Safeguarding Adults in Swindon

Annual Report
April 2016 - March 2017

Great Western Hospitals NHS
NHS Foundation Trust

Keeping Swindon Safe

Dorset & Wiltshire Fire and Rescue

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

healthwatch Swindon

Probation

NHS Swindon Clinical Commissioning Group

Swindon Borough Council

Safeguarding Adults in Swindon
Annual Report 1st April 2016 - 31st March 2017

Contents:

- *Please note, any names or initials referring to alleged victims used in case studies within this report are fictitious (with the exception of case included on page 41)*

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FOREWORD

I have great pleasure in presenting the Swindon Safeguarding Adults Board's Annual Report for 2016/17. This outlines the achievements during the year as well as highlighting some key issues to address. The report contains statements from member agencies 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 2017-20 so there is a strong link between the two documents.

During the year, the Board worked to the four priorities in the strategic plan: effective governance; performance and quality; communication and engagement; and workforce development. The Board now considers performance data at every meeting and also discusses a specific case in order to better understand the complexity, approach and outcome of partnership working. The Board is therefore clearer about the areas it needs to focus on, namely: The continuing increase in referrals, their source and quality; the gap between concerns raised and those that require an enquiry; financial abuse; ethnicity of alleged victims; the interface between safeguarding and how clinical incidents are managed; and the training of staff in care homes.

Effective partnership working is a key success factor, and resources continue to be problematic for all agencies. Consequently, the Board struggles to deliver its aspirations due to a lack of sufficient funding and its ability to implement the agreed new structure. Turnover and representation levels of Board members is a continuing factor but despite these obstacles, progress has been made and safeguarding remains a priority for member agencies. 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 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 2016/17

SECTION 1

Introduction:

Over the last 2 years, since the Care Act came into force, the Local Safeguarding Adults Board and the Adult Safeguarding team with Swindon Borough Council, has continued to develop its work and consolidate practice to fulfil statutory duties. Safeguarding Adults is included in the Care Act 2014, and the 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.

The duty to carry out safeguarding enquiries and facilitate safeguarding boards lies with the local authority. Swindon Borough Council has developed a dedicated team to manage concerns raised and ensure any necessary enquiries takes place. This team sits within adult services. The LSAB is in place to support adults with care and support needs who are unable to protect themselves, whether or not the local authority meets or funds these needs. The focus of the LSAB is around abuse and neglect and works towards prevention, protecting people when there is a concern, empowering people to participate in processes and ensuring there are proportionate responses. The Board can be held to account by the Health and Wellbeing Board and will develop partnerships to fulfil its overall functions.

According to the 2011 Census Swindon had a population of 209,159*; of those 28,854 people were aged 65 years or more (13.8%), including 13,694 aged 75 years or more (6.5%). The midyear estimate of population from the Office of National Statistics puts the total at 220,245 (15.4% of this estimate are over 65 years old and 7% are over 75) There were 5,335 people receiving services from adult social care in 2016/17 broken down into client groups as follows:

Service User Group	Age Band 18-64		Age Band 65+	
	Female	Male	Female	Male
Learning Disability Support	279	366	36	43
Mental Health Support	40	68	53	41
Physical Support - Access & Mobility	312	171	730	351
Physical Support - Personal Care Support	206	200	1361	767
Sensory Support (Dual, hearing & Visual)	19	10	75	34
Support with Memory and Cognition	6	4	108	54
Total of Clients	**862**	**819**	**2362**	**1290**

The 2016/17 figure shows a 3.82% decrease on 2015/16 when there were 5547 people receiving services. This decrease could be attributed to a number of initiatives designed to provide support, which delays or prevents people from needing social care services. For example, Swindon Circles who match volunteers with people living in the community to reduce isolation. There are also a number of schemes managed by voluntary organisations in Swindon funded to provide similar support to reduce reliance on statutory services.

*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.

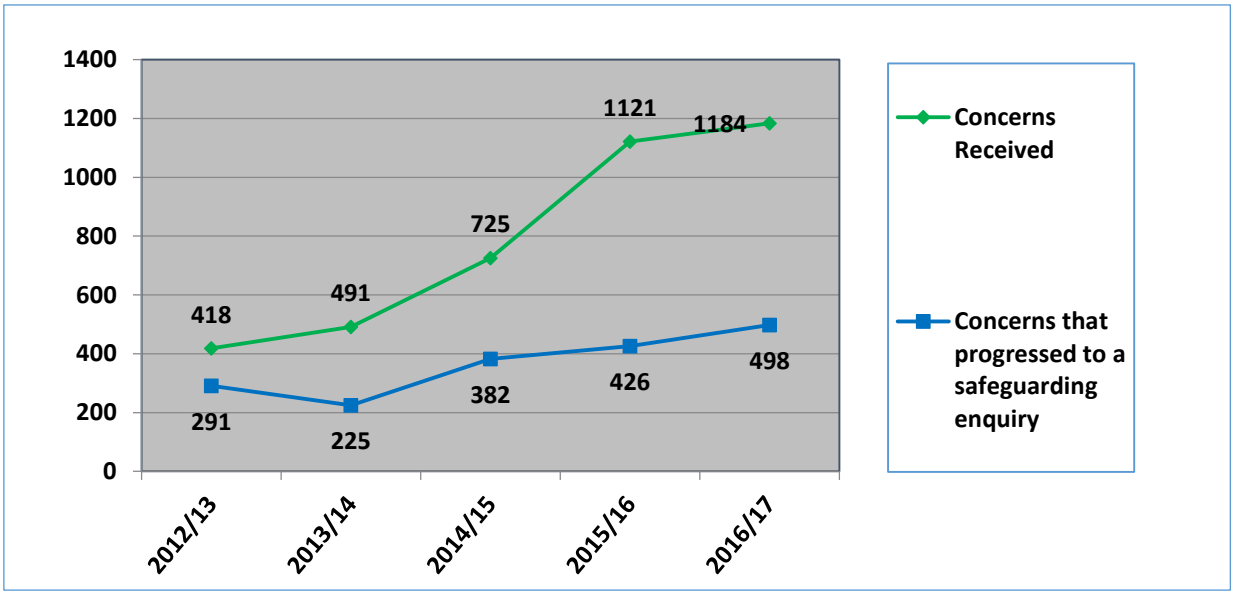
The Borough of Swindon is largely urban with small pockets of rural areas. Within Swindon there are some deprived areas which can also impact on levels of vulnerability for some of those living there. Crime volumes in Swindon and Wiltshire are low in comparison to other Police force areas although there has been an increase in the number of reported crimes. In Swindon during the period from 1st July 2016 until 30th June 2017, there were 40391 reported crimes, a 10.2% increase on the previous twelve-month period. There has also been an increase in the number of reported Hate Crimes. There is a commitment to partnership working in Swindon to: prevent Crime and anti-social behaviour; protect the most vulnerable in society; work in a person centred way and secure high quality, efficient and trusted services.

The number of concerns reported to the safeguarding team continues to increase. However, this year, it appears that the increase is lower than in previous years (5.6% increase as opposed to 56% increase in 2015/16). There has been a 17% increase in 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) enquiry. This increase could signify that the accuracy of concerns raised is improving, or the team receiving concerns are becoming cautious when screening cases out. There are a number of reasons cases do not progress to an enquiry:

- Referred to another process that is more appropriate to deal with the matter (and no enquiry is required),
- Signpost (particularly if the concern does not affect an adult in need for care and support),

- There is no further action required (for example a provider may have already carried out an enquiry, or the person is not in need for care and support, or the person is able to protect themselves or no abuse has been alleged), or
- The person who is subject of the abuse or neglect does not want any further action.

Below is a graph that shows the gap between alerts or concerns and the number of enquiries needed.



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 2016/17,
- Submissions from key partner agencies and members of the LSAB, and
- An overview of the priorities for 2017/ 18.

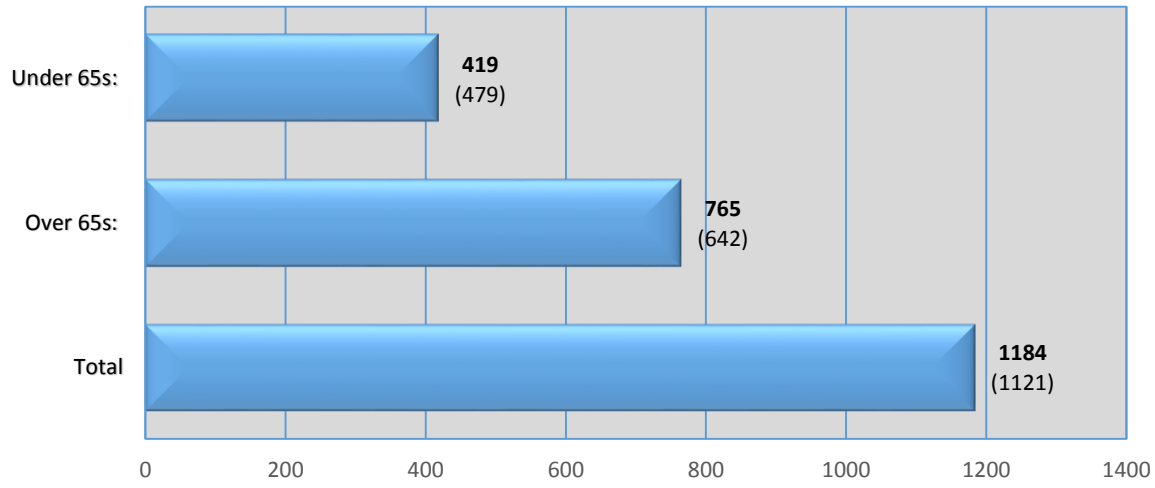
SECTION 2

Activity Data 2016 – 2017

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

The Adult Safeguarding Manager using information provided by the adult safeguarding team has collated the following data. 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



There has been a smaller increase in the number of concerns raised – a 5.6% increase. It is believed that there is some over reporting where agencies and providers are sending referrals for either minor incidents, incidents that have already been managed correctly or are not matters to be dealt with by the safeguarding team and should have been sent to the relevant care team as it highlights a need for a service.

Case Example:
The ambulance service responded to a call to treat a patient who had had fallen from his bed. They found out that his wife is his sole carer and receives no outside help. She said she had applied for carers to come in to assist but her husband asked for this to be cancelled and he did not want outside help. She requested that the ambulance service put in a referral to review their care package as she was struggling to cope. This did not require action by the safeguarding team other than to pass on the concern to the relevant care team.

Often concerns are sent through although there is a lack a clarity about what may have occurred. Sometimes care providers will send these in "to cover themselves" although there is no need for an enquiry or further action. It should be recognised that each case requires a substantial amount of work and staff time.

Case Example:
A care home for people with learning disabilities reported that an altercation had taken place between two of their residents over the TV remote control. They thought there could have been physical contact but were not sure. The referral said the manager of the home had talked to both parties who were unconcerned and they recorded it as an incident in home's records. No further action was required as no abuse had taken place and the home had already taken appropriate action. The referral was unnecessary.

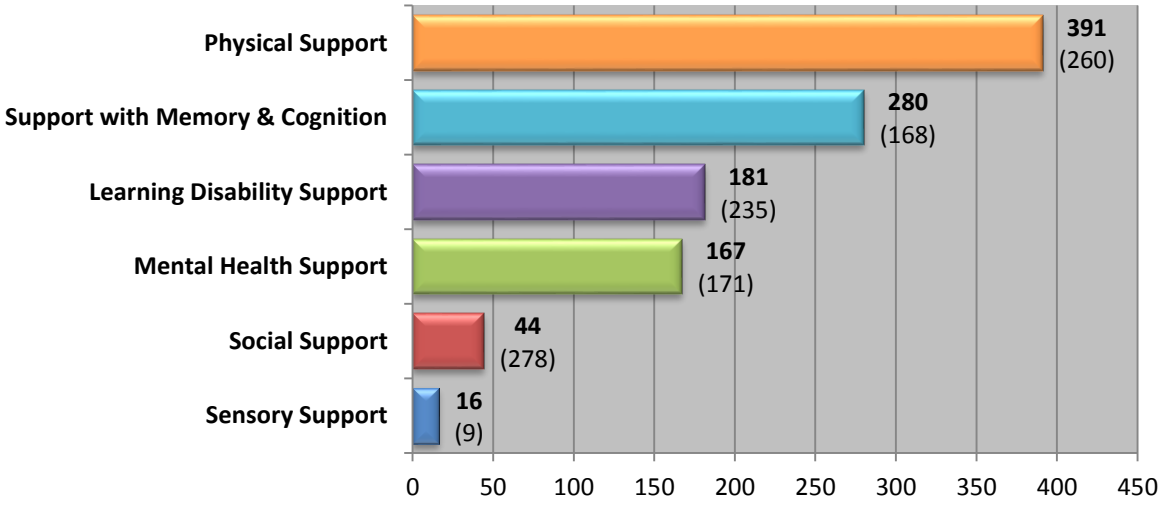
Other local authorities also continue to report increases and have worked with providers and their own teams to reduce the number of inappropriate referrals. Similar work has taken place in Swindon, for example setting up a duty manager system who can advise on the need for submitting a concern. The LSAB are monitoring this issue and are keen to see a reduction in the number of unnecessary referrals by improving training, available information and checking the effectiveness of the safeguarding team's processes.

