.

Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board

Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board Annual Report 2017-18

"Safeguarding is Everyone's Business"

CONTENTS

1 Preface

1.1 This report covers the period 1st April 2017 to 31st March 2018 in accordance with the Care Act 2014. It will be submitted to the Royal Borough of Windsor and Maidenhead (RBWM) Managing Director, Bracknell Forest Council (BFC) Chief Executive, Leaders of each local authority, the Local Police and Crime Commissioner and the Chairs of the Health and Well Being Boards. It should also be presented to the Boards of the CCG and all partner agencies.

2 Introduction

2.1 The Care Act 2014 put safeguarding adults on a legal footing for the first time and required Safeguarding Adults Boards to be set up across local authority areas to encourage partner organisations to work together and ensure local arrangements effectively help and protect adults in the local area so that everyone can live safely, free from abuse and neglect.

2.2 The Care Act 2014 also required all agencies to promote individual wellbeing with a multi-agency approach to achieving positive outcomes for people who use services. The accompanying statutory guidance - Making Safeguarding Personal – required a change in day to day practice and organisational culture to allow the person who may be at risk to be put in charge of their own life. This requires agencies to listen to the person's voice about what they want and the outcomes that they are seeking from any safeguarding intervention.

2.3 The Care Act 2014 required each local authority to establish a Safeguarding Adults Board with core membership from the local authority, the Police and the local Clinical Commissioning Group. In July 2017 The Bracknell Forest Safeguarding Adult Board and the Windsor & Maidenhead Safeguarding Adult Board merged to form the Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board.

2.4 This is the first annual report of the Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board. It describes the implementation of the Board's 2017 / 18 strategic plan as well as future challenges. In line with the requirements set out in the Care Act the Board has continued to develop its strategic plan during the year.

3 Independent Chairs Report – Terry Rich

3.1 It has been a great pleasure to have led the work to create the new Safeguarding Adults Board covering both Bracknell Forest and the Royal Borough of Windsor & Maidenhead. Whilst both previous Boards had their strengths, the new merged Board has significant advantages. Some of those include:

- A greater sense of independence for the Board – it is no longer perceived as a body of a single local authority
- Increased range of partners involved and active in the Board and its work
- The inclusion of Public Health in the Board has been a very welcome addition
- Greater opportunities for shared learning – with a wider area covered and more partners at the table
- Local benchmarking of activity and performance across the two local authority areas
- Less duplication of effort – statutory partners no longer need to attend two Boards to cover the same business

3.2 Over our first year, the Board has been working on delivering priorities brought forward from the two previous Board Business plans. Our progress is set out later in this report. An important aspect of the work has been the establishment of the Quality Assurance Sub Group which will be key to supporting the work of the Board. Already it has been exploring the possible reasons behind the very different volume of safeguarding activity across the two local authority areas. It is also delivering on our plan for regular multi agency case audits.

3.3 One of the early findings of the Board has been a stark difference in the numbers of safeguarding concerns and enquiries received and managed within the two local authority areas of RBWM and Bracknell Forest. Later in this report there is some detail of some of the work undertaken to uncover the reasons behind the variation – differences to how initial referrals are categorised for example and the far larger number of care homes within Windsor and Maidenhead compared to Bracknell Forest. However, there is still more to be done to get to the bottom of the issue. Whilst to date there is no indication that people are any more safeguarded in either authority – the very substantial difference in recorded activity could have implications for how effectively resources are being used, for example, and whether current systems for triaging and prioritising input are as effective as they might be.

3.4 The Board has managed a number of SARs over the last year. These are detailed later in the report. One SAR concerned the care given to a person with learning disabilities at the end of his life. It raised important questions about the awareness of professionals within the learning disability field of issues relating to diseases of later life and of end of life care. It has prompted the Board to arrange its first annual Safeguarding Conference and for the conference to focus on that issue. An impressive line-up of experts in the field will be attending and I hope that it will help us all to develop a better understanding

of the most appropriate models of care to keep people with learning disabilities safeguarded throughout their lives and particularly towards later and end of life.

3.5 The purpose of the Safeguarding Adults Board is to ensure that partners are working effectively together to safeguard adults with care needs. So as Independent Chair it is only proper to expect a view of whether the evidence points to those arrangements being effective in the area covered by the Board. It is clearly beyond the ability of a Chair or a Board to be able to assert that systems are such that everyone is safeguarded from harm or abuse. However, it is clear from the work of the Board and of the information provided to it, that statutory partners are effectively working together to minimise the risk of harm and where concerns arise, to make appropriate enquiries and ensure that safeguarding plans are in place to mitigate risks.

3.6 Concerns remain as to whether the discrepancies in activity across the area are significant and there is important learning to be taken and implemented from the SARs undertaken during the year to ensure that systems are improved and become even more robust. Examples of this include the importance of ensuring that awareness of fire safety is embedded within all professional practice, and that those who self-fund their care or receive direct payments are equally protected as those receiving council funded care.

3.7 I am retiring from my role of Independent Chair at the end of September 2018. Having spent 4 and a half years chair the SAB in Windsor and Maidenhead and latterly the joint board, I have seen a growth in participation and engagement of partners and a real commitment to ensuring that safeguarding is everybody's business.

3.8 For the future, I believe that it will be important that partners continue to engage in a spirit of openness and transparency – able to challenge and willing to be challenged, ready to learn and to share learning, keen to engage with those who rely on care services, and critically recognising that in today's world, the vast majority of social care and an increasing amount of health care is delivered on behalf of the traditional public sector organisations by private and independent sector organisations. The challenge will continue to be how safeguarding arrangements, including the Board, become more open and inclusive of those agencies. It will become increasingly less relevant for Safeguarding Boards to be dominated by the traditional public sector partners, and increasingly important to ensure that providers – of healthcare, of care for older adults, for providers of supported living services for people with mental health needs or learning disabilities are all brought to the table.

Terry Rich

Independent Chair, Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board

4. Safeguarding Adults Boards Governance and Accountability

4.1 The main objective of the Board is to assure itself that local safeguarding arrangements, and partners, act to help and protect adults in the area who meet the criteria set out in the Act. That is, they:

- have needs for care and support and
- are experiencing, or at risk of, abuse or neglect and
- as a result of those care and support needs are unable to protect themselves from risk of, or experience of, abuse

4.2 The SAB has a role in overseeing and leading adult safeguarding across the locality. It has a role too as a source of advice and assistance. This includes a focus on:

- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- seeking assurance that agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

4.3 The SAB has a strategic role and is comprised of three core duties:

- publishing a strategic plan for each financial year setting out how it will meet its main objective
- publishing an annual report detailing the activities of the SAB
- deciding when a safeguarding adult review (SAR) is necessary, arranging for its conduct and if it so decides, implementing the findings.

4.4 The Board has responsibility for safeguarding partnership working across other key agencies; this oversight ensures it applies effective processes and procedures to protect those adults most at risk and offers appropriate support. It also ensures that those agencies practise to a high standard and can evidence their performance.

5. Local Context

5.1 Demographics

5.1.2 Demographics provide a focus for the board; nationally between 500,000 and 800,000 older people are subject to abuse and/or neglect in the UK each year and this number is set to rise by 1.6 million by 2050. The number of people aged 18 and over in Windsor and Maidenhead is 114,639 compared to 91,273 in Bracknell Forest. The number of people aged 65 and over in Windsor and Maidenhead and in Bracknell Forest is projected to rise from the current populations of 27,293 and 16,669 respectively (ONS Mid-Year 2011 estimates). This, together with increasing numbers of people with disabilities reaching adulthood, places additional demands on adult services.

