West of Berkshire Safeguarding Adults Partnership Board

Annual Report 2021-22

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 delighted to introduce this Annual Report for the West of Berkshire Safeguarding Adults Board 2021/2022. This has been my first year as the Independent Chair of this Board and it has been a pleasure to see the dedication and commitment of staff from across a range of sectors including the formal, informal, and voluntary sector, all committed to providing the very best health and social care possible.

This has not been an easy task; indeed, it has rather been a Herculean task. The impact of the Covid pandemic did not cease in 2021/ 2022. We saw a reduction in deaths and serious illness caused by the virus, but the legacy of the virus has left us with a health and social care sector stretched at times to the very limit (and occasionally beyond all normal limits). Staff have had to deal with high sickness rates and the emotional burden of caring for people through the pandemic, and this emotional and physical toll should not be underestimated.

Given this background I am delighted to be able to report that the Board continued to function well during this time and this report demonstrates the commitment and work output of its members in their responsibilities to ensure that adults receive safe and appropriate health and social services in its area. The Board has undertaken several safeguarding reviews and published their various learning points to help improve future practice. We have also held a strategy review day to help refine the priorities of the Board. One of our planned intentions is to review and pilot a rapid review process for safeguarding adult reviews. The aim here is to ensure that lessons learnt are reported in a timelier way, and in particular to prevent the process of a review dragging on for the relatives of a family member whose death is being reviewed. We hope to be able to report on the progress and implementation of this action next year.

There are other developments that we are engaging with such as reviewing our communications strategy and our engagement with service users and their carers. I trust you will have confidence in the actions and workings of the Board within your community that we seek to serve.

Finally, I would like to personally thank the Board staff and Board members, firstly for making me feel so welcome as your Chair, but more importantly for all your hard work and dedication in the area of Safeguarding Adults. It is an area that is rapidly growing and developing in terms of scope and scale, and you continue to respond with energy, wisdom and tenacity. It is a privilege to work alongside such dedicated people in our commitment to prevent and protect adults at risk of abuse and neglect.

Prof Keith Brown
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 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 9373747 or email at CSAAdvice.Signposting@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 an online form

For help out of normal working hours contact the Emergency Duty Team on 01344 351 999or email edt@bracknell-forest.gov.uk

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

Introduction

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 [1] and Thames Valley Police. Other organisations are represented on the SAB such as 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.

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,

[1] As of the 1st July 2022, BWCCG was legally dissolved and has been replaced by a new organisation: Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB)

- Mate crime,
- Modern slavery,
- Neglect and acts of omission,
- Organisational,
- Physical,
- Psychological,
- Restraint,
- Self-neglect,
- Sexual,
- Sexual Exploitation,

Changes to our membership

In 2021-22 we saw some significant changes in our membership, we said thankyou and goodbye to Patricia Pease (MBE) who has represented the Royal Berkshire NHS Foundation Trust so effectively for many years and we said thankyou and goodbye to Teresa Bell, who has been the SAB's independent chair for five years and welcomed Professor Keith Brown who takes on the role of independent chair from April 2022. We also welcomed Jane Barnett who joined as our Business Support Officer.

Message from Teresa Bell: "I *want to thank the partnership for being such a great group of people to work with over the last 5 years. I have learned and gained so much from working with you in this role and I believe that together we have achieved many good things in these most difficult times. Thank you for your support, commitment, and tenacity in making this large partnership work. I know that with Keith as your new Independent Chair, the Board will continue to progress well in its aims to achieve the best safeguarding outcomes for people in the West of Berkshire."*

About our new Independent Chair

Professor Keith Brown was the founding Director of the National Centre for Post Qualifying Social Work and Professional Practice, and he is an Emeritus Professor at Bournemouth University where the social work department was ranked number 1 in the UK in the 2020 Guardian League Table. He is the series editor for the Sage /Learning matters post qualifying social work series which has sales more than 150,000 in the past 10 years.

