Learning from local experience

Wiltshire Safeguarding Adults Board

2018-2019 update to the strategic plan

Working together to protect adults at risk, prevent abuse and neglect and promote the rights of everyone to live free from harm.

Effectively safeguarding an adult who has complex care and support needs often relies upon all of our local agencies working successfully together, and with the adult concerned, to protect and improve the quality of their life.

Improving local lives together

Mrs A is in her early 50's and lives in her own home with 24-hour care support. She has a diagnosis of an Acquired Brain Injury (ABI) and has also suffered from a stroke. Mrs A is dependent on care and support to ensure all her daily needs are met.

Mrs A was referred to Council's Safeguarding Adults Team (SAT) following concerns that her privately funded carers were mismanaging her finances, in relation to the mismanagement of her medication and about poor care practice.

A multi-agency meeting was held that brought together colleagues from the Council, the police and health – all of the agencies involved in Mrs A's life. Professionals discussed concerns regarding Mrs A's health, about Mrs A not having been out of bed although she had requested support from her carers and concerns about how her medication was managed. As a result an urgent respite bed was arranged by health colleagues to enable a review of Mrs A's medication and to allow a full assessment to take place.

Concerns about the mismanagement of Mrs A's finances (potential theft) were predominantly lead by police colleagues while mental capacity assessments were completed by an independent health consultant. As a result the Council made an interim order to Office of Public Guardianship (OPG) to support Mr A with her finances. The OPG were informed of concerns and an application for Lasting Power of Attorney (LPA) was suspended for finance and property (which was held by one of the carers). Whilst Mrs A got gradually stronger and was able to get out of her bed.

The paperwork completed by the carers was reviewed by the local authority and financial documents were provided to the police. Concerns were raised that Mrs A had been coerced whilst potentially not having capacity to release equity on her own home and that a significant amount of that money had been spent by the carers. It was also noted that a significant number of Mrs A's personal shares had been sold whilst she was not able to recall agreeing to this.

The review of the paperwork also revealed a punitive and unprofessional approach from the carers, who did not appear to understand Mrs A's needs. The carers did not appear to fully understand the risks and needs of Mrs A in relation to her brain injury diagnosis and consequently did not provide the right care or support.

Due to a lack of information the police were not able to progress any criminal charges. However Mrs A had been supported by an advocate throughout the investigation and a civil case was brought to support Mrs A to recuperate some of her lost money. The OPG were also notified about

the poor care that Mrs A had received and this application was supported by information provided by the council, the police and health colleagues.

Although Mrs A has not recuperated all of her money, she continues to be supported by Wiltshire Council Court of Protection Team, she has also returned home. Mrs A is supported by carers who are commissioned by Wiltshire Council and she is now supported and able to spend time out of bed. Mrs A is also supported to engage with her community and the quality of her life has improved.

Mrs A continues to go from strength to strength and commissioned carers continue to support her to rebuild her community connections and to re-establish her life back at home.

Foreword

During 2017-2018 Wiltshire Safeguarding Adults Board has focused on reviewing the wider system that aims to safeguard vulnerable adults in Wiltshire. We have done this by:

- Carrying out two independent reviews after receiving referrals regarding two adults at risk in the county who died (in unrelated circumstances), to learn how partner agencies could have worked more effectively to protect those adults
- Undertaking a self-assessment audit of our Board members and identifying areas where we can improve the way local organisations work together
- The work of our Quality Assurance group to examine local data and to seek reassurance from those organisations that practice is continually improving to protect adults at risk
- Regularly meeting with service users and carers through our reference groups to learn from their experience
- Discussions at Board Meetings and with key partners about how changes to legislation, to demand on our member agencies and to service delivery are impacting on how effectively our members can work together

The Board is required to publish a strategic plan and in 2016 we published a three-year plan for 2016-2018. This report sets out what progress has already been made against that plan and what actions will be taken during 2018-19. In 2016 we set out three aims, which were to:

- Improve Board Effectiveness
- Develop the ethos and practice of Making Safeguarding Personal
- Develop and improve our preventative and responsive practice.

Since that time we have done much to improve the effectiveness of our Board. In Wiltshire, we have introduced an innovative model that brings together support for WSAB, our Local Safeguarding Children Board and the local Community Safety Partnership. This allows us a unique opportunity to examine how we are protecting vulnerable people from childhood into adulthood from neglect and abuse and from wider harms. We have also agreed a new business model for 2018-2019 which will see a smaller WSAB executive group meeting more often. This will allow us to increase the progress we are making to identify risk and weaknesses in the system and to act early to protect adults at risk.

Having made these changes our renewed focus in 2018-2019 will be on both Making Safeguarding Personal, on developing and promoting preventative practice and to:

- Share learning and provide assurance that learning from experience leads to improvements

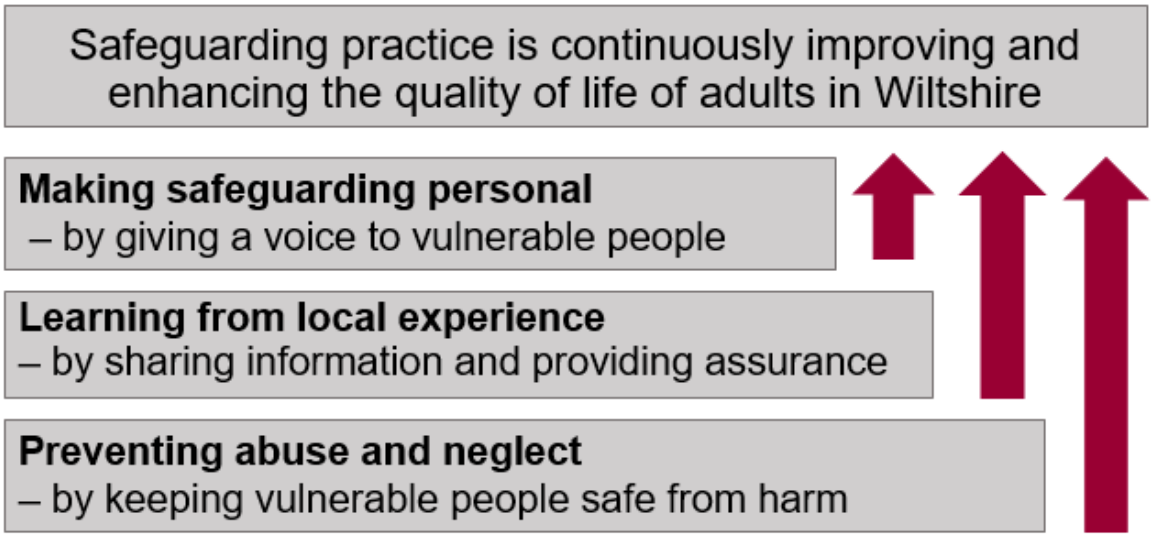
As a Board our focus in Wiltshire must be on providing assurance. This work has progressed in the 2017-2018 but we need to be able to more clearly identify and articulate levels of assurance relating to key safeguarding arrangements

In the last year we have also learned much from a regional study of Safeguarding Adults Review carried out by Professor Michael Preston-Shoot and from a review carried out in Somerset into the mistreatment and abuse of residents at Mendip House, a care home for adults with autism near Highbridge run by the National Autistic Society (NAS). In 2018-2019 we will be working to gain assurance in relation to how Wiltshire commissioners monitor the quality of internal and external placements, and crucially, how external commissioners monitor the quality of placements in Wiltshire.

