Safeguarding Adults in Swindon

Annual Report
April 2018 - March 2019

Swindon LSAB Safeguarding Adults

Avon and Wiltshire NHS Mental Health Partnership NHS Trust

Great Western Hospitals NHS NHS Foundation Trust

Swindon Borough Council

Swindon Carers Centre

healthwatch Swindon

Swindon Clinical Commissioning Group

Dorset & Wiltshire Fire and Rescue

Keeping Swindon Safe

sam Swindon Advocacy Movement

Probation

Safeguarding Adults in Swindon
Annual Report 1st April 2018 - 31st March 2019

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- *Please note, any names or initials referring to alleged victims used in case studies within this report are fictitious with the exception of case study on page 11*

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FOREWORD

Welcome to the Swindon Safeguarding Adult Board Annual Report 2018-19

The Safeguarding Adult Board is designed to bring together the range of organisations that deliver or commission services to support adults with care and support needs. In doing so, it aims to:

- Raise awareness of the need to safeguard adults with care and support needs and the risks they face;
- Create a culture of shared accountability for safeguarding adults with care and support needs;
- Understand how well agencies are safeguarding adults with care and support needs and
- Identify ways to improve how adults with care and support needs are safeguarded; including through the review of cases where an adult has died or been seriously abused or neglected.

This report provides an overview of safeguarding activity and, in particular, the nature of safeguarding adult concerns notified to the Local Authority and how these are responded to using the "Making Safeguarding Personal" (MSP) framework. The data indicates that in 52% of cases adults were asked about their desired outcomes in accordance with MSP; this indicates there is work to be completed to increase either the application or recording of the MSP framework. Of those asked, a high percentage of adults report their desired outcomes were either fully or partially achieved.

Physical abuse, neglect and financial abuse are the largest categories of abuse that result in adults with care and support needs being referred to the Local Authority. Just under half of these referrals progress to a safeguarding enquiry. It is hard to draw meaningful comparisons in terms of the conversion rate due to inconsistencies in the way Local Authorities categorise safeguarding enquiry activity. The most recently available national data is that 38% of all safeguarding concerns were converted to an enquiry. This report also provides some details of the response to the referrals that did not progress to a

safeguarding enquiry; this information had been requested to provide some assurance that a suitable response was provided to those cases that did not progress to a safeguarding enquiry.

Self-neglect referrals have increased by 90%; although the majority of these referrals did not result in action being taken by the safeguarding team. This indicates that there is a need further explore how agencies respond to adults who self-neglect in accordance with the 6 principles of adult safeguarding.

The Adult Safeguarding Board has been supported by contributions in kind by Swindon Council along with some financial contribution from Swindon CCG and Wiltshire CCG. The gap in dedicated resources has helpfully been addressed as part of the review of the safeguarding partnership arrangements that has been carried out. This is a positive development as safeguarding adult activity requires a multi-agency approach. A range of partners play a key role in preventing harm, positive risk management as well as undertaking safeguarding enquiries. I took up role in March 2019 and my early reflections are that the Safeguarding Adult Board needs to focus its efforts on bringing partners together so there is a whole system approach to safeguarding adults with care and support needs.

Prior to my arrival, domestic abuse/coercive control have been an area of consideration for the Safeguarding Adult Board. Whilst the governance of the response to domestic abuse sits with the Community Safety Partnership, this is an area of shared responsibility given the additional vulnerabilities of adults with care and support needs. To illustrate, approximately, 14% of safeguarding referrals referred featured domestic abuse. The Safeguarding Adult Board is awaiting a refreshed Domestic Abuse Strategy from the Community Safety Partnership and is keen to work with the Community Safety Partnership to ensure that the needs of adults with care and support needs are central to the local response.

Positively, efforts have been made to engage with adults with care and support needs however this has not resulted in the Safeguarding Adult Board being able to develop meaningful arrangements to engage with adults with care and support needs. The ambition to hear the voice experiences of those who receive services and/or their carers has rightfully been included in the new Safeguarding Partnership arrangements. This work, along with providing leadership and effective governance of the safeguarding system so services deliver their collective accountability to safeguard adults with care and support needs, and an enhanced learning and development offer for the multi-agency frontline should be the focus the focus of the Safeguarding Adult Partnership for 2019-20.

An important and final comment from me; in whatever role you have played, thank you for your contribution to the safeguarding adult agenda during 2018-19 . For 2019-20, I would ask that you champion the priorities of the Safeguarding Adult Partnership within your agency or community. (Please see on next page)

Adults

- To progress the business case to develop a more coordinated and consistent multi-agency contribution to a safeguarding adult front door for referrals and enquiries.
- To Complete Q3 and Q4 multi-agency adult audits which focus on; Q3 Are S.42 inquiries multi-agency in practice – and outcome? Q4 How effectively is the Mental Capacity Act applied in safeguarding practice?
- Complete timely Safeguarding Adult Reviews and Learning Reviews and develop action plans to improve quality of practice across the partnership with multi-agency involvement and ownership.
- To ensure our approach to Safeguarding adults is personal, person centred and outcomes focussed and meets the national framework of standards for good practice and outcomes in adult protection work.
- To enhance practitioner knowledge around neglect and self-neglect by gaining greater insight into self-neglect cases that do not meet S42 threshold, and improve pathways, guidance, tools & training and hold a self-neglect summit to share good practice across the Partnership
- To progress the 'Think Family' approach through the use of Joint assessments between adult and children's services following the recommendation from a recent Safeguarding Childrens review.

*See also Appendix 3 – Swindon Safeguarding Partnership Strategic plan 2019/20

Very best wishes

Liz Murphy
Independent Chair, Swindon Safeguarding Adult Board

1. Introduction

Swindon Borough Council is the lead agency for adult safeguarding arrangements in Swindon. Other statutory partners for safeguarding are Wiltshire Police and the Clinical Commissioning Group. The responsibilities of the Local Safeguarding Adults Board are in regard to those who:

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

The duties in regard to those referred to above are that:

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

The Board is required to develop a strategic plan and publish an annual report and is committed to working together to make Swindon safer for adults with care and support needs by co-ordinating and ensuring the effectiveness of work undertaken by local individuals and organisations in relation to safeguarding and promoting the welfare of adults. The Board is held to account by the Health and Wellbeing Board and will develop partnerships to fulfil its overall functions.

As lead agency, Swindon Borough Council has a team within Adult Services to consider safeguarding concerns raised and manage enquires as necessary. They may also arrange for enquires to be carried out by the appropriate social work or care teams and support these enquiries with advice and supervision. The team works closely with other services within the local authority, for example Community Safety or Housing Services. They may also arrange for enquires to carried out by other agencies.

The LSAB is in place to support adults who meet the criteria for safeguarding (listed above). The focus of the LSAB is around abuse and neglect and works towards prevention, protecting people when there is a concern, empowering people to participate in processes and ensuring there are proportionate responses.

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%). The 2017 midyear estimate of population from the Office of National Statistics puts the total at 220,363 (15.5% of this estimate are over 65 years old and 7% are over 75) At the time of drafting this report, more up-to-date data was not available. Based on the Joint Strategic Needs Assessment published in 2019 10,775 people, between 18 and 64, are estimated to have a moderate disability and a further 3,200 to have a severe disability. There are about 4,000 adults with Learning disabilities (LD) in Swindon ranging from mild to severe disability.750 people with a significant learning disability receive services from Adult Social Services In Swindon

There were 5,170 people receiving services from Adult Social Care in 2018/19, broken down into client groups as follows:

	Age Band 18-64		Age Band 65+	
Client Category (or support reason)	**Female**	**Male**	**Female**	**Male**
Learning Disability	*289*	*402*	*36*	*41*
Mental Health Support	*58*	*86*	*64*	*44*
Physical Support – Access and Mobility	*270*	*146*	*497*	*279*
Physical Support – Personal Care	*227*	*208*	*1427*	*766*
Sensory Support (Dual, Hearing & Visual)	*11*	*4*	*78*	*41*
Support with Memory and Cognition	*7*	*9*	*100*	*75*
Long Term Asylum Seeker Support	*1*			
Social Isolation		*1*		*1*
Substance Misuse		*1*	*1*	
Total Clients	***863***	***857***	***2203***	***1247***

There is a 5.86% decrease in the number of people being supported by adult social care, in 2018/19 compared to the 2017/18 figure of 5,492. This maybe as a result of an increased provision within the voluntary sector and the improved signposting to other organisations.

The Borough of Swindon is largely urban with small pockets of rural areas. Within Swindon there are some deprived areas which can also impact on levels of vulnerability for some of those living there. Crime volumes in Swindon and Wiltshire are low in comparison to other Police forces. In Swindon from March 2018 until March 2019, there were 17,390 reported crimes of which 301 were categorised as hate crimes, and of those 23 were disability hate crimes. Overall there was a 7.2% decrease in reported crimes. There is a commitment to partnership working in Swindon to: prevent Crime and anti-social behaviour; protect the most vulnerable in society; work in a person centred way and secure high quality, efficient and trusted services.

This Annual Report includes:

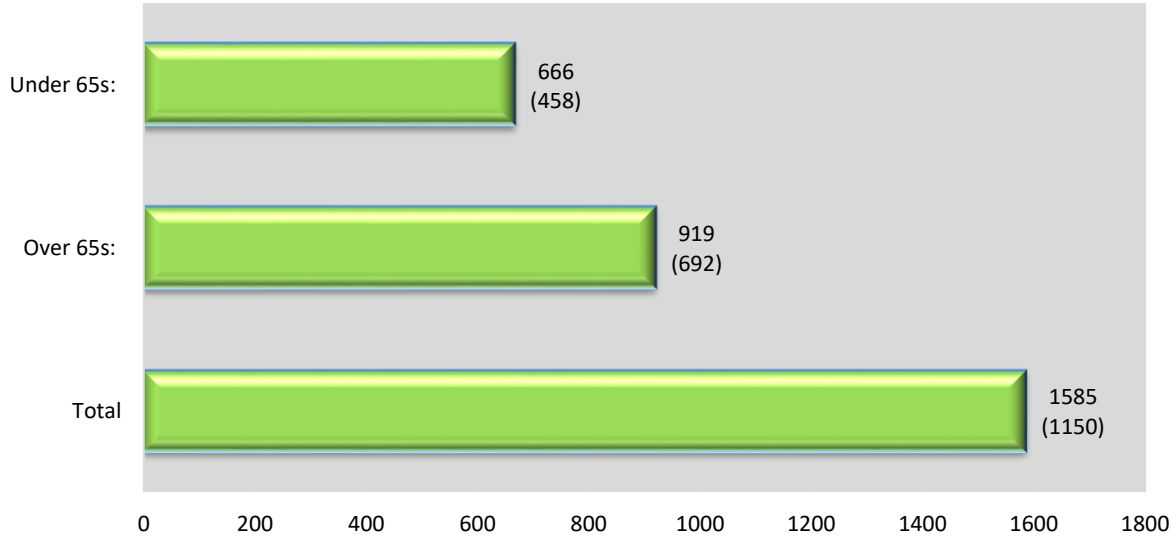
- How safeguarding adults is implemented: Information on activity and data collected throughout the year regarding safeguarding concerns and enquires made in line with local and statutory arrangements;
- The Impact of Safeguarding: An outline of the progress and updates during 2018/19 and reports from partner agencies highlighting their successes and challenges; and
- An overview of the priorities for the Board and development of the new Safeguarding Partnership 2019/20.

2. Implementation of Safeguarding Procedures - Activity Data 2018/19

(Figures in brackets relate to data in last year's Annual Report)

The following data has been collected from the Adult Safeguarding team to monitor performance. It is also used to meet Health and Social Care Information Centre requirements.

Figure 1: Total number of safeguarding referrals received



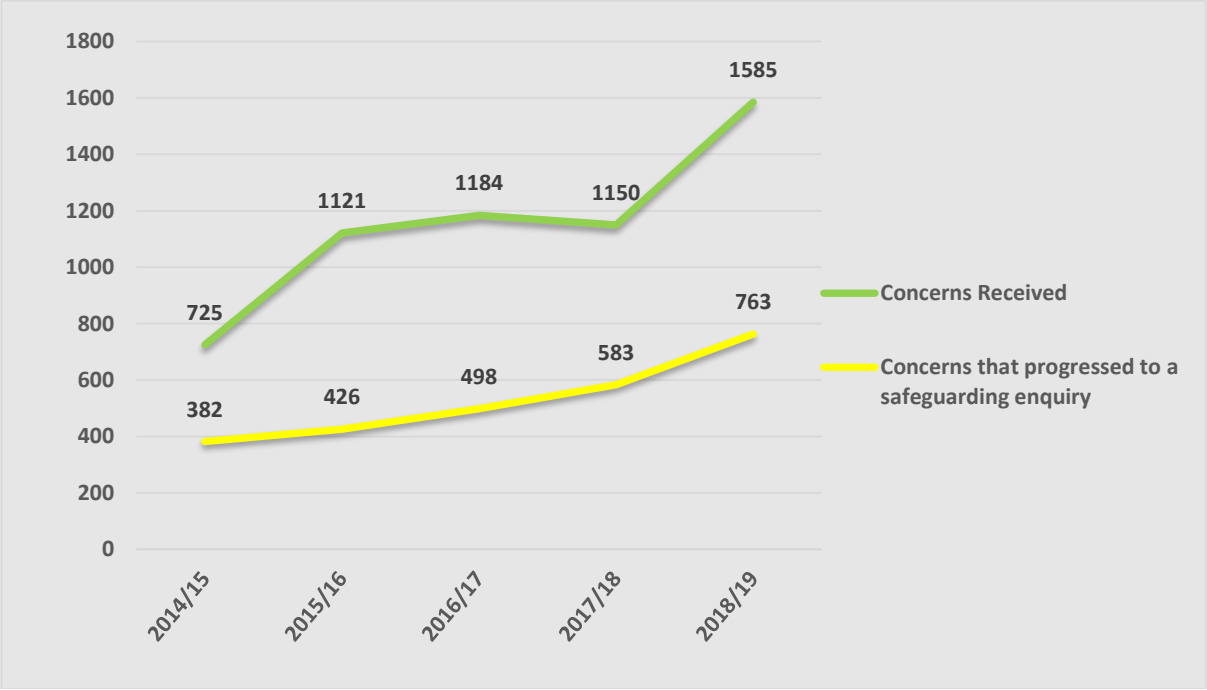
There has been a 38% increase in the number of concerns received by the Adult Safeguarding team. The reason for the increase is not clear, however those receiving and screening concerns have been less experienced and some of the referrals could have gone directly to the relevant Adult Social Care team for an assessment of need. Such an increase is not unusual as other local authorities are reporting similar numbers in relation to their population.

