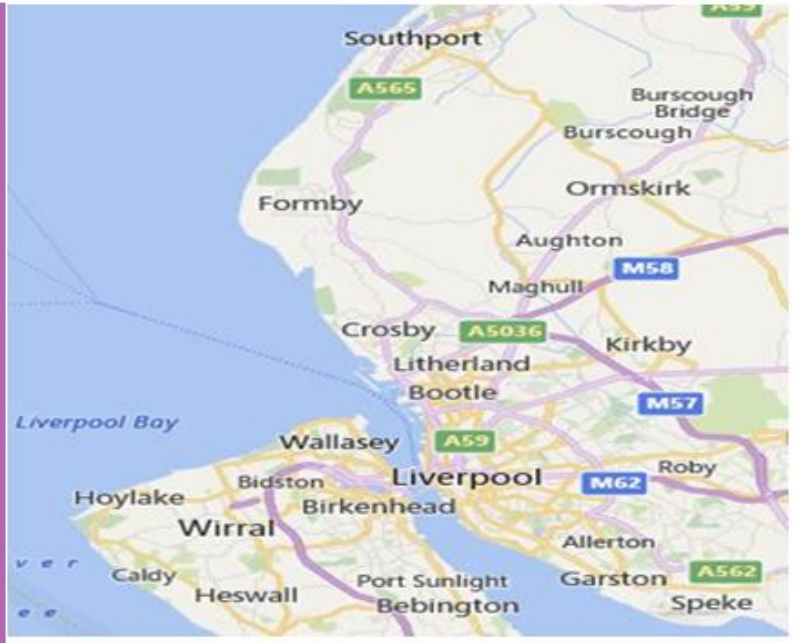
Sue Redmond – Independent Chair Merseyside Safeguarding Adults Board

Annual Report 2017 -2018

Merseyside Safeguarding Adults Board

(Knowsley, Liverpool, Sefton and Wirral)

Annual Report 2017-2018



MERSEYSIDE SAFEGUARDING ADULTS BOARD

KNOWSLEY LIVERPOOL SEFTON WIRRAL

SAFEGUARDING IS EVERYBODY'S BUSINESS

MERSEYSIDE SAFEGUARDING ADULTS BOARD

Membership

The following statutory organisations are represented on the MSAB:

Knowsley Borough Council

Liverpool City Council

Sefton Borough Council

Wirral Council

Merseyside Police

NHS Knowsley Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

NHS Wirral Clinical Commissioning Group

The non-statutory organisations include:

Merseyside Fire and Rescue Service

Healthwatch

Sefton CVS

Merseyside Community Rehabilitation Company

National Probation Service

HM Prisons

NWAS

Elected members for each constituent local authorities also sit on the board

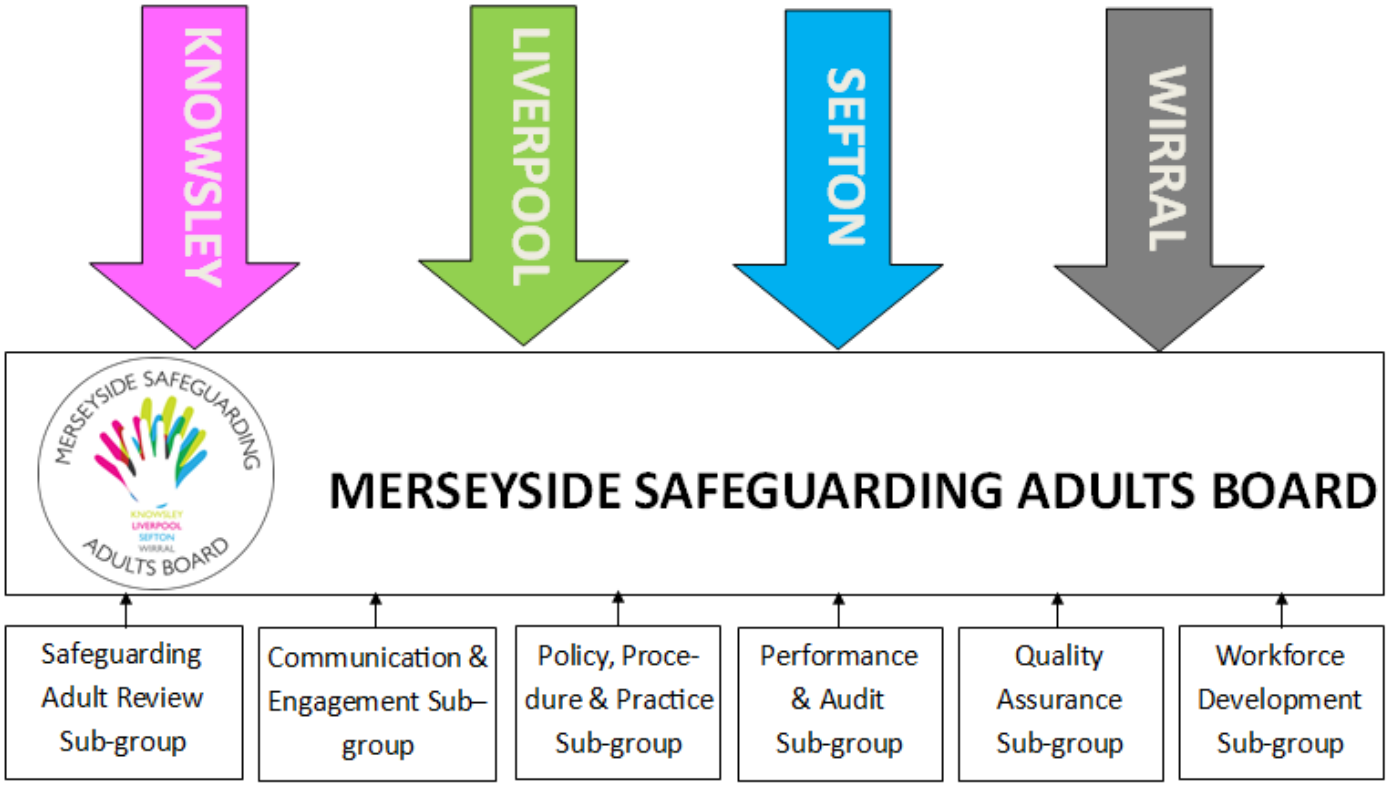
Terms of Reference

The board meets on a quarterly basis and has two development sessions a year . In order to be quorate the board must include no less than two of the statutory partners and no less than 75% of the agreed membership.

The MSAB agreed a number of sub groups to take forward various work streams

The subgroups of the MSAB are as follows:

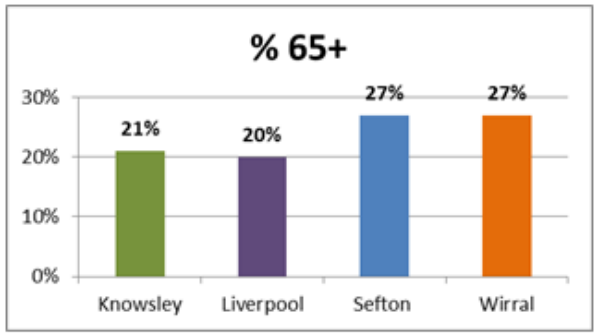
1. Safeguarding Adults Review Sub Group
2. Communication and Engagement Sub Group
3. Policy, Procedure and Practice Sub Group
4. Performance and Audit Sub Group
5. Quality Assurance Sub Group
6. Work Force Development Sub Group

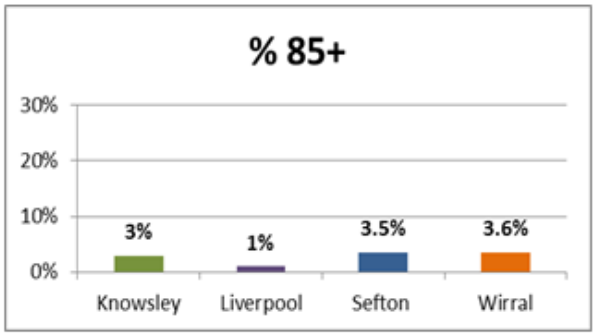


About the board

Who lives in our areas ?

