Cheshire West and Chester Local Safeguarding Adults Board (LSAB)

Annual Report 2021-22

‘Our vision is to promote partnership working by working together to help people feel safe and free from abuse and neglect.’

‘Our mission is to put the adult at risk of abuse or neglect, at the heart of everything we do.’

www.cheshirewestandchesterlocal-safeguarding-adults-board

Welcome from our Chair – Ian Cardwell

The Board, a requirement of the Care Act 2014, is made up of three statutory partners: Local Authority, NHS Clinical Commissioning Group (CCG), now known as the Integrated Care Board and the Police, together with key partners, bringing together a wide range of agencies and community groups.

This report is focused on the Boards activity over the last 12 months. Whilst the national media spotlight on the impact of the pandemic may have reduced somewhat over recent months, over the past year the safeguarding landscape has continued to face unprecedented challenges. The legacy of the pandemic has created unique demands on our service users as well as the professionals and volunteers who provide care and support every day. It is therefore important that, at the outset of the report, the Board recognises the challenges faced by those who use our services as well as the commitment and professionalism provided by front line staff across all our partners in Cheshire West.

One of the biggest challenges faced by those providing safeguarding services, both nationally and here in Cheshire West, are related staffing, particularly the recruitment and retention of staff. The Board has been regularly assured and updated by key partners, particularly the local authority and health partners, on the strategic and local work being done to address these issues and protect those at risk of neglect and abuse. There is no doubt, though, that this will be an ongoing challenge.

As during the previous year, an important focus for our Board has been to ensure that it has been 'business as usual' for delivering safeguarding services to adults in need of care and support in Cheshire West, ensuring that those services are person centred and outcome focused. Practitioners call this approach 'Making Safeguarding Personal', which is explained in more detail in the report. Further information can be found here. In summary it means that our approach is about empowering individuals to express what is important to them by whatever means appropriate.

The Board has faced other challenges alongside the legacy of the pandemic. One particularly significant, and continuing challenge is the major change created by the transition from the existing NHS Clinical Commissioning Group to a new model called the Integrated Care System, further information

about this change can be found here This change has placed substantial demands on partners, particularly those within the existing NHS Clinical Commissioning Group and the Local Authority. As Chair I must, therefore, acknowledge the commitment these and other partners have delivered to ensure 'business as usual' in Cheshire West during this complex period.

The Board has continued to build on its community engagement and communication work. This included promoting National Safeguarding Week, developing our regular newsletter and enhancing our website. Our website now provides a wide range of information for practitioners, volunteers, and members of the community. More information can be found here

Another continuing focus for the Board has been building strong partnerships between the wide number of agencies who make up the Board in Cheshire West. This is critical to delivering efficient and effective safeguarding services, as experience nationally has shown that problems often occur in 'the gaps' between organisations, such as communication or information sharing. Later in this report we will see examples using case studies of how our partners have worked together to safeguard our adult community.

A key focus for the Board has been building strong partnerships between key agencies and groups. We have continued to build our collaboration with the Safeguarding Children's Partnership, the Community Safety Partnership and the Domestic Abuse Board. The partners have also demonstrated a commitment to continuous improvement. Good examples of that commitment and collaboration were shown through the Board's Development Day and, later in the year, our Conference. It is a testament to partners' commitment that both events where well attended, despite the ongoing demands caused by the pandemic.

Our Development Day in June focused on our collaboration with the Children's Safeguarding Partners. Entitled 'Talking the same Language', the event focused on developing our joint approach to Contextual Safeguarding and how partners work together in complex, multi-age, safeguarding issues.

Our Conference in November, entitled 'It's never too late: Domestic abuse in older people', provided another detailed insight to a complex safeguarding issue. A range of expert speakers and local partners contributed to enhancing knowledge and building collaboration.

Both events have been supported with follow up action plans to ensure the momentum of the events and the commitment to continued focus would be continued.

Finally, the Report will look in detail at what has been achieved over the last 12 months, and areas of development. We will review our Business Plan and examine the data we have collected and analysed to understand trends and tackle the safeguarding challenges we face and we will briefly 'look ahead'. We will set out our Objectives focused on the coming 12 months to deliver our priorities and provide positive outcomes for those who need our services.

I would like to thank all members of the Board, particularly the Chairs of the sub-Groups, for their continued professionalism and commitment and the Safeguarding Business Unit for their hard work and support throughout 2022/22.