	No. Concerns	Progress to Safeguarding Enquiry	% progressed	Population	Rate of concerns per 100,000
65+	919	426	46.35%	35,174	2,612.73
18-64	666	336	50.45%	136,583	487.62
Total	1,585	762	48.08%	171,757	922.82

59% of the safeguarding concerns were female (39% under 65 and 61% over 65) and 41% were regarding men (45% under 65 and 55% over 65).

Information on the primary support reasons has not been included this year, as figures obtained are based on what was understood to be the support reason at the time of referral by the person raising the concern. 36% of these were recorded as “not known” or “no support reason” and is therefore not helpful in understanding the prevalence of abuse within service user groups. Only 119 concerns were attributed to people with a need for “support with memory and cognition”, half the number recorded in 17/18, and includes people with dementia. It would be expected that the number of concerns for this group of people would increase.

Figure 2: Chart shown concerns received and those progressing over 5 years



Of the 1,585 cases referred, 763 cases progressed to an enquiry, which represents a "conversion" rate of 48%. (See below for information about this in other local authority areas). 822 cases were assessed and did not progress through to a full safeguarding process. 403 of those required no further action by the Adult Safeguarding team (either because there was little evidence of abuse or neglect (or the risk of it) or the alleged victim did not wish to proceed or the alert was about a person who was not in need for care and support). 302 cases required care management input (a new care assessment, change to care plan or a review of their care). 26 were referred to another process, for example complaints action or action by the provider (e.g. disciplinary action). 46 alerts resulted in the individual being signposted to other services (for example Domestic Abuse services when the person did not have a care and support need, Neighbourhood Policing team to provide advice on home security). 39 cases were closed at the request of the individual concerned. Often in these cases further advice or guidance is given to the person should they experience any difficulties in the future and the team assess the situation to minimise any future risks.

Care Example
NHS 111 raised a concern as Rosie Mundy, aged 88, who self-medicates and had taken her medication for the evening in the morning. They categorised this as self-neglect (accidental overdose). Rosie's "carer" who arranges the medication but does not administer it confirmed that this was not the first time Rosie had done this and said Rosie was becoming more muddled about medication. NHS 111 staff flagged this up with Rosie's GP who said they would contact the family.

The case was screened out as not requiring a Safeguarding Enquiry and referred for the more proportionate action for the Adult Care team to arrange an assessment of Mrs Mundy's needs, which concluded that there was a need for increased care support with the management of her medication which was provided.

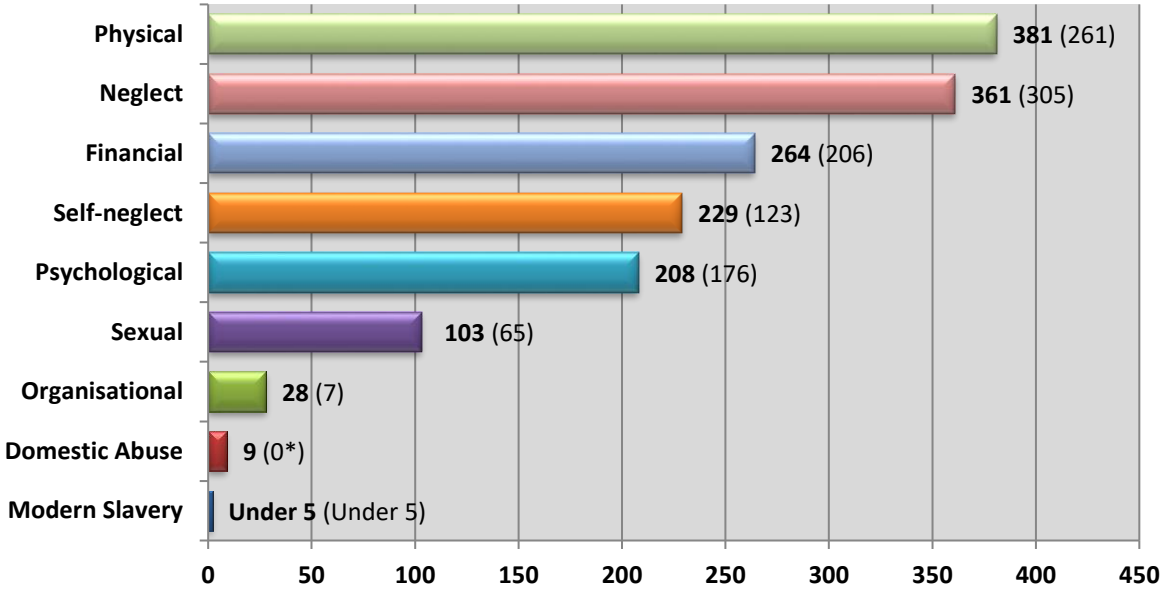
Comparisons with other area
In the main, the number of concerns coming into teams in the South West region are similar in the relation to their populations as Swindon.

Swindon continues to report a conversion rate of 48%. For the neighbouring authorities contacted to ask about their activity for this reporting period, conversion rates were:

LA1: 78% (although they reported that they do not start counting their concerns until they have been through a screening and triage process).
LA2: 17.6% (they report that a lot of action is taken outside the section 42 enquiry process but may still be included in their statistical information)
LA3: 50% (this local authority say they have an advice line that also serves to "filter" out some concerns)
LA4: 30% (this local authority has developed an advice and contact team which screens out concerns that previously went directly to their Multi Agency Safeguarding Hub).
LA5: 34% (however this local authority has 40% fewer concerns coming in although similar area in relation to population).

The national average for case converted to an enquiry (2017/18) was 38%. More up to date national figures will be available in November 2019 when NHS Digital publishes the annual safeguarding collection for 2018/19.

Figure 3 Types of Abuse Alleged



**not previously reported separately before January 2019*

There has been an increase in the number of concerns regarding physical abuse (this is greater than neglect which was the most frequent type of abuse reported in the previous year). While all abuse types have increased, the increase is not necessarily proportionate with the overall increase in concerns received. For example, self-neglect is almost 90% up on last year. This could be a reflection that more cases are being put through as safeguarding concerns unnecessarily (only 16% of these cases required intervention by the safeguarding team, while 71% required action by another team and 13% required no further action).

9 cases were reported as Domestic Abuse. This was previously not recorded as a separate abuse type but recorded against all cases as to whether domestic abuse was suspected in relation to any type of abuse, in recognition that most forms of abuse could also be domestic abuse. There were 217 case where domestic abuse was indicated on the referral form with the following types of abuse:

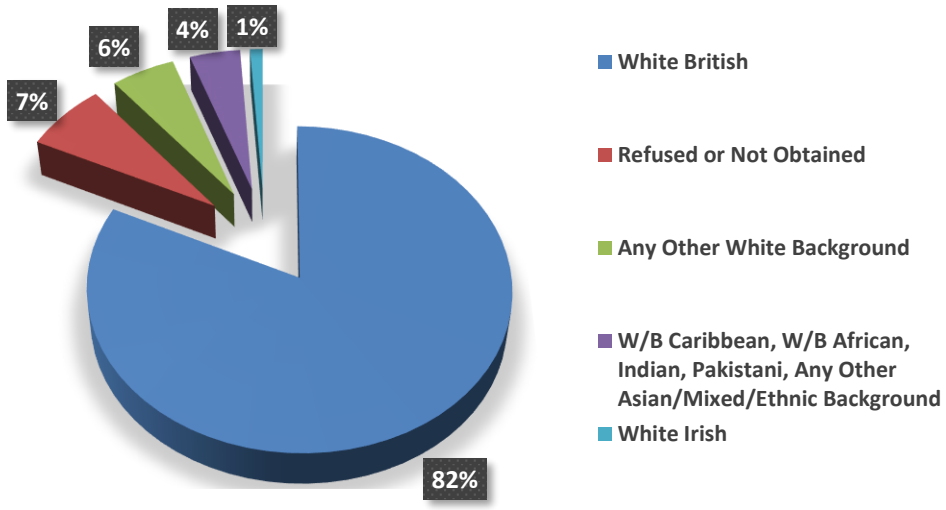
Physical:	92
Psychological:	68
Financial:	25
Sexual:	19
Neglect:	4

Case Example

The Ambulance Service raised a concern as they attended to a woman (Kelly) who had taken an overdose of medication. On taking her to hospital she disclosed that her husband was mentally abusive and manipulative. The safeguarding concern progressed to an enquiry but when contacted for her views and asked what outcomes she would like to be achieved from the enquiry, Kelly made it very clear that she did not want any action taken. The Enquiry Manager worked through the potential risks of her situation with Kelly and supported her to develop a self-management plan including contact with Swindon Women's Aid, liaison with her GP and the Mental Health worker at the hospital (she was assessed as requiring mental health services). Kelly had a plan to live with friends as a place of safety should she change her mind and leave her partner. Kelly was advised that she could contact Adult Safeguarding for further advice or future self-referral.

Most referrals come from care providers (455) with the next largest referrers being the hospital, ambulance service, adult services followed by mental health professionals. There has been a significant increase in the number of concerns being raised by GP surgeries (63). 35% of these cases progressed to safeguarding enquiries, with most of the others being referred to care management services. This increase could be due to the work of the named GP for Safeguarding who came into post during the year and has arranged a series of awareness sessions for GPs.

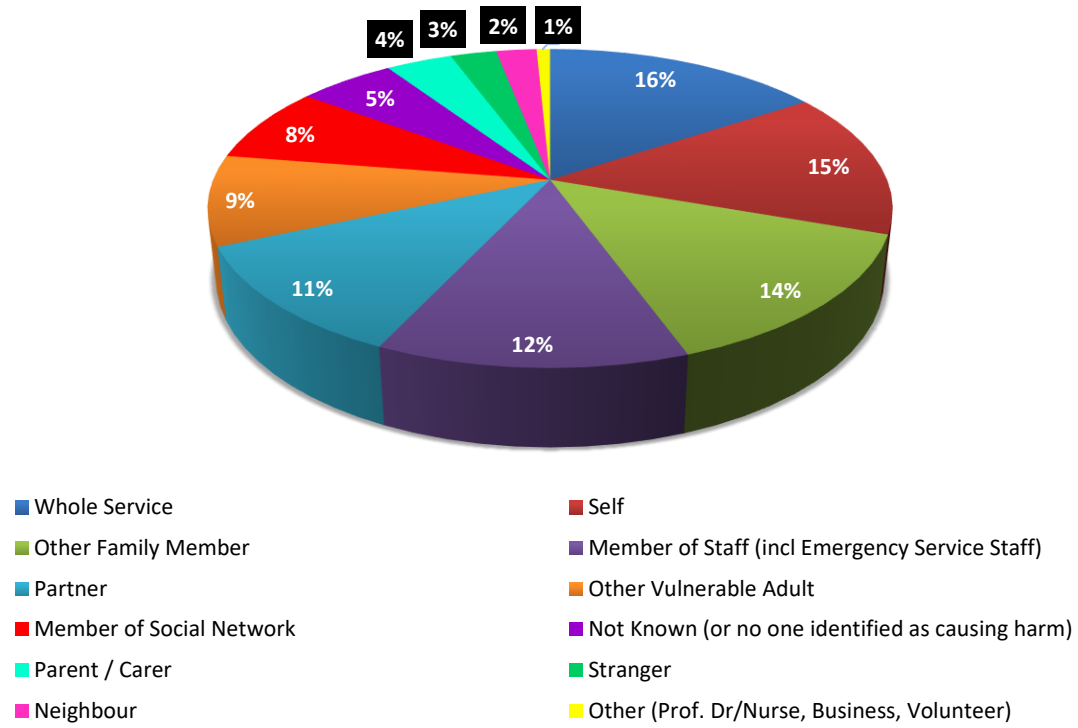
Figure 4: Ethnicity of alleged victims



For 2018/19 the number of referrals concerning non-white British people appears to be low. Overall the proportion illustrated above does not match the make-up of the wider population of Swindon based on the 2011 census. However, the numbers of those where ethnicity is not recorded is high. For some of these, the referral has not progressed to a safeguarding enquiry but there is also a lack of retrospective recording i.e. establishing ethnicity at a later stage and updating the records.

Further work is required to improve recording and the new care management recording system may improve this over time. Whether there is an issue of a lack of engagement with some groups needs to be given consideration with the development of the new Communication and Engagement Group.

Figure 8: Information on those alleged to have caused harm



There has been an increase in the number of referrals regarding whole service concerns: 248, of which 195 were recorded as neglect. These are often cases where an individual staff member was not identified or it was considered there to be organisational shortfall. 73 were concerns about a domiciliary care agency and 76 were regarding care homes. Where appropriate, large scale enquiries were held and providers were required to supply action plans that could be reviewed to check on improvement. 31 cases were regarding the hospital and for those that progressed to a section 42 enquiry, good quality clinical investigations were carried out and where necessary appropriate action taken.

