Wiltshire Safeguarding Adults Board

Annual Report 2013 – 2014

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Foreword

I am pleased to present the Annual Report of the Wiltshire Safeguarding Adults Board (WSAB) for 2013-14.

It was a year in which adult social care in general, and safeguarding within that, was more in the public eye than usual with the passage through parliament of the Care Bill, which passed into law as the Care Act in May 2014. This finally puts the safeguarding of adults at risk of harm on a statutory footing, recognising fully the rights of all adults to be able to live their lives free from abuse, neglect and discrimination. The Board welcomes the provisions of the Act and awaits the publication of the final regulations and guidance which will inform its implementation.

I have been grateful for the continuing commitment of all partner organisations to the work of the WSAB at a time of continuing pressure across all services arising in part from significantly reduced funding and in part from central decisions about organisational and service structure. I refer later in the report to the impact of this context on the membership and work of the Board.

It is good to be able to report a number of achievements during the year, about which further detail can be found in the main body of the report:

- Last year's workshop with service users has resulted in the successful establishment of Service User Reference Group, facilitated by Wiltshire Swindon User Network (WSUN). This is a lively group that is confident to raise concerns and identify successful practice, and each of their quarterly meetings is reported to the WSAB. The group has contributed to this annual report, and its impact has also included a group member attending the WSAB to talk about their own family's experience of safeguarding.
- The Business Plan actions that responded to the findings of the Winterbourne View Hospital Serious Case Review and the mid- Staffordshire Hospital reports were monitored throughout the year. The Board's role here is one of assurance, as the main actions fall to specific partners, who have continued to work on implementing the national improvement board's requirements.
- A Serious Case Review has been carried out concerning a small residential service for people with a dual diagnosis of learning disability and psychiatric disorder, arising from concerns about the quality of care offered to two particular residents. Further information about this is in Section 4, but its overall finding was that no one had acted from malice, nor had any service wilfully neglected the people in their care. There was no finding of neglect or of causing significant harm. However, the review identified a number of problems and made recommendations that affect both local and potentially national practice.
- Significant progress has been made in the WSAB's performance reporting arrangements, which enable the Board to assure itself of the quality of the services being offered, and a communications strategy has been agreed.

We are already well into the current year's work and our Business Plan, as always, builds on last year's work and aims to continue to improve our shared safeguarding work. Our overall priorities for this year are:

- Take all the action necessary to implement the requirements of the Care Act 2014 in relation to safeguarding and any other relevant aspects of the Act.
- Develop and start to implement the Action Plan arising from the Serious Case Review
- Implement the agreed quality assurance and performance management system for the Board
- Maintain the existing work with the Service User Reference Group and continue to develop its role in the work of the Board and safeguarding system. It will be important to continue to put the time and attention into maintaining work with the group and developing further the ways in which we can ensure services users voices are strongly and consistently heard.
- Develop the initial contact with Carers to enable them to be appropriately involved in the work of the Board and safeguarding system.
- Implement the agreed communications strategy to support awareness raising and good information sharing across all Wiltshire's communities; update web-based information to support this.
- Investigate in more detail the reasons for the increased numbers of alerts and referrals.
- Develop the Board's preventative activity through a task and finish group to establish whether/ how people at risk of harm can be identified and appropriate intervention offered.

Finally my thanks are due to all the members of the Wiltshire Safeguarding Adults Board for their commitment and active involvement in the Board's work, both as long-standing and newer members, and also to those who participate in the sub-groups that are so essential to our work. I am also grateful to the council's officers who provide support to the Board. I look forward to working with them this year in continuing to improve the wellbeing and safety of Wiltshire's citizens, and establishing the WSAB in its new status arising from the Care Act.

Independent Chair, Wiltshire Safeguarding Adults Board

10th September 2014

1. Background

1.1. The protection of vulnerable adults first found its place in public policy with the publication, in 2000, of "No Secrets"[1]. This set out clear guidance for responsible agencies in local areas to work in partnership to prevent abuse of vulnerable adults taking place and to deal effectively with any incidents that did occur. This came in the wake of several serious incidents in the 1980's and 90's in which adults had not received the protection and support they needed. Local authorities were given the responsibility for co-ordinating this work and the arrangements now in place, including the Safeguarding Adults Board, have developed from that guidance.

1.2. The current government issued a statement of policy in 2011 which it updated in 2013[2]. Despite extensive development of adult safeguarding services over the last fourteen years, including the establishment of Safeguarding Adults Boards across the country, *No Secrets* has remained the main policy base for this work supplemented by guidance from professional organisations and the findings of research. The Care Act 2014, which became law in May this year and will be implemented in full by 2016, finally puts safeguarding adults work on a statutory footing.

1.3. *No Secrets* defined a vulnerable adult as "a person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation." Over the years that original focus has been broadened to include adults in vulnerable situations arising from a whole range of causes and circumstances, with core safeguarding work linked to a wider network of measures that enables "all citizens to live lives that are free from violence, harassment, humiliation and degradation."[3]

1.4. The Care Act 2014 adopts the terminology "adults at risk", rather than "vulnerable adults", reflecting the preference of people with disabilities that the emphasis should be on the circumstances adults find themselves in, rather than on the individual's disability, which may or may not in itself make them "vulnerable". The safeguarding sections of the Act are part of a wider law that creates a single modern legal framework for adult care and support, as well as addressing some wider issues in health services. Section 7, below, outlines its impact further.

1.5. The other significant background factor to this Annual Report is the continuing organisational disturbance in major public services caused in part by substantially reduced funding, requiring changed leadership structures and service patterns, and in part by central decisions about organisational and service structure. So the local authority and the police have both continued to change structures and/or staffing levels in response to budget reductions. While the new NHS organisations that came into place at the start of the year under review have become more established, the Probation Service is now implementing a major change that will

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[1] *"No Secrets";* Department of Health and Home Office 2000

[2] *Statement of Government Policy on Adult Safeguarding;* DH (May 2013),

[3] *"Safeguarding Adults, A National Framework of Standards"* ADSS 2005

see a substantial part of its work externalised to Community Rehabilitation Companies.

1.6. These changes all affect not only the continuity of WSAB membership but also the working relationships at all levels that play an important role in effective multi-agency working. The increased scope of strategic managers' main roles risks having an impact on their ability to engage effectively and consistently with the partnerships that are so much a part of safeguarding and other public service activities.

1.7. Despite these pressures, the reports of the Board's partner agencies in section 6 show an impressive level of commitment and range of activity to promote and develop effective safeguarding practice across Wiltshire's communities.

2. Governance and Accountability

2.1. The purpose of the Wiltshire Safeguarding Adults Board is to ensure that all agencies work together to minimise the risk of abuse to vulnerable adults and to protect vulnerable adults effectively when abuse has occurred or may have occurred. Its Terms of Reference, which can be found in full at Appendix 1, include underpinning principles, remit, accountability and roles and responsibilities. The WSAB meets quarterly and is supported by the work of three main sub-groups and one that meets as required:

- Policy and Procedures (joint with Swindon SAB)
- Quality Assurance
- Learning and Development
- Serious Case Review (ad hoc)

Task and finish groups are used for specific time-limited tasks.

2.2. Following discussions during the course of the year, renewed representation on the WSAB from the domiciliary care sector has been arranged and the Chief Executive of Healthwatch Wiltshire will also be joining the board. Both will start their attendance in September.

2.3. Board members are expected to attend at least two of the four meetings themselves and to provide a consistent nominated substitute for any meetings they cannot attend. This is to ensure continuity in the Board's discussions and that representation is at an appropriate organisational level. The attendance record for 2013-14 can be found at Appendix 2.

2.4. Statutory partner agencies all have arrangements for reporting on safeguarding activity to their Board or equivalent. During the year the WSAB continued to agree key messages at the end of each of its meetings for use by agency representatives for briefings in their organisation, so as to ensure consistency of feedback on the Board's work.

2.5. The Board has had an Independent Chair since June 2010, and the Chair is accountable to the Corporate Director who holds the statutory role of Director of Adult Social Services. The main purpose of the role is:

- To provide independent leadership and strategic vision to the Wiltshire Local Safeguarding Adults Board (WSAB)
- To chair the WSAB
- To ensure that Wiltshire's SAB functions effectively and exercises its functions as set out in No Secrets 2000 Guidance (and any subsequent government guidance).
- To ensure the WSAB has an independent voice.

2.6. The Care Act's establishment of the WSAB on a statutory footing, while it does not make a requirement on key partners to make a financial contribution, will provide a helpful context for finalising discussions about an agreed budget and how those costs should be shared.

2.7. The WSAB is accountable through the Corporate Director to the Health and Wellbeing Board. The Chair attended to present the Annual Report 2012-13 to the Board at its meeting in November 2013, and arrangements are in place for the same meeting this year. The relevant Select Committee also has the opportunity to review and comment on the report in September. Work is about to start to consider a possible protocol to manage the relationships between the Health and Wellbeing Board, the WSAB, the Wiltshire Safeguarding Children Board and the Community Safety Partnership.

3. Summary of Activity during the Past Year

3.1. The Board priorities for 2013-14 were set out in last year's Annual Report, and reflected the overall priorities of the WSAB and some key themes from partner agencies' priorities. This section will focus on activity on the Board's shared priorities and any additional action that had to be taken during the year.

3.2. General progress over the year has been varied with some priorities progressing more steadily than others. A change of senior lead manager at the Council caused some delay in work in the first part of the year, but having an interim manager with a more focussed role meant that good progress was made later. The role of the Business Support Officer has continued to be vital to the effective functioning of the Board and its sub-groups and she also provided the administrative support for the Serious Case Review. Sub-group and task group work is still sometimes affected by attendance problems.

3.3. A range of actions arising from the **Winterbourne View and Mid-Staffordshire Hospital** reports was included in the Board's 2013-14 Business Plan. Those relating to audit activity or the need to issue guidance were generally covered by national bodies' actions. The WSAB has been briefed about the local action plan that was required by the national improvement programme arising from Winterbourne View, and this, along with providers' development of their own responses, needs to be kept under review during this year.

3.4. It is good to be able to report that the **service user reference group** has been successfully established this year with the support of Wiltshire Service Users'

Network (WSUN). The group meets quarterly between the meetings of the WSAB so that it can both receive feedback about the issues discussed at the preceding Board meeting and also influence agenda items for the coming meeting. Attendance has developed over the year and includes a reasonable cross-section of service user experience.

3.5. The group has contributed a report in Section 6, and its impact so far has included a group member attending the WSAB to talk about their own family's experience of safeguarding. Another group member will be leading some discussions at the Board's development session in September 2014. It will be important to continue to put the time and attention into maintaining the work with the group and developing further its contribution to the work of the Board and safeguarding system.

3.6. The **involvement of informal carers** has taken longer to get off the ground, partly because of changes and developments at Wiltshire Carers. However, the Chair has now had an initial meeting with a group of carers and they are considering how they can best contribute to WSAB's work and safeguarding activity more generally, in a way that takes account of their complex lives.

3.7. Work to develop a **communications strategy** was slow in the first part of the year, but has now moved forward significantly. The intention was to work jointly with the Children's Safeguarding Board to support awareness raising and good information sharing across all Wiltshire's communities, linking with the Community Safety Partnership where relevant. The shared discussions have been useful in establishing a shared understanding of each Board's current position and needs, but has identified that these are sufficiently different at this stage that actions are better pursued individually. The WSAB now has a plan in place to pursue this work.

3.8. A **Serious Case Review** was carried out during the year, and reported to the Board in June 2014. The outcomes of this review are shown in section 4 below and the Executive Summary will be published on the Council's website when the resulting Action Plan has been agreed at the Board's meeting in September 2014.

3.9. The **new quality assurance reporting** structure has continued to be developed and it has now been agreed to adopt a framework based on the "Wiltshire web" used by the WSCB, using 5 key questions as the basis for the WSAB monitoring of performance. This will be informed by:

- Individual agency self-assessment audit
- Multi-agency "deep-dive" audit of individual cases
- A core dataset including data from the Council, NHS and Police
- Quarterly reports to the Board

3.10. It had been expected that the WSAB would contribute to the **Peer Review** that was being commissioned by Wiltshire Council. However, in the event, the focus of the review changed, and safeguarding was not included.

3.11. The development of the **Care Bill** was monitored through the year. Individual organisations and the Chair, through the network of independent chairs, have contributed comments about proposed amendments as appropriate. Following the Act receiving Royal Assent draft regulations and guidance were published for consultation between May and August. The main work of the Board will be in the coming year in response to the final requirements of the Act and its associated regulations.

4. Serious Case Review

4.1. The WSAB commissioned a Serious Case Review (SCR) a year ago that was independently chaired by Professor Hilary Brown, Emeritus Professor of Social Care, who has a strong academic and national policy background in safeguarding adults. The SCR concerned a small residential service for people with a dual diagnosis of learning disability and psychiatric disorder and was prompted by concerns about the quality of care offered to two individuals, one of whom died as a result of ill-health. Safeguarding enquiries about the two individuals led to a large scale investigation of the care home provider and a range of recommended changes to their practice and processes, which the provider co-operated to implement.

4.2. The WSAB policy and procedures are clear that the purpose of having a SCR is <u>not</u> to reinvestigate or apportion blame but to:

- Establish whether there are lessons to be learnt about the way that professionals and agencies work together to safeguard adults
- review the effectiveness of procedures
- inform and improve local inter-agency practice

This case met the criteria for a SCR because a vulnerable adult had died and there were concerns that possible neglect may have contributed to her health decline.

4.3. The broad finding of the SCR was that no one had acted from malice, nor had any service wilfully neglected the people in their care. No individual or service provider had acted so far outside the bounds of accepted practice as to warrant a finding of neglect or of causing significant harm. However a number of problems were identified:

- the way that the responsible health and social care agencies worked together to provide the appropriate care and support to the residents;
- lack of good practice in the care home that had needed earlier attention
- the home was not working to current national standards and knowledge in the care of people with dual diagnosis
- placing authorities were not always providing sufficient oversight

4.4. The report makes a wide range of recommendations which are relevant to national as well as local organisations and an action plan is being prepared at the moment for approval by the WSAB at its meeting in September. As far as the specific service

provider is concerned, the Council was informed in June that the service would be closing on 1st August 2014.

5. Monitoring and Quality Assurance Activity

General performance reporting

5.1. There is a detailed set of performance data at Appendix 3, taken from the current database. Some of the key issues that emerge from that data are:

- Varied performance across the expected service standards, with good performance on the timing of Triage and Adult Protection Investigations, acceptable performance on reviews (but needs improvement) and disappointing performance on the timing of Early Strategy Actions and Adult Protection Conferences. Work has begun with the relevant teams to identify the reasons for the under-performance.
- The average number of alerts per month has increased from 126 in 2012-13 to 193 in 2013-14. This is thought to be due to a combination of the full year impact of the formation of SAMCAT, greater reporting of individual cases by care agencies and a greater awareness of safeguarding adults issues in the wider community.
- The percentage of alerts that goes on to a full investigation has remained relatively static and much lower than the national and regional average. One reason for this is possibly that the triage system means we record a higher number of alerts but screen them rigorously. However, with a higher number of alerts, numbers of investigations have also therefore increased with 645 being started in 2013-14 compared with 403 in 2012-13.

5.2. During the year the South West region of the Association of Directors of Adult Social Services (ADASS) promoted the development of a set of core safeguarding adults performance indicators to create greater transparency of activity across the region and the possibility of benchmarking our performance against each other. This work was done by a group of safeguarding lead managers from and the proposed core set of indicators presented to each SAB in March. WSAB was supportive of this approach, but recognised the potential challenge of extending the approach to measuring outcomes.

5.3. Further developments in the Board's own performance monitoring arrangements are noted at 3.10 above.

Audit findings

5.4. Wiltshire Council undertook 59 case file audits during June and July 2013 and evidence of both positive and less good practice was identified from these. Not all auditors made comments that provided evidence in this way, so the following examples (number of cases shown in brackets) are illustrative rather than indicative of overall standards.

Positive	Less good
Clear recording (14)	Timescales not recorded (13)
Timescales met (10)	Problems with case recording (11)
Good best interests assessments and decision making (4)	Minutes of meetings not sufficiently detailed (5)
Good joint working (3)	Information slow from NHS (3)
Good involvement of the adult at risk (1)	Capacity issues not addressed (2)
	Poor involvement of adult at risk (2)

5.5. The audit provided the basis for feedback to the teams to maintain good practice or address areas for improvement. As noted at 3.10 above, it has now been agreed that case audits should be multi-agency rather than focussed solely on Wiltshire Council. This should give a more rounded picture of performance in safeguarding activity to complement the internal audits the Council will continue to carry out of its own safeguarding practice.

Large Scale Investigations

5.6. This type of investigation has continued to be a significant part of the work of the Safeguarding Adults and Mental Capacity Act Team (SAMCAT), which generally takes the lead in this type of case.

5.7. The following issues have been a constant theme in large scale investigations:

- Lack of adequate staff training and ineffective supervision arrangements.
- Person centred care – not always clear evidence that this underpins the care provided.
- Lack of evidence that care plans and medical recording are detailed enough.
- Inadequate risk management process in place that is not robust enough to prevent situations from reoccurring.
- A lack of understanding of the Mental Capacity Act and the requirement for Deprivation of Liberty Safeguards authorisations.
- A lack of understanding of the safeguarding process and when it is necessary to make a safeguarding alert.
- Lack of stability in the senior management of a care home or domiciliary provider.

We have been working very closely with colleagues in the Wiltshire Council commissioning team - as well as Health, the Police and CQC - to implement action plans with providers in order that the risks of institutional harm are addressed.

Risk register

5.8. The WSAB has continued to review its Risk Register at each meeting and amend it as necessary to reflect changing pressures

Monitoring regulated services

5.9. Regular meetings have continued between Wiltshire Council, NHS Wiltshire and the CQC to discuss a range of indicators of performance available to each of them. This helps the early identification of concerns to help prevent abuse from occurring or potentially escalating.

5.10. With the reorganisation of the NHS in April 2013, Quality Surveillance Groups (QSG) were established by NHS England at their area team level; for Wiltshire this is the team covering Bath, Gloucestershire, Swindon and Wiltshire. The distinct roles and responsibilities of different organisations in the system mean that no one organisation will have a complete picture of the quality of care being provided.

