TO:	**ADULT SOCIAL CARE, CHILDREN'S SERVICES AND EDUCATION COMMITTEE**		
DATE:	**5 APRIL 2018**	**AGENDA ITEM:**	**8**
TITLE:	**SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2016-17**		
LEAD COUNCILLOR:	**EDEN**	**PORTFOLIO:**	**ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICER:	***NATELIE MADDEN***	**TEL:**	**07718 120601**
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0RGANIATION:	**WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD**		

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Safeguarding Adults Board (SAB) must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies.

1.2 The overarching purpose of a SAB is to help and safeguard adults with care and support needs. It does this by: assuring itself that local safeguarding arrangements are in place, as defined by the Care Act 2014, and statutory guidance; assuring itself that:

- Safeguarding practice is person-centred and outcome-focused;
- Working collaboratively to prevent abuse and neglect where possible;
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred;
- Assuring itself that safeguarding practice is continuously improving;
- Enhances the quality of life of adults in its area

1.3 The Annual Report 2016-17 presents what the SAB aimed to achieve on behalf of the residents of Reading, West Berkshire and Wokingham during 2016-17. This is both as a partnership, and through the work of its participating partners. It provides a picture of who is safeguarded across the area, in what circumstance and why. It outlines the role and values of the SAB, its ongoing work and future priorities.

Appendices which outline the report and its achievements are attached to the report as follows:

Appendix A Board member organisations
Appendix B Achievements by partner agencies
Appendix C Completed Business Plan 2016-17
Appendix D Business Plan 2017-18
Appendix E Partners Safeguarding Performance Annual Reports:

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

- Wokingham Borough Council

Appendix F Safeguarding Adults Training Activity

2. RECOMMENDED ACTION

2.1 That the report be noted.

3. POLICY CONTEXT

The SAB has a duty to develop and publish a Strategic Plan setting out how it will meet its objectives and how members and partner agencies will contribute. The Annual Report details how effectively these objectives have been met.

The Board's Strategic Plan will be revised and published in April 2018. It will shape the work of the Board for the next three years and will be informed by need. Partners, service users, carers and local communities will be invited to give their views on priority areas for development.

4.0. CONTRIBUTION TO STRATEGIC AIMS

4.1 The annual report outlines how partner agencies have contributed to the work of the Safeguarding Adults Board in supporting vulnerable adults, contributing to the strategy's aims 2 and 6 of: Reducing loneliness and social isolation and Making Reading a place where people can live well with dementia.

5 The proposal recognises that plans in support of Reading's 2017-20 Health and Wellbeing Strategy should be built on three foundations - safeguarding vulnerable adults and children, recognising and supporting all carers, and high quality co-ordinated information to support wellbeing. The proposal specifically addresses these in the following ways:

The report outlines how partner agencies have contributed to the work of the Safeguarding Adults Board in supporting vulnerable adults.

6. COMMUNITY & STAKEHOLDER ENGAGEMENT

6.1 Not applicable.

7. EQUALITY IMPACT ASSESSMENT

7.1 Not applicable.

8. LEGAL IMPLICATIONS

8.1 The Safeguarding Adults Board has a duty under the Care Act 2014 to publish an Annual Report detailing how effective its work has been.

9. FINANCIAL IMPLICATIONS

9.1 Not applicable.

10. BACKGROUND PAPERS

10.1 None.

West of Berkshire Safeguarding Adults Board

Annual Report 2016-17

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

Message from the Independent Chair

I am very pleased to introduce the Annual Report for the West of Berkshire Safeguarding Adults Board 2016-17. I am in my first year as the Independent Chair and I am very grateful to all partners for their welcome to me in this role, and for their ongoing support. The Annual Report reflects the partners' commitment and enthusiasm for taking forward shared vision and actions over the past year, to develop the work of the Board and to respond to the relatively new demands of statutory status.

This Report shows what the Board aimed to achieve on behalf of the residents of Reading, West Berkshire and Wokingham during 2016-17, both as a partnership and through the work of its participating partners. It illustrates an increasingly ambitious agenda and what the Board has been able to achieve, as well as those areas for action that we still need to address. The Report provides a picture of who is safeguarded across the area, in what circumstance and why. This helps us to know what we should be focussing on for the future.

We are keen to ensure that the work of the Board is accountable to local people and I am looking forward to working with partners to find new ways of hearing from and engaging with local individuals and community groups, so that our work is directly informed by learning from people's experience of local services.

I am very aware of the pressures on partners in terms of resources and capacity so would like to thank all those who have engaged in the work of the Board, for their time and effort. In particular, I would like to thank Natalie Madden, the Safeguarding Adults Board's Business Manager, for her organisational support, which makes an enormous contribution towards helping the Board deliver its aims and objectives. There is a great deal that we need and want to do to reduce the risks of abuse and neglect in our community and to support people who are most vulnerable to these risks. I am confident that the Board's partners have the vision and dedication to achieve our shared aims and I look forward to continuing to chair the partnership in the next year to progress our work.

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 West Berkshire 01635 519056 Wokingham 0118 974 6800

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:

Physical	Domestic	Sexual	Psychological
Financial	Modern slavery	Discriminatory	Organisational
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: http://www.sabberkshirewest.co.uk/practitioners/berkshire-safeguarding-adults-policy-and-procedures/

Trends across the area in 2016-17

Safeguarding trends across the area are largely the same as last year. The Board is alert to the need to consider the implications of these recurring trends and will address them in the Strategic Plan 2018-21 which will be ready for publication in April 2018.

- The number of safeguarding concerns continues to increase year on year.
- As in previous years, the majority of enquiries relate to older people over 65 years.
- More women were the subject of a safeguarding enquiry than males, as in previous years.
- Individuals with a White ethnicity are more likely to be referred to safeguarding and the proportion is higher than for the whole population.
- In all three local authority areas, the most common types of abuse were for Neglect and Acts of Omission. This was followed by Psychological Abuse and Physical Abuse in West Berkshire and Reading, but in Wokingham there were more cases of Physical Abuse than Psychological Abuse.
- For the majority of cases, the primary support reason was physical support.
- The most common locations where the alleged abuse took place were a person's own home and a care home.
- The majority of concluded enquiries involved a source of risk known to the individual in Reading and West Berkshire but the source of risk in Wokingham was social care support.

Challenges or areas of risk that have arisen during the year are recorded on the Board's risk register, along with actions to mitigate the risks. These are some of the challenges that the Board has addressed:

- Management of allegations against people in positions of trust - a multi-agency guidance document is in under development to ensure robust and consistent processes are applied by partner agencies.
- Deprivation of Liberty Safeguards (DOLS) remains an area of high demand and impact for both strategic safeguarding teams and operational services.
- Restructures within agencies and new ways of working has meant that there have been some wider operational challenges, including staff turnover and waiting lists for non-urgent case work.
- Use of advocacy and the availability of appropriate adults to support people, (for example at police interviews) are areas requiring partnership working to understand the issues and raise awareness.

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

Achievements through working together

Partners have worked together to deliver the agreed priorities and outcomes of the Business Plan 2016-17:

Priority 1 - Establish effective governance structures, improve accountability and ensure the safeguarding adults agenda is embedded within relevant organisations, forums and boards.

Develop oversight of the quality of safeguarding performance: The Board's Quality Assurance Framework (QAF) was revised and published. Its aim is to develop the Board's oversight of the quality of safeguarding performance and to promote openness and transparency across partners. Under the umbrella of the QAF:

- Partners completed a self-assessment audit of their strategic and operational arrangements to safeguard, producing an action plan to address areas for development. Themes arising from these audits were shared at the Business Planning day on 6 February 2017 and informed the development of the Business Plan for 2017-18.
- A peer review of case file audits on Section 42 safeguarding enquiries took place in August and February. This multi-agency approach encourages transparency and consistency and allows the panel to explore practice decisions and alternatives, and compare and contrast decision making. The auditing process helped identify gaps in practice knowledge, skill and application and an action plan was developed to address areas for development which will continue to be monitored in the coming year.
- Making Safeguarding Personal (MSP) principles are included in the peer review of the case file audit of Section 42 enquiries. The audits revealed that a shift in practice is still required to fully embed MSP across the partnership and this remains a focus for the coming year.
- A programme of multi-agency thematic reviews for 2017-18 has been agreed based on learning from Safeguarding Adults Reviews and other significant incidents. The themes will be dementia, pressure care and risks within own home.

Have in place an effective framework of policies, procedures and processes for safeguarding adults: Under the remit of the Berkshire Policy and Procedures Subgroup, the Berkshire Multi-Agency Safeguarding Adults Policy and Procedures were launched and consulted on, with a reviewed version published in October 2016. This year the group met quarterly to share good practice and identify opportunities for joint working, making recommendations to the Boards where additional policies and procedures were required, such as a process for managing allegations against people in positions of trust.

Raise the profile of the Board: Presentation of the Board's Annual Report 2015-16 to Health and Wellbeing Boards and other committees occurred via senior Board members within the three Local Authorities. The Board acknowledges that it needs to raise the profile of its work still further across partner organisations and this will be a focus for the new Independent Chair in the coming year.

Priority 2 - Raise awareness of safeguarding adults, the work of the board and improve engagement with a wider range of stakeholders

The Board is confident that professionals are accessing the online Berkshire Policy and Procedures: The Communication Subgroup evaluated awareness of and use of the Berkshire Policy and Procedures through a survey of practitioners and website analytics. Website analytics evidence increased number of views on the relevant page but it is anticipated that the launch of a new interactive website for the Policy and Procedures in 2017 will increase usage still further.

Communication Strategy: The Board's Communication Strategy was agreed and promoted in December in order to ensure clear communication processes and joint working in the event of a significant safeguarding incident.

All Board members understand their role: A revised Induction Pack to support new members in their role was published. Attendance at Board meetings and subgroups is monitored on a quarterly basis and any issues of non-attendance escalated to senior board members. The Board has again benefitted from good attendance this year, although it remains a priority for the Independent Chair to broaden membership of the board and subgroups to reflect a wider range of stakeholders, in particular, provider services.

Managers and staff are aware of the learning from SARs in order to keep people safe: Final reports and briefing notes summarising the learning from SARs have been produced and published. The publication of the report on the Case of Mrs H was delayed as a result of criminal proceedings, although an action plan in response to the learning was produced and delivered within agreed timescales.

Actions to raise awareness: A survey of practitioners received a very positive response of over 330 returns. In response to the findings, an action plan was delivered to help the Board raise awareness of its function and local safeguarding processes.

Briefing notes are written by the Business Manager and published quarterly, summarising Board meetings and other key information arising from the work of the subgroups, case file audits, significant incidents and other local and national developments.

Representatives from CLASP (Caring, Listening and Supporting Partnership) in Wokingham wrote the script and featured in a video produced by Berkshire Healthcare Foundation Trust, in order to raise awareness of Making Safeguarding Personal: *link to be added*

Priority 3 - Ensure effective learning is shared

Workforce development activities to ensure staff receive the appropriate level of safeguarding adults training include:

- The annual joint conference was held on 23 September 2016, based on the theme of Safeguarding Children and Adults with Disabilities. 130 practitioners attended and it was evaluated as good or excellent by 100% of delegates.
- Levels 2 and 3 safeguarding training standards were reviewed to ensure alignment with the Berkshire Policy and Procedures.
- The Safeguarding Adults Train the Trainer programme was delivered by Wokingham Borough Council and offered across the west of Berkshire.

- The Workforce Development Strategy was reviewed and updated to reflect the revised social care competence framework and intercollegiate document.
- Making Safeguarding Personal awareness training was delivered for the private, voluntary and independent sector.

Improve mechanisms to share learning from good and bad practice more widely: Workshops to share learning from a Safeguarding Adults Review (the Case of Ms F) took place. Briefing notes on Safeguarding Adults Reviews (SARs) were published and shared with trainers for inclusion in training sessions. The Board has planned a programme of multi-agency thematic audits for 2017-18 based on themes arising from SARs in order to seek assurance that learning from SARs has been embedded in practice.

Priority 4 - Coordinate and ensure the effectiveness of what each agency does

Compliance with the new Berkshire Policy and Procedures: The Berkshire Multi-Agency Safeguarding Adults Policy and Procedures 2016 were launched and support staff to respond appropriately to all concerns of abuse or neglect they may encounter, providing a consistent response across the county. They are currently published on the West of Berkshire Safeguarding Adults Board's website but it is a priority for 2017-18 to launch a new, interactive and easy to use website specifically for the Policy and Procedures. Under the Board's Quality Assurance Framework, peer reviews of case file audits are undertaken to test compliance with the Policy and Procedures and Making Safeguarding Personal, with findings reported to managers and the Board.

Service user feedback indicates that clients' desired outcomes are met, in line with MSP and the well-being principle: The Board sought assurance that local authorities collected service user feedback and measured outcomes for individuals who have been through the safeguarding process. However, in the coming year the Board will seek further assurance from the local authorities that not only robust processes are in place but that feedback is responded to and used to inform service delivery.

Involvement of advocates and independent mental capacity assessors ensure person centred responses are promoted: Feedback from practitioners and providers and quarterly performance information helped the Board identify areas where the use of advocates needed to improve. Actions were taken to raise staff awareness as to how and when to involve advocates and HealthWatch Reading presented the advocate's perspective at the Board meeting in March to help partners understand what more could be done to increase the use of advocates and improve partnership working between advocates and social workers. Involvement of advocates to ensure a person centred approach to safeguarding will continue to be monitored in the coming year.

The Board is assured that learning from SARs has been responded to appropriately by agencies: a combined action plan to embed learning from the SARs on the case of Mrs H and Mr I was developed and monitored by the Effectiveness Subgroup and in June 2017 the Board was given assurance that all actions have been delivered. The Board's self-assessment audit tool has been amended to reflect learning from these cases.

More information on how we have delivered these priorities:

- Additional achievements by partner agencies are presented in Appendix B.
- The completed Business Plan 2016-17 is provided in Appendix C.
- Training activity is provided in Appendix F.

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 Board did not commission any new Safeguarding Adults Reviews. It did oversee the development of an action plan to ensure learning from two cases commissioned in the previous year (Mrs H and Mr I) was embedded. Themes arising from these two case reviews informed a programme of multi-agency thematic reviews and a review of the self-assessment audit tool.

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

Wokingham Borough Council undertook its second Domestic Homicide Review (DHR) during this period; the Independent report is currently with the Home Office awaiting publication. Valuable learning has emerged from the review and led to specific audit outcomes for the SAB in terms of pathways for people living with dementia and the application of the principles of the Mental Capacity Act 2005. Learning outcomes have been incorporated into the training strategy in addition to recommendations on the use of recording systems and information sharing.

Key priorities for 2017-18

Priority 1 - We have oversight of the quality of safeguarding performance

- Feedback indicates that customers' desired outcomes are met, in line with Making Safeguarding Personal and the well-being principle.
- We understand what the data tells us about where the risks are and who are the most vulnerable.

Priority 2 - We listen to the service user, raise awareness of adult safeguarding and help people engage

- We work with communities to raise awareness of adult safeguarding.

- We raise awareness of the Board and the Berkshire Policy and Procedures.
- Board membership reflects a wide and varied group of stakeholders.

Priority 3 - We learn from experience and have a skilled and competent workforce

- Learning is shared and used to improve practice.
- Areas for development in 2017-18:

Safe recruitment	Allegations management	Self-neglect
Domestic Abuse	Mental Capacity Act	Mental Health

Priority 4 - We work together effectively to support people at risk

- People are supported by an advocate when they need it.
- We work within a framework of policies and procedures that keep people safe.
- Providers are supported to deliver safe, high quality services.
- We provide feedback to people who raise a safeguarding concern.
- We are assured that local arrangements to support and minimise risks for people who self-neglect are effective.
- Practitioners understand and can apply the MCA consistently in practice.
- We are assured that local arrangements to support people who have Mental Health issues are effective.
- We are assured that effective local arrangements are in place to support and minimise risks for people who experience Domestic Abuse.
- We have a modern slavery strategic pathway to help identify and support victims.

The Business Plan for 2017-18 is attached as Appendix D.

Strategic Plan 2018-21

The Board's Strategic Plan will be revised and published in April 2018. It will shape the work of the Board for the next three years and will be informed by need. Partners, service users, carers and local communities will be invited to give their views on priority areas for development.

Appendices

Appendix A Board member organisations

Appendix B Achievements by partner agencies

Appendix C Completed Business Plan 2016-17

Appendix D Business Plan 2017-18

Appendix E Partners Safeguarding Performance Annual Reports:

Berkshire Healthcare Foundation Trust

Reading Borough Council

Royal Berkshire Foundation Trust

West Berkshire Council

Wokingham Borough Council

Appendix F Safeguarding Adults Training Activity

Appendix A Board member organisations

Under the Care Act, the Board has the following statutory Partners:
Berkshire West Clinical Commissioning Group
Reading Borough Council
Thames Valley Police
West Berkshire Council
Wokingham Borough Council.

Other agencies are also represented on the Board:
Berkshire Healthcare Foundation Trust
Community Rehabilitation Service for Thames Valley
Emergency Duty Service,
National Probation Service
Royal Berkshire Fire and Rescue Service
Royal Berkshire NHS Foundation Trust
South Central Ambulance Trust
HealthWatch Reading
The voluntary sector is represented by Reading Voluntary Action, Involve Wokingham and Empowering West Berkshire.

Appendix B Achievements by partner agencies

Berkshire Health Foundation Trust (BHFT)

BHFT has achieved a 93.8% compliance at Safeguarding Level 1 training and increased compliance at Level 2 training. 86.5% of staff are now trained for PREVENT (WRAP) training and compliance for MCA and DoLS training was also achieved. Mental Capacity Act champions have been appointed for each of the community wards to improve application of the Mental Capacity Act in patient care. The safeguarding children and adults teams have amalgamated to facilitate a more joined-up, 'think family' approach to safeguarding.

BHFT has adopted the *Suicide: Aspiring for Zer*o approach to suicide reduction, a model based on the premise that suicide can be prevented. Systems have been optimised to enable staff to focus on engagement and collaborative approaches to risk assessment and management, keeping service users and carers at the centre. A new risk management tool has been developed to combine risk assessment, risk management and a service user safety plan, and the approach to risk audit has been refreshed. 'Suicide surveillance' involves the provision of timely support for those families bereaved by suicide and staff affected, as well as heightening awareness of community risks of contagion or suicide clusters and identifying public places where suicides/incidents are occurring. There is a high priority for learning from suicide deaths. Training and supervision has been implemented to equip staff with skills and competence (measured with the zero suicide surveys) to practice recovery focussed, compassionate approaches to suicide risk assessment and enable positive risk management and safety planning.

Clinical Commissioning Groups

The Clinical Commissioning Groups (CCGs) have continued to raise the profile of safeguarding adults across primary care and with health commissioned providers. In 2017, Mental Capacity Act awareness training and tools has been promoted. The 2016 GP safeguarding self-assessment audit highlighted improvements in safeguarding training compliance and the recording of safeguarding within GP practice. A 98% response rate in the audit was achieved and showed a good engagement of primary care.

The quality team and safeguarding team have in place quality monitoring indicators and processes for safeguarding for commissioned providers and this includes quality assurance visits to providers, self-assessments, quality schedule reports and close working with providers to support safe and effective care. Practical application has been a focus and has been supported by the introduction of templates for GP reporting on enquiries and the commissioning of an electronic database for continuing health care to manage Deprivation of Liberty Safeguarding cases. In addition, the safeguarding and quality team have introduced a commissioning checklist in line with safeguarding and best practice for the organisations.

The CCGs safeguarding team was restructured in 2016 and led to the appointment of two new safeguarding heads of service. The head of adult safeguarding co-facilitated and undertook a Safeguarding Adult Review on behalf of the Board in 2016 with partner agencies and has contributed to multiple reviews, including partnership learning, Domestic Homicide Reviews and individual safeguarding cases across the area. Multi-agency audits and training events have been co-ordinated and contributed to by the head of adult safeguarding.

Reading Borough Council

Reading continues to audit 20% of the safeguarding enquiries that are investigated by the teams in Reading. Feedback is given to practitioners and team managers regarding the outcomes of these audits. The safeguarding team also reviews the concerns that do not progress to enquiry to ensure consistency and continuity of decision making.

Reading Borough Council holds level 1, 2 and 3 training ensuring that staff are trained to the appropriate level depending on their job role. Feedback is received after every training session and training is quality assured.

Reading Borough Council has employed a Safeguarding Adults Manager to manage the team and a Principal Social Worker to ensure best practice and that legislation is understood and followed. The safeguarding team works closely with the Quality and Performance Team and the Registered Managers Forum to ensure that provider services are well informed on safeguarding and their responsibilities. The safeguarding team works in collaboration with other internal departments such as Housing, Environmental Health, Anti-Social Behaviour Team and Children's Social Care. The team regularly meet with the safeguarding team from BHFT to review open enquiries and ensure that due process is followed. The teams worked together over concerns at Prospect Park Hospital. They also discuss safeguarding concerns with the lead at the RBH. The team attend multi-agency meetings such as MAPPA and MARAC.

Royal Berkshire Fire and Rescue Service

Royal Berkshire Fire and Rescue Service (RBFRS) promoted their Adult at Risk Protocol and provided awareness raising training to improve referral rates. Across Berkshire, RBFRS has trained 12 organisations under the adult referral programme initiative outside of emergency service partners. This has generated 1761 vulnerable adult referrals to RBFRS across Berkshire.

RBFRS works to identify foreseeable risk to our communities and deliver effective, managed, timely performance in a wide range of disciplines, preventing and protecting the public along with delivering effective response to incidents when required. Partnership working and information sharing with a wide range of groups and agencies have enables identification and protection to the most vulnerable members of our communities. The fire risk based preventative intervention supports individuals to live independently and safely in their own homes.

The work of RBFRS has continued to drive down fire deaths and casualties in our communities. The Integrated Risk Management Process (IRMP) has been consulted on with the public, with proposals to further develop and improve the service. This will focus attention on those groups evidenced at being more vulnerable to fire death and those whose lifestyle choice places them at elevated risk of having an accidental fire and receiving associated injury.

RBFRS is working in partnership to provide falls, age related and winter warmth services, delivered as part of our Home Fire Safety Check process, signposting those people assessed as being at risk to partner agencies.

Royal Berkshire Fire and Rescue Service (RBFRS) is undergoing an internal restructure due to be completed by the end of August 2017, and will include a dedicated Designated Safeguarding Officer to provide significant increased capacity and improve service delivery.

Royal Berkshire NHS Foundation Trust

Royal Berkshire NHS Foundation Trust's strategic safeguarding committee has continued to oversee all aspects of adult safeguarding and child protection. The Safeguarding (adults) clinical governance group has gone from strength to strength. Three medical clinical leads have formed a valued part of the safeguarding team.

The Trust has seen a further rise in numbers of adults with vulnerabilities attending and admitted to the Royal Berkshire Hospital and an increase in the complexity of cases. There has been a significant amount of multiagency work to improve the safeguarding of mental health patients, governance arrangements and the application of the Mental Health Act in practice, which are encompassed in the 'Let's Talk Mental Health' programme of work.

A reduction in the numbers of DoLS applications during 2016-17 and inconsistent application of the MCA in practice are being addressed by a *Mental Capacity, DoLS and Best Interest* working group that has agreed a programme of work called 'Capacity Matters'. Training in Mental Capacity and DoLS forms part of the Core Mandatory training day held three times a month and new staff induction held monthly. Enhanced Mental Capacity Act and DoLS training compliance for senior clinical staff is as expected at 80%.

Safeguarding training continues with staff compliance at 90%.

Learning from two Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs) is included in safeguarding adults training. Learning from a DHR has been discussed at clinical governance in the area where the patient was being treated and at the Trust Quality Assurance and Learning Committee. The Lead Nurse for adult safeguarding was included as part of the review team for two SARs and as Independent Management Review (IMR) writer for the DHR.

Safeguarding concerns continue to be raised centrally via the Datix incident reporting system; this assists in giving feedback to the individual who raised the concern where available, and provides one reporting mechanism. Externally raised safeguarding concerns

trigger a fact finding exercise by the Safeguarding Nurse (Adults). This information is given to the Local Authority to decide on the outcome of the concern and next steps. The majority of safeguarding concerns raised against the Trust continues to be around pressure damage: in the majority of cases there continues to be a lack of information provided regarding pressure damage as part of the discharge process. Concerns raised about Trust staff are investigated under the Trust's Managing Safeguarding Concerns and Allegations Policy and, where appropriate, referrals made to outside agencies e.g. the police or Adult Safeguarding Manager. Quarterly review meetings to close cases and identify themes have been established.

Trust staff continue to be active members of the Board and its subgroups.

South Central Ambulance NHS Foundation Trust

South Central Ambulance NHS Foundation Trust (SCAS) works closely with partner agencies and Safeguarding Boards across the area to ensure that developments benefit the people who use services. As an organisation that covers seven counties, SCAS aims to include wherever possible all of the Boards' development plans within its own safeguarding development.

Actions for the coming year include: forge closer links with safeguarding hubs across the area; moving to a paperless referral process; regularly undertaking multi-agency audits and reviews of safeguarding referrals; and encouraging regular feedback from partner agencies with regard to safeguarding cases. These actions will form part of a SCAS action plan that will be presented and monitored on a bi-monthly basis at the Patient Safety Group meeting, which feeds directly into the Trust's board.

Thames Valley Police

Thames Valley Police (TVP) continues to work with partners and the community through Emergency Response, Investigation, and Neighbourhood Policing roles to prevent and investigate crimes and antisocial behaviour as well as manage and mitigate harms to vulnerable people and groups through integrated problem-solving. This includes the provision of specialist safeguarding resources for MARAC, MAPPA and PREVENT sessions, as well as tackling thematic issues including: Modern Slavery, Domestic Abuse, Hate Crimes and Fraud. A Police and Health collaboration for a Street Triage car to support those in Mental Health crisis and further outreach partnerships with statutory partners and third sector workers has provided capacity to support those vulnerable in the Night Time Economy, including rough sleepers, in our larger towns. A joint TVP and third sector project to support vulnerable women won the 2017 Howard League Community Award against stiff competition from across the UK and is helping in the development of a trauma-informed approach to safeguarding. TVP continue to roll out 'Need to Know' sessions to partners to raise awareness of adult exploitation by organised criminals in our communities, with 200+ frontline practitioners trained so far this year. TVP have resourced police liaison officers in Prospect Park Hospital and the Royal Berkshire Hospital to work with staff and improve

safeguarding procedures across systems and are working with the BHFT Liaison and Diversion Service to navigate people into support services and away from Criminal Justice outcomes.

Voluntary and Community Sector

During 2016/17, the voluntary and community sector has had regular attendance at the West of Berkshire SAB, with the three infrastructure organisations across Berkshire West, Reading Voluntary Action, Involve Wokingham and Volunteer Centre West Berkshire, sharing this role.

Reading Voluntary Action (RVA) raises awareness of the work of the Board with quarterly news items reaching more than 1400 voluntary and community groups and individuals. In November 2016 we published a news item "Are you aware of the Berkshire Safeguarding Adults procedures?" to inform the sector of the relevant procedures and support available. RVA began a programme of workshops specifically for trustees to ensure they are aware of their roles and responsibilities for safeguarding adults. The workshops are delivered on a quarterly basis and RVA's Advice Worker offers follow-up support to draft or review policies and procedures.

Involve

During 2016/17 the Wokingham Adults Safeguarding Forum, now chaired by a member of the voluntary sector, held regular meetings to share information and news in relation to adult safeguarding issues, initiatives, themes and training. Involve delivered two training sessions attended by 21 people from Wokingham and have an approved Level 1 facilitator. In April, Involve held a Community Awareness Event at the Earley Crescent Centre supported by public sector partners to raise awareness of the safeguarding processes at which there were 50 attendees.

The **Volunteer Centre West Berkshire (VCWB)** raises awareness of the work of the Board by the regular newsletter that goes out to over 700 voluntary and community groups and individuals. VCWB attended the newly created Making Every Adult Matter multi-agency partnership working group aimed at supporting vulnerable homeless adults and young people in West Berkshire with safeguarding being a big part of this work.

West Berkshire District Council

Ongoing collaborative and partnership working for Adult Social Care (ASC) and Prevention & Safeguarding (P&S) services has been a key highlight for the year against a background of significant organisational and staff changes.

The main achievement has been to continue to respond effectively to a high volume of demand and increased need for specific safeguarding support to ensure all concerns are responded to appropriately. Data for 2016-17 includes 266 Section 42 enquiries concluded and 705 DoLS applications received and processed.

The Making Safeguarding Personal agenda is well established and understood by practitioners although there is still room to improve the way that practitioners deliver on the agenda.

Collaborative working within WBC was undertaken to develop and agree refreshed procedures in April 2017. However, there is further strategic review and development required to ensure triangulation with the next Berkshire Multi-Agency Adult Safeguarding Policy and Procedures review planned for the autumn 2017.

Joint working with key partners and external agencies is a key focus for on-going development and strong links are being established within WBC directorates, Thames Valley Police and Health colleagues with a key focus on improving outcomes for adults at risk in a preventative manner. This includes the ongoing development of the Prevent agenda, service user forums, provider forums, and regular attendance at MARAC, MAPPA and CCG sessions.

Internally staff are sharing information and resources to improve Section 42 outcomes that include independent chairing of strategic enquiries, utilising Family Group Conference and accessing risk information from Children Services.

ASC has built on areas of joint-working with some key partners, for example with Housing colleagues and Primary Care, to improve outcomes for vulnerable people. ASC has worked to support the local implementation of the Prevent Strategy.

Wokingham Borough Council

Wokingham Borough Council (WBC) have undertaken a full training needs analysis for Adult Social Care and integrated services to support workforce development and continued professional development. The strategy aims to ensure training is focused and targeted, cost efficient and aligns to the board's priorities. Key areas such as, Self-Neglect and Hoarding, Human Trafficking and Modern Slavery, Person Centred Assessment and Recording Skills, PREVENT, Childhood Sexual Exploitation and Positive Risk Taking Principles are included.

During this period Caring Listening and Supporting Partnership (CLASP) supported the development of an online video made by people who use services. The aim was to help people understand the outcomes they want in line with Making Safeguarding Personal principles. The video was commissioned under the Communications Subgroup of the SAB and will be widely launched in the coming year.

This year has seen significant progress in embedding a multi-agency partnership approach under local Care Governance arrangements. The model developed and adopted by WBC demonstrates a strong commitment to preventative safeguarding and timely responses to quality concerns in provider services by all key partners including providers, Clinical Commissioning Groups (CCG), Care Quality Commission (CQC), local authority, Thames Valley Police (TVP) and other commissioners. By providing a clear accountability framework which triangulates information to identify emerging themes and issues, the framework aims

to reduce the risk of provider failure and addresses wider issues of potential organisational abuse from occurring. Multi-agency commitment has achieved substantial and sustained improvement and therefore has reduced impact and risk to vulnerable adults receiving services, achieving more positive outcomes. The commission of the Care Home Support Team (CHST) and Rapid Response Team (RAAT) under the Better Care Fund has been fundamental in supporting providers to improve quality and, for customers, reducing admissions to higher level or secondary care.

A review was undertaken of safeguarding prevention and community engagement activities. This has led to a forward planning programme for the year ahead to ensure multi-agency events and initiatives are maximised.

West of Berkshire Safeguarding Adults Board Business Plan 2016-17

Red	**Overdue**	**Amber**	**In progress**	**Green**	**Complete/no further action**

PRIORITY 1

ESTABLISH EFFECTIVE GOVERNANCE STRUCTURES, IMPROVE ACCOUNTABILITY AND ENSURE THE SAFEGUARDING ADULTS AGENDA IS EMBEDDED WITHIN RELEVANT ORGANISATIONS, FORUMS AND BOARDS.

Outcome	Action	Lead	Timescale	Work in progress	RAG	Success criteria
1.1 Develop oversight of the quality of safeguarding performance.	a) Review and implement the Board's Quality Assurance Framework.	Governance Subgroup	Sept 2016	**Endorsed by Board 19.09.16.**	**G**	The QA Framework is reviewed and published. Identified actions are implemented.
	b) Annual self-assessment audit to be completed by partner agencies, results received and action plans monitored.	Performance and Quality Subgroup	Dec 2016	**Results of audits shared at Business Planning Day 6.02.17**	**G**	Results of self-assessment audit evidences improvements on previous completion.
	c) Develop a Performance and Quality Assurance framework to support and promote MSP.	Performance and Quality Subgroup	Oct 2016	**Awaiting work by the national network of SAB Business Managers to develop KPI set for MSP.**	**A**	Outcome information has a focus on wellbeing as well as safety, and reflects the six safeguarding principles.
1.2 Have in place an effective framework of policies, procedures and processes for safeguarding adults.	a) Approve amendments to the Pan Berkshire Multi-Agency Policy and Procedures twice yearly.	Governance Subgroup	July 2016 and ongoing	**P&P reviewed and amended by the Pan-Berkshire Group following 3 month consultation. Revised version published.**	**G**	The Berkshire Multi-Agency Policy and Procedures are accurate and up to date. Process in place to review twice yearly.

	b) Implement a Tracker to monitor how learning from local reviews and national developments is embedded across the partnership.	Effectiveness Subgroup	Sept 2016	**Tracker tool approved by Governance Subgroup.**	**G**	Board is assured that learning from reviews and national developments is shared across partner agencies.
1.3 Raise awareness of the work of the Board within partner organisations	Present Board's Annual Report to Health and Wellbeing Boards and other committees.	Independent Chair and Board members	January 2017	**Annual Report published. On forward plan for each HWB.**	**G**	Evidence that the Annual Report is presented to the HWBs and other committees.

PRIORITY 2

RAISE AWARENESS OF SAFEGUARDING ADULTS, THE WORK OF THE SAFEGUARDING ADULTS BOARD AND IMPROVE ENGAGEMENT WITH A WIDER RANGE OF STAKEHOLDERS

Outcome	**Action**	**Lead**	**Timescale**	**Work in progress**	**RAG**	**Success criteria**
2.1 The Board is confident that professionals are accessing the online Berkshire Policy and Procedures	a) Publish and promote new Berkshire Policy and Procedures.	Communication Subgroup	April 2016 publication, with review scheduled for July.	**P&P reviewed and amended by the Pan-Berkshire Group following 3 month consultation. Changes endorsed by the 4 SABs mid-September and a revised version published and promoted.**	**G**	Audit trail of emails promoting Policy and Procedures from Board members to teams.

	b) Evaluate awareness of and use of Policy and Procedures through survey and website analytics.	Communication Subgroup	December.	**333 respondents to survey: 31% had used P&Ps. Google analytics reviewed. Format of P&Ps is under review.**	**G**	Survey monkey reveals 75% of respondents are familiar with Procedures. Website analytics evidence increased number of views on the relevant page.
2.2 All partner agencies have agreed and implemented the Board's revised Communication Strategy.	Review and promote the Board's Communication Strategy.	Communication Subgroup	June 2016	**Communication Strategy endorsed by Board in Dec 2016.**	**G**	Board endorsement of the Communication Strategy. Clear communication processes and joint working in the event of a significant safeguarding incident.
2.3 All Board members understand their role.	Review and promote the Board's Induction Pack.	Communication Subgroup	Sept 2016	**Induction Pack endorsed by Board 19.09.06. Published on website and circulated to new members.**	**G**	Evidence that members have received the Induction Pack and understand their role as Board members.
2.4 Managers and staff are aware of the learning from SARs in order to keep people safe.	Publish and disseminate learning from Safeguarding Adults Reviews and other partnership reviews.	Communication Subgroup	Sept 2016 and ongoing	**Dedicated page on Board website for publication of reviews. Briefing note under development.**	**G**	Executive summaries and briefing papers published and disseminated upon completion of review.
2.5 Practitioners are aware of the Board's function and local safeguarding processes.	Conduct survey and make recommendations to help the Board raise awareness of its function and	Communication Subgroup	Dec 2016	**Survey completed by 333 respondents. Proposal developed for Board endorsement in**	**G**	Survey completed by 200 practitioners. Recommendations endorsed by Board and actions to

	local safeguarding processes.			**March.**		implement recommendations in place.
2.6 Printed information is available to guide people through the safeguarding process.	a) Provide clear explanations for people about what is meant by safeguarding and outcomes.	Communication Subgroup	March 2017	**Website has been updated. Briefing note article on outcomes.**	**G**	People are involved more effectively in the safeguarding process.
	b) Promote the principles of Making Safeguarding Personal.	Communication Subgroup	January 2017	**SAB briefing note published in July. Accessible information on MSP developed and being consulted on. Video produced by service users for website.**	**G**	Information on MSP published and disseminated via website, briefing notes and publicity material.

