Safeguarding Adults in Swindon

Annual Report
April 2015 - March 2016

Great Western Hospitals NHS
NHS Foundation Trust

Keeping Swindon Safe

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

SEQOL
care | health | support

healthwatch
Swindon

PROBATION

DORSET & WILTSHIRE
FIRE AND RESCUE

NHS
Swindon
Clinical Commissioning Group

Swindon
BOROUGH COUNCIL

Safeguarding Adults in Swindon
Annual Report 1st April 2015 - 31st March 2016

Contents:

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

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FOREWORD

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

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

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

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

Diana Fulbrook OBE
Independent Chair of the LSAB

Safeguarding Adults in Swindon Annual Report 2015/16

SECTION 1

Introduction:

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

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

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

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

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

According to the 2011 Census Swindon had a population of 209,159*; of those 28,854 people were aged 65 years or more (13.8%), including 13,694 aged 75 years or more (6.5%). There were 5,547 people receiving services from adult social care in 2015/16 broken down into client groups as follows:

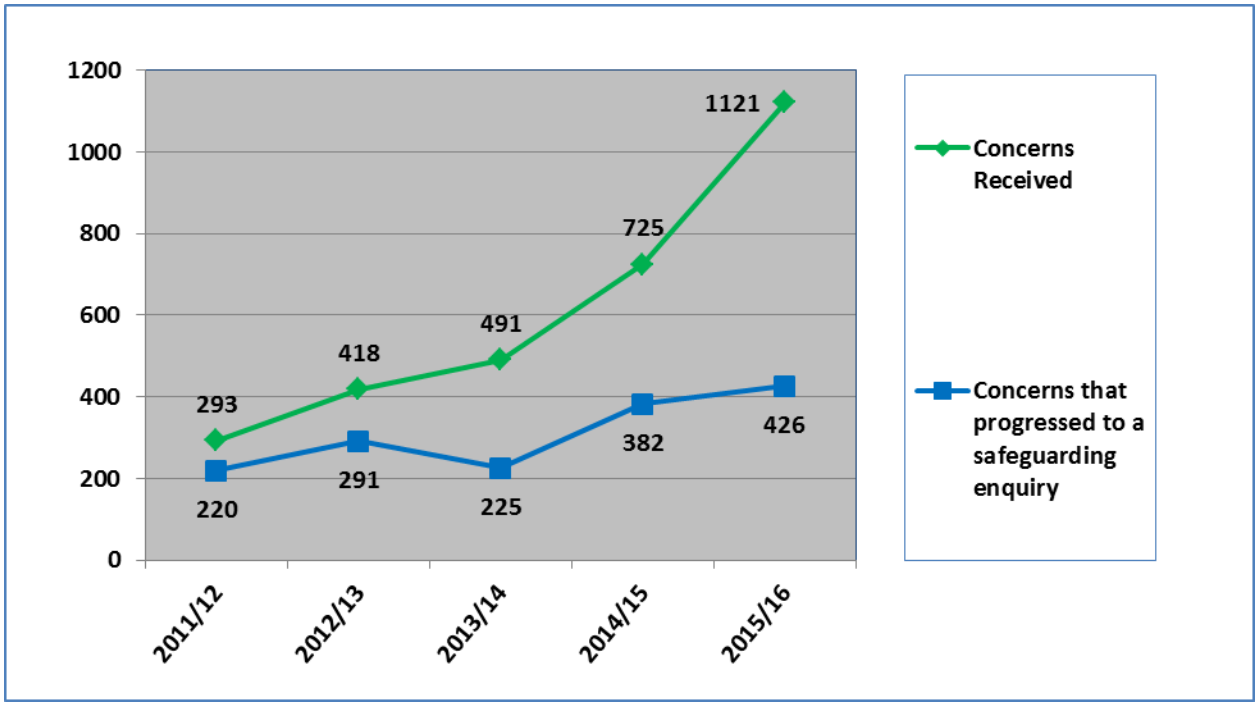
Service User Group	Age Band 18-64		Age Band 65+	
	Female	Male	Female	Male
Physical Disability	501	1980	337	1021
Sensory	29	16	112	74
Mental Health	204	203	68	51
Memory & Cognition	8	6	168	81
Learning Disability	266	349	36	37
Total of Clients	1008	2554	721	1264

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

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

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

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



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

This annual report includes:

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

SECTION 2

Activity Data 2015 – 2016

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

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

Figure 1: Total number of alerts received

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

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

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

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

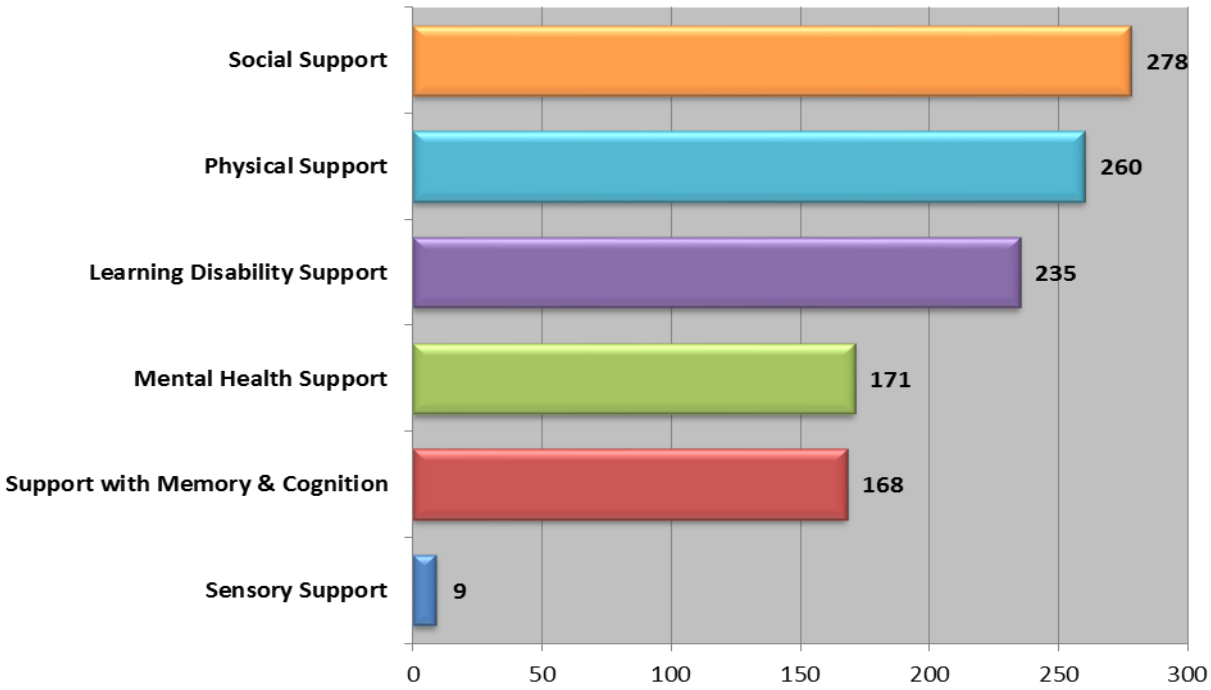
Case Example:
The ambulance service sent a referral in to the safeguarding team as there were concerns about one of their patients who had had a fall in his house which appeared to be untidy. He was diabetic and had an infection on both legs, for which he was treated. In discussion with the person the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