5.1.3 There are a significantly larger number of care homes in Windsor and Maidenhead compared to Bracknell Forest. There are 1339 care home places available in the 38 care homes in Windsor and Maidenhead compared to 439 in the 15 Bracknell Forest Care Homes.

5.2 Local Arrangements

5.2.1 At the end of 2016/17 a decision was taken to merge the Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Boards into a single Bracknell Forest and Windsor & Maidenhead SAB. Whilst this decision was one for the local authorities in consultation with their statutory partners, the matter was discussed in detail by each individual Board and subject to ensuring that a local focus is not lost, both Boards were supportive of the move.

5.2.2 The new Board has grown following the merger which was effective from 1 July 2017. The Board comprises senior leads from statutory and non-statutory partners and is supported by both local, East-Berkshire-wide and pan-Berkshire-wide sub groups. Details of member attendance at the Board are given in Appendix 1.

5.2.3 All partner organisations in Bracknell Forest and Windsor & Maidenhead are expected to prioritise safeguarding with an approach based on promoting dignity, rights, respect, helping all people to feel safe and making sure safeguarding is everyone's business. The Board leads adult safeguarding arrangements across its locality.

5.2.4 The Board develops and actively promotes a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'. The Board has an independent chair and meets on a quarterly basis. The attendance record for the Board is set out in Annex B. The Board's member organisations are currently:-

Royal Borough of Windsor and Maidenhead	Berkshire Care Association
Bracknell Forest Council	Frimley Health NHS Foundation Trust
Optalis	Royal Berkshire Fire and Rescue Service
Thames Valley Police Local Policing Areas	Involve
Thames Valley Police Protecting Vulnerable People	Alzheimer's Dementia Support
Public Health	Healthwatch
East Berkshire Clinical Commissioning Group	Care Quality Commission
Berkshire Healthcare NHS Foundation Trust	Radian Housing
West London Mental Health Trust	Bracknell Forest Homes
National Probation Service	Housing Solutions

5.2.5 The SAB met three times in the year providing oversight and direction to strategic and operational safeguarding activity across Bracknell Forest and Windsor & Maidenhead. A business planning session was held in September 2017 which was an important

opportunity to agree the new 2 year strategic business plan for the newly formed Board and setting out the priorities for the year to come.

5.3 **Finance & Resources**

5.3.1 As there is no national formula for SAB funding; levels of contribution are agreed locally. RBWM and Bracknell Forest Council, as the local authorities, currently contribute just under 66% of the Board's direct funding. In addition, Bracknell Forest Council hosts the Safeguarding Board's business unit. The CCG and Thames Valley Police are the only other partners who currently contribute to the Board. Income and expenditure for 2017/18 are shown in Appendix 2.

5.3.2 Whilst it is possible for SABs to budget for planned activities, Safeguarding Adults Reviews (SARs) or other learning reviews present unpredictable financial pressures. The SAB currently has no contingency to cover these unplanned eventualities

6 Progress on Priority Areas in Strategic Business Plan

6.1. The progress of actions in the strategic business plan, agreed at the Board development day and ratified at the Board's October meeting, have been monitored throughout the remainder of 2017/18.

6.2 Over the past year the Safeguarding Adult Board has:

- Implemented a communications strategy
- Implemented an escalation policy
- Piloted the risk framework
- Developed a newsletter
- Developed and implemented a new Board website
- Developed the structure of sub groups
- Implemented a quality assurance framework
- Developed and implemented a new safeguarding adult review protocol
- Implemented two new safeguarding reviews and concluded a third

6.3 The strategic business plan, demonstrating progress of all actions, is included in Appendix 3

7 Work of Sub Groups

7.1 Quality Assurance Sub Group

7.1.1 The Quality Assurance Sub Group has met on a quarterly basis and has developed and implemented a quality assurance framework to drive its work. This work has included:

- Monitoring performance data - bringing together quantitative multi-agency data on: trends in the nature and reporting of abuse; multi- agency responses; and outcomes for adults at risk.
- Monitoring qualitative information - collating views/ feedback from customers, carers, families, and staff to establish that safeguarding arrangements are working, delivering the outcomes people want and making a difference.
- Carrying out a desk top review of the Board's work - looking at how well the Board fulfils its statutory duties to understand if partners are working effectively together to keep people safe.
- Implementing a partners' self-assessment audit - evaluating the quality of individual agency safeguarding arrangements and developing action plans to improve how agencies keep people safe.
- Implementing local audits – evaluating the quality of concerns and enquiries recorded

7.1.2 The Sub Group identifies areas for further analysis and improvement and makes recommendations as to how these improvements can be achieved. The Quality Assurance Sub Group has reported its work to the Board on a quarterly basis.

7.2 The East Berkshire Learning and Development Sub Group

7.2.1 The Learning and Development Sub Group's membership is drawn from members of the Slough and the Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Boards. The group has been focussing on delivering a learning event to disseminate the learning resulting from a recent safeguarding adult review. The event took place in the Autumn of 2017/8 and has provided a model for future learning events.

7.2.2 The East Berkshire learning and development group will focus on developing and implementing a multi-agency training needs analysis with the further aim of developing in future years a multi-agency training programme, along with a training evaluation system to measure the impact of training provided.

7.3 The Pan Berkshire Policy and Procedures Sub Group

7.3.1 The policy and procedures sub group's membership is drawn from members of the three safeguarding adult boards in Berkshire. It has a stated purpose of:

- Ensuring that policy commissioned by the Boards across Berkshire is developed and reviewed on a regular basis (twice yearly);
- Ensuring that procedures are developed to ensure that safeguarding adults' activity in Berkshire is robustly and effectively co-ordinated between and within each agency;
- Ensuring that all policy and procedures promote confidentiality, dignity and effective access to safeguarding for all communities across Berkshire and promote Making Safeguarding Personal in line with legal requirements.

7.3.2 A new pan Berkshire policy and procedures website was developed during 2017 to host a further revised version of the pan Berkshire policy and procedures. The website was launched in November 2017 and the policy and procedures will continue to be reviewed and updated bi-annually.

7.4 The Safeguarding Adult Review (SAR) Sub Group

7.4.1 The SAR Sub Group has co-ordinated the completion of two Safeguarding Adult Reviews during 2017/8. The Board has a duty under the Care Act to report on completed Safeguarding Adult Reviews within its Annual Report and the summary of these two completed reviews are contained within Section 11.

7.4.2 The SAR Sub Group has initiated a further Safeguarding Adult Review during 2018/19. The outcomes of this review will be reported in a future annual report.

7.5 Performance Working Party

A performance working party was created to develop the performance information required for the new Board. The working party has overseen the audits of the different numbers of concern and enquiries recorded in each local authority area. Moving forward the working group will concentrate on developing a multi-agency safeguarding performance information for the Board.

7.6 Risk Framework Task and Finish Group

The Group was created to implement a new risk framework to support those who do not engage with safeguarding process and also those who do not meet safeguarding thresholds. Following a series of pilots, an implementation programme and guidance has been developed for implementation of the framework throughout the Board area.

7.7 Conference working Group

A working group was created to organise a conference to disseminate learning from a local safeguarding adult review. The conference entitled 'Ageing Well with Learning Disability' is scheduled to take place on 18 October 2018.