Ian Cardwell - Independent Chair

The Board

Cheshire West and Chester Safeguarding Adults Board – Who we are

The Safeguarding Adults Board (SAB) is a multi-agency partnership which has statutory functions under the Care Act 2014. Under the provisions of the Care Act 2014, the Board is required to:-

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an Annual Report detailing how effective their work has been.
- Commission Safeguarding Adult Review (SARs) for any cases which meet the criteria for these and where there is opportunity for multi-agency learning.

The focus of the Safeguarding Adults Board is to ensure that in the borough safeguarding arrangements work effectively so that adults at risk can live their lives free from abuse or neglect.

An adult at risk is a person aged 18 or over who has needs for care and support and as a result of those needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect. In this report we will call an adult at risk the 'adult'.

Cheshire West and Chester Safeguarding Adults Board – The Partners

Age UK Cheshire
Cheshire Police
Cheshire Fire and Rescue
Cheshire West and Chester Public Health
Cheshire West and Chester Adult Social Care
Cheshire West and Chester Elected Members
Cheshire West and Chester Children's Social Care
Cheshire West and Chester Community Safety Partnership
Cheshire West and Chester Domestic Abuse Board
Cheshire Wirral Partnership NHS
Countess of Chester Hospital NHS Foundation Trust
Disability Positive
HealthWatch Cheshire West
Mid Cheshire Hospitals NHS Foundation Trust
Cheshire and Merseyside Integrated Care Board
National Probation Service - Cheshire
North West Ambulance Service
NHS England

The purpose of the Board

Our overall purpose is to help and safeguard adults with care and support needs. The Board ensure that, locally, abuse is prevented and that, when it does occur, partners respond in line with the needs and wishes of the person experiencing harm.

A key role of the Board is to ensure that there is a partnership approach to safeguarding by promoting collaboration between all the partners for effective communication, information sharing and awareness raising.

Our aims

Working together and with adults at risk of abuse the Board aims to ensure people are: -

- safe and able to protect themselves from abuse and neglect
- treated fairly and with dignity and respect
- protected when they need to be
- able to easily get the support, protection and services that they need.

What is Safeguarding?

Safeguarding means protecting people's health, wellbeing and human rights and enabling them to live free from harm, abuse and neglect.

The work of the Board is driven by its vision to promote partnership working by working together to help people feel safe and free from abuse and neglect.

The structure of the Board – how we work

Each group has its own terms of reference and work plan based on the strategic priorities of the Board and provides regular updates to Board in respect of progress on these priorities. The Safeguarding Adult Review Panel convenes when a referral is received.

What impact did the Board make in 2021-22?

The Boards Strategic Plan 2020-23 sets out the priority areas over the next 3 years. To deliver those priorities several annual objectives are agreed. What we have done to achieve our objectives for 2021-22 are set out below:

Objective 1 – Ensuring the delivery of Safeguarding Adults at risk of neglect or abuse in both a post-Covid 19 or continuing Covid 19 environment.

Our Impact - There have been 2 board update Covid meeting and 35 other related meetings that the business team and Chair of the LSAB have had with partners in relation to partners responses during the pandemic. A range of additional Board activity took place during this period which included the following: -

- Partners updated Board on individual agency actions regarding Safeguarding Adults and provided assurances regarding compliance with the Care Act and partnership activity. Opportunities to share expertise and reduce operational blockages were also discussed.
- The Local Authority arranged regular briefing sessions with the Chair to provide update and assurance on progress made including staffing shortages, testing, Care Homes, and staff welfare.
- The Senior Manager for Adult Safeguarding within the Local Authority provided updates and assurances on Adult Social Care regarding types and numbers of referrals to the Community Access Team, number of domestic abuse incidents and the new staff operating model to respond to people who needed support in the community.
- Updated our risk register.
- Update on the issues that people with disabilities and long-term health conditions were facing and what responses were in place.
- Reports to Board including Covid 19 Winter Plans and Health providers recovery model.
- Audio calls for all partners to provide updates, which encouraged signposting, sharing of practice, and opportunity to raise practice and user issues.
- Safeguarding Adult Reviews, discretionary reviews and thematic reviews continue as a priority including panel meetings
- Work with multi agency partners to develop plans to respond to Safeguarding referral “surges.
- The Integrated Care Board made regular contact with the Trusts Named Nurses to provide a forum for practice issues and concerns as well as a multi-agency approach to intervention and risk management.