PRIORITY 3: ENSURE EFFECTIVE LEARNING FROM GOOD AND BAD PRACTICE IS SHARED IN ORDER TO IMPROVE THE SAFEGUARDING EXPERIENCE AND ULTIMATE OUTCOMES FOR SERVICE USERS.						
Outcome	**Action**	**Lead**	**Timescale**	**Work in progress**	**RAG**	**Success criteria**
3.1 Continue to ensure staff receive appropriate level of safeguarding adults training.	a) Review Levels 2 and 3 safeguarding training standards to ensure alignment with Pan-Berkshire Policy and Procedures.	Learning and Development Subgroup	December 2016	**Complete.**	**G**	Updated training standards agreed and used in developing training programmes
	b) Refresh Workforce Development Strategy to map to revised social care competence framework and intercollegiate document.	Learning and Development Subgroup	March 2017	**Refreshed Strategy (including updated training standards)**	**G**	Refreshed Strategy (including updated training standards) produced & published on SAB website

				produced & published on SAB website. (Full review scheduled for 2017-18 action plan)		
	c) Deliver Safeguarding Adults Train the Trainer programme (Wokingham BC.)	Learning and Development Subgroup	April 2016 (achieved)	**Course delivered; observations within 3 months**	**G**	Course delivered by Wokingham BC and offered across west of Berkshire
	d) In conjunction with the LSCBs, support development and delivery of the Joint Children's and Adults Safeguarding Conference on 23 September.	Learning and Development Subgroup	23 September 2016	**Complete. 150 attendees. Positive feedback.**	**G**	Conference held with attendance from adult sector
	e) Deliver Making Safeguarding Personal awareness training for private, voluntary and independent sector.	Learning and Development Subgroup	December 2016	**Complete. Sessions held and evaluated.**	**G**	Awareness workshops delivered to the local PVI sector
	f) Trading standards tailored training.	Learning and Development Subgroup	20 June 2016	**Session delivered.**	**G**	Tailored training developed and delivered
	g) Deliver core training programmes at all levels to support the sector. Report on training activity for 2015-16 for SAB annual report.	Learning and Development Subgroup	Ongoing June 2016	**Courses on offer. Training activity data published in Annual Report.**	G	Training programmes delivered and evaluated. Training data collated
3.2 Improve mechanisms to share learning from good and bad practice more widely.	Support the development of workshops and network meetings to share learning from SARs and other partnership reviews.	Learning and Development Subgroup	March 2017	**Briefing note shared with trainers.**	**G**	Information sharing sessions coordinated to respond to SARs to support Effectiveness

PRIORITY 4 **COORDINATE AND ENSURE THE EFFECTIVENESS OF WHAT EACH AGENCY DOES**						
Outcome	**Action**	**Lead**	**Timescale**	**Work in progress**	**RAG**	**Success criteria**
4.1 Agencies are implementing, and are compliant with, the new Berkshire Policy and Procedures and areas for learning and development across agencies and standards of best practice are identified.	a) Twice yearly case audit on S42 enquiries are undertaken. Themes and areas for development from S42 audits reported to the Board in June and December. Board to take required actions to address areas of identified concerns across partner agencies. Audit sample of cases against the MCA code of practice.	Effectiveness Subgroup	May and November 2016	**Established function; report to the Board twice yearly.**	**G**	Baseline established in Aug and areas for improvement identified; second audit in Feb evidences improvements in results of S42 case file audits outcomes.
	b) Undertake and publish multi-agency thematic reviews.	Effectiveness Subgroup	February 2017	**Programme of reviews for 2017-18 agreed.**	**G**	Results of thematic reviews are published and areas for development are identified for the Board to take appropriate action.
4.2 Service user feedback indicates that clients' desired outcomes are met, in line with MSP and the well-being principle.	a) Develop processes to ensure service user feedback is collected and understood.	Effectiveness Subgroup	September 2016	**Mandatory box and feedback questions developed. Board requires assurance that this is embedded in practice**	**A**	Robust, practical processes are in place across partner agencies.
	b) Develop mechanisms for measuring outcomes for individuals who have been through the safeguarding process.	Effectiveness Subgroup	March 2017	**Mandatory box and feedback questions. Board**	**A**	Increase in number of individuals whose desired outcomes have been met as

				requires assurance that this is embedded in practice		a result of the safeguarding process
4.3 Involvement of advocates and IMCAs ensure person centred responses are promoted.	Identify where there is a shortfall in the use of advocates and raise staff awareness as to how and when to involve advocates.	Effectiveness Subgroup	September 2016	**Q3 data shows improved rates of advocacy. To be kept under review and included as priority for business plan 2017-18.**	**G**	New approaches to person centred responses are promoted. Quarterly PI data indicates improvement in use of advocates.
4.4 The Board is assured that learning from SARs has been responded to appropriately by agencies.	a) The SAR Learning Monitoring Tool is used to monitor response to findings by partner agencies upon publication of SARs.	Effectiveness Subgroup	October 2016 and ongoing	**Populated with Mrs H and Mr I case reviews.**	**G**	The SAR Learning Monitoring Tool is completed and presented to the Board showing that learning from SARs is embedded within partner agencies.
	b) Subgroup to receive action plan developed by the SAR Panel, monitor completion by partner agencies and provide assurance to the Board that actions have been met.	Effectiveness Subgroup	October 2016 and ongoing	**Action plan endorsed by Board 19.09.16. Progress monitored at quarterly subgroup meetings.**	**G**	Learning from SARs is embedded within partner agencies. Actions are completed within identified timescales.

We have oversight of the quality of safeguarding performance

Feedback indicates that customers' desired outcomes are met, in line with Making Safeguarding Personal and the well-being principle.

We monitor how learning is shared and used to improve practice

We understand what the data tells us about where the risks are and who are the most vulnerable

We measure impact

We listen to the service user, raise awareness of adult safeguarding and help people engage

We work with communities to raise awareness of adult safeguarding

We raise awareness of the Board and the Berkshire Policy and Procedures

Board membership reflects a wide and varied group of stakeholders

West of Berkshire Safeguarding Adults Board
Reading, West Berkshire & Wokingham

West of Berkshire Safeguarding Adults Board Business Plan 2017-18

We learn from experience and have a skilled and competent workforce

Learning is shared and used to improve practice

Development areas for 2017-18:

- Safe recruitment
- Record keeping
- Mental Capacity Act
- Mental Health
- Allegations management
- Self-neglect
- Domestic Abuse

High risk areas for 2017-18

Mental Capacity Act and DoLS

Self-neglect

Mental health

Domestic Abuse

We work together effectively to support people at risk

People are supported by an advocate when they need it

We work within a framework of policies and procedures that keep people safe

Providers are supported to deliver safe, high quality services

We provide feedback to people who raise a safeguarding concern

We have a modern slavery strategic pathway

West of Berkshire Safeguarding Adults Board Business Plan 2017-18

PRIORITY 1 We have oversight of the quality of safeguarding performance						
Outcome	**Action**	**Lead**	**Timescale**	**Work in progress**	**RAG**	**Success criteria**
1.1 Feedback indicates that customers' desired outcomes are met, in line with Making Safeguarding Personal and the well-being principle.	a) Develop a core set of questions to collect feedback to ascertain the extent to which service users felt that they had been involved, supported, consulted and empowered during the safeguarding process.	Safeguarding Leads in Wokingham, west Berkshire and Reading Councils	April 2017			Core set of questions to collect feedback from people in place in each Council.
	b) Mandatory feedback form to be added to the Councils' electronic systems for every statutory S42 enquiry to capture feedback at the end of the S42 enquiry	Safeguarding Leads in Wokingham, west Berkshire and Reading Councils	June 2017			Mandatory feedback form added to the Councils' electronic systems for every statutory S42 enquiry.
	c) Develop systems for capturing, recording and monitoring MSP outcomes	Oversight and Quality Subgroup	Jan 2018			Systems are in place and feedback indicates that customers' desired outcomes are met
1.2 We understand what the data tells us about where the risks are and who are the most	a) Audit outcomes are analysed by Oversight and Quality Subgroup and the Board takes required actions to address areas of identified	Oversight and Quality Subgroup	September 2017 and March 2018	Twice yearly case audit on S42 enquiries are undertaken and include to what extent		Improvements in practice are evidenced in subsequent S42 case file

vulnerable	concerns across partner agencies.			Making Safeguarding Personal principles have been upheld.		audits.
	b) Develop a dashboard to present KPI data to the Board on a quarterly basis	Oversight and Quality Subgroup	December 2017			A clear overview of KPI data is presented to the Board on a quarterly basis
	c) Develop understanding of local level of risk for victims of FGM by reviewing local and national FGM data	Oversight and Quality Subgroup	Annually			FGM data provided supports the Board's understanding of local level of risk for victims of FGM
	d) Develop understanding of local level of risk for victims of Modern Slavery by reviewing local and national Modern Slavery data	Oversight and Quality Subgroup	Annually			Modern slavery data supports the Board's understanding of local level of risk for victims of modern slavery

PRIORITY 2 -We listen to service users, raise awareness of safeguarding adults and help people engage

Outcome	**Action**	**Lead**	**Timescale**	**Work in progress**	**RAG**	**Success criteria**
2.1 Board membership reflects a wide and varied group of stakeholders	a) Representatives from Housing and Provider organisations to be invited	Independent Chair	Sept 2017			Representatives from Housing and Provider organisations attend

	to attend Board meetings					Board meetings.
2.2 Local communities know about safeguarding adults and the work of the Board	a) Easy read version of the Board's Annual Report to be published	Communication & Publicity Subgroup	May 2017	CLASP commissioned to produce easy read version.		Wider range of people are able to understand the Board's work and priorities
	b) Community Awareness Event to raise awareness of safeguarding adults	Communication & Publicity Subgroup	March 2018			Community Awareness Event held in each area.
	c) The Board is assured that accessible safeguarding leaflets for customers and staff are available	Communication & Publicity Subgroup	June 2017			Safeguarding information is available in public places and partner agencies' websites
	d) Map partner agencies' external communication channels	Communication & Publicity Subgroup	June 2017			Subgroup aware of partners' external communication channels
	e) Develop calendar of local and national events relevant to safeguarding	Communication & Publicity Subgroup	June 2017			Local and national events relevant to safeguarding are promoted
2.3 Raise awareness across partner organisations and amongst practitioners about	a) a) New Berkshire Policy and Procedures website launched and promoted	Berkshire Policy and Procedures Subgroup	Dec 2017			New Berkshire Policy and Procedures website launched and promoted

the role of the Board, the website and Berkshire Policy and Procedures	b) b) Produce flyer for practitioners to raise awareness of the Board	Business Manager	April 2017			Flyer circulated across all partner organisations.
	c) Present Board's Annual Report 2016-17 to Health and Wellbeing Boards and other committees	Independent Chair	January 2018			Independent Chair presents Annual Report 2016-17 to HWB in each area by January 2018

PRIORITY 3 We learn from experience and have a skilled and knowledgeable workforce						
Outcome	**Action**	**Lead**	**Timescale**	**Work in progress**	**RAG**	**Success criteria**
3.1 The workforce has the capacity, capability, knowledge and skills to keep people safe and improve safeguarding outcomes	a) Opportunities for practitioners to explore issues when working with people in Domestic Abuse situations	Learning and Development Subgroup	May 2017			Practitioners understand the dynamics of DA in terms of coercion and control
	b) Ensure Domestic Abuse awareness training and safeguarding training cross reference.	Learning and Development Subgroup	May 2017			Consistent training standards for Level 1 produced.
	c) Promote good record keeping	Learning and Development	Sept 2017			Case file audit peer review in August and February reveals improvement in

		Subgroup				recording skills.
	d) Deliver Safeguarding Adults Train the Trainer programme (Wokingham BC deliver, open across the area)	Learning and Development Subgroup	April 2017			Course offered across West of Berkshire with positive evaluation response
	e) Joint Children's and Adults Safeguarding Conference on theme of Mental Health	Learning and Development Subgroup	23 Sep 2017			140 attendees with at least 80% of delegates rating the event as good or excellent
	f) Establish programme of Safeguarding Bite Size Workshops for multi-agency professionals	Learning and Development Subgroup	March 2018	Workshops: Sept - SAR Findings Dec- Advocacy March - Allegations management.		Workshops attended by wide range of professionals
	g) Deliver core training programmes at all levels to support the sector. Seek assurance that all SAB members deliver Level 1 to the agreed standards. Measure the impact of training on a biannual basis	Learning and Development Subgroup	Ongoing			Training programmes delivered and evaluated.

	h) Report on training activity for 2016-17 for SAB annual report	Learning and Development Subgroup	May 2017	Complete.	**G**	Training data collated and reviewed
	i) Review and update the Workforce Development Strategy	Learning and Development Subgroup	Dec 2017			Updated Strategy published on SAB website
3.2 Learning from SARs and other reviews has been shared and used to improve practice	a) The SAR Learning Monitoring Tool is used to monitor response to findings by partner agencies upon publication of SARs. b) SAR Panel to review Monitoring Tool and develop processes to hold partners to account re. responding to and embedding learning from SARs.	Effectiveness Subgroup	June 2017 and ongoing			The SAR Learning Monitoring Tool is completed and presented to the Board quarterly showing that learning from SARs is embedded within partner agencies.
	c) Multi-agency thematic audits to evaluate to what extent learning from SARs has been embedded. Priority areas for 2017 thematic audits agreed as: tissue viability, abuse in own home, dementia.	Oversight and Quality / Effectiveness Subgroup	Dec 2017			Results of thematic audits are published and areas for development are identified for the Board to take appropriate action.

	d) Evaluation template for training to include question to evaluate how practitioners have taken on and embedded learning	Learning & Development Subgroup	May 2017			Amended evaluation template used to assess how practitioners have embedded learning

PRIORITY 4 We work together effectively to support people at risk						
Outcome	**Action**	**Lead**	**Timescale**	**Work in progress**	**RAG**	**Success criteria**
4.1 Involvement of advocates and IMCAs ensure person centred responses are promoted	a) Identify where there is a shortfall in the use of advocates and raise staff awareness as to how and when to involve advocates.	Oversight and Quality Subgroup	Dec 2017			New approaches to person centred responses are promoted. Quarterly PI data indicates improvement in use of advocates.
4.2 Providers are supported to deliver safe, high quality services and the Board is assured that robust safeguarding processes	a) DASS and other commissioners provide assurance to the Board (through the annual Self-Assessment audit) that robust safeguarding processes are adhered to by commissioned services in line	DASS and other commissioners provide assurance	Jan 2018			Board is assured that robust arrangements are in place to support and challenge providers

are adhered to in line with Care Act requirements	with Care Act requirements.					
4.3 We work within a framework of policies and procedures that keep people safe	a) Organisations have in place policies and processes to manage allegations against persons in position of trust	Task and Finish Group	Sept 2017			Board is assured that partner agencies have robust policy in place to manage allegations
	b) Promote e-learning Safe Recruitment module	Learning and Development Subgroup	July 2017			e-learning Safe Recruitment module is promoted and used by practitioners
4.4. We provide feedback to people who raised a safeguarding concern	a) Each Local Authority to provide quarterly performance data on the proportion of concerns where feedback was provided to the referrer.	Oversight and Quality Subgroup / Effectiveness Subgroup	Indicator included in KPI set for Q1 data			Board is assured that feedback is provided to the referrer and takes actions to ensure practice is improved
4.5 We are assured that local arrangements to support and minimise risks for people who self-	a) Raise awareness of the issues and improve practice for working with those who self-neglect	Learning and Development Subgroup / Business Manager	Sept 2017			Raise awareness of self-neglect through website and workshop

neglect are effective	b) Review undertaken to inform the Board of prevalence of self-neglect cases reported under safeguarding framework, and outcomes for the individual	Effectiveness Subgroup & Oversight and Quality Subgroup	Sept 2017			The Board understands how cases of self-neglect are responded to and identifies areas for further development
	c) Partner agencies have clear policies and procedures in place to manage complex cases and support those who self-neglect or choose not to engage, in line with MSP and Duty of Care	Partner agencies	Jan 2018			Board is assured that each agency has clear policies and procedures to manage complex cases
4.6 Practitioners understand and can apply the MCA consistently in practice (including consent, best interest, DoLS and restraint)	a) MCA focused week of workshops for practitioners	Effectiveness / Learning and Development / Communication Subgroups	October 2017			MCA focused week of workshops attended by practitioners
4.7 We are assured that local arrangements to support people who have Mental Health	a) Raise awareness of current governance structures and accountability for mental health in the locality	Independent Chair	June 2017			Partner agencies have clarity about current governance structures for mental health

issues are effective						
4.8 We are assured that local arrangements to support and minimise risks for people who experience Domestic Abuse	a) Event on Domestic Abuse for partners to explore issues, understand priorities of each Domestic Abuse Strategy and identify gaps.	Independent Chair / Business Manager	Nov 2017			The Board is assured that commissioned DA services in each area are effective.
	b) A&E data shared to help each LA identify hotspots in their area and triangulate information	Oversight and Quality Subgroup	Oct 2017			Data shared to inform Board's understanding of DA
4.9 We have a Modern Slavery strategic pathway in place	a) Modern Slavery strategic pathway agreed and published	Policy and Procedures Subgroup	Dec 2017			Modern Slavery strategic pathway agreed and published
	b) Review and promote modern slavery e-learning	Learning and Development Subgroup	Dec 2017			Modern slavery e-learning reviewed and promoted

Berkshire Healthcare NHS
NHS Foundation Trust

Safeguarding Adults Annual Report

April 2016 – March 2017

Author: Jane Fowler Head of Safeguarding

Safeguarding Adults - Annual Report 2016/17

CONTENTS

1. Introduction

The purpose of this report is to provide assurance to the trust that it is fulfilling its statutory responsibilities in relation to safeguarding adults and to provide a review of recent service developments, highlighting areas of ongoing work and any risks for noting.

2. The Statutory Context

Adult safeguarding practice has come into sharp focus for all NHS organisations in the wake of large scale enquiries such as the Mid Staffordshire Foundation Enquiry, the *Francis Report (2013)* and the Lampard report on Saville enquiry (*Lampard K & Marsden 2015*). With the introduction and implementation of the Care Act (2014) on 1st April 2015 safeguarding adults now operates within a legal framework.

Since April 2010 all health organisations have to register and comply with Section 20 regulations of the Health and Social Care Act 2008, meeting essential standards for quality and safety. The Care Quality Commission periodically assesses the performance of all health care providers.

3. Governance

During 2016/17 the safeguarding adult team was restructured and joined with the safeguarding children team to become one team managed by the Head of Safeguarding to provide a more 'think family' approach to safeguarding. The post of safeguarding adults' co-ordinator was reduced to 0.8 whole-time equivalent (WTE) from full time when the post became vacant and re-banded to a band 7 in order to allow another safeguarding named professional in the team. The named executive for safeguarding adults in the trust is the Director of Nursing and Governance. The structure for the safeguarding team and lines of responsibility are attached at Appendix1.

The safeguarding adult group chaired by the Deputy Director of Nursing, leads and monitors safeguarding work within the trust and meets quarterly. This is a formal sub-group of the Safety, Experience and Clinical Effectiveness Group (SECEG) which reports to the Quality Executive Group (QEG) and ultimately to the Trust Board. The board also receives a monthly update on safeguarding cases of concern.

The Head of Safeguarding chairs monthly safeguarding named professional team meetings where shared visions, standardised practice and future plans are agreed and monitored. An annual plan on a page, written by the team, clearly identifies work priorities and continuous improvements to be achieved (attached as Appendix 2). There are currently 2.8 whole-time equivalent (WTE) adult safeguarding named professionals posts divided between three staff members and 6.8 WTE posts for child safeguarding. The team is supported by three part-time administrative posts and is based at two locations, St Marks Hospital in Maidenhead and Wokingham Hospital in Wokingham. The

Specialist Practitioner for Domestic Abuse works within the safeguarding team. The Head of Safeguarding works as a full time manager for the whole team.

The Deputy Director of Nursing attends the quarterly East and West Berkshire health economy safeguarding groups chaired by the Directors of Nursing for the East and West Berkshire clinical commissioning groups (CCG's). The Head of Safeguarding and the named professionals attend the East and West named and designated safeguarding groups, chaired by the designated nurses for child protection, which report to the health economy safeguarding groups. The purpose of these groups is to communicate local and national children's safeguarding issues. These meetings encourage shared learning from safeguarding practice and include case discussion and monitoring of action plans from inspections, safeguarding adult reviews and partnership reviews to provide assurance.

4. Assurance Processes

CCGs are expected to ensure that safeguarding is integral to clinical and audit arrangements. This requires CCGs to ensure that all providers from whom they commission services have comprehensive and effective single and multi-agency policies and procedures to safeguard children and vulnerable adults, and that service specifications drawn up by CCGs include clear service standards for safeguarding which are consistent with local safeguarding board policies and procedures. The trust completes a contracted annual self- assessment audit for the CCGs in September each year, to provide assurance to commissioners that safeguarding standards are met. Following submission the Head of Safeguarding meets with commissioners to discuss the audit and answer sample questions.

Safeguarding Audits

Audit is an effective means of monitoring compliance with policy and procedure as well as analysing the effectiveness of current practice. Two audits were undertaken during 2016/17

Audit	Completion
Audit of safeguarding response to alleged sexual assault/inappropriate behaviour on mental health inpatient wards	Complete
Audit of Mental Capacity Act assessments on mental health wards	Complete

Audit 1 – Audit of safeguarding response to alleged sexual assault/inappropriate behaviour on mental health inpatient wards

The safeguarding team undertook this audit following a perceived increase in sexual abuse incidents taking place on mental health inpatient units.

The audit concentrated on sexual abuse, including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts or sexual acts that the vulnerable adult has not consented to, or could not consent, or was pressured into consenting. This also includes sexual exploitation or sexual grooming of young people.

Any sexual activity on a mental health ward is not acceptable due to vulnerabilities of the patients, and their ability to consent. The trust must be confident that all instances of sexual abuse are managed appropriately and in a timely manner to reduce the risk of harm, ensure any victim of abuse is supported and reduce the risk of reoccurrence.

The audit identified several areas where policy had not been followed.

- Policies were not being adhered too, namely the Safeguarding Adults from Abuse (Local Policy) CCR089 and The Management of Sexual Relationships involving In-Patients in the Mental Health setting Policy CCR029.
- Incidents of this nature are not being sent to the local authority routinely for investigation in line with the Pan Berkshire Policies & Procedures.
- Risk assessments are not being updated routinely for the victim or perpetrators involved in these incidents.
- Staff are not systematically triangulating the risk for these incidents.
- Care plans for victims and perpetrators are not systematically being updated/ completed following these incidents.
- RIO progress notes for victims and perpetrators do not reflecting the incident on Datix.
- Transferable risk not being identified, which means that there is on-going risk to other vulnerable adults.

Recommendations from the audit were as follows:

- Repeat audit findings for October 2015 to March 2016 data by September 2016.
- The safeguarding team to check RIO for assurance and not rely on Datix alone to ensure actions taken are followed through for all sexual assault incidents.
- To develop Standard Operating Procedure guidance for staff detailing expectations of sexual assault/inappropriate behaviour management.
- To discuss individual safeguarding issues raised in greater detail.
- To determine the role of the safeguarding lead within Prospect Park Hospital.

There was a re-audit in September 2016 which showed an improvement in some of the actions being taken to safeguard patients following these incidents. The percentage of cases meeting the

standard increased in 9 of the standards selected for the audit. Three standards remained the same and five standards decreased in the number being met. An action plan was put in place.
In December 2016 a safeguarding adult named professional (mental health) was recruited into the safeguarding team to promote safeguarding in Prospect Park Hospital and a safeguarding named professional visits the wards daily to follow-up on safeguarding incidents and work with staff to improve standards.

Audit 2 – Audit of Mental Capacity Act Assessments

An audit was undertaken at the end of Quarter three to assess where services are at in regards to undertaking mental capacity assessments. 10 sets of notes were randomly audited, covering all CCG areas, to assess the quality of the mental capacity assessments being undertaken and to determine if decisions were being made which required a formal assessment of capacity.

- All 10 service users had a capacity assessment on admission appropriately using the updated capacity assessment tool. All were of high quality.
- 3 of the 10 service user's notes indicated that significant decisions were taken which required capacity. Of these 3 service users, 2 had high quality mental capacity assessment, one had it noted that they had capacity (very clearly), but no assessment was undertaken.

There appears to be a good understanding of the Mental Capacity Act across the trust and its use is becoming embedded within the mental health inpatient unit. Within community physical health wards there is an understanding of patient consent however the use of the Mental Capacity Act (MCA) within larger decision making is not implemented in the majority of incidents and when it is implemented the documentation of the assessments is poor. Significant work had been undertaken over the previous 6 months to develop the mental capacity assessment form, implement a champion system on the community wards as well as a revamp of the training. The audit indicated that further work is required to embed this practice

Recommendations from the audit:

1: Clinical Directors from the relevant localities have been informed of those patients who require a capacity assessment

2: The implementation of the MCA needs to be owned on a local level, rather than being centrally managed. It is recommended that this audit is discussed at the PSQ and ownership for improvement to be held between the Clinical Director and service manager.

3: The mental capacity champion role is not yet embedded. Further support is required to empower the champions to challenge clinicians when the MCA is not being implemented when it should.

4: The review of the teaching and training of the MCA should continue.

Audits planned for 2017-2018

Audit	Completion Due
Audit of failure to return from section 17 leave from inpatient wards	October 2017
Making Safeguarding Personal	November 2017
MCA audits x 3	January 2018

Named professionals for safeguarding adults also participate in multi-agency safeguarding audits required by each of the SAB's as part of membership of quality and performance/effectiveness sub-groups. Examples include a self-neglect audit undertaken by Slough and a dementia audit undertaken in west of Berkshire.

Supervision

All adult safeguarding named professionals receive safeguarding supervision from the Head of Safeguarding in West Berkshire on a minimum quarterly basis. They also receive an annual appraisal which is reviewed after six months.

5. Safeguarding Adults Boards

There are four Safeguarding Adult Boards (SAB) serving Berkshire: West of Berkshire SAB serving Reading, West Berkshire and Wokingham; Bracknell SAB, Royal Borough of Windsor and Maidenhead SAB and Slough SAB. The trust are represented at all boards with, the Deputy Director of Nursing sitting on the board in the West of Berkshire and the relevant Locality Director sitting on each of the 3 East boards.

Section 44 of the Care Act puts a duty upon the Safeguarding Adults Board (SAB) to arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

- There is reasonable cause for concern about how the SAB, its members or other persons with relevant functions worked together to safeguard the adult, and

- The adult has died, and the SAB 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

- If the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The Head of Safeguarding sits on the safeguarding adult review (SAR) panels for each of the Safeguarding Adult Board areas. Named professionals for safeguarding adults sit on each of the

quality and performance/effectiveness sub-groups and on the learning and development groups in East and West Berkshire. They also sit on Modern Slavery and Violence against Women and Girls Sub-committees.

Safeguarding Adult Review's/Domestic homicide reviews/Partnership reviews

During 2016/17 there were a number of safeguarding adult reviews, partnership reviews and homicide reviews in which the Trust contributed to the multi-agency learning process. Learning from the reviews has been incorporated into group scenario work in the Trust's safeguarding adults training

Safeguarding Adult Reviews (SARs)

Bracknell
A female adult who lived alone and was known to mental health services became unwell. Her family increasingly raised concerns, about her delusional behaviour, to primary care and to mental health services the day prior to her death. A fire started in her flat and she suffered critical injuries from which she died in hospital. The learning includes working with risk, engaging positively with families and carers, communication systems and fire risk referrals. Fire risk assessment and referral pathways have been added to all safeguarding training in the trust as a result of this review. The hoarding scale has been circulated to staff and information about the use of flammable creams and risk to patients.

A review has been commissioned to identify any multi-agency learning following the death of a 71 year old man with a learning disability. The gentleman lived in supported accommodation and died in hospital following a deterioration of his physical health, leading to a number of hospital admissions. The review is in progress and will look at learning around application of the Mental Capacity Act and the way agencies communicated with each other about his care.

Partnership Reviews

Slough
A review took place to consider the care received by a gentleman with learning and physical disabilities who was admitted to Prospect Park Hospital in December 2016. The mental and physical health of the gentleman rapidly deteriorated during the week prior to his admission and he was seen by numerous agencies including mental health, community team for people with learning disabilities, respite care, GP, hospital services and ambulance service. The review highlighted the need to better co-ordinate the service between the crisis team and the community disability team and an action plan is in progress.

West of Berkshire

A thematic review took place following the death of a gentleman Mr X. Mr X had a learning disability and there were issues identified around complex relationships, interdependencies and possible domestic abuse/coercive control between Mr X and his two brothers. Mr X was interviewed by police in October 2016 on a voluntary basis in relation to an allegation of historical sexual abuse. The interview was delayed due to difficulties identifying an appropriate adult. Mr X was found dead in his flat two days later. Learning was identified around complex case management, capacity assessments and multi-agency working.

Bracknell

A nineteen year old man with a learning disability was admitted to Campion ward, from his residential school in Herefordshire, when his health deteriorated rapidly following uncertainty about his next placement. His health further deteriorated and he was transferred to Royal Berkshire Hospital. No learning was identified for trust services from the review.

Domestic Homicide Reviews

Wokingham

A domestic homicide review is in progress following the death of a lady with advanced dementia, who was killed by her husband. The couple had been married for over sixty years and the husband was the main carer for his wife. The couple had some support from care agencies and their two daughters. The husband was diagnosed with cancer and was undergoing treatment, which affected his physical wellbeing and ability to care for his wife. The victim was known to the memory clinic and the community matron service. The review is ongoing.

Mental Health Homicide Review

Slough

Joint Serious Case Review and Mental Health Homicide Review

A child died with his mother when she jumped in front of a train. It is believed his mother committed suicide and the child died with her. The mother was in receipt of mental health services and was a mental health inpatient for a period prior to her death. The Mental Health Homicide Review was completed in December 2016 and has not yet been published. The serious case review found that the child's death was not predictable or preventable and there were no recommendations for agencies from the review. A learning event was held for staff and a multi-agency conference across East Berkshire on forced marriage and other harmful practice and exploitation will be held November 2017.

Serious incidents

Serious incidents within BHFT, where there has been a safeguarding aspect, are detailed and reported to the Board separately. The Safeguarding Team are involved in discussions where there has been an allegation against a member of staff. The team offer bespoke training sessions to services where themes are identified. The trust have a responsibility to consider any incident where

an individual with care and support needs, dies or experiences significant harm and if so a referral is made to the relevant SAB for consideration for a serious adult review.

6. Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS) (2007)

The Safeguarding Adults team have led the trust's responsibility for co-ordinating and raising awareness of Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) since 2012/13.

Training to staff is facilitated by the named professionals for safeguarding adults assisted by staff who have attended the MCA/DoLS 'Train the Trainer' course. Trust staff compliancy to MCA and DoLS training was above 85% by March 2017 which exceeded the target set on the Quality Schedule.

The issue of assessing an individual's mental capacity is often a central part of the safeguarding process. Support is also often required around making best interest decisions for individuals who lack capacity to make specific decisions. An understanding of the MCA is crucial to the implementation of DoLS. As awareness has been raised, staff are more frequently contacting the safeguarding team for specific advice about the MCA.

An MCA/DoLS group has been set up during 2016/17 chaired by the Clinical Director for the Trust, to look at ways of developing staff knowledge of application of the Mental Capacity Act and application of DoLS. Six MCA champions have been appointed, one on each of the community wards to support staff in their work. This group will join the safeguarding adult group once the initial task and finish work is completed.

An audit has been undertaken by the Clinical Director and an action plan is in place. An MCA form has been added to the admission pack on the community wards as a result of the audit. One of the Named Professionals for Safeguarding Children is the named MCA/DoLS lead for the Trust.

The Law Commission carried out a full review of the current DoLS framework and found the current system to be 'deeply flawed'; they proposed that the current system be replaced with a new system, to be called 'Protective Care'. Broadly speaking, protective care had three aspects: the supportive care scheme, the restrictive care and treatment scheme, and the hospitals and palliative care scheme recommended a significantly different process. The review went out to consultation in the autumn of 2015.

There was a significant amount of feedback given regarding the proposed changes. It is anticipated that a final report and draft Bill will be published in December 2017. It is unlikely that there will be any noticeable changes to practice until 2019 at the earliest.

DOLS Applications for 2016/17.

	Q1	Q2	Q3	Q4	Total
Total number of applications received:	14	23	13	15	65
Applications Declined:	1	0	1	2	4

	Q1	Q2	Q3	Q4
Henry Tudor Ward				
Windsor Ward			1	
Donnington Ward	1	1	1	2
Rowan Ward	8	15	4	9
Campion Unit				
Orchid Ward	3	4	6	3
Oakwood Unit	2	1	1	
Jubilee				
Rose		1		
Snowdrop				1
Total	**14**	**23**	**13**	**15**

All applications for DoLS require a BHFT signatory and the locality directors or their designated deputy has responsibility to ensure the application to the local authority is complete and appropriate. The Safeguarding Adults team continue to provided support and guidance to staff on DOLs applications. The CQC must be notified of all DoLS Applications and the Outcome. This should be done by the Locality Directors or agreed deputy.

There have been 65 DoLS applications during 2016/17 which is a significant rise on 2015/16 when there were 34 applications. 4 of the applications were declined as the patient was not eligible. A number of the applications ended before the assessment was made or the authorisation received. For these patients it was recorded in the record that an application had been made, but an assessment had not yet been made and the patient was being held on the ward in their best interest. Regular contact was kept with the local authorities regarding these applications

7. Prevent

Prevent' is part of the UK's counter-terrorism strategy, CONTEST. The Prevent agenda is outlined in the Department of Health document 'Building Partnerships, staying safe – the Healthcare Sector's contribution to HM Government's Prevent Strategy: for Healthcare Organisations'. The trust has a duty to adhere to the Prevent strategy. Its aim is to stop people being drawn into terrorism or supporting terrorism. Terrorist attacks have continued to take place across the world in 2016/17. There was an attack in London on the 22.3.17 at Westminster, indicating that individuals are still being radicalised. The UK's terrorist threat remains at 'Severe', at the time of this report meaning a threat is 'highly likely'.

The Prevent Lead for the trust left the safeguarding team in December 2016 and two named professionals child protection who had been delivering the WRAP (Workshop for Raising Awareness of Prevent) training, stepped into the role temporarily, whilst a replacement was sought. At the time of publication of this report a new Prevent lead has been appointed.

