Safeguarding Adults at Risk in Swindon

Annual Report
April 2013 - March 2014

Great Western Hospitals NHS
NHS Foundation Trust

Swindon LSAB
Safeguarding Adults at Risk

NHS Swindon

SEQOL
care • health • support

Keeping Swindon Safe

healthwatch Swindon

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Wiltshire Probation Trust

Swindon Borough Council

Safeguarding Adults at Risk in Swindon
Annual Report 1st April 2013 31st March 2014

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

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FOREWORD

We are pleased to present the Swindon's Safeguarding Adults Board annual report for the year ending March 31st 2014.

The report describes how the Board's agencies, both jointly and independently, work to ensure the safety of those adults within Swindon 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.

Section 2 reports an increase in the number of referrals received from last year- 473 compared to 406; a 17% rise. This increase is less than the 40% recorded in the 2012/13 report and the on-going rise is a national trend. This reporting momentum, prompted by the in depth national coverage of the shocking events at Winterbourne View hospital and the deaths at the Mid-Staffordshire hospital, has carried on, but as further exposes in the media have shown, we still need to do more work.

We will be greatly assisted in this task when the Care Act becomes law next year. Section 6 summarises the main areas of safeguarding to be included in this legislation and ensuring its effective implementation is a Board priority for 2014/15. This Act will put the safeguarding adults on a 'legal footing' for the first time.

Whilst this legislation will strengthen the work of safeguarding adults in Swindon, it is important to recognise the multi-agency work that already takes place and is making a positive difference to the lives of adults at risk. The statistics in section 2 show measures of activity in terms of numbers, demographics, types of abuse and sources of referrals etc. 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; a central theme of the report and one that needs to be considered when evaluating the outcome data.

Some Board agencies' demonstrated our commitment to hearing the voice of the victim, by participating in the 'Making Safeguarding Personal' project, sponsored by the Local Government Association (LGA). This initiative provided excellent learning opportunities (listed in section 3) and a Swindon case study was used in the subsequent LGA guidance.

The Board wants to have direct feedback from Swindon's service users and last year's report mentioned the work of the Forum which has its own independent

chair, Martin Kelly. Martin sits on the Board and makes valuable contributions to our discussions but one of the challenges for next year for us all is to recruit more members to join this group.

Section 3 outlines the Board's achievements over the past year. We continue to respond to national events such as Winterbourne View 'stocktake' required by Government and have considered individual health providers' responses to the recommendations from the Francis Report. The Board now has an agreed protocol with the Health and Wellbeing Board which gives us the opportunity to ensure that the safety of adults at risk is a key part of their deliberations.

Section 6 outlines the priorities and challenges facing the Board for 2014/15. It is an ambitious programme of work and requires commitment, determination and resources for its delivery. Whilst we are confident that everyone who works with vulnerable adults in Swindon has the necessary dedication, the report highlights areas where funding is an issue; the service user guide and training are just two examples. The report correctly identifies the pressures caused by increasing levels of reporting and that the Board need to be assured that staff have the capacity to deal with higher workloads whilst maintaining the high level of service and user engagement.

Over the coming year, the Board will be holding its members to account to ensure that safeguarding adults in Swindon remains a priority. The submissions in section 5, exemplified by the many case studies, give us confidence to believe 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
Local Safeguarding Adults Board

Brian Mattock
Cabinet Member for Health and Adult Social Care

SECTION 1

Safeguarding Adults at Risk in Swindon Annual Report 2013/14

Introduction:

Safeguarding Adults continues to be increasing in its profile and is being given a much higher level of importance. More and more organisations are seeing the value of understanding their role in procedures and in ensuring staff are made aware of their responsibilities. Further incidents within the media have bought safeguarding adults to the attention of more and more people in the community and those who may have infrequent contact with adults at risk as well as those providing or organising direct care.

The Care Act which is being finalised outlines some major changes affecting the Swindon Local Safeguarding Adults Board (LSAB) and the work it is required to do. Further information about the Care Act will be included within the main body of this report. As it stands and until legislation is enacted, Government Policy confirmed that *No Secrets (Department of Health 2000)* will stay a statutory guidance so the definition used by the LSAB and within the policy and procedures 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.*

The LSAB continues to develop and consolidate its role to ensure there are processes in place to protect adults at risk (while empowering them to make their own decisions and being able to take informed risks), preventing abuse from taking place in the first place and responding in such a way that is proportionate to the individual circumstances of the alleged victim. The Board continues to develop partnerships with the key agencies who can work together to improve outcomes for adults at risk and are accountable for their actions concerning safeguarding adults.

Working closely with the police and other key agencies, alerts of alleged adult abuse are managed in the main by SEQOL, the social enterprise providing care and support in Swindon. For people who are mentally unwell, the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) fulfils this role.

According to the 2011 Census Swindon had a population of 209,159; of those 28,854 people were aged 65 years or more (13.8%), including 13,694 aged 75 years or more (6.5%). 5,260 people were receiving services from adult social care in 2013/14 broken down into client groups as follows:

Service User Group	Age Band 18-64		Age Band 65+	
	Female	Male	Female	Male
Physical Disability	464	309	2,008	1020
Mental Health	249	262	287	136
Learning Disability	249	321	37	33
Total of Clients	962	892	2,332	1,189

The Borough of Swindon is largely urban with small pockets of rural areas. Within Swindon there are some deprived areas which can also impact on levels of vulnerability for some of those living there. In 2013 there was a drop of 4.7% in the number of reported crimes in Swindon and Wiltshire. There were 1,600 fewer victims of crime between January 2013 and December 2013. Overall Wiltshire and Swindon has one of the lowest crime rates in the country. There is still a good level of community involvement in many areas of the town and the Council and its partners continue to develop this involvement and encourage residents to support those who may need additional help and may be isolated or lonely with a view to maintain their independence.

As with previous years, as a result of increased awareness and the developing profile of safeguarding adults, this report shows an increase in the number of concerns about the abuse of adults at risk, though the year on year increase has reduced. It is not believed that continued increases in these figures are a concern and other local authority areas continue to report increases in the number of safeguarding alerts. The LSAB continues to monitor such activity and appreciates the work carried out by the teams managing adult protection. However the Board continues to be aware of the pressure increased reporting presents and needs to be assured that the teams are able to maintain the standards required to fulfil their safeguarding responsibilities.

This annual report includes:

- Information on activity and data collected throughout the year about cases alerted and investigated under Safeguarding Adults at Risk procedures;
- An outline of the progress made in addressing the priorities from the Annual Report 2012/13;
- 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.
- As requested by the Health Overview Scrutiny Committee, this year a glossary of abbreviations used has been included in Appendix 1.

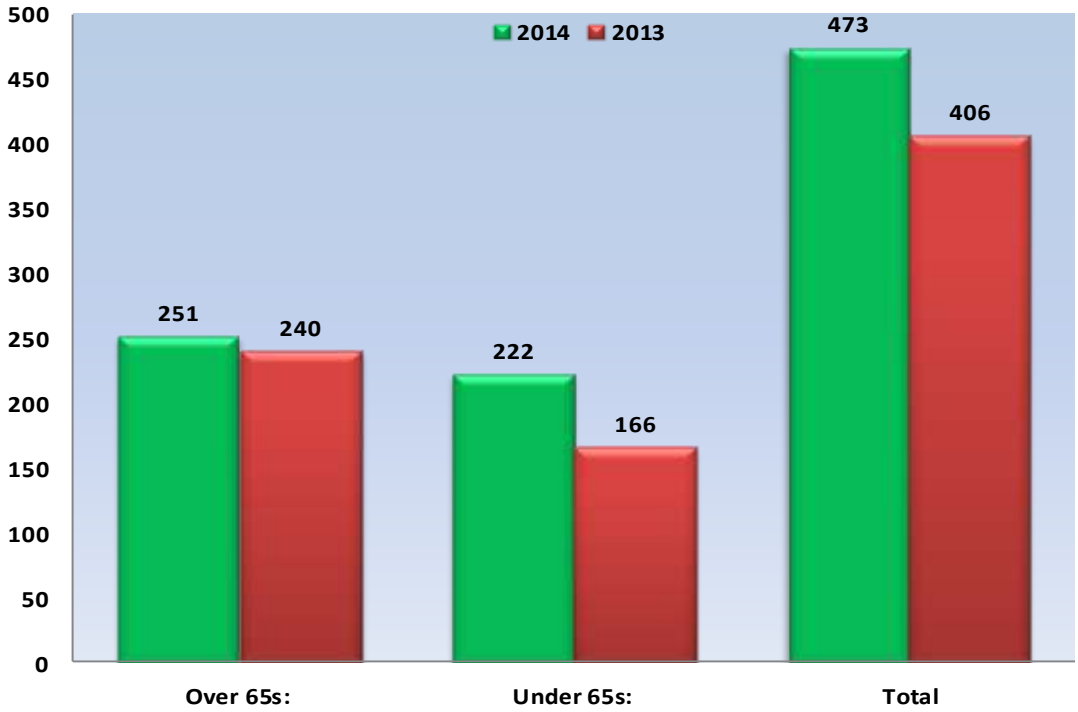
SECTION 2

Activity Data 2013 – 2014

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

The following data has been collated by the Adult Safeguarding Manager using information provided by teams managing individual cases. The information is based upon the National Health Service Information Centre requirements and requests in previous years for specific data from board members and other interested parties.

Figure 1: Total number of alerts received



In the last year, there has been an approximate increase of 17% in the number of alerts reported to adult services for further investigation, compared with 40% in 2012/13. This level of increase is not unusual as other local authorities are reporting continued increases too. It is still believed that this indicates improved awareness mostly due to some high profile national cases in the media rather than an indication that there is an increase in the amount of abuse taking place. There has been a significant rise of 34% in the number of alerts relating to people who are under 65.

Of the 473 cases recorded, 203 cases required no further action after the initial stage and 54 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. 223 did progress on to investigations under the safeguarding procedures.

There have also been improvements in the information provided by the teams investigating cases. They are better at informing the Council of cases they are not progressing or requiring another process. Often alerts are received that are not appropriate as they do not relate to an adult at risk, are not alleging abuse has taken place or are highlighting other concerns for example someone who is struggling to cope and requiring community care services, or in general, a "welfare concern". Information

on welfare concerns is also recorded to highlight if there is a training or development issue within the alerter's organisation.

Sometimes alerts are received from providers of services following a minor incident in a care setting. There can be a perception that the Care Quality Commission expect alerts to be raised whatever the incident (and at times advise it) whereas other processes should have been used for example disciplinary action, complaints action or action under the Health and Safety at Work Act. This could account for the increase in the number of cases that did not progress to a full safeguarding investigation.

Case Example

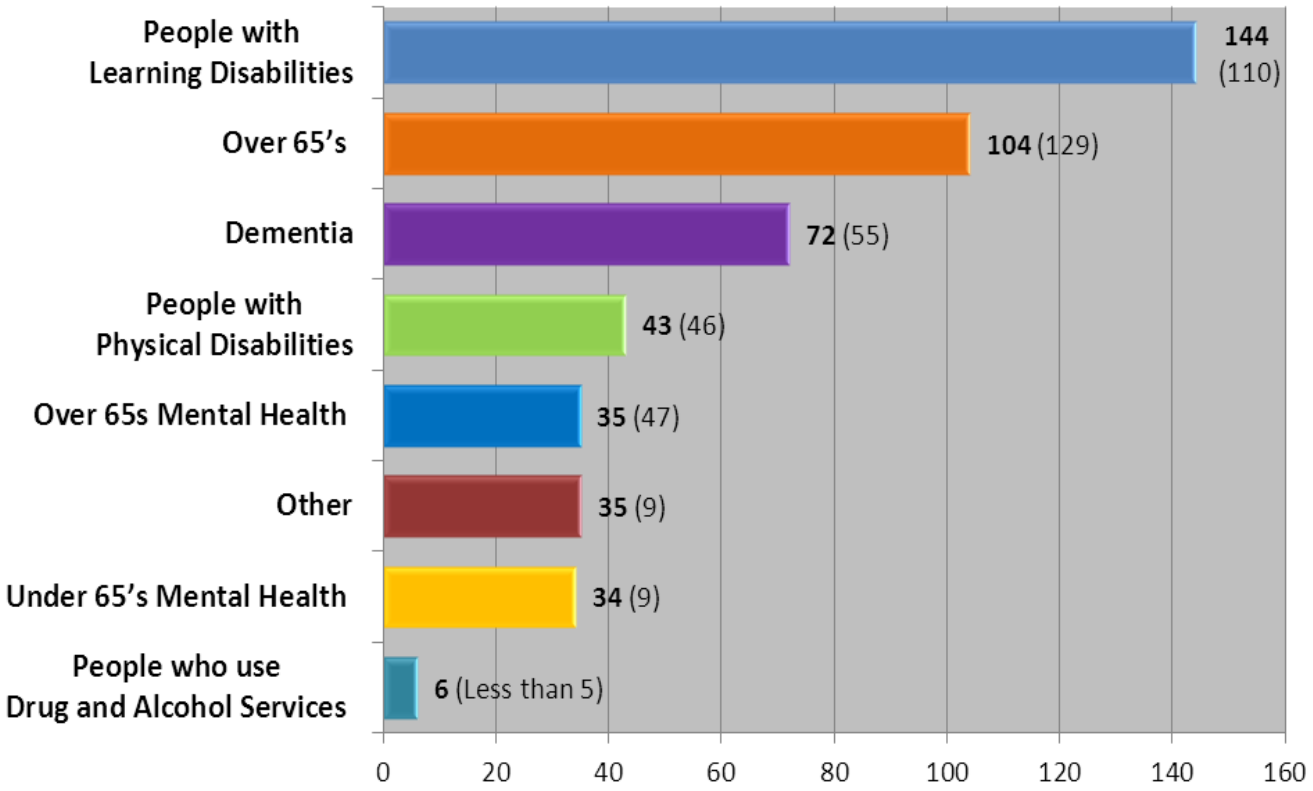
A care provider sent in a safeguarding alert form stating that during one of their night-time spot checks both waking night staff on duty were found to be asleep. The provider was told by the adult care team who assessed the alert, this did not require reporting under safeguarding procedures (as no harm came to any of their residents) and that appropriate disciplinary action was required. There was agreement from the provider that this was the course they would be taking having already suspended the staff from duty.