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

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

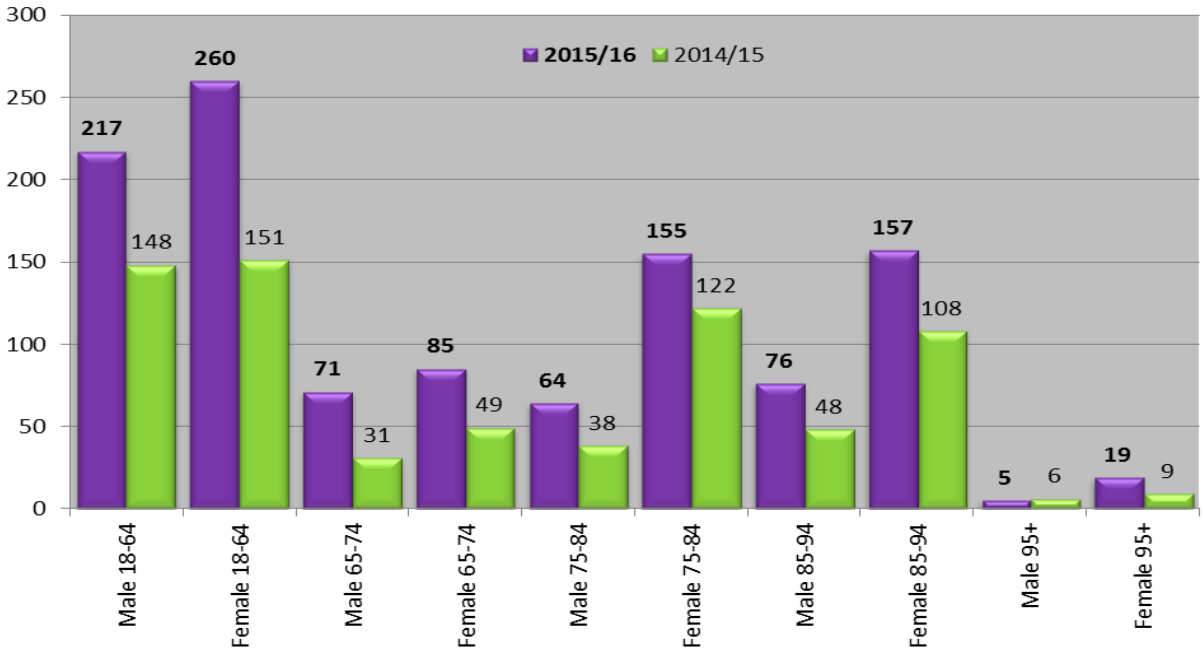
and those that require an enquiry to consider whether agencies need better information or training to promote more accurate reporting.

Figure 2: Breakdown by "Primary Support Reason"



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

Figure 3: Breakdown by Gender and Age



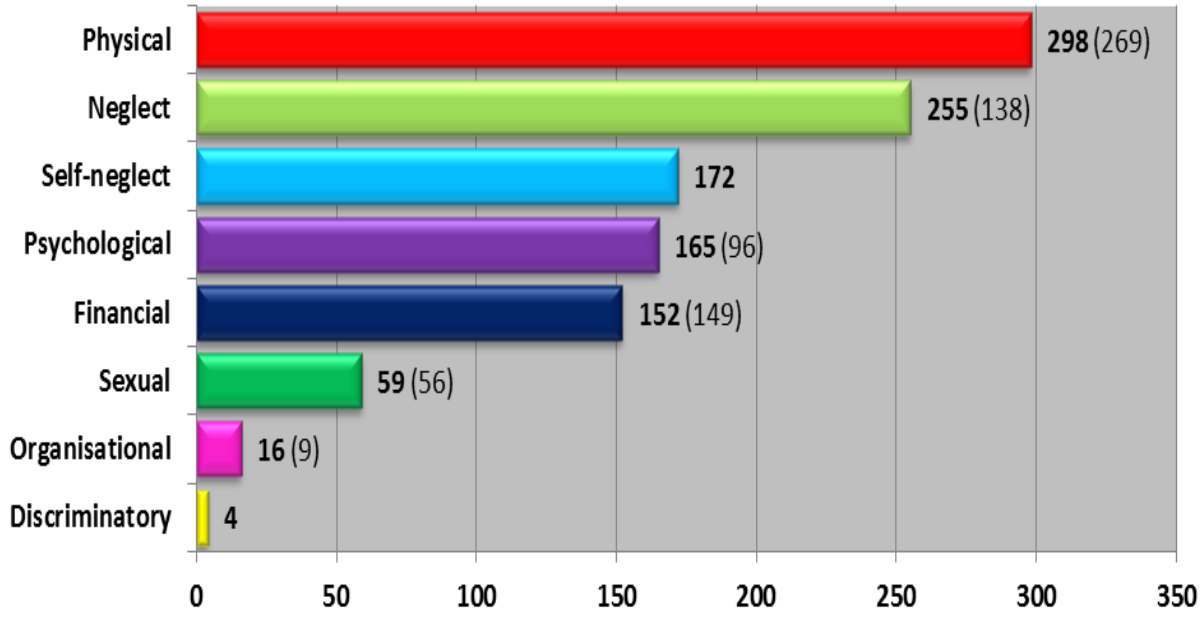
The chart on the previous page shows that the largest increase in concerns raised were regarding adults between the age of 18 and 64 (particularly women). Since the service came into the Council in April 2015, there was a marked increase in the number of referrals concerning people with mental health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