5.11. The QSG therefore brings together representatives from commissioners, regulators, training boards and Public Health at senior level in a forum for collaboration, providing the health economy with:

- a shared view of risks to quality through sharing intelligence;
- an early warning mechanism of risk about poor quality; and
- opportunities to coordinate actions to drive improvement, respecting statutory responsibilities of, and ongoing operational liaison between organisations

Training programme

5.12. Training is, as ever, an important part of ensuring quality services.

COURSE TITLE	TARGET GROUP	COURSES	ATTENDANCE
Social care induction programme – Common Induction Standard 6. Principles of safeguarding in health and social care	New social care workers in Wiltshire Council	4	91
Safeguarding awareness – e learning package; meets requirements of National Capability Framework for Safeguarding Adults (NCF) for staff group A - responsibility to contribute to safeguarding adults	Any role in public services in Wiltshire; also available to service users, carers & volunteers	-	1365
Staff group A (NCF) – responsibility to contribute to safeguarding adults	Direct care staff in registered/regulated services – independent sector	7	124
Staff group A (NCF) – responsibility to contribute to	Direct care staff in registered/regulated	12	191

safeguarding adults	services - council		
Staff group B (NCF) – Considerable professional & organisational responsibility for safeguarding adults	Managers and senior workers in registered/regulated services – independent sector & council	8	130
1 day course to get Investigating Officers up and running in the role	New Investigating Officers	3	37
3 day course covering adult protection legislation, procedures and processes including Achieving Best Evidence and report writing	Investigating Officers	2	26
Half day update & CPD session	Experienced Investigating Officers	1	20
1 day course to develop knowledge and skills in the Investigating Manager role	New Investigating Managers	1	8
Half day update & CPD session	Investigating Managers (also attended by Police, NHS & advocacy service)	3	56
WSAB Development Half day session – Board leadership capability self-assessment; learning from performance; capacity, risk and safeguarding.	WSAB members	1 session	14

5.13. The Learning and Development sub-group's priorities relate to the Business Plan objective but also to the ongoing need to ensure that appropriate training is available to and taken up by all relevant staff. The group also tries to ensure that learning is really reflected in practice.

6. Partner Reports

6.1. Wiltshire Probation Trust

Structure and approach to safeguarding adults work

The Director of Operations has responsibility for all safeguarding work and represents Wiltshire Probation Trust on the Wiltshire Safeguarding Adults Board. Two middle

managers hold the operational responsibility to ensure that safeguarding policies and practice standards are cascaded to all staff in the organisation. Wiltshire Probation Trust is committed to providing effective and individualised support to all vulnerable adults who come in contact with the Trust. Wiltshire Probation Trust considers a close working relationship with the LSAB is crucial to ensuring community confidence in the work carried out by the Trust and its partners.

The Trust works to ensure that service users, a proportion of whom would be assessed as vulnerable, receive equal access to services that will address their offending behaviour in the most effective manner. We also give support to the families of offenders, who may also be vulnerable adults. The Trust also has a responsibility to liaise with all victims of serious crime in cases where an offender received a prison sentence of at least 12 months. The Trust works directly with both perpetrators and victims of Domestic Abuse in close partnership with other relevant agencies.

Achievements in 2013-14

There are two main achievements to highlight this year, and case studies to illustrate the work are shown at Appendix 4.

Learning Disability Inspection

In January 2014, Her Majesty's inspectorate of Probation completed a thematic audit of Learning Disability at Wiltshire Probation Trust. This inspection involved meeting staff, relevant service users, and partner professionals as well as looking at case records. Although the formal findings have not been released, verbal feedback included:

- Inspectors were impressed with the professionalism and engagement of the staff they met.
- Overall the cases they audited were managed to a good standard when compared to other Trusts
- The use of mentors and health trainers to support work with offenders was commended and good examples of work being adapted to meet individual need evident
- Inspectors saw potential in the autism training and consultancy with SEQOL

There were clearly learning points as well, such as issues related to disability being identified but not always fully followed through and a lack of support for Offender Managers around this area of work. When the final report is published, a relevant action plan will be implemented to address these issues.

Autism Training and Champion

Swindon-based SEQOL was successful in winning a bid from the PCC[4] Innovation Fund, with the assistance of Wiltshire Probation. The model for this Project includes a two phase approach:

- A rolling programme of training for all Probation staff, volunteers and selected partner agencies who work directly with our Service Users; this includes basic

[4] Policy and Crime Commissioner

awareness training, and more specialised training such as working with women with autism and reception/admin training.
- Group supervision with SEQOL clinical experts, and Offender Managers/other staff around cases on the Autism Disorder Spectrum, lasting until August 2015.

An Autism Champion has been appointed, who will act as a liaison between SEQOL and Operational staff, also being available to offer advice and support. To date, the training has attracted positive feedback about both the training, and how it has made staff think more about Learning Disability. The PCC attended a session.

Training

Across the whole Trust (Swindon and Wiltshire) 90 staff in this organisation have received Adult Safeguarding training in the last 3 years. This represents about 65% of the relevant workforce; training has been targeted at operational staff and those who have direct contact with service users. Staff previously attended the training provided by Swindon and Wiltshire Councils. In the last 12 months, 47 staff have attended a half day Safeguarding Adults training sessions which covered - a Brief overview of Safeguarding Adults, Who is a Vulnerable Adult, Types of Abuse, Reporting Abuse and next steps to take. This training was specifically commissioned by Wiltshire Probation Trust to best meet the learning needs related to our area of work.

Key Plans and Objectives for 2014-15

1. The Transforming Rehabilitation Agenda has fundamentally changed how Probation services are delivered and since 2nd June has involved 2 organisations working with service users and other partners in the Wiltshire area (the National Probation Service and the West of England Community Rehabilitation Company.) The key challenge for the next 12 months will be to ensure good Adult Safeguarding practice and training is fully embedded in both organisations and that Partnership working remains effective.
2. Implement any recommendations from the Learning Disability Inspection.
3. Continue to ensure all new and current staff have access to relevant training (including refresher training)
4. Continue to support the victims of domestic violence through the work of the Partner Link worker and active contributions to other DV forums (ie MARAC, DV Disclosure Scheme)

6.2. NHS Wiltshire Clinical Commissioning Group

Structure and approach to safeguarding adults work

NHS Wiltshire CCG became a statutory organisation on 1st April 2013 replacing the PCT so this is NHS Wiltshire CCG's first partner report for Wiltshire Safeguarding Adults Board. Clinical Commissioning Groups are overseen by NHS England which has a role to ensure that Clinical Commissioning Groups have the capacity and capability to commission services successfully and to meet their financial responsibilities.

The vision of NHS Wiltshire CCG is "to ensure the provision of a health service which is high quality, effective, clinically led and local" while a focus on delivering care to people in their own homes or as close to home as possible is of paramount importance.

NHS Wiltshire CCG has clear governance and accountability arrangements that comply with the expectation of the national framework to demonstrate a clear line of accountability for safeguarding vulnerable people. The CCG Board is responsible for the overall safeguarding of vulnerable people for whom they commission services. The Chief Officer is accountable and responsible for ensuring the CCG's contributions to safeguarding and promoting the welfare of vulnerable people are discharged effectively and the Director of Quality and Patient Safety, as executive lead for safeguarding, shares this responsibility. They also ensure the CCG has management and accountability structures in accordance with statute, and national guidance for safeguarding.

The Associate Director Quality (Safeguarding Children and Adults) has strategic responsibility and represents the CCG on Wiltshire's Safeguarding Adults Board (WSAB). The Head of Safeguarding Adults and Mental Capacity Act lead is accountable to the Associate Director and represents the CCG on WSAB sub-groups and task groups. She works collaboratively across the health and social care economy.

Achievements in 2013-14

Quality & Performance

Safeguarding Adults is a standing agenda item on the NHS Wiltshire CCG Quality and Clinical Governance Committee. Quarterly reports to this committee provide detailed updates about health providers where concerns have been identified, anonymised updates on safeguarding investigations involving health funded service users, safeguarding themes and emerging concerns.

The CCG carries out a programme of announced and unannounced Quality Assurance Visits throughout the year. These visits are focussed on a number of key quality and patient safety issues, including adult safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards.

Safeguarding Adults activity is an agenda item at each quarterly Clinical Quality Review Meeting (CQRM) between the CCG and commissioned health providers and any outstanding concerns are addressed via the contract and performance meetings.

NHS Wiltshire Serious Incidents Requiring Investigation (SIRI) and Safeguarding

The NHS Wiltshire CCG Safeguarding Adults team sits within the organisation's quality team with established systems for alerting, appraisal and management of serious incidents. Serious Incident (SI) investigation reports arising from commissioned health providers are reviewed by NHS Wiltshire's Serious Incident Closure Committee. All incidents relating to Safeguarding Adults including category 3 and 4 pressure ulcers are reviewed by the Head of Adult Safeguarding.

During 13/14 The Safeguarding Adults and Mental Capacity Act Team (SAMCAT) manager and the NHS Wiltshire CCG Head of Safeguarding Adults have developed a proposed process to align NHS Wiltshire CCG serious incident processes with adult

safeguarding investigations. The process is also intended to 'close the loop' ensuring that action plans are completed and learning is shared across health and social care provider organisation and the wider health economy if appropriate.

Contracts

The CCG has a statutory responsibility to ensure that providers of commissioned services have adequate safeguarding structures in place. Its safeguarding team has strengthened its quality schedule and standard assurance framework to reduce the risk of duplication for providers who have contracts with multiple CCGs. This schedule is in all health provider contracts. A set of metrics has been developed with a reporting framework to facilitate performance monitoring.

Provider Development Meetings

The Head of Safeguarding Adults has regular meetings with provider leads to oversee and drive improvement in their safeguarding arrangements. These meetings take place on a bi monthly basis and are generally viewed positively as a support and challenge mechanism between provider and commissioner safeguarding leads.

Key plans and objectives for 2014-15

The main focus for NHS Wiltshire CCG in the coming year is to consolidate the work commenced in 2013/14. In addition to this the following areas of work are planned:

- To review capacity within the safeguarding team to enable the development of a training programme for primary care.
- To develop a programme to embed the Mental Capacity Act across the health economy in light of the Select Committee report.
- To work in partnership with Local Authority and health providers in relation to Deprivation of Liberty following the Cheshire West Judgment.
- To continue to support the development of a local authority quality team that will support care homes and providers. This project is funded through the Better Care Fund.
- The Director of Quality and Patient Safety is leading on the development of a Local Quality Surveillance Group which will work across health and social care.

6.3. Salisbury NHS Foundation Trust

Structure and Approach to safeguarding adults work

The Director of Nursing is the Executive Lead for both Safeguarding Adults at Risk and Children. Tracey Nutter was in post until the end of March 2014. Lorna Wilkinson has been appointed and will commence in August 2014. Fiona Hyett, Deputy Director of Nursing has operational responsibility for Safeguarding Adults, and represents the Trust on the WSAB.

Gill Cobham is the Safeguarding Adults at Risk/ MCA Lead Nurse and is a member of the Policy & Procedures Sub-Group. The Safeguarding Adults at Risk Lead Nurse has responsibility for supporting staff using the Safeguarding Policies & Procedures, increasing awareness of Safeguarding Adults within the Organisation and supporting

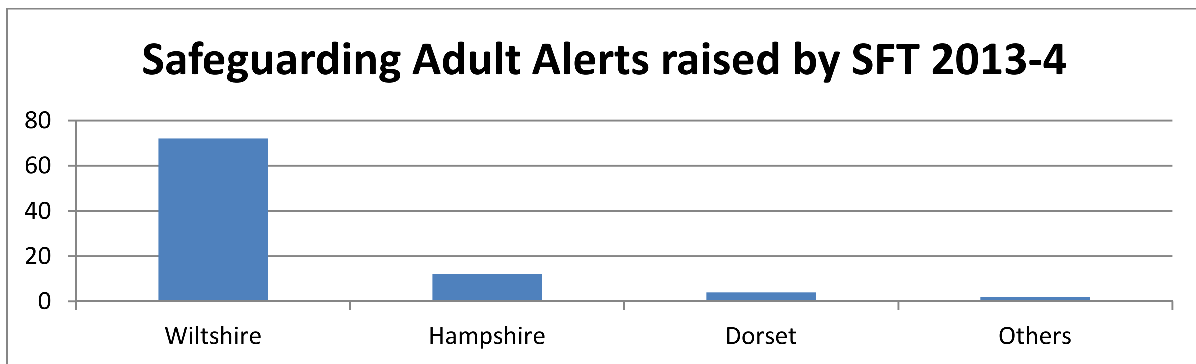
multi-agency working. The Named Nurse for Safeguarding Children and Safeguarding Adult Lead Nurse share attendance at the monthly Wiltshire MARACs

Assurance is through the Integrated Safeguarding Committee, Clinical Risk Group and Clinical Governance Committee.

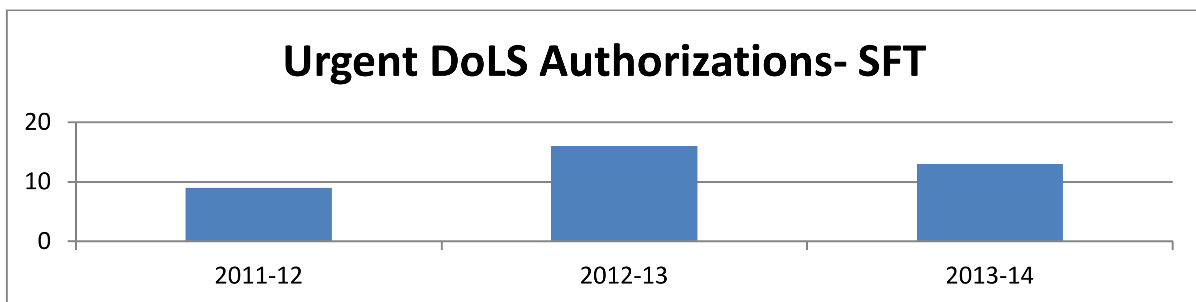
Achievements in 2013-14

The Integrated Safeguarding Committee was launched in November 2013. The Committee is chaired by the Director of Nursing, and the terms of reference include overseeing & monitoring the Safeguarding process within SFT, providing assurance to the Governance committees, clinical leadership and expertise, to inform service delivery and provide assurance and evidence in meeting core regulation.

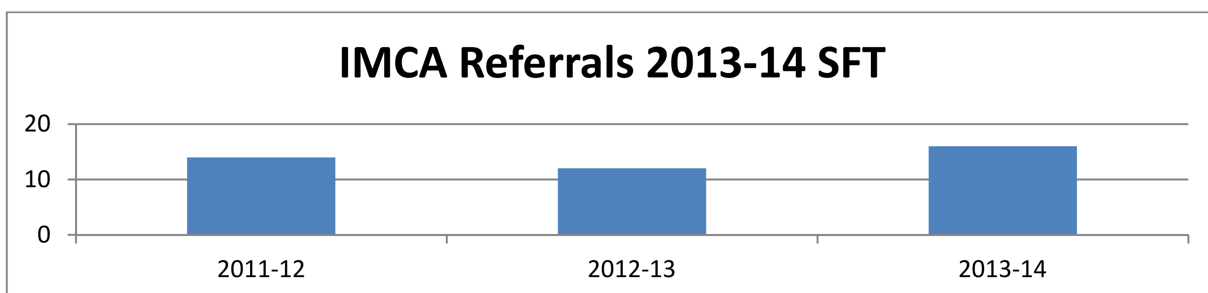
Awareness of Safeguarding continues to increase across the organization. In 2013-14 90 alerts were raised with Local Authorities, a 32% increase on 2012-13.



Deprivation of Liberty Authorizations dipped by 19% in 2013-14

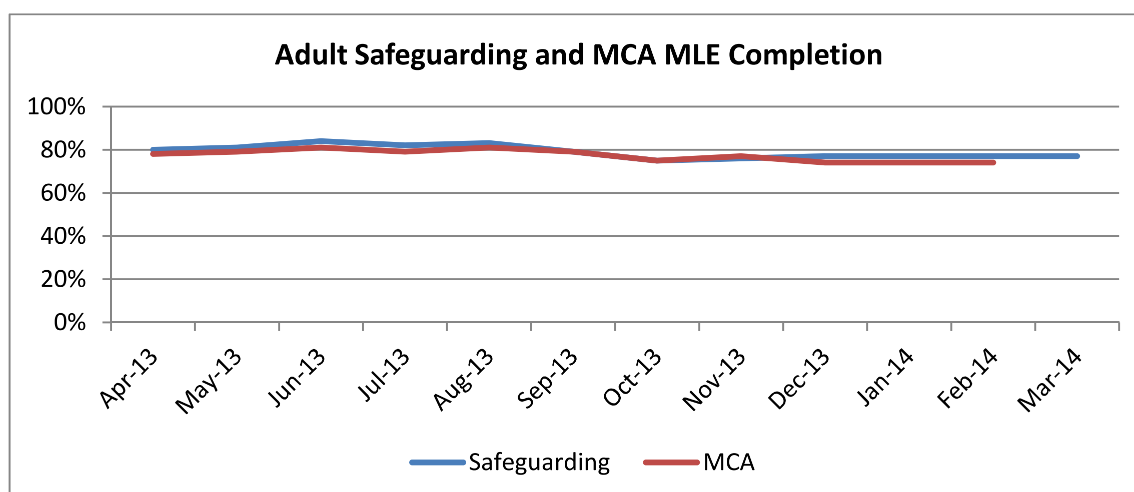


IMCA referrals increased by 25% in 2013-14



- The organisation continues to make progress with the SW Adult Safeguarding Quality and Performance Framework action plan, the Dementia Strategy and Learning Disability Work Plan.
- SFT supported the national LD Awareness week in 2013 with information stands in the main restaurant, and are now able to flag adults with an LD on our IT systems.
- Our LD Working Group now increased its membership to a patient user and Advocate from SWAN.
- There has been a continued fall in hospital acquired pressure ulcers in 2013-14, with a 30% decrease. All hospital acquired grade 3 and 4 pressure ulcers are subject to a root cause analysis and learning shared across the ward teams.
- Mental Capacity Act, Deprivation of Liberty and Safeguarding Adults at Risk polices have all been reviewed and updated.
- Weekly meetings are in place between Safeguarding Adult Lead Nurse and Hospital Social workers, to review all Safeguarding investigations related to in-patients.

Training during the year



In 2013-14, 474 staff completed Safeguarding Awareness training at Trust Induction. This covers Adult, Children and Domestic Abuse, and is delivered by either the Safeguarding Adults at Risk Lead Nurse or the Named Nurse for Safeguarding Children. An additional 57 Registered Nurses, Doctors and Therapy staff received ½ day MCA & DoLS training provided by an external trainer.

Key plans and objectives for 2014-15

- Review & further develop internal training programmes on Adult Safeguarding/ MCA and Domestic Abuse
- To access Junior Doctors training programme to provide Safeguarding & MCA training
- To develop a Safeguarding page in conjunction with Children's Safeguarding on Trust intranet

- To develop the role of a ‘Buddy’ to support adults with a Learning Disability during in-patient admissions

6.4. South Western Ambulance Services NHS Foundation Trust

Structure and approach to safeguarding adults work

South Western Ambulance Service NHS Foundation Trust (SWASFT) was formed on 1st February 2013 following the merger of the former Great Western Ambulance Service NHS Trust, which previously served the Wiltshire community, and South West Ambulance Service NHS Foundation Trust.

SWASFT is fully committed to the development of and contribution to the multi-agency Safeguarding Agenda. SWASFT is represented on the Wiltshire Safeguarding Adults Board by the Safeguarding Named Professional for the North sector of SWASFT.