A more detailed summary of what we have learnt through review of the system and the changes we hope to see made are set out in the Board's Business Plan for 2018-2019. This provides a framework by which our members and partners can measure success over the course of the next year. Our next three-year strategy will be published in 2019 and will report and build on the essential work we undertake this year.

Richard Crompton
Independent Chairman Wiltshire Safeguarding Adults Board

Wiltshire Safeguarding Adults Board 2018-2019



Our members:

Wiltshire Council – Where everybody matters

Wiltshire Police

NHS Wiltshire Clinical Commissioning Group

Dorset & Wiltshire Fire and Rescue

Salisbury NHS Foundation Trust

WSUN – Wiltshire and Swindon Users' Network

Wiltshire Care Partnership

Wiltshire Health and Care

Avon and Wiltshire Mental Health Partnership NHS Trust

healthwatch Wiltshire

NHS England

Royal United Hospitals Bath NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust

Carer Support Wiltshire

CareQuality Commission

Bristol Gloucestershire Somerset & Wiltshire Community Rehabilitation Company – Probation

A vision for Wiltshire

Effective adult safeguarding protects an adult's right to live in safety, free from abuse and neglect. It involves local people, organisations and agencies working together to prevent and stop both the risks and experience of abuse or neglect.

At the same time safeguarding means making sure that an adult's wellbeing is promoted and their views, wishes, feelings and beliefs are heard and wherever possible, play an important role in deciding on any action.

The Board's main objective is to protect all adults in Wiltshire who have needs for care and support and who are experiencing, or at risk of, abuse or neglect against which they are unable to protect themselves because of their needs. Our aims are to:

- Work together as partners to help people with care and support needs to live free from fear, harm and abuse.
- Develop a culture where services work with individuals and communities to prevent abuse and neglect; where we respond swiftly and effectively when abuse or neglect happens, and where excellent professional practice and partnership working is always found.
- Put the wishes of the person at the centre everything that we do to enable them to maintain control and make informed choices about their own lives.

We will follow the six key principles of good safeguarding:

Empowerment:	Presumption of person led decisions and informed consent
Prevention:	It is better to take action before harm occurs
Proportionality:	The least intrusive response appropriate to the risk presented
Protection:	Support and representation for those in greatest need
Partnership:	Local solutions through services working with communities
Accountability:	Accountability and transparency in delivering safeguarding

This plan will guide the work of the WSAB again this year and allow us to measure performance against a set of agreed outcomes.

However, as we learn more about how effectively the multi-agency safeguarding system is working in Wiltshire and services change the way they work so we are looking to adapt how the Board works.

This means that our renewed focus will be on embedding learning from the Safeguarding Adults Reviews (SARs) and audits we have undertaken. The work of the new WSAB Executive Board, Full Board and the subgroups will also be aligned to work to develop a successful Adult Multi-Agency Safeguarding Hub (MASH) in Wiltshire.

What we learnt from reviews in 2017-2018

Safeguarding Adults Review - Adult A

Adult A was admitted to hospital in December 2015 after having been found on the floor of her flat by the attending paramedics. There were concerns raised by the paramedics about the state of the flat and possible self-neglect. The paramedics also raised a safeguarding alert as they suspected Adult A had been financially abused by a carer.

Adult A was admitted to hospital but in the absence of any physical problems associated with the fall was released to an ICT bed. During this time Adult A exhibited some concerning behaviours and during an assessment was found to have a degree of confusion.

In mid-January Adult A activated her life line, the paramedics who attended reported that she was found in a situation of serious self-neglect sitting in a cold dark flat and was severely hypothermic. There was no fresh food in the flat and it appeared that Adult A had not been talking her medication.

Adult A died in hospital in January. The coroner noted the that at time of death was suffering from hypothermia, broncho-pneumonia, left ventricular hypotrophy, hypertension, diabetes, kidney disease and dementia. The coroner's report also stated that he did not think adequate preparation had been made to ensure Adult A had provisions and support on discharge.

The coroner concluded that Adult A would not have died at that time had Adult A not been discharged home. The review identified a number of issues, some of which may not have resulted in significant harm if they had occurred in isolation. The professionals that were interacting with each other did not challenge decisions that were made in other agencies. There was no evidence of escalation when referrals were not receiving the expected response.

Whilst the review concluded that it could be considered that ultimately, it was the discharge planning that was the final layer of defence that failed. Effective planning relied on all the other elements being effectively applied to understand what exactly needed to be part of the discharge plan and future interventions. If these had been applied robustly, Adult A may well not have been discharged at all at that time. There were many layers of protection in the system that failed at the same time culminating in a catastrophic outcome for Adult A.

The recommendations:

Single agency recommendations:

- Assurance that the learning from this review regarding accurate description financial status (the impact of someone being historically assessed as self-funding and this status not being revisited or further assessments carried out) is addressed.
- Care and Support assessments and financial arrangements are reviewed in a timely manner and in line with Care Act Requirements.
- Discharge planning procedures incorporate the learning from the review

- Organisations who employ temporary or agency staff should ensure there is easy access to safeguarding processes

Multi agency recommendations:

- WSAB should produce Multi Agency Self Neglect guidance to support practitioners in managing self-neglect.

- WSAB must assure itself that agencies can evidence how they will address the shortfalls in understanding and applying the Mental Capacity Act that this review has evidenced.

- WSAB should provide a learning briefing to all agencies regarding all the learning points from the review.

- WSAB should seek patient stories showing evidence of the effectiveness and safety of discharge planning processes.

Safeguarding Adults Review - Adult B

Adult B was diagnosed with a degenerative disease of the brain which was terminal. Adult B lived in the community in warden controlled accommodation and was able to maintain a degree of independence.

Adult B died in November 2016 in a road traffic accident after walking a significant distance from home. Prior to this fatal accident Adult B had been found on a separate occasion wandering at a considerable distance from home in a state of undress. A number of agencies were aware of Adult B and his tendency to walk long distances and become disorientated had been reported to other agencies by the police.