In 2005 Keith was awarded the Linda Ammon memorial prize sponsored by the Department for education and skills awarded to the individual making the greatest contribution to education and training in the UK. He was awarded a Chartered Trading Standard Institute [CTSI]' Institutional Hero' award in 2017 recognising the significance of his research into financial fraud and scams. He sits on the DHSC safeguarding advisory board, the joint DHSC and MOJ National Mental Capacity Leadership forum and the Home Office Joint Financial task force.

He has also recently published an All Party Parliamentary Report looking at financial fraud within families and he continues to lead research into this area.

Keith has written over 35 textbooks in the fields of social work and leadership and is particularly known for his contributions in the areas of Mental Capacity and Leadership.

Since his retirement from a full time academic post, he has been the Independent Chair of the NHS Safeguarding Adults National Network, the Independent Chair of the Worcestershire Safeguarding Adults Board and the Chair of Love Southampton a body that represents 3 food banks and 4 debt advice centres in Southampton.

His recent appointment as Independent Chair of the West of Berkshire Safeguarding Adults Board is something that he is passionate about. *"It's a simply wonderful opportunity to work with highly skilled professionals and community representatives in order to ensure that citizens in the West of Berkshire have every possible opportunity to live lives free from abuse and coercion."*

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 2021-22

We have spent a lot of time considering safeguarding adult concern numbers over the year.

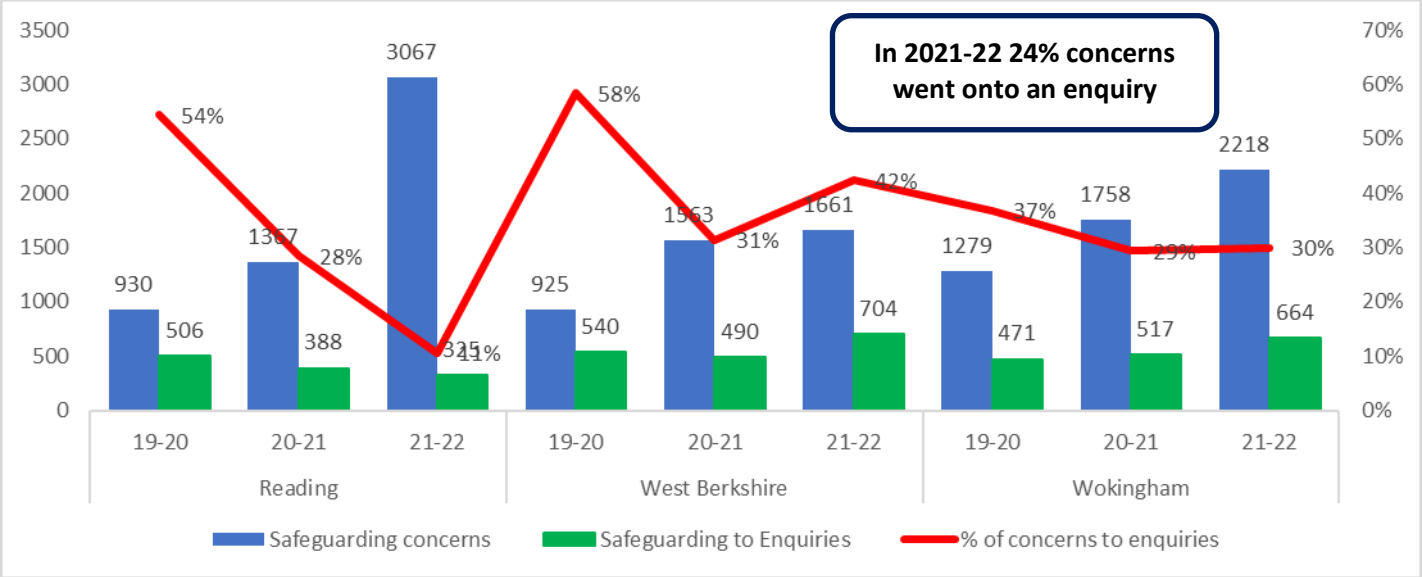
The chart below demonstrates, in 2021-22 the total number of safeguarding concerns for individuals started in period - per 100,000 population, has increased by 36% in the West of Berkshire, when comparing with 2020-21. This increases further to 77% when compared with 2019-20 figures.

