# Wiltshire Safeguarding Adults Board

# Annual Report 2018 – 2019

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## Chairman's foreword

On behalf of the Board I am pleased to present our annual report for 2018/19.

Since I became Chairman of the WSAB in 2015, much has changed but this year was particularly notable for the pace and scale of the changes made to better safeguard adults in Wiltshire.

The most significant change this year has been the introduction of a Multi-Agency Safeguarding Hub (MASH). The MASH co-locates staff from Wiltshire Council, Wiltshire Police and NHS Wiltshire Clinical Commissioning Group who work together to safeguard adults at risk of harm. The development of a MASH has been a longstanding aspiration for our Board and the investment of resources to make that aspiration a reality demonstrates the local commitment to improving the way we support vulnerable adults.

Alongside the new MASH, I have introduced a new executive group to drive forward the work of the Board. The WSAB Executive has the important task of making certain that the investment we've made in the MASH helps us to better safeguard adults at risk. Meanwhile as Chair of the Board, I now also sit on the new Safeguarding Vulnerable People Partnership (SVPP) which brings together local leaders from the police, the local authority and the Clinical Commissioning Group to tackle wider community safety and safeguarding issues. The Partnership will allow our WSAB, our Community Safety Partnership and those who run services to safeguard children and young people to work collectively.

The Board has a duty to publish an annual report detailing how effective our work has been, and this year's report outlines:

- Learning identified in the Safeguarding Adults Reviews we have now published
- The areas where there are challenges in our local safeguarding system
- How we have begun work to address those challenges
- The progress our subgroups, reference groups and member agencies have made this year
- How the Board and members plan to continue to provide assurance and to monitor any necessary improvements in the way agencies work together in the year ahead

This report provides an overview of our work in the last year. I would preface it by saying that whilst we have identified areas where we can improve practice, the local determination to overcome those challenges is made clear by the commitment agencies have made to learn from experience and develop new ways of working.

Richard Crompton
Independent Chair, Wiltshire Safeguarding Adults Board

## Executive Summary

During 2018/2019, to provide assurance that local safeguarding arrangements are continuously improving and enhancing the quality of life of adults in Wiltshire, the Board and its members:

- **Developed a new Multi-Agency Safeguarding Hub** - Wiltshire Council, Wiltshire Police and NHS Wiltshire Clinical Commissioning Group staff are now co-located to more effectively share information and expertise, to better safeguard adults at risk.

- Published four and commissioned two further **Safeguarding Adult Reviews** (SARs). Those reviews include:

    - An independent Review after the death of a 74-year-old male. Adult C was diagnosed with paranoid schizophrenia but was living independently, supported by services who managed his finances and provided mental health support. After concerns were raised about his behaviour and physical health, Adult C was recalled to a mental health hospital for assessment. A physical examination revealed he was emaciated and starved. Adult C was admitted to hospital where he died as a result of community-acquired pneumonia.

    - A Local Learning Review was carried out after a 40-year-old homeless man died. Adult D was asked to leave a train travelling through Wiltshire because he was heavily intoxicated and didn't have a ticket. He was seen by police and ambulance staff in the following hours. However, despite being seen by emergency services, he was found deceased the following morning in a public toilet block. His death was caused by acute alcohol intoxication and hypothermia.

- The reviews have led to the development and publication of:
    - An escalation policy to give professionals the tools to raise concerns when another service or organisation has not responded as required or anticipated to safeguard an adult at risk.
    - High Risk Professional Meeting tools which provide a framework for the management of very complex cases where, despite continuing work, serious risks remain and all other safeguarding options / action / protection and interventions have been exhausted.
    - Guidance to help practitioners to identify and respond to the signs an adult may be self-neglecting.

- Developed a new methodology for carrying out SARs to ensure that future reviews draw on local expertise and generate local learning which will lead to effective change. Our ambition is to invest in the implementation of learning.

- Hosted over two hundred practitioners at WSAB learning events, like the event the Board ran at Tidworth Army Garrison on safeguarding adults who are homeless, or who are at risk of homelessness.

- With the support of the Centre for Independent Living, hosted quarterly meetings for Service Users' group to ensure those who use services are informing the work of the WSAB.

- Worked closely with the Community Safety Partnership and other agencies to construct a new partnership which will ensure that we are safeguarding people throughout their life in the communities in which they live.

- Carried out a self-assessment audit and peer challenge event that established the strengths of and key challenges to the local safeguarding adults system.

## In Wiltshire

### Concerns and enquiries

The number of contacts received by the new MASH from those who were concerned that an adult may need safeguarding fell from 4641 to 4183.

This 10% fall coincides with the introduction of a new triage process. That process is designed to ensure that those calling about care and support issues, where there is no indication of abuse or neglect, are put in touch with the right people to assist rather than being put in contact with our safeguarding team.

However, whilst the number of concerns raised fell by 10%, the number of safeguarding enquiries carried out increased over 18%. In 2017/2018, 22% of concerns lead to an enquiry. This year, 30% of concerns raised led to an enquiry. Three large-scale safeguarding investigations also took place to investigate wider concerns about organisational abuse. This means that although the number of concerns raised has fallen, the amount of safeguarding activity remains high.

Despite the fall in the number of concerns raised, the figure in Wiltshire remains consistently above the national average and this has been discussed by the Board's Quality Assurance Group. Whilst the reported number of concerns remains higher than the national average, we know that there are discrepancies in national reporting practices. This means that a direct comparison between local and national data tells us little about the actual level of abuse and neglect in either of those geographies. In addition, we also know that a high level of concerns raised can reflect a willingness of professionals, and members of the public, to report their concerns. Locally, it also reflects a high number of alerts being received from providers.

The view of Board members is that data across the full year 2018/2019 shows that we have started to move in the right direction. We are seeing fewer inappropriate concerns being forwarded to MASH and consequently the conversion rate from concern to enquiry is increasing.

### Measuring success

In quarter three, there were a number of staff changes and vacancies in the new MASH and its acknowledged that processes and recording used to gather performance data were not completed consistently in every case. Trend data over a longer period will allow the Board to assess whether changes in data are the result of new arrangements or of inconsistencies in recording practices.

As planned, the function of triage services has changed with more multi-agency focus, information gathering and discussion taking place at this stage. As a result of this, the number of cases triaged in two days fell year-on-year from 98% to 85%.

In the year ahead, there will be reassessment of how we use data measures to evaluate the success of the MASH - and how we assess the effectiveness of multi-agency triage. It's believed that this fall reflects the additional work done at the initial stage to assess whether the concerns relate to safeguarding. However, the Board will want to seek reassurance that any increase in time taken to assess a case is not impacting negatively on adults at risk.

**Learning from reviews**

All of the Safeguarding Adult Reviews carried out by WSAB over the last two years have involved an adult at risk who had deteriorating or fluctuating mental capacity. The reviews indicate that more support is needed for local practitioners to help them effectively assess mental capacity and recognise the signs of self-neglect.

To reflect the findings of SARs published this year, the Board asked for data on those who lack mental capacity and are involved in a safeguarding enquiry. There were 380 adults at risk involved in concluded enquiries who lacked capacity to make decisions in relation to the enquiry. However, in another 532 cases it was not recorded on the CareFirst system whether the adult had capacity or not. This makes it difficult to assess the application of the Mental Capacity Act (2005).

In addition, whilst in 79% of cases adults who did not have capacity were recorded to have been supported by an advocate, family member or friend, in 19% of cases it is not possible to ascertain whether the views of an adult at risk who lacked capacity were represented.

**Summary**

The level of safeguarding activity has broadly increased based on the number of enquiries, large-scale investigations and Safeguarding Adult Reviews carried out. Whilst this does not necessarily indicate increased levels of abuse or neglect, further work will be required to understand the cause and impact of these changes in activity.

