Safeguarding Adults At Risk in Swindon Annual Report 2012 - 2013

SEQOL care • health • support

Avon and Wiltshire NHS Mental Health Partnership NHS Trust

NHS Swindon

Swindon Borough Council

Keeping Swindon Safe

Wiltshire Probation Trust

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Safeguarding Adults at Risk in Swindon Annual Report April 2012 March 2013

Contents:

Foreword		5
Section 1	Introduction	7
Section 2	Activity Data 2012/13	9
Section 3	Progress in 2012/13	19
Section 4	Swindon Mental Capacity Act Programme	24
Section 5	Swindon Local Safeguarding Board	26
	Board Members' Reports	27
	Sub Groups of the LSAB	35
Section 6	Priorities for 2013/14	37

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

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FOREWORD

We are pleased to present the annual report of Swindon's Safeguarding Adults Board which covers the period from April 1st 2012 to March 31st 2013.

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. It contains statistical breakdowns which show the number, type, source and demography of safeguarding referrals, and the outcomes of the subsequent investigations.

The report emphasises the increase in the number of referrals received from last year- 406 compared to 293; a 40% rise in line with the experiences of other local authorities. There is undoubtedly a greater awareness of adult safeguarding heightened by the national outrage arising from the reports into the Winterbourne View scandal in August 2012 and the publication, in February 2013, of the Francis report into the Mid-Staffordshire hospital deaths.

The Board convened an extra-ordinary meeting to consider the recommendations from the Winterbourne View Serious Case Review. The report gives more detail of our action plan and subsequent monitoring programme on pages 21 and 22. The Board also considered the local response to the Francis report and its implications for Swindon's care providers and commissioners. Agency plans are still under development and will feature in next year's report.

The Department of Health has now given the responsibility to the new Health and Wellbeing Board to oversee all aspects of the Winterbourne View action plan. The need to formalise the working relationships between the Boards has prompted discussions between the LSAB chair and the Leader of the council (who chairs the Health and Wellbeing Board). These discussions will continue during 2013.

Collaboration between partner agencies is a key theme of Swindon's safeguarding activity. Whilst the statistics are important to gauge performance, the case studies throughout the report show that safeguarding is all about making a positive difference to people's lives. It is important to

stress that any remedial action must involve the adult concerned and achieve their desired outcome.

So the emphasis is rightly upon the 'voice of the user'. In last year's report mention was made of the Service User Forum which was still in its infancy. Over the past year, the Forum has met regularly, discussed a variety of safeguarding topics and is now looking to expand its membership. It now has its own independent chair who became a Board member in February.

Another developing area of partnership is with other Safeguarding Boards. Swindon and Wiltshire LSABs have a joint training sub-group and both Boards work together to update policies and have reformed a combined policy and procedures group. The Board works with the Local Safeguarding Children Board to promote awareness of safeguarding issues across Swindon. This will continue in 2013/14 through the first joint safeguarding conference and the re-launch of the 'See the Adult, See the Child' protocol.

Section 6 outlines the priorities and challenges facing the Board for 2013/14. The new Care Bill will make the Board a statutory body. The priorities reflect the new demands and requirements for the Board under this legislation. Other priorities include increasing further the involvement of individuals involved in safeguarding, responding to neglect, and improving the quality and availability of training. The Board also needs the flexibility and capacity to consider our response to national events.

We are confident that the response to Winterbourne View and the local partnership work as exemplified by the case studies, show that Board members, both individually and collectively, are committed to ensuring the safety and well-being of those adults at risk of harm who live in Swindon.

Michael Howard
Independent Chair
of the LSAB

Brian Mattock
Cabinet Member for Health and Adult Social Care

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SECTION 1

Safeguarding Adults at Risk in Swindon Annual Report 2012/13

Introduction:

Over the past year safeguarding adults at risk has gained a great deal of attention locally and nationally particularly with events previously reported at Winterbourne View and more recently with the publication of the Francis report (issues that will be referred to later on in this report). The draft Care and Support Bill was also published recently informing the Swindon Local Safeguarding Adults Board (LSAB) of development actions required over the coming few years. Locally there has been a great deal of work developing the LSAB and perhaps gives an indication of the importance key agencies place on adult safeguarding.

As the Government Policy confirmed that *No Secrets (Department of Health 2000)* will stay a statutory guidance until at least 2014 so the definition used by the LSAB and within the policy and procedures used remains unchanged:

An Adult at Risk is 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.*

Working closely with the police and other health colleagues, alerts of alleged adult abuse are managed in the main by SEQOL, the social enterprise providing care and support that was previously provided by the Council and NHS Swindon. For people who are mentally unwell, the Avon and Wiltshire Mental Health Partnership NHS Trust fulfils this role. The work is overseen by the LSAB. As previously reported in the annual report for 2011/12, there has been considerable work on updating the policy and procedures to take into account the principles outlined in the Government Policy on safeguarding adults:

- **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.
- **Accountability** - Accountability and transparency in delivering safeguarding

Statement of Government Policy on Adult Safeguarding May 2011&13

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%). Fewer than 5,400 people were receiving services from adult social care in 2012/13 broken down into client groups as follows:

Clients	Age Band 18 - 64		Age Band 65 & Over	
	Female	Male	Female	Male
Physical Disability	414	306	1,911	939
Mental Health Need	347	356	313	164
Learning Disability	245	307	39	37
Total of Clients	**1,006**	**969**	**2,263**	**1,140**

The Borough of Swindon is largely urban with small pockets of rural areas. Within Swindon there are some deprived areas which can also impact of levels of vulnerability for some of those living there. In 2012 again there was a drop of 5% in the number of reported crimes in Swindon and Wiltshire. The number of reported crimes in Swindon fell from 19,953 in 2011/12 to 18,483 in 212/13. Overall Swindon is considered to be a safe place to live and Wiltshire 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 are keen to promote and develop this, recognising the importance of supporting communities helping people make a positive contribution at a local level under the "One Swindon" project.

The LSAB is aware of how the profile of safeguarding has impacted in many areas of the work and is reflected in the significant increase in alerts and presents a challenge to the agencies working in the field of safeguarding. Under reporting has been a long standing concern of groups like Action On Elder Abuse but the Board need to be assured that the increase in alerts is due to the increased profile and improved awareness rather than an increase in abuse taking place in the first place. The LSAB continues to be committed to improving the lives of all adults deemed at risk in Swindon and is keen to take action that not only ensures safeguarding processes and investigations take place, but measures are in place to prevent abuse and minimise harm for those at risk.

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 in addressing the priorities from the Annual Report 2011/12 particularly with the development of the Board and the formulation of an action plan following the publication of the Winterbourne View Serious Case review last summer;
- Submissions from key partner agencies and members of the LSAB ; and
- An overview of the priorities for 2013/14 and news of other local, regional and national initiatives.

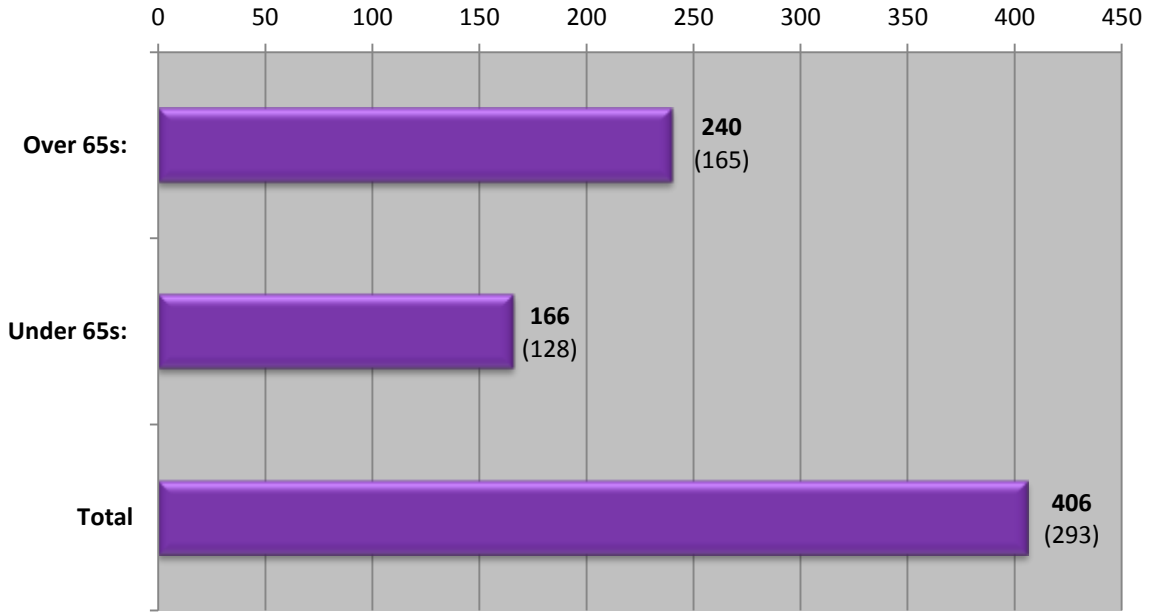
SECTION 2

Activity Data 2012 – 2013

(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 referrals received



There has been a significant increase over the last year in the number of alerts being reported to adult services for further investigation. There has been a 40% increase since March 2012, this is possibly due to improved awareness and reporting practices. Other local authorities in the South West have reported sizeable increases over the past 2 years. Some suggesting similar increases as those experienced in Swindon and some reporting a 100% increase. The national attention given to safeguarding particularly following the Winterbourne View Scandal and the Frances report on care in Mid Staffordshire Hospital Trust is believed to have led to increased awareness and reporting, leading to the increased alert rates rather than an indication that there is an increase in the amount of abuse taking place.

Of the 412 cases recorded, 110 cases required no further action after the initial stage and 15 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.