All alerts are recorded, and information gained from these can be useful. For example continued poor alerts may indicate a training need within the service and a recommendation that they make use of the Council's free Safeguarding Awareness training. Reports of low level harm are also recorded as information from these may indicate a more serious concern.

Case Example

A number of incidents had been noted in a particular care home. Most of these were around 'resident on resident' physical abuse. None of the alerts highlighted major concerns or indicated any serious injury so were mostly dealt with by a care management process, for example reviewing the resident's risk assessment or arranging for 1:1 staff at key times. However, on recording these on the database maintained by the Safeguarding Adults Support Officer, the frequency of such incidents indicated a wider issue. Concern was expressed as to whether the provider was not considering risks to others when admitting "new" service users. The Contracts and Commissioning Team within the Council were able to check and monitor the home's admissions policy.

Figure 2: Breakdown by service user groups



There has been a major improvement in the number of cases reported into the mental health team supporting people of working age and a good standard of information provided by the team. (In the past a number of alerts regarding this group were considered to be too low. Also, data previously collected by AWP's safeguarding team in Bristol and later passed to the safeguarding manager in SBC, is now sent directly to the Council assisting in more timely and accurate recording).

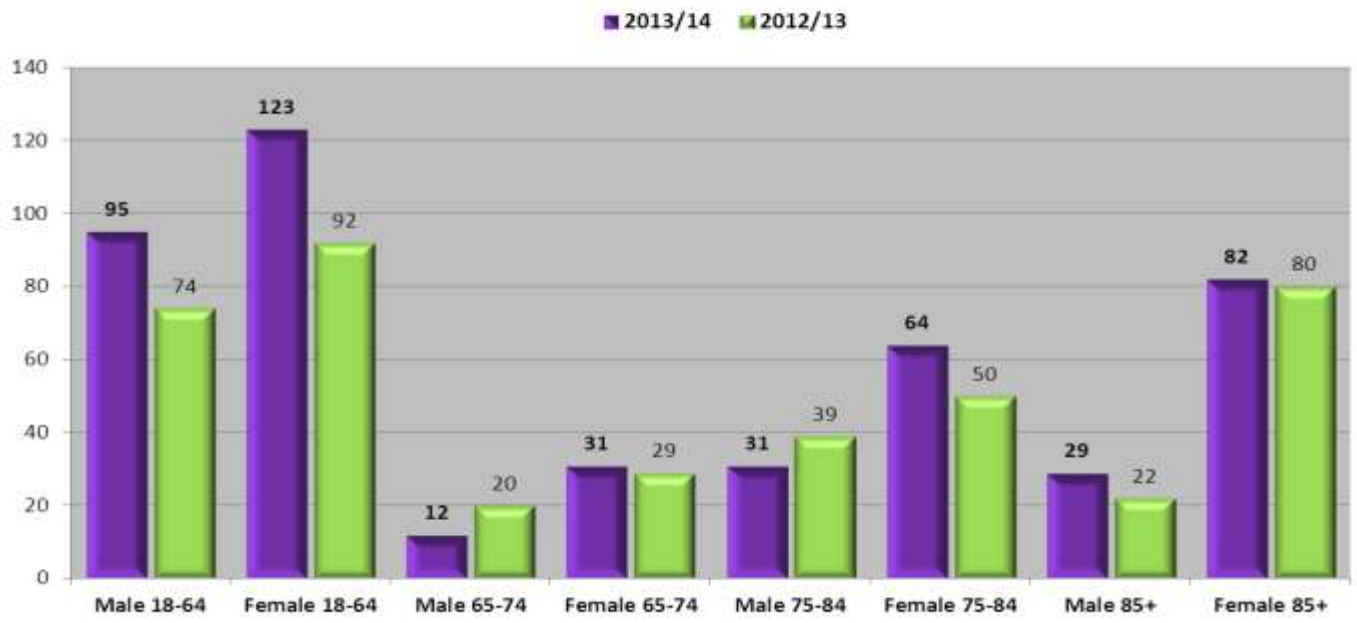
There continues to be a significant increase in the number of alerts regarding people with learning disabilities. While a number of these did not require action under the procedures and may have been inappropriate alerts perhaps indicating overzealous reporting, there were 91 that required investigating under the safeguarding policy. Two thirds of these progressed beyond the initial stage of planning the investigation. Of the cases concluded, 59 reported that following the procedures, the risks to the individual had either been removed or reduced. The increase could also signify that there is better knowledge of reporting safeguarding issues and a clearer understanding that people with learning disabilities will be eligible for support under the procedures. For example it may be more likely that someone with learning disabilities will be unable to protect themselves from harm, or a perception that this would be the case. The majority of these alerts were raised by service providers (78), of which almost half were regarding incidents within their own services, 25 being allegations against staff and 14 being allegations about other service users and 30 being family members or partners or members of the person's social network. From evaluating the information provided, there does not appear to be any worrying patterns or trends with this group of service users, however, where the standard of service provided has come into question, action by contracts officers is taken or a large scale investigation instigated.

This year, separate information has been collected concerning allegations regarding people with dementia. This accounts for why there is an apparent reduction in the

number of allegations relating to people over 65. If the figures were reported in the same way as previous years, it would show that there was no significant increase in the number of alerts relating to this group.

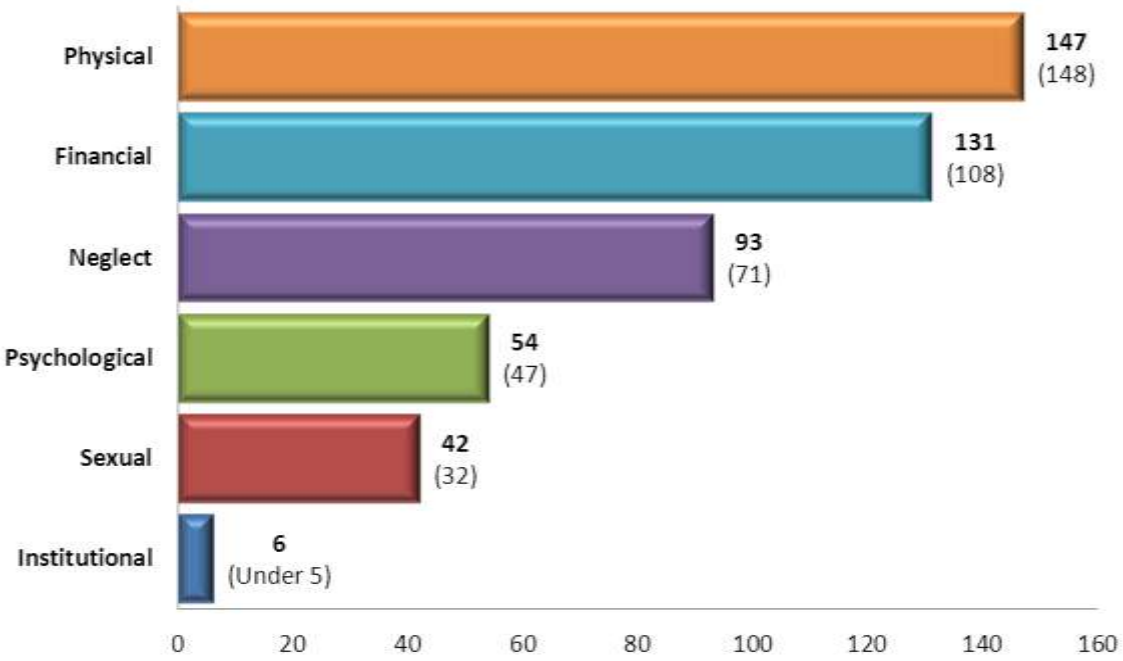
Nb. “Other” includes people with a terminal illness, hearing and vision loss, those where their client group was not identified at the initial stages, people with a head injury and those with Asperger’s/autism.

Figure 3: Breakdown by Gender and Age



The main change with regards to these figures is the increase in alerts regarding alleged victims between the ages of 18 and 65. As previously stated there has been a significant increase in the number of alerts regarding people with learning disabilities and people with mental health issues of working age which would account for this increase. There has been no significant changes overall to alleged victims over 65. In the previous year it was reported that a large increase was apparent regarding females over 85. There has been no major change with this age group this year (although there was a small increase in the number of alerts relating to males who are over 85). Overall there was a decrease in the number of men who are over 65 where abuse was alleged.

Figure 4 Types of Abuse Alleged



The number of alerts in relation to physical abuse continues to be the most prevalent form of abuse alleged. A large proportion of these relate to harm alleged to have been caused by other adults at risk, usually in a care setting. In the majority of these cases, full safeguarding procedures were not required, but did need action taken to reduce future risk, for example an amendment to the care plan of the person alleged to have caused harm. It should be noted 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.

Another sizable group alleged to have caused physical harm, are family members in the alleged victims own home. Out of a total of 59 cases 34 were reported to be the person's main carer perhaps signifying the possibility of carer stress. The outcome in the majority of these cases were to care manage the situation by reassessing the alleged perpetrator as well as revising the alleged victim's care plan. In some of the other cases, concerns around domestic abuse were raised, requiring input from the Domestic Abuse Investigation Team within Wiltshire Police.

22 cases of physical abuse were alleged by members of staff in care settings. Of these, 5 were substantiated or partially substantiated and resulted in disciplinary action being taken by the employer.

Case Example

A resident in a care home for people with learning disabilities alleged that a member of staff had "teased" him and had "struck" him and the care home raised a safeguarding alert. They had also suspended the member of staff from work pending an investigation. A safeguarding investigation was opened involving the police who interviewed both parties. It was agreed that there was not enough evidence to proceed with a criminal prosecution so the provider was asked to deal with it through their disciplinary procedures as there is a lesser "burden of proof". The provider concluded that there was also little evidence to support the allegation and decided that the member of staff would no longer work directly with the service user and that additional staff supervision would be put in place. The service user was informed of this and was satisfied with the action taken.

Financial abuse is often reported as the most prevalent form of abuse but this is not the case this year. However there has been a 21% increase in the number of cases of financial (and material) abuse alleged. These range from people alleging small amounts of money being taken, which in most cases involve a family member or a partner and resulted in the alleged victim receiving support to protect their savings or income. There can also be cases where there are concerns about large amounts of money in savings and/or their property, which can require the input from the Court of Protection and often requires a Police investigation involving officers specialising in fraud. Cases that are being reported of this type are becoming more complicated requiring complex and sometimes protracted investigations.

Case Example

Following an assessment of a service user's finances to determine if they should be paying for their care, the Finance and Benefits Team raised an alert as the person's savings had been reduced beyond the level that would be expected of someone in their circumstances. A safeguarding case was opened and a joint investigation (adult services and the police) was instigated. It confirmed that there was unusual activity on the service user's bank account and they were able to identify who was responsible for making withdrawals. The case was passed to the Crown Prosecution Service and agreement is being sought to carry out a prosecution. With the alleged victim's authorisation, her existing bank accounts were closed and new bank accounts were established which are now managed by the Local Authority to safeguard her current income and future savings.

There has also been another increase in the number of alerts relating to allegations of neglect. 23 cases (fewer than last year) were alleged to have taken place in a care setting. 11 required action under the safeguarding procedures of which only 2 were fully substantiated requiring the employer to take disciplinary action. The cases that did not progress needed to be dealt with under the provider's complaints procedures. This may indicate that there is a tendency to report issues under the safeguarding policy where a more proportionate response would have been to raise a complaint directly with the provider.

Case example

The ambulance service raised safeguarding concerns because a care home was calling them out too often for some minor issues the home should have been able to deal with directly. The crew also felt the attitude of staff towards them was not very professional. While this was an inappropriate use of their service, it did not warrant a safeguarding investigation and should have been raised as a complaint with the home. In discussion with the Contracts Team within the Council who monitor the home and looked at their handling of the complaint, it appeared that there was some confusion about the role of the ambulance service against the out of hours GP and when it was appropriate to call the respective services. The manager of the home arranged additional training about dealing with emergencies and also spoke to individual staff members in supervision about their attitude.