Links with Local Authority and Police remain strong. The trust is represented on all six channel panels and Prevent management meetings across the six Localities in Berkshire. Channel is an early intervention multi-agency process designed to safeguard vulnerable people from being drawn into violent extremist or terrorist behaviour. Channel works by partners jointly assessing the nature and the extent of the risk and where necessary, providing an appropriate support package tailored to the individual's needs.

Introducing Prevent into the induction programme in July 2016 has helped to increase our overall percentage of staff completing the WRAP training, from 75% to 87% of staff. This was a significant achievement for the team, who offered training to groups in their bases as well as part of the general training programme in order to make it easier for staff to access training and increase compliance.

For those that need the basic training Channel general awareness, 85% of staff have now completed it, compared to 50 % at the end of 2015/2016. Additional scheduled sessions have continued to be offered to reach staff within the organisation who have not yet been trained. The safeguarding adult Named Professional (Mental health) started with the team in December 2016 has also been trained internally by Safeguarding Team to deliver the WRAP training.

Staff have demonstrated an awareness of Prevent and its purpose, with several concerns being discussed with the Prevent Leads and some of those referrals meeting the threshold to be considered by the Channel Panel and in turn being adopted by the panel. There has been an increase in calls for advice on Prevent matters from 2015/16.

Having attended national conferences for Prevent with NHS England supported by the Home Office, it is clear the Prevent agenda is growing in light of the continued risk of national terrorist attacks. It is clear Prevent needs to be embedded into all aspects of practice. In order to do this the plan is to expand the Prevent aspect within the adult and children safeguarding refresher courses.

8. Modern Slavery

There is now a duty to notify the Home Office of potential victims of Modern Slavery, this came into force in November 2015. This duty is set out in Section 52 of the Modern Slavery Act 2015 and applies to public authorities. Although health organisations are not yet compelled to notify, under safeguarding arrangements, consideration should be given to making a referral to the police or local authority, should a health practitioner have reason to believe a vulnerable adult or child is being exploited or trafficked.

A Modern Slavery Sub-group has been set up in Slough, led by Police and the Community Safety Partnership and the Named Professional for Mental Health is a working member of that group. Modern Slavery training has been offered locally and nationally and has been attended by the Named Professionals. Modern Slavery is included in all Trust Safeguarding Adult training.

9. Training

As a partner of the four SAB's in Berkshire the trust is guided by the workforce development strategies' developed by the East and West Berkshire learning and development subgroups and all level 1 training adheres to the standards identified, ensuring that all staff have appropriate knowledge and competencies in relation to the:

- Potential for the occurrence of abuse and neglect
- Identification of abuse and neglect

- Safeguarding adults policy and procedures
- Requirement to report any concerns of abuse or neglect
- Internal reporting structure for such concerns

Continued training and development of trust staff on safeguarding vulnerable adults forms a primary responsibility for the safeguarding team. Lessons learned from national and local enquiries in safeguarding adults reviews have been incorporated into the trust training, programme which is delivered at two levels.

Level one training is aimed at staff whose work brings them into regular contact with patients who are in need of services, whether or not the local authority are aware of them. It comprises awareness on the different types of abuse, how to recognise signs of abuse and how to manage situations of witnessed abuse and disclosures of abuse by patients in our care.

Level two training is targeted at senior clinicians. Staff who regularly investigate and/or contribute to supporting adults at risk of abuse including safeguarding adult named professionals, attend multi-agency training at level three. This training includes multi-agency safeguarding procedures and assessing, planning, intervening and evaluating the needs of an adult where there are safeguarding concerns.

Safeguarding adults/children joint training at level one is now facilitated at Trust induction and has been well received giving a more 'think family' approach to training. All volunteers within the trust also receive safeguarding adult training as part of their induction. Bespoke training has been facilitated to hard to reach groups of staff and where particular learning has been identified.

Joint safeguarding children and adults training at level two was facilitated to community mental health team staff in September 2016 following learning from a local incident. Staff are also offered domestic abuse training from the Specialist Practitioner Domestic Abuse who sits within the safeguarding team.

A multi-agency level two refresher event was organised by one of the named professionals for safeguarding adults and included learning from local safeguarding adult reviews presented by a partner agency. Bespoke training sessions have also been facilitated to staff at Prospect Park hospital.

Compliancy for level one training rose to 93.3% by March 2017 which was a significant achievement for the team, compliancy for safeguarding adults training level two also rose from 40% to 66% but this remains below the target of 85%. A staff vacancy and long-term sick leave affected the ability to facilitate this training, but a plan is in place to increase compliancy to 90% by December 2017.

Delivery of MCA/DoLS training and Prevent training forms part of the responsibility of the safeguarding team and is included in those sections of this report.

On-going statistics for staff numbers trained are included in the quarterly reports submitted to the Deputy Director of Nursing.

10. Summary

The Care Act (2014) and Care and Support Statutory Guidance (Chapter 14-Safeguarding) has clarified our responsibilities relevant to safeguarding adults vulnerable to abuse or neglect. This legislation underpins the standards and principles of safeguarding practice at the heart of patient care at the trust and provides a legal requirement to work closely with local authorities and other partnership members of the Berkshire multi-agency safeguarding response.

The changes to terminology, categories of abuse and making safeguarding processes personal to the individual concerned are being incorporated into training and development of trust staff and volunteers and policy documents. The safeguarding team continue to work closely with external partners, developing local relationships and ensuring that adult safeguarding practices reflect local and national guidance.

Safeguarding Adult Boards have a statutory status directed by the Care Act (2014) with clearly defined roles and responsibilities to co-ordinate strategic safeguarding adult activity across all sectors and service user groups, to prevent abuse and neglect occurring and where it does, it is recognised and responded to appropriately. The SABs forms a view of the quality of safeguarding locally and challenges organisations where necessary. Senior representation on all four Berkshire SABs ensure a direct link to the Board regarding safeguarding adult concerns, enquiries and lessons learned as well as future development in practices and policies.

Application of the Mental Capacity Act is a topic that continues to be identified as an area for development both nationally and locally through SAR's, staff feedback and the recent CQC inspection.

11. Team Achievements 2016/17

The Trust Vision

The safeguarding team have provided evidence for the board on the key domains for BHFT to demonstrate the connection between the Trust vision and our service delivery:-

Striving for Excellence

The safeguarding team have increased the amount of safeguarding training courses at level one and succeeded in raising compliance of staff to level one training to over 93% to ensure staff are

competent to safeguard adults in Berkshire. This has been achieved by working closely with the learning and development team, carefully planning sessions to ensure easy to access locations across the trust, bespoke training to ward staff during the handover period and taking training to hard to reach groups. Compliance to Prevent training has also increased significantly to 87% this year. Two extra named professionals were trained as Prevent trainers and again training was taken to staff meetings, and bespoke sessions were held at times identified by teams. Prevent training was also added to induction to capture all new staff starting with the trust. Compliance to MCA and DoLS training has also risen to above 85% by March 2017.

Tailoring Care

An action plan has been developed to strengthen safeguarding at Prospect Park hospital. A safeguarding named professional (mental health) was appointed in December 2016 to offer more one to one support to staff on inpatient wards. A named professional is present at the hospital daily to visit inpatient areas for advice and support and to oversee safeguarding. Named professionals have worked with adult social care to agree referral processes.

The safeguarding team view the front line staff and services as their customers and thus always endeavour to provide a flexible service to meet need. Telephone advice is widely used and named professionals support staff with complex cases and to challenge other agencies if they are not satisfied with the outcome of a referral where they have concerns about adult abuse. The team continue to provide tailored adult safeguarding support in practice areas where serious incidents requiring investigations (SIRI)s, have highlighted learning needs with regard to adult safeguarding practice.

Maximising Value

Amalgamation of the safeguarding adult and children's teams has enabled a more joined up approach to safeguarding and an increased skill set amongst the team. Team members have increased their use of skype to reduce travel. Staff have worked together to develop a joint induction programme which includes Prevent and have piloted a joint safeguarding adults and children training at level two. This will be rolled out where appropriate to identified groups of staff. For the first time a level two safeguarding refresher forum with multi-agency speakers was facilitated and was well supported and evaluated with over 60 staff in attendance.

Delivering Success

The safeguarding team and the tissue viability service worked with a multiagency group of professionals to develop a pan-Berkshire safeguarding pressure ulcer pathway. The new

procedures were re-launched in April 2016 and information went out in Team Brief. The link is available to all staff on team net.

The safeguarding team found that there was no consistency across the trust in relation to which, if any, MCA tools were being used and worked with the Clinical Transformation team to develop a single MCA tool in Rio that can be used by all services. The tool went live in 2016. It has been designed in such a way that it will be easy to replicate for services that do not use RIO.
An MCA task and finish group was set up to work on embedding use of the MCA and increase understanding of and application of DoLS. Six safeguarding champions have been appointed on the community wards to support the safeguarding team in improving the application of MCA and DoLS across services. Difficulty in the application to practice of the MCA act is a theme that has been present in local safeguarding adult reviews. It is recognised nationally that the MCA is not well embedded in practice across health and social care and this is an area for development across BHFT. A question about capacity has been added to the safeguarding adults section of the Datix form. There has been a significant increase in the number of DoLS applications in the trust this year which is encouraging.

Working across Boundaries

The safeguarding team have continued to work closely with external agencies to improve and develop safeguarding adult practice across Berkshire. The trust are represented on all four safeguarding adult boards and on all sub-groups across Berkshire. Staff have actively participated in safeguarding adult reviews, disseminating learning to staff through multi-agency forums.

The safeguarding team organise a quarterly peer support session for all safeguarding colleagues working in health across Berkshire and host a quarterly partnership group, to which all six local authorities, both CCG leads and the acute trust leads are invited. This is an effective forum for building relationships and working together to improve practice and facilitate learning.
Named professionals meet with colleagues in social care on a monthly basis to discuss referrals and carry out investigations as required. Regular meetings have been held with police at Prospect Park hospital and a safeguarding named professional is an active member of the protocols in practice meeting at Prospect Park hospital.

Inspiring Others

The team work closely with staff to support them to manage difficult cases giving them the confidence to challenge other professionals and agencies, where appropriate, to ensure adults in Berkshire are safeguarded. The team offer a coaching philosophy and approach to safeguarding advice and encourage professional curiosity, from front line staff, to enhance their learning and improve outcomes for adults in their care**.**

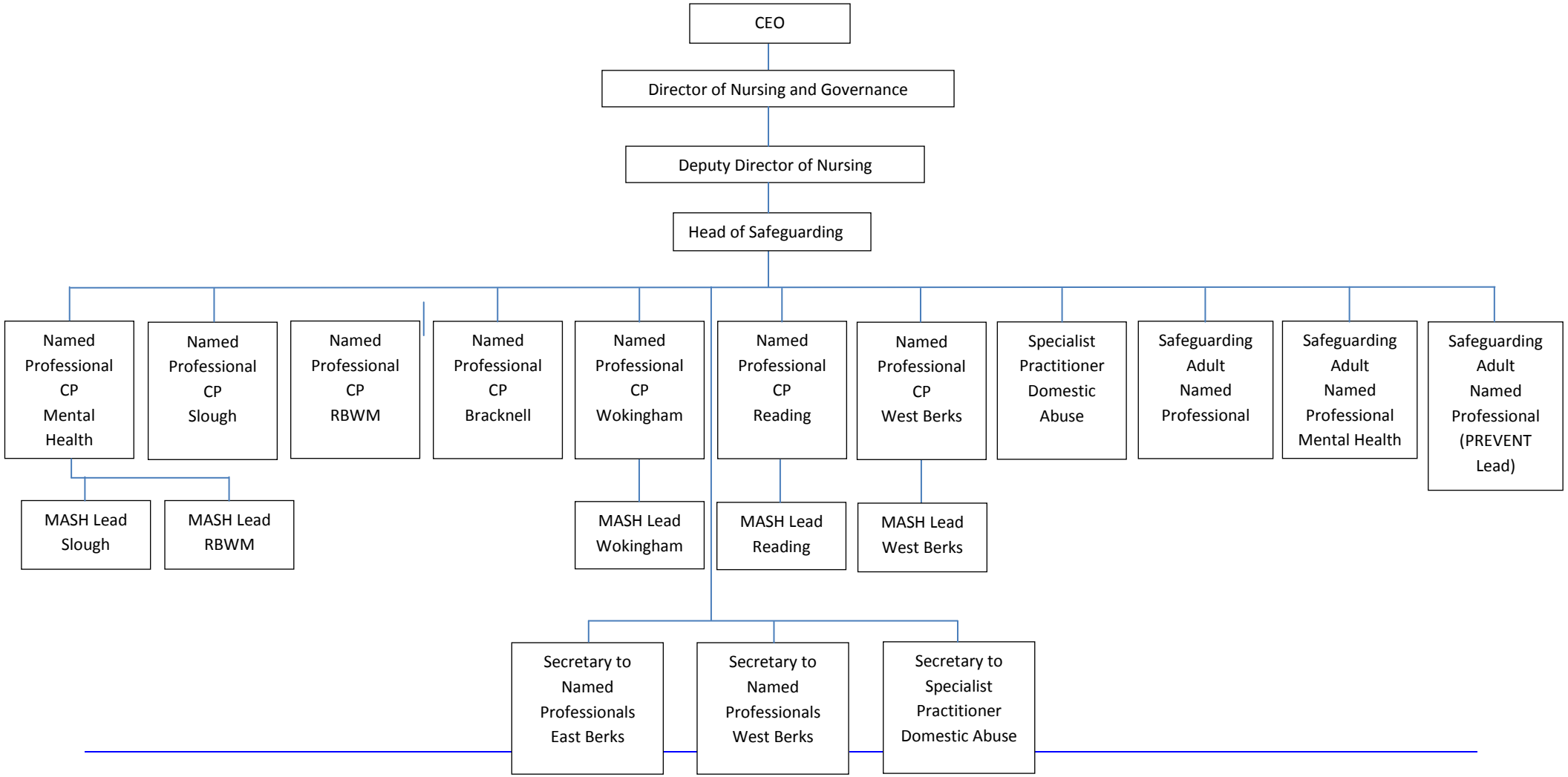
The team produce a 6 monthly safeguarding newsletter to bring any new guidance or learning to staff attention. This year screen savers have been developed to offer bite-sized reminders of important safeguarding topics, including domestic abuse and modern day slavery. Highlighting to staff what to look out for and where to get help.

12. Future Plans

- Embed the Making Safeguarding Personal principles
- Continue to ensure that the Trusts PREVENT contractual requirements are met including the delivery of WRAP3 to identified staff groups.
- Increase understanding of application of MCA in practice
- Continue to meet safeguarding adults training level one compliance at over 90%
- Increase compliance to safeguarding adults training level two to 90%
- Commitment to contributing to an outstanding care quality commission rating through maintaining a high level of skills and knowledge of the team
- Continue to develop and maintain close working relationships with partners in social care in each of the six Berkshire unitary authorities
- Continue to provide strong representation on the safeguarding adult boards and sub-committees
- Work with colleague at Royal Berkshire Hospital Trust to develop a mental capacity act policy for the trust.

APPENDIX ONE

SAFEGUARDING TEAM



APPENDIX TWO

Healthcare from the heart of your community

Team Plan Summary 2017-2018

NHS
Berkshire Healthcare
NHS Foundation Trust

Goal 1: Improving patient safety and experience

To provide safe services, good outcomes and good experience of treatment and care

- Commitment to contributing to an outstanding care quality commission rating through maintaining the high quality commission rating through maintaining the high level of skills and knowledge within the team.
- Maintain and develop safeguarding training to recognised standards for adult training and to the intercollegiate document 2014 for children, young people and families accessing Trust services.
- Continue to provide responsive children safeguarding advice to all Trust staff via the on-call advice line.
- Monitor and update compliance to Section 11 of Children Act 1989 reporting to Board and providing assurance to LSCB monitoring groups.
- Appropriately implement the Pan Berkshire escalation policy for Safeguarding.
- Access specialist training and supervision via Trust and external providers.
- Improve staff engagement in MCA assessments and DOLS
- Strengthen team knowledge of Prevent and ways to support staff

Goal 2: Supporting our staff

To strengthen our highly skilled and engaged workforce

- Improve and maintain the uptake of supervision for CAMHS and the allied professions.
- To continue to develop child and adult safeguarding training programmes.
- Maintain the presence of the adult safeguarding lead during the working week at Prospect Park Hospital providing support and advice.
- Maintain and review the children's safeguarding advice line to inform future training needs.
- Continue to monitor safeguarding practice through audit and safeguarding clinical supervision.
- Maintain and improve the safeguarding page on Team net
- Continue to support staff by providing safeguarding forums and seminars, sharing learning from serious case reviews, partnership reviews and current issues including Domestic Abuse, CSE, FGM and Prevent.

Goal 3: Money matters

To deliver services that are efficient and financially sustainable

- To complete the review of the children's safeguarding form making key safeguarding information readily available.
- Improve the use of Skype and SMART working to reduce travel and maximise team efficiency.
- Build on the planning and delivery of joint adult and children's Level 1 training.
- Introduce joint adult/child 'think family' safeguarding training at level two for appropriate staff groups.

Goal 4: Working together

Understanding and responding to local needs as part of an integrated system

- Ensuring safeguarding representation at LSCB sub-groups.
- Continue to develop and establish the MASH roles in East and West Berkshire.
- Respond to specific local safeguarding initiatives by providing joint training.
- Continue to embed partnership working practices with adult and mental health staff including the children's Berkshire Adolescent Unit.
- Continue to develop and maintain close working relationships with partners in social care in each of the six Berkshire unitary authorities
- Participate in multi-agency audits, serious case reviews and partnership reviews as required.

Our vision: To be **recognised** as the **leading community** and **mental health service provider** by **our staff, patients** and **partners.**

caring for and about **you** is our **top priority**

committed to providing **good quality, safe services**

working **together** with **you** to develop **innovative solutions**

Reading Safeguarding Annual Performance Report 2016/17

The 2016-17 Safeguarding Adults Collection (SAC) records details about safeguarding activity for adults aged 18 and over in England. It includes demographic information about the adults at risk and the details of the incidents that have been alleged.

The Safeguarding Adults Collection (SAC) is an updated version of the Safeguarding Adults Return (SAR) which collected safeguarding data for the 2013/14 and 2014/15 reporting periods so has some areas where there have been significant changes to the categories of data collected.

Section 1 - Safeguarding Activity

Concerns and Enquiries

As a result of the Care Act changes over recent years the terminology of some of the key data recorded in the Safeguarding Return in its various formats has changed. Safeguarding Alerts are now referred to as Concerns and Safeguarding Referrals are now known as Enquiries.

Another change over recent years made to the return was the mandatory requirement to collect information about 'Individuals involved in section 42 safeguarding enquiries' which replaced the collection of 'Individuals involved in safeguarding referrals'. Therefore data relating to 2015-16 onwards contained within this report relates specifically to s42 enquiries.

Table 1 shows the Safeguarding activity within Reading over the previous 3 years in terms of Concerns raised and s42 Enquiries opened and the conversion rates over the same period.

There were 2049 safeguarding concerns received in 2016/17. The number of Concerns has increased considerably over the past couple of years with a large increase of 974 over the previous year (from 1075 in 2015-16). This is partly due to changes made to the local process under the guidance of a new Service Manager which demonstrates the work being carried out in the authority to highlight the importance of recording safeguarding incidents in a more effective way. Coupled with this was the increase in Concerns passed through from the Police and Ambulance Service which may not have then needed to go on for further investigation. This follows a similar pattern identified in other authorities within West Berkshire which is being looked at generally.

481 s42 Enquiries were opened during 2016/17, with a conversion rate from Concern to s42 Enquiry of 24% which is lower than the national average which had been around 40%. This also continues the downward trajectory of this indicator as compared to previous years which had seen conversion rates of around 75% in 2014/15. This continues to demonstrate a positive shift away from the Risk Averse outlook the authority had shown historically. It is likely however that this figure has reached its lowest point and may rise again next year to maybe fall more into line with other West Berkshire authorities.

There were 416 individuals who had an s42 Enquiry opened during 2016/17 which is a decrease of 95 which is an 18.6% fall since 2015/16.

Table 1 – Safeguarding Activity for the Reporting Period 2014-17

Year	Alerts / Concerns received	Safeguarding referrals / s42 Enquiries	Individuals who had Safeguarding Referral / s42 Enquiry	Conversion rate of Concern to s42 Enquiry
2014/15	702	527	475	75%
2015/16	1075	538	511	50%
2016/17	2049	481	416	24%

Section 2 - Source of Safeguarding Enquiries

As Figure 1 shows the largest percentage of safeguarding enquiries for 2016/17 were referred from both Social Care staff (30.6%) and also by Health staff (25.6%) with Family members also providing a larger than average proportion (17.3%). The Police have also been responsible for referring 9.6% of all s42 enquiries over the past year.

The Social Care category encompasses both local authority staff such as Social Workers and Care Managers as well as independent sector workers such as Residential / Nursing Care and Day Care staff. The Health category relates to both Primary and Secondary Health staff as well as Mental Health workers.

Figure 1 - Safeguarding Enquiries by Referral Source - 2016/17

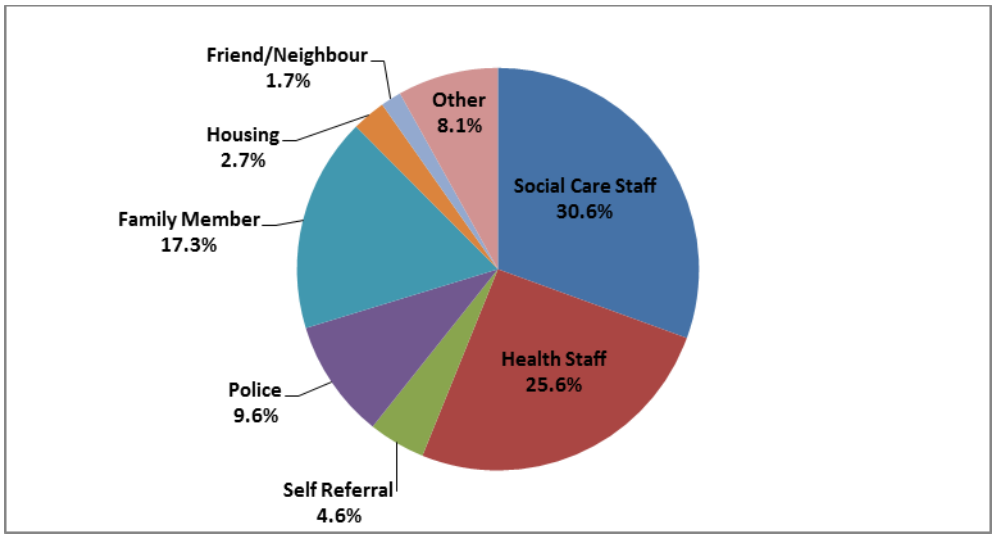


Table 2 shows the breakdown of the number of safeguarding enquiries by Referral Source over the past 3 years since 2014/15. It breaks the overarching categories of Social Care and Health staff down especially into more detailed groups where available, so a clearer picture can be provided of the numbers coming in from various areas.

For Social Care the actual numbers coming in have decreased over the year by 33 which is an 18% drop. The biggest fall in numbers is for Residential / Nursing staff which has seen a 35.4% drop over the year (from 48 in 2015/16 to 31 in 2016/17). Those referrals coming from Social Workers and Care Managers have also declined by 12 which is a 21.4% fall.

The numbers of referrals coming in from Health Staff have also declined from 144 to 123 referrals since 2015/16 (down 14.6%). This is mainly due to a 32% decrease in those coming from Mental Health staff (down 10 referrals over the year). Primary / Community Health (down 10.6%) and Secondary Health staff (down 8.5%) have also seen reductions in referrals being made since 2015/16.

In terms of other referral sources most have remained fairly consistent apart from a noticeable increase in those coming in from the Police which has risen again by 17.9% (up from 39 to 46 in the past year). We have also seen an increase, although still small numbers; for those coming via CQC (up from 2 to 4 during the year) and for Education/ Training/ Workplace Establishment (up from 0 in 2015/16 to 4 in 2016/17).

Table 2 - Safeguarding s42 Enquiries by Referral Source 2014-17

	Referrals	2014/15 (All)	2015/16 (s42 only)	2016/17 (s42 only)
Social Care Staff	**Social Care Staff total (CASSR & Independent)**	**185**	**180**	**147**
	Domiciliary Staff	26	34	36
	Residential/ Nursing Care Staff	58	48	31
	Day Care Staff	7	5	3
	Social Worker/ Care Manager	60	56	44
	Self-Directed Care Staff	3	2	3
	Other	31	35	30
Health Staff	**Health Staff - Total**	**116**	**144**	**123**
	Primary/ Community Health Staff	51	66	59
	Secondary Health Staff	31	47	43
	Mental Health Staff	34	31	21
Other sources of referral	**Other Sources of Referral - Total**	**226**	**214**	**211**
	Self-Referral	32	21	22
	Family member	84	89	83
	Friend/ Neighbour	8	9	8
	Other service user	3	1	0
	Care Quality Commission	2	2	4
	Housing	12	15	13
	Education/ Training/ Workplace Establishment	2	0	4
	Police	17	39	46
	Other	66	38	31
	Total	**527**	**538**	**481**

Section 3 - Individuals with Safeguarding Enquiries

Age Group and Gender

Tables 3, 4 and 5 display the breakdown by age group and gender for individuals who had a safeguarding enquiry in the last 3 years. The majority of enquiries continue to relate to the 65 and over age group which accounted for 62% of enquiries in 2016/17 which is up 5% over the year. Between the ages of 65 and 94 the older the individual becomes the more enquiries are raised. The 18-64 age cohort has seen a fall of 4% proportionately since 2015/16 whereas the other age groups have stayed fairly consistent over the past year.

Table 3 – Age Group of Individuals with Safeguarding s42 Enquiries, 2014-17

Age band	2014-15	*% of total*	2015-16	*% of total*	2016-17	% of total
18-64	197	*41%*	216	*42%*	160	38%
65-74	55	*12%*	66	*13%*	60	14%
75-84	103	*22%*	97	*19%*	83	20%
85-94	106	*22%*	108	*21%*	96	23%
95+	10	*2%*	21	*4%*	17	4%
Age unknown	4	*1%*	3	*1%*	0	0%
Grand total	475		511		416	

In terms of the gender breakdown there are still more Females with enquiries than Males (54% compared to 46% for 2016/17). The gap however between the two has decreased over the last year i.e. it was 18% in 2015/16 whereas it is now only 8% for the current year.

Table 4 – Gender of Individuals with Safeguarding s42 Enquiries, 2014-17

Gender	2014-15	*% of total*	2015-16	*% of total*	2016-17	*% of total*
Male	209	*44%*	208	*41%*	190	*46%*
Female	266	*56%*	303	*59%*	226	*54%*
Total	475	*100%*	511	*100%*	416	*100%*

When looking at Age and Gender together for 2016/17 the number of Females with enquiries is larger and increases in comparison to Males in every age group over the age of 65. It is especially high comparatively in the 85-94 (Females – 28.3% and Males – 16.8%) and the 95+ age groups (Females – 6.6% and Males – 1.1%). For Males there is a larger proportion in the 18-64 group which makes up 47.4% of that total whereas the proportion is only 31% for the Females in that age group.

Table 5 – Age Group and Gender of Individuals with Safeguarding s42 Enquiries, 2016/17

Age group	Female	*Female %*	Male	*Male %*
18-64	70	*31.0%*	90	*47.4%*
65-74	31	*13.7%*	29	*15.3%*
75-84	46	*20.4%*	37	*19.5%*
85-94	64	*28.3%*	32	*16.8%*
95+	15	*6.6%*	2	*1.1%*
Unknown	0	*0.0%*	0	*0.0%*
Total	226	*100.0%*	190	*100.0%*
	54%		**46%**	

Ethnicity

87.3% of individuals involved in s42 enquiries for 2016/17 were of a White ethnicity with the next biggest groups being Black or Black British (5.8%) and Asian or Asian British (5%). The White Group has risen this year by 4.1% (83.2% in 2015/16) as have the Black or Black British Group although only by 0.3%. The other Ethnic groups have seen small drops in their proportions of the overall total.

Figure 2 – Ethnicity of Individuals involved in Safeguarding s42 Enquiries for 2016/17

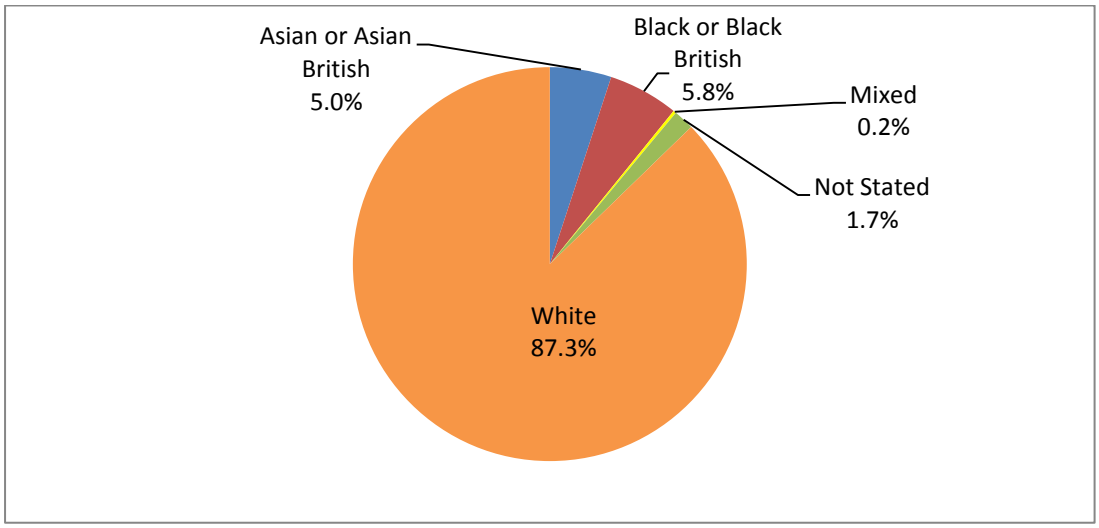


Table 6 shows the ethnicity split for the whole population of Reading compared to England based on the ONS Census 2011 data along with the % of s42 Enquiries for 2016/17 compared to 2015/16. Any Enquiries where the ethnicity was not stated have been excluded from this data in order to being able to compare all the breakdowns accurately.

Table 6 – Ethnicity of Reading Population and Safeguarding s42 Enquiries, 2014-17

Ethnic group	% of whole Reading population (ONS Census 2011 data)	% of whole England population (ONS Census 2011 data)	% of Safeguarding s42 Enquiries 2016/17	% of Safeguarding s42 Enquiries 2015/16
White	74.8%	85.5%	88.8%	86.9%
Mixed	3.9%	2.2%	0.2%	1.4%
Asian or Asian British	12.6%	7.0%	5.1%	5.5%
Black or Black British	7.7%	3.4%	5.9%	5.7%
Other Ethnic group	1.9%	1.7%	0.0%	0.4%

The numbers above suggest individuals with a White ethnicity are more likely to be referred to safeguarding. Their proportions are much higher than for the whole Reading population from the 2011 Census although are more comparable to the England Population from the 2011 Census data. It also especially shows that those individuals of an Asian or Asian British ethnicity are far less likely to be engaged in the process (12.6% in whole Reading population whereas those involved in a safeguarding enquiry is only 5.1%). Once again the Black or Black British Ethnic Group is more comparable to the local picture.

Primary Support Reason

Table 7 shows breakdown of individuals who had safeguarding enquiry by Primary Support Reason (PSR). The majority of individuals in 2016/17 had a PSR of Physical Support (50.7%) which is a similar proportion to that in 2015/16. Whilst most Primary Support Reasons have seen a small proportionate % drop over the last year, the Mental Health Support one has seen a continued rise again this year (from 16.2% in 2015/16 to 20% in 2016/17).

Table 7 – Primary Support Reason for Individuals with a Safeguarding s42 Enquiry, 2014-17

Primary support reason	2014/15	*% of total*	2015/16	*% of total*	2016/17	*% of total*
Physical Support	193	*40.6%*	262	*51.3%*	211	*50.7%*
Sensory Support	13	*2.7%*	8	*1.6%*	1	*0.2%*
Support with Memory and Cognition	84	*17.7%*	44	*8.6%*	35	*8.4%*
Learning Disability Support	83	*17.5%*	84	*16.4%*	63	*15.1%*
Mental Health Support	70	*14.7%*	83	*16.2%*	83	*20.0%*
Social Support	28	*5.9%*	30	*5.9%*	23	*5.5%*
No Support Reason	4	*0.8%*	0	*0.0%*	0	*0.0%*
Total	475	*100%*	511	*100%*	416	*100%*

Section 4 – Case details for Concluded s42 Enquiries

Type of Alleged Abuse

Table 8 shows concluded enquiries by type of alleged abuse over the last three years. An additional 4 abuse types (*) were added to the 2015/16 return so there are only comparator figures since then.

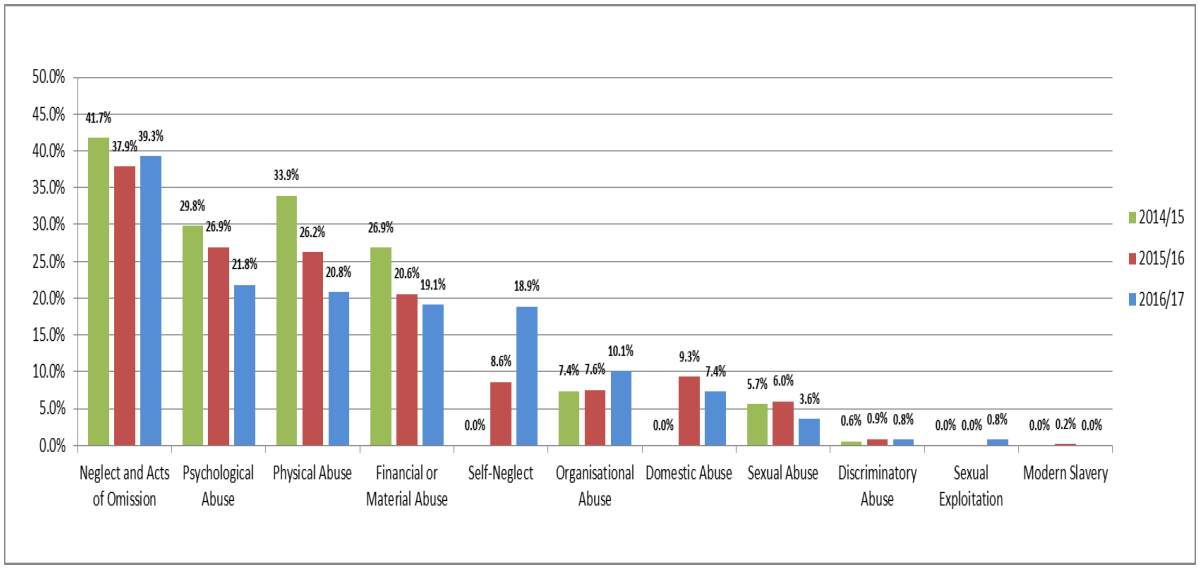
The most common types of abuse for 2016/17 were still for Neglect and Acts of Omission (39.3%), Psychological Abuse (21.8%) and Physical Abuse (20.8%) although the latter two types have seen yet another decrease since last year (5.1% and 5.4% respectively).