The table above shows there is a significant decrease in the number of concerns raised regarding females who are under 65. There have been fewer concerns from care providers and where concerns about someone's welfare was previously recorded by the safeguarding team, if their report does not contain an allegation of abuse or neglect, it is recorded separately before forwarding to the correct team.

Of the 1184 cases reported, 498 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 enquiry 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.

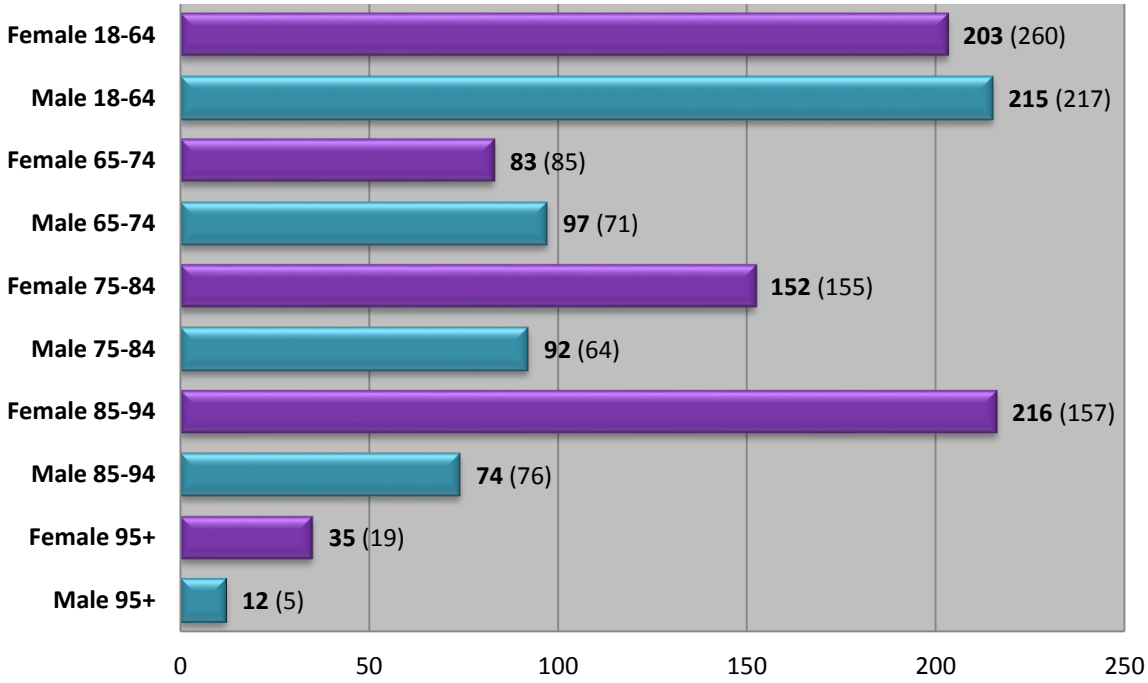
Figure 2: Breakdown by "Primary Support Reason"



The chart above shows the primary support reasons of the people who were subject of a safeguarding concern *at the point of the referral.* Although figures from the previous

year are shown in brackets, these may not be helpful as the support reasons may change. For example, someone with dementia (support with memory and cognition) may have been recorded as needing physical support as they were recovering from a fall. The vast difference in the number of people recorded as requiring 'social support' is more likely to be due to more accurate recording in 16/17 rather than there being a massive decrease in concerns for this group of people.

Figure 3: Breakdown by Gender and Age

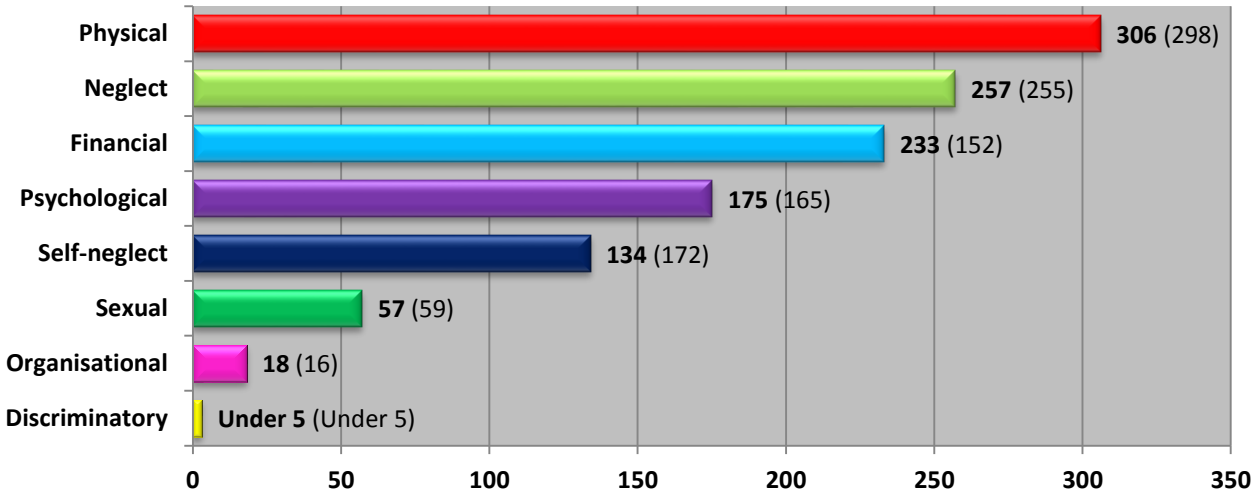


Last year, it was reported that the largest increase of reported concerns with regards to age and gender were adults between the age of 18 and 64 particularly women. This year for this group, this is the biggest decrease (59 cases). On looking further into these figures, there were a small cohort of women of working age, where a number of unrelated repeat concerns were raised. In 2016/17, either no concerns had been raised or the number of concerns reduced. In three cases, the repeat concerns were regarding their chaotic lifestyles, which were putting them at risk. These people became subject of the Risk Enablement Panel (see page 24) which has worked to resolve the risks. In one case, their risk taking behaviour resulted in a custodial sentence.

There was an increase in the number of women aged over 85. In most of these cases, they were concerns about abuse or neglect in their own home and of these, 36% of reports were with regards to a carer (not a paid member of staff) or a family member considered to be their main carers. As well as cases that could be considered to be incidents caused by carer's stress, there have been a number of cases regarding financial abuse. Often the individual does not want action taken because they do not want their family member to get in trouble. Help with managing finances could be an outcome in these circumstances, but where the victim lacks capacity, such cases can be very complex and difficult to get a resolution and require input from the Office of the Public Guardian.

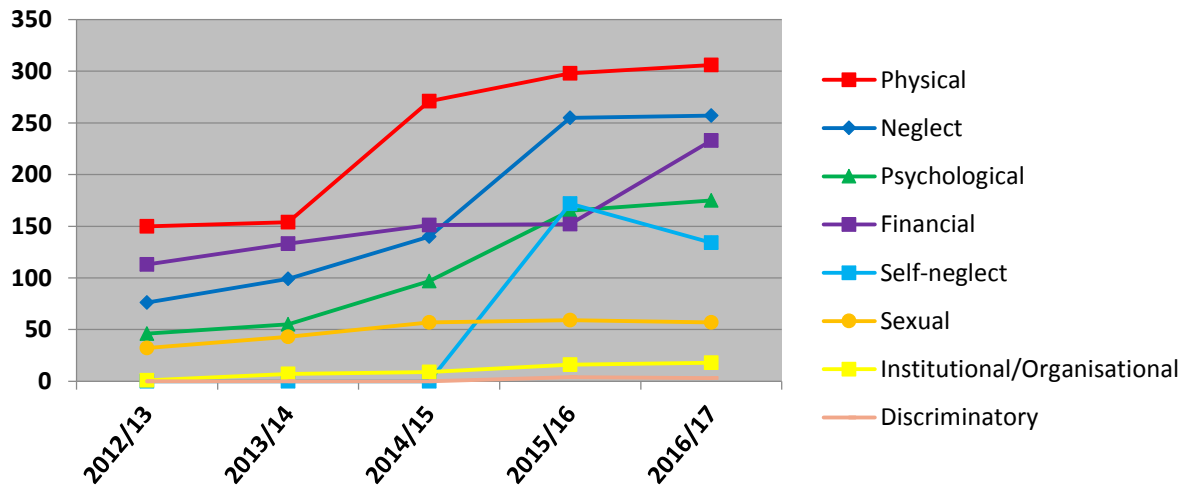
Case Study:
As a result of a financial assessment, (an assessment carried out to find out if service users need to contribute to their care costs), it was found that Mabel Jerome's savings had reduced by about £40,000 over 18 months. She no longer manages her own money and one of her family members is her Power of Attorney for property and finance. As Mabel is house bound and has a simple lifestyle, expenditure of this level was unlikely to be initiated by her. There were frequent bi-weekly withdrawals from cash machines – something Mabel has never done and is unable to do. She was also paying large mobile phone and Cable Channel bills. A safeguarding concern was raised by the Finance and Benefits Team and it was agreed that an enquiry was needed. The Police considered the case but felt there was no criminal investigation required but it was believed that it needed to be referred to the Office of Public Guardian (OPG) as the Power of Attorney might be mismanaging the finances. Following a lengthy investigation by the OPG, they revoked the Power of Attorney and advised the local authority to set up a Deputyship (see page 27).

Figure 4 Types of Abuse Alleged



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

Figure 5 Types of Abuse Alleged Over the Last 5 Years



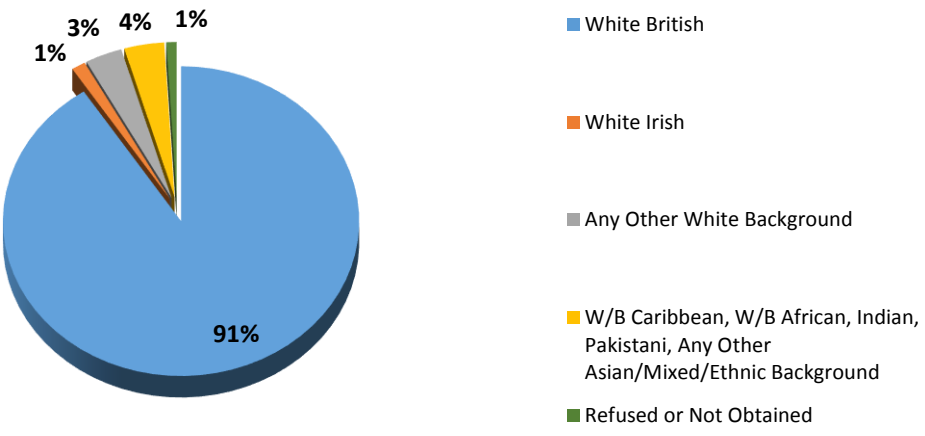
There has been a large increase in the number of concerns that relate to financial abuse. These can range from minor losses to those where there is a possibility of considerable loss of money or property. The level of concerns about financial abuse has been quite stable during the preceding two years, but there is a 53% increase in the number of these concerns. Further work was carried out to see whether the prevalence of financial abuse was greater in particular areas of the town or was more or less prevalent in deprived areas. This showed there were no particular patterns and it was as common in more affluent areas as those considered deprived.

There has been a decrease in the number of concerns recorded as self-neglect because most concerns are about people needing more support and agencies are more aware of direct referral to care teams. Although these cases may still come through to the safeguarding team, they are not included in the overall activity. In 2016, the Department of Health provided some clarification on this matter, stating that concerns about self-neglect need to be considered on a case-by-case basis. While there is less of a need to carry out an enquiry under the Care Act, it should be noted that some of the concerns raised have highlighted serious concerns of extreme self-neglect or extreme hoarding where some immediate support is required as the person has been considered to be at great risk.

Case study: There were concerns raised by a GP that Mary Ashcourt was not looking after herself. She had visited Mary's house and although she did not respond to her doorbell, the GP found that a door was open so went in to check that Mary was OK (had she had a fall? become unwell? Passed away?) The GP found that Mary's house was very untidy, full of flies, foul smelling and there was evidence of hoarding. She found Mary was in bed and took considerable time to rouse her but she was not ill and did not require emergency treatment so she left. The GP raised a concern under the safeguarding procedures and as the degree of concern was so great, it was decided that a visit would be carried out immediately. The Mental Health were also contacted and met at the property. Mary was reluctant to engage only talking through the window and said she was not concerned about her health and wellbeing. It was evident that she was mentally unwell, required action under the Mental Health Act, and admitted to hospital. The Enquiry Manager from the safeguarding team also arranged for the Environmental Health Department to carry out an urgent visit.