Objective 2 – Making sure the principles of Making Safeguarding Personal (MSP) are at the heart of operational delivery to support adults at risk to achieve the outcomes they wish.

Our Impact - Age UK Cheshire, Disability Positive, and Healthwatch Cheshire West continued services as normal during 2021/22, although with limited face-to-face contact. Services kept in touch with people in a range of ways, including through weekly ‘wellbeing’ checks, video calls and the ‘Health and Wellbeing during Coronavirus’ survey.

During the pandemic Disability Positive took on additional roles including distributing PPE to people employing Personal Assistants, providing advice on the wording of letters to clients on access to vaccines for their Personal Assistants and calling people for weekly wellbeing checks. They also worked with the Local Authority on communications, and in the initial reopening of services and shops in July 2020 and provided advice to Cheshire Police on

how to manage requirements to wear a face covering for people where this is not always possible.

They also worked and continue to work with other disabled people's organisations (DPOs) to communicate issues to government, including access to food and PPE, problems with wearing face coverings and concern about the use of Do Not Resuscitate orders (DNRs) and asking government to make sure it includes people with lived experience of disability and long-term health conditions in its future Covid 19 enquiry.

They began to offer a Counselling and Befriending Service and a General Advocacy Service, in response to the significant demand that developed during the pandemic.

The Service User Involvement group produced a 'sign song' video to support adults with care and support needs in understanding the safeguarding process and how they can have a say on what outcomes they want. An easy read summary of the Annual Report has been produced.

The partners provided evidence of Making Safeguarding Personal via the Data Scorecard submitted to our Quality Assurance sub group of the Board and commentary they provide at the Quality Assurance Group. This is also evidenced by case studies submitted to the Board, for example in the Annual Report and during the additional Covid 19 Board meetings. Other examples include Cheshire Police and the Domestic Abuse Board Facebook seminars, which allowed the public to understand Domestic Abuse in more detail, where to go for support. These seminars usually attracted approximately 20,000 views per seminar.

Objective 3 – To progress and develop in the wider context of safeguarding adults by making links with key areas of safeguarding developments including the continuing focus on 'Think Family' as well as other important areas including contextual safeguarding and transitions.

Our Impact - We have contributed to developing an All-Age Exploitation Strategy across children and adults and have agreed a vision. Further work on developing the strategy in relation to contextual safeguarding was due to take place by a joint development session in January but had to be postponed due to partners commitments to the second wave of the virus.

We have sought assurances and evidence from Board members that Partners are implementing a 'Think Family' approach were appropriate. Cheshire Wirral Partnership NHS Trust and the Countess of Chester Hospital have joint Adult and Children Safeguarding Units. Meetings between

Safeguarding Adults Board and Safeguarding Children's Partnership chairs and Council leads have commenced to drive joint work forward.

Objective 4 – To improve Communication, Community Engagement and Training and Development opportunities to raise awareness and knowledge of safeguarding adults.

Our Impact - On 29th November 2021 we held our Annual Conference, attended by over 120 people. The conference increased participants understanding of the complexity of the issues on the impact of domestic abuse on adults over 65. There was a variety of speakers that focused on the following areas: -

- How we address fundamental problems and challenge some of the thinking for people who are older experiencing domestic abuse?
- Our Police response to domestic abuse and what does the local picture look like.
- The Mankind Initiative which is a domestic violence charity and is at the forefront of providing support for male victims of domestic abuse and violence.
- The Local Authorities Domestic Abuse Board (now named Partnership) on what do we do locally, how do we respond, what is in place and how we support people.

All presentations are available via this link to the LSAB website.

We Matter Too

The We Matter Too report was sent out from the National Chairs Network and examines the disproportionate incidents of domestic abuse to people with disabilities, focusing on the age range of 16-25 years. A task and finish group was convened to review the report to provide insight and discussion and an action plan had been created to ensure we respond to the needs of people with disabilities who experience domestic abuse.

Website

The website continues to be developed with revised policies and guidance updated, increased training opportunities and any safeguarding updates both locally and nationally. The highest number of views are in relation to the training page and the professional's area, where policies and procedures can be located.