Other SARs regarding people with dementia who walk, have identified people with dementia walking and subsequently dying as a result even when they have been subject to 24-hour care provision. However, the WSAB review relating to Adult B concluded that with more robust communication, coordination and assessment alongside application of statutory processes and respectful challenge and escalation, Adult B might have benefitted from a safer and more secure care package.

Recommendations

- WSAB should seek assurance that agencies consider the elements of NICE Guidance for supporting people with Dementia that would have made a difference in this case. In particular, there should be an agreed framework for ensuring a key worker role and shared care planning.

- WSAB Quality Assurance sub group should seek information from commissioners regarding impact assessments that they are in receipt of. (Where resource implications have the potential to impact on the safety and well-being of Adults with Care and support needs who are at risk of harm). There should be a process for commissioners to share those impact assessments.

- WSAB should assure itself that agencies have robust structures in place for support and supervision of staff.

- WSAB should consider the learning from this review and undertake to ensure that there is guidance to all agencies on the importance of escalation and professional challenge. This may be undertaken by the following approaches.

  - By way of a briefing note.
  - By review of the Safeguarding Procedures that include an escalation section.
  - As part of the Operating Procedures for the Adult MASH.

- A multi-agency approach is required for managing risk in adults who have care and support needs is identified and implemented. WSAB should seek assurance that this approach is developed and embedded through audit.

- WSAB should add the learning from the review regarding understanding and application of the Mental Capacity Act, to the previously made recommendation in the Adult A SAR.

Multi-Agency Self-Assessment Audit and Peer Challenge

In November 2017, the WSAB Audit Panel met with members of key public agencies to review the responses they provided to the Board's annual Quality Assurance Self-Assessment Audit. The meetings sought to identify areas of improvement and best practice as well as challenges and concerns across agencies. The interviews were specifically focused on multi-agency safeguarding and the way agencies work together rather than on single agency performance.

Understanding of safeguarding adults and training

Based on the conversations that took place with agencies in November 2017:

- There is increased understanding of safeguarding adult thresholds and how and when to report concerns.
- Multi-agency partners are increasingly working together to more effectively safeguard vulnerable adults.
- However, there is evidence of reluctance within non-statutory partners to take a view on whether a concern relates to welfare or safeguarding. This is largely explained by a lack of a defined pathway for those issues that constitute welfare issues. This means that the Council's safeguarding team is receiving a high number of contacts that do not relate to its core work. These referrals are also causing problems in hospital settings where they can lead to delays in the patient journey.
- There is a need for more feedback on referrals and investigations from the local authority to referrers to encourage improvement in practice and the quality of referrals.
- Training programmes are often in place but uptake is hindered by the difficulty of releasing staff from other duties across agencies. The delay in publication of an intercollegiate document is also causing concern across health providers about the prioritisation of training provision across staff groups.

- Improved channels of communications and means of sharing learning across agencies would help improve the way in which teams are able to increase learning and skills in the workforce.

What WSAB will do

The Board will work to use its website more effectively to share learning. It will ask for regular updates from agencies on the feedback they get from the local authority safeguarding team and it will share case studies to highlight the difference between safeguarding and welfare concerns. The Board has a role in sharing good practice and it will work with agencies to ensure it does this effectively.

Deprivation of Liberty Safeguards (DoLS)

There has been "a tenfold increase in DoLS applications in England since the Cheshire West judgment in the Supreme Court in March 2014, leading to major processing delays" across the country. Panel interviews in November confirmed that locally there is continuing concern across health providers about the back log of DoLS assessments. A care home or hospital "must apply for, and be granted, a DoLS authorisation from a local authority".

Reassurance was provided by the Local Authority (HA) that once the application has been made the legal risk lies with the Council. However, providers remain uneasy about where the clinical risk sits and that this is not as easily defined simply by the application being lodged with the Council. Whilst the local authority awaits an announcement from the Government on the Law Commission's review of DoLs partners fear they are holding the risk and there is no certainty of changes being made nor a timeframe for any change.

What WSAB will do

The Board will receive an update at each meeting about the backlog of assessments, actions taken by the Council to address this and for assurance on the method for identifying and processing priority cases.

Mental health and capacity

"The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves". However, understanding of MCA principles remains varied across the health and care sector both nationally and locally. The council have reported that there is a need to increase knowledge and skills in this area and whilst a number of agencies, have increased training provision the impact of that training has not been measured in terms of outcomes for service users. The challenge created by MCA is commonly acknowledged and evidenced by numerous Safeguarding Adults Reviews. Whilst it is positive that agencies acknowledge that this potential gap in workforce skills there is a danger that this becomes an acceptance that this is a system wide problem to which there is no practicable solution.

In addition the Policing and Crime Act 2017 introduced changes to the Mental Health Act 1983 which will mean that:

- it is unlawful to use a police station as a place of safety for anyone under the age of 18;
- a police station can only be used as a place of safety for adults in specific circumstances;
- the previous maximum detention period of up to 72 hours has reduced to 24 hours (unless a doctor certifies that an extension of up to 12 hours is necessary);

These changes will have an impact on the local police force and health providers. Mental health remains one of Wiltshire Police's most significant challenges and is a huge issue for frontline staff, especially out of hours. s136 detentions are coming down but there is concern that if mental health providers do not have adequate resource there is little the police can do. The main challenge is around the provision of beds. Similarly, the ambulance service report that their key challenge is around mental health and "the provision of adequate services willing and able accept appropriate referral and thereby reduce the inappropriate use of police cells for patients who have committed no crime".

What WSAB will do

The QA subgroup have requested Wiltshire Police to provide data on the number of times s136 powers have been used in each quarter. Agencies will also be asked to report to the Board on instances where a place of safety could not be established to meet the new timeframes.

The Learning and Development sub-group will run a forum in 2018 to assess current levels of knowledge, appetite for training and to increase understanding of the MCA and DoLS. An action plan will also ensure learning from two local Safeguarding Adults Reviews which are due to complete in early 2018 is shared. Both reviews will look at the assessment of mental capacity of the individuals at the centre of the review.

Emerging concerns and prevention

Work is being completed by the local authority and the Clinical Commissioning Group to ensure that information is triangulated and emerging concerns about providers are identified early. There is a clear determination to work more preventatively but the systems in place are still primarily reactive rather than proactive.

The Safeguarding Adults Team will work with the ambulance service to improve the quality of information received and increase understanding of the difference between safeguarding and welfare concerns. However, this poses a question about how ambulance crews, who are often the only professionals visiting a vulnerable adult at home, can ensure information about their welfare is shared with the appropriate agency and acted on. The introduction of an Adult MASH and strengthened front door has potential to ensure this information collected and utilised more intelligently.