While in Hospital Mary started to engage well with professionals and agreed to a deep clean of the property before she returned home. When she was discharged from hospital a care package was arranged and now she has support for shopping and personal care. Mary has also been assessed for any aids for daily living to help her stay in her home. She is also considering a regular cleaner. Feedback has been provided to the GP who is happy with her progress and has since visited her.

Figure 6: Ethnicity of alleged victims



For 2016/17, the number of concerns raised broken down by ethnicity appears to indicate some under reporting regarding people from black minority and ethnic groups. There is still a requirement for work to widen engagement and awareness among community groups and this continues to be a priority for the LSAB. Previous attempts to establish an awareness and engagement group and develop a plan of action have not been successful and it may be necessary to try a different approach. It should also be noted that people raising concerns may be unaware of someone's background at the time of referral and an assumption made that the person is from a white British background. Since the last annual report, a new Translation & Interpreting Service has been commissioned of which the safeguarding team is able to access.

Figure 7: Breakdown of Source of Referrals

Source of Referral	Total 2015/16	*Total 2016/17*
Care Providers (e.g. Care Homes day services including Independent Sector)	347	*367*
Great Western Hospital NHS Foundation Trust	111	*166*
Mental Health Professionals	40	*91*
SEQOL Staff (only until 30th Sept)	126	*70*
Family/Carers	71	*66*
Ambulance Service	50	*57*
Council Employee (Adult Social Care)	20	*55*
Housing Services (including Registered Social Landlords)	43	*51*
Council Employees (not Adult Services)	30	*45*
Police	91	*45*
GP	30	*29*
Advocacy Service	21	*18*
Private Hospital	23	*17*
Members of the Public	27	*15*
Advice & Support Service	13	*9*
Educational Establishment	8	*9*
Care Quality Commission (CQC)	17	*8*
Out of Area Referrals (including NHS Direct)	12	*8*
Self-referrals	5	*8*
Volunteer/Voluntary Organisation	0	*8*
Business	4	*7*
Central Government Department	0	*7*
Substance Misuse Service	2	*7*
Fire Service	2	*6*
Probation Trust	9	*5*
Hospice	8	*5*
Other NHS Hospital	6	*2*
Personal Assistant (Direct Payments)	0	*2*
Swindon CCG	1	*1*
Anonymous	3	*0*
Office of the Public Guardian	1	*0*
Total	**1121**	***1184***

The apparent large increase in concerns being raised by Great Western Hospital can be attributed to them taking over most of the health care provision previously provided by SEQOL which ceased to exist in October 2016. The Social Care aspect of SEQOL's work came back to the Council, which accounts for the increase shown above against "Council Employee (Adult Social Care)".

There has been a change in the way "non-safeguarding" referrals (those not highlighting a concern about abuse or neglect) coming in to the safeguarding team are recorded – hence the apparent decrease in the number of "referrals" coming from them. There was an additional 78 cases sent to the team giving a total of 123 concerns from the Police.

Case Study:
A concern had been raised by an older man's daughter who lives in High Wycombe. He usually lives in Swindon and it appears he had been staying with her, but left rather abruptly. His daughter was worried as this was out of character and he had recently been bereaved and showing signs of memory loss. The police force in her area contacted Wiltshire Police requesting they check his home address. As they arrived, he was returning to his property having had used public transport, safely and effectively. He thought he had mentioned his return to his daughter and couldn't fully recount the journey he took although it was evident he did not face any difficulties.
Although the action taken by the Police was excellent and their assessment of the situation was thorough, as there were no concerns about the man's welfare, there was no need to send any information to the safeguarding team.

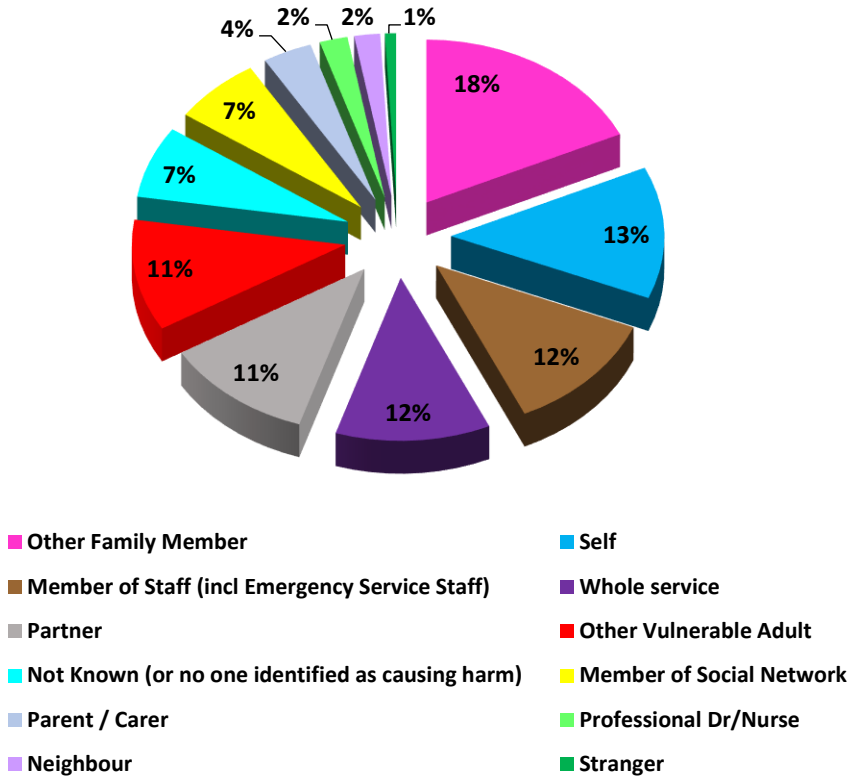
There are seven cases reported to the team from central government departments. In most cases these have come from the Home Office highlighting concerns about failed asylum seekers and how they may react to being refused rights to remain in the UK. Again, this is not a matter for the local authorities safeguarding team, but the Home Office use this route as they have a lack of information about the care teams who need to make contact and assess the person's wellbeing, human rights and care needs (if any).

There are still a high number of concerns coming from care homes. Out of the 367 referrals received, less than half required an enquiry. 103 cases referred were in relation to physical incidents by another service user. Often because of the nature of some people's conditions, physical abuse between residents is common. In most cases the response from the safeguarding team is a requirement to review and change the care plan or review their risk assessment, but in some cases, particularly where the behaviour is out of character or not previously managed correctly, an enquiry may be needed.

Case Study:
Lizzie Bowler who lives in a care home for older people has dementia and she believes a fellow resident (George) is a close relative (who passed away some 40 years ago). She has started to follow him everywhere and has begun to be physically and verbally aggressive towards him, as he's not responding in the way she wants him to. It is now apparent that she has hit George a couple of times but fortunately resulting in no injuries. The home raised the alert as they are worried that the situation could escalate and that George is becoming increasingly worried about the attention she is giving him. This case progressed under the safeguarding process. At the very least, the investigating manager would be able to monitor the response required from the Mental Health Team, the home and other professionals. Lizzie was prescribed new medication and the staff worked on a management plan to deal with her behaviour and encourage

a consistent approach from staff. There was a keenness that George could continue to move around the home without difficulty. The Investigating Manager kept the case open to ensure that any treatment worked and there was no escalation of Lizzie's behaviour. Later, the home reported that the medication change had worked and Lizzie had become calmer and relaxed. George and his family reported that he was happier and no longer felt at risk.

Figure 8: Information on those alleged to have caused harm



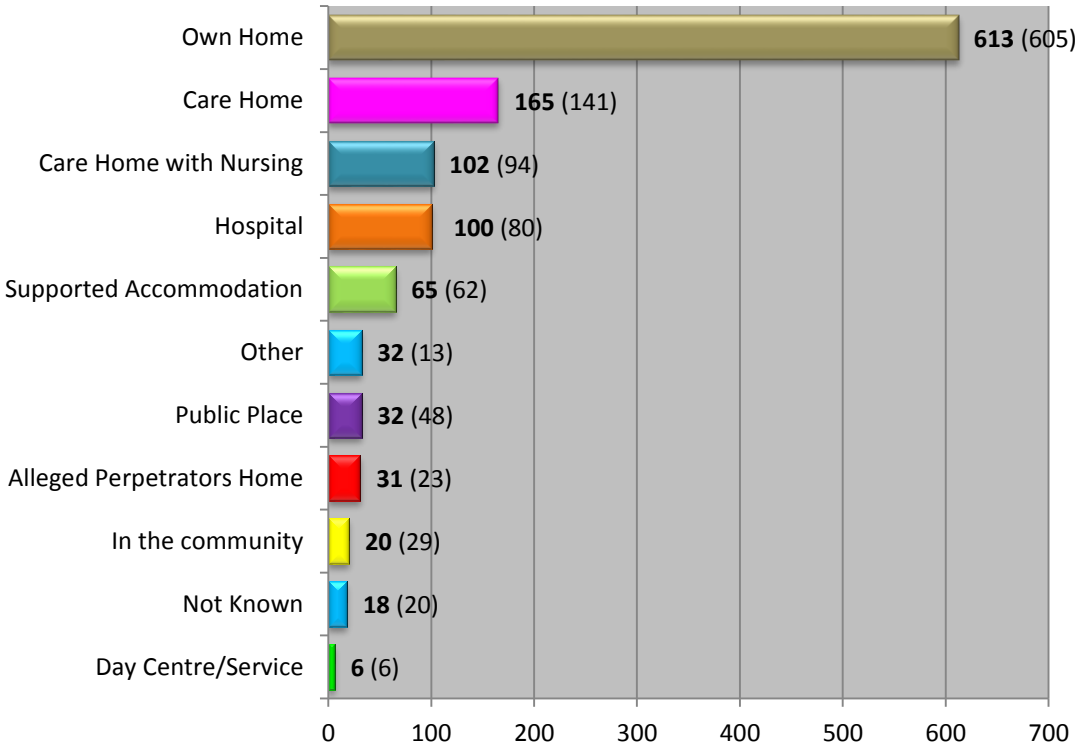
Since last year there has been an increase in the number of concerns raised about a whole service (previously reported as "manager of a service") 6% increasing to 12% here. However, there has been a 5% decrease in the number of concerns relating to allegations against a member of staff. In previous years, often where there was a concern about a service, it was recorded as a member of staff being responsible although an individual could not be identified as causing harm. This was felt not to be an accurate way of recording these incidents. Often the concern was about the quality of a service or an error which could have led to harm.

Case Study
The ambulance service sent in a referral as they had attended to a patient who had fallen and suffered an injury in a care home. It transpires that the staff decided to call the GP rather than the ambulance at the time of the fall 12 hours earlier, only calling them once he was shouting out in pain. An enquiry took place and it was found that initially staff were satisfied an ambulance was not needed as the man could weight bear and was not showing distress. There was evidence that staff were observing him. There was also a request that a contracts officer from the Council looked at the home's systems and while it was felt they needed to adjust their systems slightly; there was no major cause for concern.
This was considered a whole service concern as the ambulance crew felt the home's systems were inadequate as there was a lack of information forthcoming from staff at the time of their

call. This is also a concern that homes who have the benefit of a regular visiting GP, tend to wait for those visits, rather than taking emergency or urgent action.

The other change: 7% down from 17%, is self neglect cases. As previously stated, this is due to changes in guidance and concerns being referred directly to the adult care teams rather than dealing with them as a safeguarding concern. Especially where the issue is highlighting a need for a service rather than self-neglect.

Figure 9: Location of where alleged abuse or neglect took place



The only change highlighted by the chart above, is a 25% increase in the number of concerns raised about the Hospital. More recently issues about the hospital have been raised as safeguarding concerns, when in the past (and possibly more appropriately) these would have either been raised as a complaint and/or a clinical incident. The interface between safeguarding and how clinical incidents are managed remains an area of work for the local authority and the CCG.

Case Study
Sid Jenkins was admitted to the Hospital, as he was experiencing extreme discomfort and distress with his catheter. This was replaced. He was discharged from hospital back to his flat in a sheltered scheme unbeknown to the warden of the scheme (she later found him in bed asleep. No one had been informed of his discharge. His care agency were not informed of the need to resume home care visits.
A safeguarding referral was received by the team and screened. It was agreed for the hospital trust to carry out an investigation in to the incident, monitored by the Enquiry Manager and the Quality Lead within the CCG. Their enquiry concluded that there was no evidence that a discharge checklist had been completed. This would have highlighted the need to inform the warden of the housing scheme and the care agency. As a result an audit was carried out on the paperwork used on the unit at the hospital responsible for Sid's discharge. The Trust also discussed the matter with their Clinical Governance Group as a "lessons learnt".

