Worcestershire Safeguarding Adults Board

Annual Report 2015/16

Worcestershire Safeguarding Adults Board

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Revision History

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Contributors to the development of the document

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Contents

Chairs Foreword

This report covers our first full year as a statutory board under the Care Act 2014. Though Worcestershire Safeguarding Adults Board (WSAB) has been working as a partnership board for many years, the Care Act required some significant changes to be made, to take on a more strategic role and to get better assurance that key partners work together effectively to improve safeguarding, wellbeing and independence.

Following a consultation process at the beginning of the year, we approved our 3 Year Strategic Plan and our annual business plan to work on the priorities that had been identified during the consultation process. We are pleased to see that the new safeguarding procedures that were required by the Care Act are being implemented, as well as seeing good progress in the implementation of the Care Act across all agencies. The board has worked specifically on the development of new multi-agency guidance on Self Neglect, as this was a gap that had been identified within the Care Act. We started work on developing a new Performance & Quality Assurance Framework by mapping and collecting data and intelligence about safeguarding from all agencies. This important work will continue into next year and will help us improve our local assessment of risks and better plan our future priorities.

Protecting and safeguarding people at risk of abuse or neglect, is an important job and we have taken steps to further develop and strengthen partnership working by working more closely with our colleagues on the Worcestershire Safeguarding Children Board, Health & Well-Being Board and Community Safety Partnership on those issues that cut across all Boards. Furthermore, we have worked on improving community awareness of abuse through a range of communication activities and by continuing to develop our Prevention Strategy and Engagement Strategy.

A key challenge for the Board has been to get better engagement with people who have experienced safeguarding processes and to make sure that we listen to what people tell us. This has involved working more closely with community and voluntary groups that are led by people who use services to find out how people want to be involved with the work of the Board. We feel it is important to take the time to do this properly rather than too quickly and risk a tokenistic approach.

I have continued to be impressed with the commitment and hard work of all the partner agencies and I have no doubt that the Board will continue to build on its' current strengths to meet the challenges ahead.

Kathy McAteer
Independent Chair of Worcestershire Safeguarding Adults Board

1.0 Introduction

Annual Review 2015-16

This year Care Act (2014) guidance was published, which clearly set expectations for the minimum content for Safeguarding Adults Boards (SAB) Annual Reports (Schedule 2.4(1) a-g). In summary they must:

- Cleary state what the SAB and its members have done to carry out its objectives and strategic plan;
- Set out how the SAB is monitoring progress against policies and intentions to deliver its strategic plan;
- Provide information on safeguarding adult reviews (SARs), , ongoing undertaken or reported on that year. Reporting on what has been done to act on the findings of completed reviews.

This report is set out in four parts:

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

2.0 Background

2.1 Purpose

Worcestershire Safeguarding Adult Board (WSAB) was established in 2001 as a direct response to the publication by the Department of Health (2000) of the 'No Secrets' statutory guidance on working with vulnerable adults. Following the Care Act (2014) Safeguarding Adults Boards further statutory requirements and recommendations have been introduced. The Board has the strategic responsibility for the development, co-ordination, implementation and monitoring of multi-agency policies and procedures that safeguard and protect adults with care and support needs in Worcestershire.

The Boards purpose is to provide assurance that adults at risk are safeguarded from abuse or neglect. Members work together to ensure that people who have care and support needs are empowered to either protect themselves or, are kept safe from abuse or neglect through the intervention of those who have the powers to protect them. Also, when abuse occurs, partner organisations are able to respond effectively and proportionately.

The work of the Board is underpinned by the six safeguarding principles as defined in the Care Act (2014) which are:

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

2.2 Board Membership

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

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

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

2.3 Annual Budget and Financial Contribution

The 2015/16 annual budget for the Board was £130,800. Alongside staff and administration, this funds the cost of Safeguarding Adult Reviews. 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 Agent

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

There was a small overspend for the financial year of £1,656.21.The Board statutory partners agreed to a percentage contribution to the budget overspend, in line with their formula for contributing to the Board's annual budget.

2.4 Strategic Priorities 2015 to 2018

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

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

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

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

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

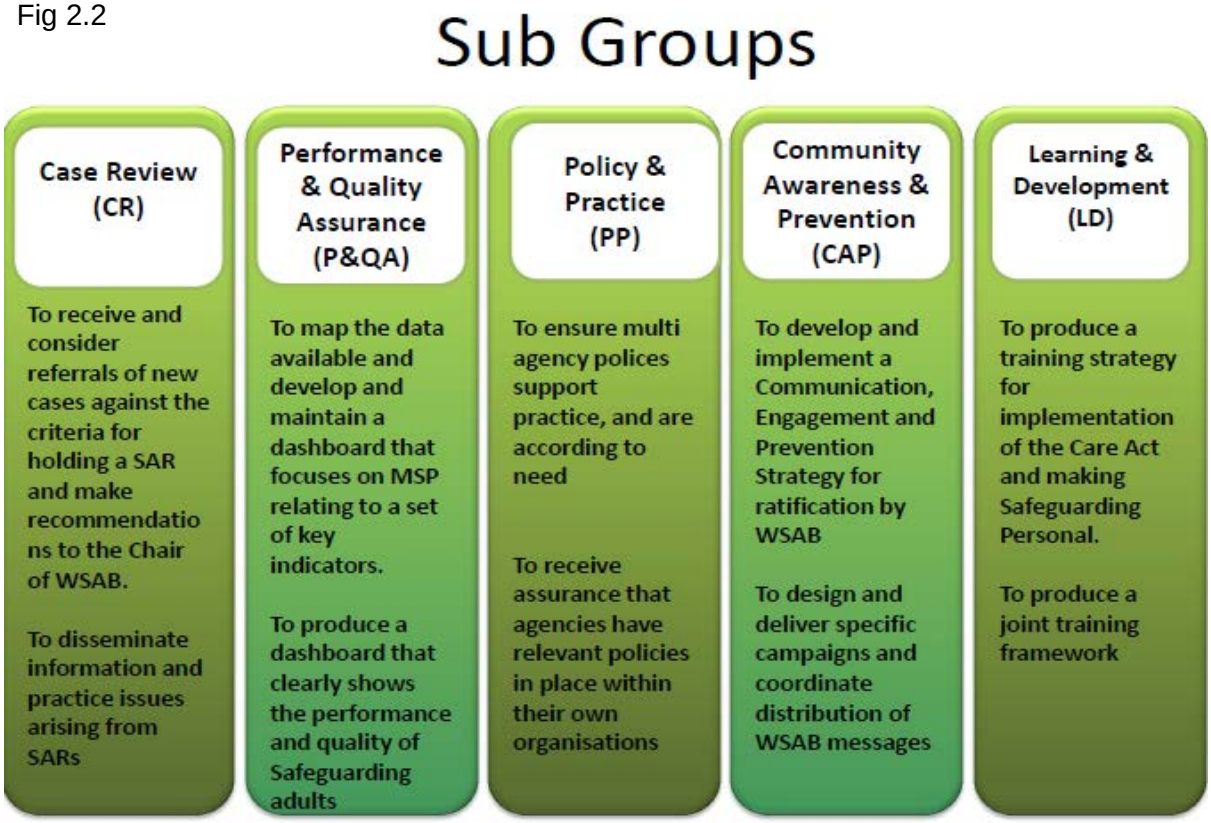
5) To learn lessons and make changes that prevents similar abuse or neglect happening to other people.