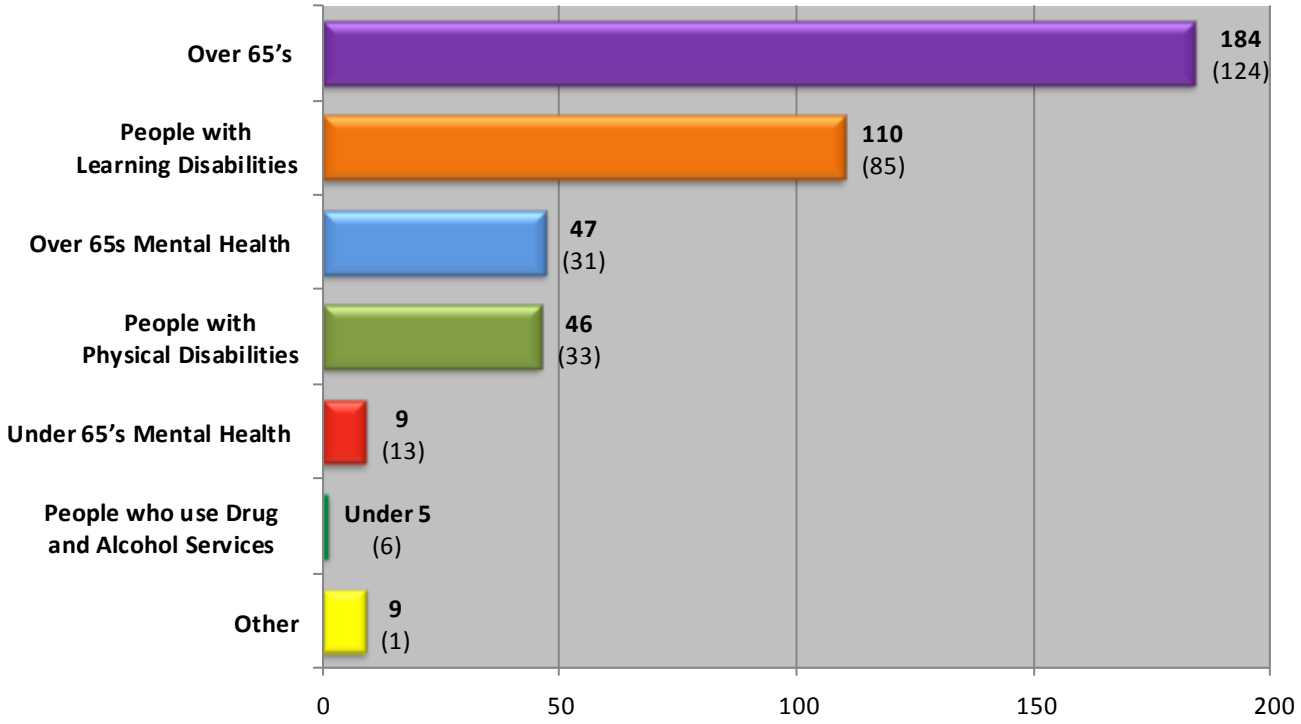
Teams are generally providing information on the cases they are not progressing under safeguarding procedures which could account for this increase, however there are times when alerts are received that do not require any action under safeguarding adults. For example, a minor drug error in a residential home, an argument between two service users where neither suffered significant harm.

Case Example

An alert was received from the ambulance service following their attendance at a service users' home where she had had a fall. They were worried that she may not be coping as she had accumulated a lot of old newspapers and "rubbish" in her house. A safeguarding alert was submitted. While action was required by adult services to make contact with the woman to see if she wanted support, no action was required under the safeguarding adult procedures as no abuse was alleged.

It is important to continue to monitor such cases. For example an incident that may initially be considered not to be serious for a response under the procedures, may be considered more serious if it reoccurs. Or it could transpire that a minor issue was affecting a number of vulnerable adults and determining this at an early stage could indicate a need for a multi-agency response to intervene to avoid more serious harm taking place. If it is evident that there are a number of frivolous alerts coming from a specific service, training may be required to improve awareness of appropriate alerting.

Figure 2: Breakdown by service user groups



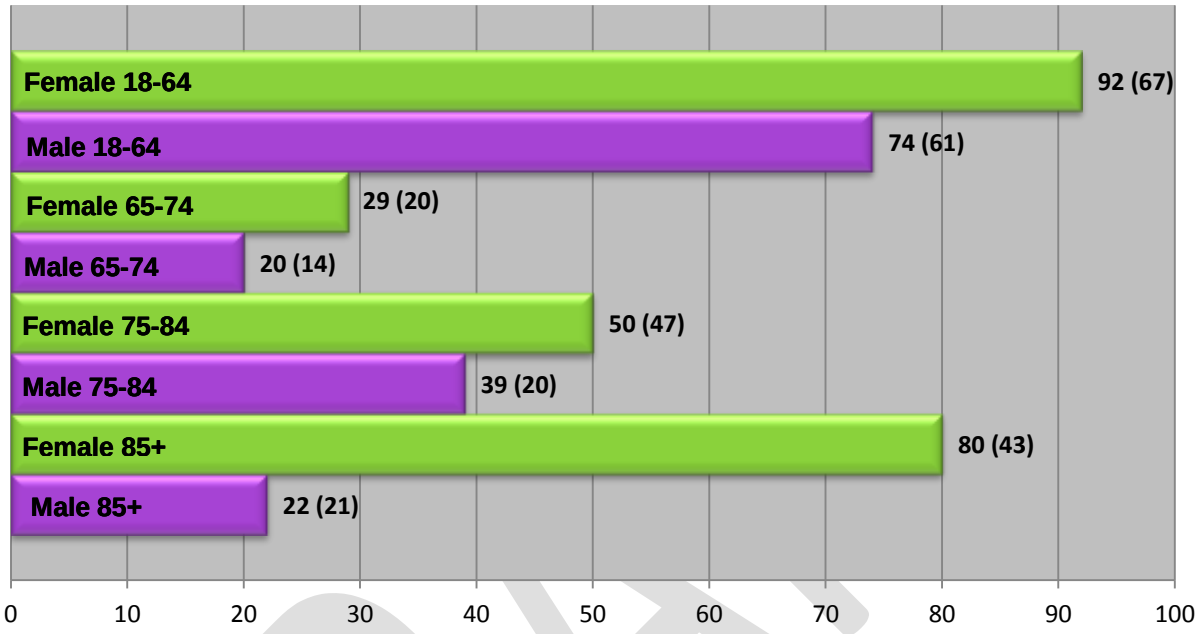
NB: Included in the figures above, there were 58 people recorded as living with dementia.

The number of cases managed by the teams working with people of working age within the Mental Health Trust has continued to decrease. Although there is a closer working relationship with these teams, there are still concerns that people with mental health issues either are not aware of the processes available or do not trust the process. Staff still need to be vigilant about safeguarding and need to know how and where to report allegations of abuse or where other processes are more appropriate for their service user.

There has been a 27% increase in the number of alerts concerning people with learning disabilities. Many of these are within care services and 30% needed no action under the safeguarding procedures. In previous years this percentage was much lower, which

may indicate that service providers are anxious to report incidents even though they may be minor concerns that need in-house action or incident reporting under Health and Safety regulations. There is no evidence to suggest that the increase in cases or the number of reported alerts regarding people with learning disabilities signifies an increase in incidents of abuse.

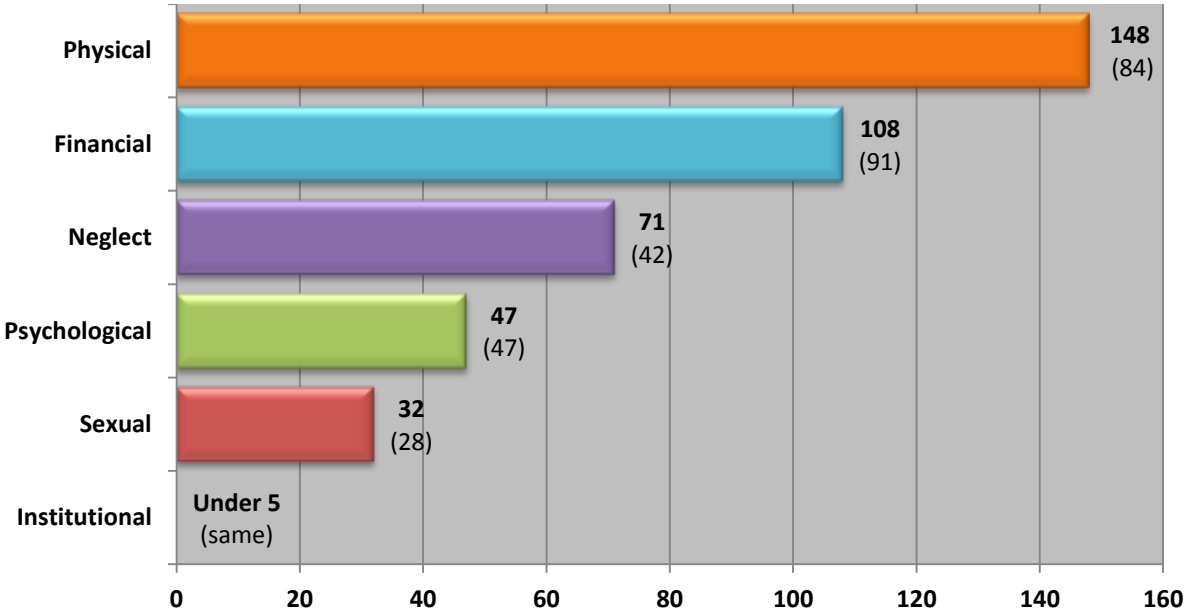
Figure 3: Breakdown by Gender and Age



Overall, the increases in the figures in this chart are in line with the total number of safeguarding alerts but the most significant change in these figures are the number of women who are over 85, which has seen an 85% increase. It is unclear as to why this is, as there has not been a similar increase in the number of new service users requiring general adult services. The majority of alerts (42) for this group involve an alert of an incident in their own home. In 20 of these cases the person alleged to have caused harm was a family member/carer or partner who had carer's responsibilities. This may signify an increase in carer stress and in most cases a proportionate response was required that included a review or increase in support. Out of these 42 cases, 6 were alerts where it was reported that members of staff were alleged to have caused harm (neglect and financial). No action was required following an investigation in all these cases.

32 of the cases involving females over the age of 85 regarded allegations within a care setting; of which 18 of those alleged to have caused harm were members of staff. All bar one resulted in full safeguarding procedures being instigated and required action under the employer's disciplinary and training procedures or additional action by the team within the Council responsible for monitoring services.

Figure 4 Types of Abuse Alleged



The number of alerts in relation to physical abuse has increased in 2012/13 and has overtaken the number of alerts relating to financial abuse – long thought to be the most prevalent form of abuse. With reference to the overall increase in reporting, there has been a marked increase in the number of alerts from care homes who previously may not have reported minor incidents of physical abuse as a safeguarding alert. These cases are often closed quite quickly as requiring changes to a behaviour management plan or other actions by the provider. It should be emphasised that serious physical assaults are not closed without proper consideration through the safeguarding process with police involvement who will consider if criminal proceedings are required.

Case Example

A service user with learning disabilities called Karen who lives in a residential home was watching her favourite TV programme and another resident (Sam) came and sat with her and started talking. Karen told Sam to "shut up" and when she continued to talk, Sam was smacked on her arm by Karen. Although she was upset by this incident, Sam was not injured and later received an apology.
The home reported it as a safeguarding incident, and the learning disability team did not proceed with the case as the provider had put measures in place to minimise similar incidents, for example maintaining a staff presence when Karen was watching her programme or giving 1 to 1 time to Sam at these times.

