West of Berkshire Safeguarding Partnership Adults Board

Annual Report 2018-19

If you would like this document in a different format or require any of the appendices as a word document, contact Lynne.Mason@Reading.gov.uk

The 2014 Care Act made it clear that safeguarding adults should be everyone's business. The multi-agency partnership across three Council areas (Reading, West Berkshire and Wokingham) which brings together the West of Berkshire Safeguarding Adults Board, remains committed to improving awareness of adults in need of care and support who may be at risk, either from others' treatment of them or from their own lifestyle choices. During this last year, case reviews brought to the attention of the Safeguarding Adults Board have highlighted important areas of learning for all of our partner agencies and these are summarised in this report. The areas for action are embedded in our business plan which is monitored closely to ensure that improvements are made, to prevent similar tragic incidents occurring in the future. Communication across agencies about safeguarding concerns remains one of the partnerships greatest challenges and should be significantly improved with the agreement and implementation of the Multi Agency Risk Toolkit by practitioners and their managers in the coming year.

Good management information is vital in identifying risks, areas for improvement and evidence of what works. The Safeguarding Adults Board continues to refine its approach to quality and performance monitoring to ensure a focussed approach by all on areas highlighted quarterly reports and from case reviews. 2018/19 data has presented some potential inconsistencies in the way information is recorded across the partnership and we will be commissioning an independent audit to understand how we can bring a more consistent approach to ensure that our management information is as effective and robust as possible.

It is important that, in addition to data, the Safeguarding Adults Board can take into account the experience that local people have of the support they are offered. We benefit from the involvement of voluntary sector and HealthWatch representatives, who are valuable partners in bringing this vital perspective to the Board's work and who are often the 'front line' in identifying safeguarding issues.

I am aware of the ever increasing pressures on partners, as demand for services grow and resources are constrained. This is reflected in the capacity of Safeguarding Adults Board representatives to maintain adequate involvement in progressing all of our agreed actions, which impedes our ability to meet all priorities. This underlines the need for our activities in the coming year to be all the more sharply focussed, well informed by effective management information and to make the very best use of our collective resources across all sectors.

Teresa Bell
Independent Chair, West of Berkshire Safeguarding Adults Board

Concerned about an adult?

If you are concerned about yourself or another adult who may be being abused or neglected, in an emergency situation call the Police on 999.

If you think there has been a crime but it is not an emergency, call the Police on 101 or contact Adult Social Care in the area in which the person lives:

Reading 0118 937 3747, or online Reading
West Berkshire 01635 519056, or online West Berkshire
Wokingham 0118 974 6863, or online Wokingham
Out of normal working hours, contact the Emergency Duty Team 01344 786 543

For more information visit the Board's website: http://www.sabberkshirewest.co.uk/

Introduction

Our vision

People are able to live independently and are able to manage risks and protect themselves; they are treated with dignity and respect and are properly supported when they need protection.

What is safeguarding adults?

Safeguarding adults means protecting others in our community who at risk of harm and unable to protect themselves because they have care and support needs. There are many different forms of abuse, including but not exclusively: Physical, Domestic, Sexual, Psychological or Emotional, Financial or Material, Modern Slavery, Discriminatory, Organisational or Institutional, Neglect or Acts of Omission, Self-neglect.

What is the Safeguarding Adults Board?

The West of Berkshire Safeguarding Adults Board covers the Local Authority areas of Reading, West Berkshire and Wokingham. The Board is made up of local organisations which work together to protect adults with care and support needs at risk of abuse or neglect. From April 2015 mandatory partners on the Board are the Local Authority, Clinical Commissioning Groups and Police. Other organisations are represented on the Board such has health services, fire and rescue service, ambulance service, HealthWatch, probation and the voluntary sector. ***A full list of partners is given in Appendix A.***

We work together to ensure there are systems in place to keep adults at risk in the West of Berkshire safe. We hold partner agencies to account to ensure they are safeguarding adults at risk and promoting their well-being. We work to ensure local organisations focus on outcomes, performance, learning and engagement.

Who do we support?

