

# Safeguarding Adults in Swindon

Annual Report  
April 2014 - March 2015



Great Western Hospitals **NHS**  
NHS Foundation Trust



Keeping Swindon **Safe**

**healthwatch**  
Swindon

**NHS**  
**Swindon**  
*Clinical Commissioning Group*



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



**SWINDON**  
BOROUGH COUNCIL

# Safeguarding Adults at Risk in Swindon Annual Report 1<sup>st</sup> April 2014 31<sup>st</sup> March 2015

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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**

As the outgoing chair of Swindon's Local Safeguarding Adults Board, I am pleased to present its Annual Report for the year ending March 31<sup>st</sup> 2015.

The report describes how the Board's agencies, both jointly and independently, work to ensure the safety of those adults within the Borough who are deemed to be most at risk of harm through the actions of other people. However as stated at the start of section 1, this is the 'old' definition which was applicable for the year under review. The Care Act 2014 which became law on April 1<sup>st</sup> 2015 has a new, more wide ranging definition. This is just one of a number of significant changes contained in the Act.

As in previous years, the report contains statistical breakdowns which show the number, type, source and demography of safeguarding referrals, and the outcomes of the subsequent investigations.

These statistics show an upward trend for reports of adult abuse; an increase of 244 (717 compared to 473) from last year- a 51% rise. There have been significant rises in the number of referrals for assault and neglect as well as psychological abuse. Swindon is not alone in experiencing such an increase in referrals and possible explanations are included on page 8. The statistics also show that of the 717 recorded cases, 308 required 'no further action' or 42%. Last year 203 cases out of 417 (43%) resulted in 'no further action'.

This is just one type of resolution and a detailed breakdown of the other outcomes is shown on pages 18 and 19. However it is important to look at the impact on the individuals rather than concentrate just on the statistics. The report contains many examples of anonymised safeguarding investigations which have a number of different resolutions but all have the active involvement and agreement of the adult concerned at each stage of the enquiry.

This 'person centric' approach is being progressed under the Making Safeguarding Personal (MSP) initiative. I mentioned this project last year and it good to see that it has progressed from the pilot stage to being central to the management of safeguarding enquires. How MSP is being embedded in practice and procedures is mentioned in section 3.

Section 3 also outlines the changes to safeguarding contained within the Care Act 2014. These changes are far reaching and section 14 of the statutory guidance describes how the new legislation will affect Safeguarding Boards. In certain key areas we have already complied with the Act; Swindon's LSAB has been in existence for some years and we have compiled annual strategies and reports throughout my time as chair.

However there are important decisions which need to be agreed by the Board in the next few months. I have already challenged members to agree how the Board will be resourced (it currently has no budget), how each member will meet the need for a Designated Safeguarding Manager and the agreement and implementation of information sharing arrangements which are both practical and understood by all staff. These issues need speedy resolution and will be progressed by my successor.

The Board needs a budget to fund case reviews which is also a new requirement under the Act. The report mentions the case review commissioned in late 2013 into the suicide of an adult considered at risk. This was an excellent example of the partnership work of the Board and page 21 describes the response to the Review. I chaired two special meetings in 2015 to implement its findings. I was pleased that the Board agreed to establish a Risk Enablement Pathway which should be operational soon. More details are contained on page 44.

The creation of this group is a significant achievement for the Board and is an excellent example of Board members working together to ensure the safety and wellbeing of a small number of individuals who are at the greatest risk of harm.

This is my final annual report as Board chair and when writing this foreword, I looked back to last year. I commented upon the need for direct feedback from Swindon's service users and mentioned the work of the Forum and the work of its chair, Martin Kelly. I said that *"one of the challenges for next year for us all is to recruit more members to join this group"*. As page 41 reports the Forum continues to meet but there is still fluctuating membership. Martin is committed to getting more members and I thank him for his perseverance.

This issue, together with the Care Act requirements mentioned previously, will be taken forward by Diana Fulbrook OBE who succeeded me on July 1<sup>st</sup>. She is an experienced and knowledgeable chair. (Diana also chairs the Local Safeguarding Children Board in Worcestershire.) I wish her and the Board well for the future.

Finally, thank you to all Board members, past and present, for their support, participation and commitment over the past 4 years. I would also like to thank Debbie Parmenter, the Board Administrator and give a special mention to Doug Bale, who has been provided sound advice and consistent support throughout my tenure as Board chair.



**Mike Howard**

Independent Chair of the LSAB

## SECTION 1

### Safeguarding Adults at Risk in Swindon Annual Report 2014/15

#### Introduction:

Safeguarding Adults continues to be a high priority locally and nationally. With the Care Act 2014, safeguarding adults will be brought onto a statutory footing and will need to be the focus of the Local Safeguarding Adults Board (LSAB) for the coming months. No Secrets, the statutory guidance that initiated adult protection and adult safeguarding in 2000 has been repealed and guidance issued to implement the Care Act has a point of reference for Boards across the country.

For the reporting period covered by this annual report, the definition for an adult at risk was:

*someone who is 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.*

From 1<sup>st</sup> April 2015, 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 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;
- Safeguarding Adults Boards need to be established;
- Ensure Safeguarding Adults Boards carry out Safeguarding Adults reviews as stipulated within the Act; and
- Where there is a need, information is supplied to enable the Board to exercise its functions.

Further discussion about these areas will be included in the priorities for 2015 /16 towards the end of this report.

For the reporting period covered by the report, teams managing the alerts of alleged adult abuse were within SEQOL, the social enterprise providing care and support in Swindon. For people who are mentally unwell, the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) fulfilled this role with both organisations providing information about their activity to the local authority.

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%). 5,375 people were 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

It is difficult to do a comparison with previous years regarding the individual service user groups as there have been changes in the categories used in 2014/15 but there has been an overall reduction of about 2% in the number of people receiving services.

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. In 2014/15 there was a drop of 2.2% in the number of reported crimes in Swindon and Wiltshire. There were 1,200 fewer reported crimes. Overall Wiltshire and Swindon has one of the lowest crime rates in the country. There is still a good level of community involvement in many areas of the town and the Council and its partners continue to develop this involvement and encourage residents to support those who may need additional help and may be isolated or lonely with a view to maintain their independence.

The upward trend for reports of adult abuse continues. This is not a situation that is confined to Swindon, other local authority areas report continued significant increases. In last year's annual report it was reported that there was a slowing down in the increase of reported cases. In 2014/15 there has been another steep increase. 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 improved provision of information from the social enterprise into the local authority on which data for this report was derived.

The LSAB continues to monitor this activity and appreciates the work carried out by the teams managing adult protection. However the Board continues to be aware of the pressure increased reporting presents and needs to be assured that the teams are able to maintain the standards required to fulfil their safeguarding responsibilities.

This annual report includes:

- Information on activity and data collected throughout the year about cases alerted and investigated under Safeguarding Adults at Risk procedures;
- An outline of the progress made during 2014/2015;
- Submissions from key partner agencies and members of the LSAB ; and
- An overview of the priorities for 2015/ 2016.

## SECTION 2

### Activity Data 2014 – 2015

(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 teams managing individual cases. The information is based upon the National Health Service 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**



In the last year, there has been a large increase in the number of alerts where abuse is alleged. There has been an increase of over 50%. Similar increases are still being experienced in other local authority areas and are believed to be an indication of improved awareness and better reporting rather than an increase in incident of abuse. In Swindon improved recording methods may also account for this increase.

There are occasions where alerts are raised for minor incidents which in the past were dealt with directly by the employer (for example) and recorded as an incident under their health and safety or complaints procedures.

#### **Case Example**

A care provider sent in a safeguarding alert form stating that one of their residents complained that a member of staff had been curt and rude to her. The provider was advised to deal with it under their complaints procedures (particularly as that was the basis in which the resident had raised the concern) and to inform the team managing alerts if anything more serious transpires during complaint investigation.

All alerts are recorded, and information gained from these can be useful. For example continued poor alerts may indicate a training need within the service and a

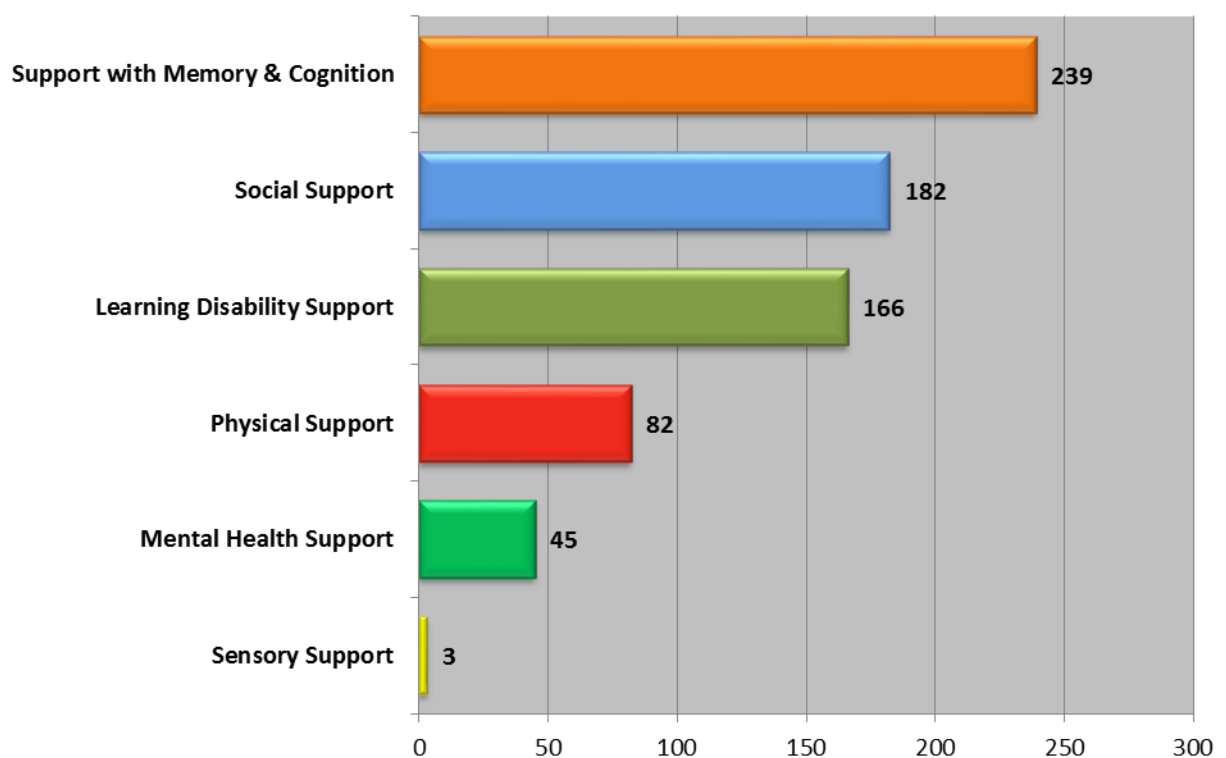


recommendation that they make use of the Council's free Safeguarding Awareness training. Reports of low level harm are also recorded as information from these may indicate a more serious concern if such occurrences appear to be taking place on an number of occasions to the same alleged victim.

Often alerts are raised as safeguarding concerns although no abuse is alleged, for example, where other agencies have been concerned that a person no longer appears to be looking after themselves very well due to deteriorating health. The correct action to take is to contact the relevant care management team for them to consider offering the "victim" an assessment of care needs.

