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

West of Berkshire Safeguarding Adults Partnership Board

Annual Report 2020-21

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

Message from the Independent Chair

I am pleased to introduce the Annual Report for the West of Berkshire Safeguarding Adults Board 2020/21. This last year has been unlike any other as we have all experienced the impact of the pandemic in our working and personal lives. On behalf of the SAB, I would like to take this opportunity to mourn the deaths of residents who have died, acknowledge the grief of their families and friends, as well as commending the hard work, dedication, and commitment of health, social care staff, volunteers, carers and all the key workers who kept everything going during this difficult period. There has been close working across agencies to meet the demands of the pandemic and lockdowns, providing assurance that they continued to meet their safeguarding responsibilities despite the additional and extreme pressures on services.

This annual report shows what the Board aimed to achieve during 2020/21 and what we have been able to achieve. The annual report provides a summary of who is safeguarded in Reading, West Berkshire and Wokingham, in what circumstances and why. This helps us to know what we should be focussing on for the future, in terms of who might be most at risk of abuse and neglect and how we might work together to support people who are most vulnerable to those risks.

There continues to be significant pressures on partners in terms of resources and capacity, especially during the Covid-19 pandemic. There is no doubt that the combined impact of the pandemic and growing demand has put huge strain on services as well as the ability to deliver all of our ambitions as a partnership. We have had to reprioritise and remain flexible, in order to respond to those issues which, require the most urgent attention. As a consequence, our Business Plan is shorter and more focussed, with a designated senior lead from the partnership for each priority to oversee progress, to ensure that we are able to make the changes and improvements we are seeking.

I want to thank all partners and those who have engaged in the work of the Board, for their time and effort and for their continued support. I feel privileged to work alongside such skilled and dedicated people in our shared aims to prevent and protect adults at risk of neglect and abuse.

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 – 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, regardless of whether or not they are receiving support for these needs. There are many different forms of abuse, including but not exclusively:

- Disability hate crime,
- Discriminatory,
- Domestic,
- Female genital mutilation (FGM),
- Financial or material,
- Forced marriage,
- Hate crime,
- Honour based violence,
- Human trafficking,
- Mate crime,
- Modern slavery,
- Neglect and acts of omission,
- Organisational,
- Physical,
- Psychological,
- Restraint,
- Self-neglect,
- Sexual,
- Sexual Exploitation,

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. Mandatory partners on the SAB are the Local Authorities, Berkshire West Clinical Commissioning Group and Thames Valley 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 and the SAB structure in Appendix B.***

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 there 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 2020-21

- Compared with 2019-20 there has been a 50% increase in the number of safeguarding concerns across the partnership.

- The number of safeguarding concerns per 100,000 of the population has increased by 30%, this is lower than the number of safeguarding concerns reported above as the number per 100,000 will only count individuals with multiple safeguarding concerns in the reporting year once.

- The level of increased of safeguarding concerns per 100,000 of the population across the three Local Authorities differs: Wokingham 40% increase, Reading 33% increase and West Berkshire 13% increase. A Business Plan action has been set for the SAB to *'review safeguarding concern numbers with Local Authority comparator groups and report findings to SAB for consideration'*, the deadline for this action is December 2021.

- It is understood that changing in recording processes for each Local Authority alongside the anxieties felt by professionals and members of the public during the pandemic during this year has contributed to this increase.

- The number of safeguarding concerns that went on to a safeguarding enquiry reduced by 39% compared with 2019-20 (47% in 2019-20 to 30% in 2020-21) so whilst there has been a significant increase in the number of safeguarding concerns recorded when comparing with previous years this has not impacted on the number of safeguarding enquires, which actually saw a 8% reduction (1517 in 2019-20 to 1395 in 2020-21).