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

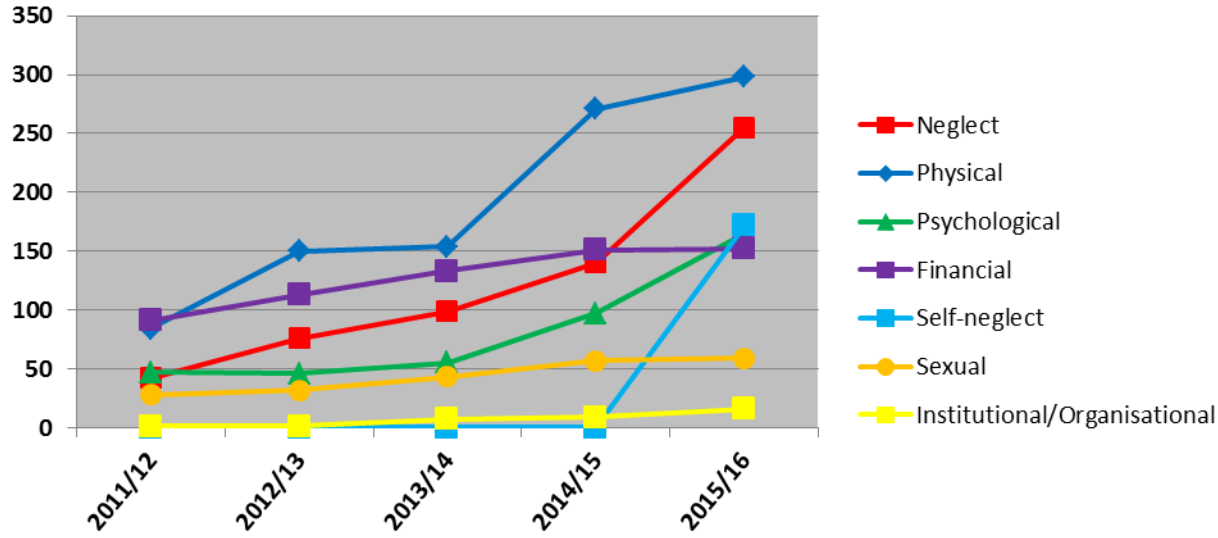
Case Study:

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

Figure 4 Types of Abuse Alleged



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



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

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

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

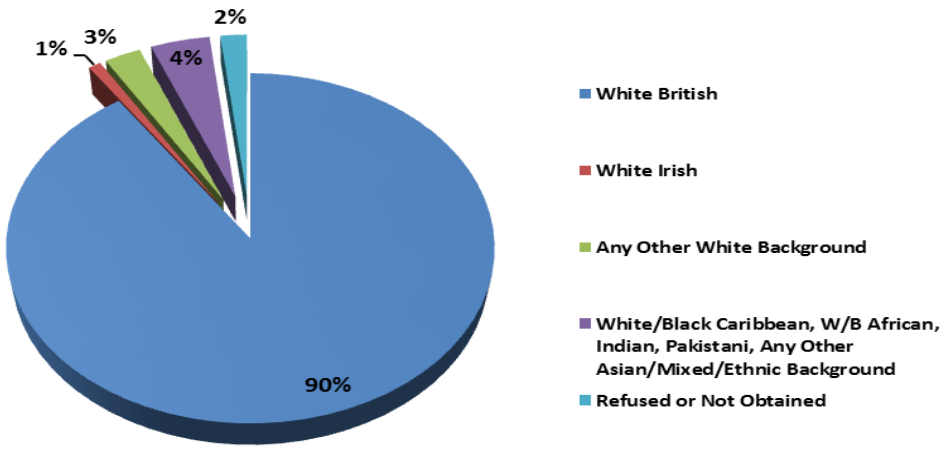
Case study:
Charlene is a 70 year old with a terminal illness. She expressed concerns that one of the carers she gets is not as helpful as the others and at times has been rude particularly following an incident where Charlene was incontinent. However in discussions with Charlene she did not want matters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

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

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

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

Figure 5: Ethnicity of alleged victims



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

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

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

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

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

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

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

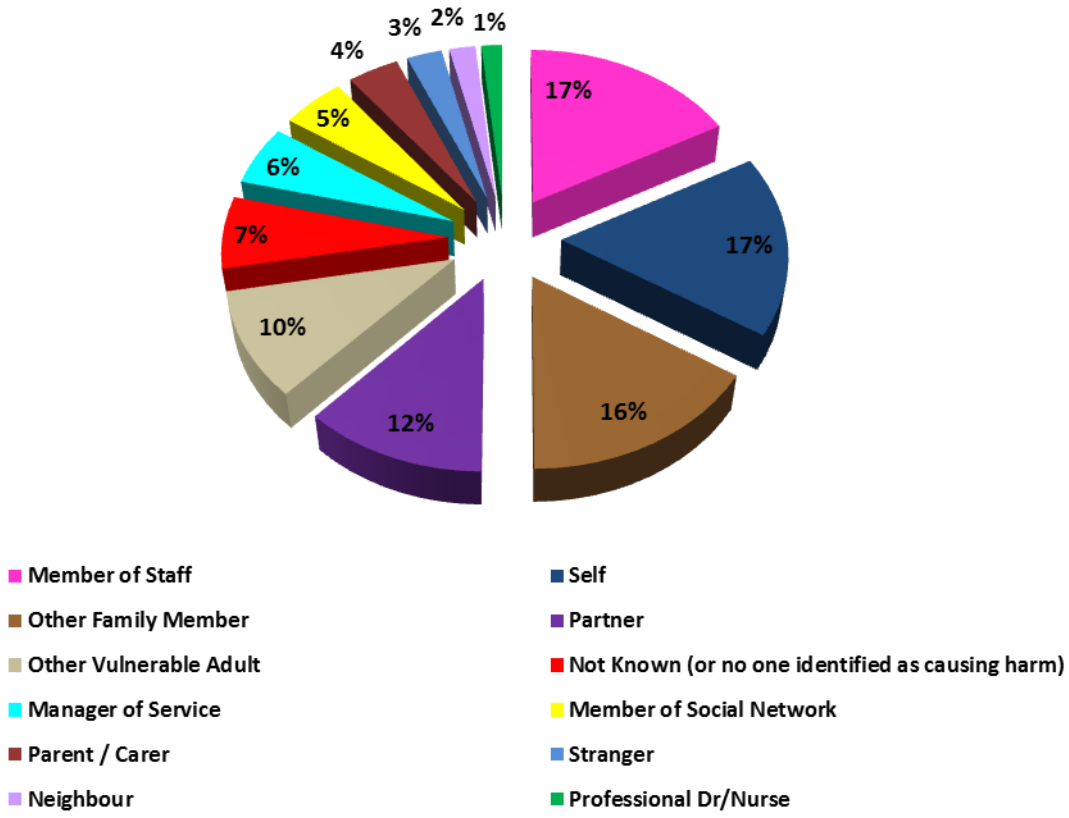
This referral was also unnecessary and should have been recorded in the home's incident book. It is clear that it does not meet the criteria for safeguarding as no abuse or neglect was suspected and the risk of abuse can be minimised by the home (e.g. by removing hazards and reviewing his care plan).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