8 Contribution of Partners

8.1 Partner organisations have continued to work together as a Board and partners' contributions have been focussed on implementing the new arrangements for the new Board. Partner contributions have included the following:

Taking part in task and finish and working groups to develop the Board's work

8.2 Partner organisation representatives have contributed to the work of all sub groups, working groups and task and finish groups. Representatives have also contributed to two development days.

Taking part in a board development questionnaire

8.3 Partners provided valuable feedback to a number of questions aimed to determine development areas for the Board as a whole. Common areas for improvement identified which were considered in the end of year development review session included:

- Improving the use of data to identify risks trends
- Strengthening links with other Strategic Partnerships

Taking part in a partner self-assessment to provide assurance that safeguarding arrangements are in place in partner organisations and to facilitate improvement planning in each organisation

8.4 During 2017/18 the self-assessment was carried out by the larger public sector partner organisations with the aim of providing assurance regarding safeguarding arrangements and identifying areas for improvement. However a more concise voluntary sector questionnaire was developed for trialling during 2018/19. A provider self-assessment will also be developed during 2018/19. Common areas for development highlighted in the self-assessments which were considered in the end of year development review session included

- Training / Assessing Competency; learning from SARs
- Embedding and recording Making Safeguarding Personal
- Capturing the voice of the adult at risk /user and community involvement
- Making information available to the public
- Auditing
- Recording
- Safeguarding arrangements for commissioning / commissioned services
- PREVENT

9 Case Studies - Examples of how partners are working together to implement the Board's strategy and Keeping People Safe through a personalised approach

The overall approach to safeguarding adults within Bracknell Forest and Windsor & Maidenhead aims to promote independence, wellbeing, social inclusion and maximise choice in service provision and safeguarding support. The following case studies demonstrate Board members approaches to keeping people safe and the commitment to "making safeguarding personal", and demonstrate partners' contributions to the Boards strategic direction through application of the multi-agency safeguarding policy and procedures and the Boards new multi-agency risk framework.

Case Study 1 – Mr and Mrs X

Mr and Mrs X are a married couple in their mid-seventies. Mrs X has the early on-set of dementia and during an argument Mr X struck Mrs X which resulted in her attending hospital. The hospital contacted the Police and Adult Social Care to inform them of safeguarding concerns for Mrs X. A practitioner from the Community Mental Health Team for Older Adults (CMHTOA) contacted Mrs X to offer support through the Safeguarding process and Mrs X agreed that this was what she wanted to happen.

Mrs X said she did not wish to return to her home and initially went to stay at her daughter's house; however this could only be a short term arrangement due to her daughter's family situation so Mrs X went to an alternative respite placement arranged by CMHTOA. Mrs X agreed to the support of an independent advocate throughout the Safeguarding enquiry and this was arranged by CMHTOA.

The advocate attended Safeguarding Meetings with Mrs X; Thames Valley Police were also there to provide updates and information on the criminal process following the assault that took place from Mr X. Berkshire Woman's Aid provided support and attended the safeguarding meetings; they advised Mrs X specifically on the domestic abuse support they would be able to offer her both at the time and beyond the Safeguarding enquiry process. Mrs X's Care Manager from CMHTOA attended the Meetings and informed her about the Adult Social Care options available to her and the options for her current accommodation situation.

At the safeguarding meeting Mrs X said she was pleased to have so much support available to her within the one place. She liked the assistance of the advocate and felt she was being supported to make the decisions she wanted too. Mrs X decided she would pursue the criminal charges outside of the safeguarding meeting so this was arranged between herself, the advocate and the police as a separate action. Mrs X said that the meeting enabled her to discuss all her options openly and without judgement from anyone; she said that her family had very clear opinions on what they felt she should do for the best but the Safeguarding process enabled her to come to the decision she wanted, away from these outside influences.

Case Study 2 – Case of "A"

A safeguarding referral was made to Optalis by the police. They had seen a rise in calls from a neighbour about 'A' concerning the alleged theft of a cat. Police had visited the address on numerous occasions to retrieve the cat and to return it to its rightful owner. On one occasion, the police called to arrest 'A' for the theft of the cat. However, 'A' was de-arrested at the scene, when the cat was found sunning itself freely in the garden.

Whilst in the garden the police noticed the dilapidation of the exterior of the property and the unkempt and unclean condition of 'A'. They did not enter the house but could see inside the front door that the house was very dark and there looked to be evidence of hoarding, as there was only a narrow walkway visible inside the door. 'A' was unclean and her clothing was dirty.

Due to repeated complaints from neighbours about rat infestation and the dilapidation of the property, Environmental Health had been called to the address, but were unable to access the property as 'A' would not let them inside. They could see that a lean-to to the rear of the property had collapsed and there was a slight bow in the roof. It was noted 'A' leaves bowls of food outside for the rats and other creatures to feed on.

Two staff from the Physical Disability and Older Persons Team (PDOPT) visited the address in response to the safeguarding referral. As the gate to the address was chained and padlocked, they could not gain entry to the garden, or knock on the door. Whilst present at the address, 'A' returned to the property and questioned the presence of the social workers. 'A' would not let them inside the gate. The social workers noted the dirty and unkempt appearance of 'A'. They were unable to fully assess her capacity as she answered a number of their questions cogently and told them she required no support from Social Services and to leave.

The police called a multi-agency meeting. In attendance were four staff from Adult Social Care, two police officers and a community support officer, Environmental Health, a senior Royal Berkshire Fire and Rescue officer and senior officer from the RSPCA. The multi-agency risk assessment was used to ascertain the risks and to allocate further follow-up tasks to professional colleagues.

At the Chaotic Lifestyles meeting chaired by TVP, further information was shared. The GP had provided health information to the Local Authority. 'A' had written to the surgery requesting she was removed from their list of patients. She had not attended the surgery for five years and had declined all routine medical checks and vaccinations.

The RSPCA had visited the property every day for a fortnight to try to catch the cat. 'A' would not allow traps to be set on her property. They did not pursue further action having spoken to the owner of the cat and confirming the cat is not confined at 'A's home and is free to come and go at will.

A further visit was made by Social Services. The interview took place over the padlocked gate. 'A' declined all services from the Local Authority. There was no evidence from the conversation 'A' lacked capacity. She looked and said she was well, although she was still unclean and was wearing the same clothes she had on 6 weeks previously. 'A' said she

had sold her property to the farmer at the end of the lane and would be moving elsewhere in September. This information was later confirmed in a letter provided to Environmental Health.

'A's daughter had been contacted by Social Services. The daughter said she was concerned by the decline in her mother. She said she last visited at Christmas, but had not been inside the house for 15 years. There had been a family break up some years earlier and the daughter had very little contact with her mother over the years. She confirmed that 'A' had always appeared to have long-standing mental health issues, but had declined all medical intervention and had no formal diagnosis of mental illness.

Adult Social Care kept the care management case open, in order to try to build a rapport with 'A'. The safeguarding enquiry was closed as it was deemed to be a care management issue.

Environmental Health continued to monitor the situation and to try to build a rapport with 'A'. They had no powers to intervene or to enter the property without the owner's consent.

The Fire Service offered fire safety advice in the form of leaflets, but could not enter and inspect the property without the consent of 'A'.

The Community Support Officer continued to make occasional visits to the address as they had built a rapport with 'A'.

At the Chaotic Lifestyles meeting, Thames Valley Police confirmed there had been no more calls to the address since the RSPCA intervened. 'A's case would continue to be reviewed at Chaotic Lifestyles Panel meetings.