The fire service highlighted multi-agency working in Dorset that allows staff to work preventatively and to refer wider welfare concerns as well as safeguarding concerns. Currently the fire service is not routinely receiving referrals from Wiltshire police regarding hoarding or potential fire risk. Work has been undertaken by the public health team to create a hoarding framework however there may also be straightforward operational changes that can be made to improve outcomes.

What WSAB will do

The Board is receiving regular updates on the development of an adult MASH in Wiltshire. The Policy and Procedures group will have a role in ensuring that any new multi-agency information sharing protocols help identify emerging concerns and enable effective preventative working.

Commissioning

There was evidence of an appetite for more joint commissioning across health and social care but further work is required to ensure that there is an agreed approach regarding the assurance mechanisms to measure quality and performance.

The CCG as part of the commissioning of services use comprehensive safeguarding reporting schedules to collect and monitor how effectively providers are adhering to a range of indicators. There is also an intention to ensure that their quality assurance process reviews outcomes data rather than simply monitoring activity.

The Council reports that there is work to be done to ensure that staff understand the difference between safeguarding and care quality issues.

Decisions on how to commission services are made by the respective agencies however it is recognised that there is potential to agree on best practice measures and outcomes which are consistent across the county to support vulnerable adults and safeguard them from harm, abuse and exploitation.

What WSAB will do

There is potential to do more to assess and understand through review of provider data and the work which is being completed across the county. The Board is working with both the CCG and Council to look at how provider data can provide assurance that local multi-agency systems are working well to safeguard adults. Currently local authority data is well utilised to reflect the number of concerns raised across agencies and how those concerns are acted on. The QA sub-group will lead on this work.

Development of an adult Multi-Agency Safeguarding Hub (MASH)

The potential to improve multi-agency working through the provision of an adult MASH is widely accepted and work is underway to make good intentions a reality. There is also potential for the development process itself to see agencies working together at an operational level leading to closer working relationships and increased understanding of the different roles single agencies play.

Colleagues were keen to have clarification of the requirement for police and health resources to enable an effective MASH that delivers more preventative work. The implementation of a MASH in itself will not help agencies to improve outcomes but with adequate resources and successful planning there is potential for this new operational arrangement to help:

- Provide effective, consistent, multi-agency safeguarding arrangements
- Increase understanding and application of the MCA
- To more effectively assess risk
- To identify emerging concerns

It is likely that the existence of a MASH will see an increase in demand on the system. That increase in demand should allow for better collection and collation of intelligence and opportunities for prevention. However, the model put in place will need to have the capacity to resource that demand and to use data intelligently.

What WSAB will do

The development of the MASH is an operational matter for agencies involved however the Board receives regular updates on progress. There is also potential for the Board to have a role in overseeing the effectiveness of new arrangements, in sharing learning and in developing multi-agency policies where appropriate, through its established sub-groups. The QA sub-group will support the development of metrics to be able to assure the board of the effectiveness of the MASH and audits that allow for this to be achieved.

WSAB Strategic Plan - annual update (2018-19)

Below is an outline of progress against actions set out in the Board's Strategic Plan 2016-2018

Outcome 1 – Improving Board Effectiveness
To ensure that the WSAB is structured, resourced and run in an efficient and effective manner. The Board must be able to fulfill all of its statutory functions to a high standard; the outcome of its work must meet the requirements of the Care Act 2014, and the Board must make a positive contribution to adult safeguarding in Wiltshire.

Outcome 2 – Making Safeguarding Personal
To ensure that the ethos of Making Safeguarding Personal is embedded within the practice of all member organisations. As a Board to become a leading example of how to listen and learn from the voices of service users and carers.

Outcome 3 – Prevention and Response
The Board wishes to see the development of a culture which prioritises the prevention of abuse. Preventative and responsive practice should occur in the context of a person-centered approach of support and personalisation, empowering people to make choices and supporting them to manage risk.

No.	Action	Update	Progress
1.1	The appointment of a full-time Board Manager.	A full-time Board Manger was appointed in October 2016	
1.2	Review structure, governance and membership of WSAB and its sub groups to ensure maximum efficiency and effectiveness	A revised structure will be implemented in early 2018/2019. Review of subgroups will be undertaken after implementation. Joint work is being undertaken with Wiltshire's Safeguarding Children's Board, Community Safety Partnership and the Children's and Young People's Trust to ensure that the wider work of these groups is effectively aligned.	
1.3	Establish proper mechanism for receiving, reviewing and making recommendations regarding future SARs	The Board's policy will be reviewed in 2018-2019 on the basis of SAR learning in 2017-2018	
1.4	Clarify Strategic Planning Process for 2016/17	A strategic plan is in place for 2016-2018. The next update to the plan will be circulated to member agencies and then open to public consultation on the new WSAB website.	

1.5	Develop an approach for engaging with the voluntary and community sector on the work of the Board and on its future priorities	A new website provides the Board with a platform to engage more effectively and a task and finish group is developing a wider engagement strategy (see action 4.1)	
1.6	Statutory Board members to confirm position on creation of a joint budget	Wiltshire Council, Wiltshire Police and NHS Wiltshire Clinical Commissioning Group have all committed to contributing to the Board's budget for 2018/19 reflecting the continuing commitment of partners to the Board's work and allowing the Board to work more effectively.	
1.7	Ensure policies, procedures and practice continue to be developed and reviewed reflecting new legislation and Care Act guidance	Staff guidance has been published and promoted to reduce the risk or neglect or abuse taking place in places were professional care is provided. There has been good engagement with the are sector with free training provided by Wiltshire Council and NHS Wiltshire CCG.	
1.8	Ensure that the Board's strategy for competence development reflects the requirements of the Care Act	A framework for training is being developed by the L&D sub-group to ensure that agency and provider training provision meets the requirements of the Care Act 2014 and the Making Safeguarding Personal guidance.	
1.9	Develop a dedicated website for the WSAB as a source of information for the general public, professionals and Board members	A website was launched in 2017 to provide resources for those suffering from or at risk or abuse or neglect and for those who care for them.	
1.10	Continue to develop and implement a process of audit which supports the achievement of the objectives within this strategy	The Board has a duty to provide assurance that safeguarding practice is continuously improving and enhancing the quality of life of adults in Wiltshire. In 2017 a new approach to audit was designed and implemented by the Chair of the Quality Assurance Group. This is approach is outlined above and has helped the Board achieve a clearer view of where challenges exist.	
1.11	Review national published SARs to identify lessons learned and implications for practice	Nationally published evidence is regularly reviewed by the L&D sub group and local reviews have provided essential learning.	
2.1	Ensure that reports of service user involvement and outcomes achieved are built into the Board's Quality Assurance framework	Further links have yet to be established between the work of the Quality Assurance group and service users.	

