

Swindon Borough Council

Health and Wellbeing Board

Wednesday, 12 October 2016

Committee Room 6, Civic Offices

At 2.00 p.m.

Contact Officers:

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AGENDA

- 1. Apologies for Absence**
- 2. Declarations of Interest**
Members are reminded that at the start of the meeting they should declare any known interests in any matter to be considered, and also during the meeting if it becomes apparent that they have an interest in the matters being discussed.
- 3. Public Question Time**
Please refer to the explanatory notes below.
- 4. Minutes** (Pages 3 - 8)
To receive the minutes of the meeting held on 13 July 2016.
- 5. Safeguarding Adults in Swindon Annual Report 2015-16** (Pages 9 - 66)
- 6. Implementation of the Special Educational Needs and Disability (SEND) Reforms** (Pages 67 - 74)
- 7. Oral Health Joint Strategic Needs Assessment** (Pages 75 - 108)
- 8. Falls and Bone Health Joint Strategic Needs Assessment** (Pages 109 - 136)
- 9. Community Services** (Pages 137 - 144)
- 10. NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan** (Verbal Report)

Date of Despatch: 04 October 2016

Public Question Time - Swindon Borough Council remains committed to increasing its accountability to the public and to promoting active citizenship. 15 minutes will be allowed at the start of all Council meetings for questions to the Chair from the public about the work of the Committee (except for confidential matters, and matters relating to planning and licensing applications). We will give priority to those who submit questions in writing at least two days before the meeting. Questions must be relevant, clear, and concise. You may not use Public Question Time as an opportunity to make speeches or statements.

Questions in writing should be sent to the Committee Officer whose contact details appear on the agenda above, or to the Director of Law and Democratic Services. We will publish it, along with the answer, alongside the Minutes. The process associated with asking a public question is set out in the "Public Question Time at Council Meetings Protocol and Guidance" available from the Committee Officer named above or on the Council's Website at:

<http://ww5.swindon.gov.uk/moderngov/ecCatDisplay.aspx?sch=doc&cat=13338&path=0>).

Access Arrangements - The venue is wheelchair accessible and an infrared receiver hearing system is provided. If you have any special requirements to enable you to attend the meeting, or would like to receive any of the pages contained in this agenda in a larger print size, please contact the Committee Officer as soon as possible prior to the date of the meeting.

HEALTH AND WELLBEING BOARD

WEDNESDAY, 13 JULY 2016

PRESENT:- Brian Mattock (Chair); Councillors Ray Ballman, Fionuala Foley, Brian Ford and David Renard (Swindon Borough Council), Dr Peter Crouch (NHS Swindon Clinical Commissioning Group) (Vice-Chair), Mark Edwards (Healthwatch Swindon), Angus Macpherson (Police and Crime Commissioner), Gill May (NHS Swindon Clinical Commissioning Group), Nicki Millin (NHS Swindon Clinical Commissioning Group) and David Wray (Voluntary Action Swindon).

Also in attendance were: Doug Bale (Adult Safeguarding Manager), Fiona Dickens (Public Health Programme Manager), Diana Fulbrook (Independent Chair of the Swindon Local Safeguarding Adults Board), John Gilbert (Chief Executive, Swindon Borough Council), Cherry Jones (Director of Public Health, Swindon Borough Council), Karen Reeve (Director of Children's Services), Sue Wald (Director of Adult Social Services, Swindon Borough Council), Matt Bywater (Service Manager, Restorative Youth Services, Swindon Borough Council), Peter Nathan (Head of Education Services), Swindon Borough Council), and Frances Mayes (Senior Public Health Manager, Swindon Borough Council).

An apology for absence was received from: Debra Elliott (NHS England).

16. Declarations of Interest

The Chair reminded Members of the need to declare any known interests in any matters to be considered at the meeting. No declarations were made.

17. Public Question Time

No public questions were received prior to or during the meeting.

18. Minutes

Resolved – That the minutes of the meeting held on 25th May 2016, be confirmed and signed as a correct record.

19. Appointment of Chair

The Board was informed that Councillor David Renard would be relinquishing his position on the Board, consequently, his position as its Chair, following Swindon Borough Council's approval of the Board's amended Terms of Reference at its meeting on 15th June 2016. It was noted that, in accordance with the revised Terms of Reference, Councillor David Renard would remain as a deputy for the Council's Conservative group members on the Board.

Resolved – That Mr Brian Mattock be appointed Chair of the Board for the remainder of the Municipal Year, 2016/17.

Mr Brian Mattock thanked the Board for his appointment and, on behalf of the Board, thanked Councillor David Renard for his service as Chair and Member of the

Board.

(Councillor Ray Ballman requested that her vote against the resolution be recorded.)

20. Local Safeguarding Adults Board 3 Year Strategic Plan 2016-2019

The Board considered a report setting out the Local Safeguarding Board's three year strategic plan for the period 2016-2019, including details of how it would meet its objectives and each organisation's responsibilities in relation to the implementation of the strategy.

Diana Fulbrook, Independent Chair of the Swindon Local Safeguarding Adults Board, introduced the report advising members that the three year rolling strategic plan complied with the Care Act and was based upon the three agreed priorities for the coming three years (Effective Governance, Performance and Quality, Communication and Engagement and Workforce Development) and the Swindon Local Safeguarding Adults Board's six principles (Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability). The Plan was also evidence based using data from the first operating year under the new statutory framework.

Following Ms Fulbrook's introduction of the report the Board discussed the main issues raised including:

- The report and in particular the apparent anomaly in the figures for the pre and post 65 Age Bands noting that this might be the result of the way these figures were recorded. The Director of Adult Social Services indicated that she would investigate this issues and report her findings to members of the Board.
- The number of referrals received by the National Health Service Swindon Clinical Commissioning Group that did not involve true safeguarding issues and need for a joint approach to ensure continuity of investigation of such cases.
- The impact on quality of care as a result of inappropriate referrals.
- The role of partner organisations within the transformation plan and whether the logos of partner organisation should be included within the plan to increase ownership responsibilities.
- The need for the Health and Wellbeing Board to be made aware of any future concerns regarding the delivery of the plan.
- The role of the voluntary sector in respect of referrals and the training offered by the voluntary sector.

Resolved – That the Local Safeguarding Adults Board three-year Strategic Plan 2016/19, as set out in Appendix 1 to the report of the Independent Chair of the Swindon Local Safeguarding Adults Board, be noted.

21. NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan

Further to Minute 59 (2015/16) the Board received an oral update on the National Health Service (NHS) Swindon Clinical Commissioning Group Sustainability and Transformation Plan.

Nicki Millin, Accountable Officer at Swindon Clinical Commissioning Group, highlighted the following issues:

- That the second draft of the NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan had been submitted, on time, by 30th June 2016.
- That the report was currently embargoed (although this was not seen as a significant issue).
- That the direction of travel (prevention) had not changed.
- The need for support for people in crisis.
- The necessity of maintaining sustainability through the NHS workforce.
- The on-going work to address the current projected deficit of £490 million which had not completely been closed in the second draft,
- That the final submission would be made in September 2016.
- That the NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan would be shared with partners and members of the Health and Wellbeing Board as soon as possible.

Resolved – That the oral update be noted.

22. Healthwatch Swindon Annual Report 2015/16

The Board received the Healthwatch Swindon Annual Report 2015/16 which provided an update on the progress of Healthwatch Swindon and highlighted ways in which it contributed to the work of the Health and Wellbeing Board in reducing health inequalities and improving the health and wellbeing of the local populace.

Mark Edwards, Project Coordinator, Healthwatch Swindon, drew members' attention to the following issues within the report:

- The work undertaken by the previous providers.
- The work undertaken by the previous Healthwatch Swindon Board in support of the Health and Wellbeing Board.
- The focused work undertaken in respect of Mental Health, General Practitioners services and NHS Complaints Advocacy.
- The sign-posting of available services, including the use of social media in this work.
- Work undertaken with partner organisations in reducing health inequalities and improving the health and wellbeing of the local populace, including support provided to the General Practitioners Forum.
- The move by Swindon Healthwatch from an Executive to an Advisory Group model.
- Priorities for 2016/17, including on the re-commissioning of community health services, diabetes and healthy weight, the NHS Sustainability and Transformation Plan and children and young people's mental health and wellbeing.

The Board discussed the potential benefits of engagement with Swindon's Youth Members of Parliament, and also the Children in Care Council regarding the priority of children, and also young people's mental health and wellbeing.

Resolved – That the Healthwatch Swindon Annual Report, as set out in Appendix 1 to the report, be noted.

23. Joint Commissioning Intentions 2016/17

Sue Wald, Director of Adult Social Services, Swindon Borough Council, presented a report setting out the draft Swindon Borough Council and Swindon Clinical Commissioning Group Joint Commissioning Intentions for 2016/17. It was noted that there was a statutory duty for Health and Wellbeing Boards to review their local Clinical Commissioning Group's commissioning intentions and plans annually. The Director commented on the funding arrangements through the Section 75 Agreement and confirmed that the direction of travel remained similar to the previous version of the document. In particular she drew Members' attention to the Executive Summary, and the priorities, set out within the document, and Appendix 2 of the document which set out how the priorities within the Commissioning Intentions matched those in the Health and Wellbeing Strategy.

Following the Director's introduction of the report, members' were given the opportunity to discuss the issues. Matters raised by members included:

- The current workload of speech therapists, the loss of Children Centres in hosting this service and the future funding of this work.
- The work under taken with respect of Delayed Transfer of Care and whether partners could offer assistance to help meet the sustainable reduction in numbers.
- Progress made on reducing delays in the provision of Social Care packages and the challenges facing continued progress.
- Lessons that might be learnt from actions taken in Wiltshire which had significantly reduced social services assessment periods.
- Work being undertaken to prevent people needing to enter hospital when care might be provided within the community to help relieve pressures on services and transfer of care.
- The role of the voluntary sector in limiting the number of hospital care referrals.
- Caseloads, staffing issues, staff retention and the use of agency staff.
- Child poverty and work being undertaken to ensure every young person in Swindon has a healthy start to life.

Resolved – That the draft Joint Commissioning Intentions 2016/17 attached as Appendix 1 to the report be agreed.

24. Swindon Breastfeeding Strategy refresh

The Board received a report of the Director of Public Health regarding the refresh of the Swindon Breastfeeding Strategy.

Fiona Dickens, Public Health Programme Manager, introduced the report highlighting the following main issues:

- That the strategy had been approved by Swindon Borough Council and the Clinical Commissioning Governing Body and ratified by all stakeholders in

2008.

- That the report had been refreshed rather than rewritten as there had been no national or local change to policy or procedure.
- The specific parts of the strategy that had been updated (set out in paragraph 3.4 of the report).
- That the strategy was a key part of the support offered to new mothers.
- That Swindon Borough Council had signed up to a national programme to support breastfeeding in public places.
- That Swindon's Health Visitors had recently received full accreditation to the Unicef Baby Friendly Programme which was used as the standard for such work.

Resolved – (1) That Swindon Borough Council's Cabinet and the Swindon Clinical Commissioning Group Governing Body be recommended to adopt the refreshed Swindon Breastfeeding Strategy for 2016/2020.

(2) That the Board's congratulations to Swindon's Health Visitors on their achievement in being awarded the full accreditation to the prestigious Unicef Baby Friendly Programme be recorded.

25. Better Care Fund Update

Sue Wald, Director of Adult Social Care, Swindon Borough Council, advised the Board that Swindon's Better Care Fund had been approved. A copy of the relevant documentation was available on Swindon Borough Council's website.

The Board noted that the Better Care Fund submission would form the Section 75 work programme.

26. Joint Commissioning Group - Minutes for Information and Comment

The Board noted the minutes of the Joint Commissioning Group meeting held on 24th June 2016. Sue Wald, Director of Adult Social Services, referred to the Local Government Association report on Learning Disability Services Efficiency Project which examined whether service improvements could be made whilst making savings, and indicated that she would forward this to Board Members.

27. Local Safeguarding Children Board Business Plan 2016/19

The Board received a report of the Independent Chair of the Local Safeguarding Children Board setting out its Business Plan for the period 2016 to 2019. Karen Reeve, Director of Children's Services, introduced the report and outlined the seven core functions and four priority areas with the report.

Councillor Fionuala Foley (Cabinet Member for Children's Services) commented on the good attendance of representatives at the Local Safeguarding Children Board and referenced the Wood Report reviewing Local Safeguarding Children Boards and any potential lessons, arising from the review, which might be integrated into the work of the Swindon Board.

Resolved – (1) That the Local Safeguarding Children Board Business Plan 2016/2019 and its links to the work of the Health and Wellbeing Board be noted.

(2) That Alex Walters, the Independent Chair of the Local Safeguarding

Children Board and her staff be thanked for their work.

Safeguarding Adults in Swindon Annual Report 2015/16

Health and Wellbeing Board

Date: 12th October 2016

Author:	Chair of the Swindon Local Safeguarding Adults Board
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 To present the Annual Reports for Safeguarding Adults in Swindon 2015/16. The Annual Reports detail progress against the Local Safeguarding Board's Strategic Plan and provides details on activity in relations to safeguarding adults.
- 1.2 The Safeguarding Adults in Swindon Annual Report 2015/16 is attached at Appendix 1 and will be available on the Swindon Borough Council website.

2. Recommendations

The Board is recommended to:

- 2.1 Note and comment on the Safeguarding Adults in Swindon Annual Report for 2015/16 attached at Appendix 1 to the report.

3. Detail

- 3.1 From the 1st April 2015 there is a statutory duty for Local Safeguarding Adults Boards (LSAB) to publish an annual report to show what the Board and member organisations have done to carryout and deliver the priorities within the LSAB Strategy.
- 3.2 This is the first annual report that reflects the statutory duties required under the Care Act 2014.
- 3.3 The annual report includes:
 - 3.3.1 Information on activity and data collected throughout the year about cases referred and enquiries held under Safeguarding Adults procedures.
 - 3.3.2 An outline of progress made in addressing the priorities from the LSAB Strategic Plan and other developments throughout the year.
 - 3.3.3 Submissions from key partner agencies and members of the LSAB.
 - 3.3.4 An overview of priorities for 2016/17.
- 3.4 Overall the report highlights the increase in safeguarding activity since the creation of a dedicated safeguarding team within the Council and the implementation of the Care Act 2014. The LSAB are monitoring this to consider

Further information on the subject of this report can be obtained from Doug Bale, 01793 463559, dbale@swindon.gov.uk.

Safeguarding Adults in Swindon Annual Report 2015/16

Health and Wellbeing Board

Date: 12th October 2016

the impact this has on resources and consider trends and remedial action to improve quality of reporting or reduce incidents of concern.

4. Alternative Options

- 4.1 There are no alternative options proposed. The publication of an Annual Report is a statutory requirement.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 There are no financial implications arising from this report.

Legal and Human Rights Implications

- 5.2 There are no direct legal or human rights implications arising from this report.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 Consideration on how abuse and neglect impact upon these areas continues to be among the topics focussed upon by the LASB.

Diversity Impact Assessment

- 5.4 A Diversity Impact Assessment has been completed covering the implementation of the Care Act and while it did not identify any adverse impact on any protected groups, it highlighted areas where additional work is required (for example) to increase engagement with some community groups. One of the main drivers behind the Care Act is to ensure consistent and fair approaches for all people with care and support needs from any community.
- 5.5 The Safeguarding Procedures are under review and during the review process a specific Diversity Impact Assessment will be completed.

Risk Management

- 5.6 There are no identified risks arising directly from this report, however, one of the key priorities within the LSAB Strategy is to develop a new Risk Register.

6. Consultees

- 6.1 The Corporate Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 None.

Further information on the subject of this report can be obtained from Doug Bale, 01793 463559, dbale@swindon.gov.uk.

Safeguarding Adults in Swindon Annual Report 2015/16

Health and Wellbeing Board

Date: 12th October 2016

8. Appendices

8.1 Appendix 1 - Safeguarding Adults in Swindon Annual Report 2015/16.

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Safeguarding Adults in Swindon

Annual Report April 2015 - March 2016



Great Western Hospitals **NHS**
NHS Foundation Trust

Keeping Swindon **Safe**

Avon and Wiltshire **NHS**
Mental Health Partnership NHS Trust

SEQOL
care | health | support

healthwatch
Swindon



**DORSET & WILTSHIRE
FIRE AND RESCUE**

NHS
Swindon
Clinical Commissioning Group



Swindon
BOROUGH COUNCIL

Safeguarding Adults in Swindon

Annual Report 1st April 2015 - 31st March 2016

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- *Please note, any names or initials referring to alleged victims used in case studies within this report are fictitious*



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FOREWORD

I have great pleasure in presenting the Swindon Safeguarding Adults Annual Report for 2015/16. This marks the end of my first year as Independent Chair and outlines the achievements during the year.

Last year necessarily focused on the implementation of the Care Act and its six principles. There is evidence that this has been achieved and that changes in practice are becoming more embedded. The report contains statements from agencies represented on the Board about their progress throughout the year that collectively provide some assurance to the Board that safeguarding principles are being developed. Reports from the sub-groups indicate the work they have undertaken to achieve the actions identified at the start of the year which have generally been achieved. Some issues have been taken forward in the 3-year Strategic Plan 2016-18 so there is a strong link between the two documents.

The Board has increasingly used performance data to inform their discussions and identify patterns and any areas of concern. The key one has been the increase in referrals and the low proportion of enquiries that have resulted which indicates a potential problem with referrers not understanding the difference between safeguarding and the need for social care. The report contains some examples of cases to illustrate this, and the issue indicates the need for continuous training and development of staff across all agencies as well as the importance of gaining service user feedback.

Effective partnership working is a key success factor. 2015/16 saw continuing change amongst several agencies with downward pressure on resources. This affected Board representation and attendance but despite this, safeguarding has generally remained a priority for member agencies and the Board has been able to focus on its priorities. Finally, I would like to pay tribute to Board members, sub group members, their agencies, the Business Support Team and of course all staff and practitioners across Swindon who work hard to ensure the safety of adults at risk of abuse or harm. We remain absolutely committed to best practice and I commend this report as a means of demonstrating this to the public of Swindon.



Diana Fulbrook OBE
Independent Chair of the LSAB

Safeguarding Adults in Swindon Annual Report 2015/16

SECTION 1

Introduction:

From April 2015, Safeguarding Adults was brought onto a statutory footing following the Care Act 2014, which was the focus of the Local Safeguarding Adults Board (LSAB) during the year. This included a number of changes required under the Act and outlined in statutory guidance. Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

The overall duty as laid out in the Care Act is:

- Where abuse or neglect is suspected (or where an adult in need of care support is at risk of abuse or neglect), local authorities make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and if so, what and by whom;
- arrange where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry;
- establish a Safeguarding Adults Boards;
- Ensure the Safeguarding Adults Boards carry out Safeguarding Adult reviews as stipulated within the Act; and
- Where there is a need, ensure information is supplied to the Board to enable it to exercise its functions.

One of the main changes to safeguarding arrangements as Local Authorities could not delegate the safeguarding function, Swindon developed and introduced a dedicated referral point and a single team within the Council responding to concerns raised. This function was previously managed by SEQOL, the social enterprise providing care and support in Swindon and the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) for people who are mentally unwell. SEQOL and AWP still have a major part to play throughout the safeguarding process particularly with regards to providing support to those who are subject of safeguarding concerns. Information about the team managing safeguarding concerns is included on [page 23](#).

According to the 2011 Census Swindon had a population of 209,159*; of those 28,854 people were aged 65 years or more (13.8%), including 13,694 aged 75 years or more (6.5%). There were 5,547 people receiving services from adult social care in 2014/15 broken down into client groups as follows:

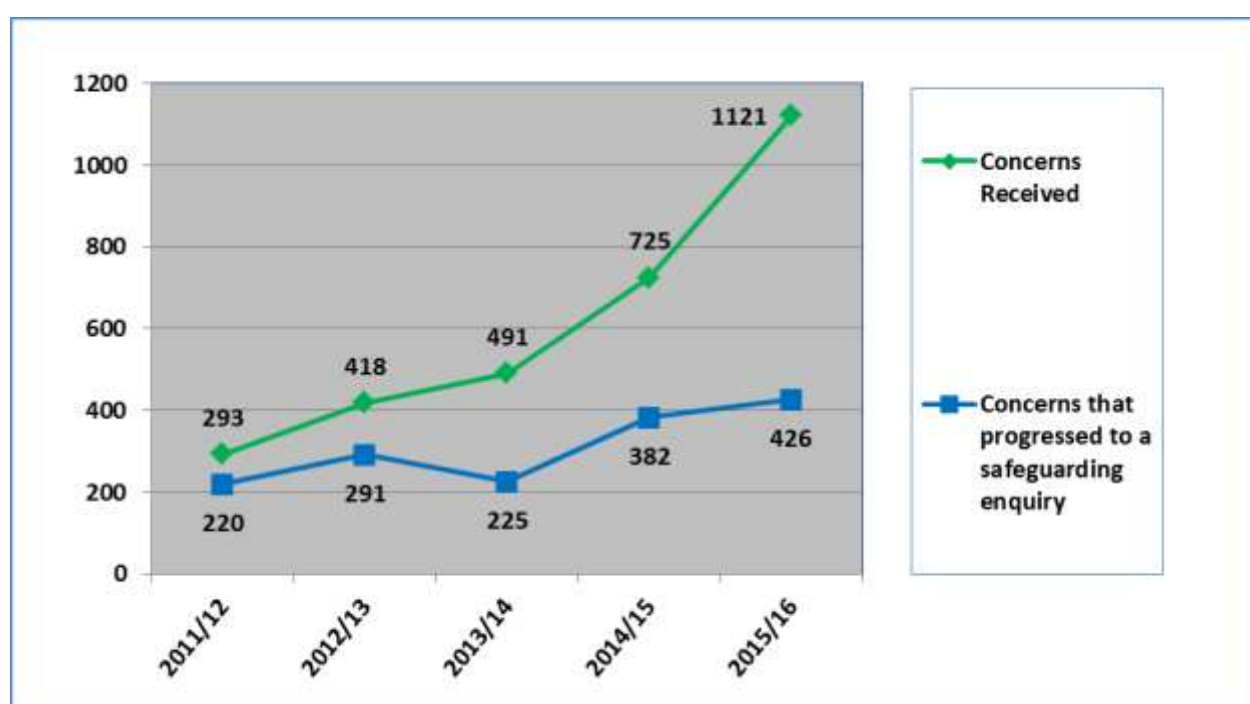
Service User Group	Age Band 18-64		Age Band 65+	
	Female	Male	Female	Male
Physical Disability	424	317	1871	951
Sensory	30	9	94	34
Mental Health	247	254	134	78
Memory & Cognition	6	6	107	65
Learning Disability	250	327	35	35
Total of Clients	957	913	2241	1163

In 2015/16 there were 5547 people receiving services compared with 5274 in 2014/15, which shows an overall increase of about 5.17%.

*Nb. The 2015 mid-year estimate of the population of Swindon produced by The Office of National Statistics puts the population of Swindon at 217,160.

The Borough of Swindon is largely urban with small pockets of rural areas. Within Swindon there are some deprived areas which can also impact on levels of vulnerability for some of those living there. Crime volumes in Swindon and Wiltshire are low in comparison to other Police force areas. There is a committed to partnership working, in Swindon to: prevent Crime and anti-social behaviour; protect the most vulnerable in society; work in a person centred way and secure high quality, efficient and trusted services.

In previous years we have reported that the number of alerts or concerns that adults in need for care and support are alleged to be abused or neglected, has increased year on year. This trend continues and is not confined to Swindon, as other local authority areas report continued significant increases, but also report (as does Swindon) that the number of concerns requiring a section 42 (the section of the Care Act requiring Local Authorities to carry out enquiries or ensure others do) has not significantly increased. Below is a graph that shows the gap between alerts or concerns and the number of enquiries needed.



This increase is still attributed to increased reporting (at times unnecessary alerts being submitted), improved awareness (and providers of services being advised and guided towards raising alerts more often “to be on the safe side”) and better knowledge of the number of cases reported due to the single access point. It is also believed that the Care Act itself may have caused an increase. For example, there were 172 cases regarding self-neglect which would not have been included in previous year’s figures. The LSAB continues to monitor this activity and in this report, further reference will be made to cases that have led to enquiries as well as outlining inappropriate alerts.

This annual report includes:

- Information on activity and data collected throughout the year regarding safeguarding concerns and enquiries made in line with local and statutory arrangements
- An outline of the progress made during 2015/16
- Submissions from key partner agencies and members of the LSAB, and
- An overview of the priorities for 2016/ 17

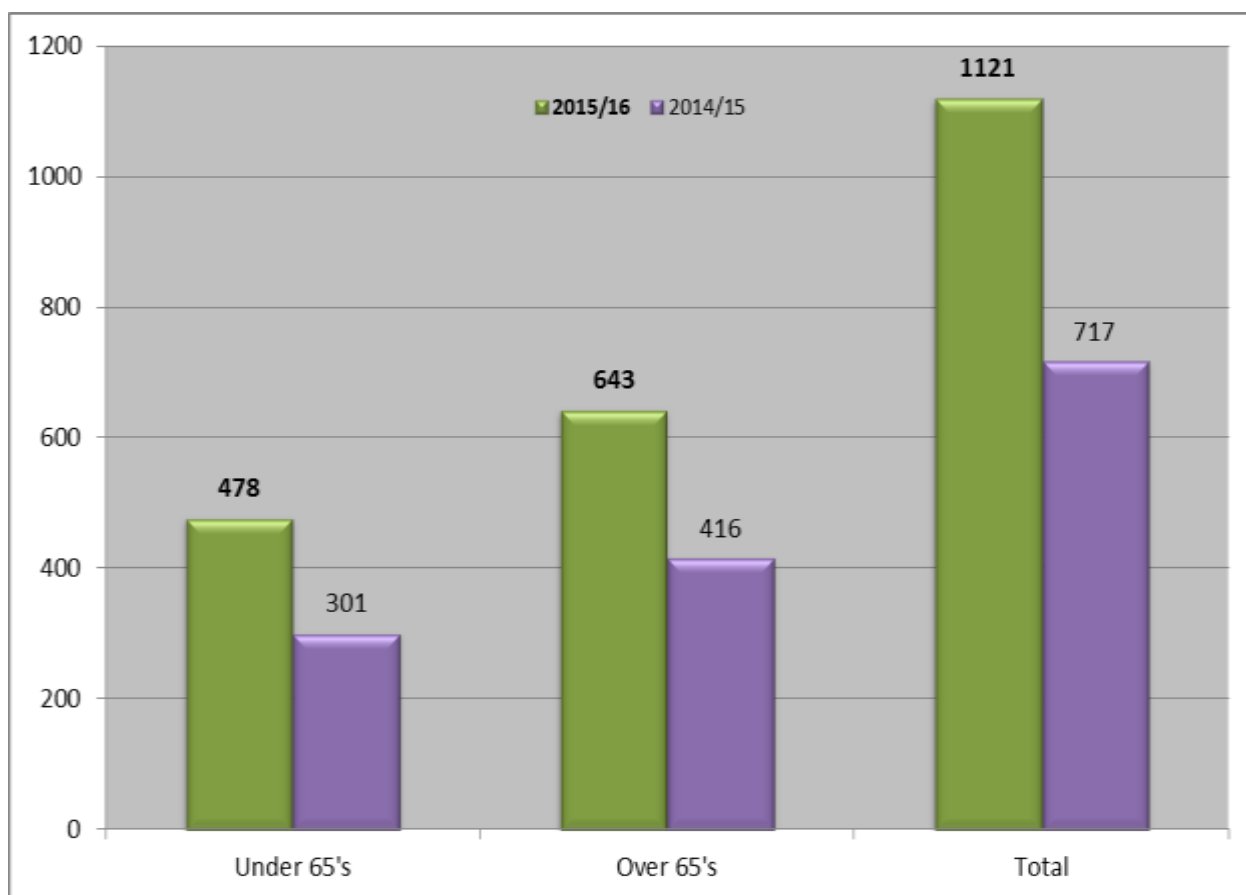
SECTION 2

Activity Data 2015 – 2016

(Where included, the figures in brackets relate to data in last year's annual report).

The following data has been collated by the Adult Safeguarding Manager using information provided by the team managing cases. The information is collected to meet Health and Social Care Information Centre requirements and requests in previous years for specific data from board members and other interested parties.

Figure 1: Total number of alerts received



Since April 2015 there has been another significant increase in the number of concerns raised – a 56% increase. There is believed to be a number of reasons for this and as experienced in other local authority areas, the Care Act may have encouraged an increase by raising awareness to safeguarding arrangements and highlighting the statutory obligations when abuse or neglect of an adult is suspected, leading to more concerns being raised. Some of these would not have been reported previously and perhaps did not warrant a referral under the current procedures. There are times where care providers raising concerns are being over cautious and should be using their own procedures, for example, incident reporting, disciplinary procedures or complaint action. Also some concerns are being raised that are not a safeguarding matter and should not be reported.

Case Study:

A nursing home raised a concern because one of their service users reported they were “forced” to have personal care and one of the staff (“the Polish bloke”) told her a rude joke. On checking the rota, there had been no male members of staff on duty at the time and no one else on duty that fitted the description of the other staff member. As the service user was displaying other behaviours the home considered whether she had an infection which can cause confusion. The service user was screened and found to have an infection which was treated. There was also no evidence of any injuries which could indicate someone physically forcing her to have personal care. The safeguarding referral was unnecessary as the home had already taken measures to determine whether any abuse had taken place and found there was nothing to indicate that the abuse had taken place. In these circumstances the home just needed to record the matter and make sure similar concerns are not raised from other residents.

Local arrangements have changed whereby there is a single team receiving referrals which has meant all concerns (irrespective of whether an enquiry is needed) is counted. In the past care teams may not have reported cases that required a different response (for example in some cases, where a matter needed to be addressed by the adult needing an assessment, the care team would arrange this and not record it as a safeguarding concern).

Care Act guidance included self neglect within the definitions of abuse for the first time and 172 cases were reported saying that “self-neglect” was a concern. In previous years such concerns would not have been recorded and without the inclusion of self neglect, the increase in concerns would have been 32%. Often the self-neglect concern does not indicate there is a serious issue and a majority of the cases reported to the adult safeguarding team are highlighting a need for a service or a reassessment as it has been found (by another agency for example) that the person they are worried about is struggling to self-care.

Case Example:

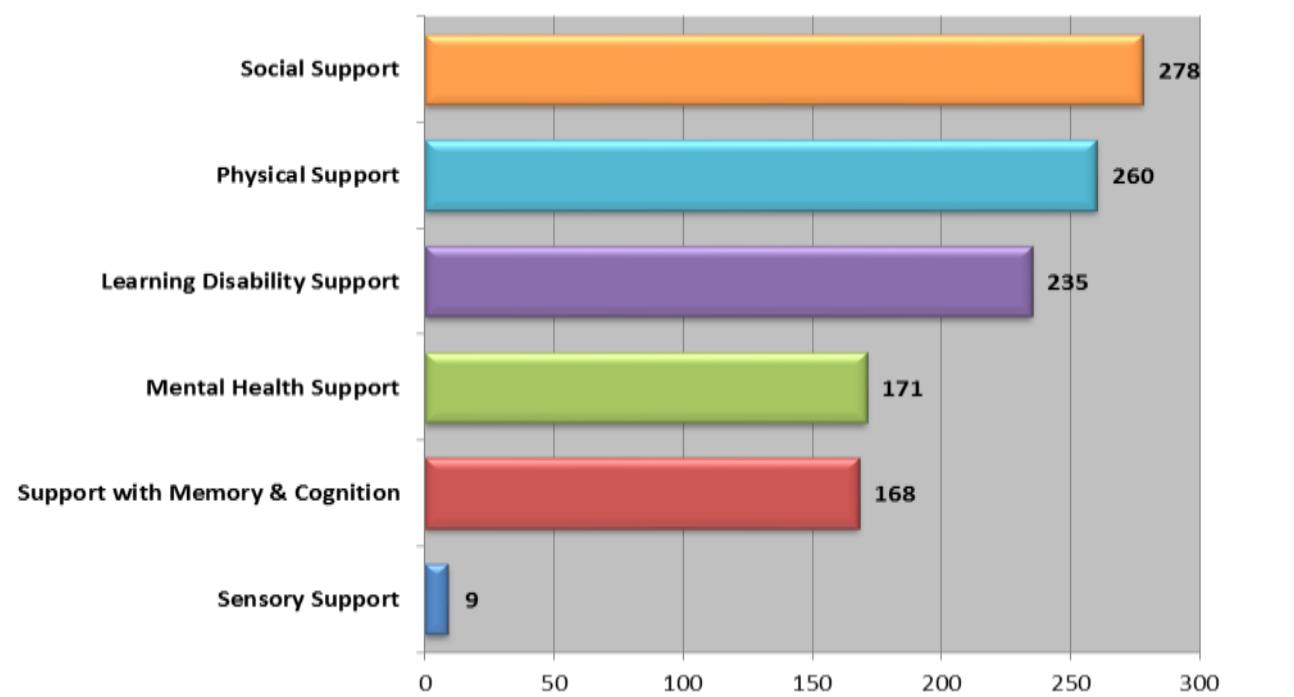
The ambulance service sent a referral in to the safeguarding team as there were concerns about one of their patients who had had a fall in his house which appeared to be untidy. He was diabetic and had an infection on both legs, for which he was treated. In discussion with the person the paramedics felt he needed a review of his care needs as he is not coping and was struggling with daily living tasks. The safeguarding team assessed the referral and did not progress it through the safeguarding process as it would be more appropriate to ensure that an assessment of his needs took place as soon as possible. However, on being contacted by the Care Team, the man said he did not want to have any additional services but did agree to some adaptations to assist with daily living to reduce trip hazards. As the gentleman was considered to have mental capacity to make decisions about his care, he was provided with contact information so should he change his mind about a new care package, he would be able to arrange this.

Of the 1121 cases reported, 426 cases required an enquiry under safeguarding procedures. Some of these required no action at all as no abuse was alleged or the person subject of the concern was not an adult in need for care and support. In 145 cases (particularly where self-neglect was a concern), the person was either sign posted to a care team or a direct referral made.

It should be recognised that although a concern may require no further work under safeguarding procedures, to enable managers to reach that conclusion a substantial amount of work is required. The LSAB are looking at the gap between concerns raised

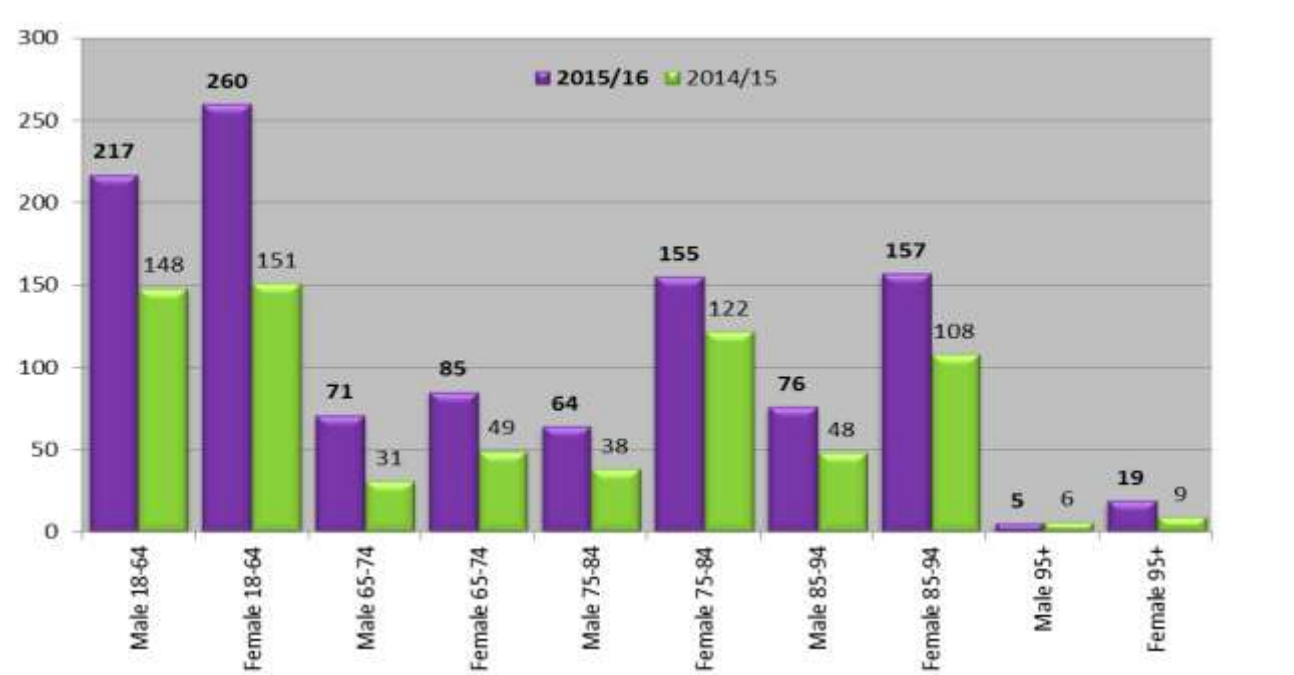
and those that require an enquiry to consider whether agencies need better information or training to promote more accurate reporting.

Figure 2: Breakdown by “Primary Support Reason”



The chart above shows the primary support reasons of the people who were subject of a safeguarding concern *at the point of the referral*. A comparison with previous years is not included as these support reasons can change from one alert to another and during the life of an enquiry as people’s needs change. Also it is dependent on the information available at the time of the referral and the person making the referral may not have an accurate understanding of the person’s needs.

Figure 3: Breakdown by Gender and Age



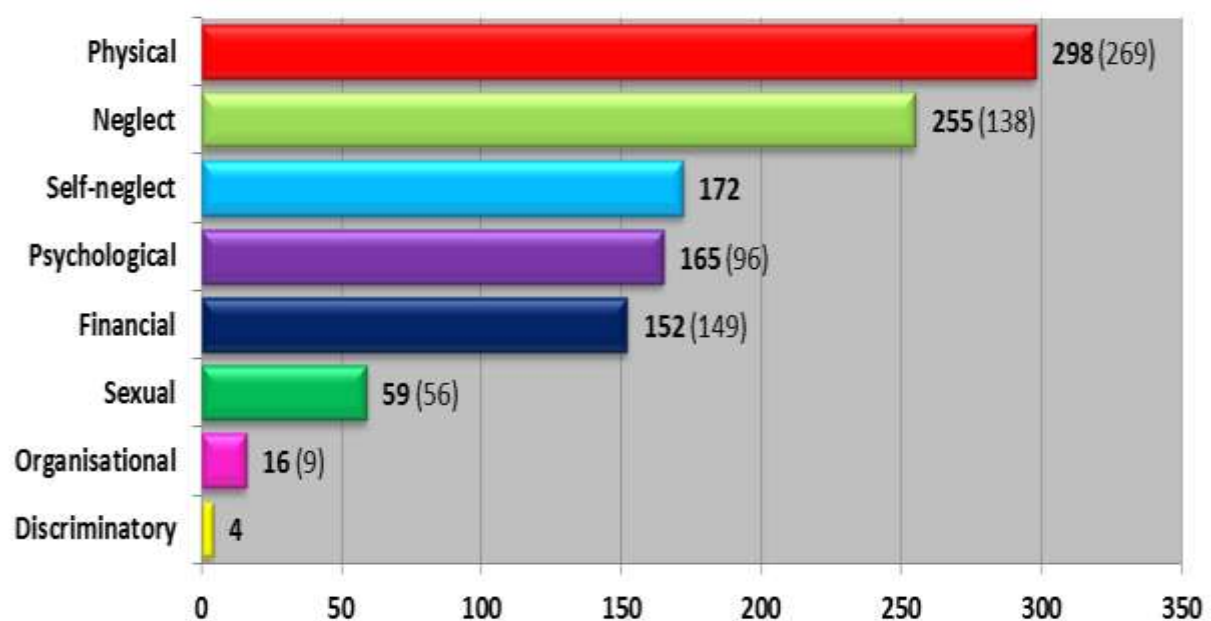
The chart on the previous page shows that the largest increase in concerns raised were regarding adults between the age of 18 and 64 (particularly women). Since the service came into the Council in April 2015, there was a marked increase in the number of referrals concerning people with mental health issues of working age (96 in 2015/16 compared to 35 in previous year). Prior to this, safeguarding cases were managed by AWP and many would not have been recorded unless the person was already known to the trust. (Some caution is required when viewing such figures, as often an assumption is made by agencies reporting abuse or neglect that someone has mental health issues as they may be exhibiting strange behaviour, appearing to be low in mood or have other indications of a mental health condition which can often be inaccurate). There was another large increase in concerns received for this age group regarding people with learning disabilities (221 referrals – an increase of 68 on the previous year).

Also there was a large increase in referrals received for people between the ages of 65 and 74 and a majority of these cases (110) were around abuse in the person's own home and over half of these could indicate that domestic abuse was a concern as the person alleged to have caused harm was a family member, partner or spouse.