Under the Care Act, safeguarding duties apply to an adult who:

- Is experiencing, or is at risk of, abuse or neglect; and
- As a result of their care and support needs, is unable to protect themselves.

Safeguarding Adults Policy and Procedures

Berkshire Safeguarding Adults Policy and Procedures are used in the West of Berkshire and their purpose is to support staff to respond appropriately to all concerns of abuse or neglect they may encounter: https://www.berkshiresafeguardingadults.co.uk/

Number of safeguarding adult concerns 2018-19

- There has been a 20% reduction in the number of safeguarding concerns compared with last year.
- When comparing 2018/19 concern figures with 2016/17 the decrease is 41%.
- The reduction goes against the national trend which saw an 8% increase when comparing 2016/17 data with 17/18 data. Comparisons could not be made with 2017/18 and 2018/19 data as at the time of endorsement of this report 18/19 national data was not published.
- The Local Authorities in the partnership were required to provide an explanation to the Board on the reasons for these reductions responses were as follows:

Reading Borough Council

- Has seen a 37% reduction in the number of concerns from 2018/19 when comparted with 2017/18.
- There has been a change in practice which began in 2017/18 where safeguarding concerns raised that did not meet the safeguarding threshold are no longer counted.
- The number of safeguarding enquires has remained stable, indicating that risks are not being missed by this change in practice, and that recording of concerns has become more accurate as a reflection of safeguarding work required in Reading.
- Audits are to be undertaken in 2019/20 to ensure that safeguarding thresholds are consistently applied.
- From 2019/20 all logging of concerns will be completed by the Safeguarding Team rather than passing this onto Adult Social Care Teams, in order to ensure consistency and centralised oversight.

West Berkshire District Council

- Have seen a 20% increase in the number of safeguarding concerns from 2018/19 comparted with 2017/18.
- The 20% increase is attributed to increase in organisational safeguarding concerns in 2018/19, where all individuals in receipt of a service from a provider where there are organisational safeguarding concerns will have a safeguarding concern logged. This is not the practice Reading Borough Council or Wokingham Borough Council follow.
- There has been a change in practice, which began in 2017/18. The change in practice was that safeguarding concerns received, that did not meet the safeguarding threshold, were not counted as a safeguarding concern, when previously they were. This has led to an increase in the the percentage of safeguarding concerns that progress into a safeguarding enquiry.
- In 2019/20 West Berkshire District Council are to review their data collection methods which is likely to increase the number of safeguarding concerns.

Wokingham Borough Council

- Have seen a 17% decrease in the number of safeguarding concerns from 2018/19 comparted with 2017/18.
- It is Wokingham Borough Council policy that if anything is raised as a safeguarding concern it is counted as one; however this policy was not implemented for all of 2018/19 which would have resulted in the reduction seen. This policy is not consistent with Reading Borough Council and West Berkshire District Council.
- In 2019/20 Wokingham will be launching the Adult Safeguarding Hub, where all concerns will be recorded centrally ensure consistency in recording of safeguarding concerns.

In response to this data and the explanation from the Local Authorities, an independent audit into the safeguarding recording process across each Local Authority will be carried out in 2020/21. To

identify the inconsistencies in recording across the partnership and for the West of Berkshire Safeguarding Adults Board to agree to an approach to address these inconsistencies.

Trends across the area in 2018/19

- 67% of enquiries relate to people over 65 years in age, a slight increase when compared with 2017/18 where it was 62%.
- As in previous years more enquiries were in relation to women than men, with 61% of enquiries involving women. There this is an increase of 7% when compared with 2017/18 data where the outturn was 57%.
- 81% of referrals were for individuals whose ethnicity is White. This is consistent with 2017/18 data.
- For 11% of referrals made, the individual's ethnicity was not known, the same outturn as 2017/18.
- As in previous years the most common type of abuse for concluded enquires were for Neglect and Acts of Omission. This was followed by Physical, Psychological or Emotional abuse and Financial abuse.
- For the majority of cases, the primary support reason was physical support. For 16% of cases no primary support reason was identified, in 2017/18 this was 7%. This increase currently being investigated by the West of Berkshire Safeguarding Adults Partnership Boards, Performance and Quality Subgroup.
- As in previous years, the most common locations where the alleged abuse took place were a person's own home and a care home.