SWASFT has a responsibility to safeguard adults in Wiltshire by acting as an alerter where there is a concern that there may be an adult at risk of abuse or neglect. Every contact with the Ambulance Service following a 999 call is an opportunity for assessment and ambulance clinicians are in a key position to raise concerns due to the nature of their work meaning that visits are never pre planned. From July 2013 - March 2014 148 referrals were made by SWASFT staff for adults in Wiltshire with 104 of these being adults aged over 65 (figures not available for March-June 2013).

Key Achievements in 2013/14

- Following organisational review new full-time post created and filled for a Safeguarding Named Professional for the North sector of SWASFT (covering Avon, Gloucestershire and Wiltshire). This provides a local contact for safeguarding within SWASFT for all other agencies and provides the Trust with a strategic lead for Safeguarding in the North sector of the Trust. The Named Professional also provides advice service for all staff who need to discuss their concerns before referral.
- Establishment of internal Safeguarding Operational Group with representation from Education, Risk, Clinical and Information Governance.
- Dementia awareness for frontline staff included on the statutory mandatory training for 2013-2014. This dementia module covered care and management of dementia patients, safeguarding awareness and issues as well as increased awareness of dignity and respect in terms of management of these patients.
- Feedback process implemented to ensure, where provided by social care, staff who have submitted safeguarding referrals receive feedback. This ensures any learning that needs to occur following feedback from social care can be reflected on and met and also provides closure for the referrer following their referral. This was not routinely done before due to capacity issues within the team.

Key plans and objectives for 2014/15

- Development of new referral form to make referral process clearer and more robust for operations staff. The form will include more sign posting for information

required and the form will be user friendly to ensure that staff can complete the referral in a timely fashion. The risk of radicalisation (Prevent) will also be included on the new forms as a cause for concern.
- Further expansion of the referral feedback process to ensure that there is continued reflective learning for staff to better ensure SWASFT referrals are of a good quality and include all relevant and required information.
- Module to be included on the statutory mandatory training for 2014-2015 to cover domestic abuse to include use of the DASH risk assessment, how to deal with a disclosure of domestic abuse, how to talk to victims alone safely and other domestic abuse learning and issues.
- Development of the workforce to include safeguarding champions within operational localities and clinical hubs.
- Development of intranet Safeguarding section to include signposting to contacts for staff (both social care and voluntary agencies), learning from SCRs, current issues on the national Safeguarding agenda and general advice and information.
- Development of a training programme for the Prevent agenda and a Prevent information base on the intranet to ensure staff have initial awareness of the Prevent strategy before they receive the HealthWRAP training.

6.5. Great Western Hospital NHS Foundation Trust

Structure and Approach to safeguarding adults work

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

Hilary Walker, Chief Nurse, is the Trust Executive lead for safeguarding and Rob Nicholls, the Deputy Chief Nurse is the operational Trust Lead for Safeguarding Adults at Risk and attends the WSAB. The Trust has invested in a Safeguarding Adults at Risk Team which include Safeguarding Adults at Risk Facilitator for the Acute Hospital site, Kat Hitch, who joined the Trust in January 2014 and Vanessa Taylor safeguarding lead who is currently the interim for Community Services post. The team also consists of administration support that is responsible for maintaining the associated safeguarding data bases.

The Acute Safeguarding Adults at Risk Facilitator attends WSAB Policy and Procedure Sub groups as well as attending a number of Trust Strategic and operational groups to ensure the Safeguarding Adults agenda is included.

The Trust has a multi-professional membership Joint Safeguarding Children and Adults Forum (SCAF) that meets bi-monthly.

Achievements in 2013-14

The major achievement of 2013-2014 for the Trust has been the implementation of a specialist, dedicated Safeguarding Adults at Risk Team to provide both support and guidance to trust staff re Safeguarding Adults, Mental Capacity Act and Deprivation of Liberty Safeguards and to support Trust development of policy, procedure and strategy.

A Learning Disability Peer Review with Gloucester NHS Foundation Trust was undertaken in March 2014. The event was a success and both Trusts gained useful learning to take forward. GWH as a result is currently evaluating the introduction of a champion role to the Trust.

Systems & Processes

The SCAF in 2014-2015 developed a joint Trust wide Safeguarding Performance Framework which includes a Safeguarding audit programme for Adults and Children and a safeguarding assurance dashboard. The Trust also has in place a Department of Health self assessment action plan.

The Trust has in place an up to date policy and procedure for Safeguarding Adults at Risk. The Trust Safeguarding Adult at Risk Team since being in post has identified further areas of development for the policy and procedure. This includes locally agreed procedures for serious incident reporting and safeguarding adults at risk which will be taken forward in the next year.

The Trust Safeguarding Adults at Risk Team has completed a revision of the Trust Mental Capacity Act Policy and Procedure to include appropriate assessment and recording tools compatible with the Mental Capacity Act 2005. The team has also commenced a programme to develop and embed staff knowledge and application of the Mental Capacity Act and Deprivation of Liberty Safeguards in the coming year.

Training during the year

In 2013-2014, 975 Trust staff completed face to face Safeguarding Adults, Mental Capacity & DoLS training as part of the Trust Induction programme. This accounts for 87% of all new starters.

2716 Trust Staff completed the Safeguarding Vulnerable Adults training online between 1st April 2013 and 31st March 2014 and 892 people completed the MCA & DoLS training online.

Moving into 2014-2015 the Safeguarding Adults at Risk team will work closely with the Trust's Academy trainers to develop the current Adults at Risk mandatory training programme and are developing systems to test knowledge including an overarching Safeguarding Adults audit programme (to audit Safeguarding Adults implementation of knowledge and processes, application of Mental Capacity Act and Deprivation of Liberty Safeguards.)

Key Plans and Objectives for 2014-15

- The Trust has Safeguarding Adults Peer Review with SEQOL planned for quarter 3
- The Trust will prioritise work streams to embed proper implementation of The Mental Capacity Act. This will include development of a Trust Mental Capacity Act and DoLS Assurance framework to support current national agenda re concerns re poor implementation and application of the Act.
- To integrate a Safeguarding Adults audit programme; to commence with a Directorate and Trust-wide service evaluation of Safeguarding, application of

Mental Capacity Act and Deprivation of Liberty Safeguards with further development of Audit programmes to support quality assurance.

- The Trust's Annual Safeguarding Forum is planned for July 2014 and has Mental Capacity Act as a theme with key speaker, Niall Fry from Department of Health confirmed.
- The Trust will continue to develop internal reporting and quality assurance processes and systems via the specialist Safeguarding Adults at Risk Team.
- The Trust will continue its commitment to the Safeguarding Adults agenda by continued development of training packages and systems which empower and support staff.

6.6. Wiltshire Police

Structure and approach to safeguarding adults work

The Wiltshire Police Safeguarding Adult Investigation Team (SAIT) consists of a Detective Sergeant, 6 investigators, a decision maker and an administrator and are specially trained investigators. The strategic lead for Safeguarding Adults is the Detective Superintendent of the Public Protection Department, Detective Superintendent Evely. Detective Inspector Paul Hacker has the operational lead for Safeguarding Adults

Achievements in 2013-14

Wiltshire Police received approximately 1272 referrals between April 2013 and April 2014. From these referrals, 555 investigations were commenced by the SAIT team, of which 174 were for alleged financial abuse. Financial abuse cases are often complex and involve dealing with fluctuating capacity in the alleged victim, powers of attorney and applications for production orders. The Safeguarding Adults Department are now referring the majority of their complex financial abuse investigations to the Wiltshire Police Complex Fraud Unit. A recent good example of this inter-force cooperation was the successful prosecution of a family member who had defrauded her mother of £150,000. The perpetrator received a three year sentence for this fraud

Prosecuting wilful ill-treatment/neglect is often a very difficult area to prosecute due to lack of witnesses/CCTV or any other corroboration.

The Safeguarding Adults team is trialling a decision maker role to review all referrals into SAIT. The decision maker is very experienced in safeguarding adults. In Wiltshire all early strategy meetings involving the Police will be held by telephone, with the decision maker taking part and then allocating any investigations to the team. This process is already freeing valuable time for investigators to get on with investigation. The investigators will attend all APR/APC. This process was identified as good practice by the Police vulnerable adult lead in the South West region, D/Superintendent Paul Northcott

SAIT is working closely with Wiltshire and Swindon Adult Social Care and Health to develop a 'deep dive' toolkit to evaluate multi-agency investigations. This will enable partners to work together to evaluate the standard of safeguarding investigations and check that we are keeping the adult at risk at the centre of our strategies and

investigations. The tool-kit is also being examined by Police Forces in the South West Region

Another area the Police, Adult Social Care and Health are currently researching is a vulnerable adult risk management panel. This panel will assess adults at risk who self neglect/self harm and who often fall outside safeguarding. The panel would involve key agencies such as Police, adult social care, health, housing, mental health, alcohol and drug agencies to share information and develop a risk management plan to coordinate our responses to adults at risk from self neglect and self harm

Officers on the Public Protection Department are omni-competent with regards to Safeguarding Adult cases.

Key Plans and Objectives for 2014-15

Wiltshire police will, in line with the policy and procedures for safeguarding vulnerable adults in Swindon and Wiltshire actively:

- work together within the agreed inter-agency framework based on the guidance contained in 'No Secrets' (2000 Department of Health, Home Office)
- work together within the agreed procedures, guidance and protocols underpinning this framework to investigate abuse and manage protection;
- promote the empowerment and well-being of vulnerable adults through the services we provide;
- support the rights of the individual to lead an independent life based on self determination and personal choice;
- promote an organisational culture within which all those who express concern will be treated seriously and will receive a positive response from management;

They will recognise:

- people who are unable to take their own decisions and/or protect themselves, their assets and their bodily integrity;
- that the right to self determination can involve risk and ensure such risk is recognised and understood by all concerned, and minimised whenever possible;
- the on-going duty of care to service users who perpetrate abuse and facilitate any necessary action to address abusive behaviour;

They will ensure:

- the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within all systems and legislation created to safeguard adults
- that when the right to an independent lifestyle and choice is at risk, the individual concerned receives appropriate advocacy, including advice, protection and support from relevant agencies;
- that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process and identify others who may be at risk of harm, including children, and effect immediate referral to the appropriate authority;

- ensure rigorous recruitment practices deter those who actively seek vulnerable people to exploit or abuse;
- ensure that all agencies working with vulnerable adults are familiar with this policy and the agreed procedures, guidance and protocols;
- ensure that confidentiality and information sharing related to protection of vulnerable adults and perpetrators of abuse in a multi-agency context are maintained with the agreed protocols; *and*
- ensure that all staff responsible for managing and conducting investigations within these procedures receive the appropriate training and support.

Their particular aims for the year will be:

- To prevent harm or further harm to both adult and child vulnerable victims.
- To bring the perpetrators of these crimes to justice.
- To prevent, where possible, perpetrators from re-offending.
- To ensure that all staff are appropriately trained and accredited to recognise and respond to Adult and Child safeguarding issues
- To strive to continuously improve systems, processes and people to provide a high quality service to the community and maintain and enhance the reputation of the Service.

6.7. Wiltshire Users Safeguarding Reference Group

Wiltshire Users Safeguarding Reference Group are hosted and facilitated by the Wiltshire and Swindon Users Network. We are made up of adult care service users with a range of perspectives—with physical and sensory impairment, mental health service users, older people and people with learning difficulties. WSUN supports service users to attend the meetings including travel costs, transport and personal care.

We meet regularly in between the Safeguarding Board Meetings and at each of our meetings Margaret Sheather, Chair of the Safeguarding Board reports on items discussed. Service users have an opportunity to comment on the any issues and raise concerns from their perspective.

A member of the group who had been involved in a safeguarding case on behalf of her mother, has spoken to Board Members about how it feels to go through the process, including the short and longer term effects on her mother, herself and the family. This included areas that need to be considered in the future and where improvements could be made.

Following on from this, it is planned that other meetings will take place where service users will speak at the main Safeguarding Board to take topics forward. We welcome the opportunity to give feedback to the Board and raise any issues that concern us as service users.

6.8. Wiltshire Council

Structure and Approach to safeguarding adults work

Maggie Rae, Corporate Director, is the safeguarding lead for Adults. On a day to day basis the Associate Director for Adult Care Commissioning, Safeguarding and Housing

provides strategic direction and the Head of Adult Safeguarding and Quality Assurance (a new post within the Council) takes on both operational responsibility for safeguarding functions and also supports the Board's work.

Councillor Keith Humphries, in his role as Cabinet Member for Public Health, Protection Services, Adult Care and Housing is the lead Member for adult safeguarding and a member of the Safeguarding Adults Board.

In Wiltshire's Business Plan 2013-17, one of the Council's three priorities is to 'protect those who are most vulnerable' and one of the 12 key actions for the coming four years is to continue to improve our safeguarding services to protect the most vulnerable in our communities." Currently the Council is the sole funder for the Safeguarding Adults Board and its sub groups.

Wiltshire Council wants to ensure that there are good links between Adults' and Children's Safeguarding. The Associate Director, Adult Care Commissioning, Safeguarding and Housing is a member of both Boards and we have adult service representation on the Prevention of Harm Sub Group, in addition to having a joint Communications and Publicity Task and Finish Group. The Chairs of the Safeguarding Adults Board, Safeguarding Children's Board, Children and Young Peoples Trust Board and Community Safety Partnership meet on a six monthly basis.

The Head of Adult Safeguarding chairs the Board's Quality Assurance Sub Group and has used the resources of the wider Council to review and update the Board's approach to quality assuring safeguarding across the whole partnership.

The Council's specialist Safeguarding Adults and Mental Capacity Act Team (SAMCAT) currently has a team manager, two professional leads (one for safeguarding and one for the Mental Capacity Act), three Level 4 Social Workers, four minute takers, a Deprivation of Liberty Safeguards (DoLS) Co-ordinator and a Business Support Officer (whose role is primarily to support the Safeguarding Adults Board).

SAMCAT has four principle functions:

- To 'triage' all new alerts coming into the Council, this being the route by which most safeguarding alerts are made
- To undertake individual investigations in circumstances where these cannot be carried out by operational teams
- To undertake large scale investigations, most of which relate to whole services such as care homes
- To offer advice and information on any matter pertaining to safeguarding or the DoLS to colleagues, providers, the third sector and - in some circumstances - members of the public

The bulk of individual safeguarding investigations are carried out by social work teams working in the fields of older people, disabled adults, learning disabilities and mental health.

Achievements in 2013-14

2013/14 has been a year when new arrangements have been consolidated and we have had an opportunity to review their effectiveness.

- The triage system has continued to be effective in ensuring that only those alerts that require further investigation are put through the safeguarding process.
- The number of investigations has greatly increased without an increase in the establishment of Council social workers, who carry out the majority of investigations. With this massive pressure on the system, the commitment of managers and staff has been a key factor in ensuring that vulnerable adults are protected. However, other high priority work has had to wait longer.
- SAMCAT has developed expertise in carrying out whole service investigations, of which there were 11 in 2013/14, compared with 16 in the previous year. There has been a large increase in incidents arising in services, particularly care homes where we are concerned about institutional abuse or neglect.
- Close working with the Council's commissioning and contracts functions ensures that effective action is taken to address safeguarding issues in care settings, including putting restrictions on new admissions to homes while we satisfy ourselves that action is being taken to resolve issues. As of 31 March 2014, there were restrictions in place in two homes. In addition, we have bi-monthly meetings with the Care Quality Commission to share knowledge and intelligence regarding areas of concern.

Both the last two activities ensure, through joint working, the safety of adults at risk in care homes that were failing to provide safe care. Other achievements during the year include:

- SAMCAT took part in the ADASS Making Safeguarding Personal initiative. Wiltshire has signed up to take this forward to the next stage by looking at embedding this way of working in the safeguarding process as a whole.
- Provision of PowerPoint presentations to a number of teams on the safeguarding process and the Mental Capacity Act.
- Strong participation in the induction of new council elected members.

During the latter part of the year the interim Head of Adult Safeguarding carried out a detailed review into the effectiveness of the Council's safeguarding function and how it will deal with future pressures on the service. Options are being considered by the senior team in the Department of Community Services and could lead to changes during 2014/15.

Training during the year

During 2013/14, staff in Wiltshire Council undertook a wide range of training in relation to safeguarding adults, organised and run by the Council's Organisational Development & Learning Service:

- 91 new social care workers covered Common Induction Standard 6 - Principles of safeguarding in health and social care as well as training on duty of care and mental capacity during the social care induction programme they attended

- 439 council staff completed an e learning module on safeguarding adults' awareness; 317 council staff completed an e learning module on Mental Capacity Act.
- 191 staff in direct care and support roles completed training on safeguarding adults in line with Group A requirements of the National Capability Framework for Safeguarding Adults (NCF)
- 8 managers and senior staff in council services regulated by CQC completed training in line with Group B requirements of the NCF
- 37 social workers and occupational therapists completed the foundation course for people who will become Investigating officers; 26 people completed the further 3 day Investigating Officer training
- 8 team managers, team leaders and level 4 social workers completed one day of training in the role of the Investigating Manager

Regular half day updates and CPD sessions were held by members of SAMCAT for Investigating Officers (20 people attended one session) and Investigating Managers (56 people attended 3 sessions).

Key plans and objectives for 2014-15

- A new Quality Assurance Team is being implemented in partnership with the NHS and is due to start in June 2014. The team has two year funding and will work with care services in order to ensure that the quality of services delivered to the people of Wiltshire does not fall below what they have the right to expect. While this will include services where there is safeguarding involvement, the team's remit is wider than and complementary to safeguarding, promoting good quality care that keeps people safe.
- We are recruiting a nurse who will be employed by the NHS and will work across the Quality Assurance Team and SAMCAT for a trial 12 month period, with the aim of improving the clinical input to safeguarding and quality assurance work undertaken by the Council.
- We are reviewing the staffing of the Court of Protection Team, which works with vulnerable adults who either cannot manage their own finances or who are being financially abused, in order to meet increasing demand.
- We are in discussions with the Police and other partners about extending the Multi-agency Safeguarding Hub (MASH) service to work with adults as well as children. This would change the way in which safeguarding alerts are 'triaged' at the initial stage of the process.
- We are updating key parts of the safeguarding guidance in relation to large scale investigations, thresholds guidance and how NHS and Council systems can work in a coordinated way where both agencies are involved.
- We intend to improve safeguarding processes including greater use of technology to reduce the need for face to face meetings, minute taking and more structured agendas and minutes.
- We are considering how the specialist safeguarding function should develop as part of a wider consideration of the role of social workers in Wiltshire.

- We are expanding our involvement in the national Making Safeguarding Personal programme with the aim of fully embedding this approach as the way we work with people who are subjects of safeguarding investigations.

6.9. Royal United Hospital Bath NHS Trust

Structure and approach to safeguarding adults work

The Director of Nursing is the Executive Lead for Adult Safeguarding within the Royal United Hospital, supported by the Deputy Director of Nursing. There is strong leadership around adult safeguarding issues provided by the Senior Nurses for Adult Safeguarding, who support clinical staff raising concerns and making safeguarding integral to care.