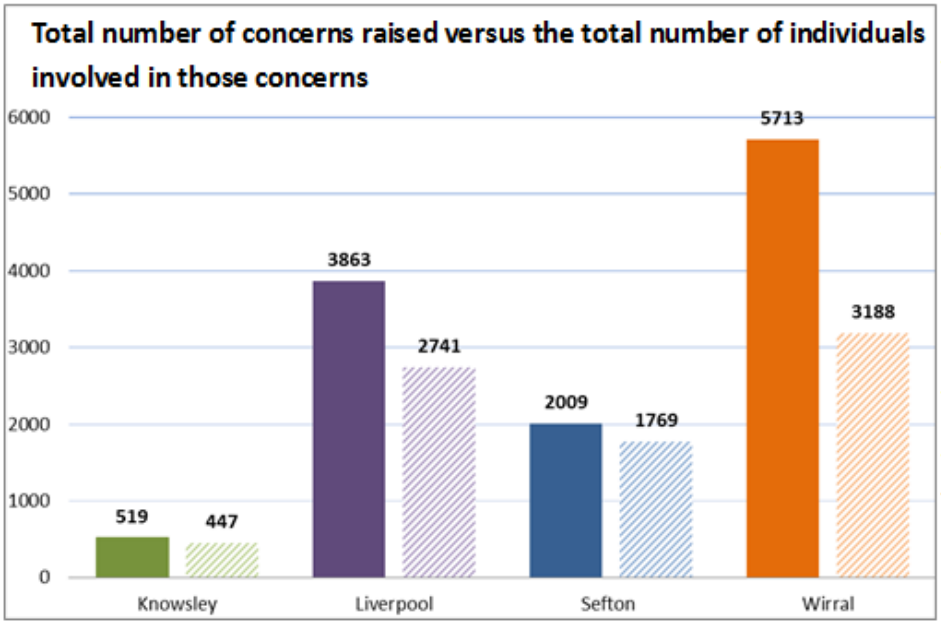
The adult population across the geographical areas of Knowsley, Liverpool, Sefton and Wirral is approximately 982,354. This is broken down into Knowsley (115,206), Liverpool (392,637), Sefton (220,902) and Wirral (253,609). Of all four areas Sefton and Wirral have the highest numbers of residents aged 85+.





Our Population

Safeguarding Concerns



Key: Solid block shows the number of concerns raised

Patterned block shows the number of individuals for whom concerns were raised

From 1st April 2017 to 31st March 2018 there were 12,104 adult safeguarding concerns received with the Adult Social Care departments across our 4 constituent Local Authority areas.

It is clear from the accompanying chart that there are significant differences between the four areas with Knowsley showing a significantly lower number of concerns received than the other 3 areas and Wirral showing the highest. The is representative of the national picture which shows the same differentials between Local Authorities across the country.

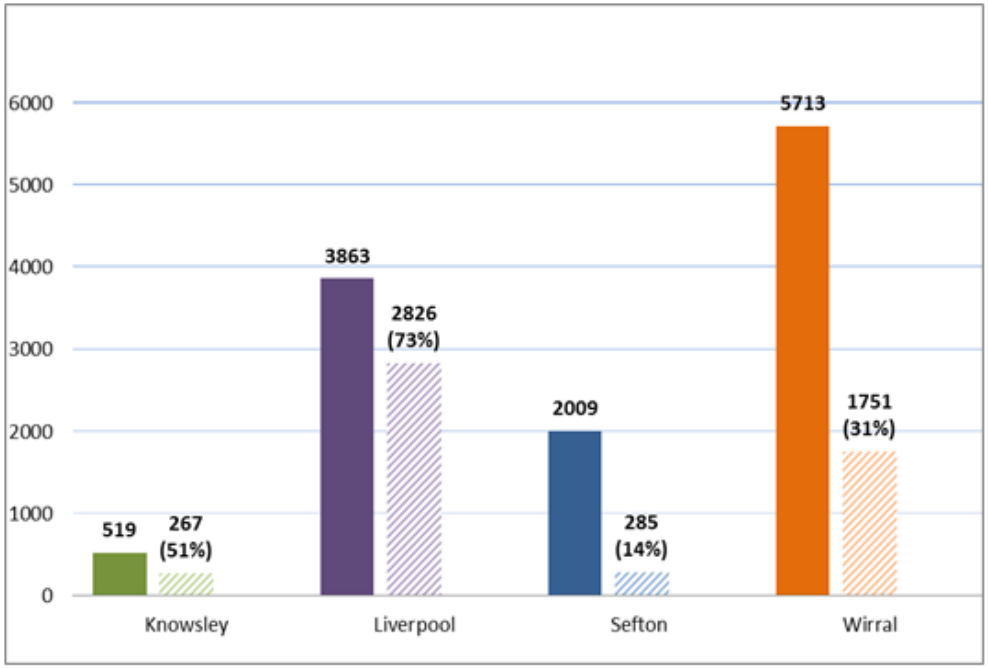
The board has recognised that there are differences in the way in which each component Local Authority classifies and records data. This is being further considered via the Performance & Audit sub group with the aim of working towards a more consistent approach in the classification and recording of information.