The main 2 types of abuse that saw increases since last year are Self-Neglect (up 10.3%) and Organisational Abuse (up 2.5%). Self-Neglect was one of the newer abuse types added in 2015/16 so it has highlighted an important safeguarding area of interest in its own right.

Table 8 – Concluded Safeguarding s42 Enquiries by Type of Abuse, 2014-17

Concluded enquiries	**2014/15**	%	**2015/16**	%	**2016/17**	%
Neglect and Acts of Omission	214	41.7%	215	37.9%	187	39.3%
Psychological Abuse	153	29.8%	153	26.9%	104	21.8%
Physical Abuse	174	33.9%	149	26.2%	99	20.8%
Financial or Material Abuse	138	26.9%	117	20.6%	91	19.1%
Self-Neglect *	0	0.0%	49	8.6%	90	18.9%
Organisational Abuse	38	7.4%	43	7.6%	48	10.1%
Domestic Abuse *	0	0.0%	53	9.3%	35	7.4%
Sexual Abuse	29	5.7%	34	6.0%	17	3.6%
Discriminatory Abuse	3	0.6%	5	0.9%	4	0.8%
Sexual Exploitation *	0	0.0%	0	0.0%	4	0.8%
Modern Slavery *	0	0.0%	1	0.2%	0	0.0%

Figure 3 – Type of Alleged Abuse over past 3 Years since 2014/15



Location of Alleged Abuse

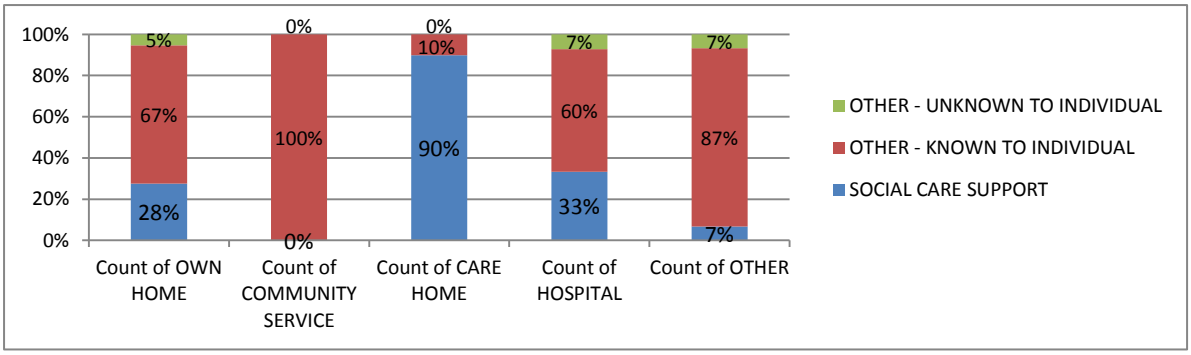
As shown in Table 9; as with previous years, still by far the most common location where the alleged abuse took place for Reading clients has been the individuals own home (67.9% in 2016/17) which has shown a 2.8% rise proportionately as compared to last year. The other locations have either increased or decreased by very small percentages.

Table 9 – Location of Abuse, 2014-17

Location of abuse	2014-15	% of total	2015-16	% of total	2016-17	% of total
Care home	112	21.8%	100	17.6%	88	18.5%
Hospital	51	9.9%	56	9.9%	42	8.8%
Own home	307	59.8%	370	65.1%	323	67.9%
Community service	14	2.7%	7	1.2%	3	0.6%
Other	56	10.9%	60	10.6%	45	9.5%

Figure 4 shows the breakdown of location of alleged abuse by source of risk. Where the alleged abuse took place in the persons 'Own Home', for the majority of cases (67%), the source of risk was an individual known to the adult at risk. This group was also the most common for those taking place in a 'Hospital' (60%), in 'Community Services' (100%) and in 'Other' locations (87%). For those taking place in a 'Care Home' the biggest source of risk by far was from Social Care Support staff (90%).

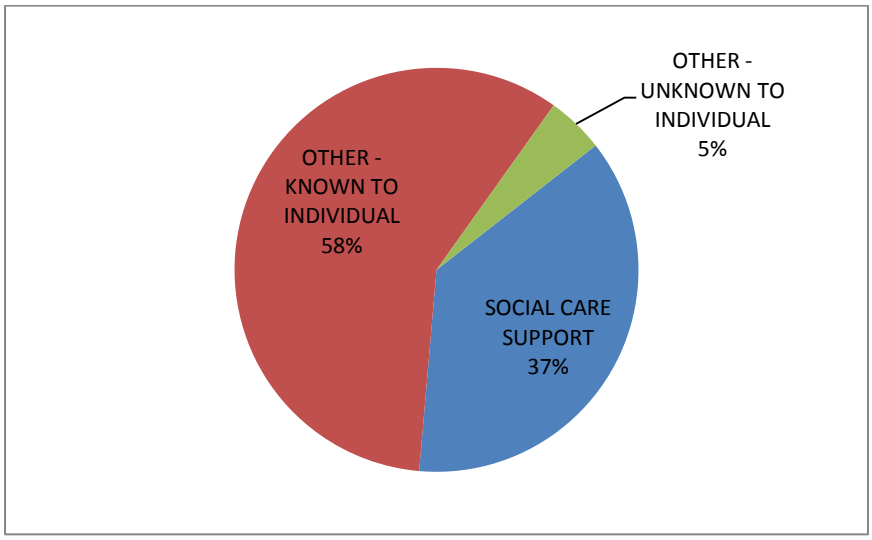
Figure 4 – Concluded Enquiries by Location of Alleged Abuse and Source of Risk for 2016/17



Source of Risk

The majority of concluded enquiries involved a source of risk 'Known to the Individual' (58%) whereas those that were 'Unknown to the Individual' only make up 5% (was 10% in 2015/16). The 'Social Care Support' category refers to any individual or organisation paid, contracted or commissioned to provide social care. This now makes up 37% of the total (up 4% on 2015/16). This is shown below in Figure 5.

Figure 5 – Concluded Enquiries by Source of Risk 2016/17



Action Taken and Result

Table 10 below shows concluded enquiries by action taken and the results for the last three years.

The figures for those cases where the risk was removed or remained saw a slight decrease again this year (down 1% and 3% respectively on 2015/16). Those with a risk reduced have seen a larger than proportionate decrease year on year from 55% in 2014/15 to 38% in 2015/16 and then to 29% in 2016/17. Those with no further action have increased proportionately each year since 2014/15 (from 21% to 42% between 2014/15 and 2015/16 and then up to 56% of the total in 2016/17).

Table 10 – Concluded Enquiries by Action Taken and Result 2014-17

Result	2014-15	% of total	2015-16	% of total	2016-17	% of total
Action Under Safeguarding: Risk Removed	75	15%	54	10%	41	9%
Action Under Safeguarding: Risk Reduced	284	55%	214	38%	139	29%
Action Under Safeguarding: Risk Remains	48	9%	58	10%	31	7%
No Further Action Under Safeguarding	106	21%	242	42%	265	56%
Total Concluded Enquiries	513	100%	568	100%	476	100%

Figure 6 shows concluded enquiries by result for 2016/17. No further action was taken under safeguarding in 56% of cases, while the risk was reduced or removed in 38% of cases.

Figure 6 – Concluded Enquiries by Result, 2016/17

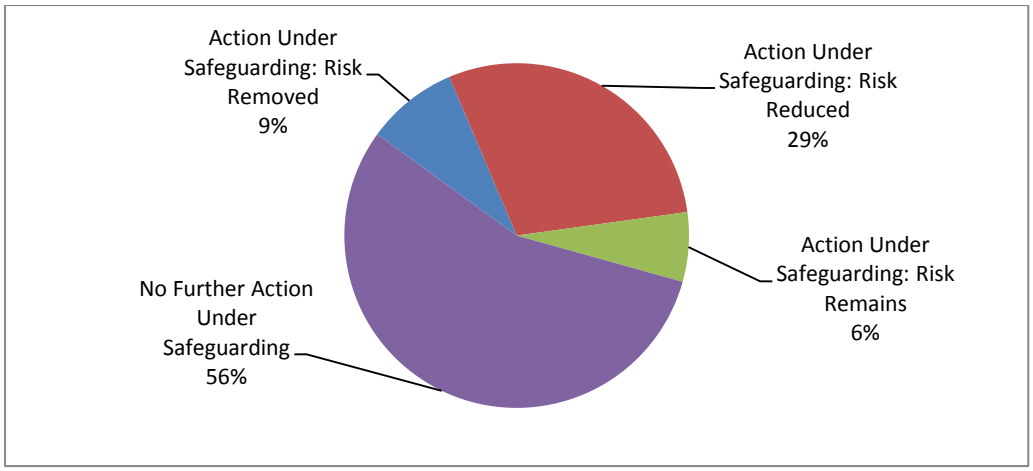
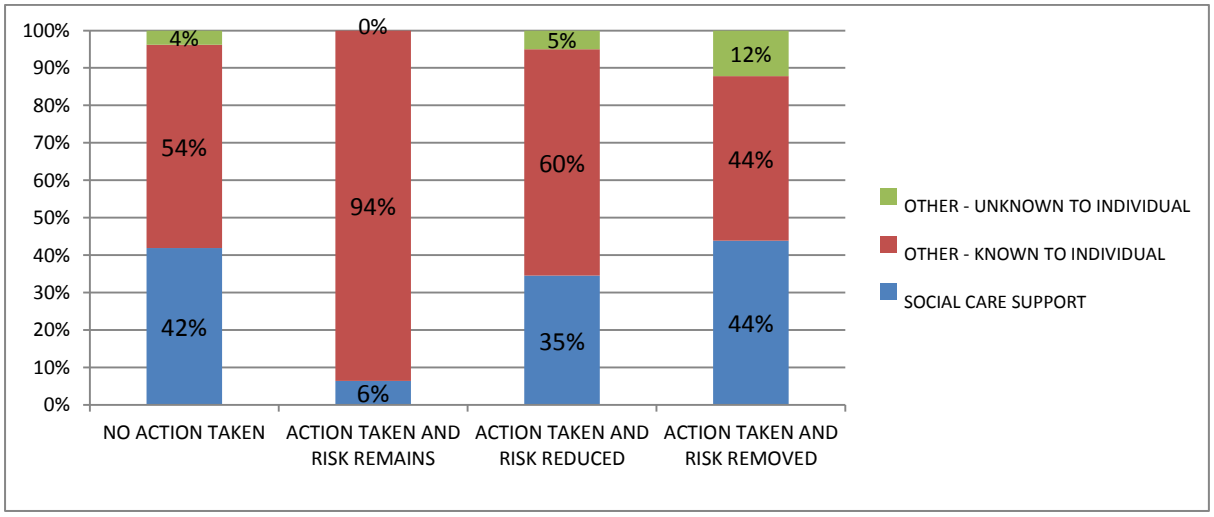


Figure 7 shows a breakdown of the results of action taken for concluded enquiries by source of risk for 2016/17. For the majority of cases where action was taken and the risk was reduced or remained the main source of risk was other individuals known to that individual. This is especially noticeable in cases where the risk remains (94% of alleged perpetrators were known to the individual).

Cases where the risk has been removed show an equal proportion in the Social Care Support and Other individuals known to that individual groups (44% each) which is a shift from 2015/16 when Social Care Support made up 50% of that total.

Where No Action was taken the largest proportion (54%) which is an increase proportionately of 3%, was attributed to people known to the individual so probably relates to family members for example where an enquiry was raised but not substantiated.

Figure 7 – Concluded Enquiries by Result of Action Taken and Source of Risk 2016/17

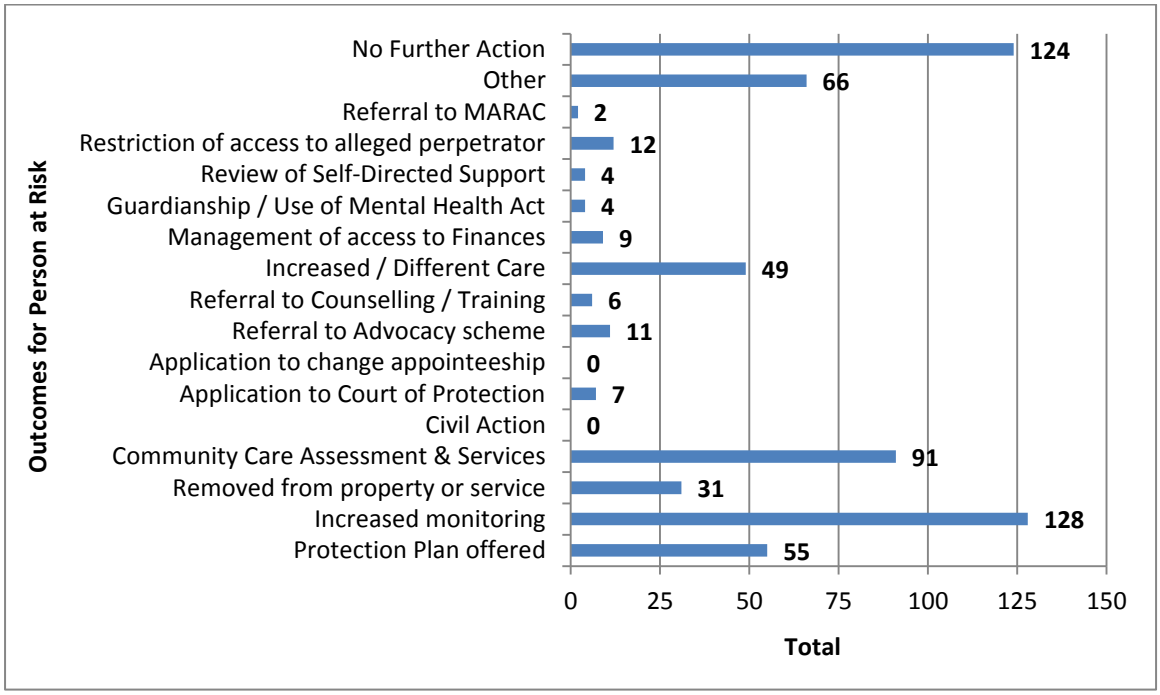


Outcomes for the Person at Risk

Figure 8 shows the Outcomes for the person at risk for concluded enquiries for 2016/17.

The most common outcomes for concluded enquiries by far were 'Increased monitoring' (26.9%), 'No Further Action' (26.1%) and 'Community Care Assessment & Services' (19.1%). As the chart below includes concluded enquiries which were not substantiated or inconclusive, this would explain some of the No Further Action outcomes for the person at risk.

Figure 8 - Outcomes for Person at Risk, 2016/17



Section 5 - Mental Capacity

Figure 9 shows the breakdown of mental capacity for concluded enquiries. In 24% of cases the individual was found to lack capacity which is a 4% rise on 2015/16.

80 of the 114 individuals (70.2%) assessed as lacking capacity were supported by an advocate, family or friend which was an 11% rise on 2015/16.

Figure 9 – Does the Individual Lack Capacity – 2016/17?

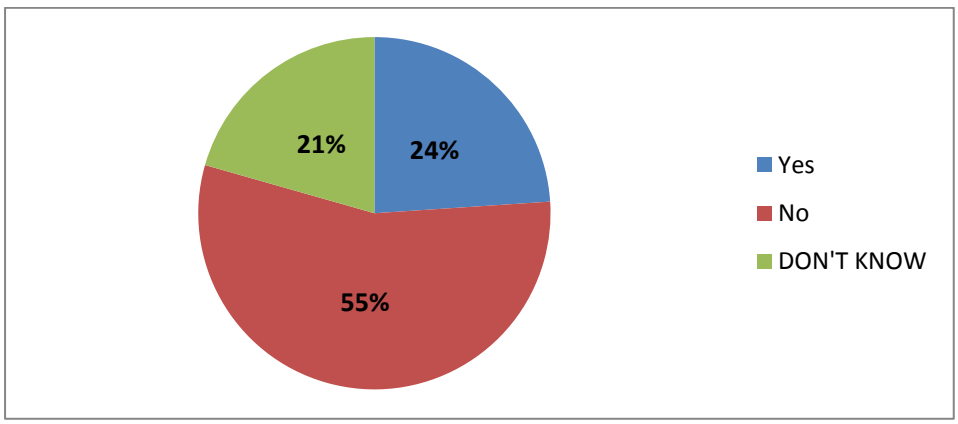
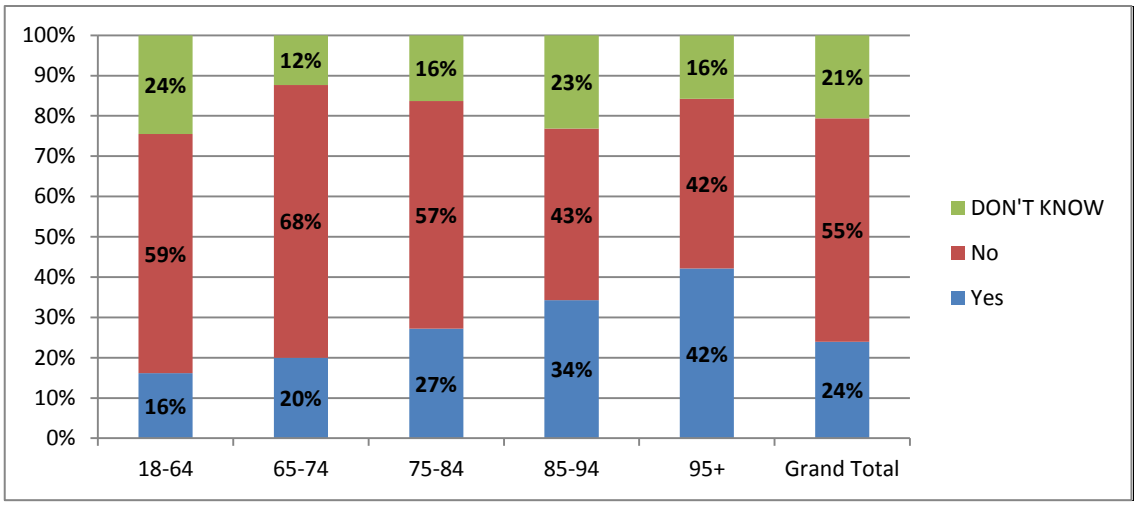


Figure 10 shows a breakdown of individuals lacking mental capacity of the person at risk by age group. The figure shows the likelihood of the person lacking capacity increases significantly at each age group, with people aged 75+ being most likely to lack capacity.

The proportions of people lacking capacity have also increased significantly this year. In 2015/16 the figure lacking capacity in the 65-74 age group was 15% but is now up to 20% and the 75-84 age group has also seen a 2% rise in this area (up from 25%). The biggest rises however have been seen in the 85-94 and 95+ age groups where those lacking capacity have seen rises of 6% and 13% respectively as compared to 2015/16 (had been 28% and 29% proportionately).

Figure 10 – Mental Capacity by Age Group of Person at Risk, 2016/17



Section 6 - Making Safeguarding Personal

Making Safeguarding Personal (MSP) was a national led initiative to improve the experiences and outcomes for adults involved in a safeguarding enquiry. This initiative was adopted by the Government and can be found within the Care Act 2014.

As at year end, 86% of all clients for whom there was a concluded case were asked about the outcomes they desired (either directly or through a representative) although 10% of those did not express an opinion on what they wanted their outcome to be (In 2015/16 this figure was 82% of which 7% did not express what they wanted their outcomes to be).

Figure 11 – Concluded Enquiries by Expression of Outcome, 2015/16 to 2016/17

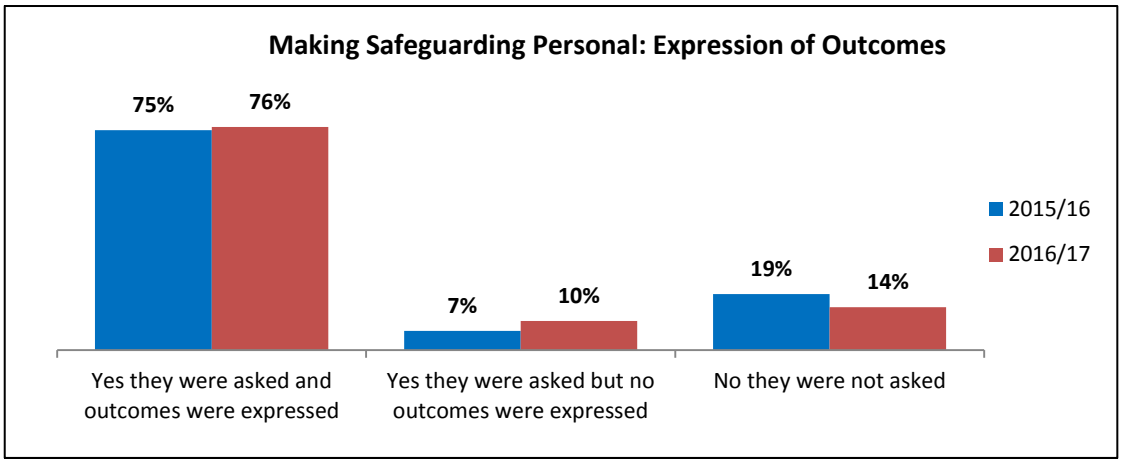
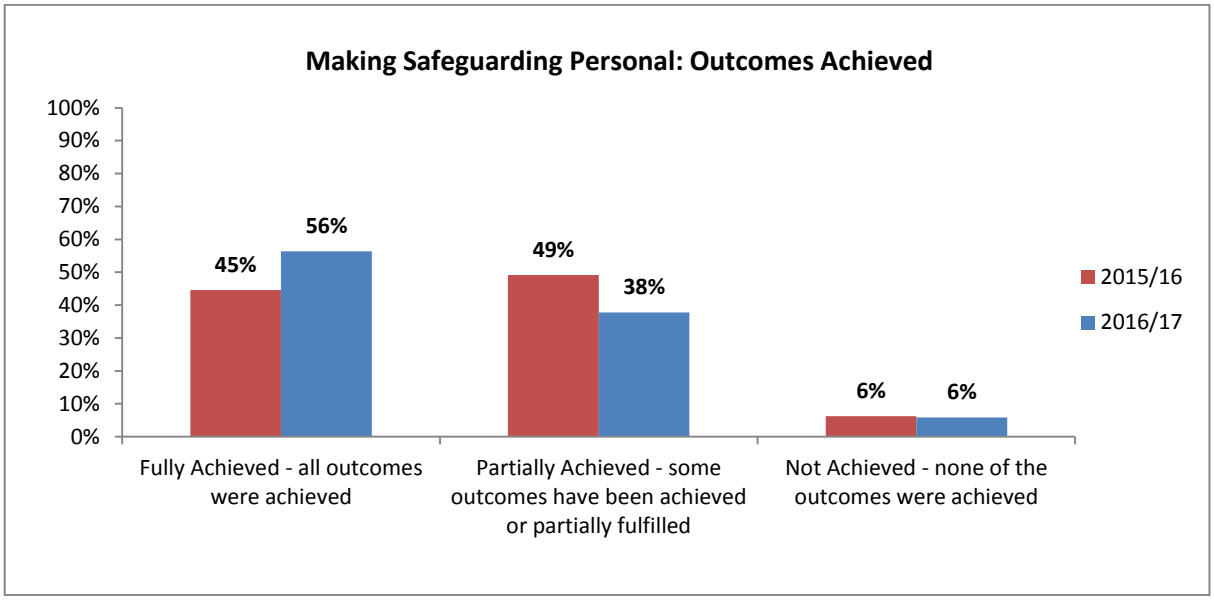


Figure 12 – Concluded Enquiries by Expressed Outcomes Achieved, 2015/16 to 2016/17



Of those who were asked and expressed a desired outcome, there has been a rise of 11% (from 45% in 2015/16 to 56% in 2016/17) for those who were able to achieve those outcomes fully, as a result of intervention by safeguarding workers.

A further 38% in 2016/17 managed to partially achieve their stated outcomes meaning only 6% did not achieve their outcomes during the previous year.

Royal Berkshire

Safeguarding Annual Report 2016/17

The Strategic Safeguarding Committee, 12th June 2017

Safeguarding is everybody's responsibility.

Formal Opening Changing Places, 16th May 2017

Executive Summary

The Royal Berkshire NHS Foundation Trust (RBFT) is dedicated to safeguarding vulnerable people. It has an experienced safeguarding team with the skills and experience to support different groups: adults, children, and people with a learning disability, people with mental health problems and families accessing our maternity services. The team provides a cohesive approach to training and support of staff to meet the needs of vulnerable people. In line with national guidance on multi agency working the safeguarding team represent the Trust on a variety of partner agency groups. They work with individual patients and teams in 'making safeguarding personal' coordinating a multi-disciplinary, multiagency agency approach balancing the principles of empowerment and autonomy with our responsibility to protect and safeguard.

There have been significant achievements and improvements in safeguarding since the publication of the Mazars Report into Southern Health, 2015 and Verita Investigation of the Myles Bradbury Case, 2015

The essence of good safeguarding is continuous learning, quality improvement, professional curiosity and challenge. We have worked with our partners to implement the recommendations from the CQC inspection of health providers, child safeguarding and looked after children report for Wokingham CCG, May 2016 and Ofsted Inspection reports for West Berkshire and Reading Local Authorities Children's Services and LSCBs published in May 2015 and August 2016. We participated in safeguarding children, neglect and domestic abuse peer reviews commissioned by West Berkshire, July 2016 and Wokingham, February 2017. We actively participated in a Wokingham Domestic Homicide Review and partnership reviews, Serious Case Reviews and Safeguarding Adult Reviews. We brought learning from these reviews back to the RBFT to improve our safeguarding systems, processes and staff knowledge and competency.

The RBFT has obligations under the Children Act 1989 and 2004, Care Act 2014, MCA, 2005, Mental Health Act (MHA), 1983 to ensure it provides safe effective and well led services which safeguard the vulnerable. Compliance with Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework and CQC regulation 13 Safeguarding Service Users from Abuse and Improper Treatment are the standards we employ to focus on our declared aim of 'promoting the safety and well-being of all children, young people and adults' who have contact with our services. Training, audit and review against those standards are the foundations of our assurance reinforced by

supervision and management overview. Our Annual Safeguarding Plan for 2016/17 was based on the findings of a Price Waterhouse Cooper audit of Safeguarding commissioned in October 2016 by our Audit and Risk Committee and the 'amber areas' of the 2015/16 annual safeguarding standards self-assessment which includes our Section 11 audit of the Children Act 2004 which is submitted to our commissioners. We actively participate in the Quality and Performance sub groups of the Local Safeguarding Children Boards and Safeguarding Adult Board for the West of Berkshire.

Challenges include training staff in all aspects of safeguarding, consistency of knowledge, competency and application in practice; transition for children to adult services including Child and Adolescent Mental Health Services (CAMHS); a year on year increase in activity for all vulnerable groups including, elderly patients living with dementia and adults with learning difficulty who are delayed in hospital; high numbers of mental health patients of all ages with complex psycho-social needs in the acute setting; an increase in the number of vulnerable patients delayed in hospital; an increase in the complexity in cases of at risk unborn babies and self-harm and suicide prevention. Monitoring the impact of health and social care budget cuts, homelessness and workforce sufficiency on services for the vulnerable, gaps in services for disabled children and children and young people with Special Educational Needs and Disability (SEND) , domestic abuse, neglect and self-neglect, safe recruitment and allegation management and the sufficiency of mental health services and the national Prevent scheme are continuing or emergent themes.

Patricia Pease, Associate Director of Safeguarding, June 2017

Introduction

This is the annual safeguarding report for the Royal Berkshire Foundation Trust (RBFT) it covers all areas of safeguarding work across the Trust and through multiagency working, and sets out our priorities for further work.

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect (CQC 2016). Safeguarding at the Royal Berkshire Hospital is fundamental to high-quality health care. Safeguarding is everybody's responsibility.

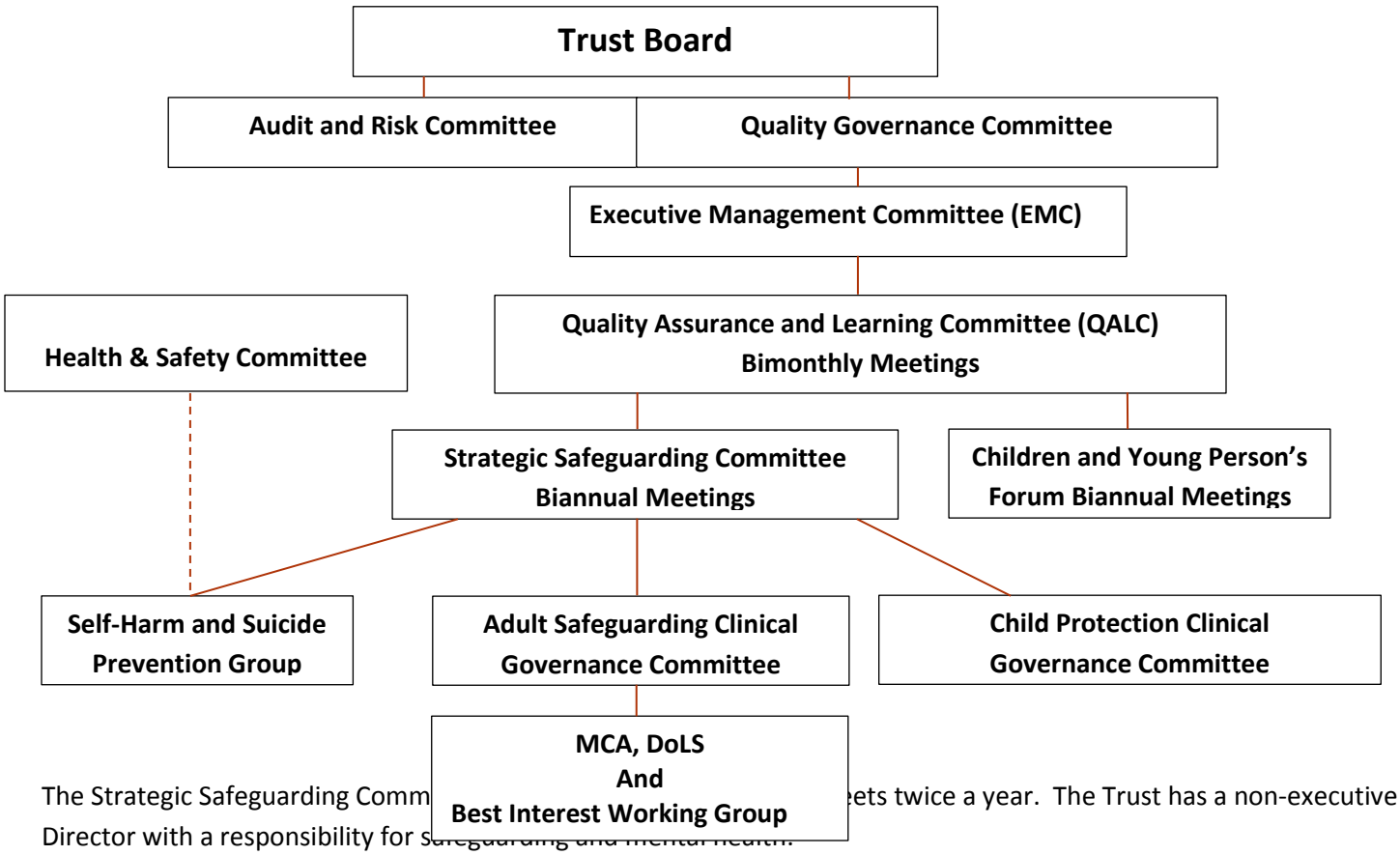
The Safeguarding Team Structure

The safeguarding team structure (nursing and administration) and lines of responsibility and accountability for the RBFT is shown on the diagram below:

Adult Safeguarding: Medical Leads	• Dr. Chris Danbury: Urgent Care Group • Dr. Kim Soulsby: Planned Care Group • Vacant: Networked Care Group
Child Protection: Medical Leads	• Dr Andrea Lomp: Designated Doctor Child Protection, Berkshire West • Locality Paediatricians to support Designated Doctor Child Protection based at Dingley Specialist Children's Centre. This team also provide Child Protection Examinations • Dr Ann Gordon: Named Doctor for Child Protection • Dr Niraj Vashist: Medical Advisor to Fostering and Adoption Panel
Child Death	• Patricia Pease: Designated Healthcare Professional Child Death Berkshire West
Sexual Health	• Julia Tassano-Smith: Nurse Consultant
Human Resources	• Suzanne Emerson-Dam: Assistant Director Workforce Designated HR Officer Safe Recruitment & Allegations Management

The Safeguarding service is accountable to the RBFT EMC and Board, Berkshire West CCG, Reading, West Berkshire and Wokingham Local Safeguarding Children Boards (LSCBs), Berkshire West Safeguarding Adult Board (SAB) and participates in Mental Health, Learning Disability, Strategic Disability and Transition partnership meetings.

Safeguarding Governance Committee Structure



The Strategic Safeguarding Comm ets twice a year. The Trust has a non-executive Director with a responsibility for s

Safeguarding and mental health quality indicators are reported monthly to the Board and CCG. A bi-monthly safeguarding and mental health report including key performance indicators is submitted to the Board as part of the QALC report.

Multidisciplinary child protection clinical governance is held every 2 months; this is chaired by the Named Nurse for Child Protection. Safeguarding Adult Clinical Governance is held every 3 months chaired by Dr. Chris Danbury. A Mental Capacity, DoLS and Best Interest Working Sub Group that includes the Head of Legal Affairs meet every 6 months, reporting to Safeguarding Adult Clinical Governance. The Mental Health Coordinator chairs a quarterly Suicide and Self Harm Prevention Group, which reports by exception to the Health and Safety Committee.

Quarterly Safeguarding Concerns and Allegations Review Meetings, chaired by the Designated HR Officer Safe Recruitment & Allegations Management, were established in 2016, live cases are reviewed to ensure timely conclusion and closed cases are reviewed in order to identify patterns or theme.

The Children and Young People's Committee monitors work streams to benchmark and improve the quality and safety of Trust services for children: the work of this group is under review.

The safeguarding nursing team meets monthly to discuss operational safeguarding issues and prepare performance reports; agendas and minutes are kept for these meetings.

Statistics/Activity - The table below sets out indicative statistics for the RBFT for information and background.

	2013/14	2014/15	2015/16	2016/17	Comment
Population number served	1,000,000	1,000,000	1,000,000	1,000,000	↔
% of population under 18 years	20%	24%	24%	24%	↔
Number of adult attendances to ED	83,298	87,288	89,711	94,348	↑4.9%
Number of attendances by under 18s to ED	26,686	27,864	29,087	29,427	↑1%
No of over 65s attending ED	22,644	24,569	25,635	27,159	↑ 5.6%
No of mental health attendances at ED all ages	2169*	2810	2809	2778	↓19%
Number of adult admissions	80,766	84,434	90,933	92,791	↑ 2%
Number of admissions to paediatric wards	7,146	7181	7607	8589	↑ 11.4 %
Number of under 18s admitted to adult wards			550	704	↑ 21.88%
No over 65s who were admitted	32,821	35142	39515	39785	↑0.68%
No over 75s admitted for >72 hrs	5,301	5288	5451	6449	↑15.48%
No over 75s admitted for >72 hrs with cognitive issues	1602	1483	1195	1,582	↑24.46%
Number of in-patients with a learning disability	227	289	315	278	↓12%
No of patients admitted because of mental health issues		798	1596	1610	↑19%
Number of babies born	5,689	5681	5596	5391	↓ 3.8%
Number of under 18s attending out-patient clinics	65,296	62,767	62,437	72,539	↑13.93%
Number of under 18s attending clinics providing sexual health services	2,959	2016	2356	2059	↓13% - episodes 4036
Dingley child protection medicals – calendar years	54	98	120	112	
Number of employees	Approx. 5000	Approx. 5000	5360	5470	

Training

Training is reported monthly to the CCG as part of the quality schedule. A Trust annual training plan for child and adult safeguarding 2017/18 has been completed and approved by the Trust Education Committee. At the end of March 2017 safeguarding training was at or above the expected and agreed level with the exception of:

- Safeguarding Children Level 1 Training – 86% against a target of 95%
- Adult Safeguarding Training – 89% against a target of 90%

All training programmes are regularly reviewed to ensure they include learning from serious case reviews and changes to national policy and guidelines.