**Of the 717 cases recorded, 308 cases required no further action after the initial stage. The percentage of cases requiring no further action is almost identical to previous years: 42%. 30 cases required other action (for example sign posting or a referral to another process more appropriate for the individual) but did not require action under the safeguarding procedures.**

**Figure 2: Breakdown by "Primary Support Reason"**



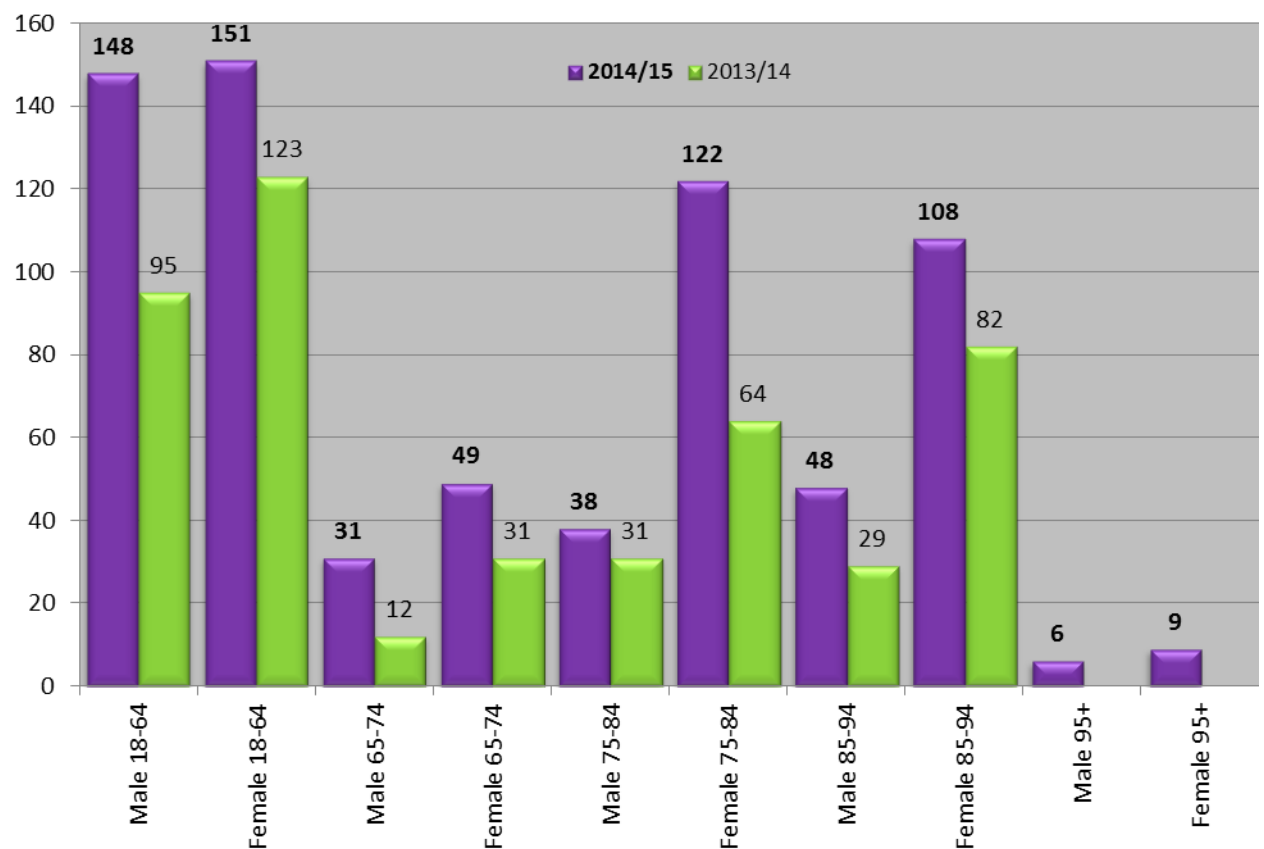
In previous annual reports, a breakdown by service user group was included. The way in which this information is recorded has changed and there is now a requirement to record a Primary Support Reason for the person subject of the safeguarding concern. This means the ability to compare service user groups information with previous years is not possible. For example last year we were able to report on the number of case involving people with dementia. This group is now included within the support reason of "memory and cognition". However as a result of a request from Public Health we have continued to collect information around alleged victims with dementia and can report that 156 safeguarding cases involved people with dementia.

In previous years some service user groups would have been included in a category marked as "other" for example terminal illness, hearing and vision loss, people with a head injury and those with Asperger's/autism. The new classifications have enabled



more clarity on this and those groups of people are now included as a primary support reason as listed above.

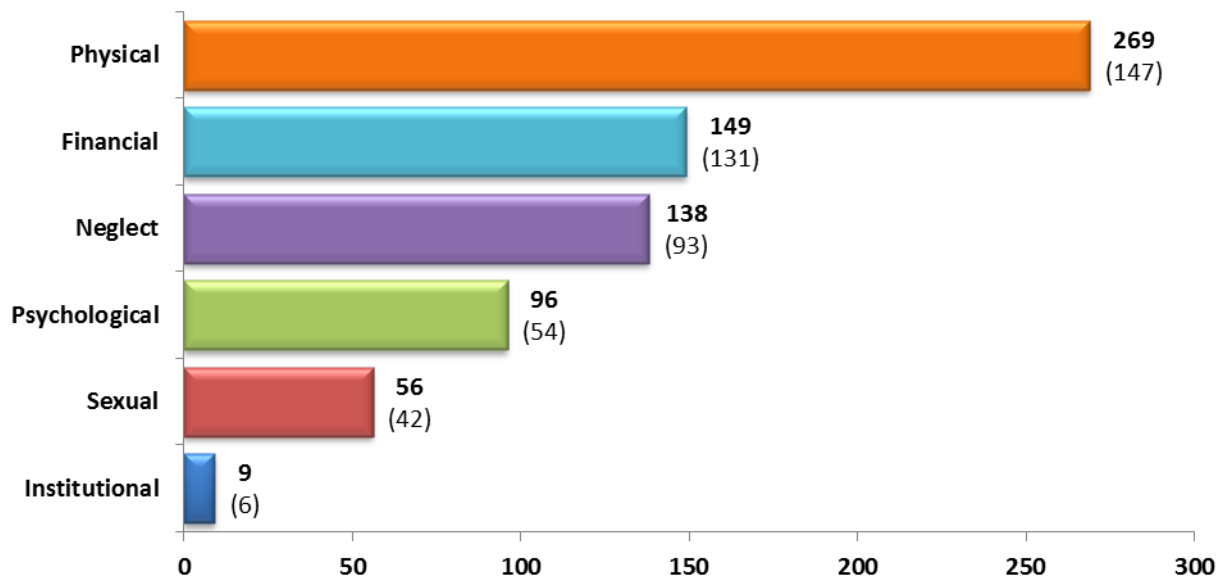
**Figure 3: Breakdown by Gender and Age**



The Chart above shows that the increase in alerts is consistent across age groups and gender. The most significant increases is in relation to females between 75 and 84. This is perhaps due to this group being more likely to be in need of community care – 73% of these people were known to adult services prior to receipt of the alert. Those alleged to have caused harm with regards to this group of people are mainly family members or partners (41%) with allegations against staff or professionals being the next significant number (30%). However over 50% of the cases regarding this group did not require action under the safeguarding procedures following the initial alert.

The other significant increase here is male alleged victims between 18 to 64. The latter is in part due to the number of cases reported regarding people with head injuries within a new specialist service within the town where behaviour management is frequently required and can result in a number of safeguarding alerts regarding physical assault.

**Figure 4 Types of Abuse Alleged**



The number of alerts in relation to physical abuse continues to be the most prevalent form of abuse alleged. In all but 4 cases, the person alleged to have caused harm was known to the adult. Most of these cases were in relation to allegations of an assault by another service user within a care setting (including supported accommodation). 65 of these cases did not require a safeguarding response, and perhaps did not need to be raised as a safeguarding alert. Often all that is required is a change to care plans or risk assessment and recorded as an incident in the service.

#### **Case example**

Mavis was sitting in the dining room in a residential home when George walked up to her and touched her on the face. Mavis responded by slapping his hand. George was upset (as “I was only trying to be nice”) but there was no injury and the slap was observed as being quite light. The team managing the alert asked the home to monitor the situation and update Mavis’ care plan accordingly.

Often these are as a result of behaviour associated with the individuals condition (for example dementia) requiring a proportionate response to minimise future risks to the victim or other victims. 35 cases did require further action under the safeguarding procedures. This is often due to concerns that a multi-agency response is required or there is a concern a severe injury resulted (or could have resulted).

#### **Case Example**

Mr Simons is relatively young and had suffered a brain injury resulting in him requiring 24 hour care. His condition means he can become aggressive. He lives in a nursing home where on one occasion, for no apparent reason he punched another resident hard. Fortunately staff intervened quickly to avoid any further injury. The case progressed under safeguarding procedures but due to Mr Simons’ impairment a criminal investigation was not pursued. It was agreed that as the incident was unprovoked there was a need to review his care provision and in light of the absence of a specialist service for Mr Simons, that he would receive one to one support at the care home. This would help to monitor Mr Simons, provide him with more stimulation and the staff member assigned to him would be able to intervene if another similar incident took place.

Another area of concern is where physical abuse has been alleged by a member of staff or professional. These cases are monitored very closely and often what is alleged is not a malicious occurrence and are incorrectly reported as physical abuse where arguably it would be more accurate to describe what occurred as neglect (e.g. a patient falls while in the care of a nurse or a resident is knocked by the “arm” of a hoist causing a bruise – often cases requiring reporting under health and safety incident procedures.) Out of 67 cases of allegations against staff 47 progressed through to a full safeguarding process. 8 cases were substantiated and resulted in either disciplinary action, further training or continued monitoring.

#### **Case Example**

A member of staff in a care home was witnessed to be “nudging” a service user with her walking stick to coax her to raise her arm. Once spotted the member of staff made light of the situation as if “they were having a joke”. It was reported to the manager who raised a safeguarding alert and also suspended the member of staff as what was witnessed was inappropriate practice. The case progressed to a full safeguarding process and in consultation with the Police, it was concluded that the best course of action would be for the home to deal with the matter under their disciplinary procedures. The service user was also consulted who spoke fondly of the member of staff and it was agreed that it was an issue of inappropriate actions on the part of the member of staff and he received a warning and was required to attend further training.

Financial abuse is also reported frequently. These cases can range from concerns that small amounts of money or possessions have gone missing to larger concerns where the alleged victim has lost substantial savings or property. (See page 41 for case example provided by Wiltshire Police). In the majority of alerts regarding financial abuse the concerns raised were about family members (65 cases).

#### **Case Example**

Cedric Hart confided in the warden of the sheltered scheme where he lives that he’s fed up with his granddaughter visiting him and taking his money and is frightened of her. A safeguarding meeting was held and it was arranged for Cedric to have help with his finances and provided with a cash tin. The housing provider asked his granddaughter not to visit the scheme which she complied with.

While many case of alleged financial abuse can be resolved quite easily by taking action to safeguard the victim’s savings (for example by arranging for the local authority to deputise for the person if there is no one more appropriate to do this) many cases can be complex and take considerable time to investigate and resolve particularly if there are concerns about property ownership and substantial savings.

There continues to be an increase in the number of alerts alleging neglect. 18 of the cases recorded should not have been raised under safeguarding procedures and were welfare concerns, an inability to self-care or self-neglect (not included under safeguarding during 2014/15). This means there was a 29% increase in the number of cases where neglect by another person was a concern. In 92 of these cases the concern related to allegations of poor service or poor practice by staff or managers of a service. In some cases issues may have previously been resolved directly with the provider of care through their complaints procedure but as there is a greater emphasis on safeguarding arrangements, alerts are being made more often. Around 40 cases did not require action under the safeguarding procedures.

**Case example**

Mabel Hill's daughter raised a safeguarding concern as her mother who had just had 10 days respite in a care home had not been bathed during her stay, did not receive pain relief, did not have her clothes and incontinence pads changed often enough and had acquired 2 pressure sores while there. Mabel has also told her that she was "scared" to go back to the Care Home. Mabel is 73 and is terminally ill.

The team managing the alert met with Mabel and discussed the concerns. She said she had been offered baths, but "didn't feel up to it". She also said that on the times they suggested a clothing change she never felt well enough. She said she was offered pain relief but wasn't in pain during her stay. She did not like the bed she was supposed to be in, so chose to sleep in a chair like she does at home and this together with her reluctance to have personal care, not being moved all the time, is likely to have exacerbated the pressure sores. When asked about being scared to return to the care home, she said that she wasn't really scared to return "as such" it was more that she did want to and would like to go somewhere else. She also said all the staff were lovely. It was concluded (and records supported this view) that the home did try to support Mabel as much as they could. It is possible that the negative report Mabel gave to her daughter was spurred on by her reluctance to return, wanting to go to a service she preferred.

A number of alerts about neglect regarding care services may require considerable involvement by agencies. The Police may consider whether what is alleged needs to be investigated as wilful neglect and ill treatment (which is unlawful but prosecutions are rare), the local authority may become involved under contract compliance arrangements and liaison may take place with Care Quality Commission to consider a compliance inspection under their regulations. 52 case of alleged neglect progressed to a full safeguarding process. Where concerns appear to show a pattern of neglect in a single service, a large scale investigation will be instigated.

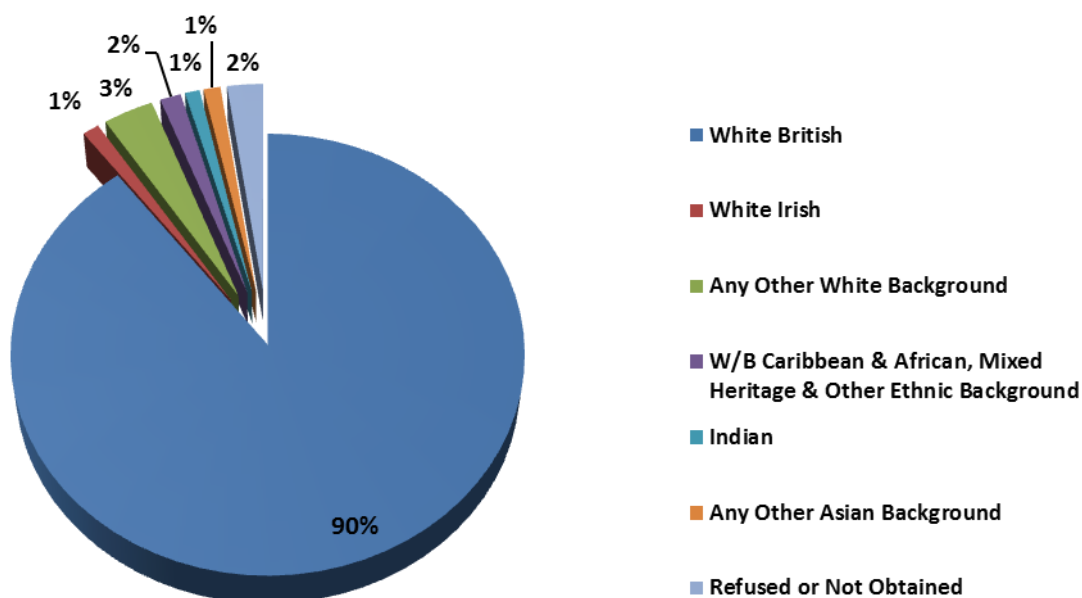
There were 119 cases where the alleged victim was not in receipt of community care services at the time of the alert being raised. This can mean that often the first contact that has been made with teams is where there is a safeguarding concern and this may well highlight a need for a service. Of these, almost half were not previously known to adult services. 17 alerts were received regarding people who receive a direct payment but there is no evidence that in these cases that by managing their own care led to the safeguarding concern i.e. none of these cases related to the person delivering their care. 78 cases were alerted where the victim funds their own care. This increase is smaller than expected considering the overall increase in alerts.