National Safeguarding Week

The 2021 Safeguarding Adults week was held between Monday 15th and Sunday 21st November 2021. The theme selected by the Ann Craft Trust

was “Creating Safer Cultures.” Promoting safer cultures is all about how organisations and individuals can take steps to minimise harm occurring in the first instance, whilst simultaneously ensuring correct policies and procedures are in place so that safeguarding concerns that are raised, are recognised and responded to effectively.
Some of the activities that took place during the week included: -

- Disability Positive service user group recorded a sign song (take 2) about stopping adult abuse to be used to promote safeguarding and ‘don’t just talk about it, report it’.
- Cheshire Police delivered a Cyber Security Presentation on identifying the early signs of becoming a victim of cyber-crime.
- Strategic Public Protection Unit ensured that all officers were aware of the different risk factors posed to the members of the public and specifically shared training materials with officers who have less experience with dealing with these safeguarding issues.
- Partners promoted the week to all members of staff.
- External communication to primary care (GP bulletin) through their weekly newsletter for the week prior to Adult Safeguarding Week
- A press release was produced
- The agreed social media communication was shared on LinkedIn, Facebook, Twitter and Instagram. The top 5 (most viewed) pages during National Safeguarding Week 2021 were:-
  Local Safeguarding Adults Board main page -147
  National Safeguarding Adults week – 54
  Annual Conference – 43
  Training – 43
  Annual Report - 32
- A briefing was circulated to Elected Members explaining what Adult Safeguarding is and promoted the activities taking place during the week.

E-bulletins

We continued to produce regular e-bulletins to ensure people understand the impact of the work of our partners of the Board who provide content for the e-bulletin, however there are specific requirements on what can be shared. During Covid 19, there has been specific safeguarding advice, with links to partner agencies on how to obtain support. Other key themes have included promoting the Mental Health helpline, Domestic Abuse Facebook sessions, Trading Standards and Scams and Public Health messages.

Training and Development

We are committed to a culture of continuous learning and improvement. There are large numbers of people working with adults both employed and

as volunteers, and it is important that they are sufficiently skilled to spot the signs of abuse. We need to know who in the workforce needs to be trained, hold their organisations to account to ensure that they receive appropriate training and to seek evidence that the training and learning opportunities have made a positive difference to safeguarding practice.

The importance of multi-agency training is reinforced through research and reinstated through local and national case reviews. Effective safeguarding is underpinned by strong multi-agency working and professionals understanding and acting upon their respective roles and responsibilities in relation to safeguarding adults.

During this period the following courses have been produced and delivered:

- Provider led Adult Safeguarding x 4 courses and 57 attendees
- Leadership in Adult Safeguarding x 5 courses and 66 attendees
- Domestic Abuse and Older People Conference and 120 attendees
- Prevent and Far Right Extremism Briefings x 5 briefings and 210 attendees
- Basic Awareness in Safeguarding Adults x 3 courses and 22 attendees
- Basic Awareness in Children and Adult Safeguarding x 2 courses and 42 attendees
- Safeguarding Champions Adult Social Care briefing x 1 and 17 attendees
- Police Cyber Crime course x 1 and 23 attendees

The LSAB website has also been updated with new e-learning courses.
The Safeguarding Children Partnership, through our joint Training and Development Hub also provide safeguarding courses across children and adult services.

As a result of our training and the self neglect policy and toolkit, we have seen an increase in the number of self-neglect referrals and people using the hoarding index to help identify the extent of the neglect.

Policies and Procedures

The following safeguarding policies have been revised and updated to keep people informed of what they are expected to do.

- Adult Safeguarding Procedures

- Contest Strategy for Counter Terrorism
- Prevent Strategy

Safeguarding Adult Review (SAR)

Safeguarding Adult Reviews are a multi-agency process that considers whether serious harm experienced by an adult at risk of abuse or neglect could have been predicted or prevented. The purpose of Safeguarding Adult Reviews is set out in the statutory guidance (Section 44) within the Care Act 2014. The reviews seek to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring. The purpose of a Safeguarding Adult Review is not to hold any individual or organisation to account as other processes exist for that purpose.

During this period the Safeguarding Adult Review panel received four referrals, reviewed a national Safeguarding Adult Review and completed a Safeguarding Adult Review that started in 2019.