There has also been an increase in the number of concerns raised about care homes. 70% of these were raised by the homes themselves and most of which related to a service user on service user incident. Considering some of the conditions people who live in care settings may experience, it is not unusual that incidents of aggression do take place. In some cases there is little or no action required by the safeguarding team (often they will seek assurance from the home that action has already been taken to reduce the risk of further incidents) or an enquiry is held to ensure that care plans and risk assessments are appropriate and up-to-date. 61 case were allegations against members of staff and around half of these progressed to an enquiry. 15 cases identified there was a risk and action was taken, for example disciplinary action, a review of procedures within the home or a review of the persons care plan.

Case study
Staff in a care home had missed that Mrs Hughes's medication had been increased and they had not replaced her existing medication with the new batch. Fortunately, this did not have a major impact on Mrs Hughes health; it delayed the start of her treatment by two weeks. Once the error had been discovered, it was rectified by the home and a disciplinary process was put in place. This concluded that additional training was needed for the members of staff involved. The safeguarding team also suggested that the written procedures in the home be reviewed for their effectiveness to ensure this was less likely to happen again, but at the very least, for the error to be picked up sooner. There was also a recommendation that other staff in the home were also trained in the corrected procedures to prevent future incidents.

Enquiries

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

Figure 10: Who Carried Out Enquiries?

Adult Safeguarding Team	183
Care Manager/Social Worker (from SBC and AWP)	91
Health Care Trust/Professional (For example the Hospital carrying out an enquiry)	64
An Employer/Provider	65
Wiltshire Police	59
Other (For example, another team or service within the Council or the Office of the Public Guardian, substance misuse service)	29
Contracts & Commissioning (SBC team who monitor care services)	7

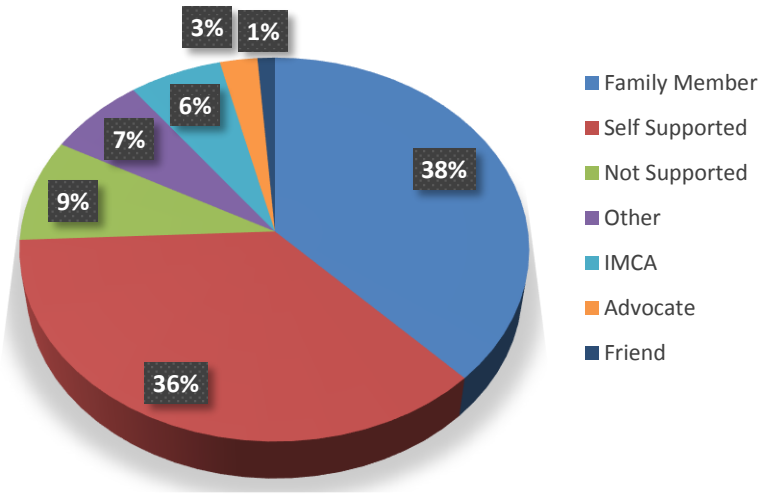
In some cases it may have been necessary for a concern to have more than one agency to carry out the enquiry. For example, one aspect may require a clinical investigation, while the Police consider if there is a criminal issue. In this case it would be recorded as a Police investigation which takes priority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

Support and Representation

The safeguarding process requires the involvement of the adult themselves. If this is not welcome by them or appropriate, their representative should be involved (e.g. family member or friend) as long as they have the person's best interests at heart. When someone has substantial difficulties in engaging with the safeguarding process, it is the duty of the local authority to engage an advocate (if the person lacks capacity, this

should be an Independent Mental Capacity Advocate). The Adult Safeguarding Team meets regularly with the service commissioned to provide advocacy (Swindon Advocacy Movement - SAM) to discuss areas of concern and to ensure data held by both teams is consistent. SAM also sits on the LSAB. Below is a chart that shows the proportion of those who provided support in cases that progressed during the year.
(Nb. This is a new chart that did not feature in last year's annual report)

Fig 11 Who supported the adult - 2016/17



Outcomes of Investigations

Between April 2016 and March 2017, 686 cases were assessed and did not progress through to a full safeguarding process. 477 of those required no further action by the safeguarding team (either because there was little evidence of abuse or neglect (or the risk of it) or the alleged victim did not wish to proceed or the alert was about a person who was not in need for care and support). 126 cases required care management input (a new care assessment, change to care plan or a review of their care). 48 were referred to another process, for example complaints action or action by the provider (e.g. disciplinary action). 34 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). 112 cases were closed at the request of the individual concerned. Often in these cases further advice or guidance is given to the person should they experience any difficulties in the future.

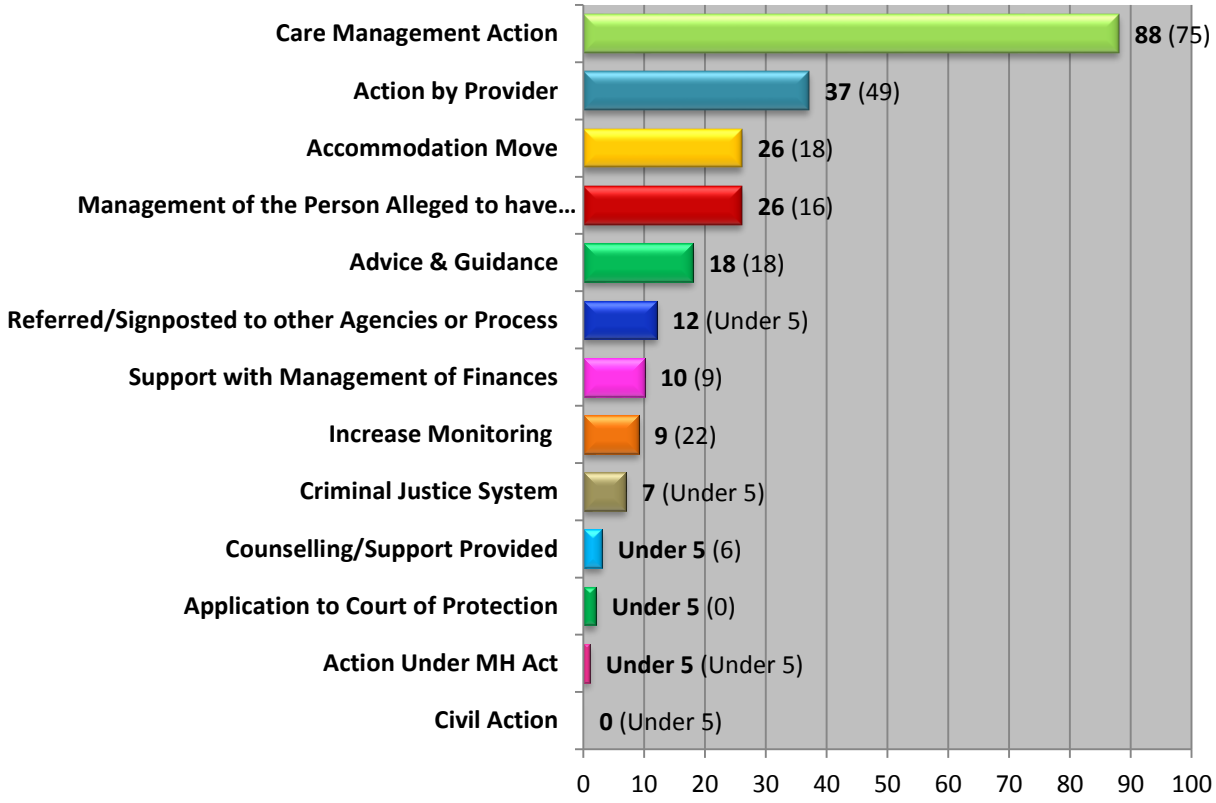
The way in which outcomes of cases are recorded has changed. In previous years the terms used were "substantiated (or partially substantiated), not substantiated, inconclusive or ceased at the individuals request. The emphasis now is on identifying risks and whether there is a need to take any action. Of the cases concluded in the year, the following table shows a breakdown of the outcomes. (Please note that some of these relate to cases that opened in the previous year, but concluded in 2016/17)

Figure 11: Outcomes of closed cases

OUTCOME	Number of cases concluded in 2016/17
Risk identified and action taken	173
Risk identified and no action taken	2
Risk - Assessment inconclusive and action taken	43
Risk - Assessment inconclusive and no action taken	14
No risk identified and action taken	77
No risk identified and no action taken	47
Enquiry ceased at individual's request and no action taken	85

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

Figure 12 Action Taken for the Adult at Risk



***NB at the time of reporting, 63 cases remained open. This is due to 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.**

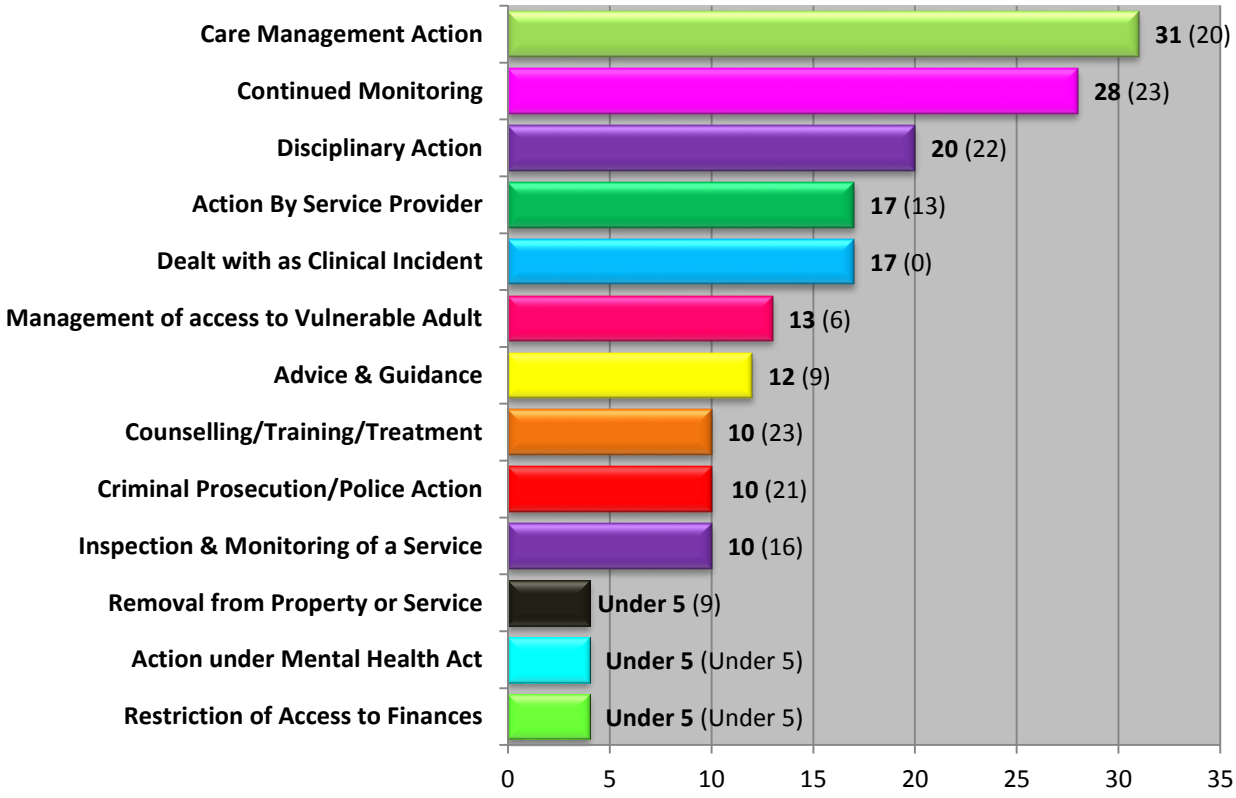
Where it states that there was no further action for the alleged victim, this may mean that the emphasis was on action required for the person alleged to have caused the harm, for example a revised care plan for another service user who attempted to assault the alleged victim.

There were 37 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 action taken with regards to the person or persons alleged to have caused harm. Often there is no action taken as the alleged victim requests it or that the action required focussed on the alleged victim (for example a review of their care plan). There are 10 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 13 Actions in relation to the person alleged to have caused harm



Care management for the person alleged to have caused harm could be as a result that they require a review of their care plan to help address changes in behaviour or it could be that a carer who has become stressed as a result of their caring role, needs a carer’s assessment as a proportionate response to a safeguarding concern.

Safeguarding Adult Reviews

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

In 2016/17 there was a review of SEQOL’s community nursing services. The report was carried out by the Queens Nursing Institute On behalf of the Clinical Commissioning

Group. The case was reported to the LSAB as it came about as a result of a number of concerns about how the service managed aspects of people's care, particularly pressure ulcers. There were inconsistent responses when there was action required and routine visits were not always timely.

The findings of the review included concerns about leadership. Senior nurses were not represented on the service's Board and did not have a clear process to highlight the difficulties they were facing. The team had difficulties in managing their case loads and plan effectively mainly due to a lack of experienced and qualified senior team members and lack of understanding of the role of "band 6" nurses. There were concerns about deficits in training and education of this group of staff and the systems used to support their activities. At the stage of the review, SEQOL had made the decision to wind up their business and alternative arrangements were made to deliver health and social care services. The new providers were made aware of the concerns raised by the review and action was taken to ensure any action required would be progressed. The leadership and structure of the new provider (GWH) was able to remedy the issues identified. There have been far fewer safeguarding concerns relating to the District Nursing Service and the Safeguarding Team have expressed a view that the new provider is far more approachable and responsive in assisting with concerns, sharing of information and have helped in a recent emergency situation demonstrating flexibility and creativity.