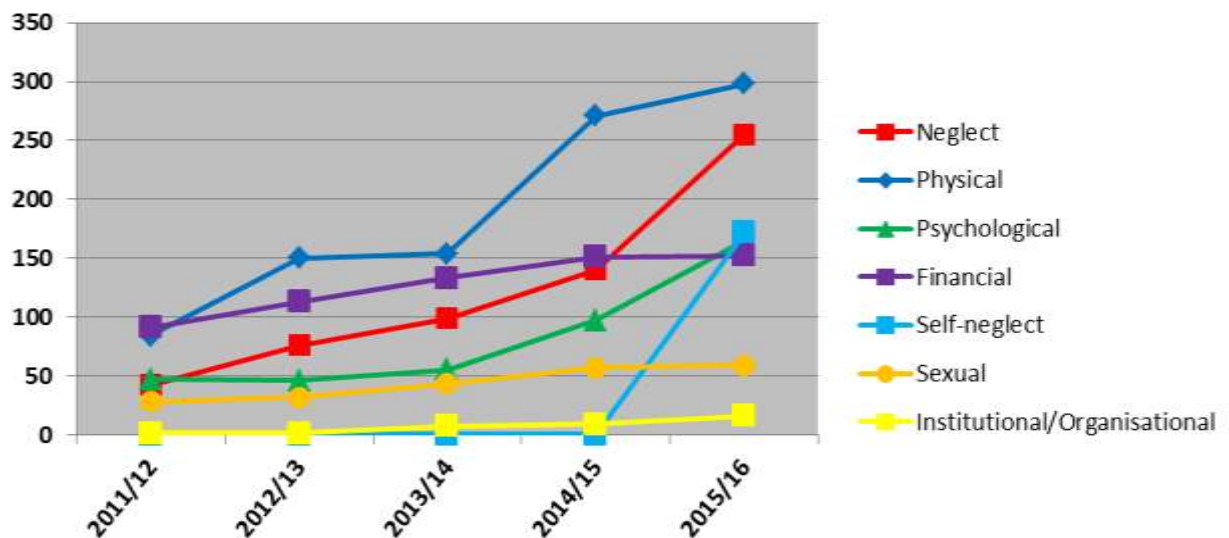
Case Study:

Mandy has mental health issues and reported that she had been sexually assaulted by her ex-husband. On further investigation and following discussions with Mandy, she withdrew the allegation 3 days later. It transpired that this was not the first time that she had made the same allegation and the Police were worried that she was being coerced by her ex-husband to withdraw the allegations and may well have been abused as initially alleged. Mandy would not confirm this so it was agreed for the case to be referred to the Multi Agency Risk Assessment Conference as involving a range of agencies and sharing information may enable evidence to be gathered from other sources that could lead to protection action or a prosecution. Through this, she was able to get support from an Independent Sexual Assault Adviser and a Domestic Abuse Advocate.

Figure 4 Types of Abuse Alleged



The following chart shows the trend for the types of abuse reported over the last 5 years.



The type of abuse with the largest increase is neglect, where a majority of these (143 cases) were reported as taking place in the person's own home. 59 of these cases alleged that the neglect was caused by a care provider or an agency staff member and half of these required an enquiry. Most resulted in action being taken by the provider for example training for individual members of staff or disciplinary action. The outcome of some of the enquiries highlighted there had been a change in the person's care needs and that the provider had been fulfilling their duty. In these circumstances, a review to the care plan was necessary.

Case study:

Jim was admitted to hospital following a fall. The ward was concerned that he was unkempt. He has carers and the hospital found that his feet had been neglected, unwashed and his toenails were too long. The Hospital submitted a safeguarding referral sighting neglect on the part of the care agency. On gathering further information, the safeguarding team found that his package of care did not include personal care (just provision of meals and prompting medication) so the agency involved would not have become aware that he required foot care. Therefore the safeguarding case was closed and a new assessment led to changes in John's care. The reason for the fall was due to trip hazards in his hallway. These were removed (with his consent) prior to him returning home.

On a few occasions the incident led to the service user who was the subject of the safeguarding concern changing to another care provider as they had lost faith in the one thought to have caused the harm.

Case study:

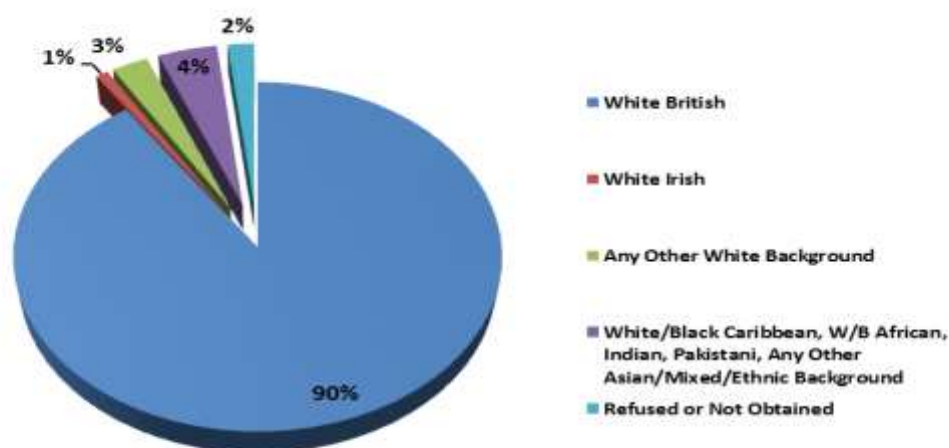
Charlene is a 70 year old with a terminal illness. She expressed concerns that one of the carers she gets is not as helpful as the others and at times has been rude particularly following an incident where Charlene was incontinent. However in discussions with Charlene she did not want matters taken any further but did not want the carer to return and would prefer a new agency to take over her care. This was arranged. Although she didn't want any further action taken, the safeguarding team did have concerns that this member of staff would be working with other service users and the employer was asked to investigate the matter under their disciplinary processes.

This was not substantiated, however the Contracts Team within adult services who monitor care providers checked the process used (which was thorough) and checked to see if other complaints had been received regarding this member of staff. No other concerns were raised.

Physical abuse continues to be the main concern raised however the increase is not as great as in previous years and the largest proportion of these relate to service user on service user incidents within a care setting. On these occasions often the incidents may be quite minor altercations that may not require a referral to safeguarding but should be recorded under health and safety legislation. However on a number of occasions an enquiry has been needed to determine if the correct procedures had been followed in the service to prevent physical incidents between residents. Sometimes this can result in a change of procedures or a revising to the person's care plan or risk assessment.

As discussed previously, self-neglect is a recent inclusion into safeguarding procedures.

Figure 5: Ethnicity of alleged victims



For 2015/16, the level of alerts broken down by ethnicity appears to be proportionate to the population of Swindon as a whole. However, as previously reported, there is still a requirement for work to widen engagement and awareness among community groups and this continues to be a priority of an Awareness and Engagement Group.

Figure 6: Breakdown of Source of Referrals (or alerts)

Source of Referrer	Total 2014/15	Total 2015/16	Number of cases that progressed following assessment
Care Providers (e.g. Care Homes day services including Independent Sector)	288	347	152
SEQOL Staff	90	129	58
Great Western Hospital NHS Foundation Trust	78	109	41
Police	35	91	12
Family/Carers	33	69	34
Ambulance Service	15	50	10
Housing Services (including Registered Social Landlords)	20	43	13
Mental Health Professionals	36	40	16
GP	10	30	6
Members of the Public	13	27	8
Council Employees (not Adult Services)	5	31	8
Private Hospital	36	23	13
Advocacy Service	13	21	7
Council Employee (Adult Social Care)	9	20	9
Care Quality Commission (CQC)	13	17	15
Advice & Support Service	0	13	4
Out of Area Referrals (including NHS Direct)	2	12	7
Probation Trust	5	9	2
Educational Establishment	5	8	1
Hospice	4	8	4
Other NHS Hospital	2	6	1
Self-referrals	0	5	0
Business	3	4	2
Anonymous	0	3	2
Substance misuse service	1	2	1
Fire Service	2	2	0
Office of the Public Guardian	1	1	0
Swindon CCG	0	1	0
Personal Assistant (Direct Payments)	2	0	0
Total	721	1121	426

As with previous years the greatest increase of sources of alerts came from Care Providers, 347 of which 152 needed an enquiry. 83 cases were in relation to allegations against other service users (mainly physical incidents) however, there were 82 cases that were concerns around allegations against staff. 47 of these cases progressed to an enquiry of which 22 were substantiated (either fully or partially) and resulted in disciplinary action or additional training for the staff member. In 2 cases, a criminal prosecution was pursued. ([See case study on page 46](#)). Whilst there have been a number of referrals from Care Providers that have highlighted some serious concerns, a great deal of referrals are recorded as not highlighting abuse or neglect and probably did not need reporting in the first place. Sometimes providers can be over cautious or have been advised to alert “to be on the safe side”.

Case Study:

Bob is a fairly able man and lives in a care home for people with mental health issues. Staff expressed concerns that his clothes were not in good order, he relies on his mother buying them for him as she has complete control of his finances. A care worker in the service raised this as a safeguarding concern that Bob was being financially abused. An Enquiry Officer visited Bob who said the reason he was short of money was because his benefits had been reduced and he has control over his own money but his mum has been helping out as much as she can.

This referral was unnecessary and the home had made some incorrect assumptions. Had they discussed the matter with Bob they would have known the reasons he was short of money and considered ways of helping Bob get new clothes and budget for the future.

Case Study:

Michael has physical disabilities and severe learning disabilities. On putting him to bed one night staff noticed 2 bruises on his legs. A referral was submitted that stated that he had unexplained bruising. In discussing the matter with the manager of the service he told the safeguarding team that he knew it was likely that abuse or neglect had not happened (as Mike is unsteady on his feet and does frequently bump into furniture) but they have to report it as its company policy.

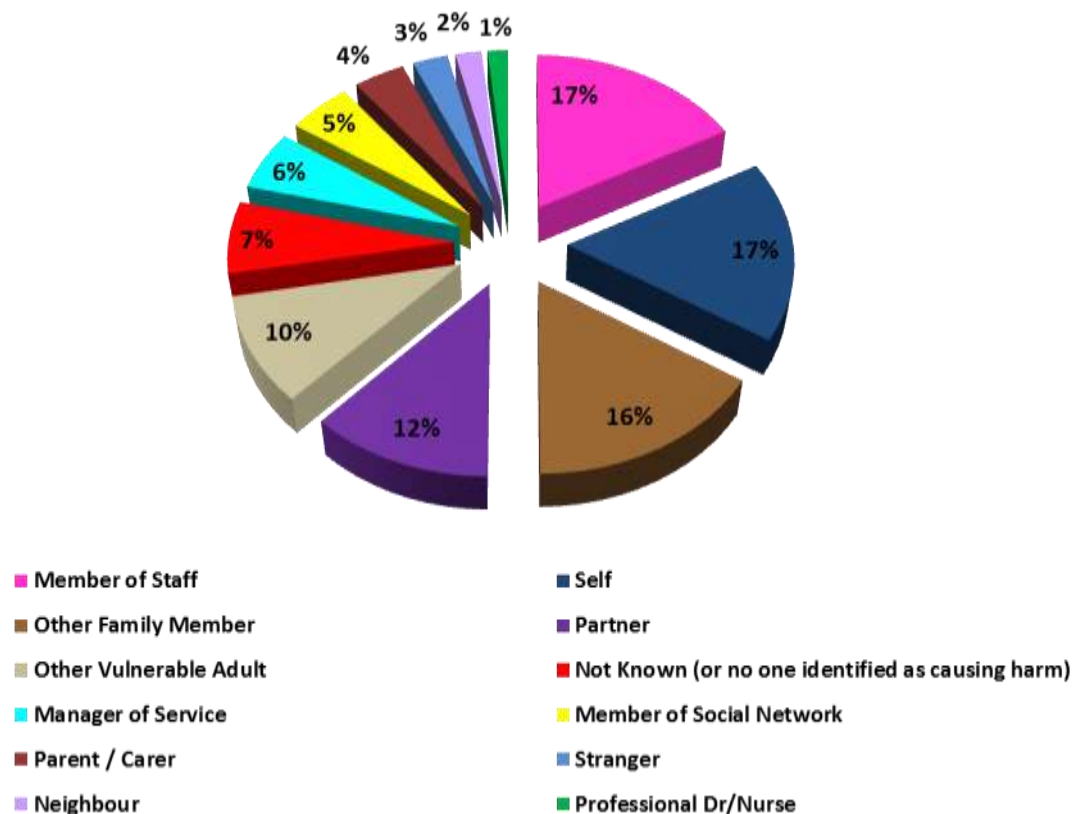
This referral was also unnecessary and should have been recorded in the home's incident book. It is clear that it does not meet the criteria for safeguarding as no abuse or neglect was suspected and the risk of abuse can be minimised by the home (e.g. by removing hazards and reviewing his care plan). The Home was asked to feedback to their company to review their reporting policy.

The LSAB are discussing how to ensure partner agencies need to be more accurate with raising safeguarding concerns. A number of the cases received by the ambulance service and the police are more around welfare concerns or are highlighting a need for a service for an individual they have been dealing with rather than identifying that abuse has occurred. Instead of sending such concerns to the safeguarding team, it would be more effective to go direct to the relevant care team via the Careline and request an assessment of care needs. Again, the inclusion of Self Neglect in to adult safeguarding has also had an impact on these figures. The ambulance service, the police and hospital staff are the main alerters for this type of abuse.

The number of concerns from a private hospital where there had been a high number of clashes between patients has reduced. The reduction on last year could be due to those alleged to have caused harm moving on. Also for part of the year, the Hospital have not been taking any new patients while making improvements on the service which has led to a reduction in the number of people receiving treatment there.

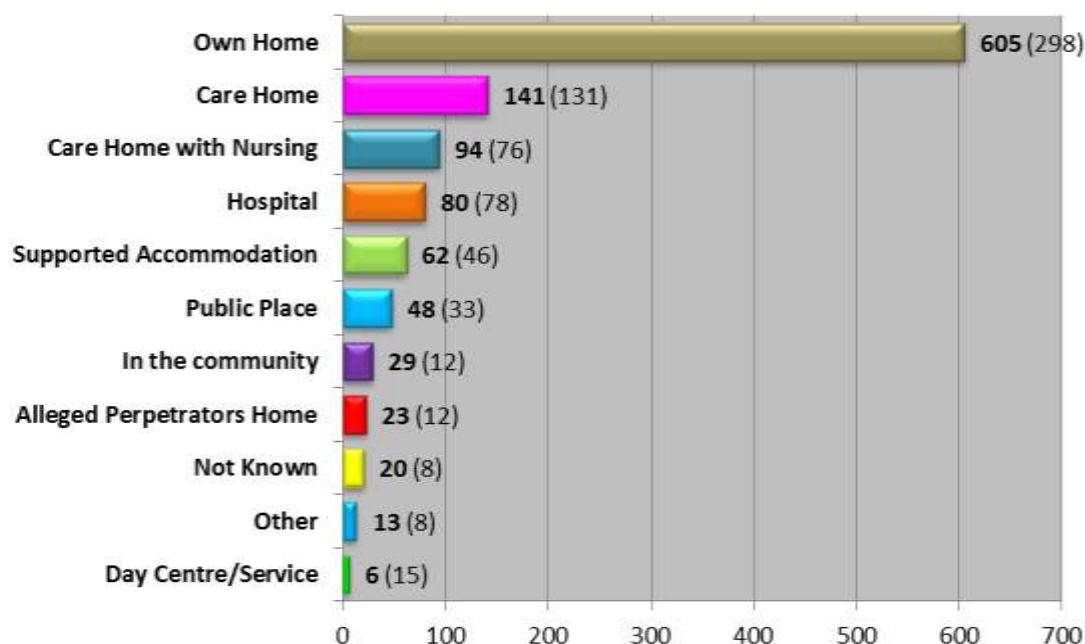
It is encouraging that there are some increases in concerns being raised by members of the public, GPs and services that do not predominately work with people with care and support needs.

Figure 7: Information on those alleged to have caused harm



It is difficult to compare these percentages with last year due to the inclusion of “self” within the chart above. Excluding “self” from the overall view of those alleged to have caused the harm, shows that there are no major increases in the percentages. “Other family members” is a 5% increase and there is a 2% increase in partners alleged to have caused harm. There is a decrease in allegations against staff (6%) however an increase of 4% where it is recorded that the manager of a service is responsible. This is often recorded in this way where a concern is expressed about service delivery and no individual member of staff has been identified as causing the harm.

Figure 8: Location of where alleged abuse or neglect took place



There has been a very large increase in the number of concerns about alleged abuse or neglect in people's own homes. The Care Act and improved awareness could account for some of this increase. Also a higher number of people receiving care and support in their own home may also have an impact as concerns could be picked up by visiting care workers and health care professionals (193 cases). Self neglect, which was not previously included in these figures, accounts for 114 of these cases. A high number of cases reported that physical abuse was suspected and in the majority of these cases, the person alleged to have caused harm were partners or family members, some of whom had caring responsibilities. Often these cases can indicate carer stress requiring a proportionate response, often a care service for the adult or an assessment for the carer. In some cases support from Domestic Abuse teams may be required, particularly if the person has expressed a view that they do not wish to pursue any further action. However, the safeguarding team need to continue to monitor these types of cases and ensure they consider a referral to the Multi Agency Risk Assessment Conference (MARAC) which can discuss strategies to minimise any risks to the alleged victim.

Case Study

Sid Jenks' daughter phoned the safeguarding team as she was worried that her mother may be physically abusing her dad, but has not witnessed anything or seen any evidence. Her mum is finding it stressful dealing with his Alzheimer's and her mental health is not good and she drinks. Sid's daughter arranged for respite to allow for some "breathing space". She did not want any action taken that could lead to a prosecution or anything that could exacerbate the situation. It was agreed that the safeguarding team would help to get support from the Adult Care team but also contacted their GP to monitor the situation but also to support Sid's daughter with initiating a care package.

Reports of neglect are also high and again those alleged to have caused harm were mainly partners and family members. About half of these cases progressed and most resulted in an assessment or a review of care needs. As adult safeguarding does need to take into account the views of the adult themselves (Making Safeguarding Personal), there are a number of cases that were pursued and the case closed as a result of the individual saying they did not want a safeguarding enquiry. There are also occasions where they have declined a care service as they felt they were able to look after

themselves. As long as the person was considered to have mental capacity to make such a decision and any risks assessed, in these cases the person would be provided with relevant information of where to get support should they feel the need in the future.

Enquiries

The Local Authority's duty with regards to adult safeguarding is to make or cause to be made whatever enquires necessary. For the cases that progressed to a safeguarding enquiry the following table shows who carried these out.

Care Manager/Social Worker (from SEQOL or AWP)	135
Adult Safeguarding Team	103
Wiltshire Police	58
Health Care Trust/Professional (For example the Hospital carrying out an enquiry)	52
Contracts & Commissioning (SBC team who monitor care services)	33
An Employer/Provider	37
Other (For example, another team or service within the Council)	8

In some cases it may have been necessary for a concern to have more than one agency to carry out the enquiry. For example one aspect may require a clinical investigation, while the Police consider if there is a criminal issue. In this case it would be recorded as a Police investigation which takes priority over other enquiries. In some other cases where there may be an equal responsibility to carry out an enquiry this has been recorded as "other".

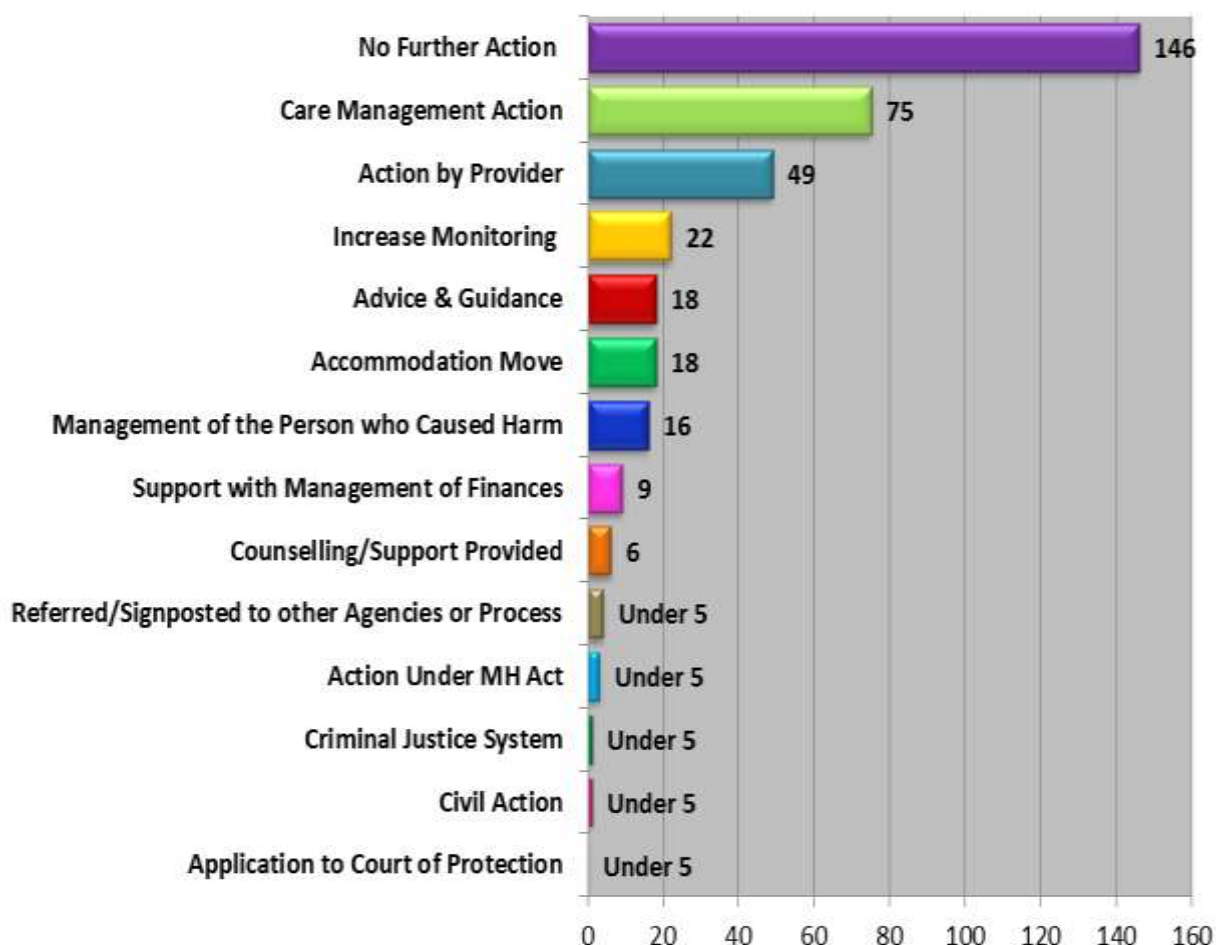
Outcomes of Investigations

In 2015/16 695 cases were assessed and did not progress through to a full safeguarding process. 491 of those required no further action (either because there was little evidence of abuse or neglect (or the risk of it) or the alleged victim did not wish to proceed or the alert was about a person who was not in need for care and support). 96 cases required care management input (a new care assessment, change to care plan or a review of their care). 58 were referred to another process, for example complaints action or action by the provider (e.g. disciplinary action). 50 alerts resulted in the individual being signposted to other services (for example Domestic Abuse team when the person did not have a care and support need, neighbourhood policing team to provide advice on home security, another local authority for when there has been allegations of abuse in another area).

426 cases progressed to a safeguarding investigation. From the information provided about cases progressed and concluded, the chart below shows the outcomes for the alleged victim by category. Nb. In some case more than one action was taken to resolve the case, however the chart below shows the primary outcome.

Overall for cases that have been concluded 149 cases were substantiated (fully or partially), 66 were inconclusive (although there may be no evidence to substantiate the concern, there may still be action required to minimise any risks in the future) and 88 cases were not substantiated. 74 cases ceased at the person's request. Again, in some circumstances there is a need to consider any risks that may still be present before closing a case or provide advice should the person feel at risk in the future.

Figure 8 Outcomes for the Adult at Risk



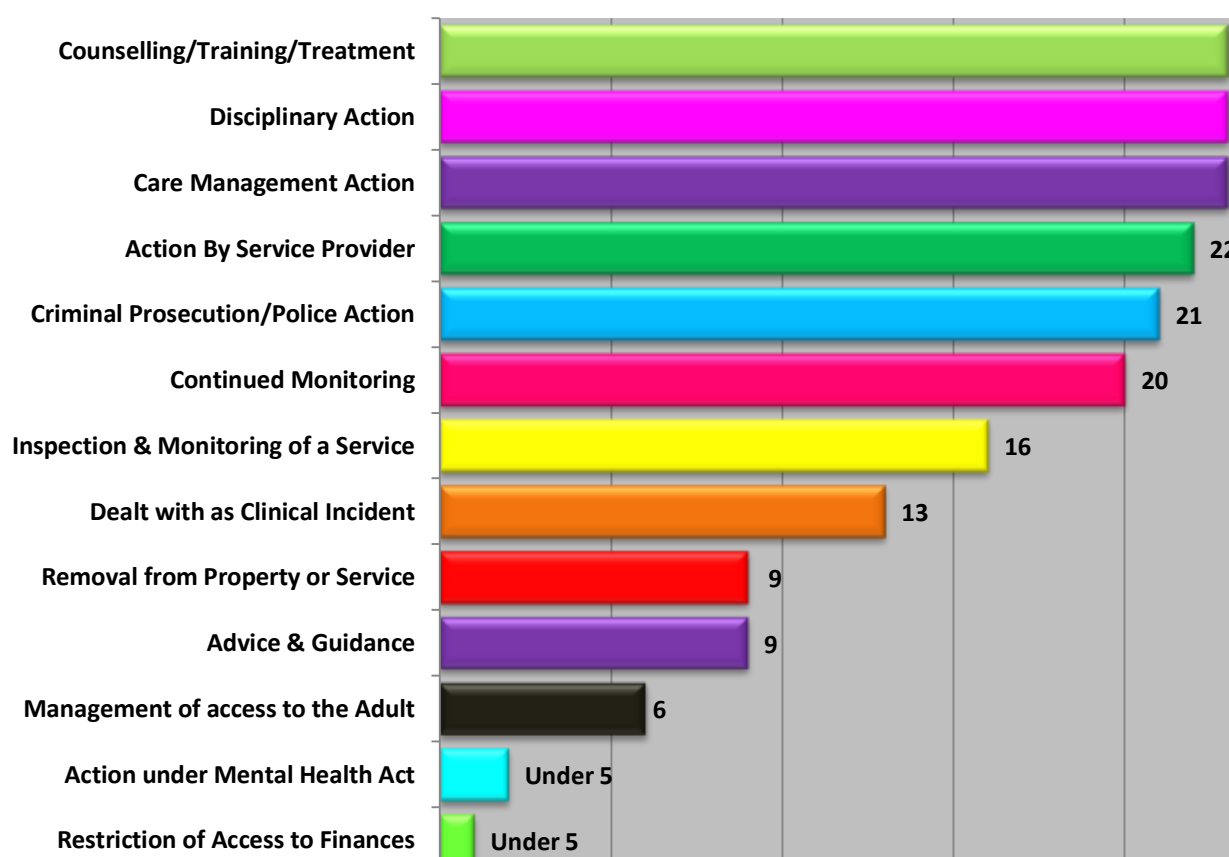
***NB at the time of reporting, 44 cases remained open. This is due to either the alert being raised towards the end of the reporting period and the cases are still under an enquiry or they are long term cases where it has been agreed that the case remains open to enable a continual review of the safeguarding plan.**

Where it states that there was no further action for the alleged victim, this may mean that the emphasis was on action required for the person alleged to have caused the harm, for example a care service for the person alleged to have caused harm. Sometimes during the enquiry the person decides they do not want action taken although initially they did.

There were 49 cases where action was required by the provider. This could include disciplinary action, action under their complaints procedure, staff training (or retraining) and changes to in-house procedures. Where dismissal could be a result of the action by the employer, a referral needs to be made to the Disclosure and Barring Service to consider inclusion on the “Barred List” which prevents the perpetrator working with “vulnerable adults” or children. Action by providers could also include changes to their procedures or even the environment to minimise the risk of further abuse or neglect.

The following chart provides an overview of the outcomes for the person or persons alleged to have caused harm. Again a number of the cases required no further action. This could be due to the alleged victim requesting no further action or that the action required focussed on the alleged victim (for example a review of their care plan). There are 15 cases that required Police action or are pending a criminal prosecution. Although these cases may be shown as closed, there may be a need for further work for the teams if the case requires action in the Courts e.g. support to give evidence.

Figure 9 Outcomes for the person alleged to have caused harm



As well as the outcomes listed above, there were 180 cases where there was no further action regarding the “source of the abuse or neglect”. As stated before, where there is no further action this could be because the emphasis is action required for the alleged victim or it could be because the person has requested that the enquiry ceases. In some circumstances although the person has expressed a wish that no further action is taken, other matters may need addressing to consider the welfare of others. For example a manager of a care home takes action that safeguards other residents in the home.

Safeguarding Adult Reviews

The Care Act also places a requirement on the LSAB to carry out Safeguarding Adult Reviews (SAR). These are when there is an adult in the area with needs for care and support (whether or not the local authority has been meeting any of those needs) and there is a concern how the Board, or members or other persons “with relevant functions” have worked together in safeguarding the adult and they have died and the cause was thought to be abuse or neglect. A SAR could also be required if the adult is still alive but has experienced serious abuse or neglect. There is also a requirement to include the findings from reviews completed during the year or that are on-going at the end of the year.

In 2015/16 there were no Safeguarding Adult Reviews completed, however there is one case that is currently being independently investigated about the standards of care delivered by a health care provider. This is still to be concluded and findings are to be shared with the Board.

Large Scale Cases

There were 2 large scale enquires during the year, that are still to be concluded. One is regarding a service where serious concerns had been expressed by the Care Quality Commission about the standards and safety of a small care home for people with Mental Health Issues. The other is around a high number of pressure ulcers that may have not been dealt with effectively and highlight a possible service delivery failure.

There was one case that was concluded which involved a Domiciliary Care Agency where there had been multiple complaints about missed visits and poor service delivery. There were concerns about how staff dealt with matters when service users rang the office to query missed or delayed calls. The enquiry concluded that whilst some of the concerns were not substantiated, a number of concerns were. Some of the service users chose to move to another agency but others were prepared to see if the service improved (they were keen to keep the staff they were used to). An action plan was developed and involved the Contracts and Commissioning Team in SBC to monitor improvements, whilst assisting the provider in making the required improvement. The provider was required to audit all their clients to consider their vulnerabilities and prioritise responses where there are difficulties in getting cover and ensure that the most vulnerable of their service users would be provided with a rota of named staff who would be visiting them to ensure consistency. All the service users who had been named in the initial concern had been contacted and where necessary had input from the Adult Care team to review their care package, assess any new risks and discuss other options should they have concerns about the standards of care. The service has since improved and no further serious concerns have been received. The service has since been inspected by the CQC and the report of the inspection stated that it still requires improvements though acknowledged that good progress had been made.

In conclusion, as reported in the last Annual Report, the LSAB are keen to monitor a number of areas:

- The overall increase in the number of concerns raised;
- (of those) the number of cases that required little or no action because they are inappropriate referrals which may indicate a lack of understanding of safeguarding among alerters and may take attention away from genuine concerns. The Quality Assurance Group of the LSAB are looking at individual cases but also where there appears to be a high level of concerns raised by a particular agency that does not lead to enquiries often because the concern did not need raising in the first place.
- How the widening of definitions within the Care Act Guidance impacts on referrals
- Last year the Board were concerned about the apparent low number of cases regarding people of working age with Mental Health issues, this has increased and is felt to be due to bring safeguarding into the local authority.
-

Areas of focus of attention for the Board next year:

- Further exploration of the reasons for the gap between concerns raised and those that require an enquiry so that these can be addressed and the gap reduced
- Identifying patterns from the data that may need a more focused approach such as specific agency issues, and the increase in alleged abuse or neglect in people's own homes
- Better understanding of the impact of self-neglect as a safeguarding category

SECTION 3

Progress, developments and news in 2015/16

Priorities for 2015/16

In previous annual reports, the priorities included in the LSAB Strategic Plan were listed and outlined how they linked to Government priorities highlighted in the guidance for the Care Act of Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability.

Empowerment - Actions: (Presumption of person led decisions and informed consent)

- *Wherever possible, the adult themselves is to be included in all stages of the safeguarding process.*
Within the new safeguarding team, Response Officers have been recruited to engage with the adult at the earliest opportunity. This is to help determine what action needs to be taken, by whom and when. This helps to apply principles included in a national initiative: *Making Safeguarding Personal*. As much as possible, key workers within SEQOL and AWP have been engaged to do this work, as they may have already developed a relationship with the person who is subject of the safeguarding concern and is likely to already have an understanding on how well the person will be able to engage. There is a Quality Assurance Group that looks at a sample of cases and considers how all of the government priorities have been applied – especially how empowered the person was.
- *Ensure that information is available to adults in need of care and support so that they know how to report abuse and neglect themselves.*
On-line resources and information has been updated. Printed materials have also been updated, however there is a need for these to be printed and distributed.
- *Publication of The Swindon Guide*
This has been produced and is a document given to service users going through the safeguarding process which contains an outline of what happens and gives contact information. There is a need to determine how well it is being used and how well it has been received by service users.
- *Development of a specific Adult Safeguarding (or LSAB) website and consider including a repository for “staying safe” advice for the general public.*
There is advice available on the “My Care My Support” Website; however, a specific Adult Safeguarding Website is still to be developed. This will be carried forward to the New Year.
- *Increase the membership of the Service User Forum.*
The Service User forum continues to operate and there is wider membership which has led to the possibility of wider representation on the LSAB.
- *Training for Enquiry Officers involved in safeguarding cases updated to include the emphasis on “Making Safeguarding Personal”.*
56 staff from SEQOL, AWP and the Local Authority attended these one day training events facilitated by Sally Watson from Awareness Training Ltd.

- *Enquiry Managers need to ensure that advocates are provided when there is a substantial need.*

Advocacy is provided by Swindon Advocacy Movement (SAM). The level of usage of the service is discussed at contract meetings. Overall their involvement is felt to be appropriate however those managing safeguarding cases need to continue to think about the need for advocacy throughout the process (not just at the beginning of it). They may also need to think differently when there are family members or friends involved, but it appears that they may not be able to represent the person who is subject of the safeguarding concern effectively. SAM has also joined the LSAB and report to the board on their work. The Chief Executive Officer of SAM also works directly with the Adult Safeguarding manager to discuss any issues that may arise between SAM and the safeguarding team and has developed an effective escalation policy which outlines action taken when there are issues about how the teams work together.

- *Information including annual reports and the Strategic Plan need to be available in easy read format.*

This is an area we need to work on more and it is recognised that the Board will need to secure resources to meet this requirement. The Strategic Plan has been considerably revised and will be available in easier to read format.

Protection – Actions:

- *Single Referral Point established within Adult Social Care.*

This was in place on 1st April 2015. There is a single phone number, fax number and email address to send concerns through to the team. There are dedicated admin officers who log concerns for consideration by Enquiry Managers, offer advice, provide admin support to the team and minute safeguarding meetings.

- *Establish team of Senior Quality Practitioners to act as Enquiry Managers for individual cases.*

There is now a dedicated team within Adult Social Care Services managing individual safeguarding cases. Senior Quality Practitioners assess and manage the cases ensuring engagement with the right people or agencies. They will liaise with Enquiry Officers from the relevant team who need to assist with participation in the process from the alleged victim or their representative. They can also help with information gathering particularly at the early stages of the concern being raised to determine the desired outcomes of the individual. If there is a delay in identifying a suitable Enquiry Officer or if the adult is not known to any services, there are Response Officers within the safeguarding team who can fulfil this role.

- *Quality Assurance Sub-group to undertake quarterly review of individual cases to evaluate quality of practice and outcomes.*

The Quality Assurance Sub-group has been established and looks at cases picked at random against the Government priorities as listed in the introduction of this section. More information on this group can be found on [page 46](#)

- *Involvement of the correct agency to carry out an enquiry following a safeguarding alert.*

The Care Act states that local authorities need to make enquires or ensure others do so. The safeguarding team are aware of this and depending upon the circumstances contact the appropriate service or agency to carry out the enquiry and report back to the team. A breakdown of who carried out enquires can be found on [page 18](#)

- *Encourage individuals (or their representatives) to provide feedback following the conclusion of the safeguarding process.*
This is an area that continues to require further work. Information is being collected about the views of the person when the case is closed by the safeguarding team, but it would be good to obtain more feedback following the case via an independent source.

Prevention - Actions:

- *Free awareness training provided for all staff who work with people with care and support needs.*
This continues to be provided on a monthly basis and for some groups, bespoke training maybe provided (e.g. to GP surgeries, to voluntary organisations). For the period covered by this report, 332 people have attended the basic awareness sessions facilitated by the Adult Safeguarding Manager. Some services prefer to provide their own or buy-in training from another training provider. All training now includes a section on the 6 Government priorities.
- *Safeguarding training provided for all private and voluntary sector managers.*
This course has now been commissioned and designed. It has been funded by the Wiltshire and Swindon Care Skills Partnership for managers and senior staff working care services in Swindon. The course will run early in the new financial year and is designed to help managers of services understand their role and responsibilities with regards to safeguarding adults, prevent abuse and neglect from happening and discuss safer recruitment of staff.
- *Ensure that safeguarding is a key consideration in the tendering and procurement process during the commissioning of all services.*
A self assessment process that prompts questions around commissioning services has been agreed by the LSAB. This has been trialled prior to further distribution.

Proportionality - Actions:

- *Establish LSAB Case Review Group.*
This has been established to look at requests for Adult Safeguarding Reviews, to decide on the method required and consider the scope of any cases requiring a review.
- *Proportionality to be included in training for all staff working with people with care and support needs.*
This is included in basic awareness training run by SBC to encourage appropriate alerts.
- *Case examples discussed at each meeting of the Board and Operational Group and included in LSAB Annual Report.*
This is a fixed agenda item in the Operational Group and some case discussions regularly take place at the LSAB.
- *The guidelines in the Policy and Procedures need to be changed to reflect the Care Act and requirements within the guidance.*
Policy and Procedures have been updated and work continues on updating guidance connected to the procedures. This has been a priority and new sections

have been agreed by the Board. However, since the last annual report, Wiltshire Safeguarding Board have made the decision to withdraw from the joint Swindon and Wiltshire policy and procedure. There is now a need to develop written Swindon only procedures.

Partnership Actions:

- *It has been agreed that a Risk Enablement Pathway which includes the creation of a multi-agency Risk Enablement Panel should be established in Swindon to work with adults*
This is now in place, more details on its progress can be found on [page 26](#).
- *Information Sharing Protocol to be developed and agreed in partnership with Local Safeguarding Children's Board.*
This has been developed and agreed by the LSAB. However, it has not been possible to develop a single protocol to cover the needs of the LSCB also.
- *Resourcing the Board. Care Act Guidance (section 14.113).*
Some progress has been made and One Swindon Board match funding has been agreed. However, there is still work required to resolve this to secure funding from other partners.
- *Learning and Development needs to reflect emerging case law, practice and changes to national, regional and local guidance.*
Safeguarding training modules relevant to job roles have been updated to include the Care Act and its guidance. Case law in regards to the Mental Capacity Act is also included in safeguarding training where it is relevant. Practitioners working in this area, especially if they are Best Interest assessors, attend regular legal updates.
- *Ensure that links are maintained and developed with Community Safety Partnership, Health and Wellbeing Board, LSCB, Domestic Violence Steering Group, Trading Standards, services involved with human trafficking / modern slavery / sexual exploitation.*
This is an ongoing work and membership of the LSAB has been reviewed in light of this (for example, Trading Standards manager has joined the Board). The LSAB continues to link with the Domestic Abuse Steering Group (being redesigned as Domestic Abuse Board).

Accountability Actions:

- *The Board to agree its position concerning the role of the Designated Safeguarding Manager for each member agency to comply with section 14.176 of the Care Act Guidance.*
This is no longer required as updated guidance (issued February 2016) removed this requirement following national feedback that the original guidance was "confusing and contradictory".
- *New Council Member training to take place.*
The Adult Safeguarding manager ran a session attended by 8 members in October 2015.

- *LSAB to be aware of increase in activity as a result of changes to definition e.g. undertaking enquiries where adults are “at the risk of abuse or neglect” (i.e. not just a victim of abuse).*

The LSAB has regular reports on activity and has expressed concern about the number of referrals received that appear to be inappropriate.

Also to be made aware of any challenges to decisions where cases are not progressed or where the adult themselves feel their privacy has been breached by agencies raising such concerns

There have been a few occasions where the person raising a concern has challenged decisions made by the Safeguarding Team. These have mostly been resolved in direct discussion with the person. Sometimes agreement has been reached that the matter raised will be monitored. There have been no complaints with regards to breaches in privacy, however from time to time, when contacted by one of the response officers from the safeguarding team, they have been met with some dismay from those unaware that they are subject to a safeguarding concern. The skills of these officers come into play to alleviate any anxiety.