- Referral one. The panel decided that it did not meet the criteria, but the case should be reviewed through a single agency review.
- Referral two. Involved an allegation of theft to a patient with care and support needs, by an adult who had been struck off the National Midwifery Council but had continued to be employed. This met the criteria for a discretionary Safeguarding Adult Review and the actions have been completed and the learning shared.
- Referral three. The panel felt that a single agency response would be more appropriate.
- Referral four. The panel were satisfied that it was an unresolved complaint where legitimate concerns were raised however the complaint was never concluded and that it was appropriate for a single agency to review this case.

A Safeguarding Adult Review that commenced in 2019 was completed during this period. It was a joint Think Family approach review with the Safeguarding Children's Partnership. It involved a family comprising of an adult with care and support needs and two children who had all experienced significant neglect.

All Safeguarding Adult Review reports are published on our website.

In addition to our referrals, we have reviewed the National Safeguarding Adult Review analysis which is based on reviews published during the period April 2017 – March 2019 and included those submitted by Cheshire West and Chester Local Safeguarding Adults Boards. The report is supported by an executive summary published in October 2020 and identifies priorities for sector led improvements under 5 key areas.

We also looked at two national reviews, the first being Norfolk's Safeguarding Adults Board Safeguarding Adult Review for Joanna, Jon and Ben who were three young adults who died at Cawston Park Hospital within a 27-month period between April 2018 and July 2020. It raised critical questions and learning – not just for Norfolk but nationally, about the care and protection of a group of our most vulnerable adults with learning disabilities and complex needs, placed in private hospitals.

The other review was David (pseudonym) was at the time of the incident a 17-year-old autistic young man, who was a looked after child under a section 20 agreement. He had been known to Special Educational Needs Services (SEND) and Neuro Disability Services since he was 5 years old. David was also known to Mental Health Services and in 2016, was placed under a section 2 and subsequently a section 3 of the Mental Health Act. At the time of the incident on 4th August 2019, David was living in a bespoke semi-independent care placement where he received 2:1 care. On the day of the incident, David was allowed independent leave between 12pm and 4pm and he informed the care staff that he was going to a local shopping centre. That afternoon David went to a public building in central London and was involved in a serious incident on a young child. The victim sustained life changing injuries requiring hospital care. The victim was not previously known to David.

Performance Activity

Safeguarding Concerns

There has been a significant increase in safeguarding concerns reported to the Local Authority during this financial year from 672 in 20/21 to 1270 in 21/22 (These totals should be 100% as all safeguarding should have a concern recorded) this is an 89% increase between years. The increase is due to improved recording on the system and changes to the process.

Section 42 and Other Enquiries

Like the number of safeguarding concerns, this financial year has seen a significant increase. There was 437 of Section 42 and Other enquiries in 19/20, 340 in 20/21 and 670 in 21/22, (19/20 – 20/21 22% decrease, 20/21-21/22 97% Increase).

As in the previous two years Neglect and Physical Abuse continue to be the highest reported risk factors in Section 42 and Other enquiries, making up for 54% of concluded cases in 2021/22. Neglect encompasses many factors which is the reason it is recorded as the highest form of abuse. Physical abuse also encompasses moving and handling, needing assistance etc. More than one form of abuse can be reported. Emotional Abuse became the third highest reporting factor, accounting for 15% of concluded cases, which is the same as the previous year. Also, of note, because of the Self-Neglect Policy and Toolkit, we have continued to see an increase this year on concluded cases with a 2% increase on last year and a 3% increase on the year before, we believe demonstrates a greater understanding of this risk factor.

The main location of abuse identified this financial year was the client's own home, with 44% of concluded cases identifying this, which is the same as the previous year followed by care homes with 35% which is a slight decrease on the previous year.

Making Safeguarding Personal

At the commencement of a Section 42 and Other enquiry the client / advocate is asked to identify what they want from this enquiry. The number of clients who expressed their wishes at the commencement of support was 83%, which remains in line with the previous two years. Of these, 99% had their outcome fully or partially achieved, which again is increasing year on year with a 2% increase on the previous year. The overall satisfaction with the enquiries has slightly decreased from 78% last year to 76% this year. This evidences that Making Safeguarding Personal is central to the support provided by the Partnership.

Cohort of Gender and Age

Females continue to be the highest ratio of clients open to Section 42 and Other enquiries, with 56% compared to males with 44%. The two highest age groups continue to be the 18-64 group (40%) and the 85+ age band (24%). The 18-64 group remains the same as the previous year and the 85+ group have shown a 5% decrease compared to the last financial

year. Age 18-64 age range includes adults with a disability and mental health. Age 85+ reflects a higher concentration of need, fragility and people living longer.