There were 123 cases where domestic abuse could be considered to be a factor of which 59 cases progressed to safeguarding procedures. In these circumstances it is likely that advice, guidance or input would be obtained from the Domestic Abuse Investigation Team. A multi-agency approach is required particularly in cases where the alleged victim is reluctant for agencies to pursue an alert. In some cases a referral to the Multi Agency Risk Assessment Conference (MARAC) has been necessary (similarly, there have also been safeguarding concerns raised as a result of a MARAC meeting. Where the alleged perpetrator is the person's main carer, this could indicate an issue of carer stress. In these circumstances a proportionate response may have been to carry out a carer's assessment and to provide additional support to them and the person for whom they are caring.

### Case Example

Alice Dance who has dementia is in hospital and told nursing staff that her husband loses his temper with her and shouts at her. A safeguarding alert was raised and the manager dealing with the alert visited Alice on the ward. She was vague about the care and support she needs but was keen to return home and be cared for by her husband. There was also a conversation with her husband who admitted that he did get stressed particularly when dealing with his wife's dementia and the symptoms of it (e.g. limited conversation). He acknowledged that his behaviour is unacceptable and appreciated the opportunity to have additional support at home. He had a carers assessment and the outcome was that a sitting service would be arranged for 6 hours a week at a time that suited him (and Alice). No further concerns have been raised and the support has been accepted. Mr Dance also took the advice to contact the Carer's Centre where he has been able to talk to other people in similar situations.

**Figure 5: Ethnicity of alleged victims**



Other ethnic groups are recorded but during the period, no alerts were raised for people in these groups. These include (for example): Traveller of Irish Heritage, Gypsy/Roma, and Black African.

For 2014/15, the level of alerts broken down by ethnicity appears to be proportionate to the population of Swindon as a whole (and the percentages are unchanged since last year). However, there is still a requirement for work to widen engagement and awareness among community groups and this continues to be a priority of the Awareness and Engagement Group – a sub group of the LSAB in collaboration with the Local Safeguarding Children's Board who also have identified this work as a priority.

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

Source of Referrer	2014/15	2013/14
Care Providers (e.g. Care Homes day services including Independent Sector)	288	185
Hospitals (Great Western Hospital: 79 Others: 38)	117	59
SEQOL Staff	86	64
Police	35	12
Mental Health Professionals	36	41
Family/Carers	33	25
Housing Services (including Registered Social Landlords)	20	26
Ambulance Services	15	10
Advocacy Service	13	6
Members of the Public	13	6
Care Quality Commission (CQC)	13	9
GP	10	5
Adult Services (SBC)	9	
Council Employees (not Adult Services or Housing Services)	5	7
Educational Establishment	5	3
Hospice	4	4
Probation Service	4	0
Business	3	3
Fire Service	2	0
Personal Assistant (Direct Payments)	2	0
Out of Area Referrals	2	9
Drug & Alcohol Services	1	1
Office of Public Guardian	1	0
Confidential Alert	0	1

The greatest increase of sources of alerts came from Care Providers. 188 of these were in relation to their own service mostly regarding incidents between service users. Another large proportion of these alerts relate to allegations against staff resulting in disciplinary action or training. A number of these alerts did not require a safeguarding response and may not have needed to be raised as a safeguarding concern (the Care Act guidance states that in a number of cases an “employer-led disciplinary response may be more appropriate”). Together with Wiltshire Council’s Safeguarding Team, discussions are taking place to improve the accuracy and need for high numbers of concerns being channelled through a safeguarding process.

**Case Example**

While 2 members of staff were in a service user's home waiting for a response from Care Line (emergency response service), they posted a "snap chat" photo of themselves with the service user on their social media account which said "love waiting for Care Line". The service user was not identifiable and no abuse occurred. This was raised as a safeguarding alert although the employer had already taken disciplinary action as it was in breach of their code of conduct. The service user was given the opportunity to complain but did not want to take any further action. This did not require any action under the safeguarding procedures.

Other alerts raised by service providers included concerns about friends, partners and family members (63 cases). These were mostly concerning allegations of physical abuse in the victims own home (as stated previously this may require support of Domestic Abuse services or a full multi-agency response or indicate carer's stress and the need for a carer's assessment).

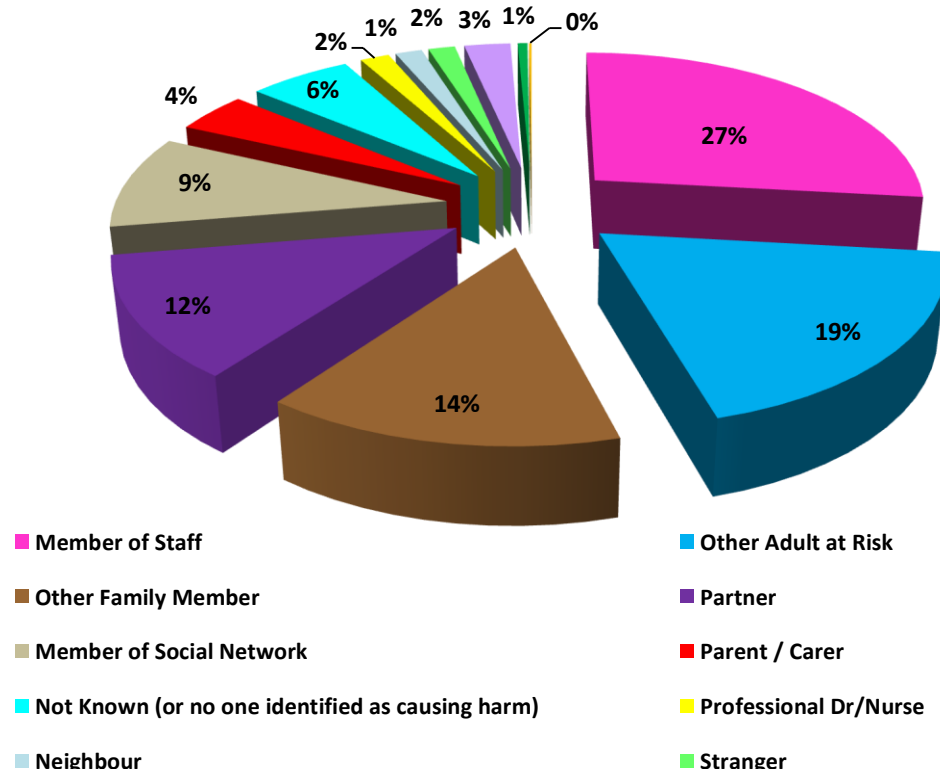
Another major increase is the number of alerts being raised by hospitals. This is mainly due to the development of a specialist hospital providing support for people with head injuries and where a number of incidents between service users are raised (as highlighted previously). However the majority of the concerns raised are from Great Western Hospital Foundation Trust (78) signifying quiet a high level of awareness among staff and managers. Most were in relation to allegations against family members or concerns about neglect from another service. 29 cases required a full response under safeguarding procedures and of these 9 were partially or fully substantiated.

There has been a small reduction in the number of alerts raised by Mental Health Teams where considering the trends in other areas an increase in alerts would be expected. Further discussion may be required to consider improving awareness among staff. Very few alerts relate to their own services which could indicate matters being handled internally.

There are no referrals recorded as originating from the adult at risk themselves. As previously reported, often, although a service user may raise a concern with their care manager (for example) the care manager may forward on a referral form and put themselves as the alerter. This may also indicate a need to increase awareness within the community and with service users themselves. Care Act Guidance promotes the need for awareness campaigns among for the general public.



**Figure 7: Information on those alleged to have caused harm**



Other than a 7% increase in allegations relating to allegations against staff members there are no major changes in the proportion of alerts regarding those who have alleged to have caused harm.

There were 184 cases where the person alleged to have caused harm was recorded as having a caring responsibility (this does not include members of staff). These included: 59 allegations of physical abuse; 52 cases of financial abuse (mainly at the hands of extended family members or adult children); 26 cases of neglect, 42 cases of alleged psychological abuse and 4 cases where sexual abuse was alleged (mainly historic or non-consensual sexual attention from a partner). 101 cases progressed to a safeguarding investigation and of those concluded 26 were substantiated, 20 were not substantiated, 14 were inconclusive and 21 ceased at the request of the alleged victim. 19 cases remain open.

### Case Example

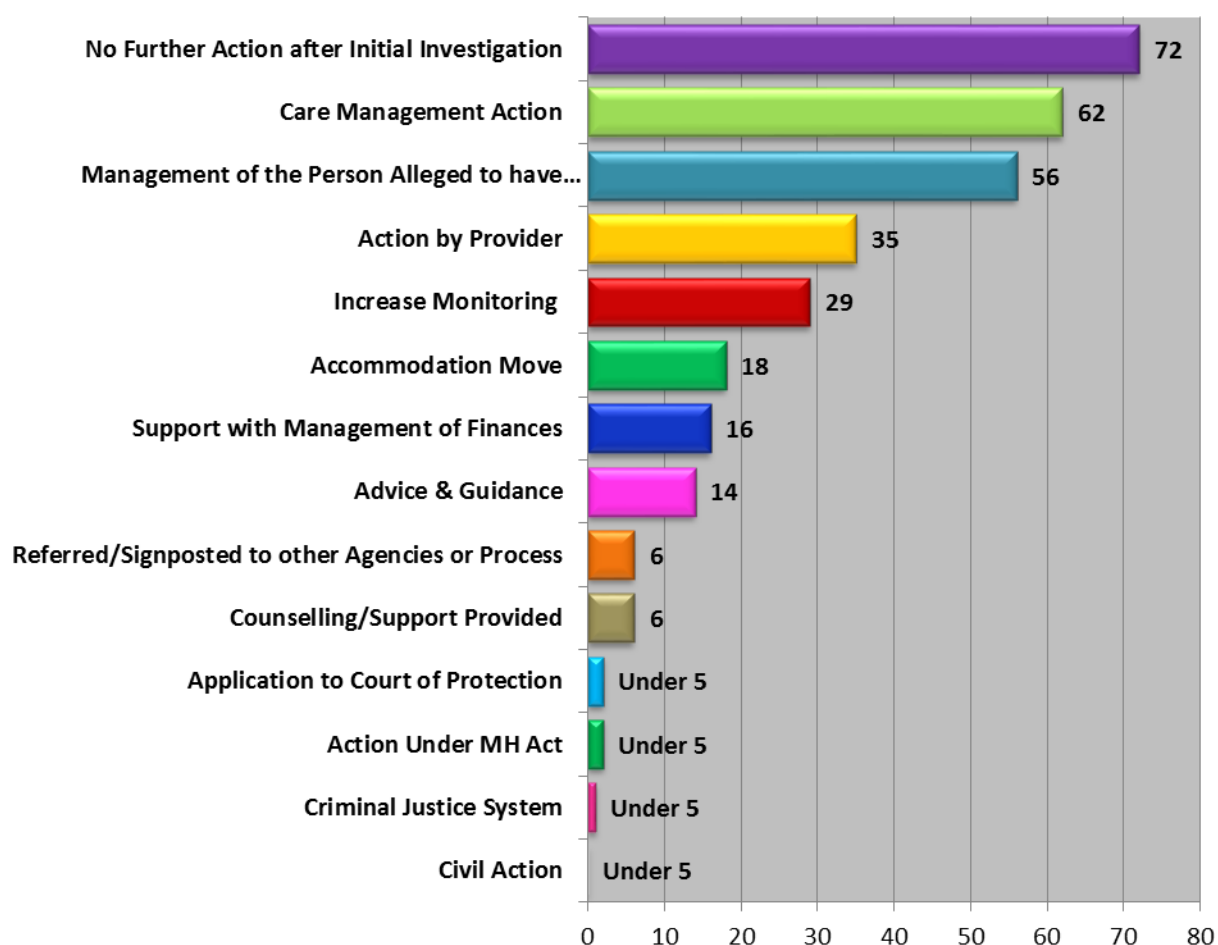
Amanda Brown lived with her main carer who announced one day that she could no longer be her carer and would have to give up the house in which they lived. As a result Amanda moved into a rehab unit at which time she discovered that at least £20,000 was missing from her bank account and it was felt that this had been taken by her ex-carer over a period of time. Amanda had entrusted her carer with her PIN number but it was alleged the carer took out more money than required. A safeguarding alert was raised and the Police were involved and investigated the case. Unfortunately as there was no proof of the excessive withdrawals they were unable to pursue the case. However, the placement in the rehab unit was very successful and with Amanda being less reliant on her "ex-main carer", she became more confident and able to cope. Amanda moved into her own flat in a sheltered scheme with her own care package. She says she loves her flat and may feel she has more control over her own life now. She was heavily involved in the safeguarding case and although disappointed that no action could be taken against the person alleged to have taken her money, she felt that overall the safeguarding process has "changed her life".