It is important to note that the Front Door arrangements for all 4 Local authorities were reviewed by the board during this time period and there was no indication that these figures highlighted a deficiency in the way that individuals were being safeguarded or that adults with care & support needs were being left at risk. The board were assured that this is a counting and classification issue and highlighted differences in pathways . The front door work also developed a good practice pathway for all councils to follow and work will be ongoing in 2018/19 to assure the board that the recommendations are being implemented.

Safeguarding Data

Safeguarding Concerns and Enquiries

Total number of Safeguarding concerns raised compared to the total number that progressed to some form of Safeguarding Enquiry



Key: Solid block shows the number of concerns raised

Patterned block shows the number and % of concerns raised which progressed to an enquiry

The total number of concerns which progressed to an enquiry across all 4 areas from April 2017 to March 2018 was 5,129.

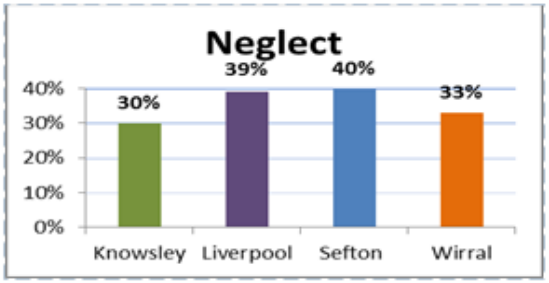
The conversion rate across our 4 areas varied between 14% and 73%. In the Northwest as a region the lowest conversion rate was 14% and the highest was 100%. Nationally the lowest conversion rate was 3.9%.

Once again the differences in conversion rates have been investigated and the board were assured that locally defined practices, pathways and triage points could explain the differentials.

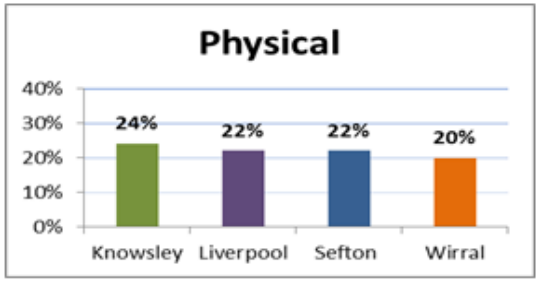
A piece of working moving forward for the board is to determine whether the variances are acceptable given their reflection of the national picture or whether a move towards more consistent application of criteria and pathways would better enable the board and partners to understand the adult safeguarding landscape across the areas.

Safeguarding Data

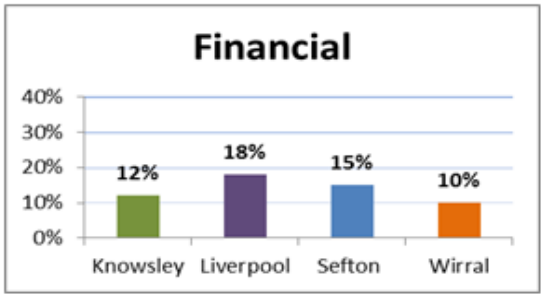
What were the most prevalent types of abuse ?



Includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, nutrition and heating.



Includes hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions.