Also during the year, a Safeguarding Adult Review was started to look at the case of a woman who died. She was not in receipt of services and had been reluctant to accept support. She was living with her son and there were some concerns about his ability to cope with a "caring role". Concerns about her welfare had escalated over the past year and multiple concerns had been raised. However, although efforts were made to engage with her earlier on in the year, it is apparent that there may have been a lack of response from agencies following new concerns in December 2016. The review is ongoing and will be presented to the LSAB towards the end of the year and a summary will be included in next year's annual report.

Large Scale Cases

There were no significant large scale enquiries during the year although the team did deal with 5 concerns regarding service providers and the contracts team in adult services carried out visits to the services and identified remedial action which was taken.

Case study
On a medication spot check within a residential home, one of the staff responsible for administering medication had pre-signed the night medication for which she was responsible for administering. Fortunately, the spot check identified the problem prior to the medication round so no medication was incorrectly issued or missed. The medication was issued by another member of staff and the home embarked on a disciplinary investigation.
Although the member of staff's conduct was otherwise good, she said she did this to save time later. The disciplinary process lead to her being demoted which meant she would not be responsible to giving medication.

In last year's annual report, there had been two large scale enquires which had not been concluded. One was 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. There was a suspension of further

placements to the home and action taken by the provider about their local, Swindon based management. It appears that they lacked creativity and drive to improve the fabric of the service and seemed to allow their residents to live in an unstimulated and unsafe way. There was considerable work carried out by the organisation over several months to drive up improvements within the home (and others in the area). This lead to vast improvements where certain aspects of the care had turned from unacceptable to outstanding.

The other large scale was regarding the high number of pressure ulcers that may not have been dealt with effectively and highlighted a possible service delivery failure by SEQOL community nursing. This was subject to a review commissioned by the CCG (see page 19).

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

- The continued overall increase in the number of concerns raised;
- 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. This continues to be a focus of the Quality Assurance Sub-group and the Joint Learning and Development Group.
- How the widening of definitions within the Care Act Guidance impacts on referrals

Areas of focus of attention for the Board next year:

- The continuing increase in referrals, their source and quality
- The gap between concerns raised and those that require an enquiry
- Financial abuse
- Ethnicity of alleged victims
- The interface between safeguarding and how clinical incidents are managed
- Training of staff in care homes

SECTION 3

Progress, developments and news in 2016/17

Priorities for 2016/17

In previous annual reports, the priorities 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.

One of the statutory requirements for the Board as a result of the Care Act is to produce a Strategic Plan. These are the priorities outlined with the revised plan included in the last annual report.

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

The Board has continued to maintain links with other partnerships, especially the Domestic Abuse Board, PREVENT Board and the Community Safety Partnership. It is still working on gaining more commitment from its members at a strategic level although there has been a good response in most cases with support required on a case by case basis. Where we have new members, we still need to have an induction process for them. This can be delivered on an informal basis, although it has been felt that a more formal process is needed (e.g. a member's pack). There is annual awareness raising delivered to SBC Councillors.

The Board has recently agreed a new Risk Register and it is to be reviewed at each Board meeting. (This can be viewed by following this link: Risk Register.) In April a Workshop was held for Board members, which highlighted a number of priorities for the coming year. There was also agreement to redesign the sub groups of the Board and give more responsibilities to other statutory partners: The Police and the CCG.

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

There are a number of specific risk areas the Board are interested in considering. They include learning disabilities, self-neglect, domestic abuse, radicalisation, hate crime, and trafficking/modern slavery. These continue to be ongoing priorities and with regard to self-neglect, practitioners within adult services and the mental health trust have received specific training. A policy and guidance document has been drafted that includes toolkits for professionals who become aware of individual cases of self-neglect, particularly hoarding behaviour. Similarly there has been some joint work with regards to modern-day slavery/human trafficking and adult services will be highly involved in a pilot on how a reception centre may work if we are faced with a major incident on this matter. Both of these areas have heavy links with the Risk Enablement work (see below).

There is a self-assessment process for partner agencies to use to demonstrate to the Board their effectiveness with regards to safeguarding. It is felt that a “peer challenge” may be a good approach to consider required improvements. There is a quality assurance process that looks at individual cases from referral to closure. This gives the opportunity for partner agencies to challenge decisions made by the safeguarding team and evaluate the effectiveness of procedures and practice.

One of the areas of concern has been with regard to the inappropriate referrals sent into the safeguarding team. The QA Sub group has looked at this but found it difficult to draw any major conclusions. The main areas that need addressing are the agencies that use the safeguarding process as a way of making referrals into the care teams indicating there is less awareness of adult services rather than a lack of awareness of safeguarding procedures. The safeguarding team do inform alerters following the receipt of a referral as to whether the case will be progressing or not. Advice is also given if the original concern should not have been sent in as a safeguarding referral.

Healthwatch Swindon have agreed to obtain feedback from those who are subject of a safeguarding concern, to ascertain their experience of the process. A process has been agreed whereby they will contact the person, invite them to attend their offices or offer a home visit. They will then report back to the Adult Safeguarding Manager with any findings who will act on any suggestions raised.

Learning from Safeguarding Adult Reviews is seen as a priority from many Boards. There are now repositories that show the reviews that have been carried out. In Swindon the role of the SAR Group is changing to look at these and see if there is any learning from reviews that needs applying to practice in Swindon. This will be a role of the new “Learning and Review” sub group.

Much of the Quality Assurance work was to be a role for the Training and Quality Assurance Manager a post funded by One Swindon, the CCG and the Police. Unfortunately, we have been unable to recruit to the post and a new approach is required to attract the appropriate candidate.

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

The LSAB does have a webpage within the SBC website. This is separate to the main safeguarding adults page. It provides information on the Board, has links to strategic plans, annual reports and minutes of the LSAB. There is still an intention for this to be a standalone website, which will be a repository for information about the Board, but will also have documents and guidance on available support to stay safe and publicise a range of initiatives linked to safeguarding. It will also be the place to obtain safeguarding policies and procedures.

During the year, all publicity materials have been updated and included on the adult safeguarding web page. Printed copies of a New Staff Guide (previously call “No Secrets in Swindon and Wiltshire”) and leaflet for the public (Safeguarding Adults in Swindon) are available. The public leaflet has been distributed to all GP surgeries. A credit card size information card has also been produced.

As highlighted within the section on activity, the possibility of lower reporting of concerns regarding adults from minority groups and there still being a need to work on engagement with the communities. This has been an area of work in the past but with minimal success. The LSAB needs to seek more support from members on how best to achieve this.

At each LSAB meeting a case is presented following a theme agreed at the previous meeting. The case is discussed and the Board given the opportunity to suggest if correct action was taken by the safeguarding team, whether they felt it was an appropriate referral to submit and whether alternative approaches should or could have been employed.

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

SBC continues to offer half-day basic awareness training to staff from any agencies working in Swindon. This is free of charge although a fee is applied for non-attendance. During the year covered by this report, 241 people have attended this training. The Adult Safeguarding manager still offers training to GP surgeries, however only one surgery (the Priory Road Medical Centre) has accepted and undertaken the training. Most surgeries who have run such sessions in the past appeared to have enjoyed the opportunity to learn and discuss specific issues they face. There have also been sessions for staff and volunteers from the voluntary sector at the Swindon Advice & Support Centre.

A new course for provider managers took place in 2016 funded by the Wiltshire and Swindon Care Skills Partnership and run by Care Quality Matters. Around 25 managers from services in Swindon attended this. Further training of this type needs to be arranged and there are further plans to develop a multi-agency basic awareness course on self-neglect.

Recording processes within the safeguarding team gives the opportunity to evaluate the quality of concerns raised which can then lead to targeted training to specific services. A questionnaire has also been sent to provider services to check how they deliver safeguarding training. Not all providers responded, but from those that were returned, few concerns were noted.

Much of the developmental work for learning and development was to be undertaken by the joint funded Training and Quality Manager. Unfortunately we were unable to recruit to this post and a new advertising campaign is required.

RISK ENABLEMENT / MANAGEMENT PANEL

The multi-agency Risk Enablement Panel (REP) has been active for twenty months and has been involved in 16 complex cases during this time. The REP process will only be enacted when all other interventions have not produced an improvement in outcomes for the individual(s) of concern. The role of the REP is to facilitate, develop risk management plans and monitor their effectiveness.

The Objective of the panel is to:

1. 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. Utilise the resources in Swindon more efficiently
5. Develop a 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. Improve agency accountability
9. Identification of a lead/key worker
10. Share risk across agencies
11. Consider options that will enhance the range of possibilities available to professionals to improve the outcome for the individual.

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

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

The REP process is very involved and requires in depth coordination and discussion. In the main participation is good and gives agencies the opportunity to share concerns and ideas. The REP Steering Group received positive feedback from those who have been involved in the process. The learning that has been achieved has included an increased knowledge and understanding of multi-agency procedures; the agreement of common language terms and definitions; improved understanding of the different roles and responsibilities of partners. Overall the risk enablement process is about concentrating on what can be achieved, rather than what cannot and the bringing together of people from different organisations to develop shared perceptions of risk.

Case study

CD often failed to engage or maintain engagement, in core services, including wider health and social care services but had multiple needs and issues that could be

addressed by a range of agencies. It was the complexity of these health and social care needs that acted as a barrier to engagement, for example the organisation of appointments for someone who has no fixed abode or stable contact information is problematic. AS CD has complex needs on-going engagement was difficult. This resulted in CD becoming socially marginalised, stigmatised and receiving less social support, less integrated in the community and became isolated from services. To enable REP to deliver on its objectives it was clear an initial engagement strategy needed putting into place. It was agreed to use an Appointeeship via SBC to help CD manage their finances as this was identified as a high risk factor but also provided a regular opportunity to engage with CD three times a week in an agreed way. This enabled a relationship to be built over time with front line staff including security staff and social workers and in turn led to regular meetings with CD, social care and mental health so an appropriate support plan could be developed.

SECTION 4

Swindon Mental Capacity Act Programme

Mental Capacity Act and Deprivation of Liberty

The funding of The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS) remains a key issue for local authorities following the Cheshire West judgment where protection was extended to many more vulnerable adults. MCA DoLS relates to people who are placed in care homes or hospitals for their care or treatment and who lack mental capacity. The safeguards protect their rights and make sure that any care that restricts a person's liberty is both appropriate and in their best interests.

MCA DoLS referrals have continued to rise and there has been a 4% increase compared to last year. In 2016/17 Swindon received a total of 1047 referrals (544 from hospitals and 503 from care homes). Capacity issues have impacted on our performance in meeting demand and on 31st March 2017, there were 537 DoLS referrals still awaiting assessment. We have re-shaped our delivery model and have put a permanent team in place since February 2017 to increase capacity to meet the rising demand. We have also trained an additional six social workers as Best Interests Assessors (BIAs) who check all referrals and prioritise those where the person (and sometimes their family) is objecting to where they live or the care they receive. Independent scrutiny from the experienced BIA improves the experience of the vulnerable adult.

Court of Protection (CoP).

Apointeeships and Deputyships held by the Council:

Swindon Borough Council Appointeeships and Deputyships Team performs an essential role for vulnerable adults who lack capacity to manage either their DWP benefits (Appointeeship) or their property and affairs (Deputyship from Court of Protection under Mental Capacity Act) where there is no one else willing and suitable to do this on their behalf - SBC is the organisation of “last resort” to ensure they are protected. There are five staff who at 31st March 2017, managed 92 appointeeships, 85 Deputyships. 42 Deputyships going through Court of Protection and 13 referrals awaiting a decision of whether they meet the criteria for this team.

Working with an individual’s resources and ensuring they are applied for their benefit in their best interests can involve a complex range of tasks from holidays to Personal Allowance, large purchases to selling or letting houses and property. Sometimes we take on either an appointeeship or Deputyship following a Safeguarding investigation when an adult who lacks capacity to manage their money is financially abused by a family member or friend.

The Appointeeship and Deputyships team had a positive annual Officer of the Public Guardian Visitor’s report. They are working towards full compliance with the OPG’s Public Authority Deputy Standards where Deputyships apply, and generally, to develop a person-centred and robust process of best interests decision-making to promote the individual’s well-being, choice and opportunities - we work closely with the person’s care manager or coordinator.

We also work closely with SBC Legal and Democratic Service to ensure robust compliance with OPG standards in the management of property, pensions and capital and to ensure we do not compromise individual best interests. For example, Standard

1a(5) of the OPG's Public Authority Deputy Standards provides: "Seek independent financial advice, where appropriate, to maximise the return on the client's savings, investments and any other assets."