The risk assessment framework was used in this case because:

- Agencies worked together to ensure all essential actions are carried out in a timely way.
- Agencies could demonstrate a 'joined-up' approach to managing the risk.
- It promoted engagement with the family and friends of the person at risk. They ensured the persons views are taken into account.
- Actions and progress were carried out at the persons pace.
- The risk assessment framework clarified the reasons behind decisions taken.
- Regular review of the risk assessment kept it current and provided timely intervention.
- It provided a multi-agency response to high levels of risk

10 Performance Information

Number of Safeguarding Concerns

	Bracknell Forest	Windsor & Maidenhead	South East	England
Concerns	**369**	**922**	**53,490**	**364,605**
Concerns per 100,000 population	**404**	**804**	**754**	**839**
Concerns progressing to enquiry	**76**	**370**	**24616**	**151160**
% of concerns progressing to enquiry	**21%**	**40%**	**46%**	**41%**

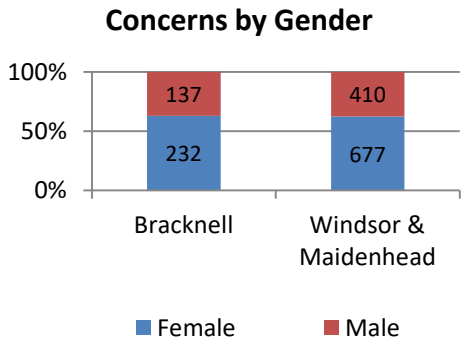
10.1 There was an increase in the number of concerns recorded in Bracknell Forest compared to the previous year (2016/17 – 293) whilst in Windsor and Maidenhead there was a decrease in the number of concerns recorded compared to the previous year (2016/17 - 293). The number of concerns recorded in Windsor and Maidenhead is similar to those recorded for the South East and England (2016-17 data) as a whole, whereas the number of concerns recorded in Bracknell Forest is much lower. An investigation has revealed that the difference in the number of concerns recorded is primarily due to the method of recording and that all concerns are analysed on receipt before being recorded, with a proportion being dealt with separately through case management or signposting to other services. In Windsor and Maidenhead there is no initial analysis and all concerns received are recorded as such, although they may be referred to case management or signposted at a later date. The investigation concluded that processes in each local authority are safe with all concerns being dealt with appropriately.

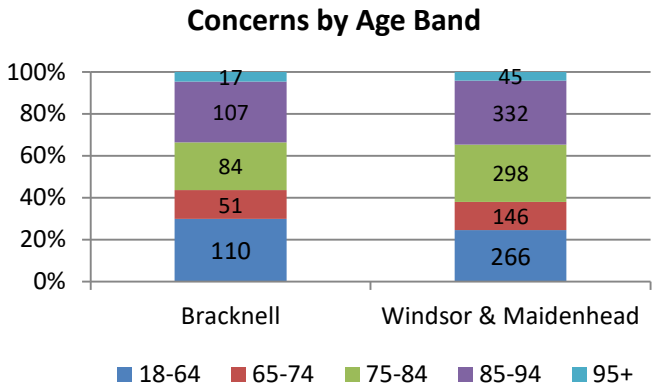
Number of Section 42 Safeguarding Enquiries Completed

	Bracknell Forest	Windsor & Maidenhead	South East	England
Number of enquiries ended	**58**	**448**	**21965**	**127625**
Number of enquiries ended per 100,000 population	**64**	**391**	**310**	**294**

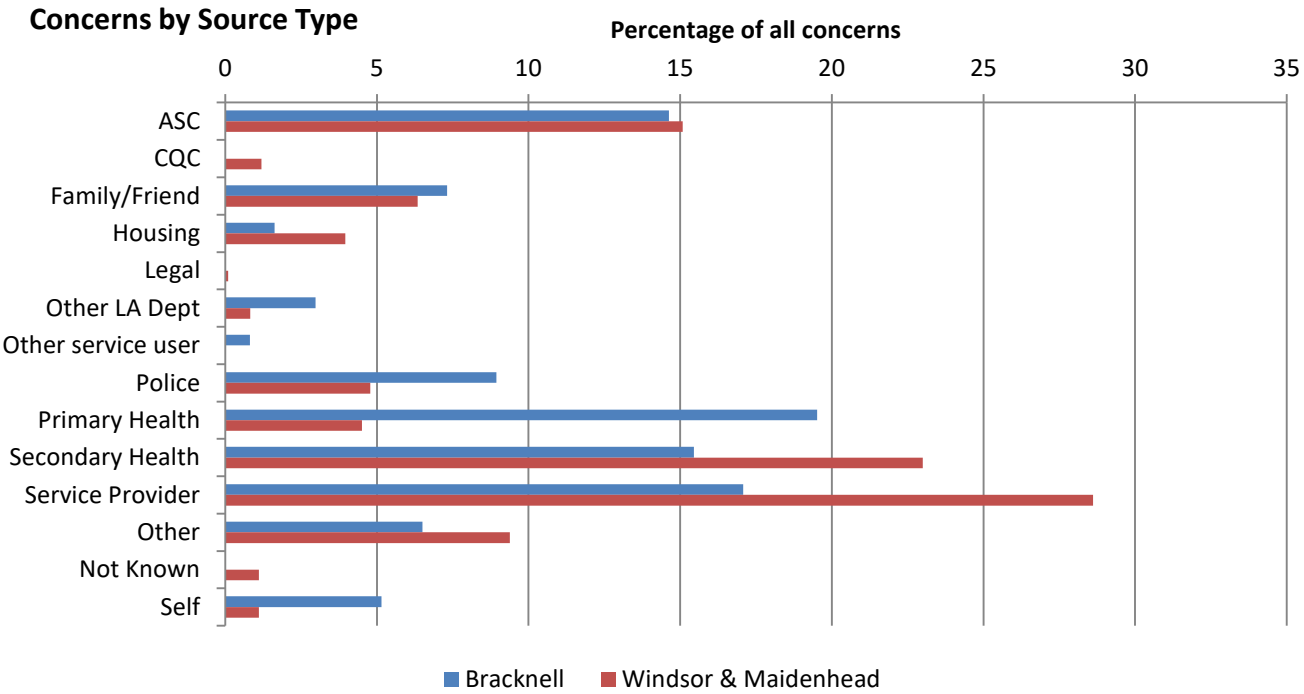
10.2 There was a slight drop in the number of enquiries ended in Bracknell Forest during 2017/18 compared to the previous year (2016/17 – 93) but the number is much lower than the number of enquiries completed in Windsor and Maidenhead. The number of enquiries completed in Windsor and Maidenhead has decreased when compared to the previous year (2016/17 – 510). An investigation into the difference in numbers recorded is on-going, although the fact that in Bracknell Forest concerns are analysed before passing to the enquiry stage, and therefore dealt with via another route, is believed to contribute to the difference. The initial findings do in fact indicate that it is the difference

in the process employed that has led to the variation in numbers of enquiries taking place, and the processes employed in each area are keeping people safe in both Bracknell Forest and Windsor and Maidenhead.

