Safeguarding Adults in Swindon

Annual Report
April 2017 – March 2018

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 2017 - 31st March 2018

Contents:

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

Swindon Borough Council
Civic Offices
Euclid Street
Swindon
SN1 2JH
Tel: 01793 445500

Website: www.swindon.gov.uk

FOREWORD

I have great pleasure in presenting the Swindon Safeguarding Adults Board's Annual Report for 2017/18. This outlines the achievements during the year as well as highlighting some key issues to address. The report contains member agencies' progress statements that collectively provide some assurance to the Board that safeguarding adults is a priority for members. Sub-group reports indicate the work undertaken on 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 2018-21

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 considers performance data at every meeting and also has a case discussion to better understand the complexity, approach and outcome of partnership working. During the year there was a Safeguarding Adult Review that identified a number of issues requiring improvement. The Board is therefore clear about the areas it needs to be better assured about, including:

- The appropriateness of referrals and agencies improving their conversion rates into an enquiry
- The proper application of the threshold guidance
- The suitability of staff training to role, and evidence that it improves practice
- Safeguarding adult review learning is properly embedded into practice
- Early identification of problems as a preventative measure
- Effective front-line identification of domestic abuse
- The proper recording of ethnicity

Effective partnership working is a key success factor, and resources continue to be problematic. During the year the Board changed its sub group structure to make best use of its stretched resources, and work has been underway to plan a more joined up approach with the Children's Board and Community Safety Partnership. Turnover and representation levels of Board members is a continuing issue but overall, progress has been made. I would like to pay tribute to Board and sub group members, their agencies, the Business Support Team and 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.

Diana Fulbrook OBE
Independent Chair of the LSAB

Safeguarding Adults in Swindon Annual Report 2017/18

SECTION 1

Introduction:

Swindon Borough Council and its partners, have responsibilities with regards to safeguarding adults. The duty as described by the Care Act 2014 applies to adults who:

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

Although Swindon has had a Local Safeguarding Adults Board for over 10 years to support adults in line with the criteria above, the statutory requirement for these was included in the Care Act. In addition to:

- where abuse or neglect is suspected (or where an adult in need of care support is at risk of abuse or neglect), local authorities make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and if so, what and by whom;
- arrange where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry;
- ensure the Safeguarding Adults 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 lead agency with regards to safeguarding adults, is the local authority. Swindon Borough Council has a specialist 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 2017 midyear estimate of population from the Office of National Statistics puts the total at 220,363 (15.5% of this estimate are over 65 years old and 7% are over 75) There were 5,492 people receiving services from adult social care in 2017/18 broken down into client groups as follows:

	Age Band 18-64		Age Band 65+	
Service User Group	**Female**	**Male**	**Female**	**Male**
Learning Disability Support	283	375	34	43
Mental Health Support	87	121	60	44
Physical Support - Access & Mobility	331	180	612	380
Physical Support - Personal Care Support	233	217	1399	767
Sensory Support (Dual, hearing & Visual)	18	10	69	37
Support with Memory and Cognition	4	5	114	69
Total of Clients	**956**	**908**	**2288**	**1340**

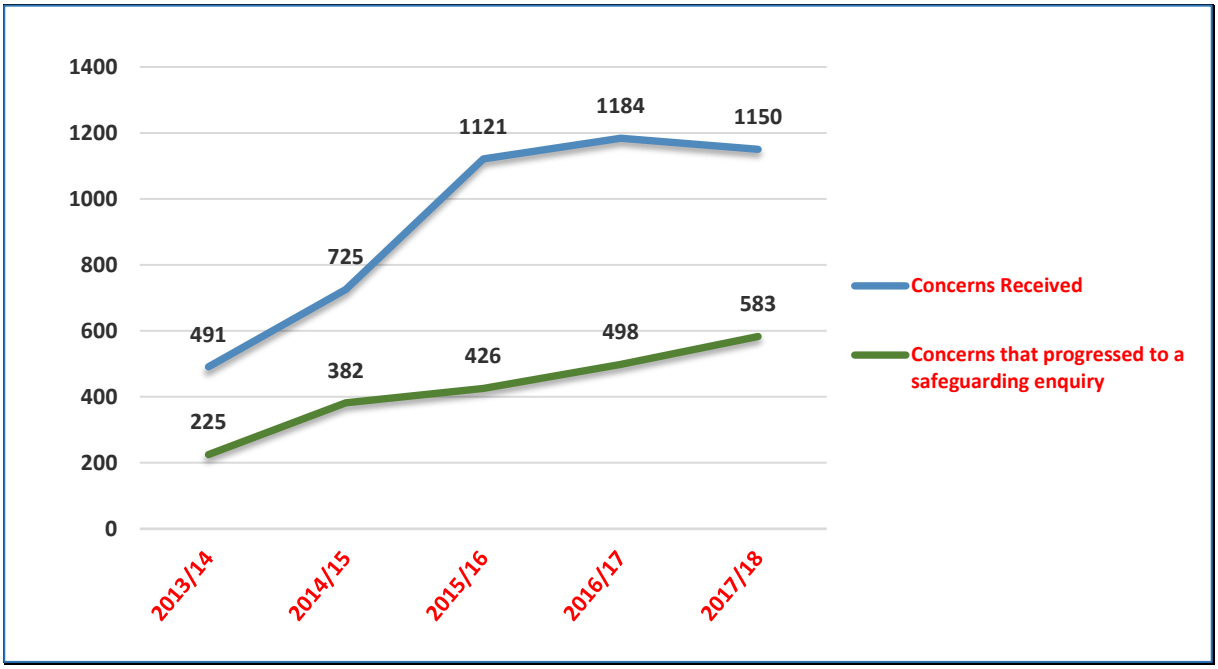
The 2017/18 figure shows a 2% increase on 2016/17 when there were 5,333 people receiving services. There continues to be a number of initiatives in place in Swindon to help prevent people from needing services which may account for why there has not been a larger increase considering the impact of there being an aging population.

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 from April 2017 until March 2018, there were 18748 reported crimes of which 291 were categorised as hate crimes of which 22 were disability hate crimes. Overall there was a 3.4% increase in reported crimes. There is a commitment to partnership working in Swindon to: prevent Crime and anti-social behaviour; protect the most vulnerable in society; work in a person centred way and secure high quality, efficient and trusted services.

The number of concerns reported to the safeguarding team has decreased slightly. However, there has been an increase in the number of concerns that have required an enquiry. There has been another 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. There are a number of reasons cases do not progress to an enquiry:

- The referral is inaccurate and does not meet the criteria for safeguarding adults;
- The issue of concern is more appropriately dealt with by another process and no enquiry is required;
- The person who is subject of the concern is “signposted” to a different service (particularly if the concern does not affect an adult in need for care and support);
- There is no further action required because all the correct action has been taken. However, to determine this, enquiries often need to be made or
- The person who is subject of the abuse or neglect does not want any further action taken and it is assessed as safe to respect their wishes.

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 and updates during 2017/18;
- Submissions from key partner agencies and members of the LSAB, and
- An overview of the priorities for 2018/19.

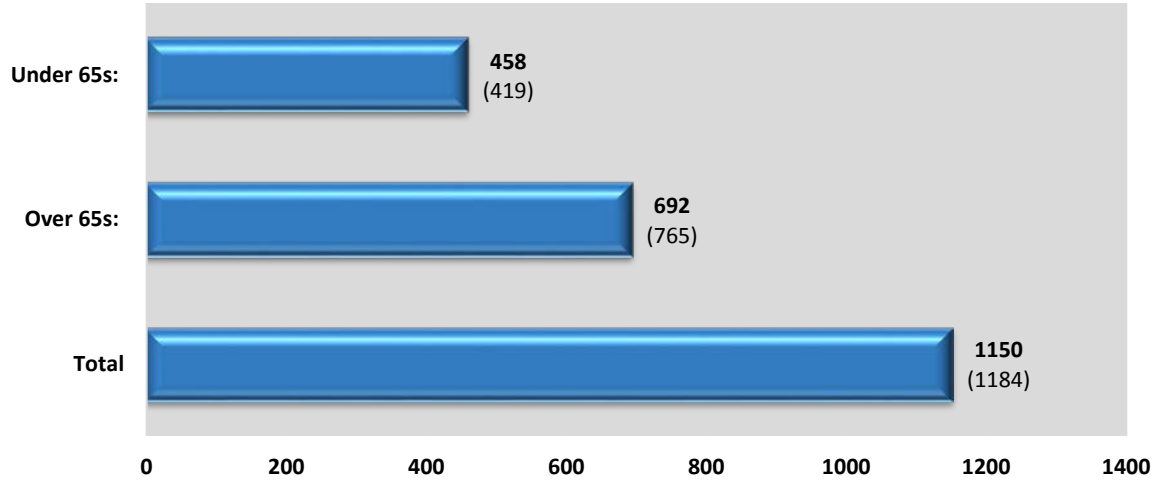
SECTION 2

Activity Data 2017 – 2018

(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



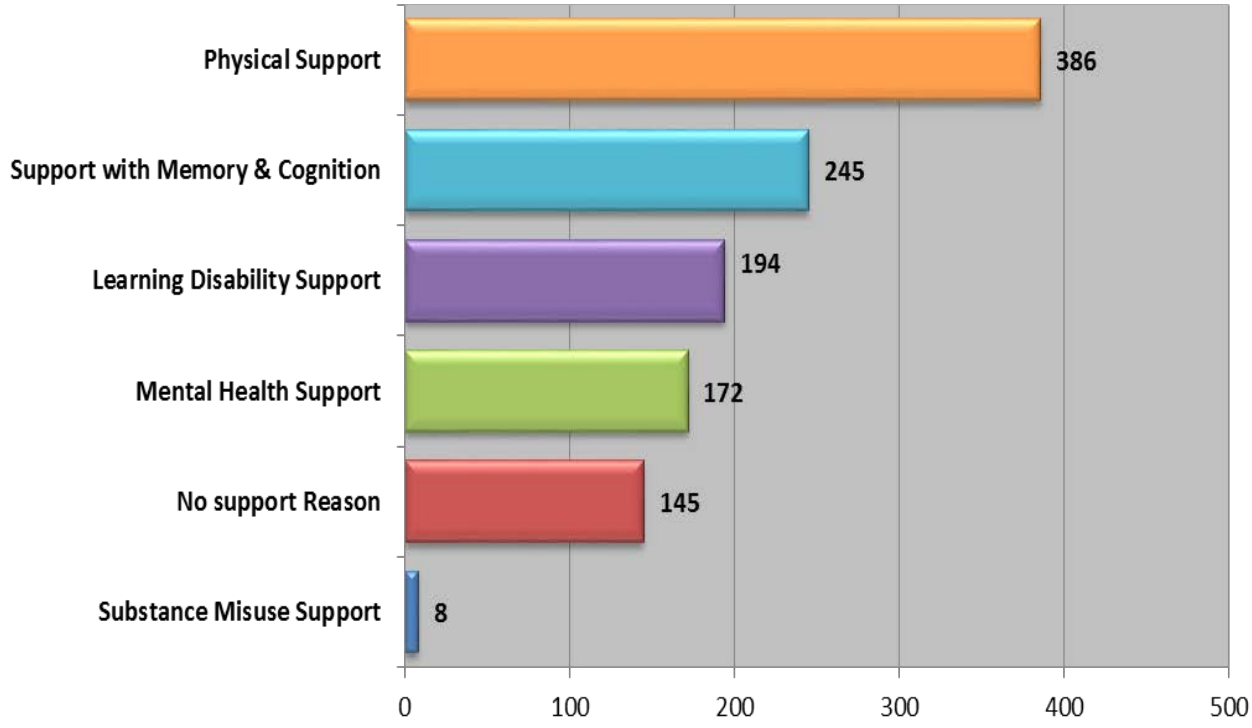
Overall there has been a small decrease in the number of referrals received by the local authority. While there has been a 9.3% increase in the number for concerns relating to people under 65 there has been a surprising 10.5% decrease in the number of concerns regarding people who are over 65. It is difficult to account for this change, however it could be as a result of more accurate reporting from care settings. For example reporting fewer minor concerns.

Case Example:
A care home put in a safeguarding referral as Joyce Jones was admitted to the home with a pressure sore. She came from her own home where she was looked after by her husband in a limited way but who became unwell himself and was struggling to cope. This did not require a safeguarding referral as abuse was not suspected as Mr Jones was unwell and lacked skills to deal with pressure sores. In discussion with the care home, they agreed that the referral was unnecessary, but reported that they had to make a referral as it was "company policy" to report all incidents of this type.

For the under 65s, one of the largest increases in referral sources was from the Police. Most of these cases did not need an enquiry, indicating they were sent through to the safeguarding team for information only. However, there are no other patterns that would account for such an increase of concerns regarding this age group.