- *To assist with the accuracy of reporting and to help simplify how information is recorded. Adult Services to commission a more up-to-date care management recording system with a detailed safeguarding module*

This is still outstanding but the intention is still to have a new care management system and work has been taking place to agree the most suitable product.

- *Ensure that training for those involved in co-ordinating and investigating cases is relevant and up to date.*

All enquiry managers have received the updated training for those coordinating cases during the year.

RISK ENABLEMENT / MANAGEMENT PANEL

In [last year's annual report](#), the details of a Case Review concerning an adult who committed suicide was included on page 20. The review highlighted a need for a more coordinated approach when dealing with people who have chaotic lifestyles and the need for “a recognised and understood multi-agency framework for case planning and decision making in Swindon leads to inconsistent and reactive practice; resulting in inconsistent and ineffective support to vulnerable people”.

In response to this, the partners within the Local Safeguarding Adults Board agreed to the development of a multi-agency risk assessment process to ensure effective case planning and decision making in relation to adults with multiple needs who do not reach the threshold of Adult Safeguarding investigations. Funding to develop this was obtained from the One Swindon Board.

The panel has now been developed together with an agreed pathway. The multi-agency process will only be enacted when all other interventions have not produced an improvement in outcomes for the individual of concern. The role of the Risk Enablement Panel is to facilitate, develop risk management plans and monitor their effectiveness.

The Objective of the panel is to:

1. To share information to identify, clarify and agree on risk
2. Promote safety and wellbeing of high risk adults in Swindon
3. Improve multi-agency communication pathways

4. To utilise the resources in Swindon more efficiently
5. To develop Risk Management Plan
6. For those who are not engaging, co-ordinate a risk management plan to seize the opportunities that can enable engagement and/or monitor the well-being of the person e.g. outreach opportunities, support from the community and locality input.
7. Ensure any actions are covered by a legal framework or is lawful
8. To improve agency accountability
9. Identification of a lead/key worker
10. To share risk across agencies
11. To consider options that will enhance the range of possibilities available to professionals to improve the outcome for the individual.

There is a steering group that has agreed the criteria for cases that can be put forward to the Risk Enablement Panel. The person concerned would be deemed to have mental capacity (as different processes would need to be put in place if some lacked capacity). It panel is for those:

- Who are at risk due to severe self-neglect/self-harm;
- With risk taking behaviours;
- Who are change resistant;
- Who refuse to engage with services;
- Who have experienced abuse by a third party but are not willing to engage in the safeguarding process or with services;
- Who are not willing to engage with eligible services;
- Who are 'frequent callers' to services; and
- Where the agency is struggling to maintain a high risk situation as a single agency.

The panel has been involved in 5 complex cases since January 2016 and in the main these have been well attended and have given agencies the opportunity to share concerns and ideas. In 2 of the cases positive solutions have been found, but for the others the work is on-going and may require some long term work.

Areas of focus of attention for the Board next year:

- Better understanding of the impact of self-neglect as a safeguarding category
- Learning from SARs or other cases both nationally and regionally as well as local in order to establish best practice in safeguarding
- Assurance that the Care Act principles underpin all practice across agencies and that Making Safeguarding Personal is embedded in the practice of all practitioners
- Working towards wider engagement and awareness amongst community groups

SECTION 4

Swindon Mental Capacity Act Programme

A joint initiative with Swindon Borough Council and NHS Swindon (CCG)

Our service and what we do: our programme is concerned with the promotion of good application of principles and practice in the use of MCA and the implementation of updated legal frameworks that protect vulnerable people where they are deprived of their liberty in whatever setting. At the time of the House of Lords scrutiny of the use of MCA in 2014, the Minister of State in the Ministry of Justice, Lord Faulks stated that “the failings at Winterbourne View were completely unacceptable, and use of the Mental Capacity Act there was poor, if not non-existent. The Government strongly believe that better implementation of the Act will greatly reduce the likelihood of a future Winterbourne View situation.” Now a key line of enquiry, CQC state that “During our inspections, we will assess how well providers are using the MCA to promote and protect the rights of people using their services”. Our concern is to support how these aims are put into practice to reinforce the protection of adults in Swindon who may be in need of care and support.

Our programme: We provide information, advice and, where appropriate, support in complex cases, for operational staff within services commissioned by Swindon Borough Council and Swindon CCG. We continue with a monthly programme of well-attended generic and bespoke learning and development workshops across all sectors in Swindon and the range has steadily expanded: for example, we have had sessions with Shared Lives, SBC Sheltered Housing Officers and with drugs and alcohol services.

We manage the DoLS service on behalf of the Council and our team has increased in response to landmark case law in 2014 known as ‘Cheshire West’ which asks local authorities to extend the protection of these frameworks to people wherever they are living.

We have a role in supporting applications to the court of Protection in a range of contexts and work closely with Swindon Legal & Democratic services. The demand in issues of best interests, challenges to DoLS Authorisations and applications for individual judicial authorisation in community settings (known as “Re X” procedure) is growing and we are engaging in more work in transitions settings where young people move from children’s to adult services.

We host the MCA Steering Group and aim to strengthen this partnership working to achieve increased partnership in the implementation of MCA and deprivation of liberty protective frameworks (linking in with safeguarding arrangements where necessary).

Deprivation of Liberty Safeguards: whilst proposals for the reform of DoLS are due in December 2016, we continue with the implementation of the present frameworks and expect this to do this in 2017. Our referral statistics below reveal the significant increase in referrals as we work as an Authority to promote compliance in protecting adults across all services. We triage referrals to enable us to direct our resources where they are most needed taking into account the impact of their circumstances on each individual. We have active partnership arrangements with our Independent Mental Capacity Advocacy (IMCA) colleagues and with a range of assessors in statutory and independent settings which gives us good levels of knowledge, skills and values to respond appropriately to the assessment of service users including in specialist settings. The table also demonstrates how health settings are working to embrace the

use of MCA legal frameworks; as a result we have a quality improvement project underway with the Hospital (GWH)

Table 1: Swindon Deprivation of Liberty Safeguards Service referral rates from 2012-2016

SWINDON MCA/DoLS SERVICE: SUMMARY OF REFERRALS, 1 st APRIL 2012 – TO 31 st MARCH 2016									
Referrals in FINANCIAL YEAR	CARE HOMES	NHS ACUTE HOSPITAL SETTINGS	NHS ACUTE HOSPITAL ITU	NHS MENTAL HEALTH UNITS FOR OLDER PEOPLE	NHS MENTAL HEALTH UNITS FOR ADULTS of WORKING AGE	INDEPENDENT BRAIN INJURY IN-PATIENT UNITS	INDEPENDENT HOSPITALS (OTHER THAN BRAIN INJURY UNITS)	REFERRALS THAT INCLUDED URGENT AUTHORISATIONS	TOTAL REFERRALS
1.4.2011 – 31.3.2012	48	7	0	4	0	0	4	35	63
1.4.2012 – 31.3.2013	64	6	0	4	0	0	3	34	77
1.4.2013 – 31.3.2014	60	19	0	0	1	7	0	46	87
1.4.2014 – 31.3.2015	420	117	0	21	1	21	4	441	584
1.4.2015 – 31.3.2016	711	269	0	16	1	8	1	690	1006

A deprivation of liberty: successive case law is clarifying our local authority responsibilities in relation to seeking individual judicial authorisations for people in a range of settings and this includes 16 -17 year olds. We have a series of initiatives in place to build on this whilst taking into account existing pressures on services.

This area of work is also leading to close working with families on these legal frameworks and, as with DoLS, as a local authority we developing resources and dialogues with families, friends and unpaid carers that reflect how MCA is about good and transparent partnership working with the service user's best interests at the core.

Court of Protection (CoP).

Appointeeships and Deputyships held by the Council:

The Borough offers these interventions as the organisation of last resort where a vulnerable person lacks the capacity to manage their welfare benefits (Appointeeship) or property / financial affairs (Deputyship) and has no social network available to take on either of these roles. Where managing money or possessions is at stake these interventions can be invaluable in the Safeguarding processes.

The downward trend in Appointee numbers has reversed slightly in this year, at the end of March 2016 there were 150 Appointeeships, this being 8 more than the previous year. Deputyships stood at 63, this being an increase of 12 since March 2015. The increase in Deputyships was predicted in last year's report and work continues to convert appointee cases that would be better governed by Deputyship.

SECTION 5

The Swindon Local Safeguarding Adults Board and its Member Organisations

1. The Board

In Swindon the body that oversees the work and implementation of the Policy and Procedures for Safeguarding Adults is the Swindon Local Safeguarding Adults' Board (LSAB), which during 2015/16 consisted of the following Members:

Independent Chair

Avon & Wiltshire Mental Health Partnership NHS Trust

Bristol, Gloucestershire Somerset and Wiltshire Community Rehabilitation Company (BGSW CRC)

Cabinet Member for Health and Adult Social Care

Care Quality Commission (annual attendance)

Dorset and Wiltshire Fire & Rescue

Great Western Hospitals NHS Foundation Trust

Healthwatch Swindon

Learning Disability Partnership Board

LSAB Service User Forum

NHS England South (South Central)

SEQOL

South West Ambulance Service NHS Foundation Trust

Swindon Advocacy Movement

Swindon Borough Council

- Board Director, Service Delivery
- Director, Public Health
- Adult Safeguarding Manager
- Head of Housing and Community Safety
- Board Director, Commissioning (DCS/DASS)
- Head of Commissioning
- Trading Standards

Swindon Care Homes Association

Swindon Clinical Commissioning Group

- Executive Nurse
- GP Lead

Wiltshire Police

The Board met on four occasions during the year where the following agenda items were covered:

- Update on Case Review (AB): meeting the family, publicity of the Case Review report, an update on the Independent Police Complaints Commission report and creation of the Risk Enablement Panel;
- Care Act compliance preparation around Information Sharing, Designated Safeguarding Adult Manager (DASM) and Resources for the Board;

- New Arrangements for Safeguarding: A team was set up within SBC to manage safeguarding directly as local authorities cannot delegate responsibilities to outside agencies under the Care Act;
- LSAB Strategy and Annual Report, including priorities for 2016/17;
- Consideration of a Case Review and notification of a Children Services Serious Case Review which may have implications for an Adult Social Care service user.
- Swindon and Wiltshire Safeguarding Policy;
- Reports with a Safeguarding element:
 - Mental Health Compliance Concordant;
 - Criminal Justice and Courts Act 2015;
 - MAPPA Annual Report; and
 - Dementia Report.
- Advocacy, IMCA and IMHA services for Safeguarding;
- Performance activity data and emerging themes;
- Quality Assurance: Outcome Performance Self-Assessment;
- Information Sharing Protocol; and
- National & Local Emerging Issues.

Each meeting also had an update from the Service User Forum and the Operational Group.

2. Board Member reports

The following are submissions from members providing an overview on their priorities regarding safeguarding:

2.1 Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Avon and Wiltshire Mental Health Partnership NHS Trust provides mental health services, including talking therapies, to adults of all ages, in the Swindon area who have a mental illness. The Trust has corporate and local Directors and a senior manager holding responsibility for delivering, developing and assuring safeguarding practice. The Trust has been a member and regular attendee to the Swindon Safeguarding Adult Board through 2015/2016.

The Trust has worked in Swindon to implement the key principles for adult safeguarding set out in the Care Act 2014 of Empowerment, Protection, Prevention, Proportionality, Partnership, and Accountability in both its safeguarding and clinical practice with service users and families in 2015/2016 by:

- Introducing modular guidance on adult safeguarding, incorporating the impact of the Care Act 2014 and Think Family principles
- Delivering and recording regular supervision to all staff, including safeguarding supervision
- Developing and extending access to Health Places of Safety
- Delivery of a Trust wide action plan on the Lampard Report recommendations (following the Savile Enquiry)
- Improving training rates, and delivering extended safeguarding training on domestic abuse and Prevent to practitioners
- Reviewing the Trust policies to reflect DBS and Care Act 2014 changes in relation to allegations management

- Actively supporting the support effective information sharing and access to Caldicott Guardian advice
- Undertaking a staff survey of adult safeguarding and MCA/DoLs
- Launching of the Trust-wide Safeguarding Supervision Tool.

The Trust also ensured that its staff and volunteers were trained to help safeguard people who were experiencing or at risk of abuse. The high level of staff trained to safeguard adults has been maintained, with 92% of staff trained at levels 1 and 2 (as of the 31/3/2016).

The Trust has developed further plans to improve safeguarding adult practice in 2016/17. The key planned objectives are:

- To further amend the RiO electronic report to ensure effective safeguarding recording and reporting, and management oversight
- To develop and implement a strategy for personalisation of adult safeguarding
- To develop guidance and support on sexual exploitation and modern day slavery
- To introduce an extended adult safeguarding and MCA service in the Trust, with locally focused Named Professionals
- To manage continuing increased demand for safeguarding activity, including safeguarding case management and enhanced safeguarding governance activity with safeguarding partnerships and commissioners
- To introduce a system for regular case audit of safeguarding adult cases to ensure compliance with regulatory, commissioning and LSAB policy and procedural standards

2.2 Dorset and Wiltshire Fire and Rescue Service

Wiltshire and Dorset Fire Services combined 1st April 2016 to form Dorset and Wiltshire Fire and Rescue Service and we remain committed LSAB partners.

Empowerment, Protection, Prevention, Proportionality and Accountability are best referred to via our new safeguarding policies and procedures which are available from the service's Safeguarding Coordinator which was put into effect following our merger. Key points to note are;

1. We now have a designated safeguarding role within the Service;
2. We are now in the process of developing bespoke training for all our Safeguarding Officers and Key Roles such as Safe and Well advisors (see below) and are developing e- learning packages on safeguarding for all staff.

With regard to **Partnership**, we now have a new head of Prevention and a significant part of their role will be around further developing our partnership working across both counties and also developing other community engagement projects such as SAIL (Safe and Independent Living) which is operating in the Swindon Borough and our Safe and Well programme, which includes teams of advisors identifying vulnerable adults in our community and providing advice, support and signposting. Additionally, organisationally, we are mindful of the risk of Post Traumatic Stress Disorder (PTSD) to our Operational Staff. We have now embarked on a programme called TRiM (Trauma Risk Management) which is an early intervention process that identifies employees at risk of or showing early signs of PTSD, then signposts them to professional support.

2.3 Great Western Hospital Foundation NHS Trust

The Great Western Hospitals NHS Foundation Trust (GWH) provides acute hospital services, (at the Great Western Hospital) and community health services across

Wiltshire. The Trust is committed to providing safe, high quality care and in the context of adult safeguarding, this includes:

- Providing leadership at all levels that builds on a culture of zero tolerance to abuse, neglect and poor care
- Ensuring our policy framework supports the national and local frameworks for adult safeguarding
- Ensuring our staff are appropriately skilled and knowledgeable in adult safeguarding.

The safeguarding structure at GWHFT has developed over the year with clear accountability to the Chief Nurse. There are now two safeguarding teams, one for the acute site and services, and one for community sites and services. Each is led by a senior clinician who works with a safeguarding lead who provides subject specialist advice and leadership to the Trust as well as to staff.

The highlight achievements within the financial year

- The appointment of a senior matron to lead the acute based safeguarding team.
- The approval of a Trust wide training strategy for safeguarding – ‘The Golden Thread’
- Development of a safeguarding database giving the Trust the ability to operate one system for the recording, reporting and analysis of safeguarding data
- Three audits led by the safeguarding teams on safeguarding, MCA and DoLs. These audits are informing the 16-17 audit plans and the Trust safeguarding work plan.
- The community services have developed a structure of Practice Influencers in all teams. This model adds resilience in terms of safeguarding specialist knowledge and guidance available to staff

Breakdown of figures for safeguarding adults staff training within the year

The chart below identifies the Trust wide level of training compliance in 2015/16. The generic Trust Mandatory training compliance threshold is 80%. GWH is currently compliant against this threshold.



Key plans or objectives for safeguarding adults on the Acute site and services in the coming year

- Further build on a culture where safeguarding is seen as 'everyone's business'
- Further development of processes and procedures to ensure that all patient facing contact actions are underpinned by the principles of the MCA (2005)
- To continue implementation of the Trust safeguarding adults at risk training strategy
- To further develop internal assurance in relation to Trust processes. The Trust safeguarding audit schedule will provide the evidence to drive forward any changes required
- Full utilisation of the safeguarding reporting system (Ulysses system)
- Explore the use of technology to promote and educate in relation to raising awareness and staff practices
- Increase opportunities for partnership working
- Undertake service improvement projects relevant to the safeguarding agenda
- Development of the safeguarding operational group to influence care delivery at ward and department level

Trust Strategic Vision

All health providers are required to have effective arrangements in place to safeguard vulnerable adults and to assure service users, carers, themselves, regulators and their commissioners that these are working. These arrangements include safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of Named Safeguarding Professionals.

The Acute Trust Safeguarding strategy aligns to these arrangements and the priorities of the LSAB, and strives to embed safeguarding across all divisions and in every aspect of the Trust's work.

2.4 Healthwatch Swindon

Healthwatch Swindon welcomes the opportunity and recognises the importance of having representation on this Board and the Children's Safeguarding Board, and being involved in the setting of the Strategic Plan for 2015-2018.

Safeguarding training forms a key part of our staff and volunteer induction. We plan in 2016 to host a safeguarding awareness session for new volunteers and extend this to include other third sector organisations based at the Swindon Advice and Support Centre (SAASC). Two Healthwatch Swindon volunteers also sit on the Safeguarding Service User Forum.

Healthwatch is the independent consumer champion in health and care, working to gather and represent the views of people who use health and care services. We listen to the views of local people about whether services are of sufficient quality to protect people's dignity and rights, that people know how to keep themselves safe and how to get help if they need it.

Healthwatch plans to conduct a number of enter and view visits in 2016/17. Trained and authorised representatives will visit publicly funded health and social care services in Swindon to see what is going on and to talk to service users, their relatives and carers, as well as staff.

Healthwatch Swindon provides an information and signposting service to the residents of Swindon. Our contract with Swindon Borough Council also includes the provision of independent complaints advocacy for NHS complaints. Work with individuals through that and other contacts with local people have and will continue to suggest on occasion that alerting is required.

Healthwatch Swindon takes its role of monitoring quality seriously and works closely with NHS and social care providers. Healthwatch Swindon comments on annual quality reports, is a member of the NHS England quality surveillance group and works closely with other neighbouring Healthwatch groups and as part of a national network. We have a place on the Overview and Scrutiny committees and the Health and Wellbeing Board where we continue to champion for high quality, safe, equitable and accessible services.

2.5 NHS England South (South Central)

NHS England (NHSE), as with all other NHS bodies has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children, young people, and adults in need of care and support. From a safeguarding assurance responsibility perspective, NHSE South Central team ensures it is appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding both adults and children, including effective mechanisms for LSCBs, LSABs and Health and Wellbeing boards to raise concerns about the engagement and leadership of the local NHS if indicated. This work is in line with the duties and approach set out within the NHS England Safeguarding Policy (2015).

The key challenge for the NHSE South Central Nursing team is satisfactorily servicing our geographical area with a limited resource of personnel. The South Central Area consists of 14 CCGs from Gloucestershire to Buckinghamshire. This effectively equates to eight LSABs (and twelve LSCBs) to meaningfully engage with. This is currently done via an informed risk approach based on regulatory ratings and CCG/Health representation, alongside any location of specific issues such as CSE or FGM concerns.

NHSE's structure and approach to safeguarding adults work

The NHSE safeguarding function for both adults and children is placed within the Nursing Directorate which holds an oversight role for Safeguarding, Quality and Safety and for Patient Experience across the South Central Clinical Commissioning Group (CCG) NHS System. During 2015/16 the team faced capacity restrictions due to an organisational restructure and delays in recruiting into key posts. In December 2015 a new Assistant Director of Nursing responsible for safeguarding was appointed and with the safeguarding lead gives increased capacity to deliver the required organisational functions.

Achievements within the financial year

During 2015, NHSE has updated and published a new edition of Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, and updated guidance on Managing Allegations against Staff. Our work contributes to public assurance that safeguarding services within the health system are subject to due oversight and direction. The dissemination of key learning, best practice directives and the benefits of professional networking and support contribute to the quality of health service safeguarding within the region.

Staff training for 2015/16

NHS England is not a patient facing organisation but has introduced a mandatory training requirement for all staff to complete a basic awareness course in safeguarding both adults and children. Safeguarding staff have trained at the appropriate level according to guidance which includes safeguarding adults, Mental Capacity Act and Prevent training.

Key plans or objectives for safeguarding adults in the coming year

National Priorities: (Requested further information about these items)

- Female Genital Mutilation
- Embedding Mental Capacity Act
- PREVENT
- Care Act 2014
- Modern Slavery
- Care in Care homes
- Quality and Safety of learning disability services

Local Priorities:

- Learning from SCRs & DHRs
- Safeguarding Boards presence
- Learning from the Primary Care Safeguarding Assurance audit

2.6 Public Health

Public Health have led and contributed to several areas of activity with regard to implementing the objectives of the LSAB. These include the development and implementation of the dementia strategy, with Public Health chairing the multi agency Dementia Steering Group. Safeguarding is fundamental to the work of this group. In addition, Public Health leads on the Suicide Prevention agenda and undertakes a review of each suicide in Swindon and shares the lessons learnt. There is a suicide prevention group established. Public Health also leads on the Substance Misuse Drug Related Death and Harm Reduction Group – this group investigates all substance misuse related deaths in Swindon and has established links with the coroner to undertake this work. The Adult Safeguarding Manager attends this group and considers if any cases discussed meet adult safeguarding criteria. Public Health has also contributed to the End of Life Care agenda that promotes the use of the end of life care plan which empowers individuals to make informed decisions and consent to care and prevents harm by protecting those most at risk at a particularly vulnerable point in life. This includes end of life care for those with substance misuse problems.

The Public Protection team have more direct links with the public through their environmental health work and have a full understanding of their responsibilities with regard to safeguarding adults. Their contribution to information sharing is key in protecting vulnerable adults particularly with the widening of the definition of adults who are supported through safeguarding arrangements as outlined in the Care Act.

Those most at risk include those who experience domestic violence and sexual abuse, and Public Health recognises the importance of safeguarding as fundamental within these agendas. Public Health commission the Health Ambassador, Befriender and Champions who during 2015-16 worked in localities to identify and work with those most at risk. These teams have a key role in the safeguarding process as do the Community Navigators, a project which uses a community based coaching and goal setting framework to support residents to manage their own long term health condition, encouraging self- care and increasing their confidence in living with their condition. This has not only improved people's quality of life but has resulted in a reduction in unnecessary visits to GP surgeries, hospital admissions and care/nursing home packages for some people on the programme.

Looking forward to 2016/17, Public Health will continue to champion and enable opportunities for strengthening knowledge, understanding and implementation of safeguarding procedures across the wider Public Health workforce.

2.7 SEQOL

SEQOL is an employee-owned social enterprise whose purpose is to support people to make the most of their lives. We provide a wide range of community and specialist services, which include Community Nursing, Urgent Care, inpatient care at our Intermediate Care Centre (SwICC), social work assessment and care management, and supported employment. At the year end, 71% of our workforce had booked or attended Safeguarding Adults training, and plans are in place for that figure to rise significantly in the first half of 2016-17.

The implementation of the Care Act 2014 on 1st April 2015 saw the management of adult safeguarding transfer from SEQOL to Swindon Borough Council. For the sake of continuity SEQOL teams managed a number of existing referrals through to closure, and now continue to fulfil the Enquiry Officer function whenever requested by the Borough's Safeguarding Team. This work is done primarily by social workers who are fully conversant with the Making Safeguarding Personal guidance and aim to ensure the response is always proportionate, inclusive and empowering (see case study below). SEQOL clinicians continue to use the defensible decision making tool to ensure they are upholding individuals' rights and freedoms at the same time as endeavouring to work with individuals to improve the choices in their life to reduce risk.

Case Study

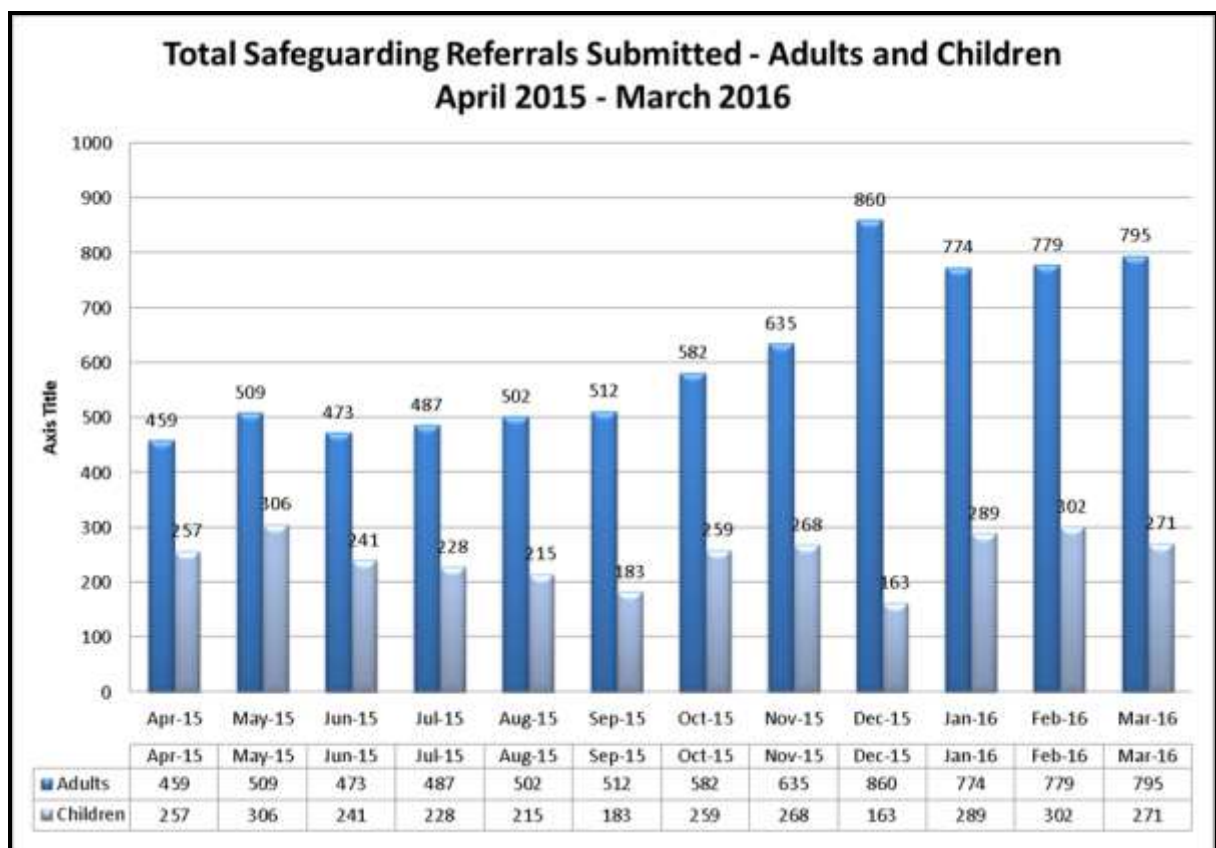
Miranda is a woman in her 60's who has a number of long term conditions and has had a stroke in the past. She lives in sheltered accommodation supported by a warden. A safeguarding referral was made by the warden pertaining to possible financial abuse by a family member. As one of the social workers had worked with Miranda recently, she was asked to act as the Enquiry Officer for the investigation. Over the course of the investigation, which lasted 3 months, the social worker visited Miranda on numerous occasions, ensuring that the safeguarding process was fully explained to her, ascertaining her desired outcomes, and ensuring that she had the opportunity to be involved throughout. Although the Police were made aware of the allegations, which appeared to be substantiated, Miranda decided she did not want to proceed with criminal charges. The social worker continued to work with her, involving an independent advocate and also arranging ongoing support with managing her finances. This enabled Miranda to continue her relationship with the family member, whilst empowering her to take back control and help keep herself safe from any similar abuse in future

SEQOL recognise that in order to deliver consistently high quality services, it is essential to embed learning from safeguarding investigations involving SEQOL employees and/or services, and to do so in an open and transparent manner. As an example, following a number of concerns relating to pressure ulcers, a Quality Improvement Plan has been put in place, one strand of which includes Assessment and Prevention of Pressure Ulcer training for all our clinicians. In addition, SEQOL has welcomed external specialist expertise in this area and will be participating in a comprehensive Audit of Wound Care which saw specialist nurses from the Welsh Wound Innovation Centre working alongside the Community Nursing Team during May 2016.

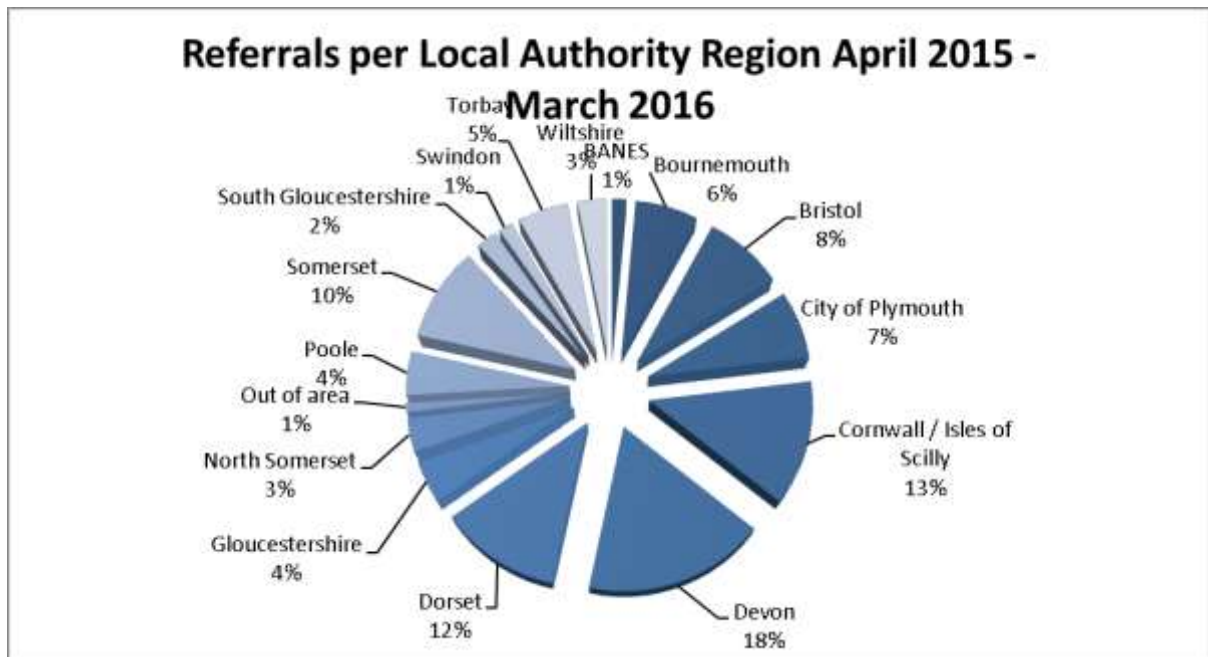
SEQOL remains an active participant of the LSAB sub-groups and welcome the opportunity these give to develop closer working relationships with all partners as well as improving performance in helping to keep the most vulnerable adults within Swindon free from harm.

2.8 South Western Ambulance Service NHS Foundation Trust (SWAST)

To give an idea of SWAST activity in Swindon, the Trust has made 44 adult referrals within the first 5 months of this year – Jan 1 – May 30 2016. Of the 44 referrals, 14 met the internal SWAST threshold for safeguarding and the remaining 30 met the SWAST threshold for welfare. Of the 14 safeguarding referrals, 3 were for Domestic Abuse, 1 for financial abuse, 2 for Neglect, 1 for physical, 1 for Prevent, and 6 for self neglect. The 30 welfare referrals included 19 for review of a care package, 1 for environmental issues, 1 for falls, 2 where a family member was unable to cope, 1 mental health, 2 quality of care, 1 self-harm, 1 suicidal, and 1 unable to cope at home. The Referrals are sent to Social Care, the Named Nurse, GP, Police or Fire, as appropriate. The total Trust safeguarding referrals for both adults and children are seen below:



Swindon (adult and child referral activity) accounts for 1% of the overall safeguarding activity in the trust. See graph below:



Overview

The SWAST Safeguarding Team provide advice, training, ad hoc supervision and support to all frontline and support staff across the trust area. There are 3 Named Professionals that individually cover each of the 3 trust localities. They each directly report to the Head of Safeguarding - Sarah Thompson. The Named Professional for the Swindon area is Simon Hester

Impact

Achievements this year

- Analysis and Review of Referral Process for efficiency and Demand Management.
- Development of a standardised audit tool to review 40 randomised cases.
- Risk assessment of the referral process.
- Delegation of whole team to triage role due to long term absence of the Triager.
- Positive feedback from 111 CQC inspections.
- IMR/SAR/DHR completed despite capacity issues.
- First module of the NHS England Safeguarding Leadership course at Taunton completed by Named Professional North (the area that includes Swindon).
- TOR and Workplan for NASG (National Ambulance Safeguarding Group) agreed March 2016.
- Managing Allegations Policy and Prevent Policy updated and agreed at Safeguarding Operational Group (SOG).
- PTS training quality assured and completed for all PTS (patient transport staff).
- Quality Assurance of community first responder Safeguarding Training
- Quality Audit of Referrals with the 111 Service

Future challenges

The fact that SWAST report to 30 safeguarding boards is a challenge in itself. It is a priority for the new Named Professional to build a relationship with the Swindon board.

The increase in referral rate reveals a steady growth over an 18-month period with a significant rate of growth in the last 5 months. The general growth rate is most likely explained by improvement in safeguarding awareness by operational staff, the ease of access to safeguarding referral processes through a new electronic recording system which is being rolled-out and changes in statutory duties (The Care Act). This has led to a greater demand on the safeguarding team to triage and process the referrals.

Objectives for 2016-2017

- Respond to the CQC Inspection on June 6th 2016
- Secure 2 seconded posts to permanent positions
- Increase the capacity of the safeguarding referral process

2.9 Swindon Borough Council – Housing Services

In 2015/16 there were 9 referrals made by Housing Officers and a considerable number of cases where support from Housing Services was required and provided. A senior representative from Housing Services sits on the LSAB Quality Assurance Sub Group and is able to consider whether cases being audited received the correct support through Housing Services. Housing staff continue to receive training in Adult Safeguarding and all Sheltered Housing Officers will be trained in the Mental Capacity Act.

As part of the Council's Adult Social Care change programme, a Housing and Adult Social Care Panel was established in June 2015. This panel was set up to discuss complex individual cases and the housing options available to them. The Panel has met fortnightly and has discussed over 40 individual cases. Of the 40 cases referred to the Panel, 30 of these have now been closed, a few have been withdrawn as circumstances have changed and a number closed with good outcomes for Housing, adult services and the individual themselves.

CASE STUDY

A tenant with learning disabilities living in a property managed by a registered social landlord for a number of years, was referred to the Housing and Adult Social Care Panel as there were concerns about her wellbeing while living in the flat. These were about the damp (caused by her use of a tumble dryer), her ability to look after herself and issues relating to her mobility. The panel was able to work together to ensure that a reassessment of her needs took place and suitable alternative accommodation was found that helped her maintain her independence whilst preventing her from self-neglect and future harm. The actions taken prevented the need for a referral to the Safeguarding Team and ensured a proportionate response to the concerns raised.

By being a key member of its steering group, Housing Services (particularly Homelessness) have had a major role in designing the Risk Enablement Panel ([see page 26](#)). Attendance at individual panels has helped to establish the local authority's housing responsibilities and developed strategies where there are concerns about people in high risk situations. Often concerns can be compounded by the individual's accommodation arrangements and a resolution can be found by improving this and ensuring a multi-agency approach to encourage stability in their living situations. Housing services can also provide some expertise with regards to the network of support within the community that may be available to help or monitor people who have chaotic lifestyles or are unwilling to engage with services.

2.10 NHS Swindon Clinical Commissioning Group

NHS Swindon CCG recognises safeguarding as a high priority for the organisation. In order to achieve this we ensure we have arrangements in place to provide strong leadership, vision and direction for safeguarding. Swindon Clinical Commissioning Group has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of adults and children at risk of abuse and is a member of the Swindon LSAB which has a responsibility to ensure that adults in need of care and support are protected from abuse and neglect.

LSAB Strategy 2015-2018

There are six principles on which the Swindon LSAB has based its newly agreed strategy for 2015-2018:

- Empowerment
- Protection
- Prevention
- Proportionality
- Partnership
- Accountability

Progress and Priorities for 2016/17

In order to meet the aims and outcomes of the Swindon LSAB strategy, during 2015/16 NHS Swindon CCG identified its roles and responsibilities against the six principles which are monitored via the LSAB, LSAB Operational Group, the CCG's Commissioning for Quality Committee and the Adult Safeguarding Quality Assurance Group.

The CCG is committed to meeting the requirements of the strategy via full implementation of key identified work streams, which has included:

Empowerment: As a member of the Quality Assurance Group, the CCG continues to contribute to a review of advocacy services to support alleged victims of abuse or neglect.

Protection: As a member of the Operational and Quality Assurance Groups the CCG has contributed to the evaluation of multi-agency working via planned joint audits with participation from relevant agencies.

Prevention: Safeguarding is a key consideration in the tendering and procurement process during the commissioning phase. All commissioned provider services have continued to be regularly monitored against compliance to safeguarding schedules, policies and procedures, with more detailed discussions held at the monthly/quarterly clinical quality review meetings (CQRMs).

The CCG has continued to work with safeguarding leads, partner agencies and commissioned provider service leads to ensure appropriate feedback is received and learning acted upon with regards safeguarding investigations associated with reported clinical incidents (such as avoidable pressure ulcers).

Outcomes, lessons learned and actions plans are shared and monitored to support a reduction in reported harm across the healthcare setting. Strong links have been established between the CCG Quality Team and Swindon Borough Council Safeguarding Team in order to share learning. This has supported collaborative learning and clarified outcomes by reducing duplication of the investigation process.

The CCG has reviewed and ratified the Safeguarding Children and Adults at risk policy during 2015/16.

All CCG staff (100%) have completed relevant mandatory safeguarding adults training.

Proportionality: The CCG has contributed to the requirements of a Case Review Group and Quality Assurance Group as led by the LSAB.

Partnership: The CCG recognises its obligations to the LSAB to provide appropriate resources and the need to maintain effective links with partner agencies such as the Community Safety Partnership and Health and Wellbeing Board. Engagement with domestic homicide reviews has highlighted actions for the CCG with regard supporting primary care and signposting to support services. As a result, the CCG is working in collaboration with NHS England to ensure a joined up approach to strengthening the safeguarding training agenda within primary care during 2016/17.

Accountability: During 2015/16 the CCG considered the need for a joint Designated Nurse / Adult Safeguarding Lead role. This followed a review of local structures and priorities, aligned to the Care Act Guidance and Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework. The appointment will be made in 2016/17 and will further strengthen the safeguarding agenda and provide strong leadership for meeting CCG duties and priorities.

2.11 Swindon Community Safety Partnership

Community Safety Partnerships (CSPs) have a statutory duty to work to reduce reoffending; to tackle crime and disorder, anti-social behaviour, alcohol and substance misuse; and any other behaviour which has a negative impact on the local community and environment. The CSP will continue to link in with the work of the LSAB and the agencies engaged with safeguarding adults at risk. There is a clear link between the work of the CSP team and the priorities of the LSAB.

There is a recognition that there is a need to ensure links are made in supporting victims of domestic abuse. Domestic abuse can be an issue where adults at risk live, particularly from adult children towards their parent or between couple who are both adults at risk. The Domestic Abuse Strategy Lead within the CSP is a member of the Operational Group of the LSAB and the Adult Safeguarding manager attends the Domestic Abuse Board. It is important that Safeguarding and the CSP continue to work collaboratively to reduce domestic abuse through the safeguarding procedures and through the safeguarding team utilising domestic abuse services to ensure perpetrators are managed effectively.

A new project has been set up to help victims of domestic abuse. This project supports victims of domestic abuse who attend their GP or Great Western Hospital. An Independent Domestic Violence Adviser (IDVA) works at GWH and an Outreach worker working across 6 GP surgeries. The IDVA has worked with 80 high risk victims in the last year. The referrals have come mainly from A and E and Midwifery, but also from Women's Services and general medicine. The Outreach Worker has worked with each surgery delivering training sessions with all staff and has worked with over 60 victims. The Outreach Worker is also running drop in sessions at the surgeries for anyone to access support in that way.

As over 30% of victims first disclose domestic abuse within health care settings, these new posts will ensure victims accessing health provision will be better supported and gain access to specialist DA services as needed.

Where there is evidence or reports that an adult at risk is a victim of anti-social behaviour it is essential that the CSP Team and the teams managing safeguarding

procedures continue to share information regarding alleged perpetrators or other adults at risk who are affected to be able to support investigations and to work with alleged perpetrators to modify or change their behaviour. There is now more of a focus on the risk to the victim now in Tasking Meetings, reinforced by the establishment of the Community MARAC.