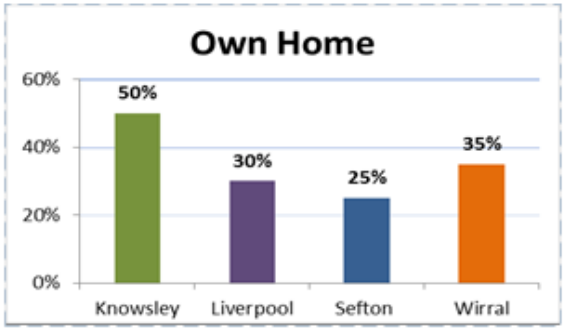
Includes theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

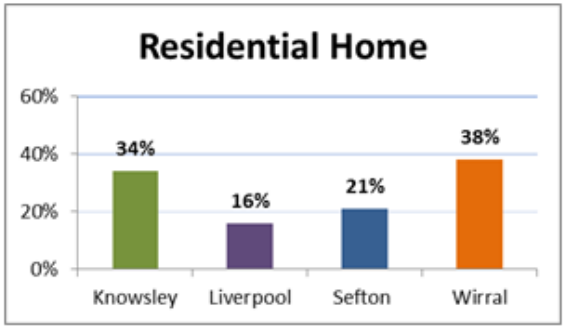
Includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

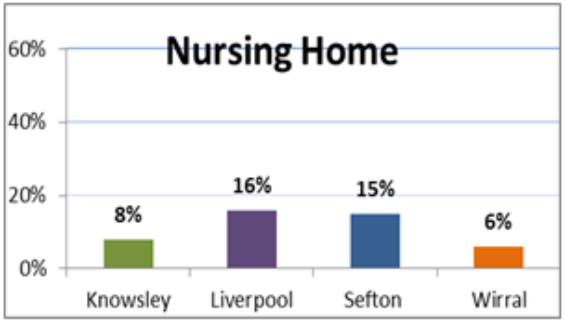
Neglect and acts of omission were the main forms of abuse experienced by adults at risk during 2017/2018 across all four local authority areas. This is in line with national reporting for the same time period and accounted for 32.1% of abuse nationally. The same trend followed nationally with Physical abuse at 22.2%, Financial abuse at 14.6% and Psychological abuse equating to 13.1% of all abuse. The lower percentage of Psychological abuse in Wirral is noted but on investigation it is believed that this is due to a more frequent use of the 'Organisational' abuse category.

Safeguarding Data

Where did the Safeguarding incidents take place ?







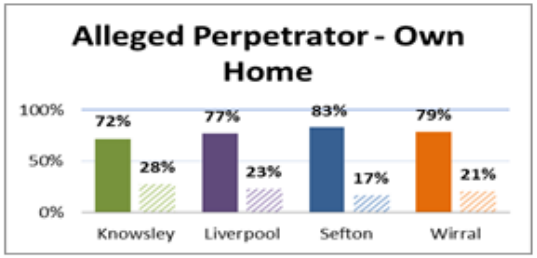
The accompanying charts show the locations in which the alleged incidents of abuse and/or neglect took place.

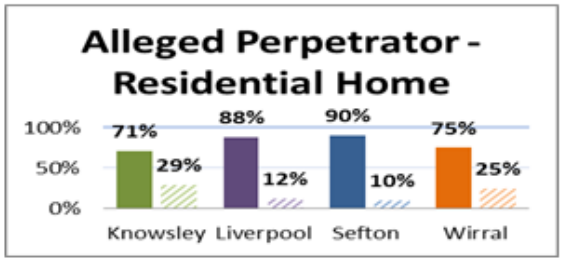
From April 2017 to March 2018 the location most frequently recorded across all four areas was 'Own Home' and 'Residential Home' and once again this reflects the national picture.