Trends across the area in 2020/21

- 58% of enquires were in relation to women, this is consistent with 2019/20.
- 62% of enquiries relate to people over 65 years in age, this again is consistent with 2019/20.
- 80% of enquires were for individuals whose ethnicity is White, this is consistent with 2019/20. The ethnicity of the remaining 20% of individuals is as follows: Not Known 11%, Asian 4%, Black 4%, Mixed 1%.
- Neglect and acts of omission was the most frequent abuse type, equating to 31% of enquiries. This was followed by physical, psychological or emotional abuse and financial abuse. There has been no change in abuse type when comparing with 2019/20.
- For the majority of enquiries (43%), the individual primary support reason was physical support. This was following by no support reason (20%), there is no change from 2019/20.
- The Performance and Quality Subgroup investigated the increase in no support reason in 2019/20, which was attributed to West Berkshire Council and confirmed that the increase was correct. Reading Borough Council and Wokingham Council reviewed their recording practices to ensure that it was consistent with NHS digital guidance.
- 69% of enquiries completed were where the alleged abuse took place in the persons own home. Whilst this is not different when comparing with 2019/20 there has been an increase of 20%. Enquiries where the alleged abuse took place in care homes has dropped by 27%, this is thought to be due to the impact of the pandemic.
- 21/22 Business Plan action has been set to *'review safeguarding concern numbers with Local Authority comparator groups and report findings to SAB for consideration'*.

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:

- As in 19/20 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.
- Service user engagement, there is not the capacity within the partnership to fully implement the 'user engagement strategy' the Voluntary and Healthwatch Subgroup, chaired by the SAB Independent Chair continues to be held, where service user experience is considered. The SAB have been challenged on feedback received from agencies have agreed to consider feedback received and take necessary action.

- It is important to the SAB that people who raise safeguarding concerns receive feedback, the SAB dashboard now includes performance data from local authorities.

- The use of advocacy continues to be monitored by the SAB, through the dashboard. In 20/21 91% of individuals, who were part of a safeguarding intervention, who were assessed as lacking capacity were recorded as having an advocate, this is a decrease from 19/20 where it was 94%. Performance is higher than the national average which was recorded as 87% in 19/20.

- 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 material 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. Through the SAB statutory partners safeguarding leads the SAB is sighted on the implementation of Liberty Protection Safeguards (LPS).

- The SAB is not complying with its Quality Assurance Framework, as the SAB do not have the capacity in the partnership to deliver the frameworks requirements. The SAB priorities for 21/24 will focus on key learning topics from SARs and the quality assurance around those topics.

- As a result of the pandemic the following risks were identified by the SAB:
    - 'Safeguarding People at risk of multiple exclusion, due to not meeting safeguarding or care management pathways.' This is not a new issue but has been exacerbated as a result of lockdown, as people have been brought to the attention of services that wouldn't have previously been before. The SAB launched the Supporting Individuals to Manage Risk and Multi Agency Framework (MARM) in July 2020 and a review of this framework schedule for 2021/22 as part of meeting the SAB priority around self-neglect.
    - The SAB are not assured that individuals within closed environments are safeguarded due to restrictions around visiting during the pandemic. The SAB asked statutory partners to respond to a set of assurance questions and responses were considered by the SAB in September 2020, December 2020 and March 2021.
    - Increase of inappropriate Safeguarding Referrals, capacity in the Local Authority Safeguarding Teams will be impacted on resulting in there being less time be available to spend on appropriate safeguarding concerns. An analysis identified that the main increase can be attributed to Thames Valley Police, the Local Authority safeguarding leads and Thames Valley Police are working together to identify a solution.
    - Hospital Discharge pathways were amended in response to the pandemic, assurance was sought from the SAB that safeguarding is appropriately considered in the revised pathways.

- The increase on carers stress as a result of the pandemic, a paper was discussed at SAB where members were required to consider and implement appropriate changes within their organisations.
- Staff wellbeing as a result of the pandemic, was asked as part of a set of assurance questions and responses were considered by the SAB in September 2020, December 2020 and March 2021.
- People are more at risk of domestic abuse as a result of the measures put in place as a result of the pandemic, the partnership will need to consider how its approach will need to be adapted. Safeguarding data suggests that there has not been a significant increase in Domestic Abuse resulting in safeguarding concerns during the pandemic. The SAB continues to promote Domestic Abuse awareness and ways in which to identify and respond to during and after the pandemic.

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

Impact of Covid-19

The SAB was responsive to the pandemic and were flexible in its approach to adult safeguarding. Full Board meetings were postponed from March 20 – June 20 however three weekly statutory partner meetings were held to understand the impact Covid had on safeguarding and to seek assurance how partners were mitigating identified risks. Regular meetings continued with the Voluntary Care Sector and Healthwatch with the SAB Independent Chair and Business Manager so the impact of the SABs response could be monitored.