Assurance about matters relating to adult safeguarding, Mental Capacity and Deprivation of Liberty Safeguards is provided to the Trust Board by the Safeguarding Adults Forum via the Operational Governance route. The Safeguarding Adults Forum is a multi-agency forum chaired by the Deputy Director of Nursing. Membership includes:

- Operational lead, Matron for Critical Care Services
- Medical Lead, Consultant Geriatrician
- Senior Nurse Adult Safeguarding
- Sister for Quality Improvement for Mental Health & Learning Disability
- Senior Nurse for Quality Improvement & Adults at Risk
- Lead for Quality Assurance
- Representatives from Social Services

The Royal United Hospital continues to play an active role within the Wiltshire Safeguarding Adults Board with Executive representation from either the Director of Nursing or the Deputy Director of Nursing. There is RUH representation at the Quality Assurance sub group, which is attended by one of the Senior Nurses for Adult Safeguarding.

Over the past 5 years there has been a consistent rise in the number of alerts made to the safeguarding leads. A total of 300 safeguarding alerts have been raised by the Royal United Hospital April 2013- March 2014, of which 166 were regarding patients in Wiltshire. During this period a total of 56 Deprivation of Liberty Safeguards urgent authorisations were sought, of which 29 were for patients from Wiltshire.

Achievements in 2013-14

The RUH is constantly working to improve the adult safeguarding service that it delivers. Achievements during 2013-14 have been:

- Development of links with the RUH's newly appointed Named Nurse for Child Protection.
- Recruitment of a Senior Nurse for Adult Safeguarding who took up post in September 2013, and a team administrator who started in December 2013.
- The Trust has continued to seek to improve its delivery of safeguarding in practice, with revision of the policy and guidance to staff and a change of referral process.

- Awareness of adult abuse and protection continues to increase across the organisation.
- Figures for staff with safeguarding training were significantly improved over last year's figures
- Successfully run "Deprivation of Liberty Safeguards" (DoLS) workshops for senior staff.
- Following CQC inspection in December 2013, the RUH is compliant with outcomes
- Successfully aligned the Serious Incident and Datix incident reporting systems with the safeguarding process.

Training

Subject	% compliance	All staff or selected
Safeguarding Adults RUH level 1	83.5%	All Staff
Safeguarding Adults RUH level 2	54.9%	Clinical staff

Key Plans and Objectives for 2014-2015

- Continue to raise awareness
- Continue to improve on training targets
- To continue to contribute to the work of the LSAB and its sub-groups
- Develop Adult Safeguarding quality dashboard
- Development of the Matrons' role within the safeguarding arena
- To launch and monitor implementation of Deprivation of Liberty Safeguards in line with the new guidance following the Cheshire West judgment.

6.10. Wiltshire Fire and Rescue Service

Structure and approach to safeguarding adults work

Safeguarding issues will usually be initially identified by responding fire crew personnel during or post incident. Any concerns regarding general welfare of the individual/family but especially vulnerability to fire will then be promptly reported to Fire Control who will forward this information onto the senior duty manager (24hrs, 7 days a week). The duty manager will risk assess the information and will either ensure a visit is made immediately if concerns are high, or within 24/48 hours if deemed appropriate.

Safeguarding policies and procedures have been introduced and are available for all personnel.

The Fire Service lead on safeguarding is taken by Barbara Owen, Service Manager, and John Popowicz, Area Manager, Service Delivery. The service is represented on the WSAB by Damien Bence, Station Manager – Prevention.

In addition to these leadership roles, the service takes part in other group and sub group attendance, for example, Yasmine Ellis (Schools & young person's education

manager) will be the information guardian for junior fire setters, and takes part in the Wiltshire Children Safeguarding Group.

The role of Nicola Cocks, Jackie Tozer, Bob Tabel & Martyn Jones as Incident Reduction Managers includes follow up visits to identified properties to ascertain the levels of risk and what other agencies should be involved. They will also manage, sift and prioritise the referrals. They will be the information guardians for the above.

Achievements in 2013-14

We have commenced and completed safeguarding training for the majority of operational and non operational staff across Wiltshire which has ensured that these staff now have sufficient knowledge and understanding in identifying and referring safeguarding concerns. This training has already led to several safeguarding issues being identified and actioned from within the Service.

New and more effective methods for reporting, recording and monitoring safeguarding concerns are currently being discussed, the conclusions of which will be added to this report at a later date.

Training during the year

The vast majority of operational and non operational staff (487 staff members, 81% of total operational staff) across Wiltshire & Swindon have now received base level training in safeguarding, which covers both children and vulnerable adults. The contents of the training include:

- Understand the key developments in legislation and awareness that have led to the current obligations for safeguarding and promoting the welfare of children and vulnerable adults
- Understand the use of the terms safeguarding, protection and vulnerable in context
- Be able to recognise the potential signs and symptoms of abuse and triggers for concern and where to go for advice about concerns.
- Understand WFRS and local safeguarding board procedures for protecting children and vulnerable adults
- Understand WFRS policy with regard to allegations made against service personnel
- Recognise and understand their own role and responsibility with regard to safeguarding and protecting the welfare of children and vulnerable adults
- Recognise appropriate and unacceptable conduct with regard to working with children, families and vulnerable adults and ways to safeguard themselves in difficult situations.
- Identify own next steps in understanding or conduct that will improve work in safeguarding and promoting the welfare of children and vulnerable adults

Key plans and objectives for 2014-15

- Completion of training for remainder of operational staff
- Revise reporting procedures to ensure a totally robust and effective system is implemented
- Joint working with Police and other partners, ie MASH

6.11. Wiltshire Care Partnership

The Wiltshire Care Partnership (WCP) was established in 2013 as a joint initiative between commissioners and independent providers of residential and nursing home care for older people. It is a member-led organisation which represents and supports care providers and works alongside commissioners to ensure the provision of high quality, safe services to older people in the county now and in the future. It is funded through its members with support from Wiltshire Council.

Following its inaugural AGM in late 2013, WCP appointed its first Chief Executive Officer, Lesley Frazer, in January 2014. WCP now has 54% of independent care homes for older people in membership, making it the largest single representative body for independent care providers ever established in the county. A range of services have been developed for its members, to enable more effective communication and promote best practice. These include a regular Members' Forum, monthly e-bulletin and workshops on key topics.

The Partnership offers a valuable opportunity for commissioners and providers of care to work together jointly to address the challenges of meeting the needs of older people. Both its Chief Executive Officer and Chair sit on a number of important boards and working groups within both Wiltshire Council and Wiltshire Clinical Commissioning Group, including the Wiltshire Safeguarding Adults Board. This sharing of intelligence, ideas and expertise allows effective use to be made of resources across the whole system in order to achieve the best outcomes for older people.

The Wiltshire Care Partnership's agreed absolute priority is to support and lead all service providers in driving the delivery of quality safe care, underpinned by the 'My Home Life' principles and standards.

6.12. Avon and Wiltshire Partnership NHS Trust

Structure and approach to safeguarding adults work

Avon and Wiltshire Mental Health Partnership NHS Trust is a specialist mental health NHS provider delivering a wide range of primary and secondary services across the geographical areas of Wiltshire, Swindon, South Gloucestershire, Bristol, North Somerset and Bath and North East Somerset and tertiary services on a regional level.

The Trust has an executive director lead (Director of Nursing and Quality) and a Head of Safeguarding with corporate management responsibility for both adult and children's safeguarding. Within Wiltshire the Clinical Director as the accountable senior manager holds responsibility for the delivery and development of safeguarding practice. The Clinical Director sits as the trust member of both the adult and children's safeguarding board. There is also a senior operational manager with a lead role for safeguarding.

Safeguarding is a standing agenda item at the monthly locality governance meeting with feedback from the board as required. Localities provide a report to the Trust on a rolling monthly basis (i.e. each area approximately 9 monthly) on safeguarding children, including assurance and performance reporting, and referencing any service and action plans in regard to safeguarding, as well as setting out challenges to safeguarding in the locality.

An annual safeguarding report from the Head of Safeguarding/Named professionals/Executive Lead is made to the Board annually.

The Trust has a Safeguarding Management Group that meets bi-monthly and reports to the Trust Executive team and Board with key partners including local and corporate leads, professional leads and service user representation. The Wiltshire Clinical Director is the clinical director representative for this group.

The head of safeguarding, Mark Dean and professional lead for adults, Fran McGarrigle both participate in the policy and procedures subgroup of the board and Paul Maddock, senior community services manager participates in the quality assurance subgroup.

Achievements in 2013-14

The Wiltshire locality's focus over the last financial year has been on building strong and effective reporting and monitoring systems within the core service areas. The supervision and governance processes have been revised to ensure a clear focus on safeguarding and staff awareness of escalation procedures. Quality assurance processes have been developed and are now in place with monthly reporting to the locality governance meeting.

The WSAB's reporting data shows an increase in reporting from mental health staff but there is further work to be done to ensure that we have a clear understanding of which staff groups are involved.

A particular focus of development work has been the MARAC and MAPPA processes with dedicated posts identified to manage this. AWP made 6 referrals in the year, and provided information in relation to 33 cases known to us.

Training during the year

In house training is provided for L1 and L2 safeguarding through learning and development. Re Level 2 Safeguarding adult training, the figures for April 2014 were 366 staff trained (78%) with a new additional e-learning course being introduced in Q1 2014/2015 to improve this rate further.

Multi agency training such as Safeguarding Adults Investigating Officer training was accessed from Wiltshire County Council.

Key plans and objectives for 2014-15

During the coming year we will be working to embed the new processes and ensure that they are robust and sustainable. As our data improves we will work with our partner organisations and the board to understand practice and identify areas for further improvement. Action plans are in place to increase the number of staff trained with in safeguarding and to monitor the alerts made and the actions resulting from them.

6.13. NHS England

Structure and Approach to Safeguarding Adults Work

NHS England is an executive non-departmental public body. It works under its Mandate from the Government to improve the quality of NHS care and health outcomes, reduce

health inequalities, empower patients and the public and promote innovation. Its key responsibilities include:

- Authorisation and oversight of CCGs and support for their on-going development
- The direct commissioning of primary care, specialised health services, prison healthcare and some public health services (including, for a transitional period, health visiting and family nurse partnerships)
- Developing and sustaining effective partnerships across the health and care system.

NHS England has a single operating model and is largely organised into three functional areas, i.e. nationally, regionally and locally. Its Safeguarding Policy is due for publication July 2014 and will provide guidance on the expectation of its entire staff in relation to Safeguarding. There is senior clinical leadership at all levels, including those with responsibility and expertise in safeguarding. The NHS England Local Area Team will each have a Director of Nursing who is responsible for supporting and providing assurance on the safeguarding of children and adults at risk of abuse or neglect. The Area Team has responsibility to ensure that the assurance of the safeguarding system is working across Primary Care and CCGs.

Key Plans and Objectives for 2014-15

For 2014/15, NHS England Bath, Gloucestershire Swindon & Wiltshire Area Team will be focusing on gaining assurance on safeguarding competencies across all staff groups within Primary Care, ensuring information and resources are available for staff to achieve the appropriate level of competence for their role. A system for providing salient Safeguarding updates across Primary Care and embedding lessons learnt in practice across the whole range of vulnerable adult groups will be implemented.

In November 2013, NHS England was required to give evidence at the House of Lords inquiry into the implementation of the Mental Capacity Act 2005(MCA). While gathering evidence for the inquiry, NHS England found a number of emerging themes relating to inconsistent application of the Act including training, patient/family and carer experience and access to advocacy. The findings of this inquiry have been published
http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/13902.htm

In anticipation of this report NHS England BGSW Area Team submitted a bid for a MCA/DoLS (Deprivation of Liberty) project that was approved and implemented.

The intended outcomes are:

- To arrange patient/carer experience events to ascertain real time feedback;
- To identify with CCG colleagues, provider organisations and local authority partners specific local requirements and consider short term secondments/pump prime initiatives; and

- To establish a development programme for MCA leaders across the system to understand their local issues and explore best practice.

The project started in April 2014 and will be reporting findings in September 2014. Following the report the Area Team will develop and implement an action plan based on the findings.

6.14. Community Safety – Domestic Abuse

Structure and approach to safeguarding adults work

The overarching governance for Domestic Abuse (DA) reduction is with the Wiltshire Community Safety Partnership. It has identified Domestic Abuse as a priority area in the Partnership Strategic Assessment. The responsibility for the delivery and implementation of the DA Strategy and Implementation Plan rests with the established multi agency Domestic Abuse Reduction Group (DARG). The DARG is chaired by the Public Protection Manager for the Safer Communities Team, who also manages the Domestic Abuse Reduction Co-ordinator and the Multi Agency Risk Assessment Conference (MARAC) Co-ordinator and attends the LSAB meetings.

Domestic Abuse (DA) is often referred to as a 'hidden crime' that will go unreported with many victims living with domestic violence and abuse on a day-to-day basis and having to deal with the effects for many years.

Achievements in 2013-14

Volume

The volume of Domestic Abuse (DA) incidents being reported to Police and Specialist Support Services has continued to increase over 2013/14 and DA related crime had increased compared to 2012/13 by 31% (n.436). Total number of referrals in 2013/14 to the Independent Domestic Violence Advisory (IDVA) service supporting high risk victims was 374, an increase of 63% (n.234) compared to the previous year. There were 684 referrals received to the service in 2013/14, 559 to the Paloma Outreach service (standard to medium risk victims), an increase of 47% (n.218 further referrals) and 125 to group work.

As domestic abuse is widely recognised to be significantly under reported, an increase in incidents reported and referrals into support services is a positive measure.

Safeguarding arrangements

Since the introduction in 2007 of the MARAC (Multi-Agency Risk Assessment Conference) referrals have increased steadily as agencies have embraced the process and embedded the safeguarding arrangements into their business. In 2013/14 there were 475 high risk cases referred to the MARAC in Wiltshire, and increase due to widening the referral route, and the rolling training programme.

Domestic Homicide Reviews

During 2013/14, Wiltshire has undertaken four Domestic Homicide Reviews. Two of these have been approved by the Home Office Quality Assurance panel and the

Executive Summaries have been published. The remaining two DHRs are pending sign off and submission to the Home Office.

Following these tragic homicides, Wiltshire Council commissioned a 12 month campaign for raising awareness of domestic abuse. This was launched in September 2013, with a 'Walk in White' through Trowbridge and has continued with a radio campaign, exhibition at County Hall, phone-in for young people on healthy relationships and a DA HR policy.

In March 2014 the Domestic Violence Protection Notice/Orders (DVPN/O) and the Domestic Violence Disclosure Schemes (DVDS), schemes were both rolled out nationally. Both schemes had been piloted in Wiltshire and are an additional tool in the box to help safeguard victims and their families.

In 2013/14, there were 53 DVPN applications, 44 resulted in a DVPO being granted. The majority of the orders were made for the maximum 28 day period supporting prohibiting conditions. Over the same reporting period there were 84 applications received in Wiltshire for the DVDS, of which 21 resulted in a disclosure being made. The majority of applications received were from professionals under the 'right to know' route.

Training during the year

348 frontline professionals have attended and completed the multi-agency training programmes for domestic abuse awareness and recognition and MARAC risk assessment and referral pathway in 2013/14. Participation has been across a wide range of agencies.

Key plans and objectives

- Refresh of the Pan-County Domestic Abuse Strategy.
- Launch of the Local Authority DA HR Policy and manager training.
- Awareness raising and a plan of events for Domestic Abuse Awareness Week in November including a conference.
- In 2014/15, a further commitment from key partners (Police, Local Authority – Public Health, C&F and ASC) to invest into the Wiltshire Domestic Abuse Pooled budget, which funds the Wiltshire Outreach support service to victims of domestic abuse (standard to medium risk).
- Currently in year four of the Home Office funding grant which Wiltshire successfully secured to support the Independent Domestic Violence Advisor (IDVA) provision – supporting high risk victims (£20k p/a) and the MARAC (Multi-Agency Risk Assessment Conference) Co-ordinator role (£15k p/a)
- Review of the Hidden Harm agenda has identified domestic abuse as a key area and proposals are currently being considered.
- The decision has been taken to commission a further Domestic Homicide Review, following a domestic-related death in April '14.

7. Local responses to national developments

7.1. The main national development has been the progress of the Care Bill through parliament to become law in May 2014. There was little direct activity needed by the Board during this time, and the main actions will come in this current year as regulations and guidance are issued in their final form later in the year. The Act puts a number of arrangements that already exist in most local authority areas on a firm statutory footing:

- The requirement to make enquiries where an adult with care and support needs is experiencing or at risk of abuse or neglect and is unable to protect themselves against it
- Local Authorities to establish a Safeguarding Adults Board in its area to help and protect such adults through co-ordinating and ensuring the effectiveness of each of the Board members' actions.
- The need to carry out a Safeguarding Adults Review (currently called a Serious Case Review) in specified circumstances in relation to the death or serious harm of an adult.
- The production of a strategic plan and annual report, and specifies that the latter must be sent to the Chief Executive of the local authority, the local policing body, the Chair of the local Healthwatch and the Chair of the Health and Wellbeing Board.

7.2. The Act also sets out the minimum required membership of a SAB and gives discretion about wider membership. It gives permission for the resourcing of the Board to be shared rather than requiring that to be the case, but does set out requirements for information sharing between partner agencies to enable the Board to carry out its functions.

7.3. Beyond that, national publications have generally been focussed on specific areas for development, which offer helpful guidance to the Board and its partners for local work. Among these have been:

- LGA (March 2013), *Councillors Briefing: safeguarding adults 2013*
- ADASS and LGA (May 2013), *Adult Safeguarding and Domestic Abuse – a guide to support practitioners and managers*
- ADASS and LGA (July 2013), *Making Effective use of Data and Information to Improve Safety and Quality in Adult Safeguarding*
- CQC (January 2014), *Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012-13*
- DH (March 2014), *Deprivation of Liberty Safeguarding, Judgement of the Supreme Court*
- SCIE (April 2014), *Adult safeguarding for housing staff*
- CQC, ADASS, LGA, NHS and ACPO (May 2014), *Safeguarding adults – roles and responsibilities in health and care services.*

7.4. The issue of the use of the Mental Capacity Act and Deprivation of Liberty safeguards (DoLS) has taken on a new focus at the end of the year (see DH letter above) following a Supreme Court case that substantially lowered the threshold at

which a DoLS assessment is required. This has led to a significantly increased workload already, with the potential to continue on this pattern throughout the year. The resources available for this task will need to be reviewed, and ADASS has issued an advice note to all local authorities about the implications of this decision.

7.5. Another national development throughout the year has been the *Making Safeguarding Personal* initiative. This is a programme led by the Local Government Association (LGA) safeguarding adults programme and by the Association of Directors of Adult Social Services (ADASS) and is motivated by the need to understand what works well in supporting adults at risk of harm and abuse, beyond the investigative processes that have now become familiar.