There continues to be issues with County Lines (dangerous drug networks) in Swindon exploiting some of the most vulnerable people in our community. Following a Home Office review a strategic response to the problem is in place, overseen by the CSP Board. The tools and powers available through the ASB, Crime and Policing Act are being used to address the concerns, through civil injunctions and closure orders. In 2015/16 there have been 21 successful outcomes at Court.

The CSP team have been trained in Safeguarding vulnerable adults, and identifying the links between anti-social behaviour, domestic abuse and safeguarding. Some staff from Adult Social Care have attended the Honour Based Violence, Forced Marriage and Female Genital Mutilation Awareness course commissioned by the CSP.

CSP and Housing has also been training staff on WRAP (Workshop to Raise Awareness of Prevent) and many have also been trained to deliver the training across SBC. The WRAP training is designed to safeguard people at risk of radicalisation. This training links in to the work of the Prevent Board and Channel Panels, which are led by CSP.

2015/16 has seen a direct link between Adult Safeguarding and CSP with the Risk Enablement Panel (REP - see [page 26](#)) and work on Modern Slavery and Human Trafficking.

Case study

An example of the success of the collaboration between CSP and Adult Safeguarding at REP was the granting of a Civil Injunction against a person who had been misusing emergency services and abusing staff and patients. The case was prepared by the CSP team after interviews and statements were taken across the South West and support for the action garnered from partners, some of whom had never been involved in such an action. The REP process also saw the award of the first Criminal Behaviour Order in Swindon and Wiltshire.

The work done between Adult Safeguarding and CSP has seen a change in strategy by Wiltshire police in their planned response to Modern Slavery and Human Trafficking with a more robust and ultimately more supportive process for victims of trafficking. The newly established pan-Wiltshire Anti-Slavery Partnership Victim Services Tactical Group was established through the work between Adult Safeguarding and CSP and is chaired by the CSP team leader.

2.12 Swindon Advocacy Movement

To implement the LSAB Strategy, Swindon Advocacy Movement has embedded the 6 principles enshrined within statutory guidance on Adult Safeguarding.

Empowerment: Every client has an advocacy plan and during the course of any safeguarding process we ensure the adult is central to the decision making process in

accordance with the 'Making Safeguarding Personal' approach. We will enable adults to:

- recognise, weigh up risk and protect themselves from abuse.
- understand their rights
- find resources and confidence needed to take action.
- understand safeguarding enquires including roles and responsibilities.
- have their voice heard.

We are members of the Service Users Safeguarding Board enabling users to inform decision making.

Prevention: All advocates and staff are trained to see signs of abuse and how to take preventative action e.g. IMCAs visiting Care Homes are trained in recognising signs of poor care before it becomes abusive. We run Staying Safe programmes informing service users of the importance of protecting themselves from abuse e.g. staying safe whilst using public transport. We inform members about participating in Swindon Safer Places scheme.

Proportionality: Our induction for advocates includes SBC Safeguarding and MCA/DoLs training. Advocates are equipped and supported to develop reflective practice and respond appropriately to safeguarding concerns through supervision, and will:

- promote the least restrictive options available to manage risks to individuals
- enable users to explore solutions and take into account their preferred outcomes
- weigh up appropriate and proportionate responses to the risks before making decisions
- deal with serious cases of abuse appropriately.

Protection: At SAM everyone knows they have a duty to report safeguarding concerns and can take appropriate action to report abuse, neglect or poor practice following clear reporting processes. All staff and volunteers have knowledge of different types of abuse and watch the accessible DVD 'Abuse is Bad' which gives clear examples. We have a whistleblowing policy enabling staff or volunteers to report concerns to senior management or to SBC, if needed.

Partnerships: Our Advocacy Engagement Protocol and Safeguarding Escalation Procedure as agreed with the SBC Commissioner and the Safeguarding Manager, enables us to appropriately and effectively challenge decisions under the Care Act. Our clients are made aware of our Confidentiality Policy and only sharing what is necessary with other partners to protect people at risk of harm. We have worked closely with local community partners with clients at risk e.g. ISIS women's centre, Swindon Drug and Alcohol service.

Accountability:

We work in line with the requirements of the Care Act and MCA and DoLs and follow the Policy and Procedures for Safeguarding adults. We have systems in place to identify, record, track and monitor outcomes of safeguarding issues which include case notes. SAM has up to date Adult Safeguarding Policy and Procedures in place with an easy read version available for service users. We meet and discuss safeguarding data every quarter with the Adult Safeguarding team and discuss any concerns, review working practice and share learning.

During 2015/16 Swindon Advocacy Movement worked with 64 cases under The Care Act and The Mental Capacity Act.

Case study

Sally needed to make a decision about moving to a new house with her friend whom she has known for 15 years. Sally's family raised a safeguarding alert because they were worried that undue pressure was being put on her to move either by her friend, his family or other people Sally lives with. An Advocate from SAM made recommendations to assess Sally's mental capacity to make this decision as this was also under question. This ensured Sally's rights were upheld. She was deemed to have capacity and the advocate ensured Sally was central to the decision making process. The advocate and Sally looked at weighing up the risks of the decision in question and the consequences of each option, taking into account Sally's preferred outcomes. She was made aware of who was involved and their responsibilities, was given the opportunity to prepare for meetings and the advocate supported Sally in the meetings to enable her voice to be heard. The advocate was able to liaise directly with appropriate professionals and the safeguarding case was closed with action taken from the safeguarding team to ensure Sally was given the opportunity to make an informed, independent decision.

2.12 Wiltshire Police

Safeguarding Adults Investigation Team (SAIT)

Wiltshire Police are fully dedicated to preventing, investigating and detecting abuse against adults in need of care and support. We have a dedicated Safeguarding Adults Investigation Team, which is made up of Detective Inspector, Detective Sergeant and six investigators. This team covers the whole of Swindon and Wiltshire, and investigates any significant abuse/risk of harm by carers, family, people in a position of trust, or fellow service users. In addition, we have a triage team based in Trowbridge, who are responsible for the receipt, review and allocation of all referrals. Strategy discussions are held by them, and they are the single point of contact prior to an enquiry. We work closely with The Local Authority and partner agencies to provide a high quality of service and safeguarding.

Since its implementation, Wiltshire Police have fully embraced Making Safeguarding Personal. Our investigations are victim led, and their wishes are ascertained at the earliest opportunity with the assistance of our partner agencies. All of the decisions that are made regarding criminal investigations have to be proportionate and lawful. The information and risk are continuously assessed in line with the National Decision Making Model. Our partner agencies form an integral part of the decisions made and all rationale is fully documented within meeting minutes, and Police investigation logs.

SAIT officers provide regular training internally and externally in relation to the Care Act 2014 and the Criminal Justice and Courts Act 2015. Presentations are tailored to the recipient and have been provided for Wiltshire Police Officers and Staff, Adult Social Care, Mental Health teams and Health Care Providers in the past year.

Neighbourhood Policing Teams have been working closely with Care Providers and also privately funded individuals within the community. They provide a valuable link with people that may not be known to Local Authority services,

Wiltshire Police are dedicated to continuing to provide a high level of service and improving any areas of work as necessary. This is a continuous process that is directed and supported by both the Chief Constable and Police & Crime Commissioner.

Case study

In February 2016 a carer pleaded guilty at Swindon Magistrates Court to the offence of ill treatment or neglect by a carer under the Criminal Justice and Courts Act 2015. The male carer dragged a service user across the floor which was captured on CCTV, resulting in injuries and significant distress to the service user. This case was managed by the Swindon Safeguarding Team and the enquiry lead by Wiltshire Police. A Community Order was received including 200 hours of unpaid work, and fines to be paid. The perpetrator is now included on the Disclosure and Barring Service list which prevents him from working with vulnerable adults or children.

3. Sub-groups of the LSAB

Operational Group: The Operational group met on four occasions during the year, with attendance from the following agencies: AWP, GWH, SEQOL, SBC (Adult Safeguarding Manager, Commissioner OP & LD (Adults), Commissioner Supported Housing, Senior Commissioner Drugs & Alcohol, Domestic Violence Co-ordinator, Head of Policy, Senior Quality Practitioner), Swindon CCG, Wiltshire Police and BGSW CRC. The aim of the group is to carry out the work of the LSAB and to look at tasks and issues in greater detail and report back to the Board as necessary.

Agenda Items during the year included:

- New Arrangements and Development for Safeguarding: A team was set up within SBC to manage safeguarding directly as local authorities cannot delegate responsibilities to outside agencies under the Care Act;
- LSAB Strategic Plan;
- Swindon Clinical Incidents & Safeguarding Interface (the relationship between investigating clinical incidents and safeguarding);
- Risk Enablement Panel;
- Quality Assurance Sub-group update;
- Law Commission review of Mental Capacity and DoLs;
- Review of Additional Findings of the AB Case Review;
- LSAB/Safeguarding Website: Review of the planned structure for the site;
- Terms of Reference review;
- Review and agree updated sections of the Swindon Policy & Procedures Guidance in-line with the Care Act:
 - Information Sharing Protocol;
 - Safeguarding Adult Review Procedures; and
 - Agency Roles & Responsibilities.
- Revised Care Act Guidance: Safeguarding (Chapter 14); and
- Discussions about current cases of interest or complexity, which is seen as a valuable part of the role of the operational group.

Quality Assurance Sub Group: This group aims to check on the quality of cases managed through the safeguarding procedures. The group met on four occasions during the year and audited 16 cases in line with the six key principles which underpin all adult safeguarding work outlined in the Care Act (Empowerment, Prevention,

Proportionality, Protection, Partnership and Accountability), to ensure cases are handled appropriately and that the adult is involved throughout the process (engaging an advocate/IMCA as appropriate) and also ensuring the outcomes/wishes of the adult are taken into consideration. Actions are reviewed at every meeting and learning points and good practice are fed back to teams as necessary.

Membership of the group includes: AWP, GWH, SEQOL, SBC (Adult Safeguarding Manager, Head of Policy, Domestic Violence Co-ordinator, Supported Housing Manager, Senior Commissioner, Drugs & Alcohol, Senior Contracts Manager and Senior Quality Practitioner), Swindon CCG and Wiltshire Police.

Learning and Development Sub-group: This is a joint sub group with the Wiltshire Safeguarding Board. It was agreed to work jointly as many of the partners work in both local authority areas. Membership includes: the local authority leads, Wiltshire CCG, SEQOL, AWP, National Probation Service, GWH, Wiltshire and Swindon Care Skills Partnership, and Wiltshire Police and was chaired by the Healthwatch Wiltshire Chief Executive.

The purpose of the subgroup is to broaden ownership of best practice in safeguarding adults through monitoring the design and delivery of good quality learning and development provided across Wiltshire and Swindon. The group has a contribution to make to the delivery of the strategic plan for the LSAB. Members of the group find it a useful forum for sharing information about approaches to learning and development. Agenda items have included the revision of both boards' training strategies, discussions about the revised Safeguarding Capability Framework, learning from a recent Serious Case Review in Wiltshire and discussions about Care Act compliance.

Policy and Procedures Sub-group: This was a joint Wiltshire/Swindon sub group managed by the Wiltshire Safeguarding Adults Board. There were only 2 meetings held during the year as Wiltshire Safeguarding Board made the decision to withdraw from joint procedures with Swindon. Swindon hosted a Task and Finishing Group to prioritise guidance updates and also developed a joint Information Sharing Protocol, which was not adopted by the Wiltshire Safeguarding Adults Board

The decision to split was disappointing for the Swindon Board which has now developed its own Policy and Procedures Group. The aim of this group is to develop, review and revise policy in relation to safeguarding adults. It may also be called upon to consider policies that are not exclusive to safeguarding adults, but may have an impact on people supported by safeguarding procedures. For example, it may be asked to consider Domestic Abuse procedures. The group has updated some sections of the guidance including: Allegations Against Staff, Agencies Roles and Responsibilities, agreed the Information Sharing Protocol and developed a Safeguarding Adults Review procedure.

Service User Forum: This continues to meet and the Chair of the Forum has been working hard to widen the membership. New members have attended showing a great interest and commitment. The Service User Forum met on 4 occasions during the year and agenda items included:

- Visitors:
 - Swindon Women Aid
 - AWP
- LSAB update

- Care Act 2014 update
- Safe Places Scheme update
- Case Review (AB) update
- Safeguarding and Services of Concern update
- Domestic Abuse
- SUF Vice Chair
- Met the new LSAB Independent Chair
- The Criminal Justice and Courts Act 2015
- The Serious Crime Bill and Coercive Behaviour
- Membership Recruitment
- Disability Hate Crime update
- LSAB Website: review of the planned Service User page

Case Review Sub-Group: The Case Review group met on two occasions this year to consider a request for a Safeguarding Adult Review. The case was very complex and required extra time to obtain records before it was able to reach the decision that the case did not meet the criteria for a Safeguarding Adult Review. Also Terms of Reference for the Group were developed and agreed. The membership of this group includes SBC, the Clinical Commissioning Group, GWH, Wiltshire Police, SEQOL, AWP, and the Probation Service. (Should any cases need to be presented in relation to a particular service, that service would not be invited to participate in the meeting).

SECTION 6

Priorities for 2016/17

One of the statutory requirements for the Board as a result of the Care Act is to produce a Strategic Plan. Whilst one was produced in 2015, it concentrated on the development of the Board and applying the statutory framework required as a result of the Care Act. Much of what was required was achieved and the LSAB agreed to develop a new 3-year Strategy. Again, this is linked to the 6 Government priorities:

Empowerment - Presumption of person led decisions and informed consent;

Protection - Support and representation for those in greatest need;

Prevention - It is better to take action before harm occurs;

Proportionality - Proportionate and least intrusive response appropriate to the risk presented;

Partnership - Local solutions through services working with their communities.

Communities have a part to play in preventing, detecting and reporting neglect and abuse; and

Accountability - Accountability and transparency in delivering safeguarding.

These are the Strategic priorities and how they link to the government priorities are in brackets after each action:

Strategic Priority 1

Effective Governance

We will develop the capacity of Swindon LSAB and its infrastructure to effectively deliver the core functions of the Board to help keep adults with care and support needs in Swindon safe

We will do this through:

- Developing links with other key partnerships and identifying areas of commonality and governance arrangements - particularly the Health and Well-Being Board, the LSCB, and the Community Safety Partnership **(Partnership)**
- Ensuring the Board is sufficiently resourced to undertake its responsibilities **(Partnership)**
- Introduce an induction programme for new Board members **(Partnership, Accountability)**
- Develop a risk register for the Board **(Accountability, Prevention, Protection)**
- Review the membership of the Board and its sub groups, and monitor attendance at Board meetings **(Partnership, Accountability)**

Strategic Priority 2

Performance and quality

We will ensure that there are effective multi agency quality assurance and performance management processes in place which will promote the welfare of adults with care and support needs and will hold partners to account

We will do this through:

- Explore the safeguarding risks in Swindon relating to known vulnerability particularly learning disabilities, self-neglect, domestic abuse, radicalisation, hate crime, and trafficking/modern slavery **(Empowerment, Protection, Prevention, Proportionality)**
- Developing a multi-agency quality assurance process and reporting system to the Board **(ALL priorities)**
- Commissioning a thematic review of inappropriate referrals by QA Sub-group with a view to increasing the proportion of enquiries that lead from concerns **(Proportionality, Protection, Accountability)**
- Identifying from audits and available data trends and research of adults in need for care and support who are or have been experiencing abuse or neglect (increase in physical abuse and abuse in people's own homes) **(Protection, Prevention, Proportionality)**
- Learning from Safeguarding Adult Reviews and Domestic Homicide Reviews **(ALL priorities (depending upon the circumstances))**
- Collecting service user experience, particularly in respect of making safeguarding personal **(Empowerment)**, and using this to drive practice improvements **(Empowerment, Proportionality Protection Prevention)**

Strategic Priority 3

Communication and engagement

We will ensure there is a consistent and co-ordinated approach to how the safeguarding message for adults is disseminated to all groups and communities in Swindon, and we will ensure that we engage adults and communities of all backgrounds and make up in the work of LSAB

We will do this through:

- Developing the website **(Empowerment, Protection, Prevention)**
- Increasing community awareness including using available opportunities to increase public involvement, and to engage media interest **(Empowerment, Protection, Prevention, Partnership)**
- Gaining, listening to and making use of the voice of service users and carers by acting on their suggestions **(Empowerment)**
- Developing the use of a safeguarding story at the start of Board meetings

Strategic Priority 4

Workforce development

We will ensure the workforce of all partner agencies has access to and has undergone robust training relevant to their role, and understand how to apply it to their role

We will do this through:

- Training particularly in respect of a consistent training package for providers **(Protection, prevention, partnership, proportionality, accountability)**
- Using feedback from referrals data with agencies to inform them of areas for improvement in understanding and safeguarding practice **(Protection, partnership, proportionality, accountability)**

Next Steps

- The Operational Group, on behalf of the Board, will draw up an annual business plan for 2016/17 that outlines how the strategic priorities will be delivered and the outcomes required to measure progress. This will be monitored by the group and reported to the Board throughout the year and will inform next year's Annual Report
- The Board will also produce a business risk register to underpin this strategic plan that will identify the key risks that have the potential to prevent its delivery

Glossary

AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BGSW CRC	Bristol, Gloucestershire Somerset and Wiltshire Community Rehabilitation Company
CCG	Clinical Commissioning Group
CoP	Court of Protection
CSE	Child Sexual Exploitation
CQC	Care Quality Commission
DASM	Designated Safeguarding Adults Manager
DASS	Director Adult Social Services
DBS	The Disclosure and Barring Service
DCS	Director Children Services
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
FGM	Female Genital Mutilation
GP	General Practitioner
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
IMR	Independent Management Review
ITU	Intensive Treatment Unit
LD	Learning Disability
LSAB	Local Safeguarding Adults Board
LSCB	Local Safeguarding Childrens Board
MARAC	Multi-agency Risk Assessment Conference
MCA	Mental Capacity Act
NASG	National Ambulance Safeguarding Group
NHS	National Health Service
NHSE	National Health Service England
OP	Older People
PTS	Patient Transport Staff
PTSD	Post-Traumatic Stress Disorder
SAASC	Swindon Advice and Support Service
SAIL	Safe and Independent Living
SAIT	Wiltshire Police Safeguarding Adult Investigation Team
SAM	Swindon Advocacy Movement

SAR	Safeguarding Adult Review
SBC	Swindon Borough Council
SEQOL	SEQOL (a Social enterprise providing health and social care and support)
SUF	Service User Forum
SOG	Safeguarding Operational Group
SWAST	South Western Ambulance Service NHS Foundation Trust
TRiM	Trauma Risk Management

The Safeguarding Adults in Swindon Annual Report 2014/15 is available on the Internet on [SBC Adult Safeguarding page](#) It may be produced in a range of languages and formats (such as large print, Braille or other accessible formats) by contacting the Customer Services Department.

Tel: 01793 445500

Fax: 01793 463982

E-mail: customerservices@swindon.gov.uk

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Implementation of the Special Educational Needs and Disability (SEND) Reforms

Health and Wellbeing Board

Date: 12th October 2016

Author:	Director of Children's Services, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 This report sets out to inform the committee of the new joint local area Special Educational Needs and Disability inspection under section 20 of the Children Act 2004.
- 1.2 From May 2016 all local areas in England will be subject to a joint inspection from Ofsted and the Care Quality Commission (CQC) to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

2. Recommendations

The Board is recommended to:

- 2.1 Note the arrangements for the forthcoming joint local area SEND inspection and monitor progress towards implementing our strategy to deliver better outcomes for children and young people with SEND in Swindon.

3. Detail

Background to the inspection

- 3.1 In April 2016 Ofsted and the Care Quality Commission published the framework for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities.
- 3.2 The inspection will review how local areas support these children and young people to achieve the best possible educational and other outcomes, such as being able to live independently, secure meaningful employment and be well prepared for their adult lives.
- 3.3 It is important to note that these inspections will evaluate how effectively the local area meets its responsibilities, and not just the local authority. This includes clinical commissioning groups (CCGs), public health, NHS England for specialist services, early year's settings, schools and further education providers.

Further information on the subject of this report can be obtained from Lyn Frith, 01793 463217, LFrith@swindon.gov.uk.

Implementation of the Special Educational Needs and Disability (SEND) Reforms

Health and Wellbeing Board

Date: 12th October 2016

- 3.4 During the inspection, inspectors will visit a range of providers to gather evidence, including nurseries, schools, colleges and specialist services.
- 3.5 If inspectors become aware of concerns of a safeguarding or child protection nature, they will make additional enquiries to satisfy themselves that such matters are being dealt with appropriately. If they remain concerned, this could include inspectors referring individual cases to the local authority or an inspection of the individual service or provider in line with Ofsted or CQC's duties and powers.
- 3.6 The starting point for the inspection is the expectation that leaders for the local area should have an understanding of strengths and aspects that require development.
- 3.7 To support local areas, assess how well arrangements are working, and compare delivery across local areas, the Department for Education has produced a local area SEND report which presents the statistics on SEND for Swindon and provides the opportunity to compare our performance with other areas.

Our self-assessment

- 3.8 Detailed self-evaluation has been an on-going process based on the local authority readiness survey of 2014, and is included in our strategic plan to deliver better outcomes for children and young people with SEND in Swindon.
- 3.9 The clinical commissioning group (CCG) governing body oversees the joint arrangements for SEND and the contribution of health. The CCG have undertaken a detailed self-evaluation and will present this to the SEND Strategic Board in September 2016. The improvement plan for the CCG will be overseen by the Joint Commissioning Group (JCG), reporting to the Health and Well-being Board.
- 3.10 The inspection framework and therefore our self-evaluation is evaluated under three headings as identified below. The areas for development are monitored through the Quality Improvement sub-group of the SEND Strategic Board, reporting through JCG to the Health and Wellbeing board. Through regular reporting to the SEND Board improvements have already been identified in a number of areas. Our strengths and areas for development will be kept under regular review every month and amended as appropriate. The key strengths and current areas for development are as follows under each heading.

3.10.1 Our effectiveness in identification of children and young people who have special educational needs and/or disabilities

Strengths

Further information on the subject of this report can be obtained from Lyn Frith, 01793 463217, LFrith@swindon.gov.uk.

Implementation of the Special Educational Needs and Disability (SEND) Reforms

Health and Wellbeing Board

Date: 12th October 2016

- Effective screening processes are in place to identify need in new-born infants
- Advisory teaching staff and educational psychologists help to ensure that children receive the support they need to be able to gain access to pre-school settings, nursery education and the Reception class in school.
- Practitioners who identify the need for additional support to help children access early-years settings can seek extra funding.
- The Special Education Needs Resource and Assessment Panel (SENRAP) contributes well to identifying and providing for the needs of young people who have special educational needs and/or disabilities.
- Assisted speech and language equipment provided to a child or young person travels with them to ensure access to the most appropriate equipment to support learning during their education and transition into adult life.
- The local area's 'early help' assessment process is a good example of joint working across the education, health and care workforce. Early help records are used effectively as part of the graduated response before a request is made for a statutory assessment of special educational needs.
- Integrated service delivery in early years has ensured timely and effective assessment of need. This helps to identify children who need referral to speech and language support and ensures that children receive in-depth assessment leading to early identification of their needs and health care.

Areas for development

- The percentage of pupils with a statement or EHC plan remains high at 3.8% compared to an average of 2.9% in all English unitary authorities. Plans are in place to understand why this figure remains so high and agree our strategic approach to reducing the % of pupils with a statement or EHC plan.
- Despite positive steps and recent improvements, there is still work to do to reduce the time that children and young people have to wait for their plan to be as short as possible and to meet the deadline for conversion statements to education, health and care plans by March 2019. In August 2016 we completed 84% of EHCP's within 20 weeks giving an average of 56% since January 2016. 44% of all conversions

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from statements to education, health and care plans have now been completed.

- Despite the clinical commissioning group recognising the need to undertake a review of children's health services, Swindon is struggling to meet the demand for referrals and diagnosis for autistic spectrum disorders (ASD). This has been prioritised by the CCG and waiting times have reduced.

3.10.2 Our effectiveness in assessing and meeting the needs of children and young people who have special educational needs and/or disabilities

Strengths

- Parents, carers and children and young people are involved in regular reviews. Co-produced plans mean that children are at the heart of the education, health and care plans.
- Access to high quality health services is well established within specialist resourced provision and special schools.
- Some good examples exist of joined-up working both within health teams and other partners. For example, the multi-agency unit based at Uplands learning campus.
- The existence of joint multi-disciplinary health clinics at the Saltway centre assist families understanding of roles and responsibilities and reduced duplication.

Areas for development

- Although the annual review process is sound if a re-referral is required, this can mean that needs are met too slowly. The policy, which outlines what happens when health appointments are missed, requires review to ensure greater flexibility when dealing with vulnerable children and parents.
- Staff changes and illness within teams' means that children and young people's needs are not met quickly enough. Changes to staffing arrangements are being explored to reduce the impact on children and families.
- Parents, carers and young people are not sufficiently aware of the role they could play in helping to shape the local offer and the mechanisms to do so. Providers and parent carer groups have a greater role to play

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in using the local offer as a medium to share information to access specialist services used by the local area.

- The local offer is not easy to navigate for some families. Some parents continue to be unaware of its purpose.
- Leaders from education, health and social care do not yet have an agreed strategy for sharing expertise and training staff to benefit children and young people who have special educational needs and/or disabilities. This limits the capacity of leaders to evaluate the impact of this work on pupils' outcomes.
- A single pathway to develop provision, particularly for young people aged 19-25 is still in development.

3.10.3 Our effectiveness in improving outcomes for children and young people who have special educational needs and/or disabilities

Strengths

- The impact and visibility of staff in specially commissioned named roles, in education and health, are having a significant positive effect on the progress of the special educational needs and disability reforms. Formal networking across education, health and social care has increased since 2014.
- The proportion of schools in the area that are good or better has risen in the last three years.
- The proportion of children and young people placed out of area as a result of their special educational needs and/or disability has reduced in the last three years.
- The % of children and young people with special educational needs and/or a disability who are permanently excluded from school remains below the national average.
- Most staff in education, health and social care accessed training on the special educational needs and disability reforms and understand their roles in implementing these reforms.
- Individual providers are aware of their responsibility to monitor children and young people's progress in a range of outcomes. Increasing numbers of children in the early year's foundation stage are meeting their developmental targets.

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- Robust checks are in place to monitor the pupils who are home educated, who have medical needs and are educated in hospital.

Areas for development

- Pathways for 19-25 year olds, to support young people into adulthood require further development. Transition is a strategic priority for the local authority and plans are in place to improve outcomes for young people as they prepare for adulthood.
- The progress of pupils who have statements or education, health and care plans and for those receiving support for special educational needs and/or disabilities is insufficient. In particular, the progress of pupils from key stage 2 to the end of key stage 4 continues to be below national levels for pupils compared with all pupils in English and mathematics.

Fixed term exclusions for children and young people with special educational needs and/or disabilities remain unacceptably high.

4. Alternative Options

- 4.1 There are no alternative options as all local areas will be inspected at least once during a five-year period.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 There are no financial or procurement implications arising as a result of this report.

Legal and Human Rights Implications

- 5.2 There are no legal and human rights implications arising as a result of this report.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 There are no other direct implications arising as a result of this report.

Diversity Impact Assessment

- 5.4 No Diversity Impact Assessment is required at this stage. Any DIA that is required will be identified at the appropriate stage.

Implementation of the Special Educational Needs and Disability (SEND) Reforms

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Risk Management

- 5.5 No risk management issues have been identified at this stage, any risk management issues will be identified at the appropriate time when a topic is under review by the Scrutiny Committee and if it makes any recommendations.

6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 The framework for the inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities.
- 7.2 DfE Local Area SEND Report - http://lginform.local.gov.uk/reports/view/send-research/local-area-send-report?mod-area=E06000030&mod-group=ADASSRegions_SouthWestern&modify-report=Apply.

8. Appendices

- 8.1 None.

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Oral Health Joint Strategic Needs Assessment

Health and Wellbeing Board

Date: 12th October 2016

Author:	Consultant in Public Health Medicine, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 The draft Joint Strategic Needs Assessment (JSNA) attached at Appendix 1 provides evidence to help us understand the oral health and wellbeing needs of people in Swindon. A healthy mouth is fundamental to our overall health and wellbeing. It allows us to speak, smile, kiss, taste, chew, swallow and cry. Oral diseases affects all ages and gender, but the burden of diseases disproportionately affects older people, people living with learning disability, people living in poverty, people with lifestyle issues, and those who are dependent on others for support.
- 1.2 Whilst significant improvements in oral health have been made, many adults and children still suffer from oral diseases. It is costly to the NHS and society. This JSNA is to inform the development of Swindon's Oral Health Strategy and to inform commissioning of oral health promotion services.

2. Recommendations

The Board is recommended to:

- 2.1 Note and approve the recommendations of the Oral Health Joint Strategic Needs Assessment, as set out in paragraph 3.11 of the report.
- 2.2 Support the development of an Oral Health Strategy for Swindon to be led by public health, and agree to consider this Strategy for approval once it has been developed.

3. Detail

- 3.1 More than one in twelve (7.9%) three year olds in Swindon experience tooth decay in a survey in 2013. On the average, these children have 2.21 (CI: 0.44-3.97) teeth that were decayed, missing or filled.
- 3.2 More than one in four (27.9%) five year olds in Swindon experience tooth decay in a survey in the 2014/15 school year. On average, these children have 2.8 (CI: 2.26-3.37) teeth that were decayed, missing or filled.
- 3.3 More than one in four (28.1%) twelve year olds in Swindon experience tooth decay in a survey in the 2008/09 school year. On average, 2.18 (CI: 1.84-2.53) teeth that were decayed, missing or filled.

Further information on the subject of this report can be obtained from Ayoola Oyinloye, 01793 444674, aoyinloye@swindon.gov.uk.

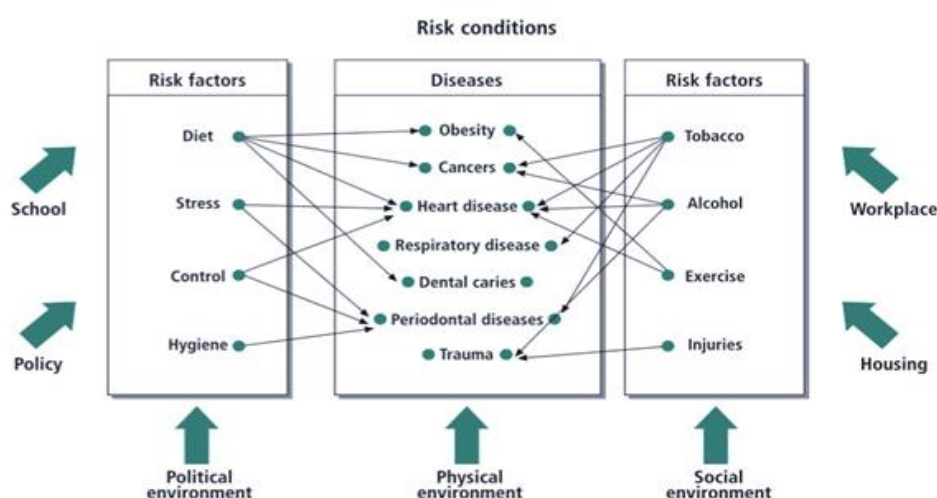
Oral Health Joint Strategic Needs Assessment

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- 3.4 Almost one in four (22%) Five year olds attending special support schools in Swindon experience tooth decay in a 2014 survey. On average, these children had 3.90 primary teeth that were obviously decayed, missing or filled. More than one in four (29%) of twelve year olds attending special support schools in Swindon experience tooth decay in the same survey. On average, these children had 2.37 permanent teeth that were obviously decayed, missing or filled. It is important to note that the sample size for this study is smaller than other DPHEP surveys and the differences are within the margins of error.
- 3.5 Data on oral diseases is less readily available for adults. An estimated 60% of adults have gum disease with around 11% experiencing severe disease, based on data from a national survey in 2009.
- 3.6 The prevalence and severity of tooth decay in Swindon is not significantly different to the rest of England.
- 3.7 Swindon is served by 26 dental practices providing NHS dentistry. All areas of Swindon are accessible by road and public transport to NHS dentists.
- 3.8 In 2011/12, Swindon had the second highest rate of admissions for tooth extractions in the South west. The rate of admissions has since fallen, similar to the rest of the Southwest.
- 3.9 Oral cancer incidence is relatively low in Swindon: 7.8 cases of oral cancer per 100,000 (age standardized rate) 2010-2012. Oral cancers are however an increasing public health problem.¹⁵ Incidence rates are rapidly rising and mortality is high and rising.
- 3.10 The determinants of good oral health are well understood and are similar to the determinants of other chronic diseases as shown in Figure 1 below.

Figure 1: Common risk factors to improving oral health



Further information on the subject of this report can be obtained from Ayoola Oyinloye, 01793 444674, aoyinloye@swindon.gov.uk.

Oral Health Joint Strategic Needs Assessment

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Date: 12th October 2016

- 3.11 The recommendations from the draft Oral Health JSNA (attached at Appendix 1) that the Board are being asked to note and approve are as follows:
- 3.11.1 Develop an Oral health strategy for Swindon.
 - 3.11.2 Tackle the causes of tooth decay in children and adults by reducing the consumption of sugar and alcohol and stopping the use of tobacco.
 - 3.11.3 Include oral health actions as the norm in strategies, programmes and services aimed at vulnerable adults and children, e.g. low sugar food policies, oral hygiene as part of individual care plans, signposting to NHS dental services.
 - 3.11.4 Review present commissioning oral health interventions, using both universal and targeted approaches, to help people keep their mouths clean, use fluoride to strengthen their teeth, increase awareness of oral cancer and visit the dentist regularly. There is an opportunity to do this now as the contracts for oral health promotion is up for renewal in 2017/18.
 - 3.11.5 Address the historical high rates of hospital admission for tooth extraction in Swindon, to ensure that all admissions are appropriate.

4. Alternative Options

- 4.1 Not commissioning oral health promotion. This is not a realistic option as oral health promotion is a statutory responsibility of Local Authorities.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 No additional financial implications identified at this stage.

Legal and Human Rights Implications

- 5.2 The Health and Social Care Act (2012) conferred the responsibility for health improvement, including oral health improvement, to Local Authorities.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 We will be working with Public Health England to develop an Oral Health Strategy for Swindon. No additional resources identified at this stage.

Diversity Impact Assessment

- 5.4 An assessment will be done on the Oral Health Strategy for Swindon.

Further information on the subject of this report can be obtained from Ayoola Oyinloye, 01793 444674, aoyinloye@swindon.gov.uk.

Oral Health Joint Strategic Needs Assessment

Health and Wellbeing Board

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6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Appendices

- 7.1 Appendix 1 – Draft Joint Strategic Needs Assessment of Oral Health in Swindon.

Draft Joint Strategic Needs Assessment of Oral Health in Swindon

Summary

- This JSNA bulletin provides evidence to help us understand the oral health and wellbeing needs of people in Swindon
- A healthy mouth is fundamental to our overall health and wellbeing. It allows us to speak, smile, kiss, taste, chew, swallow and cry.
- Oral diseases affects all ages and gender, but the burden of diseases disproportionately affects older people, people living with learning disability, people living in poverty, people with lifestyle issues and those who are dependent on others for support.
- Significant improvements in oral health have been made however; many adults and children still suffer from oral diseases. It is costly to the NHS and the society.
- More than one in twelve (7.9%) three year olds in Swindon experience tooth decay in a survey in 2013. On the average, these children have 2.21 (CI: 0.44-3.97) teeth that were decayed, missing or filled.
- More than one in four (27.9%) five year olds in Swindon experience tooth decay in a survey in the 2014/15 school year. On average, these children have 2.8 (CI: 2.26-3.37) teeth that were decayed, missing or filled.
- More than one in four (28.1%) twelve year olds in Swindon experience tooth decay in a survey in the 2008/09 school year. On average, 2.18 (CI: 1.84-2.53) teeth that were decayed, missing or filled.
- Almost one in four (22%) Five year olds attending special support schools in Swindon experience tooth decay in a 2014 survey. On average, these children had 3.90 primary teeth that were obviously decayed, missing or filled. More than one in four (29%) of twelve year olds attending special support schools in Swindon experience tooth decay in the same survey. On average, these children had 2.37 permanent teeth that were obviously decayed, missing or filled. It is important to note that the sample size for this study is smaller than other DPHEP surveys and the differences are within the margins of error.
- Data on oral diseases is less readily available for adults. An estimated 60% of adults have gum disease with around 11% experiencing severe disease, based on data from a national survey in 2009.
- The prevalence and severity of tooth decay in Swindon is not significantly different to the rest of England.

- Swindon is served by 26 dental practices providing NHS dentistry. All areas of Swindon are accessible by road and public transport to NHS dentists.
- In 2011/12, Swindon had the second highest rate of admissions for tooth extractions in the South west. The rate of admissions has since fallen, similar to the rest of the Southwest.
- Oral cancer incidence is relatively low in Swindon: 7.8 cases of oral cancer per 100,000 (age standardized rate) 2010-2012. Oral cancers are however an increasing public health problem.¹⁴ Incidence rates are rapidly rising and mortality is high and rising.

Recommendations

This JSNA will help to develop an oral health improvement strategy for Swindon to:

- Develop an Oral health strategy for Swindon
- Tackle the causes of tooth decay in children and adults by reducing the consumption of sugar and alcohol and stopping the use of tobacco.
- Include oral health actions as the norm in strategies, programmes and services aimed at vulnerable adults and children, e.g. low sugar food policies, oral hygiene as part of individual care plans, signposting to NHS dental services
- Review present commissioning oral health interventions, using both universal and targeted approaches, to help people keep their mouths clean, use fluoride to strengthen their teeth, increase awareness of oral cancer and visit the dentist regularly. There is an opportunity to do this now as the contracts for oral health promotion is up for renewal in 2017/18.
- Address the historical high rates of hospital admission for tooth extraction in Swindon, to ensure that all admissions are appropriate.

Introduction

This profile of oral health focuses on oral health and how oral diseases affect the population in Swindon Borough Council (SBC) area.

A healthy mouth is a vital part of a healthy body. Oral health has been defined as an ability to eat, speak and socialise without active disease, discomfort or embarrassment¹. Having a healthy mouth allows us to speak, smile, kiss, taste, chew, swallow and cry². These skills are fundamental to our daily living and are a key element of health and wellbeing.

Our ability to have a healthy mouth is affected by our experience of oral diseases. These include tooth decay gum disease and oral cancers. The most commonly found oral disease is tooth decay.

Oral diseases are largely preventable but are still very common. Significant improvements in oral health have been made however; many adults and children still suffer from pain and discomfort in their mouth. Some population groups are more likely to develop oral diseases, including older people, people living with learning disability³; people living in poverty, people with lifestyle issues and those who are dependent on others for support.

Impact of Oral Diseases

The impacts of oral diseases are significant: for individuals, families and society as a whole. At a society level the impact of oral diseases is substantial, particularly the cost of treatment. The NHS spends £3.4 billion per year on dental care (plus an estimated £2.3 billion is spent on privately funded dental care)⁴. Tooth decay was the most common reason for hospital admissions in children aged 5-9 years old in 2012/13, at a cost of almost £23 million⁵.

At the level of individuals and families it is well known that oral diseases cause tooth loss, pain, sensitivity, infection and, in extreme cases, a threat to life. What may be less well known however, is the impact of oral diseases on day to day life. These are summarised in figure 1.

Figure 1 The range of impact that Oral Diseases have on activities of Daily Living^{6,7}

Impacts on children	Impacts on adults	Impacts on families
<ul style="list-style-type: none"> •Reduced school readiness •Absence from school •Embarrassed to smile •Difficulty cleaning teeth •Difficulties eating •Difficulties socialising •Problems sleeping •Concentrating at school is difficult 	<ul style="list-style-type: none"> •Problems eating •Difficulty smiling •Difficulties cleaning teeth •Problems relaxing and socialising (greater risk of social isolation) •Problems with speaking •Difficulties working •Older adults less able to consume a healthy diet 	<ul style="list-style-type: none"> •Time off work •Feeling stressed, anxious or guilty •Sleep disrupted •Family activities interrupted •Financial difficulties

It is common for children and their families to report impacts of oral diseases on daily life: 21% of parents of 5 year olds, 33% of parents of 8 year olds, 32% of parents of 12 year olds and 35% of parents of 15 year olds reported that the oral health problems of their child had a negative impact on family life over a three month period⁶. In the South West, 34% of adults with teeth report at least one oral health impact on their daily life.⁷

Epidemiology of oral diseases in Swindon

Oral health survey of three-year-old children 2013⁸

Public Health England (PHE) dental public health epidemiology programme (DPHEP) survey of three-year-old children, 2013 published 2015 shows estimates for disease prevalence and severity. It is reported at national, regional, PHE centre and upper and lower-tier local authority level. This is the first survey of 3 year olds in England.

Overall, of the three-year-old children in Swindon whose parents gave consent for their participation in this survey 7.9% (CI: 3.8-12.1) had experienced dental decay. On average, these children had 2.21 (CI: 0.44-3.97) teeth that were decayed, missing or filled (at age three most children have all 20 primary teeth). This is better than the national average for England, Overall, of the three-year-old children in England whose parents gave consent for their participation in this survey 11.7% (CI: 11.4-12.0) had experienced dental decay. On average, these children had 3.07 (CI: 3.01-3.14) teeth that were decayed, missing or filled (at age three most children have all 20 primary teeth). This is summarised in figures 2-4.