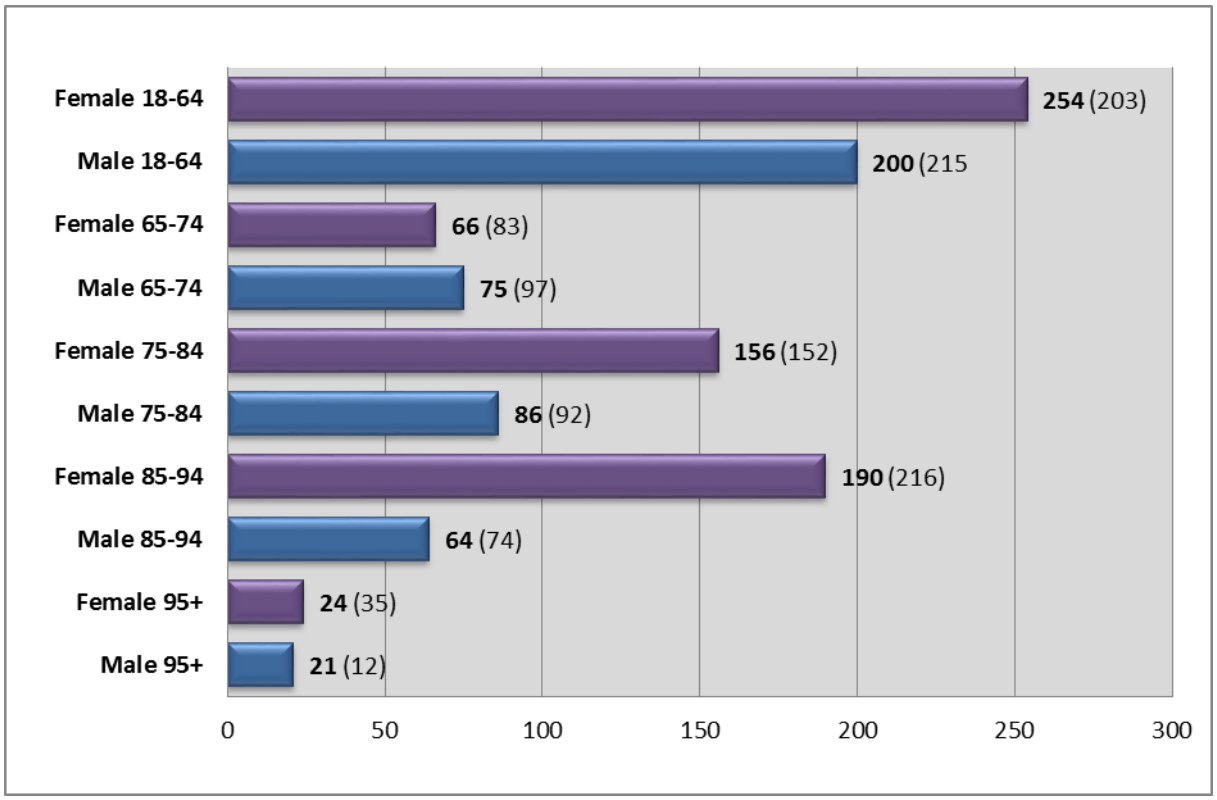
Of the 1150 cases reported, 583 cases required an enquiry under safeguarding procedures. Sometimes this is referred to as "conversion rates" i.e. the number of referrals received that then *convert* to an enquiry. While there has been a decrease in the number of referrals received, there has been an increase (17%) in the number of enquiries. Overall there is a 50% conversion rate. Last year there was some work within the South West region to compare information sent to the national Safeguarding Adult Collection and such conversion rates differed widely from one local authority to another. One had 76% conversion while the lowest rate was 11%. The national average is 37%. It is believed that the increase in Swindon could be due to some cautiousness with some managers being reluctant to screen out cases, particularly following the Safeguarding Adult Review discussed on pages 20-23 but also due to a better understanding by some referrers about what constitutes a safeguarding matter.

Figure 2: Breakdown by "Primary Support Reason"



The chart above shows the primary support reasons of the people who were the subject of a safeguarding concern at the point of the referral. Support reasons can change between different concerns being raised and during the life of their case. For example, someone with dementia may have been recorded as needing physical support as they were recovering from a fall but had previously been recorded as requiring support with memory and cognition. For this reason, a comparison with previous years has not been included.

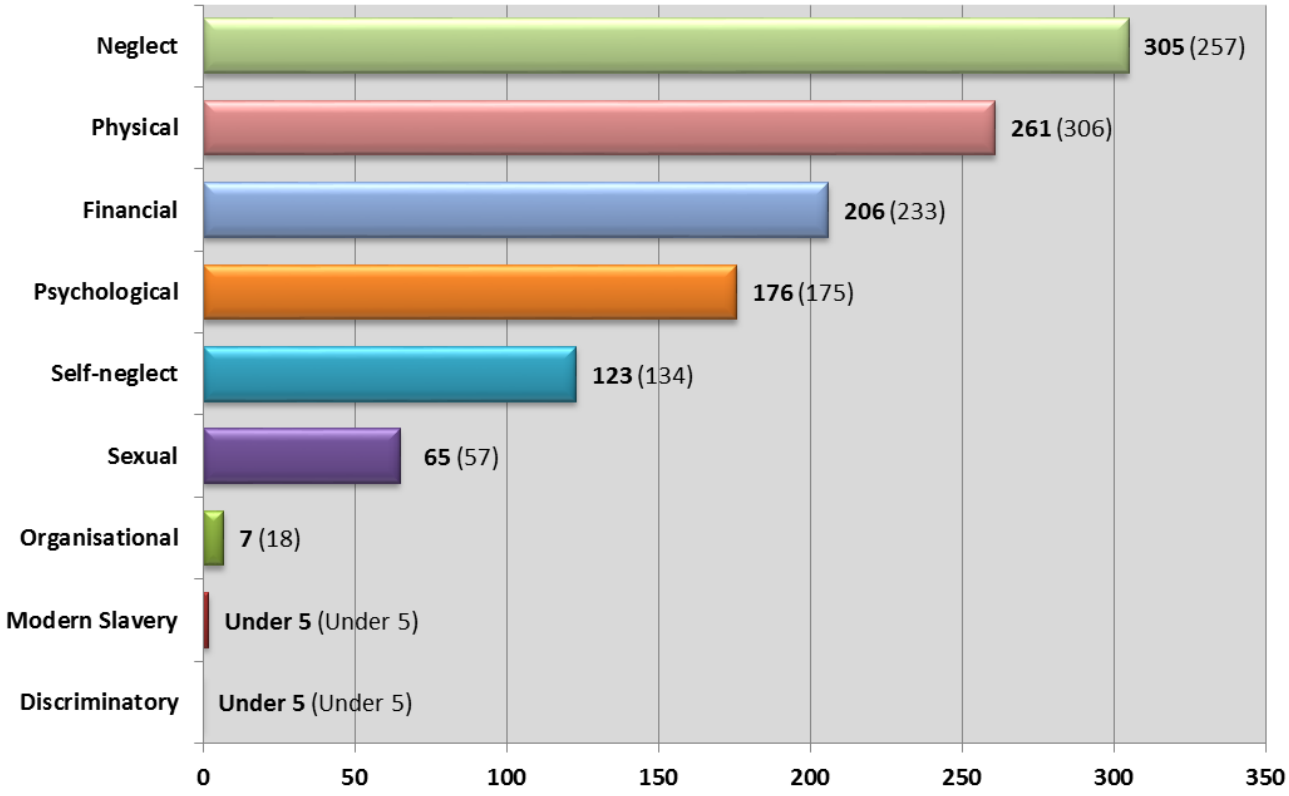
Figure 3: Breakdown by Gender and Age



Last year, it was reported that there was a decrease in the number of women between the age of 18 and 64 who were the subject of safeguarding concerns. This year there has been an increase. The majority of these people were described as needing learning disability support and physical abuse was the highest abuse type reported, followed by psychological. A high proportion of the cases progressed to an enquiry (61%) and of those completed over half concluded that risks has been identified and action was taken. There were multiple concerns raised for 29 of the individuals subject to the safeguarding concern. Where this amounts to 3 or more occasions, the safeguarding management team will review the cases.

Case Study:
Sharon Rich had been the subject of 6 safeguarding concerns and although there were different "sources" of the concern, in most cases they appeared to be linked to her vulnerability in relationships. While initially she would want action to be taken, she would change her mind and disengage with the safeguarding process. There was an additional concern with regards to a communication she had with a man on Facebook, and although no abuse took place, there was some risk taking behaviour (flirtatiousness) noted from the entries she was sending back to the man. The previous cases were reviewed by the management team and considered along with the new case with Sharon. She engaged with the social worker and response officer from the safeguarding team and seemed to have taken on board the risks she faces with her behaviour. She also had a better understanding of what action she could take if she felt threatened in the future.

Figure 4 Types of Abuse Alleged



For the first time, neglect is the most frequent form of abuse reported into the local authority. This is more in line with national trends. In previous years, physical abuse was the highest abuse type.

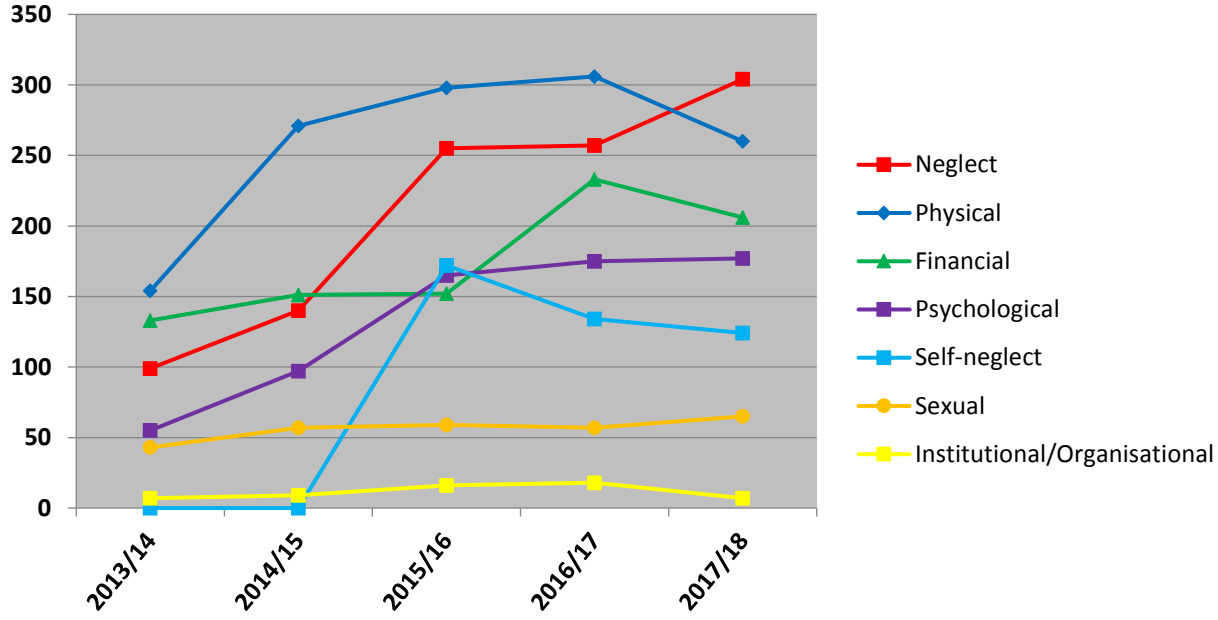
In 2017/18, the location neglect was alleged to have taken place in was the persons own home. Of the 157 cases family members were considered to be the source of the risk in 56 of them. 36 case were regarding risks (neglect) caused by members of staff, mostly from domiciliary care agencies.

Case Example:
A care agency submitted a safeguarding referral because they felt that Sid Howard who is his wife's (Ann) main carer, was not looking after her well and was rough with her when moving her from her bed to her chair. He could also be quite rude and obstructive. In discussion with Sid, it transpired he was keen to get everything done before the care agency staff arrived and was rushing. His view is that it was his job to attend to his wife and it appeared that Sid wanted to prove he did not need outside help. However, Sid himself was showing signs of frailty and the safeguarding team and the agency were worried he may injure himself as well as risking injury to Ann. It was decided to hold a meeting at the house with Sid and Ann, together with the agency's team leader and regular support worker. There was an undertaking from the care agency that they would work alongside Sid more to meet Ann's needs and not appear to take over and Sid would wait for them to attend, especially when Ann needed lifting out of bed. Although Sid was accepting of this, he was still abrupt with staff, but did realise that he could not do the "big" tasks anymore and has now asked the support worker to complete some tasks he used to do. He also said that he now realised that if he becomes exhausted or injures himself, it may result in Ann not being able to live in the family home any longer.

The Care Act guidance refers to Domestic Abuse as a category encompassing most of the abuse types recorded in fig 4. Although recording the primary type of abuse, those raising concerns are asked to indicate if domestic abuse is considered to be a factor of the concern. In 2017/18, there were 126 cases where this was recorded. 8 were financial, 7 neglect, 56 physical, 47 psychological and 8 sexual.

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



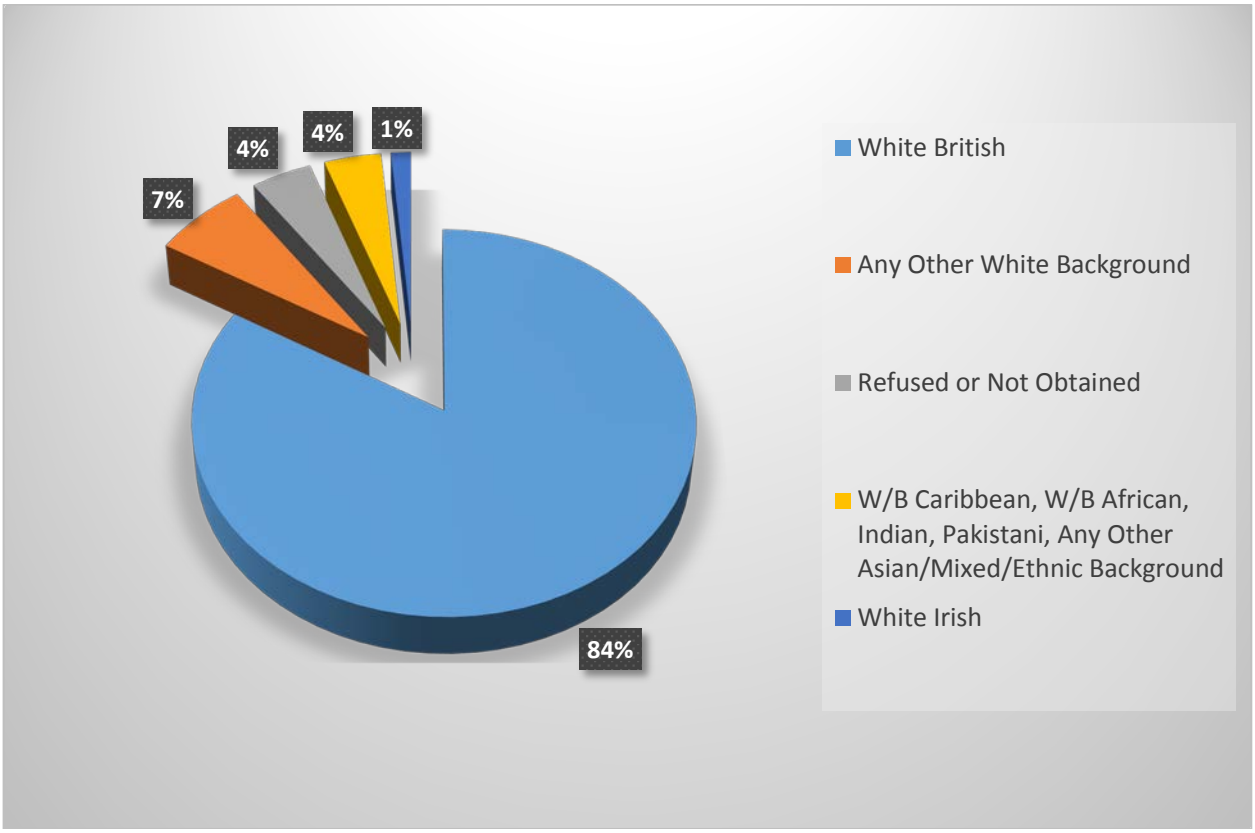
There continues to be a decrease in the number of concerns raised about self-neglect after the initial high numbers when it was included in safeguarding under the Care Act Guidance. Further guidance was issued last year which stated that in most cases of self-neglect, a section 42 enquiry may not be required and needs to be dealt with on a case by case basis. In most cases it is found that the person needs some care and support and a safeguarding referral and enquiry is unnecessary. Some agencies do now make a direct referral into adult services requesting an assessment for the person considered to be self-neglecting. However, the following case example illustrates a situation that did require a safeguarding enquiry.