It is important to note that this indicator will only count an individual once during the reporting period and therefore does not account for any multiple safeguarding concerns raised for individuals over the year, therefore the number of safeguarding concerns received is much higher than this outturn.

A total of 6955 safeguarding concerns were logged by the local authorities in 2021-22, a 48% increase when compared with 2020-21 and a 122% increase when compared with 2019-20.

Reading Borough Council and Wokingham Borough Council log all safeguarding concerns that are received as safeguarding concerns. In response to capacity issues, West Berkshire Council made the decision in this reporting year to make changes to the process of screening and recording safeguarding concerns raised by emergency service partners where the concern was clearly not related to a safeguarding matter. Those concerns were triaged in the normal way, but where they were clearly unrelated to any safeguarding matter they were not logged as a formal safeguarding concern reported under the statutory framework; the concerns, were forwarded to appropriate teams and services for action as a social welfare concern. It is acknowledged that this change in process will skew comparisons to the 2020/21 data and increase the percentage rate of conversion for West Berkshire Council.

The table below demonstrates the increase of safeguarding concerns, safeguarding enquiries and conversion rate between safeguarding concern and enquiry over the last three years by local authority.



Whilst it is evident that there has been a significant increase in the number of safeguarding concerns raised that do not meet the criteria for a safeguarding enquiry it is important to note that the number of safeguarding enquiries across the partnership started in 2021-22 has increased by 21% when compared with 2020-21. Whilst West Berkshire Council and Wokingham Borough Council saw an increase (44% and 28%) Reading Borough Council have seen a 16% decrease.

In 2021-22 there were a total of 1693 safeguarding enquiries started
335 by Reading Borough Council
704 by West Berkshire Council
664 by Wokingham Borough Council

The significant increase in out of scope safeguarding concerns has been identified as a risk on our Risk and Mitigation Log and there is an action on our Business Plan for 2022-23 to address this issue. Local authorities report that they are overwhelmed with screening the safeguarding concerns which is causing delays in responding to actual safeguarding concerns.

In December 2021 in response to the 21/22 Business Plan action: *'review safeguarding concern numbers with local authority comparator groups and report findings to SAB for consideration'* we considered a report looking at number of safeguarding concerns and the percentage that went onto enquiry over the last three years (18-19 ,19-20, 20-21), and compared outturns with the local authorities CIPFA[2] nearest neighbour comparator groups. It was identified that whilst there has been an increase in the number of safeguarding concerns there has been a decline in the percentage of safeguarding concerns that resulted in a safeguarding enquiry. This suggests that the increase in safeguarding concerns seen is mainly attributed to the changes in recording practices in each local authority and an increase in out of scope referrals.

[2] Chartered Institute of Public Finance and Accountancy

Data on safeguarding concerns is carefully considered by the performance and quality subgroup on a regular basis.

Trends across the area in 2021/22

- 56% of enquires were in relation to women, this is consistent with previous years.
- 63% of enquiries relate to people over 65 years in age, this is consistent with 2020/21.
- 84% of enquires were for individuals whose ethnicity is White, this is an increase from 2020/21 where it was 80%. The ethnicity of the remaining 16% of individuals is as follows: Not Known 7%, Asian 3%, Black 2%, Mixed 2%.
- In February 2022 the Performance and Quality Subgroup spent some focused time considering our ethnicity data. The subgroup was of the view that based on the demographics of the West of Berkshire the safeguarding concerns by ethnicity were within an acceptable range and will review this information on an annual basis.
- As in previous years neglect and acts of omission was the most frequent abuse type, equating to 33% of enquiries. This was followed by physical, psychological or emotional abuse and financial abuse. Domestic abuse, self-neglect and discriminatory abuse types have all seen a 20% increase when comparing with 2020/21.
- For the majority of enquiries (40%), the individual primary support reason was physical support. This was following by no support reason (26%), there is no change from 2020/21.
- 63% of enquiries completed were where the alleged abuse took place in the persons own home, this is a slight drop from 20/21 where it was at 69%. There has been a 77% increase in enquiries completed where the location of abuse was in hospital, equating to a total of 94 enquiries. Care Homes also saw and increase of 36%, equating to a total of 403, in 20/21 this had dropped due to the restrictions set in care homes during 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:

Risk	Consequence/Impact	Mitigation
The SAB does not know how individuals experience the safeguarding adults process. Adults with care and support needs and their carers have no involvement or engagement with the SAB.	Safeguarding adults procedures and practices are not informed by people's experiences. Lack of community understanding to inform the work of the SAB.	Voluntary Care and Healthwatch Subgroup, is in place where service user experience is considered in detail.
People who raise safeguarding concerns do not receive feedback	Impaired partnership working.	KPI in place to monitor percentage of referrers that receive feedback. Reading Borough Council are currently unable to supply this information. Assurance provided to the Performance and Quality Subgroup that plans are in place to address this.
There is inconsistent use of advocacy services to support adults through their safeguarding experience.	The voice of the service user is not heard. Service user's wishes and holistic wellbeing are not understood or prioritised	Advocacy performance is monitored on SAB dashboard. Advocacy services are members of the SAB.
Responsibilities under the Mental Capacity Act (MCA) 2005 are not fully understood or applied in practice as a safeguard for people who may lack capacity.	Significant harm to adults as risk.	Safeguarding Adult Reviews (SARs) and intelligence continue to evidence that the workforces responsibilities under the MCA is not fully understood. MCA continues to be embedded within SAB learning material.
There are capacity issues within the supervisory bodies to obtain timely DoLS[3] assessments and provide appropriate authorisation.	Risks that vulnerable people do not have the opportunity to live within the least restrictive regime possible for their condition.	Data is reported on SAB Dashboard. Performance around DoLs escalated to SAB in December 21. West Berkshire and Reading Borough Council confirmed backlog that will continue for some time due to capacity of DoLS assessors.

[3] Deprivation of Liberty Safeguards

Risk	Consequence/Impact	Mitigation
Governance arrangements to support people who have Mental Health issues are not fully understood	Significant harm to adults as risk.	Governance report presented to SAB on a six monthly basis to offer assurance on the governance arrangements.
Safeguarding People at risk of multiple exclusion, due to not meet safeguarding or care management pathways.	This is not a new issue but has been exacerbated as a result of the pandemic, as people have been brought to the attention of services that wouldn't have previously been before.	Launched Supporting Individuals to Manage Risk and Multi-Agency Risk Management Framework (MARM). In July 2020. Research paper presented to the SAB on the effectiveness of the MARM Task and Finish Group set up to review and relaunch the MARM, due to be completed in 22/23.
Lack of access to closed environments during the pandemic.	The SAB are not assured that individuals within closed environments are safeguarded due to restrictions of the pandemic.	Assurance sought during the pandemic via assurance questions and priority on organisational safeguarding has been agreed.
Increase of inappropriate safeguarding concerns.	Capacity in the local authority safeguarding teams will be impacted on capacity will be limited to address appropriate safeguarding concerns.	Discussed in detail at SAB meetings, action set in 2022/23 SAB Business Plan.
The increase on carers stress because of the pandemic.	Increased risks to carers and the individuals they are care for.	A paper was discussed at SAB where members were required to consider and implement appropriate changes within their organisations. Promoted the ADASS Advice note 'Carers and Safeguarding Adults' briefing.
Staff wellbeing as a result of the pandemic	Reduction in staff being able to identify and respond to safeguarding concerns.	Partners approaches to staff wellbeing during the pandemic was referred to in SAB assurance questions.