Figure 2 Percentage of 3 year old Children with decayed, missing or filled teeth

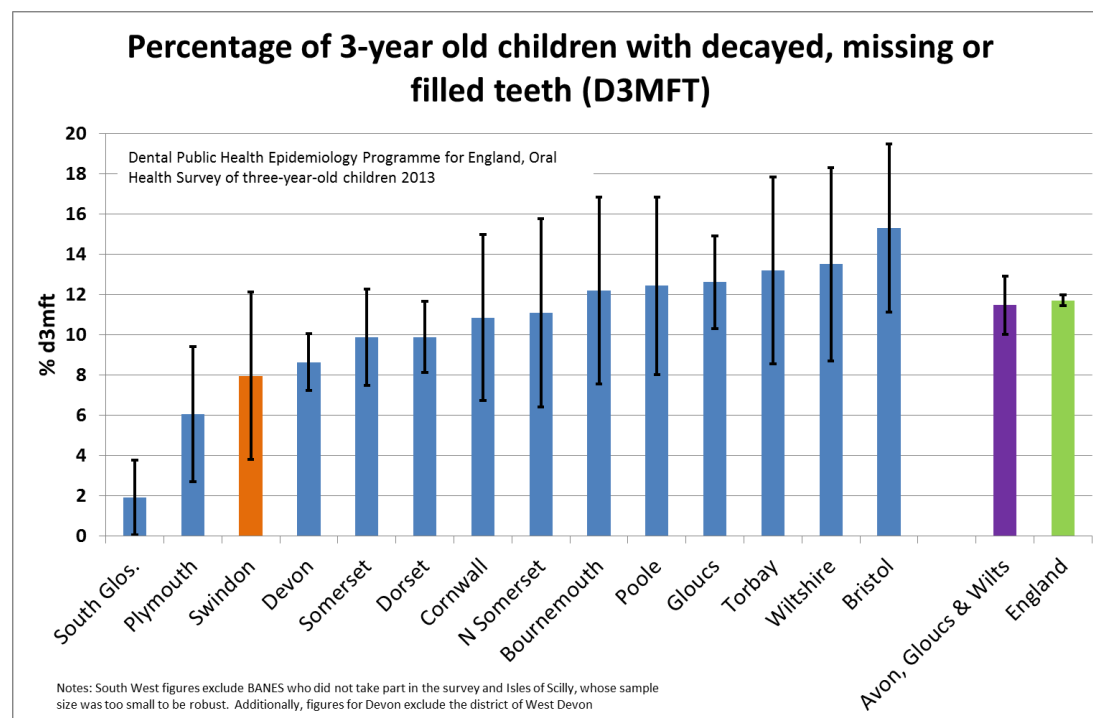
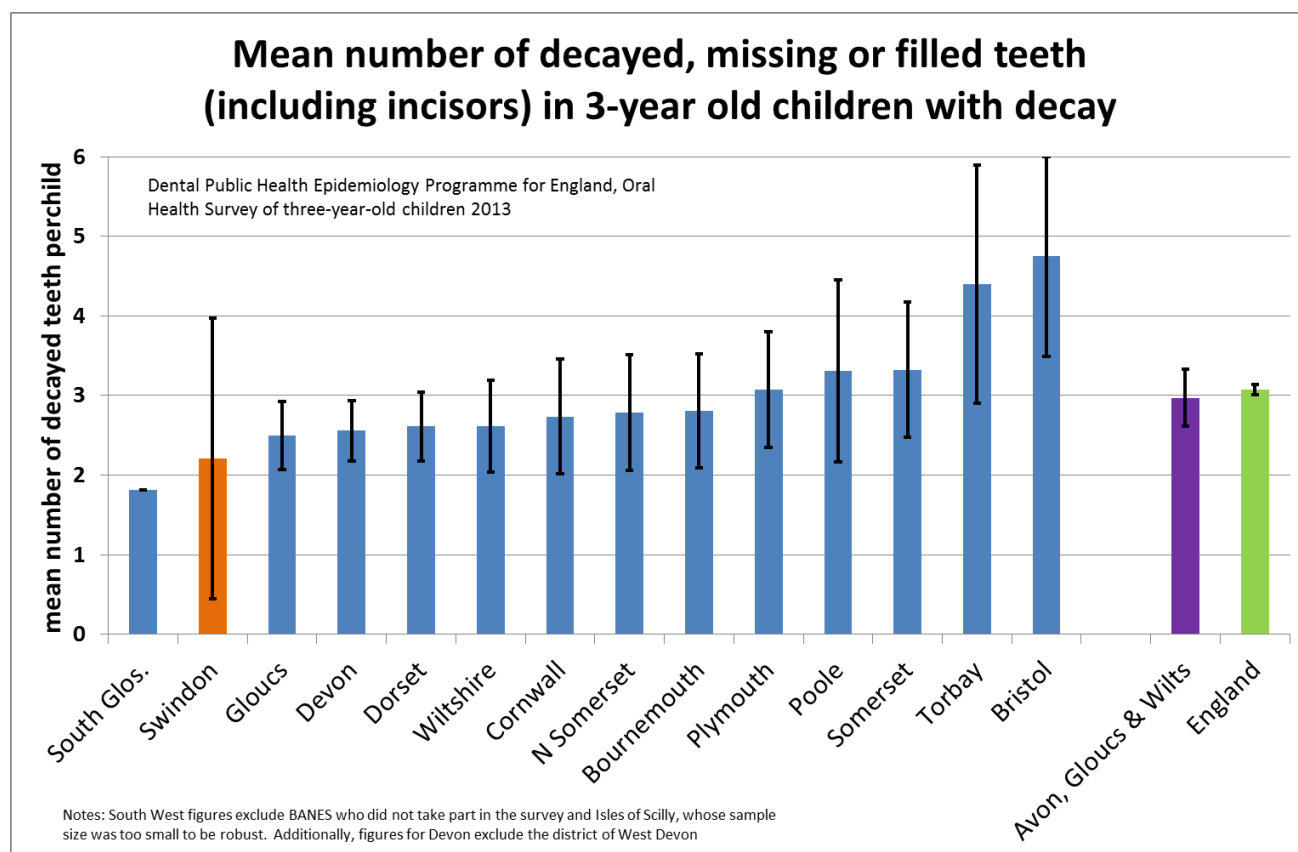


Figure 3 Mean number of decayed, missing or filled teeth in 3 year old with decay experience



Oral health survey of five-year-old children 2014-15⁹

Public Health England (PHE) dental public health epidemiology programme (DPHEP) survey of five-year-old children who attend mainstream, state funded schools across England during the 2014/15 academic year. This survey shows estimates for disease prevalence and severity. It is reported at national, regional, PHE centre and upper and lower-tier local authority level.

Overall, of the five-year-old children in Swindon whose parents gave consent for their participation in this survey 27.9% (CI: 22.2-33.5) had experienced dental decay. On average, these children had 2.8 (CI: 2.26-3.37) teeth that were decayed, missing or filled. This compares with the national average for England; overall, of the five-year-old children in England whose parents gave consent for their participation in this survey 24.7%(CI 24.48-24.98) had experienced dental decay. In the Southwest region, the figure is 21.5% (CI 20.64-22.23). On average, these children had 3.4 (CI 3.37-3.43) teeth that were decayed, missing or filled in England and 3.1(CI 2.97-3.18) in the Southwest. This is summarised in figures 5-7.

Figure 4 Percentage of 5 year old children with decayed, missing or filled teeth

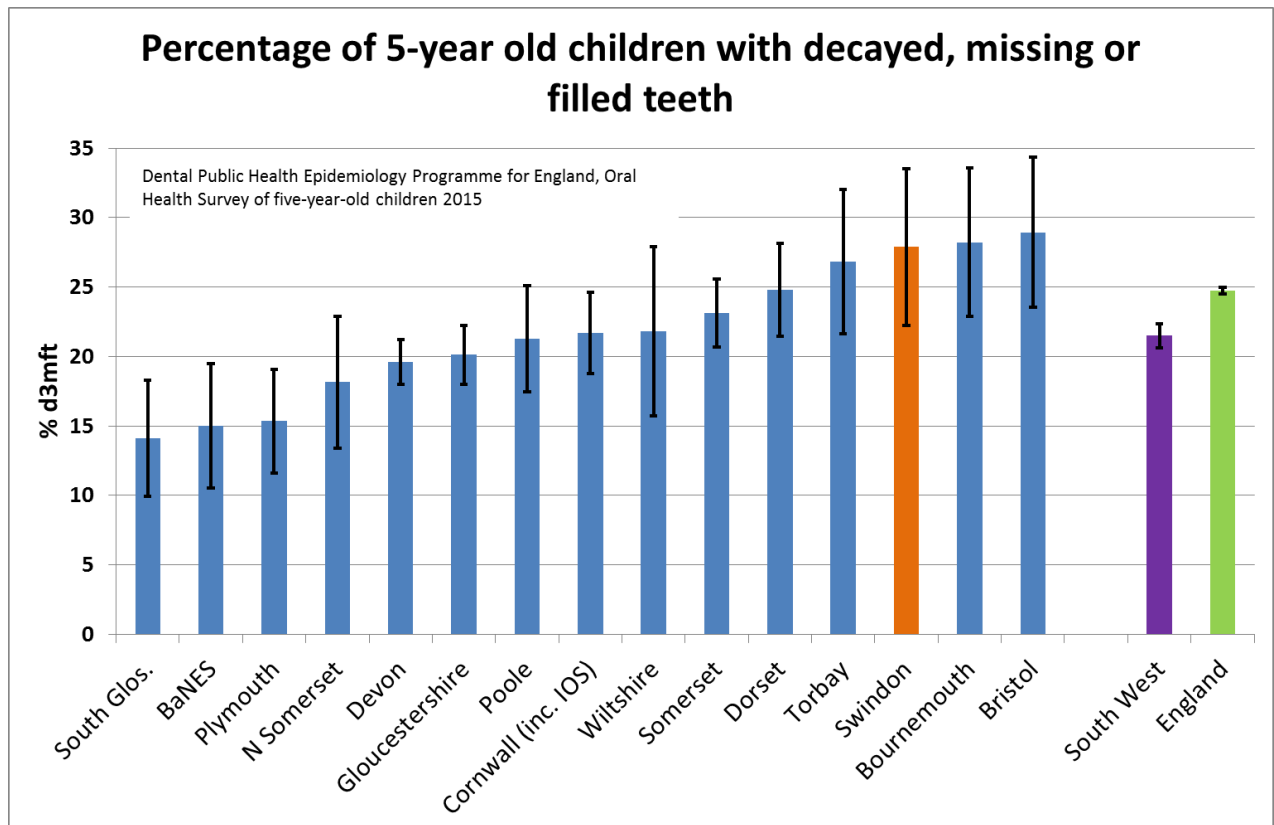
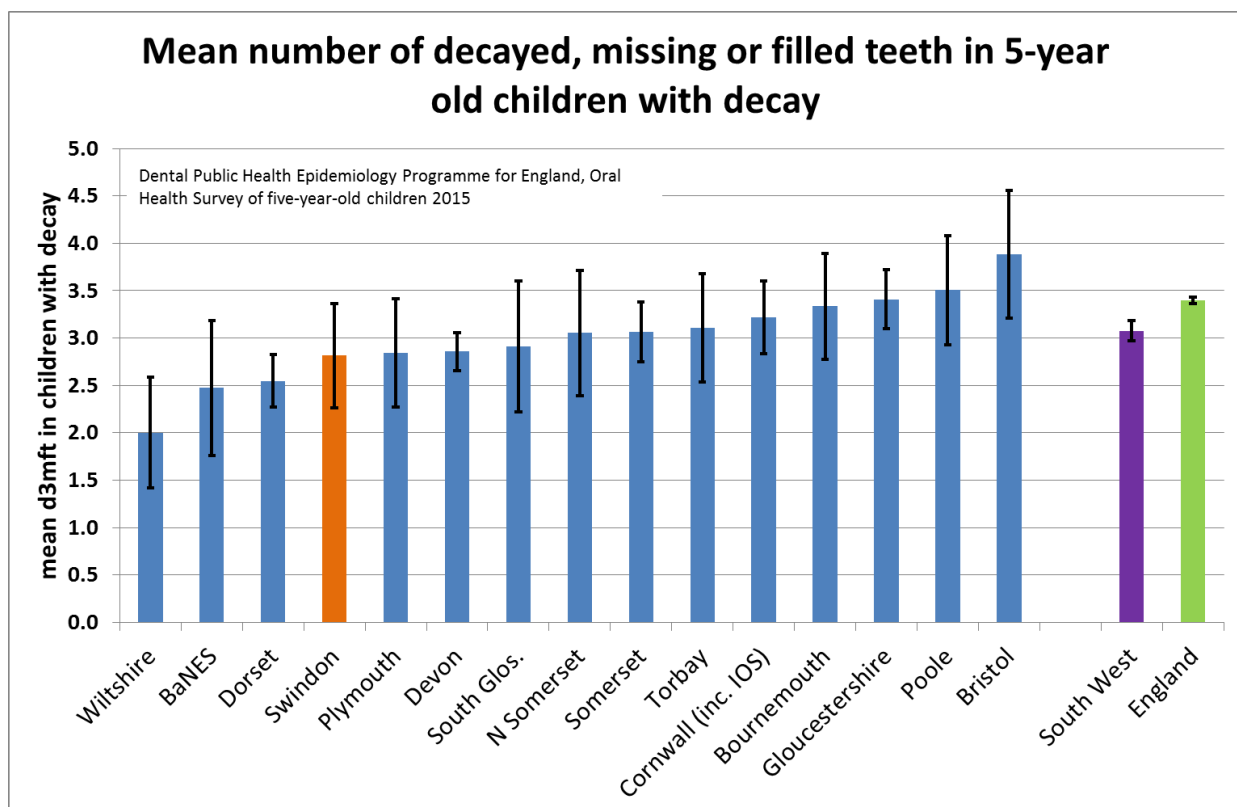


Figure 5 Mean number of decayed, missing or filled teeth in 5 year old children with decay experience



Oral health survey of Five-year-old children 2011-12¹⁰

In the previous survey done in 2012, of the five-year-old children in Swindon whose parents gave consent for their participation in this survey 24.1% (CI: 17.7%-30.5%) had experienced dental decay (figure 8 and 9). On average, these children had = 3.39 (CI: 2.61-4.16) teeth that were decayed, missing or filled (figure 10). This compares with the national average for England; overall, of the five-year-old children in England whose parents gave consent for their participation in this survey 27.9% (CI 27.7-28.1) had experienced dental decay. In the Southwest region, the figure is 26.1% (CI 25.2-27). On average, these children had 3.38 (CI 3.36-3.41) teeth that were decayed, missing or filled in England and 3.03 (CI 2.93-3.14) in the Southwest. There is no significant difference in the findings of this survey when compared to the 2014/15.

This is summarised in figures 6 and 7.

Figure 6 Comparison of prevalence of tooth decay in 5 year olds in Swindon to national Regional and Local prevalence in 2012 Source NDEP 2013

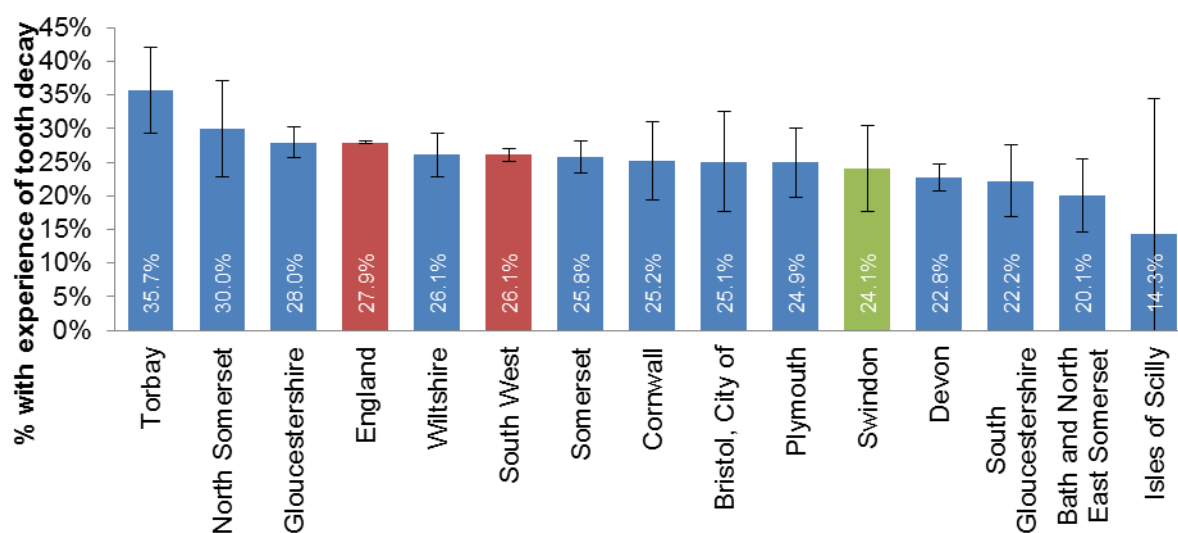
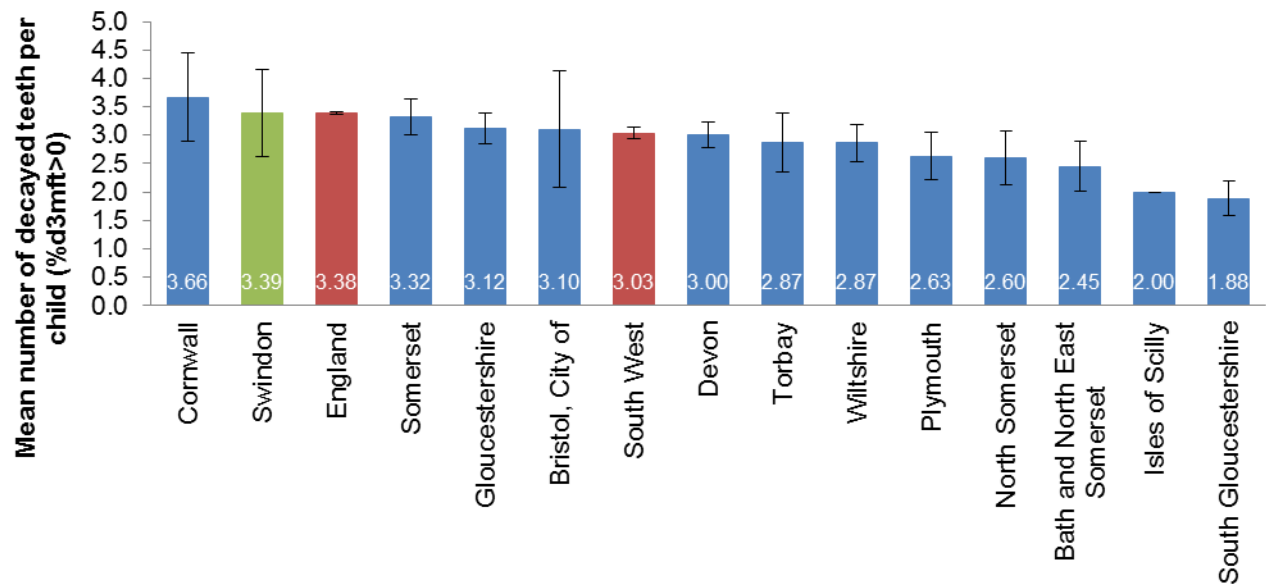
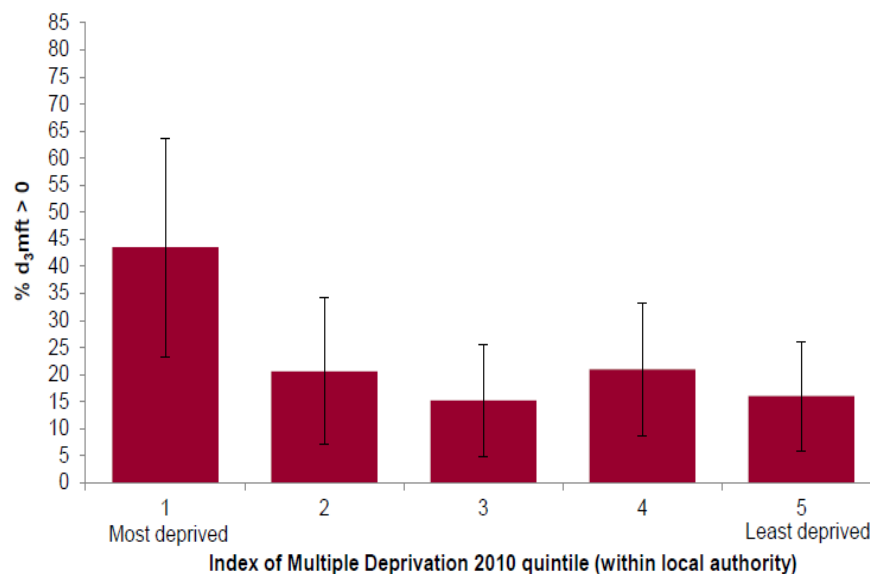


Figure 7 Average Number of teeth affected by tooth decay in five year olds with decay experience (d3mft>0)
Source NDEP 2013



Tooth decay in children is worse for lower socio economic groups. In Swindon, children in the most deprived households are more likely to have decayed, missing or filled tooth (Figure 11).

Figure 8 prevalence of tooth decay in five year olds by IMD 2010 quintiles for Swindon source: PHE Dental Health Profile Swindon Oct 2014



Oral health survey of twelve-year-old children 2008/09¹¹

Public Health England (PHE) Dental Public Health Epidemiology Programme (DPHEP) survey of Twelve-year-old children who attend mainstream, state funded schools across England during the 2008/09 academic year. This survey shows estimates for disease prevalence and severity. It is reported at national, regional, PCT and lower-tier local authority level.

Overall, of the twelve-year-old children in Swindon whose parents gave consent for their participation in this survey 28.1% (CI: 22.6%-33.6%) had experienced dental decay. On average, these children had 2.18 (CI: 1.84-2.53) teeth that were decayed, missing or filled. This is better than the national average for England. Overall, of the three-year-old children in England whose parents gave consent for their participation in this survey 33.4% (CI: 33.1-33.7) had experienced dental decay. On average, these children had 2.21 (CI: 2.19-2.23) teeth that were decayed, missing or filled. This is summarised in figures 9 and 10.

Figure 9 Percentage of 12 year old children with decayed, missing or filled teeth

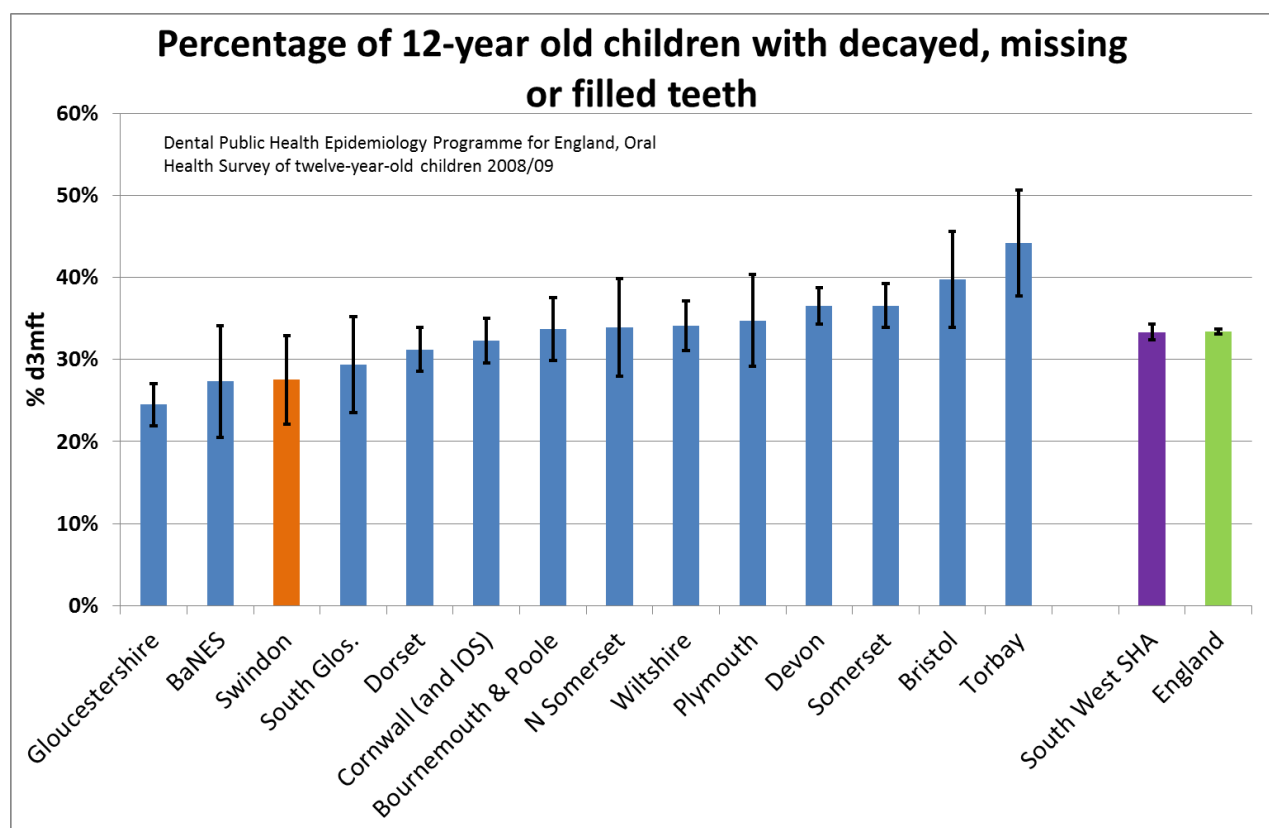
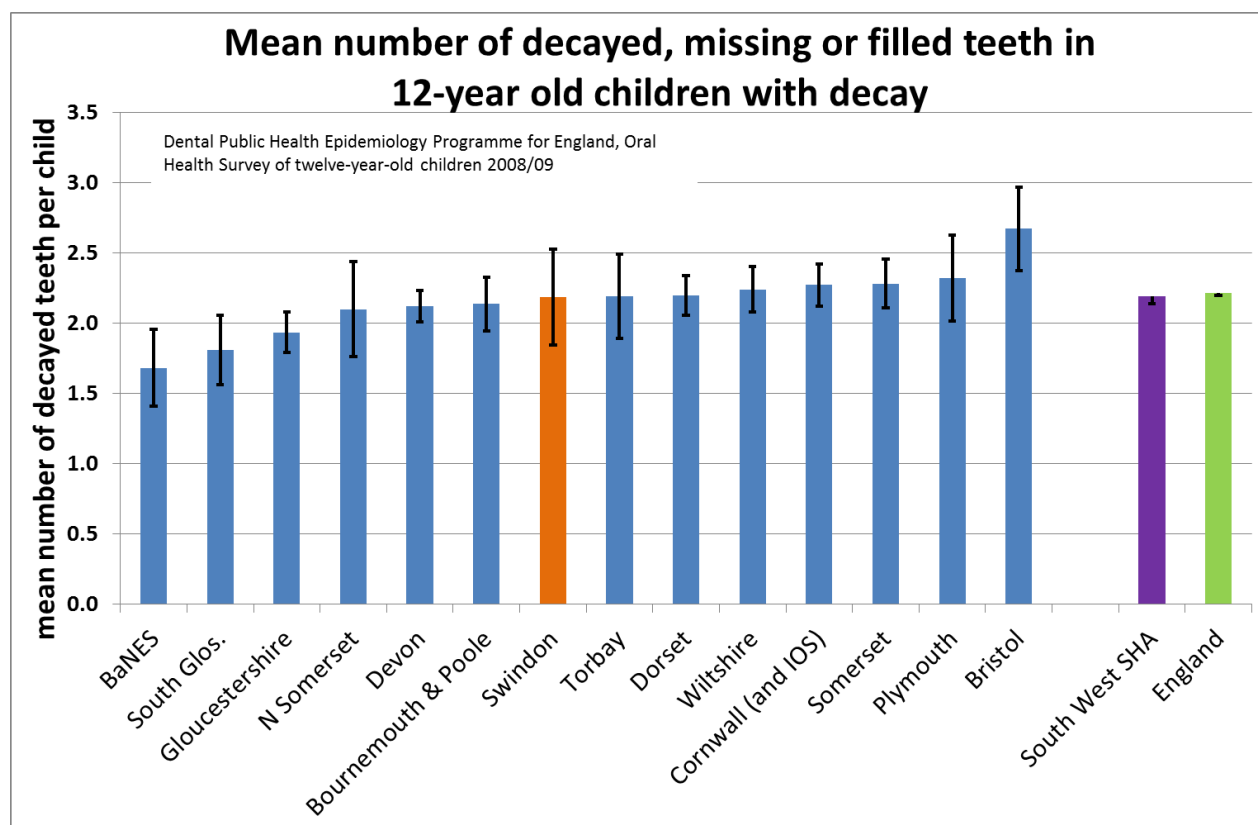


Figure 10 Mean number of decayed, missed or filled teeth in 12 year olds with decay experience



Oral health in children attending special needs schools ¹²

Public Health England (PHE) Dental Public Health epidemiology programme (DPHEP) conducted a survey of five and twelve-year-old children attending special support schools in 2014. The number of people who consented to this study and subsequent examination was small and this affects the inference from this study.

Overall, of the five-year-old children attending special needs schools in England whose parents gave consent for their participation in this survey, 22% had experienced dental decay. On average, these children had 3.90 primary teeth that were obviously decayed, missing or filled. The average number of decayed, missing or filled teeth (d3mft) in the whole sample (including the 78% who were free of obvious decay) was 0.88.

For this age group, overall severity and prevalence in children attending special needs schools were slightly lower than for children attending mainstream schools, but those who have experience of decay have more teeth affected on average. This age group were twice as likely to have had one or more teeth extracted than their mainstream-educated peers.

Among the 12-year-old children in England attending special needs schools whose parents gave consent for their participation in this survey, 29% had experienced dental decay. On average, these children had 2.37 permanent teeth that were obviously decayed, missing or filled. The average

number of decayed, missing or filled teeth (D3MFT) in the whole sample (including the 71% who were decay free) was 0.69.

For 12-year-old children attending special needs schools, again, overall severity and prevalence was lower than for children attending mainstream schools but, for those who had decay it was more severe with more teeth being affected on average. This is summarised in figures 11-16. The sample size for this study is smaller than other DPHEP surveys and the differences are within the margins of error.

Figure 11 percentages of 5 year olds in special support schools with decayed, missing or filled teeth

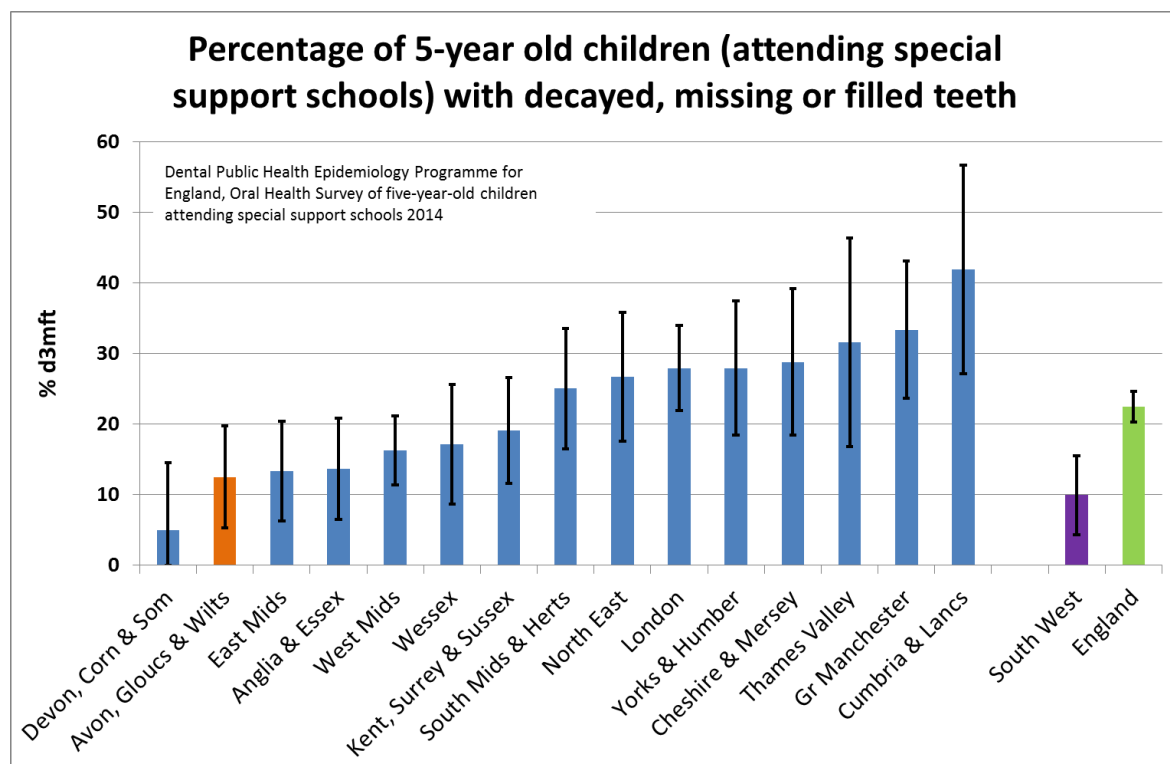


Figure 12 Mean number of decayed, missing or filled teeth in 5 year olds in special support schools with decay experience

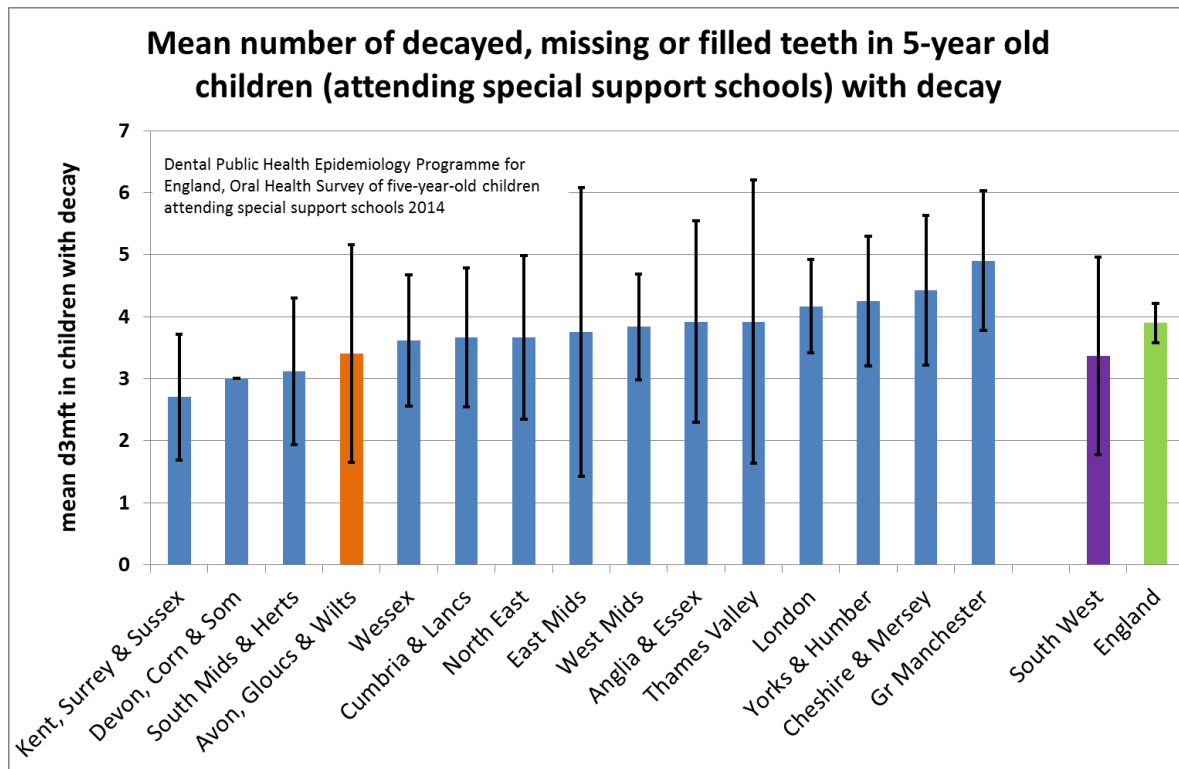


Figure 13 mean number of decayed, missing or filled teeth in 5 year olds in special support schools

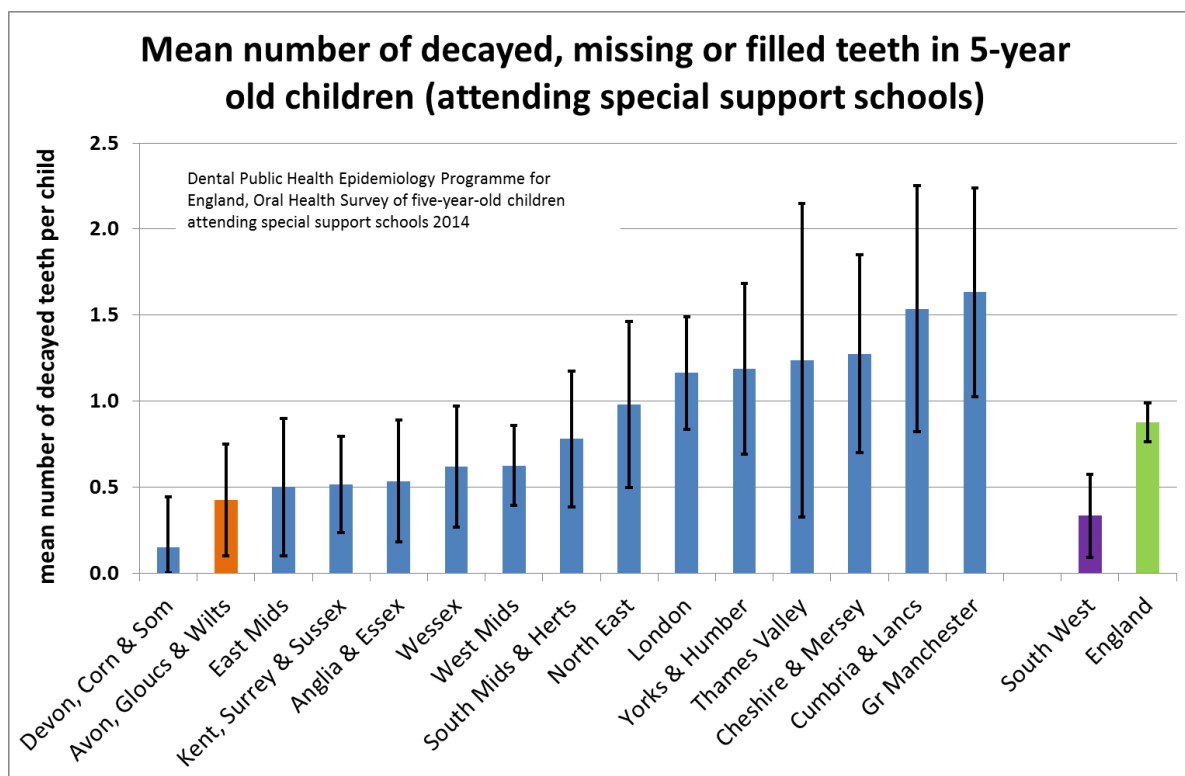


Figure 14 percentage of 12 year olds in special support schools with decayed, missing or filled teeth