The majority of safeguarding concerns raised were made by staff in social care, nursing care homes, residential care homes or domiciliary care staff. The fall in concerns raised was mirrored across those agencies who most commonly raise concerns, with a notable decrease in the number of concerns raised by domiciliary care providers.

Over half of safeguarding concerns raised locally relate to those over 65 and the majority of those concerns related to women in a care or nursing home (see figure 1).

A significant proportion of those concerns raised by professionals across social care and health do not relate to abuse or neglect and instead reflect a cautious approach to care management. However, of the 400 concerns raised by social care staff, over half were triaged out. This may suggest there is work to do to help staff understand more about safeguarding thresholds.

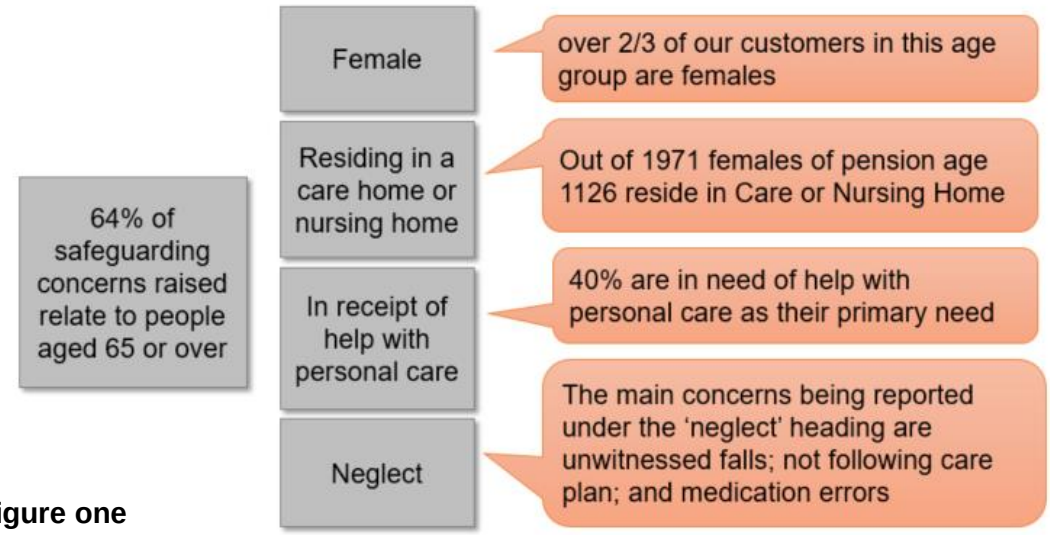



**Figure one**

The number of concerns raised by NHS staff and primary care remains relatively low.

The types of abuse reported as a proportion of all concerns remained consistent with 2017/2018. However, the number of concerns received by family and friends rose, suggesting an increasing awareness of safeguarding services.

## Nationally

At the time of writing, the National Adults Safeguarding Collection data for 2018/2019 has yet to be published. The data we do have for 2017/2018 is still experimental and local areas are asked to submit much of the data on a voluntary basis.

What we do know from national data is that older people are much more likely to be subject to a Section 42 enquiry. The most common type of risk is neglect or acts of omission and the most common location of the risk is home. Our local data reflects all of these trends.

The increase in conversion rate from concerns to enquiries brings Wiltshire closer to the national average of 38%. However, inconsistencies in practice and discrepancies in recording practices mean that local figures vary from less than 4% to 100%.

## Summary of learning from 2017/2018

Over the course of the year, the Board identified learning through a number of Safeguarding Adults Reviews, a member-led self-assessment peer challenge, data collected by the Quality Assurance group and from engagement with practitioners and service users. That learning is summarised below.

## Local Safeguarding Adults Reviews

**The last Annual Report set out learning from two reviews relating to Adult A and Adult B. Two further reports were published in 2018-2019 and can be accessed on the Board's website: www.wiltshiresab.org.uk/safeguarding-adults-reviews/**

Reviews of serious incidents can help us identify how we can more effectively safeguard adults in Wiltshire. However, it should be noted that these Reviews represent only a fraction of the many cases where vulnerable people are supported by services. In most cases, outcomes are good and effective practice protects people who may not be able to protect themselves.

The Reviews conducted by the Board have identified six main streams of learning:

## 1. Application of the Mental Capacity Act (2005)

Ineffective application of MCA featured in all four of the completed SARs, with the following common features:

- **Assessments of mental capacity should be made when professionals witness an individual making repeated unwise and potentially harmful decisions.** An adult with capacity has a right to make unwise choices. However, where an adult has care and support needs and is making decisions that are not in their own best interest, professionals should consider undertaking a capacity assessment.
- **Formal assessments of mental capacity** should happen when there is doubt over mental capacity and an adult is making more serious decisions. Formal assessments provide the legal basis on which to introduce further interventions or assessments of care and support needs. Smaller decisions can be assessed less formally but should still be recorded.
- A lack of understanding that, where mental capacity is in doubt, assessments should be **decision-specific**. This applies regardless of how big or small the decision is. Mental capacity is not binary; a person should not be deemed to 'have capacity or not'.
- **Best-interest decisions** should be made and recorded when a person is deemed not to have mental capacity for a specific issue.
- Mental capacity can **fluctuate**, either due to physiological causes such as Dementia, or because of alcohol or substance misuse. In all cases, the specific decisions about the individual's care and support needs should be made in the same way.

## 2. Self-neglect

Common threads around this issue were:

- **Self-neglect comes in many forms**, some of which are less obvious or less often recognised. Lack of personal care or a poorly cared for home environment are not the only signs that someone is not taking care of themselves.
- **Best practice approaches** to working with those who self-neglect or who are at risk of self-neglecting may look different depending on the individual's needs, which is why this is such a complex behaviour to work with.
- Working with cases of self-neglect requires **effective multi agency working** and planning, to safely assess and reduce risk. Due to its complex and sometimes

changing nature, an individual's self-neglect may present differently to different agencies. By working together and sharing their experience of working with individuals, agencies can together better safeguard an adult at risk.

- Working with self-neglect may require a **long-term intervention** and persistence when trying to engage with service users.
- Self-neglect and **mental capacity** are intrinsically linked and that should be remembered when assessing risk.
- Neglect as a wider issue is a complex and difficult area to address due to its potential subjectivity. Local authorities should develop **clear risk assessment methods** for all types of neglect, to support professionals with identifying the harm neglect and self-neglect can cause, and how they should respond.

## 3. Effective application of safeguarding procedures

Safeguarding procedures may be in place, but a number of reviews demonstrated points at which these were not effectively followed. Common themes here include:

- **Escalation**. Ensuring that staff across agencies know how to escalate a concern, and that everyone is listened to regardless of their seniority or their role in an adult's life. That means escalating concerns within their own agency and with other agencies where necessary. Staff need to feel comfortable and empowered to escalate safeguarding concerns where they feel the appropriate actions have not been taken. Without this, professionals can develop 'learned helplessness' and give up trying to make their feelings known, accepting that they won't be listened to. This is unsafe for the practitioner and puts the service user at greater risk.
- **Communication of safeguarding procedures**. As well as procedures being in place, agencies need to ensure that staff are not only aware of them but feel confident to follow these procedures and apply them whenever relevant. Effective support and supervision should address this point for all staff, but is especially valid where temporary staff are employed, or for agencies where safeguarding may not be their primary purpose.
- Remembering **Making Safeguarding Personal** guidelines should mean that the risks to individuals are considered on their own merits and reduce the likelihood that generalisations or assumptions are made.