Case Example:
Mr and Mrs Cook have been married for thirty years and live in their own home. Mr Cook was receiving support from the social care team following a number of previous concerns highlighting him and his wife's poor living conditions. Despite this input, there had been very little improvement and the care manager submitted another safeguarding referral and a joint visit was planned to assess the home situation The house was very cluttered and Mr Cook appeared very unwell and unkempt. He was lain with his top half on a table and his bottom half on a chair. The care manager felt that in the short space of time between her visits, further deterioration was immense. The couple were quite able to engage in the Safeguarding process and talk about their situation but they were both very resistant to change. As the home was assessed as high risk of fire, infection and falls, and there was an impact on their neighbours, the case proceeded to consider the best ways to change the unacceptable situation. It took nearly a year to reach a positive outcome. There were a number of honest conversations and meetings (involving Mr and Mrs Cook when possible) and some long term work to persuade them that a clean-up was necessary and pointing out the consequences if the situation

continued. During this time, Mr Cook needed Hospital treatment and further discussions took place prior to his discharge about what was needed if he were to return home.
After a while both Mr and Mrs Cook felt that they could no longer maintain their home in the way it needed and they discussed selling the house once it was cleaned up. They looked at sheltered accommodation, tried it and agreed to move. Mr Cook's health improved vastly soon after their move.

The case shows that often in self neglect cases progress can be slow and sometimes a direct approach is needed. Pointing out the consequences of action and inaction is required to promote a change, at the same time, ensuing there is continual assessment of risks to prevent even worsening conditions. This is promoted in the SBC Self Neglect/Hoarding policy.

Figure 6: Ethnicity of alleged victims



For 2017/18 there has been an increase in the number of concerns raised regarding non-white British people. The percentages reported are more in keeping with the estimated percentages of the make-up of the wider population of Swindon based on the 2011 census. However, there are a significant number of referrals where the ethnicity of the alleged victim was not known or recorded. For some of these, the referral has not progressed to a safeguarding enquiry but there is also a lack of retrospective recording i.e. establishing ethnicity at a later stage and updating the records. Adult services are working on the development of a new care management system which will help remind staff to update key information.
Since the last annual report, a new Translation & Interpreting Service has been commissioned which the safeguarding team or the teams providing social work or care management support has accessed as part of the safeguarding process.

Figure 7: Breakdown of Source of Referrals

Source of Referrer	Total 2016/17	*Total 2017/18*
Care Providers (e.g. Care Homes day services including Independent Sector)	367	**353**
Great Western Hospital NHS Foundation Trust	166	**177**
Mental Health Professionals	91	**89**
Council Employee (Adult Social Care)	55	**85**
Police	45	**70**
Family/Carers	66	**73**
Council Employees (not Adult Services)	45	**57**
Ambulance Service	57	**49**
Housing Services (including Registered Social Landlords)	51	**34**
Advice & Support Service	9	**31**
GP	29	**28**
Out of Area Referrals (including NHS 111)	8	**24**
Care Quality Commission (CQC)	8	**18**
Members of the Public	15	**10**
Advocacy Service	18	**11**
Educational Establishment	9	**11**
Fire Service	6	**4**
Business	7	**4**
Probation Service	5	**4**
Hospice	5	**4**
Other Hospital Staff	2	**3**
Substance Misuse Service	7	**3**
Swindon CCG	1	**2**
Self-referrals	8	**2**
Personal Assistant (Direct Payments)	2	**2**
Central Government Department	7	**1**
Confidential (Anonymous)	0	**1**
Private Hospital	17	**0**
Volunteer/Voluntary Organisation	8	**0**
SEQOL Staff (up to 1st October 2016)	70	**0**
Total	**1184**	**1150**

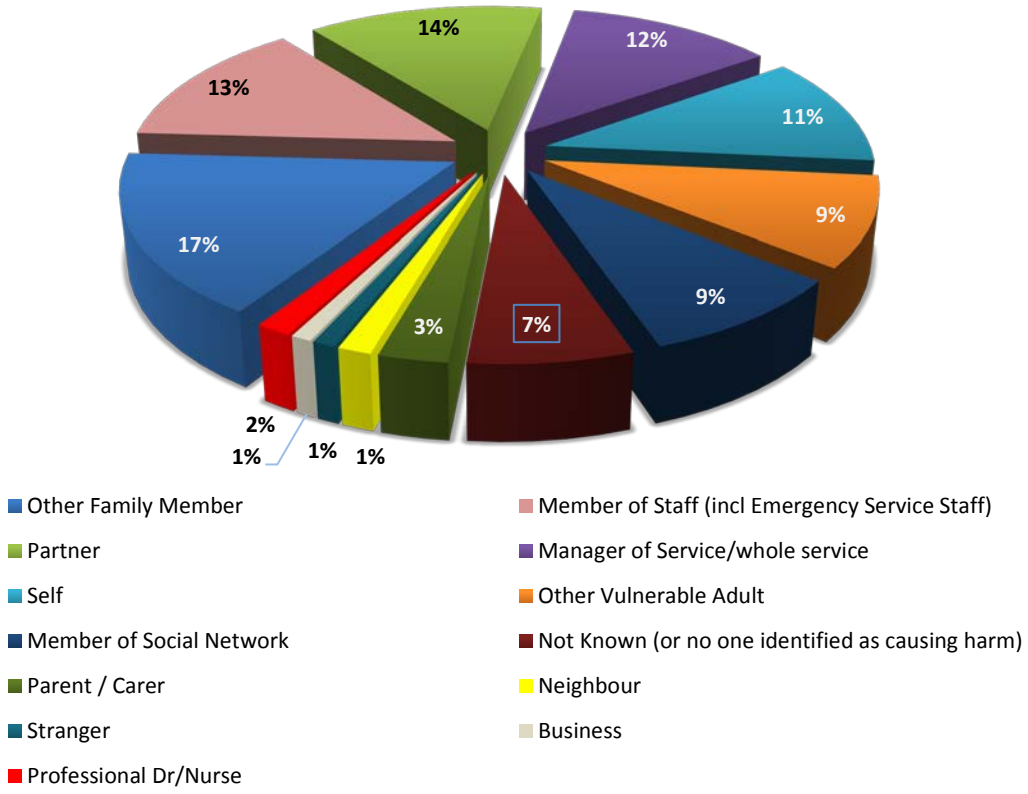
There are no significant differences between the rates of referrals between the two periods. However, there is an apparent increase in the amount of cases raised by adult social care staff mainly due to the closure of SEQOL in October 2016 where most adult services staff were employed at the time. There has been an increase in the number of concerns raised by support and advice services. This may show an improved awareness in a range services.

Case Study:
The Alzheimer's Society Dementia Advisor reported that he had visited Mary Heath with her husband Keith. During the visit it became clear that Keith was becoming more and more frustrated with this wife's behaviour, saying she was refusing to go anywhere without him and refusing to leave the house. He spoke of becoming more and more exhausted as she was becoming more demanding. He became tearful and indicated that he could smother or strangle her. Although this could indicate that Mary was at *risk of abuse*, it was felt that it was more likely that Keith was incredibly stressed and needing more support. While the safeguarding team managed the process, the case was referred for input from the Rapid Response Team which resulted in an increase in domiciliary support and more input to give Keith respite and ensure Mary went to the day centre twice a week. There were no further incidents that needed referring to the safeguarding team, although there continues to be deterioration in Marys behaviour and a year on, a review of her support plan and Keith's carers assessment was required.

There was an apparent increase in the number of concerns from the police. However, due to a change in the recording method with the council's safeguarding team, of the 75 concerns sent, the majority were welfare concerns with 26 cases requiring an enquiry.

There is still a high number of concerns received from care providers although there is a slight decrease in the number of concerns received. Often these are minor issues that needed to be recorded with their incident records (for example a minor medication error or incident between two service users where remedial action was already in place). Adult services have recently developed a Thresholds Guidance Document and care providers are expected to follow this reducing the need to report safeguarding concerns unnecessarily.

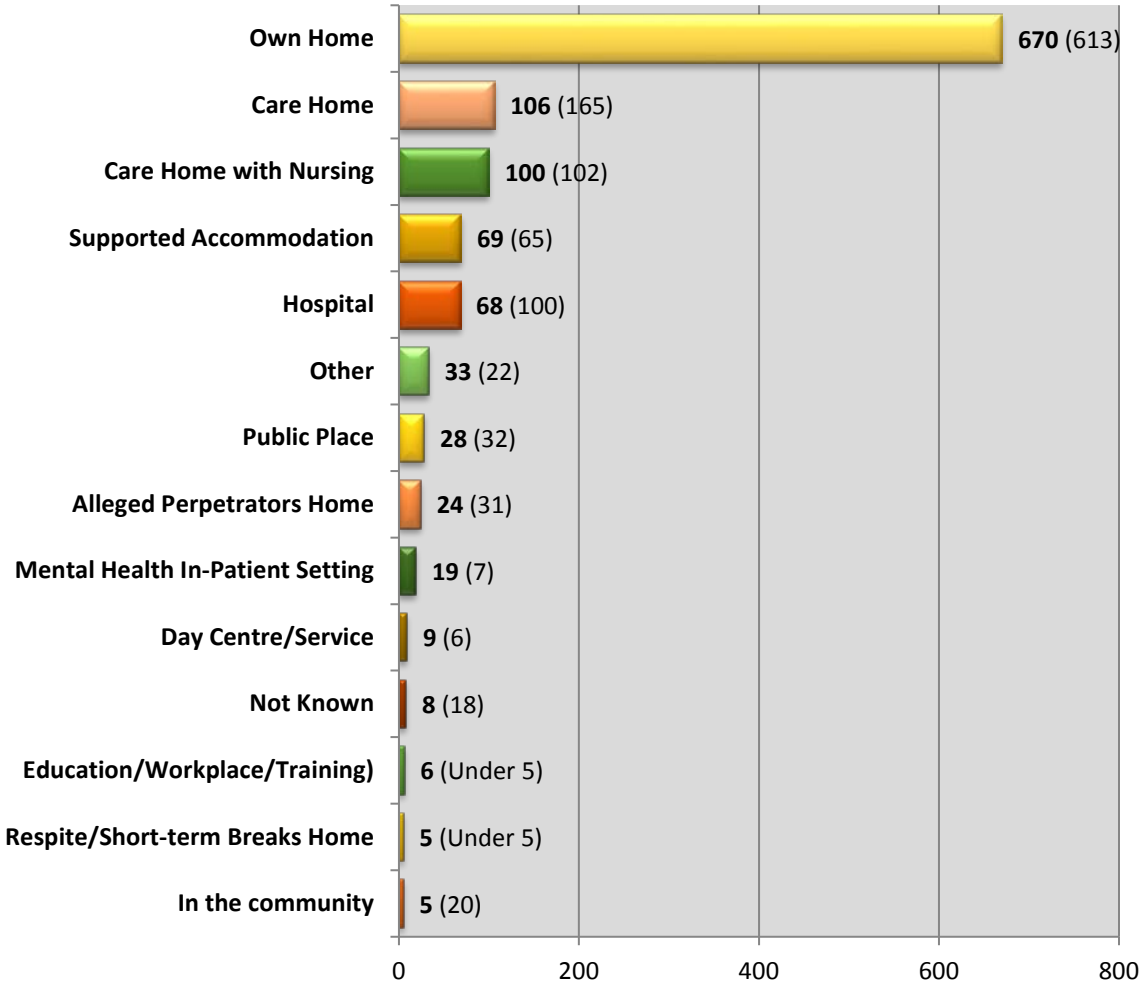
Figure 8: Information on those alleged to have caused harm



Overall there has been no major difference in numbers regarding those considered to be the source of the risk (those alleged to have caused harm). There has been a slight

increase in the number of allegations against staff (12) and a similar increase in those cases progressing to an enquiry of which the majority needed the employer to do the investigation. While there was a decrease in the number of concerns regarding other family members (21) there was an increase in the number of concerns relating to partner/spouses being the source of the risk (22). There has also been a decrease in the number of cases reported concerning another adult in need for care and support but an increase in the number of cases where a member of the person's social network was alleged to have caused harm (This maybe a recording issue as "another vulnerable adult" is often also a member of their social network).

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

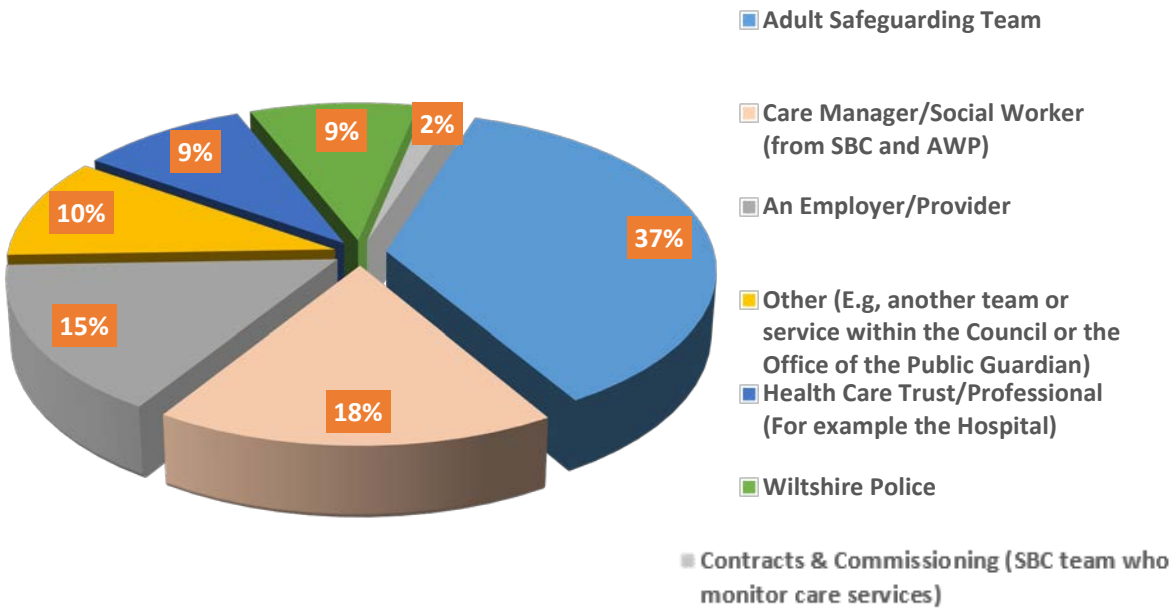


The location where most abuse was alleged to have occurred was in the adults' own home. There has been a reduction in the number of concerns within a care home without nursing and no major change for those with nursing. This could be due to improved awareness as there was also a higher proportion of incidents which justified a referral. There is a reduction in the number of concerns occurring in hospital but an increase in reports from mental health in-patient settings. Most of these were reported by the services themselves perhaps indicating improved management of safeguarding issues.