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

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

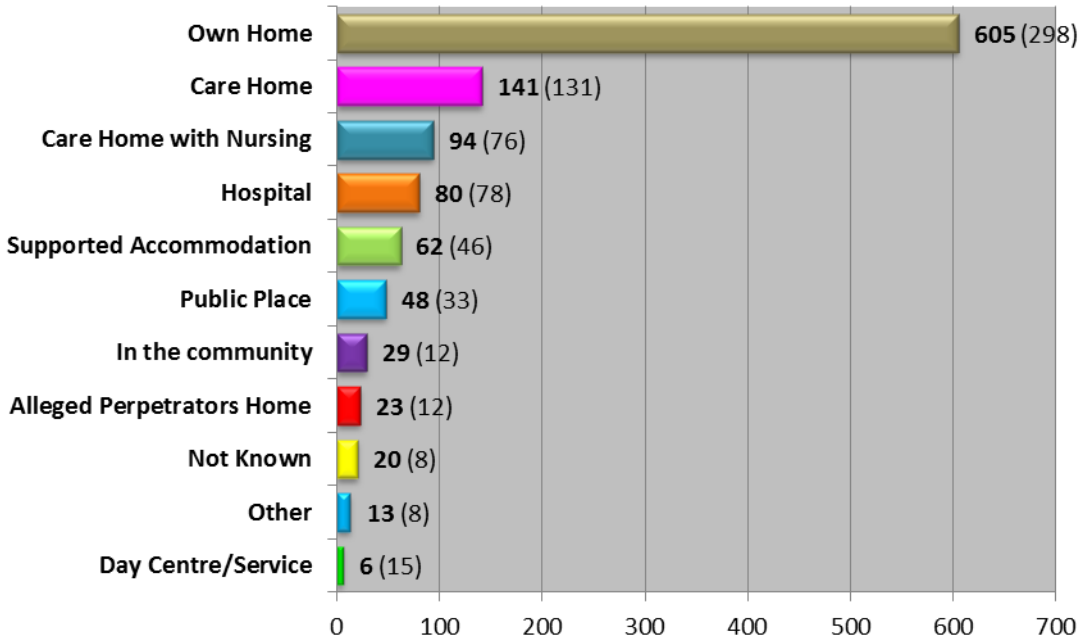
It is encouraging that there are some increases in concerns being raised by members of the public, GPs and services that do not predominately work with people with care and support needs.