While a substantial number of referrals were regarding family members or partners, there does not appear to be a significant increase in the number of cases alerted compared with last year. 377 cases were reported where the referrer said the person alleged to have caused harm had caring responsibilities. Physical and psychological abuse (both 102) were the highest type of abuse reported although the highest number of cases that

progressed to an enquiry were those reported as financial abuse, with 96 cases reported and 56 cases progressed. These cases can be very complex and take considerable time to complete and in most cases a risk identified and action taken which would indicate the concerns were substantiated.

Case Example
The Emergency Department at GWH raised a concern because one of their patients (Glenda) was admitted to hospital as the patient discovered that a family member had taken money from her bank account. This progressed to a Police investigation and a prosecution pursued.
After discussion with Glenda a multi-agency planning meeting took place at her home. Not only was it important for Glenda to achieve resolution, there was a need to plan her future as she was destitute and unable to pay her rent where she lived. The Police investigation continued while agencies safeguarded Glenda to ensure her health and safety and maintained her tenancy. The family member was convicted of theft.
This case is a good example of well-coordinated multiagency working.

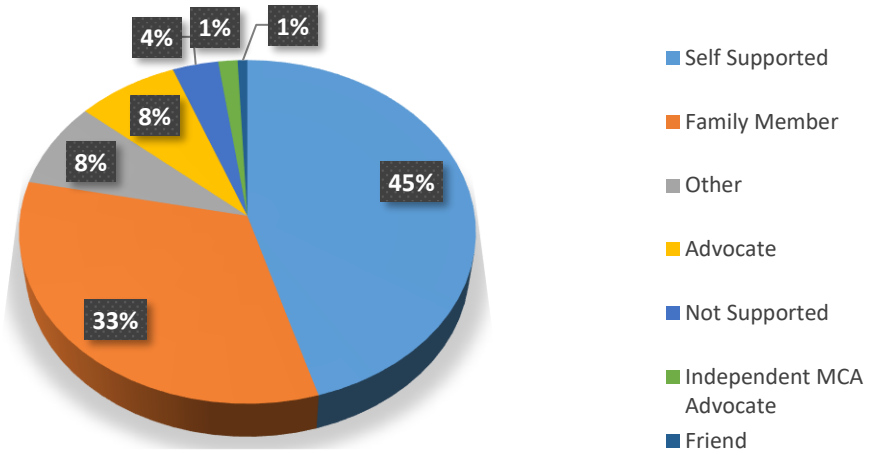
The majority of alleged abuse took place in the person's own home by a partner, spouse or other family member, with a substantial number having carer responsibilities which could signify some level of carer stress. This is unsurprising as this is where most people with care and support needs live and receive services and there is an emphasis on ensuring people can remain in their own home and maintain as much independence as possible.

The next highest number of referrals were raised from care homes (with or without nursing care). 69% of these were the services reporting themselves usually about a staff conduct issue or an incident between two of their residents. As previously reported, there has been a propensity to report minor issues to "cover ourselves". 52% of these cases progressed to an enquiry.

As previously stated, there has been an increase in the number of referrals reporting "whole service" concerns. Some of these required a whole service enquiry, particularly if the concern is a wider issue than a single incident of neglect (for example). This could be raised by the Care Quality Commission (CQC) following an inspection where the provider has been judged as inadequate or requiring improvement in a large number of areas.

Who Supported the Adult?

The Care Act stipulates that advocacy needs to be provided for adults who have a substantial difficulty in engaging with the safeguarding process and have no one else appropriate to help and support them. Swindon Advocacy Movement provides a service for those who need support. The following chart shows how support was provided to those where the concern raised progressed to an enquiry.



Other than those who support themselves, the majority of the support came from family members. The Safeguarding team liaise well with the Advocacy Service who are very responsive when there is a need for an advocate, or an Independent Mental Capacity Advocate where the person lacks capacity and has no one appropriate to help and support them. Although it is not a substantial amount, the enquiries where it is recorded that “other” supported, on closer inspection showed that a lot of these were staff members. Social work staff have been informed, that where a paid member of staff is involved they can provide basic support (for example help with communication) but cannot advocate or make decisions for the person. Staff have also been briefed that there is an Advocacy service in Swindon, and to make timely and accurate referrals for their service. Another issue is the use of the term “not supported” and clarification on whether this means that they were self-supported and this has not been recorded correctly or whether it means they were not involved. The new manager of the Safeguarding team is committed to the principles of Making Safeguarding Personal and is working with the team to reinforce this priority, to ensure those people who are the subject of safeguarding concern need to be involved at the beginning, during the safeguarding process and at the end to see if their desired outcomes have been met.

Making Safeguarding Personal (MSP)

Of the 395 cases where Desired Outcomes were expressed *(of cases that progressed)*	
292	were Fully Achieved
83	were Partially Achieved
20	were Not Achieved*

*Where desired outcomes were not achieved, this is not a poor reflection of the safeguarding process. This can occur when an enquiry did not result in prosecution which the individual hoped for (for example) or where the adult did not want action under the safeguarding procedures but it was felt that there were still risks that needed addressing. For example someone who is self-neglecting but not recognising the risks. Desired outcomes were not recorded in 368 cases. This is in part due to practice and the recording system. This weakness has been addressed in the re-modelled safeguarding team.

Outcomes of Referrals

Figure 12: Outcomes of closed cases that progressed to enquiries (including closed cases that commenced in the previous year)

OUTCOME	Number of cases concluded in 2018/19
Risk identified and action taken*	533
Risk identified and no action required	1
Risk - Assessment inconclusive and action taken*	18
Risk - Assessment inconclusive and no action required	8
No risk identified and action taken	36
No risk identified and no action required	32
Enquiry ceased at individual's request and no action taken	31

* 659 cases were concluded during the year and the aim is to reduce or remove the risk by taking appropriate action. Action taken could include the individual involved or the person alleged to have caused harm. Sometimes no direct action is required for the adult, but the focus could be on the person alleged to have caused harm. Possible actions include a change to the person's care plan, counselling, help with management of finances, training and

support, accommodation move or action by the provider. Examples of action taken with the person alleged to have caused harm include disciplinary action, restricting access to the adult, changes to their care plan and action by police with could include criminal prosecution.

3. LSAB - Progress in 2018/19

3.1. Priorities for 2018/19

The LSAB agreed an updated 3-year Strategy linked to the 6 principles that underpin adult safeguarding:
Empowerment - Presumption of person led decisions and informed consent;
Protection - Support and representation for those in greatest need;
Prevention - It is better to take action before harm occurs;
Proportionality - Proportionate and least intrusive response appropriate to the risk presented;
Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse; and
Accountability - Accountability and transparency in delivering safeguarding.

These are the Boards Strategic priorities which link to the Government priorities:

Effective Governance

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

Implementation in 2018/19

- Development of links with other key statutory partnerships (particularly the Health and Well-Being Board, the LSCB, and the Community Safety Partnership), and voluntary sector, identifying areas of commonality and governance arrangements, receiving reports from them focused on specific issues and themes;
- The Board has been sufficiently resourced by partner agencies to undertake its responsibilities including the appointment of a dedicated Board Manager and administrative support;
- Introduction of an Induction programme for new Board members;
- Completion of a self-assessment of Board development; and
- Implementation of the Board review including membership of the Board and its sub groups, and monitoring attendance at meetings.

Impact

Throughout the year the Board has discussed and consulted on the future of safeguarding arrangements across the children and adult safeguarding boards. Agreement on the future Safeguarding arrangements for Swindon was reached in April 2019 and the arrangements were published the end of April 2019 with implementation from end of July 2019. As some of the Board functions will be shared, it has been agreed to have a single team managing and administering Board work. This will help with resources to the Board, but also gives the opportunity to increase consistency and sharing of expertise across children and adult safeguarding

There will be more information on the new arrangements in the priorities for 2019/20 at the end of this report.

Performance and Quality

Intention

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

Implementation 2018/19

- Implementation of a multi-agency quality assurance process and schedule, and reporting system to the Board;
- Audits found that there was a lack of a multi-agency response in the implementation of an agreed plan in relation to financial abuse, a need to ensure a personalised approach was evidenced in all financial abuse cases, risk assessment and information sharing across agencies could be improved, a personalised approach was evidenced in domestic abuse and self-neglect cases. Social isolation was a major factor in self-neglect cases.
- Agencies were hold to account for a reduction in inappropriate referrals to ensure key risk cases are not missed;
- Identification of adults in need of care and support who are or have been experiencing abuse or neglect (increase in neglect, and abuse in people's own homes);
- In cooperation with relevant key partnership boards, the Board explored the Swindon safeguarding risks relating to known vulnerability particularly learning disabilities, self-neglect, domestic abuse, radicalisation, hate crime, trafficking/modern slavery and financial exploitation;
- Learning was shared from Safeguarding Adult Reviews and Domestic Homicide Reviews, sharing lessons learnt with the Community Safety Partnership;
- The Board received a report from Healthwatch regarding service user experience, particularly in respect of making safeguarding personal (Empowerment), and using this to drive practice improvements; and

Impact

A Quality Assurance Framework has been agreed and implemented and there were three audits (Domestic Abuse, Financial Abuse and Self Neglect). Reports have been delivered to the Board and individual agencies have developed action plans arising from the findings. There is also a self-assessment process where agencies are reporting on specific areas of safeguarding work. At the end of the report period, an audit was started on how partner agencies are working on Preventing Abuse, it will be concluded mid-2019.

As previously stated, there has been little improvement in the number of inappropriate safeguarding referrals and there has been an overall increase in concerns. The development of a Triage and Screening team within Adult Services may help to reduce these numbers by guiding those making referrals about the appropriateness of doing so. The quality assurance system does look at inaccurate concerns but also focuses on the areas Board members felt required some special attention (learning disabilities, self-neglect, domestic abuse, radicalisation, hate crime, trafficking/modern slavery and financial exploitation) and while it has not covered all these areas in detail, the new Performance and Quality Sub-group will need to continue to prioritise these areas.

The "service user" experience is still an issue that requires further action. While those involved in safeguarding cases have been offered opportunities to feedback, there has been no take up. Discussions are continuing with Healthwatch to consider different methods to encourage feedback. In the new structure there will be a Communication and Engagement Group which aims to obtain a view of how those subject of safeguarding concerns can give feedback to help improve the approaches used by the safeguarding and care teams.

Communication and Engagement

Intention

The LSAB will ensure there is a consistent and coordinated approach to how the safeguarding message for adults is disseminated to all groups and communities in Swindon, and will ensure engagement with adults and communities of all backgrounds and make up in the work of LSAB.

Implementation 2018/19

- The website has information about standards and developing it further when the new platform is in place;
- An easy read document was developed.
- Implementation of a the new model to gain the voice of service users and carers, and act on suggestions linked to existing services and groups; and
- Developing more effective use of the media.

Impact

The development of the service user forum has been slow and while there was one meeting held about on-line safety that was well attended and feedback provided to the Board, other planned forums had poor attendance

The current webpages providing information to professionals and the public have been expanded during the year and there is a separate page for the Board and related documentation. It appears these are well used, for instance online referral forms are popular and widely used.

Easy read documents are available for service users and the "Swindon Safeguarding Guide" that is used to guide people through the safeguarding process is now widely used and popular with safeguarding staff and those subject of safeguarding concerns.

Overall, with the development of the Communication and Engagement Group, there will be improved use of media opportunities and wider availability of information to the community and professionals working in all care sectors.

Workforce Development

Intention

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

Implementation 2018/19

The Council continued to offer and provide safeguarding awareness sessions to anyone who is in contact with adults in need of care and support. Over 300 staff received basic awareness training, including Care staff, GPs, Housing Services staff, volunteers connected to the Community Navigation Team and staff and volunteers from Swindon Carers Centre. Although this training is free of charge, there have been fewer providers making use of this training. It has been publicised through the Contracts and Commissioning team. It may be as a result of employers being reluctant to release staff for half a day and they may choose to access awareness training in other ways. Judging the effectiveness of this may be difficult, however reports from the Care Quality Commission often report that staff within services they inspect appear to have a good knowledge of safeguarding and know how to report concerns.

Adult Services has increased the training opportunities for staff working in different areas of Adult Social Care and safeguarding (see table below). There has been a new course on applying the Mental Capacity Act into practice and 40 staff have attended this and spoken very highly of the trainer who delivered it. As a result of the Safeguarding Adult Review on Honor, mandatory training on Domestic Abuse and Coercive Controlling behaviour took place in the early part of the year.

The following table shows the range of training provided, including numbers attended:

Basic Awareness: ½ Day (monthly) *All staff working in the Council, health services and in the private/voluntary sector who are regularly in contact with adults in need for care and support.*
206 attendees (79 from Private/Voluntary Sector & 127 Council staff (adult services, Public Health, Housing, Community Health and Wellbeing, provider services)).
Foundation Course for Enquiry Officers: 1 Day *Any staff within adult services who will undertake supporting role for section 42 enquiries. (Staff from other agencies (e.g. GWH may attend if they are to fulfil the EO role)*
29 staff mainly from SBC but also AWP, GWH and Swindon Advocacy Movement attended
Enquiry Manager Training: 2 Day *Key Staff within Adult Services who will act as Enquiry Managers*
19 staff
Provider Managers Safeguarding Training: 1 Day *Managers and senior staff from provider services – course funded and administered by Care Skills Partnership*
47 managers and senior staff – mainly from residential or nursing homes.
Coercive Controlling Behaviour and Domestic Abuse: ½ Day *All staff within adult care teams (including mental health), safeguarding and MCA/DoLS team*
Approximately 70 adult service staff including some from Mental Health Team.
Mental Capacity into Practice: 1 Day *Adult Social Care Practitioners*
18 staff from adult services
Various bespoke sessions Safeguarding awareness/updates with specific services *As required*
Community Navigation team – Volunteer Coordinator (11), GP's (30 estimate – arranged by GWH), Swindon Carer's Centre (23) and Sheltered Housing Staff (30)

Impact

- Enquiry Manager training has improved practice and awareness of legislation and application of government priorities.
- Application of Mental Capacity Act has improved, where professionals are mindful of assuming capacity, there is a need to look at the indicators which would lead to capacity assessments being required.
- There is greater awareness that while people who make unwise decisions is not an indicator of a lack of capacity, staff may need to continue to work with individuals rather than assuming lifestyle choice.
- GP awareness has improved accuracy of referrals
- The increase in referral rates maybe as a result of greater awareness.