7.6. The key focus is on developing and / or re-establishing the skills for all staff involved in safeguarding to gain a real understanding through conversation with people at risk of harm about what they wish to achieve. Those desired outcomes then need to be recorded as a key reference point for safeguarding action, and for reviewing how effectively they have been realised. All councils were invited to join this programme at one of three levels, depending on the scale of the development they wanted to pursue (gold, silver or bronze). Wiltshire joined at silver level and will be continuing with the programme as it moves into its second year.

7.7. Very positive results were reported at the end of last year's trial with adults at risk who were able to express their feelings all providing positive feedback about the outcome focused safeguarding process, saying that they felt their concerns had been addressed fully. The ongoing initiative aims to encourage practice that puts the person more in control and generates a more person centred set of responses and outcomes. In this way the outcomes focus is integral to practice and the recording of practice in turn generates information about outcomes. By entering at the silver level Wiltshire Council has demonstrated a wish to develop social work and other responses to enhance this experience including enabling responses that reduce risk of abuse.

8. Priorities for the year 2014 - 15

As ever, these priorities need to reflect national developments and local objectives. The Board's Business Plan, which can be found in full at Appendix 5 integrates these broad priorities with other continuing work and sets out timescales and lead responsibility for implementation. An innovation this year is the addition of the more detailed outcomes that we hope to achieve through the various actions in the Business Plan, which will add a further dimension to our performance assessment.

Overall Priorities

- ❖ Take all the action necessary to implement the requirements of the Care Act 2014 in relation to safeguarding and any other relevant aspects of the Act.
- ❖ Develop and start to implement the Action Plan arising from the Serious Case Review

- ❖ Implement the agreed quality assurance and performance management system for the Board
- ❖ Investigate in more detail the reasons for the increased numbers of alerts and referrals.
- ❖ Maintain the existing work with the Service User Reference Group and continue to develop its role in the work of the Board and safeguarding system
- ❖ Develop the initial contact with Carers to enable them to be appropriately involved in the work of the Board and safeguarding system.
- ❖ Implement the agreed communications strategy to support awareness raising and good information sharing across all Wiltshire’s communities; update web-based information to support this.
- ❖ Develop the Board’s preventative activity through a task and finish group to establish whether/ how people at risk of harm can be identified and appropriate intervention offered.
- ❖ Investigate in more detail the reasons for the increased numbers of alerts and referrals.

Appendix 1

WILTSHIRE SAFEGUARDING ADULTS BOARD

TERMS OF REFERENCE

1. Statement of Purpose

The purpose of the Wiltshire Safeguarding Adults Board (WSAB) is to ensure that all agencies work together to minimise the risk of abuse to adults at risk of harm and to protect and empower vulnerable adults effectively when abuse has occurred or may have occurred. The WSAB aims to fulfil its purpose by:

- Maintaining and developing inter-agency frameworks for safeguarding adults in Wiltshire, including determining policy, facilitating joint training and raising public awareness.
- Co-ordinating the safeguarding adults work undertaken by those organisations represented on the WSAB and monitoring and reviewing the quality of services relating to safeguarding adults in Wiltshire.

In doing this the Board will follow all relevant legislation and guidance[5].

2. Underpinning Principles

The Board will achieve its role by implementing the national principles of adult safeguarding[6], which are:

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

In addition, the WSAB:

[5] A list of current guidance at the time of this revision is at Appendix 1
[6] Statement of Government Policy on Adult Safeguarding; DH, May 2011.

- Supports the rights of all adults to equality of opportunity, to retain their independence, wellbeing and choice and to be able to live their lives free from abuse, neglect and discrimination.
- Values diversity and will seek to promote equal access and equal opportunities irrespective of race, culture, sex, sexual orientation, disability, age, religion or belief, marriage/ civil partnership and pregnancy /maternity.

3. Policy Statement

The WSAB will act within the framework of the law, statutory guidance and government advice. The prime consideration of the WSAB will be to oversee multi-agency responsibilities in line with the requirements of "No Secrets: guidance on developing and implementing multi-agency policy and procedures to protect vulnerable adults from above" (DH/ Home Office, 2000) and current national policy, national and regional guidance and best practice.

4. Membership and Chair

The membership of the WSAB consists of senior representatives from key organisations in Wiltshire, who must be of sufficient seniority and authority to speak on behalf of their organisation and commit resources or directly feed into decision-making that can commit resources as appropriate. Representatives of wider groups (independent providers, service users and carers) must have access to appropriate networks to communicate information to and from the Board.

Wiltshire Council	• Cabinet Member • Associate Director, Adult Care Commissioning, Safeguarding & Housing • Head of Service, Safeguarding and Quality Assurance
CCG Wiltshire	• Associate Director of Quality, Safeguarding Adults & Children
NHS England	• Patient Experience Manager
Avon and Wiltshire Mental Health Partnership NHS Trust	• Clinical Director, Wiltshire
Salisbury Hospital NHS Foundation Trust	• Deputy Director of Nursing
Royal United Hospital Bath	• Associate director of Nursing, Quality & Patient Safety
Great Western Hospital Foundation NHS Trust	• Deputy Chief Nurse
NHS Community Services	• Via GWH Representative
Wiltshire Police	• Head of Public Protection Department
Residential and Nursing Care Provider Representative	• As nominated
South Western Ambulance Service NHS Foundation Trust	• Safeguarding Manager

Wiltshire Fire & Rescue Service	• Station Commander
National Probation Service	• Assistant Chief Officer
Community Rehabilitation Company	• Assistant Chief Officer
Healthwatch Wiltshire (Joined June 2014)	• Chief Executive
Care Quality Commission (CQC)	• Compliance Manager - Annual attendance
Domiciliary Care Provider Representative	• As nominated
Carer Representation	• Under development
Service User Representation	• Through the Reference Group
Community Safety Partnership	• Head of Public Protection

During the last year arrangements for the views of service users to be effectively represented in the Board's work have progressed through the establishment of a Service User Reference Group, with the support of WSUN. The effectiveness of this approach needs to be kept under review. Efforts continue, through Carers in Wiltshire, to establish arrangements for a similar voice for Carers.

The Compliance Manager from the Care Quality Commission attends annually and the Wiltshire Council Corporate Director is an associate member, receiving all papers and attending as appropriate.

The Board is linked to the Local Safeguarding Children Board by the Head of Commissioning membership of that board and a representative from the LSCB is being sought for the SAB.

Other organisational representatives or specialist leads may be invited for reports of specific interest to them.

Chair

The Chair of the Partnership is an independent person appointed for a three year term through procurement by Wiltshire Council.

The Deputy Chair is appointed by the Board from nominations from Board members.

5. Meetings and Structure

The WSAB will meet not less than four times a year, with additional meetings as necessary. It will set time aside each year for a half day workshop to review its achievements, assess performance and effectiveness and consider future priorities.

- The quorum for meetings is that there should be at least three members present from three different agencies. OR will be one third of the usual membership providing the Council, one of the health partners and one other partner organisation is represented.

- Lack of attendance will hinder the strategic development of the inter-agency arrangements for safeguarding adults. For this reason Board members are expected to attend two out of the four main meetings; substitutions are permissible, but should be by named, regular substitutes. A register of attendance is kept and will form part of the Annual Report.

Sub-groups

The Board has three standing sub-groups which are responsible to the Board and take forward the Business Plan priorities:

- Policy and Procedures (joint with Swindon SAB)
- Learning and Development
- Quality Assurance

Task Groups

The Board may establish task and finish groups for specific, time-limited work.

6. Remit

The WSAB will be accountable for the following:

- Leading the development, approval, monitoring and review of multi-agency safeguarding policies, procedures and practice, including information sharing, and ensuring that they reflect the needs of all communities in Wiltshire, and the needs of all members of those communities
- Promoting the responsibility for safeguarding across all agencies and stakeholders, and ensuring clear leadership and accountability are in place throughout all the organisations represented on the WSAB, and overseeing safeguarding activities by agencies including reviewing progress in the recognition, reporting and response to abuse
- Preparing and securing approval and resources from member organisations for a Business Plan
- Producing an Annual Report on safeguarding adults, which reviews progress in delivery of the Business Plan
- Establishing quality assurance and audit arrangements to validate the effectiveness and quality of safeguarding services in Wiltshire and identify and address resources shortfalls where these arise.
- Involving service users and carers and adopting an inclusive approach to the role of the WSAB
- Ensuring a multi agency training strategy is in place for all workers in all sectors who have contact with vulnerable adults and receiving regular reports on its delivery and effectiveness.

- Ensuring effective engagement of safeguarding adults work with the safeguarding of children, domestic violence, bullying hate crime, MAPPA processes and wider work on community safety and public protection.
- Commissioning Serious Case Reviews where needed, maintaining the Serious Case Review protocol and contributing as appropriate to Domestic Homicide Reviews and reviews of Drug Related Deaths.
- Receiving and considering outcomes from these reviews and promoting opportunities to share learning.
- Promoting awareness of Safeguarding issues and disseminating accessible information about the work of the WSAB via a comprehensive communications strategy aimed at ensuring that abuse is recognised, reported and immediate action taken wherever it arises.
- The effective implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards.

7. Accountability and reporting

The WSAB has a reporting line to the Wiltshire Health and Wellbeing Board. It is accountable for its work to its constituent organisations and its members are individually accountable both to their own organisations and to the WSAB for the following roles and responsibilities:

- Contributing to the effectiveness of the WSAB in the achievement of safeguarding objectives, the development of policies and procedures and their implementation in their organisation
- Ensuring that their organisation shares appropriately in resourcing the operation of the WSAB, consistent with the lead role of the local authority and the shared responsibilities of all agencies.
- Disseminating information to their own organisation and related agencies
- Participation in development, training and learning activities
- Provision of a statement for the annual report outlining the contribution of their organisation to safeguarding adults and, specifically, their contribution to the Business Plan.
- Make appropriate resources available to the Board and its sub-groups and task groups.

The Board will produce an annual report prepared in line with the South West Regional template, which includes:

- Foreword
- Background Information
- Governance and accountability
- Summary of activity during the past year
- Monitoring and quality assurance activity
- Partner reports

- Local Progress in relation to national requirements
- Priorities for the coming year
- Appendices

The report will be presented to the Wiltshire Health and Wellbeing Board and then made available to the general public. WSAB members will be responsible for presenting the Board's annual report to their own organisation's executive body.

8. Review

These Terms of Reference will be reviewed at the same time as the Board's Safeguarding Policy and Procedures.

National Policy and Guidance May 2014

DH (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.*

ADASS (2005) *Safeguarding Adults – a national framework of standards for good practice and outcomes in adult protection work*

HMSO (2005) *Mental Capacity Act and (2009) Deprivation of Liberty Safeguards*

CSCI (2008) *Safeguarding Adults, a study of the effectiveness of arrangements to safeguard adults from abuse.*

Bournemouth University and Skills for Care (2010) *National Competence Framework for Safeguarding Adults*

DH (2010) *Practical approaches to safeguarding and personalisation*

DH (March 2011) *Safeguarding Adults: The role of NHS Commissioners; The Role of Health Service Managers & their Boards; The Role of Health Service Practitioners*

ADASS (April 2011) *Safeguarding Adults Advice Note*

DH (May 2011) *Statement of Government Policy on Adult Safeguarding*

ADASS (Nov 2011) *Carers and Safeguarding Adults – working together to improve outcomes.*

Care Quality Commission (June 2012) *Learning Disability Services National Overview*

DH (June 2012) *Department of Health Review: Winterbourne View Hospital (Interim Report)*

HM Government (July 2012) *Caring for our future: reforming care and support*

South Gloucestershire Safeguarding Adults Board (August 2012) *Winterbourne View Hospital, A Serious Case Review* NHS Commissioning Board (March 2013) *Safeguarding Vulnerable People in the Reformed NHS*

Local Government Association and ADASS (April 2013) *Adult Safeguarding and Domestic Abuse, a guide to support practitioners and managers*

Department of Health (May 2013) *Statement of Government Policy on Adult Safeguarding*

ADASS, LGA, NHS Confederation, ACPO, Clinical Commissioners (January 2014) *Safeguarding Adults – a Joint Statement*

HM Government (May 2014) *Care Act 2014*

Appendix 2 - Board Membership and Attendance 2013 - 2014

Organization	Designated Member	June 2013	Sept 2013	Sept 2013 Dev Day	Dec 2013	Mar 2014
Independent Chair	Margaret Sheather	✓	✓	✓	✓	✓
Wiltshire Council DCS	James Cawley	✓	A	A	✓	A
Wiltshire Council Safer Communities	Pippa McVeigh	A	✓	✓	✓	✓
Wiltshire Council Commissioning	George O'Neill (to Sept 2013) Phil Shire (from Dec 2013)	✓	✓	✓	✓	✓
Wiltshire Council Cabinet Member	Cllr Jemima Milton (to Sept 2013) Cllr Keith Humphries (from Dec 2013)	✓	✓	✓		A
Wiltshire Care Partnership	Matthew Airey	✓	✓	✓	A	✓
Wiltshire Police	Supt. Jerry Dawson (to Sept 2013) Supt Caroline Evely (from Dec 2013)	✓	✓	Ap-R	Ap-R	Ap-R
CCG Wiltshire	Jacqui Chidgey Clark (to June 2013) Karen Littlewood (from Sept 2013)	Ap-R	✓	✓	✓	Ap-R
NHS England	Kevin Elliott	✓	A	A	✓	✓
Great Western Ambulance Service	Sue Smith (to June 2013) Sarah Thompson (from Sept 2013)		✓	✓	A	A
Great Western Hospital	Robert Nicholls	✓	✓	✓	A	✓
RUH Bath	Mary Lewis (to June 2013) Helen Blanchard (from Sept 2013) Mary Lewis (from March 2013)	Ap-R	Ap-R	Ap-R	A	✓
Salisbury NHS Foundation Trust	Fiona Hyett	A	✓	✓	✓	✓
AWP	Julie Hankin	AP-R	✓	✓	Ap-R	✓
Wiltshire Probation Trust	Riana Taylor (to Dec 2013) Liz Hickey (from Mar 2014)	A	A	A	✓	✓
Wiltshire Fire & Rescue Service	John Popowicz	A	A	✓	Ap-R	Ap-R
CQC (annual only)	Alison McDonald	n/a	A	A	n/a	n/a

✓ Attended
A Sent apologies
Ap-R Sent apologies & replacement attended

Appendix 3

Performance Report of the Wiltshire Local Safeguarding Adults Board

Financial Year

2013 - 2014

PERFORMANCE REPORT OF THE WILTSHIRE SAFEGUARDING ADULTS BOARD

INFORMATION REPORT FOR THE PERIOD April 2013 – March 2014

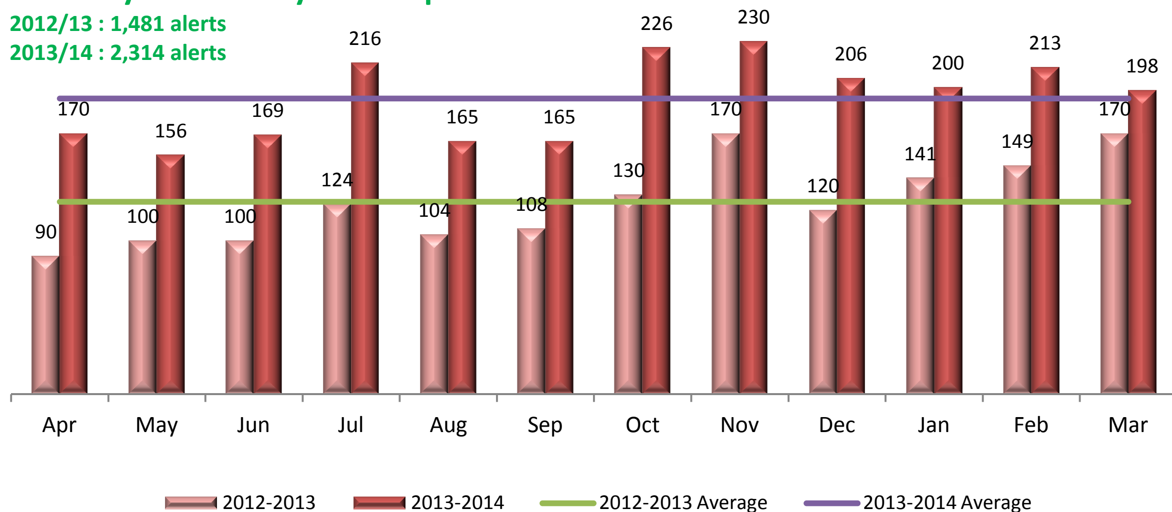
Previous year totals and comparative data, current year-to-date

	2012/13 Wiltshire total	**2013/14 Outturn**				**2013/14 Cumu-lative**	**2012/13 Averages**		**2012/13 Rate per 100,000 population (aged 18 & over)**		
		Q1	**Q2**	**Q3**	**Q4**		**England**	**South West**	**England**	**South West**	**Wiltshire**
Number of Alerts *(This excludes whole home and large scale investigations which are used for England and South West comparisons)*	1,481	495	546	662	611	2,314	1,306	1,294	473.8	453.9	450.1
	Although higher than average both nationally and in the South West in 2012/13, when populations (adults aged 18 and over) were taken into account, Wiltshire was roughly equivalent with our region but lower than England. *This is no longer collected nationally from 2013/14 onwards and is therefore unavailable*										
Number of Alerts triaged within 24 hours	1,288	449	521	638	587	2,195					
	Comparative data not available as this is not collected nationally or regionally										
Service Standard: Percentage of Alerts triaged within 24 hours	*87%*	*91%*	*95%*	*96%*	*96%*	*95%*					
	Improvements for 2013/14 are due to SAMCAT being formed part-way through 2012; therefore better achievement is attained from then on. Comparative data not available as this is not collected nationally or regionally										
Number of Early Strategy Meetings (ESM) held	410	165	159	142	185	651					
	The increase in the number of ESMs is due to increased numbers of Alerts. Comparative data not available as this is not collected nationally or regionally										
Percentage of Alerts converted to an ESM	28%	33%	29%	21%	30%	28%					
	The 'conversion rate' remains relatively constant. Comparative data not available as this is not collected nationally or regionally										
Service Standard: ESM held within 5 working days of the Alert	*n/a*	*49%*	*46%*	*43%*	*26%*	*41%*					
	This is a disappointing success rate. Work has started with teams to understand the reasons behind this.										