2.5 Delivery Model

Implementation of the Strategic Plan is achieved through the work of the Board and its five sub-groups. Each year new business objectives are developed providing details on how the Strategic Plan will be implemented including, how success will be measured.

The sub-groups (Fig 2.2) 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 2.2



2.6 .Business Objectives

Table 2.3 outlines the seven key business objectives identified for the 2015/16 financial year. The second column shows the goals which needed to be completed over this year to ensure that the three year plan can be delivered. The final column identities those actions which have been achieved (green tick), and those where progress has been made, but the goal has not quite been met (orange arrow).

Overall progress for the year was strong, with the majority of goals being met. However there were a few exceptions:

(5a) - Whilst a survey was completed in May 2016, with 366 responses, it was not carried out until the beginning of the new financial year. However, as not all key stakeholders received the survey, the Learning and Development subgroup felt that it did not provide a full analysis of safeguarding awareness across all stakeholders. This action has therefore been carried over to review and complete in year 2.

OBJECTIVES	YEAR 1 (2015/6) PLAN	ACHIEVED
1. Improve outcomes for people who Self Neglect	a) Develop a multi-agency framework and policy (P&P)	✓
	b) Develop a publicity campaign to raise the awareness of self-neglect (CAP)	✓
2. Collaborate with other partners to ensure effective assurance of cross-cutting issues.	a) Strengthen joint working with the Worcestershire Safeguarding Children's Board, focusing on the transition from children to adults.	✓
	b) Engage with other Partnerships, to scope assurance frameworks for cross cutting issues and develop joint work programmes for future years.	✓
3. Engage with key partners, including adults accessing safeguarding processes and with care & support needs	a) Develop an engagement & participation strategy, in co-production with people who use services(CAP)	✓
4. Involve the community in safeguarding and improve community awareness of abuse	a) Develop and implement a WSAB Communications, Engagement and Prevention Strategy and agree suitable methods of engagement with the wider community (CAP)	✓
	b) Co-opt representatives to support the wider engagement network (CAP)	✓
	c) Co-opt representatives to support the development of stakeholder Communication, Engagement and Prevention Strategy. (CAP)	✓
	d) Develop publicity campaigns to raise awareness of other specific WSAB priorities (CAP)	✓
5. Develop better understanding Worcestershire's risk profile to target board activity on the greatest local risks	a) Agree a process for briefing the sub-group on – DHR & SCR reviews across Worcestershire in order to consider lessons/themes arising from these (CR)	✓
	b) Survey the level of knowledge related to level 1 safeguarding competencies (L&D)	→
	c) Map the data that is available from all organisations and produce a Performance Monitoring Framework (P&QA)	→
6. Embed the new Safeguarding Adult Review (SAR) process and seek assurance that lessons are leant and embedded across agencies	a) Develop and adopt Safeguarding Adults Review(SARs) protocol (CR)	✓
	b) Review legislation, case law and national guidance, updating policy and procedures accordingly (CR)	✓
	c) Agree process to operationalise the approved protocol (CR)	✓
7. Seek assurance that all stakeholders implement training strategies which meet the requirements of the Care Act and Making Safeguarding Personal	a) Review the present training strategy against Care Act Changes, reflecting Making Safeguarding Personal (LD)	✓
	b) Develop a training strategy for 2015-18 (LD)	→

(5c) - It was not possible to map all data by the end of year 1. However this has now been completed during the first part of year 2.

(7b) - Similarly, whilst the completion and adoption of the training strategy was not met by the end of year 1 it has therefore been carried over to year 2.

3.0 Review of Activities 2015/16

3.1 Overview of Care Act Requirements

A major part of work undertaken by the WSAB Sub Groups was to make sure that partner agencies were all implementing the Care Act (2014) requirements. A wide range of activities were undertaken to ensure that local arrangements are fit for purpose and compliant with the new statutory safeguarding requirements.

The Care Act 2014 came into force in April 2015, to be implemented between 2015 and 2017. This legislation establishes safeguarding as everybody's business with the Local Authority, Police and NHS Clinical Commissioning Groups seen as key statutory partner agencies. The previous duty of partnership was replaced by a legal duty of co-operation. The new statutory framework for adult safeguarding is laid out in clauses 42-45 of the Care Act (2014) as follows:

- **Leadership by the local authority of a multi-agency local adult safeguarding system** that seeks to prevent abuse and neglect and stop it quickly when it happens;
- **Making safeguarding enquiries, or causing enquires to be made** – this allows the local authority to reasonably request that another agency carries out the enquiry and provide feedback to the safeguarding process;
- **Establishing a Safeguarding Adults Board** with the Local Authority, Police and NHS as core members and develop, share and implement a joint safeguarding strategy;
- **Carrying out safeguarding adult reviews** when there is concern that the local authority or its partners could have done more to protect a vulnerable adult;
- **Arranging, where appropriate, for an independent advocate** - this is a new requirement going beyond the expectation in relation to the Mental Capacity Act 2005.
- **Co-operation between relevant partners** – a new duty, which establishes the importance of sharing information and developing joint responses where appropriate.

3.2 Summary of Activities

The WSAB has provided a robust approach to ensuring that Care Act (2014) 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. As part of this process an Annual Assurance has been carried out across all Board members for the last two years. These identify a wide array of activities undertaken including:

- Ensuring that all Policies and Procedures are Care Act Compliant;
- Updating staff training to ensure that safeguarding principles, processes and thresholds are understood;

- Developing staff support to ensure that the principles of safeguarding and mental capacity awareness is embedded in practice;
- Utilise internal case audit and review processes to identify safeguarding issues and concerns to ensure that practice and procedures can improve;
- Raising public and service user awareness through the Boards and Partnership organisations communication networks, websites and documents;
- Embedding safeguarding requirements into external provider contracts so as to drive up service standards and responses.