3.2. Safeguarding Adult Reviews

The Care Act places a requirement on the LSAB to carry out Safeguarding Adult Reviews (SAR). These are when there is an adult in the area with needs for care and support (whether or not the local authority has been meeting any of those needs) and there is a concern how the Board, or members or other persons "with relevant functions" have worked together in safeguarding the adult and they have died and the cause was thought to be abuse or neglect. Or a SAR can be commissioned where serious abuse or neglect is suspected to have taken place.

A SAR is a multi-agency review process that seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

During 2018/19 There were no SARs completed, however the report of the SAR referred to in the last LSAB Annual Report regarding the death of Honor, a 90-year old widow living with her son, in January 2017, was widely circulated with the expectation that agencies develop action plans from the learning arising from the Review. The LSAB has been reviewing the actions required and progress made by the respective agencies.

- There are improved links between the Domestic Abuse and Violence against Women and Girls Board and the Safeguarding Board. The Community Safety Manager is now a member of the LSAB and presents relevant reports.
- Improved training has taken place around Mental Capacity with a new course, Mental Capacity into Practice. This has been widely available for adult services staff with a view to extending participation to other agencies.
- Domestic Abuse and Coercive and Controlling Behaviour training also took place and training continues to be available around Domestic Abuse.
- There are closer links with Swindon Women's Aid with some agencies (especially GWH). The CCG has identified funding to widen the links with GP practices.

- A Learning, Review and Development Sub-group has been developed to promote learning from Safeguarding Adults' Reviews and other reviews nationally and locally.
- An audit of Domestic Abuse took place between April and July 2018 and partners completed a template to capture actions taken in response to the audit findings.
- ADASS guidance on Domestic Abuse and Safeguarding has been widely distributed among adult services staff and links to this guidance is included in the Policy and Procedures for Safeguarding Adults and on the Adult Safeguarding webpage.
- Professional, independent supervisions for the Swindon Borough Council Safeguarding Team have been established
- There is a new Adult Services IT system which is developing ways to judge quality markers of safeguarding cases.
- The new Safeguarding Team is in place and led by an experienced team manager, where processes have been developed to manage increasing demand
- Safeguarding "Threshold" Guidance has been published and shared with provider service managers
- The Safeguarding Team is represented at fortnightly MARAC meetings.

3.3. Risk Enablement Panel

The multi-agency Risk Enablement Panel (REP) has been active for approximately four years. During this time the Risk Enablement Manager (now Risk Management Lead) has been involved in 56 cases. Some of these are currently open. A number of cases have not required the input of the Manager other than providing advice or ensuring that agencies have exhausted their options before referring the case to the REP manager.

The purpose of the Risk Enablement Panel is to:

- Share information to identify, clarify and agree on risk
- Promote safety and wellbeing of high risk adults in Swindon
- Improve multi-agency communication pathways
- Utilise the resources in Swindon more efficiently
- Develop a Risk Management Plan
- For those who are not engaging, co-ordinate a Risk Management Plan to seize the opportunities that can enable engagement and/or monitor the well-being of the person e.g. outreach opportunities, support from the community and locality input.
- Ensure any actions are covered by a legal framework or are lawful
- Improve agency accountability
- Identification of a lead/key worker
- Share risk across agencies
- Consider options that will enhance the range of possibilities available to professionals to improve the outcome for the individual.

The criteria for cases that can be put forward to the Risk Enablement Panel include the person concerned being deemed to have mental capacity (as different processes would need to be put in place if some lacked capacity).

The Risk Enablement Panel is for those:

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

The REP process will only be enacted when all other interventions have not produced an improvement in outcomes for the individual(s) of concern. The role of the REP is to facilitate, develop risk management plans and monitor their effectiveness. The Objective of the Panel is unchanged since the last Annual Report

Overall the risk enablement/management process is about concentrating on what can be achieved, rather than what cannot, and bringing together people from different organisations to develop shared perceptions of risk. In January 2019 the Risk Management (Enablement) Panels moved to the Community Safety Partnership from Adult Services.

Case Example

AZ was referred to the Risk Enablement Panel in 2016 and has now moved into his own accommodation with support from paid carers. AZ has complex needs and had been highly socially marginalised, stigmatised, and had become isolated from services. Although in need of in-depth assessments due to their complex presentations, AZ was unable to attend assessments as he had no fixed abode and establishing contact information was problematic. This meant services/providers did not have an evidenced based understanding of how to work with AZ to meet his care and support needs.

The Risk Enablement Panel, working in a multi-agency approach, was able to understand and work on an engagement strategy which incorporated developing and assessing mental, psychological and/or emotional health needs; economic inactivity; financial and other areas of exploitation; contact with the criminal justice system; physical health needs and experience of domestic abuse; self-neglect; and being vulnerably housed by "sofa surfing". Over a number of years engagement strategies agreed at the REP, assessments were able to take place and an enhanced understanding of the individual's care

and support needs were identified. This meant good but challenging relationships had developed with AZ and a network of professionals were there to maintain engagement and be a protective factor. As there was clear evidence of engagement, evidenced assessments and support workers in place, it meant that services which had previously exhausted their legal and moral obligations became willing to work with AZ again. This was because there was a co-ordinated understanding of the risk mitigation and management plans and how to coordinate these with services and the service user. Mainstream services which were not equipped to support individuals with overlapping needs like those of AZ were now accessible.
Being safely housed was AZ's real desire, and there had been a history of tenancies ending which was a barrier. However, housing and social care professionals recognised the work that had been achieved and agreed to look for a property. A few months later the property had been identified, refurbished and AZ with the support of carers purchased their furnishings. At the end of the tenancy sign-up meeting AZ was handed the keys and driven to the new home, which they are settling into well. Although this is one aspect of reducing their risks, the case remains open to monitor and support their transition.

4. Partner agency Reports

4.1. Swindon CCG

Successes
The CCG has continued to develop and strengthen its safeguarding adult arrangements and that of the providers we commission. The CCG governing body receives an annual report and this year also received safeguarding adults training for board members. The CCG has increased the resources to include a new band 7 post (currently being recruited to) and a full-time safeguarding administrator post for the whole team (children and adults) in recognition of the ongoing capacity issues. The CCG has re-written its joint safeguarding children and adult's policy to be explicit on the associated international and national rights related to safeguarding; has ensured all its staff are fully compliant with the requirements for safeguarding adults and Prevent training. The CCG has agreed with Wiltshire and BANES CCGs an STP wide safeguarding adult schedule and dashboard for all providers commissioned within these three areas. The CCG has engaged fully as a member of the LSAB and chairs one of its sub-groups. The CCG provides one to one support to the safeguarding adult leads within provider organisations. The CCG has ensured preparations are in place to support the CCG and providers to move to the new Liberty Protection Safeguard (LiPS) arrangements.

Challenges
Safeguarding adult challenges for the CCG relate to the high volume of alerts or concerns regarding health providers particularly care/nursing homes which the CCG are required to respond to; ensuring there is sufficient capacity within the health system to comply with new LiPS arrangements; ensuring providers are implementing the new intercollegiate guidance for safeguarding adults.

Meeting LSAB Strategic Objectives

During the last year the following have been achieved:

- The agreement of a Swindon-wide Safeguarding Policy written by Swindon CCG for all GP surgeries
- A thorough review of all areas of safeguarding within a surgery, by completion of a self-assessment audit by all surgeries. This highlights areas of weakness with GP surgeries, mainly in 2 areas, safer recruitment and audit, and the CCG is now giving targeted support in these areas.
- All surgeries have a safeguarding lead and deputy lead.
- Consent/capacity forms are drafted and given to SBC Safeguarding Adults team to use when requesting information from GPs.

- Teaching sessions – five surgeries visited, and two large teaching sessions completed.
  Intranet has been set up for surgeries to access relevant safeguarding adults' information.
- The Safeguarding Adults team at SBC has been under pressure in terms of capacity. SBC Safeguarding Adults have said to the CCG that their processes internally at SBC need improvement. The CCG is keen to work closely with this team to improve the involvement of GPs in the safeguarding of adults in their care and have approached SBC with this suggestion however capacity issues within SBC have prevented any meaningful engagement with the CCG to support and improve involvement of GPs in Safeguarding Enquiries. Once SBC have reviewed and improved their own processes we anticipate that SBC will be in a position to engage with the CCG Named GP for Safeguarding to improve the processes surrounding GP involvement and requests for information with regards Safeguarding Enquiries.
- Currently the CCG remain concerned that GPs may not always be invited nor always available to attend and contribute to strategy discussions or multi-agency professionals' meetings when they occur and where there is a Safeguarding Enquiry about their own patients. The CCG will look for better collaboration and partnership working between GPs and the safeguarding team to address this next year.
- The CCG are concerned that other agencies do not understand the rules from the GMC on when a GP can or cannot share information. In response the Named GP has revised the process of seeking information from GPs and developed forms to aid other agencies to highlight to GPs the necessary information that they need to provide to GPs in order to enable GPs to share information appropriately.
- For the next year the CCG Primary Care Safeguarding Adults aims are to include reports for Adult Safeguarding Enquiries into the Locally Enhanced Service for Safeguarding which monitors requests into GP surgeries and reports sent back to SBC, to encourage Primary Care Network Safeguarding Clinicians to be placed in post in each Primary Care network, to develop a specific form for GPs to complete for Adult Safeguarding Enquiries and to continue the teaching programme.

4.2. Wiltshire Police

Successes

Stalking and Harassment

As there was a clear challenge to develop a response to stalking and harassment, a working group involving officers from CID and CPT from each hub has been established to become champions for Stalking offences. The aim is for the champions to be upskilled with best practice and provide up to date advice to officers involved with stalking offences. A monthly report will be run and new offences of stalking identified for each hub which are reviewed by the champions to provide investigative advice and signpost officers to the Stalking and Harassment hub which contains the information and risk assessment forms they will need for the stalking investigation.

In addition to this training, Detective Sergeants and Inspectors had an input from Professor Jane Monkton-Smith, a lecturer in Stalking and Homicide, who attended a development day and involving control centre staff. This resulted in members of the contact centre correctly identifying a Stalking offence upon first report. They ask the right questions of the victim and actively put learning into practice. This has been acknowledged and the officer has since joined the working group to become a champion within the Contact Centre setting.

Herbert Protocol

The Herbert Protocol document release is due to take place at the end of July with a formal Launch on 19th September to coincide with Alzheimer's Awareness Week. The Protocol will help to manage the risk to missing persons with dementia.

Domestic Abuse

A new officer will be responsible for managing those perpetrators of domestic abuse who are identified as posing the highest risk to victims, in a bid to aid rehabilitation and reduce the risk of their reoffending. Domestic abuse is at the centre of the Com Policing team investigative standard work stream to upskill front line officers. There is a force-wide drive to improve our investigative standards especially within Community Policing, around domestic abuse investigations increase formal action taken rates and reduces repeat calls. There is a current focus on Evidence Led Prosecutions; this work stream is overseen by the Assistant Chief Constable.

Partnership working

There are strong partnership relationships across both Swindon and Wiltshire and under the new safeguarding arrangements formed from Working Together 2018, both local authority areas have taken the opportunity to work more holistically across children's, adults and CSP agendas in order to better focus on vulnerability as a life course, with an enhanced focus on prevention and early intervention. This will allow for a more effective and efficient response across the partnerships and it is hoped will reduce demand.

Challenges

Domestic Abuse

In 2018, domestic abuse crimes have increased by 14% compared to 2017 figures and there are concerns around investigatory resources being available to cope with continuing increase. There will be a review of demand on public protection in October 2019 to make sure the department are able to cope with above expected levels of demand. The Force incident manager review has factored in any potential future demand.

Frontline Resources

A critical incident has been declared in relation to levels of frontline community policing staff. This is being monitored and worked on by the executive leadership team however this is likely to have an ongoing effect on staff wellbeing and service delivery.

Stalking Clinic

Currently Wiltshire Police are considering establishing a stalking clinic to address high risk cases of Stalking but will need participation from partners and funding being available in order for it to be a viable option. The working group to address assessment of risk and establishing future best practice.

Safeguarding Adults Investigation Team

The SAIT team will be undergoing further staff modernisation in 2019. Two further Police Officers are being replaced with Police Staff investigators. Recruitment is difficult due to the investigation skills required to manage serious and complex offences, the team will be an even split of police staff and officers. To ensure sustainability of the team, an Adults AtRisk policy is being developed, to include the new adult MASH process and clarify the purpose and remit of the team focusing on investigations with a perpetrator in a position of trust or authority.