Risk	Consequence/Impact	Mitigation
The impact the pandemic has had on domestic abuse	People are more at risk of domestic abuse because 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 figures suggested that there had not been a significant increase in Domestic Abuse during the pandemic. However, the partnership continues to promote Domestic Abuse and ways in which to identify and support.
The SAB is not complying with its Quality Assurance Framework.	That the SAB do not have assurance in regard to the quality of safeguarding in its area.	In 2021/22 the SAB priorities focused on key learning topics from SARs and the quality assurance around those topics. In the 2022/23 Business Plan an action has been set for the performance and quality subgroup to review and relaunch the SAB Quality Assurance Framework.

Achievements through working together

Our priorities for **21/22** and outcomes to those priorities were:

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.

- A self- neglect appreciative inquiry was completed, and the findings report presented to the SAB.
- Training offers from the partnership on self-neglect was researched and findings report presented to the SAB.
- Key Performance Indicators on self-neglect were created and added to the SAB performance dashboard.
- Agreed the need for guidance on self-neglect for the voluntary sector was required.
- Research paper presented to the SAB on the effectiveness of the partnerships Supporting Individuals to Manage Risk and Multi-Agency Risk Management Framework (MARM). Task and Finish Group set up to review and relaunch the MARM, due to be completed in 22/23.

Priority 2: To consider SAB learning in regard to pressure care management and understand what the partnership needs to do to ensure that our way of working with people at risk of pressure sores is consistently of best practice standard.

- A presentation on a positive outcome on working with a complex case involving pressure care management, was delivered to the SAB. This is in the process of being turned into a video and practice learning note for the SAB website so the learning can be shared further.
- Key Performance Indicators on pressure care management were considered by the performance and quality subgroup, where it was determined that it would not be possible to collect meaningful data on pressure care management as it is not identified as a type of abuse and could cross over several abuse types.
- Work on a report focusing on how partners raise awareness in regard to pressure care began and was completed and presented to the SAB in June 2022.
- Identified that the issues the partnership are facing in regard to pressure care fall within the SABs self-neglect priority and its learning around professionals' approach to the MCA.
- A full review of the Pressure Ulcer Safeguarding Pathway was completed and relaunched.
- Agreed that the SAB should support national pressure awareness campaigns.

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.

- As the SAB Business Plan was designed as a 3 year business plan from 21-24, no progress was made on priority 3, the priority has been reworked for the business plan for 22/23.

Priority 4: The SAB will continue to carry out the following business as usual tasks in order to comply with its statutory obligations.

- A SAB briefing was published on a 3-monthly basis, copies of the briefings can be found here.
- A review of the SAB Dashboard was completed and continues to be considered in detail by the Performance and Quality Subgroup and presented to the SAB on a quarterly basis.

- Safeguarding concern numbers were reviewed with Local Authority comparator groups and the findings were presented to the SAB for consideration.
- Annual report for 20/21 was published.
- Followed the SAR process as per statutory requirements including publication of practice notes and development and management of SAR Action Plans.
- Delivered bitesize learning sessions on SARs published by the SAB.
- Continued to develop the SAB website.
- Created and published a safeguarding escalation plan for the partnership.
- Maintained Pan Berkshire Safeguarding Adults Policies and Procedures and hosted the meetings for 21/22.
- Ensured that the SAB costs remained within budget.

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 2021-22 is provided in Appendix D.

Further information on the achievements of partners is presented in the annual reports by partner agencies in **Appendix F** at the end of this report**.**

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 six SARs of which all were endorsed by the SAB and four 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. It is now standard practice to hold virtual bitesize learning events to promote the learning from SARs, in this year 2 sessions have been held with 231 delegates. The feedback from these sessions was extremely positive.

The SAB plans to publish the other two SARs 2022/23. Valuable learning has emerged from all SARs and has fed into the SABs priorities and Business Plan for 2022/23. The SAB continues to recognise the large workload for the SAR Panel and meetings continue to be held monthly.

The SAB continues to adapt its approach to SARs and a priority has been set for the SAB for 2022/23 to review its SAR process, in order to ensure that it is timely and good value for money.