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?



In some cases it may have been necessary for a concern to have an enquiry carried out by more than one agency. 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.

Most enquiries are carried out by the local authority and can range from a full enquiry, a multi-agency investigation or simply a conversation with the adult.

Case Example:
The police raised concerns about a known sex worker and drug user staying in Dave Jenkins's flat. They believed he has dementia and was being exploited and that she had been using his bank card and taken his mobile phone. There had been a disturbance at the flat caused by 3 visitors and Dave was advised not to allow them in. A home visit was arranged with 2 members of the safeguarding team and Dave was very clear that he knows these people well as he sees them at a lunch club he works in and considers them friends. He knew the person who was alleged to have taken his money but he said he does ask people to get money out of the bank for him but his bank card had not been stolen. He had lost his phone and thinks it may have been taken but he was not concerned about this. There was a discussion about coercive control and the possibility of cuckooing (Cuckooing is a form of crime in which drug dealers take over the home of a vulnerable person in order to use it as a base for drug dealing).
Dave had not been diagnosed with dementia and there was no indication that he was unable to make decisions for himself and he felt that he was able to protect himself. He was happy for visitors including the alleged sex worker and appeared to feel he was helping them and that they were helping him. (During the visit there was a caller who enquired about his welfare). He appeared to be managing well and did not have care and support needs. Dave said he did not want any action taken but was given contact information should he have concerns in the future.

Feedback on the home visit was given to the Police officer who raised the initial concern and appreciated that Dave had every right to associate with whoever he wanted. The officer confirmed that the neighbour policing team would continue to monitor Dave's wellbeing

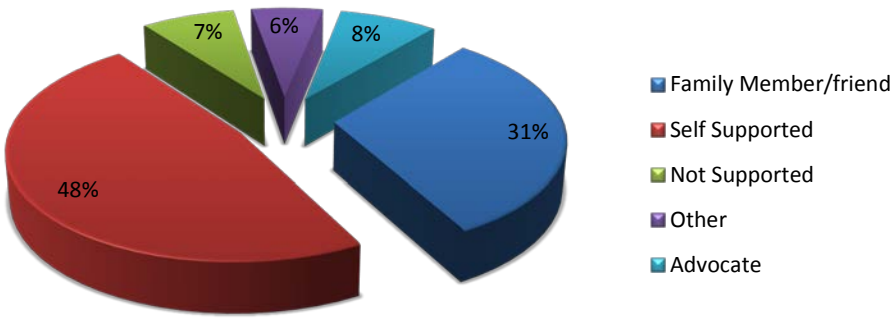
There is a large proportion where the provider of a service or employer has carried out the enquiry. This is either under their complaints or disciplinary procedures.

Case Example:
A concern was raised about Maureen Flint a resident with dementia in a care home. She became upset when staff came into her room to deliver personal care and woke her up. It was explained to her that they had come into help her but she did not accept this and refused assistance and was pushing the staff member away. One of the staff started to verbally abuse Maureen but this was overheard by other staff working in the room opposite, who firmly instructed the abusive staff member to leave the room and reported the incident to the senior on duty. They returned to reassure Maureen who had become even more distressed. After calming her, they noticed a skin tear to her elbow which was believed to have happened during the incident.
A safeguarding concern was raised by the care home and it progressed to an enquiry. The Police considered that the matter would be best dealt with as a conduct issue and the home carried out an investigation and held a disciplinary hearing. The member of staff responsible for the verbal abuse was dismissed and the person accompanying her was given a written warning with a training plan.

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 can 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 2017/18



As much as possible, the adult should be given the opportunity to advocate for themselves. The safeguarding team are aware that although someone may appear to be able to engage well with the process, this could change during the life of a referral. The safeguarding policy emphasises that independent advocacy can be instigated at any stage during a safeguarding enquiry.

Outcomes of Investigations

Between April 2017 and March 2018, 505 cases were assessed and did not progress through to a full safeguarding process. 315 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). 127 cases required care management input (a new care assessment, change to care plan or a review of their care). 46 were referred to another process, for example complaints action or action by the provider (e.g. disciplinary action). 17 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 an allegation 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.

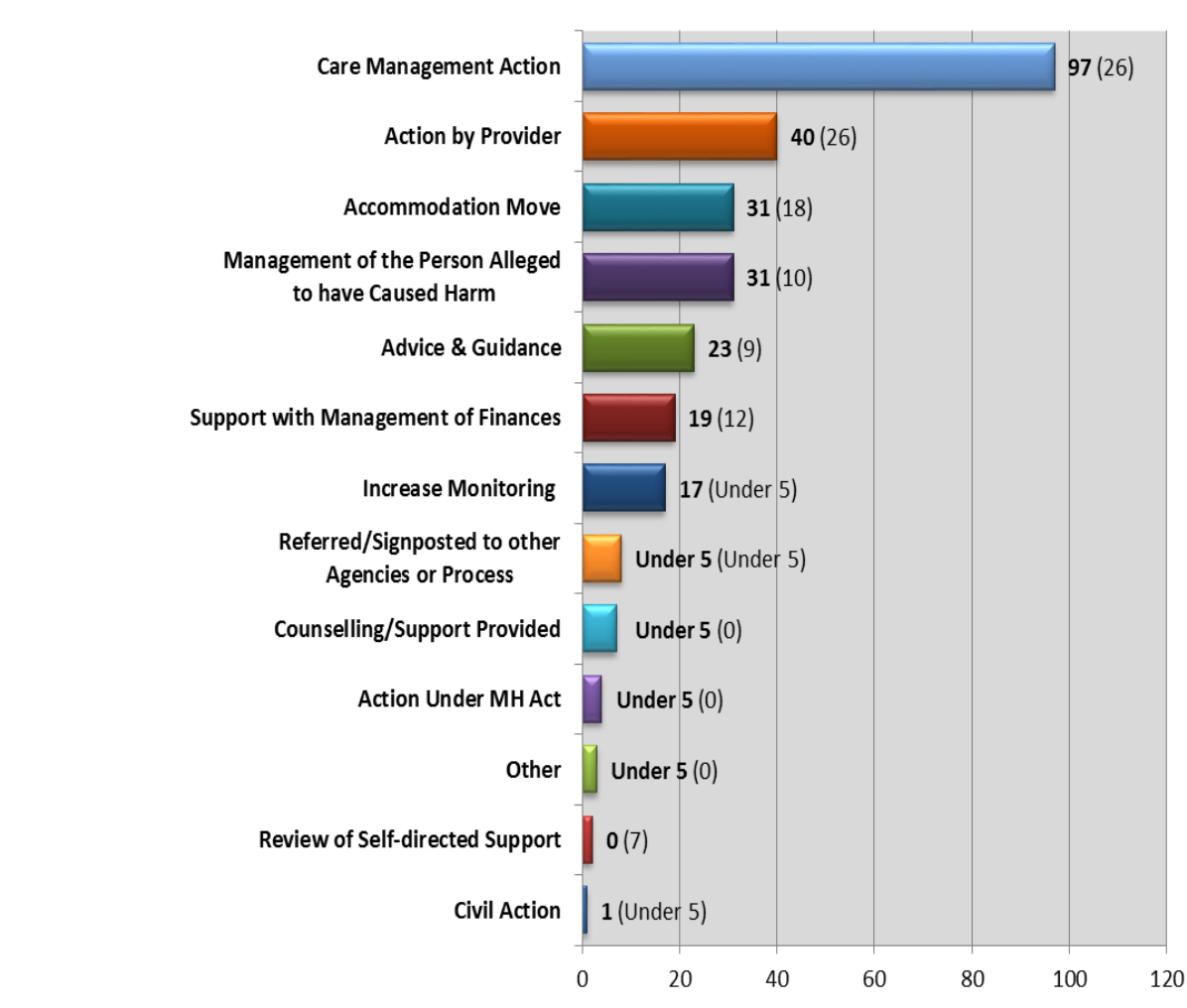
As stated in the previous annual report, outcomes are recorded and reported differently. Rather than looking at cases as substantiated or not, the emphasis within the Care Act is to consider if the enquiry highlighted any risks. The following table shows a breakdown of outcomes of cases concluded during the year. (Please note that some of these relate to cases that opened in the previous year, but concluded in 2017/18)

Figure 12: Outcomes of closed cases

OUTCOME	Number of cases concluded in 2016/17
Risk identified and action taken	392
Risk identified and no action required	0
Risk - Assessment inconclusive and action taken	54
Risk - Assessment inconclusive and no action required	8
No risk identified and action taken	55
No risk identified and no action required	43
Enquiry ceased at individual's request and no action taken	47

583 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 action.

Figure 13 Action Taken for the Adult at Risk

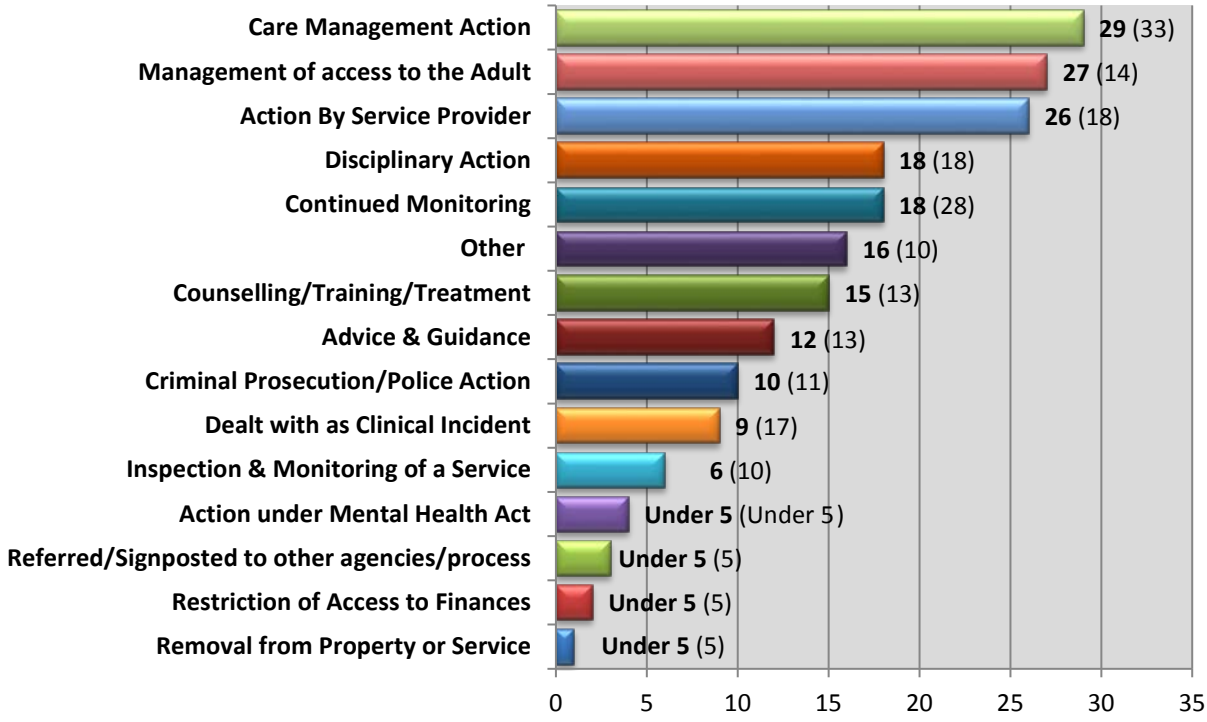


***NB at the time of reporting, 45 cases remained open. This is due to the alert being raised towards the end of the reporting period and the cases are still under an enquiry or they are long-term cases where it has been agreed that the case remains open to enable a continual review of any safeguarding plan.**

There were 40 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 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 14 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 of them requiring 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.

A SAR is a multi-agency review process that seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to

promote effective learning and improvement to prevent future deaths or serious harm occurring again.

During 2017/18 one SAR was carried out and published in May 2018.
The SAR was commissioned following the death of Honor, a 90-year old widow living with her son, in January 2017. Concerns were raised over a period of time, (predominantly by her daughter) about Honor's welfare but did not result in protective action being taken due to Honor's denial of any problems and an assessment that she had mental capacity to make her own decisions. The cause of death is recorded as bronchial pneumonia and malnutrition (with a likelihood this was caused by neglect).

The Board and all those involved offered sincere apologies and condolences to Honor's family on the circumstances surrounding her tragic death.