The statutory partners safeguarding leads set up weekly meetings, the meetings were attended by the SAB Business Manager who was able to escalate concerns regarding safeguarding practice immediately to the SAB. The meeting agreed and published a *'*Covid-19 Safeguarding Partnership Response, Escalation of safeguarding system issues in services responding to safeguarding activity during the Covid outbreak' .

A Covid information page was added to the SAB website and national and local guidance around safeguarding and Covid was added.

In December 2020 the Safeguarding Adult Review (SAR) Panel identified that there may be a potential increase in self-neglect as a result of the pandemic, in response the SAB created and published 'Self-neglect a five minute update', to raise awareness around self-neglect and the resources available.

A priority dedicated to the impact of Covid was added to the SAB's 2020/21 business plan: 'Priority 2 – The SAB will seek to understand the impact the pandemic has had on Adult Safeguarding locally'. The outcomes achieved are detailed in the next section 'Achievements of working together'.

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 **20/21** and outcomes to those priorities were:

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 4 2019- 20, 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.**

Regular meetings with the Voluntary Care Sector and Healthwatch, took place, to gather feedback from the sector on the effectiveness of statutory organisations response to safeguarding during the pandemic. Discussions based on this feedback were had at SAB meetings.

A Pan Berkshire Policy and Procedure Best Practice Guide for Decision-making: S42 Safeguarding Adults Enquiries, in response to learning from a safeguarding adult review, was published.

Reviewed the quality of Tissue Viability Management training and promotion in response to learning from SARs.

Produced a Self-Neglect 5 minute awareness document that was distributed across the SAB partnership in December 2020.

Considered a paper produced by the Performance and Quality Subgroup on the risks of targeted exploitation nationally and locally.

Priority 2 – The SAB will seek to understand the impact the pandemic has had on Adult Safeguarding locally.

The Learning and Development Subgroup sought assurance from partners regarding the delivery of safeguarding training during the pandemic and feed the findings back the SAB. The SAB partnership focused on virtual training during the national lockdowns, however successful virtual training has been

the SAB recognise there is still a need for classroom based training in some key areas of training when government Covid restrictions are eased.

The SAB reviewed the findings from the LGA[1] Insight Project, which was developed to create a national picture regarding safeguarding adults' activity during the COVID-19 pandemic.

A set of assurance questions were asked of the SAB statutory partners and responses were considered by the SAB in September 2020, December 2020 and March 2021.

A paper was considered by the SAB in December 2020 analysing the impact the pandemic has had on carers, for partners to consider and implement actions within their organisations.

Assurance was sought that safeguarding was being appropriately considered in the revised hospital discharge pathways in response to the pandemic.

Priority 3 – The SAB will continue to carry out the following business as usual tasks in order to comply with its statutory obligations.

The SAB published briefing notes in response to Board meetings held in September 2020, December 2020 and March 2021.

The SAB Annual Report for 2019/20 was published.

A total of seven SARs were endorsed by the SAB. Further details can be found further on in this report.

A database of recommendations and progress made from SARs and audits commissioned by the SAB has been maintained and progress update provided at each SAB.

The SAB's Terms of Reference, Constitution, Induction Pack and Structure was reviewed and relaunched.

The SAB Dashboard used to monitor safeguarding activity across the partnership remains in place and is considered in detail by the Performance and Quality Subgroup on a regular basis.

The SAB spent time considering the Quality Assurance Framework and agreed that a different approach to quality monitoring for 21/22 is required.

Due to the pandemic the Learning and Development Subgroup meetings were not held from March 2020 through to September 2020 so therefore quarterly bitesize learning events did not take place. However, the SAB did deliver:

- A virtual session on Financial Abuse in November 2020 with over 80 delegates attending.
- In response to the risk about increase in Hoarding due to the pandemic Hoarding training was commissioned for care workers and volunteers. The training was delivered in October 2020.

Feedback for this training was positive and the Learning and Development Subgroup will continue with the delivery of virtual bitesize training sessions in 2021/22.

[1] Local Government Association

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

- Additional achievements by partner agencies are presented in Appendix C.
- The completed Business Plan 2020-21 is provided in Appendix D.