Safeguarding Adults training

All staff need to be trained in safeguarding adults. Staff that make clinical decisions with patients need to be trained in the mental capacity act (MCA) and its application. The focus in 2017/18 will be application in practice of the MCA.

Safeguarding Children training

All staff need to be trained in child protection to the level that their job role requires 'Intercollegiate document, Child Protection Roles and Competencies for Health Staff, 2014'. A review of level 1, 2 and 3 training was undertaken during 2016/17 this included an increase in the number of hours of update training annually for specialist midwives. In 2017/18

the content of the programme for specialist midwives will be reviewed and a there will be a wider review of how we evaluate skills, knowledge and confidence of the children's workforce to inform the need for further work.

Child Sexual Exploitation (CSE) Training

CSE is embedded into safeguarding children training at all levels. Four CSE one hour updates at level 3 are available annually. The Department of Sexual health holds a one hour CSE case study peer review bimonthly. All staff can access E.learning via the CSE intranet pages. In 2017/18 we will concentrate on embedding the use of CSE assessment tools.

Domestic Abuse

Domestic abuse is raised in adult and all levels of child safeguarding mandatory and statutory training; specific domestic abuse training is available for maternity staff. Level 3 days for the children's workforce include clear guidance for staff who are working closely with children and families on how to support and refer to other agencies where there are parental risk indicators. In the 2017/18 further work will be undertaken with the Emergency Department (ED) and their Domestic Abuse champions.

Prevent (Anti-terrorism Training)

Prevent awareness forms part of the level one training for all staff and is included in adult and child safeguarding training. 1 hour Wrap training is delivered to selected staff. The focus in 2017/18 will be Human Resources, the Emergency Department, Paediatrics and the Clinical Site Management Team. This can be delivered face to face or via e-learning. An E learning has also been promoted for use with in the Trust.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs).

MCA and DoLS awareness are delivered as part of the core mandatory training day and as part of Trust induction safeguarding adults training. For patient facing staff MCA enhanced training will continue to be delivered to a selected group of staff to achieve a minimum of 80% compliance. There will be a 'MCA, Consent and Best Interests Assessment' priority programme during 2017/18 using an 'engage and enable' approach which will include roll out of flow charts and documentation to support knowledge and application in practice and promote confidence.

Mental Health Training

The Mental Health Coordinator (MHC) continues to provide training to staff on the Mental Capacity Act, the Mental Health Act (MHA), mental health disorders, stigma, and the processes in place within the hospital to ensure good patient care. The MHC provides training to ED Senior House Officers, ED Middle Grades and Health care assistants at induction. A Mental Health training day was established in 2016 for ED, Acute Medical Unit and Short Stay Unit nursing staff which includes understanding of the MHA, MCA, mental health disorders and the process if a patient is detained under the MHA. In 2017/18 this one day training will include risk management in practice, a Consultant Psychiatrist will join the team and the days will be extended to medical staff. The session already included in HCA induction will be extended to nurse, midwife and allied health professional (AHP) induction. A programme of monthly training on the application of MHA delivered by two Consultant Psychiatrists started in June 2017 – this will support the RBFT 'Quick Guide to MHA'.

Allegations and Safer Recruitment training

Safeguarding concerns and allegations awareness is delivered as part of child and adult safeguarding core mandatory training. A one off training for consultants, outpatient reception and outpatient nurses on learning from Myles Bradbury was delivered in 2016. In 2017/18 a training need analysis will be carried out to inform the need for additional training for specific staff groups and a larger cohort of managers trained to investigate allegations will be identified.

Conflict management training and training in physical restraint

Security Staff are trained in physical restraint; all are qualified in Caring Intervention level 3 Control and Restraint. Conflict management training is available and mandatory for all clinical staff and includes breakaway techniques and understanding of the application of the Mental Capacity Act. Restraint in relation to clinical treatment and best interests is discussed in Level 1 adult safeguarding training and Level 3 child protection training. In 2017/18 there will be a review of the Trust management of patient challenging behaviour, violence and aggression and restraint policies and protocols and a subsequent training needs analysis and review.

Transition training

By April 2017 transition training as part of the 'Ready Steady Go' framework for transition planning roll out was delivered to 18 adult specialties. During 2017/18 specialties' will be expected to maintain the knowledge and skills of their staff in relation to transition through ward and department training.

Learning Disability

A DVD is shown at core induction; there are raising awareness sessions for RNs and HCAs as part of nurse/HCA induction. A communication session is delivered on a training day for care crew teams. LD awareness has been included in junior doctor induction. In 2017/18 there will be work to support a consistent response to an LD flag or diagnosis 24/7.

Ongoing Challenge/Risks:

- **Training compliance of our staff in all aspects of safeguarding**
- **Consistency of knowledge and application in practice**
- **Consistency in recognition and assessment of risk and confidence of our staff to respond**

Safeguarding Audit

A comprehensive self-audit was completed for the CCG in September 2016. The audit is RAG (Red, Amber, Green) rated; there were 8 "amber" areas for improvement in 2016/17. The other 42 areas were green. Programmes of work and/or action plans were developed for each amber area. For 2017/18 the 'amber' rated areas will be reviewed by the Safeguarding Team and the CCG. A safeguarding staff survey using survey monkey will be completed in October 2017.

The Audit and Risk Committee commissioned Price Waterhouse Cooper to carry out an audit of Safeguarding in October 2016. This review covered the Trusts processes for safeguarding children and vulnerable adults, including; the training provided to staff; management of safeguarding concerns, and the Trust's involvement in and liaison with local Safeguarding Boards. Safeguarding was last reviewed by Internal Audit in 2012/13, where a high risk report was issued, largely as a result of; poor training compliance at that time; safeguarding policies and procedures requiring update and approval from the Trust Board, and limited internal reviews and assessment being undertaken. It was noted in the 2016 report that the Trust had improved in each of these areas; however at the time of the review training was not fully compliant with national targets.

The Safeguarding Team coordinates an agreed audit program that includes single and multiagency audits monitored through our internal governance systems and the quality and performance sub groups of the LSCBs and SAB.

Safer Recruitment and Allegations Management

Key Achievements

- Review of the Managing Safeguarding Concerns and Allegations Policy (April 2016), the Recruitment and Selection Policy (January 2017) and the Disclosure and Barring Policy (January 2017).
- Commenced the 3 yearly DBS checks for staff/volunteers concentrating on priority groupings.
- Implementation of Quarterly Safeguarding Review Meetings where live cases are reviewed to ensure timely conclusion and closed cases are reviewed in order to identify patterns or themes and actions identified as a result of identified themes.
- Attendance at the West Berkshire Council Serious Case Review Event in order to identify lessons learnt.

Summary of Cases

In the financial year 2016/17 a total of 17 allegations were made; 10 relating to vulnerable adults and 7 relating to children. Over the same period a total of 7 concerns were raised; 5 relating to vulnerable adults and 2 relating to children.

Of the 24 concerns/allegations raised, 16 related to Trust employees; the others related to agency workers, volunteers or "others". One of the allegations related to historical issues.

In comparison with the previous two years the number of allegations increased from 8 to 11 to 17 and the number of concerns rose from 4 to 5 to 7. In order to provide appropriate HR support to safeguarding concerns and allegations the number of HR staff trained to deal with safeguarding concerns and allegations is being increased from 1 to 3.

Key Areas of Work for 2017/18

Concerns/Allegations Management

- To work with the Associate Director for Safeguarding to provide support/guidance/templates to managers who have attended the Managing Safeguarding Concerns and Allegations Training Programme particularly in relation to report writing.
- To develop a larger cohort of mangers trained to investigate allegations
- To carry out a multidisciplinary training needs analysis of managers in relation to managing safeguarding concerns and allegations in practice

Safer Recruitment

- To review the content of the Recruitment Training Programme and the number of staff trained.

Ongoing Challenge/Risks:

- **Capacity to release clinical managers to undertake safer recruitment and allegation training**
- **Capacity of the Safeguarding team to effectively administer the investigation process given a year on year increase in concerns and allegations raised**

Child Protection and Safeguarding

Key achievements

- We worked with our partners to implement the recommendations from the CQC inspection of health providers, child safeguarding and looked after children report for Wokingham CCG, May 2016 and Ofsted Inspection reports for West Berkshire and Reading Local Authorities Children's Services and LSCBs published in May 2015 and August 2016.
- We participated in safeguarding children, neglect and domestic abuse peer reviews commissioned by West Berkshire, July 2016 and Wokingham, February 2017 and received very positive feedback.
- In May 2017, Wokingham Local Authority had a Joint Targeted Area Inspection which focused on children from 7 to 15 years old and neglect. RBFT worked closely with all agencies, feedback for the RBFT was very positive with some learning about multiagency communication in the perinatal pathway.
- We have actively participated in two partnership reviews with Reading LSCB; learning has been disseminated through training. We are currently participating in a serious case Review for Reading LSCB.
- Level 3 Multi-agency Child protection training has been embedded, delivered and adapted to the changing safeguarding environment. Partner agencies teach on the day and are invited to participate.
- The pilot of a CAMHS Urgent Response Service proved to be successful and is now commissioned to provide a more comprehensive assessment service for children and young people attending with mental health needs being seen in a timely manner and by an appropriate practitioner.
- The Named Nurse continues to meet regularly with partner agencies, good strong relationships have been developed and feedback on our service has been invited and valued.
- The annual audit of child protection referrals to Local Authorities identified staff referring appropriately, engaging with child protection thresholds, demonstrating more confidence in raising concerns and using more effective information sharing.
- Previous audits of children not brought for health appointments have demonstrated good processes in place but a need to explore the role and responsibilities of the GP. The Named Nurse for Child Protection and Safeguard Lead for GP's are repeating the audit to include GP practice.
- An audit of the pathway of referral to health visitors and school nurses in March 2017 showed that Emergency Department was very effective in their communication. The Paediatric ward showed good knowledge but inconsistent application in practice.
- Following the establishment of a task and finish group the monthly audit of young people attending adult ED with mental health issues being discussed with Children's Social Care has improved.
- In October 2016, Price Waterhouse Cooper (PWC) was commissioned to review Safeguarding Adults and Children. As a result the process for recording and reporting child safeguarding children is being reviewed to develop an electronic approach which will improve information sharing, the communication of safeguarding concerns and audits. PWC recognised that there was an established process for clinicians to follow when discharging children

where safeguarding concerns have been raised, including the completion of a specifically designed checklist. However, found no established mechanism for the Safeguarding Team to be assured that the process was adhered to – that has been remedied, an audit has been established.

Fig 1: referrals to local authority per month 2016/17 from RBFT:

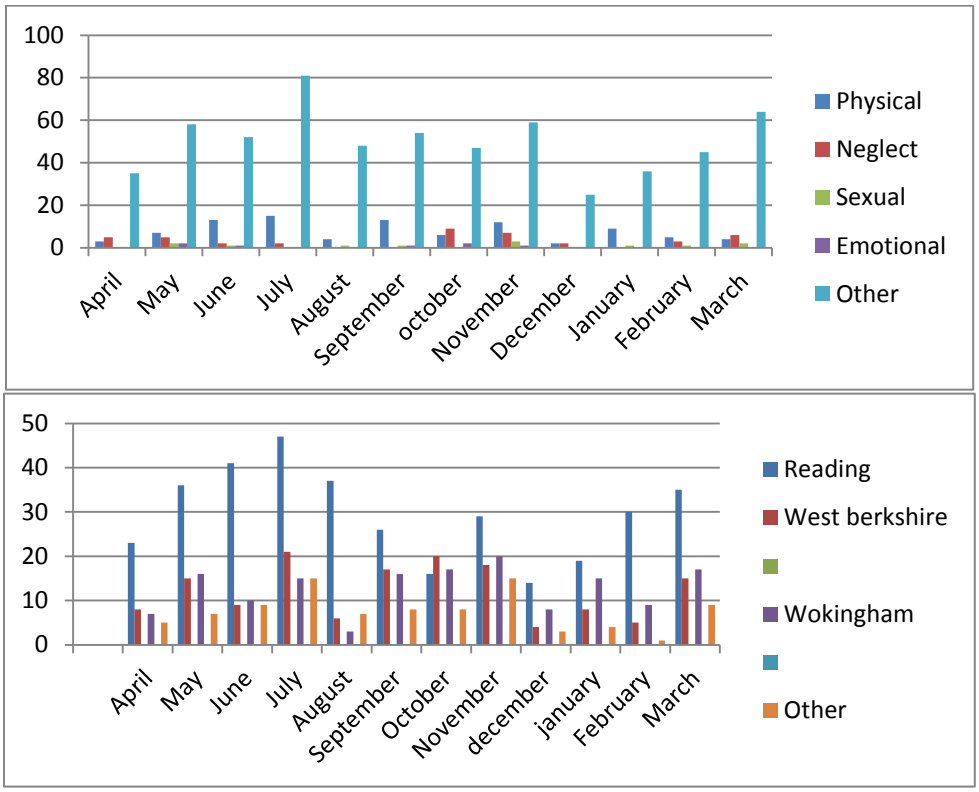


Figure 2: Referrals by category of abuse per month 2016/17 from RBFT

"Other" abuse is child protection referral for risk factors such as mental health concerns, domestic abuse, substance misuse, Female Genital Mutilation (FGM) and parenting concerns.

Key Areas of Work for 2017/18

- Continue working with Information Management and Technology (IM&T) Services, clinical teams and NHS England to ensure Child Protection Information Sharing (CP-IS) is fully integrated into unscheduled care settings by March 2018 and to develop an electronic approach to our child safeguarding referral and information sharing
- Continue working with Information Management and Technology (IM&T) to develop an electronic approach to our child safeguarding referrals and information sharing
- Continue working in partnership with BHFT, TVP, SCAS and the three local authorities in Berkshire West to pilot a high impact user multiagency risk management approach to improve care of a small group of high risk children and young people who are 'frequent attenders'
- Work in partnership with Reading local authority on their Ofsted improvement journey through active membership and participation in Reading CSIB and LSCB.
- Named Nurse for Child Protection working closely with frontline practioners in Paediatrics and ED, to raise safeguarding skills and confidence, champions are being identified and peer supervision for nurses set up.

- All face to face level 3 child safeguarding updates for 2017/18 will include a 'back to basics' session on thresholds, risk assessment and escalation
- Achieving level 1 Child Protection Compliance

Ongoing Challenge/Risks

- **RN nurse vacancies on Paediatric Wards and ED, safeguarding skills and experience of practioners managing complex cases**
- **Small group of child and young people 'frequent attenders' who are high profile in terms of self-harm, complex psychosocial issues, significant mental health concerns and increased length of stay**
- **The numbers of children and young people with mental health problems at risk from self-harm and suicidal ideation attending ED**
- **< 16s admitted to the paediatric unit and 16/17 year olds to ED Observation Bay, Acute Medical Unit or Short Stay Unit requiring admission to Tier 4 Child and Adolescent Mental Health Service bed and delayed in the Royal Berkshire Hospital**
- **The Trust does not have an adolescent or young person inpatient facility young people aged 14-18 years are either admitted to a paediatric or adult ward.**

Maternity Child Protection

Key Achievements

- Multiagency vulnerable women's meetings continue monthly, since March 2016 this has included representation from Wokingham Health Visitors. The aim is to improve communication and information sharing between the multi-disciplinary team and between agencies working with vulnerable families. In terms of early help, attendance of Perinatal Mental health services at this meeting ensures that women who suffer from poor emotional wellbeing get the support they need to allow them to care for their new born baby.
- The Child Protection Midwife continues to attend Multi Agency Risk Assessment Conferences (MARAC) in all three local Authorities. Individuals discussed at MARAC are "flagged" on EPR; this includes high risk victims' in addition to women attending Maternity Services. The Child Protection Midwife also attends Domestic Abuse Repeat Incidence meetings (DARIM), where repeat offenders of standard and medium risk domestic abuse incidences are discussed.
- The Poppy team establishment has increased; this includes a good skill mix of senior midwives. Each local authority has a named Poppy team midwife who holds a caseload and supports other midwives in the care of vulnerable women/families. The Substance Misuse midwife has been amalgamated into the Poppy team, this allows for more joined up working and greater continuity of care for women in both the hospital and community setting.
- Three Court reports were undertaken in 2016/2017.
- There has been at least a 10% increase in the number of child protection conferences in 2016-2017; midwives attended 93% compared with 80.6% in 2015-2016, there is a direct correlation between the improvements in Poppy Team establishment and improved performance in attendance at child protection conferences despite the significant increase in activity.

- Funding was identified for Named Midwife for Child Protection who is covering maternity leave until January 2018 to attend the NSPCC Supervision Course. This has allowed high quality supervision to be continued and will provide additional support for the Named Midwife for Child Protection with safeguarding supervision in the future.

Key Areas of Work for 2017/2018

- Named Midwife and Named Nurse for Child Protection will review consistency of safeguarding knowledge and practice in maternity services through competency based retraining, supervision of safeguarding cases and audit. This work will start with specialist midwifery services and be carried out in collaboration with Practice Educators, Matrons and the Director of Midwifery.
- Working with Band 5 midwives in the community setting; to provide newly qualified midwives with on the job support concerning their safeguarding practice. Teaching on the preceptorship day has been included since April, 2017.
- Named Midwife for Child Protection will provide a safeguarding training session on the Midwifery Mandatory Professional day.
- Named Midwife for Child Protection will establish group supervision/ reflective sessions for all Midwives as part of their level 3 child protection updates.

Ongoing Challenge/Risks:

- **Increase in the complexity in cases of at risk families and unborn babies**
- **Capacity of the Named Midwife to provide 1:1 safeguarding supervision for the poppy team and support safeguarding practice in the increasing number of newly trained midwives**
- **Capacity of Poppy Team to write reports and attend increased number of child protection conferences**
- **Maintaining maternity staff compliance Level 3 Safeguarding Children Training**

Looked After Children (LAC) Initial Health Assessments and Fostering and Adoption

The RBFT was commissioned to provide the Doctors to run Initial Health Assessment (IHA) clinics in 2014. In April 2016, we took over providing the administration and chaperoning of IHA clinics from BHFT.

Key achievements

- CQC report following a review of health services for children looked after and safeguarding, in Wokingham, May 2016 described our IHAs and healthcare plans for children placed within area as 'of a good standard'.
- Following an in depth review of the RBFT administration process early in 2017 IHA performance improved.
- Smooth hand over to Berkshire Healthcare Foundation Trust as providers was achieved by 1st April 2017

Key Areas of Work for 2017/18

- Consider a multiagency review/audit of the fostering and adoption pathway with Reading Children's Services including preparation for court

Female Genital Mutilation (FGM)

FGM continued as a focus for 2016/17 and will remain so in 2017/18.
FGM data reported to NHS Digital June 2016 – May 2017

- Maternity – cases reported 38, referrals to children's social care 36
- Gynae/sexual health – cases reported 2, referrals to children's social care 1
- Paediatrics – cases reported 0

Key Achievements

- The FGM pathways and tools are embedded. A Berkshire wide bespoke training package is due to be launched during the summer 2017.
- A centre for adult victims of FGM (Reading Rose Centre) is due to open in the summer. Our Maternity Services with commissioners and the Alliance for Cohesion and Racial Equality (ACRE) collaborated to develop this service and from September one of our doctors will provide clinical input.

Key Areas of Work for 2017/18

- Maternity and Information Management and Technology (IM&T) Services continue working with FGM Prevention Programme, Project Manager NHS England for them to support our implementation of FGM Risk Indication System to allow clinicians to note on a record that girls are at risk of FGM.

Child Death

46 deaths of Children and Young People < 18 years were reported to the Berkshire Child Death Overview Panel (CDOP) in 2016/17. 11 of those deaths were unexpected where 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which led to the death'. In addition, the CDOP undertook a special review of the circumstances of a serious road traffic incident on the A34 which resulted in both child and adult fatalities.

21 Children and Young People < 18 years resident in Berkshire West died 01/04/16-31/03/17

- 10 neonatal deaths due to extreme prematurity, chromosomal, genetic, congenital anomalies
- 6 expected due to chronic medical conditions, chromosomal, genetic and congenital anomalies or malignancy
- 5 unexpected child deaths – 1 of which is waiting to go to inquest and CDOP

Rapid Responses were initiated for all unexpected child deaths, including the A34 case which resulted in both child and adult fatalities and a learning event was held for the case of a child who was expected to die after an unexpected collapse where there were safeguarding concerns. The 2016-17 Berkshire West Rapid Response audit will be presented to CDOP in October 2017 and subsequently shared with the RBFT Mortality Surveillance Committee, the LSCBs of the West of Berkshire and Berkshire West CCG.

During CDOP meetings panel members categorise each child's death using 10 national categories:

Category		
1	Deliberately inflicted injury, abuse or neglect	0
2	Suicide or deliberate self-inflicted harm	0
3	Trauma and other external factors	0
4	Malignancy	1
5	Acute medical or surgical condition	0
6	Chronic medical condition	1

7	Chromosomal, genetic and congenital anomalies	12
8	Perinatal/neonatal event	3
9	Infection	1
10	Sudden unexpected, unexplained death – pathological diagnosis either 'SIDS' or unascertained	0
	Deaths waiting to go to inquest	1
	Awaiting post mortem report	1
	< 23 week gestation not categorised	1

Fig 3. 2016/17 Berkshire West Deaths by category

Key achievements and learning from CDOP:

Establishment of a Neonatal Deaths Special Review Panel

- Neonatal cases (<28 days) are numerically the largest sub-group group of all deaths in 0-18 years.
- Most deaths are due to congenital anomalies and/or perinatal medical problems, particularly complications of prematurity and low birth weight.
- The group met for the first time in March 2017 and reviewed all neonatal cases between 01/01/2016 and 31/12/2016 with a focus on categories, modifiable factors, trends and further actions.
- The panel consisted of Dr. Peter de Halpert and Gill Valentine, Director of Midwifery (RBFT) and Dr. Rekha Sanghavi (FHFT), supported by the CDOP Administrator.
- 20 deaths reviewed (three deaths at 22 weeks gestation, a gestational age not usually considered by the CDOP), ten (7, plus the three deaths at 22 weeks) found to be caused by perinatal factors and 10 by chromosomal/genetic factors.
- One of the deaths caused by perinatal factors occurred at term; all the others occurred pre-30 weeks.
- One of the deaths caused by chromosomal/genetic factors occurred at or after term.

The neonatal review identified the following learning points:

- Challenges for parents receiving appropriate bereavement support when an infant's care is transferred between two or more hospitals.
- 2 cases of preterm labour, mothers seen with signs and symptoms of a urinary tract infection a few days prior to spontaneous labour. Neither case was treated. While this may not have been causative, infection can trigger preterm labour. It is recommended to treat clinical UTIs in pregnancy
- Concern that not all cases have been notified. The CDOP coordinator has contact local trusts to review the notification process.
- The majority of the chromosomal/genetic factor cases were ante-natally diagnosed, and parents elected to continue with the pregnancy after counseling. The deaths were, in these cases, "expected".
- 3 of the 10 chromosomal/genetic factor cases were associated with consanguinity.

- A cluster of chromosomal/genetic factor deaths with Potters syndrome. However no association with modifiable factors could be made. It is likely that this is a statistical blip. CDOP will try to clarify this through the use of longitudinal data
- Midwifery representation from Frimley Health will be sought for the neonatal subgroup.
- The group unanimously felt that 22/40 gestation babies should not be included in the analysis as all national and network guidance states these babies should not be resuscitated (unless there are exceptional circumstances). As such they have been separated out for the purpose of this report.

Modifiable Factors and Learning – 7 Pan Berkshire reviewed deaths with modifiable factors:

- Co-sleeping with an infant
- Alcohol consumption
- Consanguinity
- Untreated UTI in mother before delivery
- Missed opportunity in healthcare

Some modifiable factors were relevant to more than one child death
Learning from some of the deaths reviewed led to procedural changes for the health services involved and the opportunity for learning for others:

- Consultant Paediatrician and Intensive Care Consultant review for sudden deterioration
- Consultant Paediatrician review for second presentation to A&E
- Accurate documentation during resuscitation
- Review of Sepsis triage tool and collaboration of practice across the county
- Training for healthcare professionals should include recognition of shockable rhythms and defibrillation

Other learning included:

- A recommendation that if a pathologist carries out a post mortem on an adolescent in circumstances of a medical death they should consider seeking the opinion of a paediatric pathologist
- Complete agreement with the police advice to never use a mobile phone while driving

Operational achievements:

- CDOP has maintained good operational performance against national standards. It is well attended by relevant partners. Discussions are of quality and improvements have been made to documentation to facilitate categorisation of deaths, identification of modifiable factors and recording of recommendations, which are circulated via a regular CDOP Newsletter and to LSCBs for their attention and action
- A CDOP induction pack has been issued and is available to all new (and existing) panel members
- A multi-agency training day entitled “Saving Children’s Lives” was held on 1 March 2017 in Bracknell Forest with 90 people attending. The day included a series of talks by Professor Peter Sidebotham, Associate Professor of Child Health from Warwick Medical School, followed by break out groups with practical sessions. This counted as a full day CPD training course and Level 3 Child Protection training.
- CDOP has developed a new website to support frontline practioners, parents and the public

Key Areas of Work for 2017/18

For 2017/18 CDOP will be carrying out thematic reviews on the following:

- Sepsis management/effectiveness of paediatric early warning and sepsis tools
- Knife crime (because nationally this is rising)

- Children with life limiting conditions and deteriorating neurological conditions – now the largest group we review other than neonatal
- Better community understanding of Safe Sleeping
- Home educated children, as they can become invisible

Ongoing Challenge/Risks:

- **Provision of joint home visit and immediate family support – unexpected death**
- **Appropriate bereavement support when an infant/child's care healthcare is transferred**
- **Quality of life issues for children with complex/chronic conditions**
- **Supporting schools following an unexpected death**
- **Knowledge, skills, competence and confidence of multi-agency frontline managers and practioners who rarely encounter unexpected child death**

Sexual Health

Key Achievements – service delivery and safeguarding

- Clinical Delivery in the hub at 21a Craven Road provides open access from 7am to 7pm Monday to Friday and 9.30 am to 11.30 am Saturday mornings
- There are specific outreach clinics for young people across the three Local Authorities of Berkshire West, provided in educational and non-educational settings. Staff work with multi agency partners to deliver holistic care from these venues.
- Designated Outreach posts dealt clinically with 736 vulnerable cases that would not otherwise have accessed mainstream delivery.
- The designated sexual health outreach nurse for young people is the key front line member of staff exposed to, and dealing with, operational issues and the clinical care of young people affected by or at risk of CSE.
- Safeguarding process – all young people under the age of 18 (and anyone with vulnerabilities identified during history taking) has a full safeguarding assessment carried out at the time of consultation
- Safeguarding audit completed June 2016 led to an update of safeguarding form to allow meaningful assessment of 16 and 17 year olds, and provide mechanism for recording re assessments.
- Sexual Health Department contributes to Level 3 Child Protection Training and CSE training.
- During 2016/17 a consistent and current flagging system implemented between the safeguarding team and sexual health to ensure children and young people subject to child protection plans or Looked after Children are identifiable on both EPR and the sexual health systems to alert clinical staff to vulnerabilities.

Key Achievements - Child Sexual Exploitation (CSE) information sharing and governance

- Close working relationship with Head of Children's Safeguarding for Berkshire West Clinical Commissioning Groups (CCG) sharing good practice. The Trust Safeguarding CSE proforma has been adopted by the CCG safeguarding team and rolled out for use across GP practices. This followed a CQC inspection where gaps in GPs knowledge were identified.
- Provision of equal input across all three Berkshire West local authorities which involves:

  - Preparation for and monthly attendance at each of the CSE operational group meeting in all 3 unitary authorities.
  - Attendance at CSE workshops, review meetings, audit and challenge meetings
  - Attendance at locality strategic group meeting has been scaled back due to capacity issues. Regular attendance at Reading Strategic meeting, receipt of minutes and attendance if required for West Berkshire and Wokingham
- Internal CSE Information Sharing processes have been finalised and continue to guide practice.
- Pan Berkshire Information Sharing and Assessment agreement and Protocol is embedded within Berkshire Child Protection Procedures to which all LSCB statutory partner agencies, including the RBFT are signatories
- CSE is embedded into the Trust Child Protection Clinical Governance agenda as a standing item

Ongoing Challenge/Risks:

- **Management of CSE continues to be a challenge in relation to capacity within sexual health services**

Safeguarding Adults

Key achievements

- Safeguarding (adults) clinical governance has continued throughout the year and the safeguarding team medical clinical leads have formed a valued part of the safeguarding team.
- Safeguarding concerns continue to be raised via the Datix incident reporting system. This assists in giving feedback to the individual who raised the concern where available, and means that only one reporting mechanism is used for reporting concerns about adults which supports overview and quality assessment
- Learning from two Safeguarding Adult Review (SAR) and Domestic Homicide Reviews (DHR) is included in safeguarding adults training. Learning from the DHR has been discussed at clinical governance in the area where the patient was being treated.
- The Lead Nurse adult safeguarding was included in the review team for two SARs and the Internal Management Review (IMR) writer for the DHR.
- In October 2016, Price Waterhouse Cooper (PWC) was commissioned to review Safeguarding Adults and Children. As a result the process for recording and reporting adult safeguarding concerns is being reviewed to develop an electronic approach which will improve governance.
- In March 2017 a notes audit was carried out for the Berkshire West Safeguarding Adults Board of adults with dementia to test documented evidence of mental capacity act (MCA) assessment and safeguarding principles in practice – that demonstrated that MCA and safeguarding principles were being applied in practice however the Trust's the MCA assessment was not consistently being recorded on the Trust's blue MCA assessment form.
- In March 2017 the MCA, DoLS and Best Interest Working Group met for the first time and developed a Quality Improvement project plan for 2017/18
- In November 2016 we worked with NHSI to review a case – as a result we are developing an Adult Safeguarding protocol to support our policy. This will be approved by the Adult Safeguarding Clinical Governance and the Strategic Safeguarding Committees as part of the 2017/18 Safeguarding Annual Plan.

Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

One of the key findings of the CQC inspection published in June 2014 (http://www.cqc.org.uk/location/RHW01/reports) highlighted that knowledge of the Mental Capacity Act was not sufficient. The CQC recommended that the RBFT must "increase staff knowledge of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) through necessary training to improve safeguarding". The safeguarding team has worked with support of the CCG to improve staff knowledge and competence around the MCA and DoLS. Mental capacity and DoLS training forms part of induction training and the core mandatory training day.

Enhanced metal capacity training was offered monthly through 2016 and alternate months in 2017 the 80% target was reached by March 2017. The number of DoLS applications is a key performance indicator report to the CCG as part of the Quality Schedule and in the integrated Board report monthly. Numbers of applications showed further decline in 2016/17

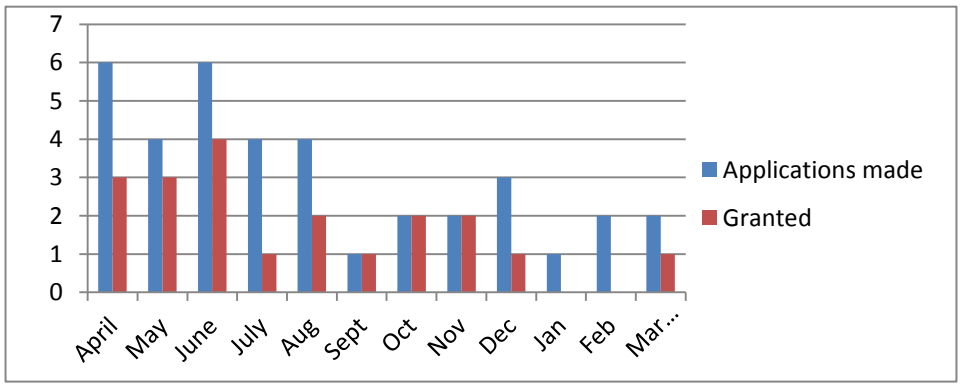


Fig 4 Deprivation of Liberty Safeguard applications for 2016/17.

Adult safeguarding concerns

	Concerns raised by the Trust where harm occurred outside the Trust.	Concerns raised against RBFT
April	17	1
May	17	4
June	23	6
July	18	1
August	20	6
September	18	4
October	30	2
November	24	5
December	17	1
January	25	3
February	19	4
March	25	3

Fig 5 Adult safeguarding concerns raised during 2016/17

All concerns raised by our staff about potential harm or abuse outside of the Trust are reviewed by the local authority and if necessary investigated through the Safeguarding process.

For externally raised safeguarding concerns a fact finding exercise is carried out by the Adult Safeguarding Nurse. This information is given to the Local Authority for them to decide on the outcome of the concern and further enquiry. The majority of safeguarding concerns raised against the Trust continues to be around pressure damage, in the majority of cases there is a lack of information/documentation provided concerning pressure damage as part of the discharge process.

Prevent (anti-terrorism)

There was 1 possible Prevent concern discussed with outside agencies related to a patient. Appropriate action was taken there was no further involvement or action for the Trust.

Key Areas of Work for 2017/18

- MCA, DoLS and Best Interest Quality Improvement project
- Continue working with Information Management and Technology (IM&T) Services to develop an electronic approach to our adult safeguarding referrals and information sharing

Ongoing Challenge/Risks:

- **Year on increase in activity for vulnerable groups with multiple co-morbidities and complex psycho-social problems**
- **Elderly patients living with dementia delayed in hospital**
- **Increasing and maintaining workforce knowledge of the Mental Capacity Act and DoLS**
- **Supporting patients and the staff caring for them where there is homelessness or other external service/resource issues beyond our control**

Mental Health Service Provisions

Poor mental health is a risk factor in the development of cardiovascular disease, diabetes, chronic lung diseases and a range of other conditions. It is a major public health issue in its own right, accounting for 23 per cent of disease in the UK. Poor mental health is associated with higher rates of smoking, alcohol and drug abuse, lower resilience, decreased social participation and weaker social relationships – all of which leave people at increased risk of developing a range of physical health problems. For most people, mental health problems begin in childhood or adolescence and can have lifelong effects. https://www.kingsfund.org.uk/publications/physical-and-mental-health/priorities-for-integrating

Activity

Activity data provided by the Trust Emergency Department (ED) shows that on average 230 people per month attended with a primary mental health presentation in 2016/17, 58% were subsequently admitted.