Challenges or areas of risk that have arisen during the year are recorded on our risk register, along with actions to mitigate the risks. These are some of the potential risks that we have addressed:

- A three year business plan was launched by the Board for 2018/19 to address the priorities in the 2018/19, however it was identified this approach meant that the actions were difficult to prioritise and monitor and therefore the Strategy and Business Plan was reviewed to ensure that the our key priorities were the main focus and we have returned to an annual business plan in 2019/20.
- We gained assurance from partners regarding the Emergency Duty Team sustainability, due to the negotiation the current contract.
- 25% reduction in Safeguarding concerns logged in 2017/18 compared with 2018/19, the reasons for this reduction was investigated and we were assured that the reduction was due to a change in the practice of recording of safeguarding concerns that did not meet the safeguarding threshold, which would have previously been counted, but were now logged and managed, through the care management process. An independent audit of this practice will be commissioned in 2020/21 to ensure that there is consistency applying the safeguarding procedures across the partnership.
- Through the Safeguarding Adults Review Process (SAR) we have identified that mechanisms and pathways in place across the locality to support people who Self-Neglect are not widely or fully understood. In response to this a Board priority for 2019/20 is: We will provide the partnership with the tools and framework to work effectively with people who Self-Neglect.
- We want to make sure that local priorities and arrangements to support and minimise risks for people who experience Domestic Abuse are fully understood. In response to this, a Board priority for 2019/20 is: The Board will work collaboratively with Local Safeguarding Children Partnerships, Community Safety Partnerships and Health and Wellbeing Boards to provide the workforce with the frameworks and tools to work with Vulnerable Adults who are at risk of Domestic Abuse.

- To ensure that arrangements to support people who have Mental Health issues were fully understood, a report detailing governance arrangements is presented to the Board on a six monthly basis.
- We are aware of capacity issues within the supervisory bodies to obtain timely Deprivation of Liberty Safeguards (DoLs) assessments and provide appropriate authorisations. This situation and numbers of DoLs applications continue to be monitored by the Board, through our Dashboard. We await national data for 2018/19 to compare performance with 2017/18.
- We have gained further intelligence to support the view that responsibilities under the Mental Capacity Act 2005 are not fully understood or applied in practice as a safeguard for people who may lack capacity. The Board accept that this is a significant challenge in safeguarding practice and will ensure that any work undertaken by the Board will ensure consideration of the Act so it is fully embedded within practice.
- We want to make sure that there is consistent use of advocacy services to support adults through their safeguarding experience. A key performance indicator is in place to monitor performance across the local authorities. Performance in has continued to improve, there has been an increase of 4% compared with the previous year (89% - 93%).
- We want to ensure that people who make safeguarding referrals receive feedback. Our training programme will be relaunched in 2019/20 where there will be emphasis on ensuring feedback is provided where appropriate, this is also checked in our safeguarding audit process where Local Authorities are required to audit 10% of completed Safeguarding Enquiries each month, using a standardised audit template.
- We want to make sure that people who experience the safeguarding adults process as adults with care and support needs, as well as their carers, have appropriate opportunities for involvement or engagement with the Board. A Task and Finish Group was held to identify a strategy, which was presented and approved in June 2019. The implementation of the strategy will take place in 2019-20.

Further safeguarding information is presented in the annual reports by partner agencies in **Appendix E.**

Achievements through working together

Our 2018/21 Strategy outlines what the Board aims to achieve in the next three years. The Board identifies strategic priorities that shape its work. These are reviewed each year and revised to reflect findings from performance information and case reviews.

Our priorities for **2018/19** and outcomes to those priorities were:

Priority 1: We will strengthen our communication and engagement across groups and communities in the West of Berkshire to ensure that our plans and actions are informed by the experience of a wide range of local people:

- The Board membership arrangements were reviewed and updated.
- There was a full review of all Board subgroups and new terms of references were set.
- A new subgroup was established to ensure that the voluntary and community sector are engaged and inform the work of the Board.

