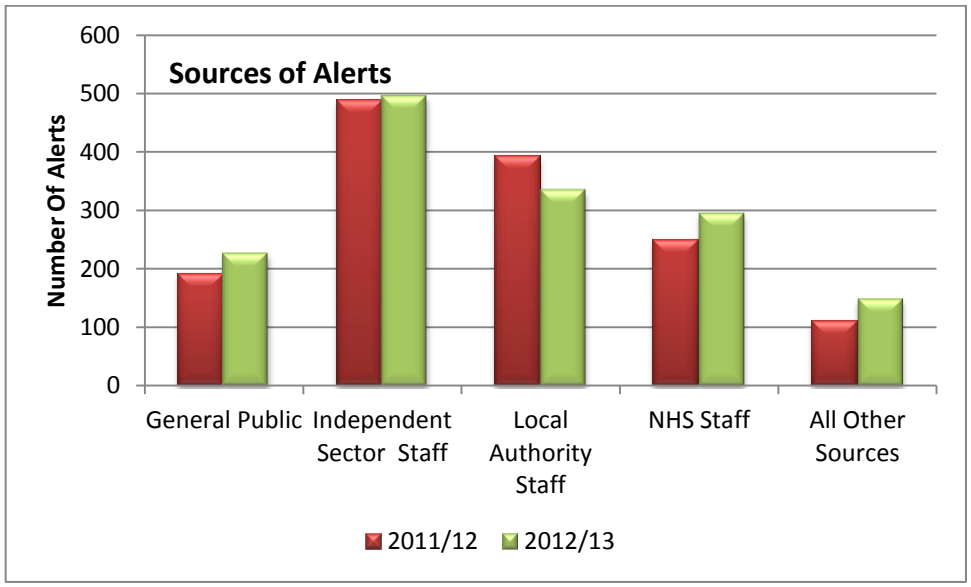
Figure 3: Worcestershire Types of Abuse 2008 - 2013



4. Sources of Alerts

This data only refers to the last two years and it is therefore too soon to start drawing any conclusions from it. There can also be difficulties distinguishing between who raises and Alert and who records it; this issue has been addressed during the year and the data should become more valid over time. The top four sources of Alerts are from the care sector, local authority social workers, NHS staff and family members. These figures reflect the safeguarding adults training and awareness-raising which agencies continue to carry out on the need to raise Alerts. One of the aims last year was to increase the number of Alerts from family members, neighbours and service users themselves; there was a numerical increase across all three groups, the biggest being in those from family members, from one hundred and twenty to one hundred and seventy four, or 45%. It may also be that some of the Alerts raised by staff in services are the result of concerns brought to their attention by family members.

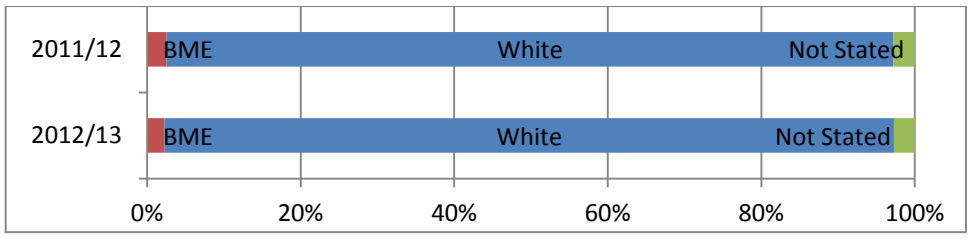
Figure 4: Sources of Alerts 2011 - 13



5. Ethnicity of Alerts

The representation of minority ethnic communities in the Alerts is roughly consistent with the Worcestershire population. The discrepancy is due to the number of cases where the ethnicity of the victim is not recorded, some 3%. As was noted in last year's Annual Report, this may reflect the sensitivity of the situation that generates the Alert; it may not be the appropriate time to be asking the question. However, it may also reflect the double isolation of the minority communities and victims of abuse.