2.2	Establish a clear picture of how well MSP principles are embedded in partner organisations	A key element of the Board's engagement strategy will be to collect views on how well local services are working from those who have been at the centre of a safeguarding investigation.	
2.3	Introduce service users stories to Board meetings	Service user experiences and case studies are brought to all Board meetings.	
2.4	To ensure Board oversight of relevant matters concerning the Mental Capacity Act 2005 and Deprivation of Liberty Standards	Regular updates are currently received by the Board	
2.5	Ensure that training which supports the objectives above is delivered by partner agencies individually and/or collectively	Work has been undertaken to assess the feasibility of producing one clear matrix across agencies and organisations with different statutory responsibilities. Delay in the publication of the NHS Intercollegiate Guidance has hampered progress. In the meantime a series of learning events will be delivered by the Board. Potential is also being explored for the existing LSCB training programme to be extended to offer provision for those working in the adult care sector.	
3.1	Develop a prevention strategy which sets out how partners are taking steps to protect vulnerable adults from all aspects of safeguarding risk	Development of a prevention strategy was reconsidered in light of wider developments in partnership working and the development of a multi-agency vulnerability strategy.	
3.2	Monitor progress in relation to the Mental Health Crisis Concordat	Discussion across partner agencies to monitor progress continues to take place.	
3.3	Agree, implement and evaluate the impact of the High-Risk Behaviours Strategy (HRBS)	It was agreed in 2017 that the implementation of a HRB Panel was an operational matter and would be included within the scope of a Multi-Agency Safeguarding Hub (MASH) for Adults in Wiltshire. Work will be necessary in 2018-2019 to seek assurance that this policy is refined and mechanisms for delivery are implemented to best effect.	
1.12	Development of a communications strategy for the WSAB	An engagement strategy is under development. Communications plans for 2017/2018 saw the Board working with partners to deliver awareness raising and events for the MCA, domestic abuse and financial abuse. A newsletter goes out on a bi-monthly basis to a wide group of stakeholders and	

		allows the Board to share information across the sector.	
3.6	Effectively share learning across agencies and with frontline staff (In line with action 2.5)	Plans for sharing learning from local Safeguarding Adults Review are being developed by all subgroups. In addition, in March 2018 the first of a series of Learning Events was run by the WSAB to share learning and increase understanding of the Mental Capacity Act (2005). The Board must do more to utilise its online space.	
3.7)	Investigate potential for establishing an adults Multi-Agency Safeguarding Hub to improve outcomes (In line with strategic objective 3 and improving the effectiveness of practice across agencies)	Development of a Safeguarding Hub is underway and the Board is continuing to bring partners together for discussion and assessment of progress.	
New action	Review assurance arrangements for all Wiltshire residents placed out of area, and monitor the implementation of actions identified through this work	This is new activity for Board based on the findings of review carried out in Somerset into the mistreatment and abuse of residents at Mendip House, a care home for adults with autism near Highbridge run by the National Autistic Society (NAS). In 2018-2019 we will be working to gain assurance in relation to how Wiltshire commissioners monitor the quality of internal and external placements, and crucially, how external commissioners monitor the quality of placements in Wiltshire.	
New action	Establish the number of people who have been placed in to services in Wiltshire by commissioners from other parts of the UK, our confidence in their assurance and monitoring arrangements, and monitor the implementation of actions identified through this work	As set out above.	

What does the data tell us?

Below are findings from the national Safeguarding Adults Return (SAR) data collection for the period 1 April 2016 to 31 March 2017 alongside data collected from the adult care team at Wiltshire Council. This short report shows:

- The level of safeguarding referrals (or enquiries) that were opened during 2016-2017 (see figure i). A safeguarding referral is where a concern is raised with the safeguarding team about a risk of abuse and warrants further investigation
- The type of abuse that referral is about (figure ii) - physical abuse, psychological abuse, financial or material abuse, neglect or acts of omission, other types of abuse
- The location of the risk reported (figure iii) - at home, at a care home, in hospital, within a community service or other
- What action was taken (figure iv)
- The number of safeguarding adults enquiries that have taken place as a result of referrals (figure v). Once a concern has been raised questions are asked and work is done to establish whether an adult is at risk. In some cases, professionals are able to swiftly establish the adult is safe and protected. In other cases, where the team remain concerned about the safety of the adult, they will hold a safeguarding adults strategy meeting to establish what action should be taken
- Where an adult at risk set out what outcomes they wanted to achieve to the safeguarding team and how successful the process was in meeting those outcomes (figure v)

It is important to note that a high level of referrals can reflect a positive culture in which people and professionals are willing and feel able to report their concerns. In addition, concerns raised represent a broad spectrum of issues and incidents. For example, staff at a care home may raise a concern when a resident falls or when there are issues between residents. Concerns raised by staff at the care home are made to protect the welfare of residents and a high number of referrals may reveal a willingness to report rather than an unsafe environment.

The data here shows that levels of referrals in Wiltshire are similar to other similar local authority areas and national averages. In Wiltshire in 96% of cases where it was established what outcomes an adult at risk wanted to reach, those outcomes were met. However, the figures also show the level of demand on the system. A high level of referrals reflects a culture in which people and professionals are willing and feel able to report their concerns but there must be adequate systems in place to deal effectively with every call that is made for professional help and advice.