	2012/13 Wiltshire total	2013/14 Outturn				2013/14 Cumu-lative	2012/13 Averages		2012/13 Rate per 100,000 population (aged 18 & over)		
		Q1	Q2	Q3	Q4		England	South West	England	South West	Wiltshire
Number of Adult Protection Investigations (API) started *(This excludes whole home and large scale investigations which are used for England and South West comparisons)*	403	143	166	172	164	645	741	650	314.54	227.9	259.9
	Wiltshire was below average at both regional and national level in 2012/13, however once population numbers were factored in, the county had a higher rate per 100,000 population than the South West but is lower than England										
Percentage of Alerts converted to an API	27%	29%	30%	26%	27%	28%	57%	50%			
	Wiltshire's 'conversion rate' was markedly lower than at national or regional level, yet remained constant. Is this because we are recording more Alerts than others and subsequently screening them out? Other local authorities' practices will undoubtedly be a factor here										
Service Standard: API held within 15 working days of the ESM	*n/a*	*99%*	*98%*	*94%*	*76%*	*92%*					
	It is good to see a high level of achievement against the Service Standard										
Number of APIs completed *(This excludes whole home and large scale investigations which are used for England and South West comparisons)*	357	114	164	155	181	614	570	510	242.15	179.0	158.1
	In 2012/13 Wiltshire was below average both regionally and nationally; this remained true when populations were taken into account. This might be due to the lower 'conversion' ratio (from Alerts to APIs). Another possible reason is that APIs can continue for a protracted period in Wiltshire and therefore fewer are concluded in the reporting year. For this latter theory, API completions should catch up in subsequent years.										
Number of Adult Protection Conferences (APC) held	235	91	92	84	75	342					
	APC numbers have risen as a result of the increased number of Alerts. Comparative data not available as this is not collected nationally or regionally										
Percentage of APIs converted to an APC	58%	64%	55%	49%	46%	53%					
	Conversion rates are falling. We need to ask why this is. Comparative data not available as this is not collected nationally or regionally										

	2012/13 Wiltshire total	2013/14 Outturn				2013/14 Cumu-lative	2012/13 Averages		2012/13 Rate per 100,000 population (aged 18 & over)		
		Q1	Q2	Q3	Q4		England	South West	England	South West	Wiltshire
Service Standard: APC held within 15 working days of the ESM	*n/a*	*43%*	*43%*	*41%*	*38%*	*42%*					
	Work has begun with teams to understand the reasons behind this low level of achievement										
Number of Adult Protection Reviews (APR) held	173	52	70	72	27	221					
	APR numbers have risen as a result of the increased number of APIs and APCs. Low Quarter 4 figures may be explained by CareFirst inputting latency. Comparative data not available as this is not collected nationally or regionally										
Percentage of APCs converted to an APR	74%	57%	76%	86%	36%	65%					
	Overall, 'conversion rates' remain relatively static but once again, CareFirst inputting delays may explain Quarter 4 numbers. Comparative data not available as this is not collected nationally or regionally										
Service Standard: APR held within 8 weeks of the APC	*n/a*	*94%*	*72%*	*80%*	*77%*	*78%*					
	The achievement rate is acceptable but should be improved upon										

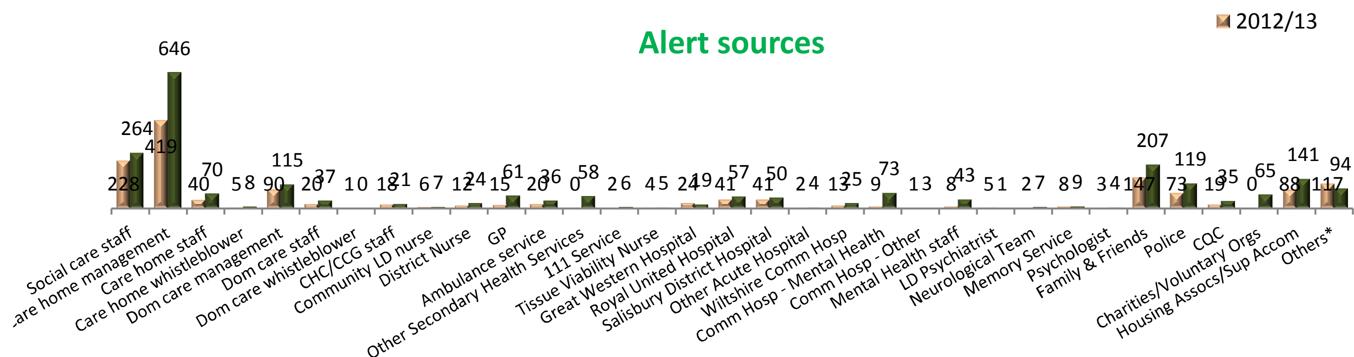
ABUSE ALERTS



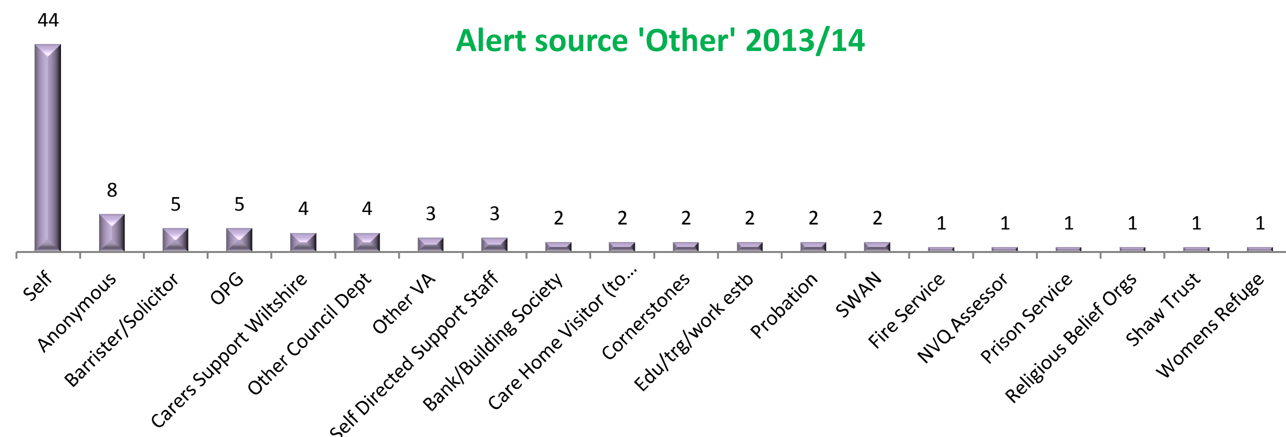
The number of Alerts has continued to increase, from an average of 126 per month in 2012/13 to 193 in 2013/14. It is thought that this arises from a combination of improved recording since the formation of SAMCAT, greater reporting of individual cases by care agencies and a greater awareness of safeguarding vulnerable adult issues in the wider community.

Alert sources:

Alerts come from a wide spectrum of professionals and society. Alerts for care homes, GPs and mental health agencies are around double from the previous year, indicating greater awareness of the importance of safeguarding issues.



'Others' account for 94 Alerts in 2013/14; these are broken down as follows:



Place of alleged abuse

Overall, the place of alleged abuse and whether or not the case went to API is similar across the 2 years, as the table below shows. Most alleged abuse takes place in the vulnerable adult's own home: 45% in 2012/13 and 46% in 2013/14 and this is also reflected in the number of cases proceeding to API: 47% in 2012/13 and 46% in 2013/14 relating to abuse in the adult's own home. 36% of Alerts proceeding to an API in 2013/14 were those where the alleged abuse took place in care homes, the same as in 2012/13.

Location of Alleged Abuse		2012/13			2013/14		
		API	No API	Total	API	No API	Total
At home	No.	204	468	672	315	752	1,067
	%	14%	32%	45%	14%	32%	46%
Care home setting	No.	154	390	544	245	630	875
	%	10%	26%	37%	11%	27%	38%
Hospital setting	No.	18	51	69	36	71	107
	%	1%	3%	5%	2%	3%	5%
Other	No.	56	140	196	93	172	265
	%	4%	9%	13%	4%	7%	11%
Total	**No.**	**432**	**1,049**	**1,481**	**689**	**1,625**	**2,314**
	%	**29%**	**71%**		**30%**	**70%**	

Type of abuse by setting (at the Alert stage)

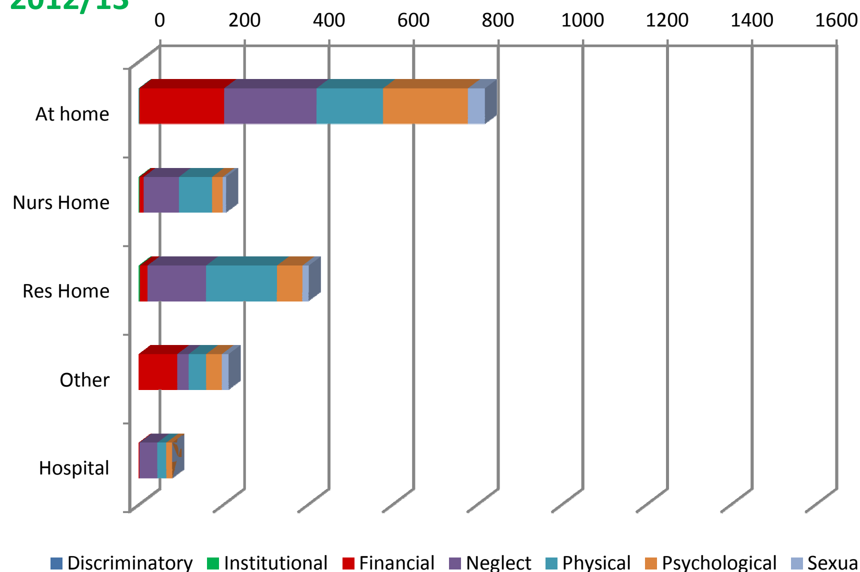
Broadly, the patterns of the type of abuse in the various settings are similar across both years. There are very few reported cases of discrimination (1 in 2012/13 and 2 in 2013/14), but it may surprise that these occurred in people's own homes rather than in care home settings, but this category includes supported accommodation. Institutional abuse is primarily reported in care homes; 83% in 2012/13 although this fell to 64% the following year.

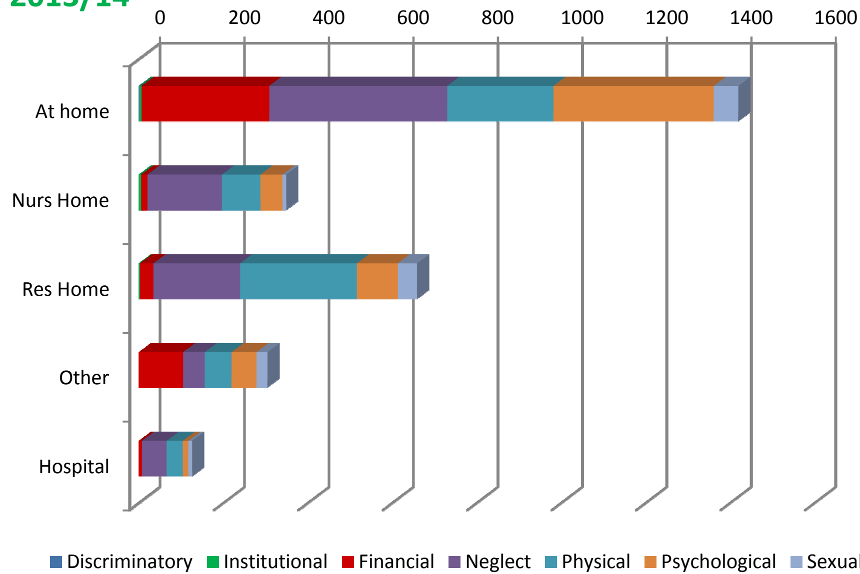
The majority of neglect or acts of omission occur in own home situations (43% of neglect cases in 2012/13 and 46% in 2013/14) sometimes related to the impact of pressure on informal carers. Care homes saw 44% of such cases in 2012/13 and 42% in 2013/14. These tend to be missed medication, not supporting transfers appropriately or failing to prevent a customer falling when mobilising. Hospitals accounted for 6% of neglect cases in 2012/13 and 5% in 2013/14.

Emotional/psychological abuse is mainly experienced by people living in their own homes by family member(s) applying pressure on vulnerable people (bullying) or threatening them with physical violence (but not actually striking them). Own home setting accounted for 60% (2012/13) of emotional/ psychological abuse, increasing in 2013/14 to 63%. Psychological abuse is often reported when sexual abuse is also said to have occurred. This latter type of abuse is also prevalent in people's own homes – 51% and 39% across the 2 years reported here. Sexual abuse at home is of a more serious nature (but not exclusive to serious incidents) whereas within care home settings this ranges from relatively minor forms to the more serious.

Care homes are also where the most physical abuse is reported (53% in 2012/13 and 51% the following year). This ranges from one resident lightly striking another, to residents fighting or causing hospitalization by their actions. Financial abuse accounts for 21% of abuse at home in 2013/14 (24% the previous year) yet this is where most abuse of this type takes place (62% of financial abuse cases were in people's own home in 2012/13, rising to 65% in 2013/14).

It is not possible to try to explain why one form of abuse increases or decreases from one year or time period to another as this is purely down to events or instances. We can merely note changes and adjust publicity and awareness campaigns accordingly.

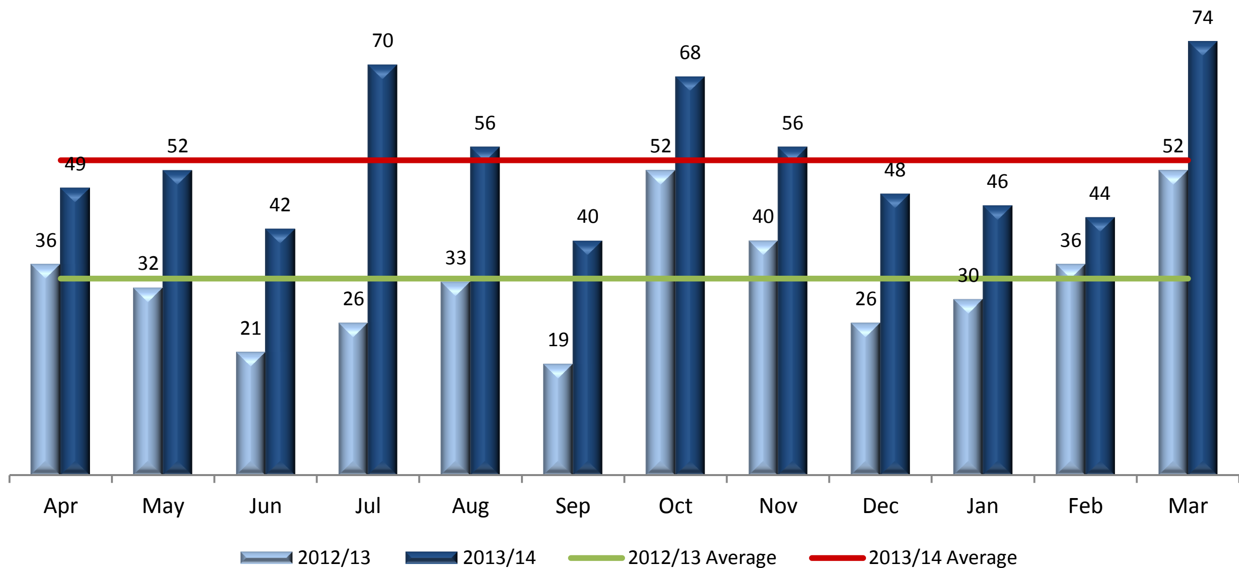




ADULT PROTECTION INVESTIGATIONS

Investigations started during the reporting period

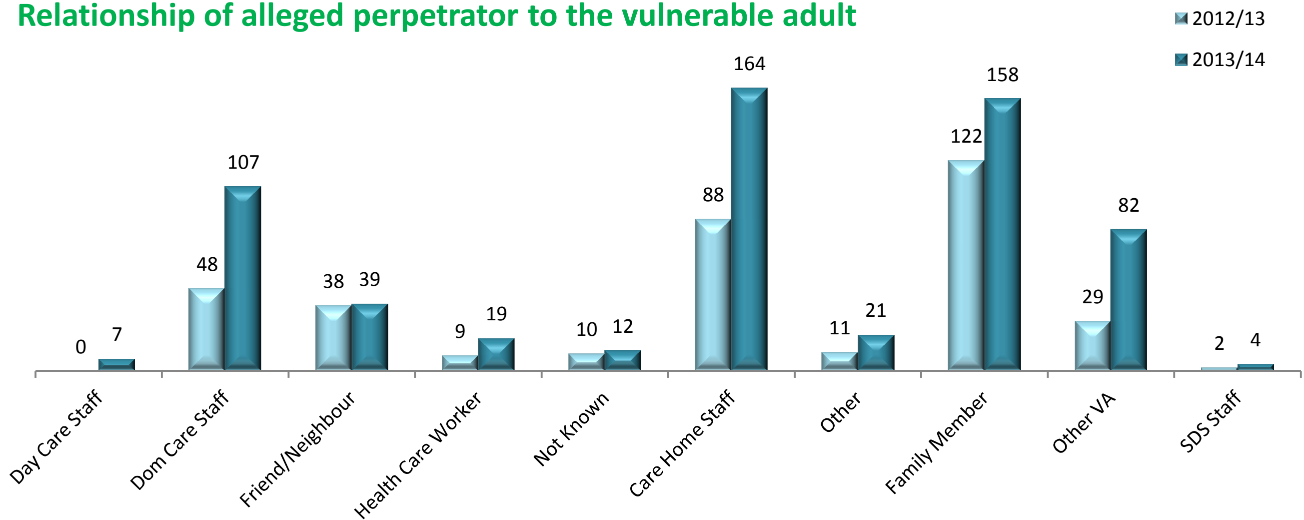
30% of alerts went on to be investigated in 2013/14, similar to 2012/13 (29%). Overall, the number of Adult Protection Investigations (APIs) has risen proportionately with the increased number of Alerts received with 645 APIs started in 2013/14 compared with 403 in 2012/13.



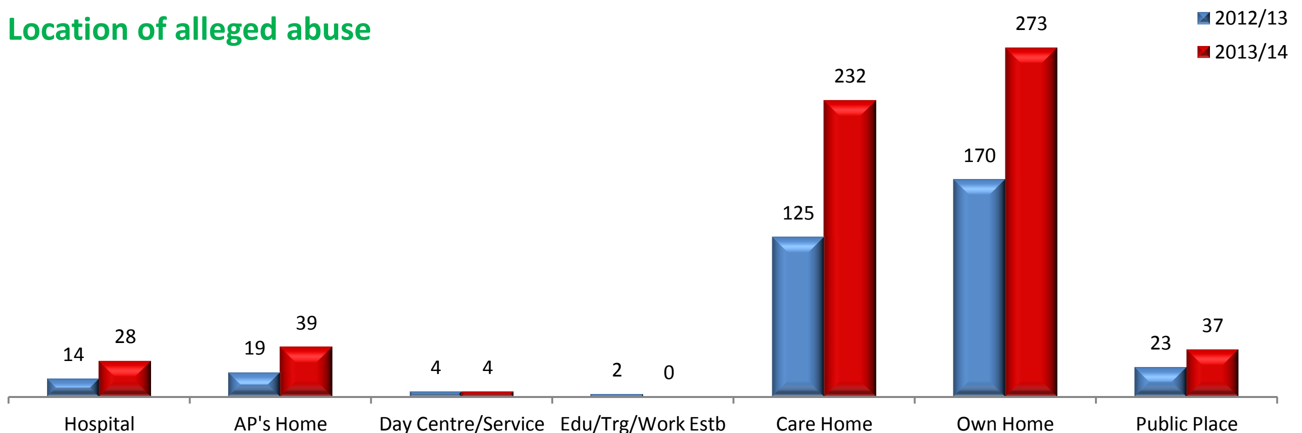
Relationship of the alleged perpetrator to the vulnerable adult

The sharply increased numbers in several of the categories in the table below needs to be seen in the context of the overall increase in alerts and investigations. There were some relevant percentage changes to note:

- During 2013/14, in 26% of cases investigated the alleged perpetrator (AP) was a relative, i.e. the victim's partner or other member of the family, down from 37% in 2012/13
- 18% were domiciliary care and self-directed support staff compared to 14% in 2012/13 and
- 27% of all concluded cases in 2013/14 related to allegations about care home staff having compared to 25% in 2012/13.