3.3 Organisational Examples

Some notable organisational approaches and achievements in building staff skills and knowledge around Safeguarding include:

- West Mercia Police –
    - A wide range of training has been introduced to ensure that all levels of officers and staff are trained on the Mental Capacity Act;

- Worcestershire County Council;
    - All staff undertake basic adult safeguarding training as a mandatory part of the corporate induction;
    - A monthly reflective practice session is held for Social Care staff, with an external facilitator. Safeguarding is a key element of these;

- Clinical Commissioning Groups
    - Safeguarding training is now mandatory for all staff;

- Worcestershire Health and Care Trust
    - Safeguarding training is mandatory for all staff to a required level for their role and over 90% of all staff have received adult safeguarding training;
    - More advanced training is now being developed for senior staff;
    - Mental Capacity Act and Deprivation of Liberty Safeguard training is in place for all staff who have patient contact;

- Worcestershire Acute Hospital Trust –
    - Over 90% of all staff have now received adults safeguarding training;
    - There is targeted Domestic Abuse training for Emergency Department staff.

3.4 Partnership Examples

Alongside individual organisations ensuring that they are able to meet the requirements of the Act there have also been some important partnership collaborative activities and achievements. These include:

WSAB – Governance:

- Introducing clear and accountable Board governance processes and structures, including a revised constitution and introducing a clear policy development and ratification process;
- Introduction and appointment of a substantive Board Manager to support the Board in its delivery of its objectives;
- Introduction of a Board Strategy Day, to review the Boards activities over the year and consider future key priorities;
- Development of a Balanced Scorecard which utilises shared partnership data to identify priorities and measure progress;
- Regulatory Services became a new Board member; recognising the key role they have in protecting adults at risk of abuse or neglect in Worcestershire. They bring a wealth of knowledge, experience and strategies in protecting those most vulnerable within our local communities.

WSAB Publications and Guidance Ratified and Published during 2015/16:

- *'Multi- Agency Escalation Procedures for Individual Cases'* – Sets out a clear process for raising concerns for individual cases, including those which cannot be resolved by one organisation
- *'Multi Agency Self Neglect Guidance'* - provide guidance for all workers from the partner agencies in Worcestershire whose role brings them into contact with individuals who may persistently self-neglect;
- *'Adults Operational Protocol for Multi-Agency Information Sharing (Safeguarding')* - An annex of the Worcestershire Safeguarding Adults Board Information Sharing Agreement, this protocol facilitates improved multi-agency working and information sharing by professionals.

WSAB Communication and Engagement:

Considerable effort was made over the last year to develop our engagement approach within the community, particularly with vulnerable groups. This was seen as an important element of the work by the Boards Chair who held two engagements events in North and South Worcestershire during November. The following are examples of key pieces of engagement activity which contributed to delivering key objectives for the year.

- **Development of Engagement Strategy** – The Board have worked collaboratively with community representatives and users of services to develop a meaningful strategy to be adopted and implemented in the new business year;

- **Leaflets and Posters** – Produced safeguarding awareness posters to highlight abuse and what to do if somebody suspects that they, or somebody else, is being abused and the person has care needs and cannot protect themselves. These include;

    - WSAB Poster Elderly Abuse;
    - WSAB Poster Mate Crime ;
    - WSAB Poster Neglect;
    - WSAB Poster Financial Abuse;

The above leaflets and publications can be found on the WSAB website at www.worcestershire.gov.uk/wsab - Select the Board Documents link.

- **Work with Housing providers –** WSAB held a workshop to explore how we can work with the independent and statutory housing sector to reduce the risks for vulnerable adults living in their properties. Actions identified are now being developed, including looking at Mental Capacity training for housing staff and targeting high risk neighbourhoods.

- **Support and Development of a Multi-agency Safeguarding Hub (MASH)** In May 2015, MASH partners co-located to Wildwood offices in Worcester and MASH processes for adults and children were developed. Agencies represented within the MASH are Adult Social Care, West Mercia Police, Children, Families & Communities, Worcestershire Health and Care NHS Trust, Worcestershire CCGs, Probation and Women's Aid. Other agencies support MASH process virtually, including Worcestershire Acute Hospitals NHS Trust, Trading Standards and Swanswell.

  The MASH process allows for timely information sharing and a co-ordinated response. It has also increased awareness and understanding of Adult Safeguarding among partners. A review of the adult MASH process is underway to ensure that the current arrangements provide the best outcomes for adults with care and support needs in Worcestershire.

3.5 Cross Cutting Partnership Work

As the work carried out by WSAB is diverse and far reaching across Worcestershire we ensure that we have worked closely with other Boards and organisations with a similar focus including;

- Worcestershire Safeguarding Children Board (WSCB);
- Health and Wellbeing Board (HWBB);
- Community Safety Partnership (CSP);
- Healthwatch.

In addition Chairs from HWBB, WSAB and WSCB, alongside the Managers, held regular meetings to look at cross cutting issues such as;

- Domestic Abuse
- Terrorism and Prevent
- Anti-social Behaviour
- Organised crime
- Hate Crime
- Sexual exploitation
- Trafficking and Modern Slavery
- ‘Mate crime’
- Female Genital Mutilation
- Forced Marriage
- Emotional wellbeing/suicide prevention
- 'Toxic Trio'– (parental mental health, drug/alcohol use, Domestic Abuse)
- Transition issues for older adolescents/
- Vulnerable young adults

Through these meetings a joint protocol has been established which defines how these boards will work together, combining resources and reducing duplication, to improve safeguarding and promote the welfare of both children and adults across the Worcestershire. The CSP have also engaged in these meetings and the protocol is being adapted to accommodate their contribution.

Transition Event

As a result of this joined up working WSAB and WSCB combined their resources to hold a Transitions Event, inviting practitioners, managers and policy makers to discuss and explore the issues surrounding vulnerable young people transitioning into adulthood. Those who attended looked at how services can best support the young people they work with and work towards the prevention of abuse and neglect. The feedback received was extremely positive with 100% of attendees rating the quality of content as very high/high. The findings from the day have been carried forward by both Boards in order to improve the services provided within our local communities.

3.6 Serious Case Reviews and Safeguarding Adults Reviews

Until April 2015 the Case Review Sub Group of the WSAB carried out Serious Case Reviews (SCRs). The Care Act (2014) removed the SCR function replacing it with a statutory requirement to undertake Safeguarding Adults Reviews (SARs). They 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 abuse or neglect.

A Safeguarding Adults Review (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.

The purpose of a SAR is to critically review;

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

A SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

In 2015/16 the Case Review Sub Group took five Serious Case Reviews and Safeguarding Adults Reviews to the Board (Table 3.1)

WSAB also commissioned a further SAR, JL, in February which was not completed prior to the end of 2015/16.