In 2016/17 we undertook a special project to ensure that Deputyships were in place for those individuals who needed to move from Appointeeship to Deputyship and of 60 identified priority cases. 56 were assessed with Deputyships granted or still underway with the CoP. Numbers are increasing incrementally month by month as shown below: we apply the criteria carefully and these figures should also be seen in the light of 26 people who died in 2016/17 who were under Appointeeships or Deputyships. We have also been liaising with our colleagues in Childrens' Services and we have extended our service to a small number of 16-17 year olds to ensure they are offered the same protection where necessary.

Swindon Borough Council Appointee & Deputyship Team current and new referrals						
Month Ending	**Appointee**	**Deputy**	**Deputy Pending**	**Total**	**Waiting**	**Total**
29/04/2016	136	63	14	213	6	219
31/05/2016	135	64	13	212	8	220
30/06/2016	137	63	13	213	8	221
29/07/2016	139	61	14	214	8	222
31/08/2016	138	65	10	213	5	218
30/09/2016	140	64	13	217	6	223
31/10/2016	127	63	30	220	8	228
30/11/2016	127	65	29	221	7	228
30/12/2016	113	73	34	220	10	230
30/01/2017	115	73	36	224	8	232
28/02/2017	98	80	43	221	11	232
31/03/2017	92	85	42	219	13	232

Our aims in 2017/18 are to further develop "money management" care plans that promote as much involvement and choice for service users as possible as well as producing a comprehensive protocol for our adult care workforce to improve the quality of our service and information in appropriate formats for our service users and their families.

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 Service
Great Western Hospitals NHS Foundation Trust
Healthwatch Swindon
Learning Disability Partnership Board
LSAB Service User Forum
NHS England South (South Central)
SEQOL (up to October 2016)
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
- Director of Adult Social Services
- 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:

- LSAB Strategy and Annual Report, including priorities for 2017/18;
- Safeguarding Impact Assessments: The National Network of LSAB Chairs asked Board partners to undertake a safeguarding impact statement, alongside equality impact assessments which it was felt were not sufficient to address safeguarding;
- Performance activity data and emerging themes;
- Wiltshire LSAB split from Swindon LSAB;
- Update of Swindon Policy & Procedures;
- Reports with a Safeguarding element:

  - Domestic Abuse Reduction Strategy;
  - National Trading Standards Scam Team.
- Board Resources;
- Strategic discussion on Making Safeguarding Personal around why it is important for us, what is the evidence for this, what are we doing already that we can build on, what can we put in place to further embrace MSP and what areas would benefit from a partnership approach;
- An annual assessment on Agency Safeguarding: each Board member gave a brief summary about what the key issues are/have been for their organisation in the previous twelve months;
- Safeguarding case discussion on current cases of interest or complexity on a theme previously agreed by Board Members;
- Review of the four Strategic Priorities, Effective Governance, Performance and Quality, Communication & Engagement and Workforce Development;
- Board and Sub-group Membership: Structure Review;
- Adult Safeguarding Training Strategy; and
- National and Regional emerging issues.

Each meeting also had an update from the Service User Forum and the Operational Group, Policy & Procedures Sub-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 Wiltshire area who have mental illness. These include inpatient services, community services, and a range of services working with primary care and acute hospitals to assess and support the care of people with mental health problems there.

The Trust has corporate and local Directors and 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 2016/2017. Additionally
The Trust has an executive director lead (Director of Nursing and Quality).

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.

2016/2017 has seen a significant amount of activity to improve adult safeguarding practice in the Trust. The key achievements included:

- Initiation of a project to ensure effective safeguarding recording and reporting, and management oversight of safeguarding adults
- Development of practice guidance on personalisation of adult safeguarding

- Development of practice guidance and support on sexual exploitation and modern day slavery
- Review and updating of adult safeguarding training, including Domestic abuse training
- Maintaining a high level of monthly supervision for staff including safeguarding via the safeguarding supervision template
- Introduction of an extended Adult Safeguarding and MCA service in the Trust, introducing locally focused Named Professionals
- Completion of the Trust wide action plan delivering the Lampard Report recommendations
- Review of Trust policies to reflect DBS and Care Act 2014 changes in relation to allegations management

2016/2017 has seen the high level of staff trained to safeguard adults further increased, with 95% of staff trained at level 1 and 90 % of staff trained at level 2 (as of the 31/3/2017), with an additional domestic abuse training module included at Level 2.

Key challenges and priorities for improving adult safeguarding in 2017/2018 are:

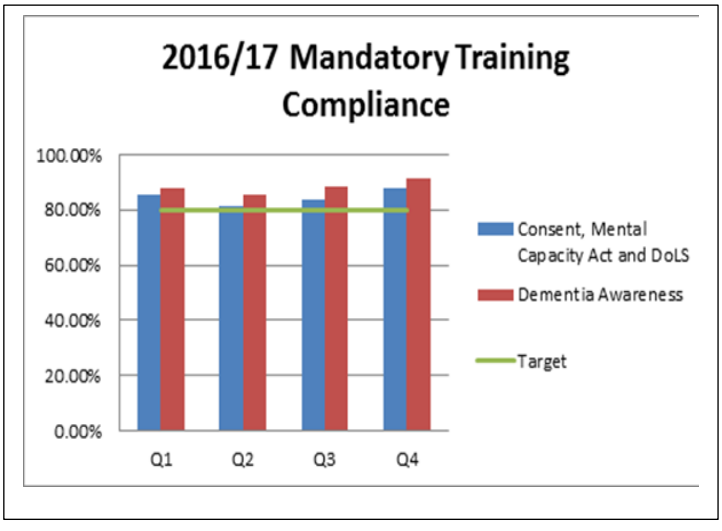
- Completion of the project to ensure effective safeguarding recording and reporting, and management oversight
- Introduction of Level 3 adult safeguarding training for relevant staff
- Improving and demonstrating the quality of safeguarding supervision provided to staff
- Introduction of local delivered practice development through the local Named Professionals for Adult Safeguarding
- Improving the support for the Swindon Safeguarding Adult Board at all levels of the partnership
- Finalise the review of Health Places of Safety

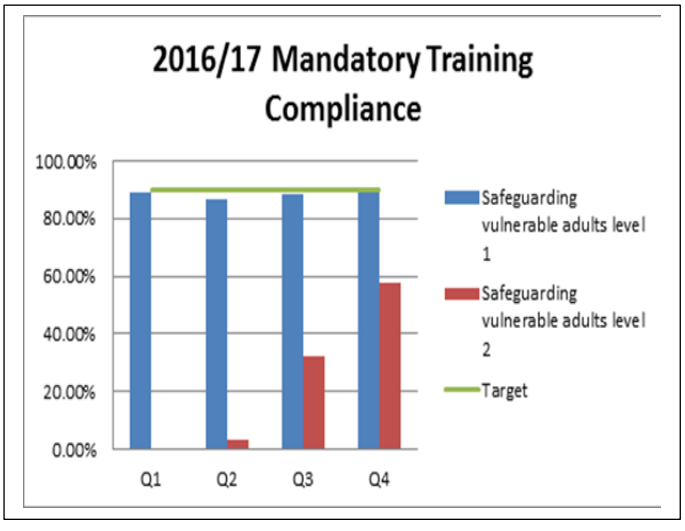
2.2 Dorset and Wiltshire Fire and Rescue Service

Report not received

2.3 Great Western Hospital Foundation NHS Trust

The charts below identify the Trust wide training targets in 2016/17 and in which areas the Trust is meeting those targets. Level 2 safeguarding training was implemented in November 2016 and has seen an increase in compliance as indicated. It is expected that the upward trend will continue in 2017/18. The generic Trust Mandatory training compliance threshold is 80%. GWH is currently compliant against this threshold. Safeguarding Adults is 90% compliance as per contract with GWH and the Clinical Commissioning Group.





Identification of achievements of the Safeguarding Adults Lead in 2016/17

Below is an overview of the main achievements of the GWH Safeguarding Adults Lead

- Quality Improvement project in relation to safeguarding adults and the Mental Capacity Act completed across 2 clinical areas. The impact of this project was demonstrated by improved practiced compliance percentages from the annual safeguarding adults at risk consent and capacity audit.
- Safeguarding Operational Group is now well established and well attended. Positive response from all staff in attendance. Attendance continues to grow in numbers on a monthly basis. Safeguarding supervision is encompassed within the group.
- Established annual audit programme in place.
- Annual audit programme completed in September 2016. Findings are based on Q1 and Q2 and demonstrate increased compliance in safeguarding adults at risk, Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DOLS). Indication shows an increase in compliance 69% compliance Trust – Wide (39% the previous year 2015).
- The Safeguarding Adults Team piloted Local Safeguarding Adults Board self-assessment tool. This is now an annual requirement and 2017 submission has been completed.
- A Safeguarding alert initial enquiry form has been implemented and a successful pilot on both Linnet Acute Medical Unit and Woodpecker testing a new enquiry form in response to any safeguarding alerts raised against GWH. The rationale behind the form is to obtain the correct information in a timely manner, and to also help guide staff. The Safeguarding initial enquiry form is completed within 7 days to help gather information.
- The following policies and guidelines have been reviewed and ratified:
- Mental Health Act Policy and Procedures. - Search and Ligature Risk staff guidance.
- Positive Behaviour Management (restraint) Policy.
- Mental Capacity Act Policy and Procedure.
- DoLS policy.
- A DoLS easy read patient information leaflet reviewed and implemented.
- GWH have developed safeguarding training at various levels to match staff roles. NHS are due to publish guidance specific to safeguarding training and it is believed the Trust is in good stead to implement a 3rd level.
- 1:1 safeguarding training has been in place since January 2017 for all overseas nurses starting in post.
- Bespoke training is provided in specific clinical areas including Intensive Care.
- CQC focus work has been completed across all areas, with concentrated focus on front door teams.
- Bi-monthly Safeguarding Simulation has now been set up with the Anaesthetics and Pain Management Clinical Lead for Simulation and Clinical Teaching Fellow. The simulation-based teaching will be for medical students and / or junior doctors working within the Trust and with potential scope to also extend to nurses, occupational therapists and physiotherapists.
- The Trust is participating in a Safeguarding Adult Review being carried out by SCIE commissioned by the LSAB.

Plans for 2017-18

- Get better at protecting people from harm to include: early and/or preventive help for those at risk of abuse, including the local priorities given: exploitation, radicalisation, domestic abuse and neglect.

- Continuation of delivery of 'Golden Thread' training strategy
- Delivery of ward accreditation programme
- Complete NICE 50 (Domestic Abuse agenda)
- Embed and implement the Care Act 2014, Making Safeguarding Personal and the Mental Capacity Act
- Improve quality of safeguarding referral by working in partnership. Safeguarding Lead will be meeting both Safeguarding Joint Operations Managers quarterly to review quality and outcome.
- Improve the consistency of application of safeguarding and MCA/MHA policies, procedures and processes across the organisation by developing web-based access to relevant safeguarding and MCA/MHA policies, guidelines, information/forms/checklists
- Continue to support and strengthen system wide safeguarding quality assurance, including monitoring visits; assisting with evidencing best practice and improvements and making a difference to improving the safety and welfare of our most vulnerable residents
- Continue to support greater system-wide learning, review and actions and evaluate outcomes of all serious case review/incident action plans of both single and inter-agency action to receive assurance that plans have been implemented and in turn improves outcomes for adults with care and support needs in Swindon and Wiltshire
- Maintain systems for safeguarding training and competencies, ensuring learning and development positively impacts on practices and in turn improves outcomes for children, adults with care needs and carers
- Production, completion and regular review of robust and timely Care plan/risk management documentation
- Continued reporting barriers with outcomes of investigations/enquiries re Safeguarding and being able to feed this information back to clinical staff

2.4 Healthwatch Swindon

Healthwatch Swindon welcomes the opportunity to contribute to this report and recognises the importance of having representation on both this Board and the Children's Safeguarding Board, and being involved in the setting of the Strategic Plan for the next period.

Strategic Priority 4: Workforce development
Safeguarding training forms a key part of our staff and volunteer induction. In 2016/17 we hosted a safeguarding awareness session for new volunteers which was also attended by 20 staff members of local third sector organisations and delivered by the council's adult safeguarding manager.

Strategic Priority 2: Performance and quality
Two Healthwatch Swindon volunteers sit on the safeguarding service user forum. Work is underway to strengthen the work of this group and increase involvement. Towards the end of the reporting year we agreed to act as the independent recipient of views from adults who had experienced the safeguarding process. The objective is to try to gain some first-hand comments in order to improve processes if need be. We recognise that the numbers responding may be small but will report to the Board on the evidence we receive.

Healthwatch Swindon provides an information and signposting service to Swindon people. 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. Our lead officer for safeguarding is the manager of Healthwatch Swindon.

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 for 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).