## Outcomes of Investigations

In 2014/15 338 cases were assessed and did not progress through to a full safeguarding process. 308 required no further action (either because there was little or no significant harm or the alleged victim did not wish to proceed or the alert was about a person who was not in need of community care services). 12 cases required a new Community Care Assessment. 17 were referred to another process, for example complaints action or action by the provider (e.g. disciplinary action).

379 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.

**Figure 8 Outcomes for the Adult at Risk**



**\*NB at the time of reporting, 60 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 investigation 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 (as described in the case example above).**

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 an accommodation move was required for the person alleged to have caused harm following a physical assault. Other reasons where no further action is required could be that during the investigation there was no significant harm, or no evidence has been found or the person has requested that the process is ended.

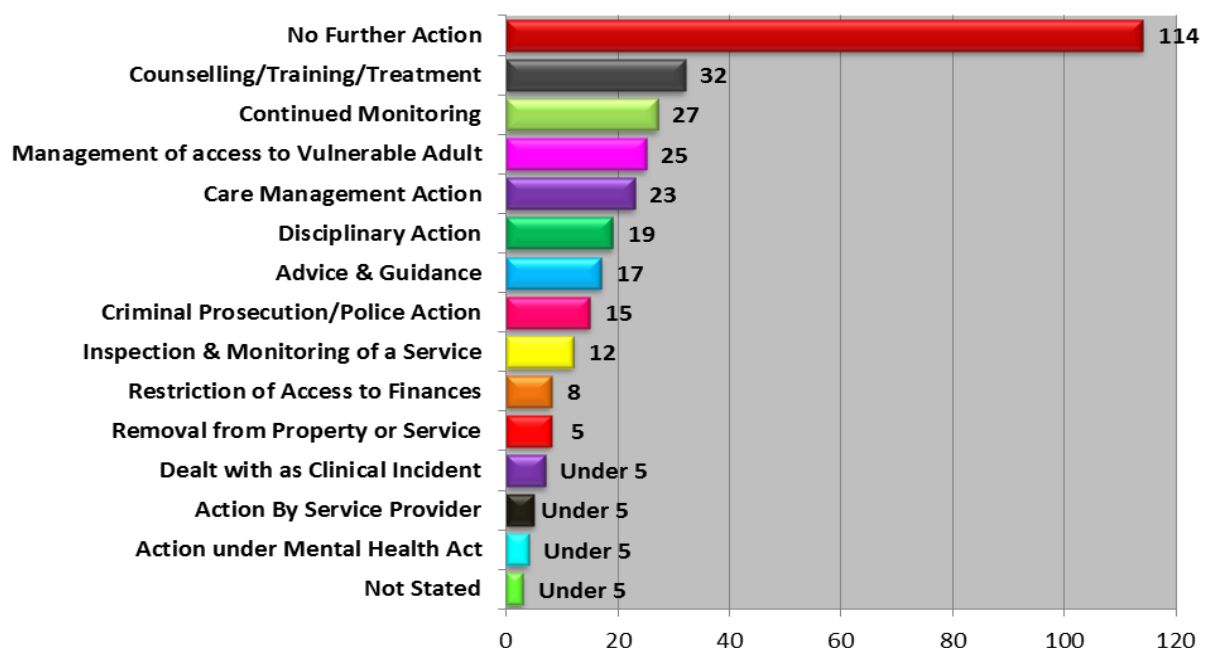
There were 62 cases where the outcome was care management action. This could include a review of the care plan, a change to the service being provided or a change to a health care plan. Care management action could also include reviewing and revising a risk assessment and making changes to reduce the risk of reoccurrence.

There were 35 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. The outcome of any disciplinary action is required before a safeguarding case is closed. This is to ensure the appropriate action has been taken and to ensure (if required) a referral is made to the Disclosure and Barring Service to include the perpetrator of the abuse on the list barring them from working with vulnerable adults or children.

An action taken in the event of allegations of financial abuse is setting up an appointee or deputyship for the adult at risk. This is where the Council (for example) or another person can protect someone's money. Appointeeships are for people on benefits and Deputyships are for people with substantial savings. This is generally for people who lack the mental capacity to manage their own finances and can help to protect their remaining funds or safeguard them from future financial harm. 16 people received this support.

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**



Overall the focus regarding the safeguarding cases that have been concluded has been on the alleged victim. Irrespective as to whether there is no outcome for the person alleged to have caused harm, additional support is often still required for the alleged victim. In some cases it may not always be possible to identify a perpetrator.

### **Case Example**

Brian Stone reported to his care team in a small supported living service that someone had come up to him in the street demanding money. Brian was visibly upset by the experience and said that he threw a lot of loose change on the ground and ran away while the alleged perpetrator picked up the money. As part of the safeguarding process the Police looked into whether there was any evidence (e.g. CCT cameras in the area) whether there were any witnesses and whether there were any other similar reports. These enquiries did not shed any further light on the matter and no further action was taken by the Police as the alleged perpetrator could not be identified. Action was still required to help Brian recover from this experience as he was reluctant to go out alone anymore and this would have an impact on his independence. Staff at the home with the help of a community nurse, were able to help Brian to feel more confident while out, alter the routes he uses and the times he would go out. He has now started making short journeys to the local shops and it is hoped he will go back to using the community the way he used to.

In conclusion, 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
- How the widening of definitions within the Care Act Guidance impacts on referrals
- The apparent low number of cases regarding people of working age with Mental Health issues

### **Serious Case Reviews and Large Scale Cases**

There were no Serious Case reviews held in Swindon concerning adults at risk however a Case Review was instigated towards the end of 2013/14 concerning the suicide of someone considered to be an adult at risk. The review used the SCIE (Social Care Institute for Excellence) Learning Together model which concentrates on looking at the systems that need to be in place to support service users and prevent other similar cases from occurring and minimise the risks to adults at risk. The review was concluded last year and a key finding was the lack of “a recognised and understood multi-agency framework for case planning and decision making in Swindon” and that without this there was ineffective support for people with chaotic lifestyles and difficulties in understanding the risks faced by these people and how to provide an appropriate response. Linked with this, it was concluded that “there is a no shared process of risk assessment & management across agencies increasing the chances of key information being missing and different professionals having different understandings of the risk to particular service users”. The LSAB held a number of Task and Finishing Groups to design a process and look at frameworks in other local authority areas and see how these could be applied in Swindon. This also led to the funding of a member of staff to coordinate practice and develop the framework further. This will continue to be a priority for the coming year.

The review also highlighted some issues within practice on how people with chaotic lifestyles are treated. There are difficulties in ensuring the correct response and the review found that there was a likelihood that people can be moved from one service to another as there is a lack of a clear diagnosis and understanding of what services are needed. It also concluded that like many other local authority areas, access to mental health services can be difficult, however it was positive about the involvement of some

services and their work in engaging with different teams, but felt that a single agency or worker “owning” required actions is needed to avoid assumptions that matters were in hand when they may not have been. The review also highlighted the difficulties in finding suitable accommodation for people with specific and complex needs which can lead to people being inappropriately placed. These matters will continue to be considered by the LSAB and the full report will be referenced in development of a risk management process.

There were 2 large scale investigations set up following concerns raised about the conduct of specific care services requiring action either by the CQC or adult services commissioners. Although both these cases are now closed, there is continued monitoring of standards with the services by the Local Authorities Contracts and Commissioning Team.

### **Case example**

A number of safeguarding concerns relating to a single service had been raised by various people (professionals, family members, the service itself). The alerts were varied and questioned the standards within the home, the safety of the people living there and the quality of the staff. Because the complaints were received over a relatively short period of time, it was agreed to carry out a large scale (or whole home) investigation into the conduct of the home. The Care Quality Commission carried out an inspection and found the home to be non-compliant in most areas. The safeguarding investigation involved continued input from the CQC, Commissioners from the Local Authority and Clinical Commissioning Group, Care Managers from SEQOL and AWP and the provider themselves. Over a number of months, contracts officers from SBC carried out weekly visits to monitor the service, support improvement and highlight any risks. The home developed an action plan linked to the requirements identified by the CQC and provided all involved agencies with weekly updates of this. While the investigation continued, the home was not able to admit new service users and had applied their own embargo on placements.

There was evidence that improvements were taking place, but agencies wanted to be assured that these were sustainable and that standards would not slide as soon as the safeguarding investigation concluded. There were also a number of personnel changes in the home and a highly experienced and competent manager was brought in to oversee and maintain improvements. On a further follow up inspection the CQC believed the home was improving at great speed and could well develop as a centre of excellence. However they have continued to be cautious about changing their overall rating because they want to see that good practice is maintained over a period of time. SBC contracts officers have continued with their visits for the same reason.

The safeguarding process closed following the follow up inspection as there had been no further concerns raised about the standards of the home and the individual cases previously alerted had been resolved. The Adult Safeguarding Manager continues to liaise with the Contracts and Commissioning team within SBC to monitor improvements.

## **SECTION 3**

### **Progress, developments and news in 2014/15**

#### **Priorities for 2014/15**

In the previous annual reports, headings were used that reflected a self-assessment process promoted by the regional Association of Directors of Adults Social Services. Over the last year much of the work of the LSAB has been prompted by the Care Act 2014 which received royal assent in May 2014 and the publication of final Care Act Guidance issued in October 2014. While a number of the priorities identified still received attention, the overriding priority was compliance with the Care Act.

#### **The Care Act 2014**

As previously stated, the Care Act puts safeguarding and the Safeguarding Boards on a statutory footing. The LSAB and the local authority was and still is required to consider changes needed to be compliant with the Care Act but also to consider other areas of the Act that may impact on safeguarding practice.

The main requirements of the Care Act regarding safeguarding have in the main been met in Swindon. There is a Safeguarding Adults' Board which has membership over and above the statutory requirements of the Act. There is a need for the LSAB to consider if there are other agencies that need to be included onto the Board as recommended (but not required) within the guidance. There is a requirement to produce annual reports and develop a strategy. There are policies and procedures in place to ensure enquiries are carried out when abuse or neglect of an adult in need for care and support is suspected or there is a risk of abuse and neglect. Arrangements are in place to engage advocacy where someone has substantial difficulties in participating in the safeguarding process. While there are procedures in place in managing Safeguarding Adult's Review (previously referred to as serious case reviews) which are required when an adult in need for care and support dies or suffers serious abuse or neglect, these need updating to be fully compliant with the act. Arrangements also need to be strengthened with regards to the supply and sharing of information in safeguarding case.

Section 79 of the Care Act concerns Delegation of Local Authority Functions. It states that one of the functions that cannot be delegated is safeguarding as previously practiced in Swindon where SEQOL and AWP managed cases on behalf of the local authority. The Council made the decision to bring this role "in house" and set up a dedicated safeguarding administrative team to take alerts via a single referral line and email address. A team of senior care managers (or Senior Quality Practitioners) within SBC has been increased and their role now includes screening concerns, identifying appropriate support and managing enquiries. There are also two staff sharing a Team manager role overseeing the work (temporary arrangements within the team have been put in place until the appointment can take place).

SEQOL and AWP staff are still involved in the procedures as appropriate to provide the Enquiry Officer role who (for example) will engage with the adult at the earliest opportunity and support the enquiry as necessary. To cover adults with care and support needs that are not being met by the local authority the intention is to extend the Safeguarding team to include additional officers to support those people.

Information on these new arrangements has been included in basic awareness training, communicated to partners and other interested parties and included on the Council's website.

The LSAB have also been considering other areas of practice within the Care Act and its guidance that needs developing in the coming months.

In describing types of abuse the guidance has increased the list of indicative types of abuse. In addition to physical, sexual, discriminatory, financial, act of omission (neglect) and psychological abuse, the list includes:

- Domestic Violence
- Modern Slavery
- Organisational abuse (formerly referred to as institutional abuse)
- Self-neglect

As reported in last year's Annual Report "Making Safeguarding Personal" or MSP has become central to the management of safeguarding enquires. MSP features heavily throughout the guidance and all teams involved in safeguarding need to ensure that this is applied to practice when managing safeguarding cases. Establishing a new team has assisted with this as practice can be established as the team develops rather than needing to retrain staff and change mind-sets. This approach is also to be included within training courses run by and for the Council.

Self-neglect was included within the guidance of "an abuse type". This has not been a requirement in the past for safeguarding arrangements to include issues other than when abuse or neglect is suspected at the hands of another person. The guidance states that "safeguarding partnerships can be a positive means of addressing issues of self-neglect at a strategic level". A basic framework has been agreed by the board in tackling self-neglect while ensuring the rights of capacitated individuals can continue to be upheld. It starts with a care management approach where it may be that the person requires support from services and what appears to be self-neglect is a need for support. Where the self-neglect is serious and or as a result of abuse from another person (for example a reaction to another form of abuse), a safeguarding response considering the availability of any legal framework should result.