The majority of neglect cases reported occurred in the alleged victim's home mostly in relation to a family member or partner. Again this may be as a result of carer stress or a lack of knowledge about how to care for the person.

Case example

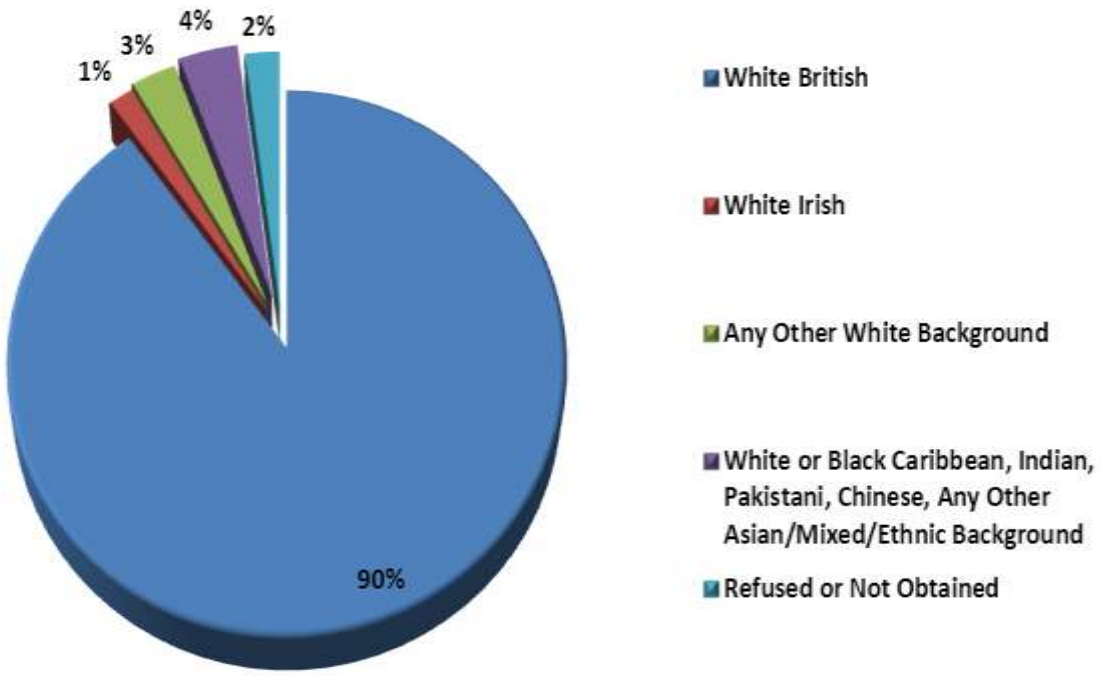
Doris H, who is 75 with limited mobility, was admitted to hospital following a fall. The ward staff noticed that she also had a grade 3 pressure ulcer at the base of her spine. Doris did not have a care package and her sole carer was her husband Ron who felt he was managing on his own quite well. An alert was raised under safeguarding but it did not progress as no abuse was considered to have taken place and any neglect was due to Ron's lack of awareness of how pressure areas could develop and how to avoid them. Doris made a full recovery, and as part of her discharge plan from hospital, a referral was made to the district nurse to provide support and guidance once she returned home. Ron also had a carer's assessment and following discussion agreed to support in the home from a care agency.

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 105 cases where the alleged victim was not in receipt of community care services at the time of the alert being raised. This is a small increase and shows how teams are aware that safeguarding procedures apply to not only those who receive services, but is also available for those who do not. Of these, almost half were not previously known to adult services. 6 alerts were received regarding people who receive a direct payment to fund their care and 68 cases were alerted where the victim funds their own care. This is an increase of 58% again, showing 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 77 cases where domestic abuse could be considered to be a factor of which 31 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. The views of the alleged victim are particularly important in these circumstances as there needs to be due regard to the wishes and choices of the alleged victim and balancing them between their safety, well-being and quality of life. A multi-agency approach is essential and it may be more appropriate for a case to be referred to the Multi Agency Risk Assessment Conference (MARAC). (See case example on page 42)

Figure 5: Ethnicity of alleged victims



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

For 2013/14, the level of alerts broken down by ethnicity appears to be proportionate to the population of Swindon as a whole. However, there is still a requirement for work to widen engagement and awareness among community groups and this continues to be a priority of the Awareness and Engagement Group – a sub group of the LSAB in collaboration with the Local Safeguarding Children's Board who also have identified this work as a priority.

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

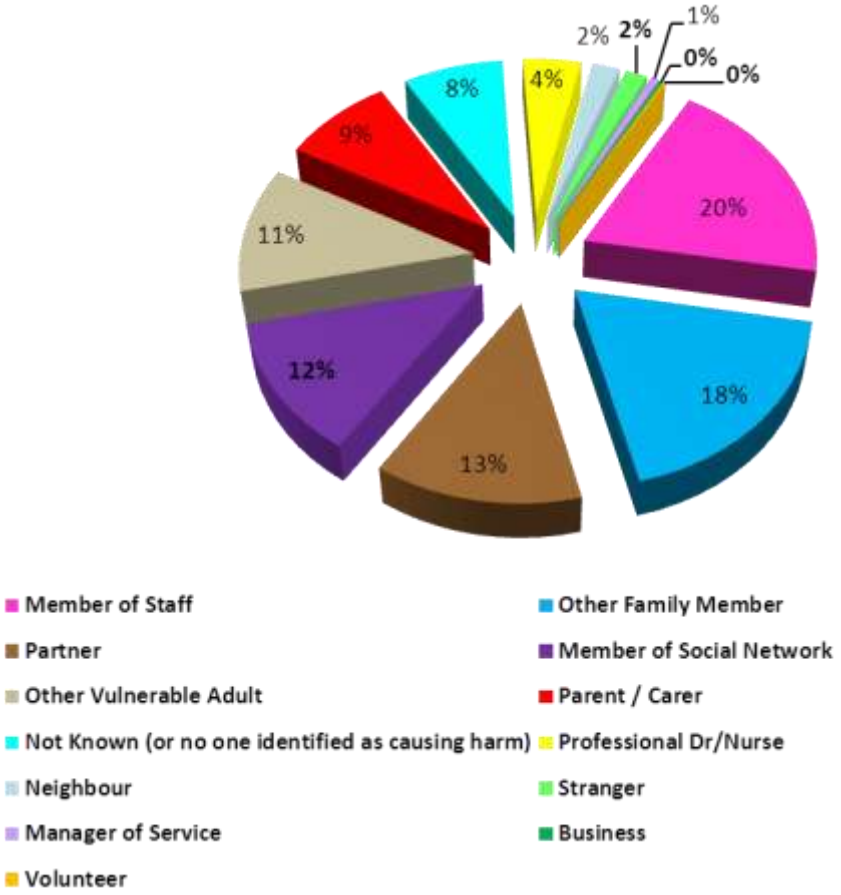
Source of Referrer	2013/14	2012/13
Care Providers (e.g. Care Homes day services including Independent Sector)	**185**	*
SEQOL Staff	**61**	*
Hospitals	**59**	23
Mental Health Professionals	**41**	30
Housing Services (including Registered Social Landlords)	**26**	11
Family/Carers	**25**	32
Police	**12**	19
Ambulance Services	**10**	13
Care Quality Commission (CQC)	**9**	3
Out of Area Referrals	**9**	2
Council Employees (not Adult Services)	**7**	8
Advocacy Service	**6**	6
Members of the Public	**6**	4
GP	**5**	2
Hospice	**4**	1
Educational Establishment	**3**	3
Business	**3**	6
Confidential Alert	**1**	2
Drug & Alcohol Services	**1**	0
Self Referrals	**0**	7
Fire Service	**0**	2
Personal Assistant (DP)	**0**	2
Coroner's Office	**0**	1

***NB Previous year's figures relating to "Care Providers" and "SEQOL staff" are not included here as this information is collected differently.**

There has been an increase in the number of alerts raised by "hospital", mainly Great Western Hospital NHS Foundation Trust. This is mainly due to a substantial training programme and the establishment of a safeguarding team within the trust. (Further information about the Trust's work on safeguarding may be found in their individual report in section 5).

There are no referrals recorded as originating from the adult at risk themselves. As previously reported, often, although a service user may raise a concern with their care manager (for example) the care manager may forward on a referral form and put themselves as the alerter. The referral form was changed to address this, but it is believed that this has made little difference. Care management teams need to be reminded about being clear who is actually raising the concern when recording them. It is also evident that care providers may raise an alert although the alleged victim may have raised the issue with them in the first place. Again, these should be recorded as self-referrals although the member of staff within the service is completing the referral form on their behalf.

Figure 7: Information on those alleged to have caused harm



Overall there has been a 7% decrease in the proportion of alerts relating to staff alleged to have caused harm. Most of these incidents took place in care settings (either care homes or supported living services) however 33 (36%) of these related to allegations in the alleged victims own home where there were concerns about a domiciliary care agency. Some of the alerts related to missed calls.

Case Example

Following a call from a whistle-blower, the CQC raised a safeguarding alert. The caller was very upset that the care agency who was supposed to be supporting his mother (Mabel) failed to attend a visit the day before. This meant that his mother was not provided with personal care or an opportunity to go to the toilet and was found to have stayed in her recliner chair overnight and was incontinent of urine. Although Mabel did not experience any physical harm, she was distressed and felt degraded. The family lost all confidence in the provider and insisted that Mabel needs to be looked after by a different agency. This was arranged. However the safeguarding concern still required action as there would be concerns about other service users the agency had been engaged to support. A strategy meeting was held and consideration given to the need for a criminal investigation (which later was not considered appropriate).
An investigation highlighted a number of management changes that took place in the agency which lead to key staff leaving their post without due regard to ensure adequate cover. Fortunately this did not result in any serious significant harm but did impact on the reputation of a provider with a previously good track record. Commissioners of the service ensured there were some strict guidelines in place to ensure a repeat of this type of incident did not take place. The Contract and Commissioning Team within the Council continue to monitor this provider, particularly with regards to staff rotas, complaints, how they deal with staff absences and covering calls at short notice.

Twenty three of the cases alerted where abuse was alleged in the person's own home progressed to a full safeguarding investigation. Nine of these were substantiated (either fully or partially) and in all cases the risks were removed or reduced as a result of the work by the teams involved.

There were 35 allegations relating to members of staff either in care homes or in supported accommodation (for example where support is provided to someone with their own tenancy). Of these, 21 cases progressed to a full safeguarding investigation, 5 cases were substantiated and resulted in disciplinary action by the provider. In most of the 14 cases that did not progress to a safeguarding process as the harm was not considered to be significant, the provider still needed to take action to address the incident that lead to the alert being raised. There has been a decrease in the number of alerts relating to incidents in residential or nursing homes. There is insufficient information to evaluate why the reduction in alerts has taken place, but it could be due to the need to increase awareness of safeguarding adults within care settings. It has been noted that fewer care home providers are sending their staff on the Council's Basic Awareness of Safeguarding Adults Course. The Training Sub Group will be carrying out an audit of how the homes are providing this training and whether what is being provided fits in with the local policy and procedures.

Case Example

A care provider alerted SEQOL that a member of their staff (Andy) had been verbally and psychologically abusive to one of their residents because he took the service user's game's console controller away from him. (It was the agreed time for him to stop using it but another member of staff reported that Andy "was a bit too forceful about it when the resident ignored him so Andy snatched it off him"). Before raising the alert, the provider had already suspended Andy, but also reported that there was a likelihood that it was more to do with a personality clash within the team. The provider agreed to continue with the disciplinary investigation and report back to the care manager in SEQOL if during their investigation they found that anything more serious took place. The care manager also advised that the service user themselves may wish to raise a complaint if they felt aggrieved by the incident. (It transpired the service user did not recall the incident).
To a certain extent, this example also demonstrates a provider who is acting cautiously by reporting this as a safeguarding concern and waiting for feedback from SEQOL before dealing with matters themselves, when it would be quite appropriate for them to deal with the matter as a staff conduct issue and/or a complaint from the service user in the first place.

There were 112 cases where the person alleged to have caused harm were recorded as having a caring responsibility (this does not include members of staff). These included: 34 allegations of physical abuse; 33 cases of financial abuse (mainly at the hands of extended family members or adult children); 30 cases of neglect and 14 cases of alleged psychological abuse. 51 cases progressed to a safeguarding investigation and of those concluded 11 were substantiated, 12 were not substantiated, 9 were inconclusive and 2 ceased at the request of the alleged victim. 17 cases remain open and in some of these cases some careful handling is required to ensure the alleged victim continues to engage with services or to ensure the relationship between the victim and the carer is supported to enable a positive outcome.