Findings and Lessons Learned
All partner agencies involved in this case engaged positively in the process of the SAR and in developing the action plan in response to the findings in the report. The main lessons learned by the Board and its member agencies include:

1. The need to improve *social work practice* in respect of:
    - risk assessments
    - making appropriate safeguarding decisions that require the balancing of mental capacity and the impact of domestic abuse on a victim's ability to self-determine
    - recognition of the impact of coercive control and domestic abuse on older people
    - using multi-agency discussions to share information prior to making key safeguarding decisions and risk evaluations
    - ensuring practitioners are aware of best practice and put this into operation

2. Detecting when cases are going wrong by:
    - improving the oversight and supervision of practice
    - having effective quality assurance processes in place

3. Improving the connection between the Safeguarding and Domestic Abuse Boards to:
    - support practitioners' understanding of the links between them
    - ensure agencies are sighted on the potential for generational abuse

Each partner organisation concerned, particularly Adult Social Care, has considered the findings and agreed its own actions to improve practice. Examples of their progress include:

Local Authority - Adult Social Care
The Local Authority fully endorses the findings of the report and accepts the need to improve social work and safeguarding practice. A separate and detailed action plan has been agreed and is being implemented. Progress against the action plan is monitored monthly by the Director of Adult Social Services. The following improvements have been made:

- A new dedicated manager for the Safeguarding Team has been appointed on an interim basis whilst a permanent appointment is made
- Specialist safeguarding supervision has been implemented for the safeguarding team and social work team
- Managers have monthly supervision and oversight of all allocated safeguarding cases to ensure a timely conclusion of investigations
- Enquiry Managers will have access to a regular 'weekly' supervision session led by a senior member of the Safeguarding Team to ensure adequate support and advice is available on a weekly basis to ensure effective, responsive decision making

- All Team Managers hold a “Learning and Development Record” of their teams learning to ensure that everyone is fully participating in regular learning opportunities
- The ADASS guidance on safeguarding and domestic abuse has been made available to all social care teams
- A new threshold document has been adopted and published on the safeguarding website
- The Director has highlighted the main lessons from the case in all staff briefings and all teams have been requested to discuss the case and action plan in team meetings in May 2018
- Staff training on domestic abuse and coercive control and mental capacity and safeguarding is taking place in May 2018 for all social care and occupational therapy staff
- A decision-making tool is being developed by the Head of Social Work that will support consistent decision making in relation to our initial response times. Each safeguarding concern/referral that progresses to a Safeguarding Enquiry will be allocated a risk rating (Red/Amber/Green) by the Adult Safeguarding Management team at the point of screening. Each rating will have an associated maximum response time. Response time performance will be monitored monthly and reported to the Director of Adult Social Services

Clinical Commissioning Group
Having raised this case initially for this review due to the concerns expressed by Honor’s GP, the CCG takes very seriously its commitment to safeguarding adults and to ensure health professionals and health organisations learn the lessons from such cases. In the work the CCG undertakes it does so ensuring safeguarding is of the highest priority and that it complies with the Care Act 2014 duties. Through its commissioning functions it has a responsibility to ensure all the services it commissions also have arrangements in place to make certain they also comply with this and other legislation relating to the welfare of adults within Swindon.

The CCG have been involved throughout this review to ensure it can take the learning back into all its functions as a commissioner to drive improvements in practice across health. In response to this review the CCG will ensure all the recommendations that apply to health professionals and health organisations are implemented without delay. The CCG has set out how it will achieve this in its action plan that aligns with the LSAB action plan to address all the findings of this review

Wiltshire Police
Head of Public Protection Detective Superintendent Deborah Smith confirmed that Wiltshire Police are fully committed to exploring the issues in more depth, and are dedicated to the delivery of a multi-agency action plan. Wiltshire Police always ensure that findings from such reviews are embedded and used to improve how the Police work with agencies to safeguard and protect vulnerable adults.

Monitoring of progress
The LSAB and individual organisation’s action plans are subject to regular monitoring and challenge and the use of audit activity to continually monitor progress against areas for improvement. The Board remains committed to ensuring that the findings are fully addressed so the same issues are not repeated in future

Large Scale Cases
There were 2 large scale enquiries started during the year both regarding care homes (one with nursing). The concerns were in relation to the management of the homes and how that may be putting their residents at risk. The first was triggered by a number of individual concerns indicating poor management and incomplete or out of date care planning. A large scale enquiry was held and working with the provider and the contracts team in adult services, risks were identified and action was required. These actions were monitored and the service demonstrated improvements. The second case showed a considerable amount of poor practice and concerns about general safety. This came to light at the end of the reporting period and is still to be concluded. There were a high number of deaths leading to the enquiry which would consider if these were related to the concerns that had been raised. The CQC carried out a responsive inspection at this time and found the home to be inadequate.

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 coming in and to monitor the "conversion rates" of cases;
- There are still a 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.
- How the widening of definitions within the Care Act Guidance impacts on referrals

Areas of focus for the Board next year:

- For the Board to consider improvements required to ensure quality and accuracy of referrals and that information provided is complete and accurate e.g. ethnicity, service user group and their views. To ensure appropriate methods are available to improve understanding of safeguarding e.g. level and appropriateness of training, awareness raising and available information. Where a particular issue does not require the safeguarding process referrers are made aware of alternative processes available e.g. referral to social work teams or signposting to other services.
- The Board needs to continue to monitor how referrals are dealt with and that resources are available to manage enquiries and ensure participation from the key agencies.
- The recent addition of the Thresholds Guidance included on the Council website has been welcomed. The Board needs to develop methods to check the effectiveness of this document to ensure it is implemented and embedded in to practice.
- Engagement with service users and methodology around service user feedback of the safeguarding process and Board members to contribute on achieving this innovatively.
- Continued learning from the Safeguarding Adult Review (see page ##) and ensure frontline staff identify domestic abuse as well as other types of abuse and raise concerns appropriately.
- To consider areas of work that impact on adults in need for care and support that are perhaps less understood for example sexual exploitation, human trafficking, self-neglect and to highlight the importance of early identification and correct referrals to the appropriate process(s). The circumstances in which abuse takes place e.g. homelessness, people in transition (Children's to Adult services) also needs understanding and addressing.
- To consider what actions need to be put in place to develop a preventative programme to include oversight of the quality of services, learning arising from case reviews (locally and nationally) and how practice needs to change to address issues identified.

SECTION 3

Progress, developments and news in 2017/18

Priorities for 2017/18

In previous annual reports, the priorities in the LSAB Strategic Plan were listed and 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 in 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. These partnerships are presenting reports and updates to the Board, outlining the impact the particular area of concern has on adults in need for care and support.
A Risk Register has been updated and is monitored at each Board.

The Board agreed to redevelop its sub-groups and this has progressed well. In February 2018, Board members attended a development session facilitated by an experienced facilitator from the Local Authorities Human Resources Department. This led to further discussions about how the LSAB could work more in tandem with the other boards for instance the Children's Board. Resources have been more forthcoming from partners which has helped with some of the financial pressures Boards face. There is still a need for other key members to help with non-financial resources.

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 have been major developments with the way in which the Board judges quality of safeguarding arrangements. A comprehensive work plan is in place that has prioritised the areas to be scrutinised. Domestic Abuse, financial abuse and self-neglect being seen as the priorities.

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

Towards the end of the year, an on line referral form was included on the website. In the main, as this is a secure method of sharing a concern, this has been very popular. There have been times when the form has "timed-out", but this is usually due to

inactivity by the user or a disconnect in their network. The webpage and referral form conform to industry standards. It is believed the form encourages visitation to the webpage but the LSAB are currently unable to obtain meaningful data on usage. There is continued liaison with the communications team to obtain information.

There is still a need to engage with the community and there is ongoing discussion with other partnerships on how best to achieve this. The Safeguarding Manager participated in a loneliness summit and delivered a presentation to Swindon Seniors Forum.

A range of printed information is available from the adult safeguarding team and services continue to request copies. The most popular is the Swindon Safeguarding Staff Guide that provides advice and guidance to those raising concerns.

A model was developed to gain the voice of the service user and/or their carers. Working with Healthwatch, a process was developed which invited people to contact them to make comments or to have an interview about their experience and just speak to someone in Healthwatch. Take up has been poor and a new approach may need developing. There continues to be a case discussion at each board for members to be aware of the issues service users experience as part of the safeguarding process.

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

Member agencies have provided basic information about their safeguarding training within their reports (see Appendix 2). Adult Services still provide basic awareness to any provider or agency free of charge (applying a charge for non-attendance). 232 people attended this training during the year. This includes a session delivered at the Swindon Advice and Support Centre for agencies based there (e.g. Citizen's Advice Service, Alzheimer's Society). 27 staff attended enquiry officer training (designed to advise staff on approaches with engaging with adults and collecting evidence and information).

There is still a need to check the quality of training delivered in a number of services who do not utilise the council run basic awareness. Contracts officers do check that training is provided, however it is not clear that it meets the requirements outlined in the National Competency Framework on safeguarding.

A specific basic awareness course was arranged at the beginning of 2018 and this was attended by 64 council staff from a range of services as well as adult services, including Housing, Environmental Health Community Health and Wellbeing and Healthy Neighbourhood. There was also a specific course focussing on the law run for Adult Services facilitated by Belinda Schwehr from Care and Health Law. This was attended by 25 social work staff from Adult Services (including AWP) and members of the safeguarding team.

RISK ENABLEMENT / MANAGEMENT PANEL

The multi-agency Risk Enablement Panel (REP) has been active for approximately three years. During this time the Risk Enablement Manager has been involved in 42 cases. Some of these are currently open. A number of cases have not required the input of the manager other than providing advice or ensuring that agencies have exhausted their options before referring the case to the REP manager.

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

The Objective of the panel is unchanged since the last annual report

Overall the risk enablement process is about concentrating on what can be achieved, rather than what cannot and bringing together people from different organisations to develop shared perceptions of risk.

Case study

A safeguarding referral was received in October 2016 for EF. As a consequence of this a planning meeting was held and later the case reviewed and concluded that remedial action was not effective and identified that concerns were escalating. It was decided to take the case to the Risk Enablement Panel.

The situation was challenging involving a complex adult family dynamic which included physical and mental health needs; drug misuse; poor money management; financial and other areas of exploitation. As well as one of the household going through the criminal justice system, there was severe trauma and neglect of the most vulnerable member of the household; animal neglect; weapons; abuse to staff and living in squalor.
This meant multi-agency working with the family with a wide group of agencies including: Community Matrons and other health professionals, Police, Housing, Environmental Health, Animal Welfare, vets, Community Safety, the courts, the council's legal services, the prison service, Social workers, Probation, Adult Safeguarding, Mental Health, Food Bank, Ambulance and Out of Hours Services.

The role of the REP was to bring together the right professionals at the right time with an understanding of the legal frameworks that could be utilised to de-escalate the levels of risk identified. There were many unexpected events that needed managing as the challenges presented required constant communication, co-ordination as well as the occasional immediate response, to support the engagement strategy and risk management plan. This meant there was an accurate, evidence-based identification of risk and the innovation for reducing these risks came from combining skills and perspectives across departments and organisations. Further to this, the professionals involved developed cross boundary skills, an enhanced understanding of others disciplines and broader perspective on the resources available.

The case was closed to the Risk Enablement Panel in May 2018 with the family agreeing to live apart. The older adult members of the family were housed in a bungalow which was adapted to suit their current and future needs, regular access to day care services was provided with on-going support from Community Matrons and Housing. The younger adult member of the family moved into a separate property and there has been no further need to use enforcement powers.

Internal Audit of Adult Safeguarding, February 2018

Swindon Borough Council's Internal Audit team carried out an audit of Adult Safeguarding in February 2018. The purpose of the Audit was to give focus to the process following the receipt of a safeguarding concern by the Council's Adult Safeguarding Team; to provide assurance through testing on a sample of safeguarding cases, that all relevant information is being used to determine whether to progress under safeguarding. They audited the response to the sample of concerns received and considered whether cases were managed effectively, in a timely manner and that cases were reviewed and closed where no further action was required.

An Action Plan was developed in response to the Audit findings, and a number of actions have been incorporated into the Safeguarding Adults Review (SAR) Action Plan as they are linked.

- Multi-agency Policies and Procedures and Additional Guidance to be reviewed against Care Act Statutory Guidance to include sources of expert advice e.g. ADASS, SCIE etc., and ensure that information sharing can be improved
- The Council's Safeguarding Adults Procedures to review and refine the Risk Assessment Tool to ensure that all risks are identified and addressed appropriately.
- The views of service users should be sought prior to making a Referral. The Safeguarding Referral Form and standard Form 75 to be amended to include a prompt to seek consent from the person subject to the safeguarding concern prior to referring (where possible), and to ask for and document the referred person's views.
- Feedback should be given to the person that made the referral, relating to the decision and why (where appropriate to do so). Compliance with this is monitored through the new Quality Assurance tool.
- Multi-agency guidance should be produced on Safeguarding Thresholds, to include examples of what constitutes a safeguarding concern and not, and communicated across the Safeguarding Team and partners/providers
- A new Quality Assurance process has been introduced to conduct quarterly audits relating to a new set of performance indicators, including the percentage of cases where screening has commenced within 24 hours, number of open and outstanding cases, length of time for completion of safeguarding enquiry to closure. These audits will be used to understand where performance and practice improvements are required without compromising the flexibilities required to address the Adult's views and desired outcomes.

SECTION 4

Swindon Mental Capacity Act Programme

Mental Capacity Act and Deprivation of Liberty

In July 2018, the Government published a Mental Capacity (Amendment) Bill, which if passed into law will reform the Deprivation of Liberty Safeguards (DoLS) which have long been considered not fit for purpose particularly in the wake of 2014 Cheshire West case law. They will be replaced with a scheme known as the Liberty Protection Safeguards: each separate health and social care public authority will be responsible for authorisation and the scheme will include 16 & 17 year olds, a transferable deprivation of liberty authorisation wherever the person resides and the introduction of an AMCP, an approved mental capacity practitioner, for complex cases where there is disagreement. Whilst the Bill draws on the Law Commission's proposals for reforming DoLS that have been subject to scrutiny and consultation throughout 2017 -18, it did not address some of the wider MCA reforms that the Law Commission suggested. Proposed reforms around supported decision-making and best interests are not included and many aspects of the proposed streamlined process have proved controversial and may be challenged as the Bill goes through Parliament.

Until the reforms are decided and a preparation period identified, we continue to implement the present scheme: in 2017/18 Swindon received a total of 907 referrals (427 from hospitals and 480 from care homes); this is a reduction in overall referrals of 13.37%. We have continued to re-shape our delivery model since the establishment of our permanent team in February 2017 and have strengthened our triage process as well as monitoring the implementation of conditions after the DoLS assessment. We continue to have a significant cohort of unassessed cases in care homes through this is gradually reducing. We are keeping up our training of Best Interests Assessors (BIAs) as these will have a key role in the future reformed DoLS. Independent scrutiny from the experienced BIA regularly improves the experience of the vulnerable adult.

As a team we continue to support the wider adult social care services in strengthening understanding and practice within MCA; we have a programme of learning and development which is increasingly bespoke and responds to the needs of individual services.

Court of Protection

The efficacy of DoLs in protecting and representing the rights of vulnerable individual means that over the last year we have seen an increase in s21A challenges in the Court of Protection.