- Links with Local Safeguarding Children Partnerships, Safer Communities, Health and Wellbeing boards have been strengthened.
- A strategy has been approved to ensure that people who use services are able to influence the work of the Board.

Priority 2: We will extend our links with other partnerships to work together to break down barriers across agencies and to promote Think/Family/Think Community approaches.

- Work is in progress to establish a data set for the Board in regards to domestic abuse. A priority for 2019/20 has been agreed as: The Board will work collaboratively with Local Safeguarding Children Partnerships, Community Safety Partnerships and Health and Wellbeing Boards to provide the workforce with the frameworks and tools to work with Vulnerable Adults who are at risk of Domestic Abuse.
- The Board review on a six monthly basis to be assured that local safeguarding arrangements for people who have Mental Health issues are effective.
- Framework for the Management of Allegations against Persons in Position of Trust has been launched and is available on our website.
- An audit on Self-Neglect was completed and recommendations used to inform the Boards 2019/20 priorities and business plan.

Priority 3: We will share learning and develop innovative ways to support both paid and unpaid organisations across partnerships to continually build confidence and the effectiveness of everyone's safeguarding practice.

- Safeguarding Adult Reviews (SARs) have been completed and where appropriate published with practise learning notes for professionals.
- Learning from SAR/Audit Implementation plan has been devised in order for the Board to track progress on learning and to test that learning is effective.
- A successful Joint Children's and Adults Safeguarding Conference on the theme of Prevention and Early Intervention was delivered in January 2019.
- The Safeguarding Audit form has been and will continue to be updated to test learning has been embedded into practise.
- Partners completed the Boards Self- Assessment.

Priority 4: We will understand how effective adult safeguarding is across the West of Berkshire to ensure that we identify emerging risks and take action accordingly

- The Board has a Performance Dashboard and Key Performance Indicator Report which is managed by the Performance and Quality Subgroup and presented to the Board on a quarterly basis.
- Data in regards to Female Genital Mutilation (FGM) and Modern Slavery is being collected and the Performance and Quality Subgroup are reviewing this data to understand what this means for the West of Berkshire.

More information on how we have delivered these priorities:

- Additional achievements by partner agencies are presented in **Appendix B.**
- The completed Business Plan 2018-19 is provided in **Appendix C**.

Safeguarding Adults Reviews

The Board has a legal duty to carry out a Safeguarding Adults Review when there is reasonable cause for concern about how agencies worked together to safeguard an adult who has died, and abuse or neglect is suspected to be a factor in their death; or when an adult has not died but suffered serious abuse or neglect. The aim is for all agencies to learn lessons about the way they safeguard adults at risk and prevent such tragedies happening in the future. The West of Berkshire Safeguarding Adults Board has a Safeguarding Adults Review Panel that oversees this work.

During the reporting year, the SAR Panel have worked on 9 SARs of which 3 were endorsed by the Board and 1 was published along with a practice learning note. The Board plans to publish the other 2 safeguarding adult's reviews in 2019/20. Valuable learning has emerged from the all SARs and has fed into the Boards priorities and Business Plan for 2019/20. It is planned for the remaining 6 SARs to be endorsed by the Board in 2019/20. The Board recognised the increase in workload for the SAR Panel and in response increased the frequency of SAR Panel meetings from quarterly to monthly.

The case summaries and the learning from the 3 SARs that have been endorsed are as follows:

Gemma

Gemma had a pressure sore. Gemma was issued with a pressure care mattress to relieve pressure from her skin, as part of the management plan to support her.

Gemma's pressure sore deteriorated to a Category 4 and Gemma sadly passed away the same month. At the time of the deterioration it was identified that Gemma's pressure care mattress was not operating as prescribed. There were incidents reported where the mattress was indicating a fault.

A safeguarding concern should have been raised by the district nurse when the deterioration in Gemma's pressure sore was identified, but was not. A concern was raised by the hospital when Gemma was admitted.

The safeguarding enquiry that was completed by the Local Authority did not meet the required standard.