The Care Act makes a requirement for the supply of Information if relevant to the function of the LSAB. While there are a number of information sharing agreements in use across a number of services and disciplines, the LSAB is keen to ensure there is one agreed by all agencies and hopefully will be relevant for other requirements (e.g. the Children's Safeguarding Board, Community Safety Partnership).

In preparation for the Care Act, SBC has commissioned an advocacy service to support adults with 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them. This is also required for other parts of the Care Act and Swindon Advocacy Movement are providing such support for all service user groups from the 1<sup>st</sup> April 2015. They are also commissioned to provide Independent Mental Capacity Advocates (who may be required for a number of reasons including safeguarding adults where there is no one appropriate to support the alleged victim when they lack mental capacity), and also Independent Mental Health Advocates (who are required when someone is subject to a section under the Mental Health Act).

Guidance included the need for each LSAB member agency should identify a Designated Adult Safeguarding Manager (DASM) who will be responsible for the management and oversight of cases relating to allegations against staff, volunteers and



students. They will also have a role to oversee the prevention of abuse within their organisation. Overall, there is a lack of clarity about this role and the LSAB will need to make a decision about how this is addressed over the coming period.

**Safeguarding Adults Review:** while Boards (including Swindon) have initiated serious case reviews or case reviews, it has not been a statutory requirement to carry these out. The LSAB have agreed to develop a Case Review Group to look at SARs and consider applications, but as previously discussed, case reviews require resources which are currently not available. It is also difficult to anticipate demand for SARs.

From the beginning of 2015, the policy and procedures for Safeguarding Adults have been revised to reflect changes in practice and definitions as outlined in the Care Act and guidance. This has been drafted and includes:

- Involvement of the alleged victim at the earliest opportunity;
- Changes in definition – e.g. adults in need for care and support;
- Terminology changes – e.g. an enquiry rather than investigations;
- Policy being less reliant on a process and more led by the wishes of the adult involved. Outlining the stages of an enquiry rather than strict timescales and formal meetings;
- Inclusion of other “abuse types” and indicators of these;
- Outlines the new arrangements in Swindon; and
- The range of agencies that should or could carry out individual enquires (it does not need to be the local authority in all cases).

### **Audit of Adult Safeguarding**

As reported in the last annual report, during 2013/14 the Council’s internal audit department carried out an audit into adult safeguarding. There were some outstanding actions from the audit:

- *Consideration is given to the introduction of a single point of reporting for safeguarding referrals a single point for safeguarding alerts;* This is now in place
- *The triage approach to prioritising safeguarding referrals should be reviewed on an annual basis by the LSAB;* All cases are to be assessed within 1 working day by a single team from 1<sup>st</sup> April 2015
- *Activity about safeguarding needs to be reported more often to the LSAB and include other information (for example, how agencies stick to timescales);* While activity to the board still needs reporting more frequently, the issues of timescale is less of a concern as there will be just one team working on all cases and there is now a relaxation of timescale in the interests of ensuring involvement of the adult in question. This still needs monitoring because in complex and serious cases, the basic timescales outlined in procedures, still need to be followed.
- *That when agencies report to the Board, they use an agreed self- assessment and they should be open to challenge by other Board members;* Self-assessment is being introduced regionally by the Association for Directors of Adult Social Services. A framework has been agreed.
- *The feasibility for a shared IT system to be used across agencies for recording safeguarding alerts , but if this is not feasible, the Council needs to be able to*

*access the Mental Health system; As there will be one team managing all cases, a single IT system is being used. However this is still reliant on paper based systems but an up-to-date system has been and is to be introduced in the next few months.*

- *There needs to be more information of the webpages currently included in the wider Council's website, including information on the LSAB, available training and news about safeguarding; Plans for a specific LSAB website are being developed.*
- *Information to the Board regarding staff training should be reviewed and to consider a standard format of reporting by all agencies; This has not been progressed but there is a need to review the training available to all parties in light of the Care Act.*

There are a number of other areas that will need to be addressed in the next few months and will be included in section 6 – Priorities for the 2014/15.

### **Training Delivered by Swindon Borough Council**

During 2014/15, training was delivered by the Local Authority to:

- Over 230 care staff or staff in roles where there is significant contact with adults at risk, received basic awareness training. This is a lower number than in previous years as we have reduced the number of participants in each training session. Also, on a number of occasions there have been a substantial number of non-attenders although registered to attend.  
An audit of training provided to care staff from other agencies has taken place to serve to remind managers of the availability of free training and to find out about the quality of the training being provided by other agencies.
- 6 senior practitioners or team managers received Investigating Manager's Training and 2 Manager's workshops took place (for legal and procedural updates).
- 9 social work staff received Investigating Officer's training.
- Adapted Basic Awareness was delivered to 12 members of the Health and Well-being Team.
- Member training took place - 5 SBC Councillors attended.
- 14 volunteers with the Swindon Circles Scheme attended safeguarding awareness sessions.
- 42 staff in 3 different GP practices.

## SECTION 4

### Swindon Mental Capacity Act Programme

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

Submission by John Hughes: Head of Policy Adult Social Care

Last year's report [\*Safeguarding Adults in Swindon 2013/14\*](#) referred to the Supreme Court handing down judgement on the Cheshire case and that of 2 sisters P & Q, on 19<sup>th</sup> March 2014. As the judgement was regarding the way that existing law should be read its interpretation had immediate effect. The key points identified at the time were the broadening of the scope of Deprivation of Liberty Safeguards (DoLS); The Supreme Court did not define a Deprivation of Liberty but gave an "acid test": Is someone, without the capacity to choose where they live and the nature of support that they need, under continuous supervision and control and not free to leave?". The court ruled that the absence of objection by the individual was of no relevance in ascertaining if someone is deprived, nor is the quality of the environment within which they are placed. Lady Hale, who led on the judgement, stated that "a cage, no matter how gilded, is still a cage"

The Supreme Court Judgement was handed down days after the publication of the House of Lords Select Committee post legislative review of the Mental Capacity Act 2005. This was a generally critical document calling into question the fitness of purpose of the Deprivation of Liberty legislation and guidance. The Government's initial response to the House of Lords Report was made at the beginning of this reporting period, the gist of that response being that the Government did not accept the need for root and branch change but recommended ways of clarifying and streamlining processes. The Government commissioned the Law Commission to carry out a contained project to consider a new legal framework to allow for the authorisation of best interests deprivations of liberty in supported living and other community care settings and the changes that would have to be made to DoLS to take account of the their work. This was published in the Twelfth Programme of Law reform 22<sup>nd</sup> July 2014. However following subsequent engagement and discussion with stakeholders, Ministers subsequently agreed that it would after all be more appropriate for the Law Commission to consider the whole of the legislation underpinning DoLS in its entirety. This broadening of scope delayed the completion of the consultation paper which was published outside of this reporting period. The consultation will have concluded by the next annual report but it is highly unlikely that the Law Commissions report incorporating responses to the consultation and draft legislation will be available by March 2016.

Case law continues to develop apace and not always in an apparently consistent manner. Predictions were initially made by ADASS were that a tenfold increase in DoLS referrals and a vast increase in cases before the Court of Protection, in part as there is no Local Authority function covering DoLS outside of its Supervisory Body role for registered Care homes and Hospitals. Therefore in Shared Lives Schemes (also known as Adult Placements) or supported living (hereinafter "domestic DoLS") the only authorisation available is through the Court of Protection.

The additional burdens arising on Local Authorities were recognised by the President of the Court of Protection. In October 2014 he handed down the "re X" ruling in which sought to rationalise and simplify the Court of Protection's processes. This ruling was supported by a new practice direction which was published in November 2014. A raft of judges around the country have been trained up, ready to deal with the expected flood of cases. However some aspects of this simplified approach were controversial and two of the individuals in the Re X cases went to the Court of Appeal arguing, among other

things, that the new process breached their human rights. Others joined the appeal on related issues for a hearing in February 2015. The judgement was not handed down until after this reporting period. An update on the implications of that ruling will have to be included in next year's report as the Supreme Court decided that the matter was outside of their jurisdiction but gave their view of what they would have determined had it been within their gift which was that P should be represented leaving the situation open to further legal debate and challenge.

It is therefore highly unlikely that the position re the scope and administration of DoLS will be resolved by next annual report. The Mental Capacity Act programme continues to strive to reach legal compliance in this very challenging landscape. Additional legal, professional and administrative and independent sector resources have been employed, recruitment has been a challenge as all Local authorities have the same challenges. The independent sector role is vital in providing both Independent Mental Capacity Advocates and Paid Persons Representatives, these roles have to be in place, but cannot be delivered directly, by the Local Authority to safeguard P where there is no suitable, willing and able independent support, these services are commission from Swindon Advocacy Movement (SAM).

**Table 1: Swindon Deprivation of Liberty Safeguards Service**

	<b>Swindon Borough Council</b>	<b>NHS Swindon (CCG)</b>	<b>Combined Total</b>
<b>Referrals April 1<sup>st</sup> 2010 – 31<sup>st</sup> March 2011</b>	<b>44</b>	<b>14</b>	<b>58</b>
<b>Referrals April 1<sup>st</sup> 2011 – 31<sup>st</sup> March 2012</b>	<b>49</b>	<b>15</b>	<b>64</b>
<b>Referrals April 1<sup>st</sup> 2012 – 31<sup>st</sup> March 2013</b>	<b>61</b>	<b>25</b>	<b>86</b>
<b>Referrals April 1<sup>st</sup> 2013 – 31<sup>st</sup> March 2014</b>	<b>63</b>	<b>26</b>	<b>89</b>
<b>Referrals April 1<sup>st</sup> 2014 – 31<sup>st</sup> March 2015</b>	<b>381</b>	<b>156</b>	<b>537</b>

**NB** health and social care referrals will continue to be recorded separately in order to be able to maintain meaningful comparisons.

This year's data shows a six fold increase in year with the trend still rising (and reviews that have to be at a maximum of 12 months but sometimes shorter driving up activity)

**Court of Protection (CoP).** Continuing the trend that was noted in last year's report we had a small but significant number of cases that have needed CoP ruling on matters of deprivation beyond the scope of the Local Supervisory Body and Best Interest decision making. Re X processes have begun to be applied and paper only renewals of Deprivation of Liberty achieved. We are fortunate to have a Judge from the Court of protection prepared to sit at Swindon County Court on these matters rather than necessitate traveling to the CoP central base which has returned to The Archway in London. This significantly reduces the burden of travel on all parties

#### **Apointeeships 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 represent a sharper focus on the Local Authority being the organisation of last resort at the end of March 2015 there were 142 Appointeeships, this being 41 less than the previous year. Deputyships stood at 51, this being a decrease of 9 since March 2014. The downward trend in these numbers will be likely to reversed in the next reporting period as work has been undertaken to identify a cohort of appointee cases that would be better governed through 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 at Risk is the Swindon Local Safeguarding Adults' Board (LSAB), which during 2013/14 consisted of the following Members:

Independent Chair

Board Director, Commissioning (DCS/DASS), Swindon Borough Council

Head of Commissioning Children & Adults, Swindon Borough Council

Director of Public Health

Cabinet Members Health and Adult Social Care

(Detective Superintendent) Head of Public Protection and Safeguarding Wiltshire Police

Executive Nurse, Swindon Clinical Commissioning Group

Chief Nurse, Great Western Hospitals NHS Foundation Trust

Head of Professions & Practice, Avon & Wiltshire Mental Health Partnership NHS Trust

Station Manager, Wiltshire Fire & Rescue

Principal Social Worker, SEQOL

Head of Safeguarding, South West Ambulance Service NHS Foundation Trust

Board Director, Service Delivery, Swindon Borough Council

Compliance Manager, Care Quality Commission (annual attendance)

Assistant Chief Officer, Bristol, Gloucestershire Somerset and Wiltshire Community

Rehabilitation Company.(BGSW CRC)

Swindon Care Homes Association (service providers representative)

Chair, Healthwatch Swindon

Chair, Learning Disability Partnership Board

Chair, LSAB Service User Forum

Chair, Swindon Care Homes Association

Head of Housing Services, Housing and Community Safety, Swindon Borough Council

Team Leader, Trading Standards (from 1<sup>st</sup> April 2015)

Adult Safeguarding Manager, Swindon Borough Council,

Safeguarding Support Manager, Swindon Borough Council,

GP Lead, Swindon Clinical Commissioning Group,

Assistant Director of Nursing, NHS England

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

- Francis Report Update: GWH and AWP asked to provide an update of their work on meeting recommendations following the publication of the Francis Report into the failings in The Mid Staffordshire Hospital Trust;
- Yearly updates regarding the members work in relation to safeguarding were received from: CCG, AWP, Ambulance Service, Public Health, Adults Social Care (Commissioning);

- Safeguarding Activity (including similar information as included in section 2 of this report);
- How safeguarding cases are managed when there needs to be a clinical incident investigation;
- The Internal Audit (as reported in section 3);
- The Business Plan & Annual Report 2013/14;
- Update on See the Adult See the Child (how adult services links up with children's services when there is a concern about the welfare of their services user and vice versa);
- Findings following Case Review (AB);
- Sub Group updates from the Training Sub Group and the Policy and Procedures Sub Group;
- Multi-Agency Audit Tool (for use when evaluating the management of individual cases);
- Multi regional policy used by ex-Avon Local Authorities;
- Local Implementation of the Care Act and Care act update (following receipt of Guidance);
- Development of a Risk Management Forum; and
- Update on large scale investigations.