Impact of Covid 19

Some carers and users of adult social care initially cancelled their care at home, day care and respite care due to concerns regarding the risks to them and their families from Covid 19. This meant that several people with care and support needs and their carers were isolated even further particularly during the first National' lockdown' in late March 2020 up until late summer 2020. During this time visits to care homes, hospitals and people's own homes were also more infrequent than usual due to the risks associated with the virus and some adults in the community who may be more susceptible to illness. This in turn meant a lower number of adult safeguarding concerns / referrals being made. Social work and other staff risk assessed every visit before they went out, despite this safeguarding never stopped and visits were still undertaken where appropriate to do so.

During the pandemic, the responsibility to safeguard adults at risk has remained a high priority for the local authority, with staff in adult social care and commissioning completing risk assessments prior to any 'face to face' contact. We have ensured staff have had appropriate personal protective equipment training from our health colleagues, access to the most up to date public health guidance and the relevant PPE at each stage of the pandemic. Where staff haven't been able to visit, other methods such as video calls, checks with other professionals such as infection control staff who have been into the care home have been used to assess risk and provide assurances about the safety of residents.

Mid Cheshire Foundation Hospital Trust

Mid Cheshire Foundation Health Trust has kept Adult Safeguarding as part of its core business throughout the Covid pandemic.
Our Trust Safeguarding Group meetings have continued, with excellent attendance from across the organisation and our external partners.
The Safeguarding team have not been diverted to other areas within the Trust, however we have, of course, supported where needed.
The team have supported the staff with all adult safeguarding issues, ensuring our patients are kept safe and free from abuse.
There have been some extremely complex cases during the pandemic, particularly in relation to mental health presentations and drug and alcohol misuse.

The work of the Dementia Specialist Nurse and the Alcohol Specialist Nurse have been pivotal, and both have supported carers and patients through some very difficult times. All deaths of patients with a Learning Disability (LD) have been reviewed using the Structured Judgement Process, and this has continued throughout the pandemic.
The Trust has supported carers and families regarding visiting our most distressed patients, and the team have made sure they have been regularly updated if visiting has been restricted.

The Safeguarding Team are now co-located with Children's Safeguarding and the Domestic Violence Advocate, ensuring that we adopt a 'Think Family' approach. Our quarterly reports and dashboards reflect a robust reporting system in place, and those referrals have continued throughout the pandemic.

Deprivation of Liberty Safeguarding (DoLS) referrals have increased significantly, and the Trust is working collaboratively to progress the transition from DoLS to Liberty Protection Safeguards (LPS).
Carers have known they have been able to liaise with the Adult Safeguarding team to discuss issues with appointments etc. and their feedback has been very positive. We have participated in Round 4 of the National Health Service England Learning Disability Improvement Standards national audit. This will enable us to review the way we care for our patients with a Learning Disability; celebrate what we are doing well and improve where we need to.
The team has had great support from our designated Adult Safeguarding leads, which has been very important during some of the most challenging times the NHS has faced.

Adult Safeguarding Case Studies

Adult Social Care

Adult Social Care were alerted by regulatory services and the Police to reports of an adult at risk in the community. The referral highlighted that hoarding and self-neglect was an issue. It was causing anti-social behaviour in the community After an initial visit to the property, it was immediately apparent that a relational social work approach was needed. The person was an extreme hoarder. Due to the hoarded items, the person had no space left to care for their own basic needs and aspects of daily living.

A safeguarding enquiry was open to bring together all professionals to safeguard the person. Fire and Rescue services deemed the property unsafe and a risk to life. Mental Capacity Assessments were carried out and

assessed the person to lack capacity in terms of care and accommodation, risks in relation to hoarding and property and affairs. Working together with the Police, Regulatory Services, Fire and Rescue, GP's, and Adult Social Care we were able to keep the person at the very heart of the support and keep them involved in the discussions and decisions. Work is ongoing to support the complexities of the hoarding disorder using a trauma informed approach, and to ensure a long-term plan includes their own aspirations for their future. This case has highlighted the complexities of working with people who have deep rooted hoarding disorders.

Adult Social Care

Adult A lived at home alone and was bed bound following a spinal injury which severely impacts upon her mobility. Adult A highlighted that she was experiencing chronic pain which has resulted in her refusing personal care intervention. As a result, there had been a state of severe self-neglect that resulted in her obtaining pressure sores and would become aggressive upon intervention and threaten the carers and the main reason for her refusal was pain.