Figure 7: Information on those alleged to have caused harm



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

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



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

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

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

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

Enquiries

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

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

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

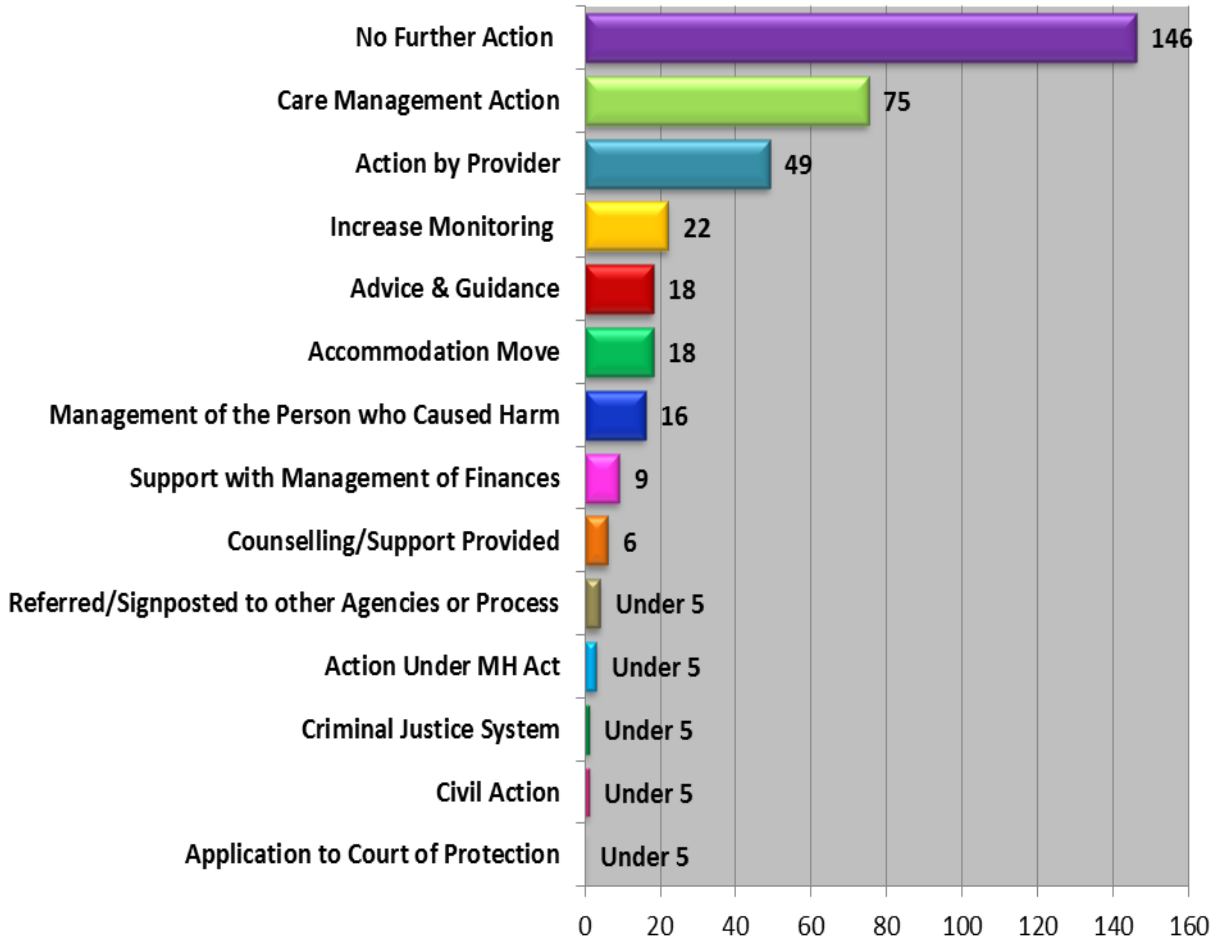
Outcomes of Investigations

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

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

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

Figure 8 Outcomes for the Adult at Risk



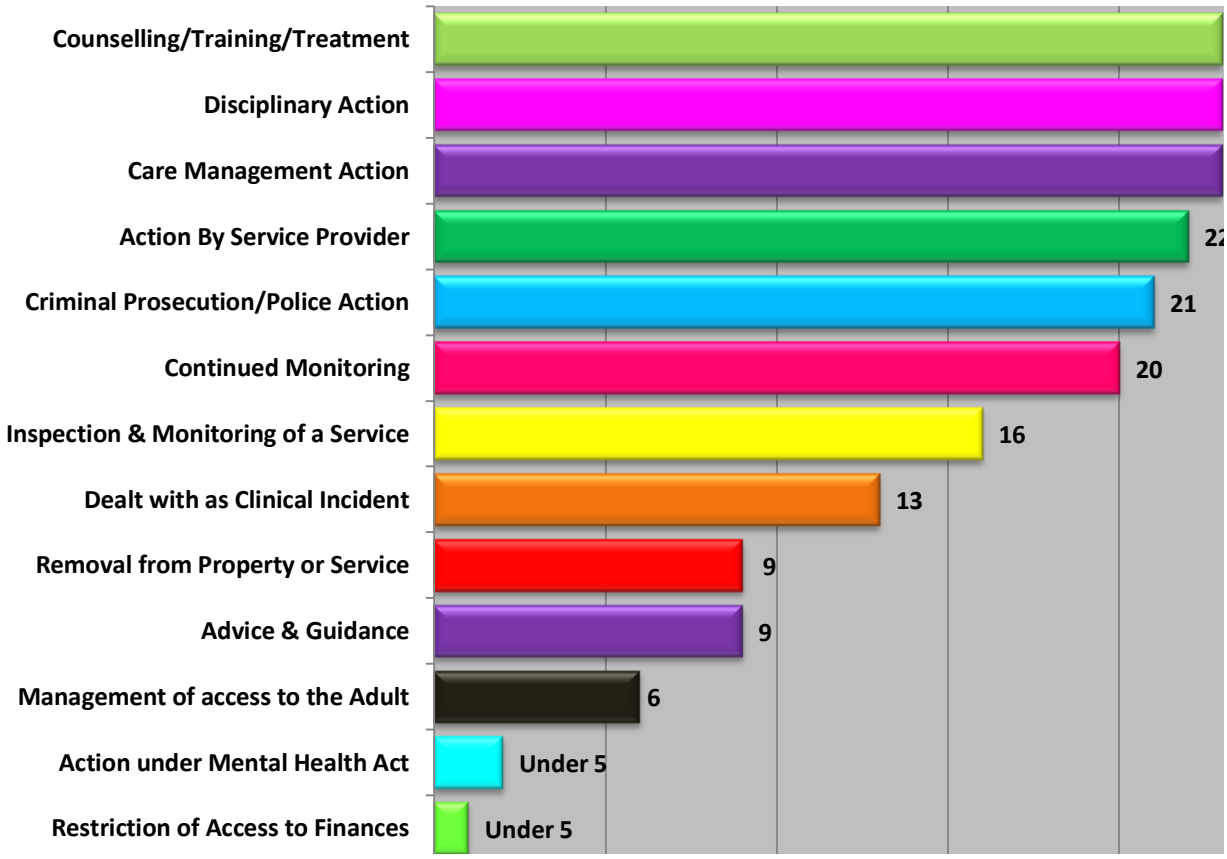
***NB at the time of reporting, 44 cases remained open. This is due to either the alert being raised towards the end of the reporting period and the cases are still under an enquiry or they are long term cases where it has been agreed that the case remains open to enable a continual review of the safeguarding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

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

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

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

Figure 9 Outcomes for the person alleged to have caused harm



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

Safeguarding Adult Reviews

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

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

Large Scale Cases

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

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

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

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

Areas of focus of attention for the Board next year:

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

SECTION 3

Progress, developments and news in 2015/16

Priorities for 2015/16

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

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

- *Wherever possible, the adult themselves is to be included in all stages of the safeguarding process*.
  Within the new safeguarding team, Response Officers have been recruited to engage with the adult at the earliest opportunity. This is to help determine what action needs to be taken, by whom and when. This helps to apply principles included in a national initiative: *Making Safeguarding Personal.* As much as possible, key workers within SEQOL and AWP have been engaged to do this work, as they may have already developed a relationship with the person who is subject of the safeguarding concern and is likely to already have an understanding on how well the person will be able to engage. There is a Quality Assurance Group that looks at a sample of cases and considers how all of the government priorities have been applied – especially how empowered the person was.

- *Ensure that information is available to adults in need of care and support so that they know how to report abuse and neglect themselves*.
  On-line resources and information has been updated. Printed materials have also been updated, however there is a need for these to be printed and distributed.

- *Publication of The Swindon Guide*
  This has been produced and is a *d*ocument given to service users going through the safeguarding process which contains an outline of what happens and gives contact information. There is a need to determine how well it is being used and how well it has been received by service users.

- *Development of a specific Adult Safeguarding (or LSAB) website and consider including a repository for "staying safe" advice for the general public.*
  There is advice available on the "My Care My Support" Website; however, a specific Adult Safeguarding Website is still to be developed. This will be carried forward to the New Year.

- *Increase the membership of the Service User Forum*.
  The Service User forum continues to operate and there is wider membership which has led to the possibility of wider representation on the LSAB.

- *Training for Enquiry Officers involved in safeguarding cases updated to include the emphasis on "Making Safeguarding Personal"*.
  56 staff from SEQOL, AWP and the Local Authority attended these one day training events facilitated by Sally Watson from Awareness Training Ltd.

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

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

Protection – Actions:

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

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

- *Quality Assurance Sub-group to undertake quarterly review of individual cases to evaluate quality of practice and outcomes.*
  The Quality Assurance Sub-group has been established and looks at cases picked at random against the Government priorities as listed in the introduction of this section. More information on this group can be found on page 46

- *Involvement of the correct agency to carry out an enquiry following a safeguarding alert.*
  The Care Act states that local authorities need to make enquires or ensure others do so. The safeguarding team are aware of this and depending upon the circumstances contact the appropriate service or agency to carry out the enquiry and report back to the team. A breakdown of who carried out enquires can be found on page 18

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

Prevention - Actions:

- *Free awareness training provided for all staff who work with people with care and support needs*.
  This continues to be provided on a monthly basis and for some groups, bespoke training maybe provided (e.g. to GP surgeries, to voluntary organisations). For the period covered by this report, 332 people have attended the basic awareness sessions facilitated by the Adult Safeguarding Manager. Some services prefer to provide their own or buy-in training from another training provider. All training now includes a section on the 6 Government priorities.