Achievements during 2016/17:

- During 2016-17 the safeguarding team restructured, of which all key safeguarding posts have been recruited. This has enabled the team to increase capacity to deliver the required organisational functions.
- 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, MCA and Prevent training.
- NHSE South Central worked in Partnership with the registered charity NAPAC (National association for people abused in childhood) to provide historical sex abuse disclosure training. This was in response to the recommendations from the Lampard Inquiry
- Several Modern Day Slavery awareness raising training sessions has been delivered by the charity UNSEEN in Partnership with NHS E South Central in support of the National priorities set to raise awareness of the issues of modern day slavery in the UK.
- Advanced safeguarding report writing training has been delivered by Niche Consulting. This was evaluated particularly well by the delegates attending.
- Two Level 4/5 Safeguarding Children training days have been delivered in the South Central Region, in partnership with BASCPAN (British Association for Study and prevention of childhood abuse and neglect). The themes of the seminars were ‘learning the lessons from serious case reviews, identifying pathways to harm’.
- Quarterly PREVENT education workshops have been delivered in conjunction with National leads and Special Branch and home office colleagues

Objectives for 2017/18:
National Priorities:

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

Local Priorities:

- Learning from Serious Case Reviews & Domestic Homicide Reviews
- Safeguarding Boards presence
- Learning from the Primary Care Safeguarding Assurance audit

2.6 Public Health

The Director of Public Health has been consistently represented at the Safeguarding Adult Board. Public Health Chairs several meetings and leads on several agendas which contributes to safeguarding of vulnerable individuals and groups. These include the County Lines (Dangerous Drug Network), Dementia, Suicide and Self Harm Prevention and Drug Related Deaths/Harm Reduction. For example any lessons learnt from the Suicide and drug related death reviews are fed back to agencies to inform the quality assurance of their service. We noted a significant proportion of our drug related deaths had not only substance misuse issues but al mental health issues. A joint review process is now in place to review these deaths together with a better links between substance misuse and mental health services.

Our suicide prevention work highlighted the negative impact that irresponsible reporting in the media can have on not only those bereaved by suicide but also those considering taking their own lives. The local press attended our Suicide Prevention Group, chaired by Public Health and with highlighted the issues by reviewing some of the recent local reporting.

Within Public Health we have two teams which provide front line services and deal directly with the public. These include the Community Health and Wellbeing Team and the Public Protection Team.

During 2016-17 the Community Health and Wellbeing Team has been doing some joined up work with their Adult Services to ensure that the clients are at the heart of developing robust ways of identifying and managing areas of safeguarding concern. All volunteers are offered Safeguarding Adults training particularly those working with vulnerable adults. All regular staff are also provided with training. Currently the team is exploring Deprivation of Liberty Safeguarding Training and training around the mental capacity actor for front line staff who are working with Adults such as Circles Links workers and Community Navigators.

The Public Protection Team provide front line support to individuals in relation to environmental health and contribute to the safeguarding agenda with regard to information sharing. Their teams have received Hostile Environment Awareness Training (HEAT) this year and work closely with the police and fire service in cases where individuals are identified as vulnerable or at risk. They are regularly involved with and contribute to the Risk Enablement Panel.

Looking forward to 207/18 public health will continue to champion and enable opportunities for strengthening knowledge, understanding the implementation of safeguarding procedures across the wider Public Health Workforce.

2.7 Swindon Learning Disability Partnership Board

The Learning Disability Partnership Board continues to ensure that the voice of adults with a learning disability (LD) is heard, promoting choice and control within their daily lives. It has been another successful year for the Board supporting adults with LD and

their carers to influence developments in Swindon in health, social care and the wider community.
The LDPB has 3 full Board meetings and 3 interactive Forums per year. Stakeholder discussions agreed the themes for the Forums for 2016/17. There were 124 attendees across the 3 forums, 46 adults with LD, 73 professionals who support adults with LD and 5 carers with the following achievements;

- "Get Active, Stay Active" – to have a go at some fun activities, think about what's good about being active, find out what's on in Swindon and discuss what we can do to get more people active
- "What does good quality support look like?" – to think about how important it is to plan together and get views listened to, support people in the way they want and enable people to take charge of their life and make decisions
- "Looking after yourself now and in the future" - to talk about the kind of services adults with LD may need as they grow older, think about how we can make Swindon a better place to live for older people and get information about keeping well

The resulting reports and newsletters were shared with all stakeholders, Learning Disabilty Provider Forum, the Joint Commissioning Managers Team and the Joint Commissioning Group as well as being fed in to the LSAB via the LDPB representative. Progress on key actions were reported back to the full Board each meeting.

Theme	Aim	Key Outcomes/Messages
"Get Active, Stay Active"	To have a go at some fun activities, think about what's good about being active, find out what's on in Swindon and discuss what we can do to get more people active	Presented findings at Sports Forum AGM Met GLL re: accessibility issues Connecting Sports Forum and LD Provider Forum
"What does good quality support look like?"	To consider the importance of planning together and getting views listened to, support people in the way they want and enable people to take charge of their life and make decisions	Meaningful support planning and review is essential to improving quality of life Staff should be respectful and include people in their support plans Improve recruitment processes by involving adults with LD on job panels and writing job descriptions with feedback from the forum Produce an easy read FAQ leaflet about support planning

2.8 South Western Ambulance Service NHS Foundation Trust (SWAST)

Achievements for 2016/17
(These relate to children and adult safeguarding)

- ·14,100 referrals submitted (up 37% on previous year).
- ·32 allegations managed.
- ·2021 external enquiries answered.
- 102 Serious Case Review requests.

- 74 chronologies completed.
- ·322 staff advice calls.
- ·74 Safeguarding Board meetings attended.
- ·83 training sessions provided.

Themes noted in 2016/17
Most common category for adult safeguarding referrals was self-neglect.
An increase in teenage suicides noted from child death reviews.

Priorities for 2017/18
The referral process to be fully embedded in the Electronic Patient Care Record (ePCR) function with updates agreed and functioning.
The Administration Team to undertake all of the triaging with support only from the Named Professionals.
The Named Professionals to be fully competent in the management of allegations.
A reduction in the number of unrecognised Non Accidental Injuries.
Staff to be confident in notifying Police when crimes are disclosed to them.

2.9 Swindon Borough Council – Housing Services

There is a new post within Housing Services, Lettings Social Care Officer. This is funded by Housing and Adult Services to work with people with learning disabilities, hospital discharge issues and any other complex adult services cases that requires a housing solution. A six month review was undertaken which provided evidence that post is providing good outcomes and details of some case studies as below:-

Case study:
Housing services were contacted by the learning disabilities team as a couple's relationship had broken down with their parents and they were expecting their first child. Discussion was needed with the couple's social workers and also the social work of the unborn child as there was no joined up care package.
The Social Care Lettings Officer arranged a multi-agency meeting, and the social workers supported the couple to complete a Housing Application form, all 3 SW's agreed plans to support the couple and the unborn child. A discretionary housing referral was submitted to the lettings manager and a direct match agreed. The family were successful in bidding and subsequently offered a local authority property.
From a safeguarding point of view this action could prevent abuse or neglect with regards to the adults as well as the child. It also helped to promote their independence and wellbeing, which is a requirement under the Care Act.

In recognition of the importance of safe and timely discharges from Hospital for patients who are not able to return home due to the unsuitable nature of their accommodation, Housing Services has worked with Adult Services to develop a Pathway flat (with bariatric capacity) . This facility will allow a safe hospital discharge for a temporary period to enable a full assessment of housing and social care needs to take place.

The Council took the difficult decision to close one of its Sheltered Housing schemes due to a combination of poor design issues and the potential for redevelopment of the site to provide new modern social housing. The process involved the decanting of 44 flats and we were acutely aware of the sensitivities and difficulties associated with this process. We committed to a high level of support to the tenants. After the moves 97% of tenants reported back via survey that they felt the council honoured its commitment to support them through the process as well as reporting that their new home met their needs better than their previous home.

Housing Services is mindful of its responsibilities with regards to reducing domestic abuse. There is a Housing Options Domestic Abuse Officer funded through a Department of Communities and Local Government grant who helps secure accommodation for victims of Domestic Abuse and helps throughput at the Swindon Refuge by working with households to identify move on accommodation from the refuge.

A new governance structure was established around Domestic Abuse, including a DA Management and Quality Assurance group which helps deliver improved outcomes to victims by scrutinising cases and leading on the Domestic Homicide Reviews. The lessons learnt and actions are implemented via this multi agency group. This has major links with the LSAB.

2.10 NHS Swindon Clinical Commissioning Group

The CCG is one of the three statutory core partners and funders of the Local LSAB. As such the CCG is in the best position to ensure that NHS providers meet their responsibilities through its commissioning arrangements. Jointly with Wiltshire CCG we have agreed a safeguarding adult schedule for GWH and for other providers. The CCG Designated Nurse safeguarding has reviewed the policies and contracts for all other providers we commission.

As a core partner the CCG has a duty to engage fully with the LSAB and its subgroups. The CCG is represented at the board via its Designated Nurse Safeguarding and following the recent restructuring of the board subgroups it is proposed that the CCG will be chairing the LSAB Quality Assurance subgroup also via the Designated Nurse.

The CCG met independently with the Chair of the board to share with their observations regarding safeguarding processes within SBC, the LSAB and gaps within GWH in relation to Ex-SEQOL health services. The CCG had been unclear about the apparent lack of a framework for raising cases of concern that meet the threshold for a safeguarding review under Section 44 of the Care Act.

The progress made within GWH following absorbing SEQOL health services into their organisation

The CCG continues to monitor closely this progress, and met with the Trust leads to raise concerns regarding the lack of progress and the limited information received following the GWH internal review of community health services. The CCG remains concerned regarding the lack of appointment to a band 7 ‘Safeguarding Advisor’ post to support community services. While the safeguarding adult named lead (Band 8) has returned from secondment, GWH are still left with a gap in leadership and support to community services. Currently GWH are trying to fill this post via existing staff at risk. Consequently this has been placed on the CCG risk register.

Recent safeguarding adult cases requiring review

The CCG have raised the following two cases with LSAB requiring a review under the Care Act:

1. Case of an older man who died as a result of sepsis in a care home. Although it was considered that abuse or neglect was not the cause of death, and therefore did not meet the criteria for a Safeguarding Adults Review, a table top learning event for all the professionals involved in the care took place. This raised issues in relation to:

- Wishes of the resident/ Family/ End of Life care
- Information sharing / Communication
- Assessment/ Care Pathway / Delivery
- Care co-ordination and oversight
- Knowledge and skills
- Quality and Performance

2. Case of an older woman where there were concerns related to abuse and neglect of a family carer. In this case the LSAB have commissioned a full SAR review by SCIE, involving two independent reviewers. This review has just started and is expected to be completed by Nov 2017 (see page 19)

2.11 Swindon Community Safety Partnership

The role of the Community Safety function remains broad but with specific priorities over the last 12 months. The Community Safety Team and the Police have increased their activity on identifying and responding to the issues of Modern Day Slavery. In particular this culminated in the Partnership organising a Modern Day Slavery Reception Centre exercise, this identified strengths in current processes and tested operational practices in the event of significant numbers of vulnerable adults coming to light as part of action against a single “employers”. This exercise involved staff from the adult services including the safeguarding team and the Risk Enablement Development Manager.

Prevent duties for Counter Terrorism remain a priority. The local Prevent Board has reviewed its action plan and shared this with the Safeguarding Board. Individual cases (Channel) remain low. The Council continues to be part of the Swindon Hate Crime Partnership and an awareness raising event is organised for October 2017.

Domestic Abuse remains a priority and again plans were shared with the Safeguarding Board. Priorities include extending work with schools and working with perpetrators.

2.12 Swindon Advocacy Movement

As an advocacy organisation we have an ongoing commitment to keeping adults with care and support needs in Swindon safe and have actively participated in all LSAB meetings for 2016/17 and sit on the Quality Assurance sub-group.

The Swindon advocacy service worked with 501 people in 2016/17, we received 40 Safeguarding referrals and made 19 safeguarding alerts. We have developed reporting systems to inform the Safeguarding Team and have attended quarterly Advocacy and Safeguarding Team Liaison meetings to strengthen our joint working practice e.g. it has provided opportunity for us to receive feedback on complex cases and review concerns or any inappropriate referrals.

We have shared advocates and service user experiences with the Safeguarding Team to inform any practice improvements and have also shared data and anecdotal evidence on known safeguarding risks or vulnerability of individuals or groups. We have raised the profile of Safeguarding and the work of the LSAB within our own workforce and Sanford House. Safeguarding and news from the LSAB are standard agenda items at our Advocacy Team meetings and we have worked with Healthwatch Swindon to ensure that Safeguarding is a regular agenda item at Sanford House tenants meetings. This has led to increased participation in Safeguarding training at SAM, with our Advocacy Managers attending Enquiry Officer training and advocates

doing refresher training, and Safeguarding training being requested via Citizen Advice for the voluntary sector at Sanford House. We have also worked with a wide range of partner services and Care Providers to raise the profile of Adult Safeguarding under The Care Act relating to individuals and the personalisation agenda.