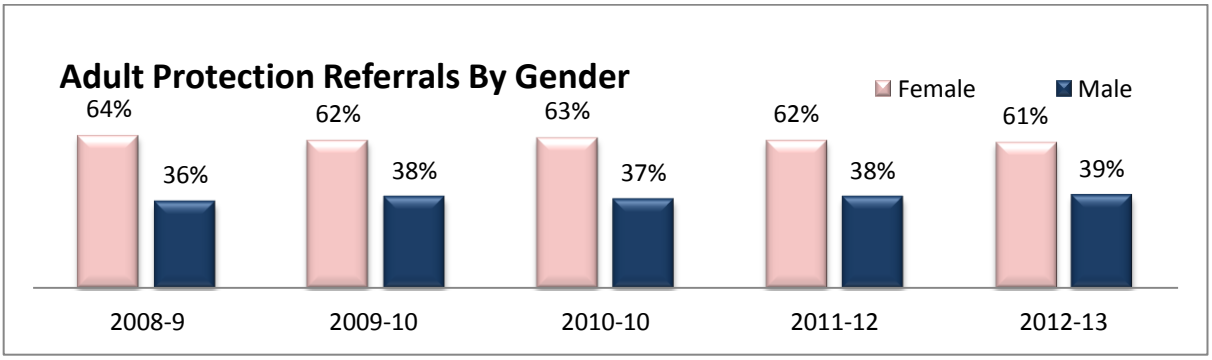
Figure 5: Worcestershire Safeguarding Adults Alerts by Ethnicity 2011 - 12



6. Gender of Alerts

The split of Alerts between men and women has remained relatively consistent over the past five years.

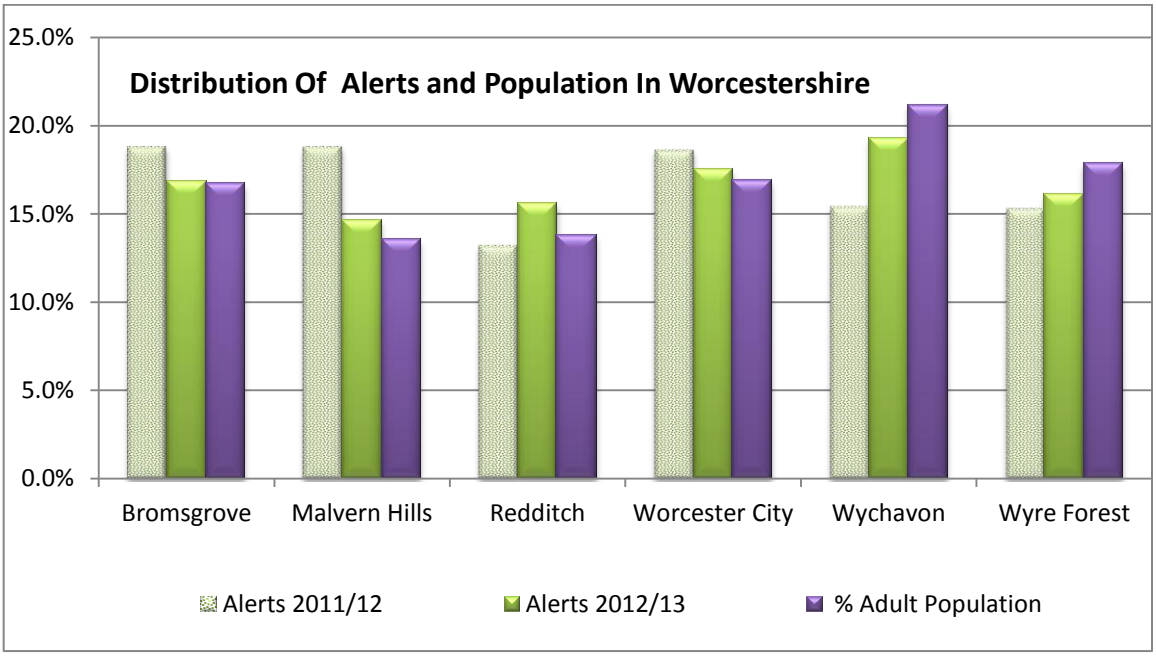
Figure 6: Gender of Alerts 2008 - 2013



7. Alerts by District

The following table shows the distribution of Alerts across the county. The table shows a higher proportion of cases in Bromsgrove, Malvern Hills, Redditch and Worcester than their share of the population, though the figures are more in proportion for Bromsgrove, Malvern Hills and Worcester City than last year. Redditch has a higher proportion of Alerts than population and Wychavon and Wyre Forest are closer to a position of balance. Various factors may be responsible for these differences and variations, including the relative age of the population and the numbers of care homes in each district which would indicate they have more vulnerable populations. However due to the complex nature and many different types of adult abuse it is not possible to identify these factors conclusively.