There has also been an increase in the number of alerts relating to allegations of neglect. In 30 cases, these took place in care settings and most progressed to full safeguarding procedures. 8 cases were found to be substantiated or partially substantiated and resulted in disciplinary action by the provider, systems changes within the service or action by the Council's commissioning team to monitor the service more closely.

Case example

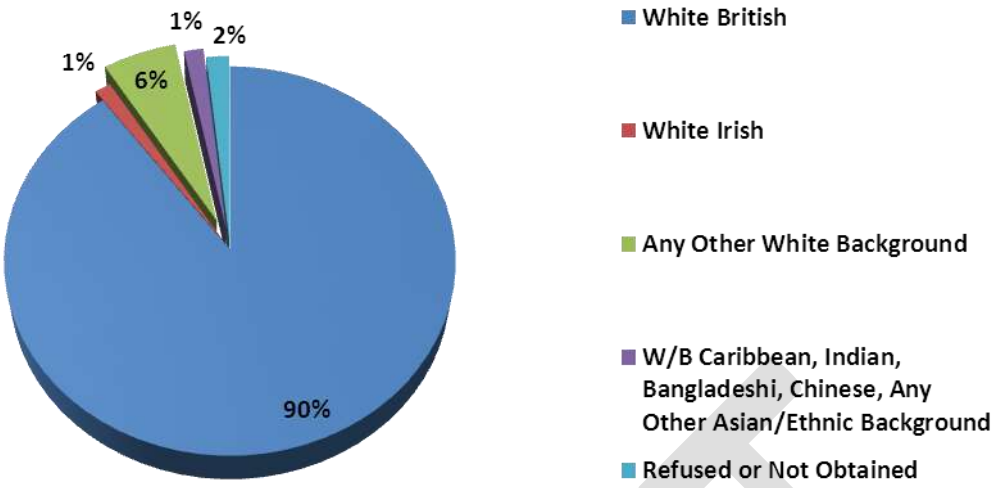
Angie is a 35 year old woman with physical disabilities who is unable to communicate and is thought to lack mental capacity. Her mother was not able to care for her and requires carers to visit 2 times a day to provide personal care. The agency alerted adult services to say that Angie's mother had refused care staff entry and was quite offensive. They also reported that on their previous visit Angie was in an extremely neglected state and worried that without visits she would get worse and her health could deteriorate very quickly. The agency worker also shared concerns that her mother had been drinking. Angie's mother also rang the agency to tell not to return to the house as one of the workers had annoyed her.
A safeguarding process was started and with the support of another service Angie was using, her wellbeing was immediately monitored and additional support for personal care was provided at that service. Adult services, the care agency and the Police met to discuss the case and agreed that it would be in Angie's best interests to work with her mother to get her to agree to support from a different agency. They also explain to her that legal action could be taken through the Court of Protection should she continue to refuse care and support for Angie. Following discussions with her mother, a new care agency was arranged and she was accepting of support. Agencies were concerned that although care and support was being accepted again, that a small incident could lead to a repeat occurrence kept the case opened so the situation could be continually monitored and reviewed.

There continues to be low reports of discriminatory and institutional abuse. This is often the case for these categories as other types of harm are reported as the primary type of abuse, for example, neglect, physical abuse or psychological abuse. However later it may transpire that the root cause could be institutional failings or discrimination.

There were 96 cases where the alleged victim was not in receipt of community care services at the time of the alert being raised. This is a major increase and indicates a good level of understanding that the procedures are not just for those who receive services or are already known to adult services. Of these, half were not previously known to adult services. Under 5 alerts were received regarding people who receive a direct payment to fund their care and 43 cases were alerted where the victim funds their own care and again, could show that there is a high level of understanding that safeguarding procedures are not just for people who receive funding for care from adult services.
There were 52 cases where domestic abuse was considered to be a factor in the case of which 40 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. Often the outcome of such cases was to increase monitoring or to provide a community care assessment. The desired outcome for the adult at risk is important in such cases when considering a proportionate response.

Case example
An alert was received from a service expressing concern about Mr and Mrs Frim who they work with and how both partners said there had been a domestic (physical) incident and Mrs Frim was attacked. A safeguarding process was started and the wife who has had mental health issues in the past was contacted by a care manager in adult services to find out what action she would like to take. She said that she needed help with her relationship and did not want any action taken against her husband as things were better at home. She was also worried about her mental health and relies on Mr Frim to care for her. She was advised to contact her GP and was referred to the Domestic Abuse outreach service who agreed to support her. There was also a referral to the Multi Agency Risk Assessment Conference (MARAC) as it was felt that there was still a high level of risk. It was agreed that it would be more appropriate to deal with the case under the domestic abuse framework rather than through safeguarding as Mrs Frim did not have any significant community care needs.

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, Black African.

Comparing these percentages with recent census data, there would appear to be an under representation of non-white victims where it would perhaps be expected incidents of discriminatory abuse or abuse as a result of discrimination would be prevalent. There is a similar "low representation" in children's safeguarding which has led to a joint adult's and children's awareness and engagement group to increase the awareness of abuse of adults at risk and children and how to report incidents.

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

Source of Referral	2012/13	2011/12
Care Providers (including Independent Sector & SEQOL)	**140**	110
Adult Social Care Staff (including LA & Independent Sector & SEQOL)	**90**	36
Family/Carers	**32**	24
Mental Health Professionals	**30**	19
Great Western Hospital NHS Foundation Trust	**23**	26
Police	**19**	8
SW Ambulance Service NHS Foundation Trust (& GWAS)	**13**	3
Housing Services (including Registered Social Landlords)	**11**	18
Council Employees (not Adult Services)	**8**	3
Self-Referrals	**7**	9
Advocacy Service	**6**	4
Business	**6**	0
Members of the Public	**4**	9
Educational Establishment	**3**	3
Care Quality Commission (CQC)	**3**	1
Out of Area Referrals (including NHS Direct)	**2**	3
GP	**2**	2
Fire Service	**2**	0
Personal Assistant (Direct Payments)	**2**	0
Confidential Alert	**2**	0
Hospice	**1**	1
Coroner's Office	**1**	0

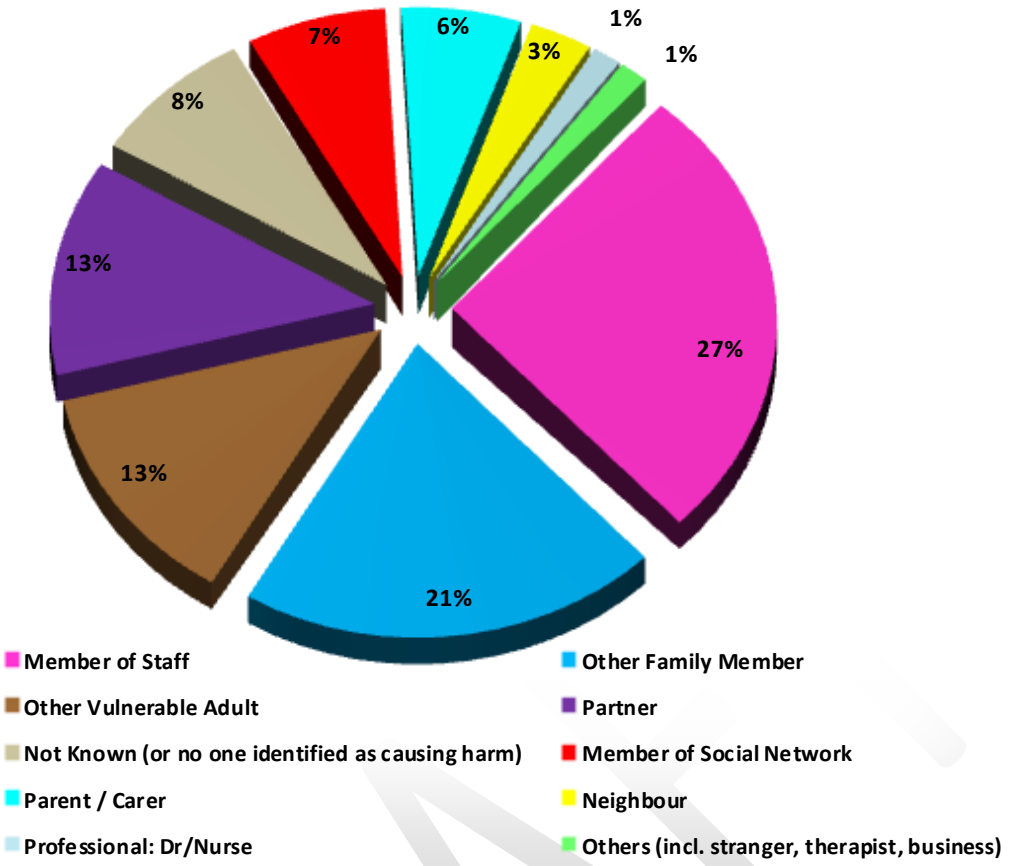
There are still a high number of alerts where the referral source is recorded as “adult social care staff”. These are mainly social workers, care managers or assistant care managers who could be receiving the alert from a third party and passing on the concern to a duty manager for assessing. The case gets recorded as the adult social care staff as the alerter rather than the third party who has (for example) rang into the team to raise the concern. The referral form was changed a few years ago in an attempt to address this. Further work with duty staff is required reminding them of more accurate recording. The low referral number recorded from CQC may not indicate low referral rates from this source. While CQC often report concerns, it is often the case the concern has already been received from other sources that are recorded as referrer (e.g. care provider). These two factors may have an impact on the accuracy of this data. (For example the low number of alerts from members of the public may not be an accurate picture, if the duty worker who received a call from a member of the public has not recorded this correctly). There could also be occasions where they wish to be anonymous.

As previously reported in last year’s annual report, numbers of referrals from the Police was very low. There have been improvements with this where referrals from the Police have more than doubled. All except one of these progressed to full safeguarding procedures, indicating also an improvement in the accuracy of the referral. Similarly there has been an increase in alerts from the ambulance service. However most of these were welfare concerns or required signposting to another service, requiring no further action under the safeguarding procedures, 5 cases required further action. Often these alerts are helpful and provide some vital information concerning an adult at risk who requires support or is struggling to care for themselves.