Appointeeships and Deputyships held by the Council

Swindon Borough Council Appointeeships and Deputyships Team is now known as Adult Social Care Money Management Team and performs an essential role for vulnerable adults who lack capacity to manage either their DWP benefits (Appointee) 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. At 31st March 2018, the team managed 80 appointees, 108 Deputyships. 40 of our service users died in this period, 36 Deputyships were going through Court of Protection and 13 referrals were awaiting a decision of whether they met the criteria for this team.

Working with an individual's resources and ensuring they are used 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 appointee 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; we have also had referrals from Court of Protection when OPG has undertaken safeguarding interventions. Our aim is to ensure that peoples' resources are adding to the quality of their life, whatever their circumstances and we will be recruiting a social worker to the MCA/DoLS team to work alongside the Money Management team to strengthen this service.

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 2017/18 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
NHS England South (South Central)
Service User Forum
South West Ambulance Service NHS Foundation Trust
Swindon Advocacy Movement
Swindon Borough Council
- Adult Safeguarding Manager
- Community Safety Partnership
- Corporate Director for Communities and Housing
- Director, Public Health
- Director of Adult Social Services
- Head of Housing and Community Safety
- Trading Standards

Swindon Care Homes Association
Swindon Carers
Swindon Clinical Commissioning Group
- Executive Nurse
- Designated 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 2018/19
- Performance activity data and emerging themes (particularly with regards to inappropriate alerts)
- Update of Swindon Policy & Procedures
- Quality Assurance
- Review of the Risk Register
- Police and Crime Act 2017

- Annual Assessment of Agency Safeguarding (all members invited to update to board on their progress with safeguarding)
- Case discussions at each meeting
- Reorganisation of the Board and its sub groups

Reports with a safeguarding element

- Illegal money lending
- Prevent Strategy
- Modern day slavery and human trafficking
- Adult exploitation
- Abuse of position of trust (National Police Chief Council)
- Risk Enablement Panel

2. Board Member reports

The following are submissions from members providing an overview on their priorities regarding safeguarding. This year we invited submissions using a proforma that also includes some measurable outcomes. These have been compiled in a table included at Appendix 2. The profromas received from each member are reproduced on the following pages:

2.1: Swindon Borough Council Adult Services (Older People with Physical Disabilities (OPPD) and Learning Disability Services

Brief outline of your Agency's Adult Safeguarding functions:

Older People with Physical Disabilities Service (OPPD)
The Initial Contact Team receive communications and enquiries from the public and wide assortment of agencies/partners. These are screened and forwarded to the Safeguarding Team for further investigation where appropriate. The Team will also conduct home visits from time to time (sometimes jointly with Safeguarding Team) to assist in ascertaining whether a case needs to progress to Safeguarding.

The Assessment & Review Team will provide professional (Social Work and/or Occupational Therapy) input to support S42 enquiries, fulfilling the Enquiry Officer function. This applies to cases they are actively working on as well as cases previously unknown. Some people will be in receipt of services and some will not. Part of the role will involve supporting the person through the investigation process, following Making Safeguarding Personal principles.

Social work input has often been required to carry out a Mental Capacity Assessment, in order to assess whether someone has capacity to consent to, and participate in, the Safeguarding process.

The Business Support Team, managed by OPPD Service Manager, provide administrative support to the Safeguarding Team which includes telephony, meeting administration, minute taking and data entry.

Learning Disability Service (LD)
- Alerting/raise concerns, participate in individual cases, supporting service users through safeguarding process, investigating cases as requested by Safeguarding Team
- Additional awareness to alert Children's Services – See The Adult, See the Child briefings given to managers – this needs refreshing in next period.
- Briefings for staff on "The right help at the right time", with LSCB and Service Managers in support across Adult Social Care

What were your Adult Safeguarding achievements in 2017/18?

OPPD:
- Social Work staff provided good quality professional input to Safeguarding investigations.
- Business Support Team provided good quality administrative support including backfilling for the one specialist worker when required.

LD:
- Timely and good quality safeguarding investigations for people with a Learning Disability when requested by Safeguarding team

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

- Promoting training for all new starters.
- Sharing and team discussion around Safeguarding Adults Review report on case relating to Honor.

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

- By participating as Enquiry Officers and case workers, supporting people through the process from time of first alert and often beyond the closure of the Safeguarding Enquiry.

What are your Adult Safeguarding objectives for 2018/19?

- Support the redesign of the Safeguarding Team and facilitate the newly appointed Senior Registered Social Work Practitioners within the Initial Contact and Assessment & Review Teams.
- Ensure that all staff have recently undergone Basic Awareness Training and other training commensurate with their role e.g. Enquiry Officer and Enquiry Manager training.

2.2: Avon and Wiltshire Mental Health Partnership NHS Trust

Brief outline of your Agency's Adult Safeguarding functions:

Avon and Wiltshire Mental Health Partnership NHS Trust provides mental health services, including talking therapies, to adults of all ages in the Swindon area who have 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 an Executive Director lead (Director of Nursing and Quality). The Swindon Clinical lead is the senior manager holding responsibility for delivering and developing safeguarding practice within the locality during 2017/2018.

What were your Adult Safeguarding achievements in 2017/18?

- An extended Adult Safeguarding and MCA service in the Trust launched introducing locally focused Named Professionals
- Modular guidance in relation to Mental Capacity Act and DoLS developed and launched
- Mental health legislation webpages enhanced to reflect the extensive interaction between the Mental Capacity Act and Mental Health Act in providing lawful and least restrictive care, and is underpinned by the key principles set out in human rights legislation and articles
- Prevent training and training matrix reviewed against NHS England Prevent training standards with a focus on delivering L3 Prevent training
- Maintained a high level of monthly supervision for staff

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

- Bespoke training and support via Safeguarding Adults in Practice development sessions
- Attendance at Quality and Standards meeting to raise awareness of safeguarding including domestic abuse
- Actively promoted Adult Abuse week throughout the Trust each day covered a different area including: Think Family, Domestic Abuse and Coercive Control, Mate Crime, Modern Slavery, FGM and honour based abuse. These were supported by a range of materials including YouTube videos, presentations

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

The work of the Swindon teams in relation to Making Safeguarding Personal is being embedded into mental health services to ensure that service users and carers are actively involved in the Safeguarding Process. Their views, wishes and expected outcomes from the safeguarding process are elicited to ensure that they feel more empowered and in control of the safeguarding experience.

Examples of how this has been achieved have included; has the person that the safeguarding consented to the referral being made and have they said what they wish to happen as a result of the safeguarding process.

If a service user is believed to lack capacity, this is assessed and if they are found to lack capacity, they can be supported by an advocate, family member or friends, depending upon their individual circumstances.

At the end of the safeguarding process they are asked if they feel safer as a result of the safeguarding process and whether the outcomes they specified at the beginning of the safeguarding process have been achieved.

What are your Adult Safeguarding objectives for 2018/19?

- Develop safeguarding in practice modules for face to face learning sessions
- Continue to focus on making safeguarding personal in practice
- Develop practice in relation to self-neglect via bespoke face to face learning sessions
- Continue to focus on achieving compliance with Prevent WRAP - Workshop Raising Awareness of Prevent, Level 3.

2.3: Swindon CCG

Brief outline of your Agency's Adult Safeguarding functions:

The CCG is a statutory member of the LSAB, as a commissioner of health care in Swindon it is responsible for ensuring all services it commissions are compliant with local safeguarding adult arrangements. The CCG has in place safeguarding adult schedules through contracts with providers to ensure it receives assurances that provider safeguarding arrangements are in place and effective.

What were your Adult Safeguarding achievements in 2017/18?

- Ensuring the CCG as an organisation are compliant with PREVENT training
- Being proactive within LSAB and its subgroups; chairing QA subgroup and developing Quality Assurance Framework (QAF)
- Commissioning a development programme for GPs to ensure their compliance with NICE/DoH guidance on domestic abuse
- Successful Independent Internal Safeguarding Audit which identified strengths and gaps in CCG safeguarding adult arrangements
- Appointment of Named GP for Safeguarding Adults

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

Mandatory training for all staff covers safeguarding adults, each new employee has to meet with the safeguarding leads as part of their induction. Staff briefings (all staff attend), as part of the internal audit staff were asked to complete a questionnaire on safeguarding which focused on their awareness of safeguarding and that they understood how their individual role relates to safeguarding.

The CCG governing body receive annual safeguarding training as a board, and an annual safeguarding report. The governing body subgroups also receive regular up-dates on safeguarding.

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

The CCG are involved in reviewing cases or organisations of concern jointly with SBC, these have a direct impact on the service delivery of those organisations or in those cases. There have been a number of serious incidents/concerns of a safeguarding nature, two concerning local care homes, a hospice and an out of county residential educational placement.
The CCG are part of the Learning Disabilities Mortality Review (LeDeR) programme to improve services to individuals with LD.
CCG undertake quality assurance visits to providers.

What are your Adult Safeguarding objectives for 2018/19?

- Ensuring all the recommendations of the internal safeguarding audit are met without delay
- Ensuring the newly created CCG safeguarding adults meeting includes representation for CHC, Mental Health and learning Disabilities so the themes and cross over points with safeguarding can be fully understood, coordinated and acted upon.
- Ensuring the CCG safeguarding adult 'team' has sufficient capacity and resources to undertake its key tasks for the CCG.
- The CCG commissions a package of training at level 4/5 for the health safeguarding adult leads across health.

In primary care:
- Continued training programme for Lead GPs and Practice Managers – programme in place until June 2019.
- Continued visits to practices to train GPs and other practice staff – two per month Commence quality assurance visits to GP practices One practice per month target (2 year cycle will cover all practices)
- Commence supervision sessions with Lead GPs Launch of a Swindon wide primary care protocol
- Review and development of Safeguarding Templates within GP IT systems.

2.4: Community Safety Partnership Team (CSP)

Brief outline of your Agency's Adult Safeguarding functions:

The CSP team provides, on behalf of the CSP Board, a statutory function to reduce crime and anti-social behaviour; domestic abuse and Violence Against Women and Girls (VAWG); risk of radicalisation; Modern Slavery and Human Trafficking; reoffending; and crime linked to substance misuse. Many of those areas of responsibility have a direct link to Adult Safeguarding and CSP and Adult Safeguarding work together on these priorities.

What were your Adult Safeguarding achievements in 2017/18?

- Chairing and helping to maintain the Risk Enablement Panel
- Developing a Community MARAC to provide an intensive service to high risk and repeat victims of domestic abuse and violent crime
- Managing the Prevent Agenda on behalf of SBC
- Developing a Reception Centre for victims of Modern Slavery and Human Trafficking
- Developing a pathway for young adults transitioning from services that are at risk of crime and exploitation.

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

- Added Adult Safeguarding Training to all staff development
- Launched 'Domestic Abuse is Everybody's Business' campaign
- Trained staff on Risk-based response to crime and anti-social behaviour

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

- Ensured safeguarding policies and procedures followed where appropriate through Risk Enablement Panels, Community MARAC, MARAC and Adult sexual Exploitation Practitioners Group.

What are your Adult Safeguarding objectives for 2018/19?

- Develop a Risk Management Model that combines work of REP and Community MARAC to ensure that vulnerable adults receive the right support.
- Work with partners to develop use of National Referral Mechanism for criminal exploitation
- Develop understanding of adults at risk of sexual exploitation to off-street sex work.

2.5: Dorset & Wiltshire Fire and Rescue (DWFRS)

Brief outline of your Agency's Adult Safeguarding functions:

DWFRS are a non-statutory organisation. Our main function is to signpost concerns. To enable this, all staff receive basic safeguarding awareness, and front facing staff have enhanced training based on their responsibilities and interactions with vulnerable groups.

What were your Adult Safeguarding achievements in 2017/18?

- The launch of an e–learning safeguarding package for all staff
- Raising the profile of the Fire Service, and that the services does so much more than putting fires out. DWFRS are regularly invited to Multi Agency Meetings.
- The Safeguarding Coordinator being accepted onto the National Fire Chiefs Council workstream group for national safeguarding across Fire and Rescue services.
- Regularly attending Safeguarding Board meetings, complete audits and reports for all boards both Children and Adults across Dorset, Poole and Bournemouth, Wiltshire and Swindon. Receiving positive feedback, sharing lessons learned across all partners.

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

All staff within the DWFRS (including agency) receive safeguarding training. Training is delivered to all new staff at Corporate Induction and is followed up within 3 months with e –learning. Front facing staff receive additional training which is delivered both in-house and externally by Local Authority.
The Safeguarding Coordinator who is the Lead for safeguarding within the service has also launched a poster campaign. This was followed up with prompt (credit) cards which are distributed to all operational and front facing staff.

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

N/A. DWFRS are a Fire Service, therefore have no statutory duty, only a signposting agency. (This is the same for any comment where it is stated that DWFRS are a fire service).

What are your Adult Safeguarding objectives for 2018/19?

- To ensure safeguarding is embedded into the service.
- To play a part in aligning Safeguarding Policies and procedures of all Fire Services nationally. This will be done by the safeguarding coordinator, working alongside the Safeguarding Workstream under the National Fire Chiefs' Council.
- To gain good results from the HMICFRS Audit.
- Continue to build better networks.

2.6: Great Western Hospitals NHS Foundation Trust (GWH)

Brief outline of your Agency's Adult Safeguarding functions:

As a Health provider, GWH is required to demonstrate that it has safeguarding leadership and commitment at all levels of the organisation and that it is fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Adult Boards and commissioners. Most importantly, GWH must ensure that a culture exists where safeguarding is everybody's business and poor practice is identified, tackled and eliminated.

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

What were your Adult Safeguarding achievements in 2017/18?

All elements of 2017/18 Safeguarding and Mental Capacity Act (MCA) audit actions are complete

- Recruitment of Swindon Community Health Service Community Safeguarding Lead. Acute lead provided induction and daily support to ensure smooth integration of services
- Homelessness guidelines added to Safeguarding Intranet pages. Project planned for Q2 to provide training in conjunction with Swindon Borough Council Homeless Lead Operations Manager
- Contribution to DHR and SAR/SILP reviews
- Alignment of Acute and Swindon Community Health Services processes and referral pathway. This has included both Safeguarding and DoLS processes that are in use at the Acute Trust, along with Standard Operational Procedure which dissects duties across these care pathways.