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

An additional meeting was also convened to discuss the findings from the Case Review (see section 2)

## **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 (AWP) is a secondary specialist provider of mental health services, these include inpatient units and community teams for both adults of working age and older adults, Psychological therapies services memory and Learning Disability services.

Within the past 12 months The Primary Care Liaison Service has undergone a redesign, with a newly developed joint triage function with LIFT Psychologist which has improved efficiency and has allowed for an increase in responsiveness, as assessments can now occur within 24hrs, if required.

Supported by and in conjunction with the Swindon Crisis Care concordat, the Trust is developing a Street triage service, which includes co-location and collaborative working with Wiltshire Police. It is hoped this service will improve the Trusts multiagency relationships across the Swindon and Wiltshire localities, and have a positive effect on those Service user who come in contact with the police.

Local Services (or Localities) have the leadership role in working with local multi-agency partnerships, their responsibilities include:

- Representation at Safeguarding Children Boards and other relevant sub committees of Boards
- Representation at Safeguarding Adults Boards and other relevant sub committees of Boards



- Representation at Local Domestic Abuse Partnerships and MARAC's
- Representation at MAPPA Strategic Management Boards and MAPP meetings
- Representation at Prevent Boards and Channel panels (process to prevent people being drawn/ radicalised into Terrorism or Domestic Extremism)
- Performance reporting and quality assurance (including framework audits) to multi-agency partnerships and commissioners
- Serious case reviews, and regulatory inspections of safeguarding (CQC/Ofsted etc.).

The Locality management team represent the Trust within the Locality Safeguarding Adult and Children boards. Representation at sub- committee meetings has been ad hoc, due to a number of vacancies within the Locality, however a Safeguarding lead for Swindon has been appointed to help rectify this. The Team works 7 days a week. The Team's key responsibilities and roles are:

- Trust Strategy, Standards and Policy Leadership for safeguarding (and safeguarding training standards)
- Professional leadership for safeguarding
- Liaison with designated safeguarding leads in lead commissioners
- Named officer role for allegations of abuse by staff and DBS variations/referrals
- Prevent Leadership and referrals
- Management of the Safeguarding Management Group
- Provision of specialist case advice to individual practitioners
- Scrutiny of safeguarding referrals and reports
- Provision of specialist supervision to relevant practitioners and teams
- Working with policy committees of safeguarding boards
- Assisting in the development of guidance, audit and educational/information resources for services, practitioners and service users (paper and IT)

For the period of this report AWP were managing the alerts of alleged adult abuse and provided information about their activity to the local authority. With the introduction of the Care Act 2014, AWP considered in collaboration with the local authority if changes were required to ensure compliance. The Trust Head of Social Work has been actively engaging with Locality Authorities to ensure consistency across the Localities, and a Swindon Care Act Lead has been appointed.

The Trust continues to ensure its staff members are trained in safeguarding this includes:

- Recognise possible signs of abuse of children or adults at risk
- Know what to do, and who to inform, if they are concerned that a child or adult at risk is being abused
- Have the opportunity to explore practical responses to safeguarding concerns through the use of case studies
- Be equipped to feel confident to use 'whistleblowing' policy and procedures when required
- Be able to comply with the national and local policies/legislation that support safeguarding activity, and understand the Trust's role as part of a multi-agency framework
- Understand Prevent and its role in recognising and reducing the risk of radicalization to commit terrorist acts

These mandatory training modules are reviewed on a monthly basis by the Locality Senior Management Team, and assessed during compliance inspection by the CQC and Trust Development Authority. AWP staff members are invited to and attend a variety of safeguarding training opportunities facilitated by the local authority.

These mandatory training modules are reviewed on a monthly basis by the Locality Senior Management Team, and assessed during compliance inspection by the CQC and TDA.

AWP staff members are invited to and attend a variety of safeguarding training within the locality facilitated by the local authority.

## **2.2 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 build 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 Chief Nurse is the Executive Lead for Safeguarding, additionally, leadership is provided by our Adult Safeguarding Team to support the clinical services across acute and community. Trust representation is provided to Adult Safeguarding Boards in both Swindon and Wiltshire.

The Trust facilitates and participates in a number of strategic and operational groups to ensure the appropriate governance of the Safeguarding Adults agenda.

### **Key Achievements in 2014-15 to meet Objectives**

- A revised Safeguarding Adults Forum (SAF) was set up in December 2014 and meets bi-monthly. The SAF is a multi-professional group set up to provide assurance to the Patient Quality Committee that GWH is safeguarding adults, is following multi-agency procedures, and meets identified national and local standards and is chaired by the Chief Nurse.
- Annual Safeguarding Forum held in July with positive feedback from all attendees.
- Further developed its internal reporting and will provide reports to the Safeguarding Adults Forum (SAF).
- Strengthened links with the lead agency to improve collaborative working and appropriate participation at all levels of the safeguarding process.
- Recruitment to both the acute and the community adult safeguarding facilitator roles.

### **Safeguarding Adults Staff Training during 2014-15**

In 2014-2015, 1,150 Trust staff completed face to face Safeguarding Adults, Mental Capacity & DoLS training as part of the Trust Induction programme.

97.76% of staff were compliant with the Safeguarding Adults Training Tracker module.

88.99% of staff were compliant with the Consent/Mental Capacity Act Training Tracker module.

83.65% of staff were compliant with the Mental Health Act Training Tracker module.

89.36% of staff were compliant with Dementia Awareness Training Tracker module.

The adult safeguarding training strategy is being finalised and this will cover the new Safeguarding Adults training programme which will include both face to face training and training tracker modules.

(\*Nb. Training Tracker is an on line training system used by GWH)

### **Implementation of the LSAB Strategic Plan**

The strategic safeguarding plan will be incorporated as part of this year's Safeguarding Adults Forum work plan based on the six Key Principles of Adult Safeguarding. Staff awareness will be raised to make safeguarding personal and ensure this is applied to practice whenever there is involvement in safeguarding cases. The Trust's Safeguarding Policy has been reviewed and updated in line with these working principles in line with the Care Act, 2014.

### **2.3 Healthwatch Swindon**

Healthwatch Swindon welcomes the opportunity and recognises the importance to have representation on this Board and the Children's Safeguarding Board, especially with the introduction of the Care Act 2014. Whilst the priorities and work programme for Healthwatch Swindon were being determined by our own Board during the year, attendance at the Local Safeguarding Adult Board (November 2014) identified an opportunity to re-engage third sector organisations in the safeguarding adults awareness sessions. Including volunteers, Healthwatch Swindon organised a session for over 30 attendees of various third sector organisations. This will continue to form part of our staff and volunteer induction programme. Two Healthwatch Swindon volunteers also sit on the Safeguarding Service User Forum.

As part of our scrutiny work during the year we have worked to understand 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. Our contract with Swindon Borough Council includes the provision of independent complaints advocacy for NHS complaints. Work with individuals through that and other contacts with local people has and will continue to suggest on occasion that alerting is required. We are a member of the Quality Surveillance Group facilitated by the NHS England area team which allows us the opportunity to raise issues of concern in a wider, sub-regional context with commissioners."

### **2.4 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 of the dementia needs assessment and strategy and Public Health Chair the Dementia Strategy Implementation 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 share 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.

Public Health has also contributed to the End of Life Care agenda which promotes the use of the end of life care place with 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.

Health Protection staff have more direct links with the public through 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 adults at risk particularly with the widening of the definition of the group safeguarding procedures needs to support with the introduction of the Care Act.

Those most at risk include those who experience domestic violence and sexual abuse; Public Health recognise the importance of safeguarding is fundamental within these agendas. Public Health Commission the Health Ambassador, Befriender and Champions who work in localities to identify and work with those most at risk. These teams have a key role in the Safeguarding process.

## **2.5 SEQOL**

This report is based around the 6 principles of the Swindon LSAB Strategy 2015-18:

### **Empowerment**

All SEQOL colleagues who are involved in undertaking the enquiry officer role are very clear that the principles of making Safeguarding Personal are to involve the individual affected at the earliest opportunity.

SEQOL clinicians are using 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.

The Case Example below shows a clear example of empowering the individual to maintain his independence and this also fits squarely within SEQOL's core values.

*The coming year...* Domestic abuse awareness and 'asking the question' training is now part of our Safeguarding training. We are working with Domestic Abuse services in Swindon to collaboratively support individuals with care and support needs who are experiencing or have experienced domestic abuse.

We are providing more training for non-social care colleagues to support individuals to make informed decisions about their life and understand the risks presenting to them and alternative options to reduce this risk.

### **Prevention**

SEQOL are delivering updated Basic Awareness training every month and have extended this to all staff.

More Safeguarding Champions are being identified and trained.

*The coming year...* More training to be delivered to individuals that access SEQOL services and may be at risk of abuse e.g. – Shared Lives service users to receive 'keeping yourself safe, keeping others safe' training and carers to receive WRAP (Workshop to Raise Awareness about PREVENT) training.

Did Not Attend policy has been drafted to help identify when adults with care and support needs may not be attending appointments due to possible abuse and/or neglect.

Continued monitoring and review of areas of SEQOL where raising of safeguarding concerns is either unusually high or low and a look at how their training compliance correlates.

### **Proportionality**

The below case example also demonstrates a proportionate response to a safeguarding concern.

Using the defensible decision tool also ensures that practitioners can be proportionate in the actions they take in relation to unwise choices.

*The coming year...* SEQOL enquiry officers are now able to squarely focus on a series of conversations to ensure a proportionate response to the individual's situation and move away from holding meetings when they are not required.

### **Protection**

Colleagues in supported employment are being delivered 'keeping safe, keeping others safe' training to ensure they are aware of their own ways of protecting themselves and their colleagues.

Advocacy is being obtained from the new locally commissioned service to ensure those that require support in the safeguarding process can do.

*The coming year...* SEQOL's new website will have a Safeguarding page to link in to how to raise concerns about an individual who may be at risk of harm.

### **Partnership**

Again the case example shows how housing, SEQOL and a volunteer service worked together to provide solutions to ensure the person retained his independence and was safeguarded from future harm whilst meeting his desired outcomes.

*The coming year...* SBC and SEQOL will meet monthly to ensure the processes between the two organisations are running smoothly and the service to individuals is seamless and effective.

### **Accountability**

SEQOL will be working closely with SBC in line with the new ways of working under the Care Act 2014. This includes improving feedback to the CCG when a serious incident meets the criteria under adult safeguarding.

*The coming year...* CCG will be attending Serious Incident Review Panel in order to improve duty of candour in relation to serious incidents which will also ensure that direct questions can be raised when incidents meet safeguarding criteria.

### **Case Example**

A concern came in from Supported Housing Officer (SHO) about an 80 Year old man (James) living in their supported/sheltered housing scheme, reporting that the niece who normally collects his pension, pays bills and does shopping had not been a reliable source of support and on many occasions over past 3 or 4 weeks had not arrived, leaving him for days without any food or any money. When she had given him money, the amounts had fluctuated by up to £50 a week. The referrer was contacted and it was agreed that she would speak to the gentleman to discuss the concerns and how he would like to proceed.

The SHO reported that James was protective of his niece and very reluctant for concerns to be raised or investigated. There were no concerns about James' mental capacity. SHO arranged for a one-off grocery shop for him so that he was not left without food. After repeated failed attempts to make contact with his niece, the niece voluntarily offered up her uncle's bank cards to the SHO following her next visit to her uncle. As a result the niece no longer has direct access to his money.

The Investigating Officer involved checked with SHO, now that the risks had been reduced by niece no longer having access to James' money, queried whether there was anyone else that could support him to access his money and groceries, or whether he would be able to regain control of his own finances.

SHO reported that there was a local volunteer who supports other residents to access shops, appointments etc., and therefore might be able to support him if he agreed. The SHO reported that they could also look into getting an electricity payment card, so that he can make regular payments.

James agreed to take responsibility for his monies and for the volunteer to take him to the Post Office weekly to collect his pension, pay his bills and grocery shop etc. The SHO completed a rough breakdown of his weekly expenditure for him and he was able to see that he should have more money in his wallet than he had been receiving. The IO advised that as James did not wish to take matters any further then case will now be closed and for the SHO to make contact again if there were any further concerns.

Outcome: James was empowered and gained more independence and control of his life, his desired outcomes were met, immediate protection action ensured he did not go without food or necessities, a preventative plan avoided any further abuse, the response was proportionate, and there was good partnership working with the individual, SEQOL, Housing Services and the volunteer service. James was aware of all concerns raised and was kept central throughout.