Table 3.1 – Summary of SCR and SARs Completed in 2015/16

Initial	Details
AP	The review was commissioned in 2014 and the final report was presented to the WSAB in September 2015. The review was undertaken by an Independent Author who made three recommendations which were all actioned and should be completed by October 2016. AP was an adult who was in receipt of care and who died five days after arriving at a new nursing home. The new nursing home made a safeguarding alert as they had concerns that AP's care may have previously been neglected.
LG	The review was commissioned in 2014 and the final report was presented to the WSAB in September 2015. The review was undertaken by an Independent Author and the learning process involved front line practitioners and their managers. A copy of the full report can be found online at WSAB - Case Review Lee Graham. LG was an adult who had a diagnosis of severe learning disability, Down's Syndrome and aspects of autistic spectrum disorder and died due to complications caused by his obesity. There were twenty recommendations arising out of the review which are due to be completed by October 2016.
TT	The review was commissioned in 2014 and the final report was presented to the WSAB in December 2015. The review was undertaken by an Independent Author and the learning process involved front line practitioners, their managers and subject matter experts. A copy of the full report can be found at: WSAB Case Review – The care and treatment of adult TT whilst detained under the Mental Health Act. TT is a young man with a diagnosis of a learning disability and autistic spectrum disorder, with challenging behaviours. The Serious Case Review (SCR) - included the appropriateness of TT's hospital placement at Wast Hills, lack of action taken by the placing authority until the crisis occurred, the removal of TT's diagnosis, the difficulty in finding TT an alternative hospital placement and information sharing about findings from other relevant investigations. There were seventeen recommendations arising out of the review which are due to be completed by October 2016.

PY	The review was commissioned in 2015 and the final report was presented to the WSAB in January 2016. The review was undertaken by an Independent Author and the learning process involved front line practitioners and their managers. A copy of the full report can be found at: WSAB Case Review PY PY was a young woman who died whilst living at home with daily support from members of her family, live-in care, domiciliary care and day care services. There were four recommendations arising out of the review which are due to be completed by October 2016.
MU	The review was commissioned in 2015 and the final report was presented to the WSAB in January 2016. The review was undertaken by an Independent Author. A copy of the full report can be found at: WSAB Safeguarding Adult Review Michael Upward MU was an elderly gentleman who was found deceased whilst in receipt of respite care MU had left the building without staff knowledge. There were four recommendations arising out of the review which are due to be completed by December 2016.

Recommendations

Each SCR and SAR through the critical review process produces a number of recommendations in order to ensure that the learning identified is acted upon. These recommendations are broken down into actions which each have target dates for completion and are monitored by the Case Review Sub Group until all actions are complete. All recommendations made in SCRs/SARs in 2015/16 have been acted upon.

Single Agency Action Plans

Each review also required those agencies involved to create their own single agency action plans. It requires each agency to the review their own actions, policies and procedures by looking inward at what areas they could improve on without the need for partnership working. Each of these actions have target dates for completion and are monitored by the Case Review Sub Group until all actions are complete

Themes

Each SCR/SAR is reviewed by the Case Review Sub Group in order to identify if there are any common themes arising from the reviews. Mental capacity was an area that appeared in most of the SCR/SARs requiring improvement in 2015/16 and this has fed into the Board's Business Objectives for 2016/17.

4.0 Safeguarding Activity and Performance 2015/16

4.1 Care Act (2014) Changes

Following the introduction of the Care Act (2014) in April 2015, there were a number of changes in safeguarding terminology and reporting criteria (Table 4.1).

Table 4.1	
Pre – Care Act (No Secrets Guidance)	Care Act 2014
Vulnerable Adult	Adult at Risk
Alleged Perpetrator	Source of Harm
Safeguarding Alert	Safeguarding Adult Concern
Safeguarding Referral	Section 42 Enquiry
Serious Case Reviews	Safeguarding Adult Reviews

The Care Act (2014) also introduced a 'three stage test', clearly outlining those adults (over 18), where safeguarding duties apply:

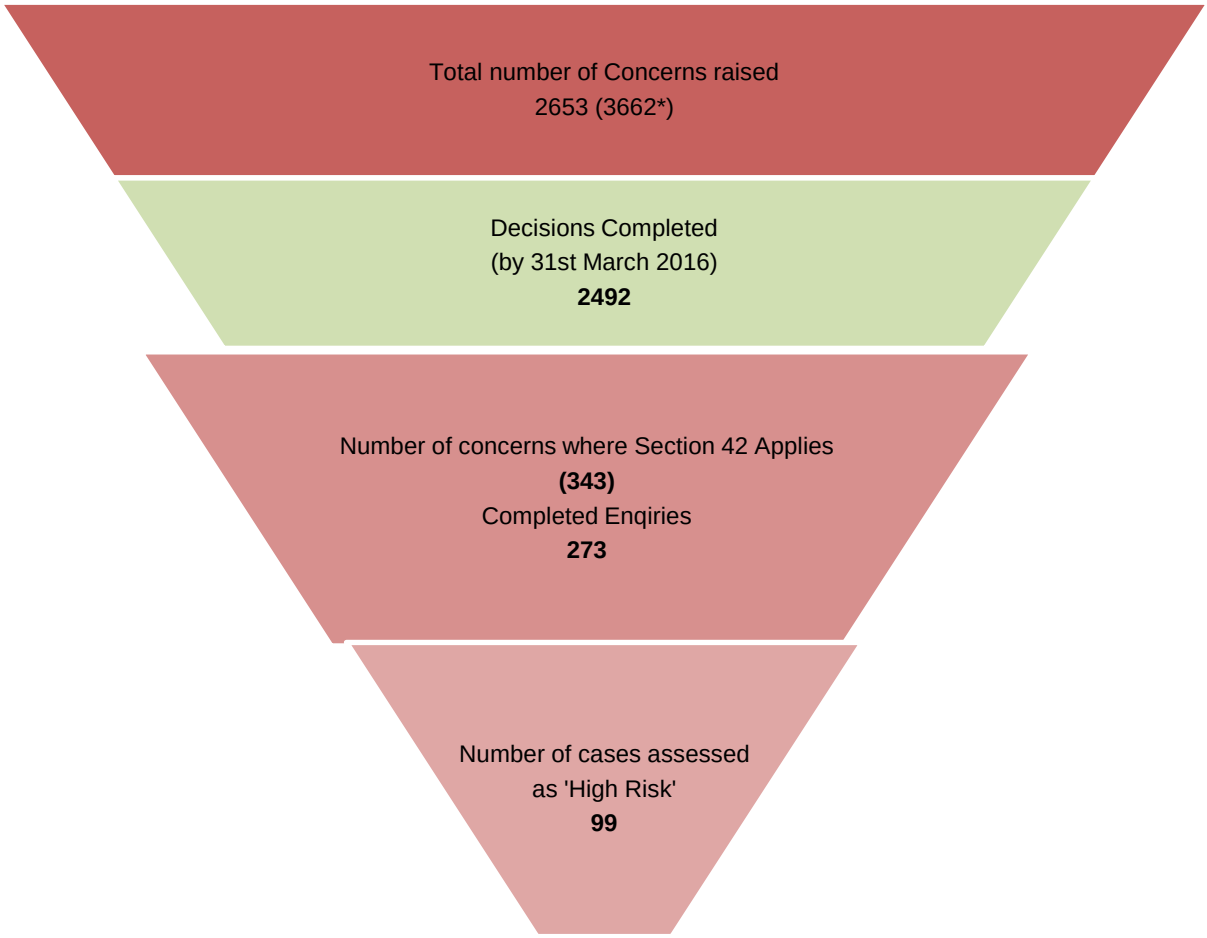
1. Has needs for care and support (whether or not the local authority is meeting any of those needs);
2. Is experiencing, or at risk of, abuse or neglect;
3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

These changes make it difficult to make absolute comparisons to previous years. Some comparisons have been made to where the criterion is similar enough to use. However it is important to recognise that due to these changes this is not an absolute and rigorous comparison.