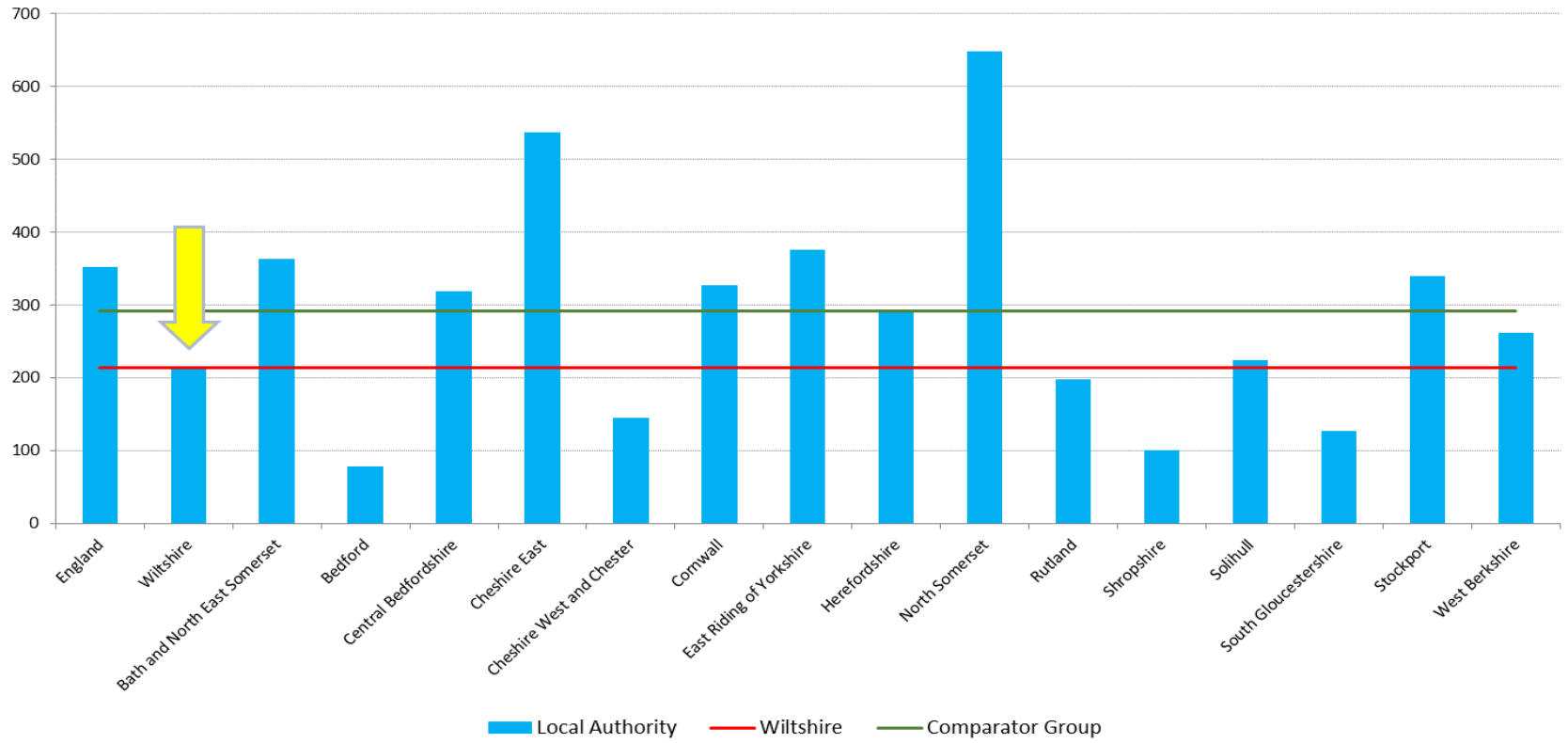
The data here only reflects where council safeguarding services have been notified of concerns. The data does not include:

- Cases where partner agencies have dealt with the allegation and not shared the information with the council
- Instances of discrimination, domestic abuse, modern slavery, sexual exploitation and self-harm or self-neglect as these are reported voluntarily only by LAs

We are working as a Board to get a fuller picture of safeguarding across Wiltshire to ensure adults at risk are well protected. It should also be noted that the data only reflects risk to people where that risk is reported. Levels of reporting vary across areas but a low level of reported concerns does not necessarily mean that there are low levels of abuse or neglect only that there is a low level of reporting.

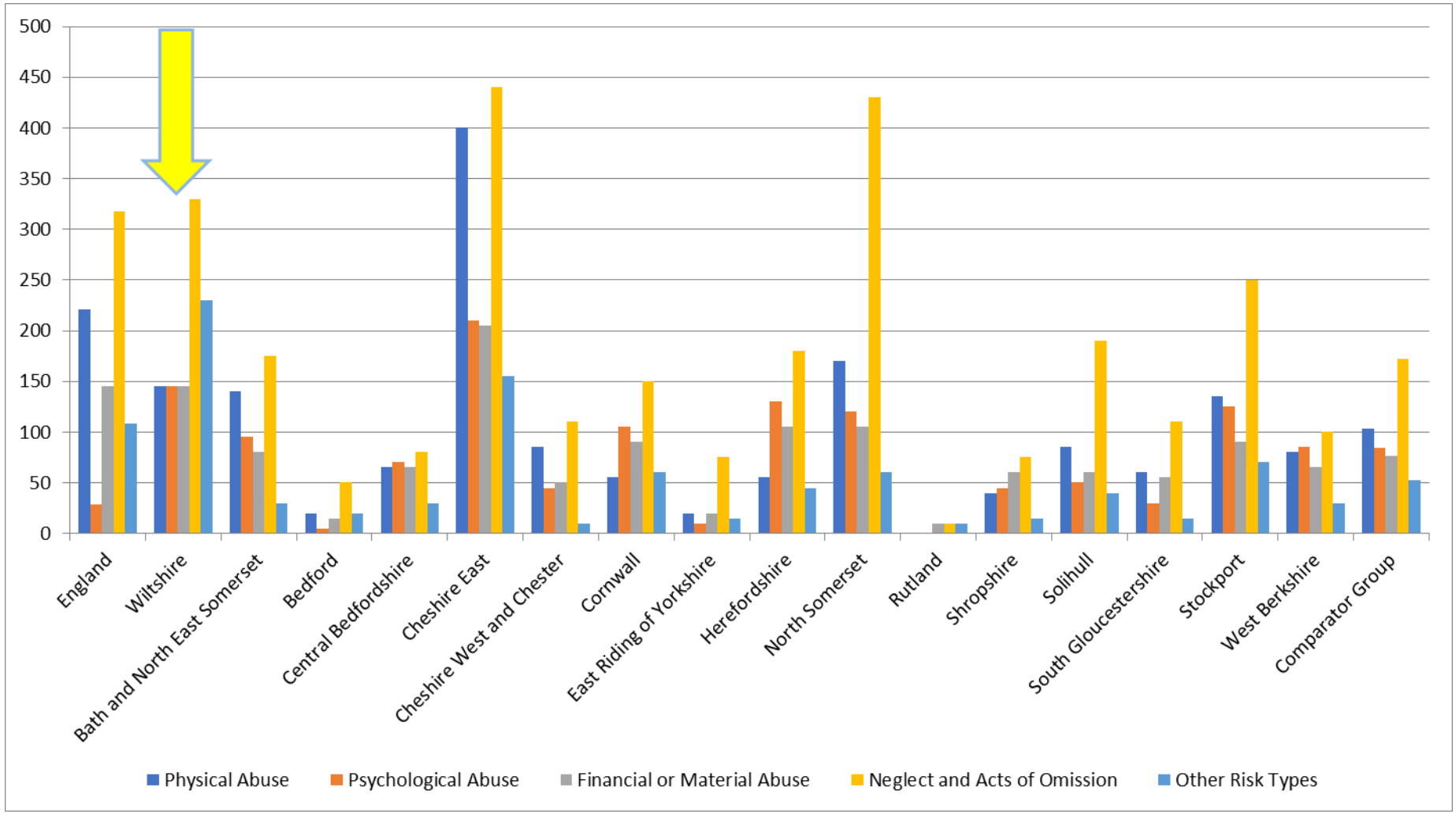
Crucially, we want professionals and members of the public to know that agencies are there to support them where they have concerns and ready to act to protect those at risk.