## **2.6 South Western Ambulance Service NHS Foundation Trust (SWAST)**

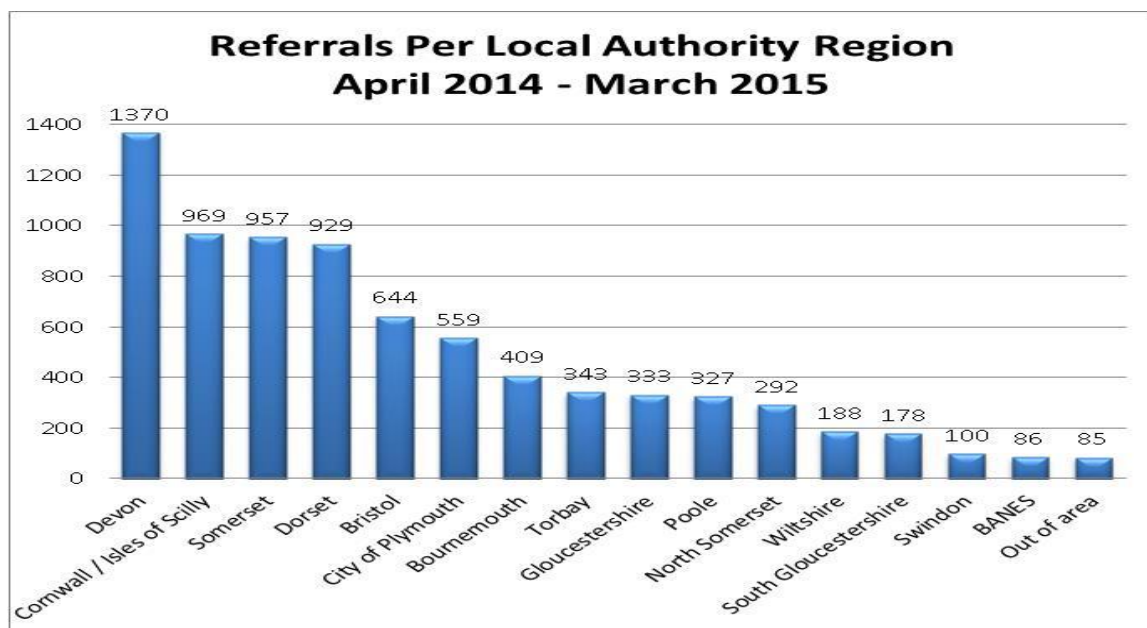
SWAST are aligned to 28 Adult and Child Safeguarding Boards within the operational area. The trust endeavours to maintain relationships with all these organisations in the interests of their responsibility to safeguard but due to the complexity and unique coverage, an efficient and pragmatic approach needed to be agreed.

Following National Guidance, the trust continues to work with the Boards under a 'memorandum of understanding' agreement to maintain communication relationships with all Boards

In order to further evidence multi agency working and other areas of work, activity data has been collected by each member of the team on a monthly basis and collated for the first time this year.

### **Safeguarding referrals (adults and children)**

In total during the year 1<sup>st</sup> April 2014 to 31<sup>st</sup> March 2015, 7,769 safeguarding referrals were submitted across South Western Ambulance Service. This is an increase of 1,945 or 33%.



## **Key progress and achievements for 2014-15**

- All Serious Case Review/Domestic Homicide Review/chronology requests were responded to in a timely fashion.
- The safeguarding referral system is more sophisticated to produce quality data.
- A successful South West (external body) Audit took place in Jan 2015.
- The Safeguarding Service worked with Alcohol Anonymous (AA) to provide a raising of awareness campaign across the trust area by use of leaflets posters etc. and as a result the AA covered the Christmas and New Year period on the alcohol recovery bus.
- All frontline staff have been offered level 2 training in safeguarding with an overall attainment of 90% staff attendance.
- All new 111 or 999 staff have had safeguarding training as part of their induction programme.
- All 111/Urgent Care Service (URC) staff have been offered level 2 training with an overall attainment of 99% preventing a CQUIN (Commissioning for Quality and Innovation (*NHS; UK*) of 100k.
- There are now 25 safeguarding champions who are active across the trust area.
- All Notice Boards in the North division stations have been updated in stations to reflect the new issues facing this agenda.
- The managing allegations policy has been further embedded in the operational services.
- Prevent training has been agreed on the Statutory mandatory Education training for 2015-16
- The Head of Safeguarding has been elected as Chair of the National Ambulance safeguarding Group (NASG) this year which reports to Nation Ambulance Services Quality Governance and Risk Directors Group
- A Safeguarding Training strategy has been agreed so all Board Members, Managers and staff are able to understand more effectively what is expected of them.

## **Priorities for 2015-16**

The priorities for the Safeguarding Service were decided at the team meeting in March 2015.

These are:

- Continue to ensure the completion of a centralised recording system for safeguarding training across all departments.
- Review the current referral system to promote a more efficient system with input from IT
- Work plan to be guided by NASG work plan and Saville Recommendations
- Embed the Prevent agenda
- Implications from the Care Act for the Trust
- Expansion of the Welfare agenda
- Consider a more resilient team by integrating more with the Governance Structure
- Agree a Supervision Strategy for the trust
- Escalation Policy to be approved

Nb. This is an extract from a larger report – available on request



## **2.7 Swindon Borough Council – Housing Services**

Housing staff are often at the forefront of identifying adults at risk and reporting concerns particularly within Sheltered Housing Schemes. Sheltered Housing Officers in the schemes are vigilant about visitors to buildings and may observe when individuals are being targeted or exploited. (See Case Example on page 35)

In 2014/15 there were 10 referrals made by Housing Officers and a considerable number of cases where support from Housing Services was required and provided. Housing Services have been engaged with the Task and Finishing Group looking into creating a risk enablement pathway. This will help those who are difficult to engage and may have chaotic or hazardous lifestyles. (See page 46 priorities for 2015/16)

A senior representative from Housing Services sits on the Quality Assurance Sub Group. As this group will be carrying out thematic audits, it has been agreed that during the year there will be an audit on referrals into safeguarding by Housing Services to consider the appropriateness and accuracy of concerns raised.

Housing staff continue to receive training and instruction on safeguarding and have received information on their responsibilities under the Care Act 2014. Safeguarding features as the first item within the newly revised Sheltered Housing Staff procedure guide issued to all relevant staff. In June 2014 the Adult Safeguarding delivered a presentation to the Tenants Association for Sheltered Housing (TASH). This was well received.

## **2.8 Swindon Clinical Commissioning Group**

During 2014/15, NHS Swindon CCG continued to fully engage with the Swindon Local Safeguarding Adults Board (LSAB), in order to contribute to inter-agency cooperation aimed at protecting adults at risk from suffering harm and abuse.

Swindon CCG's Associate Director for Quality and Patient Safety has supported rotational chairing of the LSAB Operational Group during 2014/15. The CCG also identified the Quality Improvement Manager as a member of the newly established LSAB quality assurance group.

### **Swindon CCG Mandatory Training**

All staff (100%) completed relevant mandatory safeguarding adults training during 2014/15.

### **Priorities for 2015/16**

During 2014/15 the LSAB reviewed its strategy for 2015-2018; ensuring requirements are aligned to the Care Act 2014 and Government policy on Adult Safeguarding.

### **LSAB Strategy 2015-2018**

There are six principles on which the Swindon LSAB has based its newly agreed strategy for 2015-2018 include: Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability.

In order to meet the aims and outcomes of the Swindon LSAB strategy, during 2014/15 NHS Swindon CCG identified its roles and responsibilities against the six principles which are monitored via the LSAB Operational Group, the CCG's Commissioning for Quality Committee and the newly formed Adult Safeguarding Quality Assurance Group. The Quality Assurance Group's core aim is to monitor and evaluate the effectiveness of Local Authority safeguarding activity, ensuring all partners, individually and collectively, look to safeguard and promote the welfare of adults in need of care and support and provide advice on improvements required.

The CCG is committed to meeting the requirements of the strategy via full implementation of key identified work streams which includes (but is not limited to):

Empowerment: As a member of the Quality Assurance Group, the CCG will 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 is now contributing to the evaluation of multi-agency working via planned joint audits of safeguarding cases, ensuring participation of relevant agencies. The CCG Quality Improvement Manager, as a member of the Quality Assurance group, will assist in appraising the quality of practice and lessons learned in terms of both multi-agency and multi-disciplinary practice.

The CCG will continue 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).

Prevention: Continue to ensure safeguarding is a key consideration in the tendering and procurement process during the commissioning phase. All commissioned provider services will continue 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).

Proportionality: Where appropriate, during 2015 the CCG will contribute to the requirements of a newly established Case Review 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.

Accountability: During 2015, and in agreement with the LSAB, the CCG will agree its position concerning the role of the Designated Adult Safeguarding Manager (DASM) as set out in the Care Act Guidance and Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework.

## **2.9 Swindon Community Safety Partnership**

Community Safety Partnerships (CSPs) are under a statutory duty to work to reduce reoffending; tackle crime and disorder; tackle anti-social behaviour; tackle alcohol and substance misuse; and tackle any other behaviour which has a negative effect on the local environment. The CSP is keen to continue its links with the work of the LSAB and the agencies engaged with safeguarding adults at risk. There are a number of aspects of CSP team work that has a clear link to the priorities of the LSAB.

The Domestic Abuse Reduction Strategic Lead within the CSP is a member of the Operational Group of the LSAB and the Adult Safeguarding Manager attends the Domestic Abuse Steering Group. The attendance at both of these meetings is in recognition of the links required between adult safeguarding and services supporting people who are victims of domestic abuse. Domestic abuse can be prevalent in households where adults at risk live, or between couples who are both adults at risk. It is essential that Safeguarding and CSP investigating managers are aware of the frameworks that exist where the Domestic Abuse reduction process can run in tandem with the safeguarding procedures.

As illustrated by some high profile cases in the national media, links with teams managing safeguarding procedures and the Community Safety team are essential if

there are reports of adults at risk of being victims of anti-social behaviour. The CSP team manages information sharing between partners regarding alleged perpetrators or other adults at risk who may be affected similarly; making direct contact with other agencies that are able to support an investigation and being able to make contact with alleged perpetrators directly with an outcome to change their behaviour.

Developing a pan-Wiltshire Hate Crime strategic group is a priority of the CSP and highlights a concern about specific groups at risk, for example from disability hate crime.

There is an on-going issue in Swindon with dangerous drug networks exploiting the most vulnerable in the community. There has been action taken by the CSP team and partners in using the new tools and powers available in the ASB, Crime and Policing Act 2014 to address this concern, including the use of Closure Orders and Civil Injunctions.

There is now a concerted focus from the CSP team to respond to reports of anti-social behaviour based on risk of harm rather than ASB type. This is reflected in the work of Wiltshire police. This has led to increased identification and support for the most vulnerable. In 2014/15 there was an 80% increase in the identification of vulnerable victims compared to 2013/14 and all forms of repeat offending reduced.

The role of Victim Liaison within the CSP team has been replaced by a pan-Wiltshire service through Victim Support. It is vital that good working practices are established and maintained between Victim Support and the CSP Team to ensure that the needs of vulnerable victims are met.

All members of the CSP team have been trained in safeguarding vulnerable adults and will have refresher training in 2015/16. They are also trained in the links between anti-social behaviour, domestic abuse and safeguarding.

## **2.10 Wiltshire Police**

Wiltshire Police are fully dedicated to preventing, investigating and detecting abuse against Vulnerable Adults. We have a dedicated Safeguarding Adults Investigation Team, which is made up of Detective Inspector, Detective Sergeant and 6 investigators. This team covers the whole of Swindon and Wiltshire, and investigates any significant abuse/risk of harm by carers, family, people in position of trust, or fellow service users. In addition we have a triage team based at County Hall, who are responsible for the receipt, review and allocation of all referrals. The strategy discussions held, and they are the single point of contact prior to investigation.

We work closely with The Local Authority and partner agencies to provide a high quality of service and safeguarding.

Should a crime be committed against a Vulnerable Adult, but does not sit within our remit, then the victim will receive the same standard of investigation but by our uniform or CID colleagues, who are appropriately trained in joint investigations and Achieving Best Evidence.

As part of our commitment to protecting Vulnerable Adults, we form part of the core of the Safeguarding Adults Board for both Swindon and Wiltshire.

As a SAIT team we have had a number of successful prosecutions against individuals for offences against Vulnerable Adults, which have been reported in local news.

In July 2014, we formed a triage team (Julie Withey, and Andy Guy) who are based at County Hall. As stated above they are responsible for the receipt, review and allocation of all referrals. The strategy discussions held, and they are the single point of contact prior to investigation. This has allowed a more effective and streamline approach to the initial process. Partner agencies now have a single point of contact, and deadline/timescales are being met more efficiently.

As an organisation we have embraced the Care Act 2014. Our policies have been fully scrutinised and amended where necessary. Our website has been updated, training sent out through e-briefs and internal communications. The Force training department is now providing this as part of Probationer and CID training.

Training is always on-going within Wiltshire Police. We have a number of ways in which this is done, which have all been adopted in the past year including briefing by SAIT to uniform and CID, training package to probationers and CID updated, internal communications such as Firstpoint and ebriefs.

Wiltshire Police are dedicated to continuing to providing 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 Example**

In May 2015 Dc Erica Hegg successfully prosecuted Lolita Reid for 3 offences of fraud against a Vulnerable Service user. Reid was sentenced to 2 years and 9 months imprisonment by Swindon Crown Court.