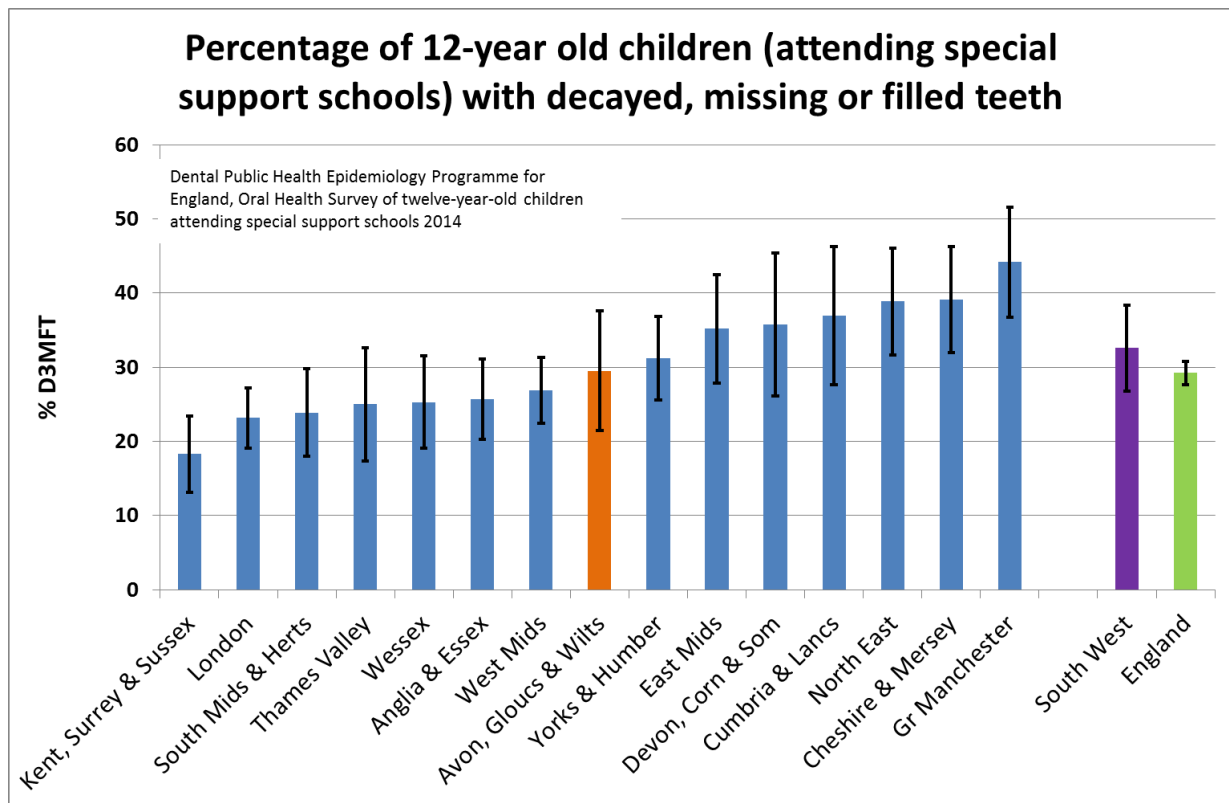


Figure 15 Mean number of decayed, missing or filled teeth in 12 year olds attending special support schools with decayed experience

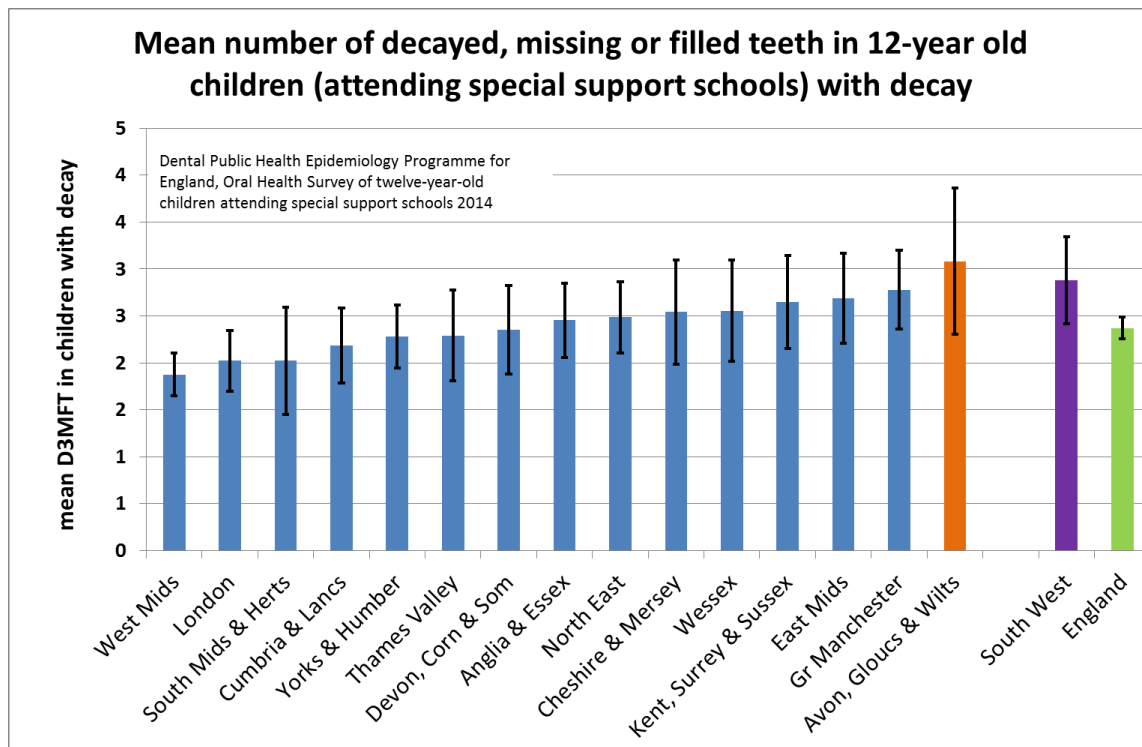
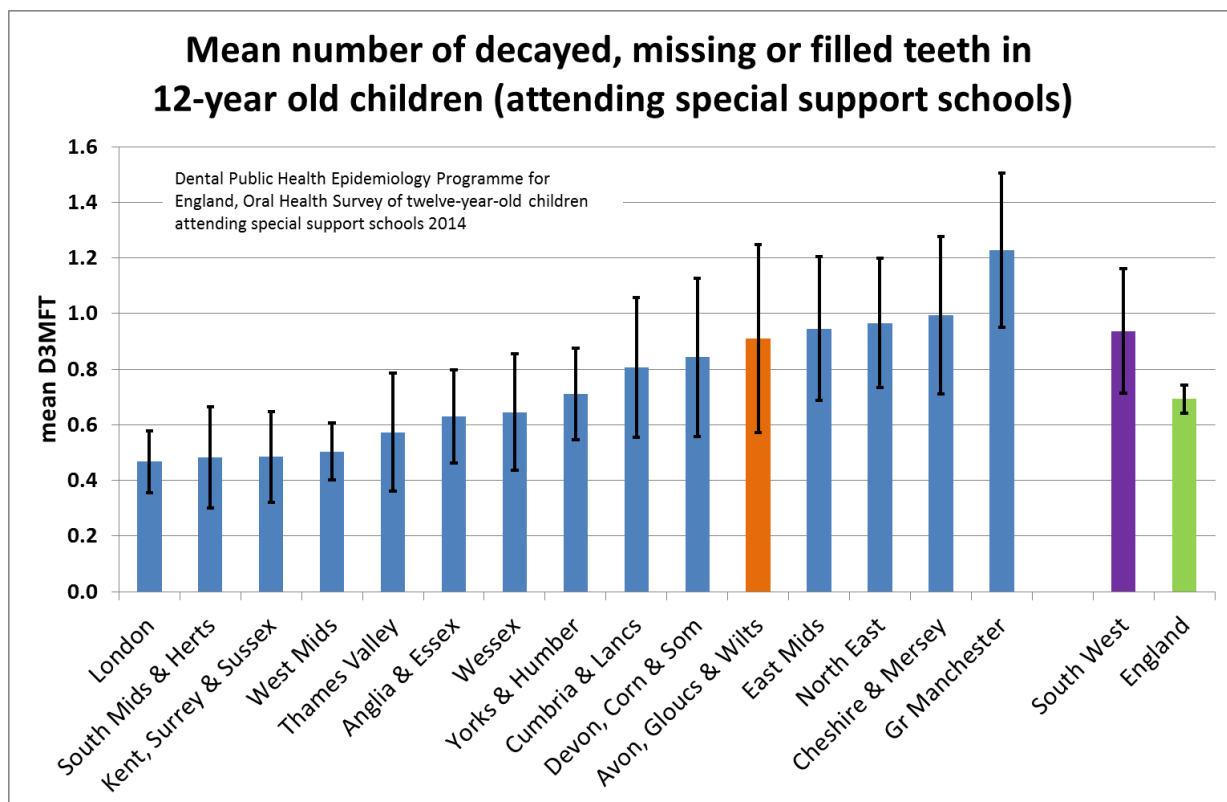


Figure 16 Mean number of decayed, missing or filled teeth in 12 year olds in special support schools



Other groups of children who are most at risk of oral diseases are summarised in table1.

Table 1 Groups of children at the highest risk of oral disease

Group	Definition	prevalence of risk factor in Swindon	prevalence of risk factor in England
Children living in areas of material or social deprivation	% of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is < 60% median income) for u-16s only	15.6% (6,640 children) 2013	18.6% South West = 14.8% Swindon significantly lower than England but significantly higher than South West.
Children who are offenders	Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population	581 per 100,000 (115 children) 2014	409 per 100,000 South West = 428 per 100,000 Swindon significantly higher than both.

Children with a physical or learning disability	2011 Census question: Are you day to day activities limited because of a health problem or disability which has lasted or is expected to last, at least 12 months?	0-15 limited a lot or a little = 3.4% (1,414 children) 16-24 limited a lot or a little = 4.7% (1,071 young people) 2011	Swindon is slightly lower than the England average for 0-15s and similar to England for 16-24s
Looked after Children	The definition of looked-after children (children in care) is found in the Children Act 1989. A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours	52 per 10,000 (250 children) 2015	60 per 10,000 South West = 52 per 10,000

Oral diseases in adults

There are no routinely collected local data collected on oral health in adults. There are however, decennial national surveys of oral health in adults which report data at a regional level ⁷.

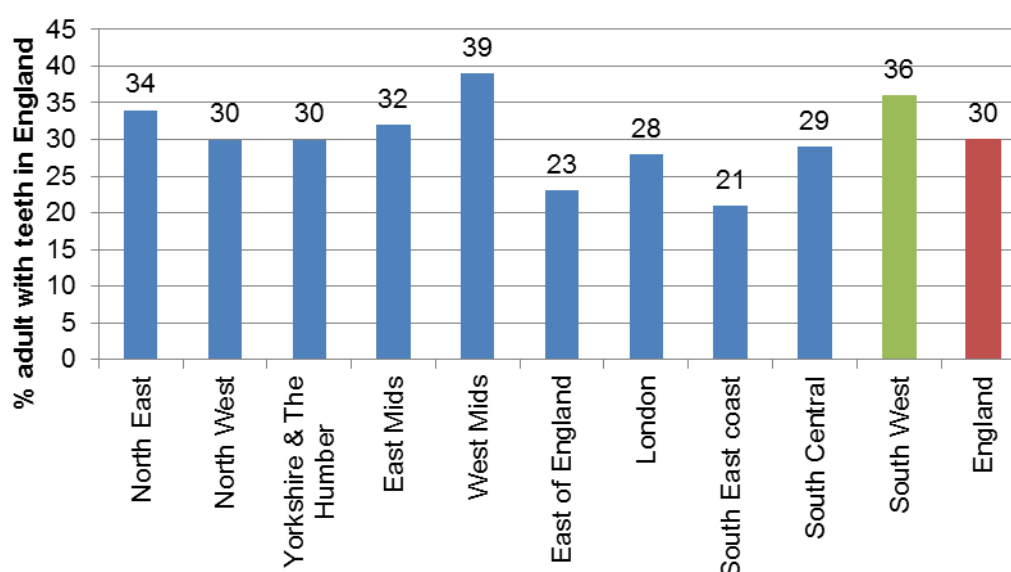
The three main oral diseases that affect adults are dental decay, gum disease and oral cancers. Data on oral health in adults is not collected locally. This means that oral health and wellbeing needs for Swindon are estimated using South West data from national oral health surveys. The most recent survey was in 2009⁷. There is an ongoing survey of the dental health of older people (>65years) with mild dependency who live in “extra care” housing establishments.

While oral health has improved overall in recent decades, it is not all good news. Inequalities in oral health are consistently seen with oral diseases increasingly concentrated in vulnerable and socially disadvantaged groups, such as frail older people or those from lower socioeconomic groups (figure 17).

Figure 17: Groups of adults at highest risk of oral disease

Tooth decay

In the South West 36% of adults have an average of 3-4 decayed teeth (figure 18). The overall prevalence of tooth decay in adults in England has fallen from 46% in 1998 to 30% in 2009. While the prevalence of decay has fallen over time, the severity is essentially unchanged.

Figure 18: Proportion of adults with any decayed teeth (%) by region (Strategic Health Authority), 2009

Source: Adult Dental Health Survey 2009

Inequalities in tooth decay

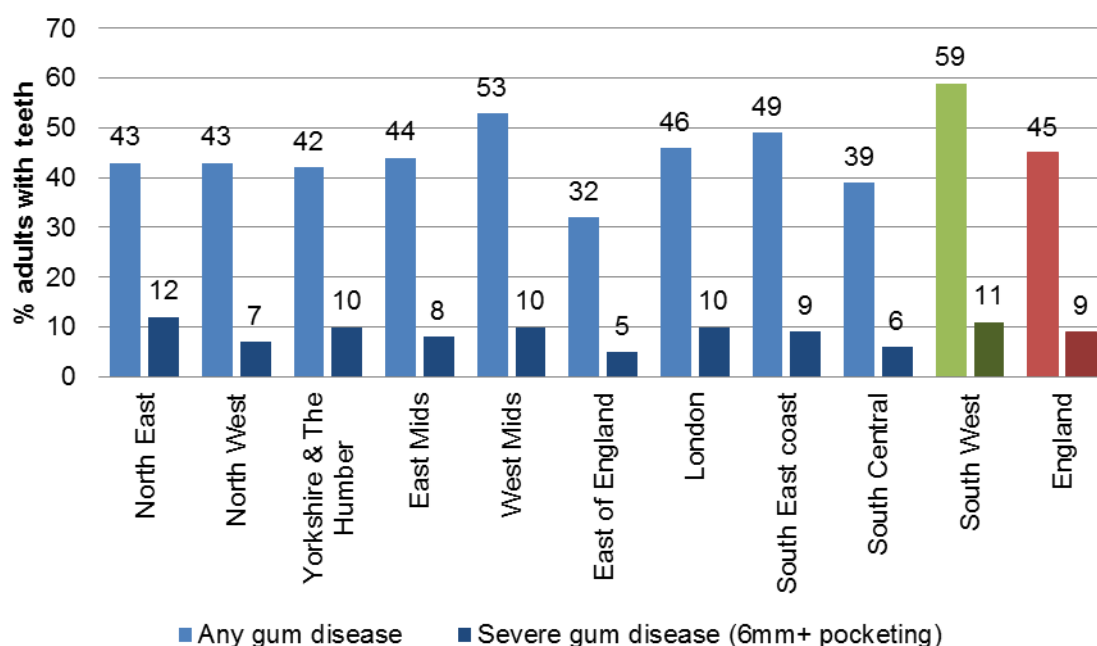
Tooth decay is strongly associated with socioeconomic deprivation. People from more deprived groups suffer from more severe decay, more urgent dental problems and are more likely to have no teeth at all. Adults who do not attend a dentist regularly also have fewer teeth and more decay⁷.

Tooth decay varies by age and prevalence is highest in adults aged 25-34 and 75 years and over. People from black and minority ethnic groups tend to experience tooth decay more frequently however, the relationship is complex and likely to be confounded by socio-economic status.¹²

Gum disease

Gum disease covers a spectrum of conditions, from swollen and bleeding gums to extensive bone loss leading to loss of teeth. In the South West, 59% of the population experienced gum disease with 11% experiencing severe disease (compared to 45% and 9% adults in England respectively)⁷ (figure 23).

Figure 19 Periodontal condition of adults with teeth (%) by Strategic Health Authority, 2009.



Source: Adult Dental Health Survey, 2009

Inequalities in gum disease

Gum disease is cumulative so prevalence increases with age. Adults from more socio-economically deprived groups are more likely to experience gum disease, as are adults of Asian origin.⁹

Oral cancer

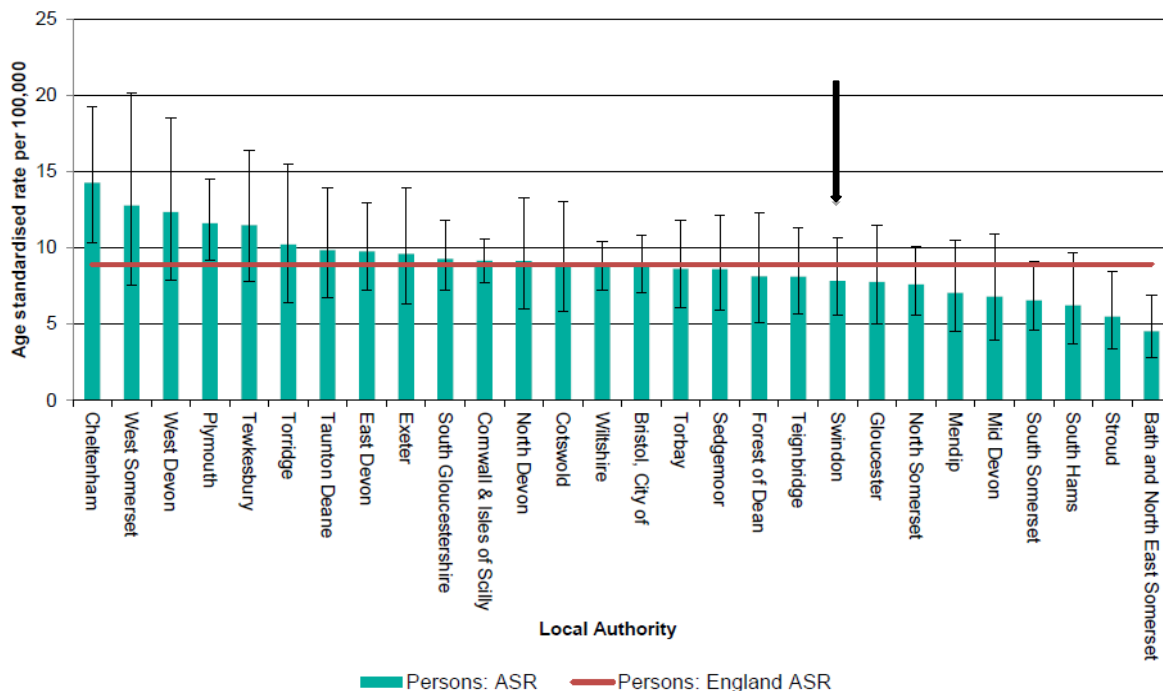
Oral cancer (a term used to encompass a number of different types of cancer of the mouth) makes up 2% of all cancer cases and 1% of all cancer deaths in the UK. Around 2,100 people died of oral cancer in 2012 in the UK, equivalent to around six people every day.¹⁵

Oral cancer incidence is relatively low, however; this is an increasing public health problem.¹⁴¹⁶ No other cancer site has shown such a rapid rise in incidence in the past quarter of a century.¹³ Mortality rates have increased by around 10% in the last decade.¹⁴ Diagnosis of oral cancer is usually

late because people can ignore symptoms: public awareness of oral cancer is low. Most sufferers die in first 2-3 years after diagnosis (there is around a 50% five year survival).¹⁵

In Swindon there were 7.8 cases of oral cancer per 100,000 (age standardised rate) 2010-2012 (figure 24). There are no statistically significant differences in either oral cancer incidence or mortality between Swindon and England.

Figure 20: Oral cancer incidence age standardised rates for Local Authorities in the South West, 2010-2012 (NCRS ONS)



Inequalities in oral cancer

Oral cancer is strongly related to socio-economic deprivation, with the highest rates occurring in the most disadvantaged groups.¹⁵ This pattern is independent of lifestyle behaviours.¹⁶

Oral cancer is more common in older adults (60+) ¹⁵, although numbers are increasing in younger adults. ¹⁶ Oral cancer is more common in men due to a higher prevalence of tobacco chewing, excessive alcohol intake and smoking in men.¹⁷ Oral cancer is more common in people from some black and minority ethnic groups that have a higher prevalence of chewing tobacco or betel quid, such as people of Bangladeshi origin.¹²

Services for oral health in Swindon

Preventive services

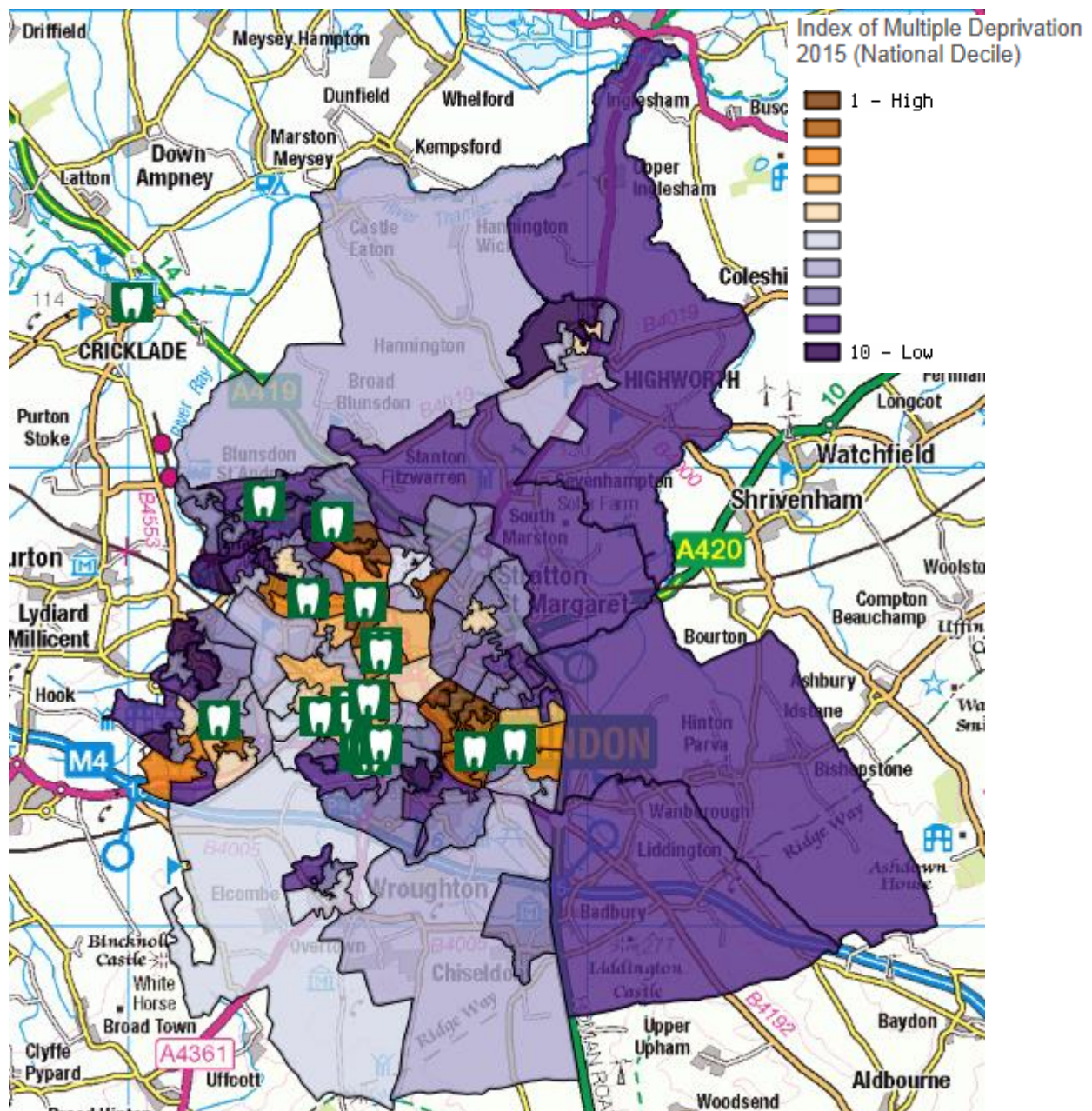
Swindon Public Health team commission the Great Western Hospital Foundation Trust Dental Service to provide oral health promotion to children in Swindon. This service provides oral health promotion advice and training to staff and pupils schools, nurseries and to health care professionals.

In addition, oral health promotion is part of school health services and is an integral part of the healthy weight strategy.

Primary Care

Swindon is well served by a network of dental practices providing NHS dentistry to the residents of Swindon. NHSE is the commissioner of primary care dentistry in Swindon and it commissions 26 dental practices to provide NHS dental services in Swindon. Areas of high Index of Multiple Deprivation (high deprivation) are well served by NHS Dentists. All areas of Swindon are easily accessible by road and public transport to NHS dentists (figure 21). A recent report from Healthwatch Swindon shows that there is no shortage of NHS dentistry in Swindon¹⁸

Figure 21 Map showing the location of primary care dentists in Swindon by IMD 2015

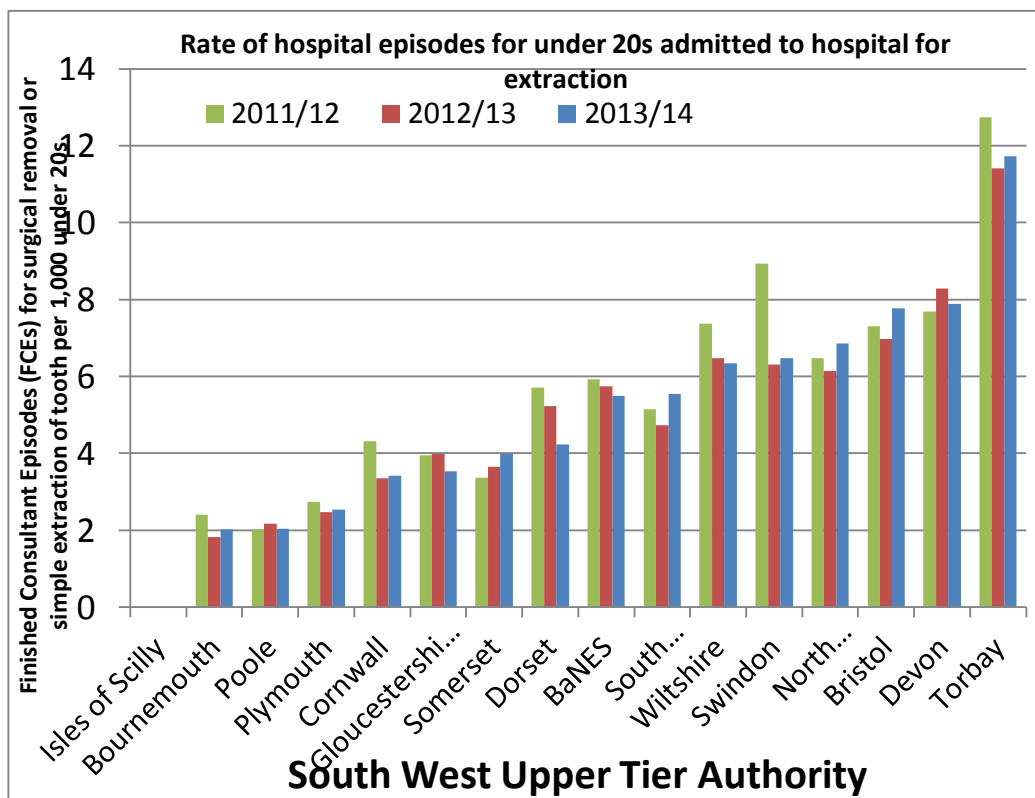


Swindon iShare GIS tool: <http://sbcvpwmism04/iShareGIS5.4.Web/iShareGIS.aspx#> (accessed 16/3/16)

Acute/ secondary Care¹⁹

The Great Western Hospitals Foundation Trust is the main provider of acute care for dentistry for Swindon residents. In 2011/12, Swindon had second highest rate of admissions for tooth extraction in the South west in children. Anecdotal evidence suggested this high rate of admissions for tooth extractions may not be entirely appropriate. NHS Swindon, as part of its QIPP programme investigated this, and developed criteria based access policy for tooth extraction in secondary care in 2012. Admission rates in subsequent years have since fallen to similar rates for the rest of the south west.

Figure 26 Rate of hospital episodes for under 20s admitted to hospital for Tooth extraction in the Southwest



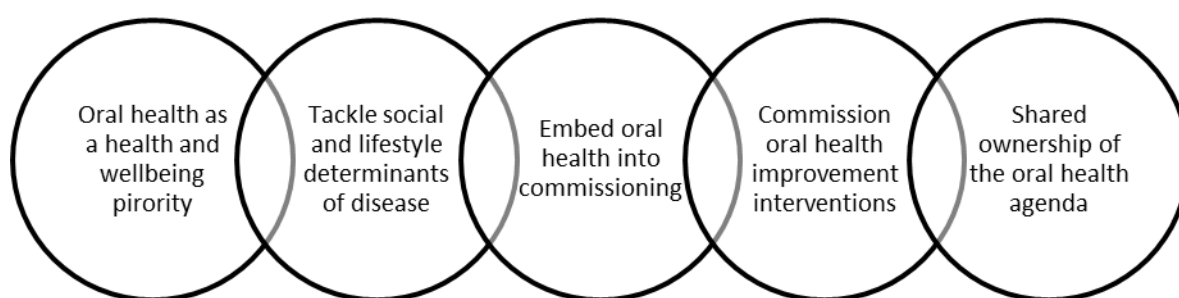
Interventions to improve oral health

It is increasingly acknowledged that investment in prevention promotes health and wellbeing and is preferable to treating diseases. Local authorities are statutorily required to commission oral health promotion surveys and to ensure the provision of a local health promotion programme to the extent which is appropriate to their local area.²⁰

While the causes of oral diseases are well understood, tackling them is complex. A whole system approach is needed that combines universal with targeted action. Targeted action needs to be focused on those groups who are more likely to experience poor oral health and less likely to access routine NHS dentistry, e.g. early years children and vulnerable adults.

Improving oral health in Swindon

Improving oral health will involve a number of elements, as follows (summarised in figure 27):

Figure 27: Actions to improve oral health and reduce oral health inequalities

Oral health as a health and wellbeing priority

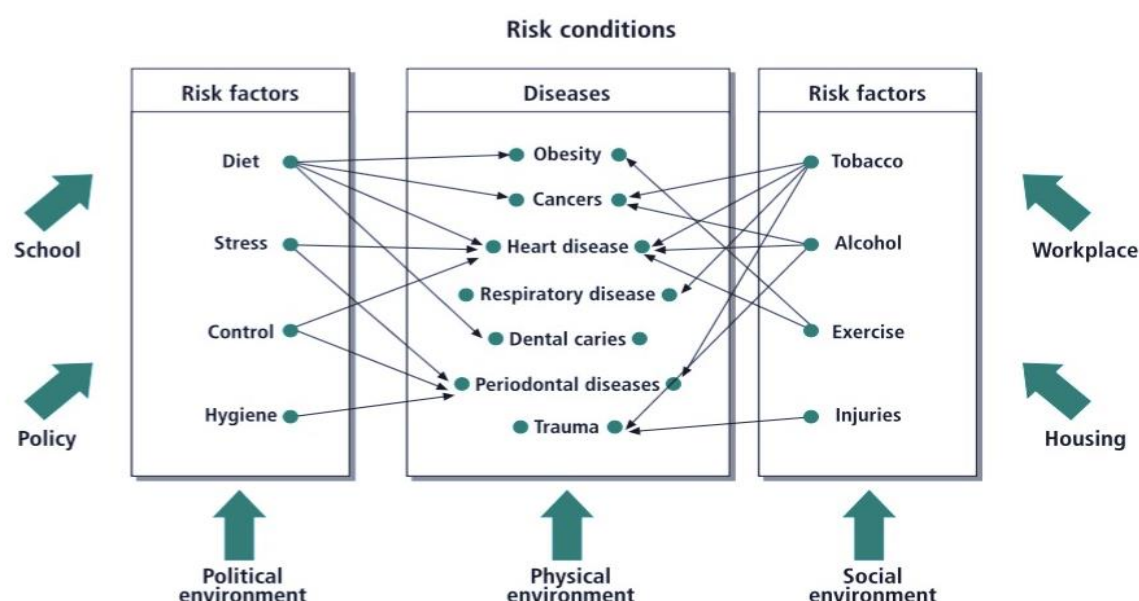
In the traditional medical approach, the mouth is seen as separate to the rest of the body. This is now known to be an outdated approach however, oral health is often forgotten when health improvement activities are designed, either at an individual or a population level. Inclusion of oral health in organisational priorities would help ensure that oral health is not forgotten by commissioners and providers. This has been included in the oral health Joint Strategic Needs Assessments (JSNA), Health and Wellbeing Strategies, Children's Poverty Commission Strategies, Children and Young People's JSNA.

Tackling social and lifestyle determinants of disease

The Common Risk Factor Approach²¹ advocates tackling the causes, and the causes of the causes, of oral diseases alongside those of other common chronic diseases. The lifestyle factors that affect oral diseases are largely well understood and the underlying influence of the wider social environment on oral health inequalities is now recognised.²²

Actions that (a) improve the circumstances in which people live and work, particularly using the principle of proportionate universalism and (b) reduce the lifestyle factors that contribute to oral diseases alongside other chronic disease, such as tobacco smoking, poor diet, high alcohol consumption, injuries (figure 28), will ultimately lead to improvements in oral health and a reduction of oral health inequalities. Reductions in tobacco use, for example, will reduce the risk of both gum disease and oral cancers. Reductions in tobacco use, for example, will reduce the risk of both gum disease and oral cancers.

Figure 28 The Common Risk Factor Approach to improving oral health



This means that many of Swindon's interventions on shared risk factors (social and lifestyle determinants) will improve oral health by reducing the overall risk of disease. A wide number of partners can contribute to improving the oral health by delivering on the following priorities:

1. Improving the environments in which people live and work
2. Making healthy choices easier with regard to healthy, sugar free foods and drinks
3. Supporting reductions in alcohol misuse and tobacco use

Actions to address the common risk factors for oral and other chronic diseases will contribute to oral health improvement regardless of whether they are nominally focused on oral health issues. There is a limit to this approach however: in many cases, oral health could be further improved by adding in specific oral health elements to a programme, e.g. training staff in oral health, supporting vulnerable people to have a clean mouth and supporting people to visit a dentist for urgent and routine care.

Embed oral health into commissioning

Oral health improvement services have traditionally been separate from generic health improvement services. This distinction is artificial and outdated as there is strong evidence to suggest that oral health is integral to general health. In older people, for example, there is a clear and consistent relationship between retention of natural teeth, a healthy diet and good nutrition.²³

Embedding oral health into the commissioning of services for children and vulnerable adults would support the promotion of oral health by services and settings that work with priority population groups. In many cases there is no need to commission separate interventions, instead oral health elements, such as the requirement for staff to be trained in oral health, can be introduced into other policies, strategies and programmes, for example:

- Service specifications, including standards and KPIs, for the commissioning of services that relate to young children and vulnerable adults, e.g. Healthy Child Programme 0-19 year olds and social care for older adults
- Strategies, such as those for healthy eating, include oral health considerations such as minimising the frequency of sugar intake as well as quantity of sugar consumed

Commission specific oral health improving interventions

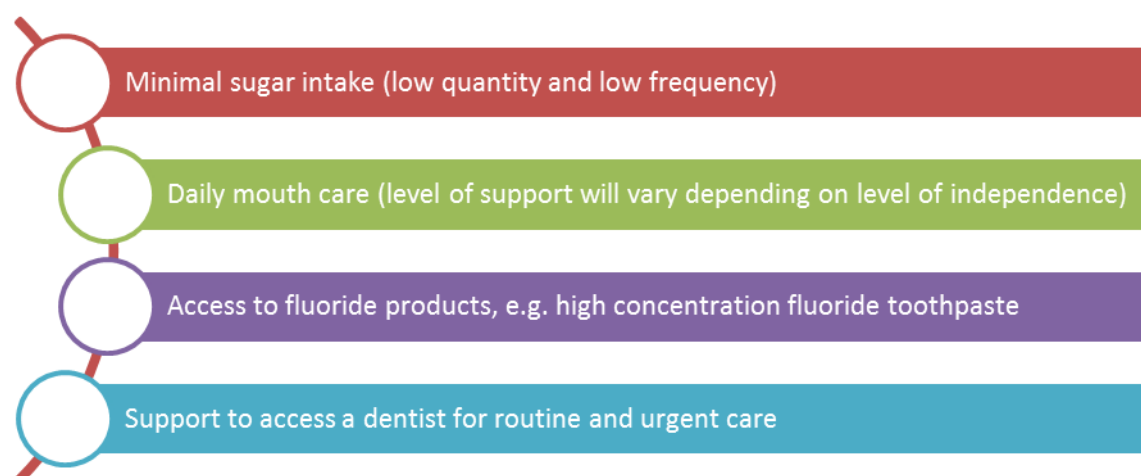
Oral health is integral to general health and quality of life but is easily forgotten when integrated health improvement services are being developed.²⁴

While many actions that improve oral health do not require specific oral health commissioning, there are certain elements of oral health improvement that cannot be bypassed. Vulnerable adults and children require four key interventions to improve or maintain their oral health, as outlined in figure 29.²⁵

Commissioned services need to promote these factors for individuals, particularly those who are most vulnerable. Anecdotal evidence suggests that, where oral health is completely integrated into general health improvement activities, these elements are easily forgotten, particularly those that relate to mouth care, fluoride delivery and access to dental treatment. For example, carers often receive no training in oral health meaning that these factors get forgotten when managing personal care, e.g. for vulnerable older people.

The requirement for providers to deliver on oral health responsibilities can be embedded in services specifications, but there is a need for oral health services to support providers to deliver against these oral health responsibilities. For example, where a service specification requires staff to be trained in oral health, a service is needed that can deliver staff training in oral health.

Figure 29: Actions needed, at an individual level, to improve or maintain their oral health



There are a number of oral health improvement interventions which local authorities can choose to commission, depending on population need and available resources. National guidance documents, from NICE and Public Health England, make clear recommendations about which interventions are supported by the evidence base. Training in oral health for health and social care staff working with

vulnerable adults and children, for example, is recommended by NICE guidance²⁶ and the PHE toolkit.²⁷ Training can be supplemented by other programmes, such as fluoride toothpaste or varnish initiatives. The evidence around the effectiveness of topical fluoride in preventing decay is firmly established based on a sizeable body of evidence (Cochrane systematic reviews).^{28,29} Fluoride can be delivered in a community setting, in a variety of ways, to strengthen teeth, e.g. free toothpaste to troubled families.

Shared ownership of the oral health agenda

The shift of commissioning of oral health improvement responsibilities from the NHS to local authorities in 2013 has connected oral health services to wider health and social care services for the first time.

Local authorities now have a remit to work across sectors, particularly with NHS England in first instance, to influence decision making and strategically plan the best way to meet population needs in relation to oral disease prevention and treatment services. This is supported by NICE guidance PH55 Error! Bookmark not defined. which suggests that development of an oral health strategy is the responsibility of a number of stakeholder including local authorities, NHS England, local Healthwatch, amongst others.

Supplemental to this is the opportunity that local authorities now have to gather vital information on where population needs are not being met. Identifying and communicating gaps in service provision, e.g. where vulnerable adults are unable to access dental care could have a powerful influence on the focus of dental commissioning strategies. This role was recently highlighted by NICE guidance on oral health in care homes which includes a recommendation for local authorities to 'ensure local oral health services address the identified needs of people in care homes, including their need for treatment'.³⁰

Discussion

A healthy mouth is a fundamental key element of health and wellbeing. Our ability to have a healthy mouth is affected by our experience of oral diseases. These include tooth decay gum disease and oral cancers. Oral diseases are largely preventable but are still very common.

Significant improvements in oral health have been made however; many adults and children still suffer from pain in their mouth, tooth loss and difficulties eating. As well as these health impacts, sufferers also experience a range of wider impacts including, difficulties smiling, working and socialising.

This JSNA relies on data from Public Health England (PHE) Dental Public Health Epidemiology Programme (DPHEP). These surveys are for 3, 5 and 12 year olds. There was also a survey of children in Special Support schools. The methodology of these studies has been published.

Estimates of tooth decay experience in 3, 5 and 12 year olds in Swindon are not significantly different from the estimates for national and regional decay experience. Decay experience for 5 year olds seems to have deteriorated between the 2011/12 and 2014 surveys (24.1% to 27.9%). However, these figures are within margins of error. This survey did not find a significant difference between children in special support schools and other children. This is most likely to be because of the small sample size of children studied.

There is less readily available data on oral diseases in older people. There is an ongoing Public Health England (PHE) Dental Public Health Epidemiology Programme (DPHEP) survey in the elderly, with results expected in 2017. There is no reason to believe that Swindon experience of oral diseases is significantly different to national estimates.

People with the greatest oral health needs are usually vulnerable or disadvantaged in some other way already. Tooth decay, gum disease and oral cancer are associated with socioeconomic deprivation and increasing age. Young adults also experience tooth decay and, increasingly, oral cancers. People from black and minority ethnic groups tend to experience more oral diseases however; the relationship is complex and likely to be confounded by socio-economic status and lifestyle factors.

The causes of oral diseases are well understood but tackling them is complex. No single intervention or agency can improve oral health alone. Instead, a multi-agency approach is needed that delivers a range of interventions that improve oral health alongside general health. This should be coordinated through an oral health strategy for Swindon.