Safeguarding Adults Reviews (SARs)

The SAB has a legal duty to carry out a 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 seven were endorsed by the SAB and six were published alongside a practice learning note. Practice learning notes are two-page documents that summarises the case, the learning and summarises best practice in key learning 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 four safeguarding adult's reviews in 2021/22 Valuable learning has emerged from the all SARs and has fed into the SABs priorities and Business Plan for 2021/24. The SAB continues to recognise the large workload for the SAR Panel and meetings continue to be held monthly.

The SAR Panel continues to adapt its approach to SARs and after reflecting on individuals and family involvement have produced an information leaflet to support individuals and family through this process.

The case summaries and the learning from the six SARs that have been published are as follows:

Ben – published September 2020

Full report
Practice learning note

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.

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 shared with the commissioning Local Authority.
- There was no safeguarding concern raised by a Nurse who visited Ben and noted that Ben had unexplained bruising. An assumption was made that the bruising was due to a general decline in Ben's health.
- There were delays in supporting Ben with his pressure care needs due to confusion around the referral process.
- Once initiated the Provider Concerns Framework was a success and a cross agency coordinated response supported the Nursing Home to improve.
- Previous safeguarding concerns raised about other residents at the Nursing Home, did not lead to further investigation, which may have identified the failings in the home sooner.
- The workforce within the SAB Partnership are not clear on the SAR process or the functions of the SAB.

Henry – published February 2021

Practice learning note

Henry was the main carer for his mother and sister, both had passed away. Henry was not in contact with any other family members and lived alone. Henry was known to a number of services. In January 2017 Henry's neighbour Iris, contacted these agencies to share her concerns about Henry's ability to look after himself. A Social Worker when visiting Henry's home identified several risks, the Social Worker assessed Henry as lacking capacity in regard to his hoarding behaviour and the disrepair of his property. However, the case was closed by the Local Authority, with no further action. Five months later Henry was referred to the Older People's Mental Health Team, Henry was discharged due to lack of engagement. Henry passed away in September 2017.

Lessons Learnt

- Henry's case was closed by Social Care practitioners incorrectly, as risks were not addressed, their actions did not comply with statutory regulations.
- A Multi-agency approach to supporting Henry to manage risks to was not considered.
- The risk of fire identified at Henry's home was not considered as a risk to others (neighbours, emergency services) and appropriate action was not taken.
- There was no consistency with the professionals who were visiting Henry (which is known to support improved engagement), or consideration of advocacy.
- The risks around possible financial abuse were not identified by the professionals visiting Henry and therefore not investigated further

Carol – published November 2020

Full report

Practice learning note

Carol's life changed significantly as Carol fell and broke her shoulder and her husband died of a cardiac arrest whilst Carol was present. Carol had moved to England to be with her husband and had no other support network. Carol started drinking alcohol and stopped taking her medication for schizophrenia. Carol was supported by a number of agencies over the next 3 months, including hospital stays, community mental health support and a package of care from a home care agency. Safeguarding concerns were raised by a number of agencies in regard to self-neglect but the local authority did not follow the Safeguarding Pan Berkshire Policies and Procedures. There were also missed opportunities for professionals to raise further safeguarding concerns. After a stay at hospital the home care agency was not informed to restart Carol's package of care, when she was discharged. When the package of care was restarted a few days after discharge from hospital, Carol did not answer the door. The following day, after Carol didn't answer the door again, the carer called the police where it was discovered that Carol had passed away.

Lessons Learnt

- That there is an emphasis on 'normal' behaviour when making decisions and that these decisions on 'normal' behaviour may not necessarily consider current circumstances. For example, being discharged from hospital without support, as Carol appeared to be coping in hospital.
- Carol's voice did not appear to be heard, Carol had to speak to a number of different professionals at a time of crisis, and advocacy was not considered.
- There was limited partnership working in this case. Agencies were working in silos, meaning Carol's situation was not fully understood.
- Self-neglect: it appears that agencies recognised self-neglect but were not clear on the most effective way to support Carol. A Strategy meeting was required.
- Bereavement: Carol was grieving and appeared to have very little support.
- Mental capacity: whilst it has been considered in chronologies it appears that capacity has been assumed and not tested further with reliance on: A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- Access of the Health Hub: Better understanding is required across the partnership about who can access the hub and when referrals should be made.
- There were a number of staff at the Emergency Duty Service (EDS) who did not follow their internal procedures.
- There was a failure to recognise on discharge that further communication was required with Carol's social worker.
- Within the local authority there were two different teams and therefore two different allocated workers and managers overseeing Carol's case, resulting in assessments not being completed at all or in a timely manner.
- Intelligence from this SAR and others along with SAR Panel member feedback evidences that safeguarding policies and procedures are not being followed