Figure 7: Alerts by District 2011 -2013



8. Safeguarding Assessments

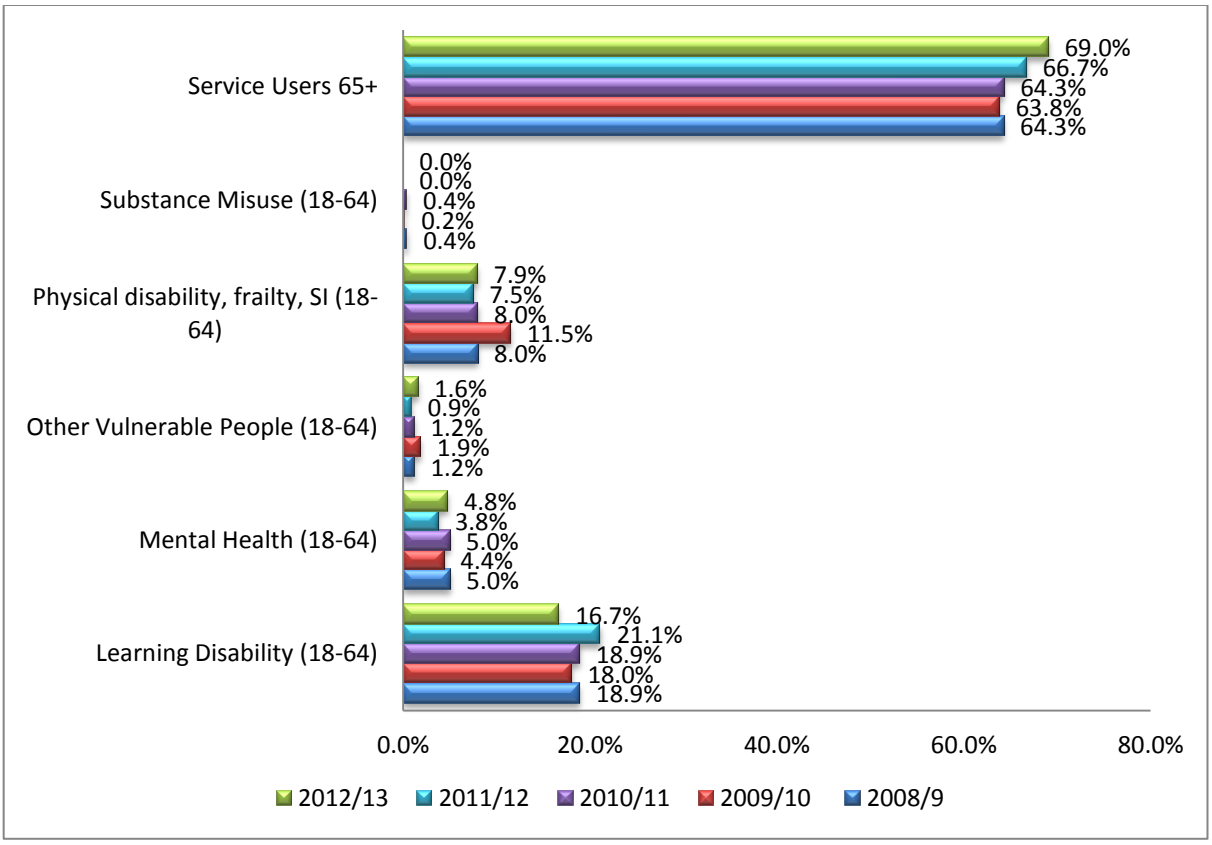
Once an Alert has been has progressed to the status of Referral an Initial Protection Plan is put in place for the adult at risk. A Strategy Discussion or Meeting is then held between the relevant agencies to identify whether a more in-depth professional assessment is

required into the nature of the suspected abuse or neglect which was identified by the Alert and, if necessary, agree an Interim Protection Package. Not all Referrals will go on to the Assessment stage, as some issues will be resolved during the Strategy Discussion or Meeting. The key aim of the safeguarding adult process is to ensure that the adult at risk is made safe as soon as possible and if this can be achieved effectively at the Strategy Stage then a further Assessment will not be required.

Data relating to the Assessments undertaken under the multi-agency Safeguarding Adults Procedures is partial as a number of Assessments will still be in progress when the data is gathered.

The majority of Assessments were of older people with the most 'at risk' age group being those over 85. The next table shows that the spread of Assessments between the different service user groups has remained essentially constant over the past five years.