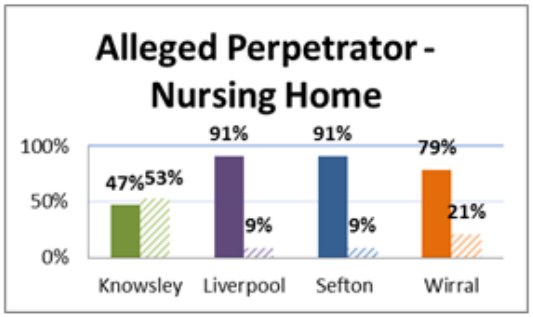
It is important to note however that an incident may have occurred in another location but was only identified in these locations. An example of this could be an individual receives unexplained bruising whilst out with family or at a day centre but they are only noted when they return home (own home/ residential or nursing home). It is also important to note that CQC reporting requirements and general surveillance within Nursing and Residential homes can increase the identification and levels of reporting of incidents from those locations.

Safeguarding Data

Who were the alleged perpetrators of the abuse ?







The accompanying charts show the location of the abuse and whether the alleged perpetrator was known to the individual.

Regardless of the recorded location of the abuse the majority of alleged perpetrators were known to the individual either personally or professionally.

Once again this is line with national reporting showing an approximate 80/20 split between own home/ nursing/ residential care against 'Other' locations such as hospitals and community services.

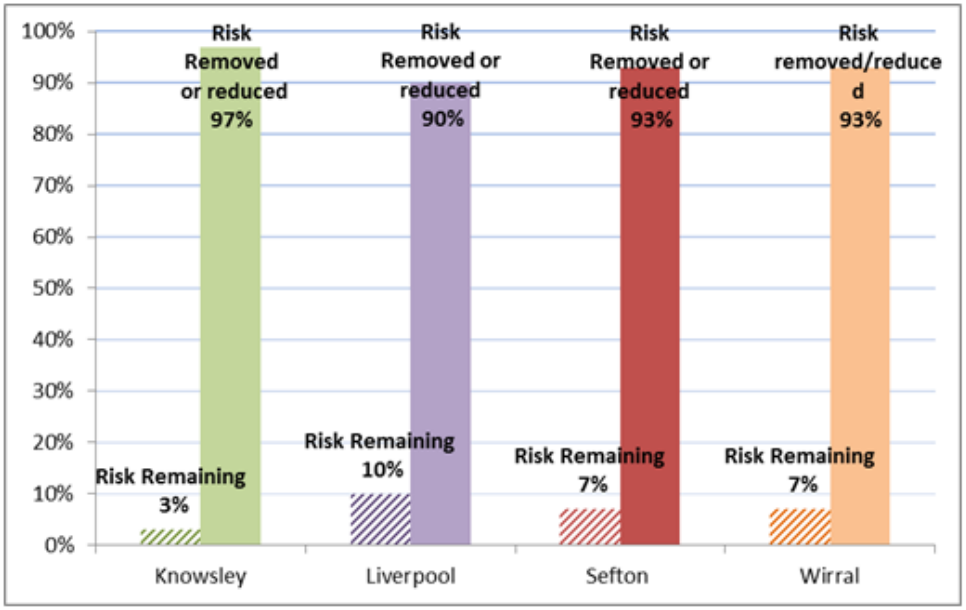
Key: Solid colour indicates the % of alleged perpetrators known to the individual

Patterned block shows the % of alleged perpetrators not known to the individual

NB. Not known categorisation is also used when the alleged perpetrator has not been recorded

Safeguarding Data

How were the risks managed ?



Key: Solid block illustrates the % of cases in which identified risks were removed or reduced

Patterned block illustrates the % of cases in which identified risks remained

The adjacent chart illustrates the outcomes of all safeguarding enquiries between April 2017 and March 2018 and whether the risk posed to the individual was reduced or removed.

In all four geographical areas the risks in over 90% of cases were removed or reduced. Whilst this does indicate that a small number of risks remained those risks may remain at the request of the individual or will have been mitigated against in consultation with the individual. This can happen in cases whereby the alleged perpetrator is a family member whom the individual wishes to remain in contact with or doesn't wish to implement safety measures. An individual has the right, with support where appropriate, to determine the most appropriate course of action for them. This is central to personalisation within adult safeguarding.

Safeguarding Data

What have people told us ?

At most board meetings we have heard directly from people who have experience of services about what matters to them.

What does the word safeguarding even mean?

You don't organise services around me!