## 4. Effective assessment

This includes assessment of risk, as well as care and support needs. Common themes are:

- **Effective risk assessment** should have multi-agency input. Risk assessments should involve information from different agencies to allow professionals to get a broader and more accurate view of the risks. Robust risk assessment means that the most appropriate actions can be taken to safeguard the individual.
- **Risk assessments should be shared between agencies**. This allows for better continuity of care and should enable more effective safeguarding as the information is available for all to access.
- Any assessment, of risk or otherwise, should include the wishes of the individual themselves. This may include the use of an advocate (see below).
- Where there is a crisis and more than once agency is involved, **risk assessments must be formally carried out and recorded**. This encourages agencies to consider their responsibilities and shows a clear rationale behind any decisions that are made. In doing this formal process, a robust outcome is more likely to be found.
- **Discharge from hospital**. Plans for hospital discharge should be shared with all the agencies involved in the adult's care and support. The plans should robustly address all the risks involved with discharge. Plans should include all the key agencies who will be involved with the individual's ongoing care and decisions should be reached

collaboratively. This would prevent incorrect assumptions being made about what any ongoing care package will provide and is the appropriate place for challenges to be made, should agencies feel discharge is premature.

- Effective assessment that involves gathering factual information from multi-agency partners and family/friends should also prevent assumptions of care being made. Clear wishes should be sought from individuals' family and friends about their ability or desire to support the individual, and their wishes respected and adhered to. Agencies should be clear about what support they are able to offer and, where this does not meet the person's needs, a suitable alternative should be sought.
- Having a standardised method of risk assessment is more likely to lead to effective and appropriate actions to safeguard a vulnerable person at risk. Local Authorities may have recommended risk assessment tools that multi-agency partners are asked to use to increase the likelihood that different risk thresholds are commonly understood.

## 5. Communication

Due to the multi-agency nature of effective safeguarding, communication is a key feature of many of the SARs. Common themes are:

- A **complete and robust handover of information** is crucial when individuals are being transferred from one service to another, or from the care of one worker to another. This may be temporary, or permanent but plays a vital part in the future care the individual receives. NICE guidelines provide more information on this subject because of the pivotal role it can play in safeguarding vulnerable people.
- Significant decisions regarding a person's care should be taken after **collective discussion**, including the individual where possible. This ensures that all relevant information is included in the decision and increases the likelihood that the best outcome is reached for that individual.
- **Access to an advocate** where needed. Individuals should be able to express their wishes regarding their care and support needs. An advocate should be sought wherever possible to facilitate this. This could be a formal advocate where, for example, mental capacity is lacking, or it could be a family/friend/long-standing professional who the individual appoints to support them. Where an agency has the individual's wishes clearly recorded, they must ensure these are shared when relevant decisions are being made.
- Making the most of the **best placed person**. Being flexible in how agencies work with vulnerable people typifies Making Safeguarding Personal guidelines. Having frequent and meaningful contact between agencies will help identify who knows the person best depending on the circumstance, and who may be able to support another agency when they are introduced to the person for the first time.

## 6. Difficulty engaging with service users

Individuals who have care and support needs do not always want to accept help from professionals, or from friends or family. Adults with capacity to make decisions have every right to say no to offers of help and so safeguarding those people when they are vulnerable can be hugely challenging. What we know from our reviews is:

- **Multi-agency working is crucial** here. Including other agencies who work with the individual may increase the chances of engaging with them effectively. That includes agencies who may have worked with the individual in the past - there may be a chance to learn 'what works' for that adult from those agencies.
- Continuous resistance from vulnerable people could lead to a **lack of professional curiosity**, where professionals stop trying to engage with someone and instead make assumptions about how the person is likely to respond. Professionals may accept what an individual tells them despite evidence (or lack of) to the contrary, in the mistaken

belief that they have at last engaged with someone and that they are now 'working in partnership'.

- **Regular supervision** for professionals working with individuals who have been resistant to engage is crucial in ensuring that the professional has the chance to talk through issues and get a second, less involved perspective, and practitioners' methods can be challenged where necessary.

**Implementing learning from Reviews**

The work of the SAR Panel and subgroups to implement learning from Reviews is outlined below. The work includes running learning events, publishing guidance and toolkits, introducing new policy and undertaking quality assurance work.

However, agencies involved in the reviews have also been tasked with implementing change. Those changes include:

**A Housing Association are now** are training frontline staff across customer services and customer accounts to understand more about safeguarding adults. Manager reviews on open safeguarding cases and safeguarding referrals take place quarterly group meetings.

**A community care provider** provided training on self-neglect and the application of the Mental Capacity Act (2005) to staff. A new Head of Operations has been employed and introduced specific team meetings for clinical leads. The organisation now has assurance that regular one-to-one meetings with clinical leads are taking place.

**A health agency** created a mandatory template that all clinicians must use to log safeguarding concerns rather than relying on third parties. Use of the form is monitored through meetings which each clinician.

**The local authority** have put in place the Help to Live at Home alliance to respond in a timelier manner to emergency situations. New workflows between health and social care are being developed to streamline and support the service.

**The Council's** Court of Protection (COP) team implemented a risk assessment for every COP Team customer, and those customers who don't engage with services and are high risk are discussed in supervision every month. There is also a new red flag system to highlight missed payments and visits which are sent to the team manager.

**A mental health provider has** incorporated a risk recording element to care plans. Staff have been trained on use this new system and monthly audits are taking place to ensure the new system is working.

The **Police, Social Care, Council and Mental Health Trust** have agreed that where cases are escalated within agency to a Service Lead, the referring professional can call a multi-agency case conference. Attendance will be treated as a priority by each agency.

## Self-assessment Audit and Peer Challenge

In Autumn of 2018, the following Board members submitted a response to the Board's annual self-assessment audit:

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Great Western Hospital, Swindon
- NHS England South Central

- Royal United Hospitals Bath NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Dorset and Wiltshire Fire and Rescue Service
- Wiltshire Council
- NHS Wiltshire Clinical Commissioning Group
- Wiltshire Police
- Wiltshire Health and Care
- South Western Ambulance NHS Foundation Trust

The reports submitted by partners identified a number of significant challenges:

- Improving the consistency of the application of safeguarding policies, procedures and processes and the Mental Capacity Act (2005) and Mental Health Act (1983).
- Planning for the changes expected when the new Mental Capacity (Amendment) Bill is implemented.
- Implementation of measures to meet requirements set out in the Healthcare Competency Framework August 2018.
- Lack of funding for Independent Domestic Violence Advisors (IDVAs), particularly in the South of Wiltshire.
- Consistent MARAC attendance.
- A backlog of unauthorised Deprivation of Liberty Safeguards (DoLS) - part of the Mental Capacity Act (2005)
- A lack of capacity within advocacy services to support vulnerable individuals, and the difficulties of cross-border working.
- A requirement for more feedback on referrals from the Council's safeguarding team to inform training.
- Delays in Mental Capacity Act (2005) assessments due to pressure on staff time.
- The increase in those found to be self-neglecting.

However, agencies also reported on how they are responding to those challenges:

- Sharing and promoting SAR learning across their agencies.
- Implementation of SAR learning being actively monitored by senior management and discussed regularly with providers.
- Reviewing and improving discharge processes, particularly complex discharges.
- Two agencies had developed a broader safeguarding improvement plan.
- Increased focus on better identification of self-neglect.
- Increased capacity within the DoLS team.
- Development of a process for identifying and assessing individuals whose care and treatment arrangements may constitute a Deprivation of Liberty in the community.
- Development of a local Dementia Plan.
- A local provider successfully bid for Health Education England funding to develop and provide an accredited 'Advanced MCA award'.

## WSAB Subgroups and Reference Groups

All of the Board's subgroups and reference groups met four times in 2018-2019. Below is an update on their work and the challenges they have faced.

## Safeguarding Adult Reviews

The Safeguarding Adult Review Panel was constituted in 2017 and is Chaired by Tracy Daszkiewicz, Director of Public Health at Wiltshire Council. The panel meets once every two months with additional meetings as required when we are undertaking a review.