4.2 Number and Source of Concerns

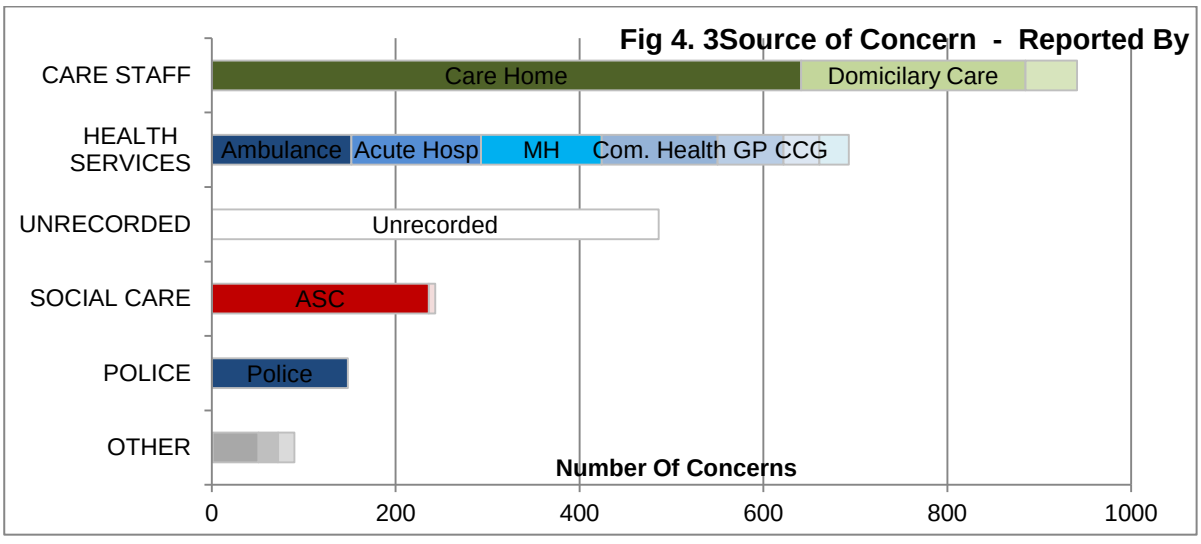
A total of 2653 "concerns" were raised during 2015/16 (Fig 4.2). It is not possible to compare this to the 3662 "Alerts" raised last year. In previous years Worcestershire was an outlier with a significantly higher number of Alerts compared to other areas. Analysis identified that this was due to low level concerns about quality being incorrectly referred as safeguarding alerts. This issue has been addressed through awareness erasing regarding the section 42 criteria, changing the pathway for reporting care quality concerns and pressure ulcers are no longer reported as a safeguarding concern unless there is evidence of abuse or neglect. In addition practice has changed significantly in line with Care Act guidance so cases are dealt with differently to the past, further making any comparison unreliable. Of the 2653 concerns Section 42 criteria only applied to 343 cases. Further work is being undertaken during 2016/17 to gain a better understanding of this.

Fig 4.2 – Numbers through the Safeguarding Pathway 2015/6



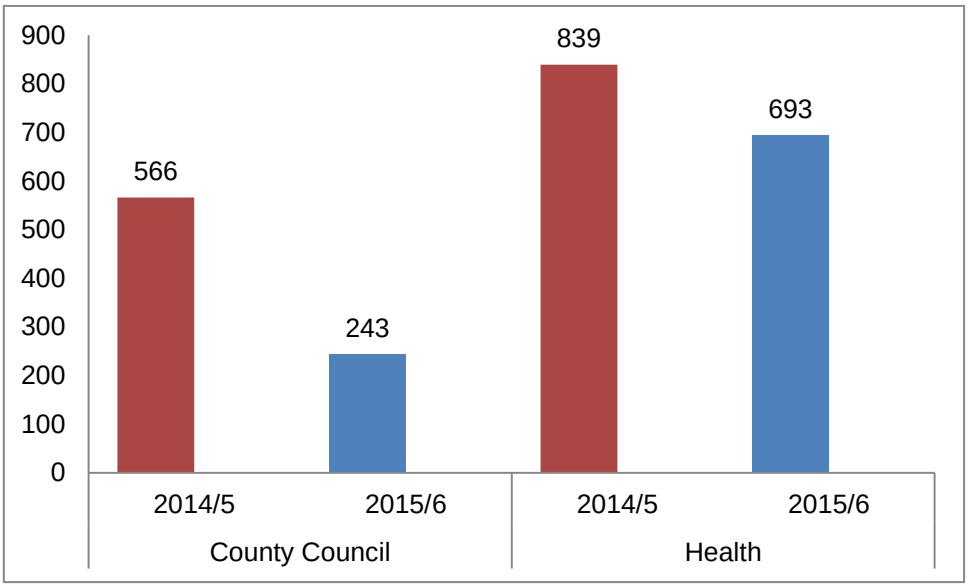
It is also important to note that a total of 345 non-statutory Enquiries were completed. This is where the mandatory requirement to complete an enquiry is not met. Whilst there is no obligation to undertake a formal enquiry, the County Council believed in these cases it was proportionate to undertake a non-statutory enquiry, as it would enable the local authority to promote the person's wellbeing and support a preventative agenda.

The data below (Fig 4.3).shows that the majority of these concerns were raised by care agencies



Whilst a similar proportion of concerns were raised by staff working across the combined statutory partners (Health, County Council and Police), comparisons with 2014/15 data on 'alerts'[1] show a significant drop in the numbers being referred by Health and County Council staff (Fig 4.4). This could provide some support for the premise that the increased emphasis on training across the statutory partners is having an impact However, within Health there was also a policy change in the threshold and process for referring grade 3 and 4 pressure ulcers, with these no longer automatically being referred as a safeguarding concern. In terms of future action there is a continuing need to ensure that training is embedded in statutory organisations. However, there is also a need to develop safeguarding training across commissioned and independent support services.