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

Key focus on training and education for Community Services

- 1:1 Quality Improvement Project completed for SwICC, including Forest and Orchard Ward. Pre and post project audits complete and shared with both areas. This involved concentrated teaching, capturing 63% of all staff. *Completed in conjunction with Swindon Community Health Services' (SCHS) Safeguarding Adults at Risk Lead
- Face to face training for Walk in Centre staff, concentrated teaching in small groups over a one week period to ensure 100% target. *Completed in conjunction with SCHS Safeguarding Adults at Risk Lead
- New Trust-Wide Domestic Abuse policy developed and ratified. This policy is integrated with Wiltshire Health and Care and Swindon Community Health Services and launched in May 2018
- Bespoke training to clinical areas, including 1:1 supervision and support
- Assisted in the creation and pilot of Ward Accreditation (WAAF) achievement guide/pack (safeguarding adults / MCA module). Awaiting date of Safeguarding and MCA launch following initial pilot / roll out
- Work undertaken to embed the use of an internally produced Best Interest Resource Pack
- All electronic resources reviewed to ensure safety, including a deep cleanse of all clinical areas to ensure all hard resources and noticeboards are up to date
- Safeguarding Adults at Risk Operational Group is now well established and well attended
- Continuation of student support and mentoring – 1 student completed placement in Q1
- L1 and L2 Safeguarding and MCA training modules reviewed and aligned to the UK Core Skills Training Framework (CSTF)

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

Referral form reviewed to include 'Making Safeguarding Personal' and to capture patient desired outcomes at point of referral.

What are your Adult Safeguarding objectives for 2018/19?

- Having secured funding for IDVA role for a further year the Trust will to continue to work collaboratively with the IDVA to ensure appropriate service support
- 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 assisting with evidencing best practice and improvements and making a difference to improving the safety and welfare of the most vulnerable patients
- 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 adults with care needs and carers

2.7: Swindon Borough Council: Housing

Brief outline of your Agency's Adult Safeguarding functions:

Swindon Borough Council Housing – housing management including repairs and maintenance of 10,500 council homes. Management of the Housing waiting list (assessing housing need and prioritising cases where housing is required urgently).
Statutory Homeless duty.

What were your Adult Safeguarding achievements in 2017/18?

- Provision of Temporary Winter Housing Provision for 12 Rough Sleepers
- Domestic Abuse campaign "DA is Everyone's Business" following Domestic Homicide Review
- 3 x Pathway flats developed in sheltered housing scheme to enable improved outcomes for hospital discharge cases.
- Development of bungalows at The Hawthorns for Adult Social Care clients
- Training delivered to Adult Social Care teams on new Homelessness Reduction Act

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

Team meetings and 121s

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

Sheltered Housing Officers support as necessary and attend case conferences.

What are your Adult Safeguarding objectives for 2018/19?

- Do an audit of training for staff and include general awareness raising of Adult Safeguarding.
- Include Adult Safeguarding awareness in Induction for new Housing staff

2.8: Swindon Borough Council: Public Health (comprising Community Health and Wellbeing Service, Trading Standards and Public Health Commissioning and Health Improvement)

Brief outline of Agency's Adult Safeguarding functions:

The Community Health and Wellbeing Service works with vulnerable adults on a day to day basis as part of programmes which include Community Navigators, Swindon Circles, Active and Inclusive, Ability Sport and Health Ambassadors. Work is carried out on a 121 or group basis and is generally short term interventions.

The Trading Standards Service's remit includes protecting consumers from rogue traders and scams. The Service undertakes a safeguarding role in identifying victims of these crimes and working to prevent further financial abuse. The service always responds to victims of doorstep crime, who are usually vulnerable. When visiting them, an assessment of the well-being etc. of the person is made, with a view that they may need a referral to other organisations. The person is reviewed them from a financial abuse point of view. In addition the service also receives referrals for follow up.

The service delivers awareness sessions for members of the public, banks, building societies and other organisations to help prevent financial abuse through doorstep crime and scams. Public Health Commissioning commissions Health and Wellbeing Services for the whole population and some targeted interventions. In relation to safeguarding some areas are more at risk such as, substance misuse, sexual health, immunisations, suicide prevention and mental health.

What were your Adult Safeguarding achievements in 2017/18?

Recording - Established a record log to capture concerns, incidences and disclosures. This record is discussed at team meetings and management meetings to aid learning and inform service practice. The Community Health and Wellbeing Team reviewed and updated their safe working practice document; taking the learning and experiences from the year

Training - Continue to train all community health and wellbeing staff in safeguarding adults training and many of the team have attended additional training related to understanding and supporting different aspects of vulnerabilities – dementia, DOLS, financial abuse

Partnerships - The Healthy Communities Team have visits from partners to advise and discuss issues as they arise. An example being, Wiltshire Police who came in to discuss working with clients who are on the Sex Offender Register. Trading Standards examples include:

- A joint visit with social services following a safeguarding referral from a bank. Prevented a resident from making unnecessary payments for services they did not require from scammers.
- Working with banks and Building Societies in Swindon in partnership with Wiltshire Police to raise awareness of financial abuse amongst staff and customers.
- Assisting Wiltshire Police with a successful prosecution of a doorstep trader who had been defrauding elderly householders.

Dealing with disclosures - Through advice and support, dealt with a disclosure from a client – this was the first time this client had told her story. Trading Standards intervened with a scam victim who had been a victim of chronic mass marketing scams to assist him and prevent further financial abuse.

Commissioning for those at risk – The newly commissioned Substance Misuse Service has been commissioned across the substance misuse and mental health providers to ensure that issues related to dual diagnosis (mental health and substance misuse) are addressed more effectively. Drug relation death and suicides reviews are co-ordinated.

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

- Training delivered both internally and to external public protection enforcement teams
- Regular communication with colleagues in Adult Services
- Team discussions and mentoring

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

- Dealing with disclosures in a timely, sensitive and professional way
- Being well informed of safeguarding duties through training and advice
- Supported clients to seek their own support through a range of providers. Signposting and accompanying (as appropriate)
- Acting as an advocate as necessary and in conjunction with professional role
- Visiting vulnerable consumers in their home, to make an assessment as to whether or not they need support from Public Health and possibly a safeguarding referral.

What are your Adult Safeguarding objectives for 2018/19?

- Carry out a monthly review of the safeguarding record log
- Train all new members of staff and set up a training 'passport' to include the relevant training we deem essential for our team
- Engage with more banks and Building Societies in Swindon to promote the Banking Protocol and increase the number of referrals made to the Police and Trading Standards.
- To improve the team's knowledge and understanding of mental capacity and how this affects dealing with financial abuse safeguarding referrals.
- To continue existing work in responding to any safeguarding referrals relating to doorstep crime and scams.
- Continue to build up relationships with other SBC internal teams and other organisations working with vulnerable adults.

2.9: Swindon Carers Centre

Brief outline of your Agency's Adult Safeguarding functions:

Swindon Carers Centre (SCC) supports Carers of all ages. The Vulnerable Adult Safeguarding Policy ensures that all Carers are supported where a safeguarding risk has been raised and SCC follows guidance outlined in LSAB guidelines. Adherence to all local safeguarding protocols including: See The Adult, See The Child and Local Safeguarding Adults Board policies (LSAB)

What were your Adult Safeguarding achievements in 2017/18?

- Low number of alerts raised
- Knowledgeable staff with confidence to seek advice / raise alerts when necessary Strong working relationship with Swindon Borough Council Social Work Team to avoid duplicate alerts Safeguarding Lead / Deputy roles within the organisation so staff have a go-to person with any queries internally
- Internal Safeguarding Vulnerable Adults training provided in-house to all staff, volunteers and trustees.

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

LSAB process posters are on display in the SCC office to reiterate guidance to staff on reporting safeguarding concerns. Policies/procedures in place for people to raise concerns about someone's behaviour towards a vulnerable adult.

Potential safeguarding risks identified by staff, service users or professional agencies working with a service user are discussed with safeguarding leads or deputies. Staff can seek advice from the Swindon Borough Council Safeguarding Team and/or make referrals where relevant. Safeguarding is discussed during supervision/peer support meetings to ensure it remains at the forefront of daily practice.

SCC's Behaviours Framework sets out expectations of all staff including safeguarding responsibilities.

Safeguarding referrals are reported to Trustees quarterly.

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

SCC supports Carers that they work with to understand what Safeguarding Vulnerable Adults processes are and how they are there to support people. SCC are as open and honest with carers about concerns / alerts that they may have to raise and the reasons for these (most common is that carers have to leave their dependant locked in / unattended rather than any malicious intent). SCC supports carers to access support for their dependant and themselves to reduce any risk to either party (Respite Care / Care Packages / Carers Relief).

What are your Adult Safeguarding objectives for 2018/19?

- Local Safeguarding meetings within Sanford House.
- To gain a more structured approach for staff to get advice from Safeguarding team at SBC if they are uncertain whether to raise an alert.
- Quarterly safeguarding lead meetings internally.
- On-going commitment to safeguarding adult training for new staff and volunteers.

2.10: Wiltshire Police

Brief outline of your Agency's Adult Safeguarding functions:

In 2000 the government published "No Secrets" which set out clear guidance for agencies to work in partnership to prevent abuse of vulnerable adults taking place and to deal robustly with any incidents. As a result, The Wiltshire Police Safeguarding Adults Investigation Team (SAIT) was set up within Wiltshire Police in 2002.

The SAIT team sits within the Public Protection Department, covering the hours of 8-5pm Monday to Friday, primarily due to the fact that such matters are normally reported during office hours by other agencies. SAIT triage staff operate within the Wiltshire Council Safeguarding Adults team at County Hall, receiving all PPD1s submitted by Police & reviewing all form 75's submitted to the verifications team in Swindon Borough Council (This is done via the telephone as the sit in Wiltshire). From these forms, discussions are generated with Partner Agencies and ESM's convened to identify safeguarding measures and whether investigations should proceed or not.

Frontline staff are required to assess and refer concerns in relation to adults whom they feel are vulnerable as part of their duties in responding to calls reported to the police.

The 'Three Strands of Vulnerability' is the policy which defines the Police processes for dealing with welfare issues, vulnerable adults and safeguarding adults. *"Vulnerable adults are defined as those whom, as a result of their situation or circumstances, are unable to protect themselves from harm".*

In June 2017, Criminal Exploitation of the Vulnerable, Modern Slavery and Human Trafficking and sexually exploited adults and radicalised adults were all areas that were added to Strand 3 of the 3 strands of vulnerability. The initial thought was this might have an impact on SAIT's workloads, but this has not been the case.

Criminal investigations committed against vulnerable adults defined under strand 3 of the 3 strands of vulnerability are investigated either by specialist investigators or investigators from the Community Policing Teams.

What were your Adult Safeguarding achievements in 2017/18?

- Case 1: The female adult victim suffers from an acquired brain injury and requires 24 hour assisted living support. Whilst visiting family her step-father sexually assaulted her when left alone with her. The offender pleaded guilty at court accepting she could not consent and was sentenced to six years and nine months imprisonment, issued with a restraining order to protect the victim and her mother, and life time registration on the sexual offender register. The sentencing Judge remarked that the aggravating factors is this case were that the victim was vulnerable and the offender took advantage of that vulnerability and that he was also in a position of trust.

- Case 2: The offender defrauded her mother-in-law to a value in excess of £30,000. She abused her husband's position of responsibility as his mother's lasting Power of Attorney for finances to steal money. The offender was convicted of Fraud by Abuse of Position and sentenced to 18 months imprisonment.

- Operation Aidant 2018 which is a joint initiative between NCA, policing and other law enforcement partners. AIDANT activity supports our aim to develop innovative and effective partnerships and processes which improve our response to MSHT at the national, regional and local level; and to deliver impact across the 4Ps (Pursue, Prevent, Protect and Prepare) to reduce the MSHT threat to the UK. Currently Op Aidant activities will be focused on the county line drugs runners currently operating in Swindon. We intend that this will fill national, regional and local intelligence gaps and it will be a coordinated multi-agency approach between law enforcement, local authorities which are necessary to safeguard children and adults at risk and there will be early engagement with local services.

- Following representations from the LSAB regarding the high rate of inappropriate referrals from the Police into adult safeguarding, a review of the processes took place along with a revised training package for Police officers and staff, this has resulted in a reduction in the number of inappropriate referrals from our agency.

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

The Adult Sexual Exploitation (ASE) team currently operate within the Public Protection department and consists of officers who cover the entire County. The aim of the officers is to safeguard and manage the daily risk of both on and off street sex workers, through close partner agency working and proactive engagement in regular joint approach to sex workers and women who may be experiencing Sexual Exploitation. The ASE team work alongside The Nelson Trust, sexual health professionals and the drug and alcohol service during evening hours to offer a dedicated outreach support.

The team have raised awareness of their work within Wiltshire Police, highlighting the issues faced by those involved in sex working and the fact that a number of those involved will have care and support needs.

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, highlighting the difference between safeguarding alerts and welfare concerns, this has resulted in a decrease of inappropriate referrals. This process is known as the 'three strands of vulnerability' and the revision of the process ensures that partner agencies are more quickly involved in the support of vulnerable adults

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

Wiltshire Police are helping to streamline processes across all relevant agencies to ensure the effective safeguarding of victims of modern slavery and human exploitation. A Swindon and Wiltshire Anti-Slavery Partnership group has been established drawing together statutory and voluntary agencies to jointly tackle offending and provide safeguarding and support for victims. This focus group has also been established to identify and share training materials and understand how Wiltshire Police can communicate with the public to raise awareness of Modern Slavery, and better support Adult slavery victims.

What are your Adult Safeguarding objectives for 2018/19?

- To increase Staffs awareness of MSP
- To reduce the amount of inappropriate referrals
- To ensure that the voice of the victim is considered during all investigations

2.11: Swindon Advocacy Movement

Brief outline of your Agency's Adult Safeguarding functions:

Swindon Advocacy Movement provides statutory advocacy for safeguarding under The Care Act.
In line with our Priority Procedure people with care and support needs are also given non-statutory advocacy support where safeguarding risk has been identified or suspected.

What were your Adult Safeguarding achievements in 2017/18?

- Worked with the LSAB to enable a restructure of the Service User Forum.
- Advocated for safeguarding at Sanford House tenants group to ensure that safeguarding and communications from LSAB are a standing agenda item at meetings.
- Attended Quality Assurance sub-group meetings and contributed to audits.
- Provided advocacy for 47 adult safeguarding section 42 enquiries to ensure individuals's voice is central to process.
- Worked closely with the Safeguarding Team to ensure accessibility to the service under The Care Act.

How did you raise awareness of Adult Safeguarding in your agency in 2017/18?