Little things have a big impact

We are NOT vulnerable

When I'm in Crisis you seem to forget me?

I want consistent carers and support.

Respect my advance statement

I don't want to go to A&E in a crisis as they see me as an attention seeker….

What gets written about me is important and needs to be right!

We are making it our top priority for the coming year to hear more from people directly and to work with them to make a difference.

What people have told us

MERSEYSIDE SAFEGUARDING ADULTS BOARD

What have we achieved?

1. We have heard the experiences of people who use our services
2. Established a sub-group structure that reports to and from board
3. Held a Self-Neglect workshop in collaboration with Liverpool John Moores University
4. Reviewed and drafted Board Policies and Procedures
5. Undertook a review of the Front Door arrangements across the four areas and recommended a good practice model
6. Established a performance framework through the collation of performance data for the four Local Authorities
7. Reviewed the Toward Excellent for Adult Social Care (National Dataset) submission's for all four areas
8. Established a directory of Service User groups and forums
9. Developed an online Safeguarding self –assessment tool for completion annually
10. Undertook a joint Domestic Homicide Review and Safeguarding Adults Review (DHR, SAR) with Liverpool Council
11. Received four completed SAR reports and recommendations
12. Developed a Board Members Handbook
13. Developed a Suite of E-Learning courses made available through the Workforce Development sub-group
14. Visited and established links with all four Safer Communities Partnerships
15. Attended Police Community Action Groups to publicise the work of the board
16. Contributed to Northwest ADASS policy development
17. Linked in with wider forums i.e. PVP group and sub groups
18. Developed a Board Website www.merseysidesafeguardingadultsboard.co.uk

What have we achieved ?

Merseyside Safeguarding Adults Board
Strategic Plan 2018 – 2020

The vision of the Merseyside Safeguarding Adults Board is that all citizens live their lives free from violence, abuse, neglect and exploitation and their rights are protected. All safeguarding work is sensitive to and firmly rooted in respect for differences in race, ethnicity, culture, ability, faith and sexual orientation.
Engaging with and being responsive to the needs of all stakeholders, including adults at risk, carers, service providers and the wider community, is essential to promote the Board's vision.

Our Aims	What we will do
Priority 1 The views and experiences of those who use services, their significant others and the people who work directly with them will be heard. They will inform the work of the board and the development of policy and practice.	1. Commission a 12 month engagement project to capture the voice of those who use services and frontline workers and act on what they tell us 2. Root the work of the board in the experiences of those who use our services, and those who work with them, through board member visits to frontline services and spotlight sessions at every board meeting
Priority 2 The MSAB will be assured of the quality of Safeguarding and related services in each of its geographical areas. It will challenge partners to continue to improve the delivery of services and the experiences of those requiring services.	1. Undertake a range of assurance activities including self-assessment and multi-agency audits 2. Use a range of intelligence to help us understand what is happening in our areas, to inform standardisation activities and drive improvements in practice and workforce development 3. Develop good practice resources drawing from local, regional and national sources of excellence
Priority 3 A robust approach to the undertaking of Safeguarding Adult Reviews will be developed. It will ensure the delivery of a consistent approach across all geographical areas and offer the broadest opportunity for learning.	1. Encourage a culture of learning and reflection in all reviews undertaken by the board 2. Establish a single Safeguarding Adult Review Group 3. Write and publish a MSAB Safeguarding Adult Review Procedure 4. Embed a comprehensive approach to the dissemination of learning encouraging a culture of learning transfer across all agencies
Priority 4 The MSAB will develop effective communication methods to support those working with adults who may be at risk of abuse and / or neglect and to increase the knowledge of adult safeguarding within local communities.	1. Establish effective sharing of information at all levels of board work 2. Drive a preventative approach to safeguarding adults in its broadest sense 3. Share the work of the board and its partners across a range of media platforms
Priority 5 The MSAB will develop as an entity to ensure it effectively meets its duties under 'The Care Act 2014'.	1. Undertake development activities as a board to build a common approach and sense of purpose 2. Adopt an ethos of continuous evaluation and improvement underpinned by transparency and accountability 3. Take a proactive approach to the satisfying all statutory responsibilities and requirements

Strategic Plan 2018-2020