# West of Berkshire Safeguarding Adults Partnership Board

## Annual Report 2019-20

### Message from the Independent Chair

I am pleased to present the West of Berkshire SAB Annual Report for 2019 – 2020. This report summarises what the Board achieved throughout the year on behalf of West of Berkshire residents, together as a partnership as well as through the work of individual partner organisations.

We have continued to look at information about safeguarding activity to inform our priorities for improvement, as well as cases where people have died and Safeguarding Adults Reviews (SARs) were done to understand what happened and what needs to change. During 2019 - 2020, the SAR Panel have been working on 10 SARs of which 2 were endorsed by the SAB in this reporting year. We plan to publish the other safeguarding adult's reviews in 2020/21. Valuable learning has emerged from the all SARs and has fed into the SABs priorities and Business Plan for 2020/21

2020 has of course seen unprecedented demands on local services as a result of Covid 19. The pandemic has and will continue to have an effect on all of us, impacting on the lives of service users and staff across the partnership. West of Berkshire SAB's priorities for 2020-21 are heavily based on our response to the current crisis and to do our utmost to ensure safeguarding adults at risk remains at the forefront of our work.

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

**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 – call 0118 937 3747 or email safeguarding.adults@reading.gov.uk or complete an online form
- West Berkshire – call 01635 519056 or email safeguardingadults@westberks.gov.uk or complete an online form
- Wokingham – call 0118 974 6371 or email Adultsafeguardinghub@wokingham.gov.uk or complete a online form

For help out of normal working hours contact the **Emergency Duty Team** on 01344 786 543 or email edt@bracknell-forest.gov.uk

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

## Introduction

### Our vision

Adult safeguarding means protecting people in our community so they can live in safety, free from abuse and neglect.

Our vision in West Berkshire is that all agencies will work together to prevent and reduce the risk of harm to adults at risk of abuse or neglect, whilst supporting individuals to maintain control over their lives and make informed choices without coercion

### What is safeguarding adults?

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

### What is the Safeguarding Adults Board?

The West of Berkshire Safeguarding Adults Board (SAB) covers the Local Authority areas of Reading, West Berkshire and Wokingham. The SAB 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 SAB are the Local Authority, Clinical Commissioning Groups and Police. Other organisations are represented on the SAB such has health services, fire and rescue service, ambulance service, HealthWatch, probation and the voluntary sector. ***A full list of partners is given in Appendix A.***

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

**Who do we support?**

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

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

**Safeguarding Adults Policy and Procedures**

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

## Number of safeguarding adult concerns 2019-20

- Compared with 2018-19 there has been an 8% increase in the number of safeguarding concerns.
- The increase is less than the national trend which saw an increase of 15%.
- The SAB has identified that there have been inconsistencies in recording safeguarding concerns which has meant that the number of concerns received in the West of Berkshire has been under reported.
- West Berkshire Council and Wokingham Borough Council have reviewed and implemented changes to their recording process which has resulted in increases of 15% and 21% when comparing 19/20 with 18/19.
- There has been a decrease of 14% at Reading Borough Council when comparing 19/20 with 18/19, this however is due to under reporting, and work is in progress to address this.
- The pandemic has not impacted on this data as the data collection period ends on the 31st March 2020.
- Number of safeguarding concerns continues to be monitored quarterly through the SAB dashboard.

## Trends across the area in 2019/20

- 57% of enquires were in relation to women, this is a decrease from 2018/19 where the outturn was 61%.

- 62% of enquiries relate to people over 65 years in age, a slight decrease when compared with 2018/19 where it was 67%.

- 33% of enquires were for individuals whose ethnicity is not White, this is a 4% higher when compared with 18/19.

- There has been an 18% rise in referrals for individuals whose ethnicity is Black when compared with 18/19.

- For 14% of referrals made, the individual's ethnicity was recorded as not known, this is an increased from the previous 2 years where the outturn was 11%.

- As in previous years the most common type of abuse for concluded enquires were for neglect and acts of omission. This was followed by physical, psychological or emotional abuse and financial abuse. There has been a 2% increase in Domestic Abuse (149 enquiries in 19/20 compared with 113 in 18/19).