Figure (i) New Section 42 Enquiries per 100,000 Adults for Comparator Group



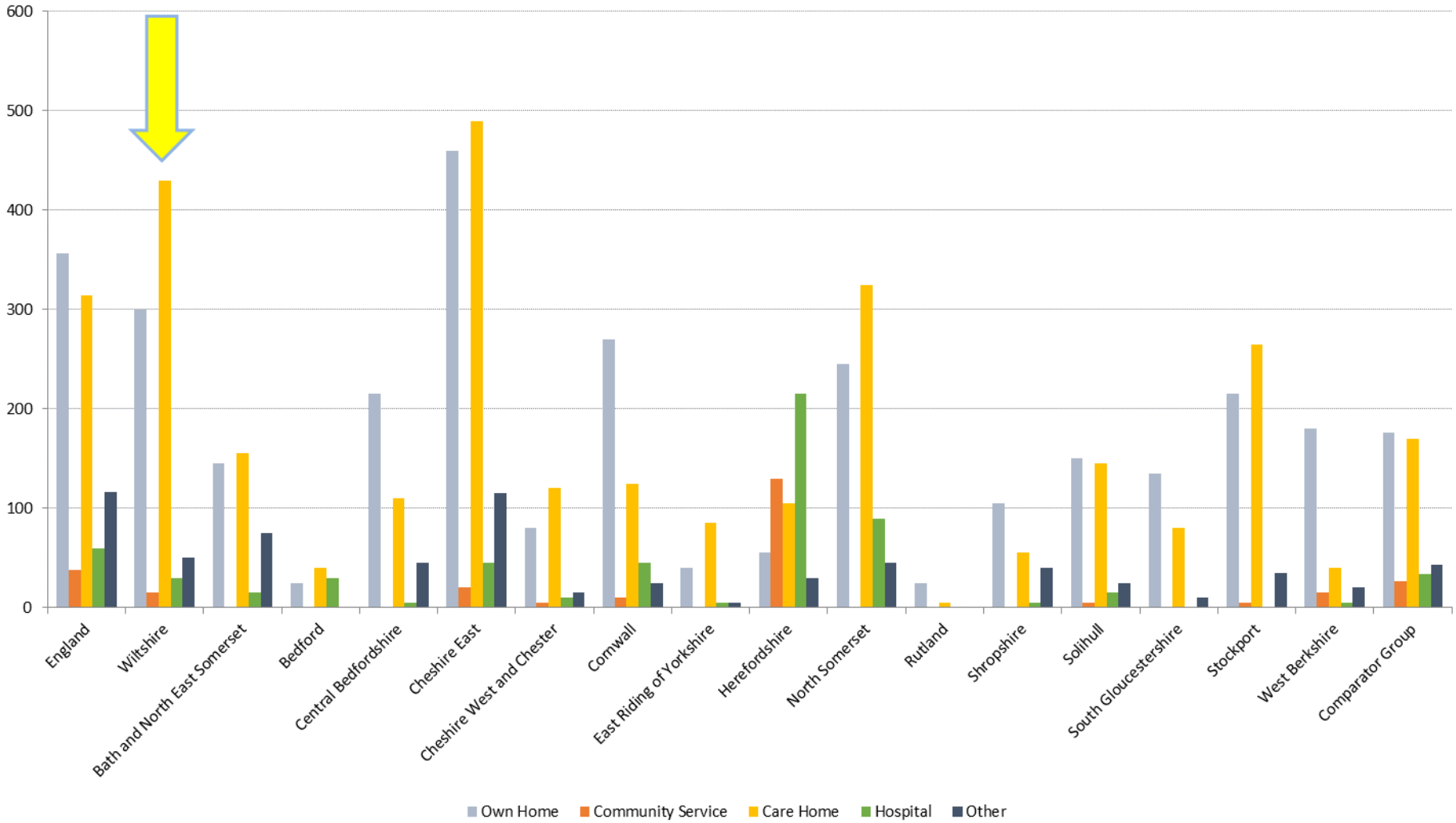
Data Source: SAC Annual Report, England 2016-17 (Experimental), Data Tables Annex B: Initiated and concluded enquiries from NHS Digital and 2016 Mid-Year Population Estimates from the Office for National Statistics

Figure (ii) Type of Risk for Comparator Group



Data Source: SAC Annual Report, England 2016-17 (Experimental), Data Tables Annex B: Initiated and concluded enquiries from NHS Digital

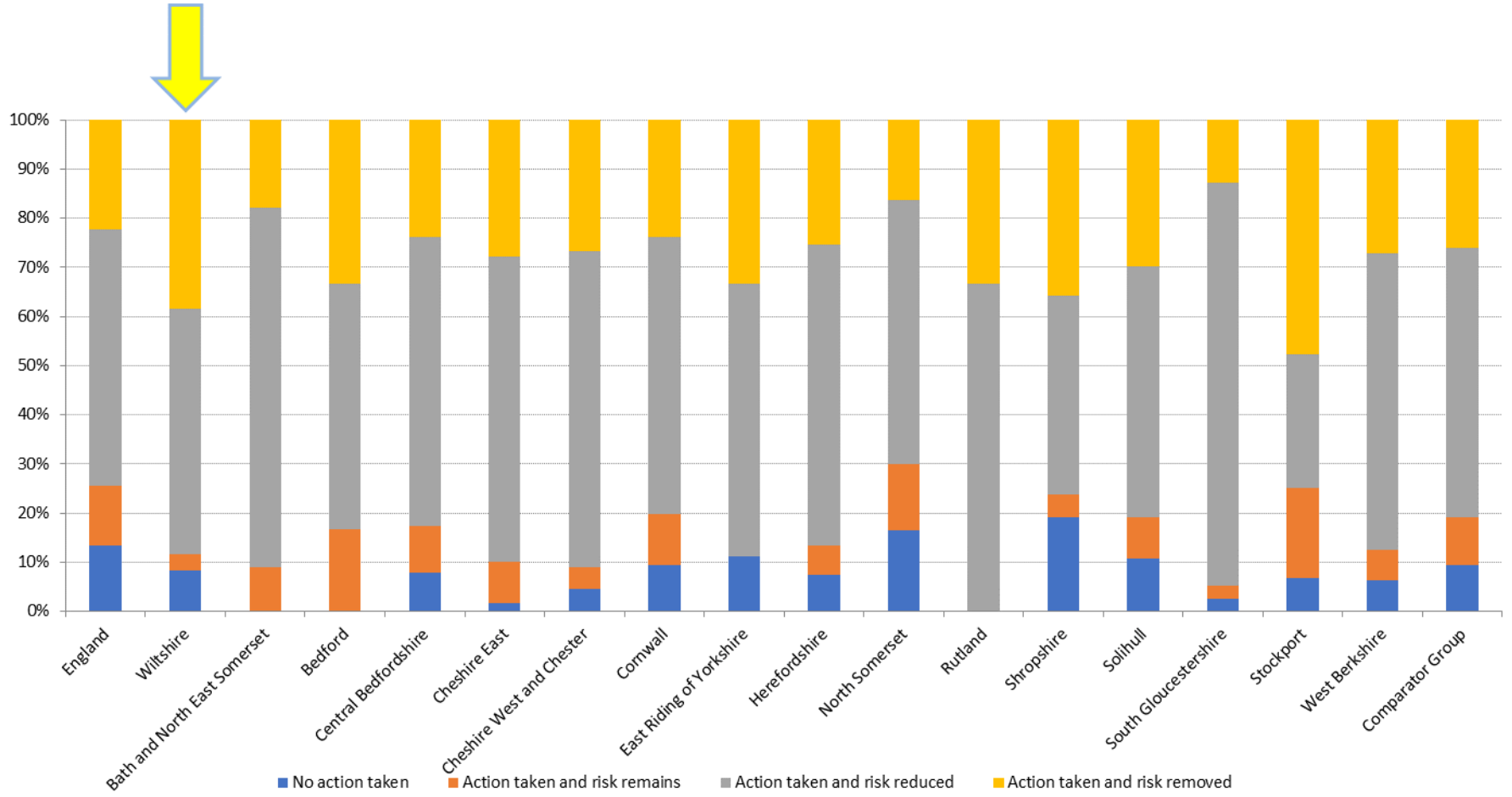
Figure (iii) Location of Risk for Comparator Group