Case Example

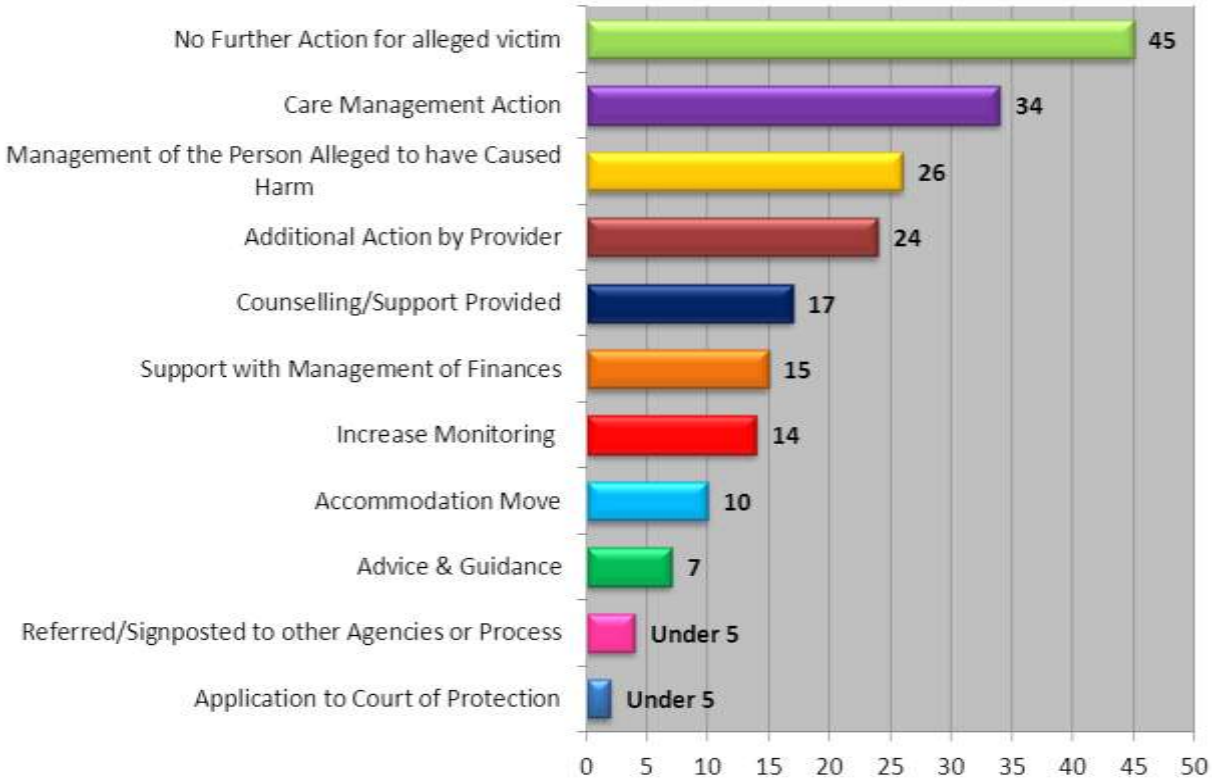
A service user with learning disabilities (Marko) used to live in a supported living environment, but decided to move back home to live with his father (although his care manager advised him against it as in the past he had been neglected at home, he was assessed under the Mental Capacity Act to be capacitated to make such decisions). After a while Marko's advocate reported to his care manager that Marko says his father often took all his money and that there is sometimes little to eat or drink in the house. Marko is often seen wearing a lot of layers of clothes because he says; there is no heating on at home. In discussions with Marko, he tells his care manager that he wants to carry on living there because he is worried that his father needs him around.
It was agreed that the case would remain open and to ensure Marko carries on working with his care manager, that a gentle, non-direct approach would be used. Regular multi-agency meetings have been put in place to monitor the situation and his care manager has managed to get Marko to agree for the Council to look after his money.

Outcomes of Investigations

In 2013/14 249 cases were assessed and did not progress through to a full safeguarding process. 203 required no further action (either because there was little or no significant harm or the alleged victim did not wish to proceed). 15 cases required a new Community Care Assessment. 30 were referred to another process, for example complaints action or action by the provider (e.g. disciplinary action). 9 cases were "signposted" to an alternative process more appropriate for the person or the allegation. For example the allegation does not involve an adult at risk as defined by safeguarding procedures but the victim was provided with information on how to access suitable support (e.g. the Domestic Abuse Investigation Team).

223 cases did progress to a safeguarding investigation. The chart below shows the types of general outcomes for the alleged victims as a result of their cases being escalated.

Figure 8 Outcomes for the Adult at Risk



***NB at the time of reporting, 40 cases remained open. This is due to either the alert being raised towards the end of the reporting period and the cases are still under investigation or they are long term cases where it has been agreed that the case remains open to enable a continual review of the safeguarding plan (as described in the case example above).**

Where it states that there was no further action for the alleged victim, this may mean that the emphasis was on action required for the person alleged to have caused harm. Other reasons where no further action is required could be that during the investigation there was no significant harm, or no evidence has been found or the person has requested that the process is ended.

There are 34 cases where the outcome was care management action. This could include a review of the care plan, a change to the service being provided or a change to a health care plan. 26 cases resulted in the focus being on the person alleged to have caused harm. For example, a service where one resident is abusive to another, the best course of action may be to review their care plan rather than the victim's to reduce the likelihood of reoccurrence. This may also include revising of risk assessments and review of behaviour plans in these circumstances.

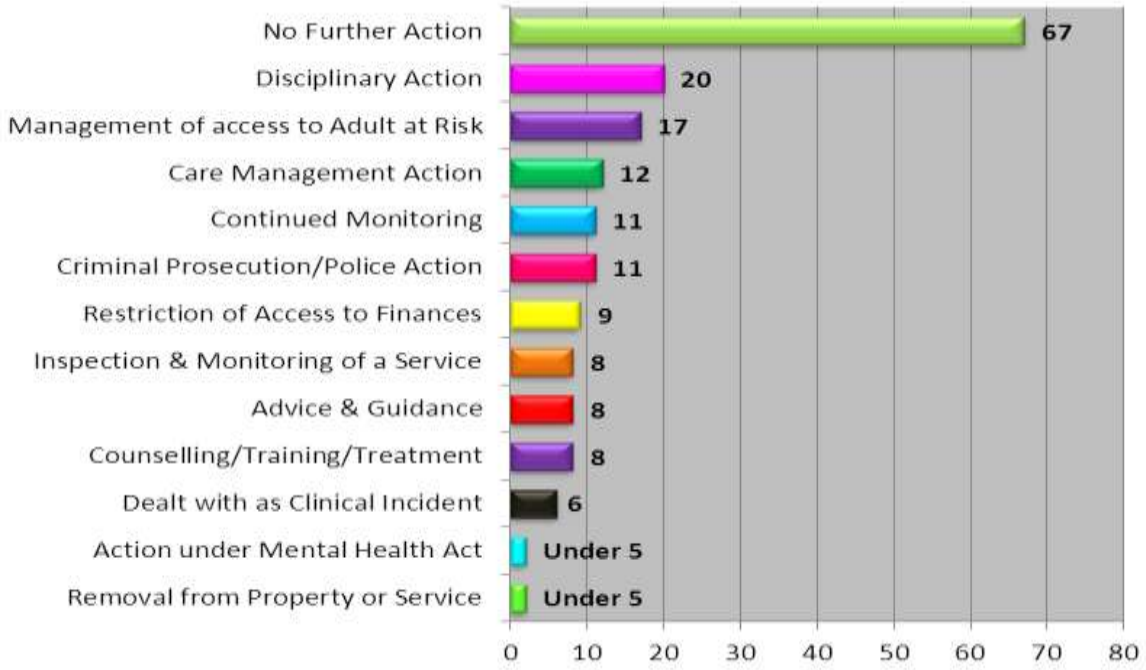
There were 34 cases where action was required by the provider. This could include disciplinary action, action under their complaints procedure, staff training (or retraining) and changes to in-house procedures.

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

The following chart provides an overview of the outcomes for the person or persons alleged to have caused harm. Again a number of the cases required no further action. This could be due to the alleged victim requesting no further action or that the action required focussed on the alleged victim (for example a review of their care plan). There

are 11 cases that required Police action or are pending a criminal prosecution. Although these cases may be shown as closed, there may be a need for further work for the teams if the case will require action in the Courts e.g. support to give evidence.

Figure 9 Outcomes for the person alleged to have caused harm



Where the outcome was to manage access to the alleged victim, this may include cases regarding incidents between residents in a care home (for example) requiring a change to a behaviour management plan or changes to living arrangements within the home to minimise or remove the risk of further occurrence.

On 6 occasions the outcome has been recorded as “dealt with as a clinical incident” i.e. a case that is being investigated by health professionals. It is believed that this should be seen as a method of carrying out an investigation rather than being seen as an outcome in its self. Teams involved in such cases need to see the result of these investigations to evaluate if it has addressed the issues raised in the original concern and consider the recommendations.

Case example

A neighbouring local authority raised a safeguarding alert because one of their service users was discharged from the hospital in Swindon and her family were concerned that the standard of care she received was poor. They also noticed severe bruising which was inconsistent with their mother’s lifestyle and she was quite disorientated. The matter was opened as a safeguarding investigation in Swindon (as the alleged abuse (or neglect) took place in Swindon) and evidence that was provided enabled an early assessment of the bruising which indicated that it was more likely to be caused by a new medical condition rather than abuse. The Police were satisfied that there was little evidence of wilful neglect and ill treatment. However, there were still concerns about the standards of care and it was agreed by the safeguarding lead and the lead from the Clinical Commissioning Group that there should be a clinical incident investigation and dealt with as a complaint by the Hospital. The Hospital Trust carried out a thorough investigation and identified a number of issues that required addressing on two wards and what appeared to be a very open and honest letter was sent to the family who

raised the initial concerns.
Through the safeguarding process, the representative from the neighbouring authority was able to check that the family were happy with the response they received from the hospital and the Clinical Commissioning Group were able to ascertain that the changes recommended had been applied to practice.

Serious Case Reviews and Large Scale Cases

There were no Serious Case reviews held in Swindon concerning adults at risk however a Case Review was instigated towards the end of the year concerning the suicide of someone considered to be an adult at risk. The review will be using the SCIE (Social Care Institute for Excellence) Learning Together model. The review will be concluded during the middle of 2014/15, when the LSAB will consider its findings.

There were 4 large scale investigations set up following concerns raised about the conduct of specific care services requiring action either by the CQC or adult services commissioners. One of these cases remains open pending improvements by the provider and confirmation of improvements from the Care Quality Commission following a follow up inspection.

SECTION 3

Progress, developments and news in 2013/14

Priorities for 2013/14

As with previous annual reports, the headings (or domains) used in the regional Self-Assessment Quality & Performance Framework for Adult Safeguarding have been used as categories for the priorities in 2013/14. There is also information within this section on the Internal Audit on Safeguarding Adults carried out towards the end of 2013/14.

Prevention & Early Intervention

- *Ensure safeguarding is a key consideration in the tendering and procurement of process during the commissioning of all services.*
  The Operational Group of the LSAB has discussed this area with the intention of looking at standard paragraphs within contracts relating to Safeguarding. While consideration has been given to Council contracts, other organisations are still to share theirs. However some good practice has been shared and there is a need to revisit this item within the next few months.

- *Monitor compliance to safeguarding elements at all levels to ensure existing guidance is implemented.*
  There is still to be a new self-assessment process that has been developed by a regional safeguarding project which will be a good process to check compliance of this issue. The framework is still to be agreed but once it is issued the Operational Group will look at this.

- *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 where the Commissioning Team in Adult Services may make a decision not to make any placements or arrange any care packages within a service where there are concerns about their ability to provide care safely. As there has been a review of how the Care Quality Commission has been arranged and how they will be regulating services, this area has been looked at in light of this but does require revisiting. Care Quality Meetings with the CQC and Wiltshire Council are still taking place and suspensions of placements remains a discussion point during these meetings and a recommendation

- *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 took place with managers who coordinate investigations under the policy and procedures. The staff guide (No Secrets in Swindon and Wiltshire) was also updated and reprinted in respect of the policy revision. Copies of the Policy and Procedures may be downloaded from http://www.swindon.gov.uk/sc/Pages/sc-adults-safeguardingadultsatrisk(adultprotection).aspx together with the staff guide. The staff guide may also be obtained by contacting the adult safeguarding manager.

- *Reconvene the Wilshire and Swindon Policy and Procedures Sub-group*
  The Policy and Procedures Sub-group has been reconvened and has met on 3 occasions. There are now agreed terms of reference and further information about this group can be found in section 5.

Responsibility & Accountability

- *Work plan for the LSAB to be agreed for 12 months and presented to the LSAB*
  A Work Plan has been agreed and is now in place. It includes regular items for discussion and a cycle of yearly reports from board members.

- *Develop a Safeguarding Strategy in line with proposed Government legislation.*
  This is still outstanding as guidance has yet to be issued on what needs to be included in a strategy.

- *LSAB to agree a pathway to view, review and evaluate the Government policy to make appropriate changes as necessary.*
  During 2013/14, Boards were still waiting for the Care Act to be bought into legislation. It is now anticipated that this will now be April 2015 but action prior to that will be needed (see section 6 of this report).

- *The LSAB reflect any changes in government policy including the inclusion of new members.*
  Again, guidance is still awaited.

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.* A joint (adults and children's board) Awareness and Engagement sub group has been in place since April 2013 further information on this group can be found in section 5. The primary focus of this group is to address this priority.