- For the majority of cases (44%), the primary support reason was physical support. This was followed by no support reason, which increased from 16% to 18% when compared with 18/19.

- The majority of cases with no support reason are attributed to West Berkshire Council at 98%. This was discussed at the SAB Performance and Quality subgroup who concluded this difference was due to West Berkshire Council opening a safeguarding enquiry for all individuals who are receiving services from a provider that is being investigated under organisational safeguarding. Reading and Wokingham Borough Councils do not open Safeguarding enquiries for all service users when service is being investigated under organisational safeguarding unless a specific safeguarding concern has been identified for that individual, therefore the figure for no support reason is significantly lower in these authorities.

- The most common locations where the alleged abuse took place was the person's own home (57% down from 61% in 18/19) and care home (26% up from 21% in 18/19, this can be attributed to West Berkshire District Council recording processes in regard to organisational safeguarding).

- The SAB had agreed to carry out an independent audit into the safeguarding recording process across each Local Authority in 20/21. In order to identify the inconsistencies in recording across the partnership and for the SAB to agree to an approach to address these inconsistencies. This will include an investigation into the appropriate recording of organisational safeguarding concerns. The audit has been deferred to 21/22 due to the pressures around capacity as a result of the pandemic.

## Risks and Mitigations

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

- The implementation of a user engagement strategy began in 19/20 and will continue to be implemented in 20/21 in order to ensure that people who experience the safeguarding adults process as adults with care and support needs, as well as their carers, have appropriate opportunities for involvement or engagement with the SAB. SAB meeting agendas have time allocated at the start of the meeting to ensure that the voice of the service user is heard, this can be through Safeguarding Adult Reviews (SARs) or presentations from partners with specific emphasis on individuals experience.

- An additional subgroup was created with members of the Voluntary Care Sector and Healthwatch's across each Local Authority area in order for the SAB to better understand the issues facing these sectors in regard to safeguarding.

- It is important to the SAB that people who raise safeguarding concerns receive feedback, local authorities have adapted their recording processes so performance in this area can be reported to the SAB from 20/21 onwards.

- The use of advocacy continues to be monitored by the SAB, through the dashboard and audits. In 20/21 95% of individuals, who were part of a safeguarding intervention, who were assessed as lacking capacity were recorded as having an advocate, this is a slight increase from 18/19 where it was 94%. Performance is much higher than the national average which was recorded as 84% in 18/19.

- The SAB accepts that understanding and implementation of the Mental Capacity Act across the partnership will be an ongoing challenge as learning from SARs and audits evidences. The principles of the Mental Capacity Act and the roles of responsibilities of professionals across the partnership continues to be promoted through learning provided by the SAB.

- The SAB understands that there are capacity issues within the supervisory bodies to obtain timely Depravation of Liberties (DoLs) assessments and provide appropriate authorisation. Performance in this area is monitored by the SAB who accept further work is required in this area. The impact of the pandemic has impacted on the way in which DoLs assessments have been conducted the SAB is awaiting data to understand this impact.

- As in 18/19 in order to ensure that arrangements to support people who have Mental Health issues were fully understood, a report detailing governance arrangements continues to be presented to the SAB on a six monthly basis.

- Business plan priorities for 19/20 were set to support the SAB to mitigate the following risks:
    - Mechanisms and pathways in place across the locality to support people who self-neglect are not widely or fully understood.
    - Local priorities and arrangements to support and minimise risks for people who experience Domestic Abuse are not fully understood.

- The partnership saw a 25% reduction in safeguarding concern from 18/19 when compared with 17/18, which is different to national trends where there has been a year on year increase. The SAB agreed to commission an independent audit in 20/21 to understand the reasons behind this. The audit has been deferred to 21/22 a due to the pressures around capacity as a result of the pandemic and assurance from Local Authorities that they are addressing issues in regards to under reporting.

- Assurance was sought from partners to ensure that plans were in place in the event of a no deal Brexit.