In 2017/18 we are keen to contribute to Strategic Priority 3 in the development of a new model to gain the voice of service users and carers and to increase community awareness.

Case Study
Mary was living in a care home, was married and had a son. The care home raised a safeguarding alert around financial abuse, Mary's son was managing her finances and Mary's client contribution had been unpaid for some time. The home had given the son many opportunities and choices to make payments and Mary's placement was at risk. An advocate worked under the Mental Capacity Act and using non-instructed approaches, empowered Mary to contribute to the process by using accessible methods as well as using a rights based approach. The advocate recognised the close relationship Mary had with her son and husband and recommended a proportionate response to a resolution. The advocate worked closely with the care home, the family and the safeguarding team and produced a report which identified Mary's views and preferred outcomes. A decision was made to apply for deputyship to safeguard Mary's finances, Mary now has security in her placement, access to her finances when she wants and has maintained her relationship with her husband and son.

2.12 Wiltshire Police

Key achievements in 2016/17

A partnership approach in relation to safeguarding adults is working well from a police perspective. Police staff are connected into the Local Authority safeguarding adults team ensuring effective multi-agency working to triage and assess cases involving vulnerable adults.

The Wiltshire Police Vulnerability Strategy was developed and published. It sets out what Wiltshire Police will do to improve the service to the most vulnerable in society. The strategy has a focus on reducing the victimisation of the vulnerable, reducing the unnecessary criminalisation of the vulnerable and reducing the exploitation of vulnerable people. A working group chaired by the head of public protection is ensuring that the strategy is being delivered across the force.

Significant improvements have been made by the police in the way that they record crimes against vulnerable adults. This change in process has resulted in an increase in recorded crimes, which has allowed the Police to better understand the volume and nature of abuse that is committed against the most vulnerable.

The process by which the Police identify vulnerable people and allocate resources to investigate crimes against the vulnerable as well as protect the vulnerable from further harm has been revised. This process is known as the 'three strands of vulnerability' and during 2016/17 all control room members of staff have received additional training. The revision of the process ensures that partner agencies are more quickly involved in the support of vulnerable adults

The Police have set up and chair the Swindon and Wiltshire Anti-Slavery Partnership. This partnership group sits quarterly and provides governance in relation to the effective reduction of modern slavery and human trafficking in the Swindon and Wiltshire areas. This includes the approach to adult sexual exploitation and labour exploitation.
The Wiltshire Police website has been updated to provide more information on adults at risk and vulnerable adult abuse. There are links to members of the safeguarding adults investigation team to make it easier for people to access support. There are also links to the relevant legislation and national guidance.

Over the last 18 months members of the Safeguarding Adults Investigation Team have continued to provide training to partner agencies to raise awareness of the abuse of adults at risk and how to report concerns. In addition, training has been provided to investigating managers, police and partner agencies in relation to Making Safeguarding Personal.

The first prosecution for wilful neglect/ill treatment of a service user by a carer under the Criminal Justices and Courts Acts 2015, was achieved illustrating the effective use of new legislation (Merryfields, Swindon 2016.)

Wiltshire Police also had a successful prosecution as an outcome from a safeguarding case in 2017.

Case Study
Following concerns about possible financial abuse perpetrated by someone who had "befriended" the victim, a sexual assault was witnessed while viewing footage from a CCTV camera installed by her family. The case came to the safeguarding team and was dealt with as a criminal investigation by Wiltshire Police.

Following the investigation and related information gathering from health and social care professionals the case went to court and Andrew NEWMAN was sentenced to 10 ½ years for multiple offences of causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity and possession of indecent images. In addition he was given a 10 year sexual harm prevention order and placed indefinitely on the sex offenders register and DBS barring list.

It is believed that this is an excellent example of good multi agency working and application of safeguarding principles.
Link to newspaper article

3 Sub-groups of the LSAB

The Operational group met on four occasions during the year, with attendance from the following agencies: The Operational group met on four occasions during the year, with attendance from the following agencies: AWP, GWH, SBC (Adult Safeguarding Manager, Commissioner OP & LD (Adults), Head of Policy, REP Development Manager, and Safeguarding Joint Operational Manager), SEQOL, Swindon CCG and Wiltshire Police

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:

- An update on the progress of the QA Sub-group;
- Review of the Chair of the Operational Group;
- Strategic Plan 2016/19, which informed the development/review of an Annual Business Plan;
- Discussions about current cases of interest or complexity;
- A Root Cause Analysis completed by AWP on a specific case;
- LSAB Risk Summary;
- Adult Safeguarding Training Strategy 2016/18;
- SCIE Case Review; and
- Proposed Re-structure of the LSAB.

Quality Assurance Sub-Group: The QA Sub-group met on four occasions during the year, with attendance from the following agencies: AWP, GWH, SBC (Adult Safeguarding Manager, Commissioning Manager, Head of Policy, REP Development Manager, Safeguarding Joint Operational Manager, Supported Housing Manager), SEQOL, Swindon Advocacy Service, Swindon CCG and Wiltshire Police.

The aim of the group is to evaluate multi-agency working, to carry out joint audits of cases and consider the participation of relevant agencies. Appraise the quality of practice and lessons to be learned in terms of both multi-agency and multi-disciplinary practice. The person responsible for the enquiry is invited to attend and talk through their rationale of their decisions.

The group audited between four and six cases at each meeting, using the six principles of safeguarding, Empowerment, Proportionality, Protection, Partnership, Prevention and Accountability using the following themes: Great Western Hospital (concerns raised by GWH and about GWH), Physical Abuse, AWP (appropriate and inappropriate concerns), Care Providers (concerns raised by providers and about providers).

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, AWP, National Probation Service, GWH, Wiltshire and Swindon Care Skills Partnership, and Wiltshire Police. This now chaired by the Learning and Development Lead from Wiltshire Council.

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. Agenda items have included the

revision of both boards' training strategies, discussions about the revised Safeguarding Capability Framework and how that will link to the NHS Intercolegial Document (still due for publication), learning from a recent Serious Case Reviews from other safeguarding boards and training audits.

Policy & Procedures Group: The Policy & Procedures Group met on four occasions during the year, with attendance from the following agencies: AWP, GWH, SBC (Adult Safeguarding Manager, Commissioner OP & LD (Adults), Head of Policy (part year), REP Development Manager, Safeguarding Joint Operational Manager and Strategic Planning Manager), SEQOL, Swindon CCG and Wiltshire Police.

The aim of the group is to develop and review the Policy and Procedures for Safeguarding Adults in Swindon and develop additional guidance as required by the LSAB.

Agenda items during the year included:

- Safeguarding Adults Staff Guide;
- Review of overall Policy and Procedures;
- Self-neglect Policy;
- Association of Directors of Adult Social Services (ADASS) Guidance: Inter-authority safeguarding arrangement;
  Prioritising and updating the Policy & Procedures Guidance in-line with the Care Act 2014 and the separation from Wiltshire SAB;
- Discussing and completing guidance on early stages of safeguarding process; Inter-authority safeguarding arrangement; report writing; developing safeguarding plans and
- Safeguarding Recording Retention Policy.

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 format of the Service User Forum is to be reviewed as part of the re-structure of the Board. The Service User Forum met on three occasions during the year and agenda items included:

- Services of Concern (update);
- Making Safeguarding Personal;
- Disability Hate Crime;
- LSAB (update);
- Safe Places (update);
- Review of the TOR;
- Report by Sir Stephen Bubb: Winterbourne View 5 years on;
- Reporting Safeguarding Concerns;
- LSAB Annual Report; and
- Visitors: Developing Health and Independence (DHI)

Case Review Sub-Group: The Case Review group met on two occasions this year to consider a request for a Safeguarding Adult Review. One case agreed to progress to a section 44 Safeguarding Adult Review (see page 20 for further details) and another case did not meet the criteria although it was agreed an event be held to consider any leaning from the case. 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 2017/18

One of the statutory requirements for the Board as a result of the Care Act is to produce a Strategic Plan. The LSAB have agreed an updated 3-year Strategy 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

Achieved through:

- Developing links with other key statutory partnerships (particularly the Health and Well-Being Board, the LSCB, and the Community Safety Partnership), and voluntary sector, identifying areas of commonality and governance arrangements, receiving reports from them focused on specific issues and themes. **(Partnership)**
- Ensuring the Board is sufficiently resourced by partner agencies 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)**
- Implement the outcome of the Board review including membership of the Board and its sub groups, and monitor attendance at Board meetings **(Partnership, Accountability)**

Measurable outcomes (details on how these will be achieved are contained in the Business Plan for 2017/18)
- To have achieved the Strategic Plan actions
- Risks to have been managed through risk register monitoring
- Survey Board members to assess level of confidence and contribution
- Attendance rate having the right level of attendance and seniority for Board and sub-group meetings
- Number of new members attending induction and fully engaging
- Receipt of reports from other partnerships as requested

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

Achieved through:

- Developing and implementing a multi-agency quality assurance process and schedule, and reporting system to the Board **(ALL priorities)**
- Holding agencies to account for a reduction in inappropriate referrals to ensure key risk cases are not missed **(Proportionality, Protection, Accountability)**
- Identifying from audits and available data trends and research of adults in need of 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)**
- In co-operation with relevant key partnership boards, explore the Swindon safeguarding risks relating to known vulnerability particularly learning disabilities, self-neglect, domestic abuse, radicalisation, hate crime, trafficking/modern slavery and financial exploitation **(Empowerment, Protection, Prevention, Proportionality)**
- Learning from Safeguarding Adult Reviews and Domestic Homicide Reviews, sharing lessons learnt with the Community Safety Partnership **(ALL priorities (depending upon the circumstances))**
- Receiving a report from Healthwatch Swindon regarding service user experience, particularly in respect of making safeguarding personal **(Empowerment)**, and using this to drive practice improvements **(Empowerment, Proportionality Protection Prevention)**

Measurable outcomes

- No more than 30% inappropriate referrals
- Baseline service user experience of service delivery
- Sharing and implementing actions from SARs and DHRs as appropriate
- Audit outcomes on key performance indicators and quality of referrals

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

Achieved through:

- Ensuring the website meets the accessibility information standards and developing it further when the new platform is in place **(Empowerment, Protection, Prevention)**
- Developing easy read versions of external documents (informed by the Service User Forum) (**Empowerment)**
- Increasing community awareness including using available opportunities to increase public involvement, and to engage media interest **(Empowerment, Protection, Prevention, Partnership)**

- Developing a new model to gain the voice of service users and carers, and act on suggestions linked to existing services and groups **(Empowerment)**
- Developing the use of a safeguarding story at the start of Board meetings **(Partnership)**
- Developing more effective use of the media **(Accountability)**

Measurable outcomes
- Number of actions taken based on service user feedback
- Number of hits, length of time and outcome of like button data on the website
- Outcomes from safeguarding stories leading to actions taken

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

Achieved through:
- Holding agencies to account for ensuring high staff training levels including GPs, dentists etc (NHS England) and Commissioners in respect of providers **(all)**
- Ensuring all agencies either use the SAB training events or their own training packages that are consistent with this **(Protection, prevention, partnership, proportionality, accountability)**
- Developing a quality assurance process of safeguarding training provided by care providers that may not be in line with the LSAB policies and procedures (**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)**
- Exploring the provision of a specific safeguarding career pathway

Measurable outcomes
- % of surveyed staff confidence and knowledge regarding safeguarding (baseline to be established)
- relevant staff trained in safeguarding at any one time

Next Steps

- The Operational Group, on behalf of the Board, will draw up an annual business plan for 2017/18 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 monitor the business risk register to underpin this strategic plan that identifies the key risks that have the potential to prevent its delivery

Glossary

ADASS	Association of Directors of Adult Social Services
AGM	Annual General Meeting
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
CQC	Care Quality Commission
DA	Domestic Abuse
DBS	The Disclosure and Barring Service
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
FAQ	Frequently Asked Questions
GLL	Greenwich Leisure Limited
GP	General Practitioner
GWH	Great Western Hospital
HEAT	Hostile Environment Awareness Training
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
LAMU	Linnet Acute Medical Unit
LD(PB)	Learning Disability (Partnership Board)
LSAB	Local Safeguarding Adults Board
LSCB	Local Safeguarding Childrens Board
MCA	Mental Capacity Act
MHA	Mental Health Act
NHS	National Health Service
NICE	National Institute For Health and Clinical Excellence
OP	Older People
OPG	Office of the Public Guardian
QA	Quality Assurance
REP	Risk Enablement Panel
SAM	Swindon Advocacy Movement
SAR	Safeguarding Adult Review
SBC	Swindon Borough Council

SCIE	Social Care Institute for Excellence
SEQOL	SEQOL (a Social enterprise providing health and social care and support)
SWAST	South Western Ambulance Service NHS Foundation Trust

The Safeguarding Adults in Swindon Annual Report 2016/17 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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Fax: 01793 463982
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