- *Improve the information available to individuals who experience harm.* The Service User Forum has approved a booklet that can be used by alleged victims involved in the safeguarding process. It includes contact guidance regarding the staff involved in the safeguarding case, additional useful contacts details, and an outline of the process in easier words and pictures and information on staying safe. There is a need to issue this and funding is required to have it properly printed. The Service User Forum believes if it is presented well, it is more likely to be kept safe and used appropriately.

- *Establish a method of collecting feedback on quality that is independent from the teams investigating cases.*
  A method has been established giving the service user (or their representative) the choice about being interviewed following the closure of a safeguarding case. Take up has been quite poor so investigating managers have been reminded about encouraging this and obtaining appropriate contact information at the final safeguarding meeting. Information obtained from this is to be used for data required for national performance indicators. SEQOL have also started to collect service user

feedback by way of a questionnaire which is also being provided to 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.*

  Information is being collected regarding these areas. This also ties in with the previous priority relating to service user feedback.

- *The level of involvement of people who use services can be monitored and challenged as appropriate.*
  Information is collected regarding this matter and some improvements have been noticed. Further work is required to ensure the alleged victim is part of their safeguarding process as part of usual practice rather than by exception.

- *Continue to develop a Service Users Reference Group & develop the role of voluntary organisations to assist with involving people who use services*
  The Service User Forum is established and continues to work on developing its membership and range of service user groups that need to be involved.

Responding to Abuse & Neglect

- *Enhance sub-groups and ensure all partner agencies participate in these and the Operational Group*.
  See section 5 with regards to the LSAB and its sub groups

- *Each organisation is asked to give a verbal account to the LSAB Chair explaining " what safeguarding adults mean to us"*
  All member organisations of the LSAB are providing reports on a yearly basis. Members are asked to say what they are doing about safeguarding adults, how they are raising awareness within their organisations and how they are responding to national reports (where appropriate) e.g. the Francis Report into standards of care it the Mid Staffordshire Hospital Trust.

- *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 between the local authority and SEQOL and AWP. The LSAB will continue to discuss effectiveness of support to the Board.

Training & Professional Development

- *That a standardisation process is set up with training providers within the Private & Voluntary sector*
  This priority has not progressed as well as was hoped. Personnel changes within the Care Skills Partnership (who were to be instrumental with this objective) have meant

a delay in progressing this. A new Organisational Development Lead has been appointed and is engaging with the private sector to ensure a uniform approach to training around safeguarding adults. Further actions are required and will be included in the priorities for the coming year.

- *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.*

  Training has been provided for new Investigating Managers and Investigating Officers. Although training has been available for minute takers, it is not specific to safeguarding and the person who runs that training believes that there is little need to provide a different course for those who minute safeguarding meetings. During the year additional sessions have been arranged for Investigating managers and officers on specific subjects. These have included On-line Safety and 2 sessions on improving awareness around legislation and the Mental Capacity Act.

  During 2013/14, training was delivered by the Local Authority to:
  - Over 400 care staff or staff in roles where there is significant contact with adults at risk, received basic awareness training
  - 13 senior practitioners or team managers received Investigating Manager's Training
  - 10 social work staff received investigating officer's training
  - At least 80 staff in 5 GP surgeries received bespoke safeguarding training (basic awareness for health staff)
  - 33 staff working for AWP received specific safeguarding awareness training
  - 50 attendees benefited from 2 session concentrating on safeguarding and the law involving the Council's head of litigation and barristers from Field Court chambers
  - 30 Hospital Staff received a presentation on safeguarding as part of a session on the Mental Capacity Act
  - 13 Council Members received bespoke training which gave the opportunity for discussions about the scenarios Councillors may encounter as part of their role
  - 11 Investigating Managers and safeguarding leads attended a half day training session on On-line Safety and the risks that may be faced by adults at risk

- *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.*
  A questionnaire has been developed but there is still the need for the Care Skills Partnership to assist in the distribution and analysis of this. This will need to be included in the priorities for the coming months.

- *Review the training strategy in line with policy updates and changes to the delivery of available training.*
  The Training Sub-group has started this work

Audit of Adult Safeguarding

During 2013/14 the Council's internal audit department has carried out an audit into adult safeguarding. As it is considered a high risk area of work for the Council, it has been agreed that an audit of adult safeguarding would take place annually.
Below are the basic findings and actions arising from the audit, which have been included in the priorities for 2014/15 (section 6)

Overall the Audit has assessed that with the current controls, the risks to the Council are moderate. The Auditor has recommended a number of areas which need to be developed or considered for improvement over the next few months. These include:

- Consideration is given to the introduction of a single point of reporting for safeguarding referrals a single point for safeguarding alerts;

- The triage approach to prioritising safeguarding referrals should be reviewed on an annual basis by the LSAB;

- Activity about safeguarding needs to be reported more often to the LSAB and include other information (for example, how agencies stick to timescales);

- That when agencies report to the Board, they use an agreed self- assessment and they should be open to challenge by other Board members;

- The feasibility for a shared IT system to be used across agencies for recording safeguarding alerts , but if this is not feasible, for the Council needs to be able to access the Mental Health system;

- There needs to be more information of the webpages currently included in the wider Council's website, including information on the LSAB, available training and news about safeguarding;

- Information to the Board regarding staff training should be reviewed and to consider a standard format of reporting by all agencies;

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

Winterbourne View

A Concordat was issued following the Serious Case Review published in 2012 commissioned by South Gloucestershire Council as a result of abuse that took place in Winterbourne View (a private hospital for people with learning disabilities). This 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 the Hospital. A major priority within this was to see that individuals received personalised care and support in appropriate community settings no later than 1 June 2014.

In July 2013, there was a requirement for all local authority areas to complete a stocktake of progress against the commitments made nationally regarding future care arrangements for people with learning disabilities, autism and behaviour that

challenges. Overall the stocktake indicates that good progress has been made in Swindon in regards to the provision of suitable alternative placements for those previously residing in treatment and assessment units. Where specialist placements are still required, 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.

As the actions arising from the Concordat are mainly concerned with commissioning and future provision of services, the Health and Well Being Board in Swindon is monitoring local progress of the Concordat.

Making Safeguarding Personal

A national project was established in 2013 that was intended to ensure that victims of adult abuse had a voice. Often in adult safeguarding procedures the victim themselves were rarely involved in proceedings and the intention was to change this practice and involve the adult in the process at the earliest stage. SBC signed up to be involved in the project at the "bronze level" involving staff from SEQOL and the Mental Health Trust to develop the area. This included:

- Enhanced social work practice to ensure that people have an opportunity to discuss the outcomes they want at the start of safeguarding activity;
- Follow-up discussions with people at the end of safeguarding activity to see to what extent their desired outcomes have been met;
- Recording results in a way that can be used to inform practice and provide information.

Extract from the project launch document issued by the Local Government Association.

A working group was established and planned to ensure 15 cases would be picked to pilot this approach. It was agreed that the involvement of victims at the earliest stage should only take place when it was considered safe to do so. Experience has shown that sometime victims can react badly once they are aware an investigation is taking place, perhaps discussing the matter with the person alleged to have caused harm which could prevent a proper investigation taking place or worse, put the alleged victim at risk of additional harm or intimidation). The working group developed a risk screening tool to help assess the safety of involving the adult at risk at every stage. Unfortunately as the timeframe for the project was quite short, it was not possible to work with the number of individuals originally proposed. However 8 cases were progressed ensuring the Making Safeguarding Personal ethos was maintained. The learning coming out of the involvement in the project showed:

- There is still a need to change the mind-set of a number of investigating managers to involve the victim at an early opportunity rather than mid-way through the process which was becoming common practice (and previously enshrined in policy);
- There was a need to amend the training courses for investigators to include ascertaining the desired outcomes of the adult at risk (but not simply close the case if there was a reluctance to pursue a line of enquiry. There may be other actions required);
- To revisit the decision made (especially if there was a reticence on the part of the individual) at regular intervals throughout the process;
- That there was an appetite for a more person centred approach with safeguarding and some managers saw it as a "permission" to work differently;
- That there would need to be a relaxation within policy, especially in regard to timescales; and

- We needed to develop a service user guide that could be used by the service to keep a record of the safeguarding process.

A project report from Swindon was provided to the Local Government Association and included a case study that was used in the National Guidance developed by the LGA and was intended to be used in forthcoming regulations and guidance around the Care Act 2014:

Taking the time to maximise the involvement of the individual:

Mrs. T has been suffering with extreme depression and is an inpatient within a local mental health unit. Extended family members have heard that she has made a will and the main beneficiary is a "lodger" who pays Mrs. T a nominal, small rent. The family members are also concerned about the "state of the house". They raised a safeguarding alert citing financial/material abuse and neglect at the hands of the "lodger".
There was some discussion of these concerns with Mrs. T on the ward. However there was concern about her capacity to consider the issues fully in her present condition. She was not able to discuss her will or talk about the relationship between her and the lodger. Mrs. T was not well enough to participate in assessing the concerns raised or in making any decisions. She did not however indicate any negative feelings towards the lodger. She agreed for social services to visit the house to consider if there would be any need for assistance once she was discharged home. It was decided to go back to Mrs. T when her condition had improved to revisit the concerns rather than initiating a full safeguarding response immediately.
A visit to the house by the care coordinator took place, and no concerns regarding the neglect outlined by extended family were noted.
After two to three weeks Mrs. T was able to discuss in detail the arrangements she had with the "lodger" and her views about recent contact with extended family members. She talked fondly of the lodger. She felt the contribution he made to the household budget was adequate, that he was good company and that he provided day to day practical support. The safeguarding adult's process was explained to Mrs. T and she did not want any further action taken in this regard. She was supported to speak with her family who were informed of the outcome. The family accepted this and the case was closed

During 2014/15 there is an intention to extend the Making Safeguarding Personal project nationally. Swindon has submitted an expression of interest to be involved again, but the working group are keen to consolidate the learning from the initial project before advancing "to the next level". There is also a need to secure funding for the service user guide.

SECTION 4

Swindon Mental Capacity Act Programme

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

Submission by John Hughes: Head of Policy Adult Social Care

Last year's report *Safeguarding Adults in Swindon 2012/13* referred to the Official solicitor pursuing an appeal to the Supreme Court regarding the Cheshire case. The appeal on this case, and that of 2 sisters P & Q, was heard before 7 Judges in the Supreme Court in November 2013. Judgement was not handed down until the 19th March 2014. As the judgement was regarding the way that existing law should be read is interpretation had immediate effect. Initial estimates regarding a national effect of a ten fold increase in the numbers of Deprivations of Liberty Safeguards began to emerge at the end of the 2013/14 period covered by this report. The actions taken to pursue legal compliance will be reported in next year's report. The Supreme Court did not define a Deprivation of Liberty but gave an "acid test": Is someone, without the capacity to choose where they live and the nature of support that they need, under continuous supervision and control and not free to leave". The court ruled that the absence of objection by the individual was of no relevance in ascertaining if someone is deprived, nor is the quality of the environment within which they are placed. Lady Hale, who led on the judgement, stated that "a cage, no matter how guilded, is still a cage"

The Supreme Court Judgement was handed down days after the publication of the House of Lords select committee post legislative review of the Mental Capacity Act 2005. This was a generally critical document calling into question the fitness of purpose of the Deprivation of Liberty legislation and guidance. The government's response to this report was outside of the reporting period but it is worth noting that the gist of that response is that it does not accept the need for root and branch change but does recommend ways of clarifying and streamlining processes which are timetabled for introduction in 2014/15 and will reported on next year.

During the period as a whole 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. Clearly we can anticipate considerably different figures in next year's report

Table 1: Swindon Deprivation of Liberty Safeguards Service

	Swindon Borough Council	NHS Swindon (CCG)	Combined Total
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	**61**	**25**	**86**

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

Court of Protection (CoP).

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

Apointeeships and Deputyships held by the Council:

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

The upward trend in Deputyships has continued to stall . There were 60 at the end of March 2014 compared to 59 at the end of the March 2013.