She was diagnosed with dementia and deemed to have fluctuating capacity regarding her care and treatment. The social worker carried out assessments and used the Self-Neglect Procedure to support with decision making. From information gathered it become apparent that it was fundamental in integrated working due to identified risks to both her health and social care needs so therefore the social worker and the district nurse carried out a joint visit.

As a result of agencies working together, which included Adult Social Care, District Nursing Team, the GP, and Occupational Therapy and listening to the wishes and feelings of Adult A, she was able to remain at home with the appropriate equipment and level of care.

Cheshire Wirral Partnership NHS Trust

The following case study involves an older person who will be referred to as Mrs X. There were some safeguarding concerns identified relating to physical abuse and domestic abuse. The alleged perpetrator of the domestic violence was her husband who will be referred to as Mr X. Mrs X was assaulted causing significant injury by Mr X and family had raised concerns with their GP around irrational behaviour and increasing agitation. It was documented that there had been no history of violence within their marriage until this incident. It was indicated that over the COVID 19 period Mrs X's behaviour had deteriorated and this had declined again following an operation. Mrs X would typically be sociable prior to COVID. Mrs X was readmitted to a mental

health inpatient ward following escalation in behaviour. This readmission was instigated following a police call due to concerns around Mrs X's escalating behaviour and Mr X unable to cope with the situation, which lead to bidirectional verbal and physical abuse.

During the inpatient stay a multiagency approach was required to ensure all necessary actions were completed in preparation for a safe discharge. The multi-agency response included agency involvement from Cheshire Wirral Partnership community mental health team, inpatient staff, and safeguarding teams, police, adult social care and family safety.

Professionals' meetings commenced and safety plans were agreed to ensure domestic support services and mental health services were involved following discharge with support from Cheshire Wirral Partnership safeguarding team. Given that there had been no previous history of domestic abuse, alongside a notable improvement in Mrs X's behaviour and their strong wishes to remain in the home together, discharge home with support and a safety plan was agreed to maintain Mrs X's safety. At this point Mrs X was deemed to have capacity to make that informed decision.

The overall work of the multiagency team allowed this couple to be safeguarded but also to support their wishes. Each agency took their part of the safeguarding and agreed to actions that subsequently kept both parties safe and continues to do so. During COVID this was particularly difficult with restrictions in place and the impact on the mental wellbeing of Mrs X. Despite the restrictions multiagency working was upheld and has reached an outcome where the couple could fulfil their wish of remaining in their own home together with support from the multiagency team.

Disability Positive

Adult B rang Adult Social Care and advised she had no care package in place as the domiciliary care package had now stopped. The Independent Living Advisor from Disability Positive made a safeguarding referral to Adult Social Care as Adult B was at risk with no care support. The Independent Living Advisor followed up on the referral and spoke to the Social Work Team who advised that the care package appeared to have stopped before Direct Payment had been set up and advised that a referral for emergency care would be made. The Independent Living Advisor followed up on the referral the next day as the client still had no care in place and explained the situation and emergency care package was put in place. The Direct Payment has now been agreed and the Independent Living Advisor is supporting Adult B to recruit a Personal Assistant.

Primary Care

A patient contacted their GP to raise concerns about their wife and potential exploitation from an estranged family friend who had recently been in touch with the couple during the pandemic to offer some support with shopping and running errands. The lady was living with mild dementia, and seemingly paying regular amounts of money to the family friend for fuel, parking, shopping, and cleaning somewhat over and above an expected cost. A telephone contact was arranged with both patients to review current health and a review of mental capacity in view of the potential exploitation. In making safeguarding personal the GP discussed the situation with their patient who disclosed feeling uncomfortable with the situation with the family friend but didn't want to offend them. It was assessed that there were no concerns with the mental capacity of the patient in relation to this situation, however some concerns were evident with their mental capacity for managing their finances. A discussion was had with Cheshire Police Public Protection Unit officers and on their advice further enquires made with the couple identified that there was no evidence of criminal activity. A referral to Adult Social Care was made to enable a care needs assessment to be completed which subsequently identified the couple required additional support. The lady had enjoyed some of the social aspects of shopping and going out post lock down as her husband was unable to drive due to long term health conditions. A referral was also made to the social prescriber at the practice and additional activities offered which were accepted as were local contact numbers to Age concern and the Alzheimer's society.