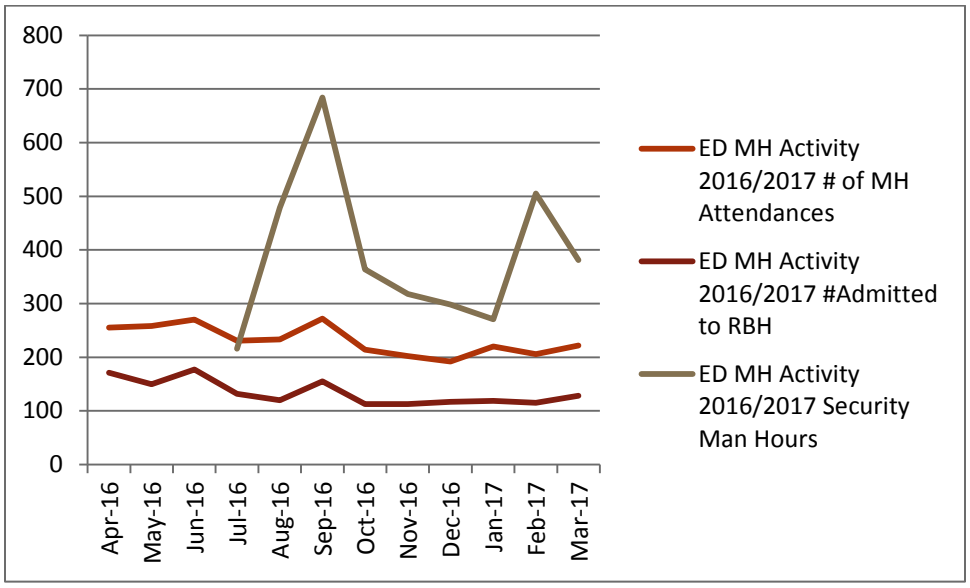
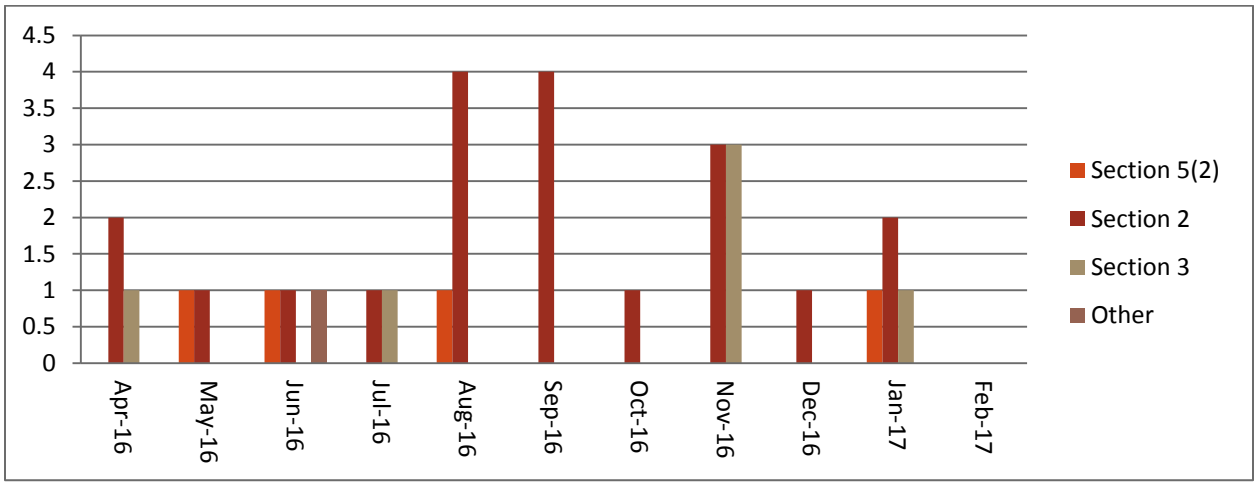


Fig 6 Mental Health presentations to ED April 2016 – March 2017 including security man hours

Mental Health Act Detentions

Fig 7 Detentions to the RBFT in 2016/17 - there were 34 detentions (plus a Community Treatment Order - CTO) compared to 12 in the same time period in 2015/16



A nearly 200% increase in MHA detentions in 2016/17 has presented a significant challenge in terms of:

- Increase in length of stay for mental health patients in the Emergency Department Observation Bay and other wards
- Increase in requirement for 1:1 nursing and security presence for patients detained under the MHA
- Increase in risk of patients being Absent Without Leave (AWOL)
- Increase in administrative and clinical work for the Mental Health Co-ordinator
- Increase in administrative and clinical work for the Clinical Site Managers who manage detentions out of hours – nights, weekends and bank holidays

Fig 8 Location of patients detained and under which section of the MHA (taken from KP90 return)

Ward/ Dept.	Sec 5(2)	Sec 2	Sec 3	CTO
ED Observation Bay	4	11		
AMU	1	1		1
SSU			1	
Sidmouth			1	
Victoria			2	
Trueta		1		
Whitley		2	1	
Woodley		1		
SAU		1		
Castle		1	1	
Lister	1			
ICU		1		
Burghfield		1		
ASU		1		
Dorrell	1			

NB whilst a number of these patients were detained to the RBH as they required treatment for both their mental and physical disorder, there were a number of patients who had no physical disorder and were awaiting a mental health placement.

Key achievements

- **Compliance with the Mental Health Act 1983 and Mental Health Act Code of Practice, 2015**
  An Annual Mental Health Act Report, April 2016 – March 2017 was submitted to QALC in June 2017 and subsequently approved by the Executive Management Team and the Quality Governance Committee. This report provided assurance about key issues, risks and themes, and Trust compliance with the Mental Health Act and Code of Practice.

- **Deaths of patients detained or likely to be detained under the MHA**
  Patients who die whilst inpatients at RBFT who are detained or likely to be detained under the MHA are subject to a full mortality review within the organisation; the outcomes and any lessons learnt are reported and monitored by the Trust Mortality Surveillance Committee. If the death reaches Serious Incident Requiring Investigation (SIRI) criteria it will be reported on STEIS, to Berkshire West CCG and to the Safeguarding Adult Board case review sub - group.
- **Section 136 of the Mental Health Act Audit**
  Currently the police have the power to place an individual under section 136 of the Mental Health Act (MHA), for a maximum of 72hrs and take them to a place of safety whilst awaiting a mental health act assessment. Audits in 2016/17 demonstrate we are compliant with the MHA code in relation to section 136. In January 2017 the Policing and Crime Act received royal assent. The act contains a wide range of measures, importantly it contains changes to MHA 1983 section 136 powers relating to the police and to the operation of Places of Safety. It is not clear when in 2017 these changes will be implemented or what impact they will have in ED. Through the Berkshire Mental Health Crisis Concordat the multiagency team is committed to making a local implementation plan.
- **Liaison Psychiatry in Emergency Department (ED) – Psychological Medicine Service (PMS)**
  There continues to be a high level of support for patients presenting with mental health needs. The team works collaboratively with ED staff to ensure that those with mental health needs are adequately assessed, treated and signposted as necessary. ED and PMS have regular operational meetings in order to achieve a collaborative way of working.
- **Suicide and Self Harm Prevention**
  The Suicide and Self Harm Prevention Clinical Governance Group and action plan works towards a zero tolerance of self-harm and suicide attempts within the Trust. The group has been instrumental in:-
    - Contributing to the Berkshire wide Suicide Prevention Strategy and action plan
    - Ensuring that a baseline ligature audit was completed in 2016 - risks identified, addressed, mitigated
    - Influencing securing funds in the 2017/18 capital programme for compliance works to the multi-storey car park
    - Regular audits of the Adapted Australian Triage Tool (AATT) leading to improved compliance in ED
    - Working alongside the Samaritans who now provide regular support for patients within the ED, as well as training for hospital staff
- **Frequent Attenders Project**

  The RBFT continues to work closely with BHFT and other agencies to develop client case management plans for the top 20 ED reattenders to reduce the number of unnecessary visits. In 2016/17 the project achieved a 46% reduction in attendances for this cohort of vulnerable people. In 2017/18 there is a national CQUIN 'Improving Service for People with Mental Health Needs who Present at A&E' the aim *'To reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable'*.
- **Berkshire Mental Health Crisis Care Concordat**
  The Trust contributes to and through partnership working has delivered improvement in care to those presenting in crisis to frontline services. The key areas of focus for the RBFT in 2017/18, our contribution to the Berkshire Crisis Concordat action plan based on our suicide prevention and safeguarding strategic statements in relation to improving the quality of care for patients with mental health disorders:
    - Collaborative working with the Psychological Medicine Service (PMS) or Child and Adolescent Mental Health Service (CAMHS) Urgent Response Service and patient families and carers to risk assess individuals who attend in crisis.

- Providing a safe environment for patients and staff - reducing access to means
- Training, supervision and support to provide staff with skills and competence to recognise risk and manage it proactively in partnership
- Collaborative working with multiagency colleagues, patients, families and carers and our staff as part of a wider 'Let's Talk Mental Health' campaign.
- Staying healthy – people with mental health conditions have ordinary as well as specific health care needs and experience more ill health than the general population – parity of esteem
- Staying Safe – people with mental health conditions are significantly more vulnerable to the effects of discrimination and abuse Healthcare workers play an important role in recognising and reporting signs and concerns of abuse, making safeguarding referrals and supporting the person who has suffered or is at risk of suffering significant harm during safeguarding investigations.

There are two programmes of work planned that will roll out collaboratively during 2017/18:

- 'Let's Talk Mental Health' – patients led by the Associate Director of Safeguarding and Mental Health
- 'Let's Talk Mental Health' – staff led by the Occupational Health Manager
- The roll out of 'Let's Talk Mental Health – patients is based on risk and urgency, the first action plan was developed up in March with the clinical and operational leaders in ED and ED Observation Bay and initial meetings have been held with Castle (Endocrinology, Rheumatology and General Medicine)
- The Acute Medical Unit/Short Stay Unit and Paediatric services will be in the next phase
- BHFT colleagues will be asked to peer review our ED & ED Obs Bay – Safe Management of Mental Health Patients action plan
- A joint RBFT/BHFT mental health clinical governance committee will be established

- **Mental Health multiagency governance arrangements and the Safeguarding Adults Board**

  During 2016/17 systemic safeguarding risks in relation to mental health were raised by the Royal Berkshire NHS Foundation Trust and Berkshire NHS Foundation Trust to the Berkshire West A&E Delivery Board in October 2016 and at an extraordinary Safeguarding Adults Board (SAB) meeting in January 2017. As a result Berkshire West CCG has worked with multiagency partners to review and revise the operational and commissioning governance and assurance framework, structure and escalation process.

  Berkshire West Clinical Commissioning Federation and the providers they commission are accountable and/or responsible for:

  - Commissioning appropriate services
  - Monitoring the quality and safety of services in the services
  - Setting and monitoring safeguarding standards
  - Working in partnership with statutory and voluntary agencies to safeguard

  Mental health is a Safeguarding Adults Board risk related priority for 2017/18.

  Key points of quality assurance and improvement

  There has been a significant amount of good multiagency partnership working in relation to safeguarding the health and wellbeing and improving safety and the experience of mental health patients in Berkshire West in the last year, demonstrating parity of esteem for mental health. This has been achieved by:

  Meetings/committee structure:

  - Establishment of weekly multiagency delayed transfer of care conference calls

- Establishment of a monthly multiagency 'Mental Health Activity' Group where key safeguarding indicators e.g. detentions under the mental health act, availability of AMHPS are reported, analysed and escalated
- Thematic review of patient experience presenting in crisis completed by Head of Patient Experience RBFT
- Establishment of Mental Health Strategy Steering Group
- Review of the monthly Berkshire Policies in Practice Group (PIP) chaired by BHFT, including reporting and escalation to the Mental Health Crisis Concordat Steering Group
- Establishment of Berkshire Suicide Prevention Steering Group and agreement of a Berkshire Suicide
- Prevention Strategy – launch event 17th October 2017, Wokingham Town Hall

Ongoing Challenge/Risks:

- **The number of mental health patients of all ages presenting to ED and being admitted**
- **Increase in complexity, homelessness, social isolation**
- **Gaps in community services for patients who are in crisis, leading to individuals attending ED**
- **Delayed Transfers of Care for Prospect Park Hospital and Royal Berkshire Hospital**
- **Increase in number of patients detained to Royal Berkshire Hospital under the Mental Health Act**
- **Delay in Approved Mental Health Professional (AMHP) attending to 'section' a patient particularly out of hours – this is a Berkshire capacity issue**
- **Capacity of the security services and nursing teams to consistently provide a safe environment for high risk patients**
- **Suitability of acute health care settings when managing patients who are a risk to themselves or others**
- **Social care supporting safeguarding risk assessments – in and out of hours, the response is variable**
- **Local authority commissioned substance abuse services – models vary across Berkshire West, access for professionals and public is confusing, capacity and effectiveness – increasing substance abuse leading to increased pressure on health services no in reach services for RBH**

Learning and Complex Disabilities - adults

There were 275 in-patients with learning and complex disabilities supported during 2016/17. Very few patients require no input at all and a number of patients require significant input. Those who are having planned medical intervention will often require input from the Learning Disability Co-Ordinator (LDC) prior to admission. The LDC provides support to the hospital staff involved with the patient and who request advice with strategies to ensure LD patients receive the most effective care.

- There were 8 families who required a great deal of support, either because of the complexity of the patient's condition or social circumstances, or because of frequent admissions. These families had particularly high expectations of the LDC who worked to meet those for the benefit of the patient. In several cases there were a number of consultants involved with individual patients, the LDC provides support for those colleagues in relation to the patient's learning disability and the best interest decision making process.
- 5 patients have required on-going and intensive support with out-patient visits and associated health care advice. Some of these patients do not meet the threshold for social care support but require help when dealing with health issues, particularly understanding information.
- There is a small group of parents with a learning disability who require support with their adult children who lack capacity to make their own decisions around healthcare.

- The LDC is contacted by families and carer about individuals who are going to be treated by the Community Dental Service at Royal Berkshire Hospital. Orientation visits are organised and information passed on to the community dental team and / or the anaesthetist as necessary.
- The LDC attends the team meetings of the community learning disability nurses for Reading to discuss care for individual patients where necessary. There has been joint working around individuals who do not use ED appropriately and those who benefit from effective partnership between acute and primary healthcare.

Key achievements

Patient experience

The Learning Disability Co-Ordinator represents the Trust on the Learning Disability Partnership Boards (LDPB) and the LDPB health sub groups for Reading, Wokingham and West Berkshire. The presence of the LDC at these meetings is valuable in terms of those people using services and their carers feeling able to discuss issues that have affected them when they have been patients. It is also useful for people to discuss concerns they may have before coming to hospital.

- During 2016 – 2017 a member of one of the LDPBs who is a family carer told the story about when her brother who has a learning disability was an inpatient to the Trust Patient Experience Facilitator, this was filmed. The film will be used as part of training to provide staff with an insight into a carer's experience of supporting a family member in hospital.
- The Enter and View team, who are part of Reading Healthwatch, continue to visit the Royal Berkshire Hospital, they made 3 visits during 2016 – 2017. They have highlighted communication consistently as being an issue, particularly for patients with a learning disability who are non-verbal.
- Free Makaton training is provided for Trust staff by Berkshire Healthcare and OTs and Practice Educators have begun to take advantage of this. Resources for wards have also been identified.
- The LDC talks to Registered Nurses, therapists and Health Care Assistants each month on induction programmes. She also talks to junior doctors at their induction about her role and some key issues affecting patients with a learning disability. A short film about the experience of patients with a learning disability is shown every month at core induction. The LDC is present at these sessions to highlight her role to all new staff
- Several times a year the LDC provides a session for HCAs involved in supporting patients on a 1:1 basis, focusing on doing that effectively with patients who have a learning disability.
- The LDC attended a sensory communication workshop to gain knowledge and ideas about how to use sensory tools and she aims to share what she learned with Trust staff who attend the 1:1 training.
- The LDC attended training around the use of Books without Words which was very useful in understanding how to communicate about sensitive issues with patients who have a learning disability. The LDC has been able to pass on this learning to others and plans to expand on that.

Familiar carers

RBFT continues to fund 1:1 familiar carers for in-patients with a learning disability who require that level of support to make them feel less anxious and more likely to comply with medical and nursing interventions in the hospital environment. Social care will not fund this type of support when an individual is in hospital as their responsibility for funding only applies to people who have been assessed as eligible for funding at home or in the community.

Work is underway on streamlining the payment process and taking it out of the job role of the LDC to improve timeliness and governance of payments.

Training secondment for experienced occupational therapist from June to December 2016

An occupational therapist who is training to become a learning disability consultant practitioner had requested to do a placement with the LDC to gain insight in to the role within an acute Trust. She was invaluable in supporting the LDC with a number of complex patients during the placement and as part of a quality improvement project established a small library of activities and sensory tools for patients with a learning disability. Her plan to employ the services of a volunteer to manage the library will be progressed.

Transition clinics

The LDC attends the neuro – rehabilitation transition clinics to meet young people and their parents who are about to start using adult services within the Royal Berkshire Hospital. This provides an opportunity to explain what they can expect in adult services and to reassure young people and their families that reasonable adjustments will be made for them. There are 3 -4 clinics each year. The paediatricians or nurse specialists notify the LDC of other young people with cognition difficulties who are transitioning to adult services within the Trust and she makes contact with those young people at clinic. Some young people do not need to be seen by clinicians on a regular basis but may use services at RBFT for emergencies or planned surgery. There is a great deal of anxiety around using adult services for young people who have cognition difficulties and the LDC supports those individuals and their families as much as is possible

Deaths of patients with a learning disability

LD patients who die whilst inpatients at RBFT are subject to a full mortality review within the organisation, the outcomes and any lessons learnt are reported and monitored by the Trust Mortality Surveillance Committee. If the death reaches Serious Incident Requiring Investigation (SIRI) criteria it will be reported on STEIS, to Berkshire West CCG and to the Safeguarding Adult Board case review sub - group.

In response to the Mazars Report into Southern Health, the CCG is establishing a review panel for all deaths of individuals with a learning disability as part of the Learning Disability Mortality Review (LeDeR) programme. The purpose of the review panel is to gather information which will ultimately contribute towards the aim of reducing premature death in people with a learning disability. The RBFT is a member of the Berkshire West LeDeR steering group.

Changing Places toilet

Work was completed on the conversion of an existing toilet in a public area to a Changing Places toilet by the end of 2016. A hoist and a changing plinth suitable for adults is incorporated into this toilet so that disabled people can be assisted by their carers easily in using the toilet and being changed. The facility was formally opened by the Chief Executive on 16th May 2017

Mental Capacity Act and DoLS training

The LDC talks to all new clinical staff at core induction each month about the Mental Capacity Act and DoLS. She also provided 26 sessions at mandatory training for clinical staff during 2016 / 2017. These sessions are in the form of questions to help staff consolidate their knowledge and discuss issues that they experience in practice.

Ongoing Challenge/Risks:

- **No significant decrease in activity for this vulnerable group, increase in complexity and family expectations**
- **Patients with LD being delayed in hospital waiting for appropriate social care placements**
- **Affordability of funding familiar carers**
- **Increasing and maintaining workforce knowledge of the Mental Capacity Act and best interest assessments**
- **Capacity of the Learning Disability Co-Ordinator to maintain the current level of service**

Disabled Children and Young People, Special Educational Needs and Disability (SEND) reforms and Transition

Disabled Children's Services

Dingley Child Development Centre provides multi-disciplinary specialist paediatric neurology/epilepsy and community paediatric services, a child protection medical service and adoption and fostering medical service to children resident in Berkshire West. They also provide tertiary services including assessment of visual impairment and spasticity and a botulinum service. The specialist paediatric inpatient therapy services are provided by the team based in Dingley.

Respite care for children with complex health needs is provided by BHFT at Ryeish Green in July 2016 they notified the CCG that they were no longer able to sustain the provision.

Key Achievements

The Trust Board has supported the future development of Dingley Child Development Centre. The plan is to relocate to a site on Reading University site in autumn 2018. This site has better access than our current location with a large number of parking spaces including over 20 disabled parking spaces. We have been assured by Berkshire Healthcare Trust that we will not have to vacate our current building until the new premises are ready.

SEND Reforms

Trust services provided to people 0- 25 years who have Special Educational Needs and Disability are subject to compliance with these reforms, essentially these are paediatric services including Dingley Child Development Centre and adult long term conditions services, particularly neurology.

Joint inspections of local area special educational needs or disabilities (or both) provision – in May 2016 Ofsted and the Care Quality Commission (CQC) started a new type of joint inspection; the aim to hold local areas to account and champion the rights of children and young people.

Key Achievements

- Together with the Berkshire West CCG and BHFT the RBFT have completed a self-audit against the SEND standards for health.
- A strategic SEND Berkshire West 10 group has been established chaired by the Director of People Services, Wokingham Borough Council, RBFT are represented.

Transition

Key Achievements

- The Safeguarding Team hosted a transition nurse post to lead a two year 'Ready Steady Go' implementation pilot until March 2017.
- The lead paediatric and adult clinicians and steering group were and are positive about developing their transition services and rolling out the Transition Plan.
- The nurse spent 1.5-2 days per week based in Reading to embed the transition plan and roll out training to Paediatrics and 18 adult specialties.
- Comparing the 2015 and 2016 surveys from young people and families demonstrated a marked improvement in the way young people/parents / carers experienced transition services at the Royal Berkshire Hospital. In the 2016 survey 100% of respondents said that they were satisfied with the services compared to 17% in 2015.
- An audit of a random sample of notes, 13 -18 year olds with long term conditions requiring transition in April 2017 showed 55/60 (92%) had a Transition Plan. 54/60 (90%) had a named transition worker documented in their Transition Plan.
- Transition is in the commissioners' quality schedule for 17/18, paediatric consultants are responsible for generating transition plans, the Paediatric Matron for carrying out quarterly audits.
- The pilot developed a platform to extend work and learning to partners in the local authority, schools, colleges, Reading University and mental health services to support young people preparing for and settling into adult services. A costed case has been written and funding is being actively sought by the Berkshire commissioners GP Lead for Children and Young People. In a recent Chief Executive engagement meeting with parent carers they indicated that transition is one of their top issues.

Ongoing Challenge/Risks:

- **No respite service would impact on children and families and lead to increased admissions and length of stay**
- **Readiness and capacity to engage with preparation for CQC/Ofsted SEND inspection**
- **Commissioning of the Designated Medical Officer - SEND**
- **Availability of a Community Paediatrics SEND data set**
- **No dedicated resource to develop and monitor transition service**
- **No clinical nurse specialist for young people and families with neurodisability in transition**

Risk Based Priorities for 2017/18

1. Multiagency working to:
    - Understand demand and develop strategies to safely manage and safeguard the rights and well-being of people with mental health disorders learning disability and complex disability, including transition.

- Implement findings of Mazars report into mental health and learning disabilities deaths in Southern Health the LeDeR mortality review programme; align with the work of CDOP
- Implement LSCB and SAB priorities e.g. neglect including self-neglect, domestic abuse, mental health, safer recruitment and allegation management, communication and information sharing and Prevent.
- To implement CP-IS and FGM RIS

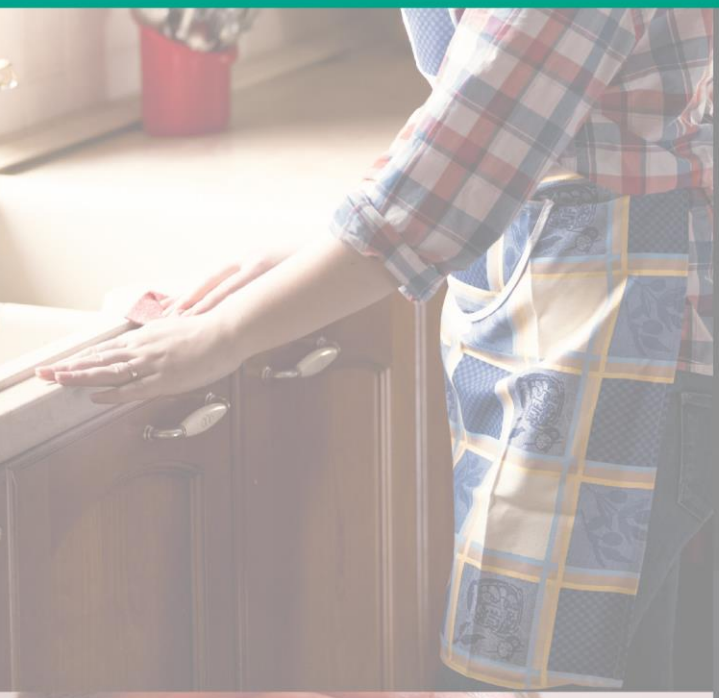
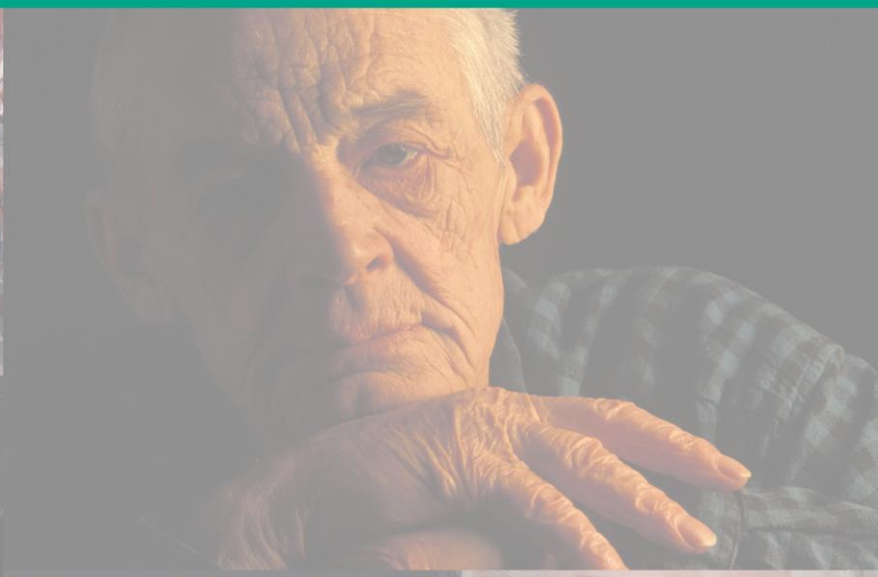
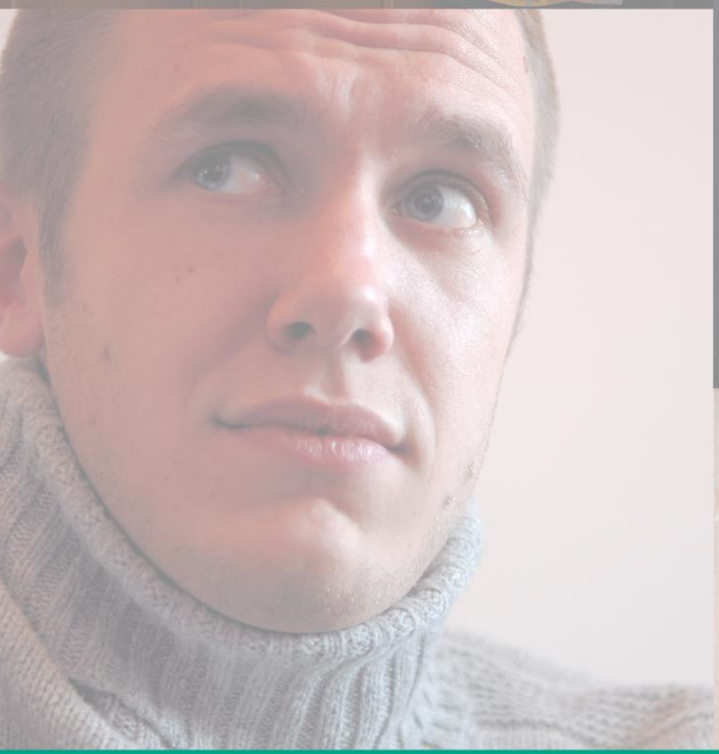
2. Partnership work to:
    - Progress improvement plans following local authority inspection judgments of 'inadequate'.
    - To further develop action plans for safe management of mental health patients with Berkshire Healthcare Foundation Trust
    - To review our safeguarding strategy and governance structures to ensure they are robust and align with the rest of the healthcare economy as part of the Berkshire West Accountable Care System

3. Training review:
    - Mental Health Act, Mental Capacity Act, DoLS, child and adult safeguarding to ensure the knowledge, competency and confidence of our staff in practice is consistent
    - Complete a frontline practioner self-assessment concerning the effectiveness of our safeguarding arrangements in October

4. Work with IT informatics and EPR:
    - To building safeguarding referral forms and risk assessments
    - Review the flagging of vulnerabilities
    - Ensure Safeguarding is a priority in the development of a digital hospital
    - To develop a SEND health data set compliant with national requirements

5. Workforce capacity:
    - Review the administrative support to the Safeguarding Team to reflect increased activity and complexity
    - Work with operational teams to monitor the impact of increased safeguarding activity/complexity in sexual health and maternity services
    - Work with our commissioners in relation the medical capacity to support SEND reforms

Safeguarding Adults
Annual Report
2016/17

West Berkshire Council

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Executive Summary

2016/17 has been a busy year for the Safeguarding Adult service. It has managed an increase in numbers of S42 enquiries initiated and completed and a significant increase in the number of DoLS applications received and processed.

Despite this increase in activity the service has raised awareness of safeguarding across West Berkshire by developing and engaging with a Safeguarding Service User Group, delivering awareness sessions and hosting stands at events in the local community, participated in a peer review in which our partners, providers and staff played a key role and actively supported training opportunities provided by the West of Berkshire Safeguarding Adults Board.

The Safeguarding Adults Forum developed an action plan based on the priorities of the Safeguarding Adults Board.

1. Raising awareness of safeguarding adults, the work of the SAB and improving engagement with a wide range of stakeholders
2. Making Safeguarding Personal
3. Ensuring effective learning from good and bad practice is shared
4. Developing an oversight of safeguarding activity

The Forum has progressively worked through the action plan during this reporting year and has developed plans for 2016/17. The partnership working developed through this forum was recognised in the peer review carried out by ADASS into the safeguarding function. This forum continues to develop its role as the operational arm of the Safeguarding Adults Board for West Berkshire.

The Making Safeguarding Personal initiative continues to be promoted and embedded in practice through training and monitoring, with local data indicating improvements are being made.

Performance data analysis is carried out on a regular basis. Rigorous interrogation ensures there continues to be a grasp of both current and emerging issues. The impact of a proactive approach by the Care Quality team with local providers appears to be having a positive impact on the types of safeguarding enquiries and source of risk.

The service continues to strike a balance between daily operations dealing with incoming safeguarding concerns and applications for Deprivation of Liberty Safeguards authorisations with raising awareness of safeguarding.

Introduction

Safeguarding Adults is a strategic priority for West Berkshire Council and a core activity of Adult Social Care. It is now, as a result of the enactment of the Care Act 2014, a statutory responsibility for Local Authorities as well as the assessment and authorisation of Deprivation of Liberty Safeguards.

This annual report evidences the key quarterly measures and trends used to monitor activity for Safeguarding Adults in West Berkshire to ensure risks are being identified and managed appropriately. Utilising the set of indicators and statutory reporting requirements for 2016/ 17, analysis of performance has developed comprehensively across the year to produce this report.

This report also focuses on the activities of the safeguarding network in West Berkshire during the reporting year.

Networks, Boards and Forums

The Care Act 2014 required all Local Authorities to form a Safeguarding Adults Board (SAB) to provide the strategic overview and direction of safeguarding, provide governance and quality assurance to the process. This includes the commissioning of Safeguarding Adults Reviews when a person has died or been significantly harmed and the SAB knows, or suspects, that the death resulted from abuse or neglect. West Berkshire Council is a member of the West of Berkshire Safeguarding Adults Board; a tri borough Board in partnership with Reading Borough Council and Wokingham Borough Council alongside other key stakeholders including, but not exclusively, Thames Valley Police, Berkshire Healthcare Foundation Trust, Royal Berkshire Hospital Foundation Trust and the local Clinical Commissioning Group. The SAB has produced its own annual report which can be viewed on its website www.**sabberkshirewest**.co.uk

The West Berkshire Safeguarding Adults Forum is the local operational arm of the SAB and consists of local partners signed up to address safeguarding matters specifically in West Berkshire. The forum produces an action plan annually drawn from the priorities set by the SAB. For 2016/17 those priorities were:

Priority 1 - We have oversight of the quality of safeguarding performance.

Priority 2 - We listen to service users, raise awareness of safeguarding adults and help people engage.

Priority 3 - We learn from experience and have a skilled and knowledgeable workforce.

Priority 4 – We work together effectively to support people at risk.

In order to achieve those priorities a number of objectives were developed into an action plan and delivered by forum members.

The Service User Safeguarding Forum was formed in 2015/16, the development of which was a key objective of the Safeguarding Adults Forum action plan. This group, made up of service users with an interest in safeguarding, meet quarterly.

Volumes and Performance

Safeguarding activity

Concerns and S42 Enquiries

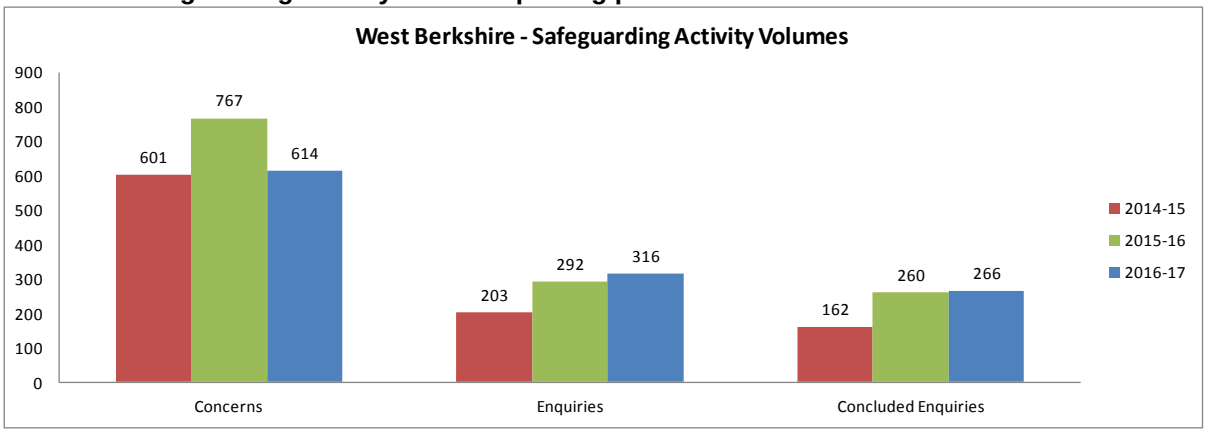
There were 614 safeguarding concerns received in 2016/17 that met the threshold for a response within the safeguarding framework. The number of concerns has decreased since 2015/16 and we believe this is as a result of working closely with providers, in particular Thames Valley Police (TVP) and Southern Central Ambulance Service (SCAS), to ensure referrals made are appropriate for safeguarding and reducing in appropriate referrals. As we continue to work closely with partners to review the process for raising safeguarding concerns we expect this to reduce further. In this context, we have seen the conversion rate of concerns that require a Section 42 enquiry will increase, we expect this trend to continue in 17/18.

However, regardless of this streamlined process, all non safeguarding welfare concerns from providers are referred onto the relevant Adult Social Care or mental health teams to ensure they are reviewed by the appropriate service.