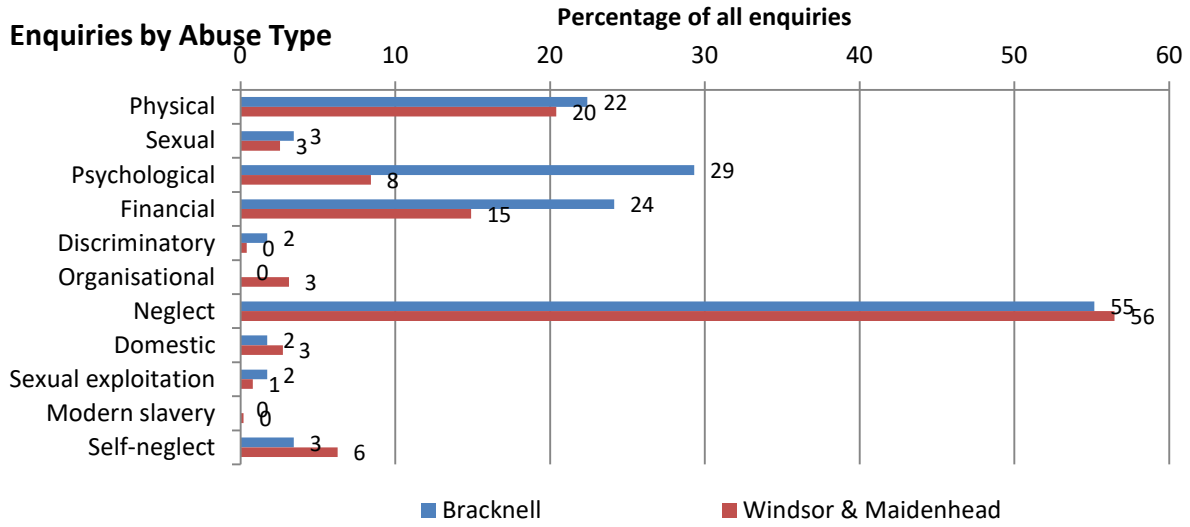




10.3 The percentage of concerns recorded by gender and age reveals broad similarities in Bracknell Forest and Windsor & Maidenhead although the numbers in each case are greater in the Royal Borough.

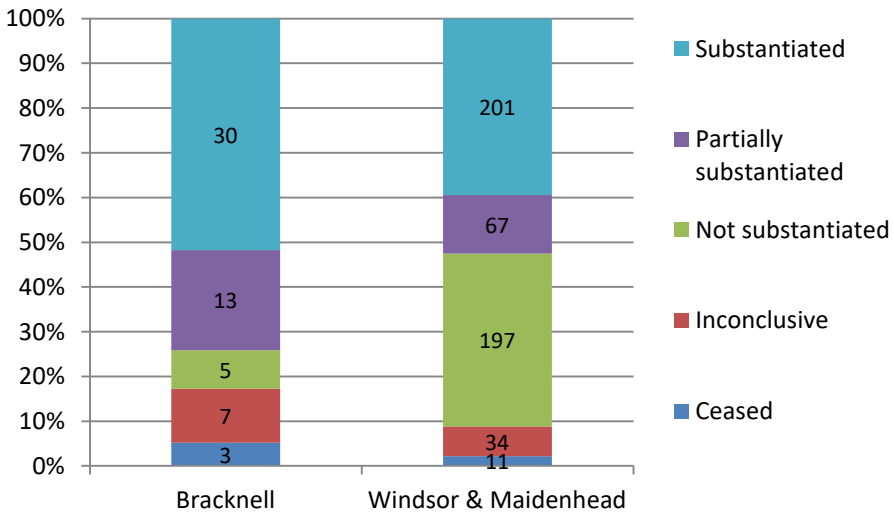


10.4 The analysis of the source of concerns received in Bracknell Forest and Windsor and Maidenhead reveals that a higher percentage of concerns are received from providers in Windsor and Maidenhead which reflects the higher number of care home places in the Royal Borough.



10.5 The percentage of enquiries by abuse type reveals that as in the previous year the greatest percentage of enquiries are due to neglect; the rate of neglect is in line with the national trend. However, the definition of neglect includes acts of omission and previous audits have revealed that act of omission can contribute to 30% of the total number of enquiries which are due to neglect. It should also be noted that the prevalence of abuse types is broadly similar between the two authorities and broadly similar to previous year's recoded data. In 2016/7 the main types of abuse identified during safeguarding enquiries were Neglect, psychological abuse and financial abuse whilst in Windsor and Maidenhead in 2016/7 the main types of abuse were neglect, physical abuse and psychological abuse.

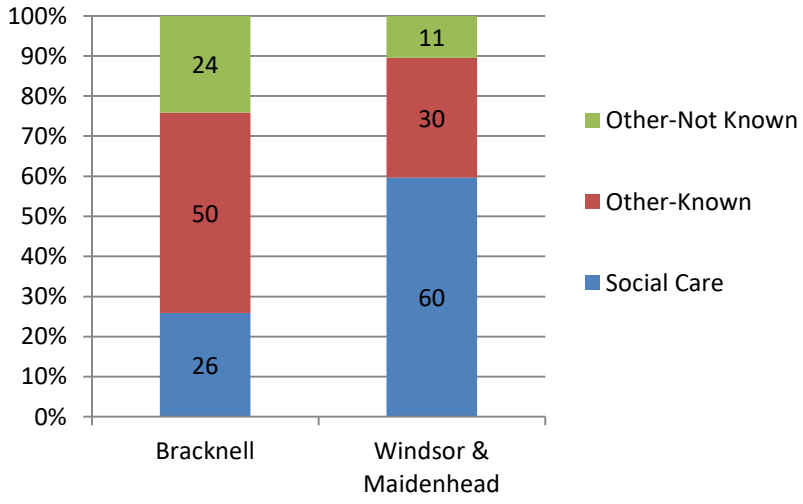
Enquiries by Conclusion



10.6 Analysis of the enquiries by conclusion reveals that a high number of enquiries are not substantiated in Windsor and Maidenhead and this may be related to the fact that concerns are not filtered when first received as is done in Bracknell Forest. Potential concerns are analysed and dealt with by case management or signposting to other services in Bracknell Forest, whereas all concerns received in Windsor and Maidenhead are recorded and passed to be dealt with as potential enquiries. The data suggests that unsubstantiated enquiries recorded in Windsor and Maidenhead may have been filtered out at an earlier stage in Bracknell Forest. This provides some explanation for the lower

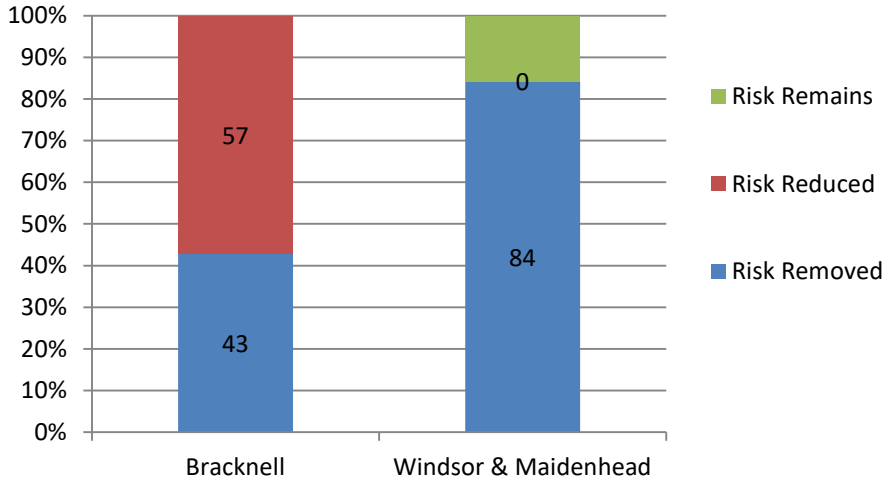
number of concerns and enquiries recorded in Bracknell Forest compared to Windsor and Maidenhead. The trends are similar to those reported for each area in 2016/7.