Case study
The Great Western Ambulance Service (now South Western Ambulance Service) sent in one of their reporting logs outlining concerns about GJ who had bruising following a number of falls. She was admitted to Hospital. The house she was living in showed signs of severe neglect and the crew questioned whether she should receive a care package (although there were family members who had said they help with general household matters but not with personal care). The case was recorded as neglect at the hands of her family members although on being interviewed by the Investigating Officer from the Hospital social work team and prior to that, the Police, they were satisfied that there was no abuse alleged, GJ (who has mental capacity) was not making any allegations but did say she was having trouble with taking care of herself and agreed to an assessment prior to returning home. The ambulance crew’s additional information on the state of her home was crucial in deciding on the care package once she returned home.

There was a reduction in the number of cases referred by the Hospital.
The lead for safeguarding within the Trust is aware of the number of alerts from staff at the hospital and a programme of awareness raising among hospital staff is underway.

Figure 7: Information on those alleged to have caused harm



There has been a 3% increase in the number of allegations against members of staff (mostly within care homes). There were 113 alerts of which 84 cases progressed through to safeguarding procedures. 28 cases were either substantiated or partially substantiated. 16 concluded cases require action under the employers' disciplinary procedures or additional staff training. In 7 cases additional monitoring was required by the Council's contracts and commissioning team. In last year's annual report it was stated that there were 67 allegations against staff signifying a 68% increase. Such a substantial increase maybe due to the recent national attention and high profile cases, especially Winterbourne View with a belief by providers that any incident, however minor needs to be reported through to safeguarding. (In other local authority areas a similar picture is emerging. Some providers have been instructed to raise alerts by the CQC when it would have been quite in order to take disciplinary action or complaints action. There have also been concerns that some employers have chosen the safeguarding route to elevate the need to take action themselves. It should also be recognised that many employers will raise alerts to demonstrate transparency and good practice. It is worth noting that many providers have been criticised in the past about not raising alerts but it is believed that better awareness raising among managers of services may be needed to promote more accurate reporting.

The next large group where there has been a significant increase is "other family members". The highest proportion of these alerts were in regard to financial abuse being alleged. Out of a total of 84 alerts received regarding allegations of all types of abuse 59 progressed to a full safeguarding investigation and 23 cases were either substantiated or partially substantiated. The outcomes for the adult at risk were increased monitoring, assistance with access to their finances or a community care assessment service.

There were 97 cases where the person alleged to have caused harm were recorded as having a caring responsibility (this does not include members of staff). Most of these took place in the alleged victim's own home and 73 where the alleged victim lives with the person alleged to have caused harm. 52 cases progressed to a safeguarding investigation of which 22 were substantiated. The outcomes of these cases included additional monitoring and care management support perhaps indicating a level of carer stress as being a factor or root cause to the alleged harm. Although the majority of the cases reported involved allegations of physical or psychological abuse (which could be an outcome of carer stress), financial abuse and neglect also feature.

Case example:

Mavis and Bill have been married 40 years. Recently Mavis has been diagnosed with early onset dementia and has become more and more repetitive. One evening Bill rang his daughter very upset as he had hit Mavis that evening as she had kept on shouting at Bill to take her to the shops (they had already been that day) and make her breakfast. Bill's daughter rang adult services as she was worried Bill was not coping (her mum did not have any injuries or bruising). The duty worker discussed the matter with her manager and while it did meet the criteria required for a safeguarding alert, it was agreed that a more proportionate response was needed and that they would carry out an urgent visit to assess Mavis and Bill and give him some coping strategies. Respite and a review of Mavis's medication were also arranged. During a care review some months later, the daughter reported there had not been any further incidents but did say her father is still upset about the incident which may well have been prompted more as a result of her diagnosis and his feelings of loss he is going through rather than Mavis behaviour towards him.

Outcomes of Investigations

In 2012/13 there were 115 cases that did not proceed under safeguarding procedures. This was either because the initial alert did not involve an adult at risk (or vulnerable adults) or did not highlight a concern where significant abuse or neglect was suspected.

37 cases remained open beyond the end of the financial year. There were 228 cases that were concluded and out of these, 99 cases were reported as substantiated or partially substantiated. 76 cases were recorded as unsubstantiated and 48 were inconclusive (for example, no evidence of abuse).

The following charts provide an overview of the outcomes for the adult at risk and the persons alleged to have caused harm. These are the main outcomes and actions arising from the safeguarding process, other actions may also have been taken. There were 126 cases that were closed following an initial investigation. This does not necessarily mean that no action was taken, it may mean that the action or intervention focused on the person alleged to have caused harm.

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Figure 8 Outcomes for the Adult at Risk

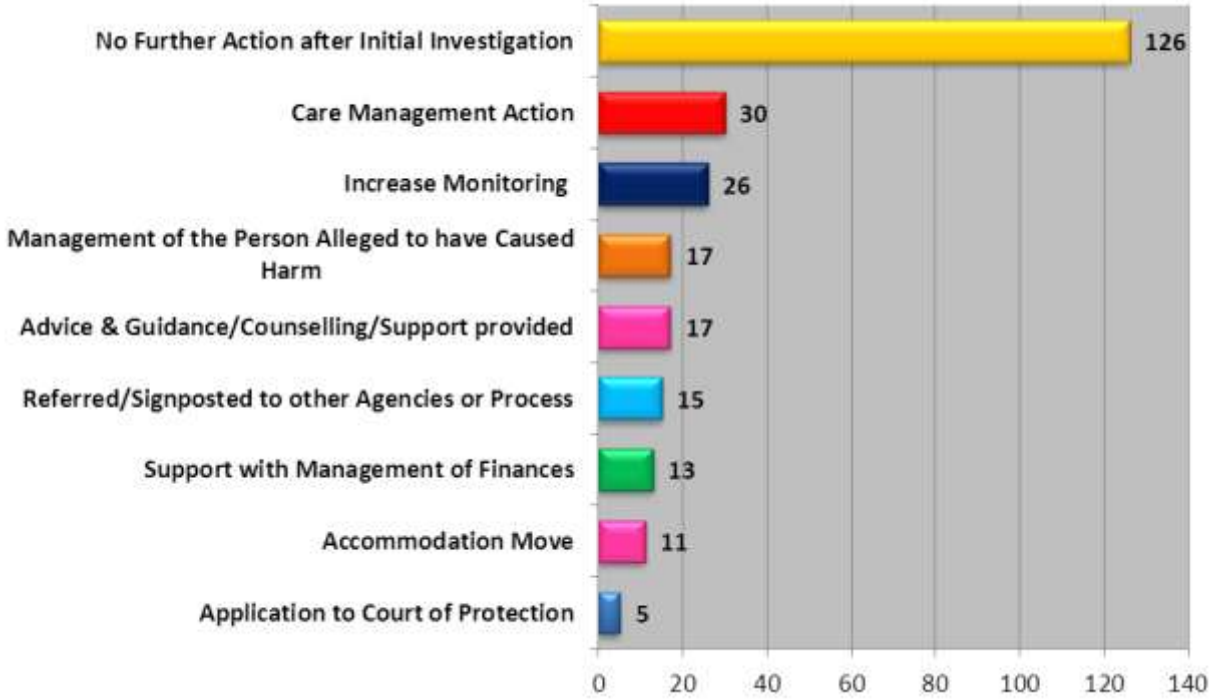
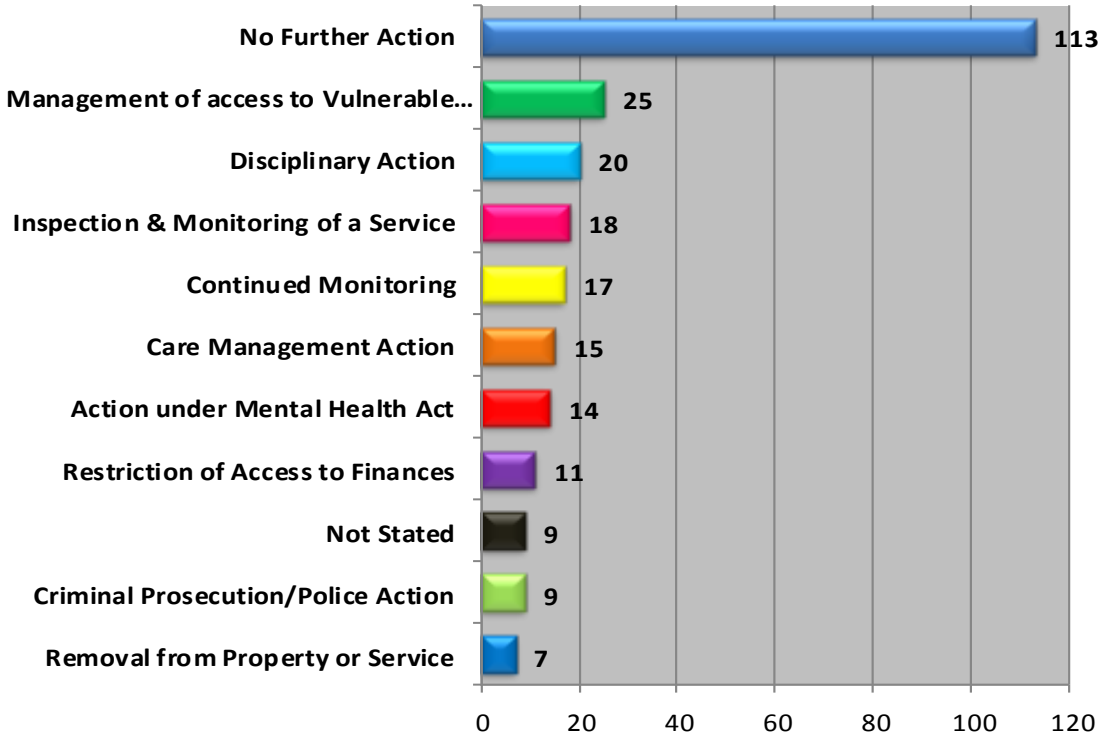


Figure 9 Outcomes for the person alleged to have caused harm



Serious Case Reviews and Large Scale Cases

There were no Serious Case reviews held in Swindon concerning adults at risk. There were 5 large scale investigations set up following concerns raised about the conduct of 4 specific care services all requiring action either by the CQC or adult services commissioners.

SECTION 3

Progress, developments and news in 2012/13

Priorities for 2012/13

For this year's annual report, the headings (or domains) used in the regional Self Assessment Quality & Performance Framework for Adult Safeguarding have been used for categories for the priorities for the coming period. As further guidance is still expected and recommendations from the enquiries into the incidents at Winterbourne View are published, priorities may change and revised actions plans will be required.

Prevention & Early Intervention

Monitoring contracts of service providers
Within adult services while monitoring providers, the contracts and commissioning team do check whether they take steps to prevent abuse and harm, know how to report abuse and know what action to take if abuse is suspected or disclosed in their services. Monitoring officers also monitor training undertaken by staff. In the past, where providers have not taken advantage of the Council's awareness training, the Council's safeguarding manager has evaluated training provided by viewing the programmes and materials used. There is a need to repeat this exercise.