Location of the alleged abuse

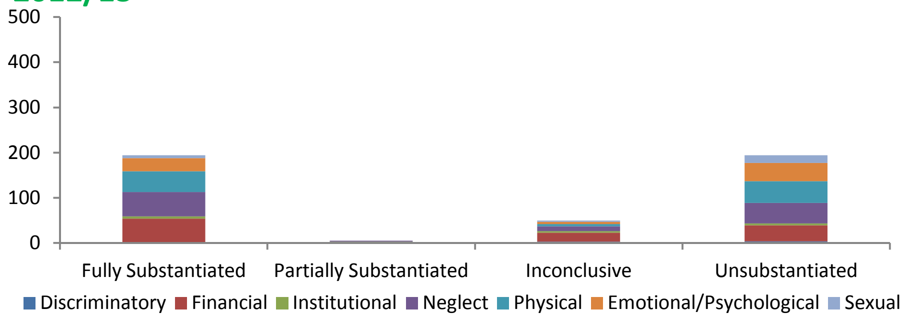


Care home and the vulnerable adults' own home dominate the locations where abuse is alleged to have taken place, with own home averaging 46% across the 2 years covered by this report and care homes averaging 36%. This reflects the relationships of the vulnerable adults to the Alleged Perpetrators above. All other locations are similar in their proportions over the 2 year period.

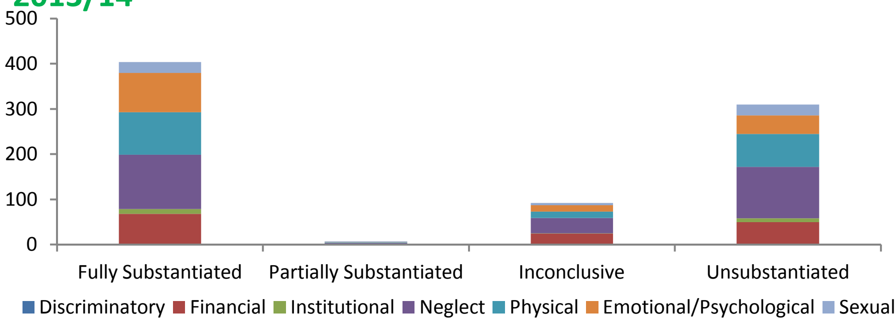
Type of abuse by investigation conclusion

In 2012/13, 357 Adult Protection Investigations (APIs) were completed; with the increased numbers of Alerts and APIs in 2013/14, this number increased to 613.

2012/13



2013/14



The chart above shows numbers of concluded cases by the type of abuse. With many cases involving multiple types of abuse, these numbers will not equal the total the number of concluded cases. The proportions are broadly similar across the two reporting periods for allegations that are substantiated. However, neglect was more significant in inconclusive cases, rising to 37% in 2013/14 from 22% in 2012/13. Conversely, in 2013/14 inconclusive cases where the alleged abuse was financial fell to 25% from 40% the previous year.

Where allegations were unsubstantiated, 24% were for neglect in 2012/13; in 2013/14 this had risen by half to 37%. The conclusion ratios over the 2 year period are:

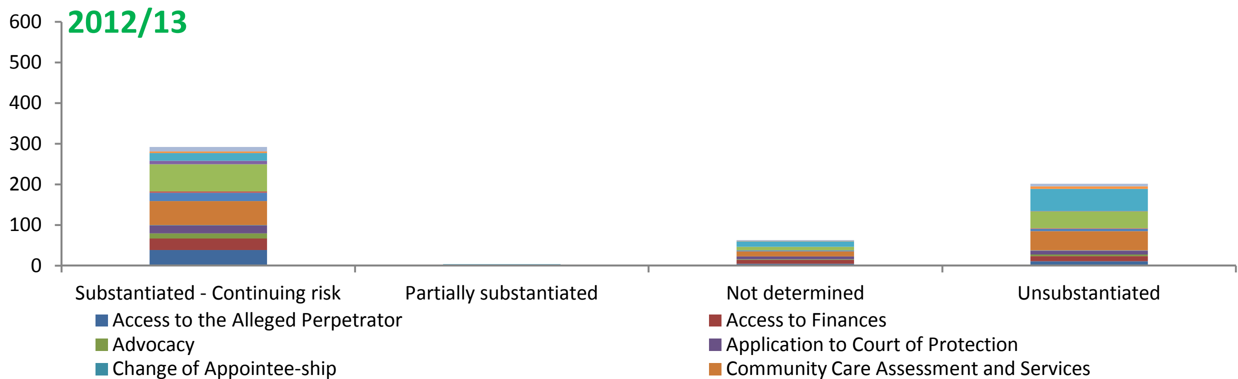
	Fully Substantiated	Partially Substantiated	Inconclusive	Unsubstantiated
	(numbers in brackets are total number for each conclusion)			
2012-2013	44% (194)	1% (5)	11% (50)	44% (194)
2013-2014	50% (404)	1% (7)	11% (92)	38% (310)

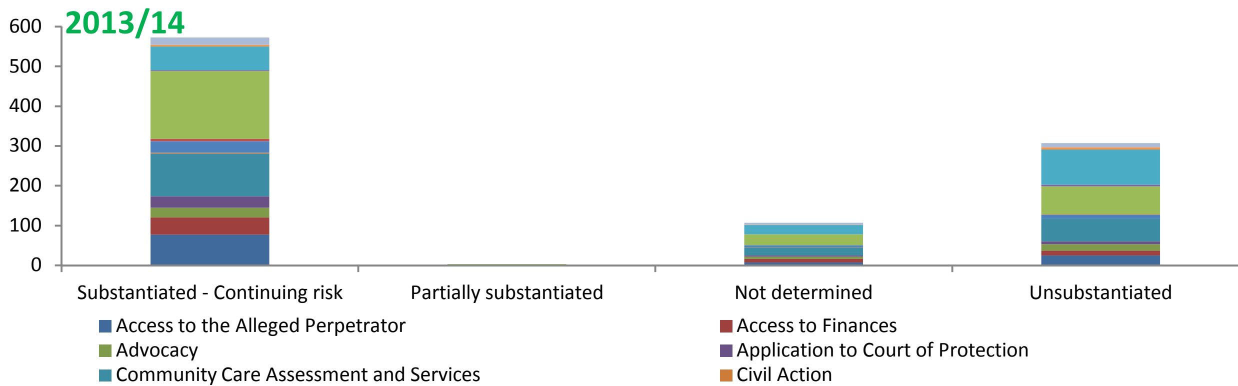
*8*Note that in 2013/14, 5 investigations ceased at the VA's request*

Outcomes for the vulnerable adults

Outcomes for the vulnerable adults will depend on the victim's circumstances, needs, what action should take place to ensure that risk of harm or neglect is removed - or at least, reduced – and their desired outcomes. This latter element is beginning to take sharper focus as the personalization agenda means that more statutory reporting of people's desired outcomes and whether these were met, will be required by the Department of Health in future years.

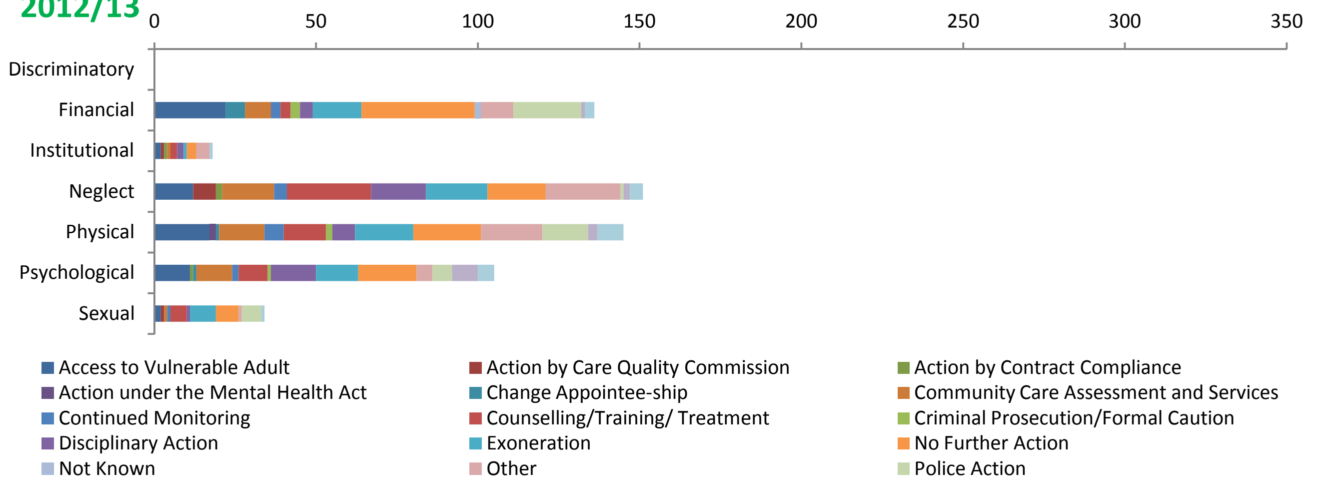
Below are cases with further action or outcomes; these are shown by the investigations' findings. Once again, people will often need more than one outcome, therefore these numbers will not equate to the number of cases concluded:

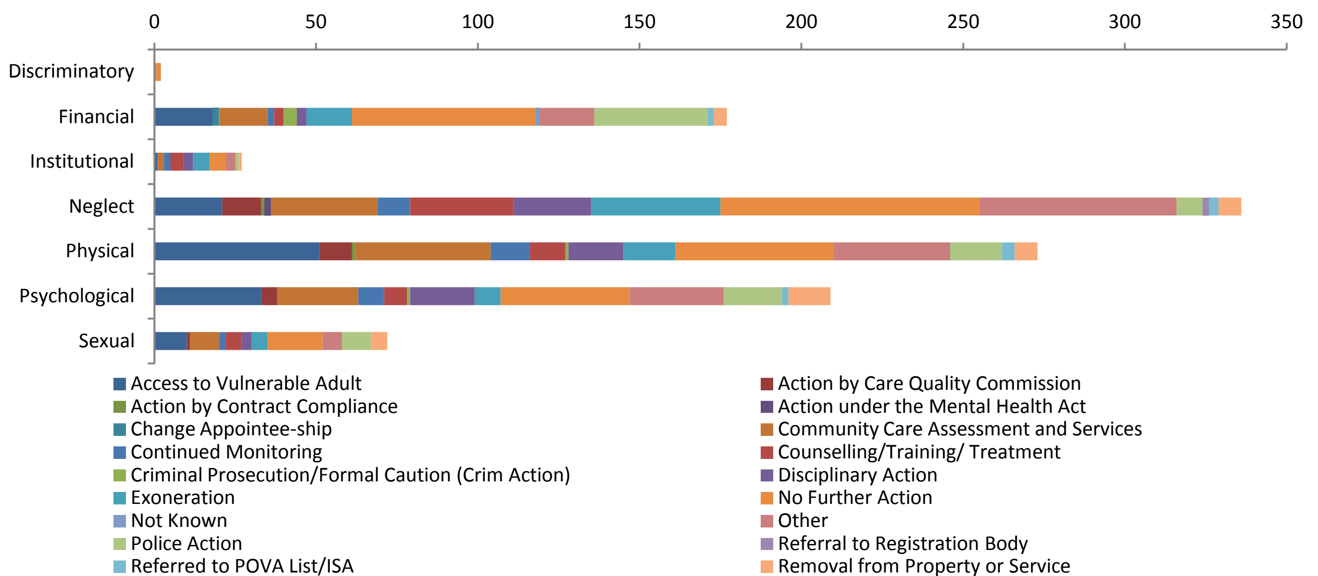




Outcomes for the alleged perpetrators

With the well-being of the victim upper most, outcomes for the alleged perpetrators will focus on removing or reducing risks to vulnerable adults and so individual cases will dictate alleged perpetrators' outcomes. These charts depict the outcome for the alleged perpetrator(s) and show the types of abuse involved:





Agencies involved in investigations (concluded APIs only)

Agency involvement with investigations is dictated by the nature of the abuse, who raised the initial allegation 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	**2012/13**		**2013/14**	
	No.	**%**	**No.**	**%**
Avon & Wiltshire MH Partnership	35	10%	38	6%
Care Home	132	37%	251	41%
Care Quality Commission	62	17%	122	20%
Court of Protection	34	10%	48	8%
Department of Community Services	357	100%	613	100%
Hospitals	53	15%	93	15%
Housing (Associations, Schemes, Dept)	22	6%	51	8%
Other Local Authorities	14	4%	32	5%
Others (Family, Health, etc)	34	10%	47	8%
Police	264	74%	292	48%
Provider Agencies (Day, Dom Care, etc)	108	30%	168	27%
Totals	**357**		**613**	

Compiled by: Paul Lipinski, Business Information Analyst, Adult Care, Wiltshire Council, Trowbridge, BA14 8JN

Tel: 01225 713975 : Email: paul.lipinski@wiltshire.gov.uk

Appendix 4 - Case Studies

Wiltshire Probation Trust

Mr. A, a young man with a Learning Disability was convicted of sexual offences against a family member who also has a learning disability. He was made subject to a Community Order and Sex Offender Registration. His Offender Manager has worked closely with other professionals to achieve positive outcomes for him and his family. This has included:

- Working with Police Colleagues to ensure his Sex offender registration paperwork was rewritten and presented to him in words he could understand
- One to one work with his Offender Manager, taking into account his specific learning needs (eg use of pictures, regular reinforcement of key messages, boundary setting)
- Working with the Social Worker and family to develop their skills in recognising and managing risky situations and behaviour
- Keep Safe work with the victim carried out by the Social Worker
- Referral to a Probation volunteer mentor to reduce Mr A's social isolation

This case study demonstrates the complexity of working with a perpetrator of abuse, who is also a vulnerable adult and the need for effective partnership work.

Wiltshire Fire & Rescue Service

CASE 1

Background

Crew referral made in December 2013. Neighbour reported that the smoke alarm was activating in the adjacent flat but she said the occupant was out picking up her child from school. Forced entry made and discovery that fire was caused by cooking being left on the hob. Crews were primarily concerned about the state of the property and the mother's mental health.

The occupant was very distressed and flustered when she came home, appearing to be finding it difficult to cope and was very tearful. She suffered from a serious form of arthritis and was in a lot of pain. She has three primary school aged children all sleeping in the same room.

Observations

Flat was cluttered with clothes and toys, disorganised with blocked exit routes. The kitchen was in a filthy state with rubbish everywhere and washing up that had been there for some time; hob top was damaged from the pan left on it cooking but also being used as a storage space so covered with combustibles on top and around it.

There was evidence of extremely mouldy conditions in the bedrooms and sitting room.

The crew had concerns that the front door to the flat was not a fire door. There was no door closer or intumescent strip in evidence.

Follow up visit

On this occasion the occupant was with her mother in the flat and was extremely tired, depressed and finding it hard to focus. The pain she experiences is severe and makes it hard for her to concentrate. She explained that she was finding it hard to make ends meet and cope with the needs of the children with the flat being so small and her condition. Her mum had done a lot of clearing up and had made the house more presentable and safe.

We spoke about keeping the kitchen cleaner in particular not using the top of the hob for storage and to make sure that all exit routes from the property and in the bedrooms were clear of clutter and trip hazards. Advice was given on agencies that could support her to make sure she was getting all the help she could and consent was obtained to refer her on to them.

Contact was also made, after the visit, with the Technical Fire Safety Department to find out when an audit was last done and what the findings were. It appears that a notice of deficiencies was outstanding from earlier in the year – TFS carried out a site visit and followed this up.

Referrals

- The Housing Officer – to look at the damp in the bedrooms and sort out damaged units in the kitchen. Also, to address the Regulatory Reform Order (Fire Safety) issues that had been identified by the crew.
- Community 4 – to look at benefits and to help complete a housing application for a move to a larger flat.
- The Children's Centre – they provide a mentoring service for parents and children at secondary school – this is accessed via the pastoral care officer at the school.
- Contact made with ex-health visitor who is aware of the situation and who could help with the referral to the pastoral care officer.

Advice was also given about the importance of getting a thorough examination and assessment from the GP who could provide the proper pain management strategy and medication to enable a better quality of life and the ability to cope better.

Outcome

- Community 4 fed back that the occupant is on the list to move to a bigger property so the children do not have to sleep in one room. The occupant was moved to Gold Band and information was given on home swapping. They made sure that she was getting the relevant benefits. They had no major concerns.
- The Housing Association had made the damaged door safe and was due to replace it with a fire door and they had visited and given advice on the mould. They had also upgraded the occupant to a higher band for a transfer.

CASE 2

Background

Post incident referral from the crew following fumes from cooking. They had found serious hoarding conditions in all rooms and hallway. The kitchen was so cluttered that food items stored on top and around the toaster on the work tops meant that the toaster became activated causing the beans on top to explode all over the walls and underneath the cupboards.

Crew referred because Mrs X appeared to be 'in a bit of a pickle' (her words) and was not coping with the situation. Her husband has kidney disease, ulcerated legs and diabetes and did not understand the seriousness of the situation and did not leave the house even though it was heavily smoke logged. He sleeps in the lounge in a chair. The whole house has a very high fire loading and passageways are cluttered.

Actions

1. Visit done and basic advice given about clearance around heaters, plugs, clearing exit routes, etc. Situation very poor. Mrs. X receiving regular visits from the GP as she has had difficulty walking. Mr. X receives regular visits from the district nurses.
2. Follow up visit to install a smoke detector in the lounge and contact with the Housing Officer to get their support for Mrs. X to help her de-clutter. An old oil fired heater was taken away as it was in a poor condition and plugs sorted out by Mr. X's chair.

   Mrs. X was extremely depressed and not coping too well as she is also a full time carer for her husband. She has been in contact with Wiltshire Carers and so will hopefully be getting support from them and has recently acquired a mobility scooter that she can use to take her dogs out walking. Biggest problem is that she continues to stockpile food items and is a compulsive buyer of catalogue items that she then has no room for.

   Main concerns are the electrics with televisions being left on, high dust levels and over use of extension leads.

   In order to address the electrical safety issue, permission was obtained from Community Safety to use Community Safety Technician's hours to support Mrs. X to declutter enough to make things safer.