Case Example

The SAIT team investigated an allegation of wilful neglect of a Swindon resident where two service users resided. During April 2018 a care worker was witnessed to assault the victim by slapping him 3 times across the face. This was reported and on further enquiries with the witness it was established that the care worker had committed other acts that amounted to wilful neglect of the victim. The Care Trust also initiated an investigation of the remaining team members and found that their level of care fell below standard and were suspended. The offender was charged with wilful neglect and is due in court on 24th June 2019. The rest of the team have been replaced.

Meeting LSAB Strategic Objectives

Mental Health

Frontline staff have received 2 day mental health training and other initiatives include a crisis café in Swindon and a safe place in the Wiltshire area. Both of these have already received significant funding and the crisis café in Swindon is due to open shortly. Both services are focusing on prevention with the aim of reducing demand by offering early intervention services in a timely manner to prevent those in need reaching crisis point and coming to the attention of agencies. These initiatives are joint ventures between health services and the voluntary sector, providing both clinical and supportive intervention. The expectation is that over time, these services will expand to provide a facility where those with mental health needs can self-refer (as well as agencies referring in) so that overall demand is reduced.

Modern Slavery and Human Trafficking

14 detectives have now completed a four day modern slavery investigators course. Wiltshire Police recently hosted a training event for Senior Investigating Officers regarding modern slavery investigations. To widen knowledge of this issue, West Midlands Police presented Operation Arkle which was a county lines investigation in relation to a male exploiting child runners to deal class A drugs, they were also missing persons from their own force areas. This presentation was attended by a range of teams within Wiltshire Police. It demonstrated a case study of a recent conviction of a male for drug and modern slavery offences and demonstrated the impact that using modern slavery legislation has. He received a higher sentence for those offences above the drug offences.

There have been a range of actions to improve awareness of human trafficking among officers so they have more operational guidance and toolkits to explain the processes around referring victims into the national referral mechanism and how to deal with operations and victims. All the community co-ordinators have been provided with training from the South West Regional Organised Crime Disruption Unit in terms of their abilities and powers to carry out premises checks. The specialist crime department have recently carried out a successful operation into sexual exploitation and they are seeking charging advice with a view to also obtaining a slavery and trafficking prevention order on conviction.

Mental Capacity Deprivation of Liberty (MCA DoLS)

MCA DoLS relates to people who are placed in care homes or hospitals for their care or treatment and who lack mental capacity to consent. The Safeguards protect their rights and make sure that any care that deprives a person of their liberty is both appropriate and in their best interests.

Currently MCA DoLS remain a key issue for local authorities both in relation to the current level of unassessed cases and the anticipated introduction of Liberty Protection Safeguards (LPS): the date for this introduction is currently not before 1st October 2020 although due to the substantial amount of implementation work needed across the health and social care sectors, there is a possibility of some further delay. Local authorities will remain responsible for the authorisation of deprivation of liberty where people live in care homes and their duties will expand to include referrals for significant numbers of people living in the community but NHS Trusts and CCG will take on the management of all health funded referrals

Compared with the previous year's referrals of 906, there has been an increase in MCA DoLS referrals in 2018/19 to 1049, 516 from hospitals and 533 from care homes. With the increase and cases from previous years, we now have approximately 441 unassessed cases (414 in care homes and 27 hospitals). The team triages all referrals in keeping with Association of Directors of Adult Social Services (ADASS) recommendations and prioritises those where the person (and sometimes their family) is objecting to where they live or the care they receive. This last year saw a marked increase in Court of Protection cases where service users and their representatives challenge the circumstances of SBC DoLS Authorisations and we are required to present detailed evidence to aid the Court in making their decision; this is a pattern seen nationally as well. It is positive that we are finally seeing an upswing in Community Deprivation of Liberty applications to the Court of Protection for approval and this will also contribute to preparation for the new Liberty Protection Safeguards (LPS).

Service pressures often restrict availability of in-house Best Interests Assessors to undertake assessments. We trained an additional 4 Best Interests Assessors (BIAs) last year and 4 are training this coming year: this supports both current need and impact of the reform where many assessments will be undertaken by the wider Adult Social Care Teams. The role of the BIA will be expanded and will be known as Approved Mental Capacity Professional (AMCP); they will have a particular role in relation to service users who object to their residence for care and treatment. The local authority will be responsible for approval of AMCPs in Swindon across all services as they are for Approved Mental Health Practitioners (AMHPs).

4.3. Swindon Carers Centre

Successes

- As an organisation we have now all had Adult Safeguarding training or are booked on this. This includes all service delivery staff, office-based staff, volunteers with minimal carer contact and Trustees.
- Adult Safeguarding is now a standing agenda item on all practitioners' supervisions as well as Management/Service Delivery & Adult Team meeting agendas
- In November 2018 our Designated Safeguarding Lead for Adults and her deputy attended the 'Safeguarding training for providers' run by Wiltshire & Swindon Care Skills Partnership, in conjunction with Swindon Borough Council. We have since rolled this out to support staff to understand that Adult Safeguarding is about 'Make Safeguarding Personal' including discussing it not just when a possible safeguarding situation arose but also during regular team meetings. This also informed our audit in late 2018/early 2019.
- The low number of actual referrals to the safeguarding team. 4 in total for the year April 2018/19 (1 in Qtr.1, 1 in Qtr.2, 2 in Qtr.3 and none in Qtr. 4)

Challenges

- Leading on/arranging the latest LSAB Sanford House Service Users forum.
- Supporting some of the longer serving staff members to recognise that Adult Safeguarding is now about MSP.

Case Study

During the registration of a carer to access SCC services the carer (aged 61) divulged that her son (29) who lived with the carer and her husband and couldn't be left alone as he had serious mental health issues and memory problems and his temperament is very volatile and aggressive and varies from day to day. The carer added that she does not trust her son, does not feel safe and is especially worried about his aggressive behaviour towards her husband. The carer said the situation is "really, really bad", but cannot leave her son for his own safety.

The son was known to mental health services who had advised they call the police if things happen at home however, the carer reported she feels reluctant to contact the police about their own son, in case things escalates further and he physically hurts one of them.

SCC input:

Our practitioner was aware of the MSP and asked the carer for and obtained permission to contact the Adult Safeguarding team about this issue for advice. A phone call was made and following this conversation, a referral form was completed and sent to safeguarding team. We then had a call back from the safeguarding team to say that they had contacted AWP and the early intervention team would take this up. The safeguarding team had also been in touch with the carer and given her the phone number for crisis team and a contact name and number in the police. We also had a call in from staff at AWP to inform us that the early intervention team would be contacting the carer

Meeting LSAB Strategic Objectives

- We now have 2 x Adult Deputy Safeguarding leads to support the DSL so that all working hours are covered. This also gives us excellent succession planning. The 2 deputies will also cover the DSL at the LSAB meetings if he is unable to attend.
- We also now have safeguarding leads on our trustee's board.
- We have our Vulnerable Adults and Children's policies in both normal and easy read versions, our safer recruitment policy available online.
- Links to the LSAB, SBC Adults Safeguarding page and LSCB are available for all carers and members of the public from our own website.
- The DSL's for Adults and Children are working closely together. Recently both attended the Joint LSAB/LSCB Event – (New Multi-agency Safeguarding Arrangements) as well as both attending the last LSAB meeting. This has enabled us as an organisation to make sure young carers and young adult carers transitioning to Adult Services are not lost with regard to safeguarding.
- Information and any training are disseminated to all staff, volunteers and trustees the DSL or deputies receive from the LSAB or safeguarding team.
- The LSAB flow chart for raising a safeguarding concern & the threshold for access to Safeguarding is prominent all around our office.
- In Feb 2019 we achieved the NCO Trusted charity award via thorough inspection including our safeguarding practices.

4.4. Swindon Advocacy Movement

Successes

SAM has provided advocacy for 41 adult safeguarding section 42 enquiries to ensure individual's voice is central to process and we have worked closely with the Safeguarding Team to ensure accessibility to the service. This has been very successful. As part of our Independent Advocacy Quality Assurance assessment we have been informed by NDTi (National Development Team for Inclusion) that Swindon is taking a national lead ensuring that service users get advocacy support through safeguarding procedures as entitled under The Care Act. Successful outcomes for people include:

- A client who wished to leave their coercive and controlling home after 19 years moved into their own independent flat after going through the safeguarding process.
- Client was enabled to understand a Root Cause Analysis process under Safeguarding with Easy Read documentation provided by advocate and had a voice through difficult process.

Challenges

Safeguarding around elderly people subject to domestic abuse has been a priority for SAM since the SCIE report being published and attending the Quality Audit groups. We have had an increasing number of referrals of this nature under the Care Act recently. In response we have made good links with Lin Williams SBC Domestic Abuse and have provided awareness raising training.

Case study
Jane* aged 19 with High Functioning Autism was a victim of sexual exploitation from a man she initially met online and then met in person. She initially made a disclosure whilst at college but had difficulty talking to anyone about it. The advocate enabled her to share her experience with others, ask questions about the safeguarding process and express her own concerns, fears and wishes.
The investigation and support process took over a year and involved many meetings with professionals from the police, social work team, education and SARC. The advocate worked with Jane to prepare her for safeguarding enquiry meetings; introducing her to the Chair, to the location and getting questions to her in advance. Jane wrote down lengthy detailed statements and attended meetings to listen as her advocate read out the statements. The police conducted a lengthy investigation but decided the enquiry couldn't progress to CPS. Jane is very disappointed with this but the safeguarding process has had positive outcomes for her. She now understands how to manage risks she may face, she is less fearful and is developing greater independence. She also has a better support network around her, including a SARC worker, who understands her individual vulnerabilities.

Meeting LSAB Strategic Objectives
We enable clients to be part of their own safeguarding plan. We provide either a one page profile if the client has capacity around the MSP principles or a non-instructed advocacy report for those who lack capacity to inform views wishes and feelings and considerations for the client. We also sit on the Quality Assurance sub-group of the board and have contributed in depth to Quality Assurance audits to ensure that the service users experience is included.

4.5. Great Western Hospital NHS Foundation Trust (GWH NHSFT)

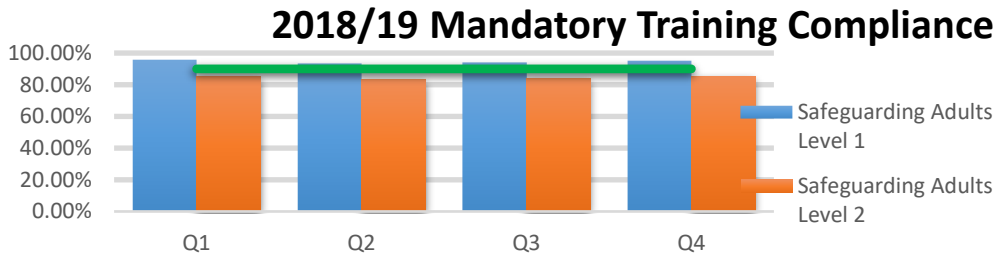
Successes
- Delivery of the internal Trust Adult Safeguarding and Mental Capacity Act (MCA)/Mental Health Act (MHA) work plans for 2018 – 2019
- Level 1 and Level 2 Safeguarding and MCA training modules reviewed and aligned to the 'UK Core Skills Training Framework' (CSTF)
- All safeguarding adults electronic resources reviewed and updated in line with national and local requirements
- Multi-agency referral form (Form 75) template revised to strengthen the Making Safeguarding Personal (MSP) section
- Changes to the Homelessness Reduction Act (2017) introducing a 'Duty to Refer' mandate for the Trust. Stand-alone guidance for staff has been developed, published and rolled out across the Trust
- New Trust-Wide Domestic abuse policy developed and ratified. This policy is integrated with Wiltshire Health and Care and Swindon Community Health Services and launched in May 2018
- Acute and Swindon Community Health Services policies and processes aligned
- Delivery of a face to face training programme for Community Services (Including the Walk in Centre – Swindon)

- Quality Improvement (QI) project undertaken for SwICC
- Work undertaken to embed the use of an internally produced Best Interest Resource Pack for use by all relevant patient facing roles
- Safeguarding Adults at Risk Operational Group is now well established; Is supporting the delivery of best practice in adult safeguarding, and is empowering others to act
- Bespoke training to clinical areas, including 1:1 supervision and support
- Continuation of student placements within the core Adult Safeguarding Team and wider 'spoke and hub' opportunities
- Contribution to, and engagement in, case reviews and learning events
- Assisted in the creation and pilot of Ward Accreditation Achievement Framework (WAAF) achievement guide/pack
- NICE Guidance - decision-making and mental capacity (NG 108) launched October 2018 baseline benchmark mapping complete – identifying 74% of recommendation have been achieved. A delivery action plan has been developed
- Intercollegiate document published October 2018, plans have been started to implement a plan for Level 1 -6 competency based training
- Completion of LSAB self-assessment focusing on the principle of 'prevention' and LSAB audit in relation to 'Financial abuse' and 'Self neglect'
- New internal Trust 'Safeguarding QI Review Programme' audit process has been developed. The programme will enable 'real time reporting'. This will encompass all audits under the Safeguarding Adult team remit. The audit will be trialled in April 2019
- Safeguarding Adults policy reviewed and ratified March 2019
- All safeguarding staff resources reviewed and refreshed to reflect changes to electronic secure referral processes
- Staff Learning Disability Practice guidance ratified and made live March 2019
- Learning Disability Education Toolkit launch nationally and Trust-wide
- Production of staff guidance on the new substance misuse and alcohol liaison services, including updated safe methadone prescription guidance

Challenges

- There is an expediential increase in demand for the Adult Safeguarding and MCA services
- Proposed changes of the Deprivation of Liberty Safeguards (DoLS) to 'Liberty Protection Safeguards (LPS)' legislation. There is no anticipated central funding attached to this forward increase in DoLS (LPS) responsibility for the Trust
- There is no central Government funding available to support NHS Trusts to comply with the NHSi Learning Disability and Autistic Spectrum Improvement Standards (2018)
- Information sharing (lack of joined up IT systems) across services and the multi- disciplinary teams to support risk reduction
- Training compliance in relation to staff turnover of staff, with particular challenges in relation to medical colleagues.