During 2018-2019:

- WSAB introduced a new Local Learning Review methodology for conducting Safeguarding Adults Reviews. The new methodology, developed by the SAR Panel, utilises expertise in the local system and ensures local partners focus on the implementation of learning as well as the review itself.
- The Panel, on behalf of the Board, oversaw three reviews, two of which have now been published.
- Two of the reviews conducted used the Local Learning Review methodology and were carried out with oversight from our Independent WSAB Chair and agencies who had not been involved in the reviewed cases.
- The subgroup also developed a new SAR Policy which is due for publication and will make the review process more effective.
- The panel considered another two referrals and concluded that, although the criteria for a SAR had not been met, single agency reviews should also help to identify learning.
- Essentially, the Panel reviewed progress to implement learning as identified through reviews to ensure that we can more effectively safeguard adults at risk by working effectively across agencies.
- The Panel ensured that learning briefings were disseminated to all member agencies following each concluded SAR.
- A learning event was held in March 2019 to bring agencies together to discuss how we can tackle challenges identified by the reviews - including how we can ensure the identification of deteriorating capacity.
- Two more specific learning events were run to increase understanding of how to support those who may be self-neglecting and to examine how we are safeguarding those who are homeless.

**Why does our new way of carrying out SARs matter?**

Carrying out a SAR traditionally involved commissioning an independent review author from outside of the local system to write a report on a case we can learn from. Whilst introducing an independent expert to carry out a review has clear benefits, it also presents challenges.

**So why have we introduced a new methodology?**

- The process of finding an author is not scientific. There are many authors out there and many review methodologies to choose from. Finding an author can involve asking other Boards for recommendations or researching which author has the right expertise to look at the case you are carrying out.
- The quality of SARs has been an issue nationally. Many are well written and result in recommendations that the Board members can make sure lead to necessary changes. However, in other cases, Boards are left with very long reviews which are only read by

those who were involved and include recommendations that make it very challenging for the Board to implement meaningful local change.

- The aim of any review is for local services to engage openly in the process and to identify learning. However local services can feel that the review is the end product. An independent person asks them to take part, they are involved in the development of the review and the review is then published. We want local services to realise that the review is only the first stage - the end product is a system that is better because we have implemented learning from these reviews.
- Reviews can be hugely costly. This should not be and is not a reason to always consider using a traditional approach with an independent author, but there are other ways of investing in our system - namely investing in ensuring that we all learn from SARs.
- Our Board has an Independent Chair, its members have a wealth of experience of case reviews and improving local services, and the Board is supported by a partnership team. These resources can be used to help us achieve learning and are supporting our new methodology. We do though ensure that both the Chair and Deputy Chair of our reviews are from an organisation who has had no involvement in the case being reviewed - only by doing this can we ensure objectivity.
- In 2019, we will be involving Healthwatch Wiltshire in our reviews to go a step further towards making our review process as transparent and open to challenge as it can be.
- Involving the adult at risk, where that is possible, or their family wherever we can, remains a priority for the Board regardless of the methodology we use for a review.

The more local approach to carrying out SARs, which we decided to adopt in Wiltshire in 2018, is now being adopted in other areas for many of the reasons set out above.

The SAR Panel will ensure that in 2019-2020, we continue to learn as we go, improving our new approach to ensure it helps us better safeguard vulnerable adults. The Panel will also always consider other approaches where we are not certain a Local Learning Review methodology will satisfactorily identify learning - and should we undertake a local review and find the case is more complex than we first believed, we will look to take a different approach.

You can find out more at www.wiltshiresab.org.uk

## Learning and Development

In 2017/2018, we reported that attendance at the Learning and Development Subgroup had been mixed and, later that year, the Chair stood down due to other commitments.

The key challenge the group faced was the assessment of training needs and agreeing plans for agencies who have different functions and statutory duties. In addition, without a budget to deliver training, group meetings generated a good exchange of ideas and experiences but did not result in an agreed programme of activity.

It was agreed that the Board would focus on delivering regular, free, training events based on learning from SARs. It was also decided that the new SAR Panel would provide recommendations to members that would ensure training was delivered as required on a single agency basis to meet need.

The group was stood down in 2018 and since that time, over 200 practitioners have attended Board learning events and a programme of multi-agency training is being delivered, led by the Council with support from the wider Board.

The decision to stand down the group will be revisited in 2019.

## Policy and Procedures

This year, the Policy and Procedures subgroup was chaired by Emma Townsend, Head of MASH, Advice and Contact at Wiltshire Council. The group met four times in 2018-2019 and is regularly attended by representatives from:

- Wiltshire Council
- Wiltshire Police
- NHS Wiltshire CCG
- Wiltshire Health and Care
- Avon & Wiltshire Mental Health Partnership NHS Trust
- Independent Provider representatives
- Medvivo

The Policy and Procedures Subgroup's role is to ensure that the WSAB has appropriate safeguarding policies that enable it to maximise the outcomes for adults at risk in Wiltshire and reflect its diverse communities.

**What did the group do in 2018/2019?**

- The group was committed to developing a multi-agency response to the High-Risk Behaviours of those with capacity who are at high risk of harm to themselves or others. This year they achieved that. The new High-Risk Professional Meeting tools provide a framework for the management of very complex cases where, despite continuing work, serious risks remain, and all other safeguarding options / action / protection and interventions have been exhausted.
- The subgroup published Self Neglect guidance in line with the recommendations from a recent SAR.
- The subgroup has reviewed the Large-Scale Investigation policy and a redrafted policy is now being consulted on.
- The group agreed a survey to test how well we are working to Make Safeguarding Personal (MSP). The survey is now being handed out to those who have been involved in an enquiry.
- The group developed and signed off the Board's Escalation Policy.
- Members were consultees on the introduction of a new methodology for SARs.
- A pilot training programme for care home staff was delivered by Wiltshire Care Partnership on behalf of the Board. The session was designed to test sector appetite for training on application of the MCA (2005).
- The group's work is published at www.wiltshiresab.org.uk/professionals/

**What will the group do in 2019/2020?**

- Publish a revised Large-Scale Investigation policy.
- Establish a clear picture of how well MSP principles are embedded in partner organisations.
- Assess local provision of advocacy services and the engagement of services with family members when an adult at risk is being transferred between settings or is in a new setting.
- Explore the impact of social isolation on the effectiveness of adult safeguarding through a needs assessment and development of an action plan as required.
- Promote and apply the new Self-Neglect Protocol across the partnership
- Evaluate and increase the impact of the High-Risk Behaviours Strategy.
- Implement a new Information Sharing Agreement for both the Board and MASH to enable the effective flow of information where necessary to safeguard individuals and improve practice.
- Update WSAB's Staff Guidance and Policy and Procedures documents to ensure there is a local framework for good practice.

- Inform and contribute to the Adult Services Transformation programme to ensure that safeguarding remains a priority in the redesign and development of operational services.
- Development of a Virtual Partnership to support the Adult MASH.
- Put in place a multi-agency protocol to support professionals who are called to attend adults at risk who are highly intoxicated and who pose a risk to themselves and, potentially, to others.
- Develop a Local Learning Framework, a Multi-Agency Risk Assessment tool and a policy in relation to People in a Position of Trust.
- Ensure that all Board members are well sighted on the development of legislation and guidance concerning adult safeguarding and that policies, procedures and practice continue to be developed and reviewed to reflect changes.

## Quality Assurance

In 2018, the Chair of the Quality Assurance (QA) Subgroup stood down and group meetings were chaired by a member of the CCG team until a new permanent Chair was nominated for the group in 2019. The new Chair is Kathryne Abbott, Designated Professional for Safeguarding Adults at the CCG. Despite these changes, the group continued to meet through 2018/2019. Members of the group represent:

- Wiltshire Council (WC)
- Wiltshire Health and Care
- Wiltshire Care Partnership
- NHS Wiltshire CCG
- Royal United Hospital (representing acute providers)
- Wiltshire Police
- Healthwatch Wiltshire

The primary role of the group is to collect and review data from the partnership which gives the Board assurance that services are working to deal effectively with concerns raised about safeguarding. The data that the subgroup have reviewed this year is provided at the end of this report and underpins the commentary included earlier.