Staff working for NHS Swindon have included the evaluation of safeguarding processes when monitoring services for which they have commissioning responsibilities. Council staff responsible for monitoring any Registered Social Landlords funded by the Supporting People Grant evaluate their procedures for safeguarding adults and reporting abuse.

Services that are commissioned to manage safeguarding cases (SEQOL and AWP), are also monitored to evaluate how they respond to alleged abuse, report abuse and manage investigations under the local safeguarding procedures.

Policy and Procedures
During the year much work has been undertaken to revise and renew the Policy and Procedures for Safeguarding Adults at Risk. Changes made include ensuring that the procedures are in line with the latest government's guidance which includes prevention, early intervention and proportionality. The policy also includes the need for investigating teams to identify and where possible adhere to the desired outcomes of the adult at risk.

Review of safeguarding processes
Resources have been secured, which has improved the arrangements around monitoring individual cases. There is now a Safeguarding Support Officer who has helped to improve the quality and timeliness of information and to send reminders for Investigating Managers to provide updates for open cases. This also acts to minimise the risk of cases "running out of steam".

During the year a 'Peer Challenge' (a process where other local authorities evaluate Swindon's performance) took place during which the Council's ability to address safeguarding was scrutinised. Among the concerns and queries raised were:

- *The need to act to ensure there is adequate Adult Safeguarding capacity;*

- *Continue to integrate Adult Safeguarding arrangements into every day performance managements; and*
- *Support the continued development of the Adult Safeguarding Board.*

There is on-going work to secure more capacity within the contracts and commissioning team. At the time of the Peer Challenge, capacity regarding adult safeguarding had been improved with an additional member of staff recruited to provide support and additional help with managing the LSAB came from the Children's Board. Additional support is also available through the commissioning team. There are additional performance measures in place to monitor the timescales that need to be adhered to when managing cases and these are to be reported every 3 months and action identified to improve performance as necessary. The LSAB continues to develop and is increasing its standing with other boards, for example the Health Overview Scrutiny Committee and developing Health and Wellbeing Board.

The Peer Challenged prompted a review of safeguarding procedures, where adult services have identified some improvements to be addressed over the coming year. While it is felt overall the procedures do work for adults at risk who use services, there are concerns that those who are not in receipt of services could miss out or could experience delays in responses. While further discussion continues with the Mental Health Trust and SEQOL, the handling of such cases are negotiated individually to secure involvement from the appropriate team.

Improvements in data collection
There have been improvements in the way data is collected and evaluated. However there is still a need to consider and improve IT systems that will be able to assist in the monitoring of information and reduce the reliance on paper based systems.

Assess actions required following Winterbourne View Report
Recommendations from The Winterbourne View Serious Case review
See below

Responsibility & Accountability

Changes to the LSAB take place in line with any Government policy
The LSAB continues to develop. There is a stable membership and attendance is good. Legislation is still awaited and further work may be required depending upon the final requirements within the legislation arising from the Care and Support Bill to put safeguarding boards on a statutory footing. It is understood that there will be a requirement for some key agencies to be core members of the Board (who are already members in Swindon) and a requirement to develop a safeguarding strategy and produce an annual report.

The LSAB is to continue to consider ways to provide shared resources
This continues to be an on-going priority. It is appreciated that all agencies have limited resources and continued requirements to reduce spending, however other types of resources are still being encouraged from board members. (e.g. resources in kind, support with administration, printing for publicity).

Judging Effectiveness of Safeguarding
Key LSAB members completed a self-assessment on their performance and where needed took action to address areas of development. The safeguarding manager continues to carry out file audits to identify whether teams have taken appropriate action

when managing safeguarding cases. Any issues found are reported back to the manager of the team and so any remedial action can be taken. This area continues to be a priority for development in the coming period.

Improve LSAB Sub Groups
There has been a great deal of improvement in the Operational Group. This has been chaired by the Lead Nurse from the Primary Care Trust whose involvement is popular and welcome. The training sub-group has met with a small group of key agencies as previously reported however the policy and procedures sub-group has not met as there has been a smaller task and finishing group working on the revision of the full policy. More information on sub-groups is included in section 5 of this report.

Access & Involvement

Service User Focus Group
There is now a Service User Forum specifically linked to the LSAB. A representative from this group sits on the main board. Membership still needs developing to include a wider range of people from different service user groups.

Service user involvement
There has been some improvement in the involvement of the victim in the safeguarding process. Where ever possible (for example where someone has the mental capacity to say what outcomes they would like as a result of a safeguarding alert) establishing the views of the alleged victim are determined. Where appropriate some safeguarding conferences have included service users or their representatives. Where this is not possible, alternative methods of involvement are arranged (for example a visit from the Investigating Officer). There is also improved awareness of the need to engage an Independent Mental Capacity Advocate when the alleged victim lacks mental capacity. Data has not been collected that includes the views of the alleged victim, however this is being developed and it is hoped this will encourage further and future involvement.

Policy and Procedures review
As referred to previously, the revised Policy and Procedures for Safeguarding Adults at Risk in Swindon and Wiltshire, makes reference for the need to respond to the desired outcomes of the individual at risk when managing safeguarding cases. During the process, keep the alleged victim up to date with developments and providing feedback is essential to “person centred” safeguarding.

Responding to Abuse & Neglect

Resources
As previously reported above (see review of Safeguarding Process) during the year additional staff have been recruited to support safeguarding and additional help has been forthcoming from the Children’s Safeguarding Board and the Commissioning team within Swindon Borough Council.

Management of Alerts
As referred to above in the section about the review of safeguarding, it is felt that in most cases the procedures are adhered to and appropriate action taken. Through performance management and contracting arrangements, there is a need to ensure that arrangements are strengthened and are robust. With SEQOL their responsibilities

regarding safeguarding are outlined in their service specification and their progress is discussed in performance meetings with the lead commissioner.

In the previous annual report, it stated that there was on going work with the Avon and Wiltshire NHS Mental Health Partnership Trust along with 5 other local authorities to reach agreement about cases they will manage. Since this time there has been further reorganisation and this will need to be considered again at a local level. One of the outcomes of this work is the local authority in Swindon now receives activity data directly so it is able to monitor cases in a more timely manner (previously, information was only provided every three months).

Training & Professional Development

Safeguarding Support Forum for trainers
With the assistance of the Wilshire and Swindon Care Skills Partnership, this has been developed with an intention for half yearly workshops to “standardise” training delivered. During the year one event took place.

Training Strategy
At its August 2012 meeting, the LSAB agreed the adoption of the Training Strategy for Safeguarding Adults at Risk. This outlines the expectations around the provision of training for staff appropriate to their role and clarifies requirements and responsibilities about updates and refresher training. The Development Manager from the Wiltshire & Swindon Care Skills Partnership was instrumental in bringing together this document and sharing it with providers in the area.

Winterbourne View

In the last two annual reports reference was made to the Winterbourne View exposé by BBC Panorama of an undercover investigation into abuse at this specialist hospital in South Gloucestershire for people with learning disabilities and mental health problems run by Castlebeck. The abuse that was shown on the programme was deeply shocking and indicated a level of cruelty that could not be considered as valid interventions for people exhibiting challenging behaviour. The police investigation resulted in convictions of a number of staff and a Serious Case Review was commissioned by South Gloucestershire Council. There were a number of recommendations arising from the Serious Case Review. A Concordat was issued which was the joint response of agencies including the LGA (Local Government Association) and the NHS to the Department of Health Transforming Care report arising from the significant failings at Winterbourne View. The Concordat contains a number of specific commitments that lead to all individuals receiving personalised care and support in community settings no later than 1st June 2014.

A national Winterbourne View Joint Improvement Programme was also announced to ensure all local authorities take action to minimise and remove risks to service users with Learning Disabilities and Autism in specialist hospitals and work towards providing appropriate accommodation more locally and in community settings.

Eleven ex-members of staff from Winterbourne View pleaded guilty to the offences witnessed in the programme in relation to Mental Health Act Legislation and were sentenced in October 2012.

The Swindon LSAB has been closely monitoring the repercussions following the Winterbourne View scandal and has developed an action plan to monitor actions arising from the recommendations within the serious case review, the Concordat and the National Winterbourne View Joint Improvement Programme.

Much of what is required is in relation to the arrangements for commissioning services for people with learning disabilities and autism and behaviour that challenges. In Swindon there are no Treatment and Assessment Units, however placements had been made out of area for such services. Although there were no allegations of abuse, soon after the broadcast, health and council colleagues took action to immediately review service users in similar settings to ensure all care plans were in place and up to date. This also gave commissioners the opportunity to look at what services were available locally to meet the individual needs in less restrictive community provision.

Further work is required on workforce development and alternatives to out of area residential placements for assessment and treatment when these are required.

Overall there has been good progress in Swindon with regards to the provision of suitable alternative placements for those previously residing in treatment and assessment units like Winterbourne View. Where specialist placements are still required for people with learning disabilities, autism and behaviour that challenges, future plans will reflect the need for more community based support that is as local to Swindon as possible. There are good partnerships and good joint working with health partners and providers. A learning event following the publication of the Serious Case Review into Winterbourne View took place in September 2012. This was well attended and all teams were represented and contributed to the discussions. It was felt this event assisted in understanding although there is no service like Winterbourne View in Swindon, managers need to be aware of services that in their nature could present a risk to vulnerable adults (for example, those large in size, or services where behaviour that challenges is common place).

South West Region Safeguarding Adults Work Programme

The South West Region Association for Directors of Adult Social Services (ADASS) has developed a work programme to develop further the work around safeguarding adults. Swindon have agreed to participate in this work and any outcomes from it will be reported in next year's annual report. Further reference to this will be included in priorities for 2013/14 in section 6 of this report.

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SECTION 4

Swindon Mental Capacity Act Programme

A joint initiative with Swindon Borough Council and NHS Swindon

Submission by John Hughes: Head of Policy Adult Social Care

Last year's report http://www.swindon.gov.uk/cd/foi/cd-foi-publicationscheme/Documents/safeguarding_vulnerable_adults_2011-12.pdf provided information regarding the proposed changes to Supervisory Body responsibilities. The changes were implemented within the proposed timescale with SBC Supervisory Body taking on responsibility for the activity previously the responsibility of the outgoing PCT on April 1st 2013.The period under review is therefore the last where 2 separate Supervisory Bodies were in place.
The referral rate continues to be (both nationally and locally) against the trend originally assumed by The Department of Health. They had anticipated an initial high number of referrals which would decline year on year thereafter; the experience has been a gradual increase.