GWH Training in 2018/2019



Prevent: the overarching e-learning mandatory training for all staff 2018/19

2018/2019	Q1	Q2	Q3	Q4
Total number of staff in the Trust who are up to date with Basic Prevent Training(BPAT)	4189	4171	4251	4198
Number of staff in the Trust who are compliant with Level 3 (WRAP) training	130	127	130	128

Case Study

GWH NHSFT Adult Safeguarding team managed a case where there was clear potential for coercion / control and sexual abuse. A multi–agency response was triggered involving all services, and the victim was effectively managed appropriately under the provision of the Mental Health Act, which allowed for an effective mental health treatment plan to be implemented.

In this case, Safeguarding Adults Team at the Trust worked closely with the respective authority to ensure all agencies were involved in care management to mitigate the presenting risks. The safeguarding safety plan provided an overarching management plan, involving all agencies which ensured risks were effectively mitigated and reduced. The patient was made central to this process, ensuring their wishes and feelings were carefully considered.

The patient was critically unwell at point of referral and due to multi-agency working has stabilised and is now continuing their personal recovery. Medical observations have since indicated that the patient is both physically and mentally much improved and has been recorded as being ‘a different person’ to the one they met during the patient’s admission in the summer 2018. This is an excellent example of multi – agency working underpinned by clear coordination across all agencies involved.

4.6. Public Health Swindon

Successes

Safeguarding adults is a key priority for the Public Health Directorate. The Trading Standards Service's top priority remains to protect vulnerable consumers. This includes identifying repeat victims of scams and rogue traders and working to prevent further financial abuse. During 2018/19 we saved or obtained redress amounting to £49,000 for Swindon consumers – the majority of whom were vulnerable. We have continued to work in partnership with other teams and organisations to support vulnerable consumers.

The Community Health and Wellbeing Team see and deal with safeguarding concerns on a weekly basis, take all concerns seriously. Good processes are in place. We all participate in training and are keen to work with expert colleagues to extend our competence and confidence. We log every concern, regardless of how small and track actions and outcomes. We regularly review these at team meetings to reflect on our practice and inform future decision making. All permanent members of the team have received Adult Safeguarding training.

Challenges

Both the Trading Standards and Community Health and Wellbeing teams have been subject to reorganisation this year resulting in a reduction in staff and post vacancies awaiting recruitment. This has led to pressures on staff but safeguarding has remained central to service delivery.

On occasions, staff have found it challenging to understand the safeguarding decision making process, and would welcome the opportunity to better understand how we can liaise with the safeguarding team to reduce the number of inappropriate referrals. We have seen an increasing number of clients who have raised safeguarding concerns with regard to self-neglect. Further work is required with regard to preventing those who may not quite require safeguarding at present but are at increasing risk from harm. It would be helpful for training to be available which could be more explicit in relation to levels of self-neglect.

Case Example

During November 2018 we received a notification from our national helpline that advice had been given to Swindon man, J. J had paid a large amount to a national building firm but was unhappy about the work carried out. Because of the age of the man and his apparent vulnerability we set up arranged an appointment at our offices. We were able to intervene in the dispute and negotiate with the company on J's behalf resulting in a refund of an overpayment and compensation for unsatisfactory work. Dealings and conversations with J raised further concerns about his situation, health and ability to cope so an appointment was made to visit him at home.

It was discovered that J was struggling at home with little support and a house in disrepair which was leading to J being overwhelmed. In discussion with J he agreed to our offer to assistance with essential repairs and equipment. A Bobby Van visit was arranged as was a referral to Homeline and to

the Community Health and Wellbeing Team who have helped and continue to help with a number of issues including income maximisation and befriending.

4.7. Dorset and Wiltshire Fire and Rescue Service

Successes
In a recent HMICFRS (Her Majesty's Inspectorate of Constabulary & Fire and Rescue Services) inspection DWFRS received a rating of 'Good' in all three core areas: effectiveness, efficiency and how well we look after our people. Feedback was positive around safeguarding training and reported staff had a good understanding of how to identify children and adults at risk from exploitation or abuse and how to make a safeguarding referral, when they need to.

A survey was circulated to all front facing staff to see if safeguarding has been embedded. Results were reviewed and indicated safeguarding is very much embedded with a 99% positive outcome.

We are taking part in a national pilot with the NFCC (National Fire Chiefs Council) on discharge teams with the British Red Cross – only 3 Fire Services are involved in this pilot. Looking to increase knowledge of community risk, share resources and increase targeting of vulnerable people.

We have analysed prevention work undertaken by operational crews with a view to increasing the number of vulnerable people reached.
Targeting of domestic properties with high number of AFA's (Automatic Fire Alarms) has taken place as these are more likely to be vulnerable people.

A Fatal Fire Conference was held where we reviewed 3 fatal fires. From these we are looking to extend our targeting into Hospital Discharge Teams due to the frequent links between those involved being recently discharged.

Challenges
Finding support for cases that do not meet the 3-point check but are in need of some positive intervention. Especially when there is severe hoarding. Raising the profile of FRS in the safeguarding arena, and that we do so much more than put out fires. We are often not considered by agencies when there are fire risks.

Meeting LSAB Strategic Objectives
As a non-statutory organisation we have more than met the objective. The HMIC report and survey referred to above reflect training is going well. We are second to none in the Prevention work we carry out and there is no doubt we save many lives through our prevention and education work.

MSP - the referral form we use to raise safeguarding concerns was recently amended to add the question, what would the person like to happen? However, as we are a sign posting organisation and often do not see the people we refer again it is hard to say if MSP was achieved.

4.8. South Western Ambulance Service NHS Foundation Trust (SWAST)

Owing to the number of Boards that SWAST feed into across the region, an individual return from them is not available. They produce an annual report specifically about safeguarding (including children) and this can be found by following this link:
https://www.swast.nhs.uk/assets/1/swasftsafeguarding_service_annual_report2018-19.pdf

4.9. **NHS England and NHS Improvement –** This report, prepared by Penny Smith Regional Head of Safeguarding - South West has been provided to all Boards and Partnerships in the South West Region.

Introduction
NHS England are focused on developing and maintaining strong safeguarding partnerships across health and social care to enhance the way we protect, support and improve the lives of those at risk in our local communities. We must always be thinking about the challenges that lie ahead. The safeguarding agenda is continuously developing, in both its complexity and scope, our priorities must also evolve. With this focus we have identified our safeguarding priorities for 2019/20 at the end of this document.

NHS England and NHS Improvement remain committed to working with our multi-agency partners to ensure that the interests of those at risk inform our decision making and that health organisations not only meet their legislative obligations, they are also listening to the voices of communities as well as those caring for them both professionally and in a caring, voluntary capacity.

NHS England and NHS Improvement Key Achievements:

- Annual conference held in September 2018, over 100 delegates from across the region attended. The focus of the day was exploitation and we welcomed a range of speakers with specialist knowledge in County Lines, Prevent, Domestic Abuse and Modern Slavery. Feedback from the delegates was very positive.
- Health Network developments across the South West. These networks brought Clinical Commissioning Group safeguarding leadership teams together to creating a community of practice and peer support. Key priorities for the network meetings were to review the challenges across their

local areas, what priorities are evident to them and to support collaboration and successes in their safeguarding work, and opportunities for learning from each other's good practice.

- A safeguarding General Practice audit tool has been developed. Dorset have taken a lead on this work and this has received good feedback from General Practice participants.
- South West Prevent workshop in March 2019 was well attended by partners from North and South. Supported by guest speakers from the Home Office and Police, attendees had the opportunity to work through Prevent issues local to them and to hear the journey of restorative care and support provided by the Home Office. Further workshops are planned for 2019/20.
- South Region Named GP Safeguarding Forum - the initial forum was convened in March and brought contribution from partners across the South. A very well attended event with over 30 Named GPs present. Further plans include a South West/South East forum in 6 months and a further pan South event in March 2020. Feedback from the event was very positive.
- A South West South rapid improvement event in November brought health and care partners together to identify challenges and areas of improvement in discharge planning and transfer of care for children and young people. Partners identified areas of good practice and shared learning and collaborated across their local areas.
- NHS England South (South West) team supported Devon safeguarding multi-agency partners to create a short film to support General Practice safeguarding.
- The South West safeguarding team have worked in partnership with the NHS England and NHS Improvement National Safeguarding Team and local safeguarding partners to support the delivery of the national safeguarding priorities across the South West, and to support the networking of professionals across England to ensure sharing of best practice and learning from risks and issues.
- The South West safeguarding networks have worked with Primary Care to support the awareness of domestic abuse/violence.
- A strong focus on learning from cases both nationally and locally has been an ongoing theme in the work of the safeguarding networks. Learning from both child and adult reviews, has supported development of health and care systems across the South West.
- NHS England South (South West) team worked closely with local representative committees in Primary Care to raise the profile of safeguarding and identify any local or regional learning needs for Primary Care providers.

4.10 Swindon Community Safety Partnership

Successes

Risk Management Panel

The Community Safety Partnership combined the Risk Enablement Panel (detailed above) and the CSP Community MARAC in into a Risk Management Panel in January 2019. The CSP Community MARAC allowed an escalation for complex high risk domestic abuse cases from MARAC as well as other complex cases that did not meet the criteria for the REP. The strong links to Adult Services have remained through the transition to

CSP and the Panel continues to have significant successes, including obtaining a Civil Injunction against one of Swindon's most prolific Domestic Abuse perpetrators.

Closure Orders

In conjunction with Housing and Wiltshire Police, the CSP team has obtained a number of Closure Orders this year. There has been a focus on making use of Partial Closure Orders in cases of the 'cuckooing' of vulnerable people by County Lines drug dealers. These Orders allow the vulnerable resident to remain in the property whilst removing those who put them at risk.

Modern Slavery and Human Trafficking

The CSP team co-ordinated a Reception Centre response for a number of women trafficked into sex working; supporting a police operation. This was the first use of the model in Swindon that brings together support agencies and provides a place of safety to victims of Modern Slavery and Human Trafficking in order to address immediate concerns and support a long-term aim to remove the victims from their situation.

Domestic Abuse and VAWG

Coercive Control training will be delivered in November 2019. Two half day sessions are fully booked. Training specifically for Adult Services is being arranged for early 2020.

HBV, FM and FGM training continues to be delivered and the dates for next year are being planned for April and October. Female Genital Mutilation specific training will also be offered.

A new Health IDVA (Independent Domestic Violence Advisor) is now in post at Great Western Hospital. The IDVA will be available every week day to meet with victims and to support staff across ED, Maternity, Sexual Health and the wards.

An IDVA to support victims from the LGBTQ community is also in post with Swindon Domestic Abuse Support Service.

Challenges

Risk Management Panel

Despite the successes noted above, the Risk Management Panel struggles to manage the volume of complex referrals made to the team. These are very complex cases that often require immediate intervention and co-ordination of agencies to support vulnerable people with multiple needs and risks. This has led to several reviews of the RMP processes and some delays in providing the necessary support.

Channel/Prevent

The Prevent Agenda and Channel Panels are a statutory responsibility of the local authority, managed on SBC's behalf by the CSP. There is always good engagement from partners but this is a resource intensive area of business. The service is currently under review by CSP with support from the Home Office and The South West Counter-Terrorism Unit.

Knife Crime

Following the government support for a public health approach to tackling knife crime, CSP is now part of a pan-Wiltshire Violent Crime Executive Board that is designed to explore and develop an approach that is best suited to Swindon and Wiltshire. This approach will learn from the significant success of the 'Glasgow model' in reducing violent crime but with a structure that meets the needs of Swindon and Wiltshire. This will not be a quick fix and will require significant investment and patience.

4.11 Swindon Borough Council Housing

Successes and Challenges

The notes below describe the services that Swindon Housing Services provide, where safeguarding referrals have been made and the challenges that have arisen.

Housing plays a significant part in the community in protecting and safeguarding adults who live in the borough. With a housing stock of 10,300 including 1,370 sheltered flats for older people, we provide services to a significant number of vulnerable persons. In addition Housing provide specialist services and accommodation which assist vulnerable adults and help to keep them safe.

The 2018/19 Temporary Winter Housing Provision assisted 17 people who are rough sleepers to have a warm bed for the night during the coldest part of the year. In addition they were able to access specialist support and health services. A number of these individuals were successfully moved on to longer term accommodation at the end of the project

Housing First scheme have provided accommodation for 15 chaotic rough sleepers. These residents are able to access daily support and health services. One client's case has been referred to safeguarding.

The Haven is a new rough sleeper day centre which commenced Dec 2018, where users receive meals, health care and support.

All the above services proactively assist potentially vulnerable persons and help to prevent more serious crises that need an emergency response. In addition Housing have recruited Rough Sleeping Navigators and Floating Support workers.

Adult Social Care Housing – Housing have provided a number of properties that are used by Adult Social Care clients. These include Firethorn Close and shared houses. These tenancies have resulted in housing officers developing greater knowledge and expertise around mental capacity and creating tenancies for this client group.

Homeline and Homeline plus - Over 3,500 residents are connected to Homeline including over 280 who receive telecare services**.** During April 2019 Homeline staff attended 360 incidents where the person had to be lifted or moved and 55 calls required the assistance of medical /care staff. This 24/7 service helps to protect and assist many vulnerable persons and staff regularly alert colleagues in adult social care when they find a person who needs assistance.