Enquiries by Alleged Perpetrator



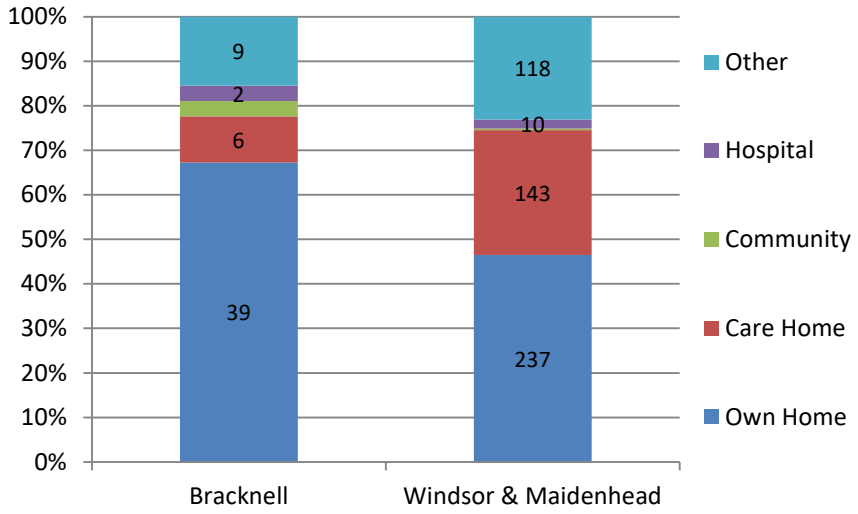
10.7 The higher percentage of enquiries where the alleged perpetrator was from the social care sector is consistent with the fact that there are a larger number of care home places in Windsor and Maidenhead and a larger number of concerns received from providers. The trends are similar to those reported for each area in 2016/7.

Enquiries by Risk Outcomes



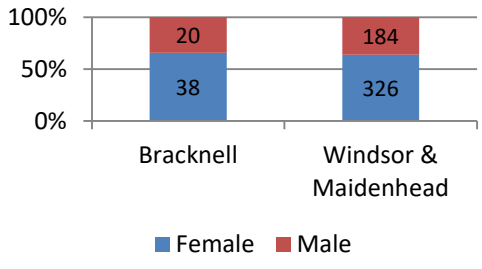
10.8 In most cases the risk to an adult at risk is either reduced or removed. In the very small number of cases where risk remains this is due to the decision of the adult at risk to accept the risk, although these cases would be monitored on an on-going basis. The trends are similar to those reported for each area in 2016/7.

Enquiries by Location

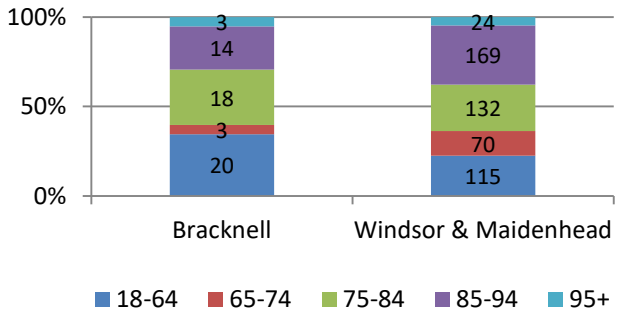


10.9 A higher percentage, and number, of enquiries relate to incidents in care homes in Windsor and Maidenhead which coincides with the higher number of care home beds available. The trends are similar to those reported for each area in 2016/7.

Enquiries by Gender



Enquiries by Age Band



10.10 The percentage of enquiries by gender and age band are similar in both Windsor and Maidenhead and Bracknell Forest with slightly higher percentages of over 65 in Windsor and Maidenhead which reflects the general demographics of the local areas

11 Safeguarding Adult Reviews

11.1 Safeguarding Adults Boards are required under Section 44 of the Care Act 2014 to arrange a Safeguarding Adults Review (SAR) when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have worked more effectively to protect them. A SAR is also intended to ensure that lessons are learned and the Board is required to publish the outcomes in its Annual Report.

11.2 The Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board completed two Safeguarding Adult Reviews during 2017/18 – see below.

11.3 A further SAR (CD) is under way which will be reported in the 2018/19 Annual Report. The review focusses on the effectiveness of the multi-agency working of the local care

governance framework and how service users, their families and other professionals involved contribute towards monitoring standards of care following a death in a local care home. As previously reported there is another completed but unpublished SAR for which an action plan is being implemented. No further information is available at this stage due to an ongoing criminal investigation

EF Safeguarding Adult Review

11.4 Mr EF was 71 years old when he died in July 2016. He had complex health and care needs including a severe learning disability, severe challenging behaviour and autism. He was able to make simple everyday decisions but had been assessed as lacking mental capacity for decisions on more significant matters. Although Mr EF's needs appeared to have been well met throughout most of his life, concerns were raised about the way in which services were provided to him and whether organisations could have worked together more effectively towards the end of his life. Bracknell Forest Safeguarding Adults Partnership Board initiated the review with a final report presented to the joint Board in December 2017.

11.5 The report found the needs, wishes and feelings of Mr EF were not taken into account fully in decisions about his care. Nor were end of life decisions made with appropriate people, for example, his support workers in absence of family. It suggests an advocate would have ensured his wishes were included in the decisions being made about him.

11.6 It also found that as Mr. EF's health was declining, assessments did not reflect this or identify that the end of Mr. EF's life was approaching. This was not shared across organisations to provide a coordinated view and enable appropriate care planning. As greater numbers of people with learning disabilities and co-morbidities live longer in community settings the Board acknowledged that it is increasingly important for approaching end of life to be recognised and has organised an event later in 2018 to share learning around this subject and share the learning from this review.

11.7 As a result of the review, an Adult at Risk Pathway for LD has been developed and implemented ensuring that key agencies are involved in the assessment and care planning for people with complex health conditions. This is part of the wider Risk Framework. The provision of Additional support has also been agreed for people with learning difficulties in hospital.

AB Safeguarding Adult Review

11.8 AB was a retired district nurse who lived alone in the community. She received direct payments to fund domiciliary care. She was immobile without assistance and a heavy smoker, known to smoke in bed. Unfortunately she died in a house fire whilst in her bed in May 2017. Windsor & Maidenhead SAB agreed the threshold for a SAR had been met and initiated the review in June 2017 with the final SAR report presented to the joint SAB in March 2018.

11.9 Although AB was recognised by professionals to be a heavy smoker, the review found that the risk was not adequately identified and dealt with. Therefore, all organisations

are training their staff to recognise fire risk and ensuring that consideration of smoking and associated fire risks are included in formal assessments.

11.10 An assumption of capacity was made by all professionals involved with AB which acted as a barrier to a formal assessment, even when her high risk and unwise decisions were potentially impacting on her health and wellbeing. As a result, organisations are reviewing their training for practitioners around working with individuals who have capacity but remain a risk as a result of their unwise decision making and/or risky behaviour.