¹ Department of Health. An Oral Health Strategy for England. London: Department of Health; 1994

² World Health Organisation website [accessed 20th November 2015] Available at http://www.who.int/oral_health/policy/en/

³ Royal College of Surgeons; Clinical Guidelines and Integrated Care Pathways for the Oral Health Care of People with Learning Disabilities 2012 available at https://www.rcseng.ac.uk/publications/docs/clinical_guidelines_oral_health_care.html?searchterm=Clinical+Guidelines+and+Integrated+Care+Pathways+for+the+Oral+Health+Care+of+People+with+Learning+Disabilities last accessed 18th April 2016

⁴ NHS England. Improving dental care and oral health – a call for action 2014

⁵ Department of Health. National schedule of reference costs 2011-12 for NHS trusts and NHS foundation trusts. 2012

⁶ Health and Social Care Information Centre. Child Dental Health Survey 2013, England, Wales and Northern Ireland. 2013. [Accessed 11th December 2015]. Available at: <http://www.hscic.gov.uk/catalogue/PUB17137>

⁷ Health and Social Care Information Centre. Adult Dental Health Survey 2009 [accessed 11th December 2015] <http://www.hscic.gov.uk/article/2021/Website-Search?productid=328&q=adult+dental+health+survey&sort=Relevance&size=10&page=1&area=both#top>

⁸ Results of survey of three year old children 2013 [http://www.nwph.net/dentalhealth/survey-results%203\(12_13\).aspx](http://www.nwph.net/dentalhealth/survey-results%203(12_13).aspx) last accessed 08/7/2016

⁹ Results of the survey of 5 year old children [http://www.nwph.net/dentalhealth/survey-results%205\(14_15\).aspx](http://www.nwph.net/dentalhealth/survey-results%205(14_15).aspx) last accessed 08/7/2016

¹⁰ Results of the survey of 5 year old children in 2011/12 <http://www.nwph.net/dentalhealth/survey-results5.aspx?id=1> last accessed 08/7/2016

¹¹ Results of 12 year old children survey 2008/2009 <http://www.nwph.net/dentalhealth/survey-results-12.aspx> last accessed 08/07/16

¹² Race Equality Foundation, Oral health and access to dental services for people from black and minority ethnic groups. 2013. [Accessed 11th December 2015]. Available at [http://www.betterhealth.org.uk/sites/default/files/briefings/downloads/health_briefing_29%20\(1\)_0.pdf](http://www.betterhealth.org.uk/sites/default/files/briefings/downloads/health_briefing_29%20(1)_0.pdf) last accessed 11th December 2015

¹³ Warnakulasuriya S Causes of oral cancer – an appraisal of controversies. *British Dental Journal*. 2009; **207**:471 – 475.

¹⁴ Cancer Research. Oral cancer key facts. 2014. [Accessed 11th December 2015]. Available from: URL http://publications.cancerresearchuk.org/cancerstats/stats_mouth/oralkeyfacts.html.

¹⁵ Cancer Research UK UK oral cancer incidence statistics. 2014. [Accessed 11th December 2015] Available from: <http://info.cancerresearchuk.org/cancerstats/types/oral/incidence/?a=5441>

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- ¹⁶ Warnakulasuriya S. Global epidemiology of oral and oropharyngeal cancer. [Oral Oncology](#). 2009; 45: 309–316.
- ¹⁷ Downer M. Public Health Aspects of Oral Diseases and Disorders – Oral Cancer’ In Pine C, Harris R. Community Oral Health 2nd edition. Surrey: Quintessence.2007.
- ¹⁸ Healthwatch Swindon, NHS Dentists in Swindon May 2015
<http://www.healthwatchswindon.org.uk/news/nhs-dentists-swindon-april-2015> April 2015
- ¹⁹ PHE, Extraction data <http://www.nwph.net/dentalhealth/extractions.aspx> last accessed 08/07/16
- ²⁰ NHS Bodies and Local Authorities (Partnership Arrangements, C.T., Public Health And Local Healthwatch) Regulations 2012. 2012: United Kingdom.
- ²¹ Sheiham A, Watt RG. The common risk factor approach: a rational basis for promoting oral health. Community Dent Oral Epidemiol. 2000 Dec;28(6):399-406
- ²² Watt RG. Strategies and approaches in oral disease prevention and health promotion. Bull World Health Org 2005;83:711–8.
- ²³ Chiappelli F, Bauer J, Spackman S, Prolo P, Edgerton M, Armenian C, Dickmeyer J, Harper S. Dental needs of the elderly in the 21st century. Gen Dent. 2002; 50(4):358-63
- ²⁴ WHO Oral health in aging societies. Integration of oral health with general health. 2006 Available from:
http://www.who.int/oral_health/events/Oral%20health%20report%202.pdf?ua=1
- ²⁵ Public Health England Delivering better oral health: an evidence-based toolkit for prevention Third edition Available at
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367563/DBOHv32014OCTM ainDocument_3.pdf [accessed 23rd July 2016]
- ²⁶ National Institute for Health and Care Excellence Oral health: approaches for local authorities and their partners to improve the oral health of their communities. 2014 NICE public health guidance 55. Available from: www.guidance.nice.org.uk/ph55
- ²⁷ Public Health England. Local authorities improving oral health: Commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities. 2014. Available from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf

²⁸ Marinho VCC, Higgins JPT, Logan S, Sheiham A. Fluoride toothpastes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews 2003, Issue 1. Art. No.: CD002278. DOI: 10.1002/14651858.CD002278

²⁹ Marinho VCC, Worthington HV, Walsh T, Clarkson JE. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews 2013, Issue 7. Art. No.: CD002279. DOI: 10.1002/14651858.CD002279.pub2

³⁰ NICE guideline Oral health for adults in care homes Published: 5 July 2016 [nice.org.uk/guidance/ng48](https://www.nice.org.uk/guidance/ng48) [accessed 25th July 2016]

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Falls and Bone Health Joint Strategic Needs Assessment

Health and Wellbeing Board

Date: 12th October 2016

Author:	Director of Public Health, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 To agree the recommendations of the draft Swindon Falls and Bone Health Joint Strategic Needs Assessment (JSNA) attached at Appendix 1 to the report, and support the ongoing work of the Swindon Falls and Bone Health Collaborative.
- 1.2 A Falls and Bone Health JSNA was produced in 2014. Although the recommendations are still relevant, it was agreed at the JSNA Steering Group that the JSNA would be updated to reflect current available data and the work of the Swindon Falls and Bone Health Collaborative to date.
- 1.3 The Collaborative is a Swindon wide multi-agency group lead by Public Health at Swindon Borough Council and NHS Swindon Clinical Commissioning Group. Membership includes Great Western Hospital Foundation Trust, SEQOL, Primary Care, South West Ambulance Foundation Trust, Dorset and Wiltshire Fire and Rescue Service, Swindon Borough Council, Avon and Wiltshire Mental Health Foundation Trust, Age UK and Healthwatch.
- 1.4 The Terms of reference for the Collaborative are to:
 - 1.4.1 Promote mobility, independence and improved quality of life for adults in Swindon and Shrivenham.
 - 1.4.2 Prevent avoidable falls and reduce the number of hospital admissions for a fall.
 - 1.4.3 Improve outcomes for people who have sustained a fracture.

2. Recommendations

The Board is recommended to:

- 2.1 Discuss and approve the draft Swindon Falls and Bone Health Joint Strategic Needs Assessment attached at Appendix 1 to the report, and support the ongoing focus on falls prevention work in Swindon.
- 2.2 Support the development of a Swindon Falls and Bone Health Strategy.

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, CherryJones@swindon.gov.uk.

Falls and Bone Health Joint Strategic Needs Assessment

Health and Wellbeing Board

Date: 12th October 2016

3. Detail

- 3.1 The aim of the Swindon Falls and Bone Health JSNA profile is to describe the epidemiology of falls in Swindon; provide a summary of current falls and bone health strategies and services; and make recommendations for future work to prevent falls in older people in Swindon. It provides an update to the previous Falls and Bone Health Profile 2014 and will inform the work of the Swindon Falls and Bone Health Collaborative.
- 3.2 Falls and fall-related injuries are a common and serious problem for older people. Each year 30% of over-65s experience one or more falls and about 50% of people aged over 80 fall. Between 10 and 25% of such fallers will sustain a serious injury (NICE 2013, DH 2009). After a first fall people have a 66% chance of having another fall within a year.
- 3.3 Falls are the most common cause of death from injury in the over 65s and cost the NHS over £2bn a year and over 4 million bed days. At an individual level, falls are the number one precipitating factor for a person losing independence and going into long term care.
- 3.4 Falls are not an inevitable part of growing old. There are clear risk factors for falling which include previous falls, fear of falling, balance problems, gait and mobility problems, pain, drugs, cardiovascular conditions, and cognitive impairment. External risk factors include poor or cold housing, poor footwear and home hazards: all of which can be modified.
- 3.5 In 2015/16 there were 1757 admissions for falls and 151 for fractured neck of femur (NoF) for people aged 50 and over in Swindon. In terms of emergency admissions for falls and number of hip fractures, Swindon is similar to the England average. Because the number of older people is predicted to increase over the next few years, the number of people falling is likely to increase if no action is taken.
- 3.6 A mapping exercise undertaken by the Swindon Falls and Bone Health Collaborative has identified that there is a wide range of existing provision in Swindon but more could be done to raise awareness between different organisations and the public of what is available and a clearer pathway is needed to look at movement between services.
- 3.7 The recommendations of the 2014 JSNA Profile are still relevant but progress has been made in each area. The Swindon Falls and Bone Health Collaborative is specifically focused on delivery of the recommendations and they will shape the Strategy and work programme going forward.
- 3.8 The recommendations together with a list of progress to date are listed below:

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, CherryJones@swindon.gov.uk.

Falls and Bone Health Joint Strategic Needs Assessment

Health and Wellbeing Board

Date: 12th October 2016

- 3.8.1 Review currently commissioned services that contribute to falls prevention, and care and support of those who fall, and explore opportunities for joined-up multi-agency approaches to commissioning to ensure that there is a clear evidence based falls and fracture care pathway in Swindon

This work is part of the remit of the Swindon Falls and Bone Health Collaborative. A mapping exercise was undertaken by the group and a draft pathway produced. Developing this and identifying opportunities for more joined up approaches is a priority for the next six months.

- 3.8.2 Develop resources and training for health and social care professionals and the community and volunteers which promote falls and osteoporosis awareness, the importance of case risk assessment and case identification, existing falls services available in Swindon and appropriate referrals to these services

A falls booklet has been produced and will be launched at the Steady Steps to Staying Active for Life Event on 5th October. This will replace the current Safe & Warm booklet. The Swindon Falls and Bone Health Collaborative is a forum where agencies are working together to learn from each other and develop a consistent approach.

- 3.8.3 Explore ways to increase capacity to undertake multifactorial falls risk assessment within health care services in Swindon. This may be through the existing community falls service or within Primary Care.

Ongoing through the work of the Swindon Falls and Bone Health Collaborative. The group is looking at how risk is assessed for people at different levels of falls risk and also reviewing the services, particularly in terms of prevention, that are available to those who have not fallen but are at risk and those who have fallen without injury to reduce the risk of falling again.

- 3.8.4 Improve referral pathways in to community falls clinic for repeat fallers attended to by the ambulance service or Homeline including redesign of current risk assessment forms used.

A working group has looked at exchange of information between homeline and Primary Care and developed a pilot project to improve this. A working group is also looking at frequent fallers. The STP work includes developing a consistent Fracture Liaison Service across the footprint.

- 3.8.5 Identify ways to extend local provision of evidence based strength and balance training through group classes and home based interventions including building links with nursing and residential care, Primary Care, Health Ambassadors and the new Community Navigators project.

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Ongoing through the work of the Swindon Falls and Bone Health Collaborative and the redesign of the Community Health and Wellbeing Service and Live Well Swindon brand.

- 3.8.6 Support national campaigns and deliver local campaigns to promote healthy ageing including physical activity and other healthier lifestyle choices and other protective factors for falls and osteoporosis; advises older people and carers on what they should do in the event of a fall or fragility fracture; advises older people and carers about risk factors for falls and fractures and the steps they can take to reduce their risk.

Ongoing via the Communications Team work and workplace health agenda. There is a Steady Steps to Staying Active for Life Event on 5th October which will promote this and provide people with information and an opportunity to try different activities.

4. Alternative Options

- 4.1 There is no alternative option as the JSNA is out of date and we need an updated JSNA to inform the new strategy and on-going work of the Collaborative.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 There are no direct financial or procurement implications arising from this report.
- 5.2 Any service reviews or service requirements which are discussed as a result of this report will be reviewed and a business case developed accordingly.
- 5.3 There are no additional recommendations beyond those which were agreed previously.

Legal and Human Rights Implications

- 5.4 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.5 There are positive implications on health from promoting falls prevention and bone health. This will benefit both the health and social community as falls have a significant economic and resource impact.

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Diversity Impact Assessment

- 5.6 A diversity impact assessment will be completed as part of the Swindon Falls and Bone Health Strategy and will be available on request. The falls and bone health action plan will include actions to work on identified gaps or issues.

Risk Management

- 5.7 No specific risks have been identified at this stage for this report.

6. Consultees

- 6.1 The Corporate Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 None.

8. Appendices

- 8.1 Appendix 1 – Draft Swindon Falls and Bone Health Joint Strategic Needs Assessment.

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Draft Swindon Joint Strategic Needs Assessment **Profile of Falls and Bone Health in Swindon 2016**

Scope and purpose of this JSNA Profile

The aim of this profile is to describe the epidemiology of falls in Swindon; provide a summary of current falls and bone health strategies and services; and make recommendations for future work to prevent falls in older people in Swindon. It provides an update to the previous Falls and Bone Health Profile 2014 and will inform the work of the Swindon Falls and Bone Health Collaborative.

INTRODUCTION

Falls and fall-related injuries are a common and serious problem for older people. Each year 30% of over-65s experience one or more falls and about 50% of people aged over 80 fall. Between 10 and 25% of such fallers will sustain a serious injury (NICE 2013, DH 2009). After a first fall people have a 66% chance of having another fall within a year.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. A fall can hasten a move into residential care; after a hip fracture 50% of people can no longer live independently (Age UK 2012). Falls are estimated to cost the NHS and Social Care more than £2.3 billion per year (NICE 2013).

In Swindon which has around 33,000 people aged over 65 it can be estimated that:

- 11365 will fall each year
- 4900 will fall twice or more
- 1600 will call the ambulance service
- 1600 fallers will attend an accident and emergency (A&E) department or minor injuries unit (MIU)
- 730 will sustain a fracture
- 260 will sustain a fracture to the hip
- 7300 people per year who fall should receive a falls assessment
- 3600 will require a brief screening of gait and balance.

(Estimates based on modelling from Department of Health Falls and fractures: Effective interventions in health and social care (DH 2009).

Falls are not an inevitable consequence of old age; falls should be considered a symptom rather than a diagnosis, so that when a patient presents with a history of falls, effort should be made to find the cause or causes. Complete prevention of falls among older people would be impossible and undesirable to achieve because of the restriction that would have to be placed on an individual's activity and autonomy. An acceptable balance between prevention and living with risk is needed.

Preventing older people from falling is a key challenge for the NHS, local authorities and the voluntary sector. It is not the preserve of one agency as the consequences of a fall and resultant fragility fracture cut across all local organisations working with older people. In Swindon a multi-agency Falls and Bone Health Collaborative has been

established to deliver the recommendations of this Profile and prevent avoidable falls and improve quality of life for people living in Swindon.

CONTEXT

National Policy Context

Falls and bone health is a national government priority; the Public Health Outcomes Framework (PHE 2016) includes national indicators for admissions to hospital for injuries due to falls in people aged 65 and over and also admissions due to hip fractures. The NHS Outcomes Framework includes indicators about the proportion of fragility fracture patients recovering to their previous levels of mobility/walking ability (HSCIC). There are also links between falls prevention and the Adult Social Care Outcomes Framework (DH 2013).

There have been a number of national policy and strategy documents related to falls and bone health published by the Department of Health, the National Institute for Health and Care Excellence (NICE) and national professional bodies such as the Royal College of Physicians.

National Policy and Strategy Documents

- The assessment and prevention of falls in older people, NICE Clinical Guidelines CG191 (2013).
- Public Health Outcomes Framework 2013 to 2016, Public Health England (2013).
- Adult Social Care Outcomes Framework 2013 to 2014, Department of Health (2013).
- Breaking Through: Building Better Falls and Fracture Services in England, Age UK and National Osteoporosis Society (2012).
- NHS Outcomes Framework 2013 to 2014, Department of Health 2012.
- Falls prevention: new approaches to integrated falls prevention services, NHS Confederation (2012).
- Implementing FallSafe care bundles to reduce inpatients falls, Royal College of Physicians (2012).
- National Audit of Falls and Bone Health in Older People. Royal College of Physicians (2011).
- Stop falling: start saving lives and money, Age UK (2010),
- Falls and fractures: effective interventions in health and social care, Department of Health (2009).
- *The Care of Patients with Fragility Fracture*, British Orthopaedic Association and British Geriatrics Society (2007).
- The assessment and prevention of falls in older people, NICE Clinical Guidance 21 (2004).

Local Policy Context

Falls prevention is a priority in Swindon and actions to reduce the number of older people who fall in Swindon and support those who do to regain their mobility and independence are reflected in many local strategies and services.

The most recent Swindon Falls & Bone Health Strategy was published in 2010 (NHS Swindon 2010). The strategy was developed jointly by Swindon Primary Care Trust and Swindon Borough Council. There have been many changes in the health and social care landscape since the publication of this strategy including the abolition of Primary Care Trusts on 31st March 2013 and the move of Public Health to Local Authorities and

much of local NHS commissioning to GP led Clinical Commissioning Groups and the NHS England Area Team for Bath, Gloucestershire, Swindon And Wiltshire.

In 2015 a Swindon Falls and Bone Health Collaborative was established with membership including NHS Swindon CCG, Swindon Borough Council, South Western Ambulance Service Foundation Trust, Dorset and Wiltshire Fire Service, Great Western Hospital Foundation Trust, SEQOL and Age UK. A new strategy will be overseen by this group.

There is a range of hospital and community based interventions and services provided in Swindon aimed at prevention, assessment and management of falls in older people. The main health care providers in Swindon are Great Western Hospitals NHS Foundation Trust and SEQOL. In 2012 Great Western Hospitals NHS Foundation Trust published a Falls Prevention Strategy (GWH 2012) which sets out the Trust's plan to implement Royal College of Physicians FallSafe care bundles to reduce inpatients and prevent and reduce falls in Acute and Community Services. SEQOL have also developed internal guidelines and care pathways for the prevention and management of falls. Other services also have an important role to play in falls prevention and caring for older people who fall, for example Swindon Borough Council which includes Social Care, the Homeline service, Health Improvement teams and the Safe and Warm service.

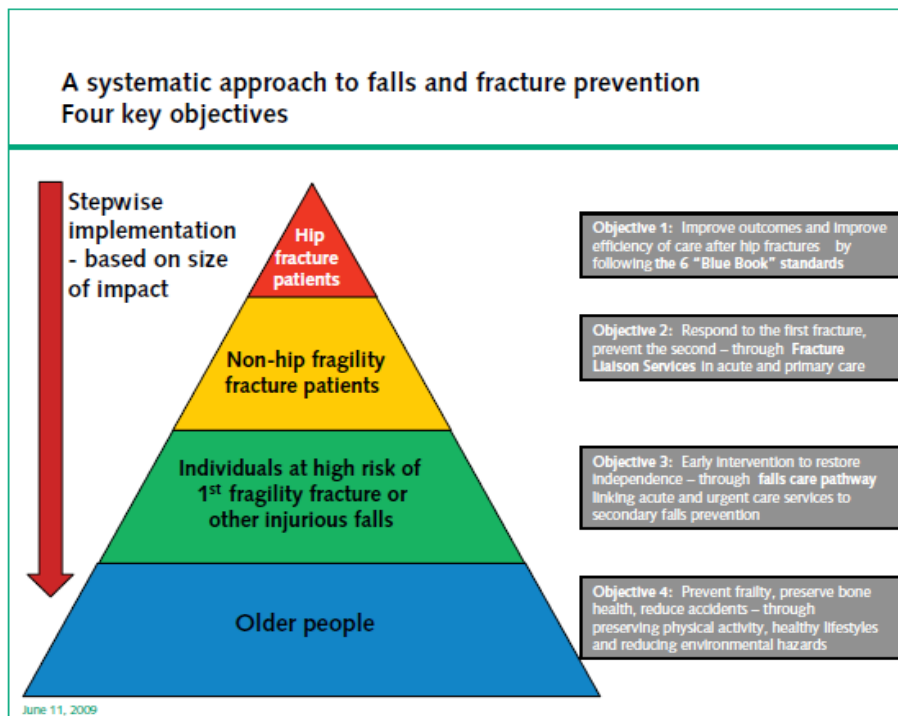
FALL AND FRACTURE PREVENTION INTERVENTIONS

Falls Prevention

The Department of Health publication *Falls and fractures: Effective interventions in health and social care* (DH 2009) describes fall and fracture prevention interventions to achieve four objectives. The publication lists these objectives in priority order in terms of impact and evidence-base, although they each have a role for different risk groups and in fact the size of the population which might be reached by objective 4 is by far the largest.

- Objective 1: Improve patient outcomes and improve efficiency of care after hip surgery through compliance with core standards.
- Objective 2: respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings.
- Objective 3: early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries.
- Objective 4: Prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards.

Figure 1. A Systematic Approach to Falls and Fracture Prevention. (Source: Falls and fractures: Effective interventions in health and social care, Department of Health)



It is recognised that prevention is a key part of any falls pathway and in particular exercise has been proven to be extremely effective in reducing falls and plays an important role in primary and secondary prevention. Multi-component group exercise sessions which include balance and muscle strengthening reduce the risk of falls but home-based exercises are also effective. Videogame based exercises are also being evaluated for their ability to reduce falls in older people.

Figure 2. Examples of evidence-based physical activity programmes. (Source: Age UK)

Type of exercise	Falls prevention?	Details
Tai Chi, dancing, gardening	Yes – Primary	Reduces risk of falls and is appropriate for younger-older adults (with only mild deficits of strength and balance) who have not experienced a fall.
Otago and Postural Stability (FaME/PSI) programmes	Yes – Secondary	Each exercise programme has been shown to prevent falls by as much as 35 per cent and 54 per cent respectively. Appropriate for older people at high risk of falls.
Chair-based	No	A modified evidence-based intervention, working towards reducing falls risk. Appropriate for those unable to exercise in a standing position, with or without support. Participants should be supported to progress according to their ability with the ultimate goal of building up to a level where they can take part in standing exercise and progress to an evidence-based programme for secondary prevention of falls.
Nordic walking, yoga	No	No evidence to support effectiveness in preventing falls though does help to maintain strength and balance (risk) and contribute to reducing risk in younger, fitter older adults or those not considered at risk.

There are NICE Guidelines for the assessment and prevention of falls in older people (NICE 2013). NICE identifies ten key recommendations for preventing falls in older people.

1. Case/risk identification

Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and those reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

2. Multifactorial falls risk assessment

Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment.

3. Multifactorial interventions

All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention that includes:

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal

4. Strength and balance training

A muscle-strengthening and balance programme should be offered. This should be individually prescribed and monitored by an appropriately trained professional. There is evidence to support Tai Chi and gardening as effective interventions, as well as specifically designed programmes such as Otago and Postural Stability.

5. Exercise in extended care settings

Multifactorial interventions with an exercise component are recommended for older people in extended care settings such as a nursing home or supported accommodation who are at risk of falling.

6. Home hazard and safety intervention

Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation.

7. Psychotropic medication review

Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling

8. Cardiac pacing

Cardiac pacing should be considered for older people with cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls.

9. Encouraging the participation of older people in falls prevention programmes

Healthcare professionals involved in the assessment and prevention of falls should discuss what changes a person is willing to make to prevent falls.

Falls prevention programmes should also address potential barriers such as low self-efficacy and fear of falling, language and accessibility barriers, and encourage activity change as negotiated with the participant.

10. Education and information giving

All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

Individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls, where they can seek further advice and assistance and how to cope if they have a fall.

FALLS AND FRACTURES – RISK FACTORS AND IMPACT

Risk Factors

Falls are not an inevitable consequence of old age; rather they are nearly always due to one or more underlying risk factors (DH 2009). A recent State of the Art Review on falls prevention in the British Medical Journal identified the following common risk factors for falls in older people in the community:

- Previous falls
- Fear of falling
- Balance problems
- Gait and mobility problems
- Pain
- Drugs
- Cardiovascular conditions
- Cognitive impairment
- Urinary incontinence
- Stroke or diabetes.

Recurrent falls are often a manifestation of impaired postural stability. This can result from a combination of factors such as conditions like arthritis, stroke or Parkinson's disease, age-related frailty and long-term cardio-respiratory conditions leading to loss of strength, balance and concentration or insight.

External factors can also contribute to falls.

Risk factors include:

- poor or cold housing
- poor footwear
- home hazards

Most falls occur in the home; however incidence rates for falls in nursing homes and hospitals are two to three times greater than in the community and complication rates are also considerably higher.

Those with osteoporosis (bone weakness) are at particularly high risk of bone fracture as a result of a fall. 25% of women 80 years or older have osteoporosis. For a woman over 50 her lifetime risk of a vertebral fracture is 1 in 3 and for a hip fracture 1 in 5.

Impact of Falls and Fractures

Although most falls do not result in serious injury, the consequences for an individual of falling or of not being able to get up after a fall can be life changing, and in many cases life threatening for older people (NICE 2013).

Consequences include:

- psychological problems, for example, a fear of falling and loss of confidence in being able to move about safely
- loss of mobility, leading to social isolation and depression
- increase in dependency and disability
- hypothermia
- pressure-related injury infection.

Fragility fractures are the commonest significant injury resulting from falls and are often the first sign clinical sign of osteoporosis which can remain undiagnosed for many years. The most common are hip or femur fractures, but other serious injuries that can occur include skull fracture, head injury, subdural haematoma (bleeding on the brain following a head injury), other fractures and soft-tissue injuries.

Falling can precipitate loss of confidence, the need for regular social care support at home, or even admission to a care home. Fractures of the hip require major surgery and inpatient care in acute and often rehabilitation settings, ongoing recuperation and support at home from NHS community health and social care teams. The additional direct cost to commissioners for hip fractures alone is estimated to be £10,000 to the NHS. In addition, hip fractures are the event that prompts entry to a care home in up to 10% of cases (DH 2009). Indeed, fractures of any kind can require a care package for most older people to support them at home.

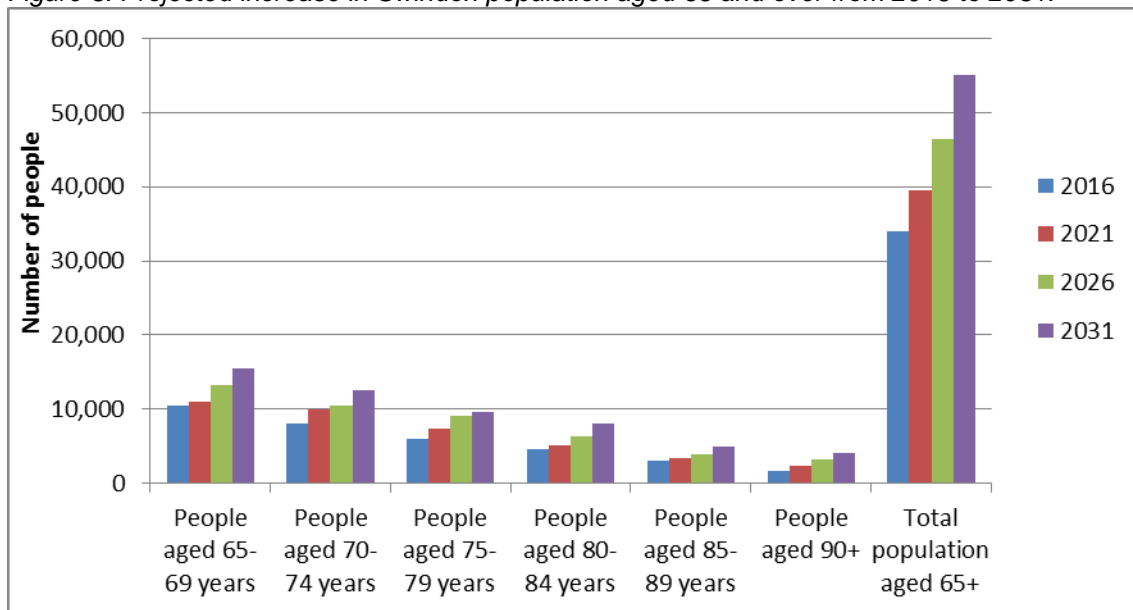
FALLS AND FRACTURES IN SWINDON – WHO IS AFFECTED?

Older People in Swindon

The population size of Swindon Borough (which includes the urban areas of Swindon and surrounding villages and rural areas) was 215,799 for the 2014 mid-year estimates with similar numbers of men (107,565) and women (108,234). Swindon's population is younger than average however, a large number of older people live in Borough; 32,237 people (15%) are aged over 65, including 14,664 aged 75 years or more (6.8%) and 4,181 (1.9%) over 85 years.

The population of Swindon by mid-2011 was estimated to be 209,700, an increase of approximately 29,600 persons from 2001 representing a growth rate of 16%, the highest in the South West and is expected to continue to grow. These projections estimate that Swindon's population could increase to 240,000 persons by 2021 and 265,400 by 2031, equivalent to growth of approximately 14% from 2011 to 2021, and a further 10% from 2021 to 2031. The largest increase in persons is projected to be in the 65 to 74 year age group, a total of 12,900 additional persons by 2031. However, the 85 years and over age group will have the largest growth rate at approximately 136%. (SBC 2014-2016)

Figure 3. Projected increase in Swindon population aged 65 and over from 2016 to 2031.



Source: Projecting Older People Population Information System (POPPI) applied to Swindon Borough Council policy led population projections.

Falls and fractures in Swindon- the size of the problem

Information about falls is available mainly through health service data. However, a large number of older people who fall do not contact a health service, and it is very difficult to obtain data about falls from Primary Care therefore the information below represents just a small proportion of all those older people who fall in Swindon every year.

Swindon Homeline

Homeline is Swindon Borough Council's telephone community alarm system, which helps elderly and vulnerable people living in the community. The service is available to anyone living in the Borough of Swindon. It operates 365 days a year, 24 hours a day. A team of mobile wardens respond to calls for assistance, often involving and liaising with other agencies such as doctors, the police and the ambulance service when appropriate. The service responds to around 1800 fallers a year, of whom less than 13% require an ambulance. A falls risk assessment form is completed for multiple fallers and sent to the community falls team for information.

Ambulance Service Data

Falls are the most common reason for 999 calls and account for 20-25% of ambulance service 999 activities (NHS Confederation 2012). From data provided by the South West Ambulance Service, in the Swindon area, 1 in 10 calls received in 2015 were as a result of a fall. However, it must be noted this may be an underestimation due to the way a call is logged, for example if the cause was unknown the call may be logged as a head injury rather than a fall. On average 10 calls a day have the categorization of a fall. Less than half (44.2%) of the calls responded to resulted in the patient being taken to the Emergency Department with a similar number of patients (44.8%) being assessed/treated at the scene. For the patients treated at the scene, ambulance crews will not usually notify the GP if the reason for the fall was mechanical or no particular illness or injury identified. This may mean an opportunity for early intervention for patients who have fallen may be missed. In the cases where the crews did identify an underlying illness or injury for the fall, a referral can be made via the GP professional line, or in the case of out of hours, to the GAP medical service via SEQOL. Swindon

CCG have recently engaged with SWAS with an invitation to a working group that has a focus on prevention and support in the home for non-injury or repeated fallers.

Over the last year (Apr 2015 to Mar 2016) there were just over 1700 attendances for falls in people aged over 65 years at the Great Western Hospital Emergency Department. This equates to 16% of all attendances to the emergency department for this age group. In this time period, around 1000 people (61%) arrived by ambulance, the second most popular method of transport was by private vehicle. Around half of attendances for falls result in an admission to hospital.

SEQOL

SEQOL are commissioned by Swindon CCG and SBC to provide assessment and support services for people who have fallen. There are multiple teams within SEQOL, However the teams that provide the most assessments are the Community Intermediate Care Team and the Swindon Intermediate Care Centre. For the period Apr 2015 to Dec 2015 (three quarters of the financial year) there were 1439 people who had contact with SEQOL which were labelled with a 'falls' code. In this group of people, the same person can have multiple contacts within SEQOL. There were 745 people recorded as having a falls risk assessment scorecard complete, 304 people had a falls assessment and 416 people had a multidisciplinary team falls assessment and within these categories 109 people were recorded as having all three of these particular type of contacts. A third of people in contact with SEQOL in this time period were recorded as having recurrent falls.

Hospital Data

In 2015/16 there were 1757 admissions for falls and 151 for fractured neck of femur (NoF) for people aged 50 and over. This is an increase year on year for falls but a decrease on fractured NoF.

Figure 4: Admissions to hospital Source: Swindon CCG

Falls:

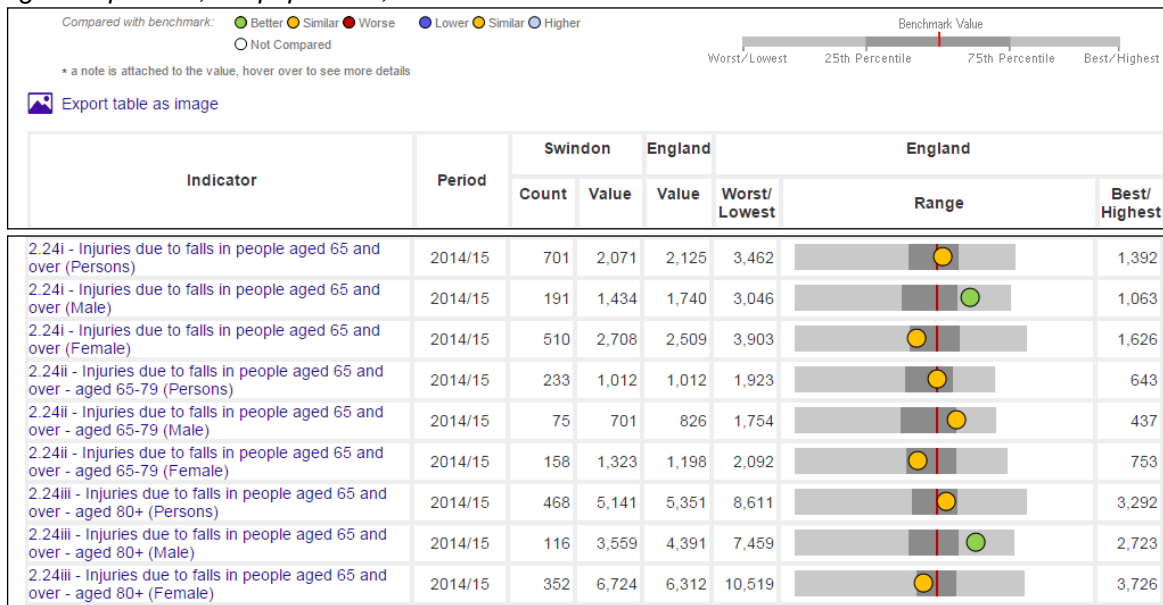
Age	2013/14	2014/15	2015/16
50-64	155	148	185
65+	1235	1371	1572
50+ Total	1390	1519	1757

Fractured NoF:

Age	2013/14	2014/15	2015/16
50-64	17	11	17
65+	186	163	134
Grand Total	203	174	151

Age-sex standardised rate of emergency hospital admissions for injuries due to falls in those aged 65 and over in Swindon are mostly similar to the national average with approximately 701 (2071 per 100,000) Swindon residents over the age of 65 years being admitted to hospital in 2014/15 as can be seen from the Public Health Outcomes Framework indicators (PHE 2016) in Figure 5 below.

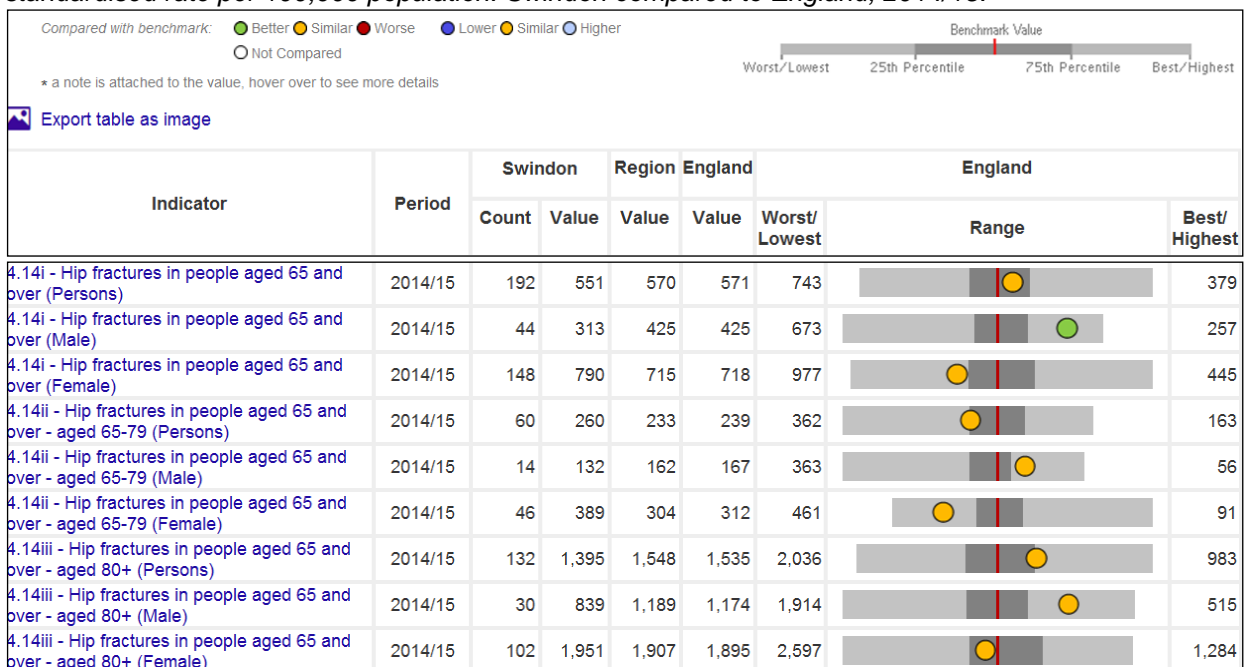
Figure 5. Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons age 65+ per 100,000 population, 2014/15



Source: Public Health Outcomes Framework

Figure 6 focuses on hip fractures and shows how this rate is split between gender and age groups for the year 2014/15. The markers that are further to the right of these bars have lower and therefore better rates. Swindon is similar to the England rate for all indicators apart from one, males that are over 65 in total.

Figure 6. Indicators for hip fracture admissions to hospital in people aged 65 and over, directly standardised rate per 100,000 population. Swindon compared to England, 2014/15.



Source: Public Health Outcomes Framework

The Falls and Fragility Fracture Audit Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and produced an inpatient falls audit in 2015. The audit had an organisational aspect and a clinical aspect. The outcome of the organisation audit was that many organisations had falls prevention policies and most policies included all the main areas of falls prevention. However, for many of these areas there was no association between what the policies included and the

assessments that a patient received once they were admitted to hospital, as shown by the clinical audit data. (FFFAP 2015)

The clinical audit collected data on whether patients had been assessed for all the risk factors of falls identified by NICE CG161 and whether there had been appropriate interventions to prevent falls. The group felt some risks were particularly indicative of good practice and achievable aims for quality improvement. These were chosen by the multidisciplinary advisory group for the audit, which includes patient representation. These seven key indicators are shown in the table below.

Clinical audit key indicators:

- Assessed for the presence or absence of delirium
- Measurement of lying and standing blood pressure
- An assessment for medications that increase fall risk
- Any assessment of vision
- Appropriate mobility aid in reach
- Continence or toileting care plan
- Call bell in sight and in reach of patient

Figure 7. Results for Clinical Audit section of National Audit of Inpatient Falls, for The Great Western Hospital NHS Trust, 2015

	Delirium	Blood pressure	Medication review	Visual impairment	Walking aids	Continence CP	Call bell
Great Western Hospital	15.0%	16.7%	61.9%	32.0%	75.0%	75.0%	73.1%

Outcomes: 80-100% 50-79% 0-49%

Source: FFFAP Audit report 2015

Figure 8. Falls resulting in harm and rate of falls per occupied bed day (OBD) across the South West, 2015

	Falls resulting in moderate/severe harm or death per 1,000 OBDs	Falls per 1,000 OBDs
National average	0.19	6.63
Dorset County Hospital NHS Foundation Trust	0.07	5.38
Gloucestershire Hospitals NHS Foundation Trust	0.08	7.17
Great Western Hospitals NHS Foundation Trust	0.19	8.33
North Bristol NHS Trust	0.33	7.03
Northern Devon Healthcare NHS Trust	0.16	9.23
Plymouth Hospitals NHS Trust	0.2	6.25
Poole Hospital NHS Foundation Trust	0.15	5.74
Royal Cornwall Hospitals NHS Trust	0.11	7.01
Royal Devon and Exeter NHS Foundation Trust	0.15	7.44
Royal United Hospitals Bath NHS Foundation Trust	0.08	5.73
Salisbury NHS Foundation Trust	0.25	7.34
South Devon Healthcare NHS Foundation Trust	0.06	3.93
Taunton and Somerset NHS Foundation Trust	0.1	6.31
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	0.19	8.96
University Hospitals Bristol NHS Foundation Trust	0.15	6.08

Weston Area Health NHS Trust	0.14	7.93
Yeovil District Hospital NHS Foundation Trust	0.16	9.19

Source: FFFAP Audit report 2015

The FFFAP audit report suggests that clinical staff and hospital managers should review the total number of falls and the number of falls with an outcome of harm per 1,000 OBDs. In GWH, the falls rate is above the national average and so it is recommended that the hospital review where these falls are taking place to see whether certain clinical areas seem to be having particular difficulty keeping their patients safe. Generally there are hot spots due to the nature of the patients, e.g. care of older people, general medicine and respiratory/thoracic medicine, among others. The risks and therefore the strategies have to be adapted to the particular problems in each area, but generally identifying delirium is a key factor.