Sheltered Housing - The majority of safeguarding referrals from Housing originate from Sheltered Housing. These are triggered because of concerns about tenants, as they become older and frailer as they struggle to live independently, relatives fail to manage the finances of vulnerable residents or because of financial abuse. Sheltered Housing Officers had refresher training about safeguarding in March 2019

Fire - Housing Officers are alert to identifying residents who are found to present a high fire risk. During the last year Housing staff have had refresher training about identifying residents who appear to be a high fire risk. Where cases are identified (typically, smoking, hoarding and cooker fires) Housing work jointly with Dorset and Wiltshire Fire and Rescue Service to reduce and monitor the risk that a person poses to themselves and their neighbours.

Home Safety Checks - The majority of our properties have to have a mandatory annual gas safety check. If during a visit, the gas engineer finds issues that are a cause for concern they will alert their manager and this will result in a follow up by tenancy services. Concerns that they find include personal neglect, hoarding and financial hardship.

Tenant Money Advisers - In March 2018 Housing appointed 2 advisers. Their role primarily is to assist tenants to claim Universal Credit. Some clients are found to be vulnerable and have difficulty interacting with service providers and as a result struggle financially or are found to be the victims of financial abuse, triggering safeguarding referrals.

REPs - Housing Staff make a significant contribution to the REP process as the provision of secure accommodation for vulnerable or chaotic individuals plays a vital part in supporting clients. These cases are some of the most challenging and difficult that staff have to deal with.

Domestic Abuse - An additional Domestic Abuse Housing Options Officer (DAHO) has been recruited to assist with advising victims of domestic abuse on their housing situation and ensuring that homelessness can be prevented for many victims. The 2 DAHOs attend MARAC and work closely

with Swindon Domestic Abuse Service. A Park North man was evicted after his partner fled Swindon due to domestic abuse. The man was living in the house alone and would not move out so the Council went to court and obtained an order forcing him to leave.

Case study Swindon Borough Council Housing

In December 2018 Housing obtained a six month injunction banning Mr X from having contact with his mother. Following discharge from hospital she first lived in a Pathway flat and was then offered a permanent tenancy in sheltered flat. Housing Officers provided statements for legal services to make the application on behalf of the Council. Mr X continued to exploit his mother. The Housing department was successful in the injunction to protect the mother and her son has now stayed away from her property and she is safe

4.12 Swindon Borough Council Adult Social Care – Older People with Physical Disabilities

Successes

- Good working relationship with Adult Safeguarding Team, including secondment of one team member from Initial Contact Team.
- Allocation of Enquiry Officers when required
- Managers / Senior Practitioners (including Occupational Therapists) have completed Enquiry Manager training
- Practitioners undertook Enquiry Officer training

Challenges

- Balancing demand of competing priorities and risks of both case management and safeguarding enquiries, within available resources. This has led to occasional delays in allocating an Enquiry Officer.

Meeting LSAB Objectives

- All staff are trained to the appropriate level.
- MSP – the safeguarding enquiries are conducted in a person centred way and staff are mindful of the importance of seeking, including and respecting the views of the person. Staff recognise their legal duties around advocacy.
- Supervision and team meetings are regularly used as a method of reflecting upon learning, in particular in relation to MSP and safeguarding.
- The strength based approach to practice which is being encouraged throughout all our work will be applied within Safeguarding Enquiries also.

Case Study Swindon Borough Council Adult Social Care, Older People with Physical Disabilities

Mrs S is 83 years old, and lives in a nursing home in Swindon funded by Swindon CCG Continuing Health Care. She has a diagnosis of advanced dementia and had been living with her husband prior to being discharged from hospital into the nursing home. Mr S (Husband) had been struggling to cope with supporting Mrs S at home but was also finding it difficult to accept that she was not returning home. Swindon Advocacy Movement was involved due to a 21A challenge.

A safeguarding concern was raised by the nursing home following an incident where Mrs S was "physically and verbally assaulted" by her husband when were together in her room.

In regards to this safeguarding concern the care home had contacted the police immediately and Mr S agreed to not visit again until he had been seen by the police. The police interviewed Mr S who said that he pushed his wife in response to her shouting at him and hitting and scratching him. The police made the decision not to take any further action. The care home, in consultation with the safeguarding team, CHC team and Mr S agreed that his visits to the home would be supervised, as a short-term arrangement. The adult social care enquiry officer established by meeting with Mrs S that she had no understanding of the incident. A multi-agency safeguarding planning meeting established support for Mr S to support him in recognising the stress his wife's deteriorating dementia had caused him. Professionals worked with Mr S for the next few weeks in developing successful coping strategies in understanding and dealing with dementia. The relationship between the couple improved substantially.

Due to the continued discussions, input and understanding of Mrs S's and her husband's needs by all parties concerned with the safeguarding enquiry, Mrs S has been able to continue to have contact with her husband and remain at the care home where her needs are being appropriately met.

4.13 Swindon Borough Council Learning Disability and Transitions Services

Successes

- Positive relationship with Adult Safeguarding Team
- Prompt allocation of LD / Transitions Enquiry Officers
- Managers / Senior Practitioners completed Enquiry Manager training
- The Team undertook Enquiry Officer training
- Enquiry Officer received a compliment for the quality of the Enquiry Officer report she completed.

Challenges

- Balancing demand of competing priorities of case management and safeguarding enquiries.
- Managers note that the greater risks are not always applicable to safeguarding cases and it's very important to pay attention business as usual which includes Care Act assessments and reviews, of which preventative safeguarding work is an important aspect.

Meeting LSAB Objectives

- As stated all staff have had safeguarding training to the appropriate level. This is also considered for all new staff.
- MSP – the safeguarding enquiries are conducted in a person centred way and staff are mindful of the importance of seeking, including and respecting the views of the person. Staff recognise the importance of and regularly refer to the advocacy service.
- Supervision and team meetings are regularly used as a method of reflecting upon learning.

Case study Swindon Borough Council Learning Disability

Safeguarding concern relates to Mary aged 50 who has a learning disability and behavioural difficulties. Mary lives in supported living accommodation. Mary had a Social Worker from the Learning Disability Team. A safeguarding concern was raised by the manager of the supported living accommodation because of unexplained bruising on Mary's thighs. A female Police officer who attended concluded that the marks were consistent with the restraint techniques. The Manager also confirmed to the social worker that she thought the bruises were caused by poor manual handling techniques.

The social worker undertook a capacity assessment and established through this that Mary was unable to express how the bruising had occurred or about her views or feelings in relation to this engage in or understand the Safeguarding process. The social worker conducted a thorough investigation with the care staff and records. In line with the Safeguarding Principles it was considered that continuing to reside at her current accommodation was the least restrictive option and also preventing Mary from becoming distressed. In coming to this decision the social worker had also considered information from the GP and the Police and had also sought the guidance of the Enquiry Manager. A multi-agency safeguarding plan was established which included unannounced visits to the accommodation, increased training and supervision of staff including agency staff. The outcome of the implementation of the safeguarding plan was that Mary continues to live in her accommodation, additional training and monitoring has been implemented and no further incidents have been identified

4.14 National Probation Service

Successes

The National Probation Service in Swindon attends and contributes to every MARAC. The service also makes referrals to MARAC and plays an active role in working with partners across the Domestic Abuse sub groups. This year, the NPS has been a representative on one DHR as a panel member. The NPS therefore contributed to the recommendations. Additionally, the NPS noted the learning from this and shared across the agency which has contributed to the continual development of staff in regard to adult safeguarding.

Challenges

On occasions this year, a challenge for the NPS in Swindon has been resourcing however our record of partnership working with other agencies to safeguard adults is positive and effective. Positively, the NPS attracts a relatively high number of learners.

Case study

A Probation Officer discovered there were some serious safeguarding concerns regarding a girlfriend (Abbey; not her real name) of a man who was being supervised by the NPS. As soon as the Probation Officer realised Adult Social Care were involved, attempts were made to secure an invite to a meeting which was scheduled. NPS raised their concerns that they had not been invited as NPS were a necessary participant given the information that the service held on the alleged harm-causer and the statutory duty they had to manage his risks of harm. Following swift contact with Adult Social Care, an invite was forthcoming and NPS attended the safeguarding meeting. The Probation Officer is now in regular liaison with the agencies involved with Abbey and a professional's team has been placed around Abbey. Adult Social Care now attend the multi-agency public protection arrangement meetings, which are focused on minimising the harm identified by the alleged perpetrator to ensure positive safeguarding.

Meeting LSAB Objectives

The NPS provides e-learning and classroom learning for all staff in relation to safeguarding adults; this forms part of induction training for staff and we expect our more experienced staff to attend for refresher training every 3 years. A risk assessment, using a nationally approved risk assessment tool is completed for all of our service users; this is tailored to the individual and identifies areas for intervention to provide public protection. These assessments enable the NPS work appropriately with partners to safeguard our service users and those at threat of harm from them. Our work with individuals through offender management provides a rehabilitative framework encouraging service users to take responsibility for their own behaviours and needs, underpinned by a rigorous risk management and sentence plan. In appropriate circumstances, NPS service users engage in Restorative Justice activities to support adult safeguarding.

4.15 **Healthwatch Swindon**

Successes and Challenges
Healthwatch attempted to facilitate a Safeguarding Adults Board User Forum jointly with Swindon Carers Centre. The purpose was to gather the service users of various partners in Sanford House to facilitate a joint service users group, with the idea that Healthwatch would gather feedback from them regarding the safeguarding process. One session was successfully run, albeit only with the service users of Swindon Advocacy Movement (SAM). Voluntary sector partners within Sanford House felt that each set of service users have their own needs, so it didn't appeal to them to join a group being run outside of this. At the last meeting, the topic was Safety in the Community. Community Police Officers were present, with Swindon Borough Council Safeguarding staff, and Swindon Carers Centre. No service users attended. It was decided not to continue with this.

- **Meeting LSAB Objectives**
  Healthwatch staff have the relevant safeguarding training appropriate to their job roles and policies and procedures are in place should a safeguarding incident occur.

4.16 **Avon & Wiltshire Mental Health Partnership**

This reported period commenced with a review of AWP corporate services and the Safeguarding Team were subjected to reorganisation. A number of experienced staff left the team and the number of senior posts were reduced. The Safeguarding portfolio moved to the Associate Director Nursing in September 2018.

The Director of Nursing (DoN) concluded an assessment of the safeguarding arrangements and informed the AWP Board and Chairs of Safeguarding Boards of her concerns relating to gaps in assurance.

The **2018 CQC Report** also found that there were inconsistencies in the reporting of safeguarding incidents through the incident reporting system.

Successes:

- **Appointment of a Head of Safeguarding** In November 2018. After a period of induction the Head of Safeguarding completed a comprehensive assessment of the form and function of Safeguarding with the Trust. The findings concurred with those of the DoN.
- A comprehensive programme of improvement was developed and commenced in December 2018.

- New reporting process from January 2019 providing central oversight of total number of referrals made for the first time
- Improved senior attendance at safeguarding board meetings
- Introduction of a Safeguarding Management group reporting to Quality Safety Risk and Assurance Group
- The **2018 CQC Report** identified that staff had a good knowledge of safeguarding processes and reporting safeguarding incidents.
- The Safeguarding Management Group was established (January 2019). This group reports to the Quality Safety Risk Assurance Group.
- The HoS sits on the Mental Health Legislation Management Group.
- Members of the Safeguarding team regularly participate in the Patient Incidents reviewing meeting and the RCA Ratification meetings.

Challenges:

- To compensate for vacancies and absences, team resources have been prioritised to support frontline work. As a consequence the ability to progress the improvement programme has been limited. Affected projects include the development of an effective system to oversee all high-level investigations and the implementation improved and efficient recording systems.
- Working across 6 local authority areas with competing demands for high priority partnership meetings
- Staff are required to utilise multiple safeguarding procedures and process
- Multiple recording systems
- CQC found inconsistencies in the reporting of safeguarding incidents through the incident reporting system.
- Training provider served notice with effect from March 2019.
- Training matrix / strategy review required which will adversely affect training compliance figures.

5. LSAB and Sub-groups

The Board met on four occasions and was well attended (see Appendix 2). Board members have now committed to consistent attendance at future meetings. The Sub-groups of the Board were quorate. The Sub-groups include:

- The Chairs Group
  Organised the work of the Board and checked on progress of individual sub-groups

- Policy & Procedures
  Directed the review and development of new and revised policy, procedures and guidance

- Quality Assurance
  Developed a framework to complete themed audits and self-assessments to ensure adherence to policy and good practice and identify areas of learning

- Learning, Review & Development
  Consideration of cases for Safeguarding Adult Reviews and looked at learning from other national and local reviews

- Learning & Development Group
  This was previously a joint group with Wiltshire that during the year agreed on a different approach (virtual meetings and annual summit). A new forum for this area of work will be developed as part of the new arrangements

6. Intent and Future Plans for Swindon Safeguarding Partnership Priorities for 2019/20

One of the statutory requirements for the Board as a result of the Care Act is to produce a Strategic Plan. On the 1st April 2019 a Partnership Event took place engaging with all partners of the Adult's and Children's boards. This highlighted the areas of priority, and behaviours expected of all members and agreed what partners want to achieve by developing a new Safeguarding Partnership.

Strategic Priority 1 - Effective Governance

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

At the event on 1st April, it was agreed that partners have a shared responsibility for the protection of children and adults at risk and collaborate in delivering improved outcomes for everyone and that partners need to be confident enough to challenge effectively without blame. It was agreed that there needed to be established behaviours to ensure that the purpose of the safeguarding partnership is fulfilled. As well as concerning itself with day to day safety, protection and safeguarding issues the event discussed the need to develop its standing in the community and be ambitious in its future goals and this needs communicating with the staff of partnership members and the wider community.