Members of staff attended SBC refresher training as needed. Safeguarding cases regularly reviewed at team meetings and in supervision.
Refreshed internal Safeguarding training for members and clients with support needs led by Management Committee members with learning difficulties e.g. held workshops around accessible safeguarding awareness film made for and by people with learning disabilities.

How did you support service users and carers through the Safeguarding Adults procedure in 2017/18?

Supported service users through 1-1 advocacy work in line with our policies and procedures as following our Quality Performance Mark in Independent Advocacy and in line with SBC Safeguarding Adults processes.
Used SBC Safeguarding Escalation Policy to raise concerns on behalf of service users when needed.

What are your Adult Safeguarding objectives for 2018/19?

- To raise awareness of the Safeguarding responsibilities for voluntary sector agencies within Sanford House.
- To review our internal Safeguarding procedures in line with renewing our Quality Performance Mark for Independent Advocacy.
- To raise awareness of safeguarding amongst our members in order to encourage people to speak openly about risk or concerns when needed.
- To increase advocacy team awareness of Domestic Abuse and Safeguarding.

2.12: South Western Ambulance Service NHS Foundation Trust (SWAST)

Owing to the number of Boards that SWAST feed into across the region, an individual return from them is not available. They produce an annual report specifically about safeguarding (including children) and this can be found by following this link: : https://www.swast.nhs.uk/assets/1/safeguardingannualreport201718.pdf

2.13: Submissions not received by the following agencies/organisations

Reports have not been received from, Probation service, Care Quality Commission Healthwatch Swindon and NHS England South (South Central).

3. Sub-groups of the LSAB

During 2017/18 the Board reviewed the structure of its Sub-groups resulting in the creation of a Chairs Group, replacing the Operational Group.

3.1. The Chairs Group will take responsibility for ensuring delivery of the 3 year strategy/strategic priorities and produce an annual business plan based on the priorities. Also, the Chairs group will ensure the sub-groups deliver their work plans and report any areas of concern.

The Group met twice during the year with attendance from, SBC (Director Adult Social Services and the Adult Safeguarding Manager), Wiltshire Police and Swindon CCG. The Group is chaired by the Independent Chair.

Agenda items included:

- The new structure, to confirm the purpose and make-up of the Chairs Group and implement the new structure. Review the membership, TOR and the work plans of the sub-groups, including proposed plans/funding for a SAB Business Manager;
- Reports from the Sub-groups, including updates on their work plans;
- Review progress of the SAB Business Plan;
- Agree the format of the planned SAB Strategic Planning Workshop; and
- Review any outstanding issues from the Operational Group.

3.2. The Operational group met twice during the year, prior to being stepped down following the restructure of the Sub-groups. The following agencies attended the group: 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 was 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:

- Agree a process of evaluation and review of the annual agency self-assessments;
- Review Board additions to the Strategic Plan, including: Performance & Quality, Communication and Engagement and Workforce Development;
- Review the SAB Business Plan, including: Community Awareness, Development of a SAB member's pack and resources in kind;
- SCIE Learning Review;
- Access to partner agency databases;
- Annual Report 2016/17; and
- The statutory annual Safeguarding Adult Collection.

3.3. 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, Care Manager, Commissioning, 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).

Following the Board restructure Swindon CCG took over the Chair's role of the group, where a new audit process was put in place to audit cases in-line with the Boards strategic priorities. The TOR were reviewed including the group's membership. Two audits were planned ……..- Work plan produced which identified audits to be completed.

3.4. 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), Domestic Violence Coordinator, Mental Capacity Act Programme Manager, 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:

- Continued review and updated of the Policy and Procedures;
- Self-neglect Policy;
- Development of an Escalation Process;
- Group set-up following the Board restructure, including the transfer of Chair to Wiltshire Police and review of TOR and group membership;
- Development of a group work Plan;
- Development of People in a position of Trust guidance; and
  Pre-alert Screening, including a revision of the referral form and development of a Thresholds guidance.

3.5. Learning, Review 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 is 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. This group and Swindon's role on it, is also subject to review.

3.6. Case Review Sub-group: The group did not meet during the year as there were no requests for consideration of Safeguarding Adult Reviews.

As part of the Board restructure the name of the group has been changed to the Learning, Review and Development group and as well as giving consideration to requests for SARs, will look at learning from national and regional Safeguarding Adult Reviews (SARs) and will meet quarterly.

3.7. Service User Forum: The Service User Forum met twice during year and agenda items included:

- National Scams;
- Future of the Service User Forum;
- Safeguarding Adult Review;
- Services of Concern update;
- Safe Places Scheme update;
- LSAB update; and
- Disability Hate Crime update;

As part of the re-structure of the Board the format of the group was reviewed and changed be less meeting based and more interactive.

SECTION 6

Priorities for 2018/19

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 including the appointment of a dedicated Board Manager and admin. support**(Partnership)**
- Introducing an induction programme for new Board members **(Partnership, Accountability)**
- Undertaking a self-assessment of Board development **(Accountability)**
- Implementing the outcome of the Board review including membership of the Board and its sub groups, and monitoring attendance at meetings **(Partnership, Accountability)**

Measurable outcomes (details on how these will be achieved are contained in the Business Plan for 2018/19)

- 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 at Board and sub-group meetings
- Number of new members fully engaging with induction process
- Number of reports from other partnerships requested and received by the LSAB
- Demonstration of Board members having had training and how that has developed Board effectiveness

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:

- 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, adults in need of care and support who are or have been experiencing abuse or neglect (increase in neglect, and abuse in people's own homes) **(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 regarding service user experience, particularly in respect of making safeguarding personal **(Empowerment)**, and using this to drive practice improvements **(Empowerment, Proportionality, Protection, Prevention)**
- Identifying ways to improve prevention - develop a prevention plan including areas of consistent messaging **(Prevention)**

Measurable outcomes

- No more than 30% inappropriate referrals
- Taken action on findings from Healthwatch report (agree KPI with them re number of service user feedbacks received)
- 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 an easy read one-page information sheet for service users
- Increasing community awareness including using available opportunities to increase public involvement, and to engage media interest **(Empowerment, Protection, Prevention, Partnership)**
- Implementing the new model to gain the voice of service users and carers, and act on suggestions linked to existing services and groups **(Empowerment)**
- Developing more effective use of the media

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
- 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
- Using feedback from referrals data with agencies to inform them of areas for improvement in understanding and safeguarding practice **(Protection, Partnership, Proportionality, Accountability)**
- Developing multi-agency training, using case studies, to change working practices including reflective practice, risk assessment and information sharing **(Protection, Prevention, Partnership)**
- Exploring the provision of a specific safeguarding career pathway

Measurable outcomes

- % of surveyed staff confidence and knowledge regarding safeguarding (baseline to be established)
- At least 80% of relevant staff trained in safeguarding at any one time
- Amount of refresher training completed by staff

Next Steps

- 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 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

Appendix 1: Glossary

ADASS	Association of Directors of Adult Social Services
ASE	Adult Sexual Exploitation
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BGSW CRC	Bristol, Gloucestershire Somerset and Wiltshire Community Rehabilitation Company
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
CSP	Community Safety Partnership
CSTF	Core Skills Training Framework
CQC	Care Quality Commission
DA	Domestic Abuse
DHR	Domestic Homicide Review
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DWFRS	Dorset & Wiltshire Fire and Rescue Service
ESM	Early Strategy Meeting
FGM	Female Genital Mutilation
GP	General Practitioner
GWH	Great Western Hospital
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services
IDVA	Independent Domestic Violence Advisors
KPI	Key Performance Indicators
LeDeR	Learning Disabilities Mortality Review Programme
LD	Learning Disability
LSAB	Local Safeguarding Adults Board
LSCB	Local Safeguarding Childrens Board
MARAC	Multi-agency Risk Assessment Conference
MCA	Mental Capacity Act
MHA	Mental Health Act
MSHT	Modern Slavery Human Trafficking
MSP	Making Safeguarding Personal
NCA	National Crime Agency
NHS	National Health Service
NICE	National Institute For Health and Clinical Excellence

(OP)PD	(Older People) with Physical Disabilities
PPD1	Wiltshire Police, Public Protection Referral Form
PREVENT	Prevent is about stopping individuals from getting involved or supporting terrorism or extremist activity.
QA(F)	Quality Assurance (Framework)
REP	Risk Enablement Panel
S42	Section 42 (of Care Act 2014)
SAB	Safeguarding Adult Board
SAIT	Safeguarding Adult Investigation Team
SAM	Swindon Advocacy Movement
SAR	Safeguarding Adult Review
SBC	Swindon Borough Council
SCC	Swindon Carers Centre
SCHS	Swindon Community Health Service
SCIE	Social Care Institute for Excellence
SEQOL	SEQOL (a Social enterprise providing health and social care and support)
SILP	Significant Incident Learning. Process
SWAST	South Western Ambulance Service NHS Foundation Trust
SwICC	Swindon Intermediate Care Centre
TOR	Terms of Reference
VAWG	Violence Against Women and Girls
WAAF	Ward Assessment and Accreditation Framework
WRAP	Workshop Raising Awareness of Prevent

Appendix 2: Partner Measurable Outcomes 2017/18

AWP	Adult Services SBC	Housing	DWFRS	GWH	CCG	Wiltshire Police	CSP	SCC
Strategic Priority 1: Effective Governance								
1.1 Your agency's attendance at LSAB Board meetings								
75%	100%	75%	25%	100%	100%	75%	100%	100%
1.2 Your agency's attendance at LSAB sub group meetings								
The Trust attends Policy and Procedures, Quality Assurance and Learning Review and Development	100%	Housing Business Development Manager and Sheltered Housing Manager attend LSAB Audit meetings and the Learning Review sub group.	As above	100% The Trust Safeguarding adult operational lead attends on behalf of the Trust	80%	Unable to calculate due to new meeting structure in the last year	100% REP and SCIE review by either CSP Leader or DA Manager	Not a member of any subgroups
1.3 Your agency's contribution to the work of the Board								
AWP does not make a financial contribution to the work of the Board.	100%	SBC Housing contribute as and when requested.	Any requests from the board are always actioned.	Participated in the function of the board (e.g. help with audits, planning days)	Attend main board, chair QA subgroup, and attend all other subgroups	Unsure how this can be represented as a percentage score	Reports submitted on Domestic Abuse	

AWP	Adult Services SBC	Housing	DWFRS	GWH	CCG	Wiltshire Police	CSP	SCC
Strategic Priority 2: Performance and Quality								
2.1 Rate of inappropriate referrals, any improvement over time and measures taken to improve								
16% There has been a reduction of 14%	13.5% This reflects the referrals from the whole of adult services in to the Adult Safeguarding Team	Not known, figures are not kept in housing.	I have not received feedback for any of the referrals made.	54% GWH 2016 – 2017 166 referrals/71 progressed = 43% GWH 2017 – 2018 177 referrals/82 progressed = 46%	CCG not a major referrer into safeguarding, we do work with providers to improve on their inappropriate referrals	61% of referrals are intended as information items – 39% progressed to enquiry	N/A	N/A
2.2. Positive service user experience of your agency's safeguarding work								
N/A This information is obtained by the safeguarding team.	See main annual report.	Not collected	We are a Fire Service	No record of feedback in respect of praise	Positive survey feedback from partners on completing a survey for internal audit on CCG and safeguarding adults		Positive feedback from REP and Community MARAC but no analysis done	100%

AWP	Adult Services SBC	Housing	DWFRS	GWH	CCG	Wiltshire Police	CSP	SCC
Strategic Priority 3: Communication and Engagement								
3.1. Your agency's communication to service users about your approach to safeguarding								
AWP has an external facing website including safeguarding adults , There are leaflets, contact details of local authority safeguarding ,	Corporate Communications – including dedicated page on the SBC Internet page. Safeguarding Leaflets	Notice boards in sheltered housing are used to highlight safeguarding and within the Sheltered Housing Tenants Handbook there is a reference to safeguarding alerts.	We are a Fire Service	Form 75 reviewed to include 'Making Safeguarding Personal' and to capture patient desired outcomes at point of referral.		In 2018 a new website was launched by Wiltshire Police, the website contains information on adults at risk of abuse. There are links to members of the safeguarding adult's investigation team for east access.	Main work is through Domestic Abuse awareness by social media, radio and local press	100% Statement on our website, reference in assessment forms, consent forms, code of conduct signed by Carers
3.2 Any media coverage of safeguarding issues by your agency								
none	N/A	Not collected	We are a Fire Service				Coverage of 'Domestic Abuse is Everybody's Business' campaign following domestic homicide	

AWP	Adult Services SBC	Housing	DWFRS	GWH	CCG	Wiltshire Police	CSP	SCC
Strategic Priority 4: Workforce Development *Note: It is each agency's responsibility to determine which of their staff members fall into the category of 'relevant' e.g. a social worker, GPs, a nurse, beat officers, staff supporting adults with care and support needs in face- to-face activities would be considered 'relevant'; however an administrator in an office setting who has no contact with adults would not be. Awareness training can be either face-to-face, e-learning or equivalent agencies need to decide*								
4.1 Relevant staff have completed relevant training appropriate to their role								
At least 80% trained at any one time SA , SC and DA L1 – 97% SA , SC and DA L2 – 92% Prevent L1 – 97% Prevent L2 - 92% Prevent L3 – n/a	Survey to be completed to confirm compliance with this target	No specific numbers recorded but training is undertaken.	All front facing (relevant) staff have received training appropriate to their role. This includes all youth intervention staff, Safe and Well Advisors and commercial Fire Safety Staff.	91%	97% CCG monitor very closely staffs compliance with all mandatory training.	100%	83%	100% of existing staff trained as of 31/3/18
4.2 Relevant staff have completed Mental Capacity Act training within 6 months new post of a level appropriate to their role								
MCA- 98% DOLS – 99%		Yes, Sheltered Housing Officers and supervisors.	Awareness training has been delivered to Safe and Well Advisors. The Safeguarding Co-ordinator is the named point of contact.	94.84% Quarter 1 (April – June 2018)	Safeguarding leads are fully compliant – CCG would need to check remaining staff	The Police do not have any staff completing these roles.		N/A

The Safeguarding Adults in Swindon Annual Report 2017/18 is available on the Internet on *SBC Adult Safeguarding page*
It may be produced in a range of languages and formats (such as large print, Braille or other accessible formats) by contacting the Customer Services Department.
Tel: 01793 445500
Fax: 01793 463982
E-mail: customerservices@swindon.gov.uk

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