In addition, an annual self-assessment challenge was completed by all 11 agencies asked to take part and led to a panel review of the reports and a Peer Challenge event. Meetings were held with all of the agencies and identified both progress and challenges, which will provide a focus for the QA group the year ahead.

The group meetings have also provided a forum to review Safeguarding Adults Collection data and to consider how partners can work together to monitor quality in the new adult MASH. Professionals now hold a weekly audit session to review cases and assess where improvements to services can be made.

To support the work of the group, the Chairman of the Board asked local commissioners to gain assurance that we are certain that those adults at risk from Wiltshire who are placed in other counties are safeguarded from harm. Responses were received from all parties and assurances provided.

The group also maintains a multi-agency risk register.

**What will the group do in 2019/2020?**

- Implement a Multi-Agency Case File Audit (MACFA) process to test multi-agency responses to the learning from this review.
- Undertake deep-dive audits to test how well the system is implementing the MCA (2005), recognising and responding to self-neglect, safeguarding people who are moving between settings and to assess the adequacy of support and supervision of frontline staff.
- Support the Board to provide effective governance, oversight and support of the Adults MASH and broadening of that hub to include other partners to meet local needs more effectively.
- Undertake assessment of the learning offer of key single agencies, assessment of where gaps in that provision may necessitate a multi-agency training offer and action to address those gaps.
- Carry out the annual self-assessment audit and peer challenge event
- Establish the number of people who have been placed into services in Wiltshire by commissioners from other parts of the UK and assess how effective safeguarding arrangements are protecting them from abuse and neglect.
- Focus on Making Safeguarding Personal and the need to develop a model of assurance that will engage with service users and their families to assess their experience.
- Explore the impact of social isolation of the effectiveness of adult safeguarding through a needs assessment and development of an action plan as required.
- Audit cases of adults at risk who received support from the Court of Protection team to assess where monthly spend is low if this coincides with potential self-neglect.
- Work with the Community Safety Partnership to examine the issues of criminal and sexual exploitation, the local evidence base and the impact on vulnerable adults in Wiltshire and respond accordingly.
- Support the Board to implement change based on learning identified by SARs.

## Service User Network Reference Group

This year Wiltshire Centre for Independent Living (WCIL) supported our Service User Network Reference Group. Meetings continue to be well attended by service users who have experience of how local systems are working from a care user's perspective, through their own experience and through the networks they have developed. WCIL have done much to support our work and to ensure the voice of service users is at the heart of the Board's work.

**Hot topics**

During the course of the year:

- Wiltshire Council's Trading Standards team came to meet service users to talk about scams and how to stay safe. Members provided feedback about their own experiences.
- The group expressed concerned about sheltered housing and how well residents with care and support needs were protected from harm. The Chair of the Board met with the Council's Executive Director with responsibility for housing to feedback members' concerns and to seek assurance that those in sheltered housing were being safeguarded from harm.
- Members of the group have designed a leaflet to promote awareness of adult safeguarding in our communities. The leaflet will be published in 2019.
- In early 2019, guests from Wiltshire's new reablement service joined the group to talk about how the service works and how it helps to protect the independence of adults at risk. The group asked questions about how the new system would work and raised concerns about delays in hospital transport and about discharges that happen late at night.

The group continues to grow in 2019 and the way meetings are now being used ensures that instead of simply providing a space to share information with members, the meetings provide a space for members to share their views with the people that design and run services.

Members also receive and have opportunity to comment on:

- Feedback from all the main Board meetings and work of the subgroups.
- The Board's annual Business Plan and Annual Report

## Carers' Reference Group

The Carers' Reference Group continues to meet but meetings were again not always well attended. Those attending are unpaid carers themselves and care for people with a range of mental and physical care and support needs. As we know, this can make attending meetings on a regular basis very challenging. However, Carer Support Wiltshire continue to facilitate the group effectively to ensure that the Chairman of the Board has a regular opportunity to meet carers in Wiltshire and hear their feedback and concerns.

This year, the hot topics discussed at meetings included:

- Concern that when you are caring for someone who is frail and elderly they may bruise more easily - these bruises may then be misconstrued by a third party.
- The closure of mental health beds - the Chair has subsequently raised these concerns with services to ensure the concerns of carers are considered.
- The Carers Emergency Card - Wiltshire Council's commissioning team came to talk to the group about the card and how they are used.
- Members reviewed and commented on the draft Hoarding Protocol and Self Neglect Guidance.

**Appendix 1 - Board Membership & Attendance**

| | May 2018 | July 2018 | Nov 2018 | Jan 2019 | March 2019 |
|---|---|---|---|---|---|
| Independent Chair | Y | Y | Y | Y | Y |
| DASS and Corporate director | Y | N | Y | Y | Y |
| Chair of the Policy and Procedures subgroup | Y | Y | Y | Y | Y |
| Detective Supt, Police | Y | Y | Y | Y | Y |
| Head of Safeguarding NHS CCG | - | - | - | Y | Y |
| NHS Wiltshire CCG | Y | Y | Y | N | Y |
| Director of Adult Care Operations, Wiltshire Council | Y | N | Y | N | Y |
| Director of Public Health and Chair of the SAR Panel | Y | N | Y | Y | N |
| Chair of the Quality Assurance subgroup | Y | Post vacant | Post vacant | Y | Y |

# 2018/2019 WSAB Dashboard

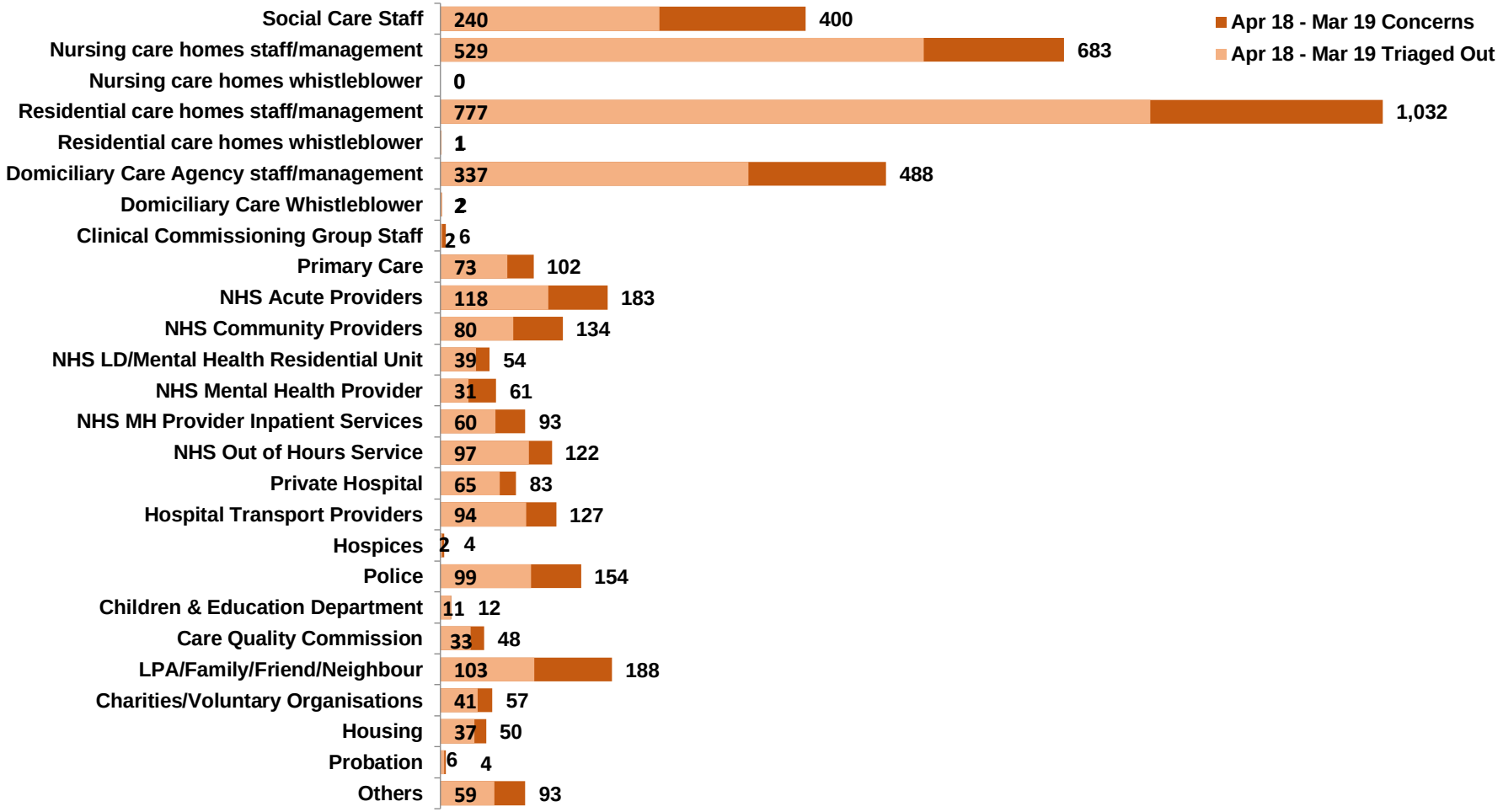
**(Sources: Wiltshire Police, Wiltshire Council Safeguarding Adults Team, Public Protection and Public Health)**