With the new structure, there will be an Executive Board that will bring Children's and Adult Safeguarding together. A Delivery Group is in place to bring the new structure together. Separate Boards will be in place, the Safeguarding Adults Board and the Safeguarding Children's Partnership. There will be sub-groups of both Boards some of which will be joint groups:

- Policy and Procedures;
- Practice Review Group (to consider the need to safeguarding reviews or serious case reviews);
- Communications and Engagement; and
- Practice Development Group (to deal with Learning and Development requirements of all partners)

There will be a Performance and Quality Group for each of the Boards due to the complexity of the tasks involved.

SAR Guidance

The SAR guidance requires updating to provide more detail on the application process, including how information should be gathered prior to the decision making on whether to carrying out a review and identifying who will make these decisions. There also needs to be an appeal process where the referrer disputes the decision made by the Board or the Practice Review Group.

Strategic Priority 2 - Performance and Quality

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

Quality Assurance

The Quality Assurance Framework will need to be updated together with a new or revised work plan for the coming year. The new sub-group, incorporating performance, will be agreeing new terms of reference and a process to evaluate cases for audit and identify thematic audits for members of the Board to contribute. The plan is to evaluate how agencies address the government priorities of which "prevention" was the first such self-assessment audit.

Self-Neglect

The increase in the number of referrals concerning self-neglect is of concern and most do not require action from the Safeguarding team. Often these cases are forwarded to the Adult Social Work teams and work is required to ensure that appropriate action is taken by those teams. The Safeguarding team will be carrying out an audit and arranging a facilitated "summit" involving all the Adult Social Care teams to discuss the processes once self-neglect cases are forwarded to the care teams. They will also refer to repeat concerns and consider whether action is required to escalate matters. For example, have protective measures been put in place? And if so, have they been only temporary fixes for the individual.

Data

Adult Services has developed a new care management IT system with an aim that data around safeguarding will be collected automatically. Further work is required to ensure that data required for the national safeguarding return, the Board and the Performance and Quality Group is accurate and available in a format that helps identify trends, assist with quality audits and demonstrates the outcomes for the individual. Senior managers from Adult Services are working on redesigning the system with the supplier and will update the Board on progress.

Multi-Agency Safeguarding Hub (MASH)

Adult Services is in discussion with relevant partners on the feasibility of developing a MASH. A business case is being developed and will be presented to senior managers within the Local Authority.

Strategic Priority 3 - Communication and Engagement

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

At the April event, the need to engage more with the community was seen as a priority for both the Children's and the Adult's Boards. So engaging with the communities that need to be aware of the support offered by safeguarding teams and ensuring those who meet the criteria for safeguarding are aware and know how to report concerns as they arise.

The voice of the person who is the subject of a safeguarding concern is also important and although some attempts have been made to address this, feedback has not been forthcoming. A priority is to work with partners based in the Swindon Advice and Support Centre, particularly with Healthwatch, to establish an effective feedback process and develop a forum that meets the needs and expectations of service users wishing to participate in the Board or discuss areas of concern that can be fed back to the board.

Strategic Priority 4 - Workforce Development

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

With the new structure of the Safeguarding Partnership there will be a joint Practice Development Group which will link the Children's Safeguarding Partnership with the LSAB. This will give the opportunity for shared training that may not have been available to Adult services in the past (e.g. safe recruitment – although a similar course has been run in the past exclusively for managers of provider services).

The Training Strategy for safeguarding adults will need to be revised and updated to include multi-agency learning and develop opportunities that are available or needs developing. As well as the current courses that include: (see over page)

Course Title & Durations	Intended Audience
Basic Awareness ½ Day	All staff working in the Council, health services and in the private/voluntary sector who are regularly in contact with adults in need for care and support.
Foundation Course for Enquiry Officers 1 Day	Any staff within adult services who will undertake supporting role for section 42 enquiries. (Staff from other agencies (e.g. GWH) may attend if they are to fulfil the EO role)
Enquiry Manager Training 2 day	Key Staff within Adult Services who will act as Enquiry Managers
Provider Managers Safeguarding Training 1 day	Managers and senior staff from provider services – course funded and administered by Care Skills Partnership
Coercive Controlling Behaviour and Domestic Abuse Half day	All staff within adult care teams (including mental health), safeguarding and MCA/DOL team/
Mental Capacity into Practice 1 day	Adult Social Care Practitioners

The previous Training Strategy also referred to supplementary courses or sessions that need to be arranged to focus on specific areas. These include: Female Genital Mutilation awareness; Domestic Abuse; Modern Slavery; Self-Neglect; Loan Shark (Illegal Money Lenders) Awareness; On-Line Safety; Dangerous Drug Gangs; County Lines; Substance misuse; PREVENT (Prevention on radicalisation) ; Management of Risk; Sexual Exploitation; Hate Crime – Mate Hate; Prevention; and Health Service Specific Issues. Often these sessions can be arranged with no cost, involving experts from specialist teams (e.g. the Illegal money lending team for Loan Shark Awareness). The Sub-group will need to consider these and prioritise the subjects for delivery.

7. Financial information

In 2018/19, The Safeguarding Adult Board was funded in kind by Swindon Borough Council with a small contribution from Swindon Clinical Commissioning Group and Wiltshire Police without the need for a separate budget for the partnership.
In 2019/20 the funding will transfer to the Swindon safeguarding partnership

8. Appendix 1 LSAB Attendance 2018/2019

Attendance Tracker	Meeting Dates						
Role	**26.04.18**	**19.07.18**	**15.11.18**	**21.02.19**	**Actual**	**Possible**	**%**
Chair	1	1	1	1	4	4	100%
AWP	0	0	0	1	1	4	25%
Care Providers			1	0	1	2	50%
CQC (Annual Attendance)	0	0	0	0	0	1	0%
Dorset & Wilts Fire Service	1	0	0	1	2	4	50%
GWH	1	0	1	1	3	4	75%
Healthwatch	1	1	1	1	4	4	100%
LD Partnership Board	1	1	1	0	3	4	75%
NHS England	0	1	0	1	2	4	50%
Probation CRC	0	0	0	0	0	4	0%
Probation NPS					0	4	0%
SAM	0	1	1	1	3	4	75%
South Western Ambulance Service	0	0	0	0	0	4	0%
SBC - Cabinet Member Health & ASC	1	1	1	0	3	4	75%
SBC - Coporate Director ASC	1	1	0	1	3	4	75%
SBC - Head of Social Work	1	0	1	1	3	4	75%
SBC - Public Health	1	1	1	1	4	4	100%
SBC - Housing	0	0	1	1	2	4	50%
SBC - Community Safegty Partnership	1	1	0	1	3	4	75%
SBC - Heaad of Safeguarding	1	1	1	1	4	4	100%
Swindon Carers Centre	1	1	1	1	4	4	100%
Swindon CCG	1	0	1	0	2	4	50%
Swindon CCG - Named GP for Safeguarding	0	0	1	0	1	4	25%
Swindon CCG - Designated Nurse	1	1	1	1	4	4	100%
Wiltshire Police	1	1	1	1	4	4	100%
Total Actual Attendances	14	12	15	15	56		
Total Possible Attendances	39	39	39	39	156		
% Attendance	36%	31%	38%	38%	36%		

Member
Delegate
No Membership

SWINDON SAFEGUARDING PARTNERSHIP: STRATEGIC PLAN

2019/2020

PURPOSE - The Swindon Safeguarding Partnership will support, enable and challenge each other to work together to:

- Deliver our shared responsibility for the safeguarding of children, young people and adults at risk in the Borough;
- Provide effective and informed leadership to the local safeguarding system;
- Promote positive working relationships with each other and children, adults and families;
- Identify and act on learning
- Provide assurance to the Swindon community

Through our **BEHAVIOURS** we will demonstrate:

❖ Accountability ❖ Openness ❖ Trust ❖ Innovation

❖ Commitment ❖ Respectfulness ❖ Curiosity ❖ Collaboration

AMBITIONS - The Partnership will act with intent and purpose to deliver measurable and meaningful improvements in outcomes for children and adults at risk. This means that the partnership will:

- Create a stronger culture of collective responsibility for safeguarding children and adults
- Act on learning so that the partnership can continuously improve its support for children and adults at risk
- Activate and empower the local community to be safeguarding partners
- Increase the involvement of children and adults in the work of the partnership
- Develop a confident and knowledgeable workforce and use their expertise to shape our work
- Use our data to develop a shared narrative about the safeguarding needs of children and adults in Swindon

CHILDREN, FAMILIES & ADULTS AT RISK

PRACTITIONER

WIDER COMMUNITY

COMMUNICATION & ENGAGEMENT

The right decision is made at the right time for children & families

- Thresholds used effectively by partner agencies to identify risk and inform timely decision making to keep children and adults safe
- MASH includes all key partners and services are effectively co-ordinated across the partnership to promote cohesive & multi-agency working that provides positive experiences for children and families
- Effective information sharing processes in place
- Effective leadership and management oversight in safeguarding practices to keep children safe
- Services will be delivered as early as possible to meet emerging need and prevent needs escalating through early intervention & strength based working

Safeguarding approach for adults with care and support needs is personalised and achieves meaningful improvement in circumstances enabling them to live safe and well

- Improvements in the quality of referrals to cover all categories of abuse leading to clear identification of safeguarding concerns and evidence of consent at initial stage
- Evidence that desired personal outcomes have been realised through ongoing engagement with people about the outcomes they want with an improved enquiry pathway
- A more co-ordinated and consistent multi-agency contribution to a safeguarding adult front door
- To meet the good practice standards and outcomes for adult protection set out in the National Safeguarding Adults Framework

Reduce the number of children and adults with care and support needs being exploited

- Children and adults with care and support needs at risk of exploitation will be helped to stay safe in their community.
- Children and adults with care and support needs affected by exploitation will receive a high level of support and protection to keep them safe
- Perpetrators will be held accountable for their actions, and where possible brought to justice.

Adults with care and support needs live in safety, free from self-neglect

- Enhance practitioner knowledge of self-neglect and the legal framework surrounding it
- Develop fit for purpose risk tools and assessment skills to support strength based recovery-led approach to working and ensures consistency in decision making
- Practitioners are pro-active, build a positive relationship with individuals who self-neglect and adopt an investigative approach
- Multidisciplinary working is embedded with each organisation taking responsibility for their role in supporting the adult to address issues caused through self-neglect

Children live in safety, free from neglect

- Development of skilled & professionally curious workforce through the provision of high quality multi-agency training and tools for children's services with the roll out of the Graded Care Profile across the partnership
- Improved recognition of neglect with better understanding of pathways into targeted services as part of the agreed multi-agency response to neglect
- Mechanisms to provide oversight and understanding of the prevalence of neglect for children and to understand the effectiveness of the multi-agency response.

Improve quality of practice & ensure children/young people and vulnerable adults are at the centre of decisions which relate to their life

- We listen to children, young people, families and adults with care and support needs and ensure their voices are heard
- Escalation is used effectively to resolve professional disagreements or concerns
- Information is shared in a timely manner
- 'Think family' and 'Think holistically' is promoted across the partnership to remove silo working between practitioners and services.
- Effective supervision and management oversight leading to better outcomes for children and adults with care and support needs at risk.
- Practitioners are professionally curious when working with children and adults with care and support needs at risk and respond to their lived experiences.

COMMUNICATION & ENGAGEMENT

WIDER COMMUNITY

PRACTITIONER

CHILDREN, FAMILIES & ADULTS AT RISK

Links to Other Partnerships

Domestic Abuse **(Community Safety Partnership)** Looked after Children **(Corporate Parenting Board)** Early Help, transitions, Emotional health and wellbeing **(Children's Strategic Partnership)** Special Educational Needs/Disability **(SEND Board)** Child exploitation will be a shared priority between children's partnership and children's safeguarding arrangements

Appendix 3: Glossary

ADASS	Association of Directors of Adult Social Services
BANES	Bath and North East Somerset
CCG	Clinical Commissioning Group
CID	Criminal Investigation Department
CPB	Children Partnership Board
CPS	Crime Prosecution Service
CPT	Community Policing Team
CSP	Community Safety Partnership
CSTF	Core Skills Training Framework
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
DSL	Designated Safeguarding Lead
GP	General Practitioner
GWH	Great Western Hospital
GMC	General Medical Council
LD	Learning Disability
LiPS/LPS	Liberty Protection Safeguard
LSAB	Local Safeguarding Adults Board
MARAC	Multi-agency Risk Assessment Conference
MASH	Multi-agency Safeguarding Hub
MCA	Mental Capacity Act
MHA	Mental Health Act
MSP	Making Safeguarding Personal
NHS	National Health Service
NICE	National Institute For Health and Clinical Excellence
QI	Quality Improvement
REP	Risk Enablement Panel
SAB	Safeguarding Adult Board
SAIT	Safeguarding Adult Investigation Team
SAM	Swindon Advocacy Movement
SAR	Safeguarding Adult Review
SARC	Swindon & Wiltshire Sexual Assault Referral Centre

SBC	Swindon Borough Council
SCC	Swindon Carers Centre
SCIE	Social Care Institute for Excellence
STP	Sustainability Transformation Partnership
SwICC	Swindon Intermediate Care Centre
WAAF	Ward Accreditation Achievement Framework

The Safeguarding Adults in Swindon Annual Report 2018/19 is available on the Internet on *SBC Adult Safeguarding page*
It may be produced in a range of languages and formats (such as large print, Braille or other accessible formats) by contacting the Customer Services Department.
Tel: 01793 445500

E-mail: customerservices@swindon.gov.uk

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