The FFFAP also produce an annual report. This report has performance indicators for each hospital, see figure 9 and 10 below.

Figure 9. FFFAP Results (1)

South West

	Hospital code	Number of cases submitted	Admitted to orthopaedic ward within 4 hours (%)	Mental test score recorded on admission (%)	Perioperative medical assessment (%)	Mobilised out of bed on the day after surgery (Q5 16–9) (%)	Received falls assessment (Q5 16–11) (%)	Received bone health assessment (Q5 16–12) (%)	Met all the criteria for best practice tariff (%)
Royal United Hospital, Bath	BAT	535	54.0	100.0	99.4	19.9	99.8	99.8	74.0
Bristol Royal Infirmary	BRI	306	23.3	99.7	94.1	80.6	99.6	99.6	71.3
Cheltenham General Hospital	CHG	225	72.0	99.6	93.3	72.8	99.5	99.5	54.8
Southmead Hospital, Bristol	FRY	440	20.1	99.3	92.3	92.0	100.0	100.0	83.4
Gloucestershire Royal Hospital, Gloucester	GLO	417	50.2	97.8	90.9	46.6	99.2	98.6	55.4
Musgrove Park Hospital, Taunton	MPH	426	83.0	94.4	93.0	64.5	99.7	99.5	67.0
North Devon District Hospital, Barnstaple	NDD	261	76.7	81.2	62.5	75.8	98.3	99.2	44.1
Poole General Hospital	PGH	963	57.4	99.5	99.8	98.6	100.0	99.5	81.4
Derriford Hospital, Plymouth	PLY	484	53.4	99.2	97.9	90.6	99.6	99.6	77.5
The Great Western Hospital, Swindon	PMS	418	33.7	97.8	95.5	81.3	99.7	100.0	76.1
The Royal Cornwall Hospital, Trisley	RCH	606	68.6	98.5	95.4	48.0	99.8	99.3	66.1
Royal Devon & Exeter Hospital, Exeter	RDE	606	58.0	99.0	98.0	82.9	99.8	99.6	72.3
Salisbury District Hospital	SAL	274	64.0	99.6	96.0	98.6	99.6	98.8	81.1
Torbay District General Hospital	TOR	471	17.7	98.9	98.3	82.5	99.8	99.8	67.2
Dorset County Hospital, Dorchester	WDH	303	71.9	99.0	89.8	99.1	100.0	98.6	77.3
Weston General Hospital, Weston-super-Mare	WGH	304	39.5	98.7	74.3	69.4	89.6	94.2	49.2
Yeovil District Hospital	YEO	264	38.8	98.5	65.9	45.5	90.1	94.6	40.5
South West (Average)		7,303	51.9	97.7	90.4	73.5	98.5	98.8	67.0
Overall (Average)		64,102	46.1	94.5	85.3	73.3	96.1	96.5	63.3

Quartile (national)	Colour grading
Top 25 %	Green
2nd quartile	Yellow
3rd quartile	Orange
Lowest 25 %	Red

Source: FFFAP Annual report 2015

GWH score highly in the top 25% of hospitals for the proportion of patients that received a perioperative medical assessment. GWH also score highly, 2nd quartile, for the proportion of patients mobilised out of bed the day after surgery. This indicator is important as a delay in the start of rehabilitation can reflect problems such as management of pain, transfusion or fluid management in the perioperative period, or difficulties in providing appropriate physiotherapist assessment or nursing help to patients who are well enough to get up. However, GWH is placed in the 3rd quartile with only a third (33.7%) of patients being admitted to an orthopaedic ward within 4 hours.

Figure 10. FFFAP Results (2)

South West

	Hospital code	Number of cases submitted	Case ascertainment (%)	Acute LOS (days)	Overall hospital LOS (days)	Return to original residence within 30 days (%)	Reoperation within 30 days (%)	Developed a pressure ulcer after presenting with hip fracture (%)	Unknown pressure ulcers (%)	Hip fractures which were sustained as an inpatient (%)
Royal United Hospital, Bath	BAT	535	88.7	14.7	14.9	60.3	2.1	0.2	0.0	2.1
Bristol Royal Infirmary	BRI	306	81.6	19.1	25.5	48.1	4.9	2.6	0.0	6.5
Cheltenham General Hospital	CHG	225	76.3	13.2	13.6	42.4	0.0	0.9	0.0	5.3
Southmead Hospital, Bristol	FRY	440	90.7	19.4	23.4	58.6	2.3	5.9	0.2	7.0
Gloucestershire Royal Hospital, Gloucester	GLO	417	91.0	17.5	17.6	55.5	0.5	1.9	0.0	3.6
Musgrove Park Hospital, Taunton	MPH	426	100.5	13.5	13.8	62.4	1.7	0.8	56.5	3.3
North Devon District Hospital, Barnstaple	NDD	261	87.0	10.3	19.1	64.0	2.2	2.9	0.8	5.0
Poole General Hospital	PGH	963	112.2	11.9	11.9	53.5	1.1	1.8	0.0	2.8
Derriford Hospital, Plymouth	PLY	484	78.1	12.7	13.1	46.9	0.4	0.4	3.5	7.6
The Great Western Hospital, Swindon	PMS	418	94.8	12.8	15.7	63.2	1.8	1.9	0.5	2.2
The Royal Cornwall Hospital, Triliske	RCH	606	92.4	10.8	12.4	32.3	0.0	1.4	0.0	3.6
Royal Devon & Exeter Hospital, Exeter	RDE	606	100.8	11.7	13.8	54.1	2.8	1.4	0.2	4.0
Salisbury District Hospital	SAL	274	92.3	19.9	20.8	63.9	2.4	1.6	0.4	4.0
Torbay District General Hospital	TOR	471	104.0	8.4	8.6	40.8	0.4	1.8	5.1	2.5
Dorset County Hospital, Dorchester	WDH	303	101.0	12.2	12.8	44.3	1.4	0.0	0.0	3.6
Weston General Hospital, Weston-super-Mare	WGH	304	91.0	15.6	19.9	58.3	0.0	2.5	0.0	1.6
Yeovil District Hospital	YEO	264	83.8	16.8	18.0	50.5	0.0	3.7	0.0	3.0
South West (Average)		7,303	92.1	14.2	16.2	52.9	1.4	1.9	3.9	4.0
Overall (Average)		64,102	93.5	15.7	20.3	53.7	1.1	2.8	3.3	4.3

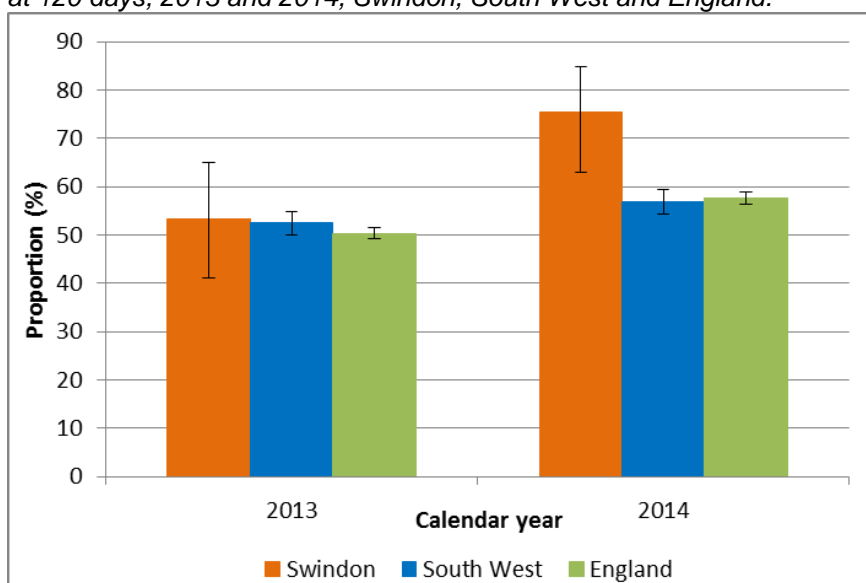
Quartile (national)	Colour grading
Top 25 %	
2nd quartile	
3rd quartile	
Lowest 25 %	

Source: FFFAP Annual Report 2015.

For the length of stay, mobility and reablement measures, GWH scores highly. It is placed in the top 25% nationally and is the only hospital in the South West to do so.

This data on reablement is reflected in figure 11 below. Although the numbers are smaller for Swindon (which is accounted for in the wide confidence intervals), the proportion of people in Swindon recovering to their previous level of mobility is better than the South West and England averages.

Figure 11. Hip fracture: Proportion of patients recovering to their previous levels of mobility/walking ability at 120 days, 2013 and 2014, Swindon, South West and England.

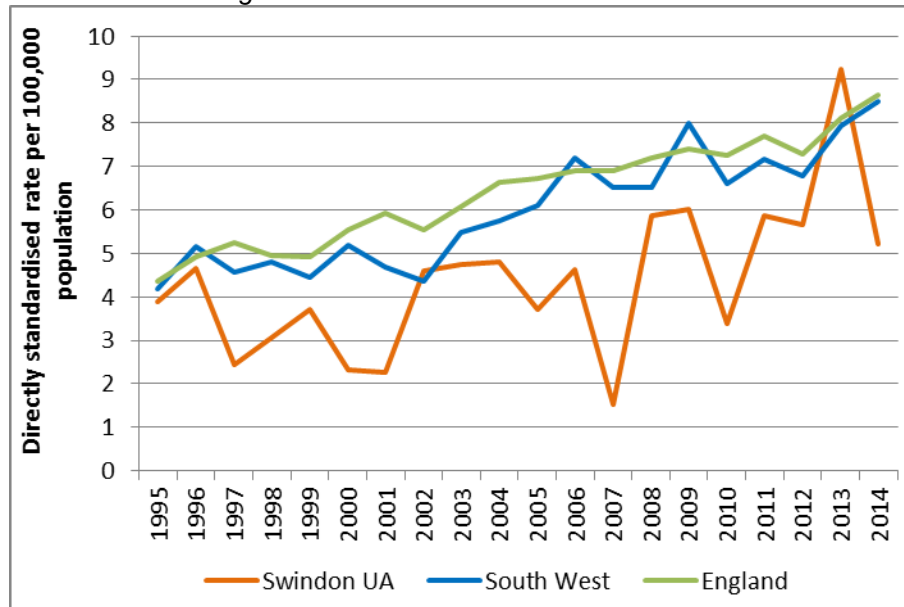


Source: Health and Social Care Information Centre, Indicator P01766

Mortality Data

Falls can be fatal. Over the last 10 years, on average 8 people die each year as a direct result of a fall (this figure includes all ages, however older people are known to be the most vulnerable). The number of deaths in Swindon is very low and the rates therefore fluctuate significantly, however in figure 12 it can be seen that mortality rates from falls are increasing across England, the South West and Swindon. This is most likely due to the growing older population.

Figure 12. Mortality from accidental falls: directly standardised rate, all ages, annual trend, Swindon, South West and England 1995 to 2014.



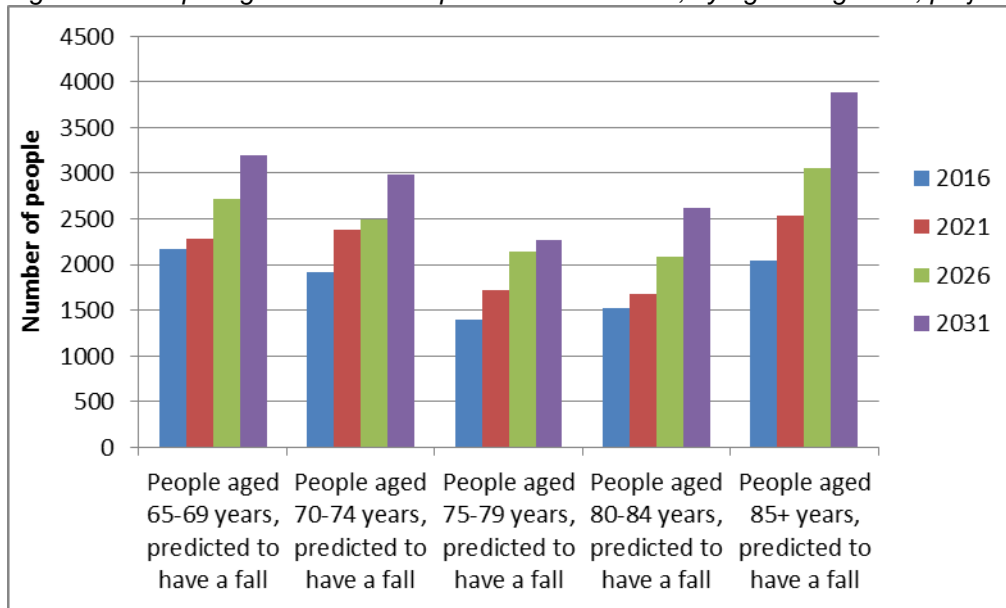
Source: Health and Social Care Information Centre, Indicator P00088

The age and frailty of hip fracture patients mean that up to a third will die within a year of the hip fracture. Only half of the deaths occurring within a few months of hip fracture can be directly attributed to the injury, hospitalisation and surgery – but patients, their families and carers often recognise the impact of hip fracture in precipitating or complicating a patient's final illness. (FFFAP Annual report supplement 2015)

Future Projections

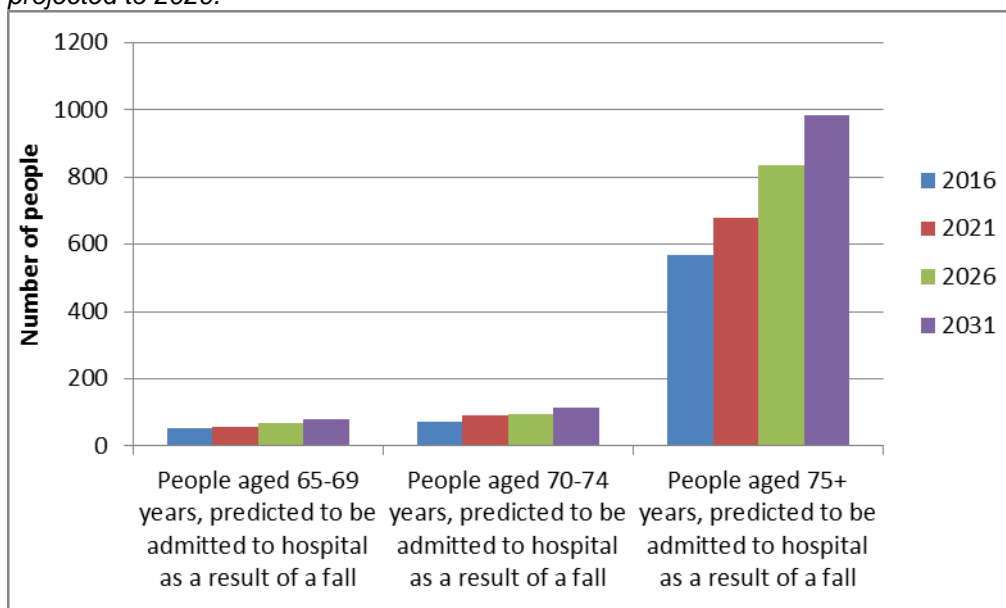
As the number of older people living in Swindon increases the number of those over the age of 65 falling is predicted to increase from around 9000 in 2016 to 15,000 in 2031. The number admitted to hospital because of a fall is also predicted to increase as can be seen in 13 and 14 below.

Figure 13. People aged 65 and over predicted have a fall, by age and gender, projected to 2020.



Source: Projecting Older People Population Information System (POPPI) and SBC policy led population projections.

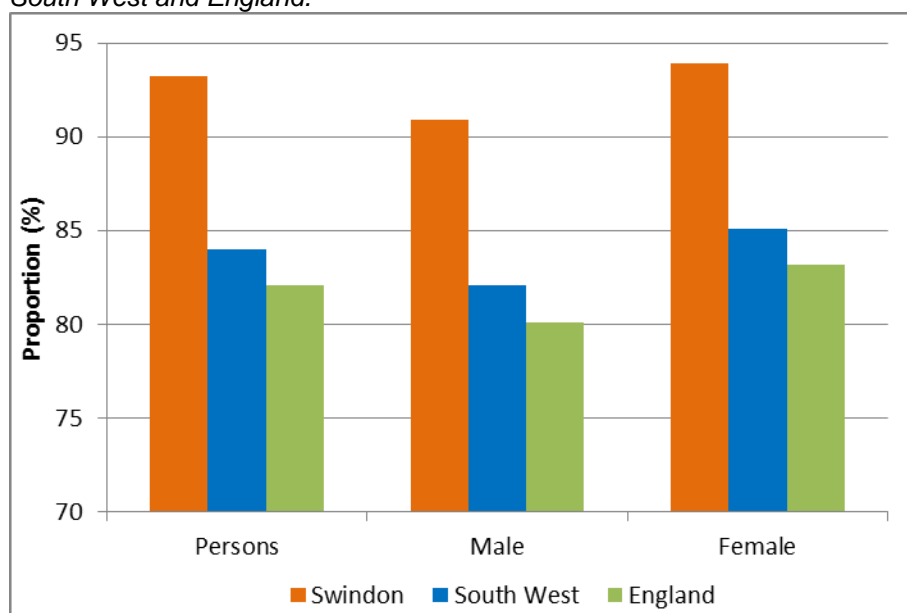
Figure 14. People aged 65 and over predicted to be admitted to hospital as a result of falls, by age, projected to 2020.



Source: Projecting Older People Population Information System (POPPI) and SBC policy led population projections

Following treatment in hospital, many people are discharged to a place for rehabilitation. As shown in figure 15 below, the proportion of people in a rehabilitation setting 91 days after discharge from hospital is higher than both the South West and England averages.

Figure 15. Proportion of people (aged 65 and over) who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital, 2014-2015, Swindon, South West and England.



Source: Health and Social Care Information Centre, Indicator P01515

WHAT SERVICES DO PEOPLE USE?

There is a large evidence base and NICE Guidelines for fall and fracture prevention. In Swindon there is a range of services and interventions available to help prevent falls in older people, and support those who seek support after a fall. However, a large number of older people who fall do not contact a health service and so do not come in contact with these services.

A mapping exercise undertaken by the Swindon Falls and Bone Health Collaborative has identified that there is a wide range of existing provision in Swindon but more could be done to raise awareness between different organisations and the public of what is available and a clearer pathway is needed to look at movement between services.

Current services include:

- **Primary Care**

Whilst there are no specifically commissioned falls services in primary care in Swindon GP Practices are the primary point of contact with the NHS for most people, and therefore have essential role in identifying patients at risk of a fall and supporting those who do fall including referring on to more specialist support services.

- **Great Western Hospital**

Acute care for those who fall and a consultant led specialist medical clinic which takes referrals from Primary Care and from other areas in the hospital. The Trust has a Falls Avoidance Nurse who works to identify those at risk of falling whilst in hospital, and also to ensure that those who are admitted because of a fall are referred to appropriate community services following discharge.

Patients who attend or are admitted to secondary care because of a fall are screened in a weekly hourly meeting by a consultant and falls avoidance nurse, and then triaged into different pathways including falls clinic appointment, community therapy or primary care. They also offer comprehensive falls assessments which includes detailed balance and syncope assessment as well as a variety of cardio vascular investigations including tilt table testing and FRAX scoring for assessing bone health.

- **SEQOL**

SEQOL offer the following services:

- Physiotherapist assessment
- Occupational therapist assessment in patient's home
- Balance and safety group over a 12 week period with regular reviews based on the FaME exercise programme
- One to one treatment sessions as tailored to the individual either by therapist if indicated or rehabilitation assistant
- OTAGO exercise programme either home based or in clinic
- Home based exercise programme
- regular reviews for individuals with movement disorders and an on-going plan for self-management of their conditions, and being able to contact or see the therapists if they have significant physical and functional problems in between their planned reviews.
- Parkinson's Disease Booster group over an 8 week period with regular reviews

The service has carried out regular evaluation and is received well by those who are referred. However, capacity is limited and there can be a long waits for availability.

The Falls & Bone Health Lead has also worked with other community health practitioners within SEQOL to increase awareness and skills relating to falls and falls prevention, particularly in District Nurses, and to improve internal practices/pathways so that those under the care of the service are identified and assessed appropriately.

- **Avon & Wiltshire Mental Health Partnership**

AWP offer falls services to anyone under their care co-ordination. Assessment on admission to the wards and care plans in are place and physiotherapy and exercise services will offer assessment and exercises alongside tailored interventions. A falls prevention group runs for in patients at the Victoria Centre.

- **Swindon Safe and Warm**

Work to help people at risk of falls in the home has become an integral part of Safe & Warm, with the available support being developed continually. Safe & Warm now not only flags up people at risk of a fall through its promotional activities, it now provides advice and support in the form of self-help booklets combined with a funding stream for minor works to reduce the risk factors within the home. It works closely with Falls Prevention professionals within SEQOL and the Great Western Hospital to ensure a coordinated and consistent approach is maintained.

To date, 459 homes have had falls prevention related measures carried out including grab rails, ramps, half steps, securing carpets, lowering shelves and cupboards, repositioning furniture and cables etc. £33,020.30 in grant funding has been provided to fund these measures, and the clients have been identified through the Safe & Warm scheme and the Hospital Discharge scheme to date. Future referrals for help will be accepted through the local Handiperson service also.

23% of residents engaged via the doorstep assessment process were identified as being at risk of a fall in the home, with 50-60% of residents engaged with the Warm Homes Healthy People funded promotional activity being identified as at risk of a fall. These people have all now received guidance on reducing their risk of a fall, with those most at risk being contacted to see if any practical measures are required to the home. (NB this part of the scheme is no longer active)

- **Swindon Borough Council Health Improvement, Physical Activity & Inclusion Team**

The Team offer Balance and Safety Classes designed specifically to help those at risk of falls by improving upper and lower body strength, mobility, co-ordination and balance. Two classes are offered each week. These are open to anyone and are promoted as a step-down following on from care provided by CICT. The service also provides a Ration Box Home Exercise in partnership with CICT which is designed to help reduce the risk of falls in the older age group, targeting those who are unable to attend group sessions. They also signpost people to the wide range of community classes including yoga, tai chi and balance.

- **Swindon Borough Council Property Adaptations**

Swindon Borough Council undertakes home adaptations for those with a disability or at high risk of falls to enable them to manage more independently for both private home owners and council housing tenants. Assessments are initially undertaken by a SEQOL Occupational Therapist.

- **Swindon Health Ambassadors**

The Health Ambassador Service provides help and support from within the community to help clients gain a healthier lifestyle. The team includes two Elder Ambassadors whose work is focussed on those over the age of 50. They offer guidance, support and motivation to make lifestyle changes such as eating more healthily, stopping smoking a becoming more physically active and are developing a role in offering home based exercise for older people in partnership with the Health Improvement Team.

- **Swindon Community Navigators**

The Community Navigator team work with local GP Practices and the Community Matrons to support people to navigate through health, social care and voluntary sector services in Swindon to improve their well-being and quality of life and enable them to become more independent and empowered in the management of their Long Term Condition and/or circumstances.

OLDER PEOPLE'S PERSPECTIVES ON FALLS

The Ageing Well JSNA will include some qualitative work looking at what would make Swindon a great place to grow old in and what some of the barriers are. Although this is not directly about falls, it will explore people's perspectives on ageing and their concerns and aspirations.

CONCLUSION AND RECOMMENDATIONS

This profile provides an update to that originally produced in 2014. The recommendations are still relevant but progress has been made in each area. The

Swindon Falls and Bone Health Collaborative is specifically focused on delivery of the recommendations and they will shape the Strategy and work programme going forward.

To date work of the Collaborative has included reviewing existing services and developing a care pathway, development of a falls prevention booklet which will be launched at a Swindon wide event in October 2016, development of a draft falls prevention strategy and action plan, piloting exchange of information between the Homeline service and GPs, and a working group looking at frequent fallers.

The group is also looking at how risk is assessed for people at different levels of falls risk and also reviewing the services, particularly in terms of prevention, that are available to those who have not fallen but are at risk and those who have fallen without injury to reduce the risk of falling again.

In 2016, a Sustainability and Transformation Partnership was established across Swindon, Wiltshire and Bath and North East Somerset. The proactive and prevention workstream includes a focus on ageing well and delivery of a consistent approach to assessing frailty and the proposed commissioning of a fracture liaison service which is aimed at people who have fallen once to reduce future falls.

Recommendations

1. Review currently commissioned services that contribute to falls prevention, and care and support of those who fall, and explore opportunities for joined-up multi-agency approaches to commissioning to ensure that there is a clear evidence based falls and fracture care pathway in Swindon

This work is part of the remit of the Swindon Falls and Bone Health Collaborative. A mapping exercise was undertaken by the group and a draft pathway produced. Developing this and identifying opportunities for more joined up approaches is a priority for the next six months.

2. Develop resources and training for health and social care professionals and the community and volunteers which promote:
 - falls and osteoporosis awareness
 - the importance of case risk assessment and case identification
 - existing falls services available in Swindon and appropriate referrals to these services

A falls booklet has been produced and will be launched at the Steady Steps to Staying Active for Life Event on 5th October. This will replace the current Safe & Warm booklet. The Swindon Falls and Bone Health Collaborative is a forum where agencies are working together to learn from each other and develop a consistent approach.

3. Explore ways to increase capacity to undertake multifactorial falls risk assessment within health care services in Swindon. This may be through the existing community falls service or within Primary Care.

Ongoing through the work of the Swindon Falls and Bone Health Collaborative. The group is looking at how risk is assessed for people at different levels of falls risk and also reviewing the services, particularly in terms of prevention, that are available to those who have not fallen but are at risk and those who have fallen without injury to reduce the risk of falling again.

4. Improve referral pathways in to community falls clinic for repeat fallers attended to by the ambulance service or Homeline including redesign of current risk assessment forms used.

A working group has looked at exchange of information between homeline and Primary Care and developed a pilot project to improve this. A working group is also looking at frequent fallers. The STP work includes developing a consistent Fracture Liaison Service across the footprint.

5. Identify ways to extend local provision of evidence based strength and balance training through group classes and home based interventions including building links with nursing and residential care, Primary Care, Health Ambassadors and the new Community Navigators project.

Ongoing through the work of the Swindon Falls and Bone Health Collaborative and the redesign of the Community Health and Wellbeing Service and Live Well Swindon brand.

6. Support national campaigns and deliver local campaigns to promote healthy ageing including physical activity and other healthier lifestyle choices and other protective factors for falls and osteoporosis; advises older people and carers on what they should do in the event of a fall or fragility fracture; advises older people and carers about risk factors for falls and fractures and the steps they can take to reduce their risk.

Ongoing via the Communications Team work and workplace health agenda. There is a Steady Steps to Staying Active for Life Event on 5th October which will promote this and provide people with information and an opportunity to try different activities.

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Community Services

Health and Wellbeing Board

Date: 12 October 2016

Author:	Director of Adult Social Services, Swindon Borough Council Executive Nurse, Swindon Clinical Commissioning Group Accountable Officer, Swindon Clinical Commissioning Group
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 To provide an overview of the procurement process for the award of adult community services contract.
- 1.2 To provide the Health and Wellbeing Board with a summary of service issues at the time of the contract transfer.

2. Recommendations

The Board is recommended to:

- 2.1 Note the contents of the report.

3. Detail

- 3.1 NHS Swindon CCG (the CCG) and Swindon Borough Council (SBC) have a long history of integrated commissioning and integrated service delivery for health and social care.
- 3.2 The CCG is the commissioner of health services in Swindon, Shrivenham and the surrounding areas and SBC is the commissioner for public health and social care for people within the Borough of Swindon. For the purpose of this tender adult community health services and some social care services were included in the contract value. The majority of community services are for Swindon only as Shrivenham receives its community services from Oxford Health NHS Foundation Trust and Oxfordshire County Council.
- 3.3 Following an extensive period of engagement and review the CCG with SBC sought to re-commission its community services via a provider model which integrated acute and community pathways, incentivised to shift the emphasis of treatment to effective prevention and management of patients, particularly those with Long Term Conditions and the Frail Elderly including alignment to adult social care.
- 3.4 The current contract for the provision of these services ends on the 17th February 2017. The CCG with SBC therefore sought to re-commission services from a capable provider who would work with the CCG and SBC over the

Further information on the subject of this report can be obtained from Gill May, 01793 683700.

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contract period to deliver services and to redesign the delivery of a community-based model of care to meet the CCG and SBC commissioning intentions and link to our plans through the Better Care Fund. The new contract for these services was awarded for a period of three years with the option to extend for any period up to 24 months and will commence from the 18th February 2017.

- 3.5 These community and social care services will be contracted on an outcomes basis reflecting the Swindon population needs. The provider will be expected to deliver transferred services within a cost envelope of circa £17,500,000 per annum representing the CCG and SBC funding. The CCG and SBC expect financial efficiencies to be delivered over the term of the contract.
- 3.6 As many NHS and social care organisations, the CCG and SBC are facing a significant challenge to ensure that high-quality, affordable, community health and care services can be delivered in the face of reductions in funding allocations and increasing demands. Service transformation will be required in order for community services in Swindon to remain at the heart of a sustainable health and care system. To this end the CCG and SBC are requiring the provider, over the period of the contract, to work with all existing health and social care providers, SBC, and the CCG to devise a reconfigured model of delivery to create sustainability, and support the transformation in line with Swindon CCG's and SBC's agenda to deliver the Five Year Forward View Vision and the Better Care Fund. This is in line with the CCG ethos of integrating health and care and empowering local communities to have greater ownership of decisions and resources, tailored to local needs.
- 3.7 SBC will be the provider of social work and some Occupational Therapy services as well as the commissioner of domiciliary, residential and nursing care. The CCG and SBC are planning to tender for a prime contractor for domiciliary care and this procurement will need to align with the work of SBC with the possibility of future links between both contracts as part of a One Swindon Budget. There is an expectation that social work services will work closely with community health services to ensure an integrated approach for patients and service users
- 3.8 A provider was sought that was able to demonstrate to the CCG and SBC that they can deliver a high quality service and that they have a clear understanding of the strategic direction for services within Swindon and of the need for close engagement and system leadership with other providers within the geography.

Procurement Process

- 3.9 In March 2016 the Integrated Adult Community Health Services were formally advertised through the Official Journal of the European Union (OJEU) and Contract Finder, and interested organisations were invited to express interest in the services. The Commissioner intended that by conducting a tender exercise, suitably qualified organisations would compete to provide the services, and

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propose innovative models of service delivery which would improve the quality of service to patients. It was anticipated that new contracts would be awarded between September 2016 and February 2017 with a view that the newly appointed provider would commence service delivery from February 2017.

- 3.10 A thorough procurement process was followed to ensure high quality tender documentation and specifications for services were produced. The NHS South, Central & West Commissioning Support Procurement Team managed the procurement process on behalf of Swindon Clinical Commissioning Group.
- 3.11 A Swindon Community Services Re-Procurement Project Board was established which was chaired by Bill Fishlock CCG Lay Member. This Board over saw the process and made a recommendation to the Governing Body on the preferred bidder for the services. A risk register was maintained and over seen by this Board.
- 3.12 Two bidders went through the full evaluation process, a Moderation meeting took place on 22nd July 2016, and a preferred bidder was identified and put forward for recommendation to the Governing Body. The evaluation panel, chaired by Swindon CCG and moderated by NHS South, Central & West Commissioning Support Procurement Team, and consisting of subject matter experts from Swindon Clinical Commissioning Group, Swindon Borough Council and service users took part in the following process.
- 3.13 In total, twenty different evaluators including service users were involved in the evaluation of bids. Each member of the evaluation panel was required to complete, sign and return conflict of interest and confidentiality forms prior to the evaluation of bids. The procurement team gave the need for confidentiality a high profile throughout the evaluation process.
- 3.14 The preferred bidder was identified as Great Western Hospitals NHS Foundation Trust. The recommendation was approved by the Governing Body and the preferred bidder notified.
- 3.15 At the same time as the completion of this process the incumbent provider SEQOL notified the CCG that they were considering their options in terms of sustainability as an organisation.

Transfer of services

- 3.16 Following a series of meetings with SEQOL key Executives it was agreed that the transfer of services should be made prior to the expected end date of the contract. This would enable staff to move to the new provider and give them some certainty for the future. The decision was taken to make the transfer prior to the increasing service pressures which are seen annually from November through to February.

Further information on the subject of this report can be obtained from Gill May, 01793 683700.

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- 3.17 The CCG approached Great Western Hospitals NHS Foundation Trust (GWH) and asked if they could take the services early under a care taker arrangement. This would involve a variation to the existing GWH contract to host the services from 1 October to SEQOL contract cease date of 17 February 2017.
- 3.18 The GWH Board agreed to this earlier transfer. As a result, GWH have not been able to complete the usual due diligence process as part of the contract award process. The CCG has agreed with GWH that both the CCG and GWH will carry out a shared due diligence process of services that transfer in the first 3 months of the care taker period. This will enable both parties to understand if there are any services issues which would need resolution prior to the formal contract start date 18 February 2017.
- 3.19 GWH retain the right to not move to contract mobilisation if the due diligence period identifies any service issues that would impact on their ability to deliver the services within the procured contract value. This would mean that the CCG would need to formally advertise and re-procure those services.
- 3.20 There are a number of other services which SEQOL provide that were not part of the procurement process. A new provider has been found for those services and the CCG will need to plan a formal re-procurement process for those within the next 3 months.

SUCCESS Services

- 3.21 SWAST will manage the Home Visiting service. Children and Young People and Urgent Care Clinics will continue to operate, with support from the host surgeries and GWH. A formal review of SUCCESS with the membership will need to take place as national guidance on funding becomes available. This will enable the model to be clarified and services to be procured.

LD and Autism services and IAPT

- 3.22 These are core services for Avon and Wiltshire Partnership Trust so they have agreed to take these services from 1 October 2016.

Adult Social Care Services

- 3.23 In light of the decision by SEQOL to request an early transfer of services given the financial sustainability of the organisation, Swindon Borough Council agreed to transfer all adult social care services from 1st October 2016. This includes social work and OT services, Fessey and Whitbourne Care Homes, day services for people with a learning disability (OK4U), Enterprise Works, Building Futures, Swindon Support, Shared Lives. The staff of the reablement team will be seconded to GWH as part of an integrated team with Rapid Response. Day Services for Older People will transfer to First City.

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Quality and patient safety concerns and early warning signs

- 3.24 The CCG became concerned in April 2015 specifically in relation to capacity, skills and leadership within the SEQOL community nursing service and lack of assurance that the Serious Incident process in SEQOL was robust.
 - 3.25 Serious incident data and analysis of complaints received by the provider and CCG identified a continued upward trend in relation to poor patient experience and clinical outcomes and was clearly highlighting gaps in relation to leadership, knowledge / expertise and workforce.
 - 3.26 To note, these concerns were placed on the CCG risk register and reported as areas of concern to the regional Quality Surveillance Group.
 - 3.27 During 2015/16, the CCG worked closely with SEQOL in order to gain detailed assurance in relation to the local quality schedule requirements and specifically the community nursing service. Assurance was sought in response to a reported increase in activity, together with identified care and service delivery problems noted within the serious incident, safeguarding and patient experience processes. A detailed community nursing action plan was submitted by SEQOL to the CCG in response to the concerns raised, which included workforce and capacity issues.
 - 3.28 The Executive Nurse informed the Care Quality Commission (CQC) of the concerns at the time and has liaised with the local CQC lead.
 - 3.29 A review of the community nursing action plan continues and is a standing agenda item within the monthly quality review meetings in order for the CCG to be assured of progress.
 - 3.30 The service remains on the CCG risk register until improvements can be fully evidenced and embedded.
 - 3.31 In May 2016 in response to a specific complaint and in addition in recognition of the outcomes of RCA investigations following reported serious incidents (most notably category III / IV pressure ulcers) an external review was commissioned by the CCG. The findings of this review have been built into the community nursing action plan.
 - 3.32 The external review focused on the following:
 - 3.32.1 Leadership of the community teams
 - 3.32.2 Their operating model, including case load allocation and public and patient access to the service
 - 3.32.3 Workforce model and skill mix (specifically impact of the band 6 Community Nursing role)
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Further information on the subject of this report can be obtained from Gill May, 01793 683700.

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3.32.4 End of life care provision

This review has been shared with both the CQC and NHS England (NHSE).

- 3.33 It should be noted that in addition to the review during April and May 2016 members of the quality and patient safety team, including the Executive Nurse CCG carried out a number of quality visits including shadowing staff on home visits. This covered both day and night nursing services. The outcome of these visits confirmed that whilst some improvements had been made to service delivery the workforce issues facing them, particularly with a loss of the band 6 workforce and having a greater dependency on the band 3 and 4 roles continued to have a direct impact on the quality of care being provided. The outcomes and learning from the RCAs provide evidence to further support this.
- 3.34 It is important to note that the CCG team shared that the staff are caring and compassionate.
- 3.35 CCG quality lead is working closely with SBC Safeguarding team in order to have oversight of any safeguarding alerts specific to the community nursing service. There have been a few alerts raised by domiciliary care agencies relating to missed visits by community nurses and lack of communication. The Safeguarding lead is a member of the CCG SI panel for review and alignment of those RCAs that are joint safeguarding investigations.
- 3.36 The external reviewer is working closely with SEQOL and has agreed a timeline for the caseload review, the methodology to be used and implementation of an acuity tool. The CCG Executive Nurse has received assurance from the reviewer that SEQOL staff were expressing positively the opportunities the announcement of the new provider could bring. A programme of learning and development support has been agreed as part of the case load review, targeting the band 6 and 5 staff specifically.
- 3.37 The CCG continues to be concerned that any assurance from SEQOL in response to improvements and implementation of the action plan are predominantly based on verbal evidence. Dedicated meetings are therefore in place to continue to provide oversight of progress in order to support transition of services to the new provider.
- 3.38 A detailed high level chronology of quality review meeting discussions, actions and outcomes has been presented to CCG Commissioning for Quality Committee.

4. Alternative Options

- 4.1 Not applicable.

Further information on the subject of this report can be obtained from Gill May, 01793 683700.

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5. Implications, Diversity Impact Assessment and Risk Management

Patient Benefits

- 5.1 The re-procurement of services followed engagement with the patients and public of Swindon. The clear indication from them was that they would want to see greater integration between health services in Swindon which reduce the duplication of care and reduce the time they spend giving their information to multiple staff.
- 5.2 The early transfer of services will support the sustainability and continuity of community and social care services for the population of Swindon.

Financial and Procurement Implications

- 5.3 To support a solvent closure of SEQOL has caused further financial pressures for the CCG. There is further detail to work through but it is anticipated that we will invest a further £0.7m plus circa £1.3m capital for purchase of assets. Swindon Borough Council also experienced financial costs due to the early transfer of services of £0.7m.
- 5.4 In addition, the CCG has had to provide legal assurances to GWH and AWP that any financial pressures found as part of due diligence will be underwritten by the CCG whilst the work takes place to mitigate those cost pressures and manage them out of the services this year.
- 5.5 Procurement implications: Those services not part of the original procurement will need to be reviewed over the next 3 months and then a procurement plan put in place.

Legal and Human Rights Implications

- 5.6 Legal advice has been taken on the details of any indemnities and the variation orders required for all providers. These document have been agreed by commissioning and provider legal firms.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.7 The early transfer of services was to support staff currently employed by SEQOL, to allow them to transfer to their new provider and have clarity about their future employment. SEQOL had reported that staff had started to leave the organisation as they were unsure about the future and this could have impacted on services sustainability.

Diversity Impact Assessment

- 5.8 Completed as part of the procurement process for community services.

Further information on the subject of this report can be obtained from Gill May, 01793 683700.

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Risk Management

- 5.9 A transition Board is in place between commissioners GWH and SEQOL to ensure executive level oversight of:
- 5.9.1 TUPE/Staff transfers
 - 5.9.2 Novation of contracts
 - 5.9.3 Leases/Estates
 - 5.9.4 Transfer of Assets
 - 5.9.5 Governance
 - 5.9.6 Records (Current and historic)
 - 5.9.7 Outstanding legal / insurance claims / complaints / NHSLA
 - 5.9.8 CQC
 - 5.9.9 Business Transfer Agreements.
- 5.10 These meetings are taking place weekly, and risks identified are on the CCG risk register.
- 6. Consultees**
- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.
- 7. Background Papers**
- 7.1 None.
- 8. Appendices**
- 8.1 None.