Figure 8: Worcestershire Safeguarding Adults Assessments by Age and Service User group 2008 - 2013



9. Location of abuse - at Assessment

The majority of Alerts continue to be raised about concerns located in in people's own homes and in care homes, including those that provide nursing care. These amount to 72% combined, 27% in people's own homes, 45% in care homes. It has to be remembered that those in care homes will be those most easily identified and monitored. However, it also has to be remembered that those in care homes of both sorts will tend to be those with higher dependency levels and therefore more vulnerable to abuse/neglect. The impact on the number and source of Alerts in the future due to the change of the role and remit of the Care Quality Commission and the move to the use of support staff

employed by the service user rather by regulated agencies will need to be monitored. The percentage that occurs in hospital has remained at 4% while the percentage that occurs in mental health in-patient settings has risen from zero from 1%. The Worcestershire Acute Hospital NHS Trust has continued to keep the Board advised of the impact of remedial action taken to address the issues identified in the recent reports from the Parliamentary Health Ombudsman and the Care Quality Commission the Board will be looking at the recommendations from the Francis Report into the Mid-Staffordshire NHS Foundation Trust to see if there are lessons to be learnt. The level of reporting in in-patient services continues to be a cause for concern, but as was recognised in last year's Annual Report, these figures may hide activity that is taken under other procedures – the Serious Incident Procedures, Disciplinary Procedures etc – but these procedures are not multi-agency and not therefore as transparent as the multi-agency safeguarding adult procedures and will not necessarily enable partner agencies to improve their own practice from the learning they generate. Further work continues to need to be done to better understand this data about the location of abuse in order to improve safeguarding practice and reporting, including awareness raising and staff training.

The statistics over the past four years show that a significant amount of abuse occurs in people's own homes by a family member. The Board is monitoring the impact on the number of Safeguarding Adult Referrals in the future due to the move to the use of support staff employed by the service user rather by regulated agencies and the changes of the role and remit of the Care Quality Commission.

Figure 9a: Worcestershire Safeguarding Adults Assessments - Location of Abuse 2012 - 2013

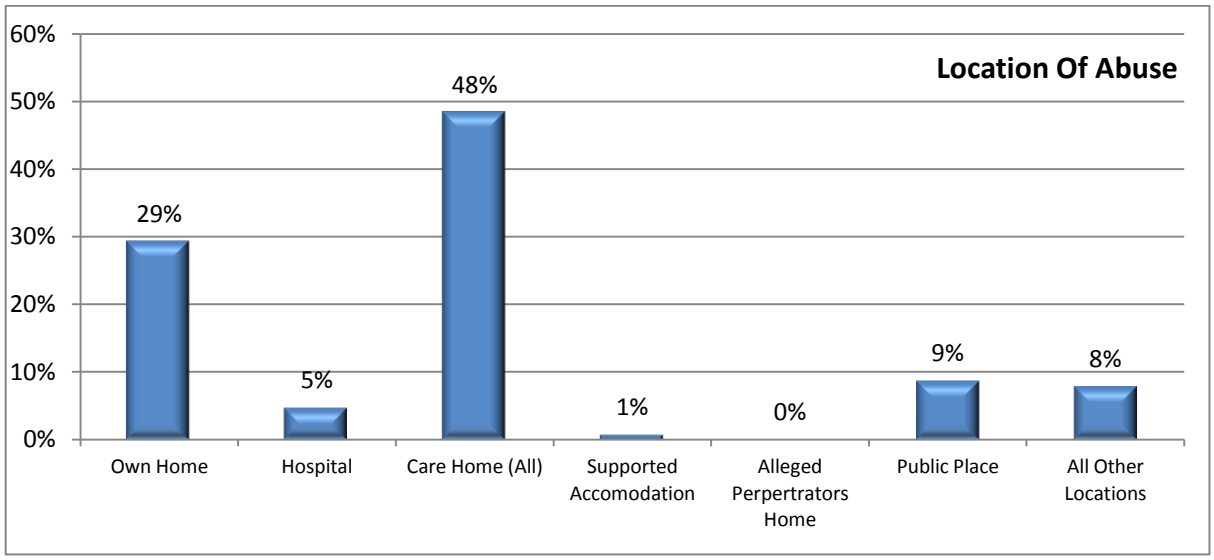
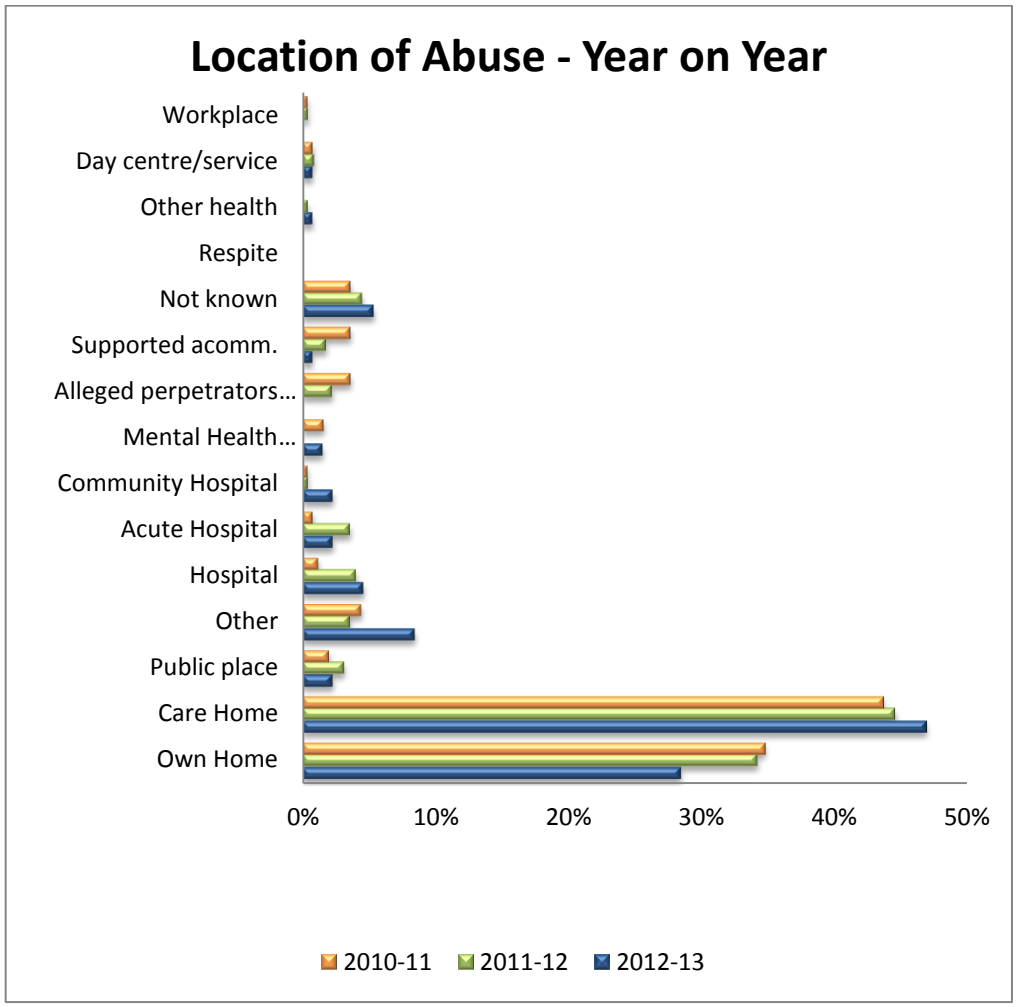