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

## Achievements through working together

Our 18/21 Strategy outlines what the SAB aims to achieve in the next three years. The SAB identifies strategic priorities that shape its work. These are reviewed each year and revised to reflect findings from performance information and case reviews.

Our priorities for **19/20** and outcomes to those priorities were:

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

- A Service User involvement strategy was approved, and part implemented, further implementation of this strategy has been added to the 20/21 Business Plan.
- The Pan Berkshire Policies and Procedures in regard to Self-Neglect were reviewed and launched in July 2020.
- A review of safeguarding training across the partnership was completed and recommendations to improve training were approved by the SAB. The SAB will look to implement these recommendations in 21/22 if there is capacity to do so.
- A best practice document has been created to support the partnership to understand the function of the Safeguarding Adults Manager (SAM) in the safeguarding process. Launch of this document is planned for 20/21.
- A review of the quality of Tissue Viability Management training across the partnership was completed and will go to the SAB for endorsement in September 2020.
- A partnership wide risk assessment tool named MARM[1] (Multi-agency Risk Management Framework) was created and launched in July 2020. A review of its effectiveness is planned in 21/22.
- Two Bitesize learning events on Royal Berkshire Fire & Rescue Service - Threat of Arson Safe and Well Processes where held. Feedback from these events was positive.

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

- The SAB are working with Local Safeguarding Child Boards and Community Safety Partnerships to support them in their priorities regarding Domestic Abuse.
- There is SAB representation at the Thames Valley Domestic Abuse coordinators meetings, where there were plans to host a Thames Valley wide conference on Domestic Abuse, these plans were unfortunately put on hold due to the pandemic.
- A bitesize learning event in conjunction with the Reading Domestic Abuse Forum, on Learning from Domestic Homicide Reviews took place.
- Pan Berkshire Policies and Procedures in relation to Domestic Abuse were reviewed and updated, these were launched in June 2020.

[1] http://www.sabberkshirewest.co.uk/practitioners/supporting-individuals-to-manage-risk-and-multi-agency-framework-marm/

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

- September 2019 SAB meeting focused on targeted exploitation with a number of speakers at the meeting.
- A modern slavery pathway was created and published.
- A research report to identify who is most at risk from Targeted Exploitation was completed by the Performance and Quality Subgroup and will be presented to the SAB in September 2020.
- Two bitesize learning events were scheduled in March 2020 on What do I do if I suspect Financial Abuse – the roles and responsibilities of agencies. Unfortunately, these sessions had to be postponed due to the pandemic, work is underway to rearrange these sessions virtually.

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

- January 2020 SAB meeting focused on organisational safeguarding, were the Care Quality Commission were represented.
- A survey was completed with care providers for the SAB to understand the issues the provider market is facing and how this impacts on safeguarding. The findings of this survey were presented to the SAB and recommendations added to the SABs Learning from Safeguarding Adult Reviews/Audit Implementation Plan.
- A meeting took place with the Care Quality Commission, Local Authorities and the Clinical Commissioning Group to discuss the increase in organisational safeguarding issues and to ensure that partners were working effectively together to address the issues being identified.
- The recommendations from the Devon Safeguarding Adults Partnership, Safeguarding Adult Review, Atlas Care Homes were considered by the SAB.
- The SAB are alerted to organisations that are subject to organisational safeguarding.
- A detailed questionnaire on commissioning and quality monitoring arrangements for external providers to the local authorities and clinical commissioning group in January 2020, findings of these questionnaire were to be considered by the SAB in order for the SAB to agree a suitable approach issues identified. Due to the pandemic not all questionnaire responses were received, and all responses will require reviewing due to the impact of the pandemic has had on commissioning and quality monitoring arrangements. This will be revisited in 20/21.

In November 2019, an extraordinary meeting of the SAB statutory partners was called to discuss the obstacles regarding communication and information across the partnership which had been identified at a SAB meeting in September 2019. The meeting was arranged to provide partners with an opportunity to have a frank and open discussion to identify the barriers regarding communication and information sharing, and to agree appropriate actions in order to better safeguard people. As an outcome of this meeting an action plan was agreed, and actions monitored through the SAB Learning from SAR/Audit Implementation Plan.