- *Safeguarding training provided for all private and voluntary sector managers*.
  This course has now been commissioned and designed. It has been funded by the Wiltshire and Swindon Care Skills Partnership for managers and senior staff working care services in Swindon. The course will run early in the new financial year and is designed to help managers of services understand their role and responsibilities with regards to safeguarding adults, prevent abuse and neglect from happening and discuss safer recruitment of staff.

- *Ensure that safeguarding is a key consideration in the tendering and procurement process during the commissioning of all services*.
  A self assessment process that prompts questions around commissioning services has been agreed by the LSAB. This has been trialled prior to further distribution.

Proportionality - Actions:

- *Establish LSAB Case Review Group.*
  This has been established to look at requests for Adult Safeguarding Reviews, to decide on the method required and consider the scope of any cases requiring a review.

- *Proportionality to be included in training for all staff working with people with care and support needs.*
  This is included in basic awareness training run by SBC to encourage appropriate alerts.

- *Case examples discussed at each meeting of the Board and Operational Group and included in LSAB Annual Report*.
  This is a fixed agenda item in the Operational Group and some case discussions regularly take place at the LSAB.

- *The guidelines in the Policy and Procedures need to be changed to reflect the Care Act and requirements within the guidance.*
  Policy and Procedures have been updated and work continues on updating guidance connected to the procedures. This has been a priority and new sections

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

Partnership Actions:

- *It has been agreed that a Risk Enablement Pathway which includes the creation of a multi-agency Risk Enablement Panel should be established in Swindon to work with adults*
  This is now in place, more details on its progress can be found on page 26 .

- *Information Sharing Protocol to be developed and agreed in partnership with Local Safeguarding Children's Board.*
  This has been developed and agreed by the LSAB. However, it has not been possible to develop a single protocol to cover the needs of the LSCB also.

- *Resourcing the Board. Care Act Guidance (section 14.113).*
  Some progress has been made and One Swindon Board match funding has been agreed. However, there is still work required to resolve this to secure funding from other partners.

- *Learning and Development needs to reflect emerging case law, practice and changes to national, regional and local guidance.*
  Safeguarding training modules relevant to job roles have been updated to include the Care Act and its guidance. Case law in regards to the Mental Capacity Act is also included in safeguarding training where it is relevant. Practitioners working in this area, especially if they are Best Interest assessors, attend regular legal updates.

- *Ensure that links are maintained and developed with Community Safety Partnership, Health and Wellbeing Board, LSCB, Domestic Violence Steering Group, Trading Standards, services involved with human trafficking / modern slavery / sexual exploitation.*
  This is an ongoing work and membership of the LSAB has been reviewed in light of this (for example, Trading Standards manager has joined the Board). The LSAB continues to link with the Domestic Abuse Steering Group (being redesigned as Domestic Abuse Board).

Accountability Actions:

- *The Board to agree its position concerning the role of the Designated Safeguarding Manager for each member agency to comply with section 14.176 of the Care Act Guidance.*
  This is no longer required as updated guidance (issued February 2016) removed this requirement following national feedback that the original guidance was "confusing and contradictory".

- *New Council Member training to take place.*
  The Adult Safeguarding manager ran a session attended by 8 members in October 2015.

- *LSAB to be aware of increase in activity as a result of changes to definition e.g. undertaking enquiries where adults are "at the risk of abuse or neglect" (i.e. not just a victim of abuse).*
  The LSAB has regular reports on activity and has expressed concern about the number of referrals received that appear to be inappropriate.
  Also to be made aware of any challenges to decisions where cases are not progressed or where the adult themselves feel their privacy has been breached by agencies raising such concerns
  There have been a few occasions where the person raising a concern has challenged decisions made by the Safeguarding Team. These have mostly been resolved in direct discussion with the person. Sometimes agreement has been reached that the matter raised will be monitored. There have been no complaints with regards to beaches in privacy, however from time to time, when contacted by one of the response officers from the safeguarding team, they have been met with some dismay from those unware that they are subject to a safeguarding concern. The skills of these officers come into play to alleviate any anxiety.

- *To assist with the accuracy of reporting and to help simplify how information is recorded. Adult Services to commission a more up-to-date care management recording system with a detailed safeguarding module*
  This is still outstanding but the intention is still to have a new care management system and work has been taking place to agree the most suitable product.

- *Ensure that training for those involved in co-ordinating and investigating cases is relevant and up to date*.
  All enquiry managers have received the updated training for those coordinating cases during the year.

RISK ENABLEMENT / MANAGEMENT PANEL

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

In response to this, the partners within the Local Safeguarding Adults Board agreed to the development of a multi-agency risk assessment process to ensure effective case planning and decision making in relation to adults with multiple needs who do not reach the threshold of Adult Safeguarding investigations. Funding to develop this was obtained from the One Swindon Board.
The panel has now been developed together with an agreed pathway. The multi-agency process will only be enacted when all other interventions have not produced an improvement in outcomes for the individual of concern. The role of the Risk Enablement Panel is to facilitate, develop risk management plans and monitor their effectiveness.

The Objective of the panel is to:

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

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

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

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

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

Areas of focus of attention for the Board next year:

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

SECTION 4

Swindon Mental Capacity Act Programme

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

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

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

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

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

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

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

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

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

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

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

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

Court of Protection (CoP).

Apointeeships and Deputyships held by the Council:

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

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

SECTION 5

The Swindon Local Safeguarding Adults Board and its Member Organisations

1. The Board

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

Independent Chair
Avon & Wiltshire Mental Health Partnership NHS Trust
Bristol, Gloucestershire Somerset and Wiltshire Community Rehabilitation Company (BGSW CRC)
Cabinet Member for Health and Adult Social Care
Care Quality Commission (annual attendance)
Dorset and Wiltshire Fire & Rescue
Great Western Hospitals NHS Foundation Trust
Healthwatch Swindon
Learning Disability Partnership Board
LSAB Service User Forum
NHS England South (South Central)
SEQOL
South West Ambulance Service NHS Foundation Trust
Swindon Advocacy Movement
Swindon Borough Council
- Board Director, Service Delivery
- Director, Public Health
- Adult Safeguarding Manager
- Head of Housing and Community Safety
- Board Director, Commissioning (DCS/DASS)
- Head of Commissioning
- Trading Standards

Swindon Care Homes Association
Swindon Clinical Commissioning Group
- Executive Nurse
- GP Lead