Figure 9b: Worcestershire Safeguarding Adults Assessments - Location of Abuse 2010 - 13



Outcomes from the Safeguarding Adults Procedures

The purpose of the Safeguarding Adult Procedures is a positive outcome for the service user that results in an improved quality of life and their exercise of choice. The main primary outcome for the service user was 'No further action' (down to 51% from 55% last year and from 64% the previous year), followed by 'Other' (consistent at 16% having risen from 11% last year) and 'Increased monitoring' (consistent at 15%). No further action indicates that the safeguarding issue does not require any further input from the responsible agency.

There is a similar picture from the data for the alleged perpetrator / organisation / service. Here the main outcomes are again 'No further action' (down to 48% from 58% last year and from 59% the previous year) and 'Continued monitoring' (up to 14% from 12% last year and from 20% the previous year) and 'Other' (up to 17% from 11% last year). For the alleged perpetrator 11% of cases resulted in disciplinary action, police action or referral to the regulator, the same as last year. For the victim 4% of cases resulted in increased care or care from a different provider, up from 3% last year.

Figure 10a Primary Outcome for Victim and 10b Alleged Perpetrator/Service

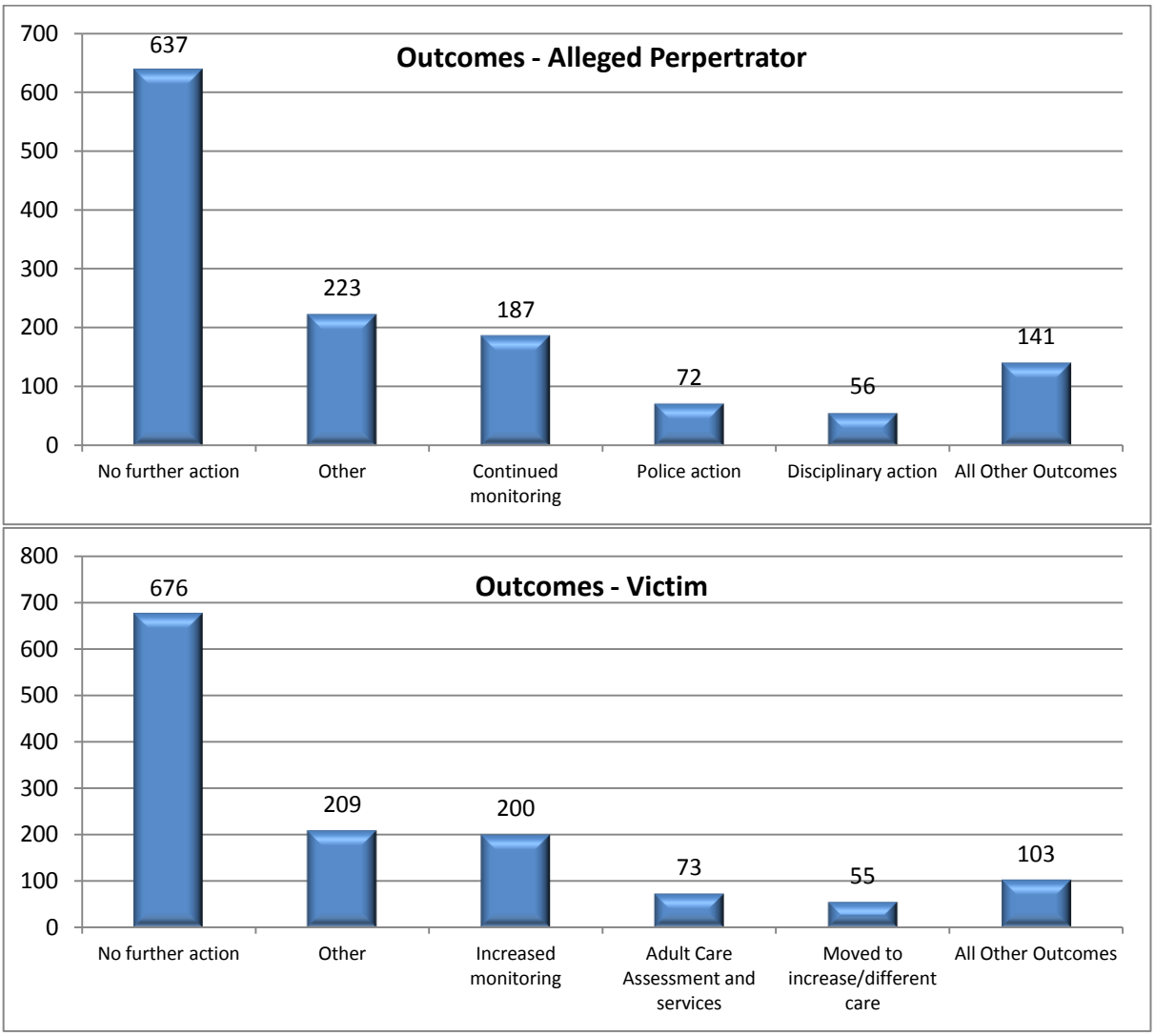
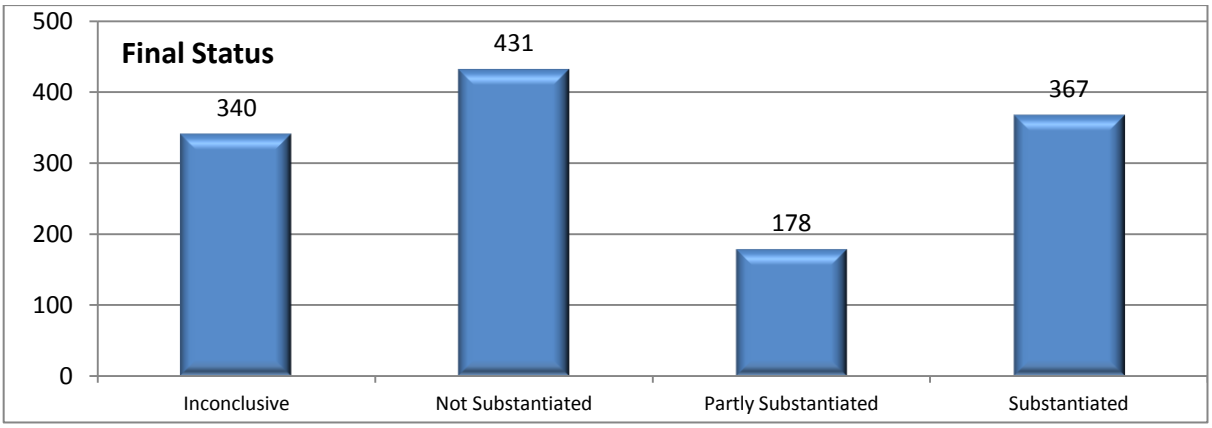