| | Time period | 18/19 | 18/19 | 18/19 | 18/19 | | Annual measure | Annual measure |
|---|---|---|---|---|---|---|---|---|
| | **Data set** | **Q1** | **Q2** | **Q3** | **Q4** | | **17/18** | **18/19** |
| 1 | No. of contacts received by the safeguarding team about possible incidents of abuse or neglect (Concerns) | 1,062 | 942 | 1,015 | 1,164 | | 4,641 | 4,183 |
| 2 | No. of those reports that are looked into (triaged) within two days | 931 | 773 | 830 | 1,042 | | 4,571 | 3,576 |
| 3 | Percentage triaged in two days (target - 97%) | 88% | 82% | 81% | 90% | | 98% | 85% |
| 4 | Number of Enquiries started | 316 | 255 | 250 | 428 | | 1,016 | 1,249 |
| 5 | Percentage of Concerns leading to an Enquiry | 30% | 27% | 25% | 37% | | 22% | 30% |
| 6 | Number of adults at risk who set desired outcomes | 90 | 109 | 102 | 107 | | 608 | 410 |
| 7 | No. of adults at risk who stated that their desired outcomes were fully or partially met | 83 | 98 | 88 | 99 | | 583 | 368 |
| 8 | % of adults at close of Enquiry who felt that their outcomes had been achieved | 90% | 90% | 86% | 93% | | 96% | 90% |
| 9 | No. of adults at risk in concluded Enquiries lacking mental capacity to make decisions relating to the safeguarding Enquiry | 74 | 88 | 105 | 113 | | 368 | 380 |
| 10 | Of the Enquiries shown in 11 above, the number of cases where support was provided by an advocate, family or a friend | 64 | 75 | 93 | 68 | | 298 | 300 |
| 11 | Percentage supported by an advocate, family or a friend | 86% | 85% | 89% | 60% | | 81% | 79% |
| 12 | No. of Large-Scale investigations (no. of beds) | 80 | 117 | 113 | 113 | | 11 | 193 |
| 13 | No. of Safeguarding Adults Reviews published | 2 | 0 | 1 | 1 | | 0 | 4 |
| 14 | No. of adults at risk awaiting a DoLS assessment | 1,783 | 1,701 | 1,771 | 1,721 | | - | - |
| 15 | Number of high-risk domestic abuse cases heard at Multi-Agency Risk Assessment Conferences (MARAC) | 104 | 223 | 178 | - | | - | - |
| 16 | No. of Domestic Abuse incidents (reported to the Police) | 886 | 1002 | 847 | - | | - | - |
| 17 | Number of Anti-Social Behaviour Risk Assessment Conference (ASBRAC) cases | 28 | 42 | 44 | - | | 148 | - |
| 18 | No. of ASBRAC victims | 40 | 40 | 85 | - | | 243 | - |