The downward trend in Appointeeship numbers has reversed almost back to March 2012 levels standing at 183 at the end of March 2014. In March 2012 the number of Appointeeships were 185 whereas at March 2013 this had decreased to 165

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), which during 2013/14 consisted of the following Members:

Independent Chair
Board Director, Commissioning (DCS/DASS), Swindon Borough Council
Head of Commissioning Children & Adults, Swindon Borough Council
Head of 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
Board Director, Service Delivery, Swindon Borough Council
Care Quality Commission (annual attendance)
Wiltshire Probation Trust
The Local Safeguarding Children's Board
Swindon Care Homes Association (service providers representative)
Healthwatch Swindon
Learning Disability Partnership Board
LSAB Service User Forum

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

- Francis Report: Reviewed what work agencies were carrying out in response to the Francis Report into the failings in The Mid Staffordshire Hospital Trust;
- LSAB Risk Register: Reviewed areas of risk and how the board and its partners need to work to minimise these risks;
- Discussion on areas of concern for LSAB: Safeguarding & Dementia, Isolation and the impact on adults at risk;
- Service User Forum: Quarterly updates on membership of the Forum and agenda items discussed;
- Joint Policy & Procedures Sub-Group: Terms of Reference (for sign off) – agreed by the Board;
- Care Quality Commission: The re-organisation of the Care Quality Commission;

- Making Safeguarding Personal: An ADASS and LGA pilot project around Making Safeguarding Personal with regular updates on progress and conclusion of the project; (see section 3)
- Operational Group: Review of the Chair and function of the Operational Group. Also quarterly updates on the work of the group;
- SCIE (Social Care Institute for Expense) Adult Case Review: Outlined a SCIE Adult Case Review with quarterly updates;
- Safeguarding Performance Activity: Reviewed performance activity for the year;
- Policy & Procedures: Discussed the revised Terms of Reference and annual Policy review;
- Items for information only: Swindon Protocol between Health & Wellbeing Board and LSAB, Domestic Abuse reduction Strategy 2013/14, London Tri-Borough National Safeguarding Bulletin, Safeguarding & NHS Reforms;
- See the Adult, See the Child;
- Winterbourne View Action Plan: Reviewed actions to ensure they were completed within timescales;
- LSAB Business Plan: Reviewed and updated the LSAB Business Plan - the Board adopted the plan; and
- LSAB Budget: Discussed future funding of the Board when it becomes a statutory body.

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)

AWP are committed to continue working effectively with our local safeguarding multi-agency partnerships.

Each locality within AWP will ensure they actively participate with local processes for:

- Safeguarding children;
- Safeguarding adults;
- Domestic abuse - (including their involvement in Multi Agency Risk Assessment Conferences (MARAC);
- Multi agency public protection arrangements (MAPPA); and
- Prevent and Pursue - the Trust has a procedure to advise staff on identifying and managing Prevent and Pursue cases.

  (Prevent: working with individuals who may be at risk of involvement in violent extremism and terrorism before they become involved in actual criminal actions or plans.
  Pursue: aims to detect threats from individuals and groups who are involved in the planning or undertaking terrorist acts at the earliest possible stage, and informs all NHS staff on what they need to do if they identify concerns that someone is planning or involved in terrorist acts.)

AWP are represented by the Managing Director and Head of Professions and Practice at the Local Safeguarding Adult Board and Safeguarding Children's Board meetings.

Dedicated leads for the Locality represent AWP at the relevant MARAC, MAPPA and Prevent and Pursue meetings.

AWP have arranged Safeguarding Awareness training across the teams within the locality, these have been facilitated by the Adult Safeguarding Manager within SBC and have been extremely well received. AWP have the desire to jointly facilitate further training within the Locality and the Head of Professions and Practice has undertaken discussions with the Trust's Safeguarding Team in Bristol and will continue to pursue this further in 2014/15.

It is felt that following regular attendance at local meetings and training events, safeguarding awareness has significantly improved within the staff groups, which has been demonstrated by the increase of safeguarding alerts regarding people of working age and the adoption of the Primary Care Liaison Service (PCLS) becoming the single point of access for Safeguarding concerns.

AWP continue to demonstrated a willingness to engage with other agencies and learn from serious incidents, which has been demonstrated by its active participation within the SCIE Learning Together, Case Review process referred to in section 2.

2.2 Great Western Hospital Foundation NHS Trust

The Great Western Hospital NHS Foundation Trust's general objectives for Safeguarding Adults are:

- To provide leadership at all levels that fosters a culture that does not tolerate abuse, neglect or poor care but is able to identify, raise or report (whistle blowing) any such concerns in order to maintain the safety and standard of care; and
- Work with partner agencies to prevent abuse and improve the outcomes for Adults at Risk of harm or neglect.

Achievements in 2013-14

The major achievement of 2013-2014 for the Trust has been the implementation of a specialist, dedicated Safeguarding Adults at Risk Team to provide both support and guidance to Trust staff re Safeguarding Adults, Mental Capacity Act and Deprivation of Liberty Safeguards and to support Trust development of policy, procedure and strategy. The Trust's Safeguarding Children and Adults Forum in 2013-2014 developed a joint Trust wide Safeguarding Performance Framework which includes a Safeguarding audit programme for adults and children and a safeguarding assurance dashboard. The Trust also has in place a Department of Health self-assessment action plan.

Breakdown of figures for safeguarding adults' staff training within the year

In 2013-2014, 975 Trust staff completed face to face Safeguarding Adults, Mental Capacity & DoLS training as part of the Trust Induction programme. This accounts for 87% of all new starters.

2716 Trust Staff completed the Safeguarding Adults at Risk training online between 1st April 2013 and 31st March 2014 and 892 people completed the MCA & DoLS training online.

Moving into 2014-2015 the Safeguarding Adults at Risk team will work closely with the Trust's Academy trainers to develop the current Adults at Risk mandatory training programme and are developing systems to test knowledge including an overarching Safeguarding Adults audit programme.

Outline key plans or objectives for safeguarding adults in the coming year

- The Trust has a Safeguarding Adults Peer Review with SEQOL planned for quarter 3
- The Trust will integrate a Safeguarding Adults audit programme; to commence with a Directorate and Trust-wide service evaluation of Safeguarding, application of Mental Capacity Act and Deprivation of Liberty Safeguards with further development of Audit programmes to support quality assurance.
- The Trust's Annual Safeguarding Forum is planned for July 2014 with key speaker, Niall Fry from Department of Health confirmed.
- The Trust will continue to develop internal reporting and quality assurance processes and systems via the Specialist Safeguarding Adults At Risk Team.
- The Trust will continue its commitment to the Safeguarding Adults agenda by continued development of training packages and systems which empower and support staff.

2.3 Healthwatch Swindon

Healthwatch Swindon has been represented on this board and the children's safeguarding board since August 2013. Whilst the priorities and work programme for Healthwatch were being determined by our own Board during the year, a fundamental aim remained our intention to meet the recommendations set out in "Establishing Local Healthwatch - Dignity, quality and safeguarding adults" published by the Local Government Association in December 2012. All those associated with Healthwatch need to know how to alert locally and appropriately if there are concerns about harm and abuse to individuals or groups. This will continue to form part of our staff and volunteer induction programme.

As part of our scrutiny work during the year we have worked to understand whether services are of sufficient quality to protect people's dignity and rights, that people know how to keep themselves safe and how to get help if they need it. Our contract with Swindon Borough Council includes the provision of independent complaints advocacy for NHS complaints. Work with individuals through that and other contacts with local people has and will continue to suggest on occasion that alerting is required. We were pleased to be invited to attend meetings of the Great Western Hospitals NHS Foundation Trust Safeguarding Forum to assure ourselves of the work being undertaken there; and we are a member of the Quality Surveillance Group facilitated by the NHS England area team which allows us the opportunity to raise issues of concern in a wider, sub-regional context with commissioners.

2.4 NHS England

NHS England is an executive non-departmental public body. It works under its mandate from the Government to improve the quality of NHS care and health outcomes, reduce health inequalities, empower patients and the public and promote innovation. Its key responsibilities include:

- Authorisation and oversight of CCGs and support for their on-going development
- The direct commissioning of primary care, specialised health services, prison healthcare and some public health services (including, for a transitional period, health visiting and family nurse partnerships)
- Developing and sustaining effective partnerships across the health and care system.

NHS England has a single operating model and is largely organised into three functional areas, i.e. nationally, regionally and locally. Its safeguarding policy is due for publication July 2014 and will provide guidance of the expectation of its entire staff in relation to safeguarding. There is senior clinical leadership at all levels, including those with responsibility and expertise in safeguarding. The NHS England Local Area Team will each have a Director of Nursing who is responsible for supporting and providing assurance on the safeguarding of children and adults at risk of abuse or neglect. The Area Team have the responsibility to ensure the assurance of the safeguarding system is working across Primary Care and CCGs.

For 2014/15, NHS England Bath, Gloucestershire Swindon & Wiltshire (BGSW) Area Team will be focusing on gaining assurance on safeguarding competences across all staff groups within Primary Care, ensuring information and resources are available for staff to achieve the appropriate level of competence for their role. A system for providing salient safeguarding updates across Primary Care and embedding lessons learnt in practice across the whole range of vulnerable adult groups will be implemented.
In November 2013, NHS England was required to give evidence at the House of Lords inquiry into the implementation of the Mental Capacity Act 2005(MCA). Whilst gathering evidence for the inquiry, NHS England found a number of emerging themes relating to inconsistent application of the Act including training, patient/family and carer experience and access to advocacy. The findings of this inquiry have been published http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm
In anticipation of this report, the NHS England BGSW Area Team bid for a MCA/DoLS (Deprivation of Liberty) project was approved and implemented.

The outcomes we are aiming for are will be reported to the Swindon Mental Capacity Act Steering Group.

- To arrange patient/carer experience events to ascertain real time feedback;
- To identify with CCG colleagues, provider organisations and local authority partners specific local requirements and consider short term secondments/pump prime initiatives; and
- To establish a development programme for MCA leaders across the system to understand their local issues and explore best practice.
- The project started in April 2014 and will be reporting findings in September 2014. Following the report the Area Team will develop and implement an action plan based on the findings.

2.5 Public Health

During 2013-14, Public Health has become embedded in the Borough Council and development of the Joint Strategic Needs Assessment (JSNA) has formed a major focus for our work. As the JSNAs focus on issues that impact on individuals' health and target those who are most at risk or who experience health and social inequalities, safeguarding in its broadest sense is embedded in this process.

Where required safeguarding has been included more specifically. For example, the Adult Mental Health and Wellbeing JSNA includes a chapter on safeguarding and has highlighted the need to improve the implementation of Section 136 of the Mental Health Capacity Act; improve the implementation of the See the Adult See the Child protocol to ensure that the needs of the whole family are considered when dealing with vulnerable adults and improve the uptake of the Independent Mental Capacity Advocate (IMCA) service. The needs assessment predicts that with the demographic changes in the population of Swindon such as social isolation, family fragmentation and aging, the demand for the IMCA services will increase.

With regard to Deprivation of Liberty Safeguards, the needs assessment also highlights the need to improve awareness of Advanced Care Planning which should include mental capacity issues particularly when an individual is diagnosed with a condition that is likely to have an impact on mental capacity such as dementia, motor neurone disease, Korsakoff's, brain injury, Parkinson's Disease, Learning Disabilities etc.

Further work is required to ensure that safeguarding with regard to adults at risk are considered specifically in every Joint Strategic Needs Assessment or commissioned service.

2.6 SEQOL

SEQOL considers safeguarding adults to be a high priority and operates a zero tolerance policy in relation to abuse. It is constantly working to improve its management of safeguarding adult's investigations and is working towards national standards of 'Making Safeguarding Personal'. SEQOL strive to be a transparent organisation open to challenge and ever striving to improve its practice for the good of the customers it serves.

Training and Development

SEQOL have taken the national framework guidance and ensured that it has a training programme to deliver to ALL staff members to ensure they have had basic awareness training. This includes ensuring a tailored package of training is available for supported employees to both keep themselves safe as well as being aware of abuse of others. Focussed refresher training is being delivered to clinical staff in order to ensure timely identification of clinical concerns that require safeguarding investigation.
Reflective safeguarding groups have been set up for the different SEQOL areas to share and reflect on their safeguarding practice and share case examples, learning and concerns.

Improving Practice and Quality Assurance

Having taken part in the pilot of 'Making Safeguarding Personal' SEQOL are now developing the quality assurance process to ensure the key principles of 'Making Safeguarding Personal' are evident in practice. All areas of SEQOL are working to ensure that the individual is at the centre of the safeguarding process with their views and desired outcomes respected and recorded and their attendance at their meetings encouraged and facilitated wherever safe and appropriate to do so.
The LSAB Service User Forum has approved the satisfaction evaluation questionnaire now being used.
SEQOL are committed to continue to look at prevention and will work on a prevention project also working with Swindon Advocacy Movement around online safety.
SEQOL are looking at serious clinical incidents through their Serious Incident Review Panel who will ensure that they are reviewed for any safeguarding concerns.
Practitioners from all areas now have guidance and documentation to support service users who have capacity that choose not to take clinical or practitioner advice, making sure that they are fully informed around the decision and that this is well documented, this can be in relation to safeguarding decisions and any other perceived 'unwise choices'. SEQOL have developed a protocol that is intended to reduce the risks at the point where service users transition into adult services who have been under child safeguarding procedures.

Quality monitoring walkabouts have been commenced and every month a group from the leadership team, with shareholders, commissioners and front line staff, monitor how quality is delivered in a different area of SEQOL, this includes their understanding and compliance with safeguarding. The findings and the plans from these walkabouts will be collated and will be presented to SEQOL Quality Forum so members of the Board can

be assured around this element of quality, any areas specific to adult safeguarding would be fed directly to the SEQOL Safeguarding Lead and subsequently available to LSAB through the quarterly reports.

Improving working partnerships with all relevant agencies
With the new Safeguarding Lead in post for SEQOL, work is underway to ensure the working partnerships between all agencies are strong, transparent and cohesive.