The SAR Panel continually seek feedback its processes and offer opportunities for the workforce to observe SAR Panels to support their understanding of the process, feedback from observers has been positive.

SAR Process Feedback received: “I must admit I have been worrying about this as I have never been involved in one before but you have a really calming way and made it easier for me so thank you” this quote was used on a practice learning note to support professionals who may be involved in a SAR in the future.

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

Margaret

Published April 2021

Practice learning note

Margaret a lady in her nineties, lives alone in sheltered accommodation which she moved into after a serious fall. There has been a steady decline in Margaret's physical and cognitive abilities over the last few years. Margaret has two sons who visit around twice a week and support with her shopping. Prior to the incident described in this learning summary, Margaret was in receipt of three calls a day from a care agency and visited a day centre once week. This was commissioned by the Local Authority.

Margaret's first language is not English but she can speak it fluently. Over time communication started to become increasingly difficult between Margaret and professionals, as Margaret will often revert back to speaking her first language. In accordance with her wishes Margaret has no formal diagnosis to her cognitive impairment. Prior to the incident Margaret was known to all services as being a heavy smoker.

Health and Social Care professionals were aware that Margaret was a heavy smoker, and of her physical and cognitive decline, but missed opportunities to identify and respond to the risks that this posed to Margaret and others living in the accommodation block.

A carer visiting Margaret on a morning call reported to their office that Margaret had sustained burns to her arms, chest, hand and face and there was evidence of a fire in the property. Learning has been identified in regard to the professional response to Margaret's injuries, which contributed to there being delays in Margaret getting the medical attention that she required.

Lessons

It is not clear how or when Margaret received her injuries, as Margaret has been unable to communicate this. It is thought that these burns were due to smoking. This SAR concluded that the key learning for the partnership is around identifying and responding to fire risks.

- Agencies held information in relation to Margaret’s smoking. There is a need to ensure that all agencies are aware of the requirement to identify, and respond to potential fire risks, for individuals, and members of the public, and to escalate when appropriate.
- Improve working relationships between Housing Associations and Health and Social Care, in order to ensure that risks are identified and addressed appropriately.
- When multiple agencies are involved in supporting an adult at risk there should be a joined up and robust risk assessment to deliver a coherent multi-agency response.
- For all Health and Social Care agencies to access the training offered via the Royal Berkshire Fire and Rescue Service through its Adults at Risk Programme.
- An interpreter could have been considered to support Margaret with her communication difficulties.

Ken

Published July 2021

Full report
Practice learning note

Ken was a white British man in his late 70's, who lived with his wife Ava and they had two adult daughters. Ken had complex health needs and was terminally ill. Ken's wishes were to die at home or if this was not possible he asked to go to a hospice.

The majority of the last six months of Ken's life were spent in hospital, Ken sustained pressure damage, exacerbated by his refusal of appropriate equipment and care. Ken passed away in hospital.

A number of professionals across the partnership worked with Ken, however this work was conducted in a compartmentalised way. A multi-agency approach may have better supported Ken and his family in their decision making during this difficult time.

In response to Ken's death, the West of Berkshire Safeguarding Adults Partnership Board commissioned a thematic Safeguarding Adult Review (SAR) comparing and contrasting findings and recommendations with five other SARs published by the SAB, which also included learning around pressure care management.