Source – Safeguarding Adults Collection (SAC) statutory return SG1f tables and SG2 tables detail concluded enquiries

	Concerns	Enquiries	Concluded Enquiries	Conversion rate of concern to S42 Enquiry Rate
2014-15	601	203	162	34%
2015-16	767	292	260	38%
2016-17	614	316	266	51%

Table 1 – Safeguarding activity for the reporting period 2014- 15 – 2016-17



Wherever possible, we seek to understand whether a concern requires a Section 42 Enquiry within 24 hours of receiving the concern. In order to make this decision, it is essential that we have all the necessary information from the referrer. In some cases, where this information from the referrer is delayed, it may take us 48 hours to make this decision – in these situations we give careful thought to the welfare of the adult who is the subject of the concern, whilst we seek the information we need to make a decision. Noting those concerns that require no further action enable the Local Authority to spot trends and monitor patterns across the District. Section 42 of the Care Act determines that where a Local Authority receives a concern and has reason to believe a person within its area who has care and support needs and is experiencing or is at risk of abuse or neglect and by virtue of their care and support needs cannot protect themselves against that abuse or neglect, the Local Authority is required to make, or cause to be made, enquiries into that concern. These are known as, and reported as, S42 Enquiries

We monitor the % of concerns that subsequently require a S42 enquiry. This is known as a conversion. During 2016/17 316 s42 enquiries were opened, with a conversion rate from concern to s42 enquiry of 51%.

Whilst the number of concerns is lower by 19% than those recorded during 2015/16, the conversion rate at 51%, is 13% higher than the previous reporting year, suggesting that concerns coming through were more appropriate and relevant to be processed through the safeguarding framework. Further analysis of contacts and enquiries is planned for the 17/18 period, to ensure that our arrangements are robust.

Individuals with safeguarding enquiries

Age group and gender

Tables 2 and 3 display the breakdown by age group and gender for individuals who had a safeguarding enquiry in the last three years.

- The majority of enquiries continue to relate to older people - the 65 and over age group accounted for 63 % of enquiries in 2016/17.
- The majority of enquiries were related to female clients, 62 %, a continuation of a trend seen in the last 3 years.

Table 2 – Age group of individuals with safeguarding enquiries opened , 2014- 15 – 2016-17

Table SG1a	Number of individuals by age			
	18-64	65-74	75-84	85+
2014/15	29%	12%	25%	34%
2015/16	34%	15%	23%	28%
2016/17	37%	11%	19%	33%

Table 3 – Gender of individuals with safeguarding enquiries opened, 2014- 15 – 2016-17

Table SG1b	Number of Individuals by gender		
	Male	Female	Total
2014/15	38%	62%	100%
2015/16	43%	57%	100%
2016/17	38%	62%	100%

Primary support reason

Table 4 shows a breakdown of individuals who had a safeguarding enquiry by Primary Support Reason (PSR).

The majority of individuals had a PSR of Physical Support, 36 %, which is consistent with the previous year. There remains an increase in enquires where the individual has a PSR of Mental Health Support.

Table 4 – Primary support reason for individuals with a safeguarding enquiry opened (SG1c)

Classification	Physical Support	Sensory Support	Support with Memory & Cognition	Learning Disability Support	Mental Health Support	Social Support	No Support Reason	Not Known
2014/15	44%	2%	27%	17%	6%	4%	0%	
2015/16	37%	1%	29%	17%	11%	3%	0%	
2016 /17	36%	3%	27%	17%	12%	4%	0%	2%

Case details for concluded enquiries

Type of alleged abuse

Table 5 shows enquiries by type of alleged abuse in the last three years for concluded enquiries. Additional categories were added with the implementation of the Care Act 2014. Those additional categories were domestic abuse, modern slavery, self neglect and sexual exploitation (a derivative of sexual abuse/modern slavery and/or domestic abuse). It should be noted that more than one category of abuse can be attributed to any single concern as often incidents are complex and comprise of various elements.

The most common types of abuse for 2016 - 17 were neglect and acts of omission 25%, psychological abuse 21% and physical abuse19 %.

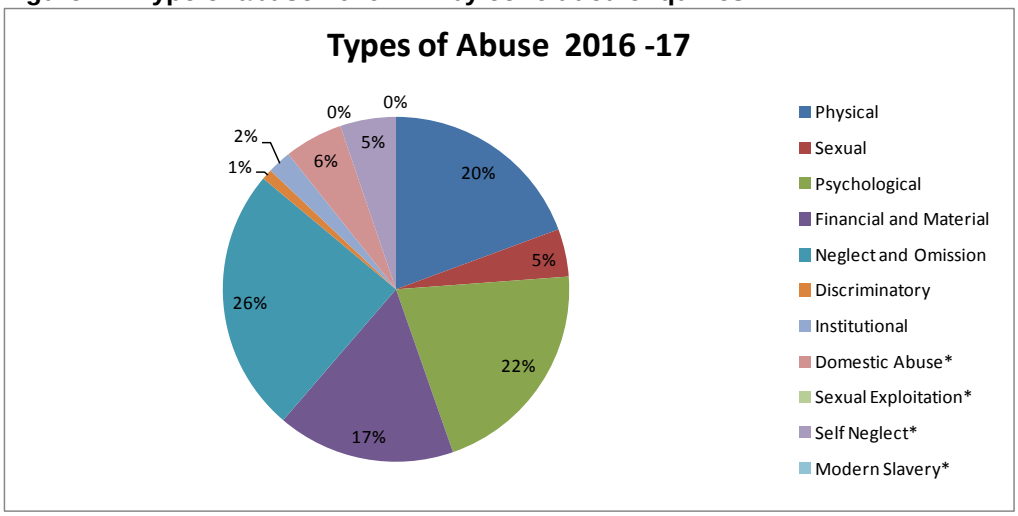
Neglect and act of omission cases are attributed to the provision of care given either by a paid or unpaid carer. The category of physical abuse also includes incidents where there has been a physical altercation between two or more residents in a domestic, care home or hospital setting.

Table 5 – Concluded enquiries by type of abuse

Type of Abuse	2014/15	2015/16	2016/17
Physical	51	74	78
Sexual	12	20	18
Psychological	44	66	84
Financial and Material	40	62	67
Neglect and Omission	72	86	100
Discriminatory	1	0	4

Organisational	10	7	9
Domestic Abuse*	0	28	22
Sexual Exploitation*	0	1	0
Self Neglect*	0	45	21
Modern Slavery*	0	0	0
Total	230	389	403

Figure 1 – Type of abuse 2016 – 17 by concluded enquiries



Location of alleged abuse

As with previous years the most common locations where the alleged abuse took place were a person's own home, 68 %, and a care home, 15 %.

A person's own home consistently remains the place in which an abusive incident is more likely to occur. This demonstrates the continual need to raise awareness of safeguarding amongst all sectors of society and improving mechanisms to report those incidents.

Table 6 – Location of abuse by concluded enquiries

Location of risk	2014/15	2015/16	2016/17
Care Home	38	45	40
Hospital	3	14	11
Own Home	96	172	181
Community Service	11	6	13
Other	14	23	21
Total	162	260	266

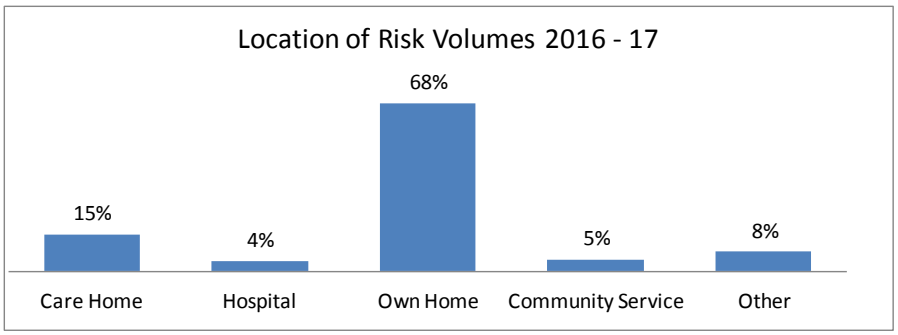
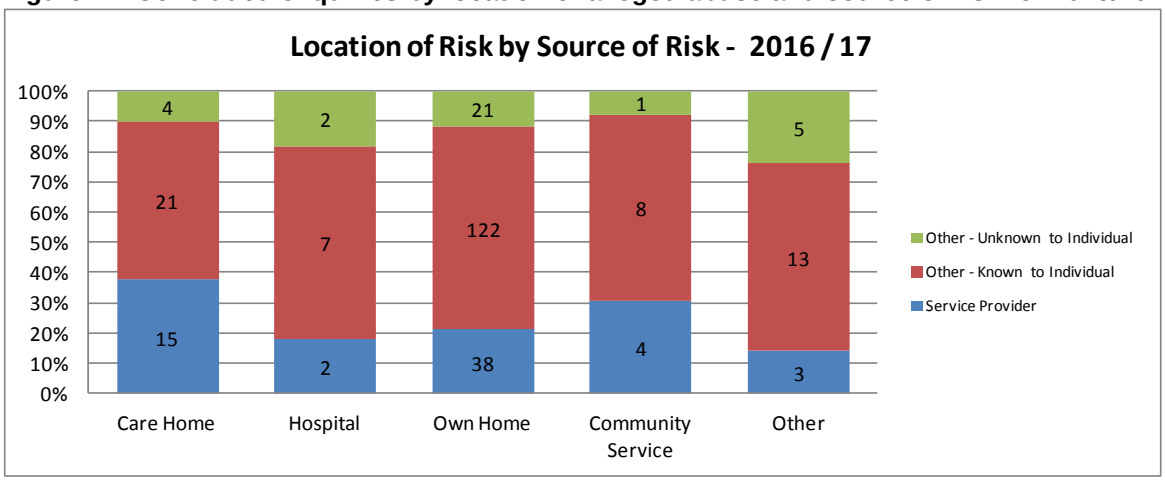


Figure 2 shows the breakdown of location of alleged abuse by source of risk.

Where the alleged abuse took place in the persons own home, for the majority of cases, 67 %, the source of risk was an individual known to the adult at risk.

Figure 2 – Concluded enquiries by location of alleged abuse and source of risk for 2015/16

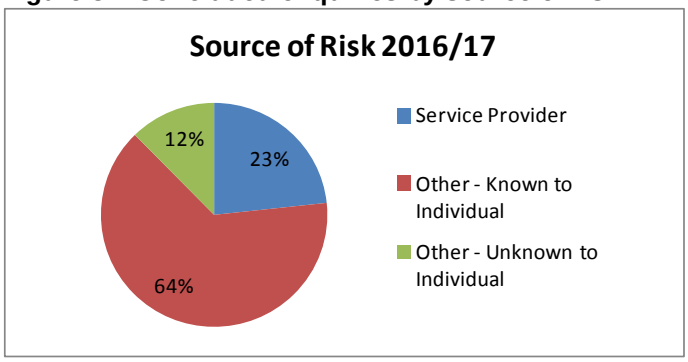


Source of risk

The majority of concluded enquiries involved a source of risk known to the individual. The service provider support category refers to any individual or organisation paid, contracted or commissioned to provide social care. Figure 3 demonstrates those sources of risk captured.

Whilst 23% of source of risk attributed to the provision of social care support remains of concern the pro active provision of support from West Berkshire's Care Quality team gives some assurance that issues which could result in a safeguarding enquiry in such settings are being addressed at an early stage.

Figure 3 – Concluded enquiries by source of risk

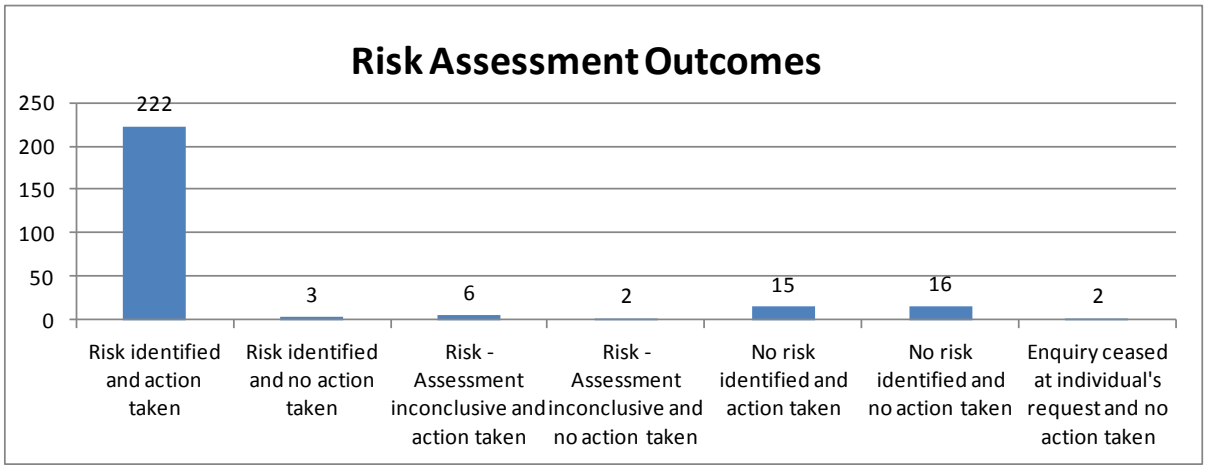


Risk Assessment Outcomes, Action taken and result

The manner in which management of risk is statutorily reported and recorded altered during 2016 -17 so there is no comparable data.

Risk Assessment Outcomes

The graph below shows concluded enquiries by reported risk assessment and action taken.
Risk identified and action taken in the majority, 83%, of cases.
Where risk was identified, no action was taken in just 3 cases – 1%.
For the remaining cases, the risk assessment was inconclusive, there was no risk identified or the enquiry ceased.



Outcome of concluded case where a risk was identified

Figure 4 shows where a risk was identified the final outcome.

Risk was removed for 28% of cases and reduced for a further 64% of cases.
Risk remains for 8% of cases.

Figure 4 – Concluded enquiries by result, 2016 17

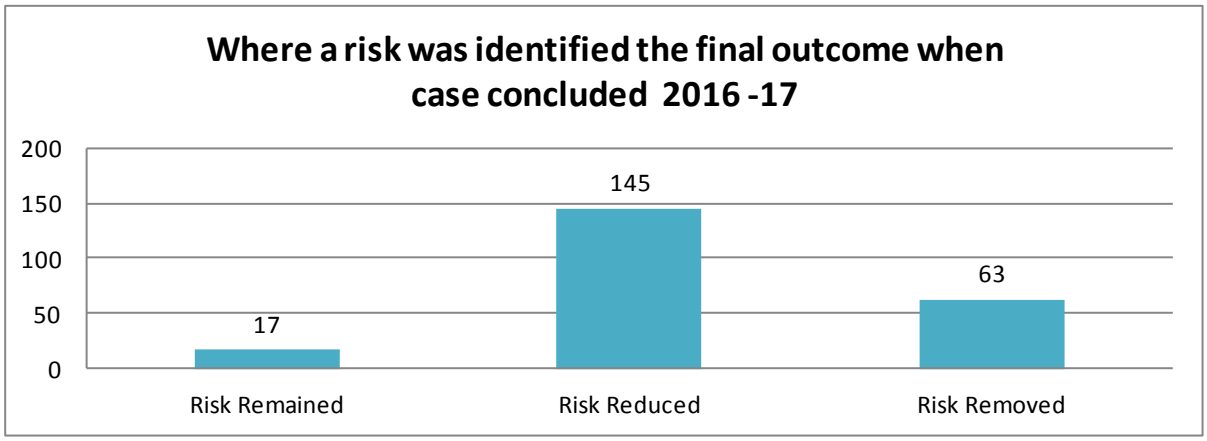
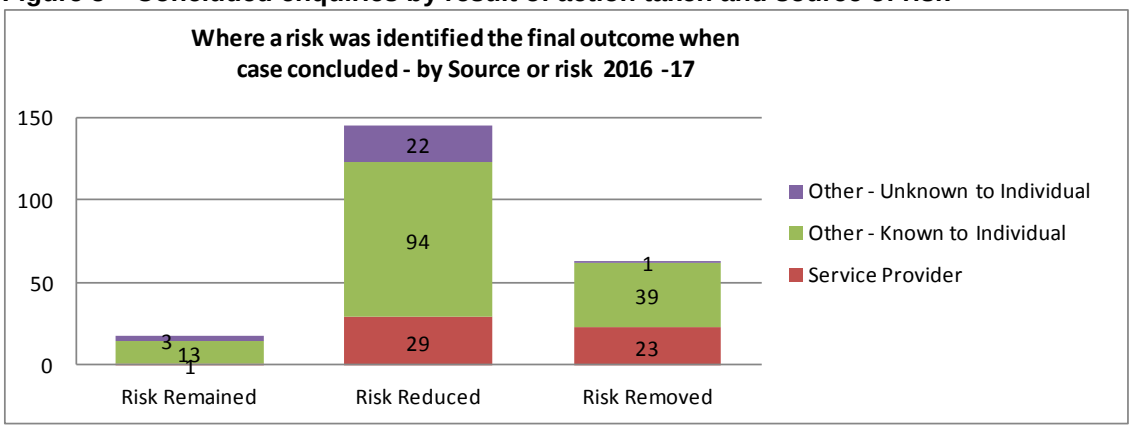


Figure 5 shows a breakdown of the final outcome for concluded enquiries by source of risk for 2015/16.

Figure 5 – Concluded enquiries by result of action taken and source of risk



Mental Capacity

In order to achieve good outcomes for individuals subject to a concern or enquiry, it is important to hear their voice. There is a statutory requirement to offer the services of an advocate to a person subject to a safeguarding intervention or review, where that person meets certain requirements if there is no other person suitable person able to advocate (for example a close family member or friend).

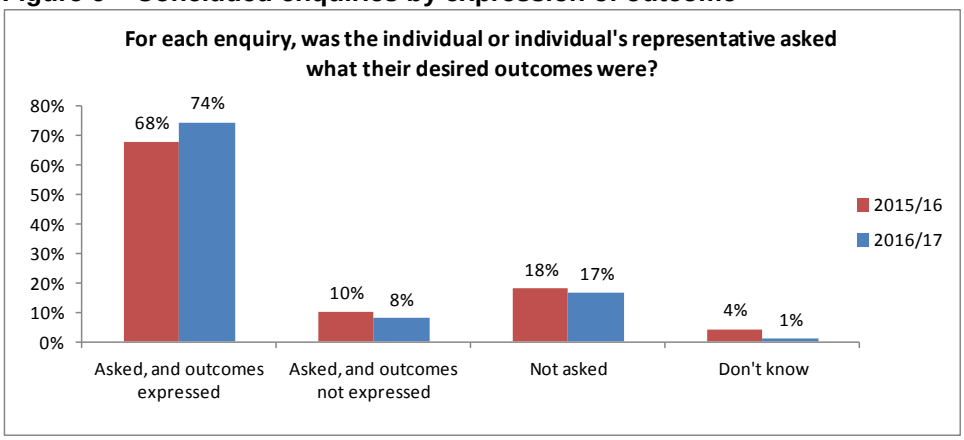
In 2016 -17, where the individual lacked mental capacity 87% were supported by an advocate, family or friend. It should be noted the national average for providing advocates in England, recorded for 2015/16, was 62%. We will seek to sustain and potentially build on this practice in 17/18. Analysis of our records sugests that we can continue to grow our understanding of how to assess mental capacity and we will focus some of our work on this area in 17/18.

Making Safeguarding Personal

Making Safeguarding Personal (MSP) is designed to improve the experiences and outcomes for adults involved in a safeguarding enquiry.

This initiative was adopted by the Government and enshrined in the Care Act 2014. Local Authorities are not currently statutorily required to report on MSP. West Berkshire Council has chosen to monitor performance in this area is as follows:

Figure 6 – Concluded enquiries by expression of outcome



By definition, a personal response to a safeguarding incident will mean different things to different people. Therefore obtaining baseline data for outcomes has presented challenges, Figure 6 demonstrates the outcome of this challenge.

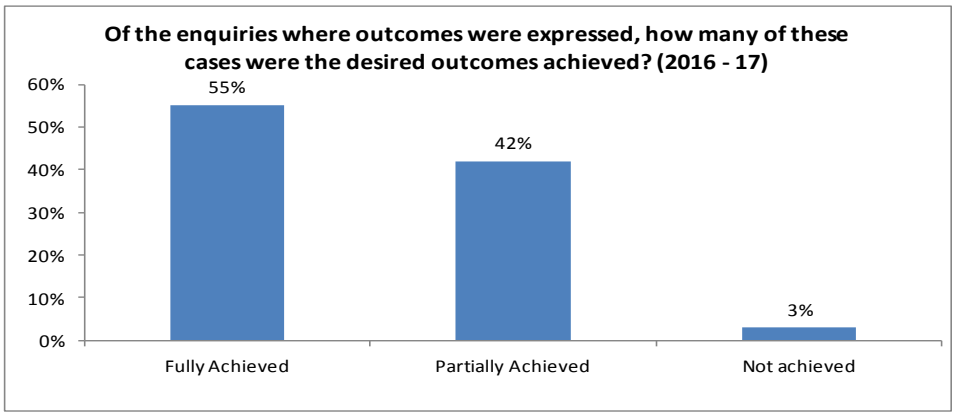
As at year end, 74% of all clients for whom there was a concluded case were asked about the outcomes they desired (either directly or through an advocate), this is an improvement from 2015 -16.

In order to benchmark usefully, options for outcomes were included as a guide, with an additional box for free text to capture those desired outcomes and wishes that were not reflected in the options provided. Clients can choose as many outcomes as

they wish and so multiple choices are normal. The option ‘to be and to feel safe’ was most frequently selected.

Of those asked, 8% did not express an outcome. Whilst this is positive, there remains 18% who did not engage in this process. These cases have been subject to further scrutiny to establish the reason engagement was not achieved and where necessary lessons learned going forward.

Figure 7 – Concluded enquiries by expressed outcomes achieved.



Of those who were asked and expressed a desired outcome, 55% were able to achieve those outcomes fully, with a further 42% partially achieved.

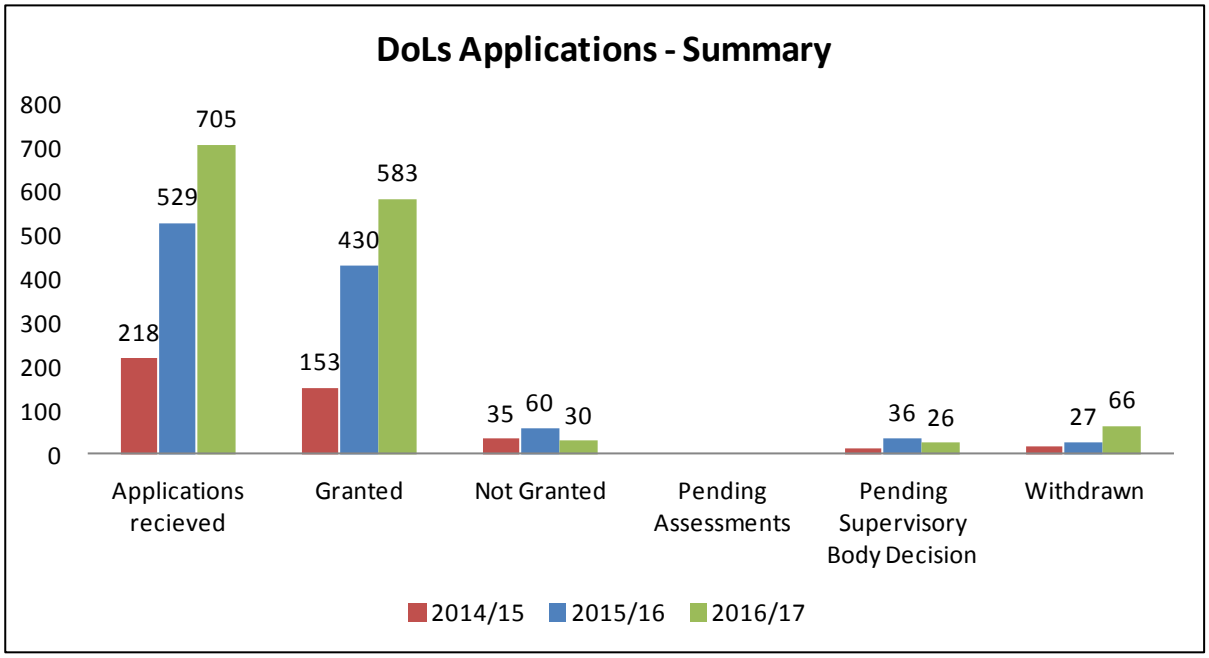
Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005 and applies in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.

Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.

DoLS authorisations must be applied for by care homes, nursing homes or hospitals (The Managing Authority) where they believe a person is living in circumstances that amount to a deprivation of liberty and that person lacks the capacity to consent to their care, treatment and accommodation, in order to prevent them from coming to harm. They apply to the Local Authority (The Supervisory Body) whose role is to arrange for the persons circumstances to be assessed in order to determine whether to grant or refuse an authorisation for those circumstances. Those living in other settings must have their deprivation considered by the Court of Protection.

Figure 8 – Total number of DoLS applications received by outcome



DoLS applications continues to rise and remains an increasing pressure.

As at the end of 2015/16 there were 529 DoLS applications in total. In 2016 -17 this increased to 705, of which 583 of those authorised, 30 not authorised (for example a person is assessed as having capacity), 66 withdrawn (for example an application from a hospital where the patient is discharged before the assessment process is completed) and 26 pending a decision as at year end.

The figure of 705 represents a 33% increase of applications received in 2015/16, in response to this increase the structure and sufficiency of the services who support DoLs will be reviewed in 17/18.

Activities

A Safeguarding Service User Group was set up In West Berkshire to provide a setting in which service users across the spectrum of adult social care needs could engage with the safeguarding team direct, share information, solve problems and increase awareness through a cascade process.

The group was consulted on a Safeguarding Adults publicity campaign in 2016/17. They were integral to the development of the publicity material including posters and leaflets, commenting on language, visuals and accessibility. In addition the group developed a safeguarding alert card for people to carry with them when they are in the community. The card has been designed to support a person to ask for help from the community if they feel unsafe.

A series of talks and events were attended by members of the safeguarding team in order to increase awareness of safeguarding across a range of settings including an evening talk to the Newbury Neighbourhood Watch scheme, delivery of an interactive session on safeguarding for service users of a supported living scheme locally and a hosting a stall at the Parish Councillors Conference.

A peer review of the safeguarding adults function was conducted by the Association of Directors of Adult Social Services (ADASS). The peer review was conducted over three days in December 2015 and included consultation with staff, external partners and providers. Feedback from the review was positive. An action plan was developed as a result of the recommendations made and the actions werecarried out during the 2016/17 period.

This included:

- A new publicity campaign to raise awareness of our shared responsibility for adult safeguarding within West Berkshire's community
- The co-design with service users of a new system to enable individuals to describe their experience of safeguarding

The service supported a joint conference for adult and children's social care staff organised by the West of Berkshire Safeguarding Adult Partnership Board and the 3 Local Safeguarding Children's Boards in the Berkshire West area. The 16/17 conference theme focused on working with local residents who experienced disability, to continue to develop the skills and sensitivity of our workforce.

The Future

Plans for 2017/18 include:

- embedding quality assurance systems and processes, to continually review the quality of our practice in safeguarding. That helps to share good practice and identify where we still might improve

- implementing a new way of working together differently and more effectively where an individuals' situation or circumstances increase the level of risk they are exposed to (RAMP)

- implementing a new ICS system Care Director, which will help to support improved recording and support increased management oversight of the timeliness of Section 42 assessments

- improving communication with partners where low level concerns about the quality of care could impact on the safeguarding of individuals who receive care

- reviewing if we have the right people in the right places with the right skills to effectively support our responsibilities around Deprivation of Liberty (DoLs) particularly

- increasing support to our workers with undertaking mental capacity assessments

- increasing support to our managers with consistently chairing strategy meetings

- reviewing our policies and procedures for Adult Safeguarding and DoLs in light of national standards and good practice; and making these policies and procedures available online.

There are also plans to develop an effective feedback process for those who have experienced a safeguarding episode. It is intended the Service User Group will be instrumental in designing the tools that may be used to capture the feedback

A new action plan for 2017/18 developed by the Safeguarding Adults Forum develops on previous learning. This includes partnership working with our colleagues in Trading Standards to tackle scams; doorstep and online scams and to support them in raising awareness with banks and building societies of coercive tactics to get vulnerable adults to withdraw large sums.
The recommendations of the ADASS peer review have been drawn into an action plan that will continue to be carried out supporting the service to improve the safeguarding experience for people through the continued development of Making Safeguarding Personal across the Council and its partners.

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The Context

This report forms part of the West Berkshire Safeguarding Adults Board's annual report which is published each year. The safeguarding performance data (part 2) for Wokingham is submitted to the safeguarding adult's board along with the other two boroughs data, Reading and West Berkshire.

The first part of this report sets out Wokingham's achievements in meeting the priorities set by the board for this reporting year 2016/17.

Part One

1. How did Wokingham achieve the priority areas set by the Board?

The safeguarding Adults Board business plan has set 2 priority areas for 2016/17

Below is a summary of Wokingham's achievements against these priorities.

Priority 1 – *To continue to engage the community and raise awareness of safeguarding adults:*

What we did

a) We continued to increase the amount of ' Safer Places' premises (a shop or establishments that have been trained in facilitating access to help when an adult at risk enters their premises requiring help) The Borough this included the introduction of the new Safer Places Scheme Cards for vulnerable adults in the community. These cards enable vulnerable adults to ask for help when they may have difficulty to verbally express that they require assistance.
b) We ensured that a PREVENT workshop was delivered to people with a learning disability in community by the Caring Listening and Supporting Partnership (CLASP) a self-advocacy group for people with a learning disability
c) We developed a programme of community events set up for the coming year utilising existing partnership arrangements and joint initiatives.
d) Ongoing promotion and engagement of the Wokingham Safeguarding Adults Forum. – This is for open forum for customers, providers, carers and partner agencies.

Priority 2 – *To measure outcomes for people who have experienced the safeguarding process;*

What we did

a) We developed a more formal process to gain feedback from individuals who have experienced safeguarding enquires, with a focus on measuring Making Safeguarding Personal outcomes.
b) We have improved methods of auditing to make sure we measure outcomes for individuals.
c) We supported and developed methods of better service user engagement with the work of the Safeguarding Adults Board.
d) We continue to monitor and review how the local a**u**thority responds to the demand and development of the DoLs (Deprivation of Liberty Safeguards) service and ensure that human rights are upheld for those that experience the process.

2. Workforce Training and development in Wokingham 2016/17

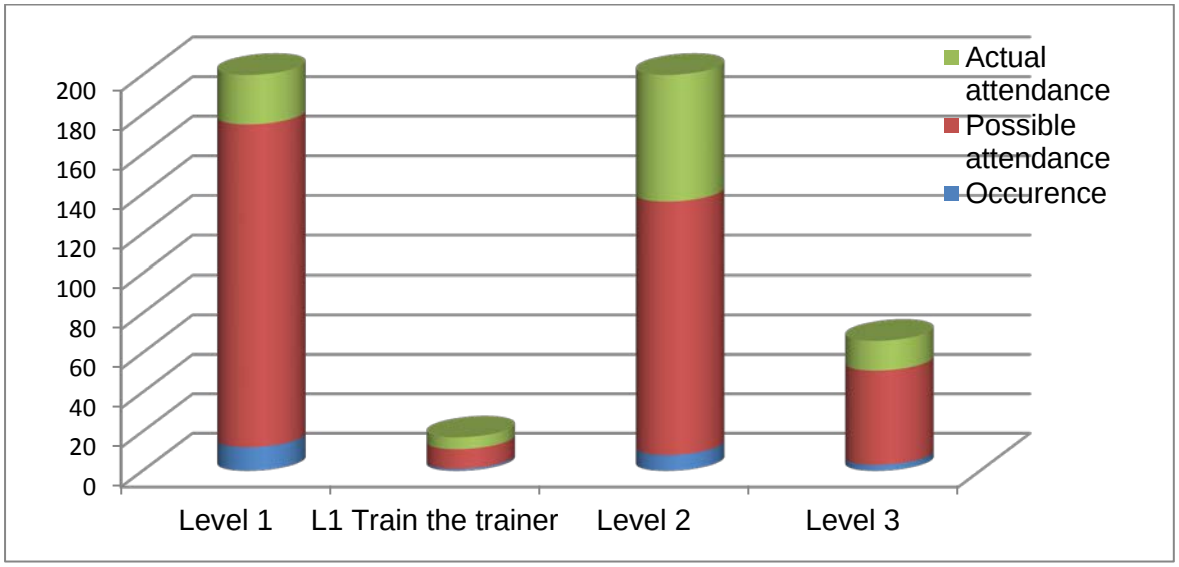
We have developed our training programme to meet the needs of the workforce and to respond to the changing landscape of safeguarding adults across our local area. The following additional training was offered alongside the levels 1, 2 and 3 safeguarding training that is routinely delivered. This training was generally delivered by external trainers.

- Self-Neglect and Hoarding
- Human Trafficking and Modern Slavery
- Person Centred Assessment and Recording Skills
- PREVENT
- Childhood Sexual Exploitation
- Positive risk taking and case management

The 2nd Conference on Mental Capacity and Deprivation of Liberty Safeguards took place this year and was hosted by Wokingham BC.

The conference was attended by approximately 100 delegates who came from various health and social care agencies from across Berkshire. It is hoped that the learning will be cascaded through all the agencies.

As part of the contribution of Boards Workforce Development Strategy the table below illustrates the frequency and volume of safeguarding training that was delivered by Wokingham Borough Council in 2016/17



Training	Occurrence	Possible attendance	Actual Attendance
Level 1	12 sessions	163	141
L1 Train the trainer	1 session	10	6
Level 2	8 sessions	128	85
Level 3	3 sessions	48	15

3. Our achievements in engaging people who use services, community awareness and prevention

1. Caring Listening and Supporting Partnership (CLASP) a self-advocacy group for people with a learning disability supported the development and creation of an online video made by people who use services. The aim was to help people understand the outcomes they wanted to achieve in keeping safe and stopping abuse. The video was commissioned by the Communications subgroup of the SAB and will be widely launched in the coming year. In addition CLASP and WBC jointly hosted a session on what Making Safeguarding Personal means and was well attended.

2. WBC in partnership with 'Involve' *(the* community voluntary sector support group), undertook some promotional work about the work of the SAB and why we have one. This was aimed at front line services, community sector and provider services in Wokingham.

4. Partnership and prevention work

1. The Care Governance Process

The work of the Care Governance Board in Wokingham which ensures quality and safety is monitored and maintained in our care homes through a process of good quality assurance mechanisms continued in 2016/17.

The monthly meetings are well attended by senior staff in our partner agencies such as in Health, Clinical Commission Group and social care partners. There is a commitment to continue with this work and some improvements have been underway in 2017/18 regarding processes. A central log is populated according by information that is referred to the local authority that is of concern. This log is a 'live' system that provides intelligence for the care governance process and enables it to make informed decisions about specific providers.

The aim of the care governance process is to deliver a sound and evidenced based quality assurance framework which is used to undertake quality assurance visits in Wokingham care home facilities.

There has been substantial and sustained improvement in 2016/17 as a result of the care governance process which reduced the impact and risk to vulnerable adults receiving services achieving positive outcomes. This year's data demonstrates a 12% reduction in concerns that where raised leading onto an enquiry in residential and nursing homes within the Wokingham borough.

As part of our preventative approach to care governance the commission of the Care Home Support Team (CHST) and Rapid Response Team (RAAT) under the Better Care Fund has proved useful in supporting providers of care in Wokingham. They have been proactive in responding to low level concerns raised about a care homes and will visit to work alongside care providers to assist them to improve their clinical practice.