2.7 South Western Ambulance Service NHS Foundation Trust (SWASFT)

South Western Ambulance Service NHS Foundation Trust (SWASFT) was formed on 1st February 2013 following the merger of the former Great Western Ambulance Service NHS Trust, which previously served the Swindon community, and South West Ambulance Service NHS Foundation Trust.
SWASFT is fully committed to the development of and contribution to the multi-agency safeguarding agenda. SWASFT is represented on the Swindon Safeguarding Adult Board by the Safeguarding Named Professional for the North sector of SWASFT.

SWASFT has a responsibility to safeguard adults in Swindon by acting as an alerter where there is a concern that there may be an adult at risk of abuse or neglect. Every contact with the Ambulance Service following a 999 call is an opportunity for assessment and ambulance clinicians are in a key position to raise concerns due to the nature of ambulance clinicians' work as visits are never pre planned.

Key Achievements in 2013/14

- Following organisational review new full-time post created and filled for a Safeguarding Named Professional for the north sector of SWASFT (covering the old Avon area, Gloucestershire and Wiltshire). This provides a local contact for safeguarding within SWASFT for all other agencies and provides the Trust with a strategic lead within Safeguarding in the north sector of the Trust. The Named Professional also provides advice service for all staff that need to discuss their concerns before referral.
- Establishment of internal Safeguarding Operational Group with representation from Education, Risk, Clinical and Information Governance.
- Dementia awareness for frontline staff included on the statutory mandatory training for 2013-2014. This dementia module covered care and management of dementia patients, safeguarding awareness and issues as well as increased awareness of dignity and respect in terms of management of these patients.
- Feedback process implemented to ensure, where provided by social care, staff who have submitted safeguarding referrals receive feedback. This ensures any learning that needs to occur following feedback from social care can be reflected on and met and also provides closure for the referrer following their referral. This was not routinely done before due to capacity issues within the team.

Key plans and objectives for 2014/15

- Development of new referral form to make referral process clearer and more robust for operation staff. The form will include more sign posting for information required and the form will be user friendly to ensure that staff can complete the referral in a timely fashion. The risk of radicalisation (Prevent) will also be included on the new forms as a cause for concern.
- Further expansion of the referral feedback process to ensure that there is continued reflective learning for staff to better ensure SWASFT referrals are of a good quality and include all relevant and required information.

- Module to be included on the statutory mandatory training for 2014-2015 to cover domestic abuse to include use of the DASH risk assessment, how to deal with a disclosure of domestic abuse, how to talk to victims alone safely and other domestic abuse learning and issues.
- Development of the workforce to include safeguarding champions within operational localities and clinical hubs.
- Development of intranet Safeguarding section to include signposting to contacts for staff (both social care and voluntary agencies), learning from SCRs, current issues on the national Safeguarding agenda and general advice and information.
- Basic awareness training programme for the Prevent agenda

2.8 Swindon Borough Council – Housing Services

Housing officers attend the training offered to help them understand the key issues and reporting procedures around vulnerable adults. Over the last 12 months this training has been particularly useful for housing officers working with older tenants in the Council's Sheltered Housing schemes.

An audit to ascertain who needs to attend Vulnerable Adult refresher training will be undertaken this year to ensure all housing staff are up to date with the Vulnerable Adult agenda and the training is already included in the induction training for relevant housing officers.

A training programme around Domestic Violence has just been completed for frontline housing staff and line managers and this learning will assist housing officers to support and keep safe all adults in Swindon.

It is planned for the Adult Safeguarding manager to be the Keynote Speaker at the AGM of Tenants Association for Sheltered Housing (TASH) in June 2014.
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2.9 Swindon Clinical Commissioning Group

The legislative and policy framework for safeguarding requires Clinical Commissioning Groups to make arrangements to ensure that in discharging their functions they have due regard to the need to safeguard adults at risk; and that appropriate arrangements are in place to meet their health needs.

During 13/14 the CCG has worked closely with the Swindon Borough Council Adult Safeguarding Lead and all provider safeguarding leads to strengthen both safeguarding arrangements in respect of commissioned services and to ensure there is continued learning across the whole health and social care community in respect of any safeguarding investigation.

March 2013 saw the publication of the NHS Commissioning Board accountability and assurance framework, Safeguarding Vulnerable People in the Reformed NHS (2013). It clarified the role and responsibility of each of the key players for safeguarding within the reformed NHS, outlining how the new system will operate and be held to account both locally and nationally, detailing the key elements of effective safeguarding arrangements which include strong leadership, committed partnership working , investment in effective coordination and robust quality assurance of safeguarding arrangements. Whilst the framework focused on the statutory requirement to safeguard

children, it made clear that the same key principles applied to the arrangements to safeguard adults.

Before May 2014 there was no single coherent framework in respect of Safeguarding Adults. This has now changed when the Care Act 2014 gained Royal Assent. Prior to this there was only a duty for NHS organisations to comply with a range of legislation including the Equality Act 2010, Human Rights Act 1998, Health and Social Care Act 2008, Mental Capacity Act 2005 and the Safeguarding Vulnerable Groups Act 2006. Providers of health and social care services are also required to comply with the Care Quality Commissioning Essential Standards for Quality and Safety to ensure that people who receive services are protected and receive the expected level of care and support that they need.

A key responsibility for the CCG has been to ensure that the organisations from which they commission services provide a safe system that safeguards adults at risk from abuse or neglect. In seeking this assurance the CCG monitors health care providers against which a number of quality indicators are reported.

The CCG has been represented at the LSAB by the Associate Director for Quality and Patient Safety. In addition the integrated commissioning arrangements in place between the CCG and Council have supported a number of quality assurance systems and processes, notably a joint approach to quality assurance that supports monitoring of commissioned services, including care homes where it has been agreed as being supportive for both the CCG and Council to work together.

The CCG is an active member of the Safeguarding Adults Operational Group, which provides assurance in line with the requirements of the LSAB business and work plan. A key improvement initiative for the CCG during 2013/14 was to strengthen multi agency learning in response to root cause analysis investigations. The Strategic Executive Information System (STEIS) is a national database utilised by NHS healthcare organisations in order to report, investigate and share learning from serious incidents. Collaborative working between the CCG, healthcare providers, LSAB and Safeguarding Adults Operational Group has enabled improvements in shared learning. Further development of collaborative investigation and learning processes with regard reported serious incidents will continue to be a key focus for the CCG during 2014/15 and beyond.

Safeguarding adults will continue to remain a key priority for the CCG during 14/15 especially in view of the Care Act which states that local CCG must be represented on the LSAB. With the investment in additional quality and patient safety resource within the team, we will be establishing further the assurance of safeguarding and monitoring of all commissioned services and continued need to embed all CCG Francis Report recommendations that aim to improve safeguarding and patient safety.

2.10 Swindon Community Safety Partnership

The Community Safety Partnership (CSP) is a multi-agency approach that includes the local authority, the Police, Public Health, the CCG, Wiltshire Fire and Rescue and Probation to address issues in relation to crime and disorder, drug misuse and public protection. The CSP are keen to continue its links with the work of the LSAB and the

agencies engaged with safeguarding adults at risk. There are two key areas where these links need to be maintained: Domestic Abuse and Anti-Social Behaviour

Domestic Abuse:
The Domestic Abuse Reduction Strategic Lead within the CSP is a member of the Operational Group of the LSAB and the Adult Safeguarding Lead attends the Domestic Abuse Steering Group. The attendance at both of these meetings is in recognition of the links required between adult safeguarding and services supporting people who are victims of domestic abuse. Domestic abuse can be prevalent in households where adults at risk live, or between couples who are both adults at risk. It is essential that Safeguarding Investigating Managers are aware of the frameworks that exist around domestic abuse, and to consider this as being a more appropriate method of intervention especially where it appears attempts to manage an allegation of abuse through the safeguarding process has not been successful. Also the Domestic Abuse reduction process can run in tandem with the safeguarding procedures. Managers also need to be more aware of the opportunities that may be offered by referring cases to Multi Agency Risk Assessment Conference.

Case example

An allegation of abuse by her partner had been made by Susan, a service user with learning disabilities. This was raised as a safeguarding concern by her care manager, but it quickly became apparent that she did not want to “make waves” and did not want the allegation pursued. Despite this, a safeguarding meeting was held as there were continued concerns about the risks to Susan and whether she was making decisions under duress. It was agreed to complete a DASH Risk Assessment and a referral would be made to MARAC. The agencies in attendance were able to put in place some strategies to help Susan including arranging contact with Swindon Women’s Aid and setting up processes whereby other people in the community can alert should there be further concerns prompting intervention by the Police. Arrangements were made to supply Susan with a mobile phone which she could keep somewhere her partner would not easily find. A flag was also put onto the Police system so if she called in they would have an awareness of her needs and prioritise response.

Anti-Social Behaviour:
As illustrated by some high profile cases in the national media, links with teams managing safeguarding procedures and the Anti-Social Behaviour Team are essential if there are reports of adults at risk of being victims of anti-social behaviour perhaps at the hands of their neighbours or others in the community. The team have also been involved directly in assisting in a multi-agency approach where adult abuse has been alleged against an individual. Support has come in the form of information sharing about an alleged perpetrator or other adults at risk who may be affected similarly, making direct contact with other agencies that are able to support an investigation and in a few cases, being able to make contact with alleged perpetrators directly with an outcome to change their behaviour. Because of the links with the wider community, the ASB Team have also managed to use their contacts to monitor situations where there has been reluctance on the part of the alleged victim to accept support from and of the agencies involved.

Case Example

Mrs Henderson has been a victim of physical abuse by her grandson. This came to the notice of agencies as she raised it with her care manager while her grandson was in prison. (It was believed that Mrs Henderson felt safe to make a disclosure while he was absent). However, as his release from prison came closer, she became more and more reluctant to engage saying "he's a good boy really, as long as he doesn't take drugs". It was also reported that a number of their neighbours were fearful of his release. As part of the safeguarding process, a member of the Anti-Social Behaviour Team helped to get evidence from the neighbours as "hearsay evidence" to obtain some legal restrictions to prevent the grandson's access to the house. Mrs Henderson was able to maintain contact by visiting him in his supported living environment to which he moved on release from prison or she met him in public. Both meeting places meant that a physical assault was less likely or at least would be witnessed and where others could intervene.

There is an emerging issue in Swindon with dangerous drug networks, and concern that these networks could exploit the most vulnerable in the community to start local networks up. We have started a program of training to highlight this issue and what intelligence is required for the police to take action. This training will be delivered to Seqol shortly, with a continuing focus of delivering this training to those officers in need. The ASB Team also recognise the importance of a continued emphasis on safeguarding adult training, and refresher training will be provided to the whole team in the forthcoming year. It is also a requirement for new officers to attend this training at the earliest opportunity.

Finally the CSP team will work with the partnership governance structures to ensure safeguarding adults are considered in the wider CSP policies context, and proactively consider the impact of the forthcoming Care Act 2014 and its implication to this agenda

2.11 Wiltshire Police

The Wiltshire Police Safeguarding Adult Investigation Team (SAIT) consists of specially trained investigators. The team consists of a Detective Sergeant, 6 investigators, a decision maker and an administrator. The strategic lead for Safeguarding Adults is the Detective Superintendent of the Public Protection Department

Wiltshire Police received approximately 1272 referrals between April 2013 and April 2014 covering Wiltshire and Swindon. From these referrals, 555 investigations were commenced by the SAIT. From the 555 investigations, 174 were for alleged financial abuse. Financial abuse cases are often complex in nature and involve dealing with fluctuating capacity, powers of attorney and applications for production orders through the Courts. The Safeguarding Adults Department are now referring the majority of their complex financial abuse investigations to the Wiltshire Police Complex Fraud Unit. A recent good example of this inter-force cooperation was the successful prosecution of a family member who had defrauded her mother of £150,000. The perpetrator received a three year sentence for this fraud.

Prosecuting wilful ill-treatment/neglect (as stated within the Mental Capacity Act 2005) is often a very difficult area to prosecute due to lack of witnesses or any other

corroboration. Wiltshire Police currently have a wilful ill-treatment/neglect case which is with the Crown Court. Further information about this case is not yet available.

The Safeguarding Adults team are trialling a decision maker to review all referrals into SAIT. The decision maker is very experienced in safeguarding adults. In Wiltshire all early strategy meetings involving the Police will be held via the telephone and the decision maker will take part in these strategy meetings. The decision maker will then allocate out any investigations to the investigation team. By utilising this process, we are saving valuable time which allows the investigators to investigate. The investigators will attend all relevant Adult Safeguarding Conferences and Reviews. This process was identified as good practice by the Police vulnerable adult lead in the South West region, D/Superintendent Paul Northcott.

SAIT are working very closely with Wiltshire and Swindon Adult Social Care and Health to develop a 'deep dive' toolkit to evaluate multi-agency investigations. The toolkit will enable partners to work together to evaluate the standard of safeguarding investigations and check that we are keeping the adult at risk at the centre of our strategies and investigations. The tool-kit is also being examined by Police Forces in the South West Region.

Another area the Police, Adult Social Care and Health are currently researching is a vulnerable adult risk management panel. This panel will assess adults at risk who maybe a risk to themselves but often fall outside safeguarding. The panel would involve key agencies such as Police, adult social care, health, housing, mental health, alcohol and drug agencies to share information and develop a risk management plan to coordinate our responses to adults at risk.