11.11 A task and finish group was created to develop a Risk Framework including a risk framework tool. This could then be used by any agency or person who felt a multi-agency meeting was appropriate in order to discuss the possible risks an individual might be open to. The tool would help identify these risks as well as possible ways to mitigate them. The agency or person calling the meeting would take the lead initially, unless it was agreed at the meeting that another agency was better placed.

11.12 The framework is now ready for roll-out to all other agencies, with training and case studies prepare; with the expectation that it will be used following training. This is planned for Autumn 2018, with a further roll-out to Slough Borough council in March 2019.

11.13 The report also acknowledged that without a single point of contact for her care, the holistic picture of AB was lost – particularly as her health deteriorated – as each organisational contact was seen in isolation.

11.14 The review highlighted a number of themes resulting in a detailed multi agency action plan which is being implemented and monitored by the SAR sub group and a briefing note to share the key learning from the review is being written.

12 Challenges and Priorities Going Forward

12.1 Key challenges identified by the Board at an end of year Board Development day which reflected on the period 2017/18 are summarised as follows:

- feedback – making sure that referrers get to know what happened
- getting a more consistent approach to people at risk of self-neglect – understanding and managing risk panels and implementing the risk framework
- working in partnership with providers –treating with respect and equality
- better use of data and intelligence sharing
- embracing prevention and strengths in communities
- improving community and user engagement – ensuring that the Board and its partners are listening to communities and users of services
- ensuring comprehensive awareness of what constitutes neglect/abuse
- promoting what 'good' looks like and developing a Charter of Good Care

12.2 These development areas will be absorbed into the 2017-2019 strategic business plan. The revised strategic plan, taking account of the development areas and the completed actions will therefore contain the following main themes

- Providing Quality Assurance & Challenge
- Managing Risk
- Developing the Workforce and Spreading Learning
- Prevention & Raising Awareness
- Communication and Community and User Involvement

12.3 The implementation of the new joint Safeguarding Adults Board covering Windsor & Maidenhead and Bracknell Forest has presented challenges but the end of year review of performance, and the feedback from partners, has overwhelmingly highlighted the benefits and new opportunities that have been gained from the merger. The new Board will need to ensure that it keeps a focus on local areas as well as recognising trends and risks that persist across a wider population base and the safeguarding adult system as a whole.

Appendix 1

Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board
Record of Attendance at Board Meetings 2017/18

Alzheimer's Dementia Support	100%
Berkshire Care Association	33%
Berkshire Care Association Berkshire	33%
BFC - Housing Strategy & Needs (represented by BFC Adult Social Care)	0%
Bracknell Forest Council – Adult Social Care	100%
CCG	100%
Children Services (Achieving for Children	33%
Frimley Park Hospital	33%
Healthcare NHS Foundation Trust	100%
Healthwatch	66%
Housing Solutions	33%
Involve	66%
National Probation	66%
Optalis	100%
Radian	0%
Royal Berkshire Fire & Rescue Service	66%
Royal Borough of Windsor & Maidenhead	100%
South Central Ambulance Service	100%
Thames Valley Police	100%
W. London Mental Health Trust (Broadmoor Hospital)	0%

Appendix 2

Safeguarding Adult Board Budget – 2017/18

Bracknell Forest and Windsor & Maidenhead Safeguarding Adult Board

Income/contribution 2017/18 - (01/07/2017 - 31/03/2018)

	2017/18 pro-rata
Bracknell Forest Council	-22,500
RBWM	-24,000
Thames Valley Police	-7,500
CCG	-15,000
Total	**-69,000**

Projected Expenditure 17/18	
Staff (including cost of Chair)	51,278
Supplies and Services	4,411
Total	**55,689**
Underspend as at 28/02/2018	**-13,311**

BRACKNELL FOREST AND WINDSOR & MAIDENHEAD SAFEGUARDING ADULTS BOARD

STRATEGIC BUSINESS PLAN
SEPTEMBER 2017 – MARCH 2019

Theme 1: Board Resilience & Partner Commitment

1.1	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
1.1.1	Revised and up to date terms of reference for Board and Sub Groups are available for all Board and Sub Group Members	Business Managers	By December 2017	Terms of reference in place	Terms of Reference agreed at Oct Board meeting	B
1.1.2	Revised Safeguarding Adults Review Guidance agreed and available to all (compare both previous Board's guidance)	Business Managers	By December 2017	Reports to SAB Evidence from minutes	Guidance agreed at Oct Board meeting	B

1.2	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
1.2.1	Updated Members Handbook is in place for all Board Members to use.	Business Managers	By December 2017	Handbook in existence & evidence of circulation to Members Chair confirms understanding with all new Board Members	Handbook completed	B
1.2.2	Board Members ensure they undertake appropriate training as required to deliver their role and are active participants in Board and Sub group meetings and	Chair	Ongoing	Chair evaluation of Board Members	Evaluation to be confirmed	A

1.2	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
	associated work;					
1.2.3	Board and Sub Group Members are held to account re lack of attendance at meetings	Chair	Ongoing	Attendance records (as recorded in the Annual Report) Challenge Log	Attendance being recorded	G
1.2.4	implement a communication strategy to include a quarterly newsletter	Business Managers	March 2018	Communication strategy in use	Communication strategy and newsletter developed in draft	G

Theme 2: Providing Quality Assurance & Challenge

2.1	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
2.1.1	Develop and promote the use of a single agency self-assessment tool audit tool across partners including implement of a bespoke CVS self-assessment audit	Quality Assurance Sub Group	Ongoing	Results of self-assessments Evidence from minutes	Partner audit tool approved and circulated for return in January. Draft CVS audit in place and in process of being trialled	G
2.1.2	Programme of multi-agency audits to test effectiveness of safeguarding arrangements, to include a focus from data analysis and recognising constraints within organisations	Quality Assurance Sub Group	Ongoing	Programme of multi-agency audits Audit reports Evidence in minutes	Local authority case file audit programme being aligned first. Initial approach to multi agency audits being developed	G
2.1.3	The SAB maintains a Challenge Issues &	Chair	Ongoing	Evidence in Challenge,	Challenge Issues and Risk log developed	G

2.1	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
	Risks Log that captures how it raises, tracks and resolves concerns about local safeguarding arrangements.			Issues & Risk Log		

2.2	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
2.2.1	Develop an appropriate multi agency dataset that collates relevant information via agreed outcome statements to support the Board in their understanding of local provision and issues; this to include a review of concerns by each organisation.	Quality Assurance Sub Group	Ongoing	Dataset Summary data Evidence in minutes	Dataset containing indicators from statutory returns being developed initially. Concerns being reviewed. Multi agency data set being explored by performance working group	**G**
2.2.2	Ensure a robust system is in place to join up intelligence to enable quality concerns in provider services to be identified early on and to put into place support to address concerns before they become significant safeguarding issues.	Quality Assurance Sub Group	Ongoing	Evidence of effective intelligence sharing mechanisms in place.	Care governance board reports being aligned. Initial reports received at the Board. Care governance reports to be reviewed by quality assurance sub group and the Board at 6 monthly intervals	**G**

	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
2.3.1	Examine training needs analysis and training evaluations to ensure multi agency safeguarding training provision is evidence	Chair of East Berks	Ongoing	evaluations evidence training feedback evidence	Multi agency workforce development strategy approved by Board. TNA and training evaluations to be developed. L/D	**A**

	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
	based and fit for purpose; this to include evidence of feedback from those trained and the use of e-learning.	SAB L & D Sub Group			group being re-developed with change of ownership and first meeting in April	