Findings

- Mattress Settings: it is the responsibility of the prescriber to follow up after installation of a pressure care mattress and to set the controls in line with the persons clinical need.
- Recording keeping: it is essential that clear records are kept, for the safe management of equipment provision and that all information relating to the device is co-ordinated and documented.
- Reporting Faults: information is always provided detailing how to contact the equipment provider, in the event of any issue with the equipment itself. The leaflet has been improved to encourage people not to throw it away.
- Review: of equipment by prescribers, is vital, to ensure that the equipment meets the persons needs.
- Safeguarding Concern: should be raised when there is a lapse in care which has led to a deterioration of a pressure sore.
- Safeguarding Enquiry: all actions taken in safeguarding enquiries must be clearly documented.

Aubrey

Aubrey was a 45-year-old man. He had significant and complex health needs. Aubrey still maintained a high degree of independence and was well known within his community. He had a supportive family network with which he maintained regular contact.

In late 2016 Aubrey was informed that his cancer had spread to his abdomen and lungs. Although offered chemotherapy, Aubrey declined this because he did not want to feel more unwell than he already did.

On June 23rd 2017, Aubrey was admitted to the Royal Berkshire Hospital with back pain, sepsis, and a sudden and marked deterioration in his speech and level of consciousness. A decision was made to provide Aubrey with palliative care to ensure comfort, and he was cared for at the Royal Berkshire Hospital until sadly he passed away on the 29th June 2017.

Aubrey's care provider was judged as an inadequate provider by the Care Quality Commission following their inspection of March 2017. All of the Packages of Care that this provider was supporting with were reviewed as a result.

Lessons Learnt

- Refusals by Aubrey to accept treatment / care and support / equipment were not fully considered.
- No formal capacity assessments recorded to determine whether Aubrey could consent to treatment / refuse equipment / care and support / be admitted to hospital etc.
- Initial assessment, risk assessment and review did not take into account need for multidisciplinary approach to working with Aubrey (given his poor health).
- Agencies did not recognise or fully assess risks resulting in Aubrey directing his own care without the full impact of these risks being mitigated by commissioners.
- Although agencies worked in a person centred way during direct intervention with Aubrey there was a lack of professional curiosity and multi-disciplinary discussion.
- Aubrey's family were heavily involved in his care and provided significant support to him. However their involvement is not reflected in work completed and consultation with Aubrey around this is also missing.
- Review of the care package carried out in late March 2017 (triggered by the CQC inspection) records that that there weren't any concerns regarding the quality of care being delivered. This appears to be solely based on Aubrey's expressed view that he was happy with his care.
- No effort was made to seek Aubrey's agreement to discuss his care with his family in order to

Paul

Paul lived with his cousin Bruce, prior to his death Paul's Uncle/Bruce's father lived with them also. Paul and Bruce had a volatile relationship but were close. When they were required to move from their family home after the death of Paul's Uncle/Bruce's father, their volatile relationship became more problematic.

Both Paul and Bruce were known to Adult Social Care and both had complex needs. Paul did not engage with services, but Bruce did. Paul's son was concerned that his father was self-neglecting.

There were numerous allegations made by Bruce that Paul had hit him, however the response from the local authority in regards to these allegations was not compliant with Section 42 of the Care Act and did not follow best practice in regards to Domestic Abuse.

Paul was discovered on the floor in his home by a visitor. He had been there for more than 24 hours; Bruce did not/could not raise the alarm. Paul passed away in hospital. There was an initial concern that Bruce had caused harm to Paul but a police investigation concluded there was no evidence of this. After his death Bruce struggled to cope and was eventually detained under the Mental Health Act.