Figure 10c: Worcestershire Safeguarding Adults Assessments Final Status of Allegation 2008-2012



The number of completed cases in 2012/13 rose to 1316, an increase of 70% over 2011/12. Of possibly greater relevance is whether or not the allegation of abuse was substantiated. Although the percentage that was substantiated fell from 35% to 28%, the percentage of 'partially substantiated rose from 10% to 14% and the 'not substantiated rose to 35% from 24%. The percentage that were 'not determined or inconclusive' fell to

23% from 31%. This data appears to conflict with the improved performance with regard to Alerts that did not progress to Referral status and may suggest that the quality of Alerts is not improving but that the threshold for progression has been lowered. The Board will look to pursue this issue in the coming year.

The Board has previously recognised that it needs to identify and collect data that is more relevant to and indicative of the experience of service users of the implementation of the Procedures; work continues to identify means of collecting this data that respect the feelings and wishes of service users and does not impose additional burdens on agencies in its collection.

Deprivation of Liberty Safeguards Assessments

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLs) were introduced in April 2009. They provide for the lawful deprivation of liberty of those people who lack capacity to consent to arrangements for their care or treatment in either hospitals or care homes and who need to be deprived of their liberty in their own best interests. Hospitals and care homes (the Managing Authorities) have been responsible for applying to the relevant Primary Care Trust (PCT) or Local Authority respectively (the Supervisory Bodies) who have been responsible for either authorising or declining the application following a robust assessment. The Supervisory Body responsibilities of the PCT transferred to the County Council in April 2013.

The total number of applications for DoLs made in Worcestershire increased by 25% to 137 from 110 last year, itself an increase from 74 the previous year. In 2012/13, the County Council authorised 39% of the applications it received (37 out of 95), a rise from 29% last year but not back to the level of the previous year, which is 44%. In the same period, the PCT authorised 24% (10 out of 42) compared to 55% (11 out of 20) last year, itself a fall from 60% (12 out of 20) the previous year. Overall, this equates to 34% of applications being authorised, the same as last year, compared to 49% the previous year.

The total numbers of assessments undertaken in Worcestershire was 30 per 100,000 population, just above the West Midlands regional average for the year and the national average of 29 applications per 100,000.

As stated in last year's Annual Report, it continues to be difficult to make meaningful comparisons with national data for Deprivations of Liberty Safeguards assessments due to variations in the way this is collected and varying operational practices. However, work to ensure consistent approached undertaken by the West Midlands Regional DoLS Group means that regional comparisons can be made. These figures, which may have been inflated last year by referrals in the wake of the concerns around the care at Winterbourne View in Bristol, suggest that the Safeguards are being more tightly managed than they were. The variation in referral and authorisation rates between the County Council and the PCT may be addressed by the transfer of responsibility for all authorisations to the County Council providing greater consistency in responses. Further work will be undertaken in the coming year by the County Council with care homes and hospitals to increase awareness and understanding of the responsibilities of the managing authority role.

BUSINESS PLAN Priorities 2012 – 2015

KEY BOARD OBJECTIVES **Board Chair to be responsible for co-ordination of work to meet the objectives**			**SUBGROUP OBJECTIVES** **Each Subgroup to produce a work plan to meet the objectives, with progress to be reported quarterly to the Board**				
Governance (Board)	**Leadership & Development** (Board)	**Partnership Working** (Board)	**Accurate Data: to be used effectively** (Audit and Good Practice Subgroup)	**Policy & Procedure: to be developed & implemented** (Policy & Procedures Subgroup)	**Public Awareness: to be increased** (Communication Subgroup)	**Training Strategy: to be fully implemented** (Training Subgroup)	**'Lessons learnt': to be Implemented** (Serious Case Review Subgroup)
Clarify purpose/role of Executive Board	Provide clear strategic Safeguarding Adults lead across Worcestershire	Work on being a partnership and forming new partnerships	Have an overview of performance to understand where & why abuse is happening	Ensure effective adoption & implementation of Pan West Midlands Policy by all agencies	Promote access for all concerned to information about abuse	Establish regular reporting of training take-up back to all agencies and the Board including information on the cascading and refreshing of training	Develop Board methods for learning from Serious Case Reviews