Wiltshire Police

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

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

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

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

2. Board Member reports

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

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

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

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

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

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

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

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

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

2.2 Dorset and Wiltshire Fire and Rescue Service

Wiltshire and Dorset Fire Services combined 1st April 2016 to form Dorset and Wiltshire Fire and Rescue Service and we remain committed LSAB partners.
Empowerment, Protection, Prevention, Proportionality and **Accountability** are best referred to via our new safeguarding policies and procedures which are available from the service's Safeguarding Coordinator which was put into effect following our merger. Key points to note are;

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

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

2.3 Great Western Hospital Foundation NHS Trust

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

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

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

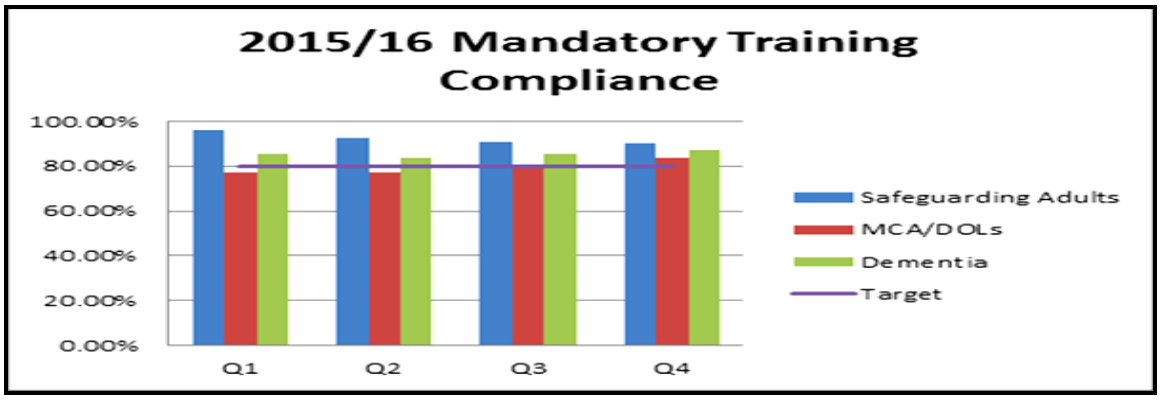
The safeguarding structure at GWHFT has developed over the year with clear accountability to the Chief Nurse. There are now two safeguarding teams, one for the acute site and services, and one for community sites and services. Each is led by a senior clinician who works with a safeguarding lead who provides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

The highlight achievements within the financial year

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

Breakdown of figures for safeguarding adults staff training within the year

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



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

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

Trust Strategic Vision

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

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

2.4 Healthwatch Swindon

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

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

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

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

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

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

2.5 NHS England South (South Central)

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

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

NHSE's structure and approach to safeguarding adults work

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

Achievements within the financial year

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

Staff training for 2015/16

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

Key plans or objectives for safeguarding adults in the coming year
National Priorities: (Requested further information about these items)

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

***Local Priorities*:**

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

2.6 Public Health

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

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

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

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

2.7 SEQOL

SEQOL is an employee-owned social enterprise whose purpose is to support people to make the most of their lives. We provide a wide range of community and specialist services, which include Community Nursing, Urgent Care, inpatient care at our Intermediate Care Centre (SwICC), social work assessment and care management, and supported employment. At the year end, 71% of our workforce had booked or attended Safeguarding Adults training, and plans are in place for that figure to rise significantly in the first half of *2*016-17.

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

Case Study

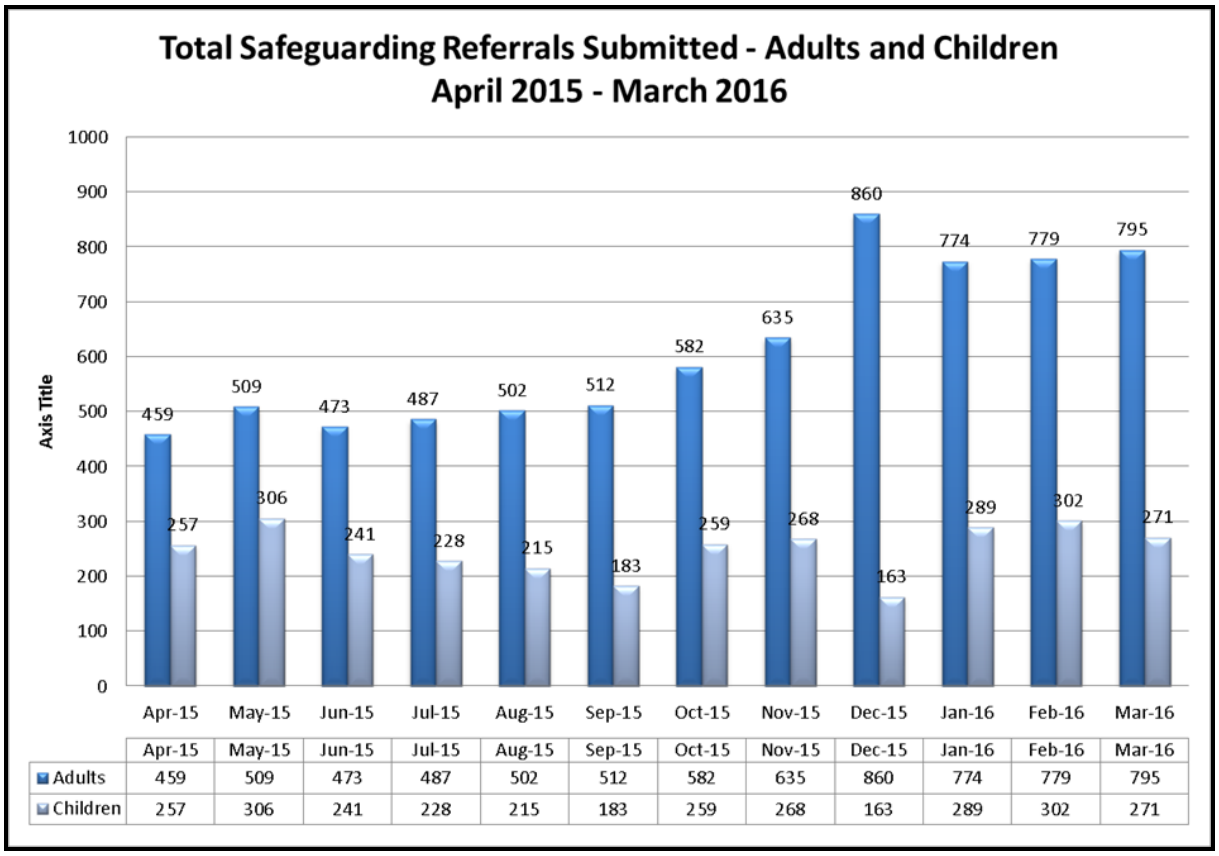
Miranda is a woman in her 60's who has a number of long term conditions and has had a stroke in the past. She lives in sheltered accommodation supported by a warden. A safeguarding referral was made by the warden pertaining to possible financial abuse by a family member. As one of the social workers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