More information on how we have delivered these priorities can be found in the following:

- Additional achievements by partner agencies are presented in Appendix B.
- The completed Business Plan 2019-20 is provided in Appendix C.

## Safeguarding Adults Reviews

The SAB has a legal duty to carry out a Safeguarding Adults Review (SAR) 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 SAB has a SAR Panel that oversees this work.

During the reporting year, the SAR Panel have worked on 10 SARs of which 2 were endorsed by the SAB and one was published along with a practice learning note. The practice learning note is a two-page document that summarises the case, key learning and pulls seven key learning points from the SAR and summarising best practice in these areas. The practice learning notes have been well received across the partnership and are used to highlight SAR learning in team meeting and training sessions.

The SAB plans to publish the other nine safeguarding adult's reviews in 2020/21. Valuable learning has emerged from the all SARs and has fed into the SABs priorities and Business Plan for 2020/21. There was delays in publication of SARS due to the pandemic resulting in the March 2020 SAB being cancelled. The SAB introduced virtual SAB sign offs in May 2020 to overcome this backlog. The SAB continues to recognise the large workload for the SAR Panel and meetings continue to be held monthly.

The case summaries and the learning from the 2 SARs that have been endorsed are as follows:

**Daniel**

Daniel is a man in his 70's, who owned his own home. Daniel has cognitive difficulties and significant physical disabilities. Daniel is estranged from his immediate family, but had support from a lady called Ellen, who referred to herself as a family member and Daniel's next of kin. No checks were made around Ellen's claims. Professionals supporting Daniel were made aware on seven occasions, that Ellen was not who she said she was, and they did not investigate this further. When concerns were discussed with Daniel these were discussed with Ellen present. 14 Safeguarding concerns were raised from numerous agencies, over a five-year period, about the possible financial abuse of Daniel by Ellen. The Local Authority did not comply with Section 42 of the Care Act or the Mental Capacity Act 2005, and as a result Daniel was failed by the agencies that were supporting him.

**Lessons Learnt**

- The importance of independent advocacy to support a person lacking capacity.
- A significant lack of professional curiosity, professionals did not have the confidence to challenge a person, who at the time did not appear to be acting in the vulnerable persons best interests.
- **I**nformation taken at face value, there was no additional verification by professionals involved. Reallocation of support workers in such complex cases should be kept at a minimum.
- A more consistent approach to Care Management will help to identify any contradictory information.
- Professionals did not listen to Daniel; Making Safeguarding Personal principles were not followed.
- There is a lack of confidence across the workforce in dealing with complex financial situations.
- The workforce needs to be equipped to challenge and ensure that service user's best interests is key to any decision being made.
- There was a lack of management oversight in this case

**Ben**

Ben, moved to a Nursing Home in August 2014, after a stay in hospital. Ben had a diagnosis of Vascular Dementia and multiple co-morbidities. Ben lacked capacity to consent to the care and support provided to him, a Best Interests Meeting decided that it would be in Ben's best interests to move into a Nursing Home.

A Nursing Home had been identified by the Local Authority. Ben's family however expressed concerns about the cleanliness of the home and requested that a placement be made closer to his family. As Ben had been in hospital for over 3 months it was decided at a further Best Interests Meeting that it was it was in Ben's best interests to move into the Nursing Home on an interim basis pending a six-week review. The six-week review concluded that the placement appeared to be working well for Ben and Ben's case was transferred over for a 12-month review.

Ben was admitted to hospital in July 2015, and the hospital immediately raised a safeguarding concern under the category of Suspected Acts of Omission and Neglect by the Nursing Home. As Ben was noted to have 12 pressure ulcers and bruises over his body. The police were also notified. As a result of this safeguarding concern the Nursing Home was investigated under the Provider Concerns Framework and a police investigation was opened.

Ben did not return to the Nursing Home and passed away in August 2015. It was noted that Ben had several pressure ulcers at the time of his death. A criminal prosecution against the provider did not take place, due to lack of evidence. The Care Quality Commission (CQC) considered action under their regulatory powers but concluded there was not enough evidence to progress.