**Supporting information - concerns, enquiries and outcomes**

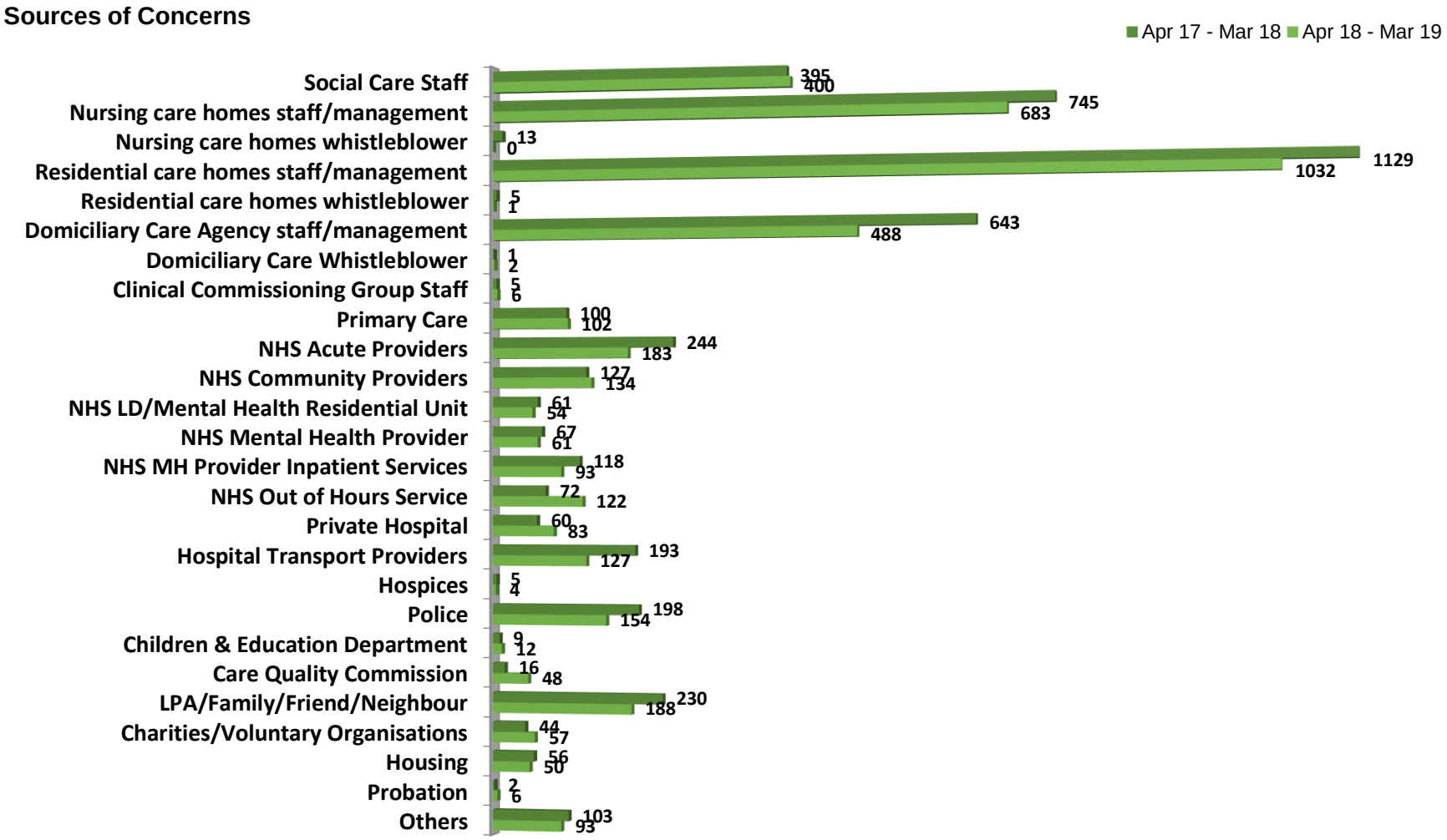
**Concerns raised (figure A)**

**Sources of Concerns:**



**Concerns raised**

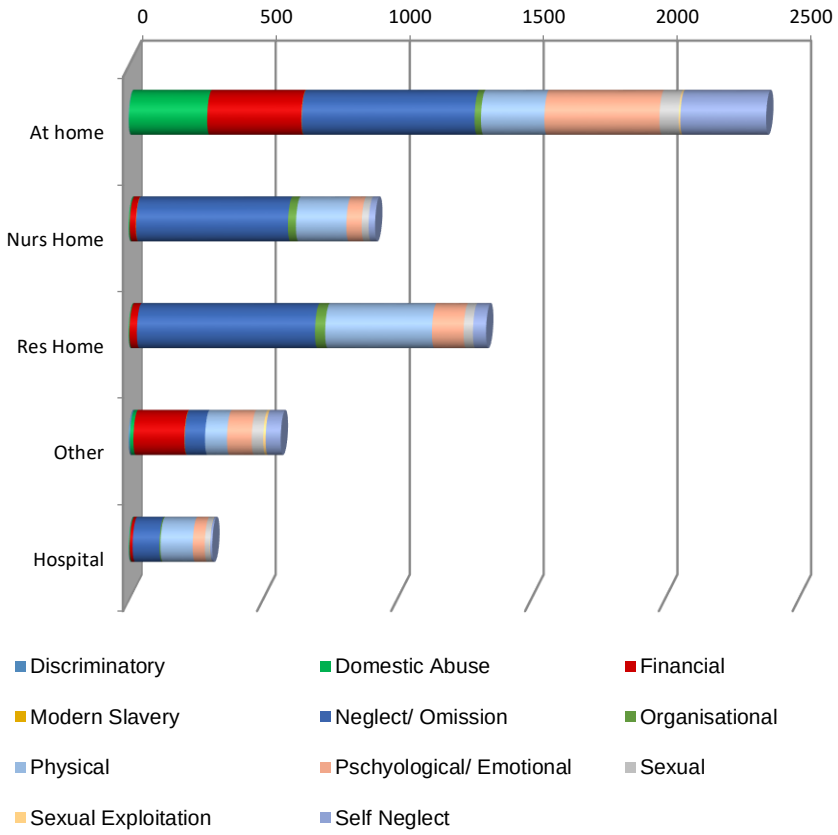
**Source (figure B)**



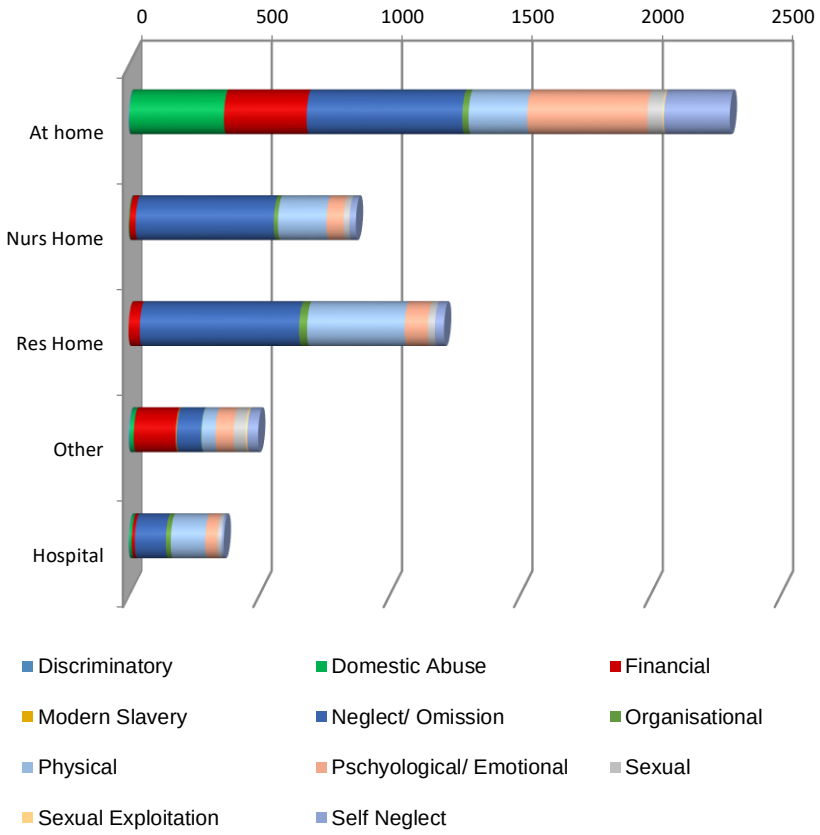
**Concerns raised (figure C)**

**Type of abuse by setting (at the Concern stage)**

**April 2017 - March 2018**

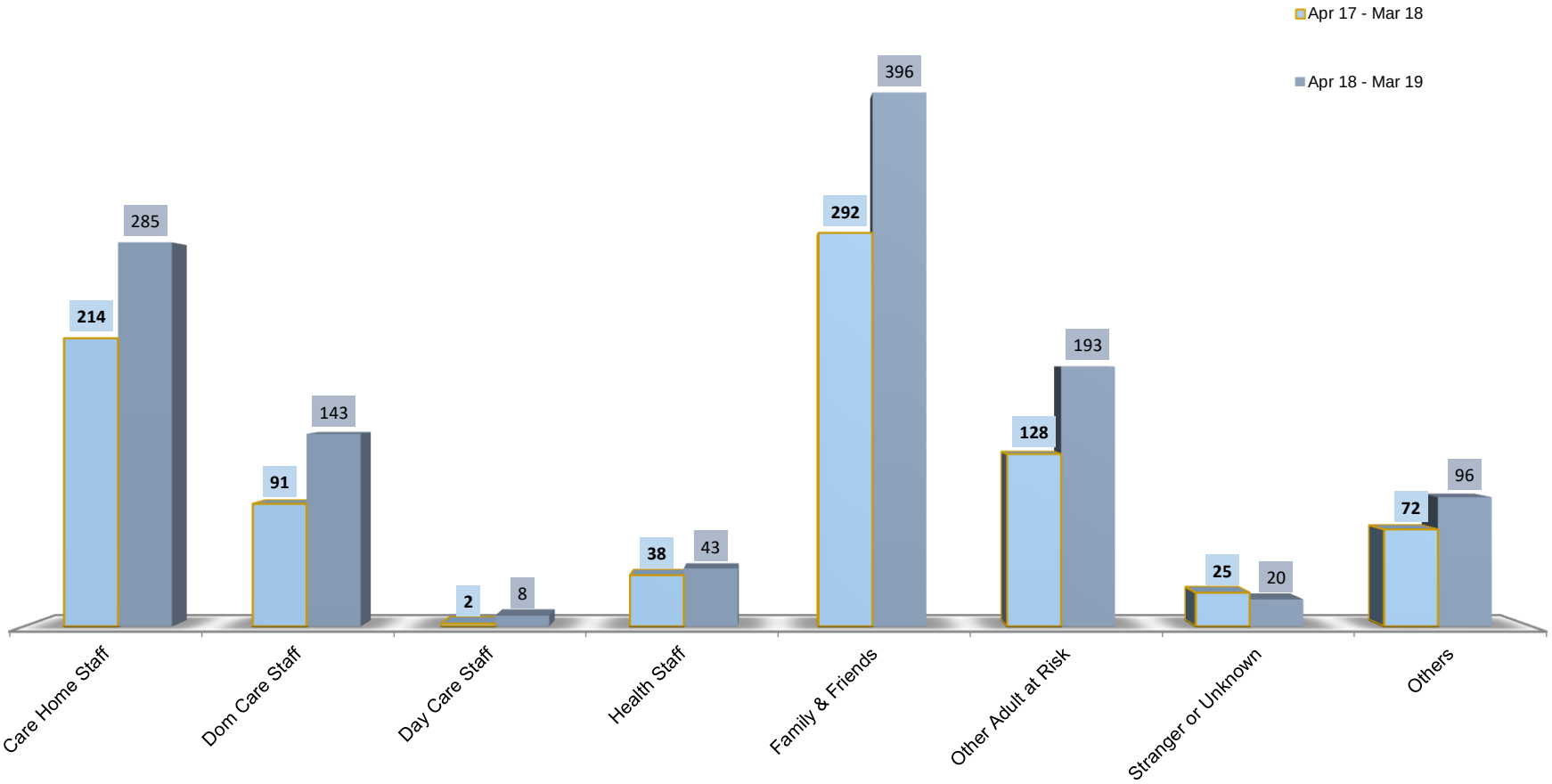



**April 2018 - March 2019**



## Enquiries (figure D)

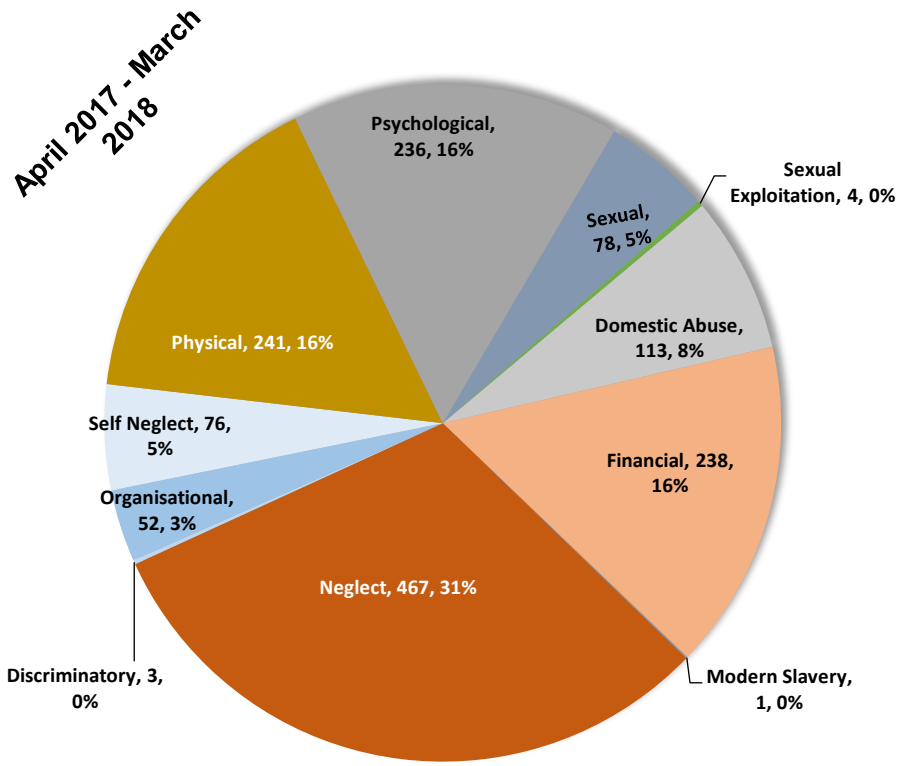
### Relationship of alleged perpetrator to the adult at risk

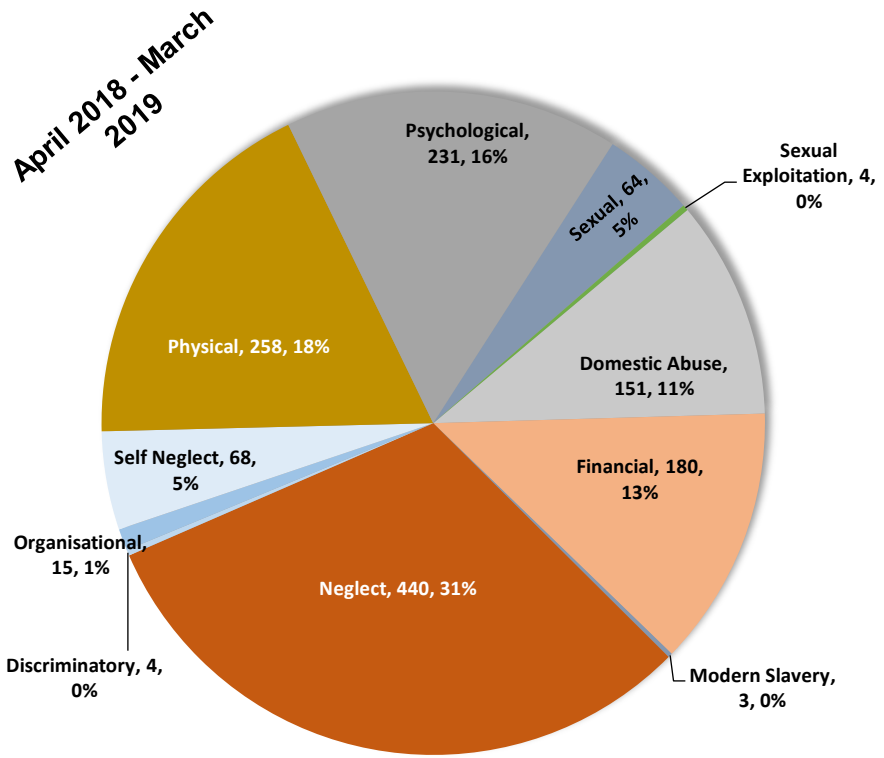


## Enquiries

## Type of alleged abuse (figure E)

### Type of abuse



## Concluded enquiries

### Agencies involved (concluded enquiries only) (figure G)

Agency involvement with investigations is dictated by the nature of the abuse, who raised the initial concern and those agencies that need to be involved with expert advice and skills to help reach an outcome and/or to help deliver future services.

| Agency | Apr 17 - Mar 18 | | Apr 18 - Mar 19 | |
|---|---|---|---|---|
| | No. | % | No. | % |
| Acute Hospitals | 101 | 12% | 86 | 7% |
| Advocacy Service | 107 | 12% | 76 | 6% |
| AWP | 85 | 10% | 97 | 8% |
| Care Home | 331 | 38% | 279 | 24% |
| Care Quality Commission | 256 | 30% | 140 | 12% |
| Community Health Services | 45 | 5% | 59 | 5% |
| Court of Protection | 46 | 5% | 28 | 2% |
| Adult Social Care | 507 | 59% | 261 | 22% |
| Housing (Associations, Schemes, Dept) | 32 | 4% | 42 | 4% |
| Other Local Authorities | 47 | 5% | 41 | 3% |
| Others (Adult or their Representative) | 153 | 18% | 160 | 14% |
| Clinical Commissioning Group | 130 | 15% | 87 | 7% |
| Police | 377 | 44% | 260 | 22% |
| Provider Agencies (Day, Dom Care, etc) | 321 | 37% | 286 | 24% |
| **Totals** | **862** | | **1,184** | |