Reid was a carer for a 91 year old service user, who suffered with dementia. During the period 2009 to 2012, Reid accessed the victims bank account using her bank card and stole around £80,000.

## **2.11 Bristol, Gloucestershire Somerset and Wiltshire Community Rehabilitation Company**

Bristol Gloucestershire Somerset & Wiltshire Community Rehabilitation Company (BGSW) works with low and medium risk of harm offenders in prison and the community with the objective of Reducing Reoffending and Protecting the Public. Vulnerable adults are clearly a significant part of the cohort with whom we work (for example, Individuals with Learning disabilities, Mental Health Issues and victims of abuse, both male and female). Each individual with whom we work has a specific sentence plan which takes into account their needs as well as the risks they present to others.

Achievements during 2014/15 to meet the objective above

To help people change their behaviour, we need to work and communicate with them in a way that suits their learning needs. BGSW works with SEQOL on an "Understanding Autism" project; this involved staff training/awareness raising and clinical supervision offered to Offender Managers to discuss individual cases. This project won the Autism Great Practice Award at the National Learning Disabilities and Autism Awards ceremony in May 2015.

Training undertaken within the organisation regarding safeguarding adults

All operational staff receive information about Adult Safeguarding at induction. We have a rolling programme of more comprehensive training that all staff are expected to attend every 3 years. An important role in protecting Vulnerable Adults is the work we do with both perpetrators and victims of Domestic Violence. New 2 day training on this area of work is currently being offered to all operational staff.

How your agency intends to implement the Strategic Plan which was agreed at the last board

BGSW CRC can most effectively contribute to the strategic plan in its Partnership working. At a strategic level, managers are represented on the Community Safety Partnership, Domestic Violence Steering Groups and other forum. On a more

operational level, Offender managers work on a sustained basis with some more “hidden” vulnerable adults and are in a position to identify vulnerability and work with partners to fulfil the needs of these individuals.

### **3. Sub-groups of the LSAB**

During the year, the LSAB decided to change the structure of some of the sub groups to include areas of work that may not have been addressed through the existing groups. The Operational Group now meets quarterly and there is now a Quarterly Quality Assurance Group. To consider Safeguarding Adults Reviews (a Care Act requirement), there is a 6 monthly review group which also meets as necessary as requests for Case Reviews are made.

**Operational Group** met on seven occasions during the year, with attendance from the following agencies: SBC (Head of Policy, Housing, Domestic Violence, Adult Safeguarding, Commissioning (adult social care and supported housing) and Commissioner for Substance Misuse), Great Western Hospital Foundation Trust, Wiltshire Police, Swindon Clinical Commissioning Group, AWP, SEQOL and BGSW. The aim of the group is to carry out the work of the LSAB and be able to look at tasks and issues in greater detail and report to the Board as necessary. Attendance was sporadic at times indicating a need to reorganise the group.

Agenda Items during the year included:

- LSAB Business Plan;
- Internal Audit on Safeguarding;
- The Care Act 2014;
- Clinical Incidents & Safeguarding (the relationship between investigating clinical incidents and safeguarding);
- Audit tool for quality assurance audits;
- Dangerous Drugs Networks;
- Revision to Procedures in light of the Care Act;
- Development of Risk Enablement Panel following AB case review;
- Swindon Safeguarding Guide (guide to be provided to individuals to help with the safeguarding process);
- Outcomes of specific Court Cases arising from safeguarding investigations;
- Review of Terms of Reference;
- The South West regional projects on developing safeguarding protocols;
- Self-Neglect; and
- Case discussions – the Operational Group will discuss 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 is a new sub Group that has been developed as a result of the reorganisation of the Operational Group. The group will look at individual cases to check through progress how well the case was handled, whether the outcomes was in line with the wishes of the alleged victim and whether the cases should have been handled differently and raises any learning points. Good practice will also be acknowledged and feedback provided to teams as necessary. The first meeting was held in January and mainly concentrated on forming the group and deciding on how it would be organised and how cases for scrutiny will be decided. Membership of this group includes SBC (safeguarding, Commissioning, substance misuse commissioner and Housing

Services), The Clinical Commissioning Group, Wiltshire Police, SEQOL, GWH and AWP.

**Learning and Development Sub-group:** This is intended to be a Wiltshire and Swindon sub Group as many agencies that need to attend work across the County. Due to changes in personnel the meetings did not take place and was to be reformed in 2015-16. The small Swindon Group also did not meet but did review the Training Strategy in light of the forthcoming Care Act Guidance.

**Policy and Procedures Sub-group:** This is a joint Wiltshire/Swindon sub group which is currently being chaired and managed by the Wiltshire Safeguarding Adults Board. The group met on three occasions during the year and a smaller group met to look specifically at policy revision. Items discussed during the year included: the Care Act, Large Scale Investigations procedures, “interface” between Safeguarding and Clinic Incident reporting, Wiltshire’s Thresholds Guidance, Self-neglect and “Vulnerable Adults Risk Management Committees”, Wiltshire’s Multi-agency Safeguarding Hub,

**Awareness and Engagement Sub-group:** Has been developed alongside the Children’s Safeguarding Board to develop the awareness of safeguarding issues across the communities in Swindon. This group met on 2 occasions over the year and was felt to require a new approach. Attendance had become intermittent and progress with its main objective, slow. There were some specific pieces of work for example the poster competition increasing awareness around online bullying, which effects adults at risk in similar ways to children and young people.

**Service User Forum:** Continues to meet but there is fluctuating membership. The chair of the Forum has been working hard to widen the membership and new members have attended showing a great interest and commitment.

The Service user forum has met on 4 occasions and agenda items have included:

- Safe Places Scheme – a scheme that provides support to vulnerable people;
- Met New Safeguarding Lead SEQOL;
- Met New Safeguarding Lead GWH;
- Swindon Safeguarding Guide;
- Hate Crime Update;
- Discussion on national cases;
- The Annual Report 2013/2014;
- Swindon Circles – project aimed to reduce isolation of some vulnerable people
- Care Home of concern; and
- Managing Risks and update on developing a risk enablement panel.

## SECTION 6

### Priorities for 2015/16

One of the statutory requirements for the Board as a result of the Care Act is to produce a Strategic Plan. The work to develop the plan began in early 2015 and was agreed by the Board in May 2015. The strategy was developed using the government priorities as highlighted in Care Act guidance:

**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.

**Source: Statement of Government Policy on Adult Safeguarding May 2013**

Priorities and future work required have been grouped under these headings. Any outstanding work from the previous annual report has also been included below.

**Empowerment - Actions:** (responsibilities and timescales at the end of each item)

- Wherever possible, the adult themselves is to be included in all stages of the safeguarding process. Audits will be undertaken to ensure that the adult is at the centre of the decision making process in accordance with the Making Safeguarding Personal approach. Audits to be undertaken through Quality Assurance Sub-group, quarterly.
- Ensure that information is available to adults in need of care and support so that they know how to report abuse and neglect themselves. Publicity material and on-line resources to be updated. Adult Safeguarding Manager - September 2015.
- Publication of The Swindon Guide – document given to service users going through safeguarding process which contains an outline of what happens and gives contact information. Adult Safeguarding Manager - September 2015.
- Development of a specific Adult Safeguarding (or LSAB) website and consider including a repository for “staying safe” advice for the general public. Adult Safeguarding Manager – December 2015
- Increase the membership of the Service User Forum. Chair of LSAB and Chair of Service User Forum. Review September 2015.

- Training for Enquiry Officers involved in safeguarding cases updated to include the emphasis on “Making Safeguarding Personal”. Adult Safeguarding Manager - June 2015.
- Enquiry Managers need to ensure that advocates are provided when there is a substantial need. Audit of use of advocacy service to support alleged victims of abuse or neglect. QA Sub-group December 2015
- Information including annual reports and the Strategic Plan need to be available in easy read format. Operational Group – November 2015

#### **Protection – Action:**

- Single Referral Point established within Adult Social Care. Strategic Commissioner for Adults. 1<sup>st</sup> May 2015. Progress report to Board November 2015.
- Establish team of Senior Quality Practitioners to act as Enquiry Managers for individual cases. 1<sup>st</sup> May 2015. Progress report to Board November 2015.
- Quality Assurance Sub-group to undertake quarterly review of individual cases to evaluate quality of practice and outcomes. QA Sub-group. From April 2015.
- Involvement of the correct agency to carry out an enquiry following a safeguarding alert. Enquiry Managers within SBC – From April 2015 (this also falls into the remit of partnership working and accountability).
- Encourage individuals (or their representatives) to provide feedback following the conclusion of the safeguarding process. Enquiry Managers and Adult Safeguarding Manager (report feedback to the LSAB – January 2016)

#### **Prevention - Actions:**

- Free awareness training provided for all staff who work with people with care and support needs. Head of Safeguarding. Report in LSAB Annual Report.
- Safeguarding training provided for all private and voluntary sector managers. Head of Safeguarding. Report in LSAB Annual Report.
- LSAB members/partners to undertake safeguarding awareness training. LSAB Chair. December 2015.
- Ensure that safeguarding is a key consideration in the tendering and procurement process during the commissioning of all services. LSAB to require all members to complete a self-assessment to demonstrate compliance with commissioning requirements and application of safeguarding procedures. Operational Group – Annually.

#### **Proportionality - Actions:**

- Establish LSAB Case Review Group. LSAB Chair. By August 2015.



- Proportionality to be included in training for all staff working with people with care and support needs. Head of Safeguarding. September 2015
- Case examples discussed at each meeting of the Board and Operational Group and included in LSAB Annual Report. LSAB Chair.
- The guidelines in the Policy and Procedures need to be changed to reflect the Care Act and requirements within the guidance. Wiltshire and Swindon Policy and Procedures Sub-group to prioritise the sections requiring revision e.g. the process required around Safeguarding Adults Reviews. Adult Safeguarding Manager – August 2015.

### **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 (who have mental capacity) who are at risk due to:

- severe self-neglect/self-harm;
  - risk taking behaviours;
  - refusal to engage with services for which they are eligible;
  - abuse by a third party – not willing to engage in safeguarding or with services;
  - that is a 'frequent caller' to services;
  - where the agency is struggling to maintain a high risk situation as a single agency; and
  - where that risk may lead to significant harm or death.
- Develop a project around introducing a Risk Enablement Pathway. Risk Enablement Development Manager. October 2015.
  - Information Sharing Protocol to be developed and agreed in partnership with LSCB. Chairs of both boards - September 2015.
  - Resourcing the Board. Care Act Guidance (section 14.113). Members of LSAB. Recognition from Board Members of their obligations to provide resources for the LSAB. Chair LSAB to raise with Members. August Board 2015.
  - Learning and Development needs to reflect emerging case law, practice and changes to national, regional and local guidance. Learning and development modules available across service areas need reviewing so the appropriate level of training is provided to staff suitable to their role. Adult Safeguarding Manager – with local Learning and Development Leads. November 2015.
  - 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. LSAB Chair.  
(nb: Bogus callers, financial scams, distraction burglaries, dangerous drugs gangs: criminals responsible for such areas of concern often target vulnerable people that may require support of the safeguarding process. Agencies outside adult services already engaged in these issues need to be available to support safeguarding

procedures but also provide advice guidance and training to social care staff who need awareness of this and will be able to help with prevention)

**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. LSAB Chair. Board meeting May 2015.
- New Council Member training to take place. Head of Safeguarding - 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). 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 – November 2015.
- 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 – Implementation due 2016.
- Ensure that training for those involved in co-ordinating and investigating cases is relevant and up to date. *This is particularly required in view of the Care Act.*
- Run training for Provider Managers to include safer recruitment, prevention and allegations against staff.

## Glossary

AA	Alcoholics Anonymous
ADASS	Association of Directors of Adult Social Services
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BGSW CRC	Bristol, Gloucestershire Somerset and Wiltshire Community Rehabilitation Company
CCG	Clinical Commissioning Group
CCTv	Close Circuit Television
CID	Criminal Investigation Department
CoP	Court of Protection
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSP	Community Safety Partnership
DASM	Designated Adult Safeguard Manager
DASS	Director Adult Social Services
DCS	Director Children Services
DoLS	Deprivation of Liberty Safeguards
DA	Domestic Abuse
GP	General Practitioner
GWH	Great Western Hospital NHS Foundation Trust
IO	Investigating Officer
IT	Information Technology
LSAB	Local Safeguarding Adult Board
LSCB	Local Safeguarding Children Board
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
MSP	Making Safeguarding Personal
NASG	National Ambulance Safeguarding Group
NHS	National Health Service
OBE	Order of the British Empire
QA	Quality Assurance
SAF	Safeguarding Adults Forum
SAIT	Wiltshire Police Safeguarding Adult Investigation Team
SAM	Swindon Advocacy Movement
SAR	Safeguarding Adults Review
SBC	Swindon Borough Council
SCIE	Social Care Institute for Excellence

SEQOL	SEQOL is the Social enterprise providing health and social care and support
SHO	Supported Housing Officer
SWASFT	South Western Ambulance Service NHS Foundation Trust
TASH	Tenants Association for Sheltered Housing
TDA	Trust Development Authority
URC	Urgent Care Service

The Safeguarding Adults at Risk in Swindon Annual Report 2014/15 is available on the Internet on [SBC Adult Safeguarding page](#)

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