BOARD			Audit and Good Practice Subgroup	Policies and Procedures Subgroup	Communications Subgroup	Training and Development subgroup	Serious Case Review Subgroup
Ensure full sign-up for Executive Board Meetings	Understand and evaluate the coordination of Safeguarding Adults in the 'wider' care market – prevention & protection	Broaden engagement in safeguarding adults by improving links to District Councils/Housing providers/non-main stream providers/GPs	Establish a standard data set	Embed robust scrutiny of P&P to ensure simplified processes, which are fit for purpose and which minimise the risk vulnerable adults falling through the net	Ensure all communities are engaged in WSAB activity	Analyse gaps in staff education and develop/implement appropriate responses	Learn from good practice and what works elsewhere
Ensure Clinical Commissioning Groups fully engaged	Ensure WSAB prepared for being put on statutory basis		Ensure all partner agencies establish data collection and monitoring systems	Improve feedback on outcome of safeguarding adults referrals	Ensure Carers feel able and know how to raise concerns about safeguarding risks to themselves	Monitor training outcomes and impact	Ensure Board evolves to understand subtleties of abuse
Be specific about expectations for all involved organisations	Ensure WSAB meets ADASS Compliance Framework		Improve data from all agencies re referrals and outcomes	Ensure clear safeguarding adults referrals pathways are established for health staff			
Hold agencies accountable	Agree Performance Indicators		Have clear mechanisms for reporting	Develop clear, consistent Information Sharing Agreements & Policy			

BOARD			Audit and Good Practice Subgroup	Policies and Procedures Subgroup	Communications Subgroup	Training and Development subgroup	Serious Case Review Subgroup
	Ensure Service Users & Carers actively involved in Safeguarding Adults Processes		Share information to identify the most vulnerable				
	Ensure WSAB Bulletin Board goes 'live'		Monitor and evaluate implementation of the Prevention Strategy				
	'Benchmark' performance against other LSABs		Increase themed multi-agency case file audits				
	Undertake 'Horizon-scanning' nationally & locally						

APPENDIX 2:

Membership of the Worcestershire Safeguarding Adults Board 2012-13

Name	Job Title 2011-12	Organisation	Role
Pete Morgan	Independent Chair		Chair
Sue Pidduck	Safeguarding Services Manager	Worcestershire County Council	Standing Member
Sarah Pilkington	Learning & Development Coordinator	Worcestershire County Council	Standing Member
Richard White	Director	Stanfield Nursing Home	Standing Member and Chair Serious Case Review Subgroup
Vicky Preece	Deputy Director of Nursing	Worcestershire Health & Care Trust	Standing Member
Michelle Norton	Deputy Chief Nurse	Worcester Acute Hospitals NHS Trust	Standing Member
Jo Galloway	Lead Nurse Quality & Safety	NHS Worcestershire	Standing Member
Phil Shakesheff	Detective Inspector	West Mercia Police	Standing Member and Chair Audit and Good Practice subgroup
Philip Talbot	Chief Executive	Age UK, Herefordshire & Worcestershire	Standing Member and Chair Communications Subgroup
Tim Rice	Community Safety Partnerships Manager	Worcestershire County Council	Standing Member
Claire Parry	DWP Partnerships Manager	Department of Working Pensions, Disability and Carers Services	Associate Member
Susannah Stennett	Senior Probation Officer	West Mercia Probation Trust	Associate Member
Sue Keating	Vulnerable Persons Co-Ordinator	Hereford & Worcester Fire and Rescue Service	Associate Member
Councillor Philip Gretton	Cabinet Member with Responsibility for Adult Social Care	Worcestershire County Council	Observer
Suzanne Hardy	Clinical Educator	Worcestershire Acute Hospital NHS Trust	Chair, Training Subgroup
Karen Rees	Integrated Safeguarding Team Manager,	Worcestershire Health and Care NHS Trust	Chair, Policy and Procedures Subgroup

APPENDIX 3:

Membership of the Worcestershire Safeguarding Adults Executive Board 2011-12

Name	Job Title 2011-12	Organisation	Role
Eddie Clarke	Director, Adult & Community Services	Worcestershire County Council	Chair
Simon Hairsnape	Chief Operating Officer	Clinical Commissioning Group, Redditch & Bromsgrove & Wyre Forest	Standing Member
Simon Trickett		Clinical Commissioning Group, South Worcestershire	Standing Member
Eamonn Kelly	Chief Executive	NHS Worcestershire	Standing Member
Sarah Dugan	Chief Executive	Worcestershire Health & Care Trust	Standing Member
Penelope Venables	Chief Executive	Worcestershire Acute Hospitals NHS Trust	Standing Member
Martin Lakeman	Detective Superintendant, Head of Public Protection	West Mercia Police	Standing Member
Councillor Philip Gretton	Cabinet Member with Responsibility for Adult Social Care	Worcestershire County Council	Observer
Pete Morgan	Independent Chair WSAB		In attendance