Table 1: Swindon Deprivation of Liberty Safeguards Service

	Swindon Borough Council	NHS Swindon	Combined
Referrals April 1st 2010 – 31st March 2011	44	14	58
Referrals April 1st 2011 – 31st March 2012	49	15	64
Referrals April 1st 2012 – 31st March 2013	64	13	77

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

Last year's report covered the role of the Court of Protection (CoP), as anticipated there have been 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.

The effect of the Cheshire Judgement of November 2011 continued to be felt throughout 2012/13. The Official solicitor has been granted leave to appeal, but the Hearing is not scheduled until November 2013 and the Judgement from that hearing is not anticipated to be received until early 2014. As a result we have one case before the Court of protection deferred until the appeal judgement is known).
Last year we reported on Apointeeships and Deputyships held by the Council. The upward trend in Deputyships did not continue. There were 59 at the end of the period (March 2013) whereas there were 65 as at March 2012.

Appointeeships
The downward trend in Appointeeship numbers continues. In March 2012 the number of Appointeeships were 185 whereas at March 2013 this had decreased to 165. This reduction reflects continued efforts to move from a paternalistic approach whilst still

recognising the value of effectively managing vulnerable adult's finances where they lack capacity and have no informal networks to support them (and are vulnerable to abuse).

It remains the case that Local Authorities do not have coercive powers regarding acting on behalf of vulnerable people. The legislation underpinning Safeguarding procedures is the legislation that permits us to assess and provide services, not to move or remove people against their will. The Mental Capacity Act does not confer any additional powers to the Local Authority in this regard. What it does allow for is a Best Interest decision making process which can allow decision of adults who lack capacity to choose where they live and / or the nature of care that they require to have protective, least intrusive decisions made on their behalf by the involvement of the significant people in that person's life. Only in the absence of objection from any of such parties (we cannot select those people who are closely involved because we agree with them or discount those we do not) can a Best Interest decision be competent. In the light of emerging case law and Care Quality Commission reports, and on the basis of local judgement from experience, the Best Interest process has taken a priority during the past year. Best Interest decision making has been supported by guidance, templates, training and mentoring.

The vital importance of Capacity assessments being conducted with an accurate focus on the decision(s) that need to be addressed and that the process is robust and auditable continues to be reinforced. Misapprehensions about capacity continue to be challenged, the statement by a professional that an individual "lacked capacity to make the right decision" indicates that we still have a long way to go in some areas. It is not the quality of the decision that someone makes that we are assessing it is whether they have the wherewithal to make the decision in question. Making unwise decisions was always recognised as an Adult right in common law. The Mental Capacity Act 2005 enshrined it in primary legislation.

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SECTION 5

The Swindon Local Safeguarding Adults Board and its Member Organisations

1. The Board

In Swindon the management committee that oversees the work and implementation of the Policy and Procedures for Safeguarding Adults at Risk is the Swindon Local Safeguarding Adults' Board (LSAB). During 2012/13 it consisted of:

Independent Chair
Board Director, Commissioning (DCS/DASS), Swindon Borough Council
Head of Commissioning Children and Adults
Director for Public Health
Cabinet Members relevant to adult safeguarding
Wiltshire Police
Executive Nurse, Swindon Clinical Commissioning Group
Great Western Hospitals NHS Foundation Trust
Avon & Wiltshire Mental Health Partnership NHS Trust
Wiltshire Fire & Rescue
SEQOL (social enterprise delivering health and social care in Swindon)
South West Ambulance Service NHS Foundation Trust (although this organisation has indicated their attendance will be by exception)
Board Director, Service Delivery, Swindon Borough Council
Care Quality Commission (annual attendance)
Wiltshire Probation Trust
Community Safety Partnership Manager
The Local Safeguarding Children's Board
Swindon Care Homes Association – service provider's representative
Learning Disability Partnership Board
LSAB Service User Forum

The Board met on five occasions during the year. An extraordinary meeting was called in October to consider Swindon's response to the Winterbourne View Serious Case Review (SCR). The meeting focused on the summary of the SCR review and the recommendations relevant to Swindon LSAB, and the individual agency responses. Agenda Items during the year included:

- Operational Group: the role, function and frequency of the Operational Group were discussed, with quarterly updates on progress/development of the Group.
- LSAB Business Plan (for sign-off): agreed by the Board
- Terms of Reference (for sign-off): agreed by the Board
- Discussion of potential areas of concern for LSAB: Missing Children & Adults Strategy, Trafficking Adults, and Self-Neglect;

- Service User Involvement: discussion held regarding the requirement for involvement of service users (or adults at risk subject to safeguarding procedures) in their Safeguarding process;
- Service User Forum: quarterly updates provided on progress/development of the Forum;
- Policy & Procedures: updates on the development of changes/amendments for the revision of the Policy & procedures, agreement of the Board and their launch in March 2013;
- Training Strategy (for sign-off): agreed by the Board;
- Winterbourne View Update: discussion of the key findings and recommendations within the report. Completion/review of the WBV Action Plan;
- See The Adult, See The Child;
- NHS Operating Framework: a self-assessment tool published by South West Association for Directors of Adult Social Services. SEQOL, AWP and GWH carried out self-assessments based on the NHS Operating framework and swapped their assessments for scrutiny and validation with each other;
- Joint Strategic Needs Assessment (JSNA): discussed the JSNA bulletin high-lighting the needs of residents in Swindon with a Learning Disability and links with safeguarding arrangements;
- LSAB Risk Register: Review of the register;
- NHS Reforms: Clinical Commissioning Groups and their role with regards to Safeguarding: discussed the Department of Health's publication 'Arrangements to secure children's and adult safeguarding in the future NHS (the new accountability and assurance framework – interim advice)', giving an outline on the emerging CCGs responsibilities and commitment required regarding safeguarding;
- Healthwatch: discussed the expectation of Healthwatch to develop a good working relationship with the local LSAB, and to play a role in supporting service user members of LSABs or LSAB sub-groups to promote participation from people who use services and carers;
- Francis Report: discussed the Executive Summary of the Francis report, which was being considered by the GWH Foundation Trust Board and the Clinical Commissioning Group; and
- LSAB Budget: discussed the increased responsibilities of the Board when it becomes statutory in 2014, and members were asked to consider the future funding of the Board.

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)

This was a year of significant change and development in the roles undertaken by AWP to safeguard adults throughout 2012/13 in Swindon.

AWP continued to play an active role in the Safeguarding Adult Board, its work and in partnership working with other health providers and agencies. AWP attended the Board on a regular basis.

AWP also has a variety of staff involved in the Board's sub groups and has chaired the working group that has updated the Swindon and Wiltshire safeguarding adult procedures.

The Trust has continued to seek to improve its delivery of safeguarding in practice, with revision of the policy and guidance to practitioners, revised documentation to support safeguarding alerts and referrals, better access to information for staff on the intranet and service users and the public on the Trust Website, and significant updates to the training of practitioners.

AWP as well as being directly involved in the wider NHS support in managing the safety and resettlement of patients from Winterbourne View Hospital during its closure, has also reviewed its services in light of the Winterbourne View Hospital reviews and developed and implemented an action plan against the relevant recommendations and incorporating the multi-agency planning undertaken in Swindon led by the Safeguarding Adult Board. It is also developing actions arising out of the recommendations from the Francis Report on Mid-Staffordshire.

The Trust has maintained compliance with Outcome 7 (Safeguarding) of the CQC Essential Standards in all CQC inspections of teams in Swindon during 2012/2013. However the Trust has identified that alert and referral rates are not consistent between teams, with lower comparative referral rates from teams providing services to younger adults being identified.

The Trust has undertaken an audit of safeguarding cases managed by AWP and implemented the recommendations arising from the findings of the audit in Swindon

The Trust has continued to ensure that its staff is trained in their role to safeguard adults at risk, with the target of 80% of staff being trained on a 2 year cycle at Alerter level (level 2) being maintained during 2012/2013. It has identified that additional training is needed for staff undertaking roles managing safeguarding investigations and alerts.

The Trust is continuing to review its joint working arrangements with Swindon Borough Council in its delegated responsibility for managing alerts, and has agreed further streamlining of data capture and management

AWP will be looking to use the current changes in its organisational structure to improve the direct relationship between its local services and the safeguarding adult partnership and Board in 2013/2014, and will be taking forward a number of key actions, including:

- Developing systems capturing and sharing risks and concerns, to assist triangulation and identify risks, and themes.

- Demonstrate compliance with the safeguarding adult requirements set out in the new NHS contact for 2013/2014

- Improving the comparative alert and referral rates from teams providing services for younger adults

- Develop joint understanding of application of clinical management and safeguarding thresholds with key partners in mental health inpatient services

- To identify and access training for staff who chair or investigate safeguarding adult alerts

- Developing effective systems to identify and manage capacity required to manage safeguarding adult referrals with Swindon Borough Council

- To complete the review of joint working arrangements with Swindon Borough Council in its delegated responsibility for managing alerts

- To further improve practice through the active involvement of the person in their own safeguarding

2.4 Great Western Hospital Foundation NHS Trust

The structure and approach to safeguarding adults work within GWH.

The Chief Nurse is the Executive Lead for Safeguarding. There is also a Non-Executive Lead for Safeguarding. The Chief Nurse assures the Trust Board of the adequacy of the systems and processes which are in place (or which are required) to support effective safeguarding measures across the organisation.

The Deputy Chief Nurse is the Operational Lead for Safeguarding Adults at risk and also Chairs the Trust Safeguarding Children and Adults Forum, providing strong leadership that support Directorates to make safeguarding integral to care. The Deputy Chief Nurse is the Trust's representative on the LSAB. The Trust has representation on the Learning and Development Sub-group.

The Trust's Safeguarding Children and Adults Forum is a multi-professional group that provides assurance to the Patient Safety and Quality Committee (Sub-Group of the Trust Board) that the Trust is protecting children and adults at risk, are following multi-agency procedures, and meets identified national and local standards**.**

Highlight achievements within the financial year 2012-13

A review conducted by the Internal Audit Services, Parkhill, in October 2012 as part of the planned Trust programme, identified a number of weaknesses in assurance. Further, a self-assessment using an assurance framework published by the Department of Health in March 2011 has been conducted to review the robustness of the Trust's current arrangements for Adult Safeguarding. The key outcomes are summarised below:

- The development of a Safeguarding Forum linking with related programmes within the Trust, e.g. Falls Prevention Strategy, Learning Disability Forum;
- Update and revision of internal safeguarding policy and procedures;
- Logging and monitoring safeguarding alerts raised by Trust staff and include lessons' learnt within the role of the Safeguarding Forum to work with Governance colleagues to align processes with the LSAB's requirements;
- Adult Safeguarding Facilitator's post developed to support and drive existing work for adult safeguarding. Also funding has been agreed to provide an administrative function to support Adult Safeguarding;
- There is appropriate and regular involvement with the LSAB and its Sub-groups;

- Close work with the Mental Health Trust.