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

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

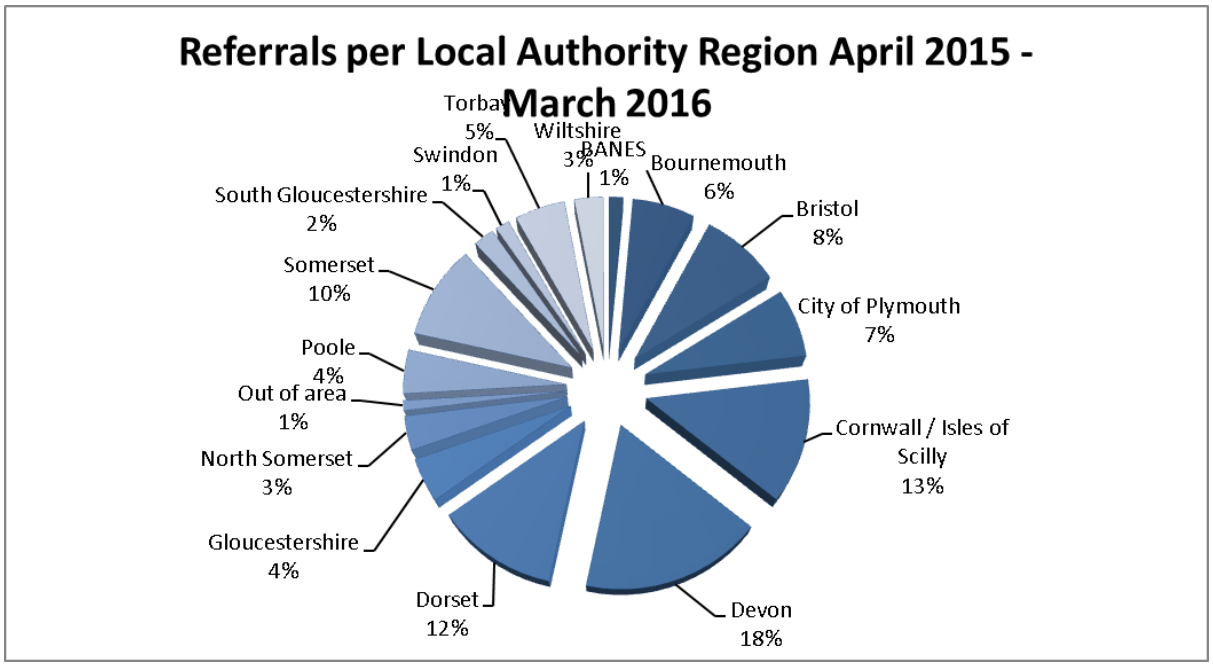
2.8 South Western Ambulance Service NHS Foundation Trust (SWAST)

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



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Adults	459	509	473	487	502	512	582	635	860	774	779	795
Children	257	306	241	228	215	183	259	268	163	289	302	271

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



Overview

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

Impact

Achievements this year

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

Future challenges

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

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

Objectives for 2016-2017

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

2.9 Swindon Borough Council – Housing Services

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

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

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

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

2.10 NHS Swindon Clinical Commissioning Group

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

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

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

Progress and Priorities for 2016/17
In order to meet the aims and outcomes of the Swindon LSAB strategy, during 2015/16 NHS Swindon CCG identified its roles and responsibilities against the six principles which are monitored via the LSAB, LSAB Operational Group, the CCG's Commissioning for Quality Committee and the Adult Safeguarding Quality Assurance Group.
The CCG is committed to meeting the requirements of the strategy via full implementation of key identified work streams, which has included:
Empowerment: As a member of the Quality Assurance Group, the CCG continues to contribute to a review of advocacy services to support alleged victims of abuse or neglect.

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

Prevention: Safeguarding is a key consideration in the tendering and procurement process during the commissioning phase. All commissioned provider services have continued to be regularly monitored against compliance to safeguarding schedules, policies and procedures, with more detailed discussions held at the monthly/quarterly clinical quality review meetings (CQRMs).
The CCG has continued to work with safeguarding leads, partner agencies and commissioned provider service leads to ensure appropriate feedback is received and learning acted upon with regards safeguarding investigations associated with reported clinical incidents (such as avoidable pressure ulcers).

Outcomes, lessons learned and actions plans are shared and monitored to support a reduction in reported harm across the healthcare setting. Strong links have been established between the CCG Quality Team and Swindon Borough Council Safeguarding Team in order to share learning. This has supported collaborative learning and clarified outcomes by reducing duplication of the investigation process.
The CCG has reviewed and ratified the Safeguarding Children and Adults at risk policy during 2015/16.
All CCG staff (100%) have completed relevant mandatory safeguarding adults training.

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

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

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

2.11 Swindon Community Safety Partnership

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

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

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

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

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

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

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

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

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

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

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

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

2.12 Swindon Advocacy Movement

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

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

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

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

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

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

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

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

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

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

Accountability:

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

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

Case study

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

2.12 Wiltshire Police

Safeguarding Adults Investigation Team (SAIT)

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

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

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

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

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

Case study

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

3. Sub-groups of the LSAB

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

Agenda Items during the year included:

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 6

Priorities for 2016/17

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

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

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

Strategic Priority 1
Effective Governance
We will develop the capacity of Swindon LSAB and its infrastructure to effectively deliver the core functions of the Board to help keep adults with care and support needs in Swindon safe

We will do this through:

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

Strategic Priority 2
Performance and quality
We will ensure that there are effective multi agency quality assurance and performance management processes in place which will promote the welfare of adults with care and support needs and will hold partners to account

We will do this through:

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

Strategic Priority 3
Communication and engagement
We will ensure there is a consistent and co-ordinated approach to how the safeguarding message for adults is disseminated to all groups and communities in Swindon, and we will ensure that we engage adults and communities of all backgrounds and make up in the work of LSAB

We will do this through:

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

Strategic Priority 4
Workforce development
We will ensure the workforce of all partner agencies has access to and has undergone robust training relevant to their role, and understand how to apply it to their role

We will do this through:

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

Next Steps

- The Operational Group, on behalf of the Board, will draw up an annual business plan for 2016/17 that outlines how the strategic priorities will be delivered and the outcomes required to measure progress. This will be monitored by the group and reported to the Board throughout the year and will inform next year's Annual Report

- The Board will also produce a business risk register to underpin this strategic plan that will identify the key risks that have the potential to prevent its delivery

Glossary

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

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

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