Findings

- **Clear accountability and coordination** Support of people with complex needs requires care management that demonstrates clear professional accountability and active coordination. Ken and his family would have benefited significantly from the appointment of a named professional to coordinate all input and proactively review their care arrangements. Perhaps most importantly the person might have built a relationship with them to understand why Ken was increasingly making what were deemed unwise decisions detrimental to his health. The appropriate professional could have been a social worker but other key professionals could have performed this role.
- **Risk assessment and management** A comprehensive risk assessment should have been undertaken that took full account of Ken's home situation, state of mind, prognosis and physical condition. Although there appears to have been no formal diagnosis, Ken's daughter described her father as "depressed", which would be understandable in his circumstances. An indication of this was his change from a very well-presented man who was house proud, to someone who cared little about his personal appearance. This warranted further investigation, particularly as it potentially contributed to his refusal of services and was therefore a factor in his physical decline.
- **Effective multi-disciplinary / agency teamwork** A recurrent theme in all cases was the lack of coordination and timely communication between different professionals. Multi-disciplinary /agency meetings were the exception rather than the rule. The experience of Ken was not unusual in comparison with the other five SARs. Where MDT meetings did occur, those attending did not have all the relevant information necessary to underpin safe decision-making.
- **Pressure ulcer prevention and care** All individuals developed pressure ulcers whilst receiving health and / or social care services. The prevention and treatment of pressure ulcers continues to challenge agencies across the partnership. Timely reporting and intervention are essential but, sadly, often lacking in the SARS reviewed.
- **Consistent application of the MCA** Ken was assessed to have capacity to make decisions regarding his care, however recording on information supplied to Ken in order to make decisions regarding his care was lacking. Therefore, it could not be evidenced whether or not Ken was making informed decisions.
- **Appropriate involvement of family members** Ken's views and choices determined the care that he received in the period under review. However, there were opportunities to consider his wife's needs and views that were missed. Closer attention to her perspective potentially would have helped her in the role of Ken's carer but also perhaps shed some light on the risky decisions that he was making. These would have benefitted from further exploration.
- **Quality Assurance** In Ken's case the delivery of home care did not match the expectations of his care plan, there needed to be more scrutiny of its delivery and effectiveness.

John

Published November 2021

Practice learning note

John had a formal diagnosis of dementia. He used to live with his wife before his condition deteriorated and his needs could no longer be met in the home environment. John had a son and a daughter Rose. Rose was John's Lasting Power of Attorney (LPA) for health & welfare. John was not estranged from his wife and son.

John was placed into residential care by the Local Authority (LA) in spring 2017. John did not have the capacity to make this decision. Rose was not in agreement with his placement and a court application was filed by the LA, in early 2018, for a decision to be made in John's best interests, as to where he should live. In late 2018, a best interest's decision was reached by the Court.

The outcome was that John moved into a LA bungalow with Rose as his main carer with a condition for the court order to be reviewed within 1 year. John received 2 care calls a day, funded via direct payments (DP). This was until the provider withdrew as they could not meet John's needs and because there was a breakdown in the relationship between the care agency and Rose. There were concerns raised by the care agency regarding Rose and John's son-in-law's use of restraint, which the LA did not respond to appropriately.

In summer 2019, after a fall at home, John was admitted to hospital. When John was fit for discharge the hospital and Rose did not agree on the discharge plan. It was recommended by professionals that John move into a nursing home, but Rose disagreed and believed that John could come home with a package of care. An application for NHS Continuing Healthcare funding was made. Attempts were made to complete the application but due to John's change in medical condition this could not be completed.

During this period of disagreement, John became unfit for discharge and Rose made attempts to discharge John, against medical advice. John passed away in hospital.

Findings from the SAR

- John's voice was not heard in care and support planning. By treating Rose as his representative in the care and support process and relying on her for assurance about the success of the care plan, a potential conflict of interest was introduced.
- Agencies, apart from when John was in hospital, dealt exclusively with Rose who was his LPA and main carer. An
- Across the health and social care system there is a strong emphasis on working closely with families, respecting autonomy, and self-determination, and minimising the interference and footprint of the state in a person's private and family life. This emphasis on family involvement, representation and advocacy should not be achieved at the expense of professional curiosity.
- That there was a lack of understanding/confidence of professionals understanding of the legal rights of an LPA and the routes to challenge the LPA's actions and decision making if there were concerns about them acting in John's best interest.
- John's support plan did not contain adequate detail on how the allocated personal budget (PB) would be used to meet John's needs.
- The LA failed to set up John's DP correctly and therefore funds were not paid in advance of care being delivered. This led to Rose thinking she was not able to commission care on John's behalf due to lack of funds.
- The lack of expenditure of John's PB was not identified by the LA as an indicator that John may not be getting the support required to manage his complex needs.
- The underlying reasons for the withdrawal of care from the care agency were not explored, which may have identified that the current support plan was not meeting John's needs and therefore there was a requirement to go back to the Court of Protection (CoP).
- There are gaps in the understanding of accountability for recognising and responding to unmet need when a DP is in place.
- Organisations involved in CoP hearings should ensure that formal mechanisms are in place to review the effectiveness of interventions for which they are responsible.
- Allegations around unlawful restraint were not adequately responded to.
- Lack of consideration for 'was not brought'.
- There was a delay in making a DoLS application.
- Communication by professionals with Rose, in regard to John's Health and Social Care Needs was not always clear.