Theme 3: Managing Risk

3.1	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
3.1.1	Refine and implement a local risk framework to encourage consistent practice across organisations and to develop multi agency response in a crisis, this to include a pilot implementation across all agencies	Task and finish	April 2018	Case audits demonstrate effective practice, robust risk assessment and protection planning	Risk framework finalised. Consideration to be given to implementation and monitoring to ensure it becomes embedded. National workshop in April to inform implementation	**A**
3.1.2	Review the Risk Framework	Task and finish	April 2019	Feedback demonstrates effective systems in place	To be implemented in 2018/19	**G**
3.1.3	Promote a good understanding of the forums available locally to address specific needs of adults at risk and promote awareness of the need to implement bespoke multi agency meetings for those cases for which there is no relevant forum.	Task and finish	April 2018 / Ongoing	Minutes demonstrate good understanding of relevant forums. Evidence of bespoke multi agency meetings taking place.	Initial work carried out by a previous task and finish group identified forums. Implementation and monitoring require confirmation as above	**A**

3.2	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
3.2.1	The Board develops, monitors and promotes an Escalation Policy	Chair	Ongoing	Escalation Policy Regular reports regarding the use of the Policy	Escalation policy approved	G

3.3	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
3.3.1	Ensure awareness of indicators of risk and ensure safe responses through awareness of referral routes and sources of support. To include fire and new abuse types	Task and finish	March 2019	Data reflects level of engagement and understanding	Initial work commenced by a previous task and finish group. Areas of risk / referral route to be communicated via website.	A
	Determine and monitor emerging significant areas of risk and ensure communication with other partnership boards.	QA Sub Group	March 2018	Emerging risks integrated into Board work plans/ strategic plan	Areas of risk being identified and communication with other partnership boards commenced. To be reviewed at development session.	A

Theme 4: Developing the Workforce and Spreading Learning

4.1	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
4.1.1	Promote engagement of the whole partnership in MSP through a focus on and	Chair	March 2019	Evidence of effective	MSP to form a focus within the Board development session and theme at the	A

4.1	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
	improvement in working within the MCA principles and through establishing confidence in taking person centred approaches to working with risk.			partnership approach to MSP through multiagency case file audit	Board with further actions developed. Multi agency audits to be developed.	
4.2.1	Seek assurance that that the five principles of the MCA and best interest decision making are a feature of practice across the partnership	QA Sub Group	On going	evidence of improved working within MCA principles through multiagency case file audit	QA framework which includes case file audits approved. The case file audit programme is being developed to include seeking assurance regarding MCA and Best Interest decision making	**G**

4.2	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
4.2.1	Continue to ensure Berkshire Multi Agency Adult Safeguarding Policies and Procedures are up to date and fit for purpose	Chair of Pan Berkshire Policy & procedures Sub Group	Ongoing	minutes of meetings feedback from staff / partners	Policy and procedures updated as part of the launch of the new website in November 2017. Further review of policy and procedures and website taking place in May 2018 by p&p sub group	**G**
4.2.2	SAB Members continue to promote the use of the Berkshire Multi Agency Adult Safeguarding Policies and Procedures.	Chair *(policy & procedures sub group)*	Ongoing	Evidence of use of policies and procedures and evidence of effective and	Policy and Procedures website launched in November 2017. Promotion work and review of website to be reviewed by p&p sub group in May 2018	**G**

4.2	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
				consistent practice		
4.2.3	The Board is sighted on the impact that multi agency adult safeguarding training is having on frontline practice. Implement a survey to evaluate training at the end of training sessions and again at three months to measure learning and improvement in confidence and practice.	Chair of East Berkshire SAB Learning & Development Sub Group	Ongoing	SAB training reports Training evaluations Case studies and audits Positive as a result of training e.g. appropriate referrals.	Chair of Learning and Development rotating for 2018 To be established and implemented following first meeting of l/d group in April	**A**
4.2.4	Implement common workforce standards to support safeguarding across the partnership.	Chair *(East Berkshire SAB Learning & Development Sub Group)*	On going	evidence that common standards framework has been implemented and evidence of a positive outcome / change	Multi agency workforce development strategy approved by Board in October 2017. To be implemented and reviewed. Learning and Development Sub Group to meet in April to co-ordinate	**A**

4.3	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
4.3.1	Identify learning from SARs and case reviews (locally and nationally) and ensure	Chair of SAR Sub	Ongoing	Evidence from minutes	Action plans being implemented and monitored as a result of SARs	**G**

4.3	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
	action plans are developed and recommendations implemented	Group				

Theme 5: Prevention & Raising Awareness

5.1	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
5.1.1	Partner agencies demonstrate that safeguarding arrangements for vulnerable young people during transition are appropriate. Establish clear understanding of definition of Transition	Chair	Ongoing	Multi agency action plans developed to address any weaknesses or to implement improvements.	Self-assessment audit tool circulated. Further work to be developed including promotion work Meetings with LSCB reps taking place	**A**

5.2	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
5.2.1	Ensure that any relevant community profiling activities undertaken by partner organisations are shared with the SAB for information and action; Establish an effective and meaningful process for people who may be in need of safeguarding services to engage with the board	Chair	Ongoing	Self-assessment Board meeting reports repository of profiling outcomes and of feedback from people who engage with	Self- assessment evaluated Community profiling commenced by performance working group Website being developed in line with communication strategy to support engagement Action to be developed and implemented.	**A**

5.2	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
				partners		
5.2.2	Work closely with the voluntary sector in recognition of its growing role in safeguarding, early intervention and prevention and community resilience; establish comprehensive representation from voluntary sector across the Board area along with effective mechanisms for information sharing across the sector	Chair (to be confirmed)	2019	evidence that local community intelligence is used to promote and target safeguarding work	CVS audit tool being trialled to develop understanding of safeguarding and information sharing needs Action to be developed	**A**
5.2.3	Promote and support identification, from the data and other intelligence, areas where safeguarding issues are commonly occurring; the Board will target these areas, seeking assurance that preventive measures are put in place; Standardise data and recording processes e.g. populations, thresholds	QA Sub group	2019	Evidence that safeguarding issues identified are being targeted for action	Performance Working group is standardising data for initial reports to the Board and QA Sub Group. Quality assurance sub group monitoring performance and investigation into concerns completed. Potential need to address promotion / prevention	**G**

5.3	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
5.3.1	Produce guidance to ensure that cases of abuse and neglect that do not meet the section 42 criteria are reported and recorded in adult safeguarding; this is particularly important for new abuse types of domestic abuse, modern slavery, exploitation and self-neglect	QA Sub Group	March 2019	Effective guidance produced which is followed	Guidance being considered by performance working group following review of concerns data	**G**
	Action	**Lead**	**Timescale**	**Success Criteria / Measure**	**Progress**	**RAG**

5.3	Action	Lead	Timescale	Success Criteria / Measure	Progress	RAG
5.3.2	Monitor data and carry out case file audits of safeguarding reports that do not meet the section 42 enquiry criteria	QA Sub Group	March 2019	Evidence from pre S42 cases in case file audit	Being implemented work of the performance working group. QA Sub Group is establishing case file audit programme.	**G**

Status legend	
Where the action is behind schedule	**RED (R)**
Where there may be delay in achieving the action	**AMBER (A)**
Where the action is not yet completed, but is on schedule	**GREEN (G)**
Where the action is completed	**BLUE (B)**
Where the action is no longer applicable for whatever reason	**GREY (Gr)**