2. Community Engagement

A review was undertaken of the WBC's Prevention and Community Engagement Strategy for safeguarding activity. A diary of events and activities were developed for the year ahead that involved partner agencies in raising safeguarding awareness amongst the community

In November 2016 we co-facilitated a Market Place Event for approved providers to promote themselves to ASC & WBC residents. 18 providers were available on the day with 25 visitors attending.

The **Wokingham Adult Safeguarding Partnership Forum** (WASPF) continues to meet 4 times a year. The areas that have been discussed are: Hate Crime, Community Safety, Local Policing Priorities and updates from providers. This forum gives 'a voice' to those in the community and a level of scrutiny about what services are in place and what needs to be provided.

3. <u>The PREVENT work</u>

In line with the Governments **PREVENT** agenda, we supported the Wokingham Learning Disability Partnership Board (WLDPB) to facilitate a session specifically for people with a learning disability. The session was well attended by 23 self-advocates plus their carer's.6 People with a learning disability attended training on 'What is Abuse'. All are either in employment or are volunteers supporting vulnerable members of the community

.

5. Qualitative case audit outcomes

As part of the Board's work in ensuring quality in safeguarding practice Wokingham participates in the quarterly audits of a selection of random safeguarding cases. The other two partner boroughs under the SAB , Reading and West Berkshire also provide data and this is considered collectively and measured against the 6 principles of the Care Act.

Accountability; Prevention; Proportionality; Protection; Partnership & Empowerment

1. Proportionality and Protection

Data shows that of the 1,523 concerns raised, 620 progressed to an enquiry (41%).

This demonstrates that there are proportionate responses to safeguarding concerns as less than half progress to an investigation stage (*section 42 enquiry*)

- **Proportionality** - The average national benchmarking of concerns leading to an enquiry has been around 48%. However it is noted that local practice in relation to transition from concern to enquiry differs depending where you live Audit outcomes indicate that staff and managers need to remain aware of when thresholds may be being applied too rigorously and to ensure enquiries are being undertaken in a timely manner when the thresholds are met.

- **Protection** - audit outcomes indicate that were protection principles have not been robust enough these have arisen from poor initial risk assessment. This is a theme that appears in audits particularly in the area of domestic violence. However it is anticipated that the additional areas included in the training strategy, such as positive risk taking principles, domestic abuse and recording skills training will support further development in these areas.

2. Empowerment , Accountability and Partnership

- **Empowerment (Making Safeguarding Personal)** - this is an area of safeguarding practice that appears to have remained one of the greatest challenges for practitioners according to the 2016/17 practice audits. We continue to promote this principle and assist practitioners to understand its relevance and meaning in good safeguarding practice. However there is anecdotal evidence that people involved in the safeguarding process are asked what outcomes they want and to request consent to progress the concern.

  Accountability and Partnership - Good partnership working was demonstrated in 69% of cases and has remain largely consistent, focus in practice for the coming year needs to ensure multi agency meetings and discussions where required are held in a timely manner and that relevant signposting or referrals are made.

3. Emerging Risks and Challenges for 2016/17

During the course of a year the SAB will identify emerging risks that may arise for one or all of the 3 boroughs. For Wokingham there were two themes

1. As per the national picture, Deprivation of Liberty Safeguards (DOLS) remains an area of corporate high risk for both the strategic safeguarding teams and operational services. Although a number of risk mitigation strategies have been implemented such as weighting list management, commissioned advocacy service monitoring, training and development, guidance policy and procedures, a full review with options appraisal will be undertaken to inform the ongoing service design and delivery.

2. Wokingham BC undertook its second Domestic Homicide Review (DHR) during this period; the Independent report is currently with the Home Office awaiting publication. Valuable learning has emerged from the review in a multi-agency context and led to specific audit outcomes for the SAB these were;

- To improve pathways for people living with dementia and the application of the principles of the Mental Capacity Act 2005.
- Learning outcomes have been incorporated in to the training strategy for multi agencies in addition to recommendations on the use of recording systems and information sharing.

The Wokigham SAB priorities for 2017/18 are:

A. To review the impact and outcomes of the previously implemented quality assurance system/process for operational safeguarding.

B. To measure improvements, identity areas for further development and ensure good safeguarding principles remain embedded in 21st century pathway design

C. To review implementation of the training strategy in operational services

D. To review of Deprivation of Liberty Safeguards strategy and risk mitigation options in readiness for possible new legislative requirements.

(These priorities will be commented on in the annual report for 2017/18)

END OF PART ONE of the Report

Part 2 - Annual Performance data and analysis 2016-17

Safeguarding activity - Concerns and enquiries

A safeguarding *concern* is reported to the local authority's Adult Social Care service by someone (ie: a professional, family member or carer) who is worried about the adult at risk who may be being neglected or abused.

A total of 1,523 safeguarding *concerns* were raised for the 2016-17 reporting year. The number of concerns has increased year on year (albeit only slightly in 2016/17) This increase suggests that safeguarding awareness amongst the public and professionals may have improved resulting in more reporting.

An *enquiry* is where a *concern* is progressed to a formal investigation stage and for 2016/17 there were 620 (41%) enquiries. The previous year there was 39% of concerns that went on to the enquiry stage.

This could suggest that while the numbers of concerns have increased the numbers that have required further investigation has remained similar over the past 2 years.

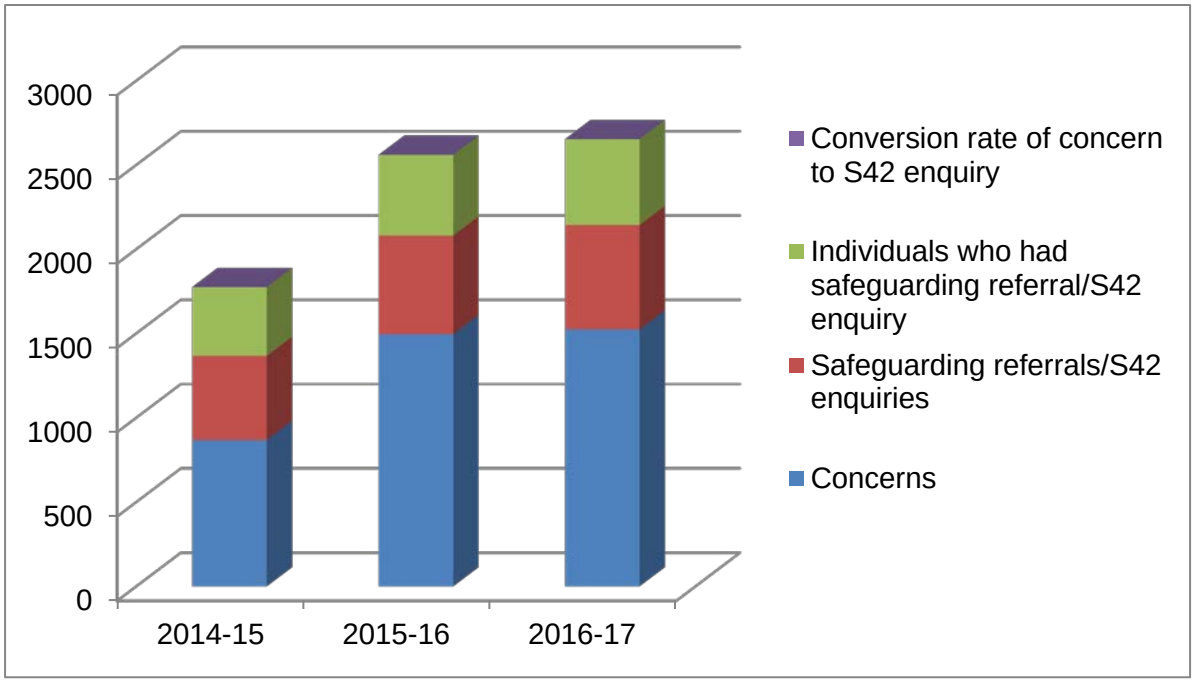


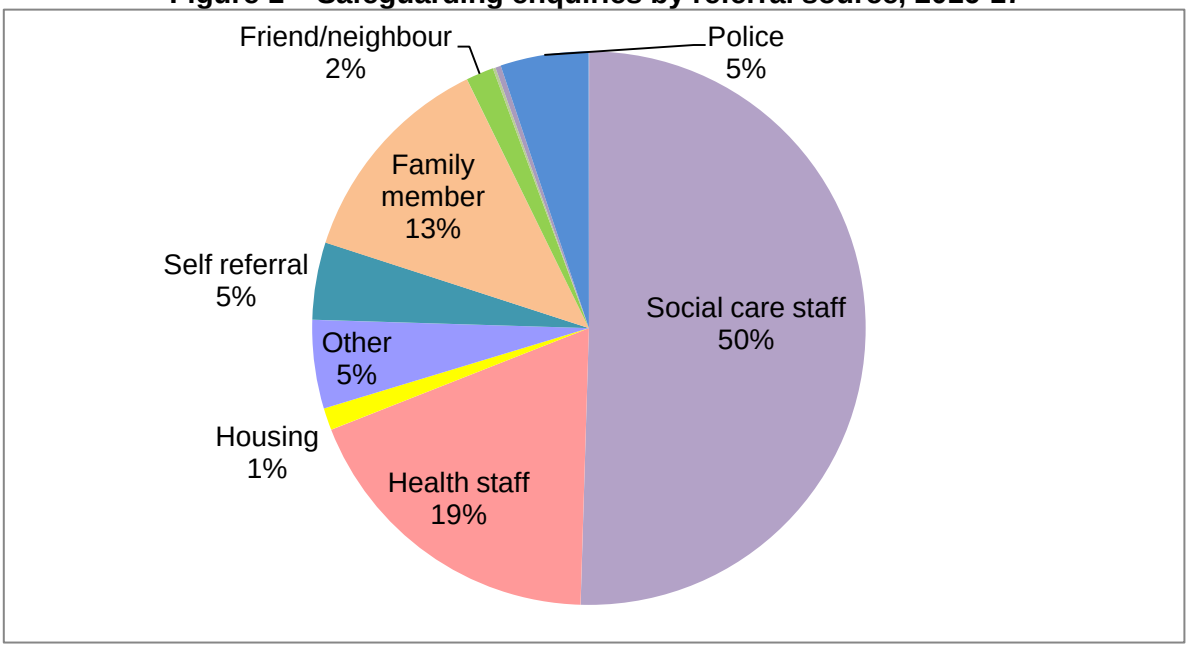
Table 1 – Safeguarding activity, 2015-17

	Concerns	Safeguarding referrals/S42 enquiries	Individuals who had safeguarding referral /S42 enquiry	Conversion rate of concern to S42 enquiry
2014-15	868	499	408	57%
2015-16	1,495	586	479	39%
2016-17	1,523	620	510	41%

Source of safeguarding enquiries

Fifty percent of safeguarding enquiries came from social care staff followed by 19% of enquiries referred by health staff. Social care staff category includes LA and independent sector staff from domiciliary, day care and residential care staff. The percentage of self-referrals and referrals from family members, friends or neighbours was 19% which shows a good level of awareness within the general community.

Figure 1 – Safeguarding enquiries by referral source, 2016-17



The table below shows comparison of safeguarding enquiries over the past 3 years. As with previous years the majority of enquiries continue to come from social care staff and health care staff. There was an increase in enquiries raised by Social Care Staff overall in 2016-17, however, those received from residential/nursing staff decreased by 12% and other service providers all showed increases.

*This could be a positive that there are fewer incidences requiring enquiries occurring in care homes, however we need to monitor ongoing data to ensure that care homes are not referring less when they should be. In addition during this period we know that some frontline staff were disproportionate in requesting providers who had care quality concerns to raise safeguarding for individuals that were not required. Guidance has been given in this respect.

Enquiries referred by Primary/community health increased in 2016-17 but enquiries raised by secondary and MH staff decreased, this is a concern and requires further exploration.

Table 2 – Safeguarding enquiries by referral source, 2014-16

	Referrals	2014-15	2015-16	2016-17
Social Care Staff	Social Care Staff total (CASSR & Independent)	259	306	313
	Of which: Domiciliary Staff	48	46	46
	Residential/ Nursing Care Staff	139	186	164
	Day Care Staff	21	15	20
	Social Worker/ Care Manager	25	35	44
	Self-Directed Care Staff	3	4	5
	Other	23	20	34
Health Staff	Health Staff - Total	77	112	115
	Of which: Primary/ Community Health Staff	38	51	65
	Secondary Health Staff	21	40	30
	Mental Health Staff	18	21	20
Other sources of referral	Self-Referral	33	21	28
	Family member	68	65	79
	Friend/ Neighbour	12	12	10
	Other service user	0	1	0
	Care Quality Commission	3	1	1
	Housing	8	3	8
	Education/ Training/ Workplace Establishment	0	2	2
	Police	6	27	32
	Other	33	36	32
	Total	**499**	**586**	**620**

Individuals with safeguarding enquiries

Age group and gender

The table below shows age groups for individuals who had a safeguarding enquiry in the previous three years. The majority of enquiries (72%) were for individuals aged 65 and over.

**compared to South East for 2015-16, Wokingham had a much higher proportion of safeguarding enquiries per 100,000 population for those aged 85+. This has reduced in 2016-17 but not by much. This would be expected in relation to a) the demographics of borough having a high aging population and b) that many individuals receiving care service in their own home or residential nursing would be older.

Table 3 – Age group of individuals with safeguarding enquiries, 2014-17

Age band	2014-15	% of total	2015-16	% of total	2016-17	% of total
18-64	117	29%	128	27%	138	27%
65-74	36	9%	61	13%	58	11%
75-84	98	24%	120	25%	150	30%
85-94	131	32%	141	29%	133	26%
95+	23	6%	26	5%	24	5%
Age unknown	3	1%	3	1%	7	1%
Grand total	**408**		**479**		**510**	

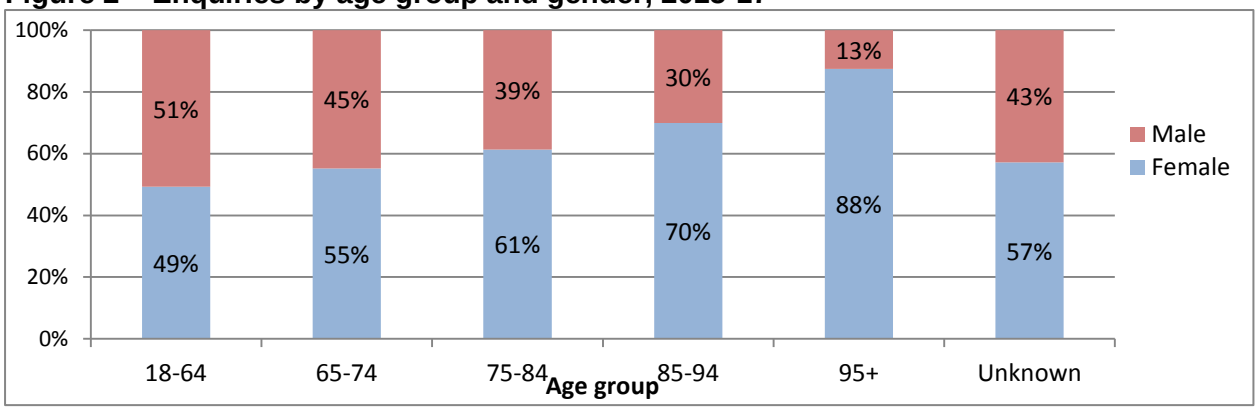
As with previous years more women were the subject of a Section 42 safeguarding enquiry than males. 61% of safeguarding enquiries started in the year were for females. This is similar to national data. 59% of Section 42 enquiries for England in 2015-16 were for females.

Table 4 – Age group and gender of individuals with safeguarding enquiries, 2016-17

Age group	Female	Male
18-64	68	70
65-74	32	26
75-84	92	58
85-94	93	40
95+	21	3
Unknown	4	3
Total	**310**	**200**

The chart below shows safeguarding enquiries increases with age for women indicating increased likelihood of abuse for older women.

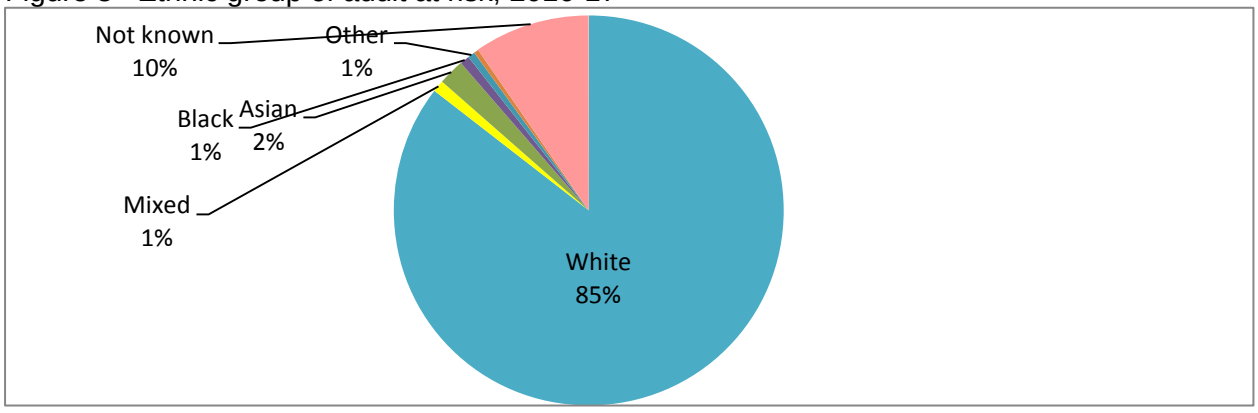
Figure 2 – Enquiries by age group and gender, 2015-17



Ethnicity

Eighty five percent of all individuals who had a safeguarding enquiry were of white ethnicity. 10% did not have any ethnicity recorded. 5% were recorded as belonging to a BME ethic group or recorded as 'other'. This is lower than the 11% reported from the 2011 Census, however comparisons are skewed by the high proportion where this information was not recorded.

Figure 3 –Ethnic group of adult at risk, 2016-17



Primary support reason

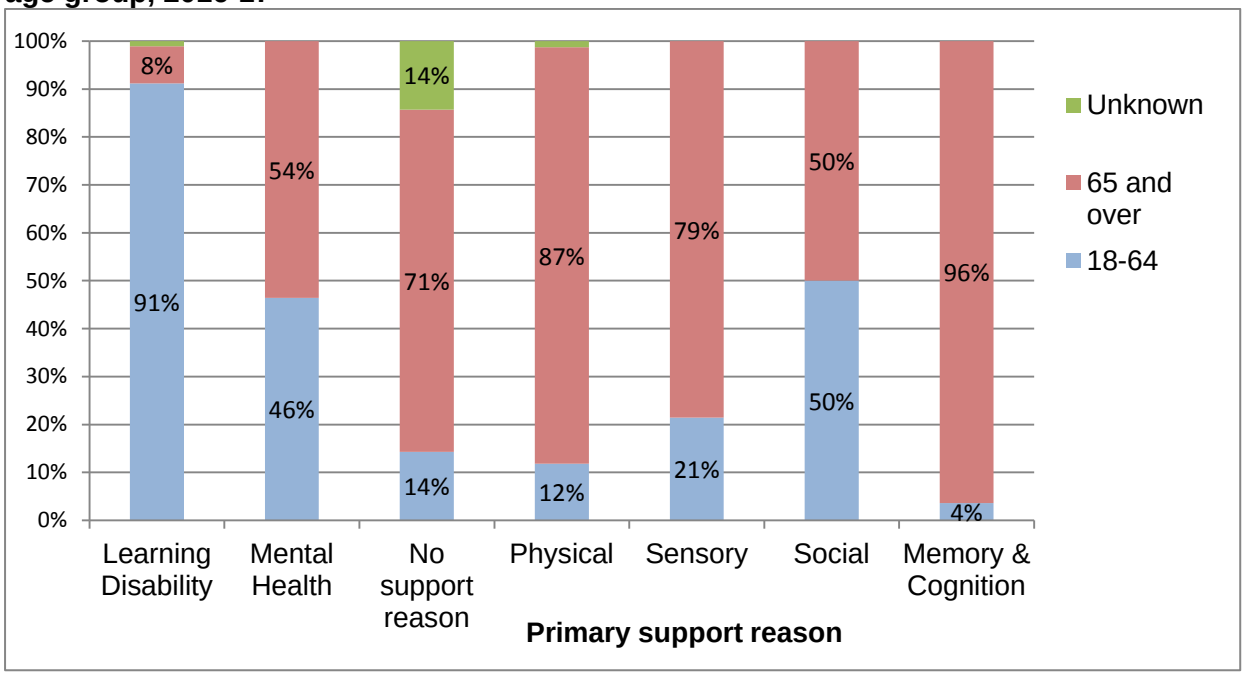
Table 5 below shows breakdown of individuals who had a safeguarding enquiry by primary support reason. For the majority of cases the primary support reason was physical support (47%) followed by support for memory and cognition (22%) and Learning disability support (18%).

The chart below (figure 4) shows enquiries broken down by age group and primary support reason. Individuals who had physical support were more likely to be aged 65 and over whereas those who had a primary support reason of learning disability were aged 18-64. This may be because even though older people may have a learning disability due to increasing frailty their primary need may be for physical support.

Table 5 – Primary support reason for individuals with safeguarding enquiries, 2014-17

Primary support reason	2014-15	% of total	2015-16	% of total	2016-17	% of total
Physical support	197	48%	225	47%	237	47%
Sensory support	8	2%	13	3%	14	3%
Support with memory and cognition	69	17%	87	18%	111	22%
Learning disability support	99	24%	101	21%	91	18%
Mental health support	17	4%	24	5%	28	5%
Social support	6	1%	9	2%	8	1%
No support reason	12	3%	19	4%	21	4%
Not known	0	0%	1	0%	0	0%
	408		479		510	

Figure 4 - Individuals who had safeguarding enquiry by primary support reason and age group, 2016-17



Case details for concluded enquiries

Type of alleged abuse

The table below shows enquiries by type of alleged abuse in the last three years.

The majority of the allegations were for neglect accounting for 39% of all recorded risks followed by physical abuse at 20% and emotional abuse at 15%.
The number of enquiries with physical alleged abuse increased in 2016-17, however the number accounts for a smaller proportion of the overall number of concluded enquiries.

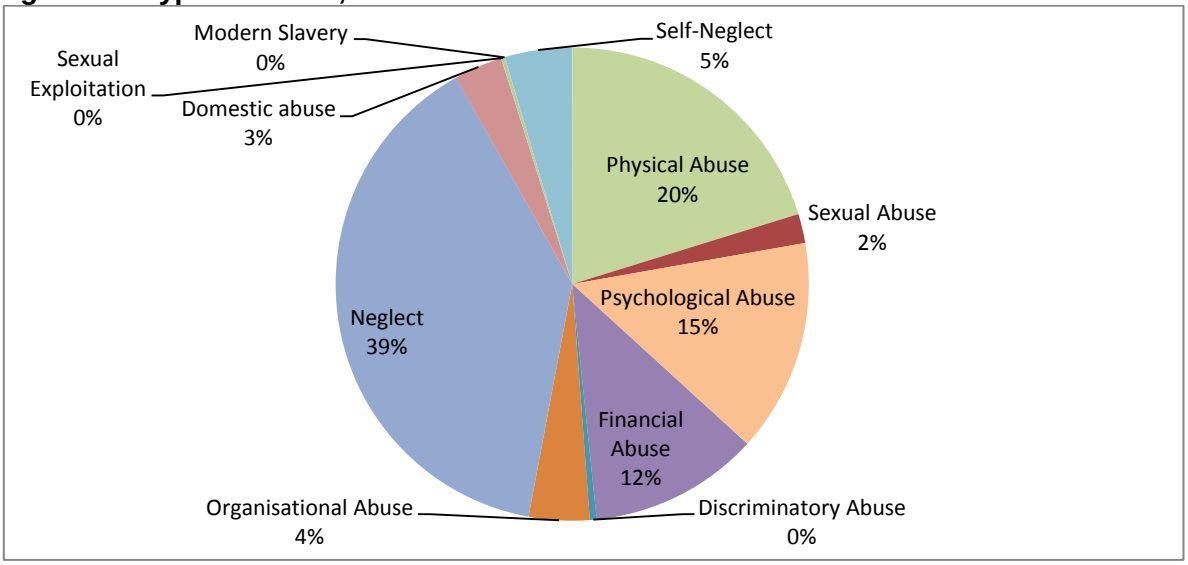
The types of abuse that increased in 2016-17 as a proportion of total concluded enquiries were self-neglect, domestic abuse and financial abuse.

**This is highly likely to be as a result of case audit outcomes and staff applying learning as these were new definitions in statutory safeguarding terms under Care Act implementation and was previously identified areas of concern in training development.

Table 6 – Concluded enquiries by type of abuse, 2015-17

Concluded enquiries	2014-15		2015-16		2016-17	
Physical	150	29%	165	26%	171	20%
Sexual	19	4%	9	1%	17	2%
Emotional/Psychological	78	15%	94	15%	123	15%
Financial	58	11%	57	9%	98	12%
Neglect	195	38%	254	41%	329	39%
Discriminatory	6	1%	4	1%	4	0%
Institutional	13	3%	23	4%	35	4%
Domestic abuse	-		8	1%	28	3%
Sexual exploitation	-		0	0%	2	0%
Modern slavery	-		0	0%	0	0%
Self-neglect	-		10	2%	39	5%

Figure 5 – Type of abuse, 2016-17



Location of alleged abuse

As with previous years the most common locations where the alleged abuse took place was a care home or the person's own home.

Table 7 – Location of abuse, 2016-17

Location of abuse	2016-17
Own Home	276
In the community (excluding community services)	33
In a community service	8
Care Home - Nursing	122
Care Home – Residential	192
Hospital - Acute	3
Hospital – Mental Health	0
Hospital - Community	4
Other	21

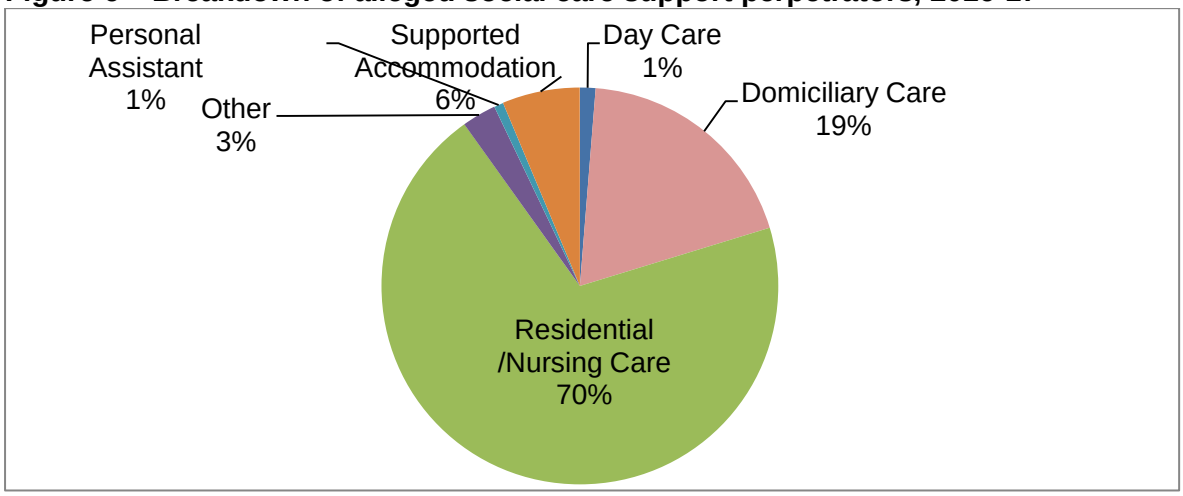
Source of risk

In the majority of cases (63%) the source of risk was social care support. Social care support refers to any individual or organisation paid, contracted or commissioned to provide social care support regardless of funding source and includes services organised by the council and residential or nursing homes that offer social care services. This category includes self-arranged, self-funded and direct payment or personal budget funded services. Health or social care staff who are responsible for assessment and care management do not fall under this category.

In 2015-16, for 60% of cases the source of risk was social care support for Wokingham. This is much greater than national and south east performance of 34% for both.

The chart below shows a breakdown of social care support category. Where the source of risk was social care support, residential and nursing care staff were most commonly reported as the alleged abuser (70%). Domiciliary care staff accounted for 19% of this category.

Figure 6 – Breakdown of alleged social care support perpetrators, 2016-17



Action taken and result

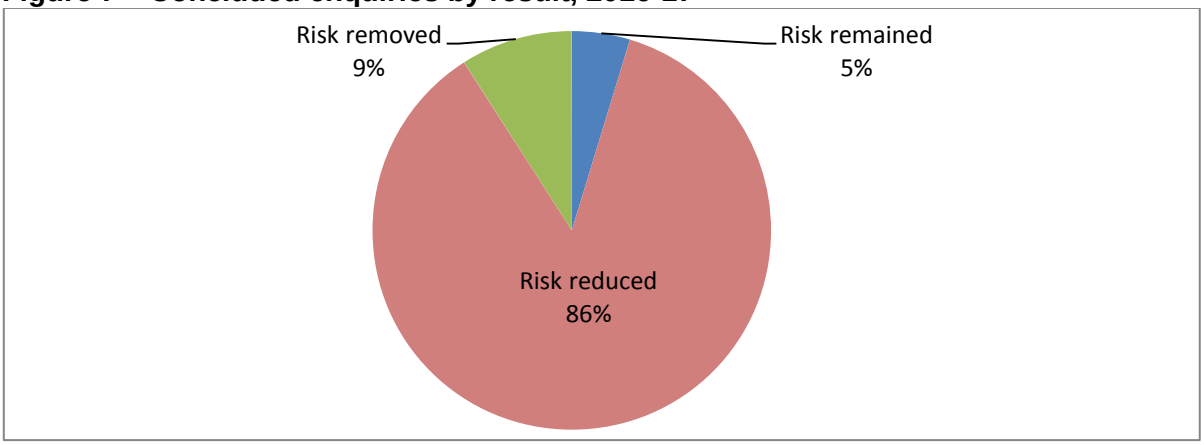
The table below shows risk assessment outcomes for concluded enquiries. In 86% of cases risk was identified and action was taken. Wokingham has a low number of concluded enquiries where no action was taken. 25% of concluded enquiries resulted in no action for all England in 2015-16, whereas Wokingham's performance was 7% for the same period.

Table 8 – Concluded enquiries by risk assessment outcomes, 2016-17

Risk assessment outcome	Total
Risk identified and action taken	542
Risk identified and no action taken	9
Risk - Assessment inconclusive and action taken	28
Risk - Assessment inconclusive and no action taken	12
No risk identified and action taken	16
No risk identified and no action taken	10
Enquiry ceased at individual's request and no action taken	10

The chart below shows concluded enquiries by result in cases where a risk was identified. In the majority of the cases the risk was reduced or removed.

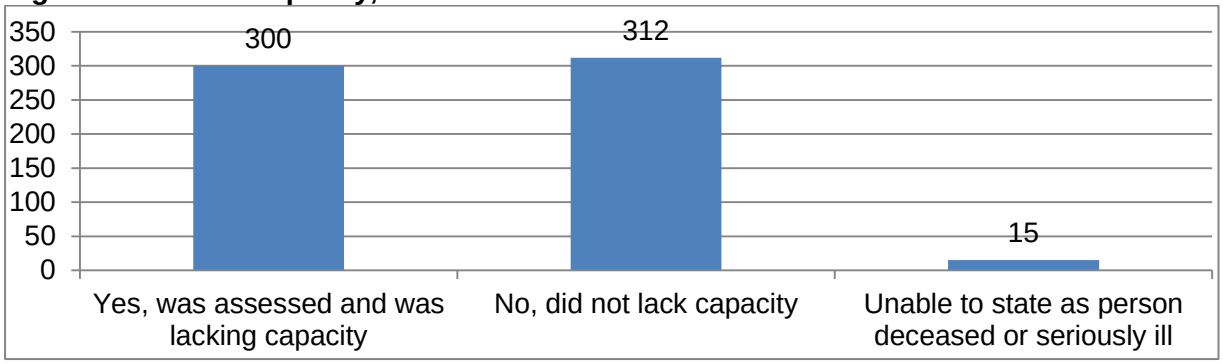
Figure 7 – Concluded enquiries by result, 2016-17



Mental Capacity and Advocacy

The chart below shows mental capacity for concluded enquiries.

Figure 8 – Mental capacity, 2016-17



Of the 300 concluded enquiries where the person at risk lacked capacity in 281 of these cases support was provided by an advocate, family or friend.

Deprivation of Liberty Standards

547 applications were received in the financial year 2016-17. This is a reduction of 3% compared to 2015-16.

333 (61%) were signed off, which is a reduction compared to 2015-16 - 425 (75%).

*This is due to an increasing waiting list and issues with internal specialist assessor capacity.

Outcome	**Count 2015-16**	**% of total signed off**	**Count 2016-17**	**% of total signed off**
Not Granted	75	16.9%	97	29.2%
Granted	369	83.1%	235	70.8%
Awaiting allocation for assessment	120		215	
Total signed off	425		332	

Fewer applications have been granted in 2016-17, this is due to the higher number of people still awaiting a decision at the end of the financial year.

The waitlist has also increased the number of applications that were not granted. This is because there are more people who have died or had a change of circumstances whilst awaiting allocation. This then ends the application and it is recorded as not granted.

The number not granted due to assessment criteria not being met has fallen due to fewer assessments taking place.

Reason not granted	**Count 2015-16**	**Count 2016-17**
Assessment criteria not met	**43**	**17**
Mental Capacity Requirement	*41*	*13*
Mental Health Requirement	*1*	*2*
Eligibility Requirement	*0*	*2*
Best Interests Requirement	*1*	*0*
Change of circumstances	**15**	**25**
Death	**17**	**55**

Appendix F Safeguarding Adults Training Activity

From 1st April 2016 to 31st March 2017

	Number of staff attended training, per sector					
Reading Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**
Level 1	152	169				226
Level 1 Refresher N/A						
Level 1 E-learning	74	332				
Level 2	50	29				
Level 3	21	11	2			
Advanced refresher N/A						
Level 1 Train the Trainer	5					
RBC Total	**302**	**541**	**2**	**0**	**0**	**226**
West Berkshire Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**
Level 1	67	76			2	185
Level 1 Refresher	33	13				16
Level 1 E-learning	68	156				
Level 2	40	6			1	
Level 3	14	26				
Level 1 Train the Trainer	n/a					
WeBC Total	**222**	**277**	**0**	**0**	**3**	**201**
Wokingham Borough Council	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	**Your PVI Delivered**
Level 1	30	57	1	3	12	
Level 1 Refresher N/A						
Level1 E-learning N/A						
Level 2	33	48			13	
Level 3	11	12				
Level 1 Train the Trainer		6				
WoBC Total	**74**	**123**	**1**	**3**	**25**	**0**
Berkshire Healthcare NHS Foundation Trust	**Own Staff**	**PVI**	**BHFT**	**RBH**	**Others**	
Level 1	1154				10	
Level1 E-learning	439					
Level 2	994				4	
BHFT Total					2587	
Royal Berkshire Hospital NHS Foundation Trust	**Staff**	**PVI**	**BHFT**	**RBH**	**Others**	
Level 1						
Level 1 E-learning						
Level 2						
RBH Total	**0**	**0**			**0**	
West Berkshire CCG	**Staff**	**PVI**	**BHFT**	**RBH**	**Others (GP)**	**Other GP training: MCA**
Level 1					171	85
Level 1 E-learning	260					
Level 2					18	
West Berks CCG Total	**260**	**0**	**0**	**0**	**189**	