Fig 4.4 Source of Alert (2014/15) Compared to source of concern (2015/16)



4.3 Source of Risk

Type of Abuse

A number of categories and definitions have changed since the introduction of the care act (2014), so it is difficult to make direct comparisons. Notable additions include:

- Domestic violence;
- Victim of hate crime ;
- Sexual exploitation;
- Modern slavery; and
- Self-Neglect.

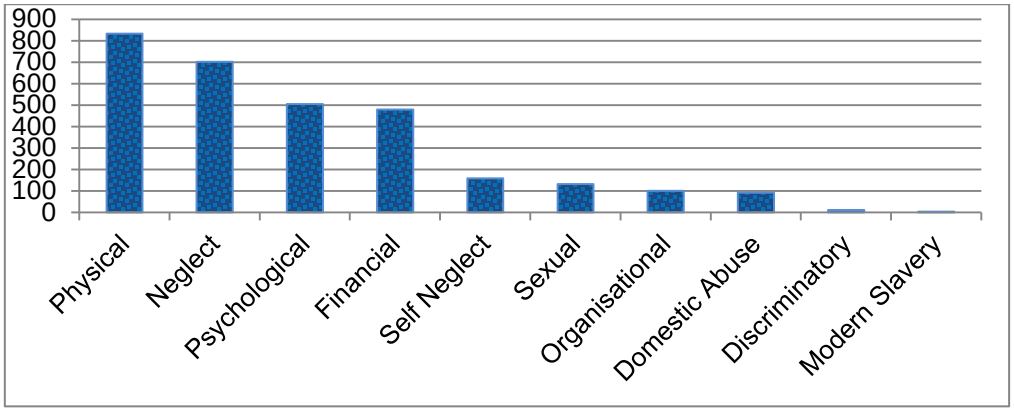
Reporting of these five types of abuse at a national level is voluntary. Worcestershire County Council has not implemented the reporting of Sexual Exploitation into its process

[1] Worcestershire Safeguarding Adults Board, Annual Report, 2014/15 (pp20)

as it is considered to be a sub set of Sexual Abuse. It was agreed that determining the difference between these two would be difficult to substantiate at the early stage of the safeguarding process.

Physical abuse appears to remain the highest reported type of abuse during 2015/16 (Fig 4.5). This is closely followed by neglect and mirrors the two highest types of alerts raised in 2014/15.

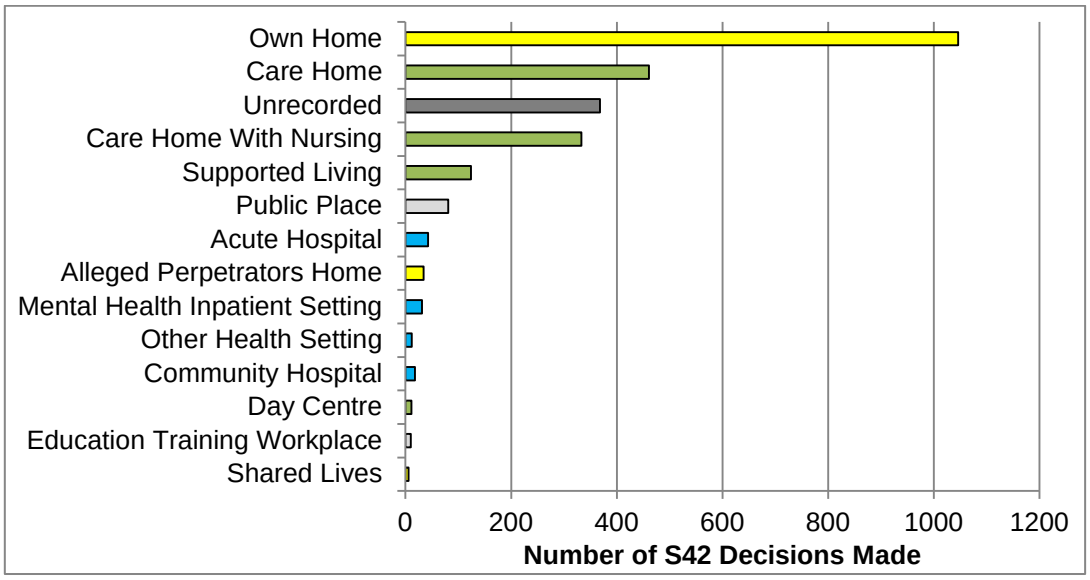
Fig 4.5 Type of Abuse –'Abuse type in completed decision making episodes'



Location

Data on the location of where safeguarding concern took place shows that overwhelming majority of incidents were recorded as taking place in the adults own home (Fig4.6)..

Fig 4.6 Location (2015/16)



It is important to note that multiple locations can be recorded, thus the total number of locations is higher than the number of concerns.

In those cases where a comparison can be made, this appears to show a slight reduction compared to the previous year when 1324 'Alerts'[2] were recorded as taking place in the adults own home, compared to 1046 this year (Table 4.7). Similarly recorded incidents located in care homes have also reduced. During 2014/15 a total of 1647[3] 'Alerts' were recorded as taking place in a Care Home compared to 994 this year. Whilst there is a significant reduction in those located in hospitals again the policy change in the threshold and process for referring grade 3 and 4 pressure ulcer is likely to have had an impact on this.

Table 4.7 Safeguarding 'concern' (2015/16) compared to 'Alerts' (2014/5) (Where a comparison can be made)

	Alert Location 2014/5	**Concern Location 2015/16**
Care Home	1647	994
Own Home	1324	1046
Hospital	262	43
Public Place	49	81
Supported Accommodation/Living	180	124
Day Centres	14	11
Education / Training /work place establishment	14	10

Other notable Changes, where reasonable comparisons can be made to the previous year, include a decrease in incidents reported as taking place in a hospital and an increase in those occurring in a public place.

4.4 Source of Risk

Over one third of those people identified as the source of risk were known to the individual (Fig 4.8), (i.e. (Fig 4.9) their partner, another family member, a friend or neighbour or, for those in a support setting another adult with support needs). A quarter of inquiries identify staff within a care setting as the source of risk. Whilst a large proportion are recorded as initially unknown, this is because the data is extrapolated from the point the incident is first reported. Some of these may be disclosed further down the investigation.