Safeguarding adults staff training within the year

The Trust places high importance on staff learning and development and delivers training to maintain a competent and capable workforce that will:

- Be able to explain the concepts of protection and vulnerability;
- Recognise the type of abuse and their related sign;
- Understand how to report concerns including whistle blowing; and
- Take personal action to safeguarding adults in their care.

Safeguarding adults training is established as mandatory for all staff groups across the organisation and compliance has improved over the past 6 months with a Trust figure of 82.2% as of March 2013.

Key plans or objectives for safeguarding adults in 2013-14

- To continue to review and further develop the Trust's internal reporting systems and evidence learning from relevant safeguarding cases;
- To review and further develop education and training and evidence that such training is having positive outcome;
- To continue to raise the profile of safeguarding through the new Integrated Safeguarding annual forum and 'Big Conversation' month planned for June 2013;
- Work is also needed to determine what training or development members of the Trust Board should receive such that they have an understanding of the requirements of the Trust and can discharge their duties in relation to Safeguarding Vulnerable Adults (Adults at Risk);
- To have supervision available and accessible for staff involved in Safeguarding Adult's procedures and processes;
- To further strengthen the work of the Trust's Safeguarding Children and Adult Forum through the operational sub-groups and the development of an overarching Safeguarding Adults Action Plan outlining local and national priorities and actions; and
- To perform an annual self-assessment on the Trust's position around safeguarding adults – December 2013.

2.6 Community Safety Partnership

Submission awaited

2.7 Healthwatch Swindon

Healthwatch was established on 1 April 2013 and subsequently invited to nominate a representative to the Swindon LSAB. This comment therefore looks forward rather than back. Whilst the priorities and work programme for Healthwatch will be determined by its own Board during the year, a fundamental aim will be to meet the recommendations set out in "**Establishing Local Healthwatch - Dignity, quality and safeguarding adults**" published by the Local Government Association in December 2012. At the very least, an early task will be to confirm the responsibility of those associated with Healthwatch to understand and act on the arrangements for alerting. This will mean that people know how to alert locally and appropriately if there are concerns about harm

and abuse to individuals or groups. It will include contributing proactively to safeguarding, working to ensure, for instance that 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. It will also include participating at and contributing to quarterly Quality Surveillance Group meetings under the auspices of the NHS England area team.

2.8 Housing Services

Submission awaited

2.9 The Local Safeguarding Children's Board (LSCB)

The LSCB representative on the Adult Board has a role to ensure there is liaison between the LSAB with regards to practice, incidents that may cross age groups and joint working arrangements on common themes. Examples include extending awareness and engagement, training opportunities and promoting their respective responsibilities with regards to safeguarding children and adults with team across services.

The audit of the use of the See the Adult See the Child (STASTC) protocol by the LSCB Management Group, prompted the creation of a See The Adult See The Child Working Group in November 2012. Its aim is to promote children's services working with adult services (and vice versa) when required particularly when children or "vulnerable adults" are at risk. The group has members from children's and adult services. The work completed to date has primarily focused on raising awareness of the protocol and addressing any barriers to its implementation. The protocol is currently being revised to bring it up to date with current legislation, policy and procedure.

An action from the first meeting of the group was the development of regular practice workshops to share learning from joint working case studies. The first workshop was facilitated by the NSPCC and, drugs agency, Include. The workshop was advertised through the LSCB and well attended. The 2013 LSCB Annual Conference will be a joint venture with the Local Safeguarding Adult Board. The themes of the conference will be parental mental health, substance and alcohol misuse, learning disability and domestic abuse. The conference will explore the impact of these issues on families and aims to promote inter agency working and information sharing between children's and adult services. The work of the STASTC Group is reported quarterly to the LSCB and LSAB respectively. Future work will include multi agency audits of joint working, the development of good practice resources that will be published on the LSCB website and commissioning of STASTC training to be delivered through the LSCB.

2.9 Public Health

Reorganisation of the NHS during 2012 – 2013 resulted in the transition of the public health responsibility for improving the health and wellbeing of those in Swindon to the Borough Council. The requirement to ensure effectively linking safeguarding adults into the Joint Strategic Needs Assessment process and the Health and Wellbeing Board will be facilitated by the representation of the Director of Public Health on the Safeguarding Adults Board. This link is reflected in the Health and Wellbeing Board Swindon Protocol (Draft). Safeguarding issues are reflected in specific joint strategic needs assessments (JSNA's) such as the Dementia JSNA, the Mental Health JSNA, the Learn Disabilities JSNA and the Domestic Violence JSNA which have been formed part of the JSNA work

streams during this period. The Swindon JSNA can be found at http://www.swindon.gov.uk/healthandwellbeing ”

The Public Health Directorate remains committed to the LSAB and its objectives and is keen to prevent harm to adults at risk and will ensure that commissioned public health services have a level of awareness to report safeguarding concerns when they come to light.

2.10 SEQOL

SEQOL staff continue to access safeguarding training on a regular basis, and more colleagues have completed the investigating managers training during the last year. Sponsorship was also made available for a Social Worker to undertake a Continued Professional Development course in Intervention and Practice - Vulnerable Adults.

Some awareness training is now being delivered in house and there are plans for safeguarding training to be a more holistic part of existing training in areas such as manual handling, falls, and dementia so that we can keep this agenda at the forefront of a larger group of staff's minds. All training provided is being cross referenced to the national capability framework for safeguarding adults.

SEQOL are active members of the local adult safeguarding training sub group, and also attend the joint meeting for Wiltshire and Swindon to share best practice.

The Team will work closely with the Professional Lead for Social Work and the Safeguarding Lead for SEQOL on an on-going basis to ensure that training meets the needs described in the framework and is responsive to issues in practice.

Through 2012/13, SEQOL reported that they had assessed 354 safeguarding alerts to consider if there was a requirement to instigate full safeguarding procedures. Of these alerts, 242 cases were managed by SEQOL under the Policy and Procedures for Safeguarding Adults in Swindon and Wiltshire. Over the year we have seen an increase in the number of investigations into financial abuse with regards to old people and people with physical disabilities and an increase in the number of cases alleging physical abuse managed by the learning disability team.

As part of our improvement plan we have seen more involvement of our customers in the safeguarding process and which is evidenced through new recording systems. We regularly use the advocacy service if we find through a best interest assessment that our customer lacks the capacity to understand the safeguarding process.

2.11 Swindon Care Homes Association

The Swindon Care Homes Association, whose members provide social and nursing care for several hundred older townspeople (including a significant number with mental health problems such as dementia), is keen to support all relevant local safeguarding policies and initiatives. The members' Home Managers are expected to use their best endeavours to ensure that their frontline care staff receive the training and guidance that is necessary for them to identify and respond proportionately to any suspected safeguarding issue that may arise on their premises. Home Managers are committed to working effectively both with and within multi-disciplinary teams whenever allegations are being investigated or followed up, and to appropriately incorporate into day-to-day

practice any lessons that may be learnt from particular issues or events, whether local or national.

2.12 Swindon Carers' Centre:

Swindon Carers Centre is fully committed to raising the profile of safeguarding within the organisation. The Carer Support Manager has lead responsibility for safeguarding and represents Swindon Carers Centre on the Local Safeguarding Adults Board. During 2012/13:

- New members of staff receive a copy of the "No Secrets" booklet and the organisations Adult Protection policy within the first few days in post as part of their induction programme;
- New members of staff (including social work students on placement) are booked onto the first available Safeguarding Vulnerable Adults Basic Awareness training course once they are in post;
- Following recruitment of a large number of new staff and volunteers a Basic Awareness Course was held in house, provided by Swindon Borough Council's Adult Safeguarding Manager;
- Training records have been checked to ensure that front line staff across all teams (including young carer support workers) have attended Safeguarding Vulnerable Adults basic awareness training;
- All new staff and volunteers who are eligible have received Enhanced Criminal Record Bureau / Disclosure and Barring Service checks, which are repeated every three years;
- All staff and volunteers are required to sign an annual declaration to confirm that they have not received any criminal convictions since the CRB / DBS check;
- All new volunteers to the Centre attend mandatory training which includes safeguarding. Guidance on safeguarding is also given to all volunteers;
- Staff in the Adult Carer Support Team have received Child Protection training, and training on See the Adult, See the Child; and
- All members of the senior management team, and other key members of staff, have attended Safer Recruitment training.

During 2013/14 we will:

- Ensure that staff maintain an awareness of safeguarding matters; and
- Continue close working relationships with partner agencies in relation to safeguarding matters.

2.13 Swindon Clinical Commissioning Group

Submission awaited

2.14 Wiltshire Police

The Wiltshire Police Safeguarding Adult Investigation Team (SAIT) consists of specially trained investigators. The team consists of a Detective Sergeant, 7 investigators and an administrator (covering Wiltshire and Swindon). Other officers from other parts of the Public Protection Department also support this team and are "Omni- competent". These officers have experience in working in domestic abuse and child protection. The strategic lead for Safeguarding Adults is the Detective Superintendent of the Public

Protection Department who also sits on the LSAB and has the operational lead for Safeguarding.

During 2012, the 'Three Strands of Vulnerability' (Welfare Concerns, Anti-Social Behaviour and Safeguarding) previously reported in 2010/11 has helped reduce the number of unnecessary referrals to the SAIT as it encourages officers to deal directly with concerned agencies (e.g. by making a call to adult services when there is a welfare concern about a vulnerable adult). There is a plan to reinforce the 'Three Strands' message within Wiltshire Police by carrying out regular briefings to neighbourhood policing teams, response officers and CID officers.

Staff from the safeguarding team are also giving presentations to Nursing Homes to improve the reporting of abuse and to make sure that evidence of any abuse is properly recorded. Recently a presentation was given to a nursing home and as a result of the training given, we saw a marked increase in referrals from this nursing home as staff there understood fully what their responsibilities were regarding the reporting of adult at risk abuse. Wiltshire Police are currently reviewing the training package for training officers to tackle adult at risk abuse.

Financial abuse accounts for approximately 30 per cent of the referrals to the Safeguarding Adults Team. These cases are often complex in nature and involve dealing with fluctuating capacity, powers of attorney and applications for production orders. The Safeguarding Adults Department are now referring the majority of their financial abuse investigations to the Wiltshire Police Complex Fraud Unit. The Complex Fraud Team have excellent expertise to tackle complex fraud and securing the evidence in an effective and efficient manner. The safeguarding team will continue to manage the safeguarding aspect of the vulnerable adults in relation to financial abuse, particularly in liaising with the Councils and Trusts finance officers. There are currently 2 cases being put before the Courts.