Strategic Priorities 2021-24

This year we undertook a review of our governance and scrutiny procedures, resulting in the publication of revised Governance Arrangements. This work was done to ensure the Board is equipped to deliver its statutory and local commitments and to add value to partnership working in safeguarding adults through effective oversight and scrutiny. Additionally, the Covid 19 crisis means that the Board needs to demonstrate support and guidance, in addition to good governance, to members at this critical time in our history, as all partners face considerable challenges and will continue to do so as we move through 2022 and beyond.

It is important to add that, in setting revised Strategic Priorities & Annual Objectives, the key aspects of the previous year's work have (where relevant) been incorporated into the new priorities and objectives, so that good practice, learning and ongoing work is not 'lost' going forward.

It is proposed that the high-level Strategic Priorities for 2020/23 remain unchanged to continue to the progress we have made over the last 12 months. These Priorities remain relevant to the activity of the Board and also represent a clear framework on which to assess progress, particularly in the context of the upheaval caused by the Covid 19 crisis. They form a comprehensive framework that captures all the key functions of the Board, focusing on three areas of equal importance; effective operational delivery; good governance; and active communication & community engagement.

Whilst the Strategic Priorities effectively remain the same, it is important to demonstrate that each has been properly reviewed in the context of the current operating environment. Each priority is set out below together with the rationale for its selections.

Strategic Priority 1: People and Outcomes – Ensuring Safeguarding services are delivered effectively and professionally, with Making Safeguarding Personal at the heart of how those services are delivered. This priority continues to be relevant, particularly during the Covid 19 crisis so that the Board's focus on adult safeguarding remains firmly on the needs and expectations of the individual at risk.

Strategic Priority 2: Governance, Systems & Processes – Ensuring that there are effective governance, scrutiny and business processes in place to ensure that the safety and well-being of adults who are subject to, or at risk of, abuse and neglect is at the heart of Board members organisational priorities. This includes ensuring that the findings from Safeguarding Adult Reviews published during 2021-22 and other key areas of Practice improvement are implemented. The Board will continue to develop and strengthen its governance arrangements. Additionally, in the context of the Covid 19 crisis, particularly the changes in relation to social distancing, client interactions, remote working and online meetings, it is important to maintain the focus on systems and processes.

Strategic Priority 3: Partnerships and Community Engagement - We will promote safeguarding adults in the community by listening to their concerns and raising awareness to prevent neglect and abuse before it happens, with a focus on diverse, isolated and under-represented communities. Additionally, in the context of the Covid 19 crisis, it is critical that effective communication and engagement with the community is maintained and that the concerns of adults at risk of abuse and neglect are listened to. We will also work with other key Groups, Committees and Partners, including the Safeguarding Children's Partnership, to build effective partnerships. We will continue to deliver training and development in areas where awareness and understanding needs to be improved, using innovative approaches to maintain delivery in the current operating environment.

Plans for our objectives for 2022-23

To deliver those Priorities, several annual objectives are proposed that will ensure we move towards delivering our Strategic Priorities, which are:-

Objective 1: Ensure the delivery of effective safeguarding services, with a focus on Making Safeguarding Personal, informed by the voice of adults who are at risk of neglect and abuse.

Objective 2: To develop, in collaboration with the Safeguarding Children's Partnership, a cross-cutting approach to safeguarding adults, children & families at risk of neglect and abuse.

Objective 3: To continue to raise awareness of adult safeguarding through effective communication and community engagement and improve our learning by means of training & development.

Objective 4: To continuously improve the effectiveness and culture of the Board, through a range of development tools, including self-assessment, peer review and benchmarking.

Stop Abuse
Stay Safe

Speak up if you are worried about something that is happening to you or someone else.

Don't just talk about it. Report it.

If you have a concern or need advice contact the
Community Access Team

- Phone: 0300 1237034
- Out of hours phone: 01244 977277 (EDT)
- Alternatively call Cheshire Police: 101 for non-emergencies or 999 in an emergency.
- Report a safeguarding concern

If you are scared, tell someone you trust who can report it for you.

We must work together to make sure people feel safe and stay safe.

For information search online for the Adult Safeguarding Board at Local Safeguarding Adults Board

Responsible officer: Dawn Lewis
dawn.lewis@cheshirewestandchester.gov.uk