Graham – published February 2021

Full report
Practice learning note

Graham was an 86 year old man diagnosed with vascular dementia and other comorbidities. Graham lived with Ava, his wife and main carer. Graham and Ava had daughters from previous marriages who lived locally. Graham was dependent on his wife Ava to provide support for all activities of daily living. He required the assistance of two people and the use of mobility equipment for all transfers. Because of his cognitive impairment, it was difficult for Graham to communicate his own views and wishes. Graham was dependent on Ava to maintain communication with the different agencies involved in his life. However, the SAR identified that professionals did not agree that the decisions Ava was making, were in Graham's best interests and there were concerns about Ava's ability to cope. Opportunities to raise safeguarding concerns were missed and Graham continued to be supported under the care management pathway. During a six month period, Graham's health deteriorated, and a safeguarding enquiry began as the concerns regarding Ava's ability to manage and decision making around supporting Graham continued to escalate. Graham was admitted to hospital after a home visit from his GP and Graham was diagnosed with pneumonia, sepsis and severe pressure ulcers. Concerns had been previously raised in regard to pressure care and visits had been undertaken by District Nurses. Graham passed away 2 days later. A safeguarding concern was raised, this did not go on to and enquiry as it was the opinion of a manager that: Ava had not intentionally neglected Graham and that it would appear that Ava needed an assessment in her own right.

Lesson Learnt

Learning was identified in:

- Making Safeguarding Personal
- Advocacy
- Safeguarding Procedures
- Mental Capacity
- Professional Curiosity/Challenge

Through the practice learning note professionals were asked to consider the following questions:
Questions for future practice Please consider and discuss with your line manager

- Are you confident in your practice, to effectively challenge family members, who may not be making decisions that are in the best interests for the individual you are working with?
- How do you ensure that advocacy is considered and implemented, as per the Care Act requirements in your work?
- Are you clear on how to escalate concerns, if in your professional opinion, risks have not been dealt with adequately?
- Are you confident in the application of the Mental Capacity Act in your practice?
- Are you clear on your responsibilities, in regard to, individuals that are assessed as self-funders?
- Do you apply Making Safeguarding Personal Principals in your practice?
- Is there anyone you are working with at the moment, who may be in a similar situation to Graham and Ava, where you think a different approach can be taken in light of this SAR?

P – published December 2020

Full report

P was a white British woman, in her sixties. P had living with secondary progressive Multiple Sclerosis (MS) for nearly 20 years. Following the death of P's husband P was in receipt of five home care visits a day. As P's MS progressed, she developed contractures in her arms and legs that made her increasingly unable to position herself. She also experienced pain when others moved her. These worsened considerably over time.

P moved to extra care sheltered housing, following an admission to hospital. P's family were concerned that P was neglecting herself and felt unsupported by care services and made a number of complaints regarding the quality of care P was receiving. P developed pressure ulcers. A number of professionals raised safeguarding concerns that were not followed up correctly. The Local Authority failed to achieve an overall improvement in the quality of care delivered by the home care agency.

P moved to a care home, at first P's pressure ulcers began to improve, however a few months later there was a marked deterioration. 9 months after her move to the care home P was admitted to hospital, P died six weeks after admission. P's death certificate states the cause of death as 1a) sepsis 1b) infected pressure ulcers and 1c) Multiple Sclerosis. 12.

The author of this SAR concluded that P's quality of life could have been substantially improved if various aspects of her care had been managed differently and that this situation long pre-dated but was not reversed by her admission to residential care.