Case example:
Following a safeguarding alert from the ambulance service, the Police Safeguarding Adults Investigation Team investigated the death of an older woman whereby a health care professional had refused to give resuscitation when the woman became seriously ill. Enquiries revealed that the victim who died did not have a 'do not resuscitate notice' and an attempt to resuscitate should have been made. A Home Office Forensic post mortem was arranged and the post mortem concluded that the adult at risk had died of a heart attack. The case is with the Coroner and the Nursing and Midwifery Council will be investigating the incident.

In last year's annual report, Wiltshire Police outlined its priorities in working in-line with the Policy and Procedures for Safeguarding Adults at Risk in Swindon and Wiltshire. To see this report, please follow this link. http://www.swindon.gov.uk/cd/foi/cd-foi-publicationscheme/Documents/safeguarding_vulnerable_adults_2011-12.pdf

The aims of all staff within the Safeguarding Adults Investigation Team within the Public Protection Department throughout this year will be:

- To prevent harm or further harm to both adult and child vulnerable victims;
- To bring the perpetrators of these crimes to justice;
- Prevent where possible, perpetrators from re-offending;
- To ensure that all staff are appropriately trained and accredited to recognise and respond to adult and children's safeguarding issues; and

- To strive to continuously improve systems, processes and people to provide a high quality service to the community and maintain and enhance the reputation of the Service.

2.15 Wiltshire Fire and Rescue Service (WF&RS)

Wiltshire Fire & Rescue Service are currently reviewing their policies and procedures for safeguarding children and adults and will deliver bespoke awareness training to all staff during the next financial year. Senior Managers and specialist roles within the service will get enhanced safeguarding training commensurate to their role.

Case example
A call was received to attend a small fire in the Swindon area. The fire was out when staff arrived. There was slight smoke "logging" which was ventilated by the fire fighters. There was one adult and one young child living in the property. The property was in a generally poor state of cleanliness, cigarette ends discarded throughout, there are no carpets in any of the areas and no food in the fridge. There is nothing to suggest there was any abuse or any deliberate neglect however the Fire Service contacted the Housing Officer and Social Services to get help and support for the family. This is good evidence of a partnership approach to 'early help' for a vulnerable family. "

2.16 Wiltshire Probation Trust

Submission awaited

2 Sub-groups of the LSAB

Operational Group met on four occasions during the year, with attendance from the following agencies: SBC (Head of Policy, Housing, Domestic Violence, Adult Safeguarding, Commissioning), Great Western Hospital Foundation Trust, Wiltshire Fire & Rescue, Wiltshire Police, NHS Swindon, Primary Care Trust and Wiltshire Probation. Agenda Items during the year included:

- Terms of Reference;
- Policy & Procedures Review;
- Services of Concern;
- Self-Assessments;
- Winterbourne View;
- LSAB Business Plan;
- Case Discussions;
- Monitoring Types of High Risk Services; and
- Francis Report.

The Training Sub-group: Has met on two occasions during the year. This is now a small group with membership from the large key agencies: SEQOL, The Council/NHS Swindon, Avon and Wiltshire NHS Partnership Mental Health Trust, Great Western Hospital Trust and the Police. Most of the work of this group has been to finalise the training strategy and consider training needs of the key agencies. As part of joint working with Wiltshire LSAB, Swindon and its key agencies have joined a Wiltshire wide

group which will meet twice a year. As Wiltshire and Swindon have joint procedures, it was felt that a pan Wiltshire approach would help to standardise the training delivered but also avoid some of the agencies who work in both local authority areas having to attend 2 meetings dealing mainly with the same issues. The first meeting is scheduled to take place in May 2013.

Policy and Procedures Sub-group: Met on one occasion during the year. The work of this group was to concentrate on the revision of the policy and procedures. This was carried out by a small "task and finishing group" involving a few agencies who work across Wiltshire. The wider group were consulted once the revision was completed.

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. Much of the work has concentrated on developing links with established community groups and seeks to provide them with presentations about safeguarding and the links they have with adults and children at risk. Membership includes SBC (Safeguarding Adults, LSCB, Localities, Children Services including, Safeguarding & QA Team, U-Turn, Early Support) SEQOL, Wiltshire Police, Harbour Project, Swindon Multi-Faith Partnership.

Service User Forum: This was launched in 2012 / 13 with the direct support and involvement by the LSAB Chair who was instrumental in establishing it to a level where it may develop. The aim is for a representative from this group to become a full member of the LSAB. Martin Kelly (a disability expert) agreed to chair the Forum and later agreed to attend the LSAB from February 2013. This group is still at a forming stage with a view to extend its membership to other relevant groups supporting adults at risk. Subjects of discussion have included similar topics covered by the main board, for example, Winterbourne View, making Swindon Safer, Hate Crime, Healthwatch, the groups' membership and Terms Of Reference.

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SECTION 6

Priorities for 2013 / 14

For this year's annual report, the headings (or domains) used in the regional Self - Assessment Quality & Performance Framework for Adult Safeguarding have been used as categories for the priorities for the coming period. These priorities have been agreed by the LSAB and are included in its business plan.

Prevention & Early Intervention

- Ensure safeguarding is a key consideration in the tendering and procurement process during the commissioning of all services.
  The Operational Group will be looking at each agency's statements that are in their contracts with suppliers/providers. By November 2013

- Monitor compliance to safeguarding elements at all levels to ensure existing guidance is implemented.
  This will be looked at through a new self-assessment process being developed by a regional safeguarding project. The Operational Group will look at these once the new framework is published.

- Establish programme of "walkabout" sessions at GWH involving Adults Safeguarding manager and other relevant personnel.
  The Executive Nurse from the Clinical Commissioning Group will be arranging this and will report to the Operational Group.

- Review the suspensions of placements policy.
  This is required again, as the way services are inspected and are rated has changed since the last policy was developed. May 2013

- Revision of the Policy and Procedures for Safeguarding Adults at Risk is finalised and launched in line with national and regional guidance.
  A launch of the revised policy will take place with managers who coordinate investigations under the policy and procedures. (By May 2013)The staff guide (No Secrets in Swindon and Wiltshire) will need to be updated in respect of the policy revision. By September 2013

- Reconvene the Wilshire and Swindon Policy and Procedures Sub-group
  Once the Policy is agreed the Policy and Procedures Group needs to be reformed to monitor practice and further changes required leading up to the development of legislation. By July 2013

Responsibility & Accountability

- Work plan for the LSAB to be agreed for 12 months and presented to the LSAB
  A development day will be arranged for board members to consider what needs to be included in the Work Plan. (Mid-year)

- Develop a Safeguarding Strategy in line with proposed Government legislation.

The LSAB will be considering its response before the end of the year. What will be required under Government legislation is not yet known.

- LSAB to agree a pathway to view, review and evaluate the Government policy to make appropriate changes as necessary.
  This work is required when there is clarity of the extent of legislation (this may not be within 2013/14.

- The LSAB reflect any changes in government policy including the inclusion of new members. *Again, once the extent of legislation is known.*

- Review of the quality and performance framework (which is taking place regionally) to be applied to local arrangements. *Once the framework has been published.*

Access & Involvement

- Develop a co-ordinated strategy for increased public awareness which will address general public, targeted groups and media. Use shared expertise and link with other initiatives to increase public engagement – e.g. CCG's Patient and Public Engagement Strategy. *From April 2013 the Awareness and Engagement Group will be working on this action.*

- Improve the information available to individuals who experience harm. *This is work that requires the involvement of the Service User's Forum. They will be looking at examples used in other areas.*

- Establish a method of collecting feedback on quality that is independent from the teams investigating cases.
  It has been agreed that investigating managers will ask alleged victims whether they would welcome an informal interview with the Adult Safeguarding Manager.

- Collect information about the outcomes for the alleged victim (or their representatives) in all safeguarding cases to include:
  - Views on the handling of the case;
  - Whether the person feels safer as a result of the case and
  - Whether the alleged victim would be willing to be interviewed about their experience.

  Logs required for completion by investigating managers revised to capture this information. To be used from April 2013.

- The level of involvement of people who use services can be monitored and challenged as appropriate.
  Information obtained from safeguarding logs completed by investigating managers from April 2013.

- Continue to develop a Service Users Reference Group & develop the role of voluntary organisations to assist with involving people who use services
  Service User Forum is in place but will need to develop its membership throughout the year.

Responding to Abuse & Neglect

- Enhance sub-groups and ensure all partner agencies participate in these and the Operational Group.

- Each organisation is asked to give a verbal account to the LSAB Chair explaining " what safeguarding adults mean to us"
  All agencies will be asked to report annually.

- Review IT systems ability to record relevant activity.
  Work on the potential to improve care systems to include safeguarding is on-going.

- Monitor the resources and support required to ensure effective safeguarding arrangements are in place within teams and to support the work of the LSAB and Head of Safeguarding.
  Again, this is on-going work that requires consideration within performance meetings with SEQOL and AWP. The LSAB will continue to discuss effective support of the Board.

Training & Professional Development

- That a standardisation process is set up with training providers with the Private & Voluntary sector
  Standardisation events to be established with the support of the Wiltshire and Swindon Care Skills Partnership. Midyear

- Ensure that training for those involved in co-ordinating and investigating cases is relevant and up to date. Training is available to all Partner agencies to include:
  - Investigating Managers;
  - Investigating Officers; and
  - Minute Takers.

  Adult safeguarding manager to ascertain the likely demand for training as listed above by September 2013.

- Carry out an audit on training delivered by independent trainers to check use of the national competence framework, common induction standards to quality assure and monitor the outcomes of training.
  Questionnaire to be developed and results considered by the Training Sub-group by December 2013.

- Review the training strategy in line with policy update and changes to the delivery of available training.
  The Training sub-group will do this before November 2013 to ensure revised policy is reflected in any training required. Particularly with regards to establishing the desired outcomes of the adult at risk.

- Resource training adequately to meet the need for all working with adults at risk to achieve the competences for their level of work.
  The LSAB Training sub-group to check funding is available to provide the required level of training (linked with audit of training required – 2nd bullet point above)

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The Safeguarding Adults at Risk in Swindon Annual Report 2012/13 is available on the Internet at ~~http://www.swindon.gov.uk/sc/sc-adults/Pages/sc-adults-protectionvulnerableadults.aspx~~
It may be produced in a range of languages and formats (such as large print, Braille or other accessible formats) by contacting the Customer Services Department.
Tel: 01793 445500
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