Steven

Published March 2022

Practice learning note

Steven was a 78-year-old male living with dementia. Steven resided in the community with his partner who was his main carer. Steven had a package of care consisting of two calls daily from spring 2017 until it was cancelled in March 2020 by Steven's partner due to the Covid-19 pandemic.

Steven was found passed away in a public area in early 2021, after being identified by his partner as missing in the early hours of the morning; the evening before his death, Steven left home in a confused state and was not dressed appropriately for the cold weather.

It appears that there was a known risk of Steven leaving the house in a confused and disorientated manner from 2017, but it is unclear whether this (and other) information was used across the system to enable effective risk management.

Learning

- **Risk Assessment, Risk Management and Information Sharing**

Professionals should be trained in risk management and there should be an appropriate risk assessment framework to include risk management. This includes seeking historical information from involved parties and being professionally curious. Information sharing between agencies regarding risk requires improvement to ensure that the right information is shared at the right time.

- **Reviews**

Annual reviews need to be dynamic and offer flexibility. If it is identified that a reassessment is needed, this should be completed dynamically and without further delay, regardless of the organisational structure, to ensure that a customer is not left with an unmet need.

- **Carers**

Carers need to be identified and offered a carers assessment in a timely manner to address any concerns, and also be offered regular reviews.

- **Technology Enabled Care / Assistive Technology**

Professionals would benefit from having an awareness of Technology Enabled Care (TEC), how it can support people like Steven and how to access it.

- **Mental Capacity**

Professionals would benefit from being alert to indicators that a mental capacity assessment may be required

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.

Each partner agency involved in the SAR is required to submit a Learning from SAR Quality Check to the Business Manager within of 3 months of the SAR endorsement to demonstrate how learning from the SAR has been embedded within their organisations.

The Learning and Development Subgroup are required to hold a bitesize learning event for all SARs endorsed by the SAB.

From the six SARs endorsed and previously endorsed SARs the SAB has agreed that its approach will be to focus at any one time on three key themes that have been identified from learning from Safeguarding Adult Reviews (SARs). The key themes from 2022 onwards have been agreed as:

- Self-Neglect
- Organisational Safeguarding
- Review of SAR process

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 2022/2022

The SAB acknowledges that there are reoccurring themes from local and national learning from SARs that must be addressed. As in 2021/22 we will continue to 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:

- **Priority 1:** To expand on learning in regard to self-neglect; to offer the partnership with resources to support them to achieve effective outcomes for individuals that self-neglect.
- **Priority 2:** To seek assurance that quality of health and social care services delivered in the West of Berkshire or those commissioned out of area for West of Berkshire residents is monitored effectively and there is a proportionate response to concerns.
- **Priority 3**: The SAB to review its Safeguarding Adult Review (SAR) process, in order to ensure that it is timely and good value for money.
- **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 2022-23 is attached as **Appendix E.**

Appendices

Appendix A - SAB Member Organisations

Appendix B - SAB Structure

Appendix C - Achievements by partner agencies

Appendix D - Completed 2021-22 Business Plan

Appendix E – 2022- 23 Business Plan

Appendix F - Partners' Safeguarding Performance Annual Reports:

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