Data Source: SAC Annual Report, England 2016-17 (Experimental), Data Tables Annex B: Initiated and concluded enquiries from NHS Digital

Figure (iv) Action and Result for Comparator Group

These charts show the proportion of each action and result for concluded Section 42 Enquiries, for the comparator councils.



Data Source: SAC Annual Report, England 2016-17 (Experimental), Data Tables Annex B: Initiated and concluded enquiries from NHS Digital

Figure (v) - Enquiries and meeting expectations

	Wiltshire 2016-17	England average 2016-17*
Number of investigations started	**818**	**994**
Number of adults at risk who set desired outcomes	**385**	**420**
Number of adults at risk who stated that their desired outcomes were fully or partially met	**370**	**391**
Percentage of adults at close of enquiry who felt that their outcomes had been achieved	**96%**	**93%**

***National figures are distorted as 59 LAs in England did not submit data, including two LAs in the South West. However, the figures above do reflect that a high proportion of those who are the subject of an enquiry, feel that their desired outcomes were met at both local and national level.**

Risk register

Risk Description	Risk Impact	Risk Likelihood	Current Risk Score	Mitigating actions	Current Risk Review Date	Ownership	Initial risk score
Staffing capacity issues across organisations impacting on the Board's ability to work collaboratively to prevent abuse and neglect where possible	Substantial	Very Likely	12	Issue of quoracy at subgroups remains an issue and has been raised at Board meetings. The implementation of a new Board model in 2018/19 will increase the number of Board meetings but will also increase the pace and profile of the work of the subgroups. Membership and the focus of the subgroups will be reviewed to ensure the relevant people are involved in the right workstreams and to reduce problems with quoracy	Q4 2018	Board Chairman / Board Manager	9
Unqualified or untrained workforce leading to low staff retention and inability to fill posts impacting on the Board's ability to work collaboratively to prevent abuse and neglect where possible	Substantial	Likely	9	The Board continues to work to increase the uptake of training in key areas. The website is used to advertise training provision / courses. Through the audit process and work of the QA subgroup the Board seeks reassurance about staff retention and vacancies and the impact this is having. Single-Agency training take up is consistently reported as high by statutory partners but there is less certainly within the wider sector. In particular, work is required to assess current provision within the domiciliary care sector.	Q4 2018	Judy Vanderpump	9

Changing governance landscape and legislative requirements impact on the Board's ability to assure itself that effective local safeguarding arrangements are in place as required	Substantial	Unlikely	6	Mental Capacity and Deprivation of Liberty - The final report and draft Bill were published on 13 March 2017. The Government's interim response was published on 30 October 2017. A final response from the Government has not yet been issued - the board will ensure members are kept informed and are appropriately briefed.	Q4 2018	Heather Alleyne	4
Inability to provide assurance that safeguarding practice is person-centered and outcome-focused	Substantial	Likely	9	A planned audit on MSP stalled and plans will need to be revisited once the council have recommissioned their service-user engagement contract in Spring 2018. In the meantime Healthwatch are working on a letter and questionnaire to be provided to all service users who go through a safeguarding investigation to allow the Board to collect feedback.	Q4 2018	Board Chairman / Board Manager	9
Failure of the Board to assure itself that safeguarding practice is continuously improving and enhancing the quality of life of adults	Substantial	Unlikely	4	A peer challenge event in November 2017 involved all statutory partners and ensured that key challenges were identified – and feedback will shape future quality assurance work. The Board is also developing an engagement strategy to ensure feedback from service users.	Q4 2018	Sarah-Jane Peffers	6

Failure to communicate effectively with key partners impacting on the Board's ability to fulfil its statutory role	Moderate	Unlikely	4	Engagement Task and Finish Group set up and learning and development events are planned for 2018. Cllr induction session delivered. Annual report and forward work plan delivered to HSC/HWB. Website set up. Social media utilised to help raise awareness of WSAB. Full engagement plan being developed.	Q4 2018	Board Chairman / Board Manager	6
Failure to share and embed learning from Safeguarding Adults Reviews	Moderate	Unlikely	4	Two reviews nearing completion and work underway in all subgroups to share the learning across agencies.	Q4 2018		4
Failure of the Board to work effectively with the Safeguarding Children Board to protect young adults from wider harms and exploitation	Unlikely	Unlikely	4	The Board support team now works across the LSAB, LSCB and Community Safety Partnership to ensure oversight of work to protect vulnerable people across the life-course from wider harms. The Chairs of the LSAB and LSCB have also sought reassurance from the LA on work to ensure systems work to protect vulnerable children and they enter adulthood. However following the publication of a review in Newcastle providing significant learning around the sexual exploitation of adults with care and support needs further local work will be necessary to share that learning.	Q4 2018		New risk
Failure of member agencies to adequately monitor out of area placements leads to a fall in standards locally and nationally	Substantial	Very likely	12	Following the publication of a review in Somerset highlighting issues related to a failure of agencies to monitor commissioned placement outside of county boarders the Board is seeking to gain assurance from local agencies.	Q4 2018		New risk