Lessons Learnt

- Person-centred practice – P's voice was rarely heard.
- Care management – P would have benefited from a named individual to bring together the understanding and expertise required to support P.
- Professional practice – professionals felt constrained by the pressure to "solve" immediate problems and move on.
- Mental Capacity - P's situation raises serious questions for all agencies about professionals' and carers' understanding and implementation of the Mental Capacity Act. Despite having previously been adamant that she did not want to move into a nursing home, P did not receive independent support when the decision was made.
- Safeguarding - there were a number of safeguarding alerts that were not dealt with thoroughly and recording was often poor in relation to what action either was or needed to be taken.
- Implementation of inter-agency protocols - there were examples across all the community agencies of gaps in this area.

Michelle – published July 2020

Full report
Learning brief

Michelle is described by her family as a funny, loving, affectionate young woman. She had a good sense of humour, was charismatic, engaging and caring with an optimistic outlook. Michelle also had long standing mental ill health and had had social work involvement in her life from an early age. When she was a teenager, she was diagnosed with depression and paranoid schizophrenia and she spent some time in adolescent mental health units. She became a looked after child in July 2017 and then moved into semi-independent provision. Michelle died in February 2019, aged 19.

The review looked at:

- The multi-agency support provided to Michelle
- How young people are supported and safeguarded through their transition into adulthood
- The effectiveness of the commissioned care provided to Michelle
- The effectiveness of Michelle's support plan/s
- Understanding how Michelle's medication was monitored in her placement.

The review was carried out by Royal Borough of Windsor & Maidenhead on behalf of the West of Berkshire Safeguarding Adults Partnership Board.

Learning Points

- The importance of commissioning suitable accommodation for young people, how young people are prepared for semi independence and the ongoing suitability of accommodation over time.
- Recognition of the complexity of supporting a young person who reaches their 18th birthday (and therefore becomes an adult) living out of area and in receipt of multiple services.
- Effective use of risk assessments and prevention plans.
- How children and adult local authority and health services work together to safeguard young adults, the role of the lead professional and balancing risk and safety in young adults.
- Ensuring that the young person is at the centre of the care planning, commissioning of places and that their views are listened to, even if they are not present at meetings with professionals.

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 seven SARs endorsed and previously endorsed SARs the SAB has agreed that its approach for the next two and a half years will be to focus at any one time on three key themes that have been identified from learning from Safeguarding Adult Reviews (SARs). The first three key themes from 2021 onwards have been agreed as:

- Self-Neglect
- Pressure Care Management
- Organisational Safeguarding

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 2021/2022

The SAB acknowledges that there are reoccurring themes from local and national learning from SARs that must be addressed. We will consider what the obstacles are in implementing recommendations and sustaining improvement and there will be a focus on good practice to promote learning, alongside an emphasis on good quality care principles and the role of effective support and supervision of the workforce to embed learning and inform future practice.

It is possible that changes to priorities will be made throughout the duration of this year in light of national and local learning in order to ensure that there is capacity within the partnership to deliver on the most pressing priorities for the West of Berkshire. Any change in priorities will be approved by the SAB.

Through its reflective learning practice the SAB have identified the following priorities, it is the expectation within each of the priorities that the following key frameworks/principles are considered: Mental Capacity, Making Safeguarding Personal, Professional Curiosity, Care Act, Equality Act. The SAB will also consider and make and implement recommendations regarding race, culture, ethnicity, local and national context and how this may impact on safeguarding.

- Priority 1: To consider SAB learning in regard to self-neglect; to understand what more we need to do to ensure that our ways of working with people who are self-neglecting are consistent and effective in mitigating and preventing risks.
- Priority 2: To consider SAB learning in regard to pressure care management and understand what the partnership need to do to ensure that our way of working with people at risk of pressure sores is consistently of best practice standard.
- Priority 3: To consider SAB learning in regard to organisational safeguarding and identify what the partnership need to do to transform our way of working with provider agencies to promote and ensure good quality, safe and consistent standards of care.
- Priority 4: The SAB will continue to carry out the following business as usual tasks in order to comply with its statutory obligations.

The Business Plan for 2021-24 is attached as **Appendix E.**

Appendices

Appendix A - SAB Member Organisations

Appendix B - SAB Structure

Appendix C - Achievements by partner agencies

Appendix D - Completed 2019-20 Business Plan

Appendix E - 2020-21 Business Plan

Appendix F - Partners' Safeguarding Performance Annual Reports:

- Berkshire Healthcare Foundation Trust

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