Findings

- Paul and Bruce's needs were assessed by Adult Social Care individually but without consideration of them holistically.
- Paul did not engage with services but this was exacerbated by the staff turnover in adult social care which was not conducive to building a relationship with him.
- Commissioning of support could have been improved to provide feedback on the home life situation of Paul and Bruce.
- Pauls' refusal of services was accepted by Adult Social Care without consideration of the risks to Paul and Bruce, or the concerns raised by Paul's family about possible self-neglect.
- Safeguarding processes were not followed, and the risks to Paul and Bruce were not effectively addressed.
- Paul and Bruce were spoken to together regarding the concerns regarding Domestic Abuse, best practice is that perpetrator and victim should never be interviewed together as this can result in greater risk to the person.
- Paul's case was closed by Adult Social Care even though there were ongoing safeguarding concerns.
- Use of advocacy was identified for Bruce but not for Paul.
- Paul and Bruce were not identified as each other's carers. Paul was sometimes identified as Bruce's carer but not the other way round. Neither Paul nor Bruce were offered carers assessments.
- When a strategy meeting was held people who needed to be involved in the case were not at the meeting, meaning that not all the risks were identified or addressed.
- Support given to Bruce after Paul's death was lacking, there was a poor partnership response to Bruce.
- Making Safeguarding Personal principles were not applied.
- Learning from previous SARs, commissioned by the Board, has not been embedded into practice.
- The Board requires assurance regarding the quality of supervision across the partnership

How is learning from SARS embedded within in practice?

The Board accepts that improvements are required in ensure that lessons learnt from SARs are embedded within practice. We have created Learning from SARS/Audit Implementation Plan where all findings from SARS and other Board learning are added and tracked. From the three SARS endorsed by the SAB have identified the following themes:

- Family/Carer Engagement
- Organisational Safeguarding
- Safeguarding Processes
- Support and Supervision
- Training
- Tissue Viability

We are committed to ensuring that our priorities are current and have and will change priorities in order to support learning from its SARs.

There is a dedicated page on the Board's website for case reviews:
http://www.sabberkshirewest.co.uk/board-members/safeguarding-adults-reviews/

Key priorities for 2019/2020

We understand that priorities will change and as we learn from partner agencies both locally and nationally and that the priorities must be achievable. The priorities for 2019/20 have been reviewed and updated to:

Priority 1: We will provide the partnership with the tools and framework to work effectively with people who Self-Neglect.

- People who use services are able to influence the work of the Board.
- Comprehensive policies and procedures are in place in regards to Self-Neglect, which are accessed and followed by the partnership.
- Safeguarding Training to be reviewed to ensure that it addresses Board Priorities.
- We are assured that there is sufficient management oversight in regards to safeguarding. There is a decision by the Board on the 'SAM' function in Local Authorities and this is implemented.
- We are assured that there is adequate training in pressure care across the partnership.
- There is a standardised approach to risk management across the partnership.

Priority 2: The Board will work collaboratively with Local Children's Safeguarding Partnership, Community Safety Partnerships and Health and Wellbeing Boards to provide the workforce with the frameworks and tools to work with Vulnerable Adults who are at risk of Domestic Abuse.

- There is a clear Domestic Abuse Strategy in conjunction with LSCPs, CSPs and H&WBBs.
- There is a clear framework and toolkits to support the partnership with regard to Domestic Abuse.

Priority 3: We will understand the main risks to our local population in regards to Targeted Exploitation and agree how best to equip the partnership to Safeguard vulnerable people against these risks.

- There is a pathway in place to support the partnership in working together to respond to Modern Slavery and Human Trafficking Issues.
- We understand who is most at risk and can agree where focus is needed.
- There is a clear plan on how to support those most at risk from targeted exploitation.

Priority 4: The Board will understand from key stakeholders, why there has been an increase in organisational safeguarding and seek assurance from commissioners, that there are adequate preventative measures in place that is consistent across the partnership where practical.

- Providers who deliver services are able to influence the work of the Board in regards to organisational safeguarding.
- We are clear on the issues facing the CQC and commissioners in regards to organisational safeguarding.
- We are fully aware of the level of organisational safeguarding across the partnership
- There is an effective framework in place for responding to organisational safeguarding concerns.
- There is a consistent approach to quality monitoring of Adult Social Care Providers across the partnerships. Frameworks are published on our Website.

The Business Plan for 2019-20 is attached as **Appendix D.**

Appendices

Appendix A - Board Member Organisations

Appendix B - Achievements by partner agencies

Appendix C - Completed 2018-19 Business Plan

Appendix D - 2019-20 Business Plan

Appendix E - Partners' Safeguarding Performance Annual Reports:

- Berkshire Healthcare Foundation Trust
- Reading Borough Council
- Royal Berkshire NHS Foundation Trust
- West Berkshire Council
- Wokingham Borough Council