The Care Quality Commission, Thames Valley Police, Clinical Commissioning Group, GP, District Nurses, Podiatry, Tissue Viability Nurses, Royal Berkshire Hospital, Wokingham Borough Council, South Central Ambulance and an independent Nursing Home. All supported Ben during the period of review and contributed to this SAR.

**Lessons Learnt**

- The Nursing Home had no pressure care prevention plan in place for Ben, despite Bens needs resulting in him being at high risk of pressure damage. This was not identified as an issue at the six-week review.
- The Mental Capacity Act was adhered to throughout Adult Social Care's involvement with Ben. Best Interest Meetings were held in regards to decisions regarding Ben's care and support.
- A Deprivation of Liberty (DoLs) assessment took place following an application by the Nursing Home, which was in line with policies and procedures.
- Concerns raised about the Nursing Home by Ben's family by the Best Interests Assessor were not

**How is learning from SARS embedded within in practice?**

The SAB captures all recommendations from SARs on a Learning from SARS/Audit Implementation Plan where all recommendations from SARs and other SAB learning is added and tracked. From the two SAR endorsed the SAB have identified improvement action required in the following areas, *description of action has or is being taken is in italics:*

- **Safeguarding processes** – *a best practice guide for the Safeguarding Adults Management (SAM) function is in the final stages of development.*
- **Professional Curiosity** – *changes to the delivery of safeguarding training across the partnership has been agreed, which will be implemented in 20/21. Professional curiosity will be a theme throughout training. Professional curiosity has been identified as a future SAB Bitesize learning topic.*
- **Financial Abuse** – *learning evidenced that workers are not confident in dealing with complex financial situations. A bitesize learning event on 'What do I do if I suspect Financial Abuse – the roles and responsibilities of agencies' with speakers from: Local Authority, Trading Standards, Thames Valley Police and the Office of the Public Guardian was arranged for March 2020 but was postponed due to the pandemic. Work is underway to rearrange the session for 20-21. The SAB had a focused meeting on targeted exploitation and each Local Authority provided a presentation on how they have responded to the learning from this SAR. Targeted exploitation was a priority for the SAB in 19/20 and continues to be in 20/21.*
- **Advocacy** – *the SAB continue to monitor through its Dashboard the use of advocacy and has seen an improvement in performance that is above the national average.*
- **Organisational Safeguarding** – *is a priority for the SAB in 19/20 and continues to be in 20/21.*
- **Tissue Viability** – *Specific action on the SAB Business Plan to look at the suitability and effectiveness of training in regard to pressure care, report will go to the SAB in 20-21.*

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

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

## Key priorities for 2020/2021

We understand that priorities will change and as we learn from partner agencies both locally and nationally and that the priorities must be achievable. The priorities for 2020/21 are:

- **Priority 1 - We will continue to work on outstanding actions from the 2019/20 from the following priorities:**
    - Priority 1 2019-20, We will provide the partnership with the tools and framework to work effectively with people who Self-Neglect
    - Priority 2 2019 -20, The SAB will work collaboratively with Local Safeguarding Children Boards, Community Safety Partnerships and Health and Wellbeing Boards to provide the workforce with the frameworks and tools to work with Vulnerable Adults who are at risk of Domestic Abuse.
    - Priority 3 2019-20, We will understand the main risks to our local population in regard to Targeted Exploitation and agree how best to equip the partnership to Safeguard vulnerable people against these risks.
- **Priority 2 – The SAB will seek to understand the impact the pandemic has had on Adult Safeguarding locally.**
- **Priority 3 – The SAB will continue to carry out the business as usual tasks in order to comply with its statutory obligations.**

The Business Plan for 2020-21 is attached as **Appendix D.**

## Appendices

**Appendix A -** Board Member Organisations

**Appendix B -** Achievements by partner agencies

**Appendix C -** Completed 2019-20 Business Plan

**Appendix D** - 2020-21 Business Plan

**Appendix E** - Partners' Safeguarding Performance Annual Reports:

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