[2] Worcestershire Safeguarding Adults Board, Annual Report, 2014/15 (pp20)

[3] Worcestershire Safeguarding Adults Board, Annual Report, 2014/15 (pp20)

Fig 4.8 At risk from

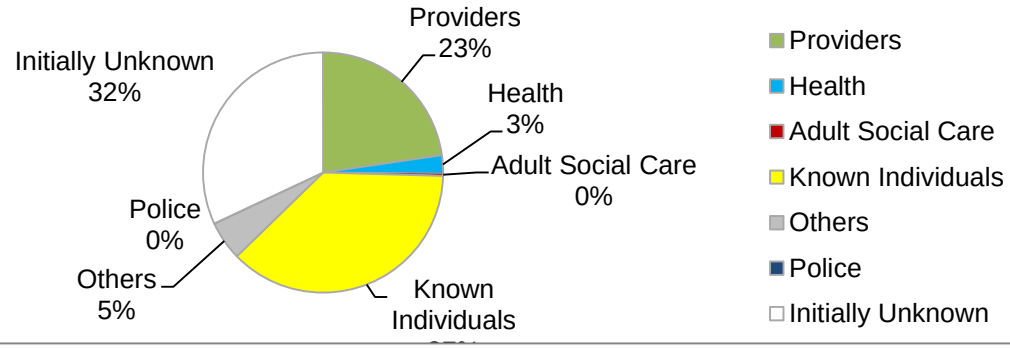
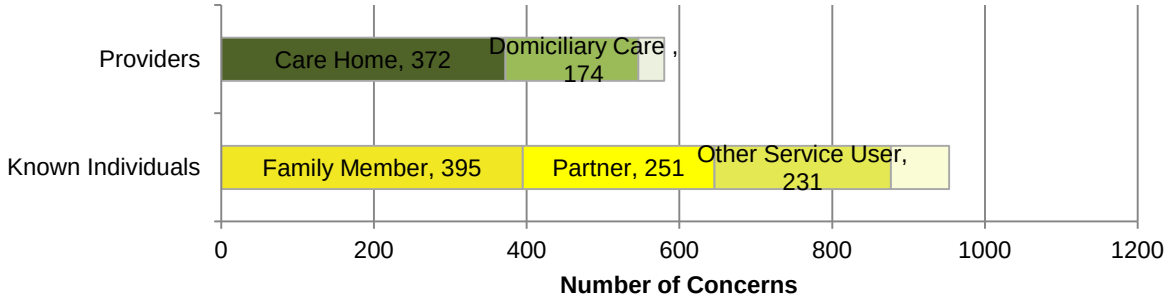


Fig4.9 At Risk From - Top Two Categories

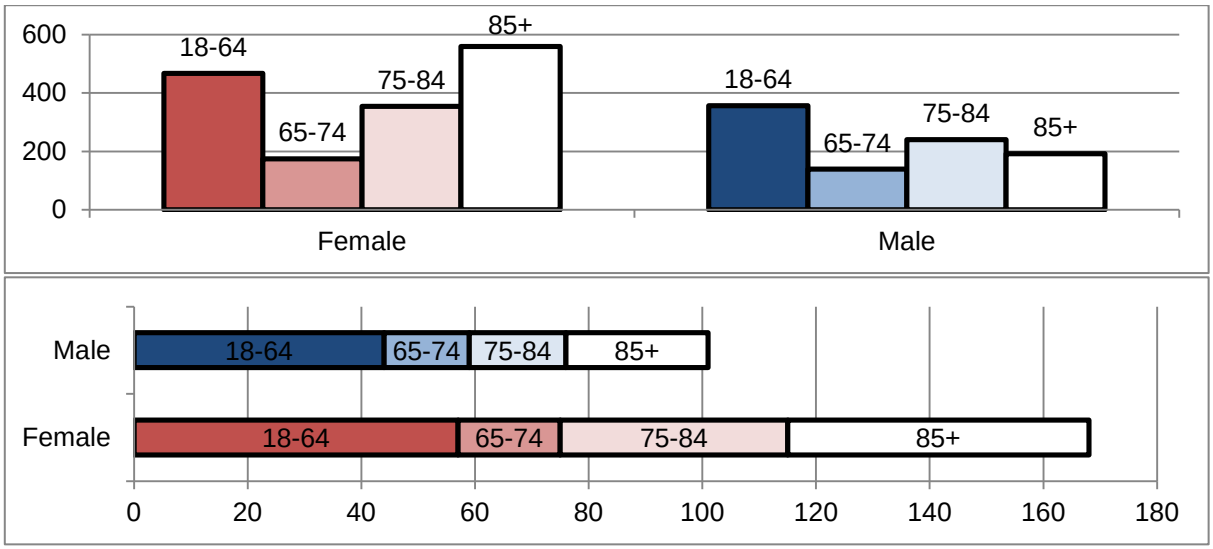


4.5 Demographic Profiles

Gender

As with the previous year, concerns raised for women significantly outnumber those raised for men (Fig 4.10) across all age groups, although in the 65-74 age group the gap is not so great. The trend in higher cases across the older groups is consistent with previous years. Alters for older women are generally higher and is reflective of the gender demographic of the County.

Fig 4.10 Decision Making Age/gender profile



Ethnicity

Again, in terms of ethnicity the number of recorded incidents mirrors previous years, with the vast majority of recorded concerns being raised for adults identified as being white (Fig 4.11).

Fig4.11 Decision making age/ethnicity

Main Ethnicity	Number of Decisions	18-64	65-74	75-84	85+	Under 18	Unknown	Percentage
Asian or Asian British	27	22	1	3	1	0	0	1%
Black or Black British	14	10	1	2	1	0	0	1%
Mixed	21	21	0	0	0	0	0	1%
Not recorded	94	37	10	23	21	0	3	4%
Not Stated	56	10	7	23	16	0	0	2%
Other Ethnic Groups	11	3	1	6	1	0	0	0%
White	2269	723	293	538	712	0	3	91%
Total	**2492**	**826**	**313**	**595**	**752**	**0**	**6**	

Within the BME groups Asian adults represent the largest group where incidents are reported, closely followed those adults identified as having a mixed ethnic background.

The percentage of safeguarding decisions made for all BME groups combined is 3 %, which is significantly lower than the 7.6% of BME groups living across the County. This could be due to underreporting within these communities. However, there is also a relatively significant number where the ethnicity is either not recorded or not stated (6%). So there could be some inaccuracies in recording amongst this group.

4.6 Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a change in approach to safeguarding work and aims to move away from safeguarding being process driven; instead placing the adult at risk at the centre of the process and working with them to achieve the outcomes they want.