3. First visit done to help declutter. Hallway cleared so that doorways not blocked. Old LP's removed and a large armchair that was taken away by Housing who also removed a large number of rubbish bags from the back garden including 2 bags of videos. Kitchen worktops cleared and cleaned. No toaster in use. All out of date food removed but the new food still put on the work top as storage.

   There was a major issue with an extension lead running from kitchen to bathroom with television and oil fired radiator plugged in adjacent to the wet room shower. The dangers of this were highlighted and all items unplugged except the heater but the extension was then sited outside the bathroom. The television could not be removed

as there was nowhere in the house to put it. Mrs X also complained about the heating in the bathroom saying it was inadequate. Housing agreed to carry out an assessment to right this problem so that the oil fired heater does not have to stay plugged in in the bathroom.

4. Second visit to install a power down plug on the television in the kitchen and remove more clutter. The television had been plugged back in and was being used again in the bathroom despite a further explanation of the risks.

5. Final visit to install a powerdown to the television in the lounge. This could not be accomplished as the plugs behind the TV were inaccessible and it was impossible to move anything. The TV was not hot and did not have a stand by light on – Mr. X said it did switch itself off if not used. Unfortunately, this risk remained and although some items were removed from the lounge it is still very cluttered with a high fire loading.
6. Additional risks in the kitchen were piles of books heaped precariously by the television. These were moved to a different location and posed less risk. More clutter was removed but the situation of high fire loading, clutter and congested exit routes remains. Mrs. X's daughter is moving out soon and so her room will be used for some of the items.

   Informed Mrs. X that if she needs support in future to remove items to call me. Housing has arranged to go in and look at the heating needs. They will also periodically make welfare visits to ensure that the hoarding is being kept under control.

   Control and crews informed of the risks.

Appendix 5

Wiltshire Safeguarding Adults Board

Business Plan 2014-16

A. Aims & Objectives of the SAB:

These are set out in the Terms of Reference, along with the membership of the Board and the means by which it intends to achieve its aims.

B. Business Planning: The purpose of this business plan is to illustrate the vision that has been agreed and to demonstrate how all relevant stakeholders will participate in achieving the goals required to make the vision a reality.

The business plan will assist the SAB to support, monitor and review what partner agencies do individually and collectively to fulfil their safeguarding duties.

In order to assure good oversight and continuity of working, the SAB has identified actions in line with the five domains and associated outcome measures of the South West Self Assessment Quality & Performance Framework for Adult Safeguarding that was approved by the South West ADASS Safeguarding Adults Advisory Group.

The Quality & Performance Framework Domains and Outcome Measures are:

1. **Prevention & Early Intervention**
   Outcome: a pro-active approach reduces risks and promotes safe services whilst ensuring independence, choice and control.

2. **Responsibility & Accountability**
   Outcome: There is a multi-agency approach for people who need safeguarding support

3. **Access & Involvement**
   Outcome; People are aware of what to do if they suspect or experience abuse
   Outcome: Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process

4. **Responding to Abuse & Neglect**
   Outcome: People in need of safeguarding support feel safer and further harm is prevented

5. **Training & Professional Development**
   Outcome: Staff are aware of policies & procedures, their practice safeguards adults and promotes understanding of harm

The SAB has agreed the appropriate actions within these domains which best address local needs and priorities. The priority areas for this year are:

- ❖ Take all the action necessary to implement the requirements of the Care Act 2014 in relation to safeguarding and any other relevant aspects of the Act.
- ❖ Develop and start to implement the Action Plan arising from the Serious Case Review

- ❖ Maintain the existing work with the Service User Reference Group and continue to develop its role in the work of the Board and safeguarding system
- ❖ Develop the initial contact with Carers to enable them to be appropriately involved in the work of the Board and safeguarding system.
- ❖ Implement the agreed communications strategy to support awareness raising and good information sharing across all Wiltshire's communities; update web-based information to support this.
- ❖ Implement the proposed quality assurance and performance management system for the Board
- ❖ Develop the Board's preventative activity through a task and finish group to establish whether/ how people at risk of harm can be identified and appropriate intervention offered.

Section 1 – Actions, Timescales and Lead Responsibility

Outcome 1. Prevention & Early Intervention: a pro-active approach reduces risks and promotes safe services whilst ensuring independence, choice and control.			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
1.1 Safeguarding is integrated into all contractual processes with clear expectations and reporting requirements to prevent harm, neglect and abuse	Scrutinise commissioners' implementation of their safeguarding responsibilities by: a) Focussed discussion based on reports from commissioning members of WSAB (to include QA function): • Send brief to Wiltshire Council, Wiltshire CCG and NHS England • Reports provided for circulation b) Board discuss and decide appropriate regular commissioner reports to the Board	1st August 13th Sept '14 23rd Sept '14	Margaret Sheather James Cawley/ Karen Littlewood/ Kevin Elliott WSAB
Outcome	**Assurance that commissioning arrangements are effectively promoting safe, good quality care and identifying risk.**		
1.2 Performance	Finalise and implement the Board's performance and QA		

Management systems are effective and include indication of the potential for vulnerability and intervention	framework including: a) Strengthened use of KPIs and other monitoring methods b) Setting clear targets for improvement c) Drawing on SCR learning and CQC reports appropriately d) Establishing whether/ how people who may be at risk of harm can be identified and appropriate intervention offered. Agree task and finish group to do this work.	June '14 then ongoing As published December '14	WSAB/QA Sub-group WSAB
Outcome	**The Board starts to be effective in monitoring and auditing how adults at risk are being offered appropriate support and care and maintains an overview of all relevant activities.**		
1.3 Policies and procedures are in place to prevent unsuitable people from working with adults at risk	Audit the impact of safer recruitment training across partner organisations and report to WSAB.	Report in December '14	Learning and Development sub-group.
Outcome	**Risks are reduced by strong recruitment practice**		
1.4 Steps are taken to prevent or reduce risk of abuse within service settings	a) Identify and review available prevention strategies and propose further action. Link to 1.2d b) Follow up Tinkers Lane Surgery report by seeking assurance that primary care settings are implementing safeguarding	TBA	Task group as above. MS /KE

	policy and procedures consistently.		
Outcome	**Organisations' ability to prevent or reduce risk is improved.**		

Outcome 2. Responsibility & Accountability: There is a multi-agency approach for people who need safeguarding support			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
2.1 There is a multi-agency Safeguarding Adults Board (SAB) of senior level officers who provide strategic leadership and address - **prevention of abuse and neglect** - **promotion of wellbeing and safety** - **effective response to instances of abuse & neglect when they occur**	i) Maintain and develop the role and functions of the WSAB to ensure its effectiveness, including: a) Implement the Care Act and related regulations and guidance, responding to consultations as appropriate b) Confirm the breakdown of costs for the Safeguarding Adults Board and establish a shared budget to meet them. c) Review roles and responsibilities in the light of recently issued joint agencies paper d) Keep Board membership under review e.g. inclusion of Healthwatch and housing providers. e) Ensure continued commitment from partners to the Board and its sub-groups	Quarterly September '14 September '14 Ongoing Ongoing	Chair WSAB meetings/ members All Chair

	ii) Consider and respond to specific guidance/ reports including • SCIE report on Safeguarding in housing • Mental Health Crisis Care concordat • Positive and Safe programme	TBC	Agenda MS / JH
Outcome	**Safeguarding Board is fit for purpose and effective, meeting statutory requirements and responding to good practice advice.**		
2.2 There are robust and current Local Multi-Agency Policies & Procedures for safeguarding adults that are in accordance with statutory requirements	Re-establish an effective Policy and Procedures sub-group, appropriately chaired in order to: a) Update policy and procedures in the light of the Care Act 2014 and regional developments re thresholds b) Re-shape large-scale investigation procedures c) Develop an early stage procedure for providers, including addressing employment issues. d) Ensure that all agencies contribute appropriately to investigations and assessments e) Receive report of council review of its safeguarding function and organisational arrangements for carrying out investigations f)	September '14 March '15 December '15	Chairs of Wiltshire and Swindon boards Policy and procedures sub-group P & P sub-group/ MA and others WSAB Phil Shire/James Cawley

	g) Monitor development of proposals for establishing a Multi-agency Safeguarding Hub (MASH) for adults		Agenda
Outcome	**Policy and procedures are an accurate and effective tool for all who need to use them**		
2.3 Clear leadership and accountability structures are in place and visible throughout the relevant organisations	a) Relationships between WSAB, WSCB and HWB clarified b) Establish regular reporting arrangements to lead Cabinet Member on safeguarding issues c) Present WSAB annual report to Health and Wellbeing Board and Wiltshire Council Cabinet d) Annual Report presented to partner Boards e) Continue to monitor organisational changes and their impact on safeguarding leadership in partner organisations. f) Consider Memorandum of Understanding between WSAB and Wiltshire Care Partnership, once MoU with Wiltshire Council has been established.	September '14 September '14 Autumn December '14 Each meeting TBC	Chair Phil Shire/ James Cawley Chair Board members All Matthew Airey/ Chair
Outcome	**Organisational accountability across the partnership is clear and reporting lines effective**		
2.4 Professionals who in the course of their work come into contact with	Distribute new awareness raising materials to all relevant organisations and follow up their use of them.	When available.	Communications task group/ WSAB

adults at risk and their carers are aware of their safeguarding responsibilities			

Outcome 3. Access & Involvement: People are aware of what to do if they suspect or experience abuse; Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
3.1 There is a comprehensive accessible public information and advice about keeping safe and what constitutes abuse of adults at risk	i) Agree actions from the report of the Communications and Publicity Task Group including:		
	a) Overall Communications Strategy	June ’14	WSAB
	b) Proposals for improved publications	December ’14	WSAB
	c) Proposals for website development	December ’14	WSAB
	ii) Review implementation	Implementation + 6 months	WSAB
	iii) Agree arrangements for maintaining good quality information.	March ‘15	WSAB

Outcome 3. Access & Involvement: People are aware of what to do if they suspect or experience abuse; Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
Outcome	**Improved awareness for communities and adults at risk about safeguarding services and issues.**		
3.2 The involvement and feedback from patients, people using services and their carers is an integral part of the design, commissioning and delivery of safe services	a) Maintain and develop the service user reference group b) Develop a more structured and comprehensive approach to the involvement of informal carers in the work of the Board and safeguarding system. c) Review service user and carer outcomes and involvement across the Board membership. d) Participate in/ receive report on NHS England events re MCA and DoLS	Ongoing December '14 March '15	MS / WSUN MS / CM/ Carers Wiltshire WSAB MS/KE to confirm
Outcome	**Two-way communication well-established between the Board and services users and carers.**		
3.3 Reports of service user involvement and outcomes are a routine part of the Board's Quality	a) Commit to the next stage of the Making Safeguarding Personal project. b) Through this and other means ensure that service user	September '14	Wiltshire Council

Outcome 3. Access & Involvement: People are aware of what to do if they suspect or experience abuse; Local practice and the commissioning of services and support are informed by feedback and satisfaction levels of those who have had experience of the safeguarding process			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
Assurance arrangements	outcomes are routinely identified, monitored and reported.	6 monthly	Agenda
Outcome	**Safeguarding services are identifying and responding to service user wishes, and the WSAB can monitor this.**		

Outcome 4. Responding to Abuse & Neglect: People in need of safeguarding support feel safer and further harm is prevented			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
4.1 Prompt action is taken and appropriate support is provided in response to concerns raised by staff, clients, patients, carers or members of the public	i) Establish Quality Assurance reporting arrangements to the WSAB, as proposed by the QA sub-group, so that the WSAB can monitor this objective and take action as necessary. a) Conduct agency self assessment audits and hold challenge events b) Carry out deep dive case audits across partner agencies to examine quality of practice c) Include opportunities to share good practice d) Assurance about systems to challenge poor practice ii) Understand the role of the Quality Assurance team and	June '14 November '14 October '14	WSAB

Outcome 4. Responding to Abuse & Neglect: People in need of safeguarding support feel safer and further harm is prevented			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
	how it contributes to safeguarding adults. iii) Investigate the increased numbers of alerts and referrals to clarify the reasons for the change	See 1.1 March '15	 QA sub-group
Outcome	**Successes and problems in quality of safeguarding response are identified and acted on.**		
4.2 If the mental capacity to make a specific decision relating to the safeguarding process cannot be assumed a Mental Capacity Assessment is undertaken as required by the Mental Capacity Act (MCA) 2005	Receive regular reports on MCA/ DoLS activity, including briefing on national policy and case law, including Supreme Court judgement. Commission audit of MCA assessments in the context of safeguarding. • MS to obtain audit method • Agree timing and report of audit	 August '14 September '14	Julie Mills/PS MS MS/JB/PS
Outcome	**Service users' views are appropriately represented in safeguarding processes**		
4.3 The subject of the alleged abuse is the main focus of all actions and proceedings that arise during the course of any enquiries and/or investigations.	See actions under Section 3 above		

Outcome 4. Responding to Abuse & Neglect: People in need of safeguarding support feel safer and further harm is prevented			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
4.4 Adult Safeguarding Investigations are appropriately resourced and supported	i) Review agencies' resources to service safeguarding work in the light of: a) The surge in alerts and referrals b) The requirements of the Care Act, Regulations and Guidance and the national agreement on roles and responsibilities. ii) Respond to service user proposal that further follow up is needed after safeguarding investigation and action		
Outcome	**Resource problems identified promptly and addressed appropriately.**		
4.5 Follow up to Serious Case Review re Winterbourne View Hospital	Continue to monitor the actions from the Serious Case Review of Winterbourne View Hospital and respond to any further requirements of the Joint Improvement Programme.	Six monthly	Agenda
Outcome	**Agreed plans are completed in service user interests and confident responses made to JIP.**		

Outcome 5. Training & Professional Development: Staff are aware of policies & procedures, their practice safeguards adults and promotes understanding of harm			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
5.1 All staff and volunteers working with adults at risk	Implement SAB Strategy for Competence Development a) Confirm arrangements to monitor training both at Board and individual organisation level	September '14	L & D sub-group

Outcome 5. Training & Professional Development: Staff are aware of policies & procedures, their practice safeguards adults and promotes understanding of harm			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
have been appropriately trained according to their role	b) Keep SAB's own training needs under review c) Identify further development needs from capabilities framework d) Agree appropriate training for provider managers with responsibilities to investigate safeguarding allegations or incidents e) Ensure safeguarding is or continues to be part of induction for elected members and Board members.	Ongoing TBA	Chair L & D sub-group
Outcome	**All staff and volunteers can respond appropriately to adults at risk**		
5.2. All staff and volunteers have the appropriate knowledge and competencies in relation to safeguarding adults	a) Safeguarding adults training is competency based, in line with the National Capability Framework for Safeguarding Adults (2012) b) Safeguarding adults training links to professional development and appraisal systems. c) Safeguarding adults training is informed by local and national lessons learned d) Develop plan for training on the safeguarding aspects of the	Ongoing Ongoing Ongoing December '14	L & D sub-group L & D sub-group L & D sub-group L & D sub-group

Outcome 5. Training & Professional Development: Staff are aware of policies & procedures, their practice safeguards adults and promotes understanding of harm			
Key Objective	**Actions required to address / meet the objective**	**By When**	**Lead Responsibility**
	Care Act 2014, including a stakeholder conference		
Outcome	**Training is kept current and linked to awareness raising about safeguarding adults and the Care Act**		
5.3 Staff use routine processes to enable people to acknowledge when they might be at risk and signpost them to effective support	Task group to consider and recommend actions.		

Appendix 6 -Glossary of Terms and Definitions[7]

Abuse

Abuse is a violation of an individual's human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

Age

Age is calculated as at the last day of the financial year (the full reporting period), i.e. 31st March or if the person has died before 31st March, their age will be reported as their age at date of death. A ***Younger Adult*** (YA) is a person aged between 18 – 64 years; an ***Older Person*** (OP) is a person who is aged 65 years and over.

Alert

An alert is a feeling of anxiety or worry that a Vulnerable Adult may have been, is or might be, a victim of abuse. An alert may arise as a result of a disclosure, an incident, or other signs or indicators.

Alleged Perpetrator

The alleged perpetrator is the person who the Vulnerable Adult, or other person/s, has asserted but not yet proven to have committed the abuse.

Ethnicity

Black, Asian and Minority Ethnic (BAME) encompasses all people who are not White British including: White Irish, White Other, Traveller of Irish Heritage, Gypsy/Roma. Gypsy/Roma includes Gypsies and or Romanies, and or Travellers, and or Traditional Travellers, and or Romanichals, and or Romanichal Gypsies, and or Welsh Gypsies/Kaale, and or Scottish Travellers / Gypsies, and or Roma. It includes all people of a Gypsy ethnic background or Roma ethnic background, irrespective of whether they are nomadic, semi nomadic or living in static accommodation. It should not include Fairground people (Showmen/women); people travelling with circuses; or Bargees unless, of course, their ethnic status is that which is mentioned above.

Known to DCS

Those customers who are assessed or reviewed in the reporting year and who have received a service, as well as those who are assessed and/or reviewed but who have not

[7] With the exception of those annotated * these definitions are reproduced courtesy of: Information and Guidance on the Abuse of Vulnerable Adults Collection (AVA), 2009, The Health and Social Care Information Centre, NHS.

received a service in that reporting year. This group includes customers receiving Direct Payments or an Individual Budget.

Gender

For the purpose of this report the gender shall be defined as 'male' or 'female'. In line with the Gender Recognition Act, transsexual people should be recorded under their acquired sex.

Not Determined/Inconclusive

This would apply to cases where it is not possible to record an outcome against any of the other categories. For example, where suspicions remain but there is not clear evidence.

Not Substantiated

It is not possible to substantiate on the balance of probabilities any of the allegations made.

Referral

A 'Referral' is an Alert which becomes a 'Referral' when the details lead to an adult protection investigation/assessment relating to the concerns reported (these relate to safeguarding referrals, not a referral for a community care assessment).

Repeat Alert

A repeat alert is a safeguarding alert, where the vulnerable adult about whom the alert has been made, has previously been the subject of a safeguarding alert during the same reporting period.

South West Local Authorities*

Bath & North East Somerset	Bournemouth	Bristol
Cornwall (incl. Isles of Scilly)	Devon	Dorset
Gloucestershire	North Somerset	Plymouth
Poole	Somerset	South Gloucestershire
Swindon	Torbay	Wiltshire

Substantiated

All of the allegations of abuse are substantiated on the balance of probabilities.

Vulnerable Adult

A Vulnerable Adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take

care of him or herself, or unable to protect him or herself against significant harm or exploitation in any care setting. This includes individuals in receipt of social care services, those in receipt of other services such as health care, and those who may not be in receipt of services. There is a danger that some Vulnerable Adults who are at risk but do not easily fit into the aforementioned categories may be overlooked, for this reason they are outlined below:

- Adults with low level mental health problems/borderline personality disorder
- Older people living independently within the community
- Adults with low level learning disabilities
- Adults with substance misuse problems
- Adults self-directing their care