Wiltshire police will, in line with the policy and procedures for safeguarding vulnerable adults in Swindon and Wiltshire:

- Actively work together with partners within the agreed inter-agency framework based on the guidance contained in 'No Secrets' (2000 Department of Health, Home Office)
- Actively work together with partners within the agreed procedures, guidance and protocols underpinning this framework to investigate abuse and manage protection;
- Actively promote the empowerment and well-being of vulnerable adults through the services we provide;
- Actively support the rights of the individual to lead an independent life based on self-determination and personal choice;
- Recognise people who are unable to make their own decisions and/or protect themselves, their assets and their bodily integrity;
- Recognise that the right to self-determination can involve risk and ensure such risk is recognised and understood by all concerned, and minimised whenever possible;
- Ensure the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within all systems and legislation created to safeguard adults
- Ensure that when the right to an independent lifestyle and choice is at risk, the individual concerned receives appropriate advocacy, including advice, protection and support from relevant agencies;
- Ensure that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process;

- Identify others who may be at risk of harm, including children, and effect immediate referral to the appropriate authority;
- Recognise the on-going duty of care to service users who perpetrate abuse and facilitate any necessary action to address abusive behaviour;
- Actively promote an organisational culture within which all those who express concern will be treated seriously and will receive a positive response from management;
- Ensure rigorous recruitment practices deter those who actively seek vulnerable people to exploit or abuse;
- Ensure that all agencies working with vulnerable adults are familiar with this policy and the agreed procedures, guidance and protocols;
- Ensure that confidentiality and information sharing related to protection of vulnerable adults and perpetrators of abuse in a multi-agency context are maintained with the agreed protocols; *and*
- Ensure that all staff responsible for managing and conducting investigations within these procedures receive the appropriate training and support.

The aim 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.
- To prevent where possible, perpetrators from re-offending.
- To ensure that all staff are appropriately trained and accredited to recognise and respond to adult and child safeguarding issues
- 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.

2.12 Wiltshire Probation Trust

Structure and approach

The Director of Operations has responsibility for all safeguarding work and represents Wiltshire Probation Trust on the Wiltshire Safeguarding Adults Board. There are two middle managers who hold the operational responsibility to ensure that safeguarding policies and practice standards are cascaded to all staff in the organisation. Wiltshire Probation Trust is committed to providing effective and individualised support to all vulnerable adults who come in contact with the Trust.

Achievements

<u>Learning Disability Inspection</u>

In January 2014, Her Majesty's inspectorate of Probation completed a thematic audit on Learning Disability at Wiltshire Probation Trust. Although the formal findings have not been released, verbal feedback included:

- Inspectors were impressed with the professionalism and engagement of the staff they met.
- The use of mentors and health trainers to support work with offenders was commended and good examples of work being adapted to meet individual need evident
- Inspectors saw potential in the autism training and consultancy with SEQOL

There were clearly learning points as well. When the final report is published, a relevant action plan will be implemented to address these issues.

Autism Training and Champion

Swindon-based SEQOL was successful in winning a bid from the PCC Innovation Fund, with the assistance of Wiltshire Probation. As a first stage there will be a rolling programme of training for all Probation staff, volunteers and selected partner agencies; this training includes basic awareness training, and more specialised training in areas such as working with women with autism. The second phase involves group supervision with SEQOL clinical experts around cases on the Autism Disorder Spectrum. An Autism Champion has been appointed, who will act as a liaison between SEQOL and Operational staff and also offer advice and support.

Training

Across the whole Trust (Swindon and Wiltshire) 90 staff in this organisation have received Adult Safeguarding training in the last 3 years. This represents about 65% of the relevant workforce; training has been targeted at operational staff and those who have direct contact with service users. In the last 12 months, 47 staff have attended a half day Safeguarding Adults training sessions, specifically commissioned by Wiltshire Probation Trust to best meet the learning needs related to our area of work.

Key Plans and Objectives

1. The Transforming Rehabilitation Agenda has fundamentally changes how Probation services are delivered and from 2/6/14 will involve 2 organisations working with service users and other partners in the Wiltshire area (the National Probation Service and the West of England Community Rehabilitation Company.) The key challenge for the next 12 months will be to ensure good Adult Safeguarding practice and training is fully embedded in both organisations and that Partnership working remains effective.

2. Implement any recommendations from the Learning Disability Inspection.

3. Continue to ensure all new and current staff have access to relevant training (including refresher training)

4. Continue to support the victims of domestic violence through the work of the Partner Link worker and active contributions to other DV forum (ie MARAC, DV Disclosure Scheme)

3. Sub-groups of the LSAB

Operational Group met on six occasions during the year, with attendance from the following agencies: SBC (Head of Policy, Housing, Domestic Violence, Adult Safeguarding, Commissioning and Commissioner for Substance Misuse), Great Western Hospital Foundation Trust, Wiltshire Fire & Rescue, Wiltshire Police, Swindon Clinical Commissioning Group, SEQOL and Wiltshire Probation. The aim of the group is to carry out the work of the LSAB and be able to look at tasks and issues in greater detail and report to the Board as necessary.

Agenda Items during the year included:

- LSAB Business Plan
- Winterbourne View action plan update
- Emergency Department Action Plan (a paper tabled by the Great Western Hospital Foundation Trust to demonstrate their processes for identifying risk and making safeguarding referrals
- Homelessness policy
- Sheltered housing;
- Case discussions;
- Guidance for directors (a good practice document developed by the Association for Directors of Adult Social Services);
- The South West regional projects on developing safeguarding protocols
- Making Safeguarding Personal (see section 3);
- Developing the LSAB Work plan;
- Safeguarding and Clinical Incidents ;
- The Risk Register (discussion on a new entry required in light of services that have not been commissioned in Swindon emerging without securing the local support required);
- Mid-year performance information;
- Isolation – discussion about social isolation and how this may be a risk to some individuals;
- Swindon Safeguarding Guide (a service user guide being developed to help alleged victims with the safeguarding process); and
- Case discussions – the Operational Group will discuss current cases of interest or complexity, which is seen as a valuable part of the role of the operational group.

The Training Sub-group: This meeting aims to meet twice yearly with colleagues in Wiltshire and twice yearly in Swindon. The Wiltshire/Swindon group met on 2 occasions while the local group only met once.

- The Wiltshire and Swindon Group concentrated on forming the pan Wiltshire sub group and developing a work plan for the group. It also concentrated on bring policy into practice and identifying the training required to ensure robust safeguarding work.
- The Swindon group only consist of 5 key members and met to start the review of the Safeguarding Training Strategy which is due for renewal in 2014/15. The group also revised the “No Secrets in Swindon and Wiltshire” staff guide for Safeguarding Adults and agreed funding of a substantial print run.

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. The group meets quarterly and has been involved in engaging with “hard to reach groups”. The group has developed a database of community groups and has written to each of them individually offering presentations from representatives from adults and children’s safeguarding. The group was also involved in a campaign to raise awareness of the risks of cyber bullying. Thanks to the involvement of the group, this campaign has been extended to include adults at risk as there is an increasing concern that on-line safety is no longer an issue exclusive to children.

Service User Forum: Continues to meet but there is fluctuating membership. The LSAB Service User Forum has been strengthened by the addition of new members, however we have had to say farewell to a few who have moved on to employment or start education courses. Over the next year the chair of the group plans to recruit new members to join the current forum and wishes to extend his appreciation of member’s contribution past and present for their input into safeguarding in Swindon.
The Service user forum has met on 4 occasions and agenda items have included:

- Discussion regarding Service User feedback following and during the Safeguarding process
- Healthwatch update
- GWH Safeguarding Forum
- Discussion regarding Information Sharing vs Confidentiality
- Safeguarding: What Happens
- Working together to make Swindon safer
- Hate crime
- Vulnerable adults and homelessness
- On-line safety
- Discussion regarding social isolation
- Engagement of Hard to Reach Groups
- NHS England Accessible Information Project

SECTION 6

Priorities for 2014/15

The Care Act

During 2014/15 the Care Act received Royal Assent. In summary the main areas of safeguarding that will be included in legislation:

- For Local Authorities to ensure an enquiry takes place when *any person who is aged 18 or over and at risk of abuse or neglect because of their needs for care and support.* An enquiry should establish whether any action needs to be taken to stop prevent abuse or neglect, and if so, by whom;
- The setting up of Safeguarding Adults Boards;
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of safeguarding action; and
- For local authorities to carry out Safeguarding Adults' Reviews when (for example) an adult with care and support needs dies as a result of abuse or neglect and there is concern about how one of the member organisations of the LSAB acted.

The LSAB will need to consider the legislation and implications arising from this and the regulations that stipulate the action required by Boards, Local Authorities and their partners and member organisations.

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

- 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.

- Review the suspensions of placements policy.
- *This is required again, as it ties in with the way the Care Quality Commission regulates services is being changed. Sometimes the local authority needs to impose a suspension of placements if, for instance, the CQC decide that enforcement action is required and the Council or one of its partners considers that future placements puts people at risk.*

- Revision of the Policy and Procedures for Safeguarding Adults at Risk in line with the Care Act 2014
- *With colleagues in Wiltshire, a decision will be required as to how far the current safeguarding policy and procedures needs to change in light of legislation.*

Responsibility & Accountability

- Develop a Safeguarding Strategy in line with proposed Government legislation. *The LSAB will be considering its response before the end of the year. It is hoped that there will be specific guidance about what will need to be included in the local strategy.*

- LSAB to agree a pathway to view, review and evaluate the Government legislations to make appropriate changes as necessary.
  This work is required following finalisation of the Care Act Regulations expected autumn 2014.

- The LSAB to review its membership in light of legislation and regulations *to include the make-up of the board and seniority of individual members.*

- Activity reported to the LSAB needs to be more frequent and include quality assurance activity.
  For example evaluations of case file audits carried out by the Adult Safeguarding manager as well as the number of alerts reported and cases managed by individual teams.

Access & Involvement

- Consider the development of a single referral point for all safeguarding alerts. *As recommended by the Internal Audit of Safeguarding.*

- Consider a triage approach for alerts. (I.e. the screening of safeguarding alerts prior to being allocated to a specific team to manage an investigation). *Consideration for this was also recommended within the Internal Audit report*

- Improve the information available to individuals who experience harm. *A service user guide has been developed and needs finalising. Funding is required to arrange a print run to produce a good quality pack.*

- Encourage individuals (or their representatives) to provide feedback following the conclusion of the safeguarding process. *We need to be more rigorous in collecting information about how the alleged victim found the safeguarding process.*

- More work is required to ensure the involvement of individual victims of abuse and or their representatives at the earliest part of the process. *This ties in with developing the Making Safeguarding Personal project.*

- The membership of the service user's forum needs to be widened. *This is to ensure there is representation from a wider group of service users.*

- To include more information in the SBC website with regards to safeguarding adults and consider developing a specific website for the Board to include publication of minutes and planned training events. (Similar to that of the Local Safeguarding Children's Board).

Responding to Abuse & Neglect

- Enhance sub-groups and ensure all partner agencies participate in these and the Operational Group. *This action is still required as often sub-groups consist of the same people representing their organisations on many sub-groups and sometimes the board itself. This can lead to poor attendance.*

- 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 reinforced by recommendations within the internal audit.

Training & Professional Development

- That a standardisation process is set up with training providers with the private & voluntary sector and an audit of safeguarding training is carried out and evaluated by the Training Sub Group.
- *Closer ties with the Wiltshire and Swindon Care Skills Partnership are required.*

- Ensure that training for those involved in co-ordinating and investigating cases is relevant and up to date. *This is particularly required in view of the Care Act.*
- Run training for Provider Managers to include safer recruitment, prevention and allegations against staff
- Review the training strategy in line with policy update and changes to the delivery of available training.
  The Training sub-group should do this before November 2014 to ensure revised policy is reflected in any training required.
- 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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Glossary

ADASS	Association of Directors of Adult Social Services
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BGSW	NHS England Bath, Gloucestershire, Swindon & Wiltshire Area Team
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CSP	Community Safety Partnership
DAIT	Wiltshire Police Domestic Abuse Investigation team
DASH (risk assessment)	Domestic Abuse, Stalking and Honour Based Violence
DASS	Director Adult Social Services
DCS	Director Children Services
DoLS	Deprivation of Liberty Safeguards
DP	Direct Payments
DA	Domestic Abuse
GP	General Practitioner
GWH	Great Western Hospital NHS Foundation Trust
IMCA	Independent Mental Capacity Act
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
LGA	Local Government Association
LSAB	Local Safeguarding Adult Board
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NHS	National Health Service
PCC	Police Crime Commissioner
PCLS	Primary Care Liaison Service
SAIT	Wiltshire Police Safeguarding Adult Investigation Team
SBC	Swindon Borough Council
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SEQOL	SEQOL is the Social enterprise providing health and social care and support
SWASFT	South Western Ambulance Service NHS Foundation Trust
TASH	Tenants Association for Sheltered Housing
WF&RS	Wiltshire Fire & Rescue Service

The Safeguarding Adults at Risk in Swindon Annual Report 2014/15 is available on the Internet at???
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.
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