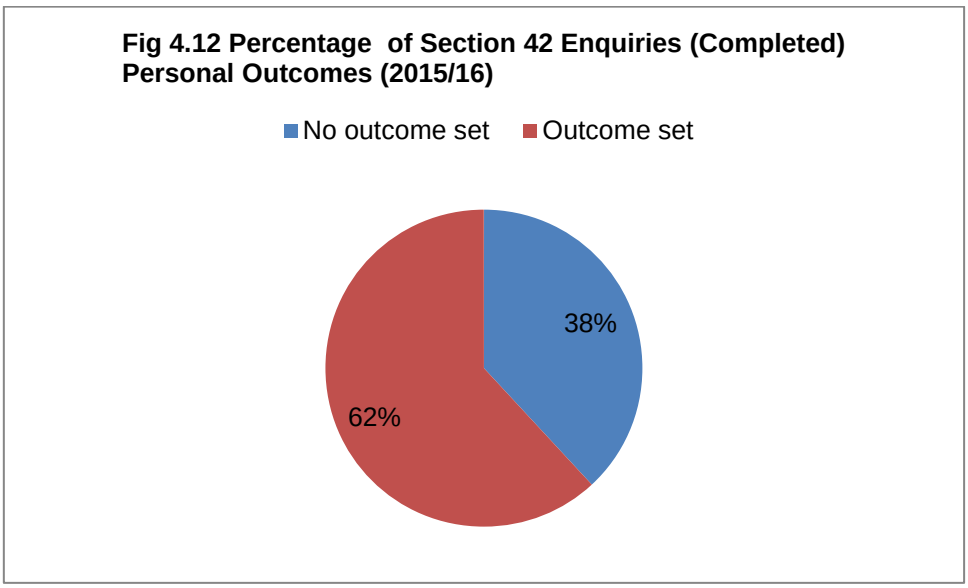
MSP also provides benefits for practitioners as it allows more in depth work at an early stage, leading to better decision making. Staff are encouraged to use their professional skills, knowledge and judgement to improve outcomes for adults. Early engagement of service users produces better outcomes and a simple approach is all that is needed.

Outcomes

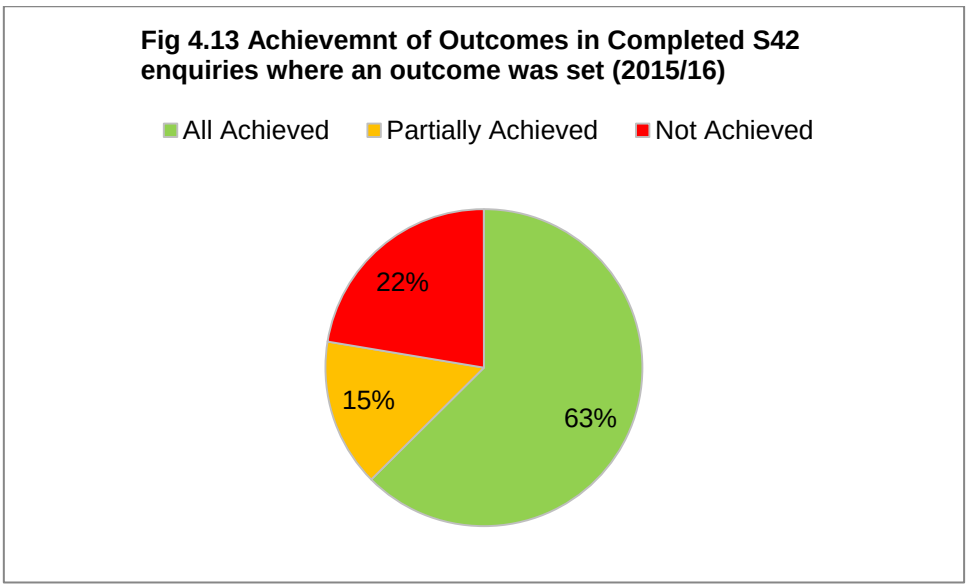
Embedding The MSP person centred approach is viewed as a key priority for the WSAB. A framework has been developed to monitor the level that adults, subject to a Section 42 Safeguarding review, who are engaged in setting the outcomes they desire for the review; alongside better understanding the type of outcomes they desire.

Of 273 cases which met the criteria for a Section 42 enquiry, and were completed during 2015/6, almost two thirds of the subjects identified personal outcomes they would like to see achieved through the enquiry at the beginning of the process.(Fig 4.12)

Fig 4.12 Percentage of Section 42 Enquiries (Completed) Personal Outcomes (2015/16)



Of those who identified an outcome, again almost two thirds felt that these outcomes were achieved (fig 4.13) and a further 15% felt they were partially met This left 22% (49) stating that the outcome had not been achieved . The WSAB have acknowledged that improvement around this is needed and this is a key priority in the year 2 (2016/17) business plan.



Types of Outcomes

Table 414 shows the type of outcomes which people wanted to achieve through the enquiry process. The most sought after outcome, identified in almost half of the enquiries was 'To be and feel safe' at the completion. Whilst over 80% felt this was achieved almost a fifth felt it wasn't. Also only 71% felt confident that this wouldn't happen again.

The next group highly desired of outcomes were around feeling better involved and maintaining control. Again the overwhelming majority of those who desired these outcomes felt they were achieved. Those who wanted to see personal improvements around their knowledge of where to get support, or maintain and improve relationships or improve their recovery were all satisfied. This feedback suggests that the process which has been developed provides a positive and potentially empowering experience.

Table 4.14 Desired Outcomes

Desired Outcome	Achieved %	Set	Achieved
To Get New Friends	100%	1	1
To Have Help To Recover	100%	9	9
To Know Where To Get Help	100%	20	24
To Maintain A Key Relationship	100%	23	23
To Know That Disciplinary Or Other Action Has Been Taken	100%	34	35
To Have Exercised Choice	100%	39	39
To Before Involved In Making Decisions	98%	58	57
To Maintain Control Over The Situation	90%	58	52
Other Outcome	83%	6	5
To Be And To Feel Safe	83%	113	94
To Know That This Wont Happen To Anyone Else	71%	38	27
To Have Access To Justice Or An Apology	64%	14	9

5.0 Priorities for 2016/17

In February 2016 the Board held a Strategy Day. The purpose of the day was to evaluate the impact of activities over the year and identify objectives for the forthcoming second year of the business plan. Alongside exploring the activity required to deliver Care Act (2014) duties and requirements, performance data was analysed and key themes, which emerged through engagement events and consultations, were reviewed. This was used to bring together the following Board Objectives for 2016/7:

1. To improve the way that we communicate with the public and our partners and explain what the Board is and what it does;

2. To check that the Mental Capacity Act and Deprivation of Liberty Safeguards are properly understood and being used fully in their everyday work by health and social care staff;

3. Improve the way that the Board listens to Worcestershire's adults with care and support needs and involve them in the Boards work. This will be clearly shown within the Board's Engagement Strategy;

4. Build on the existing work with other Boards e.g. Children's Safeguarding Board, Health and Well Being Board and Safer Communities Board. We will also make the best use of time and money and improve how we share out the work amongst all agency workers that make up the WSAB Sub Groups.

5. To continue to work with partner agencies to show where there might be risks for adults (at risk of abuse or neglect) within Worcestershire and use this to target the work of the Board, by making sure that performance frameworks are worked to and carry out at least one deep investigation;

6. Continue to improve community awareness of abuse and approve prevention
Strategy;

7. Complete any unfinished work from WSAB's 15/16 Objectives.

These will be used to complete a Business Plan for the year and aligned to the relevant sub groups to ensure that objectives are achieved.